St George's University Hospitals NHS
NHS Foundation Trust

MEETING OF THE TRUST BOARD

28th May 2015, 9.00 – 11.30
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**		9.00
2.	**Apologies for absence and introductions**		
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 30th April 2015*	TB (M)	
5.	**Schedule of Matters Arising** *To review the outstanding items from previous minutes*	TB (MA) May15	
6.	**Chief Executive's Report** *To receive a report from the Chief Executive, updating on key developments*	M Scott TB May15-01	
7.	**Quality and Performance**		9.30
7.1	**Quality and Performance Report – (To follow)** *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 1*	J Hall/S Bolam TB May 15-02 (To follow)	
	To receive a verbal report from the Quality & Risk Committee seminar held on May 2015	Sarah Wilton	
7.2	**Finance Report - (To follow)** *To receive the finance report form month 1*	S Bolam TB May 15-03 (To follow)	
7.3	**Workforce Performance Report (including MAR scheme)** *To consider and authorise the MAR scheme which will then be formally submitted to Monitor*	W Brewer TB May 15-04	
	• **Chairs report from Workforce Committee** *To receive a report from Workforce Committee meeting 21 May 2015*	S Pantelides TB May 15-05	
	BREAK		10.30
8.	**Strategy**		10.40
8.1	**Annual Plan final version** *To receive the final submitted version of Annual Plan for Board to note*	R Elek TB May 15-06	
9.	**Governance**		
	Approval of Financial Accounts, Quality Account & Annual Report *To receive recommendations from Audit Committee*	M Rappolt (verbal)	

8.2	**Risk and Compliance Report** *To review the Trust's most significant risks and external assurances received*	P Jenkinson TB May15-07	
8.3	**Annual Board Governance statement for Monitor submission** *To approve submission for Board statements to Monitor*	P Jenkinson TB May 15-08	
9.	**General Items for Information**		11.10
9.1	**Care and Environment**	E Munro TB May 15-09	
9.2	**Use of the Trust Seal** *To note use of the Trust's seal during the period (May 2015)* ***The seal has not been used in May 2015***		

9.3 Questions from the Public

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

10. Meeting evaluation

11. Date of the next meeting - *The next meeting of the Trust Board will be held on 25 June at 9.00am H2.6.*

MINUTES OF THE TRUST BOARD

30 April 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
	Mrs Kate Leach	Associate Non-Executive Director
	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
In attendance:		
Apologies:	Professor Peter Kopelman	Non-Executive Director
	Dr Judith Hulf	Non-Executive Director

15.04.11 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.

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

15.04.13 Minutes of the previous meeting
The minutes of the meeting held on 26 March 2015 were approved as an accurate record.

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

15.04.15 Chief Executive Report
The Board received and noted the chief executive's report. Mr Scott highlighted the trust's involvement in the 'breaking the cycle' initiative, a national programme aimed at improving patient flow. Ms Hall summarized some of the recommendations flowing from the programme, with action taken already beginning to show benefit.

Mrs Pantelides asked what messages were coming back from staff through the

Team Brief system, in particular with regard to the financial climate. It was agreed that the findings from the Team Brief and other staff briefings would be shared with the board.

Mrs Wilton welcomed the selection by the Council of Governors of the community outcome measures to be audited as part of the quality account, and asked what they were. Ms Hall explained that she was working with the community services division to develop them, and that for that reason she also welcomed this choice of indicator to be audited.

15.04.16 Quality and performance report

Performance report
Mr Bolam presented the performance report for month 12, highlighting areas of concern including compliance with RTT, cancer standards and ED waiting time standards. The Board noted that this resulted in a rating of 2 in the Monitor risk ratings, down from 3 reported the previous month. The board noted the risk of a governance rating of 4, once RTT performance was reinstated as a standard and should any further cancer breaches occur. This could lead to Monitor launching an investigation in potential breach of licence, based on their judgement as to the extent of the breach and any other information available to them.

The board noted that the trust expected to continue to breach the RTT target, despite the expectation that the standard would be met from April. Mr Bolam reported on the ongoing 'joint investigation' with commissioners, with a view to agreeing a joint action plan to address underperformance. In addition, the trust's capacity planning was ongoing to ensure sufficient capacity to meet requirements. However he advised that a sustainable and affordable solution to RTT was unlikely currently. The board noted that the outcome of the joint investigation would be reported to the finance and performance committee.

Mr Bolam also advised the board of a spike in diagnostic waiting times. This meant that the trust had not achieved the required trajectory as quickly as it should, but it was expected that this would be resolved by end of quarter one.

The board noted that improvement plans for the A&E 4 hour wait standard and Cancer had been reviewed in detail by the finance and performance committee.

Mrs Wilton asked what assurance the board could take that the A&E waiting time standard would be met in May. Mr Wilson reported that the trust had seen improvements in performance in April, with performance up from 88% to 92% for the month; he was therefore optimistic that the standard would be met in May, but advised that the trust was working with commissioners to ensure sustained achievement of the standard.

Quality report
Ms Hall presented the report and highlighted key points in each section.

<u>Safety domain</u>
Ms Hall highlighted an increase in the number of serious incidents being reported, as discussed at the previous meeting. She advised that there were no consistent themes emerging in the increased number, but that there was an upward trend. An investigation to determine any themes was currently ongoing. Ms Hall also reported a never event which had occurred during March, involving wrong site surgery. This was currently under investigation.

Mr Rappolt referred to a discussion at the quality and risk committee and recommended that mortality monitoring should be measured for Queen Mary's Hospital as well as the main hospital site. Ms Hall agreed that the current systems would need to be understood and developed to accommodate this.

The board also noted that the quality inspection programme would be relaunched from the beginning of June.

Ms Hall also highlighted the update on pressure ulcer incidence, reported improved performance in completion of VTE assessments and confirmed the achievement in continued reduction in clostridium difficile infections resulting in below-trajectory performance and one of the lowest rates in tertiary centres. Mr Rappolt congratulated the team for the continued improvement in infection control over the past few years.

Experience domain
The board noted the updates in the friends and family test, noting the need for consistency across the trust, and welcomed the continuing signs of improvement in complaints performance, with three of the four divisions expected to achieve the year-end target.

Safe staffing
The board noted the February return, and welcomed the current good level although it was noted that this was slightly down.

Ward heat-map
The board noted the current heat-map showing ward-level quality indicators and noted the particular areas of pressure. It was agreed that the map should include trends and comparison versus peers for the next report.

The board noted the impact that run-rate controls were having on staffing levels, and noted that a clearer view of the impact would be seen in the April figures available at the end of May.

Report from quality and risk committee
Ms Wilton presented a summary of key points raised at the last quality and risk seminar. She advised that the committee had welcomed the current low mortality rates being reported – one of only nine trusts nationally below expected levels – but noted signs of deterioration and movement towards the expected level. The committee therefore sought assurance regarding the monitoring process and noted the need for increased surgical input into that process and the need for data resource.

Ms Wilton reported on the presentations by two clinical divisions, CWDT and Community Services. CWDT had highlighted risks in availability of medical records following a recent deterioration in performance and high staff turnover, which was being investigated by the divisional governance board. Community services had reported risks in patient experience at QMH and high staff turnover.

Ms Wilton summarised other discussions, including an update on the nutrition and hydration strategy, being one of the key objectives within the quality improvement strategy, and a review of the first draft of the quality account.

15.04.17 Finance report

Mr Bolam presented the month 12 (year-end) finance report, highlighting a year-end deficit of £16.8m, £20m adverse to the plan set at the beginning of the year. He highlighted an in-month variance of £2.4m to the forecast position, which was being analysed to understand the reasons such significant variance.

The board noted that the cash forecast had been met, but only with the working capital loan and facility included in the position.

The board noted a deterioration in activity and revenue. Mr Smallwood reported on discussions at the finance and performance committee meeting the previous day, where the initial findings regarding the reasons for deterioration were discussed. There would be an additional extra-ordinary meeting of the finance and performance committee on the 13th May, prior to the submission of the annual plan on the 14th.

Mrs Pantelides asked about CIP performance. Mr Bolam explained that CIPs are entered into budgets at the beginning of the year and would then be profiled for delivery during the year. Therefore if the plans are then not delivered, there would be a negative income for that month.

15.04.18 Workforce performance report

Mrs Brewer presented the workforce report for month 12, highlighting key points.

Reducing turnover

Mrs Brewer presented a proposed trajectory for the reduction in turnover, advising that a conservative target had been proposed as it was difficult to manage some of the variable that affect turnover. The trend over the past five years was noted, with the board noting a significant increase in 2014, reflecting an increase seen nationally. The board noted the actions being taken to reduce turnover, including the use of internal transfer or promotion, as well as action being taken to address inappropriate behaviour.

The board noted particular concern regarding the turnover rate within community services, due in large to the aged staff profile and a lack of recruitment to fill those retirements, and welcomed the support being provided to the division by Mr Wilson and Mrs Brewer across a range of issues. The board also noted particular issues with turnover within HMP Wandsworth offender healthcare.

Mr Rappolt noted the trust's intention to submit a bid for the Merton community services and asked whether the issues being addressed in community services were useful in that context. Mr Wilson advised that the Merton community services would be a welcome opportunity that the trust should pursue, but that the operational risks and need for support should be acknowledged.

Mr Smallwood asked about progress in reviewing bank rates, sharing anecdotal evidence that such an increase had worked in theatres in terms of reducing agency spend. Mrs Brewer agreed that it had worked in theatres but advised caution over a blanket approach. There was a need to review the issues in each specialty to identify specific opportunities, as the trust compared reasonably well against other London providers. Mrs Pantelides agreed, advising that there was not a clear correlation between increased bank rates and decreased agency spend, and that this would need to be considered further. Ms Hall confirmed that this was being considered, but cautioned that the economic case was not

supported due to the lack of impact. There was no evidence in the few specialist areas where bank rates had been increased that agency rates had decreased.

Mrs Brewer advised that the most common reason for staff turnover was the staff experience rather than remuneration.

Transferring agency to back
Mrs Brewer presented an update, focusing on medical locums and reporting achievement of target in bank usage in administrative posts.

Mr Scott advised that the trust would need a flexible workforce and asked what the trust was doing to develop such a workforce. Mrs Brewer agreed that this was the strategy, including the development of roles such as physicians' assistants. It was agreed that this would be the subject of a more detailed briefing in due course.

Mrs Pantelides pointed out that if all the actions were implemented successfully then turnover would be reduced by 2%, and asked whether that was enough. Mr Bolam added that there had been a specific spike in turnover in November 2013, and asked whether there had been a fundamental change in working patterns or practices over the period from then until now. The board acknowledged that the national economy had improved over that period and this led to more opportunities outside of the NHS; Mrs Brewer added that the safe staffing standards had also been introduced. The board therefore agreed that the pre-November 2013 levels may not be achieved, unless other factors came to fruition – therefore the conservative approach to a target was appropriate, but the trust should still aim to surpass the target. Mr Rappolt recommended that some areas in the trust faced more significant challenges than others and therefore there should be local targets which took this into account. Mrs Brewer agreed, citing the example of paediatrics where a change in bank rates had no impact but focused work on the culture of that area had had an impact on turnover.

Report from the workforce committee
The board noted that there had not been a workforce committee meeting during the last month.

15.04.19 Quarter 4 2014/15 submission to Monitor
Mr Bolam introduced the quarterly submission process as a foundation trust, including the requirements for board to sign off finance and governance statements. He took the board through the proposed submission for quarter 4 and highlighted the proposed responses for the governance statements for that quarter, that:
For finance, the board could not confirm that "the board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months". The board agreed that this was appropriate due to the current financial position and the predicted challenges for the next financial year.
For governance, the board could not confirm that "the board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in Appendix A of the Risk Assessment Framework." The board agreed that this appropriate due to the ongoing risks of non-compliance with ED and RTT standards in particular.
For governance, the board could confirm that there were no matters arising in the quarter requiring an exception report which had not already been reported. The board agreed that this was the case – there had been one never event recorded in the quarter, which had been reported to Monitor.

The board noted and agreed exception statements to support the declarations of 'not confirmed'. The board agreed that the statement page of the submission template should be presented to the board each quarter for it to agree the statements.

15.04.19 Quarter 4 corporate objectives monitoring

Mr Elek presented the year-end summary of achievement against the corporate objectives set for 2014/15, and progress made during the quarter. He acknowledged the subjectivity of the assessment and advised that a number of other strategies or plans supported the delivery of these objectives. He highlighted that progress had been made in a broad range of objectives, but also highlighted areas where the trust had not achieved what it set out to at the beginning of the year, in particular in developing additional capacity and delivery of business cases (approval and implementation).

Mrs Pantelides agreed that a lot had been achieved but queried why finance had not been included as an area of underachievement. The board noted this as an appropriate challenge.

Mr Rappolt agreed that the summary was optimistic in nature and that in his opinion the alignment of demand and capacity was still 'red', with more work to do. Mrs Leach opined that with so many objectives it was difficult to measure achievement and recommended that more use of indicators and measures was needed for the 2015/16 plan. **R Elek May 2015**

15.04.20 Draft annual plan

Mr Elek presented the draft narrative which made up part of the annual plan submission to Monitor. It was noted that the financial plan and governance statements would be approved by the finance and performance committee on 13th May, prior to submission of all parts of the annual plan on 14th May. The narrative presented an introduction to key priorities, risks and objectives.

Mr Smallwood opined that the focus for the next year should be on reconfiguration of local hospital services and community services, from financial and quality perspectives. There was a need for the trust to be more ambitious in its pursuit of the integration agenda and in identifying how it could lead to savings. Mr Bolam agreed but advised that it was not just the local community services that needed to be included in this, but the wider population. Mr Rappolt added that the plan needed to be consistent with other plans and targets, for example delivery of cost improvement targets and the IM&T plan.

The board acknowledged that the output of the programme of work to revise the integrated business plan and long term financial model, would probably lead to a review of these priorities, but that there needed to be a plan for the interim. The output of the IBP / LTFM review was expected in the autumn so the board would review the annual plan at that stage.

The board approved the narrative for submission to Monitor along with the financial plan and statements when approved by finance and performance committee. **R Elek May 2015**

15.04.21 Communications plan 2015/16

Mr Jenkinson presented the draft communications plan for 2015/16, summarising progress made against the priorities set for last year and the proposed priorities

for the following year. He highlighted particular progress made in external communications and promoting the profile of the trust, and the focus for the next year being internal communications and staff engagement.

The Board welcomed the progress made in the last year and agreed the proposed emphasis on internal communication but added that the plan should include promoting the role of the charity, research and education should be promoted and in particular the trust's relationship with the university. The Board also noted that the plan should include raising the profile of the board, with particular emphasis on their role, contribution and connection with staff.

15.04.22 Divisional presentation – Cancer services

The board welcomed the cancer management team to the meeting, including Chloe Cox, Divisional Director of Operations and Mr Anderson, clinical lead. Mr Anderson gave an introduction to cancer services – the board noted that the trust treated over 4,000 cancer patients each year and around a fifth of the London Cancer Alliance activity. Mr Anderson also highlighted the achievement of being the most improved trust in the London Cancer Alliance and in the top ten of most improved in the UK.

Mr Anderson highlighted performance of the service, including the need to improve the recording of contacts by the clinical nurse specialists and completion of holistic needs assessment. He also highlighted that the trust had less clinical nurse specialists than other peer trusts.

Mr Anderson outlined the strategy and vision for cancer services, including the development of a dedicated cancer centre. Macmillan had contributed £2.4m towards this development, but on a matched funding basis. The trust would therefore need to be able to commit to this in the near future in order to secure the funding. This would include identification of a location including the ambulatory care setting requirement. Formal proposals for this development would be presented to the board in due course.

The board noted the key challenges and risks facing the service, including capacity, informatics, service configuration and the conflict between elective and emergency activity.

Mrs Wilton asked about trust performance in cancer waiting times and dependence on the other providers. Mr Anderson confirmed that the trust was using the Transforming Cancer Services which had been successful in north London, to develop relationships with other providers and provide a forum to resolve issues between providers.

Mr Rappolt asked why the trust had not been able to resolve the issues regarding IT systems to enable the trust to link in with IT systems in other providers and therefore enable delivery of waiting time standards. Mr Anderson explained that the previous version of the Infloflex system had not allowed this but that this should be resolved by July; however it was dependent on all trusts using a common system. The London Cancer Alliance were driving this forward but timescales for implementation were still to be confirmed.

The board concluded that key to improving the trust's performance against cancer standards was both IT systems but also building good relationships with other providers.

Mr Rappolt asked about the profitability of the service. Mrs Cox explained that it was difficult to separate cancer patients from others so it was difficult to assess the profitability of cancer services. However it was noted that, if the service were to be seeking investment then it would need to know this level of information.

The board welcomed the update on the increased use of the surgical robot, particularly in urology but also with plans to extend its use into head and neck surgery and discussions ongoing with gynaecology and lower gastroenterology.

C Cox
tbc

The board thanked the team for the presentation and noted that proposals for the cancer centre development would return in due course.

15.04.23 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 that the first risk to be reviewed using this methodology would be the risk of impact on quality from cost savings, which would be reviewed at an extra-ordinary meeting of the quality and risk committee in May.

Mr Rappolt asked whether any risk assessment had been completed regarding the outcome of the general election. Mr Jenkinson noted that it had not been completed.

15.04.24 Audit committee annual report and work plan

The board received and noted the annual report from the audit committee and noted that it would also be presented to the council of governors at their next meeting.

P Jenkinson
May 15

Mr Smallwood asked how satisfied the committee were regarding the quality of the audit, for example audits on the fundamental financial systems. Mr Rappolt advised that the review includes whether systems captured and recorded activity appropriately and therefore would judge the data quality of the accounts. However the audits did not include forecasting. The audit programme had also not included management accounting but this would be discussed at the next audit committee meeting.

Mr Rappolt added that the committee assessed the performance of auditors on an annual basis and had agreed at the last review that the performance of the auditors had been satisfactory. However the current internal auditors had been with the trust for at least the past five years so it would be good practice to retender the service; therefore this would be completed for the next financial year.

The board agreed the internal audit plan for 2015/16.

15.04.26 Use of the trust seal

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

15.04.27 Questions from the public

Doulla Manoulas asked whether the governors could get involved in the

management audit. Mr Scott advised that audit was different from accountability and that governors should hold the non-executive directors to account for the performance of the board. The involvement of governors should be developed from that principle.

Hazel Ingram raised issues of patients having to queue for the triage service in the A&E department. Ms Hall reported that action was being taken to reduce the queuing in the triage area, with additional staff being put in place at busy times and identifying attendees who didn't need the triage service, for example visitors.

Felicity Metz asked about the future of urology services and the robot. Mr Scott confirmed that urology services would remain at the trust – it was an important service to the trust and the trust would therefore work to retain it.

Doulla Manoulas asked whether there had been any progress in the implementation of electronic health records. Mr Bolam gave a summary of developments including access to records – however this would be for clinicians only at first as public access would need to be agreed nationally.

15.04.28 Any other business

There was no other business.

15.04.29 Date of the next meeting

The next meeting of the Trust Board will be held on 30 April 2015 at 9.00am.

St George's University Hospitals NHS
NHS Foundation Trust

Matters Arising/Outstanding from Trust Board Public Minutes
28 May 2015

Action No.	Date First raised	Issue/Report	Action	Due Date	Responsible officer	Status at 28 May 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	ASAP	Jennie Hall	To be placed on March Trust Board agenda - **Deferred**
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	
15.02.06	26.02.15	Quality & Performance Report:- RTT performance	Commissioners had issued a 'joint investigation' letter requiring the trust to participate in a two month project to improve performance as the trust failed to meet the target. SB to share the outcome report following the investigation	May 15	Martin Wilson	Met with commissioners and agreed an investigation and terms of reference. Part way through investigation. Conclusions will emerge during May and result in an action plan.
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	
15.04.20	28.04.15	Draft Annual Plan	Approved the narrative for submission to Monitor along with financial plan when approved by F&P	May 15	Rob Elek	ON AGENDA
15.04.15	28.04.15	Divisional Presentation – Cancer Services	Development of Cancer Centre proposal to be submitted to Board	TBC	Chloe Cox	
15.04.24	28.04.15	Audit committee annual report and work plan	Audit committee report to be presented to the council of governors at their next meeting	May 15	Peter Jenkinson	

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – MAY 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 Joint working with St. George's University of London

We are delighted at the appointment of Dr Anne-Marie Reid as the new Dean for Teaching and Learning. Currently, Dr Reid works as a Senior Lecturer at the Leeds Institute of Medical Education where her responsibilities include leading curriculum development of the MBChB programme, teaching and research. Her professional background is as a Dental Practitioner. She has been involved in lecturing in Higher Education for the past 15 years. She has also taught and managed nursing and healthcare programmes and has worked closely with the NHS in developing new assistant and advanced roles in healthcare. We look forward to working closely with her; particularly given that a key item on our work programme is the development and implementation of a joint Education Strategy.

The operational model for a greater integration of the Cardiology work done across our two organisations is still in the process of being finalised. We are also looking at how we can roll this out to other specialties.

1.02 Collaboration for Leadership in Applied Health Research and Care (CLAHRC)

Work continues on the CLAHRC South London, and the annual report for 2014-15 (its first year) has just been submitted to the National Institute for Health Research (NIHR). This year's achievements include a new MSc in Implementation and Improvement Science that will launch in September 2015. This is believed to be the first Master's focussing on implementation science in the country, created and taught by researchers from King's College London and from the Faculty of Health, Social Care and Education (a joint venture between SGUL and Kingston University).

Another highlighted achievement is for palliative and end of life care services. The research team has worked collaboratively with Hospice UK to produce resource packs that include a suite of outcome measures (chosen with the help of south London health professionals, patients and family members) and information about how to use them. These packs are now available to palliative care services across the UK. More information on the work of the CLAHRC South London, courses and events is on the ever developing website at www.clahrcsouthlondon.nihr.ac.uk

1.03 System Resilience Group

Over the last month there has been significant cross system planning work coordinated through our active involvement in the local System Resilience Group (SRG). SRGs are based around each local acute hospital, and bring together key senior leaders from all local NHS and local authority organisations to ensure the operational resilience of the local health and social care system.

The St George's, Wandsworth, Merton and Lambeth SRG has been in existence since summer 2014 and has helped to ensure very strong working relationships between the local organisations, despite the operational pressures that the system has faced over the winter due to exceptional levels of demand and on-going capacity constraints.

During the last 4-8 weeks we have been working closely together as an SRG to ensure that we have a shared system wide view of activity demand pressures, available capacity and the likely implications for service performance over the next 12 months. As not all of the anticipated bed capacity can be closed within available resources, the SRG is reviewing its ways of working to ensure a stronger focus on supporting system wide transformation, with the aim of reducing the length of stay in hospital for patients admitted to St George's. A further update on this will be provided in future Board updates.

2. IM&T

2.01 ICT – Cerner Millennium Acute Information System

The Cerner Millennium Acute Clinical Information System (iCLIP) System was successfully transferred from BT to a Cerner UK hosted service over the weekend of the 25th/26th April 2015. Cerner is now maintaining this system under a direct service contract with St George's.

3. Communications

3.01 Monitor Briefings

On Friday 1st May 2015 Monitor notified St George's University Hospitals NHS Foundation Trust of their decision to open a formal investigation into the trust's compliance with its licence. This investigation will focus on Monitor's concerns regarding the trust's financial position, as well as its performance, and will culminate in:

- A report from the independent accounting review
- An update from our turnaround advisory contract
- Plans to complete the turnaround, including clear trajectories, covering one, two, and five year horizons. These plans will confirm any capacity and capability requirements to deliver the turnaround, including the turnaround advisory support.

The independent accounting review commenced this week, and the work on turnaround will mobilise 29th May or 1st June.

<u>Staff Briefings</u>

Six Staff Briefings were held from 1st May – 8th May in order to provide staff with an update on the latest developments regarding the trust's financial position and the Monitor investigation. The slide deck presented the FY16 plan and its delivery, detailed the reasons for the Monitor Investigation, outlined measures for maintaining quality and safety and encouraged open dialogue with staff.

<u>Contact with MPs</u>

With the election having taken place and the MPs in South West London having now taken office, the trust has sent out stakeholder letters - which had already been circulated to local

councils and CCGs during purdah - to the MPs themselves so that they are aware of the current situation in St George's.

Governors Briefings

Two meetings will be organised with the Governors ahead of the Council of Governors meeting to be held on Thursday 9th July.

3.02 New Chief Officer Merton CCG

Adam Doyle, Merton CCG's current Director of Commissioning and Planning, has been appointed as their new Chief Officer. Merton CCG's current Chief Officer, Eleanor Brown, is retiring on 5th July and her final day in the office will be 19th June 2015. Adam will take up the post of Chief Officer on 6th July.

3.03 St George's celebrates International Nurses' Day

St George's marked International Nurses' Day on Friday 8th May with the trust's annual nursing awards, which identify and celebrate the nurses, midwives, healthcare assistants and mentors in the trust who have made an outstanding contribution to patient care. Awards were presented for nurse of the year, midwife of the year, healthcare assistant of the year and mentor of the year. Patients, colleagues, mentors or managers can nominate a person who has made a special contribution to nursing practice.

Jennie Hall, chief nurse and senior nursing colleagues also gave presentations on compassionate, caring and cost effective practice.

The winners of the International Nurses' Day Awards were as follows:

Names	Job title	Department	Award
Audrey Watkin-Russell	HCA	Champneys Ward	HCA of the year
Ernest Siquian	HCA	Neuro Intensive care	Runner up HCA of the Year
Nadia Stancill	Ward Sister	Florence Nightingale	Nurse of the year
Emma Cowley	Staff Nurse	Florence Nightingale ward	Runner up Nurse of the year
Jodette Holly	Midwife	Maternity	Midwife of the year
Chantelle Winstanley	Consultant Midwife	Maternity	Runner up Midwife of the year
Georgina Couchman	Junior Sister	McEntee ward	Mentor of the year
Jen Tullock	Dementia Clinical Nurse Specialist		Aunty Lucy winner of the year

3.04 Official opening of Gordon-Smith ward

The trust invited Dr Anne Rainsberry, NHS England's Regional Director for London, to open the trust's new cancer ward.

Gordon-Smith ward will provide an additional 20 beds to treat a diverse number of patient groups, including those with leukaemia, lymphoma and non-malignant conditions of the blood such as bleeding disorders, thrombosis and sickle cell anaemia, in a clean, modern inpatient environment.

Professor Ted Gordon-Smith, who was a Professor of Haematology at St George's for 25 years, was also in attendance.

3.05 National Thrombosis Week – 5th to 8th May

To mark National Thrombosis Week this year, the trust's VTE nurses, Ediscyll Lorusso and Krish Fowdar, ran a variety of activities to raise awareness of thrombosis prevention.

On the Tuesday, Ediscyll and Krish gave a showcase of VTE nurses' skills on fitting anti-embolism stockings (AES), Intermittent Pneumatic Compression Device (IPCD) and how to inject fragmin properly as well as an educational event giving staff the chance to quiz the Thrombosis Team and Pharmacist novel oral anticoagulants, referring patients to the anticoagulation team, bridging and a variety of other topics.

A "VTE champion" award was also awarded to Tricia Bennett, discharge coordinator from Brodie ward in recognition for her tireless efforts in VTE prevention.

3.06 World Asthma day – 5th May

On Tuesday 5th May, World Asthma Day, staff from respiratory physiology at the Dragon Centre showcased new equipment for children with asthma, which was funded by St George's Hospital Charity.

3.07 World Hand Hygiene day – 5th May and 7th May

World Hand Hygiene Day was celebrated at the trust on Tuesday 5th May and Thursday 7th May. It was started by the World Health Organization (WHO) and encourages patients and their family members to join health workers in their efforts to practice good hand hygiene.

As well as there being a stand encouraging staff to make pledges to provide or promote clean hands, there was also an opportunity to try new mobile SureWash machines which were funded by St George's Hospital Charity. These high-tech pieces of kit measure performance and provide real time feedback for staff on their hand washing techniques.

3.08 24 Hours in A&E filming at St George's

Filming for the second round of the flagship Channel 4 show began on Thursday May 14th, and will continue for just over two months. The next episode (still from the previous filming they did) will be aired at 9pm on Wednesday 27 May.

3.09 Reflection and sharing common experiences - Schwartz Rounds

Over 100 staff attended the first Schwartz round at the trust which gave staff a chance to discuss the highs and lows of work in a confidential, expertly facilitated environment. Participants had the opportunity to talk about the emotional and social aspects of their jobs, led by a panel of employees chosen from across the Trust.

Panellist Peter Green, Children's safeguarding lead/Wandsworth CDOP Chair, reflected on the event – "A brilliant initiative and one I am very happy to evangelise for. Well done for setting it up and thank you for asking me to help kickstart an important bit of George's future"

3.10 Antibiotic Resistance

Antibiotic resistance continues to receive a lot of media attention. We launched a new antibiotic specific trust twitter account @StGantimicrobial where the team can share information about the excellent work we are doing here to promote stewardship.

3.11 Improving our internal communications

A Listening into Action event about communications took place on Thursday 21st May – the outcome was an action plan for the team. A survey on how staff feel about internal communications was circulated to prior to the event and will fed into the discussion.

3.12 Social media

We have run two social media competitions this month. One focussed on asking our community to share why St George's is special to them, in order to help us celebrate St George's Day. We received over 20 entries including photos, special memories and poems about St George's Hospital. Our Facebook posts were seen by over 3,000 people. The winners will be going up to see our helipad view later in May. Our second competition is currently still open, challenging Tooting residents to share their talent with us to be in with the chance of winning two tickets to the 'Britain's Got Talent' LIVE semi-finals.

3.13 Macrobiotic APP

St George's launched a specialised smartphone app that will help our clinicians with antimicrobial prescribing. The Microguide App, which can run off both iPhone and Android platforms will offer staff a readily available resource, with up-to-date prescribing guidelines specific to our trust.

Our ability to update the App content will ensure that all guidelines are current so old versions are not inadvertently used. This will assist with good antimicrobial prescribing, which is crucial to an effective antimicrobial stewardship programme. The is one of the Apps clinicians are developing to improve the quality of care we provide.

3.14 Filming and Radio

NICE have visited us twice in the last month. Once to film an interview with Aidan Slowie, Lead Nurse Major Trauma about A&E safe staffing guidelines, which are due to be published in June; and the second time to record a BBC Radio 4 interview with Dr Jane Adam, discussing how NICE make decisions about which drugs to recommend. They were

particularly interested in an ovarian cancer drug called olaparib, which Jane chairs the committee for.

FreshOne productions were on site with Jamie Oliver this month. They were here to film interviews with Richard Porter, Consultant in Restorative Dentistry, and some patients about sugar and dental health. The day was a success and Jamie et al were pleased: particularly with Richard. The sugar documentary will be aired in June.

Both BBC London 94.9 Radio and ITV London News came to St George's this month to speak to Alison Loosemore, Hyper Acute Stroke Ward Sister, Barry Moynihan, Stroke Consultant, and Christine, stroke patient. This was spurred by a Stroke Association report which had drawn the conclusions that: "working age" (under the age of 60) strokes have increased, and that a sedentary lifestyle and poor diet were the driving causes for this. Unfortunately the BBC did not feature Barry's interview but they did replay snippets of Alison's words. You can listen to it here on iPlayer (01:17-01:22 and 02:19-02:23).

Catherine Collins, Principle Dietitian at St George's featured in BBC Radio 4's Today Programme, discussing aspartame sweeteners. This interest came from Pepsi's announcement that they will be removing it from their products. You can listen to interview here from 2.46 onwards.

3.15 Trust news

We published a piece on the new Gordon Smith ward opening on the site. This was shared on Facebook and twitter where is has been read by over 2,200 people, "liked" over 60 times and shared by 12 individuals. It is also being written up as an article in Wandsworth Guardian and Tooting Daily Press.

We also published an article about working with Mitie to support Project SEARCH. This was shared on twitter and Facebook where it has been read by over 1,000 people.

Additionally, we published an article about St George's celebrating International Nurses' Day with an awards ceremony. This was shared on twitter and Facebook where it has been read by over 8,000 people, "liked" nearly 80 times and shared by 15 individuals.

We published an piece on the St George's organ transplant team being one of the best in the country. This was shared on twitter and Facebook where it has been read by over 2,000 people, "liked" nearly 40 times and shared by 18 individuals.

The HSJ published an article about Monitor looking into our finances. National Health Executive, Hospital Doctor and Radio Jackie also covered this. We have published a public statement on our website.

REPORT TO THE TRUST BOARD TB May 15 – 02a

Paper Title:	Quality and performance Report to the Board for Month 1- April 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
1 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
Purpose:	To inform the Board about Quality and Operational Performance for Month 1.
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, RTT, and cancer 62 day targets performance.

The trust shows quality governance score against 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 April Quality Performance:

The Overall position in April indicates that some progress has been made against some Quality Metrics but that early trend in relation to the Mortality profile and Serious Incident numbers remain which need to be closely monitored alongside other metrics.

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. Mortality data is unchanged from the reported March position. The Trust remains fully engaged in pilot work (PRISM 2) focussing on the relationship between avoidable deaths and hospital wide standardised mortality rates.

- The Trust participated in 97.3% of national audits, an improved position from 2013/14. In the two audits we did not participate in work has now begun to collect data.
- The report indicates the position with compliance with NICE guidance for the period Jan 2010 to Jan 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 April 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 an on-going increase. Of the 16 declared the Board will note that the timeline of when the incident occurred ranges between November and March. 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 regarding a retained dental swab. 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 decreased slightly from March performance. There was a decrease in patients with old and new pressure ulcers. There was an increase in Catheter related Urinary Tract Infections. Focussed work streams continue to support improved performance i.e. pressure ulcers, falls and VTE assessment.
- The pressure ulcer profile for April reduced from the March position in terms of grade 3 and 4 ulcers (8 down to 2 cases) with a decrease also in grade 2 ulcers. As previously reported to the board a deep dive review has already been completed 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 VTE profile is largely unchanged. Following intervention with the IClip roll out the Trust is now consistently achieving the risk assessment of patients during admission, (Table 1). Table 2 indicates the findings from the snapshot audit undertaken during collection of Safety Thermometer data. Of note for the board is the requirement for the Trust to amend how the audit data is collated to ensure that the denominator figure is correct.
- The Trust has now reported 2 MRSA bacteraemia cases and 3 C-Difficile to the end of April. 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:

- The response rate for FFT decreased in but with an improvement for the inpatient wards and Emergency Department but deterioration for rates in Maternity areas. Overall score for the Trust improved in April to a score of 92.4%. 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 summary includes the quarterly summary for complaints activity during Quarter 4 of 14/15. Key headlines from the Quarter include a reduction in total complaint numbers from Quarter 3. For the year the trend is a small reduction but not statistically significant.
  - The most common themes in relation to complaints are all aspects of clinical treatment, appointment delay and cancellation, communication and attitude of staff.
  - Each Division has outlined the key areas of learning from previous complaints.

Progress has been made over the last nine months in Divisions to strengthen the learning from complaints, to ensure that appropriate actions are in place. The success of the learning is demonstrated in areas where there is a consistent reduction in complaint numbers.

- However the Turnaround time for complaints was not achieved for the 25 day target in Quarter Four despite focus and assurance from the Operational Divisions. The Board will note progress was made in relation to complaints where extensions had been agreed with individual complainants with all of the Operational Divisions achieving the internal target. 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 94.10 % across these areas. 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. A data quality review was completed to ensure accuracy of the returns in January 2015.
- Work continues to be led by the Chief Nurse to ensure that appropriate numbers of staff are recruited, to address the current turnover profile, and to drive a reduction of the vacancy factor to 10%, the establishment review and additional capacity. The Central programme is in place to coordinate activity in relation to Nursing/ Midwifery recruitment and retention activity to supplement existing Divisional activity.

Ward Heat map:

The Heat map for April 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

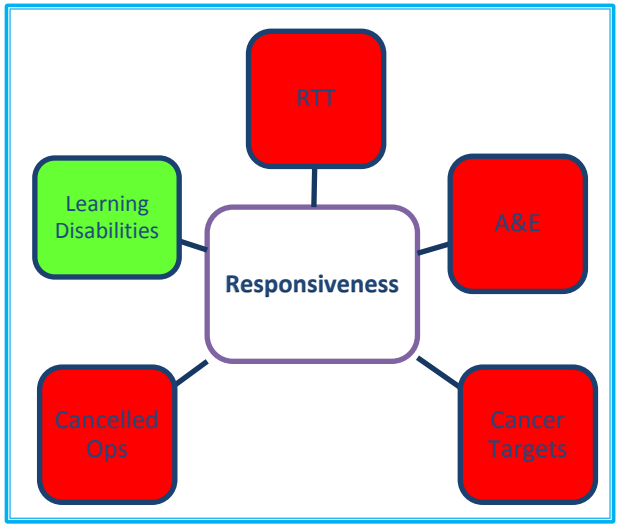
Performance & Quality Report

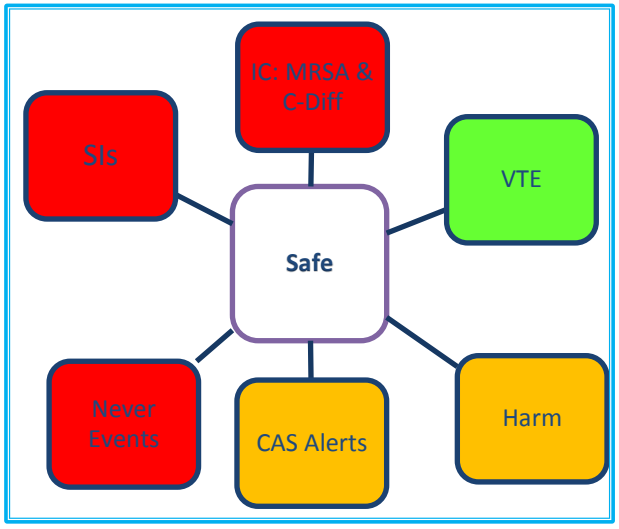
Trust Board
Month 1 – April 2015

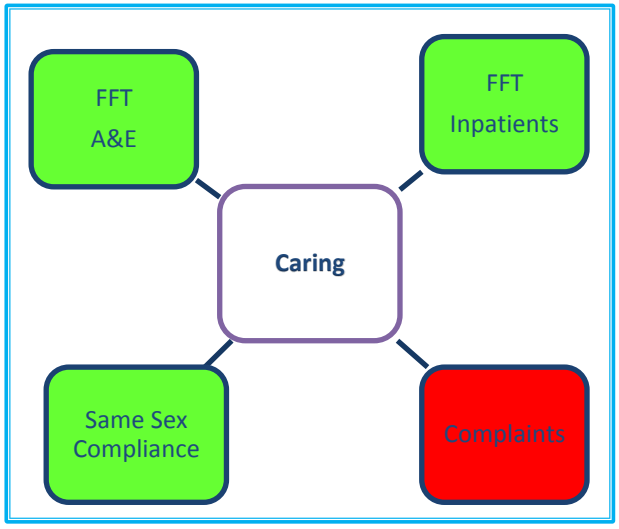
excellent kind responsible respectful

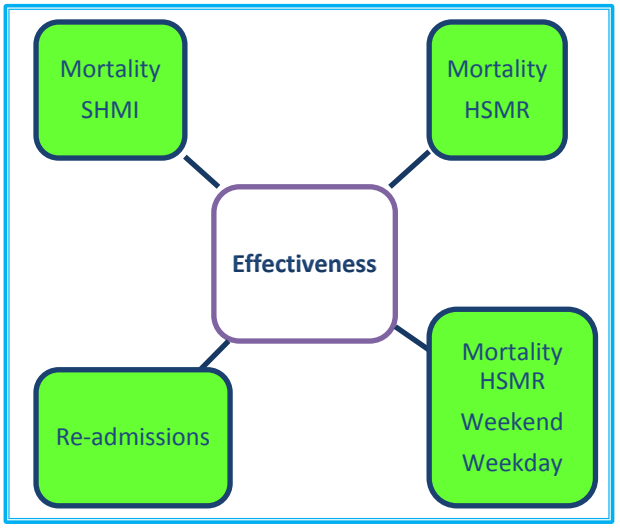
CONTENTS

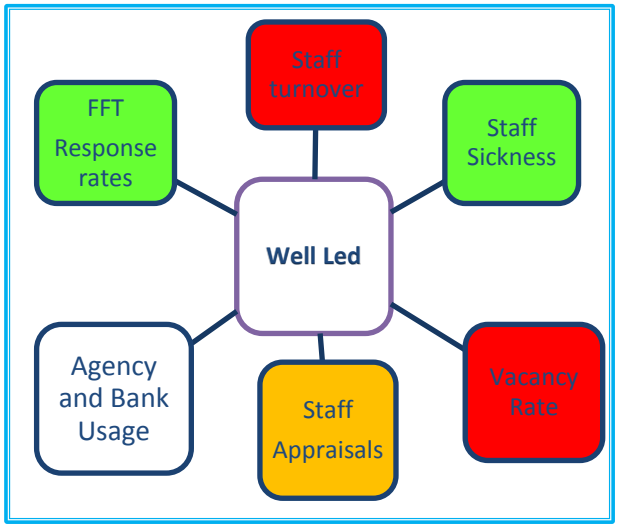
1. Executive Summary - Key Priority Areas April 2015











The above shows an overview of April 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 Q4 to March 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: April 15 Performance (Page 1 of 1)

Access							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Mar**	**Apr**	**Movement**
Referral to Treatment Admitted	90%	1	1		81.6%	84.3%	↑
Referral to Treatment Non Admitted	95%	1	0		94.9%	95.15%	↑
Referral to Treatment Incomplete	92%	1	1		89.7%		
A&E All Types Monthly Performance (Quarter to date)	95%	1	1	93.59%	88.39%	92.25%	↑
				YTD	**Q3**	**Q4**	
62 Day Standard	85%	1	1	84.7%	83.5%	82.5%	↓
62 Day Screening Standard	90%			91.5%	92.5%	87.5%	↓
31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	→
31 Day Subsequent Surgery Standard	94%		0	98.5%	98.5%	97.6%	↓
31 Day Standard	96%	1	0	97.8%	97.2%	96.9%	↓
Two Week Wait Standard	93%	1	0	95.9%	96.9%	96.8%	↓
Breast Symptom Two Week Wait Standard	93%	1	0	96.6%	96.1%	97.69%	↑

* NYA Not yet available

Outcomes							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Mar**	**Apr**	**Movement**
Clostridium Difficile - Variance from plan	31	1	0	0	-2	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		53%	53%	→
referral information	50%	1	0		88%	87%	↓
treatment activity	50%	1	0		71%	70%	↓
Trust Overall Quality Governance Score					2	**4**	→

April 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 62 Day Waits
- Cancelled Operations
- 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: April 15 Performance (Page 1 of 1)

Responsiveness Domain					
Metric	Standard	YTD	March	Apr	Movement
Referral to Treatment Admitted	90%		81.6%	84.3%	↑
Referral to Treatment Non Admitted	95%		94.9%	95.15%	↑
Referral to Treatment Incomplete	92%		89.7%		
Referral to Treatment Incomplete 52+ Week Waiters	0		1		
Diagnostic waiting times > 6 weeks	1%		2.1%	3.24%	↑
A&E All Types Monthly Performance	95%	92.52%	88.39%	92.25%	↑
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%	14.5%	17.9%	↑
Certification against compliance with requirements regarding access to health care for people with a learning disability	Compliant	Yes	Yes	Yes	→
	Standard	YTD	Q3	Q4	Movement
Two Week Wait Standard	93%	95.9%	96.9%	96.8%	↓
Breast Symptom Two Week Wait Standard	93%	96.6%	96.1%	97.69%	↑
31 Day Standard	96%	97.8%	97.2%	96.9%	↓
31 Day Subsequent Drug Standard	98%	100.0%	100.0%	100.0%	→
31 Day Subsequent Surgery Standard	94%	98.5%	98.5%	97.6%	↓
62 Day Standard	85%	84.7%	83.5%	82.5%	↓
62 Day Screening Standard	90%	91.5%	92.5%	87.5%	↓

Safe Domain					
Metric	Standard	YTD	March	April	Movement
Clostridium Difficile - Variance from plan	0	0	-2	0	↓
MRSA bacteraemia	0	2	2	2	→
Never events	0	1	1	1	→
Serious Incidents		18	26	18	↓
Percentage of Harm Free Care	95%		94.39%	94.20%	↓
Medication errors causing serious harm	0	0	2	0	↓
Overdue CAS alerts	0	2	2	2	→
Maternal deaths	1	0	0	0	→
VTE Risk Assessment (previous months data)	95%		96.03%	96.27%	↑

Effectiveness Domain					
Metric	Standard	YTD	March	April	Movement
Hospital Standardised Mortality Ratio (DFI)	100		89.8	89.8	→
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		81	86	↑
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	5%	3.14%	2.97%	3.14%	↑

Caring Domain					
Metric	Standard	YTD	March	April	Movement
Inpatient Scores from Friends and Family Test	60		95.2%	95.7%	↑
A&E Scores from Friends and Family Test	46		79.3%	83%	↑
Complaints * previous months data			78	81	↑
Mixed Sex Accommodation Breaches	0	0	0	0	→

Well Led Domain					
Metric	Standard	YTD	March	April	Movement
IP response rate from Friends and Family Test	30%		47%	38.9%	↓
A&E response rate from Friends and Family Test	20%		22%	23.8%	↑
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%		17.3%	17.54%	↑
Trust level total sickness rate	3.50%		4.2%	3.21%	↓
Total Trust vacancy rate * previous months data only	11%		13.2%	14.23%	↑
Percentage of staff with annual appraisal - Medical	85%		85.9%	87%	↑
Percentage of staff with annual appraisal - non-medical	85%		75.9%	75.23%	↓

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 5) - A&E: 4 Hour Standard

Total time in A&E - 95% of patients should be seen within 4hrs						
Lead Director	March	April	Movement	2015/2016 Target	Forecast May- 15	Date expected to meet standard
FA	88.39%	92.25%	▲	>= 95%	R	June-15

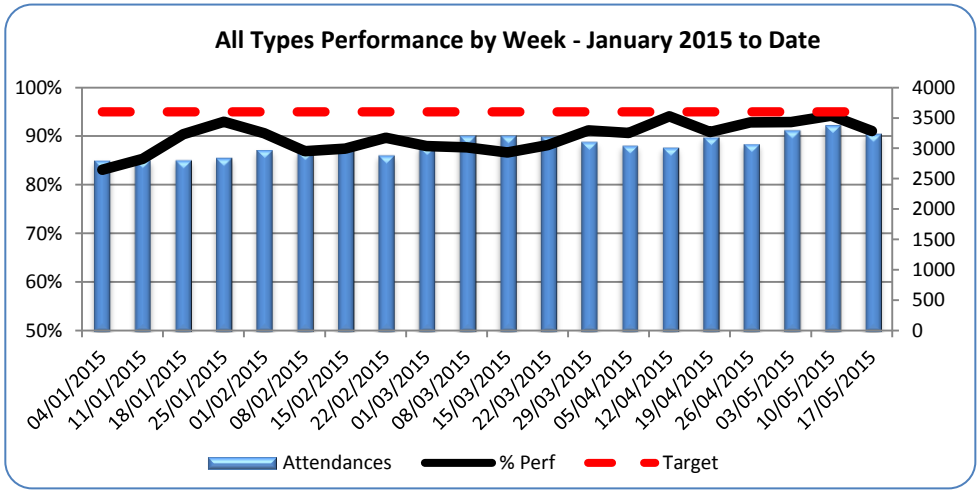
Peer Performance Q4 at end March 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
88.29%	91.9%	91.5%	85.8%	94.8%

The ED target is that 95% or more of patients should be seen and discharged within 4 hours of attending the Emergency Department. In recent weeks performance improvement can be observed, however, it is still proving to be a challenge not just for St George's, but many hospitals nationally. In April 2015, 92.25% of patients were seen within 4 hours, this is an improvement on March's position when performance was 88.4%.

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.

A small sub group of trust and commissioner executive directors is being convened to consider how best to model these themes and the envisaged impacts into the forward trajectory of demand and performance.



Performance Overview by Type			
	ED (Type 1)	MIU (Type 3)	ED & MIU (Type 1+3)
Month to Date (March)	91.45%	99.67%	92.25%
Quarter to Date	91.45%	99.67%	92.25%
Year to Date	91.45%	99.67%	92.25%

3. Performance Areas of Escalation (Page 2 of 5) - RTT Admitted Pathways

Referral to Treatment Admitted Pathways						
Lead Director	March	April	Movement	2014/2015 Target	Forecast May – 15	Date expected to meet standard
SB	81.6	84.3	▲	90%	R	TBC

Over the last 9 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
- Continue to strengthen management focus on 18 week RTT delivery within specialties, divisions and the trust as a whole

3. Performance Areas of Escalation (Page 3 of 5) - 62 Day Wait Standard

62 Day Wait Standard						
Lead Director	Q3	Q4	Movement	2015/2016 Target	Forecast Apr – 15	Date expected to meet standard
CC	83.3%	82.5%	↘	85%	G	Apr - 15

Peer Performance Latest Published Q4 2014-15				
STG	Croydon	Kingston	King's College	Epsom & St Helier
82.5%	88.6%	83.6%	83.2%	58.1%

62 Day Screening						
Lead Director	Q3	Q4	Movement	2015/2016 Target	Forecast Apr - 15	Date expected to meet standard
CC	92.5%	87.5%	↘	90%	G	Apr -15

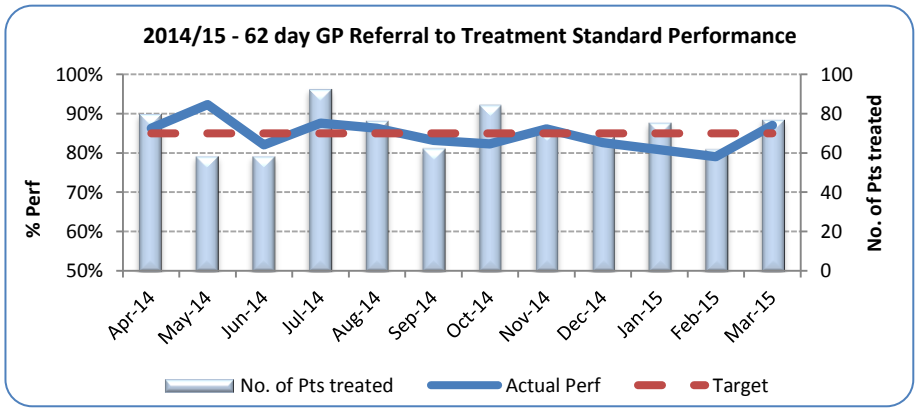
Peer Performance Latest Published Q4 2014-15				
STG	Croydon	Kingston	King's College	Epsom & St Helier
86.9%	100%	61.1%	97.5%	n/a

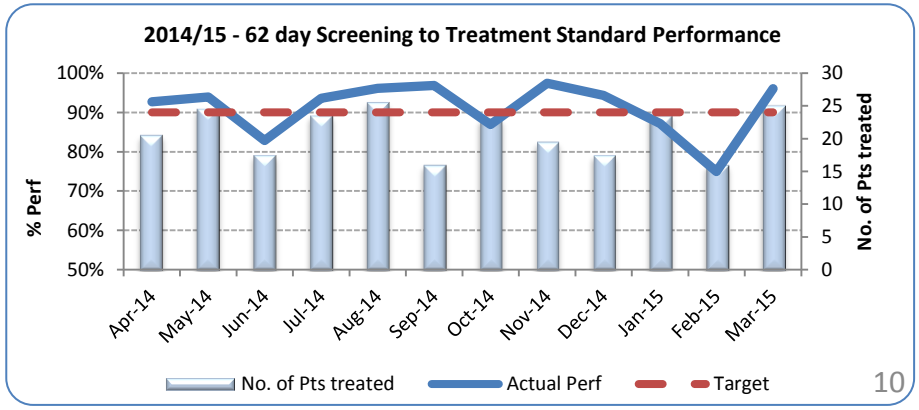
The Trust met all of its cancer targets in March, with the exception of the 62 Day Consultant upgrade where performance was 50% as a result of a shared breach in Urology with one patient. However, two targets were unmet for the quarter overall namely the 62 Day Standard with performance of 82.5% against a target of 85% and the 62 Day Screening standard with performance at 87.5% against a target of 90%. The year to date position for all cancer waits were within target with the exception of the 62 Day standard .

Key factors for underperformance in Q4 are as follows:

- Capacity constraints in particular with regards to Urology.
- Late referrals from other trusts (referrals received after day 42). 62 Day standard performance excluding late referrals would be 88% which would be within target.
- Patients on complex diagnostic pathways.

The trust continues to implement actions and pro-actively track patients to bring performance back within target. 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 in early July.

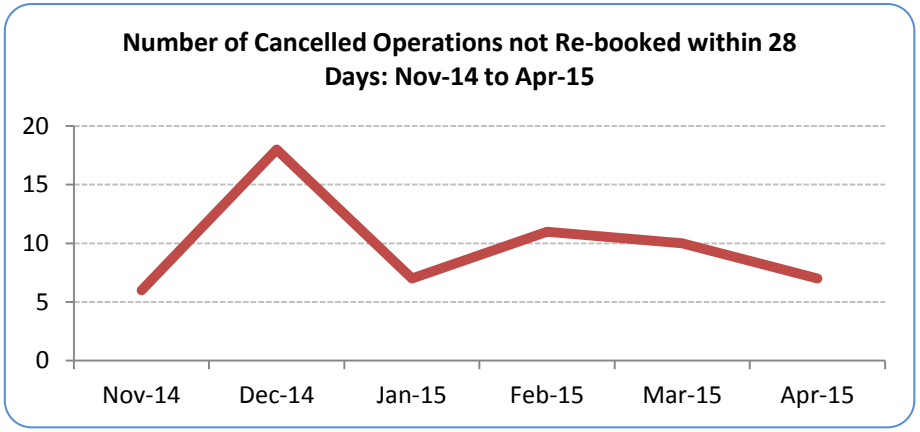


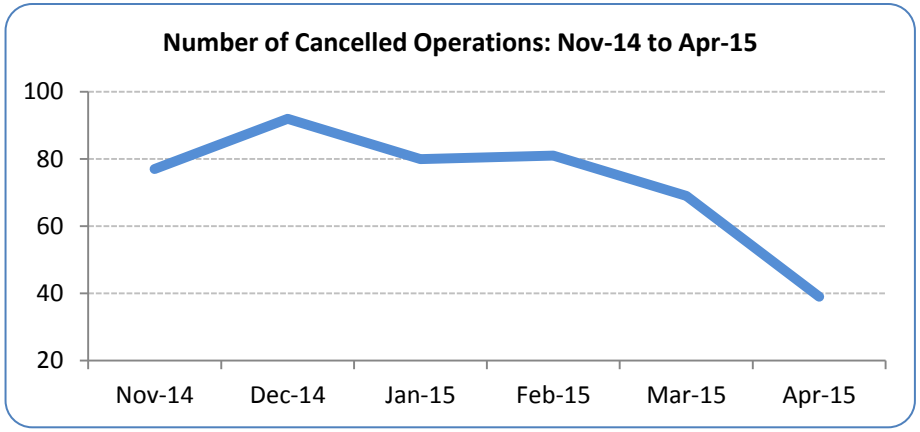


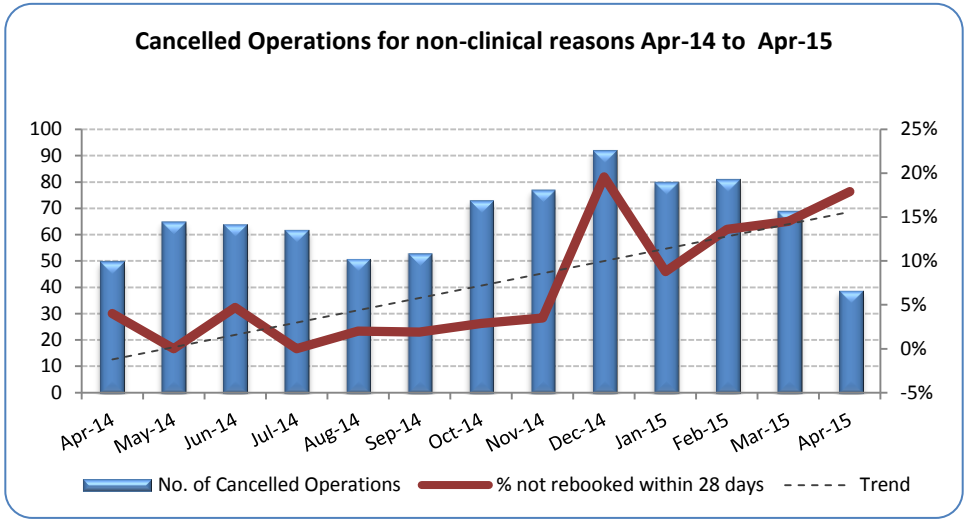
3. Performance Areas of Escalation (Page 4 of 5) - Cancelled Operations

Proportion of Cancelled patients not treated within 28 days of last minute cancellation						
Lead Director	March	April	Movement	2015/2016Target	Forecast May – 15	Date expected to meet standard
CC	14.5%	17.9%	▲	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 39 cancelled operations from 4143 elective admissions in March. 32 of those cancellations were rebooked within 28 days with 7 patients not rebooked within 28 days, accounting for 17.9 % of all cancellations. The overall number of cancellations has been seen to be reducing month on month from December-14.

The breaches were attributable to Cardiology and Vascular specialties. Key contributory factors for the cancellations were related to; clinician capacity and an increase in emergency/trauma demand and high bed occupancy resulting in a lack of ITU beds for post surgical admission.

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 5 of 5) - Diagnostic 6+ Weeks Wait

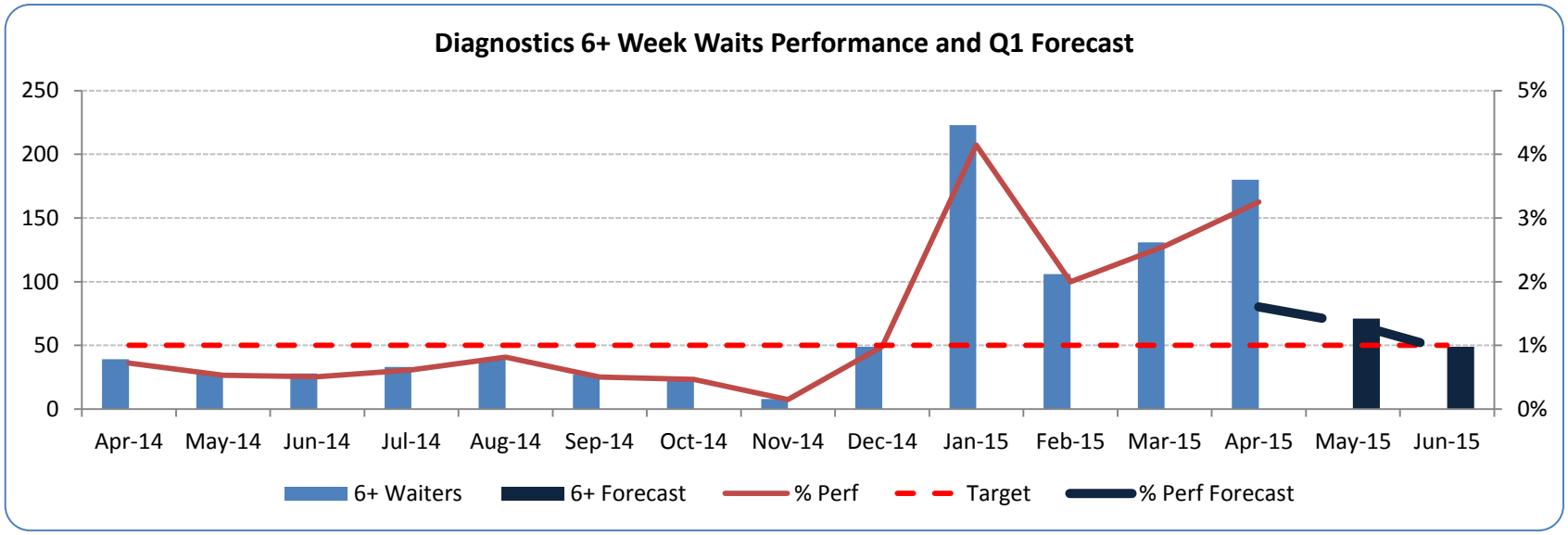
Diagnostic waiting times > 6 weeks						
Lead Director	March	April	Movement	2015/2016Target	Forecast May – 15	Date expected to meet standard
CC	2.1%	3.24%	▲	1%	R	Jun- 15

No of Patients waiting >6 weeks as at end March 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
105	2	18	191	17

The trust experienced a spike in breaches in diagnostic tests in January exceeding the target of number of patients waiting greater than 6 weeks of 1% of all waiters. The trust put actions into place and has seen positive performance improvement with a decrease in numbers waiting greater than 6 weeks. The number of patients waiting greater than 6 weeks has reduced from January position of 223 to 180 patients at end of April. The trust faced a number of challenges in April relating to staffing and capacity which affected performance and resulted in the numbers of patients waiting greater than 6 weeks to increase. Key challenged modalities include :

- MRI
- Dexa Scanning
- Non-obstetric ultrasound
- Cystoscopy

Issues affecting Dexa-scanning have been resolved and there are currently no patients waiting greater than 6 weeks. Continued areas of challenge are MRI and Non-obstetric ultrasound. A number of staffing issues are being pro-actively addressed and additional lists are being run with a positive reduction in backlog being observed. Further review of demand and capacity is being undertaken in these modalities in line with trajectory to support further reduction of the backlog and performance sustainability.



4. Divisional KPIs Overview 2014/15: April 15 Performance (Page 1 of 2)

Metric Group	MetricDesc	Unit	April 2015 COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST- ALL LEVELS
Access Metrics	CANCELLED OPERATIONS RE-BOOKED WITHIN 28 DAYS (DIVISION)	%	0	25.9	0	0	17.9
	LAS HANDOVER WITHIN 15 MINS	%					20.6
	LAS HANDOVER WITHIN 30 MINS	%					79.6
	LAS HANDOVER WITHIN 60 MINS	No.					2

Metric Group	MetricDesc	Unit	April 2015 COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST- ALL LEVELS
Quality Governance Indicators	PATIENT SATISFACTION (FRIENDS & FAMILY)	%	97.6	95	94.9	91.1	94.3
	PERCENTAGE OF STAFF APPRAISAL (MEDICAL) - (DIVISION)	%	76.8	77	77.7	74.5	75.3
	PERCENTAGE OF STAFF APPRAISAL (NON-MEDICAL) - (DIVISION)	%	66.7	86	87.7	89.7	87
	SICKNESS/ABSENCE RATE - (DIVISION)	%	5.7	3	2.9	2.3	3.2
	STAFF TURNOVER - (DIVISION)	%	19.6	18.4	14.5	18.1	17.4
	VOLUNTARY STAFF TURNOVER - (DIVISION)	%	15.6	16.1	12.3	13.5	14.1

Metric Group	*Note: Cancer performance is reported a month in arrears, thus for March 2015*	Unit	March 2015 COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST- ALL LEVELS
Access Metrics	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (BREAST SYMPTOMS) - (	%	0	0	99.2	0	99.2
	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (CANCER) - (DIVISI	%	0	0	97.4	0	97.4
	31 DAY SECOND OR SUBSEQUENT TREATMENT (DRUGS) - (DIVISION)	%	0	0	100	0	100
	31 DAY SECOND OR SUBSEQUENT TREATMENT (SURGERY) - (DI\	%			94.9		94.9
	31 DAY STANDARD FROM DIAGNOSIS TO FIRST TREATMENT - (DIVISIOI	%			97.4		97.4
	62 DAY URGENT GP REFERRAL TO TREATMENT FOR ALL CANCEI	%			87		87
	62 DAY URGENT GP REFERRAL TO TREATMENT FROM SCREENING - (D	%			96		96

4. Divisional KPIs Overview 2014/15: April 15 Performance (Page 2 of 2)

Metric Group	MetricDesc	Unit	COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST- ALL LEVELS
Outcome Metrics	C-SECTIONS (APPLICABLE TO WOMEN & CHILDREN ONLY)	%				22.7	22.7
	INCIDENCE OF C.DIFFICILE	No.	1	2	0	0	3
	INCIDENCE OF E-COLI	No.	0	28	1	3	32
	INCIDENCE OF MRSA	No.	0	1	0	1	2
	MATERNAL DEATHS	No.	0	0	0	0	0
	NEVER EVENTS	No.	0	0	1	0	1
	SERIOUS INCIDENTS (DIVISION LEVEL)	No.	1	14	3	0	18
	SHMI	Ratio					0.9
	TRUST ACQUIRED PRESSURE SORES	No.	2	2	0	1	5

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 April, 20.6% of patients had handover times within 15 minutes and 79.6% within 30 minutes. Overall performance in the sector was 44.5% for 15 minutes and 92.6% for 30 minutes, both of which are not within target.

