St George's University Hospitals NHS
NHS Foundation Trust

MEETING OF THE TRUST BOARD

3 September 2015, 11.00 - 1.00 - Richmond & Barnes Rooms
Queen Mary's Hospital

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.

Mike Rappolt , Chair

		Presented by	Time
1.	**Chair's opening remarks**		
2.	**Apologies for absence and introductions** Christopher Smallwood, Wendy Brewer		
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.*	M Rappolt	
4.	**Minutes of the previous Meeting** *To receive and approve the minutes of the meeting held 30 July 2015*	M Rappolt TB (M)	
5.	**Schedule of Matters Arising** *To review the outstanding items from previous minutes*	M Rappolt TB (MA) - 01	11.05
6.	**Chief Executive's Report** *To receive a report from the Chief Executive, updating on key developments*	M Scott TB Sept 15 - 02	11.10
7	**Quality and Performance**		
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 4* *To receive a verbal report from the Quality & Risk Committee seminar held on 26 August 2015*	J Hall/M Wilson TB Sept 15 - 03 S Wilton	11.20
7.2	**Finance Report** • *To receive the finance report form month 4* • *To receive an oral report from the Finance & Performance committee held on 26th August 2015*	S Bolam TB Sept 15 - 04	11.50
7.3	**Workforce & Performance Report** *To review month 4 workforce report*	W Brewer TB Sept 15 - 05	12.10
8.	**Governance**		
8.1	**Risk and Compliance Report**	P Jenkinson TB Sept 15 – 06	12.25
8.2	**Revalidation & Appraisal for Medical Staff**	Simon Mackenzie TB Sept 15 - 07	12.35
9.	**General Items for Information**		
9.1	**Use of the Trust Seal** *To note use of the Trust's seal during the period (August 2015) - The seal has not been used in August 2015.*		12.45
9.2	**Questions from the Public**		

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

10. Meeting evaluation

11. Date of the next meeting - *The next meeting of the Trust Board will be held on 8 October 2015*

MINUTES OF THE TRUST BOARD

30th July 2015

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

Present:	Mr Christopher Smallwood	Chair
	Mr Miles Scott	Chief Executive
	Mrs Wendy Brewer	Director of Workforce
	Professor Jennie Hall	Chief Nurse
	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	Non-Executive Director
	Dr Judith Hulf	Non-Executive Director
	Andrew Burn	Turnaround Director
In attendance:	Simon Milligan	Deputy Director of Finance
Apologies:	Mr Mike Rappolt	Non-Executive Director
	Mrs Kate Leach	Non-Executive Director
	Mr Steve Bolam	Chief Financial Officer

15.07.15 Chair's opening remarks

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.

The chairman advised those present of the decision reached in the reserved meeting to amend the board meeting cycle, which would mean that future board meetings would be held one week later than currently.

15.07.16 Declarations of interest

No interests relating to agenda items were disclosed.

15.07.17 Minutes of the previous meeting

The minutes of the meeting held on 25th June were accepted as an accurate record, subject to amendments: it was noted that the outpatient strategy update should be in October and not July as minuted.

15.07.18 Schedule of Matters Arising

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

15.07.19 Chief executive's report

Mr Scott presented his report, highlighting key points.

Mr Scott highlighted the announcement made by Monitor regarding the conclusion and outcome of their investigation. Monitor had concluded that the trust had been in breach of its licence and had accepted a series of voluntary

undertakings from the trust, including the development and delivery of a one year, two year and five year recovery plan. Action would therefore be required over the autumn to develop the five year plan to return the trust to a sustainable financial and operational balance. Monitor had also placed additional conditions on the trust's licence, including Monitor scrutiny of trust plans and agreement to any changes in governance and management structures required to deliver the plan. Mr Scott reported that there would be a number of staff and stakeholder briefings and communication over the next week.

Mr Scott highlighted some key appointments, including: Professor Higham as the new principal for St. George's University, due to take up her post in November; Dr Lisa Pickering as new divisional chair for the medicine and cardiovascular division, with effect from September; and Dr Stephen Brecker as chief of the newly established cardiology clinical academic group, with effect from September.

Mr Scott highlighted developments in community services, acknowledging the board decision not to proceed with a bid for the Merton community services due to the level of uncertainty and financial risks which meant that the trust could not submit a compliant bid or accept the risks inherent in a compliant bid. Instead the trust would take forward the collaboration with the GP federation in other ways. Mr Scott welcomed the extension to the contract for Community Adult Health Services (CAHS) in Wandsworth, which was a vote of confidence in the trust's community services and a statement of intent regarding the importance of community services to the trust.

Mr Smallwood referred to the Friends and Family Test results for staff satisfaction and agreed to defer discussion until a workshop with governors following the board meeting.

15.05.16 Quality and performance report

Performance

Mr Wilson presented the performance report for month 3, highlighting key points. He highlighted improved performance in RTT over the past month and improvements in the A&E waiting time performance, although the trust was still not meeting the standard. He also highlighted concerns regarding performance against the cancer standards, with breaches against four of the standards. A more detailed paper regarding this had been discussed at the finance and performance committee meeting the previous day, but in summary the breast symptomatic standard breaches had been driven by increased demand and capacity constraints as well as weaknesses in process. Mr Wilson reported that a weekly performance review meeting had been established with the divisions to identify and address issues. Mr Wilson reported improved performance in diagnostic waits and that the trust was now close to achieving the standards, but further improvement was required as well as investment in diagnostic equipment.

Mrs Pantelides repeated her previous concerns regarding cancer performance, pointing out an increased number of breaches despite a decreased level of activity. She reflected that one factor was annual leave and asked whether that could be managed better to provide a more consistent service. Mr Wilson confirmed that this was included in the improvement plan, including better planning around bank holidays and distribution of clinics around the week to ameliorate the impact of bank holidays.

Mrs Pantelides asked whether the trust was learning from other networked cancer

services. Mr Wilson confirmed that the trust was learning from better performing trusts and would be participating in the London-wide initiative to improve cancer services.

Quality report

Prof Hall presented the quality section of the report and highlighted a similar picture as that of previous months, with a key focus on numbers of serious incidents amongst other indicators and the development of quality assurance processes including a re-launch of the quality inspection programme.

Effectiveness domain
Prof Hall Highlighted current mortality data and the results of a recent PRISM survey which included avoidable mortality, the findings of which were currently being analysed and would be presented in more detail in the next month's report. She also highlighted the results of recent clinical audits, including the quality of patient records; the findings of this audit were being followed up with individual specialties.

Safety domain
Prof Hall acknowledged previously raised concerns by the board regarding rising numbers of serious incidents and continuing incidence of never events. Themes continued to be identified and actions followed up through the patient safety committee.

Mrs Pantelides identified an increase in deaths in custody reported as serious incidents. Prof Mackenzie advised that this matched the national picture, with numbers being driven by the requirement to automatically report some deaths as serious incidents.

Mr Smallwood asked whether the increasing numbers of serious incidents being reported was an indication of overall decline in quality. Prof Mackenzie opined that it was one of many good indicators of quality but it alone did not indicate an overall decline in quality standards; each serious incident needed to be investigated on its own merit.

Patient experience domain
Prof Hall responded to a query from the previous meeting regarding complaints responses, by confirming that no complaints were outstanding past the timescales agreed with the complainant and therefore assured the board that there wasn't a lengthy 'tail' of complaints. She also highlighted continued improvement in divisional performance in complaint responses.

Well-led domain
Prof Hall presented the safe staffing report, explaining the process for calculating safe staffing ratios and reporting. Dr Hulf suggested that staff skill-mix should also be taken into account as well as numbers. Prof Hall agreed, in particular in the case of temporary staffing.

The board also noted the heat map, with Prof Hall providing an explanation of the escalation process which would lead to intervention where and when necessary.

Report from the quality and risk committee
Mrs Wilton gave a verbal report from the last quality and risk committee meeting. She reported that the key focus of discussion had been on quality governance, in

the context of financial pressures and turnaround, with the committee noting the current quality assurance mechanisms and agreeing that a revised framework would be presented to the committee at a future meeting. The committee had also agreed for quality inspection reports to be presented to the committee.

The committee had considered the proposed process for ensuring follow-up of diagnostic tests, provided by Prof Mackenzie in response to previous serious incidents. The revised process would now include consultant accountability for follow-up of diagnostic tests. Prof Maceknzie had also updated the committee on standards being developed for daily consultant ward rounds.

The committee had received an update on medical record availability in clinic, noting improvement to 96% against the target of 98%.

The committee had considered the healthcare aspects of the HMIP inspection of HMP Wandsworth and noted the action plan developed to address weaknesses identified.

The committee had also received the clinical audit plan and agreed the need to link that audit plan with the board assurance framework. The committee had considered the current resourcing in the audit team and endorsed the need to fill current vacancies in the team.

The committee had also considered the findings of investigation into Dr Foster mortality outliers, receiving assurance that no safety issues had been identified but noting data quality issues which were being addressed.

15.07.17 Joint investigation findings / final report – RTT and A&E

Mr Wilson presented the final reports from the two joint investigations, a joint approach including the trust and commissioners from Wandsworth and Merton clinical commissioning groups to identify actions needed by all parties to ensure sustainable achievement of waiting time standards.

Mr Wilson advised that the reports were being presented to the board to provide assurance regarding the actions being taken to address compliance issues in both standards, but also to highlight risks to future compliance with the standards and the financial impact.

The board considered both reports.

<u>A&E findings</u>

The investigation had found the counting of breaches by the trust to be very open and acknowledged that recommendations from previous external reviews had been implemented, but found opportunities to go further such as the use of GP navigators in A&E.

The investigation had also acknowledged capacity issues, with occupancy rates currently at 97%. It was noted that the trust aimed to reduce this to 90%, but a target had been set for 2015/16 at 94%. The trust had invested in patient flow schemes to support the reduction of occupancy rates.

The investigation had concluded with an acknowledgement that the trust would not sustainably achieve the waiting time standard throughout the year.

<u>RTT findings</u>

The investigation had acknowledged the capacity issues and recognised the need to review the care pathway. It concluded that significant investment in capacity would be required to achieve sustainable delivery of the standard and reduce the current waiting list.

The board noted the actions and follow-up, to be monitored internally within the trusts and via the tripartite meetings with commissioners and regulators. It was noted that all parties had signed off the investigation reports.

Mrs Pantelides welcomed the collaborative approach but noted that financial penalties would be applied if the trust failed to deliver and therefore the risk remained with the trust. Mr Wilson advised that the introduction of potential penalties in the report was disappointing but was within the terms of the contract; however the penalties referred to were only 40% of the level they could have been set at and the commissioners had signed up to actions they must deliver in order to ensure the delivery of the standards, therefore they could not levy penalties where they had not delivered their required actions. He opined that as the commissioners had invested in the patient flow programmes there would be exhaustive discussions through contract meetings before any penalty would be levied.

Mr Wilson assured the board that the actions in the reports were deliverable, although there were always risks in the capacity being available.

Prof Kopelman asked what work was being done regarding length of stay and repatriation of patients. Mr Wilson updated the board on work being done with partners on appropriate repatriation of patients. It was agreed that an update on the flow programme, including discharge processes, would be presented to the board in October.

J Hall
October 15

The board noted Mr Rappolt's questions. Mr Wilson confirmed that the action plan included specific actions for the commissioners. It was not possible to determine the impact of individual actions, but it was agreed that progress against the action plan would be updated on a weekly basis and monitored monthly by the finance and performance committee.

M Wilson
Monthly

15.07.18 Finance report (month 3)

Mr Milligan presented the financial performance report for month 3, highlighting that the overall in-month performance had improved when compared with performance in the previous month, but that the year to date position remained adverse to plan.

Mr Rappolt highlighted that the main variance contributing to overspending against the plan was in unallocated CIPs. He asked whether, if the £38m CIPs were fully achieved, the trust would be back on track. Mr Milligan confirmed that, in his opinion, that would be the case – the trust could achieve the £46m deficit budget. However there were significant risks to achieving the full CIP target, based on the current risk rating of CIP schemes.

Mrs Pantelides highlighted statements within the medicine and cardiovascular division section, referring to safe staffing requirements impacting on division's ability to deliver the CIP targets. Mr Milligan confirmed that the staffing review had been completed in 2014/15 and divisional budgets had been increased to allow them to increase staffing where necessary; however this budget had then been reduced through the budget setting process. This position was being addressed

as a specific part of the £12m additional funding now being made available to divisional budgets. Mr Smallwood opined that the commentary referred to the divisions needing to use temporary staff to meet the increased staffing level required, as they had not been able to recruit substantive staff to meet those required levels. Mr Milligan confirmed that the application of the central reserves had been reflected in specific areas within divisional budgets.

Report from the finance and performance committee

Mr Smallwood gave an oral report from the finance and performance committee meeting held the previous day.

The committee had discussed interim budget and financial management, including budget management arrangements between now and the point at which the trust's budget for 2015/16 was reset. The committee agreed to recommend to the board that the £46.2m deficit budget should be reaffirmed, but that over this interim period, between now and the end of October, the divisions would be managed against agreed variances in line with the budget discussions which had now been concluded.

The committee had also reviewed operational performance, focusing on A&E, RTT and cancer where standards were not being met. Mr Wilson had reported on actions agreed with commissioners following conclusion of the joint investigation, as presented to the board at this meeting. The committee had agreed that progress against those plans should be monitored regularly by the committee. The committee had noted that the RTT performance would remain difficult as delivery of the standard on a sustainable basis would require an increase in elective activity beyond the trust's current capacity, or the commissioners' affordability. The committee had received and considered a detailed action plan to improve performance against the cancer standards and had recommended more numbers and trajectory to be added to the plan so that the committee could track progress.

The committee reviewed current financial performance and cash management, with significant concern raised about the continued slippage against plan, with income behind plan, expenditure remaining too high and CIPs falling significantly short of plan. Particular concern had been raised around pay, with temporary staff costs in June up by £0.5m compared with the previous month. Prof Hall had undertaken to provide a more detailed explanation of this to the committee. The committee had reinforced the importance of holding divisions and corporate departments rigorously to the budgets just agreed, with run-rate measures keeping the trust on track until CIP performance could be improved, a point fully recognised by the executive.

The committee received assurance that the application to Monitor and the ITFF for additional working capital of £48.7m would be successful and that cash was therefore unlikely to be a problem in 2015/16 even if a downside case were to materialise.

15.07.19 Workforce report (month 3)

Mrs Brewer presented the monthly workforce performance report and highlighted key points. She reported that work was progressing on the vacancy rate with support from KPMG, with completion due in August. Staff turnover would be the subject of a joint discussion with governors at a session following this meeting, including consideration of feedback on staff experience. The workforce committee had received and considered plans developed by each division to address staff

turnover – those plans would be further developed and brought back to the committee for further consideration.

Mrs Brewer presented an analysis of temporary staffing costs, showing an increase in costs of around £1m compared with the same period in the previous year. The board noted that actual activity had also increased, but not at the same rate as the increase in cost. Mrs Brewer advised that the costs also included non-clinical temporary staffing which previously had not gone through the payroll system. More details would be presented at the next board meeting. Mrs Pantelides advised caution over the financial budget of £46.2m, which had been set based on projected 8% use of temporary staff as informed by 2014/15 outturn; if the temporary staff costs continued over that level then that would pose a risk to achieving the agreed budget.

W Brewer September 15

Mrs Wilton asked about career development and internal promotion opportunities for staff. Mrs Brewer confirmed that internal promotion was being made simpler.

The board noted a question from Mr Rappolt, asking for assurance that performance management had been built into the appraisal system. Mrs Brewer confirmed that this was the case. A new appraisal system was being developed and implemented, with a leadership group of budget holders who would go through an interim appraisal. Then trust was also reviewing the pay scale for senior management. Mrs Brewer advised that appraisal rates were currently being compromised by time constraints and other pressures, but the re-launch of the appraisal process would enable a revision of the compliance rates.

Report from the workforce committee

Mrs Pantelides presented a report from the previous meeting of the workforce committee, reporting that the focus of the meeting had been on the family and friends survey feedback from staff, providing valuable feedback on staff experience and a leading indicator of increased turnover.

15.07.20 Monitor return – quarter 1 performance

Mr Jenkinson presented the proposed governance statements to be declared in the in-year performance submission for quarter 1 with the recommendation that, as with the previous quarter's submission, in the light of evidence reviewed by the board in the performance reports at this meeting, that the trust should declare non-compliance with the finance statement and the first governance statement and compliance with the second governance statement.

The board considered the statements in the context of the current performance as presented in previous reports and agreed with the recommended statements, but agreed that cancer performance should also be added to the existing statements regarding A&E and RTT where the board was declaring that it could not be satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets. It was agreed that Mr Wilson would provide supporting statement to be included.

Subject to this addition, the board approved the submission of the quarterly return. Mr Jenkinson would confirm submission to Monitor.

P Jenkinson July 15

15.07.21 Monitoring corporate objectives – quarter 1 review

Mr Elek presented the summary of achievement against the corporate objectives, including a forecast and critical path for the year. Mr Elek advised that the overall delivery of the annual plan was rated as red due to the current risks and

performance in finance, operations and workforce. The current forecast was the same for quarter 2.

Mr Smallwood queried the status of the bed capacity plan. Mr Elek agreed to circulate the planned and actual capacity developments and to link those to length of stay assumptions. **R Elek / M Wilson September 15**

15.07.22 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.

The board noted a query from the finance and performance committee regarding the current status of the working capital risk, proposing a reduction in the likelihood of the risk as Monitor had agreed financial support for the trust's working capital. The board discussed the concept of risk proximity in this context, as short-term working capital had been secured but that longer-term the risk remained high and might increase depending on the outcome of the budget revision. The board therefore agreed to reduce the likelihood of the risk but would review again after the budget reset process.

15.07.23 Report from the research board

Dr Hulf presented a report from the research board, and highlighted continued issues with the Joint Research and Enterprise Office (JREO) identified in a recent audit. She therefore raised the risk that the JREO was still not functioning adequately to support research in the trust, but reported that new appointments had been made and would be in post soon. The audit report would be considered in more detail at the audit committee in September.

15.06.xx Questions from the public

The chairman invited comments or questions from the public, noting that the board members and governors would be meeting following the board meeting.

Gail Adams asked whether the appraisal system would include 360 degree appraisal as there was evidence that this approach enhanced awareness and behaviour. Mrs Brewer advised that board member appraisal would include such, but for other staff there would be some sort of feedback mechanism as implementation of full 360 degree appraisals for all staff in management roles would be prohibitively expensive.

15.06.xx Any other business

There was no other business.

15.06.xx Date of the next meeting

The next meeting of the Trust Board will be held on 3rd September 2015.

St George's University Hospitals NHS
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Matters Arising/Outstanding from Trust Board Public Minutes
3 September 2015

Action No.	Date First raised	Issue/Report	Action	Due Date	Responsible officer	Status at 3 September 2015
15.06.05	25.06.15	Chief Executives Report	Update on the Immigration Pilot project with the immigration service	Oct 15	S Bolam	The CEO and the CFO recently met with the lead from the Immigration service to discuss the progress and the other steps the Trust could take to be helpful. All consider the project to be progressing well and the Immigration service will produce a more formal report soon
15.05.06	25.06.15	Quality & Performance report Performance	A detailed briefing on the discharge programme.	Nov15	J Hall	To be added to the November agenda. (Short presentation)
15.05.06	25.06.15	Quality & Performance report Performance	Potential for 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	Oct 15	M Wilson	The Trust has agreed a process with the CCGs to model the current waiting list positions, the degree to which the targets can and are being sustainably delivered and to surface areas where demand is exceeding capacity and increasing risk. Clinical summits in each challenged specialty will look at risks and options to manage and mitigate
15.06.8	25.06.15	Outpatient Strategy	Draft Outpatient strategy to be to the Board	Oct 15	R Elek	

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.
15.07.17	30.07.15	Joint investigation findings / final report – RTT & A&E	Update on the flow programme to include discharge processes.	Oct 15	J Hall	
15.07.17	30.07.15	Joint investigation findings / final report – RTT & A&E	Progress against action plan to be updated on a weekly basis and monitored by F&P committee.	Monthly	M Wilson	Update given to F&P 26/8/15.
15.07.19	30.07.15	Workforce report (month 3)	More detail to be presented on temporary staffing costs.	Sept 15	W Brewer	Agency expenditure by month to be provided from October. Information is available in the finance report.
15.07.20	30.07.15	Monitor Quarterly Submission	Following board approval of submission of quarterly return. PJ to confirm submission to Monitor	July 15	P Jenkinson	COMPLETE
15.07.21	30.07.15	Joint investigation findings / final report – RTT & A&E	Circulate the bed capacity plan and capacity developments and to link to length of stay assumptions.	Sept 15	R Elek / M Wilson	Update being provided to Board members.

St George's University Hospitals NHS
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REPORT TO THE TRUST BOARD – SEPTEMBER 2015

Paper Title:	Chief Executive's Report
Sponsoring Director:	Miles Scott, Chief Executive
Author:	Peter Jenkinson, Director of Corporate Affairs
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

1.1 Cardiology Clinical Academic Group

Following the recent appointment of Dr Stephen Brecker as Chief of Cardiology Clinical Academic Group, a general manager has been appointed, Nicola Hilton, who will support Dr Brecker in moving forward the implementation of the CAG. Interviews for the CAG leadership team will be held in early September and, on their appointment, the launch of the CAG will closely follow. As the first CAG to be established by the trust and university, this remains an exciting development for the whole of St George's and is progressing well.

1.2 Forward View into Action: FUTURE MODELS OF ACUTE CARE COLLABORATION

I am pleased to report that both of our bids for vanguard status have been short-listed – this is a significant achievement as only 28 of the 65 bids have been selected for further consideration. The next stage entails a two-day interactive event on 7th and 8th September which I and colleagues will be attending to present our proposal, and to vote on all short-listed applications

Acute Provider Collaborative

Our bid with Croydon, Kingston, and Epsom and St Helier is essentially our delivery vehicle for the next stage of the acute provider workstream, and will also address how this interfaces with the putative South West London success regime – ensuring a system-wide holistic approach to the proposals. Whilst we are yet to receive a formal response to the report submitted in July, the informal feedback has been extremely positive.

The SWL Commissioning Collaborative have agreed to continue to fund the next stage of the work, and we will be interviewing for a substantive programme director (hosted by Epsom & St Helier) on 1st September.

We will provide a more detailed report to board in the Autumn around how this fits with our overarching strategic review, and how we will secure clinical and board / council engagement in developing granular proposals.

Accountable Care Organisation

The Royal Marsden proposal for an accountable care organisation will also be considered at the two-day event. It is noteworthy that both the Christie and UCLH cancer proposals have also been short-listed, resulting in a real opportunity for a nationally scaleable innovative model of care. The Imperial medical director and I will be joining the Marsden team to give their proposal. We will be addressing the board's queries around the proposal and the impact of this on the London Cancer Alliance, and will provide a more detailed report in due course, should the bid be selected.

2. Monitor Investigation / Financial Recovery

2.1 Monitor Investigation

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The Monitor investigation has now concluded and the outcome was published on August 3rd. Monitor concluded that the trust was in breach of the conditions of its licence due to the deterioration of our finances in 2014/15, the deficit forecast in 2015/16 and the resultant need for additional financial support.

In response the trust has agreed a series of undertakings with Monitor, which include the submission and implementation of a one-year financial recovery plan in September, a recovery plan for the two years 2015/16 and 2016/17 by November and a strategic plan for the longer term sustainability of the trust by January 2017.

Additional conditions have also been imposed on the Trust's licence, including a requirement to address the governance or operational breaches that have led to the breach of the licence conditions, and to comply with the enforcement undertakings as outlined above.

With the support of KPMG we are making good progress with our turnaround plans, with progress being overseen by the turnaround board and monitored by the finance and performance committee. A report from the finance and performance committee will be provided as part of this meeting.

3. Communications

Response to the 2014 staff survey

The communications team have been supporting the HR and Workforce team on four 'themed' months in response to feedback from the national staff survey. The themed months are designed to improve staff retention rates. The education and development month ran throughout August with career drop in sessions for staff, materials distributed across the trust and newsletter designed to sign post staff to the wide range of education and CPD opportunities available.

Patient information

August has seen a number of areas of progress for patient information. Staff have been advised that we are phasing out the old design and moving to a new, simplified A4 leaflet design which has been developed in consultation with patients and service users. Staff will be able to print nearly all leaflets locally. The key benefit to this is that printing leaflets locally as and when needed ensures that the information we provide to patients is always the most up-to-date and clinically accurate. Costs are also significantly lower and fall in line with our efforts to reduce spend across the trust

Reflection and sharing common experiences - Schwartz Rounds

The trust held its fourth Schwartz round in late July. Over 400 staff attended the Schwartz rounds at the trust. These provide staff with an opportunity to discuss the highs and lows of work in a confidential and expertly facilitated environment. Participants can talk about the emotional and social aspects of their jobs, led by a panel of employees chosen from across the trust. An evaluation of the programme with take place after the six rounds

Media update

Richard Porter, St George's Max Fax consultant features in Jamie Oliver's Sugar Rush on Channel 4 this month. This hour long documentary looks at the impact of sugar on our health. Richard speaks about the role it plays in children's dental decay.

St George's Principle Dietitian, Catherine Collins was interviewed by Channel 5 News about an opinion article that claims calorie counting is not the way to maintain a healthy diet.

BBC 2's Horizon 'OCD: A Monster in my mind' featured brain anatomy lecturer Dr Paul Johns from St George's University. The Horizon team loved working with Paul and have told us that they're planning future features with him.

The Mirror published an article about Derek Campbell, a tree surgeon who had to have both his legs amputated due to a rare strain of meningitis. He underwent rehabilitation at Queen Mary's Hospital. We shared this article on Facebook where is reached nearly 3,500 people and was liked 35 times.

What do we know about men's testosterone cycles? Our consultant endocrinologist Leighton Seal featured on Woman's Hour and Late Night Woman's Hour discussing masculinity and what it means to be a modern day man in 2015.

The Kingston Guardian republished an article that appeared in the Wimbledon Guardian last month. The article looks reports on the death rate at Wandsworth prison, looking at the staffing levels and overcrowding. We gave a statement about the healthcare provided at the prison, but this has not been included.

HIMSS Europe published a YouTube interview with St George's Martin Gray about the trust achieving Level 6 accreditation.

REPORT TO THE TRUST BOARD **Paper ref: TB Sept 15 – 03a**

Paper Title:	Quality and performance Report to the Board for Month 4- July 2015
Sponsoring Director:	Jennie Hall- Chief Nurse/ Director Infection Prevention and Control Simon MacKenzie- Medical Director Martin Wilson: Director of Delivery and Improvement
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Purpose:	To inform the Board about Quality and Operational Performance for Month 4.
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 challenged with performance below required standards in ED 4 hour target, RTT incompletes, cancer waiting time targets and cancelled operations by the hospital for non-clinical reasons.

The trust shows the quality governance score against the Monitor risk assessment framework of 3 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 July Quality Performance:
The Overall position in July does not indicate any key changes from the Quarter One position in terms of the trends for the metrics with some moderate improvement across a number of indicators. Serious Incident numbers remain an area of focus in relation to themes seen and actions being taken. This is monitored through the Patient Safety Committee and SIDM.

Effectiveness Domain:

- Mortality and SHMI performance remains statistically better than expected for the Trust. Despite this position we continue to proactively investigate mortality signals at procedure and diagnosis level.
- Information from the PRISM 2 study has recently been published. This was a study where case notes from 2400 deaths across the NHS were reviewed to understand the prevalence of avoidable deaths. Data from PRISM 2 and PRISM 1 was used and the degree of association between avoidable deaths and HSMR/ SHMI was sought but found to be weak and not significant. The report authors have also been working with NHS

England on the design of a national hospital mortality review programme. This is likely to have two parts: a local element in which a standardised approach will be encouraged to enable Trusts to identify local problems and guide quality improvement initiatives; and a national element which provides an estimate of the proportion of hospital avoidable deaths in England based on several reviewers considering a large random sample of case records drawn from acute Trusts across the country.

- The results of the review of 100 cases from St George's was shared with us in conjunction with the BMJ publication. We were pleased to be one of only 2 trusts that had no avoidable mortality identified in this selected group. It is positive to note that for 88.5% of our cases where there were no problems with care (n=96) that the overall quality of care was rated as excellent or good. No patients in this group were found to have poor care. There was a finding that the quality of our medical records was adequate to make a reasonable judgement in only 81.1% of cases, compared to 90.3% nationally is a concern and contributes to the drive for improved documentation, including discharge documentation.
- In July we received notification from the CQC of the two outlier alerts that had been raised by the Dr Foster Unit at Imperial in June. We are required to investigate 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'. The review for the pacemaker group has been concluded and found no key areas of concern; the review for the other group is to be concluded in August.
- Several National Audits are within the report. The stroke sentinel audit continues to show the audit impact where patients experience any delay in access to the HASU within 4 hours. Actions being taken are outlined in the paper.
- In relation to locals audits of note the End of Life Care Home Service audit demonstrated an improved position for patients who are referred to the palliative care team, in terms of their discharge arrangements. Importantly for families and patients this support patients going to their preferred place of care at this difficult time. The median time for discharge is 4 days, in response to this the Palliative care team are working more closely with the discharge coordinators to support early discharge.
- 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 July 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 July the Board will note the issues are across a range of clinical issues, some are mandatory in terms of reporting.
- Safety Thermometer performance increased slightly from June performance remaining above the national average. There was again 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 July mirrored that of June with a single grade 3 ulcer reported but with a slight increase in grade 2 ulcers. Of note progress within the community Division who for the third month have reported no serious grade 3 or 4 pressure ulcers.
- The Trust has now reported 2 MRSA bacteraemia cases and 12 C-Difficile to the end of July. 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 Children's data is presented this month following a review of the database. The Trust is now demonstrating a compliance of 79% for level 3 training which is a stronger performance than previously reported. The board will note that the numbers of staff to be trained is known and there are agreed actions both for adult and Children's safeguarding which are being monitored by the respective safeguarding Committees.

Experience Domain:

- The response rate for FFT improved slightly with but response rates for inpatient wards decreased. The overall score for the Trust decreased marginally in July to a score of 94.6% from 94.9%. Themes arising from the FFT responses include noise at night, information about medication side effects and involvement in discharge processes. A snapshot of information that is available on rate has also been included to demonstrate how the focus on FFT is now moving towards triangulation of patient feedback and development of themes from the feedback.
- The complaints profile in relation to numbers has increased slightly in terms of numbers. Areas where complaints increased were largely within the Community Division (Adult Health Services and Offender healthcare). Information is provided regarding actions being taken in the Divisions in response to the themes from complaints in Quarter 1.
- In relation to turnaround times of complaints a decline was seen in June with 1 clinical Division (Community) achieving the target for the Quarter. The Surgical Division has also demonstrated significant progress in Q1. Actions being undertaken by the other 2 clinical Divisions were previously reported to the Board last month.

Well Led Domain:

- The safe staffing return is included for all inpatient areas. The average fill rate for the Trust is 94.93 % 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.

Ward Heat map:

The Heat map for July 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

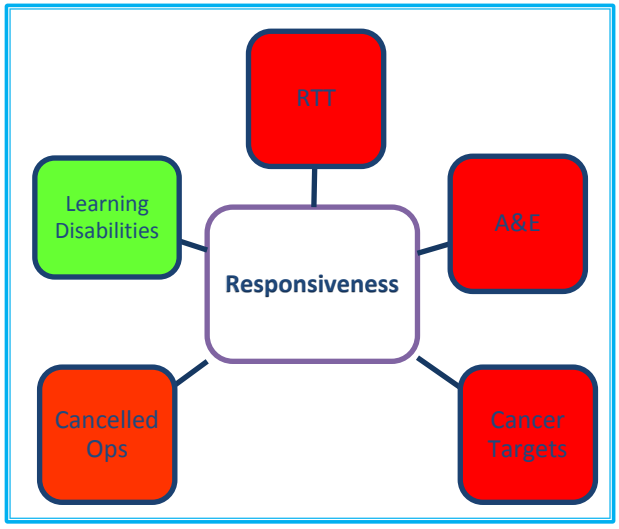
to the Finance and Performance Committee

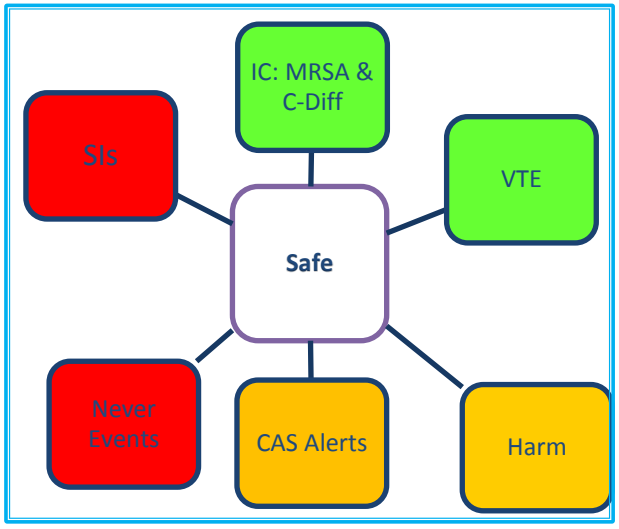
Month 4 - July 2015

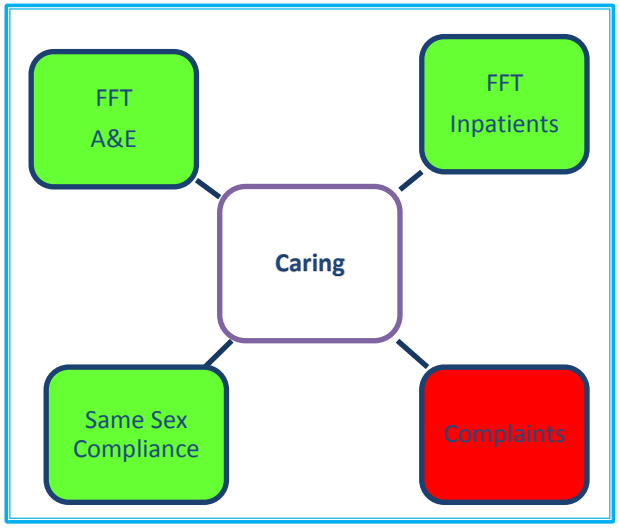
Excellence in specialist and community healthcare

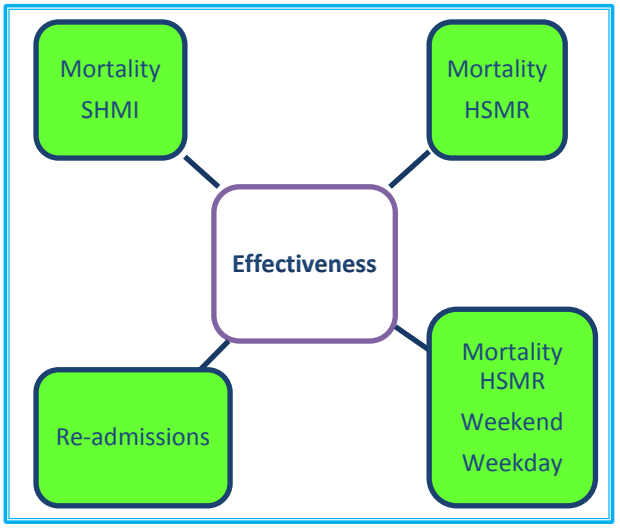
CONTENTS

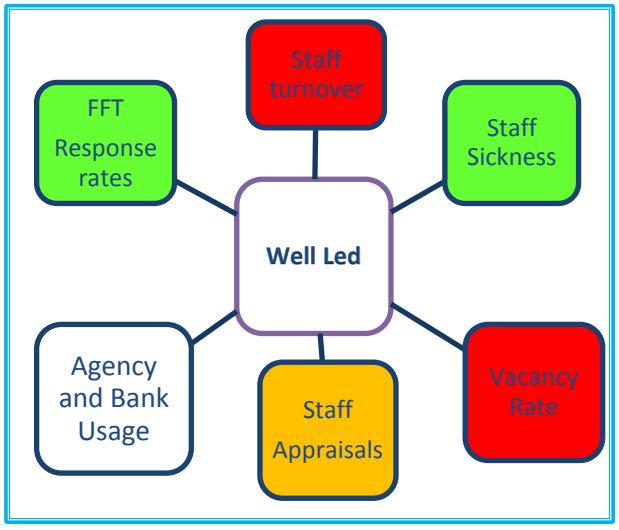
1. Executive Summary - Key Priority Areas July 2015*











The above shows an overview of July 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 June 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

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

Access							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**June**	**July**	**Movement**
Referral to Treatment Admitted	90%	0	N/A		85.6%	85.3%	➤
Referral to Treatment Non Admitted	95%	0	N/A		95.3%	95.2%	➤
Referral to Treatment Incomplete	92%	1	1		92.38%	90.62%	➘
A&E All Types Monthly Performance	95%	1	1	92.34%	91.75%	91.88%	➚
				YTD	**Q4**	**Q1**	
62 Day Standard	85%	1	1	79.7%	82.5%	79.7%	➘
62 Day Screening Standard	90%			83.4%	87.5%	83.4%	➘
31 Day Subsequent Drug Standard	98%	1	0	100%	100.0%	100.0%	➤
31 Day Subsequent Surgery Standard	94%		0	95%	97.6%	95%	➘
31 Day Standard	96%	1	0	97.3%	96.9%	97.3%	➚
Two Week Wait Standard	93%	1	1	92.5%	96.8%	92.4%	➘
Breast Symptom Two Week Wait Standard	93%	1		89.5%	97.7%	89.5%	➘

* NYA Not yet available

Outcomes							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**June**	**July**	**Movement**
Clostridium (C.) difficile – meeting the C. difficile objective (de minimis of 12 applies)	31	1	0	11	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**	➤

July 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.)

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Areas of underperformance for quality governance are:

- A&E 4 Hour Standard
- Cancer Waits
- Diagnostic Waits > 6weeks
- Cancelled Operations
- RTT

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: July 15 Performance (Page 1 of 1)

Responsiveness Domain					
Metric	Standard	YTD	June	July	Movement
Referral to Treatment Admitted	90%		85.6%	85.3%	➤
Referral to Treatment Non Admitted	95%		95.3%	95.2%	➤
Referral to Treatment Incomplete	92%		92.38%	90.62%	⮟
Referral to Treatment Incomplete 52+ Week Waiters	0		0	3	⮝
Diagnostic waiting times > 6 weeks	1%		1.44%	1.69%	⮝
A&E All Types Monthly Performance	95%	92.87%	91.75%	91.88%	⮝
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%	16.8%	19.2%	11.1%	⮟
Certification against compliance with requirements regarding access to health care for people with a learning disability	Compliant	Yes	Yes	Yes	➤
	Standard	YTD	May	June	Movement
Two Week Wait Standard	93%	92.4%	93.0%	91.7%	⮟
Breast Symptom Two Week Wait Standard	93%	89.5%	91.6%	98.4%	⮝
31 Day Standard	96%	97.3%	96.8%	98.4%	⮝
31 Day Subsequent Drug Standard	98%	100%	100%	100%	➤
31 Day Subsequent Surgery Standard	94%	95.0%	88.0%	100%	⮝
62 Day Standard	85%	79.4%	72.5%	79.2%	⮝
62 Day Screening Standard	90%	83.4%	72.7%	87.5%	⮝

Safe Domain					
Metric	Standard	YTD	June	July	Movement
Clostridium Difficile - Variance from plan	31	11	+1	+1	➤
MRSA bacteraemia	0	2	0	0	➤
Never events	0	4	1	1	➤
Serious Incidents		62	16	9	⮟
Percentage of Harm Free Care	95%		94.56	95,25%	⮝
Medication errors causing serious harm	0	2	0	0	➤
Overdue CAS alerts	0	2	2	2	➤
Maternal deaths	1	2	0	0	➤
VTE Risk Assessment (previous months data)*	95%		96.75%		⮟

Effectiveness Domain					
Metric	Standard	YTD	June	July	Movement
Hospital Standardised Mortality Ratio (DFI)	100		88.2	87.2	⮟
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		89	89	➤
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	5%	3.11%	2.19%	2.20%	⮝

Caring Domain					
Metric	Standard	YTD	June	July	Movement
Inpatient Scores from Friends and Family Test	60		93.7	94.0	⮝
A&E Scores from Friends and Family Test	46		83	85.8	⮝
Complaints			84	83	⮟
Mixed Sex Accommodation Breaches	0	0	0	0	➤

Well Led Domain					
Metric	Standard	YTD	June	July	Movement
IP response rate from Friends and Family Test	30%		49.9%	43.8%	⮟
A&E response rate from Friends and Family Test	20%		27%	33.2%	⮝
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%		17.3%	17.4%	⮝
Trust level total sickness rate	3.50%		3.6%	3.4%	⮟
Total Trust vacancy rate	11%		14.2%	14.3%	⮝
Percentage of staff with annual appraisal – Medical	85%		87.1%	85.2%	⮟
Percentage of staff with annual appraisal - non-medical	85%		74.5%	74.6%	⮝

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 8)
- A&E: 4 Hour Standard

Total time in A&E - 95% of patients should be seen within 4hrs							
Lead Director	June	July	Movement	2015/2016 Target	Board Reported Forecast Jul- 15	Forecast for Aug - 15	Date expected to meet standard
FA	91.75%	91.88%	▲	>= 95%	R	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%

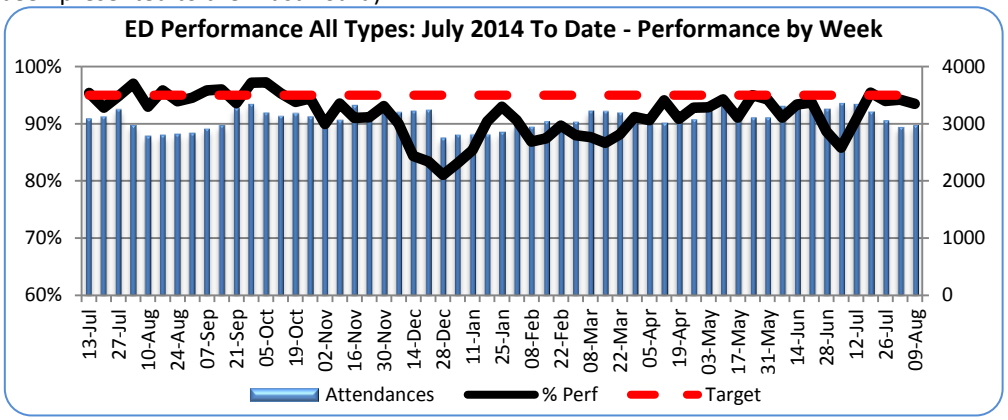
The ED target is that 95% or more of patients should be seen and discharged within 4 hours of attending the Emergency Department. Performance remains challenged with performance below that target at both the weekly and monthly level. In July 91.88% of patients were seen within 4 hours, this is a slight increase on June's performance of 91.75% . The trust al also below the target YTD with performance of 92.34%

. 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+.
- Increase in breaches for patients awaiting a specialist opinion.
- 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 14/08/2015 there were 9 delayed transfer of care patients within the hospital accounting to 112 bed days lost due to delays. In addition to this there were also 20 NDTOC (pending delays) patients within the organisation, of which 6 were due to social reasons and 14 due to health reasons/ required homecare packages.

As at 14/08/2015 there were 77 of 513 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.

The trust continues to implements action plans to recover performance as part of the Joint Investigation outcomes with commissioners. The are being reviewed monthly via the Joint Investigation 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 has been presented to the Trust Board)



Performance Overview by Type			
	ED (Type 1)	MIU (Type 3)	ED & MIU (Type 1+3)
Month to Date (July)	*90.98%*	*99.94%*	*91.88%*
Quarter to Date	*90.98%*	*99.94%*	*91.88%*
Year to Date	*91.53%*	*99.49%*	*92.34%*

3. Performance Areas of Escalation (Page 2 of 8)
- RTT Incomplete 52+ Week Waiters

Referral to Treatment Incomplete 52+ Week Waiters							
Lead Director	June	July	Movement	2015/2016 Target	Board Reported Forecast Jul- 15	Forecast for Aug - 15	Date expected to meet standard
SB	0	2	▲	0	N/A	R	Aug-15

Specialty	Patient Type	Date for patient to be treated	Commentary
General Surgery	IP	13/08/2015	This patient was transferred late to the trust from CUH. Patient had pre-op assessment scheduled for 31/07/2015 which they attended, and date for their procedure of 13/08/2015. At the time of writing it can be confirmed that the patient attended and had their procedure and has now been discharged.
Urology	IP	02/09/2015	The patient has been contacted about the delays in booking their treatment. An appointment for pre-operative assessment has been agreed and scheduled for 25/08/2015, with a subsequent date for surgery of 02/09/2015.
Gynae	IP	26/08/2015	This patient has been on a complex diagnostic pathway. The patient was admitted on 20/05/2015 for a diagnostic Laparoscopy , which was initially considered to potentially treat the patient. A subsequent follow-up was arranged for 29/06/2015 which the patient attended and a decision for surgery made. The patient was then scheduled for treatment in August. The patient has attended a pre-operative assessment appointment on 18/08/2015 and is due to have surgery on 26/08/2015.

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

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

3. Performance Areas of Escalation (Page 3 of 8) - RTT Incomplete Pathways

Referral to Treatment Incomplete Pathways						
Lead Director	June	July	Movement	2014/2015 Target	Forecast Aug – 15	Date expected to meet standard
SB	92.38%	90.62%	↘	92%	R	TBC

The trust has not achieved the 92% target for incomplete pathways in July with performance of 90.62%. The Trust was in a period of Joint Investigation with commissioners in Q1 and an Elective Pathway action plan to drive performance improvement and waiting list sustainability has been agreed.

Key areas of focus include:

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

The trust has provisionally modelled future incomplete performance which details the challenge in delivering performance to target for 2015/16. To support this the trust has also provided commissioners with details regarding key internal actions being undertaken to drive performance improvement. This includes:

- Undertaking additional activity in key specialties to reduce backlog.
- Increasing diagnostic capacity in modalities of high demand.
- Undertaking a comprehensive demand and capacity exercise to recognise:
    - the capacity constraints at St George's
    - Any additional activity that can be undertaken to support waiting list sustainability
    - Options for increase in activity to be to be undertaken off-site, through other providers
- A comprehensive programme of validation to improve data quality and accuracy of waiting list.
- Continue to strengthen management focus on 18 week RTT delivery within specialties, divisions and the trust as a whole.
- Hold specialty RTT summits with commissioners for challenged specialties as part of joint investigation and seek to get CCG support for drivers to reduce backlog and improve performance.

As part of the Joint Investigation governance arrangements, the trust has monthly meetings with commissioners to review delivery of the action plan, areas for escalation and performance improvement. To further support this and following from the Joint Investigation a RTT subgroup has been created with commissioners to pro-actively discuss and jointly drive RTT performance improvement.

3. Performance Areas of Escalation (Page 4 of 8) - Cancer Performance

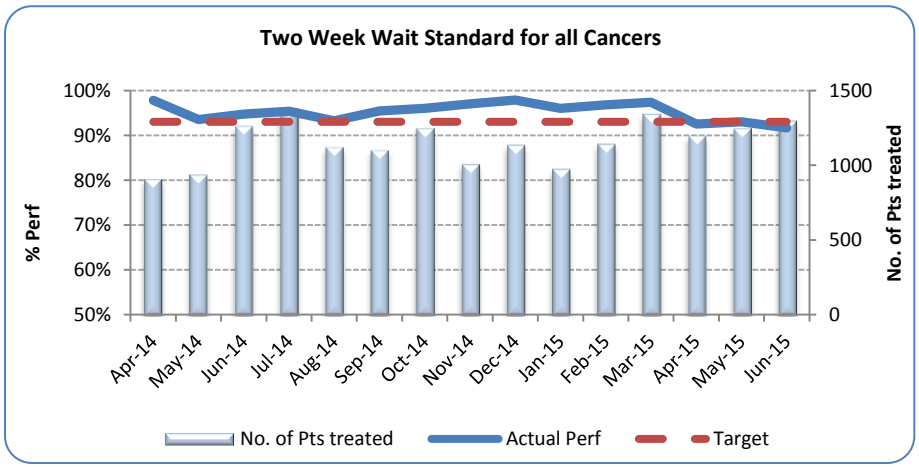
Cancer Performance							
Lead Director – CC	May	June	Movement	2015/2016 Target	Board Reported Forecast June- 15	Forecast for July - 15	Date expected to meet standard
14 Day GP Referral for all Suspected Cancers	93.0%	91.7%	▼	93%	G	R	Aug -15
62 Day Wait Standard	72.5%	79.2%	▲	85%	R	R	Aug – 15
62 Day Screening Standard	72.7%	87.5%	▲	90%	G	A	July -15

Peer Performance Latest Published Quarter 1 2015-2016				
STG	Croydon	Kingston	King's College	Epsom & St Helier
92.38 %	94.58 %	93.53%	96.97%	95.35%
79.7%	80.4%	86.08%	84.2%	74.87%
82.1%	75.0%	94.12%	96.15%	50.0%

The trust was non compliant against three of the national cancer wait targets for the month of June as detailed in the table above. In response to the recent underperformance in Q1, escalation actions including fortnightly escalation meetings continue as directed by the the Executive Director of Delivery. Continued areas of focus include:

- 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.

A trust cancer performance improvement action plan has been developed and is being reviewed at the escalation meetings. This forms part of the national work being undertaken by NHS England and the request for trusts to submit improvement action plans for the 62 day target by 22nd August.

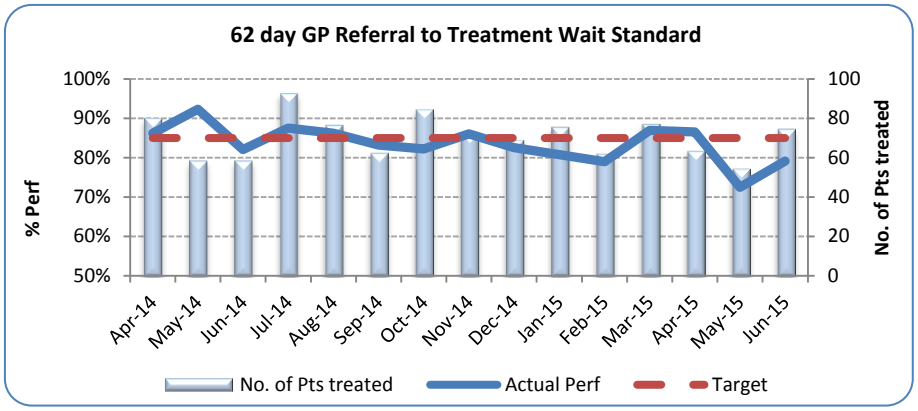


Two Week Wait Standard - Non-achievement of this target relates to 108 breaches which is unfortunately higher than the average number of breaches of 89 seen in the previous two months of Q1. Modalities of breach include: Breast, Gynae, Skin and Upper GI.

Key issues affecting performance in Q1:

- patient choice
- Capacity in particular in relation to Gynae. Capacity is currently being reviewed to ensure for future performance sustainability and the following actions are also being undertaken:
- Recruitment of additional outpatient nursing staff to ensure additional clinics requested for 15/16 are consistently staffed.
- 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 5 of 8)
- Cancer Performance



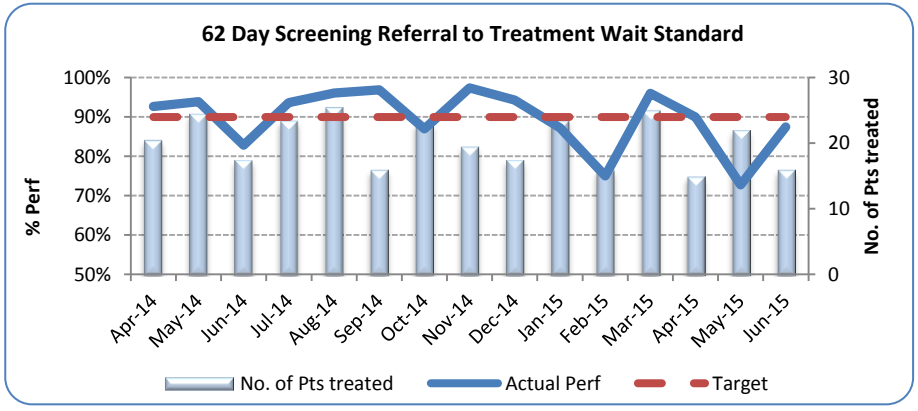
62 day GP Referral to Treatment Wait Standard - Non-achievement of this target relates to 26 patients breaching of which 21 were on a shared pathway. Unfortunately this is higher than the average number of breaches in previous months. SGH performance excluding shared patient would have been 90.9% and within target. Breaches occurred in the modalities of; Lower GI, Upper GI, Lung, and Urology.

This trust has observed some performance improvement in this standard, meeting the target in March and April 2015.

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,.
- Diagnostic 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 3 patients breaching of which 2 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 treatments in June were lower than that of May, thus breaches having a greater impact on performance.

Key issues affecting performance were:

- Late referrals from other trusts
- Capacity constraints within Endoscopy in particular for Colonoscopy.
- Poor tracking of patients breach dates.

Work with endoscopy unit continues to better plan for cancer activity . 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. PTLs structures have been reviewed and they are currently in the process of being enhanced to allow for better tracking and usability.

