St George's University Hospitals NHS
NHS Foundation Trust

Trust Board Meeting (Public)

Thursday 5th May 2016 commencing at 10:00 am
Venue: Large Seminar Room, Rose Centre

Item	Time	Item	Owner:	Board Action	Paper No:
Board Business					
1.	**10.00**	**Welcome and Apologies**		Apologies received from Jenny Higham	-
2.		**Declarations of Interest**	All	Board Members to declare any pecuniary or non-pecuniary interest in particular agenda items, if appropriate	-
3.		**Minutes of the meeting**		To consider the Minutes of the previous meeting held on 7th April 16 and check for amendments and approve	TB May 16 -01
4.		**Key Issues**	All	Board members to identify any key issues	
5.		**Schedule of Matters Arising**		To discuss any matters arising from previous meetings and provide updates and review where appropriate	TB May 16 - 02
6. Business Planning 2016/17					
6.1	**10.15**	**Estates Plan including Renal Development**	R Hancock	The Board to consider the wider estates plan including Renal Development	TB May 16 - 03
7. Patient Safety, Quality and Performance					
7.1	**10.45**	**Performance & Quality Account**	J Hall/S Mackenzie	To inform the Board about the latest performance and quality report.	TB May 16 -04
7.2		**Workforce & Performance Report**	W Brewer	To inform the Board about the latest position on workforce.	TB May 16 -05
7.3		**Quality & Risk Committee**	J Higham/S Wilton	To inform the Board about the key issues arising from the Committee	Verbal
7.4		**Frequent A&E Attenders**	A Benincasa	The Board to agree the proposed approach to more effective management of these patients	TB May 16 -07
7.5		**PPI/PPE Strategy 16/17**	J Hall	The Board to agree the proposed strategy	TB May 16 -08
8. Strategy					
8.1	**11.45**	**Update on Outpatient Strategy**	R Elek	To update the Board on the strategy	TB May 16 -09

Item	Time	Item	Owner:	Board Action	Paper No:
8.2		**Outpatient Programme – Call Centre**	A Rhodes	To note Call Centre performance and key actions.	TB May 16 - 10
8.3		**Commercial Board 2015/15 annual report**	R Elek	To note	TB May 16 -11
8.4		**Annual Plan 2015/16 Q4 review and end of year summary**	R Elek	To note	TB May 16 -12
8.5		**SW London Acute Provider Collaborative: Update to SWL acute trust boards**	R Elek	To note	TB May 16 - 13
9. Finance and Performance					
9.1	**12.10**	**Annual Report 15/16 - including the Quality Account**	R Elek	The Board to agree the Quality Account	TB May 16 -14
9.2		**Annual Plan 16/17 and APR**	R Elek		TB May 16 -15
9.3		**Finance Report – month 12**	I Lynam	To inform the Board about the latest project outturn	TB May 16 -16
9.4		**Finance & Performance Committee**	S Wilton	To inform the Board about the key issues arising from the Committee	TB May 16 -17
9.5		**16/17 Financial Plan**	I Lynam		TB May 16 - 18
10. Governance and Risk					
10.1		**Risk and Compliance Report**	J Hall	To review the Trust's most significant risks and external assurances received	TB May 16 -19
Items for Information					
11.		**Use of the Trust Seal**		To note use of the Trust seal in April 2016. The seal was not used in April 2016	
12		**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	
13		**Key reflections**	All	The Board to reflect on key issues	

Date of next meeting
The next scheduled meeting of the Board to be held in public will be 2nd June 2016

Minutes Trust Board

Minutes of the meeting Trust Board of St George's University Hospitals NHS Foundation Trust, held on Thursday 7 April 2016 in Richmond & Barnes Rooms, Queen Mary's Hospital commencing at 10am and concluding at 12.45.

PRESENT

Sir David Henshaw	DH	Chairman
Mike Rappolt	MR	Deputy Chair, Non-Executive Director
Sarah Wilton	SW	Non-Executive Director
Kate Leach	KL	Non-Executive Director
Stella Pantelides	SP	Non-Executive Director
Prof Jenny Higham	JMH	Non-Executive Director
Jennie Hall	JH	Chief Nurse
Simon Mackenzie	SM	Medical Director
Iain Lynam	IL	Chief Finance Officer
Wendy Brewer	WB	Director of Workforce
Martin Wilson	MW	Director of Transformation
Rob Elek	RE	Director of Strategy
Paula Vasco-Knight	PVK	Chief Operating Officer
Anna Anderson	AA	Director of Financial Performance & Planning
Richard Hancock	RH	Director of Estates and Facilities
Lisa Pickering	LP	Divisional Chair, Medicine and Cardiology
Alison Benincasa	AB	Divisional Chair, Community Services
Andy Rhodes	AR	Divisional Chair, Women and Children
Luke Edwards	LE	Head of Governance

Observing

Nigel Carr	Observer
Yvonne Langley	Governor, Public
Mia Bayles	Governor, Public
Hilary Harland	Governor, Public
Philip Jones	Governor, Appointed
Ian Stone	Member of the Public
Brian Dillon	Governor, Appointed
Doulla Manolas	Governor, Public
David Kirk	Governor, Public
Barbara Bohanna	Member of the Public
Ann Bohanna	Member of the Public

Agenda Item		Action
1.	**Welcome and Apologies** The Chair welcomed everyone to the meeting. Apologies were received from Miles Scott.	
2.	**Declarations of Interest** There were none.	
3.	**Minutes** The Board considered the minutes of the last meeting held on 3 March **Resolved** that the Board**:** approved the minutes as an accurate record.	
4.	**Key Issues** The Chair requested that the Board use this agenda item in future to identify and reflect on key emerging issues.	
5.	**Matters Arising** The Board noted the update and confirmed that the Outpatients Recovery Plan Update was scheduled to come to the Board in May. A formal report was requested Call Centre Performance.	**PVK May 16**
6.	**Chief Executives Report** The Board noted the Report in the Chief Executive's absence.	
	BUSINESS PLANNING 2016/17	
7.	**Business Planning Process** The Board noted that the trust had now agreed a four week extension from the original deadline of 11 April for submission of the annual plan and APR templates. The additional time would ensure that a solid set of numbers can be provided against the control total of £17.2m deficit with any potential additional funding for infrastructure and IT recovery agreed separately. SLAs have not yet been agreed across the system and this would also need to be resolved. The Board requested that IL produce a clear approvals plan with sufficient scope for appropriate scope for challenge and reflection from Non-Executives and received assurance that activity and workforce were built into the planning process. IL confirmed that final numbers would be presented to the Finance and Performance Committee in April and that he would liaise with MR to agree how to engage the Audit Committee. DH asked the secretariat to arrange Extraordinary Board Away Day in mid-April to enable the Board to get a grip on the full range of challenges facing the trust.	**IL April 16** **LE April 16**
8	**Corporate Objectives** DH asked that this item was deferred for substantive discussion at the	

planned away day and that further work was undertaken in advance of that session. The Board noted that we should be seeking to agree a small number of objectives and tracking their delivery. The communication plan needed significant development and re-working and should be withdrawn from the agenda.

9 Financial Planning

As budgets would not be agreed at the start of the financial year IL sought the Board's approval to agree spending in line with 2/12 of the revenue and capital budget against the £17.2 deficit control total in the first two months of the year. This was necessary to ensure the trust is not acting ultra vires and in breach of its SFIs. He confirmed that this included 1% provision for contingency and that the Board would have to opportunity to fully test the underpinning assumptions including, for example, the assumed asset sales.

Resolved that the Board**:** approved expenditure in April and May as proposed.

10 Key Trajectories

PVK provided the Board with an overview of the current performance and key trajectories for cancer, RTT and ED. These were submitted on 18 March to NHSE-London and NHSI for scrutiny and approval. The trust is performing positively against a number of indicators but challenges remain with the ED 4 hour target, RTT, Cancer waiting time targets and cancelled operations by the hospital for non-clinical reasons.

Cancer: the trust was non-compliant against four cancer targets in January and had a comprehensive recovery plan in place. Three of these had been recovered in February although the expectation was that March would be challenging because of the Christmas impact. The expectation was that the trust would be sustainably hitting all seven standards from April. She confirmed to the Board that missing the standards had not given rise to patient safety concerns and robust processes were in place to hit the key milestones.

RTT: performance has improved and is now at 90% compared to a target of 92%. A detailed piece of work had been undertaken to improve operational performance and a recovery plan is under development. However a technical review has identified that that there is a concern with the robustness of the underlying data and a number of patients have been incorrectly excluded from the pathway. An initial risk assessment has been completed and a clinical risk assessment will now be undertaken.

ED: The trust continues to implement its unplanned care recovery programme which encompasses the flow programme and the outputs on the One Version of the Truth work. The trajectory assumes 95% compliance can be achieved from February 2017. This is dependent on support from primary care providers, better management of frequent attenders and reducing the number of walk in patients who could be treated elsewhere

The Board received assurance that the assumptions built into the recovery

planning on staffing had been captured in the planning process and had involved divisions. It was also noted that Cardiac and ENT were not currently hitting the trajectory and that this needed to be discussed with commissioners. The future position of the Nelson contract was noted as a key issue that would also need to be discussed as part of the strategy away day.

Resolved that the Board**:**

(i) Noted the content of the report
(ii) Asked that PVK submit a written report to the Board on RTT patients as soon as the analysis has been completed.
(iii) Ensure that progress on delivering the trajectories is monitored through 2016/17

PVK April 16

11 Communications Plan

This item was deferred to the away day and not discussed.

PATIENT SAFTEY, QUALITY AND PERFORMANCE

12 Performance and Quality Report

JH introduced the report and summarised the key findings in each of the quality domains. The overall position for February remains consistent with the previous two quarters with some moderate improvements across a number of indicators.

The Board discussed the impact of the patients of the recent junior doctors strike and received assurance that there had been no impact on quality and the reliance on senior decision makers had improved discharge and flow decisions. However 400 of 2400 planned outpatient appointments had been cancelled. The impact on RTT performance had been quantified and weekend and evening clinics had been put in place. The Board noted the requirement for robust plans for the next strike particularly given that emergency cover would not be provided been 8am – 5pm.

The Board also received assurance that the work on complaints would focus on lessons learned and that that the Ward that had been placed in special measures had responded well and had showing early signs of improved performance. JH confirmed that this was the only Ward in special measures however a number of risk areas were being carefully monitored.

The Board noted the RTT access policy and the future requirement to approve this policy.

13 Workforce and Performance Report

WB introduced the workforce and performance report and highlighted that the workforce position remained challenging with staff turnover increasing after two months of reduction. There had been a marginal decrease in the vacancy factor and the trust benchmarks reasonably for sickness absence against other trusts. The recruitment campaign for 125 nurses in the Philippines had been successful and the first staff would be expected in early summer. The Board noted the deep dive review into management of agency staffing which was being supported by Monitor. WB agreed to

provide clarification around the 35% vacancy factor reported for the SWLP. **WB April 16**

The Board considered the report on workforce and staff experience action plan. WB highlighted the feedback meeting with staff on 30th April which indicated the need for fundamental shift in staff engagement with increased autonomy, clearer channels of communication, improvement management skills and freeing up time. The Board agreed that it was important to identify 2 or 3 immediate priorities for action while taking forward the broader programme of work in parallel. DH asked that a clear plan was developed to deliver a radical shift in staff engagement for this to be discussed in the strategy session. Proposals for immediate priorities should be circulated to the Board close of play Monday. This should be developed with Kate Leach and other NED colleagues as appropriate. **WB 11/04/16**

The Board noted the position on the Agency Expenditure Ceiling in 2015/16 and that the 2016/17 ceiling of £23m would be challenging for the trust to deliver against. WB also noted that the price caps were acting the level out prices as well reducing higher costs.

WB then updated the Board on the SWL Staff Bank Project and sought approval from the Board to the principle of the approach and for agreement to take forward the further work as described. This was agreed however a number of reservations were expressed around the unintended consequences and risks of this approach and the likelihood of it delivering the expected benefits. WB reassured the Board that these issues would fully considered and set out before a final decision on implementation is sought.

Resolved that the Board**:**

(i) Noted the contents of the reports
(ii) Agreed to further work being undertaken as proposed for the SWL Staff Bank
(iii) Asked that the final business for the SWL staff Bank addresses identifies and responds to the concerns identified.

14 Workforce and Education Committee Report

There were no key issues arising from the Committee.

15 Quality and Risk Committee

SW drew the Board's attention to two key issues from the Committee. The first was the concerns around diagnostic follow-up, following a number of SIs arising from such shortfalls. This issue had also been identified in two recent Audit Reports. QRC is not assured that controls are secure in all areas and has requested a full update for the next Board. The second was limited assurance provided around health, safety and fire and the extent to which the matters of concern identified in the 2014/15 Annual Report and from other sources have been addressed. RH confirmed that this was high on his priority list for 2016/17.

STRATEGY

16 Update on Renal

The Board received the report. RH outlined the progress that had been made and noted that he had appointed a project manager to focus on the initial 'make good' work. A detailed report had been commissioned and received from Stewart's Associates. This had identified the very significant scale of the problems in the Knightsbridge wing including the ability to control temperatures and the significant costs associated with resolving these problems. The medium to long term renal redevelopment plans would be considered as part of a broader estates plan and a number of options had been identified. The Board would receive an estates plan at the May meeting.

RH
May 16

Resolved that the Board noted the contents of the report

FINANCE AND PERFORMANCE

17 Finance Report – Month 11

AA introduced the report. In February the Trust had a deficit of £0.6m compared to a plan of £2.1m. The deficit was lower this month as a capital to revenue transfer of £3.6m was expected. Cumulatively the Trust had a deficit of £49.4m which was £2.9 better than expected. As reported in previous months, the main reason for this positive position is a £4.6m underspend on pay budgets largely because the pace of recruitment had been slower than planned. These underspends have been partially offset by continuing underperformance on SLA income and higher than expected SLA penalties. £37m of CIPs have been achieved to date. The underlying deficit fluctuates between £3-5m per month due to variances in the income levels.

The cash balance at the end of February was £13.4m, £10.4m more than in the original plan. In addition, use of the working capital facility was £13.5m lower than expected so overall the cash position was £23.9m better than plan. Since the end of the month, positive progress has been made in securing payment from NHSE for over performance on its contract and that dialogue is on-going. Capital spend is continuing to be slowed down as part of the overall cash management plan and to date spend has been £27.1m, £19.6m less than the revised plan. The year end outturn is still expected to improve to a £54m deficit, £2m better than the revised plan. AA agreed to provide KL with assurance that we were not carrying significant debts into 2016/17.

The Board noted that an impairments review was being undertaken and the preparatory work was currently underway. This would return to the Finance and Performance Committee and Audit Committee for a final decision in May.

18 Finance and Performance Committee

SW outlined the key messages. These included: commending the EMT for achievement of the CIP savings, while noting that a number of these were non recurrent; ensuring that the 2016/17 budgets reflected the TRP process; and the urgent need to ensure that budget holders to be determined and to have clear and agreed budgets in place.

The Board noted the key messages and emphasised the need to ensure that where commissioners were not funding services rapid decisions would need to be made to change capacity and that accurate cash flowing forecasting and adequate loan facilities would continue to be critical. The Board asked for assurance that the key assumptions underpinning the 2016/17 budget, including for example a significant reliance on asset sales, would be fully tested and the implications understood. This would need approval from the Finance and Performance and Audit Committees prior to sign off by the Board in May. IL agreed to develop an approvals plan and discuss this in more detail at the Board away day.