The trust has a zero tolerance on avoidable pressure ulcers and has placed significant importance on its prevention. In April the trust had 2 pressure ulcer SI's, 2 Grade 3'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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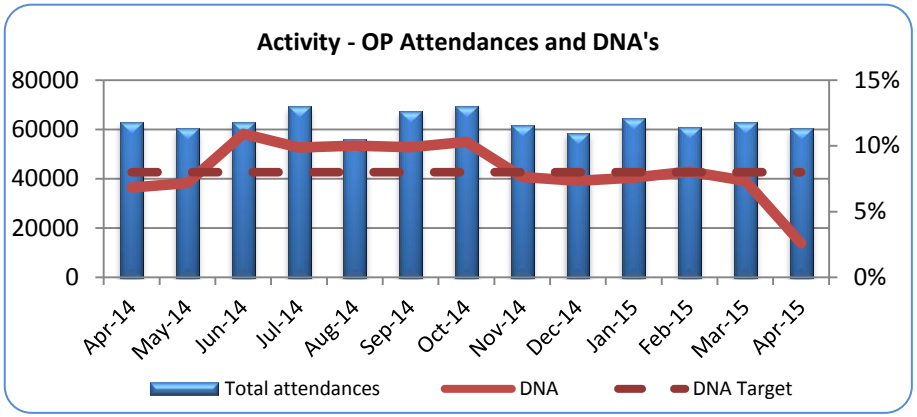
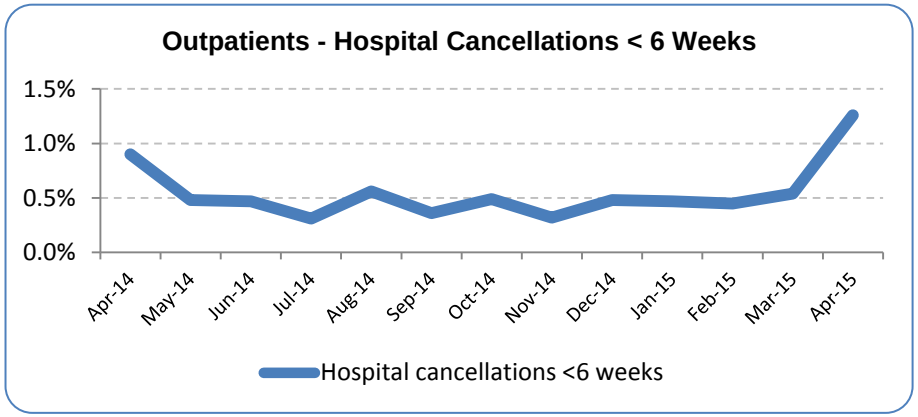
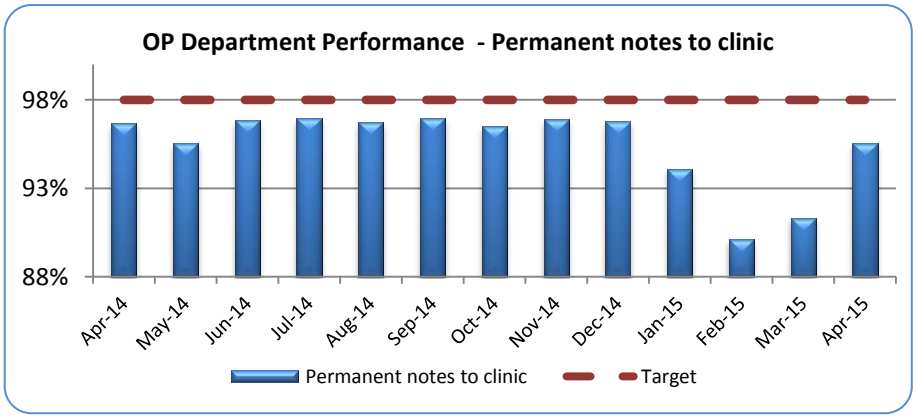
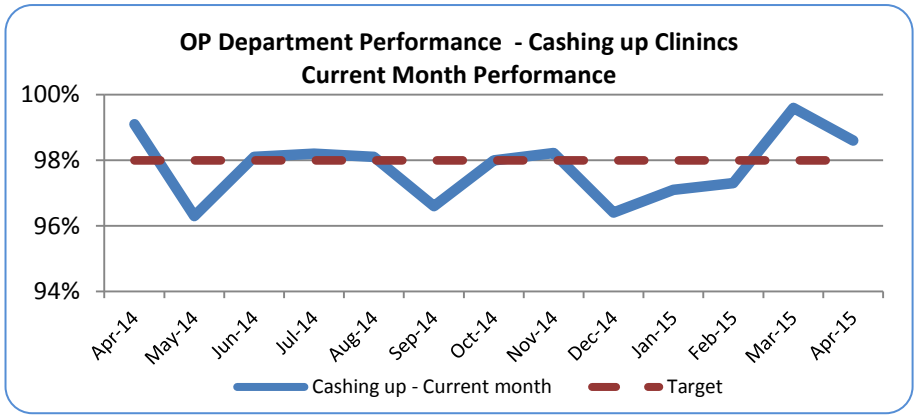
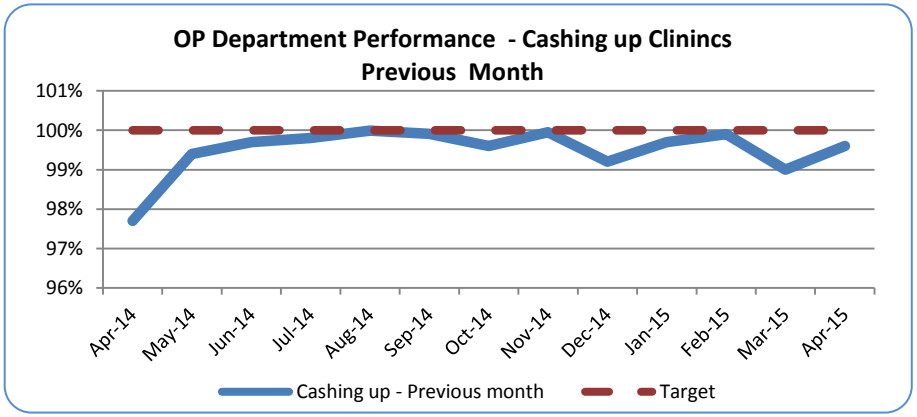
5. Corporate Outpatient Services (1 of 2) - Performance Overview

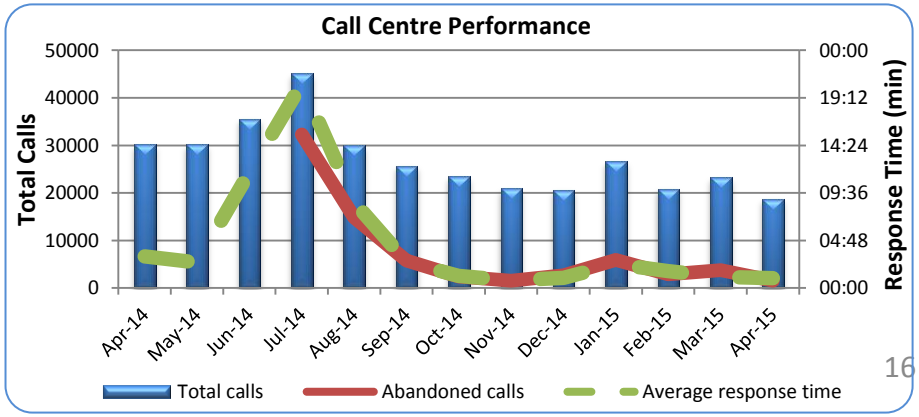












5. Corporate Outpatient Services (2 of 2) - Performance Overview

		Target	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
Activity	Total attendances	N/A	60264	62954	69250	56102	67188	69507	61879	58659	64609	60659	62946	60564
	DNA	<8%	7.18%	10.93%	9.87%	10.02%	9.89%	10.30%	7.64%	7.33%	7.58%	8.04%	7.33%	2.59%
	Hospital cancellations <6 weeks	<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%
OPD performance	Permanent notes to clinic	>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	>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%
	Cashing up - Previous month	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%
Call Centre Performance	Total calls	N/A	30116	35571	45101	30004	25674	23420	20964	20639	26565	20842	23235	18710
	Abandoned calls	<25%/< 15%			32257	14825	5794	2376	1558	2681	5923	2908	3782	1551
	Mean call response times	<1 minute	02:34	11:42	20:39	08:41	02:38	01:13	00:47	01:02	02:24	01:43	01:08	01:00

Key Messages:

- April activity has seen a decrease in comparison to that in March. Significant performance improvement in reducing DNAs is observed with DNAs reducing from 7.33% in March to 2.59% in April. Hospital cancellations have seen an increase in April with cancellations increasing to 1.26%. Performance of permanent notes to clinic is beginning to see some recovery with performance increasing from March position to 95.52%. 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 improved reducing from 16% of total calls received in March to 8% 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 with April average response time being within target of 1.0minutes.

- 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.

St George's Healthcare NHS
NHS Trust

Clinical Audit and Effectiveness

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

HSMR (Hospital standardised mortality ratio)						
Lead Director	February 15	March 15	Movement	2014/2015 Target	Forecast March 15	Date expect to meet standard
SM	85.5	86.0	↑	<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

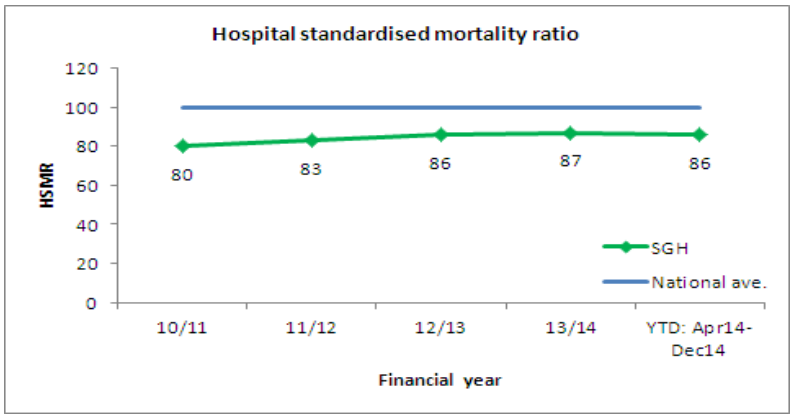
Note: Source for HSMR is Dr Foster Intelligence, published monthly. Data is most recent 12 months available. Refreshed data has not been received in April or May and the latest data is therefore from March and relates to Jan to Dec 2014, and benchmark period is to March 2014. SHMI data is published by 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.

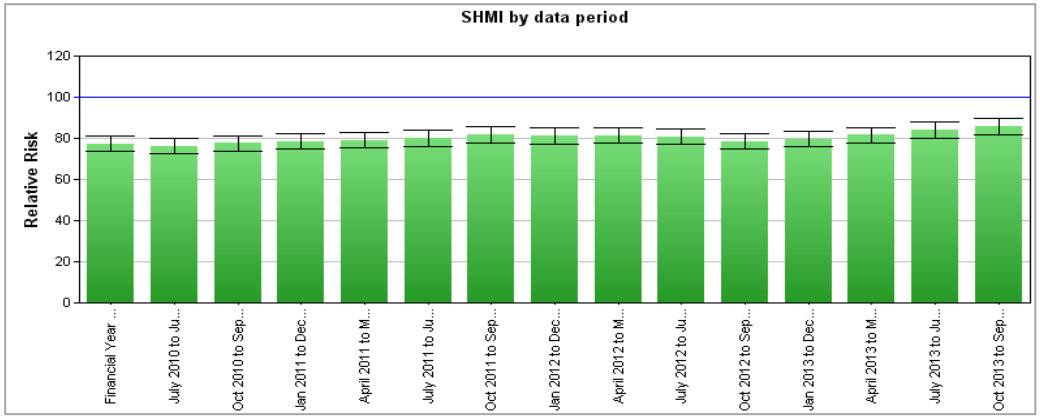
Overview:

There has been a delay to the update of data by Dr Foster Intelligence and therefore our HSMR remains unchanged from that reported last month. The latest SHMI data published in April identifies St George's as one of 16 trusts whose SHMI is 'lower than expected' (October 2013 to September 2014). Furthermore, we are one of 9 trusts with lower than expected mortality for two consecutive years; we are defined as a 'lower than expected repeat outlier'.

The quarterly data release from the Health and Social Care Information Centre (HSCIC) now includes observed and expected deaths by trust, for each of the 140 diagnosis groups that make up the SHMI. For trusts identified as either lower or higher than expected outliers the HSCIC provide more detailed information for 10 specific diagnosis groups. Although the analysis does not indicate whether differences are statistically significant, we use this data to further inform our picture of mortality. Of the 10 diagnosis groups detailed there are 2 where our observed deaths are greater than the number expected (ratio of observed to expected deaths is greater than 1), namely acute myocardial infarction (ratio 1.19) and fracture neck of femur (ratio 1.08). These diagnosis groups are being further interrogated using both SHMI raw data and our Dr Foster tool and will be reported to the Mortality Monitoring Committee.

We remain fully engaged in the programme of work which is underway to shape a national review process. Last year we participated in the PRISM 2 study which aims to evaluate the relationship between the proportion of avoidable deaths and hospital wide standardised mortality ratios. More recently, in April ,we participated in a workshop led by NCEPOD (National Confidential Enquiry into Patient Outcome and Death). The session allowed discussion of a number of approaches and will be used to provide feedback to NHS England and to make recommendations for a national review framework.





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

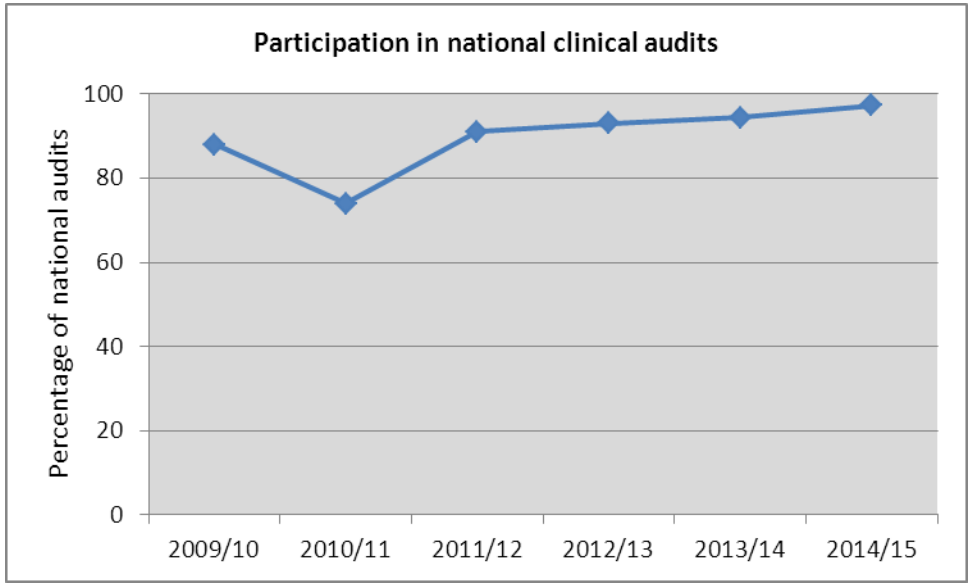
Quality Account 2014/15: Participation in national audits

Reporting participation in national clinical audits is a mandatory element of the Quality account. During 2014/15 the trust took part in 97.3% of relevant projects; our highest level of involvement to date. Furthermore, we maintained our 100% participation in national confidential enquiries.

The one project in which we did not participate was the 'Adherence to British Society for Clinical Neurophysiology and Association of Neurophysiological Scientists standards for ulnar neuropathy at elbow (UNE) testing'. It should be noted that although this audit was included in the Quality Account list, it was not part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and therefore was not mandatory. The trust was not able to participate as there were insufficient staff available and clinics were also extended.

Through compiling information for the Quality Account we have identified one or two clinical areas where staff are struggling to participate and the central team have offered support to set up robust data collection processes in order that we sustain this high level of performance in 2015/16.

It is positive to note that we have started to collect data for both of the audits in which we failed to participate in 2013/14, namely the 'Rheumatoid and Early Inflammatory Arthritis Audit' and the core aspect of the 'National Diabetes Audit'. In the report we are also required to state how many audits were reviewed by the board. We declared that 28 national and 19 local audits have been considered and we have highlighted actions taken as a result of a number of these audits.

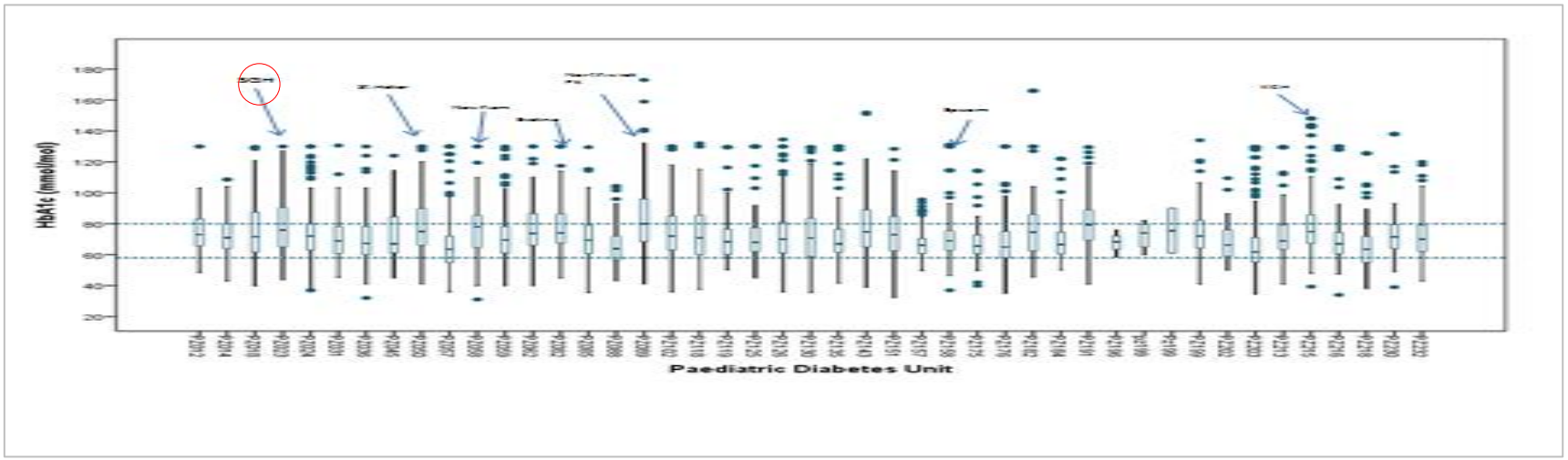


6. Clinical Audit and Effectiveness (Page 3 of 6)
- National Audits

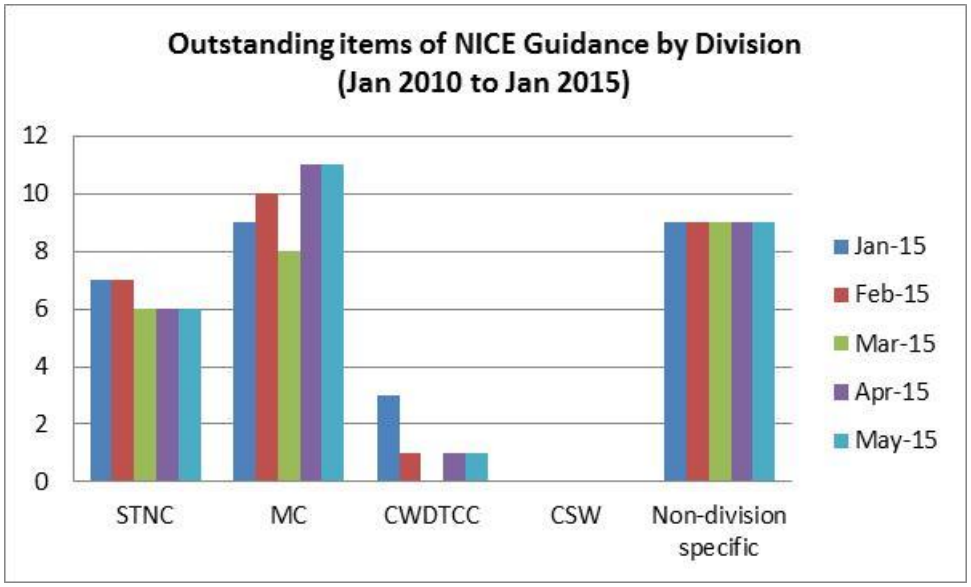
National Paediatric Diabetes Audit 2013/14

Overview:
St George's submitted data for 129 patients aged between 0 and 19 years. Of these 90.7% of cases were Type 1 diabetes.
Standards for seven processes of care apply to all cases aged 12 and over, with HbA1c applicable to all ages. The trust submitted 100% of BMI and HbA1c results, and we are seen to perform better for the other 5 criteria when compared to national and regional average. There were issues with some of our submitted data not being accepted, e.g. ethnicity and CAMHS (child and adolescent mental health services) referrals. We were unaware of data quality issues prior to publication and the service have highlighted this issue to the national audit team.
HbA1c is a key indicator for glucose control. The chart below is annotated to show St George's and our local peers. This shows there is much variability within the south east region with a tendency for higher values within London than elsewhere. The reasons for poorer diabetes control in our local population are unclear. Ethnicity & deprivation are indicated as factors on a national level but the service have undertaken a close review of data and these do not seem to be a factor in our local population, as indicated by our data and results. The p. value against demographic criteria shows that the poorer diabetes control in our population is not completely explained by deprivation, as ethnic minorities are more deprived yet have an equal prevalence of poor diabetes control.

Service Actions: (Since 2014 points 1-3 have been implemented)
1) Resources: Increased diabetes nurse specialists to 2.5WTE; increased dietician time to 1WTE and also secured 0.6WTE psychology support. Service manager in post to support improved processes of care over appointments and education activities, issuing clinic reminders and HbA1c quality control. Introduced a consultant led formal transition service for 15 to 19 year olds.
2) Education: Sessions at home and school, including special sessions for ethnic minorities.
3) Technology: Changes including pump use, with meter and pump downloads in clinic. Capillary HbA1c testing in clinic with quality control.
4) To meet best practice tariff service standards (related to seven processes of care).



6. Clinical Audit and Effectiveness (Page 4 of 6)
- NICE (National Institute of Health and Social Care Excellence) Guidance



Items of NICE Guidance with Compliance Issues (Jan 2010 to Jan 2015)	
Division	**Number**
STNC	n=7
M+C	n=17
CWDTCC	n=14
CSW	n=0
Non-division specific	n=6

Overview

There were 23 items of NICE guidance released in January and February 2015 and we have already received 17 responses, demonstrating sustained engagement. For guidance issued between January 2010 and January 2015 there are currently 27 items of guidance outstanding; which is similar to the previous report with an additional month's guidance included.

The chair of the Clinical Effectiveness and Audit Committee is currently reviewing non–division specific guidance in order to assess applicability to the trust and identify appropriate leads. It is anticipated that this will reduce the number of outstanding items considerably. Work is being progressed to understand the risk profile associated with non compliant actions and an up date will be provided to the board by the end of July at the very latest.

St George's Healthcare NHS
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Patient Safety

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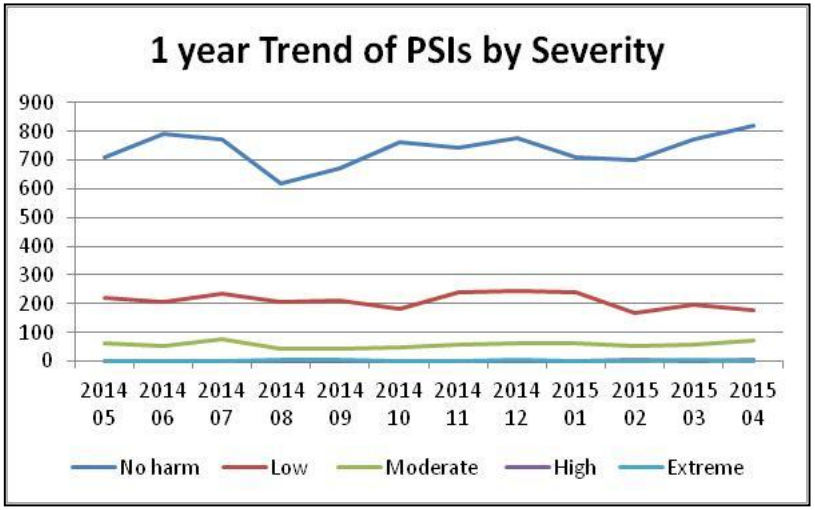
7. Patient Safety
Incident Profile: Serious Incidents and Adverse Events

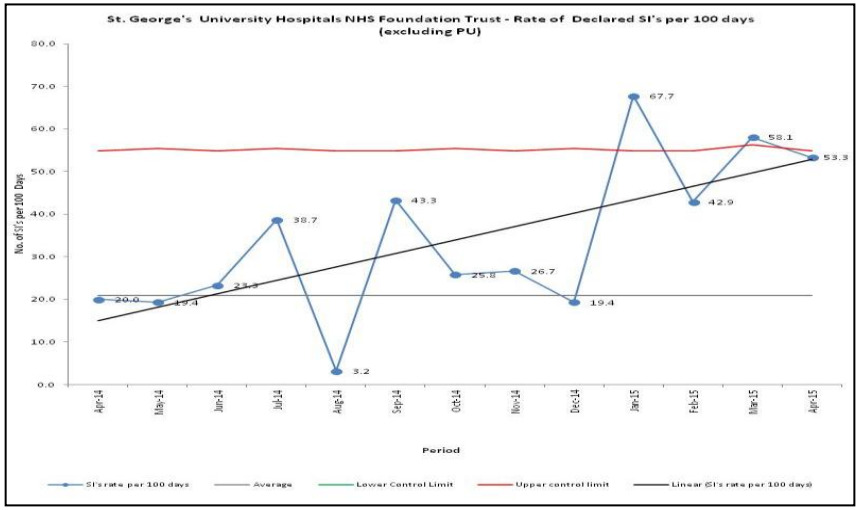
Closed Serious Incidents (not PUs)					
Type	Jan	Feb	March	April	Movement
Total	8	3	10	11	▲
No Harm	8	1	6	7	▲
Harm	0	2	4	4	▶

Table 1

S	Q1 SIs Declared by Division (Inc. Pus)				
	Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
Jan	20	8	**3**	8	0
Feb	9	1	**6**	8	0
March	9	2	**8 + 1 never**	7	0
April	14	3	**1**	0	0

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

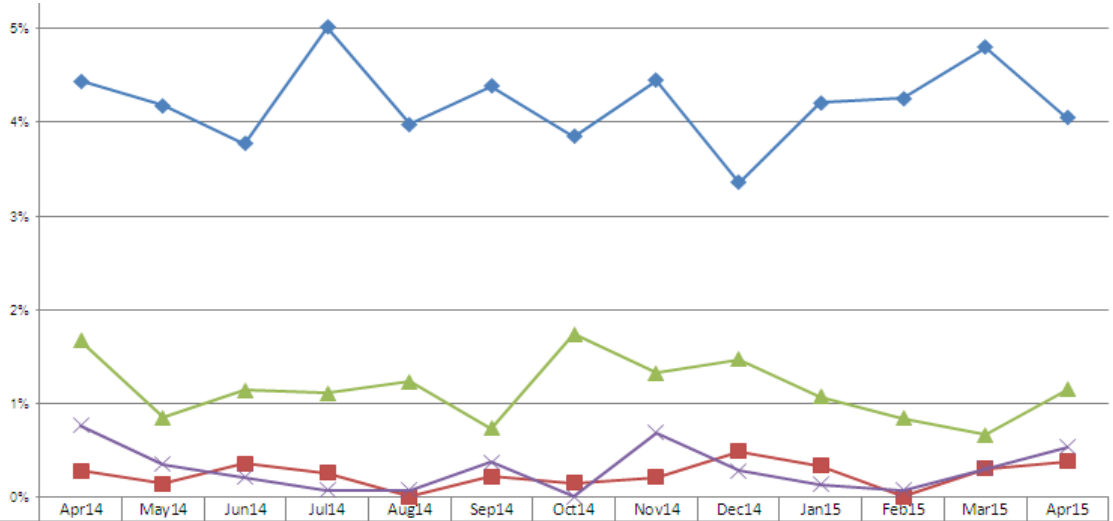
The annual trend for new serious incidents excluding pressure ulcers shown in Table 2 continues to show an increase. There were 16 general SIs reported in April. 3 of these actually happened some time ago but had only been recently identified. They 16 related to the following issues:

- An equipment problem due to a power failure
- A retained dental swab
- 2 failures to follow up on test results
- A child death following a recent attendance in A&E
- A misdiagnosis
- Incorrect management of a post-operative catheter
- 9 related to delayed ambulance handovers of which *4 occurred in February and 5 in March 15*

Analysis of incidents against safe staffing levels is being included in the SI Thematic Report which will be included in the June Quality Report.

7. Patient Safety
- Safety Thermometer

% Harm Free Care							
Lead Director	February 2015	March 2015	April 2015	**Movement**	**2014/2015 Target**	**National Average April 2015**	**Date expected to meet standard**
J Hall	94.91%	94.39%	94.20%	↓	95.00%	93.78%	March 15



	Apr14	May14	Jun14	Jul14	Aug14	Sep14	Oct14	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15
Pressure Ulcers	4.44	4.18	3.77	5.02	3.98	4.39	3.85	4.45	3.36	4.21	4.26	4.8	4.05
Falls	0.28	0.14	0.36	0.26	0	0.22	0.15	0.21	0.49	0.33	0	0.3	0.38
Catheter & UTI	1.67	0.85	1.14	1.11	1.23	0.73	1.74	1.32	1.47	1.07	0.84	0.66	1.15
New VTE	0.76	0.35	0.21	0.07	0.07	0.37	0	0.69	0.28	0.13	0.07	0.3	0.53
Patients	1441	1410	1405	1533	1458	1368	1377	1439	1429	1495	1433	1355	1310

Pressure ulcers

- 36 grade 2 (18 new, 18 old)
- 13 grade 3 (4 new, 9 old)
- 4 grade 4 (0 new, 4 old)

CAUTI

- 12 new
- 3 old

Falls

- 4 low harm fall
- 1 moderate harm fall

VTE

- 3 new PE
- 4 new other

This point prevalence audit shows that in April 2015 the proportion of our patients that received harm free care was 94.20%, which is very similar to the levels reported in recent months and is slightly better than the national average for April of 93.78%. This month we reported 80 harms to 76 patients; 72 patients experienced one harm and 4 patients had 2 harms. 46 harms are categorised as new, meaning that they either developed or treatment began whilst under our care. 34 harms were old. Details of all harms reported are provided above.

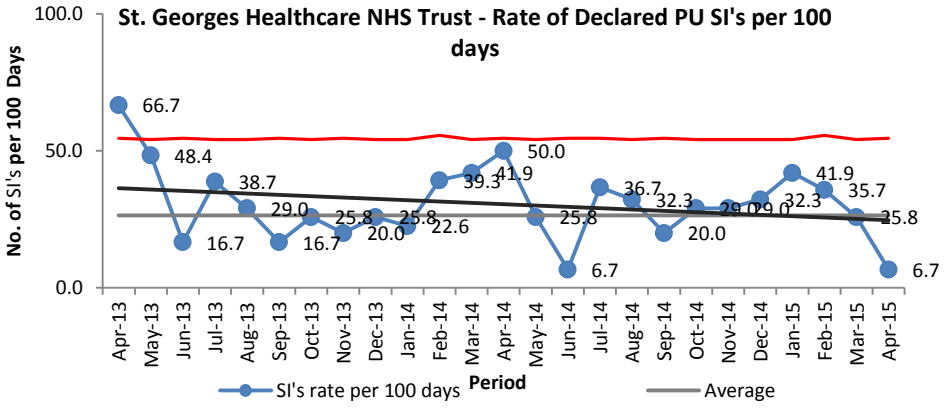
Harms related to pressure ulcers fell this month, with a reduction in both the number of new and old harms. However there was an increase in harms reported for each of the remaining categories. Validation of data continues to be a high priority, and to compliment the support from the VTE and Tissue Viability nurse specialists, the audit team are now attending the wards to confirm data where catheter associated urinary tract infection or falls are reported.

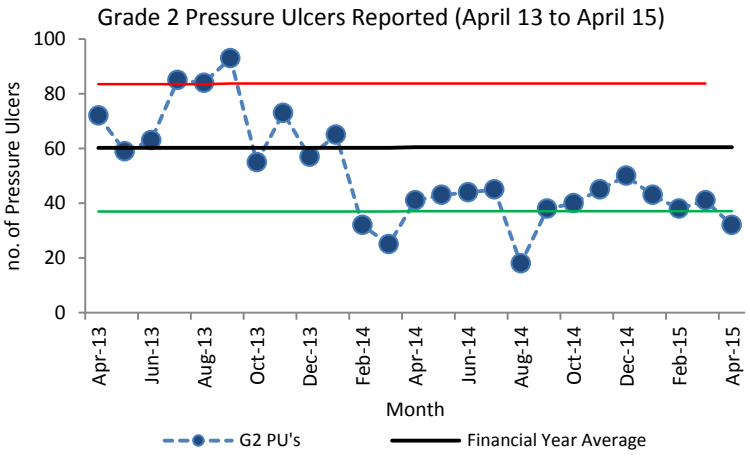
The trust continues to seek ways to make maximum the value of participation in the Safety Thermometer. We are currently piloting an approach to better identify where new harms have developed. This will allow us to provide data to teams that will better support them to improve quality. In June we also plan to launch the Children and Young Person's Safety Thermometer and re-launch and extend the Medication Safety Thermometer.

7. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers										
Type	Dec	Jan	Feb	Mar	Apr 2015	YTD To March 2015	Movement	2014/2015 Target	Forecast March 2015	Date expected to meet standard
Acute	6	10	5	5	1	**65**	⩛		G	-
Community	4	3	5	3	1	**46**	⩛		G	-
Total All	10	13	10	8	2	**111**	⩛		G	-
Total Avoidable	**6**	**8**	**3**	**TBA**	**TBA**	**55**		40		-

Grade 2 Pressure Ulcers						
Dec	Jan	Feb	Mar	Apr	Movement
33	22	18	30	25	⩛
17	21	20	11	7	⩛
50	43	38	41	32	⩛





Overview:

April has seen a reduction in the number of pressure ulcers throughout the Trust. Having only one SI in both community and acute settings is an achievement for staff

Actions:

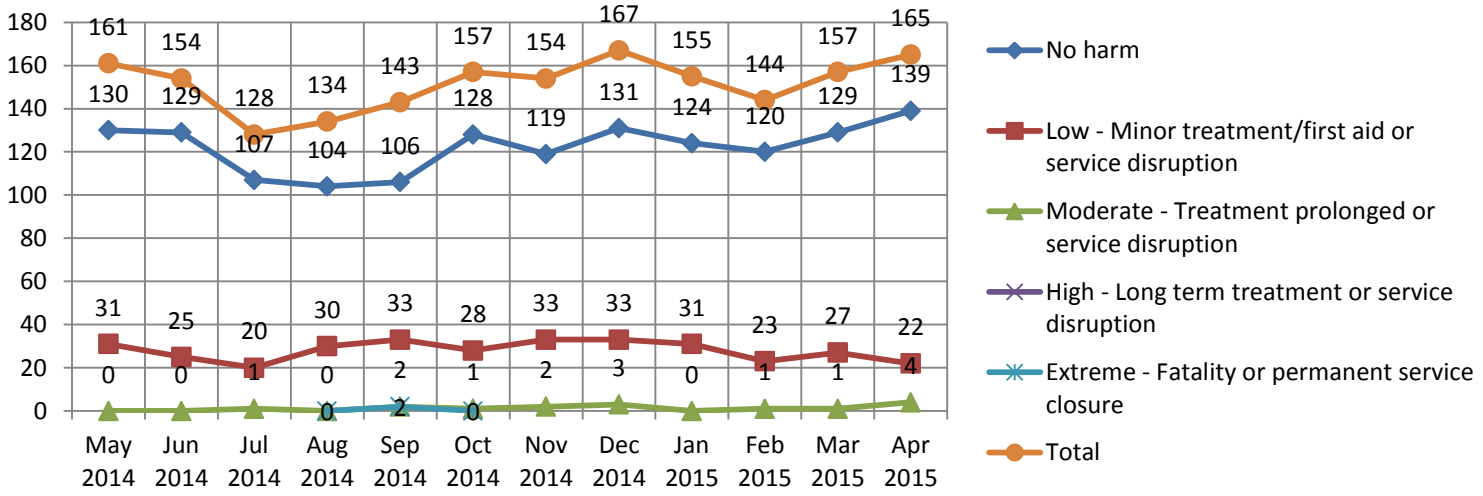
- Improved engagement from community teams on the study day on May 7th - 28 members of staff attended , 7 of whom were from the community teams
- The senior nurse study day for July is fully booked, therefore another one has been planned for October
- The new NHS Serious Incident Framework from NHS England is being prepared for implementation to ensure compliance and to formulate a "72 hour checklist" for acquired PU's
- Recruitment to 1 community TVN post successful , further vacancy in community – recruitment planning underway
- CQUIN trajectory of 40 avoidable PU SI's not met – total year to date (end of February 2015 = 55)
- Evidence for CQUIN work with Nursing Homes submitted, training completed , positive evaluations

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

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

Falls with Harm April 2014-March 2015				
No Harm	Moderate	Severe	Death	Falls related Fractures
1951	22	3	0	7

Incidents by Incident date (Month and Year) and Severity



Overview: The graph shows the profile of falls across both acute and community services including bed-based care and patients' own homes. It is important to note that this data is sourced from incident reporting and is not individually verified. The number of falls and patterns identified across the Trust remains similar month to month. **Actions:** A review of the Trust falls strategy, policy and dedicated resource to implement best practice in each division/ clinical area is required as a matter of urgency. Correlation between factors such as staffing, dementia/delirium and falls is required. A bed rail risk assessment audit is planned for the first quarter 2015 together with participation in the First National Inpatient falls audit in May. The protocol of care of patients' following an inpatient fall will also be audited in the first quarter 2015.

7. Patient Safety: April 2015 - Infection Control

MRSA						
Lead Director	March	April	Movement	2015/2016 Threshold	Forecast May-15	Date expected to meet standard
JH	1	2	▲	0	R	-

Peer Performance – YTD April 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
2	1	0	0	0

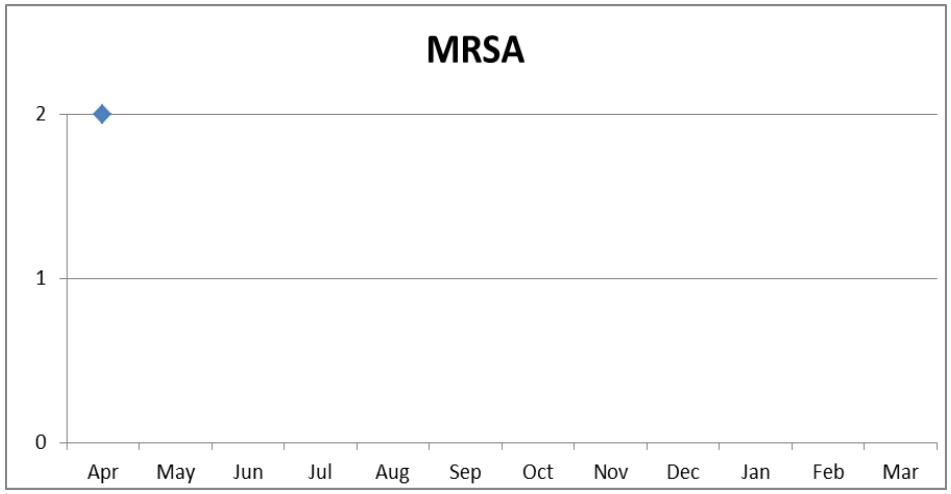
C-Diff						
Lead Director	March	April	Movement	2015/2016 Threshold	Forecast May - 15	Date expected to meet standard
JH	4	3	➤	31	G	-

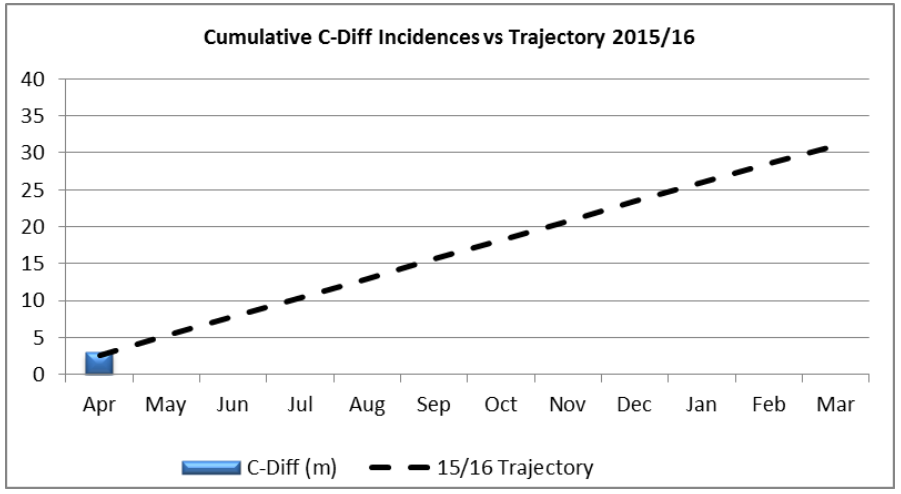
Peer Performance – YTD April 2015 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3 (31)	0	1	10	3

In 2015/16 the Trust has a target of no more than 31 C. diff incidents and zero tolerance against MRSA.

With a zero tolerance against this MRSA target, the trust is non-compliant with 2 incidents . Both incidents are now subject to Root Cause Analysis which will be presented to the infection control operational group when completed.

In April there were 3 C. diff incidents. This is against the annual threshold of 31.





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	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan (2015)	Feb	Mar	April
Unify2	96.40%	97.33%	97.28%	96.60%	96.84%	94.91%	93.18%	93.51%	95.94%	96.03%	96.27%	

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	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan (2015)	Feb	Mar	April
Safety Thermometer (SGH)	86.05%	85.22%	89.94%	86.51%	86.44%	85.39%	86.56%	75.92%	79.08%	83.89%	85.74%	89.83%
National average	84.83%	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)		70
Mortality rate	Total	8.6% (6/70)
	VTE primary cause of death	4.3% (3/70)
Initiation of RCA process		100%
RCA pending	<28 days since notification	26
	>28 days since notification (notes requested)	6
RCA complete		54.3% (38/70)

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 38 cases for whom RCA is complete):

- General breakdown includes:
  - 39.5% – patients had active cancer
  - 8 cases in regular day attenders (oncology/haematology/haemodialysis)
  - 2 cases of pulmonary embolism following stroke
  - 5 patients >100kg
- Adequate prophylaxis received 84.2% (32/38) –Examples of contributing factors to failure of prophylaxis:
  - 9 patients - malignancy +/- complications arising from malignancy
  - 8 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 15.8% (6/38) – Examples of reasons for inadequate prophylaxis:
  - 3 patients - Dose of LMWH not escalated appropriately in obesity
  - 2 patients – Doses of LMWH omitted with no clear documented reason
  - 1 patient not given extended VTE prophylaxis on discharge where indicated

Results and recommendations following RCA of 2014 HAT cases were presented at the S&N Divisional Governance meeting on 27/04/15. They will be presented at WCCC Divisional Governance meeting on 14/05/15.

7. Patient Safety
- Safeguarding Children

Safeguarding Training Compliance – Children						
Lead Director	Level 1	Level 2	Level 3	2015/2016 Target	Forecast June - 15	Date expected to meet standard
JH	85%	78%	62%	85%	A	

Target areas: In the acute service additional training has been focused on FGM (training sessions have been delivered by the Specialist Perineal Midwife on a continuum) and See the Adult See the Child awareness raising. The section 11 audit identified adult services and the recognition of adult issues impacting on children as a potential weak area thus this targeted training will continue. In the community additional training is offered on Domestic Abuse, FGM and Record Keeping .
The safeguarding team have established a working party purely to focus on improving safeguarding children training as poor compliance with the target of 80% for all 3 levels remains an issue (as evidenced by the statistics above). The group are focusing on – the accuracy of and the processes associated with the collection and recording of data and the managerial accountability for ensuring that staff are trained. Penalties for non compliance are being considered.

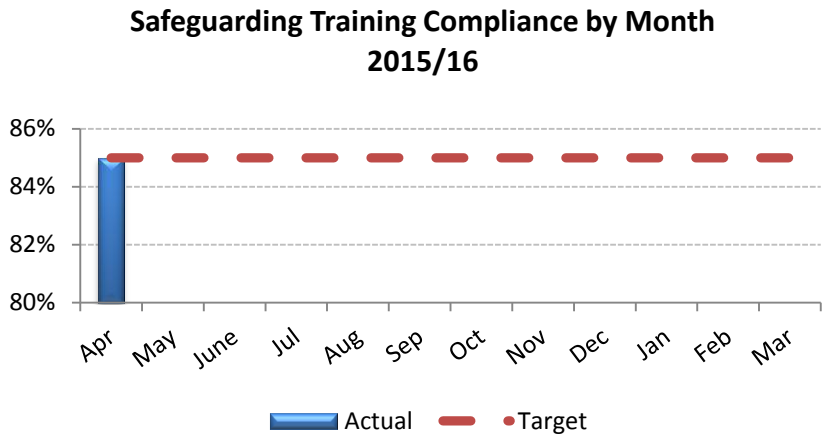
Serious Case Reviews and Internal Management Reviews: the number of SCR's/IMR's has increased year on year from 2 in 2012/13 to 8 in 2014/15. The reason for this remains unclear although it may be linked to the revised guidance for instigating an SCR as described in Working Together 2013-2015. The most recent SCR for Richmond (Child H) involves the sexual exploitation of a LAC young person. The acute service has had some involvement with the extended family (not connected with the reason for holding an SCR) and the Named Nurse has submitted a report. The high profile case for Sutton will be reporting following the conclusion of the criminal matter (father charged with murder) which is currently in the court arena. The SCR report for the family C has been delayed until September. Haringey have declared a Serious Case Review for Baby R, the 6 month old baby who died in the care of the father. St George's midwifery had some minimal involvement in this case. The Named Midwife will attend the initial meeting in Haringey for the professionals who were involved on 14/05/15.

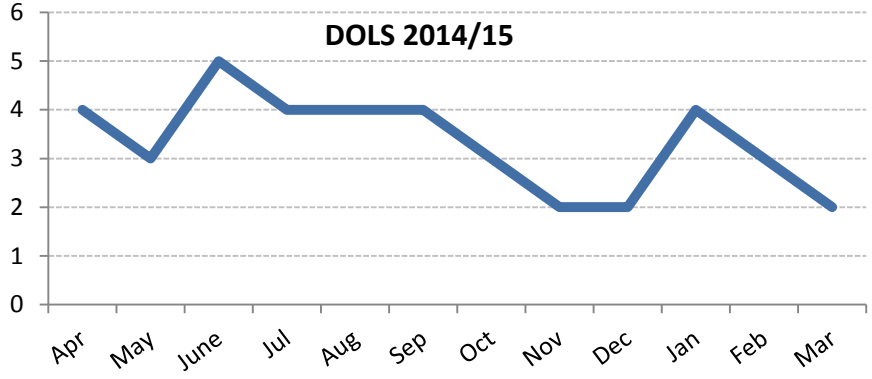
Other: The Safeguarding Children Annual Report 2015 has been completed and the Trust has contributed towards the Wandsworth SCB Annual Report. The outcome from the Section 11 audit will be shared with Merton SCB at their request. It is noted there has been some debate raised by the designated professionals as to when the acute service needs to raise a SI – the chief nurse is leading on this.

7. Patient Safety
- Safeguarding: Adults

Safeguarding Training Compliance - Adults									
Lead Director	Nov	Dec	Jan	Feb	Mar	April	2014/2015 Target	Forecast April 2015	Date expected to meet standard
JH	87.5%	87.3%	87%	86.2%	87%	85%	95%	A	-

Safeguarding Adults Training Compliance by Division – April 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

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

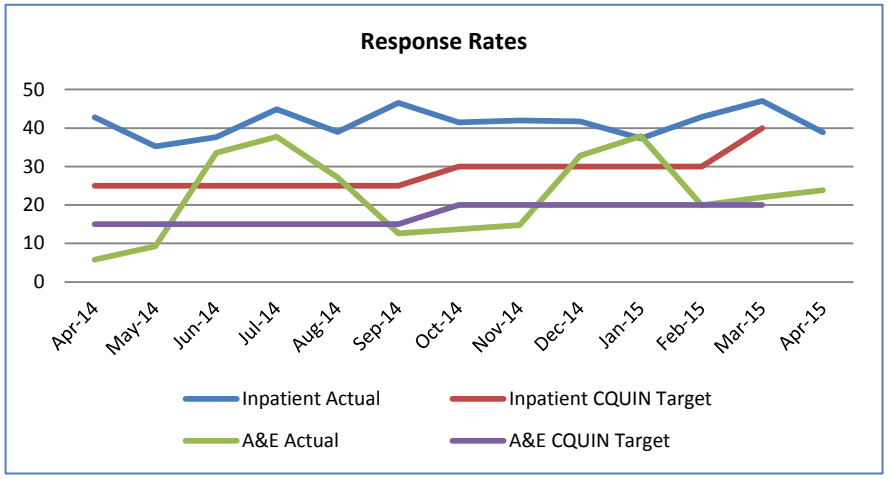
St George's University Hospitals NHS
NHS Foundation Trust

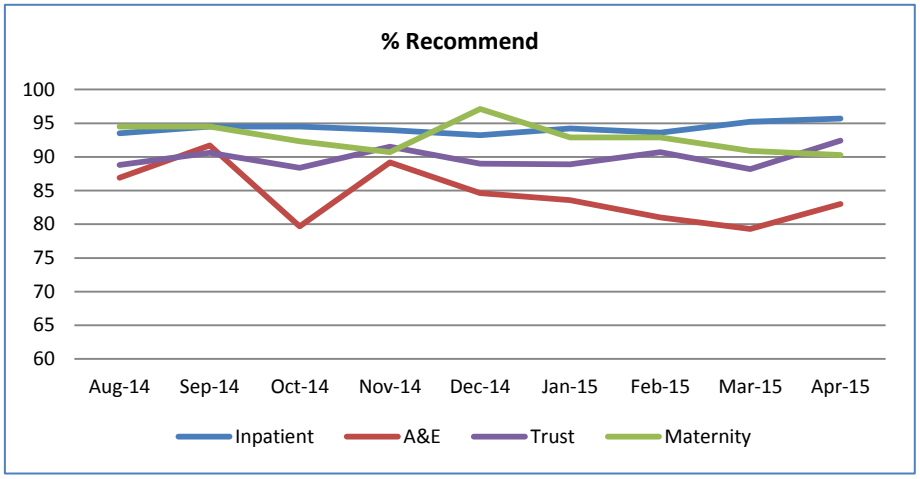
Patient Experience

8. Patient Experience
- Friends and Family Test

FFT Response Rate							
Domain	Feb-15	Mar-15	Apr-15	Movement	2014/2015 Target	Forecast	Date expected to meet standard
Trust	26.5	29.5	28.9	↓	-	-	-
Inpatient	42.9	47	38.9	↓	30%	G	-
A&E	19.9	22	23.8	↑	20%	G	-
Maternity	19.5	25.3	24	↓	-		-

	FFT Response Score			
	Feb-15	Mar-15	Apr-15	Movement
	90.7	88.2	92.4	↑
	93.6	95.2	95.7	↑
	81	79.3	83	↑
	92.9	90.9	90.3	↓





Overview : All CQUINs were met for last year. A&E averaged over the required 20% response rate for the quarter, and inpatients achieve BOTH the 30% quarterly target and the 40% target for March.

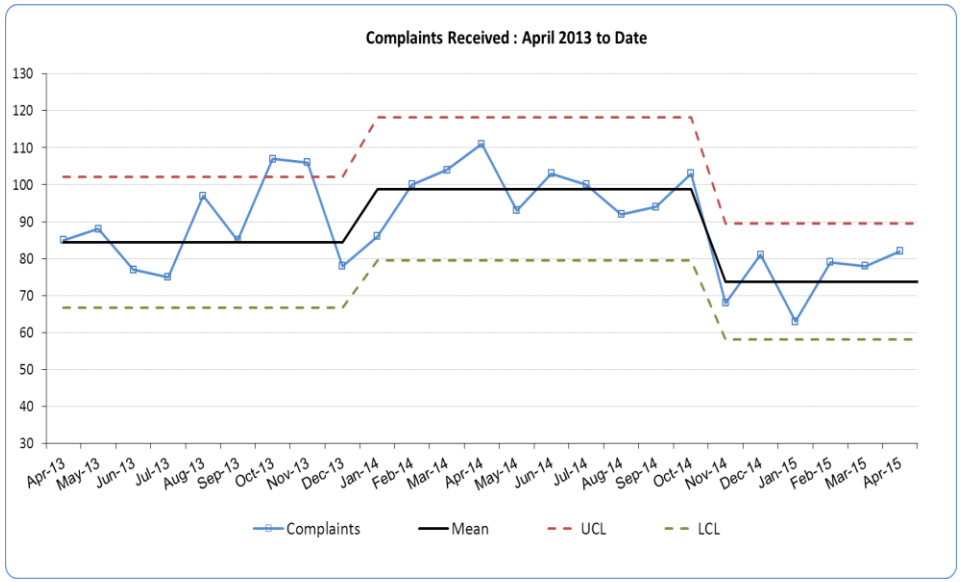
Action :

Now that the CQUINs are complete, we can shift focus to the content of feedback we receive.

- Identify and share key themes from responses at various fora and committees
- Focussed attention this year on action planning to improve scores
- Continue to monitor performance in maternity at the 4 touch points ; antenatal, birth, postnatal ward and postnatal community
- An accessible version of the survey has been rolled out. This uses simplified English and "smiley" faces to make the surveys more accessible to children, people with LDs and people who may not have English as a first language.

8. Patient Experience
- Complaints Received

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



Overview:
This report provides an update on complaints received in quarter 4 of 2014/2015 and information on responding to complaints within the specified timeframes for the same period with divisional breakdowns and analysis of the data to provide some trends and themes. It also includes actions taken and planned in quarter 4, a report of the latest work on severity rating of complaints and posts on NHS Choices and Patient Opinion.

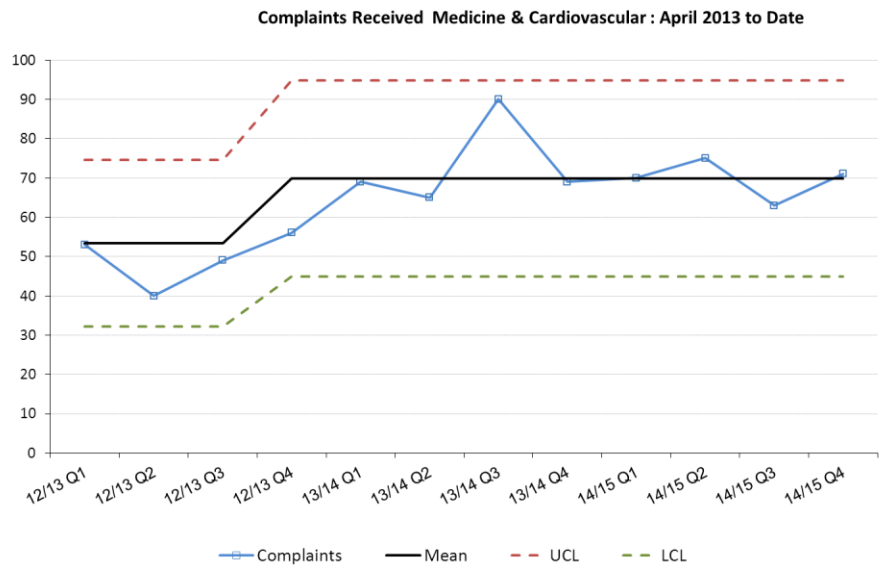
Total numbers of complaints received in Quarter 4 of 2014/2015
There were 220 complaints received in quarter 4 of 2014/2015, a reduction when compared to quarter 3 when 256 complaints were received. Complaints reduced across all divisions except for Medicine and Cardiovascular.

Total number of complaints received in 2014/2015
1052 complaints were received in 2014/2015, a slight reduction on 2013/2014 when 1085 complaints were received. The most complained about care groups were Outpatients and Medical records and Accident and Emergency. The top 4 most complained about subjects were all aspects of clinical treatment, appointment delay/cancellation, communication/information to patients and attitude of staff. Posters and leaflets are displayed around the trust and there is information on the trust website to ensure that patients are made more aware about their options and the process for how to complain. We view all types of patient feedback as positive and we are constantly looking at ways in which we encourage patients, carers and families to give their views.

National statistics will not be published until August 2015 but a survey of London trusts was undertaken and from those who responded (8 trusts) 5 reported an increase of between 6% and 84% and 3 reported a decrease of between 1% and. 25%. Reasons given for increases include the acquisition of additional hospitals, a change in the way in which complaints and concerns are being handled and changing to parking processes. A reason given for significant decrease is staff working very hard at finding opportunities to find local solutions to resolve low severity type issues (which is what we strive to achieve at St George's).

Work has begun on the detailed Complaints and PALS Annual report which will be presented to the Board in September.

8. Patient Experience
- Complaints – Q4 by division – Medicine & Cardiovascular



COMMENTARY

Complaints in the Medicine and Cardiovascular division increased to 71 in quarter 4 from 63 in quarter 3, the only division where the number of complaints being received rose. Emergency Medicine saw an increase from 23 and 30 and Specialist Medicine an increase from 6 to 11.

Renal/Haematology/Oncology

- Signage within the Oncology ward has been changed to address confusion experienced by an inpatient who was placed in area that was mistaken by a complainant to be a day ward/corridor.
- In response to a complaint regarding difficulty in accessing information and support, the answerphone message within the Macmillan cancer support area was changed to ensure that the message reflects what patients should do if they are not called back and the message specifies a time frame in which a patient should expect a call back .

COMMENTARY

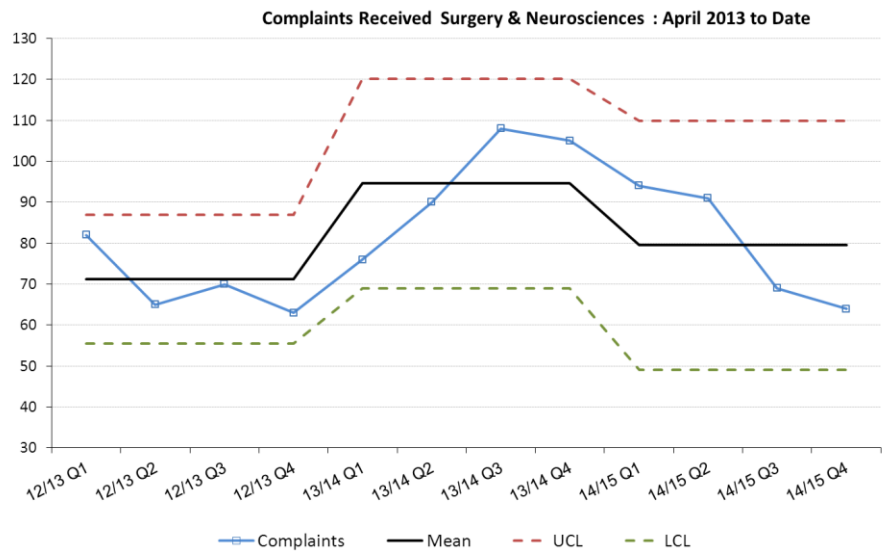
Cardiovascular

- Following a complaint from a patient who suffered an increased risk of infection within the cardiac surgical theatre, the directorate now has the facility to store harvested veins safely for up to 48 hours, in case of the requirement for use for that patient.
- Within the thoracic care group a patient complained that on attending for a chest X-ray they had to wait for a significant amount of time to return to the ward. The trust does not have the teletracking system in use at weekends, therefore the action taken is that the radiologist will review any patients waiting at fifteen minute intervals and address any delays in real time.

Emergency Department

- The Clinical Governance Lead reports on key themes that emerge from monthly complaints and actions are devised to mitigate further occurrences like reinforcing the trust values and behaviours. The ED leadership team has implemented an action plan following the work by LIAiSE, to ensure behaviours, practices and safety is improved within the workforce.
- In cases of the misdiagnosis of conditions, the education supervisor for the junior doctor is informed by the Clinical Governance Lead so that this can form part of the doctor's development plan for learning purposes.
- Customer service complaints are found to have taken place in triage some which may be due to environment (queuing system) as opposed to behaviours. The triage process is being reviewed with a view to ensuring it is fit for purposes led by the interim Head of Nursing along with core members of the medical and non-medical teams.
- The ED process has been review to ensure swift responses to complaints by clinical and non-medical teams. Consultants are responding to complaints directly and where needed responses are produced by both medical and nursing teams.

8. Patient Experience
- Complaints – Q4 by division – Surgery & Neurosciences



COMMENTARY

There has been a reduction in complaints being received for the division for the fifth consecutive quarter.

General Surgery & Urology

Waiting times for surgery – The pathway is now established to use available theatre capacity at Kingston for general surgery and at Croydon for urology. This is helping to reduce waiting times for high volume simple work. This has reduced the number of patients waiting over 18 weeks.

There is an emerging theme regarding waits for laparoscopic cholecystectomy following emergency admission. The general surgery care group is developing an action plan to respond to this and ensure compliance with NICE guidance.

Waiting times in outpatients – Changes in booking processes and clinic templates in colorectal and breast have reduced long waits in clinics for patients. New clinic capacity has been requested in order to continue this improvement and ensure that all clinics run to time and overbooking is kept to a minimum.

COMMENTARY

Trauma and Orthopaedics

Fracture Clinic- There is now a comprehensive action plan to address a range of issues within this area. This is being overseen through the Divisional Governance Board to ensure the service have the required support and are on track to meet their timelines to deliver the changes. Themes relate to triage of referrals and early booking, reduce delays for X-rays, improve patient access to the T&O team, improved nursing support, changes to the template & improved patient information - written & verbal.

Preoperative care - There have been a number of issues raised informally via the service and through formal complaints relating to this aspect of care. A full review is now taking place based upon these incidents. To date the junior doctors' rotas have been restructured and the PAs are now fully established and rotating throughout the service with a view to improving communication and continuity of care. The new governance and care group lead will lead the review and develop further actions to support the required improvements, which will be more wide reaching. This is on-going.

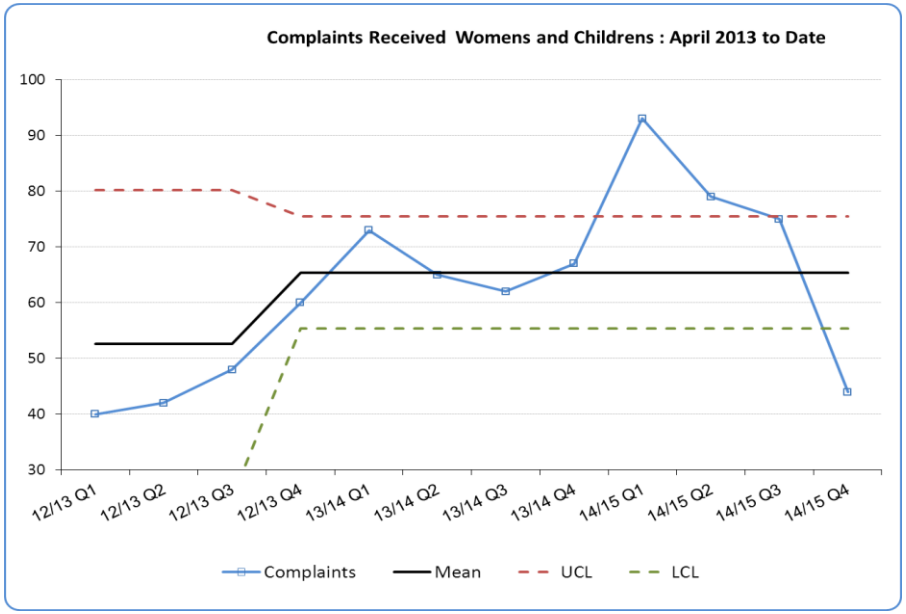
Neurosciences

Outpatient services - This work has been on-going for some time but the key elements going live this month are the implementation of the patient hotline and email address. Business cards with this number will be available and the central team will aim to diffuse and resolve issues directly. This initiative is designed to improve the many complaints about appointment times and contacting the department. A comparable initiative in T&O was effective in improving patient experience and reducing complaints.

Nursing complaints -There has been a marked improvement in both nursing recruitment and sickness; this is very positive and has seen a decrease in reliance on bank and agency staff for the wards. Successful recruitment of the additional 7 HCA's has also had a positive impact on patient care. This is starting to impact on the complaints relating to continuity and quality of care which on investigation frequently related to use of temporary staff. Monitoring continues.

Discharge Process -Neuro rehabilitation - 3 complaints with this theme have prompted a piece of work reviewing how management of complex discharges takes place, who leads, how the individual assessments and perspectives are pulled together into a final report and how patient and family views are effectively incorporated and represented. Training and development will take place with the MDT and a review of the roles and responsibilities of the discharge coordinator role.

8. Patient Experience
- Complaints – Q4 by division – Children's & Women's



COMMENTARY

There has been an overall reduction in the volume of complaints received across the division in Quarter 4, the third consecutive quarter where a reduction has been seen, with a notable decrease seen in Obstetrics and Corporate Outpatients.

Corporate Outpatients (COS)
There was a further reduction in the number of complaints received in COS in Q4, compared to Q3. The team has had a continued emphasis on local resolution of complaints which is contributing to this reduction. In addition there has been a sustained reduction in the number of complaints regarding long delays in the Central Booking Service; this is despite a recent relocation of the service. An emergent theme in Q4 however has been staff attitude within phlebotomy services, the team are now receiving additional customer care training which aims to address this issue.

COMMENTARY

Women's Services
The number of complaints received within the Women's directorate reduced in Q4; of these many continue to be complex in nature and require meetings or home visits in order to reach satisfactory resolution for the complainant. The two main themes seen within the complaints received in Q4 are clinical treatment and communication; these themes are consistent with those seen in previous quarters. The Deputy Director of Midwifery continues to focus on improving communication amongst the midwifery team. In conjunction the Midwifery Futures project is receiving on-going additional focus. Alongside this the Consultant Midwives have been undertaking a project which focuses on women centred care which includes education regarding compassion, care and appropriate communication.

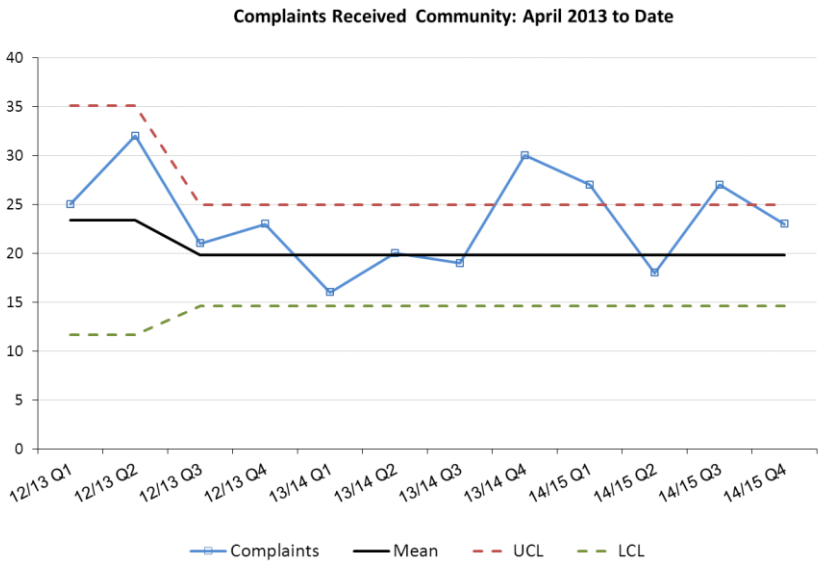
Although the number of complaints has dropped during this quarter, the overall number of complaints remains a concern within women's services. As a result the division is working with the complaints department to obtain complaints data from peer organisations regarding women's services for comparison purposes.

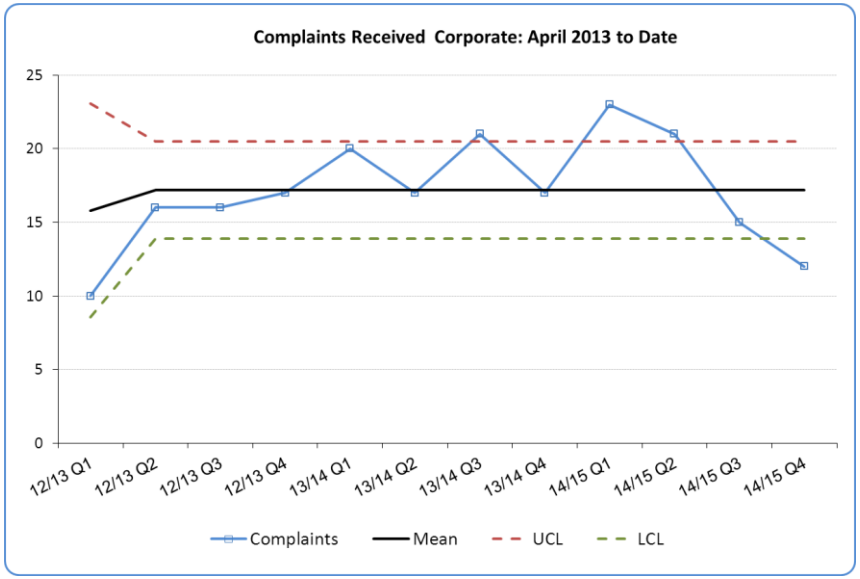
Children's Services
No real theme was seen in the Children's complaints in in Q4. However in contrast to Q3, there have been a number of complaints regarding staff attitude. The Children's Futures programme continues with communication and role modelling featuring as part of this. In addition a series of educational films are being developed that feature actual complaints, some of which highlight poor staff attitude; these will be used to educate staff on the importance of professionalism and good customer care.

