St George's University Hospitals NHS
NHS Foundation Trust

St. George's University Hospitals NHS Foundation Trust

2017/18 and 2018/19 Annual Plan

V2

Excellence in specialist and community healthcare

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1. Introduction and context

St. George's University Hospitals NHS Foundation Trust (St. George's) is currently experiencing its most difficult year since moving to Tooting in 1976. The trust is currently forecasting a deficit of £80.7m, has been rated as "Inadequate" in its recent CQC inspection, and is now in Special Measures. The trust board is grappling with a series of extremely complex inter-locking problems that will impact on both 2017/18, 2018/19 and beyond. There is no quick fix. There is however, a commitment from all those associated with the trust to work to address the problems head-on, and to put in place the foundations to enable St. George's to be a successful hospital in the future.

The size of the financial challenge will require the trust, over the next 18 months, to develop a radical set of answers, both in terms of proposed service portfolio (linking to the NHSE Review of Specialist Commissioning in London), the way we deliver care, the staff we employ to deliver that care, and our relationships with partners in the STP. Addressing the trusts financial, estate and quality challenges, therefore, will make 2017/18 the toughest yet for St. George's.

The 2016/17 Annual Plan explicitly identified 5 key areas that the trust needed to address, and experience so far this year confirms the accuracy of these choices:

1. Finding a sustainable solution to core estate and infrastructure problems
2. Addressing long term under-investment in ICT
3. Delivering access targets
4. Addressing the wider demand and capacity challenge
5. Meeting the workforce challenge

The trust has begun to deliver real progress in some of these, for example, the move of renal services out of Knightsbridge Wing, beginning the process of upgrading core support services e.g. new boilers to ensure our patients and staff are warm, and improving key target performance. Delivering the sustained improvement required by the recent CQC report will add further impetus to the trust taking forward these issues. However, despite the best efforts of a committed workforce, progress has not been as fast or as deep as the trust would like.

The main hospital site continues to present challenges to the consistent and reliable delivery of core activity, as the effects of a prolonged lack of routine preventative maintenance continue to be felt. The site does not have an adequate level of heating, electrical, or IT systems, nor roof and fire integrity. The award of £39m of treasury capital will allow the trust to begin to tackle some of the estates problems but the trust is at the start of that particular journey.

The trust is currently in negotiation with commissioners regarding activity and income for the next two years. There is a very significant difference between both sides' expectations in terms of activity in future years, which at point of submission equate to approximately £55m in value (between the trust's 17/18 initial proposal and the initial offers from commissioners). As a starting point for negotiations, the trust and commissioners have never been further apart. What is clear however, is that the trust is absolutely dependent on commissioners delivering on QIPP and other demand management projects. If the trust downsizes to meet a reduced activity plan from commissioners, it will not be able to upsize at short notice if referrals exceed agreed contract numbers.

The trust has been set control total targets of £3.5m surplus for 2017/18 and £13.3m surplus in 2018/19. The trust will strive to achieve these, but cannot also accommodate a £55m reduction in its SLA income, and its financial projections reflect this. However, the trust still recognises that it does have a responsibility to manage its operating cost base in such a manner that reflects the NHSI control totals. The Trust is proposing to deliver a financial operating plan that nets off the NHSI and commissioner elements, which results in a deficit of £52m in 2017/18 and a deficit of £42.2m in 2018/19.

The trust has identified during 2016/17 that it is undertaking work for commissioners that it has not been billing appropriately for. The trust is clear that it must be properly remunerated for the work it undertakes, and it will work with commissioners and regulators to ensure that this issue is satisfactorily addressed, and in so doing, make a material contribution to addressing the deficit at St. George's.

Alongside the reasonable expectation to be paid for what we do, the trust also knows that it needs to become more efficient and productive, delivering the same amount of work for fewer inputs, including staff, beds, and theatres. The trust has started the process of reducing its headcount, which will lead to planned reduction in the paybill of 10% by the end of 2016/17. This process is at an early stage, and delivering this level of reduction, whilst maintain quality and activity, is possibly the single biggest challenge facing the trust. In future years the organisation will need to further reduce its headcount to ensure that it lives within it means. The trust does not under-estimate the challenge this overall reduction in capacity entails.

The trust is situated in Wandsworth, in the South West London STP area. The STP makes clear that St. George's is a fixed point in the healthcare landscape as the main tertiary provider in south west London. The trust will remain a Major Trauma Centre, and our new, emerging strategy indicates that we expect to broadly continue to provide the range of services we do currently to the populations of south west London and Surrey. In a period of intense flux, this understanding is both welcome and helpful to our patients and staff alike. However, we are aware that the STP, the NHSE Specialist Service review, and our own internal requirements will mean that, over time, the mix of services on site is likely to change, and the nature of this change will start to become apparent during 2017/18.

Despite the difficult operating environment the trust finds itself in, it continues to deliver creditable achievements, for example its commended renal service, it's outstanding maternity and gynaecology services, its caring staff and its low mortality rates. Last year's annual plan stated that *"The turnaround and transformation process that is now required will require a sustained 3 to 5 year programme coupled with sustained external support and cash resource to achieve."* This remains the case, and the challenge for the trust is to deliver financial control without compromising these and other achievements.

2.0 2016/17 Activity and Capacity Plans

2.1 St. George's activity plans and SLA proposal

After many years of growth in activity and associated income, the initial offer from commissioners equates to an aspiration to reduce activity and income by £55m at St. George's, though the detail of where the activity is to be withdrawn or decommissioned has not been provided at this stage. Offers from commissioners are reflective of the financial pressures that they are under, but this proposed reduction in commissioned activity represents a significant risk for the trust, and one that, at this stage, it will not be able to mitigate financially.

The trust's realistic initial proposal was built bottom up based on a conservative set of assumptions, namely:

- M4 x 3 as the baseline, amended to reflect any changes anticipated for forecast outturn
- The addition of CCG recommended demographic growth rates, reduced where appropriate.
- The FYE of agreed business cases, through the impact of this was very limited.

Based on the above the following table illustrates at a "POD" Level, the17/18 SLA proposal to CCGs and NHSE (noting that this is at 2016/17 tariffs and with no QIPP removed). These figures do not

include additional 18 week activity which will be required to return the trust to compliance as work on developing the RTT recovery plan is still on-going.

The activity target proposed by the trust is modest and in line with previous activity and expected growth rates, but the trust does not underestimate the challenge this proposal presents to commissioners, as it is £26.7m above the 2016/17 plan.

POD	16/17 Plan	16/17 Forecast Outturn	17/18 Activity Proposal	% Activity Change 16/17 Outturn – 17/18 Proposal	17/18 current proposal income (£m)
A&E	163,121	166,867	173,253	3.8%	20,507,565
Bed Days	75,932	77,554	78,045	0.6%	64,301,673
Daycase	34,387	35,064	37,987	8.3%	32,850,534
Deliveries	5,269	4,896	5,100	4.2%	12,741,345
Diagnostics	8,194,903	8,212,949	8,215,226	0.03%	26,520,057
Elective	17,878	16,297	16,833	3.2%	71,881,281
Emergency	36,685	40,563	41,838	3.1%	119,412,335
Emergency short stay	7,020	7,655	7,767	1.5%	3,685,895
Other non-elective	2,266	1,863	1,907	2.4%	13,718,058
Outpatient	629,316	647,868	650,135	0.3%	116,033,593
Other Outpatients	26,616	19,047	19,168	0.6%	2,996,572
Regular Attenders	26,649	23,364	24,863	6.4%	4,661,152
Unbundled	112,146	155,396	157,218	1.2%	24,661,214
Value Fixed	59,160,270	61,015,308	61,015,406	0.0%	67,827,344
Variable Value	3,317,659	3,366,946	3,368,976	0.06%	28,377,770
Other	30,084	90,818	92,020	1.3%	64,736,968
Total	**71,968,207**	**74,015,687**	**74,038,792**	**0.03%**	**674,913,354**

In response to the proposal from St. George's, commissioners have sent initial offers to the trust for the next two years which, before the impact of challenges and QIPP etc. is removed, amounts to £55.5m less than the trust's proposal. The following table illustrates the challenge facing both the trust and South West London CCG commissioners in arriving at a robust and deliverable contract level.