IL
May 16

GOVERNANCE AND RISK

19. Risk and Compliance Report

JH introduced the report. Seven new risks had been added to the corporate risk register including non-adherence with FOI policy, policies and procedures being out of date, workforce engagement and the transformation programme. A revised timeline for implementing the risk management strategy has been agreed by QRC who will receive quarterly progress updates. The trust will also undergo a full announced inspection by CQC on 21st – 23rd June 2016. The second formal data return is required on 19th April which will include a self-assessment against the key lines of enquiry. The CQC Annual Update to Statement of Purpose is also required and JH confirmed to the Board that no changes to activities or locations have been made.

The Board noted that there are a number of long standing risks where the levels had not been reduced and asked for more assurance that the Corporate Risk Register was connected to the Divisional Risk Register. DH expressed his unhappiness with the trust's current approach to risk, in particular the lack of a Board Assurance Framework, and felt that this was a weak link in the chain. Greater NED involvement and challenge was required to create a climate of positive management.

Resolved that the Board**:**

(i) Noted the contents of the report
(ii) Asked that further work is undertaken to strengthen the approach to risk and that proposals are reflected in the May update
(iii) Approved the CQC Statement of Purpose

20. PWC Recommendations

IL introduced the report in MS's absence. The majority of actions had been completed and 11 of remained open. The completed actions are generally simple. The outstanding actions are generally softer and involve a judgement as to whether the action has been completed to a satisfactory level. The next step was to liaise with PWC on the extent to which there remained value in progress further work.

Resolved that the Board**:** noted the report and agreed the next steps as presented in the meeting.

21. Annual Audit Report

Resolved that: the Board noted the report.

22. Annual Audit Plan

Resolved that: the Board noted the report.

23. Report from the Audit Committee

MR thanked the two Governors who have become members of the Audit Committee for the last meeting and summarised the key messages for the Board as detailed in his report. MR concluded by welcoming our new Internal Auditors TIAA and thanking London Audit Consortium, and their lead Auditor, Lindsay Thatcher for their service to the trust.

24. Use of the Trust Seal

The seal was used 3 times:

- Noon Bicknell Lease
- Deed of Assignment for Intellectual Property – Mitral Valve Project, Brecker-Saba Atraumatic Cardiac Pacing Lead
- Deed of Assignment for Intellectual Property – Mitral Valve Project, Replacement Heart Valve

Resolved that: the Board noted the use of the Trust Seal.

25. Questions from the Public

No questions were tabled.

26. Points of Reflection

DH asked that the secretariat review the arrangements for future Board meetings and in particular ensure that microphones are available.

27. Date of next meeting

The next scheduled meeting of the Board to be held in public will be 5th May 2016.

St George's University Hospitals NHS
NHS Foundation Trust

Matters Arising/Outstanding from Trust Board Public Minutes
5 May2016

Action No.	Date First raised	Issue/Report	Action	Due Date	Responsible officer	Status at 5 May2016
7.	14 Jan 16	Quality & Performance Report	The Board discussed mortality rates that the Mortality Committee were monitoring and taking action against the increase in SHMI previously reported. MR referred to a press report on the deaths of people with mental capacity issues and if these could be identified as a group in the overall figures. It was agreed that this would be undertaken and reported back.	7 April 16	J Hall	In relation to LD there is to be a new national mortality review process introduced and that is on the agenda for discussion at MMC next week, and for fuller discussion in May when the LD team and David will attend the meeting. We have already agreed that the LD team will attend MMC's going forward as and when required. We are also aware that the CQC will shortly be carrying out a review of how trusts identify, report, investigate and learn from mortality. The review will be looking in particular at how we investigate and learn from deaths of people with LD or a mental health problem. There is not much detail available yet but will be discussed under AOB at the MMC meeting next week http://www.cqc.org.uk/content/cqc-review-how-nhs-trusts-investigate-and-learn-deaths So, although at the moment we cannot identify these patients, we are making sure that we are fully engaged with the emerging programme of work in this area.
8.4	14 Jan 16	One Version of the Truth	6 month update	July.16	C Siddall	Due July 2016
8.3	14 Jan 16	Update on Outpatient additional activity income	The strategy had a set of trajectories and KPIs. More granular patient focused KPIs are being developed by the Outpatient Strategy Board. An update on progress.	April 16	A Rhodes	Will be covered within the outpatient strategy update for April 16 Due to pressure on the agenda the item was deferred to the May Board **ON AGENDA**
4.	4 Feb 16	Minutes of previous meeting 14 Jan 16 (amendment)	Call centre performance to be looked at to aim to reduce the number of abandoned calls	TBC	A Rhodes	**ON AGENDA**

6	4 Feb 16	Chief Executives Report	In response to a question on primary care and GP involvement and views on strategic development it was noted that a report would be brought to the Boards meeting on 7 April 2016	7 April 16	R Elek	Due to pressure on the agenda, has been deferred to May **ON AGENDA**
7.	3 Mar 16	Urogynaecology Report	It was agreed that the Board would receive an update in 2-3 months' time.	June 16	A Rhodes	Due in June
12.	3 Mar 16	Outpatients Recovery Plan Update	Outpatients Strategy due at April meeting.	7 April 16	R Elek	Due to pressure on the agenda, has been deferred to May **ON AGENDA**
14.	3 Mar 16	Finance Report	Debt position NHSE and action plan	TBC	I Lynam	Covered within finance update
5.	7 April 16	Matters Arising	The Board noted the update and confirmed that the Outpatients Recovery Plan Update was scheduled to come to the Board in May. A formal report was requested Call Centre Performance	May 16		**ON AGENDA**
10.	7 April 16	Key Trajectories	A technical review has identified that that there is a concern with the robustness of the underlying data and a number of patients have been incorrectly not included within the pathway. An initial risk assessment has been completed and a clinical risk assessment will now be undertaken. Board asked for a written report on RTT	TBC	C Siddall	Initial draft sent. Imran Hussain: The trust has received a report following the IST RTT technical review. The report details' the areas which it deems appropriate as part of the trust reporting processes. However, it also challenged a number of the 281 exclusion criteria the trust currently have within their processes as either red-not appropriate or amber-requiring further clarification. The trust is currently reviewing the feedback and recommendations made. With regards to the exclusion criteria the trust are working through a process of re-integrating these patient cohorts back into reporting to assess performance impact and are further reviewing amber criteria for appropriateness against RTT guidance and assessing the potential impact of the re-integration of these records.
13.	7 April 16	Workforce and Performance Report	Provide a clarification around the 35% vacancy factor reported for the SWLP	April 16	W Brewer	

13.	7 April 16	Workforce and Performance Report	The Board agreed that it was important to identify 2 or 3 immediate priorities for action while taking forward the broader programme of work in parallel. DH asked that a clear plan was developed to deliver a radical shift in staff engagement for this to be discussed in the strategy session. Proposals for immediate the critical priorities should be circulated to the Board close of play Monday. This should be developed with Kate Leach and other NED colleagues as appropriate.	11 April 16	W Brewer	Complete
16.	7 April 16	Update on Renal	The medium to long term renal redevelopment plans would be considered as part of a broader estates plan and a number of options had been identified. The Board would receive an estates plan at the May meeting.	May 16	R Hancock	**ON AGENDA**
18.	7 April	Finance and Performance Committee	The Board asked for assurance that the key assumptions underpinning the 2016/17 budget, including for example a significant reliance on asset sales, would be fully tested and the implications understood. This would need approval from the Finance and Performance and Audit Committees prior to sign off by the Board in May. IL agreed to develop an approvals plan and discuss this in more detail at the Board away day.	May 16	I Lynam	This will be covered within the discussion on finance. **ON AGENDA**

Author : **Aditya Kashikar, Capital Projects Manager**

Date : **28 April, 2016**

Project: **Renal Facilities – estates update**

Introduction

This paper will identify capacity, timescales and financial options to deliver both one and two stage modular build to accommodate renal services on St George's site for next 24 months and beyond.

Background

The renal service at St George's may be considered under four domains of operational delivery;

- Inpatient Ward (24 beds)
- Dialysis (16 stations)
- Transplant clinic (4 clinic rooms and suitable reception area)
- Administration (senior nursing and medical staff)

Whilst it is accepted by the service that there are opportunities for some outpatient activity and administration to be permanently relocated offsite as part of an expansion to current practise on both the Colliers Wood and Queen Mary's Roehampton (QMH) sites, the position remains that if the trust is to support the continuation of Renal Services as part of its 5 year strategy there must be urgent relocation on site of both a 24 bedded ward and adjacent 16 dialysis stations. It must also be considered that an inpatient on site dialysis provision remains necessary for patients from specialties within many other specialities as well as established links with vascular surgery and Acute Kidney Injury (AKI) provision that must remain on site.

Although position paper was presented to Trust board (February 2016) denoting siting renal facilities from current Knightsbridge wing to either Grosvenor Wing or GUM (Courtyard clinic) This position paper was based on rationalised Schedule of Accommodation (SoA), which was formulated in consultation with renal clinicians, nurses and relevant staff in January.

SoA indicated preferred and minimum floor space between 3250 -3500 square metres. This floor space allows for revision to service provision and overall 45% reduction to current renal facilities Following discussions at the Renal Redevelopment Board on 18 April 2016, it was agreed that the group would proceed with the full service review under the Fixed/Close/Transfer Project. This review will be used to inform and in turn assist the completion of the FBC.

However an immediate solution in next six months to meet delivery requirements requirements is essential. Based on that premise; succeeding discussions were held with chief Nephrologist Daniel Jones on 27 April 2016 to establish bare minimum accommodation basics along with in-patient service for the next 24 months. Requirements indicate a gross internal area (GIA) of circa 1250 m2.

See appendix A: modified SoA showing minimum floor space of 1250 square metres

At the same time, following initial inquiries capital projects team met three modular building suppliers to ascertain technical standards for similar projects. Preliminary proposals from these suppliers are due on 3 May. However below is the high-level summary of new options identified by Estate; currently under consideration

See appendix B: for list of options previously considered, however now discarded

Options

1. Internal decant ward accommodation within the hospital – *options such as Richmond Annex, St James wing 3rd floor, Lanesborough wing 4th floor Champneys ward*
2. Hire (minimum 24 months lease) 1250 square metres modular ward accommodation in car park 2, next to AMW
3. Immediate Permanent modular ward accommodation in car park 2, next to AMW
4. Modular building to accommodate 3250 square metres in car park 2 with dedicated link to ground and first floor link bridges to the main hospital
5. Decant, demolish and decontaminate Knightsbridge wing site and design new modular building to accommodate 3250 square metres of renal service and / or yet another service.

See next page summary table to understand the current options and sub-options.

Project Governance

Renal Project Board (RPB)

Key decisions and direction will be provided through the Renal Project Board (RPB). The RPB has been established to provide formal oversight, control and accountability for the process of redeveloping renal services at St. George's University Hospitals NHS Foundation Trust (St. George's). The RPB will report and be formally accountable to the St. George's Executive Management Team (EMT), and will provide reports on progress to that meeting, and seek approval for all significant documents produced prior to any submission to the Trust Board or other body. The RPB will make recommendations to the EMT on proposals and EMT will make binding decisions, except where full Trust Board approval is required. The RPB meets monthly.

Steering Group

The RPB will be supported by the Renal Steering Group who will be responsibility for driving the key work-streams and to report back to the Project Board on a regular basis. The work-stream structure will include:

- Clinical & Workforce
- Quality & Patient Experience
- Estates & Design
- Finance
- Equipment & IT
- Kidney Patient User Group

Programme Management Office and Structure

The delivery of this project will require high quality leadership of the procurement process. The Programme Management Officer (PMO) will be the key to the procurement process.

A Programme Manager with appropriate experience, training and seniority will be appointed to take forward the implementation of the proposed decant and capital solution.
And the PMO will have support from the capital projects team, and external consultants.

Conclusion

Based on options presented above, Renal Project Board should understand the revenue / capital outlay for both temporary and permanent options.

Summary Table

Option	Description	Delivery Timescales	Indicative Costs	Risks	Capital / Revenue
1	**Use of other internal ward –** has been suggested by members of the service. This assumes that the renal ward can move to another ward in the hospital, that can be appropriately plumbed and that an alternative solution is found for the displaced service. This option assumes that alternative accommodation can be found for the administrative and outpatient parts of the service.	NA	NA	This option involves significant amount of building and infrastructure works to make any alternative ward fit for renal provision. (this involves RO pipework and associated diversion of services)	NA
2	**Modular build (Temporary Only)** A **temporary** (24 months hire) modular build is erected on the current AMW carpark that houses the renal ward, onsite dialysis and administrative parts of the service. This option assumes that some of the outpatient parts of the service can be delivered differently. When Knightsbridge Wing is demolished, a permanent modular build is erected on this area.	Total GIA approximately 1250 m2. Delivery timescales below; Design Period - 3 weeks Approval to proceed – 2 weeks Off-site Manufacture / Ground Works -8 weeks On-site Installation - 1 weeks On-site Fit Out -9 weeks Commissioning - 1 weeks Overall Programme Period 24 weeks (from date of order)	Circa £112,500 pcm Overall £2,700,000 for 24 months lease. Contingency 10% £270,000 Optimism Bias 10% £270,000 PM, Equipment 5% £135,000 Legal Costs £10,000 PMO / Support £10,000 **Total approx.: £3,400,000**	Temporary facility , however following standard risks to be considered; • Crane lift and associated works • Dedicated RO plant water supply • Site clearance and pad foundations • Loss of car parking spaces Planning consent required. However owing to timescales, Trust has to implement this solution at risk of seeking planning approval	**Revenue**

3	**Modular build** – A **permanent** modular build is erected on the current AMW carpark that houses the renal ward, onsite dialysis and administrative parts of the service. This option assumes that some of the outpatient parts of the service can be delivered differently	Total GIA approximately 1250 m2. Delivery timescales below; Design Period - 4 weeks Approval to proceed – 2 weeks Diversion of Services - 6 weeks Off-site Manufacture / Ground Works -8 weeks On-site Installation - 1 weeks On-site Fit Out -10 weeks Commissioning - 1 weeks Overall Programme Period 36 weeks (from date of order	Circa £5,000,000* build M&E abnormals £500,000 Contingency 10% £500,000 Optimism Bias 10% £500,000 Equipment 5% £250,000 Design & Legal Costs £100,000 PMO / Support £50,000 **Total approx: £7,300,000**	Same risks as for option 2 & The permanent facility, installation of permanent brick clad modular building will involve significant amount of ground works (including diversion of underground building services and provision of new) Planning consent required. However owing to timescales, Trust has to be implement this solution at risk of seeking planning approval Agreement with PFI legal team for service connections to the new building. Potentially relocate the drainage pumping station (currently in AMW car park). Cost for relocation excluded from above cost plan	**Capital**
4 ***Stage 1***	**Modular build (Temporary plus Permanent) 2 stage** A temporary (24 months hire) modular build is erected on the current AMW carpark that	Total GIA approximately 1250 m2. Temporary Building – 24 weeks Permanent Building – 36 weeks	Temporary Building: £3,400,000 Permanent Building: £7,300,000	As this will be the permanent facility, installation of permanent brick clad modular building will involve significant amount of ground	**Revenue** **Capital**

Stage 2	houses the renal ward, onsite dialysis and administrative parts of the service. This option assumes that some of the outpatient parts of the service can be delivered differently. When Knightsbridge Wing is demolished, a permanent modular build is erected on this area.	Overall programme period – 60 weeks	**Total Cost (approx): £10.700,000**	works (including diversion of underground building services and provision of new)	
5 ***Stage 1*** ***Stage 2***	**Modular build (Temporary plus Permanent) 2 stage** A temporary (24 months hire) modular build is erected on the current AMW carpark that houses the renal ward, onsite dialysis and administrative parts of the service. This option assumes that outpatient service will then return back to the site at the end of 24 months period. And the new permanent facility to accommodate 3250 square metres accommodation to be erected in place of Knigtsbridge Wing	Total GIA approximately 1250 m2. Temporary Building – 24 weeks Total GIA approximately 3250 m2 Permanent Building – 78 weeks Overall programme period – 102 weeks	Temporary Building: £3,400,000 Permanent Building: £13,000,000 M&E abnormals £750,000 Contingency 10% £1,300,000 Optimism Bias 10% £1,300,000 Equipment 5% £600,000 Design & Legal Costs £150,000 PMO / Support £50,000 Total Cost (approx): £16,400,000 **Overall Total cost: £19,800,000**	We should allow for all risks as highlighted above and also consider the cost for decant, removal of asbestos, decontamination and demolition of Knightsbridge Wing. Costs and risks to be factored in for separation of links to electrical and mechanical services with the main hospital.	**Revenue** **Capital**

Caveats:
Modular build options are subject to decision on the procurement procedure. However owing to the value, (in excess of £4.1m) scope and complexity of the project; a formal OJEU method (six month time under the new EU regulations) may be required.

