St George's University Hospitals NHS
NHS Foundation Trust

MEETING OF THE TRUST BOARD

30 July 2015, 12 – 14.30

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

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

Christopher Smallwood, Chair

		Presented by	
1.	**Chair's opening remarks**		
2.	**Apologies for absence and introductions** Mike Rappolt, Sarah Wilton, Kate Leach, Steve Bolam		
3.	**Declarations of interest** *For Members to declare if they have any interests as individuals or members of other organisations that might relate to Trust business or items on the agenda.*	C Smallwood	
4.	**Minutes of the previous Meeting** *To receive and approve the minutes of the meeting held 28 May 2015*	TB (M)	
5.	**Schedule of Matters Arising** *To review the outstanding items from previous minutes*	TB (MA) July 15 - 01	
6.	**Chief Executive's Report** *To receive a report from the Chief Executive, updating on key developments*	M Scott TB July 15 - 02	
7	**Quality and Performance**		12.30
7.1	**Quality and Performance Report** *To receive assurance regarding actions being taken to improve the quality of care for patients and to review the Trust's operational performance report for Month 3*	J Hall/M Wilson TB July 15 - 03	
	To receive a verbal report from the Quality & Risk Committee seminar held on 29 July 2015	S Wilton	
7.2	**Final report from joint investigation re RTT & A &E**	M Wilson TB July 15 - 04	
7.3	**Finance Report** • *To receive the finance report form month 3* • *To receive an oral report from the Finance & Performance committee held on 26th August 2015*	S Milligan TB July 15 - 05	
7.4	**Workforce Performance Report** *To received month 3 workforce report*	W Brewer / S Pantelides TB July 15 – 06a/6b	
	To receive an update from the Workforce and Education Committee meeting 23 July 2015		
7.5	**Quarter 1 performance submission to Monitor**	P Jenkinson TB July 15 - 07	
	BREAK		13.45
8.	**Strategy**		14.00
8.1	**Quarter 1 Corporate Objectives Monitoring Plan 2015/16**	R Elek / T Ellis TB July 15 - 08	
9.	**Governance**		14:15

9.1	**Risk and Compliance Report**	P Jenkinson TB July 15 - 09	
9.2	**Report from Research Board**	J Hulf TB July 15 - 10	
10.	**General Items for Information**		14:30
10.1	**Use of the Trust Seal** *To note use of the Trust's seal during the period (July 2015) - The seal has not been used in July 2015.*		

10.2 Questions from the Public

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

11. Meeting evaluation

12. Date of the next meeting - *The next meeting of the Trust Board will be held on 29 August 2015 at 9.00am.*

MINUTES OF THE TRUST BOARD

Public 25th June 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	Chief Financial Officer
	Mrs Wendy Brewer	Director of Workforce
	Professor Jennie Hall	Chief Nurse / DIPC
	Mr Peter Jenkinson	Director of Corporate Affairs
	Professor 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
	Professor Peter Kopelman (For item 15.06.09 only)	Non-Executive Director
	Dr Judith Hulf	Non-Executive Director
	Mrs Kate Leach	Non-Executive Director
	Andrew Burn	Turnaround Director
	Mr Mike Rappolt	Non-Executive Director
In attendance:	Ian Elliott, PwC	
Apologies:		

15.06.01 Minutes of the previous meeting

The chairman welcomed governors and other members of the public to the meeting. 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.

15.06.02 Declarations of interest

No interests relating to agenda items were disclosed.

15.06.03 Minutes of the previous meeting

The minutes of the meeting held on 28th May were accepted as an accurate record, subject to amendments: it was noted that Jane Ellison, MP, was not a member of the cabinet as minuted.

The board noted the concerns raised by Mrs Leach regarding never events and confirmed that the assurance on action being taken was through the quality and risk committee scrutiny; however details could be shared with other board members should they want it. It was noted that the quality triangulation would be included in the board development session in September.

15.06.04 Schedule of Matters Arising

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

The board noted that the action on the Ghana partnership had been completed **P Jenkinson**

and therefore the action removed. **July 15**

It also noted that the workforce session would be arranged for the next month, with a follow up to May's session but also including the Council of Governors and staff experience. **W Brewer / P Jenkinson July 15**

The board noted that the workforce recruitment target would be confirmed by September 2015. Ms Hall confirmed there is a Workforce plan in hand with actual numbers to be confirmed. **J Hall Sep 15**

The chairman asked what impact the recent announcement that immigrant nurses would have to return home would have on recruitment and retention. Mrs Brewer advised that the proposals were subject to consultation. The trust, like many other providers, would submit a strong response to this consultation but that tens rather than hundreds of staff would be affected.

Mrs Brewer also outlined the process to prepare for any new national controls or rules relating to agency staff

15.06.05 Chief executive's report

Mr Scott presented his report, highlighting key points. He reported that a preferred candidate had been identified for the appointment of a new principal of St. George's University of London, to be confirmed at the university's council meeting in July. He also reported that the trust was participating in a pilot project with the immigration service, piloting new methods to identify overseas patients and entitlement to treatment. It was also noted that the Department of Health and the Border Agency had entered into an agreement regarding commissioner payments for overseas patients which would reduce the risk to the trust of unfunded patients. It was agreed that an update on the pilot would be brought back to the board in three months. **S Bolam Sep 15**

Mr Scott reported that the partnership with GSTT and KCL for the development of genomic medicine was now up and running, and that Dr Francis Emslie had been appointed to the national clinical reference group for genetics.

Mr Scott welcomed the forthcoming visit to the trust by Wendy Reid, which would provide an opportunity to demonstrate the work being done in relation to education by the trust and university, and to discuss opportunities to expand and develop new roles. He also welcomed the award of trainer of the year to Dr Jonathan Round and Dr Helen Witheroe.

Mr Scott also highlighted the update from project Search. The project, providing work placements for students with learning disabilities, was now in its third year, and the trust was proud that it had employed a number of students from the project and the impact that those appointments had had on the areas where they worked.

The board also noted other achievements or celebrations, including the award of an OBE for Mr Sharma, for his contribution to reconstructive neurology, and the 100th anniversary of the Queen Mary's Hospital in Roehampton.

Mr Scott also reported on progress of the ongoing Monitor investigation, with its conclusion expected to be by the end of July in which Monitor would determine whether the trust had been in breach of its licence and any enforcement action to be taken. To inform the investigation, PwC were currently carrying out an

independent accounting review. The trust had already taken action to recover the financial position, appointing a turnaround director and additional support from KPMG to support in the delivery of the trust's recovery plan.

Mr Rappolt noted the visit by the Secretary of State to the Nelson and asked whether there was any feedback from the visit. Mr Scott advised that the visit was focused on primary rather than secondary care, as he was delivering a speech about GPs and seven day primary care services.

Mrs Leach asked whether there was any security risk arising from the joint initiative with the immigration service. Mr Bolam advised that the Home Office staff were merely supporting trust staff in carrying out their normal function and there was therefore no greater risk.

15.05.06 Quality and performance report

Performance

Mr Bolam presented the performance report for month 2, highlighting a deterioration in the trust rating to a 4 in Monitor's risk assessment framework. This was due to a failure to meet the two week cancer standard, as well as the continued failure to meet the A&E and RTT waiting time standards. He reminded the board that the A&E and RTT standards were subject to a joint investigation by the trust and commissioners, with the report and recommendations due to be published at the end of July. A review of the cancer standards, including an analysis of the causes for the deterioration in performance and remedial actions, would be completed the following week at a cancer performance meeting. This cancer review would also include a review of performance against the 62 day cancer standard, to provide assurance regarding the sustainability of meeting that standard.

Mr Bolam reminded the board that the trust's governance rating remained as 'under review' while Monitor's investigation continued. However scrutiny of the trust's operational performance would remain with the business-as-usual tripartite meetings.

Mr Bolam reported that the issues relating to diagnostic waits had been reviewed in detail at the finance and performance committee.

Mr Rappolt was concerned that the issues of non-compliance with A&E and RTT standards had persisted for some time and asked for a trajectory for improvement as an output of the joint investigation. Mr Bolam confirmed that this would be an output of the investigation. Many of the improvements required were dependent on additional capacity and would therefore not be resolved in the short-term. It was expected that the A&E trajectory would be presented at the next meeting, but that RTT would need to be confirmed; this was because the approach to improving RTT had not yet been agreed with commissioners, with affordability issues still outstanding. The board noted with concern the lack of an agreed plan but accepted that a trajectory would be produced as soon as possible.

Prof Kopelman asked for an update on the implementation of the trust's discharge improvement programme. Ms Hall reported that sustained improvement had been seen in the first phase of improvement project, including pre-11.00 discharges. The trust was currently validating the impact on short-stay beds in reducing length of stay in the second phase and the focus was now, in the third phase, on elective flow as well as stroke and critical care. Ms Hall advised that since April the main

reason for A&E breaches had no longer been bed capacity. It was agreed that a more detailed briefing of the discharge programme would be provided in September. **J Hall September 15**

Mrs Pantelides asked whether the commissioners' insistence on adherence to chronological booking of patients had an adverse impact on performance. Mr Bolam advised that the commissioners rightly challenged the trust's prioritisation of patients on the waiting list and understood the impact on performance. An agreed approach would make up part of the joint investigation recommendations.

Mrs Leach suggested that the data should be compared with the same period in the previous year as well as a month on month trend, as that would eliminate any seasonal variance. **S Bolam September 15**

Quality report

Ms Hall presented the quality section of the report and highlighted the introduction of a weekly oversight of quality metrics by a quality scrutiny group, in order to provide a rounded view of quality across the organisation.

Effectiveness domain

Ms Hall reported that a review of the Dr Foster signal regarding cardiology had concluded that the data reflected the complexity of the service provided rather than any quality issues. Work was also ongoing to establish expectations regarding compliance with the WHO safer surgery checklist.

Ms Wilton raised concern regarding the level of exceptions in practice versus the trust policy, as shown in the recent consent audit. Ms Hall advised that the greatest concern was the quality of documentation and that there was no evidence of adverse impact on patients from inappropriate consent being taken.

Mrs Leach noted that the quality inspection programme did not include mealtimes. However it was noted that nutrition audits were carried out regularly and that nutritional assessment was part of the ward heat map.

Safety domain

Ms Hall acknowledged previously raised concerns by the board regarding rising numbers of serious incidents and continuing incidence of never events. The board noted the reporting of another never event, relating to a retained object following a procedure carried out in 2009. Ms Hall however highlighted that performance against infection control targets was on track.

Mr Smallwood asked whether the rise in serious incidents could be linked with financial or workforce pressures. Ms Hall advised that serious incidents were caused by a variety of causes, including workforce issues. The root causes for every serious incident are identified and appropriate actions agreed.

The board noted that the VTE assessment would be simplified for the next report. **J Hall July 15**

Patient experience domain

Ms Hall reported that use of the Friends and Family Test (FFT) would continue despite the removal of CQUINs and reported that the themes from the FFT questionnaires were being triangulated with complaints data. She also highlighted the complaints rates and performance in responding, highlighting that the rate of complaints remained steady compared with the previous month.

The board discussed an individual case recently reported in the media, with Ms Hall explaining the incident and complaint and any learning from it. Mr Rappolt asked for assurance that there were no other complaints where the response was significantly delayed. Ms Hall assured the board that examples of this kind of delay in responding were rare and that a lot of progress had been made over the last year in reducing the 'tail' of delayed responses; she agreed to provide the board with the data relating to this 'tail'. **J Hall July 15**

Mrs Pantelides asked whether offender healthcare should be in special measures, based on workforce and quality concerns in that service, including medication incidents. Ms Hall confirmed that a process was underway to provide support to the division, including specific actions to improve quality. This process had been underway for the past three months and progress would be reported to the quality and risk committee. **J Hall July 15**

Well-led domain

Ms Hall reported that current NICE guidance was extant and therefore the trust was continuing to measure against that guidance. The board noted that the figure for the safe staffing return was being reviewed.

Ms Wilton highlighted that the heat map returns from divisions were good apart from Children's and Women's division. Ms Hall confirmed that metrics were being developed and trends were being identified and any specific areas of concern would be picked up with the respective division.

Report from the quality and risk committee

Ms Wilton gave an oral report from the quality and risk committee seminar held the previous day. The seminar had focused on a 'deep dive' review of the five capacity risks on the corporate risk register, including bed and workforce capacity. The review challenged the description, evaluation, controls and assurances for each risk. The revised risks would be reported through the next formal quality and risk committee and then to the board.

The seminar had also received presentations from two divisions, medicine and surgery, focusing on quality issues such as external assurances, risks and quality improvements. The surgery division had reported progress in sterile services and consultant ward rounds, identified risks regarding notes availability and use of IT systems. The medicine division also identified notes availability as a risk as well as workforce and power supply in the A&E department. The committee received assurance regarding the controls in place to reduce these risks, and mitigations should they materialise.

15.06.07 Divisional presentation – children's and women's division

The board welcomed Dr Andy Rhodes, divisional chair, and Sofia Colas, divisional director of operations, to the meeting. They gave a presentation covering quality, service developments and achievements, risks and plans for 2015/16. They also identified areas where they sought additional corporate support, including implementation different business models for outpatients and diagnostics, and progress in delivering business cases such as the GICU, 5th floor and the children's and women's hospital. Dr Rhodes confirmed that there were plans in place to deliver these challenges, including capital schemes for maternity, MRI and mortuary. The board also noted the development of a strategy for critical care.

Mr Smallwood referred to the ongoing service line review exercise and asked

whether the division had any feel for its output. Dr Rhodes advised that some services made some profit and some not. The first services to be reviewed would be women's services and opportunities would be identified at sub-specialty level.
Mr Rappolt asked for more details on the IT issues referred to. Dr Rhodes explained that while there had been a big improvement in IT systems and infrastructure over the past two years, that improvement had been slow and some opportunities to make changes in business processes to support the IT deployment had been missed.

Mrs Pantelides asked whether delays in business cases created a risk of losing good clinicians. Dr Rhodes confirmed that there was a risk of losing good will and clinical engagement, but opined that this could be mitigated by ensuring that communication with them over progress was clear and transparent.

Mrs Wilton asked what level of clinical engagement there was in meeting the CIP challenge. Mrs Colas confirmed that the senior divisional management team, including clinical leaders, were engaged in the savings programme and that the division had worked hard to ensure an understanding of the challenge at ward level.

Prof Kopelman asked whether implementing a CIP to reduce nursing levels in critical care was wise in the long-term. Dr Rhodes confirmed that there were sufficient staff to cover the required levels and the service was recruiting to turnover to ensure a full complement of staff.

15.06.08 Outpatient strategy

Mr Elek presented the summary of the development programme for the outpatient strategy, including the objectives of the strategy and the various workstreams looking at short-term and long-term objectives. The board also noted the patient involvement in this development programme. The host division, children's and women's, endorsed the approach and agreed the urgent need to review how outpatient services were delivered.

It was agreed that the draft strategy would be presented to the board in July. **R Elek July 15**

Mr Rappolt identified the key challenge as reconciling the demand for outpatient services against the under-utilisation of outpatient locations outside of the hospital. Mrs Colas agreed that there was a capacity shortfall at St. George's and reported that the division were looking at extending clinic times to help meet the demand. But longer-term solutions, including better use of other locations, were also being explored.

The board also acknowledged that progress was being made in addressing other outpatient issues, such as the call-centre and availability of notes in clinic, but also noted that a common feature of complaints was still about how patients navigated their care pathway, including patient letters and booking appointments. Mr Rappolt suggested that the patient experience survey results for outpatients should be presented to the board. **J Hall TBC**

15.06.09 Finance report

Mr Bolam presented the finance report for month 2 and gave a summary of performance against plan. He also gave an update on budget setting, confirming that this would be complete for month 3. The board noted that the trust was £0.62m adverse to plan for the month and that, although the cash position was ahead of plan this was supported by including the LEEF loan and working capital

loan.

Mr Scott advised the board that the key issue in month 2 was pay costs, with more progress needed to control pay.

Mrs Wilton noted that £2.4m of the adverse position was due to costs from 2014/15 being carried forward and asked whether there was likely to be more to surface. Mrs Bolam was confident that there would not be more as it was now in the third month of the year and it was safe to assume that all non-pay invoices would have been received.

The board reviewed income against plan. Mrs Leach highlighted that the outpatient income was down. Mr Bolam confirmed that income was adverse to plan but was favourable in year on year comparison. Mrs Pantelides noted that the elective plan for 2015/16 was lower than the 2014/15 plan, but Mr Bolam advised that this would need reviewing.

The board reviewed pay costs, noting that temporary pay expenditure was down but that overall pay costs were still adverse to plan. Mr Bolam explained that unallocated CIPs were a key driver behind this; he advised that the trust was getting a grip on pay costs and there was a downward trend in cost, but that this was not currently enough to mitigate the non-delivery of CIPs.

The board reviewed non-pay costs, noting the upward trend in costs and particularly in costs of premises. Mr Bolam explained that the trust had taken on more premises which led to an actual increase in costs. He also reported that work was ongoing, with KPMG's support, to establish better controls in procurement and to improve transparency in drug costs.

Mrs Pantelides asked whether the trust had underestimated the activity at the Nelson. Mr Elek advised that there had been issues with mobilising activity against commissioner expectations, but that there was also a need for clinical services to want to use the location and for job planning to allow them to use it which the divisions were now addressing.

Mr Scott agreed that the trust now had a better idea of where the underperformance issues lay in terms of outpatient activity; activity was up against plan and up against year on year comparison, but there was a need to focus on the underperformance against plan at the Nelson.

The board discussed the need for additional financial support. Mr Bolam confirmed that based on the current budget, £52m of financial support would be required. The trust would confirm the position regarding the existing £25m working capital facility and would confirm the draw down against that in the next few days. He advised that the trust would need to confirm the rest of the facility in August as the new facility would be needed in September.

Report from the finance and performance committee

Mr Smallwood gave a summary of discussions at the last finance and performance committee meeting:

- Update on turnaround plans: Mr Burn had reported progress in the KPMG support in each of the four workstreams – grip, build, grow and systems. The committee had stressed the importance of both short-term and long-term actions and agreed that the balance of effort needed to be across both these areas. The committee would be monitoring the delivery of both short-term

action on CIPs and the longer-term service review.

- Budget setting: the committee had received and considered a number of pressures which would adversely affect the previously agreed budget of £46.2m deficit. The committee received assurances that mitigations had been identified to offset these pressures and therefore the budget remained the same, however the committee noted that the downside risks outlined indicated a worst case of £75m deficit. Detailed budgets were now being set on this basis, with budget holders being asked to sign off budgets for month 3. Budget holders would then be held to account for delivery against these budgets. The committee had considered the risks and the mitigations, including the fact that the KPMG support should provide some upside benefit and possible benefits from the service line review project materialising in this year.

  The committee had noted that the budget would need to be reviewed again, with a view to re-setting the budget at the end of September. It was agreed that this process would need to be transparent, with involvement of Monitor, so that the revised budget was realistic and agreed by all parties. The committee had also noted that the revised budget should be tested by the board to establish that the assumptions on which they were based were sufficiently robust.

- Month 2 financial performance: the committee had reviewed the financial performance for month 2, as reported to the board. The committee had discussed proposals for further reductions to the capital programme in order to further improve liquidity, with the committee receiving assurance that the risk implications of this had been considered to be acceptable. The committee had reviewed the cash position, noting actions being taken by the trust to improve cash flow forecasting and liquidity which could strengthen the cash position by around £10-15m.

- Financial management action plan: the committee received and considered a draft financial management action plan, covering a series of key areas including budget setting, ownership, information flows, reporting, forecasting and systems. Work on this action plan would continue through the summer with a view to having revised systems in place from September, in order to deliver the revised budget.

- Borrowing forecasts: the committee had discussed the trust's borrowing capacity, informed by an explanation from Mr Bolam of how borrowing limits were calculated and the trust's headroom for additional borrowing. The committee had also noted the need for Interim Support Funding (ISF), with £52.2m ISF identified in the 2015/16 plan which included the £25m working capital facility. The maturity and repayment terms of this finance facility would be determined in connection with the recovery plan to be agreed with Monitor.

The board referred back to the divisional presentation and the business cases they wanted to progress, noting that in these circumstances the funding for them was not guaranteed.

15.06.10 Workforce report (month 2)

Mrs Brewer presented the month 2 workforce report and highlighted key issues, including ongoing work to reconcile HR and finance systems, developing workforce requirements for the year in line with budget setting and the resultant development of a workforce plan and weekly tracker to monitor delivery against.

The budget noted continued concern regarding the turnover rate, albeit a stabilised position. It was noted that this was not unique to the trust but a real issue for the trust. Mrs Brewer referred to the intelligence from exit interviews and reported that divisions would be presenting their plans to improve retention at the next workforce committee meeting.

The board reviewed agency usage, noting a reduction in the use of agency staff and an increased fill rate through the staff bank. It noted the work being done to better understand the reasons for use of temporary staffing. Mr Smallwood asked how sustainable this reduction in agency staff was. Mrs Brewer opined that it was probably a mixed picture, with some risks in some areas; it was also noted that the reduction may be reflective of recent reductions in activity so may not reflect a long-term reduction. Mr Scott repeated his assertion that pay costs were a key driver of the overall financial performance. He suggested that more analysis of pay costs, both temporary and substantive, would be needed as well as forecast pay costs. This would be a key focus of the turnaround plan, with increased grip on pay costs.
The board agreed that the board's assurance on the effect of the turnaround measures on pay costs would be provided through the workforce committee.

15.06.11 Planning performance agreement (PPA)

Mr Munro presented a paper to the board, explaining the purpose of a PPA – a legally binding agreement between Wandsworth Council and the trust regarding the delivery of the planning agreement timescales. He explained to the board what was involved in this process and sought approval by the board, subject to further negotiation of costs. He advised the board that this PPA covered the securing of outline planning consent for any capital developments included in the Development Control Plan (DCP) and therefore should be secured prior to working up the DCP schemes in more detail.

The board considered the proposed agreement, in the light of the current financial position and the current position regarding the DCP, and schemes within the DCP such as the private patients unit and renal unit development. It was noted that although the DCP itself had not yet been approved by the board, the known elements of the DCP, such as the private patients unit, the renal unit and Maybury street car park made up around 70-80% of the cost of this PPA. This was due to the traffic and transport assessment required for the car park and private patient unit.

The board noted that the cost of the PPA, currently £160,000, was included in the capital programme but was not reflected in the respective business cases.

The board accepted the case for securing this agreement at this stage, in order to avoid any delay in the critical path for the private patient unit development and other capital projects, and accepted that the cost would be incurred in subsequent planning applications if not included in the agreement now. The board therefore approved the trust entering into the proposed agreement. **E Munro July 15**

15.06.12 Annual health and safety report

The board received and noted the annual health and safety report. The board noted in particular the increased reporting of incidence of aggression and violence against staff and received assurance that specialist training was now available for staff in response to this.

15.06.13 Annual fire safety report

The board received and noted the annual fire safety report.

Mr Rappolt reminded the board of the challenge presented by the audit committee regarding the appointment of fire safety wardens, with only 200 appointed to date versus the target of 850, and the request for an explanation of the target of 850. Mr Scott confirmed that he and Mr Munro would pick up the appointment of fire wardens with divisions. The board agreed the need to validate the target number of 850. Mr Munro agreed to confirm the rationale for this target.

M Scott / E Munro July 15

15.06.14 Risk and compliance report

The board received and noted the risk report, noting in particular the most significant risks on the corporate risk report as recommended by the quality and risk committee and noting the process for 'deep dive' reviews of key risks and their controls and assurances being conducted by the quality and risk committee. The board noted that the controls for the most significant risks had been picked up in discussions through the agenda.

15.06.15 Board governance statements

Mr Jenkinson presented and explained the remaining annual governance statements that the board was required to submit to Monitor, following submission of the first two the previous month.

The board discussed in particular the statement 4(d) regarding financial systems, concluding that it could not confirm that it was satisfied that the trust had effective financial decision-making, management and control systems, given the current financial position and the ongoing Monitor investigation. The board therefore agreed that it should declare non-compliant against this standard and should add explanation to include the work the trust was doing with support from KPMG to strengthen financial systems and also that the board would consider and implement recommendations from PwC's independent accounting review.

P Jenkinson June 15

15.06.16 Questions from the public

The chairman invited comments or questions from the public, noting that the governors would also have the opportunity to question the non-executive directors at a meeting of governors and non-executive directors following the board meeting.

Hazel Ingram reflected on the discussion about outpatients and issues with patient correspondence, and advised the board that in her experience many of the 'did not attends' in outpatient clinics were down to poor administrative systems which led to patients not receiving their appointment letter.

Thomas Saltiel pointed out that board papers were late being published on the trust website and contained duplicate papers. Mr Jenkinson agreed to ensure that papers were published on time.

Gail Adams referred to the discussions regarding fire safety wardens and opined that there could never be too many wardens. She advised that health and safety indicators should be incorporated into the heat map view.

15.06.17 Any other business

There was no other business.

15.06.18 Date of the next meeting

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

St George's University Hospitals NHS
NHS Foundation Trust

Matters Arising/Outstanding from Trust Board Public Minutes
30 July 2015

Action No.	Date First raised	Issue/Report	Action	Due Date	Responsible officer	Status at 30 July 2015
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	ON AGENDA
15.05.14	28.05.15	Matters Arising	Report on the conclusion of the Joint investigation with commissioners into ED & RTT	June 15 (deferred to July 15)	M Wilson	ON AGENDA
15.05.16	28.05.15	Performance Report	Cancer performance – to review the implementation of IT system agreed with the commissioners.	July 15	S Bolam/M Wilson	
15.06.04	25.06.15	Matters Arising	Workforce recruitment target to be confirmed by Sept 15.	Sept 15	J Hall	
15.06.05	25.06.15	Chief Executives Report	Update on the Immigration Pilot project with the immigration service	Sept 15	S Bolam	
15.05.06	25.06.15	Quality & Performance report Performance	A detailed briefing on the discharge programme.	Sept 15	J Hall	
15.05.06	25.06.15	Quality & Performance report Performance	Adverse impact on patient due to Chronological booking/impact on performance. Data to be compared with same period in previous year as well a month on month trend to eliminate seasonal variance	Sept 15	S Bolam	
15.05.06	25.06.15	Quality Report – Safety Domain	VTE assessment to be simplified for next report	July 15	J Hall	Capture in the Quality report

15.05.06	25.06.15	Quality Report- Patient Experience Domain	Delayed complaint responses- provide data relating to the 'tail' of delayed complaint responses.	July 15	J Hall	Capture in the Quality report
15.06.8	25.06.15	Outpatient Strategy	Draft Outpatient strategy to be to the Board	Oct 15	R Elek	
15.06.08	25.06.15	Outpatient Strategy	Patient Experience survey results to be presented to the Board (Issues re call centre and availability of notes)	Aug 15	J Hall	
15.06.13	25.06.15	Annual health and safety report	Challenge regarding the appointment of fire wardens-to validate the target number of 850 EM to confirm rationale for this target.	July 15	M Scott/E Munro	The 850 fire warden figure has been derived from a previous training needs analysis as follows: 2100 staff in 45 ward areas: to allow for training, shift patterns, sickness and other absences 8 fire wardens are required per ward area; 45 x 8 = 360 6000 staff in other areas: 3 fire wardens per department/area requiring approximately 500 fire wardens in total Thus a total figure of ~ 850 Fire warden training is not mandatory, but it is the responsibility of ward/department/area managers to ensure that at least one fire warden is on duty at any time. Estates is currently working on the fire safety training strategy for SGUH and the 850 figure is utilised to enable fire officers to plan and programme fire warden training. It may be that this figure is revised once the training programme starts and we are able to make a more accurate determination of this figure.
15.06.14	25.06.15	Board governance statements	Statement 4 (d) – financial systems board concluded it could not confirm the trust had effective financial decision making arrangement. Declared non-compliant. To add explanation to include work with KPMG to strengthen financial systems. Board to consider implementing recommendations from PwC's accounting review	June 15	P Jenkinson	Completed

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – JULY 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:	All corporate objectives
Related CQC Standard:	N/A

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

If yes, please provide a summary of the key findings

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

1. Strategy

1.01 Appointment of the Chief of Cardiology, Cardiology Clinical Academic Group

The Cardiology Clinical Academic Group (CAG) is a new way to manage clinical, educational and research activities through a coherent and skilled clinical group that represents both the university and the trust. This is the first CAG to be established by the trust and university, and it is an exciting development for the whole of St George's.

As part of the first stage in establishing the CAG, we are pleased to announce the appointment of Dr Stephen Brecker to the post of Chief of Cardiology. Stephen has had almost 20 years of experience as a consultant cardiologist and honorary clinical academic at St George's University Hospitals NHS Foundation Trust and St George's, University of London. He has extensive experience in clinical and academic leadership, having held the posts of director of the Cardiac Catheterisation Laboratories, cardiology care group lead, and clinical lead for the South West London Cardiac Network. He is also a reader in cardiology in the university. The formal launch of the CAG is planned for September 2015.

I look forward to working with Stephen and supporting him in developing the CAG. The CAG will be launched in early September.

1.02 Merton ITT

The Board considered our response to the Merton Community Services ITT on 9 July. The Community Services Division had put an extensive amount of work and consideration into the proposed submission, producing a high quality bid and surfacing all foreseeable issues for the Board's benefit. After a comprehensive consideration of the bid by the Board, it was decided that the trust would withdraw from the process as the level of uncertainty over the potential risks was a very significant concern. This was communicated to the CCG and our bid partners immediately after the meeting.

The Board gave a great deal of thought to this decision, and whilst we regret being unable to pursue the opportunities the contract would have given the trust, we intend to apply the new models of care developed, to other services.

1.03 Community Adult Health Services

On 16 July, Graham Mackenzie the Chief Officer of Wandsworth CCG informed the trust that the CCG Board had recognised the significant progress made by the trust in implementing the Community Adult Health Services (CAHS) model, and its achievement in delivering such a complex change programme within so short a timescale. It was also recognised that the trust had shown strong commitment in working with commissioners and other providers to integrate the CAHS model further, through the development of a Wandsworth wide 'frailty pathway'.

With this in mind, the CCG have therefore proposed in principle to extend the CAHS contract with the trust for a further two years.

2. Academic Development

2.01 Appointment of the New Principal of the University

Whilst we are very sad at the planned departure of Professor Kopelman as Principal of SGUL, we are delighted at the recent announcement of Professor Jenny Higham as his successor. Professor Higham is presently Vice Dean for Institutional Affairs and Director of

Education in the Faculty of Medicine at Imperial College. She has had extensive experience of international medicine and is also Senior Vice Dean of the Lee Kong Chian School of Medicine in Singapore. Jenny continues to have clinical responsibilities as a Consultant Surgical Gynaecologist at St Mary's Campus, Imperial College Healthcare NHS Trust. Her research has focused on reproductive medicine and, more latterly, on simulation in education.

She will bring to SGUL a wealth of experience not simply in medicine but across all health professions. She is honorary treasurer of the Medical Schools' Council and sits on its executive.

2.02 St George's University Widening Participation initiative

In collaboration with the St. Georges' University Widening Participation initiative, some 50 students will join the trust for periods of up to five days to gain valuable work experience in all areas of the trust. The scheme aims to encourage and support young people from groups currently under-represented in Higher Education (including those from state schools, low socio-economic backgrounds, low participation neighbourhoods, students with disabilities and those with no family experience of higher education), who have the potential to make a positive contribution to the life of St George's University, and the NHS workforce.

2.03 New Appointment to the Education and Development Department

The Education and Development Department have appointed a Registered Mental Health Nurse (on a 12 month secondment funded via a successful bid to Health Education South London) to scope the mental health training needs of nursing staff and Allied Health Professionals in the trust. The new appointee will also be working collaboratively with South West Mental Health Trust to ensure their staff have physical assessment skills.

3. Workforce

3.01 Listening into Action

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

We ran the Friends and Family staff survey during the first quarter of this financial year. Here is the comparison with the same quarter last year:

	2014	2015
Number of respondents	695	740
Would recommend to friends and family as place for treatment	81%	79%
Would recommend to friends and family as place to work	59%	50%

The survey allows respondents to give the reason for their answer. Comments about St George's as a place to receive treatment are very positive, for example:

"Despite the pressures, clinicians are always lovely"
"Friendly and well trained staff with a caring nature"
"Excellent care; efficient service"

Comments about St George's as a place to work are less positive and generally reflect lower morale than this time last year. Comments range from:

> "Staff are respected and valued. The wage scales are fair"
> "I love working at George's"

to:

> "Staffing and financial situation are huge challenges to morale and providing excellent care"
> "Financial pressures are making it difficult to enjoy work"

The findings of this survey have been discussed in more detail at the workforce committee and a summary of those discussions and agreed actions are included in the workforce committee report to the board. Additionally a session is being held with governors following the board meeting this month, with a focus on staff experience.

4. Monitor Investigation / Financial Recovery

4.01 Monitor Investigation

The Monitor investigation is still ongoing, with findings expected to be reported in early August. A further update will be provided in next month's report.

5. Communications

5.01 Council of Governors

The Council of Governors held a public meeting on 9 July.

The Council welcomed three new governors: Will Hall has been elected as staff governor for the Allied Health Professional through an uncontested election; Brian Dillon has taken over as the appointed governor representing Merton Healthwatch; and Dr Tim Hodgson has taken over as the appointed governor representing Merton Clinical Commissioning Group.

The Council reviewed the monthly quality, workforce and financial performance reports, received an update on the ongoing Monitor investigation and received a briefing from the trust's turnaround director on the development of the trust's financial recovery plans. The Council also received the annual external audit opinion on both quality and financial accounts, and an annual report from the trust's audit committee; including the monitoring of internal and external audit performance. There was also an update on the various workstreams overseeing the development of healthcare in south west London, including: the recently published case for change; the South West London Collaborative Commissioning programme; the South West London Acute Provider Collaborative; and the development of proposals by the trust with provider partners for inclusion in the national programme of 'vanguard' sites.

5.02 Annual Members' Meeting

Governors, members, staff and the public were invited to our Annual Members' Meeting on Thursday 9 July at St George's Hospital. The evening included a formal presentation of our annual report and accounts for 2014/15, and celebrated our successes and achievements.

There was also an update to our financial position and the audience had the opportunity to ask the board questions. Approximately 100 people attended the event.

5.03 Wellbeing Walkabouts

On Thursday 9 July, directors and governors took part in a Listening into Action initiative called Wellbeing Walkabouts. Senior staff guided directors and governors around various areas of the trust to engage with staff and promote wellbeing at work.

We produced a special wellbeing leaflet and an annual report summary to distribute during the walkabouts. The initiative proved to be a success with many staff requesting it happens more regularly.

5.04 Filming of latest series of '24 hours in A&E' come to an end

With filming of the final episode in the latest series of '24 Hours in A&E' now complete, the production team has now begun the process of removing all the equipment from the emergency department. We will keep the trust updated on when the next series will appear on our screens.

At the same time, the final episode of the latest series has been aired, prompting a huge and highly positive reaction from the public on social media.

The first 30 episodes, which were filmed last year, have proved to be hugely popular with the public and have raised awareness of the first rate work being done in our trust.

REPORT TO THE TRUST BOARD TB July 15 – 03a

Paper Title:	Quality and performance Report to the Board for Month 3- June 2015
Sponsoring Director:	Jennie Hall- Chief Nurse/ Director Infection Prevention and Control Simon MacKenzie- Medical Director Steve Bolam- Director Finance/ Performance and Informatics/ Deputy CEO
Authors:	Jennie Hall- Chief Nurse/ DIPC Simon Mackenzie- Medical Director Matt Laundy- Infection Control Lead Corporate Nursing Team Divisional Directors Nursing/ Governance Trust Safeguarding Leads Steve Bolam- Director Finance/ Performance and Informatics/ Deputy CEO Martin Wilson – Director of Delivery and Improvement
Purpose:	To inform the Board about Quality and Operational Performance for Month 3.
Action required by the board:	To note the report and key areas of risk noted.
Document previously considered by:	Finance and Performance Committee Quality and Risk Committee

Executive summary

Performance

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

The trust has seen positive performance improvement in Diagnostics with number of patients waiting greater than 6 weeks reducing significantly and has also met the RTT national operational standard for incomplete pathways of 92%.

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

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

Key Points of Note for the Board in relation to the June Quality Performance:
The Overall position in June does not indicate and key changes from May in terms of the trends for the metrics with some moderate improvement across a number of indicators. Serious Incident numbers remain an area of focus in relation to themes seen and actions being taken. This is monitored through the Patient Safety Committee and SIDM.

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. As noted in the report if we use a longer term benchmark (discharges for the last 10 years up to December 2014) then the HSMR would be 92.4 which would still be better than expected but it is clearly higher than the other reference point being used (period April 2014 to March 2015). Despite this position we continue to proactively investigate mortality signals at procedure and diagnosis level. We have received 2 alerts from Dr Foster in June relating to 2 diagnosis groups, these are currently being reviewed alongside information from the PRISM 2 study has recently been published.
- In relation to locals audits of note the Healthcare records audit indicates limited progress for aspects of record keeping standards despite previous action. In addition there are a small number of services who have not participated in this mandatory audit for more than one quarter, these services have been instructed to complete the audit by the PSC where the outcomes for these areas will be reviewed. Work is also now underway to understand how Electronic Records will be audited going forward. The Global Trigger Tool Audit indicates the 5 most common adverse events are consistent with previous audits namely complication of treatment, wound infection, pressure ulcers, nonsocomial pneumonia and readmission in 30 days. Recent data indicates some improvement in relation to the rate of events associated with wound infections and pneumonia with some increase in pressure ulcers and complication of treatment. The rate of serious harms has also decreased (from 12.85% in 12/13 to 6.25% in 14/15) whilst the rate of temporary harm has increased (from 15.1% in 12/13 to 17.8% in 14/15).
- 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 following the DGB meetings at the end of this month.

Safety Domain:

- The number of general reported incidents in June indicates a similar trend in terms of numbers and level of harm. The Board should note that the trend for Serious Incidents indicates a gradual increase. Of those declared for May the Board will note the issues are across a range of clinical issues, some are mandatory in terms of reporting.
- Safety Thermometer performance decreased slightly from May performance but remains above the national average. There was an increase in patients with CAUTI, with a decrease in other harms reported. The Trust is participating in a wave 1 programme with the HIN to improve practice in association with the use and management of catheters to support improvement of current infection rates.
- The pressure ulcer profile for June decreased from May with a single grade 3 ulcer reported and a decrease in grade 2 ulcers. Of note progress within the community Division who for the second month have reported no serious grade 3 or 4 pressure ulcers.
- The Trust has now reported 2 MRSA bacteraemia cases and 9 C-Difficile to the end of June. The Board should note that we are now slightly ahead of the Annual Trajectory for C Difficile which is set at 31 cases for 15/16. All cases are currently subject to an RCA process.
- Safeguarding Childrens data is not presented this month as the data base I currently being reviewed. The Board will note that slight deterioration in the Adult safeguarding training activity and actions being taken.

Experience Domain:

- The response rate for FFT is static with but response rates for inpatient wards decreased. The overall score for the Trust decreased in June to a score of 94.9%. Themes arising from the FFT responses include noise at night, information about medication side effects and involvement in discharge processes. A more accessible version of the survey has been rolled out to paediatrics and also for users with learning disabilities and where English may not be a first language to improve the capture of feedback.
- The complaints profile in relation to numbers has increased slightly in terms of numbers.

Areas where complaints increased were the Medical Wards, Cardiovascular services and the Obstetric and Gynaecology care group.

- In relation to turnaround times of complaints progress is seen within 2 of the clinical Divisions with the Surgical Division now achieving both targets. Actions being undertaken by the other 2 clinical Divisions are noted within the report. It has been confirmed that there are no complaints that are delayed longer than the 25 day target or the agreed extension with individual patients or relatives.

Well Led Domain:

- The safe staffing return is included for all inpatient areas. The average fill rate for the Trust is 95.98 % across these areas against current staffing figures. There were some anomalies in the June data so the deep dive of data is being undertaken. This is against current staffing figures. This figure is being reviewed alongside other Trust information about run rates, the Trust information for staffing alerts (Red Flags) which has been implemented across the Trust, and Trust Bank information about the temporary staffing profile and fill rates.
- For information NHSE announced in June the suspension of further work regarding safe staffing as it is currently described. Focus will now include outcomes and productivity alongside the staffing numbers. Of note the current safe staffing NICE guidance which is already in practice will continue to be used. The Nursing workforce programme had already been reviewed to understand productivity metrics alongside the establishment review which is currently underway.