Reporting Commissioner	Sum of 2016/17 Recurrent Outturn £*	Sum of 2017/18 SGUH Proposal £*	CSU Initial Offer £**
NHS CROYDON CCG	24,893,504	25,880,146	23,152,000
NHS KINGSTON CCG	13,202,649	13,708,994	13,118,000
NHS MERTON CCG	66,214,753	69,403,078	61,592,000
NHS RICHMOND CCG	13,520,909	14,097,604	12,981,000
NHS SUTTON CCG	14,995,866	15,730,495	13,923,000
NHS WANDSWORTH CCG	125,681,488	130,023,621	118,420,000
Grand Total	**258,509,169**	**268,843,938**	**243,186,000**

*at 2016/17 prices **2017/18 prices

South West London CCGs have identified £16.3m of proposed QIPP schemes, which obviously addresses part of the £26m gap but project plans underpinning these are not finalised. In previous years CCG delivery of QIPP schemes has been inconsistent, which reduces confidence that the figure of £16.3m figure can or will be delivered. The trust will therefore work with commissioners to understand the nature of their QIPP proposals, and will look to ensure that the risks of non-delivery are adequately reflected in the final agreed SLA. CCGs have put in an anticipated £8m in challenges and fines, and the trust is agreement that a challenge figure will need to be included in the contract value for the coming years.

The position above is mirrored with NHSE, our single biggest commissioner, whose second offer is £225m, against a proposal from St. George's of £242m, based on forecast 2016/17 recurrent outturn. Taking other factors into account, the current gap is £20m between St. George's and NHSE.

Commissioners have indicated that they wish to commission elements of activity on a block contract i.e. payment of a fixed fee for types of activity (non-elective/elective etc.) which does not take account of activity. The trust is clear that it wishes to contract for all activity at the normal Payment by Results cost and volume contracts, where activity is purchased, and paid for, on the basis of each completed spell but recognises that this poses an affordability issue for CCGs. A block contract or a cap and collar contract leaves all the risk with the trust of over-performance so this will be the subject of debate with SWL CCGs and NHSE over the coming weeks before 23 December. SWL CCGs wish to have the same type of arrangements across all SWL providers; this is under active discussion.

In previous years, the trust has used Local Income Targets (LITs) to offset expected under-delivery of QIPPs or where the offer does not reflect the trusts view on likely activity growth. The trust is aware, with the need for triangulation between commissioner and provider plans, that this avenue is not available. The trust needs to ensure that it agrees a contracted level of activity that properly reflects the likely demand on the trust, and does not strip out capacity based on a reduced level of contracted activity, only to find commissioners unable to manage demand down. This would place the trust both financially, operationally, and most importantly, clinically at risk, and the onus remains on agreeing activity proposals and associated commitments that all parties have confidence can be delivered.

2.2 Delivering access targets

The NHS Mandate and planning guidance make clear the requirement for trusts to meet key access targets. St. George's major trauma centre, helipad, heart attack and HASU status, alongside its delivery of core local district general hospital services, has led to an increase in demand, and the acuity of that demand, on the site. This is a contributory factor, but not an excuse for, the issues the trust has experienced in the last two years in meeting these key targets. The trust is aware that

it needs to improve its performance to meet, and more importantly once met, maintain delivery of these standards.

2.2.1 18 week referral to Treatment (RTT)

The STF proposal for the trust makes clear the expectation that St. George's will meet and maintain the 18 week RTT standard from 1st April 2017. The trust has had problems across various specialties in delivering this standard, and formally stopped reporting its RTT position in June 2016, following concerns raised about the accuracy and validity of its waiting lists.

The trust is part way into a complex programme of data validation, process redesign and IT system management to ensure that its waiting lists are accurate and ensure that patients get the care they require, in the timeframe mandated. The trust is managing a process, which will conclude in 2017/18, but cannot at this stage, put a date on when the trust will return to normal reporting.

Notwithstanding these problems in terms of waiting list management, the trust has been making significant progress in understanding the scale, and beginning the clearance of, 18 week backlogs based on the current waiting lists. It has put 10 workstreams in place to address the RTT problems within the trust, including the following key ones:

Validation – the first step in the project with multiple workstreams dependent on it. Ensuring this workstream starts on time and is tightly managed will be critical. We have developed detailed plans based on validating patients of the highest risk first. A three cohort approach has been described in detail within this section

Operational Grip – which will look to maximise use of internal capacity by looking at productivity and the booking and treatment of patients. The Trust has commenced delivering Daily Control of Performance every morning with full representation of each service focussed on the delivery of capacity against demand. Services must demonstrate increased productivity and use of assets/resources against demand on a daily basis with demonstration of reduction of validated admitted backlog.

Capacity Management – detailed capacity plans will be required to treat the additional patients that are added after validation. The trust is confident that the increased productivity currently generated within services will enable the Trust to be able to cope with additional numbers of patients, but will also use independent sector as appropriate - and we have commenced this with ENT, Gynaecology and General Surgery. In addition, the trust has planned additional capacity into our future Operational Strategy, Modelling and Planning for the next 12 months. This includes greater use of Day Surgery resources (and concomitant reduction in use of Inpatient beds), and improved Unplanned Care performance.

The trust will not be submitting a trajectory at this moment in time, pending progress of the workstreams.

2.2.2 A&E 4 Hour wait target achievement

Delivery of the 4 hour target is an NHS constitution standard and an element of the nine 'must-do's' for the NHS. St. George's Emergency Department (ED) provides non-elective care to around 400 patients per day. The ED aims to assess, treat, and discharge or admit 95% of patients within four hours, in line with national emergency access standards.

The trust is still struggling to meet on a consistent basis the A&E target, though recent changes to capacity, process and systems are beginning to have an impact. Key amongst these changes are the

opening of the Surgical Assessment Unit, which is taking surgical patients direct from A&E and managing their care in a more streamlined fashion, the introduction of Rapid Assessment Triage of new ambulance patients arriving in the A&E, and work on improving flow into and out of the hospital to create capacity to take A&E patients requiring admission. All of these developments are sustainable but it is too early to confirm what the recurrent impact will be on performance.

The assumption within the 2017/18 STF funding allocation is that the trust will agree a trajectory for delivering, and maintaining the 95% target during 2017/18. Trust modelling shows that this will be difficult to achieve, as the initial trajectory, shared with Commissioners, shows. This trajectory is based on a number of variables including seasonal variation and growth in activity over past three years, the 2017/18 SLA proposal, current bed state, improved performance during 2016. No adjustments have been made for commissioner demand management, QIPP or external system improvements by CCGs.

2017 Projection	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Attendances	14,137	15,324	14,347	14,902	14,288	14,398	14,682	14,210	13,941	14,025	13,949	15,049
0-4	13,068	14,354	13,630	14,165	13,502	13,681	13,798	13,326	12,959	12,994	12,852	14,066
Breaches	1,069	971	717	737	786	717	884	884	983	1,032	1,096	983
Performance	92.4%	93.7%	95.0%	95.1%	94.5%	95.0%	94.0%	93.8%	93.0%	92.6%	92.1%	93.5%

The trust will work with commissioners on the proposed trajectory, seeking to identify if and where it can be improved, prior to the 23rd December. The trust is aware that failure to deliver a 95% performance during 2017/18 will impact on STF funding.

It should be noted that the trust continues to have problems with repatriation of tertiary patients to other trusts in the sector, and there can regularly be 20 – 30 patients in this category in the trust. The trust will look to use the opportunities presented by the STP, and other formal routes, to reduce this number to a more manageable size over the course of 2017/18.

2.2.3 Cancer Target Achievement

The trust provides secondary and tertiary cancer services for adults and children including surgery, chemotherapy and palliative care. St. George's has made significant improvements in achieving the cancer access standards over the last year and plans to continue this improvement against all cancer standards in 2017/18. In April 2016, a trajectory was agreed with commissioners for delivery of the cancer 62 day standard.

	Cancer - 62 Day												
	Baseline	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Numerator	9.5	10	9	11	11	11	9	10	9	10	10	10	10
Denominator	63	60	60	74	74	74	63	70	63	68	68	70	70
Performance	84.9%	83.3%	85.0%	85.1%	85.1%	85.1%	85.7%	85.7%	85.7%	85.3%	85.3%	85.7%	85.7%
	53.5	50	51	63	63	63	54	60	54	58	58	60	60

Since May 2016, the trust has achieved the standard in all bar one month. The trust is delivering therefore, as a result of the operational focus this and other cancer standards, but it is aware that it cannot yet provide assurance that the improvement is sustainable in the longer term. Close management and monitoring of performance remains a key priority.

There are still challenges in achieving the 2 week wait and 62 day standard in some tumour groups where demand is exceeding capacity and particularly where patients are referred late in their cancer pathway. To address this, the trust has weekly escalation conference calls with referring trusts to discuss shared pathways and compliance. The trust is also systematically reviewing existing cancer

pathways to remove any non-added value time and to ensure that each stage has sufficient capacity to meet the predicted levels of demand.

