St George's University Hospitals NHS
NHS Foundation Trust

MEETING OF THE TRUST BOARD

25 June 2015, 11.00 – 14.30

H2.5 Board Room, 2nd Floor, Hunter Wing

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

Christopher Smallwood, Chair

		Presented by	
1.	**Chair's opening remarks**		11.00
2.	**Apologies for absence and introductions** Martin Wilson		
3.	**Declarations of interest** *For Members to declare if they have any interests as individuals or members of other organisations that might relate to Trust business or items on the agenda.*	C Smallwood	
4.	**Minutes of the previous Meeting** *To receive and approve the minutes of the meeting held 28 May 2015*	TB (M)	
5.	**Schedule of Matters Arising** *To review the outstanding items from previous minutes*	TB (MA)	
6.	**Chief Executive's Report** *To receive a report from the Chief Executive, updating on key developments*	M Scott TB June 15 - 01	
7.	**Quality and Performance**		11.30
7.1	**Quality and Performance Report** *To receive assurance regarding actions being taken to improve the quality of care for patients and to review the Trust's operational performance report for Month 2*	J Hall/S Bolam TB June 15 - 02	
	To receive a verbal report from the Quality & Risk Committee seminar held on 24 June 2015	Sarah Wilton	
7.2	**Finance Report** • *To receive the finance report form month 2* • *To receive an oral report from the Finance & Performance committee held on 24th June 2015*	S Bolam TB June 15 - 03	
7.3	**Workforce Performance Report** *To received month 2 workforce report*	W Brewer TB June 15 - 04	
	BREAK		12.45
8.	**Strategy**		12.55
8.1	**Divisional presentation – Children's & Women's Diagnostics, Therapeutics and Critical Care** (To be tabled)	A Rhodes	
8.2	**Outpatient Strategy** *To approve & update*	R Elek TB June 15 - 05	
8.3	**Planning performance agreement** *To approve the legal agreement for outline planning application*	E Munro TB June 15 - 06	
9.	**Governance**		13:45

9.1	**Risk and Compliance Report** *To review the Trust's most significant risks and external assurances received*	P Jenkinson TB June 15 - 07	
9.2	**Annual Health & Safety report**	E Munro TB June 15 - 08	
9.3	**Annual Fire Safety report**	E Munro TB June 15 - 09	
9.4	**Board governance statements for approval** *To approve submission of corporate governance statements*	P Jenkinson TB June 15 - 10	
10.	**General Items for Information**		14:15
10.1	**Use of the Trust Seal** *To note use of the Trust's seal during the period (June 2015)* • **The seal was used on one occasion in June 2015. (Trident Business Centre QMR Medical Records)**		

10.2 Questions from the Public

Members of the public present are invited to ask questions relating to business on the agenda. Priority will be given to written questions received in advance of the meeting.

11. Meeting evaluation

12. Date of the next meeting - *The next meeting of the Trust Board will be held on 30 July 2015 at 9.00am.*

MINUTES OF THE TRUST BOARD

28th May 2015
H2.5 Board Room, 2nd Floor, Hunter Wing, St George's Hospital

Present:	Mr Christopher Smallwood	Chair
	Mr Miles Scott	Chief Executive
	Mr Steve Bolam	Director of Finance, Performance and Informatics
	Mrs Wendy Brewer	Director of Human Resources and Organisational Development
	Ms Jennie Hall	Chief Nurse
	Mr Peter Jenkinson	Director of Corporate Affairs
	Dr Simon Mackenzie	Medical Director
	Mr Eric Munro	Director of Estates and Facilities
	Ms Stella Pantelides	Non-Executive Director
	Mr Martin Wilson	Director of Improvement and Delivery
	Mr Rob Elek	Director of Strategy
	Ms Sarah Wilton	Non-Executive Director
	Mr Mike Rappolt	Non-Executive Director
	Professor Peter Kopelman	Non-Executive Director
	Dr Judith Hulf	Non-Executive Director
In attendance:		
Apologies:	Mrs Kate Leach	Non-Executive Director

15.05.11 Opening remarks

Mr Smallwood welcomed the governors and members of public present. He reminded all present that this was a meeting of the Board in public rather than a public meeting. However members of the public present would be given the opportunity to raise questions at the end of the meeting.

15.05.12 Declarations of interest

No declarations of interest were noted in relation to this meeting's agenda.

15.05.13 Minutes of the previous meeting

The minutes of the meeting held on 30 April 2015 were approved as an accurate record. Mr Rappolt identified several instances of where actions should have been recorded from the minutes, such as mortality at QMH (page 3) and team brief (page 2)

P Jenkinson June 2015

15.05.14 Schedule of Matters Arising

The board received and noted the schedule of matters arising, noting updates given on the schedule.

It was agreed that the action regarding the African Partnership could be closed and that a board development session on mortality would be arranged.

Mr Wilson reported that the joint investigation with commissioners into ED and RTT would be concluded by the end of the following week so would be reported to the next board meeting.

M Wilson June 2015

The board noted the actions arising from the annual plan discussion at the previous meeting, and the chairman confirmed the status of the plan – it was confirmed that the trust had agreed a plan as the output of planning work to date; however this plan would be subject to change following the conclusion of the Monitor's investigation.

The board noted that the first of the two workforce workshops was taking place that day.

15.05.15 Chief Executive Report

The Board received and noted the chief executive's report. Mr Scott highlighted the appointment of Adam Doyle as chief officer of Merton clinical commissioning group, the appointment of a new head of learning at St. George's university and the election results for the local constituencies, including the appointment of Jane Ellison to the cabinet. He also reported on the opening of the Gordon Smith ward and the start of filming for a new series of '24 hours in A&E'.

Ms Hall also highlighted the recent international nursing day which celebrated the the contribution of nurses and demonstrated the embedding of the trust values.

15.05.16 Quality and performance report

Performance report

Mr Bolam presented the performance report for month 1, highlighting a change in the format of the Monitor ratings page and explaining the ratings. He reported that the trust's governance rating was currently 'under review' due to the ongoing Monitor investigation. However the trust rating would be a '4' due to ongoing areas of underperformance, including ED, RTT and Cancer. It was also noted that the rate of cancelled operations was also rising.

It was noted that ED performance had shown signs of improvement but was not yet consistent. The board noted that the joint investigations with commissioners into ED and RTT were due to report in the next month and would be presented to the Board once published.

Mrs Pantelides raised concerns that continued failings in cancer performance demonstrated a systemic failure rather than merely a 'blip'. Mr Bolam agreed that there was a systemic issue with achieving the 62 day standard as the standard had not been achieved for the past two quarters. One of the reasons for this was the dependency on other trusts and therefore the need for a written agreement between providers regarding how shared breaches should be allocated. It was agreed that a more detailed paper, including an action plan to address performance, would be presented to the next Finance and Performance committee meeting. Mr Bolam added that the focus was currently on resolving **S Bolam June 2015**

Mr Rappolt challenged the timeliness of the trust's response to address the cancer underperformance. Mr Bolam explained that the focus had been on resolving any internal process issues through the implementation of IT system and investment in the cancer team. However there was also a need to work with the system, engaging with partner trusts. While the trust and south west London was in no worse position than other parts of London there was a need to do something different as a system. The board noted that the trust had agreed with commissioners to implement another model, such as that in operation in north London. It was agreed that this would be reviewed again in July. **S Bolam June 2015**

Mr Wilson reported that in respect of other specialties he was meeting with them to agree plans. He advised that performance may deteriorate further in the short term before progress is made to clear the backlog in the next four weeks, with additional capacity coming on stream. It was agreed that this would be reviewed by the finance and performance committee. **M Wilson June 2015**

Mr Smallwood expressed his concern that trajectories for improved ED performance had been revised a number of times but had not been met, so asked for assurance that this latest trajectory would be met. Mr Wilson explained that there continued to be pressure on the ED, particularly in the level of attendance and admission of over 70 year olds. There had also been issues with repatriating patients to other local hospitals but that this should be improved in the next year due to contractual changes. The trust was also working with social services to improve access to social care facilities. He advised that an output of the joint investigation would be a revised trajectory which all parties signed up to, and an action plan to improve performance.

Mr Scott advised that the purpose of the joint investigation was to develop plans for sustainable performance within the system, including capacity and transformation within acute, primary and social care. He added that the revised trajectory and assurance on delivery should be developed through the finance and performance committee. **M Wilson June 2015**

Prof Kopelman asked whether the reason for increased cancellations was clinical capacity. Mr Bolam clarified the data presented and the difference between the rate of cancellation of procedures and the proportion of those cancelled patients who are then not rebooked. The data showed that a small proportion of those patients cancelled are not rebooked within 28 days. Mr Wilson added that less than 1% of patients were having their procedures cancelled. Mr Scott agreed that the surgery division would be asked for an explanation of the causes of cancelled procedures, for the next finance and performance committee. **M Wilson June 2015**

Mr Rappolt shared the board's concerns that these three standards were consistently being missed and recommended that trajectories for improvements in each standard were agreed by the finance and performance committee. He accepted that the percentage of procedures being cancelled was low but cautioned that it was poor experience and worrying for individual patients.

Mrs Pantelides raised concerns regarding the rising number of never events and asked how the board receives assurance around the effectiveness of actions taken in response to incidents, citing repeated incidents involving retained swabs. Ms Hall explained that the incidents of retained swabs were not identical in nature, and were down to individual error which no system could eliminate.

Quality report

Ms Hall presented the report and highlighted key points in each section. Overall Ms Hall felt that the trust was holding a steady position regarding quality and making progress in some areas, but that focus needed to be applied to the increase in serious incidents and in monitoring mortality rates.

<u>Effectiveness domain</u>

The board noted areas of non-compliance with NICE standards. Ms Hall confirmed that these areas had been picked up with the respective services and improvement monitored through the clinical effectiveness committee.

Safety domain

The board noted the ongoing increase in serious incidents, though not a significant increase and including nine incidents relating to London Ambulance Service handover breaches in the last period. It was noted that the themes of serious incidents were reviewed by the quality and risk committee.

The board also noted that two cases of MRSA bacteraemia infections had been reported year to date – one case related to line care and the other case involved a seriously ill patient who elected to face the risk of line insertion. It was therefore noted that, although there had been a 12 month gap since the last infection caused by line management, there was a need to reinforce the importance of catheter line management.

Mr Smallwood reiterated the need to monitor any impact on, or any rising trends in, quality from the trust's challenging financial position and that the board should continue to ask itself the right questions regarding risks to quality. Prof. Kopelman reflected on discussions at the quality and risk committee the previous day and opined that there were a number of related indicators that could be used proactively to monitor the impact, such as safe staffing and the ward heat map.

Ms Hall confirmed that a process of triangulating and monitoring a core set of indicators on a weekly basis had been implemented. It was agreed that a board seminar should focus on bringing this together. **S Mackenzie, J Hall, P Jenkinson tbc**

Mr Rappolt recommended a simpler presentation of the VTE data in the report and clarity over the key messages to the board.

Experience domain

The board noted that the friends and family test scores were showing a continuing improvement and noted the quarterly report on complaints which showed that the trust had achieved the target for responding to complaints where an extension had been agreed. The target without extensions included had, however, not been achieved despite divisional assurances that it would. The board noted the positive trend in reducing numbers of complaints received.

Mr Rappolt welcomed the insertion of examples of service user experience in the report and highlighted the example involving cancelled operation in day surgery, asking for more detail as to how this incident could occur. Ms Hall agreed to give more detail at the next meeting. **J Hall June 2015**

Well-led domain

The board noted the ward heat map and that the assurance processes regarding staffing levels were being reviewed to ensure that they remained robust.

Mr Smallwood asked for an update on progress against the recruitment plan and in particular asked for assurance regarding the robustness of the trust's checks on staff recruited from overseas, following a recent national media story. Ms Hall confirmed that the trust had received assurances regarding the checks made by international recruitment firms. She reported that recruitment was ongoing, with numbers reported via the workforce report and monitored by the workforce committee. Mrs Brewer reported that the original target of 400 additional appointments over and above the 500 routinely appointed each year was now being reviewed in the light of revised capacity plan. It was agreed that a refreshed target would be reported to the board. **W Brewer /J Hall June 2015**

Report from quality and risk committee
Ms Wilton presented a summary of key points raised at the last quality and risk seminar.

Corporate outpatient improvement programme: the committee had received an update, noting that the 10 month improvement programme was now closed and all work underway had been transferred to business as usual. In general good progress had been made to improve quality across all key workstreams and the committee was assured that oversight was now incorporated in the Outpatient Strategy Board chaired by Rob Elek.

However, the committee had noted that availability of medical records for all outpatient appointments had deteriorated once more, with rates as low as 90% recorded following reduction of records storage on site. The committee was assured that considerable effort is being devoted to returning the rate to 97/98%, with current rate at 95%.

Maternity pathways: The committee had picked up this issue from the audit committee and was very concerned that IT and process developments to ensure that the mother and baby discharge reporting process is safe and complete and links securely to community services are not yet complete and are unlikely to be in place now until 2017. The trust would shortly be the only trust in London using the old system which involves manual processes and faxing details of discharges. There was a back-up system in place but is cumbersome and prone to error, especially at nights and weekends. The committee urged the children's and women's division to expedite the system improvement and the committee would monitor progress.

Safe medical staffing: the committee had discussed a report on safe medical staffing, focussing particularly on numbers and seniority of staff working in acute specialties and across the Trust out of hours. The report had identified a number of areas of concern:

- medicine has a significantly lower doctor to patient ratio compared to surgery, at night and at weekends - staff feedback is that current levels are not sufficient during out of hours period;
- the trust does not operate a critical care outreach service which many organisations use as an adjunct to assist out of hours teams in rapid escalation and admission to intensive care for the deteriorating patient
- some specific services are showing particular stress, as evidenced by high locum expenditure, reporting of staffing-related adverse incidents, difficulty in meeting London Quality Standards

The committee was pleased to note those services which had been innovative in redesigning their medical teams and using the alternative workforce to manage quality demands better. Those services with a high level of consultant presence are delivering the Consultant of the Week model and have lower rates of serious incidents. The committee noted that a number of actions were being taken forward as a result of this review, and the committee would monitor progress.

The committee had noted an outstanding action from the March meeting, relating to the issue of quality assurance for services provided on remote sites. The committee had expressed its concern that this long-standing quality risk had not yet been closed down, especially given the increasing level of activity being sub-

contracted to these remote private hospital sites. Ms Hall had agreed to report progress at the next meeting.

Serious Incidents: the committee had examined the current position and considered the six monthly thematic review by the Patient Safety manager. The committee had been very concerned to see continuing incidents relating to failure to follow up diagnostic tests, despite the assurances being sought by the medical director from each service. Dr Mackenzie was following up.

The committee had also reviewed and challenged the monthly quality report, and had welcomed continuing improvements in the ward heat map reporting and analysis showing how this data is being used to drive quality improvements. However, the committee discussed at length how improving data capture and analysis is enabling much better triangulation of serious and adverse incidents, complaints, safe staffing, safety thermometer and other measures: this needed to be a priority area for quality leadership in the trust. The committee had been concerned to note two MRSA cases already this year, and never events including one (old incident) identified that week.

Risk management: the committee had convened an additional meeting to complete a deep dive review of one of the trust's key risks, the impact of CIP programme on quality – testing the controls and assurances in place for this risk. This programme of deep dives and challenges of the assurances will continue, prioritised for high risks. Ms Wilton invited all board members to attend the next committee seminar meeting, with the focus of the meeting being a deep dive into the key capacity risks, including the physical capacity and the workforce capacity risks. There would also be a regular quality risk presentations from divisions.

Mr Rappolt questioned whether there was a disconnect between the outpatient improvement plan and the quality and performance report. Mr Wilson advised that the outpatient improvement programme should also include a review of the management of outpatient services across the organisation, to ensure efficient use of existing capacity to meet demand. Mr Elek advised the board as to the key workstreams within the improvement programme, including operational issues and the longer term strategy. It was agreed that a further update on the outpatient strategy would be presented to the next Board meeting.

R Elek
June 2015

15.05.17 Finance report

Mr Bolam presented a tabled summary of month 1 financial performance, advising that a more detailed report would be available for the finance and performance committee meeting the following week. Mr Bolam introduced a new format for the monthly report and invited comment on the format. He then highlighted key messages for month 1 position, including deficit of £1.1m adverse to the plan. The reasons for this adverse position were summarised as being:

- reduced activity levels, particularly in outpatients: it was noted that this needed to be investigated and an explanation provided to the finance and performance committee through the weekly activity tracking;
- pay costs: there had been encouraging signs that pay controls were beginning to have an effect, showing a downward trend in pay costs. However it was noted that this was not sufficient to meet the in-year CIP requirements and there remained some variances in pay budgets which needed to be resolved;
- non-pay costs: the trend remained adverse and this required further investigation;
- CIP performance: month 1 had seen underperformance against pay CIPs.

Mr Bolam reported that capital expenditure had been under budget and that this would benefit in the case of projects funded by trust capital, however where the project was externally funded this was not positive. He advised that a cash forecast would be presented to the finance and performance committee the following week, but if the month 1 position were to prove typical for the rest of the year then additional cash would be required during the year. He confirmed that the working capital facility of £25m remained in place and would be drawn down in July.

Mr Smallwood summarised what he took to be the overall messaqe from this – that the run-rate controls were having an effect but not sufficiently, as well as activity continuing to be down against plan which was a continuation of the position in quarter 4 of 2014/15. Therefore there remained a gap between income and expenditure. Mr Bolam agreed that the trend was changing albeit to an insufficient level to meet the current plan. He agreed to present a more detailed explanation regarding income to the next finance and performance committee. **S Bolam June 2015**

Ms Wilton noted that the medicine and cardiology division was already £800,000 behind plan and asked how such a deterioration against an agreed plan could happen in one month. Mr Bolam explained that there was a need to review the income variance in that division, especially in special medicine outpatients.

Ms Wilton challenged that the division should be providing this explanation as it was their business, but Mr Bolam advised that due to delays in setting budgets it was harder for divisions to understand their respective positions; normally they would be expected to provide such explanations. It was noted that budget sign-off was not yet complete at individual budget holder level, however this would be completed for month 2. Mr Scott assured the board that divisions were aware of their respective issues and had discussed them with executive colleagues.

Mr Rappolt expressed his concern that CIP underperformance would not be recovered later in the year and therefore recommended that the board needed to be realistic about the underlying position.

Ms Wilton noted the reduction in income but opined that costs should therefore also be flexed down to reflect the reduced income. The divisions should be asked to respond to this challenge.

Mr Smallwood agreed that the concern was a continuing trend from 2014/15 – it was important to note some improvement but that improvement was not sufficient. There also remained concerns about the financial management capacity at divisional level. Mrs Pantelides agreed with this, noting that the divisions needed to be able to understand their income and expenditure and forecasting, and then to be able to respond to those forecasts. Mr Bolam reported that progress had been made in forecasting activity, including the introduction of a weekly activity tracker; he agreed that the challenge was in the use of that information and agreeing a response to the information available.

All board members were invited to attend the finance and performance committee meeting the following week to further their understanding and to challenge.

15.05.18 Workforce performance report

Mrs Brewer presented the workforce report for month 1, highlighting key points. She highlighted that requests for temporary staff had now been included in the report as well as the overall cost to provide more accurate information to the

board. However she also advised that the vacancy control figures should be treated with caution as they needed further analysis.

Mrs Brewer highlighted an increase in turnover versus the target of 'steady state'. More intelligence regarding this had been discussed at the workforce committee, including information from exit surveys. The key reasons for staff leaving included the work that they were expected to do and the quality of staff relationships. The workforce committee was therefore focusing on these areas in terms of retaining staff.

The board noted the current level of performance in level 3 safeguarding training and asked for assurance that performance would be improved following a pause in the delivery of training. Mrs Brewer confirmed that the training system was now operational once again. She advised that the risk was the recording of training and the identification of appropriate staff groups. But also additional training resources had been brought on stream. Ms Hall confirmed that monitoring of incidents would identify any causal link with training, but there was no evidence of any link to date.

Dr Hulf referred to the medical staffing report discussed at the quality and risk committee and asked for more information regarding the identified gaps in staffing, especially junior doctors. Mrs Brewer confirmed that various data was being collated regarding junior doctors and would review that via the workforce committee and board.

Mr Rappolt highlighted the high turnover in the community services division, but few quality metrics available to the Board, and asked therefore how the board could be assured that the high turnover was not having an adverse effect on quality. Ms Hall confirmed that Mrs Brewer was supporting the division and she was aware of quality issues in the division, such as offender healthcare, and executive colleagues were supporting the division to address such issues. She assured the board that there was good intelligence and action was being taken. Mr Wilson also summarised the recently introduced system of divisional self-assessment and escalation and support mechanisms in place for divisions. Mr Rappolt recommended that more community quality measures were included in the quality report.

Report from the workforce committee

Mrs Pantelides presented a summary of key messages from the last workforce committee meeting, including:

- Workforce planning: the committee had noted the importance of workforce planning, particularly at 'ground level' to ensure ownership of the numbers. Work was required to agree budgets and workforce numbers;
- Nursing recruitment and retention: the committee had considered the data from the leavers survey, noting that 53% of staff leaving said that it was because of their perception of the line management or how they were treated. The committee had noted that this was positive in that this was something that the trust could improve. This added emphasis to the board development session to follow on culture and leadership;
- Agency costs: the committee had reviewed performance against the target of 3.5% and Mrs Pantelides cautioned the board to be realistic regarding achievement of the target.

Mrs Brewer
June 2015

Mrs Pantelides confirmed that recommendations were being followed up by the committee and the board agreed that the recommendation regarding agency

costs should be discussed with executive colleagues.

15.05.19 Mutually Agree Redundancy Scheme (MARS) scheme

Mrs Brewer presented the proposal to the board, seeking approval for the implementation of this national scheme. She noted the importance of transparency and equity of process for all staff and that the proposals reflected comments by Gail Adams, public governor.

Ms Wilton asked how such a scheme supported the trust's need to reduce turnover and increase recruitment. She expressed her concern that there was no area of over-staffing in the trust and therefore no need to lose staff. Mrs Brewer reminded the board that this was one of the downside mitigation actions previously agreed by the board; she assured the board that certain groups of staff would be excluded if operational requirements demanded and advised that this scheme would enable the trust to change its workforce profile through redeployment as well as leading to savings.

Mr Scott advised that there was no conflict – there were shortages in some areas and there were some areas where there was an excess of staff. In communicating the scheme there was a need to be clear about where the scheme was being targeted and why. Mrs Pantelides agreed that the scheme provided a tool which would enable a reduction in turnover and assist in the driving through of efficiencies.

The board approved the implementation of the scheme.

15.05.20 Annual plan 2015/16

Mr Elek presented the final version of the plan submitted to Monitor, for the board to note. The board noted that the narrative part of the plan was as approved by the board at the last meeting. The board also noted and endorsed the submission of the declarations which had been agreed on behalf of the board by the finance and performance committee.

The board noted that the trust would receive feedback on the plan from Monitor, in due course.

Dr Hulf asked for more explanation of the plans for e-triage in due course. It was agreed that this would be included in the outpatients strategy report being considered by the board at its next meeting. **R Elek June 2015**

The board noted the plan.

15.05.21 Annual accounts 2014/15

Mr Rappolt gave an oral report from the last audit committee meeting.

The committee had met on 26th May primarily to consider the annual financial accounts (2 sets), quality accounts and annual report. He advised that board needed to rely on the External Auditors Opinion when considering the accounts. The committee had therefore reviewed the External Audit's opinion on the accounts, learning that the auditors were satisfied with the Financial Accounts in all but one area – the going concern test. The board accepted that the trust's cash forecast for the coming year is such that it has had to apply to Monitor for an additional facility of £52m. The trust was therefore only a going concern on the basis of receiving that additional financial support.

The trust had not yet had confirmation from Monitor that this would be approved so the external auditors had highlighted this as a material uncertainty in their formal opinion. Subject to this qualification which the trust has fully disclosed and the incorporation of a number of additional minor changes the committee recommended the board approval of both sets of Financial Accounts.

Mr Rappolt explained the role of the committee in respect of the Quality Accounts – to assure itself that the underlying data upon which the Quality Accounts are based is sound. Again the committee relied on the assurances of the external auditors in this respect. They reported that they had tested two quality indicators and found them to be satisfactory; however they were unable to test the third, the local indicator selected by the governors, as the Trust did not have auditable data for this indicator. The board noted that the quality and risk committee had reviewed and signed off the content of the Quality Accounts. The committee recommended the Quality Account to the Board for approval.

Mr Rappolt also advised that the committee had reviewed the draft annual report, noting that it had been drafted as prescribed by Monitor, at the same time as the Accounts. The committee had congratulated the trust management on this achievement. The annual report was considered by the committee from the perspective of whether it accurately reflected the Accounts and was consistent with them and in particular did not provide any forecast information which was not already contained in the accounts. Again the committee relied on the opinion of the external auditors and, subject to a few minor amendments and edits, the committee recommended them to the Board for approval.

The Letter of Representation had been considered by the Audit Committee. This is a letter to the Auditors signed by the chief executive on behalf of the Board in essence confirming that the board had disclosed all that it should to the auditors before they issue their audit opinion. The committee was satisfied that the chief executive could sign this letter on behalf of the board but had pointed out that because the non-executive directors are not as close to the business as the executive directors it was normal commercial practice for the chief executive on behalf of the executive directors to issue a back to back Letter of Representation to the non-executive directors. Mr Jenkinson confirmed that this had been drafted and would be shared with the chief executive for approval.

P Jenkinson / M Scott June 2015

Mr Rappolt reported that two other matters had been considered by the committee:
The committee considered the Fire Safety Annual report that will come to the Board next month, noting the progress made in this area and that as a result the London Fire Brigade had lifted its fire enforcement notices. However the committee was still very concerned at the slow progress in appointing Fire Wardens, with only 250 out of an estimated requirement of 850 appointed to date. The committee had asked for justification of the stated requirement of 850 but also reminded the executive team that they agreed to find ways of increasing the number of Fire Wardens a couple of months ago but this does not seem to have had the required result.

The committee also received an Internal Audit report on how the partnership between the Trust and University was progressing. The report presented a mixed picture of achievement. As the report had not addressed the value for money question it had been agreed for the report to be resubmitted to the next meeting. It was noted that the report had been shared with executive colleagues in the university but not with Prof Kopelman, so this needed to be done.

The board approved the two sets of accounts, the annual report and the quality account.

15.05.22 Risk and compliance report

The board received and noted the risk report, noting the most significant risks from the board assurance framework and noting that the controls for the most significant risks had been picked up in discussions through the agenda.

Mr Jenkinson outlined the approach to reviewing the risks on the framework, agreed by quality and risk committee, which would enable a 'deep dive' review of individual risks and assurances and therefore provide the board with greater assurance around the management of risks. The board noted the output of the first risk review using this methodology – the risk of impact on quality from cost savings.

15.05.23 Board governance statements

Mr Jenkinson presented and explained two of the annual governance statements that the board was required to submit to Monitor. These statements related to compliance with corporate governance best practice.

Mr Rappolt asked about the circulation of the Monitor's monthly bulletin and audit trail of actions being taken. It was agreed that the monthly bulletin should also be circulated to non-executive directors and that a formal audit trail of actions taken should be established. **P Jenkinson June 2015**

The board discussed the development of the assurance framework, which would provide the board with ongoing assurance to enable the board to confirm compliance with governance statements. It was noted that the assurance framework would be based on Monitor's 'Well-led' framework. More detailed proposals would be presented to the quality and risk committee. **P Jenkinson July 2015**

15.05.24 Use of the trust seal

The board noted that the trust seal had not been used during the last period.

15.05.25 Questions from the public

Mike Grahn referred to the auditor's inability to audit community outcome indicators due to lack of auditable data and asked whether the board had assurance regarding the quality of community services. Ms Hall assured the board that lessons had been learnt from this process, but also assured the board that process measures for community outcomes existed. Mr Bolam added that there were a number of key performance indicators relating to community services in the contract, but the challenge would be to ensure there were auditable indicators. There was also a national initiative ongoing to identify suitable indicators for community services.

Gail Adams referred to the media story mentioned earlier in the meeting by Mr Smallwood, regarding a Philippine nurse. She reported that in this case the recruitment controls had been poor and it was impossible to mitigate against individual criminal acts, but she stressed the contribution which international nurses and health workers made to the NHS and suggested that this needed to be celebrated. Gail also recommended that the trust implement initiatives such as 'Just say thanks' to help in recruitment and retention. Mrs Brewer agreed and confirmed that this was a priority for the team.

Gail raised the likely cost of revalidation of nurses as a significant risk which the board should be aware of, with implementation due in April 2016. She advised that the trust should learn from pilot sites such as Guy's and St. Thomas'. Ms Hall confirmed that she was a member of a London wide group considering the implications and would work these through with Mrs Brewer.

15.05.26 Any other business

There was no other business.

15.05.27 Date of the next meeting

The next meeting of the Trust Board will be held on 25 June 2015 at 9.00am.

St George's University Hospitals NHS
NHS Foundation Trust

Matters Arising/Outstanding from Trust Board Public Minutes
25 June 2015

Action No.	Date First raised	Issue/Report	Action	Due Date	Responsible officer	Status at 25 June 2015
14.273	18.12.14	Chief Executive's Report: St George's – Partners in the African Patient Safety Movement	Process for approving similar future initiatives to be agreed	TBC	Miles Scott (Yvonne Connolly)	The project with the Komfo Anoyke Teaching Hospital (KATH) in Ghana has been delayed because of staff changes at their end. The charity that has funded the project is aware of the delays and working to help KATH to resolve their issues.
14.274	18.12.14	Quality and Performance Report	Board session on Mortality to be arranged as part of Board development programme	TBC	Peter Jenkinson	Date to be confirmed
15.005	29.01.15		Process for 'special measures' to be shared	August 2015	Jennie Hall	Model being worked through, Quality Inspection Process recommenced on the 1st June, Quality Standards Steering group also established.
1 5.02.14	26.02.15	Matters Arising-Outpatients	RE chairing the outpatients steering group – to report back regarding outpatient strategy	June 15	Rob Elek	ON AGENDA
15.03.04	26.03.15	Workforce Report	It was agreed to have two board development sessions – one on embedding the values (to cover bullying and discrimination) and one on developing leaders.	TBC	Wendy Brewer	
15.04.19	28.04.15	Quarter 4 corporate objectives monitoring	Alignment of demand and capacity is still 'red'. With so many objectives it is difficult to measure achievement-recommended more us of indicators and measures was needed for 2015/16	July15	Rob Elek	

15.05.14	28.05.15	Matters Arsising	Report on the conclusion of the Joint investigation with commissioners into ED & RTT	June 15 (deferred to July 15)	M Wilson	
15.05.16	28.05.15	Performance Report	Cancer performance – to review the implementation of IT system agreed with the commissioners.	July 15	S Bolam	
15.05.16	28.05.15	Quality Report – Safety Domain	It was agreed that a process of triangulating and monitoring a core set of indicators on a weekly basis – the Board seminar to focus on pulling this together	TBC	S Mackenzie / J Hall / P Jenkinson	
15.05.16	28.05.15	Quality Report – Experience Domain	Further detail regarding examples of service user experience / cancelled operation in day surgery incidents.	June 15	J Hall	Verbal Update
15.05.16	28.05.15	Quality Report – Well Led Domain	Recruitment plan – Refreshed recruitment target to be reported at next board	June 15	W Brewer / J Hall	The Nursing Work / Productivity programme is being reviewed and re-established. The recruitment target will be understood once this is completed and also the work to align the ESR/ Ledger which will strengthen understanding of the vacancy profile.
15.05.16	28.05.15	Report from Quality & Risk Committee	Update on outpatient strategy	June 15	R Elek	ON AGENDA
15.05.18	28.05.15	Workforce performance report	More community quality measures to be included in the quality report	June 15	J Hall	The community scorecard is already within the Quality Report.
15.05.18	28.05.15	Report from the Workforce committee	Recommendations regarding agency costs to be discussed with executive colleagues	June 15	W Brewer	
15.05.20	28.05.15	Annual Plan 2015/16	Plans for e-triage to be included in the Outpatient strategy report.	June 15	R Elek	ON AGENDA
15.05.21	28.05.15	Annual accounts 2014/15	Letter of representation to be shared with the chief executive for approval	June 15	P Jenkinson / M Scott	

15.05.23	28.05.21	Board of governance statements	Monthly Monitor bulletin and audit trail to be circulated to non-executives directors and formal audit trail of actions to be established	June 15	P Jenkinson	

St George's University Hospitals NHS
NHS Foundation Trust

MEETING OF THE TRUST BOARD

25 June 2015, 11.00 – 14.30

H2.5 Board Room, 2nd Floor, Hunter Wing

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

Christopher Smallwood, Chair

		Presented by	
1.	**Chair's opening remarks**		11.00
2.	**Apologies for absence and introductions** Martin Wilson		
3.	**Declarations of interest** *For Members to declare if they have any interests as individuals or members of other organisations that might relate to Trust business or items on the agenda.*	C Smallwood	
4.	**Minutes of the previous Meeting** *To receive and approve the minutes of the meeting held 28 May 2015*	TB (M)	
5.	**Schedule of Matters Arising** *To review the outstanding items from previous minutes*	TB (MA)	
6.	**Chief Executive's Report** *To receive a report from the Chief Executive, updating on key developments*	M Scott TB June 15 - 01	
7.	**Quality and Performance**		11.30
7.1	**Quality and Performance Report** *To receive assurance regarding actions being taken to improve the quality of care for patients and to review the Trust's operational performance report for Month 2*	J Hall/S Bolam TB June 15 - 02	
	To receive a verbal report from the Quality & Risk Committee seminar held on 24 June 2015	Sarah Wilton	
7.2	**Finance Report** • *To receive the finance report form month 2* • *To receive an oral report from the Finance & Performance committee held on 24th June 2015*	S Bolam TB June 15 - 03	
7.3	**Workforce Performance Report** *To received month 2 workforce report*	W Brewer TB June 15 - 04	
	BREAK		12.45
8.	**Strategy**		12.55
8.1	**Divisional presentation – Children's & Women's Diagnostics, Therapeutics and Critical Care** (To be tabled)	A Rhodes	
8.2	**Outpatient Strategy** *To approve & update*	R Elek TB June 15 - 05	
8.3	**Planning performance agreement** *To approve the legal agreement for outline planning application*	E Munro TB June 15 - 06	
9.	**Governance**		13:45

9.1	**Risk and Compliance Report** *To review the Trust's most significant risks and external assurances received*	P Jenkinson TB June 15 - 07	
9.2	**Annual Health & Safety report**	E Munro TB June 15 - 08	
9.3	**Annual Fire Safety report**	E Munro TB June 15 - 09	
9.4	**Board governance statements for approval** *To approve submission of corporate governance statements*	P Jenkinson TB June 15 - 10	
10.	**General Items for Information**		14:15
10.1	**Use of the Trust Seal** *To note use of the Trust's seal during the period (June 2015)* • **The seal was used on one occasion in June 2015. (Trident Business Centre QMR Medical Records)**		

10.2 Questions from the Public

Members of the public present are invited to ask questions relating to business on the agenda. Priority will be given to written questions received in advance of the meeting.

11. Meeting evaluation

12. Date of the next meeting - *The next meeting of the Trust Board will be held on 30 July 2015 at 9.00am.*

MINUTES OF THE TRUST BOARD

28th May 2015
H2.5 Board Room, 2nd Floor, Hunter Wing, St George's Hospital

Present:	Mr Christopher Smallwood	Chair
	Mr Miles Scott	Chief Executive
	Mr Steve Bolam	Director of Finance, Performance and Informatics
	Mrs Wendy Brewer	Director of Human Resources and Organisational Development
	Ms Jennie Hall	Chief Nurse
	Mr Peter Jenkinson	Director of Corporate Affairs
	Dr Simon Mackenzie	Medical Director
	Mr Eric Munro	Director of Estates and Facilities
	Ms Stella Pantelides	Non-Executive Director
	Mr Martin Wilson	Director of Improvement and Delivery
	Mr Rob Elek	Director of Strategy
	Ms Sarah Wilton	Non-Executive Director
	Mr Mike Rappolt	Non-Executive Director
	Professor Peter Kopelman	Non-Executive Director
	Dr Judith Hulf	Non-Executive Director
In attendance:		
Apologies:	Mrs Kate Leach	Non-Executive Director

15.05.11 Opening remarks

Mr Smallwood welcomed the governors and members of public present. He reminded all present that this was a meeting of the Board in public rather than a public meeting. However members of the public present would be given the opportunity to raise questions at the end of the meeting.

15.05.12 Declarations of interest

No declarations of interest were noted in relation to this meeting's agenda.

15.05.13 Minutes of the previous meeting

The minutes of the meeting held on 30 April 2015 were approved as an accurate record. Mr Rappolt identified several instances of where actions should have been recorded from the minutes, such as mortality at QMH (page 3) and team brief (page 2)

P Jenkinson June 2015

15.05.14 Schedule of Matters Arising

The board received and noted the schedule of matters arising, noting updates given on the schedule.

It was agreed that the action regarding the African Partnership could be closed and that a board development session on mortality would be arranged.

Mr Wilson reported that the joint investigation with commissioners into ED and RTT would be concluded by the end of the following week so would be reported to the next board meeting.

M Wilson June 2015

The board noted the actions arising from the annual plan discussion at the previous meeting, and the chairman confirmed the status of the plan – it was confirmed that the trust had agreed a plan as the output of planning work to date; however this plan would be subject to change following the conclusion of the Monitor's investigation.

The board noted that the first of the two workforce workshops was taking place that day.

15.05.15 Chief Executive Report

The Board received and noted the chief executive's report. Mr Scott highlighted the appointment of Adam Doyle as chief officer of Merton clinical commissioning group, the appointment of a new head of learning at St. George's university and the election results for the local constituencies, including the appointment of Jane Ellison to the cabinet. He also reported on the opening of the Gordon Smith ward and the start of filming for a new series of '24 hours in A&E'.

Ms Hall also highlighted the recent international nursing day which celebrated the the contribution of nurses and demonstrated the embedding of the trust values.

15.05.16 Quality and performance report

Performance report

Mr Bolam presented the performance report for month 1, highlighting a change in the format of the Monitor ratings page and explaining the ratings. He reported that the trust's governance rating was currently 'under review' due to the ongoing Monitor investigation. However the trust rating would be a '4' due to ongoing areas of underperformance, including ED, RTT and Cancer. It was also noted that the rate of cancelled operations was also rising.

It was noted that ED performance had shown signs of improvement but was not yet consistent. The board noted that the joint investigations with commissioners into ED and RTT were due to report in the next month and would be presented to the Board once published.

Mrs Pantelides raised concerns that continued failings in cancer performance demonstrated a systemic failure rather than merely a 'blip'. Mr Bolam agreed that there was a systemic issue with achieving the 62 day standard as the standard had not been achieved for the past two quarters. One of the reasons for this was the dependency on other trusts and therefore the need for a written agreement between providers regarding how shared breaches should be allocated. It was agreed that a more detailed paper, including an action plan to address performance, would be presented to the next Finance and Performance committee meeting. Mr Bolam added that the focus was currently on resolving **S Bolam June 2015**

Mr Rappolt challenged the timeliness of the trust's response to address the cancer underperformance. Mr Bolam explained that the focus had been on resolving any internal process issues through the implementation of IT system and investment in the cancer team. However there was also a need to work with the system, engaging with partner trusts. While the trust and south west London was in no worse position than other parts of London there was a need to do something different as a system. The board noted that the trust had agreed with commissioners to implement another model, such as that in operation in north London. It was agreed that this would be reviewed again in July. **S Bolam June 2015**

Mr Wilson reported that in respect of other specialties he was meeting with them to agree plans. He advised that performance may deteriorate further in the short term before progress is made to clear the backlog in the next four weeks, with additional capacity coming on stream. It was agreed that this would be reviewed by the finance and performance committee. **M Wilson June 2015**

Mr Smallwood expressed his concern that trajectories for improved ED performance had been revised a number of times but had not been met, so asked for assurance that this latest trajectory would be met. Mr Wilson explained that there continued to be pressure on the ED, particularly in the level of attendance and admission of over 70 year olds. There had also been issues with repatriating patients to other local hospitals but that this should be improved in the next year due to contractual changes. The trust was also working with social services to improve access to social care facilities. He advised that an output of the joint investigation would be a revised trajectory which all parties signed up to, and an action plan to improve performance.

Mr Scott advised that the purpose of the joint investigation was to develop plans for sustainable performance within the system, including capacity and transformation within acute, primary and social care. He added that the revised trajectory and assurance on delivery should be developed through the finance and performance committee. **M Wilson June 2015**

Prof Kopelman asked whether the reason for increased cancellations was clinical capacity. Mr Bolam clarified the data presented and the difference between the rate of cancellation of procedures and the proportion of those cancelled patients who are then not rebooked. The data showed that a small proportion of those patients cancelled are not rebooked within 28 days. Mr Wilson added that less than 1% of patients were having their procedures cancelled. Mr Scott agreed that the surgery division would be asked for an explanation of the causes of cancelled procedures, for the next finance and performance committee. **M Wilson June 2015**

Mr Rappolt shared the board's concerns that these three standards were consistently being missed and recommended that trajectories for improvements in each standard were agreed by the finance and performance committee. He accepted that the percentage of procedures being cancelled was low but cautioned that it was poor experience and worrying for individual patients.

Mrs Pantelides raised concerns regarding the rising number of never events and asked how the board receives assurance around the effectiveness of actions taken in response to incidents, citing repeated incidents involving retained swabs. Ms Hall explained that the incidents of retained swabs were not identical in nature, and were down to individual error which no system could eliminate.

Quality report

Ms Hall presented the report and highlighted key points in each section. Overall Ms Hall felt that the trust was holding a steady position regarding quality and making progress in some areas, but that focus needed to be applied to the increase in serious incidents and in monitoring mortality rates.

<u>Effectiveness domain</u>

The board noted areas of non-compliance with NICE standards. Ms Hall confirmed that these areas had been picked up with the respective services and improvement monitored through the clinical effectiveness committee.

Safety domain

The board noted the ongoing increase in serious incidents, though not a significant increase and including nine incidents relating to London Ambulance Service handover breaches in the last period. It was noted that the themes of serious incidents were reviewed by the quality and risk committee.

The board also noted that two cases of MRSA bacteraemia infections had been reported year to date – one case related to line care and the other case involved a seriously ill patient who elected to face the risk of line insertion. It was therefore noted that, although there had been a 12 month gap since the last infection caused by line management, there was a need to reinforce the importance of catheter line management.

Mr Smallwood reiterated the need to monitor any impact on, or any rising trends in, quality from the trust's challenging financial position and that the board should continue to ask itself the right questions regarding risks to quality. Prof. Kopelman reflected on discussions at the quality and risk committee the previous day and opined that there were a number of related indicators that could be used proactively to monitor the impact, such as safe staffing and the ward heat map.

Ms Hall confirmed that a process of triangulating and monitoring a core set of indicators on a weekly basis had been implemented. It was agreed that a board seminar should focus on bringing this together. **S Mackenzie, J Hall, P Jenkinson tbc**

Mr Rappolt recommended a simpler presentation of the VTE data in the report and clarity over the key messages to the board.

Experience domain

The board noted that the friends and family test scores were showing a continuing improvement and noted the quarterly report on complaints which showed that the trust had achieved the target for responding to complaints where an extension had been agreed. The target without extensions included had, however, not been achieved despite divisional assurances that it would. The board noted the positive trend in reducing numbers of complaints received.

Mr Rappolt welcomed the insertion of examples of service user experience in the report and highlighted the example involving cancelled operation in day surgery, asking for more detail as to how this incident could occur. Ms Hall agreed to give more detail at the next meeting. **J Hall June 2015**

Well-led domain

The board noted the ward heat map and that the assurance processes regarding staffing levels were being reviewed to ensure that they remained robust.

Mr Smallwood asked for an update on progress against the recruitment plan and in particular asked for assurance regarding the robustness of the trust's checks on staff recruited from overseas, following a recent national media story. Ms Hall confirmed that the trust had received assurances regarding the checks made by international recruitment firms. She reported that recruitment was ongoing, with numbers reported via the workforce report and monitored by the workforce committee. Mrs Brewer reported that the original target of 400 additional appointments over and above the 500 routinely appointed each year was now being reviewed in the light of revised capacity plan. It was agreed that a refreshed target would be reported to the board. **W Brewer /J Hall June 2015**

Report from quality and risk committee
Ms Wilton presented a summary of key points raised at the last quality and risk seminar.

Corporate outpatient improvement programme: the committee had received an update, noting that the 10 month improvement programme was now closed and all work underway had been transferred to business as usual. In general good progress had been made to improve quality across all key workstreams and the committee was assured that oversight was now incorporated in the Outpatient Strategy Board chaired by Rob Elek.

However, the committee had noted that availability of medical records for all outpatient appointments had deteriorated once more, with rates as low as 90% recorded following reduction of records storage on site. The committee was assured that considerable effort is being devoted to returning the rate to 97/98%, with current rate at 95%.

Maternity pathways: The committee had picked up this issue from the audit committee and was very concerned that IT and process developments to ensure that the mother and baby discharge reporting process is safe and complete and links securely to community services are not yet complete and are unlikely to be in place now until 2017. The trust would shortly be the only trust in London using the old system which involves manual processes and faxing details of discharges. There was a back-up system in place but is cumbersome and prone to error, especially at nights and weekends. The committee urged the children's and women's division to expedite the system improvement and the committee would monitor progress.

Safe medical staffing: the committee had discussed a report on safe medical staffing, focussing particularly on numbers and seniority of staff working in acute specialties and across the Trust out of hours. The report had identified a number of areas of concern:

- medicine has a significantly lower doctor to patient ratio compared to surgery, at night and at weekends - staff feedback is that current levels are not sufficient during out of hours period;
- the trust does not operate a critical care outreach service which many organisations use as an adjunct to assist out of hours teams in rapid escalation and admission to intensive care for the deteriorating patient
- some specific services are showing particular stress, as evidenced by high locum expenditure, reporting of staffing-related adverse incidents, difficulty in meeting London Quality Standards

The committee was pleased to note those services which had been innovative in redesigning their medical teams and using the alternative workforce to manage quality demands better. Those services with a high level of consultant presence are delivering the Consultant of the Week model and have lower rates of serious incidents. The committee noted that a number of actions were being taken forward as a result of this review, and the committee would monitor progress.

The committee had noted an outstanding action from the March meeting, relating to the issue of quality assurance for services provided on remote sites. The committee had expressed its concern that this long-standing quality risk had not yet been closed down, especially given the increasing level of activity being sub-

contracted to these remote private hospital sites. Ms Hall had agreed to report progress at the next meeting.

Serious Incidents: the committee had examined the current position and considered the six monthly thematic review by the Patient Safety manager. The committee had been very concerned to see continuing incidents relating to failure to follow up diagnostic tests, despite the assurances being sought by the medical director from each service. Dr Mackenzie was following up.

The committee had also reviewed and challenged the monthly quality report, and had welcomed continuing improvements in the ward heat map reporting and analysis showing how this data is being used to drive quality improvements. However, the committee discussed at length how improving data capture and analysis is enabling much better triangulation of serious and adverse incidents, complaints, safe staffing, safety thermometer and other measures: this needed to be a priority area for quality leadership in the trust. The committee had been concerned to note two MRSA cases already this year, and never events including one (old incident) identified that week.

Risk management: the committee had convened an additional meeting to complete a deep dive review of one of the trust's key risks, the impact of CIP programme on quality – testing the controls and assurances in place for this risk. This programme of deep dives and challenges of the assurances will continue, prioritised for high risks. Ms Wilton invited all board members to attend the next committee seminar meeting, with the focus of the meeting being a deep dive into the key capacity risks, including the physical capacity and the workforce capacity risks. There would also be a regular quality risk presentations from divisions.

Mr Rappolt questioned whether there was a disconnect between the outpatient improvement plan and the quality and performance report. Mr Wilson advised that the outpatient improvement programme should also include a review of the management of outpatient services across the organisation, to ensure efficient use of existing capacity to meet demand. Mr Elek advised the board as to the key workstreams within the improvement programme, including operational issues and the longer term strategy. It was agreed that a further update on the outpatient strategy would be presented to the next Board meeting.

R Elek
June 2015

15.05.17 Finance report

Mr Bolam presented a tabled summary of month 1 financial performance, advising that a more detailed report would be available for the finance and performance committee meeting the following week. Mr Bolam introduced a new format for the monthly report and invited comment on the format. He then highlighted key messages for month 1 position, including deficit of £1.1m adverse to the plan. The reasons for this adverse position were summarised as being:

- reduced activity levels, particularly in outpatients: it was noted that this needed to be investigated and an explanation provided to the finance and performance committee through the weekly activity tracking;
- pay costs: there had been encouraging signs that pay controls were beginning to have an effect, showing a downward trend in pay costs. However it was noted that this was not sufficient to meet the in-year CIP requirements and there remained some variances in pay budgets which needed to be resolved;
- non-pay costs: the trend remained adverse and this required further investigation;
- CIP performance: month 1 had seen underperformance against pay CIPs.

Mr Bolam reported that capital expenditure had been under budget and that this would benefit in the case of projects funded by trust capital, however where the project was externally funded this was not positive. He advised that a cash forecast would be presented to the finance and performance committee the following week, but if the month 1 position were to prove typical for the rest of the year then additional cash would be required during the year. He confirmed that the working capital facility of £25m remained in place and would be drawn down in July.

Mr Smallwood summarised what he took to be the overall messaqe from this – that the run-rate controls were having an effect but not sufficiently, as well as activity continuing to be down against plan which was a continuation of the position in quarter 4 of 2014/15. Therefore there remained a gap between income and expenditure. Mr Bolam agreed that the trend was changing albeit to an insufficient level to meet the current plan. He agreed to present a more detailed explanation regarding income to the next finance and performance committee. **S Bolam June 2015**

Ms Wilton noted that the medicine and cardiology division was already £800,000 behind plan and asked how such a deterioration against an agreed plan could happen in one month. Mr Bolam explained that there was a need to review the income variance in that division, especially in special medicine outpatients.

Ms Wilton challenged that the division should be providing this explanation as it was their business, but Mr Bolam advised that due to delays in setting budgets it was harder for divisions to understand their respective positions; normally they would be expected to provide such explanations. It was noted that budget sign-off was not yet complete at individual budget holder level, however this would be completed for month 2. Mr Scott assured the board that divisions were aware of their respective issues and had discussed them with executive colleagues.

Mr Rappolt expressed his concern that CIP underperformance would not be recovered later in the year and therefore recommended that the board needed to be realistic about the underlying position.

Ms Wilton noted the reduction in income but opined that costs should therefore also be flexed down to reflect the reduced income. The divisions should be asked to respond to this challenge.

Mr Smallwood agreed that the concern was a continuing trend from 2014/15 – it was important to note some improvement but that improvement was not sufficient. There also remained concerns about the financial management capacity at divisional level. Mrs Pantelides agreed with this, noting that the divisions needed to be able to understand their income and expenditure and forecasting, and then to be able to respond to those forecasts. Mr Bolam reported that progress had been made in forecasting activity, including the introduction of a weekly activity tracker; he agreed that the challenge was in the use of that information and agreeing a response to the information available.

All board members were invited to attend the finance and performance committee meeting the following week to further their understanding and to challenge.

15.05.18 Workforce performance report

Mrs Brewer presented the workforce report for month 1, highlighting key points. She highlighted that requests for temporary staff had now been included in the report as well as the overall cost to provide more accurate information to the

board. However she also advised that the vacancy control figures should be treated with caution as they needed further analysis.

Mrs Brewer highlighted an increase in turnover versus the target of 'steady state'. More intelligence regarding this had been discussed at the workforce committee, including information from exit surveys. The key reasons for staff leaving included the work that they were expected to do and the quality of staff relationships. The workforce committee was therefore focusing on these areas in terms of retaining staff.

The board noted the current level of performance in level 3 safeguarding training and asked for assurance that performance would be improved following a pause in the delivery of training. Mrs Brewer confirmed that the training system was now operational once again. She advised that the risk was the recording of training and the identification of appropriate staff groups. But also additional training resources had been brought on stream. Ms Hall confirmed that monitoring of incidents would identify any causal link with training, but there was no evidence of any link to date.

Dr Hulf referred to the medical staffing report discussed at the quality and risk committee and asked for more information regarding the identified gaps in staffing, especially junior doctors. Mrs Brewer confirmed that various data was being collated regarding junior doctors and would review that via the workforce committee and board.

Mr Rappolt highlighted the high turnover in the community services division, but few quality metrics available to the Board, and asked therefore how the board could be assured that the high turnover was not having an adverse effect on quality. Ms Hall confirmed that Mrs Brewer was supporting the division and she was aware of quality issues in the division, such as offender healthcare, and executive colleagues were supporting the division to address such issues. She assured the board that there was good intelligence and action was being taken. Mr Wilson also summarised the recently introduced system of divisional self-assessment and escalation and support mechanisms in place for divisions. Mr Rappolt recommended that more community quality measures were included in the quality report.

Report from the workforce committee

Mrs Pantelides presented a summary of key messages from the last workforce committee meeting, including:

- Workforce planning: the committee had noted the importance of workforce planning, particularly at 'ground level' to ensure ownership of the numbers. Work was required to agree budgets and workforce numbers;
- Nursing recruitment and retention: the committee had considered the data from the leavers survey, noting that 53% of staff leaving said that it was because of their perception of the line management or how they were treated. The committee had noted that this was positive in that this was something that the trust could improve. This added emphasis to the board development session to follow on culture and leadership;
- Agency costs: the committee had reviewed performance against the target of 3.5% and Mrs Pantelides cautioned the board to be realistic regarding achievement of the target.

Mrs Brewer
June 2015

Mrs Pantelides confirmed that recommendations were being followed up by the committee and the board agreed that the recommendation regarding agency

costs should be discussed with executive colleagues.

15.05.19 Mutually Agree Redundancy Scheme (MARS) scheme

Mrs Brewer presented the proposal to the board, seeking approval for the implementation of this national scheme. She noted the importance of transparency and equity of process for all staff and that the proposals reflected comments by Gail Adams, public governor.

Ms Wilton asked how such a scheme supported the trust's need to reduce turnover and increase recruitment. She expressed her concern that there was no area of over-staffing in the trust and therefore no need to lose staff. Mrs Brewer reminded the board that this was one of the downside mitigation actions previously agreed by the board; she assured the board that certain groups of staff would be excluded if operational requirements demanded and advised that this scheme would enable the trust to change its workforce profile through redeployment as well as leading to savings.

Mr Scott advised that there was no conflict – there were shortages in some areas and there were some areas where there was an excess of staff. In communicating the scheme there was a need to be clear about where the scheme was being targeted and why. Mrs Pantelides agreed that the scheme provided a tool which would enable a reduction in turnover and assist in the driving through of efficiencies.

The board approved the implementation of the scheme.

15.05.20 Annual plan 2015/16

Mr Elek presented the final version of the plan submitted to Monitor, for the board to note. The board noted that the narrative part of the plan was as approved by the board at the last meeting. The board also noted and endorsed the submission of the declarations which had been agreed on behalf of the board by the finance and performance committee.

The board noted that the trust would receive feedback on the plan from Monitor, in due course.

Dr Hulf asked for more explanation of the plans for e-triage in due course. It was agreed that this would be included in the outpatients strategy report being considered by the board at its next meeting. **R Elek June 2015**

The board noted the plan.

15.05.21 Annual accounts 2014/15

Mr Rappolt gave an oral report from the last audit committee meeting.

The committee had met on 26th May primarily to consider the annual financial accounts (2 sets), quality accounts and annual report. He advised that board needed to rely on the External Auditors Opinion when considering the accounts. The committee had therefore reviewed the External Audit's opinion on the accounts, learning that the auditors were satisfied with the Financial Accounts in all but one area – the going concern test. The board accepted that the trust's cash forecast for the coming year is such that it has had to apply to Monitor for an additional facility of £52m. The trust was therefore only a going concern on the basis of receiving that additional financial support.

The trust had not yet had confirmation from Monitor that this would be approved so the external auditors had highlighted this as a material uncertainty in their formal opinion. Subject to this qualification which the trust has fully disclosed and the incorporation of a number of additional minor changes the committee recommended the board approval of both sets of Financial Accounts.

Mr Rappolt explained the role of the committee in respect of the Quality Accounts – to assure itself that the underlying data upon which the Quality Accounts are based is sound. Again the committee relied on the assurances of the external auditors in this respect. They reported that they had tested two quality indicators and found them to be satisfactory; however they were unable to test the third, the local indicator selected by the governors, as the Trust did not have auditable data for this indicator. The board noted that the quality and risk committee had reviewed and signed off the content of the Quality Accounts. The committee recommended the Quality Account to the Board for approval.

Mr Rappolt also advised that the committee had reviewed the draft annual report, noting that it had been drafted as prescribed by Monitor, at the same time as the Accounts. The committee had congratulated the trust management on this achievement. The annual report was considered by the committee from the perspective of whether it accurately reflected the Accounts and was consistent with them and in particular did not provide any forecast information which was not already contained in the accounts. Again the committee relied on the opinion of the external auditors and, subject to a few minor amendments and edits, the committee recommended them to the Board for approval.

The Letter of Representation had been considered by the Audit Committee. This is a letter to the Auditors signed by the chief executive on behalf of the Board in essence confirming that the board had disclosed all that it should to the auditors before they issue their audit opinion. The committee was satisfied that the chief executive could sign this letter on behalf of the board but had pointed out that because the non-executive directors are not as close to the business as the executive directors it was normal commercial practice for the chief executive on behalf of the executive directors to issue a back to back Letter of Representation to the non-executive directors. Mr Jenkinson confirmed that this had been drafted and would be shared with the chief executive for approval.

P Jenkinson / M Scott June 2015

Mr Rappolt reported that two other matters had been considered by the committee:
The committee considered the Fire Safety Annual report that will come to the Board next month, noting the progress made in this area and that as a result the London Fire Brigade had lifted its fire enforcement notices. However the committee was still very concerned at the slow progress in appointing Fire Wardens, with only 250 out of an estimated requirement of 850 appointed to date. The committee had asked for justification of the stated requirement of 850 but also reminded the executive team that they agreed to find ways of increasing the number of Fire Wardens a couple of months ago but this does not seem to have had the required result.

The committee also received an Internal Audit report on how the partnership between the Trust and University was progressing. The report presented a mixed picture of achievement. As the report had not addressed the value for money question it had been agreed for the report to be resubmitted to the next meeting. It was noted that the report had been shared with executive colleagues in the university but not with Prof Kopelman, so this needed to be done.

The board approved the two sets of accounts, the annual report and the quality account.

15.05.22 Risk and compliance report

The board received and noted the risk report, noting the most significant risks from the board assurance framework and noting that the controls for the most significant risks had been picked up in discussions through the agenda.

Mr Jenkinson outlined the approach to reviewing the risks on the framework, agreed by quality and risk committee, which would enable a 'deep dive' review of individual risks and assurances and therefore provide the board with greater assurance around the management of risks. The board noted the output of the first risk review using this methodology – the risk of impact on quality from cost savings.

15.05.23 Board governance statements

Mr Jenkinson presented and explained two of the annual governance statements that the board was required to submit to Monitor. These statements related to compliance with corporate governance best practice.

Mr Rappolt asked about the circulation of the Monitor's monthly bulletin and audit trail of actions being taken. It was agreed that the monthly bulletin should also be circulated to non-executive directors and that a formal audit trail of actions taken should be established. **P Jenkinson June 2015**

The board discussed the development of the assurance framework, which would provide the board with ongoing assurance to enable the board to confirm compliance with governance statements. It was noted that the assurance framework would be based on Monitor's 'Well-led' framework. More detailed proposals would be presented to the quality and risk committee. **P Jenkinson July 2015**

15.05.24 Use of the trust seal

The board noted that the trust seal had not been used during the last period.

15.05.25 Questions from the public

Mike Grahn referred to the auditor's inability to audit community outcome indicators due to lack of auditable data and asked whether the board had assurance regarding the quality of community services. Ms Hall assured the board that lessons had been learnt from this process, but also assured the board that process measures for community outcomes existed. Mr Bolam added that there were a number of key performance indicators relating to community services in the contract, but the challenge would be to ensure there were auditable indicators. There was also a national initiative ongoing to identify suitable indicators for community services.

Gail Adams referred to the media story mentioned earlier in the meeting by Mr Smallwood, regarding a Philippine nurse. She reported that in this case the recruitment controls had been poor and it was impossible to mitigate against individual criminal acts, but she stressed the contribution which international nurses and health workers made to the NHS and suggested that this needed to be celebrated. Gail also recommended that the trust implement initiatives such as 'Just say thanks' to help in recruitment and retention. Mrs Brewer agreed and confirmed that this was a priority for the team.

Gail raised the likely cost of revalidation of nurses as a significant risk which the board should be aware of, with implementation due in April 2016. She advised that the trust should learn from pilot sites such as Guy's and St. Thomas'. Ms Hall confirmed that she was a member of a London wide group considering the implications and would work these through with Mrs Brewer.

15.05.26 Any other business

There was no other business.

15.05.27 Date of the next meeting

The next meeting of the Trust Board will be held on 25 June 2015 at 9.00am.

St George's University Hospitals NHS
NHS Foundation Trust

Matters Arising/Outstanding from Trust Board Public Minutes
25 June 2015

Action No.	Date First raised	Issue/Report	Action	Due Date	Responsible officer	Status at 25 June 2015
14.273	18.12.14	Chief Executive's Report: St George's – Partners in the African Patient Safety Movement	Process for approving similar future initiatives to be agreed	TBC	Miles Scott (Yvonne Connolly)	The project with the Komfo Anoyke Teaching Hospital (KATH) in Ghana has been delayed because of staff changes at their end. The charity that has funded the project is aware of the delays and working to help KATH to resolve their issues.
14.274	18.12.14	Quality and Performance Report	Board session on Mortality to be arranged as part of Board development programme	TBC	Peter Jenkinson	Date to be confirmed
15.005	29.01.15		Process for 'special measures' to be shared	August 2015	Jennie Hall	Model being worked through, Quality Inspection Process recommenced on the 1st June, Quality Standards Steering group also established.
1 5.02.14	26.02.15	Matters Arising-Outpatients	RE chairing the outpatients steering group – to report back regarding outpatient strategy	June 15	Rob Elek	ON AGENDA
15.03.04	26.03.15	Workforce Report	It was agreed to have two board development sessions – one on embedding the values (to cover bullying and discrimination) and one on developing leaders.	TBC	Wendy Brewer	
15.04.19	28.04.15	Quarter 4 corporate objectives monitoring	Alignment of demand and capacity is still 'red'. With so many objectives it is difficult to measure achievement-recommended more us of indicators and measures was needed for 2015/16	July15	Rob Elek	

15.05.14	28.05.15	Matters Arsising	Report on the conclusion of the Joint investigation with commissioners into ED & RTT	June 15 (deferred to July 15)	M Wilson	
15.05.16	28.05.15	Performance Report	Cancer performance – to review the implementation of IT system agreed with the commissioners.	July 15	S Bolam	
15.05.16	28.05.15	Quality Report – Safety Domain	It was agreed that a process of triangulating and monitoring a core set of indicators on a weekly basis – the Board seminar to focus on pulling this together	TBC	S Mackenzie / J Hall / P Jenkinson	
15.05.16	28.05.15	Quality Report – Experience Domain	Further detail regarding examples of service user experience / cancelled operation in day surgery incidents.	June 15	J Hall	Verbal Update
15.05.16	28.05.15	Quality Report – Well Led Domain	Recruitment plan – Refreshed recruitment target to be reported at next board	June 15	W Brewer / J Hall	The Nursing Work / Productivity programme is being reviewed and re-established. The recruitment target will be understood once this is completed and also the work to align the ESR/ Ledger which will strengthen understanding of the vacancy profile.
15.05.16	28.05.15	Report from Quality & Risk Committee	Update on outpatient strategy	June 15	R Elek	ON AGENDA
15.05.18	28.05.15	Workforce performance report	More community quality measures to be included in the quality report	June 15	J Hall	The community scorecard is already within the Quality Report.
15.05.18	28.05.15	Report from the Workforce committee	Recommendations regarding agency costs to be discussed with executive colleagues	June 15	W Brewer	
15.05.20	28.05.15	Annual Plan 2015/16	Plans for e-triage to be included in the Outpatient strategy report.	June 15	R Elek	ON AGENDA
15.05.21	28.05.15	Annual accounts 2014/15	Letter of representation to be shared with the chief executive for approval	June 15	P Jenkinson / M Scott	

15.05.23	28.05.21	Board of governance statements	Monthly Monitor bulletin and audit trail to be circulated to non-executives directors and formal audit trail of actions to be established	June 15	P Jenkinson	

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – JUNE 2015

Paper Title:	Chief Executive's Report
Sponsoring Director:	Miles Scott, Chief Executive
Author:	Sofi Izbudak, Corporate Administrator
Purpose: *The purpose of bringing the report to the board*	To update the Board on key developments in the last period
Action required by the board:	For information
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	N/A

Executive summary

1. Key messages

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

- Quality & Safety
- Strategic developments
- Management arrangements

2. Recommendation

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

Key risks identified:

Are there any risks identified in the paper (impact on achieving corporate objectives) – e.g. quality, financial performance, compliance with legislation or regulatory requirements?

Risks are detailed in the report under each section.

Related Corporate Objective: *Reference to corporate objective that this*	All corporate objectives

paper refers to.	
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	N/A
Equality Impact Assessment (EIA): Has an EIA been carried out? Yes **If yes, please provide a summary of the key findings** No specific groups of patients or community will be affected by the initiatives detailed in the report. Where there may be an impact on patients then consultation will be managed as part of that specific programme. **If no, please explain your reasons for not undertaking an EIA.**	

1. Strategy

1.01 Appointment of the Chair for the National Clinical Reference Group for Medical Genetics

I'm delighted to announce that Frances Elmslie – a Consultant Clinical Geneticist who has in the past been Lead Clinician for Clinical Genetics and Clinical Director for Children and Women's at St George's – was appointed to the role of Chair for National CRG for Medical Genetics. Frances will work closely with commissioners in this role and will represent the trust and its strategic goals.

1.02 Appointment of the Managing Director of the Health Innovation Network

Tara Donnelly has been appointed as the next Managing Director of the Health Innovation Network. Tara is an experienced NHS director who has most recently been leading improvement work at University College London Hospitals NHS Foundation Trust. She is also a member of the Board of Macmillan Cancer Support and was formerly Chief Executive of West Middlesex University Hospital.

1.03 Clinical Services Contract with Gibraltar Health Authority

I am pleased to announce that on 5th June 2015 the trust signed a new clinical services contract with the Gibraltar Health Authority (GHA). The trust will supply the GHA with a variety of visiting consultant services, as well as inpatient access to our specialist services, particularly: neurology and neurosurgery; cardiology and cardiac surgery; endoscopy and our bowel cancer screening programme. We expect the GHA to send circa 400 referrals to St George's per year.

1.04 Immigration Enforcement Joint Initiative.

The trust will be working together with the Home Office from Tuesday 26th May 2015 till 21st August 2015. The objective of the joint work – which was developed in collaboration with the trust's Head of Finance and Overseas Visitor teams – is to increase and 'up-skill' administration staff in the identification of potentially chargeable patients.

Non-uniformed immigration officers will be on-site, offering support, advice and training on immigration matters for the duration of the initiative. This builds on a similar approach trialled at a London NHS Trust last year.

The initiative should deliver a number of benefits for the trust, including: earlier and increased identification of chargeable patients generating revenue; potential reductions in waiting times and expenditure on non-urgent and non-necessary treatments; and increased staff awareness and confidence in dealing with immigration matters.

1.05 Genomics Medicine Centre

Good progress is being made on establishing the Genomics Medicine Centre. I am delighted to announce that St George's is the first of the four sites to have gone live with the collection of samples for rare diseases. We collected our first DNA samples this month.

1.06 South West London Commissioning Collaborative

The Acute Provide Collaborative workstream has been updating the work done previously around system demand, capacity and affordability in the revised context of new models of care, particularly out of hospital provision, and the recently surfacing immediate system financial pressures. This work supported the first key workshop for this group on Monday 15th June where the chief executives of all acute providers in SW London considered its implications and agreed a number of workstreams to inform the next workshop in early July; this will lead to the production of a paper for the commissioning collaborative to consider in August. A "Vanguard" bid to develop new models of care across South West London is currently under preparation. Further detail will be available at the Board if required.

2. Academic Development

2.01 CLAHRC

Using the expertise of staff within the CLAHRC, we are pleased to announce approval for a newly established MSc in Implementation and Improvement Science. Staff from the Joint Faculty have worked closely with staff at King's College London to establish this course. The MSc will enable students to identify the best ways to integrate research findings into healthcare policy and practice, and the best strategies for evaluating improvement and implementation in healthcare in a given environment. The first cohort of students is due to start in September 2015.

2.02 Appointment of Director of Medical Education

The Trust has appointed Dr Jonathon Round as the new Director of Medical Education in succession to Dr Cleave Gass. Cleave will continue as Associate Medical Director with an educational remit covering undergraduate, postgraduate and commissioned speciality programmes across London.

2.03 Director of Education and Quality Health Education England: Visit to the SGH and SGUL

On 29th June Wendy Reid the Director of Education and Quality at HEE will be visiting the trust and the medical school.

2.04 Appointment of Principal of St George's University of London.

On 18th June interviews were held for the appointment of the new Principal of SGUL. The successful candidate will be announced in next month's report. I look forward to working alongside the new Principal, and continuing the relationship Professor Peter Kopelman helped build between the medical school and the trust.

3. Workforce

3.01 10 Project Search

The third cohort of 10 Project Search students will complete the scheme in July and this will culminate in an awards event. Each student on the scheme rotates through four different areas of the Trust, learning valuable skills in each placement. Such is the success of the project that many of the students are successful in obtaining full-time employment post scheme.

3.02 Staff development training

Staff on bands 1-4 who have successfully completed Institute of Leadership and Management (ILM) Level 2 in Team Leading, or the ILM Level 3 in First-line Management, or the AMSPAR certificate in Medical Terminology, or who have completed their Clinical Health Level 2 Qualification Certificate Framework will be congratulated in July by Peter Jenkinson, Director of Corporate Affairs, on their hard work and achievements.

3.03 GMC National Training Survey

The results following the GMC national training survey have been received by the Trust. Whilst it appears that workload is an issue in several specialities, there were several highly positive indicators across the trust and we compare very favourably with other large teaching hospitals in South London. The DME will be working with Divisions on the action plans provided by HESL.

3.04 Massive Open Online Course

The Massive Open Online Course (MOOC), from the HESL bid with SGUL for Clinical Genetic goes live on Monday 15th June. Reports from SGUL are that there are 3000+ signed up to undertake it on this first round.

3.05 Award Announcement – Oral Maxillo Facial Surgery Trainer of the Year

Congratulations to Miss Helen Witherow, Consultant in Oral Maxillo Facial Surgery (OMFS), who was voted OMFS trainer of the year in London (as voted for by the trainees), and has subsequently won the National Award.

3.06 Listening into Action

<u>Friends and Family staff survey</u>

Last year we ran the Friends and Family staff survey three times. On the whole, 81% of respondents said they would recommend the trust as a place for treatment and 59% said they would recommend the trust as a place to work. We are currently running the survey for the first of three times this year.

The survey also provides the opportunity for respondents to make free comment. Many of the comments made last year are consistent with those of the annual staff survey. Action to address the issues raised include a renewed emphasis in key areas such as staff ‘health and

wellbeing', tackling bullying and discrimination, improving opportunities for professional development and providing more progression opportunities for staff.

LIAiSE

The LIAiSE service is going from strength to strength having received 163 referrals in its first nine months, plus 71 interactions with staff in theatres. The post holder, Sarah Hemmings, is moving to another role in the trust and recruitment is underway to find her replacement in order to ensure that momentum is maintained and sustained

3.07 Queen's Birthday Honours List

I am delighted to share that Dr Davendra Sharma, Consultant Urologist, is on the honours list. He will receive an OBE for his contribution to the care of military patients with genito-urethral injuries, through the development of the Genital Trauma Programme for severely injured soldiers.

4. Monitor Investigation / Financial Recovery

4.01 Monitor Investigation

Monitor have informed the trust that they are in the process of compiling a proposal for the Provider Regulators Executive in July, which will confirm whether the trust is in material breach of the terms of the licence authorising Foundation Trust status. This proposal will also set out the parameters of what specifically will need to be addressed by the trust, and what action will thus need to be undertaken in order for the trust to improve its financial standing and performance. We are expecting to be sent through a formal timetable for the investigation process by the Monitor team.

Additionally, Monitor have decided to place St George's on monthly monitoring from M2 (May 2015). This requires us to fill in a high level financial template, as provided by Monitor, on a monthly basis.

Independent Accounting Review

PwC have been appointed to conduct an independent accounting review. They completed two weeks of preliminary work and submitted their feedback to Monitor on 17th June, and they are projected to submit a final report of their findings to Monitor in the week commencing 13th July.

Turnaround Support

After a competitive, formal procurement process, KPMG have been appointed to provide the trust with turnaround support for a period of up to 12 months (subject to formal approval of the contract by the Board). The KPMG team – along with our new Turnaround Director Andrew Burn – have been on site since 8th June.

KPMG's support will be in four areas:

- Grip - Establishing more stringent controls over pay and non pay expenditure, bringing best practice to cash flow forecasting/management

- Build - assessment of the CIP governance programme, maturity assessment of the CIP ratings, identification and development of new CIPS (in division and Trust wide schemes)
- Grow/Optimise – focus on Trust, complex restructuring opportunities that may or may not involve collaboration with third parties, corporate cost base review
- Systems – support a rapid reestablishment of finance governance in the short term on a prioritised basis

Briefings

Staff briefings are being held on site in St George's on 22nd and 23rd June. A briefing will also be held at Queen Mary's Hospital Roehampton on 24th June.

A Council of Governors briefing will be held on 30th June.

5. Communications

5.01 Queen Mary's Hospital Centenary Exhibition

The Queen Mary's Hospital Centenary Exhibition will be officially opened on Wednesday 24th June.

This new exhibition created by the Queen Mary's Hospital Museum and Archive Group features pictures, prostheses and personal histories that tell the story of some of the amazing patient stories and pioneering medical developments that have taken place throughout the hospital's 100 year history.

Speakers include Councillor Ravi Govindia, Leader of Wandsworth Council, Sam Gallop CBE, an ex-RAF pilot and double below-knee amputee who has become a committed ambassador on issues surrounding limb loss and Gordon Jones, chairman of the Queen Mary's Archive and Museum Group.

5.02 Annual Report and Accounts 2014/15

The trust has published its Annual Report and Accounts for 2014/15. As we achieved foundation trust status mid-year, we were required to prepare a report that met both the Department for Health and Monitor's statutory reporting requirements. This included providing two sets of financial accounts as an NHS trust and as a foundation trust.

To meet Monitor's reporting requirements we were required to include a Quality Report for our period as a foundation trust. This relates to the quality of services across the entire year, including the time when they were provided by St George's Healthcare NHS trust.

The Annual Report and Accounts for 2014/15 is a comprehensive review of our financial and quality performance throughout the year and reflects the progress we're making against our objectives and aims for the future. It is available on our website as well as in hard copy.

5.03 St George's receives Accreditation HIMSS Stage 6

St George's has been recognised and accredited for its hard work in implementing clinical informatics systems within the inpatient areas of the hospital. We are the first major teaching hospital in the UK to be accredited to HIMSS Stage 6 (stage 7 is the highest achievable) and the first UK trust to be validated through an onsite visit. The Healthcare Information and Management Systems Society (HIMSS) is an international organisation dedicated to improving healthcare quality, safety, cost-effectiveness and access, through the best use of IT.

5.04 Response to the 2014 staff survey

The communications team is supporting the HR and Workforce team on four 'themed' months in response to feedback from the national staff survey. The themed months are designed to improve staff retention rates. The health and wellbeing month is the first and throughout June staff were informed of the services/ initiatives /programmes in place to encourage and support a healthy workforce.

The four themed months are as follows:

1. Health and wellbeing - June
2. Education and development – July
3. Raising concerns and (safe staffing) - September
4. Bullying and harassment – October

5.05 Dietitians Week 08-12/06

The dietetic team used social media to celebrate dietitians week and share photos and details about their work.

During the week Radio Jackie aired an interview with the mother of a patient whose son has successfully been treated at the trust with a special diet which stopped him from experiencing over 100 seizures a day. This story has also been picked up by the Evening Standard and a national news agency.

Also, as part of dietitians week, the trust's principle dietitian, Catherine Collins represented the trust at the British Dietetic Association House of Lords reception. Catherine, who is the BDA England Chair, spoke about the need to raise awareness of the profession and highlight the vital role dietetians play in patient care. On 11/06 the trust and St George's, University of London, hosted a special Dietitians Week public debate with three trust dietitians discussing the pros and cons of sugar. Over 50 people attended and what was meant to be a 60 minute lecture ended up being a 120 minute debate

5.06 Anaesthesia Clinical Services Accreditation

During May/June the Communications team publicised the Anaesthesia Clinical Services Accreditation (ACSA) to staff to prepare them for the visit at the beginning of June. This included posters, tweets, and items on the intranet and in eG. A press release will be issued when the results are officially released. An ACSA pass will be a mark of excellence in anaesthesia. We would be the first trauma centre to achieve this and only the fifth trust in the country to achieve this accreditation.

5.07 Listening into Action

An event to hear what staff think about communications took place on Thursday 21st May. As a result, an action plan is being developed by the team which will be fed back to the attendees. Common themes included improving the intranet, better accessibility of communications for ward-based staff and personalisation of content.

5.08 Reflection and sharing common experiences - Schwartz Rounds

Over 250 staff have attended the first two Schwartz rounds at the trust. These provide staff with an opportunity to discuss the highs and lows of work in a confidential and expertly facilitated environment. Participants can talk about the emotional and social aspects of their jobs, led by a panel of employees chosen from across the trust.

5.09 Media update

To mark the start of a new series of ’24 Hours on A&E’ (Channel 4, 9pm, Wednesday), ED consultant Rhys Beynon appeared on the BBC Breakfast sofa to talk about being in the programme.

Celebrity chef and healthy food campaigner Jamie Oliver visited St George’s Hospital to interview a maxillofacial dental surgeon and to talk to some patients about sugar and dental health. The sugar documentary is due to be aired in June.

In addition to the above, interviews were given to BBC London, ITV, the Evening Standard and BBC Radio 4 about strokes in the under 60s; cardiac risk in the young; the need for more medical students to train as GPs; the anniversary of the helipad and the prescribing of an ovarian cancer drug.

5.10 Dates to note

- Annual General meeting - 9th July
- Council of Governors meeting - 9th July

REPORT TO THE TRUST BOARD Paper ref: TB June 15 – 02a

Paper Title:	Quality and performance Report to the Board for Month 2- May 2015
Sponsoring Director:	Jennie Hall- Chief Nurse/ Director Infection Prevention and Control Simon MacKenzie- Medical Director Steve Bolam- Director Finance/ Performance and Informatics/ Deputy CEO
Authors:	Jennie Hall- Chief Nurse/ DIPC Simon Mackenzie- Medical Director Matt Laundy- Infection Control Lead Corporate Nursing Team Divisional Directors Nursing/ Governance Trust Safeguarding Leads Steve Bolam- Director Finance/ Performance and Informatics/ Deputy CEO Head of Performance
Purpose:	To inform the Board about Quality and Operational Performance for Month 2.
Action required by the board:	To note the report and key areas of risk noted.
Document previously considered by:	Finance and Performance Committee Quality and Risk Committee

Executive summary

Performance

Performance is reported through a number of key performance indicators (KPIs) as per Monitor Risk Assessment Framework. The trust is performing positively against the majority of the indicators within the framework, however existing challenges continue in particular: ED 4 hour target, and RTT waiting time targets. The trust has also failed to meet the cancer two week wait targets in May.

The trust shows quality governance score against the Monitor risk assessment framework of 4 with a governance rating of 'under review'.

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

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

The Overall position in May indicates a steady position 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. This is monitored through the Patient Safety Committee and SIDM.

In relation to quality oversight/ assurance additional measures have been put in place. Weekly oversight of quality metrics has been commenced at Trust and Divisional level. In addition the Quality Inspection programme recommenced on the 1st June, and a Quality Standards group.

The Quality report format is being reviewed to ensure that the report supports clear identification of trends and issues and that there is ability to benchmark against national/ international peers

going forward.

Effectiveness Domain:

- Mortality and SHMI performance remains statistically better than expected for the Trust. Despite this position we continue to proactively investigate mortality signals at procedure and diagnosis level. There have been a number of cardiology signals which are currently being reviewed alongside a wider review of the mortality review processes within the service.
- In relation to locals audits of note the WHO checklist continues to indicate that there are services where the compliance with the audit is below acceptable standards. This is a mandatory safety checklist for all applicable areas in the Trust. Whilst the Majority of services are consistently performing Cardiothoracic services, ENT and Maxillofacial did not with Cardiothoracic the poorest performing for the year. Support is being provided for all services with recognition of services which have performed also being undertaken.
- The consent audit also indicates some progress from the previous audit but also consistent areas where progress is limited. The audit has been considered at PSC with focus on the areas of underperformance with actions being agreed to be taken forward.
- The report indicates the position with compliance with NICE guidance for the period January 2010 to January 2015. Detail is available of all areas where we have declared noncompliance, the reasons for this position and action being taken. Further assurance is being sought in relation to the risk profile; any findings of note will be reported back to the board.

Safety Domain:

- The number of general reported incidents in May indicates a similar profile to previous months with a similar trend in terms of numbers and level of harm. The Board should note that the trend for Serious Incidents indicates a gradual increase. Of those declared for May the Board will note the issues are across a range of clinical issues, some are mandatory in terms of reporting. A further never event has been reported this month, the patient presented in May with clinical symptoms but if confirmed the original incident will have occurred in 2009. A foreign body it is believed has been indicated on a CT scan and this is now being reviewed by the surgical team at the Trust. This incident has to be fully investigated and therefore no conclusions can be drawn at this stage. The Trust has concluded a panel review of previous incidents with recommendations for further work. Progress against the recommendations is being overseen by the Chief Nurse/ Medical Director.
- Safety Thermometer performance increased slightly from April performance. There was a slight increase in patients with old and new pressure ulcers. There was a decrease in other harms reported.
- The pressure ulcer profile for May increased from the April position in terms of grade 3 and 4 ulcers (4 up from 2 cases) with an increase in grade 2 ulcers. Of note progress within the community Division. As previously reported to the board a deep dive review has already been completed in January within both the Surgical and Community Divisions where a number of the Ulcers occurred and actions are being taken forward. The actions include training, use of safety approaches such as “hotspots” to raise awareness and roll out of preventative strategies. The RCA analysis has yet to be completed to understand if the ulcers were avoidable or unavoidable.
- The Trust has now reported 2 MRSA bacteraemia cases and 6 C-Difficile to the end of May. All cases are currently subject to an RCA process.
- Safeguarding Adults activity across Paediatrics and Adults remains significant. The Training profile for Safeguarding Children remains a risk given the activity profile, and number of SCR cases that the Trust is involved with across a number of boroughs. Focus is being placed on further action to improve training compliance particularly at level 3.

Experience Domain:

- Within the report there is some initial triangulation of experience data. This is presented as a summary for May 2015 with a themed summary for Quarter 4 in 14/15. Going forward this will be presented as Trend data alongside a RAG profile to indicate services

of concern and ensure timely response. There is further analysis to be undertaken regarding the themed review which will be brought back to the board once completed. FFT feedback will also be included in this analysis.

- The response rate for FFT increased but response rates for inpatient wards decreased. The overall score for the Trust decreased in May to a score of 91.5%. Themes arising from the FFT responses include noise at night, information about medication side effects and involvement in discharge processes. A more accessible version of the survey has been rolled out to paediatrics and also for users with learning disabilities and where English may not be a first language to improve the capture of feedback.
- The complaints profile is similar to April in terms of numbers. Offender Health is the highest area of complaints, these relate to medication provision; a reduction in complaints within the ED department should also be noted.
- Work has already commenced to review the corporate complaints function alongside review for individual Divisions to determine how turnaround time will be improved.

Well Led Domain:

- The safe staffing return is included for all inpatient areas. The average fill rate for the Trust is 95.50 % across these areas. This is against current staffing figures. This figure is being reviewed alongside other Trust information about run rates, the Trust information for staffing alerts (Red Flags) which has been implemented across the Trust, and Trust Bank information about the temporary staffing profile and fill rates.
- For information NHSE announced in June the suspension of further work regarding safe staffing as it is currently described. Focus will now include outcomes and productivity alongside the staffing numbers. Of note the current safe staffing NICE guidance which is already in practice will continue to be used. The Nursing workforce programme had already been reviewed to understand productivity metrics alongside the establishment review which is currently underway.

Ward Heat map:

The Heat map for May is included in the Report. The detail regarding the profile within the dashboard is included in the report Work continues to develop a trend analysis for the dashboards and Divisional summary dashboards. The community dashboard is contained within the Report. Work has been undertaken to identify areas where there are particular concerns in relation to workforce and Quality indicators.

Key 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

St George's University Hospitals NHS
NHS Foundation Trust

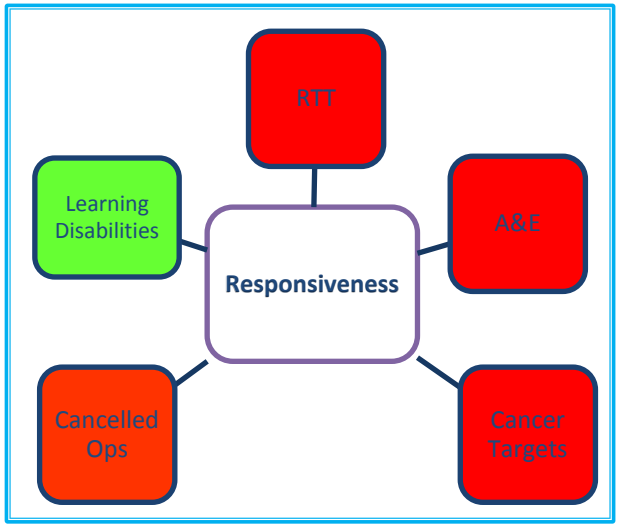
Performance & Quality Report

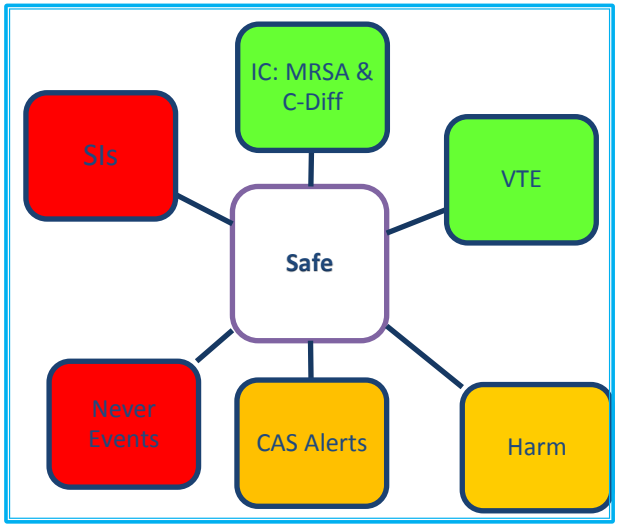
Trust Board
Month 2 – May 2015

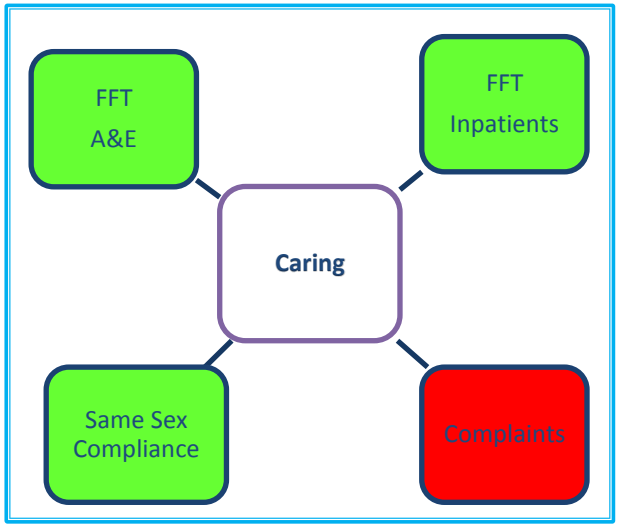
excellent kind responsible respectful

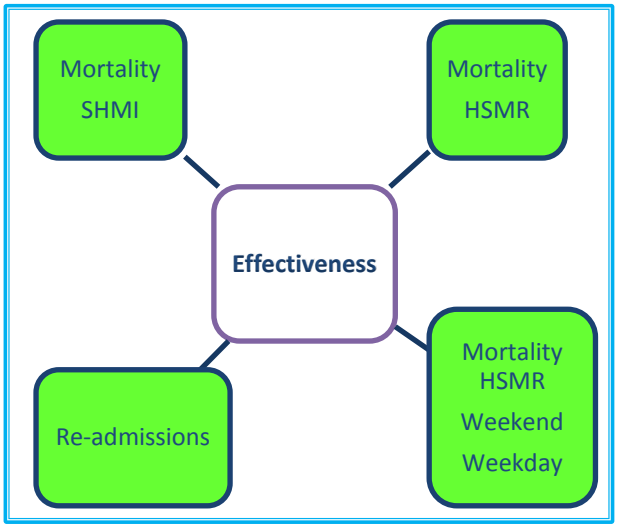
CONTENTS

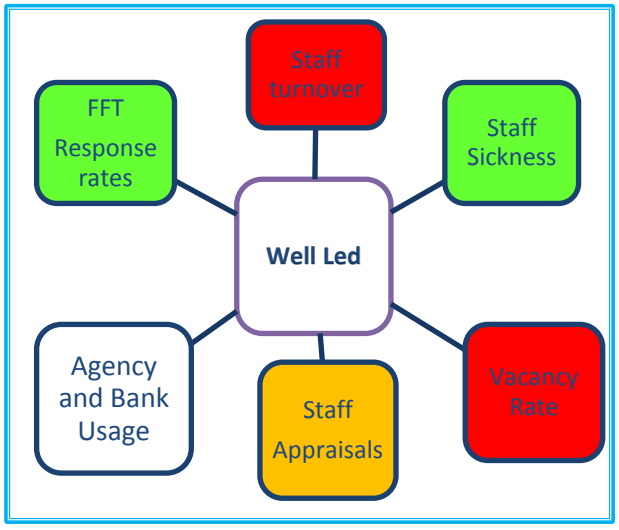
1. Executive Summary - Key Priority Areas May 2015











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

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

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

St George's University Hospitals NHS
NHS Foundation Trust

Performance against Frameworks

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

Access							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Apr**	**May**	**Movement**
Referral to Treatment Admitted	90%	1	1		84.3%	83.5%	⮟
Referral to Treatment Non Admitted	95%	1	0		95.15%	95.1%	➤
Referral to Treatment Incomplete	92%	1	1		89.04%	91.2%	⮝
A&E All Types Monthly Performance **(Quarter to date)**	95%	1	1	93.59%	92.25%	92.87%	⮝
				YTD	**Q4**	**Q1 to Date**	
62 Day Standard	85%	1	0	95.92%	82.5%	95.2%	⮝
62 Day Screening Standard	90%			90.0%	87.5%	90.0%	⮝
31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	➤
31 Day Subsequent Surgery Standard	94%		0	96.9%	97.6%	96.9%	⮟
31 Day Standard	96%	1	0	96.6%	96.9%	96.6%	⮟
Two Week Wait Standard	93%	1	1	92.5%	96.8%	92.5%	⮟
Breast Symptom Two Week Wait Standard	93%	1		78.4%	97.69%	78.4%	⮟

* NYA Not yet available

Outcomes							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Apr**	**May**	**Movement**
Clostridium Difficile - Variance from plan	31	1	0	6	0	0	➤
Certification of Compliance Learning Disabilities:							
Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	Compliant	1	0	Yes	Yes	Yes	➤
Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: · treatment options; · complaints procedures; and · appointments?	Compliant			Yes	Yes	Yes	➤
Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities	Compliant			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			Yes	Yes	Yes	➤
Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Compliant			Yes	Yes	Yes	➤
Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Compliant			Yes	Yes	Yes	➤
Data Completeness Community Services:							
Referral to treatment	50%	1	0		56%	56%	➤
referral information	50%	1	0		88%	87.9%	⮟
treatment activity	50%	1	0		69.2%	69.8%	⮝
Trust Overall Quality Governance Score					2	**4**	➤

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

The trust's quality governance rating is 'Under Review' as the trust has a governance score of 4 and monitor are reviewing key areas of underperformance with no regulatory action being taken to date. (further details in appendix 1.)

.

Areas of underperformance for quality governance are:

- A&E 4 Hour Standard
- RTT
- Cancer 2 Week Waits
- Diagnostic Waits > 6weeks

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

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 >=4.0 and >=3 consecutive quarters' breaches of single metric and with regulatory action to be taken

2. Trust Key Performance Indicators 2015/16: May 15 Performance (Page 1 of 1)

Responsiveness Domain					
Metric	Standard	YTD	Apr	May	Movement
Referral to Treatment Admitted	90%		84.3%	83.5%	↓
Referral to Treatment Non Admitted	95%		95.15%	95.1%	→
Referral to Treatment Incomplete	92%		89.04%	91.2%	↑
Referral to Treatment Incomplete 52+ Week Waiters	0		4	1	↓
Diagnostic waiting times > 6 weeks	1%		3.24%	3.65%	↑
A&E All Types Monthly Performance	95%	92.87%	92.25%	93.63%	↑
12 hour Trolley waits	0	0	0	0	→
Urgent Ops Cancelled for 2nd time (Number)	0	0	0	0	→
Proportion of patients not treated within 28 days of last minute cancellation	0%	17.9%	17.9%	4.9%	↓
Certification against compliance with requirements regarding access to health care for people with a learning disability	Compliant	Yes	Yes	Yes	→
	Standard	YTD	Q4	Q1	Movement
Two Week Wait Standard	93%	92.5%	96.8%	92.5%	↓
Breast Symptom Two Week Wait Standard	93%	78.4%	97.69%	78.4%	↓
31 Day Standard	96%	96.6%	96.9%	96.6%	↓
31 Day Subsequent Drug Standard	98%	100.0%	100.0%	100.0%	→
31 Day Subsequent Surgery Standard	94%	96.9%	97.6%	96.9%	↓
62 Day Standard	85%	95.2%	82.5%	95.2%	↑
62 Day Screening Standard	90%	90.0%	87.5%	90.0%	↑

Safe Domain					
Metric	Standard	YTD	April	May	Movement
Clostridium Difficile - Variance from plan	0	6	0	0	→
MRSA bacteraemia	0	2	2	0	↓
Never events	0	2	1	1	→
Serious Incidents		35	18	17	↓
Percentage of Harm Free Care	95%		94.2%	94.61%	↑
Medication errors causing serious harm	0	1	0	1	↑
Overdue CAS alerts	0	2	2	2	→
Maternal deaths	1	1	0	1	↑
VTE Risk Assessment (previous months data)*	95%		96..27%	96..64%	↑

Effectiveness Domain					
Metric	Standard	YTD	April	May	Movement
Hospital Standardised Mortality Ratio (DFI)	100		89.8	92.9	↑
Hospital Standardised Mortality Ratio – Weekday	100		86.08	86.08	→
Hospital Standardised Mortality Ratio – Weekend	100		83.66	83.66	→
Summary Hospital Mortality Indicator (HSCIC)	100		86	86	→
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	5%	3.11%	3.14%	3.07%	↓

Caring Domain					
Metric	Standard	YTD	April	May	Movement
Inpatient Scores from Friends and Family Test	60		95.7	94.7	↓
A&E Scores from Friends and Family Test	46		83	83.6	↑
Complaints * previous months data			71	73	↑
Mixed Sex Accommodation Breaches	0	0	0	0	→

Well Led Domain					
Metric	Standard	YTD	April	May	Movement
IP response rate from Friends and Family Test	30%		38.9%	53.9%	↑
A&E response rate from Friends and Family Test	20%		23.8%	25.5%	↑
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	61%	61%			
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	67%	69&			
Trust turnover rate	13%		17.5%	17.35%	↓
Trust level total sickness rate	3.50%		3.21%	3.44%	↑
Total Trust vacancy rate	11%		13.7%	14.4%	↑
Percentage of staff with annual appraisal – Medical	85%		75.23%	87.1%	↑
Percentage of staff with annual appraisal - non-medical	85%		87.0%	75.1%	↓

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.

St George's University Hospitals NHS
NHS Foundation Trust

Performance – areas of escalation

3. Performance Area of Escalation (Page 1 of 7) - A&E: 4 Hour Standard

Total time in A&E - 95% of patients should be seen within 4hrs						
Lead Director	April	May	Movement	2015/2016 Target	Forecast June - 15	Date expected to meet standard
FA	92.25%	93.63%	▲	>= 95%	R	TBC

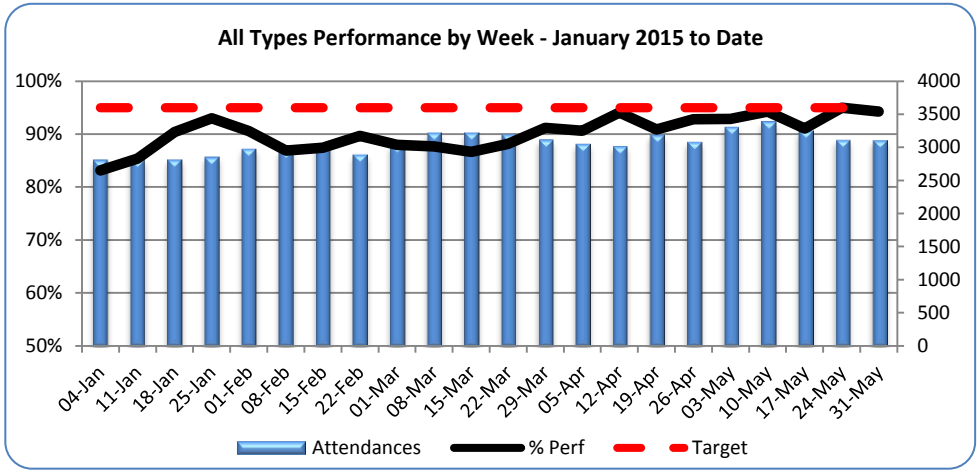
Peer Performance Quarter to Date 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
92.7%	90.8%	90.8%	88.4%	95.8%

The ED target is that 95% or more of patients should be seen and discharged within 4 hours of attending the Emergency Department. In May 2015, 93.63% of patients were seen within 4 hours, this is an improvement on April's position of 92.25%. Performance improvement can be seen in May as the trust continues to implement and further embed existing actions to maintain performance improvement. The week beginning 18th May 2015 ED performance exceeded the 95% standard.

The trust is in a period of joint investigation with commissioners where ED performance and pathways are being jointly reviewed further with additional actions for performance improvement to be identified. Key themes emerging from the review thus far are as follows:

- Opportunities to strengthen primary care arrangements for minimising impact on urgent care (and majors when primary care capacity depleted)
- Recognised need for a 'transformative' model of care that responds to the growing age profile of patients
- Protecting and expanding ambulatory care services, including through development of surgical assessment unit
- The development of ambulatory care services out of hospital, such as at the Nelson.
- Strong commissioner support for in-AMU, in-hospital flow and discharge improvement work
- Aspiration to see a set of flow based KPIs that can be monitored by commissioners.

Following the period of Joint Investigation the trust is currently in the process of agreeing an remedial action plans for implementation to recover sustainable ED performance back to target. The action plans encompass areas of: ED flow, intra hospital flow, frailty pathways and ambulatory care. These are currently in discussion/review with commissioners.



Performance Overview by Type			
	ED (Type 1)	MIU (Type 3)	ED & MIU (Type 1+3)
Month to Date (March)	92.92%	99.70%	93.63%
Quarter to Date	92.11%	99.69%	92.87%
Year to Date	92.11%	99.69%	92.87%

3. Performance Areas of Escalation (Page 2 of 7) - RTT Admitted Pathways

Referral to Treatment Admitted Pathways						
Lead Director	April	May	Movement	2014/2015 Target	Forecast June – 15	Date expected to meet standard
SB	84.3%	83.5%	⮟	90%	R	TBC

Over the last 10 months the trust has not achieved the 90% target for admitted pathways to support backlog clearance as part of the national programme. This also coincides with clear commissioner assertion of full chronological booking taking precedent.

The trust needs to further reduce its backlog to a sustainable position to allow for effective delivery of the target. In order to achieve this the trust needs to address key challenges which have currently been impacting upon performance. These include:

- Bed Capacity – including critical care capacity
- Theatre Capacity
- Outpatient clinic and staff capacity
- Improvement in data quality and process management

The trust is currently in a period of 'Joint Investigation' with commissioners who are working closely with the to support the development of a sustainable plan for 18 week referral to treatment delivery. Recent discussions have highlighted five main areas of commissioner focus:

- Ensuring appropriate outpatient referral demand and capacity modelling
- Exploiting opportunities for one-stop outpatient clinics that combine new, diagnostic and follow up consultations in a single visit
- Implementation of pre-referral agreed pathways and criteria from primary care to reduce referrals, reduce diagnostics and increase conversion rates.
- In challenged specialties – inviting GPs to refer patients direct to alternate providers
- Making best use of the independent sector through direct GP referral (at tariff price) thus reducing the performance burden on the trust and some of the financial burden on the local health economy.

Given the above context the Trust will need to:

- Develop and sign off a coherent trust plan for sustainable RTT delivery with commissioner support
- Undertake additional activity – recognising the capacity constraints at St George's any significant increase in activity will need to be undertaken off-site, through other providers
- Drive specialties to review pathways of care to identify where there are opportunities to:
    - i. Reduce unnecessary or incomplete referrals, thus leading to a higher conversion rate
    - ii. Improve productivity by bundling outpatient and diagnostic appointments into one-stop services
    - iii. Reduce activity levels in unsustainable services – through the service line review

Following the period of Joint Investigation the trust is currently in the process of agreeing an Elective Pathway remedial action plan for implementation to recover sustainable performance back to target. This is currently in discussion/review with commissioners.

3. Performance Areas of Escalation (Page 3 of 7) - RTT Incomplete 52+ Week Waiters

Referral to Treatment Incomplete 52+ Week Waiters						
Lead Director	April	May	Movement	2014/2015 Target	Forecast June – 15	Date expected to meet standard
SB	4	1	↓	0	G	June - 15

Specialty	Patient Type	Date for patient to be treated	Commentary
ENT	IP	18/06/2015	The key reasons for delay were due to human error. The referral was originally sent to SGH by a consultant from another provider who did not complete a TCI card for the patient so they were not added to the waiting list . Following this a Consultant at SGH completed a TCI card but was not forwarded to the Admissions Team adding to the delay. Patient has since attended an OP appointment on 12/05/2015 to discuss procedure and has agreed to the procedure. The consultant has decided that an ultrasound is necessary before the procedure which has been arranged for 17/06/2015 following which the procedure will be undertaken on 18/06/2015.

All 52+ week waiters reported in April have now been treated and are no longer waiting, with the exception of the ENT patient detailed above who is scheduled to have their procedure undertaken on 18/06/2015.

The trust continues to pro-actively addressing the issue of long waiters and in particular the prevention of 52+ week waiters. The following actions continue to support this:

- Weekly RTT management meetings by care group are now in place which track the PTL and review at patient level, review capacity and escalate long waits.
- A weekly email of long waiters is sent to divisional managers to review and action those patients waiting for more than 40 weeks.
- A monthly RTT Compliance meeting chaired by an Executive Director is held which reviews; performance by care group with a particular focus on patients waiting 40+ weeks to ensure treatment plans are in place, review/facilitate escalation, provide senior decision making support to drive actions forward, reviews and monitors elective cancellations, their rebooking to target and their impact on RTT performance.

3. Performance Areas of Escalation (Page 4 of 7) - Cancer - Two Week Wait Standards

Two Week Wait Standard – all cancers						
Lead Director	Q4	Q1 to Date	Movement	2015/2016 Target	Forecast June – 15	Date expected to meet standard
CC	96.8%	92.5%	↘	93%	G	June - 15

Peer Performance Latest Published Quarter 4 2014- 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
96.%	94.5%	94.5%	95.1%	96.1%

Breast Symptom Two Week Wait Standard						
Lead Director	Q4	Q1 to Date	Movement	2015/2016 Target	Forecast June - 15	Date expected to meet standard
CC	97.69%	78.4%	↘	93%	G	June -15

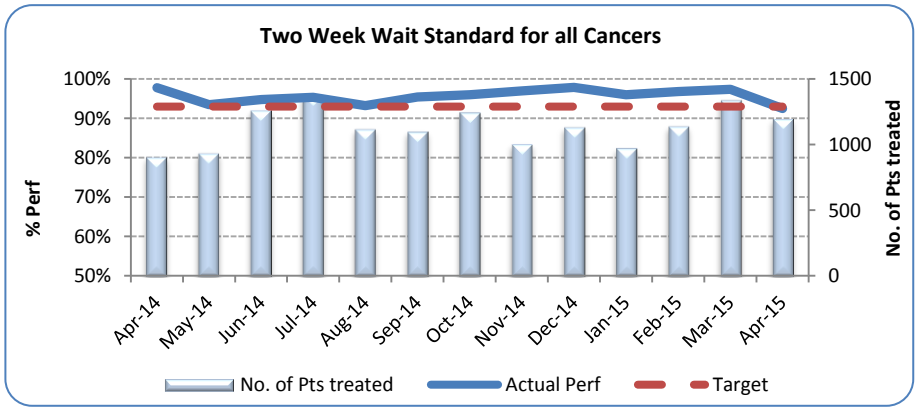
Peer Performance Latest Published Quarter 4 2014- 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
97.7%	98.5%	87%	97.8%	n/a

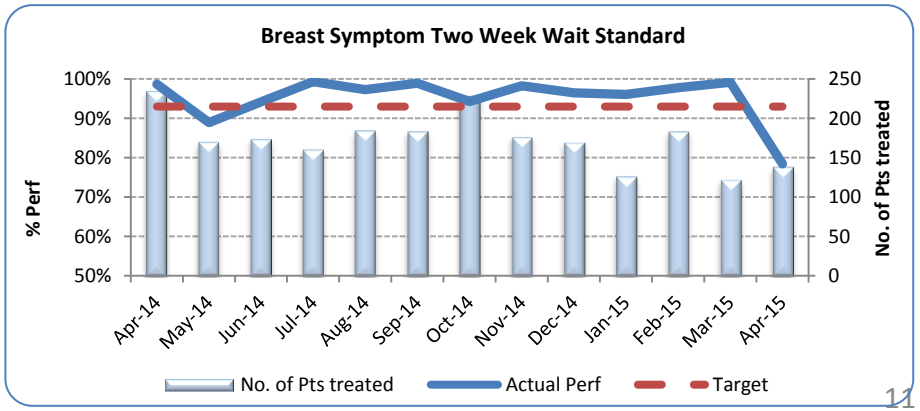
The trust was compliant against all targets except for the two week wait standard for all cancers and the 14 day breast symptomatic standard. The trust reported performance of 92.5% and 78.4% respectively in April against the national targets of 93% .

Key reasons for breaches were :

- Capacity issues in particular within modalities of breast and lower GI. Capacity is currently being reviewed to ensure for future performance sustainability.
- Patient reasons to include choice and patient cancellations were a significant factor in April. Excluding breaches due to patient choice or patient cancellations, the trust would have met the two week wait standard.

The trust will continue to monitor the situation to ensure we are flagging and acting upon known breaches at the earliest possible opportunity. The Trust anticipates that performance will be back on Track for May. In addition to this to further support trusts in delivering cancer performance with a collaborative approach, a SW London forum has been set-up to discuss and review how referrals and pathways can be streamlined across trusts. This will include representatives from SWL acute trusts, commissioners and NHS England – London Cancer team. The first meeting is due to commence on 7th July 2015

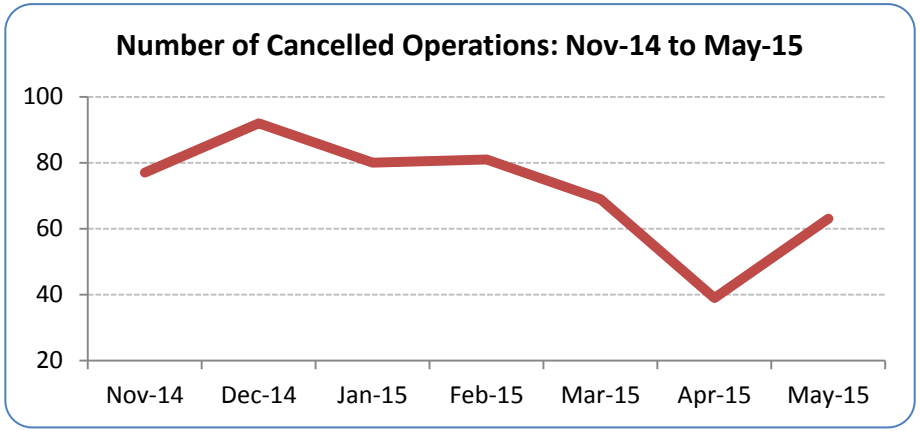


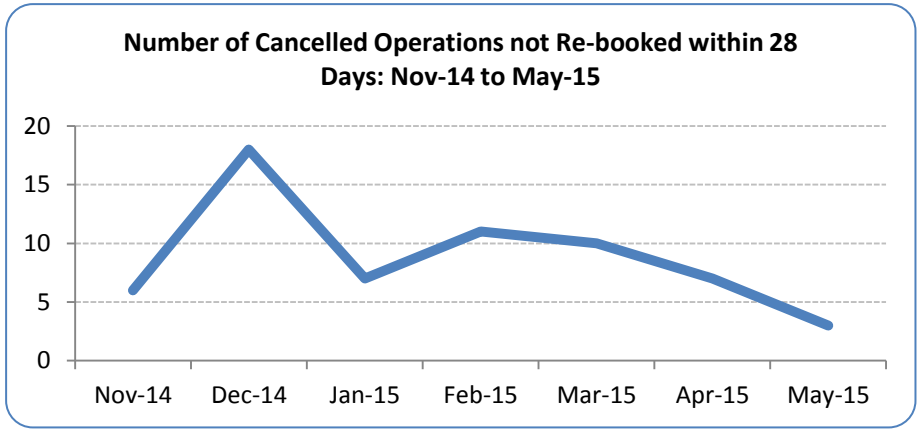


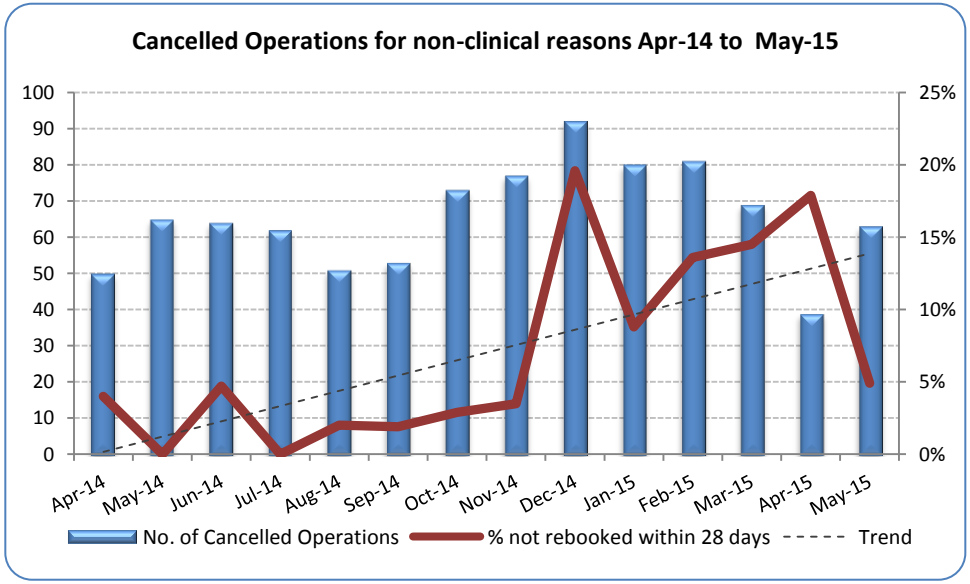
3. Performance Areas of Escalation (Page 5 of 7) - Cancelled Operations

Proportion of Cancelled patients not treated within 28 days of last minute cancellation						
Lead Director	April	May	Movement	2015/2016Target	Forecast June – 15	Date expected to meet standard
CC	17.9%	4.9%	▼	0%	G	Jun- 15

Peer Performance Comparison – Latest Available Q4 2014/15				
STG	Croydon	Kingston	King's College	Epsom & St Helier
19.7%	1.9%	17.3%	2.4%	0.8%







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 63 cancelled operations from 4261 elective admissions in May. 60 of those cancellations were rebooked within 28 days with 3 patients not rebooked within 28 days, accounting for 4.9 % of all cancellations. The overall number of breaches has been seen to be reducing month on month since February.

The breaches were attributable to Cardiothoracic, Plastics and Maxillofacial specialties. Key contributory factors for the cancellations were related to high bed occupancy resulting in a lack of ITU beds for post surgical admission and unavailability of equipment for one of the cases.

All three patients now have scheduled dates for their operations in June.

The trust pro-actively monitors its elective programme which includes all cancelled operations closely and prioritises them for re-booking. These are also reviewed with commissioners on a monthly basis.

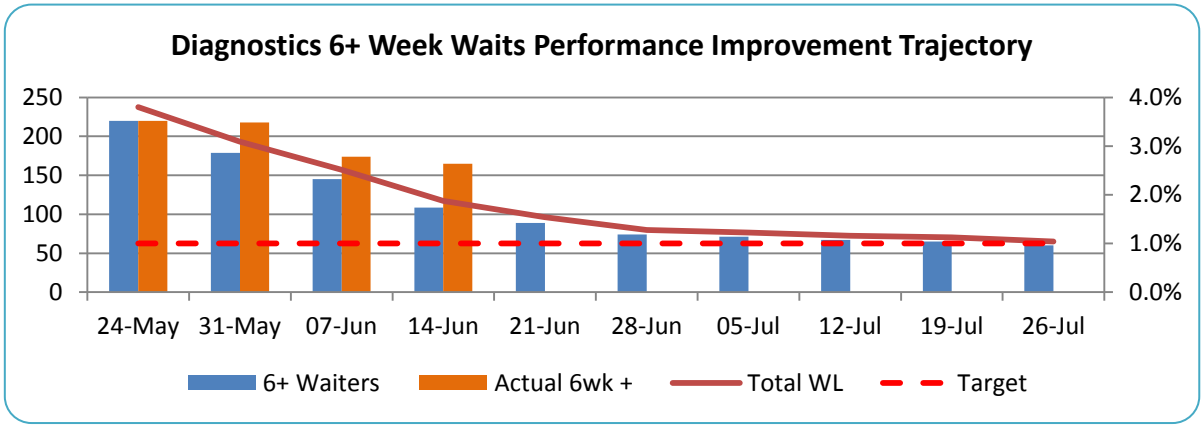
3. Performance Areas of Escalation (Page 6 of 7) - Diagnostic 6+ Weeks Wait

Diagnostic waiting times > 6 weeks						
Lead Director	April	May	Movement	2015/2016 Target	Forecast June – 15	Date expected to meet standard
CC	3.24%	3.65%	▲	1%	R	July- 15

No of Patients waiting >6 weeks – Latest Published Data April 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
180	1	25	345	23

The trust continues to face challenges with diagnostic waits greater than 6 weeks and is exceeding the target of number of patients waiting greater than 6 weeks of 1% of all waiters. The trust has put actions into place and positive performance improvement in has been observed across a number of modalities. Endoscopy waits greater than 6 weeks have reduced from 128 at the beginning of February to 28 as at 14/06/2015. The pre-dominant modalities of challenge where there are high number of patients waiting greater than 6 weeks are; MRI and Non-obstetric ultrasound.

The trust has submitted a performance improvement trajectory to commissioners as shown below. At present the trust is showing week on week reduction in waits but is not in line with the trajectory and further actions are being undertaken to expedite recovery so we are back on track.



Actions being taken to address the backlog and ensure compliance include:

Non-obstetric ultrasound - Increased waits for non-obstetric ultrasound can be attributed to both areas of Gynaecology and Radiology.

Gynaecology

- Increased robustness of administration processes and management of administrative staff involved in booking and registering patients.
- Weekly monitoring of diagnostic capacity and demand undertaken by management team.
- A minimum of 5 ad hoc scanning clinics arranged for each week since 24.4.15.
- A minimum of 1 ad hoc weekend scanning clinic arranged for each week since 27.4.15
- Activity re directed to the Nelson and St Johns when there is available capacity.
- It is forecasted that backlog clearance to support performance improvement to target will be complete by July 2015.
- The impact of the additional is having a significant positive effect as Gynaecology related non-obstetric ultrasound waits greater than 6 weeks have reduced from 176 at the end of April to 16 as at 14/06/2015.