Ward Heat map:

The Heat map for June 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

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St George's University Hospitals NHS
NHS Foundation Trust

Performance & Quality Report

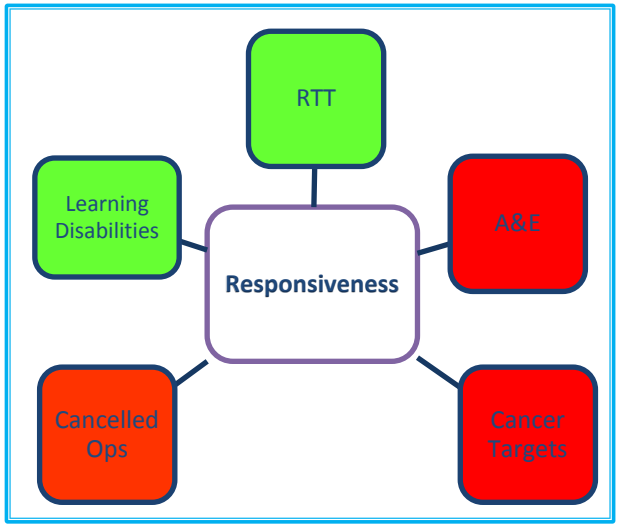
to the Trust Board

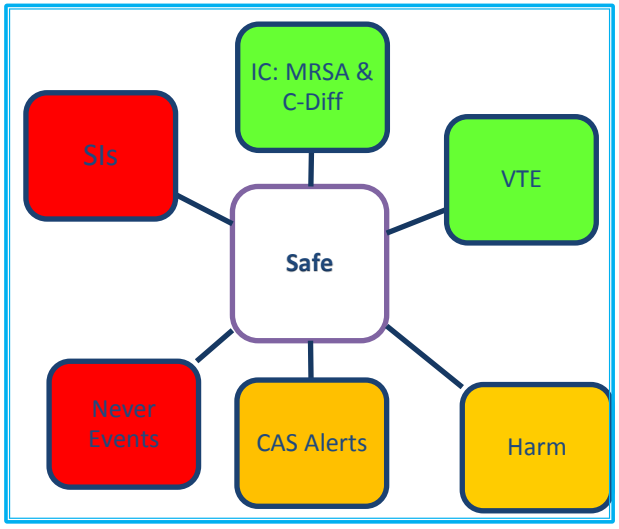
Month 3 - June 2015

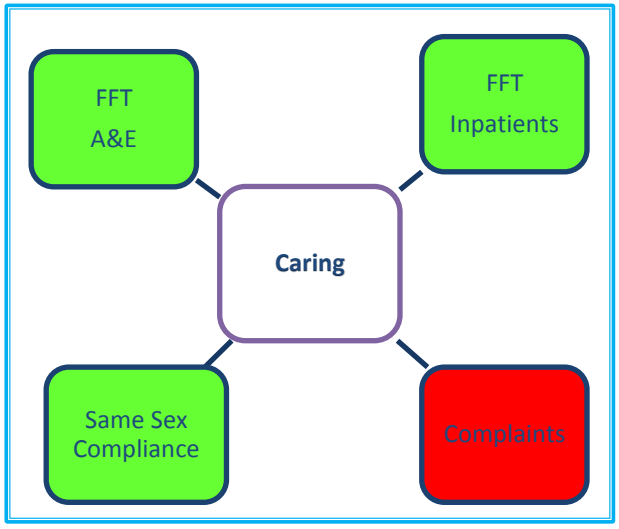
Excellence in specialist and community healthcare

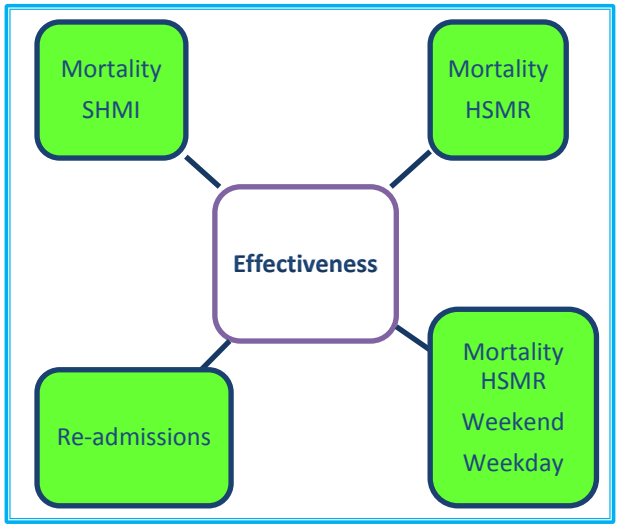
CONTENTS

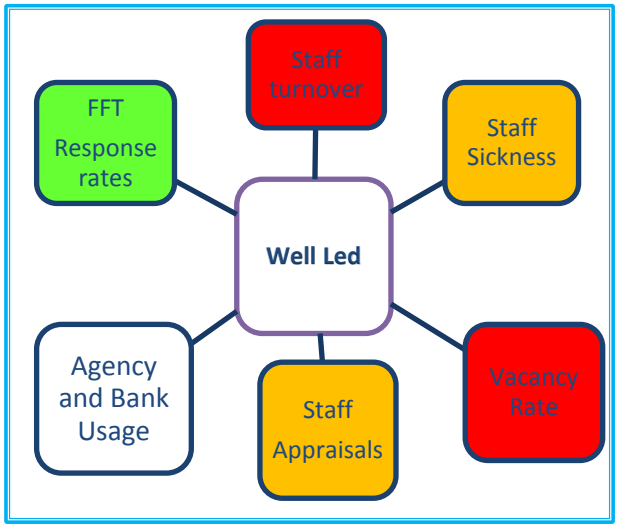
1. Executive Summary - Key Priority Areas June 2015*











The above shows an overview of June 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 May as reported one month in arrears)

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

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Performance against Frameworks

Excellence in specialist and community healthcare

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

Access							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**May**	**June**	**Movement**
Referral to Treatment Admitted	90%	0	N/A		83.5%	85.6%	↑
Referral to Treatment Non Admitted	95%	0	N/A		95.1%	95.3%	↑
Referral to Treatment Incomplete	92%	1	0		91.2%	92.38%	↑
A&E All Types Monthly Performance	95%	1	1	92.51%	93.63%	91.75%	↓
				YTD	**April**	**May**	
62 Day Standard	85%	1	1	80.1%	86.6%	72.5%	↓
62 Day Screening Standard	90%			79.7%	90.0%	72.7%	↓
31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	→
31 Day Subsequent Surgery Standard	94%		1	93%	96.9%	88.0%	↓
31 Day Standard	96%	1	0	96.7%	96.6%	96.8%	↑
Two Week Wait Standard	93%	1	1	92.8%	92.5%	93.0%	↑
Breast Symptom Two Week Wait Standard	93%	1		85.6%	78.4%	91.6%	↑

* NYA Not yet available

Outcomes							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**May**	**June**	**Movement**
Clostridium (C.) difficile – meeting the C. difficile objective (de minimis of 12 applies)	31	1	0	9	3	3	→
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 * data is for April and May 15	50%	1	0		56%	56%	→
referral information	50%	1	0		88%	87.9%	↓
treatment activity	50%	1	0		69.84%	68.93%	↑
Trust Overall Quality Governance Score					**4**	**4**	→

June 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
- Cancer Waits
- Diagnostic Waits > 6weeks
- Cancelled Operations

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: June 15 Performance (Page 1 of 1)

Responsiveness Domain					
Metric	Standard	YTD	May	June	Movement
Referral to Treatment Admitted	90%		83.5%	85.6%	↑
Referral to Treatment Non Admitted	95%		95.1%	95.3%	↑
Referral to Treatment Incomplete	92%		91.2%	92.38%	↑
Referral to Treatment Incomplete 52+ Week Waiters	0		1	0	↓
Diagnostic waiting times > 6 weeks	1%		3.65%	1.44%	↓
A&E All Types Monthly Performance	95%	92.87%	93.63%	91.75%	↑
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%	4.9%	19.2%	↑
Certification against compliance with requirements regarding access to health care for people with a learning disability	Compliant	Yes	Yes	Yes	→
	Standard	YTD	Q4	Q1 to date	Movement
Two Week Wait Standard	93%	92.8%	96.8%	92.8%	↓
Breast Symptom Two Week Wait Standard	93%	85.6%	97.69%	85.6%	↓
31 Day Standard	96%	96.7%	96.9%	96.7%	↓
31 Day Subsequent Drug Standard	98%	100.0%	100.0%	100.0%	→
31 Day Subsequent Surgery Standard	94%	93%	97.6%	93.0%	↓
62 Day Standard	85%	80.1%	82.5%	80.1%	↓
62 Day Screening Standard	90%	79.7%	87.5%	79.7%	↓

Safe Domain					
Metric	Standard	YTD	May	June	Movement
Clostridium Difficile - Variance from plan	0	9	0	+1	↑
MRSA bacteraemia	0	2	0	0	→
Never events	0	3	1	1	→
Serious Incidents		53	17	16	↑
Percentage of Harm Free Care	95%		94.61%	94.56	↓
Medication errors causing serious harm	0	2	1	0	↓
Overdue CAS alerts	0	2	2	2	→
Maternal deaths	1	2	1	0	↓
VTE Risk Assessment (previous months data)*	95%		96.64%	96.45%	↓

Effectiveness Domain					
Metric	Standard	YTD	May	June	Movement
Hospital Standardised Mortality Ratio (DFI)	100		88.3	92.4	→
Hospital Standardised Mortality Ratio – Weekday	100		86.08	86.08	→
Hospital Standardised Mortality Ratio – Weekend	100		83.66	83.66	→
Summary Hospital Mortality Indicator (HSCIC)	100		86	90	↑
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	5%	3.11%	3.07%	2.19%	↓

Caring Domain					
Metric	Standard	YTD	May	June	Movement
Inpatient Scores from Friends and Family Test	60		94.7	93.7	↓
A&E Scores from Friends and Family Test	46		83.6	83	→
Complaints			72	84	↑
Mixed Sex Accommodation Breaches	0	0	0	0	→

Well Led Domain					
Metric	Standard	YTD	May	June	Movement
IP response rate from Friends and Family Test	30%		53.9%	49.9%	↓
A&E response rate from Friends and Family Test	20%		25.5%	27%	↑
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	58%	62%			
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	3.67	3.78			
Trust turnover rate	13%		17.35%	17.3%	↓
Trust level total sickness rate	3.50%		3.44%	3.6%	↑
Total Trust vacancy rate	11%		14.4%	14.2%	↓
Percentage of staff with annual appraisal – Medical	85%		87.1%	87.1%	→
Percentage of staff with annual appraisal - non-medical	85%		75.1%	74.5%	↓

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

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Performance – areas of escalation

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3. Performance Area of Escalation (Page 1 of 6) - A&E: 4 Hour Standard

Total time in A&E - 95% of patients should be seen within 4hrs						
Lead Director	May	June	Movement	2015/2016 Target	Forecast July - 15	Date expected to meet standard
FA	93.63%	91.75%	↘	>= 95%	R	TBC

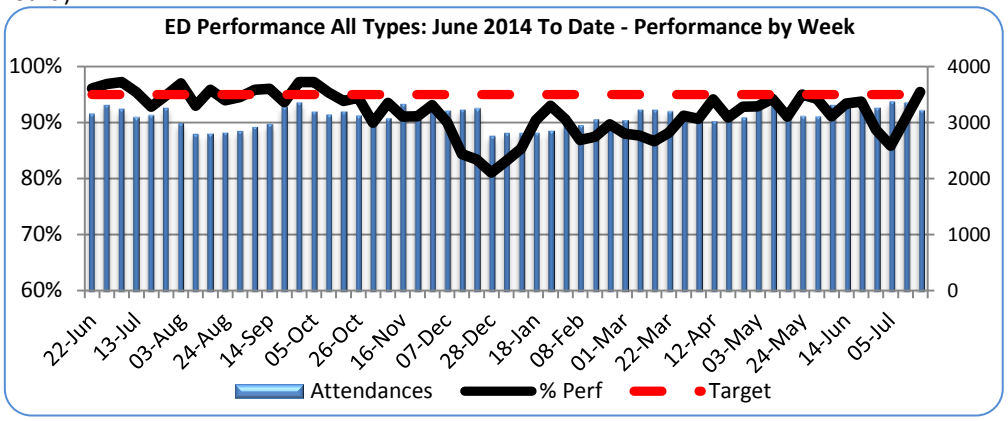
Peer Performance Quarter 1 2015 (Rank)				
STG (2)	Croydon (3)	Kingston (4)	King's College (5)	Epsom & St Helier (1)
92.5%	91.8%	90.8%	89.6%	96.1%

The ED target is that 95% or more of patients should be seen and discharged within 4 hours of attending the Emergency Department. In June 2015, 91.75% of patients were seen within 4 hours. Performance has improved from the winter period, however remains challenged with performance not meeting the 95% target at a weekly or monthly level. The trust did not meet the target for Q1 with a performance of 92.51%. Factors that continue to affect performance include:

- High level of attendance and admissions comparable to that over winter.
- Increase in numbers and admission rate for patients aged 70+.
- Bed pressures have eased at some points during Q1. However, in June in particular during the last two weeks this was an issue and remains a concern.
- Numbers of delayed transfer of care patients (DTOC) and the level of delay remains a focus area for the organisation as this has a significant impact on flow through the hospital and impact upon ED flow into the organisation. As at 22/07/2015 there were 10 delayed transfer of care patients within the hospital accounting to 103 bed days lost due to delays. In addition to this there were also 38 NDTOC (pending delays) patients within the organisation, of which 10 required nursing home placements and 14 required homecare packages.

As at 17/07/2015 there were 101 of 550 patients being tracked within the organisation that were medically fit for discharge. These encompass the DTOC, NDTOC, patients awaiting transfer to another provider and patients going home that day. The effective discharge of these patients is a priority for the trust to release capacity and improve flow, in particular with regards to patients delayed within ED due to bed capacity constraints. The trust is working with commissioners and external agencies to expedite this.

Following a period of joint investigation, action plans to recover performance have been agreed and are being implemented by the trust with an improved formal governance process in place with commissioners. The action plans focus on; ED Flow, intra-hospital flow, the frailty pathway and ambulatory care. Monthly resilience meetings are now in place to review performance recovery and implementation of action plans. (A detailed update paper will be presented to the Trust Board)



Performance Overview by Type			
	ED (Type 1)	MIU (Type 3)	ED & MIU (Type 1+3)
Month to Date (June)	90.93%	98.58%	91.75%
Quarter to Date	91.74%	99.32%	92.51%
Year to Date	91.74%	99.32%	92.51%

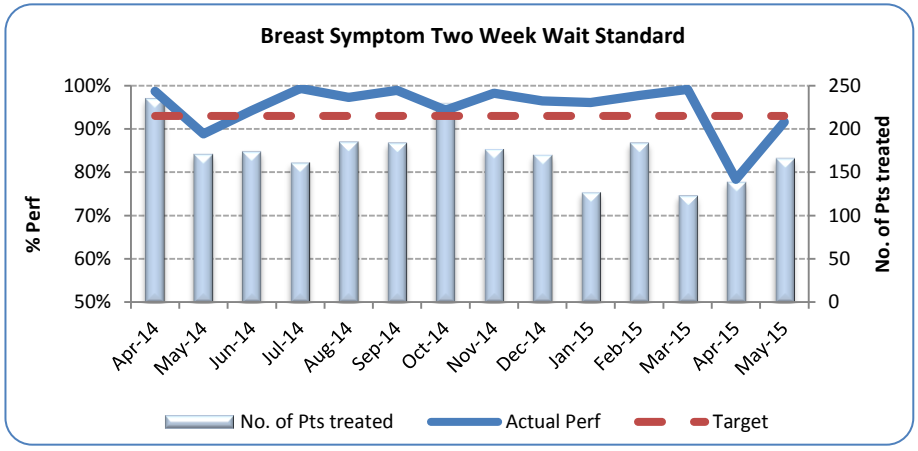
3. Performance Areas of Escalation (Page 2 of 6) - Cancer Performance

Cancer Performance						
Lead Director – CC	April	May	Movement	2015/2016 Target	Forecast June – 15	Date expected to meet standard
Breast Symptom Two Week Wait Standard	78.4%	91.6%	↑	93%	A	Aug -15
31 Day Subsequent Surgery Standard	96.9%	88%	↓	94%	G	June– 15
62 Day Wait Standard	85.2%	72.5%	↓	85%	A	Aug – 15
62 Day Screening Standard	90.0%	72.7%	↓	90%	G	June -15

Peer Performance Latest Published Quarter 4 2014- 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
97.7%	98.5%	87%	97.8%	n/a
96.7%	100%	89.2%	97.2%	80%
82.5%	87.5%	87.5%	80.3%	72.1%
87.5%	100%	61.1%	97.9%	n/a

The trust was non compliant against four of national cancer wait targets for the month of May as detailed in the table above. In response to the underperformance in May, the Executive Director of Delivery has escalated the issue and is holding fortnightly escalation meetings with General Managers and Clinical Directors focusing on:

- Rigorous PTL visibility and tracking.
- Actions being undertaken to address capacity constraints . In particular within the modalities of; Breast, Urology, and Lower GI and Lung.
- Renewed focus and improvements to MDT meetings. The meeting will also be expediting actions `arising from MDT meetings.
- Reviewing DNA rates and patient choice breaches in accordance with guidance and highlighting mechanisms by which this could be reduced.

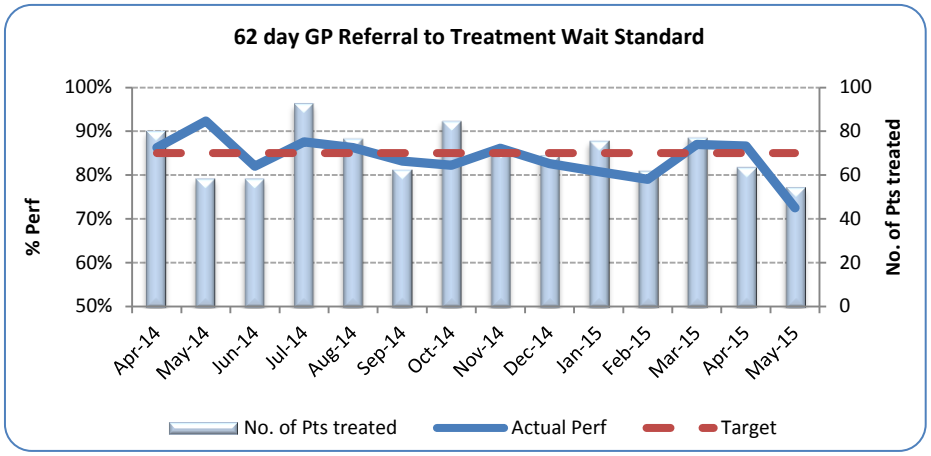


Breast Symptom Two Week Wait Standard - Non-achievement of this target relates to 14 breaches which is unfortunately higher than the average number of breaches of 5 for Q3 and Q4 in 2014/15.

Activity for the first two months of 2015/16 is 25% lower to that of the same period last year. Key issues affecting performance in May were patient choice and capacity. Capacity is currently being reviewed to ensure for future performance sustainability and the following actions are also being undertaken:

- Recruitment of locum consultant breast surgeon to permanently increase capacity
- Recruitment of additional outpatient nursing staff to ensure additional clinics requested for 15/16 are consistently staffed.
- Relocation of non-breast clinics from the Rose Centre to release available capacity.
- Early escalation of capacity shortfalls due to staffing to Divisional Director of Operations, to ensure alternatives are explored.
- Daily update on capacity concerns and breach numbers from the Two Week Wait Referral Office.

3. Performance Areas of Escalation (Page 3 of 6)
- Cancer Performance



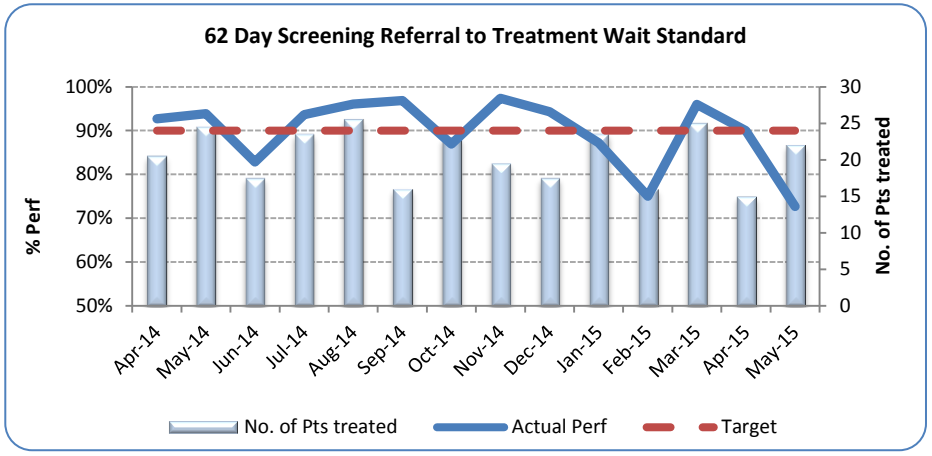
62 day GP Referral to Treatment Wait Standard - Non-achievement of this target relates to 22 patients breaching of which 14 were on a shared pathway. Unfortunately this is higher than the average number of breaches in previous months. Breaches occurred in the modalities of; Head and Neck, Lower GI, Lung, and Urology.

This trust has observed some performance improvement in this standard, meeting the target in March and April 2015. activity for the first two months of 2015/16 is 15% lower to that of the same period last year. Activity in May was the lowest it has been in the last 14 months, thus a bigger proportional impact of breaches on performance.

Key issues affecting performance were:

- Late referrals from other trusts (referrals received after day 42) and referrals with no information (a supporting completed ITT from for tracking). Work with shared providers to improve relationship s and transfer of information is being undertaken . This is also being supported by the recently formed SWL Cancer forum.
- Patients on complex diagnostic pathways, which accounted for over 40% of breaches.
- Capacity constraints within Endoscopy.
- Patient choice.

Capacity constraints within Endoscopy are being actioned as part of the on-going work in diagnostics. Additional capacity is in place and is supporting further delivery of service.



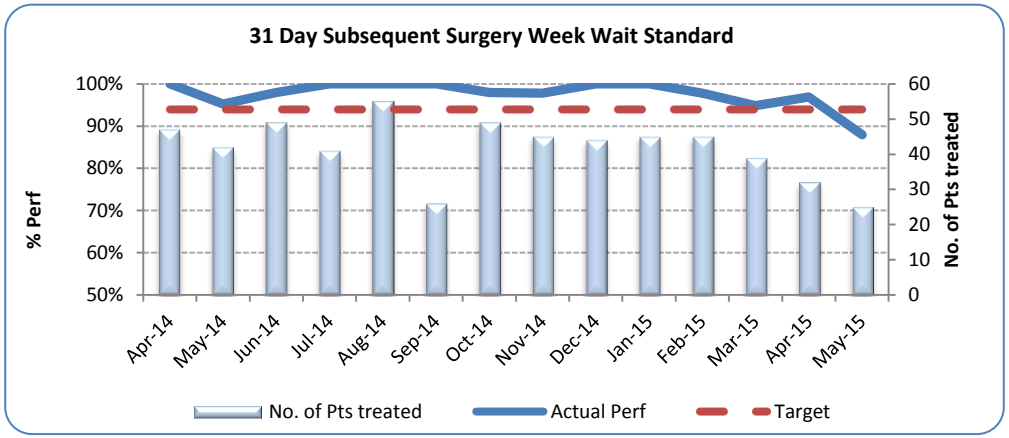
62 Day Screening Referral to Treatment Wait Standard - Non-achievement of this target relates to 8 patients breaching of which 4 were on a shared pathway with other providers. Breaches occurred in the modalities of; Lower GI and Breast.

This trust has observed some performance improvement in this standard, meeting the target in March and April 2015. Unfortunately the number of breaches in May were higher than the average number of breaches in previous months.
Key issues affecting performance were:

- Capacity constraints within Endoscopy in particular for Colonoscopy.
- Poor tracking of patients breach dates.
- Patient cancellation due to ill health.

Work with endoscopy unit to better plan for cancer activity is being undertaken. Improved robustness in tracking and visibility of patients in PTLs is a key priority area for the Executive Director of Delivery and remains a key agenda item at escalation meetings.

3. Performance Areas of Escalation (Page 4 of 6)
- Cancer Performance



31 Day Subsequent Surgery Week Wait Standard - Non-achievement of this target relates to 4 patients breaching. 3 of these were within the specialty of Skin and 1 within Urology.

This is the first time the trust has not met the target in 14 months. The number of treatments in May were significantly lower than that of the preceding 6 months. Activity for the first two months of 2015/16 is 33% lower to that of the same period of last year. Key reasons for breaches were:

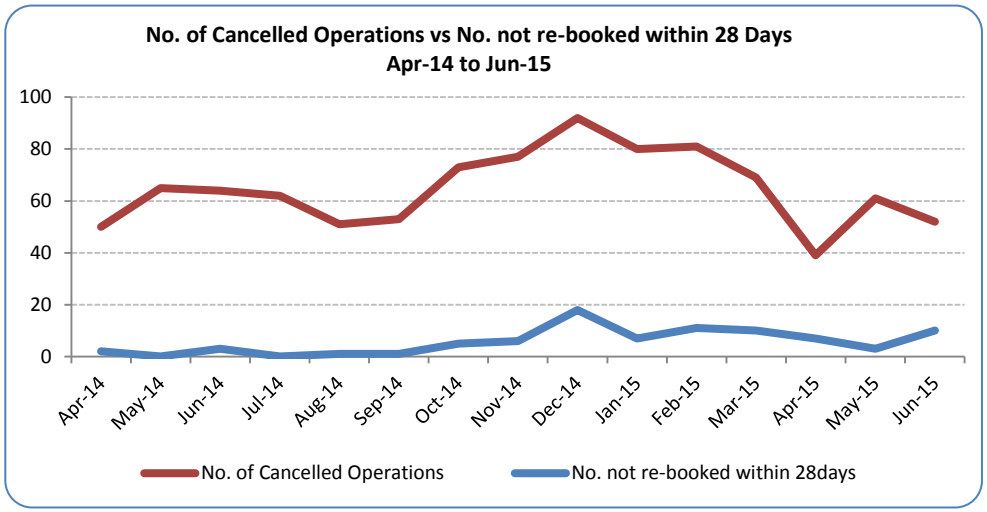
- Skin - OP clinic capacity constraints due to annual leave and a patient rescheduling.
- Urology – lack of theatre capacity for surgery.

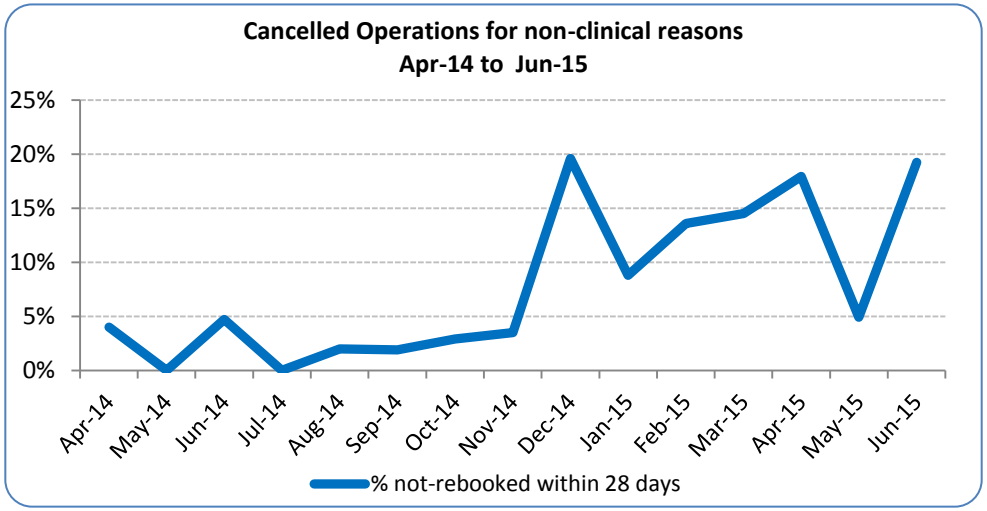
OP capacity for skin is currently being reviewed as is theatre capacity for Urology. In addition to this improved tracking of patients on PTLs and earlier escalation from MDTs is being sought. Remedial actions for improvement are to be presented to the Executive Director of Delivery at the next escalation meeting.

3. Performance Areas of Escalation (Page 5 of 6) - Cancelled Operations

Proportion of Cancelled patients not treated within 28 days of last minute cancellation						
Lead Director	May	June	Movement	2015/2016Target	Forecast July – 15	Date expected to meet standard
CC	4.9%	19.2%	▲	0%	G	July- 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 52 cancelled operations from 4568 elective admissions in June. 42 of those cancellations were rebooked within 28 days with 10 patients not rebooked within 28 days, accounting for 19.2 % of all cancellations. There were 152 operations cancelled in the quarter, with 132 rebooked within 28 days. The overall number of breaches in the quarter was 20. This is down from 230 cancelled operations and 28 breaches in Q4.

The breaches were attributable to Cardiothoracic, Vascular and General surgical specialties. Key contributory factors for the cancellations were related to high bed occupancy resulting in a lack of ITU beds for post surgical admission, an emergency case taking precedent and insufficient time due to previous complex cases over running.

Eight of the 10 patients now have scheduled dates for their operations in July and August, with dates for the remaining two patients currently being agreed.

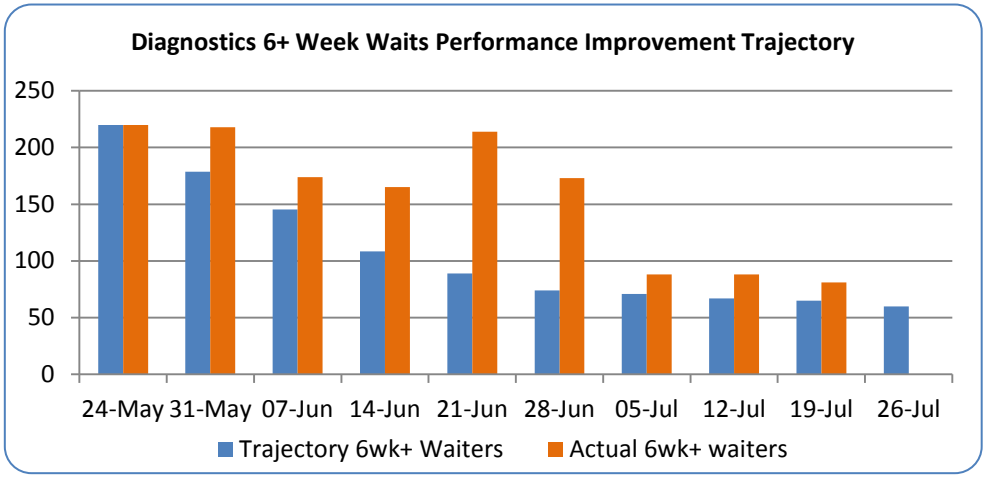
3. Performance Areas of Escalation (Page 6 of 6) - Diagnostic 6+ Weeks Wait

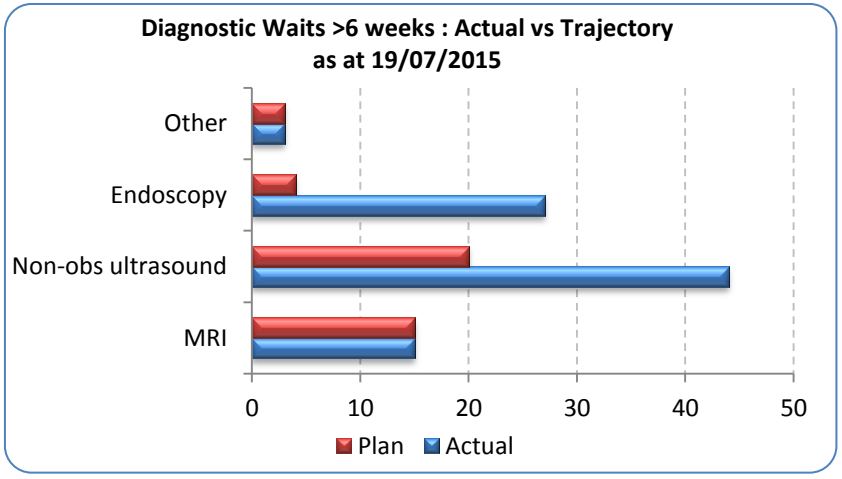
Diagnostic waiting times > 6 weeks						
Lead Director	May	June	Movement	2015/2016 Target	Forecast July – 15	Date expected to meet standard
SC	3.65%	1.44%	▼	1%	R	Aug- 15

No of Patients waiting >6 weeks – Latest Published Data May 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
197	11	15	333	25

The trust has made positive performance improvement with diagnostic waits greater than 6 weeks. However the trust is exceeding the target of number of patients waiting greater than 6 weeks of 1% of all waiters. The trust continues to drive actions put into place to further reduce the number of patients waiting in excess of 6 weeks. The pre-dominant modalities of challenge in Q1 are; MRI and Non-obstetric ultrasound. Positive improvements against these modalities has been made in Q1 with MRI breaches reducing from a peak of 37 in April to 15 as at 19/07/2015 and with non-obstetric ultrasound breaches reducing from a peak of 228 in April to 59 as at 19/07/2015.

The trust has submitted a performance improvement trajectory to commissioners as shown below. At present the trust is showing week on week reduction in waits but is slightly above the overall agreed trajectory with 81 patients waiting greater than 6 weeks against a trajectory of 65. However, performance by modality shows that the trust is in line with or ahead of the trajectory against all modalities with the exception of non-obstetric ultrasound.





Further actions are being undertaken to expedite recovery so we are back on track for non-obstetric ultrasound. Significant improvements within the modality have been made, with Gynaecology related long waits having reduced from 110 in April to 8 at the end of June. Key area of focus for the modality is now:

- Reducing number of 6+ weeks waiters through enhanced tracking at QMH following migration to new Solitan PAS system.
- Further implementation of actions to reduce radiology related long waiters in particular within MSK.
- Continuation of additional sessions to further drive backlog and to re-align waiting list for continued sustainability.

Performance against trajectory and actions for service improvement continued to be monitored weekly with executive oversight from the Executive Director of Delivery and Service Improvement.

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

June 2015

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	A&E WAITS (4 HOURS)	%	98.6	90.9			91.7
	CANCELLED OPERATIONS RE-BOOKED WITHIN 28 DAYS (DIVISION)	%	0	18.4	23.1	0	19.2
	LAS HANDOVER WITHIN 15 MINS	%					20.7
	LAS HANDOVER WITHIN 30 MINS	%					74.7
	LAS HANDOVER WITHIN 60 MINS	No.					3

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

May 2015

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (BREAST SYMPTOMS) - (DIVISION)	%	0	0	91.6	0	91.6
	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (CANCER) - (DIVISION)	%	0	0	93	0	93
	31 DAY SECOND OR SUBSEQUENT TREATMENT (DRUGS) - (DIVISION)	%	0	0	100	0	100
	31 DAY SECOND OR SUBSEQUENT TREATMENT (SURGERY) - (DIVISION)	%			88		88
	31 DAY STANDARD FROM DIAGNOSIS TO FIRST TREATMENT - (DIVISION)	%			96.8		96.7
	62 DAY URGENT GP REFERRAL TO TREATMENT FOR ALL CANCERS - (DIVISION)	%			72.5		72.5
	62 DAY URGENT GP REFERRAL TO TREATMENT FROM SCREENING - (DIVISION)	%			72.7		72.7

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

			June 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Outcome Metrics	C-SECTIONS (APPLICABLE TO WOMEN & CHILDREN ONLY)	%				22.8	22.8
	HSMR	Ratio					92.4
	INCIDENCE OF C.DIFFICILE	No.	0	0	2	0	2
	INCIDENCE OF E-COLI	No.	1	6	1	0	8
	INCIDENCE OF MRSA	No.	0	0	0	0	0
	MATERNAL DEATHS	No.	0	0	0	0	0
	MEDICATION ERRORS CAUSING SERIOUS HARM	No.	0	0	0	0	0
	NEVER EVENTS	No.	0	0	1	0	1
	SERIOUS INCIDENTS (DIVISION LEVEL)	No.	2	6	3	5	16
	SHMI	Ratio					0.9
Quality Governance Indicators	PATIENT SATISFACTION (FRIENDS & FAMILY)	%	95.2	93.2	93.2	94.7	93.6
	PERCENTAGE OF STAFF APPRAISAL (MEDICAL) - (DIVISION)	%	72.7	87.6	87.9	87.8	87.1
	PERCENTAGE OF STAFF APPRAISAL (NON-MEDICAL) - (DIVISION)	%	75.4	77.8	74.2	74.4	74.5
	SICKNESS/ABSENCE RATE - (DIVISION)	%	6	2.6	3.4	3.1	3.6
	STAFF TURNOVER - (DIVISION)	%	20.4	17.7	14.4	17.2	17.3
	VOLUNTARY STAFF TURNOVER - (DIVISION)	%	16.1	15.4	12.8	13.2	14.2

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 June, 20.7% of patients had handover times within 15 minutes and 74.7% within 30 minutes. both of which are not within target. The 30 minute handover data is currently being validated and is envisaged to significantly increase post validation. The trust had 3 60 minute LAS breaches in June which are being validated. Due to technical issues with LAS portal in July, the window for validation has been extended until 31/07/2015.

The trust has a zero tolerance on avoidable pressure ulcers and has placed significant importance on its prevention. In June the trust had 1 grade 3 pressure ulcer SI's and 0 Grade 4. All grade 3 and 4 pressure ulcers acquired in our care are investigated as serious incidents, and a. full investigation and Root Cause Analysis will be produced for each PU and reviewed at the Pressure Ulcer Strategy group, chaired by the Deputy Chief Nurse

4. Performance
- Changes to RTT operational standards and reporting arrangements

Following a review by Sir Bruce Keogh and subsequent acceptance of recommendations on improvements to current waiting time standards and reporting by Simon Stevens – NHS England Chief Executive, the following changes have been confirmed:

- The admitted and non-admitted RTT operational standards are being abolished, and the incomplete standard that 92% or more of all patients waiting should be waiting under 18 weeks. This will become the sole measure of patients' constitutional right to start treatment within 18 weeks.

- Current RTT data submissions of non-admitted activity and unadjusted admitted activity will continue. However future data requirements will be amended and will include new additions including:
    - Number of clock starts
    - Decisions to admit
    - Validation removals, this will require all trusts to place greater scrutiny on their PTLs and data quality to improve waiting list accuracy.

- The Monitor Risk Assessment Framework will reflect these changes, presumably removing the two RTT treatment operational standards from the framework. This change is envisaged to be in effect by the end of July.

- There will be no commissioner sanctions relating to performance against the admitted and non-admitted completed pathways standards. This has been back dated with effect from 1st April 2015. However, sanctions against the incomplete standard will continue to apply.

- NHS England will shortly consult on a National Variation to make in-year changes to the 2015/16 Contract to formally remove the financial sanctions for the two completed pathway standards. This will also propose increasing the value of the sanction which applies where providers are unable to achieve the incomplete pathway standard, in line with the new commitment to the incomplete standard as the single new measure of RTT performance. It is intended that the National Variation will be implemented by 1st October 2015. This means that providers have three months to improve their incomplete performance before contract sanctions increase.

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Corporate Outpatient Services Performance

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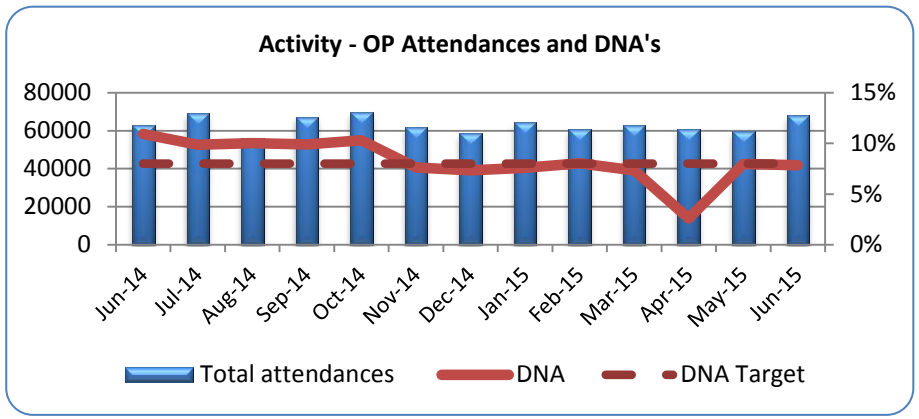
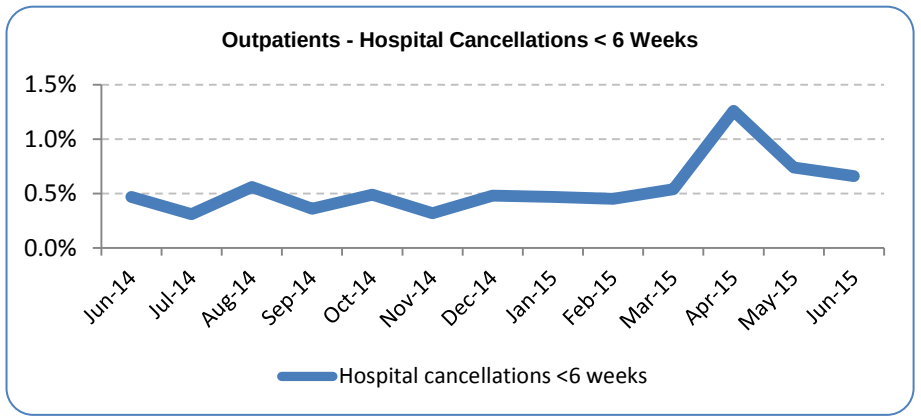
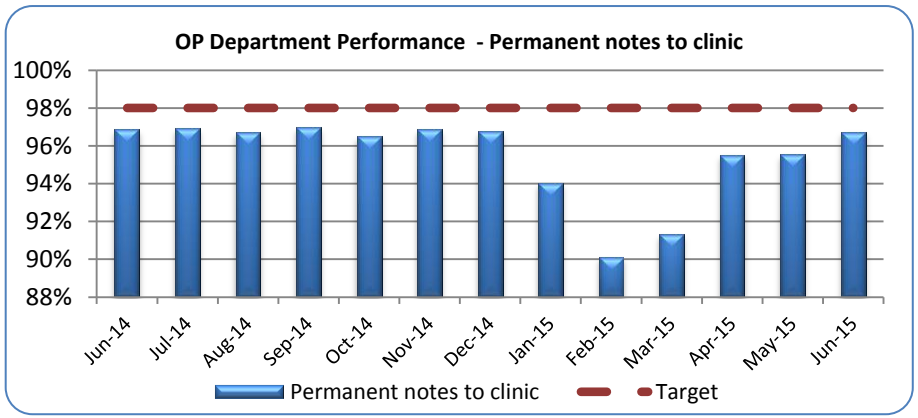
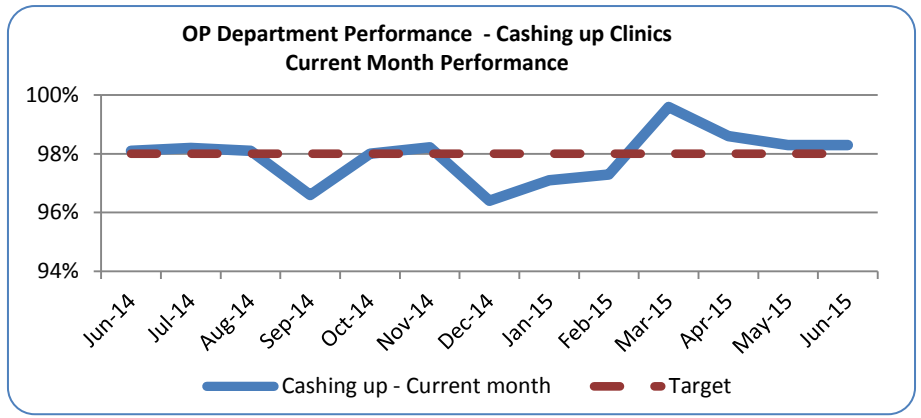
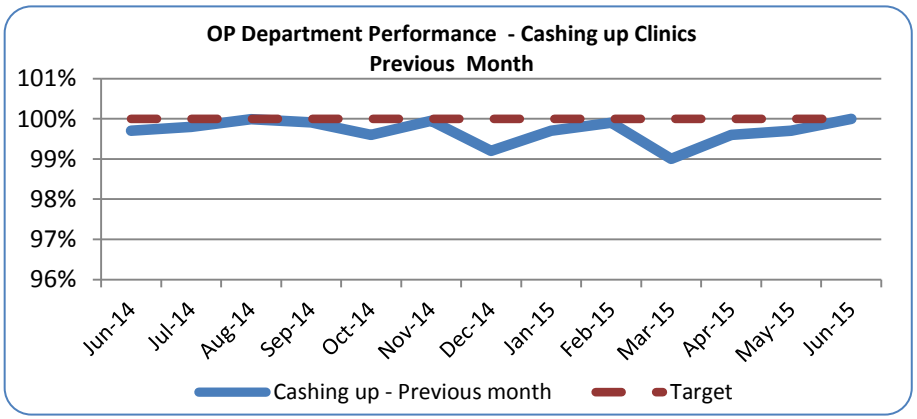
5. Corporate Outpatient Services (1 of 2) - Performance Overview

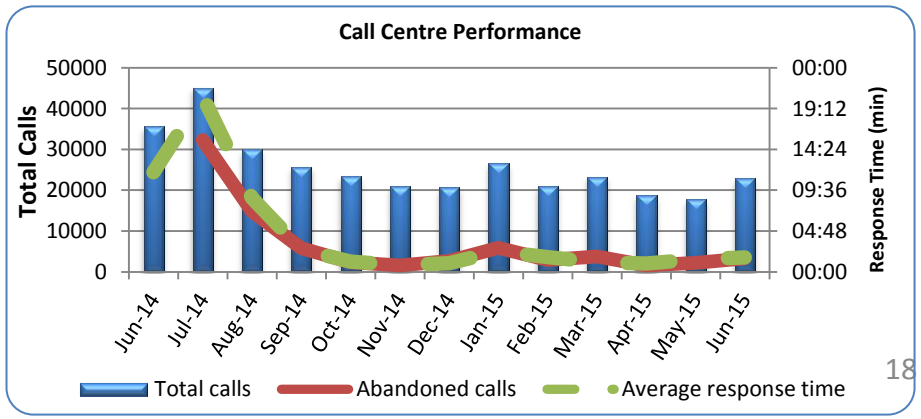












5. Corporate Outpatient Services (2 of 2) - Performance Overview

		Target	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Activity	Total attendances	N/A	69250	56102	67188	69507	61879	58659	64609	60659	62946	60564	59841	68002
	DNA	<8%	9.87%	10.02%	9.89%	10.30%	7.64%	7.33%	7.58%	8.04%	7.33%	2.59%	7.97%	7.84%
	Hospital cancellations <6 weeks	<0.5%	0.31%	0.56%	0.36%	0.49%	0.32%	0.48%	0.47%	0.45%	0.54%	1.26%	0.74%	0.66%
OPD performance	Permanent notes to clinic	>98%	96.94%	96.71%	96.98%	96.51%	96.88%	96.77%	94.05%	90.12%	91.32%	95.52%	95.54%	96.74%
	Cashing up - Current month	>98%	98.20%	98.10%	96.60%	98.00%	98.22%	96.40%	97.10%	97.30%	99.60%	98.60%	98.3%	98.30%
	Cashing up - Previous month	100%	99.80%	99.99%	99.91%	99.60%	99.95%	99.20%	99.70%	99.90%	99.00%	99.60%	99.70%	100.0%
Call Centre Performance	Total calls	N/A	45101	30004	25674	23420	20964	20639	26565	20842	23235	18710	17732	22955
	Abandoned calls	<25%/<15%	32257	14825	5794	2376	1558	2681	5923	2908	3782	1551	2237	3309
	Mean call response times	<1 minute	20:39	08:41	02:38	01:13	00:47	01:02	02:24	01:43	01:08	01:00	01:29	01:42

Key Messages:

- June activity has seen a significant increase in comparison to the average for the last six months. DNAs have marginally reduced and remain within target of less than 8%, this continues to be closely monitored going forward. Hospital cancellations have seen consecutive month on month reduction in Q1. However, this is still not within target of less than 0.5%. Performance of permanent notes to clinic has seen an improvement over the last month with performance of 96.74%. This is an on-going priority area for the service.