Therapies, Critical Care and Pharmacy Directorates
These directorates receive very few complaints and as such there are no emergent complaint themes within these services.

8. Patient Experience

- Complaints – Q4 by division – Community Services Division & Corporate Directorates





Community Services

COMMENTARY

Complaints about Adult Services reduced significantly from 14 in quarter 3 to 6 in quarter 4. Complaints about Offender Healthcare rose from 8 to 11. Below is an example of an taken in response to a complaint closed in quarter 4.

Community Nursing

A complaint was received about the attitude of a community nurse. The nurse is to attend Conflict Resolution and Customer Care courses. As a result of the investigation, an action plan has been developed with the nurse, during which her communication skills will be closely supervised and support will be offered to her to maintain an improvement. The Nurse will meet with her line manager on a weekly basis to discuss her communication style and patient and carer relationships.

Corporate Directorates

COMMENTARY

Patient Transport

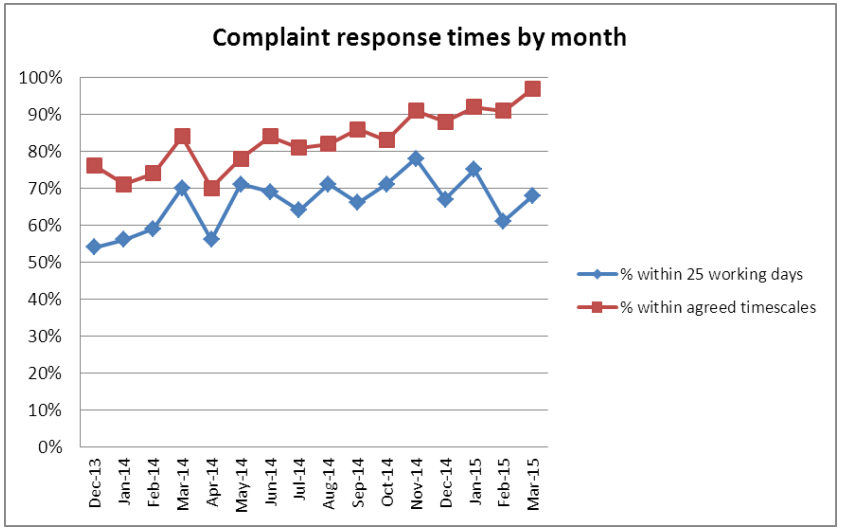
The patient transport complaints have reduced for Q4. There were 5 complaints in total. 4 of the transport complaints relating to the timing of transport with long waiting times and the 5th complaint was regarding the attitude of a driver. A new patient care and decision making training course is now in place for all the drivers to improve any conduct issues. G4S have put in place extra resources to reduce waiting times there are 6 extra vehicles on the afternoon shift – Monday to Friday, 3 extra vehicles on Saturday, and ad hoc resources arranged with prior notice.

Car parking

There has been an increase in complaints relating to a shortage of car parking spaces and high costs to park. The majority of these complaints are resolved with a telephone call. The high costs are usually linked to an overrunning clinic, for these cases there is a concession policy in place to offer a part refund. The car parking capacity remains a problem. The hourly costs to park are under review as there is concern that our car park in cheaper to park in than the local roads which results in increased usage of non-hospital business.

8. Patient Experience
- Complaints Performance against targets

Performance Against Targets quarter 4				
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	44	29	66%	98%
Medicine and Cardiovascular	71	46	65%	96%
Surgery & Neurosciences	64	45	70%	97%
Community Services	23	18	78%	97%
Corporate Directorates	12	10	83%	92%
Totals:	214	147	69%	96%



Overview:

For complaints received in quarter 4 of 2014/2015, 69% were responded to within 25 working days, a decline in performance when compared to quarter 3 when 72% of complaints were responded to within this timeframe.

For the same period 96% of complaints are planned to be responded to within 25 working days or agreed timescales, an improvement on quarter 3 when 85% of complaints were responded to within this timeframe. The final percentage may change depending on whether all of the agreed extensions are eventually met.

All divisions committed to reaching the trust targets of 85% and 100% respectively in quarter 4. Although the target of 85% was not met, great improvements were made with regard to responding to complaints within agreed timescales .

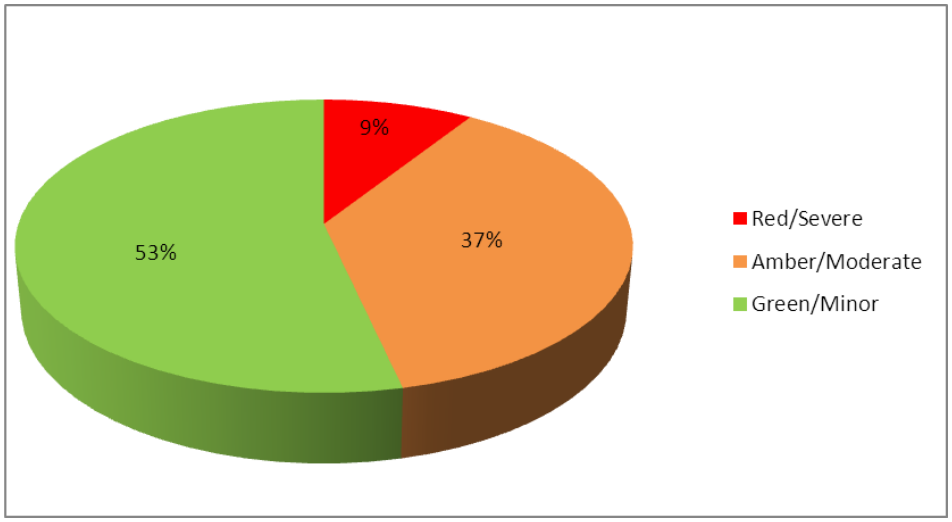
A piece of work is underway to ascertain the reasons for each late response so that actions can be taken regarding any themes or areas of particular concern that are identified.

8. Patient Experience
- Complaints severity rating overview

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

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

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



A summary of ratings for quarter 4 is presented below. A more detailed report will be presented at the Patient Experience Committee.

In Quarter 4 a total of 20 complaints we categorised as Red/Severe.
The red severity cases have been examined to decipher if they should still remain red after investigation and response completed. However some of the cases are still open therefore the total figure for red severity cases may change and will be reflected in the end of year final report.

The reasoning for the red ratings included:

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

In Quarter 4 a total of 80 complaints were categorised as Amber/Moderate.
The most common reasons for the amber ratings were an adverse injury or outcome and the complaint being complex and/or involving 2-4 services.

In Quarter 4 a total of 115 complaints were categorised as Green/Minor.

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.

Steph gave General Surgery at St George's Hospital (London) a rating of 1 stars

Communication is very poor
I brought my dad for a small day surgery operation last Thursday (30/04/2015) he received a very poor service. Having already had his surgery cancelled on the day of surgery previously he was told to come back in last Thursday at 7.30 am. He was swiftly seen by the nurse and doctor having bloods and an ECG carried out with no problems then we started the long wait. At 11 am the matron spoke to us by chance and told us my father is last on the list so could drink up till 1pm I asked what time his surgery will be 3pm. If the matron didn't talk us by chance my dad wouldn't have known he could drink and this also meant the minimum wait would be seven and a half hours which we accepted as emergencies happen (I myself work in day surgery in a different trust so understood). At around 3.30pm we enquired again about when my dad was going to theatre we were told 6pm so I headed to PALS after this the service manger come to speak to us, she was very understanding and tried hard to help us I cannot fault the service she provided. 6 o'clock came and went still my dad was not called to theatre I had to keep chasing the nursing staff for information we were told from 3.30 my dad would be next.. My dad was cancelled at 6.45pm and told he would be done first on the morning list which he was.

What I would highlight from this experience that there is poor communication between the theatre and nursing staff. Communication given to patients waiting is extremely poor as we spent the whole day chasing after people to get information no one came up to us at any point. If someone had said to us earlier in the day his op wouldn't happen we could have gone home I think 12 hours waiting for surgery is disgusting. I would not recommend St George's to any of my family or friends.

Visited in April 2015. Posted on 05 May 2015

KJ gave Urgent care centre at St George's Hospital (London) a rating of 5 stars

Great experience for first time bone breaker!
I went to St. George's A&E today after being treated at another hospital yesterday for a broken finger. I was very worried all night as it felt like my dressings were on too tight and didn't know why I wasn't given strong pain killers as I was in agony, something didn't feel right and I wanted to see someone as my follow up appointment with the other hospital wasn't scheduled for another week and a half. I've never broken anything or seriously injured myself so the whole experience was very unsettling and I was quite emotional. I felt silly for going to A&E again as didn't want to waste anyone's time, but I was treated with nothing but care and respect. I was waiting for no more than half an hour before being taken into urgent care centre, all my options were discussed, an X-ray was taken quickly, then I was seen by hand specialists who were so reassuring and thoroughly explained everything and put me at ease. The nurse was outstanding - so friendly and made what was an unpleasant experience much more tolerable. I wasn't even home yet when I got a call to schedule my follow up appointment with their hand clinic in three days time - much better than a week and a half of wondering what's happening beneath all those bandages They also prescribed me stronger painkillers (I wasn't even advised to take ibuprofen at the last place) which has made the world of difference. I cannot recommend the nurse highly enough. The hand specialists were superb!

I felt like I was in safe hands, wasn't a burden (esp as am sure my injury pales in comparison to so many others) and left feeling good about everything.

Visited in April 2015. Posted on 28 April 2015

St George's University Hospitals NHS
NHS Foundation Trust

Workforce

excellent kind responsible respectful

9. UNIFY REPORT FOR INPATIENT AREAS

Ward name	Day				Night				Day		Night	
	Registered midwives/ nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Cardiothoracic Intensive Care	6889.50	6168.50	0.00	0.00	6382.50	6167.00	264.50	264.50	89.5%	#DIV/0!	96.6%	100.0%
Carmen Suite	1450.50	1384.25	309.00	275.50	1230.50	1186.50	310.50	299.00	95.4%	89.2%	96.4%	96.3%
Champneys Ward	1240.00	1200.66	306.00	326.50	729.00	718.00	342.50	342.50	96.8%	106.7%	98.5%	100.0%
Delivery Suite	3639.00	3694.00	740.00	566.00	3461.50	3723.00	690.00	677.25	101.5%	76.5%	107.6%	98.2%
Fred Hewitt Ward	1837.00	1603.25	395.50	425.50	1414.50	1370.50	45.25	45.25	87.3%	107.6%	96.9%	100.0%
General Intensive Care Unit	6736.25	6268.00	448.50	91.50	6244.50	6028.00	195.50	195.50	93.0%	20.4%	96.5%	100.0%
Gwillim Ward	2278.00	2316.25	866.00	783.00	1058.00	1033.75	529.00	460.00	101.7%	90.4%	97.7%	87.0%
Jungle Ward	833.00	823.00	11.50	0.00	0.00	0.00	0.00	0.00	98.8%	0.0%	#DIV/0!	#DIV/0!
Neo Natal Unit	7670.00	7203.02	0.00	0.00	6965.50	7000.25	0.00	23.00	93.9%	#DIV/0!	100.5%	#DIV/0!
Neuro Intensive Care Unit	4300.00	4021.00	341.50	252.50	4082.50	4014.50	316.25	316.25	93.5%	73.9%	98.3%	100.0%
Nicholls Ward	2490.00	2278.50	325.50	276.00	1712.50	1649.00	335.50	301.50	91.5%	84.8%	96.3%	89.9%
Paediatric Intensive Care	2801.75	3124.01	526.00	440.33	2756.00	3134.00	322.00	322.00	111.5%	83.7%	113.7%	100.0%
Pinckney Ward	2179.50	2398.50	360.00	345.00	1725.00	1690.50	0.00	0.00	110.0%	95.8%	98.0%	#DIV/0!
Dalby Ward	1625.00	1487.00	1761.00	1688.00	1000.50	989.00	1161.50	1115.50	91.5%	95.9%	98.9%	96.0%
Heberden	1494.50	1286.66	1630.00	1554.26	1035.00	1023.50	929.00	929.00	86.1%	95.4%	98.9%	100.0%
Mary Seacole Ward	1550.50	1279.00	1496.98	1499.98	862.50	850.50	1161.50	1161.50	82.5%	100.2%	98.6%	100.0%
A & E Department	9736.50	8991.75	2580.00	2091.83	9015.50	8420.50	1035.00	874.00	92.4%	81.1%	93.4%	84.4%
Allingham Ward	2159.48	1820.23	918.00	907.50	1299.50	1137.50	1137.50	1115.50	84.3%	98.9%	87.5%	98.1%
Amyand Ward	2529.75	2110.75	1317.50	1303.50	1736.50	1622.50	1138.50	1139.00	83.4%	98.9%	93.4%	100.0%
Belgrave Ward AMW	2462.50	2043.00	1354.50	1031.50	1759.08	1724.58	391.00	368.00	83.0%	76.2%	98.0%	94.1%
Benjamin Weir Ward AMW	1929.00	1832.75	581.00	557.25	1989.50	1845.25	657.75	620.50	95.0%	95.9%	92.7%	94.3%
Buckland Ward	1880.50	1573.50	546.50	483.50	1069.50	1069.50	368.00	368.00	83.7%	88.5%	100.0%	100.0%
Caroline Ward	1807.50	1648.50	763.50	662.50	1380.00	1357.00	57.00	57.00	91.2%	86.8%	98.3%	100.0%
Cheselden Ward	1718.75	1638.75	363.50	283.50	1035.00	1023.50	253.00	253.00	95.3%	78.0%	98.9%	100.0%
Coronary Care Unit	2304.75	2107.75	51.25	29.50	2139.00	2054.50	46.00	23.00	91.5%	57.6%	96.0%	50.0%
James Hope Ward	1308.50	1245.50	313.50	295.50	460.00	448.50	0.00	0.00	95.2%	94.3%	97.5%	#DIV/0!
Marnham Ward	2794.50	2433.50	1193.00	862.50	2150.50	1989.50	851.00	828.00	87.1%	72.3%	92.5%	97.3%
McEntee Ward	1450.98	1349.98	702.00	663.00	1069.50	1069.50	460.00	448.50	93.0%	94.4%	100.0%	97.5%
Richmond Ward	4705.25	4321.75	2854.00	2571.50	4208.75	3907.50	2506.67	2460.17	91.8%	90.1%	92.8%	98.1%
Rodney Smith Med Ward	2031.00	1947.50	1479.25	1497.75	1278.50	1255.50	1080.75	1080.75	95.9%	101.3%	98.2%	100.0%
Ruth Myles Ward	1344.30	1278.80	523.50	567.00	966.00	931.50	402.50	391.00	95.1%	108.3%	96.4%	97.1%
Trevor Howell Ward	1994.50	1899.00	894.00	616.50	1058.00	1012.00	701.50	690.00	95.2%	69.0%	95.7%	98.4%
Winter Ward (Caesar Hawk)	1610.00	1524.50	1125.00	1006.26	1299.50	1288.00	797.50	775.50	94.7%	89.4%	99.1%	97.2%
Brodie Ward	1248.00	1195.50	703.50	660.50	1035.00	1012.00	0.00	0.00	95.8%	93.9%	97.8%	#DIV/0!
Cavell Surg Ward	1955.50	1883.42	751.50	809.36	1035.00	989.00	345.00	321.75	96.3%	107.7%	95.6%	93.3%
Florence Nightingale Ward	2086.00	1914.50	670.50	626.50	1368.50	1380.00	0.00	80.50	91.8%	93.4%	100.8%	#DIV/0!
Gray Ward	2596.00	2414.50	1182.00	848.58	1369.50	1356.75	685.00	605.00	93.0%	71.8%	99.1%	88.3%
Gunning Ward	1897.50	1733.13	899.50	780.08	1000.50	977.50	850.25	825.50	91.3%	86.7%	97.7%	97.1%
Gwynne Holford Ward	1353.00	1355.50	1354.50	1323.25	1334.00	1227.50	1386.50	1265.25	100.2%	97.7%	92.0%	91.3%
Holdsworth Ward	1786.00	1646.52	749.00	685.52	1070.00	1034.25	724.50	712.25	92.2%	91.5%	96.7%	98.3%
Keate Ward	1684.00	1627.50	590.50	519.63	1035.00	1035.00	80.50	80.50	96.6%	88.0%	100.0%	100.0%
Kent Ward	2294.50	2102.50	1665.00	1066.50	1460.50	1422.75	1046.50	1023.50	91.6%	64.1%	97.4%	97.8%
Mckissock Ward	2064.50	1906.50	940.30	763.50	1518.00	1473.75	264.50	264.50	92.3%	81.2%	97.1%	100.0%
Vernon Ward	2306.80	2136.50	756.00	556.00	1358.50	1336.00	342.50	342.50	92.6%	73.5%	98.3%	100.0%
William Drummond HASU	2970.00	2701.08	643.50	605.00	2760.00	2550.50	667.00	630.50	90.9%	94.0%	92.4%	94.5%
Wolfson Centre	1411.00	1240.50	1003.00	756.26	690.00	667.00	678.50	667.00	87.9%	75.4%	96.7%	98.3%
Gordon Smith Ward	2250.00	2193.00	761.00	691.00	1369.00	1518.50	391.00	322.00	97.5%	90.8%	110.9%	82.4%
Nightingale Step Down	1641.00	1570.05	57.75	57.75	828.00	828.00	11.50	0.00	95.7%	100.0%	100.0%	0.0%
Trust Total	122,326.06	113,923.81	39,805.03	34,704.09	93,805.83	91,543.33	25,959.92	25,085.42	93.13%	87.19%	97.59%	96.63%

Day Qual	Day HCA	Night Qual	Night HCA
93.13%	87.19%	97.59%	96.63%

9. Workforce: April 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 April 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 April the trust achieved an average fill rate of 94.10%, a slight increase from 93.22% submitted in March . 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 has changed to assist the reader in reviewing data more easily by division.

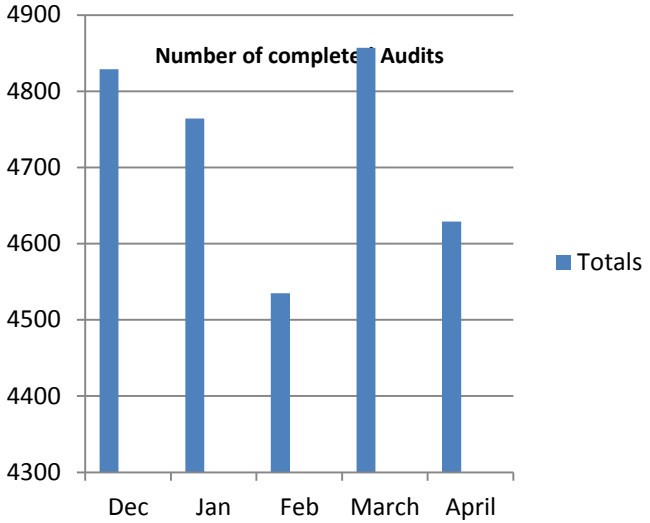
Although some of our wards are operating below 100% the data does not indicate if a ward is unsafe. Safe staffing is much more complex than an observation of percentages and takes in to account many key aspects such as:
Nurses, midwives and care staff work as part of a wider multidisciplinary ward team.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

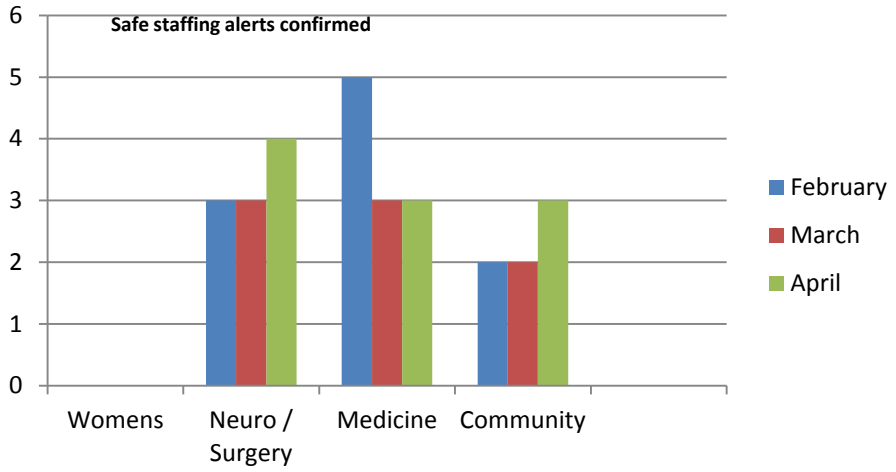
- The data does not take into account the on-going considerations for ward managers in ensuring that on each shift there is the right level of experience and expertise in the ward team.
- The nature of each ward varies. The number and type of patients seen on some wards will be relatively consistent. 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 data is collected, validated and reported.
- Anomalies in the report continue to be investigated by the leads for erostering and workforce

9. Workforce
April 2015 - Safe Staffing alerts





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

The total number of safe staffing audits completed over the past three months were: February 4535, March 4857adn April 4629. There was a slight increase in the number of final alerts reported from 8 in March to 10 in April. The number of alerts reduced to a concern (ward is safely staffed but some care needs will not be completed) has decreased during the previous three months following on the day investigation (February 32, March 25, April 15).

10 nursing related safe staffing concerns were raised on Datix system compared to 13 in March. 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.

St George's University Hospitals NHS
NHS Foundation Trust

Heatmap Dashboard
Ward view

excellent kind responsible respectful

10. Ward Heatmap

		INCIDENCE OF C.DIFFICILE	INCIDENCE OF MRSA	TRUST ACQUIRED PRESSURE SOR..	PERCENTAGE OF HARM FREE CARE	PATIENT SATISFACTION (FRIENDS & FA..	FRIENDS & FAMILY RESPONSE RATE	WARD STAFFING: UNFILLED DUTY HOURS	FALLS (WARD LEVEL)	SERIOUS INCIDENTS (WARD LEVEL)	SICKNESS/ ABSENCE RATE - (WARD)
Children & Women's	CARDIOTHORACIC IN..	0.0	1.0	0.0	94.4	100.0		6.9	0.0	0.0	3.0
	CARMEN SUITE	0.0	0.0	0.0	100.0		0.0	4.7	0.0	0.0	7.9
	CHAMPNEYS	0.0	0.0	0.0	100.0	95.7	44.3	1.1	0.0	0.0	3.5
	DELIVERY	0.0	0.0	0.0	90.0		10.0	-1.5	0.0	0.0	4.6
	FREDDIE HEWITT	0.0	0.0	0.0	100.0		0.0	6.7	1.0	0.0	1.9
	GENERAL ICU/HDU	0.0	0.0	0.0	93.3	100.0	37.5	7.6	0.0	0.0	2.6
	GWILLIM	0.0	0.0	0.0	82.6	89.1	64.8	2.9	1.0	0.0	5.7
	JUNGLE	0.0	0.0	0.0			12.5	2.5	0.0	0.0	3.2
	NEONATAL ICU	0.0	0.0	0.0	100.0	100.0		2.8	0.0	0.0	3.3
	NEURO ICU	0.0	0.0	0.0	88.9		0.0	4.8	0.0	0.0	4.2
	NICHOLLS	0.0	0.0	0.0	100.0		0.0	7.4	0.0	0.0	2.4
	PICU	0.0	0.0	0.0	100.0	100.0		-9.6	0.0	0.0	2.2
	PINCKNEY	0.0	0.0	0.0	100.0	100.0	3.7	-4.0	0.0	0.0	1.5
Medicine & Cardiovascular	ALLINGHAM	0.0	0.0	0.0	90.9	91.7	51.1	9.7	15.0	0.0	2.5
	AMYAND	0.0	0.0	0.0	100.0	100.0	17.5	8.1	8.0	0.0	4.1
	BELGRAVE	0.0	0.0	0.0	90.9	86.2	83.7	13.4	7.0	0.0	1.4
	BENJAMIN WEIR	0.0	0.0	0.0	96.4	97.9	47.5	5.8	1.0	0.0	0.6
	BUCKLAND	0.0	0.0	0.0	100.0	100.0	47.1	9.6	5.0	0.0	1.0
	CAESAR HAWKINS	0.0	0.0	0.0	90.5	100.0	38.8	4.9	5.0	0.0	11.9
	CARDIAC CARE UNIT	0.0	0.0	0.0	100.0	100.0	63.6	7.2	1.0	0.0	2.1
	CAROLINE	0.0	0.0	0.0	94.3	98.1	50.0	7.1	4.0	0.0	4.1
	CHESELDEN	0.0	0.0	0.0	95.5	100.0	52.6	5.1	3.0	0.0	5.1
	DALBY	0.0	0.0	0.0	87.5	100.0	21.9	4.8	11.0	0.0	8.6
	EMERGENCY DEPART..	0.0	0.0	0.0		76.5	24.4	8.9	3.0	10.0	2.5
	HEBERDEN	0.0	0.0	1.0	77.3	100.0	62.5	5.8	7.0	1.0	8.1
	JAMES HOPE	0.0	0.0	0.0	100.0	100.0	71.6	4.4	1.0	0.0	8.4
	MARNHAM	0.0	0.0	0.0	88.9	100.0	21.2	12.5	7.0	0.0	2.7
	MCENTEE	0.0	0.0	0.0	100.0	97.0	75.0	4.1	2.0	0.0	3.7
	RICHMOND	0.0	0.0	0.0	86.3	96.9	38.8	7.1	8.0	1.0	5.3
	RODNEY SMITH	0.0	0.0	0.0	81.5	100.0	9.1	1.5	4.0	0.0	2.0
	RUTH MYLES	0.0	0.0	0.0	91.7	100.0	40.0	2.1	0.0	0.0	3.7
	TREVOR HOWELL	1.0	1.0	0.0	100.0	91.3	53.5	9.3	2.0	0.0	7.4
Surgery & Neurosciences	BRODIE NEURO	0.0	0.0	0.0	96.7	91.3	39.0	4.0	1.0	0.0	0.1
	CAVELL	0.0	0.0	0.0	100.0	90.8	51.5	2.0	1.0	0.0	3.9
	FLORENCE NIGHTING..	0.0	0.0	0.0	100.0	95.0	106.0	3.0	2.0	0.0	2.2
	GRAY WARD	0.0	0.0	0.0	100.0	93.2	39.9	10.4	1.0	0.0	4.6
	GUNNING	0.0	0.0	0.0	82.6	96.7	53.6	7.1	4.0	0.0	1.3
	GWYN HOLFORD	0.0	0.0	0.0	96.4	100.0	85.7	4.7	7.0	0.0	5.9
	HOLDSWORTH	0.0	0.0	0.0	0.0	100.0	48.8	5.8	2.0	0.0	7.2
	KEATE	0.0	0.0	0.0	100.0	98.5	62.4	3.8	3.0	0.0	3.1
	KENT	0.0	0.0	0.0	96.8	100.0	3.5	13.2	1.0	0.0	2.2
	MARY SEACOLE	1.0	0.0	0.0	77.8	94.7	51.1	5.5	9.0	0.0	4.5
	MCKISSOCK	0.0	0.0	0.0	95.8	95.1	60.3	7.9	8.0	0.0	4.5
	VERNON	0.0	0.0	0.0	94.7	98.4	47.1	8.2	1.0	1.0	8.2
	WILLIAM DRUMMOND ..	0.0	0.0	0.0	100.0	93.3	30.9	7.9	4.0	0.0	2.8

10. Ward heatmap:
- CWDT&CC Division

Cardiothoracic Intensive Care Unit - CTICU reported a single MRSA acquisition April 2015. Due to other infection control concerns there has been and continues to be significant focus on infection control within CTICU, with an established Task and Finish group and associated action plan which is progressing well. The unit reported 94.4% for harm-free care in April 2015; this relates to 1 patient with a new grade 2 pressure ulcer out of a total of 18 patients surveyed, a similar picture was seen in March 2015.

Carmen Suite - Carmen Suite do not record the friends and family test hence the zero % should be removed.

Champneys - It is worth noting in April 2015 Champneys saw a significant improvement in the friends and family response rate. This is the first month that this has been achieved since January 2015. The objective for the team is to now sustain this; which is being addressed through a wider quality action plan that is currently being delivered on the ward.

Delivery Suite - The delivery suite recorded a performance of 90% harm free care in month, this relates to 1 patient with a catheter and old UTI out of a total of 10 patients surveyed. Since the change in Serious Incident declaration criteria, delivery suite is no longer mandated to report the unexpected admissions to NNU, hence the reduction of serious incident in this area in month.

Gwillim - There is a discrepancy in the recording of data between the heatmap data for % harm-free care and the safety thermometer record; the safety thermometer reports compliance at 100%

Jungle, Freddie Hewitt, Nicholls and Pinckney wards - The above wards reported performance ranging from 0 % to 12.5% for the friends and family response rate in month. April 2015 was the first month that this initiative was operational within these areas and additional focus is required to improve compliance in this area. General Intensive Care Unit The unit reported 93.3 % for harm free care. This relates to 1 patient with a new grade 2 pressure ulcer out of a total of 15 patients surveyed.

Neuro Intensive Care Unit - The unit reported 88.9% for harm free care. This results from 1 patient having a catheter and an old UTI out of a total of 9 patients surveyed. Sickness Several areas across the division are reporting sickness greater than the Trusts 3% target, however overall the profile for sickness has improved slightly for the division in month. Rota management meetings continue across the division to ensure adequate support for staff in the management of sickness.

10. Ward heatmap:
- STNC Division

This report focuses on those areas with any red indicator and those with 3 or more indicators. Overall within the surgical division the number of red flags has remained consistent at 12 since the last report and the amber flags have continued to decrease from 5 to 4. The key areas of focus for red flags or risk continue to relate to sickness, falls, FFT response rate & Harm free care, although improvements are being seen in the overall numbers of flags in relation to the latter two indicators as a result of on-going focused work.

Gray Ward – 2 indicators (1 red & 1 amber) – This is an improved performance since the last report with a reduction in red flags. Sickness is pregnancy related and mat leave has been commenced early in response to the relevant risk assessment. 1 wte HCA is on long term sick and meetings are in place to manage this.

Gunning ward – 2 red indicators – The Harm Free Care flag relates to 4 falls - 3 no harm and 1 with an associated minor injury, they were all mechanical. There were 2 CAUTI's for both of which the care plan was commenced appropriately and pts had a history of UTI's. There was 1 old inherited pressure ulcer and 2 new. Work is in progress and the new band 7 senior sister is cited upon the needs to focus on this area of care.

Gwynne Holford – 2 red indicators – the key are of concern being falls with 7 in total- this related to one pt falling on several occasions. The pt is restless and agitated but appropriately risk assessed and more information has been requested in relation to these incidents. Sickness is consistent with the previous month and relates to two staff on long terms sickness of which one has now returned.

Holdsworth – 1 red indicator – relates to sickness and one staff member on long term back related sickness. OH referral complete and management in place.

Kent- 2 indicators (1 red and 1 amber) – The red flag relates to FFT response rate and the service believe this data is incorrect. The issues appear to be that data collected has not been downloaded onto the system and that there are two entries for the ward. This is being investigated. The unfilled shifts relates to a number of new HCA's taking up post but being on trust induction & orientation. This should reduce in the May data.

McKissock- 2 indicators – There were 8 falls in April with 1 pt falling twice and the others being controlled, witnessed slides to the floor. Again sickness has triggered and relates to two staff on long term sickness. I is resigning and the other being managed. Short term sickness has decreased.

Vernon – 3 indictaors (2 red & 1 amber) – Sickness increased due to Flu and 2 back injuries, both staff of which are now back at work. The SI is currently being investigated and involved an agency nurse.

Areas requiring further support and investigation into issues such as falls & Harm Free Care related issues are Gwynne Holford, McKissock and Gunning. Keate and Florence continue to perform well and Cavell has shown an improvement this month.

10. Ward heatmap:
-Med Card Division

The division has seen an increase in falls for the month of April – 29 compared to the position of 22 in March, which was a decline from 35 in February.
Belgrave – Falls – 7 - This has been an increase from 3 in March. There has been no moderate or above harm caused to these patients as a result of these falls. The Matron is currently reviewing these falls with the ward sister to establish any learning from the events.
Buckland – Falls – 5 – On review of these cases some of these falls are down to a multiple faller. In this case risk assessments were appropriately completed for the patient. The Matron has also reviewed a number of other patients to ensure compliance with the falls risk assessment process and where appropriate a special has been requested.
Caroline – Falls – 4 – This has remained consistant at 4 for the last 3 month. The Matron will be working with the ward sister to review these cases to establish if there has been any themes. No moderate or above harm has been reported for these falls.
Cheselden – Sickness – 5.1% This is a combination of long term and short term sickness which is being managed in line with trust policy and one case has progressed to a stage 3 hearing which is scheduled.
T.Howell- C/Diff one case, MRSA one case and sickness at 7.4% The last 3 months have shown a slight worsening picture regarding sickness. The ward has had 2 members of staff on long term sickness which is being managed and a phased return planned for one staff member. This position has been worsened by 43 hours of short term sickness during this period which has been managed, resulting in one staff member progressing to stage 1.

MRSA– RCA is currently being completed and awaits final review. The patient was a known MRSA carrier since 2011 in their nose and groin, and was swabbed on admission, the patient had no cannulae insitu, it is felt that despite the patient having swallowing difficulties they continued to to try to eat and drink and the consultant feels they may have aspirated and possible bacteraemia came from the lungs, equally the bacteraemia may be a result of the blood sampling process during obtaining cultures. There is also discussion regarding the clinical appropriateness of obtaining blood cultures on this patient given their clinical condition.
C.Diff RCA completed – This will be presented at the Infection Control committee. Initial findings suggested that this incident is probably unavoidable and antibiotic therapy had been prescribed appropriately.

Dalby 87.5% harm free care as a result of 24 Patients survyed. 3 patients with harms all with old grade 3 pressure ulcer's. The ward has also seen an increase in falls and sickness. These cases are being reviewed to establish themes and any learning as a result of falls. Sickness is being managed in line with policy.
Heberden 77.27% Harm Free Care. 22 patients surveyed. 5 patients with harms reported. 1 patient had a fall with low harm. 1 patient had an old grade 2 pressure ulcer, 1 patient had had an old grade 3 and 1 patient had an old grade 4 pressure ulcer. There was also a patient with a new grade 2 pressure ulcer. The ward has also had attributed 1 pressure sore, which has an RCA underway to establish any learning from this incident.
Marnham 88.89% of Harm Free Care This is a result of 27 Patients surveyed. 3 patients with harms. 2 patient had a catheter and new UTI and 1 patient had an old grade 3 pressure ulcer.
Richmond 86.27% of Harm Free Care. This is a result 51 patients surveyed. 8 harms reported. 1 patient had two harms, A low harm fall and a catheter and UTI. 2 patients had old grade 2 pressure ulcer's. 1 patient had an old grade 3 pressure ulcer. 1 patient had a VTE Harm (New PE). 1 patient had a catheter and new UTI and 1 patient had a catheter and old UTI. The unit had 8 falls which is a slight increase from 7 in the previous month. The Matron and ward sister are completing documentation audits to ensure compliance with risk assessments. There has been no reports of moderate or above harms as a result of these falls. The Matron continues to meet monthly with HR to ensure management of sickness in line with trust policy.
Rodney Smith – 81.48% Harm Free Care. There were 27 patients surveyed. 5 harms reported.3 patients had VTE harms, (2 New PE'S and 1 new other). 1 patient had an old grade 4 pressure ulcer and 1 patient had an old grade 2 pressure ulcer.

11. Community Services
- CQR Scorecard – Apr 2015 Page 1 of 2

Domain	*Patient Safety & Experience*																	
	Indicator	Frequency	2015/2016 Target	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Direction
					Quarter 1 2015/16			Quarter 2 2015/16			Quarter 3 2015/16			Quarter 4 2015/16			
Patient Safety	SI's REPORTED	Monthly	0	9	1												↓
Patient Safety	Number of SI's breached	Monthly	0	0	0												→
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly	0	3	1												↓
Patient Safety	Grade 4 Pressure Ulcers	Monthly	0	0	0												↓
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly	0	22	8												↓
Patient Safety	Number of moderate falls	Monthly	0	0	1												↑
Patient Safety	Number of major falls	Monthly	0	1	0												↓
Patient Safety	Number of falls resulting in death	Monthly	0	0	0												→
Patient Safety	MRSA	Monthly	0	0	2												↓
Patient Safety	CDiff (cumulative)	Monthly	31	0	1												↑
Patient Safety	CAS ALERTS - Number ongoing-received (Trust)	Monthly	0		2												
Patient Safety	Number of Quality Alerts	Monthly	0	3	3												↑
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	95%	92% Apr 15	89.0%												↓
Safeguarding	% of staff compliant with safeguarding childrens training	Monthly	Level 1 95%	90% Apr 15	90.0%												→
			Level 2 95%	85% Apr 15	84.0%												↓
			Level 3 95%	71% Apr 15	69.0%												↓

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

Patient Outcomes	Mortality SHMI ratio (Trus)	Monthly	<100	<100	86.00%												▼
Patient Experience	Active Claims	Monthly	0		tbc												
Patient Experience	Number of Complaints received	Monthly	0	11	17												▲
Patient Experience	Number of Complaints responded to within 25 days (reporting 1 month in arrears)	Monthly	85%	100%	Data available mid May 15												
Patient Experience	Number of Complaints responded to within 25 days with an agreed extension	Monthly	95%	100%													
Patient Experience	FFT Score (Mary Seacole and MIU)	Monthly		37%	37.50%												➤
Patient Outcomes	Catheter related UTI (Trust)				tbc												
	Number of new VTE (Trust)		National 0.005		tbc												
Workforce	Number of DBS Request Made	annually			NA												
Workforce	Sickness Rate -	Monthly	3.50%	Data available mid Apr 2015	5.72%												▲
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
- Exception Reporting

Serious Incidents:

Pressure ulcers: In April there was 1 Grade 3 pressure ulcers acquired in our care (community nursing). Mary Seacole ward continues to have no reported grade 3 or 4 pressure ulcer incidents occurring in our care for >200 days.

Falls: There were 9 No Harm and Low severity fall were reported in April compared to 22 in March.

Complaints: 17 received in April (9 OHC, 1 community nursing, 4 rehab/prosthetics, 2 QMH OPD, 1 RSH). This is an increase on March 2015. No trends.

Human Resources:

- Sickness absence fell slightly in April to 5.72% compared to 6.45% in March. HR continues to work with service managers to reduce sickness absence.
- There was a slight increase in turnover from 18.84% in March to 19.64% in April. In addition to the Trust wide retention strategies, the division practices local strategies like suggestion boxes on the wards and sharing career opportunities
- The vacancy rate remains high in April at 19.41%, this is a small improvement on the previous month when it was 19.59%. A Recruitment and Retention strategy is in place, which includes a recruitment tracker and reviewing of the local induction process.
- In April Appraisal rates for Medical staff fell to 66.67% from 83.3% and the divisional non-medical appraisal rate is currently at 76.8%.

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.

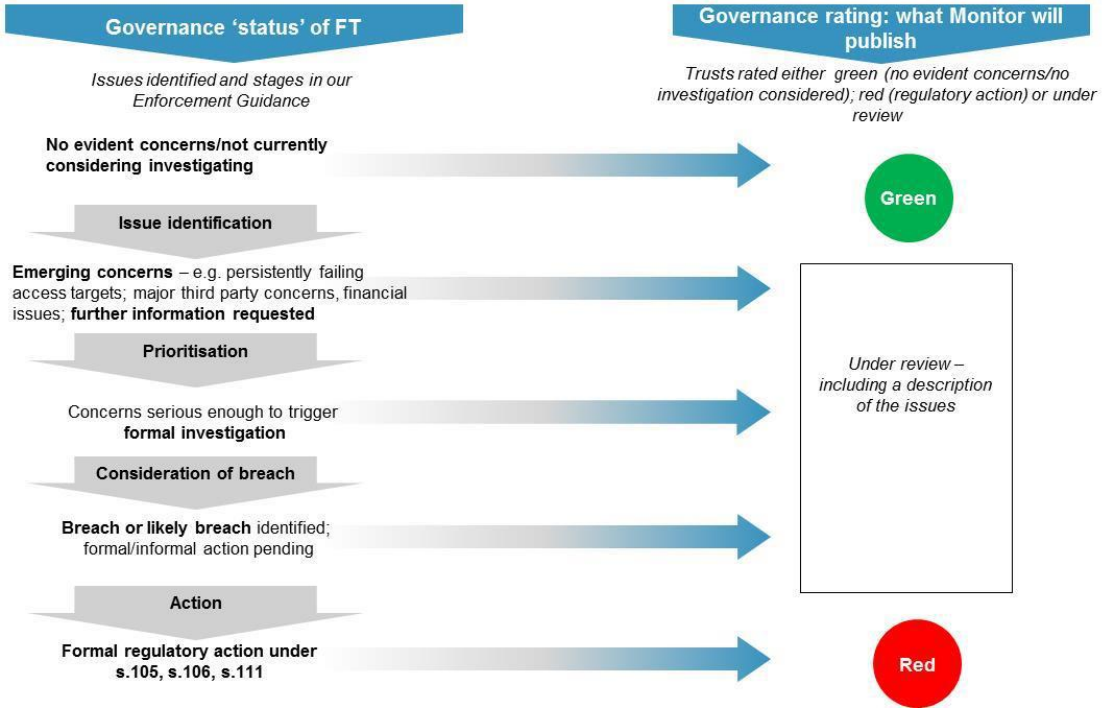
In addition to the above, when assigning governance ratings Monitor also take into account the following which may lead to overrides in the governance rating::

- 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 01 2015/16

Finance and Performance Committee Jun 4th 2015

This report summaries the financial position at m1 2015/16. Because of the focus on 2014/15 etc, the organisation is behind where it should be on issuing detailed budgets and as a consequence the finance report is more limited in scope and detail than usual and the commentary less comprehensive. A fuller finance report will be prepared for m2.

❶ Month 01 Headlines

Area of Review	Key Highlights	Month
Financial Position	As at month 1 the Trusts is showing a deficit of £7.6m against its monitor plan deficit of £6.5m giving an adverse variance of £1.1m (comprising Pay £0.7m adv, Income £0.5m adv and Non-pay £0.2m fav). This position includes £0.7m of income / costs that were missed from 2014/15 and have been charged to the current financial year. This implies that the run-rate is £0.4m 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 m2 reporting. These issues relate to cost pressures and the finalisation of the Trusts SLA.	
Activity / Income	SLA income is £0.5m behind plan mainly in out patients which is 4% 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 m1 SLAM. The Trust is £0.3m over plan on contract exclusions offset by costs. Other income includes £0.2m relating to the final TDA settlement for 14/15 not notified in time for the final accounts	
Expenditure-Pay	Pay costs are £0.7m overspent of which £0.5m relate to CIPS. The % of spend on in post increased to 87% from 85% in month. Of the £0.7m, £0.5m are coded to unallocated CIPS. For month 2, divisions need to complete their workforce plans which will align their budgets to pay groups and correctly group CIP's	
Expenditure – Non Pay	Non-pay costs are £0.2m below budgets. Where reserves are phased into the budgets these have been accrued. Non-pay expenditure contains £0.3m of costs relating to 14/15. Adjusting for this implies a run-rate non-pay of c2%	
COSRR	In M01 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 M01.	
Cash	The cash balance was £14.2m at 30th April, down £10.2m on last month but in line with plan (£14.2m). The trading deficit of £7.6m and a deterioration of £2.6m in working capital were the causes of the reduction. The under spend on capital offset the cash impact of the higher trading deficit enabling the Trust to achieve the planned cash balance. The Trust has applied for interim cash support funding of £52.2m in the plan submitted to Monitor and may draw down funds using its approved working capital facility of £25m pending approval of this application with Monitor and the ITFF. The cash forecast indicates the Trust will need to draw down approximately £2.1m in June to maintain the maximum £3m cash balance permitted under the terms of this facility.	
Capital	Capital expenditure was £2.2m in April, an under spend of £2.1m. In order to support the cash position the Trust must minimise capex until the outcome of discussions with Monitor on the level and timing of interim support funding are concluded. Budgets have been provisionally classified to determine their priority and expenditure will be frozen for schemes regarded an non-essential until further notice.	

❶ Month 01 Headlines : Conclusions and risks

Category	Conclusions / Risk	Evidence
Activity/Income	Activity is down against plan as shown in m1 SLAM particularly in out patients (4%). 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. Early indications for May is that is line with April.	Slide 5
Pay	Pay costs are £0.7m over budget mainly around CIPs. 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.	Slide 7
Pay	In April we spent £37.4m compared to £39.2m in March. Pay in posts represented 87% of costs in month compared to 85% in March. Pay costs are in line with m10 and m11 which has costs have increased by 1%.Agency/Bank WTE's in April are lower than March by 85. 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.	Slide 7
Non Pay	Non Pay costs are £0.2m below budget no emerging risks highlighted in m1. £0.3m of off site storage costs relating to 14/15 were incurred in m1.	Slide 8
Capital	Key risk for Capex is that the internal plan is on hold until the interim support is confirmed	Slide 10
Cash	Risk will remain high until the timing of the £52.2m interim supported is confirmed.	Slide 11

❷ Update on 2015/16 budget setting

- The Trust has planned a budget for 2015/16 where expenditure exceeds income by £46.2m. This is primarily as a result of i) underlying issues from 2014/15, loss of CQUIN income in 2015/16 and iii) other unavoidable cost pressures in 2015/16 and is discussed in recent Board and F&P papers.
- The 'Business Planning Model' is the primary tool that the Trust uses to ensure coherence in moving from the previous year's budgets to the budgets in the new year. This model provides control totals at the Division / Directorate (and care group) levels that are used to ensure that the detailed budgets held in the finance ledger system (Agresso) come back to the correct figures.
- Normally at this point in the year budgets would already be represented at the detailed cost centre / account code level. However this year the focus on the 2014/15 outturn (and its impact on the underlying position) has meant that the detailed budget setting process is significantly behind schedule.
- Budgets in the ledger have now been aligned to the BPM at the Directorate level and this position has been used for month 1 reporting.
- Whereas there is some way to go to ensure budgets cascade down to the lowest level, all actual income and expenditure is reported at the detailed level.
- Next steps for budget setting:
  - Ensure all budgets are properly held at the cost centre / account code level
  - Ensure that WTEs in ESR agree to the pay budgets and WTEs in the ledger
  - Resolve SLA contract positions with the CCGs and NHSE and ensure that the ledger position fully agrees.
  - Final review by EDs to agree cost pressures that will be funded.

❸ Overall Position

	Annual Budget £k	Current Budget £k	Current Amount £k	Current Variance (adv) / fav £k	%
SLA Income	624,235.0	48,600.0	48,063.8	(536.2)	*-1.1%*
Other Income	101,261.6	8,429.7	8,335.4	(94.3)	*-1.1%*
Overall Income	725,496.6	57,029.7	56,399.2	(630.5)	*-1.1%*
Pay	(441,328.6)	(36,707.0)	(37,390.0)	(683.0)	*-1.9%*
Non Pay	(294,171.5)	(23,749.5)	(23,541.5)	208.0	*0.9%*
Overall Expenditure	(735,500.1)	(60,456.5)	(60,931.5)	(475.0)	*-0.8%*
EBITDA	(10,003.5)	(3,426.8)	(4,532.3)	(1,105.5)	*-32.3%*
Dpn, PDC div etc	(36,258.3)	(3,021.7)	(3,023.5)	(1.8)	*-0.1%*
Surplus / (deficit)	(46,261.8)	(6,448.5)	(7,555.8)	(1,107.3)	*-17.2%*

- The Trust planned a significant loss for month 1 (£6.5m) and the position achieved in month 1 is a larger loss still (£7.6m). This position includes £0.7m of income / costs that were missed from 2014/15 and have been charged to the current financial year. This implies that the run-rate is £0.4m adverse to plan – see Appendix B.
- The position reported in m1 indicates that both income and pay are behind target (by 1.1% and 1.9% respectively) and that this is only partially offset by non-pay being underspent (0.9%).
- The predominant effect on the pay position is a shortfall in achieving CIPs.

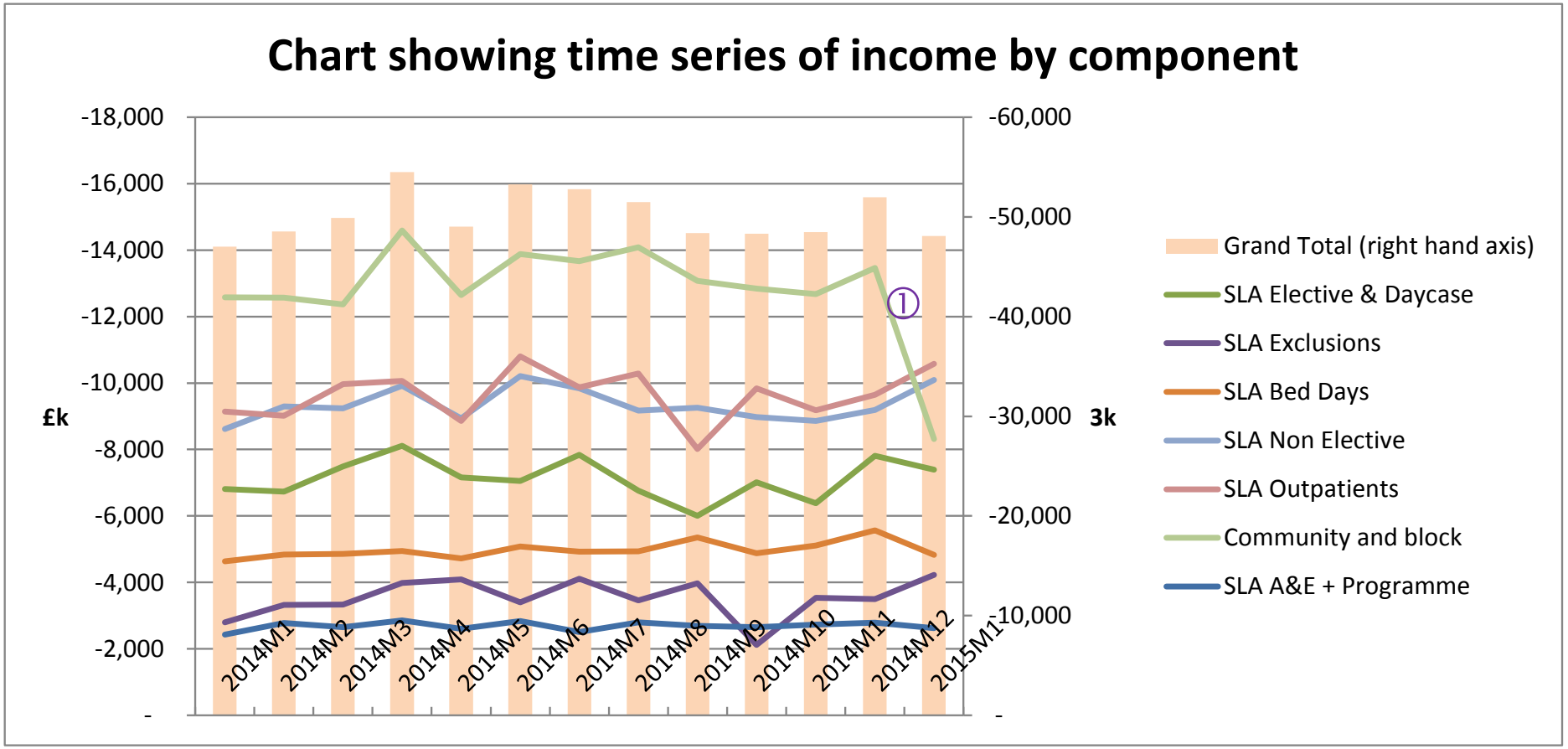
Variance (adv) / fav	CWDT £k	CSW Provider Services £k	Medicine and CV £k	Surgery and Neuro £k	Overheads £k	R&D £k	SWL Pathology £k	Reserves £k	Trust Income £k	Grand Total £k
SLA Income	(159.5)	169.7	(519.4)	(89.3)	21.1	0.0	0.0	0.0	41.2	(536.2)
Other Income	76.8	43.1	(100.2)	(33.9)	(308.1)	11.5	363.4	125.2	(272.2)	(94.3)
Non Pay	(400.8)	145.4	(118.9)	(236.8)	389.9	21.6	(434.0)	841.5	0.0	208.0
Pay	80.6	(419.3)	(52.8)	(33.9)	(322.3)	(26.2)	90.8	0.0	0.0	(683.0)
Other	(7.7)	(0.3)	2.2	(11.0)	4.9	0.0	0.0	10.1	0.0	(1.8)
Grand Total	(410.6)	(61.3)	(789.1)	(404.8)	(214.5)	6.9	20.2	976.8	(231.0)	(1,107.3)

❹ Income

Variance month 1 2015/16 (adv) / fav	CWDT £k	%	CSW £k	%	Medicine & CV £k	%	Surgery & Neuro £k	%	Trust Income £k	%	Overheads £k	%	Grand Total £k	%
SLA A&E	0.0		(13.0)	-12.7%	(116.0)	-7.9%	0.0		99.2		0.0		(29.8)	-1.9%
SLA Bed Days	(28.8)	-0.7%	5.4	1.2%	0.0		(93.9)	-15.4%	0.0		0.0		(117.3)	-2.4%
SLA Daycase	20.3	5.7%	0.0		10.9	1.2%	(49.6)	-4.5%	0.0		0.0		(18.4)	-0.8%
SLA Elective	(48.4)	-11.9%	0.0		(213.5)	-10.7%	149.7	5.4%	0.0		0.0		(112.3)	-2.2%
SLA Exclusions	3.7	2.5%	(82.6)	-11.4%	277.9	13.3%	83.4	14.7%	100.0		(17.3)	-5.1%	365.0	9.5%
SLA Non Elective	173.3	26.2%	0.0		(252.0)	-4.8%	(107.8)	-2.7%	314.7		0.0		128.2	1.3%
SLA Other	(188.2)	-11.2%	337.7	6.5%	(22.2)	-1.4%	(10.3)	-3.8%	(462.7)	697.0%	38.4	-124.3%	(307.3)	-3.6%
SLA Outpatients	(91.7)	-2.6%	(77.8)	-3.8%	(164.1)	-5.6%	(11.6)	-0.5%	(9.9)	-82.6%	0.0		(355.1)	-3.2%
SLA Programme	0.2	1.1%	0.0		(40.4)	-3.9%	(49.1)	-44.2%	0.0		0.0		(89.3)	-7.6%
Grand Total	(159.5)	-1.5%	169.7	2.0%	(519.4)	-3.0%	(89.3)	-0.7%	41.2	-75.7%	21.1	6.8%	(536.2)	-1.1%

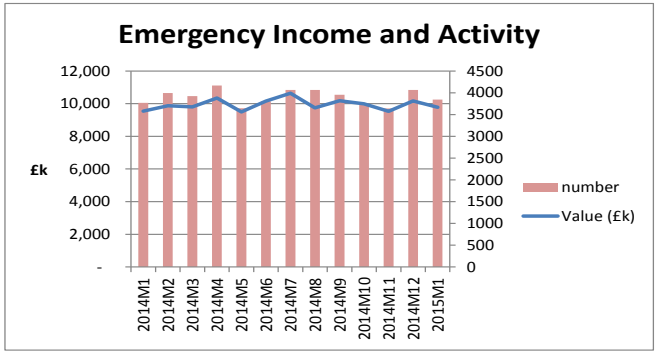
- SLA income in total is £0.5m behind plan. Adjusting for prior period issues and pass-through exclusions relating to high cost drug and devices the run-rate would be £0.9m (1.7%) behind plan
- The main POD behind plan is Outpatients with the main problem area being specialist medicine
- Nelson activity has been profiled to reflect a slow start but the low level of activity is concerning despite that.
- Provision for challenges will be finalised in the SLAs but the m1 position reflects 14/15 levels (£0.3m) adverse
- An important part of the SLA with local CCG's is a block around emergency activity supported by additional investment in capacity. This is not yet finalised but the position assumes it will be and £0.4m additional income has been accrued to reflect that.
- All SLA income is now included in one SLAM system covering Acute, QMH, Community and the Nelson.
- The level of un-coded in April is 1.9% compared to 0.7% in March. Un-coded episodes are included in the position at average tariff. Additional investment in coders has been agreed and is in progress

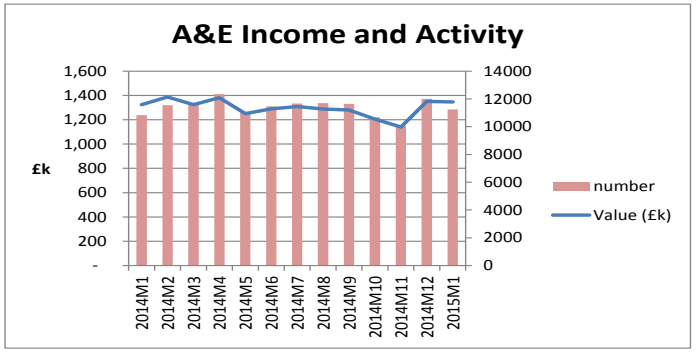
❹ Income trends



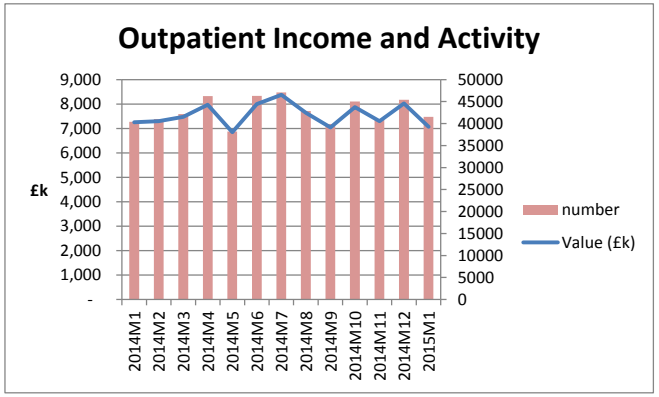
① Note QMH income all used to be coded to one account code in 14/15. Now that the QMH income has moved into SLAM in 15/16, it is being coded to account codes based on the POD, rather than one catch all account code.

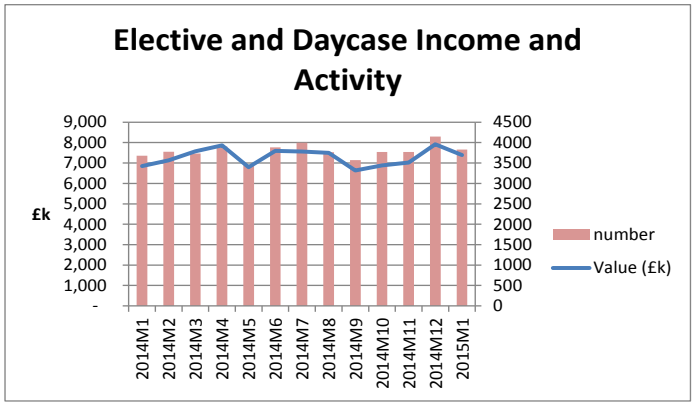
❺ Activity





Both activity and income levels were slightly down on the previous month. In addition (other than for Elective activity), both activity and income were slightly down against the month 1 15/16 plan.



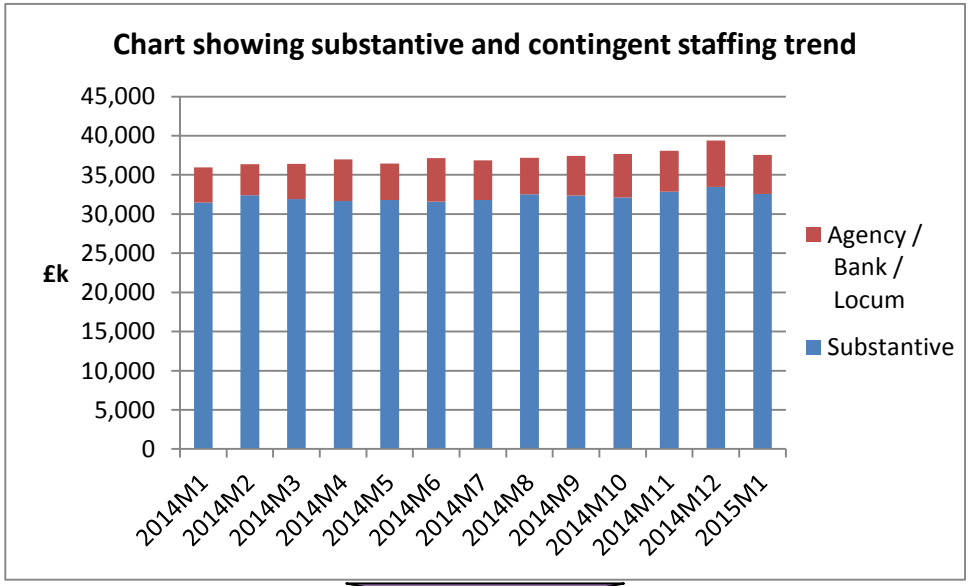


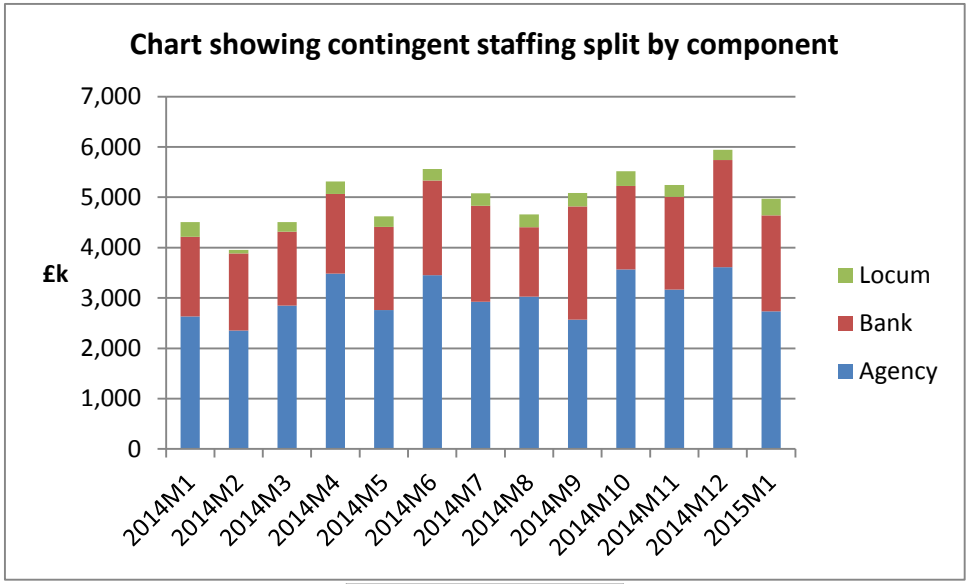
❻ Pay costs

Variance month 1 2015/16 (adv) / fav	CWDT £k	%	CSW £k	%	Medicine & CV £k	%	Surgery & Neuro £k	%	Overheads £k	%	R&D £k	%	SWL Path £k	%	Grand Total £k	%
Pay Consultants	(47.2)	-3.9%	46.3	20.1%	115.6	7.2%	65.9	3.0%	(18.3)	-22.5%	(0.3)	-1.3%	(11.0)	-1.8%	150.9	2.5%
Pay Jnr Drs	33.6	3.0%	(110.6)	-99.6%	(186.4)	-13.3%	27.5	2.1%	(1.3)	-1.8%	(1.8)		128.9	100.0%	(110.0)	-2.7%
Pay Non Clinical	(59.8)	-5.2%	57.9	8.4%	104.9	14.7%	60.0	7.3%	165.7	5.8%	(22.5)	-44.3%	(42.6)	-56.5%	263.5	4.1%
Pay Nursing	154.7	3.5%	204.6	8.6%	2.2	0.0%	310.3	8.3%	(34.1)	-12.7%	(3.5)	-4.7%	0.0		634.3	4.2%
Pay Other	(302.5)	100.0%	(646.7)	100.0%	(121.3)	100.0%	(568.9)	101.0%	(456.1)	101.2%	5.0	100.0%	132.7	100.0%	(1,957.8)	100.6%
Pay Sci, Techs, Therap	301.8	11.0%	29.2	2.6%	32.2	7.4%	71.3	7.6%	21.8	5.7%	(3.1)	-25.6%	(117.1)	-9.1%	336.1	4.9%
Grand Total	80.6	0.8%	(419.3)	-10.8%	(52.8)	-0.6%	(33.9)	-0.4%	(322.3)	-10.1%	(26.2)	-15.7%	90.8	4.1%	(683.0)	-1.9%

- In month pay costs were over budget by £0.7m
- The largest component of this is CIP under achievement against pay of £0.5m
- Divisions are in the process of finalising their establishments for 2015/16 which for m2 will align the pay groups. The CSW and Overheads Divisions also have realignment across pay and non pay to complete. These factors mean that budgets are not correctly aligned at staff group level and so the variance analysis by staff group is not yet meaningful (this shows in the large adverse position of 'Pay Other' and favourable variances in other groups).
- The split of pay costs compared to m12 is
  - In Post 87% (85%)
  - Agency 8% (10%)
  - Bank 5% (5%)
- Pay budgets have been increased for the pay award (0.7%) and employers pension (0.3%)

Pay trend (1)





monthly trend

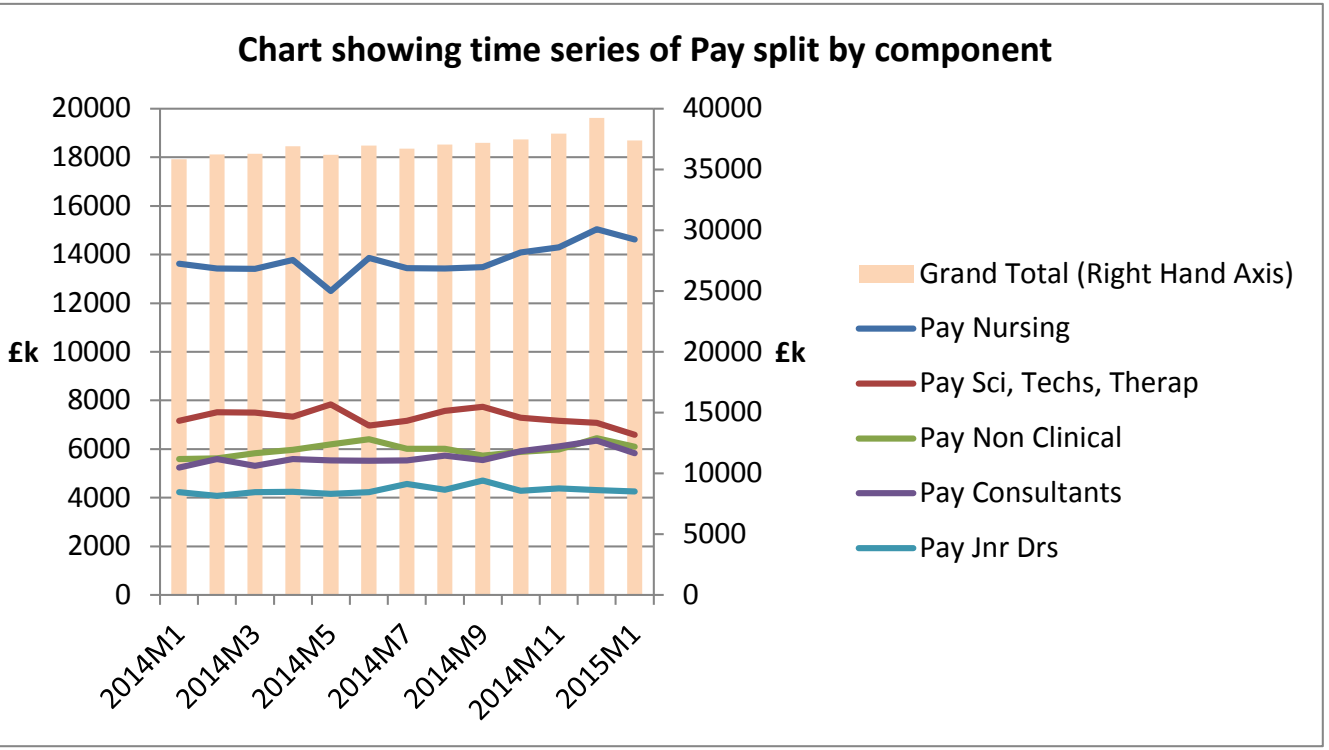
	£k	%
Substantive	105.2	0.3%
Agency /Bank /Locum	89.6	1.8%
Total	194.8	0.5%

monthly trend

	£k	%
Agency	41.7	1.5%
Bank	40.6	2.1%
Locum	7.3	2.2%
Total	89.6	1.8%

Taken as a time series over the 13 months from April-14, pay has been increasing at c£200k per month (0.5%). Slightly under half of this increase is from contingent staffing (ie Bank/Agency/locum) which is growing faster (1.8% per month) than in-post (0.3%). Pay cost will increase as a result of pay inflation and service expansion, but should reduce as a result of successful CIPs. Although the 13 month trend shows an increasing trend, it is worth noting that m1 is lower than the preceding three months.