3. Performance Areas of Escalation (Page 6 of 8)
- Cancer Performance – Q1 by Tumour Type

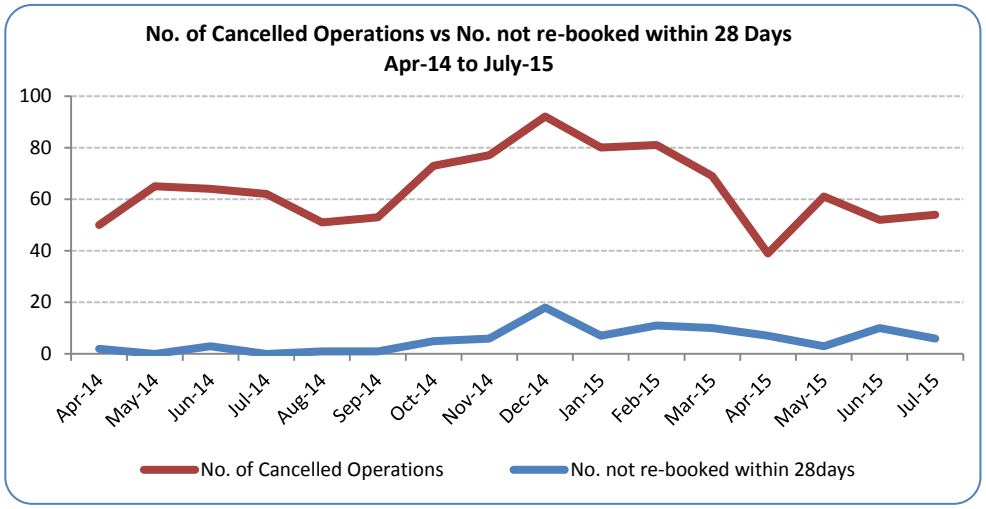
Cancer Indicator	Target	All Types	Breast	Childrens	Gynae	Haem	Head & Neck	Lower GI	Lung	Skin	Upper GI	Urological
14 Day GP Referral for all Suspected Cancers	93%	92.4%	88.8%	100.0%	81.5%	98.5%	96.8%	92.4%	98.1%	93.6%	91.3%	96.1%
14 Day Breast Symptomatic Referral	93%	89.5%	85.6%									
31 Day First Treatment	96%	97.3%	98.2%	100.0%	100.0%	100.0%	97.1%	100.0%	100.0%	92.9%	100.0%	95.3%
31 Day Subsequent Surgery Treatment	94%	95.0%	100.0%				100.0%	100.0%	100.0%	95.5%		100.0%
31 Day Subsequent Drug Treatment	98%	100.0%	100.0%		100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%
62 day GP Referral to Treatment	85%	79.4%	96.9%		80.0%	100.0%	77.8%	57.9%	57.5%	93.1%	73.7%	71.2%
62 Day Screening Referral to Treatment	90%	83.4%	87.7%				100.0%	52.9%				
62 Day Consultant Upgrade to Treatment	85%	100.0%										

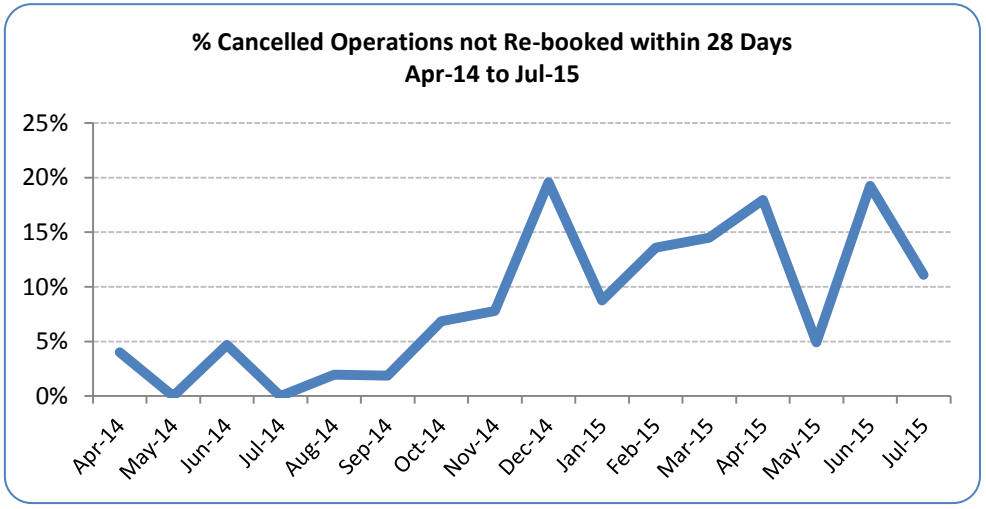
The table above details Q1 2015/16 performance against national cancer targets by tumour type.

3. Performance Areas of Escalation (Page 7 of 8) - Cancelled Operations

Proportion of Cancelled patients not treated within 28 days of last minute cancellation							
Lead Director	June	July	Movement	2015/2016 Target	Board Reported Forecast Jul- 15	Forecast for Aug - 15	Date expected to meet standard
CC	19.2%	11.1%	⮟	0%	G	G	Aug- 15

Peer Performance Comparison – Latest Available Q1 2015/16				
STG	Croydon	Kingston	King's College	Epsom & St Helier
18.7%	2.04%	9.4%	7.6%	0%





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 54 cancelled operations from 4555 elective admissions in July. 48 of those cancellations were rebooked within 28 days with 6 patients not rebooked within 28 days, accounting for 11.1 % of all cancellations. There were 202 operations cancelled in the year to date, with 168 rebooked within 28 days. The overall number of breaches in the year to date is 34.

The breaches were attributable to Cardiac, Cardiothoracic, Vascular and Plastics. Key contributory factors for the cancellations were related to emergency cases taking precedent and insufficient time due to previous complex cases over running and 1 case being postponed.

All 6 patients now have scheduled dates for their operations, with 5 being in August and 1 in September.

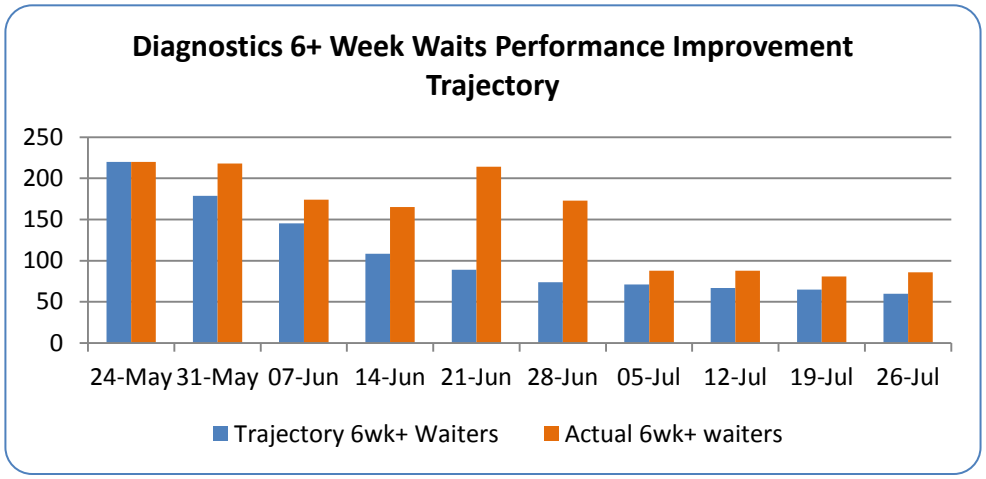
3. Performance Areas of Escalation (Page 8 of 8) - Diagnostic 6+ Weeks Wait

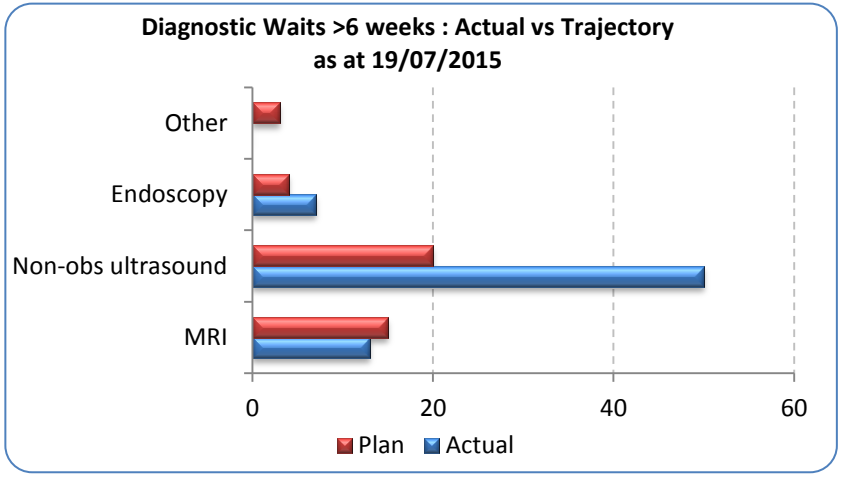
Diagnostic waiting times > 6 weeks							
Lead Director	June	July	Movement	2015/2016 Target	Board Reported Forecast Jul- 15	Forecast for Aug - 15	Date expected to meet standard
SC	1.44%	1.69%	▲	1%	R	R	Aug- 15

No of Patients waiting >6 weeks – Latest Published Data June 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
83	17	38	158	31

The trust has made positive performance improvement with diagnostic waits greater than 6 weeks. The trust is exceeding the target of number of patients waiting greater than 6 weeks of 1% of all waiters with performance at 1.69%. The trust continues to drive actions to further reduce the number of patients waiting in excess of 6 weeks. The pre-dominant modalities of challenge continue from Q1, namely; MRI and Non-obstetric ultrasound.

The trust 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 70 patients waiting greater than 6 weeks against a trajectory of 60, this equates to performance of 1.2% of all diagnostic waiters. However, performance by modality shows that the trust is broadly in line with or ahead of the trajectory against all modalities with the exception of non-obstetric ultrasound.





Further actions continue to be 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. As at 16/08/2015 this has further reduced to 5. 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.
- Increased utilisation of capacity at the Nelson, to actively reduce the backlog within the Community Division.

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: July 15 Performance (Page 1 of 2)

July 2015

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	CANCELLED OPERATIONS RE-BOOKED WITHIN 28 DAYS (DIVISION)	%	0	14.3	5.6	0	11.1
	LAS HANDOVER WITHIN 15 MINS	%					27.6
	LAS HANDOVER WITHIN 30 MINS	%					88.3
	LAS HANDOVER WITHIN 60 MINS	No.					0

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

June 2015

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (BREAST SYMPTOMS) - (DIVISION)	%	0	0	98.4	0	98.4
	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (CANCER) - (DIVISION)	%	0	0	91.7	0	91.7
	31 DAY SECOND OR SUBSEQUENT TREATMENT (DRUGS) - (DIVISION)	%	0	0	100	0	100
	31 DAY SECOND OR SUBSEQUENT TREATMENT (SURGERY) - (DIVISION)	%			100		100
	31 DAY STANDARD FROM DIAGNOSIS TO FIRST TREATMENT - (DIVISION)	%			98.4		98.4
	62 DAY URGENT GP REFERRAL TO TREATMENT FOR ALL CANCERS - (DIVISION)	%			79.2		79.2
	62 DAY URGENT GP REFERRAL TO TREATMENT FROM SCREENING - (DIVISION)	%			87.5		87.5

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

			July 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Outcome Metrics	C-SECTIONS (APPLICABLE TO WOMEN & CHILDREN ONLY)	%				24.2	24.2
	INCIDENCE OF C.DIFFICILE	No.	0	1	1	0	2
	INCIDENCE OF E-COLI	No.	0	1	1	0	2
	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
	MSSA	No.	0	0	0	0	0
	NEVER EVENTS	No.	0	0	0	1	1
	SERIOUS INCIDENTS (DIVISION LEVEL)	No.	0	3	3	3	9
	SHMI	Ratio					0.9
	TRUST ACQUIRED PRESSURE ULCERS	No.	0	0	0	1	1
	TRUST ACQUIRED PRESSURE ULCERS - GRADE 4	No.	0	0	0	0	0
Quality Governance Indicators	PATIENT SATISFACTION (FRIENDS & FAMILY)	%	100	91.2	92.4	91.9	91.8
	PERCENTAGE OF STAFF APPRAISAL (MEDICAL) - (DIVISION)	%	69.6	86.8	88.8	82.6	85.2
	PERCENTAGE OF STAFF APPRAISAL (NON-MEDICAL) - (DIVISION)	%	76	77.8	75.1	73.7	74.6
	SICKNESS/ABSENCE RATE - (DIVISION)	%	4.5	3.2	3.6	3	3.4
	STAFF TURNOVER - (DIVISION)	%	20.1	17.7	14.4	17.5	17.4
	VOLUNTARY STAFF TURNOVER - (DIVISION)	%	15.6	15.3	13	13.6	14.3

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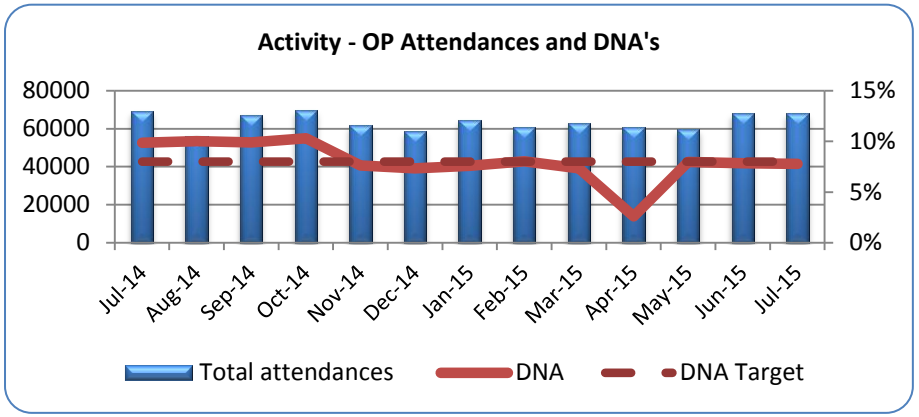
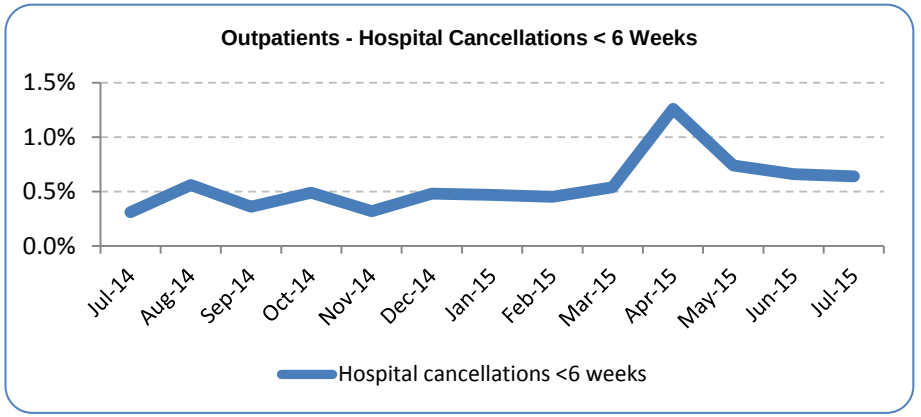
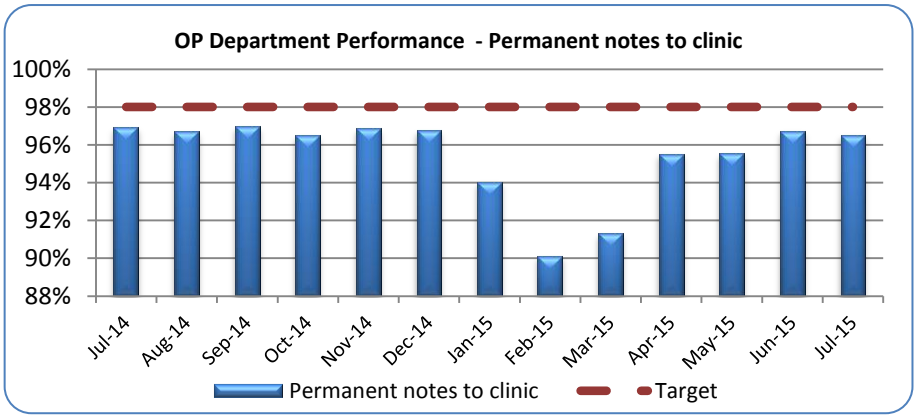
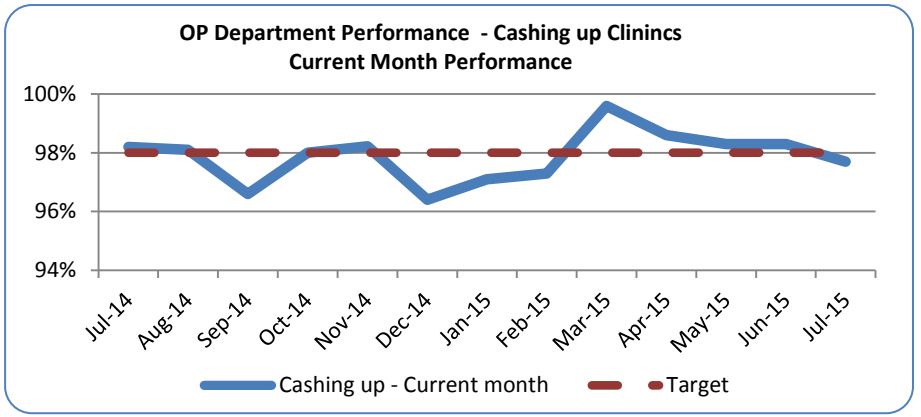
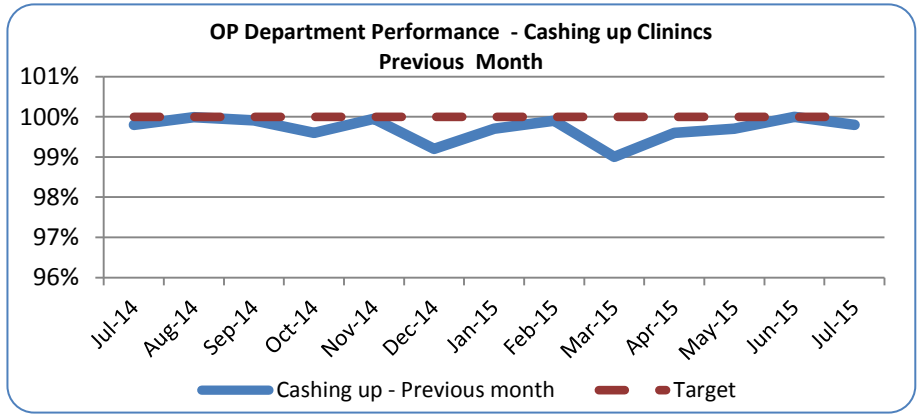
5. Corporate Outpatient Services (1 of 2) - Performance Overview

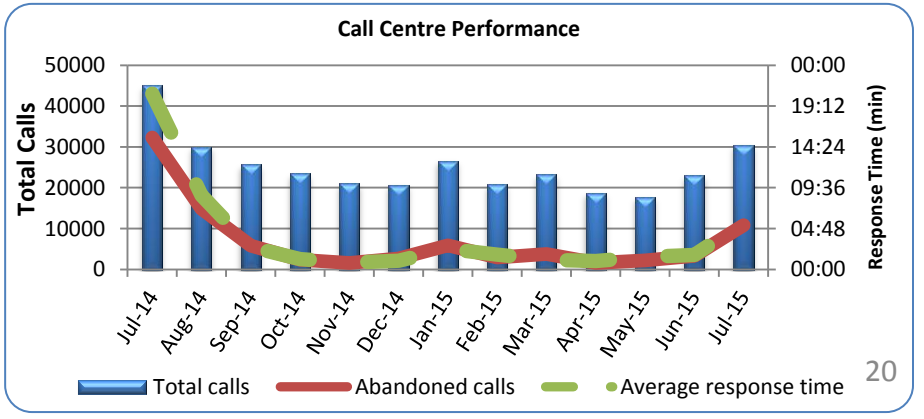












5. Corporate Outpatient Services (2 of 2) - Performance Overview

		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	Jul-15
Activity	Total attendances	N/A	69250	56102	67188	69507	61879	58659	64609	60659	62946	60564	59841	68002	68277
	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%	7.77%
	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%	0.64%
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%	96.54%
	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%	98.30%	98.30%	97.70%
	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%	100.00%	99.80%
Call Centre Performance	Total calls	N/A	45101	30004	25674	23420	20964	20639	26565	20842	23235	18710	17732	22955	30426
	Abandoned calls	<25%/<15%	32257	14825	5794	2376	1558	2681	5923	2908	3782	1551	2237	3309	10828
	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	05:31

Key Messages:

- Increase in activity from June continues to be seen in July in comparison to the average for the last six months. DNAs have marginally reduced and remain within target of less than 8%. Hospital cancellations have seen a gradual reduction in Q1. However, this is still not within target of less than 0.5%. Performance of permanent notes to clinic maintains improvement from last month with performance greater that 96%, however this is still short of the trusts 98% target. This remains a priority area for the service.

- Abandoned calls performance has been maintained remaining less than 15% for all of Q1. However, the level of activity and the number of abandoned calls have significantly increased in July with 10,828 abandoned calls, which accounts for 36% of all calls. Key reasons for this are:
  - Re-instatement of PB1 process from Mid-June which has seen the level of calls significantly rise and has had a subsequent impact on the level of abandoned calls.
  - Technical issues at Trident House, including multiple false fire alarms, networking issues and phones going down had a significant impact on the abandoned call rate. These issues have now been resolved.
  - E-triage roll out during July meant that two systems were being run in parallel (both historic paper process and e-triage process), using the same staff resource which had an impact on performance. E-triage has now been rolled out and the paper process is no longer in effect.
  - Following change of telephone flow options, there are a high number of calls that have been abandoned within 30 seconds. It is thought that this is likely due to patients choosing incorrect options and abandoning the call.
- Correlating to the increase in abandoned calls in July is the increase in average response time to 5min 31 seconds which is in excess of the 1.0minute target. Renewed focus is being placed on this to ensure consistent low response times are achieved.

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Clinical Audit and Effectiveness

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6. Clinical Audit and Effectiveness (Page 1 of 8) - Mortality

HSMR (Hospital standardised mortality ratio)							
Lead Director	May 15	June 15	July 15	Movement	2015/16 Target	Forecast March 16	Date expect to meet standard
SM	88.3	88.2	87.2	↓	<100	G	Met

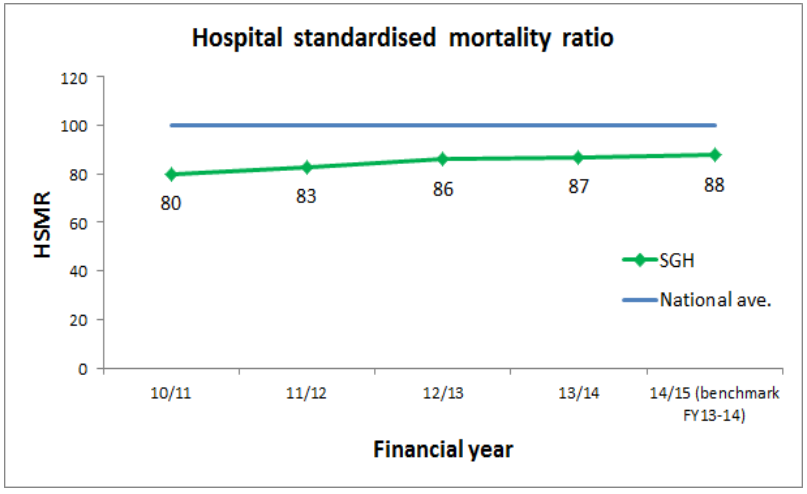
SHMI (Summary hospital-level mortality indicator)				
Jul 2014	Oct 2014	Jan 2015	Apr 2015	Jul 2015
0.80	0.81	0.84	0.86	0.89

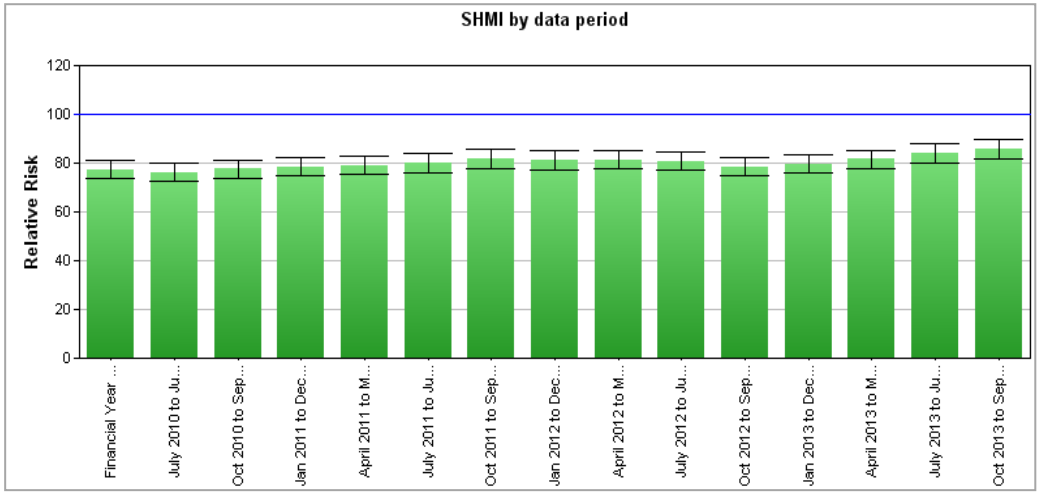
Note: Source for HSMR is Dr Foster Intelligence. Data is most recent 12 months available. For July 15 this was June 2014 to May 2015 , and benchmark period is to March 2014. SHMI data is published by the Health and Social Care Information Centre. The last 12 month period as published on 29th July 2015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

Overview:

Our most recent HSMR, as summarised above continues to be statistically significantly lower than expected compared to hospital trusts nationally and taking into account case mix. Similarly the latest SHMI data published in July identifies St George's as one of 17 trusts whose SHMI is 'lower than expected'. Furthermore, we are one of 9 trusts with lower than expected mortality for two consecutive years and are defined as a 'lower than expected repeat outlier'.

The quarterly data release from the Health and Social Care Information Centre (HSCIC) includes observed and expected deaths by trust, for each of the 140 diagnosis groups that make up the SHMI. For trusts identified as either lower or higher than expected outliers more detailed information for 10 specific diagnosis groups is also provided. Of these, there are 2 groups where our observed deaths are greater than the number expected, namely acute myocardial infarction (ratio 1.22) and gastrointestinal haemorrhage (ratio 1.08). The associated statistical process control charts do not indicate any alerts which require investigation; however, the MMC will considered this information alongside other intelligence such as Dr Foster benchmarking data, to determine if further review of either diagnosis group is required.





6. Clinical Audit and Effectiveness (Page 3 of 8)
- Mortality

PRISM 2: Avoidability of hospital deaths and association with hospital-wide mortality ratios

The PRISM2 study was a retrospective case record review study of 2400 deaths which aimed to determine the prevalence of avoidable hospital deaths and, when combined with PRISM1 (1000 deaths reviewed in 2009), the degree of association between these avoidable deaths and HSMR/SHMI. The findings were published in the BMJ on 15th July. The study found only a weak and non-significant association between Trust avoidable death proportions and their HSMR/SHMI. In addition, there was no improvement on the moderate reliability of reviewers' judgements of avoidable deaths based on case note review found in the original PRISM study. It concluded that neither approach is suitable as a standalone measure of hospital quality, but that local mortality review is an efficient way of identifying healthcare-related problems and a driver for quality improvement.

The report authors have been working with NHS England on the design of a national hospital mortality review programme. This is likely to have two parts: a local element in which a standardised approach will be encouraged to enable Trusts to identify local problems and guide quality improvement initiatives; and a national element which provides an estimate of the proportion of hospital avoidable deaths in England based on several reviewers considering a large random sample of case records drawn from acute Trusts across the country.

Overall quality of care	All PRISM2 cases with no problems in care (n=2174)	St George's cases with no problems in care (n=96)
Excellent	719 (33.4)	44 (45.8)
Good	1079 (50.1)	41 (42.7)
Adequate	324 (15.1)	11 (11.5)
Poor	28 (1.3)	0
Very poor	2 (0.1)	0
Not known	22	0

The results of the review of 100 cases from St George's was shared with us in conjunction with the BMJ publication. We were pleased to be one of only 2 trusts that had no avoidable mortality identified in this selected group. It is positive to note that for 88.5% of our cases where there were no problems with care (n=96) that the overall quality of care was rated as excellent or good. No patients in this group were found to have poor care.

There were 4 cases which were found to have a problem with care; however in no cases was death found to be avoidable. A summary of each of these cases was provided and the conclusions are summarised below:

- Earlier post-operative review may have provided more time for intervention;
- Delay in review, not treated with antibiotics as per protocol, management plan unclear;
- Delay in giving antibiotics and IV fluids, inappropriate administration of IV diuretics.

The remaining case was related to a delay in attendance by the ambulance service and was not attributable to St George's.

There was a finding that the quality of our medical records was adequate to make a reasonable judgement in only 81.1% of cases, compared to 90.3% nationally is a concern and contributes to the drive for improved documentation, including discharge documentation.

6. Clinical Audit and Effectiveness (Page 4 of 8)
- National Audits

Sentinel Stroke National Audit Programme (SSNAP)

Table 1: Overall Performances	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014	Oct-Dec 2014	Jan-Mar 2015	Performance against previous audit round
SSNAP Level	D	B↑↑	A↑	B↓	B	↑
Case Ascertainment (CA)	A↑	A	A	B↓	B	↑
Audit Compliance (AC)	A↑	A	A	A	B↓	↓
Combined Key Indicator (KI) Level	D	B↑↑	A↑	A	A	-

Table 2: Performances for Patient Centred Data	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014	Oct-Dec 2014	Jan-Mar 2015	Performance against previous audit round
D1 - Scanning	B↓	A↑	A	A	A	-
D2 - Stroke Unit	D	C↑	C	D↓	D	↑
D3 - Thrombolysis	C↓	B↑	B	B	B	-
D4 - Specialist Assessments	D	C↑	B↑	C↓	C	↑
D5 - Occupational Therapy	D↓	C↑	A↑↑	A	A	-
D6 - Physiotherapy	D↓	C↑	A↑↑	A	A	-
D7 - Speech and Language Therapy	D↓	B↑↑	B	A↑	A	↓
D8 - Multi-Disciplinary Team Working	C↑	B↑	A↑	B↓	A↑	↑
D9 - Standards by Discharge	B	B	B	B	B	-
D10 - Discharge Processes	B	B	B	A↑	B↓	↓

Table 3: Performances for Team Centred Data	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014	Oct-Dec 2014	Jan-Mar 2015	Performance against previous audit round
Key Indicator Level	D↓	B↑↑	A↑	A	A	-

Colour code of score				
A (90%+)	B (80-89%)	C (70-79%)	D (60-69%)	E (<60%)

Note: the number of arrows represents the extent of change. For example, an increase of 2 levels from D to B would be shown by the symbol - B↑↑

Background: This is the ninth clinical report produced under the auspices of the Sentinel Stroke National Audit Programme (SSNAP). It reports on patients admitted (or having stroke onset as an inpatient) and/or discharged from hospital between 1 January and 31 March 2015.

Aims of SSNAP clinical audit: The SSNAP clinical audit collects a minimum dataset for every stroke patient, including acute care, rehabilitation, 6-month follow-up, and outcome measures in England, Wales and Northern Ireland. The aims of the audit are:

- to benchmark services regionally and nationally.
- to monitor progress against a background of organisational change to stroke services and more generally in the NHS.
- to support clinicians in identifying where improvements are needed, planning for and lobbying for change, and celebrating success.
- to empower patients to ask searching questions.

Overall Performance: The trust scored as a B overall, the same as the previous report. The trust's main challenge is getting patients to the HASU within 4 hours as the unit is operating at full capacity. Repatriation of patients from the HASU is particularly difficult in winter. When patients don't get to the HASU early, this has a knock on effect and other related targets are missed.
Audit compliance decreased this quarter and is attributed to problems with finding clinical notes.

Action Plan:

- Changes have been made to the way bed managers are alerted to ED admissions.
- Work is in progress developing the stroke nurse role in ED.
- More information is being added to iClip to minimise the need for paper notes.
- A 7.15am morning MRI slot had been launched to reduce admissions for MRI.
- Discussions with local hospitals around improving repatriations are on-going.

For full report, please click on the following link:
https://www.strokeaudit.org/Documents/Results/National/JanMar2015/JanMar2015-PublicReport.aspx

6. Clinical Audit and Effectiveness (Page 5 of 8)
- National Audits

British Thoracic Society (BTS) Pleural procedures audit 2014

The summary report of the BTS National audit of pleural procedures was published in June 2015.

In 2014, SGH submitted organisational data for this project but unfortunately, due to a lack of resources, we were unable to include all eligible cases for the case note audit; however, those that were submitted were included in analysis.

The main findings of the project are summarised in the table below. The comments column compares local performance to the national average. As a result of the audit the BTS have proposed 3 National Improvement Objectives to be achieved by 2016. These are

- Written consent should be taken for greater than 95% chest drains inserted (excluding those placed in an acute emergency)
- Greater than 95% of chest drains should be placed in a dedicated clean area (procedure room), away from the patient bedside.
- Patients with chest drains should be nursed on wards with staff specifically trained in chest drain care, in more than 95% of cases.

We now have a new pleural consultant so this should help facilitate any changes needed in order for SGH to meet these objectives and we should be able to fully contribute to future audits. It is also hoped that this new post will enable management of some of these patients in an out patient setting.

Findings	Comments for SGH cases (n=4)
Procedural practice continues to improve with written consent taken for 62% of procedures and real time image guidance used for 77%, demonstrating the feasibility of change in these areas. Each local department should strive to exceed these national averages (to have written consent rates and real time image guidance in excess of 95%) over the next 12 months.	50% of the procedures audited had written consent. Ultrasound guidance was documented to have been used for 75%
Serious complications, such as organ puncture (1.5%) remain relatively frequent, highlighting the need for written consent and robust thoracic ultrasound training processes.	None of the SGH cases suffered any complications. As recommended, we do have a designated chest drain training and safety lead.
43% drains were placed on a ward at the patient bedside suggesting that local policies should be reviewed to increase use of clean procedure rooms.	All drains were placed at the patients bedside; we do not have a designated procedure room
Median length of in-patient stay was 11 days. Management on non-respiratory wards remains common.	The median LOS for SGH patients was 16.5. Two patients were admitted under general medicine but care transferred to the respiratory team. The others were admitted under the respiratory team.
There remains evidence of inappropriate use of chest drains (ie when drain insertion is not the final and definitive procedure for the patient). For example, 31% of this series had an undiagnosed effusion at the time of drain insertion, when diagnostic and therapeutic aspiration may have been a more appropriate first procedure. 61% of known malignant effusions did not undergo pleurodesis before the drain was removed, thus necessitating further fluid management procedures	50% of cases had an undiagnosed pleural effusion at the time of drain insertion , but it is not known if other procedures were considered. It was not documented that talc slurry was administered prior to drain removal in any of the cases audited.

Table 1: Key findings

6. Clinical Audit and Effectiveness (Page 7 of 8)
- Local audit

End of Life Discharge Home Service Report

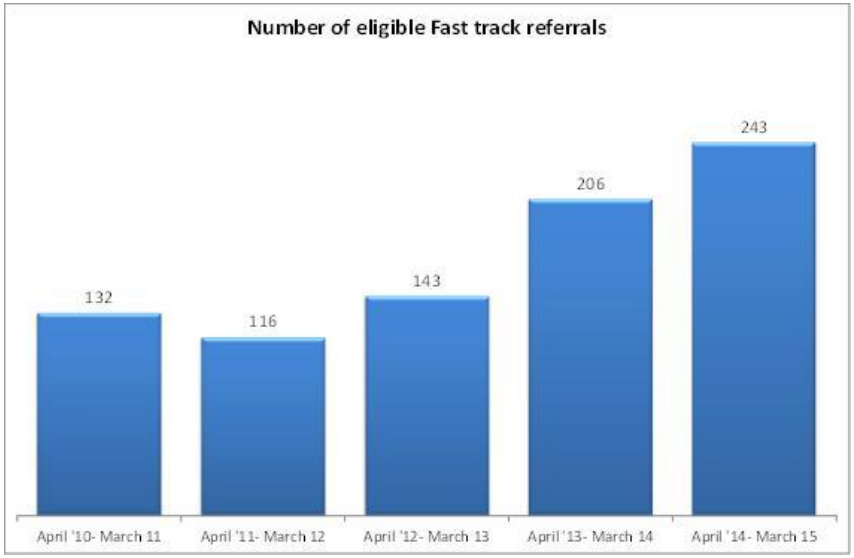


Chart 1: Referrals

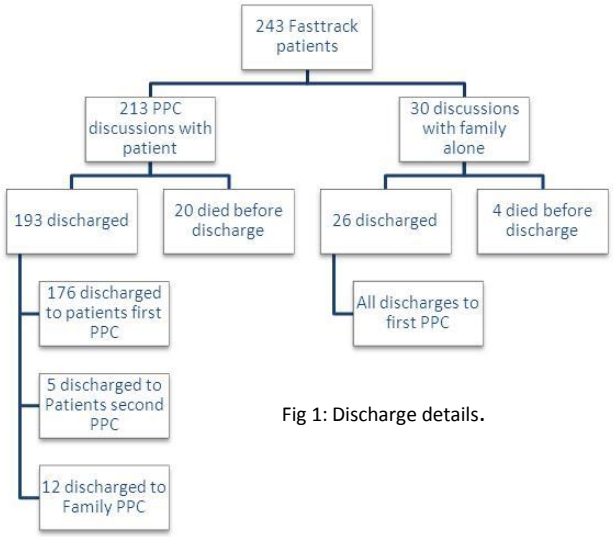


Fig 1: Discharge details.

Overview

The end of life discharge home service was designed by the palliative care team at St. George's University Hospitals NHS Foundation Trust in response to the End of Life Care Strategy (DH, 2008) with the aim of improving discharge from hospital for patients approaching the end of their life. This report provides details of the service during the year April 2014 - March 2015.

Audit Results

Chart 1 alongside, shows that numbers of patients managed under the service have continued to increase. The percentage of patients from outside of the main London areas served by the hospital has also increased and reflects St. George's activity as a tertiary referral centre for a number of specialities, and as a major trauma centre.

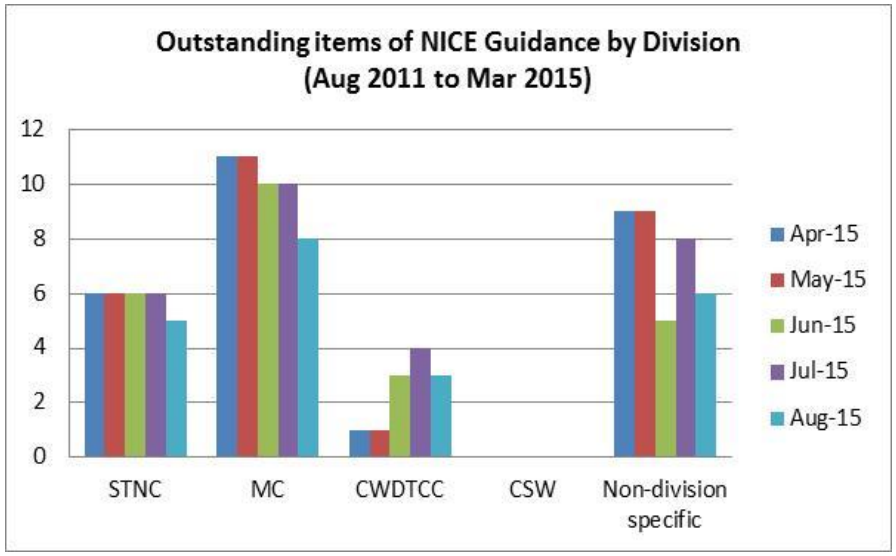
Discharge was arranged for 90% of the patients referred to the service and of these 92% achieved their first choice of PPC. The median time from decision to fast track to discharge was 4 days (weekends excluded) and over 75% of discharges were within 7 days. The main reason for delay was that families wanted time to consider their choice, although there were some system delays e.g. waiting for equipment or care packages.

The PPD was known for 202 (91%) patients (in 2013/14 it was 83%). The actual place of death is known for 179 of these patients and of these,85% achieved their PPD. This figure is a slight improvement on 2013/14 (82%). Of the 26 patients who did not achieve a PPD, half died prior to discharge, the remaining patients had been discharged to a PPC but were later transferred .

Conclusion and future actions

The end of life discharge service has demonstrated an increased demand in the year 2014/15, and achieved a high number of patients discharged to their PPC/PPD. The palliative care team are now working more closely with the ward discharge coordinators and there are proposed changes to the hospital discharge team that should help fast track patients. Additionally, the team are trialling a system of one CNS focusing just on fast tracks for a week at a time to provide better continuity.

6. Clinical Audit and Effectiveness (Page 8 of 8)
- NICE (National Institute of Health and Social Care Excellence) Guidance



Items of NICE Guidance with Compliance Issues (Jun 2010 to Feb 2015)

Division	2010	2011	2012	2013	2014	2015
STNC (n=7)		n=1	n=2	n=1	n=3	
M+C (n=12)	n=2	n=2	n=4	n=1	n=3	
CWDTCC (n=15)	n=3	n=1	n=1	n=3	n=6	n=1
CSW (n=0)						
Non-division specific (n=7)		n=2		n=4	n=1	

Overview

There were 32 items of NICE guidance released in February and March 2015 and we have already received 29 responses, demonstrating increased engagement. Due to the election there was no guidance released in April and May. We are currently contacting the leads for the guidance from June and July and will include these details in the next report.

Last month the audit team contacted leads for all outstanding items of NICE guidance between August 2011 and March 2015 (n=28) to ascertain compliance; only six responses were received. This means there are currently 22 items of guidance outstanding for this period. Those items which have been outstanding for a long time have now been escalated to the divisional chairs for action.

The audit team performed the six-monthly review of all guidance with compliance issues in June (n=45). We have received updates for 19 items of guidance of which two had achieved full compliance. The compliance issues remained the same for most of the responses received; however we had asked the leads to perform a risk assessment and to provide a risk score in order to better understand the risks associated with partial/non compliance. Risk scores were reported for 53% (9/17) items of guidance with compliance issues. Of these, 1 had extreme risk, 2 had high risk, 3 had moderate risk and 3 had low risk. The divisional compliance reports were updated with this information and circulated to the DDNGs for discussion in DGB meetings and the audit team has requested a response from the division following the discussion.

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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	Comm unity	Children's and Womens	Corporate
April	14	3	**1**	0	0
May	11 **including 1 never**	3	**1**	2	1
June	6	3	**2**	5	0
July	3 (1 shared)	3 (1 shared)	**0**	3 (including 1 never)	1 in Pathology

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

Table 1

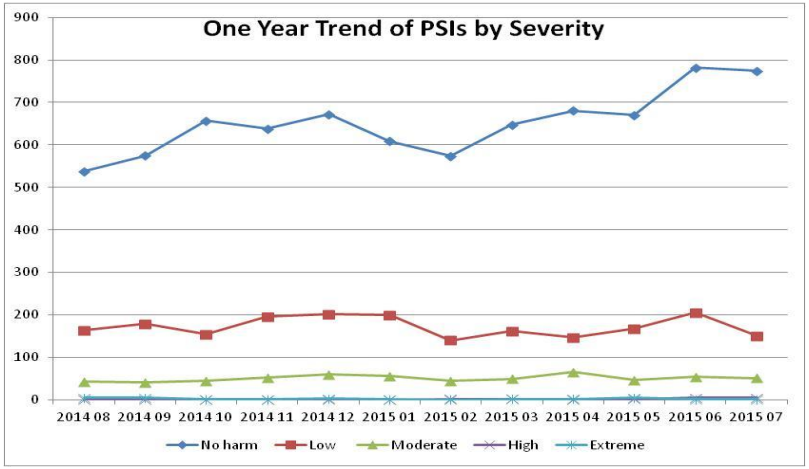
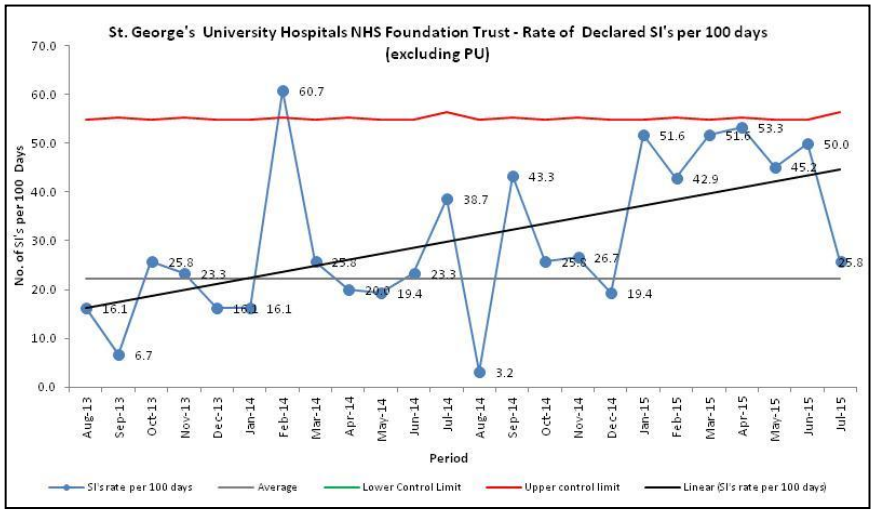


Table 2



Overview:

The numbers of general reported incidents are shown in Table 1. The number of no harm incidents is 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

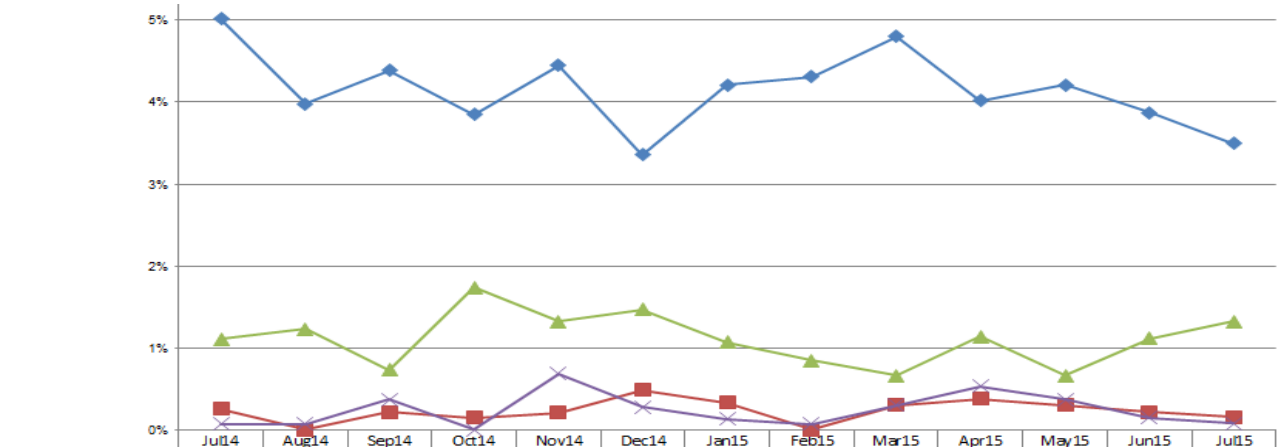
The annual trend for new serious incidents excluding pressure ulcers shown in Table 2 continues to show an increase although 9 SIs in total for a month is the lowest figure since June 2014. There were 8 general SIs reported in June(+1 pressure ulcers).

The 8 general SIs declared in July relate to a range of issues. They include:

- A maternity post partum haemorrhage
- A delay to operate on a patient with a fractured neck of femur due to delays to diagnose and lack of theatre availability
- 3 Patient falls
- Loss of a batch of diagnostic samples
- Length of wait for an appointment
- A misplaced naso-gastric tube

7. Patient Safety (Page x of x)
- Safety Thermometer

% Harm Free Care							
Lead Director	May 2015	June 2015	July 2015	**Movement**	**2015/2016 Target**	**National Average July 2015**	**Date expected to meet standard**
J Hall	94.61%	94.56%	95.25%	↑	95.00%	94.1%	March 16



	Jul14	Aug14	Sep14	Oct14	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15
Pressure Ulcers	5.02	3.98	4.39	3.85	4.45	3.36	4.21	4.31	4.8	4.02	4.21	3.87	3.5
Falls	0.26	0	0.22	0.15	0.21	0.49	0.33	0	0.3	0.38	0.3	0.22	0.16
Catheter & UTI	1.11	1.23	0.73	1.74	1.32	1.47	1.07	0.85	0.66	1.14	0.66	1.12	1.32
New VTE	0.07	0.07	0.37	0	0.69	0.28	0.13	0.07	0.3	0.53	0.37	0.15	0.08
Patients	1533	1458	1368	1377	1439	1429	1495	1415	1355	1320	1354	1343	1285

Pressure ulcers (45)

- 19 grade 2 (9 new, 10 old)
- 21 grade 3 (5 new, 16 old)
- 5 grade 4 (0 new, 5 old)

CAUTI (17)

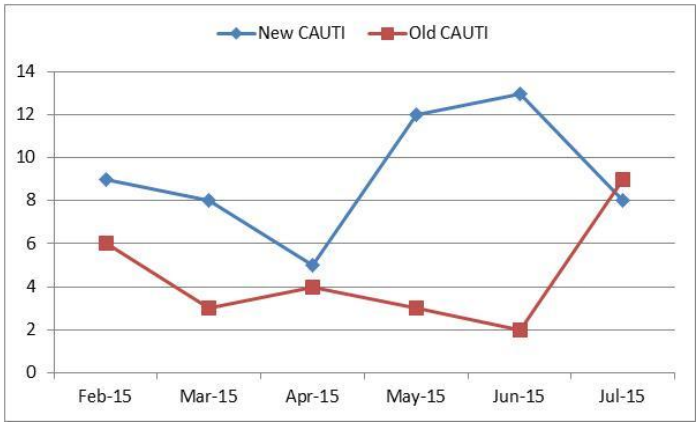
- 8 new
- 9 old

Falls (2)

- 2 low harm falls

VTE (1)

- 1 new DVT



In July 2015 the proportion of our patients that received harm free care was 95.25%, which is a slight improvement and just above our target. We reported 65 harms to 61 patients; 57 patients experienced one harm and 4 patients had 2 harms. 25 harms are categorised as new, meaning that they either developed or treatment began whilst under our care.

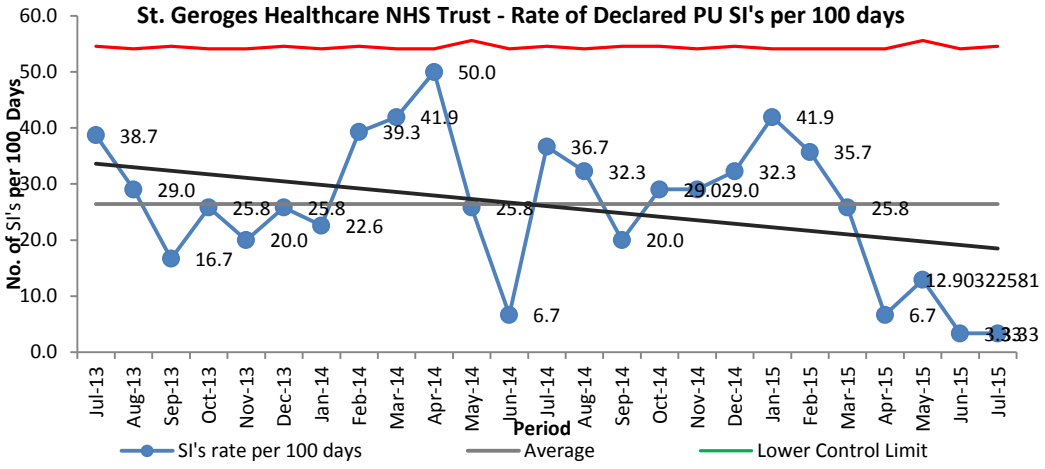
All harms decreased this month, other than catheter associated urinary tract infections (CAUTI) which increased for the second month. Data for the last 6 months shows that the number of new and old CAUTIs varies widely by month. This month there were fewer new CAUTIs observed, but an increase in old infections. This information, along with detailed information on our catheter usage is being used to inform the work being done locally as part of our involvement in the South London Health Innovation Network Safety Collaborative.

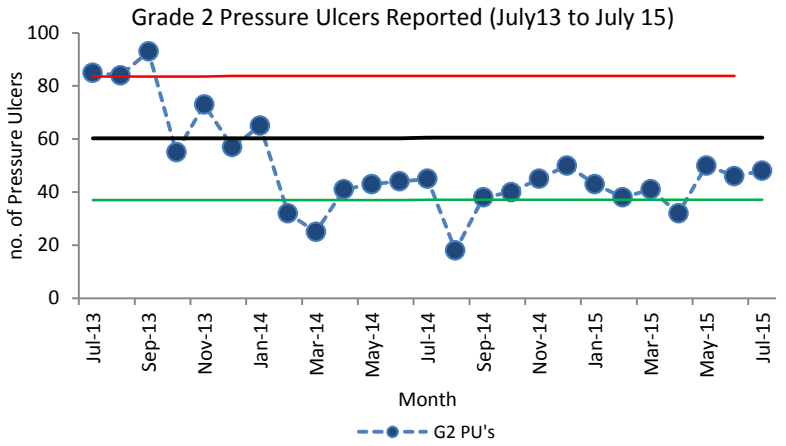
It is encouraging that pressure ulcers have decreased again this month. New PUs fell from 22 in June to 14 in July.

7. Patient Safety
- Incident Profile: Pressure Ulcers

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

Grade 2 Pressure Ulcers						
Mar	Apr	May	Jun	Jul	Movement
30	25	37	28	25	
11	7	17	18	23	
41	32	50	46	48	





Overview:

In July there was no change in the number of avoidable pressure ulcers declared, however the number remains low with only 1 declaration. Community services achieved their 3rd month in a row with no pressure ulcer serious incident declarations. There was an overall rise in the number of Grade 2 pressure ulcers, however a reduction was seen in the acute sector.