3. Performance Areas of Escalation (Page 7 of 7) - Diagnostic 6+ Weeks Wait Contd.

Actions being taken to address the backlog and ensure compliance include:

Radiology

The service have undertaken a waiting list review to identify all potential future breaches to enable the planning of additional capacity required to bring the waiting times back to target accordingly. Following the review the following measures are being implemented:

- We are planning 3 general sessions for week of 15/06/215 with additional planned if required the week after. This combined with QMR capacity (below) will mean we will have no general breaches by the 29th June.
- 6 additional sessions at QMR are available which are spread until the first week in July.
- MSK has been a key area of constraint over the last quarter. MSK sessions (at least 2/wk) will be arranged for the next 5-6 weeks. (this is contingent on staff availability). 3 sessions have been scheduled currently. This will not prevent all breaches from occurring in the short term as MSK is limited by capable staff. However the MSK waiting list will be brought under control by these extra sessions theoretically putting the list under 6 weeks by 13th July or sooner dependent on staff availability.
- We have a new MSK consultant starting in July which will augment that service to reduce any further breach occurrences.
- Sonographers have offered to do additional sessions. Number of sessions are yet to be agreed, but this will enable another group of staff to rely on for additional capacity when required.
- Undertaking activity at the Nelson. The activity sent to the Nelson (340+ pts) will not only avoid those patient breaching but will yield relinquished slots to book early appointments for potentially breaching patients. Feedback from our Nelson colleagues about these patients will enable quicker rebooking of those slots.

Currently, all new general patients are being booked within 6 weeks and the removal of the current potential breaches will mark the end of the impact felt from sessions lost in April and May.

MRI

MRI remains a challenge and in particular Cardiac MRI's with referrals increasing with limited capacity. Actions being undertaken to support reduction in waiting times includes:

- Additional weekend sessions using mobile scanner continue to be run.
- Static scanner which failed over the Easter weekend resulting in some lost capacity has now been fixed and is back in operation.
- Extending current weekend sessions to 12hrs from 8hrs.
- Review and consideration of an interim solution to upgrade the QMH mobile unit to a 'relocatable' unit(rather than trailer based, this is a unit housed in a dedicated portacabin) which is capable of a slightly wider range of examinations than a traditional mobile. This option is currently in discussion with InHealth. This will support the reduction of waiting times for currently non-mobile compatible exams
- A review of options to increase capacity for Cardiac MRIs in currently in progress.

In addition to the above work continues to further reduce the long waits within Endoscopy and in particular flexible sigmoidoscopy waits which remain a slight pressure.

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

			May 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	18 WEEKS - ADMITTED WAITS (DIVISION LEVEL)	%		89	80.3	81.3	83.5
	18 WEEKS - INCOMPLETE WAITS (DIVISION LEVEL)	%	100	92.9	89.3	89.2	91.2
	18 WEEKS – NON-ADMITTED WAITS (DIVISION LEVEL)	%	100	93.2	91.2	97.9	95.1
	52 WEEK WAITERS	No.	0	0	1	0	1
	A&E WAITS (4 HOURS)	%	99.7	92.9			93.6
	CANCELLED OPERATIONS RE-BOOKED WITHIN 28 DAYS (DIVISION)	%	0	4.3	5.3	0	4.9
	LAS HANDOVER WITHIN 15 MINS	%					13.9
	LAS HANDOVER WITHIN 30 MINS	%					75.5
	LAS HANDOVER WITHIN 60 MINS	No.					0

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

			April 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (BREAST SYMPTOMS) - (DIVISION)	%	0	0	78.4	0	78.4
	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (CANCER) - (DIVISION)	%	0	0	92.5	0	92.5
	31 DAY SECOND OR SUBSEQUENT TREATMENT (DRUGS) - (DIVISION)	%	0	0	100	0	100
	31 DAY SECOND OR SUBSEQUENT TREATMENT (SURGERY) - (DIVISION)	%			96.9		96.9
	31 DAY STANDARD FROM DIAGNOSIS TO FIRST TREATMENT - (DIVISION)	%			96.6		96.6
	62 DAY URGENT GP REFERRAL TO TREATMENT FOR ALL CANCERS - (DIVISION)	%			85.2		85.2
	62 DAY URGENT GP REFERRAL TO TREATMENT FROM SCREENING - (DIVISION)	%			90		90

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

			May 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Outcome Metrics	C-SECTIONS (APPLICABLE TO WOMEN & CHILDREN ONLY)	%				24.7	24.7
	HSMR	Ratio					92.9
	INCIDENCE OF C.DIFFICILE	No.	0	2	0	1	3
	INCIDENCE OF E-COLI	No.	0	0	1	0	1
	INCIDENCE OF MRSA	No.	0	0	0	0	0
	MATERNAL DEATHS	No.	0	0	0	1	1
	MEDICATION ERRORS CAUSING SERIOUS HARM	No.	0	0	0	0	0
	NEVER EVENTS	No.	0	1	0	0	1
	SERIOUS INCIDENTS (DIVISION LEVEL)	No.	1	11	3	2	17
	SHMI	Ratio					0.9
Quality Governance Indicators	PATIENT SATISFACTION (FRIENDS & FAMILY)	%	81.3	92.2	96.4	89.8	93.5
	PERCENTAGE OF STAFF APPRAISAL (MEDICAL) - (DIVISION)	%	72.7	87.6	87.9	87.8	87.1
	PERCENTAGE OF STAFF APPRAISAL (NON-MEDICAL) - (DIVISION)	%	75.8	78.8	75.1	74.9	75.1
	SICKNESS/ABSENCE RATE - (DIVISION)	%	6	2.9	3.1	2.9	3.4
	STAFF TURNOVER - (DIVISION)	%	19.9	18	14.3	17.7	17.4
	VOLUNTARY STAFF TURNOVER - (DIVISION)	%	15.8	15.7	12.6	13.2	14.1

Key Messages:

This section headed 'Access' indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution. The Access section is split into two components, as Cancer metric and complaints performance is reported one month in arrears.

LAS arrivals to patient handover times, continues to fluctuate. At the end of May, 13.9% of patients had handover times within 15 minutes and 75.5% within 30 minutes. both of which are not within target. The 30 minute handover data is currently being validated and is envisaged to significantly increase post validation. The trust had no 60 minute LAS breaches in May.

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

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Corporate Outpatient Services Performance

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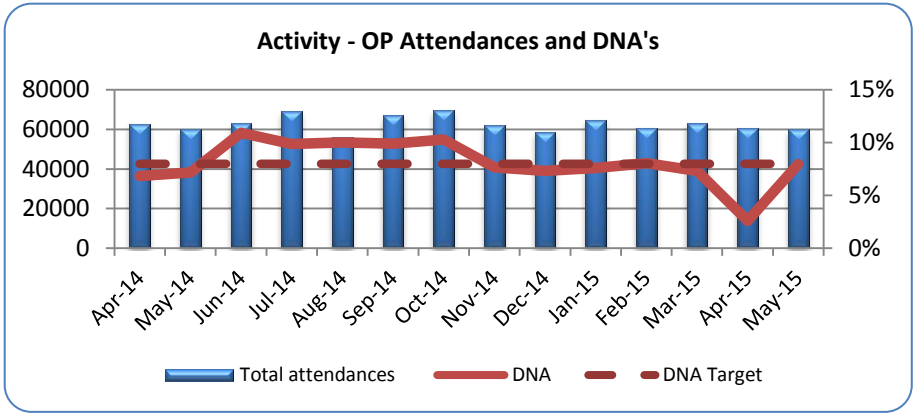
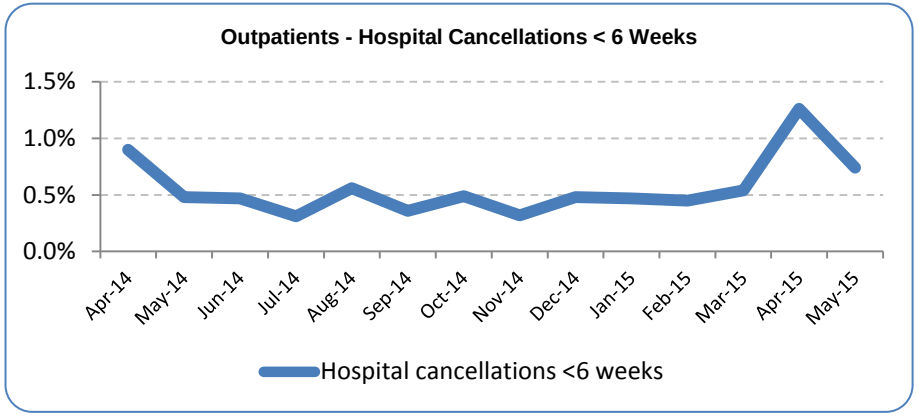
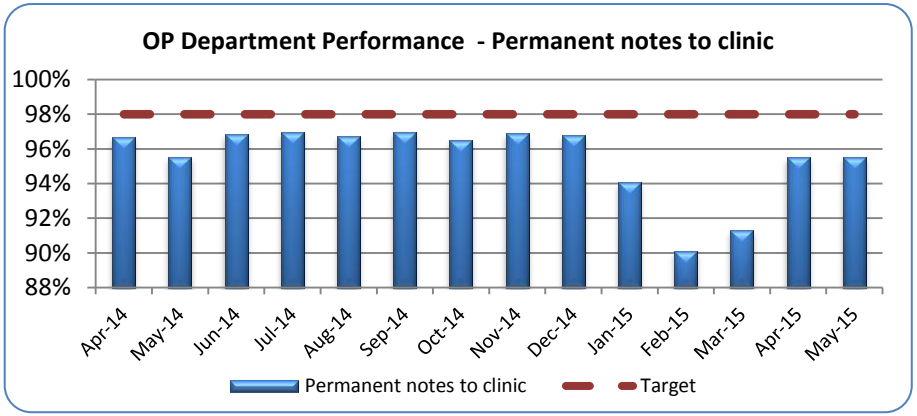
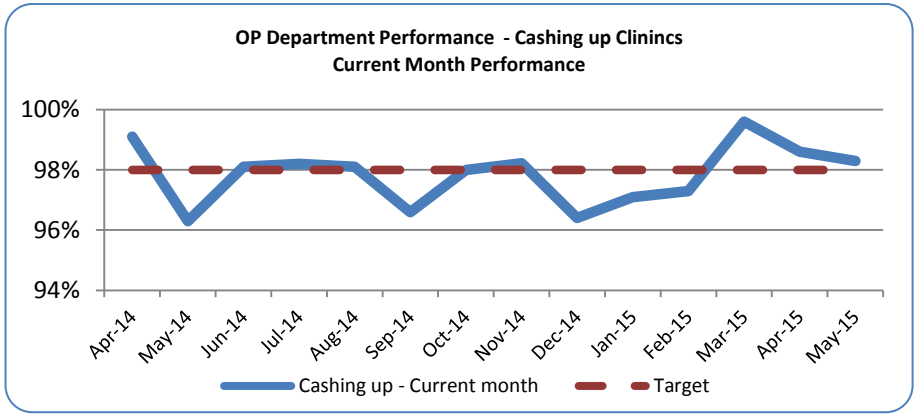
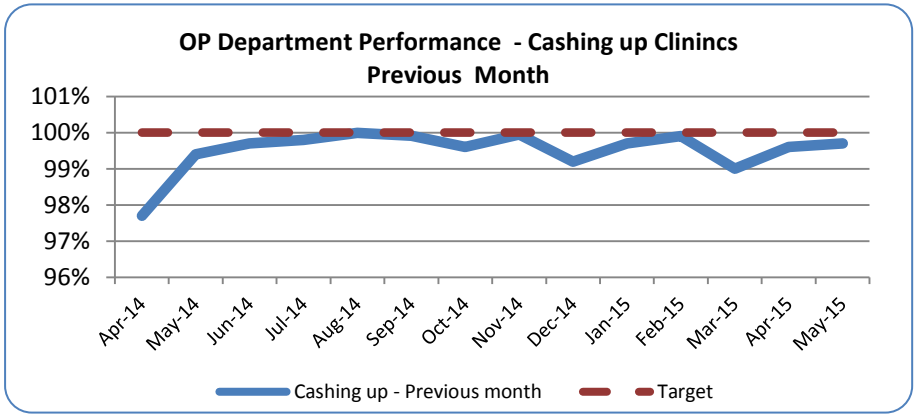
5. Corporate Outpatient Services (1 of 2) - Performance Overview

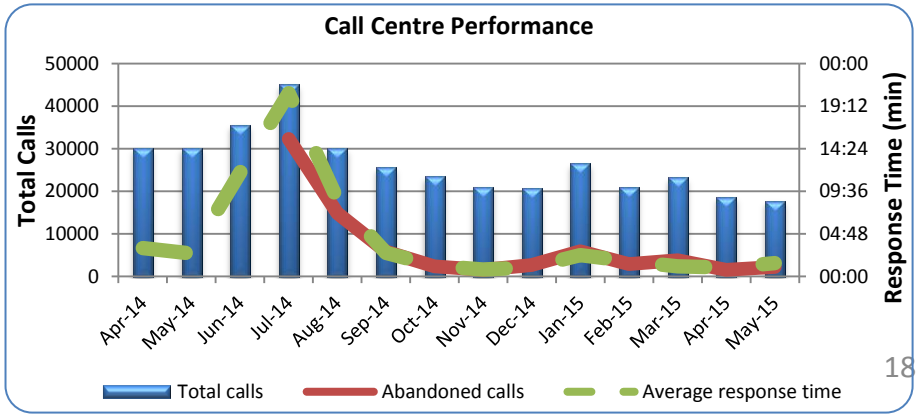












5. Corporate Outpatient Services (2 of 2) - Performance Overview

		Target	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Activity	Total attendances	N/A	62954	69250	56102	67188	69507	61879	58659	64609	60659	62946	60564	59841
	DNA	<8%	10.93%	9.87%	10.02%	9.89%	10.30%	7.64%	7.33%	7.58%	8.04%	7.33%	2.59%	7.97%
	Hospital cancellations <6 weeks	<0.5%	0.47%	0.31%	0.56%	0.36%	0.49%	0.32%	0.48%	0.47%	0.45%	0.54%	1.26%	0.74%
OPD performance	Permanent notes to clinic	>98%	96.85%	96.94%	96.71%	96.98%	96.51%	96.88%	96.77%	94.05%	90.12%	91.32%	95.52%	95.54%
	Cashing up - Current month	>98%	98.10%	98.20%	98.10%	96.60%	98.00%	98.22%	96.40%	97.10%	97.30%	99.60%	98.60%	98.3%
	Cashing up - Previous month	100%	99.70%	99.80%	99.99%	99.91%	99.60%	99.95%	99.20%	99.70%	99.90%	99.00%	99.60%	99.70%
Call Centre Performance	Total calls	N/A	35571	45101	30004	25674	23420	20964	20639	26565	20842	23235	18710	17732
	Abandoned calls	<25%/< 15%		32257	14825	5794	2376	1558	2681	5923	2908	3782	1551	2237
	Mean call response times	<1 minute	11:42	20:39	08:41	02:38	01:13	00:47	01:02	02:24	01:43	01:08	01:00	01:29

Key Messages:

- May activity has seen a decrease in comparison to the average for the last three months. DNAs have increased in May but remains within target of less than 8%, this is being closely monitored going forward. Hospital cancellations have seen a reduction from Aprils position of 1.265 to 0.74%. However, this is still not within target of less than 0.5%. Performance of permanent notes to clinic has seen little change over the last month with performance of 95.54%. This is an on-going priority area for the service.

- Call centre performance has seen an improvement from the challenges in Q4. Abandoned calls performance has been maintained remaining less than 13% in April. The division continues to monitor call centre performance to maintain abandoned call performance of less than 15% of total calls and to bring average response times to less than a minute. Average response times have seen consecutive month on month improvement from January. However, average response time in May was in excess of the 1.0minute target. Renewed focus is being placed on this to ensure consistent low response times are maintained.

- Trust OP capacity is not in line with forecasted demand as per business plans.
  - Business plan demand of 666,000 stated against actual trust built capacity of 450,000. This is currently being mitigated by overbooking and scheduling of additional ad-hoc clinics. Further work in relation to capacity and demand planning is being undertaken to address this.

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Clinical Audit and Effectiveness

6. Clinical Audit and Effectiveness (Page 1 of 5) - Mortality

HSMR (Hospital standardised mortality ratio)						
Lead Director	April 15	May 15	Movement	2014/2015 Target	Forecast March 16	Date expect to meet standard
SM	89.6	88.3	↓	<100	G	Met

SHMI (Summary hospital-level mortality indicator)				
Apr 2014	Jul 2014	Oct 2014	Jan 2015	Apr 2015
0.78	0.80	0.81	0.84	0.86

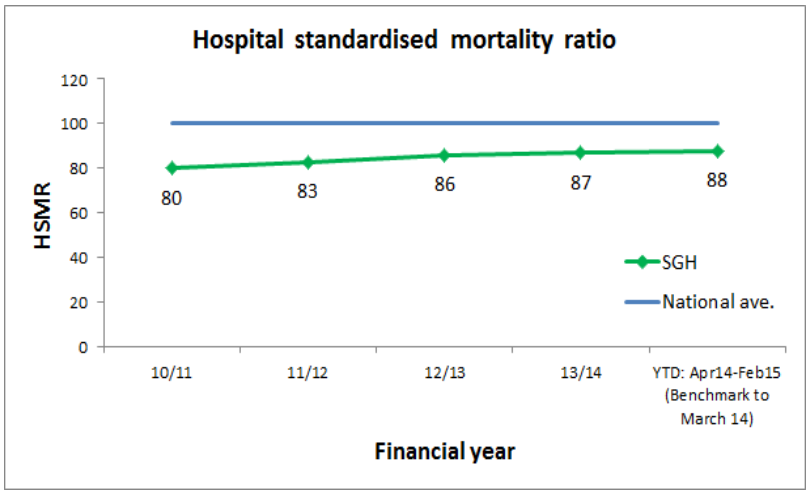
Note: Source for HSMR is Dr Foster Intelligence, published monthly. Data is most recent 12 months available. For May 15 this was March 2014 to February 2015, and benchmark period is to March 2014. An update was not provided by Dr Foster in April, however the HSMR has been calculated retrospectively from the latest refresh and relates to February 2014 to January 2015. SHMI data is published by the Health and Social Care Information Centre. The last 12 month period as published on 29th April 2015 relates to the period October 2013 to September 2014. The next publication will be at the end of July.

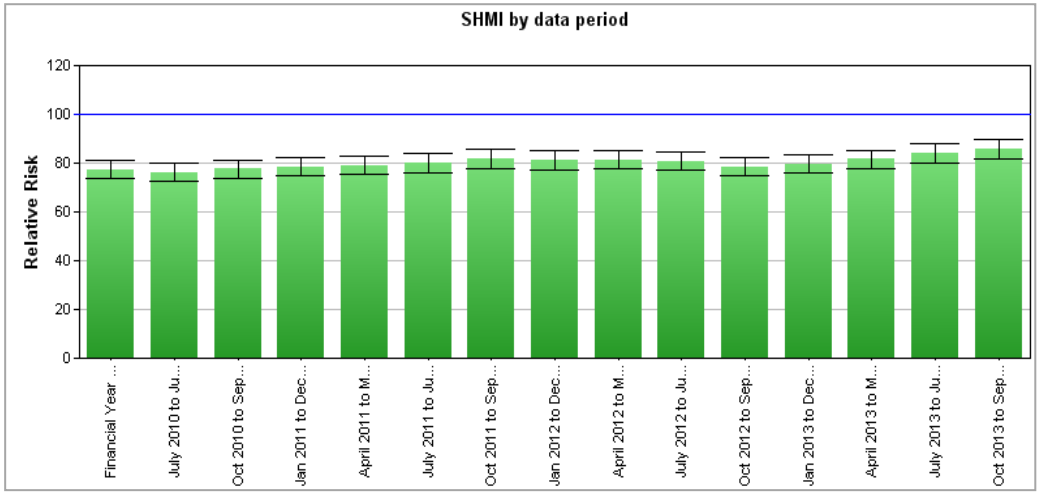
Overview:

Our overall mortality measured by both the HSMR and the SHMI remains statistically significantly better than expected. There does appear to be a trend towards the national mean which requires monitoring. We continue to investigate any mortality signals at procedure and diagnosis level which are locally identified using the Dr Foster platform. Investigation of two diagnosis groups (acute myocardial infarction and fractured neck of femur) identified through analysis of the SHMI are also underway.

This month the Mortality Monitoring Committee will present a summary to the Patient Safety Committee. The report includes an overview of all current investigations. It is noted that there are a number of cardiology signals which require investigation and therefore a wider review of mortality review processes within the service is being considered. The intention is to avoid duplication of effort and to ensure time and expertise are directed appropriately, leading to a clear understanding of outcomes.

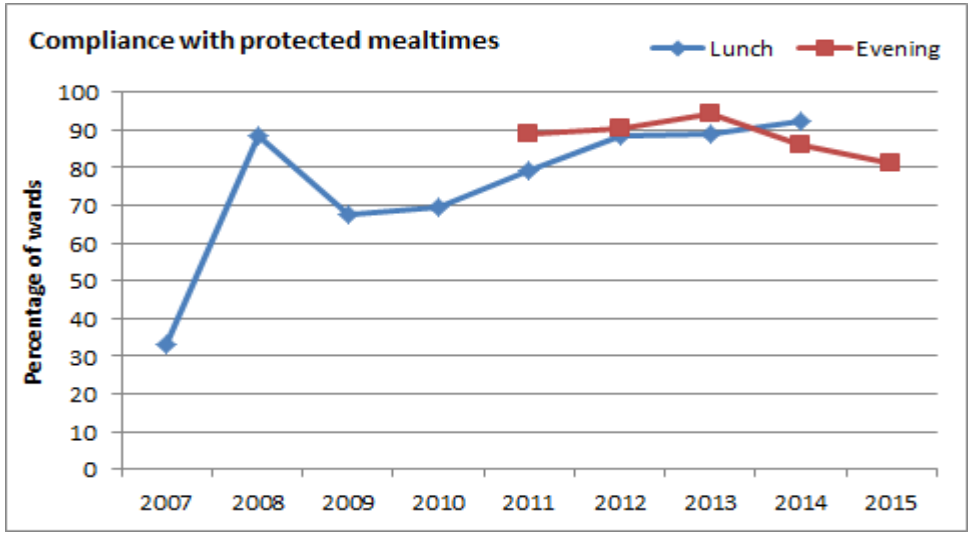
Final adjustments are being made to a report in Tableau which will provide 'real-time' mortality views, which can be filtered by specialty, date, admission type and consultant. This is seen as a useful tool in the work to progress proportionate review of all deaths. It is hoped it will also support a better understanding of crude mortality, and allow us to measure mortality in inpatient community areas.

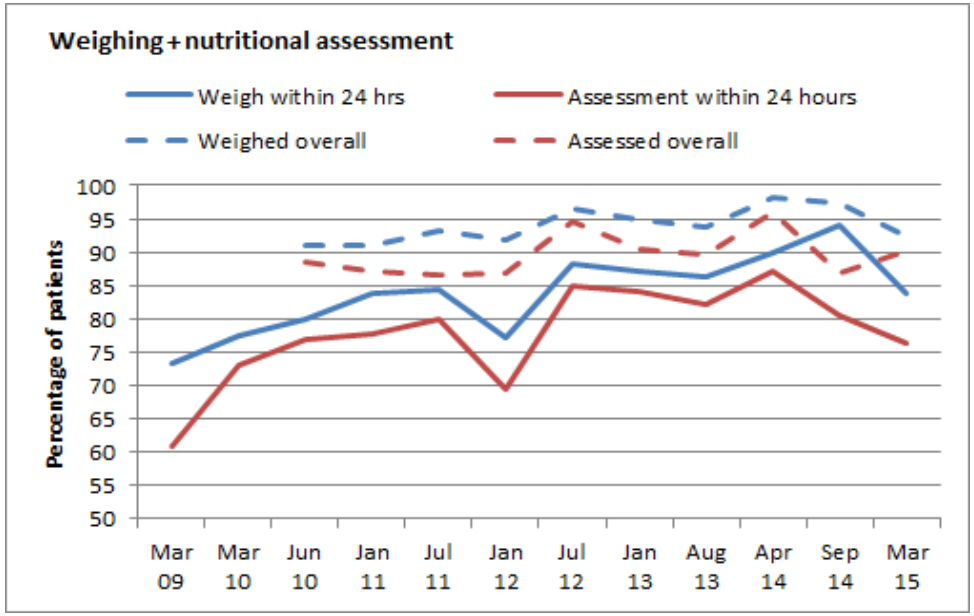




6. Clinical Audit and Effectiveness (Page 2 of 5) - Local Audits

Protected mealtimes, nutrition and hydration audit, March – May 2015





This snapshot audit of an evening meal service was conducted on 37 wards between March and May 2015.

On 30 wards (81.1%) there were no non-clinically urgent interruptions. This is a decline in performance and for the evening meal represents the lowest adherence to date.

Measures around providing assistance to patients show that in the majority of instances staff are providing adequate and timely support to patients. On 96.7 per cent of wards patients requiring assistance were helped with their meal in a timely way. These results are reinforced by the fact that 94.9 per cent of patients surveyed said they had the help that they needed at mealtimes.

Results for weighing and assessing patients within 24 hours of admission show performance has declined. Although timeliness has fallen, it is positive to note that the good practice observed in relation to accuracy of assessments and the appropriate follow-up and review has been sustained. Nutritional assessments were accurate for 97% of patient audited. Follow-up of those identified as at risk has been maintained at around 92 per cent, with appropriate review at approximately 90 per cent.

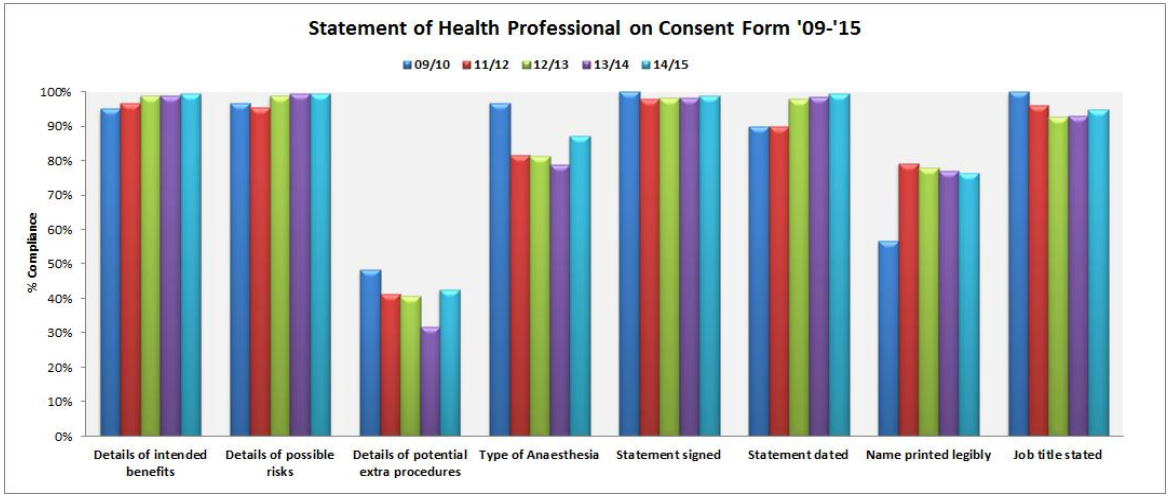
Ward analysis across 9 key measures shows that nine wards were fully compliant. Florence Nightingale, William Drummond and Freddie Hewitt also achieved full compliance at the last round of audit and are congratulated. Eleven wards were shown to have improved, 5 maintained the same level of performance and 14 performed less well.

All wards are required to enforce protected mealtimes and challenge colleagues accordingly. Ward sisters and matrons have been asked to review practice to ensure that there is a robust approach to nutritional screening and support, including the use of red trays.

This regular audit is due to be repeated in the Autumn of 2015 and will focus on the lunchtime meal service.

6. Clinical Audit and Effectiveness (Page 3 of 5)
- Local Audits

Trust-Wide Consent Re-Audit 2014/15 (#DB442)



This is an annual re-audit of consent which was performed by the clinical audit team during February and March 2015. The sample included 282 cases from 28 specialties. The audit indicated that the patient details were completed generally well on the consent form and that performance had improved from the previous year. As shown in the chart above there was improvement in the recording of procedure details and the statement of the health professional. The name of the responsible consultant was not documented in a third of cases and this needs to be urgently addressed. Legibility needs to be improved including clearer identification of the consenter in some cases. It should also be noted that we have not achieved 100% compliance for any of the measures audited which indicates overall improvement is needed.

The results indicated that the section on discussion of blood transfusion / Jehovah's witness in the new consent form (n=102) was only completed in 31.4% (n=32) cases. This needs to be significantly improved in order to provide evidence that a discussion has taken place and to ensure that patients are treated according to their wishes. In only 51.8% (n=146) of cases the carbon copy of the consent form was removed, implying that it had been given to the patient; this is similar to the previous audit (46.8%; n=130). It is best practice to provide the carbon copy to the patients and the consenter should ensure that this is offered in each instance. It is important that all staff are made aware that all sections of the consent form need be completed legibly, and a copy given to the patient.

Competency to take consent could only be assessed in 84% (n=237) cases. In all of these cases the health care professional was deemed competent. In 12.4% (n=35) cases it was not possible to ascertain the name of the consenter because it was illegible or not recorded. Legibility needs to be urgently addressed and adoption of name stamps is recommended. In the remaining cases confirmation was not received from the consultant.

The report is to be presented for discussion at the Patient Safety Committee in June. In addition, divisions have received the results, including divisional analysis to facilitate local discussion and action planning. The Legal Services Manager will include a summary of the key areas for action as part of a presentation on consent to the STNC division in June.

Currently there is no clinical lead for this audit. The associate medical director for governance is supporting the audit team to recruit a lead to help effectively drive recommendations and implement action plans.

6. Clinical Audit and Effectiveness (Page 4 of 5)
- Local audits

WHO Surgical Checklist Audit 4th Quarter 2014/15

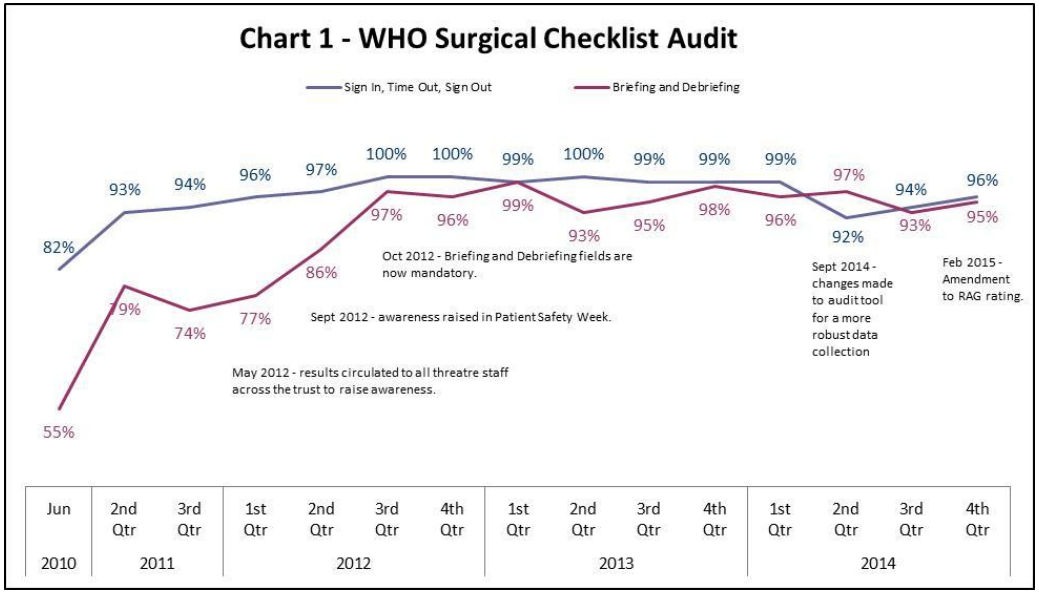


Table 1 - Results for 2014/15	Specialty	Sign In, Time Out, and Sign Out				Briefing and Debriefing			
		1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Children & Women	Gynaecology	100%	87%	97%	98%	98%	100%	100%	100%
	Obstetric - Elective	100%	90%	99%	93%	100%	100%	100%	100%
	Obstetric - Emergency	100%	91%	88%	98%	100%	88%	-	-
	Paediatric	99%	92%	96%	98%	100%	96%	100%	100%
Medicine & CardioThoracic	CardioThoracic	91%	94%	88%	79%	68%	100%	60%	64%
	Renal	100%	96%	98%	98%	100%	100%	95%	100%
	Vascular	100%	94%	99%	100%	98%	95%	100%	100%
Surgery	CEPOD	100%	94%	97%	98%	100%	100%	100%	100%
	DSU	100%	92%	98%	98%	100%	96%	92%	96%
	ENT	100%	88%	100%	100%	100%	100%	100%	100%
	General Surgery	100%	90%	94%	93%	100%	100%	100%	95%
	MaxFax	100%	96%	86%	100%	100%	100%	90%	100%
	Neuro Surgery	90%	99%	93%	93%	75%	100%	95%	94%
	Plastic	100%	88%	92%	91%	100%	100%	98%	100%
	T&O	94%	-	82%	82%	83%	-	98%	100%
	Urology	100%	98%	100%	97%	100%	100%	100%	95%

Overview

As part of the commitment to improving patient safety, the trust has adopted the WHO Surgical Safety Checklist and has been auditing compliance since 2010.

The RAG rating has been amended to reflect the drive for higher standards and is applied from this audit round. The new criteria are: Green for 100%; Amber for scores ranging between 95% and 99%; and Red for scores below 95% (previous rating - Green for 100%, Amber for scores ranging between 99% and 90%, and Red for scores below 90%).

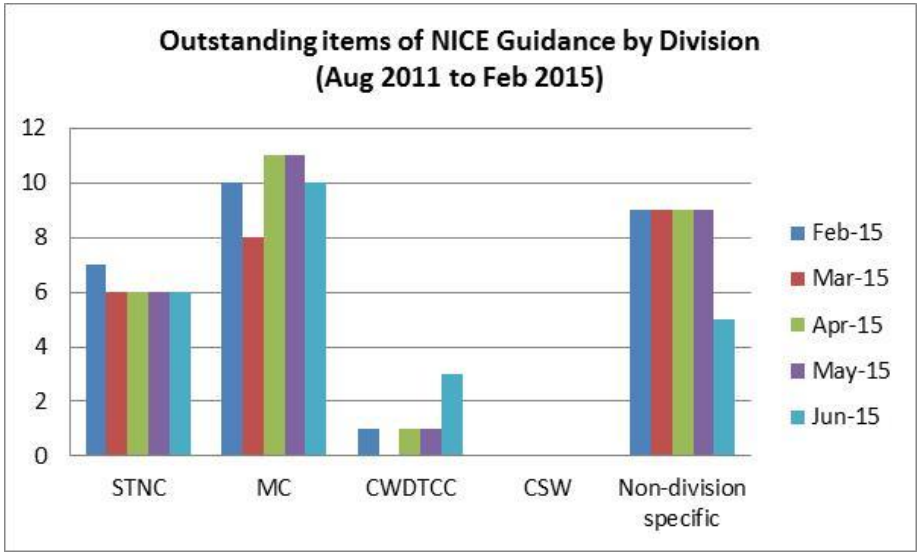
Overall Performance

Sign-in, Time Out and Sign-out – Marginal improvement to 96% (94% in the last audit round). ENT, MaxFax and Vascular scored 100% . Cardiothoracic scored 64% for Briefing/Debriefing and 79% for Sign-in/Time-out/Sign-out. These are the lowest scores in this audit round.

Action Plan: This is being led by the surgical clinical lead for WHO.

- Report circulated to Clinical Governance leads and findings will be presented at the next Theatre Care group meeting for discussion.
- Support to be given to 3 specialties with the lowest results to understand the issues they face and help improve compliance.
- Clinical lead to visit best performing areas to congratulate them and gain insight into their successful processes, which can then be shared.
- Focus on improvements to Time-out checks, with target of 100% compliance at next audit round.
- Matrons and team leaders to discuss findings with their local teams.
- Surgeons and anaesthetists to collect data for quarter 1 2015/16.

6. Clinical Audit and Effectiveness (Page 5 of 5)
- NICE (National Institute of Health and Social Care Excellence) Guidance



Items of NICE Guidance with Compliance Issues (Jun 2010 to Dec 2014)

Division	2010	2011	2012	2013	2014
STNC (n=7)		n=1	n=2	n=1	n=3
M+C (n=15)	n=2	n=3	n=4	n=1	n=5
CWDTCC (n=15)	n=3	n=1	n=1	n=3	n=7
CSW (n=0)					
Non-division specific (n=6)	n=2			n=3	n=1

Overview

There were 32 items of NICE guidance released in February and March 2015 and we have already received 23 responses. For guidance issued between August 2011 and February 2015 there are currently 24 items of guidance outstanding; which is a decrease of 3 to the previous report with an additional month's guidance included. The chair of the Clinical Effectiveness and Audit Committee has reviewed non–division specific guidance in order to assess applicability to the trust and has identified appropriate leads for the audit team to contact. This has reduced the number outstanding. It is hoped that increased focus from the M+C division, with support from the senior leadership team, will result in an improved position over the coming months.

To improve understanding and management of risks associated with either non compliance or partial compliance, the audit team is redesigning the NICE gap analysis template. This will include a risk assessment for each aspect of guidance where non- or partial- compliance is reported and will provide an overall RAG rating. The template is being developed in partnership with the Divisional Director of Nursing and Governance for the M+C division. It is anticipated that the audit team will implement the new tool this month as part of the six-monthly review of all guidance with compliance issues. This will enable the divisions to develop an accurate picture of implementation and to form an understanding of any risk associated with non-compliance.

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Patient Safety

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

S	Q1 SIs Declared by Division (Inc. Pus)				
	Med & Card	Surgery & Neuro	Community	Children's and Women's	Corporate
Feb	9	1	**6**	8	0
March	9	2	**8 including 1 never**	7	0
April	14	3	**1**	0	0
May	11 **including 1 never**	3	**1**	2	1

Closed Serious Incidents (not PUs)					
Type	Feb	March	April	May	**Movement**
Total	3	10	11	9	⮟
No Harm	1	6	7	7	➤
Harm	2	4	4	2	⮟

Table 1

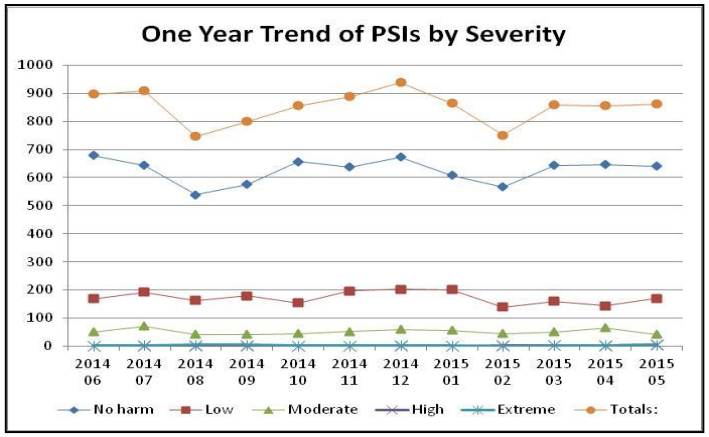
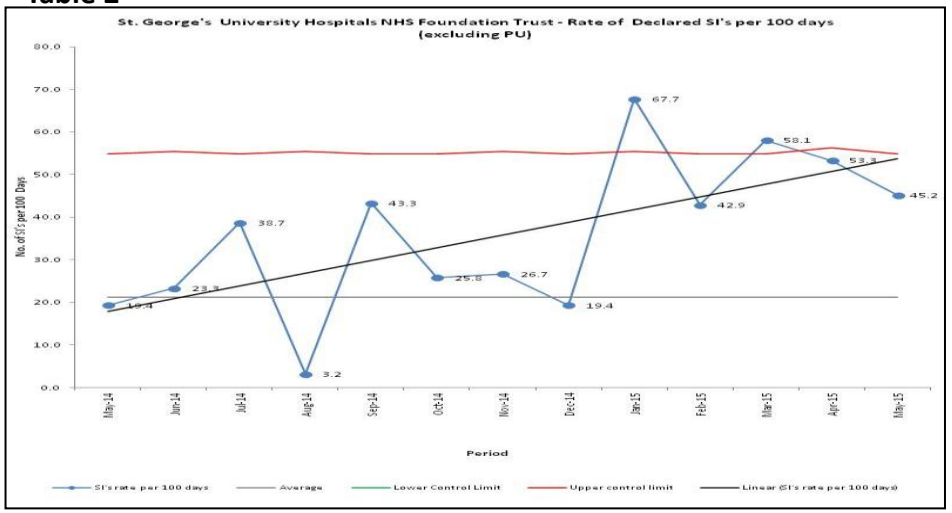


Table 2



Overview:
The numbers of general reported incidents are shown in Table 1. The number of no harm incidents appears to be increasing as are the numbers of moderate, high and extreme incidents. This trend should be observed carefully in conjunction with the trends and profile of SIs

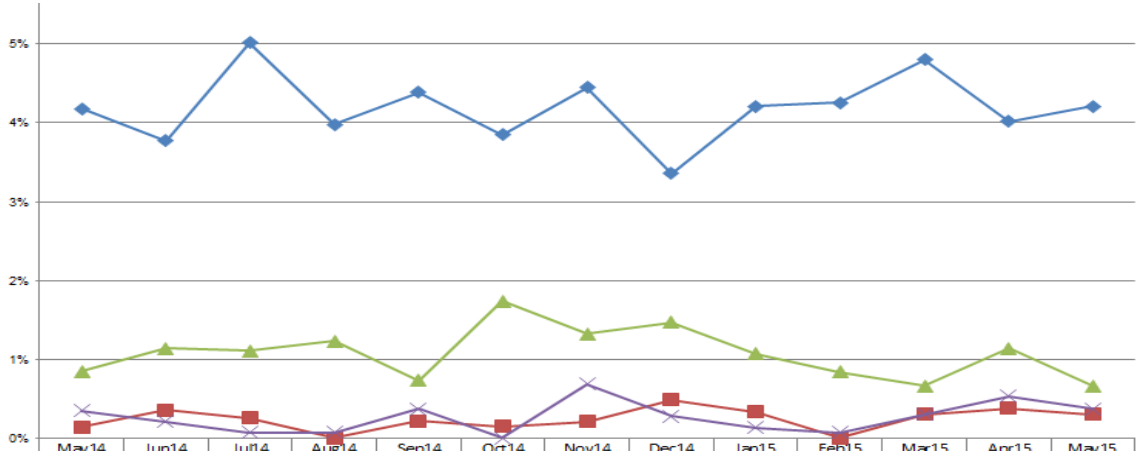
The annual trend for new serious incidents excluding pressure ulcers shown in Table 2 continues to show an increase. There were 14 general SIs reported in April (+4 grade 3 pressure ulcers).

The 14 general SIs declared in May relate to a range of different issues. They include:
- Death in custody
- Failure to follow up /assess/escalate
- Failure to follow up on test results
- Medication omission
- Maternity
- Retention of a surgical object
- 2 delayed LAS handover

The majority of these happened in one division, additional work is being done to identify themes that require additional preventative action.

7. Patient Safety
- Safety Thermometer

% Harm Free Care							
Lead Director	March 2015	April 2015	May 2015	**Movement**	**2015/2016 Target**	**National Average May 2015**	**Date expected to meet standard**
J Hall	94.39%	94.20%	94.61%	↑	95.00%	93.95%	March 16



	May14	Jun14	Jul14	Aug14	Sep14	Oct14	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15
Pressure Ulcers	4.18	3.77	5.02	3.98	4.39	3.85	4.45	3.36	4.21	4.26	4.8	4.02	4.21
Falls	0.14	0.36	0.26	0	0.22	0.15	0.21	0.49	0.33	0	0.3	0.38	0.3
Catheter & UTI	0.85	1.14	1.11	1.23	0.73	1.74	1.32	1.47	1.07	0.84	0.66	1.14	0.66
New VTE	0.35	0.21	0.07	0.07	0.37	0	0.69	0.28	0.13	0.07	0.3	0.53	0.37
Patients	1410	1405	1533	1458	1368	1377	1439	1429	1495	1433	1355	1320	1354

Pressure ulcers (57)

- 33 grade 2 (15 new, 18 old)
- 20 grade 3 (5 new, 15 old)
- 4 grade 4 (0 new, 4 old)

CAUTI (9)

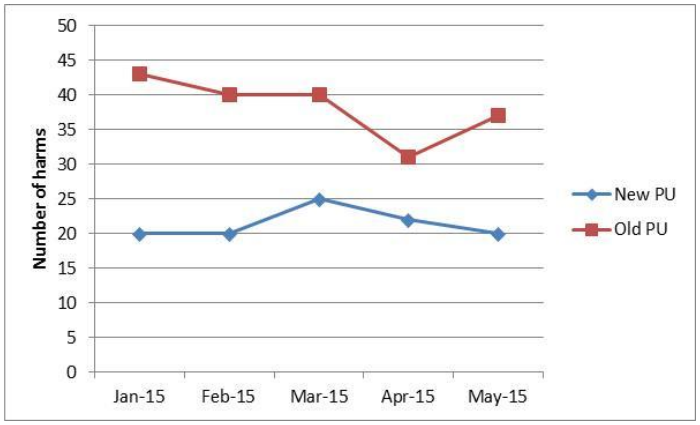
- 3 new
- 6 old

Falls (4)

- 3 low harm fall
- 1 moderate harm fall

VTE (5)

- 2 new DVT
- 3 new other



In May 2015 the proportion of our patients that received harm free care was 94.61%, which is very similar to levels reported in recent months and is slightly better than the national average for May of 93.95%. We reported 75 harms to 73 patients; 71 patients experienced one harm and 2 patients had 2 harms. 32 harms are categorised as new, meaning that they either developed or treatment began whilst under our care. Details of all harms reported are provided above.

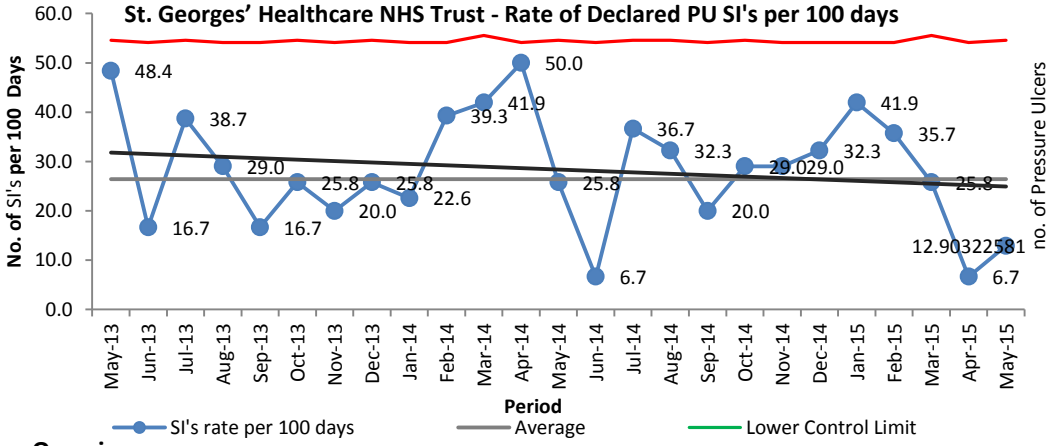
Harms related to pressure ulcers increased marginally this month. This increase is attributed to a greater number of old pressure ulcers observed. There was a decrease in harms reported for each of the remaining categories.

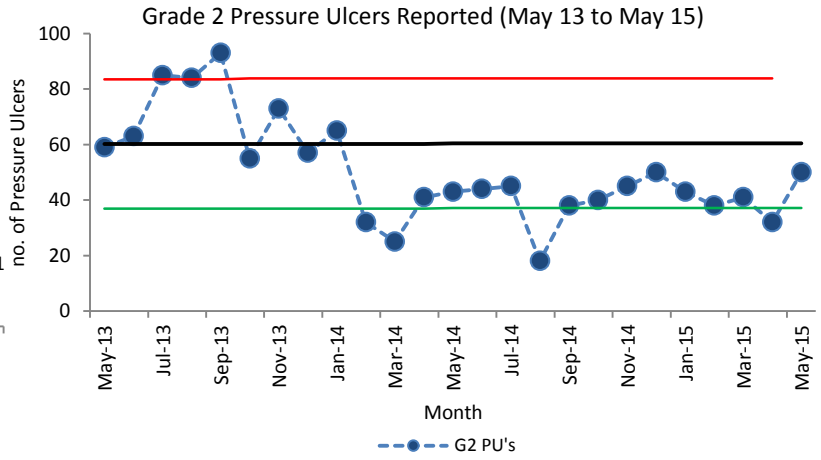
This month we received a letter from NHS England, inviting Trusts to review their approach to monitoring harm. We plan to continue using the Safety Thermometer, and will also implement the medication and children and young persons tools over the coming months.

7. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers										
Type	Jan	Feb	Mar	Apr	May	YTD April – May 2016	Movement	2015/2016 Target	Forecast March 2015	Date expected to meet standard
Acute	10	5	5	1	4	**5**	▲		G	-
Community	3	5	3	1	0	**1**	▼		G	-
Total All	13	10	8	2	4	**6**	▲		G	-
Total Avoidable	**8**	**3**	**2**	**2**	**4**	**6**		40		-

Grade 2 Pressure Ulcers						
Jan	Feb	Mar	Apr	May	Movement
22	18	30	25	37	▲
21	20	11	7	17	▲
43	38	41	32	50	▲





Overview:

May saw an increase in the total number of pressure ulcers across the trust. Despite this the community division achieved a zero incident rate of pressure ulcer SI's for the month.

Actions:

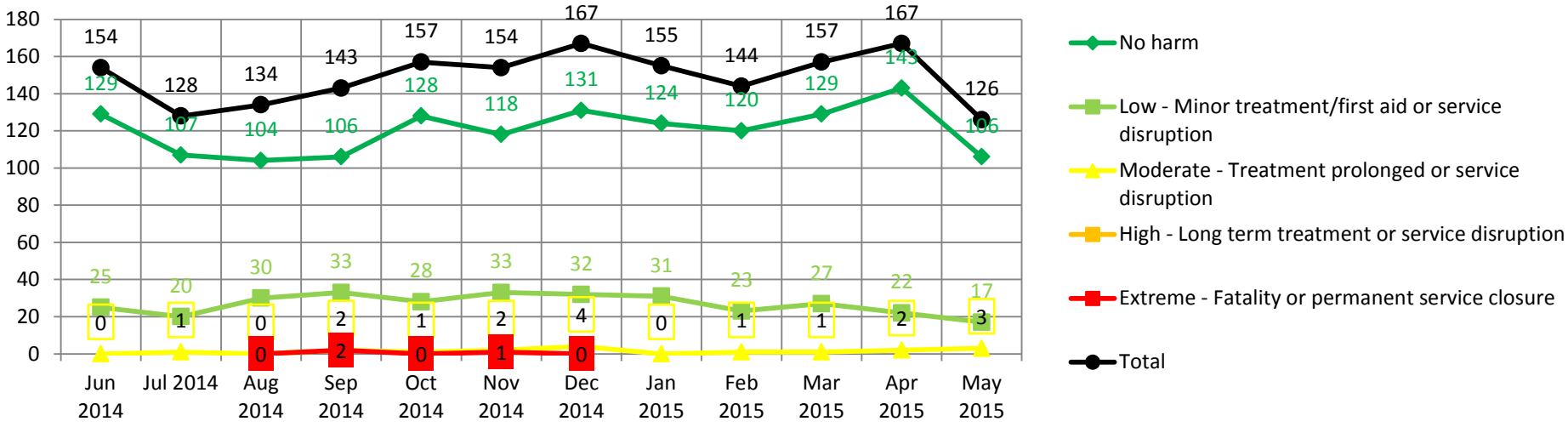
- Internal Trust trajectory set for 2015/2016 of 40 avoidable pressure ulcers , this is a 30% reduction on actual numbers last year 2014/2015
- Further work underway to agree and formulate the 72 hour checklist for avoidable pressure ulcers
- Recruitment underway for Band 7 TVN post in community and Band 6 Acute TVN – both replacement posts
- Quality improvement approach implemented to monitor trends in specific clinical areas on completion of pressure ulcer repositioning charts . Ward sisters and matrons engaged to own the progress and make changes to practice
- Pilot of a new risk assessment tool commenced on Keate ward

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

Falls														
Lead Director	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	Movement	2014/2015 Target	Date expected to meet standard
	151	151	125	143	157	154	169	154	144	157	165	126	⟷	100	July 2015

Falls with Harm April 2014-March 2015				
No Harm	Moderate	Severe	Death	Falls related Fractures
2064	25	3	0	7

Patient Falls by Incident date (Month and Year) and Severity



Overview: The graph shows the profile of falls across both acute and community services including bed-based care and patients' own homes. It is important to note that this data is sourced from incident reporting and is not individually verified. There has been a decrease in the number of falls in May which is promising but requires a further monitoring over the next few months to be significant. **Actions:** The Trust participated in the National Inpatient Falls Audit and the results will be available imminently from which an action plan will be developed. We will be auditing bed rail risk assessment compliance. We will be piloting the NICE compliant falls risk assessment in the coming months before full implementation.

7. Patient Safety: May 2015
- Infection Control

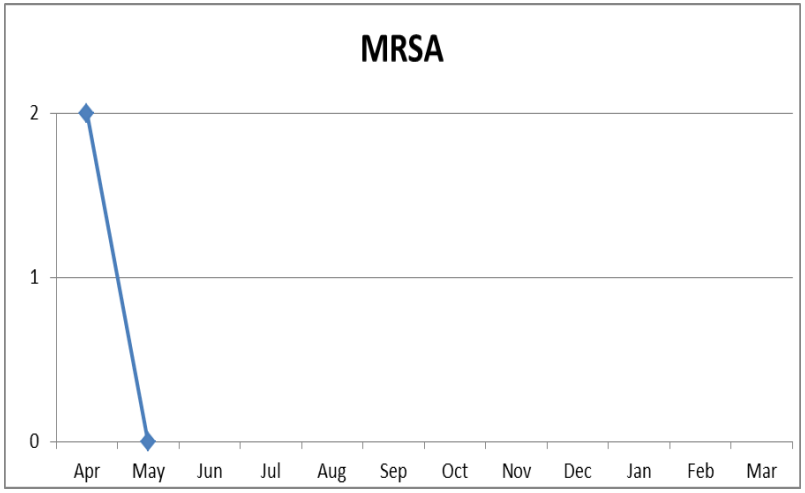
MRSA						
Lead Director	April	May	Movement	2015/2016 Threshold	Forecast June- 15	Date expected to meet standard
JH	2	0	⮟	0	G	-

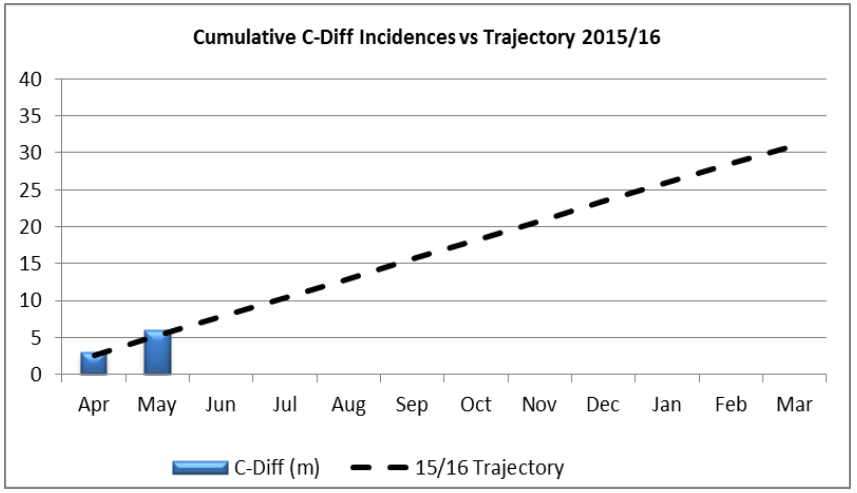
Peer Performance – YTD May 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
2	2	0	0	3

C-Diff						
Lead Director	April	May	Movement	2015/2016 Threshold	Forecast June - 15	Date expected to meet standard
JH	3	3	➤	31	R	-

Peer Performance – YTD May 2015 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
6 (31)	6(16)	10(9)	36(72)	12(39)

The MRSA bacteraemia threshold is zero. Their were no cases of MRSA bacteraemia in May. The trust is non-compliant with 2 incidents in total.
In 2015/16 the Trust has a threshold of no more than 31 C. diff incidents. In May there was 3 C. diff incidents , a total of 6 for the FY to end May.
All incidents are subject to RCA analysis with the themed reviews being considered by the Infection Control Committee.





7. Patient Safety - VTE

VTE Risk Assessment

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

Data Source	June	July	Aug	Sept	Oct	Nov	Dec	Jan (2015)	Feb	Mar	April	May
Unify2	97.33%	97.28%	96.60%	96.84%	94.91%	93.18%	93.51%	95.94%	96.03%	96.27%	96.64%	

2. Overview: Nursing staff collect data monthly across a range of safety indicators, including completion of VTE risk assessment, via the safety thermometer. Data is collected for all patients across the Trust on a single day of the month, representing a snapshot in time. Data is obtained from the drug chart and measures the total number of complete VTE risk assessments at the point of audit against the total number of beds occupied. **NB. The RAG ratings for the safety thermometer changed in April 2015 to be consistent with the UNIFY targets. This accounts for many of the red rated months below**

Data Source	June	July	Aug	Sept	Oct	Nov	Dec	Jan (2015)	Feb	Mar	April	May
Safety Thermometer (SGH)	85.22%	89.94%	86.51%	86.44%	85.39%	86.56%	75.92%	79.08%	83.89%	85.74%	89.83%	90.19%
National average	84.83%	84.62%	90.87%	85.50%	85.04%	84.19%	83.98%	84.69%	84.82%	84.69%		

Comparison of data streams:

The methodology applied to collect data and the standard being assessed differs for the above two data streams contributing to the differences in the results observed. Data submitted to UNIFY2 is generated automatically from electronic records for every patient admitted to the Trust (that meet the inclusion criteria for VTE risk assessment as outlined by NICE). The data is retrospective and records whether an assessment has been completed at any point during the patient's admission.

The Patient Safety Thermometer is a snapshot audit conducted once a month looking at every patient in the Trust at a certain point in time. A different nurse records the data on each ward which may introduce auditor variability. This audit is carried out against the standard that a patient has had a risk assessment completed on admission. If there is no risk assessment documented at the point of audit the patient is non-compliant. Up until the end of the 2014/15 financial year the % non-compliant also included patients for whom a risk assessment was 'not applicable'; for example paediatric patients or patients that were still within the first 24 hours of their admission. This contributed to lower compliance when compared to the UNIFY2 submission (for which these categories of patients were excluded). From April 2015 the patient safety thermometer data for St George's will be adjusted to remove results recorded as not applicable.

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

Current and Future developments:

- An electronic prompt has been installed in iClip to alert physicians if an admission VTE assessment has not been completed when a patient record is opened (a second prompt also triggers 18 hours after completion of the admission assessment if the follow up assessment has not been completed). Initial reports indicate that this has had a significantly positive impact on risk assessment completion and the timeliness of assessment completion in the 'live' areas.

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

Year		2015
HAT cases identified to date (attributable to admission at SGH)		88
Mortality rate	Total	11.4% (10/88)
	VTE primary cause of death	6.8% (6/88)
Initiation of RCA process		100%
RCA pending	<28 days since notification	26
	>28 days since notification (notes requested)	6
RCA complete		63.6% (56/88)

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

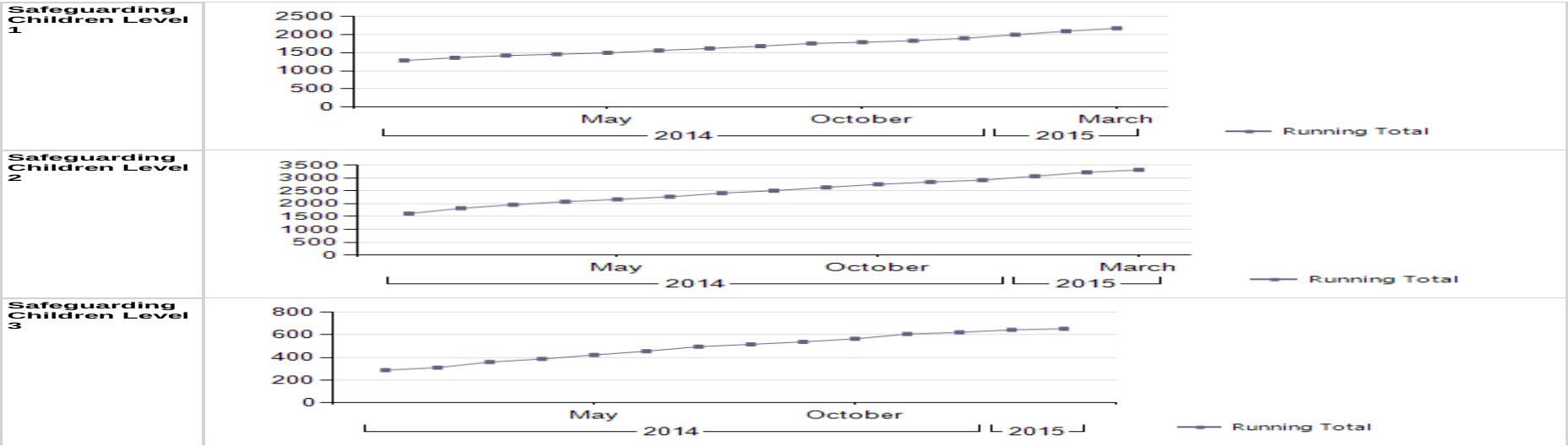
Trends identified (findings from 56 cases for whom RCA is complete):

- General breakdown includes:
  - 33.9% – patients had active cancer
  - 10 cases in regular day attenders (oncology/haematology/haemodialysis)
  - 2 cases of pulmonary embolism following stroke
  - 8 patients >100kg
- Adequate prophylaxis received 82.1% (46/56) –Examples of contributing factors to failure of prophylaxis:
  - 14 patients - malignancy +/- complications arising from malignancy
  - 10 patients – pharmacological prophylaxis contraindicated
  - 3 patients – previous VTE which recurred after stopping treatment
  - 1 patient with thrombosis due to heparin induced thrombocytopenia (HIT)
- Inadequate prophylaxis received 17.9% (10/56) – Examples of reasons for inadequate prophylaxis:
  - 3 patients - Dose of LMWH not escalated appropriately in obesity
  - 3 patients – Doses of LMWH omitted with no clear documented reason
  - 2 patients – Treatment for previous VTE stopped too soon
  - 1 patient not given extended VTE prophylaxis on discharge where indicated

Results and recommendations following RCA of 2014 HAT cases were presented at the WCCC Divisional Governance meeting on 14/05/15. They will presented at MedCard Divisional Governance Board on 18/06/2015.

7. Patient Safety
- Safeguarding Children

Safeguarding Training data 2014 -2015



Target areas: Training compliance is a targeted area for the safeguarding team and specific work has been done this month in drilling down into the data. This has enabled the team to identify areas both of particular concern and of good compliance. This deep dive into the data has revealed that a number of areas that are seen as high priority areas for safeguarding children have excellent compliance with mandatory level 3 safeguarding training . in the acute division the paediatric wards have excellent compliance; examples include Freddie Hewitt Ward (23 staff) 100% Pinckney Ward (34 staff) 97% and in the community, health visiting compliance is 93% and school nursing 95%. Another 21 staff attended training in the community on June 11th but this is not yet included in the data.
The safeguarding team working party are focusing on developing an action plan that will target the non-compliant high priority areas as a matter of urgency.

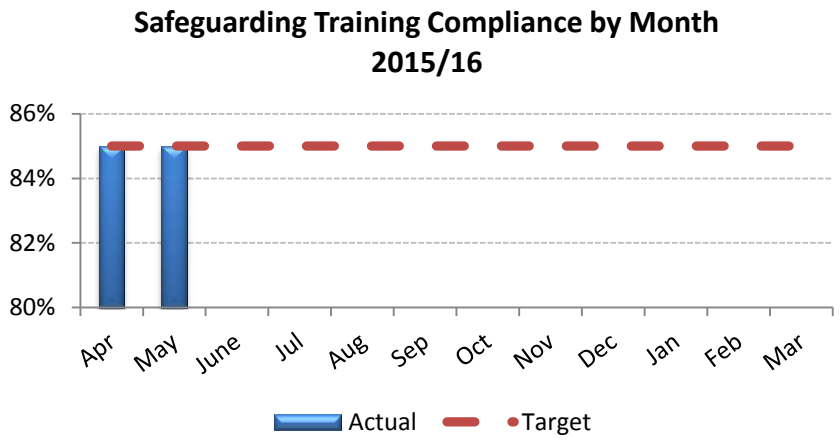
Serious Case Reviews and Internal Management Reviews: There have been no new SCR/IMR cases declared this month, although staff are still working on the cases already in progress. The Kingston SCR (Family C) timeframe has been extended to September 2015.

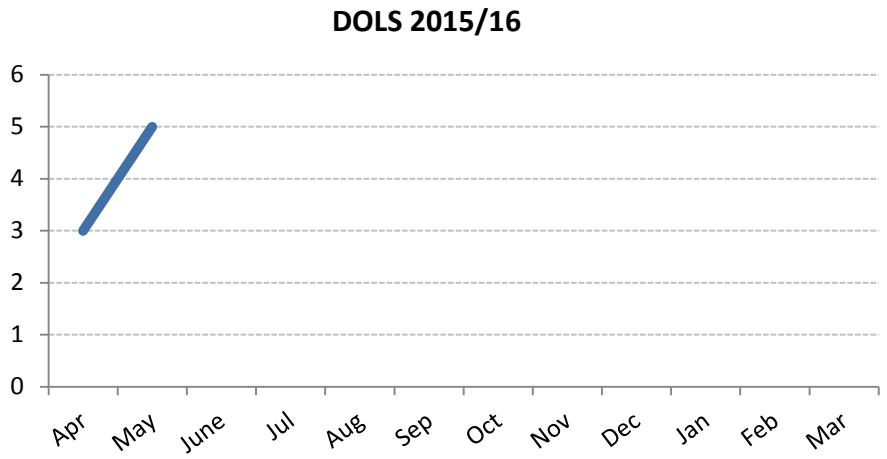
Other: Section 11 Audit – except from letter received by the Chief Nurse from Nicky Pace, the Independent Chair of Wandsworth Safeguarding Children Board
" I am writing on behalf of the WSCB and Panel to thank you and your staff for participating in the audit process this year. We were extremely impressed again, like last year, at the significant amount of workers within St George's Hospital Trust (both Acute and Community Services) who completed the S11 self-assessment questionnaire. You exceeded your great achievement of last year, from 353 to 460! Please extend my appreciation to everyone who participated in the process.

7. Patient Safety
- Safeguarding: Adults

Safeguarding Training Compliance - Adults									
Lead Director	Dec	Jan	Feb	Mar	April	May	2015/20165 Target	Forecast April 2015	Date expected to meet standard
JH	87.3%	87%	86.2%	87%	85%	85%	95%	A	-

Safeguarding Adults Training Compliance by Division – May 15				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
81%	83%	89%	88%	83%





Overview:

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

April – 74, May 76, June 77, July 84, Aug 45, Sep 74 Oct 76, Nov 75, Dec 68, Jan 77, Feb 70, Mar – 80, Apr 90, May – 70,

Currently there is no centrally held record of MCA training but as part of the action plan around MCA following the CQC report, training has been delivered and recorded, beginning with Queen Mary's, Roehampton., where 99% staff have been trained.

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

Actions:

Continue to monitor safeguarding training via ARIS

Review procedures following implementation of Care Act - Awaiting revision of Pan London Procedures due July 2015

Roll out MCA training across trust, audit effectiveness

Review DOLs activity and impact on resources. Monitor demand on services versus capacity to complete assessments. Produce fresh guidance on DOLS in conjunction with Law Society guidance. Revised briefing paper with legal team was presented to EMT In November indicating current position, impact on resources and future options to manage the governance and workload..Further review of legal position requested from Trust solicitors to ensure compliance with current case law. New DOLS paperwork circulated Jan 15. New procedure in place to ensure reporting of those subject to DOLS are reported to the coroner

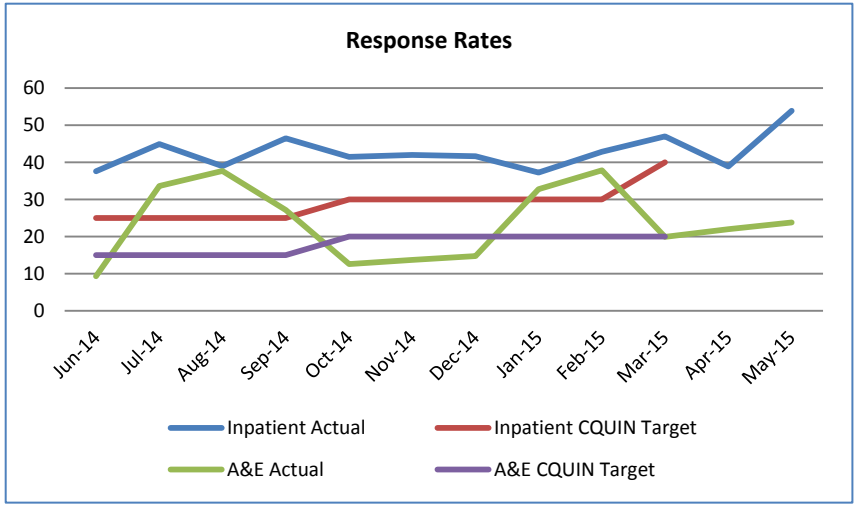
St George's University Hospitals NHS
NHS Foundation Trust

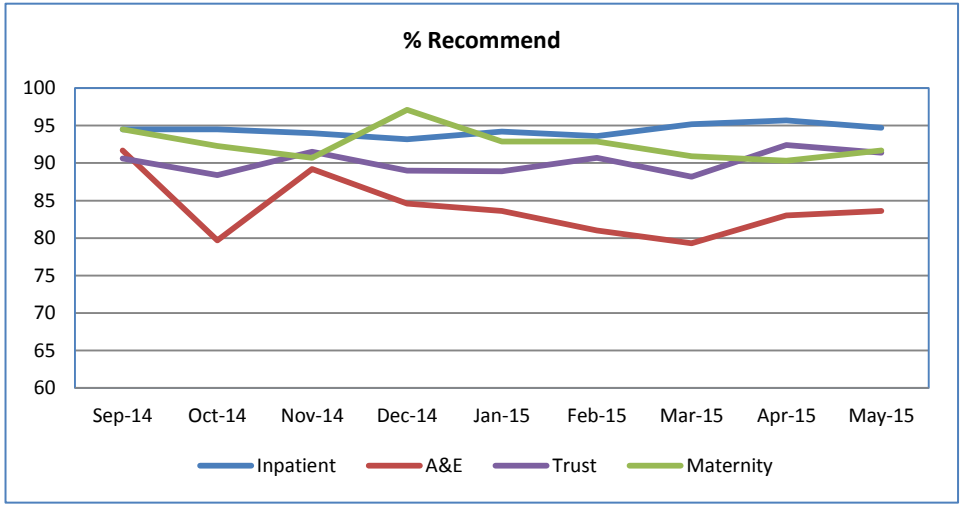
Patient Experience

8. Patient Experience
- Friends and Family Test

FFT Response Rate							
Domain	Mar-15	Apr-15	May-15	Movement	2015/2016 Target	Forecast	Date expected to meet standard
Trust	29.5	28.9	34.3	▲	-	-	-
Inpatient	47	38.9	53.9	▲	-	-	-
A&E	22	23.8	25.5	▲	-	-	-
Maternity	25.3	24	24.3	▲	-	-	-

	FFT Response Score			
	Mar-15	Apr-15	May-15	Movement
	88.2	92.4	91.4	▼
	95.2	95.7	94.7	▼
	79.3	83	83.6	▲
	90.9	90.3	91.7	▲





Overview : All CQUINs were met for last year. We are now exploring how to shift our focus from response rates to the content of what our patients are telling us. We are trialling new reports that focus on the 3 areas we score the lowest on.

Action :

Continue to monitor response rates, and monitor the 5 poorest performing services in the key areas of noise at night, information about medication side effects and involvement in the discharge process.

Improve the co-ordination of patient experience data with other quality metrics.

8. Patient Experience
- Triangulation of Patient Experience Themes – Q4 2014/15

Complaints	PALS	Inpatient Survey
1. Clinical treatment 2. Communication 3. Waiting times	1. Appointments 2. Communication 3. Request for information	1. Excessive noise at night – caused by staff and/or other patients 2. Information about medication side effects 3. Being involved in decisions about discharge

From the above, we can see similarities between the themes in complaints and PALS – these methods of patient feedback allow patients to choose their topic of concern. In contrast, our patient survey feedback is guided by the questions we ask in the survey.

Within the patient responses in the inpatient survey, there is currently a question relating to respect and dignity which has very positive responses. This could be linked to communication and staff attitude. However, further work will be required to drill down into communication and staff attitude.
This will enable us to align our survey questions to focus on the problem areas identified by Complaints and PALS.

Actions:

Conduct an in-depth analysis of complaints and PALS contacts that relate to the top three issues, and use our finding to amend the current inpatient, outpatient and community services surveys. If patients suggest they have problems with any of these themes, we will ask additional questions to fully understand the cause.

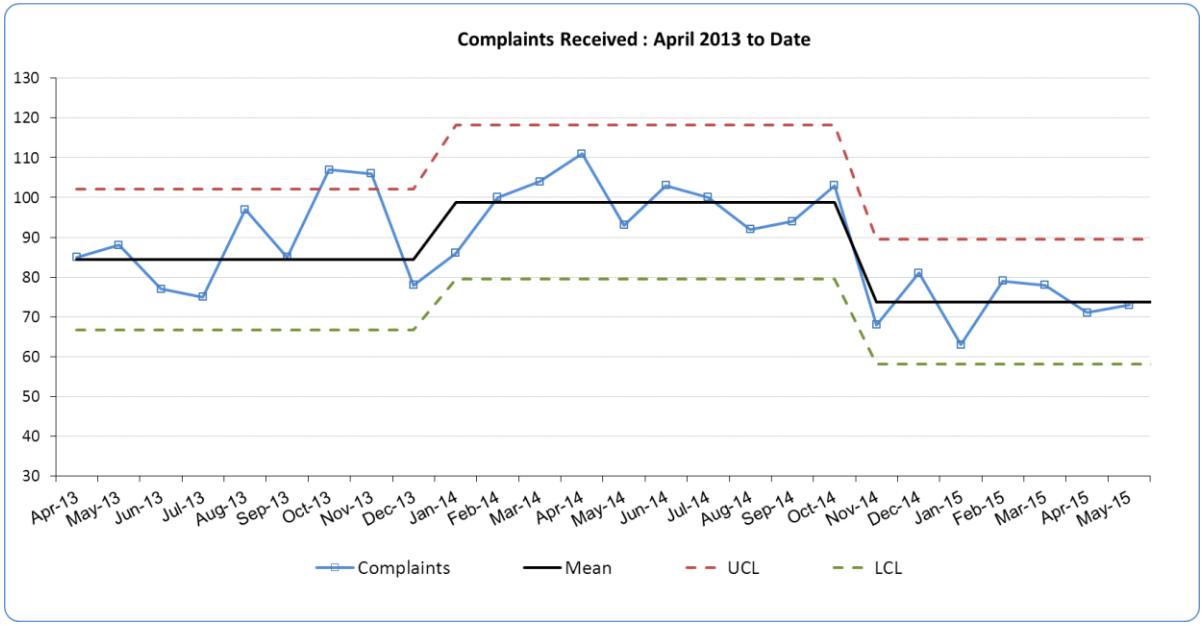
8. Patient Experience
- Triangulation of Patient Experience Data (1st May to 31st May 2015)

Specialty	PALS	Complaints	FFT Score
Accident and Emergency	3	2	85
Cardiology	6	2	92.9
Cardiothoracic Surgery	4	1	94.8
Clinical Haemotology	0	0	100
Ears Nose & Throat	8	4	97.1
Gastroenterology	4	0	89.3
General Medicine	2	3	95.2
General Surgery	10	3	95.3
Gynaecology	17	0	95
Infectious Disesases	0	0	96.6
Medical Oncology	0	0	100
Nephrology	0	0	100
Neurology	5	3	98.9
Neurosurgery	10	2	98.3
Paediatric Medicine	5	5	85.4
Plastic Surgery	9	1	98.2
Rehabilitation	0	0	100
Respiratory Medicine	0	0	100
Senior Health	3	0	88.4
Trauma & Orthopaedics	27	4	94.9
Urology	5	0	94.9

All specialties who had a 100% ‘recommend’ rate from their patients had no PALS contacts or Complaints during the month of May

8. Patient Experience
- Complaints Received

Complaints Received															
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	Movement
Total Number received	111	92	100	99	92	94	107	68	81	63	79	78	71	73	=



Overview:

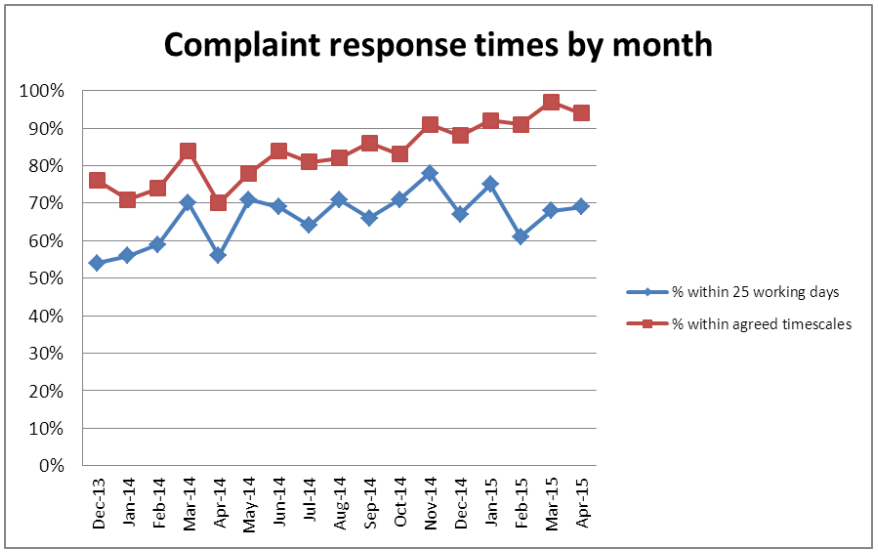
This report provides a brief update on complaints received since the last board report (so in May 2015) and information on responding to complaints within the specified timeframes for complaints received in April of 2015/2016. It also includes some posts made on NHS Choices and Patient Opinion. The board will receive more detailed information about complaints received in quarter 1 with divisional breakdowns, analysis of the data to provide trends and themes with actions planned and a severity rating report and once the target date for complaints received in quarter 1 is reached (so August 2015).

Total numbers of complaints received in May 2015

There were 73 complaints received in May of 2015, no real change from April 2015 when 71 complaints were received. 10 complaints received in April have been de-escalated since the last board report hence why 81 complaints were reported last month. Of note , there was a reduction in complaints being received about the Accident and Emergency care group from 9 complaints in April to 2 in May. There was an increase in complaints received about the Imaging care group from 0 in April to 3 in May, 1 was for Diagnostic Radiology and 2 for Breast Screening. The 2 complaints did not share any common themes. The number of complaints being received about the Offender Healthcare care group remains high with 8 having been received in April and 10 in May with the most complained about subject being clinical treatment – medication.

8. Patient Experience
- Complaints Performance against targets

Performance Against Targets April 2015				
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	11	5	45%	(4) 82%
Medicine and Cardiovascular	22	14	64%	(7) 95%
Surgery & Neurosciences	21	16	76%	(5) 100%
Community Services	16	14	88%	(2) 100%
Corporate Directorates	1	1	100%	(0) 100%
Totals:	71	50	70%	(18) 96%



Overview:

For complaints received in quarter 1 of 2015/2016 so far, so April of 2015, 70% were responded to within 25 working days, 1% higher than in quarter 4 of 2014/2015. Community Services and Corporate Directorates exceeded the target of 85% whereas the other divisions missed the target, Women's and Children's and Medicine and Cardiovascular by a considerable margin.

For the same period 96% of complaints are planned to be responded to within 25 working days or agreed timescales, the same percentage as in quarter 4 of 2014/2015. The final percentage may change depending on whether all of the agreed extensions are eventually met. For the first time three divisions are planning to respond to 100% of complaints within agreed timescales.

Actions:
There are two months left in quarter 1 in which to improve the position and an update will be provided in the July board report when the targets will have been reached for complaints received in May 2015.

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

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

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

Dennis Roberts gave Vascular Services at St George's Hospital (London) a rating of 5 stars
Abdominal aorta aneurism repair
I was admitted for the above procedure on Sunday, had two days of tests, all as previously advised. Operation took place on Wednesday taking two hours under general anaesthetic and I was discharged on Friday afternoon having had two stents fitted. I suffered no pain or after effects and am delighted with the outcome. The nursing staff also have my thanks as their care was exemplary.

I am 78 years 11 months old too ! Wow

Visited in April 2015. Posted on 27 April 2015

Anonymous gave Maternity Services at St George's Hospital (London) a rating of 5 stars
Antenatal Day Monitoring Unit
Got myself in a right state worrying about my baby's heartbeat. Made one call to the DMU in The Lanesborough Wing and was invited in that same day to have the heart listened to. Absolutely stellar care and sensitivity shown to me by members of that team: They had all the time in the world for me and made me feel so cared for. Brilliant experience, and so reassuring.

Visited in May 2015. Posted on 27 May 2015

Anonymous gave Orthopaedics at St George's Hospital (London) a rating of 1 stars
Dissatisfied with Doctor's attitude
I went to the fracture clinic with my 18 month old daughter as she had a nasty fall down the stairs yesterday and was diagnosed with a bend in the right wrist bone by the A&E at St. Georges. The doctor at the A&E put on a temporary bandage on my daughter's wrist/ arm and I was asked to book an appointment at the fracture clinic the next day to have the doctor check my daughter's wrist thoroughly (for swelling etc) and have a proper cast put on her arm. I was given a 4 pm appointment for the next day. At the fracture clinic, I waited for over 1 hour before I was finally taken to the examination room (at 5:10 pm or so). While I was waiting in the examination room, the fire alarm went off (probably a false alarm or a drill as the doctors stayed inside and did not bother coming out with the rest of us) and we (patients and nurses) moved out of the premises.

While we were moving out, I heard one of the doctors telling the nurse that this was it and no more patients could be seen, upon which the nurse (thankfully!) objected and said that this wasn't fair since I had been waiting for over 1 hour for my appointment. The said doctor obviously was in no mood to wait and while we were all waiting outside. The doctor came to me and said that they had seen the x ray and that I should come back after 2 weeks to see them, and no check up was required today. All this was brought to my notice while I was standing outside waiting for the fire alarm to go off! Interestingly, all through this conversation, the doctor kept mistaking my daughter for a boy - and that really makes me wonder if the doctor really even read the case notes! I am totally shocked and appalled at the attitude of this doctor (whose name unfortunately I don't know). They just brushed my daughter off only because checking her would have delayed them by a few minutes. She was also not given a proper cast because the doctor was ready to call it a day! I have never seen such an apathetic attitude from the medical fraternity, St. George's hospital should be ashamed of having such a bad doctor and more importantly a terrible human being on its rolls.

Visited in May 2015. Posted on 27 May 2015

St George's University Hospitals NHS
NHS Foundation Trust

Workforce

excellent kind responsible respectful

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

Overview

The information provided on the table above relates to staffing numbers at ward/department level submitted nationally on Unify for May 2015. In line with new national guidance this table shows the number of filled shifts for registered and unregistered staff during day and night shifts. In May the trust achieved an average fill rate of 95.5%, a slight increase from 94.1% submitted in April . Data cleansing continues to ensure that the report is being run consistently and only relevant front line nursing roles are included.

A new standard operating procedure was introduced which has assisted in speeding up validation of the data but still requires improvement. The presentation of the data provided internally has been changed to assist the reader in reviewing data more easily by division. For the purposes of the quality report the UNIFY report is provided.

Although some of our wards are operating below 100% the data does not indicate if a ward is unsafe. Safe staffing is much more complex than an observation of percentages and takes in to account many key aspects such as:
Nurses, midwives and care staff work as part of a wider multidisciplinary ward team. The demand on wards can change quickly and it will always be a clinical judgement as to whether to bring more staff in or reduce the amount the staff as per requirement.

- The data does not take into account the on-going considerations for ward managers in ensuring that on each shift there is the right level of experience and expertise in the ward team.
- The nature of each ward varies. The number and type of patients seen on some wards will be relatively consistent. The number and type of patients seen on other wards will vary more dramatically, meaning that there could be greater change from the planned level and the average will be somewhere in the middle of the highs and lows of this variation.
- There needs to be the operational context of the reasons for staffing levels month on month, for example reduced demand.
- Higher than 100% fill rates relate to areas which require more staff than they are profiled for. This could be because the patients the team are looking after are exceptionally unwell or require one to one nursing or supervision called specialling. This is an anomaly in the data which is to be reviewed.
- St George's Healthcare NHS Trust has a safe staffing policy and a system in place for monitoring staffing levels on a daily basis. Nursing and midwifery clinical leaders visit their clinical areas across the trust at least once a day to ensure safe staffing and staff are encouraged to escalate any concerns they have to the chief nurse on duty. The acuity/dependency of patients (how sick or dependent they are) is also monitored closely as this ultimately affects the type and amount of care patients need. If concerns are raised about staffing levels, the clinical leaders may make the decision move members of staff across the trust so that the area is safely staffed. This ensures that our patients are well cared for.

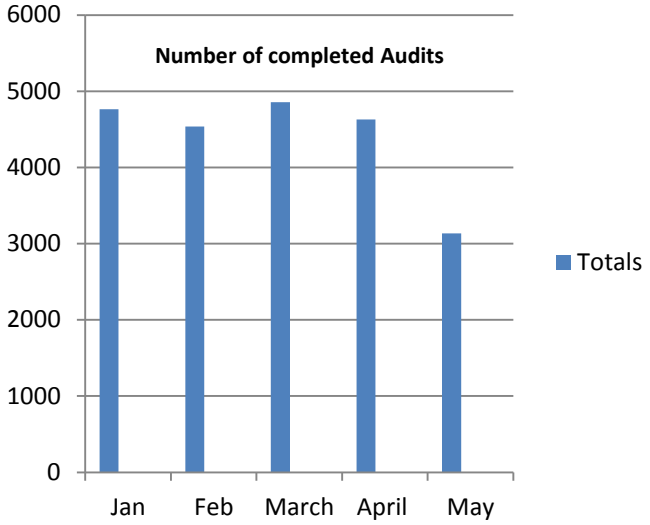
Actions

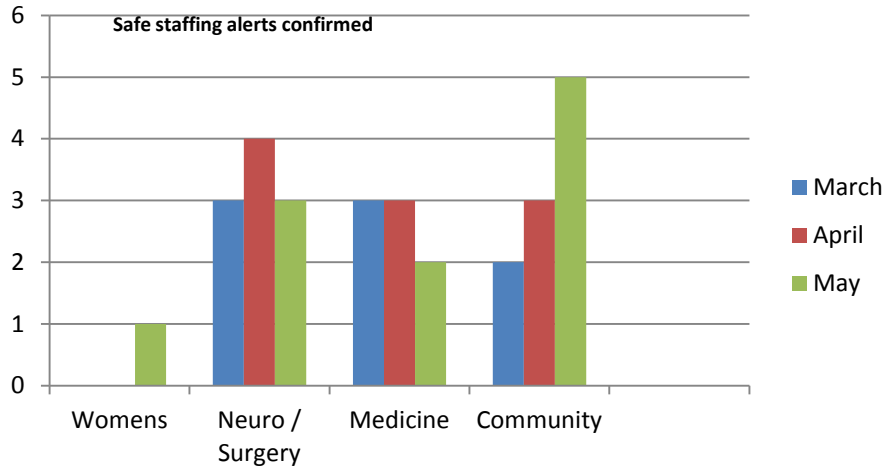
- The Deputy Chief Nurse has set up a task force to review the way UNIFY data is collected, validated and reported.
- Await reporting guidance from NICE expected in June 2015
- Review the data collection process to ensure it links with eRostering and is able to identify run rate savings

9. SAFE STAFFING: UNIFY REPORT FOR INPATIENT AREAS

	Day		Night		
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Overall %
Cardiothoracic Intensive Care Unit	90.2%	100.0%	98.5%	100.0%	94.33%
Carmen Suite	94.0%	88.2%	100.1%	93.5%	95.73%
Champneys Ward	91.6%	102.6%	98.4%	100.0%	95.84%
Delivery Suite	104.1%	87.4%	110.2%	87.1%	103.79%
Fred Hewitt Ward	91.0%	104.2%	97.6%	60.0%	94.40%
General Intensive Care Unit	94.3%	14.4%	98.9%	100.0%	93.82%
Gwillim Ward	120.1%	90.7%	100.8%	100.0%	107.13%
Jungle Ward	103.2%	#DIV/0!	#DIV/0!	#DIV/0!	103.18%
Neo Natal Unit	96.1%	-431.3%	102.2%	#DIV/0!	100.85%
Neuro Intensive Care Unit	92.9%	78.3%	98.1%	99.8%	94.92%
Nicholls Ward	93.9%	85.2%	100.3%	93.6%	95.32%
Paediatric Intensive Care Unit	120.1%	96.3%	119.4%	100.0%	116.67%
Pinckney Ward	110.2%	116.0%	98.1%	#DIV/0!	107.51%
Dalby Ward	88.6%	98.5%	96.8%	98.9%	95.45%
Heberden	93.2%	99.0%	98.0%	98.8%	97.11%
Mary Seacole Ward	92.5%	98.3%	96.7%	100.0%	96.73%
A & E Department	92.8%	80.2%	94.8%	84.7%	91.59%
Allingham Ward	85.3%	116.5%	95.2%	100.1%	96.62%
Amyand Ward	88.3%	100.0%	98.8%	98.9%	94.98%
Belgrave Ward AMW	87.7%	74.0%	100.0%	100.0%	89.09%
Benjamin Weir Ward AMW	89.9%	86.3%	99.3%	95.2%	92.76%
Buckland Ward	80.7%	93.2%	98.9%	100.0%	89.27%
Caroline Ward	89.9%	92.8%	99.2%	100.0%	93.74%
Cheselden Ward	96.7%	82.1%	95.7%	95.0%	94.68%
Coronary Care Unit	99.0%	#DIV/0!	100.0%	#DIV/0!	99.50%
James Hope Ward	95.1%	86.2%	97.3%	#DIV/0!	94.23%
Marnham Ward	80.5%	79.4%	94.7%	90.7%	85.88%
McEntee Ward	98.2%	98.9%	97.8%	100.0%	98.47%
Richmond Ward	91.1%	91.0%	94.9%	97.4%	93.28%
Rodney Smith Med Ward	90.5%	88.8%	98.9%	98.6%	93.17%
Ruth Myles Ward	97.0%	103.7%	98.9%	99.1%	98.74%
Trevor Howell Ward	97.4%	89.0%	98.9%	100.0%	96.78%
Winter Ward (Caesar Hawkins)	90.2%	90.0%	91.9%	100.0%	91.81%
Brodie Ward	93.9%	96.0%	99.7%	100.0%	96.47%
Cavell Ward	97.6%	118.5%	100.0%	100.0%	102.16%
Florence Nightingale Ward	92.6%	98.0%	103.8%	100.0%	97.27%
Gray Ward	94.5%	88.9%	98.4%	100.0%	95.21%
Gunning Ward	92.2%	82.2%	99.0%	96.9%	92.56%
Gwynne Holford Ward	79.0%	81.3%	98.4%	96.9%	86.42%
Holdsworth Ward	89.9%	97.2%	97.9%	98.5%	94.61%
Keate Ward	96.4%	96.5%	100.0%	#DIV/0!	97.59%
Kent Ward	90.9%	86.2%	99.1%	99.0%	92.87%
Mckissock Ward	92.5%	94.9%	97.6%	100.0%	95.17%
Vernon Ward	94.5%	88.6%	99.1%	99.9%	95.35%
William Drummond HASU	89.0%	85.2%	95.9%	90.0%	91.40%
Wolfson Centre	94.4%	96.5%	100.0%	100.0%	97.20%
Gordon Smith Ward	#DIV/0!	0.0%	#DIV/0!	0.0%	0.00%
Nightingale Step Down, Off Site Facility	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Trust Total	93.82%	90.40%	99.33%	97.38%	95.50%
	Day Qual	Day HCA	Night Qual	Night HCA	Overall
	93.82%	90.40%	99.33%	97.38%	95.50%

9. Workforce
May 2015 - Safe Staffing alerts





Overview: The purpose of the daily safe staffing audit is to identify areas that are unsafely staffed (known as alerts) and to ensure through a process of escalation that this situation is remedied. Alerts (identifying that a ward is unsafely staffed) are raised to senior nurses through a daily report on the RATE system. The safe staffing policy provides guidance on escalation and interventions that can be undertaken to make areas safe. The total number of audits that should be completed across the organisation monthly is approximately 6500. Wards are expected to complete the audit twice daily whilst community and out-patient teams tend to complete it on a daily basis.

The total number of safe staffing audits completed over the past three months were: February 4535, March 4857and April 4629. There was a slight increase in the number of final alerts reported from 10 in April to 11 in May. Four of the community alerts are for one service. This service has a low number of posts but a high vacancy rate. The service has an action plan in place to cover the workload. The number of alerts reduced to a concern (ward is safely staffed but some care needs will not be completed) has slightly decreased during the previous three months following on the day investigation (March 25, April 15, May 18).

2 nursing related safe staffing concerns were raised on Datix system compared to 10 in April. Only one of the Datix reports matched a similar entry on the RATE system.

Actions: Continue to raise the link between Datix and the rate system with the nursing body with the aim to achieve greater consistency.

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Heatmap Dashboard
Ward view

excellent kind responsible respectful

10. Ward heatmap

		INCIDENCE OF C.DIFFICILE	INCIDENCE OF MRSA	TRUST ACQUIRED PRESSURE ULCERS	PERCENTAGE OF HARM FREE CARE	PATIENT SATISFACTION (FRIENDS & FAMILY)	FRIENDS & FAMILY RESPONSE RATE	WARD STAFFING: UNFILLED DUTY HOURS	FALLS (WARD LEVEL)	SERIOUS INCIDENTS (WARD LEVEL)	SICKNESS/ ABSENCE RATE - (WARD)
Children & Women's	CARDIOTHORACIC INTENSIVE C..	0.0	0.0	0.0	94.1	0.0		5.7	1.0	0.0	4.7
	CARMEN SUITE	0.0	0.0	0.0	100.0		0.0	4.3	1.0	0.0	7.3
	CHAMPNEYS	0.0	0.0	0.0	100.0	95.0	50.4	4.2	0.0	0.0	6.0
	DELIVERY	0.0	0.0	0.0	100.0		0.0	-3.8	0.0	0.0	4.1
	FREDDIE HEWITT	0.0	0.0	0.0	100.0		120.0	5.6	0.0	0.0	4.7
	GENERAL ICU/HDU	0.0	0.0	0.0	82.4	0.0	0.0	6.2	0.0	0.0	3.2
	GWILLIM	0.0	0.0	0.0	100.0	87.8	51.5	-7.1	0.0	0.0	8.4
	JUNGLE	0.0	0.0	0.0			0.0	-3.2	0.0	0.0	5.2
	NEONATAL ICU	0.0	0.0	0.0	100.0	100.0		-0.8	0.0	0.0	2.7
	NEURO ICU	1.0	0.0	0.0	84.6		20.0	5.1	0.0	0.0	5.8
	NICHOLLS	0.0	0.0	0.0	100.0		0.0	4.7	1.0	0.0	2.4
	PICU	0.0	0.0	0.0	100.0	100.0		-16.7	0.0	0.0	1.6
	PINCKNEY	0.0	0.0	0.0	100.0	87.5	400.0	-7.5	0.0	0.0	1.2
Medicine & Cardiovascular	ALLINGHAM	0.0	0.0	0.0	92.9	89.3	46.7	3.4	2.0	0.0	9.1
	AMYAND	0.0	0.0	0.0	100.0	100.0	15.4	5.0	12.0	0.0	4.0
	BELGRAVE	0.0	0.0	0.0	97.1	84.3	103.4	10.9	2.0	0.0	1.8
	BENJAMIN WEIR	0.0	0.0	0.0	96.7	97.4	72.0	7.2	0.0	0.0	1.4
	BUCKLAND	1.0	0.0	0.0	94.7	100.0	39.5	10.7	1.0	1.0	3.9
	CAESAR HAWKINS	0.0	0.0	0.0	81.0	90.0	18.9	8.2	7.0	0.0	4.1
	CARDIAC CARE UNIT	0.0	0.0	0.0	100.0	93.3	125.0	0.5	1.0	0.0	1.2
	CAROLINE	0.0	0.0	0.0	100.0	94.4	55.1	6.3	3.0	0.0	1.1
	CHESELDEN	0.0	0.0	0.0	88.4	97.0	39.8	5.3	3.0	0.0	6.9
	DALBY	0.0	0.0	2.0	88.5	71.4	23.3	4.6	1.0	2.0	5.7
	EMERGENCY DEPARTMENT	0.0	0.0	0.0		52.0	25.5	8.4	1.0	2.0	2.3
	HEBERDEN	0.0	0.0	0.0	75.0	88.9	23.7	2.9	8.0	0.0	6.2
	JAMES HOPE	0.0	0.0	0.0	100.0	100.0	60.0	5.8	0.0	0.0	2.8
	MARNHAM	0.0	0.0	0.0	100.0	100.0	36.8	14.1	3.0	1.0	7.8
	MCENTEE	0.0	0.0	0.0	94.4	96.6	65.9	1.5	2.0	0.0	0.8
	RICHMOND	0.0	0.0	0.0	94.9	95.6	34.3	6.7	14.0	1.0	4.8
	RODNEY SMITH	1.0	0.0	0.0	74.1	90.0	34.3	6.8	0.0	0.0	3.8
	RUTH MYLES	0.0	0.0	0.0	100.0	100.0	40.0	1.3	0.0	0.0	0.4
	TREVOR HOWELL	0.0	0.0	0.0	94.4	100.0	38.3	3.2	2.0	0.0	5.6
Surgery & Neurosciences	BRODIE NEURO	0.0	0.0	0.0	100.0	100.0	50.0	3.5	0.0	0.0	1.2
	CAVELL	0.0	0.0	0.0	100.0	94.4	61.3	-2.2	0.0	0.0	7.0
	FLORENCE NIGHTINGALE	0.0	0.0	1.0	90.0	97.1	92.9	2.7	3.0	1.0	1.6
	GRAY WARD	0.0	0.0	0.0	100.0	96.2	40.0	4.8	3.0	0.0	4.3
	GUNNING	0.0	0.0	1.0	95.8	94.1	63.0	7.4	1.0	2.0	1.3
	GWYN HOLFORD	0.0	0.0	0.0	100.0	100.0	33.3	13.6	14.0	0.0	7.5
	HOLDSWORTH	0.0	0.0	0.0	95.2	95.6	60.0	5.4	3.0	0.0	5.6
	KEATE	0.0	0.0	0.0	100.0	98.2	92.7	2.4	0.0	0.0	0.0
	KENT	0.0	0.0	0.0	100.0	0.0	0.0	7.1	4.0	0.0	1.1
	MARY SEACOLE	0.0	0.0	0.0	77.8	0.0	14.3	3.3	4.0	0.0	10.5
	MCKISSOCK	0.0	0.0	0.0	95.0	98.3	69.8	4.8	7.0	0.0	6.1
	VERNON	0.0	0.0	0.0	96.7	94.9	56.3	4.7	2.0	0.0	4.9
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	100.0	96.7	29.7	8.6	2.0	0.0	3.6

10. Ward heatmap:
- CWDT&CC Division

ACC

- For ACC, x 1 C Diff on NICU – probably a carrier, action to ensure that the Consultant agrees to stool specimens.
- Safety thermometer, GICU x 2 UTI's. Catheters were required. NICU x 2 new Grade 3 pressure ulcers, being investigated
- FFT – Not sure why showing red as ACC do not do FFT as patients transferred within Trust not discharged

Midwifery

- Some confusion as to when FFT should be completed, Charlotte James will chase to get improvement.

10. Ward heatmap:
- STNC Division

The report focuses on areas with any red indicator or those with three or more indicators. The key areas where alerts can be seen are consistent and relate to pressure ulcers, harm free care, friends and family response rate, falls and sickness. There are 9 red alerts for May compared to 12 for the previous reporting period. There is a decrease in overall numbers of alerts from 16 to 10.

Florence Nightingale – 3 red indicators – 1 grade 3 pressure ulcer shared with GICU, the root cause of which identified shear/friction during transfer between theatres/GICU for emergency surgery. The percentage of harm free care alert related to the above pressure ulcer and 1 VTE assessment. The SI alert relates to the previously described pressure ulcer.

Gunning – 2 red indicators – 1 grade 3 pressure ulcer – The root cause analysis identified failure to assess appropriately & a delayed submission of a Datix as contributory factors. Pt admitted from A&E post fall and there was learning for both areas. The SI indicator refers to the pressure ulcer SI already outlined and an SI associated with VTE prophylaxis, which as a prescribing error.

Kent – 2 red indicators- the 4 falls were all no harm slips and one un-witnessed fall. The addition of 7 wte HCA's to support 1:1 care of head injured patients is starting to impact upon falls. The FFT data has been incorrect for some months secondary to two templates being created on the tablet neither of which linked to the other. The situation has now been resolved and daily process confirmation indicates that data collection is improving. The full impact will be seen in July.

Mckissock -1 red indicator – this relates to 7 falls. 2 of which were slips, 3 of which were slides form chairs. These were all no harm and risk assessments had been carried out appropriately.

William Drummond – 1 amber- On-going difficulty with response rates to FFT and this patient cohort. Comments are really positive where received with 97% of pt's recommending. However, more work is expected from the team to improve this score.

Gwynne Holford- 1 red indicator- Falls are generally high from this patient group and the balance between providing rehab and promoting independence with that of a secure and safe environment can be challenging. No falls were associated with any harm and each fall is reviewed to ensure learning and thematic review.
Areas requiring further support are Gunning and Gwynne Holford as a result of vacancy factor and depleted senior team members. Each directorate area is pulling together a work plan to support the development of care of patients in terms of both falls and pressure ulcers. Keate continues to perform consistently well and Brodie has seen some improvements this month and a reduction in alerts.

10. Ward heatmap: -Med Card Division

Allingham – 92.9% Harm Free Care There were 28 patients surveyed. 2 patients with harms. 1 patient had an old grade 3 pressure ulcer and 1 patient had a new grade 2 pressure ulcer.

Amyand - FFT response rate 15.4% Falls 14- No reported moderate or above harms. The ward manager and Matron completing documentation audits to ensure completion of falls risk assessment and any appropriate actions.

Buckland – C. Diff – 1 Case with an RCA being completed. 94.7% Harm Free Care of the 19 patients surveyed. 1 patient had an old grade 2 pressure ulcer. 1 Serious Incident – Investigation on going and report due 16/07/15

Caesar Hawkins – 81% Harm Free Care 21 patients were surveyed. 4 patients with harm, 2 of these patients had two harms. 1 patient had a moderate Fall and also a new grade 2 pressure ulcer. FFT response Rate 18.9% . Patients identified for discharge at the board round to be given tablet to complete FFT prior to discharge where appropriate based on patient condition.

Cheselden 88.4% Harm Free Care 43 patients surveyed. 5 harms reported. 2 patients had new grade 2 pressure ulcers. 2 patients had old grade 2 pressure ulcers and 1 patient had a low harm Fall.

Dalby 2 Acquired Pressure Ulcers, and RCA are under way. The ward have also amended the handover sheets to incorporate pressure area care, TVN teaching taking place and Matron Quality visits. 88.5% Harm Free care 26 patients surveyed. 3 harms reported. 2 patients had old grade 3 pressure ulcers and 1 patient had an old grade 2 pressure ulcer. 2 Serious Incidents recorded due to pressure sores.

Emergency Department - 2 serious Incidents report. Panel formed and investigation on going relating to the discharge of a patient. The second SI relates to failure to meet the 60minute LAS handover target.

Heberden 75% Harm Free Care 24 patients surveyed. 6 harms reported. 3 patients had old grade 4 pressure ulcers, 1 patients had an old grade 3 pressure ulcer and 1 patient had a new grade 2 pressure ulcer. There was also a patient who had a fall on the ward with low harm. Falls – There were 8 falls reported in May, due to the patients currently on the ward there are a number of high risk patients for falls. Falls risk assessments completed and reviewed, patients requiring specialing have appropriate risk assessment completed.

McEntee 94.4% Harm Free Care - 18 patients surveyed. 1 harm reported. Patient had a VTE Harm (New other)

Richmond Ward 94.9% Harm Free Care 59 patients surveyed. 3 harms reported. 1 patient had a new grade 2 pressure ulcer. 1 patient had an old grade 2 and another patient had a old grade 3 pressure ulcer. 1 Serious Incident relating to medication, investigation under way. 14 Falls were recorded for the month of May. The ward sister and Matron are conducting documentation audits to ensure compliance with the falls care bundle.

Rodney Smith 1 incidence of C. Diff reported and RCA under way. 74.1 % Harm Free Care

11. Community Services
- CQR Scorecard – May 2015 Page 1 of 3

	Patiend Safety & Experience																
				Quarter 1 2015/16			Quarter 2 2015/16			Quarter 3 2015/16			Quarter 4 2015/16				
Patient Safety	Number of SI's breached	Monthly	0	0	0											➡	
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly		1	0											⇩	
Patient Safety	Grade 4 Pressure Ulcers	Monthly		0	0											➡	
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly		10	7											⇩	
Patient Safety	Number of moderate falls	Monthly	0	2	1											➡	
Patient Safety	Number of major falls	Monthly	0	0	0											⇨	
Patient Safety	Number of falls resulting in death	Monthly	0	0	0											➡	
Patient Safety	MRSA (cumulative)	Monthly	0	0	0											⇩	
Patient Safety	CDiff (cumulative)	Monthly	31	1	0											⇨	
Patient Safety	CAS ALERTS - Number ongoing-received (Trust)	Monthly	0	2	2											➡	
Patient Safety	Number of Quality Alerts	Monthly		3	5												
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	95%	89.0%	86%											⇧	
Safeguarding	% of staff compliant with safeguarding childrens training	Monthly	Level 1 95%	90.0%	tbc												
			Level 2 95%	84.0%	tbc												
			Level 3 95%	69.0%	tbc												
Patient Outcomes	Mortality SHMI ratio (Trus)	Monthly	<100	0.86	0.86											⇨	
Patient Experience	Active Claims	Monthly		0	0											⇨	

11. Community Services
- CQR Scorecard – May 2015 Page 2 of 3

	Patiend Safety & Experience																
				Quarter 1 2015/16			Quarter 2 2015/16			Quarter 3 2015/16			Quarter 4 2015/16				
Patient Experience	Number of Complaints received	Monthly		16	18											↑	
Patient Experience	Number of Complaints responded to within 25 days (reporting 1 month in arrears)	Monthly	85%	100%	88%											↓	
Patient Experience	Number of Complaints responded to within 25 days with an agreed extension	Monthly	95%	100%	100%											→	
Patient Experience	FFT Score (Mary Seacole)	Monthly			14.3												
Patient Outcomes	Catheter related UTI (Trust)																
	Number of new VTE (Trust)		National 0.005														
Workforce	Number of DBS Request Made	Quarterly	annually	N/A	N/A												
Workforce	Sickness Rate -	Monthly	3.50%	5.72%	Available 16th June 2015												
Workforce	Turnover Rate-	Monthly	13%	19.64%													
Workforce	Vacancy Rate-	Monthly	11%	19.41%													
Workforce	Appraisal Rates - Medical	Monthly	85%	66.64%													
Workforce	Appraisal Rates - Non-Medical	Monthly	85%	76.80%													

11. Community Services
- CQR Scorecard –May 2015 Page 3 of 3

Serious Incidents: In May one serious incident was reported. This relates to death in custody within offender healthcare associated with an in cell murder.

Pressure ulcers: In May there were no Grade 3 and 4 pressure ulcers acquired in our care. MS ward had >250 days without acquiring G3 or G4 PU.

Falls: There were 7 No Harm and Low severity fall (2 MS ward, 2 patients home) were reported in May compared to 10 in April. One moderate harm (MS ward)

Complaints: Community Services received 18 complaints in May a slight increase on April's position when there were 16 complaints. For those which have been closed all were responded to within 25 working days or within agreed extensions. More detailed report will be provided in patient Experience committee bi annual review (due Aug/Sept 2015)

Human Resources: This data is not available until the 16th June

Community FFT: 34 services reporting since March 2015 over 300 responses per month. FFT Scores per month: 87%, 95% and 94% (excludes Mary Seacole ward and MIU).

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

Access targets and outcomes objectives

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

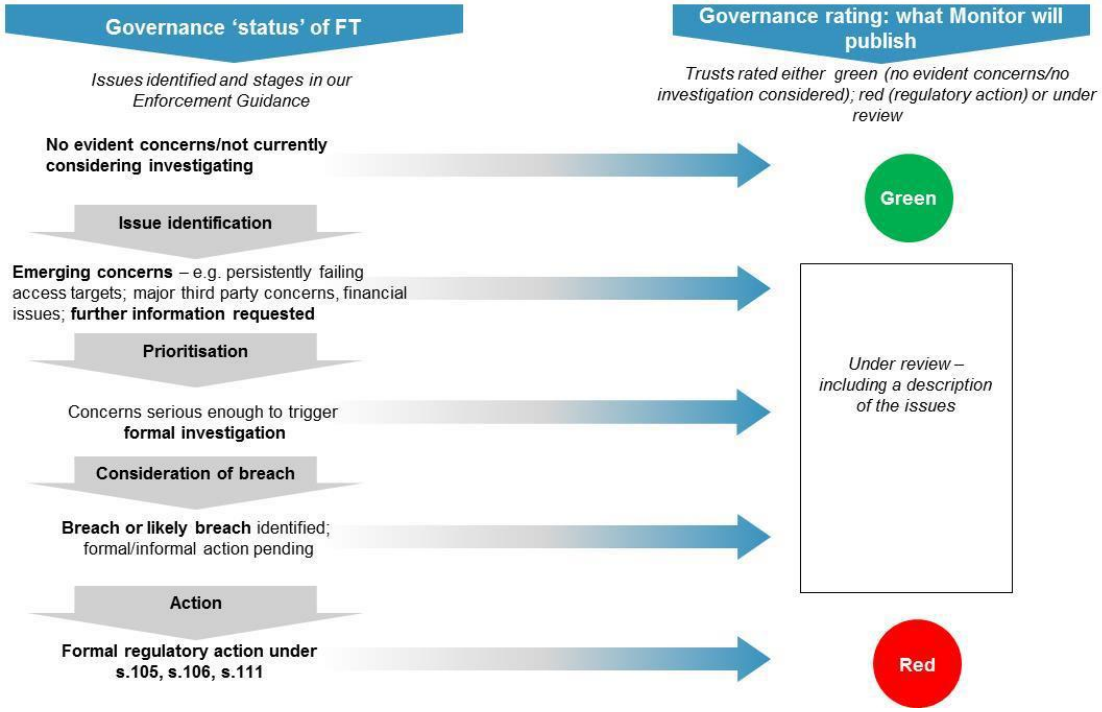
In addition to the above, when assigning governance ratings Monitor also take into account the following which may lead to overrides in the governance rating::

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

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

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

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



St George's Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD *June 2015*

Paper Title:	Workforce report
Sponsoring Director:	Wendy Brewer, Director of Workforce and Organisational Development
Author:	Wendy Brewer, Director of Workforce and Organisational Development Rebecca Hurrell, Head of Workforce Information Jacqueline McCullough, Deputy Director of HR
Purpose:	*To provide a report to the board on performance against key performance indicators*
Action required by the board:	For information
Document previously considered by:	Workforce and education committee

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

1. Key messages

The report contains detail of workforce performance against key workforce performance indicators for May2015. The report also includes available benchmark information.

Key points to note are:

- Vacancy figures should be treated with caution pending completion of work on nursing workforce demand, the finalisation of detailed budgets and synchronisation of the electronic staff records system with the financial ledger.
- Agency and bank usage are significantly reduced.
- Turnover has stabilised but is behind the target trajectory.

Key risks identified:
Key workforce risks include:

- Failure to recruit and retain sufficient staff in relation to annual turnover rates and to safely support future increases in capacity'
- Failure to reduce the unacceptable levels of bullying and harassment reported by staff in the annual staff survey.
- Possible reductions in the overall number of junior doctors available with a possible impact on particular speciality areas.
- Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	**To develop a highly skilled and engaged workforce championing our values that is able to deliver the trust's vision.**
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	**Are services well led?**

Commentary on performance in key workforce indicators

Introduction

The key message from the May board report is that there has been a continued significant reduction in bank and agency usage. This is an indicator of a positive response to the run rate controls that have been established across the trust.

Vacancy rate

The work on clarifying the financial baselines and establishments is now a key priority and, while the overall establishment figures may be broadly accurate, the detail down to ward level is subject to further review. The corporate nursing team are leading a review of nursing levels required for safe staffing and of service led demand. Once this work is complete and agreed, the changes made within the financial ledger will be synchronised with the electronic staff record data. This project is being managed within the workforce planning group and is anticipated to be complete within three to four months.

Turnover and stability

Turnover has stabilised in May but has not met the proposed trajectory. As more than 50% of leavers leave for reasons that relate to their experience at work, it is clear that the trust has the potential to reduce turnover. Divisions have been requested to report to the workforce and education committee meeting in July with their plans to reduce turnover.

Sickness absence

Sickness absence levels remain on target.

Agency and bank staff usage

There has been a sustained reduction in agency use and cost. It is also positive to see an increase in bank rather than agency fill of temporary posts.

Mandatory training and appraisal rates

Both mandatory training and appraisal rates have slipped. The monthly performance meetings focus on the support that can be provided to divisions to ensure that appraisals and mandatory training are completed.

