St George's University Hospitals NHS
NHS Foundation Trust

Trust Board Meeting (Public)

Thursday 1st September 2016 commencing at 10am
H2.8, 2nd Floor Hunter Wing, Boardroom 8

Item	Time	Item	Owner:	Board Action	Paper No:
PATIENT STORY					
Board Business					
1.		**Welcome and Apologies**	Sir D Henshaw	Apologies received from Richard Hancock, Andrew Rhodes, Jenny Higham, Luke Edwards, Larry Murphy	-
2.		**Declarations of Interest**	All	Board Members to declare any pecuniary or non-pecuniary interest in particular agenda items, if appropriate	-
3.		**Minutes of the meeting**	Sir D Henshaw	To consider the Minutes of the previous meeting held on 28th July 16 and check for amendments and approve	TB Sept 16 - 01
4.		**Key Issues**	All	Board members to identify any key issues	
5.		**Schedule of Matters Arising**	Sir D Henshaw	To discuss any matters arising from previous meetings and provide updates and review where appropriate	TB Sept 16 - 02
6. Patient, Safety, Quality and Performance					
6.1		**Performance & Quality Report**	M Gordon/H Tonge	To inform the Board about the latest performance and quality report.	TB Sept 16 - 03
6.2		**Workforce & Performance Report**	K Charman	To inform the Board about the latest position on workforce and present new focused set of priorities	TB Sept 16 - 04
6.3		**RTT Report**	M Gordon	Monthly update	
6.4		**Estates**	J Doman	Monthly update	TB Sept 16 - 05
6.5		**Complaints Action Plan**	H Tonge	Update	TB Sept 16 - 06
7. Transformation					
7.1		**Outpatient Programme presentation**	S Sewell	Progress update (including EDM and e-prescribing)	TB Sept 16 - 07
7.2		**Interim Resourcing**	I Lynam	Update	TB Sept 16 - 08

Item	Time	Item	Owner:	Board Action	Paper No:
7.3		**Update from Turnaround Board**	I Lynam	Update	TB Sept 16 - 09
8. Finance and Performance					
8.1		**Finance Report – month 4**	N Carr	To inform the Board about the latest project outturn	TB Sept 16 -10
8.2		**Finance & Performance Committee**	Sir David	To inform the Board about the key issues arising from the Committee	TB Sept 16 - 11
09. Governance and Risk					
9.1		**Risk and Compliance Report**	P Moore	To review the Trust's most significant risks and external assurances received	TB Sept 16 - 12
10. Items for Information					
10.1		**Use of the Trust Seal**	Sir David	To note use of the Trust seal in August 2016 – The seal was used on 24th August – Project Argreement for Cellular Pathology managed Service	
10.2		**Questions from the Public**		Members of the public present are invited to ask questions relating to business on the agenda. Priority will be given to written questions received in advance of the meeting	
10.3		**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 6th October 2016 at QMH

St George's University Hospitals NHS
NHS Foundation Trust

Minutes (draft) Trust Board

Minutes of the meeting Trust Board of St George's University Hospitals NHS Foundation Trust, held on Thursday 28 July 2016 in Boardroom H2.7 commencing at 10am.

PRESENT

Sir David Henshaw	DH	Chairman
Sarah Wilton	SW	Non-Executive Director
Stella Pantelides	SP	Non-Executive Director
Jenny Higham	JH	Non-Executive Director
Simon Mackenzie	SM	Chief Executive Officer
Iain Lynam	IL	Chief Restructuring Officer
Richard Hancock	RH	Director of Estates and Facilities
Andy Rhodes	AR	Medical Director
Nigel Carr	NC	Chief Finance Officer
Paul Moore	PM	Director of Quality Governance
Justin Richards	JR	Divisional Chair, Children's and Women's,
Alison Benincasa	AB	Divisional Chair, Community Services
Lisa Pickering	LP	Divisional Director of Medicine and Cardiovascular
Luke Edwards	LE	Head of Corporate Governance
Chris Rolfe	CR	Associate Director of Communications
Jacqueline McCullough	JMC	DD Workforce and OD, Item 6.3

Agenda Item	Action

1. Welcome and Apologies

The Chair opened the meeting. Apologies were received from Sir Norman Williams, Gillian Norton, Jennie Hall, Karen Charman, Larry Murphy and Corrine Siddall.

2. Declarations of Interest

No declarations of interest, pecuniary or non-pecuniary, were received.

3. Minutes

The Board considered the minutes of the last meeting held on 2 June and noted some minor amendments.

Resolved that the Board**:** approved the minutes as a true and accurate record as amended.

4. Matters Arising

The Board noted the matters arising:

- AB confirmed that 7.4 had been completed;
- IL confirmed that 8.4 would be included within the wider outpatients review at the next Board; and
- AB confirmed that the public question from Barbara Bohana (June Minutes, Section 12) had been passed to the CCG for a response.

6 PATIENT SAFETY, QUALITY AND PERFORMANCE

6.1 CQC Update

DH updated the Board that further helpful discussions had taken place with the CQC last week and the report was now expected toward the end of August. PM summarised his paper noting the areas of good practice and concern and focusing on the areas where the CQC had required immediate assurance.

The Trust had successfully provided sufficient assurance to CQC to avoid enforcement action with respect to Buckland Ward and fire detection, fire separation and water treatment in Lanesborough Wing. RH then summarised the immediate action taken which had included repairing the roof, ensuring that senior nursing staff undergo fire awareness retraining, stopping the use of beds affected by the risk of electric shock from water ingress. There had been two inspections from London Fire Brigade who provided a satisfactory report to CQC. The Trust is enacting a plan to relocate renal services with inpatient facilities moving to Champney's Ward in September and some outpatients moving to community satellite services at Colliers Wood, North Wandsworth and Kingston.

The CQC had also identified concerns with the high density of clinics in Lanesborough outpatients. However, following further detailed work we have agreed that, in view of the significant level of risk associated with a complete move, a revised plan will be adopted which will see fewer clinics move out over a longer period of time. This avoids the major disruption to services that would have been the result of moving all outpatients and will sufficiently mitigate the risk.

PM summarised the work to improve governance, including the creation of the Director of Quality Governance role. There are a number of actions that have been put in train including work to develop the Board Assurance Framework, improve the visibility of risk exposure and control, and build a Quality Improvement Programme (QIP). PM will be the Programme Director for the QIP this this will be brought forward to the Board in due course. PM noted finally that urgent action was being undertaken to stabilise the risk around the clinical prioritisation of referrals. This would be discussed in more detail later in the agenda.

Resolved: that the Board noted the update and next steps.

6.2 Performance and Quality Account

AR introduced the report in CS's absence. He noted that the Trust was struggling to deliver all three access targets (cancer, referral to treatment and 4 hour emergency department standard). For cancer the two week wait standard and 62 day standard remained problematic. RTT data performance was only 88% against the target of 92% notwithstanding the further significant challenges around the data quality. The focus for RTT is on pathway and capacity management and we have been worked with commissioners to redirect demand and reduce the load. Although the trust was not meeting the 4 hour ED standard performance had improved to 94% and remained above the trajectory agreed with commissioners. However there remained some way to go to ensure stability particularly over the winter period. There had been a number of unusually busy days recently which had impacted on performance. A new performance management framework is being developed which will ensure the issues are gripped by the Divisions.

SW highlighted her concern that the number of outstanding items of NICE guidance had increased and asked whether there were risks to patient safety. AR and LP agreed this was an important quality metric and further work was required. A new process would be applied going forward to ensure the issues were managed effectively building on the Serious Incident model. It was possible that many areas are compliant but not providing the necessary paperwork. HT noted that the clinical audit team are working with divisions to address the backlog. DH recognised the points made however he required clear evidence that compliance was greater than indicated before the Board could accept this. SM shared the Chair's concerns and reiterated the intention to make significant changes to the way in which the Executive Team related to the divisions.

SW also noted her continued concerns around complaints performance. SM highlighted that fact that many of the responses themselves were unsatisfactory and he had asked for them to be re-drafted. DH was clear that issues such as these need to be addressed. The trust had reached a good position with the regulators and that we needed to take responsibility for addressing poor performance. The report needed significant development as it explained the problem not what was being done. He expected to see real evidence of change going forward and complaints was an example of the type of problem that needed to be fixed. He asked PM to provide any early reflections.

PM felt that the information provided to the Board did not easily enable the Board to understand the position, risks and level of control and that the information provided in the performance report was lacking in a number of key areas. SM added that the Executive Management Team had discussed the report and felt it did not provide either assurance to the Board or the information necessary to enable the effective running of the organisation. An improved version would be provided for next month with further development thereafter. SW

asked that the staff staffing information to be improved and integrated with the ward heat map. AB noted that an appropriate methodology should be adopted for safe staffing in the community.

CS/HT Sept 16

Resolved: that the Board noted the report and asked for a revised report to be put forward to the next Board

6.3 Workforce Performance Report

Jacqueline McCullough joined the meeting. She summarised the report identifying the negative trend in turnover and increase in temporary staffing usage. More positively there had been continued progress in mandatory training compliance and reduction in staff sickness levels. The increase in temporary staffing is mainly the result of the trust improving its recording through the increased use of health roster. Progress has been made in resolving acting up arrangements that have lasted for more than six months. SW was disappointed that turnover had increased, stability had reduced and temporary staffing usage had increased. She asked what the trust was doing to improve staff engagement. DH felt the issues were brought together well in the CQC report and in particular the issue around staff, in particular BAME staff, not being able to challenge needed to be addressed. It was encouraging that staff felt loyal to the organisation but they needed to be better led. JMC noted that KC had been working with the team on developing a new focused set of priorities. These will be presented to the next trust board.

KC Sept 16

SM drew to the Board's attention that to fact that while the staffing profile had increased and this had not been accompanied by a reduction in temporary staff or additional income generating activity. DH felt that workforce controls needed to be much tougher and focused on value for money with a clear clinical priority. SP asked whether divisions had the finance data they required. NC confirmed that the data was available but that it is was not sufficiently used.

6.4 Quality and Risk Committee

JH summarised the key issues discussed at QRC for the Board. It has not been possible to produce a written report in view of the close proximity of the two Boards There were a number of overarching issues including actions not being closed down and the slowness of the response on complaints and adverse incidents. It was noted that the Recovery at Home presentation was not made to QRC. Other areas discussed included: that there were a variety of data sources regarding thromboprophylaxis and this needed to be resolved; the Clinical Audit programme needed to be reviewed and more effectively linked to key risks; the SI Report would be developed and focused on lessons learned; the Freedom to Speak Up Guardian appointment process was agreed and would be taken forward as a matter of urgency; and the health, fire and safety report would be developed to be more proactive. The important work of the feeder Committees was considered, in particular the work on patient experience and the terms of reference would be reviewed more fully.

6.5 RTT Update

SM introduced the item in CS's absence. The Quality Assurance Board, led by commissioners and regulators, had taken an update on the issue and it was clear they would like us to be going faster. Recruitment had been challenging but an appointment had now been made at Associate Director level to drive the work forward on a day to day basis. Work was on going to identify and Executive Director level appointment and procure a technical partner. AR was leading the work to set up the clinical harm review process and the aim was to ensure that all new referrals get a 'clock start' clearly recorded. The Health Service Journal had requested a copy of the MBI report and other documentation and we can expect them to run a story. This has the potential to be picked up by the national media.

AR updated the Board on the clinical harm review process reminding the Board that there was a patient behind every number. The NHSI national framework would be used to guide the work and cases would be reviewed through virtual clinics. This inevitably had potentially significant resource and capacity implications.

DH highlighted that this was a very significant issue and a major concern for the trust and the wider NHS. The key was to manage the problem as best as one can now it had been identified. As the data is disaggregated it was likely that the volumes will reduce dramatically due to double counting. DH was satisfied that we have a robust approach.

SW supported the actions identified in the paper but asked that they been developed into a more detailed plan. DH asked that a report comes each month to ensure that the Board retains effective oversight.

Resolved: that the Board noted update was and agreed that monthly reports would be provided

CS
Sept 16

6.6 Vascular IR Update

AR introduced the item reminding the Board that Guys and St Thomas's (GSTT) had identified concerns over the safety of the service last month. These concerns were being managed on a daily basis and work is on-going to develop a longer term plan. The workforce issues were being tackled and the trust is exploring the scope for networking with NHSI support. One option is a South London vascular network run by GSTT with a hub at St Georges.

LP added that the response to the mediation sessions had been positive and this gave a good platform for moving forward. Ensuring safe rotas remained a challenge but they were in place to the end of August and probably beyond. DH said that he had had feedback confirming that the mediation had been positive.

Resolved: that the Board noted update

7. FINANCE

7.1 NC summarised the report for the Board. The trust was £4.1m deficit in month 3 which was £1.5m adverse to plan. The year to date deficit is now £16.5m which was less than £1m below the control total of £17.2m. These figures assume that we accrue the STF funding and while the guidance for Quarter 1 remains unclear we are clearly in a very challenging position.

The month has seen the highest SLA income performance this year however expenditure continues to increase as a result of pay overspends. The trust is exceeding the Agency cap by £1m a month although some of this is due to high cost interims and it is not clear whether the agency cap is intended to capture this type of expenditure. A re-phasing of the Cost Improvement Programmes had been undertaken with a revised full year forecast of £34m against an original projection of £42.7m. At a divisional level medicine and cardiovascular and surgery are underperforming which key issues including theatre utilisation and outsourcing. Recovery meetings are due to be held next week with both areas. Cash is £3.5n better than plan due to improved management.

SW note that the CIP programme is £8m adrift at the end of quarter 1 and asked whether targeting savings of £50m by the end of the year was realistic. NC responded by saying £50m was an appropriate target but a full year value of £50m of savings realised in 2016/17 was likely to be unrealistic at this point. Action was being taken to strengthen the PMO to increase the likelihood of delivery. IL added that the current position was unsatisfactory but the aim was to target new opportunities. The focus on the CQC may have meant that some pace was lost.

DH was clear that the trust had to live within its means. This meant both focusing on running the day to day operations better and transforming the hospital longer term. There needed to be a focus on the 10 or so 'big ticket items'. For example, around £1m of work that is sent out monthly however we do not maximise theatre utilisation. Similarly action needs to be taken to manage headcount, particularly in the back office.

SP noted the positive signs around outpatients and questioned whether there are sanctions for not complying with the agency cap. NC noted that the agency cap was part of the STF criteria but also it would make the case for securing any additional funding more challenging. IL noted that we needed to do more work to define the expenditure that we felt should be covered by the agency cap as related to its original objective. SW asked that the Board be kept sighted on the cash flow position going forward and that this is stress tested.

Resolved: that the Board noted update and agreed that urgent corrective work was required.

8 Governance and risk

8.1 Risk and Compliance Report

PM updated the Board on his work to review the corporate risk register. He was not satisfied that it was fit for purpose in its present form and felt it needed to be more focused on the key risks. The conversation needed to be more focused on the treatment of the risk and the effectiveness of internal controls. The review had not concluded but the risks can be distilled into a small number of areas: ensuring patients had timely access to services, encompassing the key targets; the fragility of IT and estates; financial sustainability, encompassing the deficit and CIP; and the adequacy of governance. A Board Assessment Framework would be developed to provide a strategic overview and the format of the risk report would be developed. The detail relevant risks would also be scrutinised by the appropriate Sub-Committees of the Board going forward.

SW felt that the review was moving in the right direction but was surprised by some of the changes proposed on the scoring. PM noted that the simplified scoring methodology provided a different view and agreed to discuss this with SW in more detail outside the meeting. DH welcome the progress and felt like the Corporate Risk Register was moving beyond being a list of worries and towards an appropriate process with clear accountabilities. SP noted that the workforce cluster continues to merit focus and attention by the Executive.

Resolved: that the Board noted update and the progress made.

9 Items for Information

9.1 Capital Bid to NHSI

This was noted by the Board

9.2. Use of the Trust Seal

The use of the trust seal was noted.

9.3. Questions from the Public

Questions were raised regarding: the overall financial position of the trust in the context of the wider NHS position and specifically around the PFI liability; the reasons why theatres were not being fully utilised and around the extent of stakeholder engagement and support from CCGs. The focus on addressing the fire safety concerns was also welcomed.

DH noted that the overall position of the NSH was not within the trust's gift to influence however it was important that we made best use of the resources that were available and this would strengthen the case for additional resources. NC added that he had identified an external partner to review the PFI contract and explore the scope for better re-financing.

The Board was taking a presentation on theatre productivity in private.

There were likely to be a myriad of reasons as to why this was sub-optimal and the key at this stage was to focus on improvements. A new approach would be implemented from 1st August to address the problems.

The trust has focused on developing the relationship with the CCGs as this was an area that required improvement. This is now starting to happened supported by greater transparency. We have a new relationship with GPs and are working with them on the retendering of community services. Equally there remained challenges we needed them to address and again this had started. For example the joint work to address the 14,000 regular attenders at the emergency department, many of whom could be more effectively managed through default pathways in the community which would also release pressure on trust. Overall there was a lot more to do but the Strategic Transformation Plan had identified the trust as a fixed point and there was a recognition that we were at the start of the recovery process.

11. Date of next meeting

The next scheduled meeting of the Board to be held in public will be 1st September 2016.

St George's University Hospitals NHS
NHS Foundation Trust

Matters Arising/Outstanding from Trust Board Public Minutes

1st September 2016

Action No.	Date First raised	Issue/Report	Action	Due Date	Responsible officer	Status at Sept 2016
7.5	5 May 16	PPI/PPE Action Plan	Board agreed with the Strategy. JH to set out an action plan working with Patient representatives.	Sept 16 deferred to October 16	S Banks / H Tonge	
8.4	5 May 16	2015/16 Annual Plan Q4 Review and End of Year Summary	RE agreed to provide an update on the EDM and e-prescribing projects following the Board.	June 16	I Lynam	To be included in the wider Outpatient review at the next Board **On Agenda**
6.1	2 June 16	Patient Safety, Quality and Performance (Quality Report)	A ELOC strategy will be developed and the Board will be updated in 3 months on the longer term plans.	Oct 16	H Tonge	
6.2	28 July 16	Performance & Quality Account	The Board felt it did not provide either assurance to the Board or the information necessary to enable the effective running of the organisation. An improved version would be provided for next month with further development thereafter	Sept 16	C Siddall/H Tonge	**On Agenda**
6.3	28 July 16	Workforce Performance Report	New focused set of priorities to be presented to the board	Sept 16	K Charman	**On Agenda**
6.5	28 July 16	RTT Update	The Board supported the actions identified in the paper and asked they are developed into a more detailed plan. A report is to be submitted each month to ensure the Board retains effective oversight.	Monthly	M Gordon	**On Agenda**

St George's University Hospitals NHS
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REPORT TO TRUST BOARD

Paper Title:	Quality Report to Month 4. July 2016
Sponsoring Director:	Hazel Tonge - Acting Chief Nurse/ Director Infection Prevention and Control Andrew Rhodes- Medical Director Mark Gordon- Chief Operating Officer
Authors:	Hazel Tonge Acting Chief Nurse/ DIPC Andrew Rhodes- Medical Director Peter Riley- Infection Control Lead Corporate Nursing Team Divisional Directors Nursing/ Governance Trust Safeguarding Leads Head of Performance
Purpose:	To inform Board about Quality Performance for Month 4.
Action required by the board:	To note the report and key areas of risk noted.
Document previously considered by:	EMT

Executive summary

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

(Note: Cancer performance is reported one month in arrears, thus June performance is reported in July)

Cancer Two Week Wait Standard

The trust did not meet the 93% standard in June with performance of 90.0%. However, a positive performance improvement trend has been observed over the quarter. The standard was not met due to underperformance in the following specialties: Breast, Haem, Head and Neck, Lung, Skin, Upper GI and Urology. Key reasons cited for breaches were patient choice and capacity constraints. The trust is working with commissioners to improve communications with patients in a primary care setting.

Specialties are working to address capacity shortfalls and the project to deliver bookings by day 7 is underway.

Cancer Breast Symptom Two Week Wait Standard

The trust did not meet the 93% standard in June with performance of 85.98%. The standard was not met as there were issues with access to the one-stop screening service, due to the number of bookings in June following having taken on the QMR service. This has now been resolved and performance is back at previous levels and the activity has now been normalised. An activity plan has now been agreed which will allow for robust delivery of the standard.

Cancer 62 Day Standard

The trust did not meet the 85% standard in June with performance of 81.6%. Again, a positive performance improvement trend has been observed over the quarter. The standard was not met due to underperformance in the following specialties: Gynaecology, Head and Neck, Lung, Upper GI, Lower GI and Urology. Key reasons cited for breaches were: patient choice, capacity constraints, delays in working-up patients, referrals being received from other trusts with no information, a number of patients being on complex diagnostic pathways, and increased demand and impact on diagnostics

related to growth in referrals.

The Trust continues to follow the agreed recovery programme primarily focusing on enhancing PTL development, validation and improving tracking processes.

RTT Incomplete Pathways Standard
The trust did not meet the 92% standard in July with performance of 87.52%. The overall waiting list size and backlog size have also increased this month.

The trust reported 6 patients waiting 52+weeks at end July. These were in the following specialties: Urology, Trauma & Orthopaedics, Gynaecology and Gastroenterology. Root cause analysis investigations are being undertaken for these patients.

RTT remains a challenge and the trust acknowledges the importance of not just reducing long waiters but achieving a position of sustainability. The RTT external review by MBI has been concluded and a findings report provided to commissioners and regulators on June 30th. An RTT recovery programme and supporting structures are being put in place.

ED 4 Hour Standard
The trust did not meet the 95%standard in July. However great improvement and significant increase in performance has been seen since April. In July the trust achieved 94.4% within 4 hours which is an increase of 0.4% compared to June and also above the STF trajectory.

Contributing factors to ED performance were: Capacity and bed flow, delays in ED assessment and treatment, increase in the number of DTOC patients and an increase in the number of patients who were medically fit for discharge. These included patients awaiting transfer to another provider and patients going home that day. The trust is working with commissioners and external agencies to expedite this.

The trust continues to monitor progress against its recovery plan and trajectory with both external and executive oversight via the Flow Programme Board.

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

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

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

The report highlights the key quality metrics which have been reported during 2016/17 In terms of Quality Metrics, the Overall position in July 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 unchanged. The latest SHMI shows our mortality to be as expected and our HSMR is better than expected. The trust has been accepted as a pilot site for the National Mortality Case Record Review (NMCRR) programme. This project is being run by the RCP, with the aim of establishing and implementing a standardised methodology and process for retrospective case record review for adult acute care deaths.
- National Audits within the report: The first report examines the care of paediatric patients with diabetes. HbA1c is the primary indicator of diabetes control and this is below the national mean at SGH, along with SWL peers. Actions around education are described and will be enhanced by the recent appointment of a new dietician. The second report concerns paediatric vital signs in ED. This was based on a sample of 50 patients. Local

and national results show the need for improvement around full sets of observations. Locally, good practice was reported for taking action in response to abnormal vital signs, with compliance at 100%. Multiple actions are underway to address training and education, and to strengthen documentation and electronic systems to prompt best practice. Local re-audit is planned for September.

- Local audits included: Quarterly health records audit - participation fell and only one of 5 key standards was met. There remains variation in performance and there is little consistent improvement over time. Actions are required locally, including greater use of patient labels and name stamps. A programme of audit in response to a number of incidents of retained swabs was undertaken in obstetric theatres. Monthly audits conducted since April show that compliance has improved and now stands at 99.8%. The annual consent audit is also reported, demonstrating compliance with explanation of risks and benefits; however, documentation of possible extra procedures decreased to 33%. Competency to take consent was confirmed in 88% of cases, but could not be determined in the remaining cases. A clinical lead is required to help take this audit forward.
- The review of all NICE guidance continues. The number of outstanding items of guidance continues to fall and stands at 62. The audit team have prioritised this work and are collaborating with divisions; this month the emphasis will be on historic guidance. As part of the Quality Improvement Plan, the team are developing a process for publication and corporate oversight of clinical guidelines on the Trust intranet. This will incorporate NICE guidance, in addition to other national and local guidelines.

Safety Domain:

- Safety Thermometer performance improved with 94.78% of patients receiving harm free care. The number of new harms halved, and all types of harm decreased, other than old catheter associated UTIs.
- The number of general incidents reported continues to rise in the no harm category, generally this is thought to show a good reporting culture. In other categories there is a similar trend to previous months reporting. SI's reported for July were 6 and these are across a range of clinical issues, including Unexpected death (n3) Delay to respond to adverse test results (n1) misdiagnosis (n1) and retained foreign object (n1).
- Following a rise last month in declared pressure ulcer Si's we have returned to zero in July. With regard to grade 2 pressure ulcers there was a small rise from the acute but a significant reduction in those reported within the community sector. Overall there is a continued improvement in acquired pressure ulcers when compared to last financial year (2015/16 48 by month 4 2016/17 30).
- No further MRSA bacteraemia cases were reported for July and we remain on track to meet threshold of zero cases in the year 206/17. There are now a total of 7 C-Difficile cases to the end of July, with 2 trust apportioned cases reported for this month. Therefore we remain on target to meet the annual Trajectory for C Difficile which is set at 31 cases for 16/17. All cases are currently subject to an RCA process.
- Falls incidence has remained at a similar level to June. Work is on-going regarding actions identified in the QIP and includes reviewing training, audit and the policy around bed rails. A best practice guide for bed rails assessment and supply has been developed for the CARE folders on each ward
- VTE compliance from electronic records for July was 96.9%, safety thermometer data showing 95.7% compliance.
- Safeguarding Adults compliance for training remains a key area of focus. The Trust is now demonstrating a compliance of 84% for adult training. There continues to be a steady increase in compliance though we remain below target of 85%. Divisions have similar figures with community achieving highest rate of 87%. MCA drop in training continues to be rolled out across the trust with work being undertaken on an e learning package.
- Safeguarding Children compliance shows Medcard have significant improvements to be made with compliance at only 43%, CWDT have also slipped to 83% compliance. Of note however is evidence showing that staff who are known to be compliant are not recorded as such on ARIS, the Safeguarding Children team are continuing to take an in-depth look at the level 3 training figures on ARIS. In addition, the safeguarding team will be working with the MAST team, area department leads and HR to ensure that staff are allocated the

appropriate level of training this will start in September 2016.

Experience Domain:

- Friends and Family Test. This report draws data from all patient surveys conducted on the RaTE system; including accessible versions that were created for any patient that would have trouble understanding the standard survey question. Further breakdowns are available for services and location type. The Trust achieved 95% overall a slight rise on last month, all divisions with the exception of Community saw a small rise in patients who would recommend our services.
- 83 complaints were received in July which is the second consecutive rise since May. Turnaround times for responses to complaints showed a slight increase to 62% responded to within 25 working days, however remains significantly lower than trust target of 85%. There is a separate update on progress against action plan for presentation to the board.

Well Led Domain:

- The safe staffing return is included for all inpatient areas. The average fill rate for the Trust is 95.53 % across these areas against current staffing figures which are a slight increase on the previous month. There was a significant decrease in final alerts, from 15 in June to 6 in July with Medicine showing an increase and the highest amount of alerts, all other divisions remained static or showed a decrease. The number of alerts reduced to a concern (ward is safely staffed but some care needs will not be completed) following on the day investigation was higher at 12.
- There have been no mixed sex breaches in July

Ward Heat map:

July Heat Map and Scorecard is included for acute and community services

Risks identified:

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

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

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

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

Month 4 – July 2016

Excellence in specialist and community healthcare

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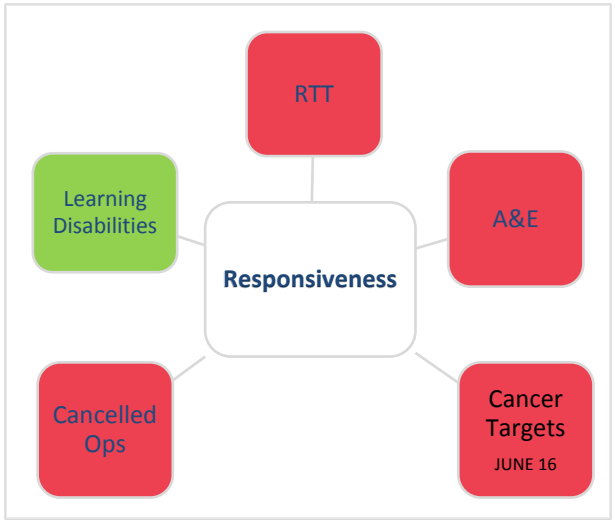
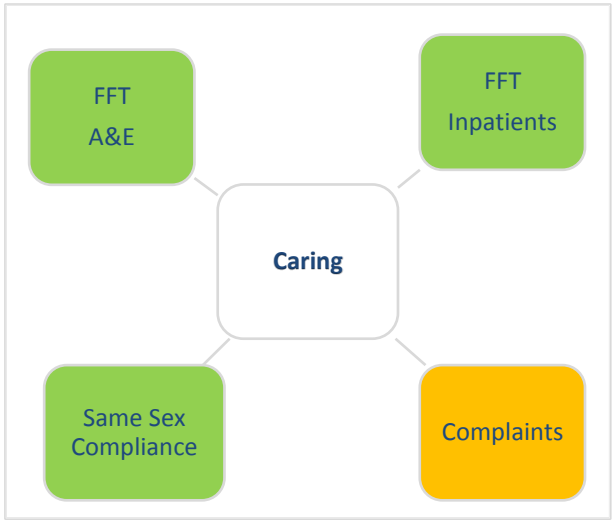
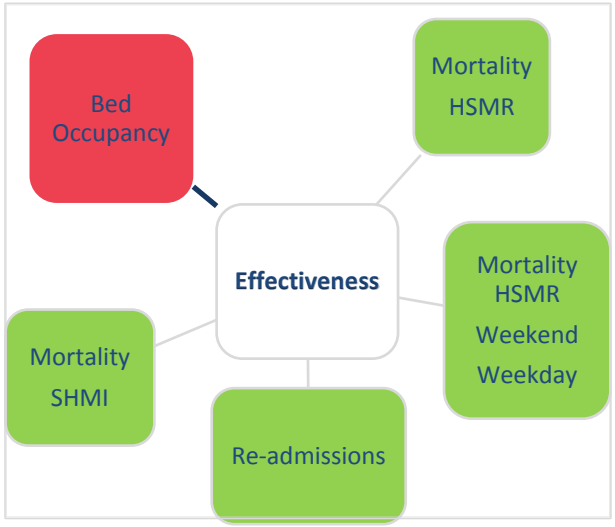
Performance against Frameworks

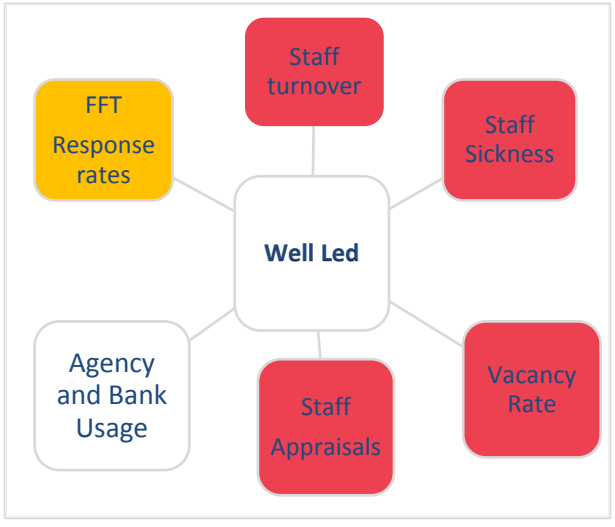
Excellence in specialist and community healthcare

1. Executive Summary - Key Priority Areas July 2016*









The above shows an overview July 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 June 2016 as reported one month in arrears)

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

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

ACCESS

Metric	Standard	Weighting	Score	YTD	Jun-16	Jul-16	Movement
Referral to Treatment Admitted	90%	N/A	N/A		69.80%	67.21%	-2.59%
Referral to Treatment Non Admitted	95%	N/A	N/A		88.50%	81.69%	-6.81%
Referral to Treatment Incomplete	92%	1	1		88.30%	87.52%	-0.78%
A&E All Types Monthly Performance	95%	1	1	93.10%	94.00%	94.40%	0.40%
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Q4**	**Q1**	**Movement**
62 Day Standard	85%	1	1	80.60%	82.95%	80.60%	-2.35%
62 Day Screening Standard	90%			91.50%	90.16%	91.50%	1.34%
31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%		0	97.80%	95.89%	97.80%	1.91%
31 Day Standard	96%	1	0	97.80%	95.02%	97.80%	2.78%
Two Week Wait Standard	93%	1	1	88.30%	91.72%	88.30%	-3.42%
Breast Symptom Two Week Wait Standard	93%	1		90.80%	95.35%	90.80%	-4.55%

OUTCOMES

Metric	Standard	Weighting	Score	YTD	Jun-16	Jul-16	Movement
Clostridium(C.) Difficile - meeting the C.difficile objective (de minimis of 12 applies)	31	1	0	7	2	2	0
Certfication of Compliance Learning Disabilities;							
Does the Trust have mechanism in place to identify and flag patients with learning disabilities and protocols that ensure the pathways of care are resonably adjusted to meet the health needs of these patients?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust provide available and comprehensive information to patients with learning disabilities about the following criteria: - treatment options; complaints procedures; and appointments?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to regulary audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Compliant	1	0	Yes	Yes	Yes	
Data Completeness Community Services:							
Referral to treatment	50%	1	0		54.6	53.2	-1.4
Referral Information	50%	1	0		87.4	87.2	-0.2
Treatment Activity	50%	1	0		70.9	71.5	0.6
Trust Overall Quality Governance Score					4	4	0

July 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.

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. Q1 relates to period Apr to June-16.

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

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

2. Trust Key Performance Indicators 2016/17: July 2016 Performance (Page 1 of 1)

RESPONSIVENESS

Metric	Standard	YTD	Jun-16	Jul-16	Movement
Referral to Treatment Admitted	90%		69.80%	67.21%	-2.59%
Referral to Treatment Non Admitted	95%		88.50%	81.69%	-6.81%
Referral to Treatment Incomplete	92%		88.30%	87.52%	-0.78%
Referral to Treatment Incomplete 52+ Week Waiters	0	17	6	6	0
Diagnostic waiting times > 6 Weeks	1%		0.99%	0.82%	-0.17%
A&E All Types Monthly Performance	95%	93.1%	94.0%	94.4%	0.40%
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%		14.77%	8.93%	-5.84%
Certification against compliance with requirements regarding access to health care with a learning disability	Compliant	Yes	Yes	Yes	

Metric	Standard	YTD	May-16	Jun-16	Movement
62 Day Standard	85%	80.60%	77.50%	81.60%	4.10%
62 Day Screening Standard	90%	91.50%	84.80%	94.80%	10.00%
31 Day Subsequent Drug Standard	98%	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%	97.8%	94.7%	96.7%	2.00%
31 Day Standard	96%	97.80%	96.30%	98.80%	2.50%
Two Week Wait Standard	93%	88.30%	87.30%	90.00%	2.70%
Breast Symptom Two Week Wait Standard	93%	90.80%	95.20%	85.90%	-9.30%

EFFECTIVENESS

Metric	Standard	YTD	Jun-16	Jul-16	Movement
Hospital Standardised Mortality Ratio (DFI)	100		83.7	85.3	1.60
Hospital Standardised Mortality Ratio - Weekday	100	0	84.3	88.1	3.8
Hospital Standardised Mortality Ratio - Weekend	100	0	85.0	91.8	6.77
Summary Hospital Mortality Indicator (HSCIC)	100	0	0.90	0.90	0.0
Emergency Re-admissions within 30 days following Elective or emergency spell within the Trust	5%		4.19%	5.00%	0.8%
Bed Occupancy - Midnight Count Generl Beds Only	85%		97.6%	98.5%	0.9%
LOS - Elective			4.3	4.2	-0.1
LOS - Non-Elective			4.4	4.2	-0.20

CARING

Metric	Standard	YTD	Jun-16	Jul-16	Movement
Inpatient Scores - Friends & Family Recommendation Rate	60		93.50%	96.10%	2.60%
A&E Scores - Friends & Family Recommendation Rate	46		82.00%	83.80%	1.80%
Complaints			78		-78
Mixed Sex Accomodation Breaches	0	0	0	0	0.0

SAFE

Metric	Standard	YTD	Jun-16	Jul-16	Movement
Clostridium Difficile - Varience from plan	31	7	2	2	0
MRSA Bacteramia	0	0	0	0	0
Never Events	0	1	0	0	0
Serious Incidents	0	34	11	5	-6
Percentage of Harm Free Care	95%		93.9%	94.9%	1.0%
Medication Errors causing serious harm	0	6	3	0	-3
Overdue CAS Alerts	0	2	2	2	0
Maternal Deaths	1	0	0	0	0
VTE Risk Assessment (previous months data)*	95%		97.60%	96.90%	-0.70%

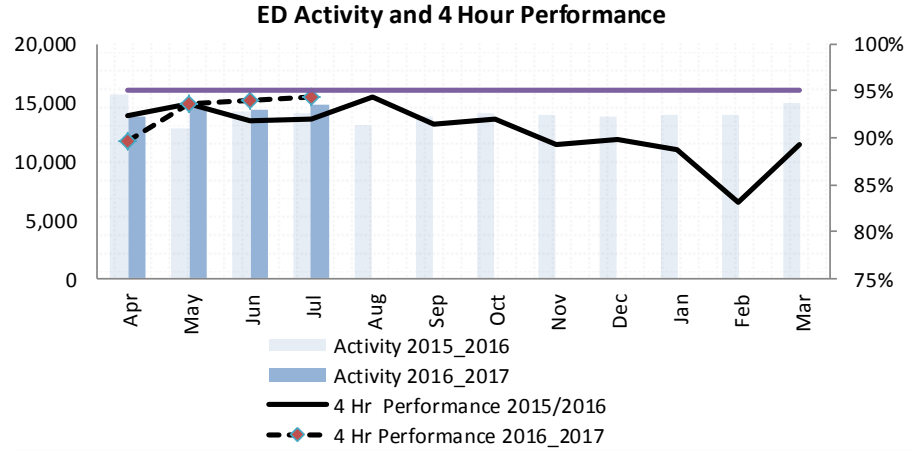
WELL LED

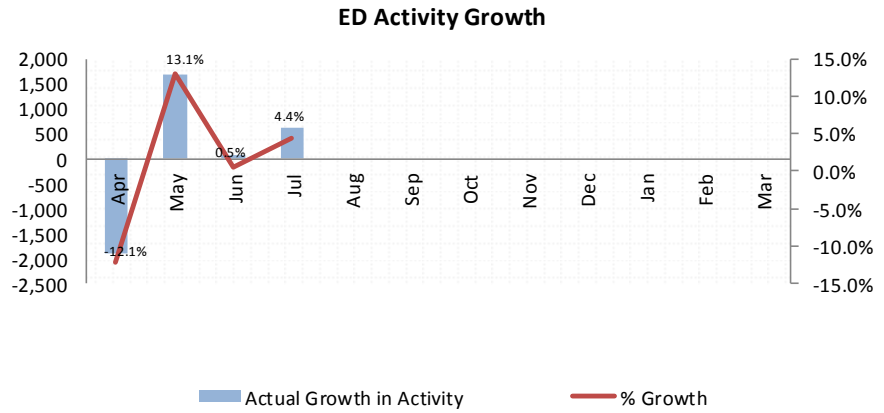
Metric	Standard	YTD	Jun-16	Jul-16	Movement
Inpatient Respose Rate Friends & Family	30%		31.3%	25.4%	-5.9%
A&E Respose Rate Friends & Family	20%		23.7%	23.4%	-0.3%
NHS Staff recommend the Trust as a place to work	58%	62.0%			
NHS Staff recommend the Trust as a place to receive treatment	4	3.78			
Trust Turnover Rate	13%		18.6%	18.9%	0.3%
Trust level sickness rate	3.5%		3.5%	3.6%	0.10%
Total Trust Vacancy Rate	11%		16.7%	16.7%	0.0%
% of staff with annual appraisal - Medical	85%		86.30%	83.00%	-3.3%
% of staff with annual appraisal - non medical	85%		69.10%	71.60%	2.5%

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

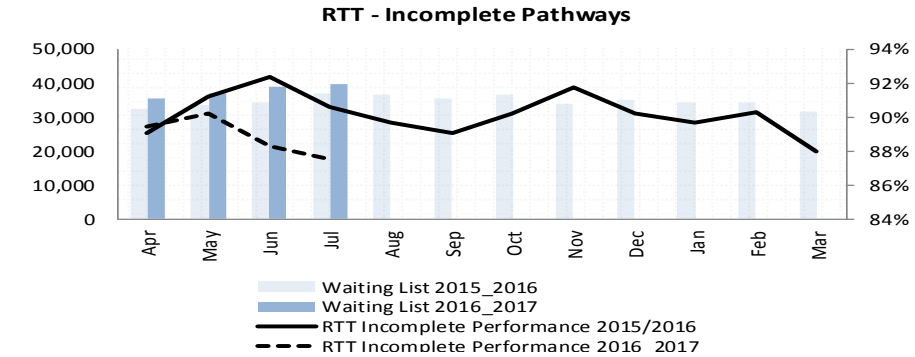
3. Trust Key Performance Areas and Activity Comparison to previous year (1 of 2)