Actions:

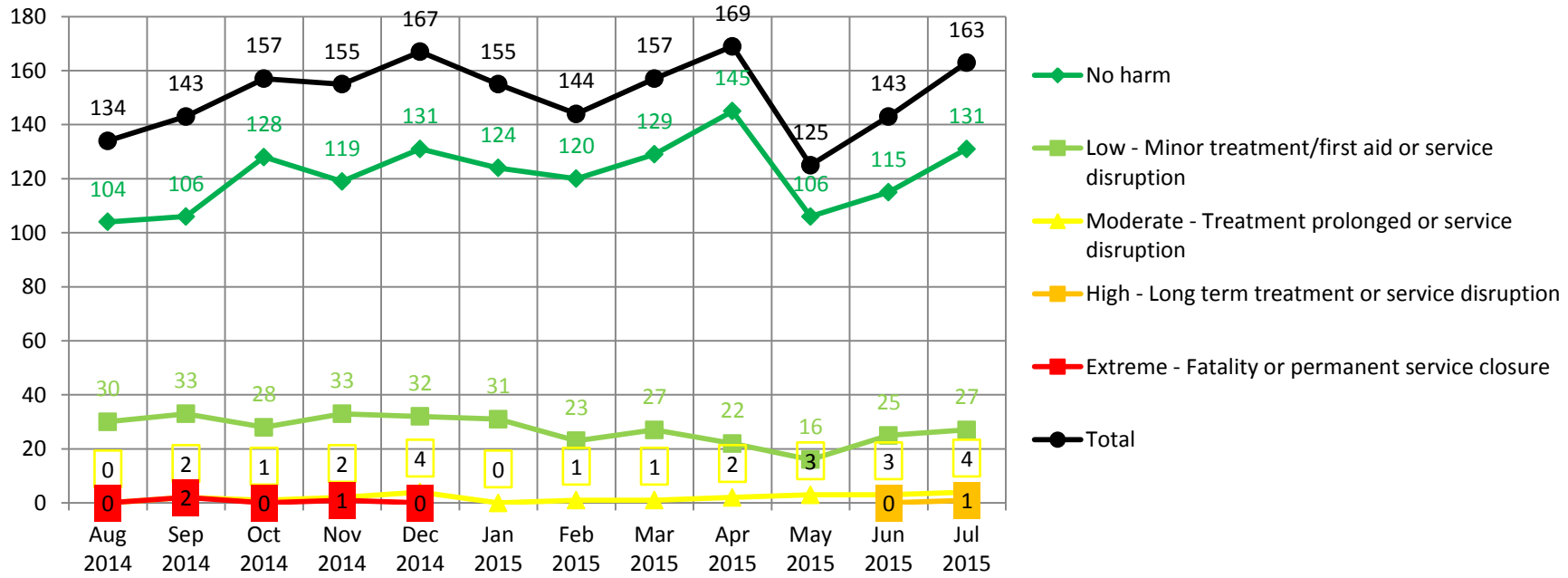
- IHI Improvement programme continues in trial areas, these areas are now beginning to track root causes against incident rates to discover the reasons for pressure ulcer acquisitions.
- 72 Hour review of all new Grade 3 and 4 pressure ulcers being undertaken to give an insight into avoidability.
- Successful 'Show and tell' day on 24th July resulted in identification of 3 mattresses to trial to find a cost effective solution to mattress supply without compromising patient care.
- Recruitment of Band 6 Tissue Viability Support nurse in the acute setting underway .
- Working closely with community teams to integrate services

7. Patient Safety: Incident Profile: Falls

Falls																	
Lead Director	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	August	Movement	2014/2015 Target	Date expected to meet standard
	151	151	125	143	157	154	169	154	144	157	165	126	144	163	↑	100	July 2015

Falls with Harm April 2014- to date				
No Harm	Moderate	Severe	Death	Falls related Fractures
2330	29	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 an increase in falls incidence in the last 2 months- mainly within acute medicine. There has been an increase in the number of neuro-rehab beds at QMH which my also have some impact. **Actions:** Deep dive in AMU and linked ward Caesar Hawkins to identify local action plan. We will be auditing bed rail risk assessment compliance.

7. Patient Safety:
- Infection Control

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

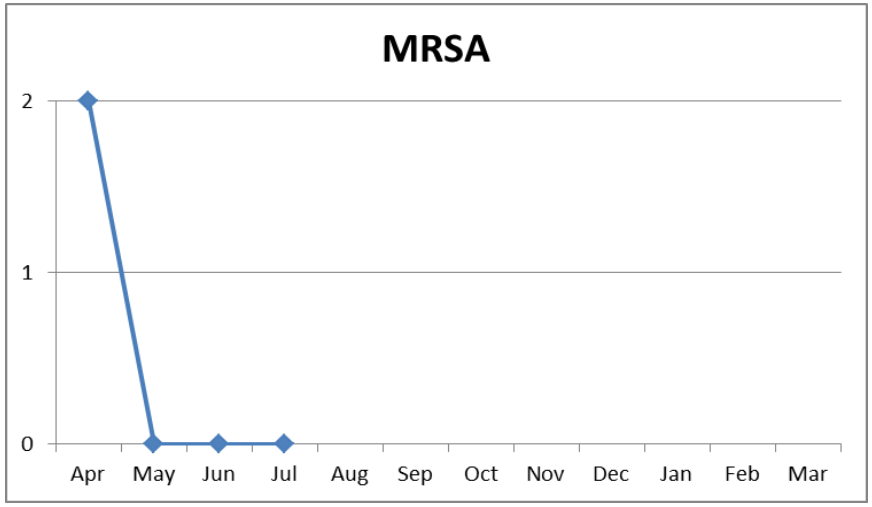
Peer Performance – YTD July 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
2	1	0	0	1

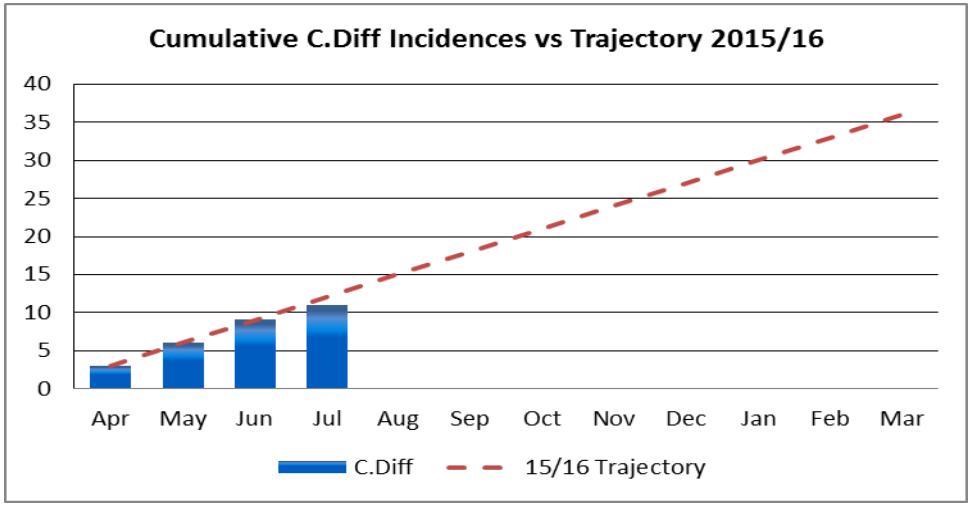
C-Diff						
Lead Director	June	July	Movement	2015/2016 Threshold	Forecast July - 15	Date expected to meet standard
JH	3	2	>	31	R	-

Peer Performance – YTD July 2015 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
11 (31)	10 (16)	8 (9)	33 (72)	8(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.

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 12 for the FY to end July. 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	Aug	Sept	Oct	Nov	Dec	Jan (2015)	Feb	Mar	April	May	June	July
Unify2	96.60%	96.84%	94.91%	93.18%	93.51%	95.94%	96.03%	96.27%	96.64%	96.45%	96.75%	

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	Aug	Sept	Oct	Nov	Dec	Jan (2015)	Feb	Mar	April	May	June	July
Safety Thermometer (SGH)	86.51%	86.44%	85.39%	86.56%	75.92%	79.08%	83.89%	85.74%	89.83%	90.19%	95.14%	94.84%
National average	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)

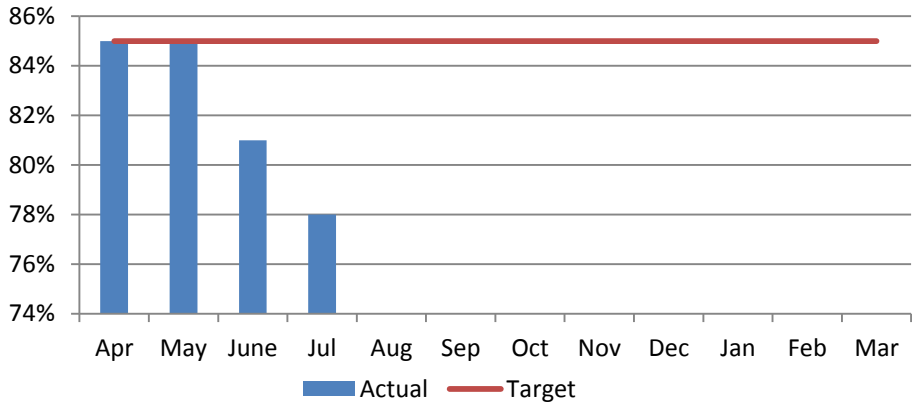
Year		2015
HAT cases identified to date (attributable to admission at SGH)		114
Mortality rate	Total	10.5% (12/114)
	VTE primary cause of death	5.25% (6/114)
Initiation of RCA process		100%
RCA pending	<28 days since notification	15
	>28 days since notification (notes requested)	8
RCA complete		78.1% (89/114)

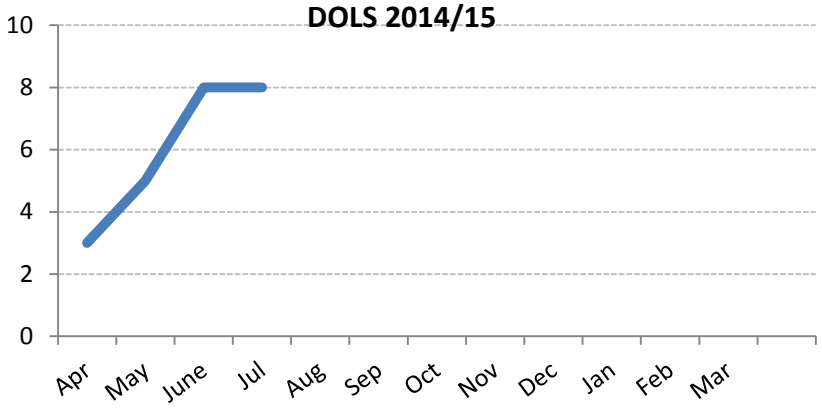
HAT case finding has significantly improved since the start of 2015 resulting in an observed increase in frequency of HAT. This increase brings incidence of HAT at SGH in line with rates observed at other Trusts in London that are of a similar size and status.

7. Patient Safety
- Safeguarding: Adults

Safeguarding Training Compliance - Adults									
Lead Director	Feb	Mar	April	May	June	July	2015/20165 Target	Forecast April 2015	Date expected to meet standard
JH	86.2%	87%	85%	85%	81%	78%	85%	A	-

Safeguarding Adults Training Compliance by Division – June 15				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
74%	75%	84%	83%	74%





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.

Apr 90, May – 70, June 78, July 70

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

Actions:

Continue to monitor safeguarding training via ARIS. 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. Task and Finish Group to commence work on outstanding actions Autumn 2015

7. Patient Safety - Safeguarding Children

Division	No. requiring training	No of staff compliant	compliant %	no. of staff not compliant	additional no. of staff to be trained to achieve 85% compliance
Children and Women's Diagnostic and Therapy Services	629	499	80%	127	36
Community Services	214	194	91%	20	
Corporate	5	3	60%	2	2
Medicine and Cardiovascular	173	120	69%	53	30
Surgery & Neurosciences	13	3	33%	10	6
Total	**1034**	**819**	79%	**215**	**74**

Target areas: Following a deep dive into the training figures, it has been shown that the ED and maternity level 3 training percentages are much improved (in Maternity from 33% - 96%). This reflects more accurate entering of the data onto the ARIS system. The safeguarding team have formulated a training action plan. (Table above shows the figures as of 07/08/2015 following the deep dive)

Serious Case Reviews and Internal Management Reviews: The Trust is waiting for an SCR to be declared from Surrey. The Named Midwife attended an IMR authors' meeting in July for the Haringey SCR for baby R. There will be a meeting in September for the Family A (Kingston) SCR, and also one for Baby V (Croydon).

Other: FGM remains a priority. The Trust held a multi-agency awareness day on 22 July. Community champions, Children's Specialist Services, Wandsworth Public Health and a Katherine Lowe support group member came together to man the stand in the main entrance and to answer any questions from staff and public.. This has opened up other links for training across the borough. A member of the Wandsworth FGM steering group now attends the Trust FGM Task and Finish Group. Midwifery has made the first post-delivery referral to Children's Specialist Services for a mother who did not disclose FGM at booking.

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Patient Experience

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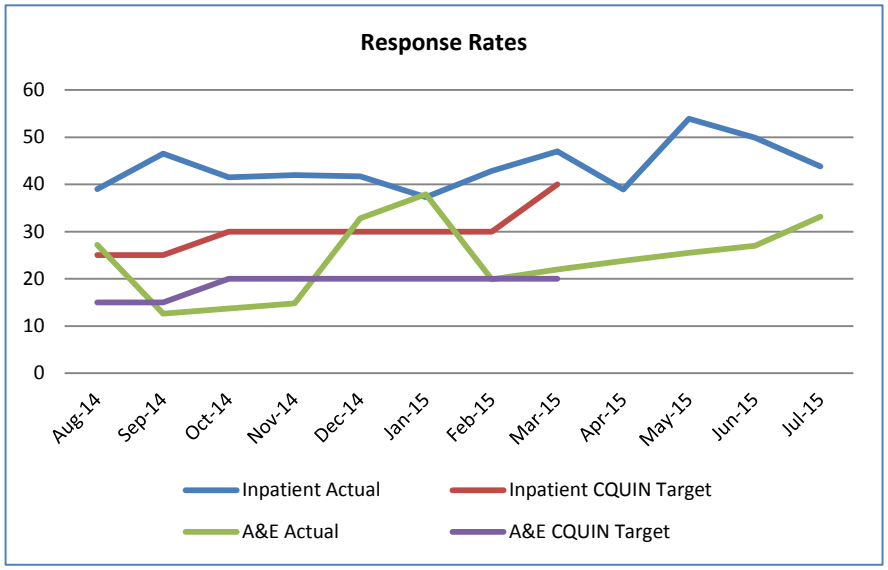
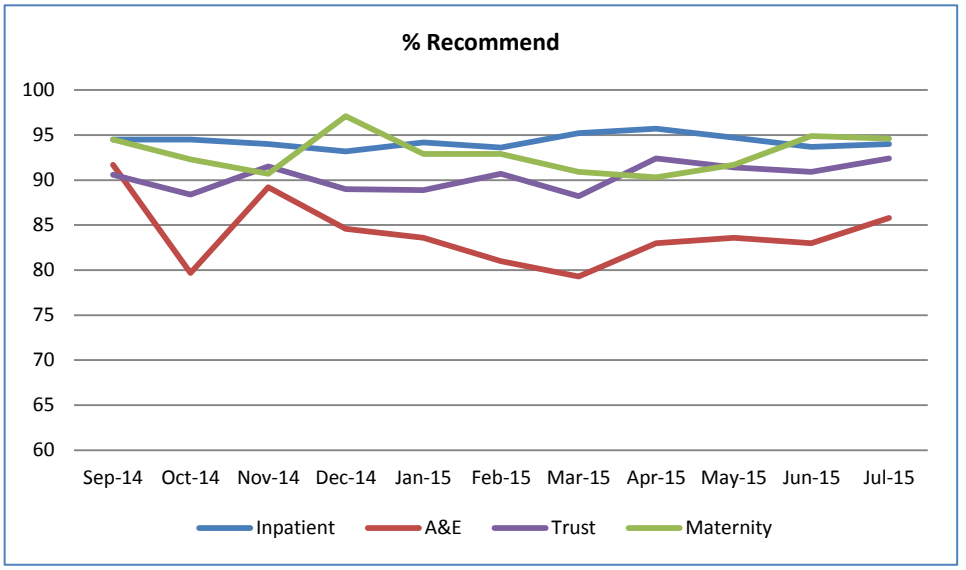
8. Patient Experience - Friends and Family Test

FFT Response Rate							
Domain	May-15	Jun-15	Jul-15	Movement	2015/2016 Target	Forecast	Date expected to meet standard
Trust	34.3	34.3	37.9	↑	-	-	-
Inpatient	53.9	49.9	43.8	↓	-	-	-
A&E	25.5	27	33.2	↑	-	-	-
Maternity	24.3	23.9	21.7	↓	-	-	-

FFT Response Score			
May-15	Jun-15	Jul-15	Movement
91.4	90.9	92.4	↑
94.7	93.7	94	↑
83.6	83	85.8	↑
91.7	94.9	94.6	↓





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. You can preview our latest draft on the next slide.

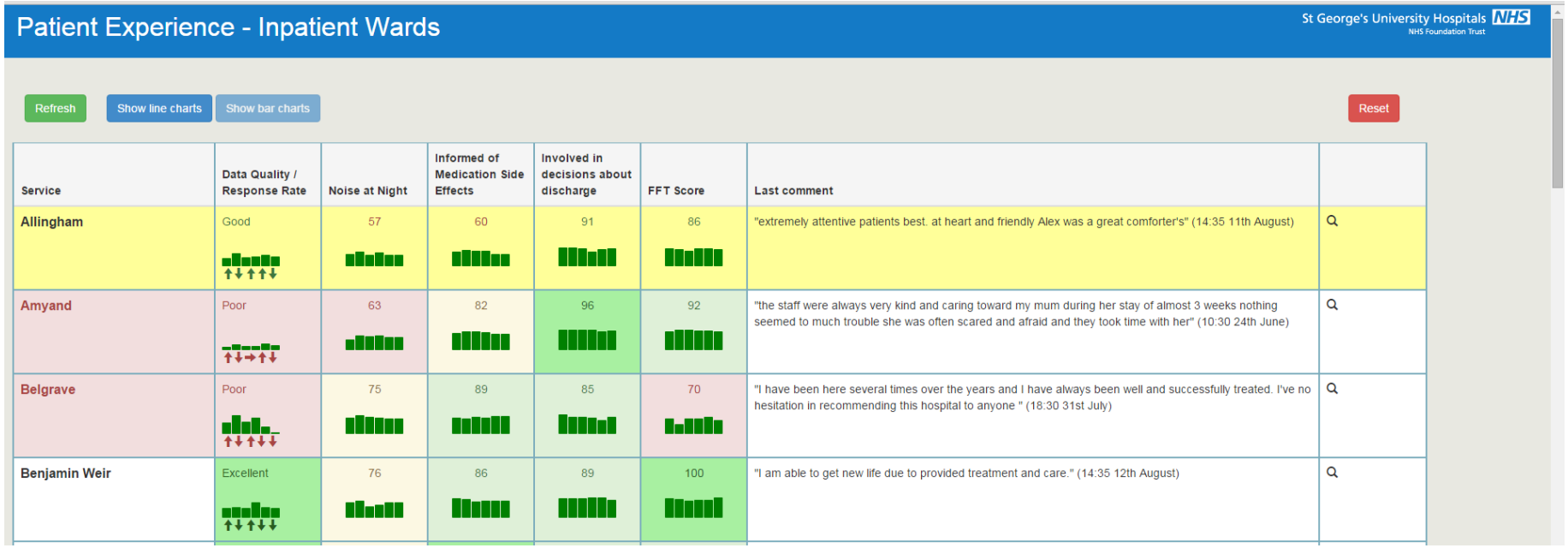
Action :

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 - New Patient Experience Reports

This is a snapshot of the data available on RaTE , showing data quality and performance in our three poorest performing areas (noise at night, information on medication side effect and involvement in the discharge process). A detailed overview of the entire survey is available real time , Trends for the last 6 months are shown, and a detailed breakdown of the scores can also be displayed.



Patient Experience - Inpatient Wards

St George's University Hospitals NHS
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Refresh | Show line charts | Show bar charts | Reset

Service	Data Quality / Response Rate	Noise at Night	Informed of Medication Side Effects	Involved in decisions about discharge	FFT Score	Last comment	
Allingham	Good	57	60	91	86	"extremely attentive patients best. at heart and friendly Alex was a great comforter's" (14:35 11th August)	
Amyand	Poor	63	82	96	92	"the staff were always very kind and caring toward my mum during her stay of almost 3 weeks nothing seemed to much trouble she was often scared and afraid and they took time with her" (10:30 24th June)	
Belgrave	Poor	75	89	85	70	"I have been here several times over the years and I have always been well and successfully treated. I've no hesitation in recommending this hospital to anyone " (18:30 31st July)	
Benjamin Weir	Excellent	76	86	89	100	"I am able to get new life due to provided treatment and care." (14:35 12th August)	

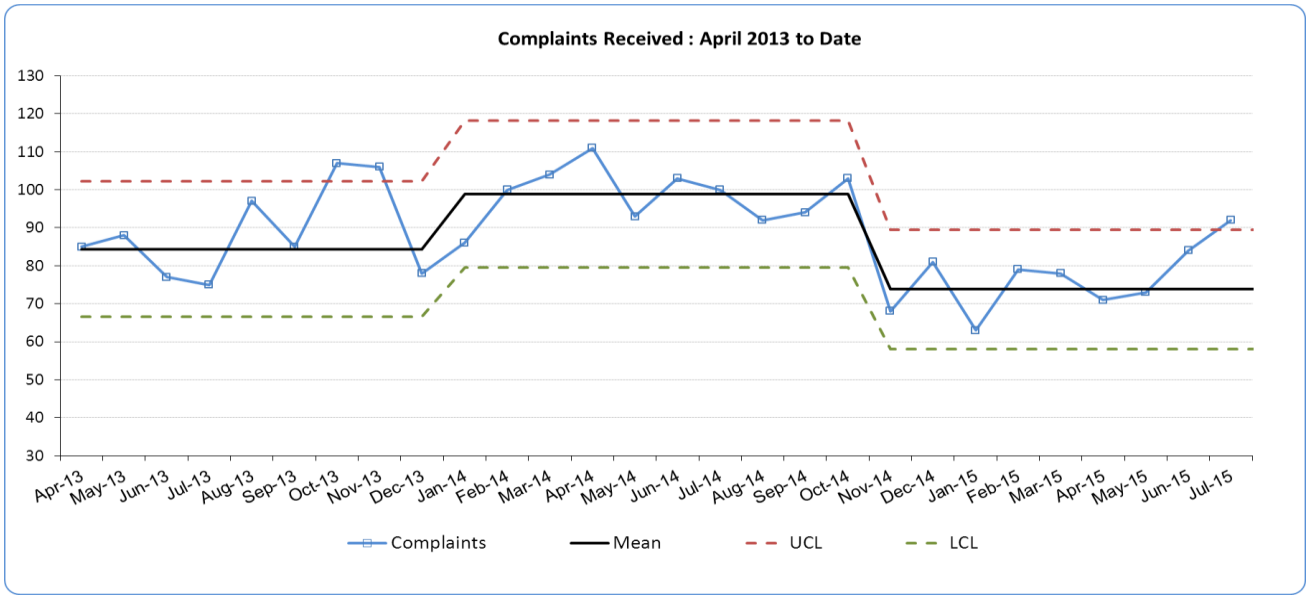
A breakdown of a service's scores, explaining what their patients are telling them.

Scores explained:	There were 28 responses out of a predicted 57 discharges. This gives a response rate of **49%**. For this area: Excellent = 61% or above Good = 44% Acceptable = 28% Poor = below 28%	6 said noise was caused by both staff and patients. 0 said noise was caused by staff. 12 said the noise was caused by patients. 10 said they were not bothered by noise.	6 patients were not told about medication side effects. 5 were told 'to some extent' 10 were told about all side effects.	0 patients did not feel involved in their discharge from hospital. 5 felt involved to some extent. 23 said they were 'definitely' involved in their discharge.	24 were 'Extremely likely' or 'Likely' to recommend the service. 3 were 'Neither likely nor Unlikely'. 0 were 'Unlikely' 0 were 'Extremely Unlikely.' 1 answered 'Don't know.'	

This work is part of an overall quality framework that allows us to monitor patient experience and safety data in real time from a single point of access.

8. Patient Experience - Complaints Received

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



Overview:

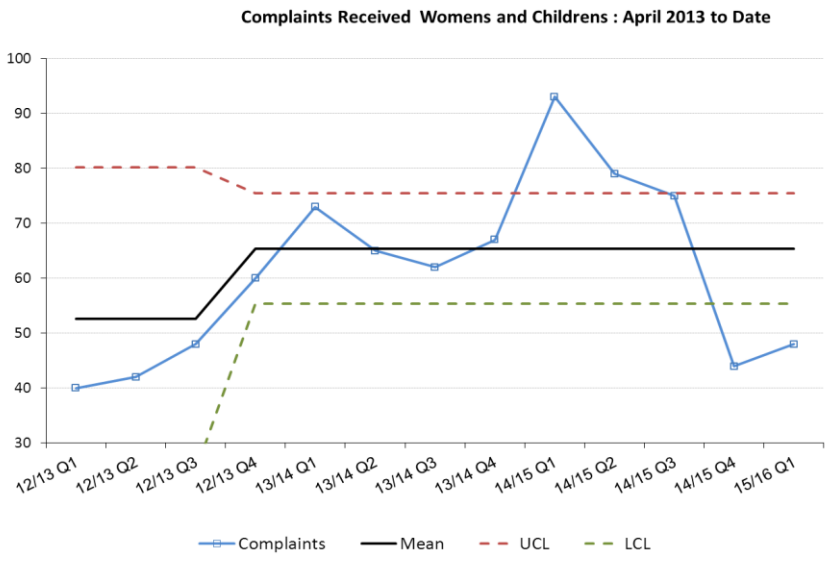
This report provides an update on complaints received in quarter 1 of 2015/2016 and information on responding to complaints within the specified timeframes for the same period with divisional breakdowns and analysis of the data to provide some trends and themes. It also includes some actions taken and planned in quarter 1, a report of the latest work on severity rating of complaints and posts on NHS Choices and Patient Opinion.

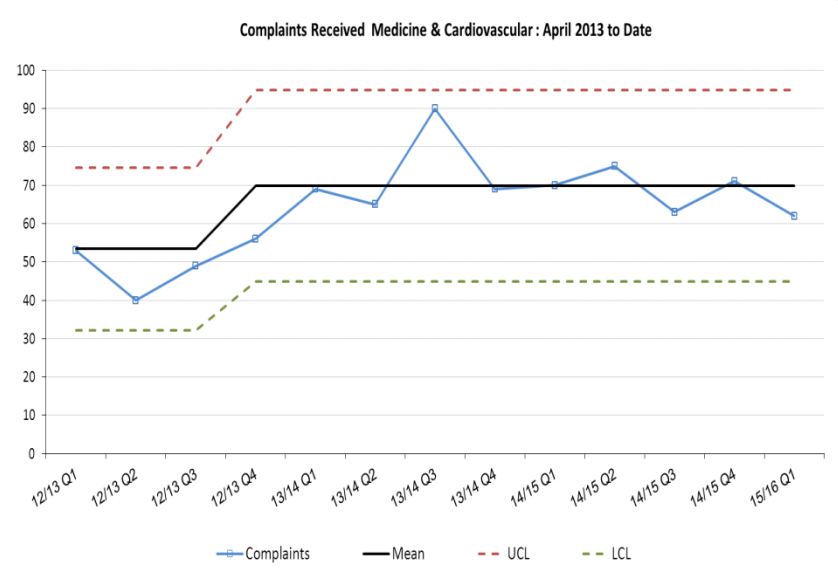
Total numbers of complaints received in Quarter 1 of 2015/2016

There were 227 complaints received in quarter 1 of 2015/2016, an increase when compared to quarter 4 of 2014/2015 when 215 complaints were received. Complaints reduced in the Medicine and Cardiovascular Division and Corporate Departments and increased in all other areas, most significantly in the Community Services Division where complaints increased from 23 to 40, Offender Healthcare and Adult Services being the care groups with the highest increases.

8. Patient Experience

- Complaints – Q1 by division





Children's, Women's, Diagnostics and Therapeutics Division

COMMENTARY

Complaints about the Children's, Women's, Diagnostics and Therapeutics Division increased slightly overall from 44 in quarter 4 to 48 in quarter 1 with a notable increase in complaints about women's services and a slight decrease in complaints about outpatients and medical records.

The following actions are being taken to address the top themes in the division:

Waiting Times

- Waiting Times - New software installed has improved call answering time and reduced call queues.
- E-triage system now live

Communication

- TTO wrong medication - All TTO's are recorded in child's health record book – Neonates
- Competency training taken place - maternity
- Customer Service training take place - imaging
- Monitoring of staff performance and attitude – across division

Medical Records

- Monitoring on a daily basis of notes availability
- Increased priority of EDM roll out
- Increased delivery and collection of offsite medical records – now twice a day

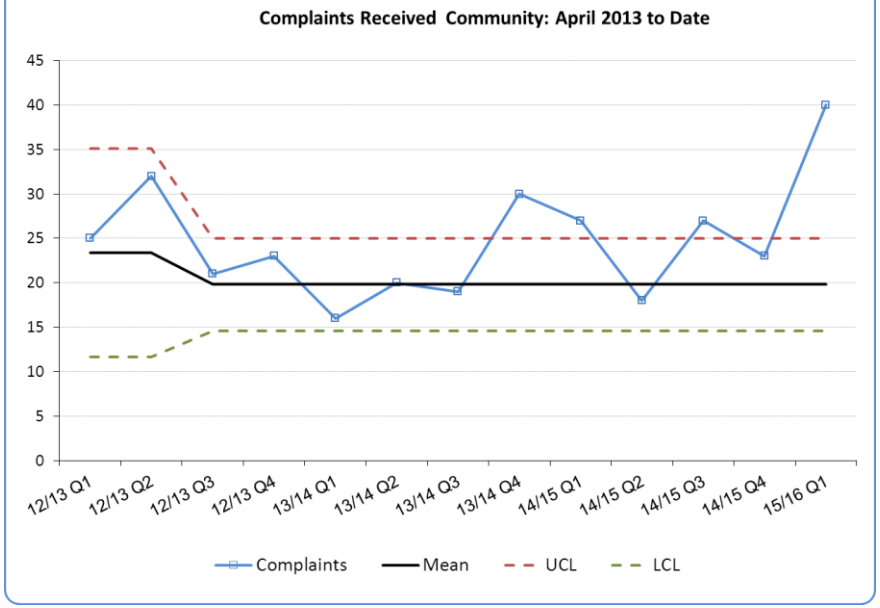
Medicine and Cardiovascular Division

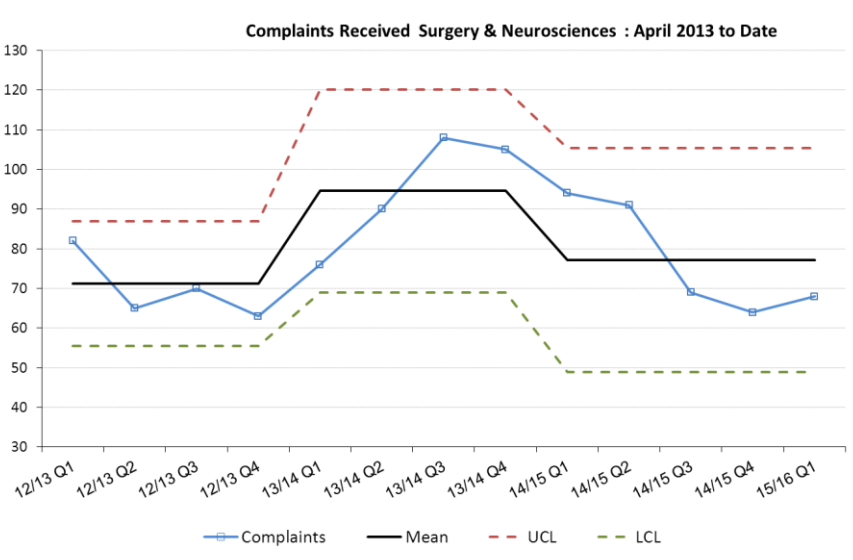
COMMENTARY

The Accident and Emergency Care Group has seen a reduction in complaints from 30 in quarter 4 to 15 in quarter 1. This is a result of local management and de-escalation of concerns by the leadership team and a number of patient experience initiatives implemented following receipt of the National Emergency Survey results 2014. These include:

- The department has implemented a Rapid Assessment Treatment model at the front door to ensure early assessment by a senior clinician and access to diagnostics, improving patient experience and time spent within the department. This model has now been expanded further to include those patients that present for Urgent Care, where an ENP performs the rapid assessment allowing for early intervention and diagnostic to be performed.
- The Matron and Head of Nursing have produced a set of values and standards for staff regarding behaviours in the department. This has been circulated to staff and is displayed within the department.
- The triage model is currently being reviewed to ensure the time patients are waiting is kept to a minimum and are triaged appropriately.

8. Patient Experience
- Complaints – Q1 by division





Community Services

COMMENTARY

Complaints about the Community Services Division increased from 23 in quarter 4 to 40 in quarter 1, Offender Healthcare and Adult Services being the care groups with the highest increases. Whilst no themes can be seen in Adult Services, Offender Healthcare complaints are in the most part about clinical treatment – medication and clinical treatment – diagnoses. It is anticipated that in quarter 2 there will be a significant reduction in the number of complaints being received due to a new process that has been implemented which involves triaging all concerns and queries that are received and speaking to patients straight away to de-escalate the issues.

In response to a complaint received about a patient's inability to access the reproductive sexual health appointment booking line an improved messaging service has been put in place and the reproductive sexual health office has been moved into the Courtyard Clinic

Surgery and Neurosciences Division

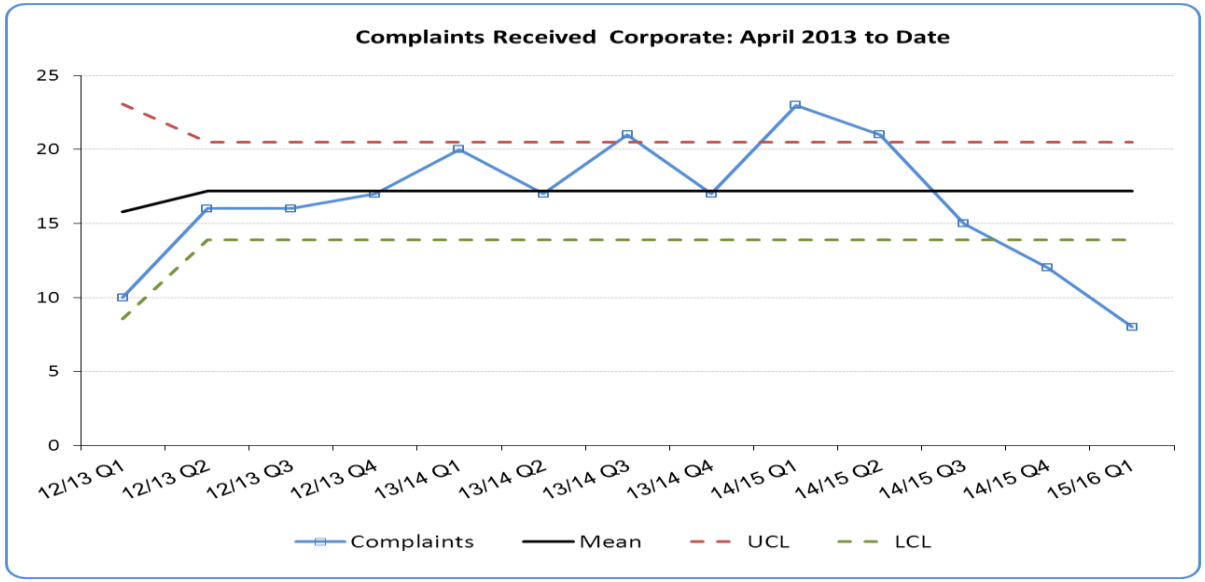
COMMENTARY

There was a slight increase in the overall number of complaints being received for the division. Complaints about General Surgery reduced from 14 in quarter 4 to 8 in quarter 1. The number of complaints being received about the Trauma and Orthopaedics care group remains high with 16 complaints being received across a number of subjects. Some actions that have resulted from these include:

- All patients admitted electively to the Trauma and Orthopaedic service the day before surgery will be seen within an hour by the specialty physician's associate and senior house officer (SHO). They will ensure that medications are reviewed and a clear plan given to the nursing team. All appropriate pre-operative assessments will be completed to ensure that the patient is ready to go to theatre and all medications prescribed. If the specialty SHO is not clear about this, then they will contact the duty anaesthetist for advice.

- The fasting policy has been distributed to the ward staff which has clear guidelines about what medications should be administered and what medications must be omitted on the day of a patients operation Greater clarity will be gained from training from the pharmacy department which has already commenced.

8. Patient Experience
- Complaints – Q1 by division



Corporate Directorates

COMMENTARY

Estates and Facilities

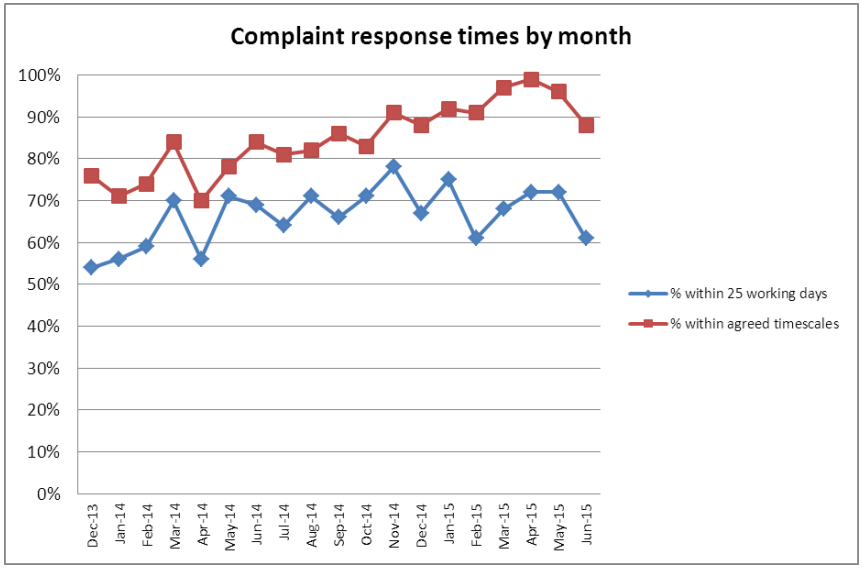
There was a reduction in complaints being received about transport from 5 to 3 and no complaints were received about car parking compared to 2 in quarter 4. In response to a complaint received regarding transport arriving late to transport a patient to their appointment, The training for those covering reception is being reviewed to ensure patients receive the correct information when making transport queries.

Other Corporate Departments

Two complaints were received for Private and Overseas Patients (one for each), one of which did not result in any action being necessary and the other remains outstanding at time of writing. One complaint was received for Bereavement Services which resulted in training needs being identified and training has been carried out.

8. Patient Experience
- Complaints Performance against targets

Performance Against Targets Quarter 1 of 2015/2016				
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	48	25	52%	(18) 90%
Medicine and Cardiovascular	62	40	65%	(21) 98%
Surgery & Neurosciences	68	50	74%	(15) 96%
Community Services	40	33	83%	(6) 98%
Corporate Departments	8	7	88%	(1) 100%
South West London Pathology	1	0	0%	(1) 100%
Totals:	227	155	68%	(60) 95%



Commentary:

Having improved in the months of April and May, complaints performance declined in June 2015 which meant that for quarter 1 overall, there was no improvement in response times when compared to quarter 4 of 2014/2015. 68% of complaints were responded to within 25 working days (against the internal trust target of 85%) with 95% within agreed timescales (against internal trust target of 100%).

Community Services is the only clinical division which is reaching both targets and they have the following action plan in place to maintain this performance:

- The Divisional Director of Nursing and Governance and the Divisional DDO review progress on complaints weekly.
- Managers have an increased focus on closing manageable complaints within time frame and being pro active in negotiating agreement on an extension with complainant where the complaint is more complex.
- Services also welcome complainants to attend meetings as part of complaints resolution.
- Complaints are monitored monthly at DGB.

Action plans for improvement in place in the Medicine and Cardiovascular and Children's and Women's Divisions were shared in the previous Board report.

In the Surgery and Neurosciences Division although for the whole quarter the 25 working day target was missed, it was met in the month of May. They report that:

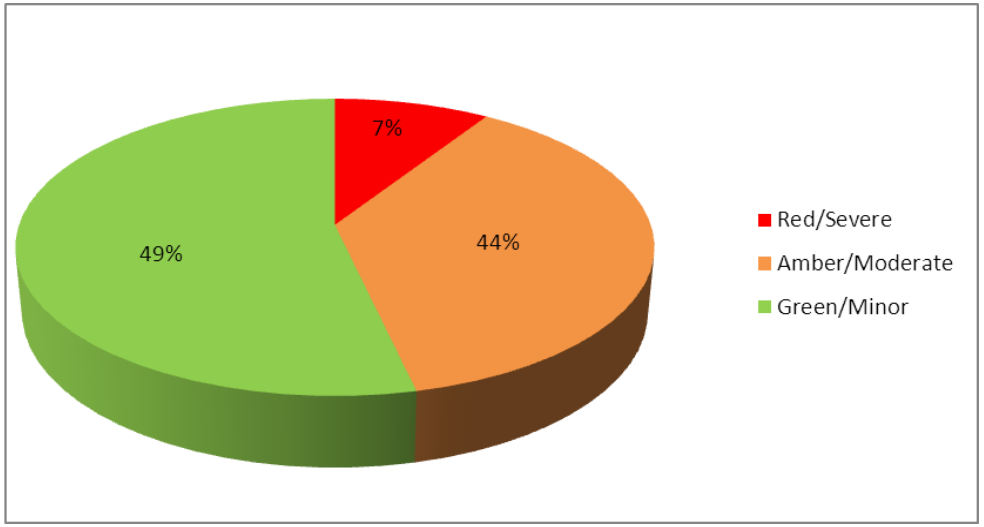
- Good divisional process in place to oversee complaints and provide support to areas with higher volumes/complex complaints will be maintained
- Engagement from managers/clinicians is good and has been sustained over the last 6 months- this has been pivotal to the change in performance
- Local complaints/governance meetings are in place – The purpose of these meetings is to review complaints themes, agree focused actions and share learning
- Divisional oversight via DGB will continue

8. Patient Experience
- Complaints severity rating overview

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

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

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



A summary of ratings for quarter 1 of 2015/2016 is presented below. A more detailed report will be presented at the Patient Experience Committee.

In Quarter 1 a total of 17 complaints were categorised as Red/Severe. All were aligned with the serious incident process where appropriate.
The red severity cases have been examined to decipher if they should still remain red after investigation and response completed. However some of the cases are still open therefore the total figure for red severity cases may change and will be reflected in the end of year final report.

The reasoning for the red ratings included:

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

In Quarter 1 a total of 98 complaints were categorised as Amber/Moderate.
The most common reasons for the amber ratings were an adverse injury or outcome and the complaint being complex and/or involving 2-4 services.

In Quarter 1 a total of 112 complaints were categorised as Green/Minor.

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

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

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

Wendy Foley gave Cardiology at St George's Hospital (London) a rating of 5 stars

Emergency heart attack admission

I got up at 815am last Sunday in Dorking with a pain in my neck and arrived at CCU ward at 1030am having had a stent fitted! 111 prompt and detailed Ambulance crew amazing both in reassurance and control/diagnosis of symptoms the doctor - such a calm and professional manner, both with me and my relatives and a speedy, successful result. The nursing staff on CCU and James Hope were caring and knowledgeable - they all seemed to know my case thoroughly. The food was hot and comforting even if it wasn't home cooked, and there was always a cup of tea available. I particularly liked the 7 - 730 shift pattern which allowed a thorough change-over/briefing without the usual disappearance of staff although those nurses must be shattered at the end of a shift Everyone kept me informed of my progress and treatment at every stage even in the middle of the night I had little rest at night but mainly due to beepers including mine, and other patients receiving care. All of this on a Sunday. Please let me know of any fund-raising events.

Visited in July 2015. Posted on 26 July 2015

Anonymous gave Neurosurgery at St George's Hospital (London) a rating of 1 stars

Appointment/Referrals

I was diagnosed with a benign brain tumour five weeks ago and was assured by St Helier that I would have an appointment with St George's neuro within two weeks. I called after 2 weeks to be told they did not have my referral. My GP faxed (yes faxed!) this to them and they assured me I would have an appointment within 10 days following triage. I called two weeks later and I was still not registered as they claimed they did not have the referral - then they found it and promised an appointment by early the following week. Another week (five weeks since diagnosis) I called again - I have been registered but not yet given an appointment - offer one in another 5 weeks. that will be 10 weeks since being told this devastating news. I was warned by many that the admin at St George's was shockingly poor - but this is awful - the tone of the staff each time in this department just simply did not care at all - my GP has been great and supportive but cannot make them go any faster - the lack of consideration of digesting such news and dealing with them has made my fear for the future worse. If they can get this first bit so wrong what is next? My saving grace is that a friend knows the consultant and says they are the best. I have to just wait - I will not make a formal complaint for fear that it will jeopardise my treatment plan. To anyone else - keep calling every day until you get your appointment. I am shocked at how this works - I have already been diagnosed by the MDT team at St George's so cannot understand why the long wait and messing about. Depression sets in quickly with a lack of knowledge and understanding with this diagnosis - and this is purely poor admin causing this. I expect that once I have met the consultant I will feel much better, but I could never forgive these members of staff who simply did not care. These people are the front line of the NHS and why the NHS gets such a poor reputation. Staff of Neuro - please if you read this put yourself in the patient's shoes and imagine what it is like to have such a diagnosis and how long you would like to wait for some reassurance?

Visited in July 2015. Posted on 31 July 2015

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NHS Foundation Trust

Workforce

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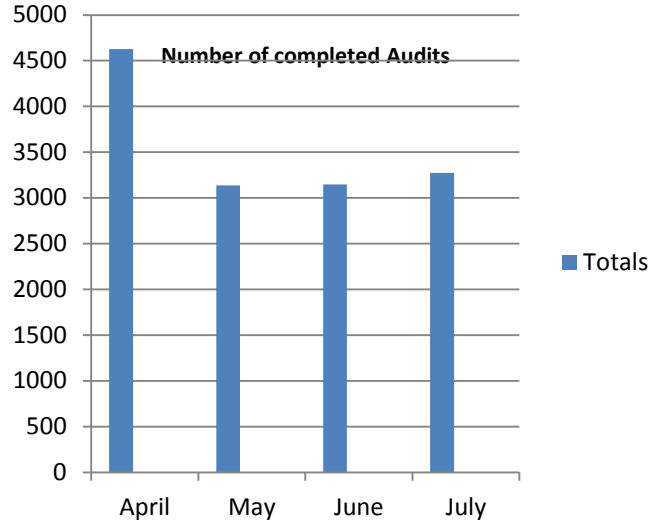
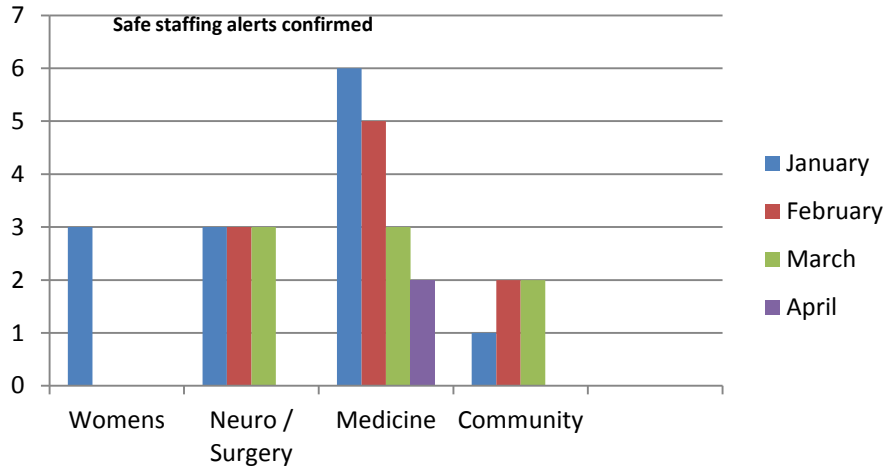
9. Workforce- July 2015 - Safe Staffing alerts





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

The total number of safe staffing audits completed over the past three months were: May 3136, June 3149 and July 3149. There was a decrease in the number of final alerts reported from 5 in June to 2 in July. The number of alerts reduced to a concern (ward is safely staffed but some care needs will not be completed) has remained stable during the previous three months following on the day investigation (May 18, June16, July 17).

10 nursing related safe staffing concerns were raised on Datix system in July compared to 6 in June. None of the datix reports matched a similar entry on the RATE system for alerts raised or alerts reduced to concern.

Actions: Raise the link between datix and the rate system with the nursing body with the aim to achieve greater consistency.

Risk: In light of the required financial savings on temporary staffing that are required, this may impact on staffing over the next month. It is agreed that safety, not finance, will be paramount when agreeing / declining temporary staffing.

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

Overview

The information provided on the table below relates to staffing numbers at ward/department level submitted nationally on Unify for July 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 July the trust achieved an average fill rate of 94.93%, a slight decrease from 95.98% submitted in June.

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 both June and July that require further review. KPMG, workforce and Corporate Nursing continue to work together to refine and improve the process.

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.
- Reporting guidance from NICE expected in June 2015 is still awaited,
- 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 – this piece of work is being led by KPMG. No feedback has been provided.
- Await finding from deep dive on potential issues with UNIFY reporting (see above).

	Day		Night	
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Cardiothoracic Intensive Care Unit	93.0%	#DIV/0!	96.0%	100.0%
Carmen Suite	99.1%	76.2%	100.1%	90.0%
Champneys Ward	95.3%	95.8%	96.7%	100.0%
Delivery Suite	100.7%	76.3%	109.4%	93.5%
Fred Hewitt Ward	89.6%	101.5%	95.3%	#DIV/0!
General Intensive Care Unit	95.3%	80.4%	99.1%	80.0%
Gwillim Ward	119.4%	80.2%	97.7%	99.8%
Jungle Ward	96.4%	#DIV/0!	#DIV/0!	#DIV/0!
Neo Natal Unit	95.9%	#DIV/0!	98.9%	#DIV/0!
Neuro Intensive Care Unit	89.6%	84.6%	94.6%	80.6%
Nicholls Ward	94.1%	101.2%	100.0%	83.3%
Paediatric Intensive Care Unit	89.1%	94.2%	100.0%	100.0%
Pinckney Ward	101.9%	77.3%	97.4%	#DIV/0!
Dalby Ward	97.4%	106.3%	101.1%	99.1%
Heberden	93.5%	100.7%	98.8%	98.9%
Mary Seacole Ward	90.7%	99.7%	100.0%	99.7%
A & E Department	94.8%	82.8%	95.3%	81.4%
Allingham Ward	89.3%	120.9%	98.0%	99.0%
Amyand Ward	88.3%	104.0%	97.5%	99.7%
Belgrave Ward AMW	84.9%	89.5%	99.4%	100.0%
Benjamin Weir Ward AMW	88.7%	95.9%	97.9%	90.7%
Buckland Ward	84.6%	93.7%	100.2%	95.7%
Caroline Ward	92.1%	93.2%	99.1%	#DIV/0!
Cheselden Ward	97.1%	85.1%	99.1%	99.8%
Coronary Care Unit	99.2%	#DIV/0!	99.5%	200.0%
James Hope Ward	88.9%	93.6%	100.0%	#DIV/0!
Marnham Ward	84.7%	88.1%	95.8%	97.3%
McEntee Ward	93.7%	97.3%	100.0%	100.0%
Richmond Ward	89.1%	91.8%	95.9%	94.7%
Rodney Smith Med Ward	92.2%	93.8%	100.0%	97.3%
Ruth Myles Ward	99.5%	109.2%	101.1%	2.2%
Trevor Howell Ward	95.4%	90.4%	99.0%	96.6%
Winter Ward (Caesar Hawkins)	85.2%	95.0%	96.8%	97.4%
Brodie Ward	91.4%	92.2%	100.0%	100.0%
Cavell Surg Ward	94.0%	117.6%	100.0%	100.0%
Florence Nightingale Ward	89.3%	95.8%	99.2%	#DIV/0!
Gray Ward	92.2%	75.2%	99.5%	94.6%
Gunning Ward	90.9%	88.5%	100.0%	100.0%
Gwynne Holford Ward	82.8%	92.9%	97.5%	97.7%
Holdsworth Ward	88.7%	90.9%	100.0%	97.2%
Keate Ward	95.0%	98.0%	96.8%	#DIV/0!
Kent Ward	93.9%	86.2%	99.3%	100.0%
Mckissock Ward	91.9%	85.9%	99.2%	100.0%
Vernon Ward	94.1%	87.1%	100.0%	92.8%
William Drummond HASU	85.2%	102.3%	92.1%	100.1%
Wolfson Centre	91.9%	91.9%	100.0%	100.0%
Gordon Smith Ward	87.2%	83.1%	98.5%	100.0%
Brodie Stroke Ward	96.1%	88.6%	86.0%	141.9%
Trust Total	92.65%	93.02%	98.11%	97.16%
	Day Qual	Day HCA	Night Qual	Night HCA
	92.65%	93.02%	98.11%	97.16%

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 ULCERS	PERCENTAGE OF HARM FREE CARE	PATIENT SATISFACTION (FRIENDS & FAMILY)	FRIENDS & FAMILY RESPONSE RATE	WARD STAFFING: UNFILLED DUTY HOURS	FALLS (WARD LEVEL)	SERIOUS INCIDENTS (WARD LEVEL)	SICKNESS/ ABSENCE RATE - (WARD)
Children & Women's	CARDIOTHORACIC INTENSI..	0.0	0.0	0.0	87.5	0.0		5.5	0.0	0.0	3.3
	CARMEN SUITE	0.0	0.0	0.0	100.0		0.0	3.7	0.0	0.0	16.1
	CHAMPNEYS	0.0	0.0	0.0	100.0	90.2	38.7	3.5	1.0	0.0	11.3
	DELIVERY	0.0	0.0	0.0	100.0		0.0	-1.5	0.0	1.0	4.8
	FREDDIE HEWITT	0.0	0.0	0.0	0.0		0.0	7.2	1.0	0.0	6.3
	GENERAL ICU/HDU	0.0	0.0	0.0	100.0	0.0	0.0	3.2	1.0	1.0	2.0
	GWILLIM	0.0	0.0	0.0	100.0	91.0	0.0	-3.2	0.0	0.0	2.9
	JUNGLE	0.0	0.0	0.0			120.0	3.6	0.0	0.0	13.5
	NEONATAL ICU	0.0	0.0	0.0	100.0	0.0		2.7	0.0	0.0	3.3
	NEURO ICU	0.0	0.0	1.0	87.5		0.0	8.7	1.0	1.0	3.8
	NICHOLLS	0.0	0.0	0.0	0.0		0.0	3.8	1.0	0.0	2.7
	PICU	0.0	0.0	0.0	100.0	100.0		5.6	0.0	0.0	3.8
	PINCKNEY	0.0	0.0	0.0	0.0	100.0	150.0	1.8	0.0	0.0	3.1
Medicine & Cardiovascular	ALLINGHAM	0.0	0.0	0.0	100.0	85.7	46.7	1.0	11.0	0.0	9.0
	AMYAND	0.0	0.0	0.0	90.6	91.7	16.9	4.1	4.0	0.0	5.0
	BELGRAVE	0.0	0.0	0.0	96.3	70.0	7.4	8.9	2.0	0.0	1.9
	BENJAMIN WEIR	0.0	0.0	0.0	100.0	100.0	45.7	7.4	2.0	0.0	2.1
	BUCKLAND	1.0	0.0	0.0	100.0	94.8	77.3	8.5	3.0	0.0	1.9
	CAESAR HAWKINS	0.0	0.0	0.0	90.0	91.7	20.7	8.3	14.0	0.0	0.0
	CARDIAC CARE UNIT	0.0	0.0	0.0	100.0	100.0	56.3	0.4	0.0	0.0	2.1
	CAROLINE	0.0	0.0	0.0	100.0	100.0	36.8	5.2	3.0	0.0	1.9
	CHESELDEN	0.0	0.0	0.0	95.2	92.0	27.2	3.2	9.0	0.0	0.9
	DALBY	0.0	0.0	0.0	82.6	100.0	4.8	-1.5	7.0	0.0	16.6
	EMERGENCY DEPARTMENT	0.0	0.0	0.0		88.9	24.0	7.3	4.0	1.0	3.3
	HEBERDEN	0.0	0.0	0.0	82.6	100.0	25.5	2.0	2.0	0.0	0.6
	JAMES HOPE	0.0	0.0	0.0	100.0	100.0	63.5	8.0	0.0	0.0	2.7
	MARNHAM	0.0	0.0	0.0	88.9	90.0	27.4	9.8	5.0	0.0	2.9
	MCENTEE	0.0	0.0	0.0	76.5	92.3	27.7	3.0	0.0	0.0	0.2
	RICHMOND	0.0	0.0	0.0	85.2	97.6	26.7	7.4	18.0	1.0	8.5
	RODNEY SMITH	0.0	0.0	0.0	85.2	93.3	24.2	4.9	3.0	0.0	5.4
	RUTH MYLES	0.0	0.0	0.0	100.0	100.0	80.0	0.1	3.0	0.0	5.3
	TREVOR HOWELL	0.0	0.0	0.0	95.0	83.3	51.7	4.3	5.0	0.0	7.0
Surgery & Neurosciences	BRODIE NEURO	0.0	0.0	0.0	100.0	91.7	97.3	5.4	0.0	0.0	4.2
	CAVELL	0.0	0.0	0.0	100.0	88.1	20.1	-0.5	1.0	0.0	5.8
	FLORENCE NIGHTINGALE	1.0	0.0	0.0	95.2	91.8	75.2	6.4	1.0	0.0	6.2
	GRAY WARD	0.0	0.0	0.0	100.0	90.9	66.0	9.2	3.0	0.0	6.7
	GUNNING	0.0	0.0	0.0	0.0	88.3	74.1	6.3	3.0	0.0	3.3
	GWYN HOLFORD	0.0	0.0	0.0	97.5	80.0	55.6	8.4	10.0	0.0	6.2
	HOLDSWORTH	0.0	0.0	0.0	100.0	84.6	21.3	6.7	1.0	2.0	8.3
	KEATE	0.0	0.0	0.0	100.0	95.3	84.8	3.9	4.0	0.0	0.5
	KENT	0.0	0.0	0.0	100.0	91.1	48.4	5.7	5.0	0.0	2.0
	MARY SEACOLE	0.0	0.0	0.0	90.0	100.0	63.9	2.9	6.0	0.0	3.3
	MCKISSOCK	0.0	0.0	0.0	100.0	90.9	68.8	6.5	1.0	0.0	2.2
	VERNON	0.0	0.0	0.0	96.3	95.0	50.5	5.4	2.0	0.0	7.2
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	100.0	97.5	33.6	9.1	2.0	0.0	0.0

10. Ward heatmap:
- CWDT&CC Division

Cardiothoracic Intensive Care Unit (CTICU)
The unit reported 87.5% for harm free care in July 2015; this relates to 2 harms that were reported out of a total of 16 patients surveyed. Specifically these was 1 patient with an old grade 4 pressure ulcer and 1 patient with a new a new grade 3 pressure ulcer, incidentally neither of these were acquired whilst in the care of CTICU.