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Workforce Performance Report
to the Trust Board

Month 2- May 2015

Excellence in specialist and community healthcare

Workforce performance report June 2014-May2015

Contents

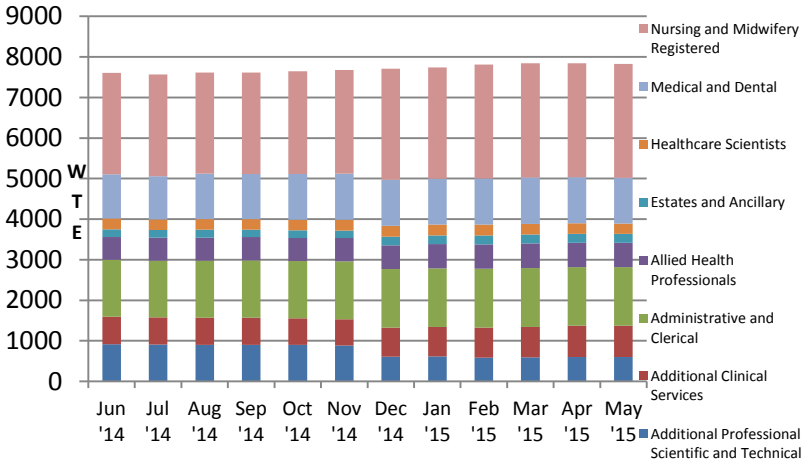
Performance summary

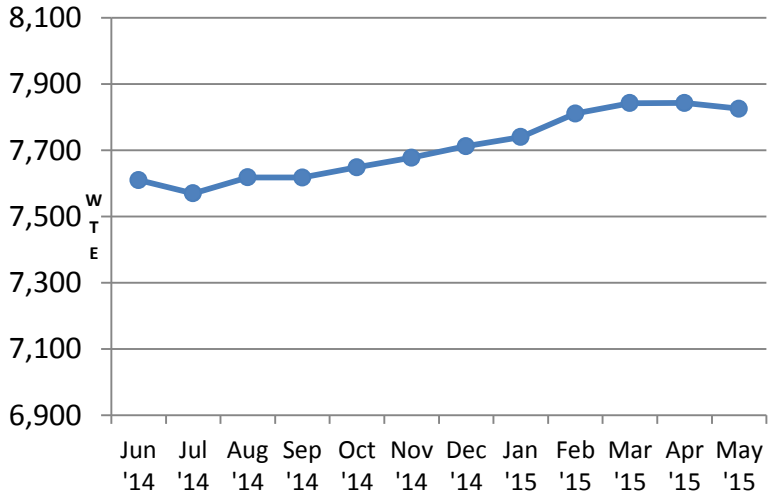
Summary of overall performance is set out below

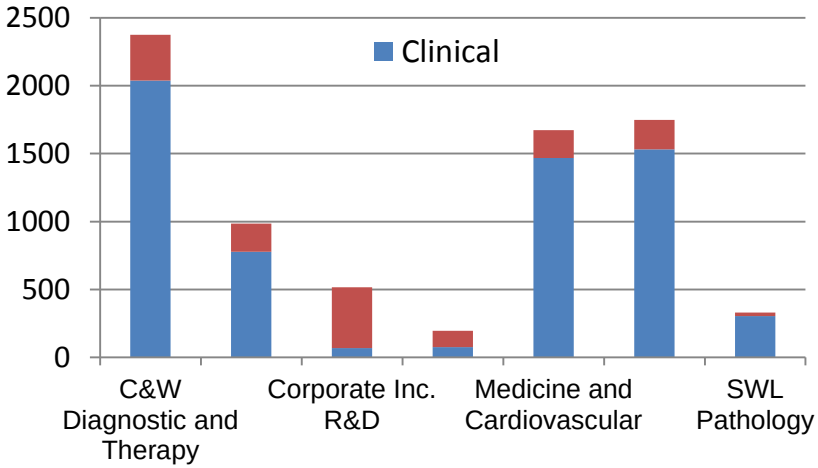
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has increased by 1.3% (subject to validation – see page 5)	12.1%	14.2%	15.5%	↗
6	Turnover	Turnover has stabilised	15.1%	17.5%	17.5%	↔
6	Voluntary Turnover	Voluntary turnover stabilised	12.3%	14.1%	14.1%	↔
7	Stability	Stability has increased this month by 0.2%	85.3%	82.8%	83.0%	↗
8	Sickness	Sickness has increased by 0.3% but remains within target	3.4%	3.2%	3.5%	↗
10-12	Temporary Staffing Usage (FTE)	Temporary staff usage has decreased by 2.1%	13.6%	16.0%	13.9%	↘
13	Mandatory Training	MAST compliance has decreased by 1.1%	75.9%	74.2%	73.1%	↘
14	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has decreased by 0.4%	75.4%	75.2%	74.8%	↘

Current Staffing Profile

The data below displays the current staffing profile of the Trust



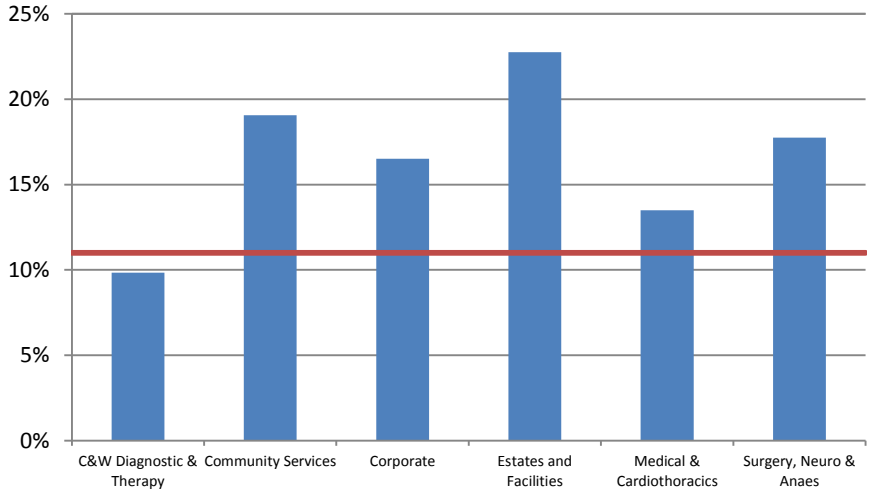


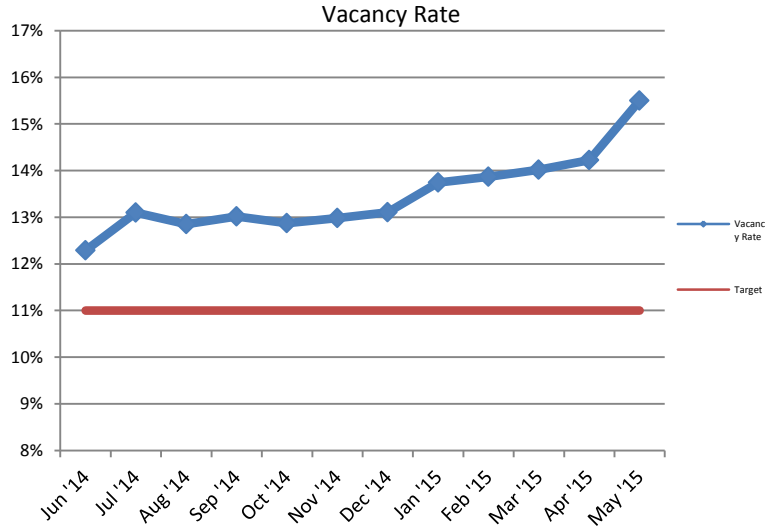


COMMENTARY

The Trust currently employs 8394 people working a whole time equivalent of 7826 which is 17 WTE lower than in April. The growth rate in the directly employed workforce since June 2014 is 242 WTE or 3.2%.

Section 1: Vacancies





Vacancies by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	9.4%	9.9%	9.9%	9.8%	↘
Community Services	20.8%	19.6%	19.4%	19.1%	↘
Corporate	14.4%	14.5%	15.4%	16.5%	↗
Estates and Facilities	12.7%	12.7%	11.4%	22.8%	↗
Medical & Cardiothoracics	13.0%	12.7%	13.4%	13.5%	↗
Surgery, Neuro & Anaes	14.3%	15.0%	14.9%	17.7%	↗
SWL Pathology	23.3%	24.2%	25.0%	28.4%	↗
Whole Trust	**13.9%**	**14.0%**	**14.2%**	**15.5%**	↗

Vacancies Staff Group	Feb '15	Mar '15	Apr '15	May '15	Trend
Add Prof Scientific and Technic	20.1%	19.6%	18.6%	16.4%	↘
Additional Clinical Services	16.4%	15.6%	16.7%	18.7%	↗
Administrative and Clerical	20.1%	20.3%	21.2%	22.6%	↗
Allied Health Professionals	3.4%	1.9%	3.7%	3.6%	↘
Estates and Ancillary	16.9%	27.8%	27.0%	22.5%	↘
Healthcare Scientists	16.3%	19.5%	20.5%	21.8%	↗
Medical and Dental	0.0%	-0.3%	-0.3%	3.2%	↗
Nursing and Midwifery Registered	14.7%	14.3%	13.9%	15.7%	↗
Total	**13.9%**	**14.0%**	**14.2%**	**15.5%**	↗

8

COMMENTARY

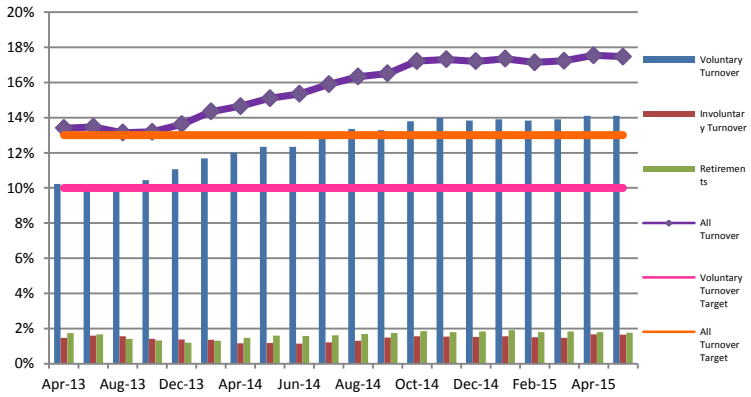
The reported vacancy rate must be treated with caution.

The establishment recorded in the electronic staff record system has not been updated to reflect the establishments that have been agreed in the budget in the review of nursing establishments.

A project to complete this work has been agreed with the Finance team and it is anticipated that it will be completed in 2 or 3 months.

Section 2: Turnover

The chart below shows turnover trends, the tables by Division and Staff Group are under:



COMMENTARY

The total trust turnover rate has remained the same this month at 17.5% which is significantly above the current target of 13%. In the last12 months there have been 1239 WTE leavers.

Each Division is developing a plan and target trajectory in response to the increase in turnover rates, based on the information available through exit questionnaire data. Reports are due to be provided to the Workforce & Education Committee in July.

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.

Communications with staff this month have focused on opportunities for wellbeing and support available.

	All Turnover				
Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	18.1%	18.1%	18.1%	17.7%	↘
Community Services	19.5%	18.8%	19.6%	19.9%	↗
Corporate	15.9%	15.9%	16.9%	18.5%	↗
Estates and Facilities	11.2%	11.9%	17.6%	17.4%	↘
Medical & Cardiothoracics	17.8%	18.2%	18.4%	18.0%	↘
Surgery, Neurosciences & Anaes	14.8%	14.6%	14.5%	14.3%	↘
SWL Pathology	16.8%	19.6%	19.4%	19.7%	↗
Whole Trust	**17.1%**	**17.2%**	**17.5%**	**17.5%**	↔

	All Turnover				
Staff Group	Feb '15	Mar '15	Apr '15	May '15	Trend
Add Prof Scientific and Technic	18.9%	18.6%	18.9%	18.2%	↘
Additional Clinical Services	19.4%	20.7%	20.4%	20.6%	↗
Administrative and Clerical	15.0%	15.1%	16.6%	16.6%	↔
Allied Health Professionals	18.4%	17.8%	18.5%	17.9%	↘
Estates and Ancillary	12.0%	12.3%	12.6%	11.3%	↘
Healthcare Scientists	15.3%	15.3%	15.9%	16.2%	↗
Medical and Dental	14.5%	14.1%	13.3%	14.1%	↗
Nursing and Midwifery Registered	18.0%	18.1%	18.1%	18.0%	↘
Whole Trust	**17.1%**	**17.2%**	**17.5%**	**17.5%**	↔

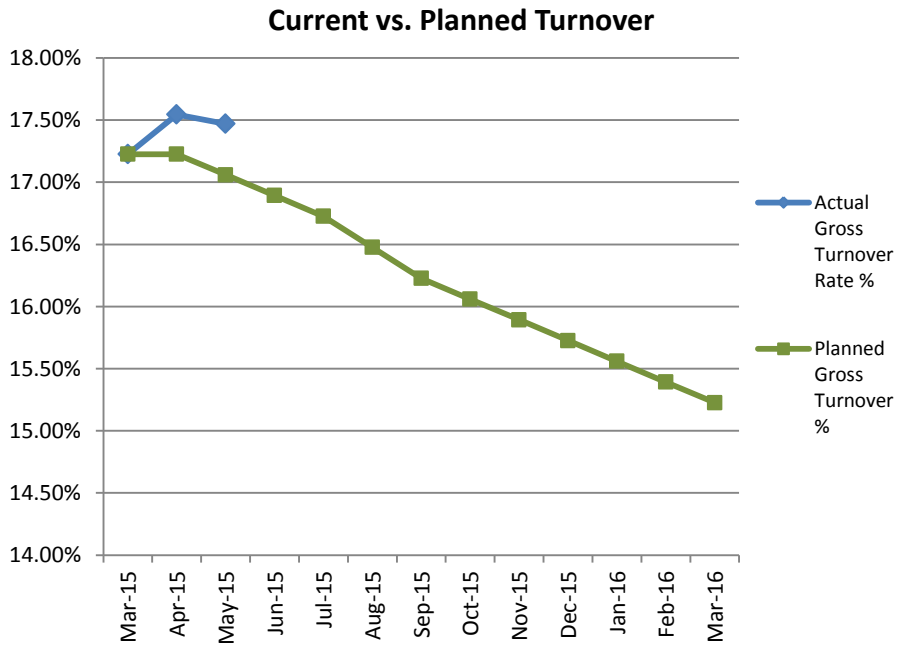
	Voluntary Turnover					Other Turnover May 2015	
Division	Feb '15	Mar '15	Apr '15	May '15	Trend	In-Voluntary	Retirement
C&W Diagnostic & Therapy	13.6%	13.4%	13.5%	13.2%	↘	2.8%	1.6%
Community Services	15.0%	14.8%	15.6%	15.8%	↗	1.1%	3.0%
Corporate	13.6%	13.5%	14.0%	15.1%	↗	1.7%	1.7%
Estates and Facilities	6.7%	7.1%	8.0%	7.6%	↘	5.9%	3.8%
Medical & Cardiothoracics	15.7%	15.9%	16.1%	15.7%	↘	1.0%	1.4%
Surgery, Neurosciences & Anaes	12.6%	12.7%	12.3%	12.6%	↗	0.7%	1.0%
SWL Pathology	14.5%	16.9%	16.5%	16.7%	↗	0.6%	2.5%
Whole Trust	**13.8%**	**13.9%**	**14.1%**	**14.1%**	↔	**1.6%**	**1.8%**

	Voluntary Turnover					Other Turnover May 2015	
Staff Group	Feb '15	Mar '15	Apr '15	May '15	Trend	In-Voluntary	Retirement
Add Prof Scientific and Technic	12.4%	12.1%	12.3%	12.0%	↘	5.9%	0.4%
Additional Clinical Services	16.5%	17.5%	17.3%	17.4%	↗	1.2%	2.0%
Administrative and Clerical	11.9%	12.2%	12.9%	13.0%	↗	1.7%	2.0%
Allied Health Professionals	17.3%	16.3%	17.3%	16.8%	↘	0.2%	1.0%
Estates and Ancillary	7.9%	7.8%	8.2%	7.3%	↘	0.9%	3.1%
Healthcare Scientists	11.6%	11.2%	11.3%	11.5%	↗	1.1%	3.5%
Medical and Dental	8.6%	8.1%	7.6%	8.2%	↗	4.6%	1.3%
Nursing and Midwifery Registered	15.3%	15.5%	15.5%	15.5%	↔	0.7%	1.8%
Whole Trust	**13.8%**	**13.9%**	**14.1%**	**14.1%**	↔	**1.6%**	**1.8%**

Caregroup	Staff in Post WTE	Leavers WTE	Voluntary Turnover Rate
Cardiac Surgery	86.7	28.8	38.0%
Gynaecology	45.0	17.4	35.2%
Trauma & Orthopaedics	122.6	32.2	30.3%
Prison Service	59.6	17.0	28.1%
Inpatient Care Older People	55.0	14.8	27.5%

Section 2: Turnover

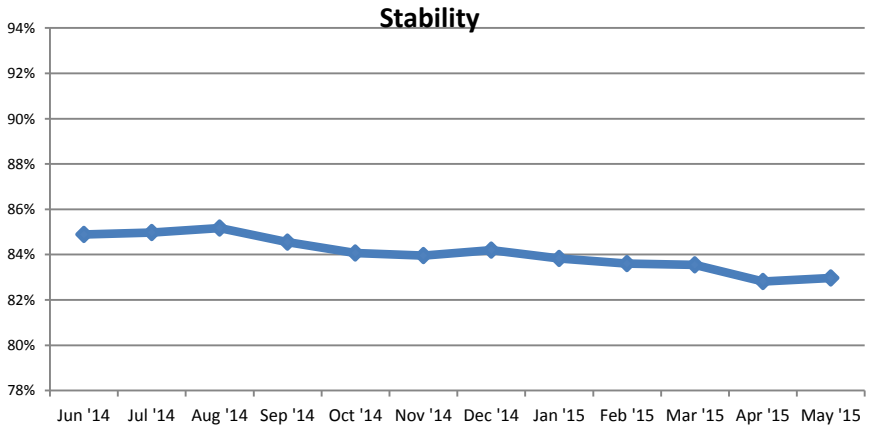
Planned reduction in turnover:



Month	Actual Gross Turnover Rate %	Planned Gross Turnover %
Mar-15	17.23%	17.23%
Apr-15	17.54%	17.23%
May-15	17.47%	17.06%
Jun-15		16.89%
Jul-15		16.73%
Aug-15		16.48%
Sep-15		16.23%
Oct-15		16.06%
Nov-15		15.89%
Dec-15		15.73%
Jan-16		15.56%
Feb-16		15.39%
Mar-16		15.23%

Section 3: Stability

The chart below shows performance over the last 12 months, the tables by Division and Staff Group are under



Stability by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	83.5%	83.1%	82.6%	82.9%	↗
Community Services	81.2%	81.0%	80.4%	80.4%	↔
Corporate	87.9%	87.8%	85.7%	85.1%	↘
Estates and Facilities	91.3%	89.8%	89.0%	84.9%	↘
Medical & Cardiothoracics	82.9%	81.4%	81.3%	82.4%	↗
Surgery, Neurosciences & Anaes	84.0%	84.0%	84.6%	84.5%	↘
SWL Pathology	82.2%	90.2%	81.7%	82.2%	↗
Whole Trust	**83.6%**	**83.5%**	**82.8%**	**83.0%**	↗

Stability Staff Group	Feb '15	Mar '15	Apr '15	May '15	Trend
Add Prof Scientific and Technic	72.7%	72.4%	72.7%	73.5%	↗
Additional Clinical Services	82.3%	80.9%	82.8%	82.8%	↔
Administrative and Clerical	87.1%	87.7%	86.4%	86.1%	↘
Allied Health Professionals	80.7%	82.1%	80.8%	80.8%	↔
Estates and Ancillary	87.8%	86.3%	85.5%	86.7%	↗
Healthcare Scientists	96.2%	95.1%	88.7%	87.3%	↘
Medical and Dental	88.5%	88.7%	87.8%	87.1%	↘
Nursing and Midwifery Registered	83.0%	82.9%	82.2%	82.6%	↗
Total	**83.6%**	**83.5%**	**82.8%**	**83.0%**	↗

COMMENTARY

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

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

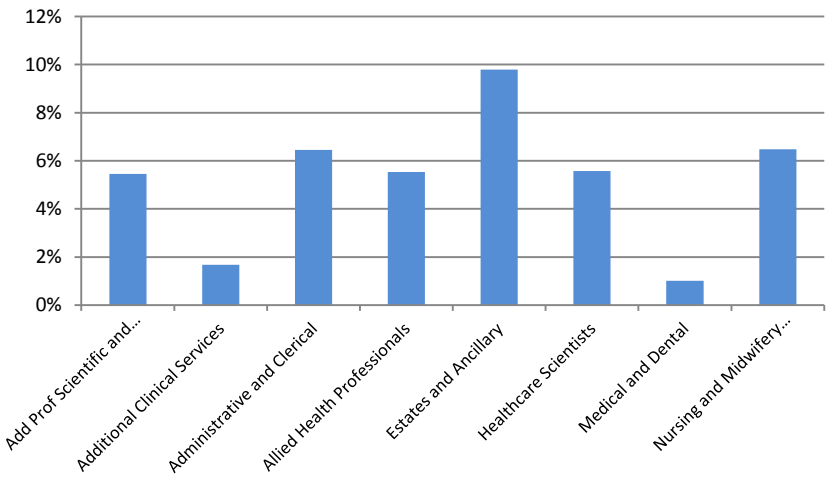
The stability rate has increased by 0.2% this month in line with a slight reduction in retirements in May.

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

Over the last 12 months the stability rate has declined by 2.4% and is now at 83%.

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 May, 44 staff were promoted, there were 71 new starters to the Trust and 222 employees were acting up to a higher grade.

Over the last year 5.4% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the Estates and Facilities Division (where a team have recently been upgraded) followed by the Corporate and Children & Women's Divisions, where there is a programme of promotion of midwives.

The graph shows that Estates & Ancillary staff were most likely to be promoted over the last year (NB this is the smallest staff group), followed by the Nursing & Midwifery employees. The majority of promotions in Nursing & Midwifery are moves from a band 5 to a band 6 post (108 employees over the year).

	No. of Promotions				
Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	14	13	8	11	↗
Community Services	13	8	4	15	↗
Corporate	2	5	3	5	↗
Estates and Facilities	0	0	20	0	↘
Medical & Cardiothoracics	10	9	1	6	↗
Surgery, Neurosciences & Anaes	5	6	3	7	↗
SWL Pathology	3	0	0	0	↔
Whole Trust Promotions	**47**	**41**	**39**	**44**	↗
New Starters (Excludes Junior Doctors)	**120**	**136**	**120**	**71**	↘

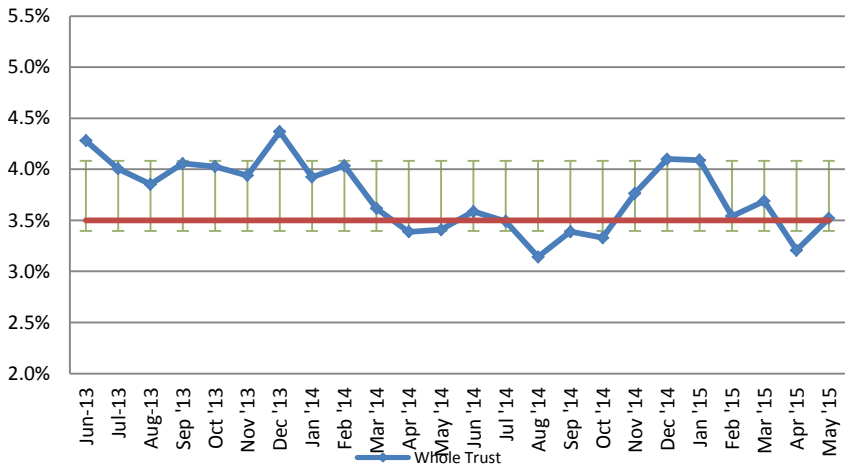
Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	1985	119	6.0%	111
Community Services	924	45	4.9%	13
Corporate	451	27	6.0%	19
Estates and Facilities	174	20	11.5%	5
Medical & Cardiothoracics	1215	68	5.6%	39
Surgery, Neurosciences & Anaes	1389	57	4.1%	23
SWL Pathology	313	11	3.5%	12
Whole Trust	**6451**	**347**	**5.4%**	**222**
New Starters (Excludes Junior Doctors)		**1460**		

	No. of Promotions				
Staff Group	Feb '15	Mar '15	Apr '15	May '15	Trend
Add Prof Scientific and Technic	4	2	1	4	↗
Additional Clinical Services	0	3	0	4	↗
Administrative and Clerical	13	8	5	14	↗
Allied Health Professionals	7	7	3	7	↗
Estates and Ancillary	0	0	20	0	↘
Healthcare Scientists	2	0	1	2	↗
Medical and Dental	3	1	0	0	↔
Nursing and Midwifery Registered	18	20	9	13	↗
Whole Trust	**47**	**41**	**39**	**44**	↗

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	513	28	5.5%	31
Additional Clinical Services	659	11	1.7%	9
Administrative and Clerical	1303	84	6.4%	76
Allied Health Professionals	524	29	5.5%	24
Estates and Ancillary	194	19	9.8%	1
Healthcare Scientists	251	14	5.6%	5
Medical and Dental	597	6	1.0%	3
Nursing and Midwifery Registered	2410	156	6.5%	73
Whole Trust	**6451**	**347**	**5.4%**	**222**

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 3.5% for May, which is a 0.3% increase since the previous month.

Sickness absence is closely monitored and action initiated by HR, in support of divisions, once pre defined sickness triggers are breached. A 'well-being' strategy was agreed by the workforce committee and there has been a lengthy review of the sickness policy in partnership with trade unions. There has been a focus on wellbeing in communications this month.

The table below lists the five care groups with the highest sickness absence percentage during May 2015. Below that is a breakdown of the top 5 reasons for absence, both by the number of episodes and the number of days lost.

Sickness by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	2.9%	2.9%	2.3%	2.9%	↗
Community Services	5.3%	6.5%	5.7%	6.0%	↗
Corporate	3.6%	4.1%	4.0%	4.0%	↔
Estates and Facilities	6.3%	7.1%	6.5%	7.6%	↗
Medical & Cardiothoracics	3.3%	3.5%	3.0%	2.9%	↘
Surgery, Neurosciences & Anaes	3.5%	3.0%	2.9%	3.1%	↗
SWL Pathology	3.3%	3.2%	2.0%	2.6%	↗
Whole Trust	**3.5%**	**3.7%**	**3.2%**	**3.5%**	↗

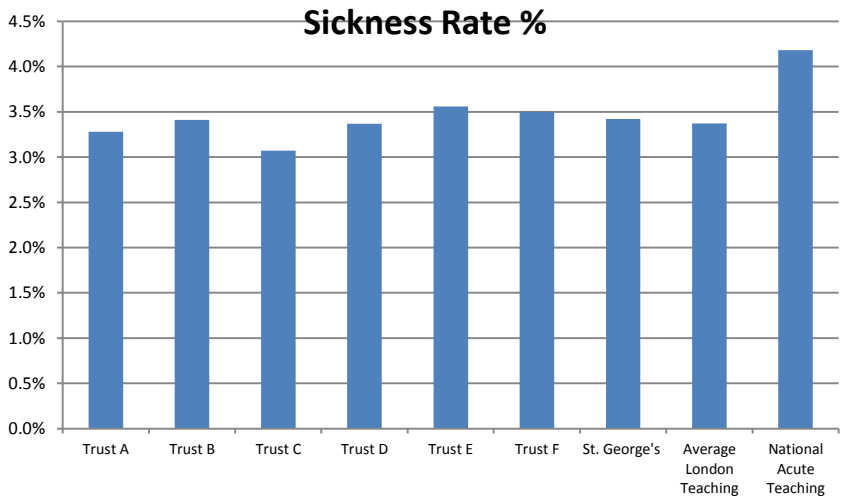
Sickness Staff Group	Feb '15	Mar '15	Apr '15	May '15	Trend
Add Prof Scientific and Technic	2.7%	2.3%	2.9%	3.0%	↗
Additional Clinical Services	4.1%	5.1%	5.4%	6.8%	↗
Administrative and Clerical	4.2%	4.5%	4.0%	4.3%	↗
Allied Health Professionals	2.5%	3.1%	2.3%	2.8%	↗
Estates and Ancillary	6.7%	5.7%	6.1%	6.4%	↗
Healthcare Scientists	2.8%	2.4%	1.8%	1.8%	↔
Medical and Dental	0.9%	0.7%	0.2%	0.9%	↗
Nursing and Midwifery Registered	4.4%	4.5%	3.6%	3.5%	↘
Total	**3.5%**	**3.7%**	**3.2%**	**3.5%**	↗

Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Prison Service	59.55	271.88	15.0%	£20,085
Security & Car Park Management	22.00	82.00	12.0%	£4,027
Intermediate Care	62.80	183.00	9.4%	£10,542
Community PLD Service	25.43	69.85	9.3%	£7,384
Engineering Services	48.00	135.00	9.1%	£8,296

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	28.13%
S25 Gastrointestinal problems	17.91%
S12 Other musculoskeletal problems	8.91%
S16 Headache / migraine	5.31%
S10 Anxiety/stress/depression/other psychiatric illnesses	5.31%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S13 Cold, Cough, Flu - Influenza	15.00%
S12 Other musculoskeletal problems	12.50%
S10 Anxiety/stress/depression/other psychiatric illnesses	12.39%
S25 Gastrointestinal problems	11.26%
S11 Back Problems	8.41%

Section 6: Workforce benchmarking**



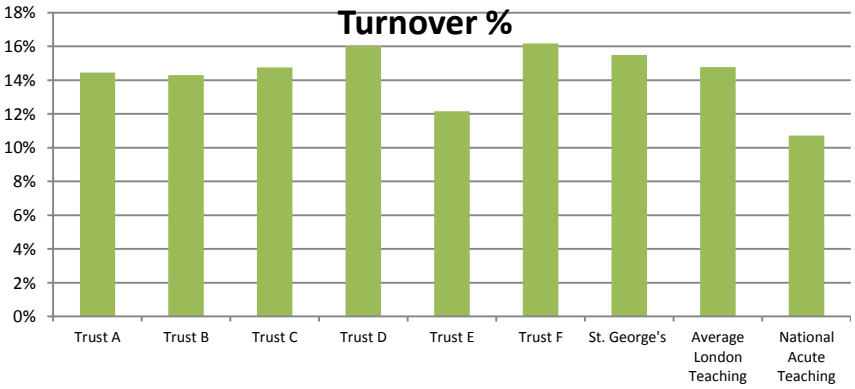
COMMENTARY

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

Sickness data shown is from February '15 which is the mot recent available. Compared to other Acute teaching trusts in London, St. Georges had a higher than average rate at 3.42%. In the top graph, Trusts A-F are the anonymised figures for this group. The Trust's sickness rate was significantly lower than the national rate for acute teaching hospitals in February.

The bottom graph shows the comparison of turnover rates for the same group of London teaching trusts (excluding junior medical staff). This is the total turnover rate including all leavers (voluntary resignations, retirements, end of fixed term contracts etc.). St. Georges currently has higher than average turnover compared to the group (12 months to end March). Stability is also slightly 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 4.7% 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	14.45%	85.32%	3.28%
Trust B	14.29%	85.30%	3.41%
Trust C	14.75%	84.85%	3.07%
Trust D	16.03%	83.78%	3.37%
Trust E	12.15%	83.52%	3.56%
Trust F	16.18%	83.27%	3.50%
St. George's	15.49%	84.06%	3.42%
Average London Teaching	14.76%	84.30%	3.37%
National Acute Teaching	10.72%	89.05%	4.18%

Section 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	1073.5	1073.5	1073.5	1073.5	↔
Community Services	592.3	594.3	593.6	593.6	↔
Corporate & R&D	50.9	50.5	53.5	59.9	↗
Medical & Cardiothoracics	1213.8	1216.8	1218.8	1220.8	↗
Surgery, Neurosciences & Anaes	1035.4	1029.7	1022.7	1107.7	↗
Total	3966.0	3964.9	3962.1	4055.5	↗

Nursing Staff in Post WTE

Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	983.7	980.6	986.0	984.7	↘
Community Services	464.2	478.5	479.7	473.9	↘
Corporate & R&D	47.2	45.3	49.1	49.2	↗
Medical & Cardiothoracics	1009.1	1017.1	1002.3	1007.6	↗
Surgery, Neurosciences & Anaes	872.8	878.1	881.5	880.1	↘
Total	3376.9	3399.4	3398.5	3395.6	↘

Nursing Vacancy Rate

Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	8.4%	8.7%	8.2%	8.3%	↗
Community Services	21.6%	19.5%	19.2%	20.2%	↗
Corporate & R&D	7.3%	10.3%	8.2%	17.8%	↗
Medical & Cardiothoracics	16.9%	16.4%	17.8%	17.5%	↘
Surgery, Neurosciences & Anaes	15.7%	14.7%	13.8%	20.5%	↗
Total	14.9%	14.3%	14.2%	16.3%	↗

Nursing Sickness Rates

Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	4.3%	4.1%	3.5%	3.9%	↗
Community Services	6.9%	7.9%	6.4%	6.3%	↘
Corporate	0.5%	0.4%	0.5%	1.6%	↗
Medical & Cardiothoracics	3.6%	4.4%	3.8%	3.5%	↘
Surgery, Neurosciences & Anaes	4.0%	3.5%	3.7%	4.1%	↗
Total	4.3%	4.5%	4.0%	4.2%	↗

Nursing Voluntary Turnover

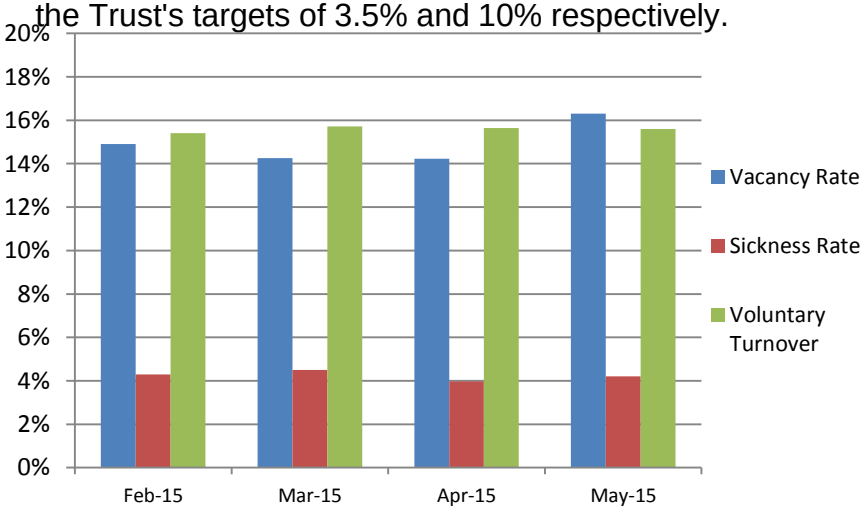
Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	13.53%	14.45%	14.78%	14.22%	↘
Community Services	17.33%	16.18%	15.59%	16.30%	↗
Corporate & R&D	13.31%	18.12%	16.89%	14.98%	↘
Medical & Cardiothoracics	18.00%	18.29%	18.72%	17.91%	↘
Surgery, Neurosciences & Anaes	13.56%	13.79%	13.02%	14.10%	↗
Total	15.4%	15.5%	15.7%	15.6%	↘

COMMENTARY

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

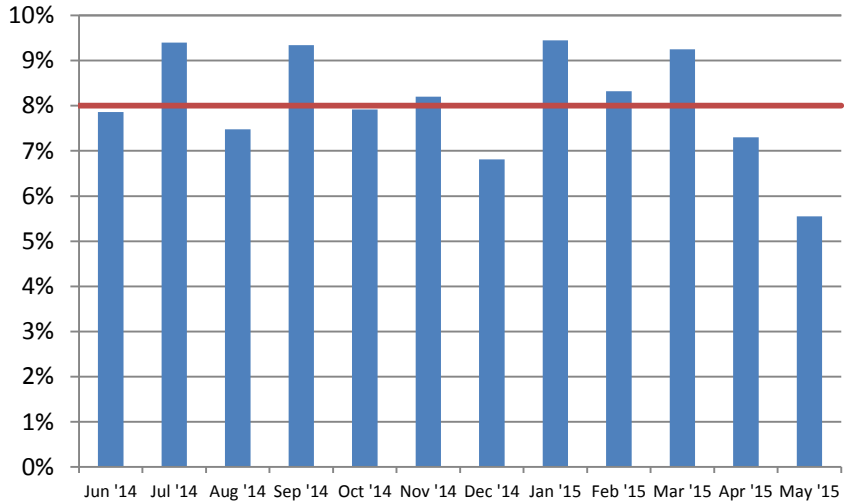
The nursing workforce has decreased slightly by 3 WTE in May, with an overall growth in nursing staff in post of 123.3 wte since September 2014. The output of the review of nursing establishments will be a revised trajectory for demand for nursing.

Both the sickness rate and voluntary turnover are above the Trust's targets of 3.5% and 10% respectively.



Section 8: Agency Staff Costs

The chart below shows agency spend by month to show both annual and seasonal trends.



Commentary

The agency spend percentage has decreased by 1.75% since April.

At the March workforce and education committee set an 8% target for agency usage.

Currently, the highest percentage spend is seen in the Community and Children & Women's Divisions.

The table below lists the five care groups with the highest agency spend percentage for May 2015

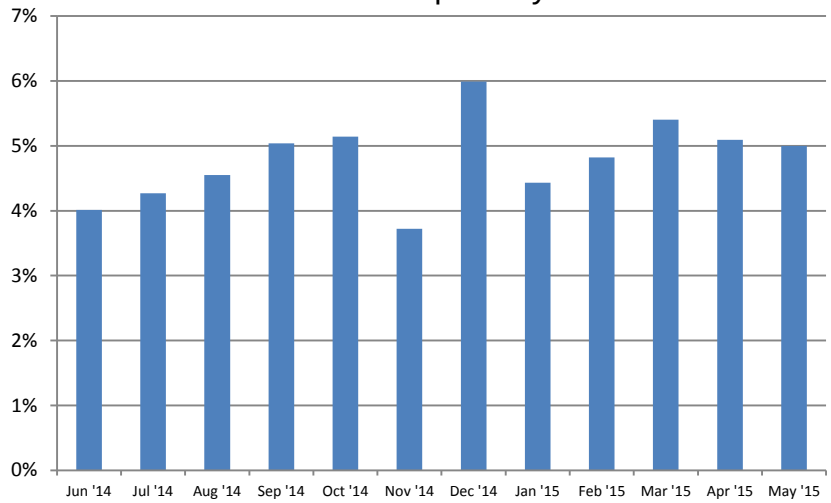
Care Group	Agency Spend % May-15	Staff In Post WTE
Inpatient Care Older People	33.73%	54.96
Prison Service	30.58%	59.55
Outpatients	20.94%	246.57
Clinical Haematology	16.62%	99.95
Community Wards	14.71%	91.36

Agency Costs by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	9.14%	8.36%	7.48%	6.73%	↘
Community Services	9.84%	16.22%	12.15%	9.45%	↘
Corporate	2.67%	3.37%	2.72%	1.22%	↘
Estates and Facilities	12.47%	25.36%	9.47%	1.47%	↘
Medical & Cardiothoracics	12.47%	9.74%	9.35%	6.10%	↘
Surgery, Neurosciences & Anaes	4.36%	6.24%	4.10%	3.24%	↘
Whole Trust	**8.32%**	**9.25%**	**7.30%**	**5.55%**	↘

Booking Reason	Medical Agency & Bank £ May-15	%
Annual Leave AL	£0	0.00%
Increased Care Needs ICN	£15,300	4.71%
Maternity Leave ML	£0	0.00%
Sickness S	£16,005	4.92%
Study Leave SL	£0	0.00%
Vacancy V	£293,686	90.37%
Total	**£324,990**	**100.00%**

Section 9: Staff Bank Costs

The chart below shows bank spend by month to show both annual and seasonal trends.



COMMENTARY

Bank spend percentage has decreased by 0.1% between April and May.

There is increased progress in the programme of transfer from agency staffing to bank staffing for administrative staff groups

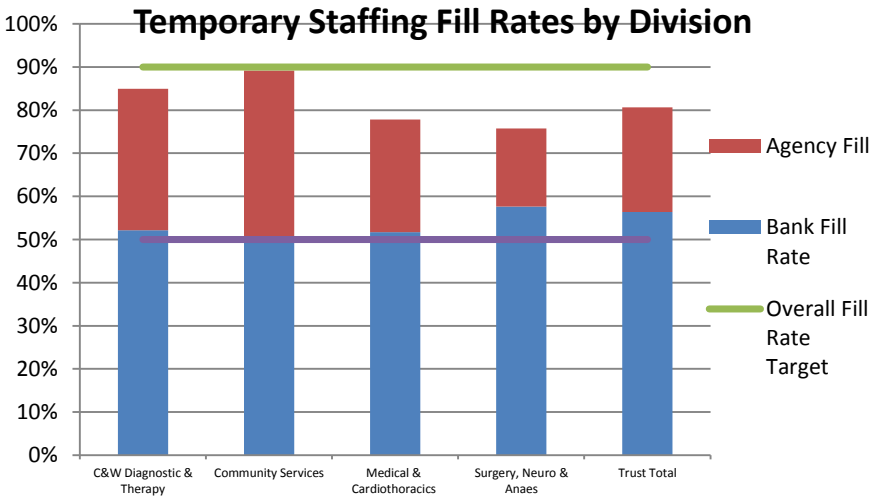
The Bank Fill rate in May 2015 was 50.24% this was an improvement of 6.0% on March 2015

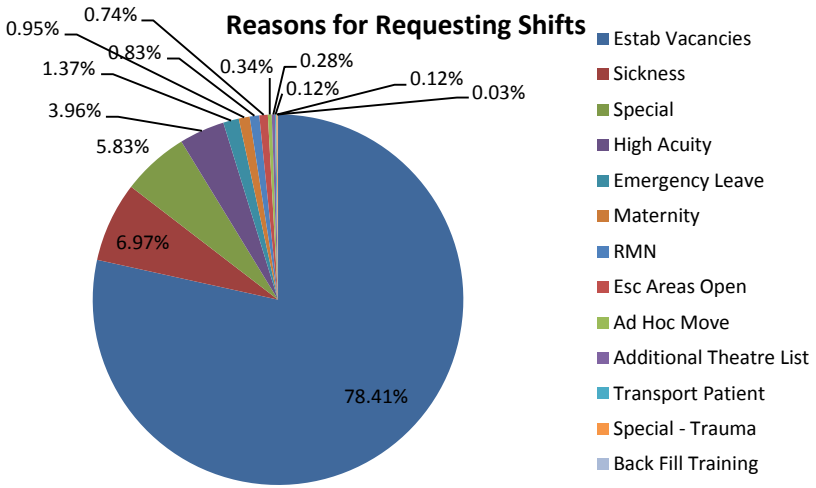
The table below lists the five care groups with the highest bank percentage spend for this month.

Bank Spend % by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	5.13%	5.96%	5.63%	5.77%	↗
Community Services	4.79%	4.87%	4.44%	4.45%	↗
Corporate	4.16%	1.47%	3.80%	4.40%	↗
Estates and Facilities	10.58%	9.86%	9.37%	10.35%	↗
Medical & Cardiothoracics	5.50%	6.89%	5.88%	6.13%	↗
Surgery, Neurosciences & Anaes	4.00%	4.67%	3.40%	3.28%	↘
Whole Trust	**4.82%**	**5.40%**	**5.09%**	**5.00%**	↘

Care Group	Bank Spend % May-15	Staff In Post WTE
Security & Car Park Management	26.95%	22.00
Portering	26.24%	77.65
Pharmacy	15.61%	165.47
Prison Service	14.68%	59.55
Outpatients	13.11%	246.57

Section 10: 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 May the Bank Fill Rate was reported at 56.4% which is 6% higher than the previous month. The Overall Fill Rate was 80.64% which is an increase of 4.3% on the previous month. The Community Services Division is currently meeting the demand for temporary staff most effectively.

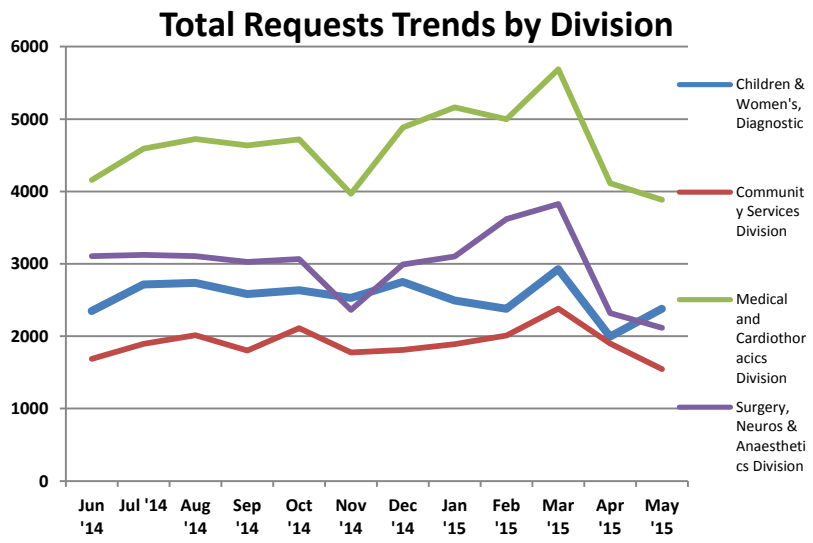
The pie chart shows a breakdown of the reasons given for requesting bank shifts in May. This is very much dominated by covering existing vacancies, specials, sickness, and high acuity patients.

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

Bank Fill Rate % by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	34.02%	34.54%	45.41%	52.14%	↗
Community Services	44.90%	41.01%	41.49%	49.51%	↗
Medical & Cardiothoracics	39.03%	37.96%	46.54%	51.69%	↗
Surgery, Neurosciences & Anaes	47.50%	48.50%	50.71%	57.66%	↗
Whole Trust	**45.15%**	**44.15%**	**50.24%**	**56.35%**	↗

Overall Fill Rate % by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	81.54%	78.72%	78.35%	84.90%	↗
Community Services	83.57%	83.28%	84.08%	89.19%	↗
Medical & Cardiothoracics	74.45%	74.98%	74.37%	77.84%	↗
Surgery, Neurosciences & Anaes	70.47%	71.92%	71.43%	75.73%	↗
Whole Trust	**77.32%**	**77.10%**	**76.37%**	**80.64%**	↗

Section 11: Temporary Staffing Duties



COMMENTARY

This data comes from the Trust's e-rostering system.

The figures show the number of bank and agency duties requested by month by Division. The graph shows a large decrease in numbers in April as tighter controls on booking and runrate initiatives have been implemented.

Division	Jun '14	Jul '14	Aug '14	Sep '14	Oct '14	Nov '14	Dec '14	Jan '15	Feb '15	Mar '15	Apr '15	May '15
C&W Diagnostic & Therapy	2349	2713	2735	2581	2636	2529	2752	2493	2378	2927	1995	2378
Community Services	1685	1893	2015	1800	2110	1774	1811	1890	2009	2380	1897	1545
Medical and Cardiothoracics	4160	4593	4723	4636	4721	3967	4885	5161	4999	5688	4113	3885
Surgery, Neurosciences & Anaes	3105	3125	3106	3028	3068	2363	2991	3101	3617	3825	2321	2114
Estates & Facilities	156	168	165	165	707	303	651	727	711	842	996	1010
Corporate	133	134	184	184	347	174	388	361	300	424	509	556
Total	**11588**	**12626**	**12928**	**12394**	**13589**	**11110**	**13478**	**14054**	**14014**	**16086**	**11831**	**11488**

Section 12: Mandatory Training

MAST Topic	Mar '15	Apr '15	Trend
Conflict Resolution	69.1	71.1	↗
Dementia Awareness	62.7	62.7	↘
Equality, Diversity and Human Rights	84.9	83.5	↘
Fire Safety	78.0	77.3	↘
Health, Safety and Welfare	85.1	83.7	↘
Infection Prevention and Control Clinical	60.8	62.1	↗
Infection Prevention and Control Non Clinical	79.5	77.2	↘
Information Governance	66.0	66.7	↗
Moving and Handling	83.6	80.8	↘
Moving and Handling Patient	58.7	55.2	↘
Resuscitation BLS	50.9	44.1	↘
Resuscitation ILS	50.7	46.5	↘
Resuscitation Non Clinical	59.9	60.2	↗
Safeguarding Adults	85.0	82.7	↘
Safeguarding Children Level 1	84.3	81.7	↘
Safeguarding Children Level 2	78.2	78.3	↗
Safeguarding Children Level 3	59.6	58.2	↘
Venous Thromboembolism	34.8	37.3	↗

MAST Compliance % by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	75.3%	75.9%	75.4%	75.0%	↘
Community Services	77.9%	77.8%	77.0%	74.7%	↘
Corporate	75.5%	75.7%	74.2%	71.9%	↘
Estates and Facilities	68.3%	66.8%	66.5%	65.9%	↘
Medical & Cardiothoracics	67.1%	67.1%	67.1%	66.4%	↘
Surgery, Neurosciences & Anaes	71.3%	71.3%	71.0%	70.3%	↘
Whole Trust	**74.7%**	**74.7%**	**74.2%**	**73.1%**	↘

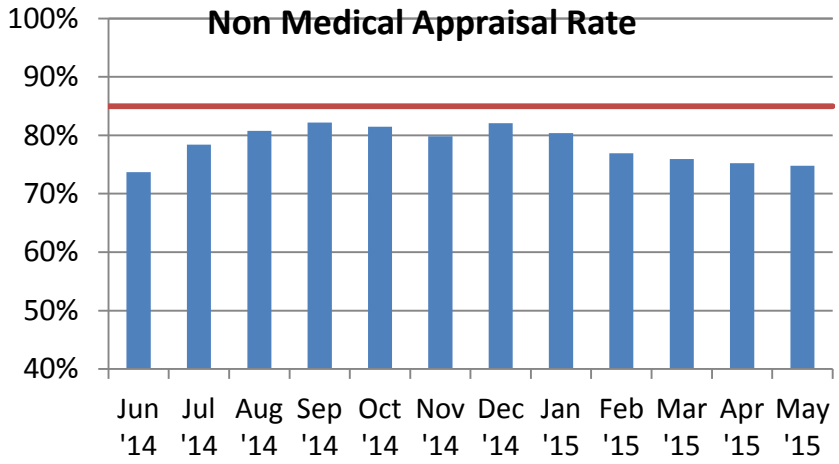
COMMENTARY

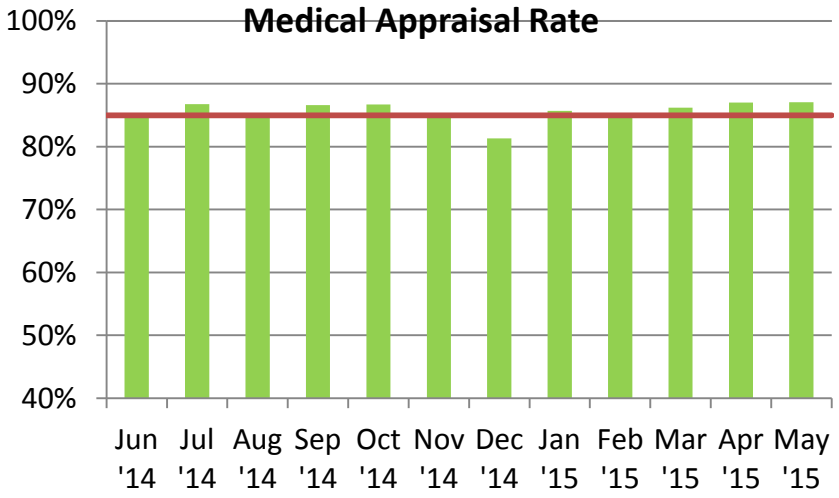
The overall Trust compliance for MAST is now at 73.1% which has decreased by 1.1% since April.

The new Learning Management System is new in place. The system will provide automatic reminders and notices to both staff members and their managers on their compliance. Managers will also be able to see at a glance their staff training data. This quick method will equip mangers with the necessary information to investigate their staff's compliance and respond accordingly.

Mandatory training compliance is included in monthly appraisal performance meetings.

Section 13: Appraisal





Non-Medical Commentary

The non-medical appraisal rate has decreased this month to 74.8%. 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 87.1% which is above the 85% target.

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Care Group	Non-Med Appraisal Rate	Staff In Post WTE
Computing Directorate	36.8%	42.67
Neurosurgery	41.3%	99.34
Paediatric Surgery	50.0%	54.38
Gynaecology	51.4%	44.99
Procurement & Materials Mgmt	51.4%	40.00

Non Medical Appraisals by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	79.4%	75.5%	74.5%	76.5%	↗
Community Services	76.8%	77.3%	76.8%	75.3%	↘
Medical & Cardiothoracics	73.6%	76.0%	77.0%	82.0%	↗
Surgery, Neurosciences & Anaes	78.9%	79.6%	77.7%	72.0%	↘
Corporate	67.2%	64.9%	65.1%	69.0%	↗
Estates & Facilities	77.9%	78.3%	76.6%	68.8%	↘
Whole Trust	**77.0%**	**75.9%**	**75.2%**	**74.8%**	↘

Medical Appraisals by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	83.7%	88.3%	89.7%	87.8%	↘
Community Services	88.9%	83.3%	66.7%	72.7%	↗
Medical & Cardiothoracics	80.6%	83.8%	86.0%	87.6%	↗
Surgery, Neurosciences & Anaes	89.1%	86.1%	87.7%	84.9%	↘
Corporate	100.0%	100.0%	100.0%	100.0%	↔
Whole Trust	**85.2%**	**86.2%**	**87.0%**	**87.1%**	↗

Name and date of meeting: **TRUST BOARD** **JUNE 2015**
Document Title: **Corporate Outpatients Improvement - Update** *An update on the Corporate Outpatient Service improvement action*
Document Author: **Laura Yarnell**, Programme Manager
Lead Director: **Rob Elek,** Director of Strategy
Action required: The Trust Board is asked to: 1. Note and welcome the on-going work being delivered to improve the operational functions of corporate outpatient services 2. Note the development of the Outpatient Strategy programme that will deliver tactical, strategic and innovation work streams for all outpatient services delivered by St George's.

Trust Board June: Corporate Outpatients Improvement Programme Update: Jan - May'15:

1. Introduction

The purpose of this paper is to provide the Trust with an update and overview on the following key areas:

- COS Improvement Programme progress from January to May 2015
- COS Operational update – CBS and medical records
- Introduction to the Outpatient Strategy Board and the planned programme of work

2. COS Improvement Programme update

The Corporate Outpatient (COS) Improvement Programme is now drawing to a close in its current format and work has been transferred to business as usual within COS. This section provides an overview of the progress of the five key work streams since January and outlines the next steps for COS to continue to take forward and build on the successes of the 10 month Improvement Programme.

Please note the following updates only relate to Corporate Outpatient Services and do not include Queen Mary's or the Nelson.

2.1. Capacity and Demand

Patients generally are booked and seen in a timely fashion but prior to commencing the corporate outpatient improvement programme in 2014 there was a widespread opinion within the Trust that current and future capacity and demand (both clinic and estate) was not fully understood nor planned and that there was very limited space potential to run extra clinics. The improvement programme sought to understand the demand and capacity issues, identify levers and put action plans in place.

2.1.1. Progress to date

- Demand for outpatient appointments and operating capacity are modelled and options are developed for alternative service delivery to resolve negative patient experiences due to capacity challenges
- Static trust wide capacity model developed revealing deficit against demand for 15/16 business plans
- Live dashboard of the same data under production by Information and Performance
- Informed the equalization of demand among medical specialities for 15/16

2.1.2. Next Steps

- Information and Performance departments now working to develop live capacity and demand dashboards for the organisation. (to be completed July 2015)
- Incorporation of capacity and demand model into capacity deficit reduction for 15/16 business year and beyond.

2.2. Bookings and Appointments

The current process for booking new referrals is a paper based process and is managed by the Corporate Outpatient's Central Booking Service. The process currently involves the paper referral moving from the central booking service to the relevant clinical service or vice versa. There was an identified risk of paper being mislaid completely or remaining for excessive times with the clinical service. Where this happens there is no record of length of time elapsed or location of referral.

Auditing the time between referrals being sent out from central booking service to the relevant clinical service and the date received back into central booking service for a sample of referrals we found:

- 57 (10%) were sent directly from GP's to Consultants and received in central booking service anything from 3 to 12 days later where known but many dates are unknown.
- 73 (12%) had no reliable dates – either no registration or return date or a number of date stamps. Many of these probably also originated with a speciality.
- The other 447 ranged from 1 to 46 working days. The calculated average was 4.4 days, the median was 3 days.
- 34 referrals took 10 days or longer

2.2.1. Progress

- Designed, developed and implemented "e_Triage" and electronic referral system that is set to reduce the amount of time from when a referral is received to when an appointment offer is made, by an average of 3.5 days.
- E-Triage completed Phase One rollout to 8 COS specialities (Nov-Feb) and the system has handled 14000 referrals so far with 2646 currently active.
- Pause to Phase 2 rollout (originally scheduled for April) to enable system issues to be fixed, further development of the system to be completed and assurance to be sought for the specialities experiencing issues.
- Auditing facilities have been developed to enable the tracking of referrals from end to end perspective.

2.2.2. Next Steps.

- Further development to the system based feedback and issues experienced by phase one specialties.
- Phase Two rollout to the 11 COS specialities will take a phased approach from 22nd June and throughout July.
- COS and IT deliver sustainability plan for the management of the e-Triage system post phase two go-live. This plan will outline the detail of how the COS management team will be able to support the users of e-Triage with any administrative queries and how the IT team will support any further system developments or technical issues that may arise.
- Management reporting and auditing tools available for COS and service users by July. These tools will enable Service Managers, consultants and CBS teams to review the progress of all patient referrals that are scanned into e_Triage.
- The e_Triage "stagnant" records report that identifies any referrals that have not been triaged within 48 hours of them being scanned into the system will form part of the weekly RTT performance meetings that are held with each of the services who deliver outpatients.

2.3. Partnership Working

- The aim of this original work stream was that Service users and COS have an effective working relationship where responsibilities and accountabilities are clear such that patients receive a consistently high level of service.
- This work stream was subsequently closed in January as a Service Level Agreement (SLA) has been developed by COS management that outlines the proposed roles and responsibilities of COS and service users.
- This SLA is set to improve relationships it is anticipated that it will set the terms of engagement for positive interaction between specialities and corporate outpatients.
- The CWDT Divisional Director of Operations is currently discussing the terms of SLA with the other Divisional Directors and it is hoped a decision on its approval will be made by end of June.

2.4. Physical Environment

The outpatient estate on St George's hospital site is extensive with high footfall and this high usage can lead to areas needing regular maintenance and updating. It was recognised that improvements could be made in some areas so we engaged with patients and staff to identify the good and bad areas in order to prioritise the work.

2.4.1. Progress

- Lanesborough: The furniture for the clinic rooms in A, B, C are now in place. Painting has started in these areas.
- Dragon Centre: new Art work in place, construction of two additional rooms by dividing rooms to help meet increasing demands on the service.
- Signage improvement recommendations have been submitted, this is with estates for final sign off.
- Additional TVs for waiting areas are being sourced.

2.4.2. Next Steps

- Discussions to take place with Audiology regarding the possibility of installing music systems in some Outpatient waiting areas.

- Lanesborough main reception area refurbishment has had to go out to tender due to cost

- Work is underway to improve the patient information that it used by Corporate outpatient services. This will involve standardising the information provided across clinics, and reviewing the current appointment letters that are generated by the Cerner IT system. A timeline for this is to be agreed between COS Management and I.T team

2.5. Staff engagement and Motivation

Staff forums were held where over 100 staff attended. Honest feedback was received on communication, responsibilities, management, empowerment, frustrations and incentivization. In addition Listening into action cards were collated. 30% of issues cited were about IT and a further 25% about frustrations with staffing.

2.5.1. Progress

- 7 training sessions were delivered to COS admin staff during February and March that were based on improving patient experience and developing an Outpatient charter for values and behaviours.

- The COS Senior management team attended similar training session on 19th May 2015.
- COS management continue to hold coffee mornings and drop in sessions to provide a forum for the COS admin teams to discuss any issues and share ideas.

2.5.2. Next Steps

- COS are in the process of recruiting in to their substantive posts to reduce the reliance on bank and agency , the benefits of this are financial and improved quality of service delivery. 40 administrative posts have been filled and the new staff are due to start work from July onwards.

- COS has a large workforce which historically has been run with over 25% of the work force been temporary workers, to ensure stability, quality and improved governance of the service the strategy has been to increase the substantive work force over the next 6 months meanwhile sustain the current workforce
- A values awards ceremony is due to be held in late June it will be opened by Miles Scott and all staff who attended the training will receive a values award.
- Patient video featuring 3 patients talking about their outpatient experiences was filmed in April 2015 and now in the process of being edited to go on to the intranet as a learning tool.

3. **COS Operational Update**

COS currently report on a variety of KPI's through their monthly directorate meetings and to the CWDT Divisional Management Board, please refer to Appendix 1 for the June COS scorecard.

Points to note:

- Management of sickness via scorecard have seen marked improvement in the sickness rates.
- The COS management team are in the process of agreeing a long term recruitment strategy for COS over next 18 months to help address on-going vacancy rates and improve the quality of the service provided to patients.
- The appointment of a substantive Head of Nursing is making a positive impact on patient experience particularly the management of complaints.

One of the main areas of focus for COS that is reported more widely to the Trust are the performance of CBS (Central Booking Service), a monthly update for this is included in the Chief Executive's Report. Please refer to Appendix 2 for the June update.

Currently COS are in the process of working with the Divisions to agree a service level agreement, this will ensure that COS is correctly remunerated for the spend it incurs delivering short notice and ad hoc clinics. COS does not currently generate any income but does incur staff costs for delivering a service and has the ongoing challenge of managing the off site storage of all notes, currently there is no destruction policy for medical records .

4. Outpatient Strategy

4.1. Overview

It is acknowledged that whilst there has been continued progress made to operationally improve corporate outpatient services the Trust lacked an explicit overarching strategy for outpatient services.

In response to this an Outpatient Strategy Board (OSB) was formed in April 2015, the purpose of this board is to oversee the development and delivery of a 5 year strategy for all outpatient services across the following sites:

- COS/St George's Hospital site
- Queen Mary's
- The Nelson
- St John's

The strategy will address issues such as the optimum configuration of clinical services between sites, the strategic management of outpatient operations and the transformation of the clinical delivery model to support greater self-management and care closer to home for patients. Please see appendix 3 for an overview of the Programme work streams and governance structure.

- **COS Tactical:** this will continue to build on the successes of the 10 month Improvement Program and will work to deliver a local programme to optimise COS service provision, addressing the on-going issues such as CBS and Medical Records.

- **Strategy:** Design and implement an optimal approach to the delivery of outpatient care through the development of core operating principles and standards to ensure patients receive a consistent level of care across ALL St George's outpatient sites. This work stream will address the current business rules, management and capacity planning between the sites.

- **Innovation:** Identify how to use technology to develop clinical and service models to enable greater self-management and to optimise the delivery of outpatient care.

4.2. Scope

The scope and breadth of this programme will cover the whole patient journey from GP referral into the organisation, the patient attending their clinic and their subsequent discharge.

At present there are multiple means of referring a patient, a range of outpatient booking systems and approaches to managing and delivering clinics across the four sites. For the Trust to deliver an optimal outpatient service with high levels of patient satisfaction then a review of the current processes across all four sites is required. This will enable the Trust to reduce variation and ensure a streamlined pathway for patients, GP' and all other users of the outpatient services.

4.3. Resource

There is currently 1 x WTE Programme Manger assigned to this programme.

There is a further resource requirement of 1 XWTE Project Manager and 1 WTE assistant project manager to support the delivery of this work.

4.4. Metrics

The focus of this programme is to drive up the quality of experience for patients; efficiencies will be delivered through the reduction in variation and standardisation of processes across the 4 sites.

The proposed draft metrics are detailed below, these will need to be worked up in more detail and approved by the OSB and each metric and its supporting data will be ratified with the Trust's Programme Management Office.

Cos Tactical	Strategy	Programme wide
Achieve the 98% notes in clinic on time target	Increase the utilisation of all clinic rooms	Improve patient Experience
CBS performance (call centre)	Efficiency gains from increased utilisation of rooms	Reduce patient complaints
COS staff retention figures	Efficiency gains from reducing business models from 1 to 3	Improve staff experience
		Meet GP's measures of success

4.5. External dependencies

This programme of work requires the engagement of a number of the Trusts key business functions, and it has dependencies on other programmes being delivered across the Trust.

IT and Informatics:

- The business case to move QMH from its current legacy system onto Iclip
- Rollout of Electronic Document Management (EDM) programme that will move the Trust's patient notes from paper to being scanned and available electronically – this has an immediate impact on the COS tactical work stream and will be required to support the implementation of a standardised referral and management of patent notes.

Elective Access policy: the OSB will review the current policy and identify each of the 4 sites current adherences to it. The policy will be considered in the development of the final business model.

St Georges Estate's plan: Eric Munroe is now a member of the Outpatient Strategy Board and the outcomes of this programme will inform the development of the Maybury Street facility.

4.6. Progress

- Mapping of the 3 different business models used to deliver outpatient services across the 4 sites has commenced. A cross divisional workshop with CWDT and Community divisional management was held on the 17th June to agree the core principles for the optimum business model. The outcomes of this workshop and a final recommendation will be tabled at August EMT and OMT for final decision.

- Engagement with Serco, an external organisation with experience in delivering outpatient services in healthcare is underway. A proposal is being drafted by Serco that outlines the specification to run a diagnostic for the current outpatient CBS and referral routes that will recommend a best practice solution.

- A review of which of the 4 sites each specialty delivers outpatient services from is underway. This will enable a strategy to be developed to maximise the use of the rooms available and to identify which locations are optimum for each speciality to be delivering an outpatient service from. This work will result in a reconfiguration of the current service offering at each location.

- IT and Information team are developing plans to be reported at the July OSB for the following:
  - Standardised reporting on core outpatient performance metrics across all 4 sites
  - Reviewing Iclip functionality to enable “real time” capacity planning and to identify a room booking system.
  - Use of current systems to enhance the referral processes for outpatients.

4.7. Next Steps

- Paper to OMT and EMT in August with recommendations on the Outpatient business model.

- On-going work to continue to scope and deliver the COS Tactical and Strategy workstreams.

- Mapping of processes and standard operating procedures will have been completed and an update will be shared to October OMT and EMT.

- Innovation work stream will start to be developed from October onwards

- The Trust Board will receive a paper updating on progress in October.

Appendix 1

Corporate Outpatient Services Monthly Scorecard

		Source	Target	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Activity	Total attendances	Cerner	N/A	60264	62954	69250	56102	67188	69507	61879	58659	64609	60659	62946	60564	59841
	DNA	Cerner	<8%	7.18%	10.93%	9.87%	10.02%	9.89%	10.30%	7.64%	7.33%	7.58%	8.04%	7.33%	7.27%	7.97%
	Hospital cancellations <6 weeks	Cerner	<0.5%	0.48%	0.47%	0.31%	0.56%	0.36%	0.49%	0.32%	0.48%	0.47%	0.45%	0.54%	1.26%	0.74%
OPD performance	Permanent notes to clinic	Manual count	>98%	95.54%	96.85%	96.94%	96.71%	96.98%	96.51%	96.88%	96.77%	94.05%	90.12%	91.32%	95.52%	
	Cashing up - Current month	Cerner	>98%	96.30%	98.10%	98.20%	98.10%	96.60%	98.00%	98.22%	96.40%	97.10%	97.30%	99.60%	98.60%	98.30%
	Cashing up - Previous month	Cerner	100%	99.40%	99.70%	99.80%	99.99%	99.91%	99.60%	99.95%	99.20%	99.70%	99.90%	99.00%	99.60%	99.70%
Call Centre Performance	Total calls	Netcall	N/A	30116	35571	45101	30004	25674	23420	20964	20639	26565	20842	23235	18710	
	Abandoned calls	Netcall	<25%/<15%			32257	14825	5794	2376	1558	2681	5923	2908	3782	1551	
	Mean call response times	Netcall	<1 m/<1m30s	02:34	11:42	20:39	08:41	02:38	01:13	00:47	01:02	02:24	01:43	01:08	01:00	
Nursing Performance	Safe staffing	RaTE	85%	96%	94%	96%	93%	93%	94%	90%	93%	93%	96%	92%	96%	
Phlebotomy Performance	Phlebotomy <30 min waiting time	Phlebotomy queue system	90%	76.42%	72.96%	72.35%	72.44%	47.86%	72.90%	67.00%	69.00%	57.00%	81.00%	81.00%	70.00%	
Quality & Experience	Complaints	C&I	<8	10	17	8	21	8	17	5	4	8	4	5	3	
	Compliments	Local record	N/A	2	2	2	3	2	4	3	6	4	3	3	2	
	Datix reported incidents	Gemma Astafanous	N/A	17	20	18	7	16	12	13	13	6	20	12	11	
	Serious incidents	Gemma Astafanous	0	0	0	0	0	0	0	0	0	0	0	0	0	
Workforce	IPR completion rate	Workforce report	>85%	65.77%	57.47%	58.56%	78.64%	76.79%	77.17%	77.06%	77.31%	80.18%	86.76%	84.40%	80.54%	
	MAST completion rate	Wired	>95%	80.09%	80.84%	76.13%	81.85%	78.30%	67.40%	67.56%	67.68%	71.00%	74.00%	66.00%	74.00%	
	Sickness rate	Workforce report	<3.5%	4.85%	6.79%	8.20%	5.19%	5.90%	4.78%	6.12%	5.35%	5.23%	3.86%	2.83%	3.23%	
	Vacancy factor	Workforce report	<20%	26.12%	26.21%	26.84%	26.08%	25.70%	25.35%	26.58%	26.45%	27.53%	29.17%	28.73%	29.86%	
	Bank & agency spend as proportion of total pay budget	Budget statement	<20%	33.34%	31.64%	38.27%	32.79%	43.66%*	34.15%	31.73%	33.64%	35.43%	30.26%	32.65%	24.20%	
Finance	Budget position in month	Budget statement	In balance	-124,622	8,709	-84,763	-101,977	-276,579	-255,861	-73,219	555,327	-203,000	73,579	-119,680	-279,426	
	CIP	CIP database	Green	Amber	Red*	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
EDM	Number of notes planned to have been scanned	EDM Business Case	N/A												210	210
	Number of Records Scanned											567	623		562	639
	Number EDM Appointments														3081	3216
	Number of Clinicians using EDM														TBC	
Comments					*EDM delays affecting CIP			£116k of VAT accruals in month							No. of EDM clinicians will be confirmed next month	

please note at the time of completing this document COS were still in the process of completing the performance data for May.

Appendix 2

June 2015 – Chief Executive's Report.

Corporate Outpatients Update - Call Centre

The Board has previously been informed of issues encountered in the call centre, which have resulted in long queues and poor patient experience.
As reported at previous meetings, an action plan to address these issues has been developed and is being implemented (table 2 below). Implementation of the action plan has led to continuing improvement as presented in table 1 below.

Table 1 - Current Performance:

Performance from the last 8 weeks:

Week Commencing	Total calls	Answered	% answered	Mean response	Median response (answered calls only)	% answered within 30 secs
13 April 2015	4636	4259	91.90%	00:53	00:20	57%
20 April 2015	4826	4046	83.80%	01:06	00:22	50%
27 April 2015	4730	4210	89.00%	01:15	00:37	43%
04 May 2015	3903	3391	86.90%	01:25	00:46	39%
11 May 2015	4537	4120	90.80%	01:07	00:32	45%
18 May 2015	4585	4031	87.90%	01:21	00:43	39%
26 May 2015	3954	3205	81.10%	02:18	01:44	34%
01 June 2015	4804	4224	87.90%	01:25	00:45	40%

Table 2 – Actions plan (outstanding and ongoing only):

No.	Action	Owner	Timescale	Anticipated impact	Progress/Rag
1	Additional space for growth in CBS resource	E&F	Revised again to 06/03/2015	Facilitate increase in resource – currently reliant on leave to enable all staff to be accommodated. *Efficiency gain – as per 3.*	Now complete.
2	Conversion of Agency to substantive staff	DC/JF	Revised to 31/03/2015	Ensure that staff turnover do not adversely affect call handling resource. Focus on part time staff to cover morning and lunchtime peaks. *Efficiency gain – as per 3*	Complete. Still awaiting start dates, delays in recruitment processing applicants.
3	Reduced number of escalated appointments	HH/ DCh	Revised to 30/06/2015	Improved first call resolution of appointment enquiries, for scheduling that cannot be completed in clinic	Capacity and demand modelling is outstanding

	due to insufficient capacity			*Efficiency gain – Reduction in queue time by 15 secs*	however introduction of fixed appointments has dramatically decreased escalation emails.
4	Full deployment of eTriage to all specialities	HH/IF	Revised to July or August 2015	Reduced time wasted looking for referrals and reduced inefficiency from two referral systems	Phase 1 roll out has highlighted system issues. Phase two roll out for all other specialities to commence before end June 2015.

Current issues

- Loss of one day's activity due to bank holiday.
- Loss of efficiency by running two referral management systems during deployment of eTriage. Once completed this will allow a subsequent efficiency gain.
- Continued significant growth in booking requests as part of work to address RTT compliance over holiday period and targeted actions for some specialities diverting resource from inbound calls.
- Ongoing issues with outpatient capacity causing a backlog of referrals and thus higher demand for immediate capacity, as indicated by "Escalation Email" activity code. Last eight weeks performance shown below:

Week commencing	**Count of calls not resolved first time**
13 April 2015	1205
20 April 2015	1206
27 April 2015	1047
04 May 2015	731
11 May 2015	979
18 May 2015	1045
26 May 2015	969
01 June 2015	1251

Next Steps

- Adherence to schedule – reporting is being developed to demonstrate this metric
- Forecasting accuracy – we are analysing nine months of inbound call data and developing a forecast. In order to be accurate the data still needs fine tuning before being shared.
- Self-service accessibility – We currently offer a web based appointment re-scheduling request function however Iclip does not allow true self service in regards to appointments. Having contacted communications there is a drive to improve our external website and discussions are on-going regarding CBS Self-service accessibility.
- Contact quality – We will be increasing our audits of calls to 2.5% from currently 1%
- Customer satisfaction – we are in contact with our call centre software provider to include a rate your call option or similar to determine customer satisfaction with service and first call resolution.

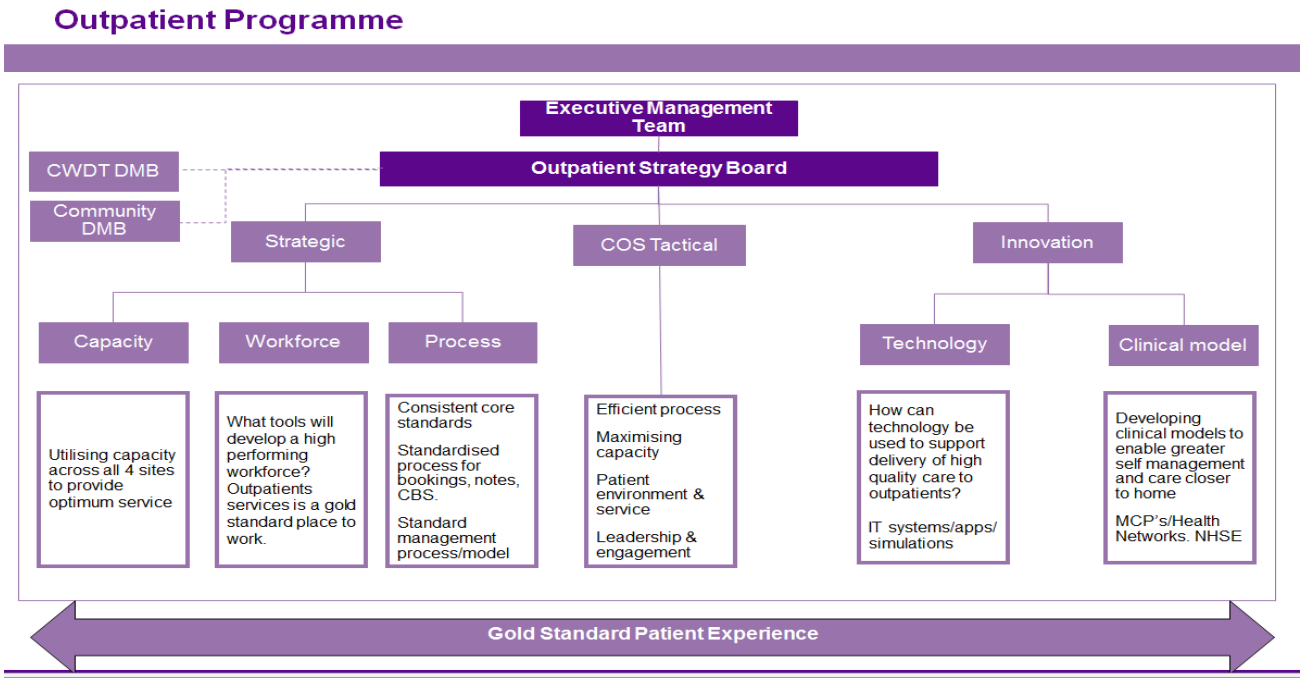
Appendix 3

OUTPATIENT STRATEGY PROGRAMME

TERMS OF REFERENCE:

Outpatient services are a major part of St George's University Hospitals, providing around 650,000 appointments per year and bring in over £110m in income. This programme of work has been established as the Trust requires an overarching strategy to ensure the delivery of world class outpatient services to its patient population.
This paper outlines governance, reporting and terms of reference for the Outpatient Strategy programme.

1) GOVERNANCE STRUCTURE



2) HIGH LEVEL OVERVIEW

	High level overview	Timeframe
Outpatient Strategy Board	• Develop the 5 year strategy for Outpatient services across St George's University Hospitals.	Ongoing
Outpatient Strategy Group	• Delivers a standard approach Process, Capacity and workforce for outpatients	Medium
Outpatient Innovation Group	• Implements the use of technology to maximise the efficiency and experience of outpatient services	Long term
COS Operational	• Delivers a focused operational plan to improve capacity, process, patient experience and leadership across COS	Short Term
Patient Experience	• The delivery of a gold standard patient experience is paramount throughout.	Ongoing

3) TERMS OF REFERENCE

	Outpatient Strategy Board	**Strategy**	**Innovation**	**COS Operational**
Purpose	Develop the 5 year strategy for Outpatient Services	Design and deliver an optimal approach to the delivery of outpatient care	Identify how to use technology to optimise and innovate the delivery of outpatient care	Deliver local level programme to optimise COS service provision
Aims	• Develop and agree the programme to deliver the 5 year strategy • Provide leadership, challenge, expert opinion and senior decision making across the programme. • Hold Community and CWDT divisions to account for the delivery of the programme • Report progress to the Executive Board	• Implement a cross divisional work programme that delivers: ○ A set of core operating principles and standards ○ A tool kit to enable a high performing workforce ○ Enables capacity to be effectively utilized across St George's estate ○ Standardised management processes and model ○ Align divisional priorities to ensure delivery	• Develop clinical models to enable greater self-management • Bring care closer to home • Identify IT and technology to improve patient care and service provision	Continue to deliver the COS Programme that addresses the four key areas: • Effective Process • Maximizing Capacity • Patient Environment • Enhancing Leadership
Membership				
Chair	**Director of Strategy**	**This will be a working group with representation from CWDT/Community and the Improvement Programme.**	**TBC**	**COS Clinical Director**
Deputy Chair	**Divisional Chair**	**As above**	**TBC**	**COS General Manager**

Core Membership	• CWDT Divisional Director of Operations • CWDT Divisional Chair • Community Divisional Director of Operations • Community Divisional Chair • CWDT DDNG • Community DDNG • Programme Manager • I.T Director, Head of Informatics and Director of Estates will be called upon as required	• CWDT Divisional Director of Operations • COS Clinical Director • COS General Manager • Community Divisional Director of Operations • Community Outpatients General Manager • Community Outpatients Clinical Director • COS Head of Nursing • Community Outpatients Head of Nursing • Programme Manager • IT/Informatics/Estates representation and contribution will be called upon as required. ***The membership of this group will be flexed depending on the requirements/timeframes of the different workstreams within this project**	• **TBC**	• COS Assistant General Manager • COS Head of Nursing This programme will be managed through the existing COS Directorate meetings.
Quorum	• 5 people – must include representation from both CWDT and Community	• The meetings will aim to include representation from both CWDT and Community	• **TBC**	• TBC
Accountability	• Executive Management Team and Trust Board	• Outpatient Strategy Board	• Outpatient Strategy Board	• CWDT Divisional Management Board
Frequency	• Monthly	• Fortnightly to start and will review	• Monthly	• Monthly
Reporting	• Programme update and exception reporting to EMT	• Monthly update report to OSB and Community and CWDT Divisional Management Boards	• Monthly update report to OSB and Community and CWDT Divisional Management Boards	• COS management team to update CWDT DMB through local reporting processes

	• It is expected that decision taken at the OSB be adhered to by CWDT and Community divisions • Members have a responsibility to ensure that decisions taken at the OSB are communicated appropriately through their management structure.	• The decisions taken at Strategy group will be adhered to by all members • Members have a responsibility to ensure that decisions taken at the OSB are communicated appropriately through their management structure.	• The decisions taken at Strategy group will be adhered to by all members	• The COS management team are responsible for the implementation of any decision taken at the COS directorate or CWDT DMB.

Declaration of interests	• All Outpatient Strategy Programme members must declare any conflict of interests, should they arise, and exclude themselves from the meeting for the duration of that specific item.
Monitoring Effectiveness:	• In order to support the continual improvement of governance standards, the Terms of Reference will be reviewed at regular intervals during the life cycle of the Outpatients Strategy Board
External	• • **NHS Five Year Forward View; Multispecialty Community Providers** "shift the majority of outpatient consultations and ambulatory care out of hospital settings". • **National Information Board** – By **2018** clinicians in primary, urgent and emergency care and other key transitions of care contexts will be operating **without needing to use paper records.** • **General Election 2015** – potential Health & Social care bill reforms, May 2015 onwards.
Internal Dependencies	• **Trust's Financial position**-limited investment available for capital builds/technology – need to identify funding from alternative sources (HSCIC?) • **Management structures-** outpatient services are currently delivered by Community and CWDT across 4 sites. • **Service Line Review –** the outcomes of the review will inform the decision around services to continue/de commission.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – JUNE 2015

Paper Title:	Planning Performance Agreement with Wandsworth Borough Council
Sponsoring Director:	Eric Munro, Joint Director of Estates and Facilities
Author:	Eric Munro
Purpose:	Negotiations on the terms of the Planning Performance Agreement with Wandsworth Borough Council have been concluded.
Action required by the board:	The Board is asked to approve the execution of the Planning Performance Agreement in the form at Appendix A.
Document previously considered by:	Not applicable

Executive summary

1. Key messages

The Trust has been in formal pre-application consultation with Wandsworth Borough Council for some months now regarding the acceptability of various proposed developments across the St George's campus. These developments are in various stages of the business case approval process. In order that the Council can understand and assess the potential cumulative effect of these proposals, it has proposed that the Trust enters into a Planning Performance Agreement with the Council to govern the process whereby the Trust seeks Outline Planning Permission for these developments.

It must the noted that the planning application is outline only, so it establishes whether the size and cumulative scale of development is acceptable in principle, with issues of materials, outward appearance and detailed design reserved for a subsequent "full" application. The Trust will want the assurance of acceptability prior to commitment of resources to developing projects and programmes.

Obtaining outline planning consent does not commit the Trust to undertaking any of the developments but will give greater delivery certainty to business cases coming forward in the future.

The Planning Performance Agreement has been prepared by Capsticks and is endorsed by them.

2. Recommendation

The Board is asked to approve the execution of the Planning Performance Agreement in the form at Appendix A.

Key risks identified: Risks are detailed in the report under each section.	
Related Corporate Objective:	
Related CQC Standard:	Not applicable.
Equality Impact Assessment (EIA): Has an EIA been carried out? No **If yes, please provide a summary of the key findings** **If no, please explain your reasons for not undertaking an EIA.** No specific groups of patients or community will be affected by the initiatives detailed in the report. Where there may be an impact on patients then consultation will be managed as part of that specific programme.	

REPORT TO THE TRUST BOARD – JUNE 2015

Planning Performance Agreement with Wandsworth Borough Council

1. INTRODUCTION AND BACKGROUND

The Trust has been in formal pre-application consultation with Wandsworth Borough Council for some months now regarding the acceptability of various proposed developments across the St George's campus. These developments are in various stages of the business case approval process.

In order that the Council can understand and assess the potential cumulative effect of these proposals, it has proposed that the Trust enters into a Planning Performance Agreement with the Council to govern the process whereby the Trust seeks Outline Planning Permission for these developments.

It must the noted that the planning application is outline only, so it establishes whether the size and cumulative scale of development is acceptable in principle, with issues of materials, outward appearance and detailed design reserved for a subsequent "full" application. The Trust will want the assurance of acceptability prior to commitment of resources to developing these projects and programmes through the business case process.

Obtaining outline planning consent does not commit the Trust to undertaking any of the developments but will give greater delivery certainty to business cases coming forward in the future.

2. SCOPE OF THE PPA

The final form of the proposed Planning Performance Agreement with Wandsworth Borough Council is attached at Appendix A.

The Planning Performance Agreement will cover Outline Planning Permission for:

- Renal Unit
- Private Patients Unit
- associated parking and road infrastructure changes around the Renal/PPU site
- Major extension to Lanesborough Wing for the new Children's and Women's Hospital
- New Outpatients Centre on the Maybury Street site
- circa 200 residential units on the Maybury Street site
- Modular build on the Bence Jones site (for office decants)
- AMW terrace expansion (2nd and 3rd floor)
- St James Critical Care expansion (1st and 2nd floor extensions)
- St James ED Clinical Decisions Unit (ground floor)

It will also approve:

- demolition of Knightsbridge Wing
- the creation of a new 300+ space patient and visitor car park on the site of Knightsbridge Wing plus new drop-off zone
- demolition of Clare House, Bronte House and the Bronte Annex
- creation of 2-way access road at Ingleby House (Pelican)
- new site infrastructure such as sub-stations, street lighting, etc.

3. PPA COSTS

The total payable to the Council under the PPA is £160k plus VAT. The normal planning fee is payable over and above this amount. It is estimated that the planning fee will be circa £25k.

4. ACTIVITIES AND TIMESCALES

The Planning Performance Agreement commits both parties to an agreed schedule of activities and timescales as follows:

Planning application stage		
Task	Responsibility	Timeframe/Target Date
Submission of planning application via Planning Portal and hardcopies	Applicant	24 July 2015
LBW to indicate **informal** acceptance of validation (so that formal consultation period does not fall in August)	LBW	21 August 2015
LBW to confirm validation of application (start of formal 28 day consultation period)	LBW	7 September 2015
Send out consultations, Planning Newsletter, undertake publicity	LBW	September 2015
Consultation	LBW and Applicant	to run until 5 October 2015
Planning application review meetings	Planning Officer and Applicant	From mid-September 2015

3. Determination Stage			
Task	Responsibility	Key Issue	Timeframe/Target Date
1st Review meeting	Applicant/Planning Officer	Identification of any further information required	By mid-September 2015
Further information identified from 1st Review submitted	Applicant	Initial issues addressed	By mid-September/late – September 2015
First discussion regarding Draft S106 Heads of Terms	Applicant/Planning Officer	Agree terms; instruct legal teams	By mid-September 2015
Optional 2nd Review meeting	Applicant/Planning Officer	Identification of further information required/issues to be addressed	By early/mid-October 2015
Further information identified from 2nd Review submitted	Applicant	Further issues addressed	By mid/late October 2015

Task	Responsibility	Key Issue	Timeframe/Target Date
Optional 3rd Review meeting	Applicant/Planning Officer	Identification of further information required/issues to be addressed	By early November 2015
EIA Regulation 19	LBW		October 2015
Final material amendment date (assuming only a 14 day reconsultation needed and no longer)	Applicant	Material Submitted	13 November 2015
Draft of Conditions and S106 Agreement	Applicant/Planning Officer	Conditions and Legal Agreement drafted	13 November 2015
Distribute report to Members	Planning Officer	Draft report, HoT and conditions	Early December 2015
Final draft of committee report including final draft of conditions and HoT	Planning Officer	Submitted for print	w/c 30 November 2015
Presentation material submitted	Applicant	Submitted	Early December 2015
Committee meeting	LBW/Applicant	Resolution of committee	15 December 2015 (best case following 16 week determination period for EIA)
Referral to GLA (Stage 2) and SoS	LBW	Submitted	By 24th December 2015
Response from GLA and SoS if necessary	GLA/LBW	Stage 2 Report	Mid/end of January 2016
Sign Section 106	LBW/Applicant	Conditions and Legal Agreement finalised	By 29 January 2016
Decision Notice issued	LBW	Decision notice issued	By 29 January 2016

5. RECOMMENDATION

The Board is asked to approve the execution of the Planning Performance Agreement in the form at Appendix A.

Eric Munro
Joint Director of Estates and Facilities
19 June 2015

APPENDIX A

PLANNING PERFORMANCE AGREEMENT

BETWEEN

LONDON BOROUGH OF WANDSWORTH

AND

ST. GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

DATED: [******]

PLANNING PERFORMANCE AGREEMENT

This Agreement is made the [*******date*********] between

(1) London Borough of Wandsworth ("LBW") of The Town Hall, Wandsworth High Street, London SW18 2PU (acting as the local planning authority)

(2) St. George's University Hospitals NHS Foundation Trust of St George's Hospital, Blackshaw Road, Tooting, London SW17 0QT ("the Applicant")

Planning Performance Agreements

Extract from the Guidance Note 'Implementing Planning Performance Agreements', produced by the Communities and Local Government in June 2008:

> *"PPAs can help deliver end-to-end planning and improve the quality of decision making for the largest and most complex planning applications.*
>
> *It is recognised that the process to achieve high-quality sustainable development is complicated and that the potential to achieve a successful outcome can be greatly improved by:*
> - *Agreeing to a shared vision and set of objectives;*
> - *Committing to a genuinely collaborative approach by all key parties;*
> - *Adopting a spatial planning approach underpinned by development management; and*
> - *Establishing a robust project management process."*

1. Recitals

1.1 LBW is the local planning authority for developments falling within its administrative area.

1.2 The Applicant intends to submit the Planning Application to LBW in respect of the proposed Development.

1.3 The Applicant and LBW recognise that the proposed Development will give rise to a wide range of planning issues and, accordingly, they acknowledge that, in order to properly assess those planning issues, a clear basis and programme for determination is required.

1.4 In these circumstances, the Applicant and the LBW agree to enter into this Planning Performance Agreement for the following purposes:

a. to agree requirements and timescales in the form of Performance Standards (as specified in Schedules 3 and 4) and a Project Programme (as indicated in Schedule 5) for the consideration and determination of the Planning Applications for the purpose of providing the Parties with certainty as to the process and timescales to be followed;

b. to establish appropriate measures for monitoring compliance with the respective parties' obligations under this Agreement;

c. to establish review mechanisms in respect of the Project Programme.

1.5 Nothing in this agreement shall restrict or inhibit LBW from properly exercising its role as the local planning authority.

1.6 Nothing in this agreement shall restrict or inhibit the Applicant from exercising their right of appeal under Section 78 of the Town and Country Planning Act 1990 or the ability to withdraw the application(s) at any time prior to determination.

2. Term

2.1 This Agreement will apply from the Commencement Date (being the date upon which this agreement was signed) and (subject to earlier determination as hereinafter provided) shall remain in force for a period of 1 (one) year (or such extension of this Term in accordance with the terms of this Agreement) or the Decision Date (being the date a planning decision is issued by LBW on the Planning Application) whichever is the earlier and upon the expiry of such period this Agreement shall cease.

2.2 The Term shall be subject to review as may be agreed between the Parties and set out below under Section 7.

2.3 Should the Applicant submit an appeal under Section 78 of the Town and Country Planning Act 1990 in relation to the Planning Application (for whatever reason) or should the Planning Application be called in by the Secretary of State, this Agreement shall automatically terminate.

3. Joint Working

3.1 All Parties shall act with the utmost fairness and good faith towards each other in respect of all matters in respect of the handling of the Planning Application and to work jointly with each other in complying with their respective obligations under this Agreement.

4. Applicant's Obligations

4.1 The Applicant agrees to use its reasonable endeavours to:

a. submit a planning application to LBW for the Development set out in Schedule 1 by the Submission Date (being the date the valid planning application is received by LBW) set out in Schedule 6.

b. submit the documents set out in Schedule 2 with the Planning Application when it is submitted to LBW.

c. comply with the Performance Standards set out in Schedule 3.

d. comply with and facilitate the compliance by LBW with the indicative Project Programme set out in Schedule 5.

e. perform the obligations set out in the Planning Performance Agreement at Schedule 6.

5. LBW's Obligations

5.1 Without prejudice to its other obligations as local planning authority, LBW agrees to use its reasonable endeavours to:

a. designate a planning officer who alone or as part of a team shall be responsible for overseeing or carrying out the functions in accordance with this agreement.

b. if the designated planning officer should become unavailable during the lifetime of this agreement for whatever reason, to designate an alternate planning officer who alone or as part of a team shall be responsible for overseeing or carrying out the functions in accordance with this agreement.

c. comply with the Performance Standards set out in Schedule 4.

d. comply with and facilitate the compliance by the Applicant with the Indicative Project Programme set out in Schedule 5.

e. perform the obligations set out in the Planning Performance Agreement at Schedule 6.

6. Joint Working Meetings

6.1 The Parties shall attend meetings in accordance with Schedule 5, at premises of LBW or such other premises as agreed by the Parties, to discuss any matters/issues arising from the Planning Application including:

a. progress in respect of fulfilling the milestones within the relevant timeframes set out in the Indicative Project Programme;

b. any amendments to the timeframes or requirements set out in the Indicative Project Programme as the Parties deem necessary;

c. any consultation response or any other communication received by LBW during the preceding period;

d. any other matters or issues arising in respect of the Planning Application.

6.2 Joint Working Meetings shall be held every 4 weeks throughout the life of the project, or such other times as may be agreed between the Parties.

6.3 Each matter/issue will be evaluated and discussed with the parties and a method of resolution agreed.

6.4 Where reasonably requested by the Applicant, LBW shall make available, within 10 working days, an officer with the appropriate level of authority and relevant experience to attend meetings with external third parties, including the Greater London Authority and English Heritage.

6.5 In addition to the Joint Working Meetings, the Parties shall be entitled, where necessary, to call additional technical meetings and the Parties will make available a team of officers or consultants from various disciplines as appropriate and in a timely fashion.

7. Breach and Termination

7.1 If any party shall commit any breach of its obligations under this Agreement and shall not remedy the breach within 10 working days of written notice from the other party to do so, then the other party may notify the party in breach that it wishes to terminate this Agreement forthwith and the agreement shall be terminated immediately upon the giving of written notice to this effect to the party in breach provided always the breach is within the control of the party that is in breach and is capable of being remedied. For clarity, in the event that the PPA is terminated by either party there will be no financial liability due by one party to the other and each party will meet their own costs.

8. Amendment/Review of Agreement

a. Amendment to the agreement and revision of timescales shall be subject to review as may be agreed between the parties.

9. Dispute resolution

9.1 The Parties agree that they will work together to secure the delivery of the objectives of this Agreement. The Parties shall first attempt to resolve any disputes between themselves, and shall be entitled to call a special meeting of such members of the Project Team as necessary (in addition to any Joint Working Meetings under clause 6).

9.2 If the Parties cannot resolve the dispute using the procedure in clause 9.1 above, the designated project managers of the Parties shall meet and seek to resolve the dispute through negotiations between them and the project managers shall have authority to settle such disputes.

10. Fee

10.1 Based on the indicative programme (Schedule 5) a capped fee of £160,000 plus VAT has been identified for the application determination period from 24 July 2015 to the decision date.

10.2 Payment by the Trust under the PPA will be quarterly in advance.

10.3 For the avoidance of doubt the PPA fee is separate from the statutory application fee. The Council will seek a separate undertaking from the applicant in regard to covering its costs for external viability and sustainability advice, and the legal costs for the associated section 106 agreement work.

SCHEDULE 1
The Development

Address of the application site (see attached plan):

St George's Hospital, Blackshaw Road, Tooting, London SW17 0QT

St George's Hospital is bounded by Blackshaw Road to the south-west, Effort Street and Maybury Street to the south-east, Coverton Road to the north-east and Kiln Mews/Hepdon Road and Fountain Street to the north-west. The site is currently occupied by multiple large and small scale (between 1 to 7 storey) buildings which form the St George's Hospital complex.

The site is located within a primarily residential area in Tooting, south-west London. The site lies outside of any Conservation Areas and there are no Listed Buildings located within the site boundary or in close proximity to the site (with the exception of locally listed Lambeth Cemetery to the south of Blackshaw Road (all lodges and mortuary chapels)).

The main vehicular access to the site is from Blackshaw Road. Pedestrian access is made from Blackshaw Road, Effort Street, Coverton Road and Cranmer Terrace.

Summary of specific relevant policy:

NPPF and NPPG
London Plan

Core Strategy (adopted and 2nd proposed submission versions)
PL1 – Attractive and distinctive neighbourhoods and regeneration initiatives
PL2 – Flood risk
PL3 – Transport
PL5 – Provision of new homes
IS1 – Sustainable development
IS2 – Sustainable design, low carbon development and renewable energy
IS3 – Good quality design and townscape
IS4 – Protecting and enhancing environmental quality
IS5 – Achieving a mix of housing including affordable housing
IS6 – Community services and the provision of infrastructure
IS7 – Planning obligations.

DMPD (adopted and 2nd proposed submission versions)
DMS1 (General development principles)
DMS2 (Managing the historic environment)
DMS3 (Sustainable design and low-carbon energy)
DMS4 (Tall buildings)
DMS5 (Flood risk management)
DMS6 (Sustainable drainage systems)
DMH3 (Unit mix in new housing)
DMH4 (Residential development including conversions)
DMH6 (Residential space standards)
DMH7 (Residential garden and amenity space)
DMH8 (Implementation of affordable housing)
DMO3 (Open spaces in new development)
DMO4 (Nature conservation)
DMO5 (Trees)
DMC1 (Protection of existing community facilities).

DMC2 (Provision of new and improved community facilities)
DMC3 of the 2nd proposed submission version (Provision of health and emergency service facilities).
DMT1 (Transport Impacts of development)
DMT2 (Parking and Servicing)
DMT4 (Land for transport functions).

Site Specific Allocations Document (adopted and 2nd proposed submission version).
Housing SPD
Planning Obligations SPD
Refuse and Recyclables in Development SPD.

Applicant:

The Applicant is St. George's University Hospitals NHS Foundation Trust. GL Hearn is appointed as the Agent for the proposed development.

Description of the Development:

Phased redevelopment of St George's Hospital to provide new hospital accommodation (Use Class C2) comprising extensions to Atkinson Morley Wing, St James' Wing and Lanesborough Wing; and the redevelopment of Maybury Street Car Park to provide a new Outpatients Department (Use Class C2), residential units (Use Class C3) and flexible commercial floorspace (Use Class A1/D1/D2); and associated highways and landscaping works (Outline Planning Application).

SCHEDULE 2

The Application Documents

The parties to this agreement agree that the Planning Application shall be accompanied by the documents detailed below:

The statutory national list of planning application requirements:

1) Completed Standard Application Form
2) Completed CIL form
3) Completed Ownership Certificate
4) Agricultural Holdings Certificate
5) Appropriate statutory application fee – circa. £25,000
6) Design and Access Statement
7) A Site Plan which identifies the land to which the application relates drawn to an identified scale
8) A Location Plan based on an up-to-date map at a scale of 1:1250 or 1:2500. The application site should be clearly edged with a red line and a blue line should be drawn around any other land owned by the Applicant, close to or adjoining the application site.
9) Other drawings/plans each with a scale bar:
    - At a scale of 1:100 or 1:200
        - Block plan showing any site boundaries
        - Existing and proposed plans, elevations and sections

The statutory local list of planning application requirements for each application to include **(taking into consideration the EIA Scoping exercise to be undertaken, and as may be updated during pre-application discussions):**

a) Planning Statement
b) Transport Assessment and Travel Plan including deliveries and servicing [appended to the ES – hospital and residential travel plans]
c) Environmental Statement [chapters to be confirmed in scoping]
d) Affordable Housing Statement as the summarised version of the full viability assessment that can be made public
e) Viability Statement – as the private and confidential financial document for the housing proposed
f) Arboricultural impact assessment and tree protection plan
g) Landscaping report
h) Flood risk assessment
i) Statement of Community Involvement
j) Sustainability and Energy Statement
k) Air quality assessment
l) Lighting Assessment
m) Draft Construction Management Plan (working document) to include demolition phase
n) Trust's Waste Management Plan
o) Tall Buildings Assessment (if 5 storeys or more) to address the 15 criteria in policy DMS4, particularly a townscape, heritage and visual impact assessment.
p) Land contamination assessment
q) Health impact assessment
r) Daylight and sunlight report for both the impacts on neighbouring site, and within the residential element of the development (depending on how developed the residential design principles are established)

s) Microclimate assessment
t) Noise assessment, particularly for any plant proposed
u) Draft s.106/HoTs
v) CIL form

SCHEDULE 3
The Applicant's Performance Standard

The Applicant agrees to use its reasonable endeavours to achieve the following performance standards at all times:

a. To wherever possible address any concerns raised by any statutory consultee prior to the submission of the Planning Application to LBW.

b. To provide LBW with such additional information as may be requested within 3 working days of such written request from LBW (or such other time period as may be agreed) in order to enable LBW to discharge its responsibilities.

c. Where circumstances beyond the reasonable control of the Applicant preventing compliance arise, the Applicant/Agent will notify the LPA by email (next working day latest).

d. To provide to LBW at least 3 working days prior to any meeting all substantive and relevant documents which are relevant to that meeting and which relate to any relevant action points or agenda identified.

e. To provide to LBW within 3 working days of any meeting the minutes or action points arising from that meeting.

f. To provide the LBW on signing of this agreement with a quarterly payment of **£40,000 plus VAT** to cover pre-application and application meetings and advice including meeting(s) on site. This is in addition to the statutory planning application fee, and separate to the applicant meeting the Council's costs for external advice on viability, sustainability and legal drafting.

SCHEDULE 4
LBW's Performance Standards

In addition to its statutory obligations, LBW agrees to use its reasonable endeavours to achieve the following performance standards at all times:

a. Respond substantively to all faxes, emails and letters within 3 working days of receipt. Respond substantively to telephone calls by the end of the following working day. Where circumstances beyond the reasonable control of LBW prevent its compliance with this Service Standard, LBW shall in each case notify the Applicant of such circumstances by the end of the next working day by e-mail.

b. Notify the Applicant and Agent no later than 3 working days prior to any meeting of the LBW Planning Applications Committee at which any report or matter relevant to the Development will be discussed and or considered and to provide the Applicant with a copy of any report to the LBW Planning Applications Committee at that time.

c. Provide to the Applicant and Agent at least 3 working days prior to any meeting all substantive and relevant documents which are relevant to that meeting and which relate to any relevant action or agenda points identified.

d. To provide to the Applicant and Agent within 5 working days of any meeting, comments/changes to the minutes or action points arising from that meeting (produced by the Applicant in accordance with Schedule 3 h).

SCHEDULE 5

The Indicative Project Programme

The parties to this agreement have agreed to use their reasonable endeavours to ensure that the Planning Application is progressed in accordance with the Planning Performance Agreement (unless subsequently varied) and the following project programme indicates the stages and timescales necessary to achieve that. For the avoidance of doubt this project programme does not form part of the Planning Performance Agreement.

1. Pre-application stage		
Task	Responsibility	Timeframe/Target Date
Joint Working Meetings	Planning Officer and Applicant	Every 4 weeks for the 12 month duration of the PPA – Week commencing 10 June
Additional technical meetings, e.g. on transport, heritage/design	LBW and Applicant	To be held on an 'as required' basis.
GLA Pre-Application Meeting	Applicant	Targeting late June [
Pre-Application Consultation with Merton Borough Council	Applicant	Targeting late June/early July
Design Review Panel Meeting	Applicant	Targeting late June/early July
Pre-Application Public Consultation Event	Applicant	Consultation Strategy to be confirmed. Strategy to identify specific dates
Signing of Planning Performance Agreement	LBW and Applicant	1 June 2015
Submit information for the LBW Planning Newsletter	Applicant	Late July/Early September 2015

2. Planning application stage		
Task	Responsibility	Timeframe/Target Date
Submission of planning application via Planning Portal and hardcopies	Applicant	24 July 2015
LBW to indicate **informal** acceptance of validation (so that formal consultation period does not fall in August)	LBW	21 August 2015
LBW to confirm validation of application (start of formal 28 day consultation period)	LBW	7 September 2015
Send out consultations, Planning Newsletter, undertake publicity	LBW	September 2015
Consultation	LBW and Applicant	to run until 5 October 2015
Planning application review meetings	Planning Officer and Applicant	From mid-September 2015

3. Determination Stage			
Task	Responsibility	Key Issue	Timeframe/Target Date
1st Review meeting	Applicant/Planning Officer	Identification of any further information required	By mid-September 2015
Further information identified from 1st Review submitted	Applicant	Initial issues addressed	By mid-September/late – September 2015
First discussion regarding Draft S106 Heads of Terms	Applicant/Planning Officer	Agree terms; instruct legal teams	By mid-September 2015
Optional 2nd Review meeting	Applicant/Planning Officer	Identification of further information required/issues to be addressed	By early/mid-October 2015
Further information identified from 2nd Review submitted	Applicant	Further issues addressed	By mid/late October 2015
Optional 3rd Review meeting	Applicant/Planning Officer	Identification of further information required/issues to be addressed	By early November 2015
EIA Regulation 19	LBW		October 2015
Final material amendment date (assuming only a 14 day reconsultation needed and no longer)	Applicant	Material Submitted	13 November 2015
Draft of Conditions and S106 Agreement	Applicant/Planning Officer	Conditions and Legal Agreement drafted	13 November 2015
Distribute report to Members	Planning Officer	Draft report, HoT and conditions	Early December 2015
Final draft of committee report including final draft of conditions and HoT	Planning Officer	Submitted for print	w/c 30 November 2015
Presentation material submitted	Applicant	Submitted	Early December 2015
Committee meeting	LBW/Applicant	Resolution of committee	15 December 2015 (best case following 16 week determination period for EIA)

Referral to GLA (Stage 2) and SoS	LBW	Submitted	By 24th December 2015
Response from GLA and SoS if necessary	GLA/LBW	Stage 2 Report	Mid/end of January 2016
Sign Section 106	LBW/Applicant	Conditions and Legal Agreement finalised	By 29 January 2016
Decision Notice issued	LBW	Decision notice issued	By 29 January 2016

3. Project Team		
Name	Position and Role	Contact Details
Tim Cronin	LBW Planning Officer	TCronin@wandsworth.gov.uk
Victoria Crosby	LBW Planning Officer (DM)	vcrosby@wandsworth.gov.uk 020 8871 6760
Nigel Granger	LBW Planning Officer	NGranger@wandsworth.gov.uk
Dave Clarke	Conservation and Urban Design Officer	DClark@wandsworth.gov.uk
TBC	Transportation Officer	
TBC	Tree Officer	
TBC	Sustainability Consultant	
TBC	Viability Consultant	
Eric Munro	The Applicant	Eric.Munro@stgeorges.nhs.uk
Sarah Hiscutt	GL Hearn	Sarah.Hiscutt@glhearn.com

SCHEDULE 6
The Planning Performance Agreement

The parties to this agreement shall use their reasonable endeavours to perform the following obligations that constitute the Planning Performance Agreement.

A	The Submission Date: the date the Planning Application is to be submitted to LBW by the applicant	24 July June 2015
B	The Determination Date: the date the Planning Application is to be reported to committee or considered under delegated powers by LBW	15 December 2015 or January 2016 [TBA]
C	The Referral Date: the date the Planning Application is referred to both Greater London Authority (GLA) and NPCU (if required by Statutory Instrument) by LBW	Not later than 5 working days after committee determination by LBW
D	The Decision Date: the date the planning decision is issued by LBW	On completion of a s106 agreement, not later than 3 weeks following referral response(s)

Agreement

The London Borough of Wandsworth and the Applicant hereby agree to the content of this Planning Performance Agreement.

London Borough of Wandsworth

Name: Nigel Granger

Signature:

Position: East Team Leader

On behalf of: London Borough of Wandsworth

Date:

St George's Healthcare NHS Trust

Name: Eric Munro

Signature:

Position: Joint Director of Estate and Facilities

On behalf of: St. George's University Hospitals NHS Foundation Trust

Date:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD ***June 2015***

Paper Title:	Risk and Compliance report for Board incorporating: 1. Corporate Risk Register 2. External assurances
Sponsoring Director:	Peter Jenkinson, Director of Corporate Affairs
Author:	Sal Maughan, Head of Risk Management
Purpose:	To highlight key risks and provide assurance regarding their management. To provide assurance to Board regarding compliance with external regulatory requirements
Action required by the committee:	To note the report and consider the assurances provided.
Document previously considered by:	Quality and Risk Committee (QRC)

Executive summary

Key Messages

Corporate Risk Register (CRR):

- The most significant risks on the CRR are detailed.
- Controls are developed for all risks, with a rolling programme of review by QRC during 2015. The next deep dive risk review will take place at QRC on 24th June and will focus upon the cohort of risks around capacity, including staffing.
- Three new risks have been identified and are proposed for inclusion on the Corporate Risk Register (CRR): two finance risks and one in relation to Deprivation of Liberty (DOLS)
- An overarching review of all finance risks on the CRR is currently being undertaken in conjunction with the Monitor investigation and the outcome will be included in the full bi-monthly update to Trust Board in July 2015.

External Assurances, including an update on the CQC Compliance and Improvements action plans:

- All actions to address the following two issues of non-compliance have been completed:
  - *Ensure that all staff understand the requirements of the Mental capacity Act 2005 and how this relates to vulnerable adults in terms of best interest decisions and informed consent*
  - *Ensure that medical records are available within the outpatient department*
- The action plans were presented to the Commissioners and the CQC via the re-scheduled Clinical Quality Review Group on 17th June. The Group agreed to close the action plans in July, subject to two further actions.
- The Intelligent Monitoring Report has now been formally published: one of two elevated risks detailed in the previous draft report has been downgraded: *Inpatient Survey 2014 - Q28 - "Did you have confidence and trust in the nurses treating you?"*
- The CQC have written to the Trust in relation to any identified quality concerns the Trust Executive Team may have in the context of the current Monitor investigation; a response has been provided including an overview of the additional quality assurance processes put in place.
- The corporate Quality Inspection programme recommenced on 1st June.

Risks

The most significant risks on the Corporate Risk Register are detailed within the report.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	All

Related CQC Standard: *Reference to CQC standard that this paper refers to.*	All CQC Fundamental standards & regulations
Equality Impact Assessment (EIA): Has an EIA been carried out? Yes **If yes, please provide a summary of the key findings**	

1. Risks – Corporate Risk Register (CRR):

This report identifies the extreme risks on the Corporate Risk Register with the details of the most significant risks provided in Table 1. An executive overview of the CRR is included at Appendix 1. The rating is prior to controls being applied to the risk. Risks are reduced once there is evidence that controls are effective. A system of 'deep dive' reviews into all risks on the CRR has been agreed with QRC to ensure all risks are reviewed over 12 months.

Table one: highest rated risks

Ref	Description	C	L	Rating ↓↑
3.2-05	The Trust does not deliver its cost reduction programme objectives	5	5	25 →
01-12	Bed capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	5	5	20 →
01-13	Theatre capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	5	4	20 →
01-14	Staffing to support capacity may not be sufficient for the Trust to open the increased bed, critical care and theatre capacity and to meet demands from activity, negatively affecting quality, throughout the year.	5	4	20 →
01-15	Critical care capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	5	4	20 →
01-07	Risk to patient safety and experience as a result of potential Trust failure to meet 95% Emergency Access Standard	4	5	20 →
3.7-06	Failure to meet the minimum requirements of the Monitor Risk Assessment Framework	4	5	20 →
3.6-05	Cashflow Risks – Operational Finance: Forecast Cash balances will be depleted	4	5	20 →
2.1-05	The tariffs applicable to Trust clinical services are adversely changed as a result of national and local tariff changes	4	5	20 →
2.3-05	Tariff Risk – CQUIN Premium Trust income is not maximised due to failure to deliver required performance against CQUIN quality standards.	5	4	20 →
3.4-05	The Trust faces higher than expected costs due to higher marginal costs - higher than expected investment required to deliver service increases.	4	4	16 →
02-01	Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)	4	4	16 →
A410-02	Failure to sustain the Trust response rate to complaints	4	4	16 →
3.3-05	The Trust faces higher than expected costs	4	4	16 →
03-01	Ability to demonstrate compliance with Regulatory Reform (Fire Safety) Order 2005	4	4	16 →
03-02	Failure to demonstrate full Estates compliance	4	4	16 →
03-03	Ability to deliver capital programme and maintenance activity within required timeframes	4	4	16 →
01-08	Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	4	4	16 →
2.4-05	Performance Penalties & Payment Challenges: Trust income is reduced by contractual penalties due to poor performance against quality standards and KPIs and also by payment challenges	4	4	16 →
3.8 – 06	Low compliance with new working practices introduced as part of new ICT enabled change programme	4	4	16 →
3.9 – 06	Risk of inappropriate deployment of e-prescribing and electronic clinical documentation	4	4	16 →

1.1 New risks proposed for inclusion on the CRR

An overarching review of all finance risks on the CRR is currently being undertaken in conjunction with the Monitor investigation and the outcome will be included in the full bi-monthly update to Trust Board in July 2015. However, two new overarching finance risks have been identified for inclusion on the CRR, which should have urgent Trust Board oversight:

Risk: The Trust will be unable to secure the required working capital in the short term; current agreement is for £25m however this will be insufficient.
Control: An application has been made to extend the working capital facility and approval is expected by end of July 2015.

Risk: The working capital (once secured) will not be sufficient.
Controls: Management actions underway to deliver on CIPs;
KPMG team reviewing current financial assumptions;
Implementation of PWC recommendations from July onwards.

The remaining finance risks on the CRR, which are the detailed IBP risks, are currently being reviewed and streamlined under the following cohorts, to be presented in July:
:

- CIPs
- Income risks
- Expenditure risks
- Overall delivery of financial plan and long term sustainability

A further potential new risk has been identified via the Safeguarding Adults Annual Report to the Patient Safety Committee:

Risk: Potential regulatory action, if inspected by the CQC, in relation to Deprivation of Liberty (DOLs) application, arising from a lack of resource to implement best practice in accordance with recent Law Society Guidance (April 2015).
Control: We are currently seeking further legal advice on the implications of the new guidance published in April 2015 on what constitutes a deprivation of liberty in order to agree the plan going forward.

The newly identified risk around further reductions in the availability of medical records in Outpatients (Ref 01-11), which was identified through discussion at the Executive Management Team and Organisational Risk Committee (ORC) has been risk assessed and is now included on the CRR – the full details of this risk and the controls in place are included at Appendix 2.

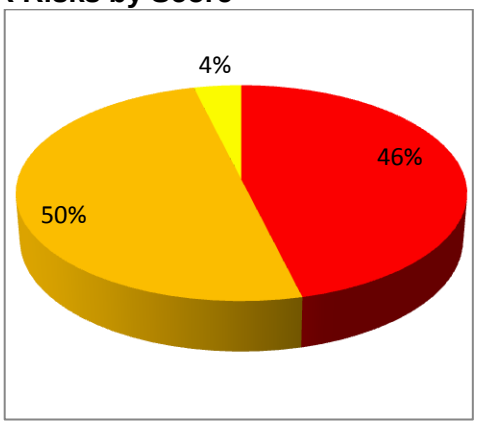
Four further identified risks are currently in the process of being risk assessed and will be included in the full bi-monthly updated CRR to board in July.

- Impact of run rate schemes in Estates and Facilities
- Impact of delays in procurement processes upon all clinical areas
- IT/iclip roll out and risks to patient safety
- Impact upon quality of capital funding decisions

1.2 Summary of risks by score and domain

Figure one demonstrates there are 24 extreme risks on the CRR (a score of 15 or above) which equates to 46% of the total risks. Of these, 10 sit within the domain of Finance and Operations. Of the total risks on the CRR, 38% relate to Finance and Operations and 35% to the Quality domain (table three).

Fig 1: CRR Risks by Score



15 and above (Extreme)	24
8-12 (High)	26
4-6 (Moderate)	2
0-3 (low)	0
Total	**52**

Table three: CRR Risks by Domain

					Total
1. Quality	9	9	0	0	18
2. Finance & Operations	10	10	0	0	20
3. Regulation & Compliance	5	2	1	0	8
4. Strategy Transformation & Development	0	2	0	0	2
5. Workforce	0	2	1	0	3
Total	**24**	**26**	**2**	**0**	**52**

1.3 Changes to risk scores

There have been no changes to risk scores during the reporting period.

1.4 Closed risks

There have been no risks proposed for closure during the reporting period

1.5 Deep Dive: Quality Risk Committee

The QRC are due to undertake a deep dive review of the following risks on 24th June 2015:

Table four

Principal Risk	Lead	Score
01-12 **Bed capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	MW	20
01-13 **Theatre capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	MW	20
01-14 **Staffing to support** capacity may not be sufficient for the Trust to open the increased bed, critical care and theatre capacity and to meet demands from activity, negatively affecting quality, throughout the year.	MW	20
01-15 **Critical care** capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	MW	20
5.1-01 Failure to recruit and retain sufficient staff to manage turnover rates and support future increases in capacity	WB	12

1.6 Summary of Extreme Risks at Divisional level:

The extreme risks from each of the divisional risk registers are included at Appendix 3.

2. Assurance Map

The Trust Assurance Map is a schedule of all external visits, inspections and reporting which captures on-going actions in response to external reviews and those underway to prepare for forthcoming visits. The assurances received from these external inspections help inform the board as to continued compliance with regulatory requirements including Care Quality Commission standards. The following section provides a summary of all external assurances acquired via external reports, visits and inspections during the reporting period.

2.1 Care Quality Commission (CQC) Compliance and improvement action plans - update

Following the CQC inspection in February 2014, the Trust received an inspection report which identified two issues upon which we must take action to improve, these are termed compliance actions:

- *Ensure that all staff understand the requirements of the Mental capacity Act 2005 and how this relates to vulnerable adults in terms of best interest decisions and informed consent (Queen Mary's Hospital)*
- *Ensure that medical records are available within the outpatient department*

In addition to the above two compliance actions, a number of further areas for improvement were also identified at inspection. A Trust wide action plan to address these issues was shared with the CQC and has been on-going to ensure all actions are addressed and that there is learning and continued improvement to the services identified.

The compliance and improvement action plans have been externally monitored via the Clinical Quality Review Group (CQRG) hosted by Wandsworth CCG and attended by CQC and Monitor (attendance by NTDA prior to February 2015). The action plan was presented to the CQRG in October 2014 and January 2015 and again on 17th June. Roger James, CQC Inspection Manager was in attendance.