- Call centre performance has seen an improvement from the challenges in Q4. Abandoned calls performance has been maintained remaining less than 15% for all of Q1. The division continues to monitor call centre performance to maintain abandoned call performance of less than 15% of total calls and to bring average response times to less than a minute. Average response times have seen consecutive month on month improvement from January. However, average response time in June was in excess of the 1.0minute target. Renewed focus is being placed on this to ensure consistent low response times are maintained.

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Clinical Audit and Effectiveness

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6. Clinical Audit and Effectiveness - Mortality

HSMR (Hospital standardised mortality ratio)						
Lead Director	May 15	June 15	Movement	2014/2015 Target	Forecast March 16	Date expect to meet standard
SM	88.3	88.2	↓	<100	G	Met

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

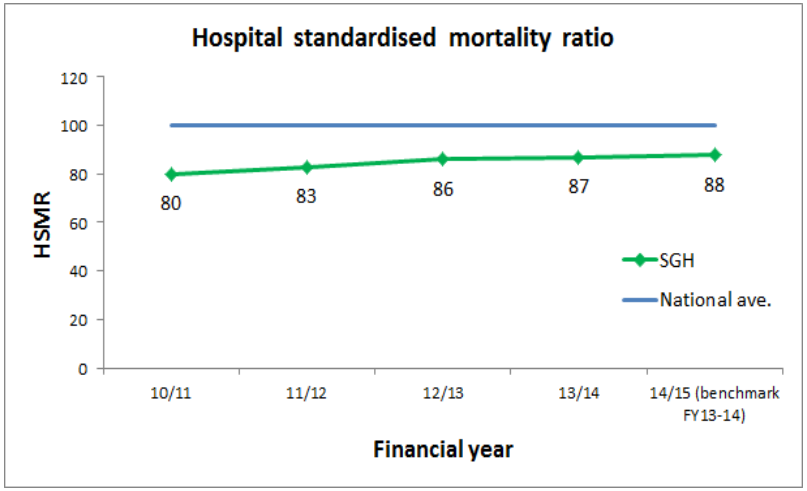
Note: Source for HSMR is Dr Foster Intelligence, published monthly. Data is most recent 12 months available. For June 15 this was April 2014 to March 2015, and benchmark period is to March 2014. SHMI data is published by the Health and Social Care Information Centre. The last 12 month period as published on 29th April 2015 relates to the period October 2013 to September 2014. The next publication will be issued on 29th July.

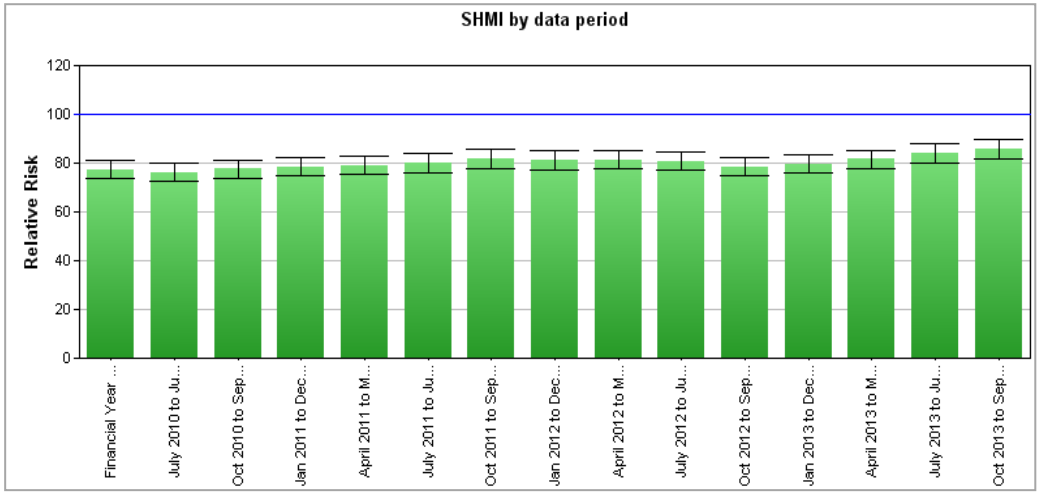
Overview:

Our overall mortality measured by both the HSMR and the SHMI remains statistically significantly better than expected as summarised above. If we use a longer term benchmark (i.e. 10 years of discharges up to December 2014) our HSMR is 92.4. Although this is still better than expected it does reinforce the need to continue our close scrutiny of mortality.

In June we received notification of two outlier alerts from the Dr Foster Unit at Imperial indicating higher than expected mortality for the diagnosis group 'Coronary atherosclerosis and other heart disease' and the procedure group 'Cardiac pacemaker or defibrillator introduced through the vein'. These alerts are shared with the Care Quality Commission. There are a number of possible reasons for these results, including random variation, data quality or coding issues, and case-mix issues; an internal review of both of these signals is underway to evaluate care provided, led by Dr Nigel Kennea (Associate Medical Director and Mortality Monitoring Committee Chair). Case note reviews are underway, with the involvement of cardiology consultants. The clinical coding team has also participated in the review, and better liaison between the clinical and coding teams already agreed. It is anticipated that both reviews will be completed by the end of the month.

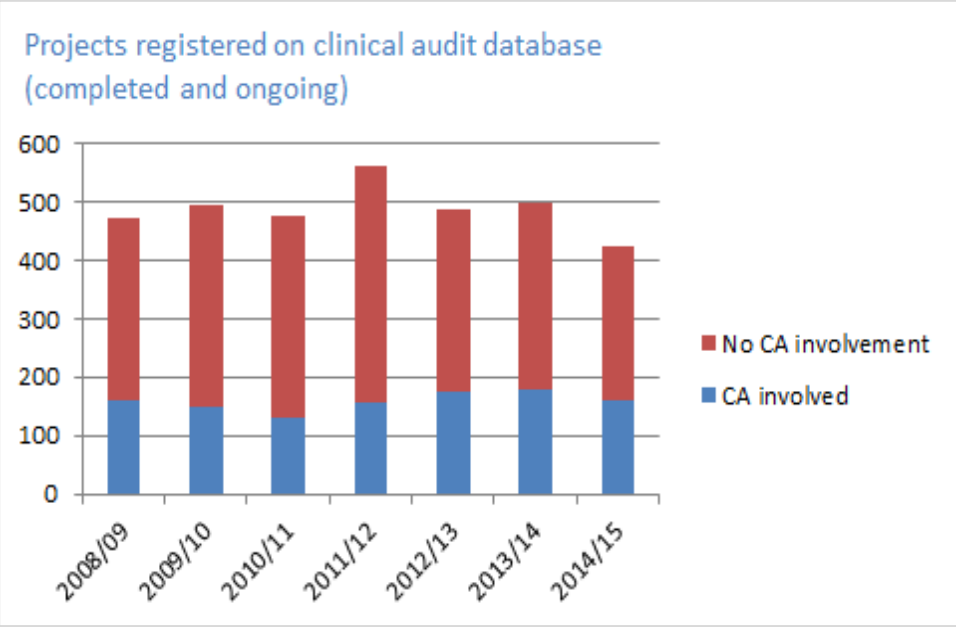
The report of the PRISM 2 study was published on 15th July. We are now looking at this in detail, along with our local results which were provided to us at the same time. We will be in a position to report fully next month.





6. Clinical Audit and Effectiveness - Local Audits

Clinical Audit + Effectiveness Annual Report 2014/15



Objectives 2015/16	
Agree second iteration of the audit strategy, supporting us to embed quality	Review roles + responsibilities within the team to ensure delivery of a valuable service
Strengthen the content of the audit programme and be better able to demonstrate impact	Increase understanding of NICE implementation and any associated risks and update policy
Build on our strong programme of mortality review and implement any new national requirements	Launch an e-learning package aligned to our established training programme
Review approach to acting on findings of confidential enquiries, and reflect in updated policy	Enhance output of the Safety Thermometer in order to inform and track safety improvements
Update audit policy, supporting staff to deliver effective audit	Begin extracting data from iClip for use in clinical audit projects

The Clinical Audit + Effectiveness Annual Report 2014/15 is to be presented to the Patient Safety Committee (PSC) in July. The report highlights the work and achievements of the clinical audit team, however all projects that have been registered on the Trust clinical audit database are also summarised. During the year 427 projects have been registered as complete or on-going, demonstrating the continuing commitment across the trust to the measurement and improvement of the quality of services. The high level of support from the audit team has been sustained, with auditors facilitating 160 of these projects. For the first time the report includes a summary of outcomes for each of the 191 audits which were on the programme approved by PSC in March 2014.

The team has continued to play a very active role in important strands of work related to clinical effectiveness and governance. Progress over the year is detailed in the report, including strengthening our processes for investigating and understanding mortality. We end the year with a better picture of NICE implementation and have also introduced regular assessment of compliance to support better understanding and management of associated risks.

Sharing of best practice and learning from audit remains a priority for the team. Enthusiasm for sharing knowledge was once again demonstrated through the annual Clinical Audit Half Day, with the highest attendance since the event was first held in 2007. We have expanded our audit library which is hosted on the intranet and we will add to this over the coming year. The team has also provided training to over 100 members of staff.

Significant strategic achievements have been made in recent years; however, we are committed to making further improvements. Specific goals for 2015/16,which are aligned to the Trust's aims and objectives, are detailed in the report and summarised in the table above. As always, collaborative working with colleagues in all specialties and at all levels will be key to the successes we can achieve in making full use of clinical audit to improve patient experience, safety and outcomes.

6. Clinical Audit and Effectiveness - National Audits

National Congenital Heart Disease Audit Report 2011/14 (NICOR)

The National Congenital Heart Disease Audit (NCHDA) collects data from all centres undertaking congenital cardiac surgery and interventional procedures in the UK. It aims to improve the quality of specialist congenital care by providing reliable data on patient outcomes.

St George's is one of 20 centres who undertake procedures in adult patients with congenital heart disease, which refers to any defect of the heart present from birth. It includes structural defects, congenital arrhythmias and cardiomyopathies. The audit does not include treatment of acquired heart disease which develops after birth.

Congenital heart disease is relatively rare and due to the relatively small number of cases the report provides composite 3 year results for procedures performed between 01/04/2011 and 31/04/2014.

Data submitted to the audit is subjected to rigorous validation comprising site visits by a clinical auditor and volunteer clinician. Following the validation visit a data quality indicator is calculated, with NICOR's expectation that units will achieve 90 per cent. St George's consistently achieves this standard, with our most recent score being 90.75.

Analysis of all hospitals shows an upward trend in survival in the most recent 18 months. The overall survival for all congenital heart disease procedures is extremely high and continues to compare very well with data from international databases in Europe and North America. The report highlights that 30 day survival rates for the 57 major surgical and transcatheter cardiovascular interventions undertaken to treat congenital heart disease is above the alert limit for all procedures, in all hospitals. St George's conducts seven of these procedures and 30 day survival is 100 per cent for all.

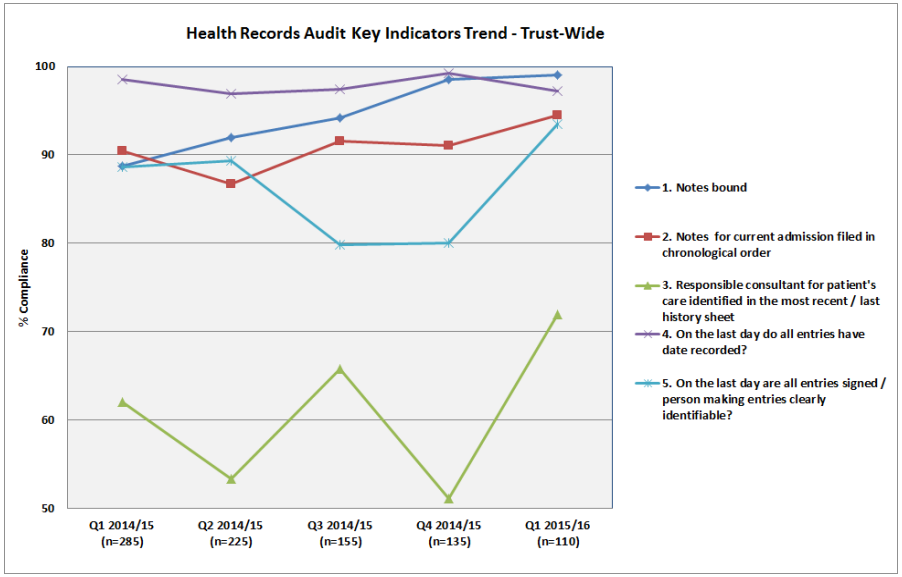
St George's 30 day survival (01/04/11 – 31/03/14)

Procedure	Cases	30 day survival
Aortic valve replacement – non Ross	7	100%
ASD closure (catheter)	59	100%
ASD repair	9	100%
Mitral valve replacement	1	100%
PFO closure (catheter)	85	100%
Subvalvar aortic stenosis repair	1	100%
VSD repair	1	100%

Source: NICOR (National Institute for Cardiovascular Outcomes Research)

6. Clinical Audit and Effectiveness - Local audit

Healthcare Records Audit Report Q1 2015/16



PARTICIPATION	Apr-Jun 2014	Jul-Sep 2014	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015
General surgery	✓	✓	✓	✓	×
Maxillofacial	✓	✓	✓	✓	×
Neuro + Amputee (Gwynne Holford)	✓	×	×	×	×
AMU	✓	✓	✓	✓	×
Chest/Respiratory	✓	×	×	×	×
Diabetes + Endocrinology	✓	×	×	×	×
Haematology	✓	✓	✓	✓	×
Oncology	✓	✓	✓	✓	×
Vascular	✓	×	×	×	×
Gynaecology	×	✓	✓	×	×
General ICU	✓	✓	✓	✓	×
Obs/Maternity	✓	✓	✓	✓	×

Participation in the ongoing quarterly audit of record keeping standards is mandatory for all inpatient services. In Q1 responses from 11 care groups (n=110) were received. Twelve specialties did not complete the audit. Ten areas were exempt from this audit as they have implemented electronic documentation. Rheumatology asked for an exemption as rheumatology inpatients are very few and spread across the hospital.

The audit was presented to the Patient Safety Committee in July. The committee has requested action plans from specialties which have not performed the audit for two or more of the last five quarters, detailing how they will ensure participation. The chair of the health records committee is planning to liaise with educational supervisors to engage junior doctors, with the aim of improving participation and learning.

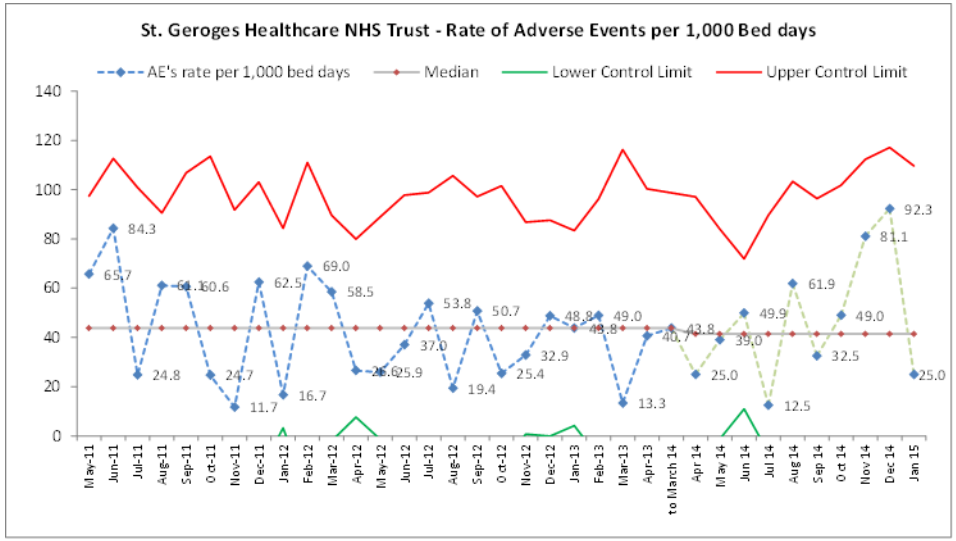
Overall our level of performance does not meet the target set by our commissioners in 2012/13 when this was a local CQUIN. Local action will be required to improve standards and to this end care group results are available alongside the trust level report. For most of the core standards improvement is required, however significant improvement is required in the recording the responsible consultant on the history sheet. Accordingly this was identified by the Patient Safety Committee as the priority area for action by divisions.

A number of other measures have been recommended at trust level, particularly around the improved access to patient labels, use of clinician name stamps, patient identification stickers and dividers in ward ring folders. Where the audit revealed that there is no access to a working label printer this has been reported to divisions for local resolution.

The clinical audit department is planning to create a report in PIEDW (iCLIP) to enable us to audit the quality of electronic documentation in areas that have gone live with clinical documentation in iClip. This is dependent on access to training, which is currently being taken forward by the iClip implementation team.

6. Clinical Audit and Effectiveness
- Local Audits

Global Trigger Tool



The Global Trigger Tool for Measuring Adverse Events (GTT) was developed by The Institute of Healthcare Improvement as a method for identifying adverse events (harm) and measuring their rate of over time, to tell if changes being made improve the safety of the care processes.

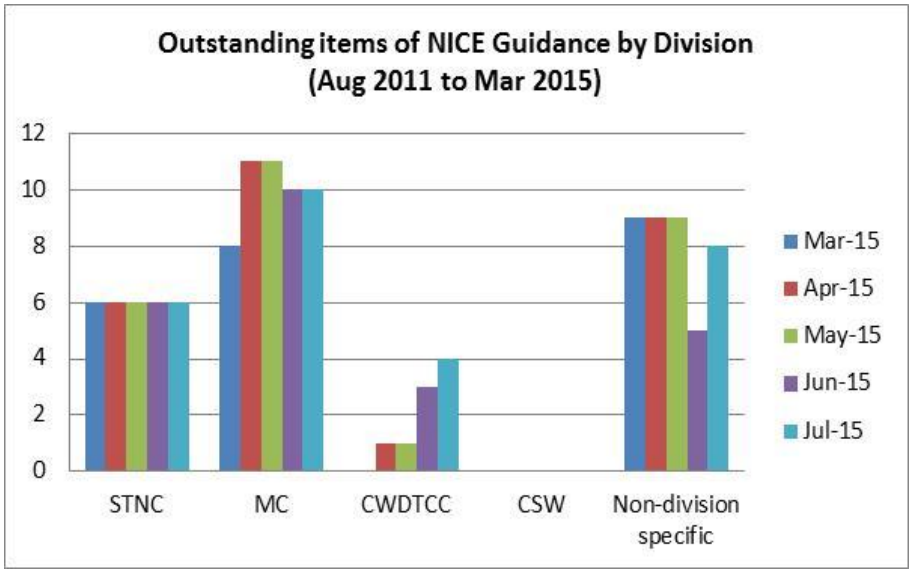
The recommended measure is to look at Adverse Events (AE's) per 1000 patient days as shown in the chart. The central line is the mean across the period. The upper and lower control limits are calculated to 3 SD's (standard deviation) and points within the two control limits are considered as normal variations. Points outside of these lines represent extraordinary variation and would require more investigation. The trigger tool has been used in SGH since 2010; however, due to a backlog of reviews it was agreed to forgo a year's worth of data. This is reflected on the chart from April 2014.

Interpretation continues to indicate that our data remains within normal variants, although there was a peak in December 2014. This corresponded to an increase in emergency admissions and mortality and has now fallen. The five most common adverse events are consistently: complication of treatment/procedure; wound infection; nosocomial pneumonia; decubiti and readmission in 30 days. Comparative results indicate that most recently there has been an increase in complications due to treatment and harm due to decubiti, and a reduction in the rate of wound infection (and urinary tract infections), and nosocomial pneumonia. There has also been a reduction in more serious harms seen (graded G, H and I). For 2014/15 it stands at 6.25% (4/64) compared with 12.85% (9/70) in 2012/13. The proportion of patients experiencing temporary harm requiring an intervention (graded E) has increased from 15.1 to 17.8%.

The most common trigger is the Early Warning Score and the review team now look at this trigger in detail. In the most recent period 70.3% of patients (142/202) had one or more error and 73% (48/66) had a high score that was not responded to. However, none of these triggers caused harm.

Whilst the GTT is primarily used for on-going surveillance of safety trends, concerns identified during the course of the reviews are highlighted to the relevant care groups and any learning is shared. An on-going concern for the project is the need to recruit more participants. This was highlighted to the Patient Safety Committee in June.

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



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

Division	2010	2011	2012	2013	2014
STNC (n=7)		n=1	n=2	n=1	n=3
M+C (n=14)	n=2	n=2	n=4	n=1	n=5
CWDTCC (n=15)	n=3	n=1	n=1	n=3	n=7
CSW (n=0)					
Non-division specific (n=6)	n=2			n=3	n=1

Overview

There were 32 items of NICE guidance released in February and March 2015 and to date we have received 28 responses.

In total there are currently 28 items of guidance outstanding, with the oldest dating back to August 2011. The number of items of guidance without a response has increased since the beginning of the financial year, despite the audit team's continued focus. We are now contacting the identified leads and asking for a response within the next 2 weeks. Anything outstanding after that point will be escalated to Divisional Chairs for action.

The audit team have just completed the six-monthly review of all guidance with compliance issues and are currently receiving updates from leads. New templates that include risk assessment for non/partial compliance were used for the review, contributing to the development of a more thorough understanding of risks associated with non implementation. Compliance reports for each division will be updated and circulated for discussion in DGB meetings by the end of the month.

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St George's University Hospitals NHS
NHS Foundation Trust

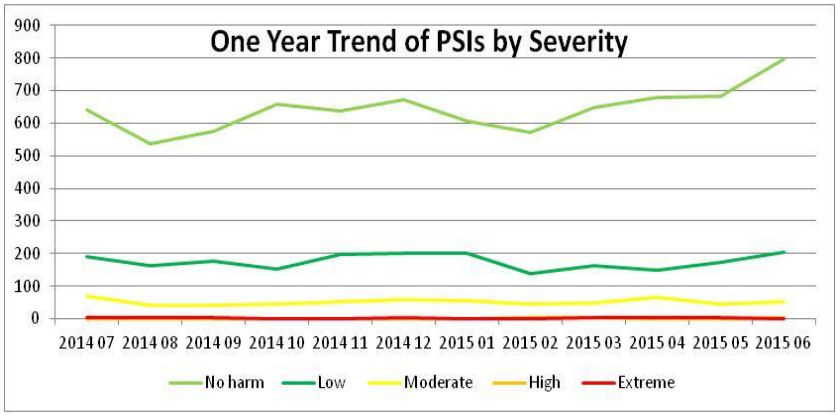
Patient Safety

Excellence in specialist and community healthcare

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

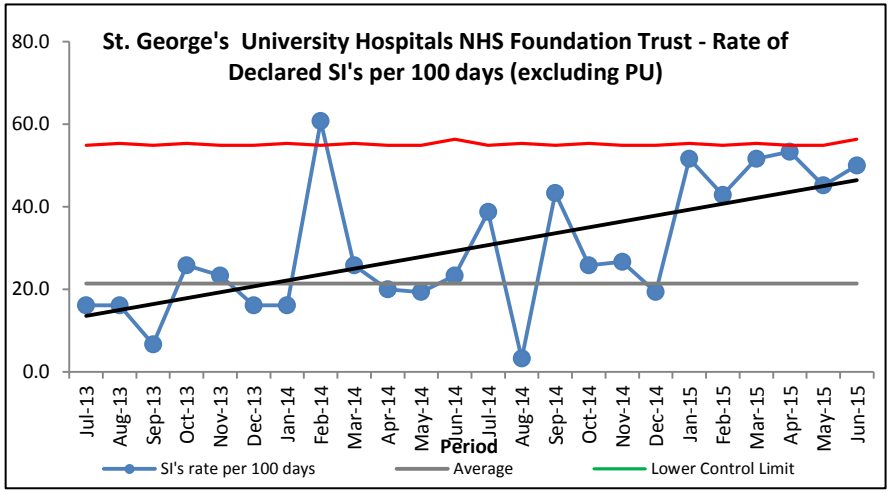
S	Q1 SIs Declared by Division (Inc. Pus)				
	Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
March	9	2	**8 including 1 never**	7	0
April	14	3	**1**	0	0
May	11 **including 1 never**	3	**1**	2	1
June	6	3	**2**	5	0

Table 1



Closed Serious Incidents (not PUs)					
Type	March	April	May	June	**Movement**
Total	10	11	9	8	
No Harm	6	7	7	5	
Harm	4	4	2	3	

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

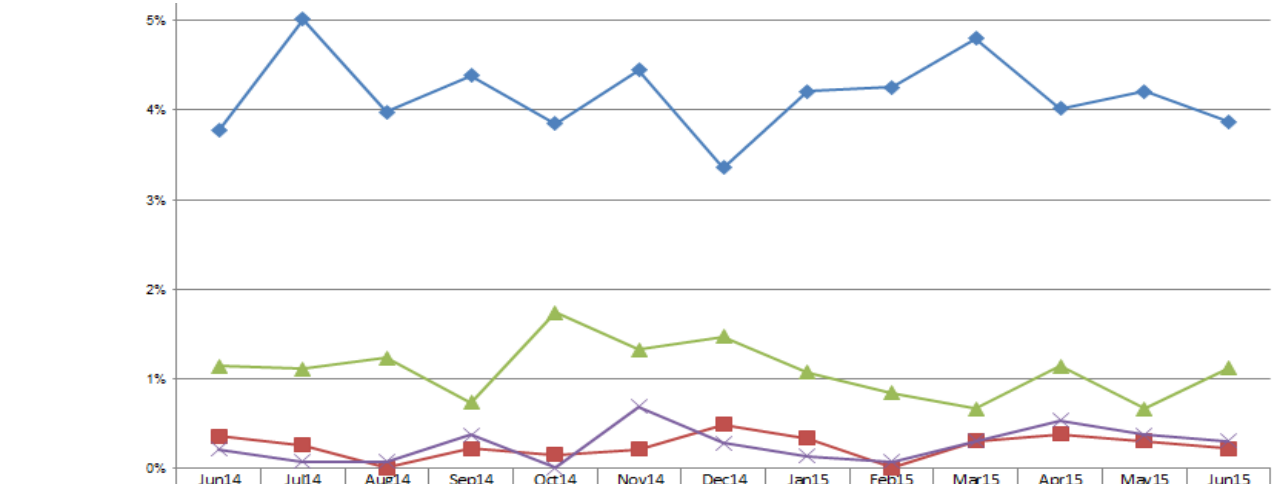
The annual trend for new serious incidents excluding pressure ulcers shown in Table 2 continues to show an increase. There were 15 general SIs reported in June(+1 grade 3 pressure ulcers).

The 15 general SIs declared in June relate to a range of different issues. They include:

- 2 Deaths in custody
- An unexpected death
- Failure to follow up
- 2 Delayed diagnosis/ appointment
- Exposure of a staff member to infection
- 2 Maternity incidents
- 4 related to surgery
- A delayed LAS handover
- A fall

7. Patient Safety - Safety Thermometer

% Harm Free Care							
Lead Director	April 2015	May 2015	June 2015	**Movement**	**2015/2016 Target**	**National Average June 2015**	**Date expected to meet standard**
J Hall	94.20%	94.61%	94.56%	↓	95.00%	94.1%	March 16



	Jun14	Jul14	Aug14	Sep14	Oct14	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15
Pressure Ulcers	3.77	5.02	3.98	4.39	3.85	4.45	3.36	4.21	4.26	4.8	4.02	4.21	3.87
Falls	0.36	0.26	0	0.22	0.15	0.21	0.49	0.33	0	0.3	0.38	0.3	0.22
Catheter & UTI	1.14	1.11	1.23	0.73	1.74	1.32	1.47	1.07	0.84	0.66	1.14	0.66	1.12
New VTE	0.21	0.07	0.07	0.37	0	0.69	0.28	0.13	0.07	0.3	0.53	0.37	0.3
Patients	1405	1533	1458	1368	1377	1439	1429	1495	1433	1355	1320	1354	1343

Pressure ulcers (52)

- 36 grade 2 (18 new, 18 old)
- 12 grade 3 (4 new, 8 old)
- 4 grade 4 (0 new, 4 old)

CAUTI (15)

- 13 new
- 2 old

Falls (3)

- 3 low harm falls

VTE (4)

- 1 new PE
- 3 new other

In June 2015 the proportion of our patients that received harm free care was 94.56%, which is very similar to levels reported in recent months the national average for May of 94.1%. We reported 74 harms to 73 patients; 72 patients experienced one harm and 1 patient had 2 harms. 42 harms are categorised as new, meaning that they either developed or treatment began whilst under our care. Details of all harms reported are provided above. Information from the Safety Thermometer will also be used in the Establishment Review which is currently underway.

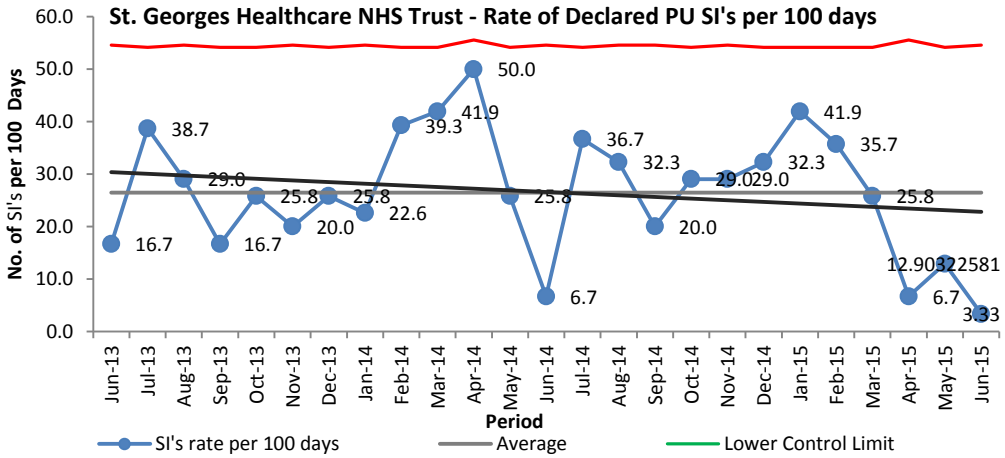
All harms decreased this month, other than catheter associated urinary tract infections (CAUTI). The number of CAUTIs overall varies widely by month; for example this month 13 new infections were recorded, whereas in May the number was 3. We are currently pulling together detailed information on our catheter usage, as well as the number of new and old infections. This will be used to inform the work being done locally as part of our involvement in the South London Health Innovation Network Safety Collaborative.

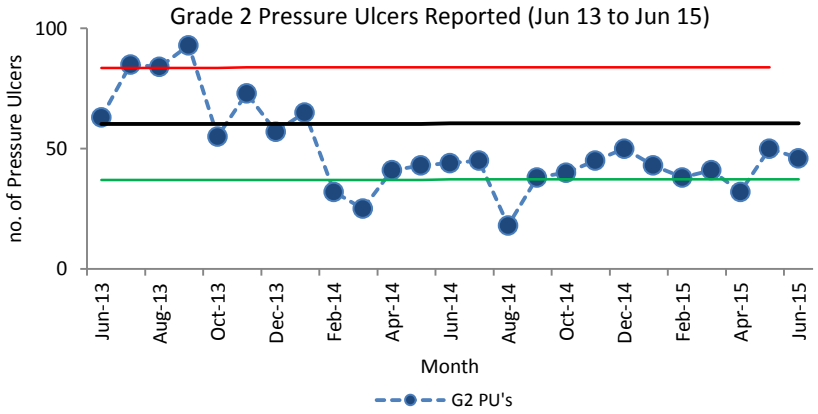
In June we began the pilot of the Children and Young Persons' Safety Thermometer, across paediatrics. This version of the tool looks at skin integrity, deterioration, pain and extravasation. It is anticipated that the pilot will run for approximately three months and when we have robust processes in place we will begin to submit data to the national tool, which will allow us to identify local areas for action.

7. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers										
Type	Feb	Mar	Apr	May	Jun	YTD April – May 2016	Movement	2015/2016 Target	Forecast March 2015	Date expected to meet standard
Acute	5	5	1	4	1	**6**	⮟		G	-
Community	5	3	1	0	0	**1**	⮟		G	-
Total All	10	8	2	4	1	**7**	⮟		G	-
Total Avoidable	**3**	**2**	**2**	**4**	**1**	**7**		40		-

Grade 2 Pressure Ulcers						
Feb	Mar	Apr	May	Jun	Movement
18	30	25	37	28	⮟
20	11	7	17	18	⮝
38	41	32	50	46	⮟





Overview:

June saw a reduction in pressure ulcers across the trust, with the acute side achieving a reduction from 4 in May to 1 in June. Community services continued its excellent work and had a second month of no Grade 3 or 4 pressure ulcer. There was also a reduction in the total number of Grade 2 pressure ulcers across the trust.

Actions:

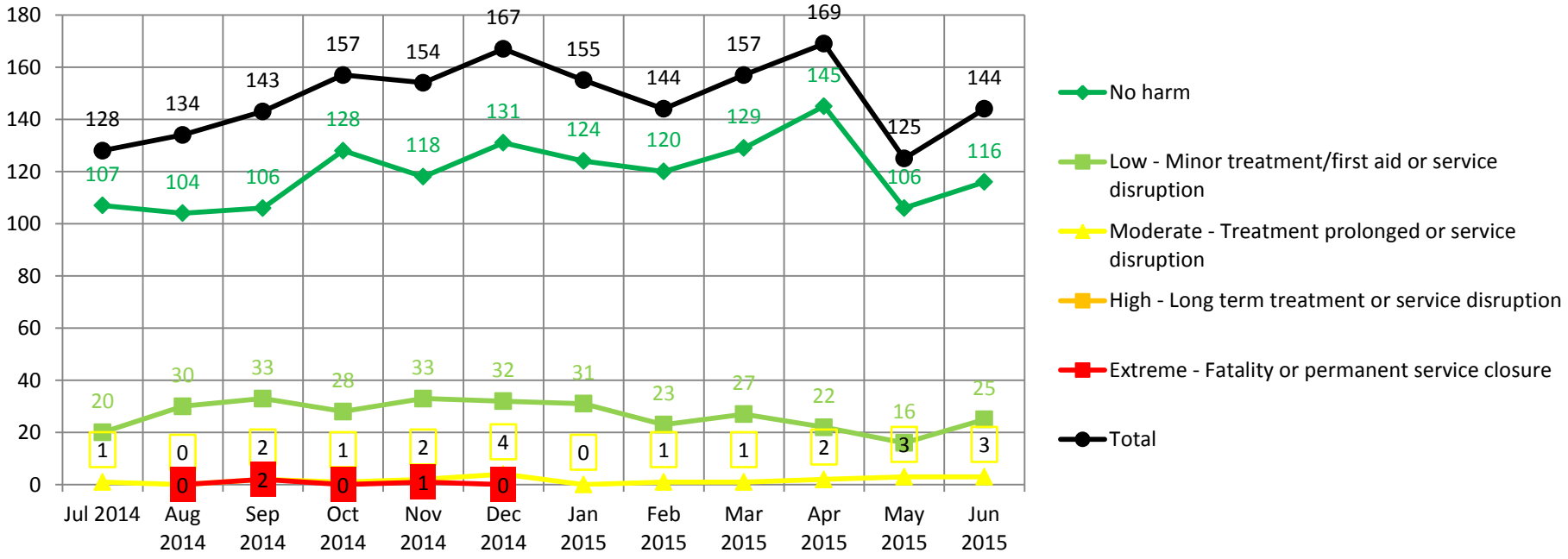
- IHI Improvement programme underway in the acute setting, pressure ulcer root causes are tracked and monitored to discover trends and areas for improvement.
- 72 Hour review of all new Grade 3 and 4 pressure ulcers being undertaken to give an insight into avoidability.
- Pressure mattress 'show and tell' day scheduled for 24th July, 8 companies invited to exhibit mattress solutions that may benefit the trust in the future and lead to savings in provision.
- Recruitment of a Band 7 TVN for the community and a Band 6 TVN for the acute setting are underway.
- Pressure Ulcer awareness month in the Surgical division underway, this has provided a noticeable increase in awareness and is being backed by senior members of the team. Due to the success of this initiative other divisions are seeking to run similar events.

7. Patient Safety:
- Incident Profile: Falls

Falls															
Lead Director	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	Movement	2015/2016 Target	Date expected to meet standard
	151	151	125	143	157	154	169	154	144	157	165	126	144	⟷	100	

Falls with Harm April 2014-March 2015				
No Harm	Moderate	Severe	Death	Falls related Fractures
2180	28	3	0	7

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



Overview: The graph shows the profile of falls across both acute and community services including bed-based care and patients' own homes. It is important to note that this data is sourced from incident reporting and is not individually verified. There has been a small increase in the number of falls in June. **Actions:** The Trust participated in the National Inpatient Falls Audit and the results will be available in October so that we can bench-mark across similar Trusts. Preliminary local analysis suggests areas for improvement in continence assessment and the management of patients with delirium and/or dementia. We will be auditing bed rail risk assessment compliance. We will be piloting the NICE compliant falls risk assessment in the coming months before full implementation.

7. Patient Safety:
- Infection Control

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

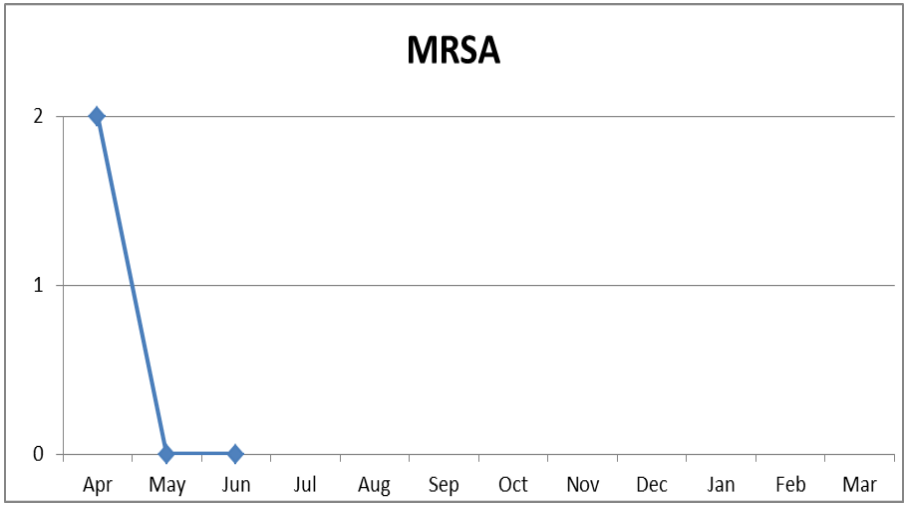
Peer Performance – YTD June 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
2	1	0	0	2

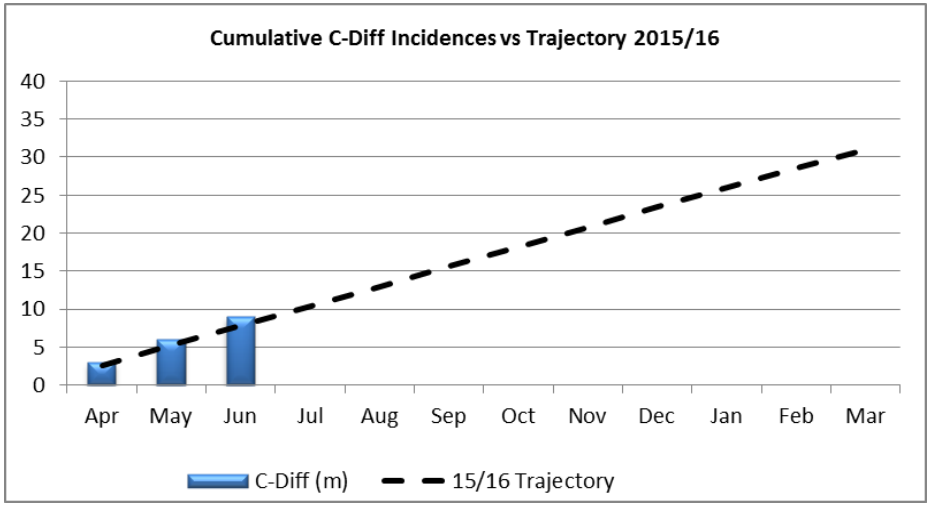
C-Diff						
Lead Director	May	June	Movement	2015/2016 Threshold	Forecast July - 15	Date expected to meet standard
JH	3	3	➤	31	R	-

Peer Performance – YTD June 2015 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
9 (31)	2(16)	6(9)	28(72)	7(39)

The MRSA bacteraemia threshold is zero. Their were no cases of MRSA bacteraemia in June. The trust is non-compliant with 2 incidents in total. There is a potential for an MRSA taken at St Helier ascribed to a CCG in May, being ascribed to us. The CCG has appealed and the MRSA may be awarded to a third party, namely us, as the patient underwent cardiac surgery 60 days prior to bacteraemia at St Georges. The panels decision is awaited.