General Intensive Care Unit (GICU)
A never event was reported in GICU in July 2015. This is a result of a misplaced nasogastric tube, this is currently being investigated by the serious incident panel and the root cause identified. There will be learning from this that will be shared across the division.

Neuro Intensive Care Unit (NICU)
NICU reported 87.5% for harm free care in July 2015. This follows a survey of 8 patients and 1 patient identified as having an old grade 4 pressure ulcer. In addition a grade 3 pressure ulcer was reported in the month which was acquired on the unit, this accounts for the pressure ulcer and the serious incident identified in the heat map.

There is on-going work across the adult critical care units in regard to the prevention of pressure ulcers and the sharing of good practice.

Delivery Suite
The 1 serious incident reported for the period July 2015 relate to an unexpected admission to NNU. This incident is currently being investigated.

10. Ward heatmap:
- STNC Division

The report focuses on areas with any red indicator or those with three or more indicators. The key areas where alerts are seen are consistent with previous reports with and relate to friends and family response rate, falls and SI's. The areas where there has been an improvement in performance as reflected by a reduction to zero in alerts for pressure ulcers and percentage of harm free care. There are 5 red alerts for July compared to 14 for the previous reporting period. There is a decrease in overall numbers of alerts seen from 10 to 7 which indicates an improvement in ward performance.

Florence Nightingale – 1 red indicator; relates to an incidence of CDT- The root cause analysis suggests this was an unpreventable episode with appropriate antibiotic usage and care and intervention when the episode commenced.

Gunning – no indicators but had 0% for Harm Free care- this is incorrect as the data was collected and is available on the rate system.

Holdsworth - 3 red indicators. These relate to a patient falls and are currently being investigated in line with the SI process. A review of all falls is taking place alongside this to ensure that all aspects of care in relation to falls are reviewed.

The FFT amber indicator related to 21.3% FFT response. The Tablet was changed at the end of this month and data was lost and not uploaded correctly due to hard ware problems.

Cavell- 1 amber indicator. This relates to the ward FFT response rate which is 20.1%. Cavell ward have consistently struggled with this aspect of patient experience. An action plan to achieve a minimum of 40% response rate each month has been compiled by the matron and ward sister.

Keate-1 red indicator relating to 4 falls. 3 falls were for the same patient. This patient was identified on admission as at risk of falls, was placed near the nursing station and all paperwork was completed pre and post falls. All 3 falls were no harm. The other fall occurred where a patient who was fully mobile patient slipped in the shower- low harm

Kent – 1 red indicator– relates to 5 falls, 3 of these were the same patient who slipped during therapy sessions or were none compliant with informing staff when attempting to mobilise. 1 patient was found on the floor when attempting to mobilise. All falls were no harm and appropriate falls and post falls risk assessments were completed. Clarity around messages to pts to support them managing there rehabilitation and return to independence will be reconsidered.

Gwynne Holford - 1 red indicator- relates to 10 falls- Overall this is a reduction in falls for the neuro-rehab area but the falls work has been reinvigorated to review what other practice can be considered to minimise pt risk in relation to this aspect of pt safety. The ten falls related to 3 patients that fell repeatedly despite appropriate risk assessments and a number were witnessed and controlled by staff. No falls related to any harm.

Vernon and Cavell have both made improvements with no flags this month and McKissock have successfully reduced their level of falls.

10. Ward heatmap:
-Med Card Division

Caesar, Amyand, - Falls – work on-going ensure that re-assessment is completed within 4 hrs of transfer and that the back page is completed

FFT - all wards continue to highlight at beginning of shift patients for discharge and nominate individual person to complete.

Heberden - Harm Free Care - X 4 old Grade 2, x 2 old Grade 3 falls= 2 (low harm) - un-witnessed. Dalby:-

Dalby -HFC 1 fall – low harm/ I catheter with a new UTI being treated, I new grade 2 PU and 1 new DVT, work is being done with the medical teams to improve the VTE assessments. FFT 4.8% Dalby will need to work on improving this as the response rate is low. This is being monitored daily and allocated to one person to lead on. Falls – patients are reviewed delay in relation to falls risk and special are put in place if required. Sickness 16.6% - all of the long term sickness is being managed with HR support.

Trevor Howell - Sickness - Two people were on long term sick , one continuous on long term the other person has returned to work .One staff nurse had two episodes and is managed as per the policy. Falls - This was higher but one patient had a couple of falls .

Ruth Myles - Sickness -The receptionist was included in the figures . One HCA sick for 2.5 weeks , both members of staff have ongoing medical problems and are managed as per the policy and HR are assisting

McEntee -17 patients surveyed. 4 patients had a harm reported. 1 patient had an old grade 2 pressure ulcer, 1 patient had an old grade 3 pressure ulcer. 1 patient had a catheter and UTI and 1 patient had a catheter and new UTI.

Richmond - 54 patients surveyed. 8 patients had harms reported. 2 patient had 2 harms reported, both patients had a grade 3 pressure ulcer, one of these patients had a catheter and new UTI and the other a catheter and old UTI. 3 other patients were reported as having a catheter and new UTI. 1 patient has an old grade 2 pressure ulcer, 1 patient had a new grade 2 pressure ulcer and 1 patient had a Fall on the ward with low harm.

R Smith - 27 patients surveyed. 4 patients had harms reported. 2 patients had new grade 2 pressure ulcers and 2 patients had old grade 3 pressure ulcers.

Marnham - 27 patients surveyed. 3 harms reported. 1 patient had two harms, patient had a catheter and old UTI and old DVT. The other 2 patients with harms reported both also had a catheter and OLD UTI.

10. Ward heatmap:
-Community Division Mary Seacole Ward A and B

Safety thermometer results: 1 new PU acquired on MSW, others were non acquired but still trigger as old PU. There was one patient who was catheterised and but date not recorded. ! patient had identified VTE risk but was not on prophylaxis.

Falls: Our falls have increased, we have had 2 patients (1 on MSW A and 1 on MSW B) who are high falls risk and both have had 2 falls with us, both were being specialed as risk had been identified, one remains on MSW and continues to require a special and one was transferred to Kingston. There were several other no harm falls but all witnessed and patient assisted to prevent injury.

11. Community Services
- CQR Scorecard – July 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
				Quarter 1 2015/16			Quarter 2 2015/16		
Patient Safety	SI's REPORTED	Monthly		1	1	2	0		
Patient Safety	Number of SI's breached	Monthly	0	0	0	0	0		
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly		1	0	0	0		
Patient Safety	Grade 4 Pressure Ulcers	Monthly		0	0	0	0		
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly		10	7	5	12		
Patient Safety	Number of moderate falls	Monthly	0	2	1	0	1		
Patient Safety	Number of major falls	Monthly	0	0	0	0	0		
Patient Safety	Number of falls resulting in death	Monthly	0	0	0	0	0		
Patient Safety	MRSA (cumulative)	Monthly	0	0	0	0	0		
Patient Safety	CDiff (cumulative)	Monthly	31	1	0	0	0		
Patient Safety	CAS ALERTS - Number ongoing-received (Trust)	Monthly	0	2	2	2	2		
Patient Safety	Number of Quality Alerts	Monthly		3	5	2	6		
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	95%	89.0%	86%	85%	84%		
Safeguarding	% of staff compliant with safeguarding childrens training	Monthly	Level 1 95%	90.0%	90.0%	85%	82%		
			Level 2 95%	84.0%	84.0%	82%	82%		
			Level 3 95%	69.0%	69.0%	82%	90.00%		
Patient Outcomes	Mortality SHMI ratio (Trus)	Monthly	<100	0.86	0.86	0.86	0.86		
Patient Experience	Active Claims	Monthly		0	0	1	3		

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

	Patiend Safety & Experience								
Domain	Indicator	Frequency	2015/2016 Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
				Quarter 1 2015/16			Quarter 2 2015/16		
Patient Experience	Number of Complaints received	Monthly		16	18	6	4		
Patient Experience	Number of Complaints responded to within 25 days (reporting 1 month in arrears)	Monthly	85%	100%	88% April 2015	78% May 2015	tbc		
Patient Experience	Number of Complaints responded to within 25 days with an agreed extension	Monthly	95%	100%	100% April 2015	100% May 2015	tbc		
Patient Experience	FFT Score (Mary Seacole and MIU)	Monthly			14.3				
Patient Outcomes	Catheter related UTI (Trust)			1.14	0.66	1.12	Not yet available		
	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	N/A		
Workforce	Sickness Rate -	Monthly	3.50%	5.72%	6.04%	6.00%	Not yet available		
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%			

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

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.

July – Nil Sis

Pressure ulcers: In June/July 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 5 No Harm and Low severity fall (4 MS ward) were reported in June compared to 7 in May. However in July the number of reported falls has increased to 12 reported falls (11 no/low harm) of which 4 MS ward with one moderate harm fall (MS ward, QMH. Patient sustained head injury due to fall, currently in KHT). The remainder no harm/low harm falls were reported from outpatient settings

Complaints: (Q1 2015) Community Services numbers of formal complaints decreasing due to de-escalation by senior manager and complainant, in particular to note: complaints relate to OHC (access to medication/treatment), MS ward – lost property, catering, staff attitude), QMH OPD, attitude of staff.

Child safeguarding Level 3: (July)

Compliance is manually counted as 90%. Staff targeted to attend training, mainly in reproductive sexual health services. Automated recording system (ARRIS) is not reflecting comparative compliance. This is being reviewed.

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 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

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.
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11. Community Services
- Friends and Family Test : 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.

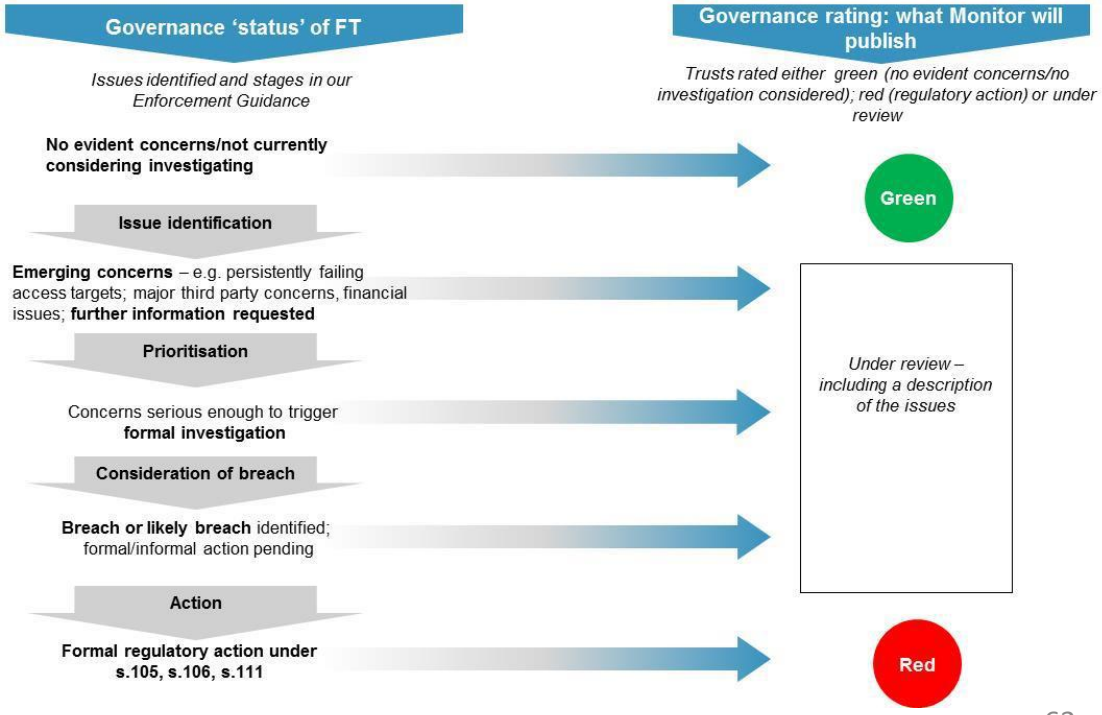
In addition to the above, when assigning governance ratings Monitor also take into account the following which may lead to overrides in the governance rating::

- 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

REPORT TO THE TRUST BOARD –SEPTEMBER 2015

Paper Title:	Trust Finance Report : Month 04 Overview
Sponsoring Director:	Steve Bolam, Chief Financial Officer & Deputy Chief Executive
Author:	Nigel Baker, Interim Director of Operational Finance
Purpose:	Monthly report to the Board on the financial position of the Trust
Action required by the board:	To review the report and identify areas where further action or assurance is required
Document previously considered by:	N/A

Executive summary

1. Key messages

Income & Expenditure

- As at month 4 the Trust is showing a deficit of £24.8m against its monitor plan deficit of £18.2m giving an adverse variance of £6.6m comprising:
  - Income £3.1m adverse
  - Pay £3.1m adverse
  - Non-pay £0.8m adverse
  - Depreciation £0.4m favourable

- The key drivers are:
  - underperformance in Outpatient activity £1.6m adverse
  - unidentified CIPs (showing mainly against pay as unallocated CIPs are split 80% pay 20% non pay) £0.9m adverse
  - prior year costs and income issues previously reported £2.5m adverse
  - potential penalties and challenges from commissioners £0.5m adverse

- Performance month on month has begun to stabilize and improve as the table below shows. Once adjusted to remove prior year items, to recognise the move of interim contract staff from the non-pay consultancy line back up to pay, and to adjust for the contingency that was accrued in months 1 to 3 but released in month 04 the underlying monthly deficit pattern is as follows:
  - M01 £6.7m deficit
  - M02 £6.3m deficit
  - M03 £5.2m deficit
  - M04 £4.1m deficit

	M01 £m	M02 £m	M03 £m	M04 £m	YTD £m	Trends
Reported Actuals						
Income	56.4	57.6	57.7	60.5	232.2	
Pay	(37.4)	(37.4)	(38.0)	(38.8)	(151.5)	
Non pay	(23.5)	(25.9)	(22.8)	(22.1)	(94.3)	
Post EBITDA	(3.0)	(2.7)	(2.6)	(2.9)	(11.2)	
Reported Deficit	**(7.6)**	**(8.3)**	**(5.7)**	**(3.3)**	**(24.8)**	
Adjustments						
Income	0.3	0.7	0.2	0.0	1.2	prior yr
Non pay	0.3	1.0	0.0	0.0	1.3	prior yr
Pay	(0.3)	(0.3)	(0.3)	0.9	0.0	interim contractors
Non pay	0.3	0.3	0.3	(0.9)	0.0	interim contractors
Non pay	0.3	0.3	0.3	(0.9)	0.0	accrued contingency
Adjustments	0.9	2.0	0.5	(0.9)	2.5	
Underlying actuals						
Income	56.7	58.3	57.9	60.5	233.4	
Pay	(37.7)	(37.7)	(38.3)	(37.9)	(151.5)	
Non pay	(22.6)	(24.2)	(22.2)	(23.9)	(93.0)	
Post EBITDA	(3.0)	(2.7)	(2.6)	(2.9)	(11.2)	
Underlying Deficit	(6.7)	(6.3)	(5.2)	(4.1)	(22.3)	
Costs / income (%)	111.7%	110.8%	108.9%	106.8%	109.5%	

- SLA income is £2.9m behind plan and £1.7m behind plan when the prior year issues are excluded. The key drivers of this are outpatient income £1.6m, which is 3% down on activity and income, and increasing levels of challenges from commissioners. Elective income has improved in month
- The underlying actuals table above shows that there has been little movement in total pay. However, there has been an increase in substantive pay and a reduction in temporary staff costs.
- There has been some fluctuation in the underlying actuals for non pay but the average remains at c£23m per month.
- Whilst the underlying deficit and the ratio of cost to income show an encouraging improving trend, it is important to note that the income will fluctuate for changes in the working days in the month, but that many of the costs are fixed from month to month.

Cost improvement programme

- Year to date, the Trust has delivered £8.1m of savings, comprising £3.9m of CIPs (of which £2.1m is from 'Green' rated schemes) and a further £4.1m of non-recurrent and run rate/vacancy control savings
- This is a shortfall of £0.9m against the phased plan
- The full year forecast for Green rated CIPs totals £7.5m being a £0.4m decrease on M03 due to removal of Green schemes following further governance reviews
- Run-rates/non-recurrent are being counted against the CIP target and therefore there are currently no mitigations to the £6.6m I&E underperformance. The divisions are being tasked with considering what additional actions are required, including reviewing activity levels in loss making activities.

Cash

- The cash balance was £6.2m at 31st July which is £2.5m favourable to plan. The adverse cash impact of the £0.9m revenue overspend in July was offset by an underspend on capital expenditure.
- The Trust cleared a significant proportion of the supplier invoice backlog in July, reducing creditor levels by approx £8.7m. This was financed in part by improved debt recovery and a reduction in debtors of c£4m

Capex

- Capital expenditure in July was £2.6m and YTD expenditure is £12m against the new YTD budget of £16.4m i.e. an under spend of £4.4m.
- The Trust is carefully controlling the pace of capital expenditure where appropriate to support the cash position until the interim support funding is agreed with Monitor/ITFF.
- £0.1m of the capital contingency budget has been applied for urgent infrastructure renewal schemes leaving £0.9m unallocated as at M04.
- Budget holders indicate that the YTD under spend relates primarily to in-year timing differences and so the forecast outturn is an underspend of only £1.6m.

2. Turnaround actions

The following are the key actions the Turnaround process has initiated :

Pay

- Weekly detailed headcount tracking – by division, care group and staff type (complete)
- Forward visibility of leavers (complete) and developing forward view of recruitment (end July)
- To understand why establishment and vacancies have increased, all open vacancies to be reconciled between Finance and HR (by 31 July) and cleansing historic and non-critical vacancies (by mid August)
- Develop process to ensure alignment of total posts between Finance and HR (31 July)
- Various controls including a vacancy control panel, temporary staffing policy were introduced prior to KPMG's arrival at the Trust
- All temporary labour spend reported in single report, on a weekly basis (w/c 20 July)
- Systemised visibility of underutilised resources across wards (w/c 20 July)
- Compliance reporting to ensure rotas approved eight weeks in advance (w/c 27 July)
- Re-model provision of medical secretary support, 20% workforce reduction target (July)
- Extend apprenticeship programme (August)
- South West London-wide shared bank (August)
- Management structures review (August)
- Medical efficiency improvements – Waiting List Initiative (August)
- Workforce efficiency – Mutually Agreed Resignation Scheme (September)

Non Pay

- Email sent from CEO, CFO and Turnaround Director to whole Trust outlining changes to spend controls
- Standing Financial Instructions ('SFIs') changed to limit financial approval levels, e.g. Band 8B or equivalent from £40k to £3k
- Daily reviews of all requests to ensure they are directed at patient activities and are required
- Email inbox setup to generate staff ideas / increase engagement
- Limit access to NHS Supply Chain and 'direct to invoice' routes (end July)
- Review of software licenses and maintenance plans (start in early August)
- Hold 'cost awareness' sessions with overspending areas (August)
- Develop guidance and materials to embed 'cost culture' (late August)

Cash

- Cash actions have created permanent and timing benefits of up to £24M (intra-month), some of which unwinds due to timing differences and increased supplier payments
- Reducing the capital plan;
- £22M early CCG receipts (14 day benefit);
- Fortnightly payment runs and reinforcing PO controls; and
- Extending creditor terms to 60 days (with exclusions).
- The backlog of aged creditors will be substantially cleared by 11 Sep 2015.
- Further actions on debt recovery and inventory are planned
- Increased governance and vigilance is in place to manage and control any risks in relation to supply of goods including urgent action to strengthen the procurement function

3. Further actions to address in year performance

To address the adverse variance to date, monthly performance review meetings have been set up with each division. These review meetings will address both financial and operational performance. The outputs of these meetings will include agreed actions to improve the financial position of each division. These will be monitored over the coming months to assess their effectiveness and whether further measures will need to be taken. The monitoring will include cross divisional checks where improvement is dependent on the actions of another division.

Whilst CIP progress will be included in the performance management reviews, the main governance vehicle for CIP performance will remain the turnaround board.

Key risks identified:

The allocation of the contingency to fund divisional cost pressures and the setting of control totals with divisions in respect of unavoidable cost pressures has indicated a risk of a further £7m deficit.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	1) Achieve financial targets in the near term 2) Achieve long term financial sustainability
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	N/A

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

If yes, please provide a summary of the key findings

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

If no, please explain your reasons for not undertaking an EIA.

Summary Finance Report
Month 04 2015/16

Trust Board 3rd September 2015

(Please see Appendix H for a summary of the reporting and accounting developments that have been taking place that underpin this Finance Report.)

❶ Month 04 Headlines

Area of Review	Key Highlights	Month
Financial Position	As at month 4 the Trust is showing a deficit of £24.8m against its monitor plan deficit of £18.2m giving an adverse variance of £6.6m (comprising Pay £3.1m adv, Income £3.0m adv and Non-pay £0.5m adv). The key drivers are underperformance in Outpatient activity, the prior year costs previously notified and unidentified CIPs	
Activity / Income	SLA income is £2.9m behind plan the key drivers of which are outpatient income (which is 3% down on activity and income) and the prior year items noted previously. Emergency and A&E income collectively is slightly above plan, but most of this element of the contract is operated as a block which means that the over-performance is not reflected in increased income. Elective income has improved in month.	
Expenditure-Pay	The element of the pay CIP target that has no 'Green' schemes to support it, created a £8.3m YTD adverse variance. Partially offsetting this are savings being made in nursing, non clinical staffing and professional and scientific pay which brings the overall adverse position on pay to £3.1m. In July the Trust incurred £38.8m of pay costs compared to £37.9m in June. However £1.2m increase relates to transfer of Interim contractors from Non pay to Pay. Pay in-post represented 86% of costs in month compared to 87% in June. Pay costs rose compared to M3 with Agency/Bank costs higher than June by £0.6m (excluding the interim contractors this would be lower).	
Expenditure – Non Pay	The element of the non-pay CIP target that has no 'Green' schemes to support it created a £2.7m YTD overspend. Partially offsetting this are savings made in a number of areas which bring the overall adverse position on non-pay to £1.4m. As mentioned last month, non-pay expenditure contains £1.3m of costs relating to 2014/15. Adjusting for this implies an underspend run-rate (post CIP) of £0.1m YTD.	
CIP	Year to date, the Trust has delivered £8.1m of savings, comprising £3.9m of CIPS (of which £2.1m are 'Green') and a further £4.1m of 'run-rate' and non-recurrent savings. This is a £4.6m adverse variance to the internal plan and £0.9m adverse to the Monitor plan.	
FSRR (formally COSRR)	In August Monitor updated the risk assessment framework to require the Trust to assign itself a financial sustainability risk rating (FSRR) replacing the COSRR. The Trust scored a 1 at M04, compared to a FSRR plan of 2, due to the adverse variance in YTD I&E performance. Under COSRR, the trust scored a 2 in line with the Annual Plan for M04.	
Cash	The cash balance was £6.2m at 31st July which is £2.5m favourable to plan. The adverse cash impact of the £0.9m revenue overspend was offset by an underspend on capital expenditure. The Trust cleared a significant proportion of the supplier invoice backlog in July– reducing creditor levels by approx £8.7m. This was financed partly by a reduction in debtors of approx £4m. The current cash forecast indicates the cash balance will be c£5m on 31st August. Monitor have advised that the Trust will now need a temporary ITFF loan rather than an increase in its working capital facility to secure finance over and above the £25m permitted under its WCF until the level of interim support funding for the year is agreed in December.	
Capital	Capital expenditure was £2.6m in July, an under spend of £1.6m against the new reduced £48m capital programme agreed in June. The YTD figure of £12m is £4.4m less than the revised plan. In order to support the cash position the Trust is continuing to slow down the rate of capital expenditure where possible until the discussions with Monitor on the interim support funding are concluded.	

❶ Month 04 Headlines : Conclusions and risks

Category	Conclusions / Risk	Evidence
Financial position	Further additional pressures to the planned deficit have been identified as the business planning process has been finalised. A turnaround reforecast is planned to be completed by November which will review the fundamental demand and capacity issues. Whilst there are non recurrent costs in the ytd position these will need to be recovered to achieve the planned outturn.	See separate SB budget setting update paper
Activity/Income	Activity is down against plan as shown in M4 SLAM particularly in out patients (3%). Action is being taken with Divisions to provide assurance that they will recover the activity	Section 3 & 4
Pay	The Trust has adopted a Turnaround approach supported by KPMG to work with the budget holders on increasing 'grip' of pay costs and developing / implementing credible CIP schemes.	Section 5
Non Pay	The Trust has adopted a Turnaround approach supported by KPMG to work with the budget holders on increasing 'grip' of non-pay costs and developing / implementing credible CIP schemes.	Section 6
Capital	The key risk for capital expenditure is that expenditure must be constrained until interim support funding is confirmed.	Section 9
Cash	Risk will remain high until the level and timing of the £48.7m (£52.2m) interim support requested is confirmed.	Section 10

❷ Overall Position

	Annual Budget £m	Current Budget £m	Current Amount £m	Current Variance (adv) / fav £m	YTD Budget £m	YTD Amount £m	YTD Variance (adv) / fav £m	%
SLA Income	623.56	53.50	52.17	(1.33)	202.79	199.85	(2.94)	*-1%*
Other Income	97.61	8.23	8.32	0.09	32.49	32.37	(0.12)	*-0.4%*
Overall Income	721.17	61.73	60.49	(1.24)	235.28	232.22	(3.06)	*-1.3%*
Pay	(446.56)	(38.09)	(38.80)	(0.71)	(148.46)	(151.53)	(3.07)	*-2.1%*
Non Pay	(284.09)	(22.94)	(22.06)	0.89	(93.47)	(94.29)	(0.81)	*-0.9%*
Overall Expenditure	(730.66)	(61.04)	(60.86)	0.18	(241.94)	(245.81)	(3.88)	*-1.6%*
EBITDA	(9.49)	0.70	(0.36)	(1.06)	(6.66)	(13.60)	(6.94)	*-104.1%*
Dpn, PDC div etc	(36.72)	(3.01)	(2.89)	0.12	(11.54)	(11.17)	0.37	*3.2%*
Surplus / (deficit)	(46.21)	(2.31)	(3.25)	(0.94)	(18.20)	(24.77)	(6.57)	*-36.1%*

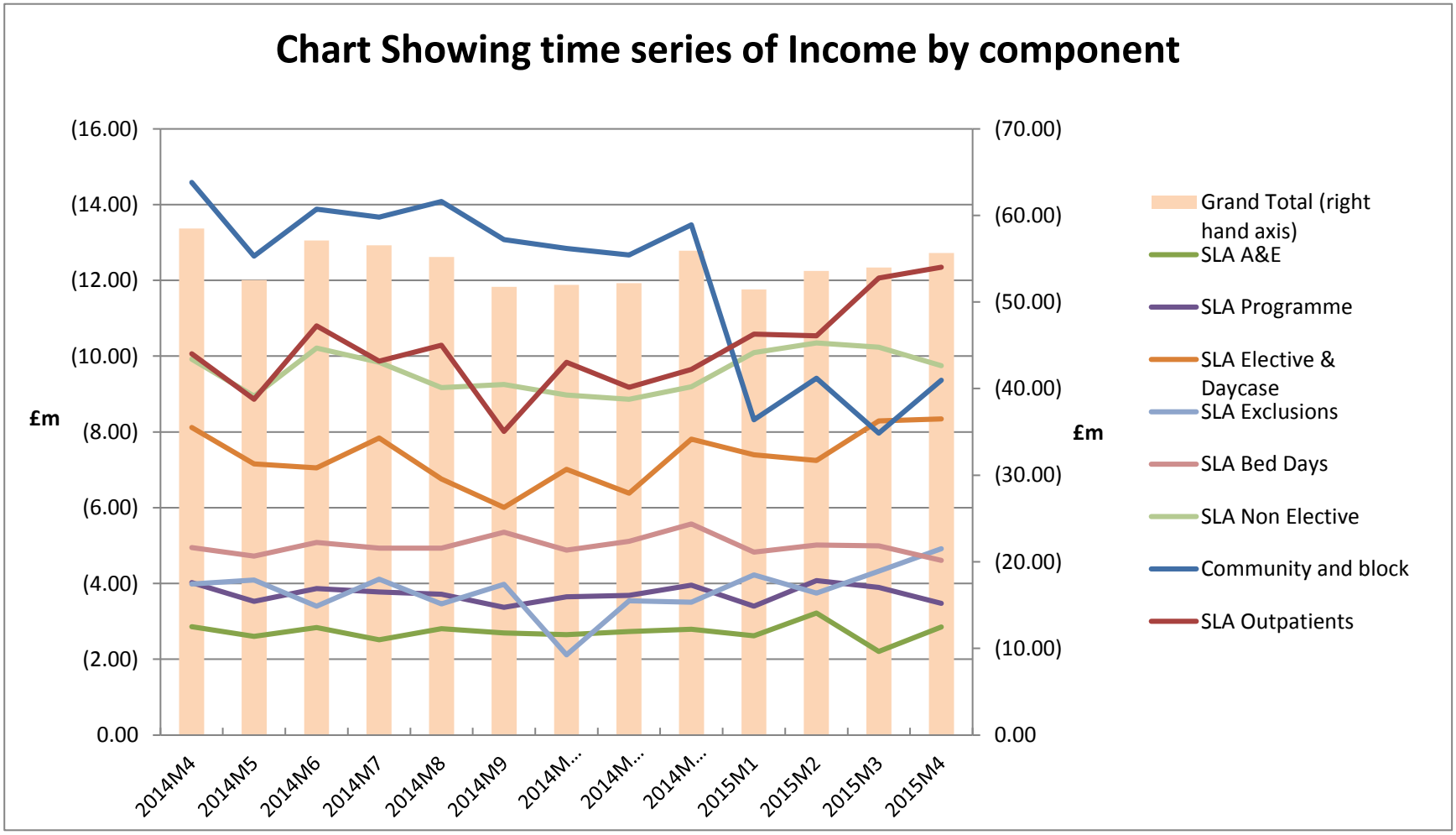
- The YTD deficit of £24.8m is £6.6m adverse to plan with the in month deficit of £3.2m being £0.9m adverse
- All elements are adverse to plan YTD, with the main drivers being underperformance in Outpatient activity, the prior year costs previously notified and unidentified CIPs
- The pay adverse variance consists of £8.3m of unidentified CIPs offset by planned and unplanned underspends on Nursing, Scientific & Technical and Admin.
- The non pay adverse variance includes £2.9m of unidentified CIPs offset by underspends on clinical consumables
- It is important to note that some £6.9m of additional CIP delivery has not achieved the milestones to be allocated in the ledger but is effectively held as favourable variances offsetting the £8.3m and £2.9m noted above
- As noted previously, some £2.5m of prior year costs and income losses have contributed to the adverse position to date.

❸ SLA Income

Variance YTD 2015/16 (adv) / fav	CWDT		CSD		Medicine & CV		Surgery & Neuro		Overheads		Central		Grand Total	
	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
SLA A&E	0.00		(0.02)	*-5.4%*	(0.03)	*-0.5%*	0.00		0.00		(0.04)		(0.09)	*-1.4%*
SLA Bed Days	(0.02)	*-0.1%*	(0.05)	*-2.8%*	0.00		0.03	*1.2%*	0.00		0.00		(0.04)	*-0.2%*
SLA Daycase	0.13	*8.7%*	0.00		(0.01)	*-0.2%*	0.13	*2.9%*	0.00		0.00		0.25	*2.6%*
SLA Elective	(0.34)	*-19.6%*	0.00		(0.19)	*-2.4%*	0.46	*4.0%*	0.00		0.06		(0.01)	*0.0%*
SLA Exclusions & Prog.	0.02	*3.6%*	0.01	*0.3%*	0.09	*0.6%*	0.11	*3.4%*	(0.08)	*-5.9%*	(0.00)	*-800.0%*	0.15	*0.7%*
SLA Non Elective	0.38	*14.1%*	0.00		0.44	*2.1%*	(0.33)	*-2.0%*	0.00		(0.31)		0.17	*0.4%*
SLA Other	(0.08)	*-1.1%*	0.18	*0.8%*	(0.25)	*-3.9%*	(0.38)	*-40.2%*	(0.06)	*-88.3%*	(1.20)	*-92.2%*	(1.78)	*-4.8%*
SLA Outpatients	(0.52)	*-4.0%*	(0.73)	*-8.4%*	(0.62)	*-5.0%*	0.06	*0.6%*	0.29	*10.9%*	(0.06)		(1.59)	*-3.4%*
Grand Total	(0.42)	*-1.0%*	(0.62)	*-1.8%*	(0.57)	*-0.8%*	0.08	*0.2%*	0.14	*3.6%*	(1.55)	*-136.8%*	(2.94)	*-1.4%*

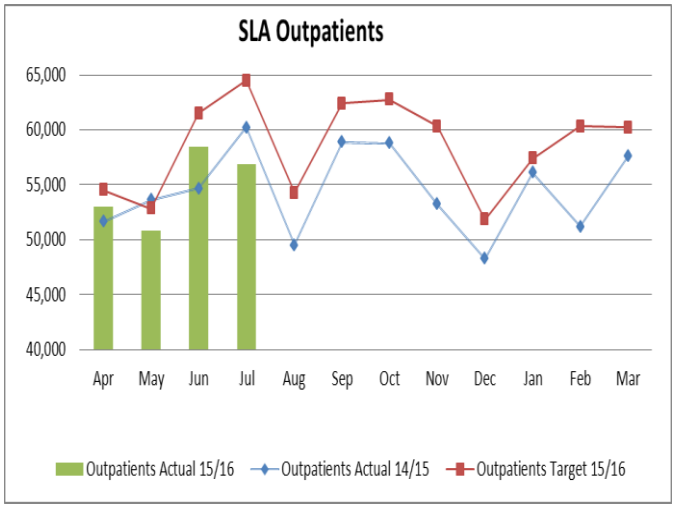
- SLA income in total is cumulatively £2.9m behind plan. Adjusting for prior period issues £1.0m, the underlying run-rate would be £1.9m (1.0%) adverse to plan
- As noted in Appendix H, the Trust has changed the way it treats 'excluded' drugs by re-profiling the in-month income and expenditure budget to remove the variances. To date £1.9m has been removed from income and expenditure budgets.
- The main POD behind plan is Outpatients with many specialties under plan. Nelson activity has been profiled to reflect a slow start and the level of activity is now starting to increase as more patients are booked in.
- An important part of the SLA with local CCGs is a block around emergency activity supported by additional investment in capacity. Emergency activity for these CCGs is above target by £0.1m and on the basis that this is a block, the income has been reduced leaving no variance for these CCGs.
- All SLA income is now included in one SLAM system covering Acute, QMH, Community and the Nelson.
- Trends of income and activity are shown on the following pages.

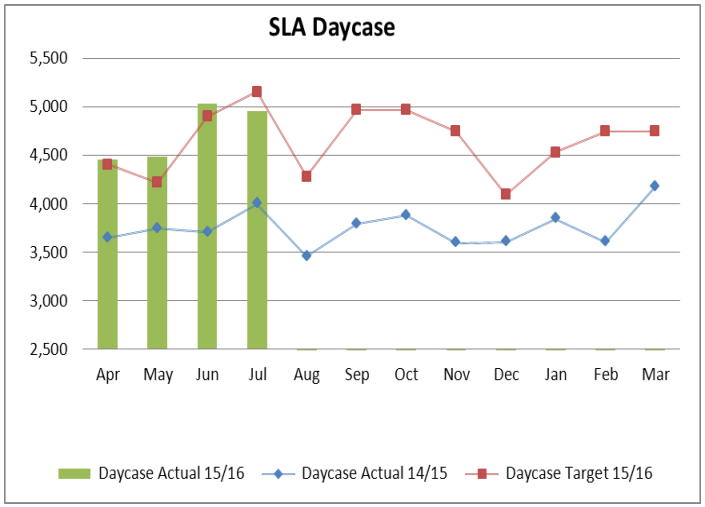
❸ Income trends

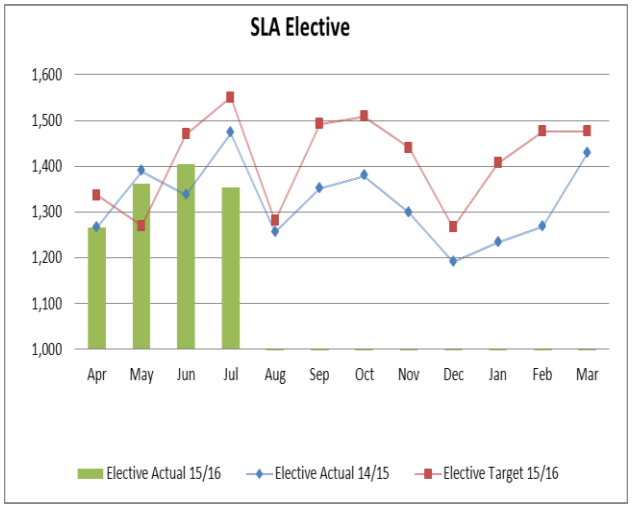


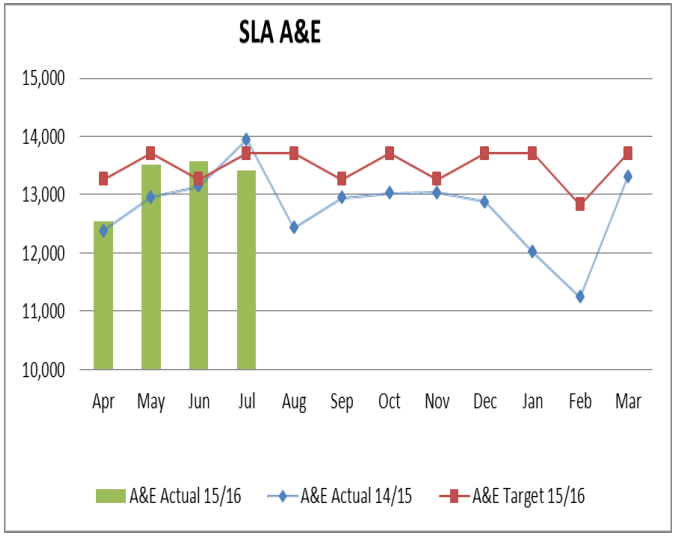
① Note QMH income all used to be coded to one account code in 14/15. Now that the QMH income has moved into SLAM in 15/16, it is being coded to account codes based on the POD, rather than one catch all account code.

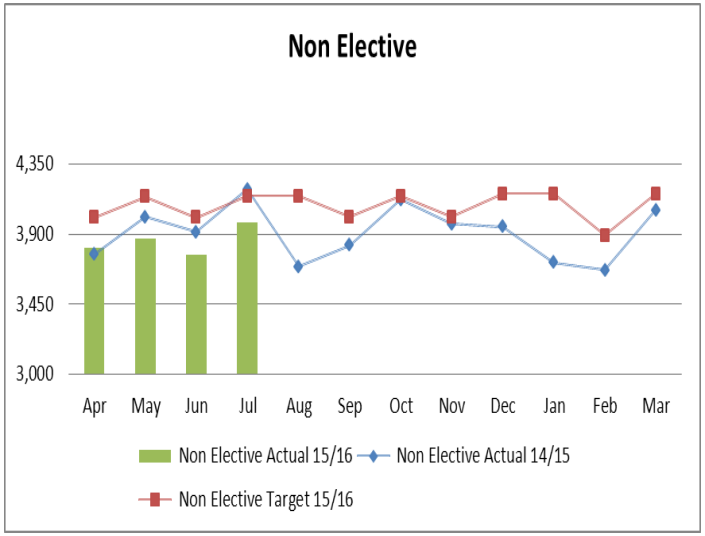
❹ Activity - 2015/16 actuals vs 2015/16 plan vs 2014/15 actuals











Both activity and income levels have risen overall in month 4 however they were lower than the planned levels.

Outpatient and elective activity continue to be significantly under plan. Non Elective activity remains under plan however the Emergency block arrangement is also adversely hitting the financial value.

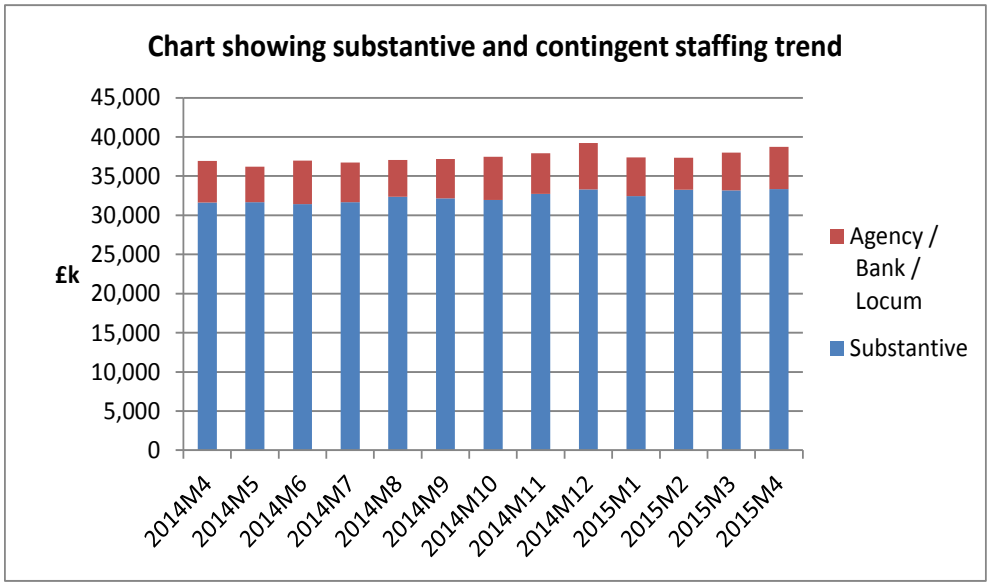
PLEASE NOTE THAT THESE GRAPHS ARE NOT BASED FROM ZERO IN ORDER TO HIGHLIGHT CHANGES IN TREND.

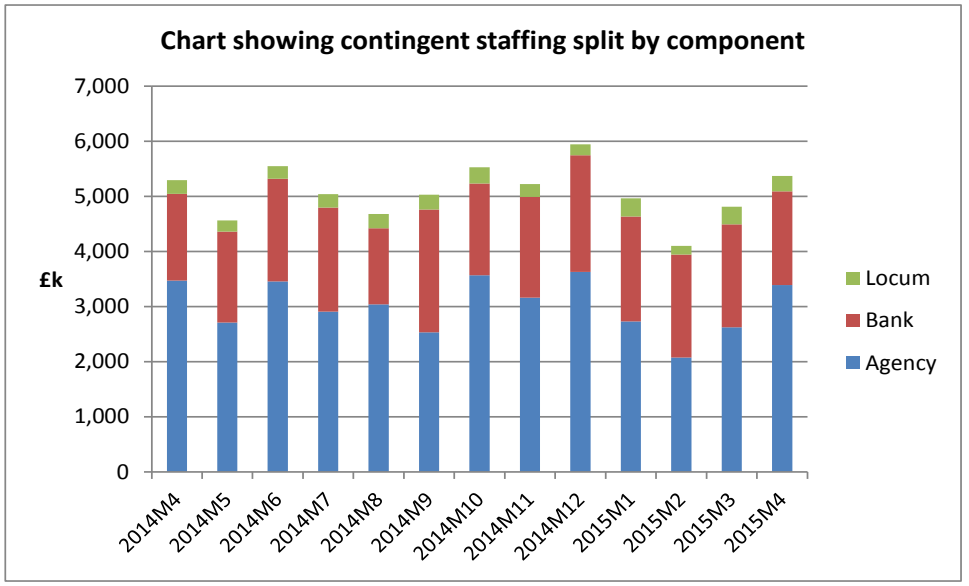
❺ Pay costs

Variance YTD 2015/16 (adv) / fav	CWDT		CSD		Medicine & CV		Surgery & Neuro		Overheads		R&D		SWL Path		Central		Grand Total	
	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
Pay Consultants	(0.32)	*-5.9%*	(0.02)	*-3.0%*	0.10	*1.6%*	(0.03)	*-0.3%*	0.05	*18.2%*	(0.00)	*-3.3%*	(0.14)	*-5.7%*	(0.06)		(0.41)	*-1.8%*
Pay Jnr Drs	0.12	*2.8%*	(0.26)	*-51.4%*	(0.02)	*-0.3%*	0.07	*1.4%*	0.05	*13.2%*	0.01		0.00		0.00		(0.01)	*-0.1%*
Pay Non Clinical	0.35	*7.1%*	0.09	*3.5%*	0.09	*3.1%*	(0.03)	*-0.9%*	0.66	*5.6%*	(0.28)	*-124.2%*	0.06	*7.4%*	(0.10)		0.85	*3.2%*
Pay Nursing	0.97	*5.5%*	0.94	*9.9%*	0.52	*2.8%*	1.30	*8.6%*	0.05	*3.9%*	(0.01)	*-4.7%*	(0.01)		0.08		3.84	*6.2%*
Pay Other	(0.01)		0.00		(0.05)		(0.40)		(0.01)		(0.00)		0.05		0.00		(0.43)	
Pay Sci, Techs, Therap	0.59	*5.7%*	0.36	*7.5%*	0.06	*3.3%*	0.22	*6.1%*	0.15	*8.3%*	(0.01)	*-14.3%*	0.07	*1.2%*	0.00		1.44	*5.1%*
Pay Unallocated CIP	(2.13)		(1.36)		(2.22)		(1.88)		(0.74)								(8.33)	
Grand Total	(0.44)	*-1.1%*	(0.25)	*-1.5%*	(1.52)	*-4.5%*	(0.74)	*-2.2%*	0.22	*1.5%*	(0.29)	*-42.4%*	0.03	*0.3%*	(0.08)		(3.07)	*-2.1%*

- In month 4 total pay expenditure of £38.8m (M3 £38.0m) was £0.8m (M3 £1.3m) over budget and is cumulatively £3.1m over budget
- Total pay rose compared to last month. There has been an increase in Agency of £0.7m while substantive spend was up £0.2m.
- Agency increase was due to the change in accounting treatment for Interim contractors who were previously recorded as consultancy under non pay but are now properly included under pay. This accounted for £1.2m of additional costs moving from non pay to pay (which included backdated costs to Month 1 of approx. £0.9m).
- Excluding this backdated impact, agency was £0.4m lower on a like for like basis than last month, mainly on Nursing costs. Overall agency use fell from 8% to 7% of total pay and bank fell to 4.5% compared to 5% last month.
- All clinical divisions have YTD adverse overall variances for pay.
- As noted in the CIP section the unidentified CIP balance of £8.3m is after only allocating Green rated schemes to specific cost codes. A further £5.2m of schemes are reporting as achieving after including amber and run rate schemes.
- If these further schemes had been allocated the favourable variances shown above by staff group of £5.3m would be fully absorbed.
- The unidentified CIP target is 80% of the balance after the green rated schemes have been allocated to specific cost centre/account codes
- Unallocated CIP targets have been split 80% to pay and 20% to non-pay, except in Estates which has used the reverse percentages
- It should be noted that all Divisions are achieving an element of their run-rate targets and that this reduces the variance from unidentified CIPs

❺ Pay trend (1)





monthly trend

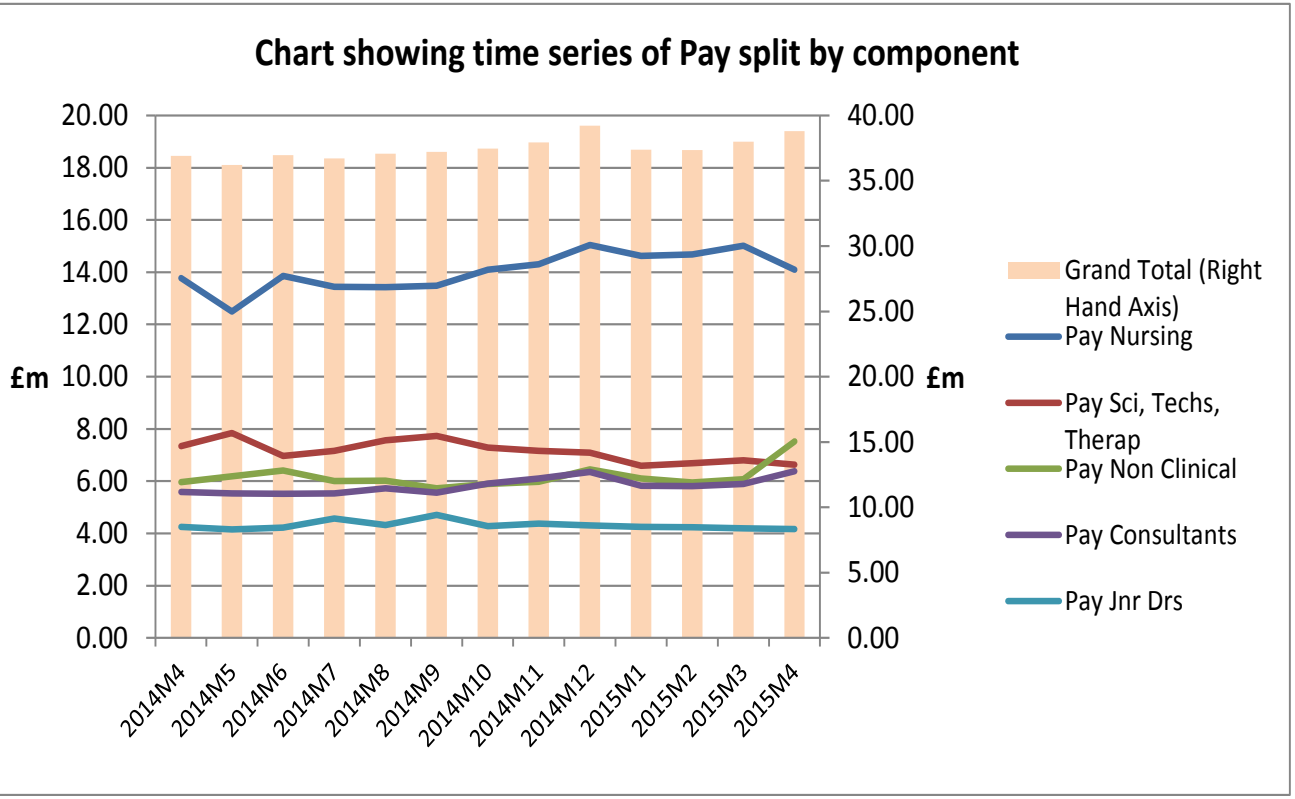
	£k	%
Substantive	164.38	0.5%
Agency /Bank / Locum	-8.91	-0.2%
Total	155.47	0.4%

monthly trend

	£k	%
Agency	-28.25	-0.8%
Bank	16.37	1.0%
Locum	2.98	1.1%
Total	-8.91	-0.2%

- Total pay of £38.8 in month 4 is £1.8m (5%) higher than the same month last year. Stripping out the interim contractors accounting change this would be £0.6m higher.
- There is a small increase in the average rate of increase per month from £147k (0.4%) to £155k (0.4%).
- The average rate of temporary agency spend has fallen by £28k over the past year while bank usage has risen mainly due to the initiative to increase bank use of admin staff.
- Pay costs increase for pay awards inflation, increments, pensions changes and service developments, and reduce through reduction in agency premiums, staff utilisation and CIP schemes.