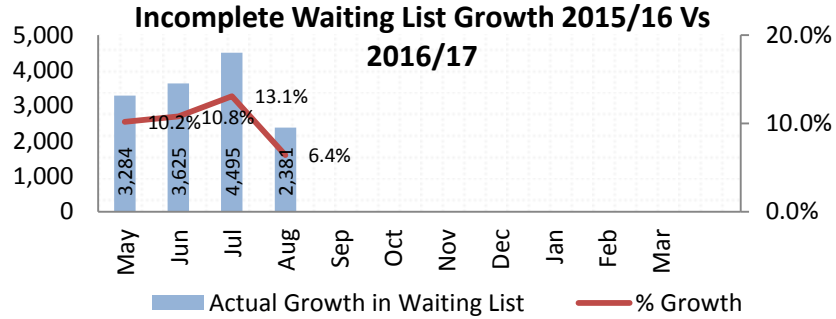
ED Performance

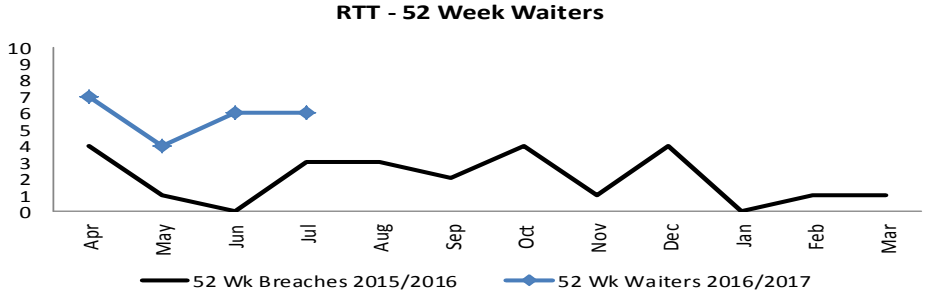


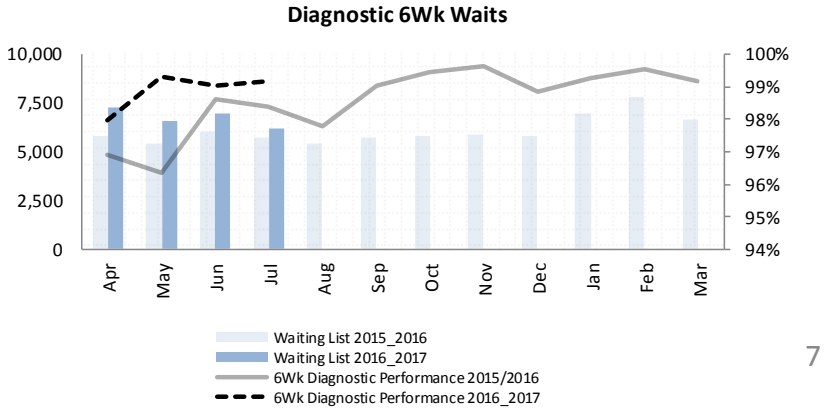


RTT & Diagnostics



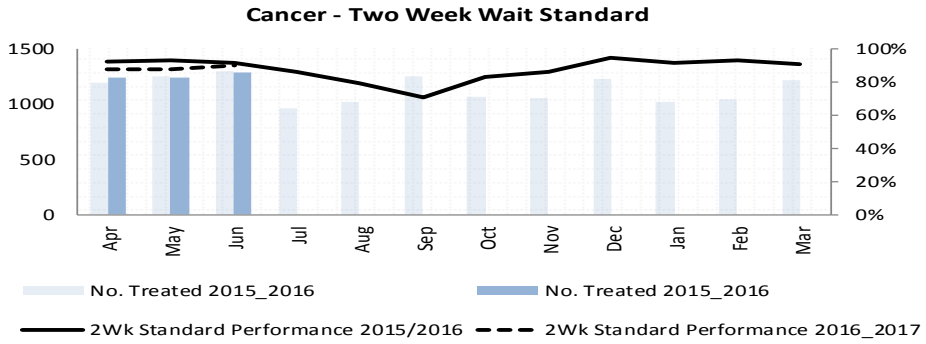


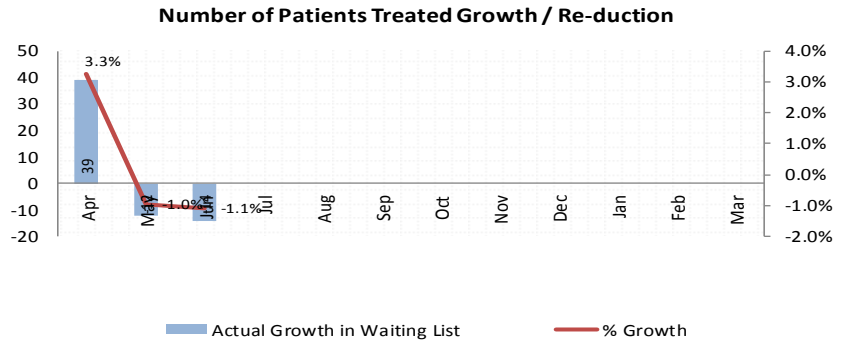




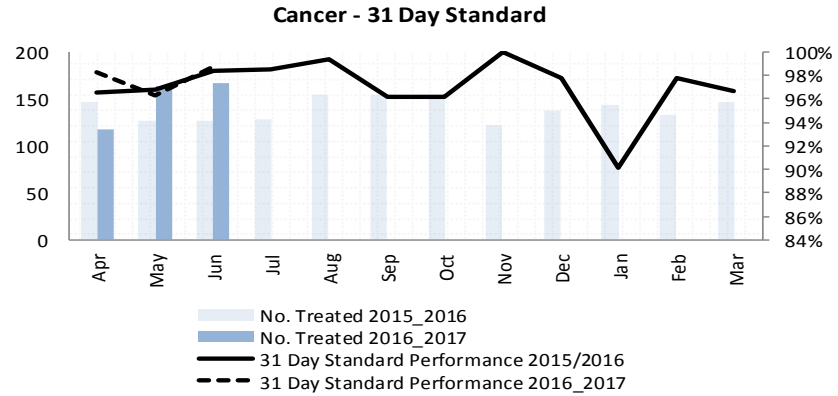
3. Trust Key Performance Indicators and Activity Comparison to previous year (2 of 2)

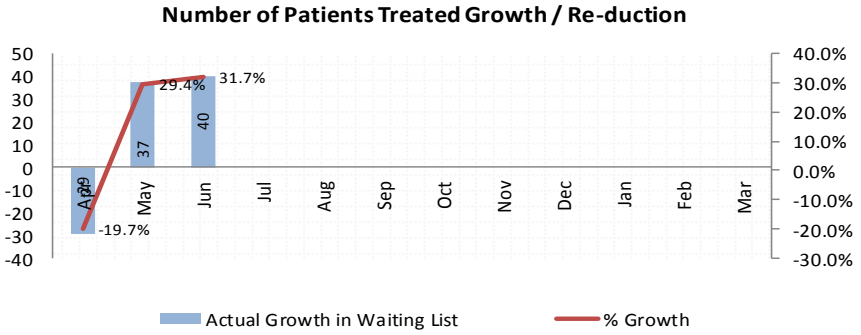
Cancer - Two Week Wait Standard



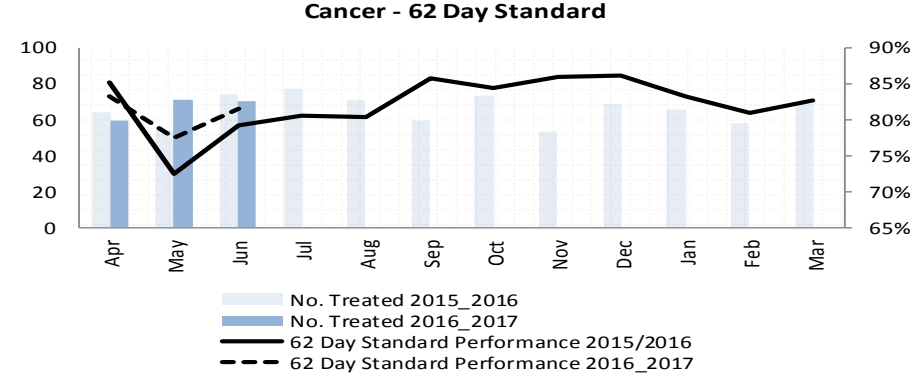


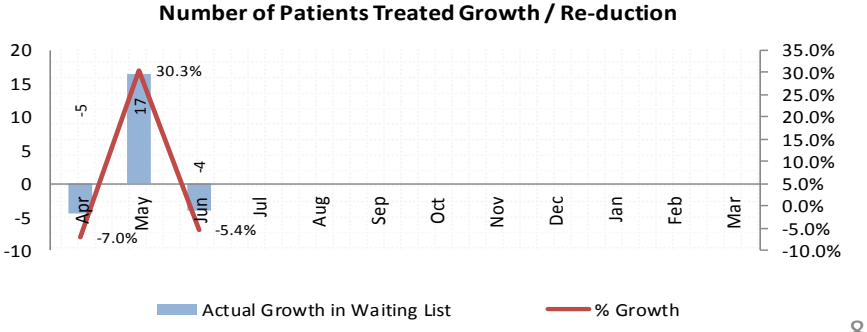
Cancer - 31 Day Standard





Cancer - 62 Day Standard





excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

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	Jun-16	Jul-16	Movement	2016/2017 Target	Forecast for Jul-16	Forecast for Aug-16	Date expected to meet standard
FA	94.00%	94.40%	↑ 0.40%	>= 95%	R	R	TBC

Peer PerformanceJuney 2016 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3	1	4	5	1
94.00%	94.60%	91.90%	83.80%	94.60%

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 against the national target being below the target at both the weekly and monthly level. However great improvement and significant increase in performance has been seen since April, and in July again, achieving 94.4% within within 4 hours. This is an increase of 0.4% compared to Jun e and also above the STF trajectory of 91.40%.

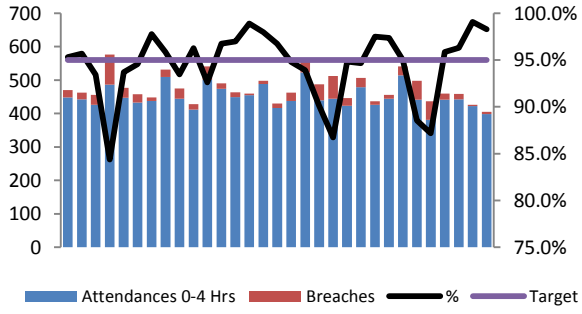
Contributing factors to ED performance were:

- Breaches were made up of delay in treatment decision (23.6% ↑), ED Assessment (6.1% ↓), wait for specialist opinion (14.8% →), ED Capacity (8.1% ↓), bed capacity (17.3%↑), clinical exception 9.8% →), other breaches include mental health, transport, diagnostics and patient factors.
- Higher proportion of breaches reported on a Monday (up to 10% higher than the remaining days of the week).
- 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 17/08/2016 there were 23DTOC and 24 Non-DTOC patients.

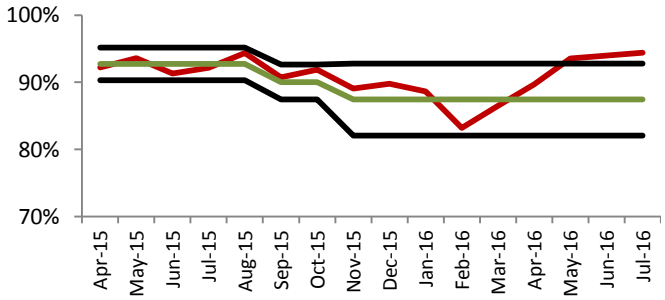
Key current actions being taken are as follows:

- Review of Monday staffing to assess if staffing models require adjustment.
- A review of UCC ways of working in light of increased workload and to identify ways in which navigation process can be further enhanced.
- Focus on development and implementation of internal professional standards.
- The OPAL service in reaching to ED is starting end July. This will support ED performance improvement.

4 Hour Performance by day - July 2016



4 Hour Performance Trend by Month



	Apr-16	May-16	Jun-16	Jul-16	Aug-16
STF Trajectory	88.80%	90.20%	91.50%	91.40%	92.80%
Actual Performance	89.70%	93.54%	94.00%	94.40%	

Failed National and STF target

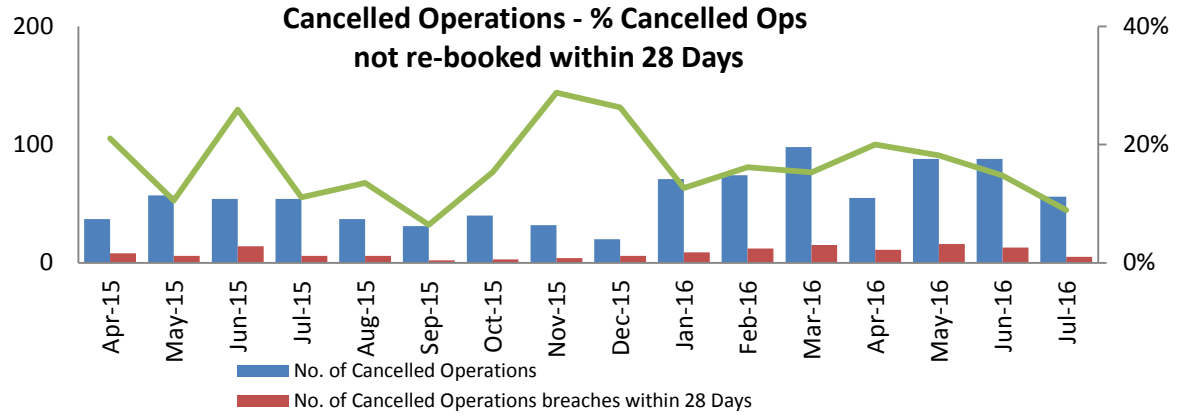
Failed National but achieved STF target

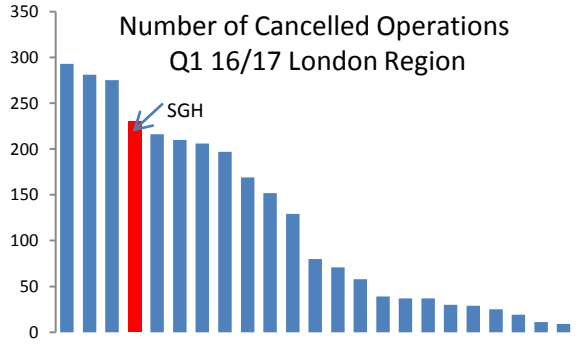
Achieved both National and STF target

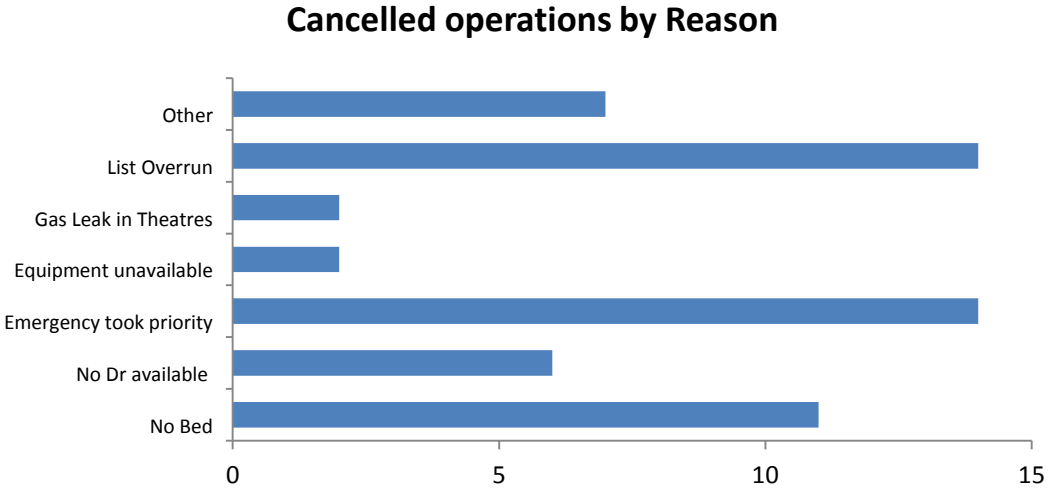
4. Performance Areas of Escalation (Page 2 of 5) - Cancelled Operations

Proportion of Cancelled patients not treated within 28 days of last minute cancellation							
Lead Director	Jun-16	Jul-16	Movement	2016/2017 Target	Forecast for Jul-16	Forecast for Aug-16	Date expected to meet standard
CC	14.77%	8.93%	↑ -5.84%	0%	G	G	Aug-16

Peer Performance Comparison – Latest Available Q1 2016/17				
STG	Croydon	Kingston	King's College	Epsom & St Helier
5	2	3	4	1
17.4%	0.0%	5.3%	20.0%	1.6%







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 56 on the day cancellations from 4,542 elective admissions in July. 51 of those cancellations were rebooked within 28 days with 5 patients not rebooked within 28 days, accounting for 8.93% of all cancellations. There was a decrease of 32 cancelled operations compared to the previous month. The majority of cases were cancelled due to bed availability, emergency cases, and list's over running / lack of theatre time.

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

Referral to Treatment Incomplete Pathways							
Lead Director	Jun-16	Jul-16	Movement	2016/2017 Target	Forecast for Jul-16	Forecast for Aug-16	Date expected to meet standard
CS	88.30%	87.52%	-0.78%	92%	R	R	

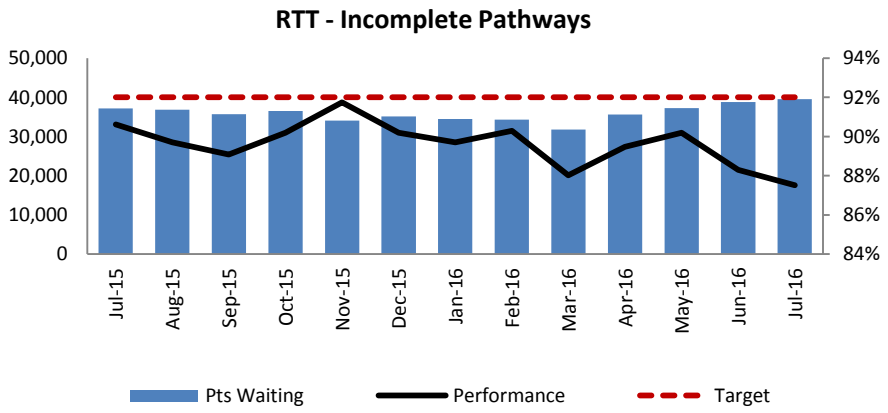
Peer Performance June 2016 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	2	1	5	3
87.52%	93.40%	96.40%	81.30%	91.50%

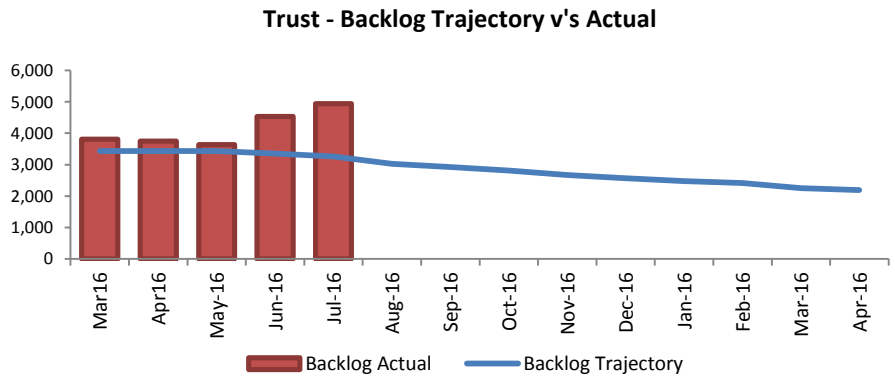
The Trust has been non-compliant against RTT incomplete pathways for a number of months. July 2016 performance decreased by 0.8% reporting 87.52%, with the number of patients above 18 weeks increasing by 399 patients. The total waiting list size at the end of July has seen an increase by 725 patients, There are a number of specialties shown in the table below who remain challenged with performance below target of 92%.

The number of 52 week breaches reportable in July performance are 6, consisting of Urology (1), Trauma & Orthopaedics (1), Gynaecology (2), Gastroenterology (2). Root cause analysis investigations have commenced.

RTT remains a challenge and the trust acknowledges the importance of not just reducing long waiters but achieving a position of sustainability. The RTT External Review by MBI has been concluded and finding report provided to commissioners and regulators on June 30th. An RTT recovery plan and supporting structure is being put in place with the following actions having been undertaken thus far:

- A senior Exec Led task force has been set-up to take this forward
- First Clinical Harm Review Group has taken place on 4th July with Medical Director in attendance.
- We are working through the procurement phase to commission external support to support the Technical and Validation stabilisation.
- Collating advice from NHSE and other Trusts on the RTT Recovery programme structure and resource requirements including the identification of work streams and our internal project plan.





4. Performance Areas of Escalation (Page 4 of 5) - Cancer 62 Day Pathway

Cancer Performance								Peer Performance Latest Published June 2016				
Lead Director – CC	May-16	Jun-16	Movement	2016/2017 Target	Forecast for Jun-16	Forecast for Jul-16	Date expected to meet standard	STG	Croydon	Kingston	King's College	Epsom & St Helier
62 Day Wait Standard	77.50%	81.60%	↑ 4.10%	85%	R	G	Jul-16	81.60%	84.55%	94.62%	89.75%	86.87%

62 Day Standard

The trust was non compliant against the 62 Day standard in June. There were a total of 13 reported breaches with the standard not being achieved in Gynae (1 breach), Head & Neck (1.5 breaches), Lower GI (1.5 breaches), Lung (2 breaches), Upper GI (3 breaches) or Urology (3.5 breaches). Contributing factors were Capacity (42%), Inter-trust transfers insufficient information (15%), and Complex diagnostic pathways (27%).

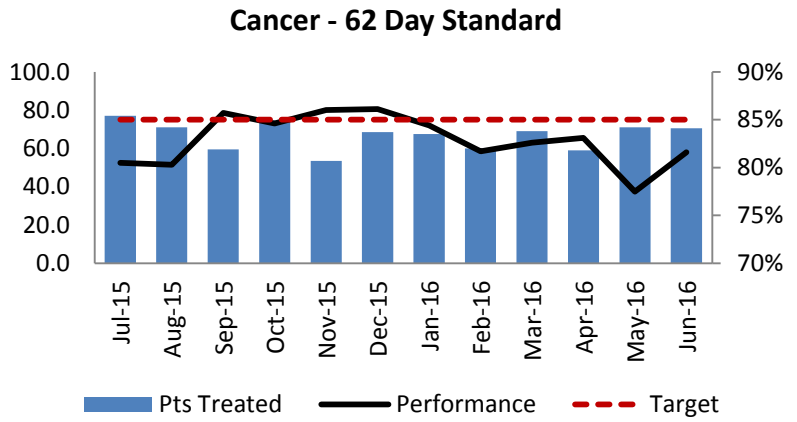
Key reasons

- The additional 2WW demand in April and May has impacted on the 62day and in particular diagnostic pathways and has further challenged diagnostic capacity
- Patients on complex diagnostic pathways have also presented challenges in being treated within 62days
- Patient choice, particularly multiple cancellations of events along the pathway
- Late ITT referrals or received with insufficient information for the Trust to be able to action next events
- Capacity issues within the MDT co-ordinator teams impacting on timeliness of tracking

The Trust continues to follow the agreed recovery plan primarily focused on enhancing PTL development, validation and improving tracking processes. Other key areas concern include:

- Theatre maintenance programme
- Gynae OP and Hysteroscopy capacity
- Head and Neck Diagnostic capacity

This remains an on-going priority for the Trust and significant work in relation to PTL enhancement has been undertaken which will allow for improved tracking, expediting and forecasting. Weekly tracking meetings are in place reviewing patients to assure that timely treatment plans are in place and expedited where necessary.



	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
All Types	83.30%	81.00%	82.60%	83.10%	77.50%	81.60%
Breast	100.0%	100.0%	100.0%	90.9%	95.7%	100.0%
Gynae	84.6%	84.6%	60.0%	100.0%	57.1%	75.0%
Haem	100.0%	85.7%	92.3%	100.0%	100.0%	100.0%
Head & Neck	50.0%	77.8%	50.0%	81.8%	57.1%	50.0%
Lower GI	100.0%	75.0%	83.3%	57.1%	80.0%	40.0%
Lung	75.0%	70.6%	42.9%	45.5%	75.0%	63.6%
Skin	85.7%	66.7%	84.0%	87.5%	94.7%	95.7%
Upper GI	0.0%		0.0%	100.0%	66.7%	50.0%
Urological	90.0%	85.0%	93.1%	81.8%	72.5%	80.0%

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

Cancer Performance								Peer Performance Latest Published June 2016- 2017				
Lead Director – CC	May-16	Jun-16	Movement	2016/2017 Target	Forecast for June	Forecast for July	Date expected to meet standard	STG	Croydon	Kingston	King's College	Epsom & St Helier
14 Day GP Referral for all Suspected Cancers	87.30%	90.00%	↑ 2.70%	93%	A	G	Jul-16	90.00%	97.06%	98.91%	95.58%	95.01%

14 Day Standard

The trust was non compliant against the two week wait target in June with performance of 90% against the target of 93%. However there has been an improvement of 2.70% compared with the previous month. There were a total of 128 reported breaches with the standard not being achieved in the following modalities: Breast (17 breaches), Haem (2 breaches), Head & Neck (13 breaches), Lung (5 breaches) Skin (53 breaches), Urology (12 breaches)

Key reasons for breaches were as follows:

- Patient choice accounting for 59% of all breaches
- Capacity constraints accounting for 41% of all breaches

This is an on-going priority area for the trust and performance is envisaged to be back on track in Q2. Weekly tracking meetings are in place support the expedition of patients where necessary.

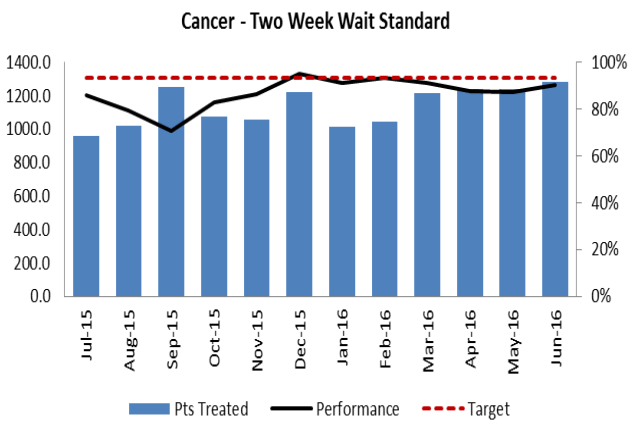
Key actions to drive performance improvement include:

- Development of 2WW PTL has now been implemented
- Weekly and monthly dashboard developed to measure key indicators that will help drive performance – deployment in July
- Capacity/ demand in 2WW to allow booking by day 7

Improvements made – Gynae have significantly improved performance against the 2 week standard with and increase of 21.5% compared to May.

- Booking within 7 days of referral is seeing a positive increase with July performance increasing to 31.7% from an average of 10%

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Varience May v's June
All Types	91.13%	93.17%	90.95%	87.60%	87.30%	90.00%	↑ 2.70%
Breast	97.64%	98.08%	93.67%	91.40%	91.30%	91.40%	↑ 0.10%
Gynae	62.38%	90.80%	73.27%	75.20%	75.20%	96.70%	↑ 21.50%
Haem	100.00%	92.31%	100.00%	85.70%	90.00%	92.00%	↑ 2.00%
Head & Neck	97.96%	93.08%	94.31%	82.00%	84.40%	90.60%	↑ 6.20%
Lower GI	99.11%	93.86%	97.16%	92.40%	95.00%	93.20%	↓ -1.80%
Lung	97.6%	96.8%	92.5%	89.40%	93.50%	87.20%	↓ -6.30%
Skin	87.57%	85.49%	87.14%	85.20%	83.60%	84.50%	↑ 0.90%
Upper GI	92.68%	98.75%	91.07%	91.70%	94.80%	91.40%	↓ -3.40%
Urological	91.38%	96.10%	96.13%	100.00%	87.90%	91.20%	↑ 3.30%
Childrens	100.0%	66.67%	71.43%	75.00%	100.00%	100.00%	↓ 0.00%



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

Monthly View

July 2016

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	A&E waits (4 hours)	%	100	93.8	0	0	94.4
	Cancelled operations re-booked within 28 days (division)	%	0	0	15.6	0	8.9
	LAS handover within 15 mins	%					51.8
	LAS handover within 30 mins	%					96
	LAS handover within 60 mins	No.					1
	No Trolley Waits in A&E - 12 hours	No.					0
	Urgent operations cancelled for the second time	No.	0	0	0	0	0

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

June 2016

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 week gp referral to first outpatient (breast symptoms) - (division)	%	0	0	85.9		85.9
	2 week gp referral to first outpatient (cancer) - (division)	%	0	0	90		90
	31 day second or subsequent treatment (drugs) - (division)	%	0	0	100		100
	31 day second or subsequent treatment (surgery) - (division)	%	0	0	96.6		96.6
	31 day standard from diagnosis to first treatment - (division)	%	0	0	98.8		98.8
	62 day urgent gp referral to treatment for all cancers - (division)	%	0	0	81.6		81.6
	62 day urgent gp referral to treatment from screening - (division)	%	0	0	94.8		94.8

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

Monthly View

			July 2016				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Outcome Metrics	Average LOS (elective) (division)	Ratio	0	5.1	4	2.8	4.2
	Average LOS (non-elective) (division)	Ratio	12	4.3	5.9	2.8	4.2
	C-sections (applicable to women & children only)	%	0	0	0	30.3	30.3
	CAS alerts	No.					2
	Falls (ward level)	No.	15	80	42	3	140
	FFT Recommended Rate- A&E	%					83.8
	FFT Recommended Rate- Inpatient	%					96.1
	HSMR	Ratio					85.3
	Incidence of c.difficile	No.	0	2	0	0	2
	Incidence of e-coli	No.	0	0	0	0	0
	Incidence of MRSA	No.	0	0	0	0	0
	Maternal deaths	No.	0	0	0	0	0
	Medication errors causing serious harm (division)	No.	0	0	0	0	0
	Mixed sex accomodation	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	1	3	5
	SHMI	Ratio					0.9
	Trust acquired pressure ulcers	No.	0	0	0	0	0
	VTE risk assessment (data submitted to unify)	%					96.9
	WHO surgical checklist (qrtly audit: briefing and debriefing)	%	0	94	100	100	98
	WHO surgical checklist (qrtly audit: sign in/time-out/sign-out)	%	0	97	97	98	97.3

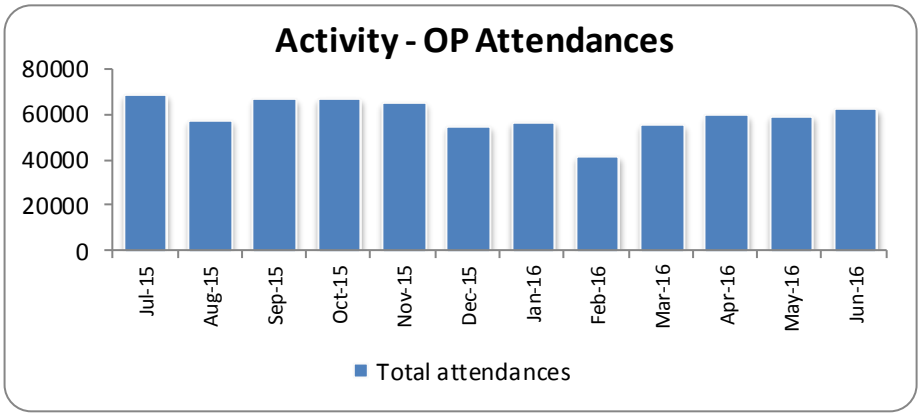
			July 2016				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Quality Governance Indicators	Friends & family response rate	%	0	25.8	23.5	29.3	25.4
	Patient satisfaction (friends & family)	%	78.6	86.6	96.4	98.8	89
	Percentage of harm free care	%	0	92.3	97.5	98.3	94.9
	Percentage of staff appraisal (medical) - (division)	%	70	79.9	84.3	86.2	83.1
	Percentage of staff appraisal (non-medical) - (division)	%	77.3	68.9	78.1	66.9	70.8
	Sickness/absence rate - (division)	%	4.5	3	3.5	3.7	3.5
	Staff turnover - (division)	%	22.1	18.6	16.3	19.9	19.1
	Vacancy rate - (ward)	%	16.7	21	26.8	11.8	19.1
	Voluntary staff turnover - (division)	%	16.7	16.2	13.1	16.5	15.7
	Ward staffing: unfilled duty hours	%	0.8	4	5.8	4.2	4.4

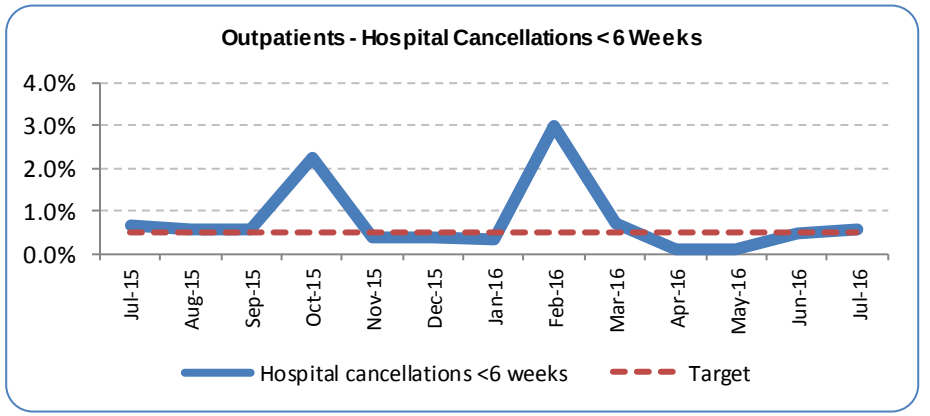
Key Messages:

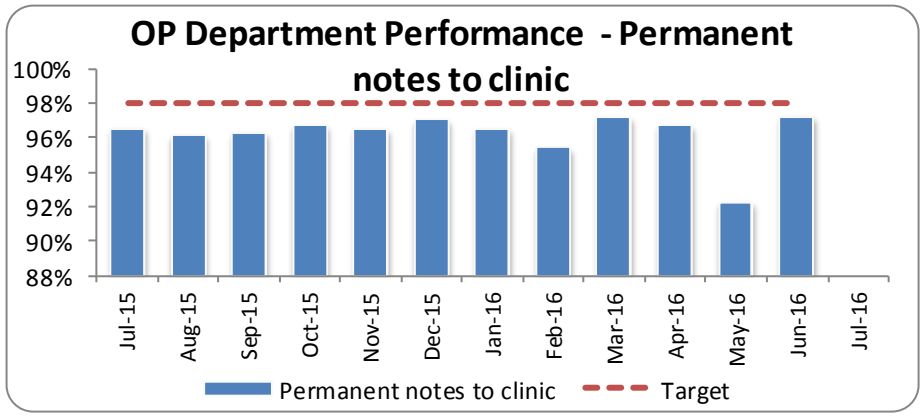
This section headed 'Access' indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution. The Access section is split into two components,. Cancer performance is reported one month in arrears.
LAS arrivals to patient handover times, continues to fluctuate. At the end of July 51.8% of patients had handover times within 15 minutes and 96% within 30 minutes, both of which are not within target. The trust had one reported 60 minute LAS handover breach in July.

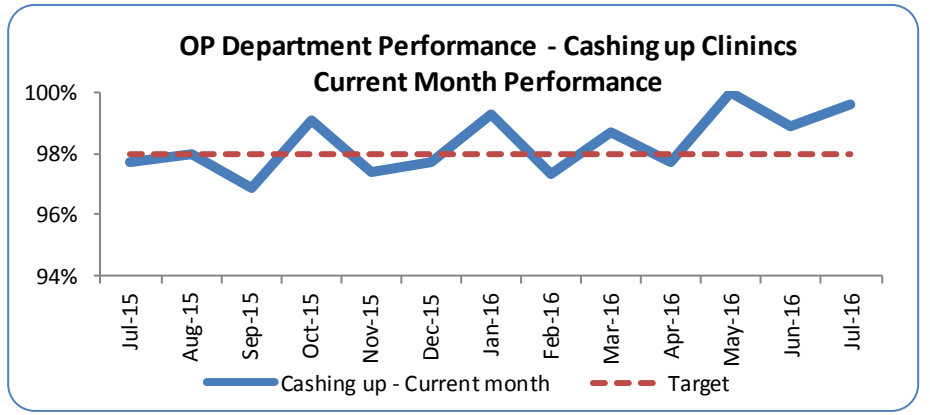
The trust has a zero tolerance policy on avoidable pressure ulcers and has placed significant importance on its prevention. In July the trust had 0 grade 3 pressure ulcer SI's and no Grade 4. All grade 3 and 4 pressure ulcers acquired in our care are investigated as serious incidents, and a. full investigation and Root Cause Analysis will be produced for each PU and reviewed at the Pressure Ulcer Strategy group, chaired by the Deputy Chief Nurse

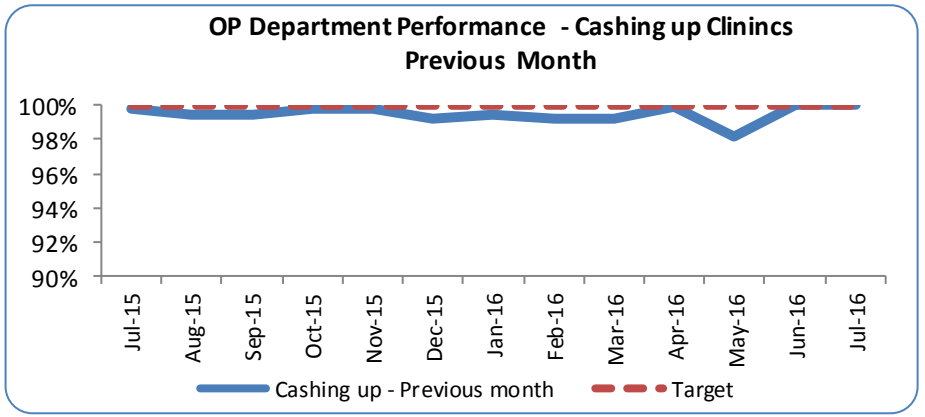
6. Corporate Outpatient Services (1 of 2)
- Performance Overview

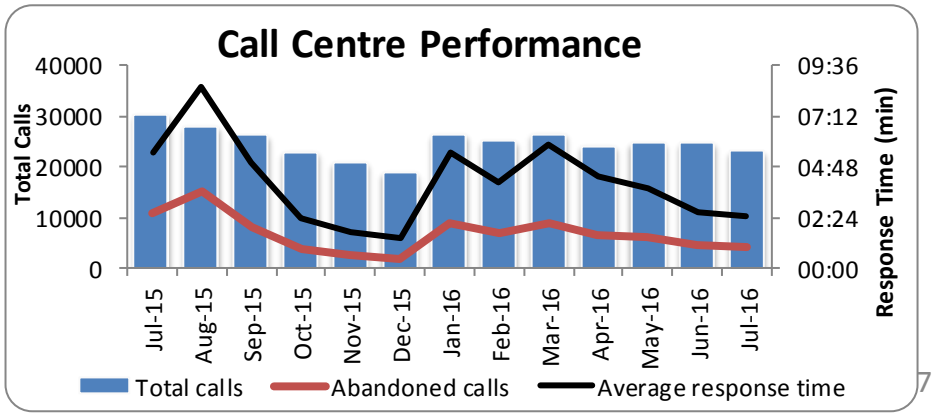












6. Corporate Outpatient Services (2 of 2) - Performance Overview

		Target	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Activity	Total attendances	N/A	68277	57188	66271	66501	64863	54618	56239	41552	55261	59211	59055	61937	57472
	Hospital cancellations <6 weeks	<0.5%	0.64%	0.56%	0.54%	2.24%	0.36%	0.37%	0.35%	2.97%	0.69%	0.11%	0.08%	0.48%	0.54%
OPD performance	Permanent notes to clinic	>98%	96.54%	96.14%	96.31%	96.72%	96.52%	97.02%	96.50%	95.42%	97.20%	96.70%	92.26%	97.22%	97.01%
	Cashing up - Current month	>98%	97.70%	98.00%	96.90%	99.10%	97.40%	97.70%	99.30%	97.30%	98.70%	97.70%	100.00%	98.90%	99.60%
	Cashing up - Previous month	100%	99.80%	99.50%	99.40%	99.80%	99.75%	99.20%	99.40%	99.20%	99.20%	99.90%	98.20%	100.00%	100.00%
Call Centre Performance	Total calls	N/A	30426	28095	26357	23138	21082	19093	26557	25273	26674	24279	24924	24881	23186
	Abandoned calls	<25%/<15%	10828	15019	8253	3930	2756	1953	9084	6949	9055	6671	6362	4542	4185
	Mean call response times	<1 m/<1m30s	05:31	08:34	04:59	02:24	01:43	01:24	05:30	04:06	05:49	04:20	03:45	02:37	02:26

Key Messages:

- Decrease in activity by 4,465 compared to June, and below same period last year, however in line with average for the year.
- Hospital cancellations <6 weeks has slightly decreased by 0.4% and currently not meeting target.
- Permanent notes to clinic has maintained improvement since February, however still remains below target of 98%. This continues to be a priority area for the service.
- The level of call activity and the number of abandoned calls remain under target , with a some improvement in reducing the number of abandoned calls. This is primarily due to shortage in staffing levels. CBS is currently going through a transformational phase and are on a active recruitment drive to fill the staffing capacity shortfall following recent vacancies which have arisen.

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St George's University Hospitals NHS
NHS Foundation Trust

Quality Report

July-2016

Excellence in specialist and community healthcare

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St George's University Hospitals NHS
NHS Foundation Trust

Clinical Audit & Effectiveness

Excellence in specialist and community healthcare

7. Clinical Audit and Effectiveness - Mortality

HSMR (Hospital standardised mortality ratio)							
Lead Director	April 16 (Feb15-Jan16)	May 16 (Mar15-Feb16)	June 16 (Apr15-Mar16 FINAL)	Movement	2016/17 Target	Forecast March 17	Date expect to meet standard
AR	86.5	84.0	85.3	↑	<100	G	Met

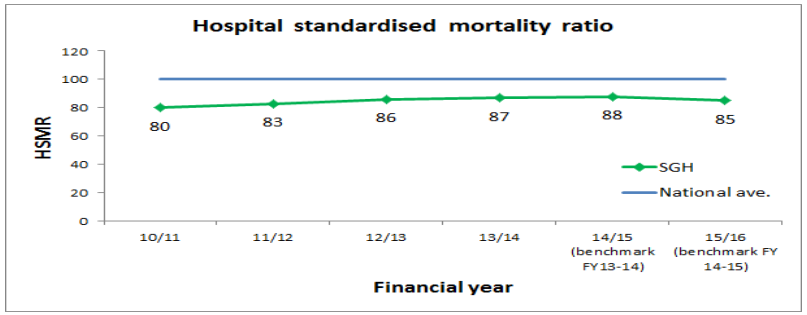
SHMI (Summary hospital-level mortality indicator)				
Jul 2015 (Jan14-Dec14)	Oct 2015 (Apr14-Mar15)	Jan 2016 (Jul14-Jun15)	Mar 2016 (Oct14-Sep15)	Jun 2016 (Jan15-Dec15)
0.89	0.92	0.90	0.91	0.91

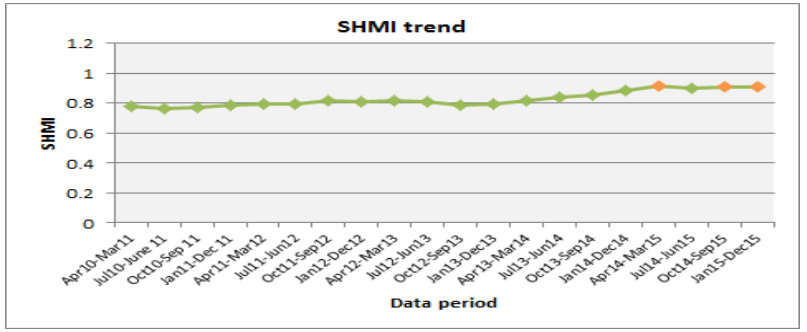
Note: Source for HSMR is Dr Foster Intelligence. Data is most recent 12 months available (updated 23/06/16) April 2015 to March 2016, and benchmark period is the financial year 2014/15. SHMI data is published by the Health and Social Care Information Centre. The last 12 month period as published on 23rd June 2016 relates to the period January 2015 to December 2015. The next publication is due in September 2016.