Pay trend (2)



monthly trend	£k	%
Pay Nursing	110.2	0.8%
Pay Sci, Techs, Therap	(37.0)	-0.6%
Pay Non Clinical	34.1	0.6%
Pay Consultants	64.2	1.1%
Pay Jnr Drs	17.5	0.4%
Grand Total	189.1	0.5%

The Nursing, consultant and non-clinical are the staff groups that show the biggest month on month trending increase in pay.

Note There is a slight reconciling difference between the above table and the one on the previous page.

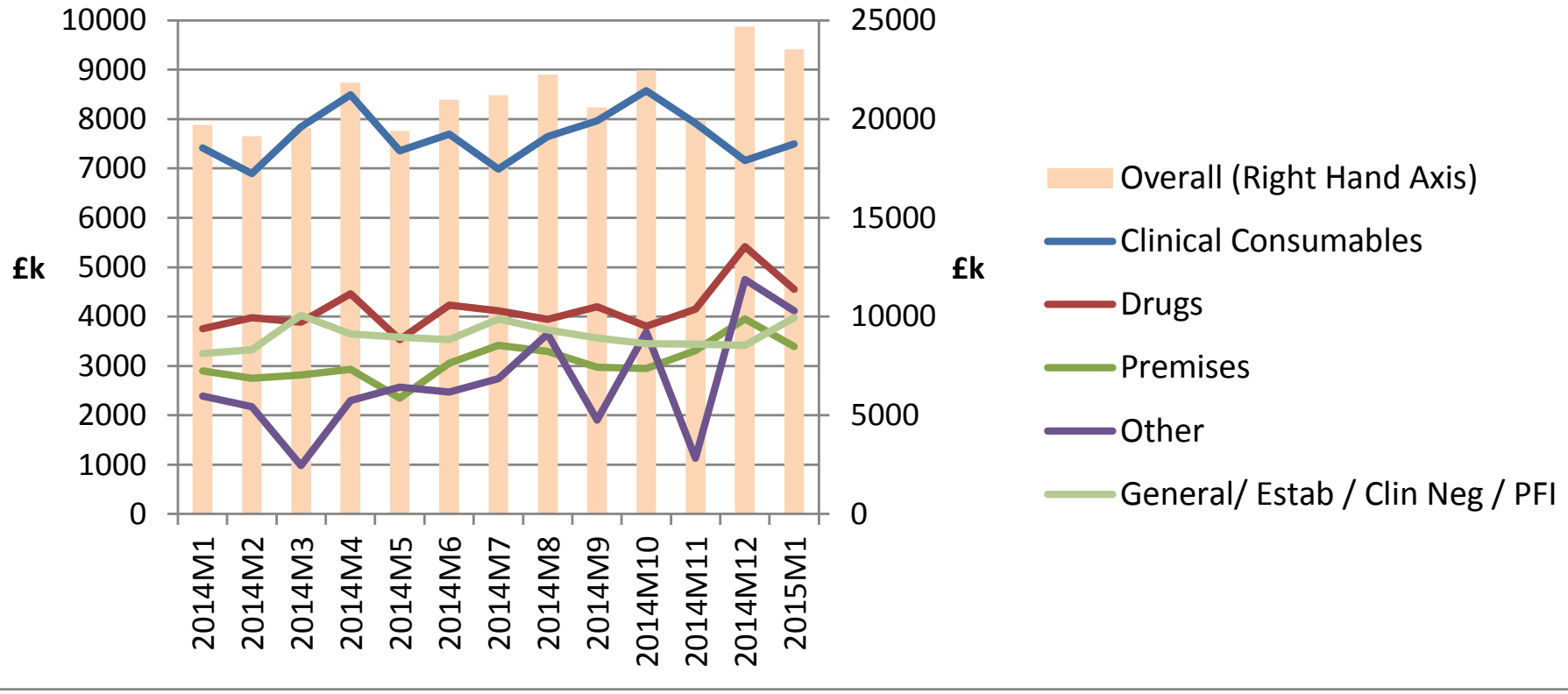
❼ Non pay costs

Variance month 1 2015/16 (adv) / fav	CWDT £k %	CSW £k %	Medicine & CV £k %	Surgery & Neuro £k %	Overheads £k %	R&D £k %	SWL Path £k %	Reserves £k %	Grand Total £k %
Clinical Consumables	143.4 *12%*	3.1 *0%*	31.8 *1%*	58.5 *3%*	(31.1) *-48%*	(0.6)	(262.0) *-27%*	240.1	183.3 *2%*
Drugs	(241.4) *-64%*	(48.5) *-6%*	292.2 *11%*	74.5 *10%*	3.4 *45%*	0.0	(8.8)	0.9	72.3 *2%*
Premises	(54.3) *-273%*	24.2 *20%*	18.0 *39%*	(6.3) *-18%*	(64.2) *-2%*	2.4 *100%*	(105.5) *-65%*	52.4	(133.3) *-4%*
Other	(244.1) *-10%*	182.9 *20%*	(488.8) *-3239%*	(373.6) *-728%*	394.7 *58%*	20.3 *63%*	(56.9) *-18%*	503.3 *-128%*	(62.2) *-2%*
General/ Estab / Clin Neg / F	(4.5) *-4%*	(16.2) *-16%*	27.9 *19%*	10.2 *15%*	87.0 *2%*	(0.5)	(0.8) *-2%*	44.8	147.9 *4%*
Grand Total	(400.8) *-10%*	145.4 *6%*	(118.9) *-2%*	(236.8) *-9%*	389.9 *5%*	21.6 *62%*	(434.0) *-29%*	841.5 *-214%*	208.0 *1%*

- Position at month 1 £0.2m favourable. Adjusting for prior period issues and pass-through exclusions relating to high cost drug and devices, the run-rate would be £0.9m (3.7%) better than plan
- Reserves releases (predominantly the reserve for cost pressures and full year effect funding not yet passed out to Divisions) of £0.8m are offsetting costs in divisions to be finalised ahead of m2 reporting
- Clinical consumables lower than m12 lower costs in diagnostics
- Drugs lower than m12 but in line with trend m12 included one off costs of Harley Street
- Premises in line with trend that now includes space costs from SGUL
- Other costs lower than m12 which included additional costs of exported activity
- Clinical negligence increase due to inflation
- Within the divisional positions CWDT includes £0.3m cost of notes storage which relates to 14/15T

Non pay trends

Chart showing time series of actual non-pay expenditure by component



❽ CIP performance

- The trust has developed £19m of forecast Green & Amber schemes. The current planning gap is £13.5m. There are £5.7m Red schemes (equivalent to a gap). This shortfall is expected to be met through £6m for turnaround (from M7) and £1m per month anticipated run-rates.
- Month 1 target is £3.2m. £2.5m CIP was reported as achieved. This leaves a shortfall of £0.7m in month. Compared to plan, the shortfall is mainly on non-pay £0.3m and pay £0.2m.
- There is some risk in validating the actuals reported, particularly on run-rate savings, as although spend has decreased compared to trend in the reported areas, the impact against budget review has not been possible for month 1.

	ANNUAL TARGET	M1 TARGET	M1 ACTUALS	VAR
Non Pay	9,167	764	446	318
Pay	22,862	1,905	1,710	195
Other Healthcare Income	1,614	134	45	89
Other Income	1,033	86	63	24
SLA Income	3,462	289	199	89
Total	38,138	3,178	2,462	716

DIVISIONAL SUMMARY	TARGET	ACTUAL YTD M1 (£m) INCOME	EXPENSE	TOTAL	OF WHICH TOTAL ACTUAL RAG RED	AMBER	GREEN	SHORT-FALL
CORP	0.2	0.0	0.1	0.1	0.0	0.0	0.1	0.1
CSD	0.5	0.0	0.2	0.2	0.0	0.1	0.0	0.3
CWDT	0.7	0.1	0.5	0.6	0.0	0.4	0.3	0.1
E&F	0.2	0.0	0.2	0.2	0.0	0.2	0.0	0.0
MEDCARD	0.9	0.2	0.6	0.7	0.0	0.5	0.2	0.2
SCNT	0.7	0.1	0.6	0.6	0.1	0.3	0.2	0.1
TW	-0.1	0.0	0.0	0.0	0.0	0.0	0.1	-0.1
Grand Total	**3.2**	**0.3**	**2.2**	**2.5**	**0.2**	**1.5**	**0.7**	**0.7**
OF WHICH RECURRENT:		0.3	0.9	1.2	0.2	0.4	0.7	2.0

I&E ANALYSIS OF ACTUAL

	SLA RED	SLA AMBER	SLA GREEN	SLA TOTAL	NON-SLA RED	NON-SLA AMBER	NON-SLA GREEN	NON-SLA TOTAL	PAY RED	PAY AMBER	PAY GREEN	PAY TOTAL	NON-PAY RED	NON-PAY AMBER	NON-PAY GREEN	NON-PAY TOTAL
CORP									0.0	0.0	0.1	0.1			0.0	0.0
CSD									0.0	0.1	0.0	0.1	0.0	0.0	0.0	0.1
CWDT		0.0	0.0	0.0	0.0	0.0	0.1	0.1		0.3	0.2	0.5	0.0	0.0	0.0	0.1
E&F										0.2		0.2			0.0	0.0
MEDCARD	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0		0.4	0.0	0.4		0.1	0.0	0.1
SCNT	0.1			0.1		0.0		0.0	0.0	0.2	0.1	0.4	0.0	0.0	0.1	0.2
TW																
Grand Total	**0.1**	**0.0**	**0.1**	**0.2**	**0.0**	**0.0**	**0.1**	**0.1**	**0.1**	**1.3**	**0.3**	**1.7**	**0.0**	**0.2**	**0.2**	**0.4**
OF WHICH RECURRENT:	0.1	0.0	0.1	0.2	0.0	0.0	0.1	0.1	0.1	0.2	0.3	0.5	0.0	0.2	0.2	0.4

DIVISIONAL SUMMARY	TARGET	FORECAST AT M1 (£m) INCOME	EXPENSE	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT-FALL
CORP	2.6	0.1	1.4	1.5	0.2	0.5	0.8	1.1
CSD	5.6	0.5	2.0	2.5	1.7	0.8	0.1	3.0
CWDT	8.9	1.7	5.7	7.4	0.7	3.7	3.0	1.5
E&F	2.9	0.0	0.4	0.4	0.0	0.3	0.0	2.5
MEDCARD	10.6	1.9	5.0	6.9	1.4	4.0	1.4	3.8
SCNT	8.7	1.3	4.7	5.9	1.8	1.4	2.7	2.8
TW	-1.1	0.0	0.0	0.0	0.0	0.0	0.0	-1.1
Grand Total	**38.1**	**5.5**	**19.1**	**24.6**	**5.7**	**10.8**	**8.1**	**13.5**
OF WHICH RECURRENT:		5.5	16.9	22.3	5.6	9.1	7.6	15.8
OBJECTIVE 2 (FYE)		6.4	18.1	24.6	6.5	10.2	7.8	13.6

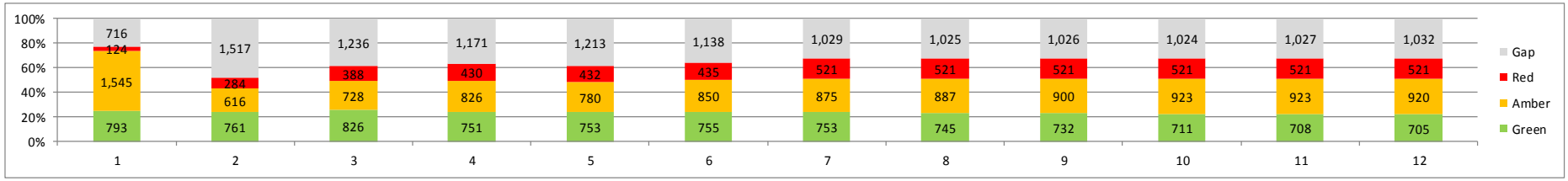
I&E ANALYSIS OF FORECAST

	SLA RED	SLA AMBER	SLA GREEN	SLA TOTAL	NON-SLA RED	NON-SLA AMBER	NON-SLA GREEN	NON-SLA TOTAL	PAY RED	PAY AMBER	PAY GREEN	PAY TOTAL	NON-PAY RED	NON-PAY AMBER	NON-PAY GREEN	NON-PAY TOTAL
CORP					0.0	0.1		0.1	0.1	0.4	0.7	1.3		0.0	0.1	0.1
CSD	0.3	0.0		0.3	0.1	0.1		0.2	1.0	0.3	0.0	1.3	0.2	0.4	0.1	0.7
CWDT		0.3	0.0	0.4	0.2	0.4	0.7	1.3	0.2	2.2	1.8	4.2	0.3	0.8	0.5	1.5
E&F										0.2		0.2		0.1	0.0	0.2
MEDCARD	0.1	0.1	0.9	1.2	0.3	0.4	0.1	0.7	0.6	1.5	0.2	2.3	0.4	2.1	0.2	2.7
SCNT	0.8	0.1		0.9	0.0	0.2	0.2	0.4	0.8	0.6	1.3	2.7	0.2	0.5	1.2	2.0
TW																
Grand Total	**1.2**	**0.6**	**1.0**	**2.7**	**0.7**	**1.2**	**0.9**	**2.8**	**2.7**	**5.2**	**4.1**	**12.0**	**1.1**	**3.9**	**2.2**	**7.2**
OF WHICH RECURRENT:	1.2	0.6	1.0	2.7	0.7	1.2	0.9	2.7	2.7	3.5	3.6	9.8	1.1	3.9	2.2	7.1
OBJECTIVE 2 (FYE)	1.2	0.8	0.9	2.9	1.0	1.6	0.9	3.5	3.1	4.0	3.8	10.9	1.1	3.9	2.2	7.3

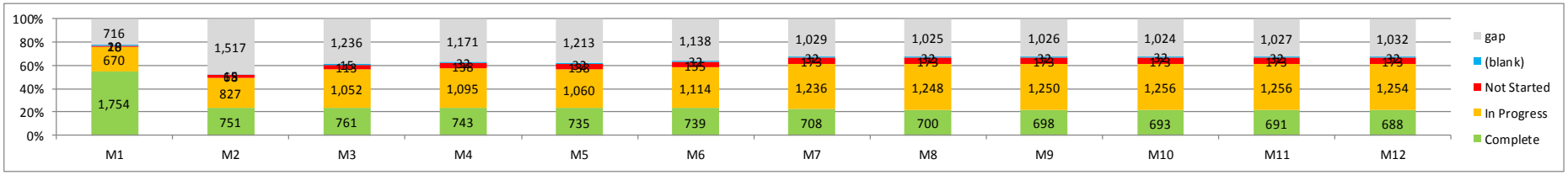
CIP performance – phased - £38.1m target

CIP PERFORMANCE	M1		M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
	FORECAST	ACTUAL	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST
Target	3,178	3,178	3,178	3,178	3,178	3,178	3,178	3,178	3,178	3,178	3,178	3,178	3,178
	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%
GREEN	793	793	761	826	751	753	755	753	745	732	711	708	705
AMBER	1,545	1,545	616	728	826	780	850	875	887	900	923	923	920
RED	124	124	284	388	430	432	435	521	521	521	521	521	521
Total schemes	2,462	2,462	1,661	1,942	2,007	1,965	2,040	2,149	2,153	2,153	2,154	2,152	2,146
GAP	716	716	1,517	1,236	1,171	1,213	1,138	1,029	1,025	1,026	1,024	1,027	1,553
RUNRATE ACTUALS INCLUDED ABOVE CIP	*1,075*	*1,075*											

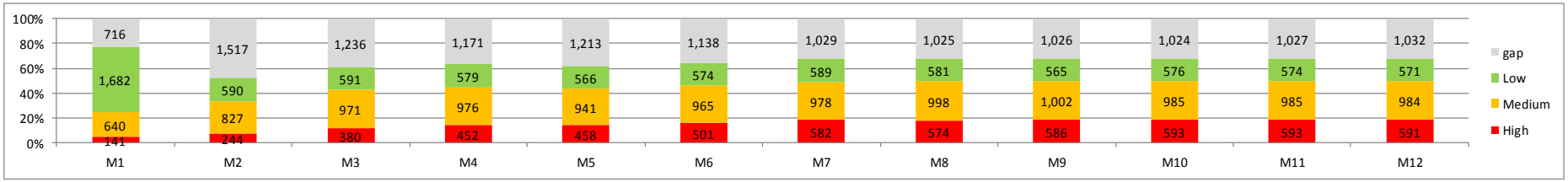
RAG BY MONTH



READINESS BY MONTH



RISK BY MONTH



CIP PERFORMANCE:	M1		M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
	FORECAST	ACTUAL	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST
SLA Total	**199**	**199**	**278**	**261**	**269**	**271**	**273**	**287**	**287**	**287**	**294**	**294**	**294**
NonSLA Total	108	108	155	155	192	203	221	270	270	280	296	296	296
Pay Total	1,710	1,710	761	967	941	894	900	940	957	959	959	959	959
NonPay Total	446	446	467	559	604	596	646	652	639	626	605	603	597
GAP	716		1,517	1,236	1,171	1,213	1,138	1,029	1,025	1,026	1,024	1,027	1,032
Grand Total	3,178	2,462	3,178	3,178	3,178	3,178	3,178	3,178	3,178	3,178	3,178	3,178	3,178

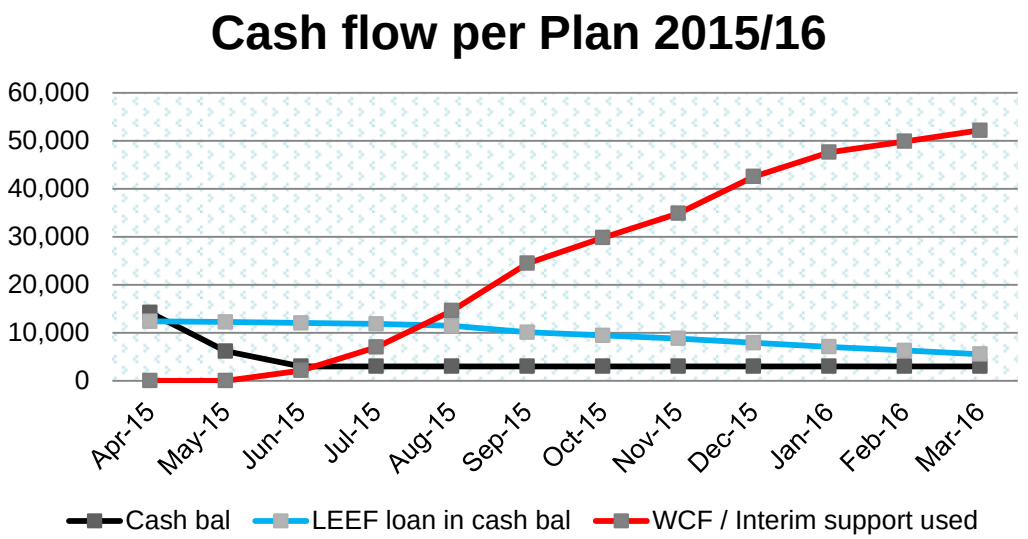
❾ Capital

- Capital expenditure was £2.3m vs plan £4.4m. i.e. an underspend of £2.1m – 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 balance of the programme of £330.2m is planned for finance by internal capital but the level of this expenditure is subject to the outcome of the application for interim support funding (see cash section). Therefore Trust needs to minimise capital expenditure – including deferring leases where possible – to support the cash position until the level and timing of the interim support funding is agreed with Monitor/ITFF.
- Budgets have been provisionally classified to determine their priority and expenditure will be frozen for schemes regarded as non-essential until further notice. Codes will be closed on the financial system to prevent orders being raised in error for 'frozen' projects

	Annual	Budget	Actual	*Variance*
	budget	M01	M01 YTD	*M01*
Summary by source of finance	**£000**	£000	£000	*£000*
Internal capital	**30,236**	1,652	1,193	*459*
LEEF loan	**6,971**	125	-210	*335*
DH capital loans	**7,260**	1,339	893	*446*
PDC capital	**1,103**	105	137	*-32*
Lease finance	**11,168**	1,145	266	*879*
Total	**56,738**	4,366	2,279	*2,087*

⑩ Cash

- Cash balance was £14.2m at 30th April down £10.2m on last month but in line with plan (£14.2m).
- This includes approx £12.5m in respect of the LEEF loan for the energy performance contract.
- No monies have been draw from the £25m working capital facility
- The reduction in cash since year end was caused by:
  - trading deficit of £7.6m and
  - deterioration of £2.6m in working capital (stock, debtors and creditors) – per plan
- The M01 under spend on capital offset the cash impact of the higher trading deficit than enabling the Trust to achieve the planned cash balance.



- 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 level and timing of the interim cash 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.
- The cash forecast indicates the Trust will need to draw down approx £2.1m in June to maintain the maximum £3m cash balance permitted under the terms of this facility – on the basis of the *planned* profile of the I&E deficit and capital programme
- The Trust can delay the point at which the facility needs to be used by delaying capital expenditure – accordingly capital budget lines have been provisionally classified as no delay or discretionary subject to further refinement by the executive team
- In order to access the working capital facility the Trust needs to submit a 13 week cash flow projection to demonstrate the requirement to Monitor/ITFF. Monies needed next month would need to be drawn down on 18th June.
- **The Trust will need to submit its 13 week cash flow in early June.**

11 Balance sheet M01 2015/16

Balance sheet April 2015		
	Apr-15	Apr-15
	£000	£000
	Plan	Actual
Fixed assets	332,731	330,516
Stock	7,157	7,840
Debtors	75,542	74,235
Cash	**14,200**	**14,189**
Creditors	-84,801	-84,222
Capital creditors	-3,476	-3,282
PDC div creditor	-590	-582
Int payable creditor	-156	-223
Provisions< 1 year	-602	-512
Borrowings< 1 year	-5,499	-5,309
Net current assets/-liabilities	**1,775**	**2,134**
Provisions> 1 year	-1,181	-1,217
Borrowings> 1 year	-86,806	-86,020
Long-term liabilities	**-87,987**	**-87,237**
Net assets	**246,520**	**245,413**
Taxpayer's equity		
Public Dividend Capital	133,761	133,761
Retained Earnings	10,250	9,283
Revaluation Reserve	101,360	101,219
Other reserves	1,150	1,150
Total taxpayer's equity	**246,521**	**245,413**

Commentary

Net current assets/liabilities (+£2.1m) were better than plan (+£1.7m) due mainly to lower capex and lower debtor levels than plan in April.

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. Further Expenditure Analysis
E. Detailed activity analysis by Division – (not attached)
F. CIP by Division
G. Movement in working capital chart and explanations
H. Detailed cash flow plan 2015/16
I. Cash balance March 2015 - plan, forecasts and outturn
J. Working Capital
K. Detailed capital expenditure
L. Aged Debt Profile
M. CoSRR detail

Appendix A– Detailed Income & Expenditure

	Annual Budget £000	CURRENT MONTH M1 Current Mth Budget £000	Current Mth Amount £000	Current Mth Variance £000
Income				
SLA Elective	67,146	5,193	5,081	(112)
SLA Daycase	29,464	2,331	2,313	(18)
SLA Non Elective	122,546	9,967	10,096	128
SLA Outpatients	142,485	10,936	10,581	(355)
SLA A&E	19,088	1,565	1,535	(30)
SLA Bed Days	61,894	4,944	4,826	(117)
SLA Programme	17,854	1,176	1,087	(89)
SLA Exclusions	58,525	3,862	4,227	365
SLA Other	111,060	9,111	8,804	(307)
SLA Provisions QiPP/KPIs/Settlement	(5,826)	(486)	(486)	0
Subtotal - SLA Income	624,235	48,600	48,064	(536)
Private & Overseas Patient	5,153	429	445	16
RTAs	4,174	348	357	9
Other Healthcare Income	137	11	44	32
Levy Income	43,871	3,656	3,652	(4)
Other Income	47,844	3,978	3,834	(144)
Total income	**725,414**	**57,023**	**56,396**	**(627)**
Expenditure				
Pay Total	(441,329)	(36,707)	(37,390)	(683)
Drugs	(55,501)	(4,626)	(4,553)	72
Clinical Consumables	(91,984)	(7,684)	(7,501)	183
Other Total	(146,686)	(11,439)	(11,487)	(48)
Total expenditure	**(735,500)**	**(60,457)**	**(60,932)**	**(475)**
EBITDA (note 1)	(10,086)	(3,434)	(4,535)	(1,102)
Disposal of Assets	(0)	(0)	(0)	0
Interest payable	(4,783)	(399)	(401)	(2)
Interest receivable	83	7	3	(4)
PDC Dividend	(6,865)	(572)	(572)	0
Depreciation	(24,610)	(2,051)	(2,051)	0
Total interest, dividends & deprec'n	**(36,175)**	**(3,015)**	**(3,021)**	**(6)**
NET -Surplus / Deficit	**(46,262)**	**(6,448)**	**(7,556)**	**(1,107)**

Appendix B - Adjusting for prior period items to give the underlying 'run-rate' position for m1

St George's University Hospitals NHS
NHS Foundation Trust

	Reported position		❶ Adjustments to derive a run-rate							Position adjusted for prior period charges	❷ Adjust for pass-thru costs	Adjusted position after correcting for pass-thru costs	
	Current Variance (adv) / fav £k	%	Iron Mountain invoices relating to 14/15 £k	Universal on-call charges relating to 14/15 £k	Charge for PAs relating to 14/15 £k	Neo-natal income relating to 14/15 £k	Debt from TDA relating to 14/15 Income written off £k	NCA income w/o relating to 15/16 £k	Total adjustment £k	Truer 'run-rate' figure for m1 £k	High Cost Drugs and Devices £k	Truer 'run-rate' figure for m1 £k	%
SLA Income	(536.2)	*-1.1%*				(120.0)		195.0	75.0	(461.2)	(387.0)	(848.2)	*-1.7%*
Other Income	(94.3)	*-1.1%*					230.0		230.0	135.7		135.7	*1.6%*
Overall Income	(630.5)	*-1.1%*	0.0	0.0	0.0	(120.0)	230.0	195.0	305.0	(325.5)	(387.0)	(712.5)	*-1.2%*
Pay	(683.0)	*-1.9%*		61.0	40.0				101.0	(582.0)		(582.0)	*-1.6%*
Non Pay	208.0	*0.9%*	290.0						290.0	498.0	387.0	885.0	*3.7%*
Overall Expenditure	(475.0)	*-0.8%*	290.0	61.0	40.0	0.0	0.0		391.0	(84.0)	387.0	303.0	*0.5%*
EBITDA	(1,105.5)	*-32.3%*	290.0	61.0	40.0	(120.0)	230.0	195.0	696.0	(409.5)	0.0	(409.5)	*-12.0%*
Dpn, PDC div etc	(1.8)	*-0.1%*							0.0	(1.8)		(1.8)	*-0.1%*
Surplus / (deficit)	(1,107.3)	*-17.2%*	290.0	61.0	40.0	(120.0)	230.0	195.0	696.0	(411.3)	0.0	(411.3)	*-6.4%*

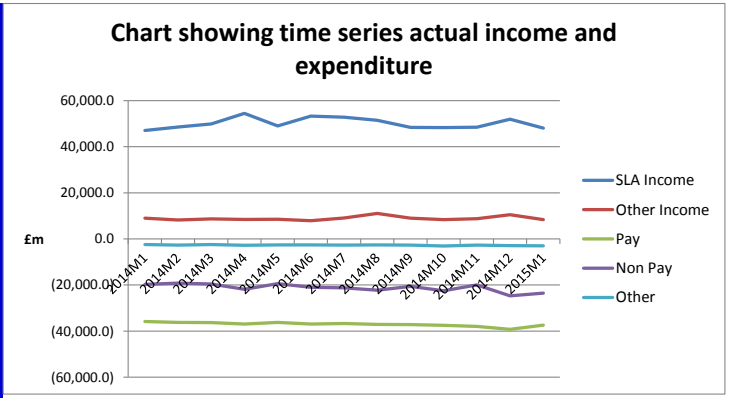
❶With the pressure to close and report, It is not uncommon that expenditure or income can be assigned to the wrong accounting period. As long as this is a small value, this is not usually a problem. However such items need to be taken into account to get a true 'run-rate' for a given period. In m1 there were c£0.7m of these adjustments, which would imply a 'run-rate' adverse variance to plan of £0.4m.

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 m2 onwards, so that these variances will not shown in the ledger].

Appendix C - Time series of Actuals

Time Series of Actuals (13 months from April 2014)

Sum of Current Amount £k	Column															
	2014												2014 Total	2015		2015 Total
Row Labels	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12		M1		
SLA Income	**(47,025.3)**	**(48,540.0)**	**(49,901.6)**	**(54,477.8)**	**(49,020.0)**	**(53,250.6)**	**(52,765.1)**	**(51,489.6)**	**(48,379.6)**	**(48,317.6)**	**(48,476.9)**	**(51,969.6)**	**(603,613.8)**	**(48,063.8)**		**(48,063.8)**
SLA A&E	(1,273.6)	(1,456.5)	(1,325.1)	(1,352.2)	(1,190.8)	(1,287.8)	(1,316.5)	(1,238.0)	(1,327.7)	(1,222.7)	(1,202.0)	(1,325.5)	(15,518.4)	(1,534.7)		(1,534.7)
SLA Bed Days	(4,637.0)	(4,835.2)	(4,858.2)	(4,948.9)	(4,721.9)	(5,080.1)	(4,930.6)	(4,933.9)	(5,351.8)	(4,877.1)	(5,111.9)	(5,567.2)	(59,853.7)	(4,826.3)		(4,826.3)
SLA Daycase	(2,072.1)	(2,176.0)	(2,292.2)	(2,510.4)	(2,112.8)	(2,320.6)	(2,577.9)	(2,148.5)	(1,998.9)	(2,216.5)	(2,156.8)	(2,491.1)	(27,073.8)	(2,312.9)		(2,312.9)
SLA Elective	(4,741.6)	(4,555.3)	(5,202.7)	(5,603.4)	(5,042.7)	(4,727.7)	(5,259.6)	(4,608.8)	(4,010.3)	(4,795.0)	(4,226.0)	(5,317.0)	(58,089.8)	(5,080.9)		(5,080.9)
SLA Exclusions	(2,803.4)	(3,326.6)	(3,329.9)	(3,982.7)	(4,090.9)	(3,400.4)	(4,113.8)	(3,457.9)	(3,977.4)	(2,117.8)	(3,540.1)	(3,503.9)	(41,644.5)	(4,227.2)		(4,227.2)
SLA Non Elective	(8,613.9)	(9,291.7)	(9,235.0)	(9,921.0)	(8,941.4)	(10,210.1)	(9,835.8)	(9,166.3)	(9,254.4)	(8,976.2)	(8,861.3)	(9,190.1)	(111,497.0)	(10,095.6)		(10,095.6)
SLA Other	(12,580.3)	(12,567.7)	(12,363.3)	(14,585.3)	(12,642.8)	(13,878.2)	(13,668.1)	(14,085.3)	(13,078.1)	(12,843.7)	(12,672.1)	(13,465.7)	(158,430.5)	(8,318.2)		(8,318.2)
SLA Outpatients	(9,142.8)	(9,010.6)	(9,963.7)	(10,064.5)	(8,863.3)	(10,798.3)	(9,869.3)	(10,285.5)	(8,012.6)	(9,839.7)	(9,179.8)	(9,647.0)	(114,677.1)	(10,581.3)		(10,581.3)
SLA Programme	(1,160.6)	(1,320.4)	(1,331.5)	(1,509.5)	(1,413.5)	(1,547.5)	(1,193.7)	(1,565.6)	(1,368.4)	(1,428.9)	(1,526.9)	(1,462.2)	(16,828.8)	(1,086.6)		(1,086.6)
Other Income	**(8,975.5)**	**(8,209.8)**	**(8,712.3)**	**(8,421.9)**	**(8,558.3)**	**(7,916.5)**	**(9,119.2)**	**(11,020.7)**	**(9,007.4)**	**(8,397.8)**	**(8,792.6)**	**(10,492.9)**	**(107,625.0)**	**(8,335.4)**		**(8,335.4)**
Interest Receivable	(4.7)	(9.2)	(4.6)	(10.9)	(2.0)	(5.2)	(7.2)	(10.2)	(6.0)	(6.1)	(2.8)	(10.1)	(79.0)	(3.0)		(3.0)
Levy Income	(4,000.7)	(3,968.8)	(3,972.5)	(4,079.8)	(3,983.1)	(3,957.8)	(4,113.7)	(4,130.9)	(4,313.2)	(3,999.6)	(3,745.6)	(3,836.2)	(48,101.9)	(3,652.3)		(3,652.3)
Other Healthcare Incom	(7.3)	(9.5)	(7.7)	(6.9)	(13.5)	(13.8)	(7.4)	(23.2)	(13.6)	(8.3)	(7.1)	(19.2)	(137.5)	(43.7)		(43.7)
Other Income	(4,263.3)	(3,547.1)	(3,920.4)	(3,522.9)	(3,996.8)	(3,316.0)	(4,150.6)	(5,926.3)	(3,784.0)	(3,326.1)	(4,313.7)	(5,733.8)	(49,800.7)	(3,834.2)		(3,834.2)
Private & Overseas Pati	(371.0)	(333.6)	(440.4)	(426.2)	(245.9)	(307.0)	(483.8)	(500.3)	(536.3)	(610.5)	(270.3)	(511.5)	(5,036.8)	(445.3)		(445.3)
RTAs	(328.6)	(341.5)	(366.6)	(375.2)	(317.1)	(316.8)	(356.5)	(429.8)	(354.3)	(447.2)	(453.2)	(382.2)	(4,469.0)	(356.8)		(356.8)
Pay	**35,856.5**	**36,238.1**	**36,288.9**	**36,923.4**	**36,211.2**	**36,959.5**	**36,720.4**	**37,061.2**	**37,201.2**	**37,466.4**	**37,934.3**	**39,231.4**	**444,092.6**	**37,390.0**		**37,390.0**
Other											0.0	0.0	0.0	0.0		0.0
Pay Consultants	5,242.8	5,594.2	5,312.1	5,591.1	5,534.2	5,516.2	5,537.2	5,728.7	5,553.0	5,913.2	6,108.2	6,346.4	67,977.4	5,829.2		5,829.2
Pay Jnr Drs	4,231.9	4,076.7	4,230.2	4,247.0	4,153.6	4,225.3	4,564.5	4,324.7	4,708.6	4,282.6	4,377.3	4,309.3	51,731.6	4,252.8		4,252.8
Pay Non Clinical	5,593.1	5,619.4	5,829.2	5,963.5	6,187.7	6,402.0	6,004.8	6,014.8	5,724.4	5,888.6	5,981.5	6,444.1	71,653.1	6,095.4		6,095.4
Pay Nursing	13,623.9	13,431.2	13,417.6	13,780.6	12,496.6	13,854.9	13,441.8	13,422.4	13,480.8	14,093.1	14,302.0	15,047.2	164,392.0	14,618.8		14,618.8
Pay Other	5.1	(1.8)	0.0	3.8	0.0	0.0	5.2	0.0	0.0	5.2	0.0	0.0	17.5	11.0		11.0
Pay Sci, Techs, Therap	7,159.8	7,518.6	7,499.8	7,337.4	7,839.1	6,961.1	7,166.8	7,570.6	7,734.5	7,283.6	7,165.3	7,084.3	88,320.9	6,582.8		6,582.8
Non Pay	**19,712.0**	**19,135.8**	**19,549.6**	**21,843.4**	**19,393.1**	**20,980.2**	**21,202.7**	**22,250.4**	**20,601.7**	**22,462.7**	**19,950.8**	**24,694.8**	**251,777.2**	**23,541.5**		**23,541.5**
Clinical Consumables	7,414.7	6,897.0	7,839.7	8,492.7	7,358.5	7,695.0	6,984.7	7,641.6	7,965.7	8,572.8	7,915.9	7,158.2	91,936.6	7,501.0		7,501.0
Clinical Negligence	809.8	776.7	812.3	738.8	807.7	828.0	922.3	757.2	790.0	829.1	747.5	833.7	9,653.2	1,221.8		1,221.8
Drugs	3,750.8	3,978.0	3,885.6	4,465.7	3,531.8	4,229.8	4,114.0	3,941.2	4,195.2	3,802.3	4,153.3	5,413.7	49,461.3	4,553.4		4,553.4
Establishment	901.2	692.1	859.4	1,011.5	899.9	670.0	1,034.6	863.7	810.6	896.3	788.2	872.5	10,300.1	812.9		812.9
General Supplies	959.4	1,289.7	1,772.6	1,341.0	1,305.9	1,461.7	1,419.3	1,538.1	1,394.5	1,151.7	1,333.7	1,142.0	16,109.4	1,348.8		1,348.8
Other	2,388.6	2,176.2	978.5	2,298.9	2,567.3	2,472.0	2,739.0	3,647.0	1,903.6	3,690.9	1,131.4	4,748.8	30,742.2	4,118.2		4,118.2
PFI Unitary payment	584.6	571.4	582.9	559.8	571.2	569.7	573.3	569.8	571.5	571.5	571.5	571.5	6,868.9	593.7		593.7
Premises	2,902.9	2,754.6	2,818.7	2,935.0	2,350.8	3,054.1	3,415.5	3,291.7	2,970.4	2,948.2	3,309.3	3,954.3	36,705.5	3,391.5		3,391.5
Other	**2,469.8**	**2,669.4**	**2,443.8**	**2,747.9**	**2,563.5**	**2,599.0**	**2,706.4**	**2,632.0**	**2,656.5**	**3,099.8**	**2,657.3**	**2,899.9**	**32,145.3**	**3,023.5**		**3,023.5**
Depreciation	1,570.1	1,770.1	1,545.2	1,803.6	1,694.8	1,694.9	1,731.6	1,731.7	1,732.0	2,192.4	1,746.6	1,854.6	21,067.4	2,050.8		2,050.8
Disposal of Assets	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	(0.0)	90.9	91.0	0.0		0.0
Interest Payable	264.2	263.9	263.3	278.9	263.3	269.2	264.9	264.9	289.1	286.1	269.1	314.0	3,290.9	400.8		400.8
PDC Dividend	635.4	635.4	635.4	665.4	605.4	634.9	709.8	635.4	635.4	621.3	641.6	640.4	7,696.0	571.8		571.8
Grand Total	**2,037.5**	**1,293.5**	**(331.6)**	**(1,385.0)**	**589.5**	**(628.5)**	**(1,254.8)**	**(566.8)**	**3,072.4**	**6,313.6**	**3,272.9**	**4,363.6**	**16,776.4**	**7,555.8**		**7,555.8**



Appendix D – Divisional I&E (CWDT)

£k	2014/15			2015/16		
	Actual m10	Actual m11	Actual m12	Budget m1	Actual m1	Variance m1
SLA Income	**11,764.3**	**10,856.2**	**11,940.5**	**10,650.2**	**10,490.7**	**(159.5)**
SLA Bed Days	4,104.6	3,850.0	4,359.1	3,868.8	3,840.0	(28.8)
SLA Daycase	361.6	391.6	476.6	356.5	376.8	20.3
SLA Elective	314.4	331.4	356.9	406.8	358.3	(48.4)
SLA Exclusions	201.7	303.6	325.1	151.4	155.2	3.7
SLA Non Elective	469.6	605.0	958.9	660.9	834.2	173.3
SLA Other	2,252.4	1,697.2	1,922.0	1,681.0	1,492.8	(188.2)
SLA Outpatients	4,057.9	3,632.6	3,512.1	3,504.4	3,412.7	(91.7)
SLA Programme	2.1	44.8	29.8	20.5	20.7	0.2
Other Income	**2,411.4**	**1,994.6**	**2,726.3**	**1,908.0**	**1,984.8**	**76.8**
Levy Income	1,319.7	1,319.7	1,089.6	1,175.4	1,175.4	0.0
Other Healthcare Income	8.3	7.1	19.2	11.4	9.8	(1.7)
Other Income	920.7	618.1	1,545.7	633.5	738.5	105.1
Private & Overseas Patient	162.7	49.7	71.8	87.7	61.1	(26.6)
Pay	**(10,915.7)**	**(10,774.4)**	**(10,850.3)**	**(10,291.5)**	**(10,210.8)**	**80.6**
Pay Consultants	(1,211.8)	(1,236.7)	(1,257.9)	(1,212.9)	(1,260.2)	(47.2)
Pay Jnr Drs	(1,201.2)	(1,067.2)	(1,115.4)	(1,107.3)	(1,073.7)	33.6
Pay Non Clinical	(1,279.8)	(1,143.6)	(1,219.1)	(1,153.3)	(1,213.1)	(59.8)
Pay Nursing	(4,409.6)	(4,459.4)	(4,391.8)	(4,371.8)	(4,217.1)	154.7
Pay Other	0.0	0.0	0.0	302.5	0.0	(302.5)
Pay Sci, Techs, Therap	(2,813.2)	(2,867.4)	(2,866.2)	(2,748.6)	(2,446.8)	301.8
Non Pay	**(4,348.7)**	**(3,981.4)**	**(5,580.3)**	**(4,120.2)**	**(4,521.0)**	**(400.8)**
Clinical Consumables	(1,292.6)	(1,239.0)	(1,359.4)	(1,160.2)	(1,016.8)	143.4
Clinical Negligence	0.0	(2.5)	0.0	0.0	0.0	0.0
Drugs	(374.6)	(483.1)	(1,182.4)	(375.3)	(616.7)	(241.4)
Establishment	(71.3)	(36.6)	(55.9)	(71.6)	(74.1)	(2.5)
General Supplies	(45.8)	(38.7)	(58.5)	(42.3)	(44.3)	(1.9)
Other	(2,661.8)	(2,176.7)	(2,914.6)	(2,451.0)	(2,695.0)	(244.1)
Premises	97.4	(4.8)	(9.5)	(19.9)	(74.2)	(54.3)
Other	**(627.6)**	**(460.1)**	**(678.8)**	**(599.4)**	**(607.1)**	**(7.7)**
Depreciation	(278.2)	(405.7)	(476.7)	(402.0)	(402.0)	(0.0)
Interest Payable	(8.5)	(9.1)	(8.9)	(8.4)	(16.1)	(7.7)
PDC Dividend	(341.0)	(45.3)	(193.1)	(189.0)	(189.0)	0.0
Grand Total	**(1,716.4)**	**(2,365.0)**	**(2,442.6)**	**(2,452.9)**	**(2,863.4)**	**(410.6)**

SLA activity income is on trend for Daycase and Elective activity and is up on trend for Non Elective activity in Paeds Surgery. Critical Care Bedday activity is down on trend £151k. The majority of the remaining income is on trend. Other income includes Pharmacy Wholesaler Dealer Licence (WDL) income £250k offsetting the Drugs spend of £212k.

Pay is £294k below trend indicating the positive impact of the run rate schemes on all categories of staffing. In addition pay includes medical staff invoices for previous years of £101k.

Nonpay is £385k above trend but includes WDL cost referred to above.

Appendix D – Divisional I&E - CSW

£k	2014/15			2015/16		
	Actual m10	Actual m11	Actual m12	Budget m1	Actual m1	Variance m1
SLA Income	**9,451.3**	**9,763.2**	**10,317.8**	**9,084.6**	**9,340.5**	**256.0**
SLA A&E	0.0	0.0	0.0	102.5	89.5	(13.0)
SLA Bed Days	0.0	0.0	0.0	466.2	471.6	5.4
SLA Exclusions	(678.5)	83.1	103.6	721.6	639.0	(82.6)
SLA Other	9,187.4	8,597.3	8,284.4	5,156.7	5,494.3	337.7
SLA Outpatients	406.5	446.3	533.6	2,060.3	1,982.5	(77.8)
Other Income	**268.0**	**318.2**	**698.1**	**288.7**	**331.8**	**43.1**
Levy Income	60.6	83.5	88.5	93.1	93.1	0.0
Other Income	206.7	230.3	608.4	187.8	235.5	47.7
Private & Overseas Patien	0.7	4.5	1.2	7.7	3.2	(4.5)
Pay	**(4,283.0)**	**(4,165.6)**	**(4,488.4)**	**(3,874.7)**	**(4,294.0)**	**(419.3)**
Pay Consultants	(251.3)	(220.7)	(224.2)	(230.7)	(184.4)	46.3
Pay Jnr Drs	(218.3)	(206.7)	(195.6)	(111.0)	(221.6)	(110.6)
Pay Non Clinical	(628.6)	(632.9)	(646.6)	(691.5)	(633.6)	57.9
Pay Nursing	(2,047.3)	(2,077.8)	(2,269.2)	(2,373.9)	(2,169.3)	204.6
Pay Other	0.0	0.0	0.0	646.7	0.0	(646.7)
Pay Sci, Techs, Therap	(1,137.5)	(1,027.5)	(1,152.8)	(1,114.2)	(1,085.0)	29.2
Non Pay	**(2,414.2)**	**(3,000.6)**	**(3,623.5)**	**(1,953.1)**	**(1,810.7)**	**142.4**
Clinical Consumables			0.0	0.0	0.0	0.0
Drugs	(721.3)	(937.3)	(1,176.4)	(836.5)	(885.0)	(48.5)
Establishment	(111.6)	(74.3)	(81.8)	(88.6)	(107.0)	(18.3)
General Supplies	174.9	(6.4)	(7.8)	(12.8)	(10.7)	2.2
Other	(521.7)	(693.9)	(1,121.4)	(894.6)	(711.7)	182.9
PFI Unitary payment	0.0	0.0	0.0	0.0	0.0	0.0
Premises	(1,234.5)	(1,288.7)	(1,236.2)	(120.5)	(96.4)	24.2
Other	**1,292.9**	**1,285.6**	**994.8**	**2,296.9**	**2,235.3**	**(61.7)**
Depreciation	(16.5)	(16.9)	(19.3)	(17.1)	(17.1)	0.0
Interest Payable	(0.0)	(0.0)	(0.0)	(0.1)	(0.5)	(0.3)
PDC Dividend	(0.2)	(0.2)	(0.2)	0.0	0.0	0.0
Grand Total	**1,309.6**	**1,302.7**	**1,014.3**	**2,314.2**	**2,252.9**	**(61.3)**

- The month one divisional position shows a £2.25m surplus against a target of £2.31m.
- SLA healthcare income is currently underperforming by £60k due to reductions in activity in GU Medicine and New HIV patients. The QMH SLA is also underperforming in High cost drugs £54k and Prosthetics equipment (£33k) although this is being off-set by the budget adjustment value of £325k.
- Other income is over-performing by £48k mainly due to additional income for the Children's continuing care service to off-set high staffing costs for particular children.
- 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 £0.3m.

Appendix D – Divisional I&E (Medicine and Cardio Vascular)

St George's University Hospitals NHS
NHS Foundation Trust

£k	2014/15			2015/16		
	Actual m10	Actual m11	Actual m12	Budget m1	Actual m1	Variance m1
SLA Income	**16,653.8**	**16,895.1**	**17,390.7**	**17,261.5**	**16,742.1**	**(519.4)**
SLA A&E	1,222.7	1,202.0	1,325.5	1,462.1	1,346.1	(116.0)
SLA Bed Days	419.7	544.0	421.9	0.0	0.0	0.0
SLA Daycase	848.6	797.6	920.9	873.5	884.3	10.9
SLA Elective	1,635.7	1,841.7	1,732.9	2,002.8	1,789.3	(213.5)
SLA Exclusions	1,789.6	2,147.4	2,497.0	2,082.8	2,360.7	277.9
SLA Non Elective	5,283.2	4,673.4	3,568.0	5,273.6	5,021.6	(252.0)
SLA Other	1,317.9	1,474.6	2,528.6	1,612.0	1,589.8	(22.2)
SLA Outpatients	2,804.4	2,850.3	3,074.7	2,910.5	2,746.4	(164.1)
SLA Programme	1,332.0	1,364.1	1,321.3	1,044.3	1,003.9	(40.4)
Other Income	**1,574.8**	**1,862.1**	**1,265.5**	**1,691.7**	**1,591.6**	**(100.2)**
Levy Income	846.5	846.5	662.4	966.7	966.7	0.0
Other Healthcare Income	0.0	0.0	0.0	0.0	23.0	23.0
Other Income	(12.4)	346.9	(22.1)	169.5	(22.7)	(192.2)
Private & Overseas Patien	293.5	215.4	243.0	207.7	267.8	60.0
RTAs	447.2	453.2	382.2	347.8	356.8	9.0
Pay	**(8,396.0)**	**(9,172.2)**	**(9,141.9)**	**(8,448.9)**	**(8,501.8)**	**(52.8)**
Pay Consultants	(1,445.8)	(1,791.9)	(1,840.8)	(1,611.1)	(1,495.5)	115.6
Pay Jnr Drs	(1,541.8)	(1,648.5)	(1,487.5)	(1,403.2)	(1,589.6)	(186.4)
Pay Non Clinical	(710.3)	(791.1)	(804.2)	(711.9)	(607.0)	104.9
Pay Nursing	(4,274.4)	(4,539.7)	(4,514.9)	(4,411.2)	(4,409.0)	2.2
Pay Other	0.0	0.0	0.0	121.3	0.0	(121.3)
Pay Sci, Techs, Therap	(423.7)	(401.0)	(494.5)	(432.9)	(400.7)	32.2
Non Pay	**(6,208.2)**	**(5,569.5)**	**(5,932.5)**	**(5,969.6)**	**(6,088.6)**	**(118.9)**
Clinical Consumables	(3,178.8)	(3,146.3)	(2,584.6)	(3,128.2)	(3,096.4)	31.8
Drugs	(2,082.8)	(2,015.3)	(2,278.1)	(2,630.3)	(2,338.1)	292.2
Establishment	(142.1)	(131.0)	(132.7)	(128.6)	(86.9)	41.6
General Supplies	(28.7)	(26.1)	(36.0)	(20.9)	(34.6)	(13.7)
Other	(744.3)	(229.3)	(888.9)	(15.1)	(503.9)	(488.8)
Premises	(31.5)	(21.5)	(12.2)	(46.5)	(28.6)	18.0
Other	**(453.5)**	**(385.2)**	**(403.4)**	**(376.7)**	**(374.4)**	**2.2**
Depreciation	(310.2)	(233.8)	(251.9)	(225.2)	(225.2)	(0.0)
Interest Payable	6.4	(1.7)	(1.8)	(1.8)	0.5	2.3
PDC Dividend	(149.7)	(149.7)	(149.7)	(149.7)	(149.7)	0.0
Grand Total	**3,170.9**	**3,630.2**	**3,178.4**	**4,158.0**	**3,368.9**	**(789.1)**

Income underperformance against Nelson activity plan (income target with no expenditure budget) - £166k
Increased Cardiac Surgery activity in the private sector due to cancellations - £206k
Lower than planned non-elective activity in Acute Medicine - £118k
Chemotherapy unbundled coding issues in Medical Oncology – £220k
Unidentified and unachieved CIP - £79k

Appendix D – Divisional I&E (SNCT)

£k	2014/15			2015/16		
	Actual m10	Actual m11	Actual m12	Budget m1	Actual m1	Variance m1
SLA Income	**11,450.5**	**11,783.7**	**13,487.2**	**11,925.8**	**11,836.6**	**(89.3)**
SLA Bed Days	505.3	579.4	668.2	608.5	514.7	(93.9)
SLA Daycase	1,006.3	967.7	1,093.5	1,101.4	1,051.8	(49.6)
SLA Elective	2,536.9	2,360.9	3,049.9	2,783.6	2,933.3	149.7
SLA Exclusions	697.8	901.6	854.8	565.8	649.2	83.4
SLA Non Elective	3,478.6	3,577.7	4,663.2	4,033.0	3,925.2	(107.8)
SLA Other	533.0	909.2	554.1	273.2	262.9	(10.3)
SLA Outpatients	2,597.8	2,369.2	2,492.4	2,449.2	2,437.6	(11.6)
SLA Programme	94.8	118.0	111.1	111.1	62.0	(49.1)
Other Income	**1,539.4**	**1,496.4**	**1,411.6**	**1,572.3**	**1,538.4**	**(33.9)**
Levy Income	1,250.2	1,252.1	1,078.2	1,239.9	1,239.9	0.0
Other Healthcare Income	0.0	0.0	0.0	0.0	0.0	0.0
Other Income	216.0	132.0	181.0	206.1	185.2	(20.9)
Private & Overseas Patien	73.2	112.3	152.4	126.3	113.3	(13.0)
Pay	**(8,490.6)**	**(8,591.4)**	**(9,069.8)**	**(8,486.2)**	**(8,520.1)**	**(33.9)**
Pay Consultants	(2,135.0)	(2,145.0)	(2,287.7)	(2,209.7)	(2,143.8)	65.9
Pay Jnr Drs	(1,334.3)	(1,357.6)	(1,355.9)	(1,321.4)	(1,293.9)	27.5
Pay Non Clinical	(576.1)	(665.3)	(824.2)	(821.2)	(761.2)	60.0
Pay Nursing	(2,839.0)	(2,872.2)	(3,596.4)	(3,754.9)	(3,444.5)	310.3
Pay Other	0.0	0.0	0.0	563.0	(5.8)	(568.9)
Pay Sci, Techs, Therap	(1,606.2)	(1,551.4)	(1,005.5)	(942.1)	(870.8)	71.3
Non Pay	**(2,837.8)**	**(2,582.1)**	**(2,605.2)**	**(2,655.1)**	**(2,891.9)**	**(236.8)**
Clinical Consumables	(1,802.2)	(1,402.8)	(1,488.4)	(1,724.5)	(1,665.9)	58.5
Clinical Negligence	0.1	0.0	1.8	(0.5)	(1.8)	(1.3)
Drugs	(614.1)	(724.0)	(759.2)	(776.0)	(701.5)	74.5
Establishment	(20.1)	(22.2)	(48.8)	(34.2)	(28.6)	5.6
General Supplies	(25.3)	(19.2)	(22.1)	(33.9)	(28.0)	5.8
Other	(325.5)	(256.2)	(253.2)	(51.3)	(424.9)	(373.6)
Premises	(50.7)	(157.7)	(35.4)	(34.8)	(41.1)	(6.3)
Other	**(275.4)**	**(322.2)**	**(352.4)**	**(325.4)**	**(336.4)**	**(11.0)**
Depreciation	(157.0)	(203.9)	(234.0)	(209.1)	(209.1)	(0.0)
Interest Payable	(3.0)	(2.9)	(3.1)	(1.0)	(11.9)	(11.0)
PDC Dividend	(115.4)	(115.4)	(115.4)	(115.4)	(115.4)	0.0
Grand Total	**1,386.2**	**1,784.4**	**2,871.4**	**2,031.4**	**1,626.6**	**(404.8)**

SLA bed day income £94k

* Lost bed day income due to transfer of beds from Thomas Young ward at SGH to QMH and income target overstated to be confirmed for M02 reporting.

SLA Non elective income £108k

- Over performance in Neurology Stroke income, offset by underperformance in Neurosurgery & General Surgery as number of emergencies were low in April 2015, compared to 14/15.

Drugs & consumables (£133k)

- Drugs under spent in Neurology and consumable under spends in Neurosurgery & Head / Neck SDU's.

Unmet CIP gap £348k

* This is 1/12th of the reported gap of £4.2m as of 3 weeks ago. Current unmet CIP gap has reduced to £3.1m which should be reflected for M02 reporting and work is continuing to reduce this gap further.

Appendix F - CIP performance - CWDT

- The CWDT Division target is £8.9m. To date there are plans valued at £7.5m and a gap of £1.4m. £2.9m of the plans are green. Runrates will continue whilst further plans are developed.
- The target for M01 is £0.7m against which schemes of £0.6m are reporting as achieved (£0.3m recurrent). These are mainly pay runrate schemes at £0.2m. Further review of runrates will be completed in M2 against budgets set rather than against trend compared to M11.
- The actual for April was consistent with forecast. The most significant achieved schemes in the month include – Divisional runrate schemes ion pay £191k ; Wholesale dealer licence for Pharmacy £61k; Reduction of 4 nurses per shift in Critical care £57k; Additional Therapies runrate schemes £53k and Therapy service review £25k

		ACTUAL YTD M1 (£m)			OF WHICH TOTAL ACTUAL RAG			SHORT FALL
	TARGET	INC	EXP	TOTAL	RED	AMBER	GREEN	
CWDT SUMMARY								
C&W OVERHEADS	0.01	0.00	0.19	0.19	0.00	0.19	0.00	-0.18
CHILDRENS	0.14	0.01	0.08	0.09	0.02	0.02	0.06	0.05
CRITICAL CARE	0.16	0.00	0.10	0.11	0.00	0.03	0.08	0.05
DIAGNOSTICS	0.11	0.00	0.07	0.07	0.00	0.02	0.05	0.04
OUTPATIENTS	0.05	0.00	0.01	0.01	0.00	0.00	0.00	0.04
PHARMACY	0.06	0.06	0.00	0.06	0.00	0.00	0.06	-0.00
THERAPIES	0.06	0.00	0.08	0.09	0.00	0.08	0.00	-0.02
WOMENS	0.15	0.00	0.02	0.02	0.00	0.02	0.00	0.13
Grand Total	**0.74**	**0.08**	**0.55**	**0.63**	**0.02**	**0.35**	**0.26**	**0.11**
OF WHICH RECURRENT:		0.08	0.25	0.33	0.02	0.08	0.23	0.41

I&E ANALYSIS OF ACTUAL

	SLA				NONSLA				PAY				NONPAY			
	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL
C&W OVERHEADS										0.19		0.19				
CHILDRENS		0.01		0.01						0.00	0.05	0.05	0.02	0.00	0.01	0.03
CRITICAL CARE			0.00	0.00			0.00	0.00		0.02	0.07	0.09		0.01	0.00	0.01
DIAGNOSTICS										0.01	0.03	0.05		0.00	0.02	0.03
OUTPATIENTS													0.00		0.00	0.01
PHARMACY					0.00		0.06	0.06								
THERAPIES						0.00		0.00		0.08	0.00	0.08		0.00	0.00	0.00
WOMENS										0.01		0.01		0.00	0.00	0.00
Grand Total	**0.01**	**0.00**	**0.01**	**0.00**	**0.00**	**0.06**	**0.07**	**0.32**	**0.15**	**0.47**	**0.02**	**0.01**	**0.04**	**0.07**		
OF WHICH RECURRENT:	0.01	0.00	0.01	0.00	0.00	0.06	0.07	0.05	0.12	0.17	0.02	0.01	0.04	0.07		

		FORECAST AT M1 (£m)			OF WHICH TOTAL FORECAST RAG			SHORT FALL
	TARGET	INC	EXP	TOTAL	RED	AMBER	GREEN	
CWDT SUMMARY								
C&W OVERHEADS	0.15	0.00	0.22	0.22	0.03	0.19	0.00	-0.06
CHILDRENS	1.70	0.20	1.43	1.62	0.21	0.74	0.67	0.08
CRITICAL CARE	1.91	0.11	1.51	1.62	0.00	0.42	1.20	0.29
DIAGNOSTICS	1.35	0.36	0.93	1.29	0.00	0.82	0.48	0.06
OUTPATIENTS	0.55	0.00	0.41	0.41	0.07	0.33	0.01	0.14
PHARMACY	0.71	0.72	0.00	0.72	0.03	0.07	0.62	-0.01
THERAPIES	0.76	0.23	0.64	0.87	0.23	0.63	0.01	-0.11
WOMENS	1.76	0.08	0.59	0.67	0.13	0.53	0.01	1.10
Grand Total	**8.90**	**1.68**	**5.73**	**7.41**	**0.69**	**3.73**	**2.99**	**1.48**
OF WHICH RECURRENT:		1.68	4.85	6.53	0.67	3.02	2.85	2.36
OBJECTIVE 2 (FULL YEAR EFFE		2.07	5.46	7.53	0.93	3.69	2.91	1.36

I&E ANALYSIS OF FORECAST

	SLA				NONSLA				PAY				NONPAY			
	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL
C&W OVERHEADS										0.19		0.19	0.03			0.03
CHILDRENS		0.14		0.14		0.06		0.06		0.50	0.56	1.06	0.21	0.05	0.11	0.37
CRITICAL CARE			0.03	0.03		0.05	0.04	0.08		0.23	1.10	1.33		0.15	0.03	0.18
DIAGNOSTICS		0.21		0.21		0.15		0.15		0.10	0.17	0.27		0.36	0.30	0.66
OUTPATIENTS									0.02	0.30		0.32	0.05	0.03	0.01	0.09
PHARMACY					0.03	0.07	0.62	0.72								
THERAPIES					0.13	0.10		0.23	0.10	0.51	0.01	0.62		0.02	0.00	0.02
WOMENS					0.08			0.08	0.05	0.35		0.40		0.18	0.01	0.19
Grand Total	**0.35**	**0.03**	**0.37**	**0.24**	**0.42**	**0.66**	**1.31**	**0.17**	**2.17**	**1.85**	**4.19**	**0.29**	**0.79**	**0.46**	**1.54**	
OF WHICH RECURRENT:	0.35	0.03	0.37	0.24	0.42	0.66	1.31	0.15	1.55	1.70	3.40	0.29	0.70	0.46	1.45	
OBJECTIVE 2 (FULL YEAR EFFE	0.51	0.03	0.54	0.39	0.50	0.65	1.54	0.26	1.89	1.75	3.89	0.29	0.79	0.49	1.57	

Appendix F - CIP performance - Medcard

- The MEDCARD Division target of £10.6m. Schemes valued at £5.9m have been developed. £1.6m of these are still Red
- The target for M01 2014-15 is £0.9m , Total achieved is £0.7m, this is £0.75m more than was forecast for April, mainly due to achievement of £112k in month savings on Imatinib (drugs used in RHO) which was £58k more than forecast. There is a recurrent in month shortfall of £0.5m.
- The division has reported £357k of runrate savings in month 1 CIP. This will require further review at M2 as the measure is against spend at M11 in lieu of budgets at the time runrates were reported. There is a risk of overstated runrates.
- Other significant achieved schemes in month include further Medicines schemes worth £75k, £25k of Procurement schemes, £22k saving in month by using Clinical Fellows instead of GPs in ED, Medical workforce restructure in ED saved £15k in month and nursing rosters in ED saved £12.5k. Savings on private facilities of St Anthonys by CVT saved £17k.

		ACTUAL YTD M1 (£m)			OF WHICH TOTAL ACTUAL RAG			SHORT FALL
	TARGET	INC	EXP	TOTAL	RED	AMBER	GREEN	
MEDCARD SUMMARY								
ACUTE MED	0.20	0.00	0.01	0.01	0.00	0.00	0.00	0.20
CARDIOVASCULAR	0.22	0.02	0.03	0.05	0.00	0.02	0.03	0.17
ED	0.14	0.01	0.06	0.07	0.00	0.07	0.00	0.07
MEDICINE OVERHEADS	0.02	0.00	0.36	0.36	0.00	0.36	0.00	-0.34
RENAL & ONCOLOGY	0.18	0.11	0.09	0.20	0.00	0.08	0.13	-0.02
SPECIALIST MED	0.12	0.01	0.03	0.04	0.01	0.02	0.02	0.08
Grand Total	**0.88**	**0.16**	**0.57**	**0.73**	**0.01**	**0.54**	**0.17**	**0.16**
OF WHICH RECURRENT:		0.14	0.21	0.35	0.01	0.18	0.16	0.53

I&E ANALYSIS OF ACTUAL

	SLA				NONSLA				PAY				NONPAY			
	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL
MEDCARD SUMMARY																
ACUTE MED										0.00		0.00		0.00	0.00	0.00
CARDIOVASCULAR						0.00	0.02	0.02		0.00	0.00	0.00		0.02	0.01	0.03
ED		0.01		0.01		0.01		0.01		0.05		0.05		0.00	0.00	0.00
MEDICINE OVERHEADS										0.36		0.36				
RENAL & ONCOLOGY			0.11	0.11						0.00	0.01	0.01		0.07	0.00	0.08
SPECIALIST MED	0.01	0.01		0.01	0.00			0.00		0.00	0.00	0.01		0.01	0.01	0.02
Grand Total	**0.01**	**0.01**	**0.11**	**0.13**	**0.00**	**0.01**	**0.02**	**0.03**		**0.42**	**0.01**	**0.43**		**0.10**	**0.03**	**0.14**
OF WHICH RECURRENT:	0.01	0.01	0.11	0.13	0.00	0.01		0.02		0.06	0.01	0.07		0.10	0.03	0.14

		FORECAST AT M1 (£m)			OF WHICH TOTAL FORECAST RAG			SHORT FALL
	TARGET	INC	EXP	TOTAL	RED	AMBER	GREEN	
MEDCARD SUMMARY								
ACUTE MED	2.41	0.09	0.58	0.67	0.35	0.30	0.02	1.74
CARDIOVASCULAR	2.66	0.21	0.94	1.14	0.16	0.89	0.10	1.52
ED	1.67	0.27	0.69	0.96	0.02	0.87	0.07	0.71
MEDICINE OVERHEADS	0.22	0.00	0.37	0.37	0.02	0.36	0.00	-0.15
RENAL & ONCOLOGY	2.21	1.02	1.43	2.46	0.54	0.82	1.10	-0.25
SPECIALIST MED	1.45	0.32	0.94	1.25	0.29	0.81	0.16	0.20
Grand Total	**10.62**	**1.91**	**4.95**	**6.86**	**1.38**	**4.04**	**1.44**	**3.76**
OF WHICH RECURRENT:		1.88	4.56	6.44	1.38	3.66	1.41	4.17
OBJECTIVE 2 (FULL YEAR EFFECT)		2.12	4.77	6.89	1.63	3.83	1.43	3.73

I&E ANALYSIS OF FORECAST

	SLA				NONSLA				PAY				NONPAY			
	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL
MEDCARD SUMMARY																
ACUTE MED	0.07			0.07		0.02		0.02	0.25	0.18		0.44	0.03	0.10	0.02	0.15
CARDIOVASCULAR					0.12	0.06	0.03	0.21		0.14	0.01	0.14	0.04	0.69	0.06	0.79
ED		0.07		0.07		0.15	0.05	0.20		0.63		0.63	0.02	0.02	0.02	0.06
MEDICINE OVERHEADS									0.02	0.36		0.37				
RENAL & ONCOLOGY			0.93	0.93	0.02	0.08		0.09	0.33	0.10	0.12	0.55	0.20	0.64	0.05	0.88
SPECIALIST MED	0.06	0.06		0.12	0.14	0.05		0.20		0.05	0.09	0.14	0.08	0.64	0.07	0.79
Grand Total	**0.13**	**0.13**	**0.93**	**1.19**	**0.28**	**0.37**	**0.08**	**0.72**	**0.60**	**1.46**	**0.22**	**2.28**	**0.38**	**2.08**	**0.22**	**2.68**
OF WHICH RECURRENT:	0.13	0.13	0.93	1.19	0.28	0.37	0.05	0.69	0.60	1.08	0.21	1.89	0.38	2.08	0.22	2.68
OBJECTIVE 2 (FULL YEAR EFFECT)	0.14	0.13	0.89	1.16	0.41	0.50	0.05	0.96	0.69	1.12	0.27	2.08	0.40	2.08	0.22	2.69

Appendix F - CIP performance - SCNT

- The division has a CIP target of £8.7m, excluding SLA contribution. £5.7m schemes have been developed and a gap of £3.1m still needs to be closed. There are still £1.8m of Red schemes requiring further work.
- In month the required CIP is £0.7m.
- The division has reported £225k of runrate schemes in month. This has been seen by a reduction in actual pay compared to trend.
- The most significant schemes reported as achieved in month include £61k on procurement schemes and a further £15k on the Stryker procurement scheme; £49k on the Theatre Productivity scheme (still Red as although expenditure is on track it is not clear if this is due to productivity or less activity that will need to be caught up); £33k on the use of HCAs for Specials instead of RMNs; £40k on less spend on private sector facilities.