The CQRG were happy to close both the compliance and action plans subject to the following two actions:

- MCA Audit: there were two queries regarding final data in the summary audit report: the CQRG requested a presentation of full MCA Audit report at CQRG meeting in July to clarify these.
- It was noted that performance of overall notes availability in outpatients is encompassed within the Quality Report to Trust Board; CQRG receive this report. However, for additional on-going assurance, the CQRG requested a monthly exception report of those specialties whose notes availability falls lower than 90% in the previous reporting period.

2.2 CQC Letter to the Trust

On 28th May Roger James, CQC Inspection Manager wrote to the Trust to request an update on actions encompassed within the compliance action plan and to ensure there were no significant quality concerns of which the board were aware, in light of the current Monitor investigation. A response was provided in line with the full update on the action plan to CQRG. Mr James was also in attendance at this meeting. The response also set out the current process in place to quality impact assess all CIP schemes and highlighted the weekly quality oversight process recently introduced to further enhance current quality performance monitoring and which is designed to ensure speedy recognition and escalation of quality concerns.

2.3 Quality Inspection Programme

The corporate Quality Inspection programme recommenced on 1st June 2015 following a temporary pause and to date there have been seven inspections carried out on in-patient wards. The programme is currently being further developed to ensure that wards with electronic

documentation can be appropriately audited and to ensure that the programme maps to other quality and environmental ward rounds ensuring synergy across the quality assurance programme. Going forward thematic analysis of the quality inspections will be incorporated into the Quality report to board.

2.4 Summary of external assurance and third party inspections - June 2015

2.4.1 CQC Intelligent Monitoring Report

The CQC published the formal intelligent monitoring report on 29th May 2015. The formal report differs from the draft report received in April 2015 whereby one elevated risk has now been downgraded, as demonstrated in table five below. The report now highlights one elevated risk and five risks the assurances are detailed below.

Table five: summary of risks

Level of Risk & change	Indicator	Assurance/Actions on-going
Elevated Risk ↓ (Previously an elevated risk in draft report)	Inpatient Survey 2014 - Q28 "Did you have confidence and trust in the nurses treating you?" (Score out of 10) (01-Jun-14 to 31-Aug-14)	Initial detailed feedback has been provided to the Trust by the Picker Institute further analysis has been carried out to identify the five key areas which require focus. A workshop is due to be held on 16th July to look at all areas of concern from the survey. In the interim, current work streams to address nursing recruitment, retention, training and development and embedding values continue.
Elevated Risk ↔	The proportion of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture data base (01/01/2013 – 31/12/2013)	An action plan is in place to address each standard which is overseen by the Care Group Lead and General Manager and is monitored by the Care Group Governance Meeting. It is anticipated the next audit will demonstrate improvements and result in a commensurate reduction in the risk.
Risk	Emergency readmissions with an overnight stay following an elective admission (01/04/2013 – 31/03/2014)	Re-admission profile by month from Aug-13 to May-14 showed our re-admission rate as having a high elevated risk from Oct-13 to Feb-14. However, from March onwards this reduced back to within expected range and for April and May our re-admissions are below that of the national average which is positive this has led to the risk being re-evaluated from a previous elevated risk. This position internally remains unchanged.
Risk	Incidence of Methicillin-resistant Staphylococcus aureus (MRSA) (01-Aug-13 to 31-Jul-14)	The Trust has now reported 2 MRSA bacteraemia cases to the end of May This is currently a high risk on the CRR: A513-01 and detailed assurance is provided to the Board through the Quality report.
Risk	Composite risk rating of ESR items relating to staff turnover (01-Jan-14 to 31-Dec-14)	The Trust is aware of the risk associated with high staff turnover and there is a high risk on the Corporate Risk Register 5.1-01 with a number of controls in place to address. The Trust has a target to reduce turnover and a workforce strategy plan that supports this work which reports to the workforce and education

		committee.
Risk	Composite indicator: NHS staff survey questions relating to abuse from other staff (01-Sep-14 to 31-Dec-14)	The Trust is aware of the high number of staff who report bullying and harassment as highlighted by the staff survey and has a strategy to reduce levels of bullying in the trust and to support staff. There is a risk on the Corporate Risk in to this A518-04 with detailed controls in place.

2.4.2 Anaesthesia Clinical Services Accreditation (ACSA) – May 2015

The Trust underwent its inspection by the Royal College of Anaesthetists in May in anticipation of achieving accreditation. The inspection went well and it is anticipated a decision will be confirmed around accreditation in September.

3. Conclusion

The programme of detailed review of risks included on the Corporate Risk register continues in order to provide stronger assurance to the Trust Board around the management of risks.

The Trust has completed all actions contained within the CQC action plans and Commissioners are happy to close the plan in July, subject to monitoring reverting to business as usual processes.

The programme of Quality Inspections has recommenced on 1st June and going forward, thematic reporting will be encompassed within the quality report.

The Trust Board can be assured that no significant risks have been identified through external inspections and reports received during the reporting period.

Appendix 1: Executive Overview of Corporate Risk Register

Domain: 1. Quality

Strategic Objective/Principal Risk	Lead	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	In month change	Change/progress
1.1 Patient Safety								↓↑	
01-12 **Bed capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	MW	25	20	20	20	20	20	→	
01-13 **Theatre capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	MW	20	20	20	20	20	20	→	
01-14 **Staffing to support** capacity may not be sufficient for the Trust to open the increased bed, critical care and theatre capacity and to meet demands from activity, negatively affecting quality, throughout the year.	MW	20	20	20	20	20	20	→	
01-15 **Critical care** capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	MW	20	20	20	20	20	20	→	
A513-O1: Failure to achieve the National HCAI targets for MRSA and C Diff	JH	16	12	12	12	12	12	→	
O1-01 A risk to patient safety of inappropriate antimicrobial prescribing due to conflicting and out of date guidance being available within the Trust.	JH	12	12	12	12	12	12	→	
01-02: 01-02 Lack of established process for use, provision, decontamination and maintenance of pressure relieving mattresses	JH	9	9	9	9	9	9	→	
01-03 Lack of embedded process for use, provision and maintenance of bed rails	JH	12	9	9	9	9	9	→	
01-04 Risk to patient safety should the organisation fail to meet its statutory duties under Section 11 in respect of number and levels of staff trained in safeguarding children.	JH	12	12	12	12	12	12	→	
01-05 Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the Trust.	JH	12	12	12	12	12	12	→	

01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	MW	15	15	15	15	15	15	→	
01-07 Risk to patient safety and experience as a result of potential Trust failure to meet 95% Emergency Access Standard	MW	20	20	20	20	20	20	→	
01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	SM	16	16	16	16	16	16	→	
01-09 Risk to patient safety due to a lack of a Trust wide visible training needs analysis, and lack of a system for ensuring these have been met in relation to Medical Devices	JH	12	12	12	12	12	12	→	
01-10 Risk to patients, staff and public health and safety in the event the Trust has failed to prepare adequately for an Ebola incident.	JH	10	10	10	10	10	10	→	
01-11 Risk to patient safety and experience where full permanent sets of medical records are not available for scheduled outpatient appointments							12	**NEW**	

Strategic Objective/Principal Risk	**Lead**	**Jan 2015**	**Feb 2015**	**Mar 2015**	**Apr 2015**	**May 2015**	**Jun 2015**	**In month change**	**Change/progress**
1.2 Patient Experience								↓↑	
A410-O2: Failure to sustain the Trust response rate to complaints	JH	16	16	16	16	16	16	→	
02-01 Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)	JH	16	16	16	16	16	16	→	

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	**Lead**	**Jan 2015**	**Feb 2015**	**Mar 2015**	**Apr 2015**	**May 2015**	**Jun 2015**	**In month change**	**Change/progress**
2.1 Meet all financial targets								↓↑	
2.2-O5 Tariff Risk – Emergency Threshold Tariff. The Trust's income and service contribution is reduced due to application of 30% tariff to emergency activity exceeding the contract thresholds	SB	9	9	9	9	9	9	→	

2.1-O5 Tariff Risk - The tariffs applicable to Trust clinical services are adversely changed as a result of National, Local and Specialist Tariff Commissioning changes. Also - transfer of tariff responsibilities to Monitor	SB	20	20	20	20	20	20	→	
1.2-O5 Volume Risk – Decommissioning of Services Activity and associated income/contribution will be lost from services decommissioned due to:- • risks to the safe delivery of care • changing national guidance • centralisation plans	SB	9	9	9	9	9	9	→	
3.3-O5 Cost Pressures * The Trust faces higher than expected costs due to:- •unforeseen service pressures •higher than expected inflation	SB	16	16	16	16	16	16	→	
3.2-O5 Cost Reduction slippage* The Trust does not deliver its cost reduction programme objectives:- •Objective 3: to detail savings plans for the next two years	SB	25	25	25	25	25	25	→	
2.3-O5 Tariff Risk – CQUIN Premium Trust income is not maximised due to failure to deliver required performance against CQUIN quality standards.	SB	8	8	20	20	20	20	→	
1.3-O5 Volume Risk – Tendering of services Activity and associated income/contribution will be lost due to:- • Competition from Any Qualified Providers • Service Line Tenders	SB	9	9	9	9	9	9	→	
1.1-05 Volume Risk – Competition with other providers Activity and associated income/contribution will be lost due to competition from other service providers resulting in reductions in market share *	SB	9	9	9	9	9	9	→	
2.4-O5 Tariff Risk – Performance Penalties & Payment Challenges. Trust income is reduced by contractual penalties due to poor performance against quality standards and KPIs and payment challenges	SB	16	16	16	16	16	16	→	
3.4-O5 The Trust faces higher than expected costs due to higher marginal costs - higher than expected investment required to deliver service increases.	SB	9	9	16	16	16	16	→	

3.5-05 - Cashflow Risks – Forecast Cash balances will be depleted due to delays in receipt of:- Major Charitable donations towards the C&W development. Land Sales receipts Loan Finance	SB	12	12	12	12	12	12	→	
3.6-05 - Cashflow Risks – Operational Finance Forecast Cash balances will be depleted due to:- Adverse Income & Expenditure performance Delays in receipt of SLA funding from Commissioners	SB	20	20	20	20	20	20	→	
3.9-05 Potential financial impact of Better Care Fund	SB	9	9	9	9	9	9	→	
3.10-05 Cash risk – there is a risk the Trust will not receive full or timely payment by commissioners for activity carried out due to data quality issues	SB				12	12	12	→	

Strategic Objective/Principal Risk	**Lead**	**Jan 2015**	**Feb 2015**	**Mar 2015**	**Apr 2015**	**May 2015**	**Jun 2015**	**In month change**	**Change/progress**
2.2 Meet all operational & performance requirements								↓↑	
3.7- 06 Failure to meet the minimum requirements of the NTDA Accountability Framework: Quality and Governance Indicators/Access Metrics.	SB	20	20	20	20	20	20	→	
3.8 – 06 Low compliance with new working practices introduced as part of new ICT enabled change programme	SB	16	16	16	16	16	16	→	
3.9 – 06 Risk of inappropriate deployment of e-prescribing and electronic clinical documentation	SB	16	16	16	16	16	16	→	
3.10-06 Risk of failure to effectively manage exit from national Cerner programme	SB	10	10	10	10	10	10	→	
3.11 - 06 Poor environment in ICT department/on site data centre may lead to interruptions or failure of essential ICT services	SB	12	12	12	12	12	12	→	
3.12-06 3.12- O6 Risk to patient safety due to data quality issues with Patient Administration System (PAS), Cerner, inhibiting ability to be able to monitor patient pathways and manage 18 week performance.	SB	9	9	9	9	9	9	→	

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	In month change	Change/progress
3.1 Maintain compliance with all statutory & regulatory requirements								↓↑	
A534-O7:Failure to provide adequate supporting evidence for all the CQC Essential standards of Quality and Safety	PJ	5	5	5	5	5	5	→	
A537-O6:Confidential data reaching unintended audiences	SM	15	15	12	12	12	12	→	
A610-O6: The Trust will not attain the nationally mandated target of 95% of all staff receiving annual information governance training	SM	15	15	15	15	15	15	→	
03-01: Risk of premises closure, prosecution and fines as a result of non-compliance with fire regulations in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)	EM	16	16	16	16	16	16	→	
03-02 Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation	EM	16	16	16	16	16	16	→	
03-03 Lack of decant space will result in delays in delivering the capital programme.	EM	16	16	16	16	16	16	→	
03-04 Delay to the ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for estates and projects works.	EM	16	16	16	16	16	16	→	
03-05 Trust wide risk to patient, public and staff safety of Legionella	EM	12	12	12	12	12	12	→	

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	Lead	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	In month change	Change/progress
4.2 Redesign & configure our local hospital services to provide higher quality care								↓↑	
A533-O8: Reconfiguration of healthcare services in SWL result in unfavourable changes to SGHT services and finances	RE	8	8	12	12	12	12	→	

Strategic Objective/Principal Risk	Lead	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	In month change	Change/progress

4.5 Drive research & innovation through our clinical services								↓↑	
05-05 Research does not form a key part of St. George's future activity which may result in the loss of funding and an inability to recruit and retain staff.	SM	8	8	8	8	8	8	→	

Domain: 5. Workforce

Strategic Objective/Principal Risk	Lead	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	In month change	Change/progress
5.1 Develop a highly skilled & engaged workforce championing our values								↓↑	
A518-O4:Failure to reduce the unacceptable levels of bullying & harassment reported by staff in the annual staff survey	WB	12	12	12	12	12	12	→	
A516-O4: Possible reductions in the overall number of junior doctors available with a possible impact on particular specialty areas	WB	6	6	6	6	6	6	→	
A520-O4: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	WB	12	12	12	12	12	12	→	
5.1-01 Failure to recruit and retain sufficient staff to manage turnover rates and support future increases in capacity	WB	12	12	12	12	12	12	→	

JH	Jennie Hall	Chief Nurse (DIPC)	EM	Eric Munro	Director of Estates & Facilities
SM	Simon Mackenzie	Medical Director	RE	Rob Elek	Director of Strategy
PJ	Peter Jenkinson	Director of Corporate Affairs	WB	Wendy Brewer	Director of Human Resources
SB	Steve Bolam	Director of Finance Performance & Information	MW	Martin Wilson	Director of Delivery & Performance

Appendix 2 – New Risk

Principal Risk	01-11 Risk to patient safety and experience where full permanent sets of medical records are not available for scheduled outpatient appointments				
Description	There is a risk to patient safety where full permanent sets of medical records are not available to clinicians for scheduled outpatient appointments. This may also adversely impact upon patient experience. The Trust target is to achieve >98% of all permanent notes available in clinic.				
Domain				**Strategic Objective**	
	Original	**Current**	**Update**	**Exec Sponsor**	Martin Wilson
Consequence	3			**Date opened**	1 Jun 2015
Likelihood	4			**Date closed**	
Score	12				
Controls & Mitigating Actions	Trust wide outpatient improvement programme focus on medical records availability Exec Director spot checks on Medical records and outpatients Trust outpatient strategy developing recommendations for board on Trist strategy towards medical records usage and storage EMT quality risk session held on medical records availability Perfect week held w/comm 11th May			**Assurance**	Report on availability of notes produced and circulated: Data reported to QRC and Board through Quality and performance report. Data reported externally on a monthly basis to commissioners. Reduced performance in Q4 with improvement in May 2015: Jan - 94.05% Feb - 90.12% Mar - 91.32% Apr - 90.45% May - 95.54%.
Gaps in controls				**Gaps in assurance**	
Actions next period:	Medical Director and Divisional Chairs to review Trust policy on retention periods and volume of history of clinical correspondence which should be scanned into EDM in order to accelerate EDM roll out and to reduce volume of medical records retained. All consultants to be consulted on approach.				

Appendix 3 – Divisional Extreme Risks

Risk Ref.	CW&DT Risk	Score	Jun 15 Change ↑↓	Rationale for change
CW057	The Division is significantly overspent due to a number of adverse movements.	25	→	
B205	Loss of data due to clinical database no longer being supported	16	→	
CW0067	Financial risk – growth. Risk of CCG not paying for increased income assumptions particularly in children services, radiology and women's	15	→	
CW0068	Financial risk – CQUIN From 15/16 Maternity will no longer get CQUIN funding and instead CCG will develop a local tariff for 2015/16. Estimated value of risk in 14/15 = £2.5m	16	→	
CW0070	Financial risk – cost. The division fails to achieve its CIP programme	15	→	
CW0071	CW0071 - Financial risk – cost. The division does not receive funding for identified cost pressures. Estimated value of risk in 14/15 = c. £1.1m	16	→	
CW0081	Temperature during the summer months in Lanesborough Wing	16	→	
CW082	Manual Handling of deceased patients into Mortuary fridges	16	→	
CW0087	Call alarms in St James' wing therapy dept not working properly – risk to patient safety in the event of an emergency	15	→	
CW089	Insufficient number of CTG monitors for a full triage and full induction bay meaning some women need to wait for monitoring	20	→	
CW090	Lack of NICU capacity – presenting both clinical and financial risk	15	→	
CW091	Lack of GICU capacity – presenting both clinical and financial risk	15	→	
CW092	Lack of CTICU capacity – presenting both clinical and financial risk	15	→	
CW093	Roof leak in room 5.011, 5th Floor Lanesborough Wing	tbc	→	
CW0094	Call bell failure on delivery suite	16	→	
CW0097	Critical Care Run Rate Risks impacting Patient Care & Staff morale	16	→	
CW0094	Call bell system on delivery suite has failed on a number of occasions. Temporary system has been used but this has also failed to work.	16	→	
CW0097	Critical Care Run Rate Risks x 2 Patient Care & Staff morale		NEW	
	M&C		**Change ↑↓**	
Risk Ref.	**Risk**	**Score**		
MC13-D1	Risk to patient safety from delay in diagnosis or failure to follow up.	15	→	
MC31-D5	Risk to patient safety as patients waiting greater than 18 weeks on elective	15	→	

	waiting list for Cardiac surgery, Thoracic Surgery and Vascular Surgery.			
MC32-D1	The division is at risk of not delivering a balanced budget if robust CIP schemes are not found. Not all schemes identified in 14/15 have delivered and therefore knock on effect for schemes in 15/16.	**15**	→	
MC37-D1	Financial and reputational risk arising from failure to meet the 95% ED standard for time attending to leaving the ED	**15**	→	
MC46-D2	Financial Risk – cost pressures within division are not funded	**16**	→	
MC48-D2	Financial risk - Volume - decommissioning of cardiology services	**15**	↑	
MC50-D2	Financial Risk – Tariff. Emergency threshold tariff	**15**	→	
MC55-D2	Financial – Volume. Lack of theatre and ITU capacity for cardiac surgery impacts on income	**20**	→	
MC59-D1	Risk to patient safety that vulnerable patients are able to access the helipad form wards in St James Wing	**15**	→	
MC61-D1	Risk to patient safety, arising from delay in seeing patients categorized as "clinically urgent" within 2 weeks of referral.	**15**	→	
	STN&C		**Change**	
Risk Ref.	**Risk**	**Score**	**↑↓**	
B253	SSD risk upgraded in light of recent significant failures and down time of SJW equipment. On-going issues. Upgraded from 12 to 16	**16**	→	
B268	Sterilisation equipment requires replacing and breakdown may cause service failure potentially resulting in cancelled surgery.	**15**	→	
C11	Failure to prescribe essential medication for patients having elective surgery	**16**	→	
C05	Financial Risk – cost. Failure to deliver CIP programme	**20**	→	
C06	Financial Risk – cost. Failure to receive divisional funding for cost pressures	**15**	→	
C19	GPs in some regions (Surrey, Croydon) not prescribing Antiepileptic drugs (AEDs) recommend by consultant neurologists	**15**	→	
C20	Lack of trained fire wardens	**15**	→	
C23	Risks to patient safety associated with roll out of electronic documentation	**20**	→	
TBC	Failure to ensure Standard Operating Procedures (SOPs) for reviewing diagnostic tests results are in place in all areas and are effective	**15**	→	
	E&F		**Change**	
Risk No.	**Risk**	**Score**	**↑↓**	
EF132	Risk of legionella management controls as Flushing of low use outlets and departments not returning data/records.	**tbc**	→	
EF176	Estates compliance – survey revealed gaps in compliance in statutory and mandatory items	**16**	→	
EF189	Standby Generators within Lanesborough Wing are at the end of their useful life and have insufficient capacity to meet the needs of current healthcare demands and will not need the demand as the building is re-developed and refurbished to	**16**	→	

	modern standards.			
EF195	Electrical upgrades/maintenance to UPS and IPS in AMW	**16**	→	
EF198	Risk of noncompliance with fire regulations as a result of the lack of fire risk assessments for some areas on the St George's Hospital site.	**15**	→	
EF200	Delay to ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for works	**16**	→	
	IM&T		**Change**	
Risk No.	**Risk**	**Score**	**↑↓**	
IT016	Reduction in capacity to deliver new infrastructure, systems and change programs	**20**	→	
IT018	Community staff experiencing access difficulties and slow response to RIO	**16**	→	
IT029	There is a risk of onsite data centre (DC) failure due to inadequate provision and support of air conditioning cooling in the DC.	**16**	→	
IT031	There is a risk to the provision of existing and future ICT applications hosted in the onsite DC due to poor environmental monitoring [UPS, air conditioning, BMS push alerts]	**16**	→	
IT032	Increased risk to network availability due to inadequate electrical supply to key locations.	**15**	→	
IT033	Increased clinical risk to patient safety resulting from lack of UPS protection for main Trust Switchboard.	**16**	→	
	CSW		**Change**	
Risk No.	**Risk**	**Score**	**↑↓**	
CSW1023-COM-D5	Cost Improvement Programme not achieving target.	**16**	→	

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – June 2015

Paper Title:	**Annual Health and Safety report 2014/15**
Sponsoring Director:	**Eric Munro, Joint Director of Estates & Facilities**
Author:	**Eric Munro, Joint Director of Estates & Facilities**
Purpose:	**For Information**
Action required by the board:	**For information**
Document previously considered by:	

Executive summary

1. Key messages

It is the Policy of St George's University Hospitals NHS Foundation Trust to take all reasonably practicable measures to ensure the health, safety and welfare of all its staff, patients, visitors, contractors and persons on the premises over which it has control; in accordance with the Health and Safety at Work etc. Act 1974, The Management of Health and Safety At Work Regulations 1999 and all other related legislation, Regulations, Approved Codes of Practice (ACOP) and Guidance documents

Since April 2014, the following investments and actions have been completed to improve Health and Safety within the Trust:

- **The introduction of a targeted Health and Safety monthly audit using the RaTE system**
- **Completed the amalgamation of all Health and Safety related policies with the former Wandsworth PCT policies.**
- **Updated the Health and Safety policy and Governance structure in line with the recently revised HSG 65.**
- **Continuation of the phased introduction of "Safer sharps" into the Trust in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations (2013)**
- **The introduction of a Management of Health and Safety module to the Band 6 training programme.**
- **Development of closer working links with the SGUL Safety, Health and Environment department allowing the Trust access to a greater range of knowledge, expertise and training skills.**
- **Completed and implemented the procedure for the control of Viral Haemorrhagic fever waste.**

The site has received 3 visits from the Health and Safety Executive over the previous 12 months

- **Inspector Kevin Shorten investigated a fall within the CDU area of the ED department which resulted in the death of a patient. The inspector was satisfied with the Trust Serious Incident report- No further action taken.**
- **Inspector Kevin Shorten visited site in relation to an incident involving a patient in transit within a G4S patient transport ambulance. The Trust was not implicated in the incident**

and no further action was taken.

- **Inspector Zameer Bhunnoo visited site to undertake a routine visit to the Mortuary area primarily to inspect the high risk post mortem room. The inspector gave some verbal advice relating to the environment and working practices. A letter of advice has been received subsequent to this visit.**

The Health and Safety department will facilitate any visit to site by the Health and Safety Executive inspectors to ensure that any issue which may be raised on the inspections are dealt with effectively.

The table below summarises the following areas of work will be prioritised on the Health and Safety improvement plan for 2015/16

Area of work priority 2015/15	Measurement
COSHH Management	1) December 2015 COSHH checklist audit 2) The development of a central database for chemicals and their respective COSHH assessments 3) Reduction in the number of exposures to hazardous substances
Management of Violence and Aggression and Lone working	1) Review and Monthly audits of the use of Lone worker devices to be introduced. 2) Revised policy to be published. 3) Reduction in Moderate and above severity incidents relating to violence and aggression.
Rationalise the areas required to complete the Calendar checklists	1) Improvement of the Calendar checklist completion rate.
Development of Management of Health and Safety E module	1) EMAST training compliance figure for the module.
Management of Needle stick injuries	1) Demonstrated implementation of safer sharps across the organisation 2) Reduction in the number of needle stick injuries sustained

Recommendation

The Board is asked to note the update to the Annual Health and Safety report and the progress made during the period.

Key Risks 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.*	

ANNUAL Health and Safety Report 2014/15

1. PURPOSE OF THE REPORT

The Health and Safety at Work etc. Act (H&SAWA) 1974 provides the legislative framework to secure the health, safety and welfare of persons at work. This Enabling Act incorporates previous (prior to 1974) statutory health and safety legislation and judgements and rulings from the civil courts; thus making it into one comprehensive system of law to deal with the health and safety of people at work, at any time in all types of occupations. It also provides protection for the wider public where they may be affected by the activities of people at work.

Under this Act it is the duty of an employer to safeguard, so far as is reasonably practicable, the health, safety and welfare of all employees including the provision and maintenance of safe plant, machinery, equipment and safe systems of work. Although the ultimate responsibility for compliance with the Act rests with employers, every employee also has a responsibility to ensure that no one is harmed as a result of their acts or omissions during the course of their work. Whilst the Trust is vicariously liable for the acts and omissions of its staff, employees also have a duty under the Act to take reasonable care to avoid injury to themselves and others and to co-operate with their employer and others in meeting the statutory requirements. The Act requires employees not to interfere with or misuse anything provided to protect theirs and other's health, safety and welfare.

Compliance with the Health and Safety at Work etc. Act 1974 (and associated Regulations) is a legal requirement. As such, an offence, committed under the Act would constitute a criminal offence and could lead to prosecution for either the Trust as a Corporate body or personal prosecutions to staff members This may result in a fine and/or a term of imprisonment.
In addition to the H&SAWA 1974, a diverse number of subordinate Regulations, Approved Codes of Practice, Guidance Notes, EC Directives, etc. also have relevance, to the NHS as a whole and are thus equally applicable to St George's University Hospitals NHS Foundation Trust. The Management of Health and Safety at Work Regulations 1999 provides a framework to assist organisations to manage the requirements of the H&SAWA 1974 and the Trust shows its commitment to complying with these Regulations and the law through its statement of intent.

The Trust uses the Health & Safety Executive (HSE) publication HSG 65 Successful Health and Safety Management .as a method of ensuring that the work of the Trust is conducted in as safe a manner so far as is reasonably practicable.

This report has been developed to provide the Trust Board of Directors accountable for the activities of the organisation with relevant information concerning the management and delivery of Health and safety to the Trust during 2014/15

2. Reports and Plans

2.1 The Health and Safety action plan

The Trust Health and Safety action plan is developed by the Health and Safety Manager to ensure that Trust wide Health and Safety issues are monitored by the Corporate body and measurable improvements are made. The action plan is based on the principles of HSG65.

i) Objective planning and policy development.
ii) Competence, Control, Co-Operation and Communication.

iii) Planning and Organisation.
iv) Measuring and monitoring performance.
The plan is presented to the Health, Safety and Fire Committee and the Organisational Risk Committee as a standing agenda item for scrutiny.

2.2 Divisional Health, Safety and Fire reports

All divisions are required provide a Health, Safety and Fire report to the Health, Safety and Fire committee on a Bi- annual basis. This report must be approved by either the Divisional Governance Board or the Senior Management team.

The divisional reports inform the committee of;

i) Non Clinical risks which cannot be managed within the division.
ii) Non Clinical incident trends and analysis.
iii) Investigations into Non Clinical incidents of moderate or above severity.
iv) Compliance with Health and Safety monthly audits.
v) Compliance with Non Clinical MAST training.
vi) Matters for escalation to the Organisational Risk Committee.

2.3 Health and Safety policies;

The Health, Safety and Fire Committee reviews and approves all policies relevant to Health and Safety within the workplace. The policies coming up for periodic review are detailed in the Health and Safety plan. The following Health and Safety related policies were reviewed during the 2014/15 financial year. The policies monitored through the committee are written by either the Health and Safety Manager or associated members of the Health and Safety committee,

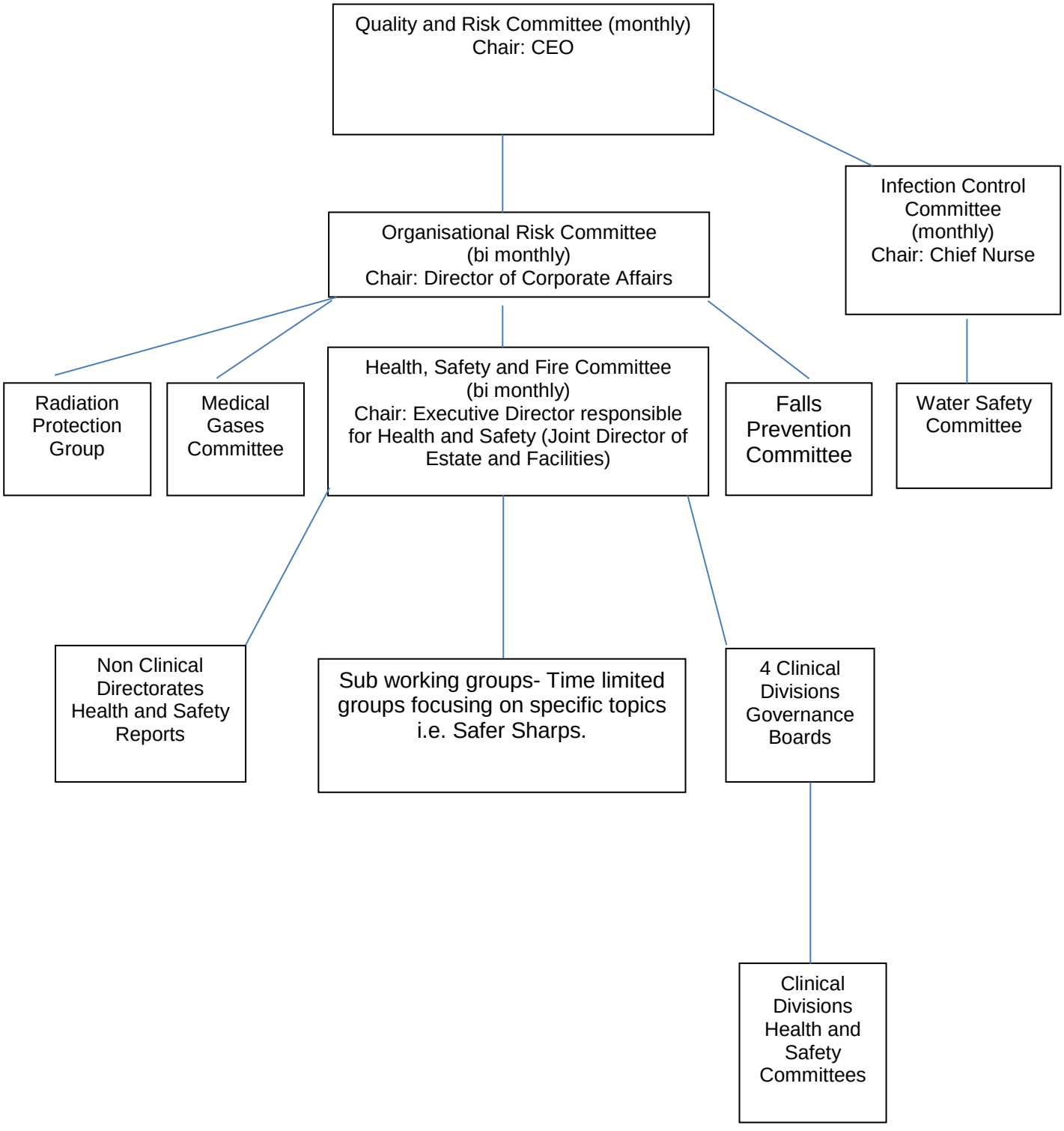
i) Health and Safety Policy
ii) Fire Safety Policy
iii) Working at Heights Policy
iv) Manual Handling Policy
v) Workplace Health, Safety and Welfare Policy
vi) Policy and Guidance on the use of Display Screen Equipment
vii) Water Safety Policy

The 2015/16 Health and Safety plan will include the review of the following policies;

i) COSHH Policy
ii) Non Ionising Radiation Policy
iii) Communicable Diseases Policy
iv) Medical Gas Policy
v) Violence and Aggression (The Management of Intimidation, Violence and Aggression Policy and Procedures)
vi) Latex and Occupational Dermatitis Policy iIncorporating Glove Selection.
vii) Lifting Operations and Lifting Equipment Policy
viii) Noise and Hand Arm Vibration Policy
ix) Provision and Use of Work Equipment Policy
x) Waste Management Policy.

3. GOVERNANCE

The Health and Safety Governance structure was reviewed as part of updated Health and Safety policy. The new governance structure is based HSG 65 and best practice across the Healthcare sector.



4.0 Health and Safety Training

Mandatory Health and Safety training is covered by an EMAST learning module on a 3 yearly basis. The compliance rates for the staff completion of this module are given below.

In addition to the E-MAST learning module The Health and Safety department has run 5 IOSH managing safely courses and also runs a module on the Band 6 development course.

In the 2015/6 financial year the Health and Safety department will be working with the Training and Development department to split the E training module into a basic module aimed at staff in bands 1-3 and a module for bands 4 and above which will focus on the Managerial responsibilities under the Trust Health and Safety policy.

Directorate	Compliance level
Capitol Division	80%
Children and Women's, Diagnostics and Therapies Services Division	90%
Community Services Davison	91%
Corporate Directories Division	87%
Estates and Facilities Division	73%
Medicine and Cardiovascular Division	81%
Research and Development Division	100%
Surgery and Neurosciences Division	85%
SWL Pathology Division	93%
Total	87%

* Note figures taken from Aris on April 14th 2015

5.0 Health and Safety Team Staffing Levels

The current Health and Safety department consists of the Health and Safety Manager, a Deputy Health and Safety Manager and an administrator. The department has developed strong links to the University Health and Safety department to ensure that both organisations benefit from an improved skills mix.

6.0 Health and Safety Calendar audits.

The Health and Safety department reviewed the format of the monthly audits at the beginning of the 2014/5 financial year. The audits were transferred on to the RaTE system and reduced to a maximum of 10 questions. The checklists are open over the relevant month and are completed by the local Health and Safety representative or Ward/ department manager.

A summary of the checklists completed across the organisation between April and December is given below.

April - Fire Safety Management	Number of services completion:	103
	Average checklist compliance:	85.07%
Checklist Themes	1) There are a number of areas which do not possess a sufficient number of trained fire wardens/ where staff have not completed the mandatory annual training. 2) A number of areas in the Community Services division do not possess Fire folders.	

Key Action Points	1) The Divisions should consider adding this to the Divisional risk register to ensure it is managed through the divisional structure. 2) Fire Folders are now issued by Essentia (Trust Community Fire provider)

May - Stress Management & First-Aid	Number of services completion:	104
	Average checklist compliance:	92.29%
Checklist Themes	1) There is some confusion on how to order/ restock first aid boxes.	
Key Action Points	1) These are available through NHS supply chain. A guide with the available options and procedure is posted on the Health & Safety checklists feedback web page Messages from RaTE	

June - Slips, Trips and Falls	Number of services completion:	118
	Average checklist compliance:	91.09%
Checklist Themes	1) A number of areas only reported that not all staff have received training in fall prevention	
Key Action Points	1) A workplace slips & trips inspection guide has been posted on the Health & Safety checklists feedback web page Messages from RaTE	

July - Adverse Incident Reporting & RIDDOR	Number of services completion:	106
	Average checklist compliance:	82.19%
Checklist Themes	1) The large number of staff responsible for carrying out incident investigations have not received training. 2) Staff , in general feel that they do not receive feedback from their non-clinical incident reports.	
Key Action Points	1) A supporting guide on adverse incident investigation & RIDDOR criteria has been posted on the Health & Safety checklists feedback web page Messages from RaTE 2) Incident investigation to be made part of the Band 4 and above EMAST training package to be developed for 2015/16	

August - Workplace Health, Safety & Welfare	Number of services completion:	106
	Average checklist compliance:	88.61%
Checklist Themes	1) A large number of areas report temperatures which they consider to be unreasonable during summer months. 2) Areas are generally aware of the Heat wave plan/ cold weather plan but do not always implement the recommendations.	
Key Action Points	1) Areas where there is a significant patient risk have now been added to the divisional risk registers and escalated to the ORC 2) Guidance documents on Workplace Welfare – Summer Plan and	

	Winter Plan have been posted on the Health & Safety checklists feedback web page Messages from RaTE

September - Personal Protective Equipment (PPE) & Dermatitis	Number of services completion:	113
	Average checklist compliance:	79.30%
Checklist Themes	1) A number of areas have reported using latex gloves. 2) Over 50% of areas report that they have no alternative products to use if the main soap is suspected to cause dermatitis in a member of staff	
Key Action Points	1 & 2) H&S department contacted spot checks which confirmed the entries were erroneous and liaised with Occupational Health Department, Infection Control and Procurement and produced a guide document on Work-Related Contact Dermatitis And Contact Urticaria, including details on alternative products ordering. The guide is available on the Health & Safety checklists feedback web page Messages from RaTE	

October – Manual Handling	Number of services completion:	89
	Average checklist compliance:	87.09%
Checklist Themes	1) The majority of the areas completing the checklists stated that suitable and sufficient risk assessments are completed the majority or all of the time. 2) 15 of the areas reported that their hoists had not been tested within 6 months as is a requirement of the LOLER regulations.	
Key Action Points	1) H&S department liaised with Manual Handling department and produced guidance documents on Manual Handling Risk Assessment & Manual Handling Equipment and Manual Handling Training & Manual Handling Back Care Facilitators which have been posted on the Health & Safety checklists feedback web page Messages from RaTE 2) The Medical Physics department provided an update on the plan for the servicing and testing of hoists to the Dec 2014 Health, Safety and Fire committee. This issue will be followed through the 2015/16 plan	

November – Security, Lone Working, Violence and Aggression	Number of services completion:	96
	Average checklist compliance:	84.94%
Checklist Themes	1) The checklist suggested that only 2/3 instances involving Violence and Aggression are reported on datix 2) A number of areas have not completed Lone worker risk assessments for staff involved in Lone working	

Key Action Points	1) A Violence and Aggression task force has been set up to look at all aspects of the management of Violence and Aggression. This will feed in to the 2015/16 plan. 2) Full lone working review to be carried out in the new HSF plan for 2015-6. Guidance on Assessing and Managing Lone Working Risk has been posted on the Health & Safety checklists feedback web page Messages from RaTE

December – Control of Substances Hazardous to Health	Number of services completion:	107
	Average checklist compliance:	71.59%
Checklist Themes	1) The majority of areas reported that they had no COSHH assessments, MSDS or chemical lists within their areas	
Key Action Points	1) COSHH project to be carried out as part of the HSF plan for 2015-16. Guidance on Material Safety Data Sheets and COSHH Assessment has been posted on the Health & Safety checklists feedback web page Messages from RaTE	

The audits provide the basis for the development of the 2015/16 Health and Safety action plan. They also provide evidence of proactive monitoring as required by the Health and Safety Executive.

The completion of the checklists is monitored by the Divisional Governance Managers and reported to the Health, Safety and Fire committee.

7.0 Non Clinical incident reports Key Performance Indicators including RIDDOR reportable incidents.

The Trust recognises that the accurate reporting of non-clinical adverse incident reporting is key to the maintenance of a good Health and Safety culture. Therefore the Trust uses the principle of Birds Triangle to set its Key Performance Indicators. This principle states that for every high severity incident an organisation will have a number of lower severity incidents or near misses. Therefore the key to demonstrating a good Health and Safety culture is, rather than reducing the number of incidents reported, to demonstrate a low percentage of higher severity incidents as opposed to near misses and low severity incidents.

The Trust sets the following KPI's for 2014/2015;

i) **To maintain a high level of total incident reporting while reducing the number of incidents rated as moderate or above severity to less than 4% of the total number of incidents reported.**

ii) **To encourage a high level of reporting in the following target categories;**
   - **a) Needle stick and splash and exposure to hazardous substances**
   - **b) Manual Handling incidents**
   - **c) Slip, trip and falls (Staff and Visitor)**
   - **d) Violence and Aggression towards staff**

While maintaining the number of moderate or above severity rated incidents to below 7%.

Year	Total Number of Non Clinical incidents	Total number of Moderate and above Severity incidents	**Target %**	**Actual %**	Incidents reportable under RIDDOR
2013/14	2680	67	**4**	2.5	48
2014/15	2697	71	**4**	2.63	49
	Total Number of Non Clinical incidents (Target areas)	Total number of Moderate and above Severity incidents (Target areas)	**Target %**	**Actual %**	
2013/14	733	40	**7**	5.45	39
2014/15	882	46	**7**	5.19	38

The table demonstrates that there has been little change in the total number of non-clinical incidents recorded. The total number of moderate incidents has increased slightly in both the target area and as a total, although not by an amount that can be deemed significant.

Target area comparison;

The table below shows a comparison with the number of incidents in the target area over the previous 2 years.

Category	Number of incidents 2013/4	No of moderate or above severity incidents	Number of incidents 2014/5	No of moderate or above severity incidents	Total +/-
Violence and Aggression towards staff	309	4	384	8	+75
Needle stick/ splash injuries/ Exposure to hazardous substances	249	7	284	9	+35
Staff falls	100	17	107	16	+7
Staff Moving and Handling	99	17	106	11	+7

There has been a very notable increase in incidents of Violence and Aggression towards staff, both in the number of incidents and the number of higher severity incidents over this period. This follows a national trend of an increase in the number of incidents of Violence and Aggression towards Healthcare workers.

This trend was noted during the course of the 2014/5 financial year leading to the setting up of a task force to examine the issue. This work stream is planned to continue during the 2015/16 financial year.

The increase in the number of exposure injuries has also increased over the period. This has included exposures to both chemical and biological agents.

The Trust Clinical procurement department has commenced a programme to replace traditional “sharps” with “safer sharps” which include safety devices to prevent contact with sharp implements used within the healthcare setting. This aims to reduce the number of injuries due to sharps.

The Trust Health and Safety department will be embarking on a major project relating to the management of COSHH with the aim of reducing the number of exposure incidents relating to both chemical and biological agents.

REPORT TO THE TRUST BOARD – JUNE 2015

Paper Title:	**Annual Fire Safety Report: 2014/15**
Sponsoring Director:	**Eric Munro, Joint Director of Estates & Facilities**
Author:	**Eric Munro, Joint Director of Estates & Facilities**
Purpose:	**For Information**
Action required by the board:	**For information**
Document previously considered by:	

Executive summary

1. Key messages

The Trust need to be able to demonstrate to LFEPA that a programme of Fire Protection and Prevention in regard to repair and maintenance is in place and properly supported and managed. The Q1 2015 inspection has now been completed with no new issues raised.

Between January 2014 and April 2015, the following investments and actions have been completed to improve Fire Safety within the Trust:

- **Update to previous 2010 Fire Safety Management Policy (H&S 6) - ratified by the Policy Approval Group in February 2015**
- **Detailed audit of all areas requiring Fire Risk Assessments (FRAs) and establishment of a detailed FRA database**
- **Detailed assessment of the risks associated with compliance with the Regulatory Reform (Fire Safety) Order 2005 (RRO) and escalation to the Board Assurance Framework**
- **Completion of a detailed Fire Risk Assessment Programme for all patient areas**
- **Introduction of a new design, more user-friendly, Fire Folder**
- **Appointment of new Deputy Head of Estates (Compliance & Fire) in January 2015 and two new permanent Fire Safety Advisers who started in April 2015 and increase to administration support.**
- **Following remedial works carried out by the Trust, LFB has now confirmed that the Grosvenor and Lanesborough Wing Enforcement Notices and the Knightsbridge Wing Deficiency Notice have now been lifted**
- **The Estates and Facilities Department completed a £1.3 million project in November 2014 for a full fire safety refurbishment of the 2nd floor plant room in Lanesborough Wing**

Continuous action is being taken to deliver fire safety, specifically against the plans agreed with the LFEPA enforcement officers. This will include:

- **Addressing compartmentation and fire doors in Lanesborough Wing, partly through our maintenance programmes and significantly through the Children's and Women's Hospital Capital Projects**
- **Bringing forward proposals to refurbish Grosvenor Wing as part of the Development Control Plan**
- **Reinvigorating the Fire Training function and establishing a dedicated training area by the end of 2015**

2. Recommendation

The Board is asked to note the update to the Annual Fire Safety Report and the progress made during the period.

Key risks identified:

BAF risk item

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

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

Appendix A:

St George's Healthcare NHS Trust

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

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

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
Fire Safety	Estates	EFM	No	18 Nov 2014

1.1 Who is responsible for this service / function / policy?
Director of Estates and Facilities

1.2 Describe the purpose of the service / function / policy?
Fire Safety for all patients, staff and visitors

1.3 Are there any associated objectives?
Not applicable

1.4 What factors contribute or detract from achieving intended outcomes?
Not applicable

1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability (physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Region or belief and Human Rights
No

1.6 If yes, please describe current or planned activities to address the impact.
Not applicable

1.7 Is there any scope for new measures which would promote equality?
No

1.8 What are your monitoring arrangements for this policy/ service
Not applicable

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

2.0. Please give you reasons for this rating
Policy applies to all persons in Trust premises

ANNUAL FIRE SAFETY REPORT: 2014/15 - UPDATE

1. BACKGROUND

In the CEO's report to Trust Board on 30th October 2014, it was reported as follows:

"I have signed the Trust's Annual Statement for the period 1 January 2013 to 31 March 2014. This is a compliance requirement under NHS Firecode. Whilst the statement is not able to confirm that all premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, it does record that a detailed programme is underway to ensure full compliance by the end of 2014/15. This is consistent with the audit report into fire safety for the same period.

The 2013/14 Annual Statement also records that two enforcement notices were received in relation to Lanesborough Wing and Grosvenor Wing on 11th February 2013. In response to these notices, a comprehensive Fire Safety Action and Investment Plan has been developed by the Trust and significant long-term works instigated in many areas of fire safety, fire risk assessments, compartmentation, fire door installation and replacement, fire safety training and fire safety procedures.

Major fire safety works have been completed to Knightsbridge Wing and Lanesborough Wing in particular and an additional Fire Safety Adviser has been recruited. A major programme for the replacement of fire doors is currently out to tender and is expected to commence in December 2014.

Whilst it was intended to bring a detailed fire safety update to the Board in September, incorporating the latest survey and inspection information from LFEPA, some of the London Fire Brigade inspections have been delayed until early November and so a detailed report, describing progress against the Fire Safety Action and Investment Plan, will be provided to Trust Board in November.

In the meantime, however, I am pleased to report that LFEPA has confirmed clearance of the deficiency notice received by the Trust on 19 June 2014 as a result of the Trust completing fire safety improvements in Knightsbridge Wing."

2. PURPOSE OF THE REPORT

The Regulatory Reform (Fire Safety) Order, that came into force on 1st October 2006, requires 'general fire precautions' to be put in place 'where necessary and to the extent that is reasonable and practical' for the protection of the 'relevant persons'.

Responsibility for complying with the Fire Safety Order rests with the responsible person. Broadly, in a workplace this would be the employer or any person who has control of any part of the premises (for example the occupier or owner). Where there is more than one responsible person such as in multi-occupied premises, all must take reasonable steps to co-operate and coordinate with each other.

The Chief Executive Officer is responsible for ensuring that, through appropriate delegation of responsibility within the organisation, current fire legislation is met and that, where appropriate, Firecode guidance is implemented in all premises owned or occupied by the Trust.

The Director of Estates and Facilities is the Executive Director with delegated responsibility for fire safety issues across the organisation and the delivery of a safe responsive system.

This report has been developed to provide the Trust Board of Directors accountable for the activities of the organisation with relevant information concerning the management and delivery of fire safety to the Trust during 2014/15, and a brief forecast into the year ahead, as in accordance with Healthcare Technical Manual 05-01: Managing Healthcare Fire Safety.

The outcome of this report will be used as the basis on which to formulate the Annual Statement of Fire Safety for 2014/15, which is to be retained by the organisation and may be presented to the CQC along with supporting documentation as evidence of performance against Outcome 10 of the "Essential standards of quality and safety".

Good management of fire safety is essential to ensure that fires are unlikely to occur; that if they do occur they are likely to be controlled or contained quickly, effectively and safely; or that, if a fire does occur and grow, everyone in the premises can escape to a place of total safety easily and quickly. The following summary gives brief details of this Trusts development towards compliance with the mandatory requirements for the NHS in England (considered as best practice for NHS Foundation Trusts).

REQUIREMENT	PROGRESS	R	A	G
Clearly defined fire policy	Compliant			
Board Level Director accountable to the Chief Executive for fire safety	Compliant			
Fire Safety Manager to take the lead on all fire safety activities	Compliant			

Have an effective fire safety management strategy which enables:

REQUIREMENT	PROGRESS	R	A	G
Preparation and upkeep of the organisation's fire safety policy	Compliant			
Adequate means for quickly detecting and raising the alarm in case of fire	Compliant			
Means for ensuring emergency evacuation procedures are suitable and sufficient for all areas, without reliance on external services	Compliant			
Staff to receive fire safety training appropriate to the level of risk and duties they may be required to perform	Levels of participation need to be increased to achieve compliance			
Reporting of fires and unwanted fire signals	Compliant			
Partnership initiatives with other bodies and agencies involved in the provision of fire safety.	Compliant			

3. TRUST FIRE POLICY AND FIRE SAFETY ACTION PLAN

The Trust's previous Fire Safety Management Policy (H&S 6) was approved by the Organisational Risk Committee on 24th November 2010. An updated version was ratified by the Policy Approval Group in February 2015.

4. GOVERNANCE - HEALTH, SAFETY AND FIRE COMMITTEE

The Health, Safety and Fire Committee reports to the Organisational Risk Committee, which in turn reports to the Quality and Risk Committee, a formal Trust Board sub-committee.

The Health, Safety and Fire Committee has continued to meet every two months and the Trust's Deputy Head of Estates (Compliance & Fire) presents an update report at each meeting as a standing agenda item.

5. RISK MANAGEMENT

5.1 Risk Registers

The ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO) is on the Estates and Facilities Departmental Risk Register as set out below. This risk is escalated such that it also appears on the Board Assurance Framework.

Ref.	Risk	Source of Risk	Rating	Summary Action Plan	Progress Against Action Plan
EF198	Ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)	Risk of prosecution	4 x 4 = 16	Detailed fire action plan in place with additional fire officer support to deliver the risk assessments. Regular meetings with fire brigade to check progress. Specialist fire safety resource in place to lead on the actions. Planned and reactive monitoring of fire safety.	On-going monitoring and actions via the Organisational Risk Committee.

The Estates and Facilities Department have prepared and are using action plans to make progress in addressing the issues highlighted by LFEPA in the two Enforcement Notices received by the Trust - these documents are shared with the inspectors from LFB and these Enforcement Notices have now been lifted. The most recent inspection was in March 2015.

Whilst the Trust will be able to show significant progress in relation to matters such as fire risk assessments, fire safety training and fire alarm maintenance, other issues such as compartmentation and systems upgrading will require continuing investment of time and capital funding.

5.2 Fire Risk Assessments and Fire Safety Manuals

During 2014/15, a detailed audit of all areas requiring Fire Risk Assessments (FRAs) was completed and a database established to record:

- each area requiring to be assessed
- the date of the last FRA and who it was assessed by
- the Responsible Manager for the area
- the date that the FRA was issued to the Responsible Manager for action
- re-inspection frequency (these vary depending on the nature of usage
- next re-inspection date
- last “no notice” inspection

The total number of areas requiring FRAs is 164 and progress as at the end of March 2015 is set out in Table 1 below. It should be noted that the FRA database also records those areas that are occupied by patients 24 hours per day and less than 12 hours per day. These areas have been a priority for FRAs in the 2014/15 programme.

Table 1: Progress on completion of Fire Risk Assessments (FRAs)

Building	No of FRAs required	No of FRAs Complete	Comment
Atkinson Morley Wing	15	11	FM areas still to be completed
Bence Jones	1	1	
Bronte House and Annex	2	2	
Chest and Breast Clinic	2	2	
Clare House	1	1	
Courtyard Clinic	1	1	
Education Centre	1	1	
Energy Centre	3	2	Switch room to be completed
Grosvenor Wing	19	18	Security Office still to be completed
Knightsbridge Wing	22	22	
Lanesborough Wing	45	44	FM area still to be completed
Max-Facs	7	7	
Occupational Therapy	2	2	
Phoenix Centre	1	1	
Robert Lowe Sports Centre	1	1	
Rose Centre	5	5	
St James Wing	36	36	
Totals	**164**	**157**	

Accordingly, the 2014/15 FRA programme consisting of 164 assessments has been substantially completed using a prioritised methodology. Fire Risk Assessment documentation is a component of the newly developed 'Departmental Fire Safety Manual' (Red Folder) which continues to be distributed to all departments Trust wide. As part of the delivery procedure managers are provided with familiarisation training. This provides managers with an opportunity to ask any relevant questions and confirm understanding of how the manual is expected to be used.

5.3 Fire Safety Action Plans and Documentation

The previously approved Fire Safety Action Plan has been updated and re-presented to the Executive Committee.

During recent checks, some departmental Fire Folders have been found to be incomplete. In addition to the scheduled Fire Risk Assessments, which include Fire Folder checks, the Fire Safety Team has introduced informal, no-notice, fire safety checks which will focus on the completion of Fire Folder information. A new, more user-friendly, Fire Folder has been designed. This Folder also contains more pertinent information and advice and is being rolled-out across the Trust via staff attending Fire Warden training and personal departmental visits by the Fire Safety Team.

5.4 Fire Safety Training

Face to face Fire Safety training is on-going for the weekly Trust Induction course. The 30 minutes now allowed for each of the Corporate and Medical Induction sessions is still less than the 45 minutes minimum required to include all aspects of the recommended syllabus. However, the Director of Estates & Facilities has recently instructed that one hour should be included on all Induction Training programmes for Fire Safety.

The previously tried Walk-Up/Drop-In Refresher and Fire Warden training sessions had a mixed reception. Few staff took advantage of the basic Refresher session although a few more attended the Fire Warden refresher training. However the new Fire Advisors will review whether the Walk-Up/Drop-In training will be re-introduced.

In order to reduce the loss of time from primary duties, Fire Warden training (which requires annual attendance) has been developed into a 3-year cycle. Year 1 training is the full (approx. 2 hour) training session; Years 2 & 3 will require an approximately 30 – 45 minute session of 'refresher' training. In years 4, 7, 10 etc. full training will be required to begin another 3-year cycle.

The availability of a permanent location for Fire Safety Training would provide huge benefits, convenience and encouragement for the training. Such a requirement is being examined with the preparation of the Development Control Plan for the redevelopment of the St George's campus.

The number of staff coming forward to be trained as Fire Wardens remains a cause for concern. The estimated requirement for Fire Wardens is approximately 850 staff (i.e. a minimum of 8 staff per 24-hour patient area and a minimum of 3 staff per non-patient areas). The number of Fire Wardens trained and in-date (annual training required) is currently around 250.

All Fire Safety training details/booking instructions are published on the Trust Intranet and e-mailed to Directors, Matrons, Heads of Departments and departmental managers at 6-monthly intervals – see Appendix 2.

5.5 Fire Safety Team Staffing Levels

The current estates fire team consists of 1 x Deputy Head of Estates (Compliance & Fire), 2 x Fire Advisors, 1 x Fire Advisor (Bank) and administration support.

The Deputy Head of Estates (Compliance & Fire) commenced with the Trust on 12th January 2015 and the Fire Advisors both commenced with the Trust on 20th April 2015, the team are building their site knowledge and reviewing existing processes and practices, including increasing the fire refresher, warden and evacuation training levels.

6. UNWANTED FIRE SIGNALS (UWFS)

False fire alarms are unwanted, an interruption to business continuity, costly and can compromise patient care. The Trust has initiated 100 unwanted fire signals since 1 April 2014 (figures up to and including the end of October 2014), an increase of 8 from the same period last year. This still exceeds the maximum number of UWFS considered tolerable (related to acceptable levels of unwanted fire signals and in accordance with HTM 05-03: Part H Reducing Unwanted Fire Signals in Healthcare Premises) for acute hospital premises of this magnitude.

To date, the Trust has received invoices from the London Fire and Emergency Planning Authority, in excess of the original *annual* budget for London Fire Brigade attendances as a result of Unwanted Fire Signals. The importance of the reduction of UWFS has now been formally included into all Fire Safety training from June 2014 have shown a significant reduction, but this needs to become a lasting trend.

From the data acquired a robust strategy needs to be put in place to raise awareness of the consequences of unnecessary fire alarm activations and our statutory duty to reduce them.

This strategy will include:

- targeted FRAs in areas with a high number of activations
- replacement of unsuitable equipment
- additional Fire Safety Training
- attending meetings with responsible persons for key "hot spots"
- Fire Safety information bulletins
- Posters and other awareness material

Healthcare Technical Memorandum 05 - 03 Part H Reducing unwanted fire signals in healthcare premises recommends a minimum reduction of **10%** activations during the next 12 month period.

In addition to the above, on 31st March 2015, the Trust implemented a call delay to the London Fire Brigade between the hours of 08:00 and 20:00 Monday to Friday. The delay allows a **MAXIMUM** time of 8 minutes between the fire alarm activation and switchboard calling the fire brigade to allow on-site staff to determine if the activation is a false alarm or an actual fire event. If the activation is a false alarm switchboard are informed **NOT** to call the fire brigade, if the activation is an actual fire event (or 8 minutes have elapsed) the fire brigade are called by switchboard.

The reductions in calls to LFB are being monitored over a 3 month period to assess the effectiveness of the above actions and will be reported on the next Fire report.

7. FIRE INCIDENTS

There have been no actual fire incidents in the Trust since 1 April 2014.

8. LFEPA INSPECTIONS AND ENFORCEMENT NOTICES

Following a series of fire safety inspections by LFB and a fire incident on 2 January 2013, LFEPA took the decision to serve the Trust with two Enforcement Notices on 11th February 2013. One related to Grosvenor Wing and the other related to Lanesborough Wing.

The two enforcement notices for Lanesborough Wing and Grosvenor Wing have been rescinded by the LFB as the Trust has made progress in addressing the issues and produced improvements. Following a small electrical fire in one of the boiler rooms of Knightsbridge Wing on 12th February 2014, the Trust received a Deficiency Notice on 19th June 2014.

Whilst the notice is not building specific (and therefore could be interpreted as a site-wide notice), the Trust has received email confirmation from LFB that the notice relates to Knightsbridge Wing only.

Following remedial works carried out by the Trust, LFB has now confirmed that the Knightsbridge Wing Deficiency Notice has been lifted.

The LFEPA inspector visited the Trust on 16th September 2014 in order to follow-up on the Deficiency Notice on Knightsbridge Wing and also to inspect a significant number of smaller buildings which had not been audited previously. Although satisfied that appropriate work had been planned and begun in Knightsbridge Wing, he noted that the standard of housekeeping in the other areas needed to improve, as this increases the risk of non-compliance with fire safety regulations. The buildings inspected included:

- Blackshaw Annex
- Old Chest & Breast Clinics
- Occupational Health 1
- Education Centre
- Robert Lowe Sports Centre
- Bence Jones
- Phoenix Centre

Since the inspection, a range of initiatives have been undertaken by the Trust to reinforce the importance of good housekeeping on fire safety. These include:

- securing unused areas
- works to compartmentalise IT servers
- promotion of “dump the junk” waste collections
- “no notice” fire safety inspections

Such efforts will need to be maintained to ensure that housekeeping practices continue to improve.

Further information on the legislative framework is contained in Appendix 2.

Due to progress made, LFEPA has now confirmed that the Grosvenor and Lanesborough Wing Enforcement Notices have now been lifted.

9. FIRE SAFETY IMPROVEMENT WORKS

9.1 Fire Compartmentation

Following completion of all FRAs for Lanesborough Wing, the Estates team drew up an improvement scheme for Lanesborough wing 2nd floor (Plant Room) as this was highlighted as a significant risk within the fire audit regarding compartmentation, fire doors and alarms.

The Estates and Facilities Department procured a £1.3 million project in March 2014 to complete a full refurbishment of the 2nd floor plant room which included the following works:

- full fire compartmentation and fire stopping repairs
- replace all fire doors with correct fire rated doors
- install new fire alarm in unprotected areas
- install new low level emergency lighting (lite4life)
- paint plant room walls
- paint and seal plant room floor
- apply photo luminescent way-finding system to floors
- install fire directional signage
- install intumescent grills
- install new partitions

The Lanesborough Wing 2nd Floor Plant Rooms fire compartmentation, fire stopping, fire doors and escape routes work has now been completed. A specification for Stage 2 (Grosvenor and St James Wings Plant Rooms) has been developed and will be tendered in the next few months.

9.2 Fire Doors /Shutters & Dampers

A full, site-wide survey of fire doors and shutters was started during March 2014; the survey is on-going and results indicate that many fire door sets are in need of repair, refurbishment or replacement.

In addition a survey of all fire dampers is currently underway and the results from this survey will enable estates to develop a planned package of works of repairs/replacements and on-going preventative maintenance.

9.3 Fire Protection Systems

The required ‘L1’ fire protection system is installed into Clare House and as part of the Lanesborough Wing Plant Room project on the second floor. In addition, there is a current project in operation, which started in April 2015, to replace the existing fire alarm system in Lanesborough Wing with a new system to L1 standards, which is estimated to take upto one year to complete.

Trinity Fire & Security Systems have had a permanent presence on site performing continuous maintenance to the existing systems.

The weekly testing of the fire alarm systems around the site are undertaken by Estates staff.

10. CONCLUSION

Whilst the Trust has made and continues to make, significant investment and progress in the improvement of Fire Safety during 2014/15 and into 2015/16, there are still significant programmes of physical works, training development and risk management required to ensure that the momentum is maintained in future years.

APPENDIX 1 – PUBLICITY FOR FIRE SAFETY TRAINING

There is a critical need, identified during previous London Fire & Emergency Planning Authority (LFEPA) inspections of the Trust, to achieve the level of Fire Safety Training which is commensurate with the requirements of the Regulatory Reform (Fire Safety) Order 2005, the provisions of Hospital Technical Memorandum (HTM) 05-01 and the Trust's Fire Safety Management Policy.

The details of all available Fire Safety Training may be accessed via the 'Fire Safety, Training & Response' link at the bottom right of the Trust Intranet Home Page. The training dates and venues are currently under review by the Fire safety Team.

Below is the previous extract of this information and included the scheduled dates/times for Fire Warden training up to March 2015:

FIRE SAFETY TRAINING

Statutory Fire Safety training for the remainder of 2015 may be arranged as shown below. Departmental Managers should nominate staff to attend the training by arrangement with the Trust Fire Safety Team [***fire.officer@stgeorges.nhs.uk*** or ***ext. 0656***].

FIRE WARDEN TRAINING

All Departments/Wards must have sufficient ***trained and 'in date'*** (annual training – see below) Fire Wardens so that at least one Fire Warden is on duty during all opening/working hours. For 24-hour patient areas, a *minimum* of 8 trained and current Fire Wardens is recommended in order to take account of shift patterns, annual leave, training days and sickness etc.

In accordance with HTM 05-01 and the Trust's Fire Safety Management Policy, Fire Warden training is required annually. With immediate effect, Fire Warden training will be provided on a 3-year cycle such that full training for new *and* experienced Fire Wardens (approx. 2 hours) will be provided every 3 years (Year 1, 4, 7 etc.) and Fire Warden refresher training (approx. 45 minutes) will be provided for Years 2 and 3 of each cycle. Fire Wardens trained up to two years ago may join this cycle.

Formal Fire Warden training is scheduled throughout the year and published twice a year on this page. Sessions from April to December 2015, for both full and refresher training are to be confirmed.

Departmental +/or Ward/Unit Managers should submit the names of selected staff to the Trust Fire Safety Team [***fire.officer@stgeorges.nhs.uk*** or ***ext. 0656***].

FIRE SAFETY REFRESHER TRAINING

In accordance with HTM 05-01 and the Trust's Fire Safety Management Policy, staff who work predominantly in clinical areas +/or with patients ***must attend annual*** 'face-to-face' Fire Safety refresher training. Staff working in non-patient areas ***must*** attend 'face-to-face' Fire Safety refresher training once every two years. This training, with a member of the Fire Safety Team, will last 1 hour; e-learning may only ***supplement*** these requirements.

Fire Safety refresher training should be arranged by Departmental Managers, typically, for example, as part of mandatory training programmes *or* Team Days and in a suitable venue with projection. Arrangements should be made Trust Fire Safety Team [***fire.officer@stgeorges.nhs.uk*** or ***ext. 0656***].

Subject to available time, the training will include the theory of evacuation and the use of 'Ski-Sheets'.

FURTHER INFORMATION

Trust Fire Safety Team [***fire.officer@stgeorges.nhs.uk*** or ***ext. 0656***].

It is the responsibility of Departmental Heads (Fire Safety 'Responsible Managers') to ensure that face to face Refresher training is up to date (annual in Patient areas) and that, in all areas, there is at least one *trained* Fire Warden on duty at all times. As a guide, we consider, that in order to take account of rotas, professional training, annual leave and sickness etc., this requires approximately *8 trained Fire Warden staff* in most 24-hour clinical units and not less than 3 in predominantly day-time areas.

Fire Warden training is required to be repeated annually but a new 3-year cycle of full & refresher Fire Warden training, which will reduce the time required for training, is explained above.

APPENDIX 2 – STATUTORY COMPLIANCE FRAMEWORK FOR FIRE SAFETY

Until 1990, NHS premises fell under the scope of Crown Immunity, which meant that they did not need to comply with "the letter of the law" relating to fire safety. However, following the NHS and Community Care Act 1990, Crown Immunity was fully removed in April 1991. Some Crown Immunity had already been removed in 1987 when the NHS became bound by the terms of the Health and Safety at Work Act 1974.

From 1990, all NHS Trusts, their staff and their fire prevention advisers were required to ensure compliance with NHS Firecode, a suite of documents first published by NHS Estates and intended to provide a systematic approach to reduce the potential for fire in health service premises. NHS Firecode compliance now falls to the Department of Health and the documents still set standards for the layout, design, construction and fire safety management of hospitals and other healthcare premises.

Firecode is underpinned by a policy and principles document and includes a number of Health Technical Memoranda (HTMs) and Fire Practice Notices (FPNs) that consider policy, technical guidance and specialist aspects of fire precautions.

STATUTORY COMPLIANCE

In addition to Firecode, the principal statutory requirements that have a direct bearing on fire safety and must be observed by NHS Hospital Trusts at all times are:

- Building Regulations 2013 Approved Document B - Fire Safety
- Regulatory Reform (Fire Safety) Order 2005.
- Fire Safety and Safety at Places of Sport Act 1987.
- Health and Safety at Work Act, including the Management of Health and Safety at Work Regulations.
- NHS Housing in the Community: Housing Act 1985.
- Registration of Houses in Multiple Occupancy.
- Places of Work Regulation 1992 (as amended).

DUTIES AND RESPONSIBILITIES

Trust Board

The Trust Board has overall accountability for the activities of the organisation. The Board should ensure they have appropriate assurance that the requirements of current fire safety legislation are met and, where appropriate, that the objectives of Firecode are met.

Chief Executive

The Chief Executive has overall responsibility for the implementation of the Trust's Fire Safety Policy and of the guidance detailed in the Department of Health "Health Technical Memorandum 05-01: Managing Healthcare Fire Safety". The Chief Executive will appoint a Fire Safety Manager to assist in the implementation of this Policy. This Officer will be of sufficient seniority/rank to be able to carry out the duties required.

Board Level Director (Director of Estates and Facilities)

The Board Level Director is responsible for fire safety issues at Board level, including programmes of work relating to Fire Safety for consideration as part of the annual Business Plan.

Fire Safety Manager

The Trust's designated Fire Safety Manager, Neil Fogg, Deputy Head of Estates (Compliance & Fire), and his principal duties include:

- appoint Deputies on all Trust sites to ensure that a designated person is always available to take command of a fire emergency until the Fire Brigade arrives.
- ensure that all staff receive clear written instructions on the actions to be taken in the event of a fire.
- liaise with all organisations working on Trust premises to ensure that they are aware of the Trust Policy and Procedures.
- co-ordinate and direct actions of staff in a fire emergency i.e., to establish control points, provide contact with the Fire Brigade and to ensure the safe evacuation of patients, visitors and staff.
- liaise with the Fire Advisor for advice on developing a plan of action for dealing with a fire emergency.
- ensure that all staff with special responsibilities in a fire emergency situation are aware of the procedure to be followed and are clear as to their role and responsibilities.
- ensure that agreed programmes of investment in fire precautions are correctly accounted for in the Trust's annual Business Plan and prepare an Annual Fire Report for submission to the Trust Board.
- establish a multi-disciplinary fire precautions group that will review the fire policy and procedure annually.
- co-ordinate all fire precautions within the Trust and have a working knowledge of fire precautions and the fire alarm systems.
- consult with the Fire Advisors and Estates Management to ensure that fire alarm systems are maintained and tested in accordance with NHS Guidance (HTM 05-03 Part B) and British Standard 5839.
- arrange for periodic site fire safety audits.
- investigate and remedy abuse of fire equipment.
- co-ordinate with Managers and the Fire Advisors to ensure that all staff participates in an annual mandatory fire training programme and required fire drills and that training records are maintained.

Fire Advisors

The Trust has statutory and other responsibilities in respect of fire safety for all its premises. As a means of fulfilling its obligation, the Trust has appointed specialist Fire Advisors. These are responsible for advising management on technical fire matters, monitoring the state of fire precautions in the Trust's premises and for arranging sufficient training sessions for all staff.

The Fire Advisors are responsible to the Deputy Head of Estates (Compliance & Fire). The duties of the Fire Advisors are to :

- provide expert advice on the application and interpretation of fire legislation and fire safety guidance, including Firecode

- advise on the content of the organisation's fire safety policy
- assist with the development of the organisation's fire strategy
- help with the development of a suitable training programme, including delivery of the training
- liaise with enforcing authorities on technical issues
- liaise with managers and staff on fire safety issues
- liaise with the Authorising Engineer (Fire)

REGULATORY REFORM (FIRE SAFETY) ORDER 2005.

The Regulatory Reform (Fire Safety) Order (known Fire Safety Order) applies to England and Wales (Northern Ireland and Scotland will have their own laws). It covers 'general fire precautions' and other fire safety duties that are needed to protect 'Relevant Persons' in case of fire in and around 'most premises'. The Order requires fire precautions to be put in place 'where necessary' and to the extent that it is reasonable and practicable in the circumstances of the case. Responsibility for complying with the Fire Safety Order rests with the 'Responsible Person'.

The Fire Safety Order is a Fire Risk Assessment based approach where the responsible person(s) for the premises must decide how to address the risks identified, while meeting certain basic requirements.

By adopting a fire risk assessment approach, the responsible person(s) will need to look at how to prevent fire from occurring in the first place, by removing or reducing hazards and risks (ignition sources) and then look at the precautions to ensure that people are adequately protected, if a fire were still to occur.

The fire risk assessment must also take into consideration the effect a fire may have on anyone in or around your premises plus neighbouring property and will need to be kept under regular review. The building fire risk assessment concentrates on the following areas:

- Elimination or reduction of risks (ignition sources),
- Suitable means of detecting and raising the alarm in the event of a fire,
- Adequate emergency escape routes and exits,
- Adequate fire compartmentation (fire and smoke spread and the protection of escape routes),
- The appropriate type and sufficient quantities of fire extinguishers,
- Correct type and sufficient quantities of fire signs and notices,
- Provisions for the correct maintenance of installed fire equipment,
- Suitable provisions for the protection of Fire Brigade personnel,
- Ensure that occupants receive the appropriate instruction and training in: 'Actions to be taken in the event of fire' and fire evacuation drills etc,

The Fire Safety Order applies to virtually all non-domestic properties, including voluntary organisations and is subject to monitoring and enforcement by the Local Authority Fire Services (LAFS).

All previous fire legislations has been repealed or revoked, including the Fire Precautions Act 1971 (Fire Certificates are abolished), the Fire Precautions (Workplace) Regulations 1997, plus 100 other pieces of fire related legislation.

Responsible Person - *(The Responsible Person)*

In relation to a workplace, it is the employer and any other person who may have control of any part of the premises, e.g. the occupier or owner for whatever they have control of:

In all other premises, the person or people in control of the premises will be responsible, those premises not falling within paragraph (a):

(a) the person who has control of the premises (as occupier or otherwise) in connection with him carrying on by him of a trade, business or other undertaking (for profit or not); or

(b) the owner, where the person in control of the premises does not have control in connection with the carrying on by that person of a trade, business or other undertaking.

In summary, the 'Responsible Person' is:

- The Employer with control of a workplace

Failing that or in addition;

- Persons with overall management control of a building (or part of the building)
- Occupier of the premises, owner of the premises (i.e. empty building),
- Landlords (in multi-occupied buildings)

ACTION BY LONDON FIRE AND EMERGENCY PLANNING AUTHORITY (LFEPA)

The Trust's premises are inspected regularly by LFEPA, who run the London Fire Brigade (LFB). The number of inspection visits have been increased in recent years as the Trust failed to heed informal warnings about its failures to comply with the Regulatory Reform (Fire Safety) Order 2005.

Under this order, there are three types of formal notice that can be served on the Trust.

Alterations notice (Article 29)

An alterations notice requires the responsible person to notify LFB of any proposed changes which may increase the risk in the premises. They are issued where LFB considers that the premises constitute a serious risk or may constitute a risk if changes are made. An alterations notice does not mean that the responsible person has failed to comply with the Regulatory Reform (Fire Safety) Order 2005.

Enforcement notice (Article 30)

An enforcement notice is issued where the responsible person has failed to comply with the Regulatory Reform (Fire Safety) Order 2005 and details corrective measures that they are legally obliged to complete within a set timescale, to comply with the law.

Prohibition notice (Article 31)

A prohibition notice is issued where the use of the premises may constitute and imminent risk of death or serious injury to the persons using them. This may be a restriction of use, for example imposing a maximum number of persons allowed in the premises, or a prohibition of a specific use of all or part of the premises, for example prohibiting the use of specific floors or rooms for sleeping accommodation.

The issue of a Prohibition Notice under the Regulatory Reform (Fire Safety) Order 2005 is the most serious enforcement option available to the LFB other than prosecution and can only be authorised by identified senior officers.

Deficiency Notice

In addition to these formal notices, LFEPA can issue a Notification of Fire Safety Deficiencies (often abbreviated as “Deficiency Notice”). A Deficiency Notice carries no statutory force but “may result in formal action being undertaken if the agreed improvements do not take place” – this is effectively an informal warning from the fire safety inspectors at LFB.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD - June 2015

Paper Title:	Board governance statements
Sponsoring Director:	Peter Jenkinson, Director of Corporate Affairs
Author:	Peter Jenkinson, Director of Corporate Affairs
Purpose:	To provide a summary of assurances available to inform the board's judgement of compliance with governance statements For the board to assess whether it can confirm compliance with annual governance statements, for submission to Monitor.
Action required by the committee:	To agree the level of compliance with the governance statements outlined due to be submitted by 30th June.
Document previously considered by:	N/A

Key Messages

Monitor's Risk Assessment Framework (RAF) requires Foundation Trusts to submit a series of governance statements as part of the annual planning process. Monitor uses the information provided in these documents primarily to assess the risk that an NHS Foundation Trust may breach its licence in relation to finance and governance. Monitor will also assess the quality of the underlying planning processes.

NHS Foundation Trusts are required to make the following annual declarations to Monitor:

1 & 2 Systems for compliance with licence conditions – in accordance with General condition 6 of the NHS provider licence;

3 Availability of resources and accompanying statement – in accordance with Continuity of Services condition 7 of the NHS provider licence;

4 Corporate Governance Statement – in accordance with the Risk Assessment Framework;

5 Certification on AHSCs and governance – in accordance with Appendix E of the Risk Assessment Framework;

6 Certification on training of governors – in accordance with s151(5) of the Health and Social Care Act

For 2015/16 these statements are made in several submissions*:*
Declarations 1& 2 were approved by the board and submitted on 29th May 2015;
Declaration 3 has been submitted as part of the annual planning process – this was approved at the finance and performance committee on 13th May 2015 and submitted on the 14th May.
Declarations 4, 5 and 6 are required to be submitted by 30th June.

These statements replace the board statements that NHS foundation trusts were previously required to submit with their annual plans under the Compliance Framework. Where facts come to light that could call into question information in the corporate governance statement, or indicate that an NHS foundation trust may not have carried out planned actions, Monitor is likely to seek additional information from the NHS foundation trust to understand the underlying situation. Depending on the trust's response, Monitor may decide to investigate further to establish whether there is a material governance concern that merits further action.

This paper therefore sets out the statements required to be submitted by 30th June, along with assurance statements which should inform the board's opinion on its declaration as to whether it can confirm or not compliance with the respective statements. Where the board determines that it cannot confirm compliance with a specific statement, it should declare 'not confirmed' and provide commentary to explain the reason for the non-compliance.

The three statements and assurance statements are attached at Appendix A. The board is required to consider and certify whether or not it can confirm compliance with each statement.

Statement 4: The Board is satisfied that the Trust effectively implements systems and/or processes:
(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements.

Statement 5: The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:
(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) That the Board receives and takes into account accurate, comprehensive, timely

and up to date information on quality of care;
(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

Statement 6: The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

Based on the corporate governance arrangements already in place and the level of assurance that the board has received in this respect over the last 12-18 months, the recommendation is that the board can confirm compliance with each of these statements.

Going forward, the trust is currently developing a new assurance framework, in line with the approach outlined in the risk management strategy approved by the board. This framework will be based around Monitor's 'Well Led Framework' and include the various governance statements so that the board can receive regular assurance regarding its compliance with governance best practice and inform its annual certification.

Recommendation

Board members are invited to consider and certify each statement, informed by the summary of controls and assurances outlined in appendix A. If unable to do so, the board should agree what supporting commentary it wishes to submit.

Risks

If the board identifies a gap in compliance with the governance statements and therefore in the trust's corporate governance arrangements, then actions will need to be agreed to address that gap through the development of the trust's assurance framework.

No such gap has been identified in this assessment.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	All
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	All CQC Fundamental standards & regulations, but particularly the 'well led' domain.

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

If yes, please provide a summary of the key findings

Appendix A: Proposed evidence for self-certification

Self-certification statement	Assurance statement
Statement 4: The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	**Internal controls and assurance** • Corporate governance structure including board sub-committees providing assurance to the board on various aspects, each board sub-committee including NED membership and chair; • Each board sub-committee has clear terms of reference and administrative arrangements, and reviews its effectiveness annually through anonymous self-assessment surveys; • Each board sub-committee reports to the board after each meeting; • Each terms of reference and trust standing orders set out administrative standards for the board / respective committee; • Standard suite of performance reports to each board meeting, including finance, quality, operational performance, workforce. • Monthly review of significant risks by board and series of 'deep dive' reviews of risks through the quality and risk committee; • Quarterly review of progress against trust annual plan objectives presented to board; • Performance management framework in place, including quarterly performance reviews with divisions and escalation procedures when necessary, which enable executive team to hold divisions to account; • Financial recovery plan developed to address financial performance short-term and long-term and ensure going concern financially, including management actions to improve financial management and controls. **External assurance** • Quality Governance Assurance Framework self-assessment and validation by Deloitte 2013/14; • 'Good' overall rating in CQC's Chief Inspector of Hospitals assessment February 2014; • Historic due diligence reports as part of foundation trust application in 2014, including financial reporting procedures (governance). **Gaps in assurance / risks** • External audit opinion on financial statements – the trust is a going concern only on the basis of receiving financial

Self-certification statement	Assurance statement
	assistance, to be confirmed as part of Monitor investigation and APR review.
Statement 5: The Board is satisfied that the systems and/or processes referred to in statement 4 should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Internal controls and assurance** • Leadership for quality at board level through chief nurse and medical director; • Non-executive chair of quality and risk committee, and two medical staff on the board as non-executive directors; • Each clinical division chaired by a medical and senior management team including a divisional director of nursing and governance; • Central to the corporate strategy is a clinical strategy and a key supporting strategy is the quality improvement strategy; • The Board and the quality and risk committee receives a monthly quality performance report, containing comprehensive range of quality metrics and a ward-level heat map. The board also receives weekly report of any new serious incidents declared and monthly update on significant incidents; • Board members and other stakeholders (governors, patient reps) participate in quality inspections; • Council of Governors meetings, briefings and seminars include regular discussion regarding quality, workforce and finance; • Trust engagement with patient reps through Patient Reference Group, regular meetings with Healthwatch and attendance at HOSC meetings; • Staff engagement in quality through regular safety fora meetings, clinical management board, consultants' meetings, nursing board; • Accountability for quality is clear at each level of divisional structure, in job descriptions; • Divisions held to account for quality through quarterly divisional performance reviews and presentation of divisional quality improvement plans at quality and risk committee; • Comprehensive internal audit programme with annual plan of audits approved by board and including financial controls and systems, quality, planning and information. **External assurance** • Quality Governance Assurance Framework

Self-certification statement	Assurance statement
	self-assessment and validation by Deloitte 2013/14; • 'Good' overall rating in CQC's Chief Inspector of Hospitals assessment February 2014; • Clinical Quality Review Meetings with commissioners, CQC and Monitor; • Board to Board meeting with Wandsworth CCG; • Wandsworth Council OSC statement on the trust's quality account; • 'Reasonable' Internal audit opinions on 'safeguarding children, 'nurse, midwifery and care establishments' and 'medical locums'; • External audit opinion on trust quality account.
Statement 6: The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Internal controls and assurance** • Established nominations and remuneration committee which approves executive appointment and reviews executive appraisals; • Nominations and remuneration committee review of succession plan for directors; • Appraisal system in place for board and whole organisation. NED appraisals to be reviewed by the Council of Governors; • Workforce committee as sub-committee of the board, providing assurance regarding workforce planning; • Education board with non-executive director input; • Safe staffing reviews every six months for nursing staff and review completed for medical staff, reported to the quality and risk committee May 2015; • Leadership development framework in place guide development of leaders throughout the organisation; • Recruitment controls to check competency and qualification of staff; • Revalidation process for medical staff. **External assurance** • Board Governance Assurance Framework assessment completed in 2014 and validated by Deloitte as part of the trust's application for foundation trust status; • 'Good' rating in 'well led' domain of the CQC's Chief Inspector of Hospitals inspection, February 2014; • Monitor board to board assessment

Self-certification statement	Assurance statement
	September 2015.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – JUNE 2015

Paper Title:	Chief Executive's Report
Sponsoring Director:	Miles Scott, Chief Executive
Author:	Sofi Izbudak, Corporate Administrator
Purpose: *The purpose of bringing the report to the board*	To update the Board on key developments in the last period
Action required by the board:	For information
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	N/A

Executive summary

1. Key messages

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

- Quality & Safety
- Strategic developments
- Management arrangements

2. Recommendation

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

Key risks identified:

Are there any risks identified in the paper (impact on achieving corporate objectives) – e.g. quality, financial performance, compliance with legislation or regulatory requirements?

Risks are detailed in the report under each section.

Related Corporate Objective: *Reference to corporate objective that this*	All corporate objectives

paper refers to.	
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	N/A
Equality Impact Assessment (EIA): Has an EIA been carried out? Yes **If yes, please provide a summary of the key findings** No specific groups of patients or community will be affected by the initiatives detailed in the report. Where there may be an impact on patients then consultation will be managed as part of that specific programme. **If no, please explain your reasons for not undertaking an EIA.**	

1. Strategy

1.01 Appointment of the Chair for the National Clinical Reference Group for Medical Genetics

I'm delighted to announce that Frances Elmslie – a Consultant Clinical Geneticist who has in the past been Lead Clinician for Clinical Genetics and Clinical Director for Children and Women's at St George's – was appointed to the role of Chair for National CRG for Medical Genetics. Frances will work closely with commissioners in this role and will represent the trust and its strategic goals.

1.02 Appointment of the Managing Director of the Health Innovation Network

Tara Donnelly has been appointed as the next Managing Director of the Health Innovation Network. Tara is an experienced NHS director who has most recently been leading improvement work at University College London Hospitals NHS Foundation Trust. She is also a member of the Board of Macmillan Cancer Support and was formerly Chief Executive of West Middlesex University Hospital.

1.03 Clinical Services Contract with Gibraltar Health Authority

I am pleased to announce that on 5th June 2015 the trust signed a new clinical services contract with the Gibraltar Health Authority (GHA). The trust will supply the GHA with a variety of visiting consultant services, as well as inpatient access to our specialist services, particularly: neurology and neurosurgery; cardiology and cardiac surgery; endoscopy and our bowel cancer screening programme. We expect the GHA to send circa 400 referrals to St George's per year.

1.04 Immigration Enforcement Joint Initiative.

The trust will be working together with the Home Office from Tuesday 26th May 2015 till 21st August 2015. The objective of the joint work – which was developed in collaboration with the trust's Head of Finance and Overseas Visitor teams – is to increase and 'up-skill' administration staff in the identification of potentially chargeable patients.

Non-uniformed immigration officers will be on-site, offering support, advice and training on immigration matters for the duration of the initiative. This builds on a similar approach trialled at a London NHS Trust last year.

The initiative should deliver a number of benefits for the trust, including: earlier and increased identification of chargeable patients generating revenue; potential reductions in waiting times and expenditure on non-urgent and non-necessary treatments; and increased staff awareness and confidence in dealing with immigration matters.

1.05 Genomics Medicine Centre

Good progress is being made on establishing the Genomics Medicine Centre. I am delighted to announce that St George's is the first of the four sites to have gone live with the collection of samples for rare diseases. We collected our first DNA samples this month.

1.06 South West London Commissioning Collaborative

The Acute Provide Collaborative workstream has been updating the work done previously around system demand, capacity and affordability in the revised context of new models of care, particularly out of hospital provision, and the recently surfacing immediate system financial pressures. This work supported the first key workshop for this group on Monday 15th June where the chief executives of all acute providers in SW London considered its implications and agreed a number of workstreams to inform the next workshop in early July; this will lead to the production of a paper for the commissioning collaborative to consider in August. A "Vanguard" bid to develop new models of care across South West London is currently under preparation. Further detail will be available at the Board if required.

2. Academic Development

2.01 CLAHRC

Using the expertise of staff within the CLAHRC, we are pleased to announce approval for a newly established MSc in Implementation and Improvement Science. Staff from the Joint Faculty have worked closely with staff at King's College London to establish this course. The MSc will enable students to identify the best ways to integrate research findings into healthcare policy and practice, and the best strategies for evaluating improvement and implementation in healthcare in a given environment. The first cohort of students is due to start in September 2015.

2.02 Appointment of Director of Medical Education

The Trust has appointed Dr Jonathon Round as the new Director of Medical Education in succession to Dr Cleave Gass. Cleave will continue as Associate Medical Director with an educational remit covering undergraduate, postgraduate and commissioned speciality programmes across London.

2.03 Director of Education and Quality Health Education England: Visit to the SGH and SGUL

On 29th June Wendy Reid the Director of Education and Quality at HEE will be visiting the trust and the medical school.

2.04 Appointment of Principal of St George's University of London.

On 18th June interviews were held for the appointment of the new Principal of SGUL. The successful candidate will be announced in next month's report. I look forward to working alongside the new Principal, and continuing the relationship Professor Peter Kopelman helped build between the medical school and the trust.

3. Workforce

3.01 10 Project Search

The third cohort of 10 Project Search students will complete the scheme in July and this will culminate in an awards event. Each student on the scheme rotates through four different areas of the Trust, learning valuable skills in each placement. Such is the success of the project that many of the students are successful in obtaining full-time employment post scheme.

3.02 Staff development training

Staff on bands 1-4 who have successfully completed Institute of Leadership and Management (ILM) Level 2 in Team Leading, or the ILM Level 3 in First-line Management, or the AMSPAR certificate in Medical Terminology, or who have completed their Clinical Health Level 2 Qualification Certificate Framework will be congratulated in July by Peter Jenkinson, Director of Corporate Affairs, on their hard work and achievements.

3.03 GMC National Training Survey

The results following the GMC national training survey have been received by the Trust. Whilst it appears that workload is an issue in several specialities, there were several highly positive indicators across the trust and we compare very favourably with other large teaching hospitals in South London. The DME will be working with Divisions on the action plans provided by HESL.

3.04 Massive Open Online Course

The Massive Open Online Course (MOOC), from the HESL bid with SGUL for Clinical Genetic goes live on Monday 15th June. Reports from SGUL are that there are 3000+ signed up to undertake it on this first round.

3.05 Award Announcement – Oral Maxillo Facial Surgery Trainer of the Year

Congratulations to Miss Helen Witherow, Consultant in Oral Maxillo Facial Surgery (OMFS), who was voted OMFS trainer of the year in London (as voted for by the trainees), and has subsequently won the National Award.

3.06 Listening into Action

<u>Friends and Family staff survey</u>

Last year we ran the Friends and Family staff survey three times. On the whole, 81% of respondents said they would recommend the trust as a place for treatment and 59% said they would recommend the trust as a place to work. We are currently running the survey for the first of three times this year.

The survey also provides the opportunity for respondents to make free comment. Many of the comments made last year are consistent with those of the annual staff survey. Action to address the issues raised include a renewed emphasis in key areas such as staff ‘health and

wellbeing', tackling bullying and discrimination, improving opportunities for professional development and providing more progression opportunities for staff.

LIAiSE

The LIAiSE service is going from strength to strength having received 163 referrals in its first nine months, plus 71 interactions with staff in theatres. The post holder, Sarah Hemmings, is moving to another role in the trust and recruitment is underway to find her replacement in order to ensure that momentum is maintained and sustained

3.07 Queen's Birthday Honours List

I am delighted to share that Dr Davendra Sharma, Consultant Urologist, is on the honours list. He will receive an OBE for his contribution to the care of military patients with genito-urethral injuries, through the development of the Genital Trauma Programme for severely injured soldiers.

4. Monitor Investigation / Financial Recovery

4.01 Monitor Investigation

Monitor have informed the trust that they are in the process of compiling a proposal for the Provider Regulators Executive in July, which will confirm whether the trust is in material breach of the terms of the licence authorising Foundation Trust status. This proposal will also set out the parameters of what specifically will need to be addressed by the trust, and what action will thus need to be undertaken in order for the trust to improve its financial standing and performance. We are expecting to be sent through a formal timetable for the investigation process by the Monitor team.

Additionally, Monitor have decided to place St George's on monthly monitoring from M2 (May 2015). This requires us to fill in a high level financial template, as provided by Monitor, on a monthly basis.

Independent Accounting Review

PwC have been appointed to conduct an independent accounting review. They completed two weeks of preliminary work and submitted their feedback to Monitor on 17th June, and they are projected to submit a final report of their findings to Monitor in the week commencing 13th July.

Turnaround Support

After a competitive, formal procurement process, KPMG have been appointed to provide the trust with turnaround support for a period of up to 12 months (subject to formal approval of the contract by the Board). The KPMG team – along with our new Turnaround Director Andrew Burn – have been on site since 8th June.

KPMG's support will be in four areas:

- Grip - Establishing more stringent controls over pay and non pay expenditure, bringing best practice to cash flow forecasting/management

- Build - assessment of the CIP governance programme, maturity assessment of the CIP ratings, identification and development of new CIPS (in division and Trust wide schemes)
- Grow/Optimise – focus on Trust, complex restructuring opportunities that may or may not involve collaboration with third parties, corporate cost base review
- Systems – support a rapid reestablishment of finance governance in the short term on a prioritised basis

Briefings

Staff briefings are being held on site in St George's on 22nd and 23rd June. A briefing will also be held at Queen Mary's Hospital Roehampton on 24th June.

A Council of Governors briefing will be held on 30th June.

5. Communications

5.01 Queen Mary's Hospital Centenary Exhibition

The Queen Mary's Hospital Centenary Exhibition will be officially opened on Wednesday 24th June.

This new exhibition created by the Queen Mary's Hospital Museum and Archive Group features pictures, prostheses and personal histories that tell the story of some of the amazing patient stories and pioneering medical developments that have taken place throughout the hospital's 100 year history.

Speakers include Councillor Ravi Govindia, Leader of Wandsworth Council, Sam Gallop CBE, an ex-RAF pilot and double below-knee amputee who has become a committed ambassador on issues surrounding limb loss and Gordon Jones, chairman of the Queen Mary's Archive and Museum Group.

5.02 Annual Report and Accounts 2014/15

The trust has published its Annual Report and Accounts for 2014/15. As we achieved foundation trust status mid-year, we were required to prepare a report that met both the Department for Health and Monitor's statutory reporting requirements. This included providing two sets of financial accounts as an NHS trust and as a foundation trust.

To meet Monitor's reporting requirements we were required to include a Quality Report for our period as a foundation trust. This relates to the quality of services across the entire year, including the time when they were provided by St George's Healthcare NHS trust.

The Annual Report and Accounts for 2014/15 is a comprehensive review of our financial and quality performance throughout the year and reflects the progress we're making against our objectives and aims for the future. It is available on our website as well as in hard copy.

5.03 St George's receives Accreditation HIMSS Stage 6

St George's has been recognised and accredited for its hard work in implementing clinical informatics systems within the inpatient areas of the hospital. We are the first major teaching hospital in the UK to be accredited to HIMSS Stage 6 (stage 7 is the highest achievable) and the first UK trust to be validated through an onsite visit. The Healthcare Information and Management Systems Society (HIMSS) is an international organisation dedicated to improving healthcare quality, safety, cost-effectiveness and access, through the best use of IT.

5.04 Response to the 2014 staff survey

The communications team is supporting the HR and Workforce team on four 'themed' months in response to feedback from the national staff survey. The themed months are designed to improve staff retention rates. The health and wellbeing month is the first and throughout June staff were informed of the services/ initiatives /programmes in place to encourage and support a healthy workforce.

The four themed months are as follows:

1. Health and wellbeing - June
2. Education and development – July
3. Raising concerns and (safe staffing) - September
4. Bullying and harassment – October

5.05 Dietitians Week 08-12/06

The dietetic team used social media to celebrate dietitians week and share photos and details about their work.

During the week Radio Jackie aired an interview with the mother of a patient whose son has successfully been treated at the trust with a special diet which stopped him from experiencing over 100 seizures a day. This story has also been picked up by the Evening Standard and a national news agency.

Also, as part of dietitians week, the trust's principle dietitian, Catherine Collins represented the trust at the British Dietetic Association House of Lords reception. Catherine, who is the BDA England Chair, spoke about the need to raise awareness of the profession and highlight the vital role dietetians play in patient care. On 11/06 the trust and St George's, University of London, hosted a special Dietitians Week public debate with three trust dietitians discussing the pros and cons of sugar. Over 50 people attended and what was meant to be a 60 minute lecture ended up being a 120 minute debate

5.06 Anaesthesia Clinical Services Accreditation

During May/June the Communications team publicised the Anaesthesia Clinical Services Accreditation (ACSA) to staff to prepare them for the visit at the beginning of June. This included posters, tweets, and items on the intranet and in eG. A press release will be issued when the results are officially released. An ACSA pass will be a mark of excellence in anaesthesia. We would be the first trauma centre to achieve this and only the fifth trust in the country to achieve this accreditation.

5.07 Listening into Action

An event to hear what staff think about communications took place on Thursday 21st May. As a result, an action plan is being developed by the team which will be fed back to the attendees. Common themes included improving the intranet, better accessibility of communications for ward-based staff and personalisation of content.

5.08 Reflection and sharing common experiences - Schwartz Rounds

Over 250 staff have attended the first two Schwartz rounds at the trust. These provide staff with an opportunity to discuss the highs and lows of work in a confidential and expertly facilitated environment. Participants can talk about the emotional and social aspects of their jobs, led by a panel of employees chosen from across the trust.

5.09 Media update

To mark the start of a new series of ’24 Hours on A&E’ (Channel 4, 9pm, Wednesday), ED consultant Rhys Beynon appeared on the BBC Breakfast sofa to talk about being in the programme.

Celebrity chef and healthy food campaigner Jamie Oliver visited St George’s Hospital to interview a maxillofacial dental surgeon and to talk to some patients about sugar and dental health. The sugar documentary is due to be aired in June.

In addition to the above, interviews were given to BBC London, ITV, the Evening Standard and BBC Radio 4 about strokes in the under 60s; cardiac risk in the young; the need for more medical students to train as GPs; the anniversary of the helipad and the prescribing of an ovarian cancer drug.

5.10 Dates to note

- Annual General meeting - 9th July
- Council of Governors meeting - 9th July

REPORT TO THE TRUST BOARD Paper ref: TB June 15 – 02a

Paper Title:	Quality and performance Report to the Board for Month 2- May 2015
Sponsoring Director:	Jennie Hall- Chief Nurse/ Director Infection Prevention and Control Simon MacKenzie- Medical Director Steve Bolam- Director Finance/ Performance and Informatics/ Deputy CEO
Authors:	Jennie Hall- Chief Nurse/ DIPC Simon Mackenzie- Medical Director Matt Laundy- Infection Control Lead Corporate Nursing Team Divisional Directors Nursing/ Governance Trust Safeguarding Leads Steve Bolam- Director Finance/ Performance and Informatics/ Deputy CEO Head of Performance
Purpose:	To inform the Board about Quality and Operational Performance for Month 2.
Action required by the board:	To note the report and key areas of risk noted.
Document previously considered by:	Finance and Performance Committee Quality and Risk Committee

Executive summary

Performance

Performance is reported through a number of key performance indicators (KPIs) as per Monitor Risk Assessment Framework. The trust is performing positively against the majority of the indicators within the framework, however existing challenges continue in particular: ED 4 hour target, and RTT waiting time targets. The trust has also failed to meet the cancer two week wait targets in May.

The trust shows quality governance score against the Monitor risk assessment framework of 4 with a governance rating of 'under review'.

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

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

The Overall position in May indicates a steady position 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. This is monitored through the Patient Safety Committee and SIDM.

In relation to quality oversight/ assurance additional measures have been put in place. Weekly oversight of quality metrics has been commenced at Trust and Divisional level. In addition the Quality Inspection programme recommenced on the 1st June, and a Quality Standards group.

The Quality report format is being reviewed to ensure that the report supports clear identification of trends and issues and that there is ability to benchmark against national/ international peers

going forward.

Effectiveness Domain:

- Mortality and SHMI performance remains statistically better than expected for the Trust. Despite this position we continue to proactively investigate mortality signals at procedure and diagnosis level. There have been a number of cardiology signals which are currently being reviewed alongside a wider review of the mortality review processes within the service.
- In relation to locals audits of note the WHO checklist continues to indicate that there are services where the compliance with the audit is below acceptable standards. This is a mandatory safety checklist for all applicable areas in the Trust. Whilst the Majority of services are consistently performing Cardiothoracic services, ENT and Maxillofacial did not with Cardiothoracic the poorest performing for the year. Support is being provided for all services with recognition of services which have performed also being undertaken.
- The consent audit also indicates some progress from the previous audit but also consistent areas where progress is limited. The audit has been considered at PSC with focus on the areas of underperformance with actions being agreed to be taken forward.
- The report indicates the position with compliance with NICE guidance for the period January 2010 to January 2015. Detail is available of all areas where we have declared noncompliance, the reasons for this position and action being taken. Further assurance is being sought in relation to the risk profile; any findings of note will be reported back to the board.

Safety Domain:

- The number of general reported incidents in May indicates a similar profile to previous months with a similar trend in terms of numbers and level of harm. The Board should note that the trend for Serious Incidents indicates a gradual increase. Of those declared for May the Board will note the issues are across a range of clinical issues, some are mandatory in terms of reporting. A further never event has been reported this month, the patient presented in May with clinical symptoms but if confirmed the original incident will have occurred in 2009. A foreign body it is believed has been indicated on a CT scan and this is now being reviewed by the surgical team at the Trust. This incident has to be fully investigated and therefore no conclusions can be drawn at this stage. The Trust has concluded a panel review of previous incidents with recommendations for further work. Progress against the recommendations is being overseen by the Chief Nurse/ Medical Director.
- Safety Thermometer performance increased slightly from April performance. There was a slight increase in patients with old and new pressure ulcers. There was a decrease in other harms reported.
- The pressure ulcer profile for May increased from the April position in terms of grade 3 and 4 ulcers (4 up from 2 cases) with an increase in grade 2 ulcers. Of note progress within the community Division. As previously reported to the board a deep dive review has already been completed in January within both the Surgical and Community Divisions where a number of the Ulcers occurred and actions are being taken forward. The actions include training, use of safety approaches such as “hotspots” to raise awareness and roll out of preventative strategies. The RCA analysis has yet to be completed to understand if the ulcers were avoidable or unavoidable.
- The Trust has now reported 2 MRSA bacteraemia cases and 6 C-Difficile to the end of May. All cases are currently subject to an RCA process.
- Safeguarding Adults activity across Paediatrics and Adults remains significant. The Training profile for Safeguarding Children remains a risk given the activity profile, and number of SCR cases that the Trust is involved with across a number of boroughs. Focus is being placed on further action to improve training compliance particularly at level 3.

Experience Domain:

- Within the report there is some initial triangulation of experience data. This is presented as a summary for May 2015 with a themed summary for Quarter 4 in 14/15. Going forward this will be presented as Trend data alongside a RAG profile to indicate services

of concern and ensure timely response. There is further analysis to be undertaken regarding the themed review which will be brought back to the board once completed. FFT feedback will also be included in this analysis.

- The response rate for FFT increased but response rates for inpatient wards decreased. The overall score for the Trust decreased in May to a score of 91.5%. Themes arising from the FFT responses include noise at night, information about medication side effects and involvement in discharge processes. A more accessible version of the survey has been rolled out to paediatrics and also for users with learning disabilities and where English may not be a first language to improve the capture of feedback.
- The complaints profile is similar to April in terms of numbers. Offender Health is the highest area of complaints, these relate to medication provision; a reduction in complaints within the ED department should also be noted.
- Work has already commenced to review the corporate complaints function alongside review for individual Divisions to determine how turnaround time will be improved.

Well Led Domain:

- The safe staffing return is included for all inpatient areas. The average fill rate for the Trust is 95.50 % across these areas. This is against current staffing figures. This figure is being reviewed alongside other Trust information about run rates, the Trust information for staffing alerts (Red Flags) which has been implemented across the Trust, and Trust Bank information about the temporary staffing profile and fill rates.
- For information NHSE announced in June the suspension of further work regarding safe staffing as it is currently described. Focus will now include outcomes and productivity alongside the staffing numbers. Of note the current safe staffing NICE guidance which is already in practice will continue to be used. The Nursing workforce programme had already been reviewed to understand productivity metrics alongside the establishment review which is currently underway.

Ward Heat map:

The Heat map for May is included in the Report. The detail regarding the profile within the dashboard is included in the report Work continues to develop a trend analysis for the dashboards and Divisional summary dashboards. The community dashboard is contained within the Report. Work has been undertaken to identify areas where there are particular concerns in relation to workforce and Quality indicators.

Key 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

St George's University Hospitals NHS
NHS Foundation Trust

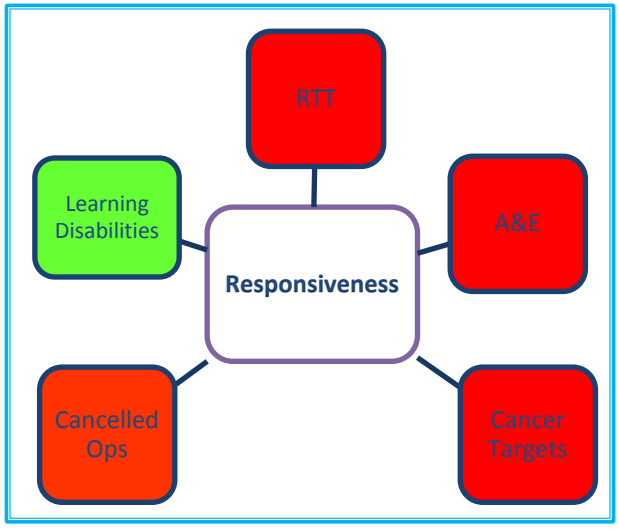
Performance & Quality Report

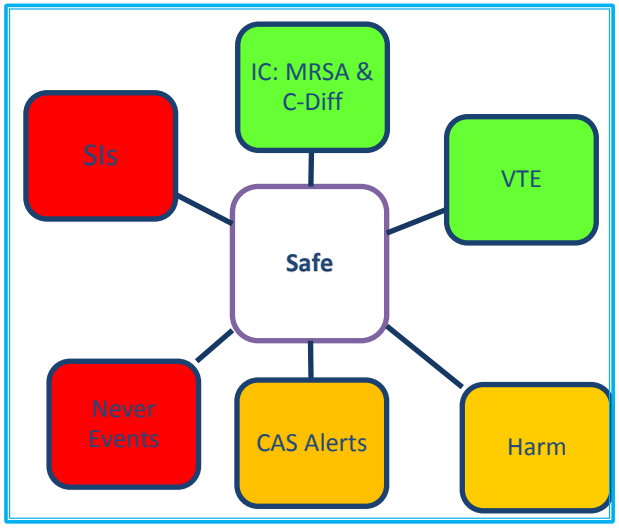
Trust Board
Month 2 – May 2015

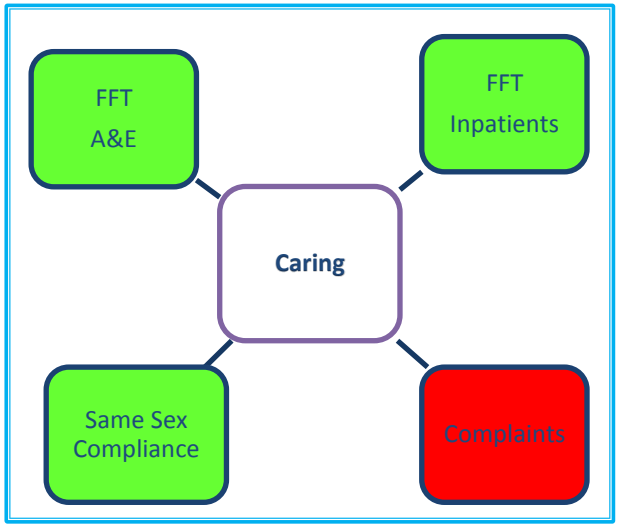
excellent kind responsible respectful

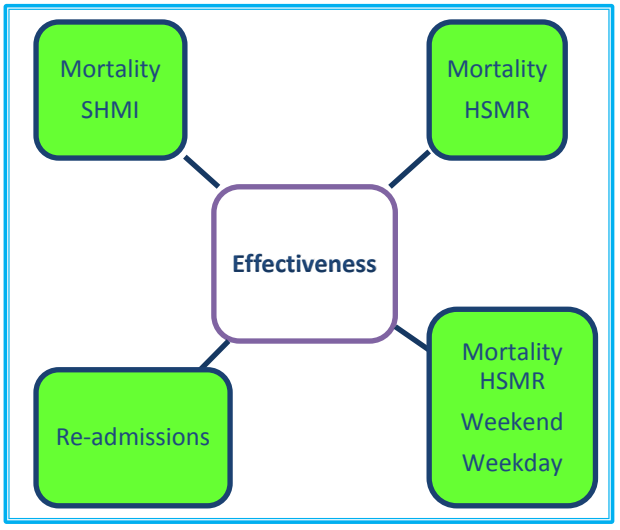
CONTENTS

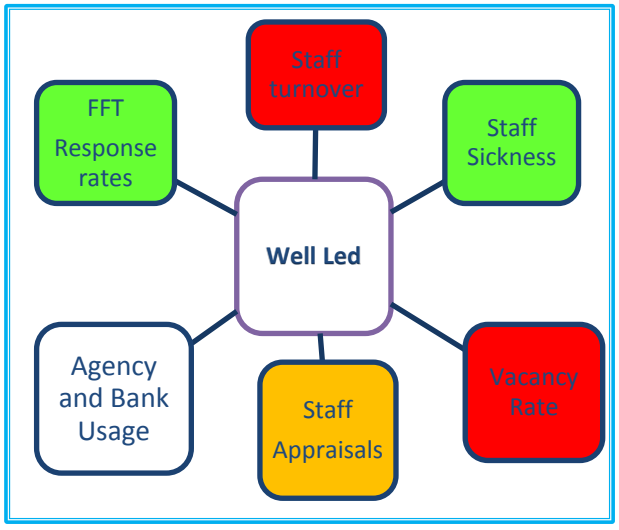
1. Executive Summary - Key Priority Areas May 2015











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

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

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

St George's University Hospitals NHS
NHS Foundation Trust

Performance against Frameworks

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

Access							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Apr**	**May**	**Movement**
Referral to Treatment Admitted	90%	1	1		84.3%	83.5%	⮟
Referral to Treatment Non Admitted	95%	1	0		95.15%	95.1%	➤
Referral to Treatment Incomplete	92%	1	1		89.04%	91.2%	⮝
A&E All Types Monthly Performance **(Quarter to date)**	95%	1	1	93.59%	92.25%	92.87%	⮝
				YTD	**Q4**	**Q1 to Date**	
62 Day Standard	85%	1	0	95.92%	82.5%	95.2%	⮝
62 Day Screening Standard	90%			90.0%	87.5%	90.0%	⮝
31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	➤
31 Day Subsequent Surgery Standard	94%		0	96.9%	97.6%	96.9%	⮟
31 Day Standard	96%	1	0	96.6%	96.9%	96.6%	⮟
Two Week Wait Standard	93%	1	1	92.5%	96.8%	92.5%	⮟
Breast Symptom Two Week Wait Standard	93%	1		78.4%	97.69%	78.4%	⮟

* NYA Not yet available

Outcomes							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Apr**	**May**	**Movement**
Clostridium Difficile - Variance from plan	31	1	0	6	0	0	➤
Certification of Compliance Learning Disabilities:							
Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	Compliant	1	0	Yes	Yes	Yes	➤
Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: · treatment options; · complaints procedures; and · appointments?	Compliant			Yes	Yes	Yes	➤
Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities	Compliant			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			Yes	Yes	Yes	➤
Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Compliant			Yes	Yes	Yes	➤
Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Compliant			Yes	Yes	Yes	➤
Data Completeness Community Services:							
Referral to treatment	50%	1	0		56%	56%	➤
referral information	50%	1	0		88%	87.9%	⮟
treatment activity	50%	1	0		69.2%	69.8%	⮝
Trust Overall Quality Governance Score					2	**4**	➤

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

The trust's quality governance rating is 'Under Review' as the trust has a governance score of 4 and monitor are reviewing key areas of underperformance with no regulatory action being taken to date. (further details in appendix 1.)

.

Areas of underperformance for quality governance are:

- A&E 4 Hour Standard
- RTT
- Cancer 2 Week Waits
- Diagnostic Waits > 6weeks

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

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 >=4.0 and >=3 consecutive quarters' breaches of single metric and with regulatory action to be taken

2. Trust Key Performance Indicators 2015/16: May 15 Performance (Page 1 of 1)

Responsiveness Domain					
Metric	Standard	YTD	Apr	May	Movement
Referral to Treatment Admitted	90%		84.3%	83.5%	↓
Referral to Treatment Non Admitted	95%		95.15%	95.1%	→
Referral to Treatment Incomplete	92%		89.04%	91.2%	↑
Referral to Treatment Incomplete 52+ Week Waiters	0		4	1	↓
Diagnostic waiting times > 6 weeks	1%		3.24%	3.65%	↑
A&E All Types Monthly Performance	95%	92.87%	92.25%	93.63%	↑
12 hour Trolley waits	0	0	0	0	→
Urgent Ops Cancelled for 2nd time (Number)	0	0	0	0	→
Proportion of patients not treated within 28 days of last minute cancellation	0%	17.9%	17.9%	4.9%	↓
Certification against compliance with requirements regarding access to health care for people with a learning disability	Compliant	Yes	Yes	Yes	→
	Standard	YTD	Q4	Q1	Movement
Two Week Wait Standard	93%	92.5%	96.8%	92.5%	↓
Breast Symptom Two Week Wait Standard	93%	78.4%	97.69%	78.4%	↓
31 Day Standard	96%	96.6%	96.9%	96.6%	↓
31 Day Subsequent Drug Standard	98%	100.0%	100.0%	100.0%	→
31 Day Subsequent Surgery Standard	94%	96.9%	97.6%	96.9%	↓
62 Day Standard	85%	95.2%	82.5%	95.2%	↑
62 Day Screening Standard	90%	90.0%	87.5%	90.0%	↑

Safe Domain					
Metric	Standard	YTD	April	May	Movement
Clostridium Difficile - Variance from plan	0	6	0	0	→
MRSA bacteraemia	0	2	2	0	↓
Never events	0	2	1	1	→
Serious Incidents		35	18	17	↓
Percentage of Harm Free Care	95%		94.2%	94.61%	↑
Medication errors causing serious harm	0	1	0	1	↑
Overdue CAS alerts	0	2	2	2	→
Maternal deaths	1	1	0	1	↑
VTE Risk Assessment (previous months data)*	95%		96..27%	96..64%	↑

Effectiveness Domain					
Metric	Standard	YTD	April	May	Movement
Hospital Standardised Mortality Ratio (DFI)	100		89.8	92.9	↑
Hospital Standardised Mortality Ratio – Weekday	100		86.08	86.08	→
Hospital Standardised Mortality Ratio – Weekend	100		83.66	83.66	→
Summary Hospital Mortality Indicator (HSCIC)	100		86	86	→
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	5%	3.11%	3.14%	3.07%	↓

Caring Domain					
Metric	Standard	YTD	April	May	Movement
Inpatient Scores from Friends and Family Test	60		95.7	94.7	↓
A&E Scores from Friends and Family Test	46		83	83.6	↑
Complaints * previous months data			71	73	↑
Mixed Sex Accommodation Breaches	0	0	0	0	→

Well Led Domain					
Metric	Standard	YTD	April	May	Movement
IP response rate from Friends and Family Test	30%		38.9%	53.9%	↑
A&E response rate from Friends and Family Test	20%		23.8%	25.5%	↑
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	61%	61%			
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	67%	69&			
Trust turnover rate	13%		17.5%	17.35%	↓
Trust level total sickness rate	3.50%		3.21%	3.44%	↑
Total Trust vacancy rate	11%		13.7%	14.4%	↑
Percentage of staff with annual appraisal – Medical	85%		75.23%	87.1%	↑
Percentage of staff with annual appraisal - non-medical	85%		87.0%	75.1%	↓

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.

St George's University Hospitals NHS
NHS Foundation Trust

Performance – areas of escalation

3. Performance Area of Escalation (Page 1 of 7) - A&E: 4 Hour Standard

Total time in A&E - 95% of patients should be seen within 4hrs						
Lead Director	April	May	Movement	2015/2016 Target	Forecast June - 15	Date expected to meet standard
FA	92.25%	93.63%	▲	>= 95%	R	TBC

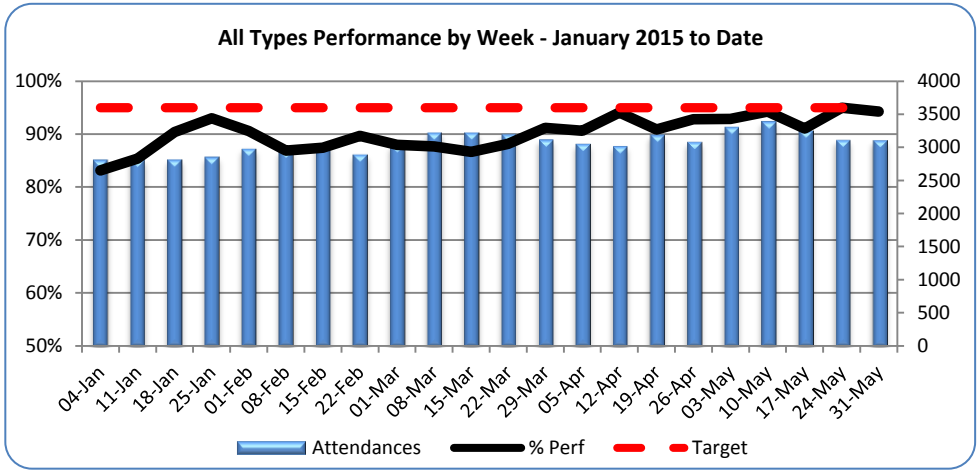
Peer Performance Quarter to Date 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
92.7%	90.8%	90.8%	88.4%	95.8%

The ED target is that 95% or more of patients should be seen and discharged within 4 hours of attending the Emergency Department. In May 2015, 93.63% of patients were seen within 4 hours, this is an improvement on April's position of 92.25%. Performance improvement can be seen in May as the trust continues to implement and further embed existing actions to maintain performance improvement. The week beginning 18th May 2015 ED performance exceeded the 95% standard.