Overview:

Since the last report to the Board there has been no update to the SHMI; the next publication is due in September. For the HSMR, the latest Dr Foster update did not extend the period that was reported last month (April 2015 to March 2016) but the tool was refreshed using the final 2015/16 HES data file based on trusts' revised SUS submission for the whole year. This has changed our ratio slightly from 83.7 to 85.3; however, our mortality measured in this way remains significantly better than expected. Looking at the HSMR for emergency admissions at weekends, our mortality is in line with expected at 91.8 and for emergency weekday admissions it is better than expected at 88.1. The data update in August will include 2 months' worth of discharges, up to and including April and May 2016.

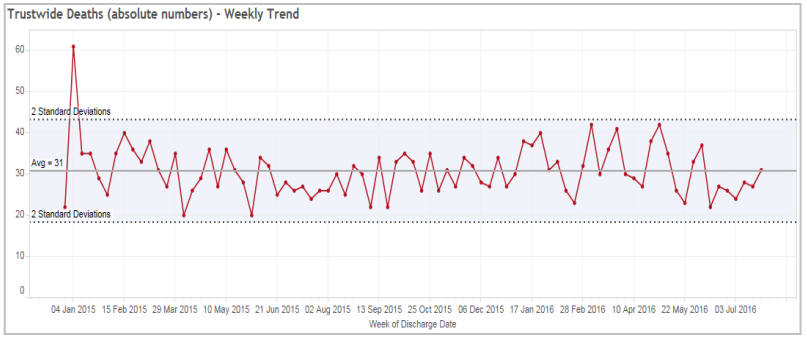
Raw mortality is also considered by the Mortality Monitoring Committee (MMC) each month. As shown by the chart alongside, our mortality continues to be within normal limits and was lower than average from the middle of June to the end of July.





National programme:

The trust has been accepted as a pilot site for the National Mortality Case Record Review (NMCRR) programme. This project is being run by the Royal College of Physicians, with the aim of establishing and implementing a standardised methodology and process for retrospective case record review for adult acute care deaths in England and Scotland. The intention is that the final methodology will improve understanding and learning about problems in care that may have contributed to patients' deaths. The pilot will involve the review of approximately 50 cases, to be shared amongst a project team of 5 or 6 clinicians. We have been selected to test the approach in patients that have an electronic record. Early in September the RCP will be visiting the trust to provide training in the review methodology. We anticipate that the pilot will be conducted in September/October in readiness for the national launch event in November in which we will be invited to participate.



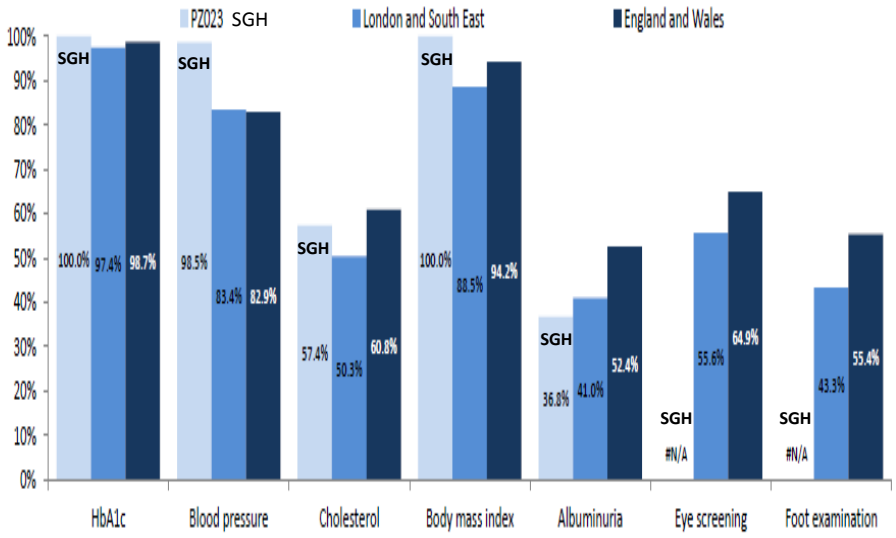
7. Clinical Audit and Effectiveness - National audit

National Paediatric Diabetes Audit 2014-15

Standards for the audit were drawn from NICE guidance [NG15 Diabetes (type 1 and type 2) in children and young people] and includes assessment of:

1. Education for children & young people with diabetes;
2. Psycho-social referrals;
3. Dietary management for type 1 diabetes;
4. Provide equipment & advise patients to test blood ketone if hyperglycaemic/unwell;
5. Type 1 diabetes: daily injection based insulin therapy regimens or continuous subcutaneous insulin infusion;
6. Blood glucose and HBA1c monitoring - patients to perform at least 5 capillary blood glucose tests per day (HBA1c levels of 6.5%);
7. Diabetic kidney disease, monitoring albuminuria.

Percentage of children and young people who received each of the seven key care process



Results:

Reporting against the 7 key process of care (see chart) finds St George's to be better than other London trusts for 4 processes and above the national in 3.

Data were not reported for retinal eye screening nor diabetic foot care; however, the team report that they ask and prompt patients regarding these matters. Eye screening data is missing due to there being no agreed process between eye clinics and St George's. There was also no data reported on coeliac disease; this was missing due to coding issues and the matter is said to be rectified.

HbA1c is the primary indicator of diabetes control, and shows SGH and other inner SW London peers to be significantly worse than the national mean. Improvement of HBA1c is dependent on the education of patients and the application of good practice.

Action Plan: Lead Murray Bain

The service continue to explore ways to improve patient education and lifestyle choices to improve personal management .

- Education of children will be undertaken jointly between the nurse specialist and dietician. The newly appointed dietician has been in post for 6 weeks and a new pump review clinic has been established.
- Missing data on coeliac disease was due to coding issues. This matter is now rectified. Albuminuria rates are low, on-going action reminding patients to present their urine samples.
- The service prompt patients on need for eye screening and foot management, but do not provide the services. Retinal screening data is an on-going issue (for all three national diabetes audits) as there is no data sharing process between eye clinics and the Trust.

7. Clinical Audit and Effectiveness - National audit

Royal College of Emergency Medicine (RCEM) Paediatric Vital Signs

Paediatric Vital Signs RCEM standards	SGH results (Sample size 50)	National results		
		Lower quartile	Median	Upper quartile
STANDARD 1a Fundamental: All children attending ED with a medical illness should have a set of vital signs consisting of **(a)** temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest.	**27%**	25%	**37%**	52%
STANDARD 1b Developmental: All children attending ED with a medical illness should have a set of vital signs consisting of (a) temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score, and **(b)** capillary refill time recorded in notes within 15 mins of arrival or triage, whichever is the earliest.	**24%**	7%	**20%**	37%
STANDARD 2 Developmental: Children with any recorded abnormal vital signs have a further complete set of vital signs recorded in the notes within 60 mins of the first set (including CRT).	**0%**	6%	**27%**	43%
STANDARD 3 Developmental: Explicit evidence in the ED record that the clinician recognised the abnormal vital signs.	**40%**	52%	**71%**	86%
STANDARD 4 Fundamental: Documented evidence that the abnormal vital signs (if present) were acted upon in all cases.	**100%**	55%	**74%**	89%
STANDARD 5 Developmental: Children with any recorded persistently abnormal vital signs who are subsequently discharged home have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor).	**N/A**	33%	**60%**	100%

CONCLUSION:
Results are disappointing; documentation of vital signs are poor and requires improvement both locally and nationally.
St George's is reported to be above the national median in reporting **Std 1b,** that is the reporting of vital signs inclusive of capillary refill. The trust is reported to be fully compliant and at the top of upper quartile for **Std 4** that relates to action where abnormal vital signs are present. SGH is found to lie below the national median for standards **Std 1a** (vital signs bundle excluding capillary refill) and **Std 2** (undertaking a second set of vital signs within 60 mins).
Std 5 was not applicable as no children with abnormal vital signs in the audit sample were reported to have been discharged home.
The completeness of the full set of vital signs in ED are seen to be poorly documented and the team are therefore undertaking action planning to achieve sustainable improvement.

ACTION PLAN:

1. Dissemination of results and staff education:

- Disseminate results to nursing and medical leads, highlighting issues and lead actions. (Rhys Beynon, July 2016)
- Triage vital signs training and nursing education. (Jane Wilson & Yasser Iqbal, July 2016)
- Reinstate POPS (Paediatric Observation Priority Scores). (RB, August 2016)

2. IT systems, mandatory fields and alerts:

- Temp, RR, HR, Oxygen sats, GCS/AVPU & Cap refill mandatory fields on paper light system. (YI)
- iClip Alert on the system for another full set of obs. (YI)
- POPS score on iClip as a mandatory field. (YI)

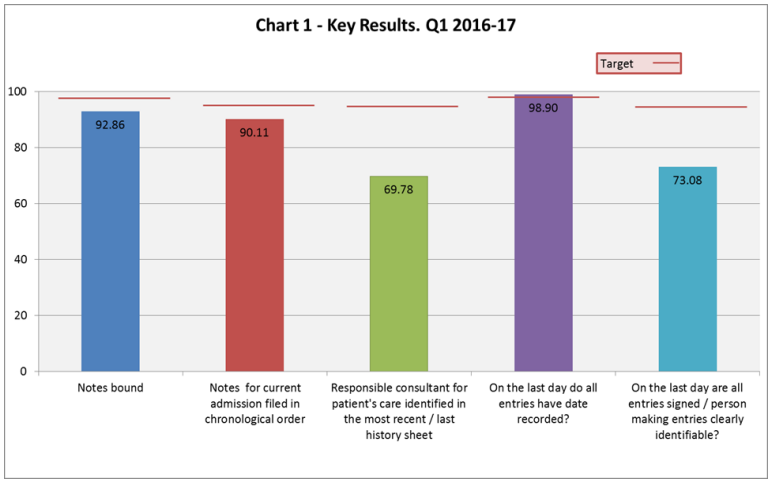
3. Monitoring & re-audit :

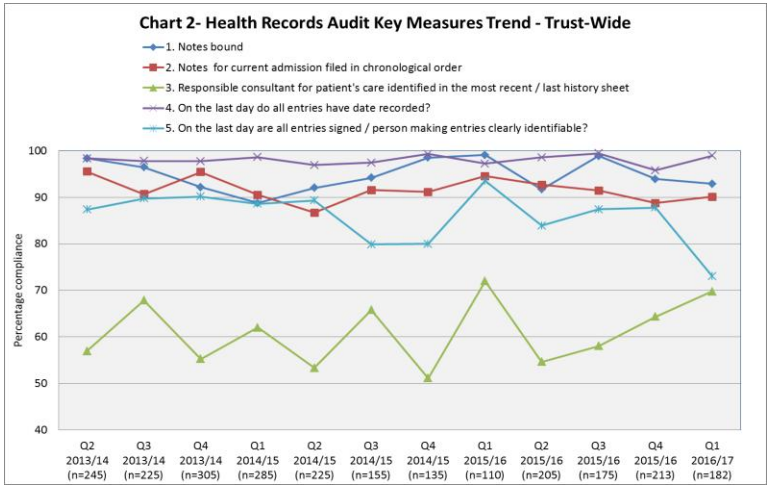
- Regular monitoring of nursing documentation. (JW)
- Those with abnormal vital signs to have a further complete set of obs. (JW)
- Re-audit September 2016. (YI)

7. Clinical Audit and Effectiveness - Local audit

Health Records audit Q1 2016-17

It is important that the Trust carry out audits of clinical record keeping in all specialties to ensure that the quality of the clinical record facilitates high quality patient care and that subsequently the health record can justify any clinical decision if required. A total of 24 care groups with paper records are asked to audit a sample of 10 records each (Maternity submits 15). The last completed episode of care is audited. The results below summarise the findings from the 18 care groups who completed the audit.





Results:

- This quarter the **response rate was down on last quarter at 75%,** with 18 out of 24 specialties submitting data. In the last two quarters all areas within the M+C Division have completed the audit
- When it comes to key measures performance in Q1 2016/17 continues to require improvement with **just one of the key standard indicators met** (Chart 1). That standard is the recording of the date and it appears to be either at or close to target in the majority of audits. In the majority of the other key standards **there remains variation in performance and there is little consistent improvement over time** (Chart 2).
- To ensure the health records remain in a good condition there is a need to **focus on the correct filing of pages and using dividers** to separate different sections.
- There is variation amongst the different divisions but performance is generally strongest in the Community Services Division. There is high levels of variability in the number of standards met in each of the other Divisions each quarter.

Actions:

- Patient labels: Continuing to increase the use of patient labels from the current level of 61% is likely to improve the results for patient identifiers on history sheets, in particular the inclusion of the NHS number.
- Dividers in ring folders
- Designation Stamps: Identification of the consultant in charge of the patient's care remains a priority area for action. Using name stamps is another suggestion that could clearly improve the recording of name and designation in entries.

7. Clinical Audit and Effectiveness - Local Audit

Accounting for Swabs, Needles and Instruments - Obstetric Theatres

Introduction

The Trust acknowledges that safeguarding of patient is paramount and that processes must be in place to ensure that no foreign body is retained by accident in any patient. As part of the commitment to improving patient safety and in light of previous retained swab serious incidents the theatre department developed the Accounting for Swabs, Needles and Instrument audit tool for obstetric cases in April 2016.

Aim/Objective

The aim of this audit is to provide evidence of the compliance rate of:

- Operative counts, which include - swabs, needles, instruments and extras, are accurate and all items are accounted for at all times during a surgical procedure;
- Swab safe trays are used for all obstetric procedures;
- Surgeons are kept informed of the outcome of counts and any discrepancy;
- Swabs are disposed of correctly after final count, and
- To identify good clinical practice within theatres and to ensure the health and safety of patients through the journey within the operating theatre.

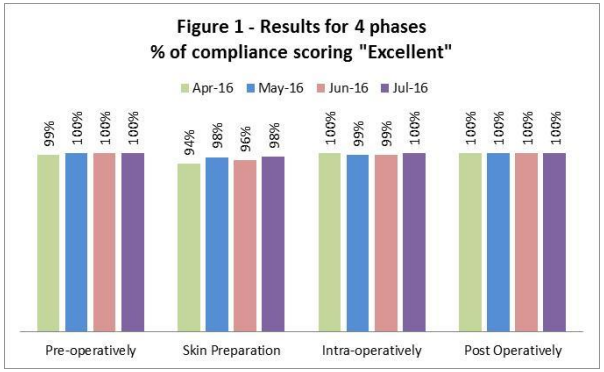
The standard for compliance is 100%.

Methodology

- The final data collection was conducted in July 2016, and a total of 20 observations were received (16 from Obs Elective and 4 from Obs Emergency).
- Data from completed tool was exported onto an Excel database, and analysed by the Clinical Auditor.

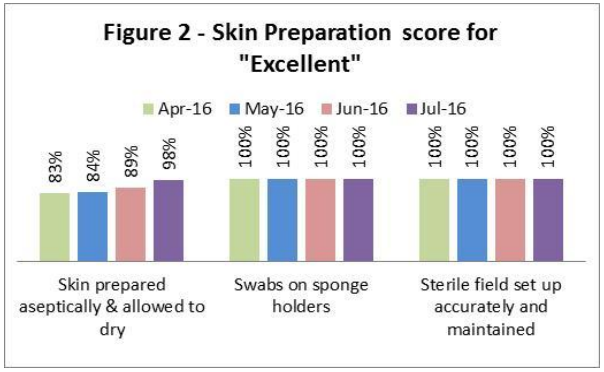
Results

The overall compliance rate in this audit is 99.8% (98% in the previous audit round). Figure 1 shows the results for the four phases – three phases scored 100% (Pre-Operatively, Intra-Operatively and Post-Operatively). Skin preparation scored 98%, although this is an improvement from 96% (previous audit round), it is still below the desired standard of 100%.



Skin Preparation (4 questions in this phase)

The overall score for this phase is 98%, an improvement from 96% in the previous audit round. The question on "Skins prepared aseptically & allowed to dry" scored 98%, an improvement from 89% in the previous audit round (Figure 2). The reason documented was: Obs Elective - *"used swab to dry the skin before the drape went on"*



Action Plan:

a) The team will continue with re-audit to maintain standards for phases that had achieved 100% and to remind staff on using the accepted method for skin preparation.

b) Plan to roll out this audit project to other theatre areas in 3rd Qtr 2016/17.

7. Clinical Audit and Effectiveness - Local audit

Annual Consent Audit 2015/16

Overview - This audit aims to assess completion of the consent form as detailed in section 6 of the Trust's Policy on Obtaining Valid Consent for Treatment Clin.5.11 (PAT2.2).

Key findings *(Table 1 shows results by division; scores below 90% have been highlighted in RED).*

Section 1 - Patient Details on Consent Form: Procedure details were recorded in all case notes audited (100%), this is similar to previous audit round, and majority of the patients' details were recorded in the consent form (98%). Although there is an improvement in the question pertaining to "name of responsible consultant" (79% compared to 67% in the last audit round), the overall score is below 90%. Medicine & Cardiovascular division scored 69% for documenting name of responsible consultant.

Section 2 - Statement of Health Practitioner: Overall score for this section shows that majority of patients were informed of the intended benefits, possible risks and their consent form was signed and dated. Significant improvement is seen in the consenter's name printed legibly (91% compared to 76% in the last audit round). 95% of forms were ticked and signed for blood transfusion; this is a significant improvement from the previous audit round of 31%.

Details of extra procedures given, scored poorly compared to previous audit round (33% against 43%), and all participating divisions scored below 60% (in the Community Services, this question was not part of their consent form). Only 10% of patients were given leaflet or tape about their proposed surgical procedure, compared to 13% in the last audit round.

Section 3 - Statement of Patient / Parent: All consent forms for paediatric cases were signed by the parents, and for adult case notes reviewed, 99% were signed and dated by the patients, a drop from 100% in the last audit round. In 45% of cases the carbon copy of the consent form was removed, implying that it had been given to the patient; this is a lower level than that observed in the previous audit (52%).

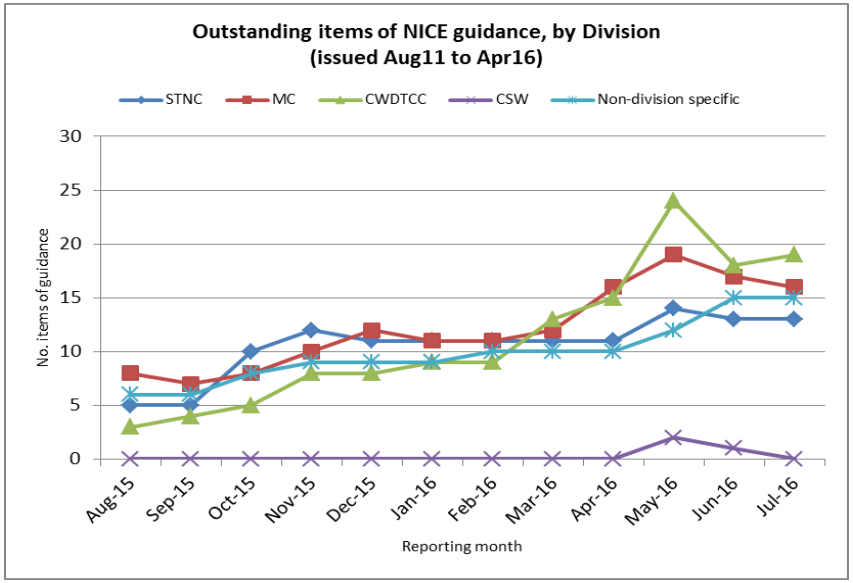
Section 4 - Competent to take consent: It was possible to assess competency to take consent in 88% of cases, an improvement form 84% in the last round. In all of these instances consent was taken by an appropriate healthcare professional. However, competency could not be assessed in 12% of cases either as the professional could not be identified, or because the Consultant did not respond to requests for confirmation. Community Services scored 100% for competency in taking consent and all consenter names were clearly documented. The other three divisions scored below 90%.

Key work in progress - The audit has been shared with clinical colleagues via the Medical Director, and he is supporting the audit team to identify a clinical lead/group to take this project forwards. This action is outstanding.

Forward plan - This audit was conducted without a clinical lead; the future direction of the audit depends on the identification of a clinician or group to help drive this forward as an improvement project, rather than solely an assurance exercise. The audit team would propose to carry out smaller, more regular audits focussed on specific aspects of policy where improvement actions have been agreed.

Table 1 - Breakdown by Division Positive outcome	Children & Women, Diagnostics, Therapeutics and Critical Care Division	Community Services Wandsworth	Medicine & Cardiovascular	Surgery, Theatres, Neurosciences & Cancer
Procedure detailed	99%	100%	100%	100%
Details of intended benefits given	100%	89%	98%	98%
Details of possible risks given	100%	96%	97%	99%
Statement signed	99%	100%	100%	98%
Statement dated	100%	100%	94%	98%
Consenter's name printed legibly	98%	63%	83%	96%
Jehovah witness ticked and signed	95%	-	100%	92%
Patient signed form	100%	100%	98%	98%
Parent signed form	100%	-	-	100%
Less than positive outcome				
Name of responsible consultant given	81%	100%	69%	82%
Details of extra procedures given	59%	-	43%	23%
Leaflet / Tape given	12%	11%	15%	6%
Carbon copy removed	62%	73%	46%	29%

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



Items of NICE Guidance with Compliance Issues (Jun 2010 to Apr 2016)

Division	2010	2011	2012	2013	2014	2015	2016
STNC (n=10)	0	1	2	1	3	1	2
M+C (n=18)	2	0	2	1	2	5	6
CWDTCC (n=16)	3	1	1	2	6	1	2
CSW (n=0)	0	0	0	0	0	0	0
Non-division specific (n=15)	0	2	0	3	2	4	4

Overview

The review of NICE guidance continued this month. The audit team has continued to work closely with divisional colleagues in Children & Women's and Medicine & Cardiovascular divisions to address the backlog and improve the understanding of our current position for those items with compliance issues. This month follow up also began with the STNC Division and will continue next month. There will also be an effort to determine leads for those items as trust-wide that have yet to have a lead identified. In addition, there are 20 items of guidance issued between 2010 and 2012 that have not been assessed or have outstanding compliance issues. The priority in the coming month will be to ensure that a final position is reached with each of these items of guidance.

During the initial stage of the review the number of outstanding items of guidance increased and this was reflected in the May numbers for both outstanding items and items with compliance issues. These numbers have continued to drop in all areas except the non-division specific guidance during July. There are currently 62 outstanding items of NICE guidance issued up to April 2016 and there are currently 59 with compliance issues. Previously the focus has been on monitoring risks associated with items identified as partially compliant, moving forward there will be a greater emphasis on addressing risks to ensure that the Trust becomes compliant. Encouragingly, response rates continue to be high for those items issued in the last few months.

As part of the Quality Improvement Plan, the clinical audit and effectiveness team will be developing and implementing a process for publication and corporate oversight of clinical guidelines on the Trust intranet. This will incorporate NICE guidance, in addition to other national and local guidelines.

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Patient Safety

Excellence in specialist and community healthcare

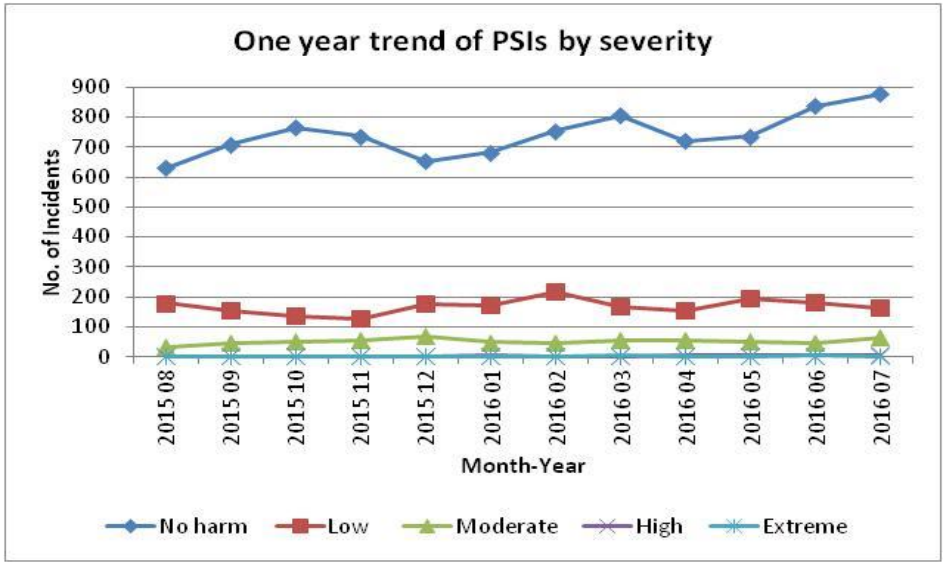
8. Patient Safety
- Incident Profile: Serious Incidents and Adverse Events

	2016/17 SIs Declared by Division (incl. PUs)					
	M&C	STN&C	CSD	C&W	Corporate	SWLP
May	3 (1 shared with C&W)	1	1	2 (1 shared with M&C)	0	0
June	5	3	0	3	3	0
July	1	1	0	3	0	1

Table 1

Closed Serious Incidents (not incl. PUs)				
Type	May	June	July	**Movement**
Total	12	14	13	▼
No Harm	4	10	7	▼
Harm	8	4	6	▲

Table 2



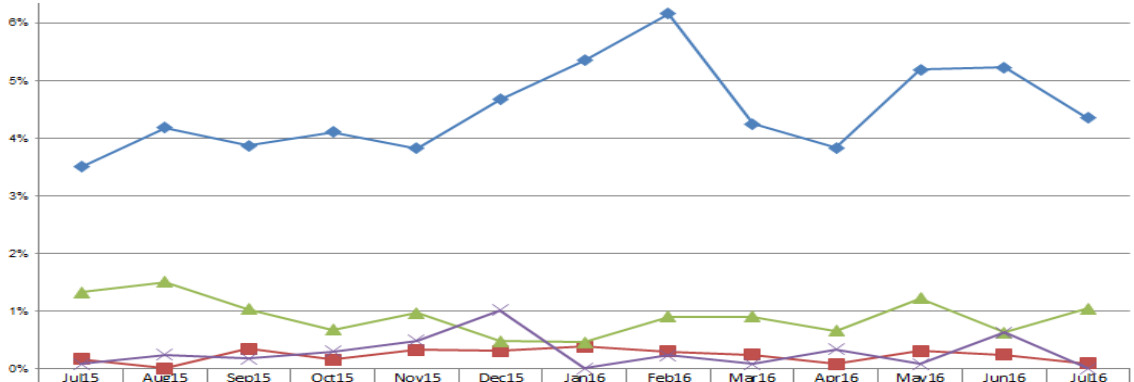
Overview:
The numbers of general reported incidents are shown in Table 1. This trend should be observed carefully in conjunction with the trends and profile of SIs. High reporting of low or no harm incidents is generally felt to be an indication of a good reporting culture.

There were 6 general SIs reported in July and the subjects are varied.

The 6 general SIs declared in July include the following categories:
- Unexpected death x3
- Delay to act on adverse test results
- Retained foreign object (swab)
- Mis-diagnosis

8. Patient Safety
- Safety Thermometer

% Harm Free Care							
Lead Director	May 2016	June 2016	July 2016	**Movement**	**2016/17 Target**	**National Average July 2016**	**Date expected to meet standard**
Chief Nurse	93.67%	93.51%	94.78%	↑	95.00%	94.29%	March 17



	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15	Jan16	Feb16	Mar16	Apr16	May16	Jun16	Jul16
Pressure Ulcers	3.5	4.18	3.87	4.1	3.82	4.67	5.35	6.16	4.24	3.83	5.19	5.22	4.35
Falls	0.16	0	0.34	0.15	0.32	0.31	0.38	0.3	0.24	0.08	0.31	0.24	0.09
Catheter & UTI	1.32	1.5	1.03	0.67	0.96	0.47	0.46	0.9	0.9	0.65	1.22	0.63	1.04
New VTE	0.08	0.24	0.17	0.3	0.48	1.01	0	0.23	0.08	0.33	0.08	0.63	0
Patients	1285	1268	1162	1341	1255	1284	1308	1331	1227	1226	1311	1264	1150

Pressure ulcers (50)

- 25 grade 2 (7 new, 18 old)
- 21 grade 3 (4 new, 17 old)
- 4 grade 4 (0 new, 4 old)

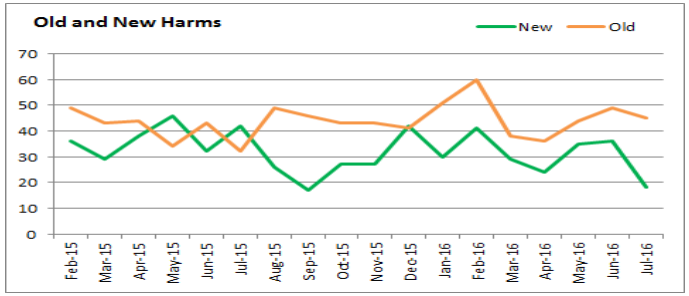
CAUTI (12)

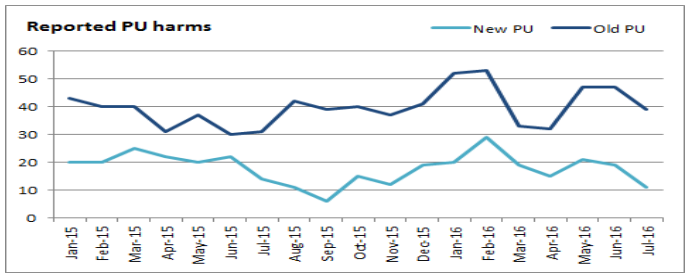
- 6 old
- 6 new

Falls (1)

- 1 moderate harm

VTE (0)





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

In July 2016 the proportion of our patients that received harm free care was 94.78 per cent, which is an improvement from the previous month and is marginally better than the national average for the month. We reported 63 harms to 60 patients; 57 patients experienced one harm and 3 patients had 2 harms. The number of new harms (n=18) reduced by half this month and accounts for less than 1 in 3 of the total harms reported.

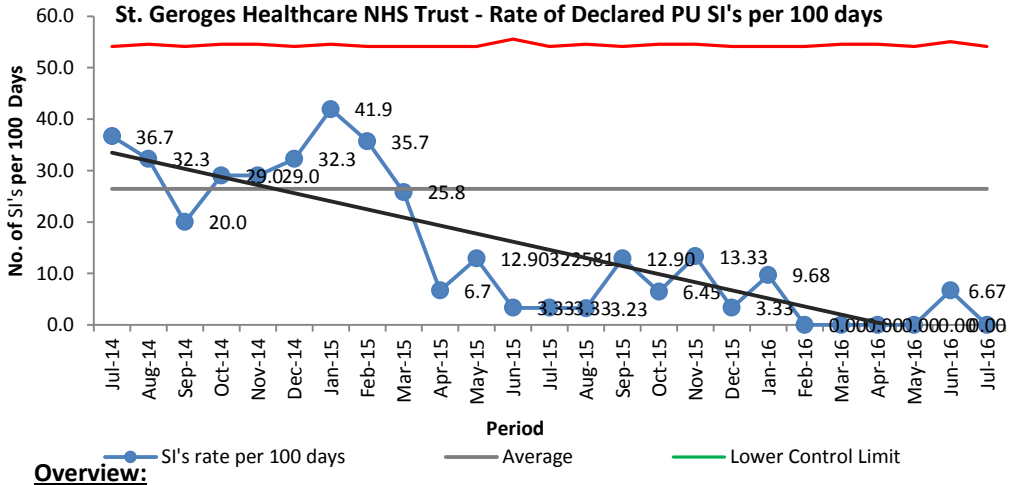
The number of pressure ulcers harms, both old and new, fell this month. Falls were also lower and there were no new VTE harms reported. The only increase was observed in catheter associated UTIs, with the number of old harms rising from 2 in June to 6 in July.

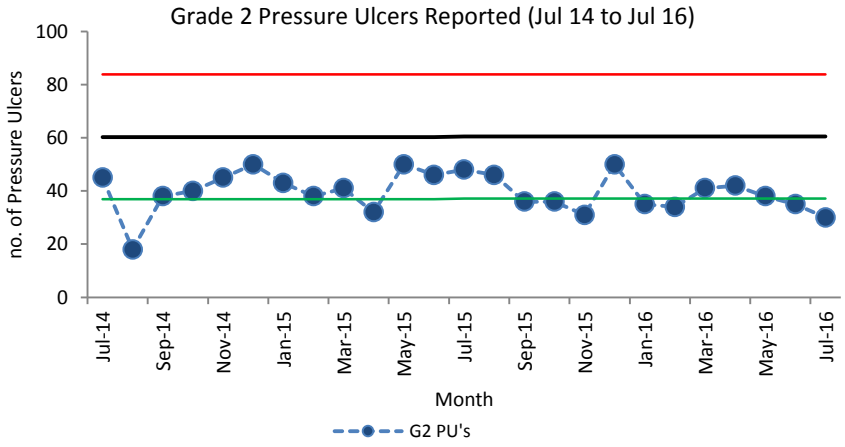
We are piloting local amendments to the data collection which will allow us to establish whether new harms are attributable to the ward on which they are reported. It is hoped that this will improve the usefulness of data for local teams and help to identify where improvements are required. It is expected that the pilot will run for approximately 3 months.

8. Patient Safety
- Incident Profile: Pressure Ulcers

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

Grade 2 Pressure Ulcers						
Mar	Apr	May	Jun	Jul	Movement
25	27	30	15	21	⩛
16	14	8	20	9	⩛
41	41	38	35	30	⩛
41	32	50	46	48	⩛





Overview:

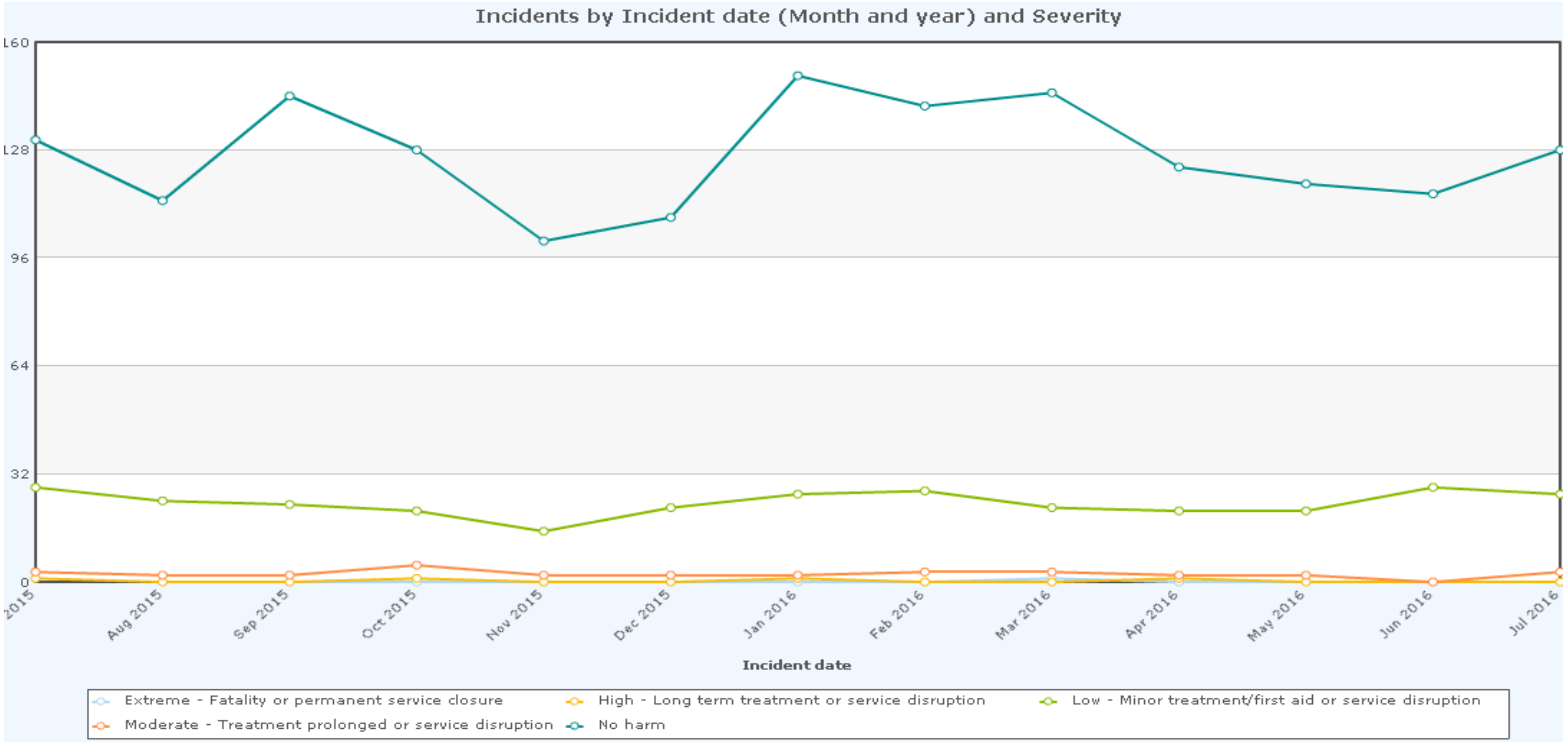
July saw a reduction in the number of pressure ulcers with zero pressure ulcer serious incident declarations. There was also a reduction in the number of Grade 2 pressure ulcers across both acute and community services. The trust remains on target for meeting its yearly target of 19 avoidable pressure ulcers (2016/17).

Actions:

- Second Band 6 Tissue Viability Support Nurse due to start on 12th September. Recruitment of outstanding Band 7 community post on-going.
- On-going education to ensure awareness of pressure ulcers remains a priority.
- Formulation of detailed action plan with aim to further reduce Grade 2 pressure ulcer incident rates.
- Planning of trust wide audit in pressure ulcer prevention and management.

8. Patient Safety:
- Incident Profile: Falls

Falls														Falls with Harm July 2015 to July 2016			
Lead Director	July	August	Sept	Oct	Nov	Dec	Jan 16	Feb	March 16	April	May 2016	June 2016	July 2016	Movement	No Harm	Low	Moderate	Severe
	163	140	168	155	118	132	179	170	171	146	140	143	157	⟷	1607	209	8	2



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 similar incidence of falls this month which may be attributed to seasonal changes. Actions include: reviewing the current training of clinical staff in falls prevention and developing a framework to include e-learning packages and face to face training . The falls policy is being reviewed and updated in line with electronic documentation. The "Safe and Effective Use of Bed rails" policy has been reviewed and updated. A best practice guide for bed rails assessment and supply has been developed for the CARE folders on each ward.

8. Patient Safety
- Infection Control

MRSA						
Lead Director	June	July	Movement	2016/2017 Threshold	Forecast August 2016	Date expected to meet standard
JH	0	0	⇔	0	G	31/03/17

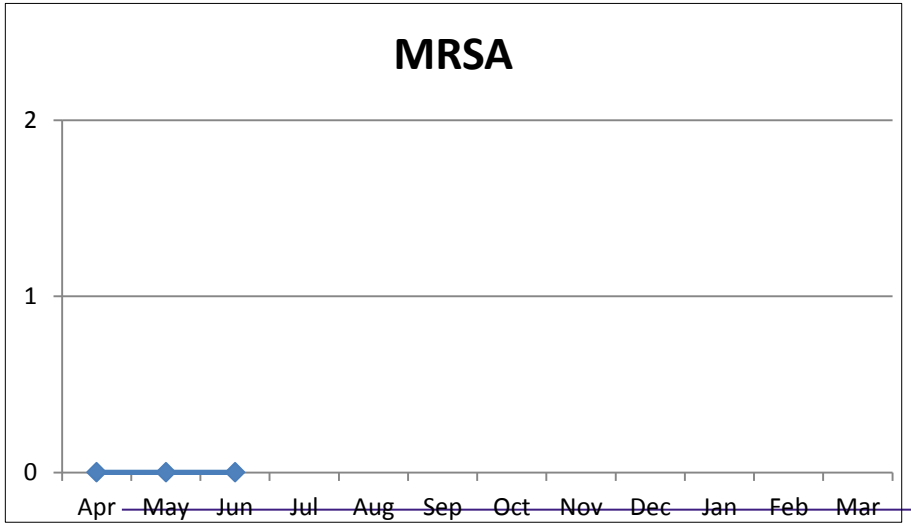
Peer Performance – YTD July 2016				
STG	Croydon	Kingston	King's College	Epsom & St Helier
0	0	0	2	3

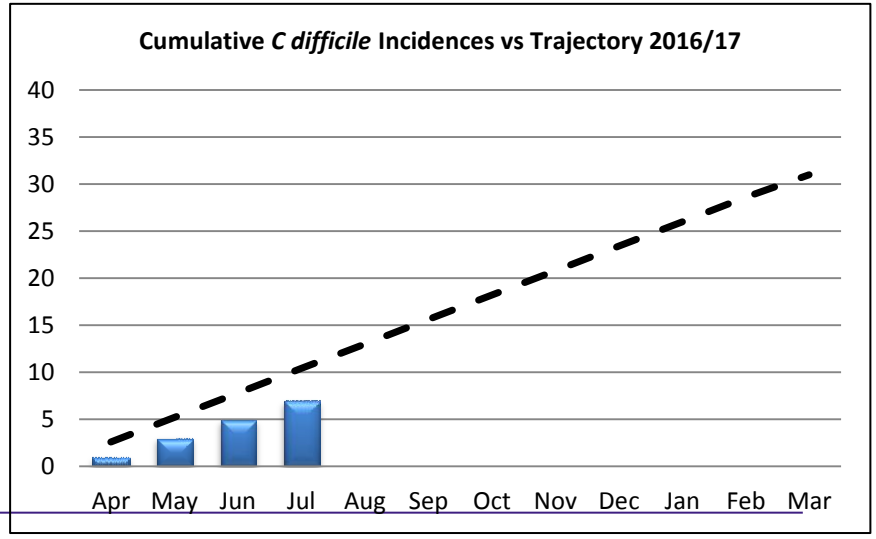
C. difficile						
Lead Director	June	July	Movement	2016/2017 Threshold	Forecast August 2016	Date expected to meet standard
JH	2	2	⇔	31	G	31/03/17

Peer Performance – YTD July 2016 (annual threshold in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
7 (31)	6 (16)	3 (9)	22 (72)	13 (39)

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

In 2016/17 the Trust has a threshold of no more than 31 *C. difficile* Trust-apportioned episodes. In July there were 2 Trust-apportioned episodes. This makes a total of 7 for the FY to end June 2016. This means that the Trust is currently on trajectory to achieve the target at the end of the FY 2016/17. There have been two patients with *C difficile* infection who died and *C difficile* was recorded on the death certificate. One of these episodes was community-acquired whereas the other was likely to have been hospital-acquired. Both of these episodes are being investigated as Serious Incidents.