Comprehensive equipment (clinical and non-clinical devices) review should be undertaken to determine the status and usage. Although majority of equipment will be transferred, an allowance should be made for split service and need for duplication

St Georges Healthcare NHS Trust
Prepared for Renal Development

Modular Build - reduced version **27.04.2016**

NO	SPACE / DESCRIPTION	QTY	NSM/SPACE	Total NSM	GIA
1	**Acute In-Patient Ward (24 BED)**				583.00
a	**Patient Care**				
	Acute Single Bedroom / Side Room	4	19	76	
	Patient Ensuite	4	4.5	18	
	Acute Multi Bedroom:2 Beds	2	29.0	58	
	Acute Multi Bedroom:4 Beds	4	61.0	244	
	Patient Ensuite: Assisted Shower & Wash	1	7.0	7	
	Isolation Lobby	2	4.5	9	
b	**Clinical Support**				
	Nurse Base	1	8	8	
	Day Room	1	9	9	
	Clean Utility	1	12	12	
	Dirty Utility	1	12.0	12	
	Ward Kitchen	1	9	9	
	MDT	1	18	18	
	Store: Renal Consumables	1	9	9	
	Store: Equipment	1	9	9	
	Store: General	1	9	9	
	Fluid Store	1	5.0	5	
	Disposal Hold	1	7.0	7	
	Cleaners	1	7.0	7	
	Linen Store	1	2.0	2	
	Accessible WC	1	4.5	4.5	
	Semi Ambulant WC	1	2.5	2.5	
c	**Staff Support**				
	Doctors Office	1	9.0	9	
	Sisters Office	1	9.0	9	
	Office:3 staff	1	13.0	13	
	Staff Rest	1	15.0	15	
	Staff WC	1	2.0	2	
2	**Chronic Dialysis**				185.50
	Side Treatment Room; dialysis, 1 patient	8	13.5	108	
	Isolation Lobby	2	5.0	10	
	Ensuite: Accessible	2	4.5	9	
	Treatment Area: 4 Beds	2	25	50	
	Accessible WC	1	4.5	4.5	
	Semi Ambulant	1	4	4	
3	**Acute Dialysis**				98.5
	Side Treatment Room	2	13.5	27	
	Isolation Lobby	2	5.0	10	
	Ensuite: Accessible	1	4.5	4.5	
	Treatment Area: 2 Beds	2	25.0	50	
	Accessible WC	1	4.5	4.5	
	Semi Ambulant WC	1	2.5	2.5	
4	**Day Case Area**				110
	Procedure Room	2	25.0	50	
	Consent/consult Room	1	6.0	6	
	Patients Recovery Area	4	13.5	54	
5	**Support Offices**				32
	Consultants Office (4 staff)	1	12	12	
	Senior Nursing (10 staff)	1	20	20	
6	**OPD Areas**				116
	Consult/Exam	4	16.5	66	
	Reception / Waiting room for 20 people	1	50	50	
7	**Plant / Equipment**				91.5
	Decontamination Room	1	7.5	7.5	
	Store: Workshop	1	10.0	10	
	Technician Room	1	10.0	10	
	Switchgear Room	2	4.5	9	
	IT Hub	1	5.0	5	
	RO Plant Room	1	50.0	50	
			Total GIA		1216.50
			30% Circulation Space (multiplier)		36.50
			Nett Total GIA		1253.00

Appendix B

Updated list of options to be considered in Renal Redevelopment Business Case

Options from the previous OBC:

Table 3a – List of siting options

Option	Description	To be taken forward?
1	**Do nothing - t**he unit stays in its current space and continues to deliver renal services from this for the foreseeable future. The expectation that there would be some upgrades to the various areas used but the fundamental infrastructure and buildings would remain as currently.	*Taken forward as mandatory option*
2	**Private patient wing scenario 1** – The proposal is that the renal unit will occupy a separate block built as part of the new private patient wing. This will provide circa 6,000 sq. meters of space and from which all renal care is delivered	*No – PPU not happening.*
3	**Private patient wing scenario 2** – That renal occupies the top floors of a new unit but seeks to put chronic HD and all renal outpatient services on the ground floor	*No – PPU not happening.*
4	**Private patient wing and new outpatient block scenario** – This option has renal occupying floors of the private patient wing but with chronic Haemodialysis and all the outpatient services, including transplant clinic, being delivered from the new outpatient block. The DCP identifies a possible new clinical block, potentially delivering outpatients, on Maybury Street Car Park (the main patient car park)	*No – PPU not happening.*
5	**Grosvenor Wing** – previously identified as siting option, prior to development of Trust DCP. This sees the renal unit move to the ground, first and potentially second floors of Grosvenor Wing	*No – not suitable to accommodate clinical services*
6	**Knightsbridge Wing** – previously identified as siting option, prior to development of Trust DCP. This sees the renal unit move to a new, purpose build in Knightsbridge Wing. Though a site on the Knightsbridge Footprint has not been identified, but working assumption is that it would be sited where Medical Physics and the small parking area next to it is based, adjacent to the AMW car park.	*Yes, however the purpose-build accommodation will require least 36 months duration and capital outlay in region of circa £40m plus*

St George's Healthcare NHS
NHS Trust

REPORT TO TRUST BOARD **Paper ref:**

Paper Title:	Quality Report to Month 12- March 2016
Sponsoring Director:	Jennie Hall- Chief Nurse/ Director Infection Prevention and Control Simon MacKenzie- Medical Director
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 Imran Hussain - Head of Performance
Purpose:	To inform Board about Quality Performance for Month 12.
Action required by the board:	To note the report and key areas of risk noted.
Document previously considered by:	QRC

Executive summary

Performance

Performance is reported through the key performance indicators (KPIs) as per Monitor Risk Assessment Framework. In 2015/16 the trust performed well against a number of indicators within the framework however existing challenges remain with the: ED 4 hour target, RTT, Cancer waiting time targets and cancelled operations for non-clinical reasons.

Performance remains below the target for ED at both the weekly and monthly level. In March 86.50% of patients were seen within 4 hours which was a 3.32% improvement from February 2016 position. Contributing factors to ED performance were Capacity and Bed flow and number of delayed transfers.

There was a slight increase in the number of cancelled operations in March, compared to the previous month. The majority of cases were cancelled due to bed availability, emergency cases, equipment failure and list's over running.

The trust was non-compliant against the 62 Day standard cancer targets in February. Following underperformance in January the trust agreed some revisions with NHSE and commissioners to the Trust recovery plan. The key focus being enhancing the patient tracking process, earlier escalation and expedition in the patient pathway. The recovery plan continues to be reviewed weekly via the trust cancer performance meetings and externally by commissioners and NHSE-London via the Elective System Resilience Group.

The Trust continues to be non-compliant against RTT incomplete pathways for a number of months with a decrease in performance from 90.30% in February to 88.02% in March.
A supporting recovery and sustainability action plan has been developed and is currently under review with commissioners. The plan details the operational and process changes required to deliver sustainability and improve the management of patient pathways.

The trust continues to show the quality governance score against the Monitor risk assessment framework of 4 following the Monitor imposed additional license conditions in relation to governance

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

The report highlights the key quality metrics which have been reported during 2015/16 against the domains of safety, effectiveness and outcomes.

In terms of Quality Metrics, the overall position in March remains consistent with the profile of the previous quarter in terms of the trends for the metrics with some moderate improvement across a number of indicators.

Effectiveness Domain:

- Mortality HSMR performance remains statistically better than expected for the Trust. Mortality remains in line with expected for admissions at the weekend and for emergency weekday admissions is better than expected. The SHMI position for the period October 14 to February 15 is now categorised "as expected". The board will note the improved profile with the number of internally driven signals and the proactive programme of work led by the Mortality Committee.
- National Audits within the report: The results of the National Diabetes inpatient audit are shown. The audit indicates the Trust position against national benchmarks in relation to the make of the specialist diabetic team, and the level of patient satisfaction. Actions are noted to take forward.
- The Local Audit in relation to use of NEWS raises a number of actions which need to be taken forward. This audit has been considered by the Patient Safety Committee and Nursing Board, focus is being placed on supporting the local areas where compliance is of greatest concern. Focus on care of the deteriorating patient of which NEWS is a subset is a quality priority for the Trust in 16/17. The Venous access audit is encouraging in the improvement of care of patients with these devices.
- The report indicates the position with compliance with NICE guidance for the period June 2010 to December 2015. The Board will note the actions being taken to review the current position with NICE compliance by July 2016 and the improved response profile in the last two months.

Safety Domain:

- The number of general reported incidents in March indicates a similar trend in terms of numbers and level of harm.
- Safety Thermometer performance is 94.62% slightly above the national average for that month. There is a reduction in new harms from the previous month. The annual performance for safety thermometer was 94.4% below out internal target of 95% but slightly above the national average of 94.2%.
- No further MRSA bacteraemia cases were reported for March the total to 3 cases year to date and no cases since Mid-September. There were a total of 29 C-Difficile cases to the end of March a 24% reduction on the previous year. All cases are currently subject to an RCA process.
- The pressure ulcer performance to the end of March shows a 57% improvement in avoidable pressure ulcers in the last 12 months, a significant positive step for patients and a reflection of the commitment of the staff.
- Safeguarding Adults compliance for training remains a key area of focus. The Trust is now demonstrating a compliance of 78% for adult training, with an improved profile over the last 2 months. The board will note that the numbers of staff to be trained is known and there are agreed actions both for adult safeguarding which is being monitored by the respective safeguarding Committee. Following validation of the Safeguarding Children data the compliance for the Trust is now 81% at level 3, this represents a positive step forward but work will continue to achieve 85% compliance.

Experience Domain:

- The FFT data has been re-profiled to indicate Patient feedback in relation to likely/ very likely to recommend a service. This report draws data from all patient surveys conducted on the RaTE system; including accessible versions that were created for any patient that would have trouble understanding the standard survey question. Further breakdowns are available for services and location type. The overall annual position indicates that 93% of patients were extremely likely or likely to recommend a service to family or friends.
- The complaints profile in relation to numbers has increased slightly. The quarter three position for complaints indicates a consistent picture in terms of overall numbers

Well Led Domain:

- The safe staffing return is included for all inpatient areas. The average fill rate for the Trust is 94.33 % 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 January is included this month for both Acute and Community services. During this month one clinical ward area was placed in escalation to support further intervention in relation to the staffing profile and to support some aspects of clinical practice. There is a plan being led by the Division which coordinates all of the intervention actions. This is being overseen by the Chief Nurse.

In addition the Board should be aware that there have been some challenges in relation to the Environment which have led to a lack of heating within some clinical areas for a period of time and resulted in the requirement to review delivery of some clinical services with areas closed. There were further problems within Knightsbridge Wing in relation to electrical infrastructure on Buckland ward. Business continuity arrangements were put in place to support safety of patient care.

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

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Performance Report for Trust Board

Month 12 – March 2016

Excellence in specialist and community healthcare

CONTENTS

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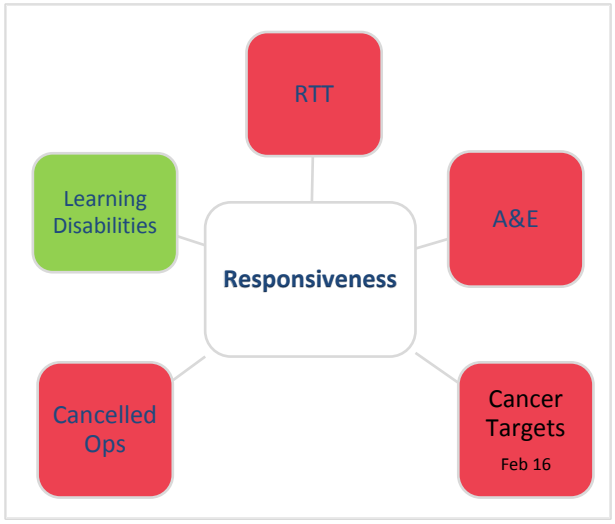
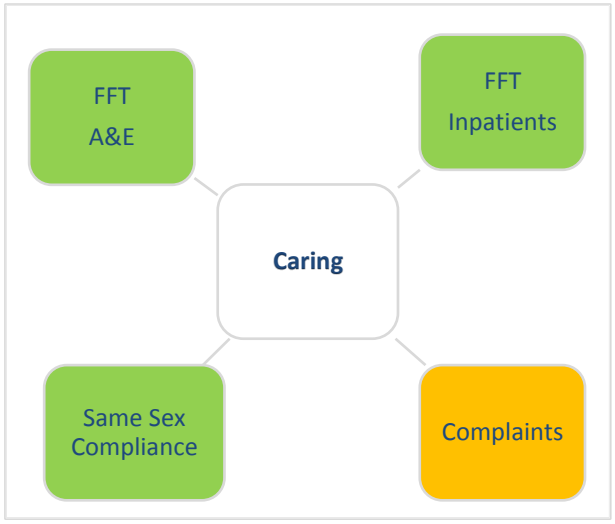
St George's University Hospitals NHS
NHS Foundation Trust

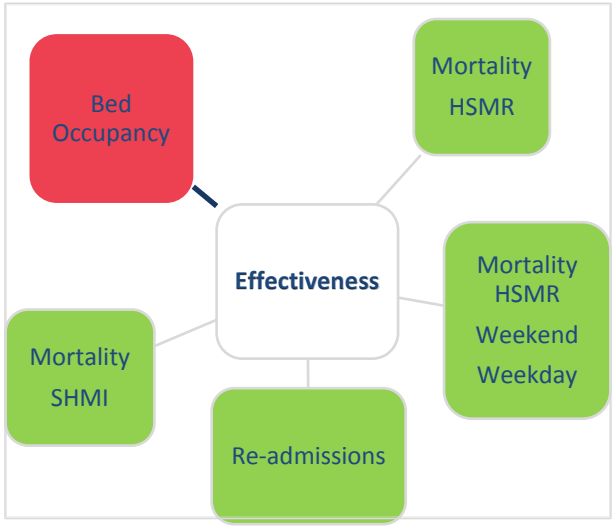
Performance against Frameworks

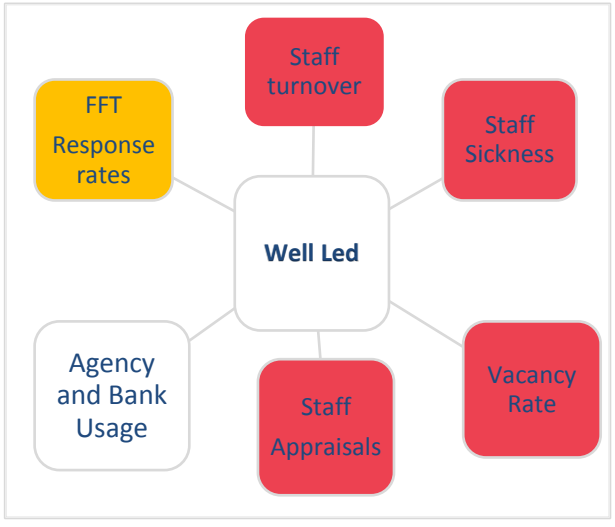
Excellence in specialist and community healthcare

