St George's University Hospitals NHS
NHS Foundation Trust

MEETING OF THE TRUST BOARD

5th November 2015, 9.00 – 12.00pm -
H2.5 Boardroom

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

Christopher Smallwood**, Chair**

		Presented by	Time
1.	**Chair's opening remarks**		
2.	**Apologies for absence and introductions**		
3.	**Declarations of interest** *For Members to declare if they have any interests as individuals or members of other organisations that might relate to Trust business or items on the agenda.*	C Smallwood	
4.	**Minutes of the previous Meeting** *To receive and approve the minutes of the meeting held 8 October 2015.*	TB Nov 15 - 01	5mins
5.	**Schedule of Matters Arising** *To review the outstanding items from previous minutes*	TB Nov 15 - 02	10mins
6.	**Chief Executive's Report** *To receive a report from the Chief Executive, updating on key developments*	M Scott TB Nov 15 - 03	10mins
7	**Quality and Performance**		09.25
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 5* *To receive a report from the Quality & Risk Committee seminar held on 28th October 2015*	J Hall/ P Vasco-Knight TB Nov 15 - 04	30mins
7.2	**Update on flow programme** (presentation to be tabled0	J Hall TB Nov 15 – 04a / b	20mins
7.3	**Finance Report** *To receive the Trust's financial performance for month 5*	S Bolam TB Nov 15 - 06	20mins
	To receive a report from the Finance and Performance Committee held on 28th October 2015	C Smallwood	20mins
7.4	**Workforce Performance Report** *To review month 6 workforce report*	W Brewer TB Nov 15 – 07a /b	
	To receive a report from the Extraordinary Workforce Committee	S Pantelides	20mins
8.	**Strategy**		
9.	**Governance**		11.15
9.1	**Risk and Compliance Report** *To review the Trust's most significant risks and external assurances received*	P Jenkinson TB Nov 15 - 08	
9.2	**Audit Committee** *To receive a report from the Audit Committee held on 26th September 2015*	M Rappolt (verbal)	

10. General Items for Information

10.1 Travel Plan for approval

E Munro
TB Nov 15 – 09

10.2 Use of the Trust Seal

To note use of the Trust's seal during the period October2015 - The seal has been used once in October 2015.

10.3 Questions from the Public

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

11. Meeting evaluation

12. Date of the next meeting - *The next meeting of the Trust Board will be held on 3 December 2015*

MINUTES OF THE TRUST BOARD

8th October 2015

Hunter boardrooms, 2nd Floor, Hunter Wing, St. George's Hospital

Present:	Mr Christopher Smallwood	Chair
	Mr Miles Scott	Chief Executive
	Mike Rappolt	Non-Executive Director
	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
	Andrew Burn	Turnaround Director
	Dr Judith Hulf	Non-Executive Director
	Mrs Kate Leach	Non-Executive Director
	Mr Steve Bolam	Chief Financial Officer
	Mrs Wendy Brewer	Director of Workforce
	Ms Hazel Tonge	Deputy Chief Nurse
	Ms Paula Vasco-Knight	Interim Chief Operating Officer
In attendance:		
Apologies:	Professor Jennie Hall	Chief Nurse

15.10.13 Chair's opening remarks

The chairman welcomed Paula Vasco-Knight, interim chief operating officer, to her first meeting.

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

15.10.14 Declarations of interest

No interests relating to agenda items were disclosed.

15.10.15 Minutes of the previous meeting

The minutes of the meeting held on 3rd September were accepted as an accurate record, subject to agreed amendments: actions regarding confirmation of a date for a report on medical records to be brought (15.09.06 on the matters arising schedule) and adding in explicit timescales in the performance report to be added to the matters arising schedule.

P Jenkinson Nov 2015

15.10.16 Schedule of Matters Arising

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

15.09.06 – well led domain / heat map – the board noted that the action to provide assurance that the complaints commentary is already embedded in all pre-operative services would be completed at the next meeting.

J Hall Nov 2015

15.06.08 – outpatient strategy – the board noted that this would now be brought to the board in December. Mr Elek explained the delay from the original date of October, as additional work was required to complete the review. **R Elek Dec 2015**

15.09.10 – Revalidation and appraisal – the board noted that proposals would be presented to the executive management team on 26th October and the outcome of those discussions would be brought back to the next meeting. **S Mackenzie Nov 2015**

Call centre performance – the board noted that an update on call centre performance would be presented to the next finance and performance committee. He provided a brief summary of current performance for the board – currently average waiting times were one minute, longest wait of 11 minutes and an abandonment rate of 20%. The board noted the improvement but stressed the need for further improvement and for it then to be sustained. The board agreed that it would receive further assurance from the finance and performance committee regarding the improvement trajectory. **M Wilson Nov 2015**

15.10.17 Chief executive's report

Mr Scott presented his report, highlighting key points including the commencement of the seasonal flu vaccination programme.

Mr Smallwood asked for more detail regarding the commissioners' investment in capacity. Mr Scott reported that the commissioners had already invested £8m in 2015/16 through the contract and the trust was not therefore expecting any additional winter funding. However the trust remained under significant capacity pressures so the system resilience group was looking for further opportunities across the health system, including community services. He advised that the opportunity to create additional capacity was now constrained.

The board noted that there had been no adverse impact from the trust's decision not to continue with the bid for Merton community services. Merton commissioners were pleased with the trust's focus on developing services at the Nelson.

Mrs Leach asked whether any further consideration had been given to the role of GPs in the emergency department. Mr Wilson confirmed that this had been picked up as part of the joint investigation with commissioners. The trust had also asked for additional slots in GP clinics for the ED navigators to book into, and for those slots to be later in the day, which the commissioners were minded to support.

Mr Smallwood asked what themes were coming out of the listening into action conversations with community services staff, which could be acted on to reduce staff turnover. Mr Scott cited the Doddington contract as an example of action taken, with the contract being changed to provide additional support. Mrs Brewer advised that key messages from the conversations were about communication and engagement with community staff, and management of the community adult health services. She felt that community services were very engaged but needed supporting.

Mrs Pantelides asked about the process for succession planning for the chairman and non-executive involvement in that process. Mr Scott advised that the appointment would be made by the Council of Governors and that proposals relating to the process would be presented at the next Council meeting on 27th October. These proposals included the composition of the appointment panel and

stakeholder involvement in the process. The intention would be to appoint the new chairman before Christmas so that he / she could be involved in the appointment of new non-executive directors in January. The process and timescales would be confirmed following agreement with the Council.

M Scott Nov 2015

15.10.18 South west London acute provider collaborative (APC) and vanguard bids – update

The board received and noted the update presented by Mr Elek. Mr Elek explained the APC process and reported that informal feedback on the output from the APC was very positive. The application for 'vanguard' status for this programme had been unsuccessful, however the whole health economy was now engaged in these strategic discussions. There was a recognition that system change was difficult and central support was forthcoming, although it was not certain what this would look like.

The board noted that the bid for 'vanguard' status in partnership with Marsden and Imperial to establish an accountable care network for cancer was successful and that clinical engagement in this partnership would be confirmed as part of the project planning.

The board welcomed the progress being made through the APC but noted the concerns that system change had been attempted several times in different guises. Mrs Wilton asked what assurance was available that this would be more successful. Mr Elek opined that partners were more engaged and supportive and that the process was more robust this time. He advised that timescales were still to be confirmed and would be constrained by resources available. The board acknowledged the risk of unsuccessful outcomes from the programme; it acknowledged that the programme governance would help control this risk but felt that the programme would need the authority derived from NHS England and Monitor to ensure success. Mr Elek stressed the importance of aligning the trust and healthcare system strategies.

The board endorsed the direction of travel outlined in the paper and noted the importance of the trust showing leadership in the system in supporting the delivery of the programme objectives.

15.10.19 Quality and performance report

The board received and noted the monthly quality and performance report.

Performance

The board received and noted the monthly performance report, noting that the trust was failing to achieve the standard in four areas: the RTT performance had deteriorated over the month, A&E performance was currently at 92% which was the second best performance amongst London trauma centres and fourth best out of seven trusts in south west London, and cancer standards with two of the nine cancer standards having been missed and having deteriorated further in month.

The board reviewed the causes of the breaches in each case and the controls being implemented to improve performance.

RTT

Mrs Wilton asked for confirmation that that appropriate quality controls were in place for the use of private sector capacity, and that the patients being redirected

to the private sector would be covered by the service level agreements established when quality controls in the private sector were first raised by the board. Mr Wilson reported that discussions were ongoing but he advised the board that this arrangement would involve patients being referred directly from commissioners to the private sector and therefore patients would not be patients of the trust. It was agreed that the arrangements would be confirmed via the quality and risk committee.

M Wilson Nov 2015

Cancer

Mr Wilson assured the board that an improvement in performance could be expected in the next month, with the implementation of recovery pans in each tumour group as presented to the last finance and performance committee.

Mr Rappolt asked for an update on the implementation of an integrated cancer system. Mr Wilson reported that the trust's Chief Information Officer was leading on a project across the system to implement an integrated system; this would take a few months so other system workarounds were being implemented in the meantime.

Prof Kopelman highlighted the performance against the 14 day standard and benchmark information which showed that other trusts were achieving the standard. He asked whether opportunities should be explored from operating as a hospital chain. Mr Wilson agreed that the system for 14 week waits needed to be reviewed, but advised that Wandsworth was experiencing higher than average referrals. The trust would not want to deter referrals so therefore there was a need to consider the capacity in outpatient clinics or identify capacity elsewhere. This would be considered as part of the development of the 'vanguard' cancer network.

Diagnostic waits

Mr Wilson reminded the board of previous issues, and reported that improvements had been made resulting in performance under the 1% target.

Mrs Wilton asked how many of the 'blocked' beds would be freed up once the Recovery at Home service was up and running. Mr Wilson advised that the service would only pick up patients who were not yet fit for discharge so would probably not affect the number of beds used by patients fit for discharge. The board agreed that as part of the reporting on the Recovery at Home pilot, the impact on ED performance should be monitored.

A&E

The board noted with concern the continued failure to meet the standard, with winter pressures still to materialise. MR Wilson assured the board that he expected the trust to maintain the current 92% performance for the rest of the financial year. He reminded the board of the risk forecasting presented to the last meeting and being developed, which included various scenarios and the impact on performance.

J Hall Nov 2015

Mr Rappolt asked for an update on the flow programme. The board agreed that there would be an update to the next board meeting, as planned, to include the key performance indicators and the dashboard being developed. Mr Wilson advised the board that the capacity planning work had assumed as a base case that the length of stay would remained at current levels and that the worst case would be that the trust returned to levels of the previous year. However the board agreed that the trust was already in the downside scenario and that it was a case

of mitigating a risk which had already materialised. This would be pursued through iteration of the risk forecasting work being led by Mr Wilson.

Quality report

Prof Hall presented the quality part of the report, summarising key messages with each section of the report.

Effectiveness domain

The board noted the continuing work in mortality to strengthen reporting and investigation. Mrs Wilton asked whether the increase in SHMI was a cause for concern, and asked for confirmation that actions arising from the cardiology alert had been actioned. Prof Mackenzie confirmed that Dr Kennea was picking up the outstanding action regarding data reporting with the clinical academic group but all other actions were complete. He advised the board that the trust's SHMI remained below average, but that the trend needed to be monitored and that factors driving the upward movement needed to be identified and addressed. Assurance regarding this would be reported to the quality and risk committee. **S Mackenzie Nov 2015**

Safety domain

The board noted the continuing increase in serious incidents being reported and the increasing number of overdue investigations, noting that this was due to increasing pressure on management and clinical capacity. The board also noted that organisational responsibility for the MRSA bacteraemia case reported in August would be decided by arbitration.

The board noted the concerns regarding current levels of safeguarding training, and the actions being implemented to address those concerns. It was noted that the training database had been improved to ensure accurate capture of training being delivered and additional training resource was now available. Divisions would be held to account for achievement of compliance through the fortnightly MAST monitoring meeting. Mrs Brewer added that the recommendation from the recent internal audit review of mandatory training were also being implemented. These would be monitored through the audit committee.

Patient experience domain

The board noted the continued level of performance in responding to complaints, noting the management capacity constraint and the impact on priorities such as responding to complaints. The board acknowledged the need to agree priorities and to demonstrate leadership with divisions in delivering those priorities. It was agreed that the executive management team would agree what those priorities are and share with the board a considered approach to the capacity to deliver them. **M Scott Nov 2015**

15.10.20

Report from the quality and risk committee

Mrs Wilton presented a report from the previous quality and risk committee meeting, summarising key points of discussion. She highlighted the discussion and actions agreed regarding the governance arrangements for the 'Recovery at Home' programme and noted the additional assurance the committee would be receiving by receiving copies of quality inspection reports.

The board noted that the next seminar session would be focusing a 'deep dive' review of the risk regarding CQC compliance and the lessons learnt from the recent inspection of Cambridge University Hospitals Foundation Trust.

15.10.21 Finance report (month 5)

Mr Bolam presented the financial performance report for month 5, highlighting overall in-month performance and year to date performance, and the key drivers for underperformance: underperformance in outpatients, unidentified cost saving programmes, prior year issues and fines and penalties levied by commissioners. The board noted a continued improvement in the underlying position but continued underperformance against the year to date budget. The board noted a stabilisation in pay and non-pay expenditure but fluctuations in income which was driving the deficit variance. Mrs Leach stressed the need to increase income, particularly in outpatient activity. The board noted an improved CIP position, with agreed plans in place for £38m, albeit with risks to achievement. It was noted that delivery of the CIPs would be vital for the year-end position.

The board noted the approval by the board in the reserved part of the meeting for additional working capital facility until January 2016. However the board noted the need for continued monitoring of the cash position and continued focus on implementation of controls to reduce expenditure.

The board noted the key risk arising from the allocation of contingency reserves which would increase the deficit by £7m.

Mrs Wilton asked whether there was anything arising from the performance review and the reforecasting process to suggest that the medicine and cardiovascular division could address their forecast and current variance. Mr Bolam explained the purpose of the reforecasting process and the challenge sessions which made up a part of the process, and the role of the turnaround board. He confirmed that the division had agreed a list of actions through both these processes, including income recovery and addressing underreporting issues. However he advised that there was no one significant scheme to address the gap but a number of individual issues which could amount to something significant. The board agreed that the finance and performance committee should scrutinise the plans from the medicine and cardiovascular division and the children, women and diagnostic division. It also noted the importance of linking all the various governance processes to ensure duplication and maximise effectiveness.

S Bolam
Nov 2015

The board agreed that the debtor weeks should be included in the finance report.

The board noted the current underspend on capital. Mr Munro advised that two large bed capacity schemes in AMW had been delayed due to delays in obtaining PFI approval which had led to the underspend.

Report from the finance and performance committee

The board noted the report from the finance and performance committee, including a summary of key discussions and decisions. The committee had noted concern regarding the development of CIPs for 2016/17, but acknowledged that the focus was beginning to shift towards this. There was also concern about the progress made to date on the five year plan. The committee had agreed the need for assurance regarding the process to identify some of the 'big ticket' opportunities

Mr Bolam gave an explanation of the trust reforecasting programme (TRP). This programme of work was beginning to provide visibility of the full-year effect of CIPs which would then feed into 2016/17. This would need to be picked up as part of the proposals for KPMG support post-October.

The board discussed and noted the process to support the TRP, including the role of non-executives in the challenge sessions. It was agreed that the overview of the programme outputs to date would be shared at the board strategy session on 29th October. **R Elek Nov 2015**

15.10.22 Workforce report (month 5)

The board received and noted the monthly workforce performance report, noting key points: turnover remained flat but high, although the level was comparable to peer benchmarks; detailed bank and agency usage; compliance levels for MAST; and appraisal rates which were deteriorating due to management constraints at an organisational level despite some good improvement made by specific services. The board noted the importance of appraisal in reducing turnover.

Mrs Wilton highlighted a sudden increase in agency costs despite greater controls being applied. The board noted that this may, in part, be due to the improved identification of expenditure on management consultancy and interim management as it was now shown as a pay cost. The board noted the necessary increase in interims in the corporate services in order to support the turnaround, but also noted an increase in medicine division due delays in recruitment driving a vacancy factor.

The board also noted that the process to reconcile the electronic staff record (ESR) and financial systems was still not completed, due to increased complexity, number of changes required and a lack of capacity to manage the reconciliation. The board noted the risk of lack of data quality while this project was incomplete and therefore asked for confirmation of a sustainable reconciliation process and timescale to be agreed through the workforce committee. **W Brewer Nov 2015**

Report from the workforce committee

The board received and noted the report from the previous workforce committee, noting in particular the role of the committee in considering the output from the establishment review and the ongoing initiatives being launched by divisions to tackle recruitment and retention. The committee had noted that the establishment review had been prioritised over the recruitment and retention initiatives, and noted concern regarding the lack of transformational impact on recruitment and retention, but that focus would return to that subject.

Mrs Leach raised concern about the lack of progress being made in the branding and communications exercise to support nurse recruitment.

The committee had also considered the 'top 100 leaders' development programme, had endorsed the approach and had recommended strong chief executive ownership.

The committee had noted the recently published national guidance on agency nursing spend and the current controls and targets, with the trust target of 10% of current expenditure on qualified nurses. There was a requirement for monthly reporting to Monitor. The committee had acknowledged concern regarding the impact on nursing levels during winter, but had welcomed the trust working with Monitor as a pilot site to reduce demand on agency.

The board noted the enclosed paper on bank and agency usage.

Mrs Leach highlighted an increase of 90 whole-time equivalents in the last 12 **W Brewer**

months which were not attributable to business cases or a rationale, and asked what the trust response would be to such increases in headcount. **Nov 2015**

15.10.23 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 the assurances received regarding the actions being taken in responses to concerns raised by the HSE and HTA regarding the mortuary. It noted that orders had been placed to provide the capacity and that Mr Munro was liaising with the HTA.

15.10.24 Report from the audit committee

The board received and noted the report from the previous meeting of the audit committee. The board noted the concerns raised regarding the follow up and closure of audit recommendations and noted that action had been agreed to address these issues.

The board also noted the lack of assurance provided by the internal audit review of diagnostic follow-up procedures, with a lack of standard operating procedures. Mr Rappolt advised the board as to the risk to patient safety and the link to recent serious incidents.

The board also noted the committee's concerns regarding the high level of standing financial instruction waivers being used.

Mr Rappolt reported that there would be an extraordinary meeting of the committee later that month with both internal and external auditors, in order to review the findings and lessons learnt from the independent accounting review completed by PwC. Following that meeting a revised audit plan for the remainder of 2015/16 would be presented to the board. **M Rappolt Nov 2015**

Mr Rappolt also gave the board an update on the ongoing tendering exercise for the internal audit function.

15.10.25 Trust seal

The board noted that the trust seal had been used on three occasions during the reporting period, relating to transfer of property and capital development schemes.

15.10.26 Questions from the public

Ms Ingram referred to the tender waivers reported by the audit committee and asked how much the specific waiver for hospitality at Cannivarro house was worth. It was agreed that the figure would be confirmed.

Mr Poloniecki tabled a written question regarding consultant activity and the weekly consultant activity report, raising concerns about the quality of the data in that report. Mr Scott agreed to provide a written response. **M Scott Nov 2015**

15.10.27 Any other business

There was no other business.

15.10.28 Date of the next meeting

The next meeting of the Trust Board will be held on 5th November 2015.

St George's University Hospitals NHS
NHS Foundation Trust

Matters Arising/Outstanding from Trust Board Public Minutes
5 November 2015

Action No.	Date First raised	Issue/Report	Action	Due Date	Responsible officer	Status at 5 November 2015
15.10.15	08.10.15	Minutes of previous meeting	Confirmation of date for a report on medical records to be brought to TB.	Nov 15	J Hall	December meeting
15.10.15	08.10.16	15.09.06 – well led domain / heat map	Action to provide assurance that the complaints commentary is already embedded in pre-operative services would be complete.	Nov 15	J Hall	Confirmation received
15.10.15	08.10.16	15.06.08 – outpatient strategy	To be brought to board in December.	Dec 15	R Elek	
15.10.15	08.10.16	15.09.10 – Revalidation and appraisal	The board noted that proposals would be presented to the executive management team on 26th October and the outcome of those discussions would be brought back to the next meeting.	Nov 15	S Mackenzie	EMT agreed a new approach on 26 October which will link future job planning to Trust objectives. Appraiser training and performance review will be introduced and responsibility for delivery clearly lies with the Divisions.
15.10.15	08.10.16	Call centre performance	The board to received further assurance from F&P committee regarding improvement trajectory.	Nov 15	Paula Vasco-Knight	Update from F&P 28.10.15
15.10.17	08.10.16	Chief executives report	Process and timescales to be confirmed on the appointment of the new chairman and new non- executive directors in January 16.	Nov 15	M Scott	Update provided in the Chief Executives report.
15.10.19	08.10.16	Quality and performance report - A&E	Update on the Flow programme to include key performance indicators and dashboard being developed	Nov 15	J Hall	On Agenda

15.10.21	08.10.15	Report from F&P committee	The board discussed and noted the process to support the TRP, including the role of non-executives in the challenge sessions. It was agreed that the overview of the programme outputs to date would be shared at the board strategy session on 29th October.	Nov 15	R Elek	Completed
15.10.22	08.10.15	Workforce report M5	The process to reconcile the electronic staff record (ESR) and financial systems was still not completed. The board noted the risk of lack of data quality while this project was incomplete and therefore asked for confirmation of a sustainable reconciliation process and timescale to be agreed through the workforce committee	Nov 15	W Brewer	This is a key element of the pay grip programme. KPMG have refined the existing process so that it will not be a breach of process to update the ledger system without updating the employee record system. The refined process is due to be signed off by the finance department on 23rd October. Monthly audits will be led by the workforce team.
15.10.22	08.10.15	Workforce report M5	Mrs Leach highlighted an increase of 90 whole-time equivalents in the last 12 months which were not attributable to business cases or a rationale, and asked what the trust response would be to such increases in headcount.	Nov 15	W Brewer	The turnaround reforecast challenge programme is identifying and challenging additional staffing costs. Removal of such posts is part of the workforce efficiency programme in development.
15.10.24	08.10.15	Report from the audit committee	Following extraordinary meeting – a revised audit plan for the remainder of 15/16 to be presented to the board.	Nov15	M Rappolt	Verbal update from Audit Committee meeting 26th October 2015
15.10.24	08.10.15	Questions from the public	Mr Poloniecki tabled a written question regarding consultant activity and the weekly consultant activity report, raising concerns about the quality of the data in that report. Mr Scott agreed to provide a written response.	Nov 15	M Scott	

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – NOVEMBER 2015

Paper Title:	Chief Executive's Report
Sponsoring Director:	Miles Scott, Chief Executive
Author:	Sofi Izbudak, Corporate Administrator
Purpose:	To update the Board on key developments in the last period
Action required by the board:	For information
Document previously considered by:	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:

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. Academic Development

1.01 Commencement in post of the new Principal of the University

It is with great sadness that we say farewell to Professor Peter Kopelman in his role as Principal of SGUL. Peter has been such a strong leader for SGUL over the last eight years, and an invaluable member of the Trust Board.

We would like to extend a warm welcome to Professor Jenny Higham, who succeeds Peter, and takes up post on 2nd November 2015. Jenny will be both the Principal for SGUL and a non-Executive Director of the Trust. Jenny joins us from Imperial College London where she was Vice Dean for Institutional Affairs and Director of Education in the Faculty of Medicine.

1.02 Education and Development Update

We are delighted to have produced a new video to be used on Induction, showcasing the many facets of St. George's and the values demonstrated by our staff in a range of roles.

Education and Development have introduced the New Consultant and New Managers Programme as part of the Leadership Academy here at St. George's. These innovative 5-day programmes, combining face to face training, paired learning and mentoring, commencing in November have been designed to ensure leaders within the organisation have the support and skills to deliver the trust's strategic objectives.

Work is on-going to support the Streamlining Project for Foundation Doctors led by South Thames Foundation School.

Part-Task Training for Healthcare Support Workers in Venepuncture and Cannulation are now available to further develop those responsible for taking bloods on the wards.

Having successfully merged trainee data with other London Trusts, St. George's is part of the single system for Intrepid, an online system which manages trainees rotations as they move between training posts in London.

Mairead Heslin has joined the Trust as the Head of Corporate Training and Leadership. She is an experienced Organisational Development Consultant, and amongst many workstreams will be leading on talent management, coaching.

2. Workforce

2.01 Listening into Action

The Listening into Action pass it on event this year - when teams showcase and celebrate their work - will take place alongside the Clinical Audit half day on Friday 4 December 2015 from 8.30am to 1pm in the Hunter Wing Boardrooms.

The process of recruiting next year's teams is underway and a number of teams have been identified. In addition, it is confirmed that the therapies and theatres teams will continue into next year.

The Listening into Action sponsor group is looking at how Listening into Action has sustained over the past three years and at ways in which Listening into Action can be "mainstreamed" into the way we do things here.

2.02 Management Arrangements

Executive Directors

The search for the posts of Chief Operating Officer and Chief of Staff/Trust Secretary is making good progress. Formal panel interviews are planned for early November for the Chief Operating Officer and for December for the Chief of Staff post.

Divisional Chairs

It is with great sadness that I announce that Andrew Fleming and Eric Chemla have now come to the end of their terms as the Divisional Chairs of the Surgery, Theatres, Neurosciences and Cancer division, and of the Medicine and Cardiovascular division respectively. I would like to thank them for their hard work and for the leadership they provided to their Divisional teams. With that said, I am delighted to confirm the appointment of Lisa Pickering as Divisional Chair for the Medicine and Cardiovascular division, and of Tunde Odutoye as Divisional Chair for the Surgery, Theatres, Neurosciences and Cancer division. I look forward to working with them both.

3. Council of Governors

3.01 Council of Governors meeting 27th October 2015

The Council of Governors met on 27th October. It received a summary of the annual appraisals of the chairman and non-executive directors and considered proposals for the appointment of a new chairman and two non-executive directors to replace Christopher Smallwood, Mike Rappolt and Judith Hulf respectively. The proposed timetable will aim to have a new chairman appointed by Christmas and then the two non-executive directors appointed by end of January 2016, when all three will step down. The Council also approved the re-appointment of Sarah Wilton as non-executive director for an additional three year period and for Prof Higham to be appointed as the non-executive director representing the university as replacement for Prof Kopelman who is retiring as principal.

The Council considered the findings of the independent accounting review conducted by PwC and received a summary of the recovery planning process, including how the governors will have an input into the forward planning.

The Council also considered the trust's public consultation regarding the future of the uro-gynaecology service, with public consultation due to run until 13th November and a decision to be made by the trust executive on 23rd November.

4. Communications

4.01 Induction film

A five minute film made to promote the trust has been shown at induction and at a screening for those who took part. It's been very well received and will be used as part of a social media recruitment campaign at the end of October.

4.02 Patient information

October saw the production of the 150th patient information resource to have been developed in accordance with the new-style, robust process. This means that within nine months of implementing the new process, over one third of known patient information within the trust has now been (re)developed:

- with a sound and confirmed evidence-base
- using appropriate multidisciplinary consultation to ensure optimal clinical accuracy
- in consultation with at least two patients/service-users; and
- within a standard, trust-approved template to ensure consistency of brand, style, tone and accessibility.

With an average of 16 new resources now submitted each month, the message regarding the review process – as well as its aims and purpose – appears to be embedding itself firmly within the trust. As a result, the trust's information provision is vastly improved in terms of both quality and safety, enabling our patients to better manage their conditions and to make fully informed decisions about their treatment and care.

4.03 Media update

Sky News

Sky News came in on 16th October to interview the Redthread team. The team's primary role is to work with 11-25 year olds who have presented with injuries secondary to violence or that are at risk of being involved in violence or sexual exploitation. The reporter spoke to Rhys Beynon about how the team can help. This is due to air in the first week of November.

BBC News

BBC News were on site on 22nd October to film a piece on the Temporary Return of Qualified Nationals set up by the International Organisation of Migration. The BBC spoke to Dr Pepera, a consultant in obstetrics and gynaecology who locums at St George's. She's used knowledge gained in the UK to set up a training programme in Ghana. The piece will air on 16th November on all bulletins and the Today Show.

24 Hours in A&E

The first episode of the new series aired on Channel 4 on 20th October and according to Channel 4 press, received an average of 2.5 million viewers.

Twitter and Facebook were very active during the show, and we gained 90 new Twitter followers.

The Guardian, the Independent, the Daily Mail and some local newspapers published reviews of the show the following day – all very positive.

Medical Technology Innovation

We recently had a journalist from 'Medical Technology Innovation' visit Medical Physics, and tour a few of our wards, to see our Philips monitors in use. Clinical Services Journal also interviewed some of our clinicians and David Tropman from Medical Physics. We are believed to be the largest install of Philips monitoring equipment in Europe that uses the hospital's existing network infrastructure. The system is designed to support improved clinical decision making, and help hospital staff to more quickly and effectively monitor changes in a patient's condition.

REPORT TO THE TRUST BOARD **Paper ref:**

Paper Title:	Quality and performance Report to EMT/ QRC for Month 6- September 2015
Sponsoring Director:	Jennie Hall- Chief Nurse/ Director Infection Prevention and Control Simon MacKenzie- Medical Director Martin Wilson: Director of Delivery and Improvement
Authors:	Jennie Hall- Chief Nurse/ DIPC Simon Mackenzie- Medical Director Peter Riley- Infection Control Lead Corporate Nursing Team Divisional Directors Nursing/ Governance Trust Safeguarding Leads Martin Wilson – Director of Delivery and Improvement
Purpose:	To inform EMT about Quality Performance for Month 6.
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

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

The Overall position in September 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. A six monthly review of serious incidents is being completed, to understand any changes in trend, the findings of this will be reported to the board next month. Routine oversight of serious incidents continues to be 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.
- National Audits within the report: The hip fracture database summary indicates areas where the Trust has improved within the last 12 months and areas where further improvement are required. The board should note the improvement trend in relation to the locally reported position in August. There are clearly further areas for improvement. The PSC will oversee assurance about the implementation of actions described within the report following the audit findings.
- The report indicates the position with compliance with NICE guidance for the period August 2011 to June 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 September 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 September 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 August performance remaining above the national average. (Note the data will need to be resubmitted in October which will show a further slight increase in performance). There was a decrease in patients with CAUTI, and other harms reported, this will be need to monitored over a period of time to see of this position can be sustained. 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 September showed deterioration with 4 grade 3/4 ulcers. 2 within the acute setting, 2 within community. This is a concern given consistent performance in the previous months.
- The Trust has now reported 4 MRSA bacteraemia cases and 17 C-Difficile to the end of September. The Board should note that the MRSA case declared in early September is going to arbitration and may subsequently be removed; we are one case above 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 74.5% for level 3 training. 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. Safeguarding Adult training data is also now a cause for concern, Data quality is being checked and actions agreed to improve the current profile.

Experience Domain:

- The response rate for FFT decreased again. Gaining feedback from patients is an important component in the triangulation of quality data The overall score for the Trust decreased in September to a score of 88.1% 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 gastroenterology department and in relation to car parking.
- In relation to turnaround times of complaints a decline still continues to be seen following improvement through to May 2015, although the clinical Division (Community) continues to achieve the target.

Well Led Domain:

- The safe staffing return is included for all inpatient areas. The average fill rate for the Trust is 95.75 % across these areas against current staffing figures. 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 September is included this month for both Acute and Community services.

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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NHS Foundation Trust

Performance and Quality Report

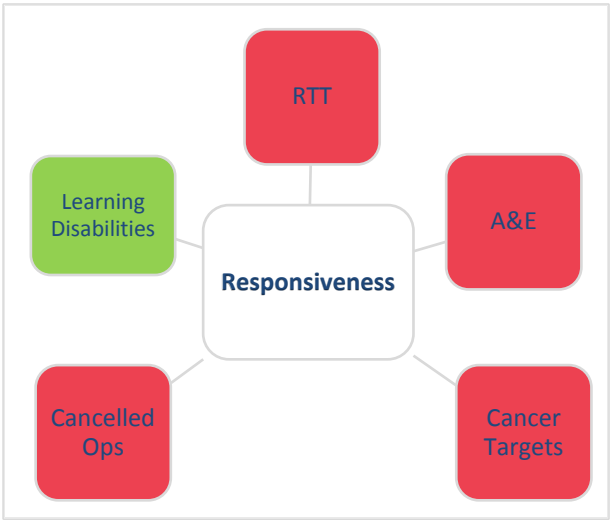
For Trust Board

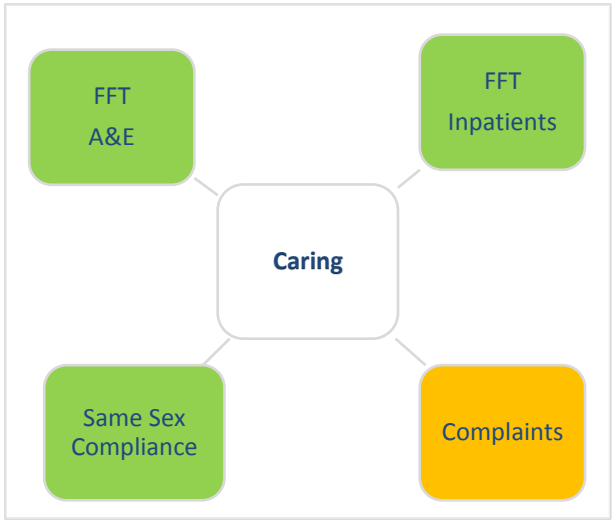
Month 6 - September 2015

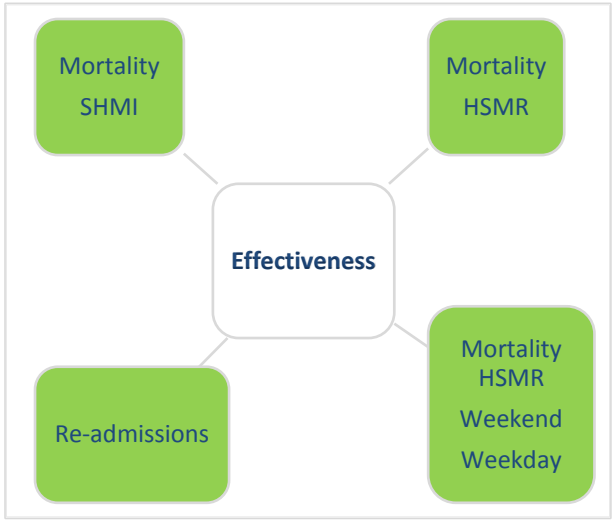
Excellence in specialist and community healthcare

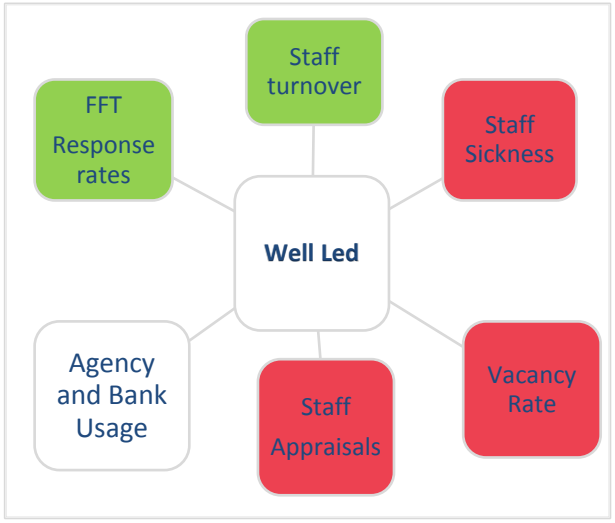
CONTENTS

1. Executive Summary - Key Priority Areas September 2015*









The above shows an overview September 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 August as reported one month in arrears)

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

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Performance against Frameworks

Excellence in specialist and community healthcare

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

ACCESS

Metric	Standard	Weighting	Score	YTD	Aug-15	Sep-15	Movement
Referral to Treatment Admitted	90%	N/A	N/A		80.20%	77.70%	-2.50%
Referral to Treatment Non Admitted	95%	N/A	N/A		93.21%	92.50%	-0.71%
Referral to Treatment Incomplete	92%	1	1		89.71%	89.10%	-0.61%
A&E All Types Monthly Performance	95%	1	1	92.67%	94.25%	91.40%	-2.85%
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Q1**	**Q2***	**Movement**
62 Day Standard	85%	1	1	79.77%	79.27%	80.41%	1.13%
62 Day Screening Standard	90%			85.95%	82.08%	91.14%	9.06%
31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%		0	96.24%	95.18%	98.00%	2.82%
31 Day Standard	96%	1	0	97.95%	97.24%	98.94%	1.70%
Two Week Wait Standard	93%	1	1	88.99%	92.38%	82.57%	-9.81%
Breast Symptom Two Week Wait Standard	93%	1		91.68%	90.45%	94.19%	3.74%

* Not Yet Avalibale (NYA)

OUTCOMES

Metric	Standard	Weighting	Score	YTD	Aug-15	Sep-15	Movement
Clostridium(C.) Difficile - meeting the C.difficile objective (de minimis of 12 applies)	31	1	0	15	2	2	0
Certfication of Compliance Learning Disabilities;							
Does the Trust have mechanism in place to identify and flag patients with learning disabilities and protocols that ensure the pathways of care are resonably adjusted to meet the health needs of these patients?	Compliant	1	0	Yes	Yes	0	
Does the Trust provide available and comprehensive information to patients with learning disabilities about the following criteria: - treatment options; complaints procedures; and appointments?	Compliant	1	0	Yes	Yes	0	
Does the Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	Compliant	1	0	Yes	Yes	0	
Does the Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	Compliant	1	0	Yes	Yes	0	
Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Compliant	1	0	Yes	Yes	0	
Does the Trust have protocols in place to regulary audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Compliant	1	0	Yes	Yes	0	
Data Completeness Community Services:							
Referral to treatment * data is for July and August 2015	50%	1	0		57.3%	55.1%	-2.2%
Referral Information	50%	1	0		88.0%	87.9%	-0.1%
Treatment Activity	50%	1	0		72.4%	69.5%	-2.9%

Trust Overall Quality Governance Score	4	4	0

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

The trust's quality governance rating is 'Red' as the trust has a governance score of 4 and Monitor have imposed additional license conditions in relations to governance. (further details in appendix 1.)

.

Areas of underperformance for quality governance are:

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

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

*Cancer Data is reported a month in arrears. Q2 relates to July and August.

Legend	
⇧	Positive Performance Change
⇩	Negative Performance Change
⇨	No Performance Change

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

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

RESPONSIVENESS

Metric	Standard	YTD	Aug-15	Sep-15	Movement
Referral to Treatment Admitted	90%		80.20%	77.70%	-2.50%
Referral to Treatment Non Admitted	95%		93.21%	92.50%	-0.71%
Referral to Treatment Incomplete	92%		89.71%	89.10%	-0.61%
Referral to Treatment Incomplete 52+ Week Waiters	0	13	3	2	-1
Diagnostic waiting times > 6 Weeks	1%		2.33%	1.01%	-1.32%
A&E All Types Monthly Performance	95%	92.67%	94.25%	91.40%	-2.85%
12 Hour Trolley Waits	0	0	0	0	0.00%
Urgent Ops Cancelled for 2nd time (number)	0	0	0	0	0.00%
Proportion of patients not treated within 28 days of last minute cancellation	0%	15.07%	13.51%	6.45%	-7.06%
Certification against compliance with requirements regarding access to health care with a learning disability	Compliant	Yes	Yes	Yes	

Metric	Standard	YTD	Jul-15	Aug-15	Movement
62 Day Standard	85%	79.77%	80.52%	81.08%	0.56%
62 Day Screening Standard	90%	85.95%	90.70%	91.67%	0.97%
31 Day Subsequent Drug Standard	98%	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%	96%	96%	100%	4.17%
31 Day Standard	96%	97.95%	98.45%	99.35%	0.91%
Two Week Wait Standard	93%	88.99%	86.01%	79.33%	-6.68%
Breast Symptom Two Week Wait Standard	93%	91.68%	94.49%	93.86%	-0.63%

EFFECTIVENESS

Metric	Standard	YTD	Aug-15	Sep-15	Movement
Hospital Standardised Mortality Ratio (DFI)	100		90.0	91.1	1.1
Hospital Standardised Mortality Ratio - Weekday	100	0	86.1	86.1	0.0
Hospital Standardised Mortality Ratio - Weekend	100	0	83.7	83.7	0.0
Summary Hospital Mortality Indicator (HSCIC)	100	0	89	90	1.0
Emergency Re-admissions within 30 days following Elective or emergency spell within the Trust	5%	3.10%	2.20%	2.90%	0.7%
Bed Occupancy - Midnight Count	85%		94.4%	98.5%	0.041
LOS - Elective			4.2	3.9	-0.3
LOS - Non-Elective			4.73	4.76	0.03

CARING

Metric	Standard	YTD	Aug-15	Sep-15	Movement
Inpatient Scores - Friends & Family Recommendation Rate	60		94.0	93.6	-0.4
A&E Scores - Friends & Family Recommendation Rate	46		85.8	86.5	0.7
Complaints (1 month in Arreas Jul & Aug data))			79	87	8.0
Mixed Sex Accomodation Breaches	0	0	0	0	0.0

SAFE

Metric	Standard	YTD	Aug-15	Sep-15	Movement
Clostridium Difficile - Varience from plan	31	15	2	2	0
MRSA Bacteramia	0	4	0	2	2
Never Events	0	6	1	1	0
Serious Incidents	0	87	13	14	1
Percentage of Harm Free Care	95%		93.8%	95.2%	0
Medication Errors causing serious harm	0	0	0	0	0
Overdue CAS Alerts	0	14	4	2	-2
Maternal Deaths	1	1	0	0	0
VTE Risk Assessment (previous months data)*	95%		96.8%		

WELL LED

Metric	Standard	YTD	Aug-15	Sep-15	Movement
Inpatient Respose Rate Friends & Family	30%		41.9%	35.7%	-6.2%
A&E Respose Rate Friends & Family	20%		21.7%	21.6%	-0.1%
NHS Staff recommend the Trust as a place to work	58%	62.0%			
NHS Staff recommend the Trust as a place to receive treatment	4	3.78			
Trust Turnover Rate	13%		17.3%	10.0%	-7.3%
Trust level sickness rate	4%		3.9%	3.9%	0.0
Total Trust Vacancy Rate	11%		11.0%	14.5%	3.5%
% of staff with annual appraisal - Medical	85%		87.1%	84.5%	-2.6%
% of staff with annual appraisal - non medical	85%		71.7%	72.6%	0.8%

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 9) - A&E: 4 Hour Standard

Total time in A&E - 95% of patients should be seen within 4hrs							
Lead Director	Aug-15	Sep-15	Movement	2015/2016 Target	Forecast for Sep-15	Forecast for Oct-15	Date expected to meet standard
FA	94.25%	91.40%	⇩ -2.85%	>= 95%	R	R	TBC

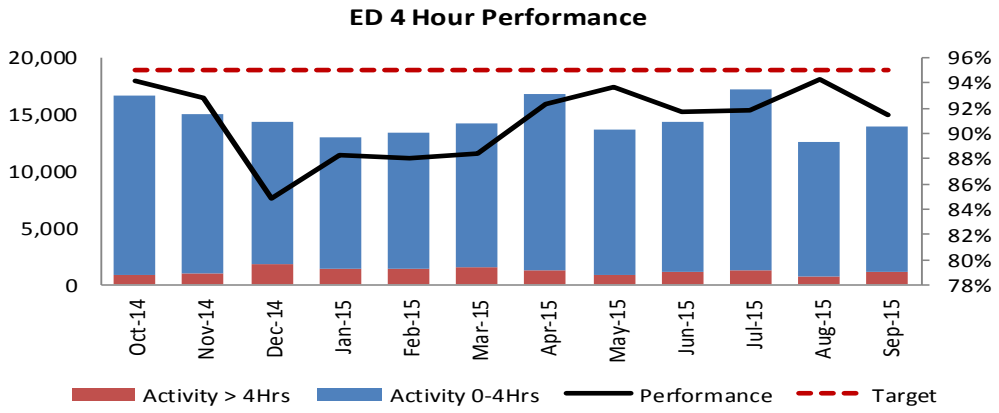
Peer Performance August 2015 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	3	2	5	1
94.40%	94.50%	95.20%	93.20%	95.70%

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 being below that target at both the weekly and monthly level. In September 91.40% of patients were seen within 4 hours, showing a decrease in Performance by 2.85% compared to August performance of 94.25% . The trust is also below the target YTD with performance of 92.47%

. Factors that continue to affect performance include:

- Increase in breaches for patients awaiting a specialist opinion and bed capacity where the Trust had an increase in bed occupancy. (bed occupancy increased to 98% in September)
- Number of mental health patients breaching. Even though the initial assessment from mental health has improved, long delays in placing the patient into the appropriate setting is resulting in breaches.
- Increase in the 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. For week ending 27/09/2015 on average there were 13 delayed transfer of care patients per day, this has already seen an increase in early October to 20 patients per day
- As at 19/10/2015 there were 75 of 646 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 trust is working with commissioners and external agencies to expedite this.

The trust continues to implement the Joint Investigation action plans to recover performance which continue to be reviewed monthly. In addition and to support the work being undertaken following the Joint Investigation process, Mckinsey and Company have been commissioned by the CCG and the Trust to undertake a further review of actions and current issues to establish 'one version of the truth' and to support in developing a recovery plan going forward. This will be overseen by the



Performance Overview by Type			
Period	ED (Type 1)	MIU (Type 3)	ED & MIU (Type 1+3)
Month to Date (Sept)	90.38%	99.86%	91.41%
Quarter to Date	91.58%	99.88%	92.42%
Year to Date	91.66%	99.59%	92.47%

3. Performance Areas of Escalation (Page 2 of 9) - RTT Incomplete 52+ Week Waiters

Referral to Treatment Incomplete 52+ Week Waiters							
Lead Director	Aug-15	Sep-15	Movement	2015/2016 Target	Forecast for Sep-15	Forecast for Oct-15	Date expected to meet standard
PVK	3	2	-1	0	R	R	Oct-15

Peer Performance August 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3	3	0	-	0

Specialty	Patient Type	Date for patient to be treated	Commentary
Gynae	Inpatient	Awaiting TCI	This is a Urogynae p atient who has been referred to Croydon as part of the new service arrangements. We are currently awaiting updates with regards to a date for treatment from CUH
Gynae	Inpatient	TBC	Patient was refereed by the Uro Gynae team to the Respiratory team for sleep studies which the patient subsequently DNA'd citing reasons of ill health on 27/08/2015. The Trust are now in the process of offering the patient a new date for sleep studies which is required to take place prior to commencement of surgery.