In 2015/16 the Trust has a threshold of no more than 31 C. diff incidents. In June there was 3 C. diff incidents , a total of 9 for the FY to end June. We are slightly above the trajectory.





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	July	Aug	Sept	Oct	Nov	Dec	Jan (2015)	Feb	Mar	April	May	June
Unify2	97.28%	96.60%	96.84%	94.91%	93.18%	93.51%	95.94%	96.03%	96.27%	96.64%	96.45%	

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	July	Aug	Sept	Oct	Nov	Dec	Jan (2015)	Feb	Mar	April	May	June
Safety Thermometer (SGH)	89.94%	86.51%	86.44%	85.39%	86.56%	75.92%	79.08%	83.89%	85.74%	89.83%	90.19%	95.14%
National average	84.62%	90.87%	85.50%	85.04%	84.19%	83.98%	84.69%	84.82%	84.69%			

Comparison of data streams:

Although there are differences in the methodology of collecting the different data streams, triangulation of both shows similar trends. 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. It has recently become possible to audit individual clinicians who are overriding alerts and to cross reference the specialty with data on risk assessments which allows clear accountability to be established.

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

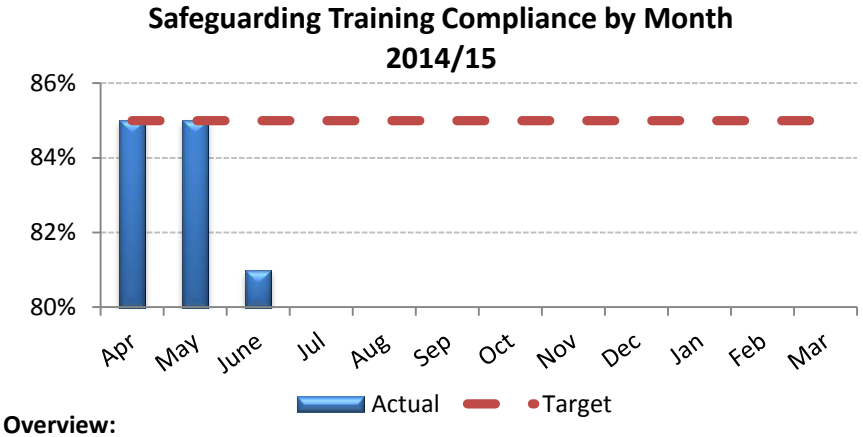
Year		2015
HAT cases identified to date (attributable to admission at SGH)		114
Mortality rate	Total	11.2% (12/107)
	VTE primary cause of death	5.6% (6/107)
Initiation of RCA process		100%
RCA pending	<28 days since notification	24
	>28 days since notification (notes requested)	6
RCA complete		72% (77/107)

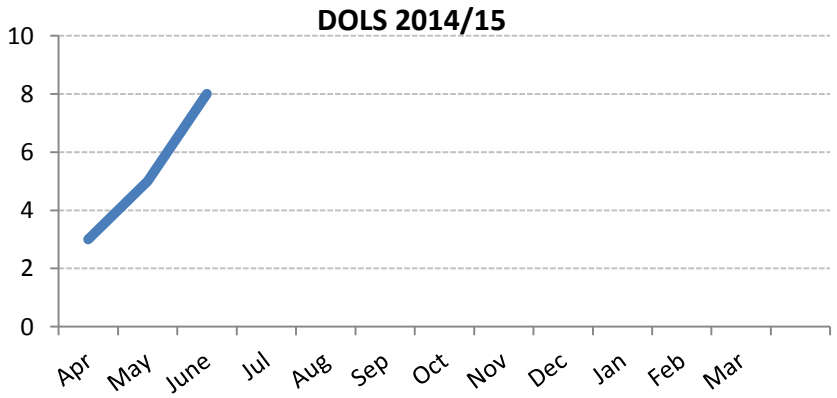
HAT case finding has significantly improved since the start of 2015 resulting in an observed increase in frequency of HAT. This increase brings incidence of HAT at SGH in line with rates observed at other Trusts in London that are of a Similar size and status.

7. Patient Safety
- Safeguarding: Adults

Safeguarding Training Compliance - Adults									
Lead Director	Jan	Feb	Mar	April	May	June	2015/20165 Target	Forecast April 2015	Date expected to meet standard
JH	87%	86.2%	87%	85%	85%	81%	85%	A	-

Safeguarding Adults Training Compliance by Division – June 15				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
77%	79%	85%	85%	77%





Overview:

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

April – 74, May 76, June 77, July 84, Aug 45, Sep 74 Oct 76, Nov 75, Dec 68, Jan 77, Feb 70, Mar – 80, Apr 90, May – 70, June 78.

CurSince 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. Divisions to take action around low compliance

Review procedures following implementation of Care Act - Awaiting revision of Pan London Procedures due Dec 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.. New procedure in place to ensure reporting of those subject to DOLS are reported to the coroner. July 15 – fresh legal advice obtained around risk to organisation and patients with regard to non application of DoLs. Revised briefing paper prepared for QRC July 2015

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NHS Foundation Trust

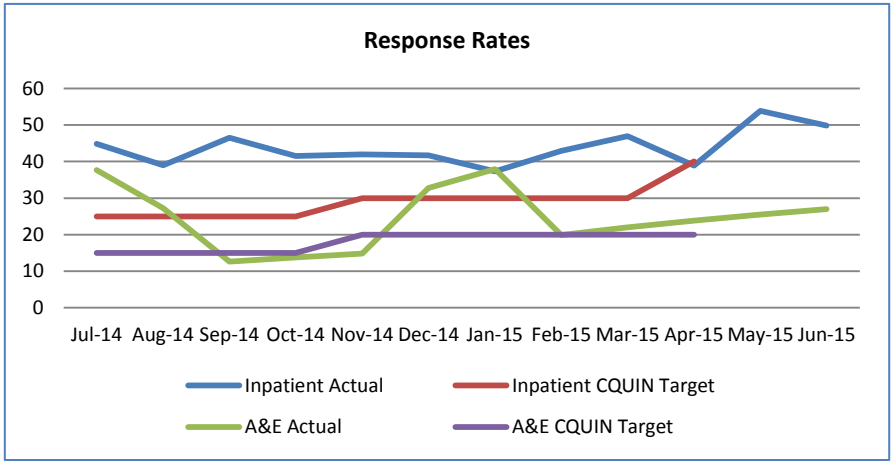
Patient Experience

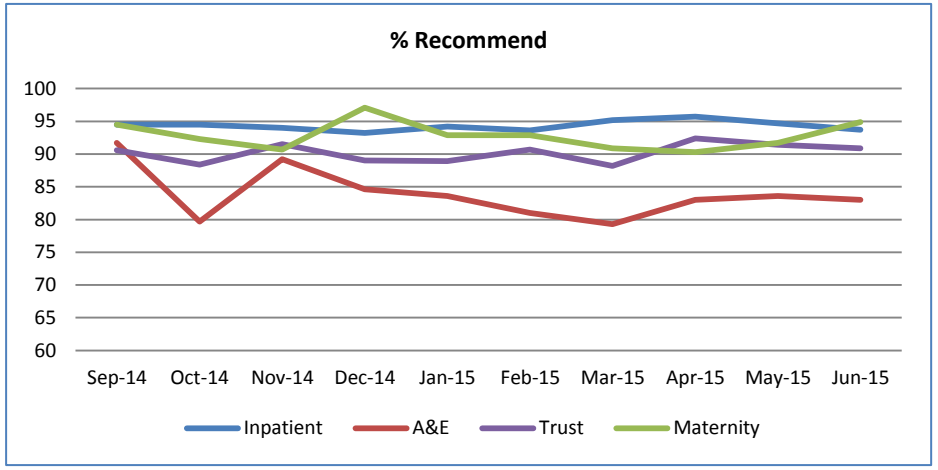
Excellence in specialist and community healthcare

8. Patient Experience
- Friends and Family Test

FFT Response Rate							
Domain	Apr-15	May-15	Jun-15	Movement	2015/2016 Target	Forecast	Date expected to meet standard
Trust	28.9	34.3	34.3		-	-	-
Inpatient	38.9	53.9	49.9	▼	-	-	-
A&E	23.8	25.5	27	▲	-	-	-
Maternity	24	24.3	23.9	▲	-	-	-

	FFT Response Score			
Apr-15	May-15	Jun-15	Movement	
92.4	91.4	90.9	▼	
95.7	94.7	93.7	▼	
83	83.6	83	▼	
90.3	91.7	94.9	▲	





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

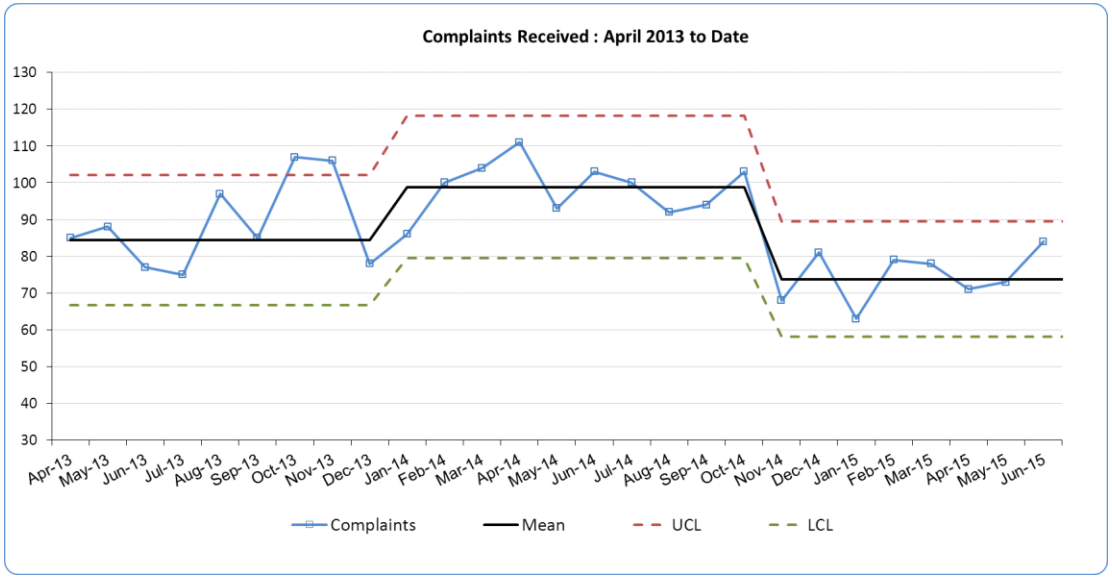
Action :

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

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

8. Patient Experience
- Complaints Received

Complaints Received															
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	Movement
Total Number received	111	92	100	99	92	94	107	68	81	63	79	78	71	72	84	



Overview:

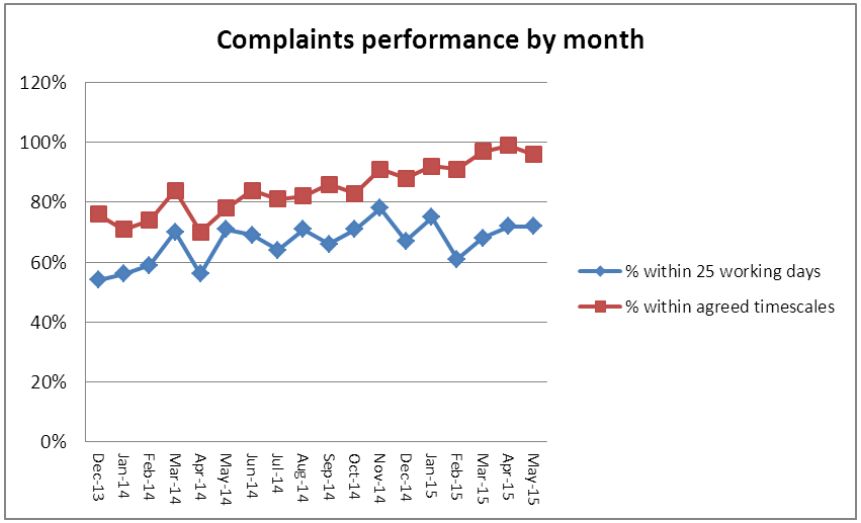
This report provides a brief update on complaints received since the last board report (June 2015) and information on responding to complaints within the specified timeframes for complaints received in May of 2015/2016. It also includes some posts made on NHS Choices and Patient Opinion. The board will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

Total numbers of complaints received in June 2015

There were 84 complaints received in June of 2015, an increase of 15% on May when 72 complaints were received. Of note , there was an increase in complaints being received for the General Medicine care group from 3 in May to 8 in June. These were across six wards and about a variety of subjects and there were no themes regarding staff involved. Complaints about the Cardiovascular directorate increased from 4 to 10 with the increases being in the Cardiology and Vascular care groups with no recurring theme in either. Complaints about the Obstetrics and Gynaecology care group increased from 4 to 12. Of the 6 complaints received about the care group of Gynaecology, 2 were about cancellation/waits for outpatient appointment sand a complaint was made about the suspension of the urogynaecology service. There were no complaints received about offender healthcare in June compared to 10 in May. Complaints about the Imaging care group reduced from 4 to 1.

8. Patient Experience
- Complaints Performance against targets

Performance Against Targets May 2015				
Division	**Total number of complaints received**	**Number within 25 working days**	**% within 25 working days**	**% within 25 working days or agreed timescales**
Children's & Women's	18	11	61%	(7) 100%
Medicine and Cardiovascular	13	8	62%	(5) 100%
Surgery & Neurosciences	19	17	89%	(2) 100%
Community Services	18	14	78%	(4) 100%
Estates and Facilities	2	2	100%	(0) 100%
Other corporate depts	2	1	50%	(0) 50%
Totals:	71	50	72%	(17) 96%



Overview:

Performance improved slightly in May with 72% of complaints being responded to within 25 working days (against internal trust target of 85%) and declined slightly on the second target with 96% within agreed timescales (against internal trust target of 100%).

Performance against 25 day timescale is currently of concern in only two clinical divisions. Action plans in place in these divisions to improve and to deliver performance against internal standards.

Women's, Children, Diagnostics and Therapeutics Division

The directorates of Women's and Children's Services struggle to meet the 25 working day target due to manpower issues and a lack of trained staff. To address this:

- Bespoke training by the complaints manager has taken place to increase the availability of staff to investigate complaints
- Children's Services – complaints are being re-distributed to utilise more management staff in the investigation of complaints
- If a directorate continues to struggle then complaints will be re-distributed within the division to areas where fewer complaints are received

Medicine and Cardiovascular Division

The following actions are being taken to improve the meeting of the 25 working day target:

- Additional resource has been brought in to assist areas receiving a high volume of complaints.
- Each complaint is now allocated to a named lead and progress monitored
- More robust internal reporting on ensuring that a complaint response reaches the complaints team on day 20.

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.

Federico gave St George's Hospital (London) a rating of 5 stars
Hand clinic appointment
I was at the Hand Clinic on the 07/07/15 for an appointment and I was impressed by the great service received. The doctors I saw were very nice to me and they took the time to explain what exactly the problem was and referred me to physio for further care. They were extremely friendly. While I was waiting I could see how busy the reception staff were and it was lovely to see that despite they were having a busy day they were so smiley with everyone and made every single patient feel looked after. I wish all hospitals could be like this

Visited in July 2015. Posted on 07 July 2015

Mrs Joan Stevenson gave Cancer Services at St George's Hospital (London) a rating of 5 stars
Oncology - Rose Clinic
I attended Rose Clinic for my first appointment with a doctor and the oncologist nurse specialist. I was extremely nervous to attend the hospital today and also my husband didn't feel that good. We were welcomed to the clinic by the doctor and nurse. From the minute we walked in I felt extremely relaxed by the professionalism we were shown, they could not have been nicer. I have lots of test to be carried out in the next two weeks but each test was explained to me in full. I know what is facing me in the near future but to know I will be under this doctor and nurse, I am sure I will get through with it.

What can I say except St Georges management should be very proud having these lovely people being employed by them.

Thank you to the doctor and nurse for everything you helped me with today

Mr and Mrs Joan and Mick Stevenson

Visited in June 2015. Posted on 23 June 2015

Anonymous gave Orthopaedics at St George's Hospital (London) a rating of 3 stars
Good clinical care; shambolic organisation, no respect
The clinical advice and interaction once the consultant arrived was extremely good and I was surprised to see a consultant for a relatively minor injury. However, the organisation of the clinic and the levels of respect for patients were absolutely zero. The reception staff were almost without exception chewing gum, I was told I was a "walk in" and didn't have an appointment. I had followed instructions, called the number and was given an appointment at 1.30pm in a clinic. I was told I wouldn't be seen before a file was made up for me - that file containing the paperwork I handed to reception. In the 21st Century can the paperwork not be scanned from hospital to hospital in advance?

I had already corrected the nurse practitioner's paperwork to note my title, Mrs. This was not transferred to the file, neither was it used by any member of staff at the clinic. I was called by my first name and nobody asked if they may do so. When I asked the nurse who called me who I would see I was told Mr xxx or Mr xxx. Perhaps someone can explain why doctors are afforded the courtesy of a title by their staff but patients are not please. This is an equality issue and I think it interesting when the NHS spends so much money on equality and diversity that it allows such inequalities to exist. Notably I heard three men called by title in the clinic but not one woman.

I spent 80 minutes in a clinic where the lack of respect for the time of patients and people as human beings was palpable. The only available parking space was 15 minutes on crutches from the fracture clinic and upon reaching the St James's Wing, the signage was almost non existent. This is totally unacceptable when people are struggling to walk due to the very nature of the clinic and need reassurance they are heading in the right direction.

In summary, the medical advice was exemplary and appeared holistic. The organisation of the clinic, communication and the cavalier disregard for patients' time and dignity were shocking.

Please don't provide an NHS speak apology and refer me to PALS. Read what I have written, go down to the clinic, observe and deal with the issues. I shouldn't have to contact PALS for hospital managers to sort out issues of signage, respect and ensure support staff have a clear enough understanding of basic professional boundaries not to chew gum as they speak to patients - it does nothing to inspire confidence and everything to underline the existence of the NHS in Little Britain?

It would be very welcome if perhaps the people responsible. In short I saw little respect for people or their time at the clinic.

Visited in June 2015. Posted on 23 June 2015

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Workforce

Excellence in specialist and community healthcare

9. Workforce:
- 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 June 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 June the trust achieved an average fill rate of 95.98%, a slight increase from 95.5% submitted in May.

Data cleansing continues to ensure that the report is being run consistently and only relevant front line nursing roles are included.

There were some anomalies in the report in June that require further review. A deep dive has been commissioned KPMG, with workforce and Corporate Nursing

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

- Nurses, midwives and care staff work as part of a wider multidisciplinary ward team. The demand on wards can change quickly and it will always be a clinical judgement as to whether to bring more staff in or reduce the amount the staff as per requirement.
- The data does not take into account the on-going considerations for ward managers in ensuring that on each shift there is the right level of experience and expertise in the ward team.
- The nature of each ward varies. The number and type of patients seen on some wards will be relatively consistent. The number and type of patients seen on other wards will vary more dramatically, meaning that there could be greater change from the planned level and the average will be somewhere in the middle of the highs and lows of this variation.
- There needs to be the operational context of the reasons for staffing levels month on month, for example reduced demand.
- St George's Healthcare NHS Trust has a safe staffing policy and a system in place for monitoring staffing levels on a daily basis. Nursing and midwifery clinical leaders visit their clinical areas across the trust at least once a day to ensure safe staffing and staff are encouraged to escalate any concerns they have to the chief nurse on duty. The acuity/dependency of patients (how sick or dependent they are) is also monitored closely as this ultimately affects the type and amount of care patients need. If concerns are raised about staffing levels, the clinical leaders may make the decision move members of staff across the trust so that the area is safely staffed. This ensures that our patients are well cared for.

Actions

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

9. Workforce: June 2015 – In patient areas Unify results

Ward name	Main 2 Specialties on each ward		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 (%)	Overall %
	Specialty 1	Specialty 2	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 Unit	170 - CARDIOTHORACIC SURGERY	320 - CARDIOLOGY	7035.00	6348.81	7.75	7.75	6566.50	6318.00	149.50	276.00	90.2%	100.0%	96.2%	184.6%	94.13%
Carmen Suite	501 - OBSTETRICS		1452.50	1433.50	363.00	341.00	1360.00	1339.00	345.00	345.00	98.7%	93.9%	98.5%	100.0%	98.24%
Champneys Ward	502 - GYNAECOLOGY		1033.50	1024.00	127.50	123.00	662.00	663.00	331.00	332.00	99.1%	96.5%	100.2%	100.3%	99.44%
Delivery Suite	501 - OBSTETRICS		3737.25	3793.85	724.50	659.00	3496.00	3865.75	690.00	655.50	101.5%	91.0%	110.6%	95.0%	103.77%
Fred Hewitt Ward	420 - PAEDIATRICS		1817.25	1596.01	350.00	368.00	1449.00	1414.50	0.00	0.00	87.8%	105.1%	97.6%	#DIV/0!	91.43%
General Intensive Care Unit	192 - CRITICAL CARE MEDICINE		6617.75	6239.52	46.00	38.00	6279.00	6166.00	184.00	184.00	94.3%	82.6%	98.2%	100.0%	96.20%
Gwilim Ward	501 - OBSTETRICS		1737.00	2089.25	726.00	557.00	1391.50	1381.50	678.50	655.50	120.3%	76.7%	99.3%	96.6%	103.31%
Jungle Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	1013.00	1005.00	11.50	0.00	0.00	0.00	0.00	0.00	99.2%	0.0%	#DIV/0!	#DIV/0!	98.10%
Neo Natal Unit	420 - PAEDIATRICS	192 - CRITICAL CARE MEDICINE	7859.25	7576.25	0.00	0.00	7394.50	7407.50	0.00	0.00	96.4%	#DIV/0!	100.2%	#DIV/0!	98.23%
Neuro Intensive Care Unit	192 - CRITICAL CARE MEDICINE	150 - NEUROSURGERY	4398.50	4155.50	333.00	287.00	4174.50	4163.00	340.00	307.00	94.5%	86.2%	99.7%	90.3%	96.39%
Nicholls Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	2470.00	2315.00	562.50	514.00	1713.50	1679.00	446.25	419.75	93.7%	91.4%	98.0%	94.1%	94.91%
Paediatric Intensive Care Unit	192 - CRITICAL CARE MEDICINE	420 - PAEDIATRICS	2738.50	3339.76	463.00	466.50	2760.00	3182.25	299.00	299.00	122.0%	100.8%	115.3%	100.0%	116.40%
Pinckney Ward	420 - PAEDIATRICS		2186.50	2387.00	360.00	345.00	1725.00	1702.00	0.00	11.50	109.2%	95.8%	98.7%	#DIV/0!	104.07%
Dalby Ward	300 - GENERAL MEDICINE		1432.00	1289.50	2114.50	2134.50	1035.00	1012.00	1471.50	1460.00	90.0%	100.9%	97.8%	99.2%	97.41%
Heberden	300 - GENERAL MEDICINE		1488.98	1376.98	2118.58	2180.08	1069.50	1058.00	1436.00	1436.00	92.5%	102.9%	98.9%	100.0%	98.99%
Mary Seacole Ward	400 - NEUROLOGY	314 - REHABILITATION	2427.75	2160.26	2102.30	2021.00	1345.50	1334.00	1880.50	1869.00	89.0%	96.1%	99.1%	99.4%	95.21%
A & E Department	180 - ACCIDENT & EMERGENCY		7970.25	7613.57	2580.00	2093.25	7621.50	7349.00	1046.50	954.50	95.5%	81.1%	96.4%	91.2%	93.71%
Allingham Ward	100 - GENERAL SURGERY		2290.96	2080.46	1233.50	1440.50	1391.50	1380.00	1456.00	1444.50	90.8%	116.8%	99.2%	99.2%	99.58%
Amyand Ward	300 - GENERAL MEDICINE		2519.17	2363.67	1361.50	1398.50	1747.50	1678.00	1079.25	1067.75	93.8%	102.7%	96.0%	98.9%	97.03%
Belgrave Ward AMW	320 - CARDIOLOGY		2574.00	2198.75	1377.50	1102.00	1725.00	1725.00	459.25	436.25	85.4%	80.0%	100.0%	95.0%	89.02%
Benjamin Weir Ward AMW	320 - CARDIOLOGY		2490.75	2192.00	633.00	560.00	1575.50	1551.75	529.00	529.00	88.0%	88.5%	98.5%	100.0%	92.44%
Buckland Ward	361 - NEPHROLOGY		2165.50	1912.00	532.00	459.50	1426.00	1426.00	345.00	345.00	88.3%	86.4%	100.0%	100.0%	92.70%
Caroline Ward	170 - CARDIOTHORACIC SURGERY		1838.50	1628.50	727.00	640.00	1380.00	1380.00	46.00	46.00	88.6%	88.0%	100.0%	100.0%	92.56%
Cheselden Ward	100 - GENERAL SURGERY		1777.50	1758.00	374.50	283.50	1035.00	1035.00	287.50	287.50	98.9%	75.7%	100.0%	100.0%	96.82%
Coronary Care Unit	320 - CARDIOLOGY	170 - CARDIOTHORACIC SURGERY	2083.50	2063.50	20.00	23.00	2070.00	2070.00	11.50	22.00	99.0%	115.0%	100.0%	191.3%	99.84%
James Hope Ward	320 - CARDIOLOGY		1552.75	1358.51	345.75	326.75	506.00	494.00	0.00	11.50	87.5%	94.5%	97.6%	#DIV/0!	93.11%
Marnham Ward	300 - GENERAL MEDICINE		2630.00	2290.00	1218.25	1085.76	2127.50	2012.00	839.50	816.50	87.1%	89.1%	94.6%	97.3%	91.02%
McEntee Ward	300 - GENERAL MEDICINE		1436.50	1429.00	634.25	611.00	1035.00	1035.00	379.50	379.50	99.5%	96.3%	100.0%	100.0%	99.12%
Richmond Ward	300 - GENERAL MEDICINE		4807.00	4599.83	2833.50	2491.42	4244.50	4149.92	2575.50	2461.41	95.7%	87.9%	97.8%	95.6%	94.76%
Rodney Smith Med Ward	302 - ENDOCRINOLOGY		1876.50	1696.00	1170.08	1104.34	1035.00	999.83	770.50	724.00	90.4%	94.4%	96.6%	94.0%	93.24%
Ruth Myles Ward	303 - CLINICAL HAEMATOLOGY		1347.50	1262.60	305.00	305.50	931.50	943.00	92.00	46.00	93.7%	100.2%	101.2%	50.0%	95.56%
Trevor Howell Ward	370 - MEDICAL ONCOLOGY		1894.80	1816.00	724.50	594.00	1035.00	1023.50	682.25	682.25	95.8%	82.0%	98.9%	100.0%	94.91%
Winter Ward (Caesar Hawkins)	300 - GENERAL MEDICINE		1836.25	1595.25	840.75	780.75	1368.50	1333.50	471.00	459.50	86.9%	92.9%	97.4%	97.6%	92.31%
Brodie Ward	150 - NEUROSURGERY		1240.00	1223.00	708.00	679.50	1035.00	1022.75	57.25	57.25	98.6%	96.0%	98.8%	100.0%	98.10%
Cavell Surg Ward	100 - GENERAL SURGERY		1962.00	1813.50	740.00	896.08	1035.00	1011.50	355.25	352.42	92.4%	121.1%	97.7%	99.2%	99.54%
Florence Nightingale Ward	120 - ENT		2078.50	1962.00	472.50	468.00	1380.00	1380.00	0.00	0.00	94.4%	99.0%	100.0%	#DIV/0!	96.92%
Gray Ward	100 - GENERAL SURGERY		2624.33	2335.00	1171.50	802.50	1380.00	1351.75	690.00	679.75	89.0%	68.5%	98.0%	98.5%	88.12%
Gunning Ward	110 - TRAUMA & ORTHOPAEDICS		2269.75	2108.76	936.00	886.00	1150.00	1150.00	690.00	676.25	92.9%	94.7%	100.0%	98.0%	95.55%
Gwynne Holford Ward	400 - NEUROLOGY		2327.50	1965.50	2589.00	2350.50	1380.00	1322.50	1380.00	1357.50	84.4%	90.8%	95.8%	98.4%	91.14%
Holdsworth Ward	110 - TRAUMA & ORTHOPAEDICS		1865.00	1723.26	734.83	635.83	1104.00	1104.00	690.00	690.00	92.4%	86.5%	100.0%	100.0%	94.52%
Keate Ward	160 - PLASTIC SURGERY		1680.50	1610.50	585.00	540.00	1046.50	1046.50	0.00	0.00	95.8%	92.3%	100.0%	#DIV/0!	96.53%
Kent Ward	400 - NEUROLOGY		2207.00	1995.26	1621.50	1433.00	1380.00	1380.00	1172.00	1149.00	90.4%	88.4%	100.0%	98.0%	93.37%
Mckissock Ward	150 - NEUROSURGERY		1947.00	1692.06	979.00	973.50	1380.00	1357.00	460.00	459.50	86.9%	99.4%	98.3%	99.9%	94.04%
Vernon Ward	101 - UROLOGY		2332.50	2185.50	727.50	640.00	1380.00	1356.50	356.50	345.00	93.7%	88.0%	98.3%	96.8%	94.38%
William Drummond HASU	400 - NEUROLOGY		2940.00	2625.50	735.00	652.26	2737.00	2582.50	690.00	679.25	89.3%	88.7%	94.4%	98.4%	92.08%
Wolfson Centre	400 - NEUROLOGY	314 - REHABILITATION	1080.00	950.00	365.00	353.26	690.00	690.00	356.50	356.50	88.0%	96.8%	100.0%	100.0%	94.31%
Gordon Smith Ward			2399.00	2225.00	805.50	765.00	1380.00	1403.00	471.50	483.00	92.7%	95.0%	101.7%	102.4%	96.44%
Brodie Stroke Ward			1078.50	976.50	723.00	701.76	1023.50	943.00	368.00	425.50	90.5%	97.1%	92.1%	115.6%	95.42%
Trust Total			122,567.74	115,379.17	41,214.54	38,118.79	94,157.50	93,372.00	27,058.50	26,674.33	94.14%	92.49%	99.17%	98.58%	95.98%

Day Qual	Day HCA	Night Qual	Night HCA	Overall
94.14%	92.49%	99.17%	98.58%	95.98%

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Heatmap Dashboard
Ward view

Excellence in specialist and community healthcare

10. Ward heatmap

		INCIDENCE OF C.DIFFICILE	INCIDENCE OF MRSA	TRUST ACQUIRED PRESSURE UL..	PERCENTAGE OF HARM FREE CARE	PATIENT SATISFACTION (FRIENDS & FA..	FRIENDS & FAMILY RESPONSE RA..	WARD STAFFING: UNFILLED DUT..	FALLS (WARD LEVEL)	SERIOUS INCIDENTS (WARD LEVEL)	SICKNESS/ ABSENCE RATE - (WARD)
Children & Women's	CARDIOTHORACIC INTENS..	0.0	0.0	0.0	94.1	83.3		5.9	0.0	0.0	2.8
	CARMEN SUITE	0.0	0.0	0.0	100.0		0.0	1.8	0.0	0.0	0.0
	CHAMPNEYS	0.0	0.0	0.0	100.0	96.3	67.8	0.6	0.0	0.0	5.0
	DELIVERY	0.0	0.0	0.0	100.0		0.0	-3.8	0.0	2.0	6.3
	FREDDIE HEWITT	0.0	0.0	0.0	0.0		0.0	6.6	2.0	0.0	8.1
	GENERAL ICU/HDU	0.0	0.0	0.0	92.3	66.7	83.3	3.8	0.0	0.0	4.7
	GWILLIM	0.0	0.0	0.0	100.0	94.0	0.0	-3.3	1.0	0.0	1.1
	JUNGLE	0.0	0.0	0.0			0.0	1.9	0.0	0.0	5.7
	NEONATAL ICU	0.0	0.0	0.0	100.0	0.0		1.8	0.0	0.0	2.3
	NEURO ICU	0.0	0.0	0.0	100.0		0.0	3.6	0.0	0.0	3.3
	NICHOLLS	0.0	0.0	0.0	100.0		0.0	5.1	0.0	0.0	2.9
	PICU	0.0	0.0	0.0	100.0	96.4		-16.4	0.0	0.0	2.0
	PINCKNEY	0.0	0.0	0.0	0.0	100.0	325.0	-4.1	0.0	0.0	0.5
Medicine & Cardiovascular	ALLINGHAM	0.0	0.0	0.0	92.6	72.7	58.9	0.4	11.0	0.0	6.6
	AMYAND	0.0	0.0	0.0	93.3	100.0	23.3	3.0	6.0	0.0	3.3
	BELGRAVE	0.0	0.0	0.0	94.1	82.0	39.1	11.0	5.0	0.0	1.2
	BENJAMIN WEIR	0.0	0.0	1.0	100.0	100.0	53.2	7.6	2.0	1.0	0.4
	BUCKLAND	0.0	0.0	0.0	100.0	91.8	60.5	7.3	2.0	0.0	6.5
	CAESAR HAWKINS	0.0	0.0	0.0	100.0	100.0	13.3	7.7	9.0	0.0	0.8
	CARDIAC CARE UNIT	0.0	0.0	0.0	100.0	100.0	56.5	0.2	1.0	0.0	1.1
	CAROLINE	0.0	0.0	0.0	95.7	95.6	38.1	7.4	0.0	0.0	0.8
	CHESELDEN	0.0	0.0	0.0	95.2	97.2	37.5	3.2	2.0	0.0	6.4
	DALBY	0.0	0.0	0.0	81.0	85.7	33.3	2.6	9.0	0.0	10.4
	EMERGENCY DEPARTMENT	0.0	0.0	0.0		90.6	27.0	6.3	5.0	1.0	2.0
	HEBERDEN	0.0	0.0	0.0	70.8	100.0	40.5	1.0	5.0	0.0	2.6
	JAMES HOPE	0.0	0.0	0.0	100.0	98.4	97.0	8.9	0.0	0.0	1.4
	MARNHAM	0.0	0.0	0.0	80.8	100.0	32.8	9.0	3.0	0.0	6.3
	MCENTEE	0.0	0.0	0.0	80.0	100.0	34.9	0.9	5.0	0.0	0.3
	RICHMOND	0.0	0.0	0.0	97.7	96.8	35.8	5.2	13.0	1.0	5.5
	RODNEY SMITH	0.0	0.0	0.0	85.7	85.7	40.4	6.8	3.0	0.0	3.3
	RUTH MYLES	0.0	0.0	0.0	100.0	100.0	90.5	4.4	0.0	0.0	3.9
	TREVOR HOWELL	0.0	0.0	0.0	100.0	88.9	61.0	5.1	3.0	0.0	7.2
Surgery & Neurosciences	BRODIE NEURO	0.0	0.0	0.0	100.0	85.7	52.8	1.9	2.0	0.0	3.3
	CAVELL	1.0	0.0	0.0	100.0	77.0	24.6	0.5	4.0	0.0	5.9
	FLORENCE NIGHTINGALE	0.0	0.0	0.0	90.9	96.5	82.7	3.1	2.0	0.0	0.9
	GRAY WARD	1.0	0.0	0.0	96.9	86.4	73.6	11.9	1.0	0.0	7.7
	GUNNING	0.0	0.0	0.0	87.5	96.0	78.1	4.5	4.0	0.0	1.1
	GWYN HOLFORD	0.0	0.0	0.0	100.0	93.3	100.0	8.9	6.0	0.0	3.9
	HOLDSWORTH	0.0	0.0	0.0	100.0	97.4	76.5	5.5	1.0	1.0	13.2
	KEATE	0.0	0.0	0.0	100.0	96.5	64.7	3.5	2.0	0.0	0.0
	KENT	0.0	0.0	0.0	92.9	97.8	47.4	6.6	7.0	0.0	2.4
	MARY SEACOLE	0.0	0.0	0.0	94.1	100.0	48.7	4.8	4.0	0.0	4.3
	MCKISSOCK	0.0	0.0	0.0	95.2	98.1	81.8	6.0	1.0	0.0	9.7
	VERNON	0.0	0.0	0.0	95.8	97.4	45.9	5.6	2.0	0.0	8.7
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	88.2	96.2	25.5	7.9	5.0	0.0	1.9

10. Ward heatmap:
- CWDT&CC Division

June 2015
Cardiothoracic Intensive Care Unit (CTICU)

The unit reported 94.12% for harm free care in June 2015; this relates to 1 patient with a new grade 2 pressure ulcer, out of a total of 17 patients surveyed; this is a similar picture to the one seen in recent months. It is worth noting that these grade 2 pressure ulcers rarely deteriorate further; the unit has reported 1 grade 3 unavoidable pressure ulcer in the last year.

Champneys
Sickness is being reported at 5.0% for the ward in month. Champneys ward has a small nursing establishment and subsequently minimal levels of sickness coupled with vacancies can result in a high score for sickness. There has however been a member of staff on long term sick which been and continues to be appropriately managed by the team.

Delivery Suite
The 2 Serious incidents reported for the period June 2015 relate to two unexpected admissions to NNU. Delivery suite is no longer mandated to report the unexpected admissions to NNU, however if certain criteria are met a serious incident will still be declared. Both incidents are currently being investigated.

General Intensive Care Unit The unit reported 92.31 % for harm free care. This relates to 1 patient with an old grade 3 pressure ulcer out of a total of 13 patients surveyed. The unit is also reporting a 4.7% sickness absence rate, this relates to a number of long term sickness cases that are all being managed in line with HR policy.

Patient satisfaction / Friends and Family There are data anomalies across the division in relation to these scores, which are currently being investigated by the information and patient experience manager. This is particularly obvious on Pinckney ward, who are reporting a response rate of 325%. It is however of note that Champneys ward who have previously struggled with this are now persistently reporting a score of above 50%.

Sickness : A number of areas across the division are reporting a sickness rate above the trust target of <3%. These are a combination of long term sickness and short term sickness absence. All cases are being managed in line with the trust policy and progressing, in addition there is a divisional bi monthly review of rotas that also assesses sickness absence rates and ensures that cases are being managed effectively and line managers are being adequately supported to do so.

10. Ward heatmap:
- STNC Division

There are 14 red alerts for June compared to 9 for the previous reporting period. There is a increase in overall numbers of alerts from 10 to 19.

Florence Nightingale – 1 amber indicator; 90.9% harm free care- 2 grade 2 pressure ulcers were acquired on the ward for June 2015. The root cause analysis showed failure to review appropriately and failure to reassess PUP for a deteriorating patient.

Gunning – 2 red indicators – The percentage of harm free care was 87.5%- 1 patient had a new UTI- which was diagnosed upon admission, 1 patient had a catheter and an old UTI, which was diagnosed prior to admission to hospital and 1 patient had a grade 2 pressure ulcer acquired on the ward. The root cause analysis into the pressure ulcer identified that appropriate repositioning was not completed during one night duty by an agency nurse and the grade 2 pressure ulcer was identified by the substantive nursing staff. The second red indicator related to 4 falls, all were no harm and one witnessed

Holdsworth- 2 red indicators. 1 SI declared- this related to Holdsworth ward and a Sub-Dural bleed that was thought to be as a result of a fall on the ward. The consultant and Neuro Consultant have both confirmed that this is not the case and that the bleed was a spontaneous bleed. This is currently been looked at to close

The sickness red indicator related to 12.2% sickness- two staff on long term sickness and some short term episodes, all were managed with policy

Vernon- 1 red indicator relating to sickness of 8.7% ,two staff members commenced long term sickness and another staff member had a two week sickness episode, all managed to policy

Cavell- 2 red indicators and 1 amber indicator. There was an incidence of C/Diff. The root cause analysis confirmed that the patient received the correct medication treatment and the learning for the nursing team was to move the patient to the side room when loose stool commenced as this did not take place in this instance. The falls red indicator related to 4 falls, all of which were no harm, 3 were slips and one witnessed. The amber indicator related to the FFT response rate of 24.6%. This is being picked up locally with the matron. The comments on the whole are positive with one patient extremely unlikely to recommend and as a result a complaint has been received and investigated.

Gray- 2 red indicators. 1 C/Diff red indicator, the root cause analysis confirmed appropriate care and treatment. The learning for nursing staff was to move patient to side room when they were concerned of the risk of C/Diff . This has been discussed with all the nursing team. The sickness red indicator of 7.7% as one member of staff was on long term sickness and other episodes of short term sickness, all were managed as per policy.

Kent – 1 red indicator and 1 amber indicator – red indicator reflects 7 falls all of which were no harm, 2 un-witnessed falls. 1 fall occurred during an OT assessment in the shower. Amber indicator relates to Harms Free Care- 92.9%- 28 patients surveyed. 1 patient had an old grade 2 pressure ulcer. 1 patient had a catheter and new UTI.

Mckissock – 1 red indicator – this relates to sickness 9.7% - B5 x1 and B2 x1 on short term sickness and B5 x1 and B2 x1 on long term sickness (both have now returned to work). All sickness/ absence being robustly managed

William Drummond – 2 red indicators and 1 amber indicator – red indicator relates to Harms Free Care- 88.2%- 17 patients surveyed. 1 patient had a low harm fall on the ward and 1 patient had a new grade 2 pressure ulcer, the root cause analysis identified poor documentation and 5 falls, -2 falls datixed twice which have been assigned incorrectly to William Drummond, 1 fall related to a slip in bathroom whilst showering, 1 witnessed fall during OT session. No falls were associated with any harm. 1 amber indicator relates to FFT on-going difficulty with response rates to FFT and this patient cohort. Comments remain really positive where received. Work remains ongoing from the team to improve this score.

Gwynne Holford - 1 red indicator and 1 amber indicator. Red indicator relates to 6 falls. 2 associated with the same patient, all no harm. This is a great reduction in falls, down from 14 in May. Amber indicator reflects sickness absence, 2 long term sick. 1 staff member has returned to work the other staff member remains on LTS and being managed as per policy.

Thomas Young – data for Thomas Young continues to be missed.

Areas requiring further support are Gunning, Holdsworth and Gwynne Holford as a result of vacancy factor and depleted senior team members. William Drummond continues to struggle with their FFT performance. The directorate area has pulled together a work plan to support the development of care of patients in terms of both falls and pressure ulcers. July 2015 is PUP awareness month in surgery and a lot of great work is currently being undertaken. Keate continues to perform consistently well and Gwynne Holford has seen some improvements this month with a reduction in falls.

10. Ward heatmap:
-Med Card Division

Richmond

- Falls 13 occurred during the month with a large proportion being un-witnessed, 2 patients had a fall despite having a special in place, this was due to the nature of the individual medical conditions which meant the patients wondered and were agitated. A band 6 senior staff nurse has been allocated as the falls link nurse to complete education and spot checks on documentation.
- One Serious Incident was reported. The incident occurred in November 2014 where a patient fell and subsequently sustained an acute subdural haematoma whilst on AMU. This was heard at Coroners court in June 2015. This was not declared as an SI at the time however following the inquiry it was deemed that a full SI was not warranted as this case had been heard by the coroner and no further investigation was required.
- Sickness absence - 5.5% During the month of June Richmond ward had 2 trained and 2 untrained staff off on long term sick. All have been seen by Occupational health.