1. Executive Summary - Key Priority Areas March 2016*









The above shows an overview March 2016 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 February 2016 as reported one month in arrears)

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

2. Monitor Risk Assessment Framework KPIs 2015/16: March2016 Performance (Page 1 of 1)

ACCESS

Metric	Standard	Weighting	Score	YTD	Feb-16	Mar-16	Movement
Referral to Treatment Admitted	90%	N/A	N/A		76.90%	78.00%	1.10%
Referral to Treatment Non Admitted	95%	N/A	N/A		89.70%	90.90%	1.20%
Referral to Treatment Incomplete	92%	1	1		90.30%	88.02%	-2.28%
A&E All Types Monthly Performance	95%	1	1	91.71%	83.18%	86.50%	3.32%
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Q3**	**Q4**	**Movement**
62 Day Standard	85%	1	1	82.52%	85.50%	82.40%	-3.10%
62 Day Screening Standard	90%			90.08%	94.25%	88.43%	-5.82%
31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%		0	96.56%	97.87%	96.15%	-1.72%
31 Day Standard	96%	1	0	97.05%	97.83%	94.20%	-3.62%
Two Week Wait Standard	93%	1	1	87.44%	88.24%	92.17%	3.92%
Breast Symptom Two Week Wait Standard	93%	1		93.42%	93.78%	96.03%	2.26%

OUTCOMES

Metric	Standard	Weighting	Score	YTD	Feb-16	Mar-16	Movement
Clostridium(C.) Difficile - meeting the C.difficile objective (de minimis of 12 applies)	31	1	0	29	3	1	-2
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	Yes	
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	Yes	
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	Yes	
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	Yes	
Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Compliant	1	0	Yes	Yes	Yes	
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	Yes	
Data Completeness Community Services:							
Referral to treatment * data is for Oct and Nov 2015	50%	1	0		54.7	54.7	0.0
Referral Information	50%	1	0		87.7	87.6	-0.1
Treatment Activity	50%	1	0		70.37	71.2	0.8
Trust Overall Quality Governance Score					4	4	0

March 2016 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
- Cancelled Operations
- RTT
- Cancer Waits

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

*Cancer Data is reported a month in arrears. Q4 relates to Jan and Feb-16 only.

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: March 2016 Performance (Page 1 of 1)

RESPONSIVENESS

Metric	Standard	YTD	Feb-16	Mar-16	Movement
Referral to Treatment Admitted	90%		76.90%	78.00%	1.10%
Referral to Treatment Non Admitted	95%		89.70%	90.90%	1.20%
Referral to Treatment Incomplete	92%		90.30%	88.02%	-2.28%
Referral to Treatment Incomplete 52+ Week Waiters	0	24	1	1	0.00%
Diagnostic waiting times > 6 Weeks	1%		0.45%	0.86%	0.41%
A&E All Types Monthly Performance	95%	91.71%	83.18%	86.50%	3.32%
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%	17.31%	16.20%	15.30%	-0.90%
Certification against compliance with requirements regarding access to health care with a learning disability	Compliant	Yes	Yes	Yes	

Metric	Standard	YTD	Jan-16	Feb-16	Movement
62 Day Standard	85%	82.52%	83.30%	81.00%	-2.30%
62 Day Screening Standard	90%	90.04%	86.40%	90.30%	3.90%
31 Day Subsequent Drug Standard	98%	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%	97%	97%	94.4%	-2.70%
31 Day Standard	96%	96.90%	90.20%	97.70%	7.50%
Two Week Wait Standard	93%	86.90%	91.10%	93.20%	2.10%
Breast Symptom Two Week Wait Standard	93%	93.20%	96.60%	95.40%	-1.20%

EFFECTIVENESS

Metric	Standard	YTD	Feb-16	Mar-16	Movement
Hospital Standardised Mortality Ratio (DFI)	100		91.0	87.5	-3.5
Hospital Standardised Mortality Ratio - Weekday	100	0	89.7	87.0	-2.7
Hospital Standardised Mortality Ratio - Weekend	100	0	92.5	91.0	-1.5
Summary Hospital Mortality Indicator (HSCIC)	100	0	0.91	0.91	0.0
Emergency Re-admissions within 30 days following Elective or emergency spell within the Trust	5%	3.10%	2.95%	3.30%	0.4%
Bed Occupancy - Midnight Count Generl Beds Only	85%		97.4%	97.0%	-0.4%
LOS - Elective			3.98	3.68	-0.3
LOS - Non-Elective			5.1	4.83	-0.27

CARING

Metric	Standard	YTD	Feb-16	Mar-16	Movement
Inpatient Scores - Friends & Family Recommendation Rate	60		93.23%	93.11%	-0.12%
A&E Scores - Friends & Family Recommendation Rate	46		83.21%	80.69%	-2.52%
Complaints (1 month in arreas)			74	79	5
Mixed Sex Accomodation Breaches	0	11	6	0	-6.0

SAFE

Metric	Standard	YTD	Feb-16	Mar-16	Movement
Clostridium Difficile - Varience from plan	31	29	3	1	-2
MRSA Bacteramia	0	3	0	0	0
Never Events	0	8	0	0	0
Serious Incidents	0	120	8	12	4
Percentage of Harm Free Care	95%		93.0%	94.6%	1.6%
Medication Errors causing serious harm	0	5	1	0	-1
Overdue CAS Alerts	0	2	2	2	0
Maternal Deaths	1	3	0	2	2
VTE Risk Assessment (previous months data)*	95%		96.70%		

WELL LED

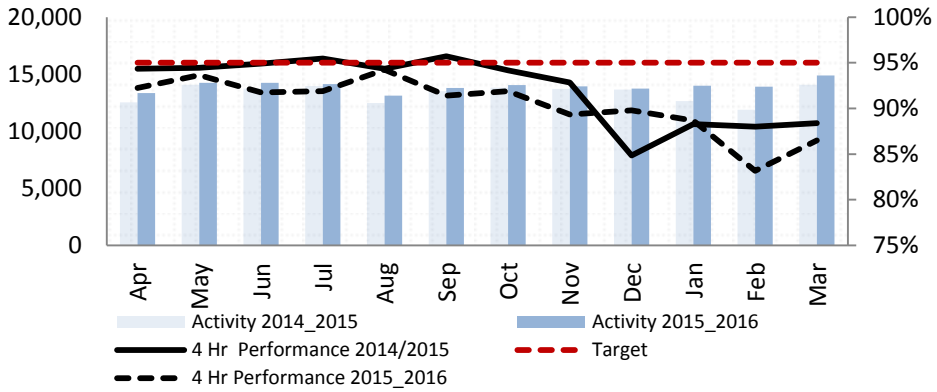
Metric	Standard	YTD	Feb-16	Mar-16	Movement
Inpatient Respose Rate Friends & Family	30%		20.1%	19.5%	-0.6%
A&E Respose Rate Friends & Family	20%		23.7%	26.0%	2.3%
NHS Staff recommend the Trust as a place to work	58%	62.0%			
NHS Staff recommend the Trust as a place to receive treatment	4	3.78			
Trust Turnover Rate	13%		18.7%	18.1%	-0.6%
Trust level sickness rate	3.5%		4.3%	3.7%	-0.6%
Total Trust Vacancy Rate	11%		15.9%	16.7%	0.8%
% of staff with annual appraisal - Medical	85%		86.4%	84.2%	-2.20%
% of staff with annual appraisal - non medical	85%		68.9%	67.3%	-1.60%

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.

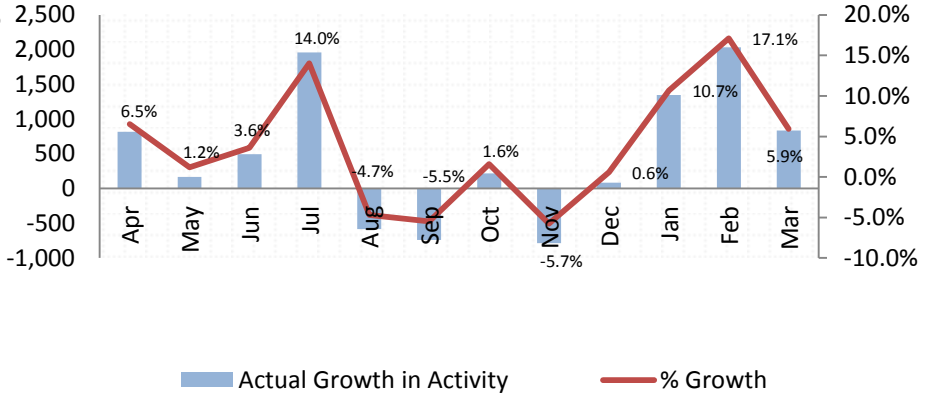
3. Trust Key Performance Areas and Activity Comparison to previous year (1 of 2)

ED Performance

ED Activity and 4 Hour Performance

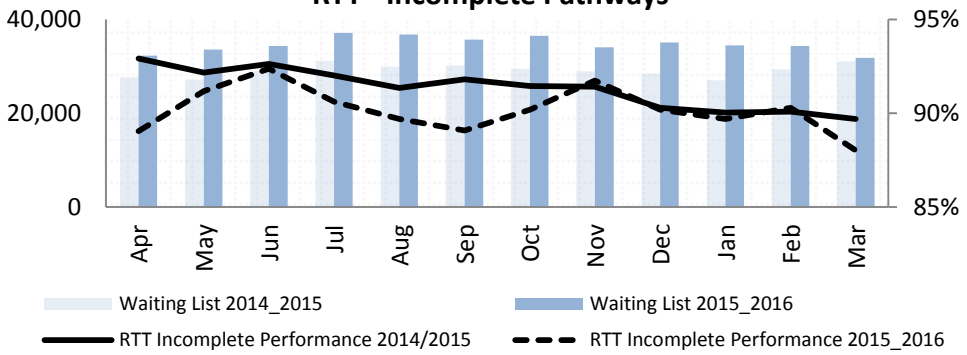


ED Activity Growth

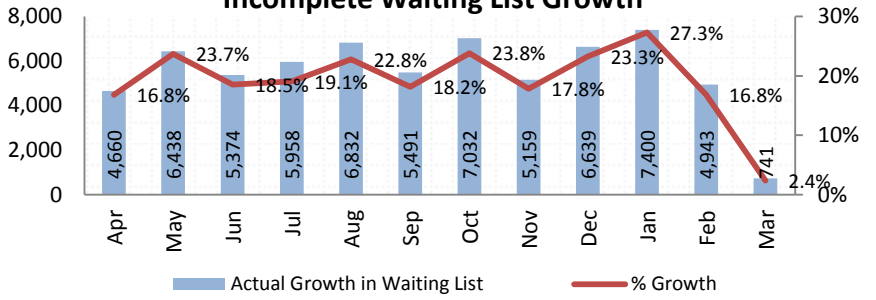


RTT & Diagnostics

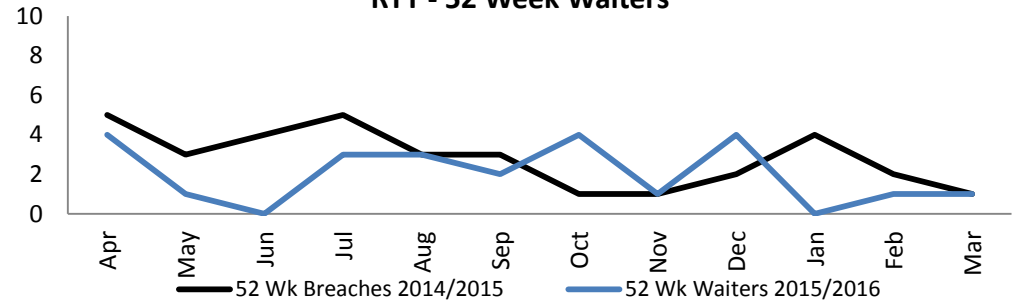
RTT - Incomplete Pathways



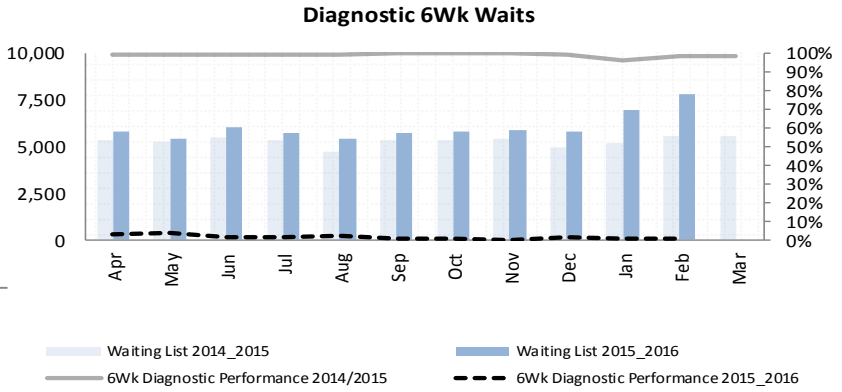
Incomplete Waiting List Growth



RTT - 52 Week Waiters

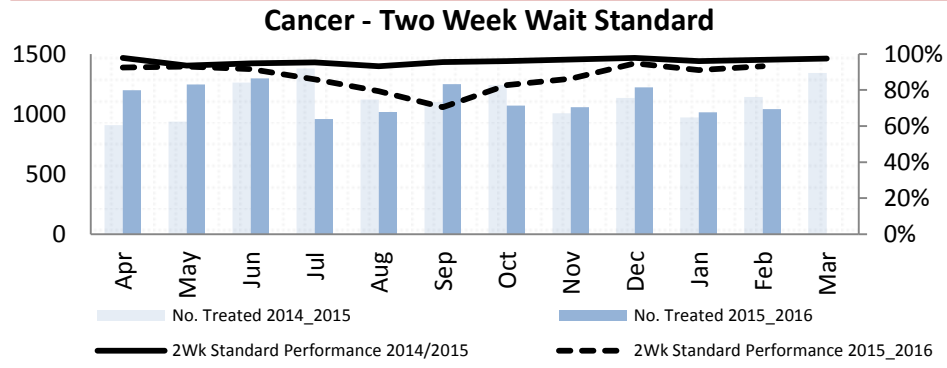


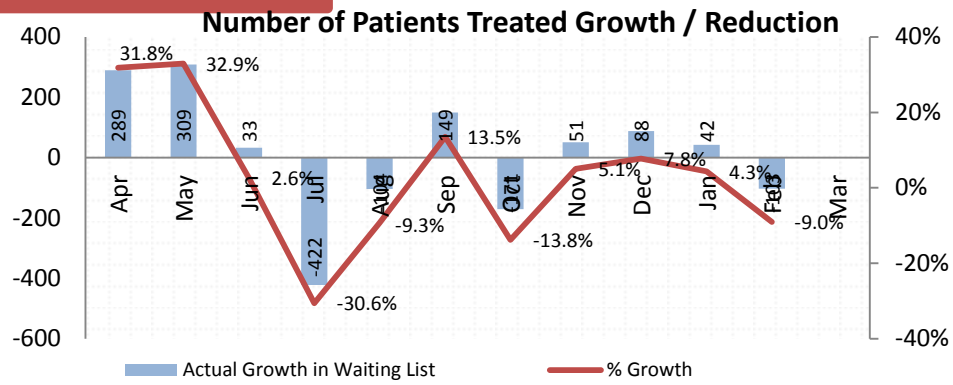
Diagnostic 6Wk Waits



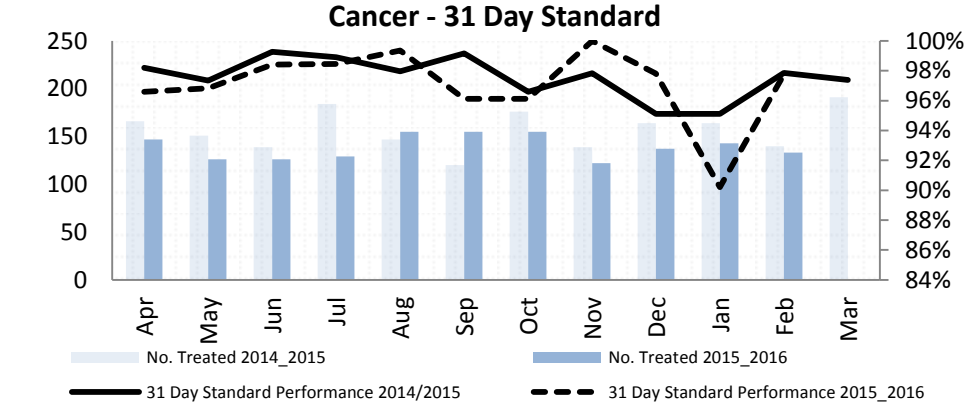
3. Trust Key Performance Indicators and Activity Comparison to previous year (2 of 2)