		ACTUAL YTD M1 (£m)			OF WHICH TOTAL ACTUAL RAG			SHORT FALL
	TARGET	INC	EXP	TOTAL	RED	AMBER	GREEN	
SCNT SUMMARY								
CANCER, HEAD & NEC	0.11	0.00	0.00	0.00	0.00	0.00	0.00	0.11
GEN SURG & UROLOG\	0.11	0.00	0.07	0.07	0.00	0.00	0.06	0.04
NEUROSCIENCES	0.16	0.04	0.13	0.17	0.04	0.04	0.09	-0.02
SURGERY OVERHEADS	0.02	0.00	0.23	0.23	0.00	0.23	0.00	-0.21
THEATRES	0.20	0.00	0.08	0.08	0.05	0.02	0.01	0.12
TRAUMA & ORTHO, PL	0.12	0.02	0.04	0.06	0.01	0.01	0.04	0.06
Grand Total	**0.73**	**0.07**	**0.55**	**0.62**	**0.11**	**0.29**	**0.22**	**0.11**
OF WHICH RECURRENT:		0.07	0.30	0.37	0.11	0.07	0.19	0.36

I&E ANALYSIS OF ACTUAL

	SLA				NONSLA				PAY				NONPAY			
	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL
CANCER, HEAD & NEC											0.00	0.00			0.00	0.00
GEN SURG & UROLOG\	0.00			0.00						0.00	0.01	0.01		0.00	0.05	0.05
NEUROSCIENCES	0.04			0.04						0.00	0.05	0.05	0.00	0.03	0.04	0.08
SURGERY OVERHEADS										0.23		0.23				
THEATRES									0.05	0.01	0.00	0.06	0.00	0.00	0.01	0.02
TRAUMA & ORTHO, PL	0.01			0.01		0.01		0.01			0.03	0.03		0.00	0.02	0.02
Grand Total	**0.06**			**0.06**		**0.01**		**0.01**	**0.05**	**0.24**	**0.09**	**0.38**	**0.00**	**0.04**	**0.12**	**0.17**
OF WHICH RECURRENT:	0.06			0.06		0.01		0.01	0.05	0.02	0.07	0.13	0.00	0.04	0.12	0.17

		FORECAST AT M1 (£m)			OF WHICH TOTAL FORECAST RAG			SHORT FALL
	TARGET	INC	EXP	TOTAL	RED	AMBER	GREEN	
SCNT SUMMARY								
CANCER, HEAD & NEC	1.31	0.12	0.16	0.28	0.01	0.12	0.15	1.03
GEN SURG & UROLOG\	1.35	0.08	1.00	1.08	0.06	0.24	0.79	0.27
NEUROSCIENCES	1.89	0.66	1.35	2.01	0.64	0.38	1.00	-0.13
SURGERY OVERHEADS	0.24	0.00	0.29	0.29	0.06	0.23	0.00	-0.05
THEATRES	2.42	0.00	1.21	1.21	0.77	0.25	0.19	1.21
TRAUMA & ORTHO, PL	1.50	0.41	0.65	1.06	0.24	0.22	0.60	0.44
Grand Total	**8.71**	**1.27**	**4.66**	**5.93**	**1.78**	**1.44**	**2.72**	**2.78**
OF WHICH RECURRENT:		1.27	4.18	5.45	1.77	1.14	2.54	3.26
OBJECTIVE 2 (FULL YEAR EFFECT		1.35	4.31	5.65	1.81	1.17	2.66	3.06

I&E ANALYSIS OF FORECAST

	SLA				NONSLA				PAY				NONPAY			
	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL
CANCER, HEAD & NEC		0.08		0.08	0.01	0.04		0.05		0.01	0.04	0.05		0.00	0.11	0.11
GEN SURG & UROLOG\	0.06			0.06			0.02	0.02		0.15	0.29	0.45		0.08	0.47	0.55
NEUROSCIENCES	0.50			0.50		0.04	0.12	0.16	0.05	0.08	0.41	0.54	0.09	0.26	0.46	0.82
SURGERY OVERHEADS										0.23		0.23	0.06			0.06
THEATRES									0.74	0.15	0.11	1.00	0.02	0.10	0.09	0.21
TRAUMA & ORTHO, PL	0.24			0.24		0.10	0.07	0.17		0.02	0.41	0.43		0.11	0.12	0.22
Grand Total	**0.80**	**0.08**		**0.88**	**0.01**	**0.17**	**0.22**	**0.40**	**0.79**	**0.64**	**1.26**	**2.68**	**0.18**	**0.55**	**1.25**	**1.98**
OF WHICH RECURRENT:	0.80	0.08		0.88	0.01	0.17	0.22	0.40	0.78	0.34	1.08	2.20	0.18	0.55	1.25	1.98
OBJECTIVE 2 (FULL YEAR EFFECT	0.81	0.10		0.91	0.01	0.20	0.23	0.44	0.80	0.34	1.18	2.32	0.19	0.53	1.26	1.99

Appendix F - CIP performance - CSW

- The division have a CIP target of £5.6m excl SLA income. At present there is a £2.6m shortfall and Red schemes of £2m.
- In month target is £0.46m. Schemes totalling £0.18m have been reported as achieved, leaving a shortfall of £0.28m. Most significant achievement is runrate at £99k in month, non-recurrent.
- Other schemes achieved in month include £37k on Procurement schemes, £10k in month on the redesign of the Community learning disability service redesign, £10k on PFI savings at QMH

		ACTUAL YTD M1 (£m)			OF WHICH TOTAL ACTUAL RAG			SHORT FALL
	TARGET	INC	EXP	TOTAL	RED	AMBER	GREEN	
CSD SUMMARY								
AMBULATORY CARE	0.14	0.00	0.02	0.02	0.00	0.01	0.01	0.12
COMM ADULT AND CHILD SV(	0.32	0.00	0.03	0.03	0.01	0.01	0.00	0.29
PROV MANAGEMENT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-0.00
PROV OVERHEADS	0.00	0.00	0.13	0.13	0.02	0.11	0.00	-0.13
Grand Total	**0.46**		**0.18**	**0.18**	**0.03**	**0.13**	**0.02**	**0.28**
OF WHICH RECURRENT:		0.00	0.08	0.08	0.03	0.03	0.02	0.38

I&E ANALYSIS OF ACTUAL

	SLA				NONSLA				PAY				NONPAY			
	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL
AMBULATORY CARE										0.00		0.00		0.01	0.01	0.02
COMM ADULT AND CHILD SV(									0.01	0.01	0.00	0.03		0.00	0.00	0.00
PROV MANAGEMENT															0.00	0.00
PROV OVERHEADS										0.10		0.10	0.02	0.01	0.00	0.03
Grand Total									**0.01**	**0.11**	**0.00**	**0.13**	**0.02**	**0.02**	**0.02**	**0.06**
OF WHICH RECURRENT:									0.01	0.01	0.00	0.03	0.02	0.02	0.02	0.06

		FORECAST AT M1 (£m			OF WHICH TOTAL FORECAST RAG			SHORT FALL
	TARGET	INC	EXP	TOTAL	RED	AMBER	GREEN	
CSD SUMMARY								
AMBULATORY CARE	1.68	0.04	0.37	0.41	0.12	0.25	0.04	1.27
COMM ADULT AND CHILD SV(	3.84	0.16	1.15	1.31	0.97	0.29	0.05	2.54
PROV MANAGEMENT	0.04	0.31	0.21	0.52	0.48	0.00	0.04	-0.48
PROV OVERHEADS	0.00	0.00	0.31	0.31	0.09	0.22	0.00	-0.31
Grand Total	**5.56**	**0.51**	**2.03**	**2.55**	**1.66**	**0.76**	**0.12**	**3.02**
OF WHICH RECURRENT:		0.51	1.93	2.45	1.66	0.67	0.12	3.11
OBJECTIVE 2 (FULL YEAR EFFECT)		0.75	2.20	2.95	1.95	0.87	0.13	2.61

I&E ANALYSIS OF FORECAST

	SLA				NONSLA				PAY				NONPAY			
	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL
AMBULATORY CARE		0.01		0.01	0.03			0.03	0.03	0.06		0.09	0.06	0.18	0.04	0.28
COMM ADULT AND CHILD SV(					0.06	0.10		0.16	0.91	0.14	0.02	1.07		0.06	0.02	0.08
PROV MANAGEMENT	0.28			0.28	0.04			0.04	0.09			0.09	0.08	0.00	0.04	0.12
PROV OVERHEADS										0.10		0.10	0.09	0.12	0.00	0.21
Grand Total	**0.28**	**0.01**		**0.29**	**0.13**	**0.10**		**0.22**	**1.03**	**0.29**	**0.02**	**1.34**	**0.23**	**0.36**	**0.10**	**0.69**
OF WHICH RECURRENT:	0.28	0.01		0.29	0.13	0.10		0.22	1.03	0.19	0.02	1.24	0.23	0.36	0.10	0.69
OBJECTIVE 2 (FULL YEAR EFFECT)	0.30	0.02		0.32	0.19	0.25		0.43	1.21	0.22	0.02	1.46	0.25	0.38	0.10	0.73

Appendix F - CIP performance - Overheads

- Estates CIP target is £2.9m for the year. The gap for the year is £2.5m. Runrates of £0.2m 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 £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.

		ACTUAL YTD M1 (£m)			OF WHICH TOTAL ACTUAL RAG			SHORT
	TARGET	INC	EXP	TOTAL	RED	AMBER	GREEN	FALL
OVERHEADS SUMMARY								
ESTATES & FACILITIES	0.24	0.00	0.21	0.21	0.00	0.20	0.01	0.03
OF WHICH RECURRENT:		0.00	0.01	0.01	0.00	0.00	0.01	0.23
CORPORATES:								
FINANCE & IT	0.12	0.00	0.05	0.05	0.00	0.02	0.03	0.07
GOVERNANCE & CEO	0.04	0.00	0.03	0.03	0.00	0.01	0.02	0.02
HR & EDUCATION	0.03	0.00	0.00	0.00	0.00	0.00	0.00	0.03
DON & OPS	0.02	0.00	0.02	0.02	0.00	0.00	0.00	0.00
Grand Total	**0.22**		**0.10**	**0.10**	**0.00**	**0.03**	**0.06**	**0.12**
OF WHICH RECURRENT:		0.00	0.08	0.08	0.00	0.02	0.05	0.14

I&E ANALYSIS OF ACTUAL

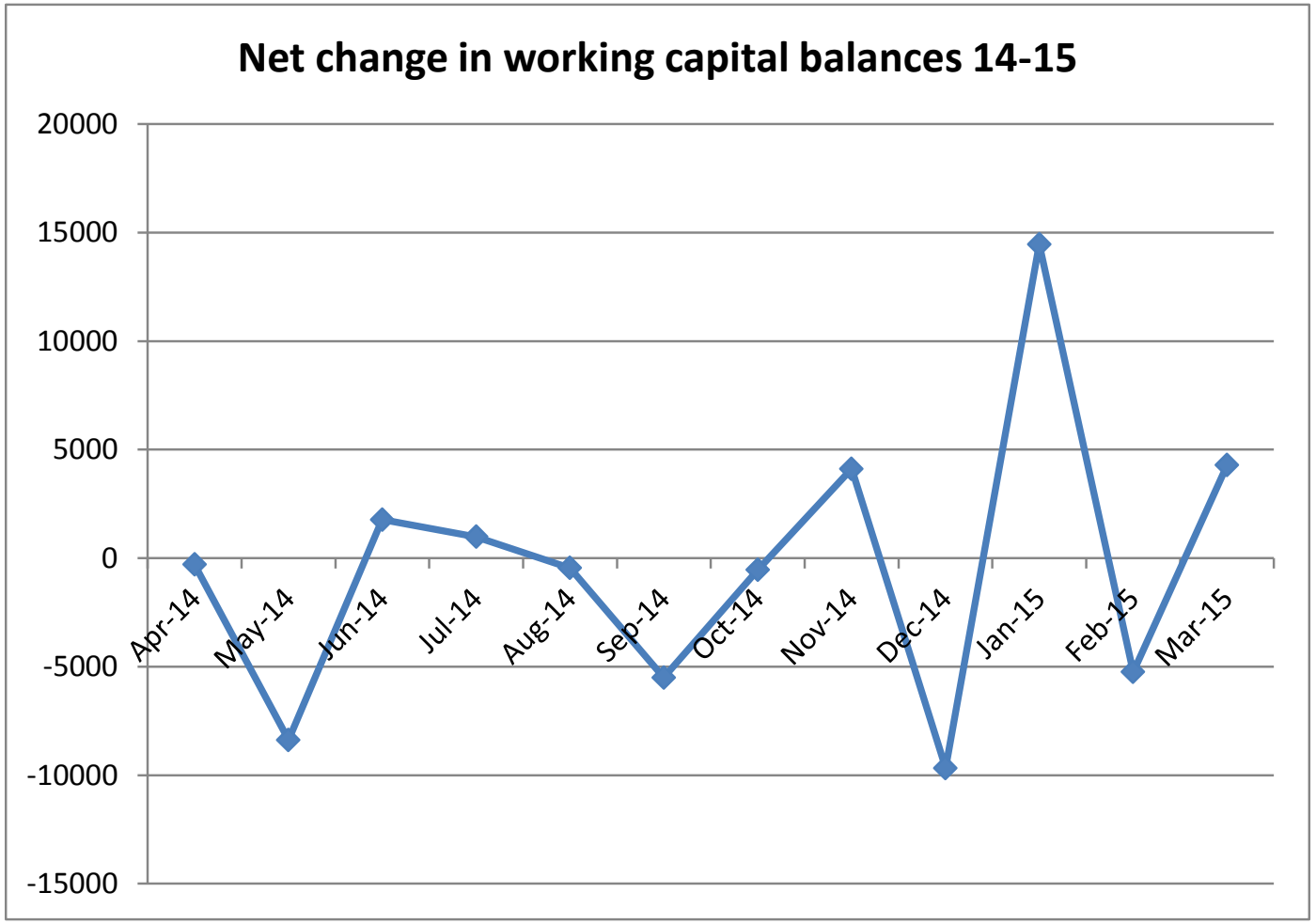
	SLA				NONSLA				PAY				NONPAY			
	RED	AMBER	GREEN	TOTA	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL
OVERHEADS SUMMARY																
ESTATES & FACILITIES										0.20		0.20			0.01	0.01
OF WHICH RECURRENT:															0.01	0.01
CORPORATES:																
FINANCE & IT									0.00	0.02	0.03	0.05			0.00	0.00
GOVERNANCE & CEO										0.01	0.01	0.02			0.00	0.00
HR & EDUCATION																
DON & OPS											0.02	0.02				
Grand Total									**0.00**	**0.03**	**0.05**	**0.09**			**0.01**	**0.01**
OF WHICH RECURRENT:									0.00	0.02	0.04	0.07			0.01	0.01

		FORECAST AT M1 (£m)			OF WHICH TOTAL FORECAST RAG			SHORT
	TARGET	INC	EXP	TOTAL	RED	AMBER	GREEN	FALL
OVERHEADS SUMMARY								
ESTATES & FACILITIES	2.89	0.00	0.38	0.38	0.00	0.34	0.04	2.52
OF WHICH RECURRENT:		0.00	0.18	0.18	0.00	0.13	0.04	2.72
CORPORATES:								
FINANCE & IT	1.44	0.00	0.81	0.81	0.09	0.32	0.40	0.62
GOVERNANCE & CEO	0.54	0.00	0.33	0.33	0.00	0.11	0.22	0.21
HR & EDUCATION	0.38	0.11	0.06	0.16	0.07	0.10	0.00	0.22
DON & OPS	0.25	0.00	0.20	0.20	0.00	0.00	0.00	0.05
Grand Total	**2.60**	**0.11**	**1.39**	**1.50**	**0.16**	**0.53**	**0.81**	**1.10**
OF WHICH RECURRENT:		0.11	1.19	1.30	0.16	0.48	0.66	1.31

I&E ANALYSIS OF FORECAST

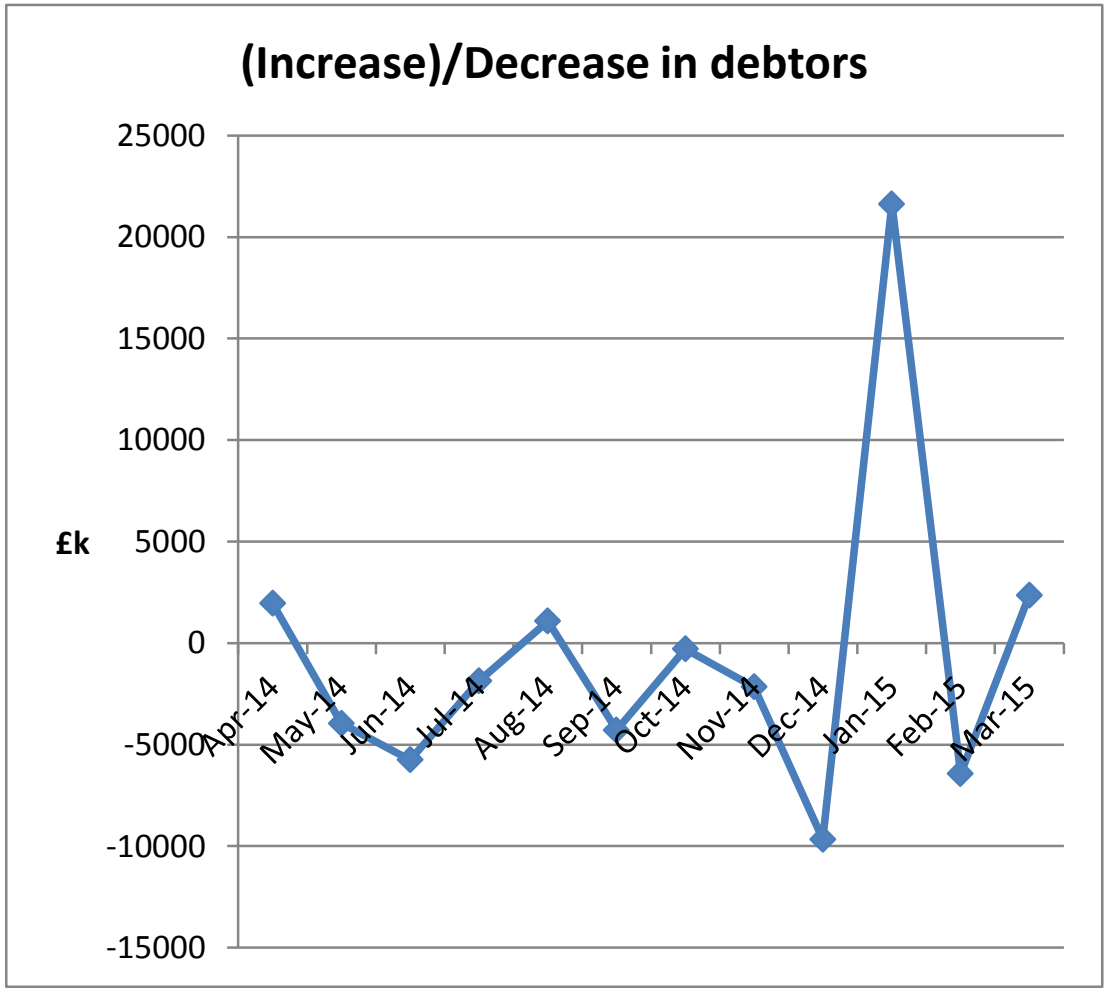
	SLA				NONSLA				PAY				NONPAY			
	RED	AMBER	GREEN	TOTA	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL	RED	AMBER	GREEN	TOTAL
OVERHEADS SUMMARY																
ESTATES & FACILITIES										0.20		0.20	0.13	0.04		0.18
OF WHICH RECURRENT:													0.13	0.04		0.18
CORPORATES:																
FINANCE & IT									0.09	0.30	0.36	0.75	0.02	0.04		0.06
GOVERNANCE & CEO										0.11	0.16	0.27		0.06		0.06
HR & EDUCATION					0.01	0.10		0.11	0.06			0.06				
DON & OPS											0.20	0.20				
Grand Total					**0.01**	**0.10**		**0.11**	**0.15**	**0.41**	**0.72**	**1.28**	**0.02**	**0.09**		**0.12**
OF WHICH RECURRENT:					0.01	0.10		0.11	0.15	0.36	0.57	1.07	0.02	0.09		0.12

Appendix G - Working Capital (1)



This is analysed further by component of working capital in the following slides

Appendix G - Working Capital (2)



M09 movement +£9.9m

NHS England invoiced debt increased by £5m – including Clinical Excellence Award funding £1.2m, M07 SLA over-performance £1.7m

NHS accrued debt increased by £3.4m in respect mainly of over-performance in-month for other CCGs.

M10 movement -£21.4m

(i) NHS England invoiced debt reduced by -£6.2m as payments received for a number of long-standing debts eg dental invoices, GUM invoices etc

(i) Community services merger accounting debtor balance -£6.4m was reversed as discussed with auditors.

(ii) Reductions in accrued debt for project diamond and education funding. Also RTT/SRG income changes.

M11 movement +£8.6m

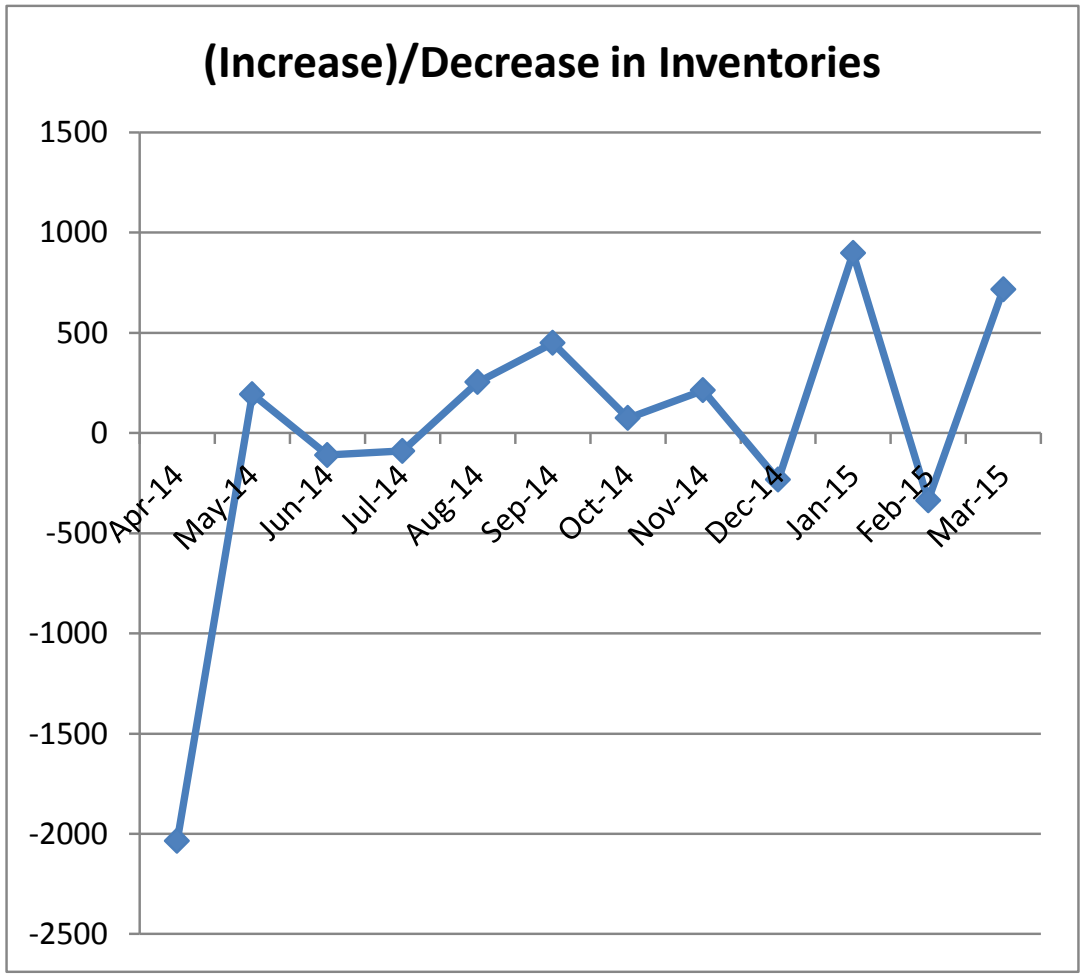
NHS invoiced debt increased by £7.7m includes:

(i) £2.73m invoice raised to NHS TDA other support funding

(ii) £1m increase in NHS Trust debt re: SWL Pathology hub – timing difference re: settlement from partner Trusts of monthly invoices

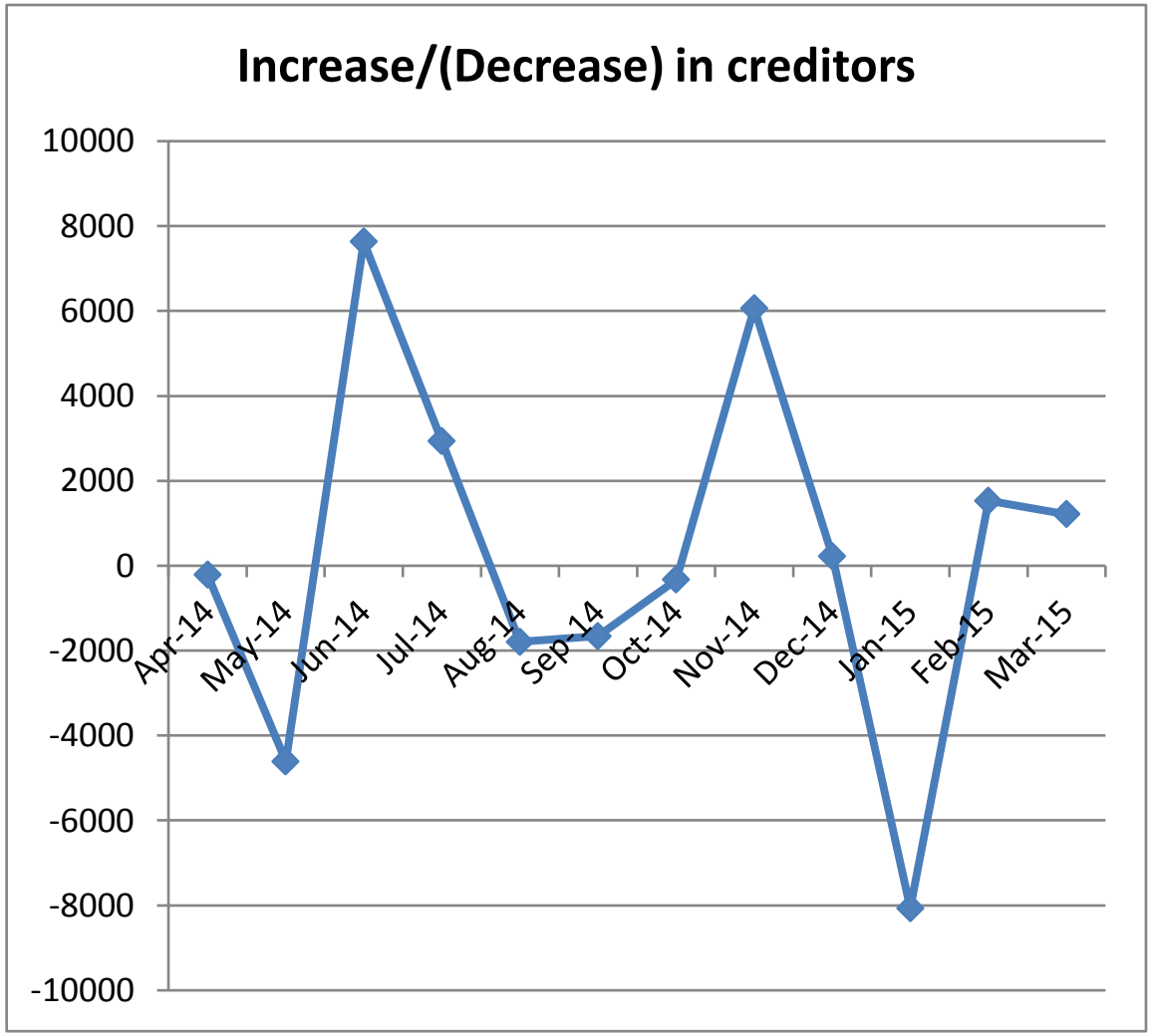
(iii) £4m across a number of CCGs

Appendix G - Working Capital (3)



The Trust implemented bulk purchase protocol and stock limits in year. All major departments except central store achieved their year end stock targets.

Appendix G - Working Capital (4)



The 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.

Appendix H - Cash balance March 2015 - plan, forecasts and outturn

The table below compares the key assumptions underpinning the cash balance projected for March 2015 per the

- 2014/ 15 TDA plan
- M06 forecast
- M09 forecast
- Outturn

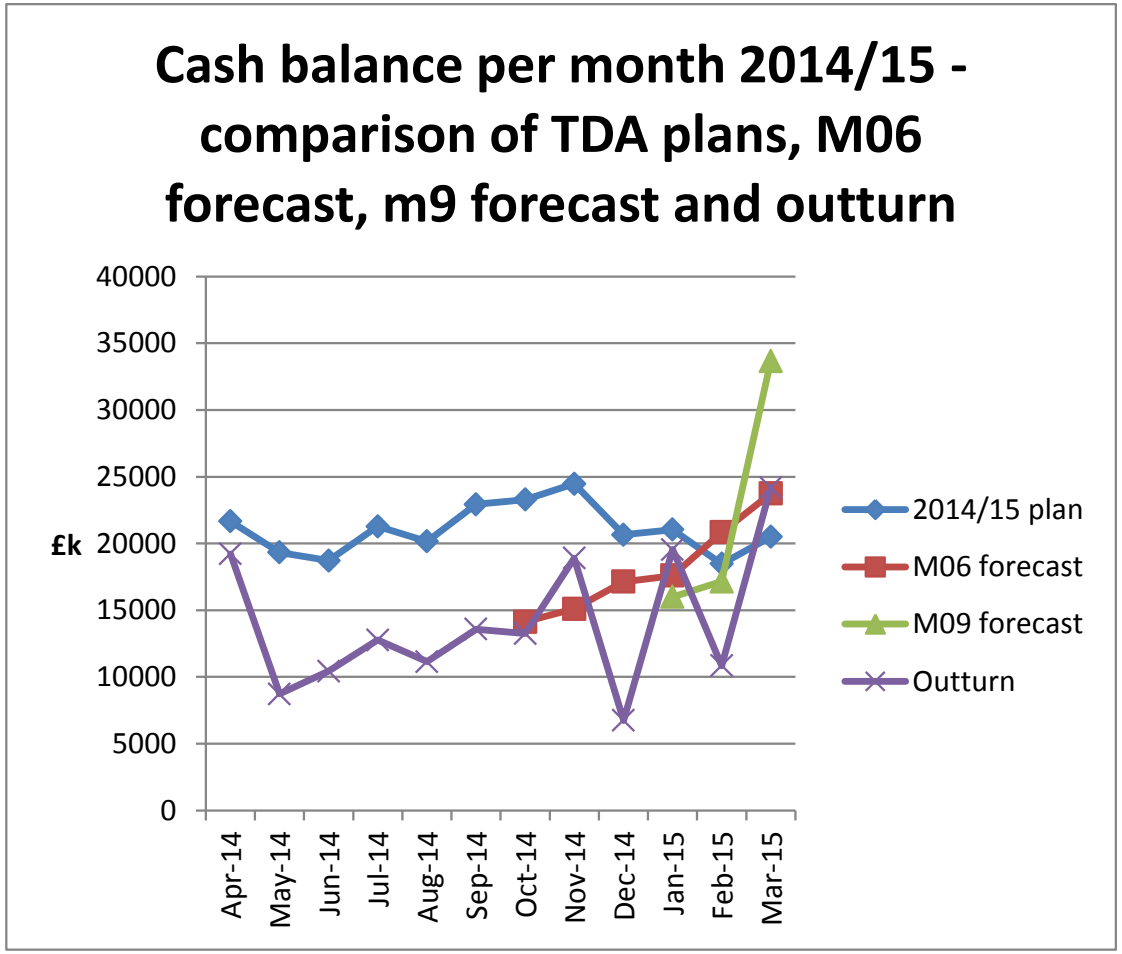
Cash balance at 31/03/15
Key assumptions per 2014/15 plan, M06 forecast, M09 forecast and outturn

	2014/15 plan £000	M06 forecast £000	M09 forecast £000	Outturn £000
Cash bal 31/03/15	20,500	23,750	33,654	24,179
Revenue surplus/-deficit (IFRS)	4,600	4,258	0	-16,756
Net movement in working capital	1,014	-6,212	-9,725	-4,469
DH capital loans	11,170	12,996	9,119	9,119
Capital payments	-41,266	-39,757	-35,235	-32,867
LEEF loan received	4,004	12,000	12,000	13,303
LEEF loan not spent in 31/03/ cash	*0*	*10,910*	*11,150*	*12,502*
WC loan in cash bal 31/03/15	0	0	15,000	15,000

The outturn cash balance was higher than TDA plan despite the revenue deficit mainly because the Trust received a £15m working capital loan and £12.5m of the LEEF loan had not been spent by year end.

Outturn working capital performance (cash effect of movements in stock, debtor, and creditor levels) was better than forecast at M06 and M09.

Appendix H - Cash April 14 – Mar 15: plan, forecasts and outturn



The M09 cash forecast was based on the M09 forecast revenue outturn for the year which was break-even. This is the main difference between the M09 forecast March cash balance of £33.7m and the actual outturn March cash balance of £24.2m.

Appendix I - Detailed monthly cash flow 2015/16

2015/16 projected monthly cash flow

	Apr-15 £000	May-15 £000	Jun-15 £000	Jul-15 £000	Aug-15 £000	Sep-15 £000	Oct-15 £000	Nov-15 £000	Dec-15 £000	Jan-16 £000	Feb-16 £000	Mar-16 £000	**Total £000**
Opening cash balance	**24,179**	**14,200**	**6,187**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	24,179
EBITDA	-3,615	-3,434	-327	665	-2,744	-155	747	-60	-2,842	-210	695	1,670	**-9,609**
Non-cash income	-15	-15	-15	-15	-15	-15	-15	-15	-15	-15	-15	-15	**-174**
Interest paid	-271	-329	-354	-282	-381	-342	-371	-484	-530	-436	-529	-449	**-4,758**
PDC dividend paid						-3,540						-3,542	**-7,082**
Operating surplus/-deficit less int and divs	-3,901	-3,778	-696	369	-3,139	-4,052	361	-558	-3,386	-660	152	-2,336	**-21,623**
Change in working capital													**0**
Change in stock		25	50	75	75	89	50	50	93	100	125	125	**857**
Change in debtors	-309	-1,691	-1,000	-1,000	500	-1,000	-1,000	0	500	-1,000	1,500	1,500	**-3,000**
Change in creditors excl those below	-2,351	651	-250	-300	-300	-250	-150	-150	200	-450	-750	-1,108	**-5,208**
													0
Net change in working capital	-2,660	-1,015	-1,200	-1,225	275	-1,161	-1,100	-100	793	-1,350	875	517	**-7,351**
													0
Provisions used	0	0	0	0	0	0	0	0	0	0	0	0	**0**
													0
Interest received	6	6	6	6	6	6	6	6	6	6	6	6	**75**
Proceeds from sale of fixed assets											PPU Ise	2,500	**2,500**
Capital spend (pymts) - external finance	-1,464	-1,661	-1,305	-1,121	-1,280	-2,208	-1,252	-674	-880	-841	-772	-773	**-14,231**
Capital spend (pymts) - internal capital	-1,757	-2,602	-2,935	-3,329	-3,402	-2,672	-3,475	-3,146	-2,979	-1,769	-1,576	-1,696	**-31,338**
Net cash inflow/-outflow frm invest activities	-3,214	-4,257	-4,233	-4,444	-4,676	-4,874	-4,721	-3,814	-3,853	-2,604	-2,341	38	**-42,994**
													0
Working capital loan received													**0**
Interim support funding			**2,138**	**4,853**	**7,634**	**9,858**	**5,324**	**5,093**	**7,644**	**5,074**	**2,274**	**2,293**	**52,185**
Loans received - LEEF													
Loans received - DH capital		1,241	1,111	907	866	882	595	26	0	0	0	0	**5,628**
Loan repayments - LEEF									-739				**-739**
Working capital loan repyments					-499.5						-499.5		**-999**
Loans repayments - DH capital								-186				0	**-186**
Loans repaid - SALIX						-193							**-193**
PFI & finance lease repayments	-204	-204	-307	-460	-460	-460	-460	-460	-460	-460	-460	-511	**-4,907**
Net cash inflow/-outflow from financing	-204	1,037	2,942	5,300	7,540	10,087	5,459	4,473	6,445	4,614	1,314	1,782	
Net cash movement in period	-9,980	-8,013	-3,187	0	0	0	0	1	-1	0	0	1	**-21,179**
Closing cash balance	**14,200**	**6,187**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	3,000

Appendix J - Cash balance March 2015 - plan, forecasts and outturn

The table below compares the key assumptions underpinning the cash balance projected for March 2015 per the

- 2014/ 15 TDA plan
- M06 forecast
- M09 forecast
- Outturn

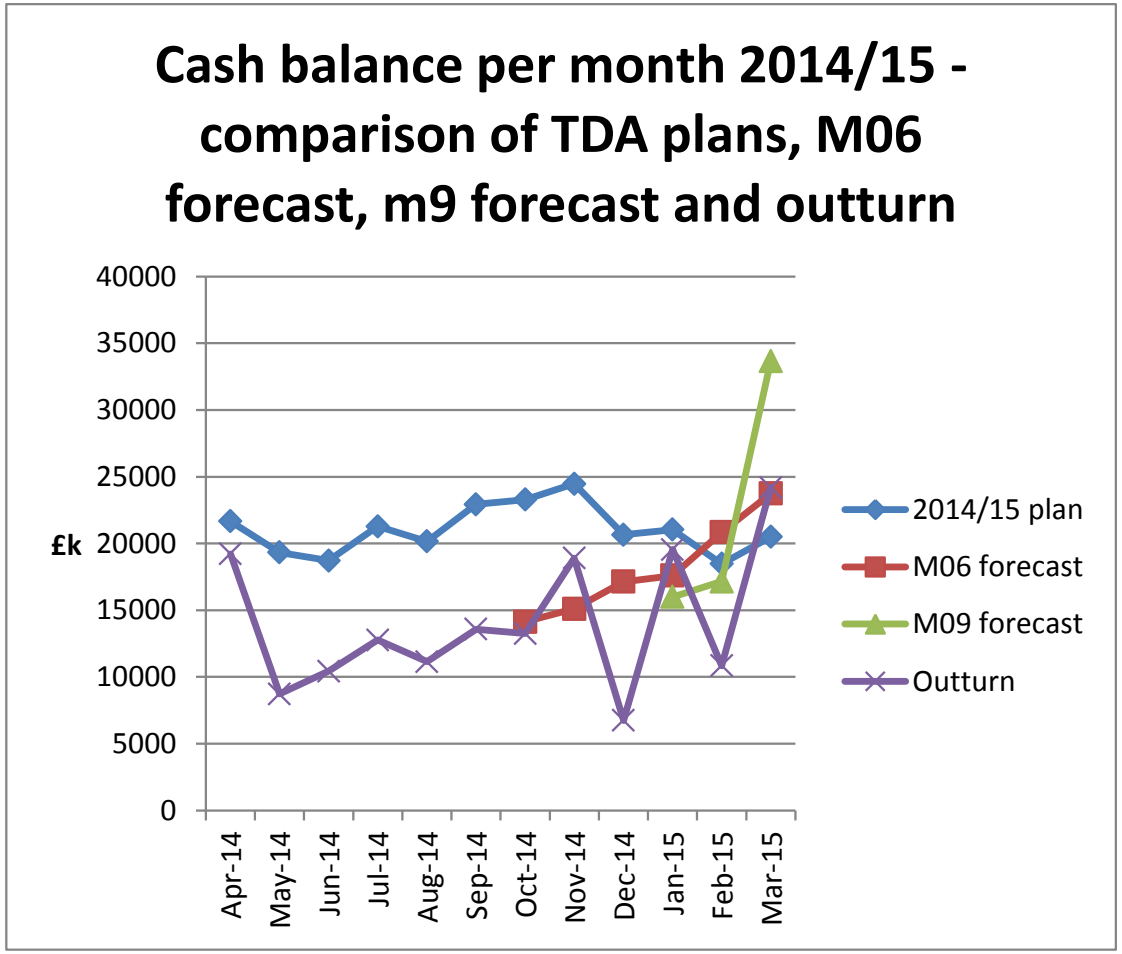
Cash balance at 31/03/15
Key assumptions per 2014/15 plan, M06 forecast, M09 forecast and outturn

	2014/15 plan £000	M06 forecast £000	M09 forecast £000	Outturn £000
Cash bal 31/03/15	20,500	23,750	33,654	24,179
Revenue surplus/-deficit (IFRS)	4,600	4,258	0	-16,756
Net movement in working capital	1,014	-6,212	-9,725	-4,469
DH capital loans	11,170	12,996	9,119	9,119
Capital payments	-41,266	-39,757	-35,235	-32,867
LEEF loan received	4,004	12,000	12,000	13,303
LEEF loan not spent in 31/03/ cash	*0*	*10,910*	*11,150*	*12,502*
WC loan in cash bal 31/03/15	0	0	15,000	15,000

The outturn cash balance was higher than TDA plan despite the revenue deficit mainly because the Trust received a £15m working capital loan and £12.5m of the LEEF loan had not been spent by year end.

Outturn working capital performance (cash effect of movements in stock, debtor, and creditor levels) was better than forecast at M06 and M09.

Appendix J - Cash April 14 – Mar 15: plan, forecasts and outturn



The M09 cash forecast was based on the M09 forecast revenue outturn for the year which was break-even. This is the main difference between the M09 forecast March cash balance of £33.7m and the actual outturn March cash balance of £24.2m.

Appendix K – capital programme 2015/16

Capital programme 2015/16 M01 - high level summary

	Annual budget £000	Budget M01 £000	Actual M01 YTD £000	*Variance M01 £000*	Budget M02 £000	Budget M03 £000	Budget M04 £000	Budget M05 £000	Budget M06 £000	Budget M07 £000	Budget M08 £000	Budget M09 £000	Budget M10 £000	Budget M11 £000	Budget M12 £000	**Budget Total £000**
Infrastructure renewal																
Internal capital	**6,359**	0	165	*-165*	34	247	357	194	168	904	1,154	1,329	999	606	366	**6,358**
LEEF loan	**6,971**	125	-210	*335*	127	194	214	414	1,326	657	648	880	841	772	773	**6,971**
																0
Medical equipment																**0**
Internal capital	**3,456**	270	144	*126*	401	450	116	949	387	479	163	49	26	57	107	**3,456**
Lease finance	**11,168**	1,145	266	*879*	845	485	245	645	1,479	2,576	1,590	245	872	245	795	**11,168**
																0
IMT																**0**
Internal capital	**5,308**	312	322	*-10*	1,371	519	784	648	441	245	245	445	152	73	73	**5,308**
PDC capital	**1,103**	105	137	*-32*	115	105	75	75	192	100	100	0	237	0	0	**1,103**
																0
Major Projects																**0**
Internal capital	**12,702**	823	394	*429*	453	1,305	1,729	1,313	1,299	1,606	1,343	1,015	183	663	973	**12,702**
DH capital loans	**7,260**	1,339	893	*446*	1,534	1,111	907	866	882	595	26	0	0	0	0	**7,260**
																0
Other																**0**
Internal capital	**2,411**	247	168	*79*	228	309	269	224	186	142	142	142	172	177	177	**2,411**
Total	**56,738**	4,366	2,279	*2,087*	5,108	4,725	4,695	5,327	6,360	7,303	5,411	4,104	3,482	2,593	3,264	**56,737**

Summary finance	**Annual budget £000**	Budget M01 £000	Actual M01 YTD £000	*Variance M01 £000*
Internal capital	**30,236**	1,652	1,193	*459*
LEEF loan	**6,971**	125	-210	*335*
DH capital loans	**7,260**	1,339	893	*446*
PDC capital	**1,103**	105	137	*-32*
Lease finance	**11,168**	1,145	266	*879*
Total	**56,738**	4,366	2,279	*2,087*

Appendix L - aged profile of invoiced debt M01 2015/16

Summary of Outstanding Invoices at 30 April 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 30/04/15 £000s	at 31/03/15 £000s	% change since last report	at 30/04/14 £000s	% change since year end		at 30/04/15 £000s	at 31/03/15 £000s	at 30/04/15 £000s	at 31/03/15 £000s	at 30/04/15 £000s	at 31/03/15 £000s	at 30/04/15 £000s	at 31/03/15 £000s	at 30/04/15 £000s	at 31/03/15 £000s
(1) NHS England - Legacy PCT balances	0%	**5**	*5*	0%	**8**			0	*0*	0	*0*	0	*0*	(2)	*(2)*	7	*7*
(2) Clinical Commissioning Groups	0%	**2,186**	*2,220*	(2%)	**(2,775)**	(179%)		(1,274)	*(1,680)*	1,615	*2,185*	1,478	*1,491*	195	*(13)*	172	*237*
(3) NHS Wandsworth CCG	0%	**5,499**	*3,876*	42%	**2,649**			3,688	*2,018*	1,105	*1,470*	355	*106*	351	*282*	0	*0*
(4) NHS Sutton CCG	0%	**1**	*(15)*	(107%)	**(358)**			(68)	*(44)*	67	*27*	0	*0*	0	*0*	2	*2*
(5) NHS Merton CCG	0%	**(426)**	*(367)*	16%	**941**			(430)	*(367)*	4	*0*	0	*0*	0	*0*	0	*0*
(6) NHS Croydon CCG	0%	**421**	*425*	(1%)	**137**			420	*424*	0	*0*	0	*0*	0	*0*	1	*1*
(7) NHS Kingston CCG	0%	**(152)**	*119*	(228%)	**(277)**			(156)	*115*	0	*0*	0	*0*	0	*0*	4	*4*
(8) NHS Lambeth CCG	5%	**(127)**	*(127)*	0%	**103**			(127)	*(127)*	0	*0*	0	*0*	0	*0*	0	*0*
(9) NHS England	15%	**13,771**	*13,645*	1%	**14,491**	(5%)		6,532	*5,031*	4,135	*6,831*	2,759	*834*	332	*936*	13	*13*
(10) Non English NHS NCA Debt	0%	**385**	*687*	(44%)	**462**	(17%)		(205)	*75*	78	*99*	18	*23*	68	*79*	426	*411*
(11) English CCG NCA Debt	5%	**3,186**	*3,238*	(2%)	**2,336**			1,076	*1,053*	553	*785*	612	*508*	510	*513*	435	*379*
Clinical Commissioning Groups subtotal	61%	**24,749**	***23,706***	4%	**17,717**	40%	**0**	**9,456**	***6,498***	**7,557**	***11,397***	**5,222**	***2,962***	**1,454**	***1,795***	**1,060**	***1,054***
(12) Other NHS Organisations	1%	**1,438**	*1,698*	(15%)	**1,059**	36%		(189)	*121*	737	*731*	136	*65*	114	*124*	640	*657*
(12.1) Health Education England	0%	**145**	*1,149*	(87%)	**26**	458%		145	*1,102*	0	*47*	0	*0*	0	*0*	0	*0*
(13) NHS Trusts	7%	**8,635**	*7,890*	9%	**5,700**	51%		1,942	*2,240*	3,012	*2,068*	778	*921*	1,265	*1,056*	1,638	*1,605*
Total NHS Invoices outstanding	69%	**34,967**	***34,443***	2%	**24,502**	43%	**0**	**11,354**	***9,961***	**11,306**	***14,243***	**6,136**	***3,948***	**2,833**	***2,975***	**3,338**	***3,316***

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 30/04/15 £000s	at 31/03/15 £000s	% change since last report	at 30/04/14 £000s	% change since year end		at 30/04/15 £000s	at 31/03/15 £000s	at 30/04/15 £000s	at 31/03/15 £000s	at 30/04/15 £000s	at 31/03/15 £000s	at 30/04/15 £000s	at 31/03/15 £000s	at 30/04/15 £000s	at 31/03/15 £000s
(14) General Debtors (Clinical/Technical Services to Non NHS orgs; etc)	5%	**3,270**	*3,845*	(15%)	**3,221**	2%	(1,207)	765	*1,977*	1,149	*581*	509	*438*	171	*160*	676	*689*
(15) Private Patients	3%	**1,437**	*1,257*	14%	**1,338**	7%	(182)	326	*145*	259	*286*	112	*96*	37	*85*	703	*645*
(15.1) Bupa Insurance Services Ltd t/a Bupa	3%	**158**	*253*	(38%)	**0**	#DIV/0!		30	*140*	53	*25*	1	*15*	74	*73*	0	*0*
(15.2) AXA PPP Healthcare Ltd	3%	**202**	*203*	(0%)	**0**	#DIV/0!		1	*76*	132	*95*	42	*6*	27	*26*	0	*0*
(16) Overseas Visitors NHS Chargeable	5%	**2,484**	*2,423*	3%	**2,219**	12%	(1,396)	72	*122*	211	*123*	211	*252*	209	*163*	1,781	*1,763*
(17) Salary Overpayments	1%	**493**	*520*	(5%)	**495**	(0%)	(120)	0	*63*	57	*7*	40	*55*	49	*50*	347	*345*
(18) Medical School	1%	**1,352**	*1,303*	4%	**318**	325%	(28)	315	*365*	417	*326*	563	*588*	49	*16*	8	*8*
(19) St George's Hospital Charity	0%	**354**	*365*	(3%)	**339**	4%	(10)	112	*154*	134	*105*	8	*5*	71	*72*	29	*29*
(20) Compensation Recovery Unit	16%	**12,159**	*12,013*	1%	**9,908**	23%	(1,847)	286	*542*	950	*740*	1,081	*1,092*	1,627	*1,624*	8,215	*8,015*
(21) UK Border Agency	0%	**180**	*177*	2%	**110**	64%	0	3	*(1)*	*25*	*50*	*43*	*25*	*34*	*28*	*75*	*75*
(22) Local Authority	0%	**4,160**	*4,219*	(1%)	**0**	#DIV/0!	0	1,059	*911*	*974*	*1,454*	*1,074*	*1,169*	*910*	*542*	*143*	*143*
Total Non-NHS Invoices outstanding	31%	**26,249**	***26,578***	(1%)	**17,948**	**12%**	**(4,790)**	**2,970**	***4,494***	**4,362**	***3,792***	**3,684**	***3,741***	**3,258**	***2,839***	**11,977**	***11,712***

Appendix M - COSRR detail

Metric Scores	Criteria	Actual M01
Liquid ratio	= A / B * C	-2.8
Capital servicing capacity	= D / E	-3.6
Metric Rating (See Thresholds)	**Weighting**	**Rating**
Liquid ratio	50%	3
Capital servicing capacity	50%	1
Weighted Average		2.0
Overriding Score		**2**

Working Capital Balance	A	= F-G+H	- 5.7
Annualised Operating Expenses	B		731.2
Days in Year	C	= 360	360.0
Revenue available for capital service	D	=J+K+L+M+N-O-P	- 4.5
Annual debt service	E	=Q+R+S	1.3
Net Current Assets	F		2.1
Inventories	G		7.8
Wholly committed lines of credit	H		-
Surplus/(Deficit)	J		- 7.6
Depreciation	K		2.1
Interest Payable	L		0.4
Dividend Payable	M		0.6
Restructuring costs & exceptionals	N		-
Gains/Losses on Asset Disposals	O		0.0
Donations to PPE/Intangibles	P		-
Repayment of loans and leases	Q		0.3
Interest Payable	R		0.4
Dividend Payable	S		0.6

CoSRR Assessment

Financial risk is now assessed by Monitor in terms of the risks to continuity of service, which is evaluated in accordance with the calculations set out in this table using two metrics of equal weight:-

(1) Liquidity [Working capital balance x 360 / Annual operating expenses]

(2) Capital servicing capacity [Revenue available for capital service / Annual debt service]

Each metric is assessed against a set of rating score thresholds to assign one of four rating categories ranging from 1, which represents the most serious risk, to 4, representing the least risk. They are then weighted and combined into a composite Continuity of Services Risk Rating score (nb scores will be rounded up, so metric scores of 3 & 4 will result in a 4).

The role of ratings is to indicate when there is a cause for concern at a provider. Only when there is a score of 2 is this likely to represent a material level of financial risk and prompt consideration of more detailed investigations by Monitor.

Under new guidance from Monitor , any individual metric score of 1 now has the same consequence as an overall score of 2.

Planned M01 Performance

The Trust is assessed as having a Risk rating of 2 based on its plan for 2015/16.

Actual M01 Performance

The Trust's overall M01 CoSRR performance is assessed as a 2 as per plan.

St George's Healthcare NHS Trust

REPORT TO THE TRUST BOARD ***May 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 April 2015. The report also includes available benchmark information.
- Key points to note are that agency and bank usage are significantly reduced, sickness absence has reduced back to target levels but turnover has increased again.
- A report from the Chair of the Workforce and Education Committee is included in the workforce board papers.
- The documentation for the proposed Mutually Agreed Resignation Scheme is included in the workforce reports, as board sign off is a HN Treasury Requirement.

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 April board report is that there has been a 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. Turnover remains concerning and has increased again this month.

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.

Turnover and stability

In April, there has been an increase again in both the voluntary and overall turnover. This is of concern. The turnover paper brought to be the board paper in April projected a steady rate of 17.23% in May. We have failed to achieve this target. In future board reports the planned trajectory will be shown on the report. Further data is available for reasons for leaving and this has been reported to the Workforce and Education Committee. There are areas within the trust that have successfully managed to control turnover and it is imperative that this good practice is spread. It is proposed that the workforce advisory team provide focused support to divisions to support the reduction of turnover in a similar way to the work that has taken place to reduce sickness absence.

The benchmarking information is included at page 10 of the report compares the trust to London teaching hospitals and is based on the most recent data available (January). In this data the trust appears to be less of an outlier on overall turnover. The trust is participating in a HESL funded study being led by St George's University of London Joint Faculty to understand the causes of turnover and to learn from good practice elsewhere in South London.

Staff career development

Exit survey data tells us that the trust is losing good members of staff because they find promotion opportunities elsewhere and, therefore, one of the responses to the increasing turnover rates has been to ensure that we are focusing on retaining, developing and promoting our own staff. The data on page 8 shows that of members of staff that have been in post for more than a year 5.4% of them have been promoted into their current post.

Sickness absence

It is reassuring to see that sickness absence levels have returned to below target levels. It is planned to adopt the focused approach to reduce sickness absence to provide support with reducing turnover.

Agency and bank staff usage

For the first time the report includes at page 15 detail of agency and bank usage in addition to the information that is provided about costs. The reports show that agency usage has reduced significantly in April reflecting the run rate controls that are now in place. It will be important that the trust sustains this position. It is also positive to see an increase in bank rather than agency fill of temporary posts.

A review of agency usage has been undertaken by the Workforce and Education Committee and it is considered reasonable to have a target of 8% for agency usage and a target fill rate of bank versus agency of 50%.

Mandatory training and appraisal rates

The mandatory training system is now available again, following upgrade.

Workforce Report

St George's University Hospitals NHS
NHS Foundation Trust

Trust Board
Month 1 – April 2015

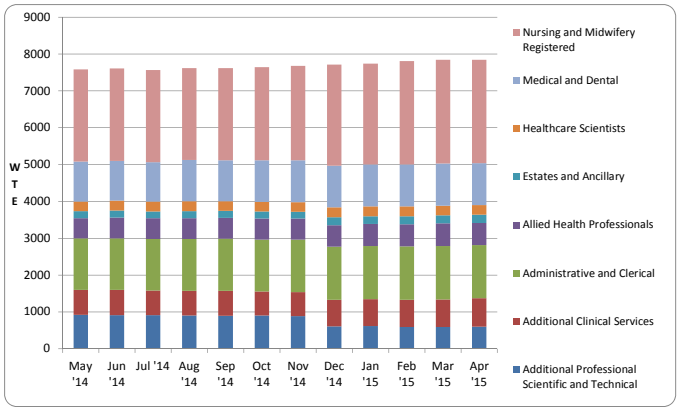
Workforce Performance Report
May 2014 - April 2015

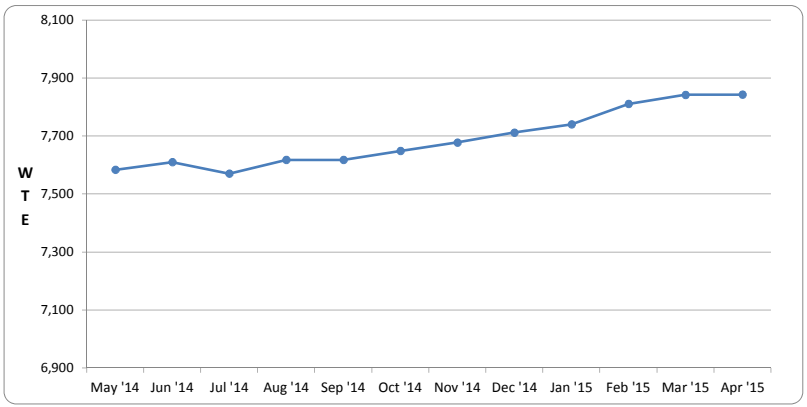
PERFORMANCE SUMMARY
Summary of overall performance is set out below:

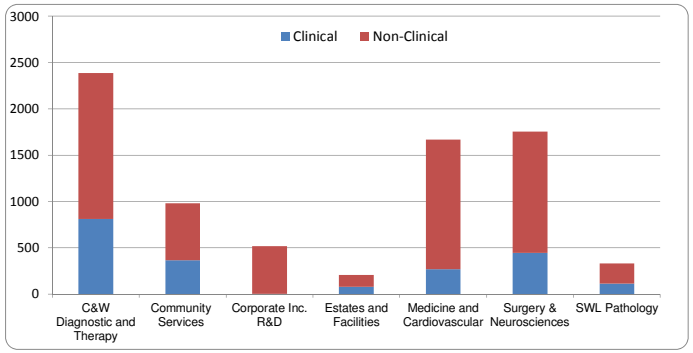
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has increased by 0.2%	11.2%	14.0%	14.2%	↗
6	Turnover	Turnover has increased by 0.3%	14.6%	17.2%	17.5%	↗
6	Voluntary Turnover	Voluntary turnover has increased by 0.2%	12.0%	13.9%	14.1%	↗
7	Stability	Stability has decreased this month by 0.7%	85.9%	83.5%	82.8%	↘
8	Sickness	Sickness has decreased by 0.5%	3.4%	3.7%	3.2%	↘
10-12	Temporary Staffing Usage (FTE)	Temporary staff usage has decreased by 0.6%	14.5%	16.7%	16.0%	↘
13	Mandatory Training	MAST compliance has decreased by 0.5%	75.6%	74.7%	74.2%	↘
14	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has decreased by 0.7%	75.4%	75.9%	75.2%	↘

CURRENT STAFFING PROFILE

The data below shows the current staffing profile of the Trust





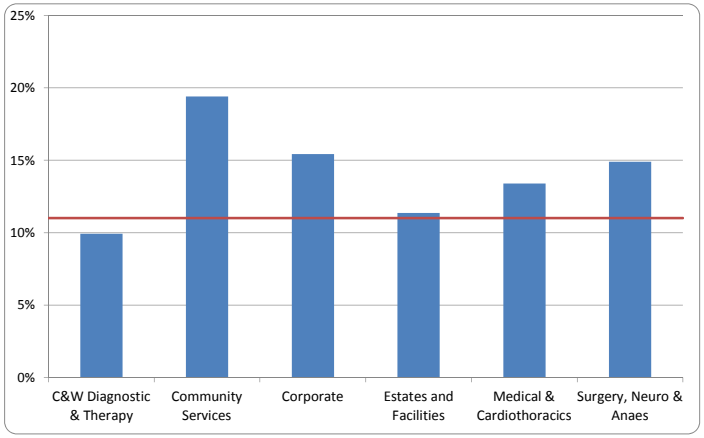


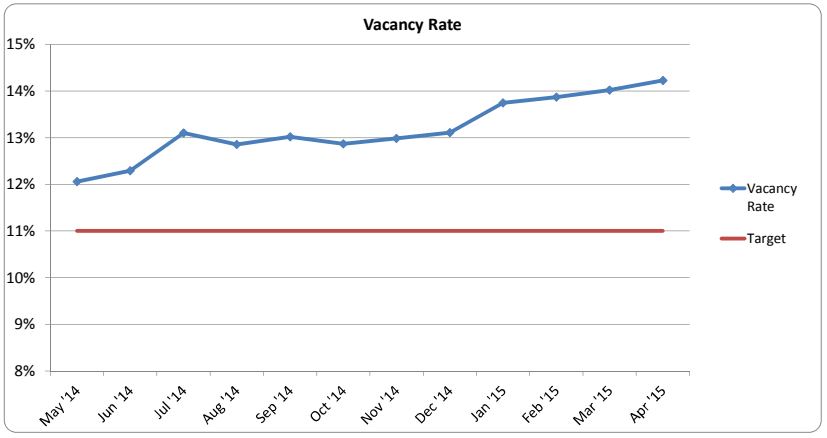
COMMENTARY

The Trust currently employs 8408 people working a whole time equivalent of 7843 which is just 0.7 WTE higher than in March. The actual growth rate in the directly employed workforce over the last year is 230 WTE or 3.0%.

Nursing & Midwifery is still the largest staff group at St. Georges and Children & Women's Diagnostic & Therapy Services is the largest Division employing over 30% of the workforce.

SECTION 1: VACANCIES





Vacancies by Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	8.8%	9.4%	9.9%	9.9%	↔
Community Services	21.7%	20.8%	19.6%	19.4%	↘
Corporate	14.6%	14.4%	14.5%	15.4%	↗
Estates and Facilities	14.8%	12.7%	12.7%	11.4%	↘
Medical & Cardiothoracics	11.2%	13.0%	12.7%	13.4%	↗
Surgery, Neuro & Anaes	15.2%	14.3%	15.0%	14.9%	↘
SWL Pathology	23.5%	23.3%	24.2%	25.0%	↗
Whole Trust	**13.7%**	**13.9%**	**14.0%**	**14.2%**	↗

Vacancies Staff Group	Jan '15	Feb '15	Mar '15	Apr '15	Trend
Add Prof Scientific and Technic	16.7%	20.1%	19.6%	18.6%	↘
Additional Clinical Services	16.1%	16.4%	15.6%	16.7%	↗
Administrative and Clerical	20.1%	20.1%	20.3%	21.2%	↗
Allied Health Professionals	4.1%	3.4%	1.9%	3.7%	↗
Estates and Ancillary	18.1%	16.9%	27.8%	27.0%	↘
Healthcare Scientists	14.9%	16.3%	19.5%	20.5%	↗
Medical and Dental	0.8%	0.0%	-0.3%	-0.3%	↔
Nursing and Midwifery Registered	14.9%	14.7%	14.3%	13.9%	↘
Total	**13.7%**	**13.9%**	**14.0%**	**14.2%**	↗

COMMENTARY

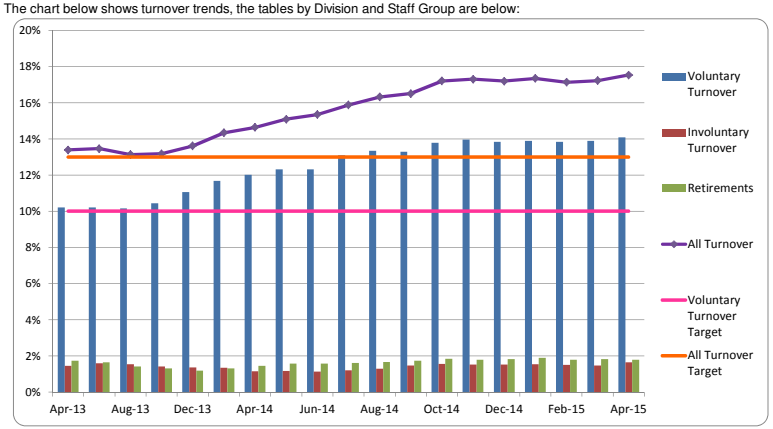
The substantive vacancy rate has increased by 0.2% in April to 14%.This figure is likley to be inflated and is subject to the establishment review.

Following the review of all budget baselines and a process for agreeing which service developments to take forward, a data cleanse of the electronic staff record system will be undertaken to remove all posts that are no longer required and which incorrectly inflate the vacancy figure.

Detailed recruitment plans are being developed within each directorate.

SECTION 2: TURNOVER

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



COMMENTARY

The total trust turnover rate has increased this month to17.5% which is significantly above the current target of 13%. In the previous 12 months there were around 1247 WTE leavers.

The Community Services Division also has relatively high levels of retirement. Additional support is being provided to the division in response to its challenges..

Each Division is developing a plan and target trajectory in response to the increase in turnover rates. One action point agreed is to investigate the reasons for leaving through promoting the increased take up of online exit questionnaires and face to face interviews.

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.