The trust continues to pro-actively address 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 review of all patients waiting greater than 44 weeks, detailing reasons for delay and plans for treatment is being undertaken post submission and shared with commissioners going forward.
- A monthly RTT Compliance meeting chaired by the new Interim Chief Operating Officer 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.

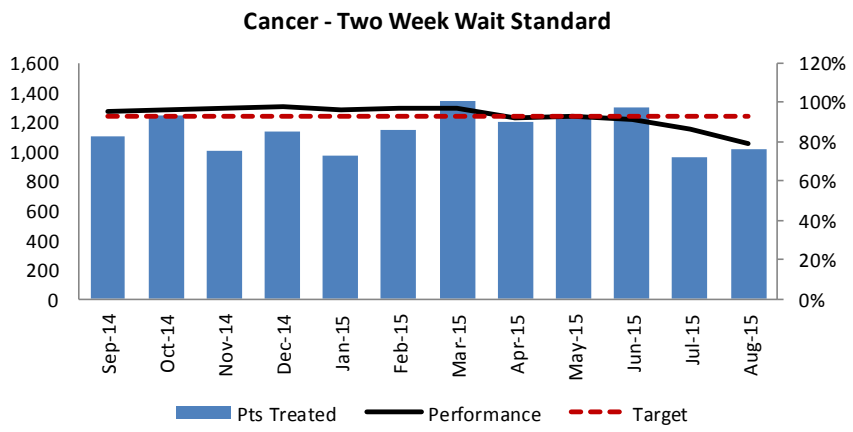
3. Performance Areas of Escalation (Page 3 of 9) - Cancer Performance

Cancer Performance								Peer Performance Latest Published August 2015- 2016				
Lead Director – CC	Jul-15	Aug-15	Movement	2015/2016 Target	Forecast for Aug-15	Forecast for Sep-15	Date expected to meet standard	STG	Croydon	Kingston	King's College	Epsom & St Helier
14 Day GP Referral for all Suspected Cancers	86.01%	79.33%	-6.68%	93%	R	R	Jan-16	79.33%	90.86%	95.32%	97.35%	93.24%
62 Day Wait Standard	80.52%	81.08%	0.56%	85%	R	R	Oct-15	81.08%	97.62%	85.15%	91.50%	77.17%

The trust was non compliant against two of the national cancer wait targets for the month of July and August 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.

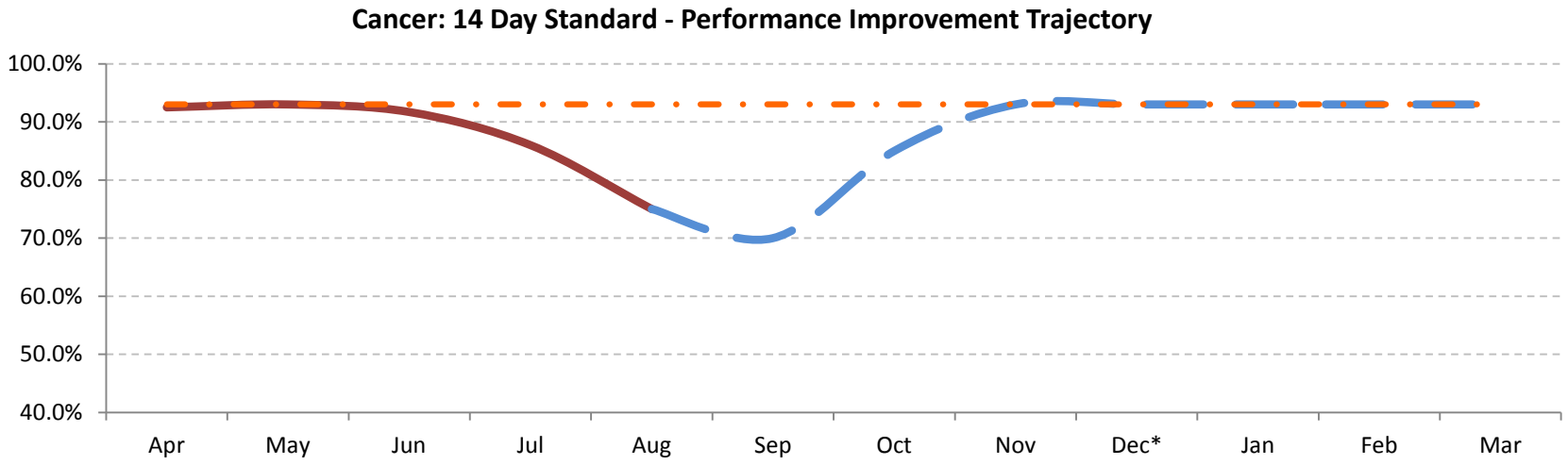
The trust continues to implement the action plan submitted to NHS England. This focuses on actions by tumour type which need to be taken to address specific key issues within each modality. The trust has also submitted a revised trajectory against the Two Week Wait standard, forecasting compliance from November onwards.



Two Week Wait Standard - Non-achievement of this target relates to 210 breaches which is unfortunately higher than the average number of breaches of 95 seen in Q1, with a correlating reduction in the number of treatments in month. Modalities of breach include: Breast, Gynae, Skin, Haematology and Upper GI.
Key issues affecting performance in August:

- patient choice - this accounted for 43 patients breaching.
- Capacity in particular in relation to Gynae and Skin. 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.
- Daily update on capacity concerns and breach numbers from the Two Week Wait Referral Office.

14 Day GP Referral for all Suspected Cancers - Trajectory



		Actual				Forecast							
	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec*	Jan	Feb	Mar
14 Day GP Referral for all Suspected Cancers	93%	92.5%	93.0%	91.7%	86.0%	75.0%	70.0%	85.0%	93.0%	93.0%	93.0%	93.0%	93.0%

* Dec perf may vary dependant on Pt Choice and referral variability over Xmas period

- The above is a provisional trajectory to recover performance against the 14 Day Standard.
- The Cancer Team with Divisions are currently undertaking a TWR demand and capacity review. Following the review divisions will have a clear understanding of the shortfall in number of TWR slots required by tumour type. These will then need to be reviewed and built into ring-fenced substantive capacity at 85% of average weekly referrals to allow for sustainability. It is envisaged that the review will be complete by mid-October. Following the completion of this exercise the above trajectory will be revised with supporting trajectories by tumour type.
- Current challenged tumour groups affecting performance include: Skin, Gynae , Upper GI and Breast.
- Positive improvement in other areas previously challenged have been made including; Lower GI and Urology.

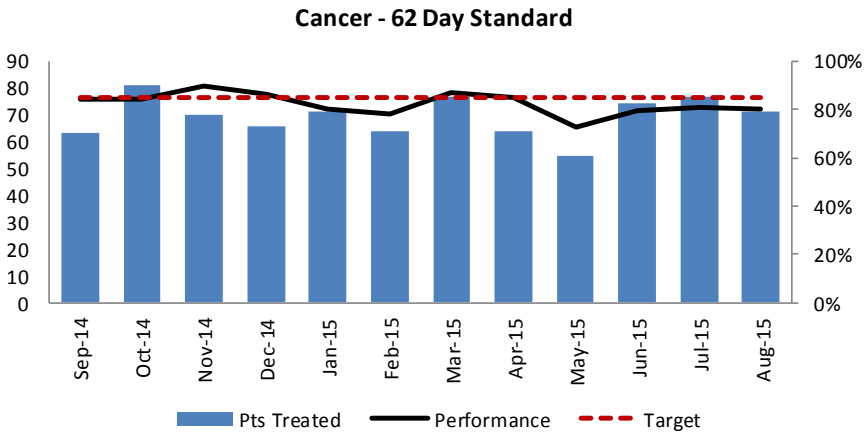
14 Day GP Referral for all Suspected Cancers: Challenged Specialties (Page 5 of 9)

					Perf Forecast			
Specialty	**Referral Vol Change**	**Activity Vol Change**	**Issues Impacting on Service Delivery**	**Remedial Actions being Taken**	**Aug**	**Sep**	**Oct**	**Nov**
Skin	Volume of referrals are relatively static with some expected seasonal variation.	Volume of activity decreased in July and further more in August. Activity has increased in September	A significant reduction in capacity experienced in July and August due to vacancies arising for a Dermatology Consultant and Specialist registrar. This was further compounded by annual leave and the bank holiday in August.	-Approximately 30 additional clinics have been run since August to catch up with the backlog. As at 02/10/2015 there are no Skin TWR patients in escalation. -The specialty have undertaken a demand and capacity review across all sites holistically to reprofile capacity. In addition to this they are working with the British Association of Dermatology to improve pathways in line with best practice. - British Association of Dermatologists (BAD) to visit STG to provide independent review of service including capacity, coding, N:F ratios and more. - Full conversion of special interests clinic to solely TWR capacity. -community and hospital Dermatology doctor team being merged into a single care-group with clinical lead to increase service resilience. -The specialty are implementing a workforce recruitment plan, with an additional Band 7 Dermatology Nurse having being recruited. As part of this the trust are also actively in the process of trying to recruit an additional Dermatology Consultant. However, this is proving challenging.				
Gynae	Volume of referrals are relatively static with little variance.	Volume of activity has been steady in Q1, with a sharp increase in June. However, volume of activity has gradually declined from July.	- Loss of management at end of Q, with a significant impact on grip. -lack of pre-existing capacity of TWR slots. -Difficulty in scheduling ad-hoc clinics with limited clinical engagement	New management leads appointed. - 1.5 additional dedicated TWR clinics per week scheduled from October for an initial period of three months to clear backlog and achieve a sustainable position. - reduction of inappropriate internal upgrades to TWR. -have recruited an additional Gynae consultant with TWR experience and capacity. This will result in increased capacity from 34 to 68 slots. -In the process of identifying and recruiting a Clinical Cancer Lead for Gynae. -Improved Gynae TWR triage process, to reduce triage time and to improve the pathway for patient who should go 'straight to test' -Clinical leadership changes anticipated.				

14 Day GP Referral for all Suspected Cancers: Challenged Specialties (Page 6 of 9)

					Perf Forecast			
Specialty	**Referral Vol Change**	**Activity Vol Change**	**Issues Impacting on Service Delivery**	**Remedial Actions being Taken**	**Aug**	**Sep**	**Oct**	**Nov**
Upper GI	Significant increase in the number of referrals against expected observed in July and August. Number of referrals in July were 35% higher than that of Q1 average.	Volume of activity in Q2 is lower that that of Q1. In particular in July and August.	- capacity shortfall in the specialty due to staff leaving in Q1, and a member of staff being on leave in August. This has required staff to cross cover in the specialty and has impacted on TWR capacity. -the specialty has experienced Difficulty in arranging additional ad-hoc clinics. the delays in ad-hoc clinics has resulted in clinics being setup with short notice. -High DNA rates for ad-hoc clinics in Q2. This is largely due to short notice of appointments offered.	- Increased clinician capacity with the recruitment of: a.Gastroenterology Consultant b. Gastroenterology Specialist Registrar. These clinicians are envisaged to start between Oct and Nov. -Additional ad-hoc clinics have been run in September and are continued to be run in October to catch up with the backlog and reach a sustainable position. This coincides with the additional capacity to take effect in Q3 with the new clinicians in post. -long term strategy to build 2 new endoscopy rooms to meet the increased endoscopy demand across the service. -Investment in dedicated Gastroenterology / Endoscopy Service Manager (starts 19/10/15) and dedicated Assistant Service Manager for Gastroenterology (advertised) to enhance management of 14day/62day/18 week pathways. -Consultant, registrar and CNS job plan review due to complete in October to release additional capacity with dedicated TWR support				
Breast	Volume of referrals are relatively static with some expected seasonal variation.	Volume of activity relatively flat month on month. However, there are in month fluctuations in activity and referrals at weekly level.	-activity is undertaken at two sites, namely QMH and SGH. Capacity at SGH has been increased to meet demand. The capacity at QMH has been problematic due to locum consultant cover provided by KHFT. -Reliability and availability of consultants at QMH to include annual leave cover particularly in August. -Delays in rescheduling appointments following DNA and cancellations, in particular for patients that are listed at QMH.	-TWR capacity reprofiled and allocated for SGH. -SGH to take over management of QMH Breast service from KHFT, with effect from January 2016. -Radiology service which support delivery of cancer waiting times, is now managed by SGH centrally. -additional capacity created at QMH by the running of ad-hoc clinics and flexing existing capacity to prioritise TWR patients -one-stop service for all patients at SGH site with effect from May 2015. This has seen a positive reduction in breaches on the SGH site. -consultant job plans under review to ensure sufficient capacity is maintained.				

3. Performance Areas of Escalation (Page 7 of 9) - Cancer Performance



62 day GP Referral to Treatment Wait Standard - Non-achievement of this target in August relates to 21 patients breaching of which 15 were on a shared pathway. SGH performance excluding shared patients would have been 90.4% and within target. Breaches occurred in the modalities of; Heam, Lower GI, Upper GI, Lung, Head and Neck and Urology.

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.
- Other medical conditions prioritised
- Diagnostic capacity constraints within Endoscopy, and lost theatre capacity due to technical issues.
- Patient choice / Patient unfit for treatment.

The trust is in the process of further reviewing and revising its 62 Day Standard performance improvement action plan.

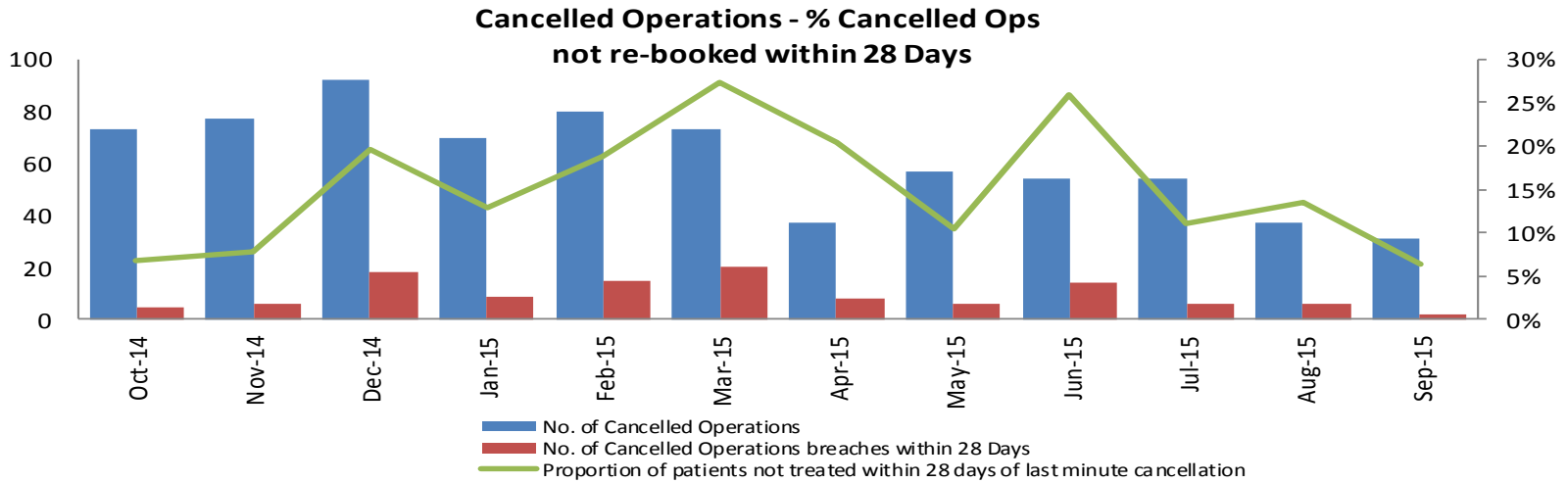
August 2015 performance against national cancer targets by tumour type.

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%	79.30%	91.00%	75.00%	48.50%	93.30%	85.60%	92.60%	88.00%	39.00%	79.70%	98.60%
14 Day Breast Symptomatic Referral	93%	93.90%	93.90%									
31 Day First Treatment	96%	99.40%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	94.40%	100.00%	100.00%
31 Day Subsequent Surgery Treatment	94%	100%										
31 Day Subsequent Drug Treatment	98%	100%										
62 day GP Referral to Treatment	85%	81.08%	92.60%			80.00%	73.30%	100.00%	78.60%	91.70%	66.70%	68.90%
62 Day Screening Referral to Treatment	90%	91.70%	91.70%	90.90%				100.00%				

3. Performance Areas of Escalation (Page 8 of 9) - Cancelled Operations

Proportion of Cancelled patients not treated within 28 days of last minute cancellation							
Lead Director	Aug-15	Sep-15	Movement	2015/2016 Target	Forecast for Sep-15	Forecast for Oct-15	Date expected to meet standard
CC	13.51%	6.45%	-7.06%	0%	G	G	Sep-15

Peer Performance Comparison – Latest Available Q1 2015/16				
STG	Croydon	Kingston	King's College	Epsom & St Helier
18.70%	2.04%	9.40%	7.60%	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 31 cancelled operations from 4518 elective admissions in September. 29 of those cancellations were rebooked within 28 days with 2 patients not rebooked within 28 days, accounting for 6.45 % of all cancellations. There has been a significant decrease in the number of cancelled operations in particular compared to the same period last year. This correlates with a reduction in the number of patients not re-booked within 28 days. There were 270 operations cancelled in the year to date, with 228 rebooked within 28 days.

The cancelled operations not re-booked were attributable to: Orthopaedics and Cardiothoracic specialties. Key contributory factors for the cancellations were related to emergency cases taking precedent and bed capacity issues for a complex case.

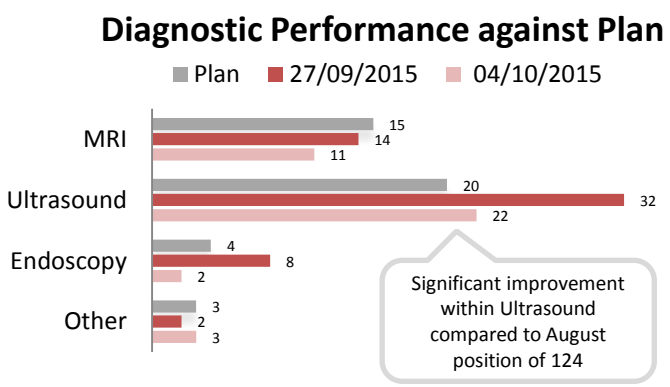
Both patients now have scheduled dates for their operations.

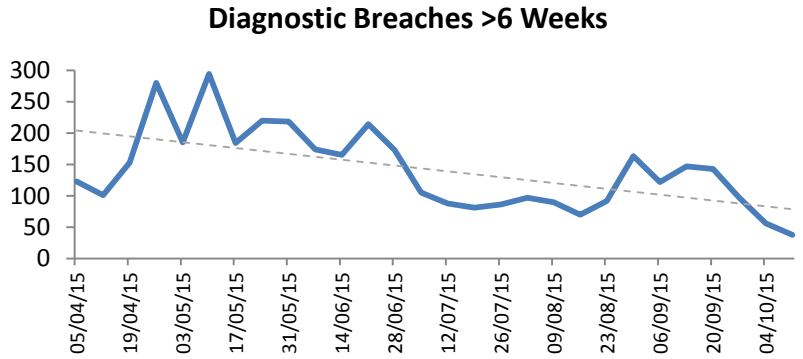
3. Performance Areas of Escalation (Page 9 of 9) - Diagnostic 6+ Weeks Wait

Diagnostic waiting times > 6 weeks							
Lead Director	Aug-15	Sep-15	Movement	2015/2016 Target	Forecast for Sep-15	Forecast for Oct-15	Date expected to meet standard
SC	2.33%	1.01%	⇧ -1.32%	1%	R	G	Oct-15

No of Patients waiting >6 weeks – Latest Published Data August 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
5	1	2	4	3
121	11	25	111	50

The trust has maintained a positive performance improvement with diagnostic waits greater than 6 weeks with an increase of 1.32% in September's performance. Modalities are now in line with the planned trajectory with the exception of Ultrasound, however the area has made a significant improvement. The trust is exceeding the target of number of patients waiting greater than 6 weeks of 1% of all waiters with performance at 1.01%. However this is a significant reduction from Aprils performance of 3.66%. 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.





Actions continue to be undertaken to maintain and further drive performance improvement for non-obstetric ultrasound. These include:

- Additional sessions to reduce waiting times and recover performance have been scheduled. This has already had a positive impact seeing a reduction in waiting times in September. Further to this and to support long term stability, the trust is actively in the recruitment process for an additional sonographer.
- Radiology related non-obstetric ultrasound remains the key area of focus. A significant decrease in waits greater than 6 weeks is being experienced at QMH and remains a priority area for improvement. The improvement follows poor performance due to issues in relation to the end of the trust contractual agreement with Kingston Hospital Trust delivering non-obstetric ultrasound services for SGH, in particular MSK sessions.
- Additional sessions at QMH continue to be scheduled, in particular MSK sessions.
- Continuation of additional sessions at SGH to allow for continued sustainability.
- Increased utilisation of capacity at the Nelson, to actively reduce the backlog within the Community Division.

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

Monthly View

September 2015

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	18 WEEKS - ADMITTED WAITS (DIVISION LEVEL)	%		84.5	72.2	81.1	77.7
	18 WEEKS - INCOMPLETE WAITS (DIVISION LEVEL)	%	99.2	89.7	87.7	86.7	89.1
	18 WEEKS – NON-ADMITTED WAITS (DIVISION LEVEL)	%	100	89.7	89.1	91.1	92.5
	52 WEEK WAITERS	No.	0	0	0	2	2
	A&E WAITS (4 HOURS)	%	99.9	90.4			91.4
	CANCELLED OPERATIONS RE-BOOKED WITHIN 28 DAYS (DIVISION)	%	0	6.3	7.7	0	6.3
	LAS HANDOVER WITHIN 15 MINS	%					30.7
	LAS HANDOVER WITHIN 30 MINS	%					87.9
	LAS HANDOVER WITHIN 60 MINS	No.					0

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

August 2015

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (BREAST SYMPTOMS) - (DIVISION)	%	0	0	93.9	0	93.9
	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (CANCER) - (DIVISION)	%	0	0	79.3	0	79.3
	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)	%			99.4		99.4
	62 DAY URGENT GP REFERRAL TO TREATMENT FOR ALL CANCERS - (DIVISION)	%			80.3		80.3
	62 DAY URGENT GP REFERRAL TO TREATMENT FROM SCREENING - (DIVISION)	%			91.7		91.7

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

			September 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Outcome Metrics	C-SECTIONS (APPLICABLE TO WOMEN & CHILDREN ONLY)	%				22.9	20.6
	HSMR	Ratio					91.1
	INCIDENCE OF C.DIFFICILE	No.	0	2	0	0	2
	INCIDENCE OF E-COLI	No.	0	4	0	0	4
	INCIDENCE OF MRSA	No.	0	2	0	0	2
	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.	1	0	0	0	1
	SERIOUS INCIDENTS (DIVISION LEVEL)	No.	4	6	3	1	14
	SHMI	Ratio					0.9
	TRUST ACQUIRED PRESSURE ULCERS	No.	2	4	0	0	6

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Quality Governance Indicators	PATIENT SATISFACTION (FRIENDS & FAMILY)	%	100	94.2	87.3	91.1	90.8
	PERCENTAGE OF STAFF APPRAISAL (MEDICAL) - (DIVISION)	%	84	87.7	87.7	86.9	87.3
	PERCENTAGE OF STAFF APPRAISAL (NON-MEDICAL) - (DIVISION)	%	68.2	73.6	74.4	69	70.6
	SICKNESS/ABSENCE RATE - (DIVISION)	%	5.5	4.4	3.4	3.9	4.1
	STAFF TURNOVER - (DIVISION)	%	21.1	19.1	13.3	18.1	17.7
	VOLUNTARY STAFF TURNOVER - (DIVISION)	%	16.8	17.2	12	14.8	14.9

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 September, 30.7% of patients had handover times within 15 minutes and 87.9% 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 zero 60 minute LAS breaches in September.

The trust has a zero tolerance on avoidable pressure ulcers and has placed significant importance on its prevention. In September the trust had 6 grade 3 pressure ulcer SI's and 0 Grade 4. All grade 3 and 4 pressure ulcers acquired in our care are investigated as serious incidents, and a. full investigation and Root Cause Analysis will be produced for each PU and reviewed at the Pressure Ulcer Strategy group, chaired by the Deputy Chief Nurse

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Corporate Outpatient Services Performance

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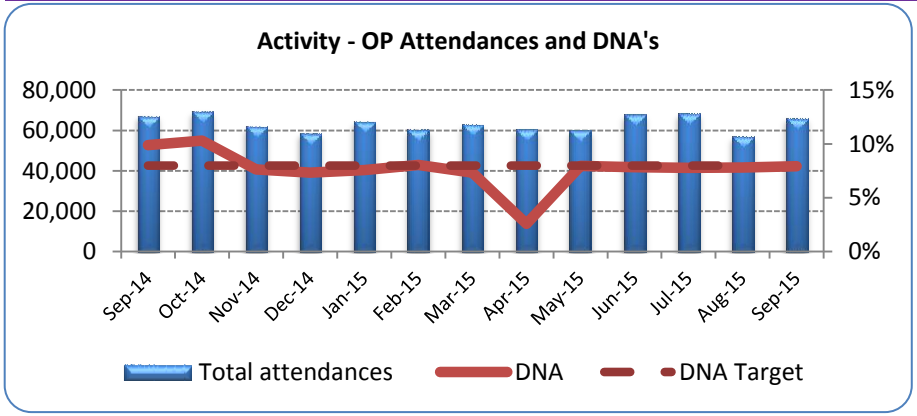
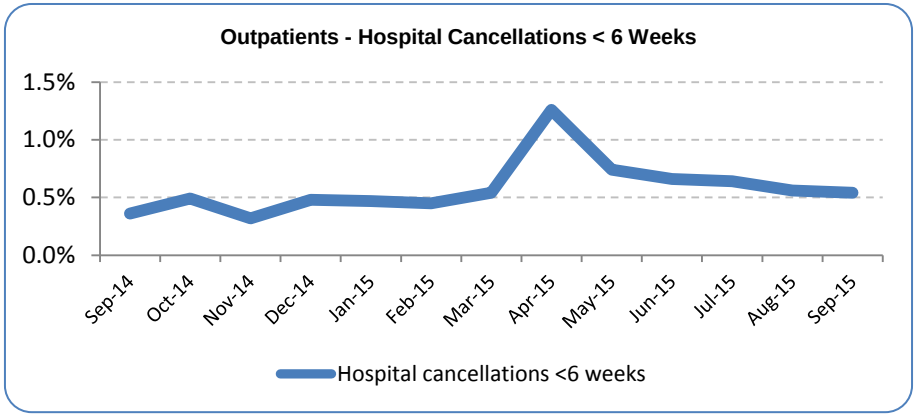
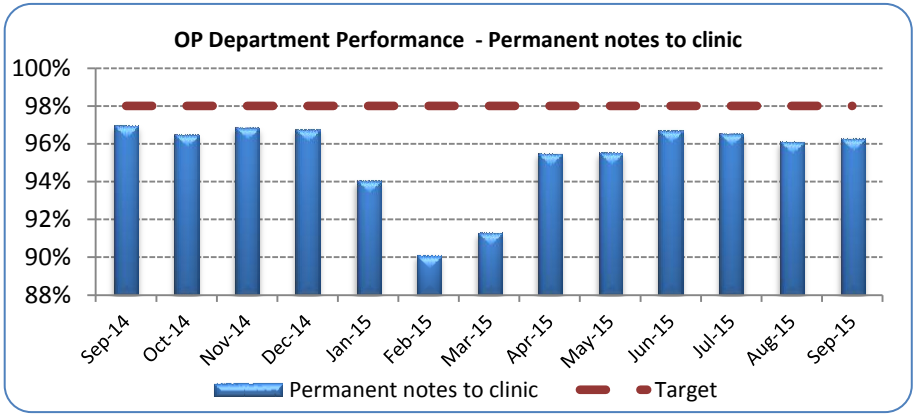
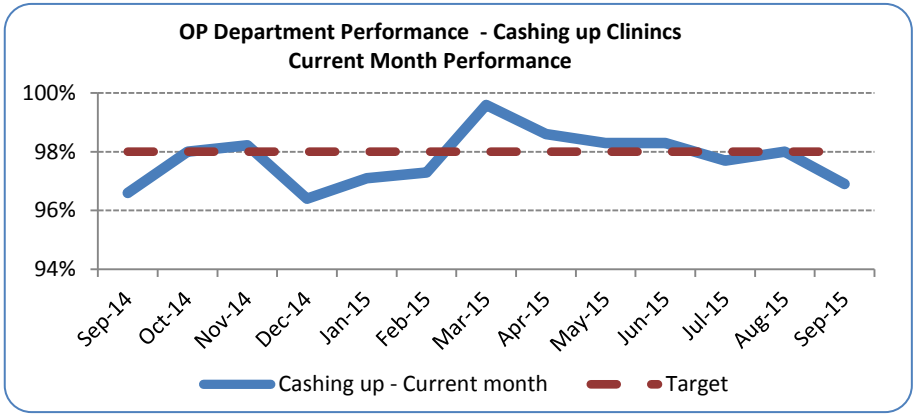
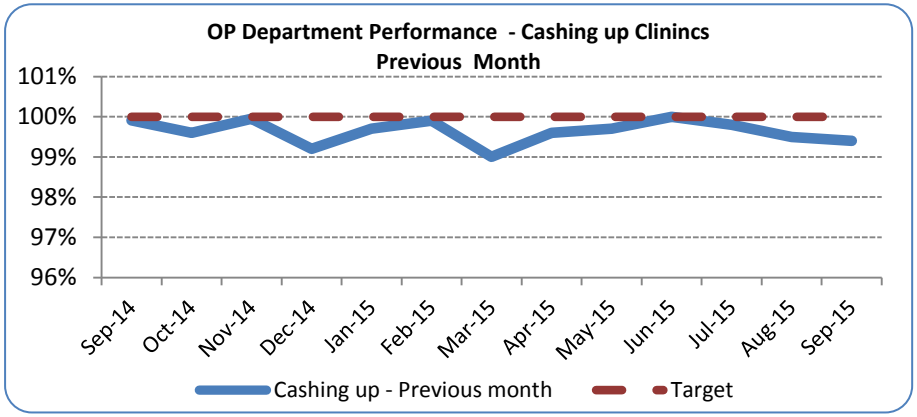
5. Corporate Outpatient Services (1 of 2) - Performance Overview

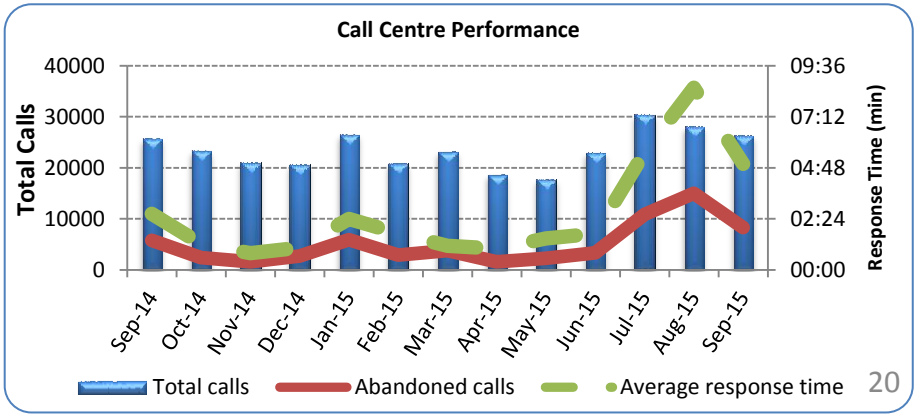












5. Corporate Outpatient Services (2 of 2) - Performance Overview

		Target	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Activity	Total attendances	N/A	67,188	69,507	61,879	58,659	64,609	60,659	62,946	60,564	59,841	68,002	68,277	57,188	66,271
	DNA	<8%	9.89%	10.30%	7.64%	7.33%	7.58%	8.04%	7.33%	2.59%	7.97%	7.84%	7.77%	7.82%	7.92%
	Hospital cancellations <6 weeks	<0.5%	0.36%	0.49%	0.32%	0.48%	0.47%	0.45%	0.54%	1.26%	0.74%	0.66%	0.64%	0.56%	0.54%
OPD performance	Permanent notes to clinic	>98%	96.98%	96.51%	96.88%	96.77%	94.05%	90.12%	91.32%	95.52%	95.54%	96.74%	96.54%	96.14%	96.31%
	Cashing up - Current month	>98%	96.60%	98.00%	98.22%	96.40%	97.10%	97.30%	99.60%	98.60%	98.30%	98.30%	97.70%	98.00%	96.90%
	Cashing up - Previous month	100%	99.91%	99.60%	99.95%	99.20%	99.70%	99.90%	99.00%	99.60%	99.70%	100.00%	99.80%	99.50%	99.40%
Call Centre Performance	Total calls	N/A	25,674	23,420	20,964	20,639	26,565	20,842	23,235	18,710	17,732	22,955	30,426	28,095	26,357
	Abandoned calls	<25%/<15%	5794	2376	1558	2681	5923	2908	3782	1551	2237	3309	10828	15019	8253
	Mean call response times	<1 minute	02:38	01:13	00:47	01:02	02:24	01:43	01:08	01:00	01:29	01:42	05:31	08:34	04:59

Key Messages:

- Increase in activity from August position which is envisaged due to the holiday period. DNAs have marginally increased and remain within target of less than 8%. Hospital cancellations have seen a gradual continued reduction since May. However, this is still not within target of less than 0.5%. Performance of permanent notes to clinic has slightly decreased after a steady improvement and remains short of the trusts 98% target. This remains a priority area for the service.

- The level of activity and the number of abandoned calls have significantly decreased in September when compared with July and August however this is still significantly under the target and with a much higher number compared to previous year. 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.
  - A programme of reducing agency staff to bank staff in COS during Q2 has resulted in a loss of capacity as some agency members have chosen to leave. Additional recruitment via staff bank is in operation. However, it takes approximately 8 weeks to get new starters fully trained and efficiently operating, thus affecting current performance.
  - 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.

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Clinical Audit and Effectiveness

Excellence in specialist and community healthcare

6.Clinical Audit and Effectiveness - Mortality

HSMR (Hospital standardised mortality ratio)							
Lead Director	July 15	August 15	September 15	Movement	2015/16 Target	Forecast March 16	Date expect to meet standard
SM	87.2	91.8	91.3	↓	<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

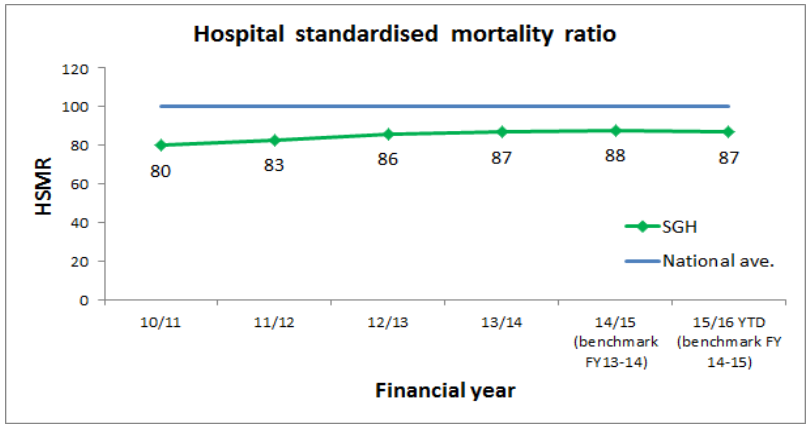
Note: Source for HSMR is Dr Foster Intelligence. Data is most recent 12 months available; currently August 2014 to July 2015, and benchmark period is the financial year 2014/15. SHMI data is published by the Health and Social Care Information Centre. The last 12 month period as published on 29th July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

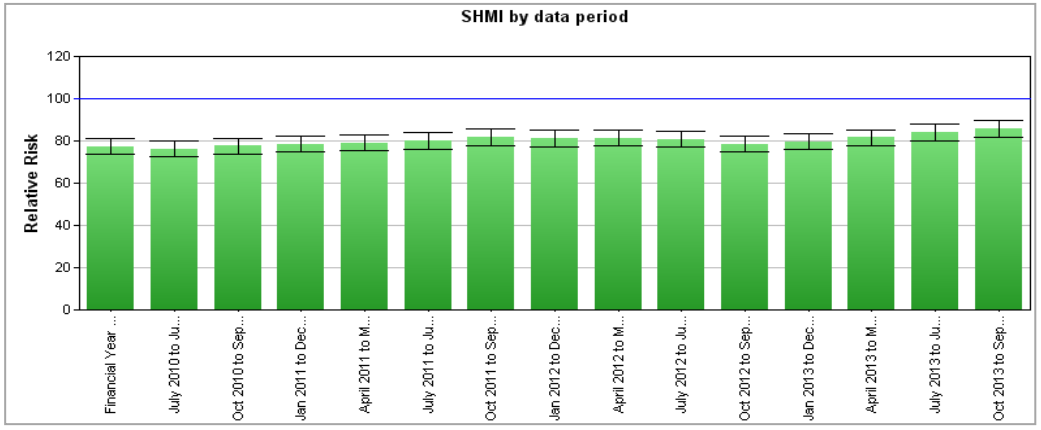
Overview:

Our overall mortality measured by both the HSMR and the SHMI remains statistically significantly better than expected. There does appear to be a trend towards the national mean which requires monitoring. We continue to investigate any mortality signals at procedure and diagnosis level which are locally identified using the Dr Foster platform. There are a number of reviews outstanding that have recently been escalated. The MMC is recruiting additional clinicians from across divisions; we are particularly keen to welcome colleagues from one or more surgical specialties.

To further strengthen our governance of mortality the Mortality Monitoring Committee has devised a protocol to guide investigations and to support the organisation's drive to ensure the proportionate review of all deaths. The protocol clearly defines approaches that will be considered, roles and responsibilities routes of escalation and reporting requirements. Implementation of this protocol will ensure more timely and robustly structured investigations are conducted, with improved local involvement and ownership, whilst at the same time minimising the duplication of effort. It is anticipated that this will lead to a more efficient review process and ultimately improve our ability to identify and share learning. The protocol will be presented to the Executive Management Team for their endorsement and support.

The pilot project designed to prospectively identify consultant level mortality and to provide clinicians with access to electronically scanned documents to facilitate timely review has been postponed temporarily. The MMC chair is working with colleagues in the Scanning Bureau, Coding, Bereavement Services and Medical Records to implement a process that will not adversely impact on mandatory processes and deadlines.





6.Clinical Audit and Effectiveness - National Audits

National Hip Fracture Database (NHFD) Report 2015

NICE QS16 for Hip Fracture	SGH 2014	SGH 2015	London 2015	National 2015	Local data Aug 2015
Number of cases submitted	247	245	5,974	64,102	-
Admitted to orthopaedic ward within 4 hours	25.2%	35.1%	29.0%	46.1%	-
Mental test score recorded	81.0%	75.1%	93.9%	94.5%	94.7%
Perioperative medical assessment (ortho-geriatrician)	32.0%	71.8%	90.0%	85.3%	100%
Mobilised out of bed day after surgery	N/A	63.6%	69.4%	73.3%	-
Received falls assessment	99.5%	100%	99.0%	96.1%	100%
Received bone health assessment	95.9%	96.9%	98.3%	96.5%	89.5%
Met all criteria for best practice tariff	17.0%	27.4%	60.7%	63.3%	59.3%
Surgery on the day of, or day after, admission	69.6%	73.0%	73.7%	72.1%	68.4%
Eligible displaced intra-capsular fractures treated with THR	N/A	18.2%	21.6%	26.1%	-
Acute LOS (days)	N/A	9.2	17.0	15.7	-
Overall hospital LOS (days)	22.2	21.2	21.5	20.3	-
Return to original residence within 30 days	46.0%	47.7%	56.4%	53.7%	-
Reoperation within 30 days	N/A	0.0%	0.7%	1.1%	-
Developed a pressure ulcer after presenting with hip fracture	2.7%	1.8%	3.3%	2.8%	-
Hip fractures which were sustained as an inpatient	N/A	3.7%	4.4%	4.3%	-

Key

2015

- Top 25%
- 2nd quartile
- 3rd quartile
- Lowest 25%

2014

- Better than the national average
- Worse than the national average

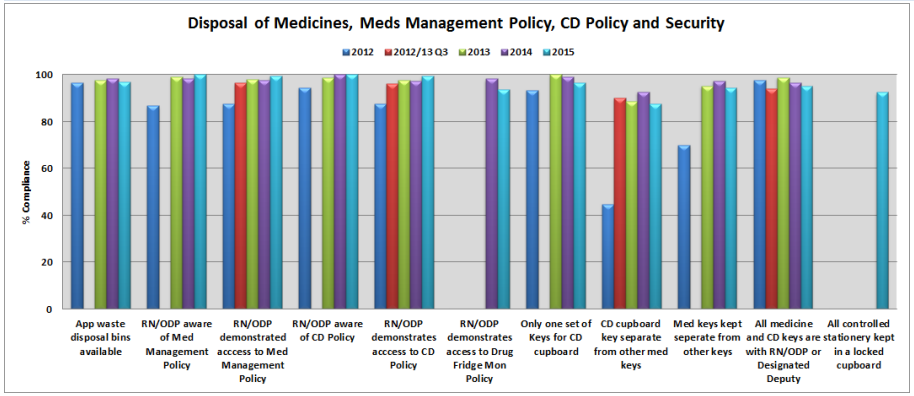
Overview Data was submitted for 245 cases (case ascertainment 80.3%) between 1st January 2014 and 31st December 2014. Comparison between 2014 and 2015 indicates an improvement in all key measures, other than for recording of mental test score. There was also a decline in the use of SHS (Sliding Hip Screw) for Inter-trochanteric fractures treated (86.3% to 62.8%). The trust performed better than the national average for falls assessment, bone health assessment and timely surgery. For pressure ulcers, inpatient hip fractures and acute length of stay St George's performed better than both London and national averages.
The joint care of patients by a surgeon and an orthogeriatrician is judged to enhance the overall level of care given. 71.8% of our patients received this care, which although significantly less than the London and national average demonstrates a year on year increase from 6% in 2012 and 14.7% in 2013 and 32% in 2014.
The best practice tariff was achieved for 27.4% of St George's patients compared to 63.3% nationally and 60.7% in London. This is an increase when compared to 2014 but a decrease when compared to the 2013 audit where 41% of our cases were eligible.

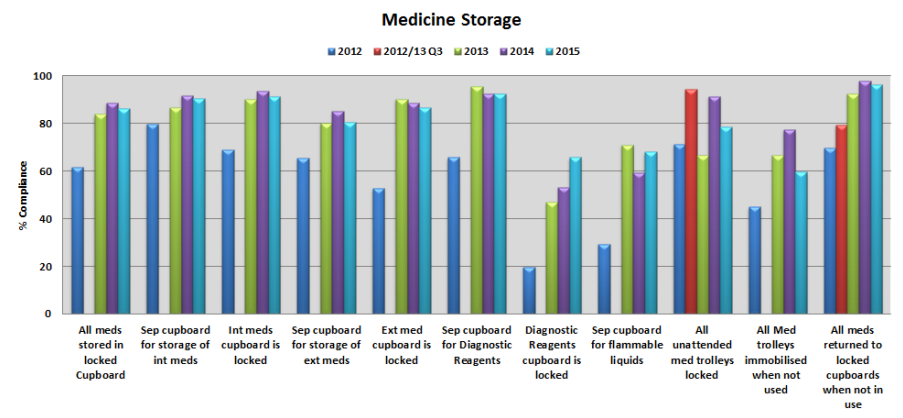
Actions A number of actions have been taken to further improve our performance. Data drawn from the NHFD for August 2015 is shown alongside the annual results to demonstrate the impact of some of these changes.

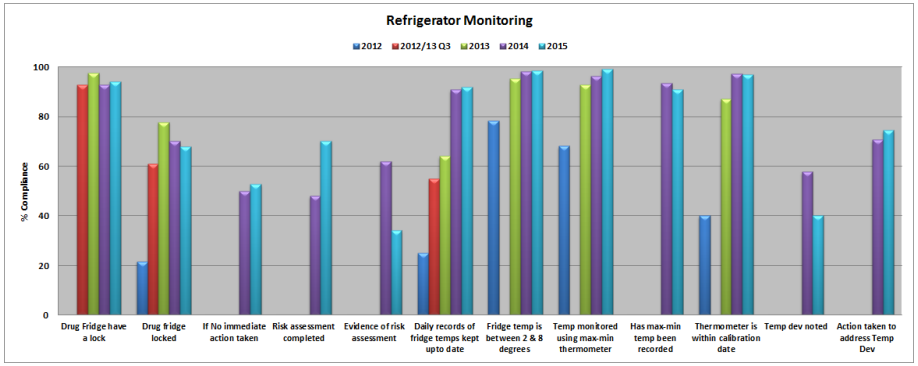
- Senior health are working with the therapy team to increase 1 day mobilisation, through dementia and pain assessment training;
- A new theatre template has been introduced to increase efficiency. As shown by the most recent results this is an area which continues to be a challenge. As it is the main reason for failure to meet the best practice tariff it is a priority area for improvement;
- There are now 2 orthogeriatricians in post and we are achieving 90-100% medical assessment rates, with 100% achieved in August 2015.
- Quarterly clinical governance presentations, using timely NHFD data to monitor performance and discuss areas of shortfall. To date this has improved AMTS scoring and BPT rates to 94.7% and 59.3% respectively.

6.Clinical Audit and Effectiveness
- Local Audits

Safe and Secure Handling of Medicines Annual Audit







This is the fourth annual audit conducted to ascertain compliance with the secure and safe storage of medicines as per the trust medicines management and controlled drugs (CD) policies. All clinical areas were asked to participate in the audit which ran from May to July 2015. Responses were received from 168/185 (90.8%) areas; higher than the previous audit conducted in 2014 for which we had 122/136 (89.7%) responses. This increase reflects the inclusion of more community areas.

When compared to the 2014 audit, there is improvement in criteria around awareness of medicine management policy and CD policy. There was a slight decline in other measures on security around keys.

Improvement is observed in storage of diagnostic reagents and flammable liquids. However, there is decline in other aspects of medicine storage including locking cupboards and medicine trolleys when compared to 2014 audit.