❺ Pay trend (2)



monthly trend	£m	%
Pay Nursing	0.14	1.0%
Pay Sci, Techs, Therap	(0.08)	-1.1%
Pay Non Clinical	0.05	0.6%
Pay Consultants	0.06	0.9%
Pay Jnr Drs	(0.01)	-0.2%
Grand Total	0.16	0.4%

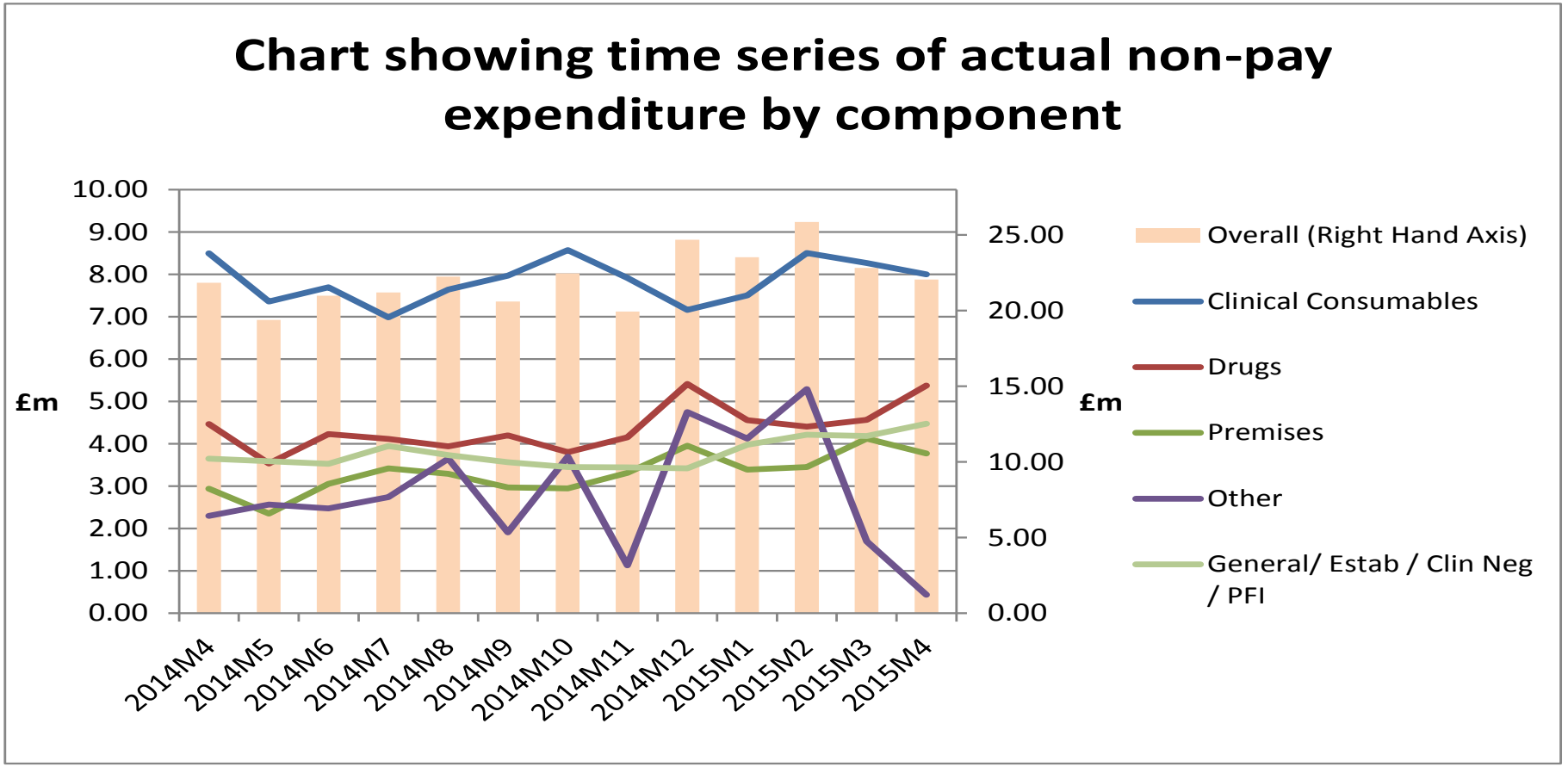
- Nursing and Consultants remain the main drivers of the trend increase in pay although total nursing fell in month 4 as fewer bank and agency shifts recorded.
- Non clinical pay rose in month due to impact of changing accounting treatment of Interim contractors from non pay consultancy to a pay cost category in month 4 including backdated impact to month 1.

❻ Non pay costs

Variance YTD 2015/16 (adv) / fav	CWDT		CSD		Medicine & CV		Surgery & Neuro		Overheads		R&D		SWL Path		Reserves/ Central		Grand Total	
	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
Clinical Consumables	0.36	7%	0.37	11%	0.05	0%	0.58	8%	(0.11)	-38%	(0.00)		0.16	4%	0.00		1.41	4%
Drugs	(0.16)	-7%	(0.25)	-6%	(0.15)	-2%	0.05	2%	0.00	3%	0.00		(0.00)	-54%	0.00		(0.51)	-3%
Other	(0.13)	-12%	0.27	30%	(0.02)	-1%	0.12	20%	0.42	2%	0.10	62%	(0.01)	-1%	0.00		0.75	3%
Premises	0.09	17%	(0.00)	-1%	0.08	44%	0.04	17%	0.34	3%	0.00	10%	(0.16)	-18%	0.00		0.38	3%
Clinical Negligence	0.00		(0.00)		0.00		(0.00)	-155%	(0.12)	-2%	0.00		0.00	0%	0.00		(0.12)	-2%
NHS and External Facilties	0.05	57%	(0.02)	-1%	(0.14)	-21%	(0.37)	-145%	(0.02)	-57%	0.00		(0.22)	-72%	0.00		(0.73)	-18%
True Reserves	0.00	0%	0.00	0%	0.00	0%	0.00	0%	0.00	0%	0.00		0.00	0%	1.04	28%	1.04	28%
Prior Year Costs	0.00	0%	0.00	0%	0.00	0%	0.00	0%	0.00	0%	0.00		0.00	0%	(1.30)		(1.30)	-23%
Central Adjustments	0.00		0.00		0.00		0.00		0.00		0.00		0.00		1.17	14%	1.17	14%
CIP Unallocated	(0.56)		(0.37)		(0.69)		(0.22)		(1.05)		0.00		0.00		0.00		(2.89)	
Grand Total	(0.36)	-4%	(0.00)	0%	(0.87)	-4%	0.20	2%	(0.54)	-1%	0.10	58%	(0.23)	-3%	0.91	21%	(0.81)	-1%

- The main driver of the adverse variance on non pay is the prior year costs as reported in previous months.
- As noted in the CIP section the unidentified CIP balance of £2.9m is after only allocating Green rated schemes to specific cost codes. A further £1.3m of schemes are reporting as achieving.
- Please note as per pay section, that interim contractors have been reclassified from non pay other to pay, backdated to month 1 giving an favourable variance of circa £0.7m.
- As noted in Appendix H, the Trust has changed the way it treats 'excluded' drugs by re-profiling the in-month income and expenditure budget to remove the variances. To date £1.9m has been removed from income and expenditure budgets.
- The unidentified CIP target is 20% of the balance after the green rated schemes have been allocated to specific cost centre/account codes.
- Unallocated CIP targets have been split 80% to pay and 20% to non-pay, except in Estates which has used the reverse percentages
- Clinical consumables spend fell by £0.4m in M4 and is underspent by £1.4m after excluding prior year costs.
- Expenditure on Drugs was higher than M3 but in line with variability of high cost drugs.
- Premises in line with trend that now includes space costs from SGUL.

❻ Non pay trends



Overall Non pay expenditure has increased over the last year. This is largely driven by increasing reclaimable drugs costs, new premises costs and use of external facilities. In Month 4 there was a further reduction in "other" non pay as interim contractor costs were recoded as pay and less reserves were accrued due to the distribution to divisions of contingencies to cover further approved cost pressures.

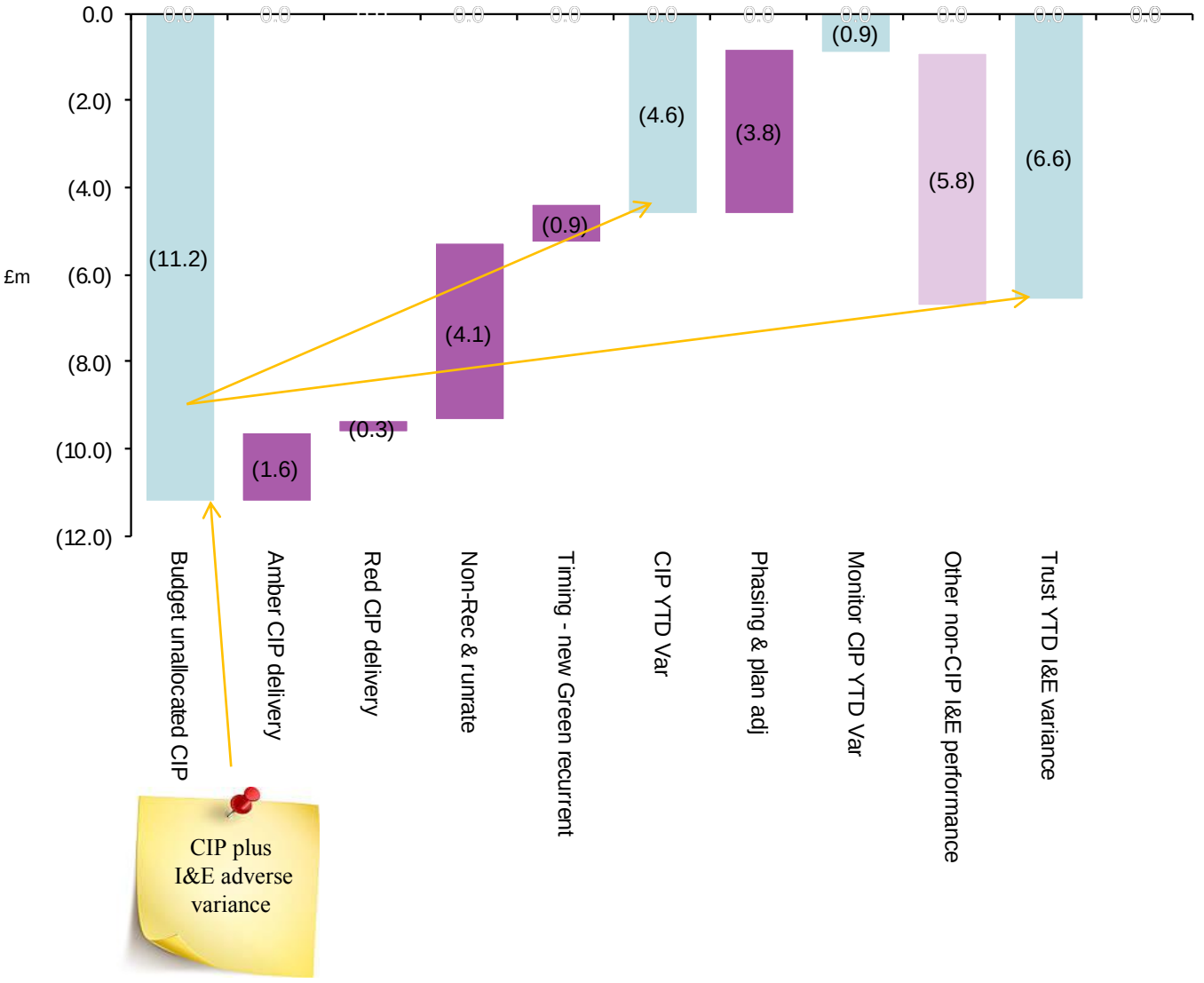
❼ Trust CIP performance

- The CIP target for 2015/16 is £38.1m and this is profiled in the budget in equal twelfths. The Monitor target is £34.2m (90%) which has a different profile to that set out in the budget.
- Year to date, the Trust has delivered £8.1m of savings, comprising £3.9m of CIPS (of which £2.1m is from 'Green' schemes) and a further £4.1m of non-recurrent and run rate/vacancy control savings This represents a £4.6m adverse variance to the budget (£0.9m adverse to Monitor).
- Green CIPS total £7.5m being a £0.4m decrease on M03 due to removal of Green schemes following further governance reviews.
- Run-rates/non-recurrent are being counted against the CIP target and therefore there are currently no mitigations to the £6.6m I&E underperformance. The divisions are being tasked with considering what additional actions are required, including the discontinuation of, or reducing activity in loss making activities. EMT/Board approvals may be required.

	ACTUAL				FORECAST										
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	SUM	M3 F&P	CHANGE
CIP PLANNING AND PERFORMANCE															
TRUST TARGET	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	38.1		
ACHIEVED YTD / FORECAST :															
GREEN CIPS	0.4	0.5	0.5	0.7	0.6	0.7	0.7	0.7	0.7	0.7	0.7	0.7	7.5	8.0	-0.4
AMBER CIPS	0.6	0.4	0.3	0.3	0.5	0.6	0.8	0.8	0.8	0.8	0.8	0.8	7.6	8.1	-0.5
RED CIPS	0.2	0.1	-0.2	0.2	0.2	0.3	0.5	0.5	0.5	0.6	0.5	0.5	4.1	6.1	-2.0
DELIVERED RUNRATES/NON-RECURRENT	1.3	1.5	0.8	0.5									4.1	2.9	1.3
FORECAST RUNRATES					1.3	1.2	1.0	0.9	0.9	0.9	0.9	0.9	7.8	7.5	0.3
	2.5	2.5	1.3	1.7	2.7	2.7	3.0	2.8	2.9	3.0	2.9	2.9	31.1	32.5	-1.4
TRUST CIP VARIANCE	-0.7	-0.7	-1.8	-1.4											
YTD TRUST CIP VARIANCE VAR	-0.7	-1.4	-3.2	**-4.6**											
FYFC CIP VARIANCE - GREEN FC ONLY												**-24.6**			
FYFC CIP VARIANCE - GREEN& AMBER FC												**-18.6**			
FYFC CIP VARIANCE - ALL RAG, N/R & RUNRATES												**-7.0**			
MONITOR TARGET RECONCILIATION															
MONITOR TOTAL TARGET	2.2	2.2	2.3	2.3	2.3	2.4	3.1	3.1	3.1	3.8	3.8	3.8	34.2		
TRUST TARGET	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	38.1		
DIFFERENCE	-1.0	-1.0	-0.9	-0.9	-0.9	-0.8	-0.1	-0.1	-0.1	0.6	0.6	0.6	-3.9		
MONITOR VAR	0.4	0.3	-1.0	-0.6	-0.9	-0.8	-1.1	-1.1	-1.1	-1.6	-1.7	-1.7	-11.0		
YTD MONITOR VAR	0.4	0.7	-0.3	**-0.9**											

Budgeted CIP reconciliation to Trust & Monitor CIP reporting and I&E

St George's University Hospitals NHS
NHS Foundation Trust



Budgets show an unallocated CIP of £11.2m across Pay and Non-pay in the divisions.

The reported YTD adverse against CIP target is £4.6m.

The difference represents CIPs delivered which have not been moved out of the CIP unidentified budget line due to timing or RAG rating.

Budgeted CIP reporting is against the £38.1m internal target. The difference between the Monitor target and the internal target is £3.8m which is due to phasing £2.5m and adjusted 90% target of £1.3m.

The £5.8m movement from the resulting £0.9m Monitor variance to the trusts YTD £6.6m adverse I&E position is due to non-CIP adverse performance.

Runrate and non-recurrent schemes are reported against CIP and are therefore not available to offset this adverse performance and further mitigations need to be found to ensure delivery of the trust's £46m deficit plan.

Divisional variances and additional CIP allocations

Reported YTD Var 2015/16 (adv) / fav	CWDT	Community Services	Medicine and CV	Surgery & Neuro	Overheads	R&D	SWL Pathology	Reserves	Central	Grand Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
SLA Income	(0.42)	(0.62)	(0.57)	0.08	0.14	0.00	0.00	0.00	(1.55)	(2.94)
Other Income	0.35	(0.01)	(0.37)	(0.35)	(0.15)	0.19	0.30	(0.00)	(0.08)	(0.12)
Pay	1.70	1.11	0.70	1.14	0.95	(0.29)	0.03	0.00	(0.08)	5.26
Pay CIP Unallocated	(2.13)	(1.36)	(2.22)	(1.88)	(0.74)					(8.33)
Non Pay	0.20	0.36	(0.18)	0.42	0.50	0.10	(0.23)	1.04	(0.13)	2.08
Non Pay CIP Unallocate	(0.56)	(0.37)	(0.69)	(0.22)	(1.05)					(2.89)
Other	(0.00)	(0.00)	0.00	(0.00)	0.03	0.00	0.00	0.00	0.34	0.37
Grand Total	(0.86)	(0.88)	(3.32)	(0.82)	(0.31)	0.00	0.10	1.04	(1.51)	(6.57)

Additional CIP allocations	CWDT	Community Services	Medicine and CV	Surgery & Neuro	Overheads	R&D	SWL Pathology	Reserves	Central	Grand Total
SLA Income	(0.07)	(0.12)	(0.09)	(0.34)						(0.62)
Other Income	(0.15)	(0.06)	(0.08)	(0.01)	(0.01)					(0.31)
Pay	(1.49)	(0.61)	(0.93)	(1.34)	(0.69)					(5.07)
Pay CIP Unallocated	1.48	0.69	1.14	1.64	0.61	0.00	0.00	0.00	0.00	5.55
Non Pay	(0.14)	(0.06)	(0.31)	(0.35)	(0.07)					(0.93)
Non Pay CIP Unallocate	0.37	0.17	0.28	0.41	0.15	0.00	0.00	0.00	0.00	1.39
Other										0.00
Grand Total	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Adjusted YTD Var 2015/16 (adv) / fav	CWDT	Community Services	Medicine and CV	Surgery & Neuro	Overheads	R&D	SWL Pathology	Reserves	Central	Grand Total
SLA Income	(0.49)	(0.74)	(0.66)	(0.26)	0.14	0.00	0.00	0.00	(1.55)	(3.56)
Other Income	0.20	(0.07)	(0.45)	(0.36)	(0.15)	0.19	0.30	(0.00)	(0.08)	(0.43)
Pay	0.21	0.50	(0.23)	(0.21)	0.26	(0.29)	0.03	0.00	(0.08)	0.19
Pay CIP Unallocated	(0.65)	(0.67)	(1.08)	(0.24)	(0.12)	0.00	0.00	0.00	0.00	(2.78)
Non Pay	0.07	0.30	(0.50)	0.07	0.44	0.10	(0.23)	1.04	(0.13)	1.15
Non Pay CIP Unallocate	(0.19)	(0.19)	(0.41)	0.19	(0.90)	0.00	0.00	0.00	0.00	(1.50)
Other	(0.00)	(0.00)	0.00	(0.00)	0.03	0.00	0.00	0.00	0.34	0.37
Grand Total	(0.86)	(0.88)	(3.32)	(0.82)	(0.31)	0.00	0.10	1.04	(1.51)	(6.57)

As shown on the previous slide there are a number of additional CIP schemes that are delivering benefit that are not yet allocated to specific cost codes in the ledger as there governance has not yet been 'green' rated.

These include the amber (£1.6m) and red (£0.3m) schemes and the non recurrent items (£4.1m) which are mainly run-rate.

Additionally some £0.9m of schemes have been confirmed as green since the ledger was closed.

These tables show how the variances in each division would be reported if these schemes had been allocated in the ledger.

❽ Divisional Summaries
CWDT - Divisional I&E

	2015/16 Annual Budget	Previous Months Actuals Trend			2015/16 Current			2015/16 YTD		
		Actual M1 £m	Actual M2 £m	Actual M3 £m	Budget M4 £m	Actual M4 £m	Variance M4 £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
SLA Income	128.42	10.49	11.13	11.52	10.93	10.05	(0.88)	41.41	40.99	(0.42)
Other Income	17.69	1.98	1.95	2.04	1.31	1.70	0.39	5.90	6.25	0.35
Pay	(123.41)	(10.21)	(10.26)	(10.16)	(10.30)	(10.04)	0.26	(40.63)	(41.07)	(0.44)
Non Pay	(25.81)	(4.52)	(3.93)	(4.54)	(2.20)	(2.51)	(0.31)	(8.45)	(8.81)	(0.36)
Other	(6.45)	(0.61)	(0.59)	(0.60)	(0.54)	(0.54)	(0.00)	(2.15)	(2.15)	(0.00)
Grand Total	(9.55)	(2.86)	(1.70)	(1.74)	(0.79)	(1.34)	(0.55)	(3.93)	(4.79)	(0.86)

YTD Var 2015/16 (adv) / fav	Childrens Services		Critical Care		CWDT Division Management		Diagnostics		Outpatients	
	£m	%	£m	%	£m	%	£m	%	£m	%
SLA Income	0.78	*6.7%*	(0.20)	*-1.9%*	0.00	*#DIV/0!*	0.03	*0.5%*	0.00	*#DIV/0!*
Other Income	0.13	*11.7%*	(0.05)	*-13.8%*	0.00	*#DIV/0!*	0.12	*6.9%*	(0.01)	*-16.5%*
Pay	(0.52)	*-5.3%*	(0.15)	*-2.1%*	(0.07)	*-20.0%*	(0.05)	*-0.7%*	0.23	*5.9%*
Non Pay	(0.09)	*-5.2%*	0.02	*1.5%*	0.03	*106.6%*	0.09	*3.3%*	(0.39)	*-580.1%*
Other	0.00	*0.0%*	0.00	*0.4%*	0.00	*0.0%*	(0.00)	*-0.1%*	(0.00)	*-0.5%*
Grand Total	0.30	*42.7%*	(0.37)	*-22.0%*	(0.05)	*-11.5%*	0.19	*8.1%*	(0.17)	*-4.4%*

YTD Var 2015/16 (adv) / fav	Pharmacy		Therapies		Womens Services		Total Sum of YTD Budget £k	
	£m	%	£m	%	£m	%	£m	%
SLA Income	0.00	*#DIV/0!*	(0.13)	*-10.2%*	(0.90)	*-7.0%*	(0.42)	*-1.0%*
Other Income	0.18	*9.2%*	(0.06)	*-60.9%*	0.03	*4.5%*	0.35	*6.0%*
Pay	(0.13)	*-5.7%*	0.09	*2.2%*	0.17	*2.5%*	(0.44)	*-1.1%*
Non Pay	(0.07)	*-5.7%*	0.04	*23.8%*	0.02	*1.6%*	(0.36)	*-4.2%*
Other	0.00	*0.0%*	(0.00)	*0.0%*	(0.00)	*-0.3%*	(0.00)	*-0.1%*
Grand Total	(0.03)	*-1.4%*	(0.06)	*-2.0%*	(0.68)	*-13.8%*	(0.86)	*-22.0%*

Actions

- CIP schemes included in the unallocated budget to be progressed under the direction of Division Turnaround Steering Group to achieve Green status and coded to where the savings will be achieved with the support of KPMG.
- Corporate Outpatients Cross Charge SLA to be completed and implemented and budgets reset
- GMs to continue to identify new schemes to close the CIP shortfall with support from KPMG.

The M04 position is overspent £0.9m YTD and £0.5m in month. There were £1.2m of EMT approved cost pressures funded in the budgets this month. Unfunded cost pressures remain contributing £0.3m overspend YTD. The Pathology directorate has moved to Corporate Directorates.

SLA Income is £10.1m for M04 and has seen a fall similar to previous years trends. Income underperformed £0.9m in month and £0.4m YTD. Current income is lower than last 4 months trend by £0.4m and is £0.7m lower than M03. Over performing in Paeds but down in Adult Critical Care due to unusually low EM activity (£0.2m Adverse M04). Daycase £0.1m favourable in Paeds services. Inpatient EM activity £0.2m YTD mainly in Paeds services has reduced in M04 following higher than expected Q1 performance. OP activity (£0.5m Adv) is down in Obstetrics Antenatal and Therapies. Gynae is £0.5madv in Elective IP and OP due to suspended Urogynae service.

Pay is £0.4m overspent YTD but £0.3m underspent in month. This includes £2.1mYTD of Unallocated CIPs and shortfall in CIP programme. Deducting this shows savings achieved of 1.7m YTD against budget and M04 actual expenditure is £0.4m below 14-15 YTD average trend. £1.2m of budget added to Pay to fund cost pressures in Diagnostics and fund marginal cost growth required to deliver Outpatient clinics for planned activity. This is resulting in underspend in Outpatients against Trustwide underperformance on activity and may require reprofile to deliver activity later in year.

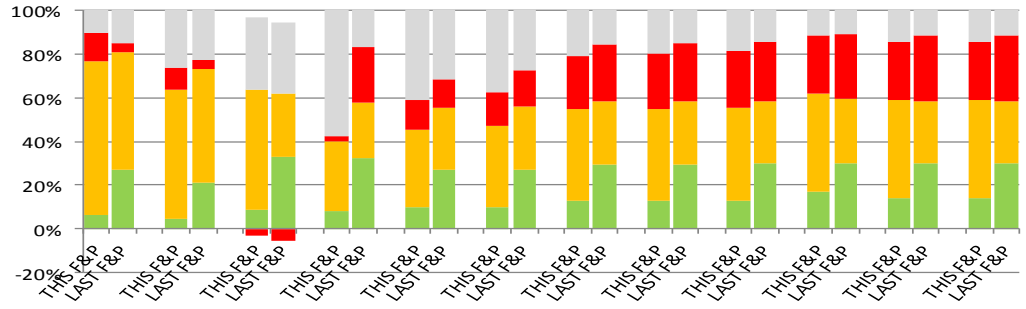
Non pay overspent £0.4m YTD M04 and £0.3min month. Includes £1.7m of unallocated CIPs which is £0.6m adverse YTD. Corporate Outpatient line for cross charging additional clinics to Specialties is £0.3m adverse. No charging has been done since M01 pending completion of SLA and data. Drugs are overspent £0.2m but consumables are overall underspent £0.4m

CWDT - Divisional CIP performance

FORECAST CWDT SUMMARY	ANNUAL TARGET	FORECAST AT M4 (£m) INC	EXP	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT FALL	
C&W OVERHEADS	0.15	0.00	0.80	0.80	0.00	0.80	0.00	-0.65	F
CHILDRENS	1.70	0.20	1.12	1.32	0.02	1.09	0.20	0.38	A
CRITICAL CARE	1.91	0.11	1.40	1.51	0.17	0.89	0.45	0.40	A
DIAGNOSTICS	1.45	0.29	0.47	0.75	0.21	0.46	0.08	0.70	A
OUTPATIENTS	0.55	0.00	0.35	0.35	0.18	0.17	0.00	0.20	A
PHARMACY	0.91	0.50	0.00	0.50	0.03	0.39	0.08	0.41	A
THERAPIES	0.86	0.14	0.14	0.28	0.13	0.13	0.02	0.58	A
WOMENS	1.36	0.09	1.00	1.09	0.78	0.16	0.15	0.28	A
Grand Total	**8.90**	**1.33**	**5.28**	**6.61**	**1.53**	**4.10**	**0.97**	**2.29**	A
OF WHICH RECURRENT:		1.33	3.59	4.92	1.52	2.47	0.93	3.98	A
OBJECTIVE 2 (FULL YEAR EFFECT		2.01	4.94	6.95	2.56	3.23	1.16	1.94	A

PERFORMANCE CWDT SUMMARY	YTD TARGET	ACTUAL YTD M4 (£m) INC	EXP	TOTAL	OF WHICH TOTAL ACTUAL YTD RAG RED	AMBER	GREEN	SHORT FALL	
C&W OVERHEADS	0.05	0.00	0.80	0.80	0.00	0.80	0.00	-0.75	F
CHILDRENS	0.57	0.07	0.34	0.40	0.00	0.35	0.05	0.16	A
CRITICAL CARE	0.64	0.04	0.36	0.40	0.02	0.28	0.10	0.24	A
DIAGNOSTICS	0.48	0.00	0.04	0.04	0.00	0.04	0.00	0.44	A
OUTPATIENTS	0.18	0.00	0.02	0.02	0.01	0.01	0.00	0.17	A
PHARMACY	0.30	0.13	0.00	0.13	0.00	0.12	0.01	0.18	A
THERAPIES	0.29	0.00	0.01	0.01	0.00	0.00	0.01	0.28	A
WOMENS	0.45	0.01	0.20	0.21	0.14	0.04	0.04	0.25	A
Grand Total	**2.97**	**0.24**	**1.76**	**2.00**	**0.16**	**1.63**	**0.21**	**0.96**	A
OF WHICH RECURRENT:		0.24	0.62	0.86	0.16	0.49	0.20	2.11	A

PHASED RAG RATED DIVISIONAL PROGRAMME - ACTUAL AND FORECAST



The CWDT Division target is £8.9m. To date there are plans valued at £6.4m and a shortfall of £2.5m. Only £1.0m of the plans are green. rated.

Diagnostics Services have removed some non recurrent savings schemes to be reported separately as run rate savings. There have been a number of non pay savings that have been identified as double counts with procurement programme.

The YTD M04 plan is £3.0m and schemes have achieved £2.0m resulting in a YTD shortfall of £1.0m.. Medicine Mgt schemes are £53k adverse YTD and Procurement savings are £254k underperforming. In the Directorates, Champneys CIP schemes are not fully implemented in Womens, Therapies are confirming their staff saving schemes as part of the completion of budget setting and Pharmacy has reduced the value of the Wholesaler Dealer Licence income generation scheme but will review and increase as they are able to demonstrate increases in income.

The Division has a pipeline list of schemes it is actively working up to achieve the Target for the year with support from KPMG. Run-rates will continue to contribute to the performance against the target
.

CSD - Divisional I&E

	2015/16 Annual Budget	Previous Months Actuals Trend			2015/16 Current			2015/16 YTD		
		Actual M1	Actual M2	Actual M3	Budget M4	Actual M4	Variance M4	Budget YTD	Actual YTD	Variance YTD
		£m	£m	£m	£m	£m	£m	£m	£m	£m
SLA Income	104.81	8.68	8.33	8.43	9.26	9.17	(0.08)	35.24	34.62	(0.62)
Other Income	3.42	0.33	0.28	0.22	0.28	0.30	0.01	1.14	1.13	(0.01)
Pay	(48.55)	(4.29)	(4.20)	(4.35)	(4.25)	(4.24)	0.01	(16.83)	(17.08)	(0.25)
Non Pay	(30.92)	(2.44)	(2.60)	(2.61)	(2.77)	(3.01)	(0.24)	(10.66)	(10.66)	(0.00)
Other	(0.21)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.00)	(0.07)	(0.07)	(0.00)
Grand Total	28.54	2.25	1.80	1.68	2.50	2.20	(0.30)	8.81	7.93	(0.88)

YTD Var 2015/16 (adv) / fav	Ambulatory Care Services		Community Adults & Children		Community Services		Total Sum of YTD Budget £k	
	£m	%	£m	%	£m	%	£m	%
SLA Income	(0.44)	*-2.7%*	(0.18)	*-0.9%*	0.00	*100.0%*	(0.62)	*-1.8%*
Other Income	(0.01)	*-4.5%*	0.00	*0.2%*	0.00	*23.5%*	(0.01)	*-0.7%*
Pay	(0.09)	*-1.9%*	(0.18)	*-1.6%*	0.03	*9.9%*	(0.25)	*-1.5%*
Non Pay	(0.22)	*-3.0%*	0.20	*5.9%*	0.01	*12.1%*	(0.00)	*0.0%*
Other	(0.00)	*-0.7%*	0.00	*0.1%*	0.00	*#DIV/0!*	(0.00)	*-0.6%*
Grand Total	(0.76)	*-18.3%*	(0.16)	*-3.2%*	0.04	*11.5%*	(0.88)	*-10.0%*

- The M04 position for CSD shows an £7.9m surplus YTD actual performance against a YTD surplus budget of £8.8m, which resulted in a YTD adverse variance of £0.9m
- **SLA income** relating to QMH underperformed by £0.5m YTD, with underperformances in Cardiology, Neurology, Dermatology and Urology outpatients. In Older Services, there was a loss of £0.1m on income from Elderly wards relating to unoccupied beds. GU Medicine Services underperformed by £0.2m in Outpatients
- **Pay** is showing an overall £0.2 YTD overspend. This is mainly within Older Services where Nurse Agency and Bank spend on Elderly Rehab ward exceeds the budget for vacant posts. Plans are in place to reduce the use of agency staff by recruiting into the substantive posts. However the most notable area of pay spend is within Palliative Care which relates to additional agency cost of £0.3m.
- **Non Pay** - Within GU Medicine £0.3m YTD overspend was as a result of exceptionally high invoices in month for HIV drugs.

Actions

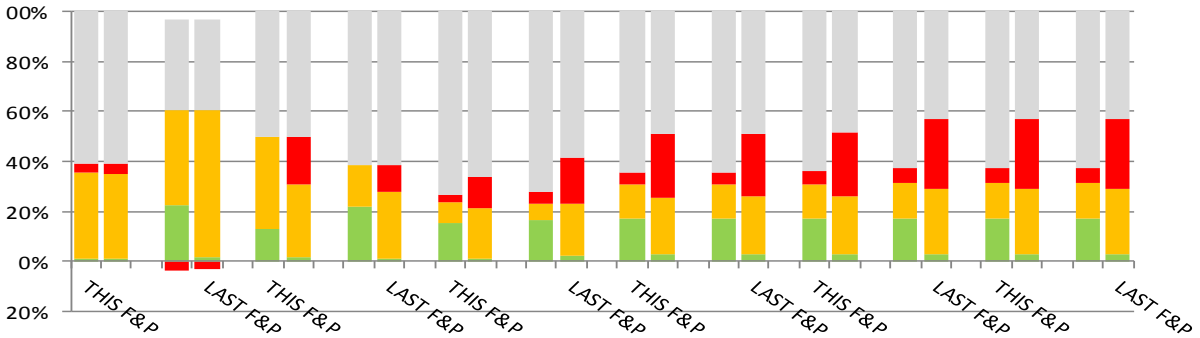
- Review of all SLA's/ Contracts ensuring adequate expenditure are reflected in relation to improving run-rates and meeting all cost reduction. All other income assumptions regarding overheads uplift should be agreed in order not to over inflate income including external SLA's.
- Liaise with General Managers to ensure that clinics are running and activity are taking place
- Assess viability of current CIP schemes with the view to turning our amber schemes to green.
- Minimise the use of agency through weekly reviews at Divisional level.
- Review all excess expenditure lines and cost pressure allocation.
- Review all High Cost Drugs ensuring these are being reclaimed in full. Also review the HIV drugs (Homecare) with Pharmacy to ensure there are no further risks in relation to a substantial increase in expenditure.
- The division will be reviewing the clinics with the view to reallocate patients to other clinics within the service that have adequate staff which would result in increased activity. A discussion is currently taking place with Wandsworth CCG to pursue this further.

CSD - Divisional CIP performance

FORECAST CSD SUMMARY	ANNUAL TARGET	FORECAST AT M4 (£m) INC	EXP	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT FALL	
AMBULATORY CARE	1.68	0.16	0.28	0.44	0.04	0.19	0.21	1.24	A
COMM ADULT AND CHILD	3.84	0.38	0.82	1.20	0.12	0.39	0.69	2.65	A
PROV MANAGEMENT	0.04	0.00	0.09	0.09	0.02	0.06	0.00	-0.05	F
PROV OVERHEADS	0.00	0.00	0.42	0.42	0.01	0.41	0.00	-0.42	F
Grand Total	**5.56**	**0.54**	**1.61**	**2.14**	**0.18**	**1.06**	**0.90**	**3.42**	A
OF WHICH RECURRENT:		0.54	1.20	1.73	0.18	0.65	0.90	3.83	A
OBJECTIVE 2 (FULL YEAR EFFECT)		0.78	1.44	2.22	0.39	0.76	1.07	3.34	A

PERFORMANCE CSD SUMMARY	YTD TARGET	ACTUAL YTD M4 (£m) INC	EXP	TOTAL	OF WHICH TOTAL ACTUAL YTD RAG RED	AMBER	GREEN	SHORT FALL	
AMBULATORY CARE	0.56	0.04	0.06	0.10	0.00	0.05	0.05	0.46	A
COMM ADULT AND CHILD	1.28	0.14	0.22	0.36	0.00	0.14	0.23	0.92	A
PROV MANAGEMENT	0.01	0.00	0.00	0.00	0.00	0.00	0.00	0.01	A
PROV OVERHEADS	0.00	0.00	0.41	0.41	0.00	0.41	0.00	-0.41	F
Grand Total	**1.85**	**0.18**	**0.69**	**0.88**	**0.00**	**0.59**	**0.28**	**0.98**	A
OF WHICH RECURRENT:		0.18	0.28	0.47	0.00	0.18	0.28	1.39	A

PHASED RAG RATED DIVISIONAL PROGRAMME - ACTUAL AND FORECAST



Community Services division has a CIP target of £5.6m excluding SLA income. At present there is a £3.3m shortfall and Red schemes of £0.4m. A number of the Rehab Therapy schemes with a total £121k were removed as it was deemed unviable.

The in month target is £1.9m however schemes totalling £0.9m have been reported as achieved, leaving a shortfall of £1m.

Major areas of under-delivery were related to the budget reviews which meant that the CIPs were no longer achievable. This was partially off-set through run rate savings.

A significant number of small budget release schemes totalling £225k were removed as these cannot be achieved. This was marginally off-set by the identification of a new scheme in Offender healthcare which improved the position by £125k. There was also a reduction in the value of Procurement opportunities by £260k which were deemed as not robust.

Medicine & Cardiovascular - Divisional I&E

	2015/16 Annual Budget	Previous Months Actuals Trend			2015/16 Current			2015/16 YTD		
		Actual M1	Actual M2	Actual M3	Budget M4	Actual M4	Variance M4	Budget YTD	Actual YTD	Variance YTD
		£m	£m	£m	£m	£m	£m	£m	£m	£m
SLA Income	221.78	16.74	18.34	17.04	18.85	18.90	0.05	71.59	71.02	(0.57)
Other Income	19.27	1.59	1.50	1.56	1.61	1.38	(0.23)	6.40	6.03	(0.37)
Pay	(101.97)	(8.50)	(8.72)	(9.03)	(8.92)	(8.91)	0.01	(33.65)	(35.16)	(1.52)
Non Pay	(75.78)	(6.09)	(5.98)	(6.33)	(5.74)	(6.28)	(0.54)	(23.82)	(24.69)	(0.87)
Other	(4.52)	(0.37)	(0.38)	(0.38)	(0.38)	(0.38)	(0.00)	(1.51)	(1.50)	0.00
Grand Total	58.79	3.37	4.75	2.86	5.42	4.71	(0.72)	19.01	15.69	(3.32)

YTD Var 2015/16 (adv) / fav	Acute Medicine		Cardiothoracic & Vascular Services		Emergency Department		Renal & Oncology		Specialist Medicine		Total Sum of YTD Budget £k	
	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
SLA Income	0.27	*2.3%*	(0.30)	*-1.4%*	(0.21)	*-3.2%*	0.02	*0.1%*	(0.35)	*-2.6%*	(0.57)	*-0.8%*
Other Income	(0.02)	*-2.3%*	0.12	*7.1%*	(0.34)	*-18.5%*	(0.18)	*-23.2%*	0.04	*3.4%*	(0.37)	*-5.8%*
Pay	(0.48)	*-5.4%*	(0.53)	*-6.9%*	(0.12)	*-2.3%*	(0.18)	*-2.7%*	(0.20)	*-4.0%*	(1.52)	*-4.5%*
Non Pay	0.12	*9.0%*	0.09	*1.2%*	(0.15)	*-17.1%*	(0.72)	*-7.2%*	(0.22)	*-4.4%*	(0.87)	*-3.7%*
Other	0.00	*0.0%*	0.00	*0.7%*	(0.00)	*0.0%*	(0.00)	*0.0%*	0.00	*0.1%*	0.00	*0.1%*
Grand Total	(0.11)	*-5.3%*	(0.62)	*-7.9%*	(0.82)	*-40.4%*	(1.06)	*-38.4%*	(0.73)	*-16.5%*	(3.32)	*-17.5%*

The £3.3m YTD adverse variance is a deterioration of £0.72m in month

Income is £0.2m adverse in M04, and £0.9m adverse YTD. The in-month adverse variance is due to underperformance in Outpatients activity across the division with major impact in Specialist Medicine and Renal largely due to capacity and staff vacancies. RTA income is also £0.1m adverse.

The adverse income variance YTD is in large part due Outpatient activity not delivering the growth as planned, due to delay in setting up clinics. Penalties and RTA also adverse. This is offset by over performance in Other Non Elective in Cardiac Surgery.

Pay is adverse by £1.5m YTD driven by the unidentified CIP balance of £2.2m offset by run rate schemes

Non-pay is adverse by £0.8m YTD driven by the unidentified CIP balance of £0.7m

Actions

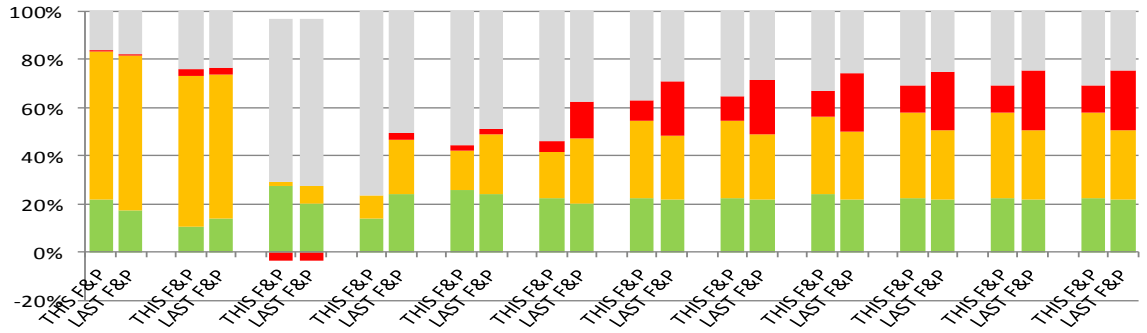
- Actions are being completed to increase Nelson activity alongside Community Services Division
- Meetings with Corporate Outpatients to ensure that resources are available and in place to deliver SLA growth plans in outpatient specialties
- KPIs to be reviewed for the SLA income penalties and to identify mitigations.
- RTA submissions claim forms process being reviewed
- Challenge Renal transplant outpatient follow ups marginal rate with NHSE
- GMs working with KPMG to close CIP gap, and move schemes from amber and red, to green. In addition run rate schemes are in place to mitigate the shortfall on a temporary basis
- Preparing business case for Cardiac Surgery to utilise Theatre 4 when the Hybrid Theatre comes online to help the division repatriate activity back from St Anthony's in the private sector
- Participating in the trust wide review of nursing budgets
- Review of accounting treatment of emergency block with income team

Medicine & Cardiovascular - Divisional CIP performance

FORECAST MEDCARD SUMMARY	ANNUAL TARGET	FORECAST AT M4 (£m) INC	EXP	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT FALL	
ACUTE MED	2.41	0.00	0.56	0.56	0.14	0.32	0.11	1.85	A
CARDIOVASCULAR	2.66	0.18	0.91	1.10	0.11	0.93	0.05	1.56	A
ED	1.67	0.13	0.80	0.93	0.18	0.15	0.60	0.73	A
MEDICINE OVERHE	0.22	0.00	0.81	0.81	0.02	0.79	0.00	-0.58	F
RENAL & ONCOLO	2.21	1.23	0.86	2.09	0.16	0.67	1.26	0.12	A
SPECIALIST MED	1.45	0.16	0.59	0.74	0.01	0.45	0.29	0.71	A
Grand Total	**10.62**	**1.71**	**4.52**	**6.23**	**0.61**	**3.30**	**2.31**	**4.39**	A
OF WHICH RECURRENT:		1.66	3.67	5.33	0.61	2.51	2.20	5.29	A
OBJECTIVE 2 (FULL YEAR EFFECT		2.13	4.06	6.20	1.26	2.60	2.34	4.42	A

PERFORMANCE MEDCARD SUMMARY	YTD TARGET	ACTUAL YTD M4 (£m) INC	EXP	TOTAL	OF WHICH TOTAL ACTUAL YTD RAG RED	AMBER	GREEN	SHORT FALL	
ACUTE MED	0.80	0.00	0.09	0.09	0.00	0.09	0.00	0.71	A
CARDIOVASCULAR	0.89	0.09	0.02	0.11	0.00	0.07	0.04	0.78	A
ED	0.56	0.01	0.11	0.12	0.00	0.01	0.11	0.43	A
MEDICINE OVERHE	0.07	0.00	0.79	0.79	0.00	0.79	0.00	-0.72	F
RENAL & ONCOLO	0.74	0.42	0.18	0.59	0.00	0.17	0.43	0.14	A
SPECIALIST MED	0.48	0.03	0.13	0.16	0.00	0.06	0.10	0.32	A
Grand Total	**3.54**	**0.55**	**1.32**	**1.87**	**0.00**	**1.20**	**0.67**	**1.67**	A
OF WHICH RECURRENT:		0.51	0.52	1.04	0.00	0.41	0.63	2.50	A

PHASED RAG RATED DIVISIONAL PROGRAMME - ACTUAL AND FORECAST



Medcard division is reporting YTD actual CIP achieved of £1.9m against a target of £3.4m. The shortfall of c£1.7m is largely under ED and CVT, however the risk is also significant in Acute Medicine.

At month 4 acute Medicine CIP YTD achieved due to impact of block contract, and summer beds closure , the impact of winter will be make this position non recurrent.

The major risk to CVT in meeting its target is the availability of beds and theatre capacity to deliver activity in cardiovascular. The division is developing a business case to use Cardiac theatre 4 and repatriate activity from the private sector leading to a contribution benefit. It is unclear if this repatriation will happen in year, so the directorate continues to identify other pipeline schemes for months 5 to 12.

The division is working closely with the KPMG turnaround team to close the gap, there are a number of schemes in the pipeline being quantified.

The Director of Turnaround has requested further analysis of more significant changes the services can safely make, particularly in acute medicine and CVT to meet the target. This work is being developed

SNTC - Divisional I&E

	2015/16 Annual Budget	Previous Months Actuals Trend			2015/16 Current			2015/16 YTD		
		Actual M1	Actual M2	Actual M3	Budget M4	Actual M4	Variance M4	Budget YTD	Actual YTD	Variance YTD
		£m	£m	£m	£m	£m	£m	£m	£m	£m
SLA Income	153.22	11.84	11.76	12.81	13.31	13.13	(0.18)	49.45	49.53	0.08
Other Income	18.44	1.54	1.42	1.50	1.49	1.31	(0.19)	6.11	5.76	(0.35)
Pay	(102.98)	(8.52)	(8.47)	(8.64)	(8.38)	(8.63)	(0.25)	(33.52)	(34.26)	(0.74)
Non Pay	(34.74)	(2.89)	(2.40)	(2.86)	(2.91)	(2.78)	0.13	(11.13)	(10.93)	0.20
Other	(3.96)	(0.34)	(0.33)	(0.33)	(0.34)	(0.33)	0.01	(1.32)	(1.32)	(0.00)
Grand Total	29.98	1.63	1.98	2.48	3.17	2.70	(0.47)	9.59	8.78	(0.82)

YTD Var 2015/16 (adv) / fav	Cancer		Neuro		Surgery		Theatres and Anaesthetics		Total Sum of YTD Budget £k	
	£m	%	£m	%	£m	%	£m	%	£m	%
SLA Income	0.00	*#DIV/0!*	(0.21)	*-1.0%*	0.28	*1.0%*	0.00	*1.2%*	0.08	*0.2%*
Other Income	0.00	*#DIV/0!*	(0.07)	*-5.0%*	(0.28)	*-9.8%*	(0.01)	*-0.4%*	(0.35)	*-5.8%*
Pay	(0.01)	*-6.4%*	(0.22)	*-2.4%*	(0.58)	*-4.6%*	0.07	*0.6%*	(0.74)	*-2.2%*
Non Pay	0.00	*11.8%*	0.85	*19.0%*	(0.72)	*-14.3%*	0.06	*3.7%*	0.20	*1.8%*
Other	(0.00)	*0.0%*	0.00	*0.1%*	0.00	*0.3%*	(0.00)	*-0.4%*	(0.00)	*0.0%*
Grand Total	(0.01)	*-5.1%*	0.36	*4.4%*	(1.29)	*-9.4%*	0.13	*1.1%*	(0.82)	*-8.5%*

The Division is reporting a **YTD adverse variance of £0.8m**, with an in- month adverse variance of £0.5m, driven by YTD favourable SLA Income of £0.1m and non pay variance of £0.2m, being offset by an adverse Pay variance of £0.8m.

The **SLA Income** variance in is largely due to favourable variances on Elective, Daycase and Outpatient activity totalling £0.7m which is offset by underperformance in Other Non-Elective (£0.4m) and Non SLA Income

Actual **Pay** costs YTD have been consistently maintained at c£8.5m per month, although they are slightly higher in Mth4 due to prior year invoices relating to social work. The YTD overspend on pay is driven by the unidentified CIP balance of £1.9m held against Pay which is partially offset by £1.0m of vacancies (mainly nursing) and run rate reductions of £1.0m YTD.

Overall **Non pay** has a minimal YTD underspend of £0.2m, mainly in clinical consumables and outpatient cross charging, which is offsetting the £0.6m spend in the private sector which has been flagged as a divisional cost pressure.

Actions

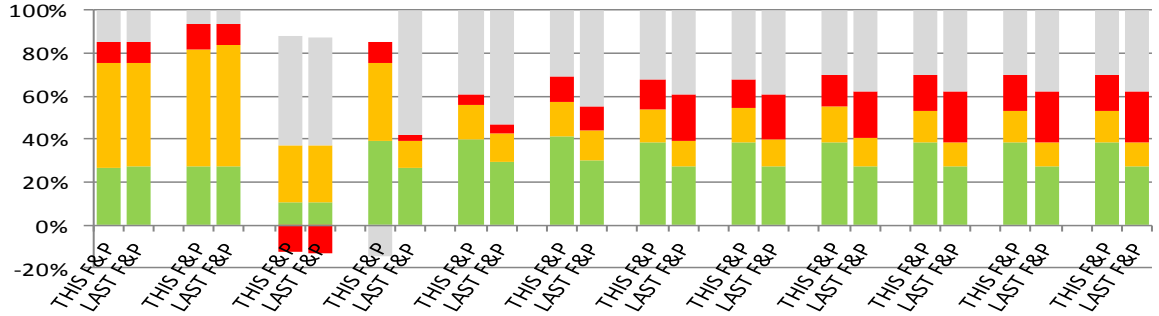
- SNTC will continue to work with Care group leads, procurement, medical staffing and other trust support services to improve efficiency and maximise SLA income
- Theatres demand and capacity modelling to be done to confirm required staffing levels
- Continue to work closely with KPMG to close the CIP gap, by turn Red schemes Green and converting pipelines schemes into viable CIPs

SNTC - Divisional CIP performance

FORECAST SCNT SUMMARY	ANNUAL TARGET	FORECAST AT M4 (£m) INC	EXP	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT FALL	
CANCER, HEAD & N	1.31	0.03	0.32	0.35	0.03	0.22	0.09	0.96	A
GEN SURG & UROL	1.35	0.08	1.09	1.17	0.17	0.16	0.85	0.18	A
NEUROSCIENCES	1.89	0.86	1.11	1.97	0.00	0.46	1.51	-0.08	F
SURGERY OVERHEA	0.24	0.00	1.00	1.00	0.00	1.00	0.00	-0.76	F
THEATRES	2.42	0.00	1.03	1.03	0.54	0.22	0.26	1.40	A
TRAUMA & ORTHO	1.50	0.28	0.57	0.85	0.18	0.21	0.45	0.65	A
Grand Total	**8.71**	**1.25**	**5.12**	**6.37**	**0.93**	**2.28**	**3.16**	**2.34**	A
OF WHICH RECURRENT:		1.25	3.63	4.88	0.91	1.08	2.89	3.83	A
OBJECTIVE 2 (FULL YEAR EFFECT		1.33	4.32	5.65	1.44	1.15	3.06	3.06	A

PERFORMANCE SCNT SUMMARY	YTD TARGET	ACTUAL YTD M4 (£m) INC	EXP	TOTAL	OF WHICH TOTAL ACTUAL YTD RAG RED	AMBER	GREEN	SHORT FALL	
CANCER, HEAD & N	0.44	0.00	0.11	0.12	0.02	0.07	0.02	0.32	A
GEN SURG & UROL	0.45	0.01	0.17	0.18	0.00	0.02	0.16	0.27	A
NEUROSCIENCES	0.63	0.27	0.42	0.69	0.00	0.18	0.52	-0.06	F
SURGERY OVERHEA	0.08	0.00	1.00	1.00	0.00	1.00	0.00	-0.92	F
THEATRES	0.81	0.00	0.18	0.18	0.06	0.05	0.07	0.63	A
TRAUMA & ORTHO	0.50	0.07	0.18	0.25	0.06	0.06	0.13	0.25	A
Grand Total	**2.90**	**0.35**	**2.06**	**2.41**	**0.14**	**1.37**	**0.90**	**0.49**	A
OF WHICH RECURRENT:		0.35	0.81	1.16	0.12	0.28	0.77	1.74	A

PHASED RAG RATED DIVISIONAL PROGRAMME - ACTUAL AND FORECAST



SNTC has a CIP target of £8.7m, with £6.4m of developed schemes leaving a gap of £2.3m.