8. Patient Safety
- VTE

VTE Risk Assessment

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

Data Source	August	Sept	Oct	Nov	Dec	Jan 2016	Feb	March	April	May	June	July	August
Unify2	96.78%	97.22%	97.10%	96.8%	96.5%	96.6%	96.7%	97.04%	96.45%	97.59%	97.6%	96.9%	

2. Overview: Nursing staff collect data monthly across a range of safety indicators, including completion of VTE risk assessment, via the safety thermometer. Data is collected for all patients across the Trust on a single day of the month, representing a snapshot in time. Data is obtained from the drug chart and measures the total number of complete VTE risk assessments at the point of audit against the total number of beds occupied. Data is adjusted by HTG to exclude 'Not Applicable' recordings (these are validated by the team). **NB. The RAG ratings for the safety thermometer changed in April 2015 to be consistent with the UNIFY targets.**

Data Source	August	Sept	Oct	Nov	Dec	Jan 2016	Feb	March	April	May	June	July	August
Safety Thermometer	92.38%	91.28%	93.40%	93.24%	88.56%	94.10%	90.2%	94.04%	95.47%	92.9%	94.5%	95.7%	

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 Quarter 1 Pharmacy-led Trust-wide audit of VTE risk assessment and prescription of appropriate prophylaxis showed Trust-wide improvement in results in comparison to the 2015/16 end of year average, across the four VTE related quality standards covered by the audit. Of particular note, targets were met consistently across the Medicine and Cardiovascular Division. There was heightened vigilance surrounding adherence to VTE prevention processes leading up to and during the CQC visit which may be reflected in these results (data collection occurred during this period). It is hoped that these high standards will continue into quarter 2.
- The next upgrade to the iClip VTE Prevention Package will be made available by Cerner by the end of July 2016. The upgrade links the VTE risk assessment with the prescribing of VTE prophylaxis within one single form/process. It is hoped that this will reduce the number of patients experiencing delays in the initiation of VTE prophylaxis following admission to the Trust.

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

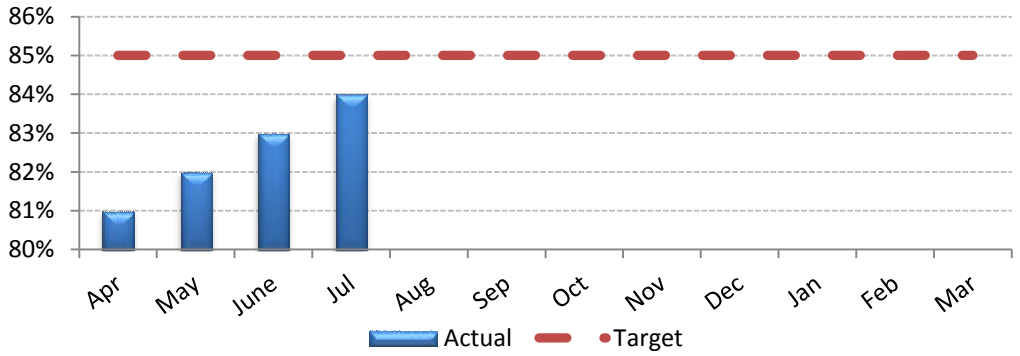
Year		2016
HAT cases identified to date (attributable to admission at SGH)		110
Mortality rate	Total	9 (8.2%)
	VTE primary cause of death	3 (2.7%)
Initiation of RCA process		100 (91%)
RCA complete		64.5% (71/110)
Cases where adequate prophylaxis was provided		61
Cases where inadequate prophylaxis was provided		7
Incidents jointly reviewed by HTG and clinical team		1
Incidents investigated as SI		1

8. Patient Safety
- Safeguarding: Adults

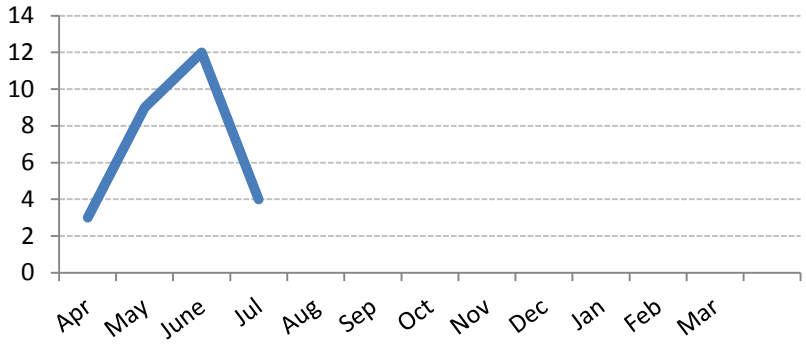
Safeguarding Training Compliance - Adults									
Lead Director	Feb	Mar	April	May	Jun	July	2015/2016 Target	Forecast April 2016	Date expected to meet standard
JH	73%	78%	81%	82%	83%	84%	85%	A	-

Safeguarding Adults Training Compliance by Division – July 16				
Med & Card	Surgery & Neuro	Community	Children's and Women's	Corporate
85%	85%	87%	84%	79%

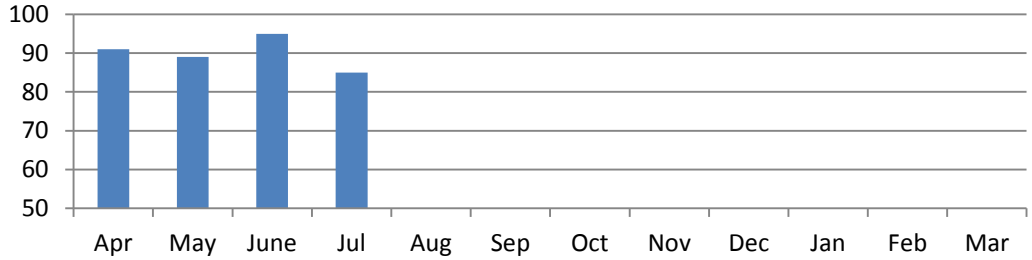
Safeguarding Training Compliance by Month 2016/17



DOLS 2016/17



Referrals



Continue to monitor safeguarding training via ARIS and MAST steering group. Divisions to take action around low compliance. Steady increase in compliance over last 6 months

Review procedures following implementation of Care Act – Pan London procedures published Feb 2016 – local guidance completed Spring 2016. E-Learning revised May 16.

Roll out MCA training across trust, audit completed Spring 2016, training commenced May 16. Drop in sessions to continue whilst e-learning package is completed

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 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. Draft MCA/DoLs Guidance produced June 16. Working party to commence Sep 16 to address issues of training, guidance, governance, audit

8. Patient Safety
- Safeguarding Children

Division	No of staff compliant	No. requiring training	compliant %
Children and Women's Diagnostic and Therapy Services	512	615	83%
Community Services	110	127	87%
Corporate	2	2	100%
Medicine and Cardiovascular (ED)	87	203	43%
Surgery & Neurosciences	22	24	98%

Training : The Safeguarding Children team are continuing to take an in-depth look at the level 3 training figures on ARIS. It remains evident that staff who are known to be compliant are not recorded as such on ARIS. In addition, the safeguarding team will be working with the MAST team, area department leads and HR to ensure that staff are allocated the appropriate level of training this will start in September 2016.

Serious Case Reviews and Internal Management Reviews: None

Other:
1 case of allegations made against staff that is currently under investigation.

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

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Patient Experience

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9. Patient Experience
- Friends and Family Test

Service	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Average
Community Services	86% n=401 ^	87% n=430 ^	94% n=1147 ^	94% n=1337 –	93% n=536 v	94% n=393 ^	92% n=408 v	93% n=360 ^	93% n=369 –	92% n=364 v	94% n=249 ^	92% n=546 v	91% n=6540
Medicine and Cardiovascular	96% n=710 ^	94% n=807 –	96% n=687 ^	96% n=724 –	97% n=615 ^	96% n=707 v	97% n=708 ^	96% n=604 v	97% n=772 ^	96% n=860 v	95% n=835 v	97% n=709 ^	96% n=8738
Surgery Anaethetics and Neuro	90% n=767 v	88% n=736 v	92% n=787 ^	90% n=709 v	91% n=642 ^	92% n=677 ^	90% n=598 v	93% n=641 ^	94% n=820 ^	95% n=807 ^	94% n=1056 v	97% n=775 ^	92% n=9015
Women and Childrens	93% n=498 ^	93% n=429 ^	93% n=480 –	93% n=397 –	91% n=336 v	92% n=273 ^	92% n=251 –	91% n=288 v	90% n=305 v	96% n=402 ^	91% n=337 v	93% n=276 ^	92% n=4272
Trust	**92% n=2376 ^**	**91% n=2402 ^**	**94% n=3101 ^**	**93% n=3167 v**	**93% n=2129 –**	**94% n=2050 ^**	**93% n=1965 v**	**94% n=1893 ^**	**94% n=2266 –**	**95% n=2433 ^**	**94% n=2477 v**	**95% n=2306 ^**	**93% n=28565**

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

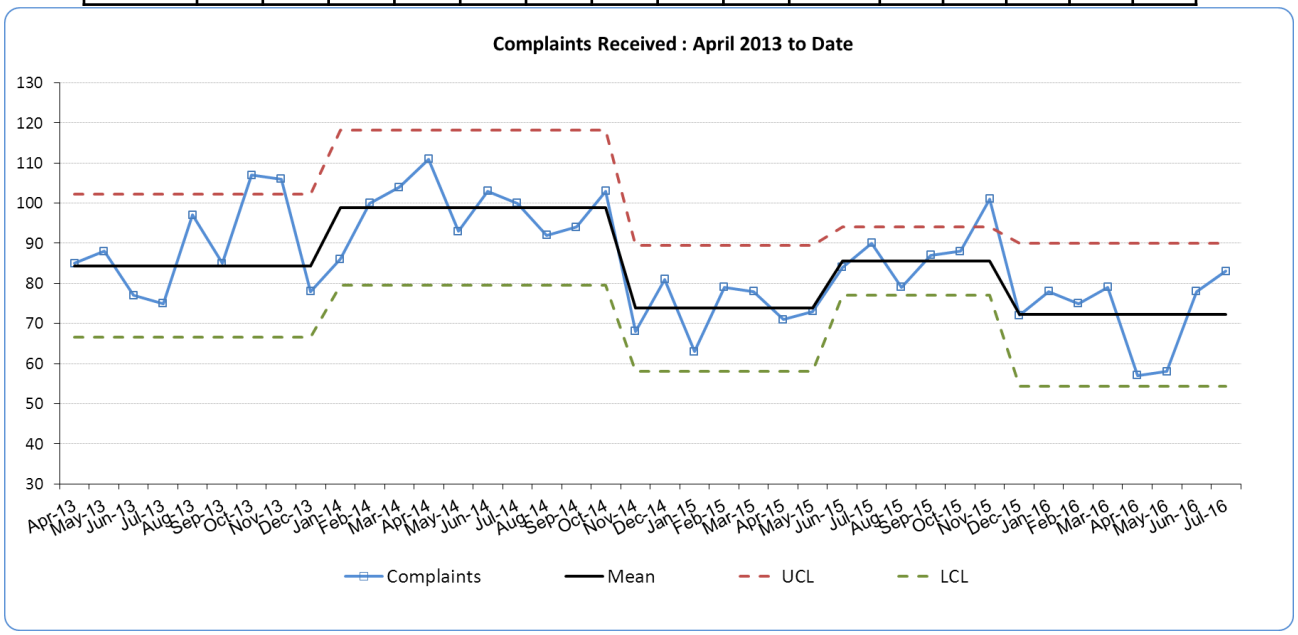
This report draws data from all patient surveys conducted on the RaTE system; including accessible versions that were created for any patient or relative that would have trouble understanding the standardised survey question.

Further breakdowns are available for services and location type.

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

9. Patient Experience
- Complaints Received

Complaints Received															
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Movement
Total Number received	84	90	79	86	88	102	72	78	74	79	57	58	78	83	



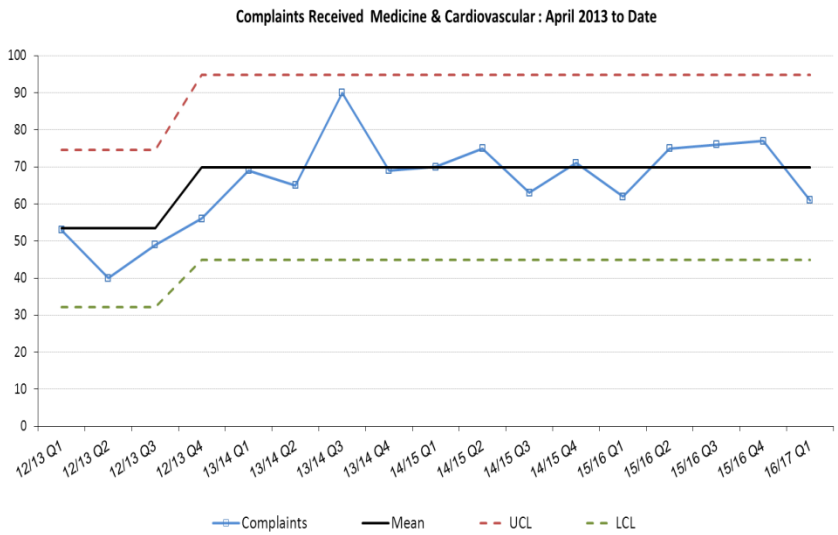
Overview:

This report provides an update on complaints received in quarter 1 of 2016/2017 and information on responding to complaints within the specified timeframes for the same period, with divisional breakdowns and analysis of the data to provide some trends and themes. It also includes some actions taken and planned in quarter 1, a report of the latest work on severity rating of complaints and posts on NHS Choices and Patient Opinion.

Total numbers of complaints received in Quarter 1 of 2016/2017

There were 190 complaints received in quarter 1 of 2016/2017, a significant decrease when compared to quarter 4 of 2015/2016 when 262 complaints were received. Complaints reduced in the Medicine and Cardiovascular, Women's and Children's and Community Services Division. Complaints increased in the Surgery and Neurosciences Division and Corporate Directorates.

9. Patient Experience
- Complaints – Q1 by division



Medicine and Cardiovascular Division Q1

Specialist Medicine Directorate:
The two main areas of concern are:
Access to the service: In Gastroenterology, there has been an increase in the referral rate, and difficulty recruiting doctors. In Dermatology, this was due to a recalibration exercise of the waiting list which is now complete. In Endoscopy – manning of phone lines.
Action taken:
A review of working practice in Endoscopy Unit and a system of ensuring that the phone line is managed more effectively and throughout working hours is now in place. Installation of a call waiting system and answerphone in progress.
In Gastroenterology: The department has now successfully recruited two new consultants which will help increase capacity.

Delayed diagnosis
This area related to a patient from the Clinical infections unit and there was difficulty in arriving at a diagnosis in a timely manner due to the complex nature of the condition. This complaint has been shared with the clinical teams to evidence the importance of communication with patients who have complex needs.

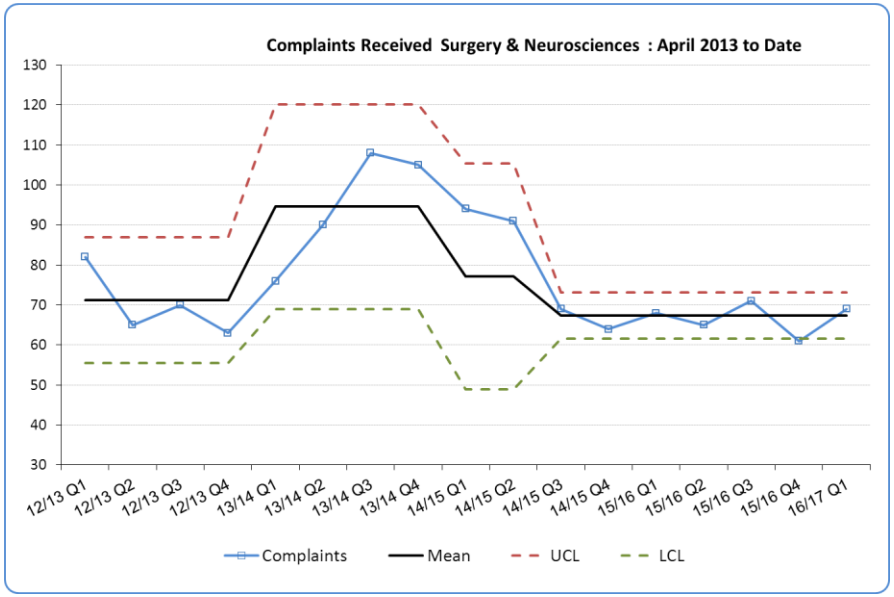
Renal Haematology and Oncology
4 complaints were received in Q1, three were managed informally and relate to communication in the written and verbal form. The actions were to remind individuals regarding their own communication styles and to ensure appropriate and accurate information is obtained. One complaint was regarding a sum of money that relatives felt had been lost or stolen, however after a thorough investigation, there was no evidence that money was brought in on admission- No actions were required.

Acute Medicine
There are 4 main themes for Acute Medicine –

1. **Patient experience** - The ward staff where the issues have been raised have been informed of the concerns regarding care. The Heads of Nursing and Matrons for the areas have met with staff and reminded them of their responsibilities towards patients and their families ensuring that patients' needs continue to meet high quality standards. This is also being addressed on a daily basis during the nursing handovers and daily nursing huddles across the wards. The Matrons will monitor patient experience as part of the daily ward visits and weekly back to the floor.
2. **Loss of property** – The directorate has experienced an increased number of complaints regarding loss of property including dentures and hearing aids. New procedures will be brought in for the wards especially when transferring patients between afferent wards. Currently on some wards twice daily safety checks are carried out to ensure that patient's dentures and hearing aids are with the patients. Staff have been particularly reminded to be vigilant with patients belongings if they are not able to do so themselves. This principle has proven effective in senior health and is being implemented across acute medicine in quarter 2.
3. **Communication regarding EoL care** - At ward handovers staff are reminded of the importance of communication between patients, staff and their families to prevent confusion and provide a clear plan of care for the relatives. This is to ensure that if there are any changes in the patient's condition or treatment that this acted upon as appropriate and the family are informed. Staff have been encouraged to 'talk to the families', go in to the room and ask if they need anything, not to assume that they wish to be on their own all the time with their loved one. The directorate has sent a number of staff on specific end of life care training with Trinity hospice and have established action learning sets on their return. The AMU will also be working with the palliative care team to deliver focused EOL training to staff and work with new staff for positive role modelling and development.
4 - **Environment** – The directorate has received complaints regarding the environment of wards. The nursing team log all issues with estates and report them to the HoN if escalation required.

Emergency Department
The ED has received complaints regarding staff attitude and perceptions that there has been a delay in treatment whilst patients have been waiting. In response to this the following actions have been taken:
• Review of triage process in ED and new model of meet and greet/streaming to be implemented in Q1, including reassessment of
patients waiting in waiting room
Review or the staffing profile against attendances and the use of temporary staff to support UCC
• Staff involved in complaints complete reflective accounts which are stored in the individuals files
• Don't take your troubles home posters displayed across ED and wards in Acute Medicine

9. Patient Experience
- Complaints – Q1 by division



Themes and associated action
August 2016 (June data)

Background
The overall context is that volumes of complaints have decreased back to the division's historical monthly level of 19/20 complaints following a slight increase in May of about 10 complaints taking the monthly volume to 30 complaints. Performance is demonstrating a slow but consistent improvement to 63% following deterioration in March to 53%.

The themes being identified remain fairly consistent from a divisional perspective with clinical treatment, care, communication (written and verbal) and waiting times being the most frequently observed. A number of actions have been generated from within each care group in response to these themes.

Themes and action by service:-
Neurosciences
Themes: Communication, Attitude, OP waiting times
Communication issues across the directorate and across different professional groups. Complaints relating to specific members of staff are brought to their attention and managed appropriately by the line manager. Feedback provided to agencies for non-trust staff.

Complaints relating to outpatients have reduced with the establishment of a local booking team. There are two remaining challenging areas for outpatients; capacity and waiting times in neurology, for which the care group have agreed actions to increase capacity.

Feedback from patient complaints shared at local team meetings, directorate meeting and individually with staff as appropriate.

Significant focus on nursing and medical recruitment to reduce use of temporary staff. Where agency is required, block booking made to increase consistency, where appropriate and training provided to frequently booked temporary staff.

Outpatient room build to commence in September/October to create outpatient capacity and reduce waiting times. Evening clinics have been increased in frequency in the short term to manage capacity hot spots.

Continue with local booking team to maintain general improvement in patient experience and reduction in complaints in this area.

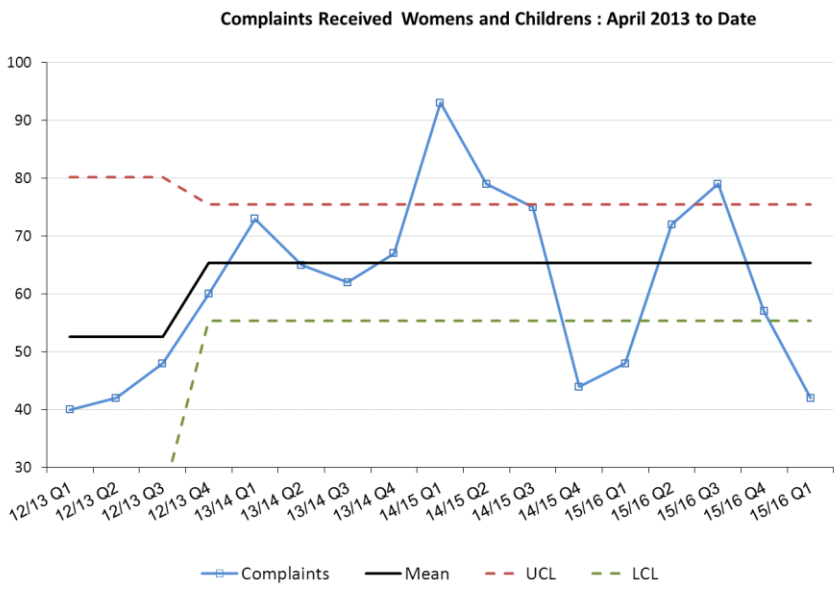
General Surgery
Themes: Consultant behaviour, long waits
The care group lead and general manager are holding monthly consultant meetings to talk about general surgery behaviour and perception of the team/service across the trust – items of discussion:

- Patient communication
- Bare below the elbows
- Interaction with nursing staff
- Teaching of junior doctors
- Result checking
- Annual leave management

The management team are actively reducing patient waits, by better utilising lists and involving the consultant body so they are fully aware of the pressure and can actively contribute to identifying solutions.

ENT and Audiology
Themes: OP waits and ability to contact the service
The OP transformation project is addressing many of these issues. ENT are sending long waiting patients out to the private sector for treatment and putting on Saturday lists to reduce OP waits.

9. Patient Experience
- Complaints – Q1 by division



Children's, Women's, Diagnostics, Therapeutics and Critical Care (CWDT&CC) Division complaints performance and themes quarter 1

The CWDT&CC Division continues to see a decrease in the number of complaints received; with 57 received in Q4 and 42 received in Q1. This reduction is a continuing trend with the numbers almost halved since Q3 when 79 complaints were received.

Women's services continue to receive the highest number of complaints.

Themes

The top themes of complaints in order of frequency within the division are:
Clinical Treatment
Communication
Care
Waiting Times

It is worth noting that the ranking of the themes have changed with clinical treatment now being the leading theme, this is compared to communication in the previous quarter. These themes do however reflect previous quarters despite various initiatives being implemented, some of which are still on-going.

:

Actions

Communication

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

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

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

Waiting Times

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

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

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

Care /Clinical Treatment

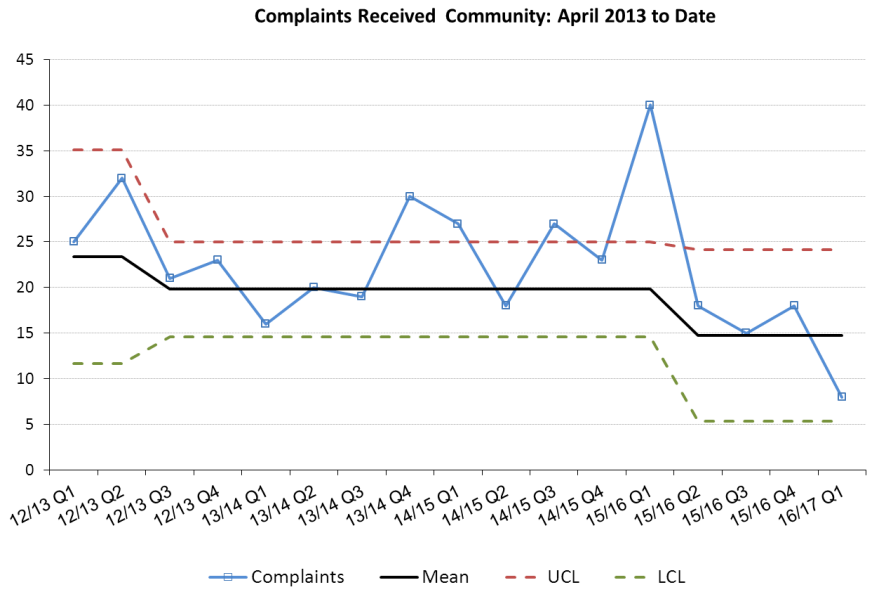
All clinical treatment concerns are addressed on a case by case basis
Maternity does however have a slightly higher proportion of complaints relating to clinical treatment and care, further analysis suggests that some complainants are unhappy with their birth experience. In recognition of this the service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

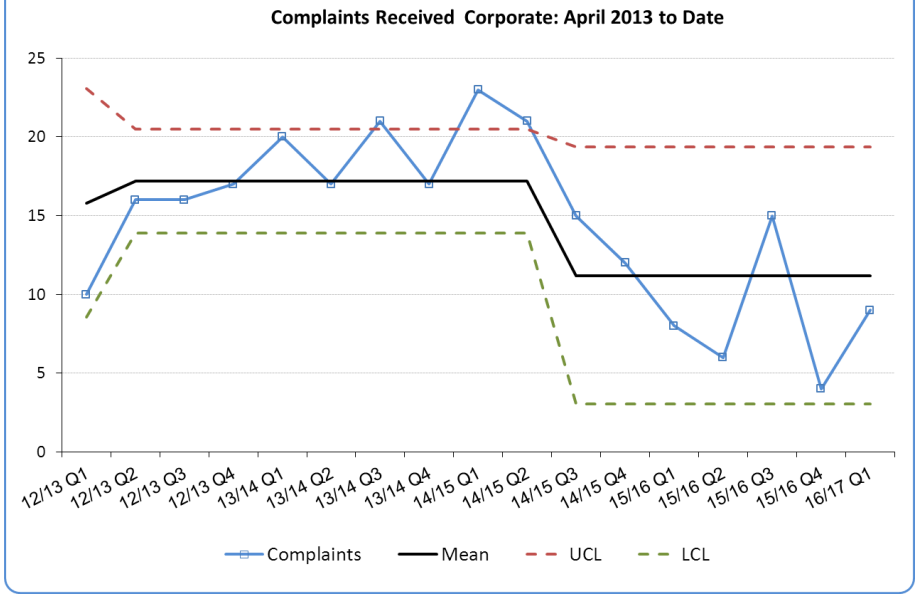
It is worth noting that there have been no complaints regarding the suspension of the urogynaecology service in this quarter.

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

9. Patient Experience

- Complaints – Q1 by division





Community Services Division Q412015/16:

In Q1 CSD only received 8 complaints – some of which were complaints about things that are not included in the commissioning contract for the services (some orthotic appliances) . An example of an action taken is that some families of disabled children have been given personal care budgets so they can select their own choice of product

Corporate Directorates

Patient Transport

The main themes are patients arriving late for appointments. There have been a number of complaints where patients have mentioned long waits for discharge but on further investigation the transport was not booked when the patient was told.

The main actions to improve the service are twofold:

The resources on the contract are being reviewed to increase the number of ambulances within budget. There are peaks in demand around lunchtime and early evenings and more drivers are needed.

The second action relates to communication to patients throughout the discharge process explaining when transport is booked. This is a key action on the flow programme. The discharge work stream has created a leaflet explaining how all areas of discharge work and also explaining that ambulances are on-going provided for those with a medical need.

Food

One patient complained about the choice for vegans. There is work underway to address this.

Estates

The main theme is uneven pavements and a loose thread on an internal staircase both resulting in falls. The areas of the falls have been fixed and the estates team are obtaining costs to fix uneven pavement across the grounds.

Car Parking

Whilst the formal complaints are low the number of PALS contacts and informal complaints are high.

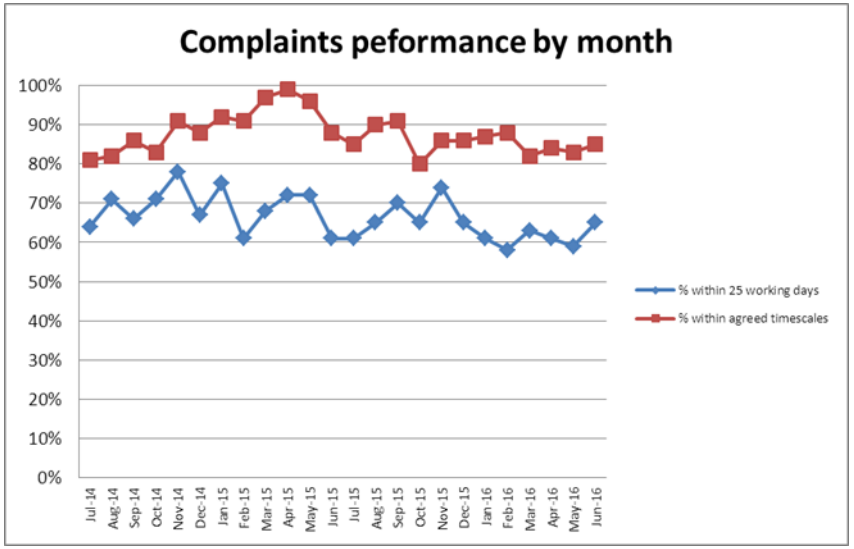
Patients complain about the cost, not being informed about the concessions and the lack of ability to pay by card.

The concessions are included on the website, in car park signage and are also regularly sent to wards and clinics to promote.

The car park machinery is too old to install card payments. The machinery will be upgraded as part of the demolition decant works as car park 1 will be expanded to provide more car parking spaces.

9. Patient Experience
- Complaints Performance against targets

Performance Against Targets Quarter 1 of 2016/2017				
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	42	23	55%	(12) 83%
Medicine and Cardiovascular	61	36	59%	(20) 92%
Surgery & Neurosciences	69	44	64%	(12) 81%
Community Services	8	8	100%	(0) 100%
Corporate Directorates	9	6	67%	(2) 89%
SWL Pathology	1	1	100%	(1) 100%
Totals:	190	118	62%	(46) 86%



Commentary:

There was no improvement in performance against either target in quarter 1 of 2016/2017 when compared to quarter 4 of 2015/2016. 62% of complaints were responded to within 25 working days (against the internal trust target of 85%) compared to 61% in quarter 4. 86% of complaints were responded to within agreed timescales (against internal trust target of 100%) compared to 84% in quarter 4.

Community Services Division and South West London Pathology were the only areas which reached both targets but these areas received a low number of complaints.

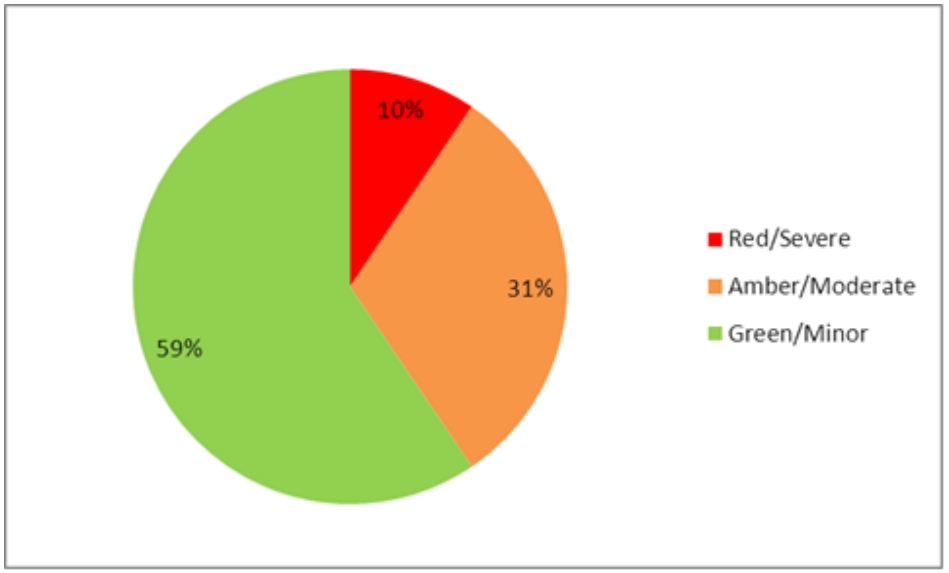
Updates on the Complaints and PALS action plan are being presented in a separate paper.

9. Patient Experience
- Complaints severity rating overview

The Complaints and Improvements Co-ordinators make an initial assessment of each complaint and grade them for severity in accordance with a matrix. It is the responsibility of the General Manager/Head of Nursing investigating the complaint to adjust the grading if necessary following the investigation.

This is vital to ensure that urgent/critical matters are dealt with by relevant senior staff and in a timely way. If there is a concern about a possible serious incident (SI) or safeguarding issue these are discussed with the risk department and the relevant safeguarding lead(s) for children or adults.

This system is an internal flag to ensure critical issues or incidents are escalated and investigated appropriately. It is not an attempt to determine how serious the complainant thinks/feels it is.



A summary of ratings for quarter 1 of 2016/2017 is presented below.

In Quarter 1 a total of 18 complaints were categorised as Red/Severe.
The red severity cases have been examined to decipher if they should still remain red after investigation and response completed. However some of the cases are still open therefore the total figure for red severity cases may change and will be reflected in the end of year final report.

The reasoning for the red ratings included:

- Death noted.
- Serious Injury/ Serious Adverse Outcome.
- Vulnerable patient, possible neglect. Safeguarding issues.
- Complex case as more than one service involved.
-

In Quarter 1 a total of 59 complaints were categorised as Amber/Moderate.
The most common reasons for the amber ratings were an adverse injury or outcome and the complaint being complex and/or involving 2-4 services.

In Quarter 1 a total of 113 complaints were categorised as Green/Minor.

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

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

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

Afia Miah *gave Cancer Services at St George's Hospital (London) a rating of 5 stars*
Excellent care provided, wonderful staff.
I would like to thank all the staff from St George's Hospital who had provided Excellent care, and supporting me whilst I was going through a difficult time fighting with cancer. The staff working in Trevor Howells Ward have been wonderful. I appreciate everything that they had done for me.. Great people, they are always willing to help. The hospital cleanliness is up to high standard. Am grateful to have had my chemo treatment at this hospital. I have experienced the care service with other hospital, but this one is the best. Thank you St George's once again. Always I would recommend this hospital to my friends and family.

Visited in August 2016. Posted on 08 August 2016

Anonymous *gave Queen Mary Hospital a rating of 1 stars*
90 mins to tell me my appointment was cancelled.
I arrived for my appointment with the stone clinic, after 90 minutes I was told that there was a new system, and no ultra sound had been made and as a result my appointment had been cancelled. I advised the HCA that I had a CT scan a week prior to appointment, the nurse went to see the consultant, after seeing the consultant they advised me that as the CT scan took place at Kingston Hospital that didn't have access to the scan. On returning home to my husband who works at Queen Mary's he told me that that was untrue and of course they access to the scan.

Visited in August 2016. Posted on 08 August 2016

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

WORKFORCE

Excellence in specialist and community healthcare

10. Patient Safety – July 2016
Mixed Sex Accommodation breaches

Mixed Sex Accommodation					
Lead Director	JUNE	JULY	2015/2016 Threshold	Forecast AUGUCT 16	Date expected to meet standard
JH	0	0	0	0	-

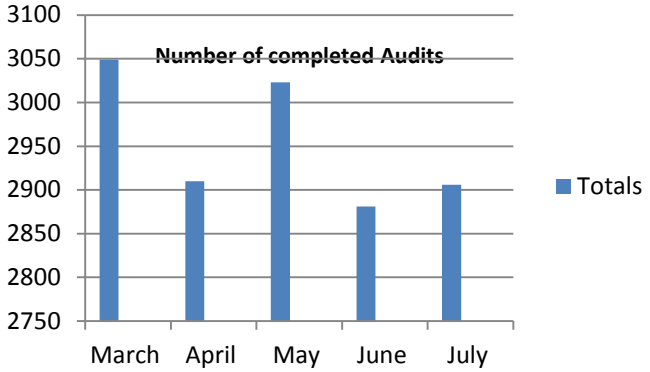
All NHS organisations are expected to eliminate mixed sex accommodation breaches except where it is in the overall best interest of the patient , or reflects their personal choice. The Mixed Sex Accommodation threshold is zero. There are two areas in the trust where mixing sexes is allowed if life is threatened (HASU and ICU).

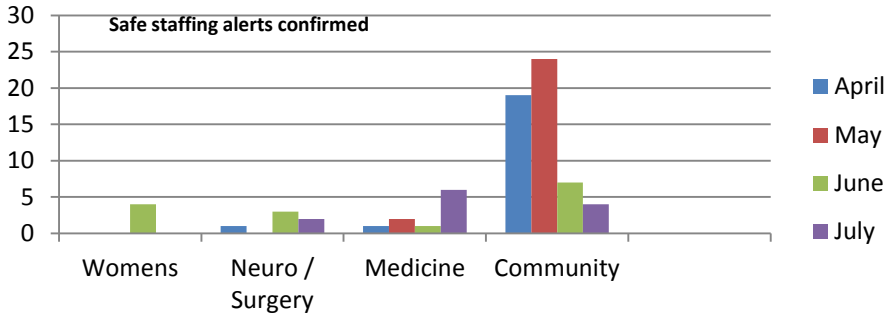
The trust has had 11 breaches year to date. A root cause analysis report is prepared for all breaches highlighting cause and actions.

There were no EMSA breaches in July 2016. The trend over the past 12 months is outlined below.

AUG 15	SEP	OCT	NOV	DEC	JAN 2016	FEB	MAR	APR	MAY	JUNE	JULY
0	0	5	0	0	0	6	0	0	0	0	0

10. Workforce July 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: May 3023, June 2881 and July 2906. There was a slight decrease in the number of final alerts reported from 15 in June to 6 in July 2016. The number of alerts reduced to a concern (ward is safely staffed but some care needs will not be completed) following on the day investigation over the past three months is May 7, June 4 and July 12.

Of 2 nursing related safe staffing concerns raised on Datix system in July (6 in June) none matched a similar entry on the RATE system. Senior nurses are made aware of alerts and concerns via email at 10am.

MONTH	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY
ALERTS	2	12	27	9	10	35	29	56	59	21	26	15	6
CONCERNS	17	24	14	37	13	10	18	33	13	5	7	4	12

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

10. Workforce: July 2016
- Care hours per patient day

Overview

Every month for the past year the trust has submitted figures for the number of filled shifts for registered and unregistered staff during day and night shifts and upload this information onto UNIFY.

From May 2016, all acute trusts with inpatient wards/units began reporting monthly CHPPD data to NHS improvement. Over time this will allow trusts to review the deployment of staff within a speciality and by comparable ward. When looking at this information locally alongside other patient outcome measures, trusts will be able to identify how they can change and flex their staffing establishment to improve outcomes for patients and improve productivity. NHS England are to provide further information on the use of the tool and how trusts can use it to plan staffing numbers.

The introduction of CHPPD for nurses and healthcare support staffing in the inpatient / acute setting is the first step in developing the methodology as a tool that can contribute to a review of staff deployment. Work has begun to consider appropriate application of this metric in other care settings and to include other health professional such as allied health professionals (AHP). As with other indicators, CHPPD, should never be viewed in isolation but as part of a local quality dashboard that includes patient outcome measures alongside workforce and financial indicators. The aim is to help ward managers, clinical matrons and hospital managers make safe, efficient and effective decisions about staff deployment.

CHPPD is calculated by adding the hours of registered nurses and healthcare support workers and dividing the total by every 24 hours of inpatient admissions (or approximating 24 patient hours by count of patients at midnight). CHPPD is reported as a total an d split by registered nurses and healthcare support workers to provide a complete picture of care and skill mix (NQB – July 16).

The data for the number of patients in a bed at 23.59 is reliant on the Iclip system being updated. For example a ward with 20 beds should never show more than 20 people in a bed at 23.59 hours. In some cases, the numbers shown were over the number of beds available. This occurs If Iclip has not been updated and patients are not discharged on time. In order to ensure the data is as accurate as possible a cap has been placed in the data collection tool to ensure the maximum number of people in a bed at midnight does not exceed the actual number of beds available. If there are less people in a bed at collection time, the data will still reflect this. We are aware that some areas may show an excess of people in a bed when they open escalation areas and this will be monitored as required.