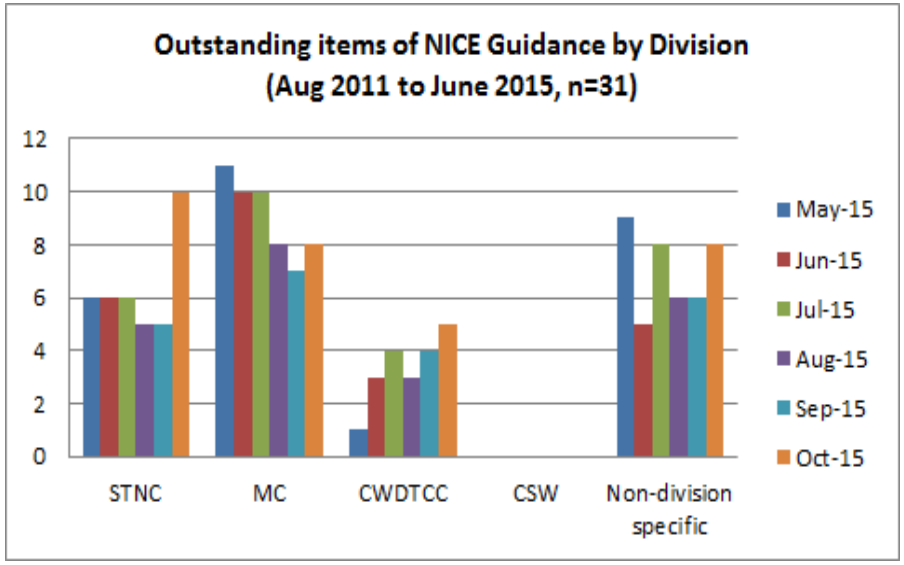
Improvement is also observed in storage of CD order/record books and in storage and access of IV fluids; sustained improvement in the locking of CD cupboard continues. There was a slight decline in 3 areas including separate CD cupboards, daily CD checks and CDs signed by two RN's compared to the 2014 audit.

Practice improved in 7 areas of refrigerator monitoring however the audit has highlighted improvements are needed to ensure, where appropriate, drug fridges are locked.

Overall the audit demonstrated some areas of improved practice over the last year and will help us to identify priorities for the coming year. The audit has also shown good engagement with an increase of 36% of areas participating in this audit compared with 2014.

This audit and action plan were discussed and agreed at Medicine Risk Management Committee in September 2015 and key headlines and action plans presented in Divisional Governance Board meetings. The findings will also be disseminated to Nursing Leads for local action planning.

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



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

Division	2010	2011	2012	2013	2014	2015
STNC (n=7)		1	2	1	3	
M+C (n=12)	2	2	4	1	3	
CWDTCC (n=15)	3	1	1	3	6	1
CSW (n=0)						
Non-division specific (n=9)		2		4	1	2

Overview

This month an increase in the number of outstanding items of guidance is reported. This is largely due to the significant amount of guidance issued in June 2015. During quarter 3 the audit team will endeavour to follow up each of the outstanding items of guidance in an effort to reduce the backlog and to ensure we make progress against our aim of developing a more complete picture of implementation. Responses from colleagues within the clinical services will be key to achieving this aim and a lack of responses will be escalated accordingly.

Audit of NICE TAs

Medicines recommended in a NICE technology appraisal (NICE TA) are automatically included in the St George's University Hospitals NHS Foundation Trust formulary in a planned manner that supports their safe and appropriate use which is relevant to local clinical practice and pathways, in accordance with the Innovation, Health and Wealth document published by the Department of Health in 2012. The drugs subject to NICE TA are automatically included in the formulary on release and can be prescribed if required. The pharmacists then contact the lead clinicians for each technology appraisal and ask them to submit an application to the Drugs and Therapeutics Committee for the drug to be officially included in the formulary and for associated prescribing protocols to be agreed.

In August 2015 a review of high cost drugs that are subject to NICE TA was performed. This project addressed the use of high cost drugs as these were identified as an initial priority area for audit; not all TAs are included in this review. The data covered the period from April 2013 to June 2015. During this period 80 drugs subject to NICE TAs were prescribed to 20,110 patients for 56 indications. The data suggests that these medications are being prescribed in accordance with NICE guidance.

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St George's University Hospitals NHS
NHS Foundation Trust

Patient Safety

Excellence in specialist and community healthcare

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

S	Q1 SIs Declared by Division (Inc. Pus)				
	Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
July	3 (1 shared)	3 (1 shared)	**0**	3 (including 1 never)	1 in Pathology
August	5 (1 shared)	4 (1 shared)	**1**	2	1 (shared)
Sept	6	3	**4**	1	0

Closed Serious Incidents (not PUs)					
Type	June	July	Aug	Sept	Movement
Total	8	9	11	8	⮟
No Harm	5	4	8	1	⮟
Harm	3	5	3	7	⮝

Table 1

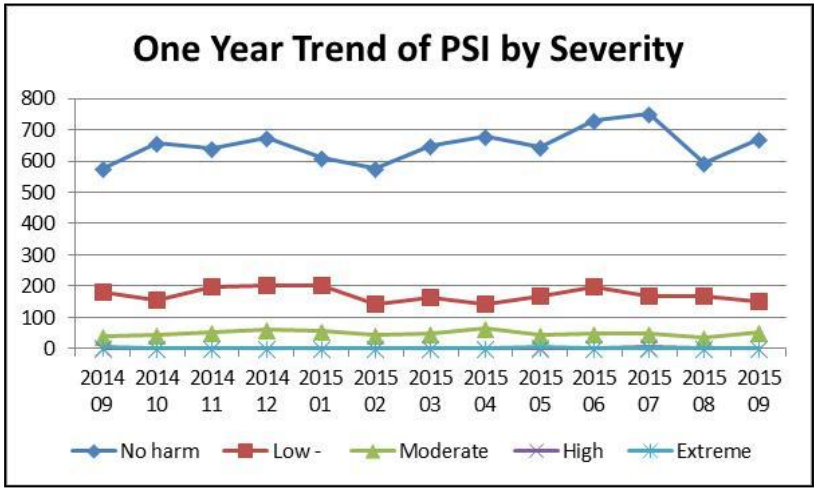
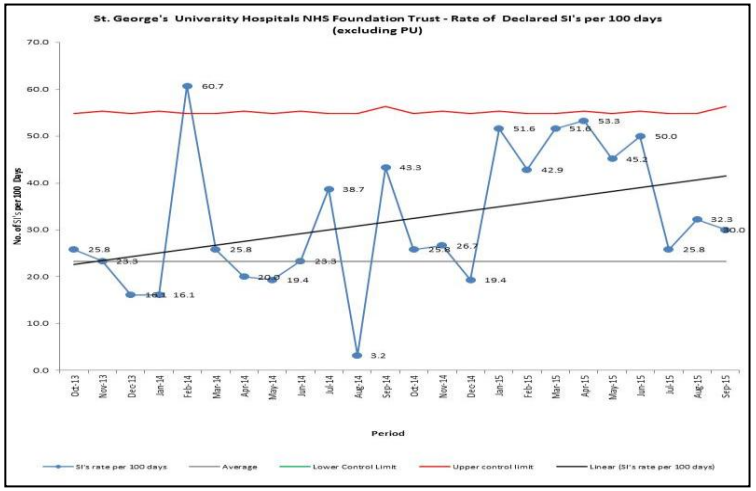


Table 2



Overview:

The numbers of general reported incidents are shown in Table 1. This trend should be observed carefully in conjunction with the trends and profile of SIs. High reporting of low or no harm incidents is generally felt to be an indication of a good reporting culture.

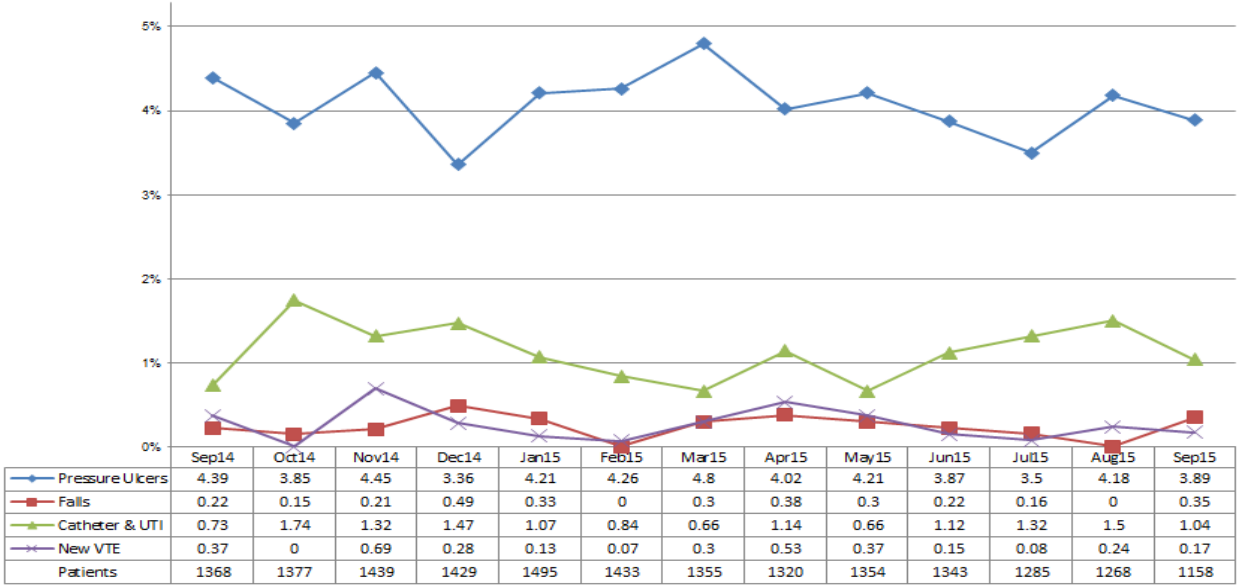
The annual trend for new serious incidents excluding pressure ulcers shown in Table 2 continues to show an increase. There were 9 general SIs reported in September(+4 pressure ulcers) and the subjects are varied.

The 9 general SIs declared in September relate to a range of issues. They include the following categories:

- Failure to act on adverse test results
- 2x Failure to follow up
- Unexpected admission to NNU
- Wrong Site Surgery
- Inappropriate/wrong treatment
- Equipment Incomplete Sterilisation
- Patient Fall
- Pulmonary Embolism (PE)

7.Patient Safety
- Safety Thermometer

% Harm Free Care							
Lead Director	July 2015	August 2015	September 2015	**Movement**	**2015/2016 Target**	**National Average September 2015**	**Date expected to meet standard**
J Hall	95.25%	94.40%	94.82%	↑	95.00%	94.31%	March 16



	Sep14	Oct14	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15
Pressure Ulcers	4.39	3.85	4.45	3.36	4.21	4.26	4.8	4.02	4.21	3.87	3.5	4.18	3.89
Falls	0.22	0.15	0.21	0.49	0.33	0	0.3	0.38	0.3	0.22	0.16	0	0.35
Catheter & UTI	0.73	1.74	1.32	1.47	1.07	0.84	0.66	1.14	0.66	1.12	1.32	1.5	1.04
New VTE	0.37	0	0.69	0.28	0.13	0.07	0.3	0.53	0.37	0.15	0.08	0.24	0.17
Patients	1368	1377	1439	1429	1495	1433	1355	1320	1354	1343	1285	1268	1158

Pressure ulcers (45)

- 19 grade 2 (1 new, 18 old)
- 23 grade 3 (4 new, 19 old)
- 3 grade 4 (1 new*, 2 old)

CAUTI (12)

- 6 new
- 6 old

Falls (4)

- 4 low harm falls

VTE (2)

- 2 new DVTs

In September 2015 the proportion of our patients that received harm free care was 94.82%. We are maintaining a consistent performance; our mean rate over the last 13 months is 94.57%, just above the national mean of 94%.

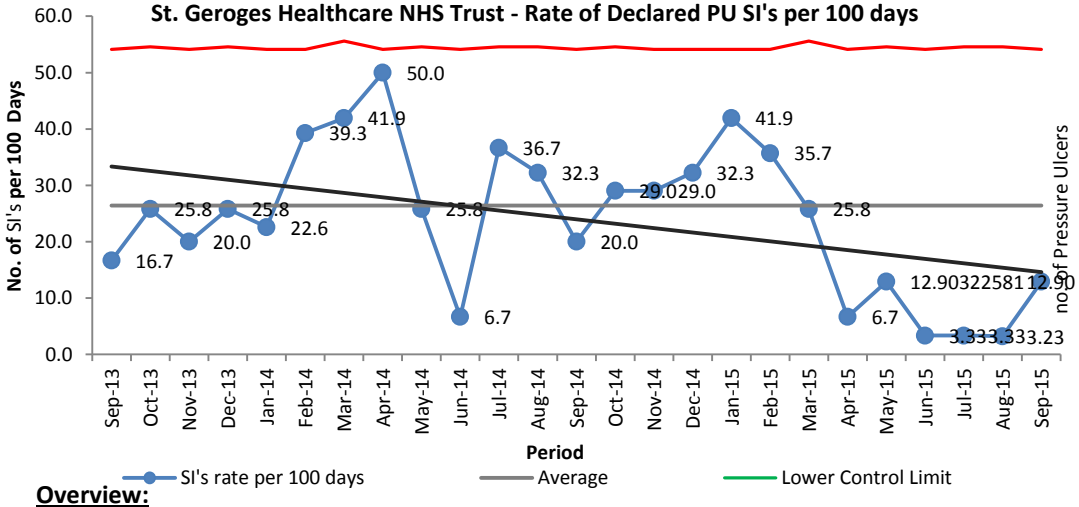
It should be noted that this month some corrections to the data were received after the submission deadline. For example, a number of low harm falls were reported in error and a grade 4 pressure ulcer was recorded incorrectly as a new harm*. We will resubmit data in October to retrospectively correct these errors. These amendments will lead to a slight improvement in the overall level of harm, and a more accurate picture of incidence.

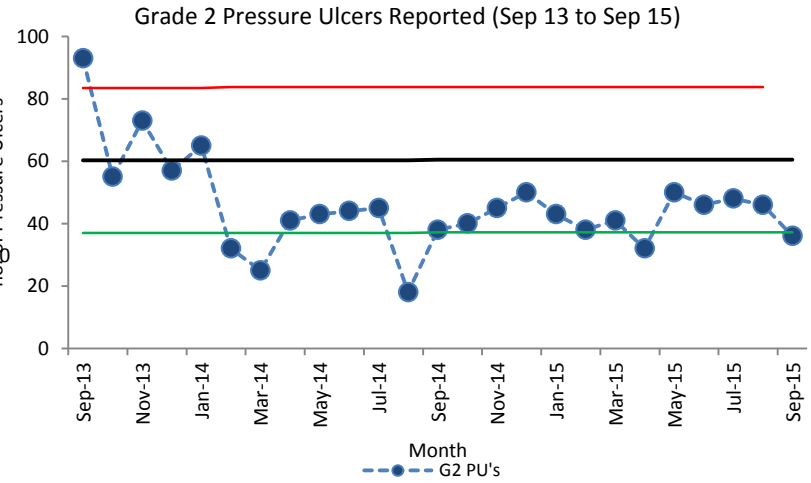
The data as it stands shows we reported 63 harms to 60 patients; 57 patients experienced one harm and 3 patients had 2 harms. It is encouraging to note that both CAUTI's and PUs fell this month.

7. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers										
Type	May	Jun	Jul	Aug	Sep	YTD April – May 2016	Movement	2015/2016 Target	Forecast March 2015	Date expected to meet standard
Acute	4	1	1	0	2	**9**			G	-
Community	0	0	0	1	2	**4**			G	-
Total All	4	1	1	1	4	**13**			G	-
Total Avoidable	**4**	**1**	1	1	4	**13**		40		-

Grade 2 Pressure Ulcers						
May	Jun	Jul	Aug	Sep	Movement
37	28	25	23	21	
17	18	23	23	15	
50	46	48	46	36	





Overview:

September saw an increase in the number of declared Pressure Ulcer Serious Incidents, with two in both the acute and community sectors. There was a reduction in the number of Grade 2 pressure ulcers seen in both areas, it is hoped that this will be reflected in future months with reductions in the number of serious incidents.

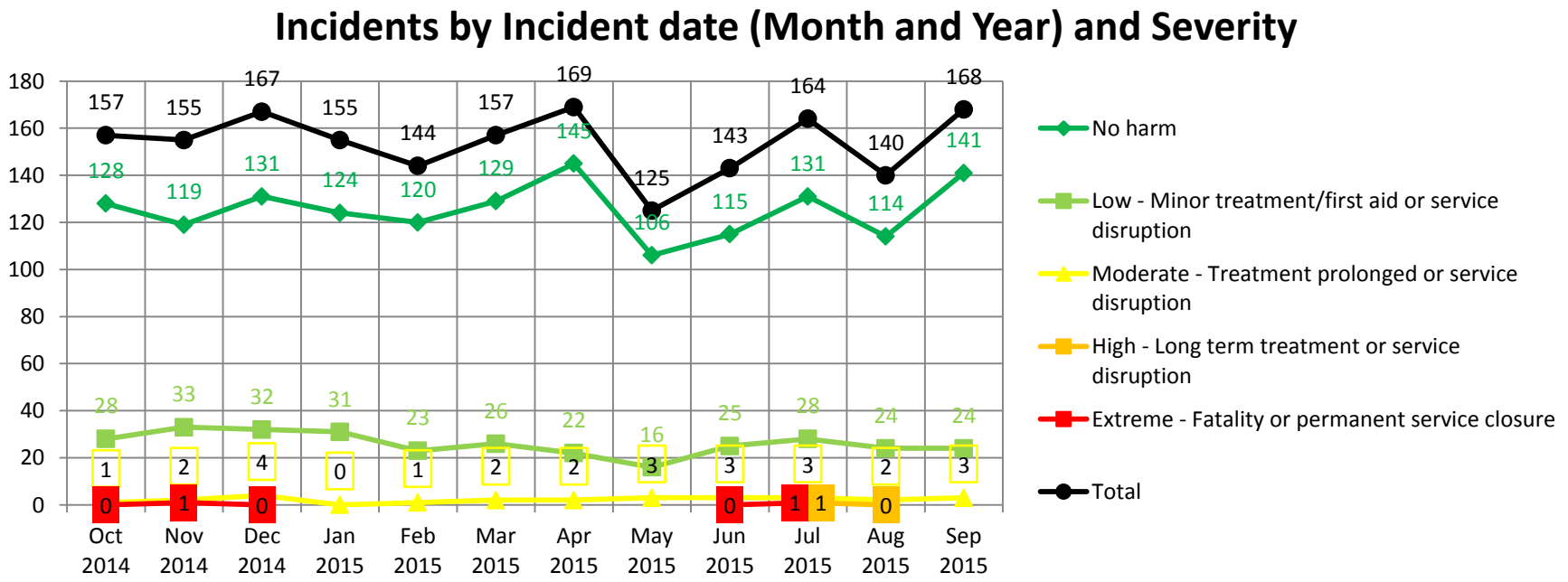
Actions:

- Vacancies in acute and community TVN services remain unfilled , despite active recruitment due to unsuitable applicants
- Review of service provision underway to provide greater integration of services across acute and community. Potential rotation of Band 6 nurses to rotate between areas, this will lead to better continuity of care for service users as well as having a positive impact on the service.
- Planning for the roll-out of the IHI Improvement work trust wide to aid in the reduction of Pressure Ulcers.
- Re-Submission of the Pressure Mattress business case to BCAG, switching to a modern system could improve patient safety as well as delivering significant savings.
- Final mattress trial underway to aid the trust in deciding on which mattress system will provide the best potential benefits.

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

Falls													
Lead Director	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	March 15	April 15	May 15	June 15	July 15	August 15	Sept 15	Movement
	157	154	169	154	144	157	165	126	144	163	140	168	

Falls with Harm April 2014- to date				
No Harm	Moderate	Severe	Death	Falls related Fractures
2510	32	3	0	7



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 on the head injury unit and across the medical wards. **Actions:** Results from bed rails audit to be shared across all areas with action plan to raise awareness of safe use of bed rails. Post fall protocol audit data collection to commence November 2015. Roll out of NICE compliant multifactorial falls risk assessment and integration of this document into the ED.

7. Patient Safety
- Infection Control

MRSA						
Lead Director	August	September	Movement	2015/2016 Threshold	Forecast October- 15	Date expected to meet standard
JH	0	2	▲	0	G	-

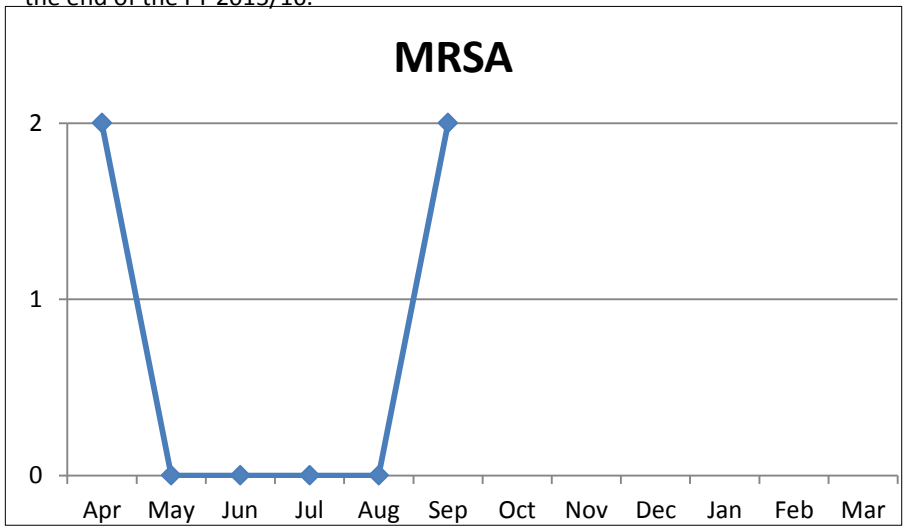
Peer Performance – YTD September 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	2	1	0	2

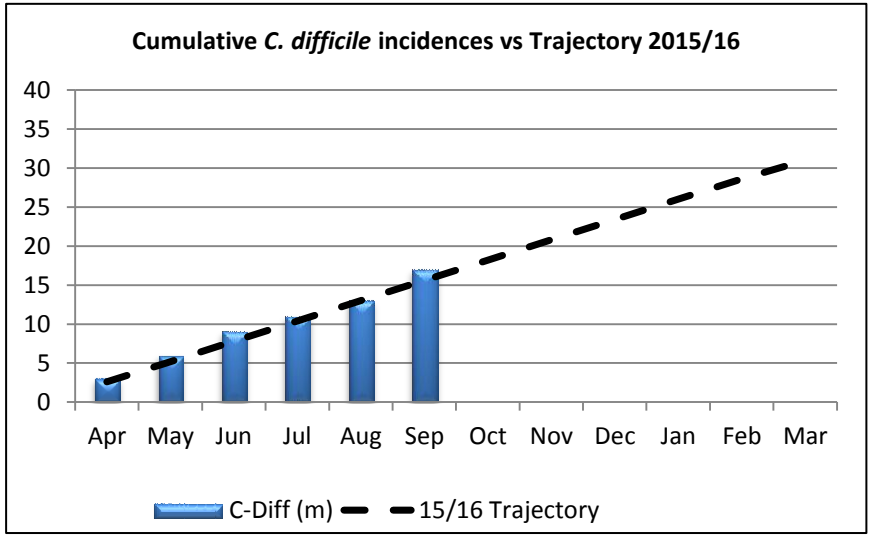
C. difficile						
Lead Director	August	September	Movement	2015/2016 Threshold	Forecast October- 15	Date expected to meet standard
JH	2	4	▲	31	G	-

Peer Performance – YTD September 2015 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
17 (31)	13(16)	12(9)	47(72)	15(39)

The MRSA bacteraemia threshold is zero. The previous scorecard reported one episode of bacteraemia in August. This was in fact an episode in early September. There has been one further episode of bacteraemia in September i.e two in total for that month. The scorecard and charts have been corrected to reflect this. The episode in early September is under arbitration and may subsequently be removed from the Trust's numbers. The Trust is non-compliant , with 4 incidents in total.

In 2015/16 the Trust has a threshold of no more than 31 *C. difficile* incidents. In August there were 2 episodes of *C. difficile* infection and 4 in September, a total of 17 for the FY to end September. This means that the Trust is currently one episode above the trajectory for the end of September, but can sill achieve the target at the end of the FY 2015/16.





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	Oct	Nov	Dec	Jan (2015)	Feb	Mar	April	May	June	July	August	Sept
Unify2	94.91%	93.18%	93.51%	95.94%	96.03%	96.27%	96.64%	96.45%	96.75%	96.56%	96.78%	

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	Oct	Nov	Dec	Jan (2015)	Feb	Mar	April	May	June	July	August	Sept
Safety Thermometer (SGH)	85.39%	86.56%	75.92%	79.08%	83.89%	85.74%	89.83%	90.19%	95.14%	94.84%	92.38%	91.28%
National average	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:

- The VTE risk assessment prompt in iClip has been developed further to allow the clinician to complete the VTE risk assessment form directly from a link attached to the alert. The activation of the 24 hour risk assessment task has been linked to the completion of the 'on admission' assessment task; clinicians will not be able to complete this second assessment until the patient has been admitted for a minimum of 18 hours; preventing both assessments being signed off at the same time. It is hoped that these changes will make it easier for clinicians using iClip to carry out VTE risk assessments and prescribe prophylaxis; and ensure reassessment is taking place at appropriate time intervals. 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. This report is being developed to provide positive feedback to clinical areas and individual staff members who demonstrate good practice in risk assessing patients for VTE.

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

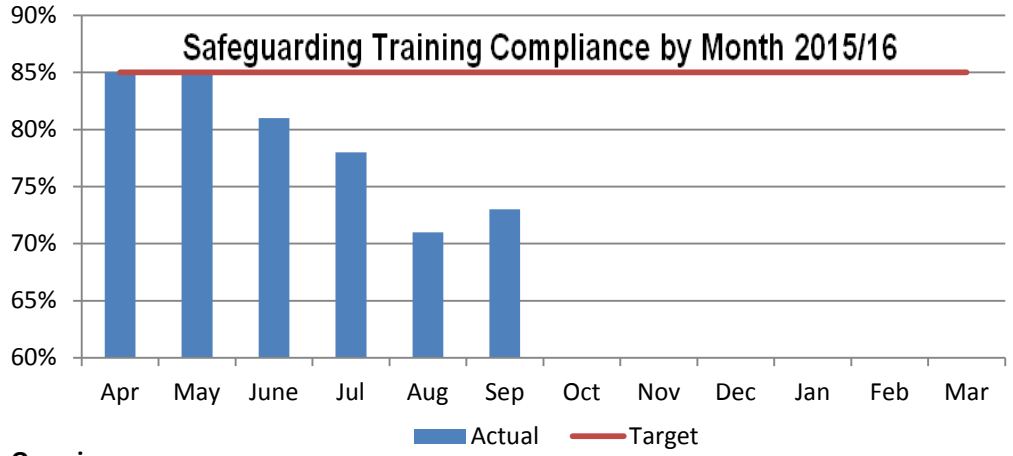
Year		2015
HAT cases identified to date (attributable to admission at SGH)		151
Mortality rate	Total	12.6% (19/151)
	VTE primary cause of death	4.6% (7/151)
Initiation of RCA process		90.1% (136/151)
RCA pending	<28 days since notification	5
	>28 days since notification (notes requested)	15
RCA complete		73.5% (111/151)

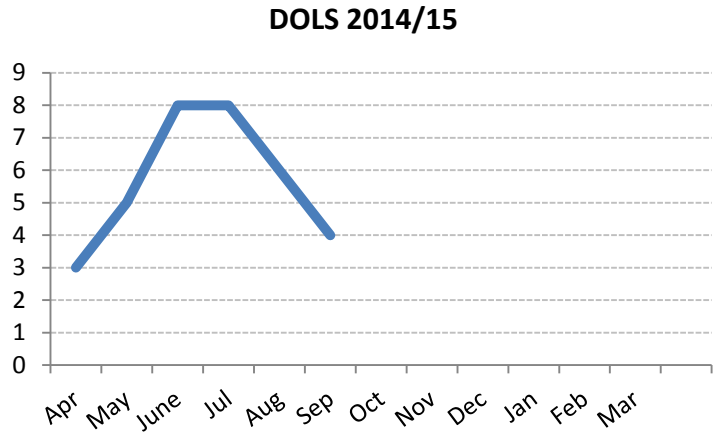
HAT case finding has significantly improved since the start of 2015 resulting in an observed increase in frequency of HAT. This increase brings incidence of HAT at SGH in line with rates observed at other Trusts in London that are of a similar size and status.

7. Patient Safety
- Safeguarding: Adults

Safeguarding Training Compliance - Adults									
Lead Director	April	May	June	July	Aug	Sep	2015/20165 Target	Forecast April 2016	Date expected to meet standard
JH	85%	85%	81%	78%	71%	73%	85%	A	-

Safeguarding Adults Training Compliance by Division – Aug 15				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
68%	72%	81%	77%	69%





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, Aug 60, Sep 91

DOLS: 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

Safeguarding Children Level 3 training Organisation Compliance

30-Sep-15

200 Children and Women's Diagnostic and Therapy Services Division	Amt. Completions	Required Training	Compliant (%)
	494	625	79%
200 Community Services Division	Amt. Completions	Required Training	Compliant (%)
	104	122	85%
200 Corporate Division	Amt. Completions	Required Training	Compliant (%)
	4	4	100%
200 Medicine and Cardiovascular Division	Amt. Completions	Required Training	Compliant (%)
	109	197	55%
200 Surgery & Neurosciences Division	Amt. Completions	Required Training	Compliant (%)
	5	13	38%
Overall for the Trust	**716**	**961**	**74.5%**

Training : The training data on ARIS remains slightly inaccurate, however the safeguarding team continue to check the data and are undertaking a data cleansing exercise quarterly to try to ensure the data is as accurate as possible. It should be noted that new staff are classed as non compliant immediately they join the trust and are dependant on being released for training, staff turnover has an impact on compliance levels, however regular advertising of safeguarding training in EG as well as targeting individuals has resulted in increased numbers attending this month.

Serious Case Reviews and Internal Management Reviews: No new SCR's have been declared this month.

Other: The Wandsworth Safeguarding Children Board held their annual conference on October 8th on Child Sexual Exploitation, the conference was well attended by a number of Multi-agency partners including a number of staff from St George's safeguarding team who will be able to cascade this learning through level 3 training. From 3Ist October 2015 all regulated health professionals i.e. nurses, doctors etc. have a duty under the Serious Crime Act 2015 to report any 'known' cases of FGM – i.e. either by visual identification or disclosure in under 18yrs,to the police. This is a mandatory reporting requirement.

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Patient Experience

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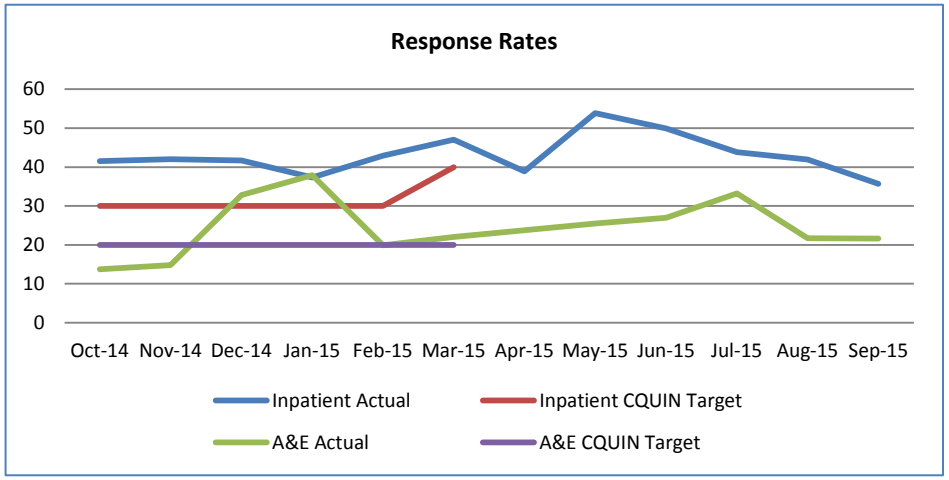
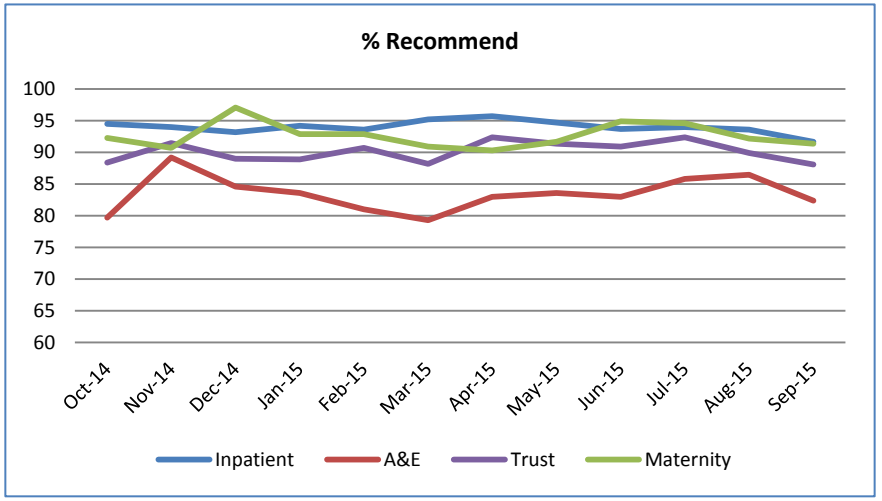
8. Patient Experience
- Friends and Family Test

FFT Response Rate							
Domain	Jul-15	Aug-15	Sep-15	Movement	2015/2016 Target	Forecast	Date expected to meet standard
Trust	37.9	27.4	26.9	⮟	-	-	-
Inpatient	43.8	41.9	35.7	⮟	-	-	-
A&E	33.2	21.7	21.6	⮟	-	-	-
Maternity	21.7	N/A	N/A		-	-	-

	FFT Response Score			
	Jul-15	Aug-15	Sep-15	Movement
	92.4	89.9	88.1	⮟
	94	93.6	91.7	⮟
	85.8	86.5	82.4	⮟
	94.6	92.2	91.4	⮟





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
- Triangulation of FFT, Complaints and PALS data

	Complaint	PALS	FFT	FFT responses
(CW) Childrens Directorate	3	15	96.5%	143
(CW) Diagnostics Clinical Directorate	2	2	No data	0
(CW) Therapeutics Clinical Directorate	9	38	52.9%	85
(CW) Womens Directorate	5	28	89.5%	239
(MC) Accident and Emergency Directorate	7	6	82.4%	1462
(MC) Acute Medicine Clinical Directorate	9	7	89.7%	117
(MC) Cardiovascular Clinical Directorate	7	16	95.9%	246
(MC) Renal, Haematology, Palliative Care & Oncology Directorate		3	93.0%	200
(MC) Specialist Medicine Clinical Directorate	9	24	100.0%	19
(SN) Neurosciences Clinical Directorate	6	29	96.6%	237
(SN) Surgery Clinical Directorate (inc. Trauma and Orthopaedics)	12	92	83.9%	461
(SN) Theatres Clinical Directorate	3		100.0%	18
Community Services	5	12	TBC	TBC
Corporate Directorates	11	22	N/A	N/A
External Organisations		10	N/A	N/A
Grand Total	88	304	89.1%	3227

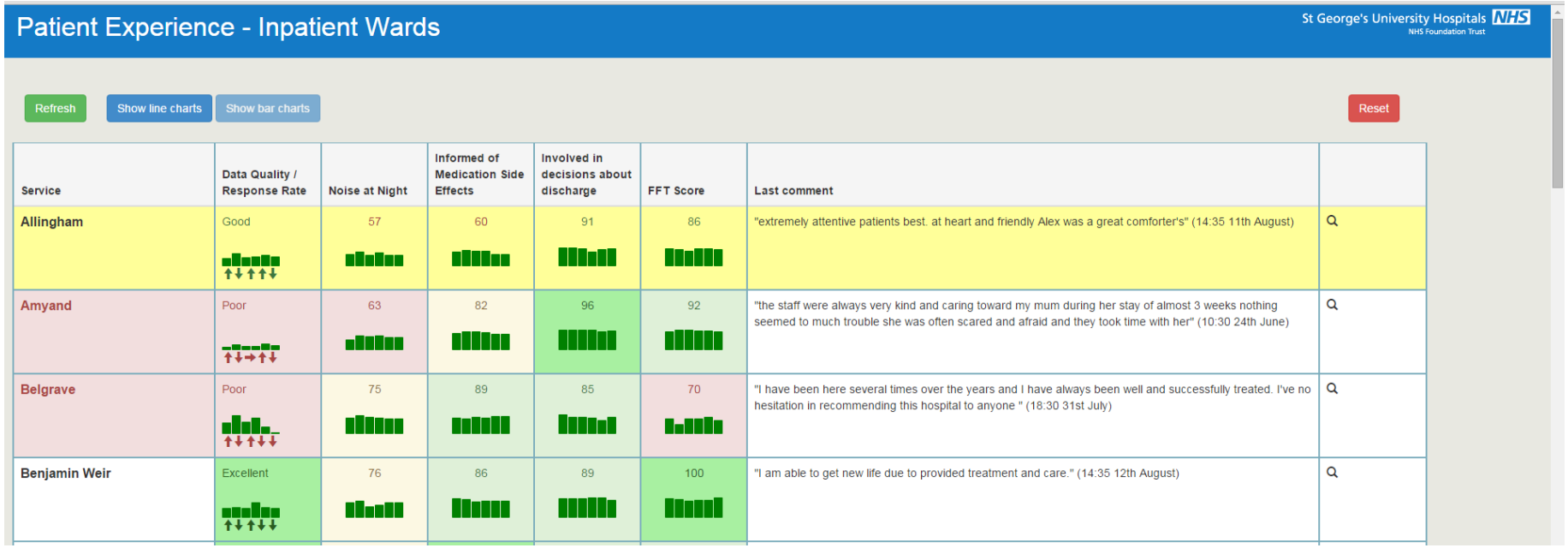
Triangulation of Patient Experience Data

Notes on the data:

This report only shows directorates that have received a complaint or PALS concern in September 2015.
Not all services are represented, due to the way that we record patient survey data (on RaTE) and PALS/Complaints data (on Datix). We are working to merge the datasets, and the accuracy of these reports will improve once this is complete.

8. Patient Experience
- New Patient Experience Reports

A detailed overview of the entire survey, 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). 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
NHS Foundation Trust

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)	

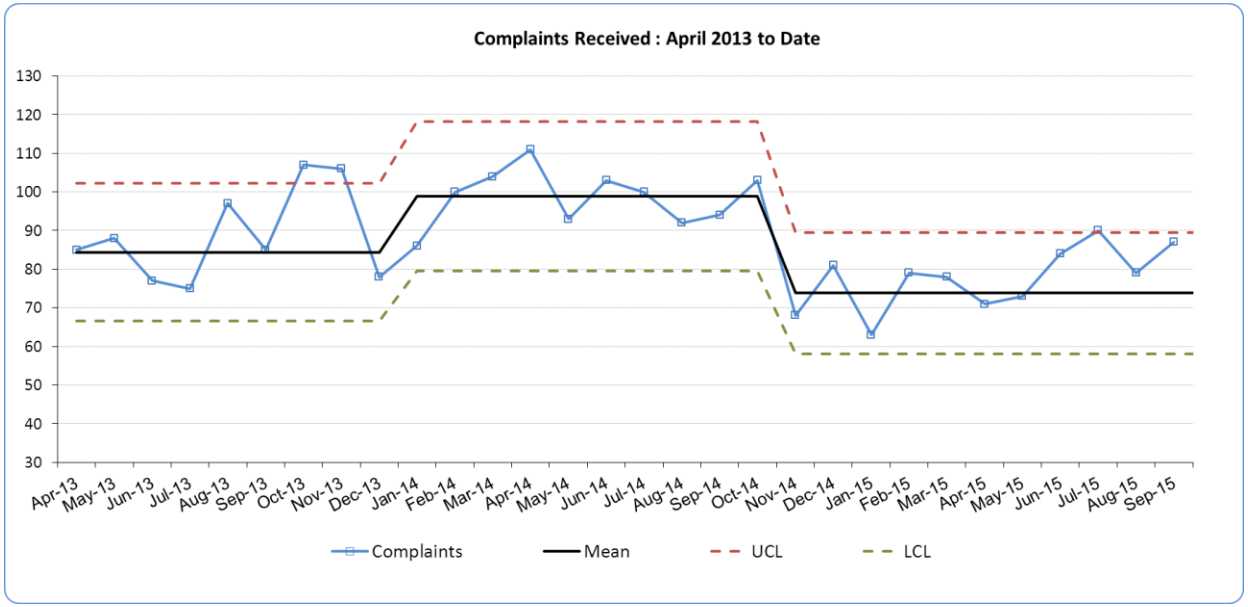
A breakdown of a service's scores, explaining what their patients are telling them.

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										
	Jan	Feb	March	April	May	June	July	Aug	Sept	Movement
Total Number received	63	79	78	71	72	84	90	79	87	▲



Overview:

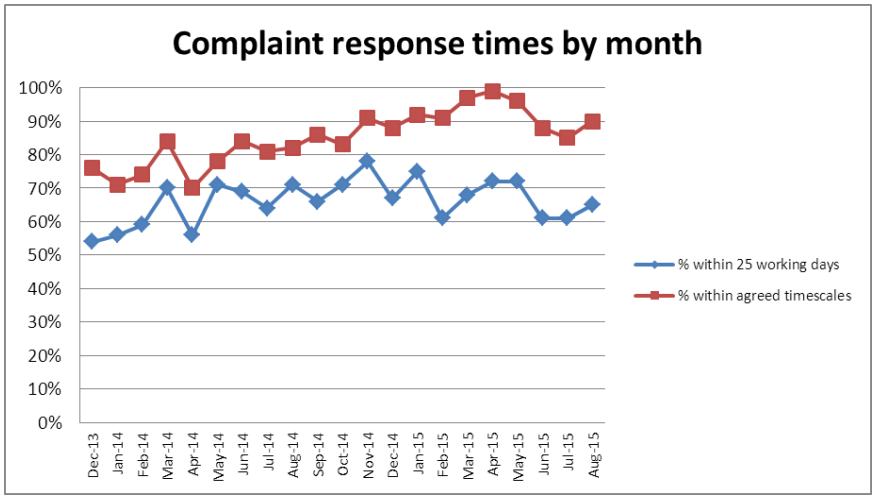
This report provides a brief update on complaints received since the last board report (so in September 2015) and information on responding to complaints within the specified timeframes for complaints received in August of 2015/2016. It also includes some posts made on NHS Choices and Patient Opinion. The board will receive more detailed information about complaints received in quarter 2 with divisional breakdowns, analysis of the data to provide trends and themes with actions planned and a severity rating report and once the target date for complaints received in quarter 2 is reached (so December 2015).

Total numbers of complaints received in September 2015

There were 87 complaints received in September of 2015, an increase when compared to August when 79 complaints were received. It was reported to the October board that 87 complaints were received in August but since then 8 complaints were deescalated or withdrawn. The biggest increases were for the Gastroenterology Speciality (from 0 to 4) with 2 complaints about delay in diagnosis, Estates and Facilities (from 3 to 9) with 3 of these being about being unable to find a parking space and Trauma and Orthopaedics (from 3 to 6), with three about clinical treatment. The biggest reductions were for Gynaecology (from 9 to 2), Adult Services (from 7 to 2) and Accident and Emergency (from 11 to 7)

8. Patient Experience
- Complaints Performance against targets

Performance Against Targets August 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	24	16	67%	(5) 88%
Medicine and Cardiovascular	24	13	54%	(6) 79%
Surgery & Neurosciences	15	8	53%	(6) 93%
Community Services	11	10	91%	(1) 100%
Corporate Directorates	5	4	80%	(1) 100%
Totals:	79	51	65%	(20) 90%



Commentary:

There was a slight improvement in performance for the trust overall when compared to July with 65% of complaints being responded to within 25 working days (against the internal trust target of 85%) compared to 62% in July and 90% within agreed timescales (against the internal trust target of 100%) compared to 85% in July.

As reported to the October Board, the poor performing divisions all have actions in place to improve response times but these have not been successful thus far except for in the Surgery and Neurosciences Division where there has been an improvement on the second target to 93%.

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.

Bella gave St George's Hospital (London) a rating of 5 stars
Give A Shout Out To All At Security!
We handed in a lost wallet to security and they sent a special mention to our school. They bought us milkshakes from M&S and even offered if we were hungry!! These people make St George's a happy place! Say 'hi' when you walk by, from Gabi and Bella.

Visited in September 2015. Posted on 18 September 2015

Anonymous **gave** Gynaecology at St George's Hospital (London) a rating of 5 stars
very good patients care
I suffered a miscarriage and I had a surgical procedure (SMM) at the day surgery unit on 30/9/15 .

I was very anxious and tearful but the registrar was so kind and reassuring that they made this sad circumstance a bit more bearable for me. I am so grateful and I will always remember their kindness and empathy when they came to talk to me after I woke up.

Same for the anaesthesist who reassured me about my fears of being put to sleep and not being able to wake up. They explained me what was going to happen and helped me to overcome my fears. I am sorry I didn't get the chance to thank them afterwards.

Also, all the nurses in recovery were very caring and professional and took care of all patients needs even if we were there for a short time.

I hope you will pass my feedback to them as they deserve to know they are doing a great job, even though I am sure they already know! Thank you all.

Visited in September 2015. Posted on 02 October 2015

Anonymous gave Cardiology at St George's Hospital (London) a rating of 1 stars
telephone incompetence
I called cardiology on the tel no listed on the website, got a voicemail, which put me through to another voicemail, then the operator who put me back to the original voicemail.

I did not have hypertension before I called, but I do now. What a useless system.

Visited in September 2015. Posted on 28 September 2015

Heather Gale gave Queen Mary Hospital a rating of 2 stars
Visiting friend who is a patient - what a depressing place!
I visited a friend yesterday who has had a stroke and is a patient in the hospital. Certainly on a Sunday it is such a depressing place. No one on reception to ask where to go. Many people looked like they had been wheeled into the Wolfson centre, dumped in front of the TV and left. No interaction, like a bad old peoples home.

And the look she received from a nurse when she asked to go to the loo!

After visiting the ward went to take my friend in her wheel chair out for fresh air, had trouble getting off ward as the door didn't open when I pressed the buzzer, but the nurse just sat and watched me struggle to open the door, move the wheel chair and fix the foot rest that had not been locked in place.

This can not help in their recovery!

Visited in October 2015. Posted on 19 October 2015

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Workforce

Excellence in specialist and community healthcare

9. Workforce: September 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 September 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 September the trust achieved an average fill rate of 94.60%, a slight increase from 93.97% submitted in August.