* Green schemes are £3.2m, amber £2.3m and red schemes £0.9m.

The largest red scheme is theatre productivity which will go green once business planning is complete and the Trust confirms number / type of theatre sessions to be provided and resource available through budget setting.

* The CIP forecast has increased from £5.3m to £6.4m. The majority [92%] of schemes are expenditure - to reduce to improve pay productivity, reducing consultant PA's during job planning, using HCA's instead of RMN specials, reduced cost in the private sector for healthcare and reducing clinical consumable spend.

* SNTC will continue to work with Care group leads, procurement, medical staffing and other Trust support services to improve efficiency and maximise SLA income.

* The YTD M04 CIP target is £2.9m, with schemes saving £1.4 m and run rate pay reductions of £1.0m, leaving a shortfall of £0.5m.

The run rate reductions are on holding vacancies mainly in theatres £0.4m and nursing £0.6m.

Overheads - Divisional I&E

	2015/16 Annual Budget	Previous Months Actuals Trend			2015/16 Current			2015/16 YTD		
		Actual M1	Actual M2	Actual M3	Budget M4	Actual M4	Variance M4	Budget YTD	Actual YTD	Variance YTD
		£m	£m	£m	£m	£m	£m	£m	£m	£m
SLA Income	11.81	0.33	0.33	0.24	1.05	1.01	(0.05)	3.97	4.11	0.14
Other Income	21.13	1.19	1.27	1.22	1.62	1.79	0.17	7.05	6.90	(0.15)
Pay	(42.18)	(3.53)	(3.34)	(3.34)	(3.68)	(4.04)	(0.36)	(14.07)	(13.86)	0.22
Non Pay	(111.01)	(6.90)	(6.95)	(7.77)	(9.05)	(8.91)	0.14	(36.68)	(37.23)	(0.55)
Other	(10.86)	(0.84)	(0.84)	(0.84)	(0.91)	(0.90)	0.01	(3.62)	(3.59)	0.03
Grand Total	(131.12)	(9.74)	(9.53)	(10.48)	(10.96)	(11.06)	(0.09)	(43.35)	(43.66)	(0.31)

YTD Var 2015/16 (adv) / fav	Corporate Directorates		Estates & Facilities		Total Sum of YTD Budget £k	
	£m	%	£m	%	£m	%
SLA Income	0.20	*7.4%*	(0.06)	*-4.6%*	0.14	*3.6%*
Other Income	0.02	*0.5%*	(0.17)	*-5.4%*	(0.15)	*-2.1%*
Pay	0.03	*0.3%*	0.19	*4.0%*	0.22	*1.5%*
Non Pay	(0.42)	*-2.4%*	(0.13)	*-0.7%*	(0.55)	*-1.5%*
Other	0.00	*0.2%*	0.03	*1.3%*	0.03	*0.8%*
Grand Total	(0.17)	*-0.8%*	(0.14)	*-0.7%*	(0.31)	*-0.7%*

Please note that Internal STG Pathology budget responsibility transferred from CWDT to Corporates in Month 4.

- Corporate Services have an in month and YTD adverse variance of £0.2m. The in month change is due to the transfer of Pathology from CWDT in M04 with a YTD deficit of £0.3m. In education, there was funding from cost pressures of £250k, however, additional expenditure is arising due to loss in outturn funding and increased costs for Library Services £240k full year and NMET Placement costs £520k full year.
- Estates and Facilities has a YTD adverse variance of £0.1m and an in month favourable variance of £0.1m. The in-month favourable is mainly due the allocation of cost pressure funding for the reduced charge to the medical school for energy
- There are a number of risks in Estates & Facilities, particularly relating to Income. The Catering MITIE rebate, Car Parking, Patient Transport and Medical Physics Income streams are all areas of concern.

Actions

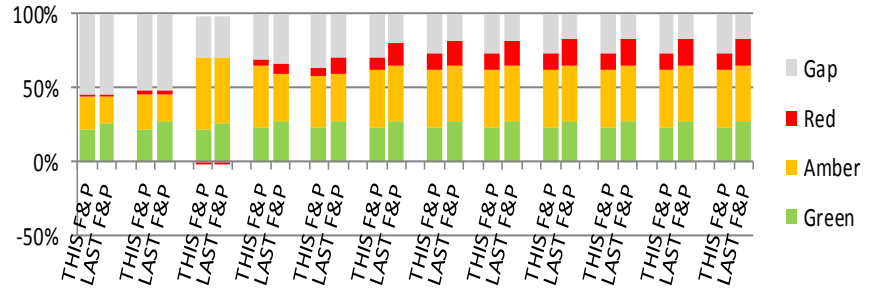
- Reconcile 14/15 outstanding CSD property charges and firm up 15/16 rent costs for all premises which have now transferred to Estates
- Budget for the service cost of running the Nelson Clinic, £0.3m, to be transferred from CSD
- The Pathology transfer to corporate needs to be analysed in more detail to establish what the cost drivers are within the service as the YTD position in non-pay currently stands at £0.5m adverse.

Overheads - Divisional CIP performance

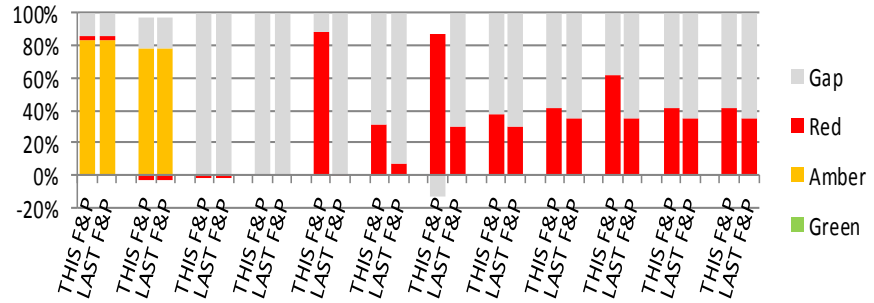
FORECAST	ANNUAL TARGET	FORECAST AT M4 (£m) INC	EXP	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT FALL	
OVERHEADS SUMMARY									
ESTATES & FACILITIES	2.89	0.53	0.98	1.51	1.11	0.40		1.38	A
OF WHICH RECURRENT:		0.39	0.27	0.66	0.66			-0.66	
CORPORATES:									
Finance & IT	1.44		0.95	0.95	0.13	0.51	0.30	0.49	A
CEO & Governance	0.20		0.20	0.20		0.11	0.09	0.00	A
HR & Education	0.38	0.09	0.05	0.13	0.06	0.08		0.24	A
DoN & Bed Manageme	0.34	0.02	0.21	0.23		0.23		0.11	A
SI & Strategy	0.24		0.24	0.24		0.04	0.20	-0.00	F
Grand Total	**2.60**	**0.10**	**1.65**	**1.76**	**0.19**	**0.97**	**0.59**	**0.85**	A
OF WHICH RECURRENT:		0.10	0.10	0.21	0.19	0.85	0.59	2.39	A
OBJECTIVE 2 (FULL YEAR EFFECT)		0.14	1.56	1.70	0.21	0.89	0.60	0.90	A

PERFORMANCE	YTD TARGET	ACTUAL YTD M4 (£m) INC	EXP	TOTAL	OF WHICH TOTAL ACTUAL YTD RAG RED	AMBER	GREEN	SHORT FALL	
OVERHEADS SUMMARY									
ESTATES & FACILITIES	0.96		0.40	0.40	0.00	0.40		0.57	A
OF WHICH RECURRENT:			0.00	0.00	0.00			0.96	A
CORPORATES:									
Finance & IT	0.48		0.24	0.24	0.01	0.13	0.09	0.24	A
CEO & Governance	0.07		0.07	0.07		0.04	0.03	0.00	A
HR & Education	0.13		0.01	0.01	0.01			0.12	A
DoN & Bed Manageme	0.11	0.01	0.09	0.09		0.09		0.02	A
SI & Strategy	0.08		0.11	0.11		0.04	0.07	-0.03	F
Grand Total	**0.87**	**0.01**	**0.50**	**0.51**	**0.01**	**0.30**	**0.19**	**0.36**	A
OF WHICH RECURRENT:		0.01	0.40	0.41	0.01	0.21	0.19	0.46	A

Corporates



Estates & Facilities



Estates & Facilities CIP YTD target is £1.0m. To date only £40k of savings have been achieved and these are currently at amber. Estates & Facilities plan to achieve the 2015/16 target by non-recurring run-rates.

The Corporate CIP YTD target is £0.9m and to date have found £0.5m, of which £0.2m are green, a shortfall of £0.4m. Run-rate savings are being achieved in the Corporate areas as the M4 outturn was a surplus of £0.3m YTD. These have not been specifically reported as CIP schemes in the CIP reporting. Corporate areas are finding it increasingly difficult to find their CIP and will use run-rate mitigations.

❾ Capital

- The 2015/16 capital programme budget was reduced from £56.7m to £48m in June. The net cash impact of the changes to capital financing expenditure assumptions was £3.8m and this was applied to reducing the forecast ISF requirement from £52.2m to £48.7m
- The table below compares the Monitor Plan with the June budget and shows the YTD and forecast outturn.

Summary cap exp by spend category	Monitor Plan £000	June Budget £000	Budget change £000	YTD Budget £000	YTD Actual exp £000	YTD Var £000	**Forecast Outturn £000**	**Forecast Var £000**
Infrastructure renewal	13,570	9,630	-3,940	1,615	1,254	*361*	**9,448**	*182*
Medical equipment	14,384	12,077	-2,307	3,625	3,186	*439*	**11,753**	*324*
IMT	6,411	6,526	115	3,705	2,382	*1,323*	**6,474**	*52*
Major Projects	19,962	17,737	-2,225	6,488	4,565	*1,923*	**16,629**	*1,108*
Other	1,911	1,557	-354	751	535	*216*	**1,591**	*-34*
SWL Path	500	500	0	187	54	*133*	**500**	*0*
Total	56,738	48,027	-8,711	16,371	11,976	*4,395*	**46,395**	*1,631*

- Capital expenditure in July was £2.6m and YTD expenditure is £12m against the new YTD budget of £16.4m i.e. an under spend of £4.4m. The detailed breakdown of the capital programme is given in appendix F.
- The Trust is deliberately slowing down capital expenditure where appropriate to support the cash position until the interim support funding is agreed with Monitor/ITFF.
- £0.1m of the capital contingency budget has been applied – for urgent infrastructure renewal schemes leaving £0.9m unallocated as at M04.
- Budget holders indicate that the YTD under spend relates primarily to in-year timing differences and so the forecast outturn is an underspend of only £1.6m.

10 Cash

Cash balance

	31-Mar £000	30-Apr £000	31-May £000	30-Jun £000	31-Jul £000
2015/16 Plan cash	n/a	14,200	6,187	3,000	3,000
Actual cash	**24,179**	**14,188**	**7,925**	**7,265**	**6,175**
Cash bal fav / (adv) variance to plan	0	-12	1,738	4,265	3,175

Working Capital Facility - ***cumulative*** drawdowns within cash balance above

	31-Mar £000	30-Apr £000	31-May £000	30-Jun £000	31-Jul £000
Plan drawdown	0	0	0	2,138	6,991
Actual drawdown	**0**	**0**	**0**	**0**	**7,671**
WCF cum drawdowns fav / (adv) variance to plan	0	0	0	2,138	-680

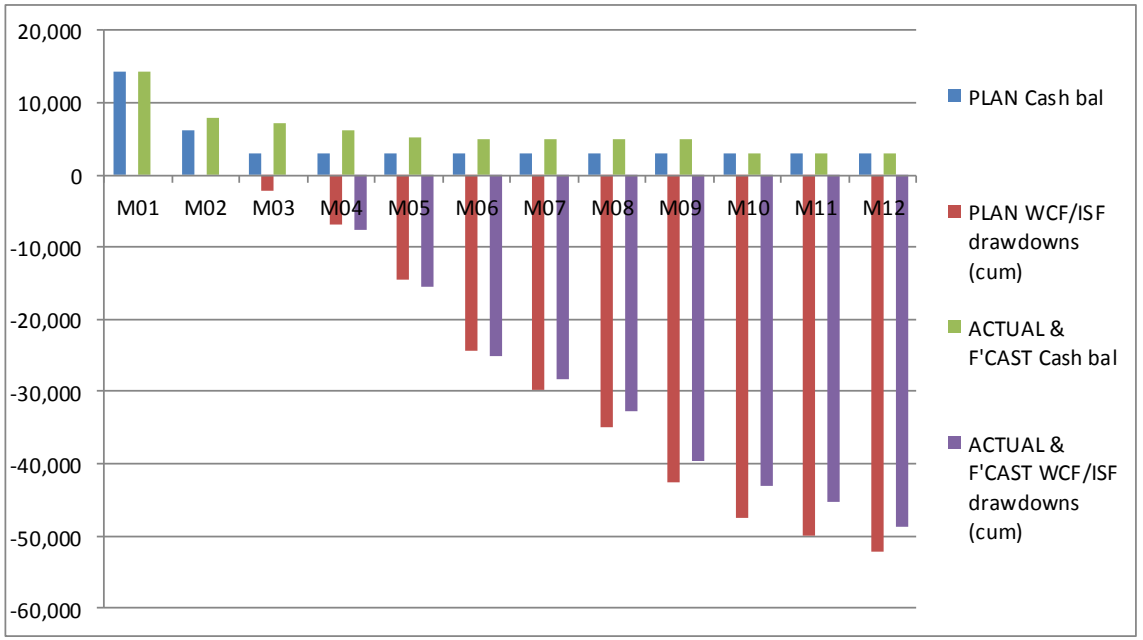
Overall Cash fav / (adv) variance to plan	**0**	**-12**	**1,738**	**6,403**	**2,495**

- Cash balance was £6.2m at 31st July including cumulative WCF drawdowns of £7.7m.
- The M04 plan cash was £3m including cumulative WCF drawdown of £7m.
- Therefore the favourable cash variance at M04 is £2.5m.
- The cash balance includes £12.3m unexpended LEEF loan for the energy performance contract and so the cash balance excl LEEF would be negative: -£6.1m
- The main factors explaining the reduction in the cash balance since year end are:
  - trading deficit of £24.8m and
  - deterioration of £2.9m in working capital (stock, debtors and creditors) – better than plan (-£6.1m).
- The better performance on working capital and the capital underspend offset the impact of the higher trading deficit enabling the Trust to achieve a June cash balance £2.5m above plan.

Cash (contd)

- The Trust is estimating an interim cash support funding request of £48.7m (Plan £52.2m) for the year to finance the planned revenue deficit. The lower request includes the reduction in the capital programme agreed last month.
- Additional cash will be secured using the Trust's approved working capital facility of £25m and a new temporary loan while the interim support funding is agreed with Monitor and the ITFF. The dependence of the cash position on securing this financing is demonstrated in the Cash summary appendices.
- The Trust drew down £7.7m from the approved working capital facility in July and a further £7.9m on 17th August. Under the terms of the facility the Trust must maintain a minimum cash balance of £5m and is forecasting a cash balance of £5m for 31st July.
- The Trust has developed turnaround cash measures which may generate total cash benefits of £10m to £15m. These include longer standard supplier payment terms (60 days implemented w/e 10th July), reduced debtor levels and lower inventory levels. The monthly cash forecast (appendix E) now includes an estimated benefit of £7m of these measures for the year and this benefit mitigates the £7.14m I&E risk relating to the allocation of contingency and divisional control totals in respect of unavoidable cost pressures which was approved by the board w/c 17/08.

CASH AND ISF/WCF funding: Actual/Forecast vs Plan



11 Balance sheet as at M04 2015/16

ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
Finance Department
Balance sheet JULY 2015

	Jul-15 Plan £000	Jul-15 Actual £000	*Variance £000*	**Explanations of balance sheet variances**
Fixed assets	341,406	334,821	*6,585*	Lower capital expenditure - so lower fixed assets
Stock	7,007	8,581	*-1,574*	Significant reported increase in pharmacy: under investigation
Debtors	79,233	82,198	*-2,965*	See appendix D
Cash	3,000	6,182	*-3,182*	Lower capex, better working capital movement - see appendix D
				Cash is £2.5m better than Plan (£3.2m - £0.7m re: more WCF drawn: £5m min cash bal)
Creditors	-84,902	-92,666	*7,764*	See appendix D
Capital creditors	-3,476	-3,439	*-37*	
PDC div creditor	-2,360	-2,360	*0*	
Int payable creditor	-200	-229	*29*	
Provisions< 1 year	-602	-512	*-90*	
Borrowings< 1 year	-13,778	-5,349	*-8,429*	(NB: WCF is classified as non-current liability c/f Plan)
Net current assets/-liabilities	**-16,078**	**-7,594**	*-8,484*	
Provisions> 1 year	-1,181	-1,146	*-35*	
Borrowings> 1 year	-89,380	-97,881	*8,501*	£7.7m WCF drawn in July. Lower capex financed by leases.
Long-term liabilities	**-90,561**	**-99,027**	*8,466*	
Net assets	**234,767**	**228,200**		
Taxpayer's equity				
Public Dividend Capital	133,761	133,761	*0*	
Retained Earnings	-1,504	-7,505	*6,001*	YTD I&E deficit worse than plan
Revaluation Reserve	101,360	100,794	*566*	
Other reserves	1,150	1,150	*0*	
Total taxpayer's equity	**234,767**	**228,200**		

12 Financial Sustainability Risk Rating (FSRR)

From August 2015 Monitor have implemented an update to the Risk Assessment Framework (RAF) requiring Foundation Trusts to assign a financial sustainability risk rating (FSRR) to their current financial performance, to replace the existing CoSRR. The FSRR includes the liquidity and capital servicing capacity metrics of the CoSRR, supplemented by two new metrics. The trust is required to calculate I&E margin (the degree to which the organisation is operating at a surplus/deficit) and variance from plan in relation to I&E margin (the variance between the organisation's plan and its actual margin). The details around scoring and weighting are outlined below (scoring for existing metrics are unchanged, whereas the weightings for each have halved to incorporate the new metrics):

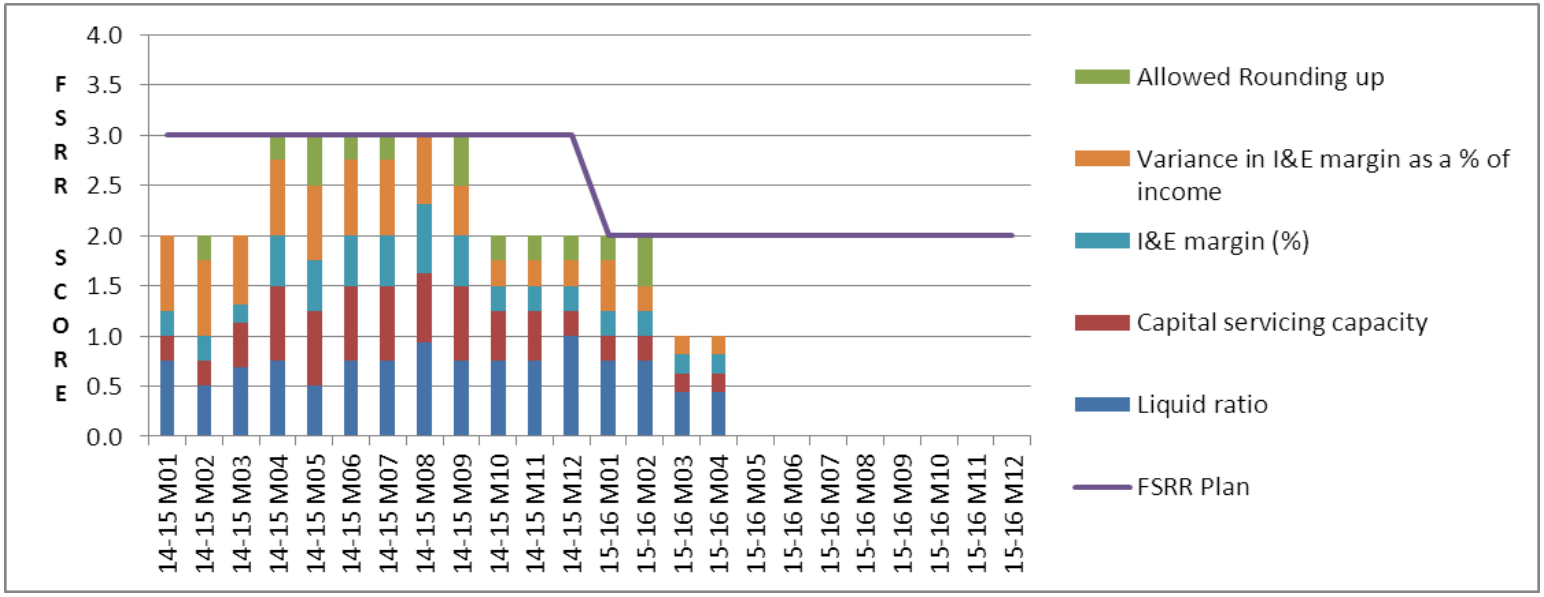
	Financial criteria	Weight (%)	Metric	Rating categories**			
				1*	2***	3	4
Continuity of services	Balance sheet sustainability	25	Capital service capacity (times)	<1.25x	1.25 - 1.75x	1.75-2.5x	>2.5x
	Liquidity	25	Liquidity (days)	<(14) days	(14)-(7) days	(7)-0 days	>0 days
Financial efficiency	Underlying performance	25	I&E margin (%)	≤(1)%	(1)–0%	0-1%	>1%
	Variance from plan	25	Variance in I&E margin as a % of income	≤(2)%	(2)-(1)%	(1)-0%	≥0%

*Scoring a 1 on any metric will cap the weighted rating to 2, potentially leading to investigation.
**Scores are rounded to the nearest number, ie if the trust scores 3.6 overall, this will be rounded to 4; if the trust scores 3.4, this will be rounded to 3.
***A 2* rating may be awarded to a trust where there is little likelihood of deterioration in its financial position.

Financial Sustainability Risk Rating (FSRR)

Metric Scores	14/15 Actual M01	14/15 Actual M02	14/15 Actual M03	14/15 Actual M04	14/15 Actual M05	14/15 Actual M06	14/15 Actual M07	14/15 Actual M08	14/15 Actual M09	14/15 Actual M10	14/15 Actual M11	14/15 Actual M12	15/16 Actual M01	15/16 Actual M02	15/16 Actual M03	15/16 Actual M04
Liquid ratio	-3.6	-7.7	-5.6	-5.5	-8.6	-0.6	-0.3	0.3	-2.2	-2.2	-4.5	1.4	-2.8	-6.6	-9.4	-7.7
Capital servicing capacity	1.0	1.1	1.4	2.2	1.8	1.9	2.1	2.1	1.9	1.5	1.3	1.0	-3.6	-4.1	-3.6	-2.8
I&E margin (%)	-3.0%	-2.4%	-1.7%	-0.7%	-0.7%	-0.4%	-0.1%	0.0%	-0.5%	-1.5%	-1.8%	-2.4%	-13.4%	-13.9%	-12.5%	-10.7%
Variance in I&E margin (%)	-0.3%	-0.3%	-0.3%	-0.2%	-0.4%	-0.6%	-0.8%	-0.7%	-1.0%	-2.1%	-2.4%	-3.1%	-2.0%	-2.7%	-3.3%	-2.8%
Metric Rating (See Thresholds)	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**	**Rating**
Liquid ratio	3	2	3	3	2	3	3	4	3	3	3	4	3	3	2	2
Capital servicing capacity	1	1	2	3	3	3	3	3	3	2	2	1	1	1	1	1
I&E margin (%)	1	1	1	2	2	2	2	3	2	1	1	1	1	1	1	1
Variance in I&E margin (%)	3	3	3	3	3	3	3	3	2	1	1	1	2	1	1	1
Weighted Average	2.0	1.8	2.3	2.8	2.5	2.8	2.8	3.3	2.5	1.8	1.8	1.8	1.8	1.5	1.3	1.3
Overriding Score	**2**	**2**	**2**	**3**	**3**	**3**	**3**	**3**	**3**	**2**	**2**	**2**	**2**	**2**	**1**	**1**

In M04 the Trust achieved a 1 overall for FSRR with the liquidity metric 2 and all other metrics 1. These are all in line with the Annual Plan for M04 apart from the variance metric that has a plan of 4.

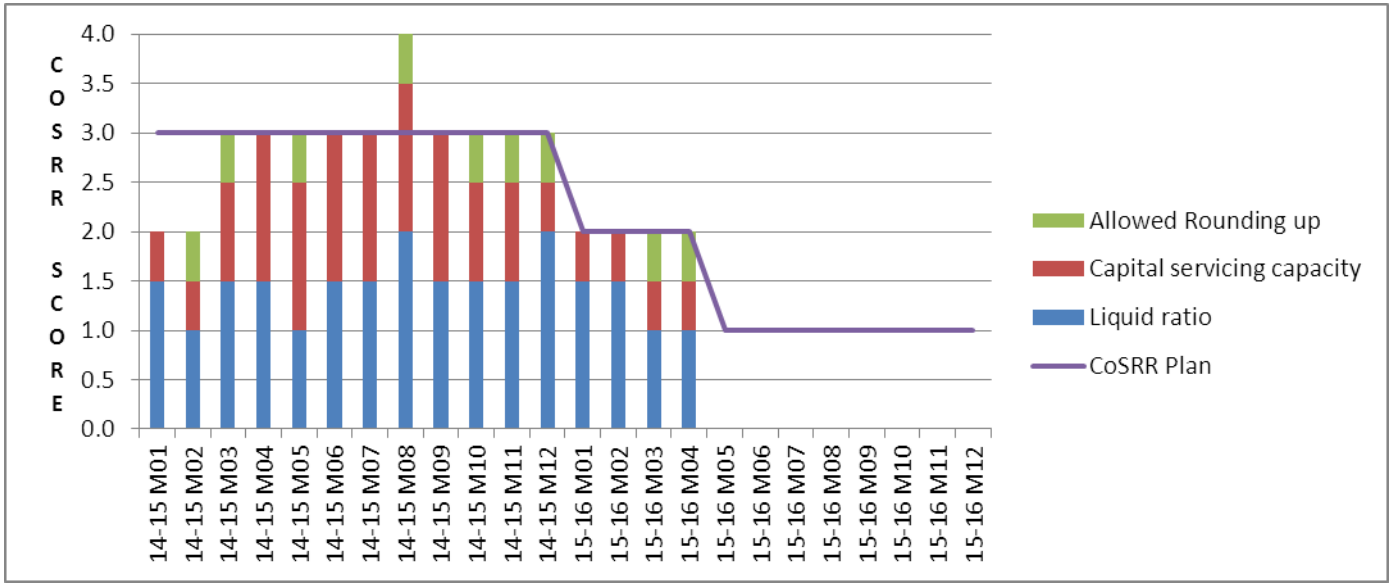


Continuity of Services Risk Rating (COSRR)

	14/15	14/15	14/15	14/15	14/15	14/15	14/15	14/15	14/15	14/15	14/15	14/15	15/16	15/16	15/16	15/16
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual
Metric Scores	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	M01	M02	M03	M04
Liquid ratio	-3.6	-7.7	-5.6	-5.5	-8.6	-0.6	-0.3	0.3	-2.2	-2.2	-4.5	1.4	-2.8	-6.6	-9.4	-7.7
Capital servicing capacity	1.0	1.1	1.4	2.2	1.8	1.9	2.1	2.1	1.9	1.5	1.3	1.0	-3.6	-4.1	-3.6	-2.8
Metric Rating (See Thresholds)	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating
Liquid ratio	3	2	3	3	2	3	3	4	3	3	3	4	3	3	2	2
Capital servicing capacity	1	1	2	3	3	3	3	3	3	2	2	1	1	1	1	1
Weighted Average	2.0	1.5	2.5	3.0	2.5	3.0	3.0	3.5	3.0	2.5	2.5	2.5	2.0	2.0	1.5	1.5
Overriding Score	**2**	**2**	**3**	**3**	**3**	**3**	**3**	**4**	**3**	**3**	**3**	**3**	**2**	**2**	**2**	**2**

Metric	Liquid ratio	Capital servicing capacity
Criteria	Liquidity	Underlying performance
Weight	50.0%	50.0%
4	0	2.50
3	-7	1.75
2	-14	1.25
1	<-14	<1.25

In M04 the Trust achieved a 2 overall for COSRR with the liquidity metric 2 and capital servicing metric 1. These are all in line with the Annual Plan for M04.



Appendices

A. Detailed Income & Expenditure
B. Income & Expenditure time series of actuals
C. Trend graphs of income and expenditure
D. Movement in working capital chart and explanation
E. Detailed cash flow plan 2015/16
F. Detailed capital expenditure
G. Aged Debt Profile
H. Developments in financial reporting

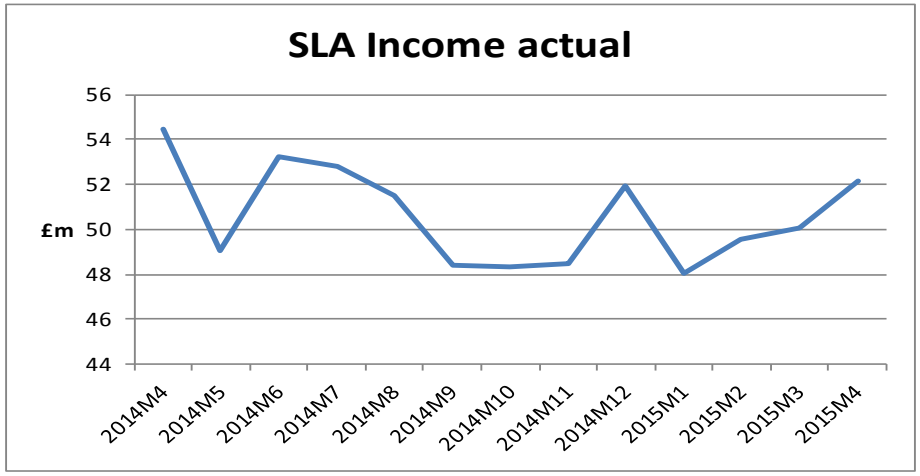
Appendix A– Detailed Income & Expenditure

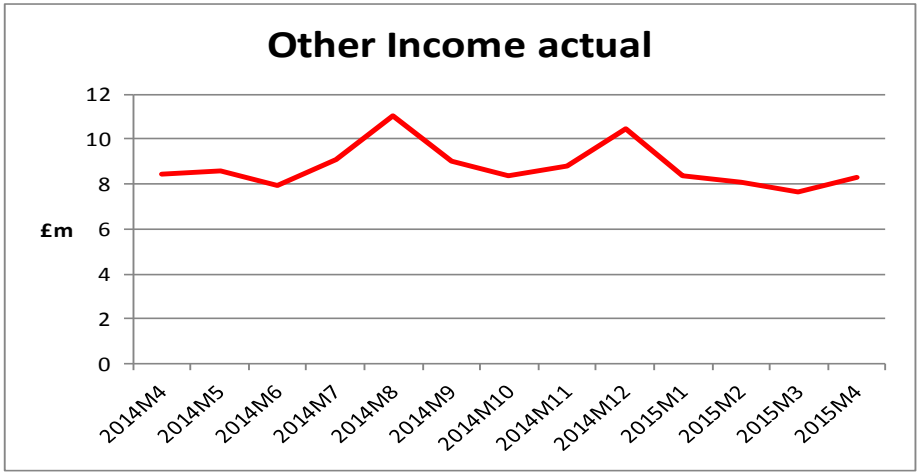
	CURRENT MONTH M4				CUMULATIVE YTD					
	Current Mth Budget £m	Current Mth Amount £m	Current Mth Variance (adv)/Fav £m	% Variance	YTD Budget £m	YTD Amount £m	YTD Variance (adv)/fav £m	% Variance	*Previous Variance (adv)/fav* £m	Annual Budget £m
Income										
SLA Elective	5.51	5.77	0.26 F	4.7%	21.23	21.21	-0.01 A	0.0%	*-0.27* A	64.54
SLA Daycase	2.69	2.57	-0.12 A	-4.6%	9.81	10.06	0.25 F	2.6%	*0.37* F	29.27
SLA Non Elective	10.17	9.75	-0.43 A	-4.2%	40.25	40.42	0.17 F	0.4%	*0.60* F	121.54
SLA Outpatients	12.89	12.34	-0.55 A	-4.2%	47.12	45.53	-1.59 A	-3.4%	*-1.04* A	142.48
SLA A&E	1.55	1.95	0.40 F	25.6%	6.21	6.12	-0.09 A	-1.4%	*-0.49* A	18.63
SLA Bed Days	4.77	4.61	-0.17 A	-3.5%	19.48	19.44	-0.04 A	-0.2%	*0.12* F	61.22
SLA Exclusions & Programme	5.98	5.83	-0.15 A	-2.6%	21.85	22.00	0.15 F	0.7%	*0.30* F	76.03
SLA Other	10.39	10.07	-0.32 A	-3.1%	38.35	37.09	-1.26 A	-3.3%	*-0.94* A	114.34
SLA Provisions QiPP/KPIs & Y/E Settlement	-0.45	-0.71	-0.25 A	-55.5%	-1.50	-2.03	-0.52 A	-34.9%	*-0.27* A	-4.51
Subtotal - SLA Income	53.50	52.17	-1.33 A	-2.5%	202.79	199.85	-2.94 A	-1.4%	-1.61 A	623.56
Private & Overseas Patient	0.40	0.44	0.04 F	11.0%	1.64	1.70	0.07 F	4.0%	*0.02* F	4.97
RTAs	0.34	0.18	-0.16 A	-46.9%	1.37	1.10	-0.27 A	-19.7%	*-0.11* A	4.16
Other Healthcare Income	0.01	0.02	0.01 F	90.2%	0.05	0.12	0.08 F	169.8%	*0.07* F	0.14
Levy Income	3.66	3.66	0.00 A	0.0%	14.61	14.58	-0.03 A	-0.2%	*-0.03* A	43.83
Other Income	3.82	4.01	0.20 F	5.2%	14.80	14.85	0.05 F	0.4%	*-0.14* A	44.44
Total income	**61.72**	**60.49**	**-1.23** A	**-2.0%**	**235.25**	**232.21**	**-3.04** A	**-1.3%**	***-1.81*** A	**721.10**
Expenditure										
Pay Total	-38.09	-38.80	-0.71 A	-1.9%	-148.46	-151.53	-3.07 A	-2.1%	*-2.36* A	-446.56
Drugs	-5.02	-5.37	-0.35 A	-7.1%	-18.39	-18.90	-0.51 A	-2.8%	*-0.16* A	-61.09
Clinical Consumables	-8.90	-8.00	0.90 F	10.1%	-33.13	-32.27	0.87 F	2.6%	*-0.03* A	-99.17
Reserves	0.24	0.56	0.32 F	136.1%	-3.77	-2.73	1.04 F	27.5%	*0.71* F	-13.04
Other Total	-9.27	-9.25	0.02 F	0.2%	-38.19	-40.39	-2.20 A	-5.8%	*-2.22* A	-110.79
Total expenditure	**-61.04**	**-60.86**	**0.18** F	**0.3%**	**-241.94**	**-245.81**	**-3.88** A	**-1.6%**	***-4.06*** A	**-730.66**
EBITDA (note 1)	**0.69**	**-0.37**	**-1.06** A	**-153.2%**	**-6.69**	**-13.61**	**-6.92** A	**-103.5%**	*-5.87* A	**-9.56**
Disposal of Assets	0.00	0.00	0.00 A	0.0%	0.00	0.00	0.00 F	0.0%	*0.00* F	0.00
Interest payable	-0.37	-0.33	0.04 F	10.7%	-1.36	-1.32	0.04 F	2.7%	*0.00* A	-5.03
Interest receivable	0.01	0.00	0.00 A	-62.4%	0.03	0.01	-0.01 A	-57.0%	*-0.01* A	0.08
PDC Dividend	-0.59	-0.59	0.00 A	0.0%	-2.36	-2.36	0.00 A	0.0%	*0.00* A	-7.08
Depreciation	-2.05	-1.97	0.08 F	4.1%	-7.82	-7.49	0.33 F	4.3%	*0.25* F	-24.61
Total interest, dividends & deprec'n	**-3.00**	**-2.88**	**0.12** F	**4.0%**	**-11.52**	**-11.16**	**0.36** F	**3.1%**	***0.24*** F	**-36.64**
NET +Surplus /-Deficit	**-2.31**	**-3.25**	**-0.94** A	**-40.5%**	**-18.20**	**-24.77**	**-6.57** A	**-36.1%**	***-5.63*** A	**-46.21**

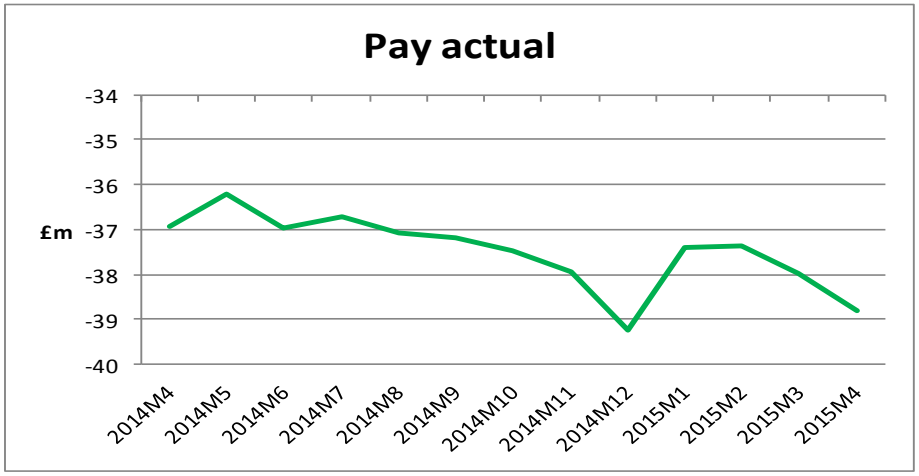
Appendix B - Time series of Actuals

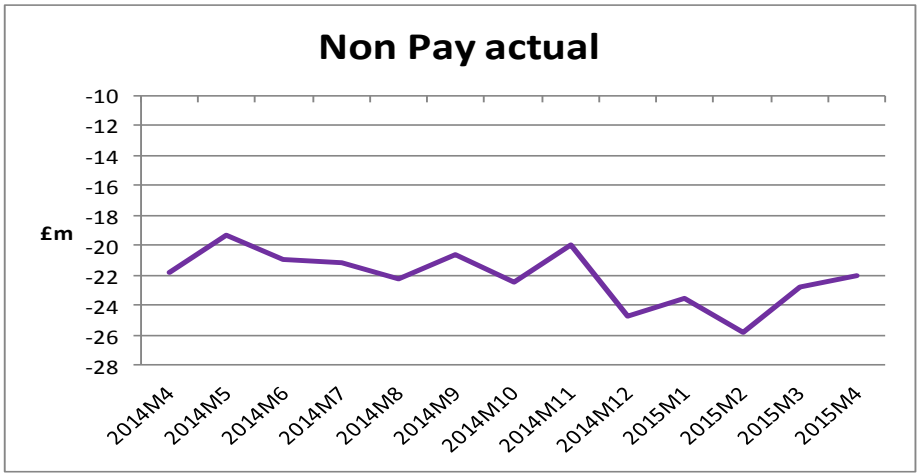
I&E Type	Type	Catergory	2014M4	2014M5	2014M6	2014M7	2014M8	2014M9	2014M10	2014M11	2014M12	2015M1	2015M2	2015M3	2015M4
Income	SLA Income	SLA A&E	-1.35	-1.19	-1.29	-1.32	-1.24	-1.33	-1.22	-1.20	-1.33	-1.53	-1.54	-1.10	-1.95
		SLA Bed Days	-4.95	-4.72	-5.08	-4.93	-4.93	-5.35	-4.88	-5.11	-5.57	-4.83	-5.01	-4.99	-4.61
		SLA Daycase	-2.51	-2.11	-2.32	-2.58	-2.15	-2.00	-2.22	-2.16	-2.49	-2.31	-2.39	-2.79	-2.57
		SLA Elective	-5.60	-5.04	-4.73	-5.26	-4.61	-4.01	-4.79	-4.23	-5.32	-5.08	-4.86	-5.50	-5.77
		SLA Exclusions	-3.98	-4.09	-3.40	-4.11	-3.46	-3.98	-2.12	-3.54	-3.50	-4.23	-3.75	-4.32	-4.92
		SLA Non Elective	-9.92	-8.94	-10.21	-9.84	-9.17	-9.25	-8.98	-8.86	-9.19	-10.10	-10.34	-10.24	-9.75
		SLA Other	-14.59	-12.64	-13.88	-13.67	-14.09	-13.08	-12.84	-12.67	-13.47	-8.32	-9.41	-7.97	-9.36
		SLA Outpatients	-10.06	-8.86	-10.80	-9.87	-10.29	-8.01	-9.84	-9.18	-9.65	-10.58	-10.54	-12.06	-12.34
		SLA Programme	-1.51	-1.41	-1.55	-1.19	-1.57	-1.37	-1.43	-1.53	-1.46	-1.09	-1.68	-1.11	-0.91
	SLA Income Total		**-54.48**	**-49.02**	**-53.25**	**-52.77**	**-51.49**	**-48.38**	**-48.32**	**-48.48**	**-51.97**	**-48.06**	**-49.53**	**-50.08**	**-52.17**
	Other Income	Levy Income	-4.08	-3.98	-3.96	-4.11	-4.13	-4.31	-4.00	-3.75	-3.84	-3.65	-3.63	-3.64	-3.66
		Other Healthcare Income	-0.01	-0.01	-0.01	-0.01	-0.02	-0.01	-0.01	-0.01	-0.02	-0.04	-0.02	-0.03	-0.02
		Private & Overseas Patient	-0.43	-0.25	-0.31	-0.48	-0.50	-0.54	-0.61	-0.27	-0.51	-0.45	-0.33	-0.48	-0.44
		RTAs	-0.38	-0.32	-0.32	-0.36	-0.43	-0.35	-0.45	-0.45	-0.38	-0.36	-0.27	-0.30	-0.18
		Other Income	-3.52	-4.00	-3.32	-4.15	-5.93	-3.78	-3.33	-4.31	-5.73	-3.83	-3.82	-3.18	-4.01
	Other Income Total		**-8.41**	**-8.56**	**-7.91**	**-9.11**	**-11.01**	**-9.00**	**-8.39**	**-8.79**	**-10.48**	**-8.33**	**-8.07**	**-7.64**	**-8.32**
Income Total			**-62.89**	**-57.58**	**-61.16**	**-61.88**	**-62.50**	**-57.38**	**-56.71**	**-57.27**	**-62.45**	**-56.40**	**-57.59**	**-57.73**	**-60.49**
Expenditure	Pay	Pay Consultants	5.59	5.53	5.52	5.54	5.73	5.55	5.91	6.11	6.35	5.83	5.81	5.90	6.39
		Pay Jnr Drs	4.25	4.15	4.23	4.56	4.32	4.71	4.28	4.38	4.31	4.25	4.24	4.19	4.16
		Pay Non Clinical	5.96	6.19	6.40	6.00	6.01	5.72	5.89	5.98	6.44	6.10	5.95	6.08	7.52
		Pay Nursing	13.78	12.50	13.85	13.44	13.42	13.48	14.09	14.30	15.05	14.62	14.68	15.02	14.09
		Pay Other	0.00	0.00	0.00	0.01	0.00	0.00	0.01	0.00	0.00	0.01	-0.01	0.00	0.01
		Pay Sci, Techs, Therap	7.34	7.84	6.96	7.17	7.57	7.73	7.28	7.17	7.08	6.58	6.68	6.79	6.63
	Pay Total		**36.92**	**36.21**	**36.96**	**36.72**	**37.06**	**37.20**	**37.47**	**37.93**	**39.23**	**37.39**	**37.36**	**37.98**	**38.80**
	Non Pay	Drugs	4.47	3.53	4.23	4.11	3.94	4.20	3.80	4.15	5.41	4.55	4.41	4.57	5.37
		Clinical Consumables	8.49	7.36	7.69	6.98	7.64	7.97	8.57	7.92	7.16	7.50	8.51	8.26	8.00
		Clinical Negligence	0.74	0.81	0.83	0.92	0.76	0.79	0.83	0.75	0.83	1.22	1.21	1.22	1.44
		Establishment	1.01	0.90	0.67	1.03	0.86	0.81	0.90	0.79	0.87	0.81	1.04	0.96	1.04
		General Supplies	1.34	1.31	1.46	1.42	1.54	1.39	1.15	1.33	1.14	1.35	1.37	1.42	1.42
		PFI Unitary payment	0.56	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.59	0.58	0.58	0.58
		Premises	2.93	2.35	3.05	3.42	3.29	2.97	2.95	3.31	3.95	3.39	3.45	4.12	3.77
		Other	2.30	2.57	2.47	2.74	3.65	1.90	3.69	1.13	4.75	4.12	5.29	1.95	0.44
	Non Pay Total		**21.84**	**19.39**	**20.98**	**21.20**	**22.25**	**20.60**	**22.46**	**19.95**	**24.69**	**23.54**	**25.86**	**22.83**	**22.06**
Expenditure Total			**58.77**	**55.60**	**57.94**	**57.92**	**59.31**	**57.80**	**59.93**	**57.89**	**63.93**	**60.93**	**63.22**	**60.81**	**60.86**
Post Ebitda	Other Income	Interest Receivable	-0.01	0.00	-0.01	-0.01	-0.01	-0.01	-0.01	0.00	-0.01	0.00	0.00	0.00	0.00
	Other Income Total		**-0.01**	**0.00**	**-0.01**	**-0.01**	**-0.01**	**-0.01**	**-0.01**	**0.00**	**-0.01**	**0.00**	**0.00**	**0.00**	**0.00**
	Other	Depreciation	1.80	1.69	1.69	1.73	1.73	1.73	2.19	1.75	1.85	2.05	1.80	1.67	1.97
		Disposal of Assets	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.09	0.00	0.00	0.00	0.00
		Interest Payable	0.28	0.26	0.27	0.26	0.26	0.29	0.29	0.27	0.31	0.40	0.28	0.32	0.33
		PDC Dividend	0.67	0.61	0.63	0.71	0.64	0.64	0.62	0.64	0.64	0.57	0.61	0.59	0.59
	Other Total		**2.75**	**2.56**	**2.60**	**2.71**	**2.63**	**2.66**	**3.10**	**2.66**	**2.90**	**3.02**	**2.68**	**2.58**	**2.89**
Post Ebitda Total			**2.74**	**2.56**	**2.59**	**2.70**	**2.62**	**2.65**	**3.09**	**2.65**	**2.89**	**3.02**	**2.68**	**2.58**	**2.88**
Grand Total			**-1.39**	**0.59**	**-0.63**	**-1.25**	**-0.57**	**3.07**	**6.31**	**3.27**	**4.36**	**7.56**	**8.30**	**5.66**	**3.25**

Appendix C – Trends of Income and Expenditure





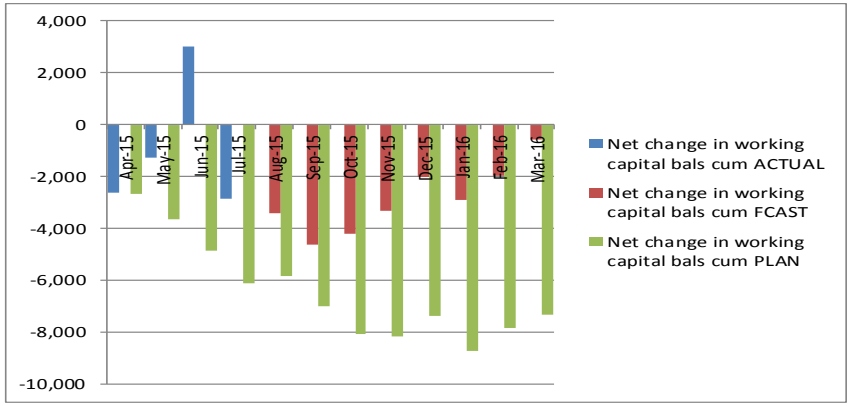




Please note that the recode of £1.2m of interim staffing costs from non pay to pay in M04 will have impacted on these graphs

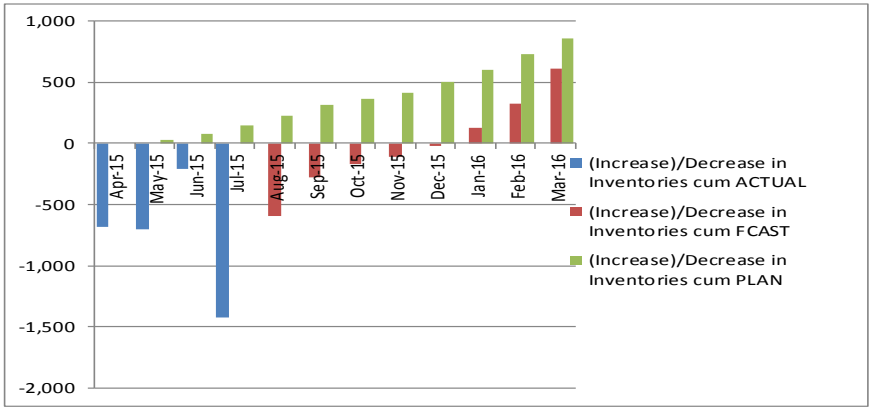
Appendix D - Working Capital movements – YTD and forecast

Change in all working capital balances 2015/16 actuals vs plan



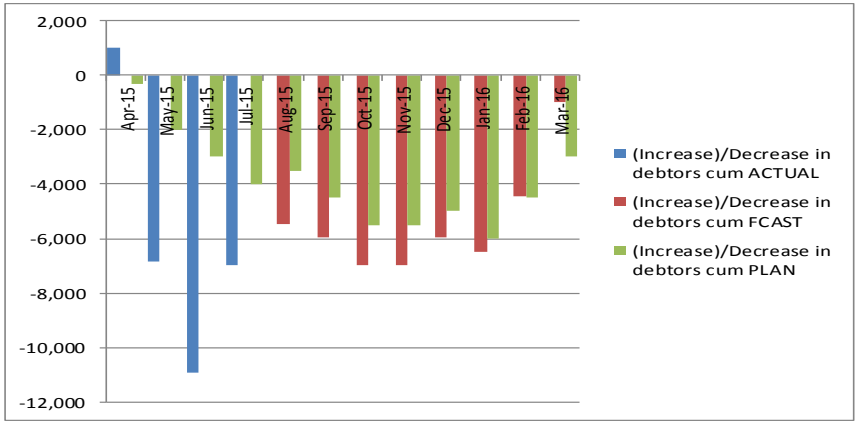
Working capital bals deteriorated by £5.8m M04 but YTD is still better than plan by £3.2m
Other 3 graphs on this slide break down this movement by inventories, debtors and creditors.

Change in inventories 2015/16 actuals vs plan



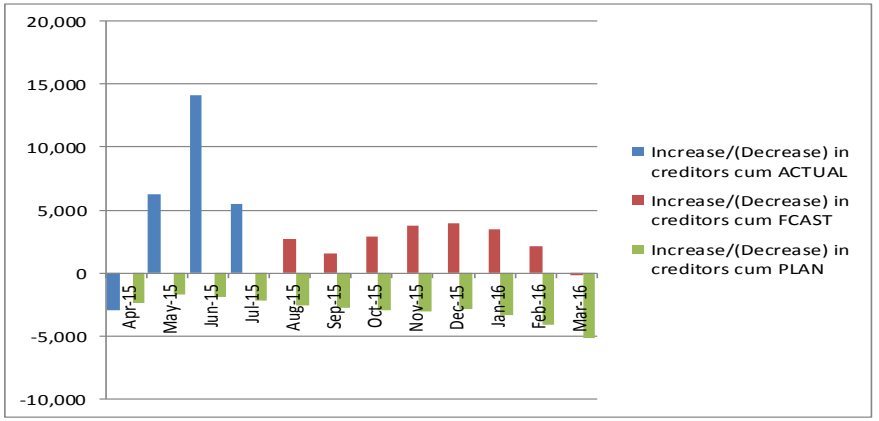
Inventories higher than plan by £1.6m at M04: big increase in pharmacy - under investigation.
Steady reduction (releasing cash) planned to year end - mainly from Central Store.

Change in debtors 2015/16 actuals vs plan



Debtors reduced by £4m in M04 but remai £3m worse than plan.
Slower collection of 14/15 NHSE debt than planned. NHSE promised £3m payment re: 14/15 debt in August.
Trust and Med School effected major payment swap on 31/07.
Trust debt reduction group targeting other disputed debts and will escalate proposals for settlements to Cash Committee.

Change in creditors 2015/16 actuals vs plan



Trust cleared significant backlog of supplier invoices in July and so creditor levels reduced by approx £8.7m in month however they remain £7.8m ahead of plan.