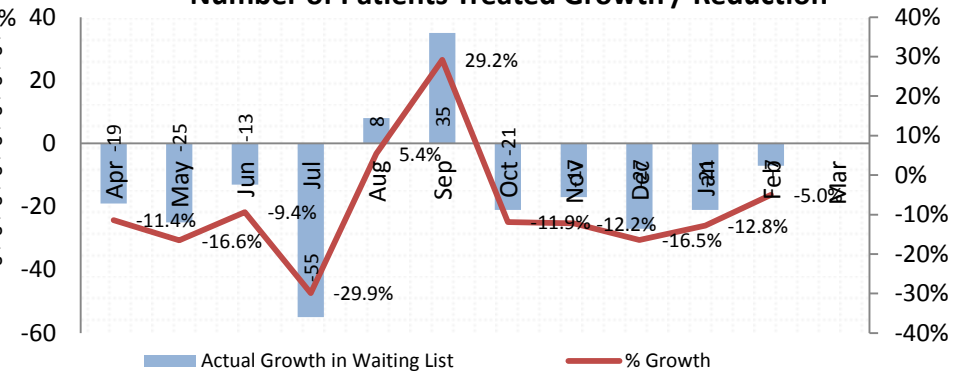
Cancer - Two Week Wait Standard



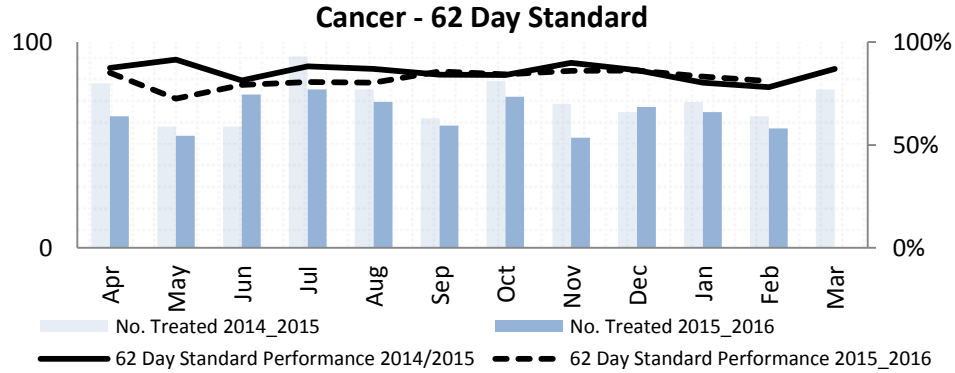


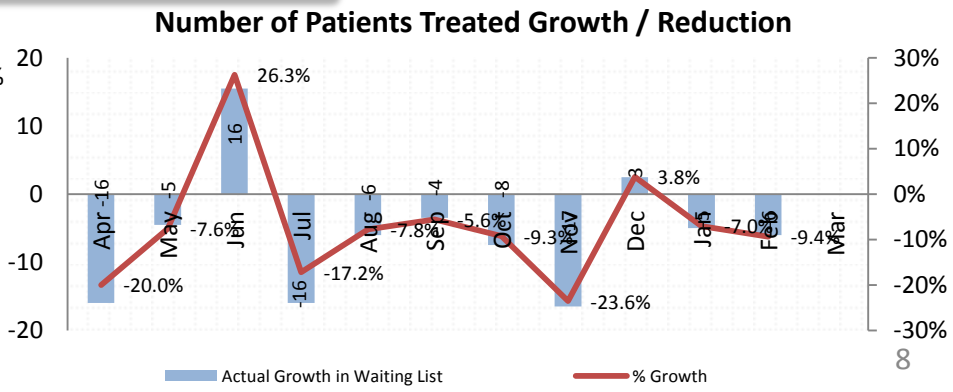
Cancer - 31 Day Standard





Cancer - 62 Day Standard





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St George's University Hospitals NHS
NHS Foundation Trust

Performance – areas of escalation

Excellence in specialist and community healthcare

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

Total time in A&E - 95% of patients should be seen within 4hrs							
Lead Director	Feb-16	Mar-16	Movement	2015/2016 Target	Forecast for Mar-16	Forecast for Apr-16	Date expected to meet standard
FA	83.18%	86.50%	⇧ 3.32%	>= 95%	R	R	TBC

Peer Performance February 2016 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	3	2	5	1
83.18%	90.10%	90.80%	82.90%	93.00%

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 the target at both the weekly and monthly level. In March 86.50% of patients were seen within 4 hours which was 3.32% improvement from February 2016 position. Contributing factors to ED performance were:

- Capacity and bed flow, with 25.4% of breach reasons attributed to ED capacity and 29.2% waiting for a bed to become available as summarised in the chart below.
- An increase in the numbers of delayed transfer of care patients (DTOC) in comparison to last month and the level of delay. This remains a focus area for the organisation as this has a significant impact on flow through the hospital and impact upon ED flow into the organisation. As at 01/04/2016 there were 23 DTOC and 22 Non-DTOC patients.
- As at 20/04/2016 there were 47 of 639 (7.5%) 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.

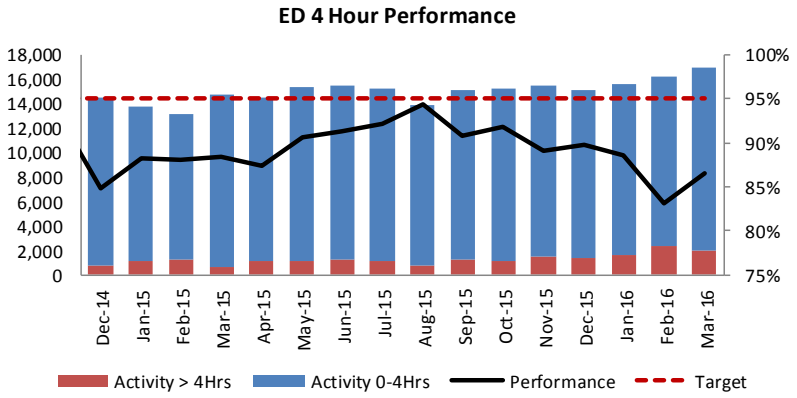
The Trust is implementing it's recovery action plan which comprises of 10 themes linked to the OVOT. A submitted trajectory has also been agreed with commissioners and submitted to NHS England.

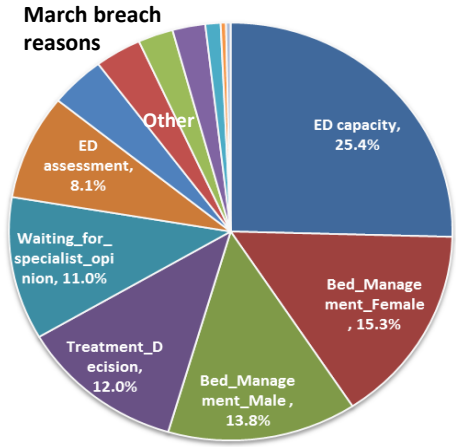
Number of DTOC at month end (snapshot)

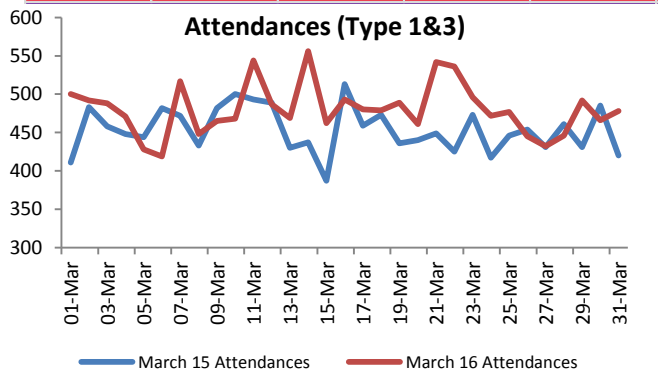
	Dec	Jan	Feb
2014/2015	5	13	8
2015/2016	12	33	16
Varience	7	20	8
% Growth	**140.0%**	**153.8%**	**100.0%**

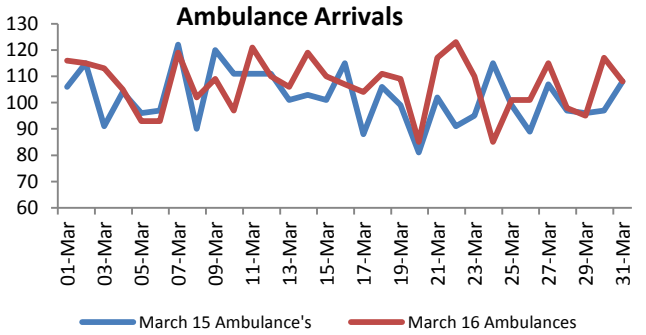
Number of Days delayed in month

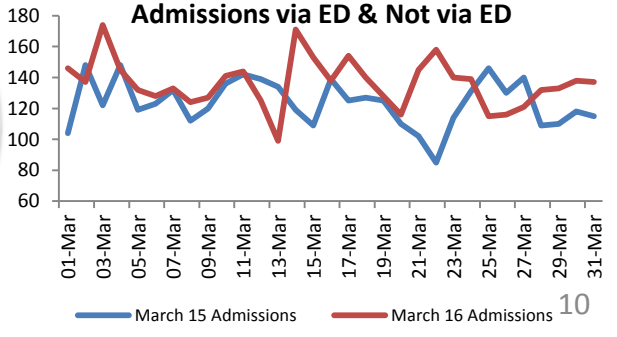
	Dec	Jan	Feb
2014/2015	166	343	209
2015/2016	463	535	275
Varience	297	192	66
% Growth	**178.9%**	**56.0%**	**31.6%**





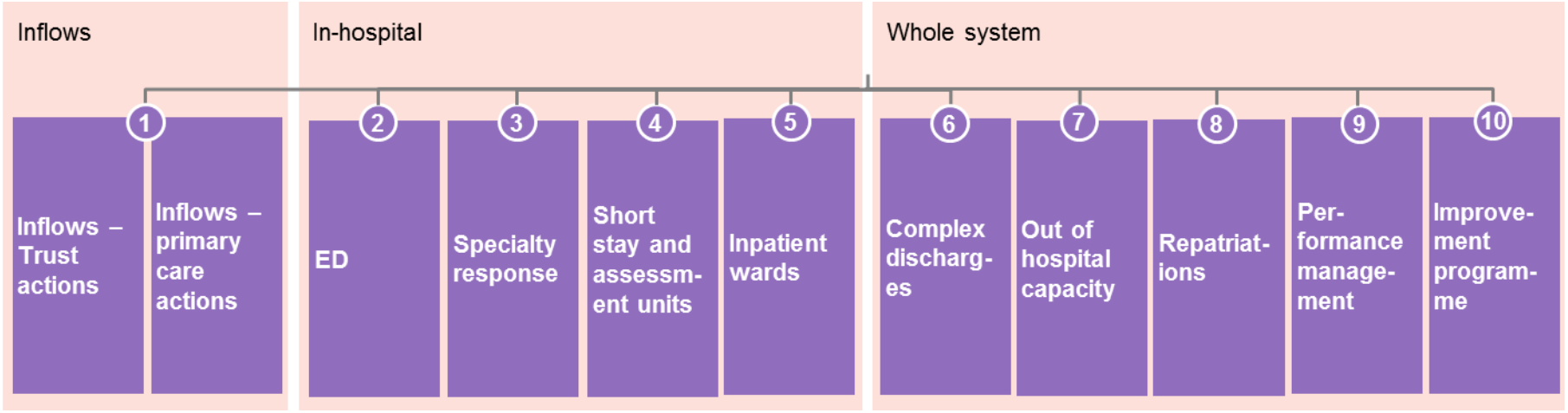






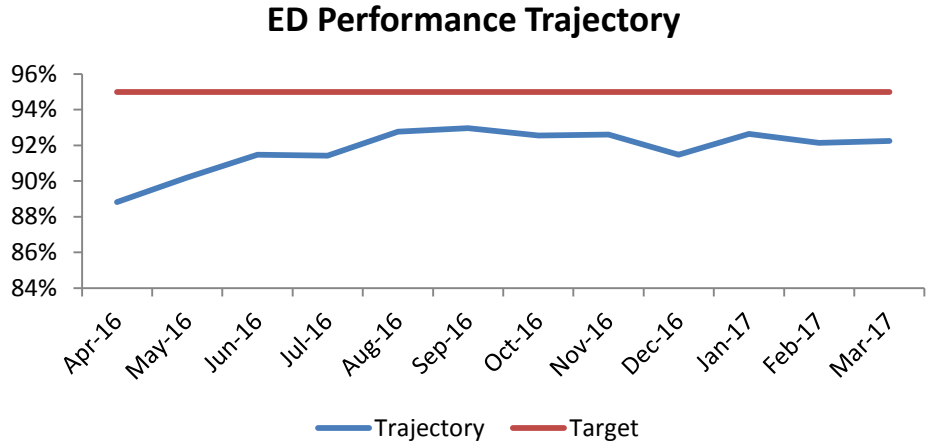
4. Performance Area of Escalation (Page 2 of 7) - A&E: 4 Hour Standard Trajectory