10. Workforce: July 2016
- Care hours per patient day

Ward name	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	Last Month
Cardiothoracic Intensive Care Unit	433	30.53	0.66	31.20	31.29
Carmen Suite	111	25.37	5.97	31.34	34.45
Champneys Ward	253	6.87	2.05	8.91	8.49
Delivery Suite	509	15.85	2.72	18.57	19.46
Fred Hewitt Ward	373	10.37	0.91	11.28	12.39
General Intensive Care Unit	361	36.25	0.64	36.88	37.42
Gwillim Ward	985	3.94	1.50	5.44	5.33
Jungle Ward					
Neo Natal Unit	397	36.00	0.00	36.00	36.35
Neuro Intensive Care Unit	334	31.16	3.73	34.89	32.69
Nicholls Ward	382	10.61	1.74	12.35	10.23
Paediatric Intensive Care Unit	200	34.29	3.77	38.06	46.35
Pinckney Ward	323	11.78	0.96	12.75	12.51
Dalby Ward	487	5.66	7.23	12.89	13.73
Heberden	628	4.42	5.98	10.39	12.49
Mary Seacole Ward	12	333.50	438.89	772.39	8.76
A & E Department					
Allingham Ward	616	6.51	4.51	11.02	9.36
Amyand Ward	749	5.42	4.78	10.20	9.22
Belgrave Ward AMW	714	5.38	2.45	7.83	8.01
Benjamin Weir Ward AMW	806	4.77	1.51	6.28	6.00
Buckland Ward	479	5.56	2.35	7.91	7.33
Caroline Ward	620	5.19	1.02	6.21	6.37
Cheselden Ward	488	5.67	2.53	8.20	6.52
Coronary Care Unit	238	18.47	1.12	19.59	19.25
James Hope Ward					
Marnham Ward	775	6.14	2.81	8.95	9.24
McEntee Ward	349	7.24	3.23	10.47	8.47
Richmond Ward	676	14.18	9.76	23.94	12.43
Rodney Smith Med Ward	308	9.29	9.79	19.08	9.34
Ruth Myles Ward	180	13.85	4.51	18.36	13.16
Trevor Howell Ward	616	4.99	2.50	7.50	11.52
Winter Ward (Caesar Hawkins)	658	4.82	2.59	7.41	7.48
Brodie Ward	603	7.68	3.06	10.74	10.83
Cavell Surg Ward	632	4.81	2.03	6.84	6.86
Florence Nightingale Ward	500	6.83	1.32	8.15	8.08
Gray Ward	644	5.97	2.96	8.93	7.50
Gunning Ward	718	4.58	2.48	7.06	7.15
Gwynne Holford Ward	165	21.70	24.83	46.53	23.06
Holdsworth Ward	496	5.70	2.83	8.52	9.22
Keate Ward	440	6.28	1.59	7.88	7.03
Kent Ward	489	7.78	7.85	15.63	13.91
Mckissock Ward	429	6.73	3.77	10.50	8.75
Vernon Ward	448	7.82	2.62	10.44	7.73
William Drummond HASU	620	8.49	2.44	10.93	13.67
Wolfson Centre	398	9.61	6.13	15.73	18.14
Gordon Smith Ward	401	8.71	2.79	11.50	10.18
Trust Total	21043	10.55	3.74	14.29	12.68

120. Workforce: July 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 July 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 July 2016 the trust achieved an average fill rate of 95.53%%, a slight increase from 93.98% submitted in June 2016. The trend over the past six months is outlined below:

MONTH	FEB 16	MAR 16	APR	MAY	JUNE	JULY
%	93.92 %	94.14 %	94.52 %	96.19 %	93.98 %	95.53 %

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 work to complete the nursing heat map adding erostering KPI's to it

Implementation of the divisional safe staffing and workforce meetings linked to the compliance framework for erostering

10. Workforce: July 2016
- 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	94.8%	#DIV/0!	98.3%	100.0%	
Carmen Suite	124.5%	80.4%	98.5%	96.8%	
Champneys Ward	95.9%	95.8%	98.4%	100.0%	
Delivery Suite	108.2%	92.1%	109.0%	100.1%	
Fred Hewitt Ward	79.8%	85.8%	93.6%	8.7%	
General Intensive Care Unit	93.6%	100.0%	98.6%	100.0%	
Gwillim Ward	131.3%	109.1%	98.0%	95.2%	
Jungle Ward	96.1%	100.0%	#DIV/0!	#DIV/0!	
Neo Natal Unit	90.5%	#DIV/0!	93.5%	#DIV/0!	
Neuro Intensive Care Unit	92.1%	90.2%	94.9%	92.5%	
Nicholls Ward	86.5%	75.9%	98.1%	86.1%	
Paediatric Intensive Care Unit	89.2%	95.0%	98.7%	100.0%	
Pinckney Ward	90.8%	80.9%	97.4%	#DIV/0!	
Dalby Ward	90.3%	96.7%	97.6%	99.0%	
Heberden	87.7%	96.8%	100.0%	100.0%	
Mary Seacole Ward	94.9%	103.5%	99.0%	99.0%	
A & E Department	97.7%	71.8%	100.0%	85.6%	
Allingham Ward	102.3%	118.8%	98.6%	100.0%	
Amyand Ward	86.5%	102.9%	98.1%	100.0%	
Belgrave Ward AMW	92.7%	75.4%	97.4%	100.0%	
Benjamin Weir Ward AMW	83.1%	92.3%	97.1%	100.0%	
Buckland Ward	86.4%	96.1%	98.4%	98.0%	
Caroline Ward	92.6%	83.9%	99.8%	#DIV/0!	
Cheselden Ward	92.9%	100.5%	98.9%	100.0%	
Coronary Care Unit	106.2%	100.0%	97.3%	100.0%	
James Hope Ward	79.7%	96.8%	90.4%	#DIV/0!	
Mamham Ward	94.5%	96.0%	98.4%	90.2%	
McEntee Ward	98.1%	98.6%	95.7%	100.0%	
Richmond Ward	93.2%	105.7%	98.0%	98.9%	
Rodney Smith Med Ward	94.4%	106.1%	100.1%	100.0%	
Ruth Myles Ward	97.5%	106.3%	100.0%	100.0%	
Trevor Howell Ward	97.4%	93.0%	98.9%	100.0%	
Winter Ward (Caesar Hawkins)	90.7%	98.0%	98.3%	100.0%	
Brodie Ward	94.6%	87.7%	95.3%	100.0%	
Cavell Surg Ward	91.0%	99.9%	100.0%	100.0%	
Florence Nightingale Ward	92.0%	84.6%	100.0%	100.0%	
Gray Ward	88.5%	89.0%	100.0%	98.7%	
Gunning Ward	91.6%	95.0%	98.9%	100.0%	
Gwynne Holford Ward	98.1%	93.1%	96.7%	99.2%	
Holdsworth Ward	92.8%	92.0%	99.8%	100.0%	
Keate Ward	94.7%	89.2%	100.0%	100.0%	
Kent Ward	89.7%	90.3%	99.3%	98.6%	
Mckissock Ward	84.0%	97.4%	94.4%	100.0%	
Vernon Ward	93.2%	102.7%	97.8%	100.0%	
William Drummond HASU	86.0%	98.8%	91.1%	110.0%	
Wolfson Centre	90.5%	90.8%	98.8%	100.0%	
Gordon Smith Ward	85.4%	92.4%	98.7%	102.9%	
	#DIV/0!				

Trust Total	93.31%	95.00%	97.96%	97.71%	95.53%

	Day Qual	Day HCA	Night Qual	Night HCA	Overall
	93.31%	95.00%	97.96%	97.71%	95.53%

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

HEATMAP DASHBOARD
WARD VIEW

Excellence in specialist and community healthcare

Nursing and Midwifery Heatmap – July 2016

Division	Ward	Incidence of c.difficile	Incidence of MRSA	Trust acquired pressure ulcers	Percentage of harm free care	Patient satisfaction (friends & family)	Friends & family response rate	Falls (ward level)	Serious incidents (ward level)
COMMUNITY SERVICES	Mary Seacole	0.0	0.0	0.0		78.6		6.0	0.0
MEDICINE	ALLINGHAM	0.0	0.0	0.0	93.3	93.9	44.0	10.0	0.0
	AMYAND	1.0	0.0	0.0	94.7	93.3	25.4	6.0	1.0
	BELGRAVE	0.0	0.0	0.0	100.0	100.0	30.6	1.0	0.0
	BENJAMIN WEIR	0.0	0.0	0.0	96.0	100.0	17.4	0.0	0.0
	BUCKLAND	0.0	0.0	0.0	100.0	96.6	42.2	0.0	0.0
	CAESAR HAWKINS	0.0	0.0	0.0	90.9	89.7	34.9	7.0	0.0
	CARDIAC CARE UNIT	0.0	0.0	0.0	100.0	100.0	100.0	0.0	0.0
	CAROLINE	0.0	0.0	0.0	100.0	100.0	55.9	3.0	0.0
	CHESELDEN	0.0	0.0	0.0	81.8	91.3	30.7	4.0	0.0
	DALBY	0.0	0.0	0.0	91.7	100.0	17.9	8.0	0.0
	EMERGENCY DEPARTMENT	0.0	0.0	0.0		83.8	23.4	3.0	0.0
	GORDON SMITH	0.0	0.0	0.0	83.3	100.0	27.1	3.0	0.0
	HEBERDEN	1.0	0.0	0.0	83.3	100.0	31.4	5.0	0.0
	JAMES HOPE	0.0	0.0	0.0	100.0	100.0	75.5	1.0	0.0
	MARNHAM	0.0	0.0	0.0	86.2	91.7	42.1	2.0	0.0
	MCENTEE	0.0	0.0	0.0	100.0	100.0	47.1	2.0	0.0
	RICHMOND	0.0	0.0	0.0	89.5	96.3	28.0	10.0	0.0
	RODNEY SMITH	0.0	0.0	0.0	83.9	95.0	54.1	2.0	0.0
	RUTH MYLES DAY UNIT	0.0	0.0	0.0	92.9	100.0	43.8	4.0	0.0
	TREVOR HOWELL	0.0	0.0	0.0	100.0	100.0	63.2	6.0	0.0

Nursing and Midwifery Heatmap – July 2016

Division	Ward	Incidence of c.difficile	Incidence of MRSA	Trust acquired pressure ulcers	Percentage of harm free care	Patient satisfaction (friends & family)	Friends & family response rate	Falls (ward level)	Serious incidents (ward level)
SURGERY	BRODIE NEURO	0.0	0.0	0.0	100.0	100.0	3.4	6.0	0.0
	CAVELL	0.0	0.0	0.0	97.1	91.9	28.1	3.0	0.0
	FLORENCE NIGHTINGALE	0.0	0.0	0.0	94.7	96.1	63.9	2.0	0.0
	GRAY WARD	0.0	0.0	0.0	100.0	94.4	61.8	1.0	0.0
	GUNNING	0.0	0.0	0.0	100.0	95.7	51.1	3.0	0.0
	GWYN HOLFORD	0.0	0.0	0.0	95.5			4.0	0.0
	HOLDSWORTH	0.0	0.0	0.0	100.0	95.2	52.5	2.0	0.0
	KEATE	0.0	0.0	0.0	100.0	100.0	46.4	2.0	0.0
	KENT	0.0	0.0	0.0	96.6	100.0	36.9	9.0	0.0
	MCKISSOCK	0.0	0.0	0.0	100.0	94.7	52.1	2.0	0.0
	THOMAS YOUNG	0.0	0.0	0.0	91.3	100.0	40.9	1.0	0.0
	VERNON	0.0	0.0	0.0	95.2	96.0	55.6	4.0	0.0
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	100.0	100.0	44.2	3.0	0.0
WOMEN & CHILDREN	CARDIOTHORACIC INTENSIV..	0.0	0.0	0.0	88.9			0.0	0.0
	CARMEN SUITE	0.0	0.0	0.0				0.0	0.0
	CHAMPNEYS	0.0	0.0	0.0	100.0	93.3	24.4	1.0	0.0
	DELIVERY	0.0	0.0	0.0	100.0	100.0		0.0	1.0
	FREDDIE HEWITT	0.0	0.0	0.0			23.7	1.0	1.0
	GENERAL ICU/HDU	0.0	0.0	0.0	93.8			0.0	0.0
	GWILLIM	0.0	0.0	0.0	100.0	100.0		0.0	0.0
	JUNGLE	0.0	0.0	0.0		100.0	32.1	0.0	0.0
	NEONATAL ICU	0.0	0.0	0.0	100.0	100.0		0.0	0.0
	NEURO ICU	0.0	0.0	0.0	100.0			1.0	0.0
	NICHOLLS	0.0	0.0	0.0		100.0	90.0	0.0	0.0
	PICU	0.0	0.0	0.0		100.0		0.0	0.0
	PINCKNEY	0.0	0.0	0.0		100.0	100.0	0.0	0.0

11. MEDCARD Heatmap:

Gordon-Smith ward

Percentage of harm free care: was 83.3% which pertains to 2 grade 2 pressure ulcers. The practice educators are completing teaching sessions on pressure ulcer prevention and management on the ward and will evidence this support on the staff's file.

Falls: the number of falls for July totalled 3 which is the threshold level for the ward. Un-witnessed falls were either low or no harm. Actions taken include moving patients at risk close to the nurses' station and documentation continues to monitored through the quality observatory audit.

Ruth Myles ward

Falls: the number of falls in July totalled 4, with no harm caused. Actions taken include robust assessment of patients and supporting with 'specials' where appropriate for at risk patients – one patient had repeated falls. Patients at risk are also moved closer to the nurses' station. Compliance with falls policy is good.

Trevor Howell ward

Falls: the number of falls totalled 6 for July which is 2 more incidents than the threshold for this patient mix. No harm caused to any patients – examples of the falls are that one patient slipped while getting out of bed, one whilst mobilising with relatives and one patient slipped to the floor from a sitting position on the bed, no harm caused. Action plan completed by the ward: falls champions created, documentation audit being completed weekly to ascertain compliance with the falls policy and bed rail assessments.

Heberden

There has been 1 C Diff in July. The RCA is completed and with the Infection Control team for review. The ward staff are awaiting the outcome of this report.
Harm Free Care – 83%. This is attributed to the following pressure ulcers that have been recorded on admission, and therefore none acquired whilst in hospital for this month: x2 grade 4, x1 grade 3 and x3 grade 2.
Falls – there have been 5 falls reported in month. All of the patients were risked assessed appropriately in line with policy. On review of these cases all measures were in place e.g high/low bed, physio review. There was no harm to the patients reported as a result of the falls.

11. MEDCARD Heatmap:

Dalby

Falls were high in month. The ward sister and matron will be reviewing these falls and the staffing skill mix for this ward, to ensure all actions had been implemented appropriately

Harm free care 91% which is an improved position for the ward, the reduction in compliance relates to non-acquired pressure ulcers.

Amyand

C Diff - The ward are awaiting the results of the RCA which has been completed and feel is unlikely to be due to lapse of care.

FFT – the poor performance is being disseminated to team and the need to improve. The nature of the client group in senior health has resulted in a number of patients being unable to complete the FFT. Patients who are being discharged are to be identified daily as part of the board round to ensure sampling.

Belgrave Ward

In month the ward had 1 fall. This fall was unavoidable. All appropriate assessments had been undertaken and the patient was appropriately found not to be a falls risk prior to this event.

James Hope

1 fall reported in month. This fall caused no harm and was due to the breaks not being used on the porters chair. The porter was reminded of the importance of using breaks when patients are transferring

Emergency Department

The falls reported in month were low and no harm, with 2 falls being reported on datix relating to staff slipping on water. The leak has now been fixed and a replacement fridge has been ordered.

113. MEDCARD Heatmap:

Allingham
The red flag showing are for 10 falls in July. These were attributed to 4 patients 2 of whom were confused. 2 of those patients slipped whilst wearing TED stockings only. Staff have been asked to ensure all patient are wearing the non- slip slipper socks. Falls risk assessments had been completed appropriately on all patients.

McEntee
Red flag showing 2 falls in July. These were in 2 separate patients one of which was getting out of the shower. Patients were reminded to request assistance from nursing staff in the future. Falls risk assessments had been completed on these patients.

Rodney Smith,
The ward was reported as having 2 falls in month. This was 2 separate patients and both were reported as low and no harm. This is an increase on last moth where 1 patient had a fall.
Harm Free Care is 83.9% on safety thermometer, this relates to x1 old grade 3 pressure ulcer. There were x2 new UTI on admission and x2 Old UTIs reported and urinary catheters were in situ on these patients.

Marnham ward
2 Falls reported for July. This was 2 separate patients and both falls were recorded as no harm.
Harm Free Care is reported as 86.2% on the safety thermometer. This included x1 Old grade 3 pressure ulcer from admission. There was x2 new grade 2 pressure ulcers and they are appropriately managed to reduce risk of escalating to grade 3.The ward is doing an audit which was set up by the Tissue Viability Nurse where the Nurse in Charge reviews x 5 patient documentation repositioning charts daily, and this is recorded on white board. This is discussed at handovers with the rest of the nursing staff to ensure all patients are safely managed. There was one new diagnosed PE that was appropriately managed

11. CSD: Heatmap:

July 2016

Cardiothoracic Intensive Care Unit (CTICU)
CTICU scored 88.9% in relation to harm free care. 9 patients were surveyed and 1 patient was found to have a single harm; a new grade 3 new pressure ulcer. This is currently under investigation; however initial findings do suggest that this may have been unavoidable due to clinical condition of the patient.

General Intensive Care Unit (GICU)
GICU scored 93.8% in relation to harm free care. 16 patients were reviewed and 1 patient was found to have a grade 2 pressure ulcer; this did not progress to a grade 3 pressure ulcer which is very positive. GICU do report a current increase in the number of grade 2 pressure ulcers and are exploring the reasons for this and reviewing interventions that can be implemented to reduce this on a sustained basis.

Friends and Family (FFT)
Champneys ward have improved performance on the previous month regarding FFT, however the target has still not been achieved. This is despite attempts to engage other members of the wider ward team to support the capture of this data. The head of nursing will now be monitoring this on a daily basis to ensure that there is a significant and sustained improvement in this valuable metric.

The FFT metrics for the other areas within the division continue to be a challenge in terms of accurate representation on the heatmap. There is on-going work with the informatics team to rectify this, so that is accurate on a consistent basis.

Serious incidents
There were 2 serious incidents declared during July 2016, one on the delivery suite and one on Freddie Hewitt ward relating to an unexpected death of a child. Both these cases are currently being investigated via the serious incident process and any learning will be shared across the division.

Falls
There were 3 falls across 3 separate areas in July 2016, none of the falls resulted in harm.

11. SNCT Heatmap:

Nursing Scorecard Report- July (June's data) - STNC Division

The report focuses on areas with any red indicators or those with three or more overall indicators. The key areas where alerts are seen relate to falls and harm free care. The areas where there have been improvements in performance are FFT satisfaction, Harm Free Care, Zero incidences of trust acquired pressure ulcers and Zero incidents of MRSA.

There are 14 red alerts for July 2016 compared to 7 for the previous reporting period and an increase in overall alerts from 10 to 17. However it should be noted that this month's and last month's scorecards did not have all the risk matrix's included in the reports. Two scorecard related risks that are missing from this month's scorecard; unfilled hours and sickness/absence information.

Falls for the surgical directorate have again triggered red indicators when they fall within set target parameters, therefore of the 13 red indicators flagged for falls in July's scorecard, 9 are incorrect as they are within acceptable limits.

Surgery Directorate

Florence Nightingale – 1 red indicator and 1 amber indicator. The red indicator related to two falls, this should not have triggered a red indicator as the falls threshold for Florence Nightingale ward is three per month. All falls were no harm.

The amber indicator was due to harm free care of 94.7%, two patients were admitted to the ward with existing pressure ulcers from an external organisation.

Gunning – 1 red indicator relating to three falls, this should not have triggered a red indicator as the accepted threshold is four per month. All falls were no harm

Holdsworth – 1 red indicator relating to two falls, this should not have triggered a red indicator as the accepted threshold is four per month. All falls were no harm

11. SNCT Heatmap:

Keate- 1 red indicator relating to two falls, this should not have triggered a red indicator as the accepted threshold is three per month. All falls were low harm

Vernon- 1 red indicator which related to four falls. One patient fell twice and all falls were no harm.

Cavell- 1 red indicator and 1 amber indicator. The red indicator related to three falls, this should not have triggered a red indicator as the accepted threshold is three per month. All falls were no harm.

The amber indicator related to a 28.1% friends and family response rate. The ward sister and staff have been reminded of their duty to capture patients and family's discharge feedback on discharge

Gray- 1 red indicator relating to one fall, this should not have triggered a red indicator as the accepted threshold is three per month. This fall was categorised as no harm.

Neuroscience Directorate

Brodie -2 red indicators. The first red indicator related to 6 falls. One patient fell three times and all falls were no harm.

The second red indicator related to a FFT response relate of 3.4%. This low percentage was due to technical issues with the portable tablet. These issues have been rectified and staff have also been reminded to ensure compliance with this discharge audit.

McKissock – 1 red indicator relating to two falls. This should not be red as the tolerance for McKissock is four. Both falls patients lost balance on mobilising.

11. SNCT Heatmap:

Kent – 1 red indicator relating to nine falls. Seven falls were no harm and two were low harm. Falls action plan is in place. This increased falls quota is related to the patient cohort and their complex needs

William Drummond – 1 red indicator relating to three falls. All three falls were low or no harm.

Thomas Young - 1 red indicator and 1 amber indicator. The red indicator related to one fall, this should not have triggered a red indicator as the accepted threshold is eleven per month. This fall was categorised as no harm.

The amber indicator related to harm free care of 91.3%. This was due to three patients being admitted to the ward with old pressure ulcers from an external organisation.

Gwynne Holford Ward – 1 red indicator relating to four falls, this should not have triggered a red indicator as the accepted threshold is seven per month. All falls were categorised as no harm and were due to rehabilitation goals.

Friends and Family not captured this month. The discharge survey had previously been captured upstairs in our day unit. However last month when the service moved downstairs to one floor discharges were missed. Action plan in place and there should be a marked improvement next month.

Summary

Overall improvements were noted in a number of wards that did not have any red or amber indicators; Gray, Gunning, Holdsworth, Keate, Gwynne Holford and McKissock wards. Kent ward has also improved in their FFT response rate.

11. CWDCT Heatmap:

Cardiothoracic Intensive Care Unit (CTICU): CTICU scored 94.1% in relation to harm free care. 12 patients were surveyed and 1 patient was found to have a single harm; a new grade 2 new pressure ulcer. There is proactive management of pressure ulcers across all of the critical care units which is reflected in the overall low numbers of grade 3 / 4 pressure ulcers.

Friends and Family: Champneys ward performance against this metric remains a cause for concern. Following senior nursing input the ward will now be looking at their wider workforce, in particular the health care assistants and ward receptionist will be supporting the team to capture this piece of useful patient feedback. There is some improvement in the overall accuracy of these metrics on the heatmap however further work is still required by the informatics team to ensure 100% accuracy of recording.

Serious incidents: There were 2 serious incidents declared on the delivery suite; these were a patient with a placental abruption and a patient with a post-partum haemorrhage. Both of these cases are currently being investigated and conclusions will be shared via the divisional governance board.

Sickness: The women's and children's directorates continue to have sickness absence rates above the trust target. There are a number of cases of long term sickness in these areas that are contributing to this; all of which are being managed in line with HR procedures. The bi – monthly divisional safe staffing and workforce meetings continue with the next one scheduled for early August.

Quality scorecard (June 2016)

Domain	Indicator	Frequency	2015/2016 Target	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
					Quarter 2 2015/16			Quarter 3 2015/16			Quarter 4 2015/16			Quarter 1 2016/17		
Patient Safety	SI's REPORTED	Monthly		2	0	1	4	1	3	1	1	0	0	0	1 (DIC)	0
Patient Safety	Number of SI's breached	Monthly	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly	0	0	0	1	2	1	1	0	1	0	0	0	0	0
Patient Safety	Grade 4 Pressure Ulcers	Monthly	0	0	0	0	0	0	0	1	1	0	0	0	0	0
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly	0	4	12	8	13	10	11	13	10	13	18	6	19	19
Patient Safety	Number of moderate falls	Monthly	0	0	1	0	0	0	2	1	0	0	0	1	0	0
Patient Safety	Number of major falls	Monthly	0	0	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	0	0
Patient Safety	MRSA (cumulative)	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Safety	CDiff (cumulative)	Monthly	31	0	0	0	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	2	2
Patient Safety	Number of Quality Alerts	Monthly		2	9	11	4	6	7	4	7	5	5	3	3	4
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	85%	85%	84%	81%	81%	77%	74%	70.0%	70.0%	68.0%	79%	82.0%	84.0%	85%
Safeguarding	% of staff compliant with safeguarding childrens training	Monthly	Level 1 85%	85%	82%	79%	88%	89%	86%	85%	89%	79%	79%	80.0%	81.0%	80%
			Level 2 85%	82%	82%	74%	66%	67%	63%	83%	80%	85%	92%	66.0%	73.0%	79%
			Level 3 85%	82%	90.00%	70%	85%	87%	84%	84%	84%	80%	80%	82.0%	82.0%	82%
Patient Outcomes	Mortality SHMI ratio (Trus)	Monthly	<100	0.86	0.86	0.86	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	tbc
Patient Experience	Active Claims	Monthly		1	3	1	0	1	0	0	0	1	0	1	0	Not yet available
Patient Experience	Number of Complaints received	Monthly		6	5	2	5	5	5	5	4	6	7	1	2	5
Patient Experience	Number of Complaints responded to within 25 days (reporting 1 month in arrears)	Monthly	85%	78%	100%	100%	85%	100%	100%	89%	100.0%	50% (3)	71%	75%	100%	100%
Patient Experience	Number of Complaints responded to within 25 days with an agreed extension	Monthly	95%	100%	100%	100%	92%	100%		78%	100%	67% (1)	50%	100%		100%
Patient Experience	FFT Score	Monthly Mary Seacole A		77.7%	71.0%	97.3%	84.2%	94.4%	94.4%	100%	90%	95%	95%	90.0%	85.7%	87.0%
		Monthly Mary Seacole B		75.00%	95.40%	90.90%	75%	90%	94%		85%					
Patient Outcomes	Catheter related UTI (Trust)			1.12	1.32	1.50	1.03	0.67	0.96	0.47	0.46	0.90	0.90	0.65	1.22	0.63
	Number of new VTE (Trust)		National 0.005	0.15	0.08	0.24	0.17	0.30	0.48	1.01	0.00	0.23	0.08	0.33	0.08	0.63
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	206	206 in 2015		
Workforce	Sickness Rate -	Monthly	3.50%	6.00%	4.69%	5.75%	5.53%	5.90%	5.71%	6.00%	6.50%	6.19%	4.70%	4.72% Mar16	5.67%	4.89%
Workforce	Turnover Rate-	Monthly	13%	20.40%	20.08%	21.00%	21.15%	20.75%	20.76%	21.20%	20.80%	21.59%	20.50%	20.54% Mar16	20.3%	18.74%
Workforce	Vacancy Rate-	Monthly	11%	19.40%	12.60%	13.42%	12.59%	15.67%	18.50%	19.40%	18.90%	18.70%	19.40%	19.43% Mar16	20.81% Apr 16	20.81%
Workforce	Appraisal Rates - Medical	Monthly	85%	69.57%	69.57%	84.00%	84.00%	79.41%	81.26%	87.10%	87.10%	83.87%	88.90%	88.89% Mar16	92.59% Apr 16	79.17%
Workforce	Appraisal Rates - Non-Medical	Monthly	85%	75.84%	75.42%	76.02%	68.22%	64.91%	62.92%	62.40%	63.20%	63.53%	63.20%	63.25% Mar16	64.48% Apr 16	77.81%

CSD scorecard exception report (June 2016)

- 0 x serious incidents
- Safeguarding: ARIS data still includes services which have been transferred out of CSD- this has been flagged with the training dept. who are leading a review of data and staff profile requirements.
- Falls : 19 , 13 of which were on MS ward of low or no harm.

Workforce update: (June 2016)

- Focused action on appraisal rates led by Divisional Chair – MAST and appraisal rate increased
- Recruitment activity continuous. Recruitment nurse appointed commence Sept. 2016
- Safe staffing alerts reflective of unfilled vacancies and shifts – bank and agency rate >85% for nursing services.

CAHS safe staffing alerts

Service	Mar-16 Concerns	Mar-16 Alerts	Apr-16 Concerns	Apr-16 Alerts	May-16 Concerns	May-16 Alerts	Jun-16 Concerns	Jun-16 Alerts	Total Concerns	Total Alerts
Community Nursing East 1	9	6	4	0	4	0	9	1	32	7
Community Nursing East 2	6	3	2	0	0	0	1	0	10	3
Community Nursing North 1	8	2	1	0	3	3	1	1	17	7
Community Nursing North 2	0	2	0	1	0	0	0	2	0	5
Community Nursing North 3	1	2	2	0	0	2	2	1	5	5
Community Nursing South 1	8	1	5	1	7	5	5	4	28	12
Community Nursing South 2	5	1	3	3	2	0	0	0	13	4
Community Nursing South 3	5	3	2	1	8	3	3	2	19	9
Community Nursing West 1	6	8	0	1	4	4	4	0	17	13
Community Nursing West 2	6	3	1	0	5	3	3	1	24	8
Complex Case Management - Night	24	3	30	2	31	1	25	0	140	6
Diabetes Specialist Nurses	1	1	0	0	1	0	0	0	4	1
Respiratory Specialist Nurses	0	0	0	0	2	5	2	0	6	5
Tissue Viability Specialist Nurses	0	20	0	20	18	2	5	0	24	42

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD ***August 2016***

Paper Title:	Workforce report
Sponsoring Director:	Karen Charman, Director of Workforce and Organisational Development
Author:	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 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 July 2016

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

Key points to note are:

- The vacancy rate has held the 2.1% decrease from last month at 17.2%
- Temporary Staffing has decreased by 0.5% however there are concerns with costs
- Stability has seen a small increase and Sickness absence has also improved
- There has been further negative movement in turnover and the Trust remains above average for London Trusts and Teaching Trusts
- There has been continued progress in mandatory training compliance exceeding 80% for the first time.
- The trust continues to benchmark reasonably well against similar London trusts for sickness absence

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?**

HR progress and priorities

Vacancy information

The overall number of staff in post has grown by 190 WTE since July 2015 and the vacancy factor has remained stable despite agreed increases in establishment. It can be seen that there has not been a compensating drop in bank and agency usage to reflect the increase in staff. As such there is currently a review of establishments together with volume and cost of temporary staffing.

Positive Changes

Positive changes in Stability (0.2%) Sickness (0.1%) and Temporary staffing usage (0.5%) may appear small however it must be noted that these are 12 month rolling averages. During the previous 12 months this figures have been consistently either moving in the wrong direction or failing to show improvement. These improvements are to be welcomed and must be viewed over a longer term trend.

MAST compliance

The hard work and commitment of clinical areas in organising the release of staff and the availability of courses has seen our MAST compliance exceed 80% for the first time in the last 12 months. This is a major achievement for all involved. We are aware however that there are key areas of provision which continue to block our ability to achieve the desired level. A review of provision of ILS and Safeguarding Children at Level 3 is currently underway.

Turnover

The biggest risk to our continued positive change in the areas above is our continued growth in Turnover. AT 18.8% we are above the average of just under 16% for London Teaching Hospitals. To date the initiatives of 100 day interviews – undertaken with staff at their 100 day anniversary which research would suggest is a key tipping point – and feedback from exit interviews has begun to see a reduction in vacancies and small growth in stability.

Working with colleagues across the Trust the HR Directorate are identifying the key priority work over the next six to nine months to capitalise on the success areas and seek to reduce turnover. This includes ensuring our recruitment process is measured as top 25% performer in terms of experience and efficiency. Our recent investment in the TRAC recruitment system and an increase in the size of the recruitment team have seen an average of 15 calendar days removed from the recruitment process. We also will be moving to values based recruitment which will move the focus on to how our managers deliver their roles and engage with staff. Staff have identified the need for varied opportunities as well as promotional development and the programme of rotational nursing opportunities between acute and community settings – including the prison – is underway. These are some of the opportunities which will be developed and monitored by the Workforce and Education Committee.

Routes into Employment

The Trust is committed to recruiting over 200 apprentices this year and as part of the diverse routes into nursing employment we have joined the nursing apprentice programme in South West London. We are a pilot site and will see the first candidates in October this year.

Fit for the Future

The Trust offers many schemes to support staff including Occupational Health, Health and Well Being, Counselling, Mediation, Listening into Action, St Georges as One etc. We will be bringing these together from September onwards under the banner of Fit for the Future – Looking after our staff whilst they care for our patients. We are hoping with consistent messaging the Trust's desire to both engage with and look after the staff will be more visible to all.

Increased Feedback

Earlier in the year the Trust Board requested that we undertake a more frequent survey of staff opinion so that we would have a more updated and relevant understanding of the pressures facing staff and the success or otherwise of any interventions. The Friends and Family Test this month is carrying eight additional questions that seek to do this and we will be able to report on these next month.

Karen Charman
Director of Workforce and Organisational Development
August 2016

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Workforce Performance Report
to the Trust Board

Month 4 - July 2016

Excellence in specialist and community healthcare

Workforce Performance Report Aug ‘15 - Jul ‘16

Contents

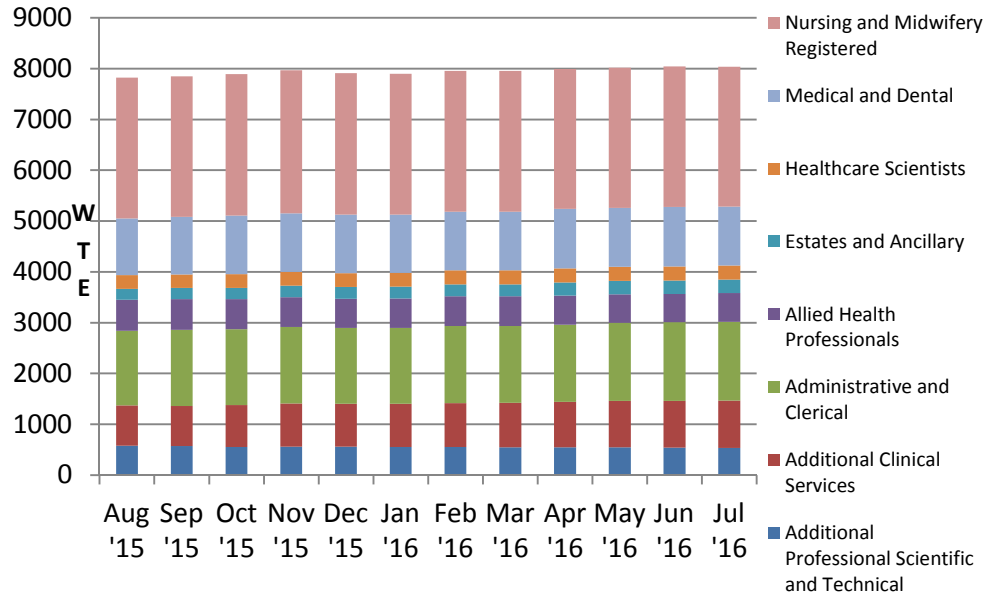
Performance Summary

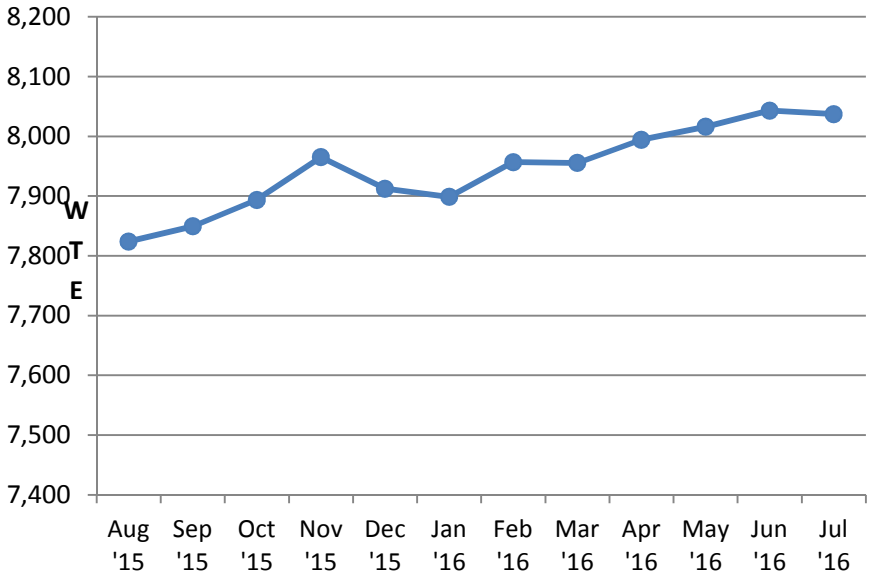
Summary of overall performance is set out below

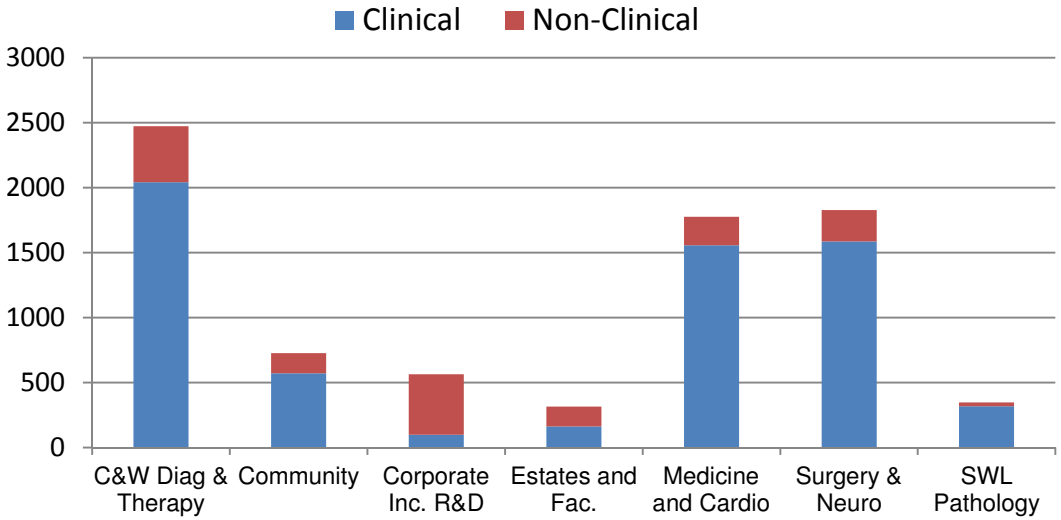
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has remained the same	14.9%	17.2%	17.2%	↔
6	Turnover	Turnover has increased by 0.2%	17.3%	18.6%	18.8%	↗
7	Voluntary Turnover	Voluntary turnover has increased by 0.3%	14.0%	15.1%	15.4%	↗
8	Stability	Stability has increased by 0.2%	83.5%	81.7%	81.9%	↗
10	Sickness	Sickness has decreased by 0.1%	3.4%	3.5%	3.4%	↘
15	Temporary Staffing Usage (FTE)	Temporary Staffing Usage has decreased by 0.5%	14.8%	15.4%	14.9%	↘
17	Mandatory Training	MAST compliance has increased by 1.1%	71.0%	79.6%	80.7%	↗
18	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has decreased by 0.5%	74.0%	69.3%	68.8%	↘

Current Staffing Profile

The data below displays the current staffing profile of the Trust





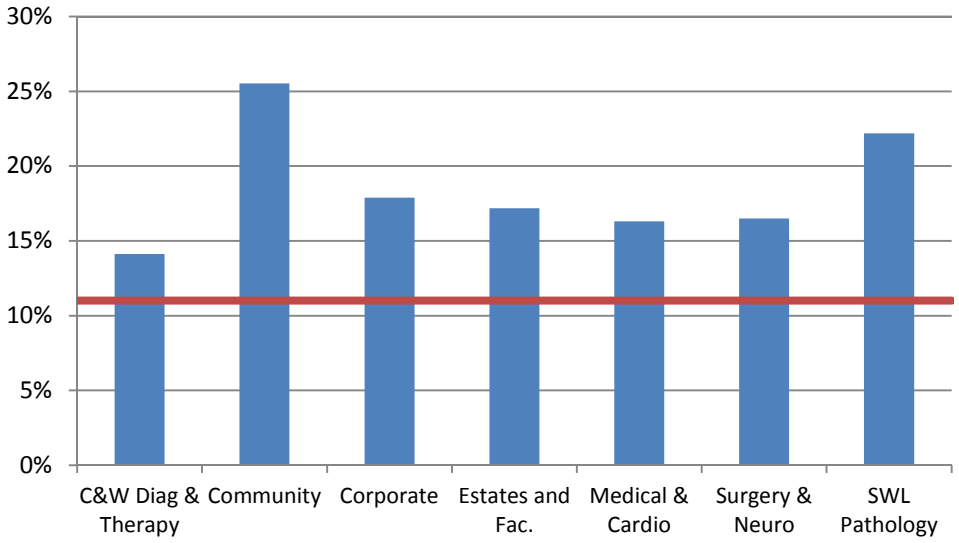


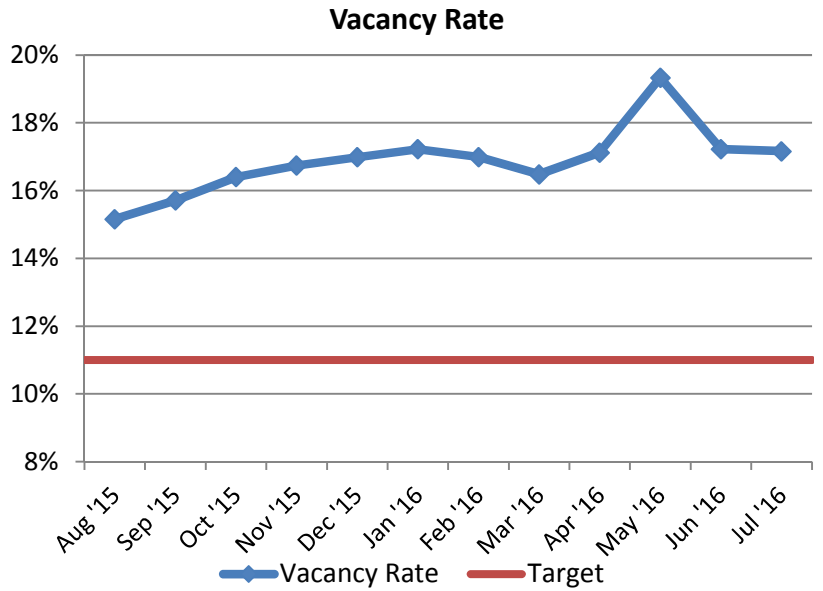
COMMENTARY

The Trust currently employs 8594 people working a whole time equivalent of 8037 which is 6 WTE lower than June. The growth rate in the directly employed workforce since July 2015 is 190 WTE or 2.4%.

The Trust also employs an additional 435 WTE GP Trainees covering the South London area, which makes the total WTE 8472.