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

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:

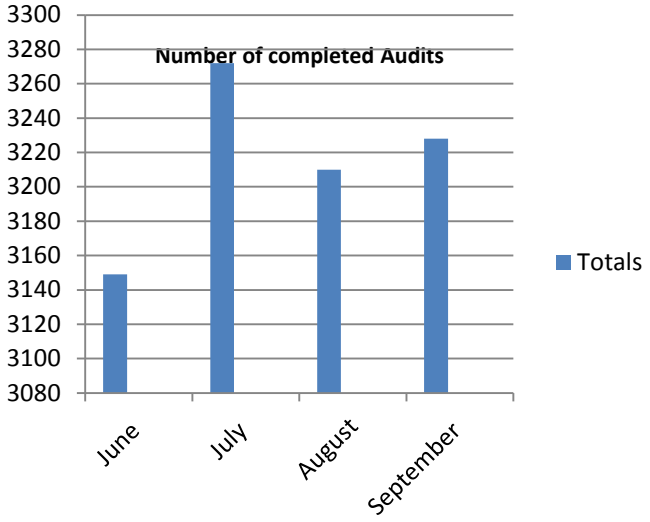
- Nurses, midwives and care staff work as part of a wider multidisciplinary ward team. The demand on wards can change quickly and it will always be a clinical judgement as to whether to bring more staff in or reduce the amount the staff as per requirement.
- The data does not take into account the on-going 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.

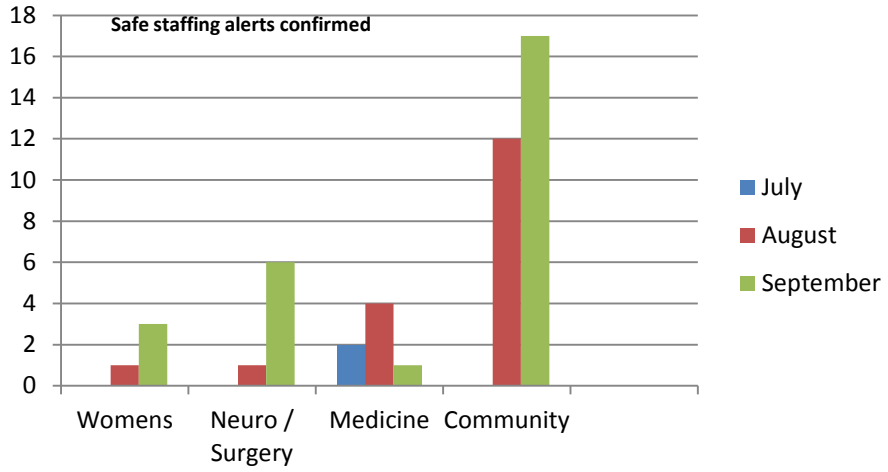
Actions

- The Deputy Chief Nurse has set up a task force to review the way UNIFY data is collected, validated and reported. There remain anomalies in the system that need to be fixed.
- A new group reorganising safe staffing is to be commenced in November / December which will also look into UNIFY reporting
- Midwifery areas are adding exact finishing times to each shift which results in % over 100

	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	93.7%	100.0%	97.5%	100.0%
Carmen Suite	128.5%	82.4%	98.3%	93.3%
Champneys Ward	90.9%	95.8%	95.1%	100.0%
Delivery Suite	106.0%	87.6%	108.1%	98.2%
Fred Hewitt Ward	87.5%	104.1%	98.5%	100.0%
General Intensive Care Unit	94.2%	100.0%	97.0%	100.0%
Gwillim Ward	127.8%	89.5%	98.4%	93.3%
Jungle Ward	99.4%	#DIV/0!	#DIV/0!	#DIV/0!
Neo Natal Unit	92.4%	#DIV/0!	96.7%	#DIV/0!
Neuro Intensive Care Unit	91.1%	96.7%	98.0%	90.2%
Nicholls Ward	89.5%	93.7%	97.9%	96.8%
Paediatric Intensive Care Unit	109.6%	97.0%	110.5%	100.0%
Pinckney Ward	105.1%	83.9%	94.7%	76.7%
Dalby Ward	102.3%	102.2%	102.4%	99.2%
Heberden	96.8%	100.9%	100.0%	100.0%
Mary Seacole Ward	90.0%	99.6%	98.3%	98.8%
A & E Department	95.2%	72.7%	93.3%	75.1%
Allingham Ward	90.2%	114.0%	98.5%	100.0%
Amyand Ward	85.5%	100.8%	98.8%	98.7%
Belgrave Ward AMW	85.9%	82.5%	98.2%	93.3%
Benjamin Weir Ward AMW	81.1%	76.1%	96.0%	97.9%
Buckland Ward	90.9%	91.4%	99.5%	96.7%
Caroline Ward	84.0%	90.8%	97.7%	97.7%
Cheselden Ward	93.5%	92.7%	98.9%	99.7%
Coronary Care Unit	1018%	#DIV/0!	99.4%	#DIV/0!
James Hope Ward	88.4%	47.3%	97.5%	#DIV/0!
Marnham Ward	84.2%	83.6%	96.3%	94.1%
McEntee Ward	91.9%	97.4%	98.9%	100.0%
Richmond Ward	87.8%	91.6%	95.3%	93.1%
Rodney Smith Med Ward	95.8%	97.0%	99.0%	98.3%
Ruth Myles Ward	98.2%	100.2%	100.0%	33.3%
Trevor Howell Ward	98.3%	97.3%	99.6%	100.0%
Winter Ward (Caesar Hawkins)	74.0%	91.4%	98.6%	97.2%
Brodie Ward	94.5%	99.8%	99.9%	100.0%
Cavell Surg Ward	83.7%	89.7%	99.3%	95.6%
Florence Nightingale Ward	88.0%	81.5%	99.2%	100.0%
Gray Ward	90.4%	78.0%	98.7%	92.9%
Gunning Ward	88.6%	91.4%	99.3%	97.9%
Gwynne Holford Ward	89.9%	85.2%	96.4%	93.4%
Holdsworth Ward	89.8%	89.0%	98.9%	96.8%
Keate Ward	89.4%	98.8%	97.2%	97.7%
Kent Ward	93.2%	91.7%	98.6%	98.2%
Mckissock Ward	91.1%	95.3%	97.4%	99.2%
Vernon Ward	89.9%	93.9%	99.5%	96.7%
William Drummond HASU	86.0%	88.7%	95.0%	95.1%
Wolfson Centre	89.7%	92.2%	100.0%	100.0%
Gordon Smith Ward	90.5%	96.0%	100.0%	100.0%
Brodie Stroke Ward	87.4%	73.0%	87.8%	90.0%
Trust Total	92.81%	9126%	98.03%	95.75%
	Day Qual	Day HCA	Night Qual	Night HCA
	92.81%	9126%	98.03%	95.75%

9. Workforce
September 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: July 3149, August 3210 and September 3228. There was a significant increase in the number of final alerts reported from 12 in August to 27 in September 2015. The number of alerts relate to one community service which is unable to provide planned care due to reduced staffing and disruption during service redesign. The HON and Matron for the area have a plan is in place. The number of alerts reduced to a concern (ward is safely staffed but some care needs will not be completed) has remained increased slightly reduced in September following on the day investigation (July 17, August 24, September 14).

7 nursing related safe staffing concerns were raised on Datix system in September compared to 13 in August. Only one of the alerts and none of the concerns matched a similar entry on the RATE system.

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

Risk: There are some areas that may not be raising alerts: the reporting process for safe staffing will be reviewed as part of the workforce programme. This should commence in November

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Heatmap Dashboard
Ward view

Excellence in specialist and community healthcare

10. Ward heatmap

Division	Ward	INCIDENCE OF C.DIFFICILE	INCIDENCE OF MRSA	TRUST ACQUIRED PRESSURE ULCERS	PERCENTAGE OF HARM FREE CARE	PATIENT SATISFACTION (FRIENDS & FAMILY)	FRIENDS & FAMILY RESPONSE RATE	FFT RECOMMENDED	WARD STAFFING: UNFILLED DUTY HOURS	FALLS (WARD LEVEL)	SERIOUS INCIDENTS (WARD LEVEL)	SICKNESS/ ABSENCE RATE - (WARD)
COMMUNITY SERVICES	MARY SEACOLE	0.0	0.0	1.0	84.6	100.0	69.7	87.0	3.7	5.0	1.0	8.6
MEDICINE	ALLINGHAM	1.0	0.0	0.0	92.9	87.5	42.9	87.5	1.5	4.0	0.0	12.5
	AMYAND	0.0	0.0	0.0	87.5	100.0	3.0	100.0	6.0	5.0	0.0	6.2
	BELGRAVE	0.0	0.0	0.0	100.0	95.3	59.3	95.3	10.6	11.0	0.0	2.3
	BENJAMIN WEIR	0.0	0.0	0.0	100.0	100.0	35.6	100.0	13.5	1.0	0.0	2.4
	BUCKLAND	0.0	0.0	0.0	89.5	96.8	77.5	96.8	6.1	0.0	0.0	3.2
	CAESAR HAWKINS	0.0	0.0	1.0	91.3	100.0	3.6	100.0	13.3	8.0	1.0	18.1
	CARDIAC CARE UNIT	0.0	0.0	0.0	100.0	90.0	71.4	90.0	-0.6	1.0	0.0	3.1
	CAROLINE	0.0	1.0	0.0	95.2	93.5	53.1	94.2	9.6	2.0	0.0	3.5
	CHESELDEN	0.0	0.0	2.0	86.4	95.0	25.0	95.0	4.5	1.0	2.0	7.1
	DALBY	0.0	0.0	0.0	85.0	88.9	52.9	88.9	-1.5	8.0	0.0	3.4
	EMERGENCY DEPARTMENT	0.0	0.0	0.0					9.5	8.0	2.0	4.6
	GORDON SMITH	0.0	0.0	0.0	94.4	100.0	24.6	100.0		2.0	0.0	3.3
	HEBERDEN	1.0	0.0	0.0	80.0	100.0	14.3	100.0	0.6	4.0	0.0	4.4
	JAMES HOPE	0.0	0.0	0.0	100.0	100.0	12.5	100.0	15.5	2.0	0.0	2.2
	MARNHAM	0.0	0.0	0.0	96.4	82.4	29.5	83.3	11.0	1.0	0.0	8.3
	MCENTEE	0.0	0.0	1.0	94.4	100.0	41.3	100.0	3.9	0.0	0.0	1.6
	RICHMOND	0.0	1.0	0.0	98.3	97.4	15.9	97.4	8.3	12.0	0.0	12.7
	RODNEY SMITH	0.0	0.0	0.0	89.3	66.7	23.1	66.7	2.7	18.0	0.0	3.0
	RUTH MYLES DAY UNIT	0.0	0.0	0.0	100.0	100.0	92.3	100.0	1.7	0.0	0.0	1.1
	TREVOR HOWELL	0.0	0.0	0.0	100.0	95.6	69.2	95.6	1.3	4.0	1.0	4.8
SURGERY	BRODIE NEURO	0.0	0.0	0.0	93.3	100.0	90.3	100.0	2.2	0.0	1.0	2.7
	CAVELL	0.0	0.0	0.0	100.0	38.4	40.2	38.4	9.8	4.0	0.0	2.7
	FLORENCE NIGHTINGALE	0.0	0.0	0.0	86.4	98.4	86.8	97.7	9.5	4.0	0.0	8.0
	GRAY WARD	0.0	0.0	0.0	100.0	98.4	78.4	95.9	9.7	3.0	0.0	4.5
	GUNNING	0.0	0.0	0.0	96.4	86.4	38.6	86.4	7.2	7.0	0.0	1.5
	GWYN HOLFORD	0.0	0.0	0.0	100.0	100.0	44.4	100.0	10.0	4.0	0.0	6.2
	HOLDSWORTH	0.0	0.0	0.0	100.0	100.0	51.1	95.7	6.9	0.0	0.0	1.5
	KEATE	0.0	0.0	0.0	100.0	91.2	67.9	91.2	6.1	0.0	0.0	1.3
	KENT	0.0	0.0	0.0	93.5	92.6	52.0	92.3	5.1	12.0	0.0	2.5
	MCKISSOCK	0.0	0.0	0.0	92.0	93.2	68.8	93.2	5.5	3.0	0.0	7.4
	VERNON	0.0	0.0	0.0	93.5	92.3	31.0	92.3	6.0	3.0	0.0	9.6
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	100.0	100.0	38.7	100.0	9.4	3.0	0.0	2.3
WOMEN & CHILDREN	CARDIOTHORACIC INTENSIV..	0.0	0.0	0.0	100.0		0.0		4.3	0.0	0.0	3.9
	CARMEN SUITE	0.0	0.0	0.0	100.0				-6.4	0.0	0.0	0.0
	CHAMPNEYS	0.0	0.0	0.0	100.0	91.1	39.5	91.1	6.0	0.0	0.0	3.9
	DELIVERY	0.0	0.0	0.0	100.0	92.3			-4.6	0.0	1.0	4.4
	FREDDIE HEWITT	0.0	0.0	0.0		100.0	54.3	96.5	6.5	1.0	0.0	13.2
	GENERAL ICU/HDU	0.0	0.0	0.0			20.0	100.0	4.4	0.0	0.0	5.1
	GWILLIM	0.0	0.0	0.0	100.0	88.3			-7.1	0.0	0.0	12.8
	JUNGLE	0.0	0.0	0.0		100.0	17.4	100.0	0.6	0.0	0.0	0.3
	NEONATAL ICU	0.0	0.0	0.0	100.0		0.0		5.5	0.0	0.0	5.4
	NEURO ICU	0.0	0.0	0.0	92.9			100.0	5.7	0.0	0.0	5.7
	NICHOLLS	0.0	0.0	0.0		100.0	100.0	100.0	6.8	0.0	0.0	13.2
	PICU	0.0	0.0	0.0	100.0	88.9	400.0	89.3	-8.3	0.0	0.0	5.3
	PINCKNEY	0.0	0.0	0.0		100.0	3.3	100.0	1.0	0.0	0.0	9.2

10. Ward heatmap:
-Med Card Division

Amyand

Percentage harm free care – a grade 4 pressure ulcer was wrongly classified as hospital acquired, the patient was admitted with this. The other harms listed were old pressure ulcers and old UTI's,
falls – on going work is taking place to ensure all patients are assessed both for falls risk and bed rails on arrival to ward.
Sickness – pertains to long term sickness which is being managed through the HR process
FFT –Ward Manager is undertaking a piece of work to review the number of patients who were not appropriate to complete an FFT due to cognitive, and also reminding ward clerk and discharge co-coordinator to complete

Caesar Hawkins

Percentage harm free care –5 patients admitted with new UTI who had catheters inserted in ED. This information has been passed to ED to review practice.
FFT –The ward has a new ward clerk starting in November and will be incorporating this into part of their role, in the meantime the ward are going to have a re focus on completion of this.
Falls - on going work to ensure all patients are assessed both for falls risk and bed rails on arrival to ward.
SI – patient fell and sustained a # NOF, died subsequently during rehab, currently awaiting outcome of SI panel

Allingham

C. Dif- One patient was admitted as a known carrier.
Sickness – This includes a high number of long term sickness which is being managed in conjunction with HR
Falls- This number is low for the type of patients cared for on this ward, and relates to a patient who had recurrent falls.

Marnham

Friends and Family 29% – Staff to be reminded to ensure that this is completed on day of discharge, however this is being impacted by the vacancy profile currently on the ward which is being addressed.
Vacancies-Risk assessment completed . DDNG to source help from the division in the first instance. X2 band 5 have been recruited (one who was a student on the ward starts 2nd November) Short listing of band 5s this week. Also recruiting on 28th November.
Sickness 8.5% Short term- all being managed with support from HR.

Rodney Smith

Friends and Family 23%- Staff to be reminded to ensure that this is completed as at least 40% uptake required.
18 *falls* for September, many of these falls are attributed to 3 patients (approx. 12) where these patients have been requiring specials due to their medical condition and risk of falls. .

Richmond

The MRSA was identified on Allingham ward as positive and no screening had been done on AMU. The matron and Sister will be communicating the need for screening as part of the admissions process to staff and include in hand over.
FFT – Ward sister allocated to lead on the compliance against FFT to ensure an improved response rate.
Falls – 12 Falls were reported during this period. A band 7 has been allocated as the falls link nurse and will be reviewing the falls that have occurred on the ward to produce a list of actions and recommendations.
Sickness: 12.7% which relates to long term sickness and pregnancy related sickness which is being managed through HR and occupational health.

10. Ward heatmap:
-Med Card Division

Trevor Howell

Falls 4 falls reported during this period. Appropriate care plans in place for these patients and the case mix for this ward results in a number of patients being at risk
Serious Incident – This incident relates to the care of a patient at end of life following a complaint that was raised to the organisation. The panel are currently investigating and may request de-escalation of this SI.
Sickness – One episode of long term sickness which is being managed through HR. There was also a number of short term sickness episodes for staff who were working there notice period.

Belgrave

Ward Staffing – unable to fill the vacant shifts from bank or agency so therefore the ward was working with a reduced number of staff. Will be taking part in divisional recruitment day in November to try and fill vacant establishment.
Falls –1 patient on the ward in September who initially was non-compliant with calling for staff to help. An HCA special was requested for him and he became much more compliant.

Ben Weir

Ward staffing – unable to fill the vacant shifts from bank or agency so therefore the ward was working with a reduced number of staff. Will be taking part in divisional recruitment day in November.

Caroline

MRSA – hospital acquired. Awaiting documentation to complete RCA
Vacancy/sickness – the ward has been without a Band 7 or a Senior Sister Band 6 despite being advertised. A Band 7 Ward Manager has just been appointed and will hopefully start in December 2015. The ward is being managed by the Band 6s with support from the Matron for that area. Band 5 and Band 2 positions are actively being recruited too.

Cheseldon

Pressure Ulcers – currently being investigated under the SI process to ascertain cause.
FFT – unclear why this has reduced but Ward Manager and Senior Sister Band 6 working with the receptionist and ward staff to improve performance.
SI -Related to Grade 3 pressure ulcers. Due to be presented at November taskforce.
Harm Free Care – The 2 grade 3 pressure ulcers have adversely affected the harm free result.
Sickness/vacancy –Ward manager is actively recruiting and managing. Will be taking part in divisional recruitment day in November. One member of staff off on long term sick due to shoulder injury. Being actively managed.

James Hope

FFT – unclear why this has reduced but Ward Manager and Senior Sister Band 6 working with the receptionist and ward staff to improve performance.
Sickness/vacancy –Ward manager is actively recruiting and managing. Will be taking part in divisional recruitment day in November.

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 and relate to sickness absence rate, falls and harm free care. The areas where there has been an improvement in performance as reflected by a reduction to zero in alerts for pressure ulcers and incidents of MRSA and C/Diff.

The key areas where alerts are seen are consistent with previous reports and relate to sickness absence rate, falls and harm free care. The areas where there has been an improvement in performance as reflected by a reduction to zero in alerts for pressure ulcers and incidents of MRSA and C/Diff. There were 17 red alerts and 5 amber alerts for September 2015- the trend for alerts were not compared with August's data as the information for August was incorrect**.** A point to note is that the local cap for accepted volumes of falls was not in place this month for this report and therefore any ward with 3 of more falls triggered a red indicator.

Florence Nightingale – 3 red indicators; 1 related to 86.4% of harm free care-this was due to: 2 patients who had an old Grade 3 and 4 pressure ulcers (admitted to ward from community), 1 patient had an old DVT and 1 patient was admitted with a new DVT from the community. The second red indicator relates to fall's. There were 4 falls in September, one patient fell twice and all falls were no harm. The third red indicator related to a sickness rate of 8%. One member of staff is on long term sickness and there were two episodes of short term sickness- all sickness episodes that triggered are being managed according to policy.

Gunning – 1 red indicator relating to 7 falls. 1 patient fell twice; no harm and the other 5 falls were mechanical and no harm.

Cavell - 1 amber and 2 red indicators. The amber and 1 red indicator relates to FFT patient satisfaction of 38.4% and FFT recommendation of 38.45%. Weekly Quality audits have been re-commenced as a result of this heat map result and the matron selects a cohort of patients to speak to daily to ensure patient satisfaction remains high and any concerns are addressed in real time. On a positive note this is the first month Cavell have met there 40% FFT compliance target. The second red indicator relates to falls. There were 4 falls on Cavell ward, all were no harm and were mechanical.

Gray-2 red indicators relating to 3 falls and a sickness absence rate of 4.5%. All falls were no harm. The sickness red indicator related to 1 staff member on long term sickness who is managed under the sickness absence policy.

Vernon-2 red and 1 amber indicators. The first red relates to 3 falls. All falls were no harm and mechanical. The second red indicator relates to a sickness absence rate of 9.6%. There were 2 staff members on long term sickness and there was 1 short term sickness absence. Again all episodes are being managed.

William Drummond-1 red indicator relating to 3 falls. Two falls were mechanical- loss of balance and a fall whilst being assessed by the OT; the other fall related to a fall out of bed. All falls were no harm.

Brodie Neuro- 1 red indicator and 1 amber indicator. The red indicator related to 1 serious incident, this is incorrect as no SI's have been raised in September. The amber indicator related to 93.3% harm free care. This low score was due to one patient having an old grade 3 pressure ulcer and one patient had a catheter and an old UTI.

10. Ward heatmap:
- STNC Division

Thomas Young

This ward was not listed on the September scorecard. The team have reviewed their local reports for September and an area of concern which potentially would have flagged as amber, related to two falls. Both falls were mechanical and no harm.

Gwynne Holfor

2 red indicators. The first red indicator related to 4 falls. One patient fell three times- all three falls were low harm. The other fall related to a patient attempting to stand up from his wheelchair without the breaks being used- low harm. The second red indicator related to a sickness rate of 6.2%. This score is incorrect as it should be 3%. One member of staff was on long term sickness which was managed to the absence policy. This an area with high vacancy factor and initiatives are in progress to recruit and different types of staff and develop alternative models of care, to ensure quality and safety are maintained.

McKissock

2 red indicators and 1 amber indicator. The first red indicator related to 3 falls. All falls were no harm and were due to: a slip out of bed, a fall whilst mobilising and a fall in the bathroom. The second red indicator related to a sickness absence of 7.4%. 1 staff member was on long term sickness and there were episodes of short term sickness- all were managed. The amber indicator related to 92% harm free care, this score was due to two patients having a catheter and new UTI's. Trust wide work on CAUTI is due to commence.

Kent

1 red indicator and 1 amber indicator. The red indicator related to 12 falls. 4 patients fell twice and were all no harm. 4 other falls were mechanical and were no harm. The amber indicator related to harm free care of 93.5%.1 patient had a catheter and a new UTI and one patient had an old grade 2 pressure ulcer.
Keate and Holdsworth wards have both made improvements with no flags this month and McKissock have successfully reduced their level of falls.

10. Ward heatmap:
- CWDT&CC Division

Sickness

Sickness was above the trust threshold in many areas in September 2015. This was a combination of long term sickness and an increase in short term sickness. In particular it was noted that a number of staff in clinical areas experienced flu like symptoms during September 2015. It is planned to increase the level of support provided by the HR team to address sickness in a more proactive way across the division.

Neuro Intensive Care (NICU)

14 patients were surveyed. 1 patient was reported to have a harm which was related to a catheter and an old UTI

Delivery Suite

The 1 serious incident reported for the September 2015 which relates to an unexpected admission to NNU. This incident is currently being investigated for learning.

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

	Patient Safety & Experience																		
Domain	Indicator	Frequency	2015/2016 Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Direction	Comments
				Quarter 1 2015/16			Quarter 2 2015/16			Quarter 3 2015/16			Quarter 4 2015/16				
Patient Safety	SI's REPORTED	Monthly		1	1	2	0	1	4								
Patient Safety	Number of SI's breached	Monthly	0	0	0	0	0	0	0								
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly		1	0	0	0	1	1								
Patient Safety	Grade 4 Pressure Ulcers	Monthly		0	0	0	0	0	0								
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly		10	7	4	12	8	13								
Patient Safety	Number of moderate falls	Monthly	0	2	1	0	1	0	0								
Patient Safety	Number of major falls	Monthly	0	0	0	0	0	0	0								
Patient Safety	Number of falls resulting in death	Monthly	0	0	0	0	0	0	0								
Patient Safety	MRSA (cumulative)	Monthly	0	0	0	0	0	0	0								
Patient Safety	CDiff (cumulative)	Monthly	31	1	0	0	0	0	0								
Patient Safety	CAS ALERTS - Number ongoing- received (Trust)	Monthly	0	2	2	2	2	2	2								
Patient Safety	Number of Quality Alerts	Monthly		3	5	2	9	3	11								
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	95%	89.0%	86%	85%	84%	81%	81%								
Safeguarding	% of staff compliant with safeguarding childrens training	Monthly	Level 1 85%	90.0%	90.0%	85%	82%	79%	88%								Changed to green because aris show as achieving
			Level 2 85%	84.0%	84.0%	82%	82%	74%	66.00%								
			Level 3 85%	69.0%	69.0%	82%	90.00%	70%	85%								
Patient Outcomes	Mortality SHMI ratio (Trus)	Monthly	<100	0.86	0.86	0.86	0.86	0.86	tbc								
Patient Experience	Active Claims	Monthly		0	0	1	3	1	tbc								
Patient Experience	Number of Complaints received	Monthly		16	18	6	5	2	5								
Patient Experience	Number of Complaints responded to within 25 days (reporting 1 month in arrears)	Monthly	85%	100%	88% April 2015	78% May 2015	100%	100%	tbc								
Patient Experience	Number of Complaints responded to within 25 days with an agreed extension	Monthly	95%	100%	100% April 2015	100% May 2015	100%	100%	tbc								
Patient Experience	FFT Score (Mary Seacole and MIU)	Monthly			14.3				see report								
Patient Outcomes	Catheter related UTI (Trust)			1.14	0.66	1.12	1.32	NA	NA								
	Number of new VTE (Trust)		National 0.005	0.55	0.37	0.30	0.08		NA								
Workforce	Number of DBS Request Made	Quarterly	annually	N/A	N/A	N/A	N/A	N/A	N/A								
Workforce	Sickness Rate -	Monthly	3.50%	5.72%	6.04%	6.00%	4.69%	5.75%	Not yet available								
Workforce	Turnover Rate-	Monthly	13%	19.64%	19.94%	20.40%	20.08%	21.00%									
Workforce	Vacancy Rate-	Monthly	11%	19.41%	19.06%	19.40%	12.60%	13.42%									
Workforce	Appraisal Rates - Medical	Monthly	85%	66.67%	72.73%	72.70%	69.57%	84.00%									
Workforce	Appraisal Rates - Non-Medical	Monthly	85%	76.80%	75.84%	75.40%	76.02%	72.82%									

Quality scorecard exception report

- **KPI Exception Report for (for period up to 30 September 2015)**
- **Serious Incidents:** In September 4 Si were reported: 1 Dermatology, 1 Pressure Ulcer Grade 3 PU has (Mary Seacole ward) 1 Grade 3 PU (community nursing) and 1 Si for HIV/GUM service for failure of failsafe for positive result reporting.

- **Complaints:** Community Services numbers of formal complaints increased to 5.

- **Child safeguarding Level 3:** (to be confirmed) L3 training is required every three years. 100 places are available each year, plus bespoke sessions as required. Attendance at sessions are approx. 75% of capacity. Number of training has increased since August 2015.

- **Quality alerts:** 5 community nursing, 5 QMH OPD, 2 generalised.

	In time	Late	Still open	Total
Community Services	5	2	4	11
Totals:	5	2	4	11

- **Human Resources:** Data not available until 17th of month

- **Key areas of concern for workforce:**
  - Access to MAST training as IT limitations prevent access for community services
  - Nursing recruitment and retention, particularly offender healthcare, Mary Seacole ward (QMH), community nursing, school nursing, specialist posts

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.

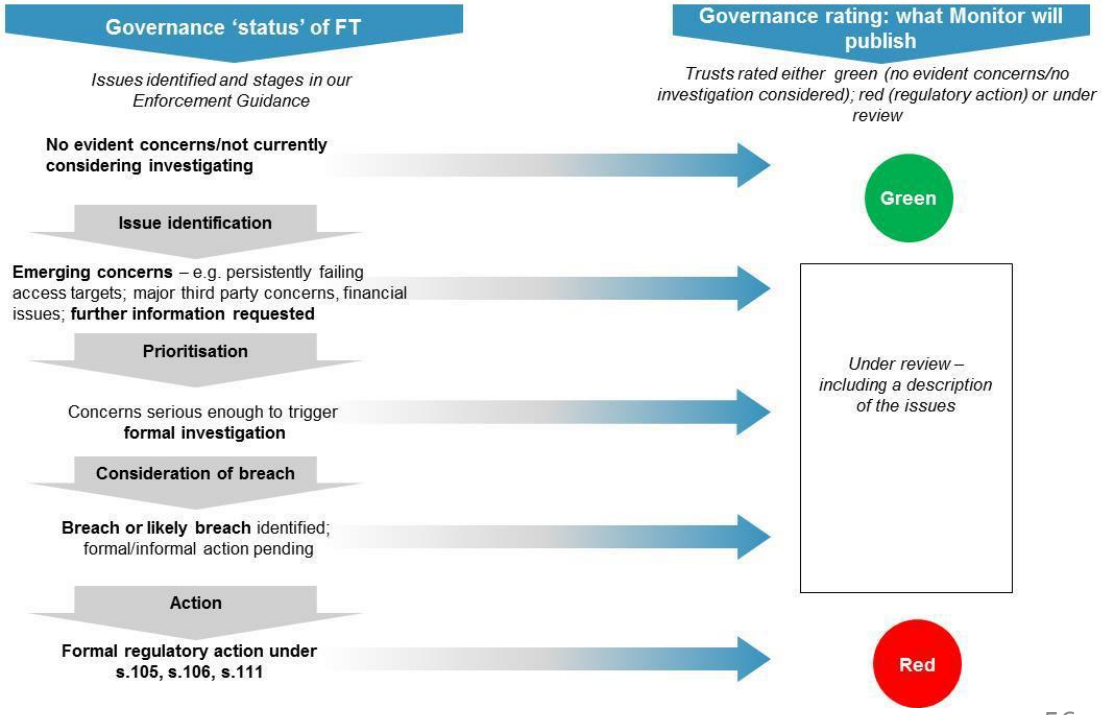
In addition to the above, when assigning governance ratings Monitor also take into account the following which may lead to overrides in the governance rating::

- 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

Paper Title:	Trust Flow Programme
Sponsoring Director:	Jennie Hall- Chief Nurse/ Director Infection Prevention and Control SRO Flow Programme
Authors:	Jennie Hall- Chief Nurse/ DIPC Jane Galloway: Service Improvement Programme manager. Helene Anderson- DDNG Dr Helen Jones Brendan McDermott- HON Dr Jane Evans Fiona Ashworth –DDO
Purpose:	To inform the Board the current
Action required by the board:	To note the report and key areas of risk noted.
Document previously considered by:	Operational Management Team Meeting

Executive summary:

Operational Capacity remains a key BAF risk for the Trust. The main SGH site is challenged potentially impacting on the delivery of safe and high quality services across both elective and non-elective pathways that involves range of clinical areas. There is a significant need to improve our current position to support a better experience for our patients but also our staff.

In response to this position there is a significant coordinated programme of work being led by the Director of Delivery and Improvement/ Interim Chief Operating Officer to address the current capacity position. The Flow work being described in this paper feeds into the overarching programme.

The Flow programme has been in place since October 2014. Phase 1 focussed on engagement, establishing work streams that addressed the key findings from an external report in July 2014, This included the establishment of a departure lounge, completion of a pilot programme within 11 inpatient wards to improve early discharge and development of improved management information to support decision making . In addition establishing direct links with external partners to develop more streamline discharge processes for patients with complex discharge, including daily face to face meetings for patients whose have stayed longer than 10 days in hospital who are not acutely unwell.

The programme moved into Phase 2 in February 2015 focusing on the flow of patients within the assessment unit, roll out of the pilot programme to support early discharge, increasing the use of departure lounge, reviewing the site team function, and implementing the use of improved information to support decision making and planning and working with partners.

The management information which is now available will be used to establish further key performance indicators to ensure there is understanding both of what the programme interventions will achieve in terms of flow and quality but to inform what impact should look like over the next 6 months in terms of overall capacity.

The Trust participated in the "Breaking the Cycle" process in April to make further progress in relation to the implementation of an electronic collection of the reasons that individual patients are in hospital, to test an approach regarding how patients are reviewed on ward rounds and the changing the profile of site meetings to support the operational flow of the site. In September the Trust undertook a "Winter Warm Up week" to test some of the interventions from phase 2 in practice and with particular focus on AMU and medical downstream wards.

The programme is now in phase 3, a review now completed to ensure that where interventions are effective and sustained these are now being managed through the Divisional routes rather than Service Improvement and to ensure that SI resources are focused to deliver the most return in terms of flow.

There is a critical interdependency with the demand and capacity work which is being undertaken as managing variation particularly in elective flow is a key success factor in managing flow. This is being taken forward by the Director of Delivery and Improvement.

In addition the flow programme is being linked with some work which has just been commissioned by the SRG "One Version of the Truth" which is designed to help to support flow across the Health and Social care system. This is a 6 week programme of work, the outputs reported to the Board by the Interim Chief Operating Officer in the future.

The report focusses on the achievement of the programme to date and areas of future focus. A critical success factor has been the engagement of a group of clinicians across professional groups and the personal commitment of the workstream leads. It also highlights where there is still further work to be undertaken and likely current priorities as the Trust goes into the Winter period.

The board is asked to note the current position and the future work that the programme will focus on.

Key risks identified:
Capacity Risks on the 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.*	

1.0 Introduction

Operational Capacity remains a key BAF risk for the Trust. The main SGH site is challenged potentially impacting on the delivery of safe and high quality services across both elective and non-elective pathways that involves range of clinical areas. There is a significant need to improve our current position to support a better experience for our patients but also our staff working hard to deliver services in sometimes challenged circumstances.

In response there is a significant coordinated programme of work being led by the Director of Delivery and Improvement and Interim COO to address the current position. The Flow work being described in this paper feeds into the overarching programme and in particular it aligns with the Emergency Department improvement work, the Capacity and the Frailty pathway work.

2.0 Background to Programme:

In the summer of 2014 a 2 day external review was carried out to look at the current approach and constraints to good quality discharge at St George's hospital (SGH). The findings were agreed with; the report contained a number of recommendations that were used as a platform to address the issues in a sustainable way going forward through a programme of work.

The flow programme has been aligned with the good practice model "SAFER" which is a set of operational standards that are evidence based and support improved flow within a hospital site.

- **S**- Senior Review: All patients will have a consultant review before midday
- **A**: All Patients will have an expected discharge date (that patients are made aware of) based on the medically fit for discharge status agreed by clinical teams
- **F**: Flow of patients will commence at the earliest opportunity (10am) from assessment Units to inpatient wards. Wards (that routinely accept patients from assessment units) are expected to discharge their first patients by 10am) to accept the patients
- **E**: Early discharge, a third of patients will be discharged from base inpatient wards before midday. TTOs for planned discharges should be prescribed the day before and dispensed the day prior to discharge wherever possible.
- **R**: Review a systematic review of patients with extended lengths of stay to identify the issues and actions required to facilitate discharge. This is led by Clinical leaders with operational support to remove barriers to effective discharge.

Elements of the SAFER tool were previously used within the Trust however these did not appear to have been fully implemented through previous interventions and this has been picked up through the current programme.

3.0 Current Programme Structure*:*

An important objective of this programme is to achieve a sustainable solution going forward with previous initiatives having mixed impact. Staff engagement in the design phase of the was a key element so a series of engagement events took place including a "Listening into Action" evening, table top workshop with Divisional Directors of Nursing and Heads of Nursing and presentations to medical staff. This enabled the Trust to develop and take ownership of the extensive programme of work.

One of the key features of the flow programme is that it is iterative with a need to be responsive to issues as they emerge and to ensure that that all actions being taken are effective and delivering anticipated outcomes. At the time of writing this report there are a number of key elements of the programme. The Governance architecture of the programme ensures that the links with the other work Trust streams i.e. capacity, frailty pathway to ensure that activity is coordinated and effective.

The flow programme (described below) presently has 5 distinct Work streams aligned with the SAFER model: Discharge Processes, Discharge management Information and Site management, working with Partners (Since Phase 1) with ED-AMU flow and Ambulatory care added in phase 2.

Work Stream	Associated SAFER Standard
Discharge Processes - **To strengthen the use of Estimated Dates of Discharge to ensure discharge planning** - **To secure greater numbers of patients being discharged before 11am discharge** - **To ensure TTO's are prescribed in a timely way.** - **Delivery of Patient and family information to support better communication.** - **Ensure effective Board and ward round framework in place** - **Review and implement criteria based discharge (non-medical discharge)** - **Review Transport and Eligibility criteria**	- Implement **daily ward/board** rounds - Agree **EDD** definition; implement improved data capture and a robust governance structure. - Do simple discharge well and increase pre 11am **early discharge.**
Discharge Management Information and Site Management - **Use of management Information to support decision making and forward planning** - **Site Management: Clarity of Team and escalation functions within the Trust** - **Departure Lounge: Use of the lounge to support early planned discharge** - **Review of the Discharge coordinator function to ensure effective working**	- Improve **flow of patients** from AAU/ED to the base wards earlier in the day - **Early discharge** facilitated by use of the departure lounge.
Working with Partners - **Standardise discharge processes across partners** - **Develop and implement a discharge menu for all Boroughs** - **Agreed processes for Delayed Transfer of Care Patients (DTOC and nDTOC in place across all partners.** - **Review of Clinical Criteria for effective use of Mary Seacole Capacity.** - **Working effectively with in-reach community partners**	- **Early review** of long stay patients on the ward and daily DTOC meetings in place. - **Early** discharge planning; improved awareness and processes for in reach from all available community services across Boroughs.
ED-AMU Flow: - **Achieve no ED bed breaches due to flow** - **To ensure an effective process to identify patients to allocate to beds on medical wards in a timely way** - **To streamline transfer time between AMU and wards** - **To ensure effective communication between the site team/ wards and AMU in relation to bed availability and allocation.** - **To secure transfer of majority of patients prior to 6pm.**	- **Senior Review** All patients will have a consultant review before midday - **Flow of patients** will commence at the earliest opportunity (10am) from assessment Units to inpatient wards. Wards (that routinely accept patients from assessment units) are expected to discharge their first patients by 10am) to accept the patients
Ambulatory Care: - **Increase percentage of non-elective medical patients being cared for in ambulatory pathways to 30% by April 2016.**	

Each workstream has a lead (Medical/ Nursing) and the programme is currently flexibly supported by a Programme manager and service improvement staff.

The flow programme in place since October 2014 during phase 1 focused on engagement, establishing work streams that addressed the key findings from an external report in July 2014. This included the establishment of a departure lounge, completing a pilot programme within 11 inpatient wards to improve early discharge and development of improved management information to support decision making.

In addition establishing direct links with external partners to develop more streamline discharge processes for patients with complex discharge, including daily face to face meetings for patients whose have stayed longer than 10 days in hospital who are not acutely unwell.

During phase 2 from February 2015 focus was placed on the flow of patients within the assessment unit, roll out of the pilot programme to support early discharge, increasing the use of departure lounge, reviewing the site team function, use of improved information to support decision making and planning and working with partners.

The programme is now in phase 3, a review now completed to ensure that where interventions are effective and sustained these are now being managed through the Divisional routes rather than Service Improvement and to ensure that SI resources are appropriately focused to deliver the most return in terms of flow.

4.0 Current Position within the Programme:

The Table below indicates the current position within each of the work streams.

In addition to the table below a "Winter Warm up week" was undertaken to test some of the initiatives described below and their effectiveness in practice. The results from the week's activities to further support identification of further work and winter preparedness. Service improvement Staff were working full time in clinical areas.

Key findings from the week:

- There was an improvement in pre 11am discharges, this practice is well embedded
- Staff were using the new transport criteria effectively, but there are challenges with waiting times for inpatient awaiting transport at some times of the day. This is being addressed with the Estates team.
- The patients identified for the Departure lounge were appropriate
- The Number of patients staying greater than 5 days reduced (note this may be due to a number of factors)
- The use of ICLIP data to inform decisions about the discharge of patients was not consistent
- The time to transfer a patient from AMU to a ward is unacceptably long and needs to improve.
- The use of board and ward rounds remains inconsistent

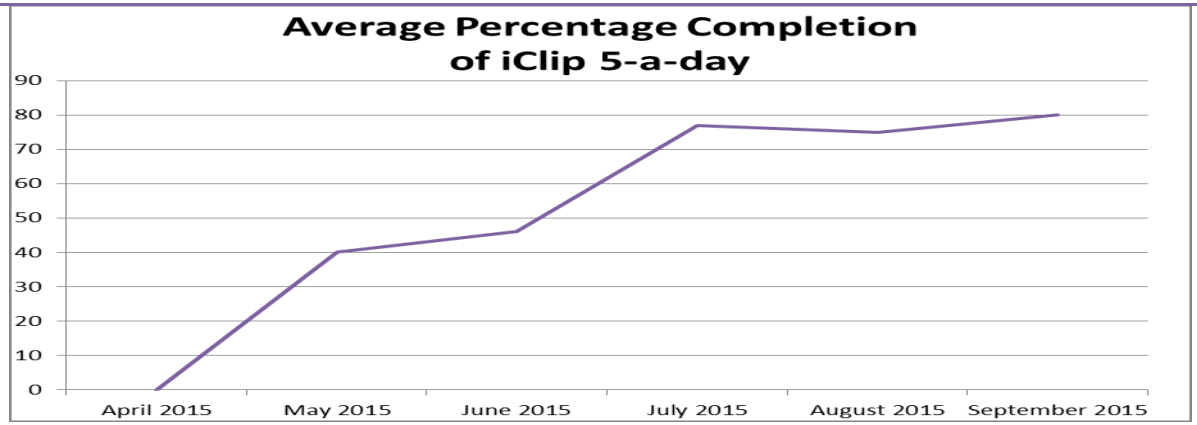
A flow dashboard has also been created to inform the impact of the programme, the data is currently pulled from a number of data sources and is manually compiled. There is a need to establish a more sustainable solution to the population of the dashboard. (See Appendix One)

A staff flow newsletter was circulated to the Trust and was well received to illustrate the progress of the flow programme.

Workstream	Tasked with	Achievements
ED-AMU-Wards	Improve flow through AMU to support the ED target and general flow.	The focus of this project has been to improve the flow into and out of AMU. A series of initiatives have taken place to tackle this: • Introduction of an AMU Patient Flow Coordinator • All eligible patients are now sent to the wards via telephone handover • New whiteboard design for AMU to support clinical planning and decision making • Embedding new ways of communication between bed management, AMU and the wards (bleeping bed availability, bed management form) • Sharing the demand in AMU with the wards so that they are aware of (a) the number of patients awaiting beds within their wards and (b) the pressure on AMU with patients awaiting beds on all downstream wards Due to the results of the Winter Warm Up, the next steps will involve trialling the presence of dedicated porters on AMU to attempt to reduce the time taken between booking porters and the patient arriving on the ward. There are also other ideas being trialled in order to try and improve the time taken from bed being available to porter being booked. These include • Write all transfer information on a visible board (to ensure ward clerks do not forget to book porters and so consultants have sight of empty beds) • Enter the bay where patient is transferring to phone ward, allocate an appropriate person so telephone handover can commence immediately • Finding suitable patients to later discharges not just empty beds so that when beds become empty the handover and booking of porters can commence immediately • Started a strict policy for escalation. An escalation log is being kept and staff know to report anything causing delay direct to the matron so it can be delay with immediately • Staff are also keeping a list of delays so we can learn the reason behind why some transfers take a long time • Record of daily transfer time for patients and review • Roles and responsibilities for nursing staff with regard to flow have been written and instilled
Ambulatory Care	Increase percentage of non-elective medical intake going through Ambulatory Care (AAA) to 30% by April 2016.	Baseline was 15%. At the end of September we are achieving 22% of the non-elective medical intake through AAA. This has been improved through a series of initiatives, including daily reviews of the HRG codes of patients admitted to AMU with stays of 0-2 days to see if any of them would have been applicable for AAA. There is also a more proactive approach to support the identification of patients from ED. The next steps are to create a single point of contact for the referrals to Ambulatory Care, and to develop a single intake list for AMU and AAA. This will enable clinicians to make recommendations regarding any patients accepted into AMU who could be eligible for AAA. The DVT and Cellulitis clinic currently run by ED will be transferring to Ambulatory Care. We are on target to achieve 30% by April 2016.

Discharge Processes	Pre-11ams – increase the number of patients discharged from SGH by 11am to match the demand for beds (baseline 12 from 11 wards in November 2014)	During Q2, coverage of the improvement initiative is in place across 30 wards with further speciality wards joining. We have averaged 126 pre-11am discharges a week (peak 145). This is a consistent performance, a stretch target of 200 patients/ week remains and work is continuing to achieve that target. Wards from all areas are now involved. The surgical division move to the Division leading this from 01/11/15, Medcard from 01/12/15, and the remaining wards from 04/01/15. .
	Discharge Tools - Simple and complex discharge, Discharge checklist, discharge policy, training	A tool has been developed for simple and complex discharge. This has been useful for new and agency staff, and for wards where patients have been placed as outliers, for example medical patients requiring complex discharges outlying on surgical wards (who may be more used to simple discharges). Discharge training has been launched, with two well attended training sessions taking place since the beginning of October 2015. This focusses on empowering nursing staff to lead on simple discharge without necessarily requiring discharge coordinator input, therefore freeing up the discharge coordinator to focus on more complex discharges. The discharge policy is updated and will be circulated following final governance approval.
	EDD capture	A definition has been agreed for Estimated Date of Discharge to ensure consistency of application and is embedded through the capture on iClip. This is driven by strong leadership. In some areas, these are now captured above patients beds which drive discussion with both the patients and their families/carers and help to prepare for departure. More sharing of good practice across wards and divisions needs to be embedded, a focus for phase 3.
	Board/Ward Rounds – agree R&Rs for board/ward rounds and implement proposals	A board/ward round audit has taken place. A supplementary questionnaire was distributed to Care Group Leads to seek feedback on the ideal times, format, roles and responsibilities for ward/board rounds. Some surgical wards have embedded a ward round checklist as an *aide memoir*. Local ward round quality audits are taking place (for example in Trauma and Orthopaedics). The audit findings will be used to support changes in practice during phase 3. This is a key element of the programme
	Criteria Led Discharge – understand current baseline for CLD and explore opportunities for rolling out further	A trial of CLD was tested during the Winter Warm Up week. This will be a future focus.
	Transport – review eligibility criteria and embed, understand training needs	The eligibility criteria have been launched on the wards and are being well adhered to. There is better availability of information by ward on transport and associated spend. The booking process has been simplified and additional training has been held. As staff get more confident in their pre-11am discharges, and the processes in place for preparing for discharge, transport is being booked ready earlier. There is further work to be done under the transport heading, and this will be a focus going forward.
	TTO – explore current waiting times and booking process, understand compliance, Satellite pharmacy in AMW	Two audits (on medical and surgical wards) have taken place to understand the processes and timings of TTOs. A location has been identified for the satellite pharmacy in Atkinson Morley Wing. This will reduce the time taken to issue TTOs due to not having to get them issued from Lanesborough Wing, on the other side of the hospital. Processes are in place within the surgical wards with pharmacy to prioritise TTOs for pre-11am discharge patients. A session has been set up to see if replication may be possible in MedCard wards.