	All Turnover				
Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	17.7%	18.1%	18.1%	18.1%	↔
Community Services	19.9%	19.5%	18.8%	19.6%	↗
Corporate	16.0%	15.9%	15.9%	16.9%	↗
Estates and Facilities	10.7%	11.2%	11.9%	17.6%	↗
Medical & Cardiothoracics	18.1%	17.8%	18.2%	18.4%	↗
Surgery, Neurosciences & Anaes	15.4%	14.8%	14.6%	14.5%	↘
SWL Pathology	18.9%	16.8%	19.6%	19.4%	↘
Whole Trust	**17.3%**	**17.1%**	**17.2%**	**17.5%**	↗

	Voluntary Turnover					Other Turnover Apr 2015	
Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend	In-Voluntary	Retirement
C&W Diagnostic & Therapy	13.3%	13.6%	13.4%	13.5%	↗	2.7%	1.9%
Community Services	15.3%	15.0%	14.8%	15.6%	↗	1.2%	2.8%
Corporate	13.3%	13.6%	13.5%	14.0%	↗	1.3%	1.5%
Estates and Facilities	5.8%	6.7%	7.1%	8.0%	↗	5.8%	3.8%
Medical & Cardiothoracics	15.9%	15.7%	15.9%	16.1%	↗	0.9%	1.4%
Surgery, Neurosciences & Anaes	12.9%	12.6%	12.7%	12.3%	↘	0.9%	1.2%
SWL Pathology	15.4%	14.5%	16.9%	16.5%	↘	0.6%	2.3%
Whole Trust	**13.9%**	**13.8%**	**13.9%**	**14.1%**	↗	**1.7%**	**1.8%**

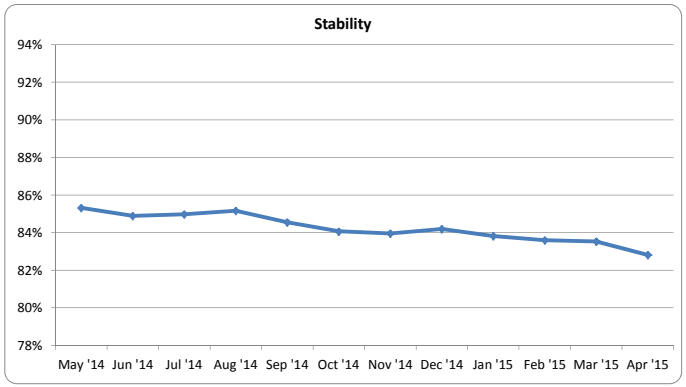
	All Turnover				
Staff Group	Jan '15	Feb '15	Mar '15	Apr '15	Trend
Add Prof Scientific and Technic	18.8%	18.9%	18.6%	18.9%	↗
Additional Clinical Services	19.8%	19.4%	20.7%	20.4%	↘
Administrative and Clerical	15.0%	15.0%	15.1%	16.6%	↗
Allied Health Professionals	18.9%	18.4%	17.8%	18.5%	↗
Estates and Ancillary	12.2%	12.0%	12.3%	12.6%	↗
Healthcare Scientists	15.2%	15.3%	15.3%	15.9%	↗
Medical and Dental	14.2%	14.5%	14.1%	13.3%	↘
Nursing and Midwifery Registered	18.4%	18.0%	18.1%	18.1%	↔
Whole Trust	**17.3%**	**17.1%**	**17.2%**	**17.5%**	↗

	Voluntary Turnover					Other Turnover Apr 2015	
Staff Group	Jan '15	Feb '15	Mar '15	Apr '15	Trend	In-Voluntary	Retirement
Add Prof Scientific and Technic	12.3%	12.4%	12.1%	12.3%	↗	5.9%	0.7%
Additional Clinical Services	16.7%	16.5%	17.5%	17.3%	↘	1.2%	1.9%
Administrative and Clerical	11.5%	11.9%	12.2%	12.9%	↗	1.6%	2.1%
Allied Health Professionals	17.8%	17.3%	16.3%	17.3%	↗	0.2%	1.0%
Estates and Ancillary	8.1%	7.9%	7.8%	8.2%	↗	0.9%	3.5%
Healthcare Scientists	11.2%	11.6%	11.2%	11.3%	↗	1.1%	3.5%
Medical and Dental	8.4%	8.6%	8.1%	7.6%	↘	4.5%	1.3%
Nursing and Midwifery Registered	15.6%	15.3%	15.5%	15.5%	↔	0.8%	1.8%
Whole Trust	**13.9%**	**13.8%**	**13.9%**	**14.1%**	↗	**1.7%**	**1.8%**

Caregroup	Staff in Post WTE	Leavers WTE	Voluntary Turnover Rate
Cardiac Surgery	88.7	26.8	35.0%
Gynaecology	48.6	17.4	30.5%
Trauma & Orthopaedics	126.6	31.7	28.0%
Therapies - Children	81.6	22.4	26.9%
Prison Service	60.5	18.6	26.1%

SECTION 3: STABILITY

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



Stability by Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	83.6%	83.5%	83.1%	82.6%	↘
Community Services	81.7%	81.2%	81.0%	80.4%	↘
Corporate	88.5%	87.9%	87.8%	85.7%	↘
Estates and Facilities	90.8%	91.3%	89.8%	89.0%	↘
Medical & Cardiothoracics	83.4%	82.9%	81.4%	81.3%	↘
Surgery, Neurosciences & Anaes	84.2%	84.0%	84.0%	84.6%	↗
SWL Pathology	81.6%	82.2%	90.2%	81.7%	↘
Whole Trust	**83.8%**	**83.6%**	**83.5%**	**82.8%**	↘

Stability Staff Group	Jan '15	Feb '15	Mar '15	Apr '15	Trend
Add Prof Scientific and Technic	76.4%	72.7%	72.4%	72.7%	↗
Additional Clinical Services	82.8%	82.3%	80.9%	82.8%	↗
Administrative and Clerical	87.3%	87.1%	87.7%	86.4%	↘
Allied Health Professionals	80.2%	80.7%	82.1%	80.8%	↘
Estates and Ancillary	88.1%	87.8%	86.3%	85.5%	↘
Healthcare Scientists	96.0%	96.2%	95.1%	88.7%	↘
Medical and Dental	89.7%	88.5%	88.7%	87.8%	↘
Nursing and Midwifery Registered	82.3%	83.0%	82.9%	82.2%	↘
Total	**83.8%**	**83.6%**	**83.5%**	**82.8%**	↘

COMMENTARY

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

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

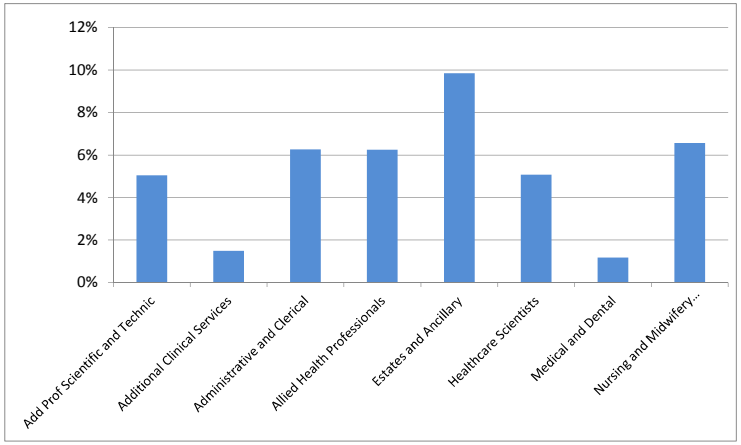
The stability rate has decreased by 0.7% this month.

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

Over the last 12 months the stability rate has declined by 3% and is now at 82.8%.

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 March, 39 staff were promoted, there were 120 new starters to the Trust and 227 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.

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 (105 employees over the year).

	No. of Promotions				
Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	26	14	13	8	↘
Community Services	18	13	8	4	↘
Corporate	10	2	5	3	↘
Estates and Facilities	0	0	0	20	↗
Medical & Cardiothoracics	15	10	9	1	↘
Surgery, Neurosciences & Anaes	10	5	6	3	↘
SWL Pathology	3	3	0	0	↔
Whole Trust Promotions	**82**	**47**	**41**	**39**	↘
New Starters (Excludes Junior Doctors)	**140**	**120**	**136**	**120**	↘

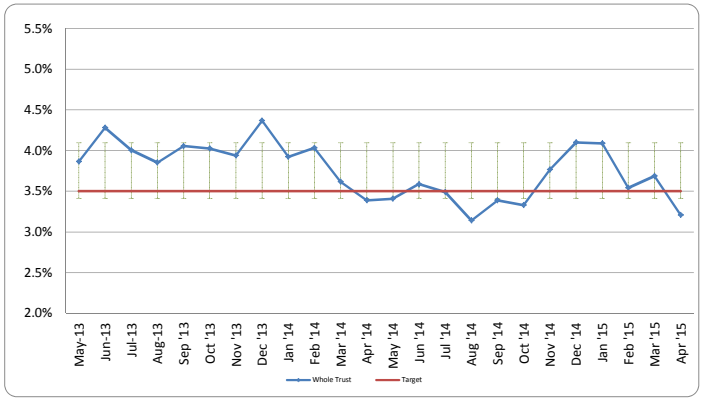
Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	1992	120	6.0%	112
Community Services	926	42	4.5%	15
Corporate	444	30	6.8%	23
Estates and Facilities	183	20	10.9%	4
Medical & Cardiothoracics	1205	68	5.6%	37
Surgery, Neurosciences & Anaes	1395	55	3.9%	23
SWL Pathology	316	12	3.8%	13
Whole Trust	**6461**	**347**	**5.4%**	**227**
New Starters (Excludes Junior Doctors)		**1461**		

	No. of Promotions				
Staff Group	Jan '15	Feb '15	Mar '15	Apr '15	Trend
Add Prof Scientific and Technic	5	4	2	1	↘
Additional Clinical Services	2	0	3	0	↘
Administrative and Clerical	26	13	8	5	↘
Allied Health Professionals	10	7	7	3	↘
Estates and Ancillary	0	0	0	20	↗
Healthcare Scientists	3	2	0	1	↗
Medical and Dental	1	3	1	0	↘
Nursing and Midwifery Registered	35	18	20	9	↘
Whole Trust	**82**	**47**	**41**	**39**	↘

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	515	26	5.0%	31
Additional Clinical Services	670	10	1.5%	10
Administrative and Clerical	1293	81	6.3%	81
Allied Health Professionals	528	33	6.3%	25
Estates and Ancillary	193	19	9.8%	0
Healthcare Scientists	256	13	5.1%	4
Medical and Dental	598	7	1.2%	3
Nursing and Midwifery Registered	2408	158	6.6%	73
Whole Trust	**6461**	**347**	**5.4%**	**227**

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 3.2% for April, which is a 0.5% decrease since the previous month and below the Trust target.

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.

The table below lists the five care groups with the highest sickness absence percentage during April 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	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	3.4%	2.9%	2.9%	2.3%	↘
Community Services	6.0%	5.3%	6.5%	5.7%	↘
Corporate	4.8%	3.6%	4.1%	4.0%	↘
Estates and Facilities	7.0%	6.3%	7.1%	6.5%	↘
Medical & Cardiothoracics	4.0%	3.3%	3.5%	3.0%	↘
Surgery, Neurosciences & Anaes	3.9%	3.5%	3.0%	2.9%	↘
SWL Pathology	2.0%	3.3%	3.2%	2.0%	↘
Whole Trust	**4.1%**	**3.5%**	**3.7%**	**3.2%**	↘

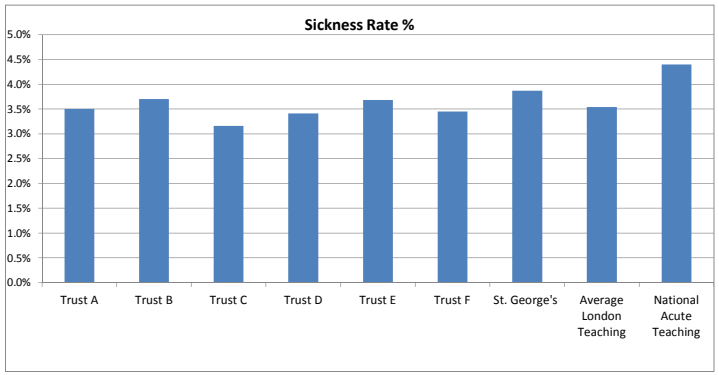
Sickness Staff Group	Jan '15	Feb '15	Mar '15	Apr '15	Trend
Add Prof Scientific and Technic	2.4%	2.7%	2.3%	2.9%	↗
Additional Clinical Services	5.0%	4.1%	5.1%	5.4%	↗
Administrative and Clerical	5.2%	4.2%	4.5%	4.0%	↘
Allied Health Professionals	2.5%	2.5%	3.1%	2.3%	↘
Estates and Ancillary	8.2%	6.7%	5.7%	6.1%	↗
Healthcare Scientists	1.4%	2.8%	2.4%	1.8%	↘
Medical and Dental	0.6%	0.9%	0.7%	0.2%	↘
Nursing and Midwifery Registered	5.3%	4.4%	4.5%	3.6%	↘
Total	**4.1%**	**3.5%**	**3.7%**	**3.2%**	↘

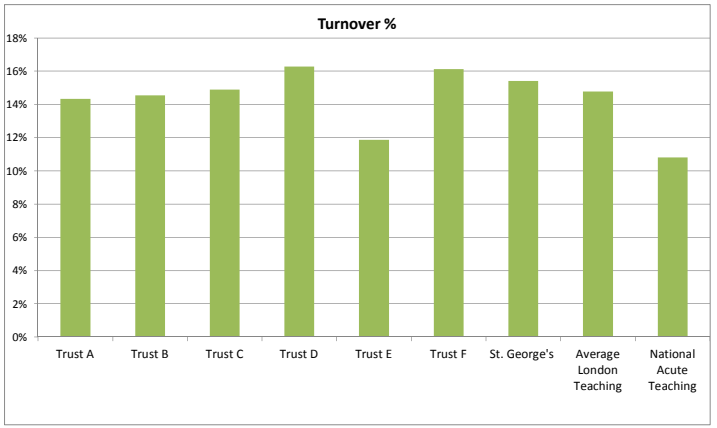
Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Prison Service	60.46	271.00	15.1%	£21,053
Security & Car Park Management	22.00	84.00	13.2%	£4,002
A & C - Non Community	44.30	148.51	11.3%	£7,900
Community PLD Service	24.43	65.87	9.4%	£6,507
Intermediate Care	63.00	166.05	8.6%	£9,964

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	28.72%
S25 Gastrointestinal problems	16.05%
S12 Other musculoskeletal problems	8.87%
S16 Headache / migraine	5.50%
S30 Pregnancy related disorders	5.50%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S13 Cold, Cough, Flu - Influenza	18.47%
S12 Other musculoskeletal problems	12.36%
S10 Anxiety/stress/depression/other psychiatric illnesses	11.81%
S25 Gastrointestinal problems	9.62%
S30 Pregnancy related disorders	6.49%

SECTION 6: WORKFORCE BENCHMARKING**





COMMENTARY

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

Sickness data shown is from January '15 which is the latest available. Compared to other Acute teaching trusts in London, St. Georges had a higher than average rate at 3.87%. 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 January.

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 February). 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 over 5% lower than St. Georges.

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

Reference Group	Gross Turnover Rate %	Stability Rate %	Sickness Rate %
Trust A	14.33%	85.39%	3.50%
Trust B	14.54%	85.06%	3.70%
Trust C	14.90%	84.74%	3.16%
Trust D	16.28%	83.61%	3.41%
Trust E	11.86%	83.84%	3.68%
Trust F	16.12%	83.32%	3.45%
St. George's	15.42%	84.14%	3.87%
Average London Teaching	14.78%	84.30%	3.54%
National Acute Teaching	10.81%	88.95%	4.40%

SECTION 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	1073.5	1073.5	1073.5	1073.5	↔
Community Services	592.3	592.3	594.3	593.6	↘
Corporate & R&D	50.9	50.9	50.5	53.5	↗
Medical & Cardiothoracics	1129.4	1213.8	1216.8	1218.8	↗
Surgery, Neurosciences & Anaes	1035.4	1035.4	1029.7	1022.7	↘
Total	3881.5	3966.0	3964.9	3962.1	↘

Nursing Staff in Post WTE

Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	983.2	983.7	980.6	986.0	↗
Community Services	459.3	464.2	478.5	479.7	↗
Corporate & R&D	44.7	47.2	45.3	49.1	↗
Medical & Cardiothoracics	977.3	1009.1	1017.1	1002.3	↘
Surgery, Neurosciences & Anaes	840.3	872.8	878.1	881.5	↗
Total	3304.7	3376.9	3399.4	3398.5	↘

Nursing Vacancy Rate

Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	8.4%	8.4%	8.7%	8.2%	↘
Community Services	22.5%	21.6%	19.5%	19.2%	↘
Corporate & R&D	12.3%	7.3%	10.3%	8.2%	↘
Medical & Cardiothoracics	13.5%	16.9%	16.4%	17.8%	↗
Surgery, Neurosciences & Anaes	18.8%	15.7%	14.7%	13.8%	↘
Total	14.9%	14.9%	14.3%	14.2%	↘

Nursing Sickness Rates

Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	5.0%	4.3%	4.1%	3.5%	↘
Community Services	6.9%	6.9%	7.9%	6.4%	↘
Corporate	5.3%	0.5%	0.4%	0.5%	↗
Medical & Cardiothoracics	4.6%	3.6%	4.4%	3.8%	↘
Surgery, Neurosciences & Anaes	5.6%	4.0%	3.5%	3.7%	↗
Total	5.3%	4.3%	4.5%	4.0%	↘

Nursing Voluntary Turnover

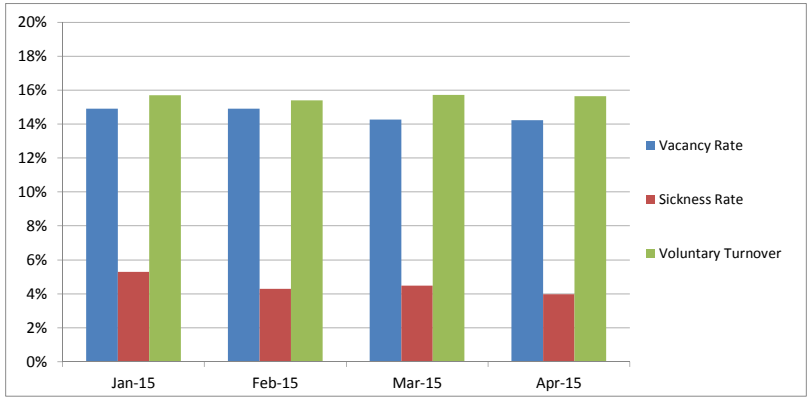
Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	13.98%	13.53%	14.45%	14.78%	↗
Community Services	17.84%	17.33%	16.18%	15.59%	↘
Corporate & R&D	11.67%	13.31%	18.12%	16.89%	↘
Medical & Cardiothoracics	18.23%	18.00%	18.29%	18.72%	↗
Surgery, Neurosciences & Anaes	13.61%	13.56%	13.79%	13.02%	↘
Total	15.7%	15.4%	15.7%	15.6%	↘

COMMENTARY

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

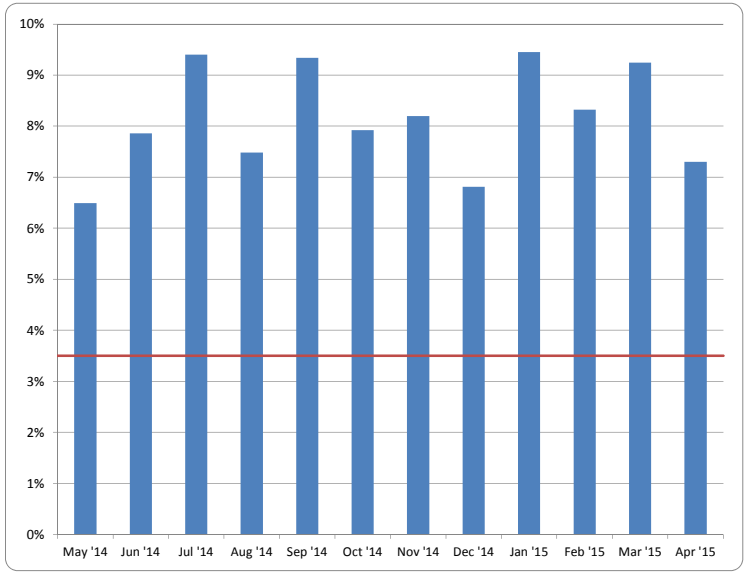
The nursing workforce has increased by 94 WTE since February 2015, however their has been a slight reduction in April 2015.

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 1.95% since march.

Although the pattern of agency expenditure tends to peak in March every year, it is disappointing that there has been a peak this year given the efforts that are being made to reduce run rate expenditure. At the March workforce and education committee it was agreed to review the targets for temporary staffing rates for 2015/16.

Currently the highest percentage spend is seen in the Medical & Cardiothoracics and Estates & Facilities Divisions.

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

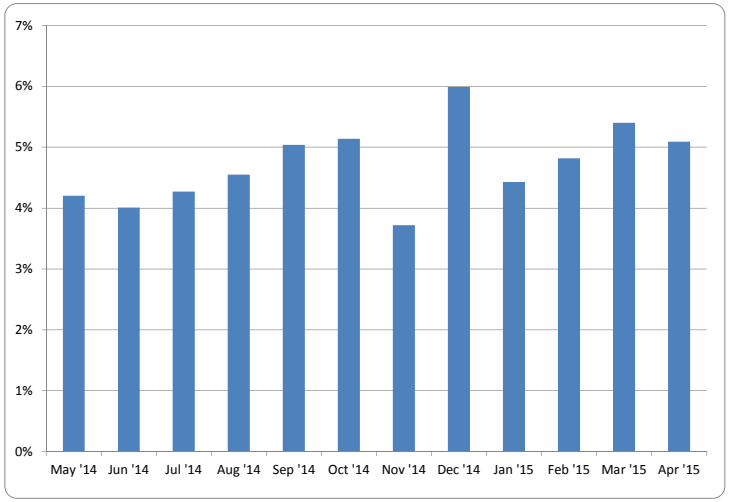
Care Group	Agency Spend % Apr-15	Staff In Post WTE
Inpatient Care Older People	39.73%	61.96
Therapies - Children	30.60%	81.55
Prison Service	24.03%	60.46
Outpatients	23.69%	247.72
Clinical Haematology	22.97%	98.01

Agency Costs by Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	11.20%	9.14%	8.36%	7.48%	↘
Community Services	12.11%	9.84%	16.22%	12.15%	↘
Corporate	4.13%	2.67%	3.37%	2.72%	↘
Estates and Facilities	19.23%	12.47%	25.36%	9.47%	↘
Medical & Cardiothoracics	10.68%	12.47%	9.74%	9.35%	↘
Surgery, Neurosciences & Anaes	5.03%	4.36%	6.24%	4.10%	↘
Whole Trust	**9.45%**	**8.32%**	**9.25%**	**7.30%**	↘

Booking Reason	Medical Agency & Bank £ Apr-15	%
Annual Leave AL	£0	0.00%
Increased Care Needs ICN	£25,813	10.08%
Maternity Leave ML	£0	0.00%
Sickness S	£10,117	3.95%
Study Leave SL	£0	0.00%
Vacancy V	£220,273	85.98%
Total	**£256,203**	**100.00%**

SECTION 9: BANK STAFF COSTS

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



COMMENTARY

Bank spend percentage has decreased by 0.3% between March and April

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

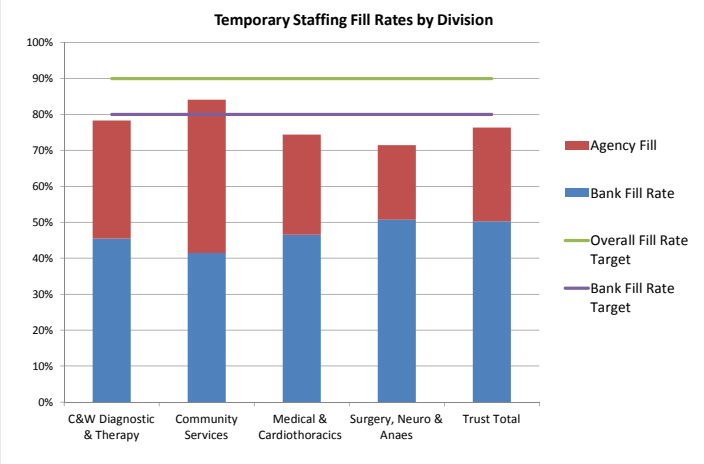
The Bank Fill rate in April 2015 was 50.24% this was an improvement of 6.0% on March 2015

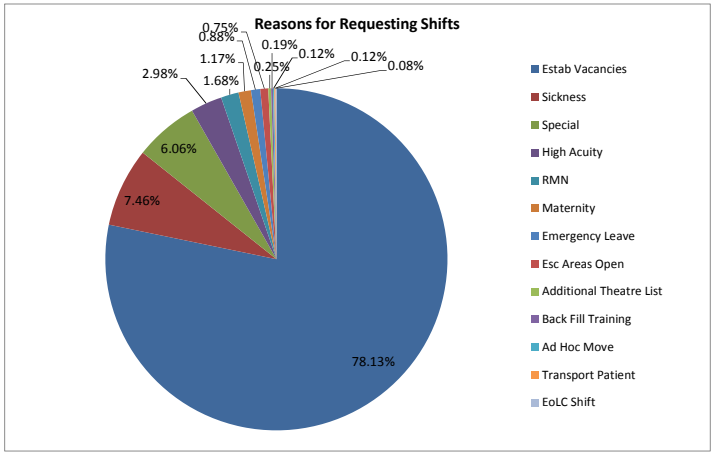
The table below lists the five care groups with the highest bank percentage spend for this month.

Care Group	Bank Spend % Apr-15	Staff In Post WTE
SWLP Central Reception	63.28%	44.65
Security & Car Park Management	25.98%	22.00
Portering	21.01%	78.65
Pharmacy	15.97%	165.47
Prison Service	15.46%	60.46

Bank Spend % by Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	3.85%	5.13%	5.96%	5.63%	↘
Community Services	3.88%	4.79%	4.87%	4.44%	↘
Corporate	3.19%	4.16%	1.47%	3.80%	↗
Estates and Facilities	9.73%	10.58%	9.86%	9.37%	↘
Medical & Cardiothoracics	4.39%	5.50%	6.89%	5.88%	↘
Surgery, Neurosciences & Anaes	3.00%	4.00%	4.67%	3.40%	↘
Whole Trust	**4.43%**	**4.82%**	**5.40%**	**5.09%**	↘

SECTION 10: TEMPORARY STAFFING FILL RATES





COMMENTARY

This is 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 April the Bank Fill Rate was reported at 50.24% which is 6% lower than the previous month. The Overall Fill Rate was 76.4% which is a decrease of 0.7% on the previous month. The Community Services Division is currently meeting the demand for temporary staff most effectively.

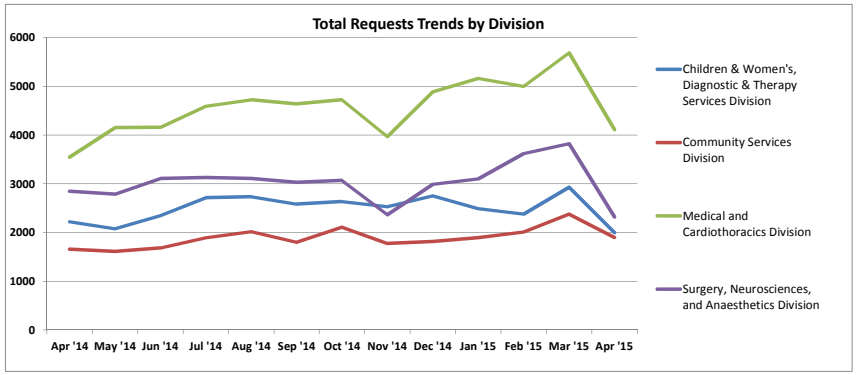
The pie chart shows a breakdown of the reasons given for requesting bank shifts in April. This is very much dominated by covering existing vacancies, specials, sickness, and high acuity patients.

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

Bank Fill Rate % by Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	33.89%	34.02%	34.54%	45.41%	↗
Community Services	47.14%	44.90%	41.01%	41.49%	↗
Medical & Cardiothoracics	37.16%	39.03%	37.96%	46.54%	↗
Surgery, Neurosciences & Anaes	44.79%	47.50%	48.50%	50.71%	↗
Whole Trust	**45.64%**	**45.15%**	**44.15%**	**50.24%**	↗

Overall Fill Rate % by Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	80.34%	81.54%	78.72%	78.35%	↘
Community Services	79.31%	83.57%	83.28%	84.08%	↗
Medical & Cardiothoracics	75.74%	74.45%	74.98%	74.37%	↘
Surgery, Neurosciences & Anaes	61.66%	70.47%	71.92%	71.43%	↘
Whole Trust	**78.20%**	**77.32%**	**77.10%**	**76.37%**	↘

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 worked by month by Division. The graph shows a large decrease in numbers in April as tighter controls on booking and runrate initiaves have been implemented.

Division	May '14	Jun '14	Jul '14	Aug '14	Sep '14	Oct '14	Nov '14	Dec '14	Jan '15	Feb '15	Mar '15	Apr '15
C&W Diagnostic & Therapy	2076	2349	2713	2735	2581	2636	2529	2752	2493	2378	2927	1995
Community Services	1609	1685	1893	2015	1800	2110	1774	1811	1890	2009	2380	1897
Medical and Cardiothoracics	4152	4160	4593	4723	4636	4721	3967	4885	5161	4999	5688	4113
Surgery, Neurosciences & Anaes	2788	3105	3125	3106	3028	3068	2363	2991	3101	3617	3825	2321
Estates & Facilities	130	156	168	165	165	707	303	651	727	711	842	996
Corporate	82	133	134	184	184	347	174	388	361	300	424	509
Total	**10837**	**11588**	**12626**	**12928**	**12394**	**13589**	**11110**	**13478**	**14054**	**14014**	**16086**	**11831**

SECTION 12: MANDATORY TRAINING

MAST Topic	Mar '15	Apr '15	Trend
Conflict Resolution	67.9	69.1	↗
Dementia Awareness	61.9	62.7	↗
Equality, Diversity and Human Rights	86.3	84.9	↘
Fire Safety	78.5	78.0	↘
Health, Safety and Welfare	86.5	85.1	↘
Infection Prevention and Control Clinical	59.5	60.8	↗
Infection Prevention and Control Non Clinical	80.7	79.5	↘
Information Governance	65.0	66.0	↗
Moving and Handling	85.1	83.6	↘
Moving and Handling Patient	58.5	58.7	↗
Resuscitation BLS	50.0	50.9	↗
Resuscitation ILS	51.4	50.7	↘
Resuscitation Non Clinical	59.2	59.9	↗
Safeguarding Adults	86.4	85.0	↘
Safeguarding Children Level 1	84.8	84.3	↘
Safeguarding Children Level 2	78.8	78.2	↘
Safeguarding Children Level 3	60.0	59.6	↘

MAST Compliance % by Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	73.1%	75.3%	75.9%	75.4%	↘
Community Services	76.1%	77.9%	77.8%	77.0%	↘
Corporate	76.0%	75.5%	75.7%	74.2%	↘
Estates and Facilities	72.3%	68.3%	66.8%	66.5%	↘
Medical & Cardiothoracics	67.0%	67.1%	67.1%	67.1%	↗
Surgery, Neurosciences & Anaes	69.4%	71.3%	71.3%	71.0%	↘
Whole Trust	**74.4%**	**74.7%**	**74.7%**	**74.2%**	↘

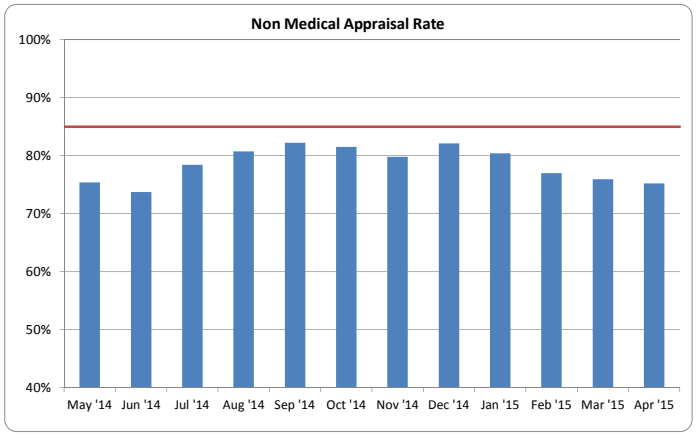
COMMENTARY

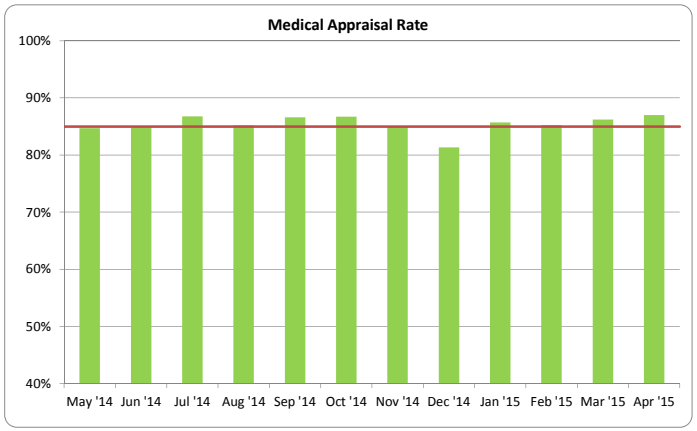
The overall Trust compliance for MAST is now at 74.2% which has decreased by 0.5% since March.

During the end of March and April, training was partially suspended due to the implementation of the Trust's new Learning Management System (LMS).

The new LMS 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.

SECTION 13: APPRAISAL





NON-MEDICAL COMMENTARY - The non-medical appraisal rate has decreased this month to 75.2%. Appraisals are still being managed closely by the appraisal project team who are monitoring progress every two weeks and scrutinising divisional plans. The Corporate Division currently has the lowest non-medical compliance rate. Appraisal completion is now linked to incremental progression for bands AFC band 7 - 9 staff. The table below lists the five care groups with the lowest non medical appraisal rate this month.

MEDICAL COMMENTARY - Medical appraisal rate compliance has increased this month to 87% which is above the 85% target.

Care Group	Non-Med Appraisal Rate	Staff In Post WTE
Pathology	25.0%	42.10
Computing Directorate	36.8%	40.67
Intermediate Care	38.2%	63.00
Community Nursing - Older People	50.0%	24.08
Neurosurgery	50.0%	103.94

Non Medical Appraisals by Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	84.0%	79.4%	75.5%	74.5%	↘
Community Services	82.1%	76.8%	77.3%	76.8%	↘
Medical & Cardiothoracics	78.1%	73.6%	76.0%	77.0%	↗
Surgery, Neurosciences & Anaes	81.4%	78.9%	79.6%	77.7%	↘
Corporate	73.8%	67.2%	64.9%	65.1%	↗
Estates & Facilities	78.1%	77.9%	78.3%	76.6%	↘
Whole Trust	**80.4%**	**77.0%**	**75.9%**	**75.2%**	↘

Medical Appraisals by Division	Jan '15	Feb '15	Mar '15	Apr '15	Trend
C&W Diagnostic & Therapy	85.6%	83.7%	88.3%	89.7%	↗
Community Services	80.0%	88.9%	83.3%	66.7%	↘
Medical & Cardiothoracics	81.5%	80.6%	83.8%	86.0%	↗
Surgery, Neurosciences & Anaes	89.0%	89.1%	86.1%	87.7%	↗
Corporate	100.0%	100.0%	100.0%	100.0%	↔
Whole Trust	**85.7%**	**85.2%**	**86.2%**	**87.0%**	↗

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD MAY 2015 **Paper Ref:**

Paper Title:	**Mutually Agreed Resignation Scheme (MARS)**
Sponsoring Director:	**Wendy Brewer**
Author:	**Jacqueline McCullough**
Purpose: *The purpose of bringing the report to the board*	*For consideration and authorisation of the MAR scheme*
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	**For decision**
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	**Executive Management Team** **Operational Management Team**

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

1. Key messages

It was agreed by the Workforce Efficiency Group that a Mutually Agreed Resignation Scheme (MARS) would form part of the Workforce Efficiency Programme for 2015-16. The scheme in 2012 realised full year effect savings of £922,000, and if similar savings are achieved this will contribute to workforce savings in 2016-17. The scheme contents are consistent with the national MAR scheme and were agreed by the Executive Management Team and the Operational Management Team prior to submission to HM Treasury via Monitor on 19th May 2015. Monitor has informed us that HM Treasury has decided to confer a delegated authority on all licensed NHS Foundation Trusts to implement local MAR schemes subject to these 5 conditions:

1) each scheme to be on the terms of the past national NHS MAR scheme (subject to 2 below); and
2) each individual payment not to be greater than £80,000 in respect of any individual; and
3) each scheme not to operate for more than 3 months in duration; and
4) each scheme to be appropriately considered and authorised by the Trust's Board; and
5) each scheme to be notified to Monitor, the sector regulator for healthcare, in advance.

Our scheme satisfies conditions 1, 2 and 3.

2. Recommendation

In order to satisfy condition 4, the Trust Board is asked to consider and authorise the scheme which will then be formally submitted to Monitor to satisfy condition 5. If delegated authority is granted we aim to run the scheme at the end of June for a period of 6 weeks.

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?* None identified.

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

Equality Impact Assessment (EIA): Has an EIA been carried out? Yes
If yes, please provide a summary of the key findings. The Trust has undertaken EIAs with all its formal workforce changes and undertakes to continue this practice with the local MARS scheme. The scheme will not be open to some staff groups or pay bands due to the fact that they are hard to recruit to posts but this will not affect staff from any particular protected characteristics.

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

St George's University Hospitals NHS
NHS Foundation Trust

Appendix A:

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

- Better heath outcomes for all
- Improved patient access and experience
- Empowered, engaged and well-supported staff
- Inclusive leadership at all levels

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
MARS	Trust-wide	Workforce Directorate	Existing Policy	20th May 2015

1.1 Who is responsible for this policy? Workforce

1.2 Describe the purpose of the policy? *Who is it intended to benefit? What are the intended outcomes?*
The scheme is intended to offer flexibility in the workforce in order to facilitate structural change and reduce workforce costs.

1.3 Are there any associated objectives? *E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives*
Workforce Efficiencies Programme as part of the Cost Improvement Programme

1.4 What factors contribute or detract from achieving intended outcomes?
The success of the scheme is dependent on sufficient number of suitable applicants applying to leave.

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

The policy will not have an effect on any particular protected group.

1.6 If yes, please describe current or planned activities to address the impact.

N/A

1.7 Is there any scope for new measures which would promote equality?
No

1.8 What are your monitoring arrangements for this policy?

All applications will be monitored against the protected characteristics.

1.9 Equality Impact Rating [low, medium, high]

Low

2.0. Please give your reasons for this rating

The scheme is dependent on applicants putting themselves forward. Approval of applications will be based on value for money.

St George's University Hospitals NHS
NHS Foundation Trust

TB May 15 – 04d

MUTUALLY AGREED RESIGNATION SCHEME (MARS)

2015

Version 1 19th May 2015

CONTENTS

Mutually Agreed Resignation Scheme (based on National Scheme)

1. Introduction

1.1 The Mutually Agreed Resignation Scheme (MARS) has been designed to support the flexibility needed to address periods of rapid change and service re-design. The scheme will form part of the Trust's Workforce Efficiency strategy for 2015-16 and contribute to the Cost Reduction Programme (CRP) by reducing the cost of the workforce.

1.2 The purpose is to create job vacancies which can be filled by redeployment of staff from other jobs or as a suitable alternative for those facing redundancy.

2. Definition

2.1 MARS is a time –limited scheme under which an individual employee, in agreement with their employer, chooses to leave employment in return for a severance payment. A Mutually Agreed Resignation (MAR) is not a redundancy[1] or a voluntary redundancy, which would currently be covered by Section 16 of the NHS terms and conditions of service handbook.

2.2 Posts vacated by MAR Scheme leavers should be advertised initially to at risk staff or otherwise to support redeployment.

2.3 If the post remains unfilled once an employee has left, there may be a risk that this shows that the business can function without the post and in effect the post is redundant. The scheme must not be used as a "disguised redundancy."

3. Business Case

3.1 Any application under MARS must demonstrate that the departure of an employee on voluntary terms would be in the financial and operational interests of the organisation.

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[1] *The definition of redundancy given by Section 139 of the Employment Rights Act 1996 states:*

"... an employee who is dismissed shall be taken to be dismissed by reason of redundancy if the dismissal is attributable wholly or mainly to:

- the fact that his employer has ceased, or intends to cease, to carry on the business for the purposes of which the employee was employed by him, or has ceased, or intends to cease, to carry on that business in the place where the employee was employed or
- the fact that the requirements of that business for employees to carry out work of a particular kind, or for employees to carry out work of a particular kind in the place where he was so employed, have ceased or diminished or are expected to cease or diminish"

3.2 The business case should be clear about the reasons for offering the MARS payment, lending clarity and providing evidence to support that this is not a "disguised redundancy". The business case should be clear about what is intended for any post vacated under the MARS and that it will be advertised initially to staff at risk.

3.3 The business case to leave under MARS will need to demonstrate:

- why the severance payment is in the public interest;
- why it represents value for money;
- how it represents the best use of public funds
- that it will not affect the organisation's financial targets.
- The estimated cost of the MARS payment
- The saving that will be realised and the timescale for these savings.

3.4 If a MAR is agreed, the department must keep the newly created vacancy open until someone at risk of redundancy is redeployed into the post or for as long as it takes for the cost of the MAR payment to be offset by savings in salary, whichever is the sooner. The department cannot use bank of agency to cover the role during this period.

3.5 The vacated post may be used to create flexibility for workforce redesign.

4. Eligibility

4.1 To be eligible staff must have a minimum service of 12 months continuous service (continuous service being defined as NHS service with no break of greater than a week).

4.2 The following groups would not normally be allowed to leave under this scheme:

- an employee who has already formally given notice of their intention to resign/retire, prior to the date when applications are formally being sought;
- an employee who has already secured employment with another employer;
- an employee who has been notified of the date of the termination of their contract of employment for any other reason;
- an employee undergoing a performance management procedure to address poor performance;
- an employee undergoing a conduct procedure;
- employees whose posts have been identified as likely to be redundant and are subject to consultation;
- employees currently in a selection pool identifying them for potential redundancy;

- employees in shortage or hard to recruit posts (we will need to provide an indicative list of these posts)

- employees in posts where delivery of service would be put at risk

4.3 Any MARS will be time-limited for the deadline for applications and the latest date for resignations to be effective.

4.4 Each application made in accordance with MARS will be considered on its own merits. The Trust reserves the right to determine whether or not an application will be approved and there will be no right of appeal on the part of those employees whose applications are not successful.

4.5 MARS is entirely voluntary from the Trust's and employee's perspective and there is no legal obligation on the part of the Trust to accept any individual application.

4.6 To mitigate against potential discrimination, e.g. fixed-term workers, the MARS should be offered to everyone in a particular staff group and then consider each application individually on its merits as set against the business criteria. (If there is an intention to renew a fixed-term contract then the employee would need to be made aware of this prior to submitting an application. If the post is not being renewed then redundancy or dismissal for some other reason may be the appropriate exit route).

4.7 Leaving dates must be mutually agreed as confirmation that the employee is leaving as a result of a resignation and not a redundancy situation. However, the scheme makes it clear that the resignations would normally be expected to take place within 2 weeks of the outcome being notified to the employee. The Trust and the employee will mutually agree a new leaving date (last day of service) which will not normally be more than 4 weeks after the employee has been notified that their application has been successful. Under the current scheme, the latest termination date is INSERT DATE

5. Re-employment

5.1 Employees who leave under MARS would not be re-employed at St. George's University Hospitals NHS Foundation Trust within 2 years of their termination date. The employee cannot be re-engaged to work at the Trust via an employment agency or through the Staff Bank during this 2-year period.

5.2 More generally, employees who leave under MARS would not be re-employed under normal circumstances by the NHS in England, in the same or a different post, before a period of one month has elapsed. If an individual does return to the NHS within one month they would be required to repay any MARS payment in full.

5.3 Where an employee returns to work for the NHS in England within six months and before the expiry date of the period for which they have been compensated (as

measured in equivalent months/part-months salary), then they would be required to repay any un-expired element of their compensation. This would be reduced to take account of any appointment to a lower grade post or reduced hours basis and reflect net salary. The compromise agreement specifies the requirement to repay monies in such circumstances.

5.4 As part of the compromise agreement employees will be required to give warranty that they had not secured another job in the NHS at the time of leaving.

6. Compromise Agreement

6.1 Employees who decide to proceed with a MAR will be issued with a compromise agreement to sign, which will set out the financial and other terms under which the employment relationship will end. A template compromise agreement is at Annex C for use.

6.2 Independent legal advice will need to be obtained by the employee before signing the Compromise Agreement. The local organisation will contribute up to a maximum of £400.00 inclusive of VAT towards the cost of this legal advice.

7. Payment Rate

MARS payments will be calculated using the model below[2].

7.1 For those earning less than £23,000 per year (full time equivalent), the MARS payment will be calculated using notional full-time annual earnings of £23,000, prorated for employees working less than full time.

7.2 For those earning over £80,000 per year (full time equivalent) the redundancy payment will be calculated using notional full-time annual earnings of £80,000, prorated for employees working less than full time.

7.3 No MARS payment will exceed £80,000 (pro-rata).

7.3 No provision will be made for payment of any notice period. Successful applicants will be expected to terminate their employment at an early date to be mutually agreed and within the time frame agreed when the MAR was approved (see 4.7 above) i.e. within 4 weeks of being notified of the outcome of their application. Notice not worked will not attract payment in lieu of notice.

[2] The rates quoted mirror those in the revised redundancy payments for NHS employees in that the maximum payment is £160,000. Under current rates of pay, the only staff to whom the ceiling might apply would be employed at band 8d and above.

Reckonable Service (Complete Years)	**Scale of Payment (Basic Salary Plus High Cost Area Supplement (HCAS) /London Weighting Only).** ***N.B. a month's basic salary is subject to the minimum and maximum amounts and calculations set out at 7.1 – 7.3 above***
1 year's continuous service (organisation/NHS)	3 months' basic salary + HCAS
2 years' continuous service (organisation/NHS)	3 months' basic salary + HCAS
3 years' continuous service (organisation/NHS)	3 months' basic salary + HCAS
4 years' continuous service (organisation/NHS)	3 months' basic salary + HCAS
5 years' continuous service (organisation/NHS)	3 months' basic salary + HCAS
6 years' continuous service (organisation/NHS)	3 months' basic salary + HCAS
7 years' continuous service (organisation/NHS)	3 ½ months' basic salary + HCAS
8 years' continuous service (organisation/NHS)	4 months' basic salary + HCAS
9 years' continuous service (organisation/NHS)	4 ½ months' basic salary + HCAS
10 years' continuous service (organisation/NHS)	5 months' basic salary + HCAS
11 years' continuous service (organisation/NHS)	5 ½ months' basic salary + HCAS
12 years' continuous service (organisation/NHS)	6 months' basic salary + HCAS
13 years' continuous service (organisation/NHS)	6 ½ months' basic salary + HCAS
14 years' continuous service (organisation/NHS)	7 months' basic salary + HCAS
15 years' continuous service (organisation/NHS)	7 ½ months' basic salary + HCAS
16 years' continuous service (organisation/NHS)	8 months' basic salary + HCAS
17 years' continuous service (organisation/NHS)	8 ½ months' basic salary + HCAS
18 years' continuous service (organisation/NHS)	9 months' basic salary + HCAS
19 years' continuous service (organisation/NHS)	9 ½ months' basic salary + HCAS
20 years' continuous service (organisation/NHS)	10 months' basic salary + HCAS
21 years' continuous service (organisation/NHS)	10 ½ months' basic salary + HCAS
22 years' continuous service (organisation/NHS)	11 months' basic salary + HCAS
23 years' continuous service (organisation/NHS)	11 ½ months' basic salary + HCAS
24 years' + continuous service (organisation/NHS)	12 months' basic salary + HCAS

Note: continuous service is defined as service with no break of greater than a week.

7.3 In some cases, severance payments are not subject to deductions in accordance with the Income and Corporation Taxes Act 1998, but the individual circumstances of each case will need to be considered. As a guide, however, current legislation can allow for voluntary severance payments to be paid without deduction of tax and national insurance up to a maximum of £30,000. Any payment made above this amount will be subject to tax and national insurance.

8. Reckonable Service

8.1 Reckonable service means continuous full-time or part-time employment with present or any previous NHS employer where there has been a break of service of 12 months or less, as at the time of leaving. Employment that has been taken into account for the purposes of a previous redundancy or loss of office payment by an NHS employer, will not count as reckonable service.

8.2 Any severance payment made will be offset against any subsequent payment made for the purposes of any future calculation of redundancy payments in subsequent employment. This would apply where the period of employment covered by the severance payment is taken into account in calculating the redundancy payment. For example, an individual leaves under the national MARS and receives a four month payment (eight years' reckonable service). If they were subsequently made redundant and this eight year period was used for the redundancy calculation, they would get their redundancy payment less any MARS payment.

8.3 The severance payment would be subject to the employee having not secured another job in the NHS at the time of leaving.

8.4 An employee accepting a MARS severance payment and resigning from the organisation may find alternative employment elsewhere in the NHS subject to the conditions set out in section 5 above. In the event that any future NHS employer intends to make the employee redundant, the employer will be notified of this provision of MARS.

8.5 The employee's proposed leaving date will be subject to negotiation and mutual agreement between the employer and employee but will normally be within 4 weeks of the date they were notified their application was successful.

9. Pensions

9.1 Staff whose application under MARS is accepted, and who have reached their 'normal pensionable retirement age', will also be eligible to claim their NHS pension benefits. This will not involve the organisation in incurring additional costs related to the payment of pension benefits. For members of the 1995 Section of the NHS Pension Scheme, normal pension age is 60 (55 for members of the 'special classes'). For members of the 2008 Section of the NHS Pension Scheme, normal pension age is 65.

9.2 Staff whose application under MARS is accepted and who have reached their minimum pension age, may also wish to apply for Voluntary Early Retirement with reduced pension benefits. For members of the 1995 Section of the NHS Pension Scheme, minimum pension age is 50 for most but 55 for some members who first joined or returned on or after 6 April 2006. For members of the 2008 Section of the NHS Pension Scheme, minimum pension age is 55.

9.3 Please note that no guarantee can be given about the timing of the payment of such benefits in line with any MARS payments and applications for pension benefits will need to be made in the normal manner by submission of a leaver form.

9.4 Further information about the NHS Pension Scheme is available at www.nhsbsa.nhs.uk/pensions

10. Application Procedure

10.1 The procedure will involve the following stages:

- an expression of interest made by an employee on application form (Annex B), after considering the full details (including the content of the compromise agreement).
- applications will be reviewed by the Divisional Director of Operations/Corporate Director and submitted to a panel comprising the Director of HR and OD, and the Chief Nurse and Director of Finance. The decision of the panel will be subject to final approval by the Nominations and Remunerations Committee.

10.2 if the application is to go ahead, the date of exit will be mutually agreed, i.e. not imposed by the employer but should not normally be later than four weeks after the date the employee was notified their application was successful.

10.3 For full details on the applications procedures please refer to Annex A

11. Equality Statement

11.1 The Trust will ensure that no employee should receive less favourable treatment on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation, or on the grounds of trade union membership.

11.2 Appropriate equality monitoring will be undertaken in line with the Equality & Diversity in Employment policy.

11.3 An equality impact assessment is attached.

12. Support for Staff

12.1 When considering applying for voluntary severance under MARS, employees will need to understand the consequences of their decision. A MAR is viewed as being a voluntary resignation on the part of the individual employee, in return for a severance payment. As there may be significant financial and life-style implications for the employee, employers should support the decision-making process by assisting individuals with understanding these implications.

12.2 Some of the implications for employees to consider when resigning would include, for example:

- the possible loss of entitlements to welfare benefits
- mortgage protection insurance policies not covering resignations
- any possible impact on pensions
- lease car penalties
- multi-post contracts

12.3 Some of the supportive measures to consider might be:

Signposting staff to the following sources of information:

- NHS Pensions: www.nhsbsa.nhs.uk/pensions
- Benefits website: www.direct.gov.uk/en/MoneyTaxAndBenefits/index.htm
- Citizens Advice Bureaux: http://www.adviceguide.org.uk/

12.4 Employers are not legally authorised under the Financial Services Act to give pensions or other financial advice to individuals. Therefore, employees should be encouraged to seek further independent financial advice. The following websites may be of assistance.

- IFA Promotion: www.unbiased.co.uk
- The Personal Finance Society: www.thepfs.org
- Money made clear www.moneymadeclear.fsa.gov.uk

13. Further Information

13.1 Further information is available on the NHS Employers website and FAQs can be found at http://www.nhsemployers.org/PayAndContracts/Mutually-Agreed-Resignation-Scheme/Pages/FAQs-Mutually-Agreed-Resignation-Scheme.aspx

ANNEX A

MARS APPLICATION PROCEDURE (See Annex B for Application Form and E for timetable)

1. Employees who wish to apply for MARS should discuss their case with their line manager in the first instance. Informal discussions will be confidential and not make a binding commitment on either party. Please note the line manager will be asked to indicate their support or otherwise for the application by completing the attached form (see Annex B), outlining the potential financial savings and payback time along with reassurance as to how the business needs of the organisation will continue to be met.

2. The scheme will be open from XXXXX until XXXXX. Members of staff should submit their application for MARS by XXXXX using the application form in Annex B. This must be submitted to your line manager in the first instance who will submit this to the Divisional Director of Operations for the relevant Division or Corporate Director who in turn will indicate whether or not they support the application.

3. Once an application is submitted, it will be dealt with in strict confidence by all those involved with the process.

4. Applications received by the Divisions or Directorates will be submitted to a MARS Panel comprising the Joint Director of Workforce, Chief Nurse and Director of Finance.

5. The Joint Director of Workforce will arrange for their application to be acknowledged within *5 days* of receipt, the information submitted will then be verified.

6. The Nominations and Remunerations Committee will give final approval.

7. Details of applications the panel wishes to support should be sent to Monitor for review on the template at Annex D. Approval from Monitor is not required.

8. Successful applicants will be advised via their Divisional Director of Operations/Corporate Director that their application has been approved. They will receive a letter from the Joint Director of Workforce, confirming the MARS payment, a mutually agreed leaving date and requesting acceptance or rejection of the offer within a prescribed timescale.

9. Where the individual intends to accept the offer they will then be issued with a compromise agreement to discuss with a legal adviser. Once the signed compromise agreement is received by HR this will indicate the final acceptance of the offer.

10. Where the application is not approved, the Joint Director of Workforce will write to the member of staff advising that their application has not been successful.

11. Details of those who are approved and who accept MARS should be provided to Monitor using the template at Annex D to enable this to be forwarded to DH to enable any leavers/returners to be tracked.

TB May 15 – 04d

Business Case for Implementation of Local MARS scheme

1. Introduction/Rationale for local MARS Scheme

St. George's will be undertaking a programme of service re-design and efficiency reviews in 2015-16 which will result in workforce changes. In previous years we have removed vacancies where possible but we now need to use the MAR scheme as a means of introducing further flexibility that will allow us to effect the changes needed in departments across the Trust.

We previously ran a MARS in 2012.

2. Estimated cost savings from running the scheme

Based on the experience 2012 we might expect to approve 32 applications with an average payment of £31,000. Using a band 5 as an average (mid-point gross costs of £36K) we would estimate the potential savings to be in the region of 50% of the FYE whole salary costs for these posts to allow offsetting for the cost of the average severance payment. It is difficult to predict exactly how many posts vacated can be offered as SAE but we will use as many posts as necessary to avoid redundancy costs.

The savings from the scheme were mostly realised in the year following the scheme and these are recorded as £922,000.

3. Timescales

It is proposed that the scheme is run between {XXXX and XXXX 2015}. The final date for termination is likely to be XXXX.

4. Equality Impact Assessments (EIA)

The Trust has undertaken EIAs with all its formal workforce changes and undertakes to continue this practice with the local MARS scheme.

5. Copy of the scheme

The scheme has previously been submitted to NHSL and it was agreed as b being acceptable.

6. Role vacated by MARS Leavers

As stated above, roles vacated by staff leaving via MARS will be made available to staff at risk of redundancy where appropriate.

7. Any further Information

None.

Meeting of Workforce & Education Committee 21.5.2015: Chair's Report

Workforce Planning

Wendy Brewer tabled the workforce plan that was submitted to Monitor. It showed an analysis of pay costs and WTEs as at March 2015 and then quarterly to the end of 15/16.

It was explained that this was a high level plan put together by Finance colleagues. It was also explained that the Workforce Planning Group was to meet the following day to agree a process of making the plan granular. It was made clear that if we are to understand pay overspends, what agency is being spent on, what to recruit to, where junior doctor gaps are opening up, etc a detailed workforce plan is required.

The Committee endorsed Wendy's proposed approach and asked to be updated on progress in arriving at such a granular plan and agreeing it with Finance. Unease was expressed that the out-turn for last year was still not entirely clear and that we are in month 2 of 15/16 with divisions still not having workforce budgets. However, it was understood that the situation was symptomatic of the broader challenges facing the trust.

Nursing Recruitment/Retention Programme

Jennie Hall updated the meeting on the progress of this programme. She summarised the areas where progress had been made and where there are still big challenges. She also acknowledged that going forward, and given the financial situation, the programme will focus resources on a smaller number of work streams (recruitment, retention, revalidation, etc). It was agreed that whilst the qualitative information provided to the Committee was helpful, for future meetings it would be clearer if a more programmatic presentation was provided which showed, by work stream, where progress was being made and what it was likely to deliver.

Plans to Reduce Turnover

The Committee received a paper showing a comprehensive analysis of leavers derived from exit questionnaire data for the year 2014/15. The data was from a total of 338 leavers (45% of all leavers in the year). The key inferences from the survey were:

- 53.6% of those who responded were 'unhappy' leavers and 42% were 'happy' leavers.
- The key reasons for leaving given by the 'unhappy' group were low morale, poor communication, not feeing valued by the trust, management not acting in the interest of staff.
- The key reasons for leaving given by those in the 'happy' group included poor work-life balance, lack of promotion opportunities, inadequate pay, unclear how to progress.

A positive finding was that very small percentages of either group left because of clinical or ethical concerns. This is consistent with responses in the staff survey in which staff are reporting that they would recommend the trust as a good place for them and their family to be treated.

The Committee made the following observations and recommendations:

- Improving retention has to be a top workforce priority and it looks from the figures above that it is within the trust's gift (and nobody else's) to stem the flow of 'unhappy' leavers.
- The HR Strategy and plan for 15/16 address this need by stepping up investment in improving line management capabilities and cultivating a healthier organisational climate.

- Whilst the trust-wide offering is appropriate and can be drawn down, it is urgent that each division looks at its own slice of the data, draws its own conclusions about why their staff are electing to leave and comes up with an action plan that is geared to their specific circumstances.
- The analysis and plan should, in turn, underpin a divisional trajectory which demonstrates how they are proposing to bring down turnover and by how much over the next 12 months.
- The Workforce Committee will be reviewing these plans in its next few meetings but most critically, these need to be owned and monitored by divisional management.

Bank and Agency Costs

The Committee received a paper (also received by the Board in its April meeting) which showed bank and agency usage and cost over the last year. The paper recommended a number of actions that are likely to support a switch to bank from agency. These included:

- Looking again at the competitiveness of our bank rates, given more recent intelligence about the rates offered by neigbouring trusts (e.g. Kingston).
- Automatically enrolling new starters on the bank and facilitating staff staying on the bank even after they'd left the trust.
- Working collaboratively with other trusts in SW London to agree, if possible, not to use one another's substantive staff through agency.

The Committee welcomed all recommendations and thought they could make a difference over time. However, the Committee judged that it is unlikely in the short term for our bank temporary fill rate to jump from 44% in 2014/15 to a target of 80%. Equally the Committee judged it impossible that the target rate of 3.5% for agency spend would materialise in 15/16. Indeed, the submission to Monitor assumes a **planned** agency rate of upwards of 8%. It was therefore recommended that the executive adapt both targets for 15/16 to what is achievable and realistic.

Workforce efficiency- recruitment efficiencies

The Committee received a paper which summarised the operational improvements to the recruitment process over the last year that led to a reduction in the 'average' time to recruit by 10 days. The paper also provided evidence of positive feedback offered by candidates on their experience of going through the revised process (with a lot of online elements).

The Committee welcomed the candidate experience feedback. However it requested that the recruitment team looks again at the statistical analysis of 'time to recruit' and also seeks further feedback from operational managers whose perception remains that the recruitment process is still very slow. Following that additional analysis and feedback it was suggested that the paper be brought back to the Committee.

Workforce Efficiency Programme

Several papers were tabled setting out the efficiency projects that were led by the efficiency group in 14/15 and the proposals made (to the CIP board) about the projects to be carried forward in 15/16 and 16/17.

The proposed list include projects such as:

- Revisiting the review of medical secretary/clinical support workforce

- Expansion of the trust salary sacrifice scheme
- 42 weeks productivity for medical staffing
- Various pan-London initiatives to collaborate on waiting list payments, possible changes to T&Cs, etc.

The Committee welcomed the work planned by the efficiency group which was largely of an enabling nature. It was however observed, that a number of other programmes (CIPs, Service Level Review, Big ideas) will be initiating projects which will have workforce implications. The Committee was concerned that within the existing governance arrangements there was no apparent mechanism for planning, monitoring or aggregating the **'workforce slice'** across all of these change initiatives. There were therefore risks of duplication, gaps and loss of control over workforce numbers and pay costs. Wendy also raised an additional concern that projects with a high workforce content may also require input from the HR team on consultation and other ER issues.

In the light of the 14/15 experience on pay costs, the Committee would like to see an over-arching governance for all efficiency/change programmes with a high workforce content.

Education Board Minutes

The Committee asked that a paper on medical workforce (numbers and training) be brought to the Committee in the near future as there has not been a substantive update for some time.

AOB

Wendy shared with the Committee that the Trust has now become Lead Employer for GP Junior doctors. The WTE and all other implications are being worked through.

SP 21.5.15

Name and date of meeting:

TRUST BOARD

Document Title:

Trust Annual 2015/16

Action for the Trust Board:

To note the Annual Plan for 2015/16 as submitted on 15th May

Summary:

The Trust is required, as part of its FT licence, to produce an Annual Plan each year, the attached plan was submitted to Monitor on 15th May (the 14th May deadline was extended for a further day).

The Annual Plan represents that approved by the board in April, subject to amendments to the corporate objectives proposed by the board, council of governors and patient reference group; and final updates to the narrative to ensure coherence with the annual report.

The corporate objectives are qualified within the document as follows: "The priorities represent the trust's plan for 2015/16 at the time of writing this document; the outcome of the strategic and service line reviews, and the outputs of the work around financial viability, may result in the trust reconsidering its priorities during the year."

The financial plan was extensively reviewed by the Finance & Performance Committee on 13th May, who approved its submission with the following caveat: "This plan reflects the outputs of the planning process at the time of writing this document, and remains subject to change with respect to on-going work.", i.e. following the outcome of the Monitor investigation

The Annual Plan includes the self-certifications on the final page, the board is asked to note that:

- Declaration of Sustainability - the board **DOES NOT** declare that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years
- Continuity of services condition 7 (Availability of Resources) - the board draws the regulator's attention to the following: "Financial sustainability. The Board has reviewed the proposed 15/16 plan in detail throughout its development from Oc14 to date. The plan is for a deficit of £46m having taken due account of the realistic underlying financial position going into 15/16, the risks and cost pressures faced in 15/16 and the level of cost reduction the organisation can be stretched to deliver. The Trust has an existing working capital facility of £25m but this will not be sufficient to meet the cash requirements of the deficit revenue position and the capital plan which has been reduced to the minimum possible requirement. The Trust therefore requires additional cash support to maintain normal operating and quality existing standards. The Board has a reasonable expectation that this will be agreed with DH with the support of the regulator".

  The board therefore declared "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box in section 4, below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services."
- Interim support requirements – the board has confirmed that DH support will be required.

The board is therefore asked to note:

- The status of the Annual Plan as a public statement of our priorities for the year and financial outlook as at 15th May, but that this position will change as our assumptions are further refined and as the on-going investigative and review work concludes.
- The formal declaration, via the Annual Plan submission, of our support requirements and "distressed" status.

Author and Date:	Rob Elek, Director of Strategy	23rd April 2015
Contact details:	Tel: x3883	E-mail: rob.elek@stgeorges.nhs.uk

St George's University Hospitals NHS
NHS Foundation Trust

TB May 15 – 06b

OPERATIONAL PLAN 2015-16

This plan reflects the outputs of the planning process at the time of writing this document, and remains subject to change with respect to on-going work.

Excellence in specialist and community healthcare

Contents

1. Introduction

St George's University Hospitals NHS Foundation Trust (the trust / St George's) is the largest healthcare provider in southwest London, with over 8,000 dedicated staff caring for patients around the clock. St George's is one of the oldest healthcare organisations in London, founded in 1733 at what is now the Lanesborough Hotel at Hyde Park Corner, before completing our move to Tooting in 1980.

The trust provides a full range of acute and community based services for the 560,000 population of Wandsworth, Merton and parts of Lambeth; and is the specialist regional centre for the 2.6 million people of southwest London and Surrey. St George's also provides a range of supra-regional services such as cardiothoracic medicine and surgery, neurosciences and renal transplantation for significant populations from southwest London, Surrey and Sussex, totalling 3.5 million people.

In the delivery of its role as the specialist tertiary centre for south west London, the trust is one of four major trauma centres, and one of only two in London currently with a Helipad, and one of eight hyper-acute stroke units serving London.

Our main site, St George's Hospital in Tooting – one of the country's principal teaching hospitals – is shared with St George's, University of London (SGUL), which trains medical students and carries out advanced medical research. St George's also hosts the St George's, University of London and Kingston University Faculty of Health and Social Care Sciences, which is responsible for training a wide range of healthcare professionals from across the region.

Following an exhaustive process of review and challenge by the NTDA and Monitor, St George's was authorised as a foundation trust on 1st February 2015, the culmination of many years of sustained improvement in the organisations performance across the widest range of indicators.

2. Sustainability

2.1 Strategy

The trust developed its strategy in 2012 and reviewed it in 2013/14. The trust's Integrated Business Plan (IBP), developed to support the foundation trust application in June 2014, reaffirmed and articulated the organisation's strategy over the following 5 years.