Heberden

- Percentage Harm Free Care 70.8 – Due to 2 old grade 2 and 2 old grade 3 pressure ulcers. " patients were also reported as having new CAUTI's and 4 patients had no VTE assessment. This has been discussed with the individual medical teams.

Dalby

- Percentage of Harm Free Care 81% this is due to 2 old grade 1 pressure ulcers, 1 new grade 2, and 3 pressure ulcer which were assessed as unavoidable. There was also 2 Catheter related UTI's, 1 old and 1 new. The ward also had a reduction in VTE assessment and prophylaxis at the time of the audit. This information and expected standards has been discussed with the medical and nursing team.
- Sickness 10.4% - The ward manager and Matron have met to review the sickness cases and all are being managed under the sickness absence policy.

Allingham

- 11 Falls- the majority of these were attributed to one patient who had multiple falls.
- Sickness - 6.6% there are two members of staff on Long term sick, and a number of short term sickness, all who are being managed in line with policy.

R Smith

- Harm free care - 85.7%. The is associated with 1 grade 3 and 1 grade 2 pressure ulcer on admission. There was 1 new UTI also reported in this period.

Marnham ward

- 80.8% Harm Free Care. On 6 patients there was no appropriate treatment scripted for VTE. Doctors have been reminded and asked to comply with the recommendations. 3 patients have Old UTI and there are 5 patients with urinary catheters less than 28 days
- Sickness 6.3% The ward has 1 long term sickness and multiple short term sickness this month which are being managed in line with policy.

Benjamin Weir

- Trust Acquired Pressure Sore – It is reported that there has been 1 pressure sore which is currently being reviewed and investigated.

Buckland

- Sickness – 6.5% due to long and short term sickness which is being managed in line with policy. Some of these staff members have now returned to work.

Emergency Department

- 1 SI has been declared due to LAS handover delays.

11. Community Services
- CQR Scorecard – June 2015 Page 1 of 4

Domain	*Patiend Safety & Experience*																
	Indicator	Frequency	2015/2016 Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Direction	Comments
				Quarter 1 2015/16			Quarter 2 2015/16			Quarter 3 2015/16			Quarter 4 2015/16				
Patient Safety	SI's REPORTED	Monthly		1	1	2											
Patient Safety	Number of SI's breached	Monthly	0	0	0	0											
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly		1	0	0											
Patient Safety	Grade 4 Pressure Ulcers	Monthly		0	0	0											
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly		10	7	4											
Patient Safety	Number of moderate falls	Monthly	0	2	1	0											
Patient Safety	Number of major falls	Monthly	0	0	0	0											
Patient Safety	Number of falls resulting in death	Monthly	0	0	0	0											
Patient Safety	MRSA (cumulative)	Monthly	0	0	0	0											
Patient Safety	CDiff (cumulative)	Monthly	31	1	0	0											
Patient Safety	CAS ALERTS - Number ongoing-received (Trust)	Monthly	0	2	2	2											
Patient Safety	Number of Quality Alerts	Monthly		3	5	2											
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	95%	89.0%	86%	85%											
Safeguarding	% of staff compliant with safeguarding childrens training	Monthly	Level 1 95%	90.0%	90.0%	85%											changed to green because aris show as achieving
			Level 2 95%	84.0%	84.0%	82%											
			Level 3 95%	69.0%	69.0%	see note											
Patient Outcomes	Mortality SHMI ratio (Trus)	Monthly	<100	0.86	0.86	0.86											
Patient Experience	Active Claims	Monthly		0	0	tbc											

11. Community Services
- CQR Scorecard – June 2015 Page 2 of 4

Domain	*Patiend Safety & Experience*																	
	Indicator	Frequency	2015/2016 Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Direction	Comments
				Quarter 1 2015/16			Quarter 2 2015/16			Quarter 3 2015/16			Quarter 4 2015/16				
Patient Experience	FFT Score (Mary Seacole and MIU)	Monthly			14.3	see note											http://www.qualityobservatory.nhs.uk/index.php?option=com_cat&view=item&Itemid=28&cat_id=589
Patient Outcomes	Catheter related UTI (Trust)			1.14	0.66	1.12											http://www.nsic.gov.uk/searchcatalogue?q=title%3A%22nhs+safety+thermometer+r
	Number of new VTE (Trust)		National 0.005	0.55	0.37	0.30											
Workforce	Number of DBS Request Made	Quarterly	annually	N/A	N/A	N/A											
Workforce	Sickness Rate -	Monthly	3.50%	5.72%	6.04%	6.00%										↓	
Workforce	Turnover Rate-	Monthly	13%	19.64%	19.94%	20.40%										↑	
Workforce	Vacancy Rate-	Monthly	11%	19.41%	19.06%	19.40%										↑	
Workforce	Appraisal Rates - Medical	Monthly	85%	66.67%	72.73%	72.70%										↓	
Workforce	Appraisal Rates - Non-Medical	Monthly	85%	76.80%	75.84%	75.40%										↓	

11. Community Services
- CQR Scorecard –June 2015 Page 3 of 4

KPI Exception Report for (for period June 2015)

Serious Incidents:
In June two serious incidents was reported on STEIS (one incident occurred in May). These incidents (death in custodies) occurred within offender healthcare. The delay in reporting to STEIS was due to clarification of ownership of SI being negotiated and agreed between contracted offender healthcare providers and NHS England resulting in all Sis will be reported as SGUFT.

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

Falls:
There were 4 No Harm and Low severity fall (4 MS ward) were reported in June compared to 7 in May.

Complaints:
(Period May 2015) Community Services received 18 complaint; a slight increase on April's position when there were 16 complaints: 10 complaints relate to OHC (access to medication/treatment), 3 (MS ward – lost property, catering, staff attitude), 3 (QMH OPD, attitude of staff).
14 of 18 complaints closed within 25 working days, and 3 of the 4 (75%) with agreed extensions have been closed within time. One complaint remains open within extended time.

Child safeguarding Level 3: (June)
Compliance is manually counted as 82%. Automated recording system (ARRIS) is not reflecting comparative compliance. This is being reviewed. L3 training available monthly. Staff allocated to attend.

Human Resources:
Sickness absence fell slightly in June to 6% compared to 6.04% in May. HR continues to work with service managers to reduce sickness absence.
There was an increase in turnover from 19.94% in May to 20.04% in June. In addition, the division continues to experience high vacancy levels, with a slight increase in the vacancy rate from 19.06% in May to 19.40% in June. The divisional recruitment tracker is being currently revised. The trust workforce team are working with divisional leads to review report structure of workforce indicators.
Appraisal rates for medical staff remained stable in June at 72% and the divisional non-medical appraisal rate is currently 75.4%. Plans are in place to ensure all outstanding appraisals are completed.

11. Community Services
- CQR Scorecard –June 2015 Page 4 of 4

Friends & Family (FFT) (Q1 2015/16)

All services are undertaking FFT. The delay of roll out of tablets to some community sites due to landlord permissions and installation has limited data collection. This has limited effective data collection. However agreements have been reached and it is anticipated that this will improve service user response. In addition staff need to continue to positively encourage survey completion.

Service	How likely are you to recommend our service to friends and family if they needed similar care or treatment?	Total Completed
Nelson - Outpatients	100%	1
Mary Seacole B	91.60%	3
Assistive Technology	90%	5
Minor Injuries Unit	94.40%	9
Special Seating	87.50%	10
Haemoglobinopathies	97.20%	10
CLD Health Team	86.70%	17
Gait Lab	100%	17
Immunisation Team	95%	20
Wheelchair Service	96.70%	23
Primary Care Therapies Team	91.30%	26
Prosthetics	92.30%	26
Health Visiting Brocklebank	93.30%	30
St John's Day Hospital	93.90%	70
Dietetics (Community and QMH)	92.90%	74
Integrated Falls Team	96.90%	131
Podiatry	94.70%	260
Total		732

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.

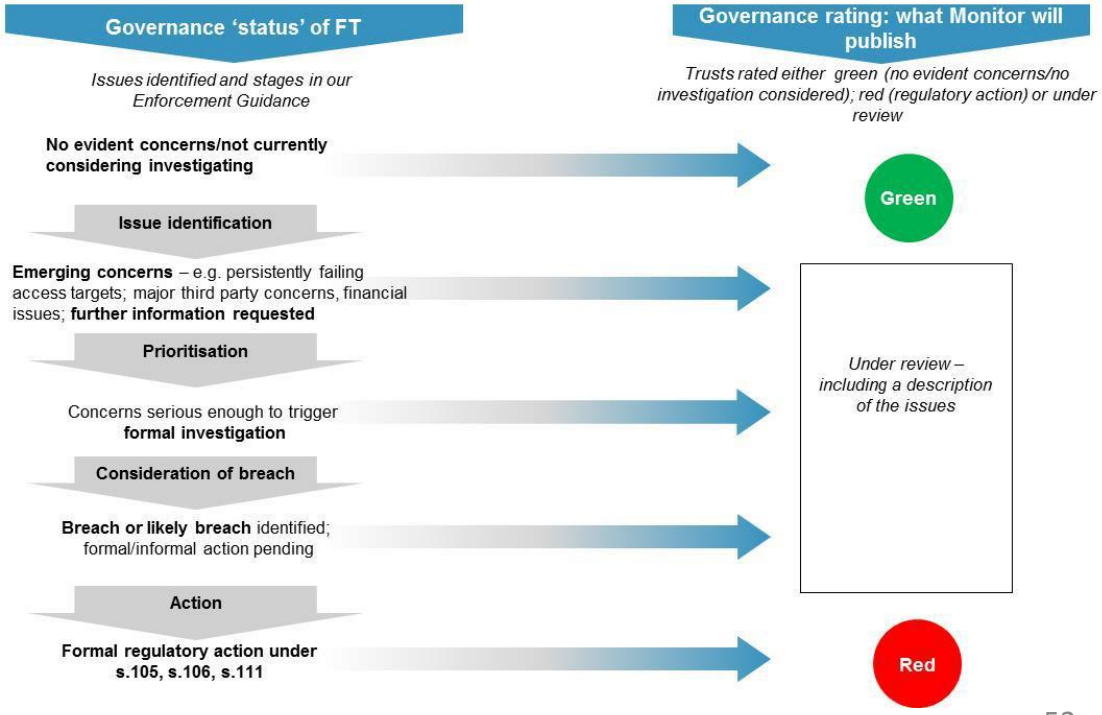
In addition to the above, when assigning governance ratings Monitor also take into account the following which may lead to overrides in the governance rating::

- 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 University Hospitals NHS
NHS Foundation Trust

Name and date of meeting: **TRUST BOARD** **30th JULY 2015**
Document Title: **Joint Trust and CCG investigation** - **4 hour emergency care and 18 week referral to treatment standards**
Document Author: **Martin Wilson, Director of Delivery and Improvement**
Action required: The Trust Board is asked to: • Note the findings of the joint investigation and the on-going risks to performance delivery. • Note that an action plan arising from the joint investigation is in place, and that non-delivery of the actions by the Trust could lead to up to £960k of funding being withheld on a monthly basis.

Summary

1. The Trust and its local Clinical Commissioning Groups share significant concern that the 4 hour emergency standard and 18 week referral to treatment standards are not being delivered. They have undertaken a joint investigation into how performance can be improved. The process has led to greater shared visibility of; the drivers of the underperformance; the actions being taken within the Trust to improve performance; and the system wide barriers to delivery in 2015/16. An action plan has been agreed which includes potential fines of up to £960,000 per month on the Trust where actions are not undertaken.

Background

2. As the 4 hour emergency standard and 18 week referral to treatment standards were not sustainably delivered in 2014/15, commissioners and the Trust agreed to implement the NHS contractual process for a 'joint investigation'. The investigation lasted approximately two months and included senior clinicians and managers from the local CCGs and St George's examining five work streams:

    - 'Denominator' review of activity included in measurement of the 4 hour standard
    - Emergency department flow – ensuring recommendations from previous external visits have been implemented and exploring opportunities for

further developing the navigator service between the emergency department and primary care

- Acute medical unit (AMU) systems and processes
- Intra-hospital flow and discharge arrangements
- Elective capacity, pathway and booking processes

Findings

3. The findings of the joint investigation can be summarised as:

(a) St George's is counting emergency department activity correctly. The 95% standard is increasingly hard for hospitals to achieve given the increased complexity of case mix being seen.

(b) Previous recommendations given to the emergency department have been implemented. There are further opportunities to reduce demand by expanding the primary care navigator service, and more significantly by future system resilience group wide transformation of services for frail patients.

(c) Significant improvements in patient flow have been made by the Trust and need to be sustained, with on-going monitoring of progress by commissioners.

(d) The commissioning of additional bed capacity, the development of a surgical assessment unit, the faster repatriation of patients by other hospitals and future system resilience group wide transformation of services for frail patients will reduce the Trust's bed capacity gap however bed occupancy is still expected to be over desired levels in 2015/16 (c94% versus 90% current aspiration). Performance is therefore not expected to return to above 95% on a sustainable basis during 2015/16.

(e) Sustainable delivery of the 18 week referral to treatment standard will require a significant increase in elective activity, above the level currently commissioned by CCGs and above the level St George's is currently able to provide. This increase is mostly to enable a significant one-off reduction in the total number (and length of time) patients are waiting for treatment, and to a lesser extent to ensure the on-going run-rate matches demand.

(f) Specialty level sustainability plans are required for each challenged service, supported by joint Trust and commissioner clinical summits to agree the actions that should and will be taken as referrers, commissioners and provider to improve delivery. These actions will include agreeing where improvements to patient pathways can be made, such as the expansion of one-stop services.

(g) The implications of national changes to the performance standards for 18 weeks (and potentially later in the year for 4 hour standard) need to be built into local plans.

Next steps

4. An action plan has been developed based on the findings. It includes 101 specific actions grouped into four themes and 17 work areas, to be completed by September 2016. A table of these themes and work areas is included in appendix 1. The Trust's director of delivery and improvement has overall responsibility for delivery of the actions in the action plan. The Trust's head of performance manages the process to ensure actions are undertaken on time and that appropriate assurance is provided to commissioners. All actions due within the action plan to date have been completed on time.

5. Progress will be monitored through a fortnightly update report and as an agenda item at the monthly 'St George's Performance and Action Plan Meetings' attended by the Trust's director of delivery and improvement and the CCGs' directors of performance and commissioning. A monthly update will be provided to the 'St George's contract and recovery meeting' whose membership includes Trust and CCG chief officers and directors from the Trust, CCGs and NHS England.

6. Financial penalties for non-delivery of these actions by the required date have been set at 4% of the total contractual value, meaning that there is a potential financial risk of £960,000 per month of income being withheld from the Trust. It is essential that the actions within the action plan are completed on time to avoid further financial and reputational risk to the organisation. Any decision to withhold payment would be made via the 'St George's contract and recovery meeting'.

7. An update on the outcome of the joint investigation and the performance challenges being faced by the whole system in 2015/16 will be discussed at a tri-partite meeting between the CCGs, Trust, Monitor and NHS England in early August.

Action required

8. The Trust Board is asked to:

    - Note the findings of the joint investigation and the on-going risks to performance delivery.

    - Note that an action plan arising from the joint investigation is in place, and that non-delivery of the actions by the Trust could lead to up to £960k of funding being withheld on a monthly basis.

Martin Wilson
Director of Delivery and Improvement

Appendix 1 – Action plan themes

Action plan theme	Work area
1. ED Flow	Revise patient navigation model
	Exit blocks that lead to crowding
2. Intra Hospital Flow	11am Discharges
	Acute Medical Unit Flow
	Board and ward rounds
	Departure/Discharge Lounge
	Discharge menu
	Estimated & Planned dates of discharge
	Inter Hospital Transfer (IHT) Standards
	Queen Mary's Hospital flow
	Simple vs. Complex Discharges
3. Frailty Pathway & Ambulatory Care	Ambulatory Care
	Frailty Pathway
4. Elective Pathway	Developing and agreeing activity plans
	Addressing challenged specialities now and in the future
	Design and implement a model for protecting elective capacity in / for SGUHFT
	Implement data quality improvements from RTT National Validation Programme and RTT sustainability tool

St George's Healthcare NHS Trust

REPORT TO THE TRUST BOARD ***July 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 workforce report includes:

- The workforce performance report June 2015
- The report from the Chair of the Workforce and Education Committee.

The workforce performance report contains detail of workforce performance against key workforce performance indicators for June 2015. The report also includes available benchmark information.

Key points to note are:

- Budgeted posts have not yet been confirmed for FY16. The Finance department are being supported so that the work on reconciliation of the general ledger to the electronic staff record can be completed. Until this work is completed, the vacancy factor should be treated with caution.
- Turnover has stabilised but is behind the target trajectory.
- Support is being provided by KPMG to identify pay costs and the report includes, for the first time a copy of the weekly workforce tracker that has been developed and is being shared with senior managers.

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 June workforce data is that there appears to be some stabilisation in the workforce metrics.

Vacancy rate

There has been greater urgency in the work to reconcile the general ledger with the electronic staff record information, with support being given to the Finance department. The corporate nursing team are leading a review of nursing levels required for safe staffing and of service led demand. Once this work is complete and agreed, the changes made within the financial ledger will be synchronised with the electronic staff record data. This project is now projected to be 75% complete by 31st July.

Turnover and stability

Turnover has stabilised in May but has not met the proposed trajectory. As more than 50% of leavers leave for reasons that relate to their experience at work, it is clear that the trust has the potential to reduce turnover. Divisions have reported to the workforce and education committee with their plans to reduce turnover and have been asked to identify the key steps that they are taking in response to specific areas of high turnover.

Sickness absence

Sickness absence levels remain on target.

Agency and bank staff usage

After the big drop in temporary staffing hours that was seen in April and that was sustained in May, there has been an increase in usage in June. The report provides detail on temporary staffing that is managed through the bank. It is becoming clear that there is significant temporary staffing within the trust that is not managed through the trust bank. There is a small task and finish group in place to identify this workforce and to control it.

Mandatory training and appraisal rates

Both mandatory training and appraisal rates have slipped. There is a programme of work in place to assess the level of risk and to increase uptake.

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St George's University Hospitals NHS
NHS Foundation Trust

Workforce Performance Report
to the Trust Board

Month 3 - June 2015

Excellence in specialist and community healthcare

Workforce Performance Report Jul ‘14 - Jun ‘15

Contents

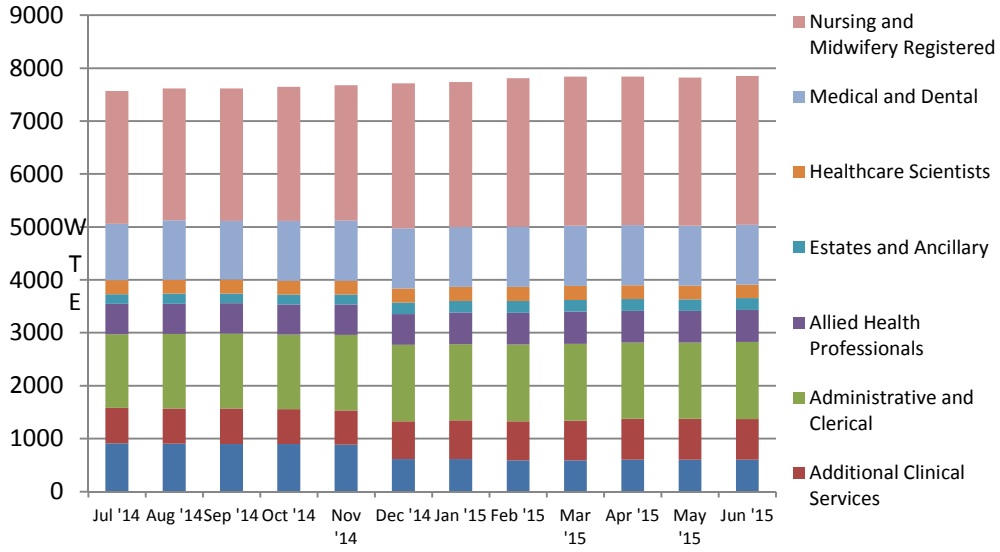
Performance Summary

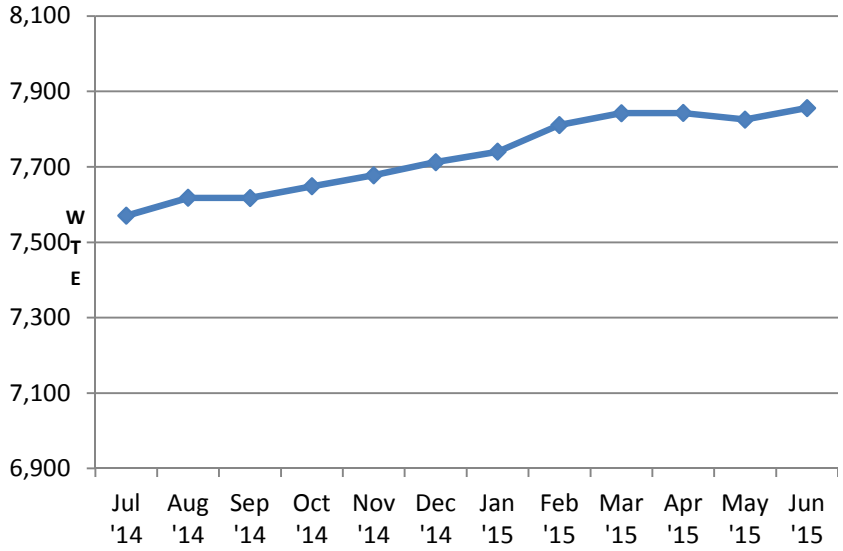
Summary of overall performance is set out below

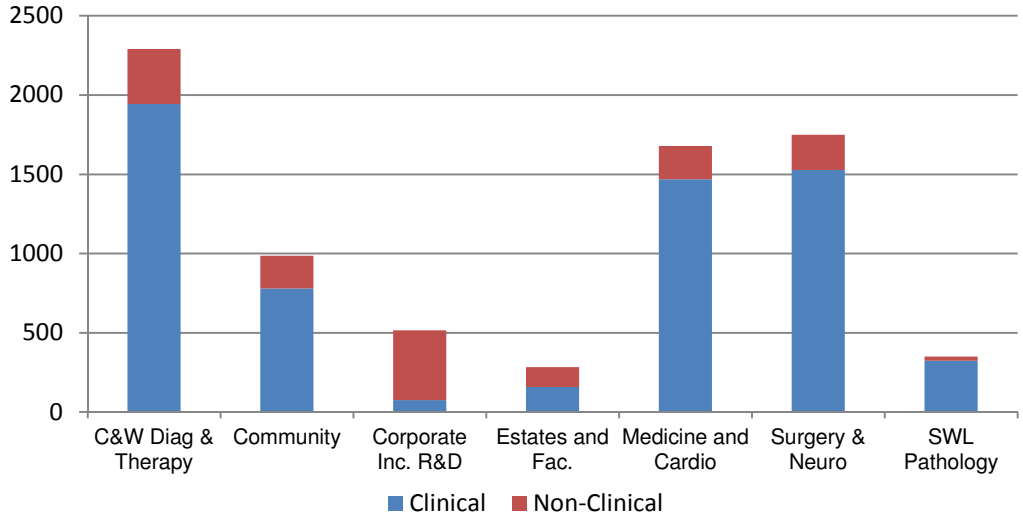
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has decreased by 0.3%	12.3%	15.5%	15.2%	↘
6	Turnover	Turnover has decreased by 0.2%	15.4%	17.5%	17.3%	↘
7	Voluntary Turnover	Voluntary turnover has has decreased by 0.1%	12.6%	14.1%	14.0%	↘
8	Stability	Stability has increased this month by 0.2%	84.9%	83.0%	83.2%	↗
10	Sickness	Sickness has remained the same	3.6%	3.5%	3.5%	↔
13-14	Temporary Staffing Usage (FTE)	Temporary staff usage has increased by 0.6%	14.9%	13.9%	14.5%	↗
17	Mandatory Training	MAST compliance has decreased by 1.1%	76.9%	73.1%	72.4%	↘
18	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has decreased by 1%	73.7%	74.8%	73.8%	↘

Current Staffing Profile

The data below displays the current staffing profile of the Trust



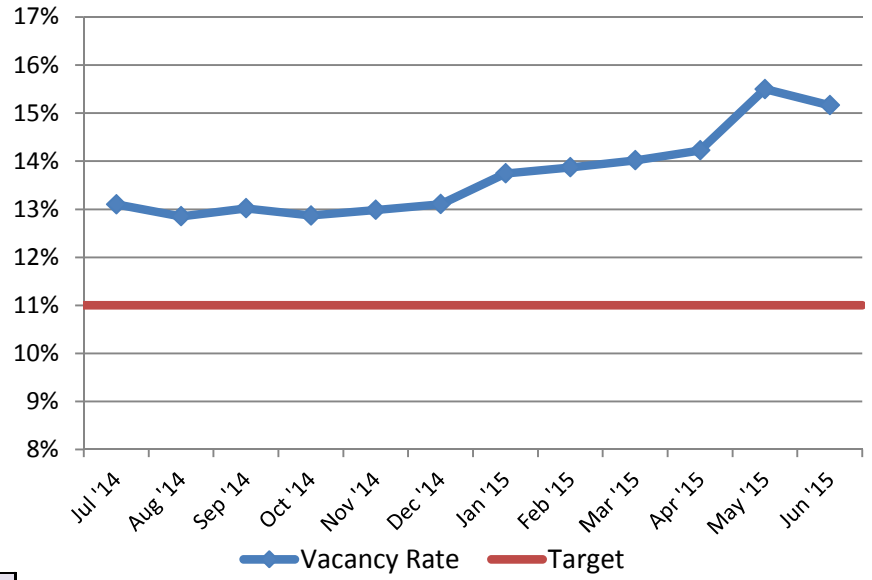




COMMENTARY

The Trust currently employs 8427 people working a whole time equivalent of 7856 which is 31 WTE higher than in May. The growth rate in the directly employed workforce since June 2014 is 246 WTE or 3.2%.

Section 1: Vacancies



Vacancies by Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diag & Therapy	9.9%	9.9%	9.8%	9.9%	↗
Community	19.6%	19.4%	19.1%	19.4%	↗
Corporate	14.5%	15.4%	16.5%	16.4%	↘
Estates and Fac.	12.7%	11.4%	22.8%	23.0%	↗
Medical & Cardio	12.7%	13.4%	13.5%	12.8%	↘
Surgery & Neuro	15.0%	14.9%	17.7%	16.9%	↘
SWL Pathology	24.2%	25.0%	28.4%	24.0%	↘
Whole Trust	**14.0%**	**14.2%**	**15.5%**	**15.2%**	↘

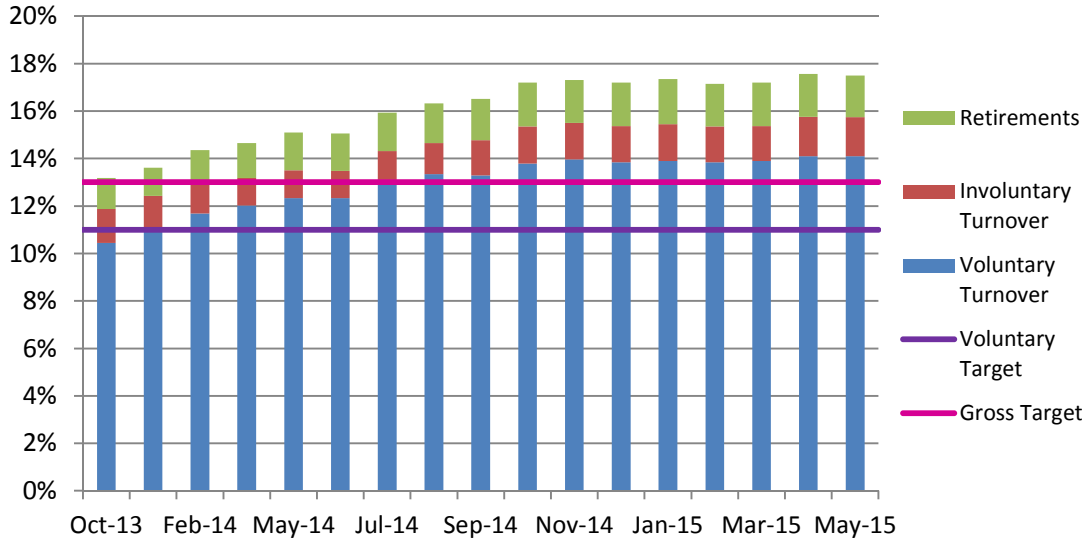
Vacancies Staff Group	Mar '15	Apr '15	May '15	Jun '15	Trend
Add Prof Scientific and Technic	19.6%	18.6%	16.4%	17.5%	↗
Additional Clinical Services	15.6%	16.7%	18.7%	18.8%	↗
Administrative and Clerical	20.3%	21.2%	22.6%	20.9%	↘
Allied Health Professionals	1.9%	3.7%	3.6%	3.1%	↘
Estates and Ancillary	27.8%	27.0%	22.5%	25.8%	↗
Healthcare Scientists	19.5%	20.5%	21.8%	21.7%	↘
Medical and Dental	-0.3%	-0.3%	3.2%	4.5%	↗
Nursing and Midwifery Registered	14.3%	13.9%	15.7%	14.9%	↘
Total	**14.0%**	**14.2%**	**15.5%**	**15.2%**	↘

COMMENTARY

Budgeted posts have not yet been confirmed for FY16. Once these are confirmed, variances against plan will be reported by Division, Directorate and Staff Group. The Finance department are being supported so that the work on reconciliation of the general ledger to the electronic staff record can be completed.

Section 2a: Gross Turnover

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



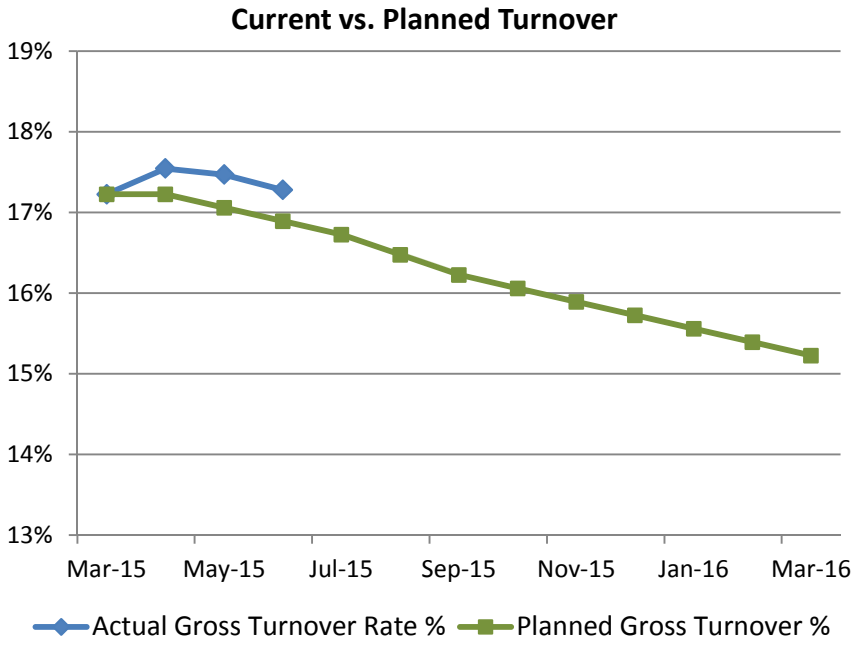
COMMENTARY

The total trust turnover rate has decreased month to 17.3%. This is significantly above the current target of 13%. In the last 12 months there have been 1231 WTE leavers.

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

	All Turnover				
Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	18.1%	18.1%	17.7%	17.2%	↘
Community Services	18.8%	19.6%	19.9%	20.4%	↗
Corporate	15.9%	16.9%	18.5%	19.7%	↗
Estates and Facilities	11.9%	17.6%	17.4%	17.0%	↘
Medical & Cardiothoracics	18.2%	18.4%	18.0%	17.7%	↘
Surgery, Neurosciences & Anaes	14.6%	14.5%	14.3%	14.4%	↗
SWL Pathology	19.6%	19.4%	19.7%	17.3%	↘
Whole Trust	**17.2%**	**17.5%**	**17.5%**	**17.3%**	↘

	All Turnover				
Staff Group	Mar '15	Apr '15	May '15	Jun '15	Trend
Add Prof Scientific and Technic	18.6%	18.9%	18.2%	17.9%	↘
Additional Clinical Services	20.7%	20.4%	20.6%	20.8%	↗
Administrative and Clerical	15.1%	16.6%	16.6%	16.9%	↗
Allied Health Professionals	17.8%	18.5%	17.9%	17.1%	↘
Estates and Ancillary	12.3%	12.6%	11.3%	10.8%	↘
Healthcare Scientists	15.3%	15.9%	16.2%	14.3%	↘
Medical and Dental	14.1%	13.3%	14.1%	13.6%	↘
Nursing and Midwifery Registered	18.1%	18.1%	18.0%	17.9%	↘
Whole Trust	**17.2%**	**17.5%**	**17.5%**	**17.3%**	↘



Section 2b: Voluntary Turnover

	Voluntary Turnover					Other Turnover Jun 2015	
Division	Mar '15	Apr '15	May '15	Jun '15	Trend	In-Voluntary	Retirement
C&W Diagnostic & Therapy	13.4%	13.5%	13.2%	13.2%	↔	2.2%	1.7%
Community Services	14.8%	15.6%	15.8%	16.1%	↗	1.1%	3.2%
Corporate	13.5%	14.0%	15.1%	15.8%	↗	1.9%	1.9%
Estates and Facilities	7.1%	8.0%	7.6%	6.4%	↘	7.6%	3.0%
Medical & Cardiothoracics	15.9%	16.1%	15.7%	15.4%	↘	1.0%	1.4%
Surgery, Neurosciences & Anaes	12.7%	12.3%	12.6%	12.8%	↗	0.6%	0.9%
SWL Pathology	16.9%	16.5%	16.7%	15.1%	↘	0.6%	1.6%
Whole Trust	**13.9%**	**14.1%**	**14.1%**	**14.0%**	↘	**1.6%**	**1.7%**

	Voluntary Turnover					Other Turnover Jun 2015	
Staff Group	Mar '15	Apr '15	May '15	Jun '15	Trend	In-Voluntary	Retirement
Add Prof Scientific and Technic	12.1%	12.3%	12.0%	11.7%	↘	5.9%	0.2%
Additional Clinical Services	17.5%	17.3%	17.4%	17.6%	↗	1.2%	2.0%
Administrative and Clerical	12.2%	12.9%	13.0%	13.2%	↗	1.7%	2.0%
Allied Health Professionals	16.3%	17.3%	16.8%	15.9%	↘	0.1%	1.1%
Estates and Ancillary	7.8%	8.2%	7.3%	6.8%	↘	0.9%	3.1%
Healthcare Scientists	11.2%	11.3%	11.5%	10.7%	↘	0.8%	2.8%
Medical and Dental	8.1%	7.6%	8.2%	8.1%	↘	4.2%	1.3%
Nursing and Midwifery Registered	15.5%	15.5%	15.5%	15.4%	↘	0.6%	1.9%
Whole Trust	**13.9%**	**14.1%**	**14.1%**	**14.0%**	↘	**1.6%**	**1.7%**

Caregroup	Staff in Post WTE	Leavers WTE	Voluntary Turnover Rate
Prison Service	56.2	19.4	33.0%
Cardiac Surgery	88.7	24.8	32.7%
Gynaecology	45.6	15.4	31.2%
Inpatient Care Older People	53.0	15.8	29.7%
Trauma & Orthopaedics	123.8	30.2	28.5%

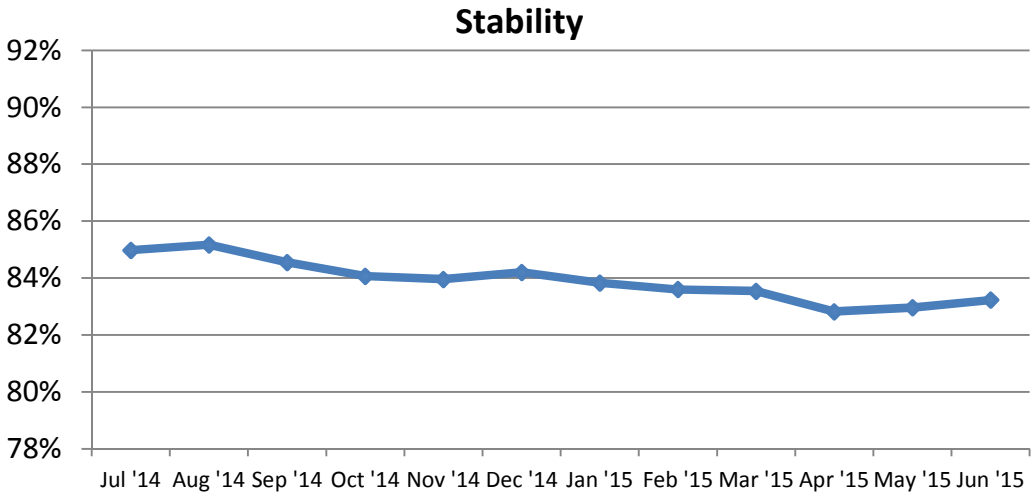
COMMENTARY

The 5 care groups currently with the highest voluntary turnover rates are shown in the bottom table. This includes care-groups with more than 20 staff only. Divisional HR Managers are working with divisions to tackle any issues within these areas.

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

Section 3: Stability

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



Stability by Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	83.1%	82.6%	82.9%	82.5%	↘
Community Services	81.0%	80.4%	80.4%	80.4%	↔
Corporate	87.8%	85.7%	85.1%	83.7%	↘
Estates and Facilities	89.8%	89.0%	84.9%	85.4%	↗
Medical & Cardiothoracics	81.4%	81.3%	82.4%	82.4%	↔
Surgery, Neurosciences & Anaes	84.0%	84.6%	84.5%	85.1%	↗
SWL Pathology	90.2%	81.7%	82.2%	88.3%	↗
Whole Trust	**83.5%**	**82.8%**	**83.0%**	**83.2%**	↗

Stability Staff Group	Mar '15	Apr '15	May '15	Jun '15	Trend
Add Prof Scientific and Technic	72.4%	72.7%	73.5%	73.7%	↗
Additional Clinical Services	80.9%	82.8%	82.8%	85.1%	↗
Administrative and Clerical	87.7%	86.4%	86.1%	85.7%	↘
Allied Health Professionals	82.1%	80.8%	80.8%	81.2%	↗
Estates and Ancillary	86.3%	85.5%	86.7%	86.0%	↘
Healthcare Scientists	95.1%	88.7%	87.3%	88.3%	↗
Medical and Dental	88.7%	87.8%	87.1%	88.5%	↗
Nursing and Midwifery Registered	82.9%	82.2%	82.6%	82.4%	↘
Total	**83.5%**	**82.8%**	**83.0%**	**83.2%**	↗

COMMENTARY

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

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

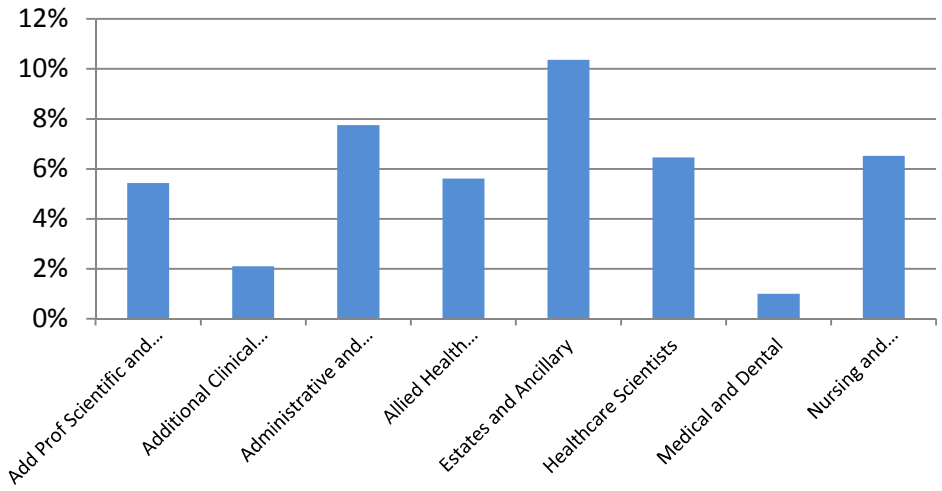
The stability rate has increased by 0.2% this month.

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

Over the last 12 months the stability rate has declined by 1.7% and is now at 83.2%.

Section 4: Staff Career Development

The chart below shows the percentage of current staff promoted in each staff group over the last 12 months.



COMMENTARY

Staff exit survey data tells us that one of the key drivers for retaining staff is to support their development within the trust. In June 58 staff were promoted, there were 94 new starters to the Trust and 242 employees were acting up to a higher grade.

Over the last year 5.7% 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 Admin & Clerical staff. There is a communications focus on education and development this month, enabling members of staff to understand what training and education opportunities are available.

	No. of Promotions				
Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	13	8	11	18	↗
Community Services	8	4	15	15	↔
Corporate	5	3	5	7	↗
Estates and Facilities	0	20	0	2	↗
Medical & Cardiothoracics	9	1	6	4	↘
Surgery, Neurosciences & Anaes	6	3	7	12	↗
SWL Pathology	0	0	0	0	↔
Whole Trust Promotions	**41**	**39**	**44**	**58**	↗
New Starters (Excludes Junior Doctors)	**136**	**120**	**71**	**94**	↗

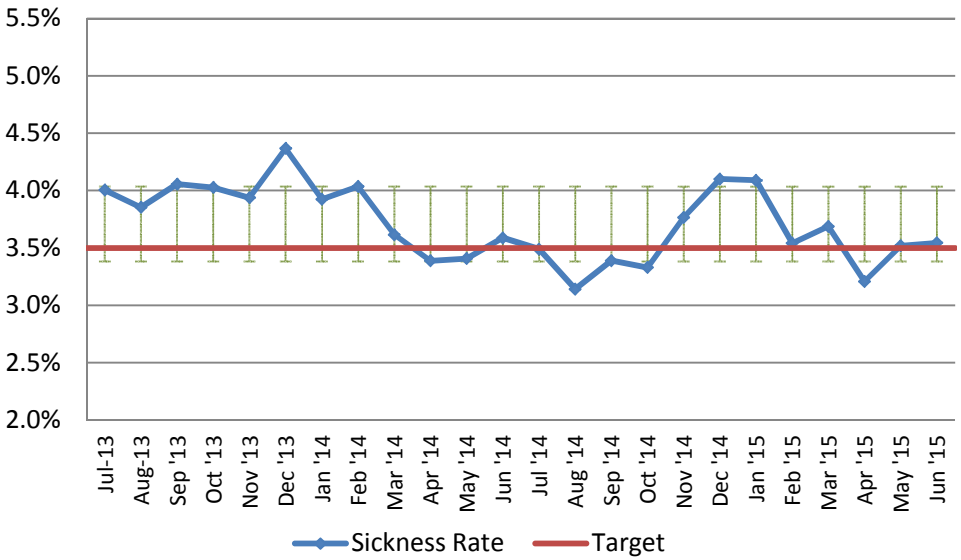
Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	1810	115	6.4%	112
Community Services	908	48	5.3%	18
Corporate	430	33	7.7%	19
Estates and Facilities	251	26	10.4%	6
Medical & Cardiothoracics	1175	62	5.3%	44
Surgery, Neurosciences & Anaes	1372	63	4.6%	27
SWL Pathology	315	11	3.5%	16
Whole Trust	**6261**	**358**	**5.7%**	**242**
New Starters (Excludes Junior Doctors)		**1441**		

	No. of Promotions				
Staff Group	Mar '15	Apr '15	May '15	Jun '15	Trend
Add Prof Scientific and Technic	2	1	4	2	↘
Additional Clinical Services	3	0	4	2	↘
Administrative and Clerical	8	5	14	22	↗
Allied Health Professionals	7	3	7	10	↗
Estates and Ancillary	0	20	0	2	↗
Healthcare Scientists	0	1	2	0	↘
Medical and Dental	1	0	0	3	↗
Nursing and Midwifery Registered	20	9	13	17	↗
Whole Trust	**41**	**39**	**44**	**58**	↗

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	479	26	5.4%	29
Additional Clinical Services	666	14	2.1%	13
Administrative and Clerical	1226	95	7.7%	80
Allied Health Professionals	517	29	5.6%	30
Estates and Ancillary	193	20	10.4%	2
Healthcare Scientists	248	16	6.5%	6
Medical and Dental	599	6	1.0%	3
Nursing and Midwifery Registered	2333	152	6.5%	79
Whole Trust	**6261**	**358**	**5.7%**	**242**

Section 5: Sickness

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



COMMENTARY

Sickness absence is at 3.5% for June, which is the same as the previous month.