Section 1: Vacancies





Vacancies by Division	Apr '16	May '16	Jun '16	Jul '16	Trend
C&W Diag & Therapy	16.0%	15.1%	15.5%	14.1%	↘
Community	20.8%	38.1%	22.6%	25.5%	↗
Corporate	20.2%	20.3%	18.2%	17.9%	↘
Estates and Fac.	5.8%	9.7%	17.7%	17.2%	↘
Medical & Cardio	15.0%	18.5%	16.8%	16.3%	↘
Surgery & Neuro	18.6%	15.8%	15.7%	16.5%	↗
SWL Pathology	19.9%	22.6%	22.5%	22.2%	↘
Whole Trust	**17.1%**	**19.3%**	**17.2%**	**17.2%**	↔

Vacancies Staff Group	Apr '16	May '16	Jun '16	Jul '16	Trend
Add Prof Scientific and Technic	15.8%	14.2%	15.8%	16.7%	↗
Additional Clinical Services	23.9%	26.5%	20.8%	20.5%	↘
Administrative and Clerical	18.2%	18.8%	17.2%	16.6%	↘
Allied Health Professionals	17.0%	19.4%	18.1%	14.4%	↘
Estates and Ancillary	4.7%	11.2%	17.3%	16.8%	↘
Healthcare Scientists	13.8%	13.3%	14.1%	14.4%	↗
Medical and Dental	5.9%	10.8%	7.9%	9.1%	↗
Nursing and Midwifery Registered	19.9%	22.4%	19.9%	20.2%	↗
Total	**17.1%**	**19.3%**	**17.2%**	**17.2%**	↔

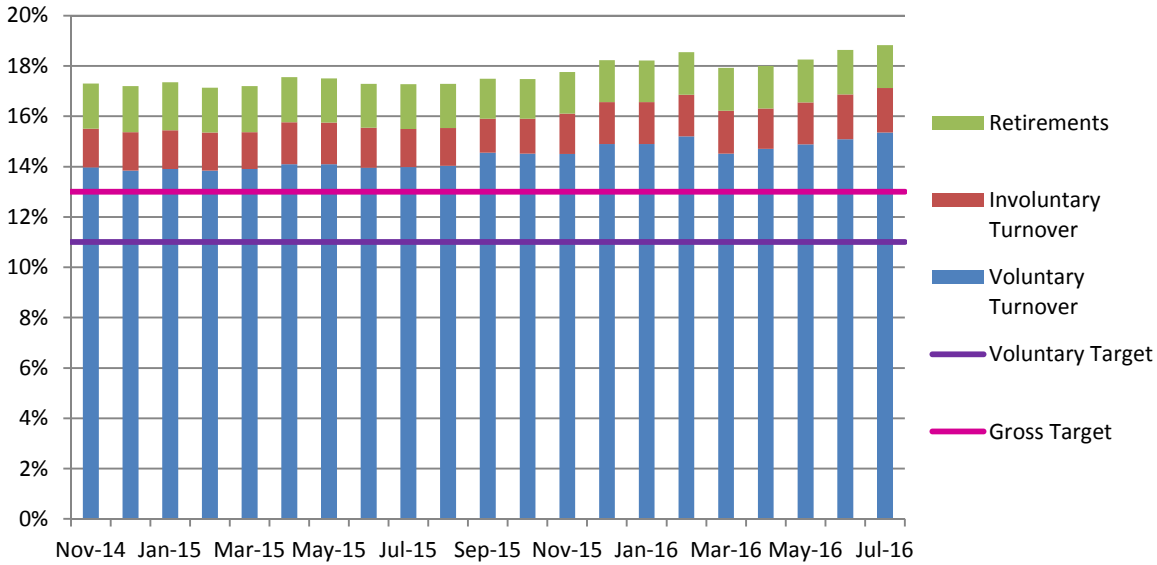
COMMENTARY

The vacancy rate has remained the same in July.

The Community Services Division still has some reconciliation work to be done as the reported rate is high (around 16% is more accurate). Work is on-going to reconcile ESR to the ledger to improve accuracy for August.

Section 2a: Gross Turnover

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



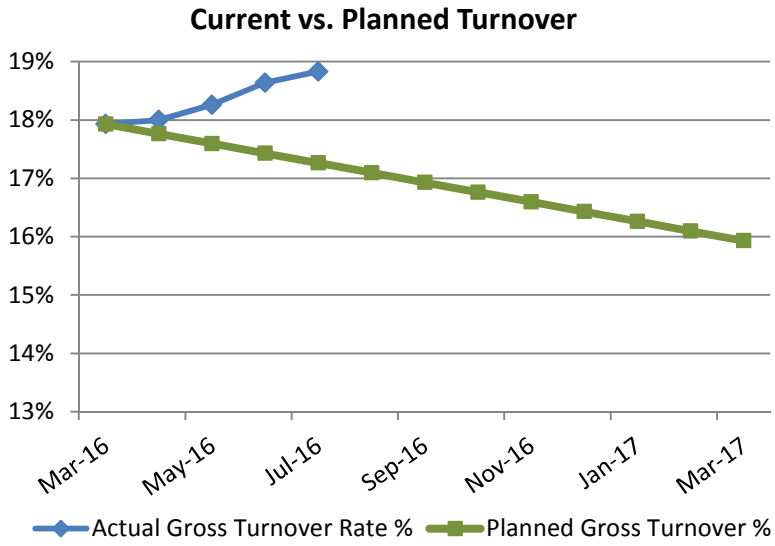
COMMENTARY

The total trust turnover rate has increased this month to 18.8%. This is significantly above the current target of 13%. In the last 12 months there have been 1376 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	Apr '16	May '16	Jun '16	Jul '16	Trend
C&W Diagnostic & Therapy	19.2%	19.6%	19.6%	19.9%	↗
Community Services	20.3%	21.0%	20.8%	22.1%	↗
Corporate	22.0%	20.9%	21.5%	21.1%	↘
Estates and Facilities	10.9%	11.5%	13.4%	13.6%	↗
Medical & Cardiothoracics	17.7%	18.2%	18.5%	18.6%	↗
Surgery, Neurosciences & Anaes	15.4%	15.5%	16.3%	16.3%	↔
SWL Pathology	19.2%	18.7%	19.7%	19.1%	↘
Whole Trust	**18.0%**	**18.3%**	**18.6%**	**18.8%**	↗

	All Turnover				
Staff Group	Apr '16	May '16	Jun '16	Jul '16	Trend
Add Prof Scientific and Technic	21.8%	22.2%	22.5%	23.5%	↗
Additional Clinical Services	17.8%	18.1%	18.7%	19.0%	↗
Administrative and Clerical	17.2%	17.4%	17.8%	18.0%	↗
Allied Health Professionals	20.1%	21.9%	23.0%	22.3%	↘
Estates and Ancillary	6.6%	7.8%	9.1%	9.8%	↗
Healthcare Scientists	17.2%	17.2%	18.2%	18.0%	↘
Medical and Dental	12.6%	12.2%	11.3%	11.1%	↘
Nursing and Midwifery Registered	19.4%	19.3%	19.7%	19.9%	↗
Whole Trust	**18.0%**	**18.3%**	**18.6%**	**18.8%**	↗



Section 2b: Voluntary Turnover

	Voluntary Turnover					Other Turnover Jul 2016	
Division	Apr '16	May '16	Jun '16	Jul '16	Trend	In-Voluntary	Retirement
C&W Diagnostic & Therapy	15.8%	16.0%	16.1%	16.5%	↗	2.1%	1.3%
Community Services	15.1%	15.6%	15.4%	16.7%	↗	1.9%	3.5%
Corporate	18.0%	17.2%	17.3%	17.1%	↘	2.0%	2.0%
Estates and Facilities	8.6%	8.8%	10.0%	9.9%	↘	2.7%	1.0%
Medical & Cardiothoracics	15.4%	15.9%	16.0%	16.2%	↗	1.3%	1.1%
Surgery, Neurosciences & Anaes	12.6%	12.5%	13.0%	13.1%	↗	1.5%	1.6%
SWL Pathology	14.5%	14.8%	14.7%	14.2%	↘	0.9%	4.1%
Whole Trust	**14.7%**	**14.9%**	**15.1%**	**15.4%**	↗	**1.8%**	**1.7%**

	Voluntary Turnover					Other Turnover Jul 2016	
Staff Group	Apr '16	May '16	Jun '16	Jul-16	Trend	In-Voluntary	Retirement
Add Prof Scientific and Technic	15.2%	15.5%	15.8%	16.8%	↗	5.6%	1.2%
Additional Clinical Services	15.0%	15.3%	15.6%	15.4%	↘	1.7%	1.8%
Administrative and Clerical	13.2%	13.2%	13.5%	13.8%	↗	1.9%	2.3%
Allied Health Professionals	18.6%	19.8%	21.0%	20.2%	↘	0.9%	1.1%
Estates and Ancillary	5.3%	6.1%	6.5%	7.3%	↗	1.2%	1.2%
Healthcare Scientists	13.9%	14.4%	14.3%	14.1%	↘	0.7%	3.1%
Medical and Dental	5.9%	5.7%	5.1%	5.5%	↗	4.1%	1.5%
Nursing and Midwifery Registered	17.1%	17.1%	17.2%	17.6%	↗	0.8%	1.6%
Whole Trust	**14.7%**	**14.9%**	**15.1%**	**15.4%**	↗	**1.8%**	**1.7%**

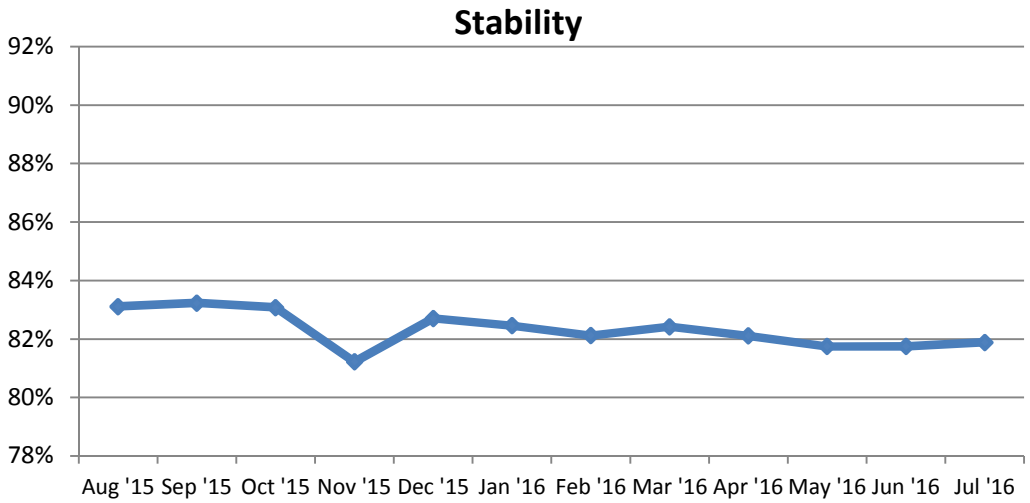
Caregroup	Staff in Post WTE	Leavers WTE	Voluntary Turnover Rate
Ops & Service Improvement	24.0	6.9	32.5%
Medical Oncology & Palliative Care	88.8	21.7	26.9%
Stroke, Neurorehab, Neurophysiology	149.2	33.0	25.3%
Pharmacy	167.7	41.0	24.9%
Neonatal	153.4	33.4	23.0%

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	Apr '16	May '16	Jun '16	Jul '16	Trend
C&W Diagnostic & Therapy	81.7%	81.0%	80.1%	80.3%	↗
Community Services	79.1%	78.8%	80.7%	80.5%	↘
Corporate	78.4%	78.5%	81.5%	81.9%	↗
Estates and Facilities	89.3%	89.0%	86.5%	85.5%	↘
Medical & Cardiothoracics	81.4%	81.2%	81.5%	82.1%	↗
Surgery, Neurosciences & Anaes	85.0%	84.5%	84.2%	84.1%	↘
SWL Pathology	81.8%	81.6%	80.8%	81.4%	↗
Whole Trust	**82.1%**	**81.7%**	**81.7%**	**81.9%**	↗

Stability Staff Group	Apr '16	May '16	Jun '16	Jul '16	Trend
Add Prof Scientific and Technic	71.5%	72.0%	71.1%	73.8%	↗
Additional Clinical Services	84.4%	85.8%	85.2%	86.6%	↗
Administrative and Clerical	84.2%	83.0%	83.9%	84.0%	↗
Allied Health Professionals	78.8%	76.3%	75.4%	75.1%	↘
Estates and Ancillary	92.1%	90.8%	88.6%	87.3%	↘
Healthcare Scientists	90.8%	91.6%	90.7%	86.1%	↘
Medical and Dental	89.6%	89.1%	90.5%	90.1%	↘
Nursing and Midwifery Registered	80.4%	80.3%	80.3%	80.3%	↔
Total	**82.1%**	**81.7%**	**81.7%**	**81.9%**	↗

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.

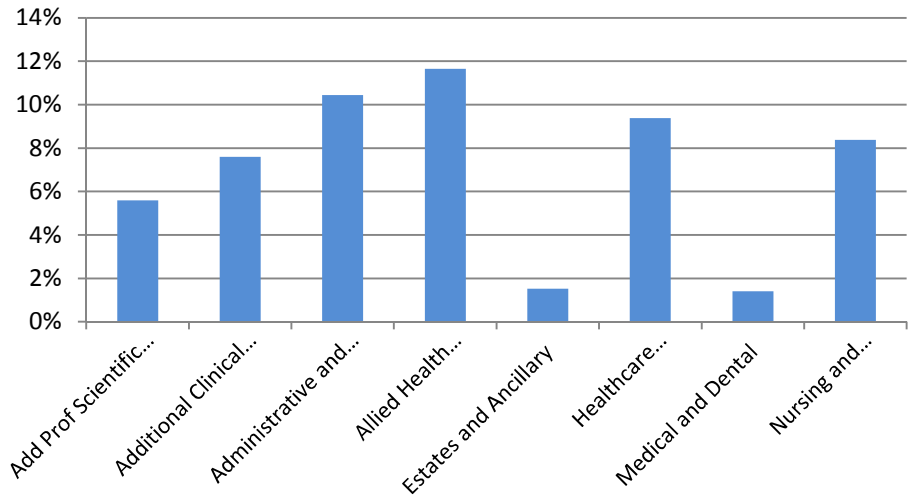
A reduction in the stability rate is of concern because of the implication that staff with longer service are leaving.

The stability rate has increased by 0.2% this month.

Over the last 12 months the stability rate has declined by 1.6% and is now at 81.9%.

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 June 43 staff were promoted, there were 124 new starters to the Trust and 186 employees were acting up to a higher grade.

Over the last year 8.1% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the SW London Pathology Division followed by Corporate.

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

The Allied Health Professionals staff group have the highest promotion rate at 11.7% followed by Admin & Clerical at 10.4%.

	No. of Promotions				
Division	Apr '16	May '16	Jun '16	Jul '16	Trend
C&W Diagnostic & Therapy	22	34	35	17	↘
Community Services	14	12	15	5	↘
Corporate	5	9	8	8	↔
Estates and Facilities	0	1	0	0	↔
Medical & Cardiothoracics	8	8	8	5	↘
Surgery, Neurosciences & Anaes	8	15	8	8	↔
SWL Pathology	3	6	2	0	↘
Whole Trust Promotions	**60**	**85**	**76**	**43**	↘
New Starters (Excludes Junior Doctors)	157	117	133	124	↘

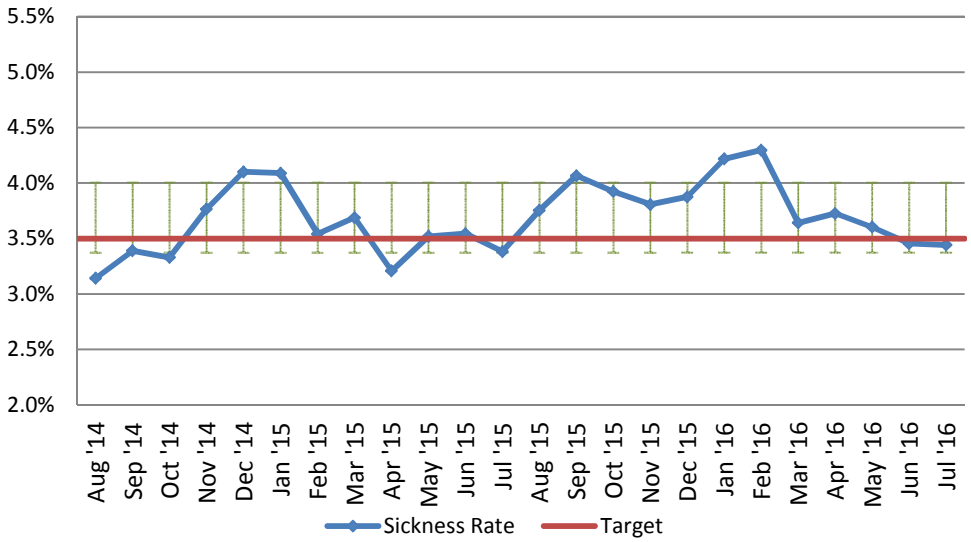
Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	2044	174	8.5%	75
Community Services	708	49	6.9%	9
Corporate	437	54	12.4%	28
Estates and Facilities	250	5	2.0%	9
Medical & Cardiothoracics	1288	92	7.1%	37
Surgery, Neurosciences & Anaes	1389	92	6.6%	21
SWL Pathology	300	52	17.3%	7
Whole Trust	**6416**	**518**	**8.1%**	**186**
New Starters (Excludes Junior Doctors)		1564		

	No. of Promotions				
Staff Group	Apr '16	May '16	Jun '16	Jul '16	Trend
Add Prof Scientific and Technic	3	1	1	1	↔
Additional Clinical Services	7	10	7	4	↘
Administrative and Clerical	15	25	27	16	↘
Allied Health Professionals	12	19	17	4	↘
Estates and Ancillary	0	0	0	0	↔
Healthcare Scientists	2	6	0	0	↔
Medical and Dental	1	0	0	0	↔
Nursing and Midwifery Registered	20	24	24	18	↘
Whole Trust	**60**	**85**	**76**	**43**	↘

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	465	26	5.6%	26
Additional Clinical Services	724	55	7.6%	8
Administrative and Clerical	1321	138	10.4%	69
Allied Health Professionals	532	62	11.7%	26
Estates and Ancillary	197	3	1.5%	4
Healthcare Scientists	245	23	9.4%	5
Medical and Dental	498	7	1.4%	3
Nursing and Midwifery Registered	2434	204	8.4%	45
Whole Trust	**6416**	**518**	**8.1%**	**186**

Section 5: Sickness

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



COMMENTARY

Sickness absence is at 3.4% for July, which is a decrease of 0.1% on the previous month. Analysis of reasons for absence this month shows colds and flu to be the main reason for being off work.

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

The table below lists the five care groups with the highest sickness absence percentage during July 2016. Below that is a breakdown of the top 5 reasons for absence, both by the number of episodes and the number of days lost.

Sickness by Division	Apr '16	May '16	Jun '16	Jul '16	Trend
C&W Diagnostic & Therapy	3.7%	3.7%	3.5%	3.7%	↗
Community Services	5.7%	5.0%	4.8%	4.5%	↘
Corporate	3.4%	3.1%	3.2%	2.6%	↘
Estates and Facilities	4.5%	4.4%	4.4%	2.8%	↘
Medical & Cardiothoracics	3.2%	3.4%	3.3%	3.0%	↘
Surgery, Neurosciences & Anaes	3.3%	3.3%	3.1%	3.5%	↗
SWL Pathology	3.9%	2.6%	2.4%	3.0%	↗
Whole Trust	**3.7%**	**3.6%**	**3.5%**	**3.4%**	↘

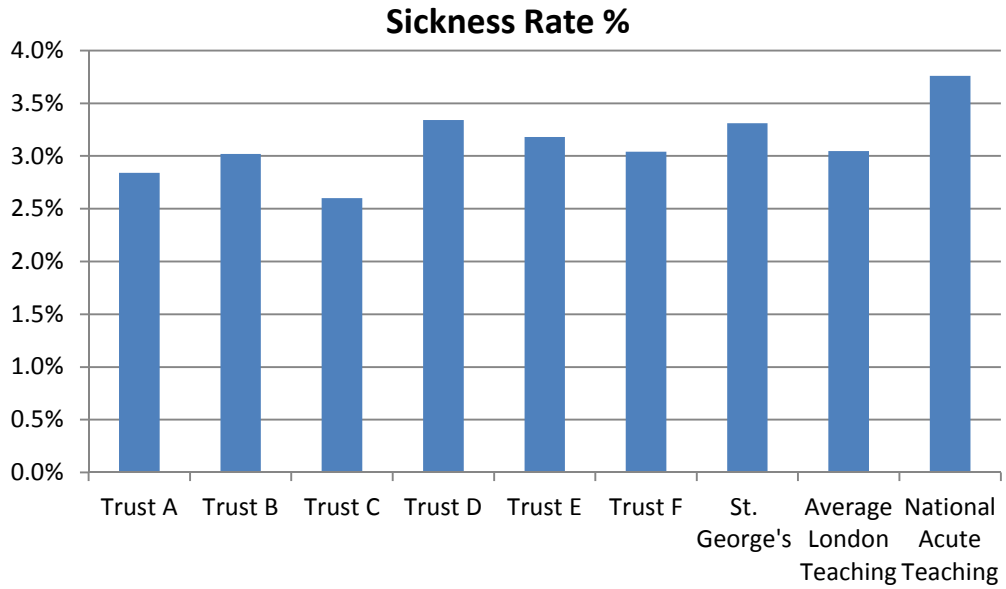
Sickness Staff Group	Apr '16	May '16	Jun '16	Jul '16	Trend
Add Prof Scientific and Technic	2.9%	2.7%	2.6%	2.8%	↗
Additional Clinical Services	5.9%	5.6%	4.9%	4.8%	↘
Administrative and Clerical	4.5%	4.2%	4.0%	4.1%	↗
Allied Health Professionals	2.9%	3.0%	3.2%	2.7%	↘
Estates and Ancillary	5.5%	5.5%	6.0%	4.0%	↘
Healthcare Scientists	2.6%	1.6%	2.5%	2.3%	↘
Medical and Dental	1.4%	1.5%	1.1%	1.5%	↗
Nursing and Midwifery Registered	3.9%	3.8%	3.8%	3.8%	↔
Total	**3.7%**	**3.6%**	**3.5%**	**3.4%**	↘

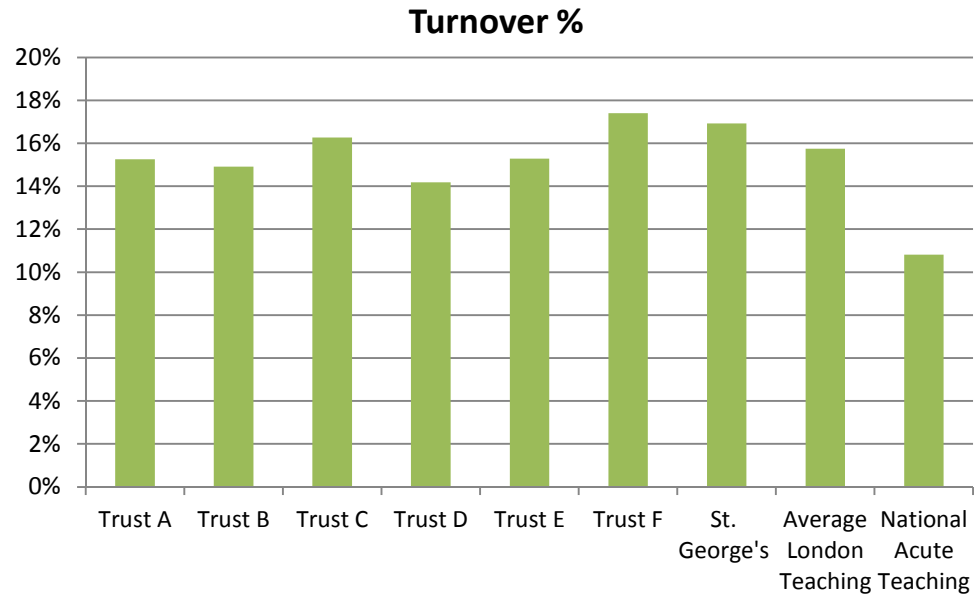
Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Offender Healthcare HMPW Services	54.63	138.21	8.1%	£9,085
Outpatients	355.62	723.20	7.7%	£37,164
Energy and Engineering	49.71	108.00	7.1%	£6,761
Community Adult Health & IP Rehab Services	246.84	532.88	6.9%	£36,522
Chief Operating Officer	42.26	85.61	6.6%	£7,074

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	25.91%
S25 Gastrointestinal problems	18.21%
S12 Other musculoskeletal problems	7.55%
S16 Headache / migraine	7.04%
S10 Anxiety/stress/depression/other psychiatric illnesses	6.89%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S10 Anxiety/stress/depression/other psychiatric illnesses	15.41%
S13 Cold, Cough, Flu - Influenza	14.94%
S12 Other musculoskeletal problems	12.64%
S25 Gastrointestinal problems	9.89%
S11 Back Problems	6.86%

Section 6: Workforce Benchmarking





COMMENTARY

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

Sickness data shown is from April '16 which is the most recent available. Compared to other Acute teaching trusts in London, St. Georges had a rate higher than average at 3.31%. 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 April.

The bottom graph shows the comparison of turnover rates for the same group of London teaching trusts (excluding junior medical staff). This is the total turnover rate including all types of leavers (voluntary resignations, retirements, end of fixed term contracts etc.). St. Georges currently has higher than average turnover compared to the group (12 months to end May). Stability is lower than average. High turnover is more of an issue in London trusts than it is nationally which is reflected in the national average rate which is 6% lower than St. Georges.

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

Reference Group	Gross Turnover Rate %	Stability Rate %	Sickness Rate %
Trust A	15.26%	84.26%	2.84%
Trust B	14.91%	84.81%	3.02%
Trust C	16.27%	83.43%	2.60%
Trust D	14.18%	85.41%	3.34%
Trust E	15.28%	84.53%	3.18%
Trust F	17.40%	82.64%	3.04%
St. George's	16.93%	82.86%	3.31%
Average London Teaching	15.75%	83.99%	3.05%
National Acute Teaching	10.82%	88.94%	3.76%

Section 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Apr '16	May '16	Jun '16	Jul '16	Trend
C&W Diagnostic & Therapy	1156.9	1174.7	1189.6	1169.2	↘
Community Services	598.4	687.8	504.5	529.4	↗
Corporate & R&D	64.1	64.3	70.7	70.7	↔
Medical & Cardiothoracics	1275.9	1316.3	1324.9	1323.9	↘
Surgery, Neurosciences & Anaes	1196.7	1165.7	1165.7	1176.7	↗
Total	4292.0	4408.7	4255.3	4269.8	↗

Nursing Staff in Post WTE

Division	Apr '16	May '16	Jun '16	Jul '16	Trend
C&W Diagnostic & Therapy	993.1	1007.7	1014.9	1006.3	↘
Community Services	429.6	386.6	387.1	382.7	↘
Corporate & R&D	54.7	55.7	56.7	57.5	↗
Medical & Cardiothoracics	1019.8	1040.9	1049.2	1052.8	↗
Surgery, Neurosciences & Anaes	910.7	920.4	923.1	930.4	↗
Total	3407.9	3411.4	3431.1	3429.7	↘

Nursing Vacancy Rate

Division	Apr '16	May '16	Jun '16	Jul '16	Trend
C&W Diagnostic & Therapy	14.2%	14.2%	14.7%	13.9%	↘
Community Services	28.2%	43.8%	23.3%	27.7%	↗
Corporate & R&D	14.7%	13.4%	19.8%	18.7%	↘
Medical & Cardiothoracics	20.1%	20.9%	20.8%	20.5%	↘
Surgery, Neurosciences & Anaes	23.9%	21.0%	20.8%	20.9%	↗
Total	20.6%	22.6%	19.4%	19.7%	↗

Nursing Sickness Rates

Division	Apr '16	May '16	Jun '16	Jul '16	Trend
C&W Diagnostic & Therapy	4.0%	4.1%	4.1%	4.2%	↗
Community Services	6.7%	5.7%	6.1%	6.2%	↗
Corporate	2.7%	4.2%	3.7%	5.7%	↗
Medical & Cardiothoracics	3.9%	3.6%	3.5%	2.7%	↘
Surgery, Neurosciences & Anaes	3.9%	4.4%	3.8%	4.3%	↗
Total	4.3%	4.2%	4.1%	4.1%	↘

Nursing Voluntary Turnover

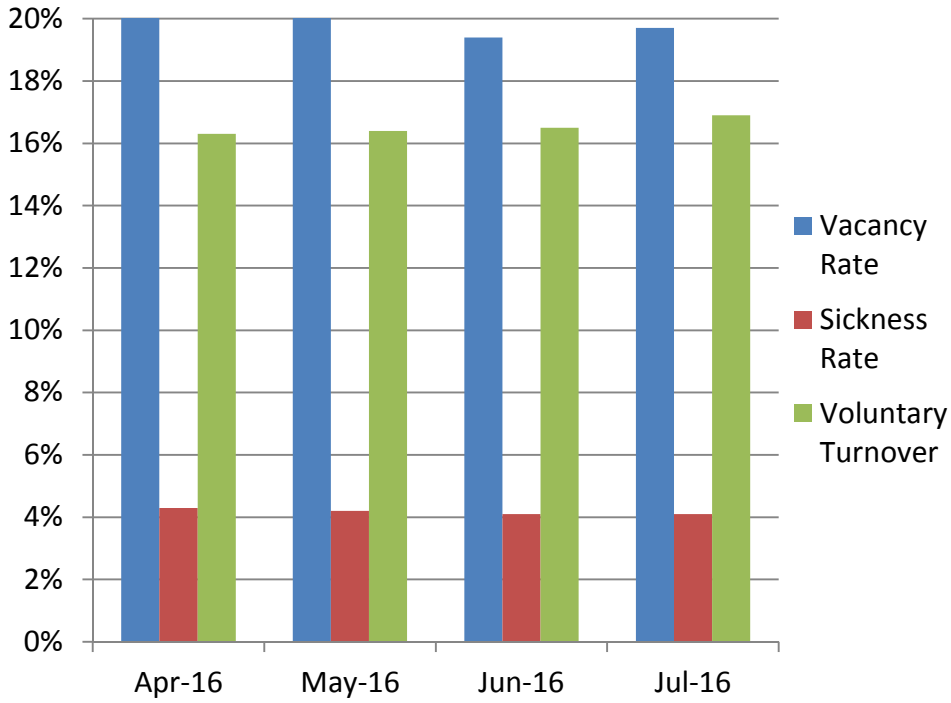
Division	Apr '16	May '16	Jun '16	Jul '16	Trend
C&W Diagnostic & Therapy	14.50%	14.18%	14.51%	14.99%	↗
Community Services	17.08%	18.05%	17.35%	18.75%	↗
Corporate & R&D	12.36%	14.08%	10.21%	8.56%	↘
Medical & Cardiothoracics	18.41%	18.94%	19.13%	19.63%	↗
Surgery, Neurosciences & Anaes	15.74%	15.42%	15.87%	15.61%	↘
Total	16.3%	16.4%	16.5%	16.9%	↗

COMMENTARY

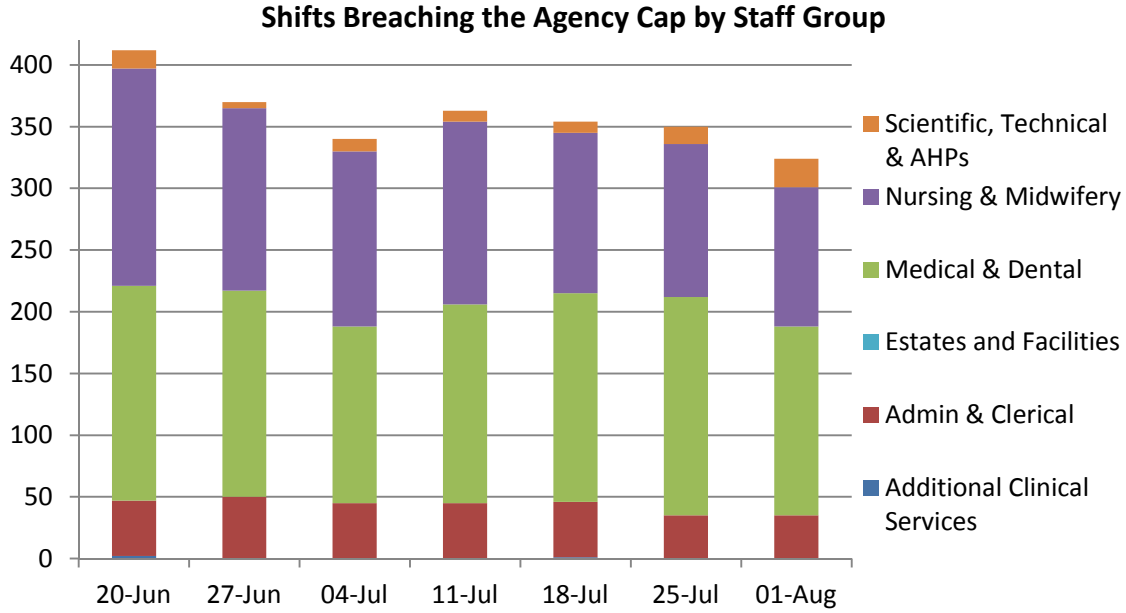
This data shows a more in-depth view of our nursing workforce (both qualified and unqualified).

The nursing workforce has decreased by 1.4 WTE in July.

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	20-Jun	27-Jun	04-Jul	11-Jul	18-Jul	25-Jul	01-Aug
Additional Clinical Services	2	0	0	0	1	0	0
Admin & Clerical	45	50	45	45	45	35	35
Estates and Facilities	0	0	0	0	0	0	0
Medical & Dental	174	167	143	161	169	177	153
Nursing & Midwifery	176	148	142	148	130	124	113
Scientific, Technical & AHPs	15	5	10	9	9	14	23
Whole Trust	412	370	340	363	354	350	324

Agency Cap Shift Breaches by Division	20-Jun	27-Jun	04-Jul	11-Jul	18-Jul	25-Jul	01-Aug
C&W Diagnostic & Therapy	94	65	55	72	68	88	85
Community Services	81	69	69	67	54	46	40
Corporate	70	75	45	66	70	60	55
Estates and Facilities	0	0	0	0	0	0	0
Medical & Cardiothoracics	117	99	98	102	114	105	84
Surgery, Neurosciences & Anaes	50	62	48	56	48	51	60
SWL Pathology	0	0	0	0	0	0	0
Whole Trust	412	370	315	363	354	350	324

COMMENTARY

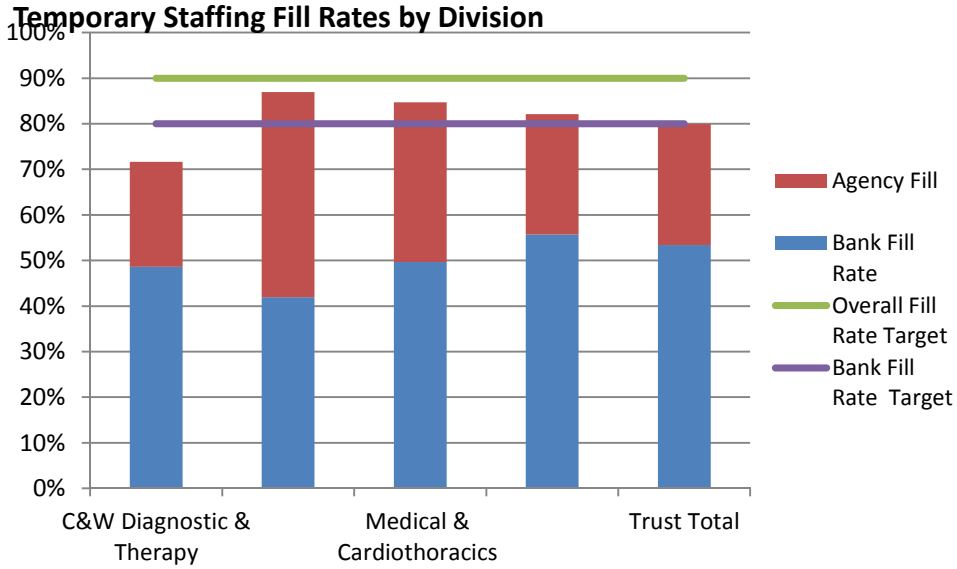
All Trusts are now required to report weekly on the number of shifts which have breached the Agency capped rates which have been set by NHS Improvement.

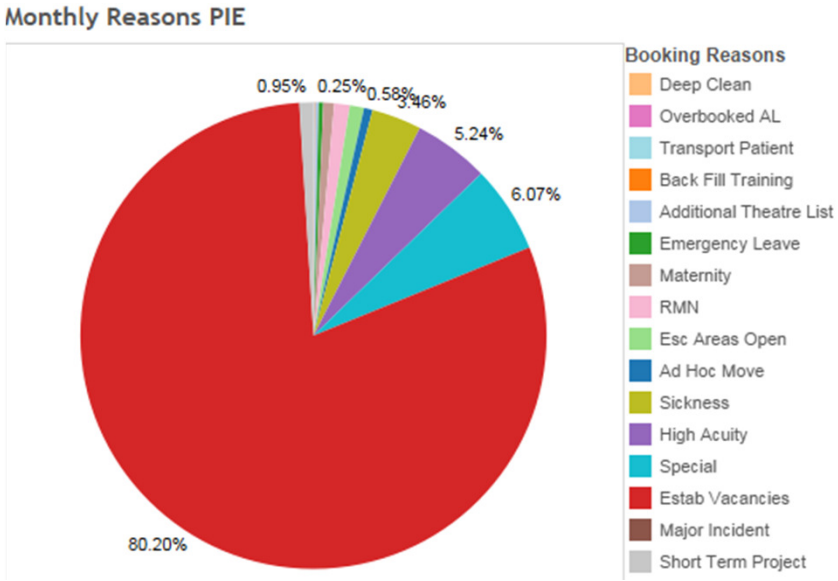
Work is on-going to stop using agencies which breach the caps where possible.

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

For the week commencing 1st of August, the Medical & Cardiothoracic Division had the largest number of breaches in the Medical and Dental staff group (72). The Children & Women's Division had the highest number of Nursing & Midwifery breaches in that week (41).

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 June the Bank Fill Rate was reported at 53.4% which is 0.6% higher than the previous month. The Overall Fill Rate was 79.9% which is an increase of 0.7%. Community Services Division is currently meeting the demand for temporary staff most effectively.

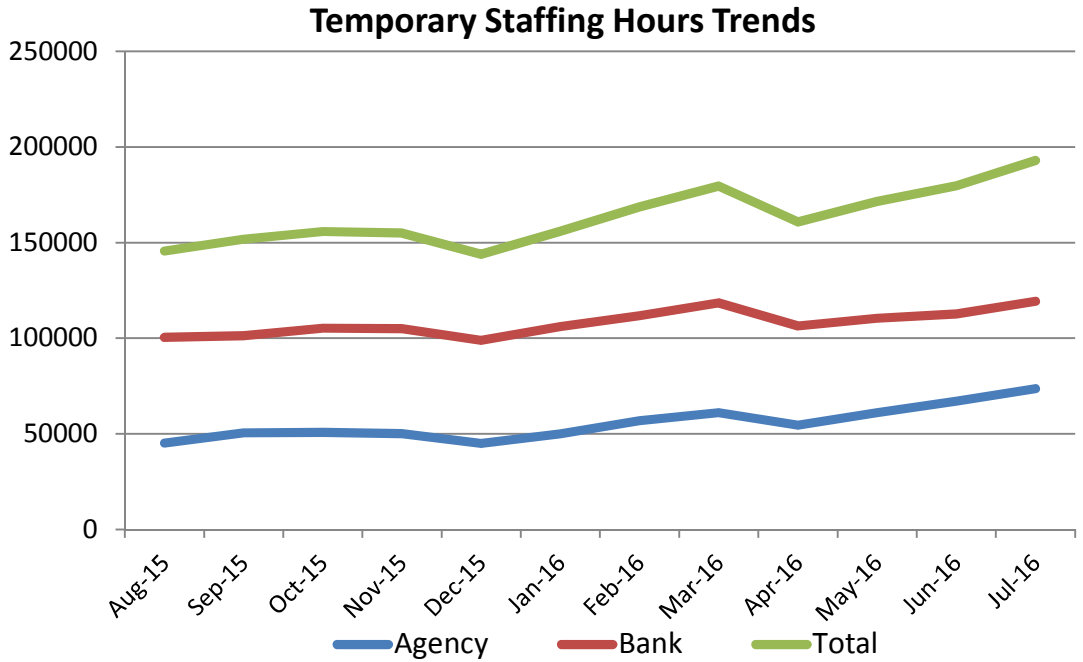
The pie chart shows a breakdown of the reasons given for requesting bank shifts in July. This is very much dominated by covering existing vacancies, specials, sickness, and high acuity patients.

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

Bank Fill Rate % by Division	Apr '16	May '16	Jun '16	Jul '16	Trend
C&W Diagnostic & Therapy	59.0%	53.9%	49.1%	48.6%	↘
Community Services	45.8%	46.4%	44.3%	42.0%	↘
Medical & Cardiothoracics	45.5%	47.0%	46.3%	49.7%	↗
Surgery, Neurosciences & Anaes	52.7%	56.7%	54.8%	55.7%	↗
Whole Trust	**55.1%**	**55.4%**	**52.8%**	**53.4%**	↗

Overall Fill Rate % by Division	Apr '16	May '16	Jun '16	Jul '16	Trend
C&W Diagnostic & Therapy	77.2%	76.5%	71.2%	71.6%	↗
Community Services	83.9%	86.7%	83.8%	86.9%	↗
Medical & Cardiothoracics	81.0%	83.5%	85.5%	84.7%	↘
Surgery, Neurosciences & Anaes	75.3%	79.6%	80.8%	82.1%	↗
Whole Trust	**79.0%**	**81.2%**	**79.2%**	**79.9%**	↗

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 increased across most Divisions in July.

Agency hours have increased in Community Services, Surgery Division and in SWL Pathology.

The Surgery and Neurosciences Division proportionately has the highest increase in bank hours this month. Departments with increases include Anaesthetics Theatre Staff and Gray Ward.