The 10-year strategy defined St. George's mission, vision and values:

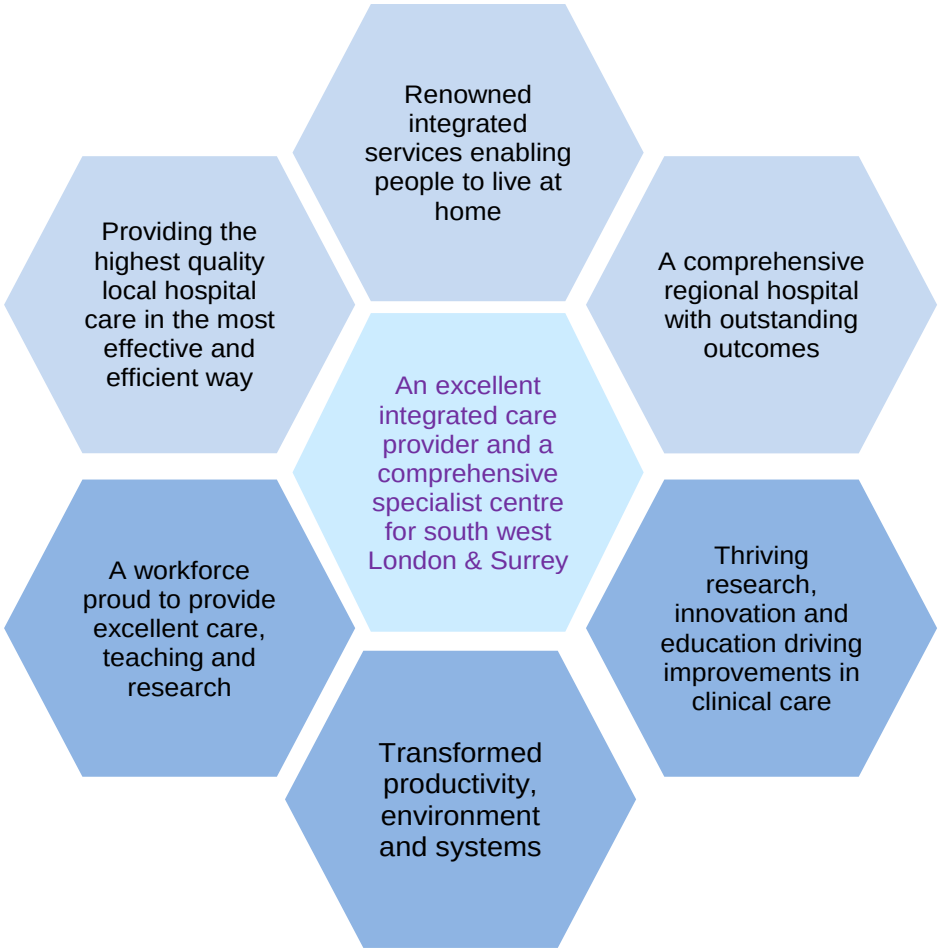
- **Our mission** – the primary purpose of the organisation, is *"To provide excellent clinical care, education and research to improve the health of the populations we serve."*
- **Our vision** – what we want to be, is *"An excellent integrated care provider and a comprehensive specialist centre for southwest London, Surrey and beyond with thriving programmes of education and research*."

Our values – guiding the way in which we work and the behaviours we would expect to see are:

excellent /
kind /
responsible /
respectful /

Alongside the values the trust the other guiding principle the Trust looked to when developing its strategy is that of quality, and delivering quality. Patients and service users are at the heart of everything we do. The trust uses the national definition of quality, which is divided into the following three domains: Patient safety; Patient experience and Patient outcomes (clinical effectiveness).

The seven strategic goals that will deliver the Trust vision are depicted below



Renowned integrated services enabling people to live at home.
We will work with primary care, social care and the third sector to deliver integrated services for those with long-term conditions, older people and children, redesigning care pathways to keep more people out of hospital; by 2022 we will:

- Be amongst the best for the quality of our community services
- Deliver the majority of care for long term conditions at or near home, keeping hospital stays to a minimum
- Have joined up hospital, community and social care services with people's needs at the centre.

Providing the highest quality local hospital care, in the most effective and efficient way
We will do this by delivery outstanding hospital care for the local population, with as much of the pathway as possible based out of the hospital; and by 2022 we will:

- Be amongst the best for the quality (patient experience, outcomes and safety) of our local hospital care.

- Enhanced services and facilities for children and women
- Be providing more ambulatory care in a community or home setting
- Have played a clinical leadership and partnership role in developing improved, high quality and sustainable local hospital services in southwest London.

Developing a comprehensive regional hospital with outstanding outcomes
We are and will be the hospital in London with the widest range of specialist services on one site, uniquely enabling us to look after patients with complex clinical needs; and by 2022 we will:

- Be amongst the best fir the quality (patient experience, outcomes and safety) of our specialist care.
- Have a dedicated Children's and Women's Hospital providing integrated and seamless services.
- Have developed clinical academic groups for our expanded cardiovascular and neuroscience services to deliver world class care and research.
- Be a renowned centre for specialist surgery, and develop and further improve cancer services.

To support the delivery of the above three strategic objectives, our strategy will also see us develop:

- Thriving research, innovation and education driving improvements in clinical care.
- A workforce proud to provide excellent care, teaching and research.
- Transformed productivity, environment, and systems.

2.2 Engagement

We already have in place governance arrangements for patient and public involvement, including a patient reference group, lay members attending key committees and regular reporting from divisions regarding service improvement initiatives involving patients. We also have a lay member as a patient ambassador within our service improvement programme.

However we recognise that we can always improve the existing framework and we also recognise the fact that we now have a new model of governance as a foundation trust, including governors and members. We are therefore undertaking a project to assess our current arrangements with a view to developing a new strategy for patient and public involvement and will involve governors and the patient representatives in this process.

A key focus for the next year will be developing the Council of Governors and ensuring that they are able to represent the views of members and engage with the Board in a meaningful way. We will also be continuing to implement our membership strategy, to ensure our members are engaged with the trust and a vibrant membership is maintained

2.3 The External Environment

The external environment has changed significantly over the last 12 months, with new strategic and quality guidance (*Five Year Forward View, Dalton Review*, *Freedom to Speak Up* report), and increased financial and operational pressure on the healthcare sector.

On 25th March NHS England (London) and the London CCGs set out plans for their vision to drive the *Five Year Forward View* (FYFV) and London Health Commission improvements in healthcare. As these plans move forward to the implementation phase, St. George's would wish to be integrally involved with this as an integrated provider of

both acute and community services, and would expect to ensure that the plans are encompassed in the operational priorities for 2015-16. Areas of particular relevance are the plans for:

- Preventing ill health and making Londoners healthier
  - Promoting health in children under 5 including uptake of immunisations
  - Developing new and stronger local partnerships to promote health, including with the health workforce and Health and Wellbeing Boards (which links to the implementation of the Wandsworth Health and Wellbeing Strategy)
- Giving London's children the best start in life
  - Develop effective interface between primary and acute care providers
  - Ensuring that agreed pan-London standards are met
- All Londoners to be able to access the best cancer care in the world
  - Improve screening uptake with targeted populations
  - Develop local strategies to deliver chemotherapy closer to home
  - Ensure delivery of cancer waiting times targets
- Transforming London's urgent care and emergency system
  - Ensure that the London quality Standards are met
  - Participate as a leader in the UEC networks to be established
- Creating world class specialised care services
  - Work with commissioners to review and agree pathway changes as appropriate
- Developing London's workforce to enable transformation of care
  - Work with commissioners to identify and support workforce productivity initiatives
  - Ensure workforce capacity plans are relevant and appropriate

The publication by Monitor and NHS England of the proposed tariffs for 2015-16 represents a significant risk to St. George's, particularly in relation to the proposals for payment of over-performance of specialised commissioning services; growth of these is a key part of the existing organisational strategy. St. George's has opted for the default tariff rollover option and the financial planning for 2015-16 is therefore based on this.

The key priorities that the Wandsworth Systems Resilience Group will oversee in 2015-16 include:

- Delivering sustainable performance in relation to the 95% A&E access standard
- The FYFV objective to provide enhance health care services into care homes, including further development of the Trust's frailty model of care
- Ensuring that demand and capacity are aligned across the local health economy

These priorities are reflected in the corporate objectives of the organisation.

2.4 Future Strategic Direction

The Trust Board has considered the current organisational strategy in light of the changes to the external environment and the financial and operational pressures that the organisation is facing. The Board has taken the view that, whilst the core aims and principles of the strategy remain appropriate, it will be refreshed in 2015/16 to ensure that the changes to the external and internal environments (in particular the tariff generally and the payment regime for specialised services, and the trust's financial position) have been fully considered in determining how the strategy is articulated and implemented.

A key part of this refresh will include consideration of how the 5 Year Forward View (5YFV) and the Dalton Review recommendations should be implemented by St. George's, and the strategic and leadership capability that will be needed for this (which links to the workforce priorities in 2015-16 to develop senior leadership capability).

St. George's is already participating in a buddying scheme with the Shrewsbury and Telford Hospital in relation to cancer patients' experience of care. This represents a significant quality improvement for St. George's, as only two years ago the organisation featured as one of the ten lowest performing organisations against the national cancer patient survey itself, and it is now one of the most improved organisations. Once details of the "kitemark" credentialing process proposed in the Dalton Review are finalised, St. George's would intend to put itself forward to obtain this.

3 2014/15 Performance

3.1 The *Five Year Forward View*

The publication of the FYFV in December 2014 provided a framework for St. George's to build on in relation to the existing strategic objectives of the organisation, particularly in relation to the objective to redesign care pathways to keep more people out of hospital.

Co-Creating New Models of Care

During 2014-15 St. George's has worked closely with Wandsworth CCG to review the frailty pathway, resulting in the redesign of the clinical pathway for community adult health services. Phase 2 of this work will be implemented during 2015-16, and although Wandsworth CCG was not successful in its vanguard site application in relation to providing enhanced health care services into care homes, this will be a key part of the redesign work.

St. George's is also working closely with Merton CCG and Merton Local Authority in relation to their integration fund, with a new initiative to be implemented in quarter 1 of 2015-16, which will be to provide specialist Senior Health consultant time into the community. This also links to the providing enhanced health care services into care homes initiative.

The South West London Collaborative Commissioning (SWLCC) Programme

SWL was a challenged local health economy (LHE), but following the development of a viable 5 year strategic plan in October this designation was removed. The "Making Local Health Economies Work Better for Patients" guidance produced in December 2014 reflects the key challenges that the SWL LHE faces, e.g. the need to secure clinical and financial sustainability; the need to ensure the right capability and capacity is in place to manage complex changes; and the need for strong clinical leadership.

The SWLCC is a system-wide programme led by commissioners, but with NHS provider organisations and local authorities also represented and integrally involved. The work of the SWLCC Programme links to the FYFV new approaches to smaller viable hospitals model of care, and a key milestone for this is May 2015, when the acute providers are due to present a proposal for consideration by the SWLCC Board regarding more innovative delivery of acute healthcare across SWL.

Engaging Communities

A key strand of the Workforce and Organisation Development Strategy implementation plan for 2015-16 links to staff as members of the community. As part of the strategic objective to *embed the Trust's values, ensuring that members of staff are recognised for their achievement and contribution based on the Trust's values, are able to achieve their maximum potential and wellbeing and that poor behaviours or performance is tackled*, are priorities to ensure that:

- St. George's meets the Race Equality standard by: establishing a St. George's As One steering group; holding a big conversation event as part of the Listening into Action programme; and commissioning further unconscious bias workshops for line managers
- A programme to support staff wellbeing is developed: this includes implementing the requirements of the DH Responsibility Partnership status; developing personal resilience support; and evaluating a case to employ a physiotherapist as part of the Occupational Health team.

Accelerating Useful Innovation

St. George's has been designated as a Genomics Medicine Centre in partnership with King's Health Partners. The organisation has delivered a SWL Pathology Service during 2014-15 in partnership with acute provider partners. These two developments place St. George's in a prime position to be involved in working with commissioners on further transformation of these services during 2015-16.

3.2 Corporate priorities 2014/15

The Annual Plan detailed the key objectives that the Trust set out to deliver during 2014/15.

2014/15 was an extremely busy and productive year, our performance across the majority of the priority areas has generally been good, with significant achievements being made across a broad and ambitious range of targets, as shown in the table on the following page. This shows that against the 9 major themes, linked to the strategic objectives of the trust, the trust has rated itself as green on 6 of them, and amber on 3.

Overall this shows positive delivery by the trust against a wide range of complex and challenging actions over the course of the year. We achieved Foundation Trust status and have made good progress towards our strategic goals; however, we have not delivered what we set out to achieve in all areas. This is in part due to the range of actions we set ourselves, as well as in-year pressures and reprioritisation that by their nature would impact on delivery. There are also some objectives and actions where we simply have not made sufficient progress despite our best efforts. The key areas where we have not performed as well as we would have like include:

- Aligning capacity to clinical need (bed and theatre capacity); though this was within the context of a significant ageing of the patient profile with more complex needs and a longer length of stay.
- The delivery of business cases (both in approval and implementation terms) has been slower than anticipated, partly due to complexity and volume, though we are now in the process of revising our prioritisation processes.

The summary annual plan dashboard is presented on the following page.

End of year summary of progress against corporate objectives

Theme	Commentary	End of year rating
0. Overall Progress	28 objectives – fourteen green, thirteen amber and one red rated at the end of the year. Our achievements far exceed those areas where progress has been slower than anticipated and overall progress is therefore assessed at green.	✓
1. Aligning capacity to clinical need	2 objectives – one amber and one red rated at the end of year. Significantly enhanced understanding of capacity and demand obtained during 14/15, enabling better planning in 15/16, where the objective remains a priority.	?
2. Securing income and achieving FT	2 objectives – both green rated at the end of year. FT authorisation was achieved on 2nd February. Tertiary services income growth has been achieved, though we have overspent in delivery.	✓
3. SG1: Redesign care pathways to keep more people out of hospital	3 objectives – two green and one amber rated at the end of year. Phase 1 of the frailty model was delivered, the CAHS service redesign was reprioritised at CCG request, and we have supported local commissioners in developing and implementing their Better care Fund plans.	✓
4. SG2: Redesign and reconfigure our local hospital services	4 objectives – one green and three amber rated at the end of year. Planning for the children's and women's hospital is proceeding, albeit to a revised programme; the surgical assessment unit decant has started, though we await CCG sign-off; we are due to transfer neuro-rehabilitation services to QMH, and we are fully engaged in the SWL commissioning collaborative.	?
5. SG3: Consolidate and expand our key specialist services	5 objectives – five amber rated at the end of year. Whilst much progress has been achieved within this theme, we reprioritised actions during the year and have not satisfactorily completed all objectives at year end.	?
6. SG4: Provide excellent and innovative education to improve patient safety, experience & outcomes	3 objectives – three green rated at the end of year. The Workforce Planning Group has been successfully established and will oversee the delivery of objectives within this theme.	✓
7. SG5: Drive research and innovation	2 objectives – both green rated at the end of year. The integration of the Clinical Research facility (CRF) into the trust structure has supported the high level of recruitment into clinical trials.	✓
8. SG6: Improve productivity, the environment and systems to enable excellent care	7 objectives – four green and three amber rated at the end of year. SWL Pathology partnership went live; the private patient contract is almost completed; and the GP relationship programme is gathering pace.	✓

3.3 Operational performance

As anticipated, 2014/15 was operationally challenging with a continued, though higher than anticipated, rise in non-elective demand and continued growth in elective demand. Additional planned bed and staff capacity was brought on line during the year to support this increased demand and to off-set existing high levels of bed occupancy however this, together with important improvements we made in our emergency flow model, were not sufficient to sustain the successful delivery of the A&E 4-hour operational standard that we achieved in the first half of the year through into the second half of the year. Disappointing performance in Q3 and 4 was also common with the NHS across London and the rest of the UK.

One of the drivers of under-delivery was a significant shift in the complexity of patients, towards a more elderly group, including a 9.4% rise in the number of patients over 70 attending the emergency department (against a south west London average of 3.3%) and a 14.2% rise in the number of patients over 70 being admitted as emergencies. This placed an exceptional demand on the trust's bed capacity through a significant increase in occupied bed days, which had not been forecast by the trust or its commissioners going into the year. In quarter three the trust was also a set, like the wider NHS by an exceptional pressure caused by an early and unusual flu pattern, which was not covered by the vaccine.

The pressures on non-elective pathways also impacted significantly on our elective programme, reducing our available capacity for elective services in Q3 and Q4. Consequently following a 25% reduction in our 18-week Referral to Treatment (RTT) backlog during the first half of the year, this backlog rose again during the latter half of the year bringing the trusts backlog to levels equal to the start of the financial year.

3.4 Quality performance

The Trusts Quality Improvement Strategy (QIS) - 2012-17 – is designed to drive Quality Improvement, underpinned by three supporting domains namely Patient Safety, Patient Experience and Patient Outcomes. As well as local quality aspirations, the trust has taken account of the Francis report, the Berwick Report and Dalton review in framing its quality agenda, and continues to seek to build on the "Good" overall rating obtained from the HM Inspector of Hospital's CQC inspection undertaken in February 2014.

The QIS annual plan agreed by the Board for 2014/15 and followed through within the Quality Account detailed a number of key priorities that would be monitored during 14/15. These priorities were contained within the QIS. The table overleaf indicates progress that has been made against the priorities since the publication of the 2013/14 Quality Account:

Improvement priority for 2014/15	Progress as of March 2015
Conduct twice yearly nursing and midwifery reviews as recommended in the National Quality Board report '*how to ensure the right people, with the right skills, are in the right place at the right time*.'	• Establishment Review completed in May, recommendations agreed by the Board with all bar one implemented during 2014/15. • Further Acuity/ Dependency Review undertaken in autumn of 2014. • Safe Staffing Framework in place and amended to include "Red flag" indicators • Monthly reporting to Board in place regarding safe staffing • Nursing / Midwifery Workforce Programme in place since August 2014 to support the forward planning for recruitment and retention of staff and the commissioning of additional operational capacity during the year.
To ensure that we implement the recommendations of the Clwyd/Hart review of the complaints system in hospitals to further strengthen our response to patient complaints, learn from their feedback and use as a means to implement improvements.	• Work undertaken to strengthen the complaints function including performance management for response time and to ensure evidence of learning from complaints. • Participation in National Patient Surveys for Inpatient, Maternity and Paediatric Settings. Final results awaited for some surveys and work to focus on response to findings. • National Cancer Patient Survey results received indicating that SGH was one of the 10 most improved Trusts. Responses to findings now agreed and being implemented. • Annual community patient survey (Sept 2014) outcomes reviewed with action plans at DGB. • Strengthening of use of Family Friendly test with FFT now in place across Inpatient, Emergency Department, Midwifery settings. A Trial of the Medication Safety Thermometer also completed. Focus on triangulation of commentary with Complaints/ Compliments data. FFT feedback and data being displayed, actions taken. ED have marked uptake in responses using SMS service.
To ensure that we meet the '*Duty of Candour*' requirements and make sure we continue to endorse and develop a culture of openness and transparency.	• Report produced to identify current practice and challenges. Monthly reports being collated to indicate compliance with Duty of Candour. • Master classes held to raise awareness with senior clinicians and support good practice with Patients. •
To ensure we focus on improving the experience of patients visiting our outpatient departments.	• Roll out of E-triage began Feb 2015. • Capacity and demand analysis completed across specialities, • Refurbishment of estate to commence April 2015 including improved signage, new furniture installed in clinic rooms, metro newspapers available in clinics, • patient experience training delivered to call centre and

Improvement priority for 2014/15	Progress as of March 2015
	clinic administrative staff March 2015, training opportunities advertised to staff, • Successful recruitment of permanent staff, on-going staff forums. Roll out of FFT in April 2015. •
To continue to focus on reducing avoidable grade 3 and 4 pressure ulcers, implementing the Sepsis Care Bundle to improve care of patients with severe sepsis and improving our discharge process.	• Patients admitted with sepsis from the ED are regularly audited to identify MISSED (Mortality In Severe Sepsis in the ED) this is reported at the sepsis group • The trend for grade 3 and 4 pressure ulcers is showing a downward trajectory.
To maintain our commitment to improving end of life care.	• Programme board established with agreed scope to take forward trust-wide actions to implement NICE standards and five priorities (which replaced Liverpool Care Pathway). • Audit of Palliative Care activity completed during the year with presentation to key committees. • Development of New Care Plan for patients. •
To establish the dementia and delirium team to meet the national CQUIN requirements, embed the 'butterfly' scheme and improve the care of this vulnerable group of patients.	• Full nursing team recruited and have to date met all CQUIN targets for 2014/15. • Dementia and Delirium Guidelines updated. • Dementia training Roll Out

3.5 Productivity and Efficiency

The trust recognises that with the continued efficiency requirements that the health sector needs to deliver, that continuing to deliver efficiencies without having a significant and adverse impact on quality will not be possible without taking a holistic approach to cost and service improvement.

The Trust has a robust and well-established approach to delivery of the productivity and efficiency challenges, overseen by Programme Management Offices for the CIP Programme and the Service Improvement Programme.

3.5.1 Service Improvement

During 2014/15 the Trust's service improvement programme has delivered quality and capacity improvements in a number of pathways, including frailty, community adult health services and breast, and managed the implementation of much needed capacity schemes. Programme resources were embedded within clinical divisions and delivered around 15 beds worth of capacity, which was some way short of the original 57 bed aspiration due to weaknesses in project planning and clinical engagement. This was also compounded by a change in the age profile of patients attending the emergency department and a 15% increase in the number of over 70 year old patients admitted as emergencies, and an increase in average length of stay due to patient complexity. This shift had not been foreseen and therefore was not factored into commissioners or Trust plans.

For 2015/16 improvement programme resources have been brought under direct central control and will focus on three key areas:

- Undertaking a trust wide Service Line Review - to ensure the sustainability of the Trust by reducing the cost base of services by circa £100 million over three years. This programme is led by the Director of Delivery and Improvement
- Improving non-elective flow and discharge. This programme is led by the Chief Nurse.
- Improving elective capacity and its management – particularly in outpatients and theatres and across the RTT pathway. This programme is led by the Director of Delivery and Improvement.

3.6 Financial Performance

The trust's financial performance was worse than planned, ending the year with a £16.8M deficit against the original planned £5.6M surplus. The deterioration was due to a combination of factors, including lower income contributions, higher divisional expenditure, pressures on staffing budgets through increasing turnover, ongoing use of the private sector to support activity because of capacity constraints, problems implementing new software and shortfall in the delivery of the trust's CIP programme.

This deterioration in financial performance has also reduced the trust's underlying cash balance from a planned level of £20.5M to -£3.3M, necessitating the drawdown of a working capital loan of £15M in 2014/15. The Trust also drew down £13.3M in LEEF loans fro the energy centre project by agreement with the lender , of which £12.5M was unspent at year end. This meant actual cash at year end was £24.2M.

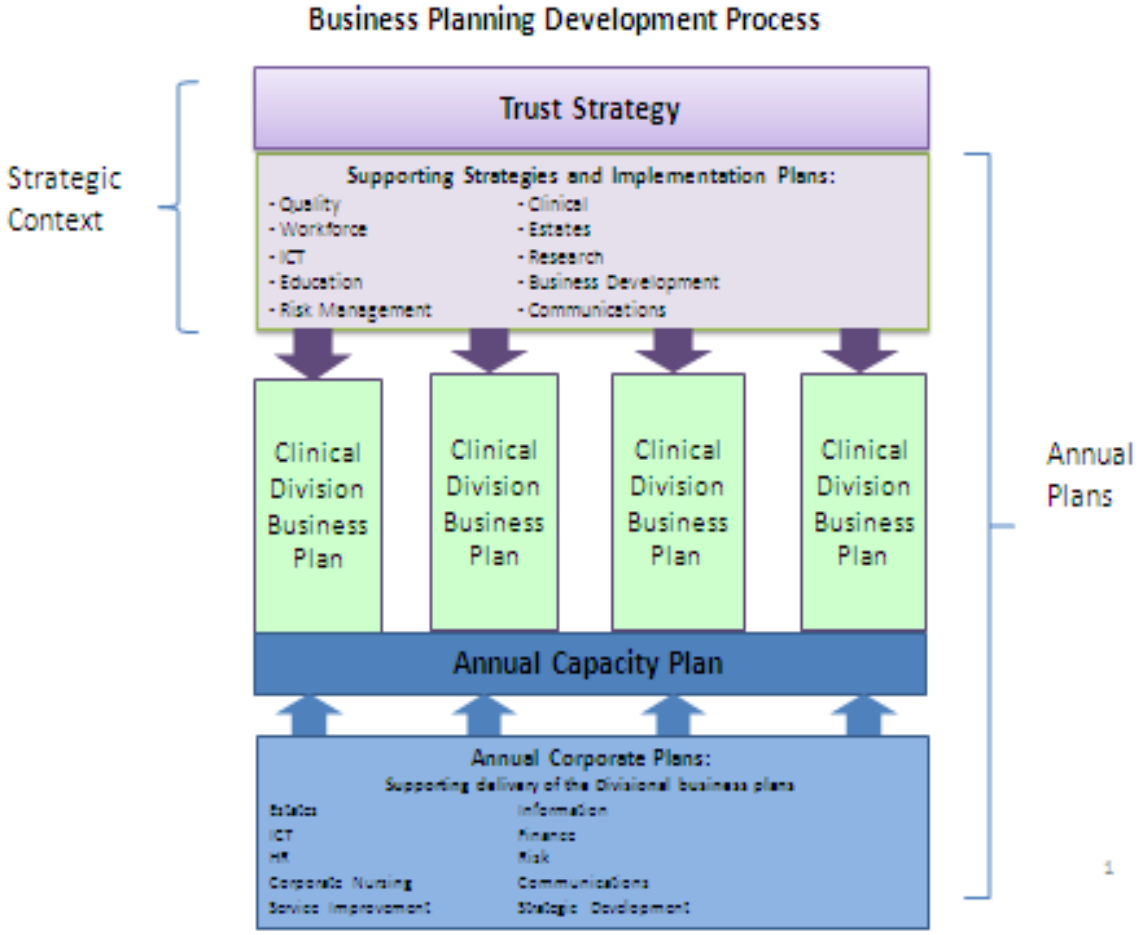
The trust's Continuity of Service Risk Rating (CoSRR) was 3 for the period from February, following authorisation as a foundation trust.

The 2015/16 financial plan (see section five) prioritises operational and quality challenges within the context of a deficit position for 2015/16 and sets out a path towards a longer-term sustainable financial position

4 Operational plan for 2015/16

4.1 Corporate priorities

The Trust has a robust business planning process in place, which ensures a clear link from the corporate priorities and strategy implementation plans, to the clinical division business plans, as shown in the diagram below.



The challenges in prioritising corporate objectives centre on finding an appropriate balance between those items that are perceived as requiring scrutiny at board level and those that are important but are “business as usual”, whilst ensuring that the objectives are real and understandable to staff and key stakeholders.

Our guiding principle is that quality underpins everything that we do, and the key quality priorities included with the relevant strategic goal represent a sub-set of quality initiatives and the Quality Plan, and its reporting mechanisms, are the means by which the Board receives assurance on the full breadth of quality improvements.

The annual plan represents our operational plan for the coming year and therefore seeks to address those operational issues that require Board scrutiny:

- The need to deliver additional capacity in line with clinical need represents a key workstream and this is presented within the relevant strategic goals.
- The organisation has faced a particular challenge in 2014-15 in delivering the 95% emergency access and 18 week referral to treatment (RTT) standards, and key

actions required to achieve more consistent performance in 2015-16 are included in the corporate priorities.

The prioritised corporate objectives will therefore ensure that the Board will receive assurance on our progress towards addressing our immediate operational concerns as well as continuing to implement our strategy.

The priorities identified by the Board for 2015-16, with the key outcomes, are:

- **Delivery of the strategic plan**
  The changes in the external environment, and our operational and financial performance, present new challenges and opportunities; in order to respond to these we will:
    - Complete a review of the current strategy to determine whether it remains robust; and / or whether the objectives to deliver the strategy remain appropriate.
    - Undertake a strategic options appraisal for all services
    - Review all recent investment decisions.
    - Agree a shortlist of 'big ideas' for alternatives to service delivery and/or organisation configuration and partnerships.

  We will continue to implement the existing strategy, particularly with respect to external stakeholders and will:
    - Work with CCGs and local authorities to implement new models of care for community adult health services, complete the redesign of services for frail older people, and support the implementation of local health & wellbeing strategies.
    - Further develop new methods for service delivery and our network of care in accordance with the Dalton Review, 5YFV and the Southwest London Commissioning Collaborative programme.
    - Increase the close working between St George's, University of London and the trust through the Joint Implementation Board by developing Clinical Academic Groups, preparing for the NIHR clinical research bid, and increasing the numbers of patients recruited to clinical studies.

- **Quality**
  In order to continue to maintain and improve the quality of our services, we will:
    - Review how we involve and listen to our patients by refreshing our patient and public engagement strategy
    - Ensure delivery of safe clean environments and use of patient feedback as a vehicle for continuous improvement and adoption of best practice.
    - Create reliable processes for reducing avoidable harm, for example around follow up of diagnostic tests, and implement a framework which will mitigate risk to an acceptable position.
    - Further develop and implement our Quality Improvement Strategy, for example commence "Sign Up to Safety Programme".
    - Redesign our cancer services in partnership with Macmillan cancer support.
    - Publish key clinical quality and safety data
    - Evaluate clinical audit results and act on findings to ensure audit contributes to improvements for patients.
    - Continue to implement our IT Strategy by further deploying electronic clinical records, electronic prescribing, document management systems and the new e-referral system.

- **Provision of additional capacity**
  In order to secure operational performance, and to support the delivery of the strategy, we will:

- Deliver a phased programme of works to provide additional bed and theatre capacity through the year.
- Continue to progress the Women and Children's project.
- Commence construction for our new renal / specialist services expansion project.
- Consider how we can release capacity and / or improve productivity, for example by working closely with the SW London Commissioning Collaborative programme and its Acute Provider and Out of Hospital workstreams, and delivering an outpatient strategy.

- **Financial viability**
  In order to secure our financial viability we will:
  - Identify and deliver CIPs to the levels planned in the IBP / LTFM.
  - Restructure the trust's cost base, reimbursement and / or service portfolio to deal recurrently with pressures beyond this level of CIP.
  - Strengthen liquidity to maintain cash balances of 15 days expenditure.
  - Revise the capital financing strategy to ensure commitment of internally generated capital can only be made once the cash has been generated, and that an affordable borrowing limit is established for the Trust within which cases can be approved for individual schemes.
  - Develop a pipeline of new income opportunities, including market share growth for NHS services, and commercial and research projects.

- **Workforce and leadership**
  To support the delivery of these priorities we will ensure that we have the right workforce and leadership in place by continuing to implement our Workforce Strategy and will:
  - Implement an organisational development programme.
  - Develop an agreed St George's leadership style, and implementing an accreditation and assessment programme for our clinical, operational and management leaders.
  - Develop and implement a programme to support a flexible workforce working across historic professional and organisational boundaries.

These priorities have been turned into more detailed objectives that the Board will oversee delivery of on a quarterly basis. As the annual plan is the primary implementation vehicle for the strategy, these detailed objectives will be presented within the context of our seven strategic goals.

The more detailed strategy implementation plans have also been approved by the relevant Board sub-committees, which will also receive a regular report of progress.

The priorities represent the trust's plan for 2015/16 at the time of writing this document; the outcome of the strategic and service line reviews, and the outputs of the work around financial viability, may result in the trust reconsidering its priorities during the year.

4.2 Quality

Quality underpins everything the trust does. The delivery of the highest quality patient care is central to St. George's Mission "*To provide excellent clinical care, education and research to improve the health of the Populations that we serve*". The Quality Improvement Strategy (2012-17) is based on the three central strands of quality of care: Patient Safety, Patient Experience, Patient Outcomes (clinical effectiveness). It is aligned with the overall Trust Strategy.

4.2.1 Quality Improvement Plan for 2015-16

The quality improvement plan priorities are taken from a range of sources, including national priorities, commissioner priorities, Board priorities and clinical services priorities. The plan is developed and agreed with input from both internal and external stakeholders, including the newly established Council of Governors. Final approval of the plan sits with the Quality and Risk Committee, a Board sub-committee with delegated authority from the Trust Board.

Local commissioning quality initiatives will be part of the on-going contract discussions with commissioners, as the Trust has opted for the default tariff rollover (DTR), and the usual CQUIN payments do not apply as part of this. At this moment in time, in line with other DTR funded trusts, St. George's is in discussion with commissioners about how quality indicators and tariffs will function during 2015/16.

Notwithstanding the CQUIN issue, the key quality priorities for St. George's in 2015-16 are:

Patient Safety

- Implement Learning from Surgical/ Obstetric Never events to enhance safer surgery
- Extend work in relation to the early detection and escalation of patient deterioration
- Strengthen Ward level data to support appropriate oversight and decision making by clinical teams
- Expand the profile of the Safety Thermometer to strengthen improvement programmes by supporting teams in addressing their most frequent themes
- Enhance learning by improving staff feedback when they have reported incidents
- Support the flow programme by linking with the programme to improve safety metrics
- Reduce avoidable harm by introducing the sepsis care bundle and reducing avoidable grade 3 and 4 pressure ulcers
- Support the Development of Care Group Clinical Leads
- Develop systems to support staff to deliver the contractual Duty of Candour
- Ensure there is a robust system in place for follow-up of diagnostic test results

St. George's is already involved in the Sign up to Safety Campaign and this will continue to be part of the "business as usual" quality objectives for the clinical divisions. In addition, the organisation will continue to make progress against the clinical standards for seven day services, as agreed with commissioners.

Patient Experience

- Roll out the Friends and Family Test to outpatients, day surgery and Community Services and act on feedback supported by National Patient Survey information.
- Introduce a Dementia and Delirium Team and continue to embed the Butterfly scheme.
- Ensure compassionate care at the end of life is supported and monitored closely following the withdrawal of the Liverpool Care Pathway.
- Improve the patient experience in the outpatient department
- To be able to evidence the changes and improvements made as a result of patient feedback and see an improvement in feedback as a result of actions taken; and ensure that patient complaints are responded to within the required standards.

- To continue to undertake a regular programme of audit and surveys relating to privacy, dignity and other indicators using the outputs to support sustainable improvements in patients experience.

Patient Outcomes (Clinical Effectiveness)

- Each Division will have a prioritised programme of local and national clinical audit activity with results, actions and outcomes registered centrally with the clinical audit team. This programme will encompass national, local and Trust-wide priorities
- Carry out investigations and act on findings in all areas where mortality appears to be higher than expected as derived from monthly Dr Foster Benchmarking and data from other sources
- Provide transparency on outcomes by publishing consultant level activity data, clinical quality measures and survival rates from all nationally agreed audits

Looking forward, there are a number of additional quality priorities that the organisation will need to implement during 2015-16, such as the outcome of the NHS England review of maternity services, which is expected to recommend choice for maternity care; plus the expected revised national cancer strategy.

4.2.2 Overview of Existing Quality Concerns

St. George's received the new format CQC Chief Inspector of Hospitals inspection in February 2014. The organisation received an overall rating of good across all services, with a rating of outstanding for adult critical care services against all five CQC domains, and a rating of outstanding for maternity services for the 'caring' domain. There were two issues of non-compliance identified as a result of the visit, requiring mandatory action, in relation to the 'safe' domain:

- Mental capacity act: people who use services and others were not protected against the risks associated with obtaining the consent of patients with limited capacity, as not all relevant staff understood the requirements of Mental Capacity Act 2005 and how this relates to vulnerable adults in terms of best interest decisions and informed consent.
- Corporate out-patient services: people who use services and others were not protected against the risks associated with not having medical records available in the outpatient department to provide appropriate care based on previous history.

An action plan was put in place to address the two identified issues of non-compliance. All actions have now been completed, however monitoring the effectiveness of these actions will continue in line with good practice. The compliance action plan was presented to commissioners in January 2015, alongside the improvement action plan to address issues where the CQC recommended that action should be considered (non-mandatory actions) e.g. regular safe staffing reports, tracker to monitor actions arising from adverse incidents, discharge and patient flow workstream, and end of life care improvement programme. Commissioners have confirmed that they consider the Trust has provided good assurance in relation to progress of both action plans, and agreed to close down the specific review meeting established to review progress. The effectiveness of both plans will now be monitored on an on-going basis through existing governance meetings and processes (e.g. the Clinical Quality Review Meetings).

4.2.3 Quality Risks

There are several risks identified on the Board Assurance Framework (BAF) that could affect the deliverability of the Quality Improvement Plan, with associated mitigations:

Risk	Mitigation
Bed capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	• Seek additional external capacity • Cap demand for services • Increased command and control of bed management and hospital flow
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.	• Seek additional external temporary staffing capacity and also external physical capacity with own staffing • Cap demand for services
Critical care capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	• Seek additional external capacity • Cap demand for services
Theatre capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.	• Seek additional external capacity • Cap demand for services
Risk to patient safety and experience as a result of potential Trust failure to meet 95% Emergency Access Standard	Emergency Access Operational Standard Action Plan developed covering capacity, pathway improvement and performance management in three areas: **1.** Emergency department actions **2.** Whole hospital actions **3.** Wider system actions Progress in delivering action plan regularly reviewed: • ED action plan via ED senior team meeting weekly • Whole hospital actions via OMT fortnightly • Wider system actions via System Resilience Group performance meeting monthly • Overall the plan is reviewed with the CEO and Director of Delivery and Improvement on a fortnightly basis • Continued close and pro-active working with ECIST • ED dashboard and operational standards agreed, finalised and in place
Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)	All schemes must have a Quality Impact Assessment covering 5 dimensions (5x5 risk scoring): • Patient Safety • Patient Outcome • Patient Experience • Staff welfare • Financial impact

Risk	Mitigation
	These are subject to local governance scrutiny and approval, at care group, directorate and divisional level. Clinical Governance Group (CGG) chaired by Medical Director – all schemes with risk score > 12 referred for consideration for approval by CGG. CGG reports exceptional risks to Quality and Risk Committee. Clinical Divisions make a self-declaration upon management of schemes not presented to CGG
Failure to sustain the Trust response rate to complaints	• Weekly spread-sheet detailing care group response times circulated and included as a measure within the divisional performance scorecard. • LEAN review of complaints process. • Greater oversight of complaints by DDNGs • Regular reporting via PEC, QRC & Trust Board. • Risk rating system implemented to identify high risk complaints. • Complaints action plan in place from November 2014 focussing on 5 key areas to ensure improved turnaround of complaints but also to strengthen learning and organisation capacity to deal with complaints. • Trust performance reviewed by PEC every 2 months and reported to Trust Board monthly
Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	• All doctors have been reminded of their responsibility for ensuring that tests that they order are followed up by Medical Director. • All Care Groups have been asked to develop Standard Operating Procedures to ensure that this happens. • All serious incidents resulting from failure to follow up tests have been reviewed and themes reported to Divisions. • Radiology have strengthened their safety net system. This now includes e mail to MDT for unexpected cancer (cancer MDTs are working through their responses to these alerts). • Cerner order comms system has ability to undertake and record result endorsement for tests organised via order comms. • Project group set up including IT, operations and service improvement to improve process of results endorsement on Cerner and roll its use out in Trust.

The most significant risks on the BAF are reported to the Trust Board on a monthly basis, and a system of 'deep dive' reviews into all risks on the BAF has been agreed with the Quality and Risk Committee (QRC), to ensure all risks are reviewed over a 12 month period. QRC is also responsible for specifically overseeing all risks related to quality.

4.3 Productivity and Efficiency

4.3.1 Service Improvement Programme

The Service Improvement Programme's primary focus in 2015-16 will be on creating capacity, which is one of the Trust's most significant risks to operational resilience.

Modelling indicates that there is a need for c.£18m of cost improvements in 2015-16 through creating capacity: both through undertaking current activity levels within less resource and through generating a margin on any additional activity through increased efficiency. This will require the creation of an additional 90 beds or the release of the same through length of stay improvements.

The agreed focus for 2015-16 is on four key areas:

- Reducing the amount of time from admission to first consultant ward round
- Implementing 7 day consultant ward rounds for all patients within medical wards
- Daily tracking through iCLIP of all patients' fitness for discharge against their expected date of discharge, supported by key performance indicators and dashboards to indicate where management intervention is required.
- Continued focus on pre-11am discharges to ensure beds are available when patients

The capacity modelling and indicative capacity gap have been discussed with commissioners who have indicated they are supportive of the approach the Trust has taken and the key findings. There will be further discussion with commissioners re. the financial implications of the capacity planning and capacity requirements within the context of agreeing the 2015-16 contract.

4.3.2 CIP Programme

The trust CIP programme comprises a number of central workstreams as well as local divisionally run savings schemes. The Trust has a PMO which reviews all CIP schemes and applies a RAG rating to inform the board on how robust the CIP programme is. The key components are:

Workstream	Focus
Procurement	run by our Procurement team who renegotiate up-coming contracts and use a Basket of Goods analysis to provide information related to number of suppliers and spend across the whole Trust for given items, which will be used to identify the potential for the Trust to obtain volume discounts
Medicine Management	Opportunities to be exploited include review of existing contracts, return and reuse of prescribed medicines, and increased use of community prescribing
Commercial	This includes expansion of private patient business, training and other non-NHS activity
Workforce	These are mainly enabling projects which change the level of resourcing the divisions require to deliver the same levels of activity. The key themes relate to: • Recruitment: time to recruit, e-recruitment • Temporary staff: Trust policy, use of staff bank • Medical staff efficiencies: clinical excellence awards, programmed activity • Sickness absence management • Others: medical secretaries, apprenticeship schemes
Corporate Back Office	a review of the Corporate back office to determine where transformational changes could be initiated and costs reduced accordingly

Other Divisional	this is the trusts main workstream. Each budget holder must seek out cost reduction schemes to meet their targets. The schemes in Other divisional will be a mixture of the drawdown of enabling workstreams such as Workforce, a direct drawdown of the Medicines and Procurement workstreams as well as range of specific schemes delivered by the budget holders. These range from skill mix review and change projects to spend controls and run-rate schemes

4.4 Operational Requirements

4.4.1 Demand and capacity

During 2015/16 we anticipate growing as a Trust to deal with an increase in population and population aging combined with the need to increase our run rate to deal with increases in demand driven largely by a growth in non-elective activity and by specialist elective activity. Overall, we anticipate an approximate 5% growth in non-elective activity levels and a 6% growth in elective activity levels in 2015/16. This growth is broadly in line with our integrated business plan and our long term financial model and underpinned by our overarching strategy to be both a community provider, a local hospital secondary care provider and a specialist centre serving South West London and Surrey.

Working closely with our Clinical Commissioning Group and NHS England Commissioning colleagues we have developed a joint demand activity and capacity plan for 2015/16 covering beds, theatres, outpatients and, to a lesser extent, other support services. This plan responds to the increase in activity expected due to demographic growth, a planned reduction in RTT backlogs and a desire by the Trust and Commissioners to reduce hospital bed occupancy to 90% as a way of supporting delivery particularly of the Emergency Department for our operational standard. This work has identified a current bed gap within the Trust of circa 90 beds which is approximately 10% of our general and acute hospital bed base. It has also identified a need for an approximate 10% increase in operating theatre sessions undertaken per week to deal with increased activity levels anticipated and to ensure improved capacity for emergency paediatric (CEPOD) activity.

The Trust and its partners have identified a number of potential schemes to close the bed capacity gap during 2015/16. This includes continuing with implementation of some existing physical new ward schemes on the St George's Hospital site, together with a range of schemes to increase capacity in the Community through a "St George's at …" model. This continues the trend over the last year of increasing bed capacity off the St George's site due to the current physical constraints on the hospital site. We are currently finalising discussions with Commissioners around which schemes implement given both the overall financial envelope and the lead-in time required. Implementation risks are being mitigated through working with tried and tested partners with experience in developing and implementing and running some of these types of schemes.

In 2015/16 we anticipate being able to increase our number of theatre sessions per week by around 8% through increased evening and weekend working. Staffing for these sessions has been secured through both recruitment and through reaching agreements with staff to work additional hours. Part of the increase in theatre capacity will be achieved through the introduction of an additional theatre in September time particularly to support an increase of cardiac activity. During the development of this work, some work will continue to be done off-site through local independent sector hospitals.

Given difficulties in 2014/15 the Trust and Commissioners are currently undertaking a contractual Joint Investigation into sustainable delivery of the 4 hour emergency standard

and the 18 week elective referral to treatment NHS constitution commitment. This investigation is looking at 5 drivers for the emergency standard (in-ED flow; the acute medical unit model; in-hospital bed capacity and flow; discharge; and structural/data issues) and 2 drivers for the RTT standard (capacity and demand; and booking).

The Trust is working with neighbouring hospitals to potentially utilise additional bed and theatre capacity on their sites to support reductions in the overall size of the Trusts RTT admitted waiting list, and also potentially for some specific adjustments to non-elective pathways within a hub and spoke model. Discussions are progressing well at this stage.

The Trust has identified that it has a 90 bed challenge in 2015-16, which will be met through a combination of building additional physical capacity on-site, utilising off-site capacity, and service improvement schemes to realise potential length of stay efficiencies.

The capacity requirements have formed a key part of discussion with commissioners as part of the contract negotiations for 2015-16, with the key service developments under discussion including:

- Additional clinical decision unit capacity
- Surgical assessment unit
- Neurosurgery expansion
- Trauma and orthopaedic expansion
- Increased ICU beds
- Spinal cord rehabilitation
- Neuro-rehabilitation beds to be provided at Queen Mary's Hospital

4.4.2 Workforce Capacity

There are five elements to the workforce and organisational development strategy action plan for 2015, which has the overall aim of developing a highly skilled, motivated and engaged workforce.

The five overall objectives are:

- **Developing leadership behaviours to deliver high quality care –** including supporting the development of the executive team, the development of a leadership development programme, ensuring that incremental progression based on performance is embedded and making Listening into Action the 'way we do things at St George's'.
- **Supporting the organisational development of the divisional governance structures** by undertaking a review of the barriers to team working.
- **Embedding the trust's values** through tackling poor behaviour and bullying, meeting the requirements of the workforce race equality standard and developing a programme that supports staff well being.
- **Deploying the workforce in the most efficient way possible and improving the efficiency of internal workforce department processes** through reducing time to recruit and continuing to reduce sickness absence.
- Finally, the fifth strand of the workforce strategy action plan is related to actual workforce capacity:

"Ensure the right number of skilled members of staff is available to provide the best possible quality of care."

There are three key objectives in 2015-16 to support the delivery of this:

1. Recruit the required nursing numbers to support safe staffing in all clinical areas:

2. Provide support to the nursing board programme in order to meet the nursing recruitment targets.

- Review and revise nursing induction: content and frequency
- Develop an induction programme for overseas nursing including acclimatisation support
- Streamline the recruitment process to ensure that the time to recruit is as short as possible.
- Work with other corporate departments to improve processes so that staff are recruited to the bank in an efficient way

3. Develop a skilled workforce:

- Review current activity and develop a learning and development plan based on contribution from professional leaders, annual business plans, and needs assessment drawn from appraisals.
- Review the opportunity to set up a learning zone facility
- Ensure implementation of care certificate for all new Health Care Assistants
- Review preceptor programme

There are in addition objectives related to the establishment of a medical workforce planning group, and supporting the development of appropriate new and changed roles (which is linked to the education strategy).

4.4.3 Information Communications and Technology (ICT)

Standardisation of care in line with best practice contributes to the quality of outcome for patients and ICT has a key role to play in the delivery of this.

The key priorities for 2015-16 are:

- Deploying the electronic patient record: ensuring safe transition from national to locally managed services for the key clinical information systems of the Trust. This includes the Cerner clinical information system at St. George's Hospital and the national PACS service at Queen Mary's Hospital
- Implement Electronic Document Management and electronic referral system for all new outpatient registrations at St. George's Hospital
- Commence joining up care records across organisations: develop the clinical portal to support the development of a SW London electronic medical record and support the delivery of SW London Pathology services
- Developing decision support capability: improve the completeness, accuracy and timeliness of the collection and the dissemination of information by the Trust to support the planning, performance monitoring and delivery of clinical services to our patients
- Ensuring appropriate governance and clinical engagement: support operational continuity and new service developments for the Trust by ensuring appropriate access and capacity to store data and access clinical and operational information to support current and new service or new service configurations
- Providing patients access to their information: develop and implement direct access pilot to the electronic medical record for patients on one of the chronic disease pathways

The Clinical Systems Programme Board tracks progress and reports, via the Executive Management Team, to the Trust Board.

4.4.4 Key Risks to Operational Delivery

The most significant risks to delivery of our operational requirements are the availability of physical capacity (beds, theatres and critical care capacity), the workforce capacity to support this, and the finance to deliver what is required.

5. Financial Plan

This financial plan reflects the outputs of the planning process at the time of writing this document, and remains subject to change with respect to on-going work.

Financial Forecasts 2015-16

The Trust is forecasting a deficit of £46.2m for the 2015/16 financial year. The deficit reflects the recurrent implications of the deficit financial performance in 2014/15 and the respective financial, activity and other cost pressures arising in 2015/16 along with the Trust's cost improvement plans.

Recurrent Financial Performance 2014/15

The financial deficit for 2014/15 was £16.8m and is expected to have a recurrent impact in 2015/16 of £27.7m after accounting for the effect of non-recurrent income and expenditure and the full year effect of part year expenditure in 2014/15.

Financial Pressures

Inflation

The key determinant of the basic level of efficiency expected of the Trust is the impact of inflationary pressures and the impact of the national tariff deflator in particular. Therefore, the impact of the changes to the national tariff and the consequences of the tariff consultation exercise have been an important factor in the Trust's plans.

The Trust considered the implications of accepting or rejecting the Enhanced Tariff Offer (ETO) and decided to accept the Default Tariff Rollover (DTR). The implication of DTR meant that there was no deflation applied to NHS clinical income. However, it also resulted in changes to the tariff business rules and the withdrawal of the national uplift for CQUIN income.

The net impact of inflation on the 2015/16 financial plans is expected to result in a pressure of £17.0m, which represents an increase in costs of 2.5%. The detailed inflation assumptions contained within the Trust's current draft plans for 2015/16 are set out in the table below:

Table 1: Impact of inflationary assumptions

Inflation / (deflation)	%	£m
NHS Clinical Income	0.0%	0.000
Non-NHS Clinical Income	1.6%	0.154
Non-Clinical Income	0.0%	0.039
Employee Expenses	1.8%	-7.984
Non-Pay Expenses	4.7%	-9.214
Inflation on underlying		-17.005
Inflation on growth		-0.530
Total Inflation		-17.535

A major element of the impact of inflation on non-pay relates to CNST expenditure (£4.95m), which reflects the significant increase to premiums notified for 2015/16.

Activity

Service growth
The expected level of additional income generated by service growth is £24.6m, after taking account of the impact of Commissioner QIPP plans and BCF schemes. This figure includes £9.3m of high cost drugs & devices and is expected to generate a contribution of £3.5m.

Other - Tariff Pressures
Impact of Tariff Business Rules
The impact of the Non-Elective Tariff Adjustment (NETA) is expected to result in a loss of £1.7m as a result of the application of the 30% marginal rate to planned increases in emergency activity above the non-elective thresholds agreed with Commissioners at the beginning of the last financial year.

CQUIN Income
This has been withdrawn by Commissioners as part of the tariff negotiations and the application of the effects of the Default Tariff Rollover (DTR) resulting in a loss of £11.9m. This is expected to be partly mitigated by either the removal of the costs of delivering the CQUIN target or the negotiation of additional income from Commissioners to maintain the targets. This is expected to reduce the impact of the CQUIN funding loss by £1.75m.

Education Tariff losses
Losses of £1.5m have been recognised in the plan as part of the agreed transition path towards the revised education tariff levels. In addition a further deterioration of £1.2m has been recognised as a result of reductions in student numbers as doctors in training numbers are reduced.

Local SLA Tariff changes
These are expected to provide a net gain of £0.7m after accounting for expected SLA tariff losses. Final evaluation of the tariff changes remain subject to finalising of the SLA negotiation process.

The tariff impacts are summarised in the table below:

Table 2: Tariff Impacts

Tariff Losses	£m	£m
Tariff Business Rules (NETA)		-1.7
CQUIN Income	-12.0	
Local Quality initiatives	1.8	-10.3
Education Losses		-2.7
Local SLA Tariff changes		1.1
		-13.5

Other - Unavoidable cost pressures

The plan has made provision for unavoidable cost pressures amounting to £20.5m.

IT Cerner costs
These are expected to present an additional pressure to the Trust of £2.36m as a result of the Trust bearing of costs previously borne by the DoH.

Local operational cost pressures
Cost pressures for 2015/16 have been subject to a review process and pressures of £10.7m to support local compliance and operational issues have been included. The figures also include the costs of investing in the new Turnaround team. The total level of approved cost pressures represents around one quarter of the value of the pressures originally put forward and the unfunded pressures still represent a risk to the Trust's position if the pressures identified cannot be successfully mitigated in other ways.

Contingency reserves
A reserve of £3.4m (0.5% of operating expenditure) has been created as mitigation against other risks to the Trust's plans.

Depreciation, interest and dividend increases
A £4.5m increase in these costs is recognised in the plan as a result of the Trust's recent and ongoing investments to maintain and develop its estates, IT and equipment infrastructure in support of its strategic development. The increases also reflect the impact of the additional cost of the new working capital loans & working capital facilities in the current plans.

A summary of the cost pressures for 2015/16 are set out in the table below:-

Table 3: Cost Pressure Summary

Description	£m
Cerner / Rio DoH Costs	-2.4
Local Cost Pressures	-10.2
Contingency Reserve	-3.4
Operating Cost Pressures	-16.0
Depreciation, Interest and Dividends	-4.5
Total Cost Pressures	-20.5

Other – Non Recurrent Impacts

Systems Resilience Group and Winter Pressures
CCG funding is expected to be reduced to £2.3m for 2015/16 with an additional £1m being negotiated from CCG Winter monies. While alternative means of investing the lower level of funds are established, the current expenditure is expected to continue into the early part of the year. When the SLA is agreed the Trust expects Commissioners to recognise the SRG investment as recurrent.

Donated Assets Income
The Trust expects to receive £0.5m charitable funding towards its capital expenditure plans in 2015-16.

Table 4: Non Recurrent impacts Summary

Description	Income £m	Expenditure £m	Net I&E £m
Systems Resilience Group	2.3	-2.3	0.0
Winter Monies	1.0	-1.0	0.0
Donated Income	0.5		0.5
Total	3.8	-3.3	0.5

Strategic Initiatives

Business Case investments
The Trust is planning to make significant investments in Neurosciences and Trauma & Orthopaedic services as well as in additional capacity and has approved a number of cases in recent months to progress these investments. Recent negotiations with the CCG Commissioners have indicated that the investments in T&O will not be supported and the Trust will therefore need to scale back its plans for these services accordingly.

Overall, the business case investments are expected to generate additional clinical income of £7.7m and cost £12.1m.

Capacity Pressures
An additional 41 beds at a cost of £7.8m has been identified through the business planning process as the minimum investment required to deliver the Trust's activity and income plans. The equivalent of 16 beds has been identified through £3.6m of investment identified in the 'capacity' business cases leaving a further 25 beds to be funded. The Trust expects to secure an additional £3.4m of funds to provide resilience into the emergency pathways and this is currently being negotiated with Commissioners.

Whether this level of investment is sufficient or whether the full year cost of the capacity investments will be funded into 2016/17 therefore remains a risk to the achievement of the Trust's plans. Further work is required to secure the contractual terms.

Nelson Services
The Trust has also recently won the contract to provide clinical services at the Nelson Hospital with an expected turnover of £4.3m.

A summary of these investments is set out below:-

Table 5: Strategic investments

Description	Income £m	Expenditure £m	Net I&E £m
Capacity Business Cases	7.7	-12.1	-4.4
Additional Capacity	3.4	-4.2	-0.8
Nelson	4.3	-4.3	0.0
Total	15.4	-20.6	-5.2

CIP programme

Estimated impact of the 2015/16 Cost Improvement Programme
The overall CIP target for 2015/16 is set at £43m, in line with the level of savings required in the LTFM for this year. After recognising the expected contribution of £5m from service growth and local tariff gains, this left a target of £38.1m. The current value of the identified schemes against the £38.1m target (cost target) is analysed by type and risk category in the table below:

Table 6: CIP Scheme 2015/16

Only schemes rated amber and green (amounting to £16m) are recognised here as likely to be achieved in year. Together with the run-rate schemes of £12m, these expected to deliver a savings programme of £28m for 2015/16. This left a shortfall of £10m, which the Trust is mitigating with investments in a Turnaround team, which is expected to support the delivery of an additional £6.2m in year, reducing the risk to £3.9m. This represents an expected level of achievement of 90% in year with the Board committed to ensure the full year effect of the schemes identified and delivered in 15/16 with Turnaround support will be at least £38.1m.

Net I&E Outturn Bridge from 2014-15 to 2015/16
The impact of the 2014/15 outturn position and the in-year assumptions, contained in the sections above on the income and expenditure position for 2015/16 are set out in the table below.

Table 7 – Net I&E Bridge 2014-15 to 2015/16 Out-turn

Description	Income £m	Expenditure £m	Net I&E £m
Recurrent Out-turn	693.2	-720.9	-27.7
Inflation	0.2	-17.7	-17.5
SLA Growth	23.3	-19.8	3.5
Tariff Pressures	-13.5		-13.5
Cost Pressures		-20.5	-20.5
Business Case Developments	15.4	-20.6	-5.2
CIPs	4.1	30.1	34.2
Non recurrent 15-16	3.8	-3.3	0.5
	726.5	-772.7	-46.2

Overall the Trust is forecasting a deficit of £46.2m

Balance sheet
The overall planned Balance sheet of the Trust is shown below (a detailed balance sheet is included within the appendices).

Table 8

Balance sheet 2015/16	Unaudited accts 31 March 2015 £000	*Projected 31 March 2016 £000*
Fixed assets	**330,274**	***360,074***
Inventories	7,157	*6,300*
Debtors	75,233	78,233
Cash	24,178	*3,000*
Creditors	-90,728	-85,735
Borrowings < 1 year	-5,329	*-60,092*
Provisions	-602	*-602*
Net current assets/(liabilities)	**9,909**	**-58,895**
Borrowings > 1 year	-86,034	*-93,229*
Provisions	-1,181	*-1,181*
Total non-current liabilities	**-87,215**	***-94,410***
Total assets employed	**252,968**	**206,769**
Public Dividend Capital	133,761	*133,761*
Retained Earnings	16,697	*-29,503*
Revaluation Reserve	101,360	*101,360*
Other Reserves	1,150	*1,150*
Total Taxpayers' equity	**252,968**	***206,769***

Fixed assets
The increase in fixed assets is based on a planned capital programme of approx. £56.7m (including £11.2m capital value of planned finance leases) subject to Monitor/ITFF approval – see separate capital section below.

Net current assets/(liabilities)
The significant adverse change in net current assets/liabilities projected for 2015/16 reflects the need to finance the planned £46.2m revenue deficit by securing interim support funding - to be agreed with Monitor and the ITFF - of £52.2m. It is assumed the interim support funding is provided in the form of a revolving working capital facility and so the £52.2m is included within Borrowings < 1 year in the balance sheet above.

Retained earnings
Similarly the revenue deficit generates a significant adverse movement in retained earnings.

Capital plans for 2015/16

Trust capital plans have been developed as part of the Business Planning process. The Finance & Performance Committee has previously considered and approved a Capital Investment Framework on behalf of the Board. The framework proposes a mechanism for determining how much St George's Healthcare NHS Trust can afford to invest in capital assets and evaluating the priorities for the use of that funding. This was updated to reflect the liquidity pressures arising from the Income & Expenditure challenges and was approved by the F&P Committee on the 25th March 2015.

The programme will continue to be reviewed through the Capital Programme Group to ensure that the organisational priorities are met. The final draft of the capital programme is summarised below. The planned level of internally cash financed capital is £27.3m in total (excluding £2.5m for the DCP which would need to be financed separately by the disposal of the PPU site), effectively funding unavoidable commitments, key income generating projects and setting contingencies for risks in the estate, medical equipment and IM&T.

Table 9 – Draft 2015/16 capital plan

	Projected financing £m	Projected expenditure £m	Current Gap £m	Notes
Cap ex financed by DH loans - secured	7.2	-7.2	0.0	1
Capex financed by LEEF loan - secured	7.0	-7.0	0.0	2
Capex financed by PDC capital - secured	1.1	-1.1	0.0	3
Capex financed by leases	11.2	-11.2	0.0	4
Capex - internal capital	27.2	-27.2	0.0	5
Capex - PPU lease land disposal - DPC exp	2.5	-2.5	0.0	6
Donated capital	0.5	-0.5	0.0	7
Projected 2015/16 capital financing/expenditure	**56.7**	**-56.7**	**0.0**	

Notes:
1. Bed capacity schemes, Hybrid theatre, Surgical Assessment Unit projects funded by DH capital loans approved in 2014/15
2. Energy Performance Project financed by London Energy Efficiency Fund (LEEF) loan already received.
3. PDC capital allocation received for IMT e-whiteboards and bedside devices
4. Major equipment replacement includes- MRI, LW CT scanners, and includes provision (value subject to change) for one extra capacity MRI
5. Internal capital financing includes the Head of Computing's 'de minimis' IMT investment requirement of £5.3m: Cerner, VDI, e-prescribing, network infrastructure, medical equipment replacement (cash-financed) and smaller projects not suitable for loan finance.
6. The proposed Development Control Plan (DCP) enabling works expenditure is dependent on securing the receipt for the long lease of land to the PPU partner.
7. Donated capital Includes £0.5m for minor projects from SGHC.

The Trust has undertaken a ranking and risk assessment process for the capital programme to ensure priority is given to projects addressing risk given the historically low level of investment planned using internal capital. This assessment was completed week ending 1st May 2015.

The following changes have been made as a result of the review of the non-financial constraints on the programme since the extraordinary Finance and Performance Committee meeting on 14th April 2015:

(i) The PICU scheme has been re-profiled into 2016/17 on the advice of CWDT division concerning the status of business planning for this project.

(ii) Children's hospital £5m expenditure has been re-profiled to 2016/17 leaving £1m - per estates new outline timeline.

(iii) The theatres expansion which is linked to the Children's' hospital scheme has also been re-phased – moving £3m expenditure into 2016/17.

All these changes have reduced the overall expenditure total to approx. £56.7m. This total includes the capital value of new finance leases planned for the year.

Key notes and assumptions

- Bed capacity schemes funded by DH loans approved in 15/16 complete in Q1 2015/16
- Energy Performance Contract - £7m expenditure in 2015/16 financed by the London Energy Efficiency Fund loan received in 2014/15
- 2015/16 programme includes a 'place holder' for c£1m operating theatres expansion with further c£11m in 2016/17. This scheme would have to be financed by DH loans from 2016/17 onwards.

Cash

The impact of the planned revenue deficit and the essential capital investments identified above is set out in the summary cash flow table below:-

Table 10

	£m	£m
Cash balance as at 31/03/15		**24.2**
IFRS revenue deficit		-46.2
Non-cash income		-0.2
Transfer donated capital grant to capital financing		-0.5
Capital programme		
Depreciation	24.6	
DH capital loans - approved 14/15	5.6	
Capex - business as usual	-27.2	
Donated capital grant	0.5	
Capex financed by donated capital (in revenue)	-0.5	
Capex financed by DH capital loans approved 14/15	-7.2	
Lease land disposal	2.5	
Capex financed by land lease disposal	-2.5	
Capital financing - internal		-4.2
Capex financed by LEEF loan (in opening cash bal)	-7.0	
Capex financed by PDC (in open cash bal)	-1.1	
Capital financing - external		-8.1
Net change in stock, debtors and creditors		-7.4
Leases - repayments		-4.9
Loans - repayments		-2.1
Interim support funding - subject to Monitor/ITFF		**52.4**
Projected cash balance as at 31/03/16		**3.0**

The following assumptions underpin the cash flow summary above:

a. 2015/16 IFRS revenue outturn is -£46.2m deficit
b. The energy performance scheme expenditure in 2015/16 is approx. £7m (financed by the loan from the London Energy Efficiency Fund (LEEF) already received in 2014/15)
c. Internally-financed capital expenditure is £27.2m in 2015/16.
d. The Trust finances £7.2m capital expenditure with DH capital loans approved in 2014/15. Due to timing differences between draw down and expenditure of approx. £1.6m in 2014/15 the remaining loan balance to be drawn down in 2015/16 is £5.6m and shown as a separate financing item.
e. **The Trust secures interim support funding of £52.2m** – this is in addition to the £15m working capital loan already received in March 2015
f. Working capital balances are projected to deteriorate by £7.4m as follows:

- Stock decrease +£0.9m
- Debt increase -£3.0m
- Creditor decrease -£5.2m

The cash flow assumes an increase in NHS debt over the year of approx. £3m to provide for expected slower payments from specialist commissioners given the difficult commissioning environment expected in 2015/16.

It should be noted that the WCBM Jan 2015 projected a reduction in debt levels of approx. £2m and assumed that £10.6m of the £15m working capital loan received in 2014/15 would be applied to reducing creditors in 2015/16.

Requirement for interim support

The cash flow includes interim support funding of £52.2m to finance the revenue deficit and the net outflow of investment and financing activities. The plan assumes that this interim support funding is provided in the form of a revolving working capital facility and in accordance with Monitor guidance interest payable on this facility is included in the Plan and calculated using the interest rate of 3.5% pa.

Table 9 demonstrates that the Trust would have £3m cash in March 2016 after taking all the actions described in the cash section above.

A full balance sheet and a detailed monthly cash flow projection for 2015/16 is shown in Appendix 3.

Sensitivities

Assessment of Residual Risk on Income and Expenditure Plans

The table below sets out the additional key ***Residual Risks*** to the pressures identified above showing the extent to which they may vary in a upside or downside position. These 'residual risks' form a potential downside and if all were to happen, would move the deficit by £26.4m to £72.2m.

Table 10 – Residual Risks and Mitigations – Impact on I&E

	Downside £m	Upside £m
CIP	(6.2)	0.0
Cost pressures	(1.5)	0.0
Contingency	(3.4)	0.0

SLA changes	(8.5)	2.6
adj to 14/15 underlying	(6.9)	2.4
15/16 plan	(26.5)	5.0

The CIP risk reflects the extent to which the investment in Savings Programme Delivery will not mitigate the current shortfall and risks to the current programme.

The Cost pressures risk reflects the concern that plans to mitigate risks of unapproved local cost pressures may be unsuccessful and that the cost of increasing capacity may be greater than planned.

Contingency risk reflects the concern that 0.5% provision may not be sufficient to address other unanticipated risks.

SLA risks relate to both upside and downside risks to the local tariffs to be applied in 2015-16 and the consequences of over-performance against a lower than proposed SLA value. The Trust may be able to agree higher tariffs for Neuro-rehabilitation services and secure more income in respect of local quality requirements amounting to £2.6m

The downside reflects the risk that the NHSE may endeavour to avoid paying for over-performance and that the agreement yet to be secured with CCGS for non-elective services may not allow for the non-delivery of their QIPP plans. There is also concern that any T&O investments will not be funded by CCGs. Altogether, these will amount to £8.5m.

Underlying 14-15 position risk reflects the remaining uncertainty over the recurrent impact of the deficit position, which could worsen by £6.9m or improve by £2.4m.

In total, the downside position would increase the deficit to £72.7m and the upside position could decrease the deficit to £41.2m

Appendix 1: Board Declarations

Self Certification

1 Declaration of sustainability

The board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years time.

i — Not Confirmed (to explain in written plan)

2 Continuity of services condition 7 - Availability of Resources

EITHER:

2a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. — N/A

OR

2b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box in section 4, below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. — Confirmed

OR

2c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. — N/A

3 Declaration of interim and/or planned term support requirements

The trust forecasts a requirement for Department of Health (DH) interim support or planned term support for the year ending 31 March 2016 — DH Support Required

Note: If interim support is forecast in the plan period, but was not required in the preceding year, the trust should contact its relationship team by 31 January 2015, and before including any amounts in their plan (unless the DH has already approved the interim support funding). Further information regarding the requirements for trusts forecasting a need for DH funding support can be found in the planning guidance and template guidance.