		Prescribing pharmacists and nursing leadership have been drivers for success. A strong next step would be for an SHO to stay behind after ward/board rounds to do the TTOs for those patients to be discharged in the next 24-48 hours.
	Patient Information – update patient information	A suite of patient information leaflets and bedside information have been developed to better prepare patients for discharge, from the point of admission. These are streamlined and simplified to contain clear messages regarding our commitment to the patients, and what we hope for from them in return. Funding is being sought from charity funds for printing costs. Once this is secured, withdrawal of conflicting patient information and a complete launch of this information will be the next step.
Working with Partners	Discharge Knowledge – Up to date information for all partners. Including inclusion/ exclusion criteria, leaflets, and referral methods in an easily accessed format.	The discharge menu for Wandsworth went live on the 1st July. We are currently developing the Merton menu. This will ensure that the wealth of services provided for residents of the borough is easily accessible to staff. Elements of a discharge information pack (for staff) including time scales and pathways have been developed. Further support is required to develop this fully.
	In Reach Opportunities – For staff to be aware of what is available to support with discharging their patients as well as on-going input in the community.	A key link person has been identified as the single point of contact for the inreach services. A piece of work still needs to be done around roles and responsibilities. A forum is being set up for key inreach personnel providing services to St George's.
	Working with Partners – Streamlined processes for referrals, communication and escalation of flow blockages related to partners set up	Creation of KPIs for complex discharge. DTOC meetings take place three times a week. This is being reviewed to establish a multiagency meeting to actively try and deal with complex discharges before patients become a DTOC. A database has been developed for the improved capture of (N)DTOC patients which is used to share key information and escalate with partners. This database also provides us with the means to capture most of the KPIs.
	Mary Seacole Ward – Full review of flow into and out of the Ward including communications with main site and partners, referral pathways in and onto partners, pilot new ways of working such as electronic referrals and explore ward staff ordering equipment.	The team has developed pathway maps for the current referrals system. Work is underway with MedCard to establish the best pathway for referrals going forward. Verbal referrals have been rolled out on two surgical wards with training taking place to facilitate appropriate referral. If successful this will be rolled out further. It has not been necessary to establish ward staff ordering equipment due to a focus on inreach staff processes which have negated the need for this as they now do this. Electronic notifications to social services are ready to go live once we have received the forms from HCSIC.
Site Management	Information Management – Develop a Flow Dashboard. Increase the compliance with the iClip 5-a-day including improving the use of the information in daily bed management	The trust now has access to a Flow Dashboard which maps the operational trends. IClip 5-a-day has been a very successful initiative. For the first time we are able to demonstrate the number of 'fit' and 'unfit' patients in SGH at any one time. We are also able to explain what our cohort of 'fit' patients are waiting for, and whether these are elements of care within, or outside of, SHG sphere of influence. Compliance with the iClip 5-a-day sits at between 80-85%. This allows for the turnover of patients.



Review and Improve the Site Management Function – develop and implement a SOP, including action cards.	The SOP has been reviewed. A set of action cards have been developed to guide the site management meetings during time of surge. This helps all those attending to understand their role and what is expected of them. This should ensure smoother running during winter and other times of surge.
Departure lounge – improve the utilization for the departure lounge. The target is to discharge 20 patients per day from the departure lounge.	The departure lounge opened on December 1st 2014 and is open from 08:30 – 19:30, Monday to Friday. The monthly average waiting time (based on Q1 15/16) runs between 1 hour and 1 hours 30 minutes.
Discharge Coordinator Structure – map the current structure and embed refreshed structure.	Both MedCard and Surgery divisions have reviewed their discharge coordinator structure and confirmed proposals for an extended service. This is currently out to consultation. Cover will be provided in the evenings and six days a week. The refreshed roles and responsibilities will enable a better understanding of, and way of working, with the various inreach services.

	Operational Days	Number of patients	Pre-noon patients
July	23	365 15.9av pd	130 36%
August	20	323 16.2av pd	109 34%
September	22	362 16.5av pd	112 31%

5.0 Next Steps

At the previous Board update a number of actions were outlined which have largely been achieved and are described within the overall table.

Key Areas for focus during phase three are:

To ensure a strong link with the demand and capacity modeling work programme and to support different ways of working

Reducing the number of elements within the programme that are now implemented and handing them over to Divisional management teams to maintain and manage.

Work with colleagues in Medcard Division to ensure that all elements of the existing ED flow work programme are able to progress.

Within the AMU there is now key focus to reduce the time taken to fill beds on the medical wards once they become available. This is a key element to prevent backflow into the ED and to prevent late transfers after 6pm.

To ensure there is a more consistent model of Ward and Board rounds across the Trust to secure senior medical review and decision making leading to more effective discharge planning. In tandem to strengthen and widen medical engagement in the programme.

To review the provision of non-emergency patient transport to ensure that it meets the needs of both outpatient and inpatient activity.

To implement and strengthen criteria led discharge where appropriate to support timely discharge.

To implement the transfer pathways and more effective clinical use of community bed provision to prevent empty capacity not being fully utilised.

To achieve greater standardisation of social service processes eg documentation to prevent delays in assessment.

Consider the introduction of “discharge to assess” for patents being discharged home with community services input and “placement without prejudice” for patients being discharge to a new nursing home. Both initiatives would reduce hospital discharge delays.

Work with SRG partners to streamline multiple rehabilitation services providing similar services across the borough.

Ongoing focus regarding repatriation of patients.

The key to all of the above will be the on-going input and leadership from the wards and increased involvement of the medical teams.

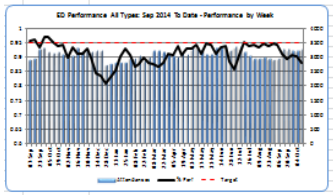
Our systematic approach aims to embed and deliver all the separate elements of the SAFER bundle together to sustain improved patient flow.

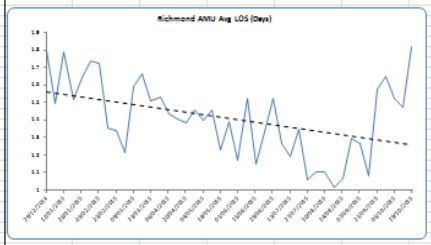
Appendix One: Flow Dashboard

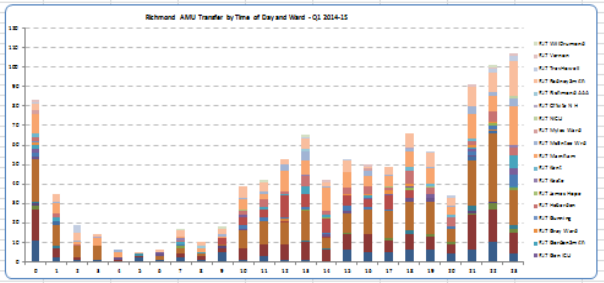
Flow Overview Scorecard - Draft V1.2
Updated to Week Ending 22/10/2015

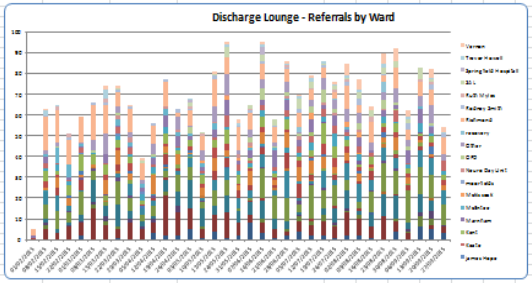
St George's University Hospitals NHS
NHS Foundation Trust

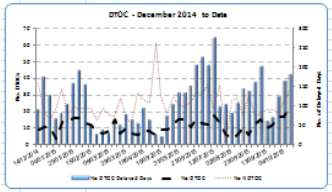
		21/06/2015	28/06/2015	05/07/2015	12/07/2015	19/07/2015	26/07/2015	02/08/2015	09/08/2015	16/08/2015	23/08/2015	30/08/2015	06/09/2015	13/09/2015	20/09/2015	27/09/2015	04/10/2015	11/10/2015	18/10/2015	Trend
PATIENT FLOW	Total Admissions	1555	1592	1566	1539	1574	1533	1547	1519	1507	1501	1437	1413	1595	1613	1593	1523	1548	1645	
	Total Discharges	1554	1593	1543	1627	1501	1565	1574	1543	1483	1429	1522	1370	1460	1595	1582	1593	1461	1672	
	Net Total Discharges Vs Admissions	-1	1	-23	88	-73	32	27	24	-24	-62	85	-43	-135	-18	-11	70	-87	27	
	% IP Discharges before Midday (Average)	24%	24%	23%	22%	26%	26%	27%	26%	26%	25%	26%	25%	26%	26%	24%	23%	25%	24%	
	% IP Discharges before 4pm (Average)	62%	62%	62%	61%	64%	65%	63%	62%	62%	60%	62%	64%	60%	60%	62%	63%	64%	62%	
	Number of Admissions to Richmond AMU	222	215	206	206	229	205	212	204	199	201	197	187	210	180	202	186	187	182	
	Number of transfers from Richmond AMU to	82	84	51	86	86	91	88	93	97	83	101	88	103	83	89	96	71	85	
	% Transfer from Richmond AMU by 11am	27%	26%	51%	27%	24%	41%	28%	32%	31%	17%	33%	22%	23%	40%	40%	25%	28%	40%	
	% discharges from Richmond AMU by 11am	16%	19%	8%	12%	10%	13%	10%	13%	12%	5%	15%	20%	8%	7%	18%	9%	11%	16%	
	Number of predicted discharges																			
	Number of actual discharges																			
	Number of Outliers	10	15	17	8	8	11	8	3	3	5	8	5	11	19	11	8	13	6	
	No. of DTOC	15	13	12	18	13	7	4	6	11	6	12	15	10	12	17	17	24	23	
	No of Delayed Days - DTOC	207	228	205	277	101	106	83	109	147	141	162	204	64	72	125	165	184	184	
	No. of NDTOC	31	31	36	22	36	2	27	28	18	30	17	19	21	21	20	27	33	34	
	Average LOS - Non-elective	5.00	5.78	5.27	5.12	6.23	5.94	4.66	4.83	4.45	4.86	5.08	5.79	5.19	4.35	4.87	5.23	4.75	4.43	4.28
	Average LOS - Elective	5.1	3.4	5.4	4.5	5.1	5.8	4.4	5.7	5.0	5.2	5.9	4.2	3.3	4.6	4.47	4.46	3.74	3.43	4.83
	Average LOS Richmond AMU	1.15	1.33	1.53	1.27	1.19	1.35	1.06	1.10	1.02	1.07	1.30	1.27	1.08	1.58	1.65	1.53	1.48	1.82	
DEPARTURE LOUNGE	Number of referrals	58	86	70	79	86	76	85	77	64	90	92	62	83	82	83	88	77	80	
	% of referrals by 12pm	26%	35%	33%	35%	38%	34%	38%	35%	38%	32%	32%	26%	30%	39%	45%	33%	36%	49%	
	Number of referrals by ward																			
	Time between referral and transfer																			
	Average waiting times	01:37	01:12	06:58	01:37	01:02	01:09	05:52	11:17	01:40	01:28	01:23	01:35	01:28	01:25	01:05	01:08	00:57	01:15	
	Max waiting time	06:45	04:05	07:10	07:45	03:02	04:00	08:05	05:50	06:25	06:32	05:30	04:50	09:05	07:42	06:35	06:00	04:05	06:25	
	No. of Patient requiring hospital transport	31	33	38	39	40	36	34	29	27	37	42	31	49	50	42	36	32	27	
	No. of Patients with a problem on admission	10	17	5	11	15	9	15	1	14	16	21	13	16	16	19	18	8	8	
Repat	No. of Patients for Repatriation			17	28	27	27	35	41	48	24	28	30	52	43	41	25			
	No. Repatriated within 24 hours			8	6	3	8	8	6	7	2	4	5	8	6	4	7			
	% Repatriated within 24 Hours			47%	21%	11%	30%	23%	15%	15%	8%	14%	17%	15%	14%	10%	28%			
	No. Repatriated within 48 hours			12	14	12	12	14	13	18	10	10	15	19	18	14	7			
	% Repatriated within 48 Hours			71%	50%	44%	44%	40%	32%	38%	42%	36%	50%	37%	42%	34%	28%			
	Average Transfer Time (hrs)			35	69	70	65	83	106	95	90	109	74	87	68	91	117			
	Average Transfer Time (days)			1.3	2.8	2.7	2.6	3.3	4.2	3.8	3.6	4.6	3.0	3.5	2.9	3.6	4.8			
	Specialty Split - Stroke			1	8	12	6	9	8	7	6	7	12	16	10	17	3			
	Specialty Split - Neurosurgery			4	5	8	9	12	14	14	4	9	6	9	14	12	8			
	Specialty Split - Cardiology			4	3		4	3	1	7	2	1	1	7	2	1	1			
	Specialty Split - Other			8	12	7	8	11	18	20	12	11	11	20	17	11	13			
	ED 4 Hour Performance (All Types)	93.73%	88.69%	85.82%	90.62%	95.42%	93.97%	94.19%	93.48%	94.94%	93.89%	94.69%	94.25%	91.22%	89.57%	90.88%	90.25%	88.27%	94.03%	

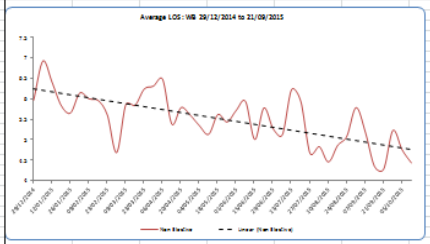


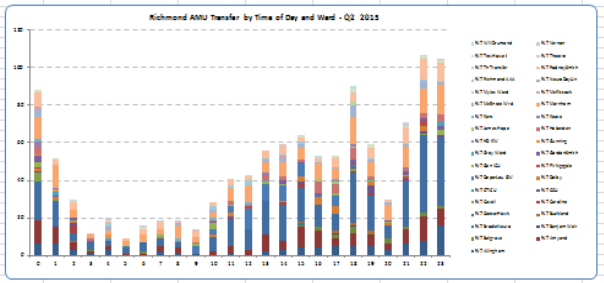


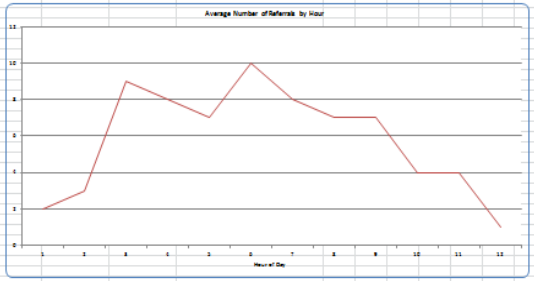












St George's University Hospitals NHS
NHS Foundation Trust

PATIENT FLOW PROGRAMME Newsletter

2014/15 AVERAGE PER DAY:

400
patients seen in ED

175
elective inaptient and day case procedures

140
non elective patients admitted

2500
outpatient appointments

This is the first of a series of regular newsletters designed to explain how the patient flow programme affects us all and how we each have a role to play in improving the flow of patients around the hospital. Each newsletter will provide an update on the great work that is going on, show you the data that is driving the programme and demonstrate, as winter approaches, why we need we need everyone working together as a team to ensure the effective flow of patients.

FLOW = The movement of patients along their care pathway, from arrival to discharge.

FLOW PROGRAMME = The process and operational changes we can make to improve the flow of patients through the trust.

> *"The effective flow of patients through our hospital means that patients who are coming for planned care as well as those who come to us for emergency care will have a better experience through being able to access their treatment in a timely way. It will also help us to support delivery of that care in a way that mirrors our values. Both of these elements will help to support the financial well-being of the trust"*

Jennie Hall
chief nurse / director of infection prevention and control

THE 95% ED TARGET

We all know about the 95% ED target. We all know that if you are a patient who needs to be admitted to hospital, it's better for you to be on a ward rather than in ED. We all know that a hospital is not the place to be if you don't need to be.

If a hospital is under pressure then the problems start at the front door. The Emergency Department will stack up if the hospital is not flowing. At very busy times this creates further problems as sometimes patients are transferred to any available bed, which means they may not be on the right specialist ward (these patients are called outliers). This means they need to be moved at a later time, which is not good for the patient's experience and it increases their length of stay in hospital.

The flow programme is about making sure that patients are being seen in the right place, the first time, with access to the best care to support them to be back in their place of residence as soon as possible.

The patient flow programme has been in existence at St George's for the past 12 months. As a result new processes and tools have been developed to help patients flow through their patient journey without unnecessary non-clinical delay. Many of you will have worked with the service improvement team and within your directorates to gather data that better helps us to understand where we need to make changes. This data underpins the work of the four Patient Flow workstreams.

ED TO AMU WARD FLOW

AMU have transferred 16% more patients pre 3pm (March-June 2015 versus the same period in 2014)

CURRENT PROJECTS

Increasing activity to Ambulatory Care

Bleep Ward Code upon Discharge

Exchange use of Information regarding empty beds and later discharges

Decreasing patient transfer time

RECENT SUCCESSES

Activity to Ambulatory Assessment Area has increased by 5% since project began in June 2015 (measured till July 2015)

AMU have discharged 4% above their standard discharge rate pre 3pm (Baseline Feb14-Jan15 versus March-June 2015)

Despite a 37% growth in AMU admissions, AMU breaches due to bed availability have actually reduced (Baseline Feb14-Jan15 versus March-June 2015)

"I feel that by doing all we can to remove the barriers that prevent empty beds being filled efficiently we can significantly improve patient flow"

ED to AMU Ward Flow programme lead Orlagh Flynn, The Improvement Programme

SUPPORTING DISCHARGE

A one day snapshot at 11am August 28th 2015 of how many patients are ready to leave

74 Fit for discharge
429 Unfit for discharge
157 No data recorded

CURRENT PROJECTS

A simple/complex discharge tool to easily identify discharges is being trialled in a number of wards

Welcome cards to help patients prepare for discharge

Working towards 200 pre-11am discharges a week from today's 140.

RECENT SUCCESSES

27 wards live with pre-11am discharge targets – currently exceeding 140 a week

Transport eligibility and authorisation flowchart rolled out in Surgery and MedCard

Patient leaflets revised and updated

"Clear consistent communication and proactive planning is the key to a positive patient experience of discharge"

Supporting Discharge programme lead Helene Anderson, divisional director of nursing, surgery, theatres, neurosciences and cancer

WORKING WITH PARTNERS

Social care colleagues have been working very closely with the trust, but the increasing complexity of patients means we are dealing with a 33% increase in referrals on last year

Referrals to Wandsworth social services

201 referrals
January to March 2014

267 referrals
January to March 2015

CURRENT PROJECTS

A Discharge Menu that sign-posts staff to all local boroughs sites

Electronic referrals to Social Services

RECENT SUCCESSES

Electronic version of Discharge Menu for Wandsworth on the intranet

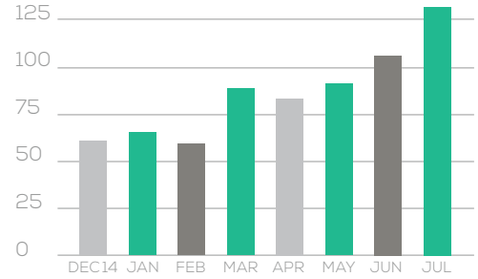
Daily Delayed Transfer of Care meetings with all partners to facilitate timely discharge and resolve issues face-to-face

"We are ensuring we have clear and straightforward procedures for complex discharges, and that this information is easily available so that we can work efficiently and reduce confusion and duplication"

Working with Partners programme lead Dr Helen Jones, consultant geriatrician and physician

SITE MANAGEMENT

The overall monthly number of pre-midday admissions to the Discharge Lounge has doubled since December 2014 indicating a shift of patient flow towards an increased number of morning discharges.



CURRENT PROJECTS

Site management meetings reviewed to improve ways of working

Stretchers to be accommodated in Departure Lounge

Discharge co-ordinator role review

RECENT SUCCESSES

iClip 5-a-day collection has allowed daily reporting on the number of fit/unfit patients

"The accuracy of information that the site management team obtains has a direct impact on decisions regarding the patients journey"

Site Management programme lead, Brendan Mcdermott, head of operations

WHAT DOES IT MEAN FOR ME?

In recent months, we have made encouraging progress with the weekly targets set for almost all wards for pre-11am discharges. Pre-11am discharges are important as ED begins to get busy from midday so the earlier we can discharge patients the more likely we can admit patients to the right place of care. Elective patients also begin to return from surgery from 9/10am onwards. Each week the data on pre-11am discharge is collated and shared with Jennie Hall, chief nurse and senior managers, including your own senior staff.

Of course sometimes there are reasons why a ward may not have reached target and these reasons are reported. However, it is really important that the focus on earlier discharge is kept up to help patient flow.

HOW WILL THE PATIENT FLOW PROGRAMME BENEFIT ME?

- Earlier preparation will allow you to plan discharges at times when wards are fully staffed, rather than adding to your workload at busier times
- Better planning will mean smoother running of the ward, helping to avoid large numbers of patients leaving and arriving at the same time
- Wards will no longer have to accept patients out of hours when ward staffing is at its lowest so staff can concentrate on patient care
- Less pressure to find beds
- More patients will be on the correct ward
- Your patients will be happier because they will not feel unprepared or have to tackle last minute issues, which cause additional stress
- Patients not being kept in hospital for an unnecessarily lengthy time, where their condition may deteriorate
- Earlier preparation with tasks such as TTOs limits delays, such as getting the patient's medication from pharmacy

WHAT CAN I DO TO HELP THE PATIENT FLOW PROGRAMME?

- Medical lead attending every ward round and identifying a discharge date
- A focus on one or two patients who are planned for discharge the next day to ensure they have everything in place for discharge, especially the TTOs, Discharge Letter, equipment
- Make sure the patient/their family knows their EDD, that they are expected to leave before 11am and that they will be waiting in the Departure Lounge
- Encourage patients/families to think about what the patient needs when they go home, e.g. keys, money for a taxi, adequate clothing, food in the house, heating on
- Use the Departure Lounge whenever this is appropriate
- Only using transport when the patient meets the eligibility criteria and ensure they are "booked ready" as soon as possible
- Ensure your ward notifies the Bed Management Team when an empty bed is available

WHAT IS WINTER WARM UP WEEK?

This week's Winter Warm up Week involving staff from AMU, Allingham, Amyand, Caesar Hawkins, Marnham, Dalby, Heberden and Rodney Smith wards was an opportunity to embed the tools we have been using over the past 12 months to improve the patient flow from our Emergency Department (ED) to our Acute Medical Unit (AMU) to our General Medical Wards through to discharge. See the next newsletter for the lessons learned from the week and the links to the other intervention strategies.

WHAT IS 5-A-DAY?

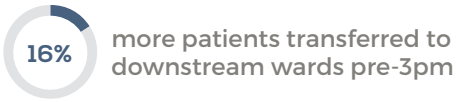
From the moment a patient is admitted onto a ward at St George's, we need to be planning for their discharge. For each patient that is admitted, we need to commit to giving them an estimated date of discharge within 24 hours of them arriving on the ward. With the easy drop down menu for iClip, we can ensure that we are both setting those targets and striving to achieve them.

CONGRATUALATIONS TO OUR WARDS

Our General Medical Wards have been working very hard to improve processes to support patient flow from AMU. Surgical Wards are contributing the majority of pre 11 discharges each week (around 70%) and that have been leading the trialling of tools such as patients 'Welcome Cards' and the Simple/Complex Discharge Tool. The teams have worked tirelessly in workshops and actively participated in initiatives which have released the following benefits:

Our General Medical wards can now boast:

Our Acute Medical Unit, Richmond ward can now boast:



Figures from project start: March–Jun/Jul 2015 comparable to the same time period 2014

HOW TO GET INVOLVED

Many of you will already be involved through your day-to-day work and particular initiatives such as pre-11am Discharge, but we need more people to get involved. If you are interested in contributing to a particular part of the Programme, please contact:

Ele Cerri, Michelle Woodward, or Orlagh Flynn, project & change managers, Service Improvement:

ele.cerri@stgeorges.nhs.uk
michelle.woodward@stgeorges.nhs.uk
orlagh.flynn@stgeorges.nhs.uk

Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – November 2015 **Paper Ref:**

Paper Title:	**Finance Report for Month 6 2015/16**
Sponsoring Director:	Steve Bolam, Chief Financial Officer & Deputy Chief Executive
Author:	Anna Anderson, Interim Operational Director of Finance
Purpose:	To inform the Board about the Trust's financial position at the end of September 2015
Action required by the board:	For review and to identify where further action or assurance is required
Document previously considered by:	Finance and Performance Committee

Executive summary

Income and expenditure performance in September was an improvement on previous months, and actual performance was a deficit of £3.3m, only £0.2m worse than plan. The underlying position was a deficit of £2.2m in the month. Whilst this improvement is good news it is too early to conclude that this is the start of a trend.

The cumulative deficit was £34.6m, £7.5m worse than plan and, as reported in previous months, the main contributory factors are: low outpatient income (£3.2m), costs/income adjustments relating to the prior year (£4m) and a £1.9m shortfall on savings. The full year effect of prior year adjustments is expected to be £3.3m once aged creditors are fully cleared in month 07. Work is progressing to improve data capture, systems and the accuracy of reporting (particularly for temporary staff and drugs), and to ensure actions are being taken to manage performance issues in each division.

£11.7m of CIPs have been achieved to date, and there are plans for a further £15.2m of red/amber/green schemes for the rest of the year. There is also a pipeline of £13.3m of further initiatives. £22.4m needs to be delivered in the second half of the year to reach the £34.2m, 90%, requirement in the annual plan.

Evidence of grip is starting to be seen in the reduction of agreed agency staff but these changes are not yet big enough to show in overall spend levels. Processes for control of temporary staff and non pay spend have been improved but again the impact of this on expenditure levels is not yet visible.

Cash management actions are being implemented and these have contributed to a cash position £4.7 better than plan at the end of September. The cash improvement is the main factor which has led to an improvement in the Trust's overall risk rating from 1 to 2 bringing it back up to plan.

Capital spend is continuing to be slowed down as part of the overall cash management plan and to date spend has been £16m against a plan of £27m.

The reforecasting exercise will be brought to a conclusion in November with the agreement of further actions needed to reduce spend in order to achieve an outturn no worse than the planned £46m deficit.

Enclosure:

Key risks identified: The control of expenditure and the delivery of a higher level of savings in the second half of the year when winter pressures will also be experienced. The need to balance financial measures with maintaining the quality of patient care.	
Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	Achieve financial targets in the near term 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? No No specific groups of patients of communities will be affected by the items in this report. Where there may be an impact on patients consultation will be managed as part of that specific programme.	

St George's Healthcare NHS
NHS Trust

Appendix A:

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

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

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
				15 Oct 2010
1.1 Who is responsible for this service / function / policy?				
1.2 Describe the purpose of the service / function / policy? *Who is it intended to benefit? What are the intended outcomes?*				
1.3 Are there any associated objectives? *E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives*				
1.4 What factors contribute or detract from achieving intended outcomes?				
1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability (physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Region or belief and Human Rights				

Enclosure:

1.6 If yes, please describe current or planned activities to address the impact.
1.7 Is there any scope for new measures which would promote equality?
1.8 What are your monitoring arrangements for this policy/ service
1.9 Equality Impact Rating [low, medium, high] **2.0. Please give your reasons for this rating**

Summary Finance Report
Month 6 2015/16

Trust Board 1st December 2015

1. Month 6 Headlines & Actions – I&E

Area of Review	Metric	Key Highlights	Actions	RAG
Overall financial performance in September	Deficit £3.3m, £0.2m worse than plan	September was an improvement on previous months with a deficit of £3.3m, only £0.2m worse than plan. After adjusting for one off turnaround spend, high cost drugs that related to earlier in the year and income provisions relating to the year to date, the underlying position was a deficit of £2.3m. Income was £2.3m worse than plan (mainly due to outpatient shortfalls and provisions) and expenditure was £2.1m less than plan resulting in a small net deficit. It is too early to conclude the improvement is the start of a downward trend.	- Review performanc in divisions to ensure variances are understood and appropriate action is being taken to address emerging/continuing issues - Complete the reforecasting exercise to assess likely year end outtun -Assess risks -Identify and agree actions to improve the overall position as much as possible in the second half of the year	
Overall financial performance - year to date	Deficit £36.4m, £7.5m worse than plan	The year to date deficit has increased from £31.3m at the end of August to £34.6m at the end of September. This is £7.5m worse than the plan. As a result of better performance in September the variance from plan has only increased by £0.2m in the month. The three main factors causing the deficit are as reported previously - low outpatient income, £3.2m, £4m of cost/income adjustments relating to 2014/15 which will reduce to £3.3m in month 07 once aged creditors are cleared and a savings shortfall of £1.9m.	- As above	
Activity/Income	Year to date income is £6.9m below plan.	As reported previously, low outpatient activity and prior year adjustments for 2014/15 income losses are the main contributors to the overall income shortfall. In addition, in September, higher provisions have been made for contract penalties and challenges. The outpatient shortfall is currently £3.2m, prior year losses are £1.2m and penalties etc are £1.3m higher than plan.	- Ensure outpatient recovery plans already agreed are implemented and further plans are developed -Negotiate options for reinvestment of penalties with CCGs -Ensure actions are taken to minimise further penalties, in particular RTT breaches.	
Expenditure-Pay	Year to date £3.4m worse than plan	The overspend is mainly due to the use of temporary staff to cover vacancies and also due to unidentified CIPs. Temporary spend has reduced in September and there is evidence of agency reductions and transfers to bank/permanent posts in a few areas. It is too early to say if this is a trend.	- Recruit permanent staff where possible - Switch from agency to bank or ideally to permanent posts - Identify further posts that can be cut from establishments - Improve controls on temporary staff e.g. through increased use of the e-rostering system - In the short term, improve systems for tracking and accounting for temporary staff not on e-rostering to allow better understanding of usage and control	
Expenditure-Non Pay	Year to date £2.2m better than plan	£1m of the underspend in September is in drugs and largely reflects flexing of the high cost drug budget. The calculation is being checked as it may be too high. This does not affect actual income or spend, only the variance reported. The CIP phasing adjustment of £0.8m is included in non pay and improves the position as does the CIP reserve. It is difficult to see a direct correlation between spend and activity as a variety of factors influence spend levels.	- Continue to develop 'grip' initiatives - Continue to review mechanisms for accounting for spend to maximise clarity of reporting and aid better control	
CIP	Delivery to date is £11.7m which is £1.9m below plan	Increase in green schemes from £12.7 last month to £18.1m at the end of September but overall value of RAG shemes has reduced by £1.7m in the month to £26.9m.	-Continue to work up amber and green schemes to green,complete governance processes and implement actions to deliver savings - Assess and agree further measures to reduce the likely year end deficit -Board discussion planned shortly.	

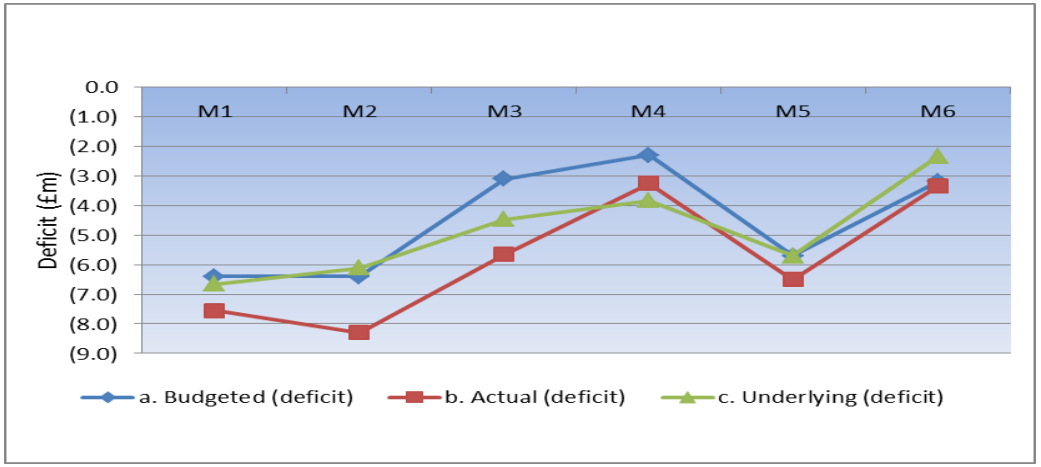
2. Month 6 Headlines & Actions – Cash and Capital

Area of Review	Metric	Key Highlights	Actions	RAG
Cash	Balance of £8.3m, £4.7m better than plan	The cash balance was £8.3m at 30th September which is £4.7m favourable to plan. The current cash forecast indicates the cash balance will be at least £6.5m on 31st October. Since month-end the Trust has drawn down a further £1.3m under the new £19.6m WCF approved by the board and ITFF at the end of September. The minimum cash balance required under this new working capital facility is £3m.	The Trust has in place a new Working Capital Facility of £19.6m to cover forecast cash financing requirements October to January inclusive. The level of interim support funding for 2015/16 will be finalised following the budget re-forecast exercise.	
Capital	YTD spend £16.2m, £10.9m less than plan.	Capital expenditure was £2.4m in September, an under spend of £3.7m in month against the reduced £48m capital programme agreed in June. The YTD expenditure total of £16.2m is £10.9m less than the revised budget.	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.	
FSRR (formally COSRR)	Rating of 2	The Trust scored a rating of 2 at month 6, in line with the September plan. This is an improvement on the month 5 position and is due to a higher cash balance.	Work on delivering savings to reduce the deficit and strong cash management referred to above should help to maintain an overall rating of 2, in line with the plan, for the rest of the year.	

3. Overall Position for the 6 months to 30th September

Income & Expenditure	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
SLA Income	626.2	55.3	52.9	(2.4)	308.2	301.7	(6.5)
Other Income	100.1	8.6	8.7	0.1	50.1	49.7	(0.4)
Overall Income	**726.3**	**63.9**	**61.6**	**(2.3)**	**358.3**	**351.4**	**(6.9)**
Pay	(453.9)	(37.7)	(37.8)	(0.1)	(224.3)	(227.7)	(3.4)
Non Pay	(281.9)	(26.3)	(24.1)	2.2	(143.5)	(141.3)	2.2
Overall Expenditure	**(735.8)**	**(64.1)**	**(62.0)**	**2.1**	**(367.8)**	**(369.0)**	**(1.2)**
EBITDA	(9.5)	(0.1)	(0.4)	(0.2)	(9.5)	(17.6)	(8.1)
Financing Costs	(36.7)	(3.0)	(3.0)	0.1	(17.6)	(17.0)	0.6
Surplus / (deficit)	**(46.2)**	**(3.2)**	**(3.3)**	**(0.2)**	**(27.1)**	**(34.6)**	**(7.5)**

Budget, Actual & Underlying surplus/(deficit) by month



Commentary

- The September deficit of £3.3m was only £0.2m worse than plan which is an improvement on previous months. The year to date deficit is £34.6m, £7.5m worse than plan
- Income is £6.9m under plan to date mainly due to underperformance in outpatients, prior year income losses previously notified and provision for challenges/fines
- Pay is £3.4m worse than plan to date as a result of agency cover of vacancies and unidentified CIPs
- Non pay expenditure is £2.2m under budget in part to high cost drugs flexing correction for August and a higher budget this month than prior months average
- Monthly underlying deficits are shown in the graph. In September adjustments have been made for one off turnaround costs, new income provisions that relate to the whole 6 month period and high cost drug income that should have been reported in month 5. These adjustments improve the position by £1m

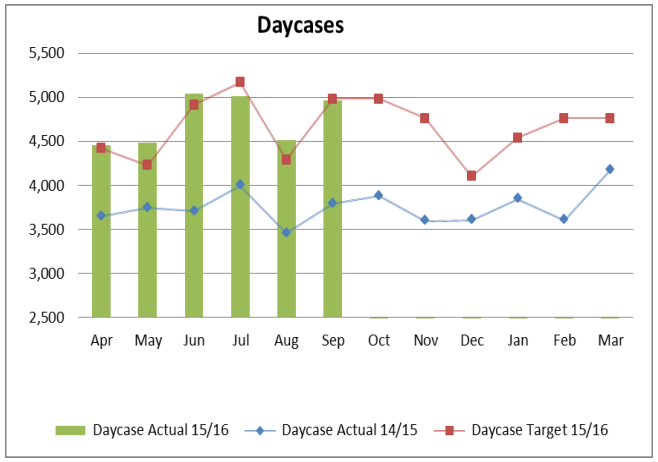
4. SLA Income for the 6 months to 30th September

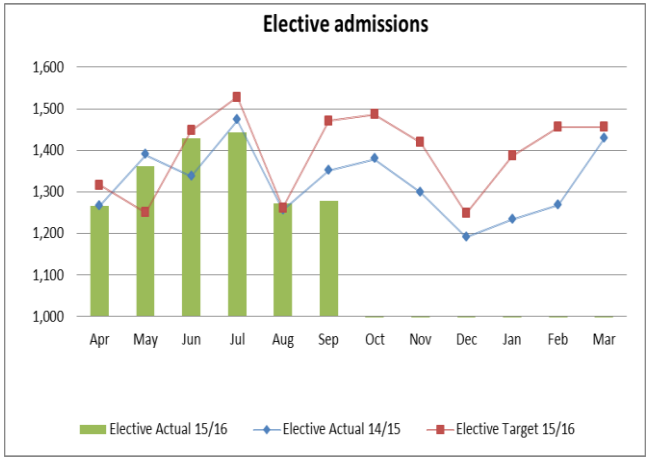
Activity	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
A&E	18.6	1.5	1.5	(0.0)	9.3	9.2	(0.1)
Bed Days	61.2	5.0	4.8	(0.2)	29.4	28.8	(0.6)
Daycase	29.5	2.6	2.7	0.1	14.7	15.1	0.4
Elective	64.5	5.7	5.6	(0.1)	31.7	32.2	0.4
Non Elective	121.8	9.9	9.9	(0.0)	60.4	60.4	(0.1)
Outpatients	142.7	12.7	11.8	(0.8)	70.9	67.7	(3.2)
Exclusions	76.2	8.4	8.1	(0.3)	35.9	36.0	0.0
Challenges/Penalties	(4.5)	(0.4)	(1.0)	(0.7)	(2.3)	(3.5)	(1.3)
Other	116.2	9.9	9.5	(0.4)	58.1	55.9	(2.2)
Grand Total	**626.2**	**55.3**	**52.9**	**(2.4)**	**308.2**	**301.7**	**(6.5)**

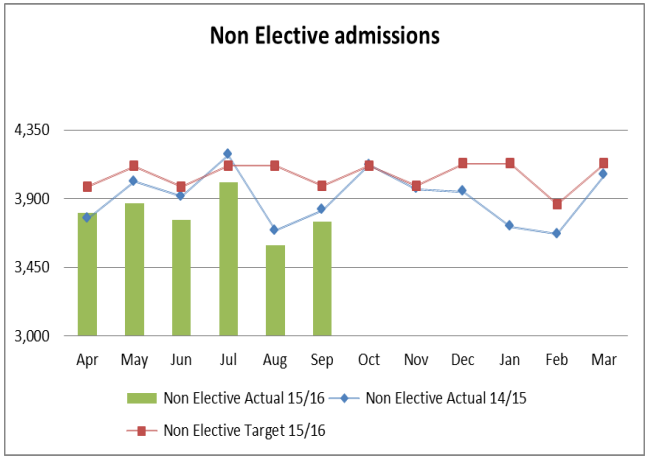
Commentary

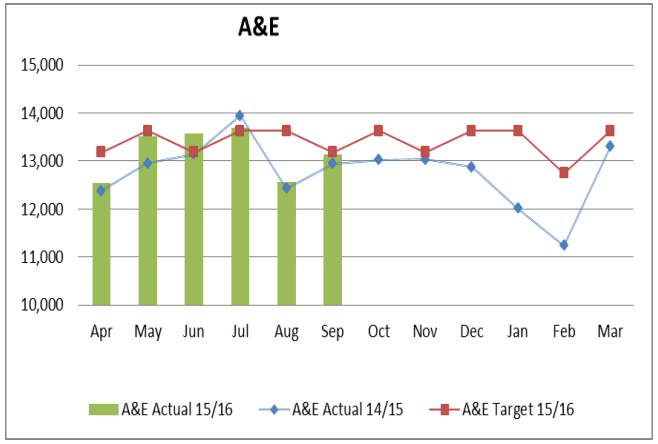
- SLA income was £2.4m below plan in the month and £6.5m below for the year to date
- The greatest variance was in outpatients and income is now £3.2m below plan to date. £1.9m of this relates to the main hospital, the shortfall at QMH was £0.7m and at the Nelson it was £0.6m after allowing for the Minimum Income Guarantee (MIG) which provides a benefit of £0.6m
- Emergency activity for 4 local CCGs is covered by a block contract which is currently providing a benefit of £0.3m as activity to date is below the block level. This is expected to change later in the year as the number of emergency patients rises
- Provisions of £3.5m have been made for penalties and KPI challenges
- Activity trends are shown on the next page

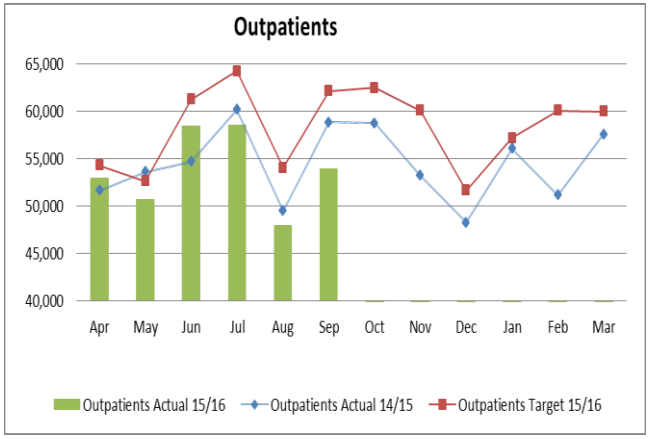
5. Patient activity compared to plan (for the 6 months to 30th September)











Commentary

In September (M6) activity across all areas has increased compared to August which is as expected.

Day case activity is 15% above last year and in line with plan.

Elective admissions are below plan and last year, partly due to uro-gynaecology

Non elective admissions are 6% below plan and 3% below last year

A&E attendances are 3% above last year but 1% below plan

Outpatient attendance are close to last year's level but 10% below plan.

6. SLA Income by Commissioner for the 6 months to 30th September

Income	Annual Budget (£m)	Year to Date		
		Budget (£m)	Actual (£m)	Better/(Worse) than Budget
NHSE Specialist	212.9	103.5	110.7	7.2
NHSE Public Health	23.7	11.7	11.9	0.1
NHSE Secondary Dental Care Services	8.6	4.3	4.3	0.0
NHSE Cancer Drugs Fund	2.9	1.4	1.4	0.1
Public Health England	0.4	0.2	0.5	0.3
Subtotal NHSE	**248.4**	**121.1**	**128.9**	**7.7**
NHS Wandsworth	146.9	73.4	74.1	0.7
NHS Merton	58.5	29.2	31.1	1.8
NHS Croydon	21.3	10.6	11.5	0.9
Other CCGs	21.2	10.3	8.9	(1.3)
NHS Lambeth	20.0	10.0	10.2	0.3
Surrey CCG	20.0	10.0	9.9	(0.1)
Other CCGs	38.2	19.1	18.8	(0.3)
Subtotal CCGs	**326.1**	**162.5**	**164.5**	**2.0**
Non Contracted Activity (NCA)	7.9	3.9	4.4	0.4
Other Trusts	1.1	0.5	0.6	0.1
Other Local Authority	8.0	4.0	3.9	(0.1)
Subtotal CCGs	**17.0**	**8.5**	**8.9**	**0.5**
Internal Targets: Growth, Business Cases etc	26.8	12.2	(4.4)	(16.5)
Ex SLA Income	7.9	3.9	3.8	(0.2)
Total NHS Healthcare Income	**626.2**	**308.2**	**306.1**	**(6.5)**
Other Income				
Private & Overseas Patient	5.1	2.5	2.7	0.2
Road Traffic Accidents (RTAs)	4.5	2.3	2.1	(0.2)
Other Healthcare Income	0.1	0.1	0.2	0.1
Education & Training Income	43.9	21.9	21.9	0.0
Other Income	46.5	23.3	22.9	(0.4)
Total 'Other' Income	**100.0**	**50.0**	**49.7**	**(0.4)**
Total income	**726.2**	**358.2**	**355.8**	**(6.8)**

Commentary

This table shows the Trust's performance against the contract values agreed with each major commissioner.

The Trust is over performing significantly on the NHSE and local CCG – particularly Wandsworth, Merton, Lambeth and Croydon contracts.

The Trust has set additional internal targets to reflect patient activity that was expected over and above agreed contract values. Taking this into account the Trust is below its total planned activity targets by £6.5m year to date.