The trust is in a period of joint investigation with commissioners where ED performance and pathways are being jointly reviewed further with additional actions for performance improvement to be identified. Key themes emerging from the review thus far are as follows:

- Opportunities to strengthen primary care arrangements for minimising impact on urgent care (and majors when primary care capacity depleted)
- Recognised need for a 'transformative' model of care that responds to the growing age profile of patients
- Protecting and expanding ambulatory care services, including through development of surgical assessment unit
- The development of ambulatory care services out of hospital, such as at the Nelson.
- Strong commissioner support for in-AMU, in-hospital flow and discharge improvement work
- Aspiration to see a set of flow based KPIs that can be monitored by commissioners.

Following the period of Joint Investigation the trust is currently in the process of agreeing an remedial action plans for implementation to recover sustainable ED performance back to target. The action plans encompass areas of: ED flow, intra hospital flow, frailty pathways and ambulatory care. These are currently in discussion/review with commissioners.



Performance Overview by Type			
	ED (Type 1)	MIU (Type 3)	ED & MIU (Type 1+3)
Month to Date (March)	92.92%	99.70%	93.63%
Quarter to Date	92.11%	99.69%	92.87%
Year to Date	92.11%	99.69%	92.87%

3. Performance Areas of Escalation (Page 2 of 7) - RTT Admitted Pathways

Referral to Treatment Admitted Pathways						
Lead Director	April	May	Movement	2014/2015 Target	Forecast June – 15	Date expected to meet standard
SB	84.3%	83.5%	⮟	90%	R	TBC

Over the last 10 months the trust has not achieved the 90% target for admitted pathways to support backlog clearance as part of the national programme. This also coincides with clear commissioner assertion of full chronological booking taking precedent.

The trust needs to further reduce its backlog to a sustainable position to allow for effective delivery of the target. In order to achieve this the trust needs to address key challenges which have currently been impacting upon performance. These include:

- Bed Capacity – including critical care capacity
- Theatre Capacity
- Outpatient clinic and staff capacity
- Improvement in data quality and process management

The trust is currently in a period of 'Joint Investigation' with commissioners who are working closely with the to support the development of a sustainable plan for 18 week referral to treatment delivery. Recent discussions have highlighted five main areas of commissioner focus:

- Ensuring appropriate outpatient referral demand and capacity modelling
- Exploiting opportunities for one-stop outpatient clinics that combine new, diagnostic and follow up consultations in a single visit
- Implementation of pre-referral agreed pathways and criteria from primary care to reduce referrals, reduce diagnostics and increase conversion rates.
- In challenged specialties – inviting GPs to refer patients direct to alternate providers
- Making best use of the independent sector through direct GP referral (at tariff price) thus reducing the performance burden on the trust and some of the financial burden on the local health economy.

Given the above context the Trust will need to:

- Develop and sign off a coherent trust plan for sustainable RTT delivery with commissioner support
- Undertake additional activity – recognising the capacity constraints at St George's any significant increase in activity will need to be undertaken off-site, through other providers
- Drive specialties to review pathways of care to identify where there are opportunities to:
    - i. Reduce unnecessary or incomplete referrals, thus leading to a higher conversion rate
    - ii. Improve productivity by bundling outpatient and diagnostic appointments into one-stop services
    - iii. Reduce activity levels in unsustainable services – through the service line review

Following the period of Joint Investigation the trust is currently in the process of agreeing an Elective Pathway remedial action plan for implementation to recover sustainable performance back to target. This is currently in discussion/review with commissioners.

3. Performance Areas of Escalation (Page 3 of 7) - RTT Incomplete 52+ Week Waiters

Referral to Treatment Incomplete 52+ Week Waiters						
Lead Director	April	May	Movement	2014/2015 Target	Forecast June – 15	Date expected to meet standard
SB	4	1	↓	0	G	June - 15

Specialty	Patient Type	Date for patient to be treated	Commentary
ENT	IP	18/06/2015	The key reasons for delay were due to human error. The referral was originally sent to SGH by a consultant from another provider who did not complete a TCI card for the patient so they were not added to the waiting list . Following this a Consultant at SGH completed a TCI card but was not forwarded to the Admissions Team adding to the delay. Patient has since attended an OP appointment on 12/05/2015 to discuss procedure and has agreed to the procedure. The consultant has decided that an ultrasound is necessary before the procedure which has been arranged for 17/06/2015 following which the procedure will be undertaken on 18/06/2015.

All 52+ week waiters reported in April have now been treated and are no longer waiting, with the exception of the ENT patient detailed above who is scheduled to have their procedure undertaken on 18/06/2015.

The trust continues to pro-actively addressing the issue of long waiters and in particular the prevention of 52+ week waiters. The following actions continue to support this:

- Weekly RTT management meetings by care group are now in place which track the PTL and review at patient level, review capacity and escalate long waits.
- A weekly email of long waiters is sent to divisional managers to review and action those patients waiting for more than 40 weeks.
- A monthly RTT Compliance meeting chaired by an Executive Director is held which reviews; performance by care group with a particular focus on patients waiting 40+ weeks to ensure treatment plans are in place, review/facilitate escalation, provide senior decision making support to drive actions forward, reviews and monitors elective cancellations, their rebooking to target and their impact on RTT performance.

3. Performance Areas of Escalation (Page 4 of 7) - Cancer - Two Week Wait Standards

Two Week Wait Standard – all cancers						
Lead Director	Q4	Q1 to Date	Movement	2015/2016 Target	Forecast June – 15	Date expected to meet standard
CC	96.8%	92.5%	↘	93%	G	June - 15

Peer Performance Latest Published Quarter 4 2014- 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
96.%	94.5%	94.5%	95.1%	96.1%

Breast Symptom Two Week Wait Standard						
Lead Director	Q4	Q1 to Date	Movement	2015/2016 Target	Forecast June - 15	Date expected to meet standard
CC	97.69%	78.4%	↘	93%	G	June -15

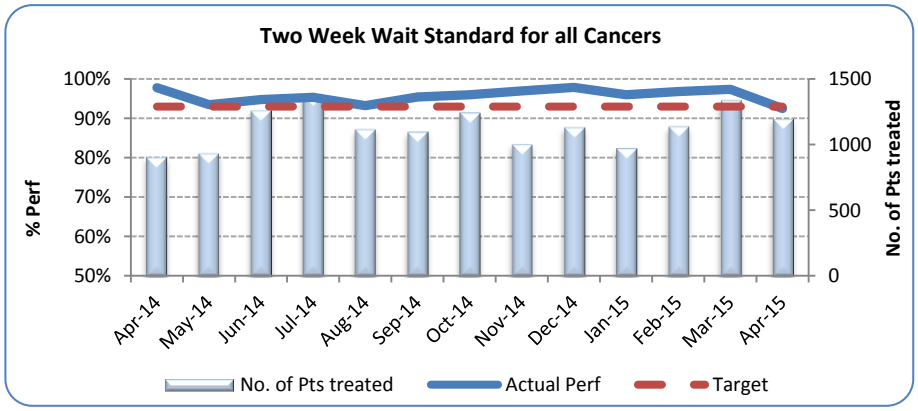
Peer Performance Latest Published Quarter 4 2014- 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
97.7%	98.5%	87%	97.8%	n/a

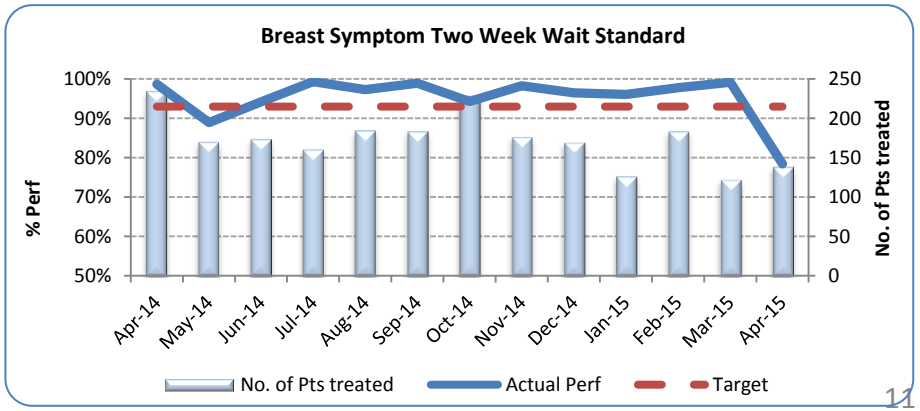
The trust was compliant against all targets except for the two week wait standard for all cancers and the 14 day breast symptomatic standard. The trust reported performance of 92.5% and 78.4% respectively in April against the national targets of 93% .

Key reasons for breaches were :

- Capacity issues in particular within modalities of breast and lower GI. Capacity is currently being reviewed to ensure for future performance sustainability.
- Patient reasons to include choice and patient cancellations were a significant factor in April. Excluding breaches due to patient choice or patient cancellations, the trust would have met the two week wait standard.

The trust will continue to monitor the situation to ensure we are flagging and acting upon known breaches at the earliest possible opportunity. The Trust anticipates that performance will be back on Track for May. In addition to this to further support trusts in delivering cancer performance with a collaborative approach, a SW London forum has been set-up to discuss and review how referrals and pathways can be streamlined across trusts. This will include representatives from SWL acute trusts, commissioners and NHS England – London Cancer team. The first meeting is due to commence on 7th July 2015

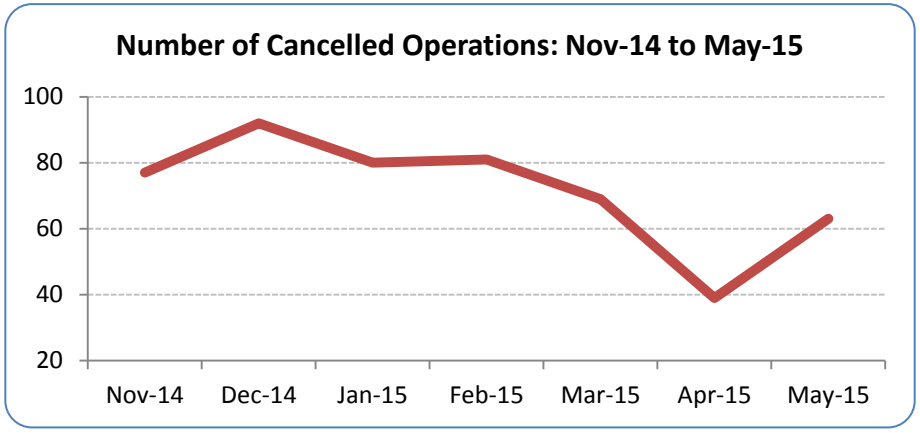


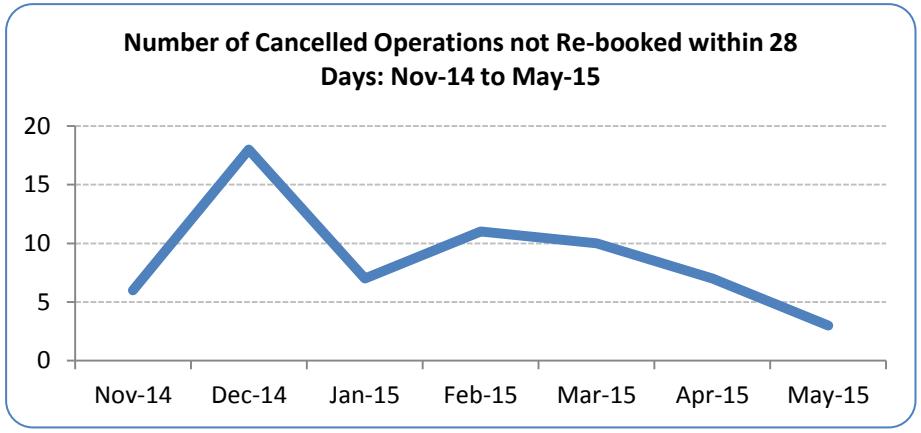


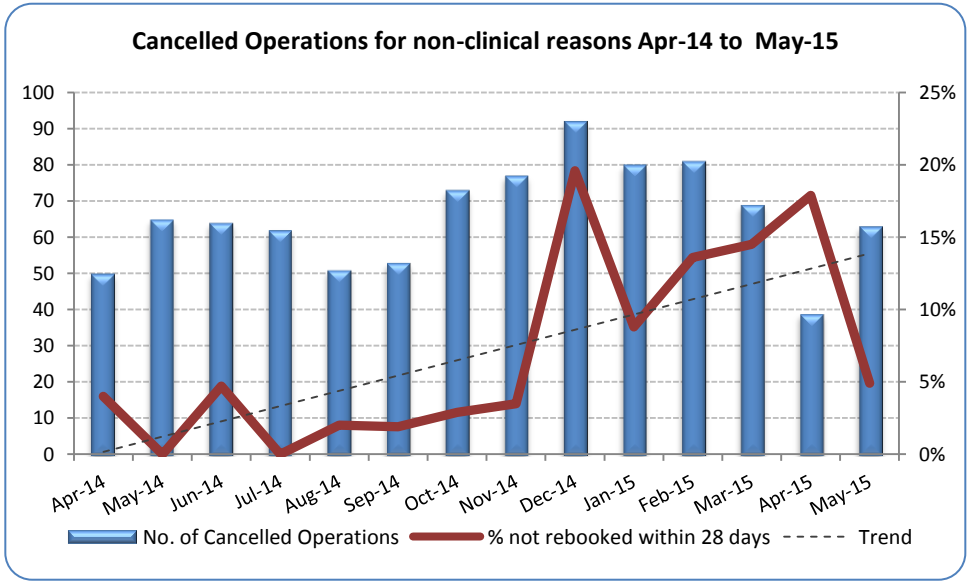
3. Performance Areas of Escalation (Page 5 of 7) - Cancelled Operations

Proportion of Cancelled patients not treated within 28 days of last minute cancellation						
Lead Director	April	May	Movement	2015/2016Target	Forecast June – 15	Date expected to meet standard
CC	17.9%	4.9%	▼	0%	G	Jun- 15

Peer Performance Comparison – Latest Available Q4 2014/15				
STG	Croydon	Kingston	King's College	Epsom & St Helier
19.7%	1.9%	17.3%	2.4%	0.8%







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 63 cancelled operations from 4261 elective admissions in May. 60 of those cancellations were rebooked within 28 days with 3 patients not rebooked within 28 days, accounting for 4.9 % of all cancellations. The overall number of breaches has been seen to be reducing month on month since February.

The breaches were attributable to Cardiothoracic, Plastics and Maxillofacial specialties. Key contributory factors for the cancellations were related to high bed occupancy resulting in a lack of ITU beds for post surgical admission and unavailability of equipment for one of the cases.

All three patients now have scheduled dates for their operations in June.

The trust pro-actively monitors its elective programme which includes all cancelled operations closely and prioritises them for re-booking. These are also reviewed with commissioners on a monthly basis.

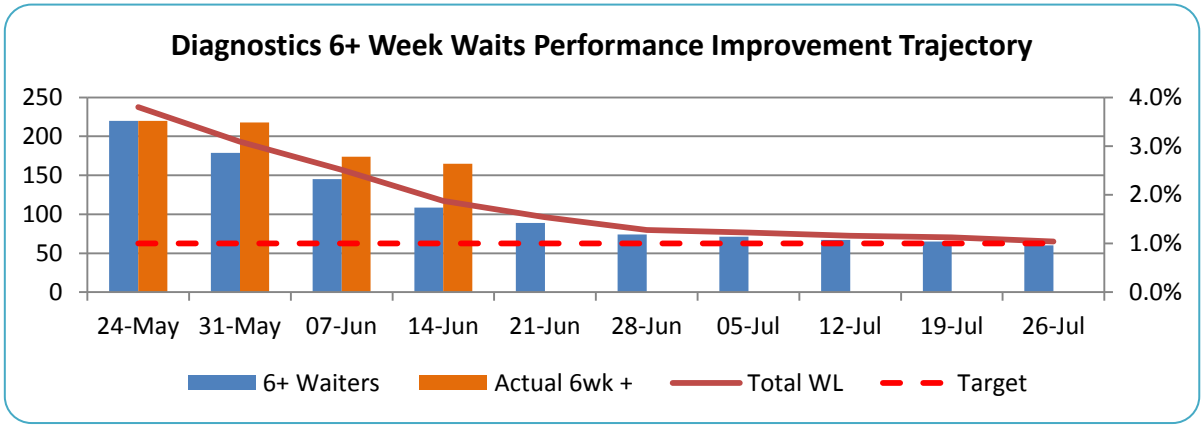
3. Performance Areas of Escalation (Page 6 of 7) - Diagnostic 6+ Weeks Wait

Diagnostic waiting times > 6 weeks						
Lead Director	April	May	Movement	2015/2016 Target	Forecast June – 15	Date expected to meet standard
CC	3.24%	3.65%	▲	1%	R	July- 15

No of Patients waiting >6 weeks – Latest Published Data April 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
180	1	25	345	23

The trust continues to face challenges with diagnostic waits greater than 6 weeks and is exceeding the target of number of patients waiting greater than 6 weeks of 1% of all waiters. The trust has put actions into place and positive performance improvement in has been observed across a number of modalities. Endoscopy waits greater than 6 weeks have reduced from 128 at the beginning of February to 28 as at 14/06/2015. The pre-dominant modalities of challenge where there are high number of patients waiting greater than 6 weeks are; MRI and Non-obstetric ultrasound.

The trust has submitted a performance improvement trajectory to commissioners as shown below. At present the trust is showing week on week reduction in waits but is not in line with the trajectory and further actions are being undertaken to expedite recovery so we are back on track.



Actions being taken to address the backlog and ensure compliance include:

Non-obstetric ultrasound - Increased waits for non-obstetric ultrasound can be attributed to both areas of Gynaecology and Radiology.

Gynaecology

- Increased robustness of administration processes and management of administrative staff involved in booking and registering patients.
- Weekly monitoring of diagnostic capacity and demand undertaken by management team.
- A minimum of 5 ad hoc scanning clinics arranged for each week since 24.4.15.
- A minimum of 1 ad hoc weekend scanning clinic arranged for each week since 27.4.15
- Activity re directed to the Nelson and St Johns when there is available capacity.
- It is forecasted that backlog clearance to support performance improvement to target will be complete by July 2015.
- The impact of the additional is having a significant positive effect as Gynaecology related non-obstetric ultrasound waits greater than 6 weeks have reduced from 176 at the end of April to 16 as at 14/06/2015.

3. Performance Areas of Escalation (Page 7 of 7) - Diagnostic 6+ Weeks Wait Contd.

Actions being taken to address the backlog and ensure compliance include:

Radiology

The service have undertaken a waiting list review to identify all potential future breaches to enable the planning of additional capacity required to bring the waiting times back to target accordingly. Following the review the following measures are being implemented:

- We are planning 3 general sessions for week of 15/06/215 with additional planned if required the week after. This combined with QMR capacity (below) will mean we will have no general breaches by the 29th June.
- 6 additional sessions at QMR are available which are spread until the first week in July.
- MSK has been a key area of constraint over the last quarter. MSK sessions (at least 2/wk) will be arranged for the next 5-6 weeks. (this is contingent on staff availability). 3 sessions have been scheduled currently. This will not prevent all breaches from occurring in the short term as MSK is limited by capable staff. However the MSK waiting list will be brought under control by these extra sessions theoretically putting the list under 6 weeks by 13th July or sooner dependent on staff availability.
- We have a new MSK consultant starting in July which will augment that service to reduce any further breach occurrences.
- Sonographers have offered to do additional sessions. Number of sessions are yet to be agreed, but this will enable another group of staff to rely on for additional capacity when required.
- Undertaking activity at the Nelson. The activity sent to the Nelson (340+ pts) will not only avoid those patient breaching but will yield relinquished slots to book early appointments for potentially breaching patients. Feedback from our Nelson colleagues about these patients will enable quicker rebooking of those slots.

Currently, all new general patients are being booked within 6 weeks and the removal of the current potential breaches will mark the end of the impact felt from sessions lost in April and May.

MRI

MRI remains a challenge and in particular Cardiac MRI's with referrals increasing with limited capacity. Actions being undertaken to support reduction in waiting times includes:

- Additional weekend sessions using mobile scanner continue to be run.
- Static scanner which failed over the Easter weekend resulting in some lost capacity has now been fixed and is back in operation.
- Extending current weekend sessions to 12hrs from 8hrs.
- Review and consideration of an interim solution to upgrade the QMH mobile unit to a 'relocatable' unit(rather than trailer based, this is a unit housed in a dedicated portacabin) which is capable of a slightly wider range of examinations than a traditional mobile. This option is currently in discussion with InHealth. This will support the reduction of waiting times for currently non-mobile compatible exams
- A review of options to increase capacity for Cardiac MRIs in currently in progress.

In addition to the above work continues to further reduce the long waits within Endoscopy and in particular flexible sigmoidoscopy waits which remain a slight pressure.

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

			May 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	18 WEEKS - ADMITTED WAITS (DIVISION LEVEL)	%		89	80.3	81.3	83.5
	18 WEEKS - INCOMPLETE WAITS (DIVISION LEVEL)	%	100	92.9	89.3	89.2	91.2
	18 WEEKS – NON-ADMITTED WAITS (DIVISION LEVEL)	%	100	93.2	91.2	97.9	95.1
	52 WEEK WAITERS	No.	0	0	1	0	1
	A&E WAITS (4 HOURS)	%	99.7	92.9			93.6
	CANCELLED OPERATIONS RE-BOOKED WITHIN 28 DAYS (DIVISION)	%	0	4.3	5.3	0	4.9
	LAS HANDOVER WITHIN 15 MINS	%					13.9
	LAS HANDOVER WITHIN 30 MINS	%					75.5
	LAS HANDOVER WITHIN 60 MINS	No.					0

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

			April 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (BREAST SYMPTOMS) - (DIVISION)	%	0	0	78.4	0	78.4
	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (CANCER) - (DIVISION)	%	0	0	92.5	0	92.5
	31 DAY SECOND OR SUBSEQUENT TREATMENT (DRUGS) - (DIVISION)	%	0	0	100	0	100
	31 DAY SECOND OR SUBSEQUENT TREATMENT (SURGERY) - (DIVISION)	%			96.9		96.9
	31 DAY STANDARD FROM DIAGNOSIS TO FIRST TREATMENT - (DIVISION)	%			96.6		96.6
	62 DAY URGENT GP REFERRAL TO TREATMENT FOR ALL CANCERS - (DIVISION)	%			85.2		85.2
	62 DAY URGENT GP REFERRAL TO TREATMENT FROM SCREENING - (DIVISION)	%			90		90

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

			May 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Outcome Metrics	C-SECTIONS (APPLICABLE TO WOMEN & CHILDREN ONLY)	%				24.7	24.7
	HSMR	Ratio					92.9
	INCIDENCE OF C.DIFFICILE	No.	0	2	0	1	3
	INCIDENCE OF E-COLI	No.	0	0	1	0	1
	INCIDENCE OF MRSA	No.	0	0	0	0	0
	MATERNAL DEATHS	No.	0	0	0	1	1
	MEDICATION ERRORS CAUSING SERIOUS HARM	No.	0	0	0	0	0
	NEVER EVENTS	No.	0	1	0	0	1
	SERIOUS INCIDENTS (DIVISION LEVEL)	No.	1	11	3	2	17
	SHMI	Ratio					0.9
Quality Governance Indicators	PATIENT SATISFACTION (FRIENDS & FAMILY)	%	81.3	92.2	96.4	89.8	93.5
	PERCENTAGE OF STAFF APPRAISAL (MEDICAL) - (DIVISION)	%	72.7	87.6	87.9	87.8	87.1
	PERCENTAGE OF STAFF APPRAISAL (NON-MEDICAL) - (DIVISION)	%	75.8	78.8	75.1	74.9	75.1
	SICKNESS/ABSENCE RATE - (DIVISION)	%	6	2.9	3.1	2.9	3.4
	STAFF TURNOVER - (DIVISION)	%	19.9	18	14.3	17.7	17.4
	VOLUNTARY STAFF TURNOVER - (DIVISION)	%	15.8	15.7	12.6	13.2	14.1

Key Messages:

This section headed 'Access' indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution. The Access section is split into two components, as Cancer metric and complaints performance is reported one month in arrears.

LAS arrivals to patient handover times, continues to fluctuate. At the end of May, 13.9% of patients had handover times within 15 minutes and 75.5% within 30 minutes. both of which are not within target. The 30 minute handover data is currently being validated and is envisaged to significantly increase post validation. The trust had no 60 minute LAS breaches in May.

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

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Corporate Outpatient Services Performance

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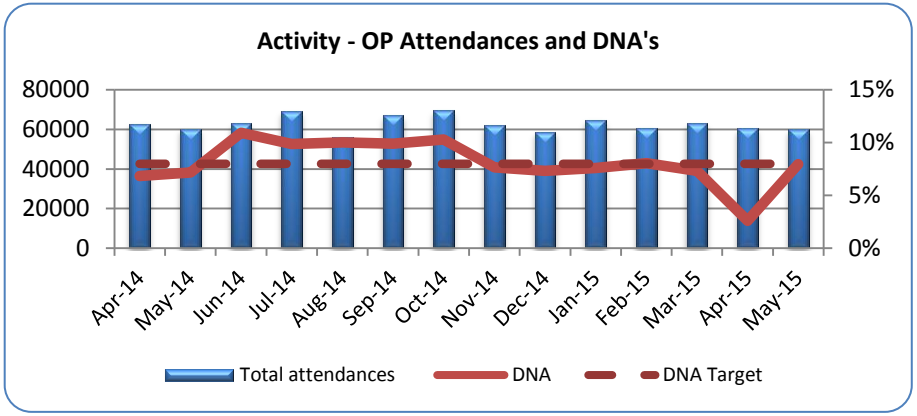
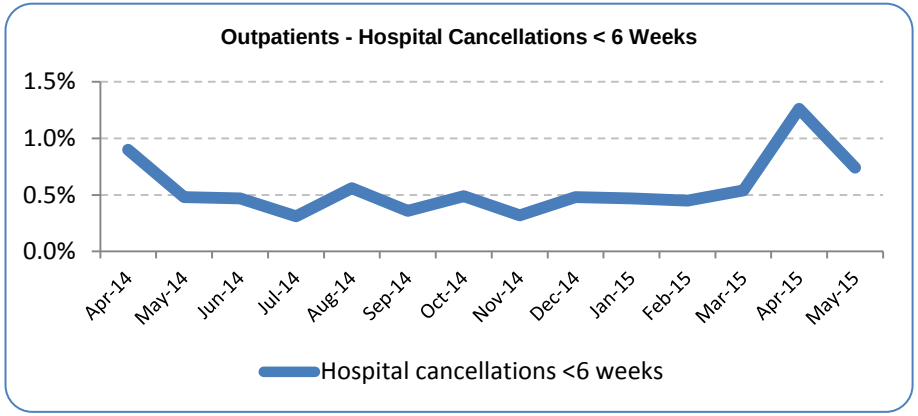
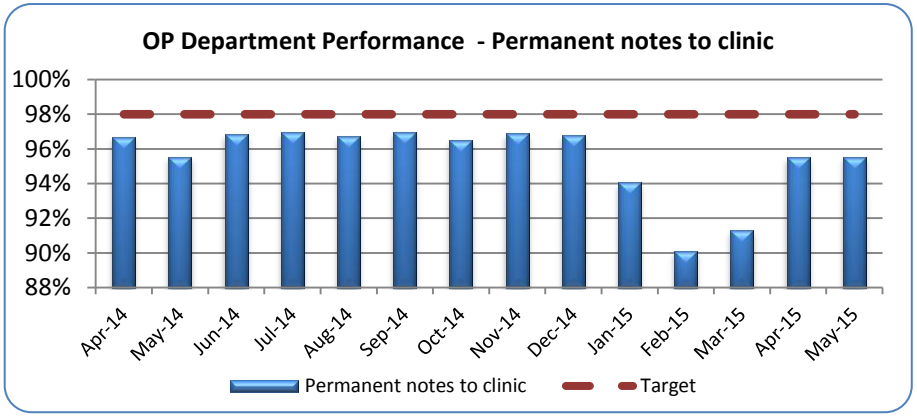
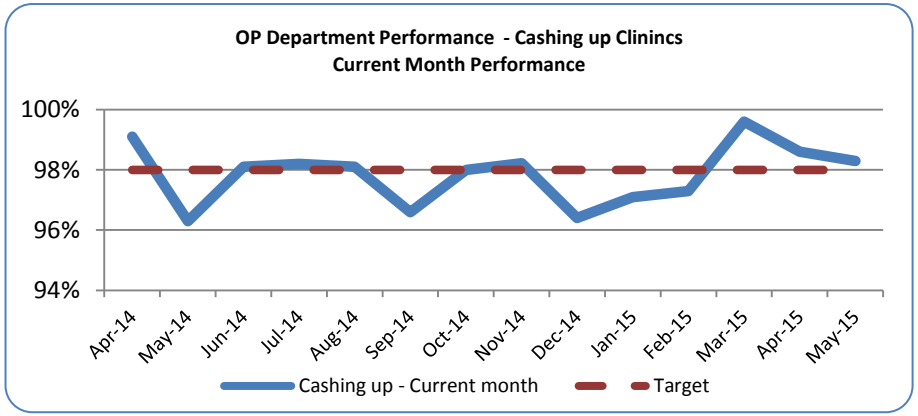
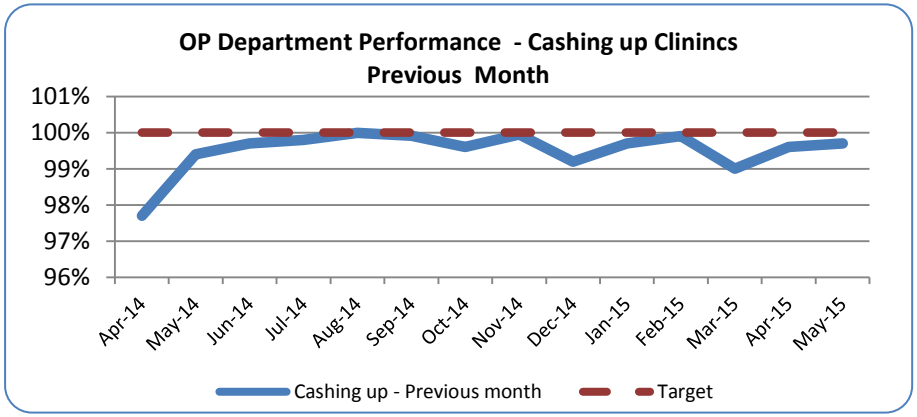
5. Corporate Outpatient Services (1 of 2) - Performance Overview

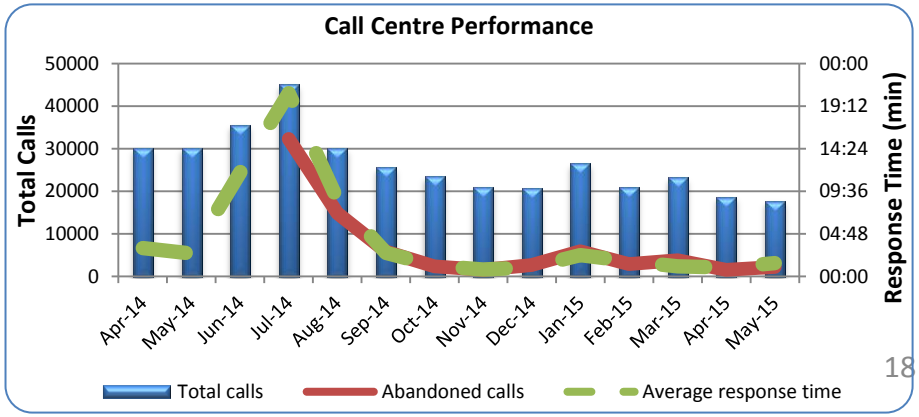












5. Corporate Outpatient Services (2 of 2) - Performance Overview

		Target	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Activity	Total attendances	N/A	62954	69250	56102	67188	69507	61879	58659	64609	60659	62946	60564	59841
	DNA	<8%	10.93%	9.87%	10.02%	9.89%	10.30%	7.64%	7.33%	7.58%	8.04%	7.33%	2.59%	7.97%
	Hospital cancellations <6 weeks	<0.5%	0.47%	0.31%	0.56%	0.36%	0.49%	0.32%	0.48%	0.47%	0.45%	0.54%	1.26%	0.74%
OPD performance	Permanent notes to clinic	>98%	96.85%	96.94%	96.71%	96.98%	96.51%	96.88%	96.77%	94.05%	90.12%	91.32%	95.52%	95.54%
	Cashing up - Current month	>98%	98.10%	98.20%	98.10%	96.60%	98.00%	98.22%	96.40%	97.10%	97.30%	99.60%	98.60%	98.3%
	Cashing up - Previous month	100%	99.70%	99.80%	99.99%	99.91%	99.60%	99.95%	99.20%	99.70%	99.90%	99.00%	99.60%	99.70%
Call Centre Performance	Total calls	N/A	35571	45101	30004	25674	23420	20964	20639	26565	20842	23235	18710	17732
	Abandoned calls	<25%/< 15%		32257	14825	5794	2376	1558	2681	5923	2908	3782	1551	2237
	Mean call response times	<1 minute	11:42	20:39	08:41	02:38	01:13	00:47	01:02	02:24	01:43	01:08	01:00	01:29

Key Messages:

- May activity has seen a decrease in comparison to the average for the last three months. DNAs have increased in May but remains within target of less than 8%, this is being closely monitored going forward. Hospital cancellations have seen a reduction from Aprils position of 1.265 to 0.74%. However, this is still not within target of less than 0.5%. Performance of permanent notes to clinic has seen little change over the last month with performance of 95.54%. This is an on-going priority area for the service.

- Call centre performance has seen an improvement from the challenges in Q4. Abandoned calls performance has been maintained remaining less than 13% in April. The division continues to monitor call centre performance to maintain abandoned call performance of less than 15% of total calls and to bring average response times to less than a minute. Average response times have seen consecutive month on month improvement from January. However, average response time in May was in excess of the 1.0minute target. Renewed focus is being placed on this to ensure consistent low response times are maintained.

- Trust OP capacity is not in line with forecasted demand as per business plans.
  - Business plan demand of 666,000 stated against actual trust built capacity of 450,000. This is currently being mitigated by overbooking and scheduling of additional ad-hoc clinics. Further work in relation to capacity and demand planning is being undertaken to address this.

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Clinical Audit and Effectiveness

6. Clinical Audit and Effectiveness (Page 1 of 5) - Mortality

HSMR (Hospital standardised mortality ratio)						
Lead Director	April 15	May 15	Movement	2014/2015 Target	Forecast March 16	Date expect to meet standard
SM	89.6	88.3	↓	<100	G	Met

SHMI (Summary hospital-level mortality indicator)				
Apr 2014	Jul 2014	Oct 2014	Jan 2015	Apr 2015
0.78	0.80	0.81	0.84	0.86

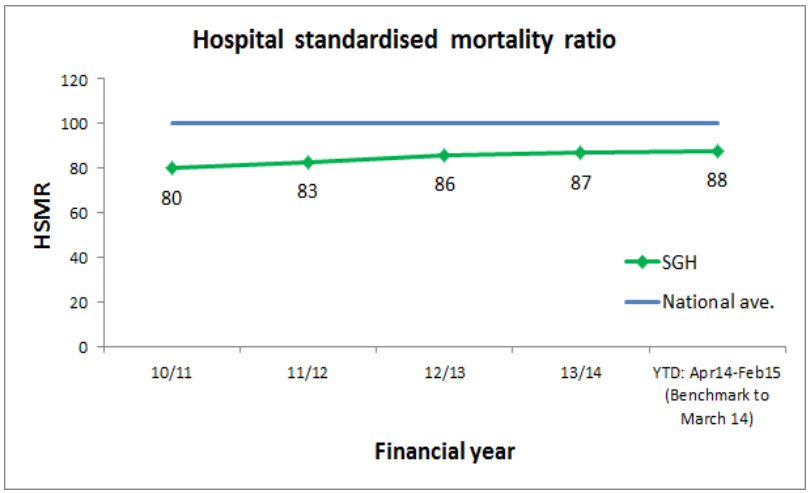
Note: Source for HSMR is Dr Foster Intelligence, published monthly. Data is most recent 12 months available. For May 15 this was March 2014 to February 2015, and benchmark period is to March 2014. An update was not provided by Dr Foster in April, however the HSMR has been calculated retrospectively from the latest refresh and relates to February 2014 to January 2015. SHMI data is published by the Health and Social Care Information Centre. The last 12 month period as published on 29th April 2015 relates to the period October 2013 to September 2014. The next publication will be at the end of July.

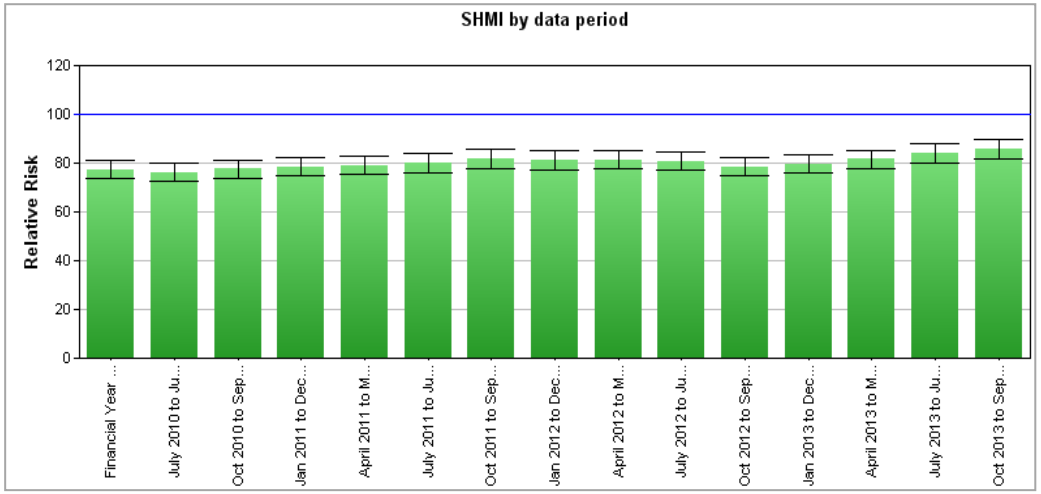
Overview:

Our overall mortality measured by both the HSMR and the SHMI remains statistically significantly better than expected. There does appear to be a trend towards the national mean which requires monitoring. We continue to investigate any mortality signals at procedure and diagnosis level which are locally identified using the Dr Foster platform. Investigation of two diagnosis groups (acute myocardial infarction and fractured neck of femur) identified through analysis of the SHMI are also underway.

This month the Mortality Monitoring Committee will present a summary to the Patient Safety Committee. The report includes an overview of all current investigations. It is noted that there are a number of cardiology signals which require investigation and therefore a wider review of mortality review processes within the service is being considered. The intention is to avoid duplication of effort and to ensure time and expertise are directed appropriately, leading to a clear understanding of outcomes.

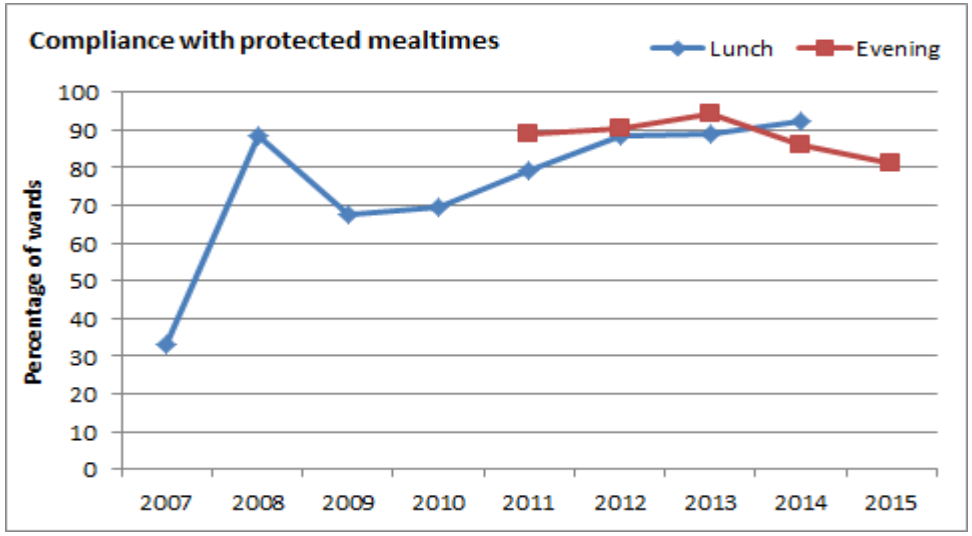
Final adjustments are being made to a report in Tableau which will provide 'real-time' mortality views, which can be filtered by specialty, date, admission type and consultant. This is seen as a useful tool in the work to progress proportionate review of all deaths. It is hoped it will also support a better understanding of crude mortality, and allow us to measure mortality in inpatient community areas.

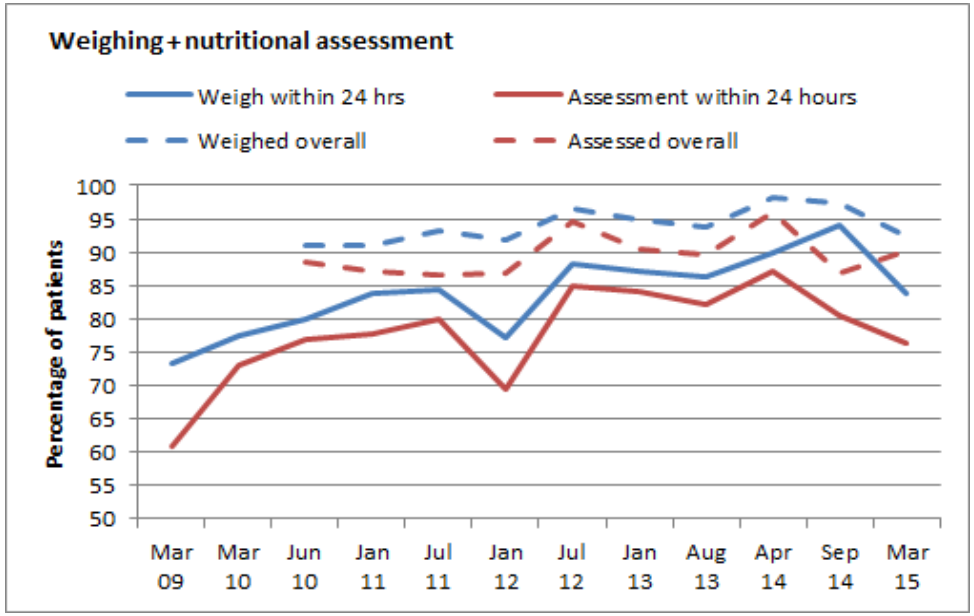




6. Clinical Audit and Effectiveness (Page 2 of 5) - Local Audits

Protected mealtimes, nutrition and hydration audit, March – May 2015





This snapshot audit of an evening meal service was conducted on 37 wards between March and May 2015.

On 30 wards (81.1%) there were no non-clinically urgent interruptions. This is a decline in performance and for the evening meal represents the lowest adherence to date.

Measures around providing assistance to patients show that in the majority of instances staff are providing adequate and timely support to patients. On 96.7 per cent of wards patients requiring assistance were helped with their meal in a timely way. These results are reinforced by the fact that 94.9 per cent of patients surveyed said they had the help that they needed at mealtimes.

Results for weighing and assessing patients within 24 hours of admission show performance has declined. Although timeliness has fallen, it is positive to note that the good practice observed in relation to accuracy of assessments and the appropriate follow-up and review has been sustained. Nutritional assessments were accurate for 97% of patient audited. Follow-up of those identified as at risk has been maintained at around 92 per cent, with appropriate review at approximately 90 per cent.

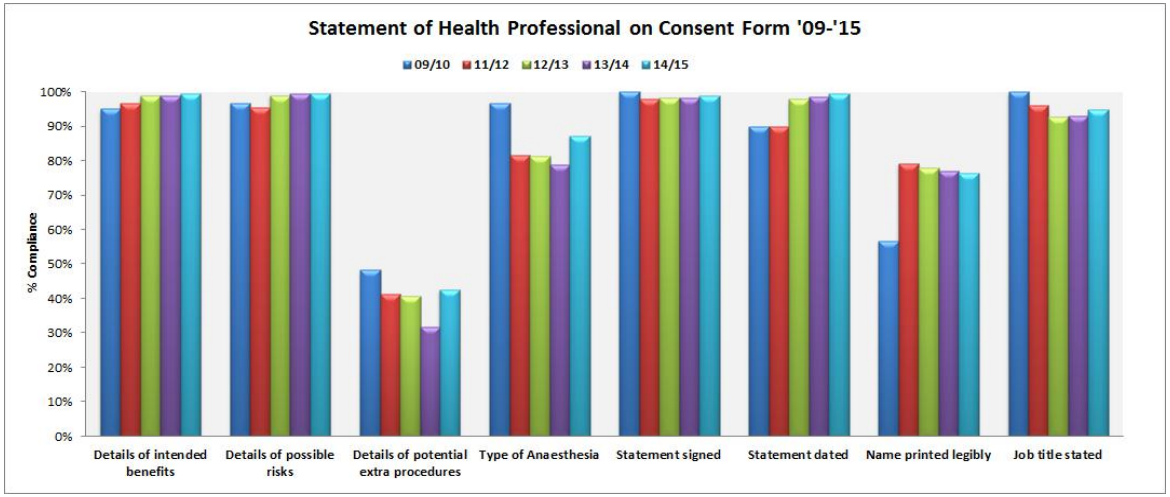
Ward analysis across 9 key measures shows that nine wards were fully compliant. Florence Nightingale, William Drummond and Freddie Hewitt also achieved full compliance at the last round of audit and are congratulated. Eleven wards were shown to have improved, 5 maintained the same level of performance and 14 performed less well.

All wards are required to enforce protected mealtimes and challenge colleagues accordingly. Ward sisters and matrons have been asked to review practice to ensure that there is a robust approach to nutritional screening and support, including the use of red trays.

This regular audit is due to be repeated in the Autumn of 2015 and will focus on the lunchtime meal service.

6. Clinical Audit and Effectiveness (Page 3 of 5)
- Local Audits

Trust-Wide Consent Re-Audit 2014/15 (#DB442)



This is an annual re-audit of consent which was performed by the clinical audit team during February and March 2015. The sample included 282 cases from 28 specialties. The audit indicated that the patient details were completed generally well on the consent form and that performance had improved from the previous year. As shown in the chart above there was improvement in the recording of procedure details and the statement of the health professional. The name of the responsible consultant was not documented in a third of cases and this needs to be urgently addressed. Legibility needs to be improved including clearer identification of the consenter in some cases. It should also be noted that we have not achieved 100% compliance for any of the measures audited which indicates overall improvement is needed.

The results indicated that the section on discussion of blood transfusion / Jehovah's witness in the new consent form (n=102) was only completed in 31.4% (n=32) cases. This needs to be significantly improved in order to provide evidence that a discussion has taken place and to ensure that patients are treated according to their wishes. In only 51.8% (n=146) of cases the carbon copy of the consent form was removed, implying that it had been given to the patient; this is similar to the previous audit (46.8%; n=130). It is best practice to provide the carbon copy to the patients and the consenter should ensure that this is offered in each instance. It is important that all staff are made aware that all sections of the consent form need be completed legibly, and a copy given to the patient.

Competency to take consent could only be assessed in 84% (n=237) cases. In all of these cases the health care professional was deemed competent. In 12.4% (n=35) cases it was not possible to ascertain the name of the consenter because it was illegible or not recorded. Legibility needs to be urgently addressed and adoption of name stamps is recommended. In the remaining cases confirmation was not received from the consultant.

The report is to be presented for discussion at the Patient Safety Committee in June. In addition, divisions have received the results, including divisional analysis to facilitate local discussion and action planning. The Legal Services Manager will include a summary of the key areas for action as part of a presentation on consent to the STNC division in June.

Currently there is no clinical lead for this audit. The associate medical director for governance is supporting the audit team to recruit a lead to help effectively drive recommendations and implement action plans.

6. Clinical Audit and Effectiveness (Page 4 of 5)
- Local audits

WHO Surgical Checklist Audit 4th Quarter 2014/15

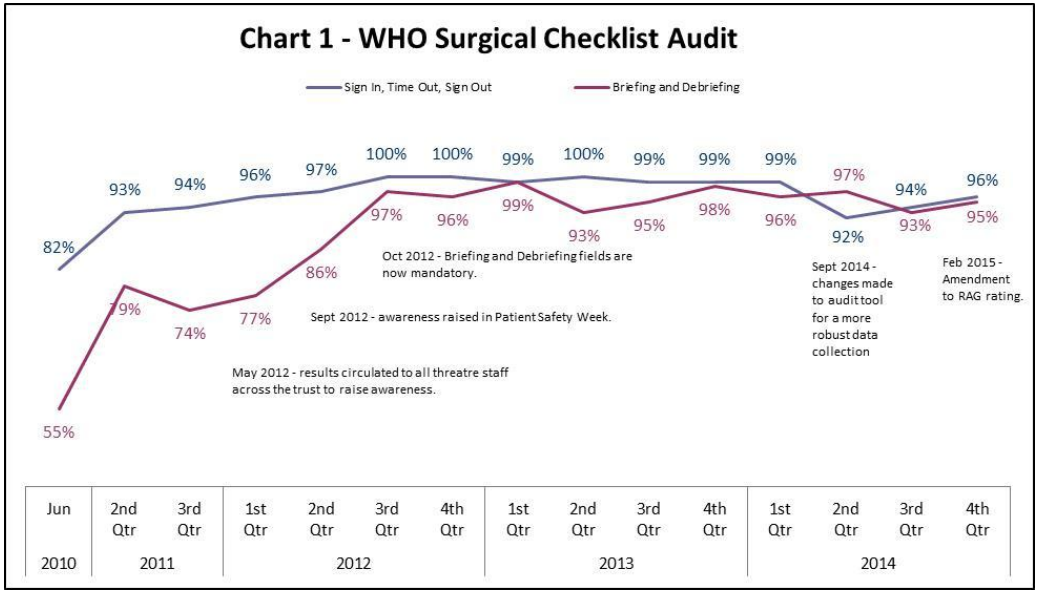


Table 1 - Results for 2014/15	Specialty	Sign In, Time Out, and Sign Out				Briefing and Debriefing			
		1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Children & Women	Gynaecology	100%	87%	97%	98%	98%	100%	100%	100%
	Obstetric - Elective	100%	90%	99%	93%	100%	100%	100%	100%
	Obstetric - Emergency	100%	91%	88%	98%	100%	88%	-	-
	Paediatric	99%	92%	96%	98%	100%	96%	100%	100%
Medicine & CardioThoracic	CardioThoracic	91%	94%	88%	79%	68%	100%	60%	64%
	Renal	100%	96%	98%	98%	100%	100%	95%	100%
	Vascular	100%	94%	99%	100%	98%	95%	100%	100%
Surgery	CEPOD	100%	94%	97%	98%	100%	100%	100%	100%
	DSU	100%	92%	98%	98%	100%	96%	92%	96%
	ENT	100%	88%	100%	100%	100%	100%	100%	100%
	General Surgery	100%	90%	94%	93%	100%	100%	100%	95%
	MaxFax	100%	96%	86%	100%	100%	100%	90%	100%
	Neuro Surgery	90%	99%	93%	93%	75%	100%	95%	94%
	Plastic	100%	88%	92%	91%	100%	100%	98%	100%
	T&O	94%	-	82%	82%	83%	-	98%	100%
	Urology	100%	98%	100%	97%	100%	100%	100%	95%

Overview

As part of the commitment to improving patient safety, the trust has adopted the WHO Surgical Safety Checklist and has been auditing compliance since 2010.

The RAG rating has been amended to reflect the drive for higher standards and is applied from this audit round. The new criteria are: Green for 100%; Amber for scores ranging between 95% and 99%; and Red for scores below 95% (previous rating - Green for 100%, Amber for scores ranging between 99% and 90%, and Red for scores below 90%).

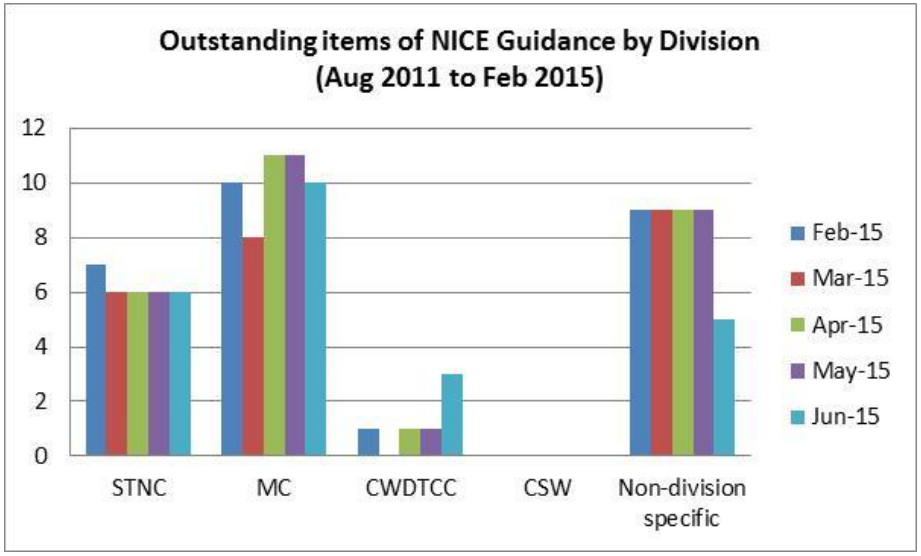
Overall Performance

Sign-in, Time Out and Sign-out – Marginal improvement to 96% (94% in the last audit round). ENT, MaxFax and Vascular scored 100% . Cardiothoracic scored 64% for Briefing/Debriefing and 79% for Sign-in/Time-out/Sign-out. These are the lowest scores in this audit round.

Action Plan: This is being led by the surgical clinical lead for WHO.

- Report circulated to Clinical Governance leads and findings will be presented at the next Theatre Care group meeting for discussion.
- Support to be given to 3 specialties with the lowest results to understand the issues they face and help improve compliance.
- Clinical lead to visit best performing areas to congratulate them and gain insight into their successful processes, which can then be shared.
- Focus on improvements to Time-out checks, with target of 100% compliance at next audit round.
- Matrons and team leaders to discuss findings with their local teams.
- Surgeons and anaesthetists to collect data for quarter 1 2015/16.

6. Clinical Audit and Effectiveness (Page 5 of 5)
- NICE (National Institute of Health and Social Care Excellence) Guidance



Items of NICE Guidance with Compliance Issues (Jun 2010 to Dec 2014)

Division	2010	2011	2012	2013	2014
STNC (n=7)		n=1	n=2	n=1	n=3
M+C (n=15)	n=2	n=3	n=4	n=1	n=5
CWDTCC (n=15)	n=3	n=1	n=1	n=3	n=7
CSW (n=0)					
Non-division specific (n=6)	n=2			n=3	n=1

Overview

There were 32 items of NICE guidance released in February and March 2015 and we have already received 23 responses. For guidance issued between August 2011 and February 2015 there are currently 24 items of guidance outstanding; which is a decrease of 3 to the previous report with an additional month's guidance included. The chair of the Clinical Effectiveness and Audit Committee has reviewed non–division specific guidance in order to assess applicability to the trust and has identified appropriate leads for the audit team to contact. This has reduced the number outstanding. It is hoped that increased focus from the M+C division, with support from the senior leadership team, will result in an improved position over the coming months.

To improve understanding and management of risks associated with either non compliance or partial compliance, the audit team is redesigning the NICE gap analysis template. This will include a risk assessment for each aspect of guidance where non- or partial- compliance is reported and will provide an overall RAG rating. The template is being developed in partnership with the Divisional Director of Nursing and Governance for the M+C division. It is anticipated that the audit team will implement the new tool this month as part of the six-monthly review of all guidance with compliance issues. This will enable the divisions to develop an accurate picture of implementation and to form an understanding of any risk associated with non-compliance.

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Patient Safety

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

S	Q1 SIs Declared by Division (Inc. Pus)				
	Med & Card	Surgery & Neuro	Community	Children's and Women's	Corporate
Feb	9	1	**6**	8	0
March	9	2	**8 including 1 never**	7	0
April	14	3	**1**	0	0
May	11 **including 1 never**	3	**1**	2	1

Closed Serious Incidents (not PUs)					
Type	Feb	March	April	May	**Movement**
Total	3	10	11	9	⮟
No Harm	1	6	7	7	➤
Harm	2	4	4	2	⮟

Table 1

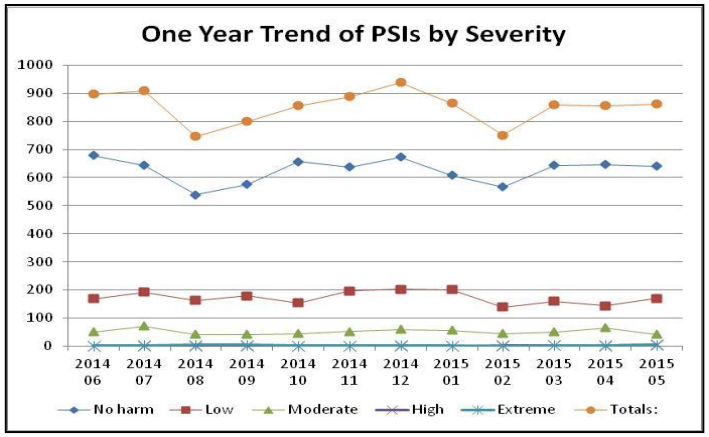
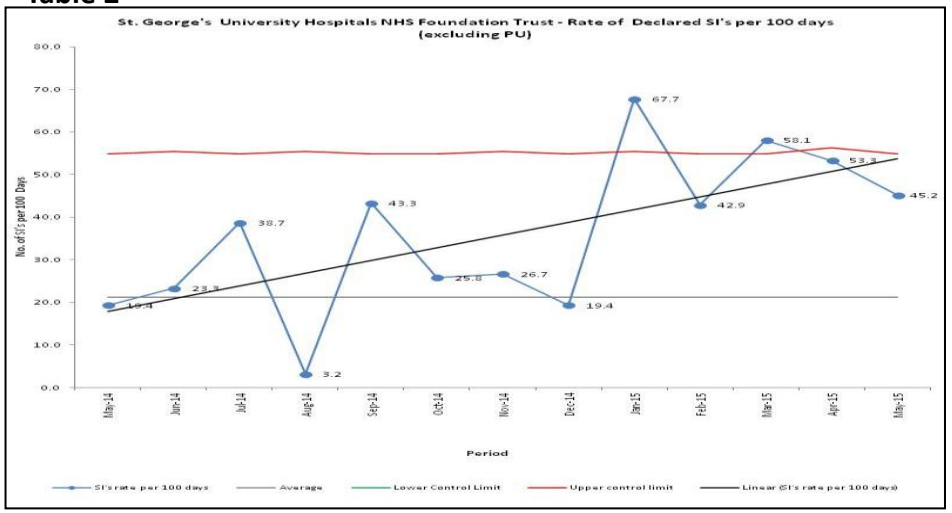


Table 2



Overview:
The numbers of general reported incidents are shown in Table 1. The number of no harm incidents appears to be increasing as are the numbers of moderate, high and extreme incidents. This trend should be observed carefully in conjunction with the trends and profile of SIs

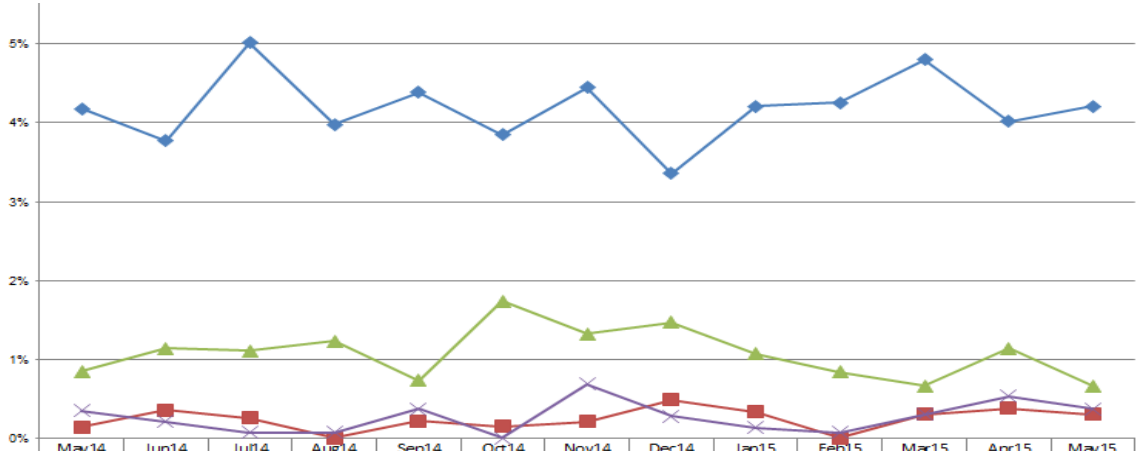
The annual trend for new serious incidents excluding pressure ulcers shown in Table 2 continues to show an increase. There were 14 general SIs reported in April (+4 grade 3 pressure ulcers).

The 14 general SIs declared in May relate to a range of different issues. They include:
- Death in custody
- Failure to follow up /assess/escalate
- Failure to follow up on test results
- Medication omission
- Maternity
- Retention of a surgical object
- 2 delayed LAS handover

The majority of these happened in one division, additional work is being done to identify themes that require additional preventative action.

7. Patient Safety
- Safety Thermometer

% Harm Free Care							
Lead Director	March 2015	April 2015	May 2015	**Movement**	**2015/2016 Target**	**National Average May 2015**	**Date expected to meet standard**
J Hall	94.39%	94.20%	94.61%	↑	95.00%	93.95%	March 16



	May14	Jun14	Jul14	Aug14	Sep14	Oct14	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15
Pressure Ulcers	4.18	3.77	5.02	3.98	4.39	3.85	4.45	3.36	4.21	4.26	4.8	4.02	4.21
Falls	0.14	0.36	0.26	0	0.22	0.15	0.21	0.49	0.33	0	0.3	0.38	0.3
Catheter & UTI	0.85	1.14	1.11	1.23	0.73	1.74	1.32	1.47	1.07	0.84	0.66	1.14	0.66
New VTE	0.35	0.21	0.07	0.07	0.37	0	0.69	0.28	0.13	0.07	0.3	0.53	0.37
Patients	1410	1405	1533	1458	1368	1377	1439	1429	1495	1433	1355	1320	1354

Pressure ulcers (57)

- 33 grade 2 (15 new, 18 old)
- 20 grade 3 (5 new, 15 old)
- 4 grade 4 (0 new, 4 old)

CAUTI (9)

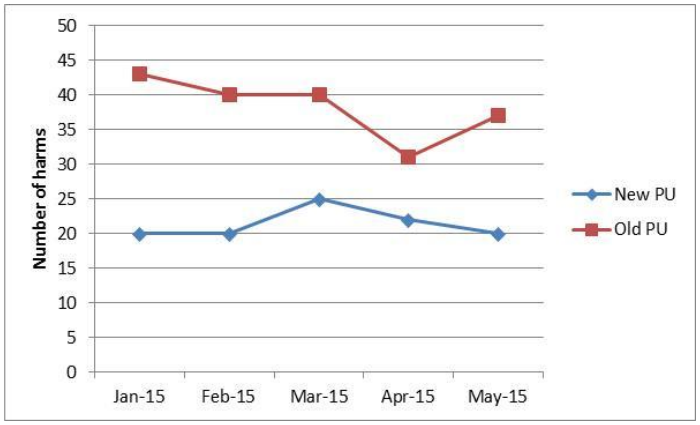
- 3 new
- 6 old

Falls (4)

- 3 low harm fall
- 1 moderate harm fall

VTE (5)

- 2 new DVT
- 3 new other



In May 2015 the proportion of our patients that received harm free care was 94.61%, which is very similar to levels reported in recent months and is slightly better than the national average for May of 93.95%. We reported 75 harms to 73 patients; 71 patients experienced one harm and 2 patients had 2 harms. 32 harms are categorised as new, meaning that they either developed or treatment began whilst under our care. Details of all harms reported are provided above.

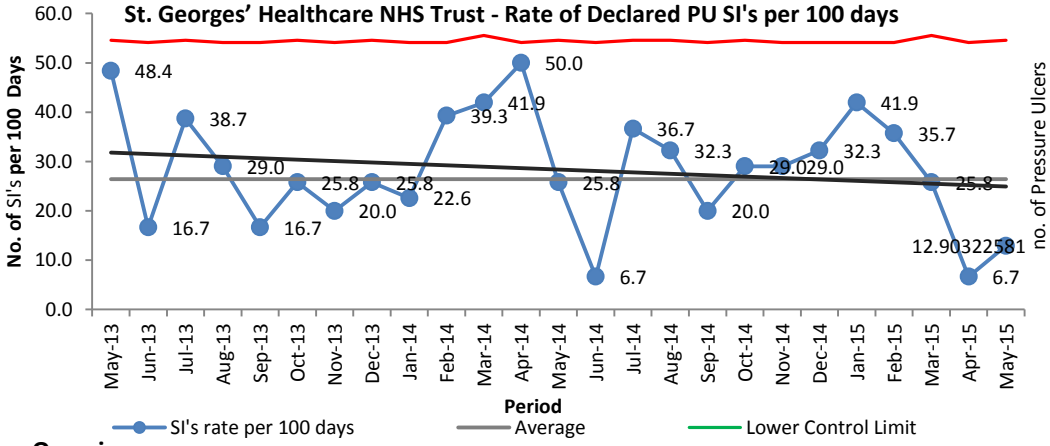
Harms related to pressure ulcers increased marginally this month. This increase is attributed to a greater number of old pressure ulcers observed. There was a decrease in harms reported for each of the remaining categories.

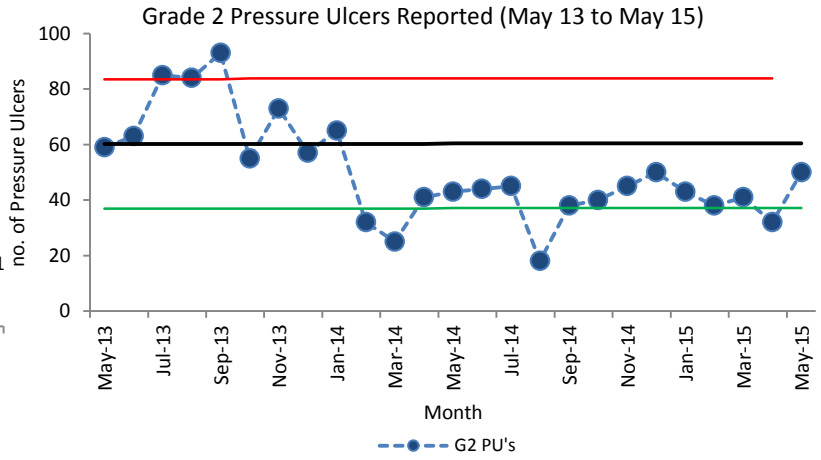
This month we received a letter from NHS England, inviting Trusts to review their approach to monitoring harm. We plan to continue using the Safety Thermometer, and will also implement the medication and children and young persons tools over the coming months.

7. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers										
Type	Jan	Feb	Mar	Apr	May	YTD April – May 2016	Movement	2015/2016 Target	Forecast March 2015	Date expected to meet standard
Acute	10	5	5	1	4	**5**	▲		G	-
Community	3	5	3	1	0	**1**	▼		G	-
Total All	13	10	8	2	4	**6**	▲		G	-
Total Avoidable	**8**	**3**	**2**	**2**	**4**	**6**		40		-

Grade 2 Pressure Ulcers						
Jan	Feb	Mar	Apr	May	Movement
22	18	30	25	37	▲
21	20	11	7	17	▲
43	38	41	32	50	▲





Overview:

May saw an increase in the total number of pressure ulcers across the trust. Despite this the community division achieved a zero incident rate of pressure ulcer SI's for the month.

Actions:

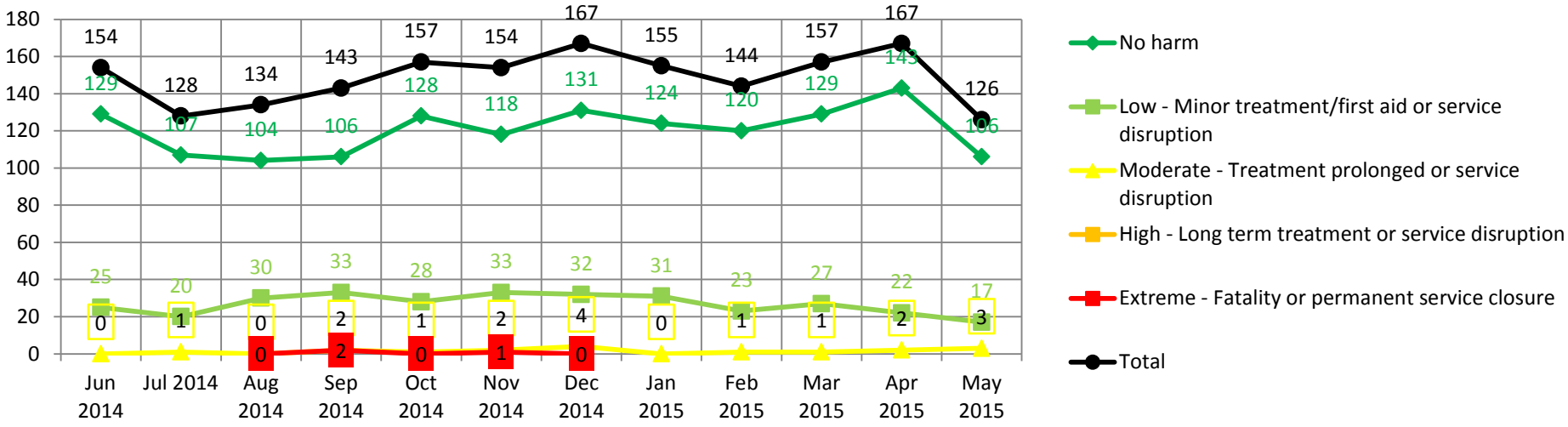
- Internal Trust trajectory set for 2015/2016 of 40 avoidable pressure ulcers , this is a 30% reduction on actual numbers last year 2014/2015
- Further work underway to agree and formulate the 72 hour checklist for avoidable pressure ulcers
- Recruitment underway for Band 7 TVN post in community and Band 6 Acute TVN – both replacement posts
- Quality improvement approach implemented to monitor trends in specific clinical areas on completion of pressure ulcer repositioning charts . Ward sisters and matrons engaged to own the progress and make changes to practice
- Pilot of a new risk assessment tool commenced on Keate ward

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

Falls														
Lead Director	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	Movement	2014/2015 Target	Date expected to meet standard
	151	151	125	143	157	154	169	154	144	157	165	126	⟷	100	July 2015

Falls with Harm April 2014-March 2015				
No Harm	Moderate	Severe	Death	Falls related Fractures
2064	25	3	0	7

Patient Falls by Incident date (Month and Year) and Severity



Overview: The graph shows the profile of falls across both acute and community services including bed-based care and patients' own homes. It is important to note that this data is sourced from incident reporting and is not individually verified. There has been a decrease in the number of falls in May which is promising but requires a further monitoring over the next few months to be significant. **Actions:** The Trust participated in the National Inpatient Falls Audit and the results will be available imminently from which an action plan will be developed. We will be auditing bed rail risk assessment compliance. We will be piloting the NICE compliant falls risk assessment in the coming months before full implementation.

7. Patient Safety: May 2015
- Infection Control

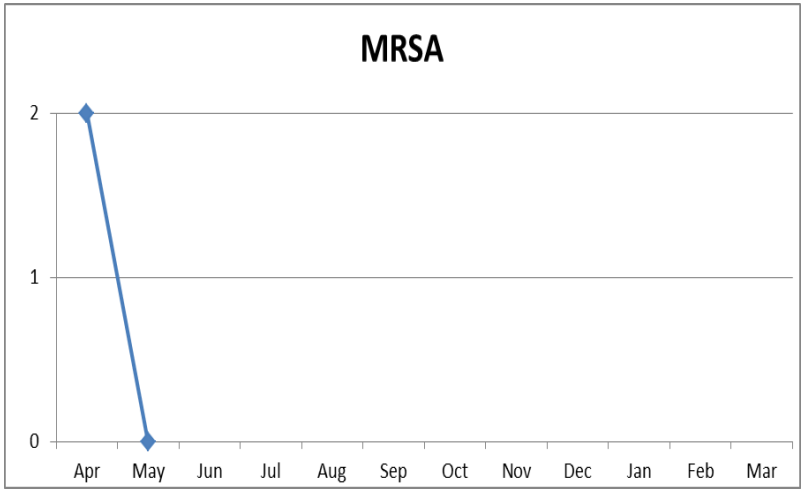
MRSA						
Lead Director	April	May	Movement	2015/2016 Threshold	Forecast June- 15	Date expected to meet standard
JH	2	0	⮟	0	G	-

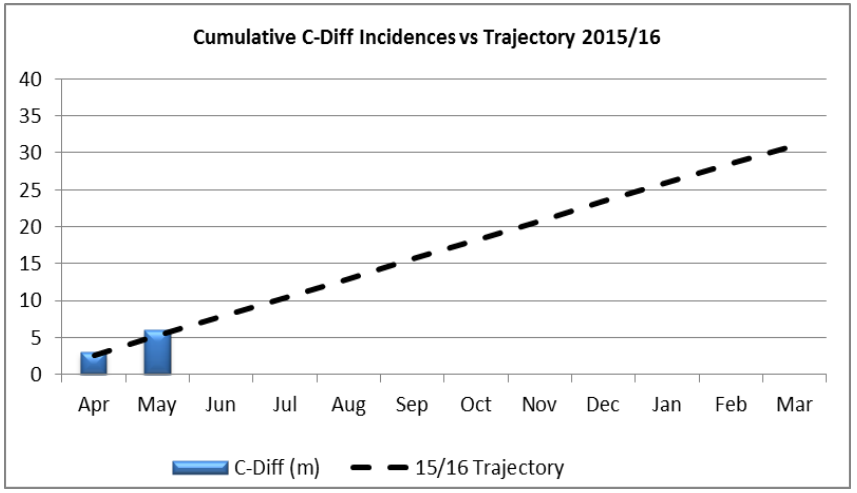
Peer Performance – YTD May 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
2	2	0	0	3

C-Diff						
Lead Director	April	May	Movement	2015/2016 Threshold	Forecast June - 15	Date expected to meet standard
JH	3	3	➤	31	R	-

Peer Performance – YTD May 2015 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
6 (31)	6(16)	10(9)	36(72)	12(39)

The MRSA bacteraemia threshold is zero. Their were no cases of MRSA bacteraemia in May. The trust is non-compliant with 2 incidents in total.
In 2015/16 the Trust has a threshold of no more than 31 C. diff incidents. In May there was 3 C. diff incidents , a total of 6 for the FY to end May.
All incidents are subject to RCA analysis with the themed reviews being considered by the Infection Control Committee.





7. Patient Safety - VTE

VTE Risk Assessment

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

Data Source	June	July	Aug	Sept	Oct	Nov	Dec	Jan (2015)	Feb	Mar	April	May
Unify2	97.33%	97.28%	96.60%	96.84%	94.91%	93.18%	93.51%	95.94%	96.03%	96.27%	96.64%	

2. Overview: Nursing staff collect data monthly across a range of safety indicators, including completion of VTE risk assessment, via the safety thermometer. Data is collected for all patients across the Trust on a single day of the month, representing a snapshot in time. Data is obtained from the drug chart and measures the total number of complete VTE risk assessments at the point of audit against the total number of beds occupied. **NB. The RAG ratings for the safety thermometer changed in April 2015 to be consistent with the UNIFY targets. This accounts for many of the red rated months below**

Data Source	June	July	Aug	Sept	Oct	Nov	Dec	Jan (2015)	Feb	Mar	April	May
Safety Thermometer (SGH)	85.22%	89.94%	86.51%	86.44%	85.39%	86.56%	75.92%	79.08%	83.89%	85.74%	89.83%	90.19%
National average	84.83%	84.62%	90.87%	85.50%	85.04%	84.19%	83.98%	84.69%	84.82%	84.69%		

Comparison of data streams:

The methodology applied to collect data and the standard being assessed differs for the above two data streams contributing to the differences in the results observed. Data submitted to UNIFY2 is generated automatically from electronic records for every patient admitted to the Trust (that meet the inclusion criteria for VTE risk assessment as outlined by NICE). The data is retrospective and records whether an assessment has been completed at any point during the patient's admission.

The Patient Safety Thermometer is a snapshot audit conducted once a month looking at every patient in the Trust at a certain point in time. A different nurse records the data on each ward which may introduce auditor variability. This audit is carried out against the standard that a patient has had a risk assessment completed on admission. If there is no risk assessment documented at the point of audit the patient is non-compliant. Up until the end of the 2014/15 financial year the % non-compliant also included patients for whom a risk assessment was 'not applicable'; for example paediatric patients or patients that were still within the first 24 hours of their admission. This contributed to lower compliance when compared to the UNIFY2 submission (for which these categories of patients were excluded). From April 2015 the patient safety thermometer data for St George's will be adjusted to remove results recorded as not applicable.

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

Current and Future developments:

- An electronic prompt has been installed in iClip to alert physicians if an admission VTE assessment has not been completed when a patient record is opened (a second prompt also triggers 18 hours after completion of the admission assessment if the follow up assessment has not been completed). Initial reports indicate that this has had a significantly positive impact on risk assessment completion and the timeliness of assessment completion in the 'live' areas.

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

Year		2015
HAT cases identified to date (attributable to admission at SGH)		88
Mortality rate	Total	11.4% (10/88)
	VTE primary cause of death	6.8% (6/88)
Initiation of RCA process		100%
RCA pending	<28 days since notification	26
	>28 days since notification (notes requested)	6
RCA complete		63.6% (56/88)

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

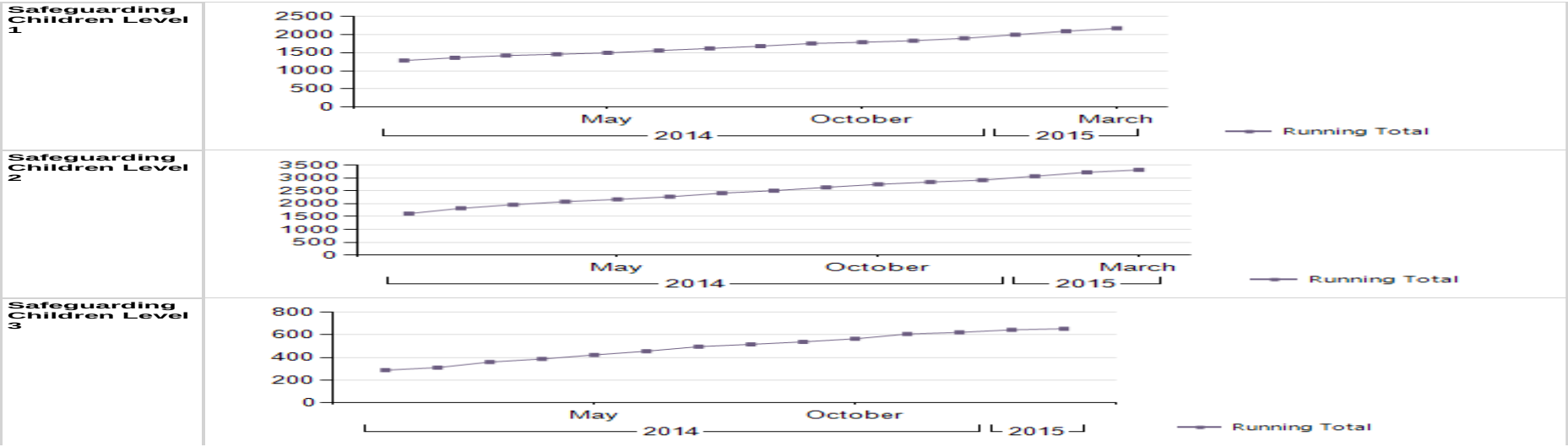
Trends identified (findings from 56 cases for whom RCA is complete):

- General breakdown includes:
  - 33.9% – patients had active cancer
  - 10 cases in regular day attenders (oncology/haematology/haemodialysis)
  - 2 cases of pulmonary embolism following stroke
  - 8 patients >100kg
- Adequate prophylaxis received 82.1% (46/56) –Examples of contributing factors to failure of prophylaxis:
  - 14 patients - malignancy +/- complications arising from malignancy
  - 10 patients – pharmacological prophylaxis contraindicated
  - 3 patients – previous VTE which recurred after stopping treatment
  - 1 patient with thrombosis due to heparin induced thrombocytopenia (HIT)
- Inadequate prophylaxis received 17.9% (10/56) – Examples of reasons for inadequate prophylaxis:
  - 3 patients - Dose of LMWH not escalated appropriately in obesity
  - 3 patients – Doses of LMWH omitted with no clear documented reason
  - 2 patients – Treatment for previous VTE stopped too soon
  - 1 patient not given extended VTE prophylaxis on discharge where indicated

Results and recommendations following RCA of 2014 HAT cases were presented at the WCCC Divisional Governance meeting on 14/05/15. They will presented at MedCard Divisional Governance Board on 18/06/2015.

7. Patient Safety
- Safeguarding Children

Safeguarding Training data 2014 -2015



Target areas: Training compliance is a targeted area for the safeguarding team and specific work has been done this month in drilling down into the data. This has enabled the team to identify areas both of particular concern and of good compliance. This deep dive into the data has revealed that a number of areas that are seen as high priority areas for safeguarding children have excellent compliance with mandatory level 3 safeguarding training . in the acute division the paediatric wards have excellent compliance; examples include Freddie Hewitt Ward (23 staff) 100% Pinckney Ward (34 staff) 97% and in the community, health visiting compliance is 93% and school nursing 95%. Another 21 staff attended training in the community on June 11th but this is not yet included in the data.
The safeguarding team working party are focusing on developing an action plan that will target the non-compliant high priority areas as a matter of urgency.

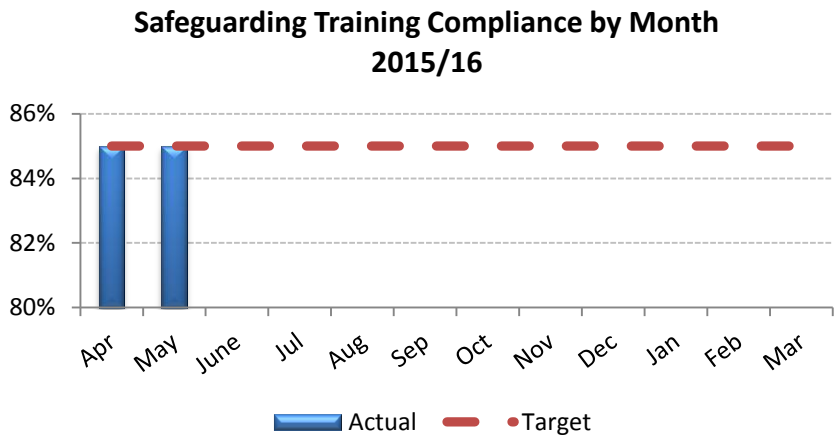
Serious Case Reviews and Internal Management Reviews: There have been no new SCR/IMR cases declared this month, although staff are still working on the cases already in progress. The Kingston SCR (Family C) timeframe has been extended to September 2015.

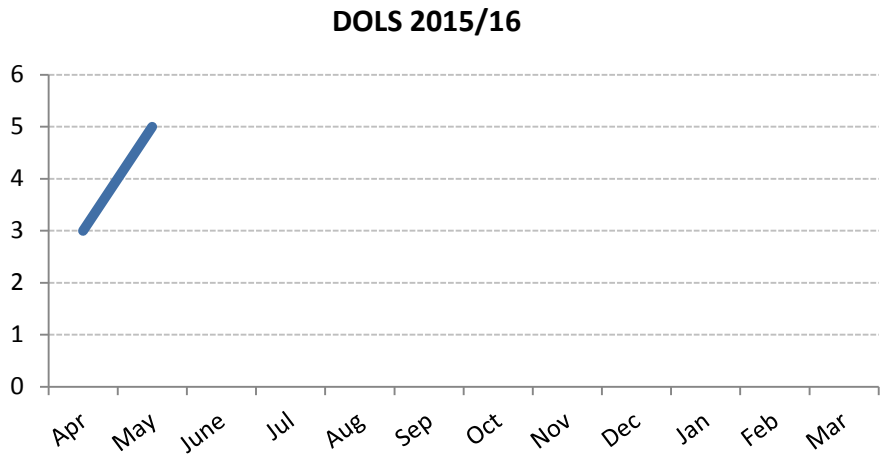
Other: Section 11 Audit – except from letter received by the Chief Nurse from Nicky Pace, the Independent Chair of Wandsworth Safeguarding Children Board
" I am writing on behalf of the WSCB and Panel to thank you and your staff for participating in the audit process this year. We were extremely impressed again, like last year, at the significant amount of workers within St George's Hospital Trust (both Acute and Community Services) who completed the S11 self-assessment questionnaire. You exceeded your great achievement of last year, from 353 to 460! Please extend my appreciation to everyone who participated in the process.

7. Patient Safety
- Safeguarding: Adults

Safeguarding Training Compliance - Adults									
Lead Director	Dec	Jan	Feb	Mar	April	May	2015/20165 Target	Forecast April 2015	Date expected to meet standard
JH	87.3%	87%	86.2%	87%	85%	85%	95%	A	-

Safeguarding Adults Training Compliance by Division – May 15				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
81%	83%	89%	88%	83%





Overview:

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

April – 74, May 76, June 77, July 84, Aug 45, Sep 74 Oct 76, Nov 75, Dec 68, Jan 77, Feb 70, Mar – 80, Apr 90, May – 70,

Currently there is no centrally held record of MCA training but as part of the action plan around MCA following the CQC report, training has been delivered and recorded, beginning with Queen Mary's, Roehampton., where 99% staff have been trained.

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

Actions:

Continue to monitor safeguarding training via ARIS

Review procedures following implementation of Care Act - Awaiting revision of Pan London Procedures due July 2015

Roll out MCA training across trust, audit effectiveness

Review DOLs activity and impact on resources. Monitor demand on services versus capacity to complete assessments. Produce fresh guidance on DOLS in conjunction with Law Society guidance. Revised briefing paper with legal team was presented to EMT In November indicating current position, impact on resources and future options to manage the governance and workload..Further review of legal position requested from Trust solicitors to ensure compliance with current case law. New DOLS paperwork circulated Jan 15. New procedure in place to ensure reporting of those subject to DOLS are reported to the coroner

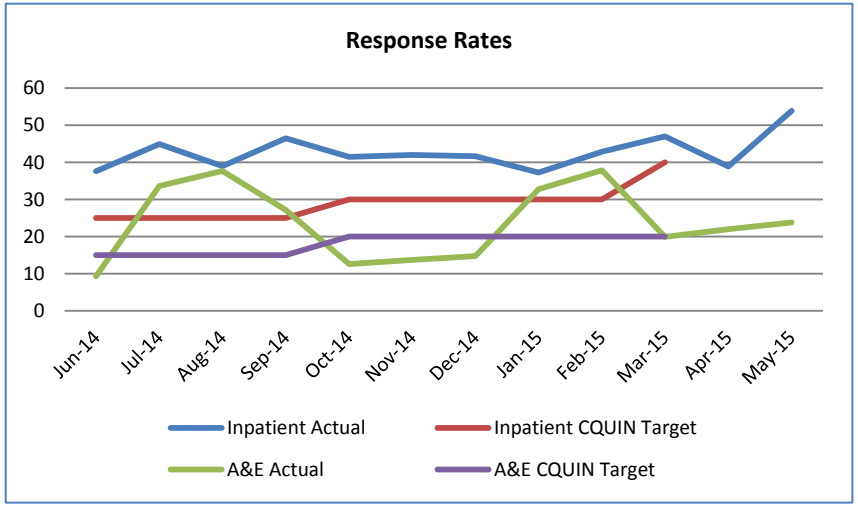
St George's University Hospitals NHS
NHS Foundation Trust

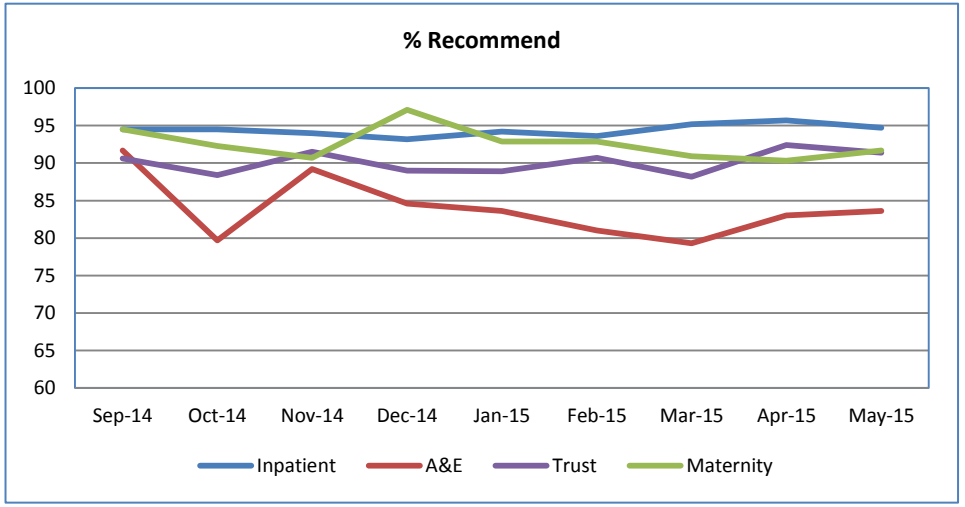
Patient Experience

8. Patient Experience
- Friends and Family Test

FFT Response Rate							
Domain	Mar-15	Apr-15	May-15	Movement	2015/2016 Target	Forecast	Date expected to meet standard
Trust	29.5	28.9	34.3	▲	-	-	-
Inpatient	47	38.9	53.9	▲	-	-	-
A&E	22	23.8	25.5	▲	-	-	-
Maternity	25.3	24	24.3	▲	-	-	-

	FFT Response Score			
	Mar-15	Apr-15	May-15	Movement
	88.2	92.4	91.4	▼
	95.2	95.7	94.7	▼
	79.3	83	83.6	▲
	90.9	90.3	91.7	▲





Overview : All CQUINs were met for last year. We are now exploring how to shift our focus from response rates to the content of what our patients are telling us. We are trialling new reports that focus on the 3 areas we score the lowest on.

Action :

Continue to monitor response rates, and monitor the 5 poorest performing services in the key areas of noise at night, information about medication side effects and involvement in the discharge process.

Improve the co-ordination of patient experience data with other quality metrics.

8. Patient Experience
- Triangulation of Patient Experience Themes – Q4 2014/15

Complaints	PALS	Inpatient Survey
1. Clinical treatment 2. Communication 3. Waiting times	1. Appointments 2. Communication 3. Request for information	1. Excessive noise at night – caused by staff and/or other patients 2. Information about medication side effects 3. Being involved in decisions about discharge

From the above, we can see similarities between the themes in complaints and PALS – these methods of patient feedback allow patients to choose their topic of concern. In contrast, our patient survey feedback is guided by the questions we ask in the survey.

Within the patient responses in the inpatient survey, there is currently a question relating to respect and dignity which has very positive responses. This could be linked to communication and staff attitude. However, further work will be required to drill down into communication and staff attitude.
This will enable us to align our survey questions to focus on the problem areas identified by Complaints and PALS.

Actions:

Conduct an in-depth analysis of complaints and PALS contacts that relate to the top three issues, and use our finding to amend the current inpatient, outpatient and community services surveys. If patients suggest they have problems with any of these themes, we will ask additional questions to fully understand the cause.

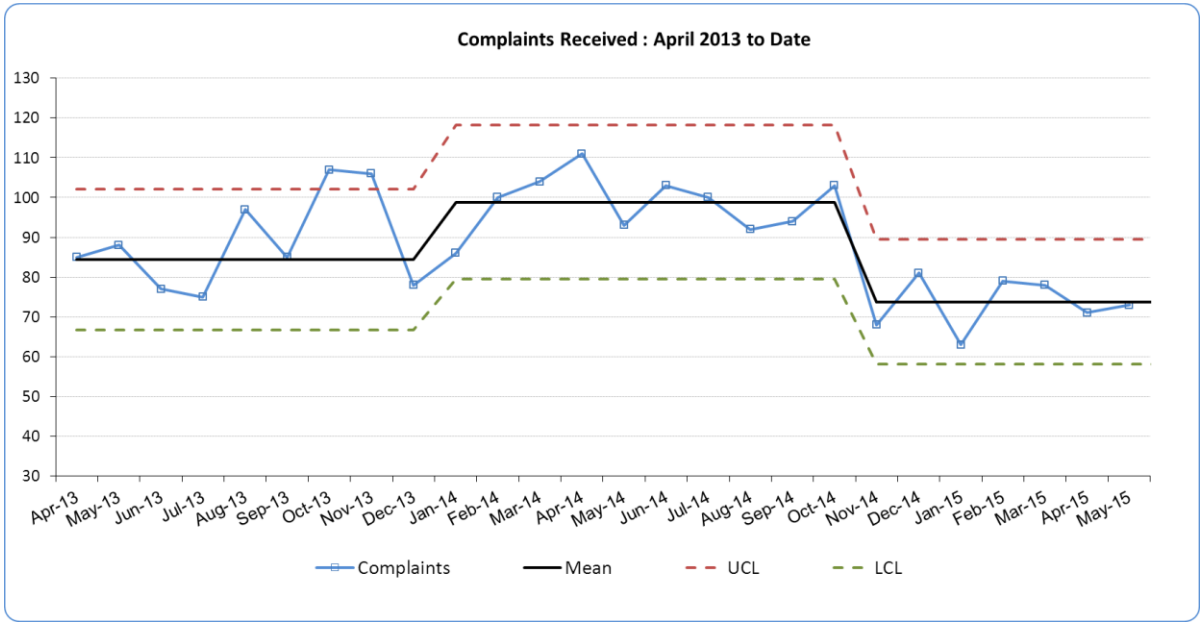
8. Patient Experience
- Triangulation of Patient Experience Data (1st May to 31st May 2015)

Specialty	PALS	Complaints	FFT Score
Accident and Emergency	3	2	85
Cardiology	6	2	92.9
Cardiothoracic Surgery	4	1	94.8
Clinical Haemotology	0	0	100
Ears Nose & Throat	8	4	97.1
Gastroenterology	4	0	89.3
General Medicine	2	3	95.2
General Surgery	10	3	95.3
Gynaecology	17	0	95
Infectious Disesases	0	0	96.6
Medical Oncology	0	0	100
Nephrology	0	0	100
Neurology	5	3	98.9
Neurosurgery	10	2	98.3
Paediatric Medicine	5	5	85.4
Plastic Surgery	9	1	98.2
Rehabilitation	0	0	100
Respiratory Medicine	0	0	100
Senior Health	3	0	88.4
Trauma & Orthopaedics	27	4	94.9
Urology	5	0	94.9

All specialties who had a 100% ‘recommend’ rate from their patients had no PALS contacts or Complaints during the month of May

8. Patient Experience
- Complaints Received

Complaints Received															
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	Movement
Total Number received	111	92	100	99	92	94	107	68	81	63	79	78	71	73	=



Overview:

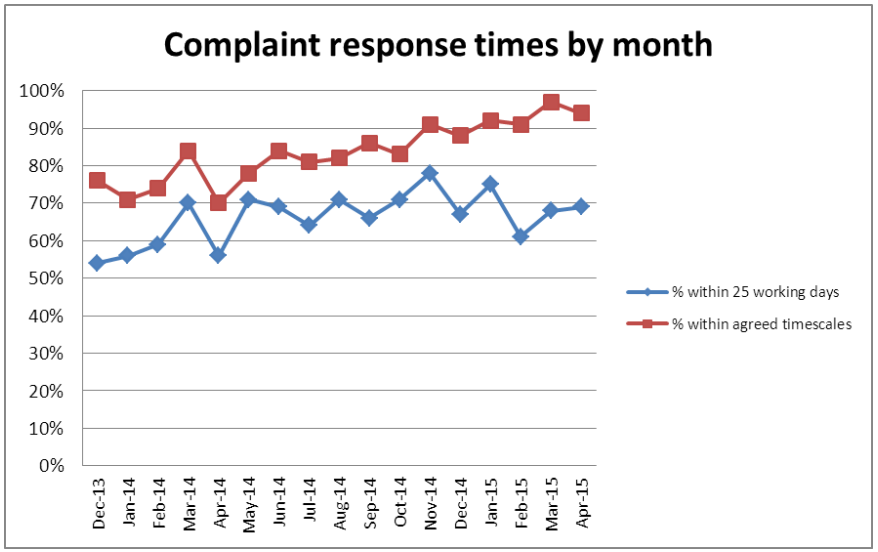
This report provides a brief update on complaints received since the last board report (so in May 2015) and information on responding to complaints within the specified timeframes for complaints received in April of 2015/2016. It also includes some posts made on NHS Choices and Patient Opinion. The board will receive more detailed information about complaints received in quarter 1 with divisional breakdowns, analysis of the data to provide trends and themes with actions planned and a severity rating report and once the target date for complaints received in quarter 1 is reached (so August 2015).

Total numbers of complaints received in May 2015

There were 73 complaints received in May of 2015, no real change from April 2015 when 71 complaints were received. 10 complaints received in April have been de-escalated since the last board report hence why 81 complaints were reported last month. Of note , there was a reduction in complaints being received about the Accident and Emergency care group from 9 complaints in April to 2 in May. There was an increase in complaints received about the Imaging care group from 0 in April to 3 in May, 1 was for Diagnostic Radiology and 2 for Breast Screening. The 2 complaints did not share any common themes. The number of complaints being received about the Offender Healthcare care group remains high with 8 having been received in April and 10 in May with the most complained about subject being clinical treatment – medication.

8. Patient Experience
- Complaints Performance against targets

Performance Against Targets April 2015				
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	11	5	45%	(4) 82%
Medicine and Cardiovascular	22	14	64%	(7) 95%
Surgery & Neurosciences	21	16	76%	(5) 100%
Community Services	16	14	88%	(2) 100%
Corporate Directorates	1	1	100%	(0) 100%
Totals:	71	50	70%	(18) 96%



Overview:

For complaints received in quarter 1 of 2015/2016 so far, so April of 2015, 70% were responded to within 25 working days, 1% higher than in quarter 4 of 2014/2015. Community Services and Corporate Directorates exceeded the target of 85% whereas the other divisions missed the target, Women's and Children's and Medicine and Cardiovascular by a considerable margin.

For the same period 96% of complaints are planned to be responded to within 25 working days or agreed timescales, the same percentage as in quarter 4 of 2014/2015. The final percentage may change depending on whether all of the agreed extensions are eventually met. For the first time three divisions are planning to respond to 100% of complaints within agreed timescales.

Actions:
There are two months left in quarter 1 in which to improve the position and an update will be provided in the July board report when the targets will have been reached for complaints received in May 2015.

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

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

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

Dennis Roberts gave Vascular Services at St George's Hospital (London) a rating of 5 stars
Abdominal aorta aneurism repair
I was admitted for the above procedure on Sunday, had two days of tests, all as previously advised. Operation took place on Wednesday taking two hours under general anaesthetic and I was discharged on Friday afternoon having had two stents fitted. I suffered no pain or after effects and am delighted with the outcome. The nursing staff also have my thanks as their care was exemplary.

I am 78 years 11 months old too ! Wow

Visited in April 2015. Posted on 27 April 2015

Anonymous gave Maternity Services at St George's Hospital (London) a rating of 5 stars
Antenatal Day Monitoring Unit
Got myself in a right state worrying about my baby's heartbeat. Made one call to the DMU in The Lanesborough Wing and was invited in that same day to have the heart listened to. Absolutely stellar care and sensitivity shown to me by members of that team: They had all the time in the world for me and made me feel so cared for. Brilliant experience, and so reassuring.

Visited in May 2015. Posted on 27 May 2015

Anonymous gave Orthopaedics at St George's Hospital (London) a rating of 1 stars
Dissatisfied with Doctor's attitude
I went to the fracture clinic with my 18 month old daughter as she had a nasty fall down the stairs yesterday and was diagnosed with a bend in the right wrist bone by the A&E at St. Georges. The doctor at the A&E put on a temporary bandage on my daughter's wrist/ arm and I was asked to book an appointment at the fracture clinic the next day to have the doctor check my daughter's wrist thoroughly (for swelling etc) and have a proper cast put on her arm. I was given a 4 pm appointment for the next day. At the fracture clinic, I waited for over 1 hour before I was finally taken to the examination room (at 5:10 pm or so). While I was waiting in the examination room, the fire alarm went off (probably a false alarm or a drill as the doctors stayed inside and did not bother coming out with the rest of us) and we (patients and nurses) moved out of the premises.

While we were moving out, I heard one of the doctors telling the nurse that this was it and no more patients could be seen, upon which the nurse (thankfully!) objected and said that this wasn't fair since I had been waiting for over 1 hour for my appointment. The said doctor obviously was in no mood to wait and while we were all waiting outside. The doctor came to me and said that they had seen the x ray and that I should come back after 2 weeks to see them, and no check up was required today. All this was brought to my notice while I was standing outside waiting for the fire alarm to go off! Interestingly, all through this conversation, the doctor kept mistaking my daughter for a boy - and that really makes me wonder if the doctor really even read the case notes! I am totally shocked and appalled at the attitude of this doctor (whose name unfortunately I don't know). They just brushed my daughter off only because checking her would have delayed them by a few minutes. She was also not given a proper cast because the doctor was ready to call it a day! I have never seen such an apathetic attitude from the medical fraternity, St. George's hospital should be ashamed of having such a bad doctor and more importantly a terrible human being on its rolls.

Visited in May 2015. Posted on 27 May 2015

St George's University Hospitals NHS
NHS Foundation Trust

Workforce

excellent kind responsible respectful

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

Overview

The information provided on the table above relates to staffing numbers at ward/department level submitted nationally on Unify for May 2015. In line with new national guidance this table shows the number of filled shifts for registered and unregistered staff during day and night shifts. In May the trust achieved an average fill rate of 95.5%, a slight increase from 94.1% submitted in April . Data cleansing continues to ensure that the report is being run consistently and only relevant front line nursing roles are included.

A new standard operating procedure was introduced which has assisted in speeding up validation of the data but still requires improvement. The presentation of the data provided internally has been changed to assist the reader in reviewing data more easily by division. For the purposes of the quality report the UNIFY report is provided.

Although some of our wards are operating below 100% the data does not indicate if a ward is unsafe. Safe staffing is much more complex than an observation of percentages and takes in to account many key aspects such as:
Nurses, midwives and care staff work as part of a wider multidisciplinary ward team. The demand on wards can change quickly and it will always be a clinical judgement as to whether to bring more staff in or reduce the amount the staff as per requirement.

- The data does not take into account the on-going considerations for ward managers in ensuring that on each shift there is the right level of experience and expertise in the ward team.
- The nature of each ward varies. The number and type of patients seen on some wards will be relatively consistent. The number and type of patients seen on other wards will vary more dramatically, meaning that there could be greater change from the planned level and the average will be somewhere in the middle of the highs and lows of this variation.
- There needs to be the operational context of the reasons for staffing levels month on month, for example reduced demand.
- Higher than 100% fill rates relate to areas which require more staff than they are profiled for. This could be because the patients the team are looking after are exceptionally unwell or require one to one nursing or supervision called specialling. This is an anomaly in the data which is to be reviewed.
- St George's Healthcare NHS Trust has a safe staffing policy and a system in place for monitoring staffing levels on a daily basis. Nursing and midwifery clinical leaders visit their clinical areas across the trust at least once a day to ensure safe staffing and staff are encouraged to escalate any concerns they have to the chief nurse on duty. The acuity/dependency of patients (how sick or dependent they are) is also monitored closely as this ultimately affects the type and amount of care patients need. If concerns are raised about staffing levels, the clinical leaders may make the decision move members of staff across the trust so that the area is safely staffed. This ensures that our patients are well cared for.

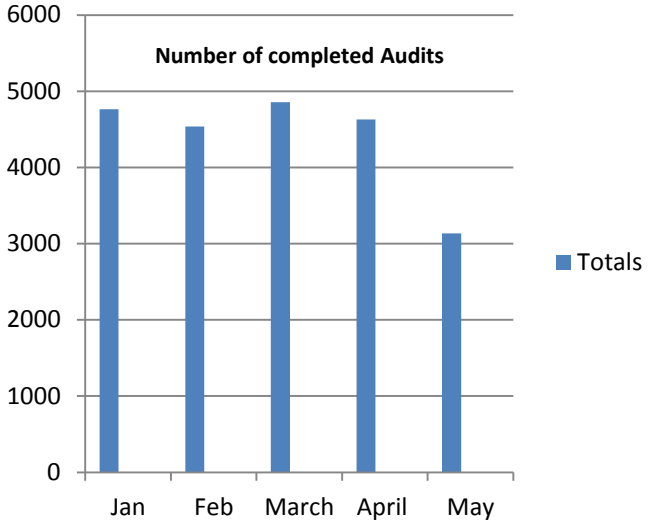
Actions

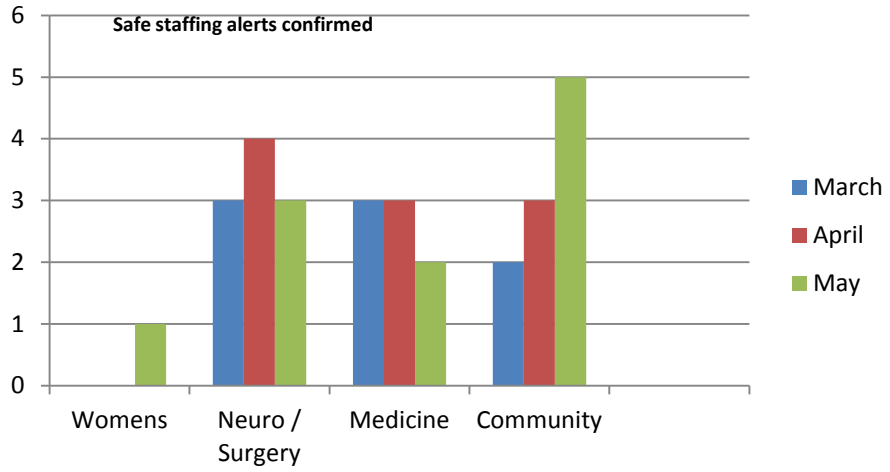
- The Deputy Chief Nurse has set up a task force to review the way UNIFY data is collected, validated and reported.
- Await reporting guidance from NICE expected in June 2015
- Review the data collection process to ensure it links with eRostering and is able to identify run rate savings

9. SAFE STAFFING: UNIFY REPORT FOR INPATIENT AREAS

	Day		Night		
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Overall %
Cardiothoracic Intensive Care Unit	90.2%	100.0%	98.5%	100.0%	94.33%
Carmen Suite	94.0%	88.2%	100.1%	93.5%	95.73%
Champneys Ward	91.6%	102.6%	98.4%	100.0%	95.84%
Delivery Suite	104.1%	87.4%	110.2%	87.1%	103.79%
Fred Hewitt Ward	91.0%	104.2%	97.6%	60.0%	94.40%
General Intensive Care Unit	94.3%	14.4%	98.9%	100.0%	93.82%
Gwillim Ward	120.1%	90.7%	100.8%	100.0%	107.13%
Jungle Ward	103.2%	#DIV/0!	#DIV/0!	#DIV/0!	103.18%
Neo Natal Unit	96.1%	-431.3%	102.2%	#DIV/0!	100.85%
Neuro Intensive Care Unit	92.9%	78.3%	98.1%	99.8%	94.92%
Nicholls Ward	93.9%	85.2%	100.3%	93.6%	95.32%
Paediatric Intensive Care Unit	120.1%	96.3%	119.4%	100.0%	116.67%
Pinckney Ward	110.2%	116.0%	98.1%	#DIV/0!	107.51%
Dalby Ward	88.6%	98.5%	96.8%	98.9%	95.45%
Heberden	93.2%	99.0%	98.0%	98.8%	97.11%
Mary Seacole Ward	92.5%	98.3%	96.7%	100.0%	96.73%
A & E Department	92.8%	80.2%	94.8%	84.7%	91.59%
Allingham Ward	85.3%	116.5%	95.2%	100.1%	96.62%
Amyand Ward	88.3%	100.0%	98.8%	98.9%	94.98%
Belgrave Ward AMW	87.7%	74.0%	100.0%	100.0%	89.09%
Benjamin Weir Ward AMW	89.9%	86.3%	99.3%	95.2%	92.76%
Buckland Ward	80.7%	93.2%	98.9%	100.0%	89.27%
Caroline Ward	89.9%	92.8%	99.2%	100.0%	93.74%
Cheselden Ward	96.7%	82.1%	95.7%	95.0%	94.68%
Coronary Care Unit	99.0%	#DIV/0!	100.0%	#DIV/0!	99.50%
James Hope Ward	95.1%	86.2%	97.3%	#DIV/0!	94.23%
Marnham Ward	80.5%	79.4%	94.7%	90.7%	85.88%
McEntee Ward	98.2%	98.9%	97.8%	100.0%	98.47%
Richmond Ward	91.1%	91.0%	94.9%	97.4%	93.28%
Rodney Smith Med Ward	90.5%	88.8%	98.9%	98.6%	93.17%
Ruth Myles Ward	97.0%	103.7%	98.9%	99.1%	98.74%
Trevor Howell Ward	97.4%	89.0%	98.9%	100.0%	96.78%
Winter Ward (Caesar Hawkins)	90.2%	90.0%	91.9%	100.0%	91.81%
Brodie Ward	93.9%	96.0%	99.7%	100.0%	96.47%
Cavell Ward	97.6%	118.5%	100.0%	100.0%	102.16%
Florence Nightingale Ward	92.6%	98.0%	103.8%	100.0%	97.27%
Gray Ward	94.5%	88.9%	98.4%	100.0%	95.21%
Gunning Ward	92.2%	82.2%	99.0%	96.9%	92.56%
Gwynne Holford Ward	79.0%	81.3%	98.4%	96.9%	86.42%
Holdsworth Ward	89.9%	97.2%	97.9%	98.5%	94.61%
Keate Ward	96.4%	96.5%	100.0%	#DIV/0!	97.59%
Kent Ward	90.9%	86.2%	99.1%	99.0%	92.87%
Mckissock Ward	92.5%	94.9%	97.6%	100.0%	95.17%
Vernon Ward	94.5%	88.6%	99.1%	99.9%	95.35%
William Drummond HASU	89.0%	85.2%	95.9%	90.0%	91.40%
Wolfson Centre	94.4%	96.5%	100.0%	100.0%	97.20%
Gordon Smith Ward	#DIV/0!	0.0%	#DIV/0!	0.0%	0.00%
Nightingale Step Down, Off Site Facility	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Trust Total	93.82%	90.40%	99.33%	97.38%	95.50%
	Day Qual	Day HCA	Night Qual	Night HCA	Overall
	93.82%	90.40%	99.33%	97.38%	95.50%

9. Workforce
May 2015 - Safe Staffing alerts





Overview: The purpose of the daily safe staffing audit is to identify areas that are unsafely staffed (known as alerts) and to ensure through a process of escalation that this situation is remedied. Alerts (identifying that a ward is unsafely staffed) are raised to senior nurses through a daily report on the RATE system. The safe staffing policy provides guidance on escalation and interventions that can be undertaken to make areas safe. The total number of audits that should be completed across the organisation monthly is approximately 6500. Wards are expected to complete the audit twice daily whilst community and out-patient teams tend to complete it on a daily basis.

The total number of safe staffing audits completed over the past three months were: February 4535, March 4857and April 4629. There was a slight increase in the number of final alerts reported from 10 in April to 11 in May. Four of the community alerts are for one service. This service has a low number of posts but a high vacancy rate. The service has an action plan in place to cover the workload. The number of alerts reduced to a concern (ward is safely staffed but some care needs will not be completed) has slightly decreased during the previous three months following on the day investigation (March 25, April 15, May 18).

2 nursing related safe staffing concerns were raised on Datix system compared to 10 in April. Only one of the Datix reports matched a similar entry on the RATE system.

Actions: Continue to raise the link between Datix and the rate system with the nursing body with the aim to achieve greater consistency.

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Heatmap Dashboard
Ward view

excellent kind responsible respectful

10. Ward heatmap

		INCIDENCE OF C.DIFFICILE	INCIDENCE OF MRSA	TRUST ACQUIRED PRESSURE ULCERS	PERCENTAGE OF HARM FREE CARE	PATIENT SATISFACTION (FRIENDS & FAMILY)	FRIENDS & FAMILY RESPONSE RATE	WARD STAFFING: UNFILLED DUTY HOURS	FALLS (WARD LEVEL)	SERIOUS INCIDENTS (WARD LEVEL)	SICKNESS/ ABSENCE RATE - (WARD)
Children & Women's	CARDIOTHORACIC INTENSIVE C..	0.0	0.0	0.0	94.1	0.0		5.7	1.0	0.0	4.7
	CARMEN SUITE	0.0	0.0	0.0	100.0		0.0	4.3	1.0	0.0	7.3
	CHAMPNEYS	0.0	0.0	0.0	100.0	95.0	50.4	4.2	0.0	0.0	6.0
	DELIVERY	0.0	0.0	0.0	100.0		0.0	-3.8	0.0	0.0	4.1
	FREDDIE HEWITT	0.0	0.0	0.0	100.0		120.0	5.6	0.0	0.0	4.7
	GENERAL ICU/HDU	0.0	0.0	0.0	82.4	0.0	0.0	6.2	0.0	0.0	3.2
	GWILLIM	0.0	0.0	0.0	100.0	87.8	51.5	-7.1	0.0	0.0	8.4
	JUNGLE	0.0	0.0	0.0			0.0	-3.2	0.0	0.0	5.2
	NEONATAL ICU	0.0	0.0	0.0	100.0	100.0		-0.8	0.0	0.0	2.7
	NEURO ICU	1.0	0.0	0.0	84.6		20.0	5.1	0.0	0.0	5.8
	NICHOLLS	0.0	0.0	0.0	100.0		0.0	4.7	1.0	0.0	2.4
	PICU	0.0	0.0	0.0	100.0	100.0		-16.7	0.0	0.0	1.6
	PINCKNEY	0.0	0.0	0.0	100.0	87.5	400.0	-7.5	0.0	0.0	1.2
Medicine & Cardiovascular	ALLINGHAM	0.0	0.0	0.0	92.9	89.3	46.7	3.4	2.0	0.0	9.1
	AMYAND	0.0	0.0	0.0	100.0	100.0	15.4	5.0	12.0	0.0	4.0
	BELGRAVE	0.0	0.0	0.0	97.1	84.3	103.4	10.9	2.0	0.0	1.8
	BENJAMIN WEIR	0.0	0.0	0.0	96.7	97.4	72.0	7.2	0.0	0.0	1.4
	BUCKLAND	1.0	0.0	0.0	94.7	100.0	39.5	10.7	1.0	1.0	3.9
	CAESAR HAWKINS	0.0	0.0	0.0	81.0	90.0	18.9	8.2	7.0	0.0	4.1
	CARDIAC CARE UNIT	0.0	0.0	0.0	100.0	93.3	125.0	0.5	1.0	0.0	1.2
	CAROLINE	0.0	0.0	0.0	100.0	94.4	55.1	6.3	3.0	0.0	1.1
	CHESELDEN	0.0	0.0	0.0	88.4	97.0	39.8	5.3	3.0	0.0	6.9
	DALBY	0.0	0.0	2.0	88.5	71.4	23.3	4.6	1.0	2.0	5.7
	EMERGENCY DEPARTMENT	0.0	0.0	0.0		52.0	25.5	8.4	1.0	2.0	2.3
	HEBERDEN	0.0	0.0	0.0	75.0	88.9	23.7	2.9	8.0	0.0	6.2
	JAMES HOPE	0.0	0.0	0.0	100.0	100.0	60.0	5.8	0.0	0.0	2.8
	MARNHAM	0.0	0.0	0.0	100.0	100.0	36.8	14.1	3.0	1.0	7.8
	MCENTEE	0.0	0.0	0.0	94.4	96.6	65.9	1.5	2.0	0.0	0.8
	RICHMOND	0.0	0.0	0.0	94.9	95.6	34.3	6.7	14.0	1.0	4.8
	RODNEY SMITH	1.0	0.0	0.0	74.1	90.0	34.3	6.8	0.0	0.0	3.8
	RUTH MYLES	0.0	0.0	0.0	100.0	100.0	40.0	1.3	0.0	0.0	0.4
	TREVOR HOWELL	0.0	0.0	0.0	94.4	100.0	38.3	3.2	2.0	0.0	5.6
Surgery & Neurosciences	BRODIE NEURO	0.0	0.0	0.0	100.0	100.0	50.0	3.5	0.0	0.0	1.2
	CAVELL	0.0	0.0	0.0	100.0	94.4	61.3	-2.2	0.0	0.0	7.0
	FLORENCE NIGHTINGALE	0.0	0.0	1.0	90.0	97.1	92.9	2.7	3.0	1.0	1.6
	GRAY WARD	0.0	0.0	0.0	100.0	96.2	40.0	4.8	3.0	0.0	4.3
	GUNNING	0.0	0.0	1.0	95.8	94.1	63.0	7.4	1.0	2.0	1.3
	GWYN HOLFORD	0.0	0.0	0.0	100.0	100.0	33.3	13.6	14.0	0.0	7.5
	HOLDSWORTH	0.0	0.0	0.0	95.2	95.6	60.0	5.4	3.0	0.0	5.6
	KEATE	0.0	0.0	0.0	100.0	98.2	92.7	2.4	0.0	0.0	0.0
	KENT	0.0	0.0	0.0	100.0	0.0	0.0	7.1	4.0	0.0	1.1
	MARY SEACOLE	0.0	0.0	0.0	77.8	0.0	14.3	3.3	4.0	0.0	10.5
	MCKISSOCK	0.0	0.0	0.0	95.0	98.3	69.8	4.8	7.0	0.0	6.1
	VERNON	0.0	0.0	0.0	96.7	94.9	56.3	4.7	2.0	0.0	4.9
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	100.0	96.7	29.7	8.6	2.0	0.0	3.6

10. Ward heatmap:
- CWDT&CC Division

ACC

- For ACC, x 1 C Diff on NICU – probably a carrier, action to ensure that the Consultant agrees to stool specimens.
- Safety thermometer, GICU x 2 UTI's. Catheters were required. NICU x 2 new Grade 3 pressure ulcers, being investigated
- FFT – Not sure why showing red as ACC do not do FFT as patients transferred within Trust not discharged

Midwifery

- Some confusion as to when FFT should be completed, Charlotte James will chase to get improvement.