4 Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account, as stated in section 2b above, by the Board of Directors are as follows:

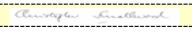
Financial sustainability. The Board has reviewed the proposed 15/16 plan in detail throughout its development from Oc14 to date. The plan is for a deficit of £46m having taken due account of the realistic underlying financial position going into 15/16, the risks and cost pressures faced in 15/16 and the level of cost reduction the organisation can be stretched to deliver. The Trust has an existing working capital facility of £25m but this will not be sufficient to meet the cash requirements of the deficit revenue position and the capital plan which has been reduced to the mininum possible requirement. The Trust therefore requires additional cash support to maintain normal operating and quality existing standards. The Board has a reasonable expectation that this will be agreed with DH with the support of the regulator

In signing below, the board is confirming that:

To the best of its knowledge, using its own processes and having assessed against Monitor's Risk Assessment Framework, the financial projections and other supporting

Signed on behalf of the board of directors, and having regard to the views of the governors

i

Signature		
Name	Christoper Smallwood	Miles Scott
Capacity	Chairman	Chief Executive
Date	15/05/2015	15/05/2015

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD

Paper Title:	Risk and Compliance report for Board incorporating: 1. Board Assurance Framework 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 outcome of the first deep dive risk review: 02-01 - Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs), which was undertaken by QRC on 13th May, is included within the report.
- Six new risks have been identified and are proposed for inclusion on the corporate Risk register (CRR)
- One risk is proposed for closure and a proposal to merge two further risks is outlined in the report.
- An overarching review of all finance risks on the CRR is about to be undertaken. This will happen simultaneously with the Monitor investigation ensuring there is interaction between the two in order that any early findings from the Monitor investigation are appropriately reflected on the CRR.

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*
- Whilst the actions taken to address notes availability have been completed, showing good improvements throughout 2014, there has been a decreasing performance since January due to a new set of issues. Hence the intended improved performance has not been sustained. As such the decreasing performance in notes availability has been proposed for inclusion as a new risk on the Corporate Risk register.
- The action plans are presented to the Commissioners, CQC and Monitor via the Clinical Quality Review Group on 20th May to request closure of the action plan with the plan to ensure monitoring of effectiveness through existing formal Trust committee structures

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

New risks have been identified for inclusion on the corporate risk report (CRR), identified from various sources including aggregation and escalation from divisional risk registers. All new risks will be evaluated and controls identified prior to inclusion on the CRR.

- **Further reductions in the availability of medical records** – identified through discussion at the Executive Management Team and Organisational Risk Committee (ORC) where a continued deterioration in the availability of medical records was reported by CW&DT as an emergent risk on the divisional risk register. The committee considered this should be escalated for inclusion on the CRR and noted that this was an issue of non-compliance at requiring action at CQC inspection in February 2014.

- **Impact of run rate schemes in Estates and Facilities** - identified through discussion at ORC where it was noted that there is an increasing backlog and delays in dealing with logged requests impacting upon services it is linked to following potential risk as some delays are incurred due to lack of available parts.

- **Impact of delays in procurement processes upon all clinical areas** – Identified at ORC by all Divisions when analysing recorded adverse incidents relating to delays in the provision of essential kit due to procurement process – aggregated risk across all areas to be escalated

- **IT/iclip roll out and risks to patient safety** – identified through ORC; aggregated risk which has been entered into all divisional risk registers. The executive management team will consider this risk and the iClip roll out programme at its meeting on 8th June.

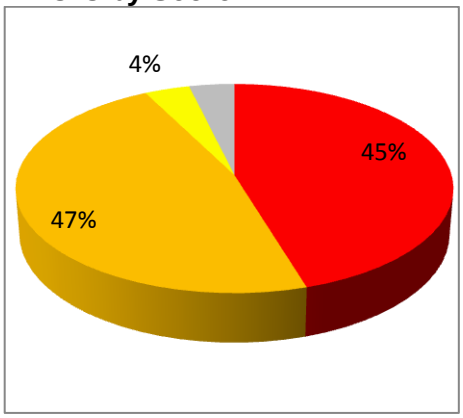
- **Strategic risk of partnership working** – identified through an internal audit report which recommended the risks to effective partnership arrangements be considered for inclusion on the Strategy Corporate Directorate Risk register and/or potential for escalation/inclusion on the CRR.

- **Impact upon quality of capital funding decisions** - identified through deep dive review at QRC where it was considered this should sit outside the current risk to quality of CIP schemes as one represents recurrent revenue and the other a one off spend.

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 45% of the total risks. Of these, 10 sit within the domain of Finance and Operations. Of the total risks on the CRR, 39% relate to Finance and Operations and 33% to the Quality domain (table three).

Fig 1: CRR Risks by Score



15 and above (Extreme)	24
8-12 (High)	25
4-6 (Moderate)	2
0-3 (low)	0
Proposed for closure	2
Total	**53**

Table three: CRR Risks by Domain (excluding risks to be closed)

					Total
1. Quality	9	8	0	0	17
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	3	1	0	4
Total	**24**	**25**	**2**	**0**	**51**

1.3 Changes to risk scores

There have been no changes to risk scores during the reporting period.

An overarching review of all finance risks on the CRR is about to be undertaken. This will happen simultaneously with the Monitor investigation ensuring there is interaction between the two in order that any early findings from the Monitor investigation are appropriately reflected on the CRR. All changes will be reflected in full in the next board report.

1.4 Closed risks

The following risk is proposed for immediate closure:

- **02-02** Risk of poor patient experience due to long delays when trying to contact central booking service: this risk is now resolved and call response times are now within normal parameters.
- **01-08** Prolonged strategic uncertainty in SW London and Surrey. Proposal for risk to be merged with A533-08

1.5 Deep Dive: Quality Risk Committee

The QRC undertook a deep dive review of the following risk on 13th May 2015:

02-01: Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)

The methodology for 'deep dive' risk reviews involves the committee considering whether:

- The risk is correctly described with root cause and impact clearly articulated?
- The score is correct including consideration of the residual risk
- Are the controls are appropriate, robust (and timely) enough and are actions in place to address the identified gaps?
- Whether assurances are robust enough to assess the effectiveness of controls?

Using this methodology, the committee:

- Agreed that some minor changes should be made to the principal risk and description to reflect the three domains of quality: Safety, outcome and experience.

- Was assured that the gaps in controls are well understood and that actions are currently underway to address these identified gaps.

- Challenged the current assurances and overall agreed these were not comprehensive or robust. These will be further strengthened and clearly defined internal and external assurances; both qualitative and quantitative will be detailed in order for the committee to provide full assurance to the Trust Board.

The risk will be updated to reflect the outcome of the review and presented for approval by QRC as part of the continuing process of review.

1.6 Summary of Extreme Risks at Divisional level:

Following review at the forthcoming Organisation Risk Committee on 6th May, the extreme risks from each of the divisional risk registers will be included on the corporate risk register. These 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 is 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 will be presented again on 20th May 2015.

2.1.1 MCA training and audit at Queen Mary's Hospital

The Trust has made good progress in relation to MCA training at QMH where all staff have been trained to a level commensurate with the requirements of their role. All actions on the action plan are completed. In order to measure the effectiveness of the actions taken, two case note audits have been undertaken which revealed areas for further improvement and the recommended actions, in line with a staff survey currently underway, will be used to inform a wider Trust programme of improvement which will report to Adult Safeguarding Board.

2.1.2 Notes availability in outpatients

Following a period of improvement during 2014, performance has declined more recently in terms of the number of medical records being available in clinic. The below table shows the performance for the last four months:

Jan-15	Feb-15	Mar-15	Apr-15
94.05%	90.12%	91.32%	90.45%

Whilst all actions contained within the action plan were completed to address this issue, continued improvements have not been sustained.

In summary, 120,000 set of notes have been moved into offsite storage to create sufficient space for the newly commissioned multi faith centre and the Electronic Document Management (EDM) scanning bureau that will support the trust's transition onto the electronic documentation system. As a result, however, there has been an impact on the availability of notes in clinics and the volume of notes being moved between the sites each day.

To help us to understand what is causing these additional problems the Trust has held a focus week from 8th-15th May where twice daily checks (09.00 and 15.00) have been undertaken with Corporate Outpatient Service (COS) Managers on the notes situation in their clinics. The information collected will focus on a range of issues such as missing notes, offsite notes and temporary notes. We will use the outcomes from this week to inform the further improvements to the processes that support patient notes within the trust.

The potential risk to patient safety arising from a lack of notes availability has been captured on the Divisional risk registers and was escalated through discussion at the Organisational Risk Committee on 6th May for inclusion on the Corporate Risk Register as previously detailed in the report. The further targeted work is underway and is overseen by the Outpatients Management Team.

2.1.3 Improvement action plan

The Trust has reported to the CQRG that all actions on the improvement action plans are either completed, have reverted to be managed as business as usual or are encompassed within overarching Trust work streams which are monitored regularly both internally and externally by high level committees. In recognition of the potential duplication which could occur, and to prevent issues being reviewed in isolation, it was provisionally agreed that the Trust has were requested closure of the compliance and improvement action plans. The action plans have been presented to the QRC in full on 27th May 2015.

2.2 Summary of external assurance and third party inspections May 2015

2.2.1 CQC Intelligent Monitoring Report

At the time of writing the report, the Trust awaits the formal publication of the report due end of May.

2.2.2 PLACE – Patient Led Assessments of the Care Environment

PLACE is the system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The Trust has undergone inspection across 13th/14th May and initial feedback is positive, particularly in relation to food quality. There are some recurrent themes form the previous inspection around estates maintenance and an action plan is currently being developed. Formal scores will become available in September.

2.2.3 HMP Inspector of Prisons / CQC Visit to HMP Wandsworth March 2015

The HM Inspector of Prisons carried out a full inspection of HMP Wandsworth across a three week period in March. Following formal feedback, an action plan is being developed to address the findings ahead of receiving the final report and will be presented to the Patient Safety Committee in May 2015.The CQC will not issue a stand-alone report following this inspection but will contribute to the overall HMIP report, the Trust currently awaits this report.

3. Conclusion

A programme of detailed review of risks included on the Corporate Risk register has commenced in order to provide stronger assurance to the Trust Board around the management of risks. Through this process of review and escalation at the Organisational Risk Committee, a number of potential risks to quality were identified arising from CIP and run-rate schemes. Strengthened controls are currently being developed by the Chief Nurse and Medical Director to ensure there is timely and robust quality oversight of the impact upon quality of this aggregated risk.

The Trust has completed all actions contained within the CQC action plans however some benefits have not been realised in relation to notes availability, placing the Trust at risk of re-inspection. This risk has been proposed for inclusion on the CRR.

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	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 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	20	25	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	16	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	12	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	16	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	→	

Strategic Objective/Principal Risk	**Lead**	**Dec 2014**	**Jan 2015**	**Feb 2015**	**Mar 2015**	**Apr 2015**	**May 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	→	
02-02 Risk of poor patient experience due to long delays when trying to contact central booking service	MW	12	9	9	9	9	9		Proposal to close

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	**Lead**	**Dec 2014**	**Jan 2015**	**Feb 2015**	**Mar 2015**	**Apr 2015**	**May 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	12	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	8	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	12	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	9	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	16	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	→	

Strategic Objective/Principal Risk	**Lead**	**Dec 2014**	**Jan 2015**	**Feb 2015**	**Mar 2015**	**Apr 2015**	**May 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	16	20	20	20	20	20	→	
3.8 – 06 Low compliance with new working practices introduced as part of new ICT enabled change programme	SB	12	16	16	16	16	16	→	
3.9 – 06 Risk of inappropriate deployment of e-prescribing and electronic clinical documentation	SB	12	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	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 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	15	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	Dec 2014	Jan 2015	Feb 2015	Mar 2015	April 2015	May 2015	In month change	Change/progress
4.1 Redesign pathways to keep more people out of hospital								↓↑	
01-O8 Prolonged strategic uncertainty in SW London and Surrey.	RE	12	12	12	12	12	12		Proposal to close and merge with A533-08

Strategic Objective/Principal Risk	Lead	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 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	8	12	12	12	→	

Strategic Objective/Principal Risk	Lead	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 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	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 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	4	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 – Significant Risks - CRR

Principal Risk	3.2-O5 Cost Improvement Programme slippage. The Trust does not deliver its cost improvement programme objectives				
Description	▪ Opportunities for savings schemes are not identified ▪ Opportunities to save are not sufficiently developed to deliver the value required ▪ Savings identified within schemes are overoptimistic / savings are double counted ▪ Savings are redeployed ▪ Savings schemes are not delivered as planned or are delivered late ▪ Capacity constraints prevent delivery of activity plans ▪ Savings identified are only non-recurrent				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update Mar 2015**	**Exec Sponsor**	Steve Bolam
Consequence	5	5	5	**Date opened**	01/12/2012
Likelihood	4	5	5	**Date closed**	
Score	20	25	25		

Controls & Mitigating Actions	Controls ▪ Cost Improvement Programme Board instigated from December 2014 to take a lead role in developing, driving and delivering a robust CIP programme for 2015/16 and subsequent years ▪ Over-programming -Additional Schemes to be developed above annual requirement as a contingency against under-delivery ▪ Benchmarking St. George's services to ensure that opportunities are found ▪ Role of PMO in managing CIP programme. ▪ Rigorous PID development to support projects to be delivered ▪ Divisional Management Board oversight, review and sign-off of projects to ensure that only projects that have a realistic chance of delivery are agreed and implemented. ▪ Risk assessment of all schemes, challenge on the value of savings achievable and monitoring of scheme progress, with reporting back to F&P Committee and the Board. ▪ Future CIP strategy to identify pipeline of future projects from productivity based Service Improvement Programme ▪ Development of in-house expertise to support development of service improvement culture ▪ Weekly meetings between directorates, divisions and the PMO to monitor scheme performance. All projects across the trust have clear directorate and divisional leads. ▪ The trust is engaging with outside expertise to develop further robust CIP savings schemes for future years.	**Assurance**	Audit Reports Internal review of PMO processes by Governance Team Benchmarked controls against Monitor's guide on "Delivering Sustainable Cost Improvement Programmes" (19-01-2012). Audit Reports Internal review of PMO processes by Governance Team NTDA review and approval of 2 year CIP programme as presented in preparation for NTDA approval of FT application Monitor review of CIP plans and process as part of FT application

	Mitigating Actions 1.To develop further in-year non-recurrent CIP schemes to offset the non-delivery of the full CIP programme. These would include: ▪ Vacancy freezes ▪ Reductions in procurement spend ▪ Slowing of in-year capital programme 2. Review list of downside mitigations to see what can be actioned now		
Gaps in controls	Over-programming yet to be achieved Lack of consistent pipeline of future projects Gaps in opportunities identified in work streams especially in creating capacity	**Gaps in assurance**	Review of capacity planning and service improvement benefits expected indicates material gaps in 15/16 plans have opened up and need to be filled with alternative schemes Inadequate progress to date on filling gaps
Actions next period:	▪ Continued review and development of schemes to deliver the 2015/16 programme ▪ Develop and in-house process and methodology to identify 2016/17 CIP programme. Process to be overseen by the Business Planning Steering Group and CIP Board ▪ Continued work at work-stream and divisional level to identify and improve risk rating of 15/16 schemes ▪ LTFM/IBP review led by CEO to look at more radical change		

Principal Risk	**01-12 Bed capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.				
Description	Requirement for high activity volumes in some specialities in order to meet patient and commissioner needs, and to deliver income margin as part of Trust Cost Improvement Programme. Potential for commissioner challenges and financial penalties Unlimited demand on A&E which impacts on increase in emergency admissions & capacity for elective admissions affecting 28 day rebook timeframes. Potential subsequent impact on patient pathways & patient safety. Delayed patient repatriation to host hospitals block beds for emergency/elective activity. Reduced numbers of discharges at weekends and on bank holidays causing capacity problems. 14.2% increase in emergency admissions in patients over 70 Adverse reputation				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated May 15**	**Exec Sponsor**	Martin Wilson
Consequence	5	5	5	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	4	4	4	**Date closed**	
Score	20	20	**20**		
Controls & Mitigating Actions	**Controls:** Director of Delivery and Improvement appointed to lead organisation's work on (in year and next year) capacity planning and delivery. Supported by full time Programme			**Assurance**	Negative assurance: - 4 hour operational standard performance - RTT backlog of patients- cross ref BAF Risk 01-06

	Manager dedicated to capacity. Proposals for additional bed capacity Made to CCG as part of contract discussion Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. Business Planning commenced and has identified 93 beds are required in 15/16 There are however risks with respect to the timing and delivery of both aspects of the plan. To control these risks, we have: Ensured that maximum possible resource is deployed towards the improving patient flow programme so that optimal delivery can be achieved A structured approach to appraising the options for creating further physical capacity for 2015-16 and beyond. This work is underway. Increased capital project management capability **Mitigations:** • Seek additional external capacity • Cap demand for services • Increased command and control of bed management and hospital flow		- Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014 Joint trust & CCG capacity planning for 15/16 undertaken and approved by SRG Internal audit report has not provided a formal level of assurance but has set out that the current approach to capacity planning and plans that are underway to address identified capacity gaps will provide a reasonable level of assurance once these are fully implemented. Risk reduced following challenge at QRC February 2015 when it was agreed the likelihood of the risk materialising had lessened due to the controls in place.
Gaps in controls	Commissioners financial support to address shortfall in no of beds not yet secured	**Gaps in assurance**	
Actions next period:	Realisation of new physical bed capacity Development of critical path for all forecast building schemes, and embedding the holding to account of Senior Responsible Owners for delivery of agreed schemes. Trust and commissioners to agree 15/16 contract & finding to enable capacity to be delivered		

Principal Risk	**01-13 Theatre capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.				
Description	Requirement for high activity volumes in some specialities in order to meet patient and commissioner needs in particular to deliver 18 week RTT standards, and to deliver income margin as part of Trust Cost Improvement Programme. Potential for commissioner challenges and financial penalties Adverse reputation				
Domain	**2. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated May 2015**	**Exec Sponsor**	Martin Wilson
Consequence	5	5	5	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	4	4	4	**Date closed**	
Score	20	20	20		

Controls & Mitigating Actions	**Controls:** Director of Delivery and Improvement appointed to lead organisation's work on (in year and next year) capacity planning and delivery. Supported by full time Programme Manager dedicated to capacity. Theatre Capacity Plan for 2015 to 2018 developed by Director of Delivery and Improvement with senior leadership from SNCT leadership team. Plan reviewed by extraordinary OMT and regularly reviewed by EMT. Additional capacity being realised through: • Increased in session utilisation within existing theatre sessions • All day operating sessions within day surgery • Extended day operating in main theatres • Commissioning the planned Hybrid theatre as an additional theatre • Building 6 additional theatres on site (part in conjunction with Moorfields) • Offsite capacity options (NHS and independent sector) The above require significant additional staff (Cross ref 01-14) Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. Business Planning for 2015/16 commenced with focus on aligning divisional activity and capacity plans. Specific theatre capacity analysis and plan developed linked to a longer term theatres strategy currently in development.. Ensured that maximum possible resource is deployed towards the improving patient flow programme so that optimal delivery can be achieved A structured approach to appraising the options for creating further physical capacity for 2015-16 and beyond. This work is underway. Increased capital project management capability Star chamber held by Director of Finance and Director of Delivery and Improvement with each divisional leadership team to ensure that planned activity numbers are robust. 2015/16 business planning accelerated.	**Assurance**	Internal theatres capacity plan and tactical implementation plan developed by Director of Delivery and Improvement. Approved by Executive Management Team. Reported to Finance and Performance committee. Participation in System Resilience Group that has reviewed Trust's capacity plans. Additional funds secured through SRG 1 elective RTT funds. Negative assurance: - RTT backlog of patients- cross ref BAF Risk 01-06 - Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014 Internal audit report has not provided a formal level of assurance but has set out that the current approach to capacity planning and plans that are underway to address identified capacity gaps will provide a reasonable level of assurance once these are fully implemented. 6 of the 13 Day Surgery Unit extended day, (including reallocating sessions of activity from main theatres) 2015/16 theatre capacity timetable shared in draft via EMT, showing how vast majority of theatre sessions identified in business planning will be delivered. Plan currently being validated by divisions.

	Mitigations: • Seek additional external capacity • Cap demand for services		
Gaps in controls	Maintenance of theatres behind plan for a number of years, leading to a risk that theatres will break down.	**Gaps in assurance**	Admitted backlog of over 18 week waiters greater than sustainable. Non-admitted backlog numbers not being reduced at planned rate. Theatre performance data dashboards not yet fit for purpose with divisional clinical teams.
Actions next period:	Continue with remainder of DSU sessions to be reallocated Continue installation of new hybrid theatre Develop business case for Lanesborough 1st floor additional theatres Secure additional off site theatre and bed capacity through other providers		

Principal Risk	**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.				
Description	Trust is planning to open significant additional beds (6 -10% + of current stock), theatre sessions (6-10% + of current lists), and critical care beds (c30% of current bed stock) however this will require significant additional staffing (nursing, medical, other clinical and other support staff). In many of these staff groups there are already high vacancy levels so staffing will be a significant challenge. Additional staff are required for high activity volumes in some specialities in order to meet patient and commissioner needs in particular to deliver emergency services, 18 week RTT standards, and to deliver income margin as part of Trust Cost Improvement Programme. Potential for commissioner challenges and financial penalties Adverse reputation				
Domain	**3. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated May 2015**	**Exec Sponsor**	Martin Wilson (as exec lead for capacity) Jennie Hall (as exec lead for nursing and safe staffing) Wendy Brewer (as exec lead for staffing and recruitment)
Consequence	5	5	5	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	4	4	4	**Date closed**	
Score	20	20	20		
Controls & Mitigating Actions	**Controls:** Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. OCP managed by Programme Manager and includes 4 key areas: staffing, clinical pathway; physical capacity; and commercial / contracting arrangements. Director of Delivery and Improvement appointed to lead organisation's work on (in year and next year) capacity planning and delivery. Supported by full time Programme			**Assurance**	Workforce updates given to Trust Board. Nursing staffing plan considered by Trust Board. Participation in System Resilience Group that has reviewed Trust's capacity plans. Additional funds secured through SRG 1 & 2 non elective winter funds, and through SRG 1 elective RTT funds. Monitor FT assessment process has scrutinised Trust Capacity Plan ECIST reviews (September 2013 and May 2014) Negative assurance: - 4 hour operational standard performance - RTT backlog of patients- cross ref BAF Risk 01-06

	Manager dedicated to capacity, who is mapping total additional staffing required by week for each new scheme. Chief Nurse and Director of Human Resources working closely together to lead recruitment to staff new schemes and to reduce existing staff turnover. Business Planning for 2015/16 commenced with focus on aligning divisional activity and capacity plans. **Mitigations:** • Seek additional external temporary staffing capacity and also external physical capacity with own staffing • Cap demand for services		- Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014 Internal theatres capacity plan and tactical implementation plan developed by Director of Delivery and Improvement. Approved by Executive Management Team. Reported to Finance and Performance committee. CQC Intelligent Monitoring report – new risk identified around staff turnover rates
Gaps in controls		**Gaps in assurance**	
Actions next period:	Enhanced programme of staff recruitment underway.		

Principal Risk	**01-15 Critical care capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.				
Description	Requirement for high activity volumes in some specialities in order to meet patient and commissioner needs in particular to support emergency services and deliver 18 week RTT standards. Also any shortage in critical care capacity will impact on trust's ability to deliver income margin as part of Trust Cost Improvement Programme. Potential for commissioner challenges and financial penalties and adverse reputation				
Domain	**4. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated May 2015**	**Exec Sponsor**	Martin Wilson
Consequence	5	5	5	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	4	4	4	**Date closed**	
Score	20	20	20		
Controls & Mitigating Actions	**Controls:** Director of Delivery and Improvement appointed to lead organisation's work on (in year and next year) capacity planning and delivery. Supported by full time Programme Manager dedicated to capacity. Critical Care Business Case for additional neuro and general ITU beds developed by divisional leadership team and shortly to be considered by EMT Trust Capacity Plan for 2015 to 2018 developed by Director of Delivery and Improvement with senior leadership from SNCT leadership team. Plan reviewed by extraordinary OMT and regularly reviewed by EMT. Design plans and costs for 3/4 additional beds in coronary			**Assurance**	Negative assurance: - RTT backlog of patients- cross ref BAF Risk 01-06 - Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014 Internal audit report has not provided a formal level of assurance but has set out that the current approach to capacity planning and plans that are underway to address identified capacity gaps will provide a reasonable level of assurance once these are fully implemented.

	care to be considered and where appropriate – approved. **Mitigations:** • Seek additional external capacity • Cap demand for services		
Gaps in controls		**Gaps in assurance**	
Actions next period:	Business case for additional critical care beds in an expanded expansion plan for GICU to be considered byEMT. Secure approval and business case		

Principal Risk	01-07 Risk to patient experience and safety as a result of potential Trust failure to meet 95% Emergency Access Standards				
Description	Should the Trust recurrently fail to meet 95% Emergency Access Standards there would be a risk to: - *Patient experience whereby patients would not be treated or transferred within four hours* - *Patient safety – delays in patients receiving ED or specialist senior clinical input* - Risk of regulatory action including from commissioners and regulators - Trust reputational damage of failure to deliver the 95% clinical standard				
Domain	**5. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated May 2015**	**Exec Sponsor**	Martin Wilson
Consequence	4	4	4	**Date opened**	1/6/2014
Likelihood	4	5	5	**Date closed**	
Score	16	20	20		
Controls & Mitigating Actions	Emergency Access Operational Standard Action Plan developed covering capacity, pathway improvement and performance management in three areas: 1. Emergency department actions – led by DDO and Clinical Director for ED 2. Whole hospital actions – led by Chief Nurse through 'Flow' programme 3. Wider system actions – led by SRG Progress in delivering action plan regularly reviewed: • ED action plan via ED Senior team meeting weekly • Whole hospital actions via OMT fortnightly • Wider system actions via System Resilience Group performance meeting monthly • Overall the plan is reviewed with the CEO and Director of Delivery and Improvement on a fortnightly basis Continued close and pro-active working with ECIST			**Assurance**	Q3 and Q4 performance standard has not been met Daily reporting to Exec team Escalation meetings between division & CEO ECIST review of action plan Risk being realised with continued high volume and pressure upon ED during Dec 2014 has resulted in challenges to meet 95% standard Monthly assurance to TB and Monitor

	ED dashboard and operational standards agreed, finalised and in place		
Gaps in controls		**Gaps in assurance**	
Actions next period:	Continue implementation of improvement plan (particularly focussed on whole hospital and wider system actions)		

Principal Risk	3.7-06 Failure to meet the minimum requirements of the Monitor Performance Framework may result in reputational damage or regulatory action.				
Description	There is a risk to the Trust's authorisation should it fail to perform against the Access Metrics set out by Monitor Performance Framework particularly in relation to:- 18 weeks- A&E Waits (4 hours)- Cancer waits (TWR, 31 & 62 day targets).Individual risks, controls and actions to mitigate are set out in Divisional risk registers				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.2 Meet all performance targets**
	Original	**Current**	**Update Mar 2015**	**Exec Sponsor**	Steve Bolam
Consequence	4	4	4	**Date opened**	30/05/2013
Likelihood	4	5	5	**Date closed**	
Score	16	20↑	20		
Controls & Mitigating Actions	Management framework in place which measures performance across key domains including operational performance. Divisions are held to account through formal quarterly performance reviews, monthly reporting and monitoring and escalation where required through the DoFPI The Trust has a performance management framework A&E performance meeting is held routinely within the Med/Card division to scrutinise and review ED performance Finance & Performance Committee meets monthly to review in detail the performance report including all areas of the TDA accountability framework Reporting to F&P includes description of key actions and sharing of recovery plans where necessary e.g. cancer recovery plan 12/13 Q4 Reporting continues to be improved and developments including desktop access to scorecards for Divisions and the introduction of risk forecasting are in train External scrutiny: Performance is reviewed by the TDA as part of the Accountability Framework and the Trust is held to account at a monthly meeting of senior teams Clinical Quality Review meeting and contract performance meetings are held monthly with commissioners where performance and remedial action is further scrutinised			**Assurance**	Positive assurance •HDD, BGAF and QGAF assessments •Internal audit Worsening ED performance Dec 2014 – cross ref BAF Risk 01-07

	Mitigating Actions •Additional capacity is being introduced to support the Divisions and the performance framework in the shape of a Head of Performance and 2 x Divisional Performance leads •Reporting continues to be improved and developments including desktop access to scorecards for Divisions and the introduction of risk forecasting are in train •Developmental work in place to introduce formal monthly scoring system for Divisions within the performance framework to improve visibility over performance risks and the effectiveness of remedial action •Additional capacity is being introduced to support the Divisions and the performance framework in the shape of a Head of Performance and 2 x Divisional Performance leads		
Gaps in controls	Absence of risk forecasting which is in development	**Gaps in assurance**	
Actions next period:	Recruit to staff new capacity		

Principal Risk	3.6-05 Cash-flow Risks – Operational Finance: Forecast Cash balances will be depleted due to:- •Adverse Income & Expenditure performance •Delays in receipt of SLA funding from Commissioners				
Description	The Trust's cash balances will be significantly depleted due to an adverse I&E position or delays in receipt of commissioner funding. Risk is currently greater due to change in Commissioner landscape.				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update Mar 2015**	**Exec Sponsor**	Steve Bolam
Consequence	3	4	4	**Date opened**	01/06/2013
Likelihood	3	5	5	**Date closed**	
Score	9	20↑	20		
Controls & Mitigating Actions	Established SLA negotiation process: •SLA negotiation issues are escalated to FD/CE and reported to Finance and Performance Committee. •Locally agreed estimated values for contracts to allow appropriate levels of funding to be made ahead of final contract signature. •SLAs include special clause for interim invoicing of over-performance in advance of freeze date - enhances cash flow. Established Financial Management regime: •Adverse Income and Expenditure results are monitored in-year through the financial reporting regime. •New pressures are identified as early as possible and the financial impact			**Assurance**	Detailed monitoring and forecasting of cash flow and agreed debt through Finance and Performance Committee. HDD1 and HDD2 working capital reviews

	is reported to the Finance and Performance committee. •Trust has set month-end cash balance target against which cash performance is measured: 10 days of operating expenses (in 2013/14 this is approx. £18m). .Working Capital Management •The Trust Cash Position is reported to the Board each month as part of the finance report, including detailed cash flow statements and 2-3 year cash projections. •Changes in debtors, stock and creditors reported and explained within finance report to Finance and Performance Committee and Board. •SLA interim invoicing – as above. Mitigating actions Manage Working Capital • Improve Debt Collection • Delay payment of creditors / manage balances with major creditors e.g. SGUL • Reduce stock levels e.g. extend scope of consignment stock to deliver one-off improvement in liquidity – subject to VFM and affordability tests (i.e. higher unit costs). Delay capital investments in line with reduced funding due to reduction in Trust surpluses Extend scope of leasing to finance capital programme subject to VFM and affordability tests. Explore opportunities for sale and leaseback arrangements LEEF loan agreed to be drawn down early at no additional expense / risk to Trust		
Gaps in controls	Contract with NHSE likely to include unidentified QIPP leading to over performance on contract maybe c£1m per month & cash flow problems	**Gaps in assurance**	External audit opinion on current process
Actions next period:	Seek to agree payment for over-performance in the contract with NHSE Further review of timing of CAPEX to ensure phased towards 2nd 6 months 14/15 and examine profile going forwards Review of cash position under best, most likely and worst case I&E scenarios to November F&P Cttee Agree loan draw down with DH to ensure no cashflow risks from major loan funded projects Cash management review by external audit Further escalation through NHSE Resolve outstanding data quality problems delaying payment Draw down working capital loan of £15m on 23/03/2015		

<table>
<tr><td>Principal Risk</td><td colspan="5">2.1-O5 Tariff Risk - The tariffs applicable to Trust clinical services are adversely changed as a result of:
•National Tariff changes
•Local Tariff changes
•Specialist Commissioning changes
• Transfer of tariff responsibilities to Monitor</td></tr>
<tr><td>Description</td><td colspan="5">There is a risk that future tariff changes will be more challenging:-
▪ Tariff for specialist services in 2015/16 proposes that over performance against a 2014/15 baseline will only be funded at 70%. This represents a serious potential threat to St. George's long term financial plans
▪ Local Tariff changes e.g. proposed reductions in charges for Sexual Health services & Community Cost & Volume tariffs for services, for example, delivered from Queen Mary's Hospital Roehampton.
▪ The major trauma service fails to achieve best practice tariff
▪ Risks of CCGs not paying for increased income assumption based on improved coding e.g. for obstetrics</td></tr>
<tr><td>Domain</td><td colspan="3">2. Finance & Operations</td><td>Strategic Objective</td><td>2.1 Meet all financial targets</td></tr>
<tr><td></td><td>Original</td><td>Current</td><td>Update Mar 2015</td><td>Exec Sponsor</td><td>Steve Bolam</td></tr>
<tr><td>Consequence</td><td>3</td><td>4</td><td>4</td><td>Date opened</td><td>01/12/2012</td></tr>
<tr><td>Likelihood</td><td>4</td><td>5</td><td>5</td><td>Date closed</td><td></td></tr>
<tr><td>Score</td><td>12</td><td>20↑</td><td>20</td><td></td><td></td></tr>
<tr><td>Controls & Mitigating Actions</td><td colspan="3">Controls
▪ Influence the development of future tariffs and related service specifications
▪ Active membership of Project Diamond provides the Trust with a London wide voice to reflect Tertiary Hospital views in the development of the tariff.
▪ Active membership of FT Network.
▪ Negotiation with commissioners.
▪ Agreement to phased introduction of change through SLA negotiation process will mitigate impact. Where local tariffs are reduced, trust to negotiate for compensatory changes in other, less favourable tariffs where commissioners currently benefit, seeking to ensure a reduced overall impact Opportunities to offset loss e.g. through bidding for whole pathway tariffs, or through reviewing structure of service, are identified

Mitigating actions:
Divisions, services where tariff loses impact on overall service financial baseline to develop plans to review productivity opportunities, remove costs, and identify opportunities to grow activity at marginal cost. Where local tariffs are reduced to such an extent that the service</td><td>Assurance</td><td colspan="2">External reviews:- E&Y report on the impact of the current tariff structure for members of Project Diamond has been acknowledged by D Flory and has resulted in explicit tariff subsidies for major London Trusts</td></tr>
</table>

	becomes recurrently loss making, to review overall service viability and make decisions around longer term service structure Participation in Monitor 2013/14 PLICs voluntary data collection Trust has objected to 2015/16 tariff proposals and is on 14/15 tariffs for 2015/16 by default with the loss of CQUIN incomes that results		
Gaps in controls	▪ Pathway based service costing. ▪ Benchmarking of Local Tariff Services - Identifying those services which currently attract a relatively high local tariff will enable the Trust to examine opportunities to address future risk.	**Gaps in assurance**	
Actions next period:	▪ Negotiations with commissioners managed by Director of Finance with regular reporting to Trust Board ▪ Engagement with Project Diamond group to develop a response to DOH/NHSE tariff proposals over MFF ▪ Development of database solution to ensure long term capture of major trauma activity – for completion by end 2014/15 ▪ Lobbying with other NHS organisations to ensure tariffs for 2015/16 appropriately remunerate tertiary trusts for high end clinical work. ▪ Follow up tariff consultation process and objections depending upon Monitor/NHSE response ▪ Joint work with CCG to understand implications of withdrawal of maternity CQUIN in particular and impact of loss of CQUIN fuinding on quality more generally		

Principal Risk	2.3-O5 Tariff Risk – CQUIN Premium. Trust income is not maximised due to failure to deliver required performance against CQUIN quality standards.				
Description	CQUINs are not met at the level that the trust has assumed in its financial plans - in 2015/16 Maternity will no longer receive CQUIN funding with this being replaced by a CCG local tariff. Value circa £1.8M in 2015/16 - Future requirements not adequately identified. -Insufficient investment made in delivery				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update Mar 2015**	**Exec Sponsor**	Steve Bolam
Consequence	4	4	4	**Date opened**	01/12/2012
Likelihood	4	2	5	**Date closed**	
Score	16	8	20		

Controls & Mitigating Actions	Controls Governance Arrangements ▪ Build expected level of CQUIN non-achievement, 15%, into financial baseline for the trust. Trust met 87% of CQUIN target in 2013/14 so surpassing internal target by 2%. ▪ Leads identified for each CQUIN	**Assurance**	Internal Audit in 2011 highlighted CQUIN performance insufficiently resourced. Two additional central posts (one nursing, one admin) appointed to assist in the delivery of CQUINs on the wards Commissioners agreed 95% CQUIN achievement as part of year end statement

	▪ CQUIN leads share reports on trust wide CQUINs with DDNGs to feed into divisional meetings. Assessment of risks related to each CQUIN shared with DDOs who are asked to develop mitigating action plans. ▪ Performance monitoring of CQUIN performance to ensure early identification of any variance from plan and identify and implement remedial actions. ▪ CQUIN achievement considered at quarterly divisional performance reviews. ▪ Investment in Delivery e.g. TB nurse recruitment ▪ Appropriate requirements are identified by divisions in Business Planning process – overseen by Business Planning Implementation Group and reported to EMT. ▪ For maternity – on-going discussions with CCGs to ensure that non-recurrent expenditure is met from recurrent CCG funding, minimising any overall loss to the trust. Mitigating actions: 1.Invest resources in – year to improve CQUIN performance, based on a cost-benefit analysis of undertaking that investment 3.Year End Settlement discussions – the level of risk relating to CQUINs is mitigated by agreement with commissioners to a year-end settlement, managed through the SLA negotiation process		
Gaps in controls	CQUIN performance is insufficiently embedded in Divisional Governance structures. Accountability and performance management arrangements need to be improved and adequately resourced.	**Gaps in assurance**	
Actions next period:	▪ Finance & Performance Committee now receives quarterly CQUIN Performance Report to give Board sub-committee oversight. ▪ Next step is to develop CQUIN performance dashboard/oversight process at Divisional level ▪ Identify all areas of income and spend supported by CQUIN funding and understand action exit plan and/or mitigation		

Principal Risk	3.4-O5 The Trust faces higher than expected costs due to higher marginal costs - higher than expected investment required to deliver service increases.				
Description	The additional costs of delivering increased activity are higher than expected due to: •Poor cost estimates •Premium costs of securing increases in capacity outside normal hours or in the private sector				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update Mar**	**Exec Sponsor**	Steve Bolam

			2015		
Consequence	3	3	4	**Date opened**	01/12/2012
Likelihood	3	3	4	**Date closed**	
Score	9	9	16		

Controls & Mitigating Actions	Controls ▪ Marginal costs of additional activity are identified through the Business Planning process, which is overseen by the Business Planning Steering Group and reported to EMT. Prudent costing approach identifying only site and trust level infrastructure and management costs as fixed. ▪ Costs are based on data from robust historical costing systems including PLICS and Reference Costs which have been calculated in line with national guidance. ▪ Capacity requirements of additional activity are identified through the Capacity Management element of the Business Planning process, overseen by the Business Planning Steering Group and reported to EMT Short term funding for premium costs of temporary increases in demand is negotiated with commissioners through SLA negotiation process. SLA negotiation is escalated to FD/CE and reported to Finance and Performance Committee. Business case approval process rigorously tests income and expenditure assumptions for new developments, minimising the risk of cost pressures developing as a result of new service developments	**Assurance**	.
Gaps in controls	Divisional use of PLICS and SLR data not as complete as required.	**Gaps in assurance**	Insufficient understanding of where steps in fixed costs are incurred Shortfall in capacity for 15/16 and costs for addressing look to be unaffordable to the system
Actions next period:	Document PLICS strategy Implement agreed implementation plan for PLICS Further work with SRG on capacity, costs and mitigations. Agree joint demand and capacity plan.		

02-01

410-02

Principal Risk	3.3-O5 Cost Pressures - The Trust faces higher than expected costs due to:- •unforeseen service pressures •higher than expected inflation

Description	The Trust has to meet costs of unforeseen changes in service requirements for example the on-going and evolving understanding of meeting requirements associated with Francis Report outcomes or other compliance requirements. The cost of meeting new and existing service standards are higher than expected. Inflationary cost pressures are greater than expected e.g. changes in energy costs. In addition, costs incurred from the usage of private sector capacity to deliver waiting time targets or services out of hours, will increase marginal costs and decrease contribution from individual services e.g. Cardiology and Cardiac Surgery				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update Mar 2015**	**Exec Sponsor**	Steve Bolam
Consequence	4	4	4	**Date opened**	01/12/2012
Likelihood	4	4	4	**Date closed**	
Score	16	16	16		

Controls & Mitigating Actions	Controls ▪ The expected impact of cost pressures on financial performance is considered as part of the Trust's business planning process. Robust provisions are made for future increases in cost in line with high level Guidance from Monitor. ▪ Adequate Contingency Reserves are set aside in line with NHS Guidance at 1% of Turnover ▪ The business planning process is overseen by Business Planning Steering Group which reports to EMT. ▪ Cost pressures are monitored in-year through the financial reporting regime. New pressures are identified as early as possible and the financial impact is reported to the Finance and Performance committee. ▪ Reduced use external capacity by better capacity planning and management of internal resources. **Mitigating actions** Development of In Year Recovery Plans if required, recovery plans are formulated in response to monthly forecasts produced as part of financial reporting process. The Trust has a number of actions it can deploy to recover its financial position if it is adversely affected by cost pressures, e.g. vacancy freezes, controls on discretionary expenditure, etc.	**Assurance**	The Trust has a good track record of delivering its financial targets in recent years. Cost pressures in 14/15 are high as a result of further compliance, staffing and other imperatives. Choices have been made on which top priority pressures must be funded. This is expected to continue to be an issue going forward
Gaps in controls	None identified	**Gaps in assurance**	

Actions next period:	New pressures are identified as early as possible and the financial impact is reported to the Finance and Performance committee. 2015/16 Business Planning process +has started. The process will identify 2015/16 and 2016/17 cost pressures and CIP programmes and efficiency gains to offset these additional costs

Principal Risk	02-01 Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)- Currently under revision following QRC deep dive				
Description	As Cost Improvement Programmes continue to be rolled out, there is a potential risk that inadequate identification, monitoring and mitigating actions will fail to ensure that quality of care is preserved.				
Domain	**1.Quality**			**Strategic Objective**	**1.2 Patient Experience**
	Original	**Current**	**Updated May 2015**	**Exec Sponsor**	Simon Mackenzie
Consequence	4	4	4	**Date opened**	01/07/2013
Likelihood	4	4	4	**Date closed**	
Score	16	16	16		

Controls & Mitigating Actions	All combined schemes (divisional improvement programmes, run rates) must have a Quality Impact Assessment covering 5 dimensions (5x5 risk scoring): - Patient Safety - Patient Outcome - Patient Experience - Staff welfare - Financial impact Combined schemes are subject to local governance scrutiny and approval, at care group, directorate and divisional level; overseen by Divisional triumvirate including Divisional Chair, Divisional Director of Operations and Divisional Director of Nursing & Governance. CGG chaired by Medical Director – all schemes with risk score over 12 also referred for consideration for approval by CGG. CGG is dynamic. CGG reports exceptional risks to QRC. Process of assurance feeds up from DGBs not just Risk Registers Divisions encouraged to bring run-rate schemes. Divisions make a self-declaration upon management of schemes not presented to CGG	**Assurance**	Positive assurance: External scrutiny of process by Trust Board, commissioners. Each scheme has KPIs related to their risk registers which are regularly reviewed. High level governance structure robust Clinical Procurement management Committee now reports to CGG Evidence that this mechanism has led to review and modification or rejection of proposals
Gaps in controls	Potential that not all risks are recognised and that 5x5 risk scoring application is inconsistent across divisions. Reliance upon divisions recognising clinical risks	**Gaps in assurance**	Relies on robust divisional governance structure – recent divisional governance review identified that historically, not all CIPs which impact upon quality of care receive

	Insufficient mitigations & increased pressure to deliver CIPs may result in less rigorous application of QIA process. Not picking up cross Trust schemes adequately – these to commence coming to CGG i.e. capacity		received nursing/clinical sign-off.
Actions next period:	Continued oversight by CGG and refinement of CGG process Trust wide scheme to come to CGG		

Principal Risk	A410-O2: Failure to sustain the Trust response rate to complaints				
Description	Risk of failure to deliver a sustained ability to turnaround of complaints within agreed timescales, also to maximise the learning from complaints. Negative impact on the Trust's reputation and loss of patient and public confidence				
Domain	**1.Quality**			**Strategic Objective**	**1.2 Patient Experience**
	Original	**Current**	**Update May 2015**	**Exec Sponsor**	Jennie Hall
Consequence	4	4	4	**Date opened**	30/04/2009
Likelihood	4	4	4	**Date closed**	
Score	16	16	16		
Controls & Mitigating Actions	Weekly spread-sheet detailing care group response times circulated. Included as a measure within the divisional performance scorecard. LEAN review of complaints process. Greater oversight of complaints by DDNGs Regular reporting via PEC, QRC & Trust Board. Implemented a risk rating system to identify high risk complaints. Complaints action Plan in place from November 2014 focussing on 5 key areas to ensure improved turnaround of complaints but also to strengthen learning and organisation capacity to deal with complaints. Trust performance reviewed by PEC every 2 months Reported to TB monthly			**Assurance**	Moderately improved performance across all divisions in quarter three (66 – 72%). Performance against 25 day timescale is currently below 85% - internal Trust standard, internal trajectory to deliver performance against internal standards Quarterly performance review with Divisions and monthly performance review from October 2014 undertaken by the Chief Nurse with the DDNGs. Detailed thematic analysis at care group level to ensure causes of complaints are well understood has been provided to divisions. Focus is on actions being put in place that lead to improvements (and therefore a reduction in complaints).
Gaps in controls				**Gaps in assurance**	
Actions next period:	Divisions with high volume of complaints, i.e. STNC, CWDT and Medcard have weekly meeting with care groups All divisions to continue to implement improvement plan (with trajectory) to improve response rate Draft further survey of complainants to obtain feedback in line with new CQC requirements upon complaints handling				

Principal Risk	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)				
Description	Ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)				
Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Update**	**Updated May 2015**	**Exec Sponsor**	Eric Munro
Likelihood	5	4	4	**Date opened**	14/03/2013
Consequence	3	4	4	**Date closed**	
Score	15	16	16		
Controls & Mitigating Actions	Robust action plan in place being led by the fire safety team and monitored through the Health, Safety & Fire Committee. Regular meetings/communication with Fire Brigade to check progress. Specialist fire safety resource in place to lead on the actions. Planned and reactive monitoring of fire safety. Fire risks assessments (FRAs) prepared by Fire Safety Specialists and issued to space/premises managers			**Assurance**	Reporting on fire risk assessments to Health, Safety and Fire Committee and escalate any issues to the Organisational Risk Committee. LFEPA regularly visit usually on a quarterly basis Head of Estates Compliance now in post Two permanent Fire Officers in post (April 15)reporting to Head of Estates Compliance
Gaps in controls	Comprehensive surveys and assessments of compartmentation. There remains a gap in ensuring there are responsible persons identified for all individual areas subject to FRAs.			**Gaps in assurance**	Not all staff appropriately trained to increase rate of compliance • General staff • Fire Marshalls Key performance indicators are required for reporting to Health safety and Fire committee, ORC and QRC.
Actions next period:	Implement action plan in period. (Fire risk assessments, training, infrastructure, governance). Monitor progress through Health, Safety & Fire Committee and via Organisational Risk Committee.				

Principal Risk	03-02 Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation				
Description	There are gaps in the mandatory and statutory estates compliance documentation. There is a lack of written evidence and historical data of compliance demonstrating that planned and reactive maintenance is being undertaken.				
Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Current**	**Updated May 2015**	**Exec Sponsor**	Eric Munro
Likelihood	4	4	4	**Date opened**	October 2012
Consequence	4	4	4	**Date closed**	
Score	16	16	16		

Controls & Mitigating Actions	Revised estates permanent management structure is in place this includes a compliance manager. Planet FM system (the estates helpdesk and job request system) is being upgraded to allow compliance to be monitored. An audit on the gaps in compliance has been completed. There is a planned programme in place to close the gaps in compliance.	**Assurance**	Estates compliance records being assembled. Action plan being monitored and progress updates to the Operational Management Team. Authorising engineers appointed across all main risk areas. This risk is monitored via the Health, Safety & Fire Committee and overseen by the Organisational Risk Committee. Head of Estates Compliance now in post
Gaps in controls	The action plan will be further developed as higher risk items are closed.	**Gaps in assurance**	Full compliance reports not yet available.
Actions next period:	Await final internal audit report (Jan 2015) and implement the actions from arising. To ensure that regular updates are provided to the committees monitoring this risk.		

Principal Risk	03-03 Lack of decant space will result in delays in delivering the capital programme.				
Description	Lack of decant space for capital schemes delays the ability to deliver large capital schemes.				
Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Current**	**Updated May 2015**	**Exec Sponsor**	Eric Munro
Likelihood	4	4	4	**Date opened**	May 2014
Consequence	4	4	4	**Date closed**	
Score	16	16	16		

Controls & Mitigating Actions	Risk assessments undertaken for each project. Space surveys are undertaken on an annual basis to provide room usage data to enable the project manager to work out a plan. Monitored through the Capital Programme Board & Project Programme Board Detailed decant plans will sit under the Trust's Development Control Plan Mitigating Action: The Trust received full Planning permission for the new Wandle annex – 4 storeys c 5000m2 in February 2015.	**Assurance**	Documented risk assessments Capital project delivery is reviewed through Capital Programme Board & Project Programme Boards.
Gaps in controls	Short term planning brings forward new priorities that unbalance existing plans.	**Gaps in assurance**	Financial position may mean potential inability to finance mitigating actions
Actions next period:	The list of space requests are being collated to assess the requirements. This will form the basis to find and agree the location of a decant space. There is work underway to deliver a portakabin to move transactional staff out of clinical areas and release space for redevelopment.		

Principal Risk	01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results				
Description	Should the Trust fail to ensure robust mechanisms for the timely and appropriate follow up of all diagnostics tests undertaken and critical test results eg blood tests , cell path and radiology this may result in adverse impact upon patient care in terms of delays in treatment				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated May 2015**	**Exec Sponsor**	Simon Mackenzie
Consequence	4	4	4	**Date opened**	16.7.14
Likelihood	4	4	4	**Date closed**	
Score	16	16	16		

Controls & Mitigating Actions	All doctors have been reminded of their responsibility for ensuring that tests that they order are followed up. All Care Groups have been asked to develop Standard Operating Procedures to ensure that this happens. All serious incidents resulting from failure to follow up tests have been reviewed and themes reported to Divisions. Radiology have strengthened their safety net system. This now includes e mail to MDT for unexpected cancer (cancer MDTs are working through their responses to these alerts Cerner order comms system has ability to undertake and record result endorsement for tests organised via order comms. Project group set up including IT, operations and service improvement to improve process of results endorsement on Cerner and roll it's use out in Trust.	**Assurance**	Whilst actions have been taken as described, and most Care Groups have SOPS in place, there have been further instances of serious incidents due to failure to follow up test results. This indicates that significant risk continues. Chief Clinical Information Officer (CCIO) has developed a proposal for electronic sign off
Gaps in controls	Some SOPs are outstanding and the effectiveness of others has not been verified. There are a number of practical issues which need to be resolved before we can use IT to ensure test endorsement at present which include: Not all tests on Cerner, consultant attribution often incorrect, large backlogs of unendorsed results, delays getting results to cerner with some provisional results appearing earlier on EPR, ease and familiarity of EPR vs Cerner use, presence of historical data on EPR but not Cerner. These are being worked upon.	**Gaps in assurance**	Some Care Groups have not developed SOPs and implementation is not confirmed.
Actions next period:	CCIO proposal to be endorsed by Divisional Chairs and implementation plan developed. All divisions to present at PSC in May/June		

Principal Risk	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- payment challenges				
Description	Targets or KPIs within the contract are not met and the level of financial penalties is higher than anticipated. Main KPIs are:-1st to FU ratios-Re-admission rates. In 2014/15 risk around Cardiac activity related to non-achievement of 18 week standard. The level of payment challenges due to data quality issues is higher than anticipated. Main data issues are:--Multiple 1st OP appointments-Ensuring correct recording of Emergency and Other Non-Elective method of admission. Risk in 2014/15 around payment challenges associated with major trauma service and not achieving best practice tariff				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update Mar 2015**	**Exec Sponsor**	Steve Bolam
Consequence	5	4	4	**Date opened**	01/12/2012
Likelihood	3	4	4	**Date closed**	
Score	15	16↑	16		

Controls & Mitigating Actions	Controls Governance Arrangements: ▪ Good clinical engagement in local KPI target setting e.g. 1st to Follow up OP ratios, consultants are signed up to the levels in the contract. Much clinical engagement in the joint readmissions audit, to set the threshold appropriately. The budget for the level of challenges is based on challenges levied in prior years. Divisions are sighted on their level of budgeted challenges and the actions they must take to prevent challenges or to mitigate them. ▪ Negotiation of appropriate and realistic thresholds and targets with local CCG's to minimise trust exposure to challenges. ▪ Training of staff & data validation routines ▪ Ensure that data is recorded and charged for appropriately and that PbR Guidance is followed e.g. that OP appointments are appropriately recorded as First or Follow Up and that the correct method of admission is recorded for non-elective patients ▪ For Major trauma tariff new admin team recruited to ensure that activity accurately captured and coded. Mitigating Actions: ▪ Utilise clinical expertise to explain changes and challenge penalties imposed by CCG's. ▪ Year End Settlement discussions – the risk of income losses relating to further in-year challenges is mitigated by agreement with commissioners to a year-end	**Assurance**	In year performance monitoring of level of both accepted and rejected challenges, Current performance is within the budgeted levels.

	settlement through the SLA negotiation process.		
Gaps in controls	The Trust needs to more pro-actively identify specific areas of risk ahead of challenges e.g. Chemotherapy charges	**Gaps in assurance**	Readiness for proposed 15/16 penalties re provision of data
Actions next period:	▪ Good clinical engagement in local KPI target setting E.g. 1st to Follow up OP ratios, consultants are signed up to the levels in the contract. Much clinical engagement in the joint readmissions audit, to set the threshold appropriately. ▪ The budget for the level of challenges is based on challenges levied in prior years. ▪ Divisions are sighted on their level of budgeted challenges and the actions they must take to prevent challenges or to mitigate them. ▪ Cardiac review of skill mix, capacity and referral patterns to address 18 week underperformance ▪ New database solution agreed for Major trauma activity – to be in place by end 2014. ▪ Assessment of organisational status vs proposed 15/16 penalty regime		

Principal Risk	3.8-06 Low compliance with new working practices introduced as part of new ICT enabled change programme				
Description	Partial adoption of new working practices could lead to inconsistencies in management of patient care. Failure to conform to new operational procedures could lead to decrease in organisational efficiency.				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.2 Meet all performance targets**
	Original	**Current**	**Update Mar 2015**	**Exec Sponsor**	Steve Bolam
Consequence	4	4	4	**Date opened**	02/06/2013
Likelihood	3	4	4	**Date closed**	
Score	12	16↑	16		
Controls & Mitigating Actions	Each project within ICT programme is:- Managed using PRINCE methodology- Has a clinical lead- Reports to clinical systems programme board- Has individual risks and issues register managed on-going Director of FPI is SRO and sits on programme board. Regular programme board reports to Executive Management team Programme board highlight reports to EMT include RAG status and provides assurance project on track – this reporting mechanism promotes transparency and challenge Chief Clinical Information Officer in post 18 Champion Users seconded to support deployment Mitigating actions centre upon phases of engagement:- Involve clinical staff/health care groups in system design- Healthcare groups involved in implementation- H/care groups involved in endorsement of new working practices Weekly (monday) i-clip meeting now takes place and all issues fed back live			**Assurance**	Programme Board highlights reports to EMT to include RAG status and provides assurance project on track. Chief Information Officer in post 18 Champion users seconded to support development Now over-arching clinical governance in place, including clinically led gateway review of ICT clinical programme 15 of the secondments have ended with clinical champions returned to their substantive roles

Gaps in controls	Ensuring full and representative health care professionals' input into key areas Some constraints of operating within national programme for IT framework	**Gaps in assurance**	
Actions next period:	Development of process for transition of clinical information projects into business as usual via the ICT Service Improvement Programme. Ensure lessons learned are captured during pause period		

Principal Risk	3.9-06- Risk of inappropriate deployment of e-prescribing and electronic clinical documentation				
Description	There is a risk that if e-prescribing and electronic documentation is inappropriately deployed this will have an adverse impact on patient care and clinical continuity.				
Domain	**2. Finance & Performance**			**Strategic Objective**	
	Original	**Current**	**Update Mar 2015**	**Exec Sponsor**	Steve Bolam
Consequence	4	4	4	**Date opened**	1.7.14
Likelihood	3	4	4	**Date closed**	
Score	12	16↑	16		
Controls & Mitigating Actions	Deployment project being managed with PRINCE 2 methodology Clinical lead in place to ensure clinical input on programme board Gateway thresholds established for technical readiness and staff readiness Each clinical area has a task group with a clinical lead who has power to sign off to roll out in their area Overall deployment is subject to regular gateway reviews.			**Assurance**	Reporting on progress of project to Clinical Information Systems Programme Board On-going modification of deployment plan in response to lessons learned from early adoption means project is flexible and responsive to ensure success. Deployment model broadly successful but sustainability to end point currently not viable Early indications are that in areas where deployment has taken place quality has improved as well as revealing/creating challenges to existing practice Deployment system paused until 2015/16 which brings further risk of operating dual systems for longer than planned Clinical systems Progarmme Board currently reviewing options for completion of deployment in order to make a recommendation to EMT in April 2015
Gaps in controls				**Gaps in assurance**	None identified
Actions next period:	Continue to react to feedback On-going changes to project and implementation as a result of lessons learned.				

Appendix 3 – Divisional Extreme Risks

Risk Ref.	CW&DT Risk	Score	May 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	→	New trolleys have arrived – risk likely to be reduced after agreement at next DGB
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	→	Score to be agreed at May DGB but anticipated to be extreme
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	NEW	
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	↑	Risk increased in Jan 15 following an SI

MC31-D5	Risk to patient safety as patients waiting greater than 18 weeks on elective waiting list for Cardiac surgery, Thoracic Surgery and Vascular Surgery.	**15**	→	
MC32-D1	The division is at risk of not delivering a balanced budget if robust CIP schemes are not found. Not all schemes identified in 14/15 have delivered and therefore knock on effect for schemes in 15/16.	**15**	→	
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**	**NEW**	
	STN&C		**Change**	
Risk Ref.	**Risk**	**Score**	**↑↓**	
B253	SSD risk upgraded in light of recent significant failures and down time of SJW equipment. On-going issues. 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**	**NEW**	
	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	**16**	→	

	and will not need the demand as the building is re-developed and refurbished to 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 TRUST BOARD - May 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 two governance statements outlined due to be submitted by 29th May.
Document previously considered by:	N/A

Key Messages

The 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 are to be submitted by 29th May;
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 two statements required to be submitted by 29th May, 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 two 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 1: The Board is satisfied that the trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

Statement 2: The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time

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.

The assurances for declarations 4, 5 and 6 will be presented to the next board meeting in June.

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
1. The Board is satisfied that the trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Internal controls and assurance** • Standing orders and scheme of delegation in place setting out standard operating procedures for the Board and sub-committees; • Self-evaluation of the effectiveness of board sub-committees completed annually; • Terms of reference for board sub-committees reviewed annually; • Board composition consists of a majority of independent non-executive directors; • Director of Corporate Affairs & Trust Secretary in post to advise the board on good corporate governance; • Appointment of a Senior Independent Director; • Trust constitution approved by Board of Directors and Council of Governors; • Corporate Governance section of Annual Report outlining Code of Governance compliance; • Audit & Board approved Annual Governance Statement and Auditors' opinions; • Board agendas and sub-committees covers all domains of performance – quality, finance, workforce, operations and risk; • Board and QRC review of risk register each month • Information Governance Toolkit self-certification and implementation work; • Standards of Business Conduct policy in place; • Review of whistleblowing procedures by audit committee every six months; • Internal audit plan and audit committee workplan approved by audit committee and board; • Revised risk management strategy approved by QRC and board; • Board completion of declarations of interest annually and at each board meeting; • Review of divisional governance arrangements completed February 2014. **External assurance** • QGAF self-assessment and external assurance by Deloitte • BGAF self-assessment and external assurance by Deloitte • External Audit Opinion – annual report and quality accounts • Head of Internal Audit Opinion and audit of quality indicators • CQC CIH inspection February 2014 and monthly Intelligent Monitoring Reports presented to board; • Historic due diligence assessment by Ernst Young 2014, including financial reporting (governance)

	arrangement; • Monitor Provider Assessment Team assessment of board and governance arrangements as part of trust's foundation trust authorisation.
2. The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	• Monitor's monthly bulletin circulated to all executive directors with actions assigned accordingly; • Agreed protocol in place for the relationship management with Monitor compliance team and for submission of required returns; • Board performance reports reviewed against Monitor's Risk Assessment Framework; • Trust annual report includes statements of compliance against Monitor's Code of Governance; • Trust's assurance framework is being redeveloped, to be modelled around Monitor's 'well led framework' published April 2015

Enclosure:

St George's Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD 28th May 2015 Paper Ref:

Paper Title:	Care & Environment Report
Sponsoring Director:	Eric Munro, Joint Director Estates & Facilities
Author:	Sharon Welby, Assistant Director Capital Projects
Purpose:	To update the Board on progress with improving care and the environment across the Trust
Action required by the board:	For information
Document previously considered by:	None

Executive summary

1. **Key messages:** Improvements to the Hospital Environment & Medical Equipment from14th February 2015 to 7th May 2015

Capital Developments:

The Wolfson Neuro-rehabilitation Centre relocation to Queen Mary's Hospital Project Value: £4.2m
The Wolfson Neuro-rehabilitation Centre at Queen Mary's Hospital has been expanded to provide an enhanced space for patients receiving specialist and multi-disciplinary therapy following acquired neurological conditions that result in physical or psychological disabilities. Work has been completed to enhance the existing accommodation and extend into vacant space to create an additional 16 inpatient beds, 2 rehabilitation gyms, therapy and treatment rooms in addition to a dedicated dining space, OT kitchen and patient lounge that support patient's progression from the inpatient setting to the home environment. Day patient spaces have also been developed, with the department moving into space vacated by teams moving to 166 Roehampton Lane to create the Wolfson Assessment Centre; providing a comprehensive service for cognitive and vocational rehabilitation at all stages of the care pathway.

Specialist physiotherapy equipment for use during a patients' rehabilitation programme have been purchased by the Trust in addition to new beds and clinical support equipment to accommodate the increased occupancy of the unit. Patient Dispensing Lockers for self-administration of medication have been provided to facilitate the growth of independent development and new furniture throughout the therapy and treatment rooms, dining room spaces and OT kitchen have been included within the project delivery. A Wi-Fi system has been incorporated into the patient and therapy areas to support the vocational rehabilitation programmes and provide flexibility to the multi-disciplinary clinical teams using the space. All equipment purchased as part of the development has been added to the lifecycle maintenance contract forming the PFI agreement, providing diagnostic support and repair throughout the assets expected lifespan.

The project was delivered through a variation to the existing PFI arrangement with Roehampton Hospitals Plc and NHS Property Services. Sodexo are responsible for the soft FM provision for the development with Cofely providing the construction and hard FM support.

CT Replacement, second floor, Atkinson Morley Wing: Project value £1,170,000
The Neuro CT scanner in AMW was replaced with a new scanner. This replaces an aged system and will ensure that there is no lost activity or delays to patient treatment due to mechanical breakdowns. Work completed February 2015

Enclosure:

Microbiology Laboratory Kiestra, 1st floor, Jenner Wing (part of the final phase of works for South West Pathology): Project Value £245,000
The works have provided the accommodation and installation of a new Kiestra machine with increased capacity that will allow the microbiology department to double their testing capacity. The final phase of works started in February 2015 and completed in March 2015. The Kiestra, laboratory robotics, is the largest of its kind in Europe.

Lanesborough Wing, Dragon Centre, Clinical Room 0.089: Project value £18,000
To split 1 large clinical room into two consulting rooms, to enable Consultants to be able to see more Paediatric patients and reduce waiting times. The work involved erecting a soundproofed stud wall, installing a new door onto the corridor and replicating sanitary ware, desking etc.

Caroline Ward staff room: **Project value £40,000**
Caroline ward, AMW Level 3 has now been offered larger staff room by combining two offices. This room will not only offer rest space for Caroline ward staff but also to the additional nursing staff for the proposed cardiology elective ward.
This offers shared facilities and provides additional space for staff lockers.

Scanning Bureau: Project value £175,000
As part of EDM roll-out project, the scanning bureau has now been moved from lower ground AMW to ground floor Grosvenor wing within the health records footprint. These works were facilitated as part of the health records off-site decant project which has resulted in space to accommodate the bureau.

Capital medical equipment purchased from 14th February to 7th May 2015

Description of Investment	Total costs incl VAT	Reason for purchase
Two transport ventilators for the neonatal unit	£20,000 (charity purchase)	Replacement of old ventilators and improvement on accuracy of pressure measurements.
Ultrasound scanner + probes for Da Vinci robotic surgery	£71,500 (charity purchase)	New system to improve image quality and speed in robotic surgery.
Pharmacy drugs manufacturing management software and labelling system	£78,000	Replacement of old system which will provide the pharmacy manufacturing staff greater security in label production, governance and financial accountability.
Ultrasound scanner for Radiology	£76,400 (lease)	Replacement of old equipment. New scanner has elastography capabilities bringing the service up to speed with modern practice.
Mortuary trolley	£8,000	Replacement of old trolley and reduce manual handling risks.
Fibrescope for cardiac theatres	£16,300	Required for the expansion of thoracic surgery service.
Stack system for ENT theatres	£77,600 (lease)	Replacement of old and unreliable equipment.

Ultrasound scanner for Paediatric theatres	£26,500 (lease)	To keep up with increasing service demands.
Collinear clamp for T&O theatres	£6,400	To improve surgical techniques. Very good for minimally invasive reductions, lowering surgical time and post-op pain.
Ultrasound scanner for vascular surgery	£20,000	To adhere with current aneurysm scanning standards.
Equipment for the Nelson hospital	£35,000	Starting of new service at the Nelson hospital. Please note most of the other items have been ordered but not receipted and so will appear in the next set of updates.
Equipment for the Nelson hospital	57,000 (lease)	Starting of new service at the Nelson hospital. Please note most of the other items have been ordered but not receipted and so will appear in the next set of updates.

On top of this various purchases have been made for the continuation of the multi-parameter monitors' standardisation project.

2. **Recommendation:** The report is for information purposes only. The Board are asked to note the improvements to the environment and medical equipment since February 2015.

Key risks identified:

None

Related Corporate Objective:	Strategic Aim no.6 - Continually improve our facilities and environment. Objective 19 - To continually improve efficiency of Estates and Facilities Services
Related CQC Standard:	Regulation 15

Equality Impact Assessment (EIA): Has an EIA been carried out? (Yes)
If yes, please provide a summary of the key findings If no, please explain you reasons for not undertaking and EIA.

Appendix A:

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

- Better heath outcomes for all
- Improved patient access and experience
- Empowered, engaged and well-supported staff
- Inclusive leadership at all levels

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment

1.1 Who is responsible for this service / function / policy?
Eric Munro

1.2 Describe the purpose of the service / function / policy?
To improve the environment of the estate.

1.3 Are there any associated objectives?
Patient Led Assessment of the Care Environment (PLACE)

1.4 What factors contribute or detract from achieving intended outcomes?
N/A

1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability (physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Region or belief and Human Rights

No

1.6 If yes, please describe current or planned activities to address the impact.

1.7 Is there any scope for new measures which would promote equality?
N/A

1.8 What are your monitoring arrangements for this policy/ service
N/A

1.9 Equality Impact Rating

2.0. Please give you reasons for this rating