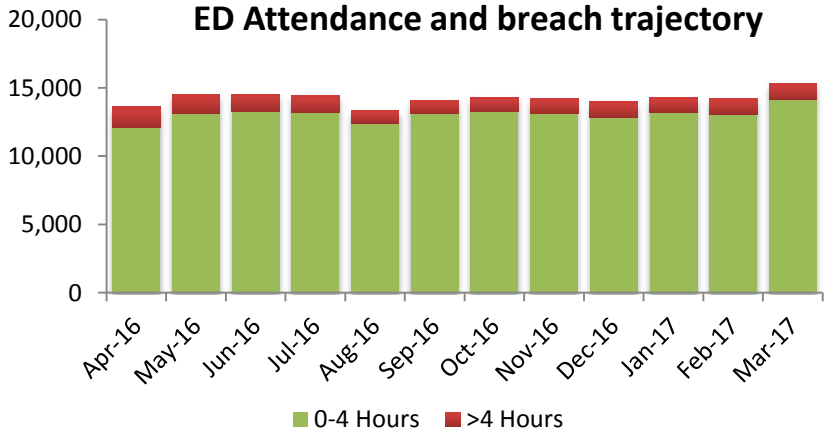
The implementation plan comprises of 10 themes linked to the OVOT



Performance Trajectory for ED

	ED												
	Baseline	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Numerator	11578	12085	13098	13286	13176	12407	13086	13252	13157	12811	13225	13081	14129
Denominator	13919	13606	14521	14523	14413	13373	14075	14317	14207	14006	14275	14197	15317
Performance	83.18%	88.82%	90.20%	91.48%	91.42%	92.77%	92.97%	92.56%	92.61%	91.47%	92.65%	92.14%	92.24%

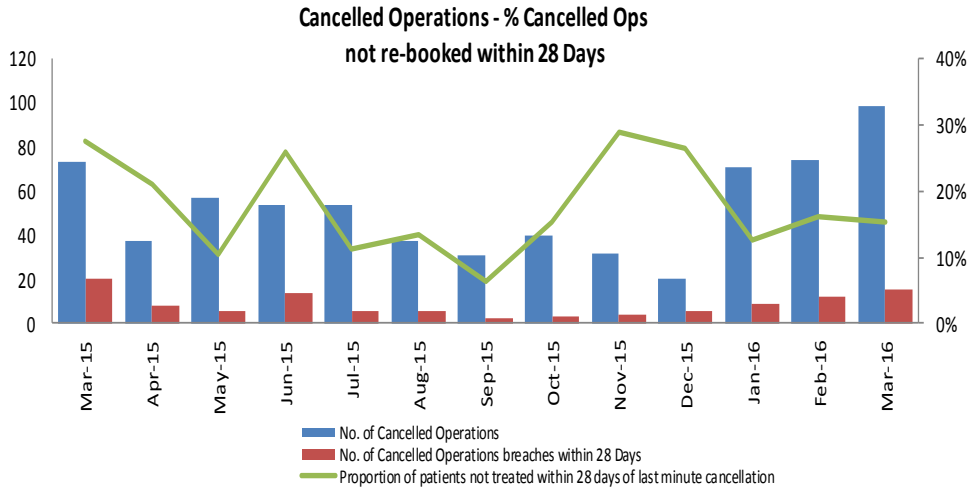


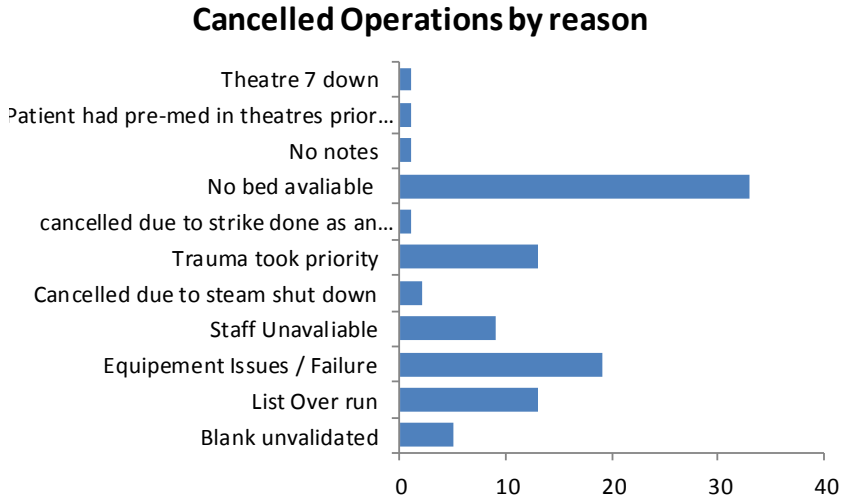


4. Performance Areas of Escalation (Page 3 of 7) - Cancelled Operations

Proportion of Cancelled patients not treated within 28 days of last minute cancellation							
Lead Director	Feb-16	Mar-16	Movement	2015/2016 Target	Forecast for Mar-16	Forecast for Apr-16	Date expected to meet standard
CC	16.20%	15.30%	-0.90%	0%	G	G	

Peer Performance Comparison – Latest Available Q3 2015/16				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	2	5	3	1
23.5%	2.3%	0.0%	12.0%	1.2%





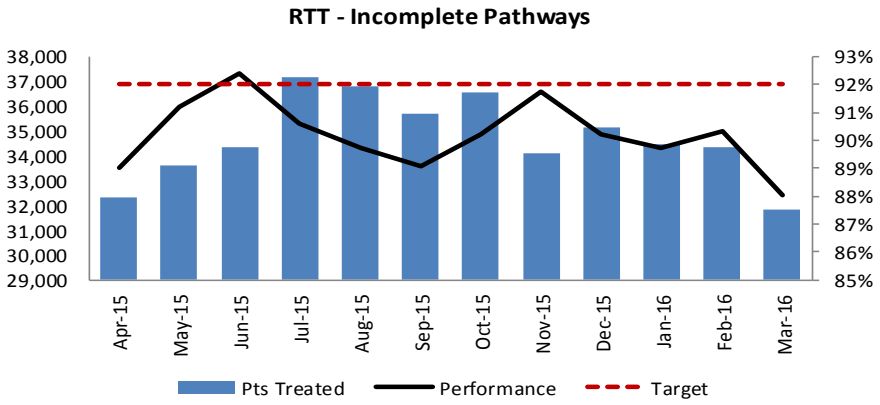
The national standard is that all patients whose operation has been cancelled for non clinical reasons should be treated within 28 days.

The trust had 98 cancelled operations from 4494 elective admissions in March. 83 of those cancellations were rebooked within 28 days with 15 patients not rebooked within 28 days, accounting for 15.3% of all cancellations. There was an increase of 24 cancelled operations compared to the previous month. The majority of cases were cancelled due to bed availability, emergency cases, equipment failure and list's over running.

4. Performance Areas of Escalation (Page 4 of 7) - RTT Incomplete Pathways

Referral to Treatment Incomplete Pathways							
Lead Director	Feb-16	Mar-16	Movement	2015/2016 Target	Forecast for Mar-16	Forecast for Apr-16	Date expected to meet standard
PVK	90.30%	88.02%	-2.28%	92%	R	R	Mar-17

Peer Performance February 2016 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	2	1		3
90.30%	94.60%	97.00%	-	92.40%



The Trust has been non-compliant against RTT incomplete pathways for a number of months. However, there was a decrease in performance from 90.30% in February to 88.02% in March. This was somewhat envisaged as an outcome of the validation programme focusing on patients waiting <18 weeks.

As part of the trust RTT recovery and sustainability programme, through validation at month end the waiting list size reduced by 7.3%, with the biggest decrease in Gynaecology (-526 pts) and T&O (-280 pts). There are a number of specialties shown in the table below who remain challenged with performance below target of 92%.

RTT remains a challenge and the trust acknowledges the importance of not just reducing long waiters but achieving a position of sustainability. The trust following work with the IST has developed a trajectory for performance recovery for 2016/17. A supporting recovery and sustainability action plan to deliver the trajectory has been developed and is currently under review with commissioners. The plan details the operational and process changes required to deliver sustainability and improve the management of patient pathways. Further to the plan the Trust is currently reviewing options for additional support to aid recovery.

	Waiting List Size					Backlog Size (18+)					Performance			
Specialty	Jan-16	Feb-16	Mar-16	Var	Var%	Jan-16	Feb-16	Mar-16	Var	Var%	Jan-16	Feb-16	Mar-16	Var%
Gen Surg	3,311	3062	3091	29	0.9%	383	343	400	57	17%	88.4%	88.80%	87.06%	-1.7%
Urology	1,600	1593	1456	-137	-8.6%	167	177	208	31	18%	89.6%	88.89%	85.71%	-3.2%
T&O	3,178	3130	2850	-280	-8.9%	572	560	577	17	3%	82.0%	82.11%	79.75%	-2.4%
ENT	2,981	2960	3105	145	4.9%	518	522	666	144	28%	82.6%	82.36%	78.55%	-3.8%
Ophthalmology	269	264	267	3	1.1%	2	7	25	18	257%	99.3%	97.35%	90.64%	-6.7%
Oral Surgery	1,927	2076	1987	-89	-4.3%	39	49	42	-7	-14%	98.0%	97.64%	97.89%	0.2%
Neurosurgery	915	976	748	-228	-23.4%	51	37	50	13	35%	94.4%	96.21%	93.32%	-2.9%
Plastic Surgery	1,126	1141	1057	-84	-7.4%	169	137	179	42	31%	85.0%	87.99%	83.07%	-4.9%
Cardiothoracic	348	349	332	-17	-4.9%	109	119	117	-2	-2%	68.7%	65.90%	64.76%	-1.1%
General Medicine	617	661	630	-31	-4.7%	32	23	46	23	100%	94.8%	96.52%	92.70%	-3.8%
Gastroenterology	2,375	2402	2233	-169	-7.0%	381	296	335	39	13%	84.0%	87.68%	85.00%	-2.7%
Cardiology	1,702	1656	1669	13	0.8%	102	85	114	29	34%	94.0%	94.87%	93.17%	-1.7%
Dermatology	2,645	2542	2503	-39	-1.5%	279	279	276	-3	-1%	89.5%	89.02%	88.97%	-0.1%
Thoracic Surgery	933	1064	942	-122	-11.5%	77	119	122	3	3%	91.7%	88.82%	87.05%	-1.8%
Neurology	1,225	1171	901	-270	-23.1%	30	33	20	-13	-39%	97.6%	97.18%	97.78%	0.6%
Geriatric Medicine	37	33	30	-3	-9.1%	0	0	1	1	0%	100.0%	100.00%	96.67%	-3.3%
Rheumatology	1,031	983	849	-134	-13.6%	39	38	49	11	29%	96.2%	96.13%	94.23%	-1.9%
Gynaecology	2,903	3023	2497	-526	-17.4%	453	328	375	47	14%	84.4%	89.15%	84.98%	-4.2%
Other	5,344	5254	4671	-583	-11.1%	164	163	211	48	29%	96.9%	96.90%	95.48%	-1.4%
Total	34,467	34340	31818	-2,522	-7.3%	3,567	3315	3813	498	15%	89.7%	90.35%	88.02%	-2.3%

4. Performance Areas of Escalation (Page 5 of 7) - RTT Incomplete Pathways Trajectory

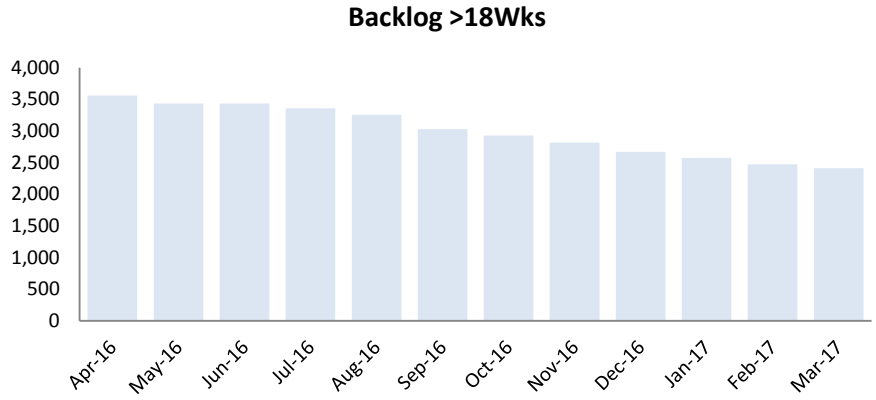
Recovery

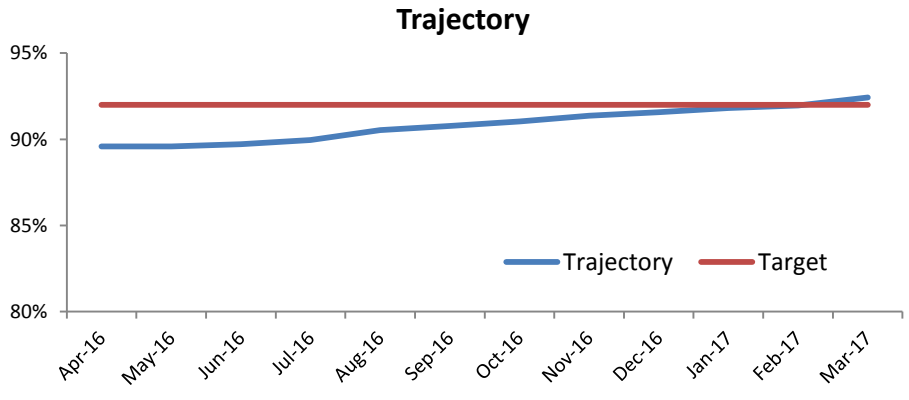
Specialty level action plans have been developed to support the reduction of the backlog (18+), performance recovery and sustainability. There are a number of system wide changes and improvements that need to be made which are also part of the over-arching action plan submitted and agreed with commissioners. The review and monitoring of these actions will be undertaken weekly at the internal RTT Recovery meetings and externally via SRG. There are a number of risks and mitigations each service have identified within the action plan. Key domains within the action plans are as follows:

- Chronological Booking
- Use of outcome forms to update system
- Improved PTLs to enable better monitoring
- Additional Theatre & Endoscopy space
- Project Cerner – use system appropriately to enable staff to track rather than validate
- Improved Escalation Process
- Emergency Winter Planning

Performance Trajectory for RTT Incomplete Pathways

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Waiting List	32,957	32,957	32,618	32,419	31,985	31,721	31,392	30,943	30,504	30,205	29,968	29,765
<18 Weeks	29,526	29,526	29,261	29,162	28,956	28,794	28,577	28,274	27,932	27,734	27,558	27,511
Performance	89.6%	89.6%	89.7%	90.0%	90.5%	90.8%	91.0%	91.4%	91.6%	91.8%	91.96%	92.4%





4. Performance Areas of Escalation (Page 6 of 7) - Cancer 62 Day Pathway

Cancer Standard	Target	Q1 15/16 Apr-Jun	Q2 15/16 Jul-Sep	Q3 15/16 Oct-Dec	Q4 15/16 Jan - Feb
62 Day Standard	85%	79.7%	81.9%	85.5%	82.4%
62 Day Screening Standard	90%	82.1%	92.7%	94.3%	88.4%
31 Day Subsequent Drug Standard	98%	100.0%	100.0%	100.0%	100.0%
31 Day Subsequent Surgery Standard	94%	95.2%	97.5%	97.9%	96.2%
31 Day Standard	96%	97.2%	97.9%	97.8%	94.2%
Two Week Wait Standard	93%	92.4%	77.9%	88.2%	92.2%
Breast Symptom Two Week Wait Standard	93%	90.4%	94.5%	93.8%	96.0%

Cancer Standard	Target	Oct-16	Nov-16	Dec-16	Jan-16	Feb-16
62 Day Standard	85%	84.4%	86.0%	86.1%	83.3%	81.0%
62 Day Screening Standard	90%	89.2%	98.7%	91.1%	86.4%	90.3%
31 Day Subsequent Drug Standard	98%	100%	100%	100%	100%	100%
31 Day Subsequent Surgery Standard	94%	100%	100%	96.0%	97.1%	94.4%
31 Day Standard	96%	96.1%	100%	97.8%	90.2%	97.7%
Two Week Wait Standard	93%	82.7%	86.2%	94.8%	91.1%	93.2%
Breast Symptom Two Week Wait Standard	93%	89.6%	93.7%	97.1%	96.6%	95.4%

62 Day Standard

The trust was non compliant against 1 cancer target in February, the 62 Day standard. There were a total of 11 reported breaches with the standard not being achieved in Gynae (1 breach), Head & Neck (1 breach), Lower GI (1 breaches), Lung (2.5 breaches) or Skin (2 breaches). The numbers of patients treated in February were 9.5% below the planned numbers in the agreed trajectory.