Appendix E - Detailed monthly cash flow forecast 15/16

ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
Finance Department
Cash flow modelling M04 2015

ACTUAL & FORECAST CASH FLOW

	PLAN 2015/16 YTD	Actual 2015/16 YTD	VAR 2015/16 YTD	PLAN 2015/16 Aug-15	*2015/16 Aug-15*	PLAN 2015/16 Sep-15	*2015/16 Sep-15*	PLAN 2015/16 Oct-15	*2015/16 Oct-15*	PLAN 2015/16 Nov-15	*2015/16 Nov-15*	PLAN 2015/16 Dec-15	*2015/16 Dec-15*	PLAN 2015/16 Jan-16	*2015/16 Jan-16*	PLAN 2015/16 Feb-16	*2015/16 Feb-16*	PLAN 2015/16 Mar-16	*2015/16 Mar-16*	PLAN 2015/16 TOTAL	Total
EBITDA	£000	£000	£000	£000	*£000*	£000	*£000*	£000	*£000*	£000	*£000*	£000	*£000*	£000	*£000*	£000	*£000*	£000	*£000*	**£000**	£000
IFRS net surplus/-deficit	-18,202	-18,202	0	-5,740	*-5,740*	-3,195	*-3,195*	-2,375	*-2,375*	-3,192	*-3,192*	-6,002	*-6,002*	-3,425	*-3,425*	-2,508	*-2,508*	-1,561	*-1,561*	**-46,200**	-46,200
I&E risk - control totals approved by board w/c 17/08		-6,567	-6,567		*-300*		*-200*		*-73*												-7,140
Profit on disposal of fixed assets														0	*0*						0
Add back:																					0
Interest payable	1,336	1,325	-11	363	*363*	406	*406*	438	*438*	448	*448*	477	*477*	502	*501*	490	*489*	515	*527*	**4,974**	4,974
Interest receivable	-25	-11	14	-6	*-7*	-6	*-7*	-6	*-7*	-6	*-7*	-6	*-8*	-6	*-8*	-6	*-8*	-6	*-12*	**-75**	-75
PDC Dividend	2,360	2,360	0	590	*590*	590	*590*	590	*590*	590	*590*	590	*590*	590	*590*	590	*590*	592	*592*	**7,082**	7,082
Depreciation	7,820	7,487	-333	2,050	*1,967*	2,050	*1,967*	2,100	*2,017*	2,100	*2,017*	2,100	*2,017*	2,130	*2,047*	2,130	*2,047*	2,130	*2,044*	**24,610**	23,610
EBITDA	-6,711	-13,608	-6,897	-2,744	*-3,127*	-155	*-439*	747	*590*	-60	*-144*	-2,841	*-2,926*	-210	*-295*	695	*610*	1,670	*1,590*	**-9,609**	**-17,749**
Opening cash balance	24,179	24,179		3,000	*6,184*	3,000	*5,195*	3,000	*5,000*	3,000	*5,000*	3,000	*5,000*	3,000	*5,000*	3,000	*3,000*	3,000	*3,000*	24,179	24,179
EBITDA	-6,711	-13,608	-6,897	-2,744	*-3,127*	-155	*-439*	747	*590*	-60	*-144*	-2,841	*-2,926*	-210	*-295*	695	*610*	1,670	*1,590*	**-9,609**	-17,749
Non-cash income	-58	-58	0	-15	*-15*	-15	*-14*	-15	*-14*	-15	*-14*	-15	*-15*	-15	*-15*	-15	*-14*	-15	*-14*	**-174**	-173
Interest paid	-1,236	-1,196	40	-381	*-381*	-342	*-342*	-371	*-371*	-484	*-484*	-530	*-530*	-436	*-436*	-529	*-529*	-449	*-490*	**-4,759**	-4,759
PDC dividend paid	0	0	0			-3,540	*-3,540*											-3,542	*-3,542*	**-7,082**	-7,082
Operating surplus/-deficit less interest and dividends paid	-8,005	-14,862	-6,857	-3,139	*-3,523*	-4,052	*-4,335*	361	*205*	-558	*-642*	-3,386	*-3,471*	-660	*-746*	152	*67*	-2,336	*-2,456*	**-21,623**	-29,763
Change in working capital																					
Change in stock	150	-1,424	-1,574	75	*826*	89	*324*	50	*110*	50	*50*	93	*93*	100	*150*	125	*200*	125	*285*	**857**	614
Change in debtors	-4,000	-6,966	-2,966	500	*1,500*	-1,000	*-500*	-1,000	*-1,000*	0	*0*	500	*1,000*	-1,000	*-500*	1,500	*2,000*	1,500	*3,466*	**-3,000**	-1,000
Change in creditors (excl int pay/cap/pdc)	-2,250	5,516	7,766	-300	*-2,868*	-250	*-1,062*	-150	*1,311*	-150	*849*	200	*200*	-450	*-494*	-750	*-1,308*	-1,108	*-2,352*	**-5,208**	-208
Net change in working capital	-6,100	-2,874	3,226	275	*-542*	-1,161	*-1,238*	-1,100	*421*	-100	*899*	793	*1,293*	-1,350	*-844*	875	*892*	517	*1,399*	**-7,351**	*-594*
Provisions used		-126	-126	0	*-15*	0	*-19*	0	*-23*	0	*-23*	0	*-23*	0	*-23*	0	*-23*	0	*-23*	**0**	-300
Interest received	25	11	-14	6	*8*	6	*8*	6	*8*	6	*8*	6	*8*	6	*8*	6	*8*	6	*8*	**75**	75
Proceeds from sale of fixed assets	0	0	0															2,500	*0*	**2,500**	0
Capital spend (pymts) - external finance	-5,551	-1,183	4,368	-1,280	*-1,572*	-2,208	*-2,269*	-1,252	*-2,710*	-674	*-1,858*	-880	*-634*	-841	*-1,582*	-772	*-1,232*	-773	*-888*	**-14,231**	-13,928
Capital spend (pymts) - internal capital	-10,623	-9,052	1,571	-3,402	*-2,385*	-2,672	*-2,984*	-3,475	*-981*	-3,146	*-2,276*	-2,979	*-3,004*	-1,769	*-1,882*	-1,576	*-860*	-1,696	*-953*	**-31,338**	-24,377
Net cash inflow/-outflow from investing activities	-16,149	-10,224	5,925	-4,676	*-3,949*	-4,874	*-5,245*	-4,721	*-3,683*	-3,814	*-4,126*	-3,853	*-3,630*	-2,604	*-3,456*	-2,341	*-2,084*	38	*-1,833*	**-42,994**	-38,230
Working capital loan received																					
Interim support funding	6,991	7,671	680	7,634	*7,909*	9,858	*9,420*	5,324	*3,256*	5,093	*4,488*	7,644	*6,981*	5,074	*3,480*	2,274	*2,116*	2,293	*3,379*	**52,185**	48,700
Loans received - LEEF	0	0	0																	**0**	0
Loans received - DH capital	3,259	3,569	310	866	*0*	882	*1,825*	595	*234*	26		0		0		0		0		**5,628**	5,628
Loan repayments - LEEF	0	0	0									-739	*-739*							**-739**	-739
Working capital loan repyments	0	0	0	-499.5	*-499.5*											-499.5	*-499.5*			**-999**	-999
Loans repayments - DH capital	0	0	0							-186	*-186*							0	*0*	**-186**	-186
Loans repaid - SALIX	0	0	0			-193	*-193*													**-193**	-193
PFI & finance lease repayments	-1,176	-1,149	27	-460	*-370*	-460	*-410*	-460	*-410*	-460	*-410*	-460	*-410*	-460	*-410*	-460	*-468*	-511	*-466*	**-4,907**	-4,503
PDC capital (assume £1.5m extra received)	0	0	0																	**0**	0
Net cash inflow/-outflow from financing	9,074	10,091	1,017	7,540	*7,040*	10,087	*10,642*	5,459	*3,080*	4,473	*3,892*	6,445	*5,832*	4,614	*3,070*	1,314	*1,149*	1,782	*2,913*	**50,789**	47,708
Net cash movement in period	-21,179	-17,995	3,184	0	*-990*	0	*-195*	0	*0*	1	*0*	-1	*0*	0	*-2,000*	0	*0*	1	*0*	**1**	-21,179
Closing cash balance	3,000	6,184	3,184	3,000	*5,195*	3,000	*5,000*	3,000	*5,000*	3,000	*5,000*	3,000	*5,000*	3,000	*3,000*	3,000	*3,000*	3,000	*3,000*	3,000	3,000
Cash balance excl unexpended LEEF loan	-8,842	-6,080		-8,428	*-6,793*	-7,102	*-5,529*	-6,445	*-5,068*	-5,796	*-4,676*	-4,917	*-3,706*	-4,076	*-4,775*	-3,305	*-3,871*	-2,531	*-3,023*	-2,531	
WCF / Interim support funding cum (WCF £25m)	6,991	7,671	680	14,625	*15,580*	24,483	*25,000*	29,807	*28,256*	34,900	*32,744*	42,544	*39,725*	47,618	*43,205*	49,892	*45,321*	52,185	*48,700*		

Appendix F – capital programme 2015/16

CPG Finance report Month 04

BUDGETS APPROVED BY FINANCE COMMITTEE JUNE 2015: Discretionary budgets have been removed M04-M12 inclusive

Summary cap exp by source of finance	NEW Budget £000	Budget YTD £000	Actual M01 £000	Actual M02 £000	Actual M03 £000	Actual M04 £000	Actual YTD £000	Variance YTD £000	Forecast M05 £000	Forecast M06 £000	Forecast M07 £000	Forecast M08 £000	Forecast M09 £000	Forecast M10 £000	Forecast M11 £000	Forecast M12 £000	Budget Total £000	Forecast Outturn £000	Forecast outturn var £000
Internal capital	**24,994**	**9,482**	1,164	2,303	2,099	1,487	**7,053**	*2,429*	2,700	2,667	2,851	3,229	2,134	1,645	860	953	**24,994**	**24,092**	*902*
LEEF loan	**6,782**	**541**	-210	107	190	150	**237**	*304*	276	1,459	461	392	970	931	904	848	**6,782**	**6,478**	*304*
DH capital loans	**6,810**	**3,721**	922	363	377	850	**2,512**	*1,209*	832	935	279	413	534	651	328	40	**6,810**	**6,523**	*287*
PDC capital	**1,103**	**400**	137	0	219	41	**397**	*3*	149	192	100	100	0	237	0	0	**1,103**	**1,175**	*-71*
Lease finance	**8,337**	**2,227**	266	1,036	449	26	**1,777**	*450*	740	1,334	2,431	1,445	100	100	100	100	**8,337**	**8,127**	*210*
Total	**48,027**	**16,371**	2,279	3,809	3,334	2,554	**11,976**	*4,395*	4,697	6,587	6,122	5,579	3,738	3,564	2,192	1,940	**48,027**	**46,395**	*1,632*

Summary cap exp by budget category and source of finance	Annual budget £000	Budget YTD £000	Actual M01 £000	Actual M02 £000	Actual M03 £000	Actual M04 £000	Actual YTD £000	Variance M02 £000	Forecast M05 £000	Forecast M06 £000	Forecast M07 £000	Forecast M08 £000	Forecast M09 £000	Forecast M10 £000	Forecast M11 £000	Forecast M12 £000	Budget Total £000	Forecast Outturn £000	Forecast Outturn Var £000
Infrastructure renewal																			
Internal capital	**2,608**	**834**	165	185	197	470	**1,017**	*-183*	219	153	173	228	256	308	296	82	**2,608**	**2,730**	*-122*
LEEF loan	**6,782**	**541**	-210	107	190	150	**237**	*304*	276	1,459	461	392	970	931	904	848	**6,782**	**6,478**	*304*
Lease finance	**240**	**240**	0	0	0	0	**0**	*240*	240	0	0	0	0	0	0	0	**240**	**240**	*0*
Medical equipment																			
Internal capital	**3,980**	**1,638**	144	1,065	11	189	**1,409**	*229*	477	307	309	839	297	79	62	88	**3,980**	**3,866**	*114*
Lease finance	**8,097**	**1,987**	266	1,036	449	26	**1,777**	*210*	500	1,334	2,431	1,445	100	100	100	100	**8,097**	**7,887**	*210*
IMT																			
Internal capital	**5,423**	**3,305**	240	470	1,005	270	**1,985**	*1,320*	748	641	546	375	487	302	119	97	**5,423**	**5,299**	*123*
PDC capital	**1,103**	**400**	137	0	219	41	**397**	*3*	149	192	100	100	0	237	0	0	**1,103**	**1,175**	*-71*
Major Projects																			
Internal capital	**10,927**	**2,767**	365	431	689	568	**2,053**	*714*	1,039	1,343	1,682	1,646	953	774	152	465	**10,927**	**10,106**	*821*
DH capital loans	**6,810**	**3,721**	922	363	377	850	**2,512**	*1,209*	832	935	279	413	534	651	328	40	**6,810**	**6,523**	*287*
Other																			
Internal capital	**1,557**	**751**	168	131	192	44	**535**	*216*	175	181	100	100	100	100	150	150	**1,557**	**1,591**	*-34*
SWL Path																			
Internal capital	**500**	**187**	82	21	5	-54	**54**	*133*	42	42	42	42	42	82	82	72	**500**	**500**	*0*
Total	**48,027**	**16,371**	2,279	3,809	3,334	2,554	**11,976**	*4,395*	4,697	6,587	6,122	5,579	3,738	3,564	2,192	1,940	**48,027**	**46,395**	*1,632*

Forecast assumptions

1 Contingency budget of £1m. £100k committed at M04 leaving unallocated bbudget of £0.9m.
Forecast assumes remaining contingency budget is spent in full by year end.
2 PPU land disposal £2.5m capital receipt is NOT received in 2015/16
3 CCU2 scheme (£900k) is now included - replaced Mortuary which is deferred to 2016/17 following executive review of programme.

Appendix G - aged profile of debt M04 2015/16

Summary of Outstanding Invoices at 31 July 2015

NHS Invoices outstanding																
Category of Debtor	**% of Total Debt**	**Total Outstanding Debt**			**Prior year position**		**Up to 30 Days**		**1 - 3 months old**		**3 - 6 months old**		**6 - 12 months old**		**Over 12 months old**	
		at 31/07/15 £000s	at 30/06/15 £000s	% change since last report	at 30/06/14 £000s	% change since year end	**at 31/07/15 £000s**	at 30/06/15 £000s	**at 31/07/15 £000s**	at 30/06/15 £000s	**at 31/07/15 £000s**	at 30/06/15 £000s	**at 31/07/15 £000s**	at 30/06/15 £000s	**at 31/07/15 £000s**	at 30/06/15 £000s
St George's Debtors																
(1) Clinical Commissioning Groups	3.41%	**2,122**	*1,469*	44%	(1,250)	0%	(102)	*21*	596	*(177)*	773	*1,071*	852	*605*	3	*(51)*
(1.1) NHS England	21.43%	**13,350**	*11,515*	16%	11,323	0%	349	*(2,390)*	6,181	*10,671*	3,889	*2,275*	2,920	*946*	11	*13*
(1.2) NHS Wandsworth CCG	7.73%	**4,816**	*5,750*	0%	4,077	0%	870	*373*	2,027	*4,377*	1,265	*649*	372	*351*	282	*0*
(1.2.1) WCCG - non EEA incentive scheme	0.11%	**70**	*0*	0%	0	0%	70	*0*	0	*0*	0	*0*	0	*0*	0	*0*
(1.3) NHS Croydon CCG	-0.04%	**-22**	*421*	0%	690	0%	(1)	*0*	(22)	*420*	0	*0*	0	*0*	1	*1*
(1.4) NHS Sutton CCG	-0.07%	**-41**	*11*	0%	(367)	0%	3	*10*	(75)	*(1)*	29	*0*	0	*0*	2	*2*
(1.5) NHS Lambeth CCG	0.06%	**39**	*-127*	0%	113	0%	0	*0*	39	*(127)*	0	*0*	0	*0*	0	*0*
(1.6) NHS Kingston CCG	-0.17%	**-105**	*-152*	0%	(264)	0%	0	*0*	(109)	*(156)*	0	*0*	0	*0*	4	*4*
(1.7) NHS Merton CCG	-0.67%	**-420**	*-431*	0%	255	0%	12	*1*	(443)	*(432)*	11	*0*	0	*0*	0	*0*
(1.8) NHS England - Legacy PCT balances	0.00%	**1**	*-1*	(200%)	5		0	*0*	0	*0*	0	*0*	0	*0*	1	*(1)*
(2) English CCG NCA Debt	5.80%	**3,613**	*2,828*	0%	2,379	0%	576	*461*	1,335	*893*	651	*655*	765	*510*	286	*309*
(3) Non English NHS NCA Debt	0.98%	**611**	*668*	(9%)	489	25%	51	*33*	86	*95*	60	*52*	54	*65*	360	*423*
(4) Other NHS Organisations	0.14%	**88**	*178*	(51%)	1,024	(91%)	13	*14*	5	*76*	19	*6*	0	*30*	51	*52*
(4.1) The Department Of Health	0.00%	**0**	*2,600*	0%	0	0%	0	*2,600*	0	*0*	0	*0*	0	*0*	0	*0*
(4.2) NHS Property Services Ltd	1.07%	**664**	*665*	0%	0	0%	0	*0*	0	*56*	56	*56*	167	*112*	441	*441*
(4.3) Public Health England	0.46%	**286**	*415*	0%	0	0%	42	*67*	185	*154*	44	*179*	0	*0*	15	*15*
(4.4) Jersey Health & Social Services	0.44%	**273**	*274*	0%	0	0%	(1)	*0*	3	*3*	2	*2*	0	*0*	269	*269*
(4.5) Health Education England	0.21%	**131**	*160*	0%	63	0%	42	*27*	89	*133*	0	*0*	0	*0*	0	*0*
(5) NHS Trusts	5.31%	**3,306**	*3,053*	8%	9,094	(64%)	482	*654*	945	*736*	542	*230*	71	*481*	1,266	*952*
(5.1) Kingston Hospital NHS Foundation Trust	4.93%	**3,073**	*2,869*	7%	0	0%	126	*(26)*	876	*1,925*	1,234	*204*	224	*167*	613	*599*
(5.2) Croydon Health Services NHS Trust	3.01%	**1,878**	*1,798*	4%	0	0%	82	*(224)*	765	*1,194*	255	*74*	499	*548*	277	*206*
(5.3) Epsom & St Helier University Hospitals NHS Trus	1.71%	**1,063**	*1,287*	(17%)	0	0%	85	*188*	540	*879*	253	*60*	134	*157*	51	*3*
(5.4) Chelsea & Westminister Hospital NHS Foundatio	0.91%	**568**	*507*	12%	0	0%	255	*230*	292	*271*	15	*0*	0	*(5)*	6	*11*
(5.5) Moorfields Eye Hospital NHS Foundation Trust	0.52%	**327**	*458*	(29%)	0	0%	157	*265*	56	*79*	11	*49*	58	*20*	45	*45*
Total NHS Invoices outstanding	57.29%	**35,691**	***36,215***	**(1%)**	**27,631**	29%	**3,111**	*2,304*	**13,371**	*21,069*	**9,109**	*5,562*	**6,116**	*3,987*	**3,984**	*3,293*
Non-NHS Invoices outstanding																
(6) Compensation Recovery Unit	19.72%	**12,287**	*12,114*	1%	10,596	16%	249	*275*	922	*1,078*	1,137	*1,158*	1,640	*1,548*	8,339	*8,055*
(7) Local Authority	7.23%	**4,506**	*4,668*	(3%)	0	#DIV/0!	221	*429*	1,307	*1,670*	1,176	*1,191*	1,550	*1,151*	252	*227*
(8) General Debtors	5.46%	**3,399**	*3,339*	2%	4,581	(26%)	464	*725*	1,014	*1,459*	877	*203*	499	*427*	545	*525*
(9) Overseas Visitors NHS Chargeable	4.29%	**2,672**	*2,516*	6%	2,314	15%	103	*44*	178	*221*	220	*197*	301	*237*	1,870	*1,817*
(10) Private Patients	1.30%	**809**	*831*	(3%)	1,503	(46%)	122	*110*	128	*183*	117	*135*	108	*65*	334	*338*
(10.1) Bupa Insurance Services Ltd t/a Bupa	0.83%	**518**	*589*	(12%)	0	#DIV/0!	84	*96*	85	*182*	49	*14*	61	*59*	239	*238*
(10.2) AXA PPP Healthcare Ltd	0.84%	**523**	*485*	8%	0	#DIV/0!	79	*72*	153	*156*	81	*87*	52	*26*	158	*144*
(11) Medical School	1.11%	**694**	*1,469*	(53%)	920	(25%)	196	*117*	471	*702*	12	*411*	5	*231*	10	*8*
(12) St George's Hospital Charity	0.71%	**441**	*515*	(14%)	320	38%	122	*184*	241	*157*	(3)	*71*	66	*74*	15	*29*
(13) Salary Overpayments	0.94%	**583**	*478*	22%	503	16%	37	*(1)*	93	*46*	43	*16*	62	*72*	348	*345*
(14) UK Border Agency	0.29%	**181**	*184*	(2%)	110	65%	1	*4*	1	*13*	27	*45*	68	*47*	84	*75*
Total Non-NHS Invoices outstanding	42.71%	**26,613**	***27,188***	(2%)	**20,847**	28%	**1,678**	*2,055*	**4,593**	*5,867*	**3,736**	*3,528*	**4,412**	*3,937*	**12,194**	*11,801*
Total invoices		**62,304**	**63,403**	**-0**	**48,478**	**1**	**4,789**	**4,359**	**17,964**	**26,936**	**12,845**	**9,090**	**10,528**	**7,924**	**16,178**	**15,094**

Appendix H - Developments in financial reporting

A significant amount of work is being undertaken to improve the financial reporting to the organisation. The following have been reflected in the month 4 finance report:

a) Specific accounting changes

a) Updated how CIPs are shown in the Divisions – only 'Green' Schemes are removed in detail from Divisional budgets. However all other schemes 'Amber' 'Red' and 'run-rate' are contributing to the Divisional positions and a schedule of the impact of these is include in this pack

b) SLA challenges have been devolved to Divisions / Directorates as they are best placed to have an impact on the challenges

c) Excluded drugs – rather than report over-achievement of income targets and overspends on expenditure budgets (or the converse), the in-month budget has been re-profiled to remove these variances. This simplifies the understanding of the individual income and expenditure positions by removing a set of equal and opposite variances and does not affect the bottom-line position.

d) As approved by the Board £3.8m of contingency fund has been devolved to Divisions / Directorates to fund unavoidable cost pressures

b) Reporting developments

a) Clarity has been refined over the treatment of central adjustments and true reserves with the establishment of unique cost-centres to record these items

b) The reporting ledger hierarchies have been overhauled to be able to make reporting meaningful (eg removal of Other/Other categories) and to clearly separate business as usual operations from technical adjustments

c) This month we have reallocated £1.2m from non pay to pay relating to interim staff costs that had previously been recorded against 'professional services/consultancy'. This includes £0.9m relating to months 1 to 3

d) Some other costs have also been moved from the 'professional services/consultancy' code to more appropriate codes within non pay.

These are part of a suite of planned developments, the rest of which will be taking place in future months.

REPORT TO THE TRUST BOARD *September 2015* TB Sept 15 – 05a

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:	Executive Management Team Meeting

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

1. Key messages

The workforce report includes:

- The workforce performance report July 2015

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 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 July 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 missed the 75% completion date by the end of July but assurance has been given that it is on track for completion by the end of September.

Turnover and stability

Turnover has stabilised in July 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

The agency figures have been amended to include interim consultancy, which was previously reported through non-pay. A small task and finish group in place to identify this the temporary workforce that is not being managed through the staff bank process. The challenge sessions are beginning to grip with 68 people with exit dates and no replacement, 39 transfers from agency to bank, 89 transfers to substantive posts (including apprenticeships) and further meetings scheduled to take place. The impact of this work will not be seen until the month five information is available.

Mandatory training and appraisal rates

Appraisal rates have steadied but remain below target. Mandatory training levels have slipped again. Recommendations from the recent internal audit report will be implemented. There is a programme of work in place to assess the level of risk and to increase uptake.

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Workforce Performance Report
to the Trust Board

Month 4 - July 2015

Excellence in specialist and community healthcare

Workforce Performance Report Aug ‘14 - Jul ‘15

Contents

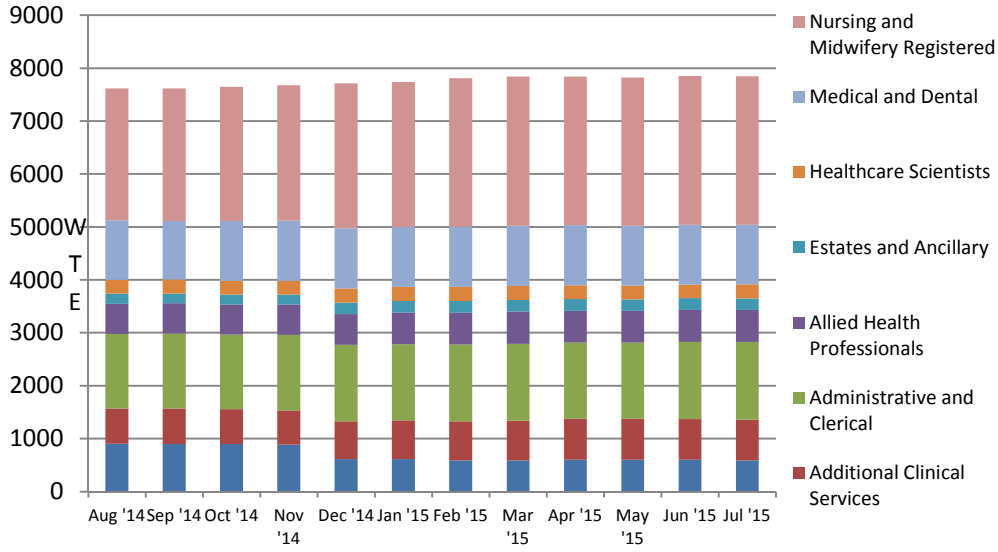
Performance Summary

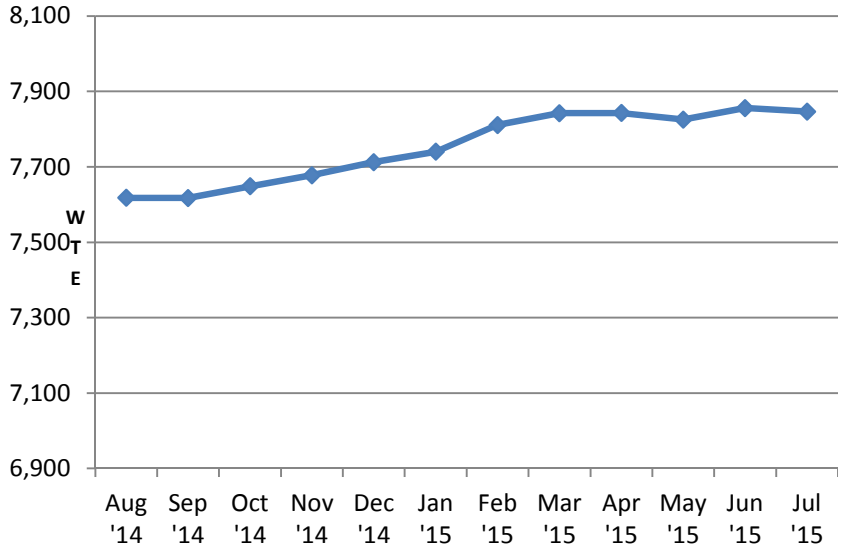
Summary of overall performance is set out below

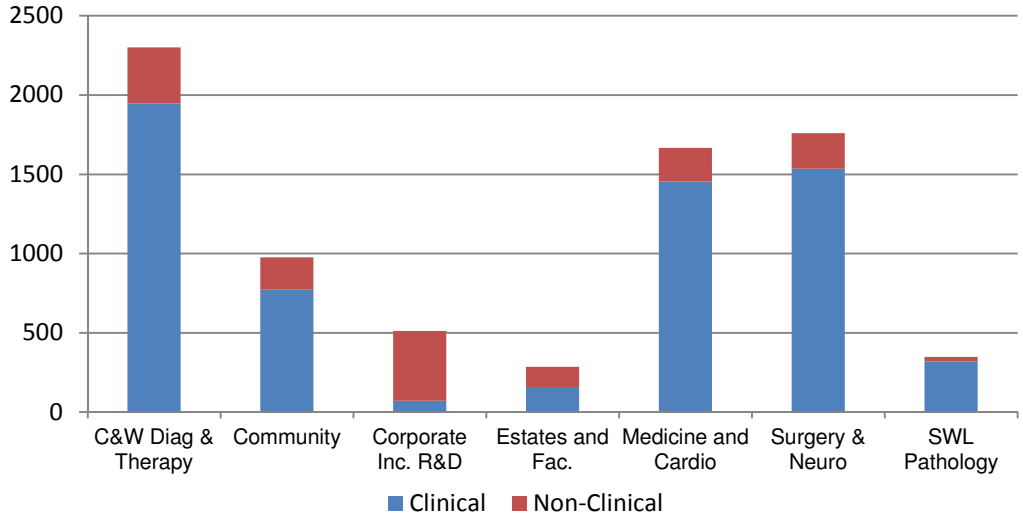
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has decreased by 0.2%	13.1%	15.2%	14.9%	↘
6	Turnover	Turnover has remained the same	15.9%	17.3%	17.3%	↔
7	Voluntary Turnover	Voluntary Turnover has remained the same	13.1%	14.0%	14.0%	↔
8	Stability	Stability has increased this month by 0.3%	85.0%	83.2%	83.5%	↗
10	Sickness	Sickness has decreased by 0.1%	3.5%	3.5%	3.4%	↘
13-14	Temporary Staffing Usage (FTE)	Temporary Staffing Usage has increased by 0.3%	17.0%	14.5%	14.8%	↗
17	Mandatory Training	MAST compliance has decreased by 1.4%	77.4%	72.4%	71.0%	↘
18	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has increased by 0.2%	78.4%	73.8%	74.0%	↗

Current Staffing Profile

The data below displays the current staffing profile of the Trust



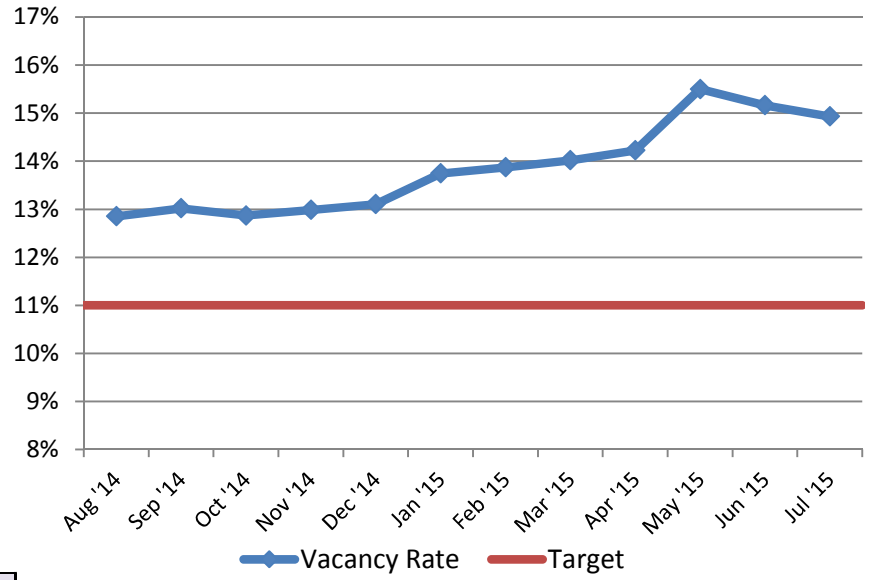




COMMENTARY

The Trust currently employs 8412 people working a whole time equivalent of 7847 which is 9 WTE fewer than June. The growth rate in the directly employed workforce since July 2014 is 277 WTE or 3.7%.

Section 1: Vacancies



Vacancies by Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diag & Therapy	9.9%	9.8%	9.9%	9.5%	↘
Community	19.4%	19.1%	19.4%	12.6%	↘
Corporate	15.4%	16.5%	16.4%	18.2%	↗
Estates and Fac.	11.4%	22.8%	23.0%	15.6%	↘
Medical & Cardio	13.4%	13.5%	12.8%	17.4%	↗
Surgery & Neuro	14.9%	17.7%	16.9%	16.7%	↘
SWL Pathology	25.0%	28.4%	24.0%	23.6%	↘
Whole Trust	**14.2%**	**15.5%**	**15.2%**	**14.9%**	↘

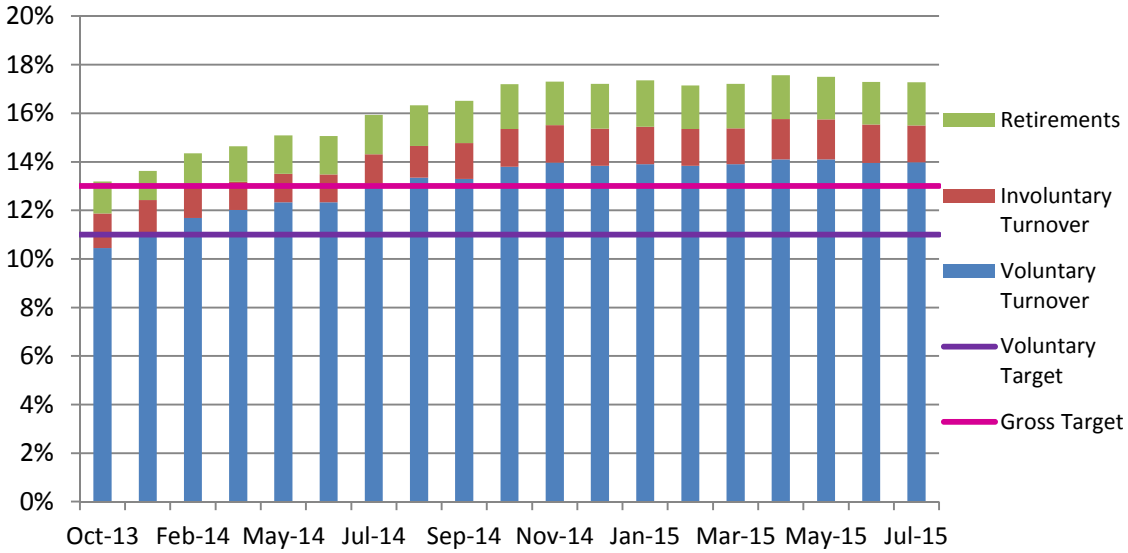
Vacancies Staff Group	Apr '15	May '15	Jun '15	Jul '15	Trend
Add Prof Scientific and Technic	18.6%	16.4%	17.5%	17.5%	↔
Additional Clinical Services	16.7%	18.7%	18.8%	18.5%	↘
Administrative and Clerical	21.2%	22.6%	20.9%	16.8%	↘
Allied Health Professionals	3.7%	3.6%	3.1%	8.6%	↗
Estates and Ancillary	27.0%	22.5%	25.8%	18.9%	↘
Healthcare Scientists	20.5%	21.8%	21.7%	18.7%	↘
Medical and Dental	-0.3%	3.2%	4.5%	6.8%	↗
Nursing and Midwifery Registered	13.9%	15.7%	14.9%	15.9%	↗
Total	**14.2%**	**15.5%**	**15.2%**	**14.9%**	↘

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:



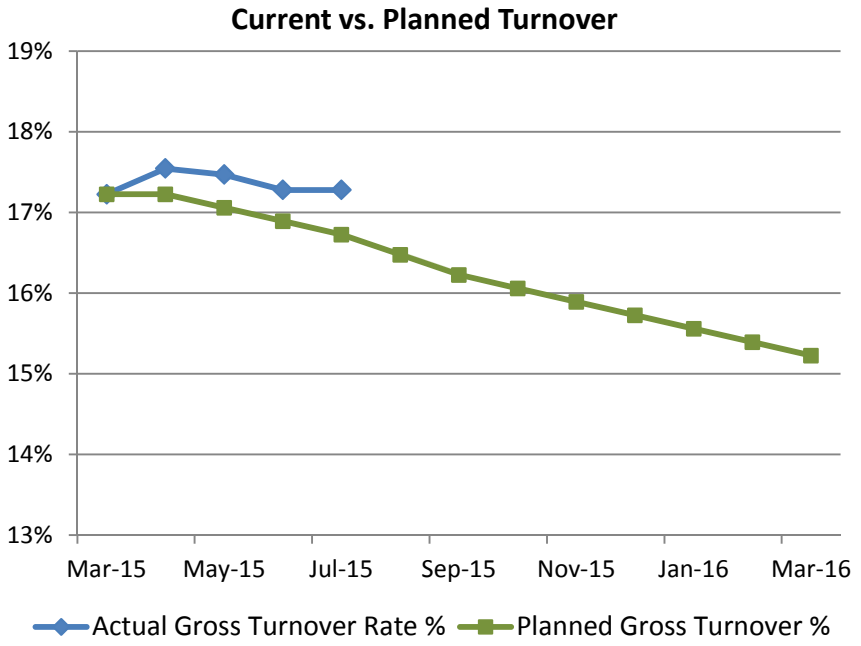
COMMENTARY

The total trust turnover rate has remained static this month at 17.3%. This is significantly above the current target of 13%. In the last 12 months there have been 1223 WTE leavers.

Each Division is developing a plan and target trajectory in response to the increase in turnover rates which are based on the information available through exit questionnaire data.

	All Turnover				
Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	18.1%	17.7%	17.2%	17.5%	↗
Community Services	19.6%	19.9%	20.4%	20.1%	↘
Corporate	16.9%	18.5%	19.7%	20.0%	↗
Estates and Facilities	17.6%	17.4%	17.0%	16.5%	↘
Medical & Cardiothoracics	18.4%	18.0%	17.7%	17.7%	↔
Surgery, Neurosciences & Anaes	14.5%	14.3%	14.4%	14.4%	↔
SWL Pathology	19.4%	19.7%	17.3%	16.3%	↘
Whole Trust	**17.5%**	**17.5%**	**17.3%**	**17.3%**	↔

	All Turnover				
Staff Group	Apr '15	May '15	Jun '15	Jul '15	Trend
Add Prof Scientific and Technic	18.9%	18.2%	17.9%	18.6%	↗
Additional Clinical Services	20.4%	20.6%	20.8%	20.1%	↘
Administrative and Clerical	16.6%	16.6%	16.9%	17.0%	↗
Allied Health Professionals	18.5%	17.9%	17.1%	17.9%	↗
Estates and Ancillary	12.6%	11.3%	10.8%	10.0%	↘
Healthcare Scientists	15.9%	16.2%	14.3%	12.7%	↘
Medical and Dental	13.3%	14.1%	13.6%	12.2%	↘
Nursing and Midwifery Registered	18.1%	18.0%	17.9%	18.2%	↗
Whole Trust	**17.5%**	**17.5%**	**17.3%**	**17.3%**	↔



Section 2b: Voluntary Turnover

	Voluntary Turnover					Other Turnover Jul 2015	
Division	**Apr '15**	**May '15**	**Jun '15**	**Jul '15**	**Trend**	**In-Voluntary**	**Retirement**
C&W Diagnostic & Therapy	13.5%	13.2%	13.2%	13.6%	↗	2.2%	1.7%
Community Services	15.6%	15.8%	16.1%	15.6%	↘	1.1%	3.5%
Corporate	14.0%	15.1%	15.8%	15.9%	↗	2.0%	2.1%
Estates and Facilities	8.0%	7.6%	6.4%	5.9%	↘	7.6%	3.0%
Medical & Cardiothoracics	16.1%	15.7%	15.4%	15.3%	↘	0.9%	1.4%
Surgery, Neurosciences & Anaes	12.3%	12.6%	12.8%	13.0%	↗	0.4%	1.0%
SWL Pathology	16.5%	16.7%	15.1%	14.6%	↘	0.3%	1.4%
Whole Trust	**14.1%**	**14.1%**	**14.0%**	**14.0%**	↔	**1.5%**	**1.8%**

	Voluntary Turnover					Other Turnover Jul 2015	
Staff Group	**Apr '15**	**May '15**	**Jun '15**	**Jul '15**	**Trend**	**In-Voluntary**	**Retirement**
Add Prof Scientific and Technic	12.3%	12.0%	11.7%	12.6%	↗	5.7%	0.2%
Additional Clinical Services	17.3%	17.4%	17.6%	16.9%	↘	1.2%	2.0%
Administrative and Clerical	12.9%	13.0%	13.2%	13.2%	↔	1.7%	2.1%
Allied Health Professionals	17.3%	16.8%	15.9%	16.6%	↗	0.2%	1.1%
Estates and Ancillary	8.2%	7.3%	6.8%	5.5%	↘	0.9%	3.6%
Healthcare Scientists	11.3%	11.5%	10.7%	9.9%	↘	0.4%	2.4%
Medical and Dental	7.6%	8.2%	8.1%	6.9%	↘	4.0%	1.3%
Nursing and Midwifery Registered	15.5%	15.5%	15.4%	15.7%	↗	0.6%	1.9%
Whole Trust	**14.1%**	**14.1%**	**14.0%**	**14.0%**	↔	**1.5%**	**1.8%**

Caregroup	**Staff in Post WTE**	**Leavers WTE**	**Voluntary Turnover Rate**
Prison Service	56.6	19.4	32.6%
Cardiac Surgery	85.7	22.8	31.2%
Gynaecology	45.6	14.6	30.8%
Inpatient Care Older People	52.4	16.0	30.1%
Chest Medicine	23.4	6.8	29.3%

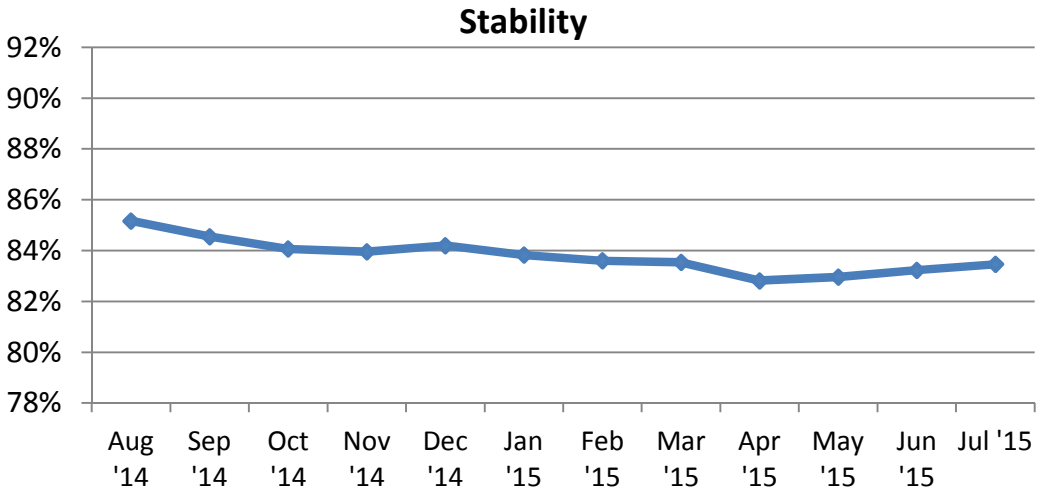
COMMENTARY

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 Education & Development including sessions on Career development.

Section 3: Stability

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



Stability by Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	82.6%	82.9%	82.5%	82.8%	↗
Community Services	80.4%	80.4%	80.4%	80.9%	↗
Corporate	85.7%	85.1%	83.7%	82.6%	↘
Estates and Facilities	89.0%	84.9%	85.4%	86.1%	↗
Medical & Cardiothoracics	81.3%	82.4%	82.4%	82.5%	↗
Surgery, Neurosciences & Anaes	84.6%	84.5%	85.1%	85.5%	↗
SWL Pathology	81.7%	82.2%	88.3%	89.4%	↗
Whole Trust	**82.8%**	**83.0%**	**83.2%**	**83.5%**	↗

Stability Staff Group	Apr '15	May '15	Jun '15	Jul '15	Trend
Add Prof Scientific and Technic	72.7%	73.5%	73.7%	72.8%	↘
Additional Clinical Services	82.8%	82.8%	85.1%	85.6%	↗
Administrative and Clerical	86.4%	86.1%	85.7%	85.7%	↔
Allied Health Professionals	80.8%	80.8%	81.2%	81.5%	↗
Estates and Ancillary	85.5%	86.7%	86.0%	86.8%	↗
Healthcare Scientists	88.7%	87.3%	88.3%	92.8%	↗
Medical and Dental	87.8%	87.1%	88.5%	89.1%	↗
Nursing and Midwifery Registered	82.2%	82.6%	82.4%	82.5%	↗
Total	**82.8%**	**83.0%**	**83.2%**	**83.5%**	↗

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.

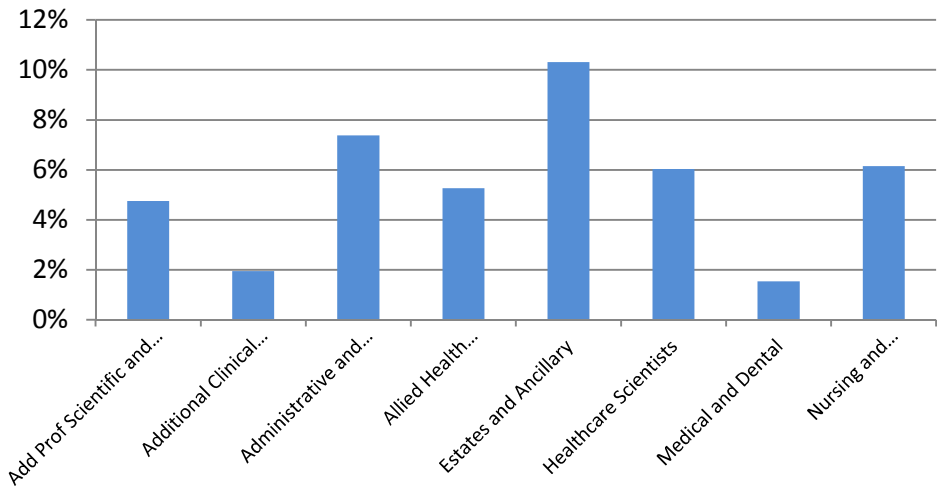
The stability rate has increased by 0.3% this month.

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 1.5% and is now at 83.5%.

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 July 44 staff were promoted, there were 83 new starters to the Trust and 246 employees were acting up to a higher grade.

Over the last year 5.6% 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 were upgraded in April 2015) 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.

	No. of Promotions				
Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	8	11	18	15	↘
Community Services	4	15	15	12	↘
Corporate	3	5	7	6	↘
Estates and Facilities	20	0	2	0	↘
Medical & Cardiothoracics	1	6	4	6	↗
Surgery, Neurosciences & Anaes	3	7	12	5	↘
SWL Pathology	0	0	0	0	↔
Whole Trust Promotions	**39**	**44**	**58**	**44**	↘
New Starters (Excludes Junior Doctors)	**120**	**71**	**94**	**83**	↘

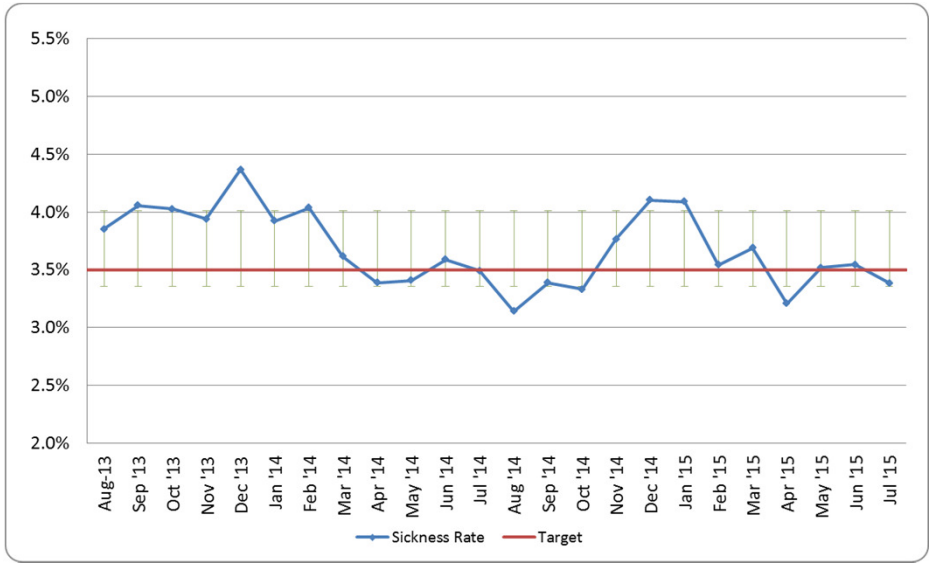
Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	1876	112	6.0%	118
Community Services	923	44	4.8%	18
Corporate	442	35	7.9%	22
Estates and Facilities	257	26	10.1%	5
Medical & Cardiothoracics	1172	60	5.1%	42
Surgery, Neurosciences & Anaes	1349	61	4.5%	26
SWL Pathology	330	15	4.5%	15
Whole Trust	**6349**	**353**	**5.6%**	**246**
New Starters (Excludes Junior Doctors)		**1454**		

	No. of Promotions				
Staff Group	Apr '15	May '15	Jun '15	Jul '15	Trend
Add Prof Scientific and Technic	1	4	2	1	↘
Additional Clinical Services	0	4	2	6	↗
Administrative and Clerical	5	14	22	16	↘
Allied Health Professionals	3	7	10	7	↘
Estates and Ancillary	20	0	2	0	↘
Healthcare Scientists	1	2	0	0	↔
Medical and Dental	0	0	3	1	↘
Nursing and Midwifery Registered	9	13	17	13	↘
Whole Trust	**39**	**44**	**58**	**44**	↘

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	505	24	4.8%	34
Additional Clinical Services	670	13	1.9%	12
Administrative and Clerical	1302	96	7.4%	81
Allied Health Professionals	551	29	5.3%	30
Estates and Ancillary	194	20	10.3%	2
Healthcare Scientists	265	16	6.0%	7
Medical and Dental	457	7	1.5%	3
Nursing and Midwifery Registered	2405	148	6.2%	77
Whole Trust	**6349**	**353**	**5.6%**	**246**

Section 5: Sickness

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



COMMENTARY

Sickness absence is at 3.4% for July, which is a decrease of 0.1% on the previous month.

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 July 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	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	2.3%	2.9%	3.1%	3.0%	↘
Community Services	5.7%	6.0%	6.0%	4.7%	↘
Corporate	4.0%	4.0%	4.8%	2.5%	↘
Estates and Facilities	6.5%	7.6%	4.5%	3.8%	↘
Medical & Cardiothoracics	3.0%	2.9%	2.6%	3.2%	↗
Surgery, Neurosciences & Anaes	2.9%	3.1%	3.4%	3.6%	↗
SWL Pathology	2.0%	2.6%	2.5%	2.6%	↗
Whole Trust	**3.2%**	**3.5%**	**3.5%**	**3.4%**	↘

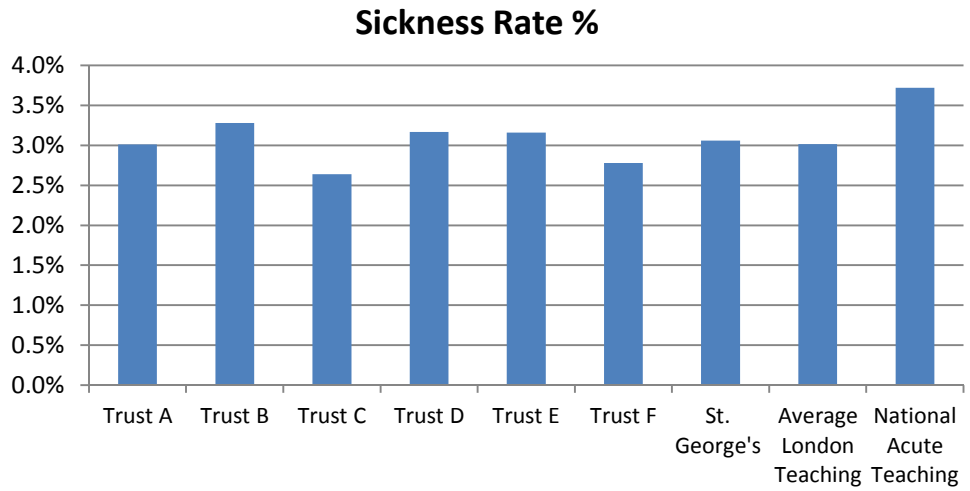
Sickness Staff Group	Apr '15	May '15	Jun '15	Jul '15	Trend
Add Prof Scientific and Technic	2.9%	3.0%	3.0%	2.9%	↘
Additional Clinical Services	5.4%	6.8%	6.7%	6.8%	↗
Administrative and Clerical	4.0%	4.3%	4.5%	3.4%	↘
Allied Health Professionals	2.3%	2.8%	2.7%	2.2%	↘
Estates and Ancillary	6.1%	6.4%	5.7%	4.4%	↘
Healthcare Scientists	1.8%	1.8%	1.6%	2.0%	↗
Medical and Dental	0.2%	0.9%	0.6%	1.0%	↗
Nursing and Midwifery Registered	3.6%	3.5%	3.7%	3.7%	↔
Total	**3.2%**	**3.5%**	**3.5%**	**3.4%**	↘

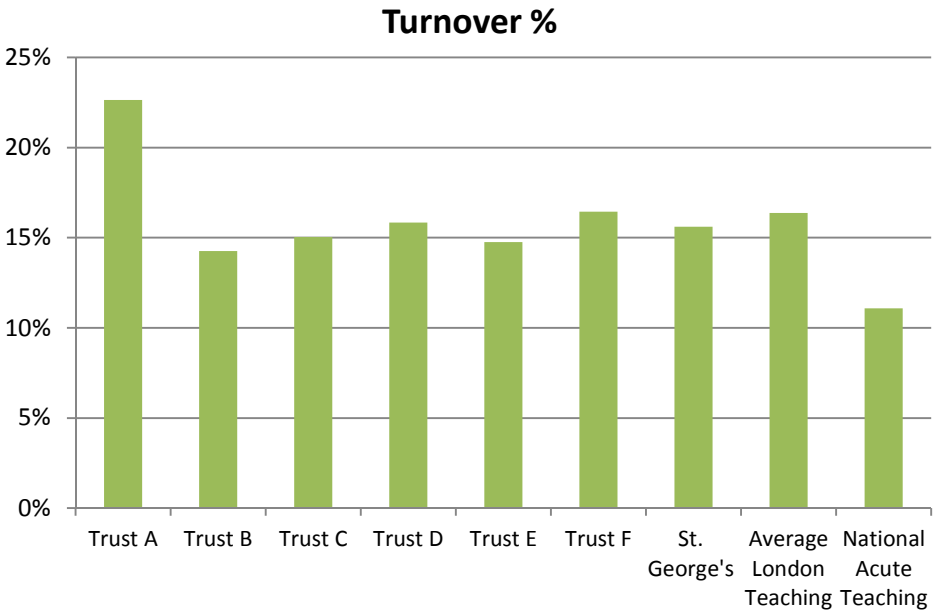
Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Intermediate Care	59.71	213.23	11.5%	£13,231
Prison Service	56.63	179.00	10.6%	£14,308
Dentistry	46.47	114.44	8.2%	£6,150
Procurement & Materials Mgmt	38.00	96.00	8.0%	£6,350
A & C - Non Community	46.20	107.00	7.3%	£4,807

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	21.01%
S25 Gastrointestinal problems	18.99%
S12 Other musculoskeletal problems	9.18%
S16 Headache / migraine	8.72%
S10 Anxiety/stress/depression/other psychiatric illnesses	6.85%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S10 Anxiety/stress/depression/other psychiatric illnesses	117312.10%
S12 Other musculoskeletal problems	98111.27%
S13 Cold, Cough, Flu - Influenza	85335.26%
S25 Gastrointestinal problems	70941.84%
S11 Back Problems	70510.66%

Section 6: Workforce Benchmarking





COMMENTARY

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

Sickness data shown is from April '15 which is the mot recent available. Compared to other Acute teaching trusts in London, St. Georges had a slightly higher than average rate at 3.06%. 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 April.