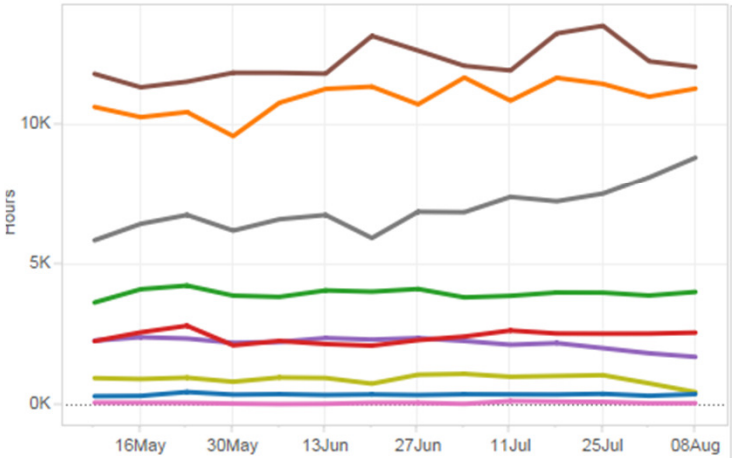
TYPE	Division	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Agency	C&W Diagnostic & Therapy	9408	10033	11112	10724	11615	11158	14779	16404	14872	16869	19956	21545
	Community Services	6422	6421	7086	6605	6715	7298	8717	10225	8709	9108	8989	10423
	Corporate	46	423	402	384	541	1021	793	610	866	1401	999	1089
	Estates and Facilities	0	0	4	166	322	140	176	180	361	549	321	364
	Medical & Cardiothoracics	20348	24428	21792	22626	19732	23154	23159	23779	21106	24231	26734	25648
	Surgery, Neurosciences & Anaes	8730	8860	9994	9362	5953	7161	9211	9885	8584	8767	9887	11503
	SWL Pathology	245	352	267	150	143	0	0	0	0	90	257	3013
Agency Total		**45199**	**50517**	**50657**	**50017**	**45021**	**49932**	**56835**	**61083**	**54498**	**61015**	**67143**	**73584**
Bank	C&W Diagnostic & Therapy	26657	30745	32858	31790	30886	33343	34999	32870	31037	30935	31409	31919
	Community Services	9033	8695	9149	9133	9005	9225	9796	10885	9005	8916	9340	8974
	Corporate	7206	8828	11156	9858	8426	8674	8773	9078	10249	10124	10224	10824
	Estates and Facilities	8910	8264	8506	9423	8467	8428	10122	10078	9021	9739	9914	9370
	Medical & Cardiothoracics	29728	27842	26409	28073	25363	26990	26921	29610	25231	27418	28459	32165
	Surgery, Neurosciences & Anaes	15545	16118	16265	15754	15791	18358	20155	22946	18370	19098	18549	21180
	SWL Pathology	3389	803	821	839	998	1016	1050	3063	3463	4281	4668	4879
Bank Total		**100468**	**101295**	**105164**	**104870**	**98936**	**106034**	**111816**	**118530**	**106376**	**110511**	**112563**	**119312**
Temporary Staff Total		**145667**	**151811**	**155821**	**154887**	**143957**	**155966**	**168651**	**179613**	**160874**	**171526**	**179706**	**192896**

Section 11: Temporary Staffing Weekly Tracking

Weekly Hours Used By Division

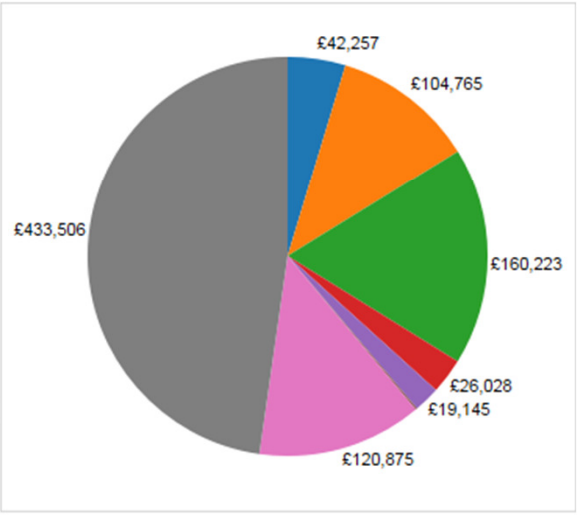
Division	09 May	16 May	23 May	30 May	06 Jun	13 Jun	20 Jun	27 Jun	04 Jul	11 Jul	18 Jul	25 Jul	01 Aug	08 Aug
Capital Division	316	327	465	373	388	362	379	359	385	381	376	401	329	390
Children and Women's Diagnostic and..	10,659	10,295	10,476	9,618	10,809	11,303	11,384	10,753	11,708	10,882	11,698	11,481	11,023	11,314
Community Services Division	3,653	4,127	4,256	3,898	3,853	4,085	4,039	4,136	3,836	3,891	4,010	4,005	3,902	4,030
Corporate Division	2,278	2,590	2,824	2,126	2,283	2,174	2,115	2,313	2,441	2,656	2,549	2,544	2,546	2,580
Estates and Facilities Division	2,295	2,419	2,370	2,217	2,249	2,387	2,332	2,386	2,284	2,149	2,208	2,029	1,844	1,716
Medicine and Cardiovascular Division	11,839	11,360	11,560	11,880	11,876	11,846	13,193	12,670	12,126	11,960	13,281	13,556	12,289	12,089
Research & Development Division	89	83	77	52	37	44	79	80	43	141	122	110	65	66
Surgery & Neurosciences Division	5,870	6,456	6,773	6,214	6,619	6,772	5,950	6,887	6,871	7,418	7,261	7,536	8,141	8,846
SWL Pathology Division	959	928	976	830	982	966	761	1,081	1,111	1,007	1,037	1,066	773	462
Grand Total	37,957	38,585	39,777	37,207	39,098	39,938	40,232	40,664	40,804	40,484	42,541	42,725	40,912	41,491

Weekly Hours Used Trends



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

Weekly Spend by Staff Group



Total Cost
£907,999

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

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

Section 12: Mandatory Training

MAST Topic	Jun '16	Jul '16	Trend
Conflict Resolution	89.4	91.2	↗
Equality, Diversity and Human Rights	82.2	84.2	↗
Fire Safety	86.0	87.2	↗
Health, Safety and Welfare	84.9	86.2	↗
Infection Prevention and Control Clinical	74.3	73.4	↘
Infection Prevention and Control Non Clinical	77.5	79.3	↗
Information Governance	81.6	81.9	↗
Moving and Handling	82.4	83.9	↗
Moving and Handling Patient	68.7	69.8	↗
Resuscitation BLS	56.5	57.5	↗
Resuscitation ILS	57.2	57.0	↘
Resuscitation Non Clinical	74.0	74.5	↗
Safeguarding Adults	82.8	84.1	↗
Safeguarding Children Level 1	80.3	82.2	↗
Safeguarding Children Level 2	80.1	80.1	↗
Safeguarding Children Level 3	72.0	71.7	↘

COMMENTARY

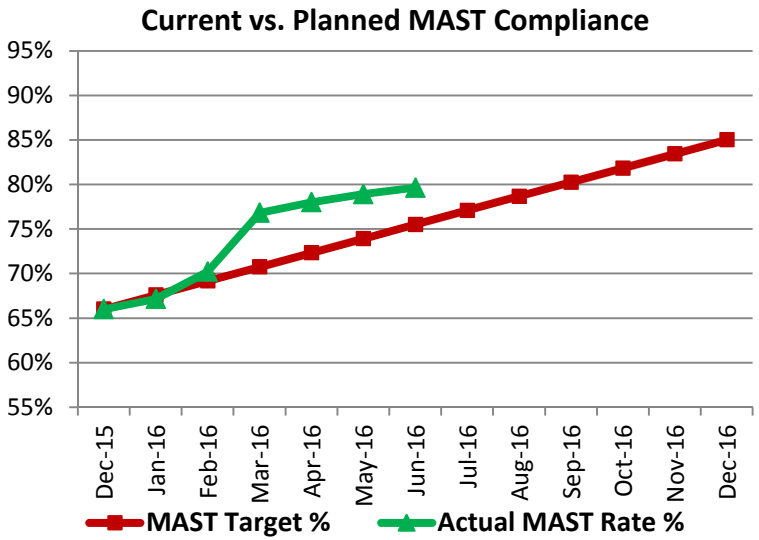
A programme of working is taking place including:

- 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.

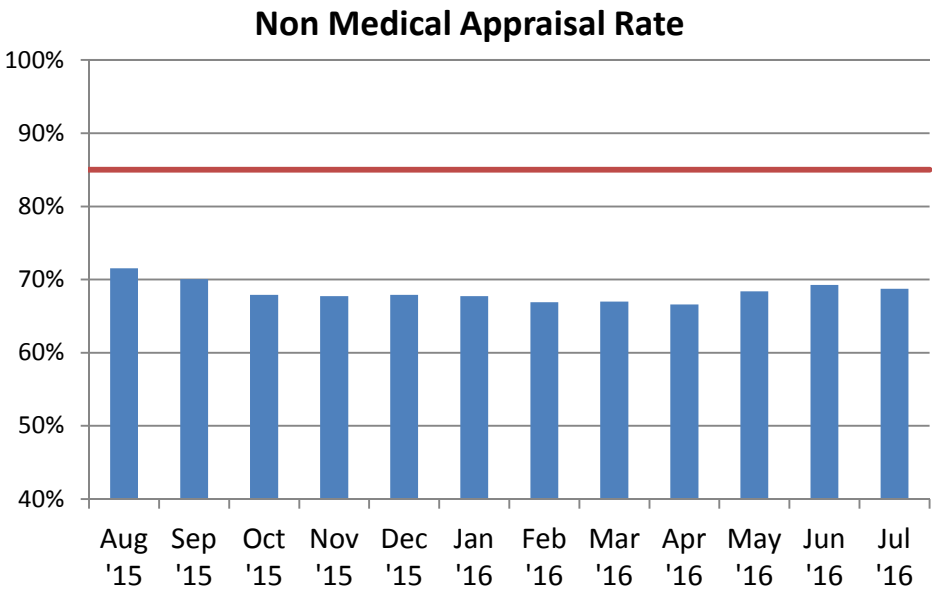
Current Issues:

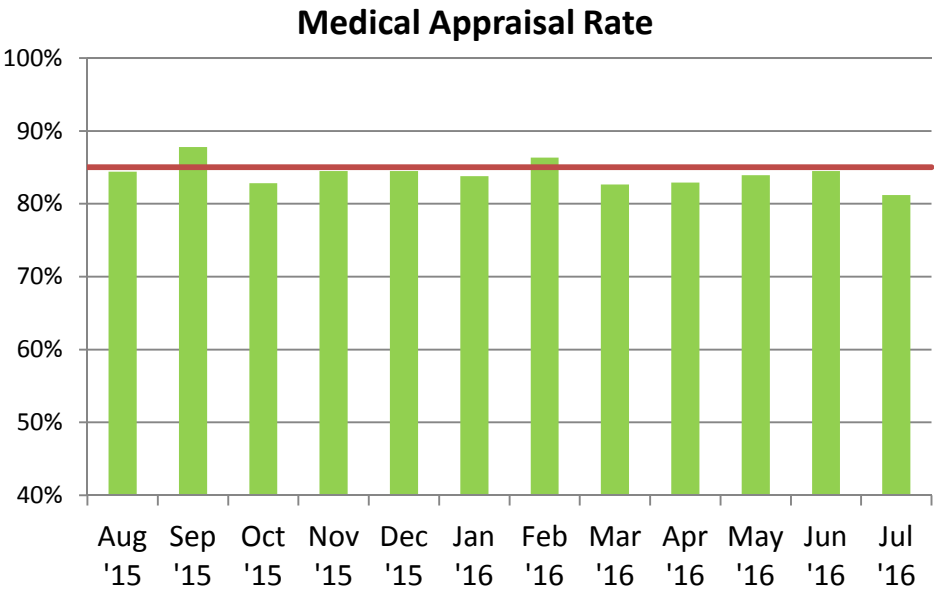
- Fall in compliance rates – largely due to staffing pressures
- Community access to Totara is on the risk register, in the interim we are visiting community sites with tablets and developing a permanent solution in parallel
- Staff unable to access training externally- Software and licencing and IG 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	Apr '16	May '16	Jun '16	Jul '16	Trend
C&W Diagnostic & Therapy	77.8%	78.9%	79.4%	80.0%	↗
Community Services	81.0%	82.7%	83.6%	84.9%	↗
Corporate	77.6%	78.5%	77.9%	77.8%	↘
Estates and Facilities	70.1%	68.4%	69.5%	74.4%	↗
Medical & Cardiothoracics	75.5%	76.6%	77.8%	78.5%	↗
Surgery, Neurosciences & Anaes	76.1%	77.0%	78.2%	79.4%	↗
Whole Trust	78.0%	78.9%	79.6%	80.7%	↗



Section 13: Appraisal





Non-Medical Commentary

The non-medical appraisal rate has decreased by 0.5% this month to 68.8%. Appraisals are still being managed closely by the appraisal project team who are monitoring progress every two weeks and scrutinising divisional plans. The Estates & Facilities Division currently has the lowest non-medical compliance rate. Appraisal completion is now linked to incremental progression for bands AFC band 7 - 9 staff. The table below lists the five care groups with the lowest non medical appraisal rate this month

Medical Commentary

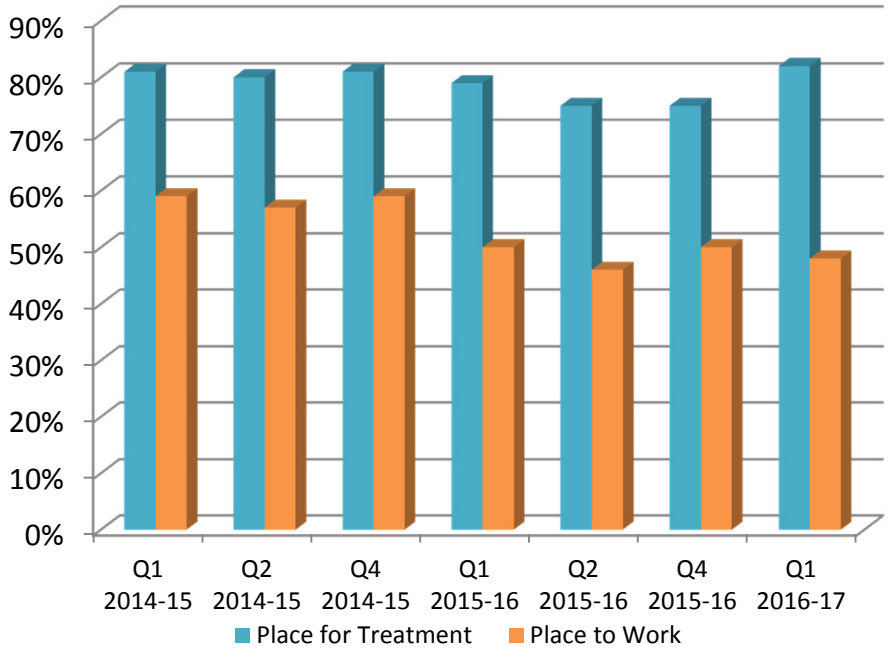
Medical appraisal rate compliance has increased this month to 81.2% which is below target.

Care Group	Non-Med Appraisal Rate	Staff In Post WTE
SWLP Haematology	8.9%	58.31
SWLP Central Reception	9.4%	57.27
Energy and Engineering	25.6%	49.71
SWLP Biochemistry	26.9%	56.40
Chief Operating Officer	40.0%	42.26

Non Medical Appraisals by Division	Apr '16	May '16	Jun '16	Jul '16	Trend
C&W Diagnostic & Therapy	63.5%	63.8%	66.3%	66.9%	↗
Community Services	64.5%	66.6%	77.8%	77.3%	↘
Medical & Cardiothoracics	68.3%	70.8%	69.7%	68.9%	↘
Surgery, Neurosciences & Anaes	73.3%	77.1%	80.2%	78.2%	↘
Corporate	62.0%	64.0%	65.2%	63.3%	↘
Estates & Facilities	64.5%	64.0%	62.8%	57.8%	↘
Whole Trust	**66.6%**	**68.4%**	**69.3%**	**68.8%**	↘

Medical Appraisals by Division	Apr '16	May '16	Jun '16	Jul '16	Trend
C&W Diagnostic & Therapy	85.5%	85.4%	87.3%	86.2%	↘
Community Services	92.6%	87.5%	79.2%	70.0%	↘
Medical & Cardiothoracics	85.4%	86.8%	82.0%	79.9%	↘
Surgery, Neurosciences & Anaes	83.4%	87.5%	86.6%	84.3%	↘
Corporate	100.0%	75.0%	75.0%	100.0%	↗
Whole Trust	**82.9%**	**83.9%**	**84.5%**	**81.2%**	↘

Section 14: Friends & Family Test



Quarter	No. of Respondents	Place for Treatment	Place to Work
Q1 2014-15	772	81%	59%
Q2 2014-15	908	80%	57%
Q4 2014-15	1112	81%	59%
Q1 2015-16	695	79%	50%
Q2 2015-16	274	75%	46%
Q4 2015-16	508	75%	50%
Q1 2016-17	655	79%	50%

The NHS Friends and Family Test (FFT) for staff has been carried out at the Trust since June 2014 and is a measure of staff engagement.

The information shown here are the responses given by our staff to the following questions:

“How likely are you to recommend this organisation to friends and family if they needed care or treatment?”

“How likely are you to recommend this organisation to friends and family as a place to work?”

The figures show a downward trend in the percentage of staff recommending the Trust as a place to work. The percentage who recommend the Trust as a place for treatment has remained fairly stable at around 80%.

Estates & Facilities

- SAU/Nye Bevan Unit opened;
- Theatres 5 & 6 delayed but opening imminently
- Demolition timetable;
  - Wandle vacated & demolition started this month
  - All other target sites down ASAP this year
- Extra Boiler on site by end September;
- Mortuary Phase 2 by end September;
- New lift servicing firm onsite;
- CQC: OPD 15% Reduction Progress
- CQC: Renal relocation, dates, deals & dependencies, comms, lorries on site; total new running costs Sept.
- Temporary Occ Health move to Norman Tanner
- New Operations Centre being planned.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD ***SEPTEMBER 2016*** **:**

Paper Title:	**Updates on Complaints and PALS Action Plan 2016/2017**
Sponsoring Director:	**Hazel Tonge, Acting Chief Nurse**
Author:	**Sarah Duncan, Patient Experience Manager** **Helene Anderson, Jo Haworth and Robert Bleasdale, Divisional Directors of Nursing and Governance** **Alison Benincasa, Divisional Chair for Community Services**
Purpose: *The purpose of bringing the report to the board*	*To provide an update on the progress made on the Complaints and PALS action plan previously presented to June Trust Board*
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	**For information**
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	**Executive Management Team**

Executive summary

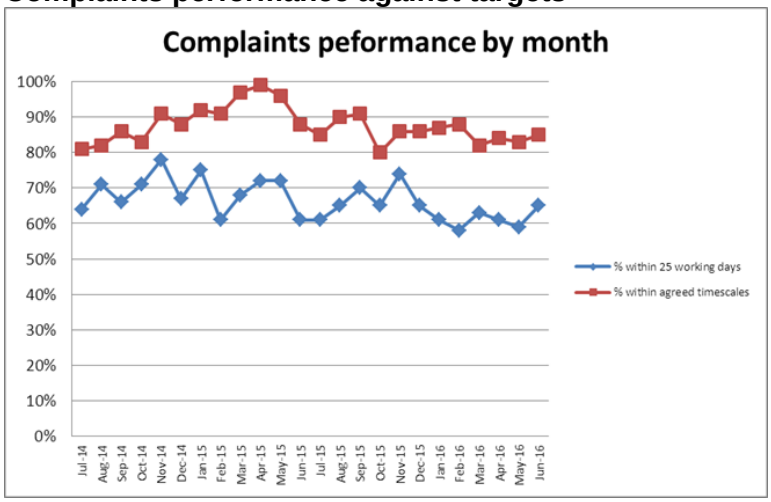
In response to poor performance in relation to the trust's complaint response targets over the last few years, a workshop was held on 19 April 2016 to discuss how the complaints process is working, identify areas for improvement and share learning. Participating were the Deputy Chief Nurse, Patient Experience Manager, Divisional Directors of Nursing and Governance, Heads of Nursing, General and Service Managers, Divisional Governance Managers and the corporate complaints and PALS teams. Following the workshop an action plan was developed by the Deputy Chief Nurse, Patient Experience Manager and Divisional Directors of Nursing and Governance. This paper provides an update on action by divisions and corporately.

Key messages

The key areas identified for improvement were:

- To reduce the number of complaints received in the trust through identification of issues at an earlier point of the patient journey.
- To improve the quality of complaint responses.
- To improve the timeliness of our responses achieving a sustainable performance within the trust.
- Strengthen learning from complaints

Complaints performance against targets



The Local Authority Social Services and National Health Service Complaints (England)

Regulations 2009 set out the rights of complainants and the expectations on the trust to investigate and respond in an appropriate and timely manner. Best practice is that each complainant is contacted to discuss their complaints and negotiate both the process of resolution and the timescale.

The regulations state that complaints should be responded to within six months however the trust has chosen to maintain a 25 working day response time and the target is that 85% of complaints should be responded to within this timescale. If a complaint is not responded to within 25 working days an extension must be agreed with the complainant. The target is that 100% of complaints should be responded to within 25 working days or agreed timescales.

Across the years the trust has consistently failed to meet these targets. For example for complaints received in quarter 1 of 2016/2017 62% of complaints were responded to within 25 working days 86% of complaints were responded to within agreed timescales.

The Deputy Chief Nurse has met with Divisional Complaints leads who have presented their action plan and trajectories. The detailed divisional action plans were presented to EMT on 22 August and will be monitored via DMBs.

Weekly meetings between divisions and the Deputy Chief Nurse are being set up to review the progress on the action plans and performance. Divisions will be held to account for delivering against their trajectories to improve and it is envisaged that over the next few months there will be an improvement as new systems will be implemented.

Trajectories for improvement

Complaints and Improvements Team

- Send out newly received complaints to divisions within 2 working days by September

Medicine and Cardiovascular Division

- Complaints received in August - 100% responded to within agreed timescales
- To be complaint as division with 85% for complaints received in September

Women's, Children's, Diagnostics and Therapeutics Division
To be compliant with both targets for complaints received in September

Surgery, Neurosciences and Cancer Divisions
To be compliant with both targets for complaints received in September

Community Services Division
Compliant with both targets now looking across a number of months (as so few complaints received one breach in one month can mean 85% target is missed).

A further update will be presented to the November Board when September targets have been reached.

Update regarding quality of complaint responses

This is being measured by the percentage of responses being rejected/queried by the Chief Executive prior to sign off. There has been an improvement across the past three months.

June – 18%
July – 12%
August (to 24th) – 6%

Update regarding strengthening learning

- The weekly overview complaints report now includes actions taken for complaints closed in previous week as well as synopses of complaints received so that learning is shared.
- The upgrade of the DATIX Risk Management system took place end of July. Following a time delay in getting DATIX reinstalled on some PCs the Patient Experience Manager discussed functionality with the Risk Manager who feels that the action tracking function does not work well on main application and is not useful. We are investigating switching to DATIX Web. In the meantime we continue to report actions to the Board, PEC and QRC as part of the Performance and Quality Report and divisions report them to PEC as part of their divisional report.
- Further actions are set out in the detailed divisional action plans reported to EMT on 22 August and to be monitored at DGBs.

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?

Recent/current challenges faced have impeded the Complaints and Improvement team's ability to send out and log complaints in a timely manner. These include staff sickness, maternity leave, IT issues (DATIX and unexplained deletion of emails from generic inbox).

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

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

Complaints and PALS 2016/2017 action plan

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

Aim:	Actions	By When	By Who	Progress/risks August 2016
To reduce the number of complaints received in the trust through identification of issues at an earlier point of the patient journey:				
Encourage patients to give feedback whilst they are being treated. Concerns are identified and resolved in real time.	• Email DDNGS to advise all areas to put up "Don't take your troubles home" posters and business cards	Immediate	DCN	Complete
	• Ward / department leads to have up to date photos taken by photo media services	End June 2016	Matrons and Senior Nurses	Detailed divisional action plans in place reported to EMT on 22 August and to be monitored at DGBs.
	• "Don't take your troubles home" posters and business cards to be displayed in wards and clinic areas.			
	• Matrons roles and responsibilities to be reviewed, to be more visible on wards and in clinic areas.	July 2016	DDNGs and Corporate Nursing	Action closed – Matrons and HoNs all participating in back to the floor
	• Ensure that PALS leaflets and posters are available in all areas	Ongoing	PALS and ward and clinic staff	Ongoing
Staff are empowered to resolve concerns as they arise rather than escalating.	• Staff to attend Customer Service Excellence training	Ongoing	Staff identified via their line managers.	Customer Service Excellence training is available to staff on a monthly basis facilitated by PALS. Courses can be booked on the Education and Development intranet site.

Increase availability of PALS resource	• Review PALS workload and make recommendations • Consider aligning PALS resource to divisions • Strengthen PALS team to enable greater support to the division	July 2016	Patient Experience Manager/Deputy Chief Nurse/Chief Nurse	Risk – No additional resource available. Not yet commenced due to competing work pressures taking precedence. PE Manager to discuss with DCN in September.
To improve the quality of complaint responses				
To have a cohort of staff who can effectively write complaint responses thereby reducing the time for the trust to respond. Increase in complaints responses cleared for sending on presentation to CEO, CN.	• Ensure every staff member who has responsibility to manage complaints attends training • Divisions to identify staff who are required to attend training. • Divisions to identify "complaints champions" who can buddy up with those less confident.	Ongoing June 2016 July 2016	DDNGs, General Managers, Heads of Nursing to identify staff	Investigating and Responding to Complaints training is available to staff on a monthly basis facilitated by the Corporate Complaints Team. Courses can be booked on the Education and Development intranet site. Detailed divisional action plans in place reported to EMT on 22 August and to be monitored at DGBs.
Access to resources and guidance to be available for staff to reference.	Complaints resources page on the intranet to be updated and publicised (pending the new intranet being build).	By end June	Patient Experience Manager and Digital Design Officer	Completed 8 July 2016
To improve the timeliness of our responses achieving a sustainable performance within the trust:				
Complaints team to send out new complaints to divisions within 2 working days of receipt	Agree addition Complaints and Improvements Co-ordinator cover.	By September 2016 dependent on cover being agreed.	Deputy Chief Nurse/Patient Experience Manager	Recent/current challenges faced have impeded the team's ability to send out and log complaints in a timely manner. Staff sickness, maternity leave, IT issues (DATIX and unexplained deletion of emails from generic

				inbox).
Strengthen and clarify roles and responsibilities of who manages, inputs and assures timeliness and quality of complaints	• To clarify roles and responsibility and accountability within the divisions for complaints at all levels – Divisional Chair, DDO, DDNG, governance resource, HON, Matron, GM etc • Clarify expectations of each role within the complaints process • Identify if extra resource is required and clarify for which particular task. • Allocate tasks and hold individuals to account for delivering in a timely manner	June 2016	DDNGs	Detailed divisional action plans in place reported to EMT on 22 August and to be monitored at DGBs.
Strengthen Staff held to account for poor performance.	• At weekly divisional complaints meetings. • At directorate and care group meetings • At quarterly performance quality meetings	Immediate July 16	DDNGs, GMs	Detailed divisional action plans in place reported to EMT on 22 August and to be monitored at DGBs.
To strengthen monitoring of performance	• To reset and agree divisional performance targets within 16/17 which are realistic and deliver the trust standards • To review the performance against targets and agree which meetings this review will occur • Scoping exercise regarding other trust's targets and	End July 2016	Patient Experience Manager/complaints team/DDNGS/DCN	Not yet commenced due to staff absence not allowing capacity to release staff member.

	performance.			
Strengthen learning from complaints:				
Clear visibility of actions available which were taken in response to complaints and evidence portfolio available.	Investigate capabilities/functionality of new DATIX software.	June 2016	Patient Experience Manager	Upgrade took place end of July. Then time delay in getting DATIX reinstalled on some PCs. Have discussed functionality with Risk Manager who feels that function does not work well on main application, not useful. We are investigating switching to DATIX Web. In the meantime actions are sent out to divisions on weekly basis so that learning can be shared.
To use a range of approaches to support effective learning from complaints.	• Complaints themes and lessons learned to be presented at directorate and care group meetings as standing agenda item. • Weekly overview complaints report to include actions taken for complaints closed in previous week as well as synopses of complaints received. • Undertake scoping exercise of practice at other trusts.	July 2016 End May 2016 July 2016	DDNGs to cascade Complaints team Patient Experience Manager and Complaints team.	Detailed divisional action plans in place reported to EMT on 22 August and to be monitored at DGBs. Ongoing. Not yet commenced due to staff absence not allowing capacity to release staff member (as with other scoping exercise). .

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Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

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

Paper Title:	**Outpatient Programme Board Update**
Sponsoring Directors:	**Professor Andrew Rhodes, Alison Benincasa**
Author:	**Steve Sewell, Programme Director**
Purpose: *The purpose of bringing the report to the board*	*To provide the Board with an update on progress following the agreement of the OP Review*
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	**For information / ~~For decision~~** *(delete as appropriate)*
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	**Executive Management Team, Turnaround Board**

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

1. Key messages

- Board support for the OP Review recommendations led to a reset of the Outpatient Programme, this reset is described in narrative form in a Value Proposition
- Following approval at Turnaround Board, the key elements of the Value Proposition have been transferred to the Trust wide standard DIP format.
- The attached paper provides a summary of the Value Proposition covering the 3 key workstreams, outcomes to be delivered, key milestones, financial impact and progress over the past few weeks.
- The supporting Board presentation will pick out the key elements of the paper and outline the level of ambition for the Design work for the programme.

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?

- Complexity and interdependencies with other change initiatives across the Trust
- Emerging Organisation challenges change the scope, focus and direction of the programme.
- Engagement of Key Stakeholders
- Design of new Outpatient Model and New Models of Care may conflict with Optimise workstream.
- Culture of Organisation is not supportive of Change and Innovation.

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

Enclosure:

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.

A QIA has been undertaken for the whole programme. EIA requirements is/will need to be embedded into all initiatives within the overall programme and the requirements and impact will differ greatly across each initiative.

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

1.1 Who is responsible for this service / function / policy?
1.2 Describe the purpose of the service / function / policy? *Who is it intended to benefit? What are the intended outcomes?*
1.3 Are there any associated objectives? *E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives*
1.4 What factors contribute or detract from achieving intended outcomes?
1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability (physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Region or belief and Human Rights
1.6 If yes, please describe current or planned activities to address the impact.
1.7 Is there any scope for new measures which would promote equality?
1.8 What are your monitoring arrangements for this policy/ service
1.9 Equality Impact Rating [low, medium, high]

Enclosure:

2.0. Please give your reasons for this rating

Outpatient Programme
Board Update August 2016

St George's University Hospitals NHS
NHS Foundation Trust

Introduction

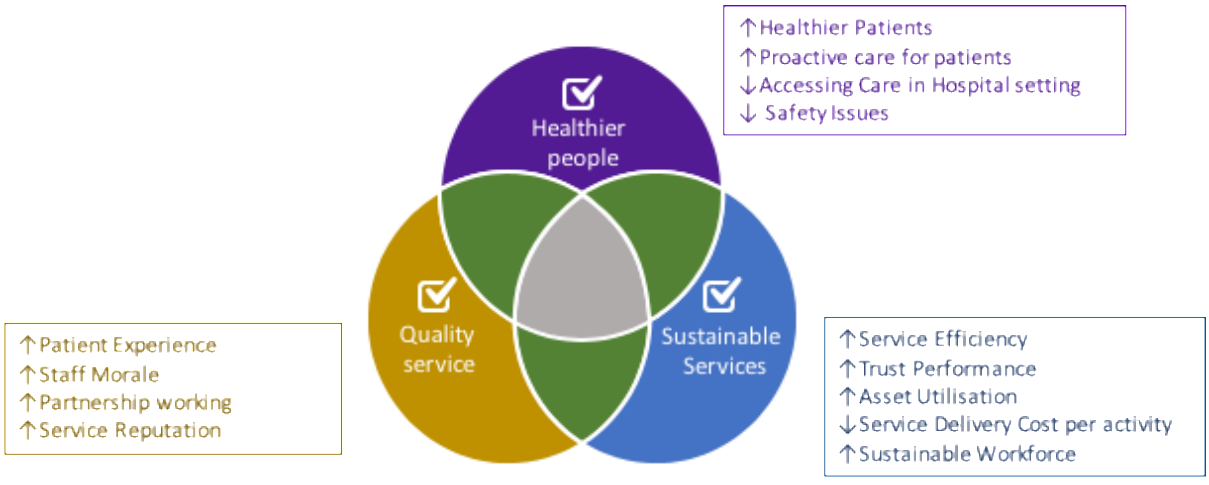
Following acceptance of the Outpatient Review recommendations (June 2016), appointment of a Senior Responsible Owner and Clinical Responsible Owner, an Outpatient Programme has been established that balances the focus on the many current issues within outpatients as well as developing significantly better operating models for the future. A Value Proposition document was developed for 2016/17 and sets out the proposed scope, benefits, plans, priorities, risks and resourcing to deliver these. Following Turnaround Board approval of the programme Value Proposition, the programme DIP has been updated.

This paper summarises the 2016/17 Value Proposition and describes some of the various elements of progress.

It is provided to Trust Board for information only.

2016/17 Value Proposition Summary

The purpose of the programme is to deliver benefits that are in line with the Trust strategy and address many of the well known outpatient service issues. Using the IHI triple aim approach the benefits can be broadly split into 3 categories, which are completely interdependent; Healthier people, Quality Service and Sustainable Services. These, and their key supporting drivers are shown visually below



Whilst these are a wider set of benefits for the programme overall, the focus for 2016/17 are the following:

- Improved outpatient patient experience
- Fewer patient safety issues created by poor administrative processes
- Improved staff morale of those working in outpatient areas
- Greater outpatient service efficiency
- Improved outpatient service reputation

- Improved outpatient service contribution to Trust service performance
- Improved clinic room utilisation
- Greater financial sustainability through optimised income or reduced service cost.

In 2016/17, the agreed benefit trajectories are as follows:

Metric	Baseline	Q2	Q3	Q4
Total DNA's across the Trust	14.2%	12.5%	10.3%	9.0%
Underpinning Assumptions: based on reductions from early rollout to specialities.				
Monthly Total of Adhoc Clinics	177	150	100	75
Underpinning Assumptions: Based on Template Fix pace of rollout				
Monthly Clinics Cancelled < 6weeks notice	78	60	50	25
Underpinning Assumptions: Linked to Business Rules implementation, 20% of excess clinics in Q2, 50% in Q3 & 75% in Q4				
Number of Patients that would recommend the Trust to Friends and Family	88% (April 16)	89%	90%	90.5%
Underpinning Assumptions: Improved call centre and communication to patients				
Utilisation of Nelson Clinic Space	49%	75%	90%	90%
Underpinning Assumptions: Monday – Friday, 2 clinic days, St. George's clinic space only (excludes Moorfields)				
Trust Reputation with GPs	tbd			
Underpinning Assumption: Need a GP/Commissioner Survey developed and executed to generate a baseline				
No. of incorrect referral entries on iClip (monthly)	1750	1300	875	400
Underpinning assumption: Built on referral hardening plans and elimination of incorrect entries				
Total Number of calls answered within 60 seconds	20% (May 16)	75%	95%	96%

To enable these during 2016/17 the programme will be seeking to achieve a set of programme objectives. The full Value Proposition describes how these objectives will be delivered by describing the plans, measurable ambitions, risks, governance etc. These objectives are set out below:

- Clear and consistent operational rules that clarify the relationship between outpatient support services and the rest of the organisation (Q2 2016/17)
- Increase the number of high value clinic appointments (Ongoing)
- Improve the efficiency and consistency of outpatient processes to improve the data quality in the core iClip system (Ongoing)
- Review recently introduced technology capabilities that haven't been fully exploited and optimise the unrealised benefits (Q4, 2016/17)
- Design a UK best practice operating model for outpatients (Q3 2016/17)
- Facilitate the rationalisation of estate at St. George's site (Ongoing)
- Develop a business case for the delivery of a UK best practice operating model for outpatients. (Q4 2016/17)
- Respond to commissioner priorities for changing outpatient service models through joint definition and delivery of 4 CQUIN schemes (Q4 2016/17)
- Increase the utilisation of the Nelson Health Centre facilities to 90% (Q3 2016/17)
- In conjunction with commissioners develop and implement a sustainable model for services delivered in Nelson Health Centre (Q4 2016/17)
- Improvements in Call Centre Performance (Q3 2016/17).

Outpatient Programme
Board Update August 2016

To deliver these objectives, plans have been divided three key areas (workstreams), setting ambitious goals for each of these for the remainder of 2016/17. The three workstreams provide a holistic approach to the short and medium term issues, demands and pressures on outpatients. These areas are:

1. Optimise: To ensure a greater number of clinic appointments that are, 'the right patient with the right specialist, in the right place, at the same time, with the right information, followed by timely communication of the outcome of the clinic appointment'.
2. Redesign: In 2016/17 the vision to develop the design and robust justification for the introduction of a UK best practice outpatient operating model and transformation of the existing model.
3. New Models of Care: Develops and learns from innovative service models, that provide better outcomes, improves efficiency or integrates services across Divisions or with other providers, both on and off a hospital site. Thus, the vision helps the Trust prepare for the impact of the '5 Year Forward View' NHS strategy.

The impact of the work described will have a financial impact although in some cases this is difficult to quantify. For the elements that are quantifiable, the programme is aiming to deliver on £0.99m of CQUIN income (£160k greater than the Trust financial plan) and through increasing available clinic capacity we estimate a further financial benefit of around £2.1m in 2016/17 (£4.1m recurrent). This financial benefit is outlined in Appendix A.

In addition, the programme will impact on:

- avoiding additional cost, e.g. additional clinic space through better utilising Nelson Health Centre,
- reducing RTT penalties, although the measurement of this against a changing situation will be difficult,
- being better able to operate within existing operational costs or vacancy rates, e.g. efficiencies in the booking centre,
- reduction in legal cases as a result of poor outpatient processes,
- securing existing GP referral behaviours through improving reputation.

The programme continues to seek opportunities to reduce cost or increase income from existing capacity and so financial benefits may increase during the remainder of the financial year. However, much of the design work in outpatients is aimed at significant financial benefits in future years.

These financial benefits are set against a 2016/17 delivery resource plan, and additional investment requirement of £1.66m. This requirement excludes ICT resource costs, which will need to be developed following deep dives into each of the existing projects that form part of the programme. A summary of resource costs are outlined in the table below:

Outpatient Programme
Board Update August 2016

Investment Area (all cost in £k's)	Overall Cost 16/17	Secondments	Contractors	Consultancy	Other Costs
Programme Office	449	13	388		48
Optimise Workstream	706	321	215	120	50
Redesign Workstream	401	83	68	250	
New Models of Care	108	60	48		
Total to ensure 2016/17 delivery	**£1.66m**				

Resourcing of the programme will be challenging and require capacity and capabilities not normally available within the Trust. The resourcing strategy to ensure a legacy for the Trust is to work closely with operational staff, second other staff from the Trust into the programme and combine this with experienced external contract and consultancy to work together in an integrated fashion. The resource plan reflects this.

The greatest risks to the programme being successful have been identified as:

- Complexity and interdependencies with other change initiatives across the Trust
- Emerging Organisation challenges change the scope, focus and direction of the programme.
- Engagement of Key Stakeholders
- Design of new Outpatient Model and New Models of Care may conflict with Optimise workstream.
- Culture of Organisation is not one of being supportive of Change and Innovation.

The programme will impact on many people, both inside and outside the Trust, thus there is a need for a comprehensive communications approach. A communications and engagement strategy is outlined in the value proposition document as well as some of the analysis of stakeholder and communication channels we intend to use.

Turnaround Board reviewed and approved the value proposition on 20th July.

Outpatient Programme
Board Update August 2016

Key Progress during the initial weeks of the reset programme

During the past few weeks, there are early signs that the activities and approach being taken within the programme is having some impact with the key highlights being:

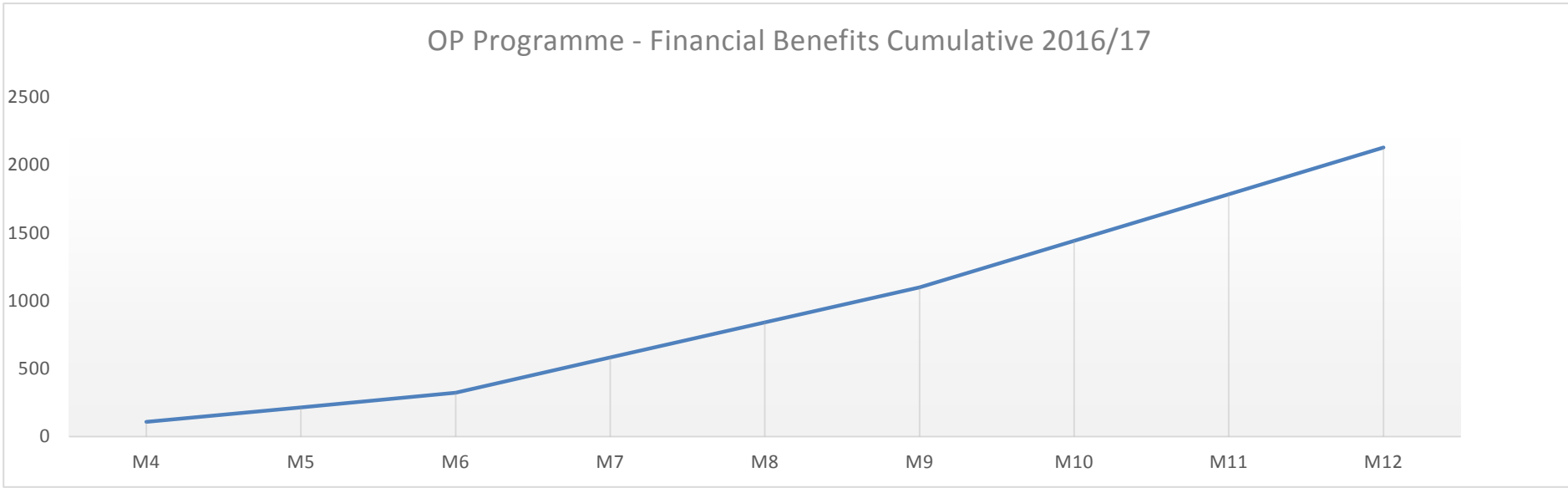
- Text reminders for appointments have been rolled out across Dermatology, Paediatrics and Gastroenterology. Other specialities are due to be rolled out very soon. As QHM has a separate main IT system, current rollout doesn't include outpatient services at QMH however a solution is being sought for this.
- Over 2000 redundant clinic templates have been removed from the iClip system.
- The backlog of clinic template requests has been reduced down to a minimum and requests are being dealt with in a timely fashion.
- Call centre performance has improved with the percentage of calls answered within 60 seconds having risen from 20% in May to 77% in the final week of July.
- In the call centre the total number of answered calls remains steady, however the number of unanswered calls has dropped from 45% to 5% when comparing May with late July.
- One of the issues with call centre performance in the past has been performance across the lunchtime period, where on busy days in early July no calls were answered within 30 seconds, in the most recent week this has risen to about 30%.
- A new set of business rules for outpatients has been approved by EMT.
- Through a focused team approach, the number of incorrect referral entries on iClip has dropped dramatically. The 16/17 target has been achieved, however we will monitor this to ensure this is maintained.
- A series of technical issue with eTriage software and processes have been identified and solutions are currently being tested.
- Developed and submitted a plan to Merton CCG to increase the utilisation of the Nelson Health Centre.
- A review of the eDM (electronic document management) has been undertaken with the conclusion that the current rollout strategy won't achieve the objectives set for the rollout. Two options are currently being modelled and the resulting appraisal of these options being presented to EMT in September.