The trust is a partner in Royal Marsden partners cancer vanguard which aims to deliver the "5 Year forward view" for cancer through improved pathways and early diagnosis. To that aim the trust is implementing a number of pathway improvements including straight to test pathways for upper gastro-intestinal and lower gastrointestinal suspected cancer referrals; one stop head and neck lump clinic as well as redesigning the colorectal pathway to reduce time from referral to diagnosis. Many of the changes described are in their infancy, and will take time to bed down and become business as usual. This presents risks to on-going delivery of all cancer targets, and the trust will be working to monitor our progress on delivering improvements, taking remedial action if performance drops below required standards or agreed trajectories.

2.3 St. George's capacity and demand

Over the past few years the trust's overall bed stock has incrementally increased. The trust has no plans to add to its current bed stock, and the trend will be reversed over the coming years for two main reasons:

1. The requirement to refurbish a large number of wards across the trust, reducing on a rolling basis the bed stock by 20 – 30 beds at any one time
2. The need to live within our financial means, facilitated by delivering a leaner service, putting more patients through fewer beds, theatres and other clinical areas.

This trend has already started, with the model taking account of the loss of renal beds which have been moved elsewhere (following closure as a result of CQC inspection), and the removal of Healthcare @ Home capacity, the contract for which is due to end in January 2017. The one contra to the above direction of travel is the potential impact of the STP which, as a result of any proposed reconfiguration across the sector, might see an increase in beds at St. George's.

The following table shows the current bed stock available to the trust, as used in its demand and capacity modelling:

Category	Baseline Position 01/10/16
Acute ward beds adult	781
Adult ICU	57
Obstetrics	51
Paed acute	51
Neo-natal / paed ICU	51
Community / Intermediate Care / virtual community beds	129
TOTAL BEDS	**1,120**

2.3.1 Demand and Capacity Modelling

Modelling and demand and capacity is a challenge for all NHS organisations, and the trust has utilised a number of demand and capacity models, with varying accuracy, in each of the last three years. For 2017/18, the trust has focussed on developing a relatively straightforward inpatient demand and capacity model that utilises a number of parameters to arrive at robust and realistic outputs. The parameters used, all of which have been verified with the clinical services themselves, are:

- Actual beds per speciality
- Length of stay, for each of the past four quarters.
- An agreed occupancy rate, specific to each specialty
- The 2016/17 planned activity and 2017/18 proposed activity

In contrast to 2015/16, where bed occupancy reached 97% in Q3, bed occupancy in the first two quarters has been 92.8% in quarter one and 93.7% in quarter two. This reduction is as a result of direct management action, for example focussing on the patient pathway for elderly patients coming in through A&E.

The outputs of the model are as follows:

Specialty Grouping	Q1	Q2	Q3	Q4
Cardiac	-4.25	0.03	-8.87	-2.55
Acute medicine and senior health	-39.53	-39.45	-50.15	-56.47
Vascular	-6.11	-2.32	-3.15	-3.37
Renal	0.45	1.88	4.06	4.71
Haem oncology	-2.97	1.78	-7.13	-1.46
Surgery	5.86	6.24	-8.20	0.91
T&O	-0.46	-6.32	-13.12	-9.79
Neuro	16.41	8.16	24.51	11.24
Sub-total (excluding Obstetrics)	**-30.60**	**-30.01**	**-62.05**	**-56.78**
Obstetric beds	16.82	13.30	14.10	13.17
All beds	**-13.77**	**-16.70**	**-47.95**	**-43.60**
Excluded Virtual beds				
Healthcare @ Home	0	0	0	0
Stephen Elek virtual ward	15	15	15	15
Nye Bevan reductions	11.5	11.5	11.5	11.5
Claverdale	5	5	5	5
Initial Final Position	**0.90**	**1.49**	**-30.55**	**-25.28**
Paediatrics	1.73	4.66	-2.45	-0.86

What the above table is showing that, for most services, there is a slight shortfall in capacity, but one that with business as usual improvements, targeted efficiency projects, and the on-going impact of flow improvement work, should be sufficient to deliver the final, agreed SLA. The model has been shared with Commissioners and the trust is awaiting initial feedback.

As noted above, the trust has reduced bed capacity already this year, and this is part of the reason for the negative bed position in the last two quarters. However there are a number of variables that make modelling activity over the next two years particularly problematic, including:

- The outputs of the SLA negotiations, and the unquantified commissioner proposal to reduce activity
- Agreeing RTT recovery, and any additional capacity needed to deliver this target (though this is complicated by the current non-reporting of 18 week figures due to our IT constraints)
- Loss of capacity through a programme of managed refurbishment of wards and clinical areas
- Potentially offset by the impacts of work to transform patient pathways, improve daycase rates and other programmes of work
- The finalisation of the trust strategy, the NHSE Review of Specialist Services, and the outputs of the STP in terms of service configuration

- The impact of St. George's own decisions on service and specialty mix, and a potential reduction of the overall service delivered from the St George's site

Alongside bed modelling, there are also implications in terms of capacity constraints or opportunities, in outpatients (reducing on site but better utilisation of off-site facilities including the Nelson and Queen Mary's Roehampton), theatres (a programme of refurbishment, offset by proposed changes to theatre templates and ways of working to allow the trust to deliver more activity through fewer theatres) and diagnostics (fixed capacity of major equipment, challenges around workforce recruitment and retention) all of which are currently being worked through.

Notwithstanding the challenges in accurately forecasting demand and capacity at this stage in the planning process, the trust has confidence that it is putting in place a range of tools that will allow it to respond with a degree of confidence to the evolving outputs of the planning process.

3.0 Workforce Planning

Staff costs account for 61% of St. George's expenditure. Recent years have seen a steady growth in workforce numbers, and this growth has been a contributory factor to the deficit in both 2014/15 and 2015/16. The following table illustrates the changes in workforce over the past year. The trust will be reversing the trend for increasing workforce over the coming 18 months, as it seeks to stabilise as a leaner, more productive organisation.

	Staff In Post		Establishment	
Staff Group	**31-Oct-15**	**31-Oct-16**	**31-Oct-15**	**31-Oct-16**
Add Prof Scientific and Technic	552	556	714	648
Additional Clinical Services	830	998	1,028	1,187
of which Healthcare Assistants	591	666	757	827
Administrative and Clerical	1,490	1,564	1,795	1,879
Allied Health Professionals	592	607	688	674
Estates and Ancillary	223	271	276	317
Healthcare Scientists	268	291	332	327
Medical and Dental	1,156	1,225	1,209	1,282
of which Consultants	486	514	495	536
Nursing and Midwifery Registered	2,784	2,829	3,400	3,469
of which Midwives	191	194	214	221
Total	**7,895**	**8,341**	**9,442**	**9,783**

3.1 New Workforce Priorities Plan

In July 2016 the revised workforce priorities plan , 'Doing it Right' was developed following discussions with staff and managers and from information available from staff surveys, Staff Friends and Family test and exit surveys. This shorter term plan is required to stabilise the workforce metrics of turnover, vacancy and recruitment timelines prior to a longer term strategy being developed in 2017. These feedback mechanisms identified the issues that were contributing to turnover such as time to recruit, access to training and bullying, and that St. George's needed to address if it was to be able to both recruit and retain a workforce comprising the right people, with the rights skills in the right numbers. This meant focussing on some key priorities that would make a difference in a short period of time. This plan was approved by the Trust Board in September 2016.

The trust values are well known and understood in the organisation, and the trust has responded to feedback from staff that they wanted access to promotion and development opportunities in a way that felt fair. Work on increasing transparency has already been implemented and work on implementing Values Based Recruitment for managerial roles is underway. All managers at all levels

will be required to demonstrate that they have the necessary skills to engage and lead their staff – empathy, compassion, mindfulness.

3.2 Changing St. George's Workforce

A key priority for this year is to 'right-size' the trust's workforce to match activity levels and funding. Each clinical Division is responsible for developing a workforce plan that is matched to activity and achieves the workforce reductions required to achieve the Cost Improvement Plan. The trust's workforce plans will be built from the bottom up to deliver activity, and will include reductions linked to the 10% workforce savings.

The 10% workforce savings are being realised from October 2016 to March 2017 in order to deliver a full year effect in 2017/18. The savings are seeking to protect front line services however where these are no longer progressing – i.e. additional Heart Failure Unit beds – or have been reduced then clinical posts will be removed. The savings are also a mixture of 50% post removals and a further 50% of the cost reduction being delivered from Agency to Bank conversions due to improved recruitment to both substantive and bank posts.

All posts and services are risk assessed and any risk above 16 or a reduction in excess of £100K to any service line, are reviewed jointly by the Chief Nurse and Medical Director. Savings can only proceed if they are cleared from a quality and safety perspective through this QIA process, which is detailed in section 4.4 below.

The trust does not underestimate the challenge in reducing the cost of the workforce by 10%, and the trust is currently behind trajectory to reduce by this amount by the end of 2016/17. If the trust does not deliver the full 10% by year end, then this work will obviously require delivery by the trust in the first quarter of 2017/18.