10. Ward heatmap:
- STNC Division

The report focuses on areas with any red indicator or those with three or more indicators. The key areas where alerts can be seen are consistent and relate to pressure ulcers, harm free care, friends and family response rate, falls and sickness. There are 9 red alerts for May compared to 12 for the previous reporting period. There is a decrease in overall numbers of alerts from 16 to 10.

Florence Nightingale – 3 red indicators – 1 grade 3 pressure ulcer shared with GICU, the root cause of which identified shear/friction during transfer between theatres/GICU for emergency surgery. The percentage of harm free care alert related to the above pressure ulcer and 1 VTE assessment. The SI alert relates to the previously described pressure ulcer.

Gunning – 2 red indicators – 1 grade 3 pressure ulcer – The root cause analysis identified failure to assess appropriately & a delayed submission of a Datix as contributory factors. Pt admitted from A&E post fall and there was learning for both areas. The SI indicator refers to the pressure ulcer SI already outlined and an SI associated with VTE prophylaxis, which as a prescribing error.

Kent – 2 red indicators- the 4 falls were all no harm slips and one un-witnessed fall. The addition of 7 wte HCA's to support 1:1 care of head injured patients is starting to impact upon falls. The FFT data has been incorrect for some months secondary to two templates being created on the tablet neither of which linked to the other. The situation has now been resolved and daily process confirmation indicates that data collection is improving. The full impact will be seen in July.

Mckissock -1 red indicator – this relates to 7 falls. 2 of which were slips, 3 of which were slides form chairs. These were all no harm and risk assessments had been carried out appropriately.

William Drummond – 1 amber- On-going difficulty with response rates to FFT and this patient cohort. Comments are really positive where received with 97% of pt's recommending. However, more work is expected from the team to improve this score.

Gwynne Holford- 1 red indicator- Falls are generally high from this patient group and the balance between providing rehab and promoting independence with that of a secure and safe environment can be challenging. No falls were associated with any harm and each fall is reviewed to ensure learning and thematic review.
Areas requiring further support are Gunning and Gwynne Holford as a result of vacancy factor and depleted senior team members. Each directorate area is pulling together a work plan to support the development of care of patients in terms of both falls and pressure ulcers. Keate continues to perform consistently well and Brodie has seen some improvements this month and a reduction in alerts.

10. Ward heatmap: -Med Card Division

Allingham – 92.9% Harm Free Care There were 28 patients surveyed. 2 patients with harms. 1 patient had an old grade 3 pressure ulcer and 1 patient had a new grade 2 pressure ulcer.

Amyand - FFT response rate 15.4% Falls 14- No reported moderate or above harms. The ward manager and Matron completing documentation audits to ensure completion of falls risk assessment and any appropriate actions.

Buckland – C. Diff – 1 Case with an RCA being completed. 94.7% Harm Free Care of the 19 patients surveyed. 1 patient had an old grade 2 pressure ulcer. 1 Serious Incident – Investigation on going and report due 16/07/15

Caesar Hawkins – 81% Harm Free Care 21 patients were surveyed. 4 patients with harm, 2 of these patients had two harms. 1 patient had a moderate Fall and also a new grade 2 pressure ulcer. FFT response Rate 18.9% . Patients identified for discharge at the board round to be given tablet to complete FFT prior to discharge where appropriate based on patient condition.

Cheselden 88.4% Harm Free Care 43 patients surveyed. 5 harms reported. 2 patients had new grade 2 pressure ulcers. 2 patients had old grade 2 pressure ulcers and 1 patient had a low harm Fall.

Dalby 2 Acquired Pressure Ulcers, and RCA are under way. The ward have also amended the handover sheets to incorporate pressure area care, TVN teaching taking place and Matron Quality visits. 88.5% Harm Free care 26 patients surveyed. 3 harms reported. 2 patients had old grade 3 pressure ulcers and 1 patient had an old grade 2 pressure ulcer. 2 Serious Incidents recorded due to pressure sores.

Emergency Department - 2 serious Incidents report. Panel formed and investigation on going relating to the discharge of a patient. The second SI relates to failure to meet the 60minute LAS handover target.

Heberden 75% Harm Free Care 24 patients surveyed. 6 harms reported. 3 patients had old grade 4 pressure ulcers, 1 patients had an old grade 3 pressure ulcer and 1 patient had a new grade 2 pressure ulcer. There was also a patient who had a fall on the ward with low harm. Falls – There were 8 falls reported in May, due to the patients currently on the ward there are a number of high risk patients for falls. Falls risk assessments completed and reviewed, patients requiring specialing have appropriate risk assessment completed.

McEntee 94.4% Harm Free Care - 18 patients surveyed. 1 harm reported. Patient had a VTE Harm (New other)

Richmond Ward 94.9% Harm Free Care 59 patients surveyed. 3 harms reported. 1 patient had a new grade 2 pressure ulcer. 1 patient had an old grade 2 and another patient had a old grade 3 pressure ulcer. 1 Serious Incident relating to medication, investigation under way. 14 Falls were recorded for the month of May. The ward sister and Matron are conducting documentation audits to ensure compliance with the falls care bundle.

Rodney Smith 1 incidence of C. Diff reported and RCA under way. 74.1 % Harm Free Care

11. Community Services
- CQR Scorecard – May 2015 Page 1 of 3

	Patiend Safety & Experience																
				Quarter 1 2015/16			Quarter 2 2015/16			Quarter 3 2015/16			Quarter 4 2015/16				
Patient Safety	Number of SI's breached	Monthly	0	0	0											➡	
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly		1	0											⇩	
Patient Safety	Grade 4 Pressure Ulcers	Monthly		0	0											➡	
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly		10	7											⇩	
Patient Safety	Number of moderate falls	Monthly	0	2	1											➡	
Patient Safety	Number of major falls	Monthly	0	0	0											⇨	
Patient Safety	Number of falls resulting in death	Monthly	0	0	0											➡	
Patient Safety	MRSA (cumulative)	Monthly	0	0	0											⇩	
Patient Safety	CDiff (cumulative)	Monthly	31	1	0											⇨	
Patient Safety	CAS ALERTS - Number ongoing-received (Trust)	Monthly	0	2	2											➡	
Patient Safety	Number of Quality Alerts	Monthly		3	5												
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	95%	89.0%	86%											⇧	
Safeguarding	% of staff compliant with safeguarding childrens training	Monthly	Level 1 95%	90.0%	tbc												
			Level 2 95%	84.0%	tbc												
			Level 3 95%	69.0%	tbc												
Patient Outcomes	Mortality SHMI ratio (Trus)	Monthly	<100	0.86	0.86											⇨	
Patient Experience	Active Claims	Monthly		0	0											⇨	

11. Community Services
- CQR Scorecard – May 2015 Page 2 of 3

	Patiend Safety & Experience																
				Quarter 1 2015/16			Quarter 2 2015/16			Quarter 3 2015/16			Quarter 4 2015/16				
Patient Experience	Number of Complaints received	Monthly		16	18											↑	
Patient Experience	Number of Complaints responded to within 25 days (reporting 1 month in arrears)	Monthly	85%	100%	88%											↓	
Patient Experience	Number of Complaints responded to within 25 days with an agreed extension	Monthly	95%	100%	100%											→	
Patient Experience	FFT Score (Mary Seacole)	Monthly			14.3												
Patient Outcomes	Catheter related UTI (Trust)																
	Number of new VTE (Trust)		National 0.005														
Workforce	Number of DBS Request Made	Quarterly	annually	N/A	N/A												
Workforce	Sickness Rate -	Monthly	3.50%	5.72%	Available 16th June 2015												
Workforce	Turnover Rate-	Monthly	13%	19.64%													
Workforce	Vacancy Rate-	Monthly	11%	19.41%													
Workforce	Appraisal Rates - Medical	Monthly	85%	66.64%													
Workforce	Appraisal Rates - Non-Medical	Monthly	85%	76.80%													

11. Community Services
- CQR Scorecard –May 2015 Page 3 of 3

Serious Incidents: In May one serious incident was reported. This relates to death in custody within offender healthcare associated with an in cell murder.

Pressure ulcers: In May there were no Grade 3 and 4 pressure ulcers acquired in our care. MS ward had >250 days without acquiring G3 or G4 PU.

Falls: There were 7 No Harm and Low severity fall (2 MS ward, 2 patients home) were reported in May compared to 10 in April. One moderate harm (MS ward)

Complaints: Community Services received 18 complaints in May a slight increase on April's position when there were 16 complaints. For those which have been closed all were responded to within 25 working days or within agreed extensions. More detailed report will be provided in patient Experience committee bi annual review (due Aug/Sept 2015)

Human Resources: This data is not available until the 16th June

Community FFT: 34 services reporting since March 2015 over 300 responses per month. FFT Scores per month: 87%, 95% and 94% (excludes Mary Seacole ward and MIU).

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

Access targets and outcomes objectives

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

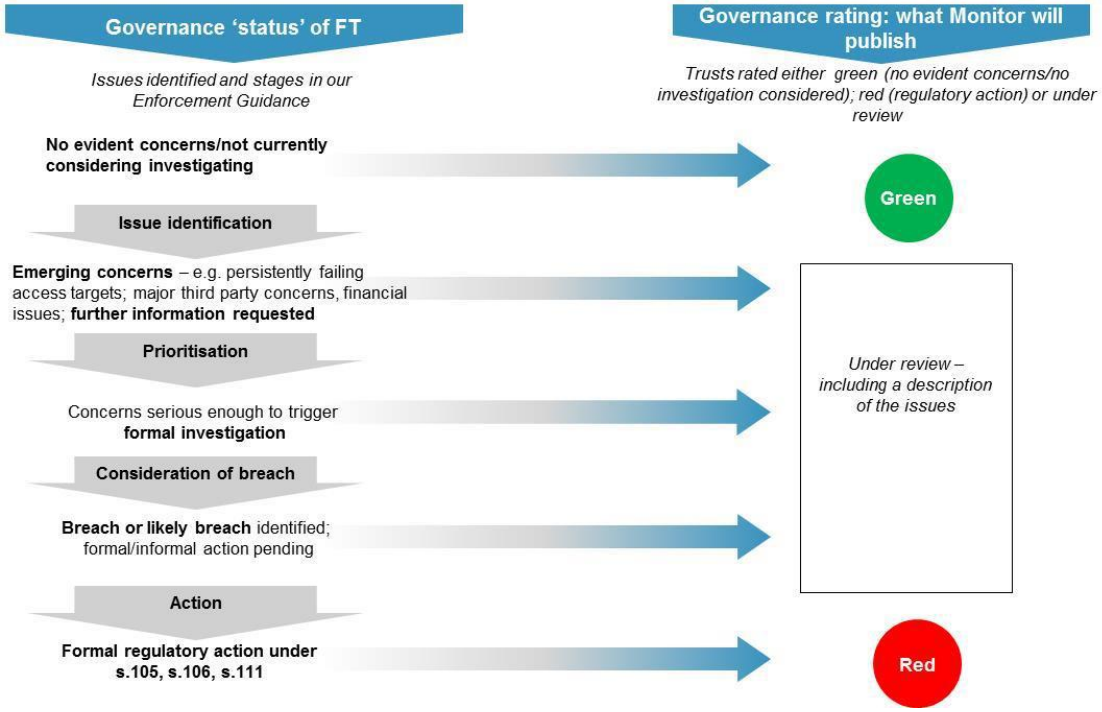
In addition to the above, when assigning governance ratings Monitor also take into account the following which may lead to overrides in the governance rating::

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

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

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

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



St George's
Summary Finance Report
Month 02 2015/16

Finance and Performance Committee June 24th 2015

As noted in the previous report, the organisation is behind where it should be on issuing detailed budgets. This month, further adjustments to the business planning model have been made in the general ledger at directorate level by SLA income, other income, pay and non-pay. Analysis of variances at these levels is reliable but further in-depth analysis is distorted until the detailed budget setting exercise is complete. Finance and operational managers are working on the full allocation of detailed budgets such that they will be available for month 3 reporting.

❶ Month 02 Headlines

Area of Review	Key Highlights	Month
Financial Position	As at month 2 the Trust is showing a deficit of £15.9m against its monitor plan deficit of £12.8m giving an adverse variance of £3.1m (comprising Pay £1.1m adv, Income £1.3m adv and Non-pay £0.6m adv). This position includes £2.4m of non recurrent income / costs that relate to 2014/15 or are part of disputes around final 2014/15 contract invoicing and credit notes. These have been charged to the current financial year. This implies that the run-rate is £0.6m adverse to plan. Budgets have been uploaded in line with the business planning model and these are being validated with divisions and the final budgetary issues to be resolved for m3 reporting. These issues relate to cost pressures and the finalisation of the Trust's SLA.	
Activity / Income	SLA income is £0.9m behind plan mainly in out patients which is 3% down on activity and income. The impact of the emergency block is included in the income figures which improves the income figure by £0.4m over m2 SLAM. The Trust is £0.6m under plan on contract exclusions offset by lower High Cost Drugs costs. This relates to delayed publication of NHSE national policy for giving patients access to new Hep C treatments compared to expectations in the plan. This has been published in June.	
Expenditure-Pay	Pay costs are £1.1m overspent of which mainly relate to CIPS. Of the £1.1m, unallocated CIPS requirements are offset by underspends in Nursing and Non clinical staff. In May we spent £37.4m compared to £37.4m in April. Pay in posts represented 89% of costs in month compared to 87% in April. Pay costs are in line with m1 and lower than m12 Agency/Bank costs in May are lower than April by £0.7m.	
Expenditure – Non Pay	Non-pay costs are £0.6m above budgets. Non-pay expenditure contains £1.3m of costs relating to 14/15. Adjusting for this implies a underspent run-rate non-pay of c3%	
CIP	Year to date, we have delivered £4.9m of savings, comprising £2.8m of CIPS and a further £2.1m of cost avoidance actions (run rate savings). This represents a £1.4m adverse variance to the budget.	
COSRR	In M02 the Trust achieved a 2 overall for COSRR . This is in line with the Annual Plan for M02.	
Cash	The cash balance was £7.9m at 31st May which is £1.7m favourable to plan. The trading deficit of £8.3m was £2m higher than plan but the cash impact of this overspend was more than offset by a better performance than plan on net working capital and a further under spend on capital. The Trust is planning to draw down funds of up to £7.8m using its approved working capital facility of £25m in July as approved by the Committee on 4th June. The current daily cash flow forecast (as at 18th June) indicates the cash balance will be approx £3m on 30th June –as anticipated in the 13 week forecast reviewed on 13th June and in line with plan. The exact value of the July drawdown will be determined week ending 26th June.	
Capital	Capital expenditure was £3.8m in May, an under spend of £1.3m. The YTD figures of £6.1m is £3.4m less than plan. In order to support the cash position the Trust must minimise capex until the discussions with Monitor on the interim support funding are concluded. The main capital budget holders have re-forecast their expenditure for the year and the executive has undertaken a third review of budget lines and their classifications as 'no delay' or 'discretionary' and is proposing to reduce the budget from £56.7m to £48m – see separate cash and capital update paper	

❶ Month 02 Headlines : Conclusions and risks

Category	Conclusions / Risk	Evidence
Financial position	Further additional pressures to the planned deficit have been identified as the business planning process has been finalised. Mitigations to offset these pressures are proposed such that the planned deficit of £46.2m can be maintained. Whilst there are non recurrent costs in the ytd position these will need to be recovered to achieve the planned outturn	See separate SB budget setting update paper
Activity/Income	Activity is down against plan as shown in m2 SLAM particularly in out patients (3%). The specialties affected will need to book to catch up. Action is being taken with Divisions to provide assurance that they will recover the activity in short order.	Section 5
Pay	Pay costs are £1.1m over budget mainly around CIPs delivery. Divisions need to complete their workforce plans for Finance, HR and Divisions to triangulate. The risk of WTE and £'s not being aligned will be mitigated by a HR\Finance reconciliation using budgets and ESR. For month 3, divisions need to complete their workforce plans which will align their budgets to pay groups and correctly group CIP's	Section 7
Pay	Pay CIPS are behind plan so although pay costs do show a reduction over March they are not yet at the level needed to achieve the 15/16 plan.	Section 7
Non Pay	Non Pay costs are £0.6m above budget, no emerging risks highlighted in m2. £0.3m of contract services costs and £0.7m of consumables costs relating to 14/15 were accounted for in m2.	Section 8 & Appendix B
Capital	Key risk for Capex is that expenditure must be constrained until interim support funding is confirmed. See separate capital and cash update paper. . The executive is also evaluating additional measures to reduce the level of capital expenditure below this level and/or provide temporary cash flow relief.	Section 10
Cash	Risk will remain high until the level and timing of the £52.2m interim support requested is confirmed.	Section 11

Overall Position

	Annual Budget	Current Budget	Current Amount	Current Variance (adv) / fav	YTD Budget	YTD Amount	YTD Variance (adv) / fav	
	£m	£m	£m	£m	£m	£m	£m	%
SLA Income	624.59	49.93	49.53	(0.40)	98.53	97.59	(0.94)	-1%
Other Income	100.93	8.38	8.07	(0.31)	16.81	16.41	(0.40)	-2.4%
Overall Income	725.53	58.31	57.60	(0.71)	115.34	114.00	(1.34)	-1.2%
Pay	(444.11)	(36.98)	(37.36)	(0.38)	(73.68)	(74.75)	(1.06)	-1.4%
Non Pay	(291.01)	(25.02)	(25.86)	(0.84)	(48.77)	(49.40)	(0.63)	-1.3%
Overall Expenditure	(735.12)	(62.00)	(63.22)	(1.22)	(122.46)	(124.15)	(1.69)	-1.4%
EBITDA	(9.60)	(3.69)	(5.62)	(1.93)	(7.12)	(10.15)	(3.03)	-42.6%
Dpn, PDC div etc	(36.67)	(2.66)	(2.68)	(0.02)	(5.68)	(5.70)	(0.02)	-0.3%
Surplus / (deficit)	(46.26)	(6.35)	(8.30)	(1.95)	(12.80)	(15.86)	(3.05)	-23.8%

- The Trust planned a significant loss for month 2 ytd (£12.8m) and the position achieved at month 2 ytd is a larger loss still (£15.9m). However this position includes £2.4m of non recurrent income / costs that relate to 2014/15 or are part of disputes around final 2014/15 contract invoicing and credit notes. These have been charged to the current financial year. This implies that the run-rate for the first two months is £0.6m adverse to plan – see Appendix B.
- The position reported in m2 indicates that both income and pay are behind target (by 1% and 1% respectively).
- The predominant effect on the pay position is a shortfall in achieving CIPs.

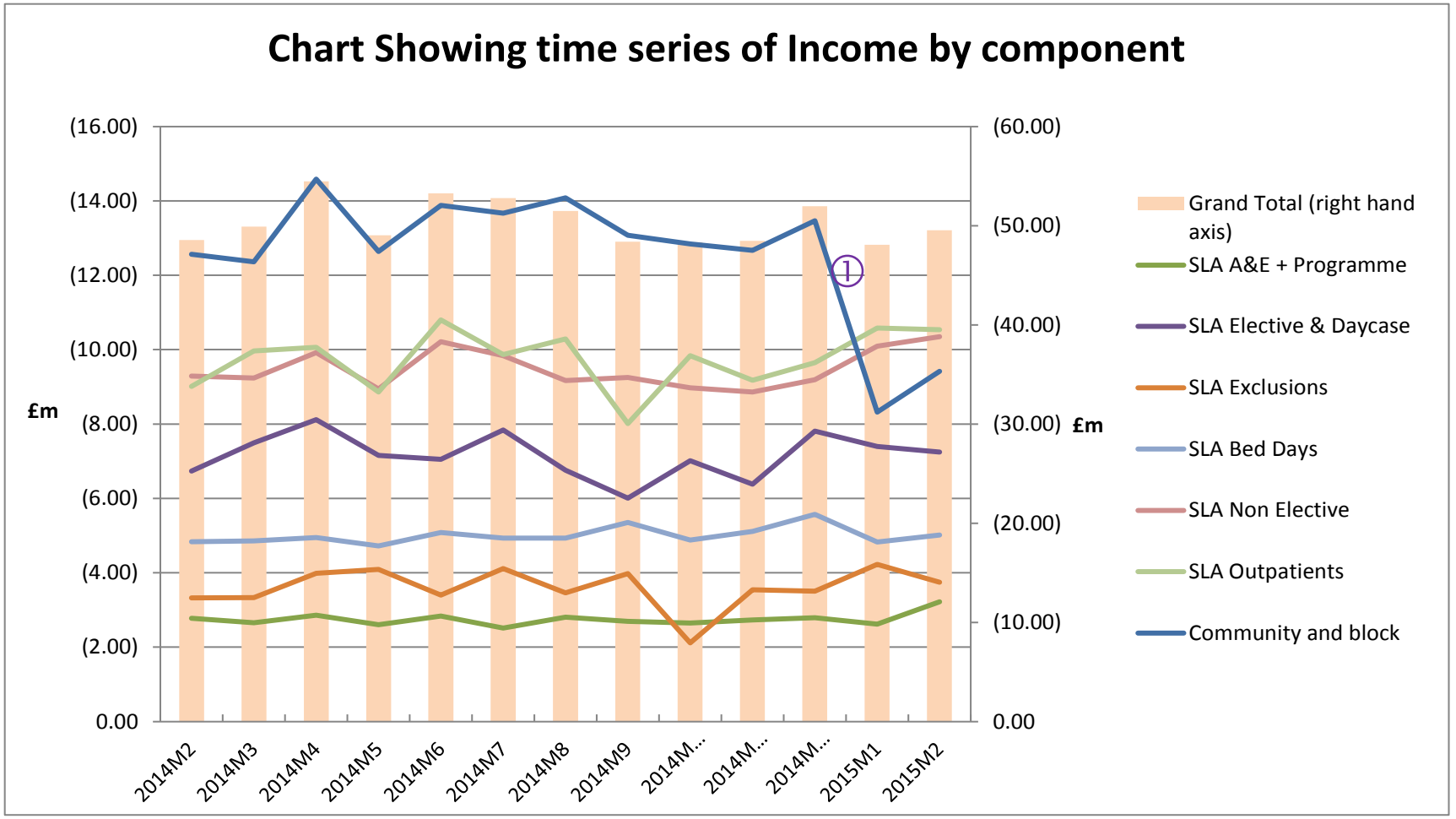
YTD Variance (adv) / fav	CWDT	CSW Provider Services	Medicine and CV	Surgery and Neuro	Overheads	R&D	SWL Pathology	Reserves	Trust Income	Grand Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
SLA Income	0.43	(0.22)	(0.27)	(0.18)	0.03	0.00	0.00	0.00	(0.72)	(0.94)
Other Income	(0.03)	0.04	(0.23)	(0.18)	(0.39)	0.07	0.74	(0.03)	(0.39)	(0.40)
Pay	(0.26)	(0.25)	(0.33)	(0.16)	(0.17)	(0.08)	0.18	0.00	0.00	(1.06)
Non Pay	(0.39)	(0.06)	(0.02)	0.00	0.26	0.03	(0.77)	0.53	(0.21)	(0.63)
Other	0.00	(0.00)	0.00	(0.01)	0.01	0.00	0.00	(0.02)	0.00	(0.02)
Grand Total	(0.24)	(0.49)	(0.84)	(0.53)	(0.26)	0.02	0.14	0.48	(1.33)	(3.05)

❸ Income

Variance YTD 2015/16 (adv) / fav	CWDT		CSW		Medicine & CV		Surgery & Neuro		Trust Income		Overheads		Grand Total	
	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
SLA A&E	0.00		(0.02)	-8.0%	(0.07)	-2.4%	0.00		(0.02)		0.00		(0.11)	-3.3%
SLA Bed Days	0.08	1.0%	(0.05)	-5.4%	0.00		(0.08)	-6.5%	0.00		0.00		(0.05)	-0.5%
SLA Daycase	0.07	10.1%	0.00		0.05	3.0%	(0.00)	-0.1%	0.02		0.00		0.14	3.2%
SLA Elective	(0.11)	-14.3%	0.00		(0.27)	-6.9%	0.20	3.6%	(0.00)		0.00		(0.19)	-1.9%
SLA Exclusions	(0.00)	-1.0%	(0.18)	-12.6%	(0.28)	-5.8%	(0.07)	-5.4%	(0.00)		(0.04)	-5.1%	(0.56)	-6.6%
SLA Non Elective	0.10	7.1%	0.00		0.41	3.8%	(0.17)	-2.0%	(0.17)		0.00		0.17	0.9%
SLA Other	0.37	12.0%	0.23	2.2%	0.05	1.7%	0.14	34.1%	(0.68)	-214.9%	0.06	132.1%	0.18	1.0%
SLA Outpatients	(0.06)	-0.9%	(0.21)	-5.3%	(0.34)	-5.9%	(0.14)	-2.9%	0.12	380.7%	0.00		(0.63)	-2.9%
SLA Programme	(0.00)	-8.1%	0.00		0.17	7.3%	(0.06)	-23.4%	0.00		0.00		0.10	3.9%
Grand Total	0.43	2.0%	(0.22)	-1.3%	(0.27)	-0.8%	(0.18)	-0.8%	(0.72)	-207.5%	0.03	4.2%	(0.94)	-1.0%

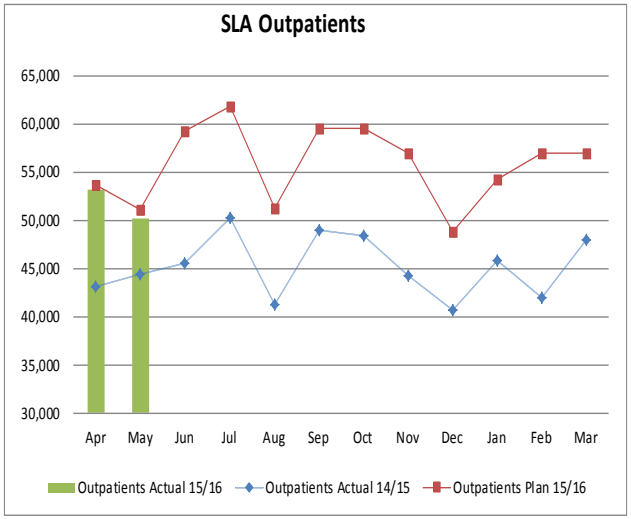
- SLA income in total is cumulatively £0.9m behind plan. Adjusting for prior period issues and pass-through exclusions relating to high cost drug and devices the run-rate would be £0.4m (0.4%) favourable to plan – See Appendix B
- The main POD behind plan is Outpatients with the main problem area being slow uptake of the Nelson facility for Medicine.
- Nelson activity has been profiled to reflect a slow start but the low level of activity is concerning despite that.
- An important part of the SLA with local CCGs is a block around emergency activity supported by additional investment in capacity. Emergency activity for these CCGs is below target by £xk and on the basis that this is a block, the income has been assumed leaving no variance for these CCGs
- Provision for challenges will be finalised in the SLAs, the m2 position includes £0.7m and reflects an assessment of 14/15 levels less contract adjustments for KPIs now covered in the EM block agreement with local commissioners.
- All SLA income is now included in one SLAM system covering Acute, QMH, Community and the Nelson.
- Trends of income and activity are shown on the following pages

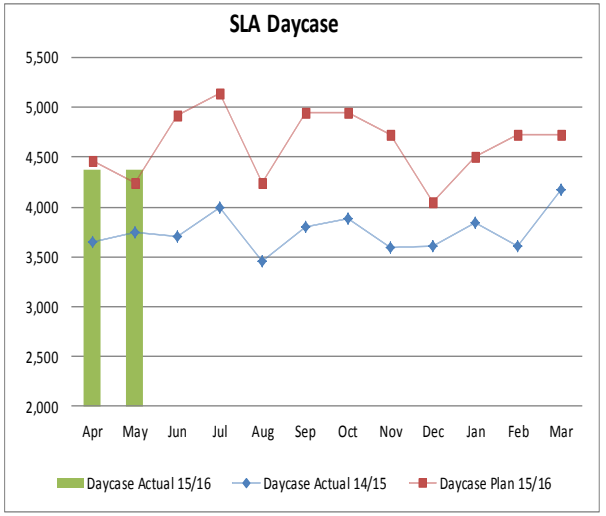
❸ Income trends

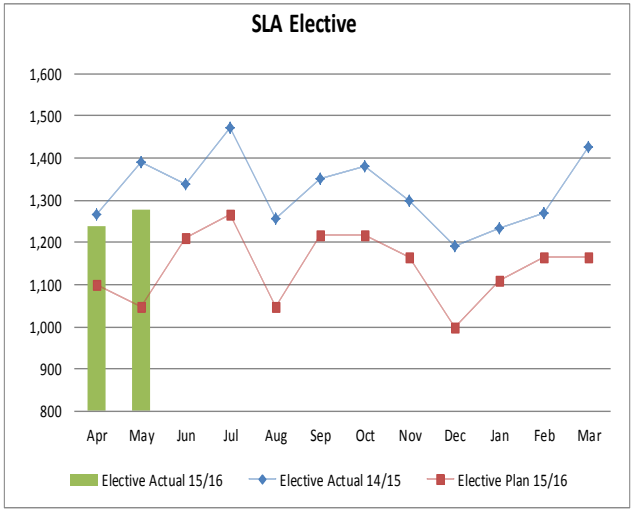


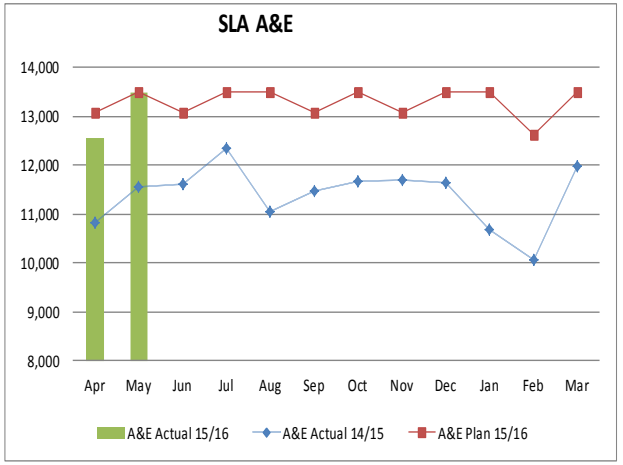
① Note QMH income all used to be coded to one account code in 14/15. Now that the QMH income has moved into SLAM in 15/16, it is being coded to account codes based on the POD, rather than one catch all account code.

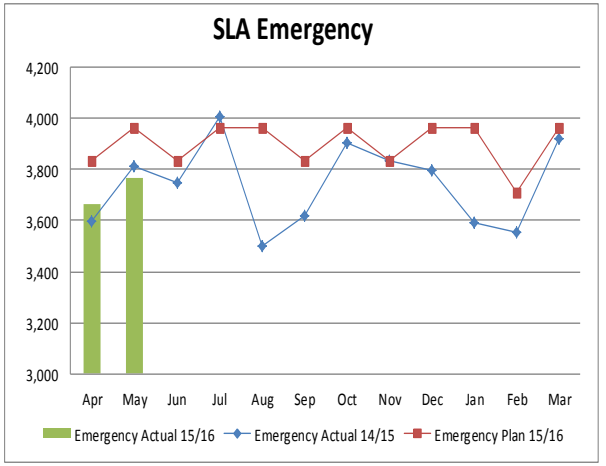
❹ Activity - 2015/16 actuals vs 2015/16 plan vs 2014/15 actuals











Both activity and income levels have improved overall in month2 although there were reductions in outpatient and daycase activity consistent with the phased plan.

The most significant increases have been in A&E and elective activity.

The Month 01 figures have been refreshed to reflect the most recent position.

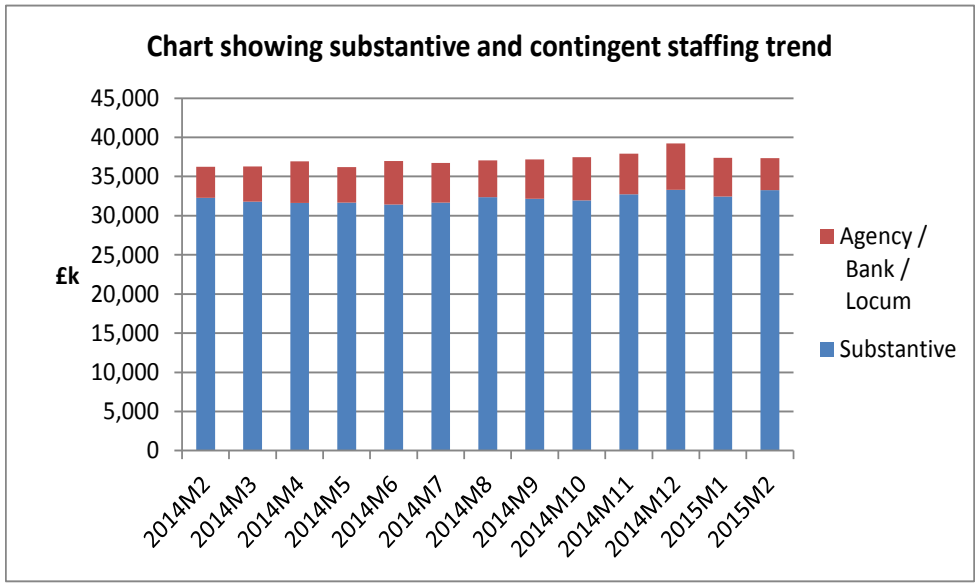
PLEASE NOTE THAT THESE GRAPHS ON NOT BASED FROM ZERO IN ORDER TO HIGHLIGHT CHANGES IN TREND.

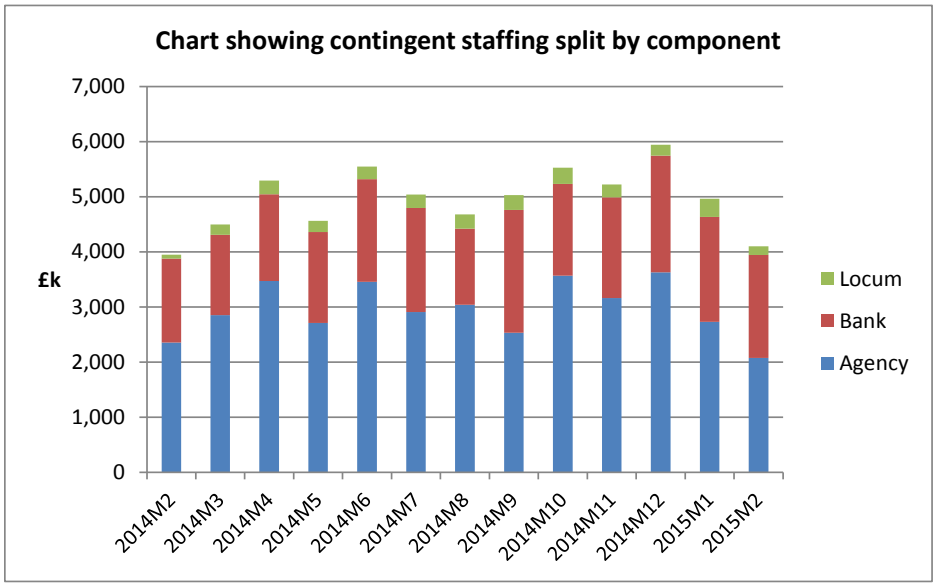
❺ Pay costs

Variance YTD 2015/16 (adv) / fav	CWDT		CSW		Medicine & CV		Surgery & Neuro		Overheads		R&D		SWL Path		Grand Total	
	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
Pay Consultants	(0.02)	-1.0%	0.09	20.4%	0.22	6.6%	0.19	4.2%	(0.03)	-21.1%	(0.03)	-55.5%	(0.03)	-2.2%	0.38	3.2%
Pay Jnr Drs	0.03	1.6%	(0.21)	-112.4%	(0.37)	-13.0%	0.08	3.1%	0.02	10.8%	0.00		0.26	100.0%	(0.19)	-2.3%
Pay Non Clinical	(0.04)	-1.7%	0.08	5.8%	0.07	5.0%	0.16	9.8%	0.49	8.6%	(0.04)	-39.2%	(0.08)	-55.0%	0.64	5.0%
Pay Nursing	0.24	2.8%	0.30	6.5%	0.03	0.4%	0.58	7.7%	(0.01)	-2.4%	(0.02)	-14.6%	0.00		1.12	3.7%
Pay Other	(0.99)	-100.0%	(0.59)	-100.0%	(0.29)	-100.0%	(1.35)	-100.0%	(0.67)	-100.8%	0.01	100.0%	0.27	100.0%	(3.60)	-100.1%
Pay Sci, Techs, Therap	0.52	9.4%	0.08	3.8%	0.01	0.7%	0.17	9.1%	0.04	5.3%	(0.00)	-16.4%	(0.23)	-9.0%	0.58	4.2%
Grand Total	(0.26)	-1.3%	(0.25)	-3.0%	(0.33)	-1.9%	(0.16)	-1.0%	(0.17)	-2.5%	(0.08)	-24.9%	0.18	4.1%	(1.06)	-1.4%

- In month 2 total pay expenditure of £37.4m (M1 £37.4m) was £0.4m (M1 £0.7m) over budget and is cumulatively £1.1m over budget
- Whilst total pay was unchanged from month 1 there has been a reduction in Agency of £0.7m and a corresponding increase in substantive spend. (please note that the method for accruing for agency expenditure has been changed this month and is now based on e-rostering information)
- Agency has reduced from 8% to 6 % of pay and bank remains at 5%
- All divisions have YTD adverse variances in total for pay
- Overall the key contributor to the adverse variances is the underachievement of CIPs
- Divisional budgets are not yet fully allocated to the specific staff group types with any budgets still to be allocated, and the unidentified CIP target both shown under Other
- Unallocated CIP targets have been split 80% to pay and 20% to non-pay, except in Estates which has used the reverse percentages
- Whilst specific variances cannot be satisfactorily analysed, it should be noted that all divisions are achieving an element of their run rate targets which reduces the variance from unidentified CIPs
- Budget setting at the detailed level will be completed for month 3 reporting enabling comprehensive analysis

❺ Pay trend (1)





monthly trend

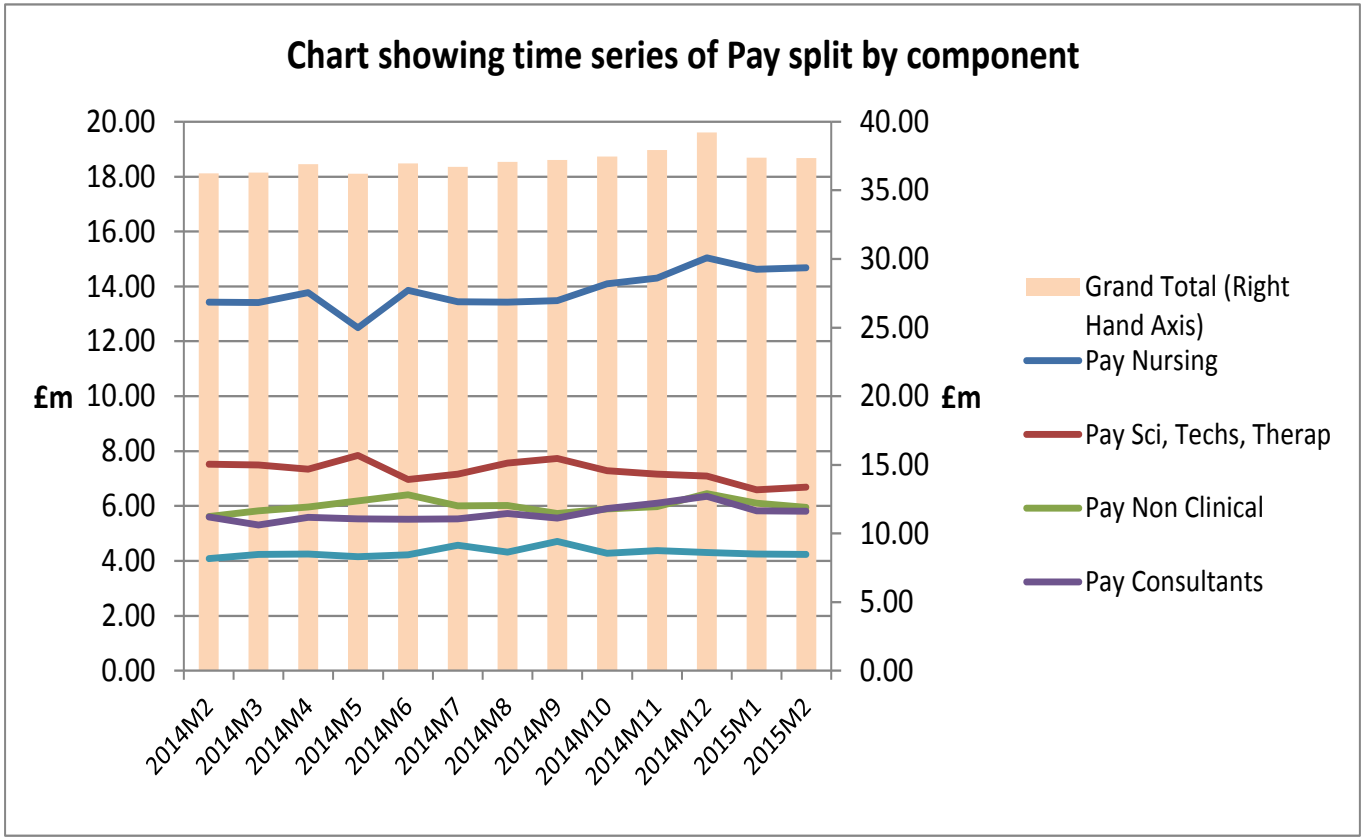
	£k	%
Substantive	111.84	0.3%
Agency /Bank / Locum	42.64	1.0%
Total	154.48	0.4%

monthly trend

	£k	%
Agency	-2.43	-0.1%
Bank	38.24	2.0%
Locum	6.83	4.3%
Total	42.64	1.0%

- Total pay of £37.4m in month 2 is £1.1m (3%) higher than the same month last year
- This is a reduction in the average rate of increase per month from £200k (0.5%)to £160k (0.4%)
- In particular agency spend is lower than the same month last year and is the lowest month for over a year
- Pay costs increase for inflation, increments and service developments, and reduce through reduction in agency premiums, staff utilisation and CIP schemes

❺ Pay trend (2)



monthly trend

	£m	%
Pay Nursing	0.13	0.9%
Pay Sci, Techs, Therap	(0.06)	-0.9%
Pay Non Clinical	0.02	0.3%
Pay Consultants	0.05	0.9%
Pay Jnr Drs	0.01	0.3%
Grand Total	0.15	0.4%

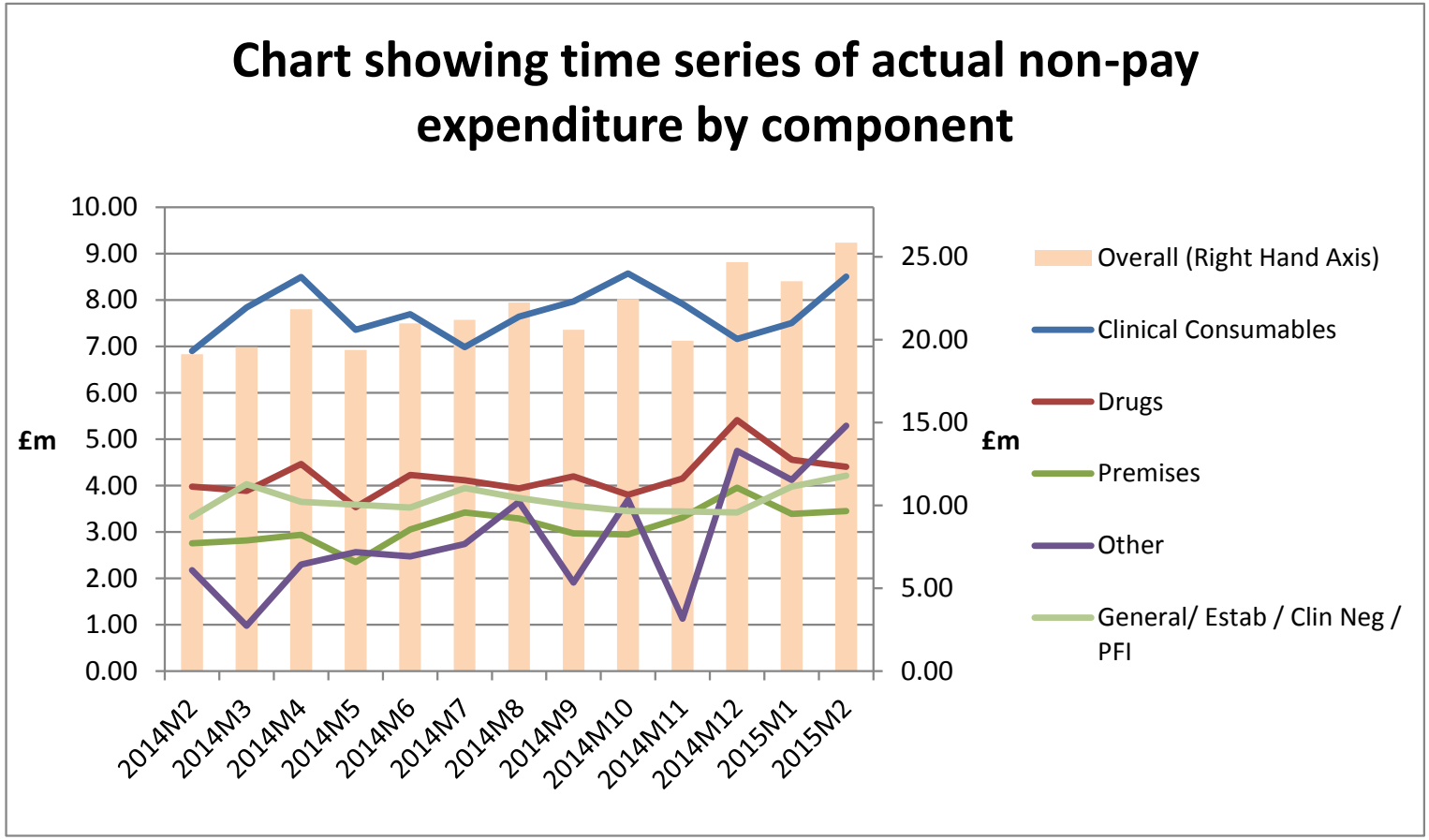
- Nursing and Consultants remain the main drivers of the trend increase in pay
- Scientists, Technicians and Therapists have had a reduction over the previous year but month 2 is slightly up on month 1

❻ Non pay costs

Variance YTD 2015/16 (adv) / fav	CWDT		CSW		Medicine & CV		Surgery & Neuro		Overheads		R&D		SWL Path		Reserves/ Central		Grand Total	
	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
Clinical Consumables	0.36	*16%*	(0.09)	*-7%*	0.10	*2%*	0.28	*8%*	(0.09)	*-72%*	(0.00)		(0.38)	*-20%*	(0.81)		(0.63)	*-4%*
Drugs	(0.29)	*-32%*	(0.09)	*-5%*	0.62	*12%*	0.21	*13%*	0.01	*51%*	0.00		(0.01)		(0.00)		0.44	*5%*
Premises	(0.13)	*-229%*	(0.01)	*-7%*	0.05	*52%*	0.09	*132%*	0.03	*0%*	0.00	*100%*	(0.15)	*-46%*	(0.21)		(0.33)	*-5%*
Other	(0.39)	*-9%*	0.15	*9%*	(0.74)	*-513%*	(0.61)	*-684%*	0.26	*31%*	0.04	*66%*	(0.23)	*-36%*	1.33	*93%*	(0.20)	*-2%*
General/ Estab / Clin Neg / PFI	0.06	*25%*	(0.02)	*-9%*	(0.04)	*-13%*	0.03	*25%*	0.06	*1%*	(0.02)		0.00	*5%*	0.01		0.09	*1%*
Grand Total	(0.39)	*-8%*	(0.06)	*-4%*	(0.02)	*-11%*	0.00	*5%*	0.26	*31%*	0.03	*44%*	(0.77)	*-120%*	0.31	*22%*	(0.63)	*-7%*

- Position YTD at month 2 £0.6m adverse. Adjusting for prior period issues and pass-through exclusions relating to high cost drug and devices, the run-rate would be £0.1m (0.2%) better than plan.
- Reserves releases (predominantly the reserve for cost pressures and full year effect funding not yet passed out to Divisions) of £2.5m are offsetting costs in divisions to be finalised ahead of m3 reporting.
- Clinical consumables rose in m2 due to recognition of additional prior year costs.
- Drugs lower than m1 but in line with trend m12 included one off costs of Harley Street agreement. Underspend largely due to new Gastro drugs in contracts but pending national prescription agreement.
- Premises in line with trend that now includes space costs from SGUL.
- Other costs include additional costs of exported activity.
- Clinical negligence increase due to inflation and new premiums regime introduced in 15/16.

❻ Non pay trends



Taken as a time series over the last 13 months. The overall Non pay expenditure has been increased over the year. This is largely driven by increasing premises costs and use of external facilities. In Month 2 there was a significant increase in Consumables and other non pay relating to prior year costs feeding through.

❼ Trust CIP performance

- The CIP target for FY14/15 is £38.1m, profiled in the budget in equal twelfths. As required, the Monitor return assumes a delivery of £34.2m, 90 per cent. of the target and has a profile different to that set out in the budget.
- Year to date, we have delivered £4.9m of savings, comprising £2.8m of CIPS and a further £2.1m of cost avoidance actions (run rate savings). This represents a £1.4m adverse variance to the budget.
- Currently green rated CIPS total £8.8m (£1.5m delivered year to date).
- Therefore, against the annual target of £38.1m there is a gap of £25.9m assuming all green rated CIPs deliver as expected in the remainder of the year.
- Against this gap, the amber schemes amount to £9.5m although these are still subject to challenge. Accordingly it is essential that the runrate actions continue to be maintained and where possible strengthened.
- It should be noted that PwC and KPMG are currently independently reviewing the RAG rated CIPs and therefore the forecast benefits assumed above may change.

EXPECTED RELEASE TO ALIGN MONITOR AND CIP REPORTING - ACTUALS

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	SUM
MONITOR TOTAL TARGET	2.2	2.2	2.3	2.3	2.3	2.4	3.1	3.1	3.1	3.8	3.8	3.8	34.2
TRUST TARGET	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	38.1
DIFFERENCE	-1.0	-1.0	-0.9	-0.9	-0.9	-0.8	-0.1	-0.1	-0.1	0.6	0.6	0.6	-3.9
ACHIEVED YTD / FORECAST :													
GREEN CIPS	0.8	0.7	0.8	0.8	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	8.8
AMBER CIPS	0.5	0.7	0.8	1.0	0.9	0.9	0.9	1.0	1.0	1.0	1.0	1.0	10.7
DELIVERED RUNRATES	1.1	1.1											2.1
RED CIPS	0.1	0.1	0.4	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	4.3
FORECAST RUNRATES			1.0	1.0	1.0	1.0	0.8	0.8	0.8	0.8	0.8	0.8	8.5
	2.5	2.5	2.9	3.1	3.0	3.0	2.9	2.9	2.9	2.9	2.9	2.9	34.4
VARIANCE BASED ON ACTUAL YTD AND ONLY GREEN/AMBER SCHEMES:													
TRUST VAR	0.7	0.7	1.6	1.4	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	16.3
YTD TRUST VAR	0.7	1.4	3.0	4.4	5.9	7.4	8.9	10.4	11.9	13.3	14.8	16.3	
MONITOR VAR	-0.3	-0.3	0.4	0.2	0.3	0.4	1.0	0.9	0.9	1.6	1.6	1.6	8.3
YTD MONITOR VAR	-0.3	-0.6	-0.3	-0.1	0.3	0.7	1.6	2.6	3.5	5.1	6.7	8.3	

❽ Divisional Summaries
CWDT - Divisional I&E

St George's University Hospitals NHS
NHS Foundation Trust

	2015/16 Annual Budget	Previous Months Actuals Trend			2015/16 Current			2015/16 YTD		
		Actual M11 £m	Actual M12 £m	Actual M1 £m	Budget M2 £m	Actual M2 £m	Variance M2 £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
SLA Income	135.96	10.86	11.94	10.49	10.54	11.13	0.59	21.19	21.62	0.43
Other Income	23.82	1.99	2.73	1.98	2.05	1.95	(0.11)	3.96	3.93	(0.03)
Pay	(122.52)	(10.77)	(10.85)	(10.21)	(9.92)	(10.26)	(0.34)	(20.21)	(20.47)	(0.26)
Non Pay	(48.33)	(3.98)	(5.58)	(4.52)	(3.95)	(3.93)	0.02	(8.07)	(8.45)	(0.39)
Other	(7.19)	(0.46)	(0.68)	(0.61)	(0.60)	(0.59)	0.01	(1.20)	(1.20)	0.00
Grand Total	(18.26)	(2.36)	(2.44)	(2.86)	(1.87)	(1.70)	0.17	(4.33)	(4.57)	(0.24)

YTD Var 2015/16 (adv) / fav	Childrens Services		Critical Care		CWDT Division Management		Diagnostics		Outpatients		Pharmacy		STG Pathology		Therapies		Womens Services		Total Sum of YTD Budget £k	
	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
SLA Income	0.38	6.6%	(0.00)	0.0%	0.00	#DIV/0!	0.09	3.7%	0.00	#DIV/0!	0.00	#DIV/0!	0.07	5.1%	(0.12)	-18.5%	0.01	0.2%	0.43	2.0%
Other Income	(0.05)	-8.4%	(0.03)	-17.2%	0.00	#DIV/0!	(0.02)	-2.6%	(0.00)	-31.0%	0.23	29.5%	(0.07)	-7.1%	(0.04)	-57.9%	(0.03)	-10.6%	(0.03)	-0.8%
Pay	(0.25)	-5.1%	(0.06)	-1.8%	(0.05)	-24.6%	(0.20)	-6.8%	(0.02)	-1.1%	0.04	3.4%	0.16	170.5%	0.05	2.7%	0.07	2.0%	(0.26)	-1.3%
Non Pay	0.09	8.5%	(0.11)	-15.8%	0.03	81.9%	0.11	8.4%	(0.10)	-979.5%	(0.25)	-77.0%	(0.20)	-4.9%	0.04	33.7%	0.02	2.5%	(0.39)	-4.8%
Other	0.00	0.0%	0.00	0.7%	0.00	0.0%	(0.00)	-0.2%	(0.00)	-1.1%	0.00	0.0%	0.00	2.2%	(0.00)	0.0%	(0.00)	-0.1%	0.00	0.2%
Grand Total	0.16	82.4%	(0.20)	-25.1%	(0.02)	-9.1%	(0.03)	-2.2%	(0.12)	-6.6%	0.02	1.7%	(0.04)	-2.3%	(0.07)	-5.1%	0.07	3.5%	(0.24)	-5.5%

Actions

- BPM v4.9 is being review by GMs. The impact of SLA agreements need to be understood and outstanding lists of issues resolved for CWDT. Other BPM issues are SWLP plan for pathology, replacement of the Maternity CQUIN and Pharmacy use of SRG allocations.
- Budget setting needs to be completed. The balancing figures with the BPM v4.9 need to be integrated into the SLUs. Proposal for coding and tracking CIPs to be implemented. The budgets for the cross charge for additional clinics need to be reset in both the Specialties and Corporate Outpatients to match the changes in the monthly charging and eliminate offsetting variances.
- CIPs need green rated schemes to be signed off, ambers and reds progressed. GM's continue to find new CIP schemes or run rates savings and have requested assistance from KPMG. Procurement have confirmed their schedule of savings plans need to be completed.
- To align the budgets to spend to the Business Planning model to enable clarity in relation to planning, monitoring and better forecasting moving forward. With the view to a DDO/GM sign-off for the end of June 2015.

The Financial Position for CWDT Division in M02 YTD is an overspend of £238k and an underspend in month of £173k. This is against a budget with balancing adjustments to BPM v4.9. The budget includes £990k (£160k YTD) of SRG funds for Pharmacy and Therapy some of which is earmarked for new expenditure so may marginally overstate M02 financial performance. Pathology has been set up as a separate Directorate.

SLA Income in M02 is down £388k compared to the last 4mth trend of 2014-15 but is £641k higher than M01 this year. This increase is due to recoding of £247k Community block income from Childrens to CSW (with budget), Bed day income £106k for Adult and Paeds Critical Care, Deliveries in Womens £161k and Outpatient activity in Diagnostics and Obstetrics £290k. Non Elective activity in Childrens was above average last month explaining the fall of £229k in M02.

Pay spend is £255k overspent YTD £48k higher than in M01. The actual trend shows a reduction of £237k below 14-15 4mth indicating the impact of the run rate schemes on pay. There is a £61k invoice (in M01) for medical staff 2 years back pay from the Medical School.

Nonpay is overspent £383k YTD M02 including £338k for unidentified CIP schemes in line with the Business Planning Model. Drugs is overspent £248k offset by Other Income due to the Wholesaler Dealer License in Pharmacy which has made a net contribution of £70k YTD. Consumables and Other Non pay are underspent helped by the removal of a £289k Iron Mountain 2014-15 invoice in Corporate Outpatients to Reserves. In Cross Charges the Corporate Outpatient line for charging additional clinics to Specialties is being reviewed and is £83k adverse to budget.

The trend for the Division is an improvement of over £0.5m compared to last years 4mth average (excl. CQUINs). The run rate scheme continue to control costs, activity income has improved and work continues to identify more CIP schemes.

CWDT - Divisional CIP performance

FORECAST	ANNUAL TARGET	FORECAST AT M2 (£m) INC	EXP	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT FALL	
CWDT SUMMARY									
C&W OVERHEADS	0.15	0.00	0.42	0.42	0.02	0.40	0.00	-0.27	F
CHILDRENS	1.70	0.14	1.39	1.53	0.34	0.54	0.65	0.17	A
CRITICAL CARE	1.91	0.11	1.45	1.56	0.00	0.33	1.23	0.35	A
DIAGNOSTICS	1.45	0.35	0.97	1.32	0.06	0.75	0.51	0.13	A
OUTPATIENTS	0.55	0.00	0.41	0.41	0.07	0.33	0.01	0.14	A
PHARMACY	0.91	0.72	0.00	0.72	0.00	0.07	0.65	0.19	A
THERAPIES	0.86	0.22	0.64	0.85	0.23	0.61	0.01	0.00	A
WOMENS	1.36	0.41	0.67	1.08	0.57	0.50	0.01	0.29	A
Grand Total	**8.90**	**1.93**	**5.96**	**7.89**	**1.28**	**3.53**	**3.07**	**1.00**	A
OF WHICH RECURRENT:		1.93	4.88	6.81	1.26	2.66	2.89	2.09	A
OBJECTIVE 2 (FULL YEAR EFFECT		2.30	5.48	7.78	1.63	3.20	2.96	1.12	A

PERFORMANCE	YTD TARGET	ACTUAL YTD M2 (£m) INC	EXP	TOTAL	OF WHICH TOTAL ACTUAL YTD RAG RED	AMBER	GREEN	SHORT FALL	
CWDT SUMMARY									
C&W OVERHEADS	0.03	0.00	0.40	0.40	0.00	0.40	0.00	-0.37	F
CHILDRENS	0.28	0.02	0.14	0.16	0.00	0.06	0.10	0.13	A
CRITICAL CARE	0.32	0.01	0.17	0.18	0.00	0.03	0.15	0.13	A
DIAGNOSTICS	0.24	0.00	0.14	0.14	0.00	0.00	0.13	0.10	A
OUTPATIENTS	0.09	0.00	0.01	0.01	0.01	0.00	0.00	0.08	A
PHARMACY	0.15	0.12	0.00	0.12	0.00	0.00	0.12	0.03	A
THERAPIES	0.14	0.00	0.16	0.16	0.00	0.16	0.00	-0.02	F
WOMENS	0.23	0.00	0.03	0.03	0.00	0.03	0.00	0.19	A
Grand Total	**1.48**	**0.15**	**1.05**	**1.20**	**0.01**	**0.69**	**0.51**	**0.28**	A
OF WHICH RECURRENT:		0.07	0.19	0.26	0.01	0.16	0.42	1.22	A

- The CWDT Division target is £8.9m.
- A planning shortfall of £1.12m and Red schemes of £1.63m suggest that there will be a forecast shortfall of £2.75m against the target.
- Runrates will continue whilst further plans are developed.
- The target for M01 is £1.48m against which schemes of £1.2m are reporting as achieved (£0.59m recurrent). These are mainly pay schemes at £0.91m.

- The actual for May was consistent with forecast. The most significant achieved schemes in the month include – Runrate identified as CIP schemes in pay of £175k ; Reduction of 4 nurses per shift in Critical care £113k; Wholesale dealer licence for Pharmacy £110k; Procurement plans of £641K will be confirmed by Procurement dept and the actuals achievement to date.

CSD - Divisional I&E

	2015/16 Annual Budget	Previous Months Actuals Trend			2015/16 Current			2015/16 YTD		
		Actual M11	Actual M12	Actual M1	Budget M2	Actual M2	Variance M2	Budget YTD	Actual YTD	Variance YTD
		£m	£m	£m	£m	£m	£m	£m	£m	£m
SLA Income	104.69	9.13	8.92	8.68	8.73	(8.33)	0.39	17.23	17.01	(0.22)
Other Income	3.45	0.32	0.70	0.33	0.29	(0.28)	0.01	0.57	0.61	0.04
Pay	(47.08)	(4.17)	(4.49)	(4.29)	(4.37)	4.20	(0.17)	(8.24)	(8.49)	(0.25)
Non Pay	(28.96)	(3.96)	(4.10)	(2.44)	(2.40)	2.60	0.20	(4.99)	(5.05)	(0.06)
Other	(0.21)	(0.02)	(0.02)	(0.02)	(0.02)	0.02	0.00	(0.04)	(0.04)	(0.00)
Grand Total	31.89	1.30	1.01	2.25	2.23	(1.80)	0.43	4.54	4.05	(0.49)

- The M02 divisional position shows an £4.05m YTD actual performance against an YTD budget of £4.54m, which resulted in an YTD adverse variance of £490k.
- SLA healthcare income underperformed in Dermatology by £51k, Urology department £77k, Minor Injuries Unit £17k, Elderly Rehab £32k, other associated income £31k and GU Medicine Services £14k due to a reduction in Outpatients attendance.
- In addition to this, other income over-performed by £49k mainly within the Children and Family Services for palliative care and family nurse partnership.
- Pay is slightly reduced from the average spend last year (when excluding the Nightingale and the Nelson £4.1m compared to £4.2m last year).
- The Division has made some reductions in spend through run rate schemes although this hasn't off-set the Divisional CIP gap of £0.5m.

YTD Var 2015/16 (adv) / fav	Adult + Diagnostic Srvcs		Children+FamilySer vices		Community PLD		GU Medicine		Prison Services		Provider Management		Provider Older Services		Provider Overheads		Total Sum of YTD Budget £k	
	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
SLA Income	(0.10)	*-2.1%*	0.12	*4.8%*	(0.00)	*-0.1%*	(0.05)	*-1.7%*	0.03	*2.5%*	(0.02)	*-15.0%*	(0.19)	*-4.0%*	0.00	*#DIV/0!*	(0.22)	*-1.3%*
Other Income	(0.01)	*-47.0%*	0.05	*19.6%*	0.00	*0.0%*	0.00	*0.8%*	0.00	*6.5%*	0.01	*#DIV/0!*	(0.02)	*-12.9%*	(0.00)	*-19.3%*	0.04	*6.6%*
Pay	(0.20)	*-22.6%*	(0.13)	*-7.7%*	(0.02)	*-10.3%*	0.04	*5.6%*	(0.03)	*-4.4%*	0.01	*6.2%*	0.09	*2.3%*	0.00	*#DIV/0!*	(0.25)	*-3.0%*
Non Pay	0.07	*4.2%*	(0.04)	*-450.6%*	0.02	*97.6%*	(0.07)	*-5.2%*	(0.04)	*-7.5%*	(0.02)	*-404.1%*	0.03	*1.7%*	0.00	*6.4%*	(0.06)	*-1.2%*
Other	(0.00)	*-4.4%*	0.00	*0.2%*	0.00	*0.0%*	(0.00)	*0.0%*	0.00	*0.0%*	0.00	*#DIV/0!*	0.00	*0.0%*	0.00	*#DIV/0!*	(0.00)	*-1.0%*
Grand Total	(0.24)	*-9.4%*	(0.01)	*-0.9%*	(0.00)	*-1.7%*	(0.08)	*-7.3%*	(0.03)	*-25.3%*	(0.02)	*-1201.1%*	(0.10)	*-32.0%*	(0.00)	*-2.0%*	(0.49)	*-10.8%*

Actions

- To align the budgets to spend to the Business Planning model to enable clarity in relation to planning, monitoring and better forecasting moving forward. With the view to a DDO/GM sign-off for the end of June 2015.
- Review of all SLA's/ Contracts ensuring adequate expenditure are reflected in relation to improving run-rates. All other income assumptions regarding overheads uplift should be agreed in order not to over inflate income.
- Liaise with General Managers to ensure that clinics are running and activity are taking place in order to understand what the bottlenecks are and also the likely impact of non-achieving income targets.
- Assess viability of current CIP schemes with the view to turning our amber schemes to green. The forum for this is through weekly divisional finance meetings.
- To minimise the use of agency through weekly reviews at Divisional level. Work is currently undergoing to minimise the use of agency staff across the division.
- Currently we are in the process of transferring Community Therapies Service and Palliative Care from Community Services division across to Children's and Women division which would aid in clarifying our true financial position.

CSD - Divisional CIP performance

FORECAST	ANNUAL TARGET	FORECAST AT M2 (£m) INC	EXP	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT FALL	
CSD SUMMARY									
AMBULATORY CARE	1.68	0.04	0.34	0.38	0.07	0.28	0.04	1.30	A
COMM ADULT AND CHILD SVCS	3.84	0.13	1.05	1.18	0.26	0.88	0.05	2.66	A
PROV MANAGEMENT	0.04	0.34	0.16	0.50	0.46	0.00	0.04	-0.46	F
PROV OVERHEADS	0.00	0.00	0.41	0.41	0.06	0.34	0.00	-0.41	F
Grand Total	**5.56**	**0.51**	**1.97**	**2.48**	**0.85**	**1.50**	**0.13**	**3.09**	A
OF WHICH RECURRENT:		0.51	1.74	2.25	0.85	1.27	0.13	3.31	A
OBJECTIVE 2 (FULL YEAR EFFECT)		0.71	1.92	2.63	0.98	1.52	0.13	2.93	A

PERFORMANCE	YTD TARGET	ACTUAL YTD M2 (£m) INC	EXP	TOTAL	OF WHICH TOTAL ACTUAL YTD RAG RED	AMBER	GREEN	SHORT FALL	
CSD SUMMARY									
AMBULATORY CARE	0.28	0.00	0.05	0.05	0.00	0.04	0.02	0.23	A
COMM ADULT AND CHILD SVCS	0.64	0.01	0.15	0.16	0.02	0.13	0.01	0.48	A
PROV MANAGEMENT	0.01	0.00	0.01	0.01	0.00	0.00	0.01	-0.00	F
PROV OVERHEADS	0.00	0.00	0.24	0.24	0.00	0.24	0.00	-0.24	F
Grand Total	**0.93**	**0.01**	**0.46**	**0.47**	**0.02**	**0.41**	**0.03**	**0.46**	A
OF WHICH RECURRENT:		0.01	0.15	0.16	0.02	0.18	0.03	0.77	A

- Community Services division has a CIP target of £5.6m excluding SLA income. Forecast delivery shortfall is currently £4m due to a £2.9m planning shortfall and Red schemes of £0.98m.
- The YTD target is £0.93m. Schemes totalling £0.47m have been reported as achieved, leaving a shortfall of £0.46m. Most significant achievement is the runrate at £143k in month non-recurrent. Other schemes achieved in month include £30k Procurement schemes, £10k on the redesign of the Community learning disability service redesign and £10k on PFI savings at QMH.

Medicine & Cardiovascular - Divisional I&E

	2015/16 Annual Budget	Previous Months Actuals Trend			2015/16 Current			2015/16 YTD		
		Actual M11 £m	Actual M12 £m	Actual M1 £m	Budget M2 £m	Actual M2 £m	Variance M2 £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
SLA Income	223.28	16.90	17.39	16.74	18.08	18.34	0.25	35.35	35.08	(0.27)
Other Income	19.90	1.86	1.27	1.59	1.62	1.50	(0.13)	3.32	3.09	(0.23)
Pay	(102.44)	(9.17)	(9.14)	(8.50)	(8.45)	(8.72)	(0.28)	(16.90)	(17.22)	(0.33)
Non Pay	(72.33)	(5.57)	(5.93)	(6.09)	(6.09)	(5.98)	0.10	(12.06)	(12.07)	(0.02)
Other	(4.52)	(0.39)	(0.40)	(0.37)	(0.38)	(0.38)	(0.00)	(0.75)	(0.75)	0.00
Grand Total	63.88	3.63	3.18	3.37	4.80	4.75	(0.05)	8.96	8.12	(0.84)

YTD Var 2015/16 (adv) / fav	Acute Medicine		Cardiothoracic & Vascular Services		Emergency Department		Renal & Oncology		Specialist Medicine		Total Sum of YTD Budget £k	
	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
SLA Income	0.13	*2.2%*	0.21	*2.1%*	(0.03)	*-0.9%*	0.07	*0.8%*	(0.65)	*-9.3%*	(0.27)	*-0.8%*
Other Income	(0.01)	*-3.7%*	0.07	*7.0%*	(0.13)	*-14.4%*	(0.10)	*-23.8%*	(0.05)	*-7.0%*	(0.23)	*-6.8%*
Pay	(0.27)	*-6.4%*	0.07	*1.8%*	(0.11)	*-4.3%*	0.08	*2.2%*	(0.10)	*-3.9%*	(0.33)	*-1.9%*
Non Pay	0.06	*11.3%*	(0.53)	*-17.7%*	0.09	*16.1%*	(0.37)	*-7.9%*	0.73	*22.7%*	(0.02)	*-0.1%*
Other	0.00	*0.0%*	0.00	*0.9%*	(0.00)	*0.0%*	(0.00)	*0.0%*	0.00	*0.6%*	0.00	*0.3%*
Grand Total	(0.09)	*-7.2%*	(0.18)	*-4.9%*	(0.18)	*-16.8%*	(0.32)	*-28.2%*	(0.06)	*-3.5%*	(0.84)	*-9.3%*

The Division is reporting a £48k adverse variance in month 2, and an £837k adverse variance year to date.

Income is £126k favourable in M2, and £494k adverse year to date. The reason for the in-month favourable variance is due to the month 1 and month 2 effect of the non-elective block contract being devolved to the division in month 2. The benefit of the block contract to the division is £467k year to date.

The reason for the adverse variance in income year to date is due to the use of new NICE approved hepatitis C drugs (PbR excluded) in gastroenterology now not coming online until August. The corresponding underspend is seen within drugs expenditure (£720k YTD). In addition the division has seen an underperformance in outpatient income against plan, due to the delay in setting up clinics for SLA growth at St George's, and underperformance against activity targets at the Nelson. This is offset by over performance in day cases in Endoscopy.

Pay is £276k averse in month and £329k adverse year to date. This is in part due to cost pressures awaiting funding (£181k YTD), with the remainder due to 80% of unidentified CIP sitting within pay.

Non-pay is £103k favourable in month 2, and £16k adverse year to date. Underspend on Hepatitis C pass through drugs, is masking an overspend due to delivering Cardiac Surgery activity in the private sector (£225k YTD, awaiting cost pressure funding), and high cost drugs and devices inflation which is awaiting funding (£190k YTD). In addition, £168k of invoices relating to 2014/15 are in the position.

Actions

- Actions are being completed around Nelson activity alongside Community Services Division.
- Regular meetings occurring with Corporate Outpatients to ensure that resources are available and in place to deliver SLA growth plans in outpatient specialties.
- Hepatitis C drug income and expenditure budgets to be re-profiled to eliminate variance.
- GM's working to close CIP gap, and move schemes from amber and red, to green. In addition run rate schemes are in place to mitigate the shortfall on a temporary basis.
- Business case being worked up for Cardiac Surgery to utilise Theatre 4 when the Hybrid Theatre comes online to help the division repatriate activity back from St Anthony's in the private sector.
- The Division is attempting to close capacity during the quieter summer months to save on nursing.
- The Division continues to work to resolve outstanding business planning and cost pressure issues.

Medicine & Cardiovascular - Divisional CIP performance

FORECAST	ANNUAL TARGET	FORECAST AT M2 (£m) INC	EXP	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT FALL	
MEDCARD SUMMARY									
ACUTE MED	2.41	0.09	0.78	0.87	0.07	0.74	0.06	1.55	A
CARDIOVASCULAR	2.66	0.19	1.03	1.22	0.18	0.96	0.08	1.44	A
ED	1.67	0.19	0.59	0.78	0.02	0.69	0.08	0.88	A
MEDICINE OVERHEADS	0.22	0.00	0.81	0.81	0.02	0.79	0.00	-0.59	F
RENAL & ONCOLOGY	2.21	1.05	1.37	2.42	0.63	0.86	0.92	-0.21	F
SPECIALIST MED	1.45	0.46	0.92	1.38	0.21	0.83	0.34	0.07	A
Grand Total	**10.62**	**1.98**	**5.50**	**7.48**	**1.13**	**4.88**	**1.48**	**3.14**	A
OF WHICH RECURRENT:		1.97	4.61	6.58	1.13	4.00	1.45	4.04	A
OBJECTIVE 2 (FULL YEAR EFFECT)		2.23	4.84	7.07	1.34	4.21	1.52	3.55	A

PERFORMANCE	YTD TARGET	ACTUAL YTD M2 (£m) INC	EXP	TOTAL	OF WHICH TOTAL ACTUAL YTD RAG RED	AMBER	GREEN	SHORT FALL	
MEDCARD SUMMARY									
ACUTE MED	0.40	0.01	0.03	0.03	0.01	0.02	0.00	0.37	A
CARDIOVASCULAR	0.44	0.02	0.09	0.11	0.00	0.08	0.03	0.34	A
ED	0.28	0.01	0.03	0.05	0.00	0.04	0.01	0.23	A
MEDICINE OVERHEADS	0.04	0.00	0.79	0.79	0.00	0.79	0.00	-0.75	F
RENAL & ONCOLOGY	0.37	0.24	0.14	0.38	0.02	0.12	0.24	-0.01	F
SPECIALIST MED	0.24	0.01	0.03	0.05	0.01	0.02	0.02	0.19	A
Grand Total	**1.77**	**0.29**	**1.12**	**1.40**	**0.04**	**1.07**	**0.29**	**0.37**	A
OF WHICH RECURRENT:		0.13	0.11	0.24	0.04	0.27	0.29	1.53	A

- At month 2, there remain a number of issues in relation to business planning and cost pressures which remain unresolved. However at the time of reporting the division has identified £7.48m of CIP's, against a target of £10.62m, leaving a shortfall of £3.14m. £0.9m of these schemes are red, £4.88m are amber, and £1.7m are green.
- Against a year to date target of £1.77m, the division has delivered £1.4m of CIP schemes, leaving a shortfall of £0.37m. £0.79m of this delivery was in non-recurrent run rate schemes.

The 3 main areas with CIP shortfall are Acute, ED and CVT.

- 56% of the Acute expenditure budget is nursing, with a CIP not possible without reducing staffing levels below the level in the nursing review. This gap is being addressed through run rate schemes where possible, although the gap in funding of cost pressures for nursing posts make this challenging.
- Similarly, 79% of the ED expenditure budget is Pay, with the reduction of head count needing to be managed against the delivery of performance. Again, this shortfall is being managed through the run rate schemes, with shifts not being covered on an ad-hoc basis, at the judgement of the directorate team.
- The CVT directorate is impacted on by capacity constraints, with a proportion of cardiac surgery activity being done in the private sector, leading to a loss of contribution from this activity. It is likely that the division will need to move further cases than currently planned to the private sector, which impacts even further on budget and contribution, we are working with theatres to resolve this where possible.

Each directorate continues to look for new schemes to either close their gap, or over perform if possible.

SNCT - Divisional I&E

	2015/16 Annual Budget	Previous Months Actuals Trend			2015/16 Current			2015/16 YTD		
		Actual M11	Actual M12	Actual M1	Budget M2	Actual M2	Variance M2	Budget YTD	Actual YTD	Variance YTD
		£m	£m	£m	£m	£m	£m	£m	£m	£m
SLA Income	154.56	11.78	13.49	11.84	11.85	11.76	(0.09)	23.78	23.59	(0.18)
Other Income	18.81	1.50	1.41	1.54	1.56	1.42	(0.15)	3.14	2.95	(0.18)
Pay	(103.48)	(8.59)	(9.07)	(8.52)	(8.34)	(8.47)	(0.13)	(16.83)	(16.99)	(0.16)
Non Pay	(31.96)	(2.58)	(2.61)	(2.89)	(2.64)	(2.40)	0.24	(5.30)	(5.29)	0.00
Other	(3.90)	(0.32)	(0.35)	(0.34)	(0.33)	(0.33)	(0.00)	(0.65)	(0.66)	(0.01)
Grand Total	34.03	1.78	2.87	1.63	2.10	1.98	(0.13)	4.14	3.60	(0.53)

YTD Var 2015/16 (adv) / fav	Cancer		Neuro		Surgery		Theatres and Anaesthetics		Total Sum of YTD Budget £k	
	£m	%	£m	%	£m	%	£m	%	£m	%
SLA Income	(0.01)	*-100.0%*	(0.20)	*-2.1%*	0.04	*0.3%*	(0.01)	*-3.7%*	(0.18)	*-0.8%*
Other Income	0.00	*#DIV/0!*	(0.08)	*-11.3%*	(0.10)	*-7.0%*	0.00	*0.1%*	(0.18)	*-5.8%*
Pay	0.02	*17.9%*	0.18	*3.9%*	(0.26)	*-4.2%*	(0.11)	*-1.8%*	(0.16)	*-1.0%*
Non Pay	(0.01)	*-970.7%*	0.32	*15.0%*	(0.28)	*-11.4%*	(0.02)	*-3.1%*	0.00	*0.1%*
Other	(0.00)	*-0.1%*	0.00	*0.1%*	0.00	*0.6%*	(0.01)	*-5.0%*	(0.01)	*-2.0%*
Grand Total	(0.00)	*-0.4%*	0.22	*5.8%*	(0.60)	*-9.6%*	(0.15)	*-2.6%*	(0.53)	*-12.9%*

The Division is reporting a YTD M02 deficit of £0.50m, a deterioration of £0.1m from the M01 deficit of £0.4m
The M02 £0.1m over spend comprises: £0.2m income under performance, £0.1m pay over spend & (£0.2m) non pay overspend / unmet CIP gap.

Income YTD M02 is a deficit of £0.3m [1% over performance]. The month 02 £0.2m deficit [2% over performance] is due to OP under performance at Nelson hospital and recharging CCG's expensive Neurology drugs was over stated in M01.
The overall income position is reporting a deficit on, Neuro-rehab bed days [due to transfer of beds from QMH to STG], Neuroradiology business case funding overstated and Neurosciences private patient income. Recharging CCGs Neurology expensive drugs although reporting an under performance is offset by a drugs under spend in non pay.

The Pay YTD M02 position is over spent £0.2m [1% unfavourable]. (£0.4m) of vacancies [mainly Neuro nursing] and run rate reductions are offsetting the unmet CIP pay gap of £0.6m

The Non pay YTD M02 under spend (£0.2m) includes consumables / equipment across the division and Neurology drugs offset by RTT / SRG funding shortfall in business planning.
The YTD M02 unmet CIP non pay / business planning gap is £0.2m

Actions

- Improvements from CIP's and actions planned - The £6.1m of CIP's forecast is mostly on expenditure schemes to improve pay productivity, reducing consultant PA's during job planning, using HCA's instead of RMN specials, reduced cost in the private sector for healthcare and reducing clinical consumable spend. SCNT will continue to work with Care group leads, procurement, medical staffing and other trust support services to improve efficiency and maximise SLA income.
- Key uncertainties - Not being fully funding for business cases and other budgeting issues identified on the divisions cost pressure list. Delays in completing capital schemes to provide additional capacity. The ability to continue to hold vacancies. A more comprehensive list of issues will be given for M03 reporting.

SCNT - Divisional CIP performance

FORECAST	ANNUAL TARGET	FORECAST AT M2 (£m) INC	EXP	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT FALL	
SCNT SUMMARY									
CANCER, HEAD & NECK	1.31	0.12	0.28	0.40	0.01	0.26	0.14	0.90	A
GEN SURG & UROLOGY	1.35	0.08	0.98	1.06	0.05	0.23	0.77	0.29	A
NEUROSCIENCES	1.89	0.65	1.18	1.83	0.10	0.34	1.39	0.06	A
SURGERY OVERHEADS	0.24	0.00	0.58	0.58	0.04	0.54	0.00	-0.34	F
THEATRES	2.42	0.00	1.18	1.18	0.59	0.27	0.32	1.25	A
TRAUMA & ORTHO, PLAST	1.50	0.40	0.64	1.05	0.00	0.33	0.72	0.45	A
Grand Total	**8.71**	**1.25**	**4.85**	**6.10**	**0.79**	**1.98**	**3.34**	**2.61**	A
OF WHICH RECURRENT:		1.25	3.85	5.10	0.79	1.23	3.08	3.61	A
OBJECTIVE 2 (FULL YEAR EFFECT)		1.31	3.98	5.29	0.79	1.30	3.20	3.42	A

PERFORMANCE	YTD TARGET	ACTUAL YTD M2 (£m) INC	EXP	TOTAL	OF WHICH TOTAL ACTUAL YTD RAG RED	AMBER	GREEN	SHORT FALL	
SCNT SUMMARY									
CANCER, HEAD & NECK	0.22	0.00	0.04	0.04	0.00	0.03	0.01	0.18	A
GEN SURG & UROLOGY	0.23	0.00	0.11	0.12	0.00	0.00	0.11	0.11	A
NEUROSCIENCES	0.31	0.08	0.24	0.32	0.02	0.04	0.26	-0.01	F
SURGERY OVERHEADS	0.04	0.00	0.53	0.53	0.00	0.53	0.00	-0.49	F
THEATRES	0.40	0.00	0.16	0.16	0.10	0.02	0.04	0.24	A
TRAUMA & ORTHO, PLAST	0.25	0.04	0.09	0.13	0.00	0.03	0.10	0.12	A
Grand Total	**1.45**	**0.13**	**1.17**	**1.30**	**0.12**	**0.66**	**0.52**	**0.16**	A
OF WHICH RECURRENT:		0.06	0.25	0.32	0.12	0.10	0.46	1.13	A

- SCNT has a CIP target of £8.7m, with £6.1m of developed schemes and a gap of £2.6m.
- The red schemes have reduced from £1.8m reported at M01 to £0.8m.
- The largest red scheme is theatre productivity which will go green once business planning is complete and the Trust confirms number / type of theatre sessions to be provided.
- The £6.1m of CIP's forecast 15/16 is mostly on expenditure schemes to improve pay productivity, reducing consultant PA's during job planning, using HCA's instead of RMN specials, reduced cost / usage in the private sector for healthcare and reducing clinical consumable spend.
- SCNT will continue to work with Care group leads, procurement, medical staffing and other Trust support services to improve efficiency and maximise SLA income.
- The YTD M02 CIP target is £1.45m, with schemes saving £0.8m and run rate pay reductions of £0.5m, leaving a shortfall of £0.15m.
- The run rate reductions are on holding vacancies mainly in theatres £0.3m and nursing £0.2m.

Overheads - Divisional I&E

	2015/16 Annual Budget	Previous Months Actuals Trend			2015/16 Current			2015/16 YTD		
		Actual M11 £m	Actual M12 £m	Actual M1 £m	Budget M2 £m	Actual M2 £m	Variance M2 £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
SLA Income	3.81	0.36	0.38	0.33	0.32	0.33	0.01	0.63	0.66	0.03
Other Income	17.17	1.07	1.22	1.19	1.36	1.27	(0.08)	2.86	2.46	(0.39)
Pay	(40.43)	(3.21)	(3.28)	(3.53)	(3.50)	(3.34)	0.15	(6.70)	(6.87)	(0.17)
Non Pay	(84.65)	(4.63)	(5.68)	(6.90)	(6.82)	(6.95)	(0.13)	(14.11)	(13.85)	0.26
Other	(10.12)	(0.81)	(0.89)	(0.84)	(0.84)	(0.84)	0.01	(1.69)	(1.68)	0.01
Grand Total	(114.23)	(7.23)	(8.26)	(9.74)	(9.48)	(9.53)	(0.05)	(19.01)	(19.27)	(0.26)

YTD Var 2015/16 (adv) / fav	Corporate Directorates		Estates & Facilities		Total Sum of YTD Budget £k	
	£m	%	£m	%	£m	%
SLA Income	0.00	*0.0%*	0.03	*4.3%*	0.03	*4.2%*
Other Income	(0.20)	*-16.6%*	(0.19)	*-11.6%*	(0.39)	*-13.7%*
Pay	0.05	*1.1%*	(0.22)	*-11.0%*	(0.17)	*-2.5%*
Non Pay	0.05	*1.2%*	0.20	*2.2%*	0.26	*1.8%*
Other	(0.00)	*-0.2%*	0.01	*1.3%*	0.01	*0.7%*
Grand Total	(0.10)	*-1.1%*	(0.17)	*-1.7%*	(0.26)	*-1.4%*

- Corporate Services performance showed a YTD deficit of £95k, and an in month deficit of £147k. There are outstanding cost pressures awaiting agreement and the main pressure this year will be on Education which is currently £139k over YTD. Governance, Ops, Procurement and Strategy are in surplus by £165k YTD.

- The Estates and Facilities service showed a YTD deficit of £169k but an in month surplus of £98k. There is a £100k cost for variations which is awaiting approval to transfer to Capital. If agreed, the position will improve by a further £100k. There are cost pressures awaiting agreement and this will also reduce the deficit.

Actions

- Estates & Facilities will achieve CIP targets by using run-rate savings. Corporate areas are finding it increasingly difficult to find CIPs and will use run-rate mitigations.

There are a number of risks which will swing the outturn. The main areas are in E&F and particularly with energy recharges to SGUL. There is also work to reconcile 14/15 outstanding CSD property charges and to firm up 15/16 rent costs for all premises which have now transferred to the E&F Division.

Overheads - Divisional CIP performance

FORECAST	ANNUAL TARGET	FORECAST AT M2 (£m) INC	EXP	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT FALL	
OVERHEADS SUMMARY									
ESTATES & FACILITIES	2.89	0.00	0.48	0.48	0.08	0.40	0.00	2.41	A
OF WHICH RECURRENT:		0.00	0.00	0.00	0.00	0.00	0.00	0.00	
		0.00	0.00	0.00	0.00	0.00	0.00	0.00	
CORPORATES:		0.00	0.00	0.00	0.00	0.00	0.00	0.00	
FINANCE & IT	1.44	0.00	0.82	0.82	0.08	0.34	0.39	0.62	A
GOVERNANCE & CEO	0.54	0.00	0.33	0.33	0.00	0.11	0.22	0.21	A
HR & EDUCATION	0.38	0.10	0.05	0.15	0.06	0.09	0.00	0.23	A
DON & OPS	0.25	0.00	0.20	0.20	0.00	0.00	0.00	0.05	A
Grand Total	**2.60**	**0.10**	**1.39**	**1.50**	**0.14**	**0.54**	**0.61**	**1.11**	A
OF WHICH RECURRENT:		0.10	1.19	1.29	0.14	0.49	0.66	1.31	A
OBJECTIVE 2 (FULL YEAR EFFECT)		0.14	1.23	1.36	0.17	0.54	0.66	1.24	A

PERFORMANCE	YTD TARGET	ACTUAL YTD M2 (£m) INC	EXP	TOTAL	OF WHICH TOTAL ACTUAL YTD RAG RED	AMBER	GREEN	SHORT FALL	
OVERHEADS SUMMARY									
ESTATES & FACILITIES	0.48	0.00	0.40	0.40	0.00	0.40	0.00	0.08	A
OF WHICH RECURRENT:		0.00	-0.01	-0.01	0.00	0.00	0.00	0.49	A
CORPORATES:		0.00	0.00	0.00	0.00	0.00	0.00	0.00	
FINANCE & IT	0.24	0.00	0.12	0.12	0.01	0.05	0.06	0.12	A
GOVERNANCE & CEO	0.09	0.00	0.05	0.05	0.00	0.02	0.04	0.04	A
HR & EDUCATION	0.06	0.00	0.00	0.00	0.00	0.00	0.00	0.06	A
DON & OPS	0.04	0.00	0.03	0.03	0.00	0.00	0.00	0.01	A
Grand Total	**0.43**		**0.20**	**0.20**	**0.01**	**0.07**	**0.10**	**0.23**	A
OF WHICH RECURRENT:		0.00	0.16	0.16	0.01	0.05	0.11	0.27	A

- Estates CIP target is £2.9m for the year. The gap for the year is £2.4m. Runrates of £0.4m have been captured and reported in month. The directorate is planning to deliver most of the CIP target by runrate for the year but have warned that the Estates maintenance spend holds need to be stopped due to safety concerns.

- Corporates have a target of £2.6m. The planning gap is at £1.1m ,mainly in Finance and IT. In month 2 £0.1m of savings have been made in Corporate mainly from cancellation of service improvement consultancy spend budget £17k, holding 8d post in Governance £9k, £18k on IT staffing reductions, £10k from saving against strategy post being held vacant for the month.

❾ Capital

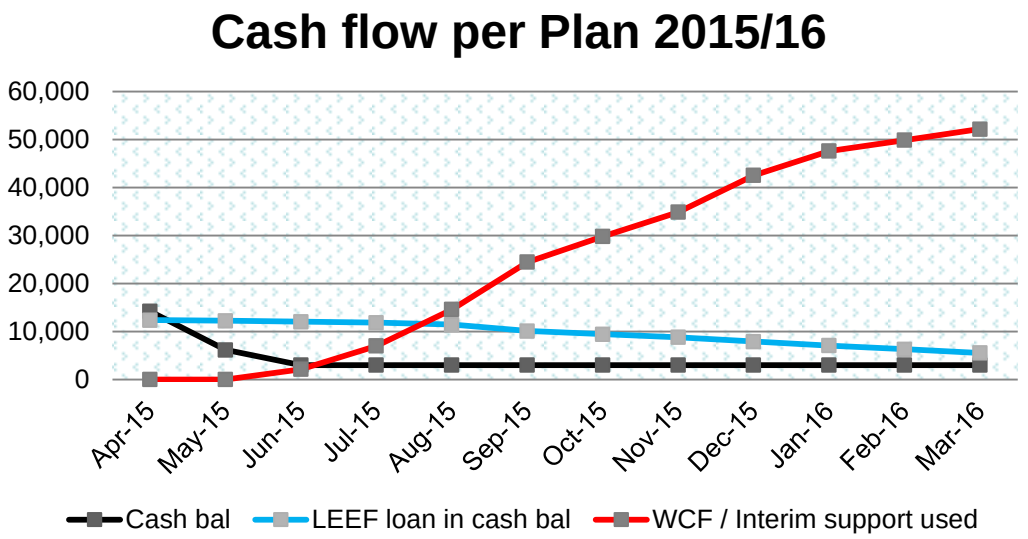
- Capital expenditure in May was £3.8m vs plan £5.1m. i.e. an under spend of £1.3m. Capital expenditure YTD is £6.1m vs plan £9.5m i.e. an under spend of £3.4m – see below for breakdown by source of finance
- The Trust has secured external finance of approx £26.5m for 2015/16 expenditure comprising:
    1. the energy performance project financed by the LEEF loan = £7m ,
    2. IMT projects - financed by PDC capital = £1.1m
    3. SAU, QMR and hybrid theatre projects - financed by DH capital loans approved last year = £7.3m.
    4. Lease finance is available when required for equipment items = £11.2m
- The £30.2m balance of the programme is planned for finance by internal capital but this is subject to the application for interim support funding. Therefore Trust needs to minimise capital expenditure to support the cash position until the interim support funding is agreed with Monitor/ITFF.
- Following a re-forecast exercise by the main budget holders, the executive have completed another review of budget lines and is proposing a reduction in the budget of £8.7m to £48m (see separate cash and capital update paper). The changes include:
    - deferring replacement of LW stand-by generators to next year (£2.7m): operational/clinical risk is mitigated by temporary plant.
    - removal of general leases budget for equipment: existing leases will be reviewed on case by case basis and may be extended

Summary cap exp by source of finance	**Monitor Plan £000**	M02 budget YTD £000	M02 actual YTD £000	M02 Var YTD £000
Internal capital	**30,236**	4,139	3,467	*672*
LEEF loan	**6,971**	252	-103	*355*
DH capital loans	**7,260**	2,873	1,285	*1,588*
PDC capital	**1,103**	220	137	*83*
Lease finance	**11,168**	1,990	1,302	*688*
Total	**56,738**	**9,474**	**6,088**	*3,386*

⑩ Cash

Steve – LEEF loan is £12.7m on this page and £7m on previous page – is this right? Nigel

- Cash balance was £7.9m at 31st May, down £6.3m on last month but above plan of £6.2m. This includes £12.6m unexpended LEEF loan for the energy performance contract. Therefore the cash balance excl LEEF is negative: -£4.7m
- Drawdowns from £25m working capital facility: £nil at 31st May
- The reduction in cash since year end was caused by:
  - trading deficit of £15.9m and
  - deterioration of £1.3m in working capital (stock, debtors and creditors) – better than plan (-£3.7m).
- The under spend on capital and the better performance on working capital more than offset the impact of the higher trading deficit enabling the Trust to achieve a May cash balance £1.7m above plan.



- The Trust has applied for interim cash support funding of £52.2m in the plan submitted to Monitor to finance the planned revenue deficit. Additional cash may be secured using the Trust's approved working capital facility of £25m while the interim support funding is agreed with Monitor and the ITFF. The dependence of the cash position on securing this financing is demonstrated in the Cash summary appendices.
- Last month's 13 week cash flow forecast projected a cash balance of £3m on 30th June. The latest daily cash forecast (as at 18th June) also projects a cash balance of approx. £3m and therefore the Trust is planning to draw down funds from the approved working capital facility on 13th July as approved by the Committee on 4th June. The exact value of the drawdown will be determined week ending 26th June.
- The Trust's objective is to minimise the level of interim support funding by delaying capital expenditure – and the executive is proposing a reduction in the capital programme of £8.7m – see the separate cash and capital update paper.
- Furthermore the Finance department is working with KPMG on refining cash flow forecasting and on exploring ways of generating/preserving cash e.g by revising supplier payment terms.

11 Balance sheet as at M2 2015/16

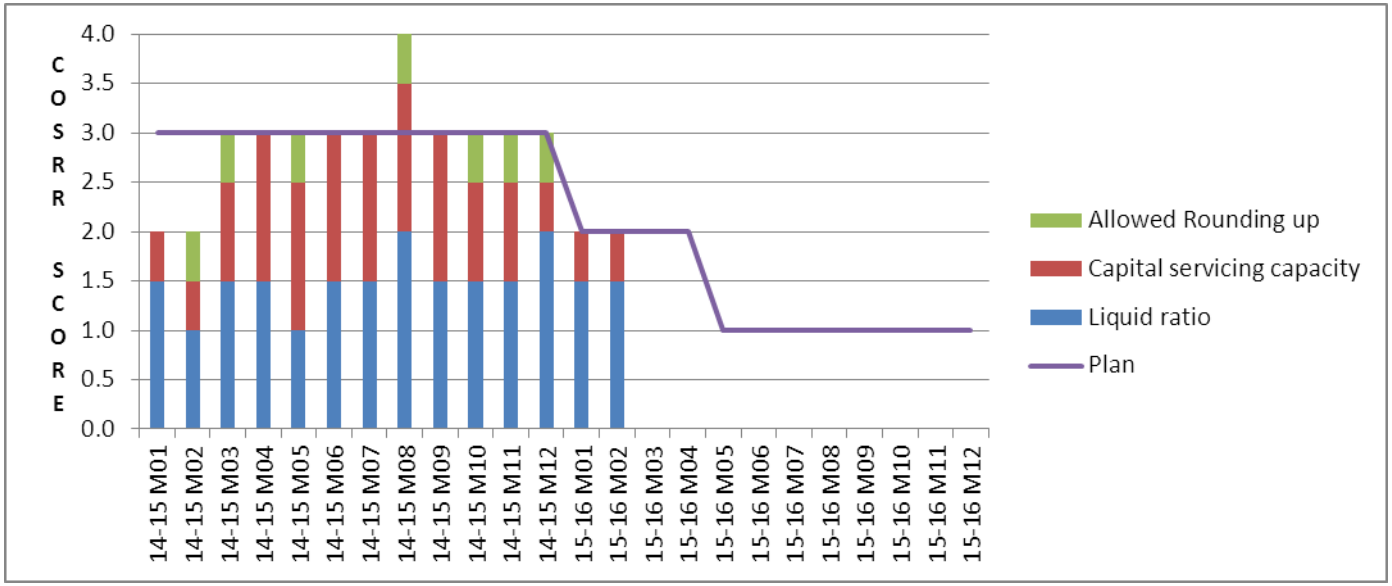
	May-15 £000 Plan	May-15 £000 Actual	£000 Variance	Notes on variances vs Plan
Fixed assets	335,931	332,547	(3,384)	Capex lower than plan - as intended.
Stock	7,132	7,863	731	Pharmacy stock rose in April - y/e level not sustainable over year
Debtors	77,233	82,057	4,824	NHSE SLA not yet signed. Income > budget not invoiced.
Cash	**6,187**	**7,925**	**1,739**	Cash above plan but down £16.2m since y/e (main cause: trading deficit £15.9m)
Creditors	(85,452)	(93,399)	(7,947)	Tight management of supplier payments. Also includes £3m accruals against reserves.
Capital creditors	(3,476)	(3,524)	(48)	
PDC div creditor	(1,180)	(1,180)	0	
Int payable creditor	(157)	(187)	(30)	
Provisions< 1 year	(602)	(512)	90	
Borrowings< 1 year	(5,853)	(5,314)	539	Lease capex lower than plan - as intended
Net current assets/-liabilities	**(6,168)**	**(6,271)**	**(103)**	
Provisions> 1 year	(1,181)	(1,182)	(1)	
Borrowings> 1 year	(88,333)	(87,981)	352	Lease capex lower than plan - as intended
Long-term liabilities	**(89,514)**	**(89,163)**	351	
Net assets	**240,249**	**237,113**	**(3,136)**	
Taxpayer's equity				
Public Dividend Capital	133,761	133,761	0	
Retained Earnings	3,978	1,125	(2,853)	YTD trading deficit higher than plan
Revaluation Reserve	101,360	101,077	(283)	
Other reserves	1,150	1,150	0	
Total taxpayer's equity	**240,249**	**237,113**	**(3,136)**	

12 Continuity of Services Risk Rating (COSRR)

	14/15	14/15	14/15	14/15	14/15	14/15	14/15	14/15	14/15	14/15	14/15	14/15	15/16	15/16
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual
Metric Scores	**M01**	**M02**	**M03**	**M04**	**M05**	**M06**	**M07**	**M08**	**M09**	**M10**	**M11**	**M12**	**M01**	**M02**
Liquid ratio	-3.6	-7.7	-5.6	-5.5	-8.6	-0.6	-0.3	0.3	-2.2	-2.2	-4.5	1.4	-2.8	-6.6
Capital servicing capacity	1.0	1.1	1.4	2.2	1.8	1.9	2.1	2.1	1.9	1.5	1.3	1.0	-3.6	-4.1
Metric Rating (See Thresholds)	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**
Liquid ratio	3	2	3	3	2	3	3	4	3	3	3	4	3	3
Capital servicing capacity	1	1	2	3	3	3	3	3	3	2	2	1	1	1
Weighted Average	2.0	1.5	2.5	3.0	2.5	3.0	3.0	3.5	3.0	2.5	2.5	2.5	2.0	2.0
Overriding Score	**2**	**2**	**3**	**3**	**3**	**3**	**3**	**4**	**3**	**3**	**3**	**3**	**2**	**2**

Metric	Liquid ratio	Capital servicing capacity
Criteria	Liquidity	Underlying performance
Weight	50.0%	50.0%
4	0	2.50
3	-7	1.75
2	-14	1.25
1	<-14	<1.25

In M02 the Trust achieved a 2 overall for COSRR with the liquidity metric 3 and capital servicing metric 1. These are all in line with the Annual Plan for M02.



Appendices

A. Detailed I/E
B. Adjusting for n/r items to give the underlying ‘run-rate’ position for m1
C. I/E time series of actuals
D. Movement in working capital chart and explanations
E. Detailed cash flow plan 2015/16
F. Detailed capital expenditure
G. Aged Debt Profile

Appendix A– Detailed Income & Expenditure

	CURRENT MONTH M2				CUMULATIVE YTD						
	Current Mth Budget £m	Current Mth Amount £m	Current Mth Variance (adv)/Fav £m	% Variance	YTD Budget £m	YTD Amount £m	YTD Variance (adv)/fav £m	% Variance	*Previous Variance (adv)/fav £m*	Annual Budget £m	Forecast Outturn £m
Income											
SLA Elective	4.93	4.86	-0.08 A	-1.6%	10.13	9.94	-0.19 A	-1.9%	*-0.11* A	67.15	66.01
SLA Daycase	2.23	2.39	0.16 F	7.3%	4.56	4.71	0.14 F	3.2%	*-0.02* A	29.46	30.33
SLA Non Elective	10.30	10.34	0.05 F	0.4%	20.27	20.44	0.17 F	0.9%	*0.13* F	122.55	123.59
SLA Outpatients	10.81	10.54	-0.27 A	-2.5%	21.75	21.12	-0.63 A	-2.9%	*-0.36* A	142.49	138.73
SLA A&E	1.62	1.54	-0.08 A	-4.7%	3.18	3.07	-0.11 A	-3.3%	*-0.03* A	19.09	18.45
SLA Bed Days	4.95	5.01	0.06 F	1.3%	9.89	9.84	-0.05 A	-0.5%	*-0.12* A	61.89	61.58
SLA Programme	1.49	1.68	0.19 F	13.0%	2.66	2.77	0.10 F	3.9%	*-0.09* A	17.85	18.48
SLA Exclusions	4.67	3.75	-0.93 A	-19.9%	8.54	7.97	-0.56 A	-6.6%	*0.37* F	58.53	55.15
SLA Other	9.19	9.68	0.49 F	5.3%	18.30	18.48	0.18 F	1.0%	*-0.31* A	110.10	111.18
SLA Provisions QiPP/KPIs & Y/E Settlement	-0.27	-0.27	0.00 A	0.0%	-0.75	-0.75	0.00 A	0.0%	*0.00* F	-4.51	-4.51
Subtotal - SLA Income	49.93	49.53	-0.40 A	-0.8%	98.53	97.59	-0.94 A	-1.0%	-0.54 A	624.59	618.97
Private & Overseas Patient	0.43	0.33	-0.10 A	-23.1%	0.86	0.78	-0.08 A	-9.7%	*0.02* F	5.15	4.65
RTAs	0.35	0.27	-0.08 A	-23.6%	0.70	0.62	-0.07 A	-10.5%	*0.01* F	4.17	3.73
Other Healthcare Income	0.01	0.02	0.01 F	115.6%	0.02	0.07	0.05 F	199.0%	*0.03* F	0.14	0.41
Levy Income	3.65	3.63	-0.02 A	-0.5%	7.30	7.28	-0.02 A	-0.3%	*0.00* A	43.81	43.68
Other Income	3.94	3.82	-0.12 A	-3.1%	7.92	7.65	-0.26 A	-3.3%	*-0.14* A	47.58	46.00
Total income	**58.30**	**57.59**	**-0.71** A	**-1.2%**	**115.32**	**113.99**	**-1.33** A	**-1.2%**	***-0.63*** A	**725.45**	**717.45**
Expenditure											
Pay Total	-36.98	-37.36	-0.38 A	-1.0%	-73.68	-74.75	-1.06 A	-1.4%	*-0.68* A	-444.11	-450.50
Drugs	-4.77	-4.41	0.37 F	7.7%	-9.40	-8.96	0.44 F	4.7%	*0.07* F	-56.36	-53.73
Clinical Consumables	-7.69	-8.51	-0.81 A	-10.6%	-15.38	-16.01	-0.63 A	-4.1%	*0.18* F	-92.02	-95.80
Reserves	-4.06	-2.30	1.76 F	43.4%	-6.09	-3.62	2.47 F	40.6%	*0.71* F	-34.68	-19.83
Other Total	-8.50	-10.65	-2.15 A	-25.3%	-17.90	-20.82	-2.91 A	-16.3%	*-0.76* A	-107.95	-105.59
Total expenditure	**-62.00**	**-63.22**	**-1.22** A	**-2.0%**	**-122.46**	**-124.15**	**-1.69** A	**-1.4%**	***-0.47*** A	**-735.12**	**-725.46**
EBITDA (note 1)	**-3.70**	**-5.62**	**-1.93** A	**-52.1%**	**-7.13**	**-10.16**	**-3.03** A	**-42.4%**	*-1.10* A	**-9.67**	**-8.00**
Disposal of Assets	0.00	0.00	0.00 F	0.0%	0.00	0.00	0.00 F	0.0%	*0.00* F	0.00	0.00
Interest payable	-0.26	-0.28	-0.02 A	-6.6%	-0.66	-0.68	-0.02 A	-2.9%	*0.00* A	-4.97	-5.09
Interest receivable	0.01	0.00	0.00 A	-52.5%	0.01	0.01	-0.01 A	-55.0%	*0.00* A	0.08	0.03
PDC Dividend	-0.61	-0.61	0.00 A	0.0%	-1.18	-1.18	0.00 A	0.0%	*0.00* F	-7.08	-7.08
Depreciation	-1.80	-1.80	0.00 A	0.0%	-3.85	-3.85	0.00 A	0.0%	*0.00* F	-24.61	-24.61
Total interest, dividends & deprec'n	**-2.66**	**-2.68**	**-0.02** A	**-0.8%**	**-5.67**	**-5.70**	**-0.03** A	**-0.5%**	***-0.01*** A	**-36.59**	**-36.75**
NET +Surplus /-Deficit	**-6.35**	**-8.30**	**-1.95** A	**-30.6%**	**-12.80**	**-15.86**	**-3.05** A	**-23.8%**	***-1.11*** A	**-46.26**	**-44.75**

Appendix B - Adjusting for prior period items to give the underlying 'run-rate' position for M2 & YTD

St George's University Hospitals NHS
NHS Foundation Trust

Current Month Analysis	Reported Position		Adjustments to derive Run Rate				Pass thru Costs	Adjusted Run Rate	
						❶	❷		
	YTD Variance (adv)/fav	%	Community KHT SLA services 14/15	SLA Income 14/15 Freeze Shortfall	Infusion Pumps costs relating to 14/15	Truer Run Rate For M2 (adv)/fav	High Cost Drugs and Devices	Truer Run Rate For M2 (adv)/fav	%
	£m		£m	£m	£m	£m	£m	£m	
SLA Income	(0.40)	*-0.8%*		0.70		0.30	0.93	1.23	*2.5%*
Other Income	(0.31)	*-3.7%*				(0.31)		(0.31)	*-3.7%*
Total Income	(0.71)	*-1.2%*		0.70		(0.01)	0.93	0.92	*1.6%*
Pay	(0.38)	*-1.0%*				(0.38)		(0.38)	*-1.0%*
Non Pay	(0.84)	*-3.3%*	0.33		0.70	0.19	(0.93)	(0.74)	*-2.9%*
Total Expenditure	(1.22)	*-2.0%*	0.33		0.70	(0.19)	(0.93)	(1.12)	*-1.8%*
EBITDA	(1.93)	*-52.1%*	0.33	0.70	0.70	(0.20)	0.00	(0.20)	*-5.3%*
Dprn, PDC, Interest	(0.02)	*-0.8%*				(0.02)		(0.02)	*-0.8%*
Surplus/Deficit	**(1.95)**	***-30.6%***	**0.33**	**0.70**	**0.70**	**(0.22)**	**0.00**	**(0.22)**	*-3.4%*

Year to Date Analysis	Reported Position		Adjustments to derive Run Rate								Pass thru Costs	Adjusted Run Rate	
	YTD Variance (adv)/fav	%	Community KHT SLA services 14/15	SLA Income 14/15 Freeze Shortfall	Infusion Pumps costs relating to 14/15	Iron Mountain Invoices	TDA Debt 14/15 Written Off	NCA income w/o relating to 14/15	Other Items relating to 14/15	Truer Run Rate For M2 (adv)/fav	High Cost Drugs and Devices	Truer Run Rate For M2 (adv)/fav	%
	£m		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	
SLA Income	(0.94)	*-1.0%*		0.70				0.20	(0.12)	(0.16)	0.56	0.40	*0.4%*
Other Income	(0.40)	*-2.4%*					0.23			(0.17)		(0.17)	*-1.0%*
Total Income	(1.33)	*-1.2%*		0.70		0.00	0.23	0.20	(0.12)	(0.33)	0.56	0.23	*0.2%*
Pay	(1.06)	*-1.4%*							0.10	(0.96)		(0.96)	*-1.3%*
Non Pay	(0.63)	*-1.3%*	0.33		0.70	0.29				0.69	(0.56)	0.13	*0.3%*
Total Expenditure	(1.69)	*-1.4%*	0.33		0.70	0.29	0.00	0.00	0.10	(0.28)	(0.56)	(0.84)	*-0.7%*
EBITDA	(3.03)	*-42.4%*	0.33	0.70	0.70	0.29	0.23	0.20	(0.02)	(0.60)	0.00	(0.60)	*-5.9%*
Dprn, PDC, Interest	(0.03)	*-0.5%*								(0.03)		(0.03)	*-0.5%*
Surplus/Deficit	**(3.05)**	***-23.8%***	**0.33**	**0.70**	**0.70**	**0.29**	**0.23**	**0.20**	**(0.02)**	**(0.63)**	**0.00**	**(0.63)**	*-4.0%*

With the pressure to close and report, late receipt of bills which are under accrued or disputes carrying on in the background it is not uncommon that expenditure or income can be assigned to the wrong accounting period. As long as this is a small value, this is not usually a problem. However such items need to be taken into account to get a true 'run-rate' for a given period

❶ In m2 there were c£1.7m of these adjustments, which would imply a 'run-rate' adverse variance to plan in month of £0.2m.

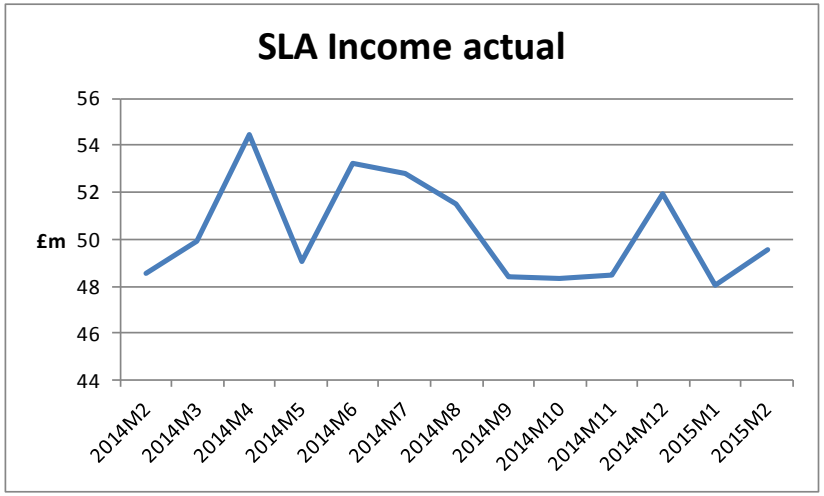
YTD there have been c£2.4m of these adjustments, which would imply a 'run-rate' adverse YTD variance to plan of £0.6m.

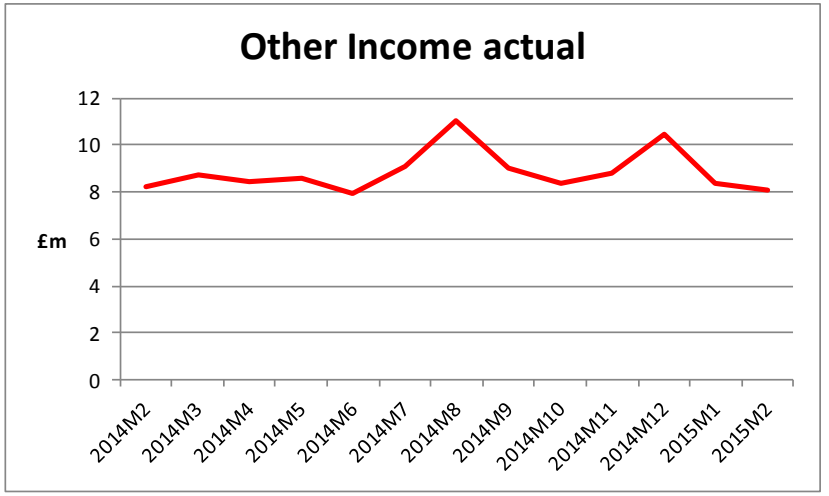
❷ The Trust budgets for a certain level of High Cost Drugs and Devices and an equivalent level of recharge (ie income). Usage generally runs higher than plan and this leads to a favourable income variance and adverse cost variance. This column removes both of these variances as they can mask other issues. [The finance team are considering changing the accounting treatment for m3 onwards, so that these variances will not shown in the ledger].