Following the underperformance in January and the continued under performance within the 62 day pathway, the Trust had a meeting with NHSE and commissioners and some revisions to the Trusts recovery plan were agreed. These primarily focused on enhancing PTL development, validation and improving tracking processes. Some positive performance improvement has been observed with the Trust meeting all targets in February with the exception of the 62 day target. This remains an on-going priority for the Trust and significant work in relation to PTL enhancement has been undertaken in March which will allow for improved tracking, expediting and forecasting. The Trust continues to implement its recovery and sustainability action plan, which continues to be reviewed weekly via the Trust cancer performance meeting and externally by commissioners and NHSE-London via the Elective System Resilience Group.

February 2016 performance against national cancer targets by tumour type

Cancer Standard	Target	All Types	Breast	Gynae	Haem	Head & Neck	Lower GI	Lung	Skin	Upper GI	Urological
62 Day Standard	85%	81.0%	100.0%	84.6%	85.7%	77.8%	75.0%	70.6%	66.7%		85.0%
62 Day Screening Standard	90%	90.3%	96.4%				42.9%				
31 Day Subsequent Drug Standard	98%	100%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%
31 Day Subsequent Surgery Standard	94%	94.4%	100.0%	100.0%		100.0%		100.0%	75.0%		100.0%
31 Day Standard	96%	97.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	84.6%	100.0%	96.9%
Two Week Wait Standard	93%	93.2%	98.1%	90.8%	92.3%	93.1%	93.9%	96.8%	85.5%	98.8%	96.1%
Breast Symptom Two Week Wait Standard	93%	95.4%	95.4%								

Peer Performance Latest Published January 2016				
STG	Croydon	Kingston	King's College	Epsom & St Helier
83.40%	86.02%	96.74%	91.59%	87.10%

4. Performance Areas of Escalation (Page 7 of 7) - Cancer 62 Day Trajectory

Performance Trajectory for Cancer 62 Day Pathway

	Cancer - 62 Day												
	Baseline	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
Numerator	9.5	10	9	11	11	11	9	10	9	10	10	10	10
Denominator	63	60	60	74	74	74	63	70	63	68	68	70	70
Performance	84.9%	83.3%	85.0%	85.1%	85.1%	85.1%	85.7%	85.7%	85.7%	85.3%	85.3%	85.7%	85.7%

The Trust has collated a revised action plan to focus on the following domains:

Data Visibility & Tracking

- Daily PTL
- Enhancement of Infoflex standard build to improve functionality and to establish automated links between Trust PAS systems and Infoflex
- Enhanced 62 day PTL : Included DTT and TCI fields.
- Increased automation of PTL.
- Increased real time data entry via MDT process.
- Enhanced process to ensure patients are referred out in a timely manner
- Standardised protocols for BAU validation to ensure accuracy of PTLs

Booking Processes and Escalation

- Relocation of TWR office to Trident House, to allow for increase in team size
- Revised escalation protocol to include: No bookings permitted past breach date without permission from General Manager
- Reduce booking window standard to 7 – 10 days
- Review diagnostic pathways escalation process
- Improve adherence with IPT policy from other trusts through enhanced communication and engagement and also internally for patients going out.
- Integration of QMH and St Georges PAS datasets to allow for visibility for all patients across all sites
- Staff training needs assessment and subsequent training resources to allow for best practice

Capacity: Non-Clinical Staffing

- Recruitment to all vacancies
- Clear recruitment plans and timelines need to be in place
- Temporary staff to cover maternity leave in the cancer data team
- Increased technical resource to develop and build PTLs and reporting infrastructure
- I-Clip back office development resource plan

Capacity: Clinical Staffing

- Recruitment to all clinical vacancies
- Clear recruitment plans and timelines need to be in place.
- Temporary arrangements to cover shortfall
- Diagnostic demand and capacity as part of national programme review to identify any shortfall and particular constraints impacting on turnaround times.
- Review SWL pathology recovery plan

OP Clinic Slot Capacity

- Building of substantive TWR capacity at 85% of average weekly demand
- Schedule of interim ad-hoc clinics to cover shortfall until substantive development complete. Ensure ad-hoc clinics are scheduled in advance to allow a reasonable window for booking and attendance
- Executive agreement that TWR capacity scheduling will be prioritised by corporate outpatients
- Cancer patients are to be prioritised for theatre capacity where available
- Engagement and utilisation of the IS where clinically appropriate
- Plan to undertake additional activity to bring down average wait times to sustainable position

5. Divisional KPIs Overview 2015/16: March 16 Performance (Page 1 of 2)

Monthly View

March 2016

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	18 weeks - admitted waits (division level)	%		86.8	71.8	80.2	78
	18 weeks - incomplete waits (division level)	%	98.4	87.4	85.6	89.9	88
	18 weeks – non-admitted waits (division level)	%	100	86.4	85	94.3	90.9
	52 week waiters	No.	0	0	0	1	1
	A&E waits (4 hours)	%	99.9	85.2			86.5
	LAS handover within 15 mins	%					31.3
	LAS handover within 30 mins	%					88.4
	LAS handover within 60 mins	No.					1
	6 week diagnostic waits	%					99.1

Note: Cancer performance is reported a month in arrears, thus for February 2016

February 2016

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 week gp referral to first outpatient (breast symptoms) - (division)	%			95.4		95.4
	2 week gp referral to first outpatient (cancer) - (division)	%			93.2		93.2
	31 day second or subsequent treatment (drugs) - (division)	%			100		100
	31 day second or subsequent treatment (surgery) - (division)	%			94.4		94.4
	31 day standard from diagnosis to first treatment - (division)	%			97.7		97.7
	62 day urgent gp referral to treatment for all cancers - (division)	%			81		81
	62 day urgent gp referral to treatment from screening - (division)	%			90.3		90.3

5. Divisional KPIs Overview 2015/16: March 16 Performance (Page 2 of 2)

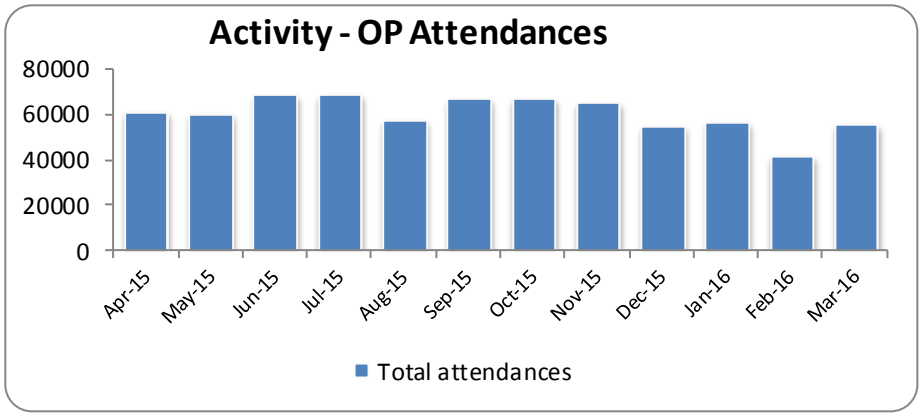
			March 2016				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Outcome Metrics	C-sections (applicable to women & children only)	%				19	19
	CAS alerts	No.					2
	Falls (ward level)	No.	18	80	51	4	153
	HSMR	Ratio					87.5
	Incidence of c.difficile	No.	0	0	1	0	1
	Incidence of e-coli	No.	0	4	1	0	5
	Incidence of MRSA	No.	0	0	0	0	0
	Maternal deaths	No.	0	1	0	1	2
	Medication errors causing serious harm (division)	No.	0	0	0	5	5
	Mixed sex accomodation	No.	0	0	0	0	0
	MSSA	No.	0	0	0	0	0
	Never events	No.	0	0	0	0	0
	Serious incidents (division level)	No.	0	4	2	4	12
	SHMI	Ratio					0.9
	Trust acquired pressure ulcers	No.	0	0	0	0	0
	WHO surgical checklist (qrtly audit: sign in/time-out/sign-out)	%		97	95	99	97
Quality Governance Indicators	Friends & family response rate	%	31.2	26.1	33.1	30.4	29.7
	Patient satisfaction (friends & family)	%	100	94.4	91.8	89.7	92.4
	Percentage of harm free care	%	68.2	93.1	97.5	96.8	94.6
	Percentage of staff appraisal (medical) - (division)	%	88.9	82.1	84.9	84.1	84.2
	Percentage of staff appraisal (non-medical) - (division)	%	63.2	69.2	73.5	65.1	67.3
	Sickness/absence rate - (division)	%	4.7	2.9	3.3	4.1	3.7
	Staff turnover - (division)	%	20.5	17.5	14.9	18.7	18.1
	Vacancy rate - (division)	%	19.4	16.2	17.6	15.1	16.7
	Voluntary staff turnover - (division)	%	15.1	15	12.2	15.5	14.9
	Ward staffing: unfilled duty hours	%	4.7	5.9	8	4.4	5.9

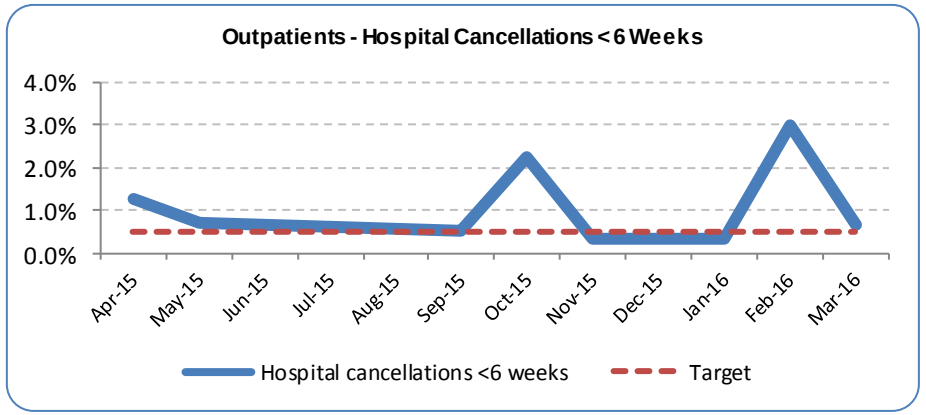
Key Messages:

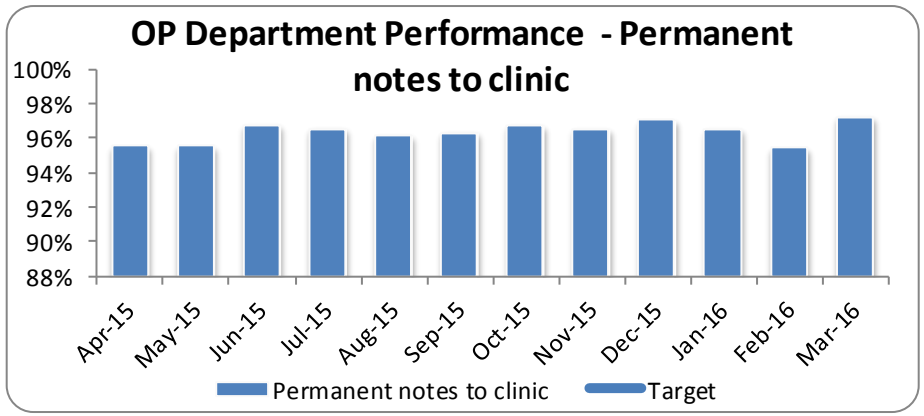
This section headed 'Access' indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution. The Access section is split into two components,. Cancer performance is reported one month in arrears.
LAS arrivals to patient handover times, continues to fluctuate. At the end of March 31.3% of patients had handover times within 15 minutes and 88.4% within 30 minutes. both of which are not within target. The trust had one 60 minute LAS handover breach in March

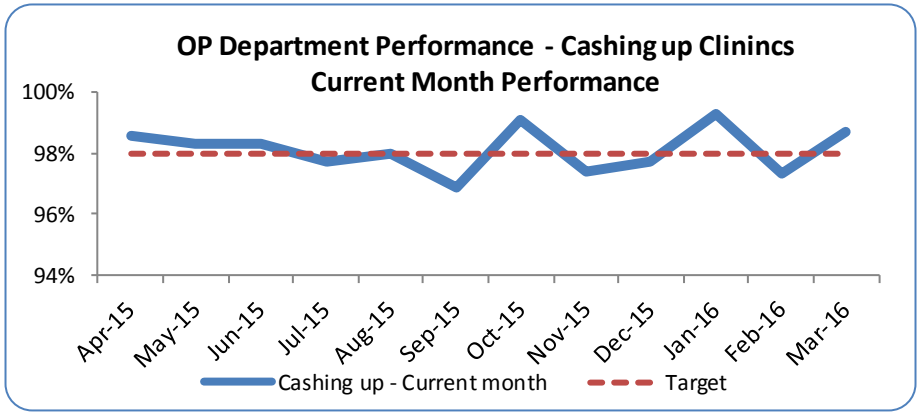
The trust has a zero tolerance on avoidable pressure ulcers and has placed significant importance on its prevention. In March the trust had no grade 3 pressure ulcer SI's and no Grade 4. All grade 3 and 4 pressure ulcers acquired in our care are investigated as serious incidents, and a. full investigation and Root Cause Analysis will be produced for each PU and reviewed at the Pressure Ulcer Strategy group, chaired by the Deputy Chief Nurse

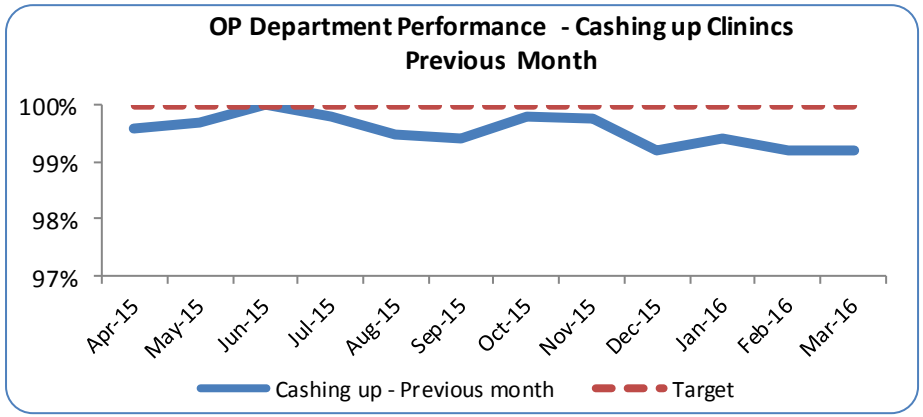
6. Corporate Outpatient Services (1 of 2) - Performance Overview