3.3 Recruitment and Workforce Transformation

In common with many Trusts, St. George's is unable to fill all its vacancies for some key clinical roles.eg Radiographers, Neonatal nurses, and I.T. specialists. Traditional recruitment routes have not provided staff in sufficient numbers, and St. George's workforce plan includes looking at how we provide diverse routes into nursing employment which includes focussing on recruiting local people so that the trust has a long-term sustainable workforce. Some of the plans the trust have include:

- The trust has been successful in our bid to introduce the new Nursing Associate role and the pilot will be commencing in January 2017 and lasting 2 years will provide highly skilled support to registered nurses in Neurosciences and Medicine. The trainees will gain experience in community and home settings as well as in acute care. Currently a foundation degree, it is expected that the apprenticeship framework will be developed for this role during the pilot period.
- The trust view the Associate Practitioner band 4 role in Peri-operative care and Neonatal care as continuing to transform the workforce, with a further cohort commencing in January 2017. Band 4 roles will be developed for these staff to perform in at the end of the 2 year training (foundation degree/apprenticeship).
- The Apprenticeship for Healthcare Assistant roles means that St. George's will be better placed to close the skills gap in the future. The trust will also be piloting a 4 year nursing apprenticeship from September 2017 as an alternative to UCAS entry. The plan for apprenticeships will mean that St. George's is offering 200 placements from April 2017 to seek to maximise return on the Apprentice Levy which comes into force from this date. A pilot cohort of nurse apprentices will offer an innovative way to offset the potential negative consequences of the withdrawal of the bursary for student nurses. The apprentice nurses will rotate through surgical, medical, rehabilitation and emergency placements. A trailblazer apprenticeship in being developed in

therapies for a higher level support role. Taken together the apprenticeship route offers a new, innovative, and potentially sustainable supply of new staff that the trust can train and retain, helping address staffing shortfalls in the coming years.

- St. George's continues to be the leading user of the Physician Associate role, and will continue to roll out its deployment.

One of the areas where the trust has most difficulty in recruiting nursing staff is in HMP Wandsworth, and in response to this St. George's has developed the role of pharmacy technicians in the prison so that nursing time is released for nursing duties. The trust is developing a training programme to be delivered by Occupational Therapists to Teaching Assistants and parents in both special and mainstream schools in Wandsworth. The programme will commence in January with accreditation being sought later in the year. This will help occupational therapists to set care and treatment plans, but for delivery to come 'in place'.

The trust is continuing to provide training to our staff on mental health issues so that patients presenting with mental health issues are not only more appropriately cared for but to also reduce reliance on mental health nurse agency specials.

In addition the trust will continue to invest in its recruitment infrastructure so that it can recruit staff as quickly as possible. The trust has recently reviewed its recruitment process to ensure that it can shorten the recruitment timeline to match the top quartile.

3.4 Skills Development

St. George's will reinvigorate the performance management and appraisal system led by the Director of Workforce and Organisational Development so that all staff are aware of how their role contributes to delivering services. This will combine encouraging staff to reflect on current performance and discuss their career ambitions. The plan includes improving the quality of line managers' skills to ensure that the trust achieves the best out of its current workforce through development of their skills and identifying opportunities for them. Retaining key staff is a critical part of the trust strategy as its attempts to tackle the turnover challenge facing all trusts. St. George's leadership development strategy will support this work and will include training for management at all levels including clinical managers.

St. George's is developing a rotational development programme for newly qualified nurses where they will gain experience in the community, prison and acute setting underpinned by a post graduate qualification. For unregistered staff the trust offers training in mental health skills so that they are better equipped to care for patients, and to reduce reliance on agency RMNs.

3.5 STP Collaborative Working

St. George's is currently part of a pilot with other trusts in South West London to introduce a Staff Bank for nursing and midwifery staff across the sector. The trust is working in collaboration with neighbouring trusts who are part of the pilot to harmonise rates of pay, and will use eRostering so that all rotas are released at the same time. The ability of the trusts in the sectors to access each other's bank staff will contribute to the reduction in the use of agency staff. In addition to the current project the HR Directors will investigate how the learning from the bank project can be extended to medical and AHP staff.

St. George's is working with South West London & St George's mental health trust to accommodate their staff on acute medicine placements, so that we avoid patient admissions for issues such as pressure sores. St. George's staff will work with Psychiatric liaison to improve confidence in assessing and nursing patients who also have mental health needs. St. George's will explore the

provision of its high quality simulation training services to other local hospitals with talks currently underway with Kingston.

The trust will share its emerging workforce plan with commissioners and providers through the STP as appropriate to help south west London as a whole to develop sector wide plans to address shortages in key staff, as well as to identify areas where closer working will deliver benefits to all parties.

3.6 Staff Engagement

The trust is aware from the Staff Survey and the Medical Scale report that there is much work to do in terms of staff engagement. St. George's will continue to support its Listening into Action service to empower staff to discover and implement their own solutions for local issues. The trust will be taking forward work started in September 2016 to improve 'joined-up' working between Allied Health Professionals and a separate piece of work involving stakeholders, including commissioners to identify ways in which all staff can work together to provide excellent end of life care in support of the trust's End of Life Care 5 year strategy.

St. George's is implementing a wide-ranging health and wellbeing programme to underpin its workforce strategy and ensure that are staff are themselves fit and well. Staff often work in pressurised situations and central to St. George's support for staff is training on resilience and stress management. The trust has already appointed 60 staff as health and wellbeing 'champions' to ensure the benefits of a healthy lifestyle can be embrace by our staff. Finally, the trust provides a staff support service within Occupational Health to provide expertise to staff and managers on managing pressure.

3.7 Monitoring Progress

St. George's acknowledges that there is further work to do to improve on its job planning process, and the trust is looking to improve this critical function over the coming year. The next round of job planning will look to ensure that job plans are aligned more closely with actual activities undertaken, building on work done earlier this year. Job plans signed off at Directorate and Divisional level with regular reporting to the Executive Management Team and the Trust Board.

The Divisional workforce plans will set out how staff can be organised differently and used most effectively to deliver services. A nursing workforce project is underway to ensure maximisation of the eRostering programme to map rotas to activity and ensure the need for using temporary staffing is reduced to achieve the nursing temporary staffing spend cap and the trusts funded workforce levels. In some cases this will mean moving staff to where they are needed and in others changing shift patterns to reflect new activity. The trust has reviewed the payment system for internal medical locums to ensure consistency of payment rates when it needs St. George's doctors to carry out additional work. This will reduce reliance on agency doctors.

Progress towards achieving the workforce strategy is monitored formally through the Workforce and Education Committee which in turn provides assurance to the Trust board. Each Division is required to attend the Workforce and Education Committee which meets bi-monthly to confirm how they are implementing elements of the plan within their Divisions. Additionally, progress will be monitored at the monthly Divisional Performance Management meetings which are attended by key Executive Directors who can direct remedial action as necessary.

4.0 Quality Planning

St. George's is on a quality journey. There is much that the trust does well, but much that can be improved upon, which the recent CQC inspection and report identified. The trust was rated as "Inadequate", down from a "Good" rating in 2014, and the necessary and appropriate response of the trust is to focus on addressing the recommendations of the CQC in its quality planning.

Given the importance the trust attaches to the delivery of high quality, safe and robust services, quality is a direct executive responsibility for three key Directors:

- Andy Rhodes, Medical Director
- Suzanne Banks, Chief Nurse and Director of Infection Prevention and Control
- Paul Moore, Director of Quality Governance

This triumvirate is overseeing the response to the CQC inspection report and the overall development of the quality agenda in the trust.

4.1 2016 CQC Inspection Report

In June 2016, the St Georges received a planned inspection by the Care Quality Commission (CQC). A team of 60 inspectors interviewed staff, talked to patients about the care they received, inspected premises and monitored the care provided. The final inspection report was published on 1st November 2016, rating St Georges overall as 'Inadequate'. The five domains were rated as following, with the detail provided also:

Ratings	
Overall rating for this trust	Inadequate
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Inadequate

Overview of ratings

Our ratings for St George's Hospital - Tooting

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	☆ Outstanding	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Requires improvement	Good
Community health services for children, young people and families	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Community health inpatient services	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Community End of Life Care services	Requires improvement	Inadequate	Good	Requires improvement	Inadequate	Inadequate
Overall Community	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

In response to the findings the trust has produced a Quality Improvement Plan (QIP), which defines and tracks the improvements St. George's needs to make. It captures all of the immediate requirements and 'Must Do/ Should do' recommendations arising from the CQC's visit and subsequent report; a total of 87. Crucially, it provides a focal point for our longer-term improvement journey, and the various quality improvement initiatives occurring across the organisation, both now and in the future, helping the trust to move from its current position of 'Inadequate' to 'Requires Improvement' and progressing onto 'Good' with the aspiration of being

classed as 'Outstanding'. It is recognised that this will not be achieved overnight, and is a journey that requires the engagement of all staff within the trust.