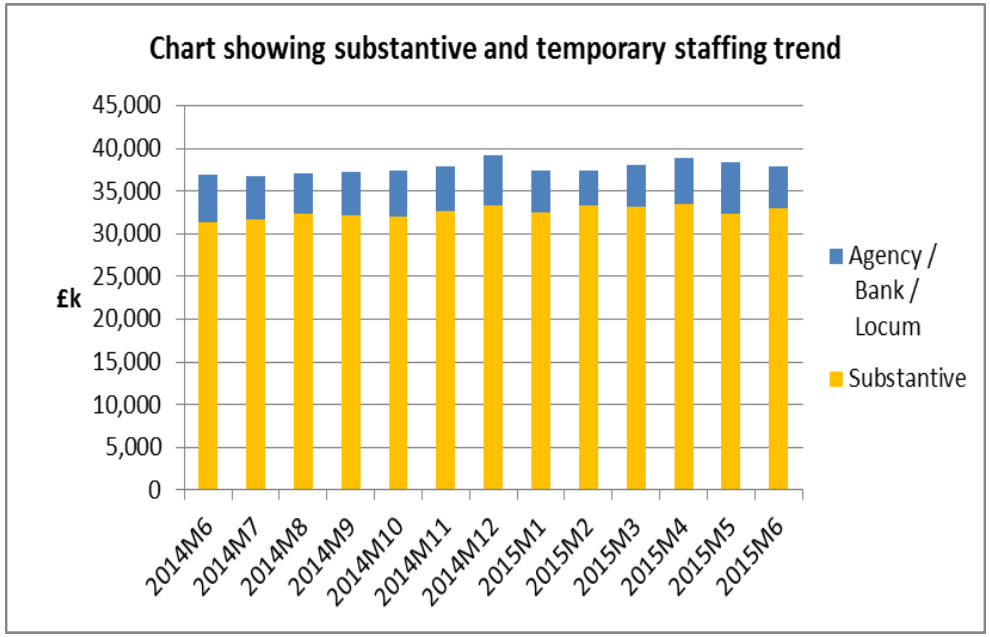
7. Pay costs for the 6 months to 30th September

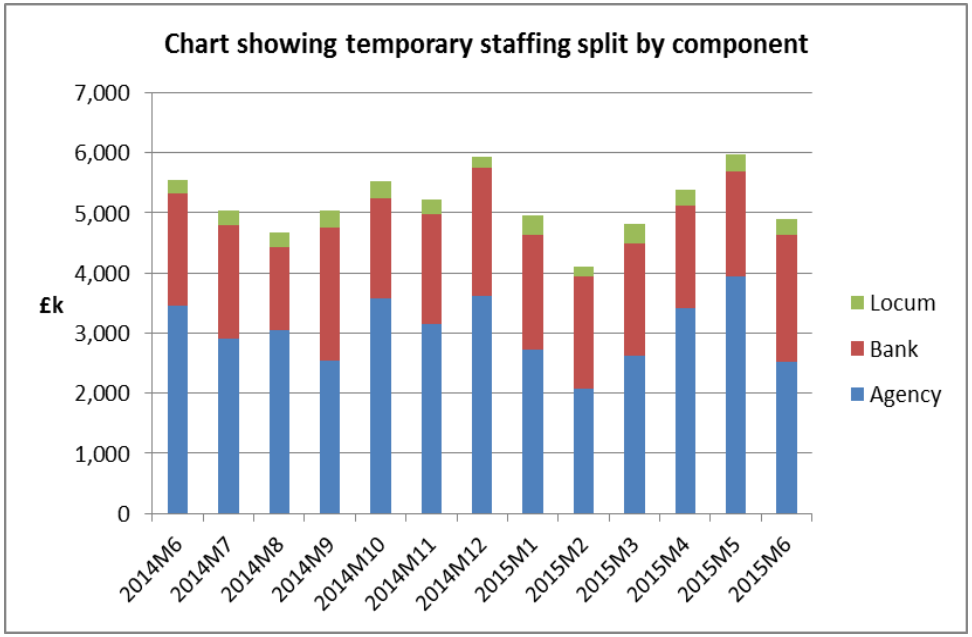
Pay Summary by Staff Type	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
Consultants	(71.4)	(5.7)	(6.2)	(0.4)	(35.2)	(36.0)	(0.8)
Junior Doctors	(50.1)	(3.6)	(4.0)	(0.4)	(24.6)	(25.1)	(0.5)
Non Clinical	(78.7)	(5.9)	(6.3)	(0.4)	(39.1)	(38.6)	0.6
Nursing	(187.1)	(14.0)	(14.6)	(0.7)	(91.6)	(87.5)	4.1
Other	15.6	(2.4)	0.0	2.4	7.1	(0.0)	(7.1)
Scientists, Technicians, Therapists	(83.5)	(6.1)	(6.7)	(0.5)	(41.5)	(40.5)	1.0
Unallocated	1.4	0.1	0.0	(0.1)	0.7	0.0	(0.7)
Grand Total	(453.9)	(37.7)	(37.8)	(0.1)	(224.3)	(227.7)	(3.4)

Commentary

- In September total pay spend was only marginally more than planned and cumulatively it is is £3.4m above plan.
- There has been a £0.4m decrease in non nursing agency spend reported in September. A review has identified that not all of administrative agency staff have been booked through the bank office system so there is a greater level of estimation of accruals for hours worked but not invoiced. Spend appears to have reduced more than usage. This is an area of joint work between finance and HR teams, with support from KPMG, to improve control, reduce spend and improve the accuracy of reporting.
- The reduction in agency staff and the conversion of agency staff to bank or permanent planned as part of 'Grip' is starting to be seen but is not yet on a large enough scale to be visible in overall Trust spend levels. Administrative agency staff numbers have reduced.
- Overall agency spend as a percentage of the total pay bill in September is unchanged from the previous average of 7%, while bank spend increased by 1% to 6%.
- All clinical divisions are showing overspends on pay, due to use of temporary staff to cover vacancies, unidentified CIPs and CIP phasing which is adjusted for centrally (see non-pay slide)

8. Pay trend





Commentary

- Total pay of £37.8m in month 6 is £0.9m (16%) higher than the same month last year. 2.5% can be attributed to pay awards and increments, the balance relates to service developments such as the Nelson and additional capacity, such as Gordon Smith, less savings
- Temporary (bank/locum/ agency) spend for the year to date averages 13% of the total monthly pay bill. 57% of this temporary staff spend relates to agency while the remaining 43% is bank/locum staff. As part of the turnaround process work is progressing to reduce agency staff and to grow the bank and also to increase the proportion of posts filled with permanent staff
- The reduction in agency spend shown in September includes early benefits from switching away from agency usage though these are relatively small scale initially. Work is progressing to understand the complexities of temporary pay reporting, minimise swings between months due to timing and processing issues and to allow a better understanding of trends.

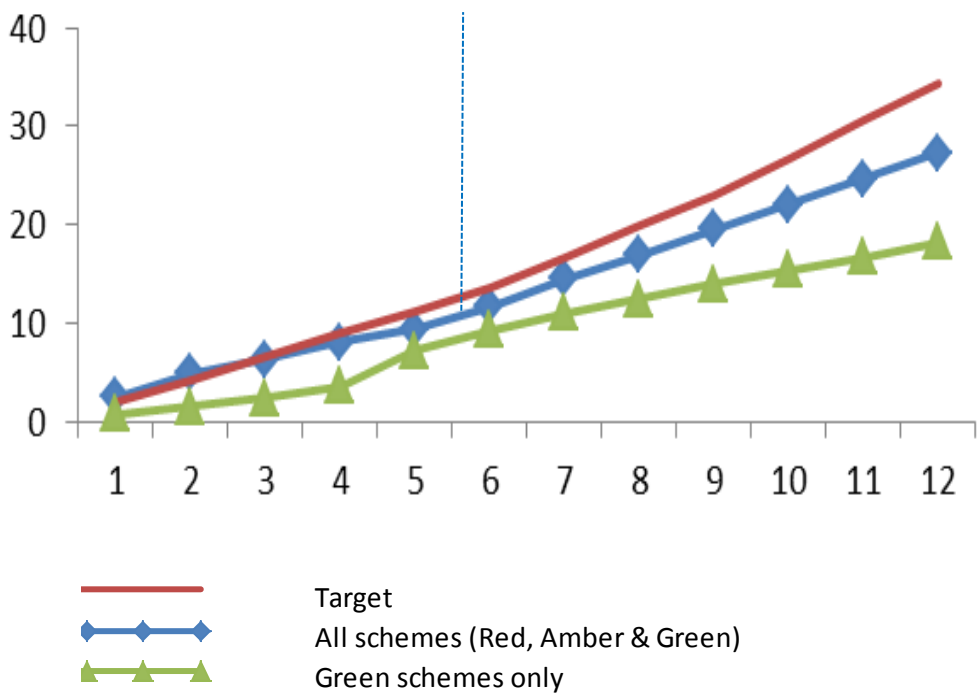
9. Non pay costs for the 6 months to 30th September

Non Pay Category	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
Clinical Consumables	(98.1)	(8.2)	(7.9)	0.3	(49.5)	(48.0)	1.5
Drugs	(61.3)	(7.0)	(6.0)	1.0	(29.5)	(30.0)	(0.5)
Premises	(43.1)	(3.0)	(3.3)	(0.3)	(21.7)	(20.8)	0.9
Clinical Negligence	(14.9)	(1.2)	(1.3)	(0.0)	(7.4)	(7.6)	(0.2)
Establishment	(10.8)	(0.8)	(0.9)	(0.2)	(5.4)	(5.7)	(0.3)
General Supplies	(16.7)	(1.4)	(1.3)	0.0	(8.4)	(8.3)	0.0
Non Pay Unallocated	0.2	0.0	(0.0)	(0.0)	0.1	(0.0)	(0.1)
PFI Unitary payment	(7.0)	(0.6)	(0.6)	0.0	(3.5)	(3.5)	(0.0)
Other	(47.9)	(5.3)	(5.4)	(0.1)	(23.9)	(27.4)	(3.5)
Reserves	(12.1)	(0.8)	(0.3)	0.5	(5.5)	(3.1)	2.5
Prior Year Costs	0.0	0.0	0.0	0.0	0.0	(1.3)	(1.3)
Trust Central	29.8	2.0	2.8	0.8	11.3	14.5	3.2
Grand Total	**(281.9)**	**(26.3)**	**(24.1)**	**2.2**	**(143.5)**	**(141.3)**	**2.2**

Commentary

- September non pay spend was £2.2m less than budget, the budget for September was also higher than the average for previous months
- Clinical consumables spend in month was £0.3m below plan and to date there is an underspend of £1.5m. There is not a clear correlation between overall spend and activity
- Drug spend in the month was £1m below budget. £0.7m of the underspend relates to budget adjustments to correct the month 5 reported overspend on high cost drugs. The flexing adjustment (to eliminate variances on pass through drug use matched by income) is being reviewed as it appears to have been overstated. This does not affect actual spend reported. The process for accounting for all aspects of high cost drugs is being documented to avoid further problems
- The variance of £0.5m on reserves relates to release of the monthly CIP reserve
- 'Trust Central' is made up of SWLP Consortium accounting adjustments and the CIP phasing adjustment. The September variance is £0.8m better than plan, and year to date is £3.2m better than the plan. This relates to favourable budget adjustment of £0.9m (and £3.8m to date) to align the ledger with the Monitor plan where CIP phasing is end loaded (CIPs are in equal 1/12th in the ledger)

10. Trust CIP performance



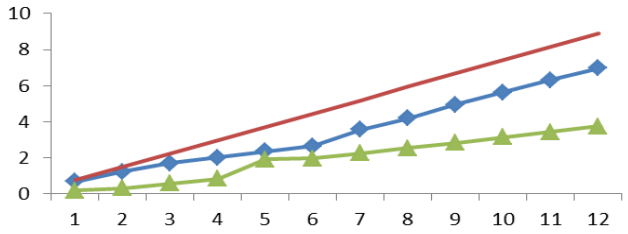
Commentary

- The divisional CIP target for 2015/16 is £38.1m and this is profiled in the budget in 1/12s. The financial plan agreed with Monitor assumes 90% of this, i.e. £34.2m, is achieved and that delivery is phased more towards the latter part of the year
- The chart shows CIP plans and delivery against the Monitor plan
- In the year to date the Trust has delivered £11.7m of savings compared to a plan of £13.6m. Of the £11.7m delivered so far, £6.5m is CIPs and the balance of £5.3m is non-recurrent and run rate/vacancy control savings
- £22.4m more CIPs are required in the second half of the year to meet the overall financial plan but there are currently only plans for £15.2m. This is a continuing focus of activity to complete plans and to deliver the full sum required
- Since month 5 the total value of red/amber and green schemes has reduced by £1.7m as procurement savings have been reassessed and future run rate savings have been reduced. However within this the value of green schemes has increased from £12.7m last month to £18.1m at the end of September which is positive
- The total value of red, amber and green schemes is £27m and there is a pipeline of £13.3m bringing the total up to a potential £40.3m if all schemes deliver
- Looking to 2016/17 the extra full year effect of 2015/16 schemes is £6.3m however this is more than offset by the loss of 2015/16 non recurring schemes of £8.1m. In addition £3.8m of new CIPs have so far been identified for 2016/17

11. Trust CIP performance - divisions

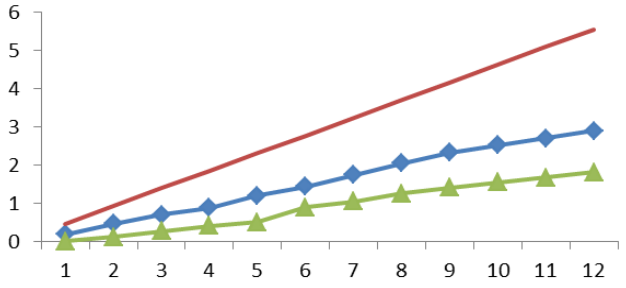
Children and Women

£7.0m schemes have been developed against the £8.9m target so there is a gap of £1.9m. To date £1.9m less than plan has been saved and this gap is expected to continue. Green schemes are 53% of the total identified so far.



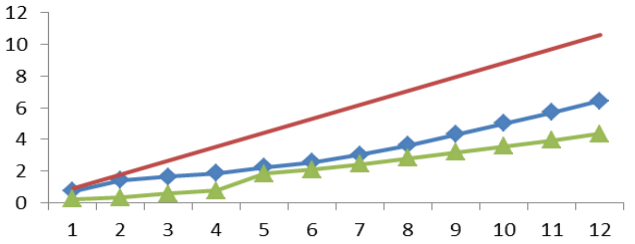
Community Services

£2.9m schemes have been developed against the £5.6m target, the gap is £2.7m and is not expected to be eliminated. Year to date underperformance is £1.3m. Green schemes are 62% of the total.



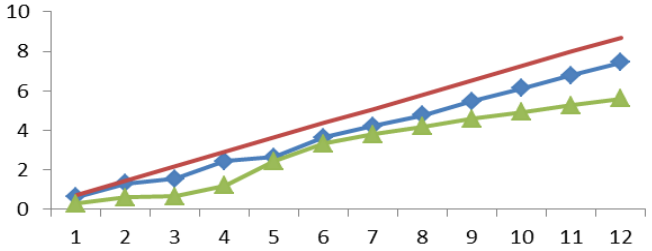
Medicine & Cardiovascular

£6.0m schemes have been developed against the £10.6m target. The gap is £4.6m. Year to date underperformance is £2.7m. Green schemes are 72.5% of the total.



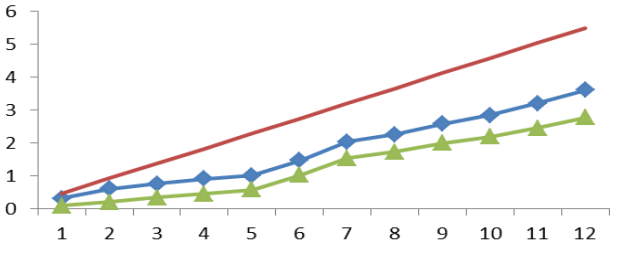
Surgery and Neurosciences

£7.4m schemes have been developed against a £8.7m target. The gap is £1.3m. Year to date savings are £0.7m below plan. Green schemes are 75% of the total. The division expects to close the gap with run rate schemes.



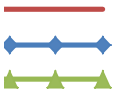
Overheads

£3.6m schemes have been developed against £5.6m target. The gap is £2.7m. In the year to date £1.3m less than plan has been saved. Green schemes are 77% of the total. Corporate functions are close to closing the gap with the schemes submitted recently. Estates & Facilities expect to close the gap through run rate savings



Commentary

- Divisional targets are based on the £38.1m target phased in 1/12s.The 10% CIP provision is held centrally.
- The biggest forecast shortfall is £4.6m in Medicine.
- Further work is on-going to firm up on red/amber schemes and to complete governance processes so they can become green.
- Additional schemes have been added after the cut-off date for F&P reporting



Target
All schemes (Red, Amber & Green)
Green schemes only

12. Divisional Summaries for the 6 months to 30th September
KEY HEADLINES

Area of Review	Key Highlights
Medicine & Cardiovascular	The division's performance was close to plan in September and is £3.9m worse than plan to date. SLA income is £1m worse than planned due to underperformance on Outpatients. Pay is £1.7m and non pay £1.1m worse than plan mainly due to unidentified CIPs and temporary cover of vacancies . The balanced performance this month is partly due to an adjustment to increase the budget for high cost drug issues incorrectly reported in month 5.
Surgery, Neurosciences Theatres & Cancer	The division is £2.3m adverse to plan to date, driven by a £1.9m pay and non-pay overspend as a result of unidentified CIPs and use of external providers. In month, the division is £0.7m worse than budget even following in month adjustment to the drugs budget to correct overspend reported last month for high cost drugs. This is largely due to use of external facilities and unidentified CIPs
Community Services	The division is £1.2m behind plan year to date, largely driven by underperformance in SLA outpatient income across a number of services at QMH. There are also unidentified CIPs contributing to the adverse variance from plan. In month, the division was broadly in line with budget.
Children, Women and Diagnostics	Overall the division is £1.5m behind its year to date plan, driven by underperformance in SLA income relating to the cessation of the Uro-gynaencology service, low outpatient activity and pay and non pay overspends due to unidentified CIPs.
Overheads	Overhead services performance was is £0.3m worse than plan in September and are £0.6m behind cumulatively. This is driven by SWL Pathology recharges and additional turnaround costs.

Medicine & Cardiovascular - Divisional I&E for the 6 months to 30th September

Medicine and Cardiovascular

Income & Expenditure	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
SLA Income							
A&E	17.4	1.4	1.4	0.0	8.7	8.7	(0.0)
Daycase	11.6	1.0	1.1	0.1	5.7	5.8	0.1
Elective	23.5	2.1	2.3	0.2	11.8	12.1	0.2
Exclusions	33.0	4.1	4.1	0.0	16.4	16.3	(0.1)
Non Elective	64.5	5.3	5.1	(0.2)	32.1	32.4	0.3
Other	19.0	1.6	1.5	(0.1)	9.5	9.0	(0.5)
Outpatients	37.0	3.3	3.1	(0.2)	18.5	17.4	(1.0)
Programme	15.9	1.2	1.0	(0.2)	6.5	6.5	(0.0)
	222.0	20.0	19.7	(0.4)	109.2	108.2	(1.0)
Other Income	19.4	1.6	1.6	(0.1)	9.7	9.5	(0.1)
Overall Income	**241.4**	**21.7**	**21.2**	**(0.4)**	**118.9**	**117.7**	**(1.1)**
Pay							
Consultants	(19.6)	(1.6)	(1.7)	(0.1)	(9.8)	(9.6)	0.1
Junior Doctors	(19.0)	(1.4)	(1.5)	(0.1)	(9.3)	(9.4)	(0.1)
Non Clinical	(8.5)	(0.7)	(0.7)	(0.1)	(4.2)	(4.3)	(0.1)
Nursing	(54.9)	(4.1)	(4.3)	(0.2)	(27.1)	(26.5)	0.6
Other	4.6	(0.5)	0.0	0.5	2.3	0.0	(2.3)
Scientists, Technicians, Therapists	(5.3)	(0.4)	(0.4)	0.0	(2.7)	(2.6)	0.1
Pay Unallocated	0.0	(0.1)	0.0	0.1	0.0	0.0	(0.0)
	(102.8)	(8.8)	(8.6)	0.2	(50.8)	(52.5)	(1.7)
Non-Pay							
Clinical Consumables	(37.4)	(3.1)	(3.3)	(0.2)	(19.2)	(19.5)	(0.3)
Drugs	(33.0)	(4.0)	(2.9)	1.1	(15.4)	(14.9)	0.4
Establishment	(1.5)	(0.1)	(0.2)	(0.0)	(0.8)	(0.9)	(0.1)
General Supplies	(0.2)	(0.0)	(0.0)	(0.0)	(0.1)	(0.2)	(0.1)
Non Pay Unallocated	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Other	(2.4)	0.2	(0.2)	(0.4)	(1.2)	(2.3)	(1.1)
Premises	(0.5)	(0.0)	(0.0)	(0.0)	(0.2)	(0.2)	0.1
	(75.0)	(7.1)	(6.7)	0.4	(36.9)	(38.0)	(1.1)
Overall Expenditure	**(177.8)**	**(15.9)**	**(15.3)**	**0.6**	**(87.6)**	**(90.5)**	**(2.8)**
EBITDA	**63.6**	**5.8**	**6.0**	**0.2**	**31.2**	**27.3**	**(3.9)**
Financing Costs	(4.5)	(0.4)	(0.4)	(0.0)	(2.3)	(2.3)	0.0
Surplus / (deficit)	**59.1**	**5.4**	**5.6**	**0.2**	**29.0**	**25.0**	**(3.9)**

Commentary

The division's surplus for the month was £0.2m better than plan and the year to date position is now a surplus of £25m which is £3.9m worse than plan.

Income is £0.4m below plan in the month. This is mainly due to low outpatient numbers particularly in dermatology and gastroenterology . These are expected to improve later in the year. There is also an issue relating to renal where the Trust is only being paid a marginal rate and the contract team is in discussion with NHSE to resolve this.
There has been an error this month which has distorted variances for high cost drug/device income and spend. This does not affect actual spend reported and will be corrected next month.
Cumulatively the main income challenge is outpatients where income is £1m worse than plan in specialist medicine and at the Nelson, overall growth anticipated in the budget has not been achieved.

Pay is £0.2m below plan in month due to lower accruals for agency nurses as previous spend had been too high. Pay is £1.7m over budget cumulatively due to unidentified CIPs.

Non-pay is favourable by £0.4m in month and £1.1m to date. The latter is due to prior year invoices and unidentified CIPs.

Surgery, Neurosciences, Theatres & Cancer - Divisional I&E for the 6 months to 30th September

Surgery and Neurosciences

Income & Expenditure	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
SLA Income							
Bed Days	7.4	0.6	0.5	(0.1)	3.7	3.5	(0.3)
Daycase	13.5	1.2	1.2	(0.0)	6.8	6.9	0.1
Elective	35.9	3.1	2.9	(0.2)	17.4	18.0	0.7
Exclusions	10.6	1.6	1.5	(0.1)	5.3	5.5	0.1
Non Elective	50.0	4.1	4.4	0.3	24.7	24.5	(0.2)
Other	2.5	0.2	0.2	(0.0)	1.3	0.9	(0.4)
Outpatients	31.3	2.8	2.8	0.0	15.5	15.6	0.1
Programme	1.9	(0.0)	0.0	0.0	0.3	0.3	0.0
	153.1	13.5	13.4	(0.1)	74.8	75.0	0.2
Other Income	18.5	1.6	1.4	(0.1)	9.2	8.6	(0.6)
Overall Income	**171.6**	**15.1**	**14.9**	**(0.2)**	**84.0**	**83.6**	**(0.4)**
Pay							
Consultants	(25.6)	(1.9)	(2.1)	(0.2)	(12.6)	(13.0)	(0.5)
Junior Doctors	(15.2)	(1.0)	(1.3)	(0.3)	(7.5)	(7.8)	(0.2)
Non Clinical	(9.4)	(0.7)	(0.8)	(0.1)	(4.6)	(4.7)	(0.1)
Nursing	(45.8)	(3.1)	(3.7)	(0.6)	(22.0)	(21.0)	1.0
Other	2.3	(1.2)	0.0	1.2	0.7	0.0	(0.7)
Scientists, Technicians, Therapists	(11.1)	(0.8)	(0.9)	(0.1)	(5.4)	(5.3)	0.1
Pay Unallocated	1.2	0.1	0.0	(0.1)	0.6	0.0	(0.6)
	(103.7)	(8.6)	(8.8)	(0.2)	(50.8)	(51.8)	(1.0)
Non-Pay							
Clinical Consumables	(22.3)	(1.8)	(1.8)	0.0	(11.1)	(10.5)	0.6
Clinical Negligence	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Drugs	(9.7)	(1.3)	(1.0)	0.4	(4.6)	(4.5)	0.1
Establishment	(0.4)	(0.0)	(0.0)	(0.0)	(0.2)	(0.2)	(0.0)
General Supplies	(0.3)	(0.0)	(0.0)	0.0	(0.2)	(0.2)	0.0
Non Pay Unallocated	0.2	0.0	0.0	(0.0)	0.1	0.0	(0.1)
Other	(0.4)	0.4	(0.3)	(0.7)	0.1	(1.5)	(1.5)
Premises	(0.8)	(0.1)	(0.1)	(0.0)	(0.3)	(0.3)	0.0
	(33.7)	(2.9)	(3.2)	(0.3)	(16.2)	(17.1)	(0.9)
Overall Expenditure	**(137.4)**	**(11.5)**	**(12.0)**	**(0.5)**	**(67.0)**	**(68.9)**	**(1.9)**
EBITDA	**34.2**	**3.6**	**2.9**	**(0.7)**	**16.9**	**14.7**	**(2.3)**
Financing Costs	(4.0)	(0.3)	(0.3)	0.0	(2.0)	(2.0)	0.0
Surplus / (deficit)	**30.3**	**3.3**	**2.6**	**(0.7)**	**15.0**	**12.7**	**(2.3)**

Commentary

The division's surplus was £2.6m in September which was £0.7m worse than plan. The year to date surplus is now £2.3m worse than plan. Most of this variance relates to expenditure which is £1.9m higher than budgeted.

Income

Elective income in the month was low (£0.2m) due to theatre closures, a reduction in the bariatric tariff and underperformance in breast activity. Cumulatively elective income is still above plan by £0.7m.

There continues to be a deficit year to date on other income as the Trust has not assumed any profit share from the Elective Orthopaedic Centre (£0.4m) due to a current underperformance of activity. Neuroscience private income is £0.2m less than the uplifted budget for the year and income for work in Gibraltar is not yet reflected in the divisional income position and is being investigated.

Pay

The year to date pay overspend of £1.0m is mainly due to the unidentified CIP gap and non-recurrent prior year costs from Wandsworth borough council social workers of £0.2m.

Non-Pay

£0.6m of the deficit is due to unidentified CIPs. There is an overspend of £0.9m on use of the private sector which was raised and agreed as a £1.8m cost pressure for 15/16. This has contributed to the current month variance on 'Other' along with a re-phasing of the budget for the Clavadel ward.

Community Services - Divisional I&E for the 6 months to 30th September

Community Services

Income & Expenditure	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
SLA Income							
A&E	1.3	0.1	0.1	(0.0)	0.6	0.6	(0.0)
Bed Days	5.6	0.5	0.5	0.0	2.8	2.7	(0.1)
Exclusions	8.4	0.9	0.9	0.0	4.4	4.4	(0.0)
Other	65.4	5.7	5.5	(0.2)	32.7	32.5	(0.3)
Outpatients	26.0	2.3	2.1	(0.2)	13.1	12.0	(1.1)
	106.7	9.5	9.1	(0.4)	53.6	52.1	(1.5)
Other Income	3.4	0.3	0.2	(0.1)	1.7	1.6	(0.1)
Overall Income	**110.1**	**9.8**	**9.3**	**(0.5)**	**55.3**	**53.7**	**(1.6)**
Pay							
Consultants	(2.4)	(0.2)	(0.2)	(0.0)	(1.2)	(1.2)	0.0
Junior Doctors	(1.4)	(0.1)	(0.2)	(0.1)	(0.7)	(1.1)	(0.4)
Non Clinical	(7.6)	(0.5)	(0.6)	(0.2)	(3.8)	(3.8)	0.0
Nursing	(28.9)	(2.4)	(2.0)	0.4	(14.4)	(12.7)	1.7
Other	3.5	0.0	0.0	(0.0)	1.8	0.0	(1.8)
Scientists, Technicians, Therapists	(13.6)	(0.9)	(1.1)	(0.1)	(6.9)	(6.6)	0.3
Pay Unallocated	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)
	(50.2)	(4.2)	(4.1)	0.0	(25.2)	(25.5)	(0.2)
Non-Pay							
Clinical Consumables	(9.2)	(0.8)	(0.8)	(0.1)	(4.9)	(4.6)	0.4
Clinical Negligence	0.0	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)
Drugs	(11.3)	(1.1)	(1.0)	0.0	(5.8)	(6.0)	(0.2)
Establishment	(1.0)	(0.1)	(0.1)	(0.0)	(0.5)	(0.6)	(0.1)
General Supplies	(0.1)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Non Pay Unallocated	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Other	(9.2)	(1.1)	(0.7)	0.4	(4.8)	(4.2)	0.5
Premises	(0.6)	(0.0)	(0.0)	0.0	(0.4)	(0.3)	0.0
	(31.5)	(3.1)	(2.7)	0.4	(16.5)	(15.8)	0.7
Overall Expenditure	**(81.7)**	**(7.2)**	**(6.8)**	**0.4**	**(41.7)**	**(41.2)**	**0.4**
EBITDA	**28.4**	**2.5**	**2.5**	**(0.1)**	**13.6**	**12.4**	**(1.2)**
Financing Costs	(0.2)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)
Surplus / (deficit)	**28.2**	**2.5**	**2.5**	**(0.1)**	**13.5**	**12.3**	**(1.2)**

Commentary

In September the division was virtually in line with the £2.5m planned deficit. The year to date position is a surplus of £12.3m which is £1.2m worse than plan.

Income

Outpatients income continues to be under plan at Queen Mary's and in sexual health and the year to date variance now stands at £1.1m.

Expenditure

Recruitment difficulties in Offender Services have contributed to the underspend on nursing in September.

The total nursing underspend to date is now £1.8m.

CIP under-delivery is the main factor contributing to the cumulative 'other' variance on pay.

In non pay 'other' the underspend relates to contracts with Kingston Hospital and other contract services.

Children, Women, Diagnostics & Therapies - Divisional I&E for the 6 months to 30th September

C&W, Diagnostics, Therapies

Income & Expenditure	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
SLA Income							
Bed Days	48.2	3.9	3.8	(0.1)	22.9	22.7	(0.2)
Daycase	4.4	0.4	0.4	0.0	2.2	2.4	0.2
Elective	5.1	0.5	0.3	(0.1)	2.5	2.1	(0.5)
Exclusions	1.8	0.2	0.2	0.0	0.9	1.0	0.1
Non Elective	8.1	0.7	0.6	(0.0)	4.0	4.4	0.4
Other	20.1	1.7	1.6	(0.0)	10.0	9.9	(0.1)
Outpatients	40.2	3.6	3.3	(0.3)	19.8	18.6	(1.2)
Programme	0.4	0.0	0.0	0.0	0.1	0.1	0.0
	128.2	10.9	10.3	(0.6)	62.5	61.3	(1.2)
Other Income	19.0	1.6	2.3	0.7	9.5	10.3	0.9
Overall Income	**147.2**	**12.5**	**12.6**	**0.1**	**72.0**	**71.6**	**(0.4)**
Pay							
Consultants	(16.9)	(1.4)	(1.5)	(0.1)	(8.2)	(8.5)	(0.3)
Junior Doctors	(13.3)	(1.1)	(1.0)	0.0	(6.5)	(6.3)	0.1
Non Clinical	(14.8)	(1.0)	(1.1)	(0.1)	(7.1)	(6.9)	0.3
Nursing	(53.0)	(4.0)	(4.2)	(0.2)	(25.9)	(25.0)	0.8
Other	3.7	(0.7)	0.0	0.7	1.6	0.0	(1.6)
Scientists, Technicians, Therapists	(31.8)	(2.2)	(2.5)	(0.3)	(15.4)	(15.0)	0.3
Pay Unallocated	0.2	0.0	0.0	(0.0)	0.1	0.0	(0.1)
	(126.0)	(10.3)	(10.3)	0.0	(61.4)	(61.8)	(0.4)
Non-Pay							
Clinical Consumables	(14.3)	(1.2)	(0.7)	0.5	(7.1)	(6.3)	0.7
Drugs	(7.2)	(0.7)	(1.2)	(0.5)	(3.6)	(4.4)	(0.8)
Establishment	(0.8)	(0.1)	(0.1)	0.0	(0.4)	(0.3)	0.1
General Supplies	(0.5)	(0.0)	(0.0)	0.0	(0.3)	(0.2)	0.0
Non Pay Unallocated	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Other	(0.9)	(0.3)	(0.2)	0.1	(0.4)	(1.3)	(0.8)
Premises	(1.6)	(0.1)	(0.1)	0.0	(0.8)	(0.7)	0.1
	(25.3)	(2.4)	(2.3)	0.0	(12.5)	(13.2)	(0.7)
Overall Expenditure	**(151.3)**	**(12.7)**	**(12.7)**	**0.0**	**(73.9)**	**(75.1)**	**(1.1)**
EBITDA	**(4.2)**	**(0.2)**	**(0.1)**	**0.2**	**(2.0)**	**(3.5)**	**(1.5)**
Financing Costs	(6.4)	(0.5)	(0.5)	0.0	(3.2)	(3.2)	(0.0)
Surplus / (deficit)	**(10.6)**	**(0.8)**	**(0.6)**	**0.2**	**(5.2)**	**(6.7)**	**(1.5)**

Commentary

The division had a deficit of £0.6m in September which was £0.2m better than plan, though year to date the deficit is £1.5m worse than plan.

SLA Income in month 6 was worse than plan by £0.6m. This is mainly due to low outpatient activity, partly related to cessation of the Urogynaecology service, therapy activity was also low but a recovery plan has been agreed to improve this. Low antenatal activity is being investigated.

Other Healthcare income is £0.7m better than plan due to increased activity on the Pharmacy wholesale dealer licence which is also matched by an increase in drugs costs (this is a contribution generating income CIP).

Pay is on plan in September and the variances show the removal of CIPs/run rate savings and a reduction in the unallocated CIP negative budget labelled as 'other'. The adverse year to date position is due to unidentified CIPs offset by other underspends.

Non pay – Clinical consumable spend is down in month due to lower than planned activity and lower than planned use of mobile diagnostics. The drug overspend relates to pharmacy commercial activity which is offset by additional wholesale dealer drugs income. Unidentified CIPs are also reflected in the year to date position.

Overheads - Divisional I&E for the 6 months to 30th September

Overheads

Income & Expenditure	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
SLA Income							
Exclusions	4.2	0.4	0.3	(0.1)	2.1	2.0	(0.1)
Other	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Outpatients	7.8	0.7	0.6	(0.1)	3.9	4.0	0.1
	12.0	1.0	0.9	(0.2)	6.0	6.0	(0.0)
Other Income	21.0	1.8	1.6	(0.2)	10.4	10.0	(0.4)
Overall Income	**33.0**	**2.9**	**2.5**	**(0.4)**	**16.5**	**16.0**	**(0.4)**
Pay							
Consultants	0.9	0.1	0.0	(0.0)	0.4	0.4	(0.0)
Junior Doctors	(1.2)	(0.1)	(0.1)	0.0	(0.6)	(0.5)	0.1
Non Clinical	(35.4)	(2.8)	(2.8)	(0.0)	(17.7)	(16.8)	0.9
Nursing	(3.6)	(0.3)	(0.3)	(0.0)	(1.8)	(1.8)	0.0
Other	1.5	(0.1)	0.0	0.1	0.8	(0.0)	(0.8)
Scientists, Technicians, Therapists	(5.3)	(0.4)	(0.4)	0.0	(2.6)	(2.4)	0.2
Pay Unallocated	(0.0)	(0.0)	0.0	0.0	(0.0)	0.0	0.0
	(43.1)	(3.6)	(3.6)	(0.0)	(21.5)	(21.1)	0.4
Non-Pay							
Clinical Consumables	(0.9)	(0.1)	(0.2)	(0.1)	(0.4)	(0.7)	(0.2)
Clinical Negligence	(14.9)	(1.2)	(1.3)	(0.0)	(7.4)	(7.6)	(0.2)
Drugs	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.0)
Establishment	(6.7)	(0.4)	(0.4)	0.0	(3.4)	(3.3)	0.0
General Supplies	(15.5)	(1.3)	(1.2)	0.0	(7.8)	(7.7)	0.1
Non Pay Unallocated	(0.0)	(0.0)	0.0	0.0	(0.0)	0.0	0.0
Other	(29.2)	(4.0)	(3.3)	0.7	(14.6)	(15.4)	(0.8)
PFI Unitary payment	(7.0)	(0.6)	(0.6)	0.0	(3.5)	(3.5)	(0.0)
Premises	(37.0)	(2.5)	(3.0)	(0.6)	(18.6)	(18.1)	0.5
	(111.2)	(10.1)	(10.0)	0.1	(55.7)	(56.3)	(0.6)
Overall Expenditure	**(154.3)**	**(13.7)**	**(13.6)**	**0.1**	**(77.2)**	**(77.4)**	**(0.3)**
EBITDA	**(121.3)**	**(10.8)**	**(11.1)**	**(0.3)**	**(60.7)**	**(61.4)**	**(0.7)**
Financing Costs	(10.9)	(0.9)	(0.9)	0.0	(5.4)	(5.4)	0.0
Surplus / (deficit)	**(132.1)**	**(11.7)**	**(12.0)**	**(0.3)**	**(66.2)**	**(66.8)**	**(0.6)**

Commentary

Overheads in September shows deficit of £12m which is £0.3m worse than plan. To date, the £66.8m deficit reported for the Division is £0.6m worse than plan.

Income

Month 6 income is £0.4m worse than plan due to St. George's Pathology under performance on Outpatient income and on Other income.

Expenditure

Pay spend for September is in line with plan. To date, pay is underspent by £0.4m.

Non Pay for the division is broadly in line with budget and spend to date remains £0.6m worse than plan. In September, budget transfer from Premises to 'Other' is reflected in the offsetting over and underspends reported this month.
Non pay £0.6m over spend to date is mainly due to turnaround costs.

Underspends on premises is mitigating over spends on consumables (by Medical Physics and STG Pathology) and overspend on clinical negligence relating to Estates & Facilities legal costs relating to rental lease agreements.

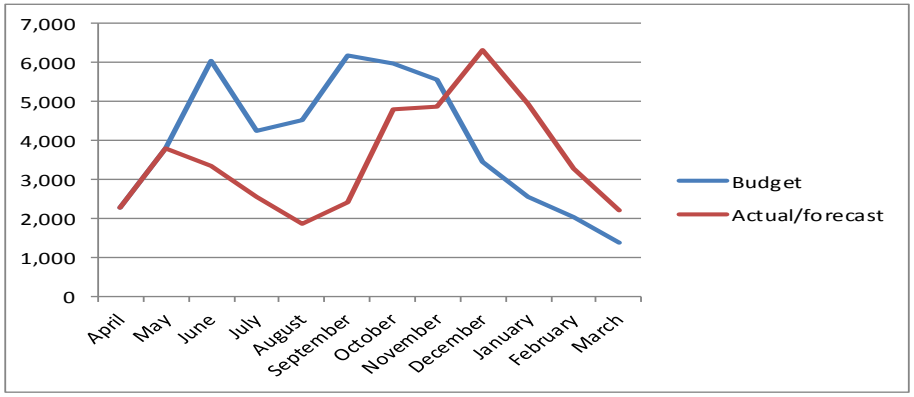
13. Month 6 Working Capital & Other Key Performance Indicators

Key Performance Indicators	Currency	Monthly Performance					
		Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6
Debtor days (debt at b/s sheet debt / ave daily income for last 12 mths)							
NHS income debtor days	days	-18.5	-18.8	-19.5	-19.4	-19.4	-20.1
Non-NHS income debtor days	days	-204.9	-202.0	-219.3	-229.0	-205.1	-199.2
DWP/CRU debt	days	-981.1	-986.8	-1000.1	-1029.1	-1077.7	-1019.2
Overseas patient income	days	-807.0	-789.1	-768.6	-752.9	-761.3	-739.5
Total	days	-31.5	-31.6	-32.8	-33.2	-32.6	-33.3
Creditor days (crs at b/s date / planned spend per day)	days	83	96	106	96	95	93
Reported Surplus / (deficit) by month	£m	-7.6	-8.3	-5.7	-3.3	-6.5	-3.3
Cumulative Surplus / (deficit)	£m	-7.6	-15.9	-21.5	-24.8	-31.3	-34.6
Underlying Surplus / (deficit) by month	£m	-6.7	-6.1	-4.5	-3.8	-5.7	-2.3
Cumulative underlying surplus / (deficit)	£m	-6.7	-12.8	-17.2	-21.1	-26.8	-29.1
Capital service capacity	£m	-3.6	-4.1	-3.6	-2.8	-2.8	-2.2
Liquid ratio	days	-2.8	-6.6	-9.4	-7.7	-7.5	-3.7
FSRR (weighted average)	ave	1.8	1.5	1.3	1.3	1.3	1.5
FSRR	score	2.0	2.0	1.0	1.0	1.0	2.0
Cash							
Closing balance	£m	14.2	7.9	7.3	6.2	6.1	8.3
In month maximum	£m	46.0	42.8	45.4	61.0	54.1	58.7
In month minimum	£m	5.6	7.9	6.9	6.1	6.1	8.2
Facility available - original	£m				25.0	25.0	25.0
Facility available - new	£m						19.6
Facility used	£m				7.7	15.6	25.0

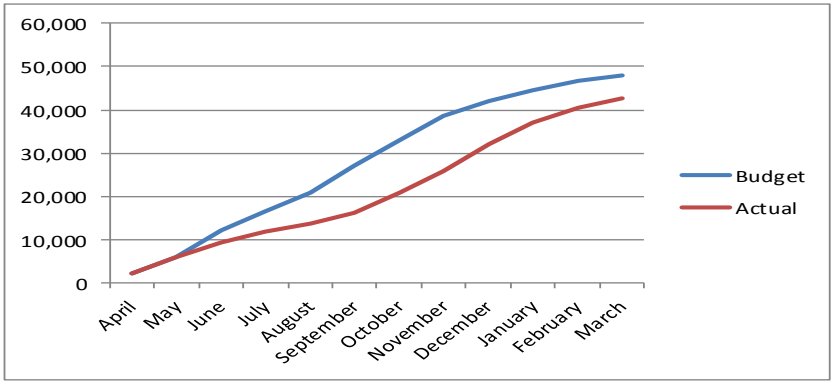
14. Capital

- 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 interim support funding requirement from £52.2m to £48.7m

Monthly capital expenditure 2015/16 at M06



Cumulative capital expenditure 2015/16 at M06



- Capital expenditure in September was £2.4m and YTD expenditure is £16.2m against the new YTD budget of £27.1m i.e. an under spend of £10.9m.
- 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. Capital budget holders have completed a re-forecast exercise for month 06 for the year and the forecast outturn under spend is approx £5.4m (M05 £3.1m) . The forecasts indicate a marked acceleration in spend in the last 6 months of the year: £26.3m vs £16.3m M01-M06.

Summary cap exp by spend category	New Budget £000	YTD Budget £000	YTD Actual £000	YTD Var £000	F/cast Outturn £000	F/cast Var £000
Infrastructure renewal	9,630	3,782	2,581	1,201	8,726	905
Medical equipment	12,077	6,243	3,882	2,361	11,112	965
IMT	6,526	5,060	3,349	1,711	5,772	754
Major Projects	17,737	10,749	5,794	4,955	15,526	2,211
Other	1,557	957	571	386	1,071	486
SWL Path	500	270	60	210	422	78
Total	48,027	27,062	16,237	10,825	42,629	5,398

15. Cash 1

	31-Mar £000	30-Apr £000	31-May £000	30-Jun £000	31-Jul £000	31-Aug £000	30-Sep £000
2015/16 Plan cash	n/a	14,200	6,187	3,000	3,000	3,000	3,000
Actual cash	**24,179**	**14,188**	**7,925**	**7,265**	**6,175**	**6,097**	8,258
Cash bal fav / (adv) variance to plan	0	-12	1,738	4,265	3,175	3,097	5,258

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

	31-Mar £000	30-Apr £000	31-May £000	30-Jun £000	31-Jul £000	31-Aug £000	30-Sep £000
Plan drawdown	0	0	0	2,138	6,991	14,625	24,483
Actual drawdown	**0**	**0**	**0**	**0**	**7,671**	**15,580**	**25,000**
WCF cum drawdowns fav / (adv) variance to plan	0	0	0	2,138	-680	-955	-517

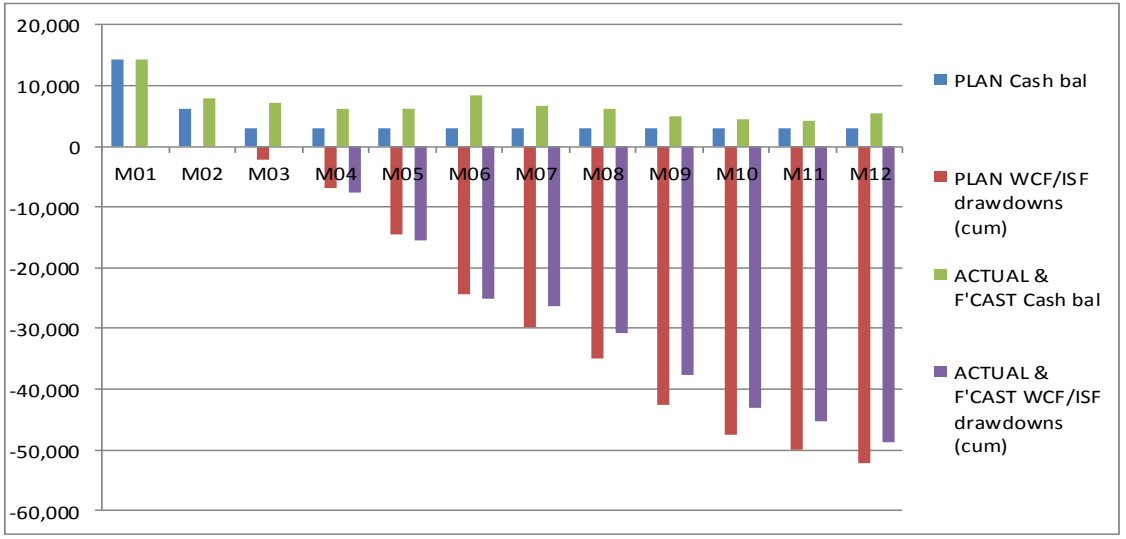
Overall Cash fav / (adv) variance to plan	**0**	**-12**	**1,738**	**6,403**	**2,495**	**2,142**	**4,741**

- Actual cash balance was £8.2m at 30th September including cumulative WCF drawdowns of £25m.
- Plan cash balance was £3m including cumulative WCF drawdown of £24.5m.
- Therefore the cash balance was £4.7m better than plan overall..
- The cash balance includes £11.9m unexpended LEEF loan for the energy performance contract and so the cash balance excluding LEEF would be negative: -£3.7m
- The main factors explaining the reduction in the cash balance since year end are:
  - revenue deficit of £34.6m and
  - deterioration of £5.5m in working capital (stock, debtors and creditors) – but this is £1.5m better than plan (-£7m).
- The better performance on working capital and the capital underspend offset the impact of the higher trading deficit enabling the Trust to achieve a September cash balance £4.7m above plan.