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

The focus on well-being communications that took place in June was well received and included well-being walkabouts where governors and the leadership team personally thanked staff and gave them information on the well-being support available.

The table below lists the five care groups with the highest sickness absence percentage during June 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	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	2.9%	2.3%	2.9%	3.1%	↗
Community Services	6.5%	5.7%	6.0%	6.0%	↔
Corporate	4.1%	4.0%	4.0%	4.8%	↗
Estates and Facilities	7.1%	6.5%	7.6%	4.5%	↘
Medical & Cardiothoracics	3.5%	3.0%	2.9%	2.6%	↘
Surgery, Neurosciences & Anaes	3.0%	2.9%	3.1%	3.4%	↗
SWL Pathology	3.2%	2.0%	2.6%	2.5%	↘
Whole Trust	**3.7%**	**3.2%**	**3.5%**	**3.5%**	↔

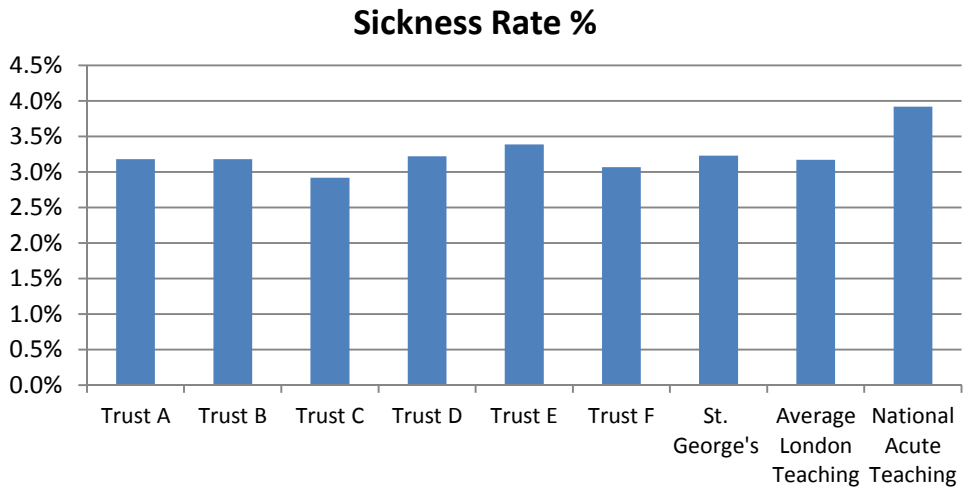
Sickness Staff Group	Mar '15	Apr '15	May '15	Jun '15	Trend
Add Prof Scientific and Technic	2.3%	2.9%	3.0%	3.0%	↔
Additional Clinical Services	5.1%	5.4%	6.8%	6.7%	↘
Administrative and Clerical	4.5%	4.0%	4.3%	4.5%	↗
Allied Health Professionals	3.1%	2.3%	2.8%	2.7%	↘
Estates and Ancillary	5.7%	6.1%	6.4%	5.7%	↘
Healthcare Scientists	2.4%	1.8%	1.8%	1.6%	↘
Medical and Dental	0.7%	0.2%	0.9%	0.6%	↘
Nursing and Midwifery Registered	4.5%	3.6%	3.5%	3.7%	↗
Total	**3.7%**	**3.2%**	**3.5%**	**3.5%**	↔

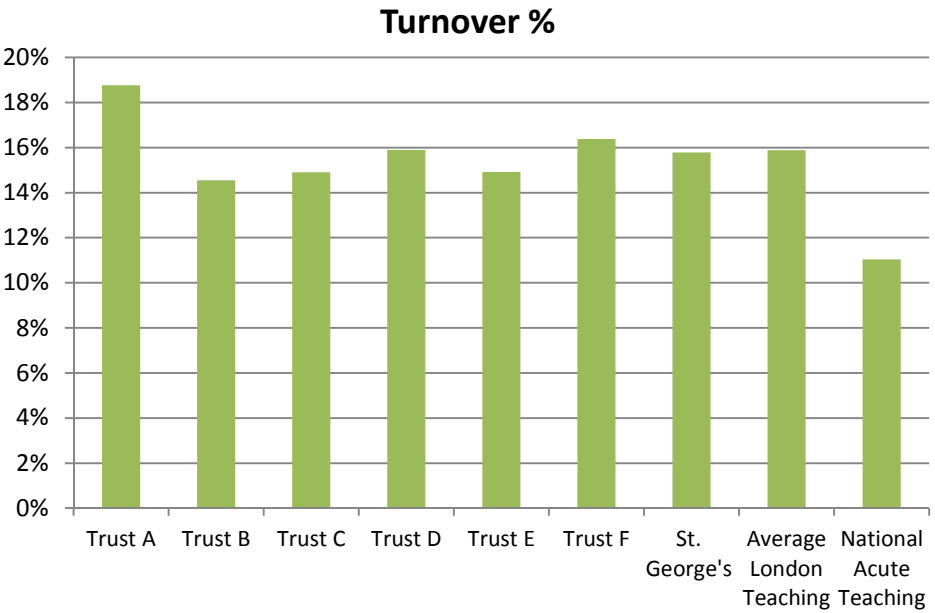
Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Prison Service	56.23	266.97	15.3%	£18,784
Intermediate Care	61.51	208.91	11.4%	£12,284
Community PLD Service	25.43	84.31	11.0%	£9,002
Engineering Services	48.50	120.00	8.3%	£7,310
Therapies - Children	90.57	203.18	7.5%	£15,603

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	19.81%
S25 Gastrointestinal problems	19.73%
S12 Other musculoskeletal problems	8.89%
S16 Headache / migraine	7.45%
S10 Anxiety/stress/depression/other psychiatric illnesses	7.03%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S10 Anxiety/stress/depression/other psychiatric illnesses	15.11%
S12 Other musculoskeletal problems	13.51%
S25 Gastrointestinal problems	11.78%
S13 Cold, Cough, Flu - Influenza	11.51%
S11 Back Problems	8.66%

Section 6: Workforce Benchmarking





COMMENTARY

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

Sickness data shown is from March '15 which is the mot recent available. Compared to other Acute teaching trusts in London, St. Georges had a higher than average rate at 3.23%. 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 March.

The bottom graph shows the comparison of turnover rates for the same group of London teaching trusts (excluding junior medical staff). This is the total turnover rate including all leavers (voluntary resignations, retirements, end of fixed term contracts etc.). St. Georges currently has a lower than average turnover compared to the group (12 months to end April). Stability is also slightly higher than average. High turnover is more of an issue in London trusts than it is nationally which is reflected in the national average rate which is 4.9% 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	18.77%	81.39%	3.18%
Trust B	14.55%	85.02%	3.18%
Trust C	14.90%	84.70%	2.92%
Trust D	15.90%	83.87%	3.22%
Trust E	14.92%	79.96%	3.39%
Trust F	16.38%	83.12%	3.07%
St. George's	15.79%	83.94%	3.23%
Average London Teaching	15.89%	83.14%	3.17%
National Acute Teaching	11.04%	88.74%	3.92%

Section 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	1073.5	1073.5	1073.5	1074.5	↗
Community Services	594.3	593.6	593.6	594.6	↗
Corporate & R&D	50.5	53.5	59.9	60.9	↗
Medical & Cardiothoracics	1216.8	1218.8	1220.8	1207.3	↘
Surgery, Neurosciences & Anaes	1029.7	1022.7	1107.7	1098.7	↘
Total	3964.9	3962.1	4055.5	4036.0	↘

Nursing Staff in Post WTE

Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	980.6	986.0	984.7	985.3	↗
Community Services	478.5	479.7	473.9	471.3	↘
Corporate & R&D	45.3	49.1	49.2	54.0	↗
Medical & Cardiothoracics	1017.1	1002.3	1007.6	1006.5	↘
Surgery, Neurosciences & Anaes	878.1	881.5	880.1	884.0	↗
Total	3399.4	3398.5	3395.6	3401.2	↗

Nursing Vacancy Rate

Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	8.7%	8.2%	8.3%	8.3%	↗
Community Services	19.5%	19.2%	20.2%	20.7%	↗
Corporate & R&D	10.3%	8.2%	17.8%	11.2%	↘
Medical & Cardiothoracics	16.4%	17.8%	17.5%	16.6%	↘
Surgery, Neurosciences & Anaes	14.7%	13.8%	20.5%	19.5%	↘
Total	14.3%	14.2%	16.3%	15.7%	↘

Nursing Sickness Rates

Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	4.1%	3.5%	3.9%	4.3%	↗
Community Services	7.9%	6.4%	6.3%	6.2%	↘
Corporate	0.4%	0.5%	1.6%	6.6%	↗
Medical & Cardiothoracics	4.4%	3.8%	3.5%	3.3%	↘
Surgery, Neurosciences & Anaes	3.5%	3.7%	4.1%	4.5%	↗
Total	4.5%	4.0%	4.2%	4.3%	↗

Nursing Voluntary Turnover

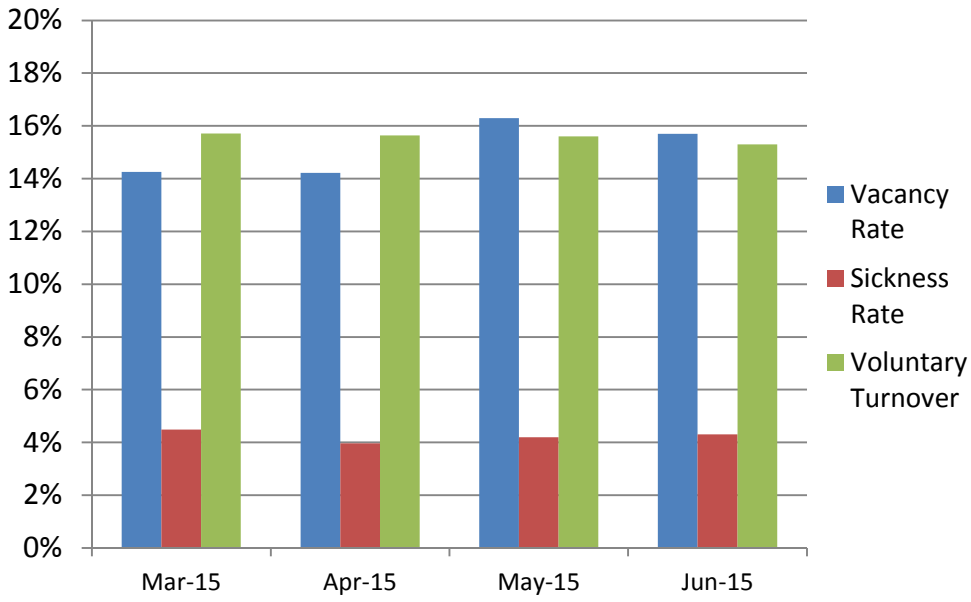
Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	14.45%	14.78%	14.22%	14.02%	↘
Community Services	16.18%	15.59%	16.30%	17.31%	↗
Corporate & R&D	18.12%	16.89%	14.98%	14.25%	↘
Medical & Cardiothoracics	18.29%	18.72%	17.91%	17.48%	↘
Surgery, Neurosciences & Anaes	13.79%	13.02%	14.10%	13.38%	↘
Total	15.5%	15.5%	15.7%	15.3%	↘

COMMENTARY

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

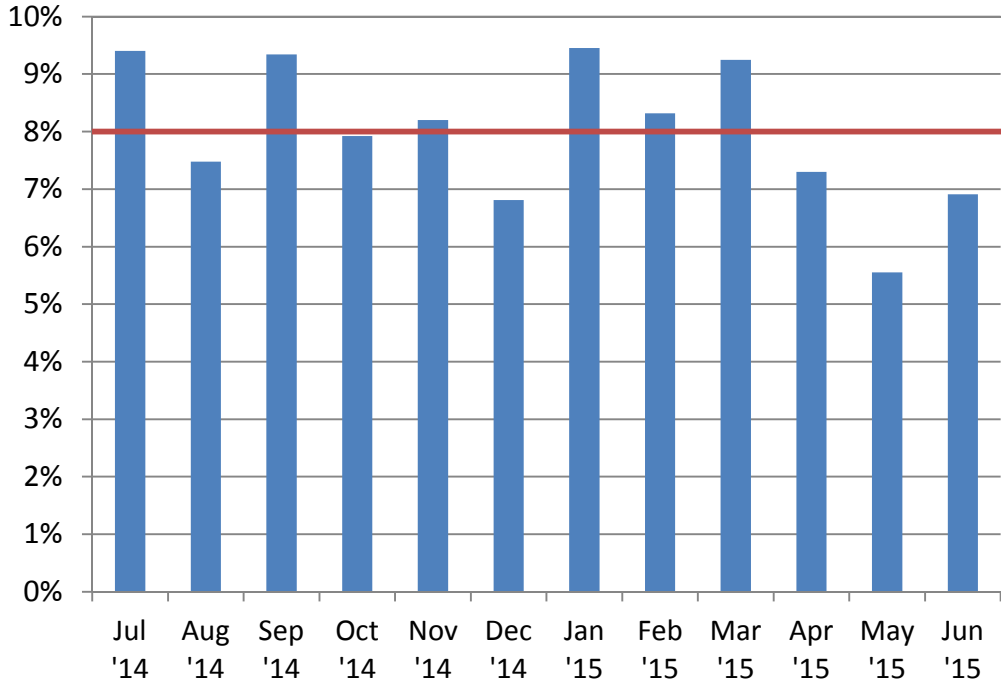
The nursing workforce has increased slightly by 5.6 WTE in June. The output of the review of nursing establishments will be a revised trajectory for demand for nursing.

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



Section 8: Agency Staff Costs

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



COMMENTARY

The agency spend percentage has increased by 1.4% since May.

Currently, the highest percentage spend is seen in the Community and Medical & Cardiothoracics Divisions.

Significant support is being given to the trust by the turnaround team to identify and control all temporary staffing usage. The workstream reports through to the Workforce Efficiency Group.

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

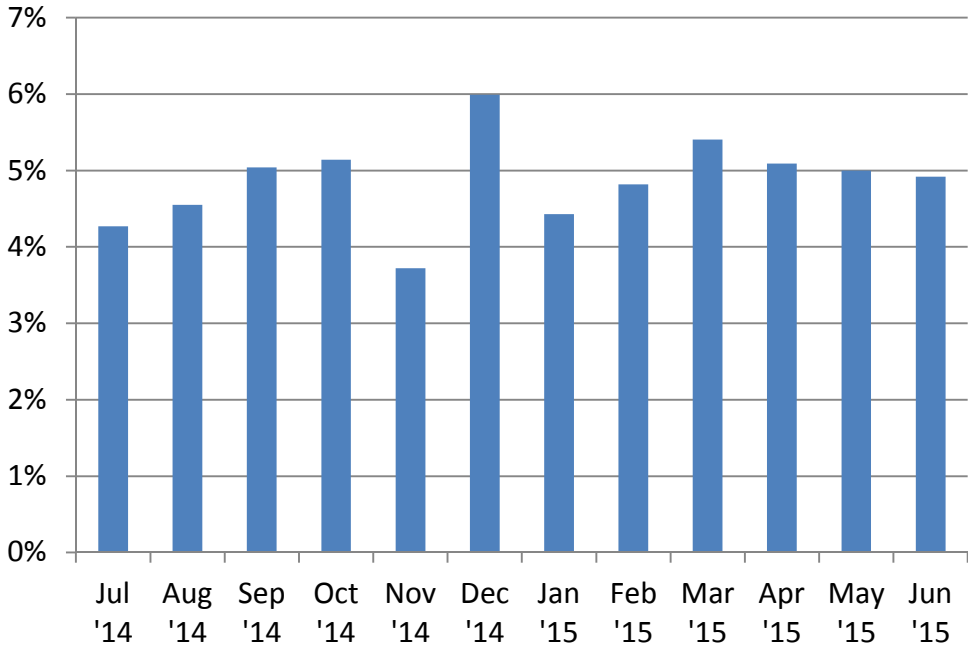
Agency Costs by Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	8.4%	7.5%	6.7%	6.4%	↘
Community Services	16.2%	12.2%	9.5%	12.9%	↗
Corporate	3.4%	2.7%	1.2%	2.9%	↗
Estates and Facilities	25.4%	9.5%	1.5%	3.5%	↗
Medical & Cardiothoracics	9.7%	9.4%	6.1%	8.4%	↗
Surgery, Neurosciences & Anaes	6.2%	4.1%	3.2%	3.9%	↗
Whole Trust	**9.2%**	**7.3%**	**5.6%**	**6.9%**	↗

Care Group	Agency Spend % Jun-15	Staff In Post WTE
Therapies - Children	36.5%	90.6
Prison Service	29.7%	56.2
Inpatient Care Older People	29.6%	53.0
Outpatients	23.7%	258.4
Community Wards	21.7%	103.5

Booking Reason	Medical Agency & Bank £ Jun-15	%
Annual Leave AL	£0	0.00%
Increased Care Needs ICN	£14,186	4.21%
Maternity Leave ML	£0	0.00%
Sickness S	£2,718	0.81%
Study Leave SL	£1,046	0.31%
Vacancy V	£319,196	94.68%
Total	**£337,146**	**100.00%**

Section 9: Staff Bank Costs

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



COMMENTARY

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

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

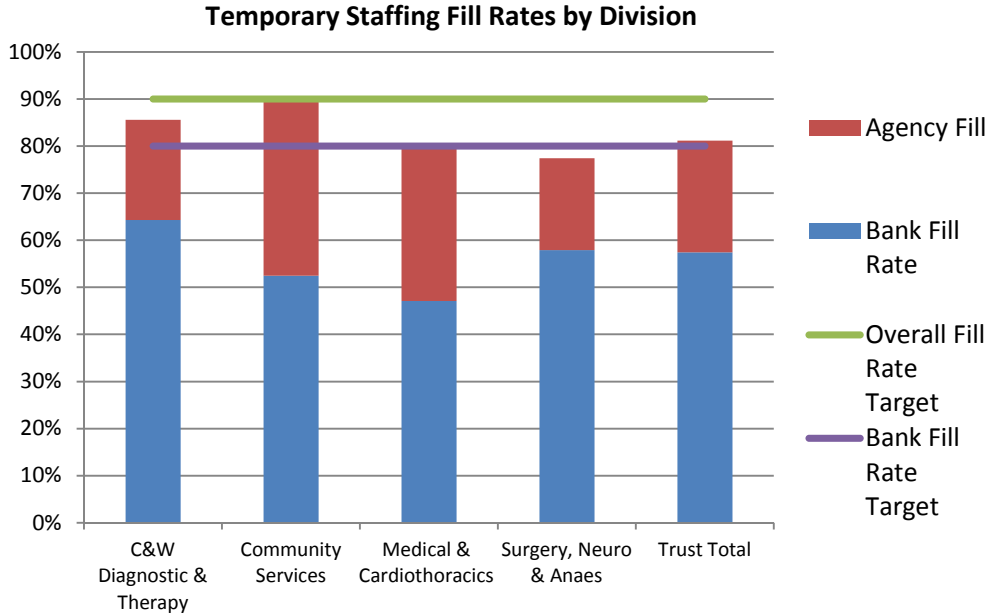
The Bank Fill rate in June 2015 was 57.5% this was an improvement of 13.3% on March 2015

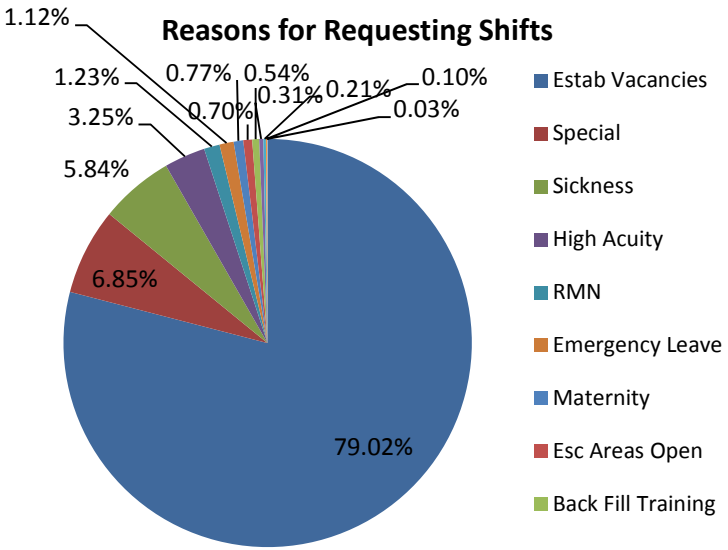
The table below lists the five care groups with the highest bank percentage spend for this month.

Bank Spend % by Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	6.0%	5.6%	5.8%	5.5%	↘
Community Services	4.9%	4.4%	4.5%	3.5%	↘
Corporate	1.5%	3.8%	4.4%	3.5%	↘
Estates and Facilities	9.9%	9.4%	10.4%	12.7%	↗
Medical & Cardiothoracics	6.9%	5.9%	6.1%	6.7%	↗
Surgery, Neurosciences & Anaes	4.7%	3.4%	3.3%	3.3%	↗
Whole Trust	**5.4%**	**5.1%**	**5.0%**	**4.9%**	↘

Care Group	Bank Spend % Jun-15	Staff In Post WTE
Security & Car Park Mgt	34.1%	22.0
Portering	29.9%	77.7
Senior Health	15.3%	91.6
Prison Services	14.4%	56.2
Pharmacy	14.0%	166.3

Section 10: Temporary Staff Fill Rates





COMMENTARY

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

The "Overall Fill Rate" is the percentage number of requests made to the Staff Bank to cover shifts which were filled by either trust bank staff, or by an agency. The remainder of requests which could not be covered by either group are recorded as being unfilled. The "Bank Fill Rate" describes requests that were filled by bank staff only, not agency.

In June the Bank Fill Rate was reported at 57.5% which is 1% higher than the previous month. The Overall Fill Rate was 81.2% which is an increase of 0.6% on the previous month. The Community Services Division is currently meeting the demand for temporary staff most effectively.

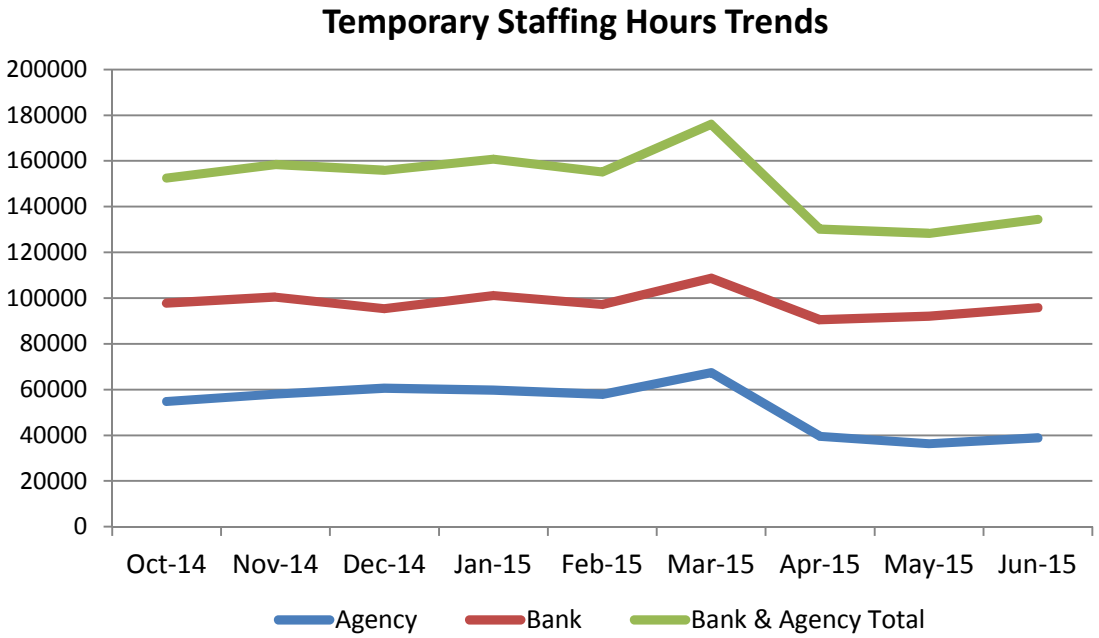
The pie chart shows a breakdown of the reasons given for requesting bank shifts in June. This is very much dominated by covering existing vacancies, specials, sickness, and high acuity patients.

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

Bank Fill Rate % by Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	34.54%	45.41%	52.14%	64.34%	↗
Community Services	41.01%	41.49%	49.51%	52.46%	↗
Medical & Cardiothoracics	37.96%	46.54%	51.69%	47.10%	↘
Surgery, Neurosciences & Anaes	48.50%	50.71%	57.66%	57.94%	↗
Whole Trust	**44.15%**	**50.24%**	**56.35%**	**57.45%**	↗

Overall Fill Rate % by Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	78.72%	78.35%	84.90%	85.58%	↗
Community Services	83.28%	84.08%	89.19%	90.39%	↗
Medical & Cardiothoracics	74.98%	74.37%	77.84%	79.92%	↗
Surgery, Neurosciences & Anaes	71.92%	71.43%	75.73%	77.42%	↗
Whole Trust	**77.10%**	**76.37%**	**80.64%**	**81.20%**	↗

Section 11: Temporary Staffing Duties



COMMENTARY

This data comes from the Trust's e-rostering system combined with numbers of hours booked via Hi-com.

The figures show the number of bank and agency hours worked by month by Division. The graph shows a large decrease in numbers in April as tighter controls on booking and runrate initiatives have been implemented. Both Bank and agency hours worked have increased in June.

TYPE	Division	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Agency	C&W Diagnostic & Therapy	15399	18212	17355	15424	15305	16737	9484	10711	8637
	Community Services	5482	6626	6035	6111	7424	9595	7825	5500	4873
	Corporate	4251	4061	3772	3454	2763	3488	1246	1331	949
	Estates and Facilities	0	0	0	0	0	0	0	0	0
	Medical & Cardiothoracics	19047	18425	22413	24222	21659	25750	14372	13140	17691
	Surgery, Neurosciences & Anaes	10541	10604	10984	10418	10739	11798	6532	5457	6351
	SWL Pathology							119	204	241
Agency Total		**54720**	**57929**	**60559**	**59629**	**57890**	**67367**	**39579**	**36342**	**38742**
Bank	C&W Diagnostic & Therapy	26343	26993	27287	28597	27691	31831	28040	29006	29330
	Community Services	10073	10976	11088	10061	9354	10548	8368	7606	7650
	Corporate	5481	7131	7405	7497	6939	7641	7188	6922	8074
	Estates and Facilities	6962	7026	6867	7446	6808	7744	6885	7502	8177
	Medical & Cardiothoracics	28236	27707	24432	25536	25076	27528	23749	24816	24926
	Surgery, Neurosciences & Anaes	17839	18005	15389	18840	18430	20376	13524	13484	14523
	SWL Pathology	2783	2619	2901	3134	2947	2953	2753	2620	3052
Bank Total		**97717**	**100457**	**95368**	**101111**	**97245**	**108622**	**90507**	**91956**	**95732**
Temporary Staff Total		**152436**	**158386**	**155927**	**160741**	**155136**	**175990**	**130085**	**128298**	**134474**

Section 12: Headcount Tracking
Week 4 – 20 July 2015

Introduction

- This report is for information purposes only as budgeted posts have not yet been confirmed for FY16. Once these are confirmed, variances against plan will be reported by Division, Directorate and Staff Group.

Status

- Weekly movements in ESR to Sunday, 19 July. Source: Workforce Intelligence – showing WTE in post.
- In the week to 19 July, there were 27 joiners and 24 leavers – net 3 WTE increase. An additional 3 WTE change is seen due to staff increasing their hours resulting in a 6 WTE movement overall.
- In the seven weeks from 31 May – 43 WTE increase, of which net 32 WTEs are 'Admin and clerical' staff.
- Next steps:

1. Reconciling differences between ESR and budget – starting w/c 20 July (delayed due to delay in finalising budgeted posts), to have reconciled 75% by 31 July
2. Showing trends and impacts on temporary staffing spend – 22 July
3. Analysis of known leavers – 22 July
4. Handover of tracker to Workforce Intelligence (to consider uploading onto Tableau) – 21 July

Section 12: Headcount Tracking by Division

Week 4 – 20 July 2015

Headcount tracking and movements

As at 20-Jul
Showing WTE (in post)
Vacancies excluded

DRAFT - SUBJECT TO VALIDATION AND FOR DISCUSSION ONLY

Function	Opening Baseline 31 May 15 ACT	ESR Prior week 13 Jul 15 ACT	ESR Current week 20 Jul 15 ACT	Variance (in week) comparing 13-Jul to 20-Jul Joiners VAR	Leavers VAR	Change in WTE VAR	Change in function* VAR	Total VAR	Variance (to date) comparing 31 May to 20-Jul Joiners VAR	Leavers VAR	Change in WTE VAR	Change in function VAR	Total VAR
200 Medicine and Cardiovascular Division	1,699	1,692	1,698	10	(3)	-	(1)	6	41	(36)	(3)	(3)	(1)
200 Children and Women's Diagnostic and Therapy Services Division	2,307	2,316	2,317	8	(8)	(0)	2	2	63	(46)	(0)	(5)	11
200 Community Services Division	992	988	986	2	(5)	-	-	(2)	24	(23)	(2)	(5)	(6)
200 Surgery & Neurosciences Division	1,758	1,774	1,773	5	(6)	(0)	-	(1)	48	(32)	(1)	(1)	15
200 Research & Development Division	12	15	15	-	-	-	-	-	3	-	-	-	3
200 Corporate Division	515	513	513	1	(3)	2	-	0	17	(18)	1	(1)	(2)
200 Estates and Facilities Division	283	284	285	1	-	-	-	1	2	-	-	-	2
200 Capital Division	12	12	12	-	-	-	-	-	-	-	-	-	-
200 SWL Pathology Division	328	349	350	1	-	-	-	1	7	(3)	(0)	18	22
Total	**7,906**	**7,943**	**7,950**	**27**	**(24)**	**2**	**1**	**6**	**204**	**(159)**	**(5)**	**3**	**43**

* Change in function does not equal to zero as it reflects changes in function but also changes in function and WTE hours.

- Variance in week shows an overall increase of 6 WTE during the period from 13th July to 20th July 2015.
- Variance to date also shows a positive variance of 43 WTE from the opening baseline period as at 31st May 2015.
- Medicine and Cardiovascular Division experienced an increase of 6 WTE in the week to 20th July.

Section 13: Mandatory Training

MAST Topic	May '15	Jun '15	Trend
Conflict Resolution	71.1	72.4	↗
Dementia Awareness	62.7	62.5	↘
Equality, Diversity and Human Rights	83.5	82.8	↘
Fire Safety	77.3	76.7	↘
Health, Safety and Welfare	83.7	82.4	↘
Infection Prevention and Control Clinical	62.1	62.8	↗
Infection Prevention and Control Non Clinical	77.2	75.4	↘
Information Governance	66.7	66.1	↘
Moving and Handling	80.8	77.7	↘
Moving and Handling Patient	55.2	55.3	↗
Resuscitation BLS	44.1	43.5	↘
Resuscitation ILS	46.5	46.7	↗
Resuscitation Non Clinical	60.2	61.4	↗
Safeguarding Adults	82.7	80.3	↘
Safeguarding Children Level 1	81.7	80.4	↘
Safeguarding Children Level 2	78.3	78.8	↗
Safeguarding Children Level 3	58.2	59.2	↗
Venous Thromboembolism	37.3	37.5	↗

MAST Compliance % by Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	75.9%	75.4%	75.0%	74.7%	↘
Community Services	77.8%	77.0%	74.7%	73.8%	↘
Corporate	75.7%	74.2%	71.9%	70.5%	↘
Estates and Facilities	66.8%	66.5%	65.9%	66.0%	↗
Medical & Cardiothoracics	67.1%	67.1%	66.4%	66.3%	↘
Surgery, Neurosciences & Anaes	71.3%	71.0%	70.3%	69.4%	↘
Whole Trust	74.7%	74.2%	73.1%	72.4%	↘

COMMENTARY

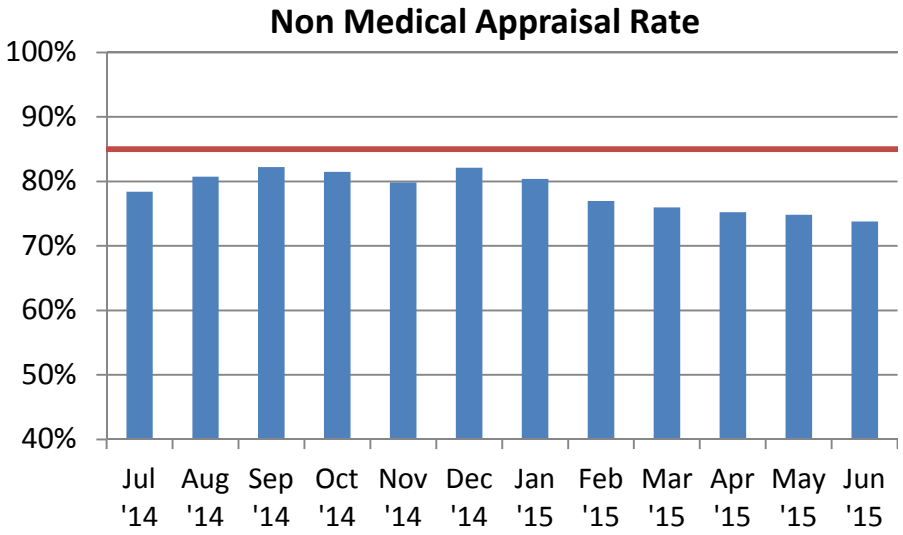
A programme of working is taking place including:

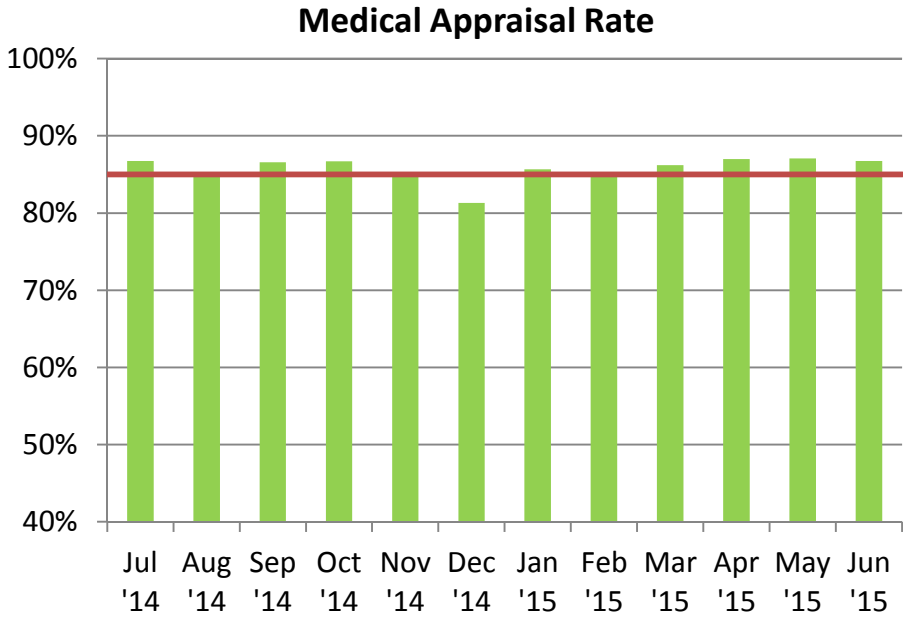
- Changing the method of delivery to on-line testing as far as possible and only training when required
- Reviewing who needs to access the training
- Reviewing the frequency of refresher periods
- Providing and accessible on-line system
- Introduced monthly meetings where divisions report on progress and are held to account by Director of Workforce
- Embedded Training evaluation to e-learning
- Reporting compliance futures for departments so that they are proactive with compliance
- System changes so that accessibility issues are resolved.
- Introduced governance meetings with training leads to ensure that issues are resolved and all are working together.

Current Issues:

- Fall in compliance rates – largely due to staffing pressures
- Community access to Totara is on the risk register, in the interim we are visiting community sites with tablets and developing a permanent solution in parallel
- Staff unable to access training externally- Software and licencing and IG issue
- Process review between Recruitment/Payroll/Education Department for new starters
- Study leave policy to be changed to say that CPPD will not be offered if the individual is not compliant
- Non-medical appraisal documentation to include confirmation of the staff members' compliance.

Section 14: Appraisal





Non-Medical Commentary

The non-medical appraisal rate has decreased this month to 73.8%. Appraisals are still being managed closely by the appraisal project team who are monitoring progress every two weeks and scrutinising divisional plans. The Estates & Facilities Division currently has the lowest non-medical compliance rate. Appraisal completion is now linked to incremental progression for bands AFC band 7 - 9 staff. The table below lists the five care groups with the lowest non medical appraisal rate this month

Medical Commentary

Medical appraisal rate compliance has decreased slightly this month to 86.7% which is still above the 85% target.

Care Group	Non-Med Appraisal Rate	Staff In Post WTE
Portering	41.1%	77.65
Paediatric Surgery	46.4%	54.80
Neurosurgery	47.1%	98.73
Procurement & Materials Mgmt	47.1%	39.00
Intermediate Care	48.5%	61.51

Non Medical Appraisals by Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	75.5%	74.5%	74.9%	74.4%	↘
Community Services	77.3%	76.8%	75.8%	75.4%	↘
Medical & Cardiothoracics	76.0%	77.0%	78.8%	77.8%	↘
Surgery, Neurosciences & Anaes	79.6%	77.7%	75.1%	74.2%	↘
Corporate	64.9%	65.1%	65.2%	66.4%	↗
Estates & Facilities	78.3%	76.6%	80.7%	80.7%	↔
Whole Trust	**75.9%**	**75.2%**	**74.8%**	**73.8%**	↘

Medical Appraisals by Division	Mar '15	Apr '15	May '15	Jun '15	Trend
C&W Diagnostic & Therapy	88.3%	89.7%	87.8%	87.1%	↘
Community Services	83.3%	66.7%	72.7%	69.6%	↘
Medical & Cardiothoracics	83.8%	86.0%	87.6%	87.7%	↗
Surgery, Neurosciences & Anaes	86.1%	87.7%	84.9%	84.9%	↔
Corporate	100.0%	100.0%	100.0%	50.0%	↘
Whole Trust	**86.2%**	**87.0%**	**87.1%**	**86.7%**	↘

St George's University Hospitals NHS
NHS Foundation Trust

Meeting of the Workforce and Education Committee 23 July 2015

Char's Report to the Board

Actions arising log

The following actions were captured in the minutes of the March '15 meeting. It was agreed that they needed to find their way onto the action log.

1. Nursing Recruitment plan: Request for a more programmatic presentation of progress and likely delivery against each workstream.
2. Ensuring that % targets for agency and bank are aligned to monetary values for temporary pay costs in the 15/16 budgets.
3. Provide an update on improvements in the recruitment process at the September meeting.

Workforce Plans

Jennie Hall shared with the Committee the process through which the nursing establishment is being validated. She explained that this is a huge task as it relates to 3000+ nursing staff. She anticipated this being ready for approvals by the end of September '15. Simon Mackenzie explained that a parallel process needs to be conducted for medical staff to ensure safe medical staffing, particularly out of hours. It was also confirmed that the two processes (for nursing and for medical staff) will need to be triangulated where they impacted each other (e.g. requirement for specialist nurses).

The Committee welcomed the rigour of these processes. It remained however, unclear as to how the timing of this work will impact budget finalisation. It was suggested that this be picked up at the Turnaround Board.

Wendy Brewer updated the Committee on the development of the weekly tracker which tracks headcount movements in substantive staff. The tracker is being expanded so that it can also report on leavers and temporary staff. As budgets get finalised and, consequently, budgeted posts are confirmed, the tracker will be used to investigate variances to plan, make resourcing decisions and challenge use of temporary resources.

In the light of the Trust's financial challenges, questions were asked about the growth in the number of substantive staff captured by the tracker (43 in the period 31 May- 20 July) a large proportion of whom were not in nursing. It was explained that the growth was in clerical and admin staff in Outpatients. It was agreed that a comparison will be provided to the Committee of the growth in numbers over the same period last year.

Terms of Reference and Evaluation of Effectiveness of the Committee

The Committee reviewed its terms of reference and reaffirmed its purpose and objectives. It agreed to share the annual work plan with all of its members so that it becomes clearer what each meeting is aiming to cover and so that preparation of papers can be planned in advance.

The responses to the Committee Effectiveness Survey provided assurance that the Committee conducts its business effectively. Areas of improvement suggested were:

- Increased divisional input with action points and metrics being division/service specific;
- Clearer understanding and assessment of financial implications of workforce issues.

It was agreed that both of these points will be taken forward starting with the plans that were on this meeting's agenda.

Workforce Strategy

Wendy presented highlights from progress made in Q1 against the workforce strategy and staff survey action plan.

The Committee welcomed the level of detail in the plan and the fact that it is geared towards tackling the big workforce issues (right number of staff, efficient deployment, reduction in turnover and vacancies, raising leadership capability and improving behaviours). In line with the PWC recommendations it was suggested that the financial implications of these actions become more explicit. It was also suggested that some of the deadlines for completion be looked at again, as they seemed ambitious.

Staff Turnover Divisional Plans

As a follow up to the findings of the exit survey reported at the March Committee meeting (53.6% 'unhappy leavers') each division presented their plan on how they intended to reduce staff turnover in their own division.