The trust will have 9-12 months from 1st November 2016 to complete the actions within the QIP or show significant progress against them. The trusts performance in delivering the QIP actions will be closely monitored by both the CQC and NHSI.

4.2 The Quality Improvement Plan

The QIP is made up of 9 workstreams. Each workstream has a number of areas, across which are incorporated a total of 321 actions, the delivery of which will address those areas identified as inadequate or requiring improvement in the inspection. The workstreams and areas are broken down as follows:

Workstream	**Personalised Care**	**Executive Lead**	Chief Nurse
As well as addressing some specific ward concerns raised by the CQC, this workstream will be looking trust wide at issues such as End of Life Care, Safeguarding, Infection prevention, dementia care, paediatric care and privacy and dignity. The following give two examples of the work the trust is doing in these areas: **End of Life Care** – the trust has a comparatively well-resourced palliative care team that offer excellent care to patients in the organisation. The trust needs to build on this to ensure that all staff are able to treat patients appropriately, and to do this a new trust strategy is in the final stages of development. This strategy has six ambitions for patients, and under each, a set of actions that will need to be delivered by all staff. The ambitions are: Each person is seen as an individual; Each person gets fair access to care; Maximising comfort and wellbeing; Care is co-ordinated; All staff are prepared to care; Each community is prepared to help. The new strategy is ambition both for care delivered in house and in the community. A set of Key Performance Indicators will be set, a baseline established, and then performance will be monitored going forward. **Infection Prevention** – Performance during 2015/16 was strong, with for example, on 3 MRSA cases and 29 c-difficile. Performance year to date during 2016/17 has remained strong, supported by the trust's Infection Prevention and Control Action Plan for 2016/17. The trust has identified a number of priority areas in the plan, with monitoring being undertaken on a fortnightly basis. Priority areas include: Alert Organisms and Conditions; Surveillance and Management – managing and reducing the case of healthcare acquired infection; strengthening Surgical Site Infection surveillance in the trust; devolved divisional infection prevention and control programmes to address local issues; and ensuring training and communications around infection are compliant and accessible			

Workstream	**Safety Culture**	**Executive Lead**	Medical Director
This workstream will be looking trust wide at issues such as Medicines Management, Radiation Safety, Management of the deteriorating patient, Implementation of the WHO "Five Steps to Safer Surgery" and clinical records security.			

Workstream	**Governance**	**Executive Lead**	Director of Quality Governance
This workstream will be looking trust wide at issues such as overall governance arrangements within the trust, strengthening where required, Serious Incident Management, Complaints Management, Risk Management System and an open and learning culture. The following give two examples of the work the trust is doing in these areas:			

Serious Incident Management – focussing on mortality review aspect of it, the trust will implement the national standardised methodology for case note review, both at service and organisation level including participation in pilot, which will afford the trust the opportunity to influence the project and to act as an early implementer. The trust will review all mortality, including expected deaths, to allow St. George's to identify strategies that may positively impact on care, such as implementation of bundles and care pathways, and in so doing develop a clearer view of 'avoidable' mortality. At a local level, ensure a robust and consistent approach to M&M meetings across all care groups, and developing practical help for clinical teams to develop service specific systems.

Complaints and Friends & Family tests – the trust takes the management and response to complaints extremely seriously, but needs to better embed the learning that can come out of individual complaints within the services concerned and more widely across the trust. The trust also welcomes feedback on patient experience in a variety of ways including the Friends and Family Test (FFT), national patient survey and PALS concerns. For FFT 94.3% of patients are "Extremely likely" or "Likely" to recommend the trusts services to friends or family members (out of 26,568 surveyed from November 2015-October 16). For the National Inpatient Survey 2015 the trust performed "better" than other trusts regarding questions about the Emergency Department and "about the same" as other trusts in all other areas. Actions to improve in response to feedback are reported to divisional governance boards and various committees.

Workstream	**Human Resources**	**Executive Lead**	Director of Workforce & OD
This workstream will be looking trust wide at issues such as Recruitment and retention, Workforce development (please see Section 3, workforce planning, regarding both), Mandatory Training, Caring for Staff, and the Fit and Proper Persons requirement			

Workstream	**Estates**	**Executive Lead**	Director of Estates & Facilities
The CQC's findings mirrored the Trust's own assessment of the condition of its estate. This workstream will be looking trust wide at issues such as buildings management, water safety, fire safety, electrical safety and refurbishment of key estate, through the delivery of an "Estate's Recovery Plan". ▪ A request to NHS Improvement for emergency capital funding to address urgent and extensive infrastructure backlog maintenance (including fire, water and electrical safety issues) ▪ Commenced a programme to decant and demolish inadequate accommodation (Knightsbridge Wing and portacabins) ▪ Looking at options to create decant space for the refurbishment of wards for immediate improvements while longer-term options are explored ▪ Prioritising safety and compliance improvement works to buildings that accommodate staff and patients (Lanesborough Wing, Outpatients and Knightsbridge prior to decant)			

Workstream	**Operations**	**Executive Lead**	Chief Operating Officer
This workstream will be looking trust wide at issues such as Safe Staffing; Equipment requirements; Neuro- rehabilitation & amputation service strategy; Community Adult Health strategy; Divisional Trust Ops communications; Data Management; and Health Visiting			

Workstream	Healthcare Informatics	Executive Lead	Director of IT
The trusts IT infrastructure is facing serious challenges, and requires significant investment to ensure the system is stable and provides a stable platform for the wide variety of clinical and other systems running off it. Alongside the IT infrastructure elements, the workstream will also be reviewing systems for data collection to ensure they are fit for purpose.			

Workstream	Leadership	Executive Lead	Chief Executive Officer
This workstream will be looking at the development of a new long term trust strategy, taking into account factors such as the STP, the NHSE specialised service review, and the trusts own internal requirements. It will also focus on the stabilisation of the senior leadership team to implement and deliver on these and the other challenges facing the trust.			

Workstream	Access	Executive Lead	Chief Operating Officer
This workstream will solely look at the issues around referral to treatment target recovery, referred to in the activity section previously.			

4.3 Governance Arrangements for management and oversight of the QIP

The Director for Quality Governance has responsibility for oversight and delivery of the QIP. Together with the QIP manager they meet with the workstream leads at a confirm and challenge monthly meeting to review progress against actions and adherence to time scales. Each action is rated according to delivery against an agreed target date as follows:

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date. Off track and now unlikely to deliver by target date
Amber	Off track but recovery action planned to bring back on line to deliver by target date
Green	Completed / on track to deliver by target date.

The Executive leads bring their respective progress reports before the Quality Improvement Board. The QIP meets monthly and is chaired by the CEO. At the QIP frank and open discussion takes place if progress is failing to meet agreed milestones and evidence is provided where actions are rated as blue.

A QIP summary is provided to the Trust Quality Committee, Chaired by a NED, on a monthly basis where it undergoes further scrutiny. This in turn is reported to the Trust Board at the next Board meeting. In addition to this, each clinical division reviews and manages its own quality agenda, linked to delivery of the trusts QIP but also addressing local quality concerns. Clinical divisions drive implementation of their quality strategies through Divisional Governance Board meetings, as well as attending the Quality and Risk Committee to report on progress.

4.4 Quality Impact Assessment Process

The need for St. George's to have a robust Quality Impact Assessment (QIA) process is paramount, given the twin pressures of meeting the financial challenge the organisation faces, as well as addressing the outputs of the CQC inspection, as well as the range of other challenges that form part of the normal day to day activities within the trust. St Georges approach to the assessment of services changes considers the Quality Impact Assessment against the three core quality domains of patient safety, clinical effectiveness and patient experience

With a stated goal of reducing the trust employed headcount by 10%, the trusts CIP and Transformation plans will need to have a full and robust QIA undertaken to ensure that any risks to

quality of the service are appropriately understood and owned, and that appropriate controls and mitigations are put in place.

All staff within the trust accept that the trust faces extreme challenges, that will impact on the range of services delivered, and more particularly, how those services are delivered. No savings scheme that has a clinical or nursing component is developed in isolation from local clinical and nursing leadership, and that the trust acknowledges that a significant part of the long term answer to St. George's sustainability lies in the knowledge, ideas and insight held within our clinical services. CIP and Transformation schemes therefore have as an integral part, clinician engagement. This does not mean that clinicians, nurses and other staff will always be in agreement with proposed changes – no one party has a veto in this process. However, where there is concern about proposed changes the QIA process is designed to pick up on and address these.

The following outlines the formal process that all efficiency, productivity, savings or CQC related schemes will need to adhere to.