15. Cash 2

- 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.
- Additional cash has been secured since July using the £25m approved working capital facility. The Trust drew down £9.42m in September bringing cumulative drawdowns to £25m – exhausting the existing WCF in September as forecast since M02.
- Since month-end the Trust has drawn down a further £1.3m under the new £19.6m WCF approved by the board and ITFF/Monitor at the end of September. This new temporary facility provides additional cash support for the period October to January inclusive. From the end of January the Trust will use the agreed **interim support funding (ISF)** for further cash requirements. The ISF will be confirmed with Monitor/ITFF as a result of the re-forecasting exercise in January.
- The Trust is implementing longer standard supplier payment terms (60 days from w/e 10th July), reduced debtor levels and lower inventory levels to support the cash position. Stretch targets for reductions in overdue debt by year end were set last month. These would increase the level of cash benefits to approx £20m if achieved in full. The monthly cash flow forecast includes £7.14m for the unfunded, unmitigated and unavoidable cost pressures which were addressed by the budget adjustments approved by the board in August and therefore the forecast provides for an I&E deficit of approx £53.5m for the year. The Trust has included cash benefits from actions on creditors and debtors of £7m and is working towards the target of £20m cash benefits by year end.

CASH AND ISF/WCF funding: Actual/Forecast vs Plan M06

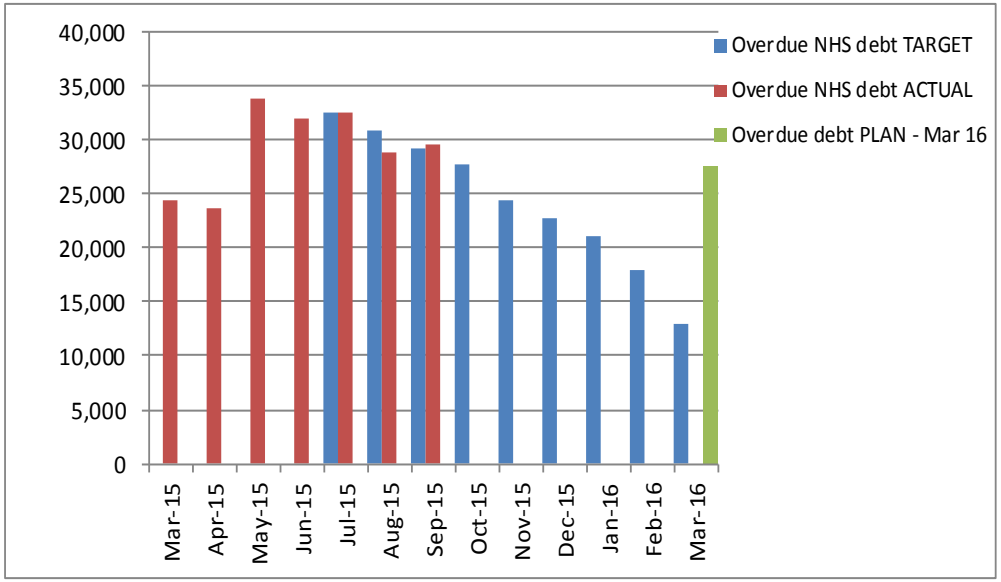


15. Cash 3

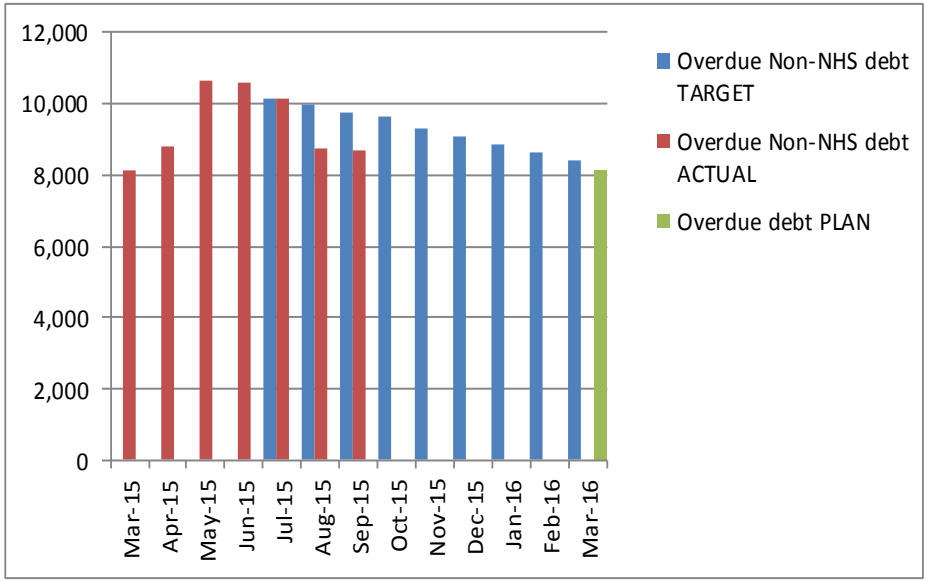
Debt reduction targets

- The Cash Committee approved 'stretch' debt reduction targets for 2015/16 and the baseline is the level of overdue debt (over 30 days old) as at M04.
- Delivery of the stretch targets by March 2016 would reduce the requirement for interim support funding by approx £14.2m.
- Overdue debt has reduced by £4.5m since M04 and is ahead of target by £0.9m at M06.

Overdue NHS debt: performance vs stretch reduction targets



Overdue non-NHS debt: performance vs stretch reduction targets



16. Balance sheet as at M06 2015/16

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

	Sep-15 Plan £000	Aug-15 Actual £000	*Variance £000*	Explanations of balance sheet variances
Fixed assets	349,022	335,174	*13,848*	Lower capital expenditure - so lower fixed assets
Stock	6,843	7,787	*-944*	Stock action group formed to progress safe reductions in levels.
Debtors	79,733	83,750	*-4,017*	This includes accruals and current debt. Overdue debt has reduced by £4.5m since M04
Cash	3,000	8,260	*-5,260*	Lower capex, better working capital movement
				Cash is £4.7m better than Plan after taking account of slightly higher (£0.5m) WCF drawdowns
Creditors	-84,352	-90,784	*6,432*	Longer supplier payment terms implemented in July - slowing rate of payments
Capital creditors	-3,476	-2,827	*-649*	
PDC div creditor	0	0	*0*	
Int payable creditor	-245	-310	*65*	
Provisions< 1 year	-602	-512	*-90*	
Borrowings< 1 year	-31,460	-5,588	*-25,873*	(NB: WCF is classified as non-current liability c/f Plan)
Net current assets/-liabilities	**-30,560**	**-223**	*-30,337*	
Provisions> 1 year	-1,181	-1,146	*-35*	
Borrowings> 1 year	-91,448	-115,455	*24,007*	(NB: WCF is classified as non-current liability c/f Plan)
Long-term liabilities	**-92,629**	**-116,601**	*23,972*	
Net assets	**225,833**	**218,350**		
Taxpayer's equity				
Public Dividend Capital	133,761	133,761	*0*	
Retained Earnings	-10,439	-17,074	*6,635*	YTD I&E deficit worse than plan
Revaluation Reserve	101,360	100,512	*848*	
Other reserves	1,150	1,150	*0*	
Total taxpayer's equity	**225,832**	**218,349**		

17. 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%

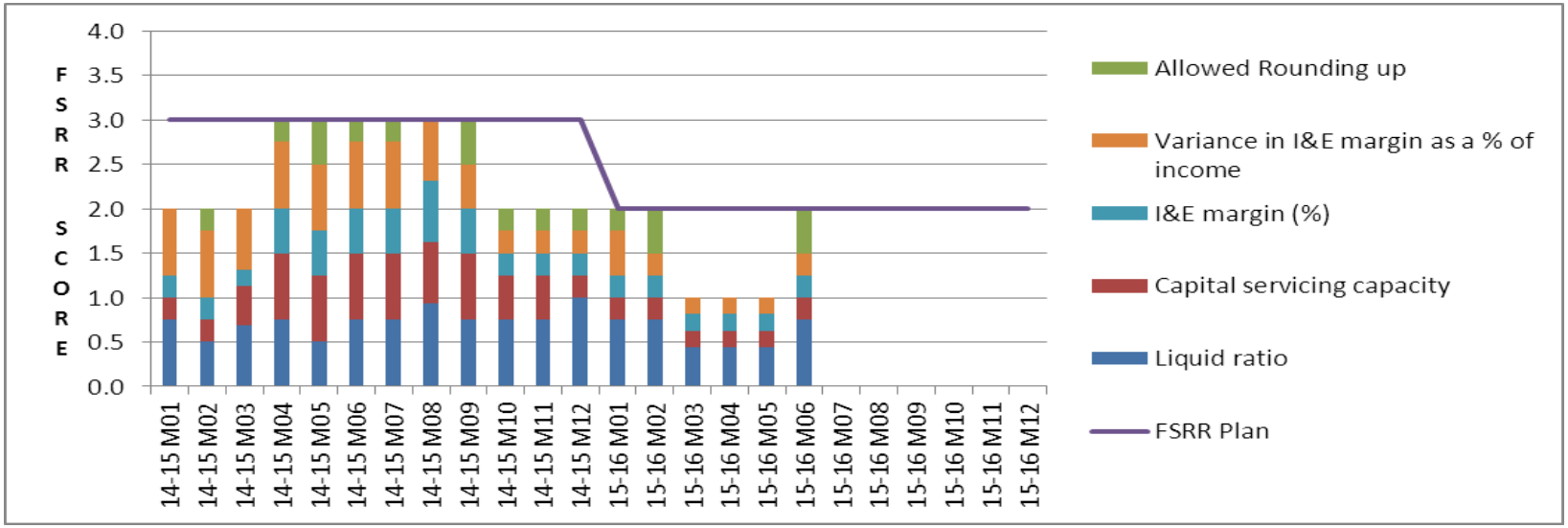
*Scoring a 1 on any metric will cap the weighted rating to 2, potentially leading to investigation.
**Scores are rounded to the nearest number, ie if the trust scores 3.6 overall, this will be rounded to 4; if the trust scores 3.4, this will be rounded to 3.
***A 2* rating may be awarded to a trust where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

17. Financial Sustainability Risk Rating (FSRR)

	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	15/16	15/16
	Actual	Actual	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	M05	M06
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	-7.5	-3.7
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	-2.8	-2.2
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%	-10.8%	-9.9%
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%	-2.5%	-2.1%
Metric Rating (See Thresholds)	Rating	Rating	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	2	3
Capital servicing capacity	1	1	2	3	3	3	3	3	3	2	2	1	1	1	1	1	1	1
I&E margin (%)	1	1	1	2	2	2	2	3	2	1	1	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	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	1.3	1.5
Overriding Score	**2**	**2**	**2**	**3**	**3**	**3**	**3**	**3**	**3**	**2**	**2**	**2**	**2**	**2**	**1**	**1**	**1**	**2**

In M06 the Trust achieved a 2 overall for FSRR which is line with plan.

Individual metrics are in line with plan apart from variance in I&E margin which had a plan of 4 and liquidity which had a plan of 1.



St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD ***Nov 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

Assurance:

- A full review and redesign of the board assurance framework is currently underway; the central principles were presented and approved by the QRC. The underpinning procedural document will now be developed to be presented to the Executive Management Team and trust board in due course (by no later than year-end).

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.

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**	**4**	**20 →**
01-13	Theatre capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	**5**	**4**	**20 →**
01-07	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 →**
01-18	Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products	**5**	**4**	**20 →**
3.7-06	Failure to meet the minimum requirements of the Monitor Risk Assessment Framework	**4**	**5**	**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 →**
3.20-05	Income Volume Risk (Capacity) – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.	**5**	**4**	**20 →**

1.1 New risks proposed for inclusion on the CRR

There have been two new risks included during the reporting period, finalised risk assessments with detailed controls will be included in the December board report:

- General management resource in divisions as well as executive capacity to safeguard core business whilst meeting the demands of turnaround programme.
- Clinical impact of delays in procurement and/or authorisation of medical supplies and equipment

1.2 Changes to risk scores

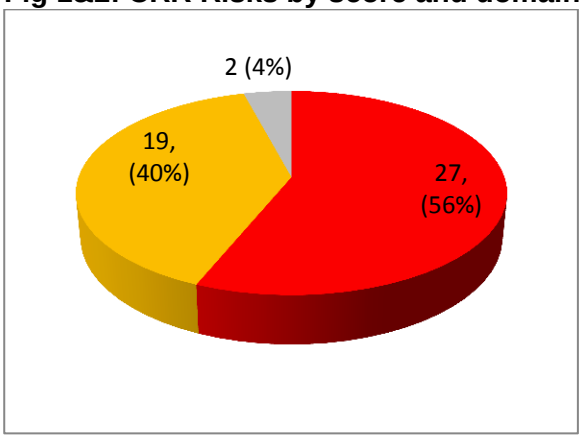
One risk score has been reduced, the rationale included at Appendix 1.

Ref	Risk	Previous	Current
01-18	Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products	**20**	**16↓**

1.3 Summary of risks by score and domain

There are 48 risks on the CRR of which 27 are extreme (a score of 15 or above) this equates to 56% of the total risks, which compares with 62% in Sept 2015. Of these extreme risks, 11 sit within the domain of Quality and seven within Finance and Operations. Of the total risks on the CRR, 44% relate to Quality and 19% to the Finance and Operations domain.

Fig 1&2: CRR Risks by score and domain



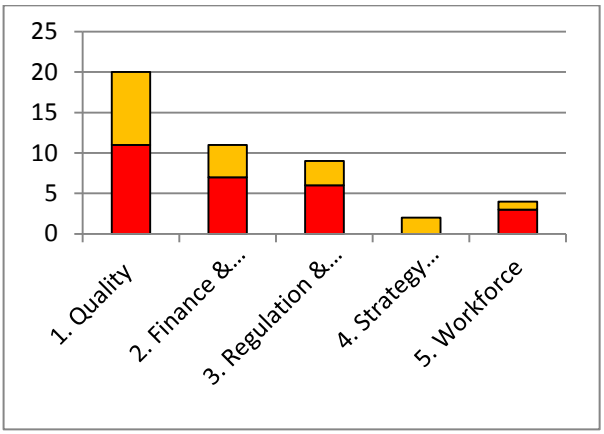


Table three: CRR Risks by Domain

	15 or above (Extreme)	8-12 (High)	4-6 (Moderate)	0-3 (low)	Score tbc	Total
1. Quality	11	9	0	0	1	21
2. Finance & Operations	8	3	0	0	0	11
3. Regulation & Compliance	6	3	0	0	0	9
4. Strategy Transformation & Development	0	2	0	0	0	2
5. Workforce	3	1	0	0	1	5
Total	**27**	**19**	**0**	**0**	**2**	**48**

1.5 Deep Dive: Quality Risk Committee

The QRC carried out a deep dive into the following risks on 28th October 2015:

- *A534-07: Failure to provide adequate supporting evidence for all the CQC Essential standards of Quality and Safety*

The risk was reviewed following a detailed presentation around trust compliance with CQC Regulations and Fundamental standards of Care which came in to force on 1st April 2015. The presentation set out the current quality assurance arrangements in place to provide assurance to the board; the current trust position, and work underway to strengthen collection and utilisation of ward audit to understand and provide assurance around standards of quality of care.

The QRC considered the information presented, which included a gap analysis with the findings of other recent CQC inspection and agreed the risk score should be updated to C5 x L5 = 15 (extreme). The detailed risk description, controls and assurances will be updated to reflect the deep dive discussion and will be approved by QRC before inclusion in December board report.

- *01-08: Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results*

The current work to date around standardising procedures to ensure follow up of diagnostic tests was presented to the QRC. Divisional Chairs were also in attendance to provide position statement for each of the Divisions. The risk score remains unchanged and the controls and assurances will be updated for QRC approval as above.

2. Board Assurance Framework and Assurance Map

The Board Assurance Framework is currently under review to develop a new framework which maps to:

- Monitor Well Led Framework
- Annual governance statements
- CQC characteristics of a well led organisation
- Current corporate risk register

This full review and redesign of the board assurance framework was presented to the QRC for approval in principle. An underpinning procedural document will now be developed to be presented to the Executive Management Team and trust board in due course and by no later than year-end.

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 – Oct 2015

2.1.1 HTA Inspection re Licence 12462: 20th August (announced)

The HTA has confirmed receipt and has approved the action plan in response to the recent inspection where two concerns were identified. The action plan will now revert to business as usual monitoring through to completion.

2.1.2 NHS Quality Assurance: Breast Cancer Screening Programme

Quality assurance (QA) is the process of checking that national standards are met (ensuring that screening programmes are safe and effective) and encouraging continuous improvement. Public Health England (PHE) is responsible for the NHS Screening Programmes and National Screening Quality Assurance.

The Trust is underwent a QA inspection on 27th October and is awaiting the formal outcome.

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.

The board assurance framework is currently in development and is designed to strengthen the types and level of assurance to board and to support the board discharge its duties in relation to the annual governance statements.

Appendix 1: Executive Overview of Corporate Risk Register

Domain: 1. Quality

Strategic Objective/Principal Risk	Lead	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 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 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	25	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	16	16	16	→	
A513-O1: Failure to achieve the National HCAI targets for MRSA and C Diff	JH	12	12	12	12	12	12	→	
01-01 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	9	9	→	
01-02: 01-02 Lack of established process for use, provision, decontamination and maintenance of pressure relieving mattresses	EM	9	9	9	9	9	9	→	
01-03 Lack of embedded process for use, provision and maintenance of bed rails	EM	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	16	16	→	
01-18 Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products	SM			20	20	20	16	↓	Aligned to SWLP risk score – following progress in procurement
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	16	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.	EM				12	12	12	→	
01-19 Clinical impact of delays in procurement and/or authorisation of medical supplies and equipment	JH						tbc	**NEW**	

Strategic Objective/Principal Risk	**Lead**	**May 2015**	**Jun 2015**	**Jul 2015**	**Sept 2015**	**Oct 2015**	**Nov 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**	**May 2015**	**Jun 2015**	**Jul 2015**	**Sept 2015**	**Oct 2015**	**Nov 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	10	10	→	
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	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	20	20	→	
3.16-05 Market Share risks – that the trust loses market share, negatively impacting on the trusts activity and income.				20	20	10	10	→	
3.17-05 Cost Improvement Programme slippage - The Trust does not deliver its cost improvement programme objectives				20	20	15	15	→	
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	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	16	16	→	
3.20-05 Income Volume Risk (Capacity) – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.						20	20	→	

Strategic Objective/Principal Risk	**Lead**	**May 2015**	**Jun 2015**	**Jul 2015**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**In month change**	**Change/progress**
2.2 Meet all operational & performance requirements								↓↑	
3.7- 06 Failure to meet the minimum requirements of Monitor Risk Assessment Framework:	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	12	12	→	
3.9 – 06 Risk of inappropriate deployment of e-prescribing and	SB	16	16	12	12	12	12	→	

electronic clinical documentation									

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 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	JH	5	5	5	5	5	15	↑	Following deep dive review at QRC
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	12	12	→	
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	15	15	→	

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	Lead	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 2015	In month change	Change/progress
4.2 Redesign & configure our local hospital services to provide higher quality care								↓↑	

A533-O8: Reconfiguration of healthcare services in SWL result in unfavourable changes to SGHT services and finances	RE	12	12	12	12	12	12	→	

Strategic Objective/Principal Risk	Lead	Apr 2015	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 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	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 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	16	16	16	→	
A516-O4: Possible reductions in the overall number of junior doctors available with a possible impact on particular specialty areas	WB	6	6	6	9	9	9	→	
A520-O4: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	WB	12	12	12	16	16	16	→	
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	16	16	16	16	→	
5.1-02 General management resource in divisions as well as executive capacity to safeguard core business whilst meeting the demands of turnaround programme.							tbc	**NEW**	

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

Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD *MONTH & YEAR* **Paper Ref:**

Paper Title:	**Travel Plan 2015**
Sponsoring Director:	**Eric Munro – Director of Estates and Facilities**
Author:	**Mary Prior – General Manager Facilities**
Purpose: *The purpose of bringing the report to the board*	*For approval of the Travel Plan for the St George's Hospital Site*
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	**The Board is required to approve the Travel Plan in accordance with NHS Policy on Sustainable Health**
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	**Transport For St George's Committee**

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

1. Key messages

The overall aim of the Travel Plan is to:
"Facilitate and promote convenient, efficient, healthy, sustainable travel to St. George's Hospital for staff, patients and visitors through improvements to information and transport facilities."

The aim is supported by the following objectives:

- To reduce the number of staff travelling to work by car
- To increase the number of staff travelling to work by sustainable methods of travel.
- To assist in reducing the Trust's carbon footprint through transport emissions;
- To contribute to the Trust's corporate social responsibility agenda and assist in being a good member of the community;
- To ensure St. George's Hospital Staff are engaged, informed and aware of the impacts of their travel patterns in terms of health, the environment, and the community; and
- To seek opportunities for additional funding for infrastructure improvements relating to walking, cycling and public transport.
- To improve access to the St. George's Hospital site for Patients, Visitors and staff;

These objectives are supported both by a set of targets and a range of supporting initiatives focused on meeting the objectives set out above and facilitating sustainable travel by the full range of transport options available for those travelling to St. George's Hospital.

2. Recommendation

To approve the Travel Plan for the St George's Hospital site at Blackshaw Road.

Enclosure:

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?* The key risk is unavailability of future funding to support the objectives contained in the plan.	
Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	10 year strategy: Maximise the wellbeing of our staff and their levels of contribution and engagement Trust Values : Responsible : Use resources wisely NHS Sustainable Development Management Plan – National Carbon Reduction Strategy and Healthier Communities
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	
Equality Impact Assessment (EIA): Has an EIA been carried out? (Yes / No) **If yes, please provide a summary of the key findings** **If no, please explain you reasons for not undertaking and EIA.**	

St George's Healthcare NHS
NHS Trust

Appendix A:

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

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

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
Facilities	Corporate	Mary Prior	Revised Plan	15 Oct 2015
1.1 Who is responsible for this service / function / policy? **Transport For St George's Committee**				
1.2 Describe the purpose of the service / function / policy? *Who is it intended to benefit? What are the intended outcomes?* Key motivations for development of this Travel Plan are: • To improve access to the St. George's Hospital site for Patients, Visitors and staff; • To bring transport and travel policies together in a coordinated way; • To lead by example in terms of promoting the health benefits of active travel; • To provide a mechanism for educating staff about the benefit of sustainable travel options;				

- • To contribute to St. George's corporate social responsibility agenda;
- • To mitigate the resultant loss of car parking from the re-development proposals; and
- • To mitigate the environmental impacts of staff travel.

1.3 Are there any associated objectives? *E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives*

National Policy
Travel Plans have become an important tool for the delivery of national, regional and local transport policy. There have been a number of national, regional and local policies and other initiatives that have influenced Travel Plan development and take-up both nationally and across London. Transport policy is contained in the following documents

- National Planning Policy Framework;
- The London Plan (March 2015); and
- London Borough of Wandsworth Local Plan.

London-specific Policy/ Guidance
The Mayor's Transport Strategy (2010) intends, through TfL, and working with the London Boroughs and other stakeholders to use smarter travel initiatives, including travel planning, across London to formulate more effective use of the transport system including mode shift to cycling, walking, and public transport and encouraging take up of healthier travel options.

1.4 What factors contribute or detract from achieving intended outcomes?

The main factors will be a shortage of funding to invest in alternative travel options and also a shortage of space on site to accommodate some of the schemes (for example communal showers and more space for cycles).

1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability (physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Region or belief and Human Rights

Positive impact in improving access for patients, staff and visitors with a disability. There is an objective for reducing the number of staff that drive to work which will need to be carefully managed to ensure staff are supported through this change.

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

1.7 Is there any scope for new measures which would promote equality?

1.8 What are your monitoring arrangements for this policy/ service
The objectives of the plan will be measured by the Transport for St Georges Committee as this will be a standing item on the agenda.

1.9 Equality Impact Rating [low, medium, high]
Low

2.0. Please give your reasons for this rating
The plan has been written to improve access and will have a positive impact.

REPORT TO THE TRUST BOARD *October 2105*

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 September 2015.

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

Key points to note are:

- Turnover remains high and has slightly increased in month. High turnover is a problem for all London trusts and St George's compares well with benchmarked trusts. However, high turnover has a significant impact on the trust.
- KPMG are providing support on getting a grip on pay costs, both in temporary staffing and in ledger and ESR reconciliation.

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 September workforce data is that turnover continues to be at high levels, impacting all 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 have completed the first stage of the nursing establishment review and the budget reforecast is now nearing completion. Once this work is complete and agreed, the changes made will need to be reflected in the ledger and ESR. KPMG have developed a process plan, which requires ESR update before the ledger can be updated. This process is due to be signed off by the Finance department on 30th October. The workforce department will take responsibility for auditing compliance but actual compliance with the agreed process will remain with the finance team.

Turnover and stability

Turnover has increased again in September. 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 have increased, largely due to an increase in coughs and colds across the trust.

Agency and bank staff usage

A detailed paper was provided to the board in September regarding the drivers for temporary staffing usage and the programme of work being undertaken to manage usage and costs. There are two key strands to this agency grip work, which KPMG are supporting:

1) Ensuring that all non-nursing agency usage has a planned exit strategy, via bank, substantive staffing or removal of the post. Good progress has been made with this work.
2) Understanding financial spend versus usage. Usage information does not include any activity that is not booked through the bank (specifically it does not include interims). On review there appear to be issues with the timeliness of the spend information and this information is not currently an accurate indicator of usage.

Support is being given to ensure that all usage is able to be measured accurately and to ensure that cost information reflects in month spend.

Mandatory training and appraisal rates

There will be a mid-year appraisal for all management posts from November with agreed and consistent objectives being delivered to all leaders.

A detailed paper regarding mandatory training was provided to the board in September. A paper setting out the planned trajectory for improvement will be presented to the board in December.

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Workforce Performance Report
to the Trust Board

Month 6 - September 2015

Excellence in specialist and community healthcare

Workforce Performance Report Oct ‘14 - Sep ‘15

Contents

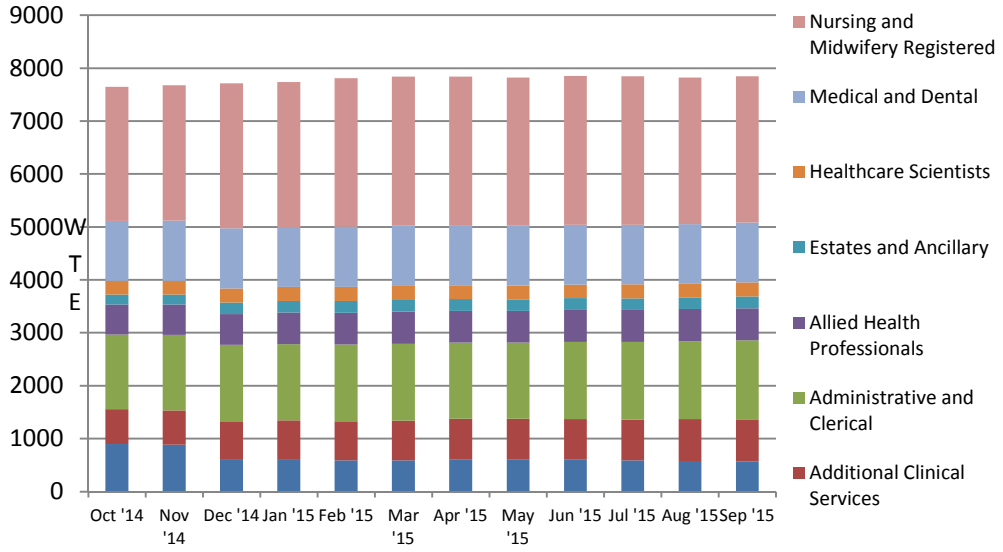
Performance Summary

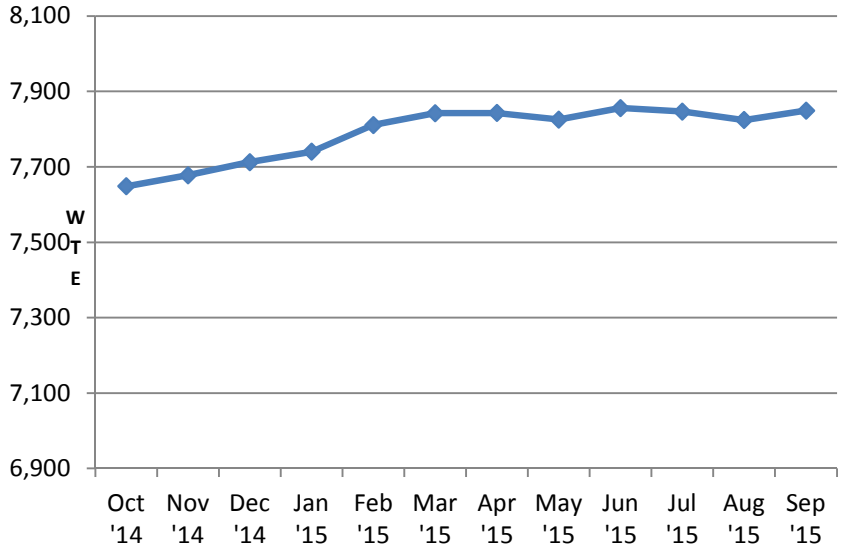
Summary of overall performance is set out below

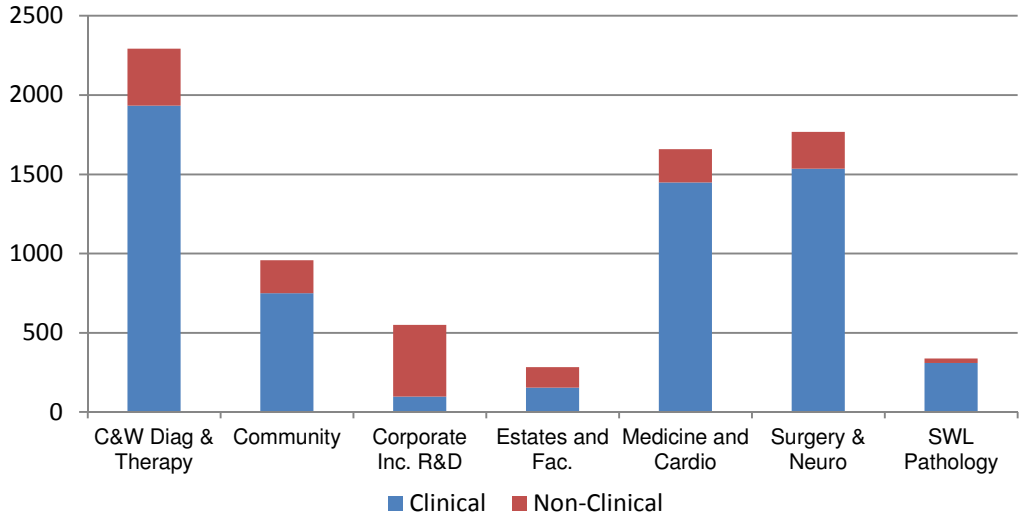
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has increased by 0.5%	13.0%	15.2%	15.7%	↗
6	Turnover	Turnover has increased by 0.2%	16.5%	17.3%	17.5%	↗
7	Voluntary Turnover	Voluntary Turnover has increased by 0.6%	13.3%	14.0%	14.6%	↗
8	Stability	Stability has increased this month by 0.1%	84.6%	83.1%	83.2%	↗
10	Sickness	Sickness has increased by 0.3%	3.4%	3.8%	4.1%	↗
13-14	Temporary Staffing Usage (FTE)	Temporary Staffing Usage has decreased by 1.1%	17.9%	15.9%	14.8%	↘
17	Mandatory Training	MAST compliance has decreased by 0.6%	77.1%	67.8%	67.2%	↘
18	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has decreased by 1.5%	82.2%	71.5%	70.0%	↘

Current Staffing Profile

The data below displays the current staffing profile of the Trust





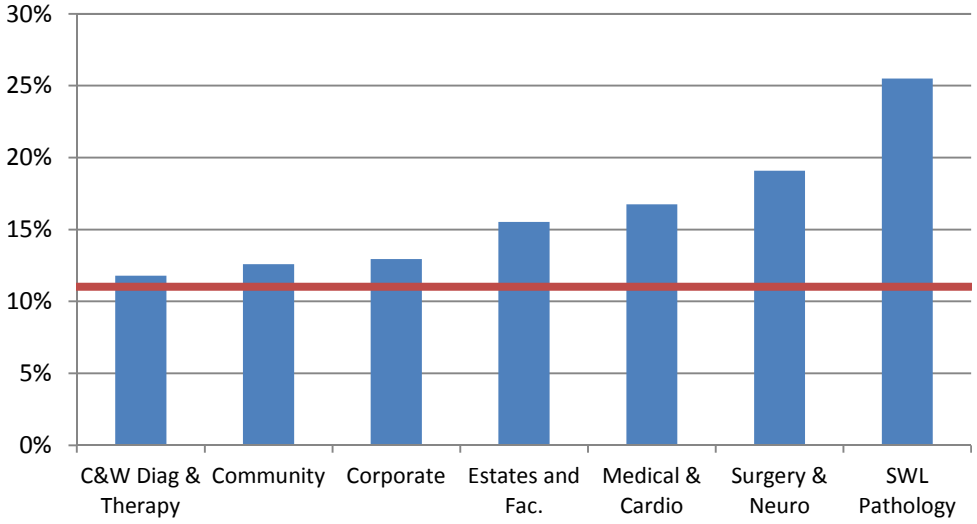


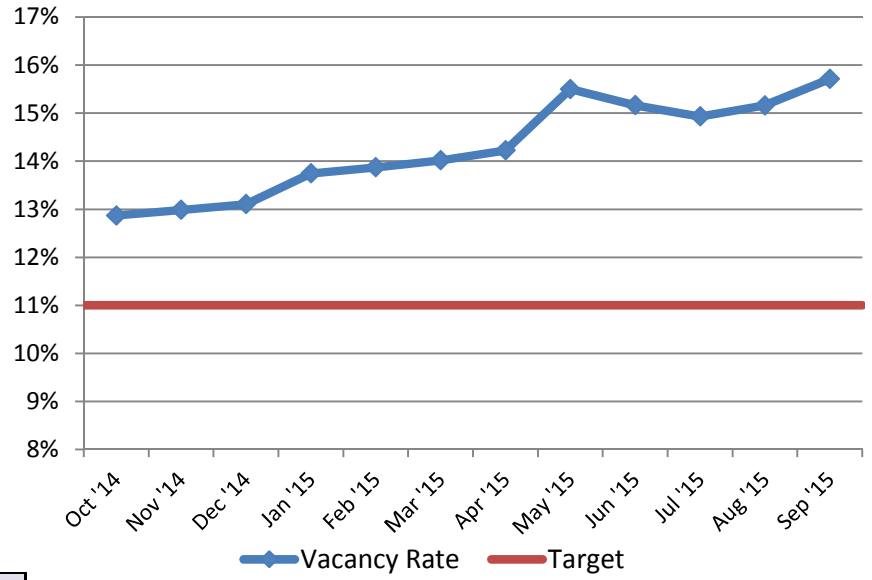
COMMENTARY

The Trust currently employs 8405 people working a whole time equivalent of 7850 which is 25 WTE more than August. The growth rate in the directly employed workforce since September 2014 is 232 WTE or 3%.

The Trust has also employs an additional 470 WTE GP Trainees covering the South London area making bringing the total WTE to 8319.

Section 1: Vacancies





Vacancies by Division	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diag & Therapy	9.9%	9.5%	10.9%	11.8%	↗
Community	19.4%	12.6%	13.4%	12.6%	↘
Corporate	16.4%	18.2%	16.4%	12.9%	↘
Estates and Fac.	23.0%	15.6%	15.0%	15.5%	↗
Medical & Cardio	12.8%	17.4%	16.7%	16.8%	↗
Surgery & Neuro	16.9%	16.7%	16.7%	19.1%	↗
SWL Pathology	24.0%	23.6%	24.9%	25.5%	↗
Whole Trust	**15.2%**	**14.9%**	**15.2%**	**15.7%**	↗

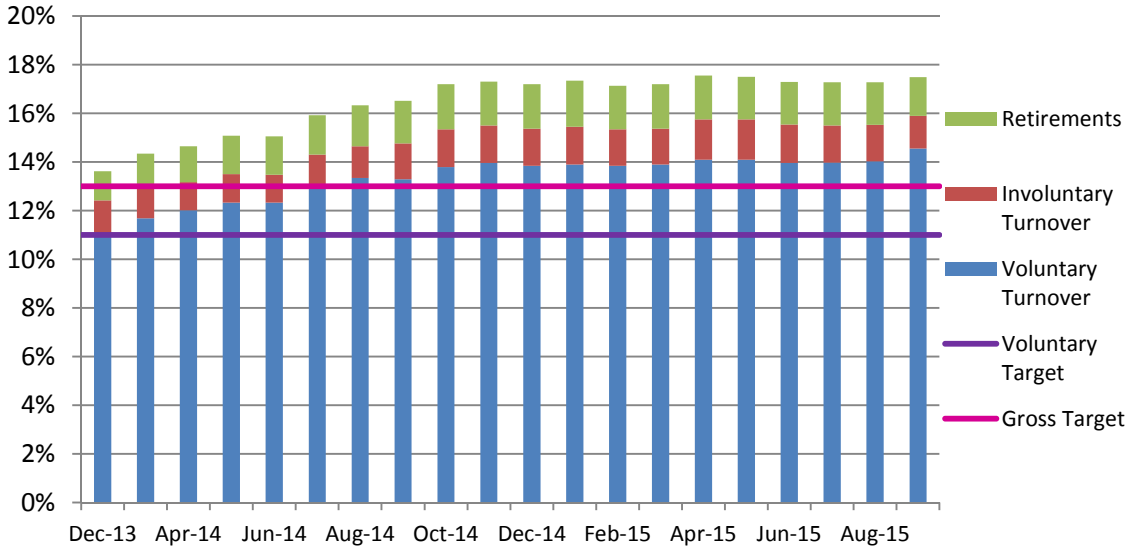
Vacancies Staff Group	Jun '15	Jul '15	Aug '15	Sep '15	Trend
Add Prof Scientific and Technic	17.5%	17.5%	21.9%	22.7%	↗
Additional Clinical Services	18.8%	18.5%	17.3%	19.4%	↗
Administrative and Clerical	20.9%	16.8%	15.2%	15.2%	↔
Allied Health Professionals	3.1%	8.6%	9.4%	5.9%	↘
Estates and Ancillary	25.8%	18.9%	20.1%	19.1%	↘
Healthcare Scientists	21.7%	18.7%	18.2%	18.5%	↗
Medical and Dental	4.5%	6.8%	5.9%	5.6%	↘
Nursing and Midwifery Registered	14.9%	15.9%	16.8%	18.3%	↗
Total	**15.2%**	**14.9%**	**15.2%**	**15.7%**	↗

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:



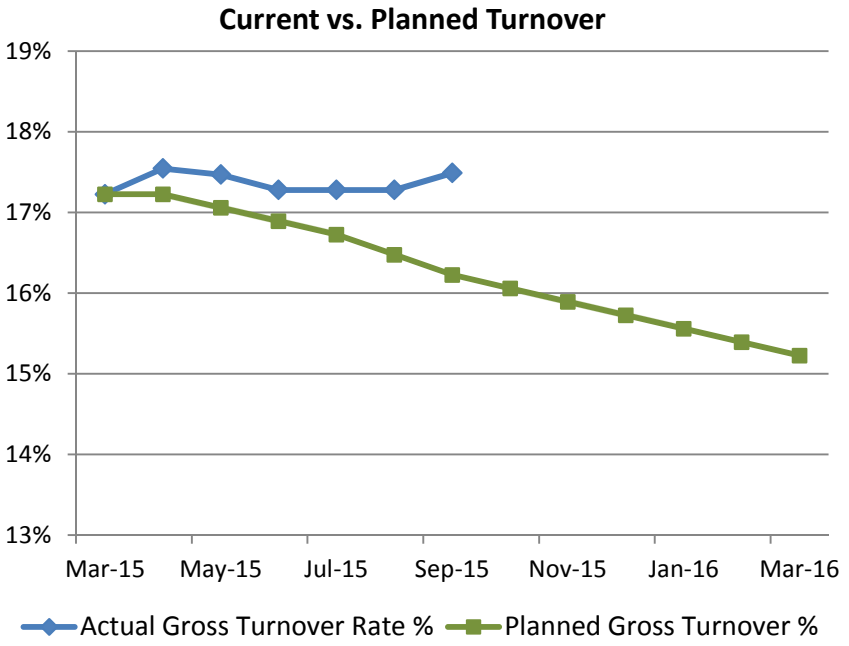
COMMENTARY

The total trust turnover rate has increased slightly this month to 17.5%. This is significantly above the current target of 13%. In the last 12 months there have been 1244 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	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	17.2%	17.5%	17.4%	18.1%	↗
Community Services	20.4%	20.1%	21.0%	21.1%	↗
Corporate	19.7%	20.0%	20.6%	18.8%	↘
Estates and Facilities	17.0%	16.5%	16.8%	16.5%	↘
Medical & Cardiothoracics	17.7%	17.7%	17.5%	19.1%	↗
Surgery, Neurosciences & Anaes	14.4%	14.4%	13.7%	13.3%	↘
SWL Pathology	17.3%	16.3%	16.9%	14.4%	↘
Whole Trust	**17.3%**	**17.3%**	**17.3%**	**17.5%**	↗

	All Turnover				
Staff Group	Jun '15	Jul '15	Aug '15	Sep '15	Trend
Add Prof Scientific and Technic	17.9%	18.6%	19.2%	18.6%	↘
Additional Clinical Services	20.8%	20.1%	19.5%	19.6%	↗
Administrative and Clerical	16.9%	17.0%	16.5%	16.4%	↘
Allied Health Professionals	17.1%	17.9%	17.0%	16.3%	↘
Estates and Ancillary	10.8%	10.0%	8.9%	8.5%	↘
Healthcare Scientists	14.3%	12.7%	14.6%	14.5%	↘
Medical and Dental	13.6%	12.2%	11.8%	11.5%	↘
Nursing and Midwifery Registered	17.9%	18.2%	18.7%	19.6%	↗
Whole Trust	**17.3%**	**17.3%**	**17.3%**	**17.5%**	↗



Section 2b: Voluntary Turnover

	Voluntary Turnover					Other Turnover Sep 2015	
Division	Jun '15	Jul '15	Aug '15	Sep '15	Trend	In-Voluntary	Retirement
C&W Diagnostic & Therapy	13.2%	13.6%	14.0%	14.8%	↗	1.9%	1.4%
Community Services	16.1%	15.6%	16.2%	16.8%	↗	1.1%	3.2%
Corporate	15.8%	15.9%	15.0%	14.7%	↘	1.9%	2.2%
Estates and Facilities	6.4%	5.9%	6.6%	8.3%	↗	5.5%	2.7%
Medical & Cardiothoracics	15.4%	15.3%	15.4%	17.2%	↗	0.7%	1.2%
Surgery, Neurosciences & Anaes	12.8%	13.0%	12.3%	12.0%	↘	0.5%	0.8%
SWL Pathology	15.1%	14.6%	15.3%	12.6%	↘	0.6%	1.1%
Whole Trust	**14.0%**	**14.0%**	**14.0%**	**14.6%**	↗	**1.3%**	**1.6%**

	Voluntary Turnover					Other Turnover Sep 2015	
Staff Group	Jun '15	Jul '15	Aug '15	Sep '15	Trend	In-Voluntary	Retirement
Add Prof Scientific and Technic	11.7%	12.6%	13.2%	14.4%	↗	4.0%	0.3%
Additional Clinical Services	17.6%	16.9%	16.3%	16.9%	↗	0.9%	1.8%
Administrative and Clerical	13.2%	13.2%	12.7%	12.6%	↘	1.6%	2.2%
Allied Health Professionals	15.9%	16.6%	15.9%	15.6%	↘	0.1%	0.7%
Estates and Ancillary	6.8%	5.5%	4.8%	5.4%	↗	0.0%	3.2%
Healthcare Scientists	10.7%	9.9%	11.8%	12.0%	↗	0.8%	1.7%
Medical and Dental	8.1%	6.9%	6.6%	6.7%	↗	4.0%	0.8%
Nursing and Midwifery Registered	15.4%	15.7%	16.3%	17.2%	↗	0.6%	1.7%
Whole Trust	**14.0%**	**14.0%**	**14.0%**	**14.6%**	↗	**1.3%**	**1.6%**

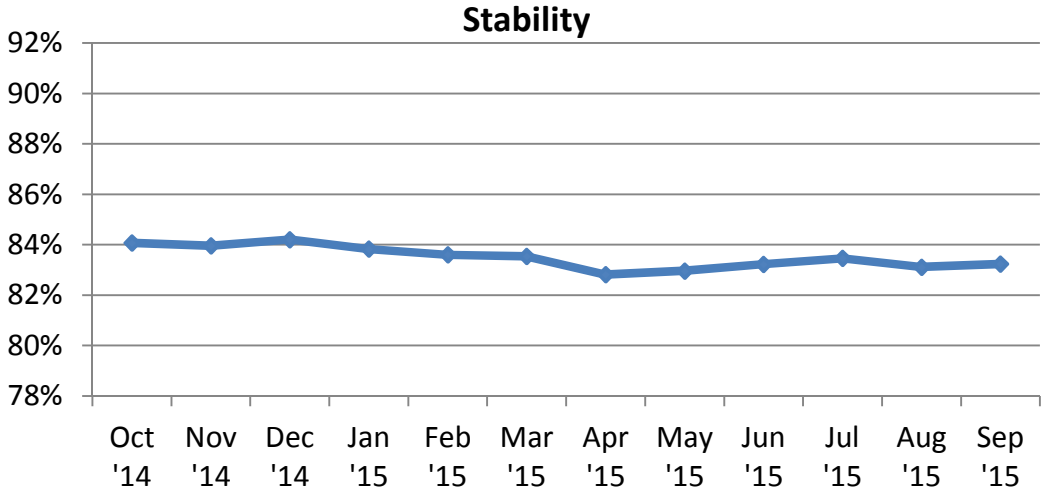
Caregroup	Staff in Post WTE	Leavers WTE	Voluntary Turnover Rate
Cardiac Surgery	89.7	28.8	37.6%
Gynaecology	43.0	15.7	34.1%
Medical Oncology & Palliative Care	86.3	24.2	32.0%
Chest Medicine	24.0	7.4	31.8%
Offender Healthcare HMPW Services	56.2	18.5	31.3%

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.