Although a number of thoughtful actions were reported by each division, it became apparent early on in the reporting back process that the four plans were not focussed or granular enough to give the Committee or, indeed, the divisions, the assurance that 'hotspots' of high turnover will be tackled with appropriately targeted actions. It was encouraging that when probed, divisional representatives came up with lots of specific ideas of what needed to be done, where and by whom and offered to come back to the Committee in September with more granular and specific plans.

Leadership Development

Sarah James gave a verbal report on what a trust-wide leadership development programme might look like and shared some of the emerging challenges to its delivery such as funding and engagement in the current circumstances.

The Committee asked that Sarah submits a written report that sets out what she considers to be an appropriate and relevant plan for leadership development at the trust. The plan should make explicit what the objectives of each of its component parts are. It should also demonstrate how it might help the Trust's performance in terms of:

- raising capability when it is known to be weak and to be contributing to business issues;
- reducing staff turnover (key cause of vacancies and use of temporary staff); and
- improving behaviours where there is evidence (through the staff survey, exit interviews and FFT data) that they are causing damage.

In other words, the plan needed to demonstrate how it could contribute to improved performance and reduced costs.

Sarah agreed to circulate a written plan out of Committee so that time is not lost.

Listening into Action Staff Survey Friends and Family Test

Liz Woods reported on the latest FFT staff survey for the period 1 April to 30 June 2015. The two key questions staff were asked were whether they would recommend the trust to their friends and family (a) as a place to be treated and (b) as a place to work.

The key finding from this survey was that the endorsement of the trust as a place to work went down from 59% to 50% since the last time the survey was ran.

The Committee had the opportunity to read the reasons given by individuals for the answer they had chosen. The themes were similar to what had emerged in most previous surveys and exit interviews (communication, level of support and understanding from line management, behaviours). The trust's financial situation was explicitly mentioned as a contributory factor by those who would not recommend the trust as a place of work. Although there was no statistical evidence for this, Liz thought that this factor probably accounted for most of the deterioration in the level of endorsement.

Executive members and divisional representatives with day to day experience of the trust confirmed that the financial situation is causing insecurity, frustration (empty shelves, requests turned down, bureaucracy) and shock and disbelief about the gap between the promise of becoming an FT and the reality.

It was thought that a steady stream of communication which explains honestly and contextualises the trust's situation is essential.

It was also striking to read the comments of those respondents who would recommend the trust to their friends and family. They talked about supportive managers, good teamwork, friendly environment and interesting work. This reinforced further the view that strong leadership can help staff make sense of the situation and help them focus on what is positive and within their control to influence.

Medical Staffing

It was agreed that the Medical Workforce summary business plan together with Sarah Hammond's paper on medical staffing be rolled over to the September Committee meeting to ensure it receives the time and attention it merits

Stella Pantelides

23 July 2015

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – JULY 2015

Paper Title:	In-year submissions to Monitor - Quarter 1 submission
Sponsoring Director:	Peter Jenkinson, Director of Corporate Affairs Steve Bolam, Chief Financial Officer
Author:	Imran Hussain, Head of Performance Kirit Shah, Financial Controller
Purpose: *The purpose of bringing the report to the board*	To present to the Board the draft quarterly performance submission to Monitor with proposed governance statements
Action required by the board:	To agree responses to the in-year governance statements
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	Monthly performance has previously been discussed at the finance and performance committee

Executive summary

1. Key messages

As part of the in-year reporting requirement as a foundation trust, the trust is required to submission quarterly performance submissions to Monitor.

The submission dates for 2015/16 are:

- Quarter 1 FY 16 – 31st July 2015
- Quarter 2 FY 16 – 31st October 2015
- Quarter 3 FY 16 – 31st January 2016
- Quarter 4 FY 16 – 30th April 2016

The quarterly submission covers:

- Financial performance, including income and expenditure, statement of financial position and cash flow performance
- Operational performance, including performance against access and outcomes standards
- Elections to the Council of Governors
- Executive departures / appointments
- In-year governance statements

For the governance statements, the Board must respond *'confirm'* or *'not confirmed'* to the following statements:

For finance, that the board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least three over the next 12 months

For governance, that the board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework *(included in the 'Targets and Indicators' worksheet on the attached*

template); and a commitment to comply with all known targets going forward.
Otherwise, that the Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor *(examples as per the risk assessment Framework, copied as an appendix to this report)* which have not already been reported.

In the case of the board not being able to confirm any of these statements, the Board must submit an explanation and a summary of actions being taken to address any issues identified.

As with the previous quarter's submission, in the light of evidence reviewed by the board in the performance reports at this meeting, it is recommended that the trust should declare non-compliance with the finance statement and the first governance statement and compliance with the second governance statement.

As we have declared non-compliance, we need to submit an explanation. The proposed explanation for each statement is copied below:

A. **For finance:** The Board is not able to confirm that the Trust will continue to maintain a Continuity of Service risk rating of 3 over the next 12 months because the Trust is expecting to incur a significant revenue deficit in 2015/16. The Trust is planning to secure additional interim financial support as a 'distressed provider' as classified by Monitor to address the liquidity impact of this deficit. The forecast Continuity of Service Rating for 2015/16 is 1.

B. **For governance:** It is forecasted that the Trust will continue to face continued challenges in meeting the national RTT standard(s).

The Trust has recently completed a joint investigation into RTT delivery with local commissioners that has identified the system wide capacity gap which must be addressed in order to sustainably deliver the RTT targets, and the approach that will be taken on a specialty by specialty basis to agree sustainable delivery plans. Following the change to the national commissioner targets on RTT towards the incomplete standard, the Trust is planning to undertake a significant validation of the incomplete PTL in order to determine the level of on-going risk. Commissioners are currently considering what level of additional activity they may wish to commission to support a reduction in overall waiting list (PTL) size.

It is forecasted that the Trust will continue to face some continued challenges in meeting the A&E 4 hour standard.

The changed profile of patients attending the emergency department and the increased length of stay of admitted patients continues to drive capacity pressures which are most evident in the emergency department and result in the 4 hour A&E standard not being met. A&E performance improvement is being pro-actively addressed system-wide with support of commissioners via the System Resilience Group. The Trust has recently completed a joint investigation into 4 hour delivery with local commissioners that has confirmed that there remains a system wide capacity gap (preventing the trust from lowering bed occupancy to the 90% local aspirational level for 2015/16) and agreeing a joint action plan to maximise delivery within these constraints. Key areas of focus include: front door frailty services, internal hospital flow, increased bed capacity, and system wide transformation (community services, discharge and frailty pathways).

Performance improvement has been noticeable in late July, however, pressures and challenges remain. The trust continues to implement and further embed existing actions to maintain performance improvement.

Recommendation
The board is asked to:

- agree responses to the governance statements and actions where the board agree a response of 'not confirmed' for any of the statements;
- approve delegated authority for the chairman and chief executive to sign off the submission

of the completed template.	
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 exist on the corporate risk register relating to maintaining compliance with performance standards. The Board should consider the current risks as stated, as part of this review, and identify any new risks in agreeing the governance statements.	
Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	All corporate objectives
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	Well-led domain Effectiveness domain
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.**	

Appendix A – Risk assessment framework – examples of exception reporting (extract from Monitor's Risk Assessment Framework)

Continuity of Service	• Unplanned significant reductions in income or significant increase in costs
	• Discussions with external auditors which may lead to a qualified audit
	• Future transactions which may affect the Continuity of Service rating
	• Risk of failure to maintain registration with CQC
	• Loss of accreditation for a Commissioner Requested Service (CRS)
	• Proposals to vary CRS provision or dispose of assets, including:
	  ○ Cessation or suspension of CRS
	  ○ Variation of asset protection processes
	• Proposed disposals of CRS-related assets

Financial governance	• Requirement for additional working capital facility • Failure to comply with the statutory reporting guidance • Adverse report from internal auditors • Significant third party investigations or reports that suggest material issues with governance • Care Quality Commission inspections and outcomes • Performance penalties to commissioners
Governance	• Significant third party investigations or reports that suggest material issues with financial, operational, quality or other aspects of trust activities which could indicate material issues with governance • Care Quality Commission inspections and outcomes • Changes in chair, senior independent director or executive director • Never events • Other serious incidents or patient safety issues which may impact compliance with the licence
Other risks	• Enforcement notices or other sanctions from other bodies implying potential or actual significant breach of a licence condition • Patient group concerns • Concerns from whistleblowers or complaints • Any significant reputational issues, for example any adverse national press attention

Name and date of meeting:

TRUST BOARD 30TH JULY 2015

Document Title:

Annual (Operational) Plan Q1 monitoring report

Action for the Trust Board:

To note the detailed progress report against the objectives and associated actions that underpin delivery of our strategy, and to consider the critical path progress report against the top priorities set by the Board.

Introduction:

The Annual Plan document was approved by the board in April, subjected to further 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; and was submitted to Monitor on 15th May 2015 (the 14th May deadline was extended for a further day).

The corporate objectives were 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."

Progress report:

The Annual Plan is the primary delivery vehicle for the trust's strategy and the objectives and actions are presented within the strategic themes.

The Q1 detailed report on our granular progress towards delivery of the annual plan is attached to this cover paper as a separate document (Appendix 1).

The dashboard on the following page below highlights the key issues and presents an appraisal on performance against the objectives and associated actions associated with each strategic theme.

The Annual Plan document presented the Board's priorities for the year and these are appended to this paper (Appendix 2).

The Board requested that we also develop a critical path approach to monitoring the annual plan, highlighting those key milestones that would give assurance on delivery against these priorities.

The critical path appraisal is shown on the page following the objective based dashboard.

Annual Plan dashboard – Q1 performance summary

Theme	Commentary	Q1 Rating
0. Overall Progress	6 themes – 3 green, 3 amber, 0 red 34 objectives – 16 green, 17 amber, 1 red	?
1. Redesign care pathways to keep more people out of hospital	6 objectives – 4 green, 1 amber, 1 red Frailty model in recruitment phase; new Community and Adult Health services operational; proactive decision not to bid Merton community services; Vanguard bid(s) drafted; A&E and RTT targets not met.	✓
2. Redesign and reconfigure our local hospital services	5 objectives – 1 green, 4 amber, 0 red Some delays in capacity delivery; 5th floor Children's scheme reprogrammed to 2016; PPU preferred bidder letter signed; Nelson implementation slow; SWL acute provider scoping phase almost complete	?
3. Consolidate and expand our key specialist services	5 objectives – 2 green, 3 amber, 0 red Renal OBC approved; Cardiology expansion delayed; MacMillan partnership £600k funding approved; Neurosciences – QMH beds open / additional SGH beds awaiting prioritisation.	?
4. Drive research and innovation	4 objectives – 3 green, 1 amber, 0 red Planning for NIHR bid underway; Chief of Cardiology CAG appointed (July); Commercial pipeline cleansed.	✓
5. Improve productivity, the environment and systems to enable excellent care	9 objectives – 5 green, 4 amber, 0 red Cerner contract exited & EDM development on-going; Outpatient strategy scoping in progress; Flow re-profiling complete; Reliable processes for reducing avoidable harm SOPs in place; Sign up to Safety.	✓
6. Develop a highly skilled and engaged workforce championing our values	5 objectives – 1 green, 4 amber, 0 red Values continue to embed; workforce issues re bank / agency; shared bank programme under development	?

Annual Plan critical path appraisal – Q1 performance summary and Q2 forecast

	Q1 report	Q2 forecast	Q3	Q4
Strategic plan	SLR PPE post 2013 investments SWL acute provider scoping	SLR Wider scope investment review SWL APC report & Vanguard Radical service redesign	SLR 2016/17 business planning Strategy refresh	SLR 2016/17 annual plan 5 year plan
Capacity and flow	QMH beds Re-profile	7 beds / Hybrid theatre Winter planning	55-70 beds / 7 ICU Winter delivery	Rehab strategy + beds Winter delivery
(Income)				
Quality - outcomes, safety, experience	Audit programme Sign up to Safety planning MacMillan partnership	Implement safe environments action plans Outpatient strategy scoping	Publish clinical outcome indicators Complete implementation of process to reduce avoidable harm Cancer services redesign starts	Outpatient strategy implementation
(Operational performance)				
Leadership / OD Workforce	Leadership scoping Workforce controls	OD programme International recruitment	Leadership programme HR processes	
Financial viability	CIP development	Grip	Optimise	Grow

Overall position				

Conclusion:

The trust set 34 corporate objectives for 2015/16:

- 16 are RAG rated as Green at quarter 1,
- 17 as Amber, and
- 1 Red (access target achievement).

Of the 6 strategic themes, 3 are RAG rated as Green and 3 at Amber.

Overall performance, when measured quantitatively against these objectives, would therefore be assessed as **Amber**.

However, the appraisal of the priorities articulated within the main body of the Annual Plan, how they impact on income and operational performance, and what we consider the resultant overall organisation position to be would lead to a **Red** assessment.

The Board is asked to consider the assessments arising from these different approaches, and note both the on-going work around Turnaround, and the consequential impact on prioritisation, as the recovery programme takes shape and moves into delivery.

As progress develops during the year it will be easier to make firmer judgements about overall objective achievement and the anticipated end of year position.

The structure and content of the corporate objectives are fixed for 2015/16. However, it is the intention to review and update the structure of the corporate objectives for 2016/17. This is to ensure that there are clearer linkages between this and the Annual Plan, as well as key divisional issues that might need to be picked up through this process. This will be as part of a wider piece looking at the business planning process, and the suite of documents and plans that form the outputs of that process.

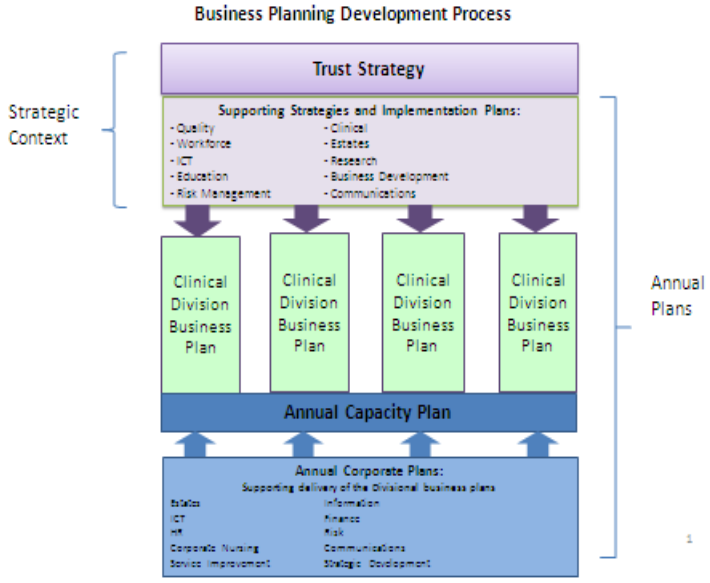
Author and Date:	Rob Elek, Director of Strategy	21st July 2015
Contact details:	Tel: x3883	E-mail: rob.elek@stgeorges.nhs.uk

APPENDIX 2 – Extract from Operation Plan document

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.

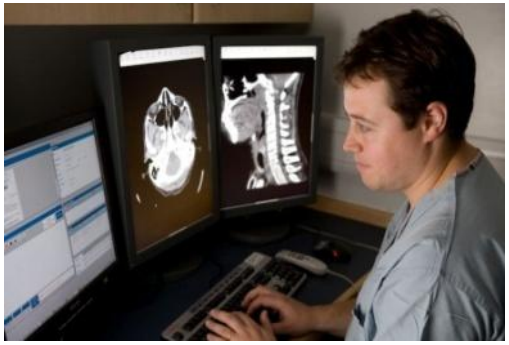
The priorities represent the trust's plan for 2015/16 at the time of writing this document; the outcome of the strategic and service line reviews, and the outputs of the work around financial viability, may result in the trust reconsidering its priorities during the year.

St George's University Hospitals NHS
NHS Foundation Trust

ST GEORGE'S HEALTHCARE NHS TRUST: THE NEXT DECADE

Corporate Objectives 2015/16
Delivery Plan and Monitoring – Quarter 1

Delivery of our 15/16 Annual Plan and Objectives



This document sets out the proposed corporate priorities (in line with the discussions at the Board Strategy Seminar in February 2015), and key actions and milestones that the Trust will take to ensure these are delivered.

The priorities identified by the Board for 2015-16 are:

- The strategic plan
- Additional capacity
- Quality
- Financial viability
- Workforce and leadership

These are the priority objectives that the Board will oversee delivery of, with quarterly reporting of progress. There are further objectives that need to be delivered in 2015-16, that will be monitored by the relevant Board Sub-Committees, in line with the governance arrangements detailed on the following slide (previously presented to the Board in February 2015).

Governance: Reviewing progress

We will use a number of different mechanisms to ensure that we are able to track progress against the annual objectives. These are:

- Reporting to the Trust Board quarterly on the corporate priorities for 2015-16
- The monthly scorecard for the Trust Board to monitor delivery against quality, finance, workforce and operational targets
- Detailed review of key plans through the relevant Board sub -committees/ EMT:
    - Quality and Risk Management: QRC
    - Workforce and Education: Workforce Committee
    - IT: EMT
    - Estates: EMT
    - Business Development: Commercial Board
    - Research: Research Committee
    - Communications: Trust Board
- Quarterly reviews with the clinical divisions
- Clinical Divisions monitoring their own plans at Division and Directorate levels via DMB and DGB

Progress Tracker – Position at Q1

RAG STATUS	QUARTER				Quarter 1Commentary
	Q1 Position	Q 2 Position	Q3 Position	Q4 Position	
GREEN	16				47% of objectives (16 / 34) have been classified as Green. Good progress made to delivering the milestones set for the quarter.
	47 %				
AMBER	17				50% of objectives (17/ 34) have been classified as amber. In the main there has been significant progress towards achieving the milestones set for the objectives during the quarter but the actual delivery will be during quarter 2. It is not possible for many of these project to predict whether this will have knock-on effects on delivery for the remainder of the year
	50 %				
RED	1				3% of objectives (1/34) have been classified as red. This relates to delivery of access targets.
	3 %				

Redesign care pathways to keep more people out of hospital: 1

Objective and lead	Actions		RAG
	Q1 actions	Update on progress	
Implement the new model of care in community adult health services (CAHS) *Director of Delivery and Improvement / Divisional Chair CS Division*	Fully operationalise CAHS	• CAHS model operational from 1st April 2015. • Service challenged to some extent by staff vacancy levels.	
Complete the redesign of services for frail older people *Director of Delivery and Improvement / Divisional Chair MC Division*	• Continue to work jointly on Frailty Model across both Divisions and link to overall Discharge Improvement programme work. • Handover St George's @ beds (Nightingale) to MedCard Division.	• Secured funding from CCGs to develop a front door frailty service. Model being recruited to. • Nightingale House unit closed 8th May due to lack of SRG funding but will re-open in October 2015.	
Bid to provide Community Services to the residents of Merton *Director of Strategy/ Divisional Chair CS Division*	Submit PQQ	An ITT was developed in partnership with other providers, however the trust decided not to submit a bid owing to the risk profile of the specification / staffing / activity data / intermediate care provision / potential capital costs / mobilisation costs (in-year) and delivery RAG rating green as Trust has made an informed decision to withdraw from the process	

Redesign care pathways to keep more people out of hospital: 2

Objective and lead	Actions		RAG
	Q1 Actions	Update on progress	
Support the delivery of the Wandsworth joint health and well being strategy *Director of Strategy / Divisional Chair CS Division*	Launch of Health & Well being strategy	Engagement with H&WB partnership continues – workshop on 16th July re Children's services. Overall, the trust has supported the H&WB as requested.	
Develop and implement new models of care and further develop the St. George's network as per 5YFV *Director of Strategy / Director of Delivery & Improvement / Divisional Chair CS Division*	Engage with Monitor / NHSE	• Vanguard bids under development for acute provider new models of care through SWL acute provider collaborative – as the delivery vehicle for implementing the SWL provider sustainability agenda; and with Royal Marsden to develop an Accountable Care Network for cancer. • The radical service redesign programme will also further consider 5YFV. • Engagement with GP federations will forma key part of Q2 workstreams.	
Deliver access targets - RTT, A&E and Cancer through 1. Robust use of information 2. Aligning capacity and demand 3. Working in partnership with providers *Director of Delivery & Improvement*	Ensure that the Trust has robust information on RTT performance	• RTT and A&E targets not being met. • Daily web report of ED performance and of all specialty responsiveness within 30 minutes now available. • Capacity and demand plan for beds signed off with CCGs, recognising av. 45 bed gap remains 15/16 across year. • Joint ED and RTT investigation with CCGs completed, with shared action plan. Capacity and demand gap jointly owned. • Discussions and planning underway with Croydon re capacity/service provision in 2-3 sub-speciality pathways.	

Redesign and reconfigure our local hospital services to provide higher quality care: 1

Objective and lead	Actions		RAG
	Q1 Actions	Update on progress	
Delivering additional capacity in line with clinical need *Director of Estates & Facilities / Director of Delivery and Improvement*	Nightingale 2nd Floor 20 beds, subject to commissioner agreement for Q1	• Nightingale beds closed 8th May as part of CCG contract funding for 15/16 with plan to re-open later in year. • Delays in contract sign-off add additional risk to already challenged plan for creating capacity. • Nightingale Hammerson (NH) have rejected the Trust's initial proposal to rent the unit on a commercial rent basis for 5 years. We are awaiting a counter-proposal from the operator. Plan B is a similar service contract to last year without staff provision by NH.	
Women and Children's Hospital *Director of Strategy*	Complete enabling work/ actions for the 5th Floor redevelopment	• Timescales for delivery of project have been lengthened during Q1 • The Children & Women's project board has widened its scope to include programme management of all workstreams to enable and develop the project. Next steps require a dedicated resource to develop the strategy and drive the OBC forward. • The 5th floor scheme has unresolved critical interdependencies with Dalby ward relocation and Moorfields vacation – business cases for these are required by September if the project can commence to its revised programme in mid 2016.	
Private Patients Unit *Director of Finance, Performance and Informatics*	Preferred bidder letter signed	• Preferred Bidder terms agreed with HCA to include the development of a new adjacent Renal Unit. Preferred Bidder letter issued 1 June 2015, however not yet signed by HCA – negotiations on-going but nearing completion • Guaranteed Maximum Rent and final version of the Operating Agreement to be agreed by 31 July 2015.	

Redesign and reconfigure our local hospital services to provide higher quality care: 2

Objective and lead	Actions		RAG
	Q1 actions	Update on progress	
Implement all Merton CCG requirements at the Nelson Health Centre *Director of Delivery and Improvement / Director of Strategy / Divisional Chair CS Division*	• Begin service delivery and negotiate additional service developments to be included at the site • Set up redesign groups • Implement cardiology redesign	• Service delivery commenced early April. • Direct referrals and outpatient activity well below plan. • Cardiology service operational. • Redesign groups not established due to focus on ensuring sufficient clinic activity.	
South West London Service Reconfiguration – Continue to work closely with the SW London Collaborative Commissioning Programme and take a leadership role in the Acute Provider and Out of Hospital projects *CEO/ Director of Strategy*	• Delivery of the Acute Providers proposal for future provision of acute services to the SWLCC Board • Trust Board to approve the outcomes of the proposal	• The first acute provider collaborative workshop took place in June, and the final session is on 20th July. The board will receive a progress update and the final report in July for approval. • The Out of Hospital group will become key, as the health system needs to shift approximately 20% of bed base into community settings, and change the way outpatient care is delivered. The group is still emergent though an initial workshop will take place in 17th July.	

Consolidate and expand our key specialist services: 1

Objective and lead	Actions		RAG
	Q1 actions	Update on progress	
Renal Redevelopment at St. George's *Director of Strategy / Director of Estates & Facilities*	OBC approved by Trust Board	The outline business case was approved at the April Trust Board. Board outlined clear areas for focus for the Full Business Case, which is currently due to return to the Trust Board in September 2015 Preferred Bidder terms agreed with HCA to include the development of a new adjacent Renal Unit. Preferred Bidder letter issued 1 June 2015. Guaranteed Maximum Rent and final version of the Operating Agreement to be agreed by 31 July 2015.	
Cardiology expansion *Director of Delivery and Improvement / Divisional Chair MC Division*	Will be developed in Q1 and inform actions for remainder of the year	Scheme delayed due to PFI / capital building works issues and reduced CCG funding for heart failure. Updated plan will be developed during Q2	
Deliver redesigned cancer services in partnership with MacMillan *Director of Strategy / Chief Nurse & DIPC / Divisional Chair SNT Division*	Programme Board to agree the priorities for delivery in 2015-16 from long-list	A great deal of progress has been made – development work has been completed and the grant application to MacMillan was approved, securing £600,000 funding for the first year of a three year programme.	

Consolidate and expand our key specialist services: 2

Objective and lead	Actions		RAG
	Q1 actions	Update on progress	
Neurosciences Expansion *Director of Delivery and Improvement/ Divisional Chair STNC Division*	• Additional physical capacity delivered – Thomas Young and QMH Beds • Professor of Neurology interviews	• QMH beds opened. • Awaiting capital funding review for commencement of estate works to open Thomas Young additional neuro beds. • Professor of Neurology appointed.	
Develop and implement a rehabilitation strategy Establish a 6 bedded spinal rehabilitation service in partnership with the Royal National Orthopaedic Hospital, Stanmore *Director of Delivery and Improvement/ Director of Strategy*	• Establish Divisional Rehabilitation Strategy Group • Cohort existing spinal beds together as pilot	• Rehab strategy groups established meeting monthly. • Cohorting of patients to be implemented once new Thomas Young beds open. • Discussions underway with CCG re commissioning a spinal rehab unit in partnership with RNOH.	

Drive research and innovation through our clinical services: 1

Objective and lead	Actions		RAG
	Q1 actions	Update on progress	
Continue to increase the number of patients recruited into NIHR studies excluding the impacts of large one off studies *Medical Director*	• International Clinical Trials event supported • Research Handbook launched • Appointment of Clinical research Fellow • Delivery of EDGE training or research teams	• National Event run on the 20th May. Stall in front of Grosvenor Entrance hosted by the Research Office, targeting patients and staff, and sign-posting the event "Clinical Research – from Cell to Cell-Phone and back again' See more at: http://tooting-news.dailyprss.co.uk/tabs/blog/2015/05/open-day-at-the-clinical-research-facility-st-georges-hospital • Research handbook launched and available on intranet • Applications were reviewed and award given. Processing HR details: start Date Oct 2015 • South London CRN is the prime contract holder with the EDGE team. Prime contract only signed few weeks ago (was expected by April 2015) – St George's in only a subcontract partner. It was not possible to move this action forward until contract signed. • We have access to the EDGE database, and it is a core objective Q3	
Ensure the Trust is in a position to make a successful bid for NIHR Clinical Research Facility funding *Medical Director / Chief Nurse*	Establish Steering Group	Initial management group has met to discuss. The group now needs to extend membership and review fully the requirements of the NIHR Clinical Research Facility Funding to ensure (i) we are eligible (ii) There is an effective business case	

Drive research and innovation through our clinical services: 2

Objective and lead	Actions		RAG
	Q1 actions	Update on progress	
Increase collaborations between SGUL Institutes and Trust clinical directorates through the development of further CAGs: Cardiology Neurosciences *Director of Strategy*	Establish steering group to oversee operational delivery of Cardiology CAG	The Steering group, chaired by the CEO, has been meeting on a monthly basis to oversee the development and successful implementation of the Cardiology CAG. The Chief of Cardiology CAG was appointed July 2015, and this postholder will be instrumental in driving forward implementation.	
Develop additional commercial income streams *Director of Strategy*	No specific actions outlined for Q1	Initial actions have focused on a review of existing workstreams, removing those projects unlikely to deliver, and concluding those that will deliver in-year. Q2 will see the development of the future pipeline, further process improvements, and the scoping of a corporate delivery / incubation resource	

Improve productivity, the environment and systems to enable excellent care: 1

Objective and lead	Actions		RAG
	Q1 actions	Update on progress	
Complete the deployment of electronic prescribing, drug administration and clinical documentation to inpatients, theatres and the emergency department on the St. George's Hospital site *Director of Finance, Performance and Informatics*	• Complete exit from the BT contract for Cerner services • Identify, agree and enable approach to delivery of new maternity reporting requirements	• Exit from contract and transfer to new hosting services for Cerner was completed on 26th April 2015 • A meeting to review options between corporate ICT and Maternity has been scheduled for July 2015	
Implement electronic document management and electronic referral system for all new out-patient registrations at St. George's *Director of Finance, Performance and Informatics*	Complete recruitment to in house scanning bureau	Recruitment exercise has been completed and HR in process of making offers to successful candidates	

Improve productivity, the environment and systems to enable excellent care: 2

Objective and lead	Actions		RAG
	Q1 actions	Update on progress	
Develop and implement an Outpatient Strategy *Director of Strategy / Divisional Chair CWDTCC Division*	Establish OP Strategy Board	The board is now fully established, has developed terms of reference and scoping for the overall project. Progress will be monitored through the tactical, strategic and innovation workstreams. Q2 will focus on delivery of quick wins, and defining further project resource requirements	
Objective to support both effective elective and non-elective flow through the organisation to improve the Patient Experience and support performance standards where applicable *Chief* Nurse & DIPC	• Re-profile and position work programme to ensure appropriate action being taken. • Strengthen performance management oversight to ensure delivery of critical path.	• Work programme successfully re-profiled to fully reflect patient pathway from front door to departure, to support delivery of elective capacity and stroke patient flow. • Programme structure reviewed to include all flow work streams across the trust • A flow scorecard is being developed and will form a key part of performance management when implemented	
Provide transparency on outcomes by publishing consultant level activity data, clinical quality measures and survival rates from all nationally agreed audits *Medical Director*	• Agree data sources and publishing format. • Consider patient confidentiality issues. • Build on data presentation and dissemination using electronic systems.	• Comply with publication of Consultant-level national audit data. Link on website. • Published activity data available for National Audits. No mortality or complication outliers. • Action to continually improve participation in national audit, and develop local activity data sources.	

Improve productivity, the environment and systems to enable excellent care: 3

Objective and lead	Actions		RAG
	Q1 actions	Update on progress	
Creating Reliable processes for reducing avoidable harm - Follow Up of Diagnostic Tests - to implement a framework which will mitigate risk to an acceptable position *Medical Director*	• Software solution in place • Standard Operating Procedures in place across all areas	A workable solution for mandatory electronic sign off of radiology and histopathology results has been agreed and approved by EMT for implementation from September 2015 All Care Groups have been reminded of requirement for Standard Operating Procedures and compliance checking is due at July Patient Safety Committee.	
Commence Sign Up to Safety Programme as element of Quality Improvement Strategy *Chief Nurse & DIPC / Medical Director*	Scoping and Planning of programme profile	The trust has not been successful in its bid to NHSLA for funding for the programme (equivalent to 10% of NHSLA premium charged), and will therefore have to look internally for funding. As a result of this the programme is being re-profiled and the results will be managed through the Quality Improvement Strategy	

Improve productivity, the environment and systems to enable excellent care: 4

Objective and lead	Actions		RAG
	Q1 actions	Update on progress	
Ensure delivery of safe clean environments and use of patient feedback as a vehicle for continuous improvement and adoption of best practice *Chief Nurse & DIPC*	• Continue with Outpatient Improvement programme • Ensure that Actions are agreed and Implemented for Patient Surveys across a range of settings within the Trust • Ensure FFT, Complaints and other patient feedback data is available for both Divisional Teams and Patients/ Public • Complete review of PPI/ PPE approach for 15/16 to complement existing work programme	• Outpatient Improvement programme transferred to Outpatient Strategy objective • Feedback for divisional teams on-going on outcomes of patient feedback • Looking to triangulate information by clinical area to develop a truly informed picture of current position which can be shared with clinical teams • Patient and Public Involvement/Engagement is behind schedule and will report in Q2	
Evaluation of Clinical Audit results and Acting on findings to ensure audit contributes to improvements for patients *Chief Nurse & DIPC*	• Agreed Divisional Programme in place • Quarterly monitoring of Programme against Plan. • Monthly reporting to Board of Key Audits • Ensure Key Actions from Audit findings	• Audit programme is in place, taken down to a monthly level of planned activity • Undertaking a process of reviewing and refreshing outputs of previous audits in relevant committees to ensure previous learning is being embedded – Patient consent and WHO surgical checklist a key focus of Q1 and Q2	

Develop a highly skilled and engaged workforce championing our values: 1

Objective and lead	Actions		RAG
	Q1 actions	Update on progress	
Develop leadership behaviours to deliver high quality *Director of HR and OD*	• Establish an agreed St George's leadership style • Develop timescale, scope and cost of leadership programme • Review appraisal process and develop programme to improve including engagement with staff • Embed Liam programme for 15/16	• 1st discussion session in May. 2nd to take place July. • Further programme to be developed following July Board • Appraisal design commenced. • Liam principles included in St George's as One event-Sep	
Implement an organisational development programme that supports the Divisional governance review findings *Director of HR and OD/ Director of Corporate Affairs*	• Work with divisions to identify effective team working and where there is a need for team support • Continue to support the midwifery and Children's Future programme	• Initial meetings have taken place. Scoping of further work being undertaken • Midwifery and Children's Futures support continues	

Develop a highly skilled and engaged workforce championing our values: 2

Objective and lead	Actions		RAG
	Q1 actions	Update on progress	
Embed the Trust values, recognise achievement and ensure staff achieve their maximum potential as well as takling poor performance *Director of HR and OD*	• Include overall trust objectives in individual objectives • Monitor progress on CQC identified problem areas • Identify problem areas and specific responses • Establish "St. George's as One" steering group • Publish Race Equality Scheme metrics • Implement requirements of DH Responsibility Partnership status	• Mid year review for whole trust planned for October • Board and Governor session due July to discuss CQC identified problem areas • Will follow on from July Board/ Governor sessions • St George's as One inclusivity group established • RES metrics published • Partnership status conferred. 1st conference attended	
Ensure the right number of skilled members of staff are available to provide the best possible quality of care *Director of HR and OD / Chief Nurse & DIPC*	• Publish workforce plan • Provide monthly progress reports to the Board • Establish medical workforce planning group • Staff bank recruitment process improved • Ensure implementation of care certificate for all new HCAs	• ESR/ledger reconciliation issue being progressed by KPMG • Medical Workforce Planning group in place - funding required. • Recruitment improvement embedded, further work being scoped. Induction process reviewed and redesigned. • Further work to be scoped for Bank recruitment • HCA Care Certificate in place	

Develop a highly skilled and engaged workforce championing our values: 3

Objective and lead	Actions		RAG
	Q1 actions	Update on progress	
To deploy the workforce in the most efficient way possible and improve the efficiency of internal workforce departmental processes *Director of HR and OD*	• Agree 15/16 programme including pan-London working opportunities and reviews of productivity • Scope establishment of London wide benchmarking group • Clarify role of HR team in supporting managers within the Trust • Review occupational health process and simplify	• WB is leading work across London on identifying shared opportunities for workforce efficiency. The trust has signed up to be a pilot site for a shared medical locum bank staff and is scoping work re sharing the nursing bank staff across SW London. • Mediation training tender awarded • Work role of HR team supporting mangers to be undertaken in Q2 • Revised pre-employment health screening (work health assessment) in place	

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD ***July 2015***

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

Executive summary

Key Messages

Corporate Risk Register (CRR):

- The most significant risks on the CRR are detailed.
- Controls are developed for all risks, with a rolling programme of review by QRC during 2015.
- One new risk has been identified and is proposed for inclusion on the Corporate Risk Register.
- An overarching review of all finance risks on the CRR has been undertaken in conjunction with the Monitor investigation. Seven new finance risks have been proposed which supersede the existing 14 finance risks which are proposed for closure.

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

- The full assurance map is presented to the QRC and exceptions are included in this report.

Risks

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

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	All
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	All CQC Fundamental standards & regulations

Equality Impact Assessment (EIA): Has an EIA been carried out? Yes
If yes, please provide a summary of the key findings

1. Risks – Corporate Risk Register (CRR):

This report identifies the extreme risks on the Corporate Risk Register with the details of the most significant risks (scoring 20 or above) summarised in Table 1. An executive overview of the CRR is included at appendix 1. The rating is prior to controls being applied to the risk. Risks are reduced once there is evidence that controls are effective. The detailed controls of each of the most significant risks are detailed at appendix 2. 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 ↓↑
Quality	01-12	Bed capacity for adult G&A beds may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience	5	5	20 →
	01-13	Elective theatre capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience	5	4	20 →
	01-15	Adult critical care capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience	5	4	20 →
	01-07	Risk to patient safety and experience as a result of potential Trust failure to meet 95% Emergency Access Standard	4	5	20 →
	01-06	Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	5	4	20 →
	01-12	Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products	5	4	20 NEW
Finance & Performance	3.7-06	Failure to meet the minimum requirements of the Monitor Risk Assessment Framework	4	5	20 →
	3.13-05	Working capital – the Trust will not be able to secure the working capital necessary to meet its current plans	5	4	20 NEW
	3.14-05	Working capital – the Trust will require more working capital than planned due to: Adverse in year I&E performance Adverse in year cash-flow performance	5	4	20 NEW
	3.15-05	Risks to income – that national and local tariffs do not deliver the required income to ensure an at minimum, break even position for the trust.	5	4	20 NEW
	3.16-05	Market Share risks – that the trust loses market share, negatively impacting on the trusts activity and income.	5	4	20 NEW
	3.17-05	Cost Improvement Programme slippage - The Trust does not deliver its cost improvement programme objectives	5	4	20 NEW

1.1 New risks proposed for inclusion on the CRR

One new risk has been escalated by the Organisational Risk Committee (ORC) and is included on the CRR (risk details are included in appendix 2):

- 01-12: Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products

  ORC considered a risk assessment regarding ongoing issues with the failure of the current outdated blood track system and the impact on clinical work. ORC received assurance that a replacement system had been identified and funding secured, and business continuity procedures were in place while the replacement system was procured and implemented.

Following a review of all finance risks on the CRR, it is proposed to close the current cohort of finance risks; these have now been superseded by five new aggregated risks as detailed in table two (detailed controls at appendix 2&3). A further two new overarching finance risks regarding

working capital have also been included on the CRR and have been approved by the Executive Management Team and the Chief Financial Officer.

Table two: closed and new finance risks

Closed risk	Previous score	New risk	Current score
n/a		**Working capital**: the Trust will not be able to secure the working capital necessary to meet its current plans	5x4=20
n/a		**Working capital**: the Trust will require more working capital than planned due to: - Adverse in year I&E performance - Adverse in year cash-flow performance	5x4=20
2.2-05 Tariff Risk – Emergency Threshold Tariff.	3x3=9	**Risks to income** – that national and local tariffs do not deliver the required income to ensure an at minimum, break even position for the trust.	5 x4 =20
2.1-05 Tariff Risk – national tariffs	5x4=20		
2.3 Tariff Risk – CQUIN Premium	5x4=20		
2.4-05Tariff Risk – Performance Penalties & Payment Challenges	4x4=16		
3.9-05 Potential financial impact of Better Care Fund	3x3=9		
1.2-05 Volume Risk – Decommissioning of Services	3x3=9	**Market Share risk** – that the trust loses market share, negatively impacting on the trusts activity and income.	5 x4 =20
1.3-05 Volume Risk – Tendering of services	3x3=9		
1.1-05 Volume Risk – Competition with other providers	3x3=9		
3.3-05 Cost pressures	4x4=16	**Cost Pressures** - The Trust faces higher than expected costs due to: unforeseen service pressures higher than expected inflation higher marginal costs or costs required to deliver key activity	4x4=16
3.4-05 The Trust faces higher than expected costs due to higher marginal costs	4x4=16		
3.5-05 Cash flow Risks – Forecast Cash balances	4x3=12	**Cash-flow Risks** – Cash balances will be depleted due to: - Delays in receipt of SLA funding from Commissioners - Capital overspends	4x3=12
3.6-05 Cash flow Risks – Operational Finance	5x4=20		
3.10-05 Cash risk – timely payment due to data quality challenge	4x3=12		
3.2-05 Cost Reduction slippage	5x5=25	**Cost Improvement Programme** slippage: The Trust does not deliver its cost improvement programme objectives	5 x4 =20

A further two previously identified risks related to estates and facilities have had the risk assessment completed, included in appendix 3:

- There is a potential risk to the quality and safety of patient care in the event the Estates and Facilities team are unable to complete required estates works in a timely way due to the impact of run rate schemes.
- There is a potential risk to the quality and safety of patient care in the event that required works cannot be undertaken due to capital funding decisions not to fund such projects.

One previously identified risk is still to have the risk assessment completed – this will be finalised after discussion at quality and risk committee:

- Potential regulatory action, if inspected by the CQC, in relation to Deprivation of Liberty (DOLs) application, arising from a lack of resource to implement best practice in accordance with recent Law Society Guidance (April 2015).

1.2 Changes to risk scores

There have been three changes to risk scores during the reporting period and the rationale is included in table three:

Table three: changes to risk scores

Ref	Description	C	L	Rating ↓↑
5.1-01	Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost *(Risk ref 01-14 now closed and merged with this risk)* Upgraded following review of residual risk score by QRC	**4**	**4**	**16↑**
01-11	Risk to patient safety and experience where full permanent sets of medical records are not available for scheduled outpatient appointments Upgraded following discussion at ORC: to align with current divisional risk	**4**	**4**	**16 ↑**
3.9 – 06	Risk of inappropriate deployment of e-prescribing and electronic clinical documentation Downgraded due to further positive assurances around implementation	**4**	**3**	**12 ↓**

1.3 Closed risks

In addition to the closed finance risks, a further three risks have been closed; one of these was extreme and the remaining two were high risks, as detailed in table four:

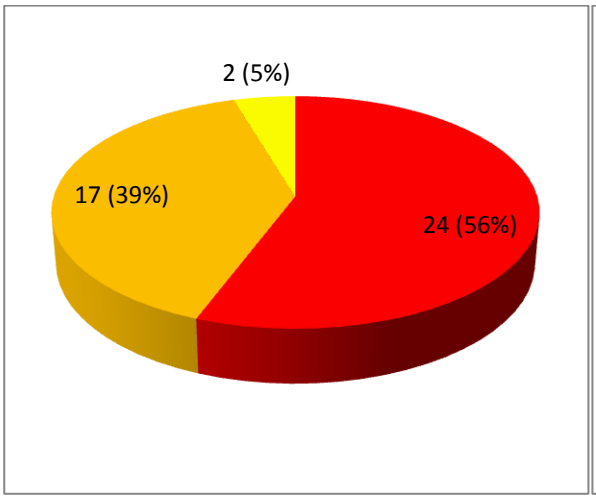
Table four: closed risks

Ref	Risk	Score	Reason for closure
3.10-06	Risk of failure to effectively manage exit from national Cerner programme	5x2=10	Exit from Cerner successful – risk did not materialise
3.11-06	Poor environment in ICT department/on site data centre may lead to interruptions or failure of essential ICT services	4x3=12	Risk has been treated – a permanent fix is now in place
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.	5x4=20	Risk merged into: 5.1-01 Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost (4x4=16)- score reviewed and approved by QRC

1.4 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 56% of the total risks, this compares with 46% in June 2015. Of these extreme risks, 10 sit within the domain of Quality and eight within Finance and Operations. Of the total risks on the CRR, 42% relate to Quality and 26% to the Finance and Operations domain which is due to several finance risks having been aggregated during the reporting period (table two).