Outpatient Programme
Board Update August 2016

Appendix A – Financial Benefits

	Q2			Q3			Q4		
	M4	M5	M6	M7	M8	M9	M10	M11	M12
Financial Benefit - reduced DNAs	108	108	108	259	259	259	343	343	343
Projected DNA Rate	12.5%	12.5%	12.5%	10.3%	10.3%	10.3%	9.0%	9.0%	9.0%
Cumulative Financial Benefit	108	216	324	583	842	1101	1444	1787	2130

note: all figures are £k's



These projections are based on the following assumptions:

- Activity levels and balance between new and follow up appointments will be maintained
- The schedule for implementation of the Text Reminder service is achieved
- An average of a 37% reduction in DNAs is seen in each speciality (based on evidence from early rollout)
- 80% of benefits relates to additional income and 20% to the removal of additional clinics. The RTT position of each speciality will determine which is the most appropriate.
- This spare capacity can be aggregated to release specific clinic reduction at specialty level. (i.e. it can be realised at whole clinic level)
- The limiting factor of overbooked clinics is negligible
- Cancelled appointments are filled
- The impact of moving to fixed booking does not have an adverse impact on DNA levels.

REPORT TO THE TRUST BOARD - 1st September 2016

Paper Title:	**Interim Resourcing**
Sponsoring Director:	**Iain Lynam, Chief Restructuring Officer**
Author:	Iain Lynam, Chief Restructuring Officer
Purpose: *The purpose of bringing the report to the board*	The Board asked for an update on interim resourcing.
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	**To note the paper and approve the next steps as detailed above**
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	Executive Management Team meeting (EMT) 22.08.16

Executive summary

The Trust has 1128.38 WTE of temporary staff currently working in the Trust. This number includes a total of 61 WTE interims and 12 WTE of KPMG consultants. Of the 61 WTE interims 35 are supporting back office functions which have suffered a crisis or collapse has suffered immensely leading to a significant loss of substantive staff; 5 are senior interims operating at Board level; 6 support the divisions; and 15 support turnaround or the PMO. The use of KPMG consultants is anticipated to reduce significantly by September 2016.

Next Steps
Every interim position will be reviewed over the next few weeks to ensure it is justified and an exit date is agreed. An update will be provided once this is complete.

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?

No specific risks are identified

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

Equality Impact Assessment (EIA): Has an EIA been carried out? (Yes / No)
If yes, please provide a summary of the key findings. No, not applicable.

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

Briefing Paper on Interim Resourcing

1. Background

1.1. At 1 August 2016, the Divisional WTE Workforce Tracker showed that we had a total 1128.38 WTE temporary staff working at the Trust. By far the majority of which were bank and agency staff providing shift and holiday cover.

1.2. Separately the PMO tracks the number of interims and KPMG management consultants within the Trust, which sit within the overall totals of temporary staff as above.

1.3. The total interims, as at 28 July 2016, was 61 WTE and the total KPMG consultants, during July 2016, averaged 12 WTE. Together these two categories of 73 WTE represent 0.8% of the total 9,657.66 Workforce WTE, including GP Trainees and SWL Pathology Division.

1.4. Interim for this purpose is defined as those temporary staff that are contracted to be present in the Trust for longer than one month. KPMG are the management consultants who have supported the Trust in Project Bold and its turnaround activities over the last year.

2. Interims

2.1. The 61 WTE interims comprise temporaries in the following divisions and departments: -

IT and Information Management	27
"Turnaround" including PMO	15
Finance	7
Divisions and Operations	6
Members of the EMT	5
Procurement	1
Total	**61**

2.2. In summary 35 WTE of this total support those back office departments, which have suffered a crisis or collapse leading to a significant or complete loss of substantive staff. This includes IT, Finance and until recently Procurement (although this has now almost completed its substantive recruitment to restore the normal position.)

2.3. There are 5 WTE who are the most senior interims and who fill director level positions in the EMT, which because of the current position of the Trust cannot at present be filled substantively.

2.4. There are 6 WTE who support the divisions and there are finally 15 WTE who comprise Turnaround and PMO resource.

2.5. It is recognised that most of these roles will need to be substantively recruited, once conditions allow, and that the balance are genuinely temporary in nature. Accordingly it is intended that each and every position will be reviewed over the next month to ensure that every interim is justified and that there is a proper target exit plan or conversion to substantive for each.

2.6. An update will be provided once this review has been completed.

3. KPMG

3.1. Although there were 16 consultants giving a total of an average 12 WTE input for each week in July 2016, this has fallen significantly in August as individual CIP project work streams have been completed and handed over.

3.2. The present work estimate for September 2016 is that only remain 5 individual consultants contributing 3.4 WTE will remain working on site.

3.3. Of these, two individuals are managing FCT CIP work streams that are due to conclude by the end of September, two hold line positions in Finance, including the role of CFO itself, and one provides part-time support to selection and sourcing of interims under the PMO.

3.4. The KPMG position will be reviewed again shortly, as is the case every month, and again prior to the end of September with a view to agree final conclusion dates for all KPMG involvement.

3.5. It should be noted that KPMG have since the start of their work been subject to Monitor and now NHSI oversight, who formally approve the forecast expenditure each month and it is with their full involvement that we are now working to conclude KPMG assistance to the Trust.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD - 1st September 2016

Paper Title:	**Update from Turnaround Board**
Sponsoring Director:	**Iain Lynam, Chief Restructuring Officer**
Author:	**Iain Lynam, Chief Restructuring Officer**
Purpose: *The purpose of bringing the report to the board*	To provide an updated position following the predicted shortfall from the CIP programme reported at the last Board.
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	**For information and to note**
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	**Turnaround Board (TAB) 18.08.16** **Executive Management Board (EMT) 22.08.16**

Executive summary

This note sets out an update on the current position following a predicted shortfall of £14.6 million for the CIP programme for the year and actions to be put in place to provide new CIPs to begin the recovery process. A wide range of new savings ideas have been initiated and listed in early August. That these would come under the control of a single programme director, who would be asked to report back to TAB with a detailed list of the proposed initiatives, an estimate of what they might save, a phasing and then be asked to assist in ensuring their delivery

Recommendation
The Board is asked to note the next steps.

Key risks identified:
Failure to deliver sufficient CIP savings will significantly impact on the Trusts financial position.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	Deliver our Transformation Programme enabling the trust to meet its operational and financial targets
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	

Equality Impact Assessment (EIA): Has an EIA been carried out?
No, an EIA will be carried out as necessary on individual proposals.

Update from Turnaround Board held on Thursday 18 August 2016

1. Background

1.1. At the meeting of TAB held last Thursday 18 August 2016, it was reported that the CIP programme for the year was showing a predicted £14.6 million shortfall against budget at Month 4.

1.2. It was reported that in response to this the Executive Management Team was drawing together ideas for a number of actions that would be designed to provide effectively new CIP ideas/stretch and start the process of recovering the shortfall.

2. CIP Shortfall

2.1. The original CIPs in the budget were £42.7 million.

2.2. At Month 4 end, the projected CIPs that would be achieved in year were £35,377k, as reported to the PMO. This figure was then risk assessed by the PMO and reduced to a revised total of £31,093k, a shortfall of some £14.6 million. (Although this had been reported to Finance and adopted as £14.3 million, a slight difference.)

2.3. This decline in the forecast CIPs was disappointing as a full reforecast and rephrasing exercise had been undertaken at Month 3 and had predicted a year end CIP total of £34,147k only a month earlier.

2.4. However it has sadly continued a trend, which has been evident for some time. It seems fair to observe that the Trust currently finds it very hard to embrace the CIP process and deliver on its own projections.

2.5. The £14.6 million shortfall is broken down by individual CIP as below, but the material variations may be summarised as: -

- Workforce Efficiency – which has declined from a budget of £9,965 million to a forecast at M4 of £3,129 million, a negative variance of £6.836 million.
- Stretch - the failure to identify any stretch possibilities to give a negative variance of £6.282 million.
- Corporate Efficiency - which has declined from a budget of £6,050 to a forecast at M4 of £4,451, a variance of £1.599 million. Although there are reasons to hope that once the new team in Procurement becomes established that they will catch up any present shortfall.

2.6. Finally it should be noted that a separate major sensitivity is the divisional CIPs of £10 million, which it is still assumed will be delivered in full.

3. Requirement for Additional CIPs

3.1. At TAB, it was reported that the Executive Management Team recognised that a major effort would be necessary to address the decline in the savings anticipated to be derived from the CIP programme and to institute a set of further steps designed to restore the total CIP for the year. At the very least to attempt to catch up the present £14.6 million shortfall.

3.2. This had resulted in a round table discussion early in August where a wide range of new saving ideas had been discussed and listed. Although the short hand name for this list of initiatives adopted in that meeting was Project Alpha, TAB recognised that this was in reality just a set of new saving ideas to address a current shortfall and as such was part of the normal process of any good CIP approach and process.

3.3. At the heart of the round table discussions was analysis, which showed that employee WTE had increased from 7,150 WTE in April 2014 to 7,582 WTE in post in July 2016, with no material increase in activity. This was before any effect from any change in temporary staff.

4. New ideas for CIPs and opportunities for closing the gap

4.1. It was explained at TAB that the intent was now to produce a listing of further CIP and saving opportunities. That these would come under the control of a single programme director, who would be asked to report back to TAB with a detailed list of the proposed initiatives, an estimate of what they might save, a phasing and then be asked to assist in ensuring their delivery.

Turnaround Programme: M4 risk assessed position

	M3 £'000			M4 £'000		
	TOTAL	Original Board	Variance	Reported	Risk %	Risk assessed
Diagnostics	733	988	(255)	733	0%	733
Flow	1,991	2,375	(384)	1,991	0%	1991
Outpatients	-	-	-	2,132	100%	2132
Theatres Transformation	4,017	2,169	1,848	4017	75%	3013
CLINICAL TRANSFORMATION	**6,741**	**5,532**	**1,209**			
Corporate Efficiency (Back office)	-	50	(50)	0		0
Procurement	5,998	6,000	(2)	5,236	-15%	4451
CORPORATE EFFICIENCY	**5,998**	**6,050**	**(52)**			
Private Patients	479	445	35	0	-100%	0
Service Sustainability	3,680	3,026	655	3680	0	3680
PORTFOLIO OPTIMISATION	**4,160**	**3,470**	**689**			
Medical Secretaries and Clinical Correspondence	-	163	(163)	0	0	0
Medical Workforce Review	1,913	1,823	90	2,228	-93%	156
Nursing Establishment	1,323	2,621	(1,298)	1323	0	1323
Nursing temporary staffing	1,408	1,492	(85)	1,408	-30%	986
Reducing Pay Costs	206	3,139	(2,933)	206	0	206
Spans and Layers	458	555	(97)	458	0%	458
South West London Bank	-	171	(171)	0	0	0
WORKFORCE EFFICIENCY	**5,308**	**9,965**	**(4,657)**			
Infrastructure	(25)	(430)	405	0	0	0
INFRASTRUCTURE	**(25)**	**(430)**	**405**			
Medicines Optimisation	1,965	1,831	134	1965	0	1965
DIVISIONAL IMPROVEMENT INCL MEDICINES	**1,965**	**1,831**	**134**			
Divisions	10,000	10,000	0			
DIVISIONS *	**10,000**	**10,000**	**0**	10000	0	10000
Stretch	-	6,282	(6,282)			
STRETCH TARGET	-	**6,282**	**(6,282)**			
		-				
TRUST TOTAL	**34,147**	**42,700**	**(8,553)**	**35,377**		**31,093**

The 2016/17 Board approved target is £42.7m. A full reforecast and rephasing exercise was undertaken in M3, forecasting £34m in-year benefit.

The reported forecast from the programmes suggests a slight net improvement in M4, mainly attributed to the inclusion of an in-year benefit against the Outpatients programme and a forecast reduction in Procurement.

The PMO risk assessed position is based on new slippage and realistic phasing of benefit realisation subject to lead times.

The externally reported slippage was £14.33m on the basis that the Theatres benefits are not included as the programme is at an early stage of development.

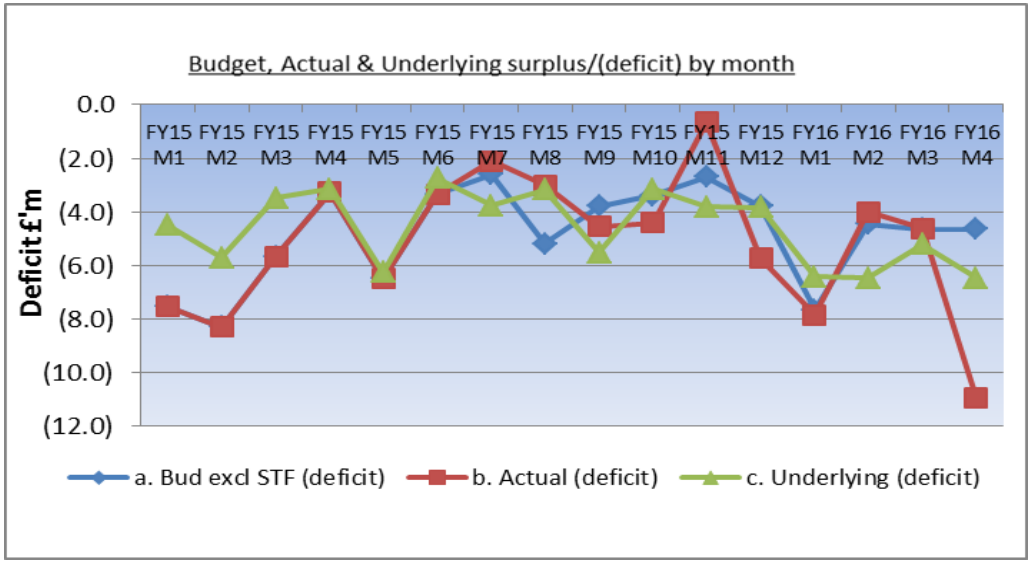
Summary Finance Report
Month 04 2016/17

Trust Board 1st September 2016

Contents

1. Financial Position for the month July 2016

Income & Expenditure	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £m	Year to Date (YTD) Budget £'m	Year to Date (YTD) Actual £'m	Year to Date (YTD) Variance £m
SLA Income	666.9	53.9	53.7	(0.2)	214.4	212.6	(1.7)
STF Income	17.6	1.5	(4.4)	(5.9)	5.9	0.0	(5.9)
Other Income	111.5	9.4	10.2	0.8	37.1	38.4	1.3
Overall Income	**778.4**	**64.7**	**59.5**	**(5.2)**	**257.4**	**251.1**	**(6.3)**
Pay	(486.6)	(40.7)	(41.0)	(0.3)	(161.5)	(162.4)	(0.9)
Non Pay	(273.9)	(23.1)	(26.6)	(3.5)	(98.5)	(104.4)	(5.9)
Overall Expenditure	(760.5)	(63.8)	(67.5)	(3.8)	(260.1)	(266.8)	(6.7)
EBITDA	17.9	1.0	(8.0)	(9.0)	(2.7)	(15.7)	(13.1)
Financing costs	(35.1)	(2.9)	(3.0)	(0.0)	(11.7)	(11.7)	0.0
Surplus/(deficit)	**(17.2)**	**(2.0)**	**(11.0)**	**(9.0)**	**(14.4)**	**(27.4)**	**(13.1)**
Memo: Below the Line Items	0.0	0.0	(0.7)	(0.7)	0.0	(3.8)	(3.8)



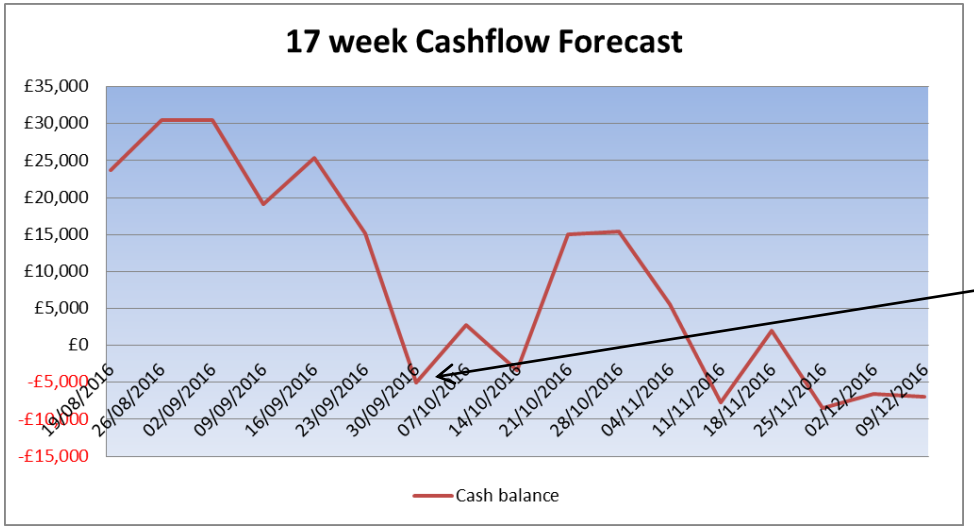
Commentary

- An in-month deficit of £11.0m is reported in July which is £9.0m adverse from plan. This includes £5.9m adverse variance due to the exclusion of STF income from the position. The adverse variance excluding this adjustment is £3.1m.
- **SLA income** - £0.2m adverse to plan in month and £1.7m YTD. business cases have slipped in Neurosurgery and Cardiology and there has been a failure to deliver planned activity in Surgery.
- **STF Income -** previously accrued; no longer expected to be received, leading to a £5.9m adverse variance in month and YTD.
- **Other income -** A VAT reclaim has been offset by an increase in provision for bad debts. YTD performance is £1.3m favourable due to commercial pharmacy income offset by an overspend on drugs in non-pay.
- **Pay**- £0.3m adverse to plan as a result of spend on unbudgeted interim staff, as well as CIP shortfalls in clinical divisions.
- **Non pay** - Planned CIP schemes of £2m in month have not been achieved. The remaining overspends within non-pay are offset with income over performance (pass-through and commercial pharmacy)
- **Below the line** - £3.8m of cost year to date relate to items outside the Trust's initial plan regarding unforeseen, one off issues associated with CQC, the estate, IT infrastructure, additional senior management support and Junior Doctors strike.
- **The M4 underlying (excl. STF)** deficit of £6.5m, is a £1.3m deterioration from the M3 position, and on trend with M1 and M2. The M4 deterioration compared to M3 is due to a reduction in outpatient income of £1m within Surgery. The deterioration in the underlying position since 15/16 is due to higher: pay costs as a result of pay award & pension cost increases; spend on interims; soft FM costs; and reactive maintenance. This analysis is work in progress ahead of further review on 31/08/2016.

2. Cash Summary at M4

Source and application of funds - cash movement analysis: YTD and forecast vs Plan

	Actual vs Plan YTD			Forecast £53.3m deficit		
	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
Opening cash 01.04.16	**7.4**	**7.4**		**7.4**	**7.4**	
Operating surplus/-deficit	**-6.1**	**-17.1**	**-11.1**	**7.6**	**-28.3**	**-35.9**
Change in stock	-0.4	-1.1	-0.8	0.6	0.6	0.0
Change in debtors	-2.2	-10.4	-8.3	1.8	1.8	0.0
Change in creditors	6.5	33.5	27.1	-5.5	-5.5	0.0
Net change in working capital	**3.9**	**22.0**	**18.0**	**-3.1**	**-3.1**	**0.0**
Capital spend (excl leases)	-12.8	-7.3	5.5	-33.4	-72.5	-39.1
Other	-2.6	-2.4	0.2	-7.8	-7.8	0.0
Investing activities	**-15.4**	**-9.7**	**5.7**	**-41.4**	**-80.5**	**-39.1**
WCF/ISF borrowing	**13.1**	**0.0**	**-13.1**	**32.5**	**107.7**	**75.2**
Closing cash 31.07.16 / 31.03.17	**3.0**	**2.6**	**-0.4**	**3.0**	**3.2**	**0.2**



- M4 YTD cash movement:

The better performance on working capital (+£18m) and cash under spend on capital (+£5.5m) is offset by the adverse impact of the higher operating deficit (-£11m) delivering a combined cash and borrowing position ahead of plan. However the trust deferred a supplier payment run from late July to early August and this partly explains the favourable creditors variance.

- Forecast outturn:

The cash position is deteriorating given the worse revenue deficit and the trust drew down £20.9m from facilities on 15th August. The forecast outturn is based on a revenue deficit of £53.3m.

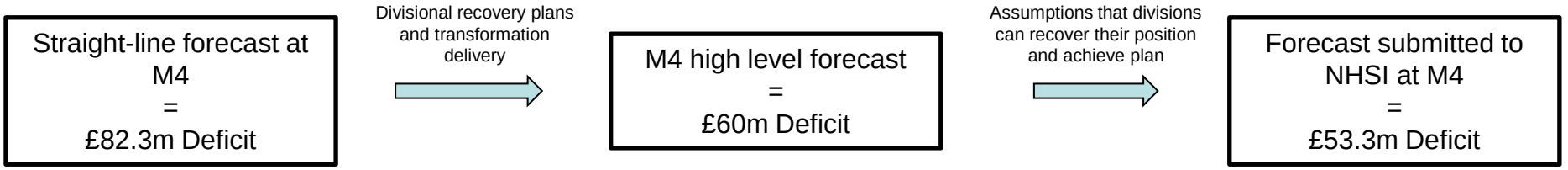
The total forecast borrowing requirement for the year would be £107.7m, £75.2m higher than planned. This includes the emergency capital funding request of £39.1m for urgent estates investment and the £36.1m extra borrowing needed to finance the higher operating deficit. NB this borrowing requirement does not yet include the £20m cash headroom the trust is requesting.

The £53.3m deficit forecast would mean the Trust would run out of cash at the end of September, in the absence of additional drawdowns.

3a. M4 Forecast - Context

- At the beginning of the financial year, the Trust agreed a control total of a £17.2m deficit for 2016/17 with NHS Improvement.
- The phasing of this plan included savings schemes to be delivered in the later part of the year, with a less favourable position planned at the start of the year
- Committee members will recall that the Trust has reported an adverse position to plan in each of the 4 reporting months to date. The YTD deficit is £27.4m, with a monthly run rate deficit of c£6.5m (as per underlying graph on slide 1). It is considered unlikely that the control total of £17.2m deficit can now be achieved.
- The consequence of this phasing of the plan is that in the absence of significant action taken to improve the Trust's financial position, the deterioration against plan will accelerate in future months.
- The Trust has no cash headroom in the £17.2m deficit plan, meaning cash is a significant risk as a result of the current breach of control total.
- NHS Improvement has written to the Trust requesting a detailed reforecast to be completed at Q2.
- The purpose of the forecast is to:
    - Provide an initial assessment of the scale of the financial risk.
    - Outline plans to develop risk mitigation strategies, to include supplementary recovery plans.

3b. M4 Forecast – Current Position



- A straight-line forecast of the M4 deficit of £27.4m YTD position (slide 1) leads to a deficit of £82.3m.
- A high level forecast was completed at M4 resulting in a £60m deficit, which includes £15.0m additional achievement of transformation CIP, as well as divisional recovery plans.
- A forecast of £53.3m deficit was submitted to NHSI with an adjustment for more aggressive improvements within clinical divisions (full recovery of YTD adverse variance).
- The two most significant reasons for this variance from plan are the non achievement of £17.6m STF funding, as well as £14.33m slippage in the transformation programme.

Risks

- Costs/loss of income associate with service moves (Renal and Lanesborough) has not been worked though in detail, and therefore is not included.
- No provision has yet been included for further costs associated with the full CQC report.

A risk adjusted forecast at M4 is a deficit of £68.1m

3c. M4 Forecast – Next Steps

- NHS Improvement has written to the Trust requesting a detailed reforecast to be completed at Q2.
- A refreshed high level forecast will be provided to the committee at month 5. This will provide the committee with assurance of the deliverability, as well as the risks to delivery of this forecast. This will provide particular focus on the delivery of divisional recovery, and transformation savings.
- A cash flow forecast will also be provided as cash will be challenged as a result of the significant variance to I&E plan.
- At month 6, a detailed reforecast will be provided to the committee in line with the submission to NHSI.
- Plans for the delivery of transformation savings are to be validated by the finance team to ensure no double counts with divisional recovery plans.
- Divisional recovery plans require significant further work to convert to delivery.
- Plans are at a primitive stage to further improve the position to recover divisional positions in their entirety. These need to be worked through in more detail.
- A 2 year plan is required for submission to NHSI by 23rd December 2016, to include agreed control totals for the following 2 year period.

St George's University Hospitals NHS
NHS Foundation Trust

M4 F&P Summary

Month 4 financial position

Nigel Carr presented the Committee with the month 4 financial position. The Trust is reporting a £27.4m deficit at month 4, which is £13.1m adverse to plan. The adverse variance is within the below areas:

Division	Full Year Budget	YTD Budget	YTD Actuals	YTD Variance
C&W, Diagnostics, Therapies	£14,919,462	£5,745,009	£5,609,693	-£135,316
Medicine and Cardiovascular	-£66,002,157	-£21,603,455	-£19,061,076	£2,542,379
Surgery and Neurosciences	-£36,218,058	-£11,265,334	-£8,045,726	£3,219,608
Community Services	-£19,162,849	-£6,451,878	-£6,948,111	-£496,233
Overheads	£146,059,735	£48,641,432	£51,186,097	£2,544,666
Research & Development	£200,000	£67,781	£67,781	-£0
SWL Pathology	-£0	-£0	£0	£0
Reserves	-£20,828,209	£24,839	£275	-£24,564
Central	-£1,768,121	-£793,575	£4,622,151	£5,415,726
Grand Total	**£17,199,805**	**£14,364,818**	**£27,431,085**	**£13,066,267**

The main reasons the Trust is reporting an adverse variance to plan are:

- STF funding is no longer expected to be received due to the Trust not achieving its control total (£6m YTD)
- Failure within Medcard and SNCT divisions to deliver savings targets and activity projections (£5.7m)
- Additional interim staff within overheads that were not budgeted for (£0.7m)
- Urgent remedial work required within estates and IT (£0.9m)

Month 4 Forecast

A high level forecast was completed at Month 4, showing a deficit position of between £53.3m and £82m. £53.3m was shared with NHS Improvement, the highlights of which being:

- £17.6m Shortfall due to lack of STF funding
- £14.3m slippage on the transformation program
- £7.2m below the line items due to unforeseen issues (RTT, Estates backlog etc.)

The committee was asked to note and approve spend against the £7.2m of below the line items.

Divisional Recovery

The two most financially challenged divisions presented their recovery plans to the committee. These plans showed a £4.9m gap in SNCT, and £2m gap in Medcard. Both divisions were given the action of coming up with headcount reductions, as well as working with Mark Gordon on theatre efficiency improvement to close the gap further.

Cash

The committee was informed that the Trust has drawn down £20.9m of its working capital facility on 15th August. It was noted that cash will run out in the absence of further draw down by the end of September.

The Trust will require £75.2m more than the planned level of borrowing to fund the increased deficit position, as well as for urgent remedial works required on the Estates and IT infrastructure (£39.1m). A business case has been submitted to NHSI for the release of this. The Trust has proceeded at risk against some of these items.

Actions

Issue / Report	Action	Due date	Responsible officer
Demand and Capacity Management	Trust demand and capacity management and bed modelling	Sep-16	Iain Lynam
Operational performance	Divisional Leads to present an updated recovery plan	Oct-16	Fiona Ashworth/ Chloe Cox
Winter Planning	Paper on winter planning	Board Meeting	
Engagement with Consortiums	Identification of Consortiums Identification of lead executives to sit on board Agreed feedback and governance arrangements	Sep-16	Nigel Carr

St George's University Hospitals NHS
NHS Foundation Trust

Corporate Risk Report (August 2016)

Presented for:	Review, challenge and discussion
Presented by:	Paul Moore, Director of Quality Governance
Author(s)	Paul Moore, Director of Quality Governance
Corporate objective:	All Corporate Objectives

Key points		
1.	Caution is advised when interpreting this analysis. The risk profile remains under review and development at the time of report. The Corporate Risk Register may not yet fully reflect all material risk exposures on divisional risk registers which are currently being examined by the Executive.	Information
1.1	The Trust's overall level of exposure to core operational risk is extreme. Core operational risk exposure has been grouped under the following risk areas: • **Timely Access to Clinical Services/Patient Harm** • **Insufficient Resilience/Unstable Critical IT & Estates Infrastructure** • **Expanding Financial Deficit - Unsustainable Financial Position 2016/17** • **Inadequate Governance/Reputation Loss**	Awareness

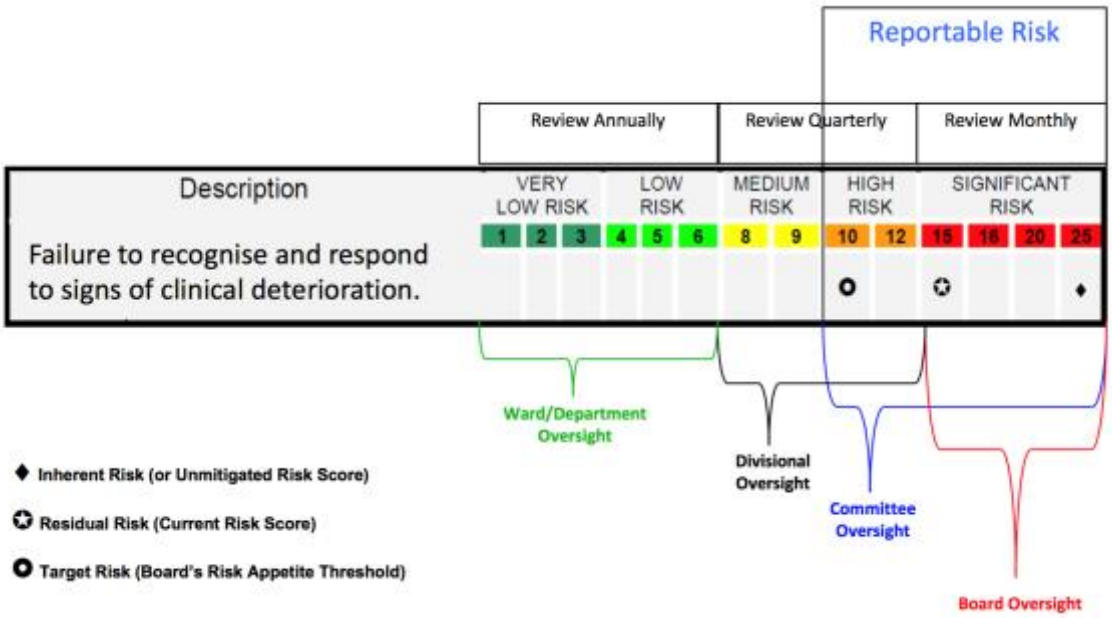
2.	The Committee is invited to: (i) work through each decision point highlighted in this report; (ii) consider, challenge and confirm the correct strategy has been adopted to treat reportable risk; (iii) consider any alternative approaches to treating intractable risks to which the assessment suggests the Trust is over-exposed; (iv) where required validate new significant risks identified since the last meeting and approve their admission to the Corporate Risk Register where agreed; (v) seek assurance that reportable risk is under sufficient control; and (vi) to make decisions where necessary that allow risk to be managed in accordance with the Board's risk appetite.	Decision, challenge and action - All

Contents

Risk Grading Matrix

SEVERITY MARKERS		LIKELIHOOD MARKERS*		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more CSUs; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more CSUs; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or < 1 in 1000 chance (or less) within 12 months

Risk Escalation Arrangements (illustrated)



Briefing

1. The Corporate Risk Register (CRR) has been reviewed with input from the Executive during July and continuing into August 2016. The CRR is currently being rebuilt and reassessed accordingly. This work remains ongoing at time of report. This follows: (i) a simplification and rationalisation of the arrangements for risk management and escalation; (ii) consideration and acceptance by the Board in August of a range of proposals to enhance governance and risk; and (iii) a decision to accelerate the migration of risk registers at divisional and corporate levels into a single electronic database within Datix. The latter had been formerly held by risk owners in multiple documents and formats making analysis impossible and escalation unreliable. These matters needed addressing urgently in order to examine the risk profile in totality. The migration of risk records, scheduled for completion by 1st September 2016, has been brought forward and completed. To produce a report on which the Board can rely for assurance and decision making purposes, it is anticipated that substantial enhancements will be required to individual risk records to make them fit for purpose. This may require, in some cases, the closure and introduction of new risk records where standards are not met. Training is being rolled out to support and assist risk register gatekeepers at divisional and corporate levels. This will allow efficient analysis, better oversight and enhanced risk escalation arrangements. Until this work is concluded caution is advised when interpreting the CRR. The CRR may change as further analysis, challenge and development of the risk profile progresses.

On The Radar

Core Operational Risk

2. The understanding of corporate risk is evolving rapidly as the Executive identify and address uncertainty ahead. Analysis and challenge during July and August 2016 has identified a range of significant/extreme operational risks, which are currently being mitigated, whose impact could have a direct bearing on requirements within NHSI's Risk Assessment Framework, ongoing CQC Registration or the achievement of Trust policies, aims and objectives should the mitigation plans be ineffective. Figure 1 illustrates using a driver diagram the primary cause, effect and potential impact of core operational risks currently on the CRR. The Board is currently exposed to significant/extreme risk in the following areas:

    - **Timely Access to Clinical Services/Patient Harm**
    - **Insufficient Resilience/Unstable Critical IT & Estates Infrastructure**
    - **Expanding Financial Deficit - Unsustainable Financial Position 2016/17**
    - **Inadequate Governance/Reputation Loss**

3. In due course, once divisional risk registers have been examined more closely, the Corporate Risk Register will contain all risks rated 15 or more and verified by the Risk Management Committee.

Core Strategic Risk

4. The Board's strategic risks are currently being assessed ahead of producing a new Board Assurance Framework (BAF) by the 30th September. The strategic risk vectors identified for inclusion in the BAF are as follows (in no particular order):

    - **Corporate strategy not aligned to commissioning intentions or anticipated regulatory changes** (i.e. the Trust, CCGs or regulators are moving in different directions - one of the causes might be that commissioning intentions are not known to the Trust, or a lack of clarity regarding corporate strategy. Other potential causes might include conflict, competition or poor stakeholder relations.)
    - **Exposure to local and specialist commissioner affordability**
    - **Loss of influence within and across the local health economy** (one of the potential causes might be inadequate stakeholder relationships)

- **Addressing demand for care** (on the assumption that demand for services will continue to grow and supply-side resources continue to be stretched)
- **Future supply, recruitment and retention of the workforce** (thereby affecting staffing levels, quality, safety and operational compliance)
- **Failure to acquire new business and/or retain current contracts** (one of the causes might be poor quality/performance/outcomes, or inadequate stakeholder relationships)
- **Expanding deficit and non-delivery of the financial plan** (to incorporate the combined effects of income volatility, liquidity and CIP delivery)
- **Poor or insufficient quality governance** (i.e. poor standards of care, unintended consequences of CIP, poor risk management, non-compliance with CQC)
- **Insufficient performance against contracts and KPIs** (to incorporate applicable KPIs in the NHS Outcomes Framework)
- **Poor service user experience** (inadequate user satisfaction with services for example)
- **Failure to deliver the estate improvement or backlog maintenance**
- **Failure to deliver improved productivity and operational efficiency through the utilisation, development and advancement of IT**

Decision Points

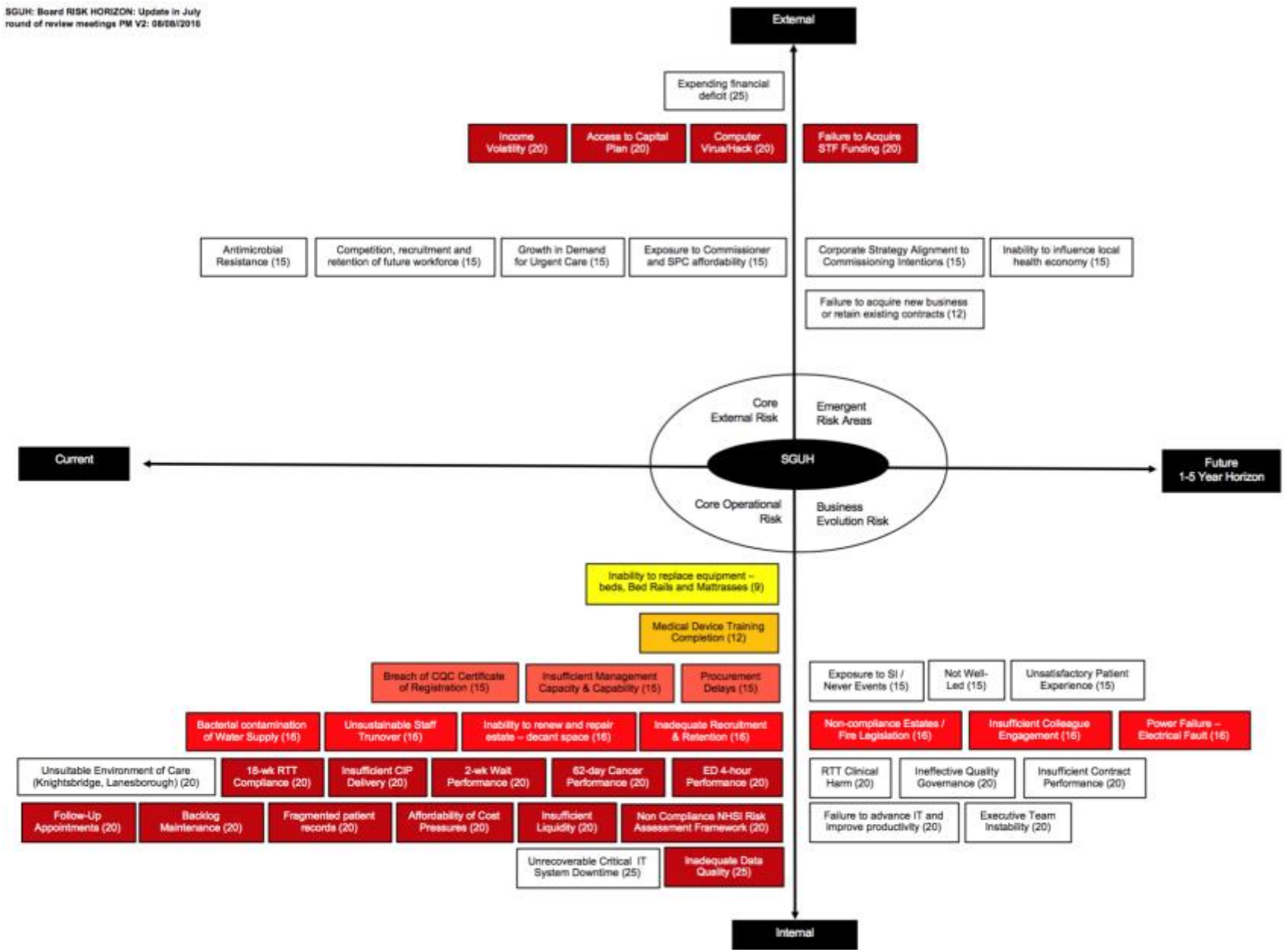
(a) The Board are invited to acknowledge the risks which currently pose a significant or extreme threat to the delivery of corporate objectives in 2016/17; and
(b) Note that the strategic risk vectors shall be incorporated into the BAF which is on track to be completed by 30th September and reported to the Board in October 2016 as planned.

Paul Moore
Director of Quality Governance
19/08/2016

Figure 1: Core Operational Risk Drivers – AUG 2016

PRIMARY CAUSE	RATING	EFFECT	POTENTIAL IMPACT 16/17
Increasing 18-Week RTT backlog with potential for clinical harm	20	Timely Access to Clinical Services / Patient Harm	Continuity of Clinical Services Material Breach of Licence Conditions Integrity of CQC Certificate of Registration
Below target 2-week wait performance	TBC		
Below target 62-day cancer performance	TBC		
Failure to arrange follow-up appointments or treatments (where clinically required)	TBC		
Below target ED 4-hour performance	20		
Inadequate data quality, completeness or consistency	20		
Unsuitable environment of care (Renal Unit, Lanesborough OPD) – risk of premises closure, prosecution, fire	16	Insufficient Resilience / Unstable critical IT and Estates Infrastructure	
Potential unplanned closure of premises / non-compliance with estates or Fire legislation	16		
Bacterial contamination of water supply (Legionella, Pseudomonas)	16		
Inability to address backlog maintenance requirements	20		
IT storage: unrecoverable IT system downtime (affecting critical clinical, web and email systems)	25		
Vulnerability to computer virus or attack	20		
Inability to renew and repair clinical areas due to high bed occupancy and no decant options	16		
Power failure – electrical fault	16		
Income volatility	20	Expending Financial Deficit Unsustainable Financial Position in 2016/17 and beyond	
Insufficient CIP delivery in 2016/17	20		
Insufficient liquidity	20		
Lack of access to capital to address in-year IT, Estates and equipment replacement cost pressures	20		
Failure to acquire a share of STF funding in 2016/17	20		
CQC rating less than 'Good' – insufficient safety, effectiveness, caring, responsiveness or not well-led	15	Inadequate Governance / Reputation Loss	
Failure to recognise, communicate and act on abnormal clinical findings	16		
Ongoing exposure to high numbers of serious incidents and never events	15		
Fragmented electronic and manual patient records	20		
Unsustainable levels of staff turnover	16		
Insufficient management capacity or capability to deliver turnaround programme	15		
Failure to secure colleague engagement	16		

Figure 2: Emergent Risk Horizon Scan – AUG 2016



Appendix 1: Interpreting the Risk Horizon