The bottom graph shows the comparison of turnover rates for the same group of London teaching trusts (excluding junior medical staff). This is the total turnover rate including all 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 May). 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 4.5% lower than St. Georges.

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

Reference Group	Gross Turnover Rate %	Stability Rate %	Sickness Rate %
Trust A	22.65%	78.00%	3.01%
Trust B	14.26%	85.14%	3.28%
Trust C	15.04%	84.56%	2.64%
Trust D	15.84%	83.93%	3.17%
Trust E	14.76%	80.17%	3.16%
Trust F	16.45%	83.09%	2.78%
St. George's	15.61%	84.11%	3.06%
Average London Teaching	16.37%	82.71%	3.01%
National Acute Teaching	11.08%	88.71%	3.72%

Section 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	1073.5	1073.5	1074.5	1068.5	↘
Community Services	593.6	593.6	594.6	569.3	↘
Corporate & R&D	53.5	59.9	60.9	59.9	↘
Medical & Cardiothoracics	1218.8	1220.8	1207.3	1268.1	↗
Surgery, Neurosciences & Anaes	1022.7	1107.7	1098.7	1097.7	↘
Total	3962.1	4055.5	4036.0	4063.5	↗

Nursing Staff in Post WTE

Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	986.0	984.7	985.3	984.0	↘
Community Services	479.7	473.9	471.3	466.5	↘
Corporate & R&D	49.1	49.2	54.0	50.0	↘
Medical & Cardiothoracics	1002.3	1007.6	1006.5	994.3	↘
Surgery, Neurosciences & Anaes	881.5	880.1	884.0	897.6	↗
Total	3398.5	3395.6	3401.2	3392.4	↘

Nursing Vacancy Rate

Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	8.2%	8.3%	8.3%	7.9%	↘
Community Services	19.2%	20.2%	20.7%	18.1%	↘
Corporate & R&D	8.2%	17.8%	11.2%	16.4%	↗
Medical & Cardiothoracics	17.8%	17.5%	16.6%	21.6%	↗
Surgery, Neurosciences & Anaes	13.8%	20.5%	19.5%	18.2%	↘
Total	14.2%	16.3%	15.7%	16.5%	↗

Nursing Sickness Rates

Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	3.5%	3.9%	4.3%	4.1%	↘
Community Services	6.4%	6.3%	6.2%	5.3%	↘
Corporate	0.5%	1.6%	6.6%	1.6%	↘
Medical & Cardiothoracics	3.8%	3.5%	3.3%	4.0%	↗
Surgery, Neurosciences & Anaes	3.7%	4.1%	4.5%	5.1%	↗
Total	4.0%	4.2%	4.3%	4.4%	↗

Nursing Voluntary Turnover

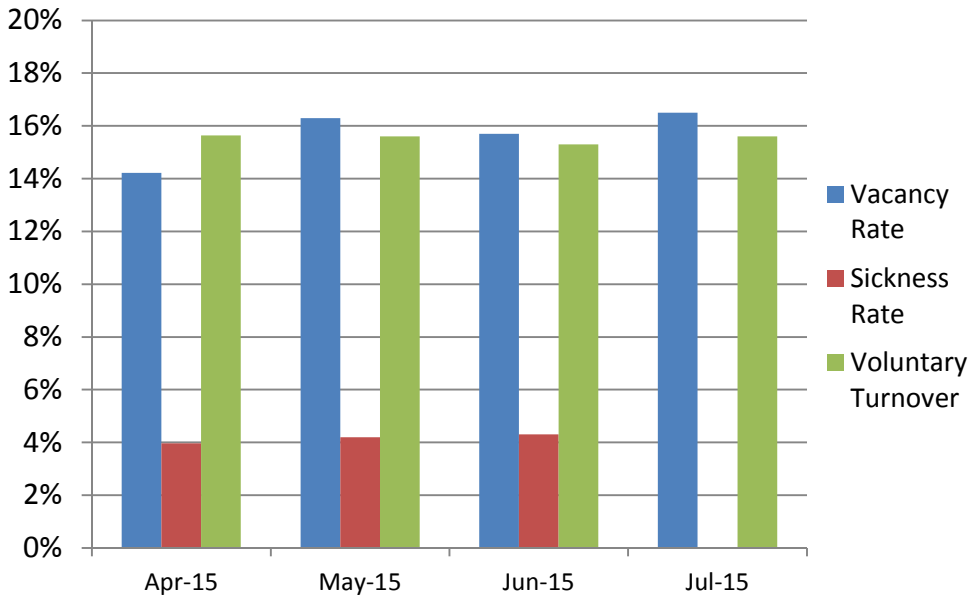
Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	14.78%	14.22%	14.02%	14.11%	↗
Community Services	15.59%	16.30%	17.31%	16.61%	↘
Corporate & R&D	16.89%	14.98%	14.25%	16.97%	↗
Medical & Cardiothoracics	18.72%	17.91%	17.48%	17.46%	↘
Surgery, Neurosciences & Anaes	13.02%	14.10%	13.96%	14.42%	↗
Total	15.6%	15.6%	15.5%	15.6%	↗

COMMENTARY

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

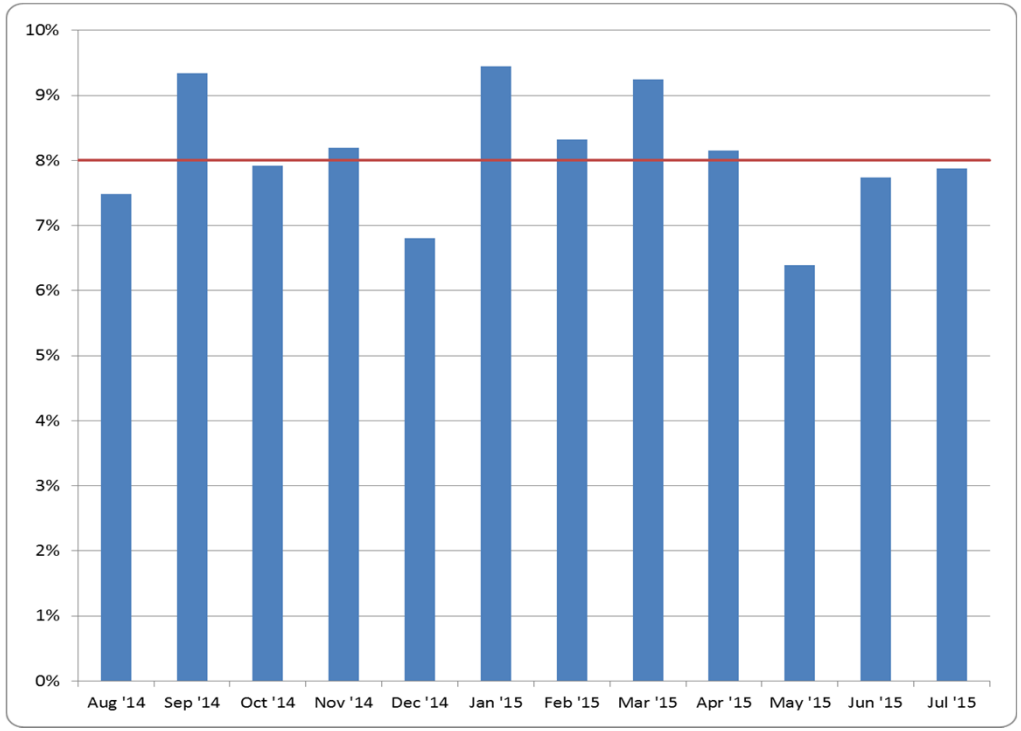
The nursing workforce has decreased by 9 WTE in July. The output of the review of nursing establishments will be a revised trajectory for demand for nursing.

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 0.2% since June.

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 July 2015

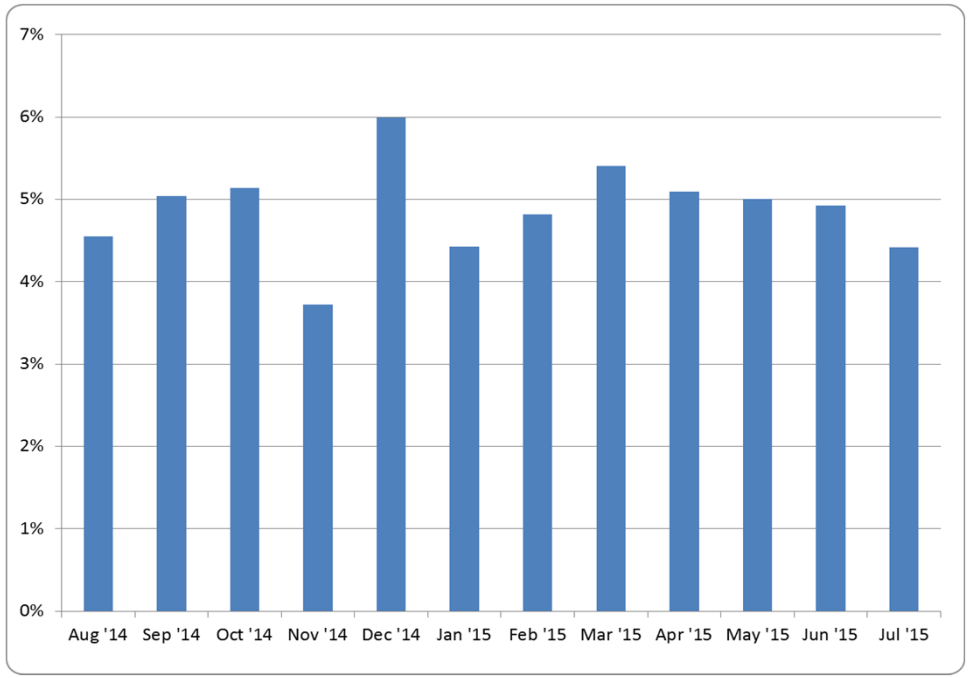
Agency Costs by Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	7.5%	6.7%	6.4%	4.6%	↘
Community Services	12.2%	9.5%	12.9%	10.0%	↘
Corporate	12.8%	9.8%	11.5%	12.0%	↗
Estates and Facilities	9.5%	1.5%	3.5%	8.5%	↗
Medical & Cardiothoracics	9.4%	6.1%	8.4%	9.1%	↗
Surgery, Neurosciences & Anaes	4.1%	3.2%	3.9%	3.1%	↘
Whole Trust	**8.2%**	**6.4%**	**7.7%**	**7.9%**	↗

Care Group	Agency Spend % Jul-15	Staff In Post WTE
Medicine Directorate Overhead	30.8%	24.8
Engineering Services	23.2%	49.0
Outpatients	20.2%	261.4
Acute Medicine	16.6%	342.0
SWLP Microbiology	16.2%	74.8

Booking Reason	Medical Agency & Bank £ Jul-15	%
Annual Leave AL	£0	0.00%
Increased Care Needs ICN	£17,394	4.45%
Maternity Leave ML	£2,727	0.70%
Sickness S	£6,773	1.73%
Study Leave SL	£263	0.07%
Vacancy V	£363,283	93.04%
Total	**£390,440**	**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 0.5% between June and July.

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

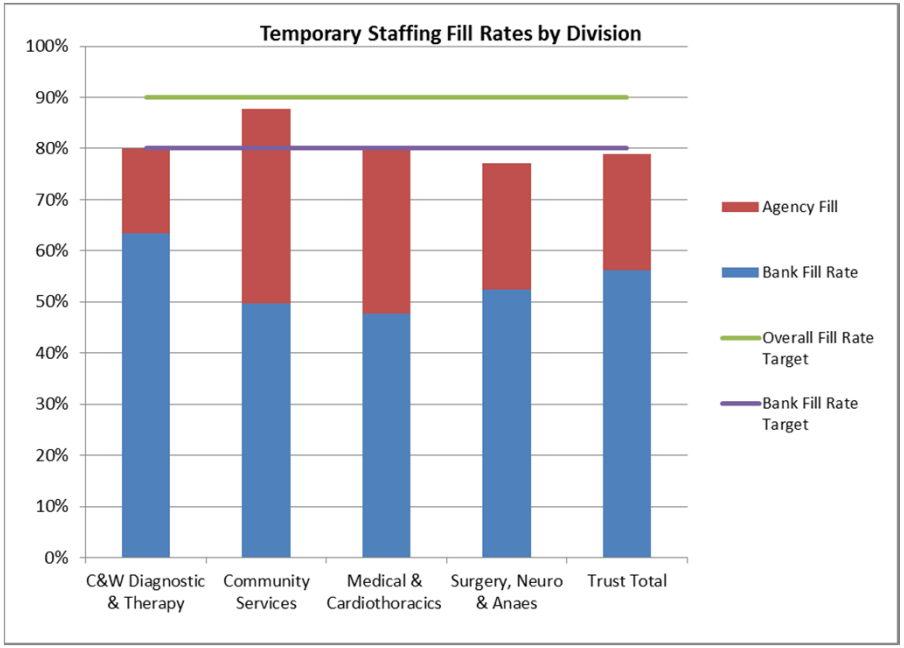
The Bank Fill rate in July 2015 was 56.2% this was an improvement of 12.0% on March 2015

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

Bank Spend % by Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	5.6%	5.8%	5.5%	10.0%	↗
Community Services	4.4%	4.5%	3.5%	3.5%	↗
Corporate	5.1%	5.0%	4.9%	4.4%	↘
Estates and Facilities	9.4%	10.4%	12.7%	10.2%	↘
Medical & Cardiothoracics	5.9%	6.1%	6.7%	5.4%	↘
Surgery, Neurosciences & Anaes	3.4%	3.3%	3.3%	3.4%	↗
Whole Trust	**5.1%**	**5.0%**	**4.9%**	**4.4%**	↘

Care Group	Bank Spend % Jul-15	Staff In Post WTE
SWLP Central Reception	31.8%	43.0
Portering	27.7%	77.7
Security & Car Park Manageme	26.3%	22.0
Pharmacy	17.1%	175.3
Outpatients	10.0%	261.4

Section 10: Temporary Staff Fill Rates



COMMENTARY

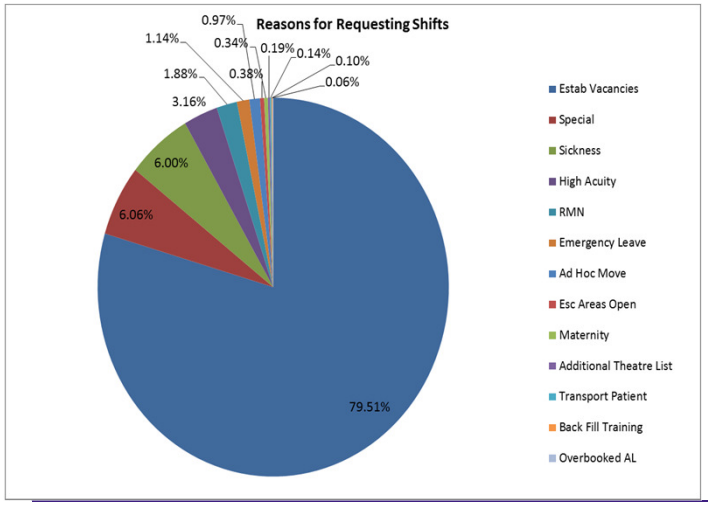
This data comes from the Trust's e-rostering system.

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 July the Bank Fill Rate was reported at 56.2% which is 1% lower 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.

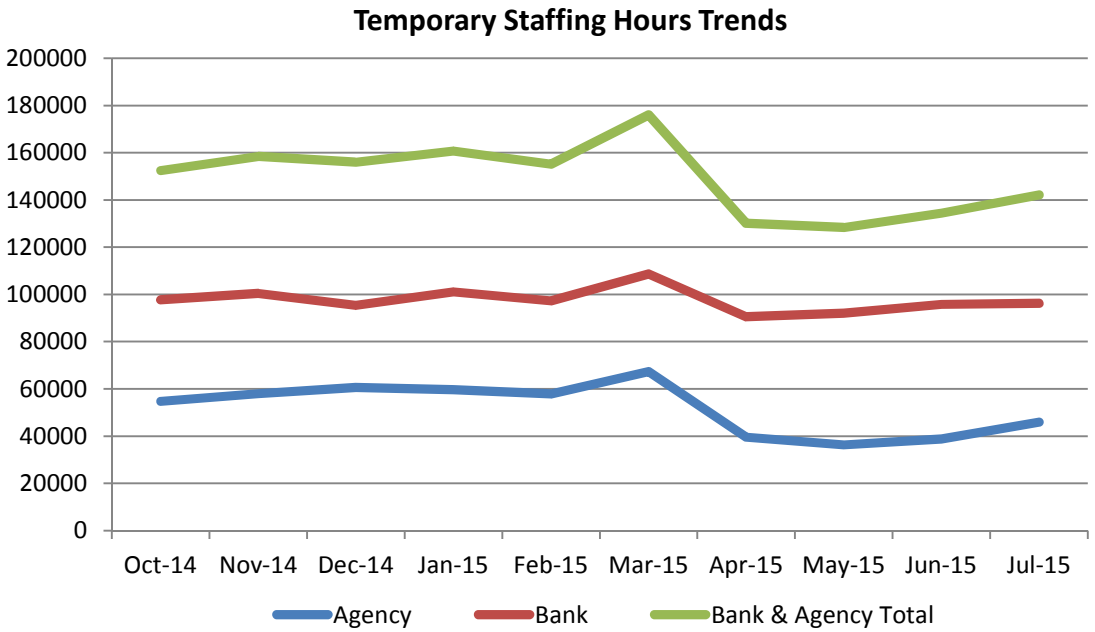
This data only shows activity requested through the Trust's bank office.



Bank Fill Rate % by Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	45.41%	52.14%	64.34%	63.41%	↘
Community Services	41.49%	49.51%	52.46%	49.76%	↘
Medical & Cardiothoracics	46.54%	51.69%	47.10%	47.72%	↗
Surgery, Neurosciences & Anaes	50.71%	57.66%	57.94%	52.50%	↘
Whole Trust	**50.24%**	**56.35%**	**57.45%**	**56.22%**	↘

Overall Fill Rate % by Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	78.35%	84.90%	85.58%	80.00%	↘
Community Services	84.08%	89.19%	90.39%	87.80%	↘
Medical & Cardiothoracics	74.37%	77.84%	79.92%	79.90%	↘
Surgery, Neurosciences & Anaes	71.43%	75.73%	77.42%	77.10%	↘
Whole Trust	**76.37%**	**80.64%**	**81.20%**	**78.90%**	↘

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 July.

In August a Temporary staffing challenge programme was put in place initial output is showing good progress.

TYPE	Division	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
Agency	C&W Diagnostic & Therapy	15399	18212	17355	15424	15305	16737	9484	10711	8637	9623
	Community Services	5482	6626	6035	6111	7424	9595	7825	5500	4873	5995
	Corporate	4251	4061	3772	3454	2763	3488	1246	1331	949	529
	Estates and Facilities	0	0	0	0	0	0	0	0	0	0
	Medical & Cardiothoracics	19047	18425	22413	24222	21659	25750	14372	13140	17691	20391
	Surgery, Neurosciences & Anaes	10541	10604	10984	10418	10739	11798	6532	5457	6351	9171
	SWL Pathology	0	0	0	0	0	0	119	204	241	228
Agency Total		**54720**	**57929**	**60559**	**59629**	**57890**	**67367**	**39579**	**36342**	**38742**	**45937**
Bank	C&W Diagnostic & Therapy	26343	26993	27287	28597	27691	31831	28040	29006	29330	25904
	Community Services	10073	10976	11088	10061	9354	10548	8368	7606	7650	8189
	Corporate	5481	7131	7405	7497	6939	7641	7188	6922	8074	7943
	Estates and Facilities	6962	7026	6867	7446	6808	7744	6885	7502	8177	9416
	Medical & Cardiothoracics	28236	27707	24432	25536	25076	27528	23749	24816	24926	26199
	Surgery, Neurosciences & Anaes	17839	18005	15389	18840	18430	20376	13524	13484	14523	14740
	SWL Pathology	2783	2619	2901	3134	2947	2953	2753	2620	3052	3751
Bank Total		**97717**	**100457**	**95368**	**101111**	**97245**	**108622**	**90507**	**91956**	**95732**	**96142**
Temporary Staff Total		**152436**	**158386**	**155927**	**160741**	**155136**	**175990**	**130085**	**128298**	**134474**	**142079**

Section 12: Headcount Tracking by Division

Week 9 – 24 August 2015

Headcount tracking and movements

DRAFT - SUBJECT TO VALIDATION AND FOR DISCUSSION ONLY

As at Showing Vacancies: 24-Aug
WTE (in post) excluded

Function	Opening Baseline 31 May 15 ACT	ESR Prior week 17 Aug 15 ACT	ESR Current week 24 Aug 15 ACT	Variance (in week) comparing 17-Aug to 24-Aug Joiners VAR	Leavers VAR	Change in WTE VAR	Change in function VAR	Total VAR	Variance (to date) comparing 31 May to 24-Aug Joiners VAR	Leavers VAR	Change in WTE VAR	Change in function VAR	Total VAR
200 Medicine and Cardiovascular Division	1,699	1,690	1,692	11	(10)	0	1	2	182	(161)	(4)	(24)	(7)
200 Children and Women's Diagnostic and Therapy Services Division	2,307	2,324	2,320	10	(12)	(1)	(1)	(4)	167	(146)	(2)	(5)	14
200 Community Services Division	992	982	978	-	(4)	0	0	(4)	47	(53)	(3)	(5)	(14)
200 Surgery & Neurosciences Division	1,758	1,778	1,781	4	-	(0)	-1	3	146	(114)	(3)	(6)	22
200 Research & Development Division	12	18	19	1	-	-	0	1	7	-	-	-	7
200 Corporate Division	515	976	985	14	(5)	(1)	1	10	489	(40)	(1)	23	470
200 Estates and Facilities Division	283	282	281	-	(1)	-	0	(1)	2	(4)	-	-	(2)
200 Capital Division	12	12	12	-	-	-	0	-	-	-	-	-	-
200 SWL Pathology Division	328	347	346	-	(1)	-	0	(1)	9	(10)	(0)	19	18
Total	**7,906**	**8,409**	**8,416**	**41**	**(32)**	**(2)**	**-**	**6**	**1,048**	**(529)**	**(13)**	**2**	**509**

* 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 305 WTE during the period from 3rd August to 10th August 2015
- Variance to date shows a positive variance of 339 WTE from the opening baseline period as at 31st May 2015.
- New GP Trainees are currently sitting in the Corporate Division
- The large in-week changes in other Divisions mostly relate to new Junior Doctors on rotation. Corresponding leavers are still being processed

Section 13: Mandatory Training

MAST Topic	Jun '15	Jul '15	Trend
Conflict Resolution	72.4	72.9	↗
Dementia Awareness	62.5	62.5	↗
Equality, Diversity and Human Rights	82.8	81.0	↘
Fire Safety	76.7	75.6	↘
Health, Safety and Welfare	82.4	80.6	↘
Infection Prevention and Control Clinical	62.8	61.2	↘
Infection Prevention and Control Non Clinical	75.4	73.3	↘
Information Governance	66.1	64.4	↘
Moving and Handling	77.7	76.8	↘
Moving and Handling Patient	55.3	53.9	↘
Resuscitation BLS	43.5	40.4	↘
Resuscitation ILS	46.7	43.7	↘
Resuscitation Non Clinical	61.4	60.0	↘
Safeguarding Adults	80.3	78.2	↘
Safeguarding Children Level 1	80.4	77.3	↘
Safeguarding Children Level 2	78.8	76.8	↘
Safeguarding Children Level 3	59.2	69.7	↗
Venous Thromboembolism	37.5	31.9	↘

MAST Compliance % by Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	75.4%	75.0%	74.7%	73.6%	↘
Community Services	77.0%	74.7%	73.8%	72.9%	↘
Corporate	74.2%	71.9%	70.5%	68.8%	↘
Estates and Facilities	66.5%	65.9%	66.0%	64.9%	↘
Medical & Cardiothoracics	67.1%	66.4%	66.3%	64.4%	↘
Surgery, Neurosciences & Anaes	71.0%	70.3%	69.4%	68.5%	↘
Whole Trust	74.2%	73.1%	72.4%	71.0%	↘

COMMENTARY

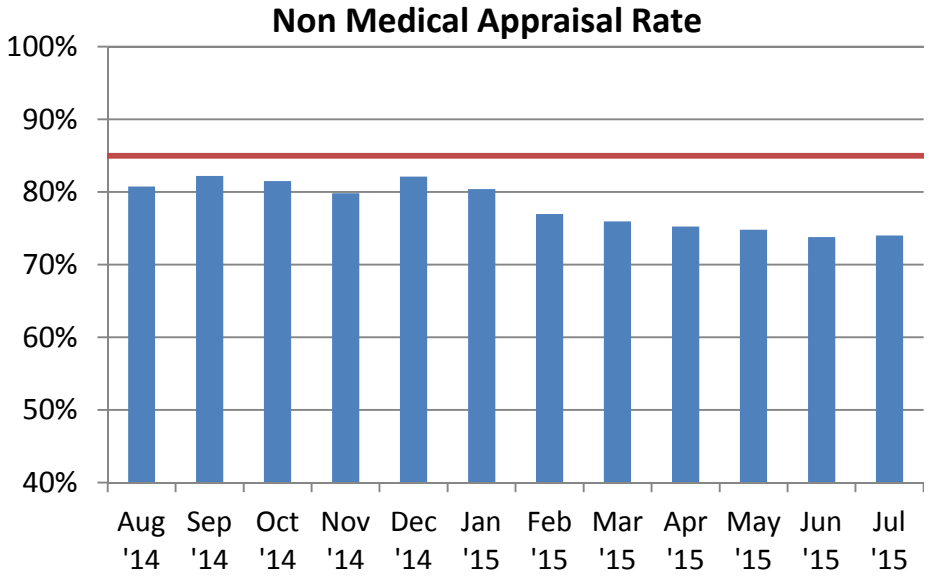
A programme of working is taking place including:

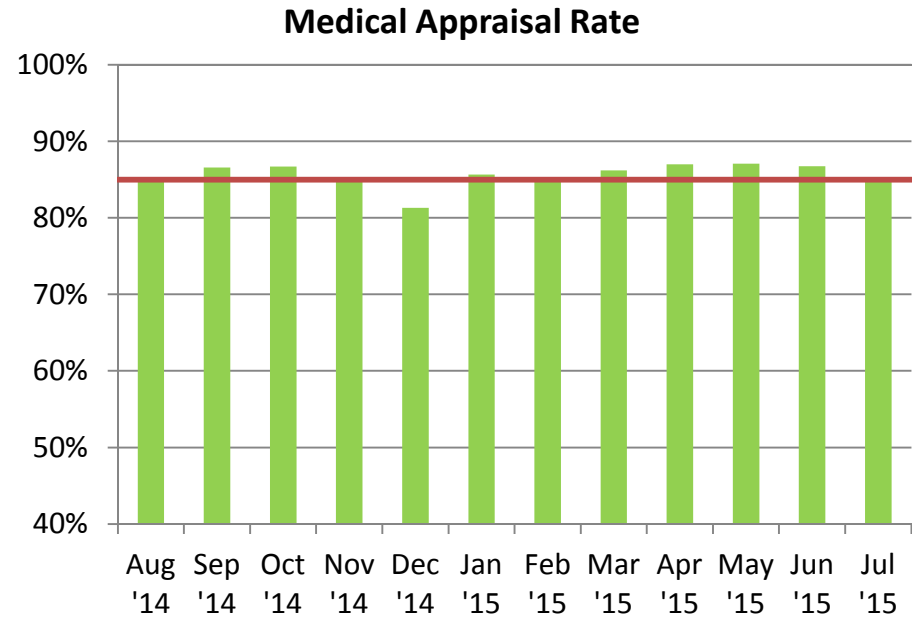
- Changing the method of delivery to on-line testing as far as possible and only training when required
- Reviewing who needs to access the training
- Reviewing the frequency of refresher periods
- Providing and accessible on-line system
- Introduced monthly meetings where divisions report on progress 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 increased slightly this month to 74%. Appraisals are still being managed closely by the appraisal project team who are monitoring progress every two weeks and scrutinising divisional plans. The Corporate Division currently has the lowest non-medical compliance rate. Appraisal completion is now linked to incremental progression for bands AFC band 7 - 9 staff. The table below lists the five care groups with the lowest non medical appraisal rate this month

Medical Commentary

Medical appraisal rate compliance has decreased this month to 85.1% which is still just above target.

Care Group	Non-Med Appraisal Rate	Staff In Post WTE
Intermediate Care	46.3%	59.71
Paediatric Surgery	46.4%	53.84
Inpatient Care Older People	46.9%	52.42
SWLP Haematology	54.7%	66.41
Neurosurgery	55.2%	97.23

Non Medical Appraisals by Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	74.5%	74.9%	74.4%	73.7%	↘
Community Services	76.8%	75.8%	75.4%	76.0%	↗
Medical & Cardiothoracics	77.0%	78.8%	77.8%	77.8%	↔
Surgery, Neurosciences & Anaes	77.7%	75.1%	74.2%	75.1%	↗
Corporate	65.1%	65.2%	66.4%	66.8%	↗
Estates & Facilities	76.6%	80.7%	80.7%	74.7%	↘
Whole Trust	**75.2%**	**74.8%**	**73.8%**	**74.0%**	↗

Medical Appraisals by Division	Apr '15	May '15	Jun '15	Jul '15	Trend
C&W Diagnostic & Therapy	89.7%	87.8%	87.1%	82.6%	↘
Community Services	66.7%	72.7%	69.6%	69.6%	↔
Medical & Cardiothoracics	86.0%	87.6%	87.7%	91.2%	↗
Surgery, Neurosciences & Anaes	87.7%	84.9%	84.9%	88.8%	↗
Corporate	100.0%	100.0%	50.0%	50.0%	↔
Whole Trust	**87.0%**	**87.1%**	**86.7%**	**85.1%**	↘

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD ***Sept 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.
- Three new risks are proposed for inclusion on the Corporate Risk Register.
- The CRR undergoes a full update bi-monthly and this report summarises the interim position with a full update to Board in October 2015.

External Assurances:

- The trust has undergone an unannounced inspection by the Human Tissue Authority (HTA) in July and a series of urgent actions are underway to address the findings. A new risk is included on the CRR in response to the potential risk of regulatory action in this regard.

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. 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 ↓↑
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 →**
03-06	There is a risk of regulatory action should the trust fail to ensure compliance with its HTA licence in relation to the mortuary	**5**	**4**	**20 NEW**
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 →**
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 →**
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 →**
3.16-05	Market Share risks – that the trust loses market share, negatively impacting on the trusts activity and income.	**5**	**4**	**20 →**
3.17-05	Cost Improvement Programme slippage - The trust does not deliver its cost improvement programme objectives	**5**	**4**	**20 →**

1.1 New risks proposed for inclusion on the CRR

Three new risks have been included on the CRR (risk details are included at appendix 2):

Table two: new risks

Ref	Risk	C	L	Scoring
01-16	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. (Escalated via ORC)	4	4	16
01-17	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.(Escalated via ORC)	4	3	12
03-06	There is a risk of regulatory action should the trust fail to ensure compliance with its HTA licence in relation to the mortuary (identified following inspection)			20

A further two potential risks have been identified and are currently undergoing risk assessment:

- Clinical impact of delays in procurement and/or authorisation of medical supplies and equipment
  Controls:
  This risk was escalated via the Quality Fundamental Standards meeting (20th August) and urgent actions have been taken to understand the scope of the issues being reported, a 'life- critical' list of equipment to be created to streamline authorisation process for these items ensure a clinical representative at key procurement decision making committees and urgent staff communications to ensure requisitions of supplies are actioned prospectively and in good time.

- Risk to theatre capacity through downtime of theatres due to maintenance issues
  Controls:
  This risk has arisen as several theatres have been out of action for a number of days due to maintenance issues. The Director of Estates and facilities is leading urgent work to address these issues

1.2 Changes to risk scores

There have been no changes to risk scores during the reporting period

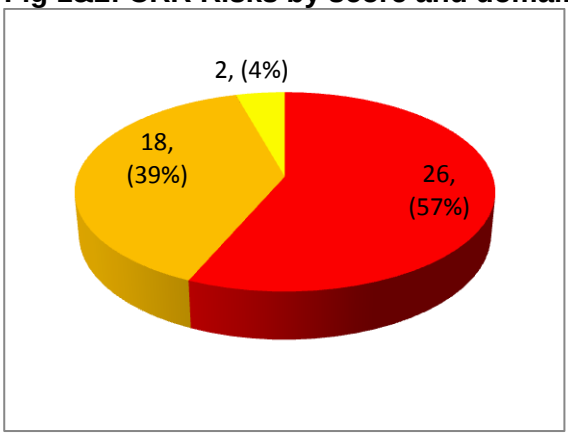
1.3 Closed risks

No risks have been proposed for closure during the reporting period.

1.4 Summary of risks by score and domain

Figure one demonstrates there are 26 extreme risks on the CRR (a score of 15 or above) which equates to 57% of the total risks, this compares with 56% in July 2015. Of these extreme risks, 12 sit within the domain of Quality and eight within Finance and Operations. Of the total risks on the CRR, 41% relate to Quality and 24% to the Finance and Operations domain.

Fig 1&2: CRR Risks by score and domain



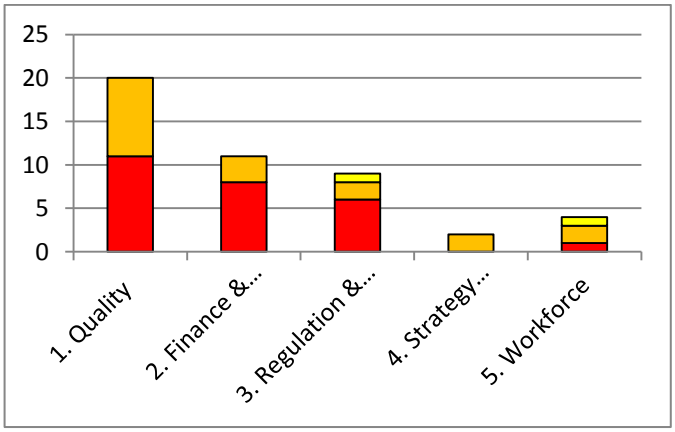


Table three: CRR Risks by Domain

	15 or above (Extreme)	8-12 (High)	4-6 (Moderate)	0-3 (low)	Total
1. Quality	11	9	0	0	20
2. Finance & Operations	8	3	0	0	11
3. Regulation & Compliance	6	2	1	0	9
4. Strategy Transformation & Development	0	2	0	0	2
5. Workforce	1	2	1	0	4
Total	**26**	**18**	**2**	**0**	**46**

1.5 Deep Dive: Quality Risk Committee

The QRC have undertook a deep dive into five risks on August 26th, the controls and assurance detailed for each of these risks are currently being updated to reflect the QRC review and will be presented to Board in October once approved by QRC. The risks reviewed and proposed changes to risk scores are summarised in table four:

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

Ref	Changes to risk description (red)	Current score	Revised score ↓↑
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)	16	16 →
03-02	Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation	16	12 ↓
03-03	Lack of decant space will result in delays in delivering the capital programme	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.	16	16 →
03-05	Trust wide risk to patient, public and staff safety of Legionella	12	12 →

2. Assurance Map

The Trust Assurance Map is a schedule of all external visits, inspections and reporting which captures on-going actions in response to external reviews and those underway to prepare for forthcoming visits. The assurances received from these external inspections help inform the board as to continued compliance with regulatory requirements including Care Quality Commission standards. The following section provides a summary of all external assurances acquired via external reports, visits and inspections during the reporting period.

2.1 Summary of external assurance and third party inspections – Aug- Sept 2015

2.1.1 Human Tissue Authority (HTA) licence no. 12387

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 trust underwent an unannounced inspection of its mortuary premises on 27th July 2015 in relation to its licence for the following activity:

- making of a post mortem examination;
- removal from the body of a deceased person
- storage of the body of a deceased person or human tissue.

The HTA considered the trust was in breach of its licence and must take a number of urgent actions in response. The HTA advised that they would re-inspect the mortuary on 1st September at which time they will expect significant progress to have been made. The required actions relate to:

- Limited storage capacity of the mortuary – leading to use of bespoke temporary storage units;
- Length of stay of some deceased patients (a high proportion are Coronial cases);
- Air quality in the post-mortem room and;

- Ability to safeguard the dignity of deceased patients and maintain high hygiene standards whilst using temporary storage.

A task and finish group was convened to oversee the urgent work and weekly updates provided to the HTA upon progress. The trust is fully prepared for re-inspection. A new risk has been include don the Corporate risk register and in addition to an existing risk on the Divisional risk register.

2.1.2 HTA licence no. 12462

The trust underwent an unrelated and routine inspection on 20th August 2015 in relation to its licence for the following activity:

- procurement, testing, storage and distribution of human tissues and cells for human application;
- storage of relevant material which has come from a human body for use for a scheduled purpose.

The informal feedback confirmed there were no significant issues but one identified minor shortfall in relation to consent training. Further evidence has been provided post inspection and the trust awaits the final report.

2.2 Forthcoming third party inspections

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

The trust will undergo a further inspection in relation to the HTA licence on 1st September, as detailed above.

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 overall long-term risk profile for the trust continues to be driven by the continued financial and operational pressures faced by the trust. In the short-term there have been some significant issues materialise around theatre maintenance and mortuary compliance; both of which are being addressed through executive management action.

Appendix 1: Executive Overview of Corporate Risk Register

Domain: 1. Quality

Strategic Objective/Principal Risk	Lead	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Sept 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	→	
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	→	
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	→	
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	MW				12	16	16	→	
01-12 Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products	tbc					20	20	→	
01-16 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.	EM						16	**NEW**	Escalated following discussion at ORC
01-17 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.	EM						12	**NEW**	Escalated following discussion at ORC

Strategic Objective/Principal Risk	**Lead**	**Mar 2015**	**Apr 2015**	**May 2015**	**Jun 2015**	**Jul 2015**	**Sept 2015**	**In month change**	**Change/progress**
1.2 Patient Experience								↓↑	
A410-O2: Failure to sustain the trust response rate to complaints	JH	16	16	16	16	16	16	→	
02-01 Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)	JH	16	16	16	16	16	16	→	

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	**Lead**	**Mar 2015**	**Apr 2015**	**May 2015**	**Jun 2015**	**Jul 2015**	**Sept 2015**	**In month change**	**Change/progress**
2.1 Meet all financial targets								↓↑	
3.13-05 -Working capital – the trust will not be able to secure the working capital necessary to meet its current plans						20	20	→	

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	20	→	
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	20	→	
3.16-05 Market Share risks – that the trust loses market share, negatively impacting on the trusts activity and income.						20	20	→	
3.17-05 Cost Improvement Programme slippage - The Trust does not deliver its cost improvement programme objectives						20	20	→	
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	16	→	
3.19-05 Cash-flow Risks – Cash balances will be depleted due to: - Delays in receipt of SLA funding from Commissioners - Capital overspends						12	12	→	

Strategic Objective/Principal Risk	**Lead**	**Mar 2015**	**Apr 2015**	**May 2015**	**Jun 2015**	**Jul 2015**	**Sept 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	12	12	→	

3.12-06 3.12- O6 Risk to patient safety due to data quality issues with Patient Administration System (PAS), Cerner, inhibiting ability to be able to monitor patient pathways and manage 18 week performance.	SB	9	9	9	9	9	9	→	

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Sept 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	12	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 of non-compliance with fire regulations in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)	EM	16	16	16	16	16	16	→	
03-02 Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation	EM	16	16	16	16	16	16	→	
03-03 Lack of decant space will result in delays in delivering the capital programme.	EM	16	16	16	16	16	16	→	
03-04 Delay to the ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for estates and projects works.	EM	16	16	16	16	16	16	→	
03-05 Trust wide risk to patient, public and staff safety of Legionella	EM	12	12	12	12	12	12	→	
03-06 There is a risk of regulatory action should the trust fail to ensure compliance with its HTA licence in relation to the mortuary	JH						20	**NEW**	Escalated form Divisional Risk register and following HTA inspection on 27.7.15

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	Lead	Mar	Apr	May	Jun	Jul	Sept	In month	Change/progress

		2015	2015	2015	2015	2015	2015	change	
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	12	12	12	12	12	12	→	

Strategic Objective/Principal Risk	Lead	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Sept 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	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Sept 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	16	16	→	

JH	Jennie Hall	Chief Nurse (DIPC)	EM	Eric Munro	Director of Estates & Facilities
SM	Simon Mackenzie	Medical Director	RE	Rob Elek	Director of Strategy
PJ	Peter Jenkinson	Director of Corporate Affairs	WB	Wendy Brewer	Director of Human Resources
SB	Steve Bolam	Director of Finance Performance & Information	MW	Martin Wilson	Director of Delivery & Performance

Appendix 2 – New CRR risks

Principal Risk	01-16 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 monitored.			**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.
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	01-17 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.					

Principal Risk	03-06 There is a risk of regulatory action should the Trust fail to ensure compliance with its HTA licence in relation to the mortuary				
Description	The mortuary functions as a hospital and a public mortuary. And has capacity for 87 adult bodies including 6 bariatric fridge spaces. The expansion of hospital activity together with increasing local (Wandsworth & Merton) population has resulted in increased numbers of deceased requiring mortuary storage. This is compounded by an increase in the average length of stay of deceased patients within the mortuary. This has resulted din the Trust having to use temporary storage fridges due to a lack of capacity. At unannounced inspection in July 2015, the Human Tissue Authority (HTA) found temporary storage inadequate. Failure to correct the issues identified within required timescales may result in the Trust licence for post mortems and storage of the deceased to be revoked and the mortuary closed.				
Domain	**3. Regulation and Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Current**	**Update**	**Exec Sponsor**	Chief Nurse/DIPC (Jennie Hall)
Consequence	5	5		**Date opened**	27.8.2015 – escalated from Divisional Risk Register/following inspection
Likelihood	5	4		**Date closed**	
Score	25	20			
Controls & Mitigating Actions	Task and finish group set up to oversee programme of work to address all required actions, led by DDNG for CWDT with representation from: Estates, Pathology, Health & Safety, SWLP, Risk , Infection control, Capital projects Comprehensive action log to ensure readiness for re-inspection Working with local undertakers to ensure any available facility at the undertakers is being used for body storage. Capital projects managing provision of bespoke additional accommodation outside the current footprint but within the lower ground floor of Jenner wing within the security cordon of the current cellular pathology department. Length of stay monitored and reported (via OMT & Datix)			**Assurance**	**Internal** Reports to DGB/DMB via DDNG Reports to EMT via CN Report to OMT monthly re LOS EMT approved funding for temporary storage 27.8.15 **External** Weekly reports to the HTA on progress 2 x notifiable incidents to HTA in July Critical HSE report March 2015
Gaps in controls	Inability to exert significant influence on wider system – i.e. Coroner to expedite removal of deceased.			**Gaps in assurance**	First Trust to be subjected to more stringent HTA inspection and as such there is a lack of benchmarking in best practice against recommendations made.
Actions next period:	Drive required actions by 1st Sept visits by HTA Secure funding for additional temporary storage which meets with HTA requirements without further delay (decision at EMT 27.8.15)				

St George's University Hospitals NHS
NHS Foundation Trust

Executive Summary

The annual organisation audit submitted to NHS England recorded 699 doctors with a prescribed connection to St George's University Hospitals NHS Foundation Trust NHS Trust as at 31st March 2015. This has increased by 114 from last year's annual organisation audit. The figure does not include Doctors in Training, who are recorded by Health Education South London. The annual organisational audit recorded the appraisal rate for all doctors with a prescribed connection as 62.66%. This was calculated from the record of appraisals kept by the Revalidation Team. There are discrepancies between this and the current monthly appraisal rate recorded by the Workforce Information Team which is 85.05%, just above the Trust target of 85%. This is because the Workforce Information report does not currently include most Trust grade, Honorary, 0 hours or Clinical Academics that we are responsible for as a Designated Body.

This is addressed within the risk and issues section of the report.

Purpose of the Paper

The purpose of this paper is to provide the Board with a Framework of Quality Assurance in order that a Statement of Compliance can be signed and sent to the Department of Health.

Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Governance Arrangements

- All doctors are sent regular reminders from the Revalidation Team that their appraisal is due. Each month, Care Group and Divisional Leads are also sent an update of who in their department is outstanding an appraisal.
- Doctors are all sent reminders in relation to their revalidation date. Care Group Leads are notified where an individual is not fully engaging or communicating in the process.
- The list of doctors on the GMC database (GMC Connect) is checked and updated monthly by the Revalidation Team. In addition to this, there is regular communication with the University to ensure accurate records are held for both organisations.
- Honorary and 0 hours staff are contacted to ensure that their connection to the Trust is valid.
- New starters are sent information on appraisal and revalidation at recruitment stage and the Revalidation Team also contacts new starters to identify their appraisal date.

Medical Appraisal

Appraisal and Revalidation Performance Data

Each month, the Workforce team produce a medical appraisal report. It includes details of the number of doctors in each Division and the number of complete/incomplete appraisals. This report is circulated to Managers and Divisional Leads to cascade. The report is discussed at the monthly appraisal meeting, chaired by the HR Director. The Revalidation Team uses their own records to include all other Doctors that are not included in the report. This is in order to identify who is due due/overdue an appraisal so that reminders can be sent.

Appraisers

There are currently 130 appraisers listed in the Trust. Top up training is available to all doctors who have previously carried out Medical Appraisals as well as for Education Supervisors.

Quality Assurance

Each individual appraisal folder is reviewed by both the Revalidation Team and the Responsible Officer prior to revalidation recommendations. This provides assurance that:

- the pre-appraisal declarations and supporting information provided is available and appropriate
- the appraisal outputs: PDP, summary and sign offs are complete and to an appropriate standard
- Key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs.

Clinical Governance

- The Revalidation Team checks DATIX and provides information of complaints within the appraisal period to each individual doctor prior to their appraisal. Confirmation is sent to individual that they have/have not been named in any complaints. This ensures appropriate reflection where applicable.
- Transfer of information requests are sent to other organisations in which individuals work, prior to revalidation, to confirm they have no fitness to practice concerns.

Revalidation Recommendations

The number of recommendations between April 2014 and March 2015 totalled 251

- All 251 Recommendations were completed on time
- The number recommendations to revalidate totalled 189
- The number of recommendations to defer totalled 62
- There were no recommendations of Non Engagement

Responding to Concerns and Remediation/Monitoring Performance

Medical Staff at St George's are monitored under the Maintaining High Professional Standards policy. This is the disciplinary policy for Medical and Dental Staff. In addition to this policy, there is a monthly meeting attended by the Medical Director, the Deputy Director of HR, Associate Medical Director (HR), Medical HR Manager and Divisional HR Manager (where appropriate) whereby current or possible formal cases are monitored to ensure sufficient progress. The Responsible Officer meets regularly with Liaison Officers from the GMC and NCAS.

Risk and Issues

A number of issues have become apparent after three years of revalidation. These are essentially the result of the increased volume of information and turnover in staff. They include:

Policy and Guidance

- It is clear that some aspects of the guidance are not well understood, particularly in relation to the fact that our trust doctor posts must follow the same process for appraisal as Consultants and Associate Specialists. .
- There is inconsistent ownership of the process of appraisal by Care Group Leads.

Medical Appraisal

Performance Data

Although the revalidation team are aware of all the doctors with a connection to the Trust, the monthly Medical Appraisal Report is not reflective of the total number of Doctors that the Trust is responsible for as follows:

- Consultant, Locum Consultant, Specialty Doctor/Associate Specialist –500
- Medical School including Clinical Research Fellows – 59
- Trust Doctors - 106
- Bank/Honorary - 34

It also does not include certain information or provide information in a way that is easy to reflect in the quarterly and annual audits that NHS England require. There are various reasons for this such as:

- Trust doctors are in position numbers on the electronic staff records (ESR) that relate to Doctors in Training and vice versa. This is not an issue for the doctor as it does not affect their pay, but the Workforce Information Team will exclude the Doctors in Training as the Trust does not need to report on them.
- Not all honorary doctors, including those employed by the University are recorded on ESR. This is because historically they would not have needed an ESR so it is a relatively new process that they are now entered on ESR
- There is currently no mechanism to identify the 0 hours and honorary doctors that are recorded on ESR to include in the report, as there will be many 0 hours and bank staff who have a designated body elsewhere and therefore they would not need to be included

Appraisers

The Trust is not able to confirm that all appraisals are undertaken by appraisers who have undergone the necessary enhanced appraiser training and that the ratio of appraiser to appraise is correct. There are several reasons for this:

- The record of trained appraisers is out of date. Some of the original trained appraisers may have left.
- Some individuals have started to undertake appraisals without such training.
- Due to more doctors being identified as needing appraisal i.e. University, Trust Grade etc., there are not enough appraisers within some Care Groups
- Full Appraiser training is currently not available to new appraisers

Quality Assurance

- Quality assessment of appraisals only takes place shortly before revalidation when the RO reviews the portfolio. This is time consuming and ineffective now that there are several years to review (in the first year only a single appraisal was required, it will shortly be five. The quality of appraisal documentation is highly variable. This is inadequate for two reasons: firstly because the RO cannot do anything about a poor quality appraisal several years ago and has to make a recommendation on information which is sub-optimal and secondly because concerns about an individual doctor may not be drawn to the RO's attention in sufficient time to allow corrective action.
- There is no mechanism for monitoring and managing the performance of appraisers including appraisal calibration events, feedback from appraises on appraisers and a review of the outputs of appraisers by the RO.

Clinical Governance

- It is time consuming for the Revalidation Team to request the transfer of information from other organisations and this should be done by the individual as part of their annual appraisal

Corrective Actions, Improvement Plan and Next Steps

The RO has discussed these issues with the Senior Responsible Officer NHS England and the RO of other Trusts. The Revalidation Team have also met with their counterparts at other Trusts. An action plan can be found at appendix A.

In summary, the Revalidation Team needs to:

- Work with Divisions to ensure that the responsibilities for delivery of appraisal are understood and fulfilled.
- Develop additional guidance and provide more regular communication with everyone that has a prescribed connection to St George's Healthcare NHS Foundation Trust, in particular the Trust Doctors
- Implement/improve on systems to enable accurate reporting that can be easily reflected in quarterly/annual audits for NHS England
- Ensure that the register of trained appraisers is accurate and that only fully trained appraisers undertake appraisal
- Provide annual refresher training for all appraisers and ensure full training for new appraisers
- Implement a quality assurance process for appraisals
- Implement a quality assurance process for appraisers including formal feedback between appraise and appraiser.
- Work with the Senior Responsible Officer and other Trusts to complete audit/review of appraisal/revalidation process

Recommendations

The Board are asked to accept this annual report and annual audit. This report will be shared with NHS England along with the quarterly information reports.

The Board are asked to approve the "statement of compliance" confirming that St George's University Hospitals NHS Foundation Trust, as a designated body, is in compliance with the Revalidation regulations.

St George's University Hospitals NHS
NHS Foundation Trust

Action Plan

Policy and Guidance

- Review differences that have developed between policy and current practice and ensure they align.
- Continue discussion with other local Trusts to review our policies and possibly develop a joint policy/shared processes, particularly as many of our doctors' work across these local Trusts.
- Develop additional guidance and provide more regular communication with everyone that has a prescribed connection to the Trust
- Include brief introduction on appraisal and revalidation at Trust Induction to ensure doctors are aware of appraisal and revalidation requirements
- Medical Director will ensure that Care Group Leads are clear that it is their responsibility to ensure that all doctors on their list are appraised and that Divisional Chairs include this in performance framework

Medical Appraisal

Performance Data

- Implement/improve on systems to enable accurate reporting that can be easily reflected in quarterly/annual audits for NHS England
- A new Learning Management System (Totara) is being introduced (estimated roll-out from October 2015). One of the functionalities is that it will record medical appraisal and should provide more accurate reports
- Ensure ESR/GMC Connect captures all doctors with a prescribed connection
- Possibly introduce a Revalidation Management System for more accurate reporting
- Ensure all new starters provide date of last appraisal at pre-employment check stage

Appraisers

- Update register of trained appraisers
- Ensure only fully trained appraisers undertake appraisal
- Provide top up training to those applicable such as Educational Supervisors
- Provide full training for new appraisers
- Provide annual refresher training for all appraisers

Quality Assurance

- Implement a quality assurance process for appraisals
- Implement a quality assurance tool for appraisers i.e. formal feedback from appraise. Explore tools that are available within Totara or other AMS/RMS
- Work with the Senior Responsible Officer and another Trust to complete audit/review of appraisal/revalidation process

Clinical Governance

- Review process for obtaining transfer of information from other organisations

REPORT TO THE TRUST BOARD *September 2015* Paper Ref: TB ~Sept 15 - 07c

Paper Title:	**Annual Report to Trust Board on Medical Staff Appraisal and Revalidation**
Sponsoring Director:	Professor Simon Mackenzie Medical Director
Author:	Nicola McDonald Revalidation Support Officer
Purpose: *The purpose of bringing the report to the Board*	*To provide the Board with assurance on the linked issues of medical staff appraisal and revalidation including steps to be taken to address emerging issues.*
Action required by the board: *What is required of the board – e.g. to note, to approve …?*	The Board is asked to note the report and agree that the Statement of Compliance can be sent to the Department of Health.
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	

Executive summary

All doctors are required to undergo revalidation with the General Medical Council ('GMC'). St George's University Hospitals NHS Foundation Trust is a designated body to which doctors employed by the Trust are connected for this purpose and the Medical Director who is appointed as the Responsible Officer by the GMC is required to make recommendations. These recommendations are based on enhanced appraisal. The Trust acts as a designated body for all doctors employed by the Trust except those who are in a training position through HESL. This includes clinical fellows and locums. The Trust also acts as a designated body for doctors employed by SGUL.

Revalidation was introduced in 2012 and is becoming embedded. As at 31 March 2015, there were 699 doctors with a prescribed connection to the Trust and in the year, the GMC required recommendations for 251 of these. All of these recommendations were completed on time. Appraisal is well established within the consultant community but there are challenges within the non-consultant group. There are a variety of reasons for this many of which are administrative. We have been working with other Trusts and are aware that they are facing similar issues. An action plan jointly owned by the Medical Director and Medical HR department is being developed to address these.