- At the initial level, divisions will sign off on projects (Divisional Chair and Divisional Director of Ops and others as appropriate to the scheme) subject to the saving being under £100k, and any residual risks exceeding 12 on the NHS risk matrix. Any project exceeding these limits must be signed off by the Medical Director and Chief Nurse using the standard QIA sign-off process
- The trusts Programme Management Office have develop a revised QIA template that facilitates an accurate description of service based risks and mitigations associated with CIP, savings and transformation projects
- No scheme can go live until completion of the full sign-off process, which includes the QIA forms appropriately signed-off.
- Responsibility for compliance with the standards for full completion of the QIA and Saving Scheme Form sign-off is the responsibility of the
    - Divisional Steering Committees for divisional projects, or
    - Programme Steering Group for the Turnaround programmes.
- A Programme Management Office (PMO) will provide oversight of the project sign-off process and will undertake a quarterly review of the governance process and provide assurance reporting to the Turnaround Board
- The PMO will initiate the establishment on a weekly basis for the purpose of review and approval of all QIAs signed-off by the divisions. The purpose of this meeting is to provide executive level oversight and approvals of projects
- A process of regular review of programmes; work-streams; projects; QIAs; and risk-logs is being introduced with a requirement for Divisional Steering Committees to ensure that a regular review of QIAs and risk-logs for on-going projects is undertaken, with issues escalated to the Turnaround Board as necessary

As demonstrated both the QIA process itself, and the governance overseeing the implementation of the QIP plan provide clear safeguards and escalation spaces to identify if care is in danger of being compromised by any process or proposal being adopted in the trust. The Trust Board is very attuned to the clinical and quality risks inherent in addressing the scale of the financial challenge facing the organisation, and through its monthly board will monitor delivery of the trusts QIP and financial plans in a holistic way, seeking sufficient assurance that clinical care and quality is not being compromised by delivering CIPs or the other transformation schemes the trust needs to deliver to bring the organisation back to a financially sustainable position.

To this end baseline data collection forms part of the QIA process, and will therefore be monitored as schemes are implemented. In terms of potential cumulative impact of several schemes on a particular pathway, service, team etc., this again, should be picked up in the QIA process, and also

the Divisional Management Boards will also provide a further assurance of local intelligence on cumulative impact being picked up early.

4.5 Triangulation of indicators

As part of the trust performance framework, St. George's undertakes quarterly executive performance reviews where a series of indicators and their interdependencies in relation to performance, finance, quality, workforce, and risk are reviewed and key items for escalation are addressed. Areas of underperformance are reviewed in terms of delivery against national/internal standards, financial implications, impact on quality and patient care and experience, and workforce implications associated with it. In addition to this the impact of potential workforce issues are discussed and their impact on respective areas, both short and long term with remedial proposals for action.

Some of the key indicators reviewed at the quarterly meeting include:

- National access and cancer targets
- HR Targets in relation to CQC Well Led domain, to include Friends & Family Tests, turnover, sickness, vacancy and training/appraisal compliance rates.
- Finance – activity, divisional financial positions, fines
- CQC compliance

Key actions from reviews are also discussed and monitored at various forums in relation to key domains, namely: Finance and Performance Committee, Quality and Risk Committee, Workforce and Education Committee and Monthly Finance and Performance Reviews.

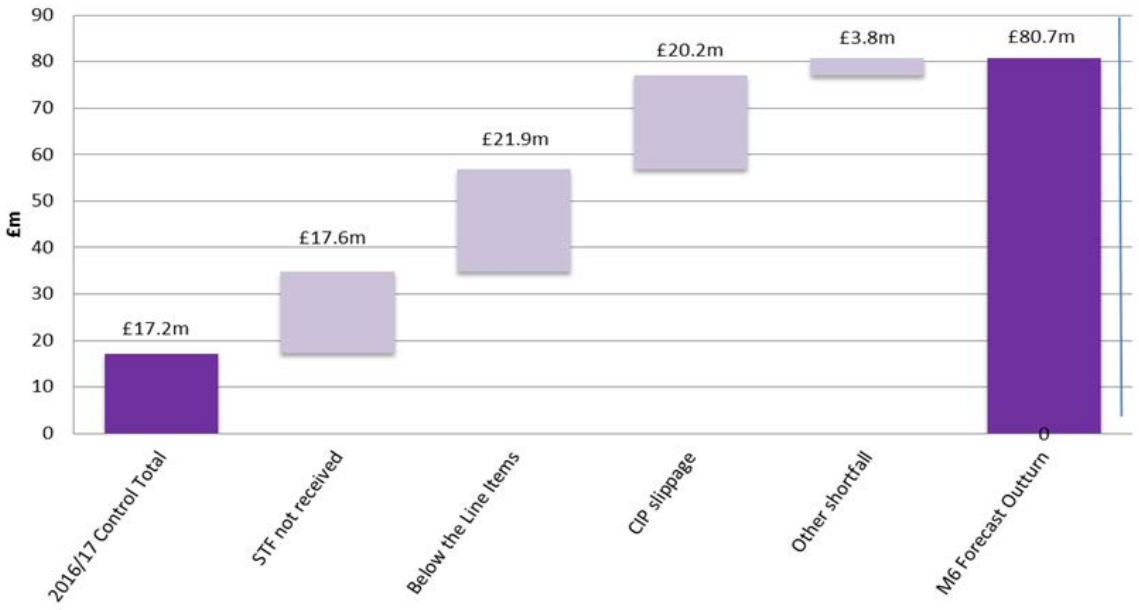
Further triangulation and board scrutiny of key areas is undertaken at monthly trust Board and key indicators from all domains are reported in the monthly trust Board Performance and Quality Report. The Board scrutinise indicators/performance, request further details or recovery action plans where required. Also, in relation to particular areas the board may request specific thematic analysis and forecast for future performance and any associate implications. The board will then use this data to identify key priority and development areas for the trust for both the immediate term and strategic long term.

5.0 Financial Planning

5.1 Financial context, forecasts and modelling

2016/17 is proving to be an extremely financially challenging year. The original financial control total of a £17.2m deficit has failed to be delivered, resulting in the loss of £17.6m STF funding allocation, and the reforecasting exercise carried out at Month 7 is indicating a full year forecast outturn of an £80.7m deficit.

The table below details the main financial elements which have moved the forecast outturn to an £80.7m deficit:



The above revised forecast outturn creates the starting point for producing the proposed financial plans for the years 2017/18 and 2018/19. It needs to be noted that the trust is currently undertaking a reforecast process for NHSI which obviously may well change the starting position for future years.

5.2 Headline Financial Plans for 2017/18 and 2018/19

NHS Improvement (NHSI) informed the trust in writing on the 1st November that the expected control totals for 2017/18 and 2018/19 would be £3.5m surplus and £13.3m surplus respectively and that the sustainability and transformation monies of £17.6m for each year would be dependent upon the Trust accepting the proposed control totals.

In discussions with the trust's Commissioners regarding the services to be provided in 2017/18 it has been indicated that the Commissioners will reduce the activity they commission at the trust and associated income by approximately £55.5m.

It is extremely difficult to accommodate such a significant reduction in commissioner funding, and to meet the proposed control totals from NHSI. However, the trust still recognises that it does have a responsibility to manage its operating cost base in such a manner that reflects the NHSI control totals. The Trust is proposing to deliver a financial operating plan that nets off the NHSI and Commissioner elements, which results in a deficit of £52m in 2017/18 and a deficit of £42.2m in 2018/19. Once agreed by the Trust Board, the financial templates will be completed using these assumptions.

The Trust's thinking around adopting the proposed deficit plans is that these numbers are a product of an eighteen month run rate development from its current full year forecast outturn for 2016/17 of an £80.7m deficit.