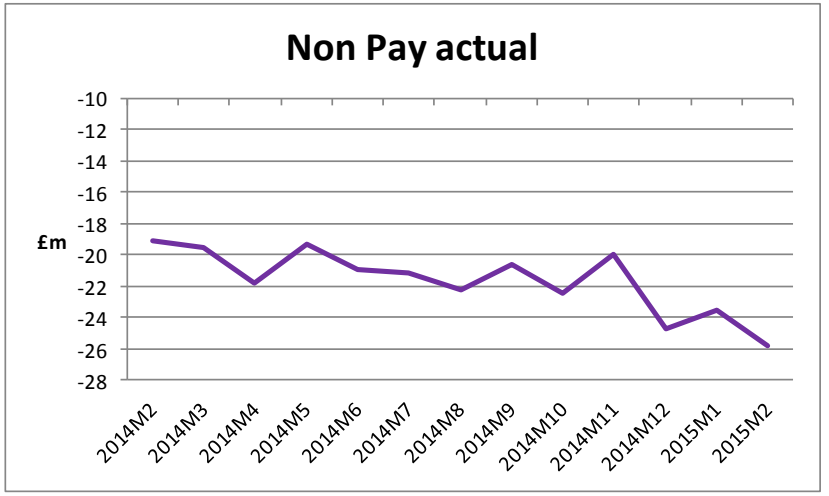
Appendix C1 - Time series of Actuals

I&E Type	Type	Catergory	2014M2	2014M3	2014M4	2014M5	2014M6	2014M7	2014M8	2014M9	2014M10	2014M11	2014M12	2015M1	2015M2
Income	SLA Income	SLA A&E	-1.46	-1.33	-1.35	-1.19	-1.29	-1.32	-1.24	-1.33	-1.22	-1.20	-1.33	-1.53	-1.54
		SLA Bed Days	-4.84	-4.86	-4.95	-4.72	-5.08	-4.93	-4.93	-5.35	-4.88	-5.11	-5.57	-4.83	-5.01
		SLA Daycase	-2.18	-2.29	-2.51	-2.11	-2.32	-2.58	-2.15	-2.00	-2.22	-2.16	-2.49	-2.31	-2.39
		SLA Elective	-4.56	-5.20	-5.60	-5.04	-4.73	-5.26	-4.61	-4.01	-4.79	-4.23	-5.32	-5.08	-4.86
		SLA Exclusions	-3.33	-3.33	-3.98	-4.09	-3.40	-4.11	-3.46	-3.98	-2.12	-3.54	-3.50	-4.23	-3.75
		SLA Non Elective	-9.29	-9.23	-9.92	-8.94	-10.21	-9.84	-9.17	-9.25	-8.98	-8.86	-9.19	-10.10	-10.34
		SLA Other	-12.57	-12.36	-14.59	-12.64	-13.88	-13.67	-14.09	-13.08	-12.84	-12.67	-13.47	-8.32	-9.41
		SLA Outpatients	-9.01	-9.96	-10.06	-8.86	-10.80	-9.87	-10.29	-8.01	-9.84	-9.18	-9.65	-10.58	-10.54
		SLA Programme	-1.32	-1.33	-1.51	-1.41	-1.55	-1.19	-1.57	-1.37	-1.43	-1.53	-1.46	-1.09	-1.68
	SLA Income Total		**-48.54**	**-49.90**	**-54.48**	**-49.02**	**-53.25**	**-52.77**	**-51.49**	**-48.38**	**-48.32**	**-48.48**	**-51.97**	**-48.06**	**-49.53**
	Other Income	Levy Income	-3.97	-3.97	-4.08	-3.98	-3.96	-4.11	-4.13	-4.31	-4.00	-3.75	-3.84	-3.65	-3.63
		Other Healthcare Income	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.02	-0.01	-0.01	-0.01	-0.02	-0.04	-0.02
		Private & Overseas Patient	-0.33	-0.44	-0.43	-0.25	-0.31	-0.48	-0.50	-0.54	-0.61	-0.27	-0.51	-0.45	-0.33
		RTAs	-0.34	-0.37	-0.38	-0.32	-0.32	-0.36	-0.43	-0.35	-0.45	-0.45	-0.38	-0.36	-0.27
		Other Income	-3.55	-3.92	-3.52	-4.00	-3.32	-4.15	-5.93	-3.78	-3.33	-4.31	-5.73	-3.83	-3.82
	Other Income Total		**-8.20**	**-8.71**	**-8.41**	**-8.56**	**-7.91**	**-9.11**	**-11.01**	**-9.00**	**-8.39**	**-8.79**	**-10.48**	**-8.33**	**-8.07**
Income Total			**-56.74**	**-58.61**	**-62.89**	**-57.58**	**-61.16**	**-61.88**	**-62.50**	**-57.38**	**-56.71**	**-57.27**	**-62.45**	**-56.40**	**-57.59**
Expenditure	Pay	Pay Consultants	5.59	5.31	5.59	5.53	5.52	5.54	5.73	5.55	5.91	6.11	6.35	5.83	5.81
		Pay Jnr Drs	4.08	4.23	4.25	4.15	4.23	4.56	4.32	4.71	4.28	4.38	4.31	4.25	4.24
		Pay Non Clinical	5.62	5.83	5.96	6.19	6.40	6.00	6.01	5.72	5.89	5.98	6.44	6.10	5.95
		Pay Nursing	13.43	13.42	13.78	12.50	13.85	13.44	13.42	13.48	14.09	14.30	15.05	14.62	14.68
		Pay Other	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.01	0.00	0.00	0.01	-0.01
		Pay Sci, Techs, Therap	7.52	7.50	7.34	7.84	6.96	7.17	7.57	7.73	7.28	7.17	7.08	6.58	6.68
	Pay Total		**36.24**	**36.29**	**36.92**	**36.21**	**36.96**	**36.72**	**37.06**	**37.20**	**37.47**	**37.93**	**39.23**	**37.39**	**37.36**
	Non Pay	Drugs	3.98	3.89	4.47	3.53	4.23	4.11	3.94	4.20	3.80	4.15	5.41	4.55	4.41
		Clinical Consumables	6.90	7.84	8.49	7.36	7.69	6.98	7.64	7.97	8.57	7.92	7.16	7.50	8.51
		Clinical Negligence	0.78	0.81	0.74	0.81	0.83	0.92	0.76	0.79	0.83	0.75	0.83	1.22	1.21
		Establishment	0.69	0.86	1.01	0.90	0.67	1.03	0.86	0.81	0.90	0.79	0.87	0.81	1.04
		General Supplies	1.29	1.77	1.34	1.31	1.46	1.42	1.54	1.39	1.15	1.33	1.14	1.35	1.37
		PFI Unitary payment	0.57	0.58	0.56	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.59	0.58
		Premises	2.75	2.82	2.93	2.35	3.05	3.42	3.29	2.97	2.95	3.31	3.95	3.39	3.45
		Other	2.18	0.98	2.30	2.57	2.47	2.74	3.65	1.90	3.69	1.13	4.75	4.12	5.29
	Non Pay Total		**19.14**	**19.55**	**21.84**	**19.39**	**20.98**	**21.20**	**22.25**	**20.60**	**22.46**	**19.95**	**24.69**	**23.54**	**25.86**
Expenditure Total			**55.37**	**55.84**	**58.77**	**55.60**	**57.94**	**57.92**	**59.31**	**57.80**	**59.93**	**57.89**	**63.93**	**60.93**	**63.22**
Post Ebitda	Other Income	Interest Receivable	-0.01	0.00	-0.01	0.00	-0.01	-0.01	-0.01	-0.01	-0.01	0.00	-0.01	0.00	0.00
	Other Income Total		**-0.01**	**0.00**	**-0.01**	**0.00**	**-0.01**	**-0.01**	**-0.01**	**-0.01**	**-0.01**	**0.00**	**-0.01**	**0.00**	**0.00**
	Other	Depreciation	1.77	1.55	1.80	1.69	1.69	1.73	1.73	1.73	2.19	1.75	1.85	2.05	1.80
		Disposal of Assets	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.09	0.00	0.00
		Interest Payable	0.26	0.26	0.28	0.26	0.27	0.26	0.26	0.29	0.29	0.27	0.31	0.40	0.28
		PDC Dividend	0.64	0.64	0.67	0.61	0.63	0.71	0.64	0.64	0.62	0.64	0.64	0.57	0.61
	Other Total		**2.67**	**2.44**	**2.75**	**2.56**	**2.60**	**2.71**	**2.63**	**2.66**	**3.10**	**2.66**	**2.90**	**3.02**	**2.68**
Post Ebitda Total			**2.66**	**2.44**	**2.74**	**2.56**	**2.59**	**2.70**	**2.62**	**2.65**	**3.09**	**2.65**	**2.89**	**3.02**	**2.68**
Grand Total			**1.29**	**-0.33**	**-1.39**	**0.59**	**-0.63**	**-1.25**	**-0.57**	**3.07**	**6.31**	**3.27**	**4.36**	**7.56**	**8.30**

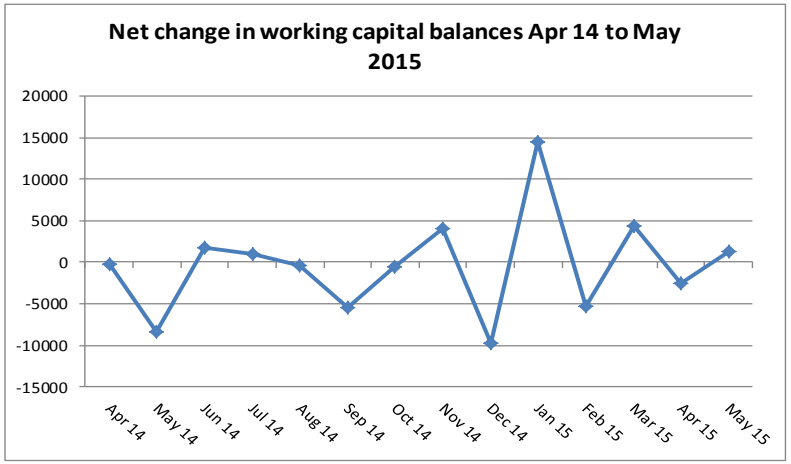
Appendix C2 – Trends of Income and Expenditure



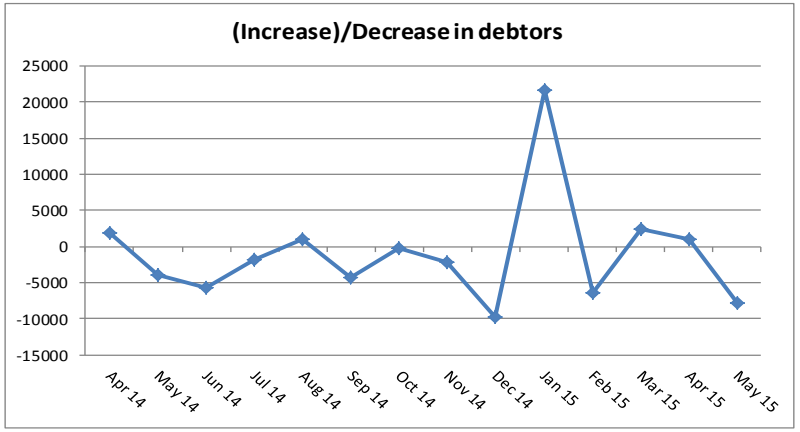




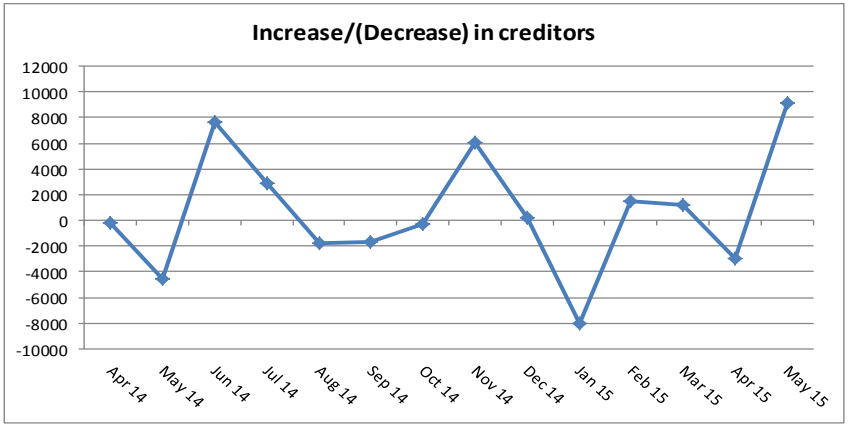
Appendix D - Working Capital trends



Trust implemented bulk purchase protocol and stock limits in year
All major depts except central store achieved their year end stock targets



NHSE accrued debt is approx £5m in May 2015 - income recognised but not invoiced as SLA not yet agreed as at 31st May. GUM invs to be paid by LBW in June.



Trust had to exert tight control over payments to suppliers to manage cash flow and this is reflected particularly in months 3 and 8.The BPPC performance worsened over the year as a consequence
April and May 15 creditors include accruals against reserves

Appendix E - Detailed monthly cash flow forecast 2015/16 – updated for proposed reduction in capex

St George's University Hospitals NHS
NHS Foundation Trust

2015/16 forecast monthly cash flow

	Plan April 15 £000	Actual Apr-15 £000	Plan May-15 £000	Actual May-15 £000	Plan Jun-15 £000	Forecast Jun-15 £000	Plan Jul-15 £000	Forecast Jul-15 £000	Plan Aug-15 £000	Forecast Aug-15 £000	Plan Sep-15 £000	Forecast Sep-15 £000	Plan Oct-15 £000	Forecast Oct-15 £000	Plan Nov-15 £000	Forecast Nov-15 £000	Plan Dec-15 £000	Forecast Dec-15 £000	Plan Jan-16 £000	Forecast Jan-16 £000	Plan Feb-16 £000	Forecast Feb-16 £000	Plan Mar-16 £000	Forecast Mar-16 £000
Opening cash balance	24,179	**24,179**	**14,200**	**14,188**	**6,187**	**7,925**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,453**	**3,000**	**3,438**	**3,000**	**4,284**	**3,000**	**3,982**	**3,000**	**4,522**	**3,000**	**4,706**	**3,000**	**5,658**
EBITDA	-3,615	-4,525	-3,434	-5,635	-327	-327	665	665	-2,744	-2,744	-155	-156	747	746	-60	-61	-2,841	-2,842	-210	835	695	1,740	1,670	2,695
Non-cash income	-15	-15	-15	-14	-15	-15	-15	-15	-15	-15	-15	-14	-15	-14	-15	-14	-15	-14	-15	-14	-15	-14	-15	-15
Interest paid	-271	-278	-329	-311	-354	-354	-282	-282	-381	-381	-342	-342	-371	-371	-484	-484	-530	-530	-436	-436	-529	-529	-449	-461
PDC dividend paid											-3,540	-3,540											-3,542	-3,542
Operating surplus/-deficit less int and divs paid	-3,901	-4,818	-3,778	-5,960	-696	-696	369	368	-3,139	-3,140	-4,052	-4,052	361	361	-558	-559	-3,386	-3,386	-660	385	152	1,197	-2,336	-1,323
Change in working capital																								
Change in stock		-683	25	-23	50	50	75	75	75	75	89	89	50	50	50	50	93	93	100	349	125	400	125	333
Change in debtors	-309	998	-1,691	-7,822	-1,000	908	-1,000	-4,138	500	500	-1,000	-1,000	-1,000	-1,000	0	0	500	500	-1,000	-1,000	1,500	1,500	1,500	7,554
Change in creditors excl those below	-2,351	-2,930	651	9,178	-250	-758	-300	-409	-300	-340	-250	-251	-150	-150	-150	-151	200	200	-450	-1,744	-750	-1,558	-1,108	-6,294
Net change in working capital	-2,660	-2,615	-1,015	1,333	-1,200	200	-1,225	-4,472	275	235	-1,161	-1,162	-1,100	-1,100	-100	-101	793	793	-1,350	-2,395	875	342	517	1,593
Provisions used	0	-54	0	-35	0	-21	0	-21	0	-21	0	-21	0	-21	0	-21	0	-21	0	-21	0	-21	0	-21
Interest received	6	3	6	3	6	6	6	6	6	7	6	7	6	7	6	7	6	7	6	7	6	7	6	8
Proceeds from sale of fixed assets																							2,500	0
Capital spend (pymts) - external finance	-1,464	-713	-1,661	-470	-1,305	-1,531	-1,121	-1,549	-1,280	-1,305	-2,208	-2,255	-1,252	-943	-674	-814	-880	-1,250	-841	-1,011	-772	-1,418	-773	-335
Capital spend (pymts) - internal capital	-1,757	-1,495	-2,602	-2,064	-2,935	-3,687	-3,329	-2,592	-3,402	-2,715	-2,672	-2,583	-3,475	-2,605	-3,146	-3,312	-2,979	-2,097	-1,769	-1,445	-1,576	-520	-1,696	-983
Net cash inflow/-outflow from investing activities	-3,214	-2,205	-4,257	-2,531	-4,233	-5,212	-4,444	-4,135	-4,676	-4,013	-4,874	-4,831	-4,721	-3,541	-3,814	-4,119	-3,853	-3,340	-2,604	-2,449	-2,341	-1,931	38	-1,310
Working capital loan received																								
Interim support funding					**2,138**	**0**	**4,853**	**7,392**	**7,634**	**7,233**	**9,858**	**9,858**	**5,324**	**5,324**	**5,093**	**5,093**	**7,644**	**7,644**	**5,074**	**5,074**	**2,274**	**2,274**	**2,293**	**2,293**
Loans received - LEEF																								
Loans received - DH capital			1,241	1,241	1,111	1,111	907	1,217	866	1,029	882	796	595	233	26	0	0	0	0	0	0	1	0	0
Loan repayments - LEEF																	-739	-739						
Working capital loan repyments									-499.5	-499.5											-499.5	-499.5		
Loans repayments - DH capital															-186	-186							0	0
Loans repaid - SALIX											-193	-193												
PFI & finance lease repayments	-204	-299	-204	-311	-307	-307	-460	-350	-460	-370	-460	-410	-460	-410	-460	-410	-460	-410	-460	-410	-460	-410	-511	-406
Net cash inflow/-outflow from financing	-204	-299	1,037	930	2,942	804	5,300	8,259	7,540	7,393	10,087	10,051	5,459	5,147	4,473	4,497	6,445	6,495	4,614	4,664	1,314	1,366	1,782	1,887
Net cash movement in period	-9,980	-9,991	-8,013	-6,263	-3,187	-4,925	0	-1	0	453	0	-15	0	846	1	-303	-1	541	0	183	0	952	1	826
Closing cash balance	14,200	**14,188**	**6,187**	**7,925**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,453**	**3,000**	**3,438**	**3,000**	**4,284**	**3,000**	**3,982**	**3,000**	**4,522**	**3,000**	**4,706**	**3,000**	**5,658**	**3,000**	**6,484**
LEEF loan	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303	-13,303
Exclude unexpended LEEF loan	-12,377	-12,711	-12,250	-12,604	-12,056	-12,292	-11,842	-11,960	-11,428	-11,684	-10,102	-10,225	-9,445	-9,764	-8,797	-9,372	-7,917	-8,402	-7,076	-7,471	-6,304	-6,567	-5,531	-5,719
Cash balance excl unexpended LEEF loan	**1,822**	**1,477**	**-6,063**	**-4,679**	**-9,056**	**-9,292**	**-8,842**	**-8,960**	**-8,428**	**-8,231**	**-7,102**	**-6,787**	**-6,445**	**-5,480**	**-5,796**	**-5,390**	**-4,917**	**-3,880**	**-4,076**	**-2,765**	**-3,305**	**-909**	**-2,531**	**765**

Appendix F – capital programme 2015/16

Summary cap exp by budget category and source of finance	Annual budget £000	Budget M01 £000	Budget M02 £000	Budget YTD £000	Actual M01 YTD £000	Actual M02 YTD £000	Actual YTD £000	*Variance M02 £000*	Forecast M03 £000	Forecast M04 £000	Forecast M05 £000	Forecast M06 £000	Forecast M07 £000	Forecast M08 £000	Forecast M09 £000	Forecast M10 £000	Forecast M11 £000	Forecast M12 £000	Budget Total £000	Forecast Outturn £000	utturn Var £000
Infrastructure renewal																					
Internal capital	**6,359**	0	34	34	165	185	350	*-316*	247	238	179	153	173	228	256	308	296	82	**6,358**	**2,508**	*3,850*
LEEF loan	**6,971**	125	127	252	-210	107	-103	*355*	312	332	276	1,459	461	392	970	931	904	848	**6,971**	**6,783**	*188*
Lease finance	**240**	0	0	0	0	0	0	*0*	240	0	0	0	0	0	0	0	0	0	**240**	**240**	*0*
Medical equipment																					
Internal capital	**3,456**	270	401	671	144	1,065	1,209	*-538*	297	132	475	309	371	815	145	78	62	88	**3,456**	**3,980**	*-524*
Lease finance	**10,928**	1,145	845	1,990	266	1,036	1,302	*688*	585	100	500	1,334	2,431	1,445	100	100	100	100	**10,927**	**8,097**	*2,830*
IMT																					
Internal capital	**5,308**	312	1,371	1,684	240	470	710	*974*	1,861	784	648	441	245	245	412	127	0	0	**5,308**	**5,473**	*-165*
PDC capital	**1,103**	105	115	220	137	0	137	*83*	188	75	75	192	100	100	0	237	0	0	**1,103**	**1,103**	*0*
Major Projects																					
Internal capital	**12,702**	823	453	1,276	365	431	796	*480*	806	1,165	1,146	1,290	1,575	1,783	1,143	553	535	135	**12,702**	**10,927**	*1,775*
DH capital loans	**7,260**	1,339	1,534	2,873	922	363	1,285	*1,588*	1,219	1,217	1,029	796	482	422	280	80	1	0	**7,260**	**6,810**	*450*
Other																					
Internal capital	**1,911**	205	186	391	168	131	299	*92*	245	157	150	156	100	100	100	100	100	100	**1,911**	**1,607**	*304*
SWL Path																					
Internal capital	**500**	42	42	83	82	21	103	*-20*	42	42	42	42	42	42	42	42	42	22	**500**	**500**	*0*
Total	**56,738**	4,366	5,108	9,474	2,279	3,809	6,088	*3,386*	6,043	4,241	4,519	6,171	5,979	5,571	3,447	2,556	2,039	1,374	**56,736**	48,027	*8,709*
Summary by classification																					
NO DELAY	**48,192**	3,991	4,556	8,547	1,747	3,515	5,262	*3,285*	5,436	3,913	4,380	6,035	5,740	5,370	3,298	2,429	1,911	1,116	**48,192**	**44,889**	*3,302*
Discretionary	**8,546**	375	552	927	532	294	826	*101*	607	328	139	136	239	201	149	127	128	258	**8,544**	**3,138**	*5,406*
Total	**56,738**	4,366	5,108	9,474	2,279	3,809	6,088	*3,386*	6,043	4,241	4,519	6,171	5,979	5,571	3,447	2,556	2,039	1,374	**56,736**	**48,027**	*8,709*

Appendix G - aged profile of debt M02 2015/16

Summary of debt balances at 31st May 2015

NHS Invoices outstanding

NHS DEBT Category of debt (Invoiced only)	% of unpaid invoices	Total Outstanding Debt			Prior year position		Bad Debt Provision available	Up to 30 Days		1 - 3 months old		3 - 6 months old		6 - 12 months old		Over 12 months old	
		at 31/05/15 £000s	at 30/04/15 £000s	% change since last report	at 31/05/14 £000s	% change since year end		at 31/05/15 £000s	at 30/04/15 £000s	at 31/05/15 £000s	at 30/04/15 £000s	at 31/05/15 £000s	at 30/04/15 £000s	at 31/05/15 £000s	at 30/04/15 £000s	at 31/05/15 £000s	at 30/04/15 £000s
(1) Clinical Commissioning Groups	2%	1,469	2,186	(33%)	(1,757)	(184%)		21	(1,274)	(177)	1,615	1,071	1,478	605	195	(51)	172
(1.1) NHS England	18%	11,515	13,771	(16%)	14,693	(22%)		(2,390)	6,532	10,671	4,135	2,275	2,759	946	332	13	13
(1.2) NHS Wandsworth CCG	9%	5,750	5,499	5%	2,352	144%		373	3,688	4,377	1,105	649	355	351	351	0	0
(1.3) NHS Croydon CCG	1%	421	421	0%	137	207%		0	420	420	0	0	0	0	0	1	1
(1.4) NHS Sutton CCG	0%	11	1	1000%	(358)	(103%)		10	(68)	(1)	67	0	0	0	0	2	2
(1.5) NHS Lambeth CCG	0%	(127)	(127)	0%	10	(1370%)		0	(127)	(127)	0	0	0	0	0	0	0
(1.6) NHS Kingston CCG	0%	(152)	(152)	0%	(277)	(45%)		0	(156)	(156)	0	0	0	0	0	4	4
(1.7) NHS Merton CCG	-1%	(431)	(426)	1%	939	(146%)		1	(430)	(432)	4	0	0	0	0	0	0
(1.8) NHS England - Legacy PCT balances	0%	(1)	5	(120%)	6	(117%)		0	0	0	0	0	0	0	(2)	(1)	7
(2) English CCG NCA Debt	4%	2,828	3,186	(11%)	2,313	22%		461	1,076	893	553	655	612	510	510	309	435
(3) Non English NHS NCA Debt	1%	668	379	76%	448	49%		33	(208)	95	75	52	18	65	68	423	426
(4) Other NHS Organisations	0%	178	199	(11%)	0			14	(208)	76	321	6	38	30	0	52	48
(4.1) The Department Of Health	4%	2,600	0	#DIV/0!	0			2,600	0	0	0	0	0	0	0	0	0
(4.2) NHS Property Services Ltd	1%	665	665	0%	0			0	0	56	56	56	56	112	112	441	441
(4.3) Public Health England	1%	415	435	(5%)	0			67	18	154	360	179	42	0	3	15	12
(4.4) Jersey Health & Social Services	0%	274	274	0%	0			0	3	3	2	2	0	0	0	269	269
(4.5) Health Education England	0%	160	145	10%	0			27	145	133	0	0	0	0	0	0	0
(5) NHS Trusts	5%	3,053	2,742	11%	0			654	762	736	278	230	228	481	583	952	891
(5.1) Kingston Hospital NHS Foundation Trust	5%	2,869	2,160	33%	0			(26)	198	1,925	1,118	204	102	167	218	599	524
(5.2) Croydon Health Services NHS Trust	3%	1,798	2,066	(13%)	0			(224)	95	1,194	1,149	74	323	548	319	206	180
(5.3) Epsom & St Helier University Hospitals NHS T	2%	1,287	1,211	6%	0			188	558	879	442	60	68	157	140	3	3
(5.4) Chelsea & Westminister Hospital NHS Founda	1%	507	255	99%	0			230	255	271	0	0	0	(5)	0	11	0
(5.5) Moorfields Eye Hospital NHS Foundation Trus	1%	458	202	127%	0			265	72	79	26	49	58	20	5	45	41
Total NHS Invoices outstanding	57%	36,215	35,097	3%	18,506	96%	0	2,304	11,351	21,069	11,306	5,562	6,137	3,987	2,834	3,293	3,469

Uninvoiced NHS debt		
NHS Debt - accruals	7,503	35
2013/14 Partially Completed Spells	4,748	4,748
Total NHS Debt	48,467	39,881

Actual 30/11/13	6%	32%	58%	32%	15%	17%	11%	8%	9%	10%
Target - 31/03/14	60%		34%		5%		1%		0%	

Non-NHS Invoices outstanding

Non-NHS Debt Category of debt (Invoiced only)	% of unpaid invoices	Total Outstanding Debt			Prior year position		Bad Debt Provision available	Up to 30 Days		1 - 3 months old		3 - 6 months old		6 - 12 months old		Over 12 months old	
		at 31/05/15 £000s	at 30/04/15 £000s	% change since last report	at 31/05/14 £000s	% change since year end		at 31/05/15 £000s	at 30/04/15 £000s	at 31/05/15 £000s	at 30/04/15 £000s	at 31/05/15 £000s	at 30/04/15 £000s	at 31/05/15 £000s	at 30/04/15 £000s	at 31/05/15 £000s	at 30/04/15 £000s
(6) Compensation Recovery Unit	19%	12,114	12,159	(0%)	10,102	20%	(1,847)	275	286	1,078	950	1,158	1,081	1,548	1,627	8,055	8,215
(7) Local Authority	7%	4,668	4,160	12%				429	1,059	1,670	974	1,191	1,074	1,151	910	227	143
(8) General Debtors	5%	3,339	3,138	6%	3,473	(4%)	(1,207)	725	765	1,459	1,149	203	509	427	170	525	545
(9) Overseas Visitors NHS Chargeable	4%	2,516	2,484	1%	2,205	14%	(1,396)	44	72	221	211	197	211	237	209	1,817	1,781
(10) Private Patients	1%	831	999	(17%)	1,323	(37%)	(182)	110	259	183	259	135	112	65	37	338	332
(10.1) Bupa Insurance Services Ltd t/a Bupa	1%	589	388	52%				96	30	182	53	14	1	59	74	238	230
(10.2) AXA PPP Healthcare Ltd	1%	485	412	18%				72	68	156	132	87	42	26	28	144	142
(11) Medical School	2%	1,469	1,352	9%	574	156%	(28)	117	315	702	417	411	563	231	49	8	8
(12) St George's Hospital Charity	1%	515	354	45%	335	54%	(10)	184	112	157	134	71	8	74	71	29	29
(13) Salary Overpayments	1%	478	493	(3%)	477	0%	(120)	(1)	0	46	57	16	40	72	49	345	347
(14) UK Border Agency	0%	184	180	2%	110	67%		4	3	13	25	45	43	47	34	75	75
Total Non-NHS Invoices outstanding	43%	27,188	26,119	4%	18,599	12%	(4,790)	2,056	2,969	5,868	4,361	3,528	3,684	3,937	3,258	11,801	11,847

Uninvoiced non-NHS Debt:		
Provision for impairment of Non-NHS invoiced debt	(4,790)	(4,790)
Non-NHS Debt -accruals	2,611	3,554
VAT and Prepayments	3,223	3,564
Total Non NHS Debt	28,232	28,447
Grand Total Debt	76,699	68,328

Actual - 30/11/13 (exc RTA)	7%	11%	21%	17%	13%	14%	14%	12%	43%	45%
Target - 31/03/14 (exc RTA)	44%		22%		2%		7%		25%	

1. Uninvoiced debt is debt which had not been invoiced the debtor at the month-end. Uninvoiced debt excludes 'Provision for impairment of debts.'
2. Gross debt is total debt with the provision for impairment of debt added back.
3. Non-NHS targets exclude RTA debt which is raised and collected by the Compensation Recovery Unit (CRU) on the Trust's behalf.

St George's Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD *June 2015*

Paper Title:	Workforce report
Sponsoring Director:	Wendy Brewer, Director of Workforce and Organisational Development
Author:	Wendy Brewer, Director of Workforce and Organisational Development Rebecca Hurrell, Head of Workforce Information Jacqueline McCullough, Deputy Director of HR
Purpose:	*To provide a report to the board on performance against key performance indicators*
Action required by the board:	For information
Document previously considered by:	Workforce and education committee

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

1. Key messages

The report contains detail of workforce performance against key workforce performance indicators for May2015. The report also includes available benchmark information.

Key points to note are:

- Vacancy figures should be treated with caution pending completion of work on nursing workforce demand, the finalisation of detailed budgets and synchronisation of the electronic staff records system with the financial ledger.
- Agency and bank usage are significantly reduced.
- Turnover has stabilised but is behind the target trajectory.

Key risks identified:
Key workforce risks include:

- Failure to recruit and retain sufficient staff in relation to annual turnover rates and to safely support future increases in capacity'
- Failure to reduce the unacceptable levels of bullying and harassment reported by staff in the annual staff survey.
- Possible reductions in the overall number of junior doctors available with a possible impact on particular speciality areas.
- Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	**To develop a highly skilled and engaged workforce championing our values that is able to deliver the trust's vision.**
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	**Are services well led?**

Commentary on performance in key workforce indicators

Introduction

The key message from the May board report is that there has been a continued significant reduction in bank and agency usage. This is an indicator of a positive response to the run rate controls that have been established across the trust.

Vacancy rate

The work on clarifying the financial baselines and establishments is now a key priority and, while the overall establishment figures may be broadly accurate, the detail down to ward level is subject to further review. The corporate nursing team are leading a review of nursing levels required for safe staffing and of service led demand. Once this work is complete and agreed, the changes made within the financial ledger will be synchronised with the electronic staff record data. This project is being managed within the workforce planning group and is anticipated to be complete within three to four months.

Turnover and stability

Turnover has stabilised in May but has not met the proposed trajectory. As more than 50% of leavers leave for reasons that relate to their experience at work, it is clear that the trust has the potential to reduce turnover. Divisions have been requested to report to the workforce and education committee meeting in July with their plans to reduce turnover.

Sickness absence

Sickness absence levels remain on target.

Agency and bank staff usage

There has been a sustained reduction in agency use and cost. It is also positive to see an increase in bank rather than agency fill of temporary posts.

Mandatory training and appraisal rates

Both mandatory training and appraisal rates have slipped. The monthly performance meetings focus on the support that can be provided to divisions to ensure that appraisals and mandatory training are completed.

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Workforce Performance Report
to the Trust Board

Month 2- May 2015

Excellence in specialist and community healthcare

Workforce performance report June 2014-May2015

Contents

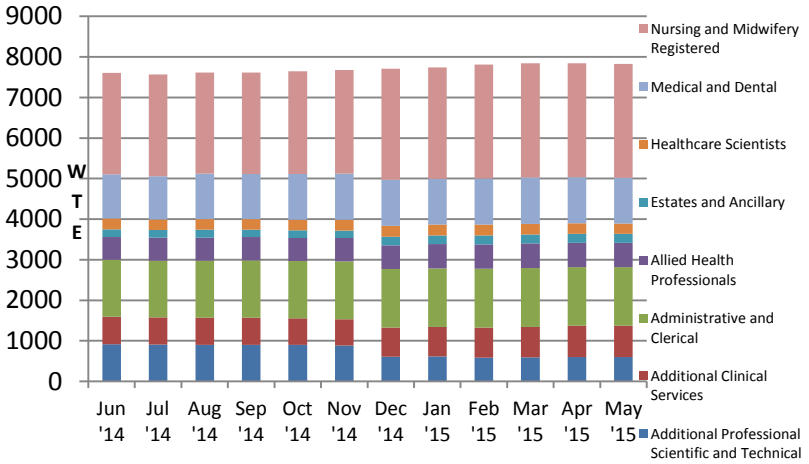
Performance summary

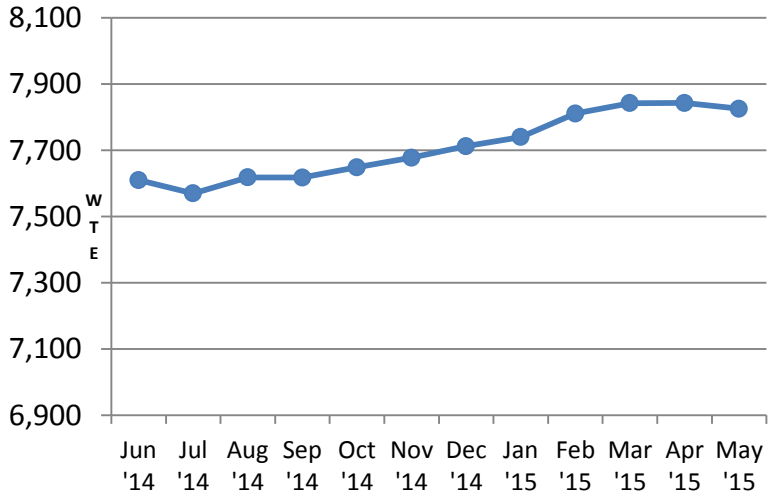
Summary of overall performance is set out below

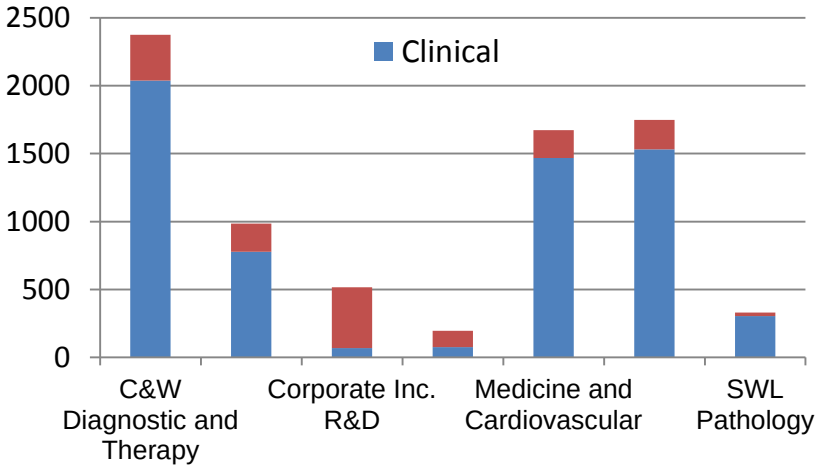
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has increased by 1.3% (subject to validation – see page 5)	12.1%	14.2%	15.5%	↗
6	Turnover	Turnover has stabilised	15.1%	17.5%	17.5%	↔
6	Voluntary Turnover	Voluntary turnover stabilised	12.3%	14.1%	14.1%	↔
7	Stability	Stability has increased this month by 0.2%	85.3%	82.8%	83.0%	↗
8	Sickness	Sickness has increased by 0.3% but remains within target	3.4%	3.2%	3.5%	↗
10-12	Temporary Staffing Usage (FTE)	Temporary staff usage has decreased by 2.1%	13.6%	16.0%	13.9%	↘
13	Mandatory Training	MAST compliance has decreased by 1.1%	75.9%	74.2%	73.1%	↘
14	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has decreased by 0.4%	75.4%	75.2%	74.8%	↘

Current Staffing Profile

The data below displays the current staffing profile of the Trust



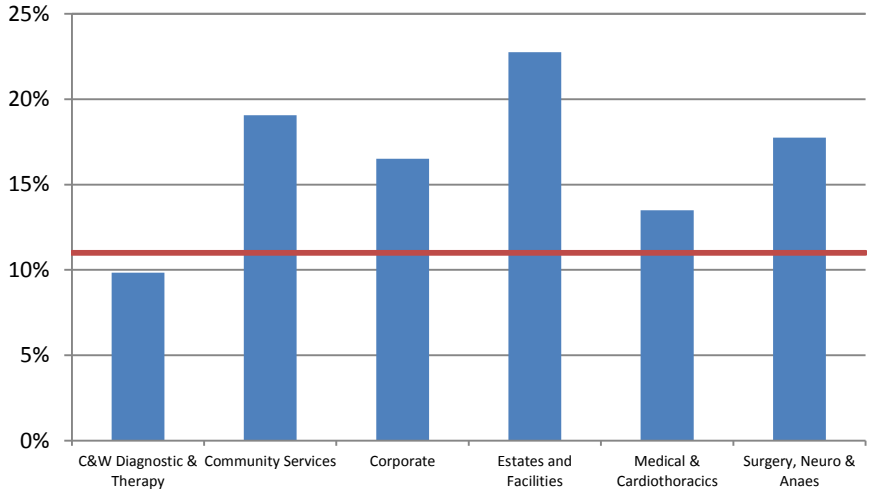


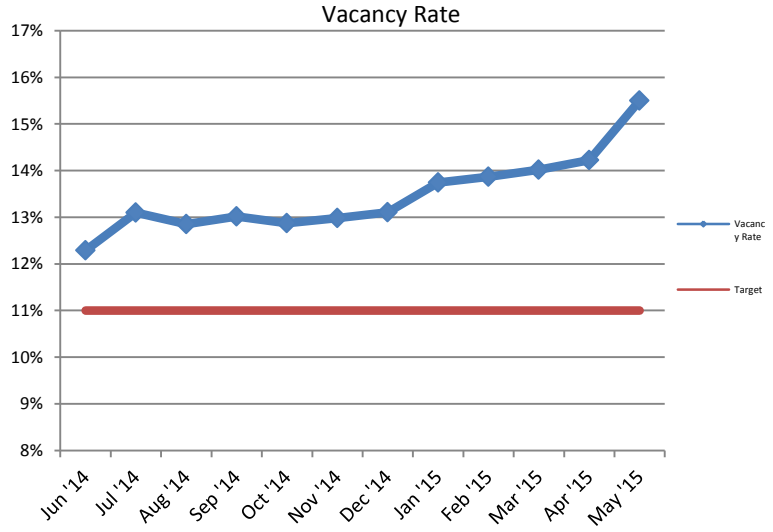


COMMENTARY

The Trust currently employs 8394 people working a whole time equivalent of 7826 which is 17 WTE lower than in April. The growth rate in the directly employed workforce since June 2014 is 242 WTE or 3.2%.

Section 1: Vacancies





Vacancies by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	9.4%	9.9%	9.9%	9.8%	↘
Community Services	20.8%	19.6%	19.4%	19.1%	↘
Corporate	14.4%	14.5%	15.4%	16.5%	↗
Estates and Facilities	12.7%	12.7%	11.4%	22.8%	↗
Medical & Cardiothoracics	13.0%	12.7%	13.4%	13.5%	↗
Surgery, Neuro & Anaes	14.3%	15.0%	14.9%	17.7%	↗
SWL Pathology	23.3%	24.2%	25.0%	28.4%	↗
Whole Trust	**13.9%**	**14.0%**	**14.2%**	**15.5%**	↗

Vacancies Staff Group	Feb '15	Mar '15	Apr '15	May '15	Trend
Add Prof Scientific and Technic	20.1%	19.6%	18.6%	16.4%	↘
Additional Clinical Services	16.4%	15.6%	16.7%	18.7%	↗
Administrative and Clerical	20.1%	20.3%	21.2%	22.6%	↗
Allied Health Professionals	3.4%	1.9%	3.7%	3.6%	↘
Estates and Ancillary	16.9%	27.8%	27.0%	22.5%	↘
Healthcare Scientists	16.3%	19.5%	20.5%	21.8%	↗
Medical and Dental	0.0%	-0.3%	-0.3%	3.2%	↗
Nursing and Midwifery Registered	14.7%	14.3%	13.9%	15.7%	↗
Total	**13.9%**	**14.0%**	**14.2%**	**15.5%**	↗

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COMMENTARY

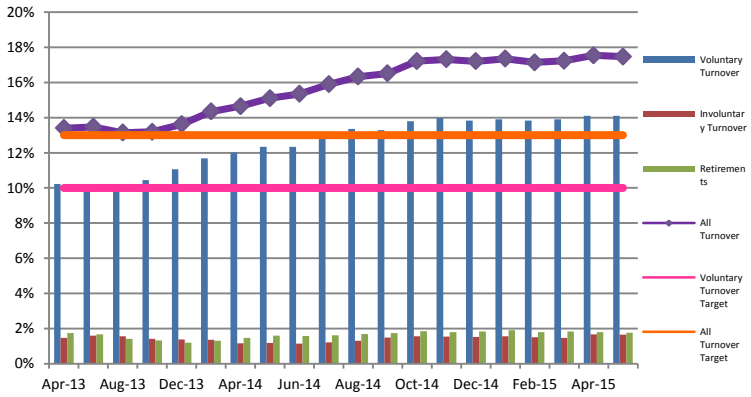
The reported vacancy rate must be treated with caution.

The establishment recorded in the electronic staff record system has not been updated to reflect the establishments that have been agreed in the budget in the review of nursing establishments.

A project to complete this work has been agreed with the Finance team and it is anticipated that it will be completed in 2 or 3 months.

Section 2: Turnover

The chart below shows turnover trends, the tables by Division and Staff Group are under:



COMMENTARY

The total trust turnover rate has remained the same this month at 17.5% which is significantly above the current target of 13%. In the last12 months there have been 1239 WTE leavers.

Each Division is developing a plan and target trajectory in response to the increase in turnover rates, based on the information available through exit questionnaire data. Reports are due to be provided to the Workforce & Education Committee in July.

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.

Communications with staff this month have focused on opportunities for wellbeing and support available.

	All Turnover				
Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	18.1%	18.1%	18.1%	17.7%	↘
Community Services	19.5%	18.8%	19.6%	19.9%	↗
Corporate	15.9%	15.9%	16.9%	18.5%	↗
Estates and Facilities	11.2%	11.9%	17.6%	17.4%	↘
Medical & Cardiothoracics	17.8%	18.2%	18.4%	18.0%	↘
Surgery, Neurosciences & Anaes	14.8%	14.6%	14.5%	14.3%	↘
SWL Pathology	16.8%	19.6%	19.4%	19.7%	↗
Whole Trust	**17.1%**	**17.2%**	**17.5%**	**17.5%**	↔

	All Turnover				
Staff Group	Feb '15	Mar '15	Apr '15	May '15	Trend
Add Prof Scientific and Technic	18.9%	18.6%	18.9%	18.2%	↘
Additional Clinical Services	19.4%	20.7%	20.4%	20.6%	↗
Administrative and Clerical	15.0%	15.1%	16.6%	16.6%	↔
Allied Health Professionals	18.4%	17.8%	18.5%	17.9%	↘
Estates and Ancillary	12.0%	12.3%	12.6%	11.3%	↘
Healthcare Scientists	15.3%	15.3%	15.9%	16.2%	↗
Medical and Dental	14.5%	14.1%	13.3%	14.1%	↗
Nursing and Midwifery Registered	18.0%	18.1%	18.1%	18.0%	↘
Whole Trust	**17.1%**	**17.2%**	**17.5%**	**17.5%**	↔

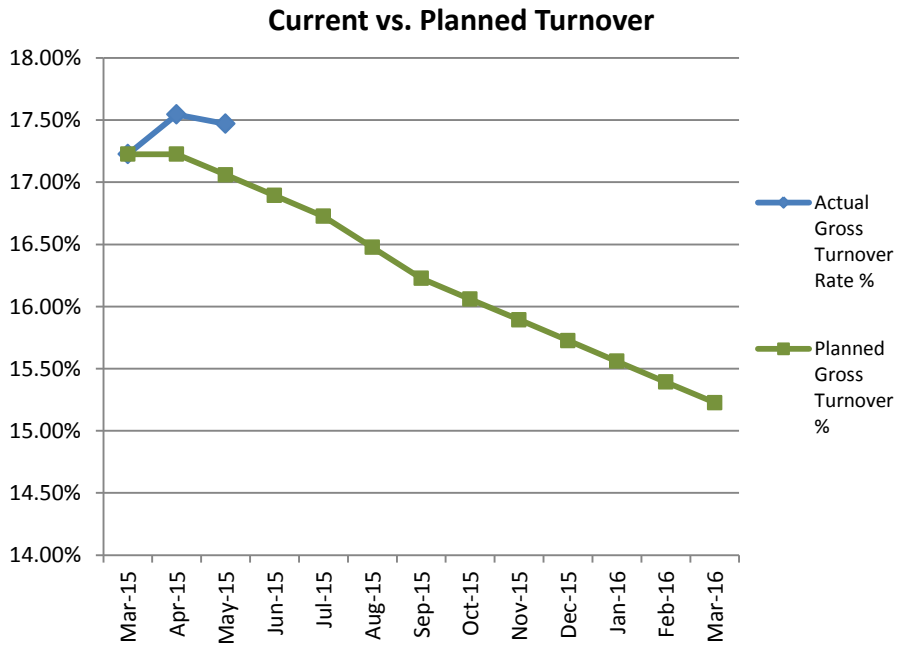
	Voluntary Turnover					Other Turnover May 2015	
Division	Feb '15	Mar '15	Apr '15	May '15	Trend	In-Voluntary	Retirement
C&W Diagnostic & Therapy	13.6%	13.4%	13.5%	13.2%	↘	2.8%	1.6%
Community Services	15.0%	14.8%	15.6%	15.8%	↗	1.1%	3.0%
Corporate	13.6%	13.5%	14.0%	15.1%	↗	1.7%	1.7%
Estates and Facilities	6.7%	7.1%	8.0%	7.6%	↘	5.9%	3.8%
Medical & Cardiothoracics	15.7%	15.9%	16.1%	15.7%	↘	1.0%	1.4%
Surgery, Neurosciences & Anaes	12.6%	12.7%	12.3%	12.6%	↗	0.7%	1.0%
SWL Pathology	14.5%	16.9%	16.5%	16.7%	↗	0.6%	2.5%
Whole Trust	**13.8%**	**13.9%**	**14.1%**	**14.1%**	↔	**1.6%**	**1.8%**

	Voluntary Turnover					Other Turnover May 2015	
Staff Group	Feb '15	Mar '15	Apr '15	May '15	Trend	In-Voluntary	Retirement
Add Prof Scientific and Technic	12.4%	12.1%	12.3%	12.0%	↘	5.9%	0.4%
Additional Clinical Services	16.5%	17.5%	17.3%	17.4%	↗	1.2%	2.0%
Administrative and Clerical	11.9%	12.2%	12.9%	13.0%	↗	1.7%	2.0%
Allied Health Professionals	17.3%	16.3%	17.3%	16.8%	↘	0.2%	1.0%
Estates and Ancillary	7.9%	7.8%	8.2%	7.3%	↘	0.9%	3.1%
Healthcare Scientists	11.6%	11.2%	11.3%	11.5%	↗	1.1%	3.5%
Medical and Dental	8.6%	8.1%	7.6%	8.2%	↗	4.6%	1.3%
Nursing and Midwifery Registered	15.3%	15.5%	15.5%	15.5%	↔	0.7%	1.8%
Whole Trust	**13.8%**	**13.9%**	**14.1%**	**14.1%**	↔	**1.6%**	**1.8%**

Caregroup	Staff in Post WTE	Leavers WTE	Voluntary Turnover Rate
Cardiac Surgery	86.7	28.8	38.0%
Gynaecology	45.0	17.4	35.2%
Trauma & Orthopaedics	122.6	32.2	30.3%
Prison Service	59.6	17.0	28.1%
Inpatient Care Older People	55.0	14.8	27.5%

Section 2: Turnover

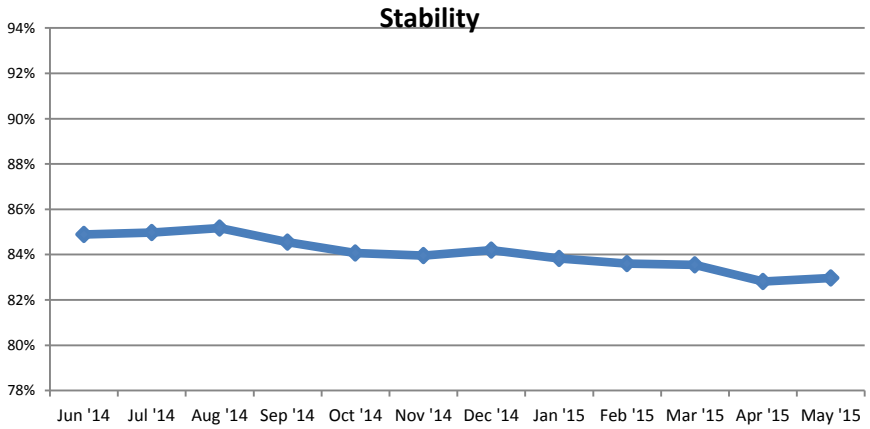
Planned reduction in turnover:



Month	Actual Gross Turnover Rate %	Planned Gross Turnover %
Mar-15	17.23%	17.23%
Apr-15	17.54%	17.23%
May-15	17.47%	17.06%
Jun-15		16.89%
Jul-15		16.73%
Aug-15		16.48%
Sep-15		16.23%
Oct-15		16.06%
Nov-15		15.89%
Dec-15		15.73%
Jan-16		15.56%
Feb-16		15.39%
Mar-16		15.23%

Section 3: Stability

The chart below shows performance over the last 12 months, the tables by Division and Staff Group are under



Stability by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	83.5%	83.1%	82.6%	82.9%	↗
Community Services	81.2%	81.0%	80.4%	80.4%	↔
Corporate	87.9%	87.8%	85.7%	85.1%	↘
Estates and Facilities	91.3%	89.8%	89.0%	84.9%	↘
Medical & Cardiothoracics	82.9%	81.4%	81.3%	82.4%	↗
Surgery, Neurosciences & Anaes	84.0%	84.0%	84.6%	84.5%	↘
SWL Pathology	82.2%	90.2%	81.7%	82.2%	↗
Whole Trust	**83.6%**	**83.5%**	**82.8%**	**83.0%**	↗

Stability Staff Group	Feb '15	Mar '15	Apr '15	May '15	Trend
Add Prof Scientific and Technic	72.7%	72.4%	72.7%	73.5%	↗
Additional Clinical Services	82.3%	80.9%	82.8%	82.8%	↔
Administrative and Clerical	87.1%	87.7%	86.4%	86.1%	↘
Allied Health Professionals	80.7%	82.1%	80.8%	80.8%	↔
Estates and Ancillary	87.8%	86.3%	85.5%	86.7%	↗
Healthcare Scientists	96.2%	95.1%	88.7%	87.3%	↘
Medical and Dental	88.5%	88.7%	87.8%	87.1%	↘
Nursing and Midwifery Registered	83.0%	82.9%	82.2%	82.6%	↗
Total	**83.6%**	**83.5%**	**82.8%**	**83.0%**	↗

COMMENTARY

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

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

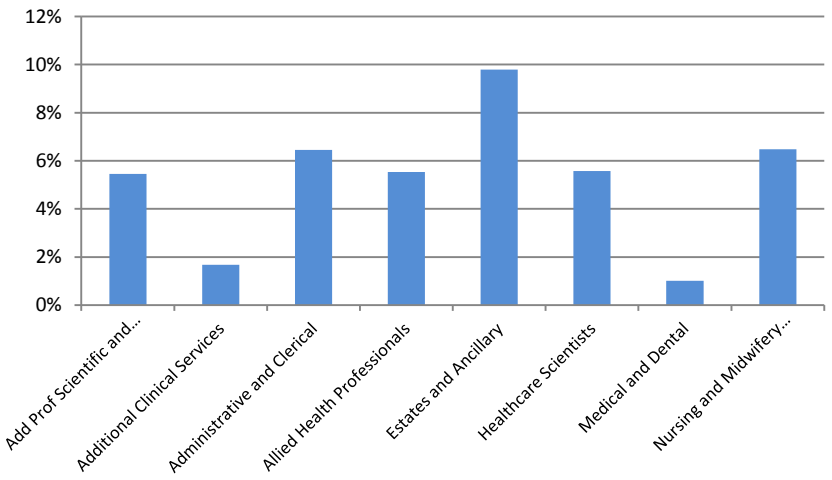
The stability rate has increased by 0.2% this month in line with a slight reduction in retirements in May.

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

Over the last 12 months the stability rate has declined by 2.4% and is now at 83%.

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 May, 44 staff were promoted, there were 71 new starters to the Trust and 222 employees were acting up to a higher grade.

Over the last year 5.4% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the Estates and Facilities Division (where a team have recently been upgraded) followed by the Corporate and Children & Women's Divisions, where there is a programme of promotion of midwives.

The graph shows that Estates & Ancillary staff were most likely to be promoted over the last year (NB this is the smallest staff group), followed by the Nursing & Midwifery employees. The majority of promotions in Nursing & Midwifery are moves from a band 5 to a band 6 post (108 employees over the year).

	No. of Promotions				
Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	14	13	8	11	↗
Community Services	13	8	4	15	↗
Corporate	2	5	3	5	↗
Estates and Facilities	0	0	20	0	↘
Medical & Cardiothoracics	10	9	1	6	↗
Surgery, Neurosciences & Anaes	5	6	3	7	↗
SWL Pathology	3	0	0	0	↔
Whole Trust Promotions	**47**	**41**	**39**	**44**	↗
New Starters (Excludes Junior Doctors)	**120**	**136**	**120**	**71**	↘

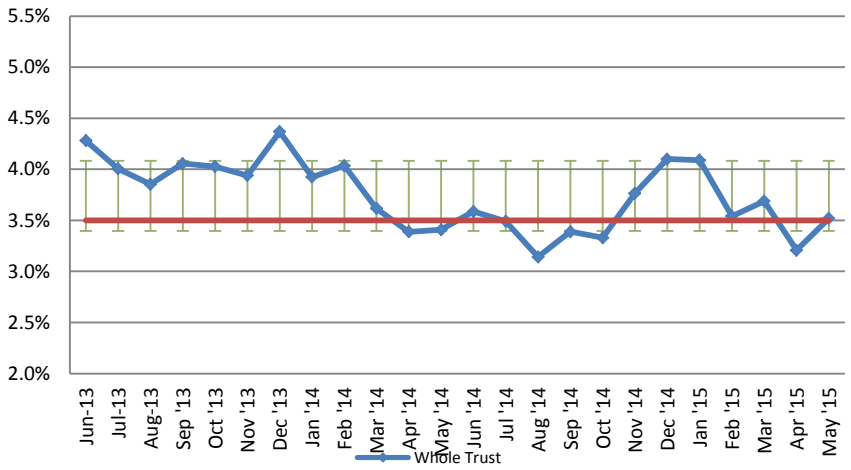
Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	1985	119	6.0%	111
Community Services	924	45	4.9%	13
Corporate	451	27	6.0%	19
Estates and Facilities	174	20	11.5%	5
Medical & Cardiothoracics	1215	68	5.6%	39
Surgery, Neurosciences & Anaes	1389	57	4.1%	23
SWL Pathology	313	11	3.5%	12
Whole Trust	**6451**	**347**	**5.4%**	**222**
New Starters (Excludes Junior Doctors)		**1460**		

	No. of Promotions				
Staff Group	Feb '15	Mar '15	Apr '15	May '15	Trend
Add Prof Scientific and Technic	4	2	1	4	↗
Additional Clinical Services	0	3	0	4	↗
Administrative and Clerical	13	8	5	14	↗
Allied Health Professionals	7	7	3	7	↗
Estates and Ancillary	0	0	20	0	↘
Healthcare Scientists	2	0	1	2	↗
Medical and Dental	3	1	0	0	↔
Nursing and Midwifery Registered	18	20	9	13	↗
Whole Trust	**47**	**41**	**39**	**44**	↗

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	513	28	5.5%	31
Additional Clinical Services	659	11	1.7%	9
Administrative and Clerical	1303	84	6.4%	76
Allied Health Professionals	524	29	5.5%	24
Estates and Ancillary	194	19	9.8%	1
Healthcare Scientists	251	14	5.6%	5
Medical and Dental	597	6	1.0%	3
Nursing and Midwifery Registered	2410	156	6.5%	73
Whole Trust	**6451**	**347**	**5.4%**	**222**

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 3.5% for May, which is a 0.3% increase since the previous month.

Sickness absence is closely monitored and action initiated by HR, in support of divisions, once pre defined sickness triggers are breached. A 'well-being' strategy was agreed by the workforce committee and there has been a lengthy review of the sickness policy in partnership with trade unions. There has been a focus on wellbeing in communications this month.

The table below lists the five care groups with the highest sickness absence percentage during May 2015. Below that is a breakdown of the top 5 reasons for absence, both by the number of episodes and the number of days lost.

Sickness by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	2.9%	2.9%	2.3%	2.9%	↗
Community Services	5.3%	6.5%	5.7%	6.0%	↗
Corporate	3.6%	4.1%	4.0%	4.0%	↔
Estates and Facilities	6.3%	7.1%	6.5%	7.6%	↗
Medical & Cardiothoracics	3.3%	3.5%	3.0%	2.9%	↘
Surgery, Neurosciences & Anaes	3.5%	3.0%	2.9%	3.1%	↗
SWL Pathology	3.3%	3.2%	2.0%	2.6%	↗
Whole Trust	**3.5%**	**3.7%**	**3.2%**	**3.5%**	↗

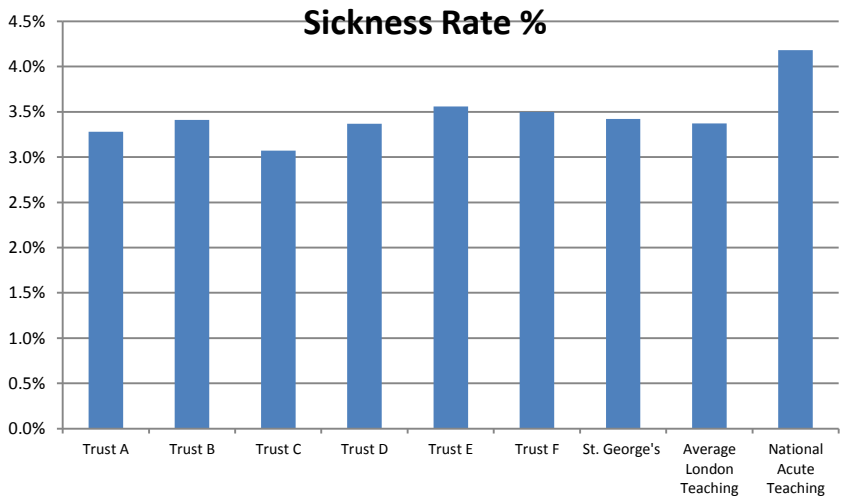
Sickness Staff Group	Feb '15	Mar '15	Apr '15	May '15	Trend
Add Prof Scientific and Technic	2.7%	2.3%	2.9%	3.0%	↗
Additional Clinical Services	4.1%	5.1%	5.4%	6.8%	↗
Administrative and Clerical	4.2%	4.5%	4.0%	4.3%	↗
Allied Health Professionals	2.5%	3.1%	2.3%	2.8%	↗
Estates and Ancillary	6.7%	5.7%	6.1%	6.4%	↗
Healthcare Scientists	2.8%	2.4%	1.8%	1.8%	↔
Medical and Dental	0.9%	0.7%	0.2%	0.9%	↗
Nursing and Midwifery Registered	4.4%	4.5%	3.6%	3.5%	↘
Total	**3.5%**	**3.7%**	**3.2%**	**3.5%**	↗

Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Prison Service	59.55	271.88	15.0%	£20,085
Security & Car Park Management	22.00	82.00	12.0%	£4,027
Intermediate Care	62.80	183.00	9.4%	£10,542
Community PLD Service	25.43	69.85	9.3%	£7,384
Engineering Services	48.00	135.00	9.1%	£8,296

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	28.13%
S25 Gastrointestinal problems	17.91%
S12 Other musculoskeletal problems	8.91%
S16 Headache / migraine	5.31%
S10 Anxiety/stress/depression/other psychiatric illnesses	5.31%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S13 Cold, Cough, Flu - Influenza	15.00%
S12 Other musculoskeletal problems	12.50%
S10 Anxiety/stress/depression/other psychiatric illnesses	12.39%
S25 Gastrointestinal problems	11.26%
S11 Back Problems	8.41%

Section 6: Workforce benchmarking**



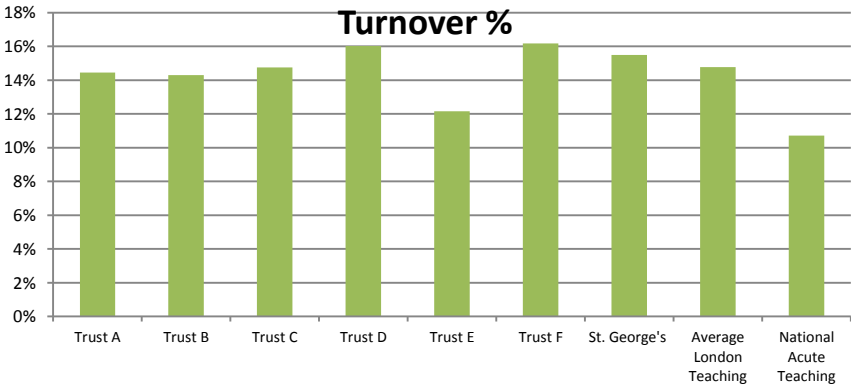
COMMENTARY

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

Sickness data shown is from February '15 which is the mot recent available. Compared to other Acute teaching trusts in London, St. Georges had a higher than average rate at 3.42%. In the top graph, Trusts A-F are the anonymised figures for this group. The Trust's sickness rate was significantly lower than the national rate for acute teaching hospitals in February.

The bottom graph shows the comparison of turnover rates for the same group of London teaching trusts (excluding junior medical staff). This is the total turnover rate including all leavers (voluntary resignations, retirements, end of fixed term contracts etc.). St. Georges currently has higher than average turnover compared to the group (12 months to end March). Stability is also slightly 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 4.7% 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	14.45%	85.32%	3.28%
Trust B	14.29%	85.30%	3.41%
Trust C	14.75%	84.85%	3.07%
Trust D	16.03%	83.78%	3.37%
Trust E	12.15%	83.52%	3.56%
Trust F	16.18%	83.27%	3.50%
St. George's	15.49%	84.06%	3.42%
Average London Teaching	14.76%	84.30%	3.37%
National Acute Teaching	10.72%	89.05%	4.18%

Section 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	1073.5	1073.5	1073.5	1073.5	↔
Community Services	592.3	594.3	593.6	593.6	↔
Corporate & R&D	50.9	50.5	53.5	59.9	↗
Medical & Cardiothoracics	1213.8	1216.8	1218.8	1220.8	↗
Surgery, Neurosciences & Anaes	1035.4	1029.7	1022.7	1107.7	↗
Total	3966.0	3964.9	3962.1	4055.5	↗

Nursing Staff in Post WTE

Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	983.7	980.6	986.0	984.7	↘
Community Services	464.2	478.5	479.7	473.9	↘
Corporate & R&D	47.2	45.3	49.1	49.2	↗
Medical & Cardiothoracics	1009.1	1017.1	1002.3	1007.6	↗
Surgery, Neurosciences & Anaes	872.8	878.1	881.5	880.1	↘
Total	3376.9	3399.4	3398.5	3395.6	↘

Nursing Vacancy Rate

Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	8.4%	8.7%	8.2%	8.3%	↗
Community Services	21.6%	19.5%	19.2%	20.2%	↗
Corporate & R&D	7.3%	10.3%	8.2%	17.8%	↗
Medical & Cardiothoracics	16.9%	16.4%	17.8%	17.5%	↘
Surgery, Neurosciences & Anaes	15.7%	14.7%	13.8%	20.5%	↗
Total	14.9%	14.3%	14.2%	16.3%	↗

Nursing Sickness Rates

Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	4.3%	4.1%	3.5%	3.9%	↗
Community Services	6.9%	7.9%	6.4%	6.3%	↘
Corporate	0.5%	0.4%	0.5%	1.6%	↗
Medical & Cardiothoracics	3.6%	4.4%	3.8%	3.5%	↘
Surgery, Neurosciences & Anaes	4.0%	3.5%	3.7%	4.1%	↗
Total	4.3%	4.5%	4.0%	4.2%	↗

Nursing Voluntary Turnover

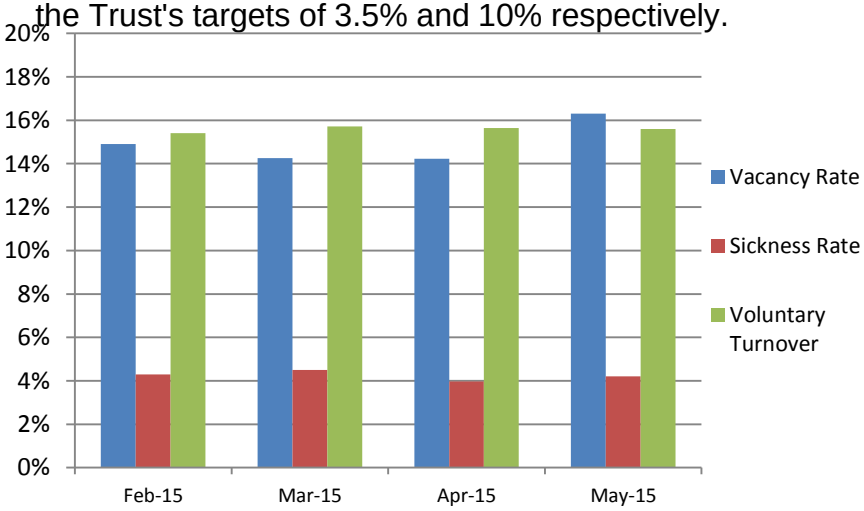
Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	13.53%	14.45%	14.78%	14.22%	↘
Community Services	17.33%	16.18%	15.59%	16.30%	↗
Corporate & R&D	13.31%	18.12%	16.89%	14.98%	↘
Medical & Cardiothoracics	18.00%	18.29%	18.72%	17.91%	↘
Surgery, Neurosciences & Anaes	13.56%	13.79%	13.02%	14.10%	↗
Total	15.4%	15.5%	15.7%	15.6%	↘

COMMENTARY

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

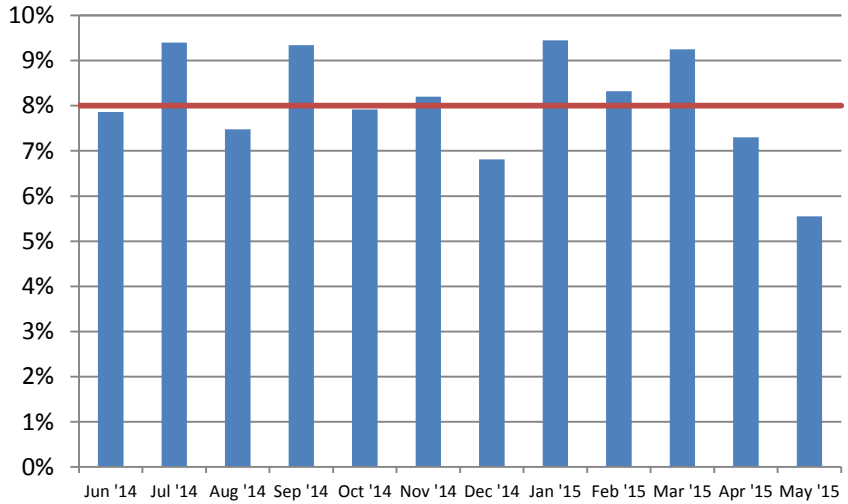
The nursing workforce has decreased slightly by 3 WTE in May, with an overall growth in nursing staff in post of 123.3 wte since September 2014. The output of the review of nursing establishments will be a revised trajectory for demand for nursing.

Both the sickness rate and voluntary turnover are above the Trust's targets of 3.5% and 10% respectively.



Section 8: Agency Staff Costs

The chart below shows agency spend by month to show both annual and seasonal trends.



Commentary

The agency spend percentage has decreased by 1.75% since April.

At the March workforce and education committee set an 8% target for agency usage.

Currently, the highest percentage spend is seen in the Community and Children & Women's Divisions.

The table below lists the five care groups with the highest agency spend percentage for May 2015

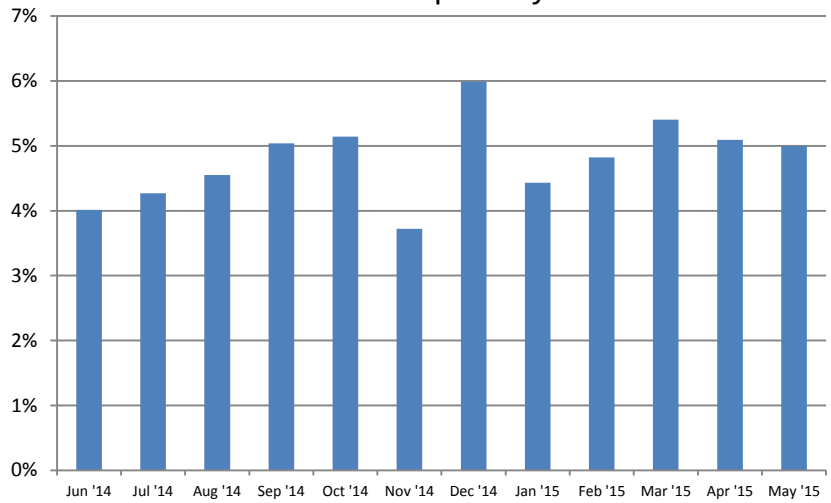
Care Group	Agency Spend % May-15	Staff In Post WTE
Inpatient Care Older People	33.73%	54.96
Prison Service	30.58%	59.55
Outpatients	20.94%	246.57
Clinical Haematology	16.62%	99.95
Community Wards	14.71%	91.36

Agency Costs by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	9.14%	8.36%	7.48%	6.73%	↘
Community Services	9.84%	16.22%	12.15%	9.45%	↘
Corporate	2.67%	3.37%	2.72%	1.22%	↘
Estates and Facilities	12.47%	25.36%	9.47%	1.47%	↘
Medical & Cardiothoracics	12.47%	9.74%	9.35%	6.10%	↘
Surgery, Neurosciences & Anaes	4.36%	6.24%	4.10%	3.24%	↘
Whole Trust	**8.32%**	**9.25%**	**7.30%**	**5.55%**	↘

Booking Reason	Medical Agency & Bank £ May-15	%
Annual Leave AL	£0	0.00%
Increased Care Needs ICN	£15,300	4.71%
Maternity Leave ML	£0	0.00%
Sickness S	£16,005	4.92%
Study Leave SL	£0	0.00%
Vacancy V	£293,686	90.37%
Total	**£324,990**	**100.00%**

Section 9: Staff Bank Costs

The chart below shows bank spend by month to show both annual and seasonal trends.



COMMENTARY

Bank spend percentage has decreased by 0.1% between April and May.

There is increased progress in the programme of transfer from agency staffing to bank staffing for administrative staff groups

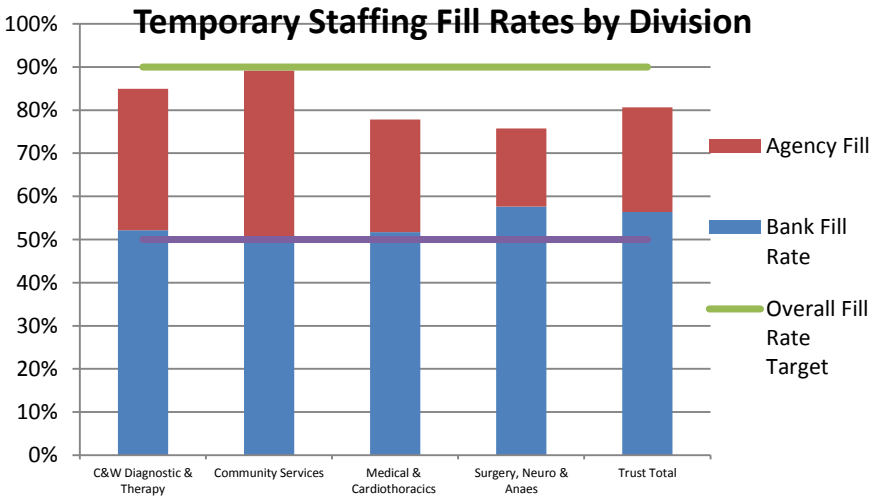
The Bank Fill rate in May 2015 was 50.24% this was an improvement of 6.0% on March 2015

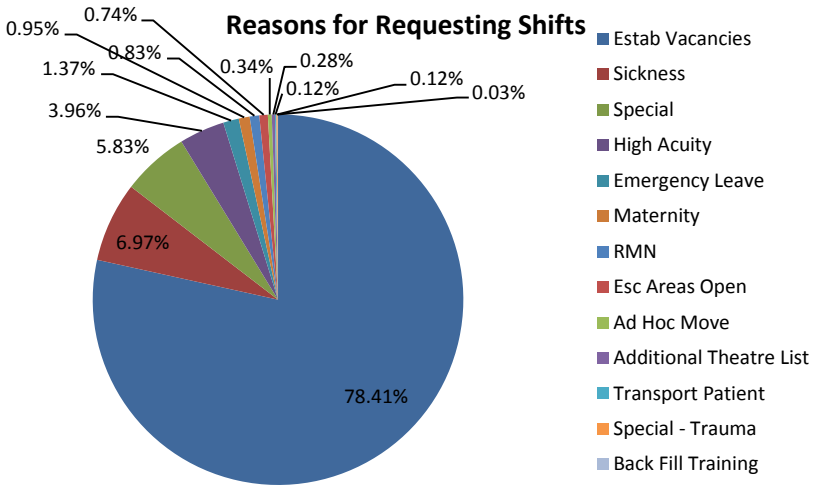
The table below lists the five care groups with the highest bank percentage spend for this month.

Bank Spend % by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	5.13%	5.96%	5.63%	5.77%	↗
Community Services	4.79%	4.87%	4.44%	4.45%	↗
Corporate	4.16%	1.47%	3.80%	4.40%	↗
Estates and Facilities	10.58%	9.86%	9.37%	10.35%	↗
Medical & Cardiothoracics	5.50%	6.89%	5.88%	6.13%	↗
Surgery, Neurosciences & Anaes	4.00%	4.67%	3.40%	3.28%	↘
Whole Trust	**4.82%**	**5.40%**	**5.09%**	**5.00%**	↘

Care Group	Bank Spend % May-15	Staff In Post WTE
Security & Car Park Management	26.95%	22.00
Portering	26.24%	77.65
Pharmacy	15.61%	165.47
Prison Service	14.68%	59.55
Outpatients	13.11%	246.57

Section 10: 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 May the Bank Fill Rate was reported at 56.4% which is 6% higher than the previous month. The Overall Fill Rate was 80.64% which is an increase of 4.3% on the previous month. The Community Services Division is currently meeting the demand for temporary staff most effectively.

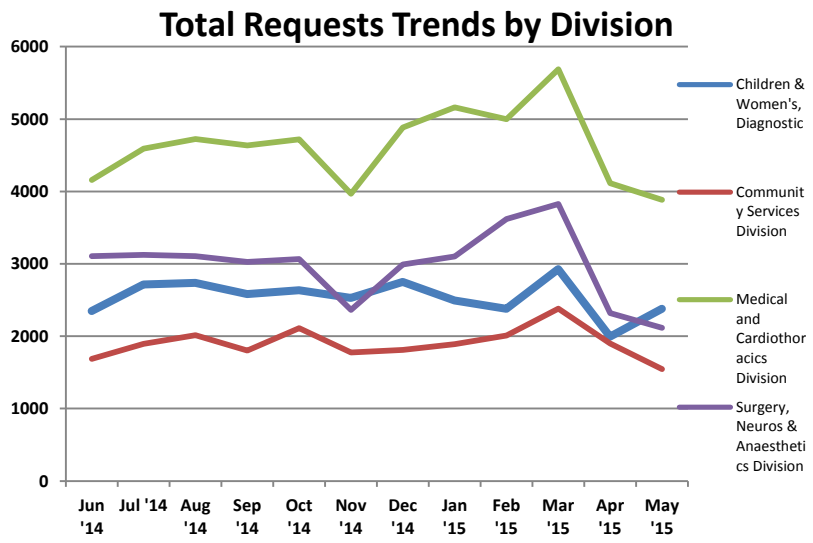
The pie chart shows a breakdown of the reasons given for requesting bank shifts in May. This is very much dominated by covering existing vacancies, specials, sickness, and high acuity patients.

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

Bank Fill Rate % by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	34.02%	34.54%	45.41%	52.14%	↗
Community Services	44.90%	41.01%	41.49%	49.51%	↗
Medical & Cardiothoracics	39.03%	37.96%	46.54%	51.69%	↗
Surgery, Neurosciences & Anaes	47.50%	48.50%	50.71%	57.66%	↗
Whole Trust	**45.15%**	**44.15%**	**50.24%**	**56.35%**	↗

Overall Fill Rate % by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	81.54%	78.72%	78.35%	84.90%	↗
Community Services	83.57%	83.28%	84.08%	89.19%	↗
Medical & Cardiothoracics	74.45%	74.98%	74.37%	77.84%	↗
Surgery, Neurosciences & Anaes	70.47%	71.92%	71.43%	75.73%	↗
Whole Trust	**77.32%**	**77.10%**	**76.37%**	**80.64%**	↗

Section 11: Temporary Staffing Duties



COMMENTARY

This data comes from the Trust's e-rostering system.

The figures show the number of bank and agency duties requested by month by Division. The graph shows a large decrease in numbers in April as tighter controls on booking and runrate initiatives have been implemented.

Division	Jun '14	Jul '14	Aug '14	Sep '14	Oct '14	Nov '14	Dec '14	Jan '15	Feb '15	Mar '15	Apr '15	May '15
C&W Diagnostic & Therapy	2349	2713	2735	2581	2636	2529	2752	2493	2378	2927	1995	2378
Community Services	1685	1893	2015	1800	2110	1774	1811	1890	2009	2380	1897	1545
Medical and Cardiothoracics	4160	4593	4723	4636	4721	3967	4885	5161	4999	5688	4113	3885
Surgery, Neurosciences & Anaes	3105	3125	3106	3028	3068	2363	2991	3101	3617	3825	2321	2114
Estates & Facilities	156	168	165	165	707	303	651	727	711	842	996	1010
Corporate	133	134	184	184	347	174	388	361	300	424	509	556
Total	**11588**	**12626**	**12928**	**12394**	**13589**	**11110**	**13478**	**14054**	**14014**	**16086**	**11831**	**11488**

Section 12: Mandatory Training

MAST Topic	Mar '15	Apr '15	Trend
Conflict Resolution	69.1	71.1	↗
Dementia Awareness	62.7	62.7	↘
Equality, Diversity and Human Rights	84.9	83.5	↘
Fire Safety	78.0	77.3	↘
Health, Safety and Welfare	85.1	83.7	↘
Infection Prevention and Control Clinical	60.8	62.1	↗
Infection Prevention and Control Non Clinical	79.5	77.2	↘
Information Governance	66.0	66.7	↗
Moving and Handling	83.6	80.8	↘
Moving and Handling Patient	58.7	55.2	↘
Resuscitation BLS	50.9	44.1	↘
Resuscitation ILS	50.7	46.5	↘
Resuscitation Non Clinical	59.9	60.2	↗
Safeguarding Adults	85.0	82.7	↘
Safeguarding Children Level 1	84.3	81.7	↘
Safeguarding Children Level 2	78.2	78.3	↗
Safeguarding Children Level 3	59.6	58.2	↘
Venous Thromboembolism	34.8	37.3	↗

MAST Compliance % by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	75.3%	75.9%	75.4%	75.0%	↘
Community Services	77.9%	77.8%	77.0%	74.7%	↘
Corporate	75.5%	75.7%	74.2%	71.9%	↘
Estates and Facilities	68.3%	66.8%	66.5%	65.9%	↘
Medical & Cardiothoracics	67.1%	67.1%	67.1%	66.4%	↘
Surgery, Neurosciences & Anaes	71.3%	71.3%	71.0%	70.3%	↘
Whole Trust	**74.7%**	**74.7%**	**74.2%**	**73.1%**	↘

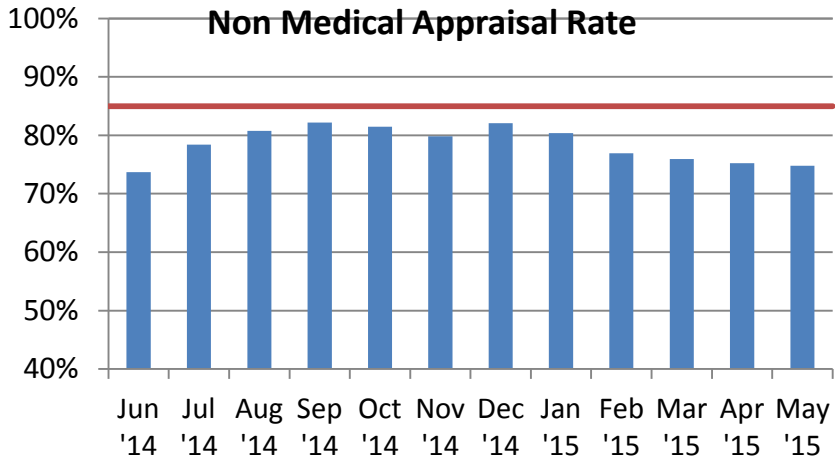
COMMENTARY

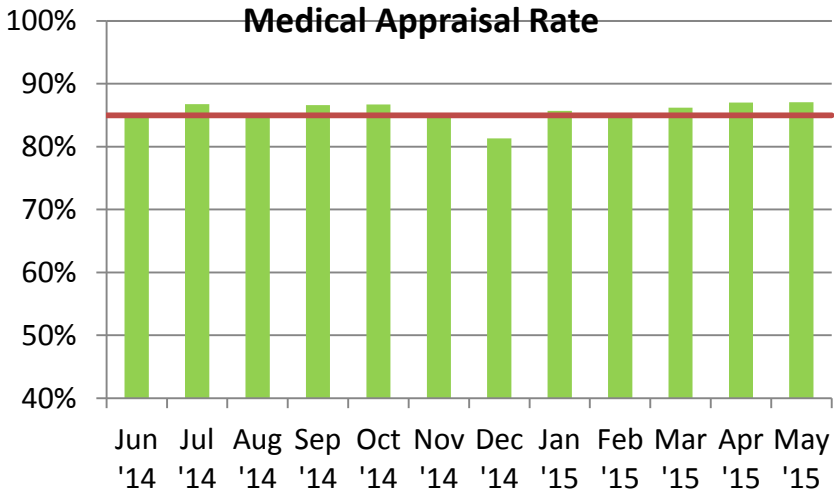
The overall Trust compliance for MAST is now at 73.1% which has decreased by 1.1% since April.

The new Learning Management System is new in place. The system will provide automatic reminders and notices to both staff members and their managers on their compliance. Managers will also be able to see at a glance their staff training data. This quick method will equip mangers with the necessary information to investigate their staff's compliance and respond accordingly.

Mandatory training compliance is included in monthly appraisal performance meetings.

Section 13: Appraisal





Non-Medical Commentary

The non-medical appraisal rate has decreased this month to 74.8%. 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 87.1% which is above the 85% target.

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Care Group	Non-Med Appraisal Rate	Staff In Post WTE
Computing Directorate	36.8%	42.67
Neurosurgery	41.3%	99.34
Paediatric Surgery	50.0%	54.38
Gynaecology	51.4%	44.99
Procurement & Materials Mgmt	51.4%	40.00

Non Medical Appraisals by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	79.4%	75.5%	74.5%	76.5%	↗
Community Services	76.8%	77.3%	76.8%	75.3%	↘
Medical & Cardiothoracics	73.6%	76.0%	77.0%	82.0%	↗
Surgery, Neurosciences & Anaes	78.9%	79.6%	77.7%	72.0%	↘
Corporate	67.2%	64.9%	65.1%	69.0%	↗
Estates & Facilities	77.9%	78.3%	76.6%	68.8%	↘
Whole Trust	**77.0%**	**75.9%**	**75.2%**	**74.8%**	↘

Medical Appraisals by Division	Feb '15	Mar '15	Apr '15	May '15	Trend
C&W Diagnostic & Therapy	83.7%	88.3%	89.7%	87.8%	↘
Community Services	88.9%	83.3%	66.7%	72.7%	↗
Medical & Cardiothoracics	80.6%	83.8%	86.0%	87.6%	↗
Surgery, Neurosciences & Anaes	89.1%	86.1%	87.7%	84.9%	↘
Corporate	100.0%	100.0%	100.0%	100.0%	↔
Whole Trust	**85.2%**	**86.2%**	**87.0%**	**87.1%**	↗

Name and date of meeting: **TRUST BOARD** **JUNE 2015**
Document Title: **Corporate Outpatients Improvement - Update** *An update on the Corporate Outpatient Service improvement action*
Document Author: **Laura Yarnell**, Programme Manager
Lead Director: **Rob Elek,** Director of Strategy
Action required: The Trust Board is asked to: 1. Note and welcome the on-going work being delivered to improve the operational functions of corporate outpatient services 2. Note the development of the Outpatient Strategy programme that will deliver tactical, strategic and innovation work streams for all outpatient services delivered by St George's.

Trust Board June: Corporate Outpatients Improvement Programme Update: Jan - May'15:

1. Introduction

The purpose of this paper is to provide the Trust with an update and overview on the following key areas:

- COS Improvement Programme progress from January to May 2015
- COS Operational update – CBS and medical records
- Introduction to the Outpatient Strategy Board and the planned programme of work

2. COS Improvement Programme update

The Corporate Outpatient (COS) Improvement Programme is now drawing to a close in its current format and work has been transferred to business as usual within COS. This section provides an overview of the progress of the five key work streams since January and outlines the next steps for COS to continue to take forward and build on the successes of the 10 month Improvement Programme.

Please note the following updates only relate to Corporate Outpatient Services and do not include Queen Mary's or the Nelson.

2.1. Capacity and Demand

Patients generally are booked and seen in a timely fashion but prior to commencing the corporate outpatient improvement programme in 2014 there was a widespread opinion within the Trust that current and future capacity and demand (both clinic and estate) was not fully understood nor planned and that there was very limited space potential to run extra clinics. The improvement programme sought to understand the demand and capacity issues, identify levers and put action plans in place.

2.1.1. Progress to date

- Demand for outpatient appointments and operating capacity are modelled and options are developed for alternative service delivery to resolve negative patient experiences due to capacity challenges
- Static trust wide capacity model developed revealing deficit against demand for 15/16 business plans
- Live dashboard of the same data under production by Information and Performance
- Informed the equalization of demand among medical specialities for 15/16

2.1.2. Next Steps

- Information and Performance departments now working to develop live capacity and demand dashboards for the organisation. (to be completed July 2015)
- Incorporation of capacity and demand model into capacity deficit reduction for 15/16 business year and beyond.

2.2. Bookings and Appointments

The current process for booking new referrals is a paper based process and is managed by the Corporate Outpatient's Central Booking Service. The process currently involves the paper referral moving from the central booking service to the relevant clinical service or vice versa. There was an identified risk of paper being mislaid completely or remaining for excessive times with the clinical service. Where this happens there is no record of length of time elapsed or location of referral.

Auditing the time between referrals being sent out from central booking service to the relevant clinical service and the date received back into central booking service for a sample of referrals we found:

- 57 (10%) were sent directly from GP's to Consultants and received in central booking service anything from 3 to 12 days later where known but many dates are unknown.
- 73 (12%) had no reliable dates – either no registration or return date or a number of date stamps. Many of these probably also originated with a speciality.
- The other 447 ranged from 1 to 46 working days. The calculated average was 4.4 days, the median was 3 days.
- 34 referrals took 10 days or longer

2.2.1. Progress

- Designed, developed and implemented "e_Triage" and electronic referral system that is set to reduce the amount of time from when a referral is received to when an appointment offer is made, by an average of 3.5 days.
- E-Triage completed Phase One rollout to 8 COS specialities (Nov-Feb) and the system has handled 14000 referrals so far with 2646 currently active.
- Pause to Phase 2 rollout (originally scheduled for April) to enable system issues to be fixed, further development of the system to be completed and assurance to be sought for the specialities experiencing issues.
- Auditing facilities have been developed to enable the tracking of referrals from end to end perspective.

2.2.2. Next Steps.

- Further development to the system based feedback and issues experienced by phase one specialties.
- Phase Two rollout to the 11 COS specialities will take a phased approach from 22nd June and throughout July.
- COS and IT deliver sustainability plan for the management of the e-Triage system post phase two go-live. This plan will outline the detail of how the COS management team will be able to support the users of e-Triage with any administrative queries and how the IT team will support any further system developments or technical issues that may arise.
- Management reporting and auditing tools available for COS and service users by July. These tools will enable Service Managers, consultants and CBS teams to review the progress of all patient referrals that are scanned into e_Triage.
- The e_Triage "stagnant" records report that identifies any referrals that have not been triaged within 48 hours of them being scanned into the system will form part of the weekly RTT performance meetings that are held with each of the services who deliver outpatients.

2.3. Partnership Working

- The aim of this original work stream was that Service users and COS have an effective working relationship where responsibilities and accountabilities are clear such that patients receive a consistently high level of service.
- This work stream was subsequently closed in January as a Service Level Agreement (SLA) has been developed by COS management that outlines the proposed roles and responsibilities of COS and service users.
- This SLA is set to improve relationships it is anticipated that it will set the terms of engagement for positive interaction between specialities and corporate outpatients.
- The CWDT Divisional Director of Operations is currently discussing the terms of SLA with the other Divisional Directors and it is hoped a decision on its approval will be made by end of June.

2.4. Physical Environment

The outpatient estate on St George's hospital site is extensive with high footfall and this high usage can lead to areas needing regular maintenance and updating. It was recognised that improvements could be made in some areas so we engaged with patients and staff to identify the good and bad areas in order to prioritise the work.

2.4.1. Progress

- Lanesborough: The furniture for the clinic rooms in A, B, C are now in place. Painting has started in these areas.
- Dragon Centre: new Art work in place, construction of two additional rooms by dividing rooms to help meet increasing demands on the service.
- Signage improvement recommendations have been submitted, this is with estates for final sign off.
- Additional TVs for waiting areas are being sourced.

2.4.2. Next Steps

- Discussions to take place with Audiology regarding the possibility of installing music systems in some Outpatient waiting areas.

- Lanesborough main reception area refurbishment has had to go out to tender due to cost

- Work is underway to improve the patient information that it used by Corporate outpatient services. This will involve standardising the information provided across clinics, and reviewing the current appointment letters that are generated by the Cerner IT system. A timeline for this is to be agreed between COS Management and I.T team

2.5. Staff engagement and Motivation

Staff forums were held where over 100 staff attended. Honest feedback was received on communication, responsibilities, management, empowerment, frustrations and incentivization. In addition Listening into action cards were collated. 30% of issues cited were about IT and a further 25% about frustrations with staffing.

2.5.1. Progress

- 7 training sessions were delivered to COS admin staff during February and March that were based on improving patient experience and developing an Outpatient charter for values and behaviours.

- The COS Senior management team attended similar training session on 19th May 2015.
- COS management continue to hold coffee mornings and drop in sessions to provide a forum for the COS admin teams to discuss any issues and share ideas.

2.5.2. Next Steps

- COS are in the process of recruiting in to their substantive posts to reduce the reliance on bank and agency , the benefits of this are financial and improved quality of service delivery. 40 administrative posts have been filled and the new staff are due to start work from July onwards.

- COS has a large workforce which historically has been run with over 25% of the work force been temporary workers, to ensure stability, quality and improved governance of the service the strategy has been to increase the substantive work force over the next 6 months meanwhile sustain the current workforce
- A values awards ceremony is due to be held in late June it will be opened by Miles Scott and all staff who attended the training will receive a values award.
- Patient video featuring 3 patients talking about their outpatient experiences was filmed in April 2015 and now in the process of being edited to go on to the intranet as a learning tool.

3. **COS Operational Update**

COS currently report on a variety of KPI's through their monthly directorate meetings and to the CWDT Divisional Management Board, please refer to Appendix 1 for the June COS scorecard.

Points to note:

- Management of sickness via scorecard have seen marked improvement in the sickness rates.
- The COS management team are in the process of agreeing a long term recruitment strategy for COS over next 18 months to help address on-going vacancy rates and improve the quality of the service provided to patients.
- The appointment of a substantive Head of Nursing is making a positive impact on patient experience particularly the management of complaints.

One of the main areas of focus for COS that is reported more widely to the Trust are the performance of CBS (Central Booking Service), a monthly update for this is included in the Chief Executive's Report. Please refer to Appendix 2 for the June update.

Currently COS are in the process of working with the Divisions to agree a service level agreement, this will ensure that COS is correctly remunerated for the spend it incurs delivering short notice and ad hoc clinics. COS does not currently generate any income but does incur staff costs for delivering a service and has the ongoing challenge of managing the off site storage of all notes, currently there is no destruction policy for medical records .

4. Outpatient Strategy

4.1. Overview

It is acknowledged that whilst there has been continued progress made to operationally improve corporate outpatient services the Trust lacked an explicit overarching strategy for outpatient services.

In response to this an Outpatient Strategy Board (OSB) was formed in April 2015, the purpose of this board is to oversee the development and delivery of a 5 year strategy for all outpatient services across the following sites:

- COS/St George's Hospital site
- Queen Mary's
- The Nelson
- St John's

The strategy will address issues such as the optimum configuration of clinical services between sites, the strategic management of outpatient operations and the transformation of the clinical delivery model to support greater self-management and care closer to home for patients. Please see appendix 3 for an overview of the Programme work streams and governance structure.

- **COS Tactical:** this will continue to build on the successes of the 10 month Improvement Program and will work to deliver a local programme to optimise COS service provision, addressing the on-going issues such as CBS and Medical Records.

- **Strategy:** Design and implement an optimal approach to the delivery of outpatient care through the development of core operating principles and standards to ensure patients receive a consistent level of care across ALL St George's outpatient sites. This work stream will address the current business rules, management and capacity planning between the sites.

- **Innovation:** Identify how to use technology to develop clinical and service models to enable greater self-management and to optimise the delivery of outpatient care.

4.2. Scope

The scope and breadth of this programme will cover the whole patient journey from GP referral into the organisation, the patient attending their clinic and their subsequent discharge.

At present there are multiple means of referring a patient, a range of outpatient booking systems and approaches to managing and delivering clinics across the four sites. For the Trust to deliver an optimal outpatient service with high levels of patient satisfaction then a review of the current processes across all four sites is required. This will enable the Trust to reduce variation and ensure a streamlined pathway for patients, GP' and all other users of the outpatient services.

4.3. Resource

There is currently 1 x WTE Programme Manger assigned to this programme.

There is a further resource requirement of 1 XWTE Project Manager and 1 WTE assistant project manager to support the delivery of this work.

4.4. Metrics

The focus of this programme is to drive up the quality of experience for patients; efficiencies will be delivered through the reduction in variation and standardisation of processes across the 4 sites.

The proposed draft metrics are detailed below, these will need to be worked up in more detail and approved by the OSB and each metric and its supporting data will be ratified with the Trust's Programme Management Office.

Cos Tactical	Strategy	Programme wide
Achieve the 98% notes in clinic on time target	Increase the utilisation of all clinic rooms	Improve patient Experience
CBS performance (call centre)	Efficiency gains from increased utilisation of rooms	Reduce patient complaints
COS staff retention figures	Efficiency gains from reducing business models from 1 to 3	Improve staff experience
		Meet GP's measures of success

4.5. External dependencies

This programme of work requires the engagement of a number of the Trusts key business functions, and it has dependencies on other programmes being delivered across the Trust.

IT and Informatics:

- The business case to move QMH from its current legacy system onto Iclip
- Rollout of Electronic Document Management (EDM) programme that will move the Trust's patient notes from paper to being scanned and available electronically – this has an immediate impact on the COS tactical work stream and will be required to support the implementation of a standardised referral and management of patent notes.

Elective Access policy: the OSB will review the current policy and identify each of the 4 sites current adherences to it. The policy will be considered in the development of the final business model.

St Georges Estate's plan: Eric Munroe is now a member of the Outpatient Strategy Board and the outcomes of this programme will inform the development of the Maybury Street facility.

4.6. Progress

- Mapping of the 3 different business models used to deliver outpatient services across the 4 sites has commenced. A cross divisional workshop with CWDT and Community divisional management was held on the 17th June to agree the core principles for the optimum business model. The outcomes of this workshop and a final recommendation will be tabled at August EMT and OMT for final decision.

- Engagement with Serco, an external organisation with experience in delivering outpatient services in healthcare is underway. A proposal is being drafted by Serco that outlines the specification to run a diagnostic for the current outpatient CBS and referral routes that will recommend a best practice solution.

- A review of which of the 4 sites each specialty delivers outpatient services from is underway. This will enable a strategy to be developed to maximise the use of the rooms available and to identify which locations are optimum for each speciality to be delivering an outpatient service from. This work will result in a reconfiguration of the current service offering at each location.

- IT and Information team are developing plans to be reported at the July OSB for the following:
  - Standardised reporting on core outpatient performance metrics across all 4 sites
  - Reviewing Iclip functionality to enable “real time” capacity planning and to identify a room booking system.
  - Use of current systems to enhance the referral processes for outpatients.

4.7. Next Steps

- Paper to OMT and EMT in August with recommendations on the Outpatient business model.

- On-going work to continue to scope and deliver the COS Tactical and Strategy workstreams.

- Mapping of processes and standard operating procedures will have been completed and an update will be shared to October OMT and EMT.

- Innovation work stream will start to be developed from October onwards

- The Trust Board will receive a paper updating on progress in October.

Appendix 1

Corporate Outpatient Services Monthly Scorecard

		Source	Target	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Activity	Total attendances	Cerner	N/A	60264	62954	69250	56102	67188	69507	61879	58659	64609	60659	62946	60564	59841
	DNA	Cerner	<8%	7.18%	10.93%	9.87%	10.02%	9.89%	10.30%	7.64%	7.33%	7.58%	8.04%	7.33%	7.27%	7.97%
	Hospital cancellations <6 weeks	Cerner	<0.5%	0.48%	0.47%	0.31%	0.56%	0.36%	0.49%	0.32%	0.48%	0.47%	0.45%	0.54%	1.26%	0.74%
OPD performance	Permanent notes to clinic	Manual count	>98%	95.54%	96.85%	96.94%	96.71%	96.98%	96.51%	96.88%	96.77%	94.05%	90.12%	91.32%	95.52%	
	Cashing up - Current month	Cerner	>98%	96.30%	98.10%	98.20%	98.10%	96.60%	98.00%	98.22%	96.40%	97.10%	97.30%	99.60%	98.60%	98.30%
	Cashing up - Previous month	Cerner	100%	99.40%	99.70%	99.80%	99.99%	99.91%	99.60%	99.95%	99.20%	99.70%	99.90%	99.00%	99.60%	99.70%
Call Centre Performance	Total calls	Netcall	N/A	30116	35571	45101	30004	25674	23420	20964	20639	26565	20842	23235	18710	
	Abandoned calls	Netcall	<25%/<15%			32257	14825	5794	2376	1558	2681	5923	2908	3782	1551	
	Mean call response times	Netcall	<1 m/<1m30s	02:34	11:42	20:39	08:41	02:38	01:13	00:47	01:02	02:24	01:43	01:08	01:00	
Nursing Performance	Safe staffing	RaTE	85%	96%	94%	96%	93%	93%	94%	90%	93%	93%	96%	92%	96%	
Phlebotomy Performance	Phlebotomy <30 min waiting time	Phlebotomy queue system	90%	76.42%	72.96%	72.35%	72.44%	47.86%	72.90%	67.00%	69.00%	57.00%	81.00%	81.00%	70.00%	
Quality & Experience	Complaints	C&I	<8	10	17	8	21	8	17	5	4	8	4	5	3	
	Compliments	Local record	N/A	2	2	2	3	2	4	3	6	4	3	3	2	
	Datix reported incidents	Gemma Astafanous	N/A	17	20	18	7	16	12	13	13	6	20	12	11	
	Serious incidents	Gemma Astafanous	0	0	0	0	0	0	0	0	0	0	0	0	0	
Workforce	IPR completion rate	Workforce report	>85%	65.77%	57.47%	58.56%	78.64%	76.79%	77.17%	77.06%	77.31%	80.18%	86.76%	84.40%	80.54%	
	MAST completion rate	Wired	>95%	80.09%	80.84%	76.13%	81.85%	78.30%	67.40%	67.56%	67.68%	71.00%	74.00%	66.00%	74.00%	
	Sickness rate	Workforce report	<3.5%	4.85%	6.79%	8.20%	5.19%	5.90%	4.78%	6.12%	5.35%	5.23%	3.86%	2.83%	3.23%	
	Vacancy factor	Workforce report	<20%	26.12%	26.21%	26.84%	26.08%	25.70%	25.35%	26.58%	26.45%	27.53%	29.17%	28.73%	29.86%	
	Bank & agency spend as proportion of total pay budget	Budget statement	<20%	33.34%	31.64%	38.27%	32.79%	43.66%*	34.15%	31.73%	33.64%	35.43%	30.26%	32.65%	24.20%	
Finance	Budget position in month	Budget statement	In balance	-124,622	8,709	-84,763	-101,977	-276,579	-255,861	-73,219	555,327	-203,000	73,579	-119,680	-279,426	
	CIP	CIP database	Green	Amber	Red*	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
EDM	Number of notes planned to have been scanned	EDM Business Case	N/A												210	210
	Number of Records Scanned											567	623		562	639
	Number EDM Appointments														3081	3216
	Number of Clinicians using EDM														TBC	
Comments					*EDM delays affecting CIP			£116k of VAT accruals in month							No. of EDM clinicians will be confirmed next month	

please note at the time of completing this document COS were still in the process of completing the performance data for May.

Appendix 2

June 2015 – Chief Executive's Report.

Corporate Outpatients Update - Call Centre

The Board has previously been informed of issues encountered in the call centre, which have resulted in long queues and poor patient experience.
As reported at previous meetings, an action plan to address these issues has been developed and is being implemented (table 2 below). Implementation of the action plan has led to continuing improvement as presented in table 1 below.

Table 1 - Current Performance:

Performance from the last 8 weeks:

Week Commencing	Total calls	Answered	% answered	Mean response	Median response (answered calls only)	% answered within 30 secs
13 April 2015	4636	4259	91.90%	00:53	00:20	57%
20 April 2015	4826	4046	83.80%	01:06	00:22	50%
27 April 2015	4730	4210	89.00%	01:15	00:37	43%
04 May 2015	3903	3391	86.90%	01:25	00:46	39%
11 May 2015	4537	4120	90.80%	01:07	00:32	45%
18 May 2015	4585	4031	87.90%	01:21	00:43	39%
26 May 2015	3954	3205	81.10%	02:18	01:44	34%
01 June 2015	4804	4224	87.90%	01:25	00:45	40%

Table 2 – Actions plan (outstanding and ongoing only):

No.	Action	Owner	Timescale	Anticipated impact	Progress/Rag
1	Additional space for growth in CBS resource	E&F	Revised again to 06/03/2015	Facilitate increase in resource – currently reliant on leave to enable all staff to be accommodated. *Efficiency gain – as per 3.*	Now complete.
2	Conversion of Agency to substantive staff	DC/JF	Revised to 31/03/2015	Ensure that staff turnover do not adversely affect call handling resource. Focus on part time staff to cover morning and lunchtime peaks. *Efficiency gain – as per 3*	Complete. Still awaiting start dates, delays in recruitment processing applicants.
3	Reduced number of escalated appointments	HH/ DCh	Revised to 30/06/2015	Improved first call resolution of appointment enquiries, for scheduling that cannot be completed in clinic	Capacity and demand modelling is outstanding

	due to insufficient capacity			*Efficiency gain – Reduction in queue time by 15 secs*	however introduction of fixed appointments has dramatically decreased escalation emails.
4	Full deployment of eTriage to all specialities	HH/IF	Revised to July or August 2015	Reduced time wasted looking for referrals and reduced inefficiency from two referral systems	Phase 1 roll out has highlighted system issues. Phase two roll out for all other specialities to commence before end June 2015.

Current issues

- Loss of one day's activity due to bank holiday.
- Loss of efficiency by running two referral management systems during deployment of eTriage. Once completed this will allow a subsequent efficiency gain.
- Continued significant growth in booking requests as part of work to address RTT compliance over holiday period and targeted actions for some specialities diverting resource from inbound calls.
- Ongoing issues with outpatient capacity causing a backlog of referrals and thus higher demand for immediate capacity, as indicated by "Escalation Email" activity code. Last eight weeks performance shown below:

Week commencing	**Count of calls not resolved first time**
13 April 2015	1205
20 April 2015	1206
27 April 2015	1047
04 May 2015	731
11 May 2015	979
18 May 2015	1045
26 May 2015	969
01 June 2015	1251

Next Steps

- Adherence to schedule – reporting is being developed to demonstrate this metric
- Forecasting accuracy – we are analysing nine months of inbound call data and developing a forecast. In order to be accurate the data still needs fine tuning before being shared.
- Self-service accessibility – We currently offer a web based appointment re-scheduling request function however Iclip does not allow true self service in regards to appointments. Having contacted communications there is a drive to improve our external website and discussions are on-going regarding CBS Self-service accessibility.
- Contact quality – We will be increasing our audits of calls to 2.5% from currently 1%
- Customer satisfaction – we are in contact with our call centre software provider to include a rate your call option or similar to determine customer satisfaction with service and first call resolution.

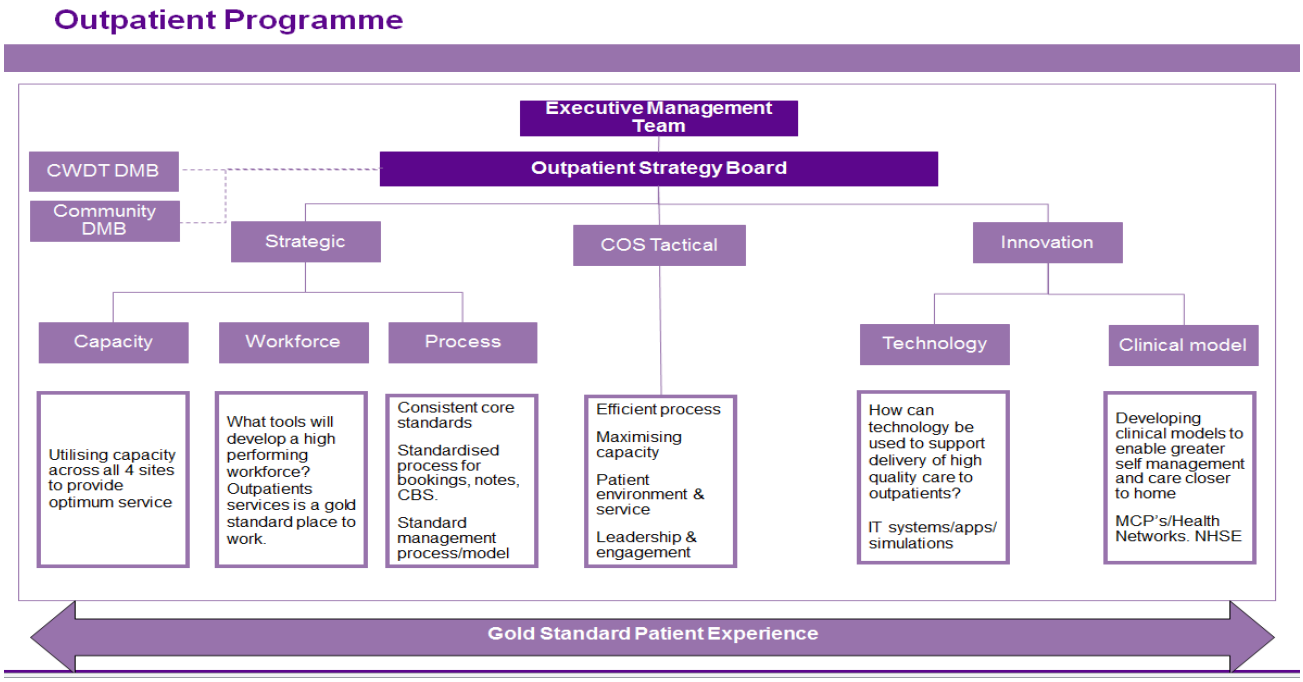
Appendix 3

OUTPATIENT STRATEGY PROGRAMME

TERMS OF REFERENCE:

Outpatient services are a major part of St George's University Hospitals, providing around 650,000 appointments per year and bring in over £110m in income. This programme of work has been established as the Trust requires an overarching strategy to ensure the delivery of world class outpatient services to its patient population.
This paper outlines governance, reporting and terms of reference for the Outpatient Strategy programme.

1) GOVERNANCE STRUCTURE



2) HIGH LEVEL OVERVIEW

	High level overview	Timeframe
Outpatient Strategy Board	• Develop the 5 year strategy for Outpatient services across St George's University Hospitals.	Ongoing
Outpatient Strategy Group	• Delivers a standard approach Process, Capacity and workforce for outpatients	Medium
Outpatient Innovation Group	• Implements the use of technology to maximise the efficiency and experience of outpatient services	Long term
COS Operational	• Delivers a focused operational plan to improve capacity, process, patient experience and leadership across COS	Short Term
Patient Experience	• The delivery of a gold standard patient experience is paramount throughout.	Ongoing

3) TERMS OF REFERENCE

	Outpatient Strategy Board	**Strategy**	**Innovation**	**COS Operational**
Purpose	Develop the 5 year strategy for Outpatient Services	Design and deliver an optimal approach to the delivery of outpatient care	Identify how to use technology to optimise and innovate the delivery of outpatient care	Deliver local level programme to optimise COS service provision
Aims	• Develop and agree the programme to deliver the 5 year strategy • Provide leadership, challenge, expert opinion and senior decision making across the programme. • Hold Community and CWDT divisions to account for the delivery of the programme • Report progress to the Executive Board	• Implement a cross divisional work programme that delivers: ○ A set of core operating principles and standards ○ A tool kit to enable a high performing workforce ○ Enables capacity to be effectively utilized across St George's estate ○ Standardised management processes and model ○ Align divisional priorities to ensure delivery	• Develop clinical models to enable greater self-management • Bring care closer to home • Identify IT and technology to improve patient care and service provision	Continue to deliver the COS Programme that addresses the four key areas: • Effective Process • Maximizing Capacity • Patient Environment • Enhancing Leadership
Membership				
Chair	**Director of Strategy**	**This will be a working group with representation from CWDT/Community and the Improvement Programme.**	**TBC**	**COS Clinical Director**
Deputy Chair	**Divisional Chair**	**As above**	**TBC**	**COS General Manager**

Core Membership	• CWDT Divisional Director of Operations • CWDT Divisional Chair • Community Divisional Director of Operations • Community Divisional Chair • CWDT DDNG • Community DDNG • Programme Manager • I.T Director, Head of Informatics and Director of Estates will be called upon as required	• CWDT Divisional Director of Operations • COS Clinical Director • COS General Manager • Community Divisional Director of Operations • Community Outpatients General Manager • Community Outpatients Clinical Director • COS Head of Nursing • Community Outpatients Head of Nursing • Programme Manager • IT/Informatics/Estates representation and contribution will be called upon as required. ***The membership of this group will be flexed depending on the requirements/timeframes of the different workstreams within this project**	• **TBC**	• COS Assistant General Manager • COS Head of Nursing This programme will be managed through the existing COS Directorate meetings.
Quorum	• 5 people – must include representation from both CWDT and Community	• The meetings will aim to include representation from both CWDT and Community	• **TBC**	• TBC
Accountability	• Executive Management Team and Trust Board	• Outpatient Strategy Board	• Outpatient Strategy Board	• CWDT Divisional Management Board
Frequency	• Monthly	• Fortnightly to start and will review	• Monthly	• Monthly
Reporting	• Programme update and exception reporting to EMT	• Monthly update report to OSB and Community and CWDT Divisional Management Boards	• Monthly update report to OSB and Community and CWDT Divisional Management Boards	• COS management team to update CWDT DMB through local reporting processes

	• It is expected that decision taken at the OSB be adhered to by CWDT and Community divisions • Members have a responsibility to ensure that decisions taken at the OSB are communicated appropriately through their management structure.	• The decisions taken at Strategy group will be adhered to by all members • Members have a responsibility to ensure that decisions taken at the OSB are communicated appropriately through their management structure.	• The decisions taken at Strategy group will be adhered to by all members	• The COS management team are responsible for the implementation of any decision taken at the COS directorate or CWDT DMB.

Declaration of interests	• All Outpatient Strategy Programme members must declare any conflict of interests, should they arise, and exclude themselves from the meeting for the duration of that specific item.
Monitoring Effectiveness:	• In order to support the continual improvement of governance standards, the Terms of Reference will be reviewed at regular intervals during the life cycle of the Outpatients Strategy Board
External	• • **NHS Five Year Forward View; Multispecialty Community Providers** "shift the majority of outpatient consultations and ambulatory care out of hospital settings". • **National Information Board** – By **2018** clinicians in primary, urgent and emergency care and other key transitions of care contexts will be operating **without needing to use paper records.** • **General Election 2015** – potential Health & Social care bill reforms, May 2015 onwards.
Internal Dependencies	• **Trust's Financial position**-limited investment available for capital builds/technology – need to identify funding from alternative sources (HSCIC?) • **Management structures-** outpatient services are currently delivered by Community and CWDT across 4 sites. • **Service Line Review –** the outcomes of the review will inform the decision around services to continue/de commission.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – JUNE 2015

Paper Title:	Planning Performance Agreement with Wandsworth Borough Council
Sponsoring Director:	Eric Munro, Joint Director of Estates and Facilities
Author:	Eric Munro
Purpose:	Negotiations on the terms of the Planning Performance Agreement with Wandsworth Borough Council have been concluded.
Action required by the board:	The Board is asked to approve the execution of the Planning Performance Agreement in the form at Appendix A.
Document previously considered by:	Not applicable

Executive summary

1. Key messages

The Trust has been in formal pre-application consultation with Wandsworth Borough Council for some months now regarding the acceptability of various proposed developments across the St George's campus. These developments are in various stages of the business case approval process. In order that the Council can understand and assess the potential cumulative effect of these proposals, it has proposed that the Trust enters into a Planning Performance Agreement with the Council to govern the process whereby the Trust seeks Outline Planning Permission for these developments.

It must the noted that the planning application is outline only, so it establishes whether the size and cumulative scale of development is acceptable in principle, with issues of materials, outward appearance and detailed design reserved for a subsequent "full" application. The Trust will want the assurance of acceptability prior to commitment of resources to developing projects and programmes.

Obtaining outline planning consent does not commit the Trust to undertaking any of the developments but will give greater delivery certainty to business cases coming forward in the future.

The Planning Performance Agreement has been prepared by Capsticks and is endorsed by them.

2. Recommendation

The Board is asked to approve the execution of the Planning Performance Agreement in the form at Appendix A.

Key risks identified: Risks are detailed in the report under each section.	
Related Corporate Objective:	
Related CQC Standard:	Not applicable.
Equality Impact Assessment (EIA): Has an EIA been carried out? No **If yes, please provide a summary of the key findings** **If no, please explain your reasons for not undertaking an EIA.** No specific groups of patients or community will be affected by the initiatives detailed in the report. Where there may be an impact on patients then consultation will be managed as part of that specific programme.	

REPORT TO THE TRUST BOARD – JUNE 2015

Planning Performance Agreement with Wandsworth Borough Council

1. INTRODUCTION AND BACKGROUND

The Trust has been in formal pre-application consultation with Wandsworth Borough Council for some months now regarding the acceptability of various proposed developments across the St George's campus. These developments are in various stages of the business case approval process.

In order that the Council can understand and assess the potential cumulative effect of these proposals, it has proposed that the Trust enters into a Planning Performance Agreement with the Council to govern the process whereby the Trust seeks Outline Planning Permission for these developments.

It must the noted that the planning application is outline only, so it establishes whether the size and cumulative scale of development is acceptable in principle, with issues of materials, outward appearance and detailed design reserved for a subsequent "full" application. The Trust will want the assurance of acceptability prior to commitment of resources to developing these projects and programmes through the business case process.