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	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	82.5%	82.8%	83.1%	83.1%	↔
Community Services	80.4%	80.9%	80.1%	79.7%	↘
Corporate	83.7%	82.6%	78.1%	79.1%	↗
Estates and Facilities	85.4%	86.1%	84.9%	85.5%	↗
Medical & Cardiothoracics	82.4%	82.5%	82.1%	81.7%	↘
Surgery, Neurosciences & Anaes	85.1%	85.5%	86.2%	86.2%	↔
SWL Pathology	88.3%	89.4%	89.2%	92.1%	↗
Whole Trust	**83.2%**	**83.5%**	**83.1%**	**83.2%**	↗

Stability Staff Group	Jun '15	Jul '15	Aug '15	Sep '15	Trend
Add Prof Scientific and Technic	73.7%	72.8%	70.4%	70.6%	↗
Additional Clinical Services	85.1%	85.6%	86.3%	83.8%	↘
Administrative and Clerical	85.7%	85.7%	85.5%	85.6%	↗
Allied Health Professionals	81.2%	81.5%	81.9%	83.0%	↗
Estates and Ancillary	86.0%	86.8%	86.7%	88.8%	↗
Healthcare Scientists	88.3%	92.8%	92.3%	92.8%	↗
Medical and Dental	88.5%	89.1%	88.3%	88.3%	↔
Nursing and Midwifery Registered	82.4%	82.5%	82.1%	82.6%	↗
Total	**83.2%**	**83.5%**	**83.1%**	**83.2%**	↗

COMMENTARY

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

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

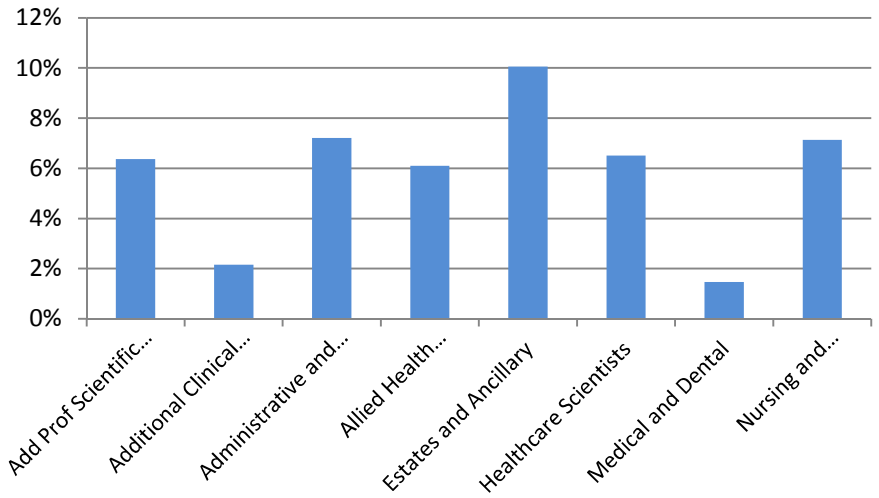
The stability rate has increased by 0.1% this month.

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 1.3% and is now at 83.2%.

Section 4: Staff Career Development

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



COMMENTARY

Staff exit survey data tells us that one of the key drivers for retaining staff is to support their development within the trust. In September 61 staff were promoted, there were 153 new starters to the Trust and 231 employees were acting up to a higher grade.

Over the last year 6.1% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the Estates and Facilities Division (where a team have recently been upgraded) followed by the Corporate and SW Pathology 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	Jun '15	Jul '15	Aug '15	Sept '15	Trend
C&W Diagnostic & Therapy	18	15	13	16	↗
Community Services	15	12	16	18	↗
Corporate	7	6	10	5	↘
Estates and Facilities	2	0	0	1	↗
Medical & Cardiothoracics	4	6	17	8	↘
Surgery, Neurosciences & Anaes	12	5	6	11	↗
SWL Pathology	0	0	11	2	↘
Whole Trust Promotions	**58**	**44**	**73**	**61**	↘
New Starters (Excludes Junior Doctors)	**94**	**83**	**121**	**153**	↗

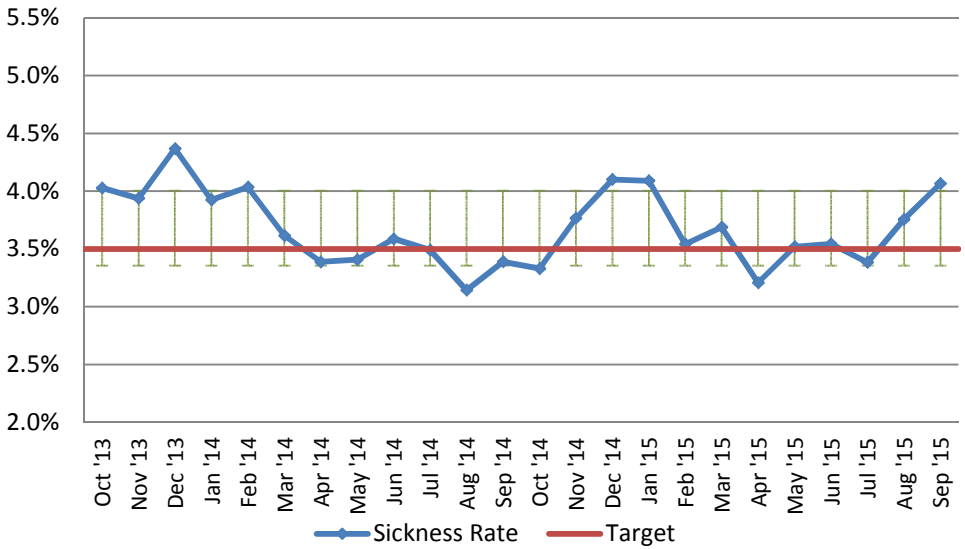
Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	1884	112	5.9%	110
Community Services	903	48	5.3%	16
Corporate	449	36	8.0%	23
Estates and Facilities	258	22	8.5%	7
Medical & Cardiothoracics	1172	79	6.7%	40
Surgery, Neurosciences & Anaes	1357	70	5.2%	22
SWL Pathology	322	22	6.8%	13
Whole Trust	**6345**	**389**	**6.1%**	**231**
New Starters (Excludes Junior Doctors)		**1436**		

	No. of Promotions				
Staff Group	Jun '15	Jul '15	Aug '15	Sept '15	Trend
Add Prof Scientific and Technic	2	1	3	7	↗
Additional Clinical Services	2	6	7	4	↘
Administrative and Clerical	22	16	21	15	↘
Allied Health Professionals	10	7	7	9	↗
Estates and Ancillary	2	0	0	1	↗
Healthcare Scientists	0	0	5	1	↘
Medical and Dental	3	1	0	2	↗
Nursing and Midwifery Registered	17	13	30	22	↘
Whole Trust	**58**	**44**	**73**	**61**	↘

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	487	31	6.4%	33
Additional Clinical Services	650	14	2.2%	11
Administrative and Clerical	1317	95	7.2%	84
Allied Health Professionals	557	34	6.1%	29
Estates and Ancillary	199	20	10.1%	4
Healthcare Scientists	261	17	6.5%	6
Medical and Dental	478	7	1.5%	3
Nursing and Midwifery Registered	2396	171	7.1%	61
Whole Trust	**6345**	**389**	**6.1%**	**231**

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 4.1% for September, which is a increase of 0.3% 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 table below lists the five care groups with the highest sickness absence percentage during September 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	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	3.1%	3.0%	3.7%	3.9%	↗
Community Services	6.0%	4.7%	5.7%	5.5%	↘
Corporate	4.8%	2.5%	3.2%	3.6%	↗
Estates and Facilities	4.5%	3.8%	3.9%	4.0%	↗
Medical & Cardiothoracics	2.6%	3.2%	3.9%	4.4%	↗
Surgery, Neurosciences & Anaes	3.4%	3.6%	3.1%	3.4%	↗
SWL Pathology	2.5%	2.6%	2.2%	4.3%	↗
Whole Trust	**3.5%**	**3.4%**	**3.8%**	**4.1%**	↗

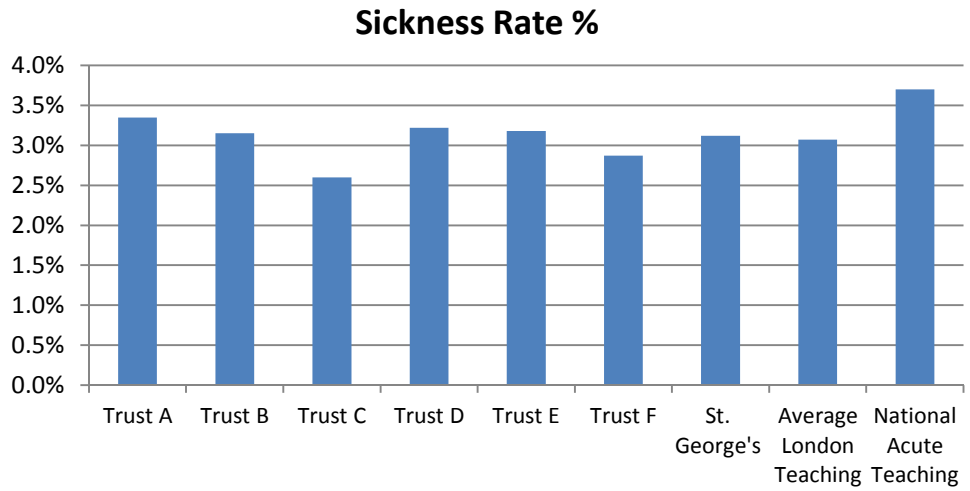
Sickness Staff Group	Jun '15	Jul '15	Aug '15	Sep '15	Trend
Add Prof Scientific and Technic	3.0%	2.9%	3.6%	3.2%	↘
Additional Clinical Services	6.7%	6.8%	7.1%	7.5%	↗
Administrative and Clerical	4.5%	3.4%	4.2%	4.2%	↔
Allied Health Professionals	2.7%	2.2%	1.9%	2.9%	↗
Estates and Ancillary	5.7%	4.4%	5.6%	5.7%	↗
Healthcare Scientists	1.6%	2.0%	1.4%	3.0%	↗
Medical and Dental	0.6%	1.0%	0.9%	1.2%	↗
Nursing and Midwifery Registered	3.7%	3.7%	4.2%	4.6%	↗
Total	**3.5%**	**3.4%**	**3.8%**	**4.1%**	↗

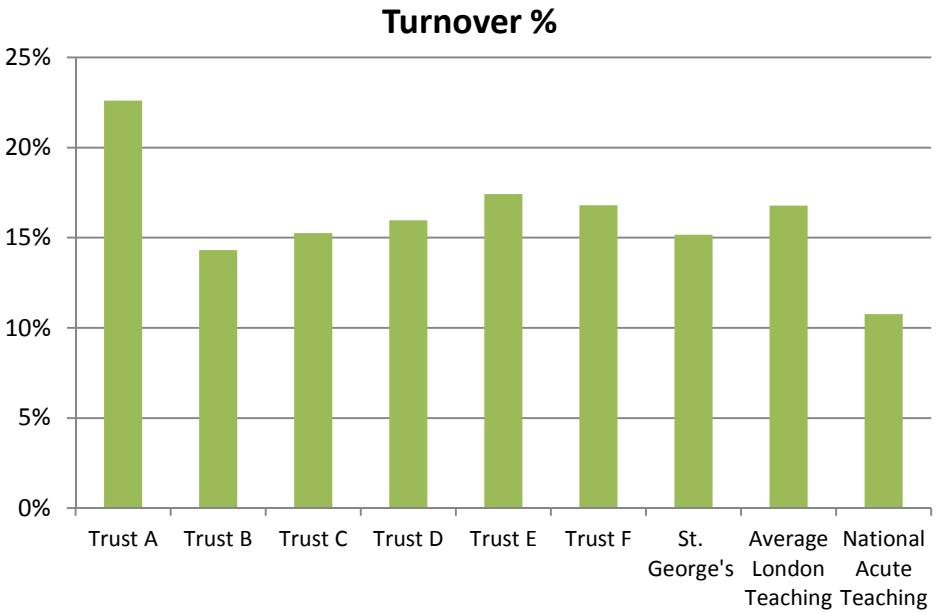
Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Procurement & Materials Mgmt	39.00	127.00	11.4%	£8,115
Integrated Sexual Health Services	68.57	170.64	8.9%	£23,071
Breast Screening	53.95	119.28	8.2%	£9,538
Acute Medicine	332.17	753.29	8.0%	£45,206
Paediatric Surgery	55.23	112.00	7.6%	£9,230

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	34.79%
S25 Gastrointestinal problems	15.24%
S12 Other musculoskeletal problems	7.62%
S16 Headache / migraine	6.74%
S10 Anxiety/stress/depression/other psychiatric illnesses	5.87%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S13 Cold, Cough, Flu - Influenza	18.22%
S10 Anxiety/stress/depression/other psychiatric illnesses	14.02%
S12 Other musculoskeletal problems	12.19%
S25 Gastrointestinal problems	9.47%
S11 Back Problems	6.89%

Section 6: Workforce Benchmarking





COMMENTARY

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

Sickness data shown is from June '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 3.12%. 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 June.

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 July). 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 over 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	22.60%	77.94%	3.35%
Trust B	14.31%	85.15%	3.15%
Trust C	15.26%	84.34%	2.60%
Trust D	15.96%	83.77%	3.22%
Trust E	17.42%	82.77%	3.18%
Trust F	16.80%	82.88%	2.87%
St. George's	15.17%	84.52%	3.12%
Average London Teaching	16.79%	83.05%	3.07%
National Acute Teaching	10.77%	89.06%	3.70%

Section 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	1074.5	1068.5	1069.5	1098.6	↗
Community Services	594.6	569.3	569.5	583.1	↗
Corporate & R&D	60.9	59.9	68.2	68.2	↔
Medical & Cardiothoracics	1207.3	1268.1	1248.3	1248.3	↔
Surgery, Neurosciences & Anaes	1098.7	1097.7	1111.7	1152.0	↗
Total	4036.0	4063.5	4067.2	4150.2	↗

Nursing Staff in Post WTE

Division	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	985.3	984.0	973.1	982.8	↗
Community Services	471.3	466.5	461.2	447.7	↘
Corporate & R&D	54.0	50.0	46.0	46.0	↔
Medical & Cardiothoracics	1006.5	994.3	985.9	985.8	↘
Surgery, Neurosciences & Anaes	884.0	897.6	906.8	899.2	↘
Total	3401.2	3392.4	3373.0	3361.5	↘

Nursing Vacancy Rate

Division	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	8.3%	7.9%	9.0%	10.5%	↗
Community Services	20.7%	18.1%	19.0%	23.2%	↗
Corporate & R&D	11.2%	16.4%	32.5%	32.5%	↔
Medical & Cardiothoracics	16.6%	21.6%	21.0%	21.0%	↗
Surgery, Neurosciences & Anaes	19.5%	18.2%	18.4%	21.9%	↗
Total	15.7%	16.5%	17.1%	19.0%	↗

Nursing Sickness Rates

Division	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	4.3%	4.1%	5.3%	5.6%	↗
Community Services	6.2%	5.3%	6.3%	6.4%	↗
Corporate	6.6%	1.6%	3.5%	4.5%	↗
Medical & Cardiothoracics	3.3%	4.0%	4.4%	5.3%	↗
Surgery, Neurosciences & Anaes	4.5%	5.1%	4.2%	4.2%	↗
Total	4.3%	4.4%	4.8%	5.2%	↗

Nursing Voluntary Turnover

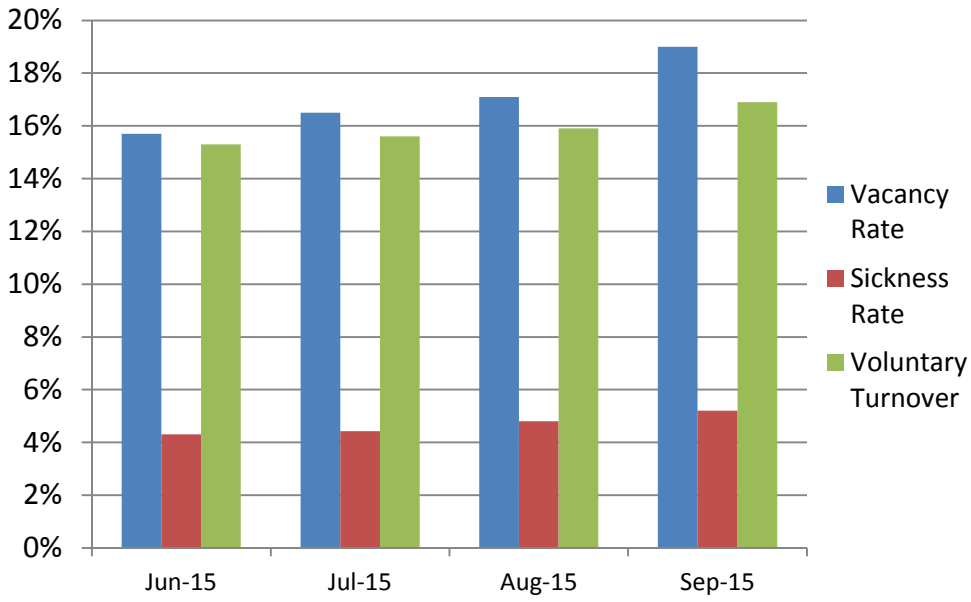
Division	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	14.02%	14.11%	14.81%	15.59%	↗
Community Services	17.31%	16.61%	18.23%	19.38%	↗
Corporate & R&D	14.25%	16.97%	15.37%	14.88%	↘
Medical & Cardiothoracics	17.48%	17.46%	17.97%	19.82%	↗
Surgery, Neurosciences & Anaes	13.96%	14.42%	13.49%	13.72%	↗
Total	15.5%	15.5%	15.9%	16.9%	↗

COMMENTARY

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

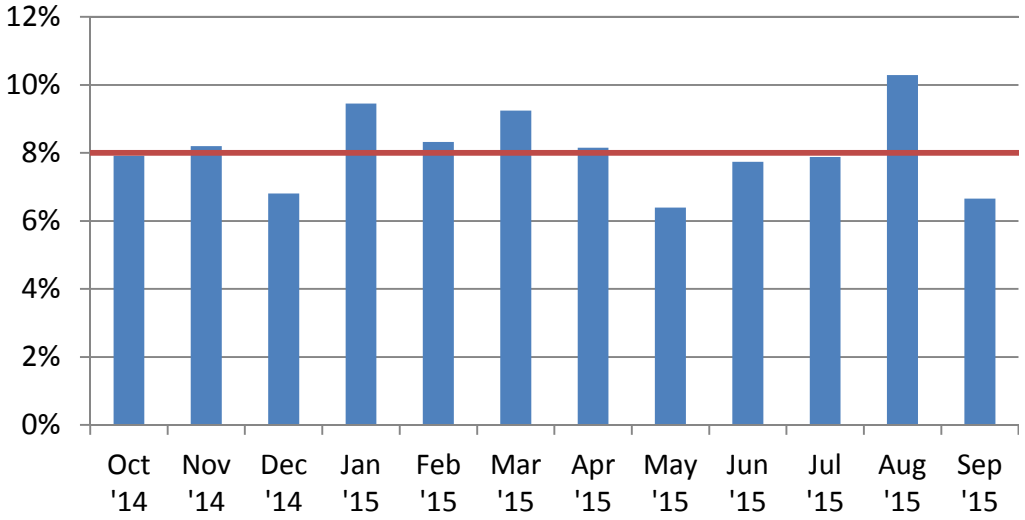
The nursing workforce has decreased by 11.5 WTE in September. The output of the review of nursing establishments will be a revised trajectory for demand for nursing.

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



Section 8: Agency Staff Costs

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



COMMENTARY

The agency spend percentage has decreased by 3.6% since August.

Currently, the highest percentage spend is seen in the Community Services Division. The highest actual spend is seen in Medicine and Cardiothoracics at £756K for August.

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

The agency cost data does not appear to reflect known usage. KPMG are supporting a detailed review of how costs are reported.

Agency % Spend by Division	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	6.4%	4.6%	8.4%	5.4%	↘
Community Services	12.9%	10.0%	3.5%	9.6%	↗
Corporate	11.5%	12.0%	17.1%	5.8%	↘
Estates and Facilities	3.5%	8.5%	9.3%	3.2%	↘
Medical & Cardiothoracics	8.4%	9.1%	10.2%	8.8%	↘
Surgery, Neurosciences & Anaes	3.9%	3.1%	6.9%	3.8%	↘
Whole Trust	**7.7%**	**7.9%**	**10.3%**	**6.7%**	↘

Agency Costs £ by Division	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	£647,593	£460,175	£879,472	£558,470	↘
Community Services	£560,800	£421,845	£669,773	£397,852	↘
Corporate	£65,977	£725,851	£439,482	£141,546	↘
Estates and Facilities	£37,748	£95,853	£100,971	£36,523	↘
Medical & Cardiothoracics	£754,322	£814,214	£888,472	£756,538	↘
Surgery, Neurosciences & Anaes	£333,300	£266,435	£603,013	£336,308	↘
Whole Trust	**£2,623,925**	**£3,412,750**	**£3,944,780**	**£2,519,156**	↘

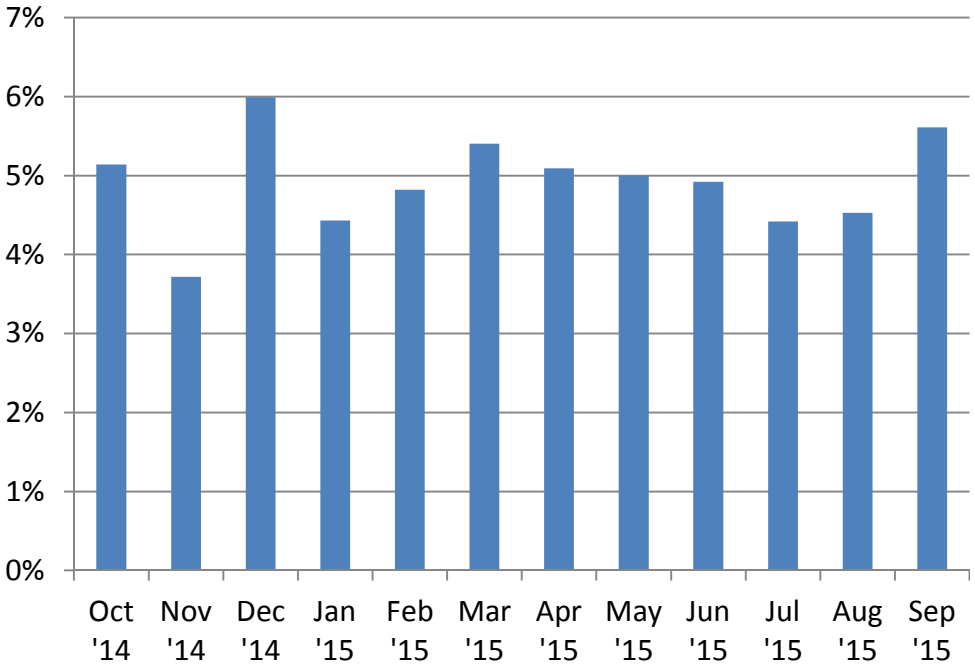
Care Group	Agency Spend % Sep-15	Staff In Post WTE
Procurement & Materials Mgmt	31.4%	39.0
Offender Healthcare HMPW Serv	22.3%	56.2
Finance Directorate	19.6%	120.9
Clinical Haematology	19.4%	114.9
Engineering Services	15.5%	51.0

Booking Reason	Medical Agency & Bank £ Sep-15	%
Annual Leave AL	£998	0.21%
Increased Care Needs ICN	£1,383	0.30%
Maternity Leave ML	£0	0.00%
Sickness S	£2,160	0.46%
Study Leave SL	£638	0.14%
Vacancy V	£461,213	98.89%
Total	**£466,392**	**100.00%**

Nursing & Midwifery Staff Group	Jun '15	Jul '15	Aug '15	Sep '15
Agency Spend %of Paybill	10.45%	9.10%	12.61%	10.30%
Agency Spend £	£1,414,034	£1,152,439	£1,644,350	£1,350,555

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 increased by 1.1% between August and September.

In September, the analysis of hours worked shows an increase in Admin & Clerical staff in Children and Women's outpatient clinics and in Corporate areas. Medical staff bank usage in the Surgery & Neuro Division has also increased. Nursing & Midwifery bank hours were lower than August across all Divisions apart from Surgery & Neurosciences (both Registered and Unregistered staff).

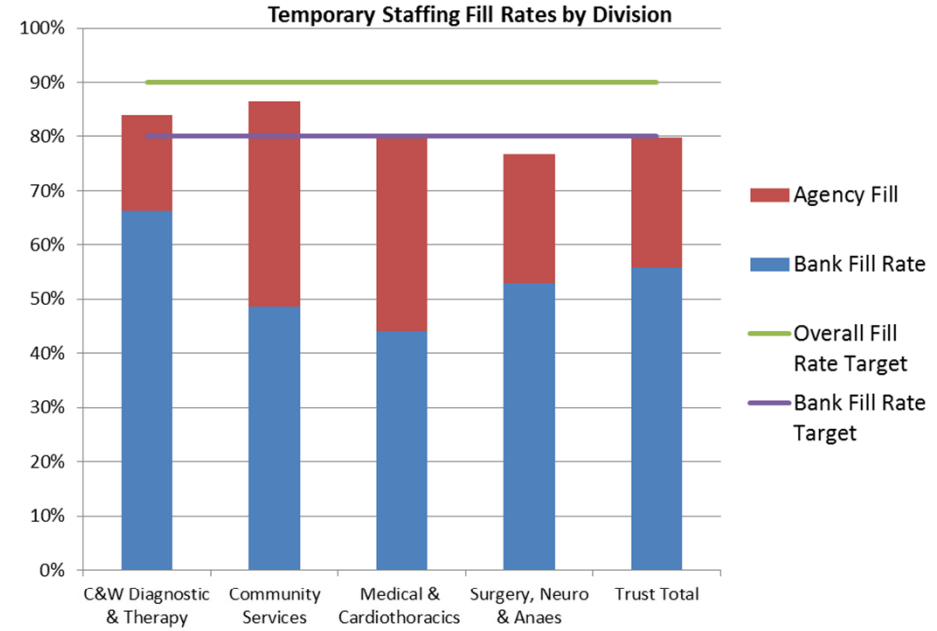
There has been a programme of work to transfer temporary administrative staffing from agency to bank. This appears to be having an impact.

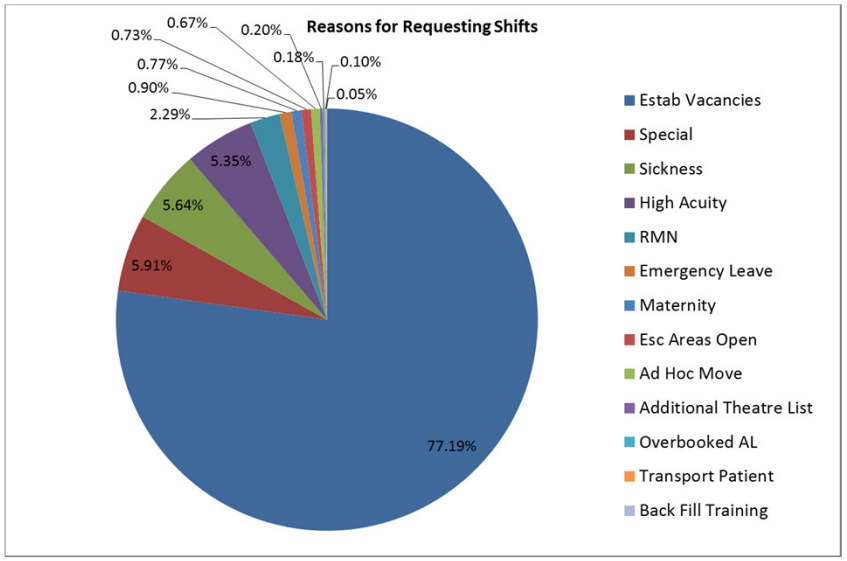
The table below lists the five care groups with the highest bank percentage spend for this month.

Bank Spend % by Division	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	5.5%	10.0%	4.7%	6.0%	↗
Community Services	3.5%	3.5%	3.5%	5.0%	↗
Corporate	4.9%	4.4%	3.7%	8.3%	↗
Estates and Facilities	12.7%	10.2%	8.3%	13.1%	↗
Medical & Cardiothoracics	6.7%	5.4%	6.9%	5.5%	↘
Surgery, Neurosciences & Anaes	3.3%	3.4%	2.4%	4.7%	↗
Whole Trust	**4.9%**	**4.4%**	**4.5%**	**5.6%**	↗

Care Group	Bank Spend % Sep-15	Staff In Post WTE
Portering	33.8%	77.0
Security & Car Park Managemer	30.0%	22.0
SWLP Central Reception	22.0%	38.8
Offender Healthcare HMPW	19.8%	56.2
Human Resources Directorate	18.2%	83.3

Section 10: Temporary Staff Fill Rates





COMMENTARY

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

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

In August the Bank Fill Rate was reported at 56.8% which is 0.5% higher than the previous month. The Overall Fill Rate was 79.5% 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.

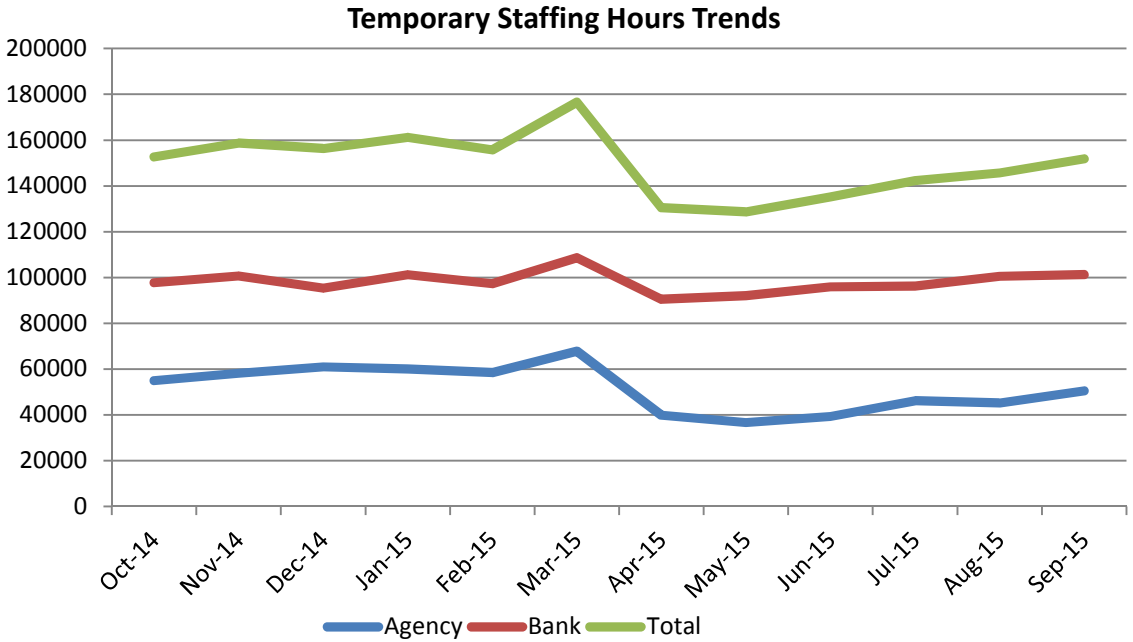
The pie chart shows a breakdown of the reasons given for requesting bank shifts in August. This is very much dominated by covering existing vacancies, specials, sickness, and high acuity patients.

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

Bank Fill Rate % by Division	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	64.34%	63.41%	68.14%	66.33%	↘
Community Services	52.46%	49.76%	50.84%	48.59%	↘
Medical & Cardiothoracics	47.10%	47.72%	47.68%	44.11%	↘
Surgery, Neurosciences & Anaes	57.94%	52.50%	50.91%	53.02%	↗
Whole Trust	**57.45%**	**56.22%**	**56.78%**	**55.74%**	↘

Overall Fill Rate % by Division	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	85.58%	80.00%	85.82%	83.88%	↘
Community Services	90.39%	87.80%	86.29%	86.55%	↗
Medical & Cardiothoracics	79.92%	79.93%	78.84%	80.02%	↗
Surgery, Neurosciences & Anaes	77.42%	77.08%	74.92%	76.73%	↗
Whole Trust	**81.20%**	**78.95%**	**79.53%**	**79.78%**	↗

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. Banks & Agency hours have both increased in September. The most significant increases are seen in the Medical & Cardiothoracics agency hours where a shift is seen towards agency rather than bank staff which have reduced since last month.

TYPE	Division	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Agency	C&W Diagnostic & Therapy	15471	18378	17489	15550	15363	16791	9525	10750	8656	9638	9408	10033
	Community Services	5483	6333	6146	6208	7800	9890	7938	5769	5245	6077	6422	6421
	Corporate	4251	4061	3772	3454	2763	3488	1246	1331	949	529	46	423
	Estates and Facilities	0	0	0	0	0	0	0	0	0	0	0	0
	Medical & Cardiothoracics	19168	18614	22515	24387	21773	25876	14492	13202	17823	20429	20348	24428
	Surgery, Neurosciences & Anaes	10572	10732	11041	10454	10809	11833	6582	5462	6386	9195	8730	8860
	SWL Pathology	0	0	0	0	0	0	119	204	241	228	245	352
Agency Total		**54946**	**58118**	**60964**	**60053**	**58508**	**67877**	**39901**	**36717**	**39299**	**46097**	**45199**	**50515**
Bank	C&W Diagnostic & Therapy	26353	27015	27280	28605	27697	31824	28052	28994	29353	25997	26657	30745
	Community Services	10058	10996	11092	10097	9360	10560	8379	7619	7704	8252	9033	8695
	Corporate	5496	7131	7405	7497	6939	7641	7176	6915	8116	7965	7205	8827
	Estates and Facilities	6962	7050	6867	7446	6807	7744	6885	7502	8178	9216	8910	8264
	Medical & Cardiothoracics	28231	27769	24451	25548	25083	27553	23755	24829	24969	26255	29728	27842
	Surgery, Neurosciences & Anaes	17828	18024	15382	18855	18438	20376	13521	13495	14553	14740	15545	16118
	SWL Pathology	2783	2619	2901	3134	2947	2953	2753	2620	3052	3751	3389	803
Bank Total		**97711**	**100604**	**95376**	**101182**	**97271**	**108650**	**90522**	**91974**	**95925**	**96177**	**100466**	**101293**
Temporary Staff Total		**152657**	**158722**	**156340**	**161235**	**155779**	**176528**	**130423**	**128691**	**135224**	**142273**	**145665**	**151808**

Section 11: Temporary Staffing Weekly Tracking

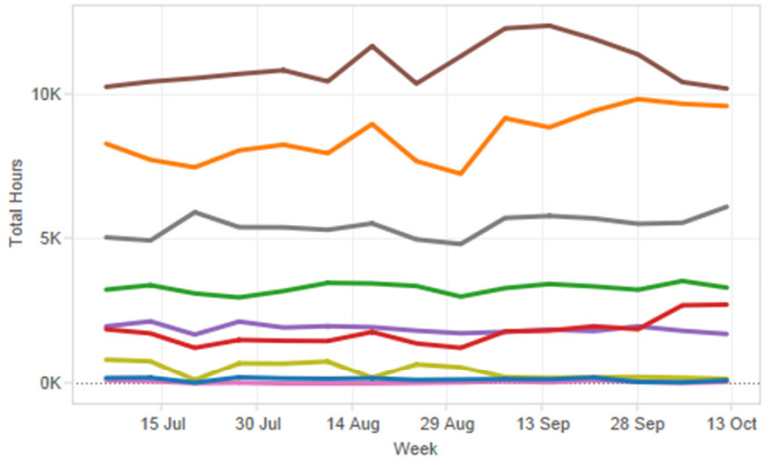
Weekly Hours Used

Division	20 Jul	27 Jul	03 Aug	10 Aug	17 Aug	24 Aug	31 Aug	07 Sep	14 Sep	21 Sep	28 Sep	05 Oct	12 Oct
Capital Division	40	225	187	174	192	134	148	163	153	214	63	52	115
Children and Women's Diagnostic and Ther..	7,476	8,058	8,254	7,960	8,964	7,690	7,254	9,164	8,852	9,416	9,823	9,661	9,583
Community Services Division	3,140	3,002	3,222	3,503	3,484	3,396	3,030	3,324	3,466	3,382	3,267	3,569	3,340
Corporate Division	1,269	1,543	1,514	1,505	1,817	1,421	1,270	1,835	1,863	2,012	1,911	2,732	2,757
Estates and Facilities Division	1,725	2,173	1,969	2,017	1,981	1,861	1,771	1,817	1,900	1,846	2,010	1,857	1,747
Medicine and Cardiovascular Division	10,540	10,687	10,815	10,430	11,647	10,356	11,296	12,253	12,347	11,895	11,358	10,408	10,186
Research & Development Division	20	40	8		13		47	85	50	119	69	31	62
Surgery & Neurosciences Division	5,932	5,418	5,413	5,328	5,548	4,999	4,838	5,736	5,806	5,723	5,534	5,569	6,119
SWL Pathology Division	134	735	725	798	211	697	595	233	205	227	238	210	174
Grand Total	30,276	31,879	32,106	31,715	33,856	30,552	30,247	34,610	34,641	34,832	34,271	34,088	34,084

Division
- Capital Division
- Children and Wome..
- Community Service..
- Corporate Division
- Estates and Faciliti..
- Medicine and Cardi..
- Research & Develo..
- Surgery & Neurosci..
- SWL Pathology Divi..

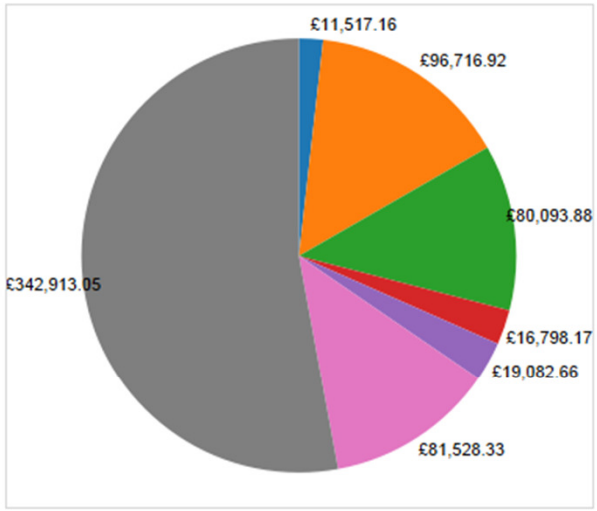
Type
- Agency
- Bank

Weekly Hours Used



Division
- Capital Division
- Children and Women's Diagnostic and Therapy Services Division
- Community Services Division
- Corporate Division
- Estates and Facilities Division
- Medicine and Cardiovascular Division
- Research & Development Division
- Surgery & Neurosciences Division
- SWL Pathology Division

Weekly Spend by Staff Group



Weekly Cost £
£648,650.18

DATE (Week)
12/10/2015

Staff Group
- Add Prof Scientific
- Additional Clinical Services
- Admin & Clerical
- Allied Health Professionals
- Estates & Facilities
- Medical & Dental
- Nursing & Midwifery

Section 12: Mandatory Training

MAST Topic	Aug '15	Sep '15	Trend
Conflict Resolution	73.2	73.2	↗
Equality, Diversity and Human Rights	77.5	76.4	↘
Fire Safety	72.3	71.1	↘
Health, Safety and Welfare	76.8	75.6	↘
Infection Prevention and Control Clinical	58.2	58.1	↘
Infection Prevention and Control Non Clinical	70.0	67.8	↘
Information Governance	61.1	60.3	↘
Moving and Handling	72.3	69.7	↘
Moving and Handling Patient	52.0	50.2	↘
Resuscitation BLS	37.9	41.2	↗
Resuscitation ILS	40.7	52.9	↗
Resuscitation Non Clinical	59.3	59.1	↘
Safeguarding Adults	74.3	72.7	↘
Safeguarding Children Level 1	73.8	71.7	↘
Safeguarding Children Level 2	73.6	72.2	↘
Safeguarding Children Level 3	71.3	71.9	↗

MAST Compliance % by Division	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	74.7%	73.6%	70.4%	68.4%	↘
Community Services	73.8%	72.9%	70.4%	70.1%	↘
Corporate	70.5%	68.8%	64.1%	65.4%	↗
Estates and Facilities	66.0%	64.9%	64.5%	61.9%	↘
Medical & Cardiothoracics	66.3%	64.4%	60.8%	61.6%	↗
Surgery, Neurosciences & Anaes	69.4%	68.5%	65.9%	66.5%	↗
Whole Trust	72.4%	71.0%	67.8%	67.2%	↘

COMMENTARY

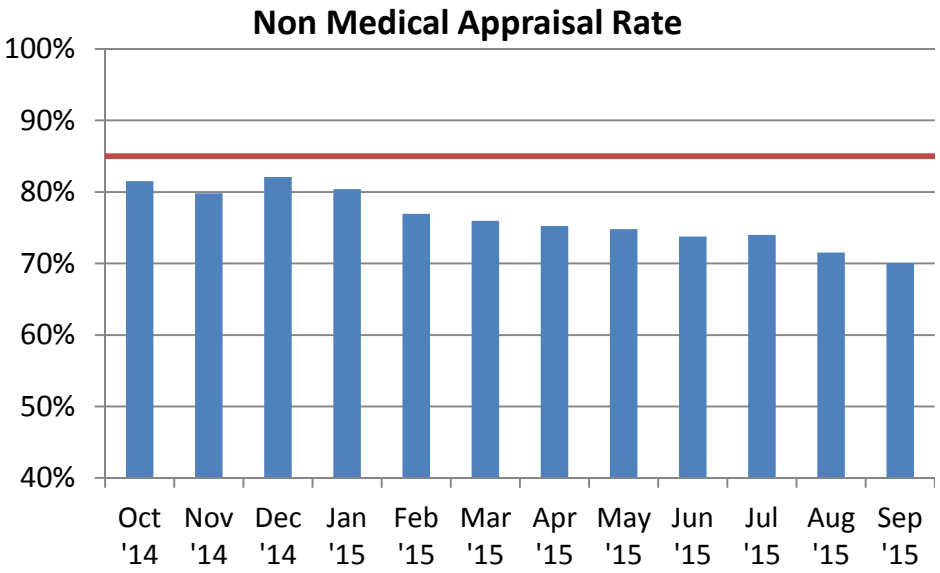
A programme of working is taking place including:

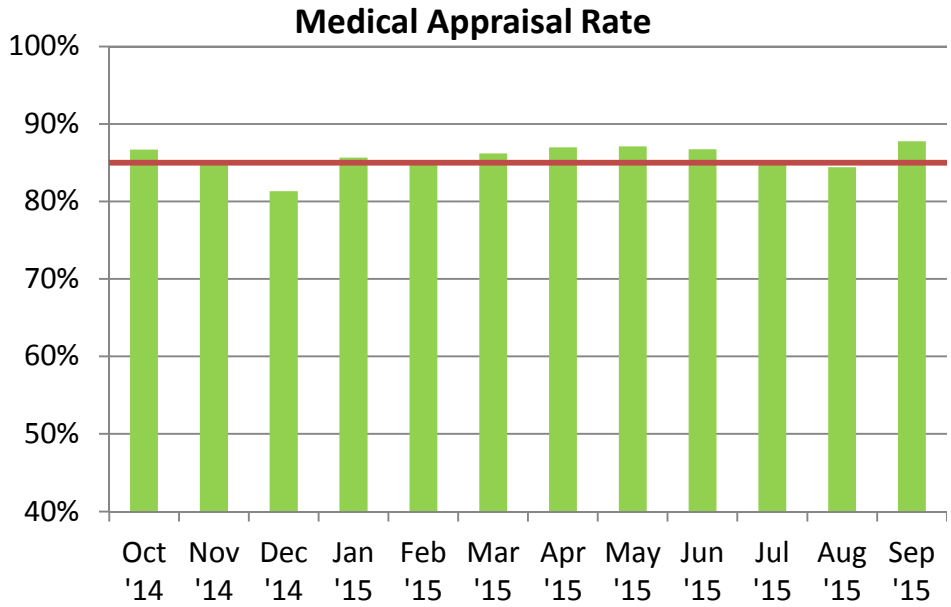
- Changing the method of delivery to on-line testing as far as possible and only training when required
- Reviewing who needs to access the training
- Reviewing the frequency of refresher periods
- Providing and accessible on-line system
- Introduced monthly meetings where divisions report on progress 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.
- Not enough capacity to provide the training for the needs identified, particularly in resuscitation.

Section 13: Appraisal





Non-Medical Commentary

The non-medical appraisal rate has decreased by 1.5% this month to 70%. Appraisals are still being managed closely by the appraisal project team who are monitoring progress every two weeks and scrutinising divisional plans. The Corporate Division currently has the lowest non-medical compliance rate. Appraisal completion is now linked to incremental progression for bands AFC band 7 - 9 staff. The table below lists the five care groups with the lowest non medical appraisal rate this month

Medical Commentary

Medical appraisal rate compliance has increased this month to 87.8% which is back above target.

Care Group	Non-Med Appraisal Rate	Staff In Post WTE
Engineering Services	7.9%	51.00
Obstetrics	27.2%	285.99
Urology	37.2%	70.52
Procurement & Materials Mgmt	41.2%	39.00
SWLP Central Reception	41.9%	38.82

Non Medical Appraisals by Division	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	74.4%	73.7%	69.2%	69.0%	↘
Community Services	75.4%	76.0%	72.8%	68.2%	↘
Medical & Cardiothoracics	77.8%	77.8%	74.8%	73.6%	↘
Surgery, Neurosciences & Anaes	74.2%	75.1%	75.2%	74.5%	↘
Corporate	66.4%	66.8%	63.6%	64.3%	↗
Estates & Facilities	80.7%	74.7%	77.7%	64.0%	↘
Whole Trust	**73.8%**	**74.0%**	**71.5%**	**70.0%**	↘

Medical Appraisals by Division	Jun '15	Jul '15	Aug '15	Sep '15	Trend
C&W Diagnostic & Therapy	87.1%	82.6%	84.1%	86.9%	↗
Community Services	69.6%	69.6%	84.0%	84.0%	↔
Medical & Cardiothoracics	87.7%	91.2%	85.2%	87.7%	↗
Surgery, Neurosciences & Anaes	84.9%	88.8%	84.3%	87.7%	↗
Corporate	50.0%	50.0%	100.0%	100.0%	↔
Whole Trust	**86.7%**	**85.1%**	**84.4%**	**87.8%**	↗