Detailed below is a high level financial bridge showing the movement from the preceding year's financial outturn to the respective annual deficit totals:

2017/18 Control Total Challenge	£'s m
Brought forward 2016/17 opening deficit	-80.7
Identified in year cost pressures	-29.6
Removal of previous years non-recurrent items	21.9
Sustainability & transformation funding for non-financial targets	18
Revised operating run rate	-70.4
Anticipated reduction in Commissioner funding in 2017/18 of £55.5m.	-55.5
CIP and Transformation required.	73.9
Planned Deficit for 2017/18	-52

2018/19 Control Total Challenge	£'s m
Brought forward 2017/18 opening deficit	-52
Identified in year cost pressures	-29
Sustainability & transformation funding for non-financial targets	0
Revised operating run rate	-81
Anticipated reduction in Commissioner funding in 2017/18 of £55.5m.	0
CIP and Transformation required.	38.8
Planned Deficit for 2018/19	-42.2

The delivery of the proposed deficit plans are centred on the following key issues:

- In Month 6 of 2016/17 the trust commenced an initiative to assess how much income it was losing through counting and coding errors, and how much it was therefore not appropriately billing for. The initial sample testing indicated that the Trust was probably losing around £20m per annum, this amount is being pursued with commissioners ahead of the 23rd December plan submission. Any positive resolution with commissioners regarding these non-billed items will have the effect of reducing the 2017/18 in year CIP target, at the present time the trust feels that the prudent approach is to note the upside income opportunity but to still maintain the CIP challenge at the £73.9m level.
- The NHSI proposed Sustainability and Transformation Funding has been included in both years at the full amount of £17.6m. The rationale behind including the full STF funding is that the trust's underlying plans do deliver the stated NHSI control totals in each of the years before the negative impact of the reduced commissioner funding i.e. £3.5m surplus minus the £55.5m commissioner funding gives an overall deficit in 2017/18 of minus £52m, the same logic is applied to 2018/19 giving a deficit of minus £42.2m. The trust clearly feels that it has a responsibility to manage its operating cost base within the constraints of the specified NHSI control totals but cannot be held to account for the arbitrary reduction of £55.5m in commissioner funding. The trust has not been given sight of any detail behind the proposed commissioner funding reduction or the associated QIPP plans.
- Included within the annual operating run rates are identified in year cost pressures of £29.6m (2017/18) and £29m (2018/19). Within these cost pressures is an allowance for the RTT backlog and potential costs resulting from the CQC inspection.
- The brought forward annual operating run rates for both years have been appropriately adjusted to take account of non-recurrent cost pressures arising in the respective years.
- Income has been based upon expected prior year outturn adjusted for known service changes and developments,

All of the above are actions that are within the trusts own control, and move the trust towards delivery of the control total. However this is now compromised by the Commissioners expressed intention to reduce the available funding by £55.5m in 2017/18 and in turn this has also been reflected in 2018/19 via the brought forward deficit run rate.

The plan does not include an adjustment for the South West London Orthopaedic Collaborative. The Trust is anticipating a material reduction in profit share from Epson and St Helier NHS Trust due to tariff changes, which will result in a control total adjustment between Trusts, as per NHSI instruction. This is to be agreed ahead of the December submission.

5.3 Delivering Carter opportunities

The Trust has invested in a new Procurement Service which became fully resourced in Q2 2016/17. The new service has focussed on delivery of the Carter recommendations and is an active and successful user of Purchase Price Index and Benchmarking data since its launch last month, identifying opportunities for reducing cost via collaboration (via LPP etc.) and direct re-negotiation of contracts to bring pricing in line with the best performing acute providers. The establishment of a culture of controls and compliance has commenced within the procurement and purchase to pay environments, driving spend to fewer providers and reducing off contract expenditure. Further detailed collaborative work is underway with SWL partners to progress opportunities to reduce costs and improve efficiency.

The trust has helped lead the way with the consolidation of pathology services, with South West London Pathology, a partnership vehicle between St. George's, Kingston, and Croydon Hospitals which came into being during 2015. Savings have been considerable and broadly in line with the original business case projections. The trust is continuing to explore opportunities for back office consolidation with other providers in south west London and will look to deliver savings from these projects during the two year period of this plan, though at this stage, no concrete plans are in place.

5.4 Cash flow and financial support

In 2016/17 the trust maintained the improvements in cash management made in 2015/16 e.g. through longer supplier payment terms and credit control actions to reduce overdue debt.

However the higher income and expenditure deficit than original plan has required higher borrowing than plan. The trusts forecasting exercise is projecting an £80.7m deficit, however it is currently conducting a re-forecasting exercise with the aim of meeting the NHSI target deficit figure of £55.5m. Meeting this lower target would result in the trust projecting a total borrowing requirement for £109.9m in 2016/17 including £39.12m for emergency capital monies – as set to in the forecast outturn submitted to NHSI at M07.

The trust's forecast cash balance on 31 March 2017 is £3.4m after loan drawdowns of £109.9m

The trust' projected borrowing requirement for 2017/18 is £87.6m comprising £63.3m to finance the planned revenue deficit and working capital and £24.4m further capital loans to finance emergency capital investment necessitated by urgent priorities identified in the estate and IT infrastructure.

5.5 Capital Planning

The trust has identified a number of very urgent priorities for capital investment in the estate infrastructure and IT infrastructure. The current inadequate standard of fire safety, buildings fabric and network resilience requires significant investment to meet the required minimum standards.

Accordingly the trust submitted to NHSI an initial emergency capital bid in June 2016 for £39.12m for estate and IT capital monies.

The trust has refined the bid since June and will submit the final version week ending 25/11/16. This final version requests emergency capital monies of approx. £63.5m. In order to maintain consistency with the NHSI M07 return forecast outturn, £39.1m of this emergency capital is assumed to be received and spent in 2016/17, leaving the balance of £24.4m to be received and spent in 2017/18.

The capital planning and prioritisation process is as follows:

- Clarification on the available funding for the capital programme was given based on the forecast deficit for this year and next.
- Emergency capital investments identified and included in the submission week ending 24/11.
- The master list is checked to ensure all items were captured and risk assessed, with risk description and mitigation should the item not be prioritised.

Based on the above, the trust has undertaken the trust is looking to invest in the following major programmes during 2017/18.

- **IM&T** – Major areas of investment are around basic infrastructure renewal – improving network capacity and resilience, implementing changes to the trusts main PAS system and electronic document management and prescribing systems, which improve patient safety.
- **Infrastructure Renewal** – Major expenditure on generator renewal and fire safety projects, lift upgrades, standby generators, water management and theatre refurbishment
- **Energy Contract** – the trust will complete the renewal of its energy centre, the plant that supplies the energy to the main site. This project is financed by a secured loan from the London Energy Efficiency Fund (LEEF).
- **Major projects** – Completing the demolitions programme, re-location of renal services, refurbishment and replacement of the cath labs.
- **Medical equipment** –funded by finance leases where appropriate and a combination of emergency capital and internal capital.

The trust is exploring ways of better using assets, including:

- Exploring a managed equipment solution to the catheter laboratories upgrade that is required in the coming year
- Extending asset lives where risk is low
- Reviewing the community estate currently owned and managed by the trust, and looking to reduce the total number of bases within the community, whilst still delivering a high quality community service.

5.5 CIPs and Transformation

The achievement of the proposed planned deficits will rely heavily upon the delivery of the expected CIP and transformation savings which for 2017/18 and 2018/19 are £73.9m and £38.8m respectively. The Trust is planning for a full year effect of the 10% pay cost reduction to significantly contribute to the delivery of the savings plans along with savings to be delivered through potential theatre and ward closures, alongside these schemes detailed divisional savings plans are under development between the Trust PMO, Divisions and Divisional Heads of Finance. Linked to the 10% pay cost reduction, the trust will meet the agency cap of £24m for both years.

The schedule below details a high level view of the CIP plans currently under development:

CIP for 2017/18 - 2018/19 Planning			
	£m	Total 2017/18	Total 2018/19
Clinical Transformation		**39.2**	**14.8**
	Theatres	12.2	0.2
	Outpatients	5.2	4.8
	Flow	10.9	5.1
	Diagnostics	-	-
	Fix Close Transfer	0.9	4.7
Medicine Optimisation		**1.1**	**-**
Back Office		**2.7**	**2.3**
Procurement		**6.8**	**6.1**
Workforce Efficiency		**24.0**	**15.6**
	Nursing workforce	5.8	3.8
	Medical workforce	4.1	2.7
	Clinical Admin	1.9	1.3
	Non-medical workforce	7.8	5.1
	AHP	2.8	1.8
	other	1.5	1.0
	TOTAL	**73.9**	**38.9**

Any positive outcome from the discussions to be held with commissioners relating to the unbilled activity identified through the trust's month six coding review exercise will relieve the pressure on the very challenging CIP targets for both years.

6.0 The Sustainability & Transformation Plan

Delivery of the aspirations of the emerging Sustainability and Transformation Plans (STPs) are one of the 9 'must-do's' of the NHS for the next two years. St. George's is very supportive of the aims and aspirations of the South West London STP. The guidance makes it very clear the importance of individual organisations plans for the coming two years being clearly linked to the STPs plans, and the trust recognises that the successful delivery of the STP is part of the solution for St. George's long term viability and health.