Obtaining outline planning consent does not commit the Trust to undertaking any of the developments but will give greater delivery certainty to business cases coming forward in the future.

2. SCOPE OF THE PPA

The final form of the proposed Planning Performance Agreement with Wandsworth Borough Council is attached at Appendix A.

The Planning Performance Agreement will cover Outline Planning Permission for:

- Renal Unit
- Private Patients Unit
- associated parking and road infrastructure changes around the Renal/PPU site
- Major extension to Lanesborough Wing for the new Children's and Women's Hospital
- New Outpatients Centre on the Maybury Street site
- circa 200 residential units on the Maybury Street site
- Modular build on the Bence Jones site (for office decants)
- AMW terrace expansion (2nd and 3rd floor)
- St James Critical Care expansion (1st and 2nd floor extensions)
- St James ED Clinical Decisions Unit (ground floor)

It will also approve:

- demolition of Knightsbridge Wing
- the creation of a new 300+ space patient and visitor car park on the site of Knightsbridge Wing plus new drop-off zone
- demolition of Clare House, Bronte House and the Bronte Annex
- creation of 2-way access road at Ingleby House (Pelican)
- new site infrastructure such as sub-stations, street lighting, etc.

3. PPA COSTS

The total payable to the Council under the PPA is £160k plus VAT. The normal planning fee is payable over and above this amount. It is estimated that the planning fee will be circa £25k.

4. ACTIVITIES AND TIMESCALES

The Planning Performance Agreement commits both parties to an agreed schedule of activities and timescales as follows:

Planning application stage		
Task	Responsibility	Timeframe/Target Date
Submission of planning application via Planning Portal and hardcopies	Applicant	24 July 2015
LBW to indicate **informal** acceptance of validation (so that formal consultation period does not fall in August)	LBW	21 August 2015
LBW to confirm validation of application (start of formal 28 day consultation period)	LBW	7 September 2015
Send out consultations, Planning Newsletter, undertake publicity	LBW	September 2015
Consultation	LBW and Applicant	to run until 5 October 2015
Planning application review meetings	Planning Officer and Applicant	From mid-September 2015

3. Determination Stage			
Task	Responsibility	Key Issue	Timeframe/Target Date
1st Review meeting	Applicant/Planning Officer	Identification of any further information required	By mid-September 2015
Further information identified from 1st Review submitted	Applicant	Initial issues addressed	By mid-September/late – September 2015
First discussion regarding Draft S106 Heads of Terms	Applicant/Planning Officer	Agree terms; instruct legal teams	By mid-September 2015
Optional 2nd Review meeting	Applicant/Planning Officer	Identification of further information required/issues to be addressed	By early/mid-October 2015
Further information identified from 2nd Review submitted	Applicant	Further issues addressed	By mid/late October 2015

Task	Responsibility	Key Issue	Timeframe/Target Date
Optional 3rd Review meeting	Applicant/Planning Officer	Identification of further information required/issues to be addressed	By early November 2015
EIA Regulation 19	LBW		October 2015
Final material amendment date (assuming only a 14 day reconsultation needed and no longer)	Applicant	Material Submitted	13 November 2015
Draft of Conditions and S106 Agreement	Applicant/Planning Officer	Conditions and Legal Agreement drafted	13 November 2015
Distribute report to Members	Planning Officer	Draft report, HoT and conditions	Early December 2015
Final draft of committee report including final draft of conditions and HoT	Planning Officer	Submitted for print	w/c 30 November 2015
Presentation material submitted	Applicant	Submitted	Early December 2015
Committee meeting	LBW/Applicant	Resolution of committee	15 December 2015 (best case following 16 week determination period for EIA)
Referral to GLA (Stage 2) and SoS	LBW	Submitted	By 24th December 2015
Response from GLA and SoS if necessary	GLA/LBW	Stage 2 Report	Mid/end of January 2016
Sign Section 106	LBW/Applicant	Conditions and Legal Agreement finalised	By 29 January 2016
Decision Notice issued	LBW	Decision notice issued	By 29 January 2016

5. RECOMMENDATION

The Board is asked to approve the execution of the Planning Performance Agreement in the form at Appendix A.

Eric Munro
Joint Director of Estates and Facilities
19 June 2015

APPENDIX A

PLANNING PERFORMANCE AGREEMENT

BETWEEN

LONDON BOROUGH OF WANDSWORTH

AND

ST. GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

DATED: [******]

PLANNING PERFORMANCE AGREEMENT

This Agreement is made the [*******date*********] between

(1) London Borough of Wandsworth ("LBW") of The Town Hall, Wandsworth High Street, London SW18 2PU (acting as the local planning authority)

(2) St. George's University Hospitals NHS Foundation Trust of St George's Hospital, Blackshaw Road, Tooting, London SW17 0QT ("the Applicant")

Planning Performance Agreements

Extract from the Guidance Note 'Implementing Planning Performance Agreements', produced by the Communities and Local Government in June 2008:

> *"PPAs can help deliver end-to-end planning and improve the quality of decision making for the largest and most complex planning applications.*
>
> *It is recognised that the process to achieve high-quality sustainable development is complicated and that the potential to achieve a successful outcome can be greatly improved by:*
> - *Agreeing to a shared vision and set of objectives;*
> - *Committing to a genuinely collaborative approach by all key parties;*
> - *Adopting a spatial planning approach underpinned by development management; and*
> - *Establishing a robust project management process."*

1. Recitals

1.1 LBW is the local planning authority for developments falling within its administrative area.

1.2 The Applicant intends to submit the Planning Application to LBW in respect of the proposed Development.

1.3 The Applicant and LBW recognise that the proposed Development will give rise to a wide range of planning issues and, accordingly, they acknowledge that, in order to properly assess those planning issues, a clear basis and programme for determination is required.

1.4 In these circumstances, the Applicant and the LBW agree to enter into this Planning Performance Agreement for the following purposes:

a. to agree requirements and timescales in the form of Performance Standards (as specified in Schedules 3 and 4) and a Project Programme (as indicated in Schedule 5) for the consideration and determination of the Planning Applications for the purpose of providing the Parties with certainty as to the process and timescales to be followed;

b. to establish appropriate measures for monitoring compliance with the respective parties' obligations under this Agreement;

c. to establish review mechanisms in respect of the Project Programme.

1.5 Nothing in this agreement shall restrict or inhibit LBW from properly exercising its role as the local planning authority.

1.6 Nothing in this agreement shall restrict or inhibit the Applicant from exercising their right of appeal under Section 78 of the Town and Country Planning Act 1990 or the ability to withdraw the application(s) at any time prior to determination.

2. Term

2.1 This Agreement will apply from the Commencement Date (being the date upon which this agreement was signed) and (subject to earlier determination as hereinafter provided) shall remain in force for a period of 1 (one) year (or such extension of this Term in accordance with the terms of this Agreement) or the Decision Date (being the date a planning decision is issued by LBW on the Planning Application) whichever is the earlier and upon the expiry of such period this Agreement shall cease.

2.2 The Term shall be subject to review as may be agreed between the Parties and set out below under Section 7.

2.3 Should the Applicant submit an appeal under Section 78 of the Town and Country Planning Act 1990 in relation to the Planning Application (for whatever reason) or should the Planning Application be called in by the Secretary of State, this Agreement shall automatically terminate.

3. Joint Working

3.1 All Parties shall act with the utmost fairness and good faith towards each other in respect of all matters in respect of the handling of the Planning Application and to work jointly with each other in complying with their respective obligations under this Agreement.

4. Applicant's Obligations

4.1 The Applicant agrees to use its reasonable endeavours to:

a. submit a planning application to LBW for the Development set out in Schedule 1 by the Submission Date (being the date the valid planning application is received by LBW) set out in Schedule 6.

b. submit the documents set out in Schedule 2 with the Planning Application when it is submitted to LBW.

c. comply with the Performance Standards set out in Schedule 3.

d. comply with and facilitate the compliance by LBW with the indicative Project Programme set out in Schedule 5.

e. perform the obligations set out in the Planning Performance Agreement at Schedule 6.

5. LBW's Obligations

5.1 Without prejudice to its other obligations as local planning authority, LBW agrees to use its reasonable endeavours to:

a. designate a planning officer who alone or as part of a team shall be responsible for overseeing or carrying out the functions in accordance with this agreement.

b. if the designated planning officer should become unavailable during the lifetime of this agreement for whatever reason, to designate an alternate planning officer who alone or as part of a team shall be responsible for overseeing or carrying out the functions in accordance with this agreement.

c. comply with the Performance Standards set out in Schedule 4.

d. comply with and facilitate the compliance by the Applicant with the Indicative Project Programme set out in Schedule 5.

e. perform the obligations set out in the Planning Performance Agreement at Schedule 6.

6. Joint Working Meetings

6.1 The Parties shall attend meetings in accordance with Schedule 5, at premises of LBW or such other premises as agreed by the Parties, to discuss any matters/issues arising from the Planning Application including:

a. progress in respect of fulfilling the milestones within the relevant timeframes set out in the Indicative Project Programme;

b. any amendments to the timeframes or requirements set out in the Indicative Project Programme as the Parties deem necessary;

c. any consultation response or any other communication received by LBW during the preceding period;

d. any other matters or issues arising in respect of the Planning Application.

6.2 Joint Working Meetings shall be held every 4 weeks throughout the life of the project, or such other times as may be agreed between the Parties.

6.3 Each matter/issue will be evaluated and discussed with the parties and a method of resolution agreed.

6.4 Where reasonably requested by the Applicant, LBW shall make available, within 10 working days, an officer with the appropriate level of authority and relevant experience to attend meetings with external third parties, including the Greater London Authority and English Heritage.

6.5 In addition to the Joint Working Meetings, the Parties shall be entitled, where necessary, to call additional technical meetings and the Parties will make available a team of officers or consultants from various disciplines as appropriate and in a timely fashion.

7. Breach and Termination

7.1 If any party shall commit any breach of its obligations under this Agreement and shall not remedy the breach within 10 working days of written notice from the other party to do so, then the other party may notify the party in breach that it wishes to terminate this Agreement forthwith and the agreement shall be terminated immediately upon the giving of written notice to this effect to the party in breach provided always the breach is within the control of the party that is in breach and is capable of being remedied. For clarity, in the event that the PPA is terminated by either party there will be no financial liability due by one party to the other and each party will meet their own costs.

8. Amendment/Review of Agreement

a. Amendment to the agreement and revision of timescales shall be subject to review as may be agreed between the parties.

9. Dispute resolution

9.1 The Parties agree that they will work together to secure the delivery of the objectives of this Agreement. The Parties shall first attempt to resolve any disputes between themselves, and shall be entitled to call a special meeting of such members of the Project Team as necessary (in addition to any Joint Working Meetings under clause 6).

9.2 If the Parties cannot resolve the dispute using the procedure in clause 9.1 above, the designated project managers of the Parties shall meet and seek to resolve the dispute through negotiations between them and the project managers shall have authority to settle such disputes.

10. Fee

10.1 Based on the indicative programme (Schedule 5) a capped fee of £160,000 plus VAT has been identified for the application determination period from 24 July 2015 to the decision date.

10.2 Payment by the Trust under the PPA will be quarterly in advance.

10.3 For the avoidance of doubt the PPA fee is separate from the statutory application fee. The Council will seek a separate undertaking from the applicant in regard to covering its costs for external viability and sustainability advice, and the legal costs for the associated section 106 agreement work.

SCHEDULE 1
The Development

Address of the application site (see attached plan):

St George's Hospital, Blackshaw Road, Tooting, London SW17 0QT

St George's Hospital is bounded by Blackshaw Road to the south-west, Effort Street and Maybury Street to the south-east, Coverton Road to the north-east and Kiln Mews/Hepdon Road and Fountain Street to the north-west. The site is currently occupied by multiple large and small scale (between 1 to 7 storey) buildings which form the St George's Hospital complex.

The site is located within a primarily residential area in Tooting, south-west London. The site lies outside of any Conservation Areas and there are no Listed Buildings located within the site boundary or in close proximity to the site (with the exception of locally listed Lambeth Cemetery to the south of Blackshaw Road (all lodges and mortuary chapels)).

The main vehicular access to the site is from Blackshaw Road. Pedestrian access is made from Blackshaw Road, Effort Street, Coverton Road and Cranmer Terrace.

Summary of specific relevant policy:

NPPF and NPPG
London Plan

Core Strategy (adopted and 2nd proposed submission versions)
PL1 – Attractive and distinctive neighbourhoods and regeneration initiatives
PL2 – Flood risk
PL3 – Transport
PL5 – Provision of new homes
IS1 – Sustainable development
IS2 – Sustainable design, low carbon development and renewable energy
IS3 – Good quality design and townscape
IS4 – Protecting and enhancing environmental quality
IS5 – Achieving a mix of housing including affordable housing
IS6 – Community services and the provision of infrastructure
IS7 – Planning obligations.

DMPD (adopted and 2nd proposed submission versions)
DMS1 (General development principles)
DMS2 (Managing the historic environment)
DMS3 (Sustainable design and low-carbon energy)
DMS4 (Tall buildings)
DMS5 (Flood risk management)
DMS6 (Sustainable drainage systems)
DMH3 (Unit mix in new housing)
DMH4 (Residential development including conversions)
DMH6 (Residential space standards)
DMH7 (Residential garden and amenity space)
DMH8 (Implementation of affordable housing)
DMO3 (Open spaces in new development)
DMO4 (Nature conservation)
DMO5 (Trees)
DMC1 (Protection of existing community facilities).

DMC2 (Provision of new and improved community facilities)
DMC3 of the 2nd proposed submission version (Provision of health and emergency service facilities).
DMT1 (Transport Impacts of development)
DMT2 (Parking and Servicing)
DMT4 (Land for transport functions).

Site Specific Allocations Document (adopted and 2nd proposed submission version).
Housing SPD
Planning Obligations SPD
Refuse and Recyclables in Development SPD.

Applicant:

The Applicant is St. George's University Hospitals NHS Foundation Trust. GL Hearn is appointed as the Agent for the proposed development.

Description of the Development:

Phased redevelopment of St George's Hospital to provide new hospital accommodation (Use Class C2) comprising extensions to Atkinson Morley Wing, St James' Wing and Lanesborough Wing; and the redevelopment of Maybury Street Car Park to provide a new Outpatients Department (Use Class C2), residential units (Use Class C3) and flexible commercial floorspace (Use Class A1/D1/D2); and associated highways and landscaping works (Outline Planning Application).

SCHEDULE 2

The Application Documents

The parties to this agreement agree that the Planning Application shall be accompanied by the documents detailed below:

The statutory national list of planning application requirements:

1) Completed Standard Application Form
2) Completed CIL form
3) Completed Ownership Certificate
4) Agricultural Holdings Certificate
5) Appropriate statutory application fee – circa. £25,000
6) Design and Access Statement
7) A Site Plan which identifies the land to which the application relates drawn to an identified scale
8) A Location Plan based on an up-to-date map at a scale of 1:1250 or 1:2500. The application site should be clearly edged with a red line and a blue line should be drawn around any other land owned by the Applicant, close to or adjoining the application site.
9) Other drawings/plans each with a scale bar:
    - At a scale of 1:100 or 1:200
        - Block plan showing any site boundaries
        - Existing and proposed plans, elevations and sections

The statutory local list of planning application requirements for each application to include **(taking into consideration the EIA Scoping exercise to be undertaken, and as may be updated during pre-application discussions):**

a) Planning Statement
b) Transport Assessment and Travel Plan including deliveries and servicing [appended to the ES – hospital and residential travel plans]
c) Environmental Statement [chapters to be confirmed in scoping]
d) Affordable Housing Statement as the summarised version of the full viability assessment that can be made public
e) Viability Statement – as the private and confidential financial document for the housing proposed
f) Arboricultural impact assessment and tree protection plan
g) Landscaping report
h) Flood risk assessment
i) Statement of Community Involvement
j) Sustainability and Energy Statement
k) Air quality assessment
l) Lighting Assessment
m) Draft Construction Management Plan (working document) to include demolition phase
n) Trust's Waste Management Plan
o) Tall Buildings Assessment (if 5 storeys or more) to address the 15 criteria in policy DMS4, particularly a townscape, heritage and visual impact assessment.
p) Land contamination assessment
q) Health impact assessment
r) Daylight and sunlight report for both the impacts on neighbouring site, and within the residential element of the development (depending on how developed the residential design principles are established)

s) Microclimate assessment
t) Noise assessment, particularly for any plant proposed
u) Draft s.106/HoTs
v) CIL form

SCHEDULE 3
The Applicant's Performance Standard

The Applicant agrees to use its reasonable endeavours to achieve the following performance standards at all times:

a. To wherever possible address any concerns raised by any statutory consultee prior to the submission of the Planning Application to LBW.

b. To provide LBW with such additional information as may be requested within 3 working days of such written request from LBW (or such other time period as may be agreed) in order to enable LBW to discharge its responsibilities.

c. Where circumstances beyond the reasonable control of the Applicant preventing compliance arise, the Applicant/Agent will notify the LPA by email (next working day latest).

d. To provide to LBW at least 3 working days prior to any meeting all substantive and relevant documents which are relevant to that meeting and which relate to any relevant action points or agenda identified.

e. To provide to LBW within 3 working days of any meeting the minutes or action points arising from that meeting.

f. To provide the LBW on signing of this agreement with a quarterly payment of **£40,000 plus VAT** to cover pre-application and application meetings and advice including meeting(s) on site. This is in addition to the statutory planning application fee, and separate to the applicant meeting the Council's costs for external advice on viability, sustainability and legal drafting.

SCHEDULE 4
LBW's Performance Standards

In addition to its statutory obligations, LBW agrees to use its reasonable endeavours to achieve the following performance standards at all times:

a. Respond substantively to all faxes, emails and letters within 3 working days of receipt. Respond substantively to telephone calls by the end of the following working day. Where circumstances beyond the reasonable control of LBW prevent its compliance with this Service Standard, LBW shall in each case notify the Applicant of such circumstances by the end of the next working day by e-mail.

b. Notify the Applicant and Agent no later than 3 working days prior to any meeting of the LBW Planning Applications Committee at which any report or matter relevant to the Development will be discussed and or considered and to provide the Applicant with a copy of any report to the LBW Planning Applications Committee at that time.

c. Provide to the Applicant and Agent at least 3 working days prior to any meeting all substantive and relevant documents which are relevant to that meeting and which relate to any relevant action or agenda points identified.

d. To provide to the Applicant and Agent within 5 working days of any meeting, comments/changes to the minutes or action points arising from that meeting (produced by the Applicant in accordance with Schedule 3 h).

SCHEDULE 5

The Indicative Project Programme

The parties to this agreement have agreed to use their reasonable endeavours to ensure that the Planning Application is progressed in accordance with the Planning Performance Agreement (unless subsequently varied) and the following project programme indicates the stages and timescales necessary to achieve that. For the avoidance of doubt this project programme does not form part of the Planning Performance Agreement.

1. Pre-application stage		
Task	Responsibility	Timeframe/Target Date
Joint Working Meetings	Planning Officer and Applicant	Every 4 weeks for the 12 month duration of the PPA – Week commencing 10 June
Additional technical meetings, e.g. on transport, heritage/design	LBW and Applicant	To be held on an 'as required' basis.
GLA Pre-Application Meeting	Applicant	Targeting late June [
Pre-Application Consultation with Merton Borough Council	Applicant	Targeting late June/early July
Design Review Panel Meeting	Applicant	Targeting late June/early July
Pre-Application Public Consultation Event	Applicant	Consultation Strategy to be confirmed. Strategy to identify specific dates
Signing of Planning Performance Agreement	LBW and Applicant	1 June 2015
Submit information for the LBW Planning Newsletter	Applicant	Late July/Early September 2015

2. Planning application stage		
Task	Responsibility	Timeframe/Target Date
Submission of planning application via Planning Portal and hardcopies	Applicant	24 July 2015
LBW to indicate **informal** acceptance of validation (so that formal consultation period does not fall in August)	LBW	21 August 2015
LBW to confirm validation of application (start of formal 28 day consultation period)	LBW	7 September 2015
Send out consultations, Planning Newsletter, undertake publicity	LBW	September 2015
Consultation	LBW and Applicant	to run until 5 October 2015
Planning application review meetings	Planning Officer and Applicant	From mid-September 2015

3. Determination Stage			
Task	Responsibility	Key Issue	Timeframe/Target Date
1st Review meeting	Applicant/Planning Officer	Identification of any further information required	By mid-September 2015
Further information identified from 1st Review submitted	Applicant	Initial issues addressed	By mid-September/late – September 2015
First discussion regarding Draft S106 Heads of Terms	Applicant/Planning Officer	Agree terms; instruct legal teams	By mid-September 2015
Optional 2nd Review meeting	Applicant/Planning Officer	Identification of further information required/issues to be addressed	By early/mid-October 2015
Further information identified from 2nd Review submitted	Applicant	Further issues addressed	By mid/late October 2015
Optional 3rd Review meeting	Applicant/Planning Officer	Identification of further information required/issues to be addressed	By early November 2015
EIA Regulation 19	LBW		October 2015
Final material amendment date (assuming only a 14 day reconsultation needed and no longer)	Applicant	Material Submitted	13 November 2015
Draft of Conditions and S106 Agreement	Applicant/Planning Officer	Conditions and Legal Agreement drafted	13 November 2015
Distribute report to Members	Planning Officer	Draft report, HoT and conditions	Early December 2015
Final draft of committee report including final draft of conditions and HoT	Planning Officer	Submitted for print	w/c 30 November 2015
Presentation material submitted	Applicant	Submitted	Early December 2015
Committee meeting	LBW/Applicant	Resolution of committee	15 December 2015 (best case following 16 week determination period for EIA)

Referral to GLA (Stage 2) and SoS	LBW	Submitted	By 24th December 2015
Response from GLA and SoS if necessary	GLA/LBW	Stage 2 Report	Mid/end of January 2016
Sign Section 106	LBW/Applicant	Conditions and Legal Agreement finalised	By 29 January 2016
Decision Notice issued	LBW	Decision notice issued	By 29 January 2016

3. Project Team		
Name	Position and Role	Contact Details
Tim Cronin	LBW Planning Officer	TCronin@wandsworth.gov.uk
Victoria Crosby	LBW Planning Officer (DM)	vcrosby@wandsworth.gov.uk 020 8871 6760
Nigel Granger	LBW Planning Officer	NGranger@wandsworth.gov.uk
Dave Clarke	Conservation and Urban Design Officer	DClark@wandsworth.gov.uk
TBC	Transportation Officer	
TBC	Tree Officer	
TBC	Sustainability Consultant	
TBC	Viability Consultant	
Eric Munro	The Applicant	Eric.Munro@stgeorges.nhs.uk
Sarah Hiscutt	GL Hearn	Sarah.Hiscutt@glhearn.com

SCHEDULE 6
The Planning Performance Agreement

The parties to this agreement shall use their reasonable endeavours to perform the following obligations that constitute the Planning Performance Agreement.

A	The Submission Date: the date the Planning Application is to be submitted to LBW by the applicant	24 July June 2015
B	The Determination Date: the date the Planning Application is to be reported to committee or considered under delegated powers by LBW	15 December 2015 or January 2016 [TBA]
C	The Referral Date: the date the Planning Application is referred to both Greater London Authority (GLA) and NPCU (if required by Statutory Instrument) by LBW	Not later than 5 working days after committee determination by LBW
D	The Decision Date: the date the planning decision is issued by LBW	On completion of a s106 agreement, not later than 3 weeks following referral response(s)

Agreement

The London Borough of Wandsworth and the Applicant hereby agree to the content of this Planning Performance Agreement.

London Borough of Wandsworth

Name: Nigel Granger

Signature:

Position: East Team Leader

On behalf of: London Borough of Wandsworth

Date:

St George's Healthcare NHS Trust

Name: Eric Munro

Signature:

Position: Joint Director of Estate and Facilities

On behalf of: St. George's University Hospitals NHS Foundation Trust

Date:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD ***June 2015***

Paper Title:	Risk and Compliance report for Board incorporating: 1. Corporate Risk Register 2. External assurances
Sponsoring Director:	Peter Jenkinson, Director of Corporate Affairs
Author:	Sal Maughan, Head of Risk Management
Purpose:	To highlight key risks and provide assurance regarding their management. To provide assurance to Board regarding compliance with external regulatory requirements
Action required by the committee:	To note the report and consider the assurances provided.
Document previously considered by:	Quality and Risk Committee (QRC)

Executive summary

Key Messages

Corporate Risk Register (CRR):

- The most significant risks on the CRR are detailed.
- Controls are developed for all risks, with a rolling programme of review by QRC during 2015. The next deep dive risk review will take place at QRC on 24th June and will focus upon the cohort of risks around capacity, including staffing.
- Three new risks have been identified and are proposed for inclusion on the Corporate Risk Register (CRR): two finance risks and one in relation to Deprivation of Liberty (DOLS)
- An overarching review of all finance risks on the CRR is currently being undertaken in conjunction with the Monitor investigation and the outcome will be included in the full bi-monthly update to Trust Board in July 2015.

External Assurances, including an update on the CQC Compliance and Improvements action plans:

- All actions to address the following two issues of non-compliance have been completed:
  - *Ensure that all staff understand the requirements of the Mental capacity Act 2005 and how this relates to vulnerable adults in terms of best interest decisions and informed consent*
  - *Ensure that medical records are available within the outpatient department*
- The action plans were presented to the Commissioners and the CQC via the re-scheduled Clinical Quality Review Group on 17th June. The Group agreed to close the action plans in July, subject to two further actions.
- The Intelligent Monitoring Report has now been formally published: one of two elevated risks detailed in the previous draft report has been downgraded: *Inpatient Survey 2014 - Q28 - "Did you have confidence and trust in the nurses treating you?"*
- The CQC have written to the Trust in relation to any identified quality concerns the Trust Executive Team may have in the context of the current Monitor investigation; a response has been provided including an overview of the additional quality assurance processes put in place.
- The corporate Quality Inspection programme recommenced on 1st June.

Risks

The most significant risks on the Corporate Risk Register are detailed within the report.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	All

Related CQC Standard: *Reference to CQC standard that this paper refers to.*	All CQC Fundamental standards & regulations
Equality Impact Assessment (EIA): Has an EIA been carried out? Yes **If yes, please provide a summary of the key findings**	

1. Risks – Corporate Risk Register (CRR):

This report identifies the extreme risks on the Corporate Risk Register with the details of the most significant risks provided in Table 1. An executive overview of the CRR is included at Appendix 1. The rating is prior to controls being applied to the risk. Risks are reduced once there is evidence that controls are effective. A system of 'deep dive' reviews into all risks on the CRR has been agreed with QRC to ensure all risks are reviewed over 12 months.

Table one: highest rated risks

Ref	Description	C	L	Rating ↓↑
3.2-05	The Trust does not deliver its cost reduction programme objectives	5	5	25 →
01-12	Bed capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	5	5	20 →
01-13	Theatre capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	5	4	20 →
01-14	Staffing to support capacity may not be sufficient for the Trust to open the increased bed, critical care and theatre capacity and to meet demands from activity, negatively affecting quality, throughout the year.	5	4	20 →
01-15	Critical care capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	5	4	20 →
01-07	Risk to patient safety and experience as a result of potential Trust failure to meet 95% Emergency Access Standard	4	5	20 →
3.7-06	Failure to meet the minimum requirements of the Monitor Risk Assessment Framework	4	5	20 →
3.6-05	Cashflow Risks – Operational Finance: Forecast Cash balances will be depleted	4	5	20 →
2.1-05	The tariffs applicable to Trust clinical services are adversely changed as a result of national and local tariff changes	4	5	20 →
2.3-05	Tariff Risk – CQUIN Premium Trust income is not maximised due to failure to deliver required performance against CQUIN quality standards.	5	4	20 →
3.4-05	The Trust faces higher than expected costs due to higher marginal costs - higher than expected investment required to deliver service increases.	4	4	16 →
02-01	Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)	4	4	16 →
A410-02	Failure to sustain the Trust response rate to complaints	4	4	16 →
3.3-05	The Trust faces higher than expected costs	4	4	16 →
03-01	Ability to demonstrate compliance with Regulatory Reform (Fire Safety) Order 2005	4	4	16 →
03-02	Failure to demonstrate full Estates compliance	4	4	16 →
03-03	Ability to deliver capital programme and maintenance activity within required timeframes	4	4	16 →
01-08	Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	4	4	16 →
2.4-05	Performance Penalties & Payment Challenges: Trust income is reduced by contractual penalties due to poor performance against quality standards and KPIs and also by payment challenges	4	4	16 →
3.8 – 06	Low compliance with new working practices introduced as part of new ICT enabled change programme	4	4	16 →
3.9 – 06	Risk of inappropriate deployment of e-prescribing and electronic clinical documentation	4	4	16 →

1.1 New risks proposed for inclusion on the CRR

An overarching review of all finance risks on the CRR is currently being undertaken in conjunction with the Monitor investigation and the outcome will be included in the full bi-monthly update to Trust Board in July 2015. However, two new overarching finance risks have been identified for inclusion on the CRR, which should have urgent Trust Board oversight:

Risk: The Trust will be unable to secure the required working capital in the short term; current agreement is for £25m however this will be insufficient.
Control: An application has been made to extend the working capital facility and approval is expected by end of July 2015.

Risk: The working capital (once secured) will not be sufficient.
Controls: Management actions underway to deliver on CIPs;
KPMG team reviewing current financial assumptions;
Implementation of PWC recommendations from July onwards.

The remaining finance risks on the CRR, which are the detailed IBP risks, are currently being reviewed and streamlined under the following cohorts, to be presented in July:
:

- CIPs
- Income risks
- Expenditure risks
- Overall delivery of financial plan and long term sustainability

A further potential new risk has been identified via the Safeguarding Adults Annual Report to the Patient Safety Committee:

Risk: Potential regulatory action, if inspected by the CQC, in relation to Deprivation of Liberty (DOLs) application, arising from a lack of resource to implement best practice in accordance with recent Law Society Guidance (April 2015).
Control: We are currently seeking further legal advice on the implications of the new guidance published in April 2015 on what constitutes a deprivation of liberty in order to agree the plan going forward.

The newly identified risk around further reductions in the availability of medical records in Outpatients (Ref 01-11), which was identified through discussion at the Executive Management Team and Organisational Risk Committee (ORC) has been risk assessed and is now included on the CRR – the full details of this risk and the controls in place are included at Appendix 2.

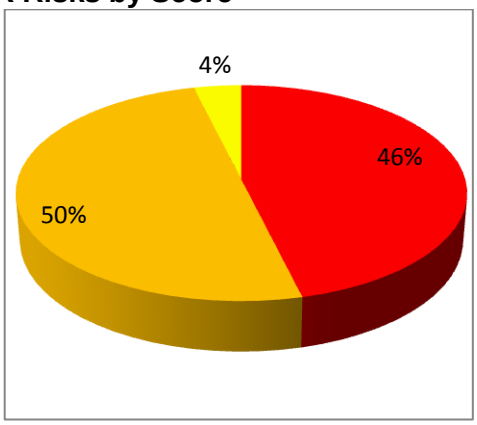
Four further identified risks are currently in the process of being risk assessed and will be included in the full bi-monthly updated CRR to board in July.

- Impact of run rate schemes in Estates and Facilities
- Impact of delays in procurement processes upon all clinical areas
- IT/iclip roll out and risks to patient safety
- Impact upon quality of capital funding decisions

1.2 Summary of risks by score and domain

Figure one demonstrates there are 24 extreme risks on the CRR (a score of 15 or above) which equates to 46% of the total risks. Of these, 10 sit within the domain of Finance and Operations. Of the total risks on the CRR, 38% relate to Finance and Operations and 35% to the Quality domain (table three).

Fig 1: CRR Risks by Score



15 and above (Extreme)	24
8-12 (High)	26
4-6 (Moderate)	2
0-3 (low)	0
Total	**52**

Table three: CRR Risks by Domain

					Total
1. Quality	9	9	0	0	18
2. Finance & Operations	10	10	0	0	20
3. Regulation & Compliance	5	2	1	0	8
4. Strategy Transformation & Development	0	2	0	0	2
5. Workforce	0	2	1	0	3
Total	**24**	**26**	**2**	**0**	**52**

1.3 Changes to risk scores

There have been no changes to risk scores during the reporting period.

1.4 Closed risks

There have been no risks proposed for closure during the reporting period

1.5 Deep Dive: Quality Risk Committee

The QRC are due to undertake a deep dive review of the following risks on 24th June 2015:

Table four

Principal Risk	Lead	Score
01-12 **Bed capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	MW	20
01-13 **Theatre capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	MW	20
01-14 **Staffing to support** capacity may not be sufficient for the Trust to open the increased bed, critical care and theatre capacity and to meet demands from activity, negatively affecting quality, throughout the year.	MW	20
01-15 **Critical care** capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	MW	20
5.1-01 Failure to recruit and retain sufficient staff to manage turnover rates and support future increases in capacity	WB	12

1.6 Summary of Extreme Risks at Divisional level:

The extreme risks from each of the divisional risk registers are included at Appendix 3.

2. Assurance Map

The Trust Assurance Map is a schedule of all external visits, inspections and reporting which captures on-going actions in response to external reviews and those underway to prepare for forthcoming visits. The assurances received from these external inspections help inform the board as to continued compliance with regulatory requirements including Care Quality Commission standards. The following section provides a summary of all external assurances acquired via external reports, visits and inspections during the reporting period.

2.1 Care Quality Commission (CQC) Compliance and improvement action plans - update

Following the CQC inspection in February 2014, the Trust received an inspection report which identified two issues upon which we must take action to improve, these are termed compliance actions:

- *Ensure that all staff understand the requirements of the Mental capacity Act 2005 and how this relates to vulnerable adults in terms of best interest decisions and informed consent (Queen Mary's Hospital)*
- *Ensure that medical records are available within the outpatient department*

In addition to the above two compliance actions, a number of further areas for improvement were also identified at inspection. A Trust wide action plan to address these issues was shared with the CQC and has been on-going to ensure all actions are addressed and that there is learning and continued improvement to the services identified.

The compliance and improvement action plans have been externally monitored via the Clinical Quality Review Group (CQRG) hosted by Wandsworth CCG and attended by CQC and Monitor (attendance by NTDA prior to February 2015). The action plan was presented to the CQRG in October 2014 and January 2015 and again on 17th June. Roger James, CQC Inspection Manager was in attendance.

The CQRG were happy to close both the compliance and action plans subject to the following two actions:

- MCA Audit: there were two queries regarding final data in the summary audit report: the CQRG requested a presentation of full MCA Audit report at CQRG meeting in July to clarify these.
- It was noted that performance of overall notes availability in outpatients is encompassed within the Quality Report to Trust Board; CQRG receive this report. However, for additional on-going assurance, the CQRG requested a monthly exception report of those specialties whose notes availability falls lower than 90% in the previous reporting period.

2.2 CQC Letter to the Trust

On 28th May Roger James, CQC Inspection Manager wrote to the Trust to request an update on actions encompassed within the compliance action plan and to ensure there were no significant quality concerns of which the board were aware, in light of the current Monitor investigation. A response was provided in line with the full update on the action plan to CQRG. Mr James was also in attendance at this meeting. The response also set out the current process in place to quality impact assess all CIP schemes and highlighted the weekly quality oversight process recently introduced to further enhance current quality performance monitoring and which is designed to ensure speedy recognition and escalation of quality concerns.

2.3 Quality Inspection Programme

The corporate Quality Inspection programme recommenced on 1st June 2015 following a temporary pause and to date there have been seven inspections carried out on in-patient wards. The programme is currently being further developed to ensure that wards with electronic

documentation can be appropriately audited and to ensure that the programme maps to other quality and environmental ward rounds ensuring synergy across the quality assurance programme. Going forward thematic analysis of the quality inspections will be incorporated into the Quality report to board.

2.4 Summary of external assurance and third party inspections - June 2015

2.4.1 CQC Intelligent Monitoring Report

The CQC published the formal intelligent monitoring report on 29th May 2015. The formal report differs from the draft report received in April 2015 whereby one elevated risk has now been downgraded, as demonstrated in table five below. The report now highlights one elevated risk and five risks the assurances are detailed below.

Table five: summary of risks

Level of Risk & change	Indicator	Assurance/Actions on-going
Elevated Risk ↓ (Previously an elevated risk in draft report)	Inpatient Survey 2014 - Q28 "Did you have confidence and trust in the nurses treating you?" (Score out of 10) (01-Jun-14 to 31-Aug-14)	Initial detailed feedback has been provided to the Trust by the Picker Institute further analysis has been carried out to identify the five key areas which require focus. A workshop is due to be held on 16th July to look at all areas of concern from the survey. In the interim, current work streams to address nursing recruitment, retention, training and development and embedding values continue.
Elevated Risk ↔	The proportion of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture data base (01/01/2013 – 31/12/2013)	An action plan is in place to address each standard which is overseen by the Care Group Lead and General Manager and is monitored by the Care Group Governance Meeting. It is anticipated the next audit will demonstrate improvements and result in a commensurate reduction in the risk.
Risk	Emergency readmissions with an overnight stay following an elective admission (01/04/2013 – 31/03/2014)	Re-admission profile by month from Aug-13 to May-14 showed our re-admission rate as having a high elevated risk from Oct-13 to Feb-14. However, from March onwards this reduced back to within expected range and for April and May our re-admissions are below that of the national average which is positive this has led to the risk being re-evaluated from a previous elevated risk. This position internally remains unchanged.
Risk	Incidence of Methicillin-resistant Staphylococcus aureus (MRSA) (01-Aug-13 to 31-Jul-14)	The Trust has now reported 2 MRSA bacteraemia cases to the end of May This is currently a high risk on the CRR: A513-01 and detailed assurance is provided to the Board through the Quality report.
Risk	Composite risk rating of ESR items relating to staff turnover (01-Jan-14 to 31-Dec-14)	The Trust is aware of the risk associated with high staff turnover and there is a high risk on the Corporate Risk Register 5.1-01 with a number of controls in place to address. The Trust has a target to reduce turnover and a workforce strategy plan that supports this work which reports to the workforce and education

		committee.
Risk	Composite indicator: NHS staff survey questions relating to abuse from other staff (01-Sep-14 to 31-Dec-14)	The Trust is aware of the high number of staff who report bullying and harassment as highlighted by the staff survey and has a strategy to reduce levels of bullying in the trust and to support staff. There is a risk on the Corporate Risk in to this A518-04 with detailed controls in place.

2.4.2 Anaesthesia Clinical Services Accreditation (ACSA) – May 2015

The Trust underwent its inspection by the Royal College of Anaesthetists in May in anticipation of achieving accreditation. The inspection went well and it is anticipated a decision will be confirmed around accreditation in September.

3. Conclusion

The programme of detailed review of risks included on the Corporate Risk register continues in order to provide stronger assurance to the Trust Board around the management of risks.

The Trust has completed all actions contained within the CQC action plans and Commissioners are happy to close the plan in July, subject to monitoring reverting to business as usual processes.

The programme of Quality Inspections has recommenced on 1st June and going forward, thematic reporting will be encompassed within the quality report.

The Trust Board can be assured that no significant risks have been identified through external inspections and reports received during the reporting period.

Appendix 1: Executive Overview of Corporate Risk Register

Domain: 1. Quality

Strategic Objective/Principal Risk	Lead	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	In month change	Change/progress
1.1 Patient Safety								↓↑	
01-12 **Bed capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	MW	25	20	20	20	20	20	→	
01-13 **Theatre capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	MW	20	20	20	20	20	20	→	
01-14 **Staffing to support** capacity may not be sufficient for the Trust to open the increased bed, critical care and theatre capacity and to meet demands from activity, negatively affecting quality, throughout the year.	MW	20	20	20	20	20	20	→	
01-15 **Critical care** capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	MW	20	20	20	20	20	20	→	
A513-O1: Failure to achieve the National HCAI targets for MRSA and C Diff	JH	16	12	12	12	12	12	→	
O1-01 A risk to patient safety of inappropriate antimicrobial prescribing due to conflicting and out of date guidance being available within the Trust.	JH	12	12	12	12	12	12	→	
01-02: 01-02 Lack of established process for use, provision, decontamination and maintenance of pressure relieving mattresses	JH	9	9	9	9	9	9	→	
01-03 Lack of embedded process for use, provision and maintenance of bed rails	JH	12	9	9	9	9	9	→	
01-04 Risk to patient safety should the organisation fail to meet its statutory duties under Section 11 in respect of number and levels of staff trained in safeguarding children.	JH	12	12	12	12	12	12	→	
01-05 Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the Trust.	JH	12	12	12	12	12	12	→	

01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	MW	15	15	15	15	15	15	→	
01-07 Risk to patient safety and experience as a result of potential Trust failure to meet 95% Emergency Access Standard	MW	20	20	20	20	20	20	→	
01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	SM	16	16	16	16	16	16	→	
01-09 Risk to patient safety due to a lack of a Trust wide visible training needs analysis, and lack of a system for ensuring these have been met in relation to Medical Devices	JH	12	12	12	12	12	12	→	
01-10 Risk to patients, staff and public health and safety in the event the Trust has failed to prepare adequately for an Ebola incident.	JH	10	10	10	10	10	10	→	
01-11 Risk to patient safety and experience where full permanent sets of medical records are not available for scheduled outpatient appointments							12	**NEW**	

Strategic Objective/Principal Risk	**Lead**	**Jan 2015**	**Feb 2015**	**Mar 2015**	**Apr 2015**	**May 2015**	**Jun 2015**	**In month change**	**Change/progress**
1.2 Patient Experience								↓↑	
A410-O2: Failure to sustain the Trust response rate to complaints	JH	16	16	16	16	16	16	→	
02-01 Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)	JH	16	16	16	16	16	16	→	

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	**Lead**	**Jan 2015**	**Feb 2015**	**Mar 2015**	**Apr 2015**	**May 2015**	**Jun 2015**	**In month change**	**Change/progress**
2.1 Meet all financial targets								↓↑	
2.2-O5 Tariff Risk – Emergency Threshold Tariff. The Trust's income and service contribution is reduced due to application of 30% tariff to emergency activity exceeding the contract thresholds	SB	9	9	9	9	9	9	→	

2.1-O5 Tariff Risk - The tariffs applicable to Trust clinical services are adversely changed as a result of National, Local and Specialist Tariff Commissioning changes. Also - transfer of tariff responsibilities to Monitor	SB	20	20	20	20	20	20	→	
1.2-O5 Volume Risk – Decommissioning of Services Activity and associated income/contribution will be lost from services decommissioned due to:- • risks to the safe delivery of care • changing national guidance • centralisation plans	SB	9	9	9	9	9	9	→	
3.3-O5 Cost Pressures * The Trust faces higher than expected costs due to:- •unforeseen service pressures •higher than expected inflation	SB	16	16	16	16	16	16	→	
3.2-O5 Cost Reduction slippage* The Trust does not deliver its cost reduction programme objectives:- •Objective 3: to detail savings plans for the next two years	SB	25	25	25	25	25	25	→	
2.3-O5 Tariff Risk – CQUIN Premium Trust income is not maximised due to failure to deliver required performance against CQUIN quality standards.	SB	8	8	20	20	20	20	→	
1.3-O5 Volume Risk – Tendering of services Activity and associated income/contribution will be lost due to:- • Competition from Any Qualified Providers • Service Line Tenders	SB	9	9	9	9	9	9	→	
1.1-05 Volume Risk – Competition with other providers Activity and associated income/contribution will be lost due to competition from other service providers resulting in reductions in market share *	SB	9	9	9	9	9	9	→	
2.4-O5 Tariff Risk – Performance Penalties & Payment Challenges. Trust income is reduced by contractual penalties due to poor performance against quality standards and KPIs and payment challenges	SB	16	16	16	16	16	16	→	
3.4-O5 The Trust faces higher than expected costs due to higher marginal costs - higher than expected investment required to deliver service increases.	SB	9	9	16	16	16	16	→	

3.5-05 - Cashflow Risks – Forecast Cash balances will be depleted due to delays in receipt of:- Major Charitable donations towards the C&W development. Land Sales receipts Loan Finance	SB	12	12	12	12	12	12	→	
3.6-05 - Cashflow Risks – Operational Finance Forecast Cash balances will be depleted due to:- Adverse Income & Expenditure performance Delays in receipt of SLA funding from Commissioners	SB	20	20	20	20	20	20	→	
3.9-05 Potential financial impact of Better Care Fund	SB	9	9	9	9	9	9	→	
3.10-05 Cash risk – there is a risk the Trust will not receive full or timely payment by commissioners for activity carried out due to data quality issues	SB				12	12	12	→	

Strategic Objective/Principal Risk	**Lead**	**Jan 2015**	**Feb 2015**	**Mar 2015**	**Apr 2015**	**May 2015**	**Jun 2015**	**In month change**	**Change/progress**
2.2 Meet all operational & performance requirements								↓↑	
3.7- 06 Failure to meet the minimum requirements of the NTDA Accountability Framework: Quality and Governance Indicators/Access Metrics.	SB	20	20	20	20	20	20	→	
3.8 – 06 Low compliance with new working practices introduced as part of new ICT enabled change programme	SB	16	16	16	16	16	16	→	
3.9 – 06 Risk of inappropriate deployment of e-prescribing and electronic clinical documentation	SB	16	16	16	16	16	16	→	
3.10-06 Risk of failure to effectively manage exit from national Cerner programme	SB	10	10	10	10	10	10	→	
3.11 - 06 Poor environment in ICT department/on site data centre may lead to interruptions or failure of essential ICT services	SB	12	12	12	12	12	12	→	
3.12-06 3.12- O6 Risk to patient safety due to data quality issues with Patient Administration System (PAS), Cerner, inhibiting ability to be able to monitor patient pathways and manage 18 week performance.	SB	9	9	9	9	9	9	→	

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	In month change	Change/progress
3.1 Maintain compliance with all statutory & regulatory requirements								↓↑	
A534-O7:Failure to provide adequate supporting evidence for all the CQC Essential standards of Quality and Safety	PJ	5	5	5	5	5	5	→	
A537-O6:Confidential data reaching unintended audiences	SM	15	15	12	12	12	12	→	
A610-O6: The Trust will not attain the nationally mandated target of 95% of all staff receiving annual information governance training	SM	15	15	15	15	15	15	→	
03-01: Risk of premises closure, prosecution and fines as a result of non-compliance with fire regulations in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)	EM	16	16	16	16	16	16	→	
03-02 Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation	EM	16	16	16	16	16	16	→	
03-03 Lack of decant space will result in delays in delivering the capital programme.	EM	16	16	16	16	16	16	→	
03-04 Delay to the ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for estates and projects works.	EM	16	16	16	16	16	16	→	
03-05 Trust wide risk to patient, public and staff safety of Legionella	EM	12	12	12	12	12	12	→	

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	Lead	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	In month change	Change/progress
4.2 Redesign & configure our local hospital services to provide higher quality care								↓↑	
A533-O8: Reconfiguration of healthcare services in SWL result in unfavourable changes to SGHT services and finances	RE	8	8	12	12	12	12	→	

Strategic Objective/Principal Risk	Lead	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	In month change	Change/progress

4.5 Drive research & innovation through our clinical services								↓↑	
05-05 Research does not form a key part of St. George's future activity which may result in the loss of funding and an inability to recruit and retain staff.	SM	8	8	8	8	8	8	→	

Domain: 5. Workforce

Strategic Objective/Principal Risk	Lead	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	In month change	Change/progress
5.1 Develop a highly skilled & engaged workforce championing our values								↓↑	
A518-O4:Failure to reduce the unacceptable levels of bullying & harassment reported by staff in the annual staff survey	WB	12	12	12	12	12	12	→	
A516-O4: Possible reductions in the overall number of junior doctors available with a possible impact on particular specialty areas	WB	6	6	6	6	6	6	→	
A520-O4: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	WB	12	12	12	12	12	12	→	
5.1-01 Failure to recruit and retain sufficient staff to manage turnover rates and support future increases in capacity	WB	12	12	12	12	12	12	→	

JH	Jennie Hall	Chief Nurse (DIPC)	EM	Eric Munro	Director of Estates & Facilities
SM	Simon Mackenzie	Medical Director	RE	Rob Elek	Director of Strategy
PJ	Peter Jenkinson	Director of Corporate Affairs	WB	Wendy Brewer	Director of Human Resources
SB	Steve Bolam	Director of Finance Performance & Information	MW	Martin Wilson	Director of Delivery & Performance

Appendix 2 – New Risk

Principal Risk	01-11 Risk to patient safety and experience where full permanent sets of medical records are not available for scheduled outpatient appointments				
Description	There is a risk to patient safety where full permanent sets of medical records are not available to clinicians for scheduled outpatient appointments. This may also adversely impact upon patient experience. The Trust target is to achieve >98% of all permanent notes available in clinic.				
Domain				**Strategic Objective**	
	Original	**Current**	**Update**	**Exec Sponsor**	Martin Wilson
Consequence	3			**Date opened**	1 Jun 2015
Likelihood	4			**Date closed**	
Score	12				
Controls & Mitigating Actions	Trust wide outpatient improvement programme focus on medical records availability Exec Director spot checks on Medical records and outpatients Trust outpatient strategy developing recommendations for board on Trist strategy towards medical records usage and storage EMT quality risk session held on medical records availability Perfect week held w/comm 11th May			**Assurance**	Report on availability of notes produced and circulated: Data reported to QRC and Board through Quality and performance report. Data reported externally on a monthly basis to commissioners. Reduced performance in Q4 with improvement in May 2015: Jan - 94.05% Feb - 90.12% Mar - 91.32% Apr - 90.45% May - 95.54%.
Gaps in controls				**Gaps in assurance**	
Actions next period:	Medical Director and Divisional Chairs to review Trust policy on retention periods and volume of history of clinical correspondence which should be scanned into EDM in order to accelerate EDM roll out and to reduce volume of medical records retained. All consultants to be consulted on approach.				

Appendix 3 – Divisional Extreme Risks

Risk Ref.	CW&DT Risk	Score	Jun 15 Change ↑↓	Rationale for change
CW057	The Division is significantly overspent due to a number of adverse movements.	25	→	
B205	Loss of data due to clinical database no longer being supported	16	→	
CW0067	Financial risk – growth. Risk of CCG not paying for increased income assumptions particularly in children services, radiology and women's	15	→	
CW0068	Financial risk – CQUIN From 15/16 Maternity will no longer get CQUIN funding and instead CCG will develop a local tariff for 2015/16. Estimated value of risk in 14/15 = £2.5m	16	→	
CW0070	Financial risk – cost. The division fails to achieve its CIP programme	15	→	
CW0071	CW0071 - Financial risk – cost. The division does not receive funding for identified cost pressures. Estimated value of risk in 14/15 = c. £1.1m	16	→	
CW0081	Temperature during the summer months in Lanesborough Wing	16	→	
CW082	Manual Handling of deceased patients into Mortuary fridges	16	→	
CW0087	Call alarms in St James' wing therapy dept not working properly – risk to patient safety in the event of an emergency	15	→	
CW089	Insufficient number of CTG monitors for a full triage and full induction bay meaning some women need to wait for monitoring	20	→	
CW090	Lack of NICU capacity – presenting both clinical and financial risk	15	→	
CW091	Lack of GICU capacity – presenting both clinical and financial risk	15	→	
CW092	Lack of CTICU capacity – presenting both clinical and financial risk	15	→	
CW093	Roof leak in room 5.011, 5th Floor Lanesborough Wing	tbc	→	
CW0094	Call bell failure on delivery suite	16	→	
CW0097	Critical Care Run Rate Risks impacting Patient Care & Staff morale	16	→	
CW0094	Call bell system on delivery suite has failed on a number of occasions. Temporary system has been used but this has also failed to work.	16	→	
CW0097	Critical Care Run Rate Risks x 2 Patient Care & Staff morale		NEW	
	M&C		**Change ↑↓**	
Risk Ref.	**Risk**	**Score**		
MC13-D1	Risk to patient safety from delay in diagnosis or failure to follow up.	15	→	
MC31-D5	Risk to patient safety as patients waiting greater than 18 weeks on elective	15	→	

	waiting list for Cardiac surgery, Thoracic Surgery and Vascular Surgery.			
MC32-D1	The division is at risk of not delivering a balanced budget if robust CIP schemes are not found. Not all schemes identified in 14/15 have delivered and therefore knock on effect for schemes in 15/16.	**15**	→	
MC37-D1	Financial and reputational risk arising from failure to meet the 95% ED standard for time attending to leaving the ED	**15**	→	
MC46-D2	Financial Risk – cost pressures within division are not funded	**16**	→	
MC48-D2	Financial risk - Volume - decommissioning of cardiology services	**15**	↑	
MC50-D2	Financial Risk – Tariff. Emergency threshold tariff	**15**	→	
MC55-D2	Financial – Volume. Lack of theatre and ITU capacity for cardiac surgery impacts on income	**20**	→	
MC59-D1	Risk to patient safety that vulnerable patients are able to access the helipad form wards in St James Wing	**15**	→	
MC61-D1	Risk to patient safety, arising from delay in seeing patients categorized as "clinically urgent" within 2 weeks of referral.	**15**	→	
	STN&C		**Change**	
Risk Ref.	**Risk**	**Score**	**↑↓**	
B253	SSD risk upgraded in light of recent significant failures and down time of SJW equipment. On-going issues. Upgraded from 12 to 16	**16**	→	
B268	Sterilisation equipment requires replacing and breakdown may cause service failure potentially resulting in cancelled surgery.	**15**	→	
C11	Failure to prescribe essential medication for patients having elective surgery	**16**	→	
C05	Financial Risk – cost. Failure to deliver CIP programme	**20**	→	
C06	Financial Risk – cost. Failure to receive divisional funding for cost pressures	**15**	→	
C19	GPs in some regions (Surrey, Croydon) not prescribing Antiepileptic drugs (AEDs) recommend by consultant neurologists	**15**	→	
C20	Lack of trained fire wardens	**15**	→	
C23	Risks to patient safety associated with roll out of electronic documentation	**20**	→	
TBC	Failure to ensure Standard Operating Procedures (SOPs) for reviewing diagnostic tests results are in place in all areas and are effective	**15**	→	
	E&F		**Change**	
Risk No.	**Risk**	**Score**	**↑↓**	
EF132	Risk of legionella management controls as Flushing of low use outlets and departments not returning data/records.	**tbc**	→	
EF176	Estates compliance – survey revealed gaps in compliance in statutory and mandatory items	**16**	→	
EF189	Standby Generators within Lanesborough Wing are at the end of their useful life and have insufficient capacity to meet the needs of current healthcare demands and will not need the demand as the building is re-developed and refurbished to	**16**	→	

	modern standards.			
EF195	Electrical upgrades/maintenance to UPS and IPS in AMW	**16**	→	
EF198	Risk of noncompliance with fire regulations as a result of the lack of fire risk assessments for some areas on the St George's Hospital site.	**15**	→	
EF200	Delay to ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for works	**16**	→	
	IM&T		**Change**	
Risk No.	**Risk**	**Score**	**↑↓**	
IT016	Reduction in capacity to deliver new infrastructure, systems and change programs	**20**	→	
IT018	Community staff experiencing access difficulties and slow response to RIO	**16**	→	
IT029	There is a risk of onsite data centre (DC) failure due to inadequate provision and support of air conditioning cooling in the DC.	**16**	→	
IT031	There is a risk to the provision of existing and future ICT applications hosted in the onsite DC due to poor environmental monitoring [UPS, air conditioning, BMS push alerts]	**16**	→	
IT032	Increased risk to network availability due to inadequate electrical supply to key locations.	**15**	→	
IT033	Increased clinical risk to patient safety resulting from lack of UPS protection for main Trust Switchboard.	**16**	→	
	CSW		**Change**	
Risk No.	**Risk**	**Score**	**↑↓**	
CSW1023-COM-D5	Cost Improvement Programme not achieving target.	**16**	→	

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – June 2015

Paper Title:	**Annual Health and Safety report 2014/15**
Sponsoring Director:	**Eric Munro, Joint Director of Estates & Facilities**
Author:	**Eric Munro, Joint Director of Estates & Facilities**
Purpose:	**For Information**
Action required by the board:	**For information**
Document previously considered by:	

Executive summary

1. Key messages

It is the Policy of St George's University Hospitals NHS Foundation Trust to take all reasonably practicable measures to ensure the health, safety and welfare of all its staff, patients, visitors, contractors and persons on the premises over which it has control; in accordance with the Health and Safety at Work etc. Act 1974, The Management of Health and Safety At Work Regulations 1999 and all other related legislation, Regulations, Approved Codes of Practice (ACOP) and Guidance documents

Since April 2014, the following investments and actions have been completed to improve Health and Safety within the Trust:

- **The introduction of a targeted Health and Safety monthly audit using the RaTE system**
- **Completed the amalgamation of all Health and Safety related policies with the former Wandsworth PCT policies.**
- **Updated the Health and Safety policy and Governance structure in line with the recently revised HSG 65.**
- **Continuation of the phased introduction of "Safer sharps" into the Trust in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations (2013)**
- **The introduction of a Management of Health and Safety module to the Band 6 training programme.**
- **Development of closer working links with the SGUL Safety, Health and Environment department allowing the Trust access to a greater range of knowledge, expertise and training skills.**
- **Completed and implemented the procedure for the control of Viral Haemorrhagic fever waste.**

The site has received 3 visits from the Health and Safety Executive over the previous 12 months

- **Inspector Kevin Shorten investigated a fall within the CDU area of the ED department which resulted in the death of a patient. The inspector was satisfied with the Trust Serious Incident report- No further action taken.**
- **Inspector Kevin Shorten visited site in relation to an incident involving a patient in transit within a G4S patient transport ambulance. The Trust was not implicated in the incident**

and no further action was taken.

- **Inspector Zameer Bhunnoo visited site to undertake a routine visit to the Mortuary area primarily to inspect the high risk post mortem room. The inspector gave some verbal advice relating to the environment and working practices. A letter of advice has been received subsequent to this visit.**

The Health and Safety department will facilitate any visit to site by the Health and Safety Executive inspectors to ensure that any issue which may be raised on the inspections are dealt with effectively.

The table below summarises the following areas of work will be prioritised on the Health and Safety improvement plan for 2015/16

Area of work priority 2015/15	Measurement
COSHH Management	1) December 2015 COSHH checklist audit 2) The development of a central database for chemicals and their respective COSHH assessments 3) Reduction in the number of exposures to hazardous substances
Management of Violence and Aggression and Lone working	1) Review and Monthly audits of the use of Lone worker devices to be introduced. 2) Revised policy to be published. 3) Reduction in Moderate and above severity incidents relating to violence and aggression.
Rationalise the areas required to complete the Calendar checklists	1) Improvement of the Calendar checklist completion rate.
Development of Management of Health and Safety E module	1) EMAST training compliance figure for the module.
Management of Needle stick injuries	1) Demonstrated implementation of safer sharps across the organisation 2) Reduction in the number of needle stick injuries sustained

Recommendation

The Board is asked to note the update to the Annual Health and Safety report and the progress made during the period.

Key Risks 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.*	

ANNUAL Health and Safety Report 2014/15

1. PURPOSE OF THE REPORT

The Health and Safety at Work etc. Act (H&SAWA) 1974 provides the legislative framework to secure the health, safety and welfare of persons at work. This Enabling Act incorporates previous (prior to 1974) statutory health and safety legislation and judgements and rulings from the civil courts; thus making it into one comprehensive system of law to deal with the health and safety of people at work, at any time in all types of occupations. It also provides protection for the wider public where they may be affected by the activities of people at work.

Under this Act it is the duty of an employer to safeguard, so far as is reasonably practicable, the health, safety and welfare of all employees including the provision and maintenance of safe plant, machinery, equipment and safe systems of work. Although the ultimate responsibility for compliance with the Act rests with employers, every employee also has a responsibility to ensure that no one is harmed as a result of their acts or omissions during the course of their work. Whilst the Trust is vicariously liable for the acts and omissions of its staff, employees also have a duty under the Act to take reasonable care to avoid injury to themselves and others and to co-operate with their employer and others in meeting the statutory requirements. The Act requires employees not to interfere with or misuse anything provided to protect theirs and other's health, safety and welfare.

Compliance with the Health and Safety at Work etc. Act 1974 (and associated Regulations) is a legal requirement. As such, an offence, committed under the Act would constitute a criminal offence and could lead to prosecution for either the Trust as a Corporate body or personal prosecutions to staff members This may result in a fine and/or a term of imprisonment.
In addition to the H&SAWA 1974, a diverse number of subordinate Regulations, Approved Codes of Practice, Guidance Notes, EC Directives, etc. also have relevance, to the NHS as a whole and are thus equally applicable to St George's University Hospitals NHS Foundation Trust. The Management of Health and Safety at Work Regulations 1999 provides a framework to assist organisations to manage the requirements of the H&SAWA 1974 and the Trust shows its commitment to complying with these Regulations and the law through its statement of intent.

The Trust uses the Health & Safety Executive (HSE) publication HSG 65 Successful Health and Safety Management .as a method of ensuring that the work of the Trust is conducted in as safe a manner so far as is reasonably practicable.

This report has been developed to provide the Trust Board of Directors accountable for the activities of the organisation with relevant information concerning the management and delivery of Health and safety to the Trust during 2014/15

2. Reports and Plans

2.1 The Health and Safety action plan

The Trust Health and Safety action plan is developed by the Health and Safety Manager to ensure that Trust wide Health and Safety issues are monitored by the Corporate body and measurable improvements are made. The action plan is based on the principles of HSG65.

i) Objective planning and policy development.
ii) Competence, Control, Co-Operation and Communication.

iii) Planning and Organisation.
iv) Measuring and monitoring performance.
The plan is presented to the Health, Safety and Fire Committee and the Organisational Risk Committee as a standing agenda item for scrutiny.

2.2 Divisional Health, Safety and Fire reports

All divisions are required provide a Health, Safety and Fire report to the Health, Safety and Fire committee on a Bi- annual basis. This report must be approved by either the Divisional Governance Board or the Senior Management team.

The divisional reports inform the committee of;

i) Non Clinical risks which cannot be managed within the division.
ii) Non Clinical incident trends and analysis.
iii) Investigations into Non Clinical incidents of moderate or above severity.
iv) Compliance with Health and Safety monthly audits.
v) Compliance with Non Clinical MAST training.
vi) Matters for escalation to the Organisational Risk Committee.

2.3 Health and Safety policies;

The Health, Safety and Fire Committee reviews and approves all policies relevant to Health and Safety within the workplace. The policies coming up for periodic review are detailed in the Health and Safety plan. The following Health and Safety related policies were reviewed during the 2014/15 financial year. The policies monitored through the committee are written by either the Health and Safety Manager or associated members of the Health and Safety committee,

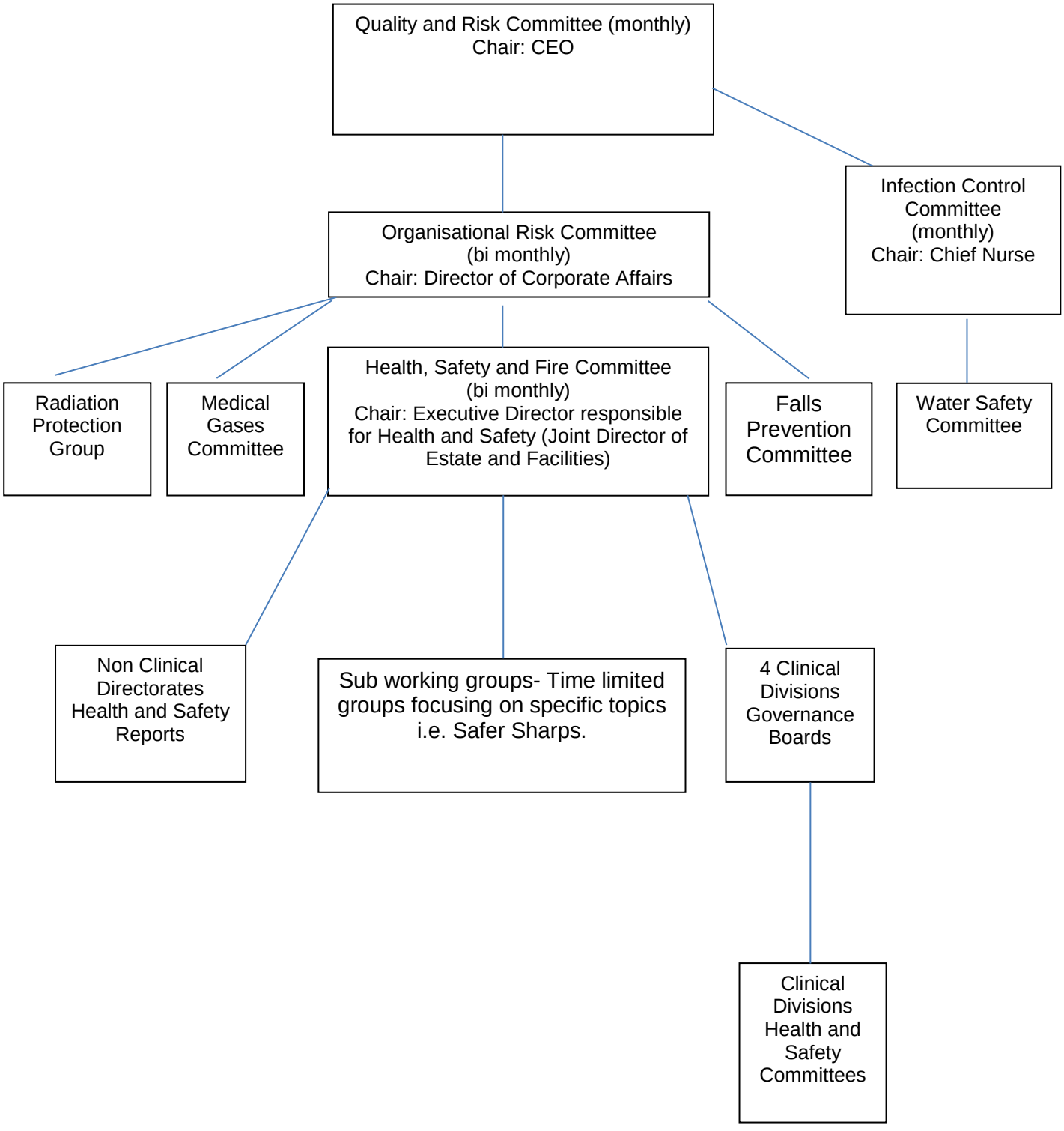
i) Health and Safety Policy
ii) Fire Safety Policy
iii) Working at Heights Policy
iv) Manual Handling Policy
v) Workplace Health, Safety and Welfare Policy
vi) Policy and Guidance on the use of Display Screen Equipment
vii) Water Safety Policy

The 2015/16 Health and Safety plan will include the review of the following policies;

i) COSHH Policy
ii) Non Ionising Radiation Policy
iii) Communicable Diseases Policy
iv) Medical Gas Policy
v) Violence and Aggression (The Management of Intimidation, Violence and Aggression Policy and Procedures)
vi) Latex and Occupational Dermatitis Policy iIncorporating Glove Selection.
vii) Lifting Operations and Lifting Equipment Policy
viii) Noise and Hand Arm Vibration Policy
ix) Provision and Use of Work Equipment Policy
x) Waste Management Policy.

3. GOVERNANCE

The Health and Safety Governance structure was reviewed as part of updated Health and Safety policy. The new governance structure is based HSG 65 and best practice across the Healthcare sector.



4.0 Health and Safety Training

Mandatory Health and Safety training is covered by an EMAST learning module on a 3 yearly basis. The compliance rates for the staff completion of this module are given below.

In addition to the E-MAST learning module The Health and Safety department has run 5 IOSH managing safely courses and also runs a module on the Band 6 development course.

In the 2015/6 financial year the Health and Safety department will be working with the Training and Development department to split the E training module into a basic module aimed at staff in bands 1-3 and a module for bands 4 and above which will focus on the Managerial responsibilities under the Trust Health and Safety policy.

Directorate	Compliance level
Capitol Division	80%
Children and Women's, Diagnostics and Therapies Services Division	90%
Community Services Davison	91%
Corporate Directories Division	87%
Estates and Facilities Division	73%
Medicine and Cardiovascular Division	81%
Research and Development Division	100%
Surgery and Neurosciences Division	85%
SWL Pathology Division	93%
Total	87%

* Note figures taken from Aris on April 14th 2015

5.0 Health and Safety Team Staffing Levels

The current Health and Safety department consists of the Health and Safety Manager, a Deputy Health and Safety Manager and an administrator. The department has developed strong links to the University Health and Safety department to ensure that both organisations benefit from an improved skills mix.

6.0 Health and Safety Calendar audits.

The Health and Safety department reviewed the format of the monthly audits at the beginning of the 2014/5 financial year. The audits were transferred on to the RaTE system and reduced to a maximum of 10 questions. The checklists are open over the relevant month and are completed by the local Health and Safety representative or Ward/ department manager.

A summary of the checklists completed across the organisation between April and December is given below.

April - Fire Safety Management	Number of services completion:	103
	Average checklist compliance:	85.07%
Checklist Themes	1) There are a number of areas which do not possess a sufficient number of trained fire wardens/ where staff have not completed the mandatory annual training. 2) A number of areas in the Community Services division do not possess Fire folders.	

Key Action Points	1) The Divisions should consider adding this to the Divisional risk register to ensure it is managed through the divisional structure. 2) Fire Folders are now issued by Essentia (Trust Community Fire provider)

May - Stress Management & First-Aid	Number of services completion:	104
	Average checklist compliance:	92.29%
Checklist Themes	1) There is some confusion on how to order/ restock first aid boxes.	
Key Action Points	1) These are available through NHS supply chain. A guide with the available options and procedure is posted on the Health & Safety checklists feedback web page Messages from RaTE	

June - Slips, Trips and Falls	Number of services completion:	118
	Average checklist compliance:	91.09%
Checklist Themes	1) A number of areas only reported that not all staff have received training in fall prevention	
Key Action Points	1) A workplace slips & trips inspection guide has been posted on the Health & Safety checklists feedback web page Messages from RaTE	

July - Adverse Incident Reporting & RIDDOR	Number of services completion:	106
	Average checklist compliance:	82.19%
Checklist Themes	1) The large number of staff responsible for carrying out incident investigations have not received training. 2) Staff , in general feel that they do not receive feedback from their non-clinical incident reports.	
Key Action Points	1) A supporting guide on adverse incident investigation & RIDDOR criteria has been posted on the Health & Safety checklists feedback web page Messages from RaTE 2) Incident investigation to be made part of the Band 4 and above EMAST training package to be developed for 2015/16	

August - Workplace Health, Safety & Welfare	Number of services completion:	106
	Average checklist compliance:	88.61%
Checklist Themes	1) A large number of areas report temperatures which they consider to be unreasonable during summer months. 2) Areas are generally aware of the Heat wave plan/ cold weather plan but do not always implement the recommendations.	
Key Action Points	1) Areas where there is a significant patient risk have now been added to the divisional risk registers and escalated to the ORC 2) Guidance documents on Workplace Welfare – Summer Plan and	

	Winter Plan have been posted on the Health & Safety checklists feedback web page Messages from RaTE

September - Personal Protective Equipment (PPE) & Dermatitis	Number of services completion:	113
	Average checklist compliance:	79.30%
Checklist Themes	1) A number of areas have reported using latex gloves. 2) Over 50% of areas report that they have no alternative products to use if the main soap is suspected to cause dermatitis in a member of staff	
Key Action Points	1 & 2) H&S department contacted spot checks which confirmed the entries were erroneous and liaised with Occupational Health Department, Infection Control and Procurement and produced a guide document on Work-Related Contact Dermatitis And Contact Urticaria, including details on alternative products ordering. The guide is available on the Health & Safety checklists feedback web page Messages from RaTE	

October – Manual Handling	Number of services completion:	89
	Average checklist compliance:	87.09%
Checklist Themes	1) The majority of the areas completing the checklists stated that suitable and sufficient risk assessments are completed the majority or all of the time. 2) 15 of the areas reported that their hoists had not been tested within 6 months as is a requirement of the LOLER regulations.	
Key Action Points	1) H&S department liaised with Manual Handling department and produced guidance documents on Manual Handling Risk Assessment & Manual Handling Equipment and Manual Handling Training & Manual Handling Back Care Facilitators which have been posted on the Health & Safety checklists feedback web page Messages from RaTE 2) The Medical Physics department provided an update on the plan for the servicing and testing of hoists to the Dec 2014 Health, Safety and Fire committee. This issue will be followed through the 2015/16 plan	

November – Security, Lone Working, Violence and Aggression	Number of services completion:	96
	Average checklist compliance:	84.94%
Checklist Themes	1) The checklist suggested that only 2/3 instances involving Violence and Aggression are reported on datix 2) A number of areas have not completed Lone worker risk assessments for staff involved in Lone working	

Key Action Points	1) A Violence and Aggression task force has been set up to look at all aspects of the management of Violence and Aggression. This will feed in to the 2015/16 plan. 2) Full lone working review to be carried out in the new HSF plan for 2015-6. Guidance on Assessing and Managing Lone Working Risk has been posted on the Health & Safety checklists feedback web page Messages from RaTE

December – Control of Substances Hazardous to Health	Number of services completion:	107
	Average checklist compliance:	71.59%
Checklist Themes	1) The majority of areas reported that they had no COSHH assessments, MSDS or chemical lists within their areas	
Key Action Points	1) COSHH project to be carried out as part of the HSF plan for 2015-16. Guidance on Material Safety Data Sheets and COSHH Assessment has been posted on the Health & Safety checklists feedback web page Messages from RaTE	

The audits provide the basis for the development of the 2015/16 Health and Safety action plan. They also provide evidence of proactive monitoring as required by the Health and Safety Executive.

The completion of the checklists is monitored by the Divisional Governance Managers and reported to the Health, Safety and Fire committee.

7.0 Non Clinical incident reports Key Performance Indicators including RIDDOR reportable incidents.

The Trust recognises that the accurate reporting of non-clinical adverse incident reporting is key to the maintenance of a good Health and Safety culture. Therefore the Trust uses the principle of Birds Triangle to set its Key Performance Indicators. This principle states that for every high severity incident an organisation will have a number of lower severity incidents or near misses. Therefore the key to demonstrating a good Health and Safety culture is, rather than reducing the number of incidents reported, to demonstrate a low percentage of higher severity incidents as opposed to near misses and low severity incidents.

The Trust sets the following KPI's for 2014/2015;

i) **To maintain a high level of total incident reporting while reducing the number of incidents rated as moderate or above severity to less than 4% of the total number of incidents reported.**

ii) **To encourage a high level of reporting in the following target categories;**
   - **a) Needle stick and splash and exposure to hazardous substances**
   - **b) Manual Handling incidents**
   - **c) Slip, trip and falls (Staff and Visitor)**
   - **d) Violence and Aggression towards staff**

While maintaining the number of moderate or above severity rated incidents to below 7%.

Year	Total Number of Non Clinical incidents	Total number of Moderate and above Severity incidents	**Target %**	**Actual %**	Incidents reportable under RIDDOR
2013/14	2680	67	**4**	2.5	48
2014/15	2697	71	**4**	2.63	49
	Total Number of Non Clinical incidents (Target areas)	Total number of Moderate and above Severity incidents (Target areas)	**Target %**	**Actual %**	
2013/14	733	40	**7**	5.45	39
2014/15	882	46	**7**	5.19	38

The table demonstrates that there has been little change in the total number of non-clinical incidents recorded. The total number of moderate incidents has increased slightly in both the target area and as a total, although not by an amount that can be deemed significant.

Target area comparison;

The table below shows a comparison with the number of incidents in the target area over the previous 2 years.

Category	Number of incidents 2013/4	No of moderate or above severity incidents	Number of incidents 2014/5	No of moderate or above severity incidents	Total +/-
Violence and Aggression towards staff	309	4	384	8	+75
Needle stick/ splash injuries/ Exposure to hazardous substances	249	7	284	9	+35
Staff falls	100	17	107	16	+7
Staff Moving and Handling	99	17	106	11	+7

There has been a very notable increase in incidents of Violence and Aggression towards staff, both in the number of incidents and the number of higher severity incidents over this period. This follows a national trend of an increase in the number of incidents of Violence and Aggression towards Healthcare workers.

This trend was noted during the course of the 2014/5 financial year leading to the setting up of a task force to examine the issue. This work stream is planned to continue during the 2015/16 financial year.

The increase in the number of exposure injuries has also increased over the period. This has included exposures to both chemical and biological agents.

The Trust Clinical procurement department has commenced a programme to replace traditional “sharps” with “safer sharps” which include safety devices to prevent contact with sharp implements used within the healthcare setting. This aims to reduce the number of injuries due to sharps.

The Trust Health and Safety department will be embarking on a major project relating to the management of COSHH with the aim of reducing the number of exposure incidents relating to both chemical and biological agents.

REPORT TO THE TRUST BOARD – JUNE 2015

Paper Title:	**Annual Fire Safety Report: 2014/15**
Sponsoring Director:	**Eric Munro, Joint Director of Estates & Facilities**
Author:	**Eric Munro, Joint Director of Estates & Facilities**
Purpose:	**For Information**
Action required by the board:	**For information**
Document previously considered by:	

Executive summary

1. Key messages

The Trust need to be able to demonstrate to LFEPA that a programme of Fire Protection and Prevention in regard to repair and maintenance is in place and properly supported and managed. The Q1 2015 inspection has now been completed with no new issues raised.

Between January 2014 and April 2015, the following investments and actions have been completed to improve Fire Safety within the Trust:

- **Update to previous 2010 Fire Safety Management Policy (H&S 6) - ratified by the Policy Approval Group in February 2015**
- **Detailed audit of all areas requiring Fire Risk Assessments (FRAs) and establishment of a detailed FRA database**
- **Detailed assessment of the risks associated with compliance with the Regulatory Reform (Fire Safety) Order 2005 (RRO) and escalation to the Board Assurance Framework**
- **Completion of a detailed Fire Risk Assessment Programme for all patient areas**
- **Introduction of a new design, more user-friendly, Fire Folder**
- **Appointment of new Deputy Head of Estates (Compliance & Fire) in January 2015 and two new permanent Fire Safety Advisers who started in April 2015 and increase to administration support.**
- **Following remedial works carried out by the Trust, LFB has now confirmed that the Grosvenor and Lanesborough Wing Enforcement Notices and the Knightsbridge Wing Deficiency Notice have now been lifted**
- **The Estates and Facilities Department completed a £1.3 million project in November 2014 for a full fire safety refurbishment of the 2nd floor plant room in Lanesborough Wing**

Continuous action is being taken to deliver fire safety, specifically against the plans agreed with the LFEPA enforcement officers. This will include:

- **Addressing compartmentation and fire doors in Lanesborough Wing, partly through our maintenance programmes and significantly through the Children's and Women's Hospital Capital Projects**
- **Bringing forward proposals to refurbish Grosvenor Wing as part of the Development Control Plan**
- **Reinvigorating the Fire Training function and establishing a dedicated training area by the end of 2015**

2. Recommendation

The Board is asked to note the update to the Annual Fire Safety Report and the progress made during the period.

Key risks identified:

BAF risk item

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

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

Appendix A:

St George's Healthcare NHS Trust

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

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

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
Fire Safety	Estates	EFM	No	18 Nov 2014

1.1 Who is responsible for this service / function / policy?
Director of Estates and Facilities

1.2 Describe the purpose of the service / function / policy?
Fire Safety for all patients, staff and visitors

1.3 Are there any associated objectives?
Not applicable

1.4 What factors contribute or detract from achieving intended outcomes?
Not applicable

1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability (physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Region or belief and Human Rights
No

1.6 If yes, please describe current or planned activities to address the impact.
Not applicable

1.7 Is there any scope for new measures which would promote equality?
No

1.8 What are your monitoring arrangements for this policy/ service
Not applicable

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

2.0. Please give you reasons for this rating
Policy applies to all persons in Trust premises

ANNUAL FIRE SAFETY REPORT: 2014/15 - UPDATE

1. BACKGROUND

In the CEO's report to Trust Board on 30th October 2014, it was reported as follows:

"I have signed the Trust's Annual Statement for the period 1 January 2013 to 31 March 2014. This is a compliance requirement under NHS Firecode. Whilst the statement is not able to confirm that all premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, it does record that a detailed programme is underway to ensure full compliance by the end of 2014/15. This is consistent with the audit report into fire safety for the same period.

The 2013/14 Annual Statement also records that two enforcement notices were received in relation to Lanesborough Wing and Grosvenor Wing on 11th February 2013. In response to these notices, a comprehensive Fire Safety Action and Investment Plan has been developed by the Trust and significant long-term works instigated in many areas of fire safety, fire risk assessments, compartmentation, fire door installation and replacement, fire safety training and fire safety procedures.

Major fire safety works have been completed to Knightsbridge Wing and Lanesborough Wing in particular and an additional Fire Safety Adviser has been recruited. A major programme for the replacement of fire doors is currently out to tender and is expected to commence in December 2014.

Whilst it was intended to bring a detailed fire safety update to the Board in September, incorporating the latest survey and inspection information from LFEPA, some of the London Fire Brigade inspections have been delayed until early November and so a detailed report, describing progress against the Fire Safety Action and Investment Plan, will be provided to Trust Board in November.

In the meantime, however, I am pleased to report that LFEPA has confirmed clearance of the deficiency notice received by the Trust on 19 June 2014 as a result of the Trust completing fire safety improvements in Knightsbridge Wing."

2. PURPOSE OF THE REPORT

The Regulatory Reform (Fire Safety) Order, that came into force on 1st October 2006, requires 'general fire precautions' to be put in place 'where necessary and to the extent that is reasonable and practical' for the protection of the 'relevant persons'.

Responsibility for complying with the Fire Safety Order rests with the responsible person. Broadly, in a workplace this would be the employer or any person who has control of any part of the premises (for example the occupier or owner). Where there is more than one responsible person such as in multi-occupied premises, all must take reasonable steps to co-operate and coordinate with each other.

The Chief Executive Officer is responsible for ensuring that, through appropriate delegation of responsibility within the organisation, current fire legislation is met and that, where appropriate, Firecode guidance is implemented in all premises owned or occupied by the Trust.

The Director of Estates and Facilities is the Executive Director with delegated responsibility for fire safety issues across the organisation and the delivery of a safe responsive system.

This report has been developed to provide the Trust Board of Directors accountable for the activities of the organisation with relevant information concerning the management and delivery of fire safety to the Trust during 2014/15, and a brief forecast into the year ahead, as in accordance with Healthcare Technical Manual 05-01: Managing Healthcare Fire Safety.

The outcome of this report will be used as the basis on which to formulate the Annual Statement of Fire Safety for 2014/15, which is to be retained by the organisation and may be presented to the CQC along with supporting documentation as evidence of performance against Outcome 10 of the "Essential standards of quality and safety".

Good management of fire safety is essential to ensure that fires are unlikely to occur; that if they do occur they are likely to be controlled or contained quickly, effectively and safely; or that, if a fire does occur and grow, everyone in the premises can escape to a place of total safety easily and quickly. The following summary gives brief details of this Trusts development towards compliance with the mandatory requirements for the NHS in England (considered as best practice for NHS Foundation Trusts).

REQUIREMENT	PROGRESS	R	A	G
Clearly defined fire policy	Compliant			
Board Level Director accountable to the Chief Executive for fire safety	Compliant			
Fire Safety Manager to take the lead on all fire safety activities	Compliant			

Have an effective fire safety management strategy which enables:

REQUIREMENT	PROGRESS	R	A	G
Preparation and upkeep of the organisation's fire safety policy	Compliant			
Adequate means for quickly detecting and raising the alarm in case of fire	Compliant			
Means for ensuring emergency evacuation procedures are suitable and sufficient for all areas, without reliance on external services	Compliant			
Staff to receive fire safety training appropriate to the level of risk and duties they may be required to perform	Levels of participation need to be increased to achieve compliance			
Reporting of fires and unwanted fire signals	Compliant			
Partnership initiatives with other bodies and agencies involved in the provision of fire safety.	Compliant			

3. TRUST FIRE POLICY AND FIRE SAFETY ACTION PLAN

The Trust's previous Fire Safety Management Policy (H&S 6) was approved by the Organisational Risk Committee on 24th November 2010. An updated version was ratified by the Policy Approval Group in February 2015.

4. GOVERNANCE - HEALTH, SAFETY AND FIRE COMMITTEE

The Health, Safety and Fire Committee reports to the Organisational Risk Committee, which in turn reports to the Quality and Risk Committee, a formal Trust Board sub-committee.

The Health, Safety and Fire Committee has continued to meet every two months and the Trust's Deputy Head of Estates (Compliance & Fire) presents an update report at each meeting as a standing agenda item.

5. RISK MANAGEMENT

5.1 Risk Registers

The ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO) is on the Estates and Facilities Departmental Risk Register as set out below. This risk is escalated such that it also appears on the Board Assurance Framework.

Ref.	Risk	Source of Risk	Rating	Summary Action Plan	Progress Against Action Plan
EF198	Ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)	Risk of prosecution	4 x 4 = 16	Detailed fire action plan in place with additional fire officer support to deliver the risk assessments. Regular meetings with fire brigade to check progress. Specialist fire safety resource in place to lead on the actions. Planned and reactive monitoring of fire safety.	On-going monitoring and actions via the Organisational Risk Committee.

The Estates and Facilities Department have prepared and are using action plans to make progress in addressing the issues highlighted by LFEPA in the two Enforcement Notices received by the Trust - these documents are shared with the inspectors from LFB and these Enforcement Notices have now been lifted. The most recent inspection was in March 2015.

Whilst the Trust will be able to show significant progress in relation to matters such as fire risk assessments, fire safety training and fire alarm maintenance, other issues such as compartmentation and systems upgrading will require continuing investment of time and capital funding.

5.2 Fire Risk Assessments and Fire Safety Manuals

During 2014/15, a detailed audit of all areas requiring Fire Risk Assessments (FRAs) was completed and a database established to record:

- each area requiring to be assessed
- the date of the last FRA and who it was assessed by
- the Responsible Manager for the area
- the date that the FRA was issued to the Responsible Manager for action
- re-inspection frequency (these vary depending on the nature of usage
- next re-inspection date
- last “no notice” inspection

The total number of areas requiring FRAs is 164 and progress as at the end of March 2015 is set out in Table 1 below. It should be noted that the FRA database also records those areas that are occupied by patients 24 hours per day and less than 12 hours per day. These areas have been a priority for FRAs in the 2014/15 programme.

Table 1: Progress on completion of Fire Risk Assessments (FRAs)

Building	No of FRAs required	No of FRAs Complete	Comment
Atkinson Morley Wing	15	11	FM areas still to be completed
Bence Jones	1	1	
Bronte House and Annex	2	2	
Chest and Breast Clinic	2	2	
Clare House	1	1	
Courtyard Clinic	1	1	
Education Centre	1	1	
Energy Centre	3	2	Switch room to be completed
Grosvenor Wing	19	18	Security Office still to be completed
Knightsbridge Wing	22	22	
Lanesborough Wing	45	44	FM area still to be completed
Max-Facs	7	7	
Occupational Therapy	2	2	
Phoenix Centre	1	1	
Robert Lowe Sports Centre	1	1	
Rose Centre	5	5	
St James Wing	36	36	
Totals	**164**	**157**	

Accordingly, the 2014/15 FRA programme consisting of 164 assessments has been substantially completed using a prioritised methodology. Fire Risk Assessment documentation is a component of the newly developed 'Departmental Fire Safety Manual' (Red Folder) which continues to be distributed to all departments Trust wide. As part of the delivery procedure managers are provided with familiarisation training. This provides managers with an opportunity to ask any relevant questions and confirm understanding of how the manual is expected to be used.

5.3 Fire Safety Action Plans and Documentation

The previously approved Fire Safety Action Plan has been updated and re-presented to the Executive Committee.

During recent checks, some departmental Fire Folders have been found to be incomplete. In addition to the scheduled Fire Risk Assessments, which include Fire Folder checks, the Fire Safety Team has introduced informal, no-notice, fire safety checks which will focus on the completion of Fire Folder information. A new, more user-friendly, Fire Folder has been designed. This Folder also contains more pertinent information and advice and is being rolled-out across the Trust via staff attending Fire Warden training and personal departmental visits by the Fire Safety Team.

5.4 Fire Safety Training

Face to face Fire Safety training is on-going for the weekly Trust Induction course. The 30 minutes now allowed for each of the Corporate and Medical Induction sessions is still less than the 45 minutes minimum required to include all aspects of the recommended syllabus. However, the Director of Estates & Facilities has recently instructed that one hour should be included on all Induction Training programmes for Fire Safety.

The previously tried Walk-Up/Drop-In Refresher and Fire Warden training sessions had a mixed reception. Few staff took advantage of the basic Refresher session although a few more attended the Fire Warden refresher training. However the new Fire Advisors will review whether the Walk-Up/Drop-In training will be re-introduced.

In order to reduce the loss of time from primary duties, Fire Warden training (which requires annual attendance) has been developed into a 3-year cycle. Year 1 training is the full (approx. 2 hour) training session; Years 2 & 3 will require an approximately 30 – 45 minute session of 'refresher' training. In years 4, 7, 10 etc. full training will be required to begin another 3-year cycle.

The availability of a permanent location for Fire Safety Training would provide huge benefits, convenience and encouragement for the training. Such a requirement is being examined with the preparation of the Development Control Plan for the redevelopment of the St George's campus.

The number of staff coming forward to be trained as Fire Wardens remains a cause for concern. The estimated requirement for Fire Wardens is approximately 850 staff (i.e. a minimum of 8 staff per 24-hour patient area and a minimum of 3 staff per non-patient areas). The number of Fire Wardens trained and in-date (annual training required) is currently around 250.

All Fire Safety training details/booking instructions are published on the Trust Intranet and e-mailed to Directors, Matrons, Heads of Departments and departmental managers at 6-monthly intervals – see Appendix 2.

5.5 Fire Safety Team Staffing Levels

The current estates fire team consists of 1 x Deputy Head of Estates (Compliance & Fire), 2 x Fire Advisors, 1 x Fire Advisor (Bank) and administration support.

The Deputy Head of Estates (Compliance & Fire) commenced with the Trust on 12th January 2015 and the Fire Advisors both commenced with the Trust on 20th April 2015, the team are building their site knowledge and reviewing existing processes and practices, including increasing the fire refresher, warden and evacuation training levels.

6. UNWANTED FIRE SIGNALS (UWFS)

False fire alarms are unwanted, an interruption to business continuity, costly and can compromise patient care. The Trust has initiated 100 unwanted fire signals since 1 April 2014 (figures up to and including the end of October 2014), an increase of 8 from the same period last year. This still exceeds the maximum number of UWFS considered tolerable (related to acceptable levels of unwanted fire signals and in accordance with HTM 05-03: Part H Reducing Unwanted Fire Signals in Healthcare Premises) for acute hospital premises of this magnitude.

To date, the Trust has received invoices from the London Fire and Emergency Planning Authority, in excess of the original *annual* budget for London Fire Brigade attendances as a result of Unwanted Fire Signals. The importance of the reduction of UWFS has now been formally included into all Fire Safety training from June 2014 have shown a significant reduction, but this needs to become a lasting trend.

From the data acquired a robust strategy needs to be put in place to raise awareness of the consequences of unnecessary fire alarm activations and our statutory duty to reduce them.

This strategy will include:

- targeted FRAs in areas with a high number of activations
- replacement of unsuitable equipment
- additional Fire Safety Training
- attending meetings with responsible persons for key "hot spots"
- Fire Safety information bulletins
- Posters and other awareness material

Healthcare Technical Memorandum 05 - 03 Part H Reducing unwanted fire signals in healthcare premises recommends a minimum reduction of **10%** activations during the next 12 month period.

In addition to the above, on 31st March 2015, the Trust implemented a call delay to the London Fire Brigade between the hours of 08:00 and 20:00 Monday to Friday. The delay allows a **MAXIMUM** time of 8 minutes between the fire alarm activation and switchboard calling the fire brigade to allow on-site staff to determine if the activation is a false alarm or an actual fire event. If the activation is a false alarm switchboard are informed **NOT** to call the fire brigade, if the activation is an actual fire event (or 8 minutes have elapsed) the fire brigade are called by switchboard.

The reductions in calls to LFB are being monitored over a 3 month period to assess the effectiveness of the above actions and will be reported on the next Fire report.

7. FIRE INCIDENTS

There have been no actual fire incidents in the Trust since 1 April 2014.

8. LFEPA INSPECTIONS AND ENFORCEMENT NOTICES

Following a series of fire safety inspections by LFB and a fire incident on 2 January 2013, LFEPA took the decision to serve the Trust with two Enforcement Notices on 11th February 2013. One related to Grosvenor Wing and the other related to Lanesborough Wing.

The two enforcement notices for Lanesborough Wing and Grosvenor Wing have been rescinded by the LFB as the Trust has made progress in addressing the issues and produced improvements. Following a small electrical fire in one of the boiler rooms of Knightsbridge Wing on 12th February 2014, the Trust received a Deficiency Notice on 19th June 2014.

Whilst the notice is not building specific (and therefore could be interpreted as a site-wide notice), the Trust has received email confirmation from LFB that the notice relates to Knightsbridge Wing only.

Following remedial works carried out by the Trust, LFB has now confirmed that the Knightsbridge Wing Deficiency Notice has been lifted.

The LFEPA inspector visited the Trust on 16th September 2014 in order to follow-up on the Deficiency Notice on Knightsbridge Wing and also to inspect a significant number of smaller buildings which had not been audited previously. Although satisfied that appropriate work had been planned and begun in Knightsbridge Wing, he noted that the standard of housekeeping in the other areas needed to improve, as this increases the risk of non-compliance with fire safety regulations. The buildings inspected included:

- Blackshaw Annex
- Old Chest & Breast Clinics
- Occupational Health 1
- Education Centre
- Robert Lowe Sports Centre
- Bence Jones
- Phoenix Centre

Since the inspection, a range of initiatives have been undertaken by the Trust to reinforce the importance of good housekeeping on fire safety. These include:

- securing unused areas
- works to compartmentalise IT servers
- promotion of “dump the junk” waste collections
- “no notice” fire safety inspections

Such efforts will need to be maintained to ensure that housekeeping practices continue to improve.

Further information on the legislative framework is contained in Appendix 2.

Due to progress made, LFEPA has now confirmed that the Grosvenor and Lanesborough Wing Enforcement Notices have now been lifted.

9. FIRE SAFETY IMPROVEMENT WORKS

9.1 Fire Compartmentation

Following completion of all FRAs for Lanesborough Wing, the Estates team drew up an improvement scheme for Lanesborough wing 2nd floor (Plant Room) as this was highlighted as a significant risk within the fire audit regarding compartmentation, fire doors and alarms.

The Estates and Facilities Department procured a £1.3 million project in March 2014 to complete a full refurbishment of the 2nd floor plant room which included the following works:

- full fire compartmentation and fire stopping repairs
- replace all fire doors with correct fire rated doors
- install new fire alarm in unprotected areas
- install new low level emergency lighting (lite4life)
- paint plant room walls
- paint and seal plant room floor
- apply photo luminescent way-finding system to floors
- install fire directional signage
- install intumescent grills
- install new partitions

The Lanesborough Wing 2nd Floor Plant Rooms fire compartmentation, fire stopping, fire doors and escape routes work has now been completed. A specification for Stage 2 (Grosvenor and St James Wings Plant Rooms) has been developed and will be tendered in the next few months.

9.2 Fire Doors /Shutters & Dampers

A full, site-wide survey of fire doors and shutters was started during March 2014; the survey is on-going and results indicate that many fire door sets are in need of repair, refurbishment or replacement.

In addition a survey of all fire dampers is currently underway and the results from this survey will enable estates to develop a planned package of works of repairs/replacements and on-going preventative maintenance.

9.3 Fire Protection Systems

The required ‘L1’ fire protection system is installed into Clare House and as part of the Lanesborough Wing Plant Room project on the second floor. In addition, there is a current project in operation, which started in April 2015, to replace the existing fire alarm system in Lanesborough Wing with a new system to L1 standards, which is estimated to take upto one year to complete.

Trinity Fire & Security Systems have had a permanent presence on site performing continuous maintenance to the existing systems.

The weekly testing of the fire alarm systems around the site are undertaken by Estates staff.

10. CONCLUSION

Whilst the Trust has made and continues to make, significant investment and progress in the improvement of Fire Safety during 2014/15 and into 2015/16, there are still significant programmes of physical works, training development and risk management required to ensure that the momentum is maintained in future years.

APPENDIX 1 – PUBLICITY FOR FIRE SAFETY TRAINING

There is a critical need, identified during previous London Fire & Emergency Planning Authority (LFEPA) inspections of the Trust, to achieve the level of Fire Safety Training which is commensurate with the requirements of the Regulatory Reform (Fire Safety) Order 2005, the provisions of Hospital Technical Memorandum (HTM) 05-01 and the Trust's Fire Safety Management Policy.

The details of all available Fire Safety Training may be accessed via the 'Fire Safety, Training & Response' link at the bottom right of the Trust Intranet Home Page. The training dates and venues are currently under review by the Fire safety Team.

Below is the previous extract of this information and included the scheduled dates/times for Fire Warden training up to March 2015:

FIRE SAFETY TRAINING

Statutory Fire Safety training for the remainder of 2015 may be arranged as shown below. Departmental Managers should nominate staff to attend the training by arrangement with the Trust Fire Safety Team [***fire.officer@stgeorges.nhs.uk*** or ***ext. 0656***].

FIRE WARDEN TRAINING

All Departments/Wards must have sufficient ***trained and 'in date'*** (annual training – see below) Fire Wardens so that at least one Fire Warden is on duty during all opening/working hours. For 24-hour patient areas, a *minimum* of 8 trained and current Fire Wardens is recommended in order to take account of shift patterns, annual leave, training days and sickness etc.

In accordance with HTM 05-01 and the Trust's Fire Safety Management Policy, Fire Warden training is required annually. With immediate effect, Fire Warden training will be provided on a 3-year cycle such that full training for new *and* experienced Fire Wardens (approx. 2 hours) will be provided every 3 years (Year 1, 4, 7 etc.) and Fire Warden refresher training (approx. 45 minutes) will be provided for Years 2 and 3 of each cycle. Fire Wardens trained up to two years ago may join this cycle.

Formal Fire Warden training is scheduled throughout the year and published twice a year on this page. Sessions from April to December 2015, for both full and refresher training are to be confirmed.

Departmental +/or Ward/Unit Managers should submit the names of selected staff to the Trust Fire Safety Team [***fire.officer@stgeorges.nhs.uk*** or ***ext. 0656***].

FIRE SAFETY REFRESHER TRAINING

In accordance with HTM 05-01 and the Trust's Fire Safety Management Policy, staff who work predominantly in clinical areas +/or with patients ***must attend annual*** 'face-to-face' Fire Safety refresher training. Staff working in non-patient areas ***must*** attend 'face-to-face' Fire Safety refresher training once every two years. This training, with a member of the Fire Safety Team, will last 1 hour; e-learning may only ***supplement*** these requirements.

Fire Safety refresher training should be arranged by Departmental Managers, typically, for example, as part of mandatory training programmes *or* Team Days and in a suitable venue with projection. Arrangements should be made Trust Fire Safety Team [***fire.officer@stgeorges.nhs.uk*** or ***ext. 0656***].

Subject to available time, the training will include the theory of evacuation and the use of 'Ski-Sheets'.

FURTHER INFORMATION

Trust Fire Safety Team [***fire.officer@stgeorges.nhs.uk*** or ***ext. 0656***].

It is the responsibility of Departmental Heads (Fire Safety 'Responsible Managers') to ensure that face to face Refresher training is up to date (annual in Patient areas) and that, in all areas, there is at least one *trained* Fire Warden on duty at all times. As a guide, we consider, that in order to take account of rotas, professional training, annual leave and sickness etc., this requires approximately *8 trained Fire Warden staff* in most 24-hour clinical units and not less than 3 in predominantly day-time areas.

Fire Warden training is required to be repeated annually but a new 3-year cycle of full & refresher Fire Warden training, which will reduce the time required for training, is explained above.

APPENDIX 2 – STATUTORY COMPLIANCE FRAMEWORK FOR FIRE SAFETY

Until 1990, NHS premises fell under the scope of Crown Immunity, which meant that they did not need to comply with "the letter of the law" relating to fire safety. However, following the NHS and Community Care Act 1990, Crown Immunity was fully removed in April 1991. Some Crown Immunity had already been removed in 1987 when the NHS became bound by the terms of the Health and Safety at Work Act 1974.

From 1990, all NHS Trusts, their staff and their fire prevention advisers were required to ensure compliance with NHS Firecode, a suite of documents first published by NHS Estates and intended to provide a systematic approach to reduce the potential for fire in health service premises. NHS Firecode compliance now falls to the Department of Health and the documents still set standards for the layout, design, construction and fire safety management of hospitals and other healthcare premises.

Firecode is underpinned by a policy and principles document and includes a number of Health Technical Memoranda (HTMs) and Fire Practice Notices (FPNs) that consider policy, technical guidance and specialist aspects of fire precautions.

STATUTORY COMPLIANCE

In addition to Firecode, the principal statutory requirements that have a direct bearing on fire safety and must be observed by NHS Hospital Trusts at all times are:

- Building Regulations 2013 Approved Document B - Fire Safety
- Regulatory Reform (Fire Safety) Order 2005.
- Fire Safety and Safety at Places of Sport Act 1987.
- Health and Safety at Work Act, including the Management of Health and Safety at Work Regulations.
- NHS Housing in the Community: Housing Act 1985.
- Registration of Houses in Multiple Occupancy.
- Places of Work Regulation 1992 (as amended).

DUTIES AND RESPONSIBILITIES

Trust Board

The Trust Board has overall accountability for the activities of the organisation. The Board should ensure they have appropriate assurance that the requirements of current fire safety legislation are met and, where appropriate, that the objectives of Firecode are met.

Chief Executive

The Chief Executive has overall responsibility for the implementation of the Trust's Fire Safety Policy and of the guidance detailed in the Department of Health "Health Technical Memorandum 05-01: Managing Healthcare Fire Safety". The Chief Executive will appoint a Fire Safety Manager to assist in the implementation of this Policy. This Officer will be of sufficient seniority/rank to be able to carry out the duties required.

Board Level Director (Director of Estates and Facilities)

The Board Level Director is responsible for fire safety issues at Board level, including programmes of work relating to Fire Safety for consideration as part of the annual Business Plan.

Fire Safety Manager

The Trust's designated Fire Safety Manager, Neil Fogg, Deputy Head of Estates (Compliance & Fire), and his principal duties include:

- appoint Deputies on all Trust sites to ensure that a designated person is always available to take command of a fire emergency until the Fire Brigade arrives.
- ensure that all staff receive clear written instructions on the actions to be taken in the event of a fire.
- liaise with all organisations working on Trust premises to ensure that they are aware of the Trust Policy and Procedures.
- co-ordinate and direct actions of staff in a fire emergency i.e., to establish control points, provide contact with the Fire Brigade and to ensure the safe evacuation of patients, visitors and staff.
- liaise with the Fire Advisor for advice on developing a plan of action for dealing with a fire emergency.
- ensure that all staff with special responsibilities in a fire emergency situation are aware of the procedure to be followed and are clear as to their role and responsibilities.
- ensure that agreed programmes of investment in fire precautions are correctly accounted for in the Trust's annual Business Plan and prepare an Annual Fire Report for submission to the Trust Board.
- establish a multi-disciplinary fire precautions group that will review the fire policy and procedure annually.
- co-ordinate all fire precautions within the Trust and have a working knowledge of fire precautions and the fire alarm systems.
- consult with the Fire Advisors and Estates Management to ensure that fire alarm systems are maintained and tested in accordance with NHS Guidance (HTM 05-03 Part B) and British Standard 5839.
- arrange for periodic site fire safety audits.
- investigate and remedy abuse of fire equipment.
- co-ordinate with Managers and the Fire Advisors to ensure that all staff participates in an annual mandatory fire training programme and required fire drills and that training records are maintained.

Fire Advisors

The Trust has statutory and other responsibilities in respect of fire safety for all its premises. As a means of fulfilling its obligation, the Trust has appointed specialist Fire Advisors. These are responsible for advising management on technical fire matters, monitoring the state of fire precautions in the Trust's premises and for arranging sufficient training sessions for all staff.

The Fire Advisors are responsible to the Deputy Head of Estates (Compliance & Fire). The duties of the Fire Advisors are to :

- provide expert advice on the application and interpretation of fire legislation and fire safety guidance, including Firecode

- advise on the content of the organisation's fire safety policy
- assist with the development of the organisation's fire strategy
- help with the development of a suitable training programme, including delivery of the training
- liaise with enforcing authorities on technical issues
- liaise with managers and staff on fire safety issues
- liaise with the Authorising Engineer (Fire)

REGULATORY REFORM (FIRE SAFETY) ORDER 2005.

The Regulatory Reform (Fire Safety) Order (known Fire Safety Order) applies to England and Wales (Northern Ireland and Scotland will have their own laws). It covers 'general fire precautions' and other fire safety duties that are needed to protect 'Relevant Persons' in case of fire in and around 'most premises'. The Order requires fire precautions to be put in place 'where necessary' and to the extent that it is reasonable and practicable in the circumstances of the case. Responsibility for complying with the Fire Safety Order rests with the 'Responsible Person'.

The Fire Safety Order is a Fire Risk Assessment based approach where the responsible person(s) for the premises must decide how to address the risks identified, while meeting certain basic requirements.

By adopting a fire risk assessment approach, the responsible person(s) will need to look at how to prevent fire from occurring in the first place, by removing or reducing hazards and risks (ignition sources) and then look at the precautions to ensure that people are adequately protected, if a fire were still to occur.

The fire risk assessment must also take into consideration the effect a fire may have on anyone in or around your premises plus neighbouring property and will need to be kept under regular review. The building fire risk assessment concentrates on the following areas:

- Elimination or reduction of risks (ignition sources),
- Suitable means of detecting and raising the alarm in the event of a fire,
- Adequate emergency escape routes and exits,
- Adequate fire compartmentation (fire and smoke spread and the protection of escape routes),
- The appropriate type and sufficient quantities of fire extinguishers,
- Correct type and sufficient quantities of fire signs and notices,
- Provisions for the correct maintenance of installed fire equipment,
- Suitable provisions for the protection of Fire Brigade personnel,
- Ensure that occupants receive the appropriate instruction and training in: 'Actions to be taken in the event of fire' and fire evacuation drills etc,

The Fire Safety Order applies to virtually all non-domestic properties, including voluntary organisations and is subject to monitoring and enforcement by the Local Authority Fire Services (LAFS).

All previous fire legislations has been repealed or revoked, including the Fire Precautions Act 1971 (Fire Certificates are abolished), the Fire Precautions (Workplace) Regulations 1997, plus 100 other pieces of fire related legislation.

Responsible Person - *(The Responsible Person)*

In relation to a workplace, it is the employer and any other person who may have control of any part of the premises, e.g. the occupier or owner for whatever they have control of:

In all other premises, the person or people in control of the premises will be responsible, those premises not falling within paragraph (a):

(a) the person who has control of the premises (as occupier or otherwise) in connection with him carrying on by him of a trade, business or other undertaking (for profit or not); or

(b) the owner, where the person in control of the premises does not have control in connection with the carrying on by that person of a trade, business or other undertaking.

In summary, the 'Responsible Person' is:

- The Employer with control of a workplace

Failing that or in addition;

- Persons with overall management control of a building (or part of the building)
- Occupier of the premises, owner of the premises (i.e. empty building),
- Landlords (in multi-occupied buildings)

ACTION BY LONDON FIRE AND EMERGENCY PLANNING AUTHORITY (LFEPA)

The Trust's premises are inspected regularly by LFEPA, who run the London Fire Brigade (LFB). The number of inspection visits have been increased in recent years as the Trust failed to heed informal warnings about its failures to comply with the Regulatory Reform (Fire Safety) Order 2005.

Under this order, there are three types of formal notice that can be served on the Trust.

Alterations notice (Article 29)

An alterations notice requires the responsible person to notify LFB of any proposed changes which may increase the risk in the premises. They are issued where LFB considers that the premises constitute a serious risk or may constitute a risk if changes are made. An alterations notice does not mean that the responsible person has failed to comply with the Regulatory Reform (Fire Safety) Order 2005.

Enforcement notice (Article 30)

An enforcement notice is issued where the responsible person has failed to comply with the Regulatory Reform (Fire Safety) Order 2005 and details corrective measures that they are legally obliged to complete within a set timescale, to comply with the law.

Prohibition notice (Article 31)

A prohibition notice is issued where the use of the premises may constitute and imminent risk of death or serious injury to the persons using them. This may be a restriction of use, for example imposing a maximum number of persons allowed in the premises, or a prohibition of a specific use of all or part of the premises, for example prohibiting the use of specific floors or rooms for sleeping accommodation.

The issue of a Prohibition Notice under the Regulatory Reform (Fire Safety) Order 2005 is the most serious enforcement option available to the LFB other than prosecution and can only be authorised by identified senior officers.

Deficiency Notice

In addition to these formal notices, LFEPA can issue a Notification of Fire Safety Deficiencies (often abbreviated as “Deficiency Notice”). A Deficiency Notice carries no statutory force but “may result in formal action being undertaken if the agreed improvements do not take place” – this is effectively an informal warning from the fire safety inspectors at LFB.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD - June 2015

Paper Title:	Board governance statements
Sponsoring Director:	Peter Jenkinson, Director of Corporate Affairs
Author:	Peter Jenkinson, Director of Corporate Affairs
Purpose:	To provide a summary of assurances available to inform the board's judgement of compliance with governance statements For the board to assess whether it can confirm compliance with annual governance statements, for submission to Monitor.
Action required by the committee:	To agree the level of compliance with the governance statements outlined due to be submitted by 30th June.
Document previously considered by:	N/A

Key Messages

Monitor's Risk Assessment Framework (RAF) requires Foundation Trusts to submit a series of governance statements as part of the annual planning process. Monitor uses the information provided in these documents primarily to assess the risk that an NHS Foundation Trust may breach its licence in relation to finance and governance. Monitor will also assess the quality of the underlying planning processes.

NHS Foundation Trusts are required to make the following annual declarations to Monitor:

1 & 2 Systems for compliance with licence conditions – in accordance with General condition 6 of the NHS provider licence;

3 Availability of resources and accompanying statement – in accordance with Continuity of Services condition 7 of the NHS provider licence;

4 Corporate Governance Statement – in accordance with the Risk Assessment Framework;

5 Certification on AHSCs and governance – in accordance with Appendix E of the Risk Assessment Framework;

6 Certification on training of governors – in accordance with s151(5) of the Health and Social Care Act

For 2015/16 these statements are made in several submissions*:*
Declarations 1& 2 were approved by the board and submitted on 29th May 2015;
Declaration 3 has been submitted as part of the annual planning process – this was approved at the finance and performance committee on 13th May 2015 and submitted on the 14th May.
Declarations 4, 5 and 6 are required to be submitted by 30th June.

These statements replace the board statements that NHS foundation trusts were previously required to submit with their annual plans under the Compliance Framework. Where facts come to light that could call into question information in the corporate governance statement, or indicate that an NHS foundation trust may not have carried out planned actions, Monitor is likely to seek additional information from the NHS foundation trust to understand the underlying situation. Depending on the trust's response, Monitor may decide to investigate further to establish whether there is a material governance concern that merits further action.

This paper therefore sets out the statements required to be submitted by 30th June, along with assurance statements which should inform the board's opinion on its declaration as to whether it can confirm or not compliance with the respective statements. Where the board determines that it cannot confirm compliance with a specific statement, it should declare 'not confirmed' and provide commentary to explain the reason for the non-compliance.

The three statements and assurance statements are attached at Appendix A. The board is required to consider and certify whether or not it can confirm compliance with each statement.

Statement 4: The Board is satisfied that the Trust effectively implements systems and/or processes:
(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements.

Statement 5: The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:
(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) That the Board receives and takes into account accurate, comprehensive, timely

and up to date information on quality of care;
(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

Statement 6: The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

Based on the corporate governance arrangements already in place and the level of assurance that the board has received in this respect over the last 12-18 months, the recommendation is that the board can confirm compliance with each of these statements.

Going forward, the trust is currently developing a new assurance framework, in line with the approach outlined in the risk management strategy approved by the board. This framework will be based around Monitor's 'Well Led Framework' and include the various governance statements so that the board can receive regular assurance regarding its compliance with governance best practice and inform its annual certification.

Recommendation

Board members are invited to consider and certify each statement, informed by the summary of controls and assurances outlined in appendix A. If unable to do so, the board should agree what supporting commentary it wishes to submit.

Risks

If the board identifies a gap in compliance with the governance statements and therefore in the trust's corporate governance arrangements, then actions will need to be agreed to address that gap through the development of the trust's assurance framework.

No such gap has been identified in this assessment.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	All
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	All CQC Fundamental standards & regulations, but particularly the 'well led' domain.

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

If yes, please provide a summary of the key findings

Appendix A: Proposed evidence for self-certification

Self-certification statement	Assurance statement
Statement 4: The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	**Internal controls and assurance** • Corporate governance structure including board sub-committees providing assurance to the board on various aspects, each board sub-committee including NED membership and chair; • Each board sub-committee has clear terms of reference and administrative arrangements, and reviews its effectiveness annually through anonymous self-assessment surveys; • Each board sub-committee reports to the board after each meeting; • Each terms of reference and trust standing orders set out administrative standards for the board / respective committee; • Standard suite of performance reports to each board meeting, including finance, quality, operational performance, workforce. • Monthly review of significant risks by board and series of 'deep dive' reviews of risks through the quality and risk committee; • Quarterly review of progress against trust annual plan objectives presented to board; • Performance management framework in place, including quarterly performance reviews with divisions and escalation procedures when necessary, which enable executive team to hold divisions to account; • Financial recovery plan developed to address financial performance short-term and long-term and ensure going concern financially, including management actions to improve financial management and controls. **External assurance** • Quality Governance Assurance Framework self-assessment and validation by Deloitte 2013/14; • 'Good' overall rating in CQC's Chief Inspector of Hospitals assessment February 2014; • Historic due diligence reports as part of foundation trust application in 2014, including financial reporting procedures (governance). **Gaps in assurance / risks** • External audit opinion on financial statements – the trust is a going concern only on the basis of receiving financial

Self-certification statement	Assurance statement
	assistance, to be confirmed as part of Monitor investigation and APR review.
Statement 5: The Board is satisfied that the systems and/or processes referred to in statement 4 should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Internal controls and assurance** • Leadership for quality at board level through chief nurse and medical director; • Non-executive chair of quality and risk committee, and two medical staff on the board as non-executive directors; • Each clinical division chaired by a medical and senior management team including a divisional director of nursing and governance; • Central to the corporate strategy is a clinical strategy and a key supporting strategy is the quality improvement strategy; • The Board and the quality and risk committee receives a monthly quality performance report, containing comprehensive range of quality metrics and a ward-level heat map. The board also receives weekly report of any new serious incidents declared and monthly update on significant incidents; • Board members and other stakeholders (governors, patient reps) participate in quality inspections; • Council of Governors meetings, briefings and seminars include regular discussion regarding quality, workforce and finance; • Trust engagement with patient reps through Patient Reference Group, regular meetings with Healthwatch and attendance at HOSC meetings; • Staff engagement in quality through regular safety fora meetings, clinical management board, consultants' meetings, nursing board; • Accountability for quality is clear at each level of divisional structure, in job descriptions; • Divisions held to account for quality through quarterly divisional performance reviews and presentation of divisional quality improvement plans at quality and risk committee; • Comprehensive internal audit programme with annual plan of audits approved by board and including financial controls and systems, quality, planning and information. **External assurance** • Quality Governance Assurance Framework

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	self-assessment and validation by Deloitte 2013/14; • 'Good' overall rating in CQC's Chief Inspector of Hospitals assessment February 2014; • Clinical Quality Review Meetings with commissioners, CQC and Monitor; • Board to Board meeting with Wandsworth CCG; • Wandsworth Council OSC statement on the trust's quality account; • 'Reasonable' Internal audit opinions on 'safeguarding children, 'nurse, midwifery and care establishments' and 'medical locums'; • External audit opinion on trust quality account.
Statement 6: The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Internal controls and assurance** • Established nominations and remuneration committee which approves executive appointment and reviews executive appraisals; • Nominations and remuneration committee review of succession plan for directors; • Appraisal system in place for board and whole organisation. NED appraisals to be reviewed by the Council of Governors; • Workforce committee as sub-committee of the board, providing assurance regarding workforce planning; • Education board with non-executive director input; • Safe staffing reviews every six months for nursing staff and review completed for medical staff, reported to the quality and risk committee May 2015; • Leadership development framework in place guide development of leaders throughout the organisation; • Recruitment controls to check competency and qualification of staff; • Revalidation process for medical staff. **External assurance** • Board Governance Assurance Framework assessment completed in 2014 and validated by Deloitte as part of the trust's application for foundation trust status; • 'Good' rating in 'well led' domain of the CQC's Chief Inspector of Hospitals inspection, February 2014; • Monitor board to board assessment

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	September 2015.