Fig 1&2: CRR Risks by score and domain



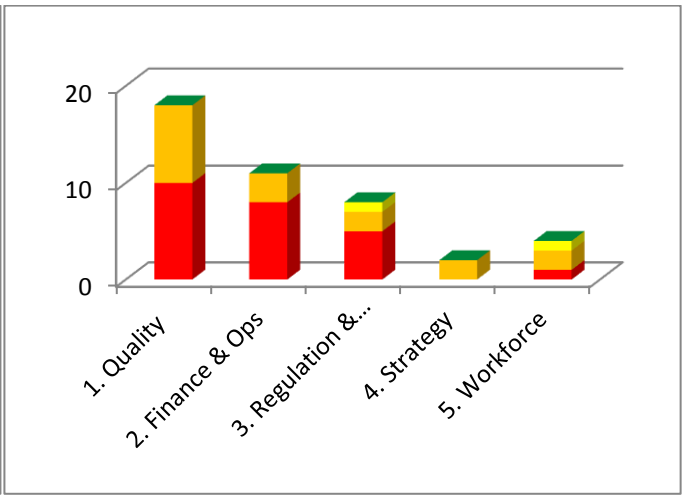


Table three: CRR Risks by Domain

	15 or above (Extreme)	8-12 (High)	4-6 (Moderate)	0-3 (low)	Total
1. Quality	10	8	0	0	18
2. Finance & Operations	8	3	0	0	11
3. Regulation & Compliance	5	2	1	0	8
4. Strategy Transformation & Development	0	2	0	0	2
5. Workforce	1	2	1	0	3
Total	**24**	**17**	**2**	**0**	**43**

1.5 Deep Dive: Quality Risk Committee

The QRC have undertaken a deep dive review of six risks during May and June. Changes to the risk description and scores reviewed have been made along with significant strengthening of both controls and assurances for each. Reworked risks have been submitted for approval to the QRC meeting in July and high level changes to descriptions and scores are detailed in table six:

Table six: summary of changes to risk description & scores following deep dive reviews

Ref	Changes to risk description (red)	Changes to Score ↓↑
02-01	02-01 Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)	⇔
01-12	Bed capacity for adult G&A beds may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience	⇔
01-13	Elective theatre capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience	⇔
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.	**n/a**
01-15	Adult critical care capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience	⇔
5.1-01	Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost	↑

A further cohort of Estates and facilities risks under the domain 'Regulation and compliance' will be subject to review at the QRC seminar in August 2015:

- 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)
- 03-02 Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation
- 03-03 Lack of decant space will result in delays in delivering the capital programme
- 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.
- 03-05 Trust wide risk to patient, public and staff safety of Legionella.

1.6 Summary of Extreme Risks at Divisional level:

Divisional risk registers are presented at ORC bi-monthly, in July the divisions reported eight new extreme risks and a further four previously high risks have now been upgraded to extreme. Two extreme risks have been closed and one extreme risk has been down-graded to a high risk. The extreme risks from each of the divisional risk registers are included at Appendix 4

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 and the full assurance map has been presented to the QRC.

2.1 Summary of external assurance and third party inspections - July 2015

There have been no external inspections during the reporting period.

2.2 Forthcoming third party inspections

2.2.1 HTA inspection of St George's Healthcare NHS Trust: HTA licence

The Trust will undergo an inspection in respect of its licences on 20th August 2015.The HTA works under two laws: the Human Tissue Act 2004 (HT Act) and the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (Q&S Regulations). As part of the regulatory framework, the HTA licenses establishments and carries out inspections to assess whether sector specific standards are met. The inspection will focus upon the following lines of enquiry:

- Consent
- Governance and quality systems
- Premises, facilities and equipment
- Disposal

The Trust is fully prepared for this inspection.

3. Conclusion

The programme of detailed review of risks included on the Corporate Risk register continues in order to provide stronger assurance to the Trust Board around the management of risks.

The range and profile of risks on the corporate risk register has changed significantly due to several finance risk having been closed to be replaced with aggregated risks. It is envisaged that at as the outcome of the Monitor investigation becomes available, the profile of finance related risks will continue to be dynamic in order to align with business and financial planning.

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	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	In month change	Change/progress
1.1 Patient Safety								↓↑	
01-12 Bed capacity for adult G&A beds may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience	MW	20	20	20	20	20	20	→	Risk re-worded following QRC deep dive Jun 2015
01-13 Elective theatre capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience	MW	20	20	20	20	20	20	→	Risk re-worded following QRC deep dive Jun 2015
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			Propose closure – now merged into risk Ref 5.1-01 following deep dive at QRC Jun 2015
01-15 Adult critical care capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience	MW	20	20	20	20	20	20	→	Risk re-worded following QRC deep dive Jun 2015
A513-O1: Failure to achieve the National HCAI targets for MRSA and C Diff	JH	12	12	12	12	12	12	→	
O1-01 A risk to patient safety of inappropriate antimicrobial prescribing due to conflicting and out of date guidance being available within the Trust.	JH	12	12	12	12	12	12	→	
01-02: 01-02 Lack of established process for use, provision, decontamination and maintenance of pressure relieving mattresses	JH	9	9	9	9	9	9	→	
01-03 Lack of embedded process for use, provision and maintenance of bed rails	JH	9	9	9	9	9	9	→	
01-04 Risk to patient safety should the organisation fail to meet its statutory duties under Section 11 in respect of number and levels of staff trained in safeguarding children.	JH	12	12	12	12	12	12	→	
01-05 Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the Trust.	JH	12	12	12	12	12	12	→	

01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	MW	15	15	15	15	15	15	→	
01-07 Risk to patient safety and experience as a result of potential Trust failure to meet 95% Emergency Access Standard	MW	20	20	20	20	20	20	→	
01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	SM	16	16	16	16	16	16	→	
01-09 Risk to patient safety due to a lack of a Trust wide visible training needs analysis, and lack of a system for ensuring these have been met in relation to Medical Devices	EM	12	12	12	12	12	12	→	
01-10 Risk to patients, staff and public health and safety in the event the Trust has failed to prepare adequately for an Ebola incident.	JH	10	10	10	10	10	10	→	
01-11 Risk to patient safety and experience where full permanent sets of medical records are not available for scheduled outpatient appointments						12	16	↑	Increased risk score to align with Divisional risk
01-12 Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products							20	**NEW**	

Strategic Objective/Principal Risk	**Lead**	**Feb 2015**	**Mar 2015**	**Apr 2015**	**May 2015**	**Jun 2015**	**Jul 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	→	Reworked risk following QRC deep dive, score unchanged.

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	**Lead**	**Feb 2015**	**Mar 2015**	**Apr 2015**	**May 2015**	**Jun 2015**	**Jul 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			Propose closure to be superseded by aggregated finance risks

2.1-O5 Tariff Risk - The tariffs applicable to Trust clinical services are adversely changed as a result of National, Local and Specialist Tariff Commissioning changes. Also - transfer of tariff responsibilities to Monitor	SB	20	20	20	20	20			Propose closure to be superseded by aggregated finance risks
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			Propose closure to be superseded by aggregated finance risks
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			Propose closure to be superseded by aggregated finance risks
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			Propose closure to be superseded by aggregated finance risks
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	20	20	20	20			Propose closure to be superseded by aggregated finance risks
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			Propose closure to be superseded by aggregated finance risks
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			Propose closure to be superseded by aggregated finance risks
2.4-O5 Tariff Risk – Performance Penalties & Payment Challenges. Trust income is reduced by contractual penalties due to poor performance against quality standards and KPIs and payment challenges	SB	16	16	16	16	16			Propose closure to be superseded by aggregated finance risks
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	16	16	16	16			Propose closure to be superseded by aggregated finance risks

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			Propose closure to be superseded by aggregated finance risks
3.6-05 - Cashflow Risks – Operational Finance Forecast Cash balances will be depleted due to:- Adverse Income & Expenditure performance Delays in receipt of SLA funding from Commissioners	SB	20	20	20	20	20			Propose closure to be superseded by aggregated finance risks
3.9-05 Potential financial impact of Better Care Fund	SB	9	9	9	9	9			Propose closure to be superseded by aggregated finance risks
3.10-05 Cash risk – there is a risk the Trust will not receive full or timely payment by commissioners for activity carried out due to data quality issues	SB			12	12	12			Propose closure to be superseded by aggregated finance risks
3.13-05 -Working capital – the Trust will not be able to secure the working capital necessary to meet its current plans							20	**NEW**	
3.14-05 Working capital – the Trust will require more working capital than planned due to: - Adverse in year I&E performance - Adverse in year cash-flow performance							20	**NEW**	
3.15-05 Risks to income – that national and local tariffs do not deliver the required income to ensure an at minimum, break even position for the trust							20	**NEW**	
3.16-05 Market Share risks – that the trust loses market share, negatively impacting on the trusts activity and income.							20	**NEW**	
3.17-05 Cost Improvement Programme slippage - The Trust does not deliver its cost improvement programme objectives							20	**NEW**	
3.18-05 Cost Pressures - The Trust faces higher than expected costs due to:- - unforeseen service pressures - higher than expected inflation - higher marginal costs or costs required to deliver key activity							16	**NEW**	
3.19-05 Cash-flow Risks – Cash balances will be depleted due to: - Delays in receipt of SLA funding from Commissioners - Capital overspends							12	**NEW**	

Strategic Objective/Principal Risk	Lead	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	In month change	Change/progress
2.2 Meet all operational & performance requirements								↓↑	
3.7- 06 Failure to meet the minimum requirements of the NTDA Accountability Framework: Quality and Governance Indicators/Access Metrics.	SB	20	20	20	20	20	20	→	
3.8 – 06 Low compliance with new working practices introduced as part of new ICT enabled change programme	SB	16	16	16	16	16	16	→	
3.9 – 06 Risk of inappropriate deployment of e-prescribing and electronic clinical documentation	SB	16	16	16	16	16	12	↓	Proposal to down-grade risk
3.10-06 Risk of failure to effectively manage exit from national Cerner programme	SB	10	10	10	10	10			Propose closure - successfully migrated
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			Propose closure - permanent fix in place
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	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 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	12	12	12	12	12	→	
A610-O6: The Trust will not attain the nationally mandated target of 95% of all staff receiving annual information governance training	SM	15	15	15	15	15	15	→	
03-01: Risk of premises closure, prosecution and fines as a result	EM	16	16	16	16	16	16	→	

of non-compliance with fire regulations in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)									
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	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 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	12	12	12	12	12	→	

Strategic Objective/Principal Risk	Lead	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 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	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	In month change	Change/progress
5.1 Develop a highly skilled & engaged workforce championing our values								↓↑	
A518-O4:Failure to reduce the unacceptable levels of bullying & harassment reported by staff in the annual staff survey	WB	12	12	12	12	12	12	→	

A516-O4: Possible reductions in the overall number of junior doctors available with a possible impact on particular specialty areas	WB	6	6	6	6	6	6	→	
A520-O4: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	WB	12	12	12	12	12	12	→	
5.1-01 Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost	WB	12	12	12	12	12	16	↑	Re-worked and increased risk score following QRC deep dive

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

Quality Domain: 1.1 Patient Safety

Principal Risk	**01-12 Bed capacity** for adult G&A beds may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience				
Description	Root cause: Requirement for high activity volumes in order to meet patient and commissioner needs, and to deliver income margin as part of Trust Cost Improvement Programme. Unlimited demand on A&E which impacts on increase in emergency admissions & capacity for elective admissions affecting 28 day rebook timeframes. Delayed patient repatriation to host hospitals block beds for emergency/elective activity. 14.2% increase in emergency admissions in patients over 70 Challenges in both delivering addition capacity and releasing capacity through flow, to agreed timelines Impact: Potential for commissioner challenges and financial penalties due to breach of ED and RTT targets Potential subsequent impact on patient pathways & patient safety. Adverse reputation				
Domain	1. **Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Jul 15**	**Exec Sponsor**	Martin Wilson
Consequence	4	4	4	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	5	5	5	**Date closed**	
Score	20	20	**20**		
Controls & Mitigating Actions	**Controls:** Overall: 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. Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. Existing capacity: Maximum possible resource is deployed towards the improving patient flow programme so that optimal delivery can be achieved New capacity: Business Planning identified ~93 beds are required in 15/16 Proposals for additional bed capacity agreed with commissioners Risks exist with respect to the timing and delivery of plan.			**Assurance**	Negative assurance: - 4 hour operational standard performance - RTT backlog of patients- cross ref BAF Risk 01-06 - Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014 Internal capacity assurance: 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. Follow-up capacity audit is to be completed in Q3 Flow programme dashboard provides real-time analysis of performance against targets External capacity assurance: KPMG reviewing 15/16 trust business plans and PMO structure ALOS benchmarking will provide insight into areas of strong and weak patient flow

	To control these risks, we have increased capital project management capability **Mitigations:** • Seek +/- acquire additional external capacity • Cap demand for services • Increased command and control of bed management and hospital flow • Work with SRG to produce system-wide solutions		
Gaps in controls	Ability to deliver agreed additional capacity schemes to agreed timelines remains a challenge	**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 Elective theatre capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience				
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	1. **Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Updated Jul 2015**	**Exec Sponsor**	Martin Wilson
Consequence	4	4	4	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	5	5	5	**Date closed**	
Score	20	20	20		

Controls & Mitigating Actions	**Controls:** Overall: 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. Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. 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. Existing capacity: Business Planning for 2015/16 commenced with focus on aligning divisional activity and capacity plans. 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. Care groups held to account for monthly performance via DMB Ensured that maximum possible resource is deployed towards the improving patient flow programme so that optimal delivery can be achieved 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	**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 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. 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. Theatres dashboard in development – enables tracking of theatres throughput and utilisation External assurance: Participation in System Resilience Group that has reviewed Trust's capacity plans. Additional funds secured through SRG 1 elective RTT funds.

	• 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) Specific theatre capacity analysis and plan developed linked to a longer term theatres strategy currently in development.. A structured approach to appraising the options for creating further physical capacity for 2015-16 and beyond. This work is underway. **Mitigations:** • Seek additional external capacity • Cap demand for services • Divisional management teams & boards to monitor activity against plan ensuring full use of allocated capacity, driving productivity improvements within sessions and outsourcing activity to other providers		
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	**01-15 Adult critical care capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience				
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	**1.Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Updated Jul 2015**	**Exec Sponsor**	Martin Wilson
Consequence	4	4	4	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	5	5	5	**Date closed**	
Score	20	20	20		

Controls & Mitigating Actions	**Controls:** Overall: 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 care to be considered and where appropriate – approved. **Mitigations:** • Seek additional external capacity • Cap demand for services	**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 assurance: 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. External assurance: ICNARC benchmarking analysis provided to adult critical care monthly showing delays in discharging patients to acute beds due to bed occupancy pressures. Exec DoDI assures capacity delivery with reporting via EMT
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 by EMT. Secure approval and business case		

Principal Risk	01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists				
Description	Risk to patient safety and patient experience as patients waiting greater than 18 weeks on elective waiting lists. Possible impact that patient's condition deteriorates. Specific issues regarding cardiothoracic surgery waiting lists in particular.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Updated Jul 2015**	**Exec Sponsor**	Martin Wilson (shared with Jennie Hall re Patient Safety)
Consequence	5	5	5	**Date opened**	31.5.2014
Likelihood	3	4	4	**Date closed**	
Score	15	20	20		

Controls & Mitigating Actions	Management of the RTT 18 week standard is the responsibility of clinical divisions and their general management teams. They are supported in their work by the Information Team and the 18 Week Validation Team which reports into Deirdre Baker – Assistant Director of Finance. Governance arrangements are: Executive leadership for RTT transferred to the Director of Delivery & Improvement Joint trust & CCG contractual investigation to develop and deliver RTT sustainability plan completed June 2015 overseen by DoDI, Surgical Divisional Chair and GP CQR lead (Dr T Coffey). Joint Trust & CCG RTT action plan in place with fortnightly reporting to joint trust & CCG action planning performance group. Compliance Meeting chaired monthly by the Director of Delivery & Improvement, attended by General Managers, Information Team and the 18 weeks team Sub groups for admitted and non- admitted pathways which involve service managers and the 18 weeks team. RTT performance is reported to the FPI Committee on a monthly basis and the issues concerning any particularly challenged specialty are discussed in detail. Performance is also monitored by commissioners at the monthly commissioner/SGH meeting and any clinical quality issues discussed at the monthly commissioner/SGH Clinical Quality Review meetings. RTT performance delivery plan to ensure full chronological	**Assurance**	Negative assurances Some cancellations in routine elective surgery due to bed pressures Some cancelled patients are not able to be rebooked within 28 days target (7 out of 90 in January) RTT backlog rising in Q4 and now back to end of 2013/14 level of circa 800 patients. Failure to develop RTT sustainability plan by Dec 2014; leading to joint trust/CCG investigation. Whole system does not yet have a plan for sustainable delivery of RTT standard

	booking and achievement of RTT aggregate trust levels standards agreed with commissioners. Divisions have reviewed clinical review of waiting lists to ensure any clinical risks due to waiting are reviewed and managed. Approach reviewed by QRC and CQRM committees. Trust data quality group established		
Gaps in controls	Delivery on action plan	**Gaps in assurance**	
Actions next period:	1. Continue to undertake RTT joint investigation with commissioners. 2. Develop specialty level sustainability plans for all RTT specialties 3. RTT programme manager to be appointed 4. Gooroo 18 week software to be piloted 5. Move to use of patient tracking lists for booking all outpatient appointments in sequential order 6. Data quality board established		

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	**2. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Updated Jul 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	Joint Trust and CCG 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			**Assurance**	Q4 and Q1 performance standard has not been met Daily reporting to Exec team Escalation meetings between division & DoDI ECIST review of action plan

	• 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 4. Increases in bed capacity 5. Investments in patient flow schemes (£4m)		
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	01-12 – Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products				
Description	Kiosks are old and are breaking down on a daily/weekly basis Trust virus scanner impacts on system responsiveness Loss of Connectivity which results in gaps to Cold Chain records Current version not compatible with Windows Operating System 7 and there is no possibility of development of functionality to system Loss of System leads to unrestricted access to blood fridge and incomplete cold chain records				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update**	**Exec Sponsor**	TBC
Consequence	4	4		**Date opened**	1.7.2015
Likelihood	5	5		**Date closed**	
Score	20	20			
Controls & Mitigating Actions	Kiosks are sent for repair When system fails manual/papers based system is used. On-going monitoring of failures Functionality complies with current BSQR - but may not be compliant if future changes are required Paper records can be introduced that will satisfy BSQR, but increased risk of non-compliance with recording requirements SWLP met with SGH Director IM&T - Recognised that full mitigation			**Assurance**	Repair times for kiosks are adequate, however breakdown is now happening far more frequently (increased over last 6 months) and time to repair increases. Number of failures and several clinical incidents related to delays in providing blood. Failures are happening on a daily/weekly basis. Presented to Organisational Risk Committee in July 2015; agreement to escalate to CRR. £50K of the required capital agreed and identified from IM&T; remaining amount to be confirmed from finance therefore risk is anticipated to be closed imminently once new system procured.

	will require system upgrade. Business case prepared. A preliminary business proposal for the Trust to financially support a system upgrade was presented to CIOC and a full business case is being prepared for presentation at the Capital Bids Meeting		Lead time for the upgrade: it is likely to take at least 12 weeks.
Gaps in controls		**Gaps in assurance**	
Actions next period:	Procure new system Implement new system		

Finance & Performance Domain: 2.2 Meet all operational & performance requirements

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	**Residual**	**Update Jul 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			**Assurance**	Positive assurance •HDD, BGAF and QGAF assessments •Internal audit Worsening ED performance across Q1– cross ref BAF Risk 01-07

	teams Clinical Quality Review meeting and contract performance meetings are held monthly with commissioners where performance and remedial action is further scrutinised **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		

Finance & performance Domain: 2.1 Meet all financial targets

Principal Risk	**3.13-05 - Working capital** – the Trust will not be able to secure the working capital necessary to meet its current plans				
Description	The Trust's current income and expenditure plans will require more cash than can be met from the current £25m working capital facility				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update**	**Exec Sponsor**	Steve Bolam
Consequence	5	5		**Date opened**	20/07/15
Likelihood	4	4		**Date closed**	
Score	20	20			

Controls & Mitigating Actions	Working Capital Management, reporting and forecasting • Monthly Cash flow forecasts report the impact of the Trust's financial performance on the Trust's cash position **Distressed Trust Regime** • The current provider management regime allows for FTs to seek interim Support when in financial difficulty. • Such support is defined within Secretary of State's guidance	**Assurance**	Monitor have agreed to submit an application for Interim financial support to the ITFF on the Trust's behalf

	under section 42A of the National Health Service act 2006 (Section 42A Guidance - https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts). It is used to provide transitional financial support to an FT or NHS Trust in financial difficulty where it is necessary to support the continued delivery of services for a period during which an assessment of the underlying problem is carried out and a Recovery Plan is developed which forecasts a return to a financially sustainable position. **Mitigating Actions:** Minimising Support requirement • Trust has reviewed the commitments against the current capital programme to ensure that the Trust does not need to make an application for capital interim support • Through the cost pressure process, the Trust has ensured that increases in the requirement for new revenue expenditure have been minimised. • The Trust is reviewing its working capital management processes to maximise liquidity Interim Financial Support application • Through the APR submission, the Trust has advised Monitor of its financial difficulties. • Monitor is preparing a submission to the ITFF for Interim Financial support on behalf of the Trust		
Gaps in controls		**Gaps in assurance**	
Actions next period:			

Principal Risk	**3.14-05 Working capital –** the Trust will require more working capital than planned due to:

	Adverse in year I&E performance Adverse in year cashflow performance				
Description	The Trust's working capital requirement will increase further due to a deterioration in the income and expenditure plans and adverse cashflow movements				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update**	**Exec Sponsor**	Steve Bolam
Consequence	5	5		**Date opened**	20/07/15
Likelihood	4	4		**Date closed**	
Score	20	20			

Controls & Mitigating Actions	Details of the contributory risks to working capital from the Income and Expenditure performance are provided under the following financial risks: • Income • Market Share • Cost Pressures • Cost Improvement Programme Details of the additional risks to working capital due to other cashflow changes are set out in the cash flow risk. **Mitigating Actions:** **Minimising Support requirement** • Trust has reviewed the commitments against the current capital programme to ensure that the Trust does not need to make an application for capital interim support • Through the cost pressure process, the Trust has ensured that increases in the requirement for new revenue expenditure have been minimised. • The Trust is reviewing its working capital management processes to maximise liquidity **Interim Financial Support application** • Through the APR and monthly monitoring discussions, the Trust has advised Monitor of the uncertainty of its financial difficulties. • Monitor are preparing a provisional submission to the ITFF for Interim Financial support on behalf of the Trust, and have indicated that they will submit a further application when the Trust has revised its financial plans in September.	**Assurance**	Monitor have agreed to submit a provisional application for Interim financial support to the ITFF on the Trust's behalf in July and intend to submit a further application once the Trust has revised its financial plans in September.
Gaps in controls		**Gaps in assurance**	

Actions next period:	

Principal Risk	**3.15-05 Risks to income** – that national and local tariffs do not deliver the required income to ensure an at minimum, break even position for the trust.				
Description	A key determinant of Trust overall financial position is the tariff income that the trust receives in for the clinical work that it undertakes. Income is received from NHSE (the single biggest commissioner of St. George's activity) and CCG's, of which Wandsworth, as our local commissioner is the biggest. The other south west London CCG's and Surrey form the core of other CCG income. There is the potential for the income position for the trust to worsen during 2015/16 due to a range of factors linked to the national tariff. Key issues are: ▪ The impact of the Non-Elective Threshold Adjustment (NETA) on the trust, which is undertaking increasing non-elective work, for which the trust is only paid 30% of the tariff ▪ That national and local tariffs adversely impact the trust financial position due to a range of issues including: o Use of block contract, with risk transfer to St. George's. o Failure to achieve best practice tariffs o CCGs not paying for coding improvements ▪ That the loss of CQUIN income, with no viable replacement, leaves the trust with an income gap which the removal of CQUIN projects/posts will only partially mitigate or present an unacceptable quality risk ▪ Trust income is reduced by contractual penalties due to poor performance against quality standards and KPIs- payment challenges e.g. RTT performance or 1st to follow up ratios ▪ The impact of the Better Care Fund is greater than currently anticipated, and the trust receives increased activity from CCG areas where BCF has reduced income				
Domain	**Finance & Operations**			**Strategic Objective**	
	Original	**Residual**	**Update**	**Exec Sponsor**	Steve Bolam
Consequence	5	5		**Date opened**	20/07/15
Likelihood	4	4		**Date closed**	
Score	20	20			

Controls & Mitigating Actions	**Controls** ▪ Engagement with, and development of good and positive relationships with all main commissioners. ▪ Inclusion of robust NETA assumptions in business planning and income targets ▪ Accurate coding of all activity ▪ Support commissioners to develop realistic and deliverable QIPP plans to manage demand for emergency services ▪ Proactive identification of changes to patient pathways leading to expected increase in emergency admissions ▪ Active membership of Project Diamond provides the Trust with a London wide voice to reflect Tertiary Hospital views in the development of the tariff.	**Assurance**	▪ Role on System Resilience Working Group to positively influence how emergency care is managed in the local health economy and how retained funds are spent ▪ Reported value of emergency threshold tariff loss ▪ SWL system receiving support from PWC as part of 5 year planning process to ensure plans are coherent, consistent and deliverable. ▪ Annual business plans and business planning process though to Finance & Performance Committee and Trust Board

	▪ Active membership of FT Network to influence tariffs at a national level. ▪ Good clinical engagement to ensure that services maximise income e.g. by not incurring payment or performance penalties ▪ Negotiation of appropriate and realistic thresholds and targets with local CCG's to minimise trust exposure to challenges. ▪ Ensure that data is recorded and charged for appropriately. ▪ That St. George's will work constructively with and through South West London Collaborative Commissioning to influence and mitigate the impact of the BCF on St. George's. **Mitigating actions:** ▪ Central role played on System Resilience Working Group will allow St. George's to influence how the local health economy operates ▪ Development of admissions avoidance projects in-year which reduce the overall number of patients being admitted to the trust ▪ SLR review to improve productivity ▪ Removal of CQUIN funded posts from establishment if commissioners not prepared to fund ▪ Utilise clinical expertise to explain changes and challenge penalties imposed by CCG's. ▪ Year End Settlement discussions to mitigate income losses by agreement with commissioners to a year-end settlement through the SLA negotiation process.		
Gaps in controls	▪ Inability to influence QIPP schemes or lack of delivery of those QIPP schemes ▪ The Trust needs to more pro-actively identify specific areas of risk ahead of payment/performance challenges	**Gaps in assurance**	Access to representation on System Resilience Working Groups outside of Wandsworth/ Merton/Lambeth where significant level of STG funding sits
Actions next period:	▪ Begin process of business planning for 2016/17 ▪ Robust dialogue and negotiations with commissioners for additional funding through 2016/17		

Principal Risk	**3.16-05 Market Share risks** – that the trust loses market share, negatively impacting on the trusts activity and income.				
Description	A key determinant of Trust overall financial position is the tariff income that the trust receives in for the clinical work that it undertakes. Income is received from NHSE (the single biggest commissioner of St. George's activity) and CCG's, of which Wandsworth, as our local commissioner is the biggest. The other south west London CCG's and Surrey form the core of other CCG income. There is the potential for the income position for the trust to worsen during 2015/16 due to a range of factors linked to the national tariff. Key issues are: ▪ 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 in areas that St. George's, for financial or strategic reasons, wishes to grow activity in. For example, Cardiology going to GSTT from SWL and Surrey, or Neuroscience activity going to inner London providers. ▪ That the impact of potential decommissioning of services will reduce the trusts market share and hence income. ▪ That the trust makes a nuanced judgement about which services to tender for (or not e.g. Merton community services) and then actively aims to win all those services which are tendered				
Domain	**Finance & Operations**			**Strategic Objective**	
	Original	**Residual**	**Update**	**Exec Sponsor**	Steve Bolam
Consequence	5	5		**Date opened**	20/07/15
Likelihood	4	4		**Date closed**	
Score	20	20			

Controls & Mitigating Actions	**Controls** ▪ Engagement with, and development of good and positive relationships with all main commissioners to help ensure that St. George's remains referral unit of choice in south west London ▪ Growing understanding of market share, competitors for services and development of marketing plans to capture activity. ▪ Development of GP liaison role to market to individual referrers ▪ Development of marketing plans for indusial services e.g. Cardiology ▪ Benchmark for quality and performance to understand how the St. George's service compares to competitors ▪ On-going improvement in service quality, to maintain market share and encourage patients to actively choose St. George's. ▪ Divisional annual business plans to identify threats in the market, and how the service will respond to those issues ▪ The trust aims to deliver services in line with commissioner requirements, in advance of any service line tenders or wider commissioning decisions. This will ensure the trust is well placed to win any tender, or to offer a service that commissioners no longer feel the need to tender for ▪ Decision to enter tender process for each invitation received, based on current strategic and service fit and financial	**Assurance**	▪ On-going market share monitoring via SLAM and Dr. Foster data. ▪ Business planning processes to identify risks and market strategy ▪ Trust has won the Nelson Tender. This follows on from the winning of the Prison Tender. Winning both these illustrate and demonstrate that the trust has a track record on winning tenders, and has confidence that it can produce robust and innovative responses to any future tender of services

	contribution/profitability. ▪ Win new tenders e.g. Nelson Local Care Centre, to maintain and expand market share **Mitigating actions:** ▪ Develop deliverable and measurable action plans in response to any significant loss of market share, focusing on reclaiming lost referrals ▪ To develop action plan to develop new markets, focussing on Surrey referrals and south west London activity currently going out of sector. ▪ Cost removal – assuming that substitute activity cannot be grown to detail where cost will be taken out ▪ That St. George's wins any tenders that it chooses to bid for, negating the need for other mitigating actions ▪ Lost service Line Tenders: TUPE of all staff involved. Identification of any potential substitution activity that retained assets – staff or facilities – can undertake service lines are lost in tender process		
Gaps in controls	▪ Inability to influence QIPP schemes or lack of delivery of those QIPP schemes ▪ The Trust needs to more pro-actively identify specific areas of risk ahead of payment/performance challenges ▪ Lack of highly developed marketing plans for many clinical services	**Gaps in assurance**	Access to representation on System Resilience Working Groups outside of Wandsworth/ Merton/Lambeth where significant level of STG funding sits
Actions next period:	▪ Begin process of business planning for 2016/17 ▪ Robust dialogue and negotiations with commissioners for additional funding through 2016/17		

Principal Risk	**3.17-05 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	**Residual**	**Update**	**Exec Sponsor**	Steve Bolam
Consequence	5	5		**Date opened**	20/07/15
Likelihood	4	4		**Date closed**	
Score	20	20			

Controls & Mitigating Actions	Controls ▪ Turnaround Board to oversee Trusts response to 2015/16 financial challenge by taking a lead role in developing, driving and delivering a robust CIP programme for 2015/16 and subsequent years ▪ 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. ▪ Weekly meetings between directorates, divisions and the PMO to monitor scheme performance. All projects across the trust have clear directorate and divisional leads. Mitigating Actions ▪ To develop further in-year non-recurrent CIP schemes to offset the non-delivery of the full CIP programme. These would include: o Vacancy freezes	**Assurance**	▪ KMPG role in reviewing and risk assuring the CIP programme ▪ 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 ▪ Monitor review of CIP plans and process as part of FT application

	○ Reductions in procurement spend ○ Slowing of in-year capital programme ▪ Review list of downside mitigations to see what can be actioned now		
Gaps in controls	▪ 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:			

Appendix 3: New risks (those not previously included at appendix 2: significant risks)

Principal Risk	**3.18-05 TBC Cost Pressures** - The Trust faces higher than expected costs due to:- ▪ unforeseen service pressures ▪ higher than expected inflation ▪ higher marginal costs or costs required to deliver key activity				
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. ▪ 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 ▪ That extra activity costs more than anticipated due to poor cost estimation or that capacity secured off site costs more than anticipated in business planning / budget setting process				
Domain	**Finance & Operations**			**Strategic Objective**	**Meet all financial targets**
	Original	**Residual**	**Update**	**Exec Sponsor**	Steve Bolam
Consequence	4	4		**Date opened**	20/07/15
Likelihood	4	4		**Date closed**	
Score	16	16			
Controls & Mitigating Actions	**Controls** ▪ KPMG input into increasing robustness of trust finance function ▪ 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. ▪ 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. ▪ Costs are based on data from robust historical costing systems including PLICS and Reference Costs which have been calculated in line with national guidance.			**Assurance**	

	▪ 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 ▪ 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.		
Gaps in controls	Divisional use of PLICS and SLR data not as complete as required.	**Gaps in assurance**	Shortfall in capacity for 15/16 and costs for addressing look to be unaffordable to the system
Actions next period:			

Principal Risk	**3.19-05 Cash-flow Risks –** Cash balances will be depleted due to: Delays in receipt of SLA funding from Commissioners Capital overspends				
Description	The Trust's cash balances will be significantly depleted due to delays in receipt of commissioner funding. Risk is currently greater due to high level of over-performance above agreed SLA values assumed in the Trust's plans and recent data quality issues				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update**	**Exec Sponsor**	Steve Bolam
Consequence	4	4		**Date opened**	20/07/15
Likelihood	3	3		**Date closed**	
Score	12	12			
Controls & Mitigating Actions	**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			**Assurance**	Detailed monitoring and forecasting of cash flow and agreed debt through Finance and Performance Committee. HDD3 working capital reviews

	and Board. • 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). • SLA interim invoicing – as above. **Contract Documentation** • SLAs include special clause for interim invoicing of over-performance in advance of freeze date - enhances cash flow. **Controls:-Capital Expenditure Management** • Capital Programme Group (CPG) oversees the planning and monitoring of the annual and five year capital programme, which reports to Executive Management Team • Monthly capital finance reports on funding and expenditure are submitted to the CPG for review and forecasts updated. The Finance and Performance Committee and Trust Board receives a summary financial report on the capital programme as part of the finance report and significant variances and changes to plan explained. • Maintain reasonable and prudent capital cash flow projections based on detailed returns from capital budget holders commensurate with agreed funding and ensuring they are updated regularly to reflect changes in project timescales and in the receipt of external funding. **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 **Address Data Quality issues** • Agreed additional investment in Data Quality Team as part of 15/16 cost pressure funding • Action plan in place to address issues with data quality - actions include:		Previous track record in managing capital programme within plan Contract query notice served by CCGs in Q3 2014/15 has been lifted (March 2015) following implementation of actions outline

	• Ensuring fields in minimum data set (Monthly SLAM/SUS reconciliations) are completed • Rolling programme of monthly locking down data • Strengthened process of ensuring "flex" and 'freeze' reports to commissioners as per contract • Future upgrades to Cerner will first be tested in a test environment before going live		under controls
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**	Data quality risks: Potential new data challenges from commissioners which have not yet surfaced Whilst resource focused on ensuring recording of data may limit capacity to understand scope of problem to treat and ensure no recurrence Future issues with data capture occurring or being revealed by subsequent Cerner system upgrades
Actions next period:	• Seek to agree payment for over-performance in the contract with NHSE • 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		

Principal Risk	Ref – TBC: There is a potential risk to the quality and safety of patient care in the event the Estates and Facilities team are unable to complete required estates works in a timely way due to the impact of run rate schemes.				
Description	In order to achieve identified savings targets, the Estates and Facilities Department has to reduce labour and materials expenditure on its planned and reactive maintenance service.				
Domain				**Strategic Objective**	
	Original	**Residual**	**Update**	**Exec Sponsor**	Eric Munro
Consequence	4	4		**Date opened**	1 July 2015 (Identified by ORC)
Likelihood	5	4		**Date closed**	
Score	20	16			
Controls & Mitigating Actions	Revised estates permanent management structure is in place including Maintenance Manager. Health and Safety management function closely involved in maintenance service. Planet FM system (the estates helpdesk and job request system) is being upgraded to allow prioritisation and work backlog to be			**Assurance**	Works procurement and prioritisation process being assembled. Action plan being monitored and progress updates to the Operational Management Team. This risk is monitored via the Health, Safety & Fire Committee and overseen by the Organisational Risk Committee.

	monitored.		
Gaps in controls	The action plan will be further developed as higher risk items are closed.	**Gaps in assurance**	Quality Impact assessment process of run rate schemes.
Actions & timescale:	Works procurement and prioritisation process to be in place by 1 September 2015.		

Principal Risk	Ref – TBC: There is a potential risk to the quality and safety of patient care in the event that required works cannot be undertaken due to capital funding decisions not to fund such projects.				
Description	Reduction of the scale of the Trust's capital programme means that not all of the Trust's high priority projects can be funded at the time they are needed.				
Domain				**Strategic Objective**	
	Original	**Residual**	**Update**	**Exec Sponsor**	Eric Munro
Consequence	4	4		**Date opened**	1 July 2015 (identified via ORC)
Likelihood	4	3		**Date closed**	
Score	16	12			
Controls & Mitigating Actions	Risk assessments undertaken for each project. Monitored through the Capital Programme Board & Project Programme Board. Engage with the department early in the capital scheme and jointly agree how this can be managed. Delivery of Lanesborough 1st Floor project/Hybrid theatres and Bed capacity Project will provide further mitigations.			**Assurance**	Monitoring of project and maintenance activity through project/programme boards and Divisional Governance Boards. Capital Programme Group has representation from all Divisions and quality and safety of patient care is the highest prioritisation for all capital projects.
Gaps in controls	None identified			**Gaps in assurance**	Quality Impact assessment process of schemes
Actions & timescale:	Preparation of new 5 year capital programme by 1 October 2015 with prioritisation from quality and safety leads.				

Appendix 4 – Divisional Extreme Risks

Risk Ref.	CW&DT Risk	Score	Jun 15 Change ↑↓	Rationale for change
CW026	Delay in starting or continuing Induction of Labour on Delivery Suite due to High activity and capacity Issues leading to avoidable adverse outcomes	15	↑	
CW049	Delivery of sub-standard care to sick and premature infants due to insufficient neonatal trained nurses on the neonatal unit	16	↑	
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	-	Closed – risk treated
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	12	↓	
CW084	Insufficient capacity in the mortuary resulting in closure of the mortuary	16	↑	
CW0087	Call alarms in St James' wing therapy dept not working properly – risk to patient safety in the event of an emergency	15	→	
CW089	Insufficient number of CTG monitors for a full triage and full induction bay meaning some women need to wait for monitoring	20	→	
CW090	Lack of NICU capacity – presenting both clinical and financial risk	15	→	
CW091	Lack of GICU capacity – presenting both clinical and financial risk	15	→	
CW092	Lack of CTICU capacity – presenting both clinical and financial risk	15	→	
CW093	Roof leak in room 5.011, 5th Floor Lanesborough Wing	25	→	
CW0094	Call bell failure on delivery suite	16	→	
CW0097	Critical Care Run Rate Risks impacting Patient Care & Staff morale	16	→	
CW0094	Call bell system on delivery suite has failed on a number of occasions. Temporary system has been used but this has also failed to work.	16	→	

CW0097	Critical Care Run Rate Risks x 2 Patient Care & Staff morale		→	
CW098	Medical Records patient safety & staff safety risk	**16**	**NEW**	
CW099	Unable to meet requirements for accreditation by UKAS due to Genetics Vacancies	**15**	**NEW**	
CW101	Lack of Storage Trauma & Orthopaedic Therapy Gym, 5th Floor St James' Wing	**15**	**NEW**	
CW105	(C4 x L5 = 20) - STOW (safe transfer of women) maternity system - Missed or delayed postnatal care for mother and baby	**20**	**NEW**	
	M&C		**Change ↑↓**	
Risk Ref.	**Risk**	**Score**		
MC13-D1	Risk to patient safety from delay in diagnosis or failure to follow up.	**15**	→	
MC31-D5	Risk to patient safety as patients waiting greater than 18 weeks on elective 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**	→	
MC57-D3	Fire risk on Knightsbridge wing – following review at April DGB, this risk was increased to reflect the concerns of the LFB regarding no means of stopping smoke from spreading.	**15**	↑	
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**	→	
MC66-D1	-Risk to patient safety and organisation's reputation through increase in cardiac surgical site infection.	**16**	**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.	**20**	→	
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**	→	
C24	Failure to ensure Standard Operating Procedures (SOPs) for reviewing diagnostic tests results are in place in all areas and are effective	**15**	→	
tbc	Feedback from Major trauma National Peer review – March 2015: Performance against the BOAST 4 guidelines for the management of open fractures is below the national average.	**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 and will not need the demand as the building is re-developed and refurbished to modern standards.	**16**	→	
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**	→	
EF204	Failure of hot water system (HWS) calorifiers serving St James Wing.	**25**	**NEW**	
	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	2014/15 Cost Improvement Programme not achieving target.	**16**	→	To close – risk materialised 2014/15
CSW1032-COM-D5	2015/16 Cost Improvement Programme and run rate reduction plans not achieving target.	**20**	**NEW**	

TRUST BOARD

Research Board Update

July 2015

The Trust Board has previously agreed to increase the scrutiny and visibility of the research agenda. The Research Board has so far met infrequently, but will strive to meet quarterly in future. Attendance from divisions was now good, and the majority of positions were now filled.

Activity and Performance

Recruitment to NIHR portfolio clinical trials in 2014/15 was excellent, with St George's reporting the highest number of patients recruited to commercial trials in South London. However, three unusually high-recruiting studies, which will not be replicated 2015/16, contributed very significantly to this performance, and without similar trials, it will be a challenge to meet recruitment targets in 2015/16.

The rate for meeting the *"70 day target" for time from submission of SSI form to first patient recruited* dropped from 80% in December (in line with target rate) to 73.5% in most recent quarter. The rate for meeting *target recruitment on commercial trials* had been variable over the year, partly due to long-running 'legacy' trials where there is no scope to improve performance. A range of factors contribute to non-achievement of these targets, but the Research Board noted that Care Groups and Divisions need to be more involved in ensuring they are met.

Research Strategy Implementation

The implementation plan 2015/16 progresses well. Discussion at the Research Board focused on increasing engagement with care groups and divisions, through improved communication and the recruitment of divisional research facilitators. There remains a challenge in seeing Research as core business in some care groups, given the current financial pressures and impact on clinical areas. There is also a challenge, in the current financial environment, in recognising the value of some research outputs (e.g. publications) that have no financial benefits but are central to the Trust's mission.

The first six research sabbaticals to be funded have now completed their funding periods, with three grant proposals submitted so far and the remainder expected to submit later in 2015. The first clinical research fellowship, jointly funded with the charitable foundation, has been awarded and is expected to start in September 2015.

Research Structure and Organisation

CRN London South required its 12 member Trusts to undertake an internal audit of processes relating to CRN and commercial research funding in late 2014/15. The report and action plan had been considered by the Trust's Audit Committee. St George's was given limited assurance as a result of the audit and will be subject to a follow-up audit within 12 months to ensure the action plan has been implemented and adequate controls have been established to mitigate the weaknesses identified. The Research Board noted that the R&D Finance section has not functioned well for a long period of time, and this contributed to the poor audit outcome.