The STP is clear that a "no-change" scenario is not viable either clinically or economically, with the sector facing a deficit of £828m p.a. by the end of 2020/21. The STP's plan, at a high level, is to:

1. Set up locality teams, providing integrated care, for populations of circa 50,000
2. Increase capacity in the community, by using workforce differently, to reduce hospital admissions and deliver more care in the community
3. Review acute hospital configuration to meet changing demand and deliver high quality care
4. Address both mental and physical needs in an integrated way
5. Introduce new technologies to deliver better patient care
6. Make best use of acute staff through clinical networking and redesigning clinical pathways
7. Review specialised services in south London

At the moment the STP is still a work in progress, with detail underpinning how the above are to be delivered still being developed. However, the trust is making progress on contributing to, or implementing and delivering programmes of work that will directly feed into the delivery of these goals. Key amongst these are:

6.1 Locality Teams

Central to the STP model is the transformation of community based models of care to ensure that people receive their care and treatment in the most appropriate setting based on their needs. St George's is fully supportive of this approach and recognises the benefits of the anticipated reduction in A&E attendances and emergency admissions and the increase in timely discharge from hospital.

St George's is the community provider for Wandsworth and is well advanced in developing the STP Locality Team model of care. We have been working with the CCG for the best part of 5 years developing integrated community teams working on a locality basis around GP practices. Wandsworth is divided into four localities (aligned with GP practices) with community services working as one team around the patient. The integrated team includes the patient's registered GP, community GP, community nurse, community therapist, specialist nurse (respiratory, heart failure, diabetes), community pharmacist, social worker, mental health nurse and voluntary services co-ordinator.

The trust has shown that this model is successful in Wandsworth albeit for up to 200 patients (50 patients per locality) whereas the STP aspiration is for locality teams to support care and treatment for 50,000 patients. In 2017/18 onwards the trust is are looking to develop locality team working further with the enhanced care pathway 500 initiative providing an MDT approach for patient's care, all overseen by a Consultant Geriatrician.

The trust is also working collaboratively with Merton's new community provider, CLCH, as many of our patients are discharged to Merton, to seek standardisation between our two main boroughs, where practical and sensible. This is with particular reference to home first: discharge to access, an initiative which will see a reduction in the number of inpatient beds.

6.2 Acute Sector Reconfiguration

The STP identifies that up to 55% of patients in hospital beds do not need to be in them, either because they could have been better treated outside of an acute setting, or having been treated, they could have been discharged earlier. The STP states that the sector will need to reduce its acute footprint, whilst increasing its provision of community support and step down facilities, and it states that "*difficult decisions about the configuration*" will have to be made.

In addition to this, none of the four trusts are consistently delivering NHS Constitution standards for A&E, elective surgery or cancer, nor delivering 7 day services. The STP states that it does not feel it will be able to deliver the 7 day standard across the five acute sites given the inability to recruit or pay for sufficient workforce.

The central premise of the acute reconfiguration element of the plan is to drop from the current five acute sites – St. George's, Croydon, Kingston, St. Helier and Epsom Hospital's – to four. In reducing from five to four the sector will be able to meet key clinical quality standards alongside delivery robust 7 day services. Both St. George's and St. Helier sites have major estate problems with St. George's identifying a requirement of £295m over the coming five years. Despite this the STP states that *"The only site which we believe is a "fixed point" is St. George's Hospital….since it provides hyper-acute stroke, major trauma and other services which are served by highly specialist equipment an estates, which be very expensive to re-provide elsewhere in south west London*", and that the NHSE review of specialised services is unlikely to change the fundamentals of this.

6.3 Specialist Commissioning

As referred to above, the specialist commissioning challenge, identified as £99m by the STP, will be addressed through the Specialist Commissioning Review. This review is proposed to be completed

by December 2016. St. George's is one of three trusts – along with Kings College and Guys & St. Thomas's – providing tertiary care to patient of south London. In addition, St. George's also provides much of the tertiary care to Surrey. At this stage the trust does not anticipate significant change to the mix of services commissioned by NHSE on site, given, for example, the range of services required to deliver its function as a Major Trauma Centre. However, the trust is not complacent about the review, will work constructively with it, and will ensure that the outcomes are implemented in a safe and sustainable way.

6.4 Delivering for frail, elderly people

The trust is in the process of redesigning the unplanned care pathway for frail older patients with a view to admission avoidance in addition to the introduction of a new Rapid Access Clinic 5 days a week based at QMH from October 2016. Frail, elderly patients are to be assessed in the Emergency Department and short stay wards and redirected towards alternative community pathways where clinically appropriate. Delivery should enable able all appropriate patients to receive care in a community environment.

6.5 Getting the model of care right

St. George's has an important role to play in the delivery of networked services. The trust, for many specialties, often has the largest consultant workforce in south west London. This puts the trust in a position to both be part of the answer in terms of networked models of care, and to also benefit from the skills and expertise of the workforce working elsewhere in south west London. To this end, it will work closely with the other three trusts on implementing the 2016 "Better Births – National Maternity Review", as well as looking to ensure that networked arrangements for paediatrics offer safer, more consistent care for all children. St. George's, as a major provider of maternity and paediatric services will obviously play a pivotal role in developing these programmes of work.

6.6 Addressing Workforce Gaps

St. George's, along with other trusts, is experiencing a difficulty in recruiting and retaining staff. This is driven by a range of factors, including a shortage of qualified staff in certain fields and the high cost of living in London. To help address these gaps the STP is proposing changes to the models of care, increased networking arrangements, and the reconfiguration of acute services, all previously referred to. The trust is supportive of all of these proposals.

6.7 Closing the financial gap and capital requirements

As noted, the financial gap in the health economy will be £828m by 2020/21. Many of the ways to close that are detailed above. Alongside the reduction in acute beds days of 44%, the STP is aiming for circa 20% reduction in outpatient appointments and a 13% reduction in elective surgical activity. Though the detail of these has to be worked out, they will undoubtedly impact on St. George's, either through a reduction in capacity on site, or through taking more work on site to facilitate other reconfiguration changes.

The STP notes that *"All acute sites have areas of capital which they must urgently address in respond to requirement from the CQC or as part of ensuring that their sites are fit for purpose."* St. George's has begun this process, but it will take up to the full five years of the STP to bring the estate up to an appropriate condition.

7.0 Foundation Trust Membership and elections

As St George's gets more established as a Foundation Trust, so its confidence in how best to work with its Governors and Members has grown.

Throughout 2016/17, it has developed stronger working relationships between the Council of Governors and the Board of Directors. All Governors have a standing invitation to attend Board or Committee meetings (except the Remuneration Committee) including meetings that are held in private. This provides a great opportunity for the Governors to observe the Non-Executive Directors (NEDs) and build an evidence base against which they can assess the NEDs' performance at the end of the year. Governors simply need to provide prior notification of planned attendance through the Membership Office and time is built in to these meetings for the Governors to ask questions or make comments.

There are two joint Council-Board events in the 2016/17 programme – one was held in July 2016 and one is planned following the Governor elections in February 2017. The Governors had a very successful Away Day with the NEDs in November 2016 and structured time is being built into the Governor programme in 2017/18 to ensure that the Governors and NEDs can meet on a regular basis. The Lead Governor is invited to attend the Board strategy away days and feedback to the rest of the Governors.

Governors with a DBS check and who have been trained have also been involved in mock CQC inspections – particularly important in a year when St George's has been the subject of considerable regulatory scrutiny. The Quality Inspection programme, led by the Chief Nurse, is being reinstated in the Trust and interested Governors will also be invited to participate. St. George's is striving to ensure that Governors are offered training to enhance their role and encourage them to attend Governwell Governor networking events and courses.

The terms of office for seven elected Public Governors and two elected Staff Governors (32% of the Council of Governors) will expire at the beginning of February 2017 and already the Trust has started to publicise the vacancies amongst the Membership and hold workshops for those interested to learn more about the Governor role. The Trust anticipates that the majority of existing Governors will stand for re-election but in case they are not successful, it is already gearing up to induct and train new Governors.

Member numbers grew by 6% over the year. In November 2016, there are 21,664 Members in total, comprising 12,297 public and 9,347 staff. The increase of 1,281 new Members was due to increases in staffing numbers at St George's throughout 2016. However with the work planned to "right size" the organisation and reduce the paybill by 10%, it is highly likely that this will result in fewer staff members in 2017/18.

The Trust has an active programme of events for Members throughout the year, with topics ranging from dementia to organ donation which is a great way for the Governors to engage with the Membership. There is a monthly 'meet your Governor/Membership recruitment' stand in the main reception area at the Tooting hospital site where Governors can help recruit new Members and engage with existing Members and Members receive a monthly ebulletin to update them on news from around the Trust. The Trust magazine will be re-launched by our communications team before the end of the year and Members will be able to collect a printed copy when they visit any of our sites or view on the Trust website.

This year's Annual Members Meeting was attended by 80 people and the average turnout at Membership events is 35. Given the Trust's financial position, rather than spending money trying to recruit new Members, it is instead seeking to build greater awareness and understanding of the hospital amongst the current Membership. The cost of running the Council of Governors and the Membership Office every year is £100,000 and as with all other areas of cost within the Trust, the Membership team regularly reviews how money could be saved or used more efficiently.