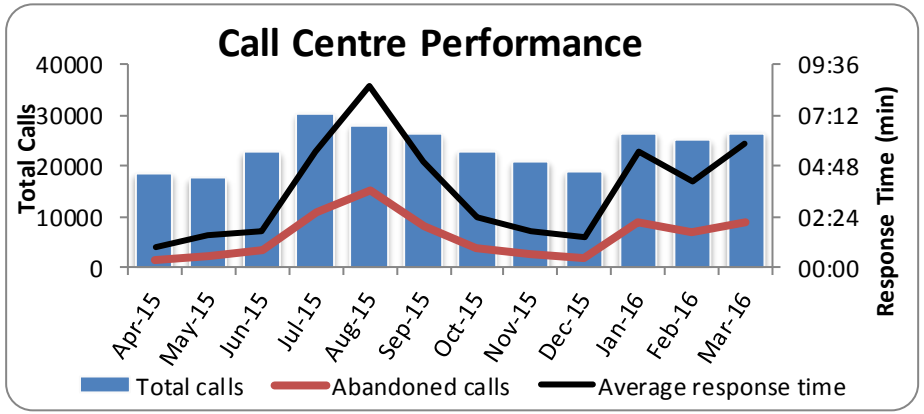












6. Corporate Outpatient Services (2 of 2) - Performance Overview

		Target	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Activity	Total attendances	N/A	62946	60564	59841	68002	68277	57188	66271	66501	64863	54618	56239	41552	55261
	Hospital cancellations <6 weeks	<0.5%	0.54%	1.26%	0.74%	0.66%	0.64%	0.56%	0.54%	2.24%	0.36%	0.37%	0.35%	2.97%	0.69%
OPD performance	Permanent notes to clinic	>98%	91.32%	95.52%	95.54%	96.74%	96.54%	96.14%	96.31%	96.72%	96.52%	97.02%	96.50%	95.42%	97.20%
	Cashing up - Current month	>98%	99.60%	98.60%	98.30%	98.30%	97.70%	98.00%	96.90%	99.10%	97.40%	97.70%	99.30%	97.30%	98.70%
	Cashing up - Previous month	100%	99.00%	99.60%	99.70%	100.00%	99.80%	99.50%	99.40%	99.80%	99.75%	99.20%	99.40%	99.20%	99.20%
Call Centre Performance	Total calls	N/A	23235	18710	17732	22955	30426	28095	26357	23138	21082	19093	26557	25273	26674
	Abandoned calls	<25%/<15%	3782	1551	2237	3309	10828	15019	8253	3930	2756	1953	9084	6949	9055
	Mean call response times	<1 m/<1m30s	01:08	01:00	01:29	01:42	05:31	08:34	04:59	02:24	01:43	01:24	05:30	04:06	05:49

Key Messages:

- Increase in activity compared to February, however in line with November and December activity.
- Compared to March 2015 there has been a decrease in activity of 12.2%
- Improvement made in Hospital cancellations <6 weeks compared with February, currently 0.69% however still below target
- Permanent notes to clinic has seen a slight improvement of 1.78% however still remains below target of 98%. This continues to be a priority area for the service.
- The level of call activity and the number of abandoned calls remain under target for the third consecutive month which is primarily due to shortage in staffing levels. CBS is currently going through a transformational phase and are on a active recruitment drive to fill the staffing capacity shortfall following recent vacancies which have arisen.

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Clinical Audit & Effectiveness

Excellence in specialist and community healthcare

7. Clinical Audit and Effectiveness - Mortality

HSMR (Hospital standardised mortality ratio)							
Lead Director	February 16	March 16	April 16	Movement	2016/17 Target	Forecast March 17	Date expect to meet standard
SM	90.9	87.5	86.5	↓	<100	G	Met

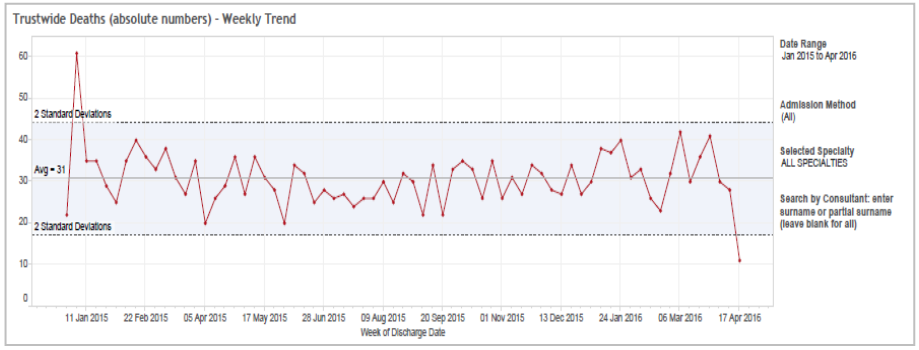
SHMI (Summary hospital-level mortality indicator)				
Apr 2015	Jul 2015	Oct 2015	Jan 2016	Mar 2016
0.86	0.89	0.92	0.90	0.91

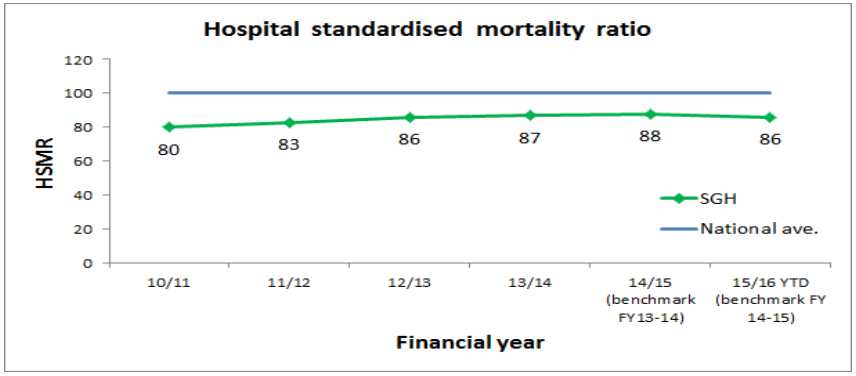
Note: Source for HSMR is Dr Foster Intelligence. Data is most recent 12 months available (updated 21/04/16) February 2015 to January 2016, and benchmark period is the financial year 2014/15. SHMI data is published by the Health and Social Care Information Centre. The last 12 month period as published on 23rd March 2016 relates to the period October 2014 to September 2015. The next publication is due in June 2016.

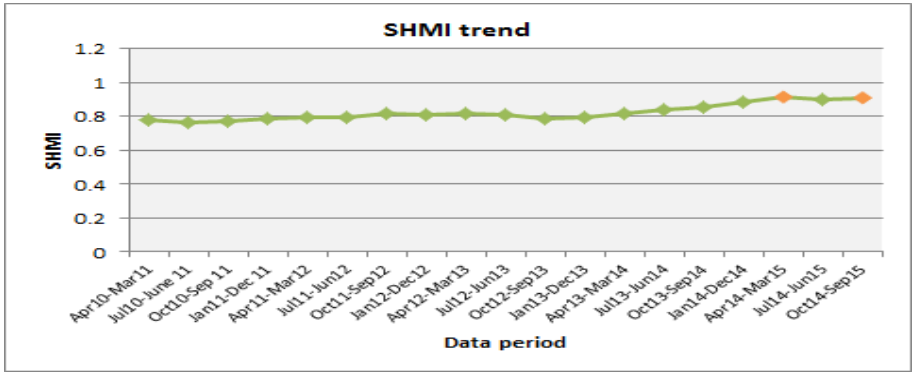
Overview:

Our mortality as measured by the HSMR remains significantly lower than expected; for the period February 2015 to January 2016 our ratio is 86.5. Looking at the HSMR for emergency admissions analysed by day of admission, shows that for both patients admitted at weekends and patients admitted on weekdays, mortality is significantly better than expected at 87.8 and 86.7 respectively. Our SHMI for the period October 2014 to September 2015 is 0.91, which is categorised as 'as expected'. Raw mortality is also considered by the MMC each month, and as shown by the chart below, continues to be within normal limits.

The Mortality Monitoring Committee continue to scrutinise mortality at diagnosis and procedure group level and lead investigations of any areas where mortality is higher than expected. The number of these internally derived signals has decreased in the most recent two months, particularly in cardiology. It is believed that in large part this is due to improvements in the accuracy of clinical coding brought about through close liaison between the clinical team and the coding team.



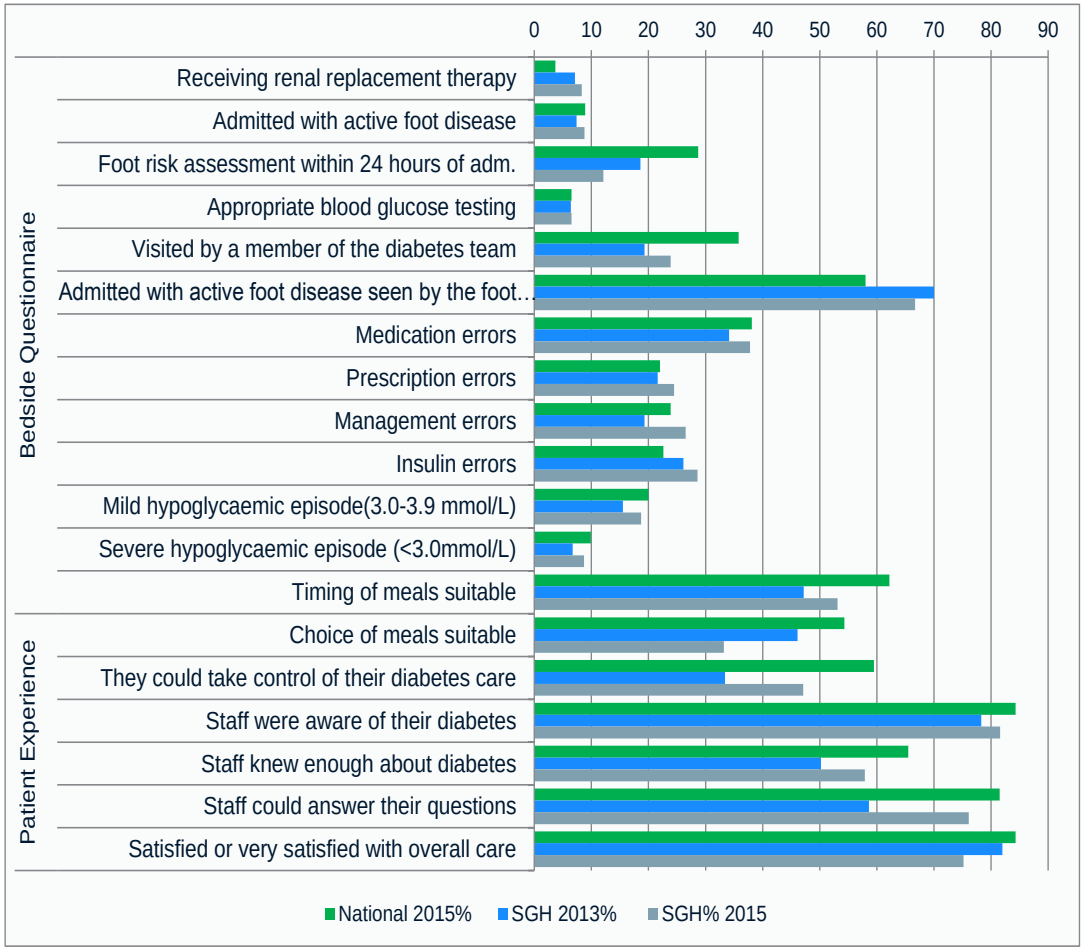




7. Clinical Audit and Effectiveness - National audit

National Diabetes Inpatient Audit 2015

The National Diabetes Inpatient audit was conducted in September 2015. The audit comprised an organisational audit, a bedside audit of casenotes looking at diabetes care and management, plus a questionnaire completed by patients about their inpatient experience. Our provider level report shows that within St George's 120 inpatients were identified with diabetes at the time of the audit, which represents 15.7% of all inpatients. Of these 39.3% had Type 1 diabetes or Type 2 diabetes treated with insulin. Nationally these figures were 16.6% and 35.9%



The Organisational audit revealed that SGH has fewer specialist nursing and consultant hours per week per patient than the national average, but more dietitian and podiatry hours. This correlates with the results of the bedside audit which shows SGH to have fewer patients visited by members of the diabetes team but also fewer admitted with active foot disease and better management of those who are. Results are compared with 2013 (there was no audit in 2014) and overall are slightly worse that in the previous audit. The main point of focus locally is the resource challenge reflecting a wider problem as nationally many of the measured parameters are less good than in 2013.

The patient experience questionnaire was completed by 80 patients. Overall 75.2% reported that they were satisfied or very satisfied with the care of their diabetes whilst in hospital. This is less than in 2013(82%) and the national average (84.3%) The main area of concern seems to be in the choice of meals as other areas show an improvement. In particular, patients view of staff knowledge of diabetes and their ability to answer questions has improved.

These results will be discussed within the diabetes care group and a monthly meeting is to be introduced to address areas of concern. A full national report and recommendations are scheduled for publication in June 2016 and will further guide actions and response.

7. Clinical Audit and Effectiveness
- National Audits

National Prostate Cancer Audit Second Year Annual Report 2015

Table 1: Period between 1 April 2014 and 31 July 2014 *(Source: NPSA Annual Report 2015, page 45)*	**National Score**	**St Georges**	**Royal Marsden Group** (Kingston Hospital, Croyal Health Services, St George's, The Royal Marsden, and Epsom & St Helier)
Case ascertainment: % of expected cases with NPCA record and ≥ TNM	56%	94%	77%
Performance status complete	38%	6%	15%
ASA completed	34%	0	10%
PSA completed	72%	9%	59%
Gleason Score complete	67%	4%	49%
TNM Completed	53%	48%	69%
≥1 planned treatment recorded	53%	0%	48%

Overview

The National Prostate Cancer Audit (NPCA) Second Year Annual Report – Organisation of Services and Analysis of Existing Clinical Data was published in November 2015. It is based at the Clinical Effectiveness Unit (CEU) at the Royal College of Surgeons of England and is managed in partnership with the British Association of Urological Surgeons (BAUS), the British Uro-Oncology Group (BUG) and the National Cancer Registration Service (NCRS).

This annual report covers the work undertaken since April 2014 and includes a analysis of the NPCA's organisational audit, an analysis of existing datasets including patients with prostate cancer in England, and the design of the NPCA's prospective audit dataset.

The audit aims to determine the availability of essential diagnostic, staging and therapeutic facilities, how prostate cancer services are organised and delivered, and the functioning of local and specialist multidisciplinary teams (MDTs).

The NPCA has started to measure patients' own views of the impact of radical therapies on their lives and their experience of care. This is expected to be presented in the 3rd Annual Report later this year (2016).

The audit looks at whether NHS services in England and Wales for men diagnosed with prostate cancer meet recommended standards. The audit found that nationally men with locally advanced prostate cancer are increasingly being offered radical treatments in line with national guidelines. The percentage of men with this stage of prostate cancer who had radical treatment went up from 27% between 2006 and 2008 to 47% between 2010 and 2013.

Key Findings:

The national result for case ascertainment rate was 56% which varied by Trust and specialist MDT. There was a significant level of missing data which varied by Trust and specialist MDT. Trust score is 94%, above the National and Royal Marsden Group scores.

Prostate cancer disease status could only be defined for 69% of men. ASA and performance status, data items crucial for risk-adjusted comparisons among Trusts, were especially poorly recorded. In the 2014 audit report, the audit department had assurance from the Prostate Cancer Tumour Group that data from 1st April 2014 had been submitted and is 100% complete. However, in this audit report, the Trust scores for ASA and ≥1 planned treatment recorded are 0% for both fields.

Action Plan

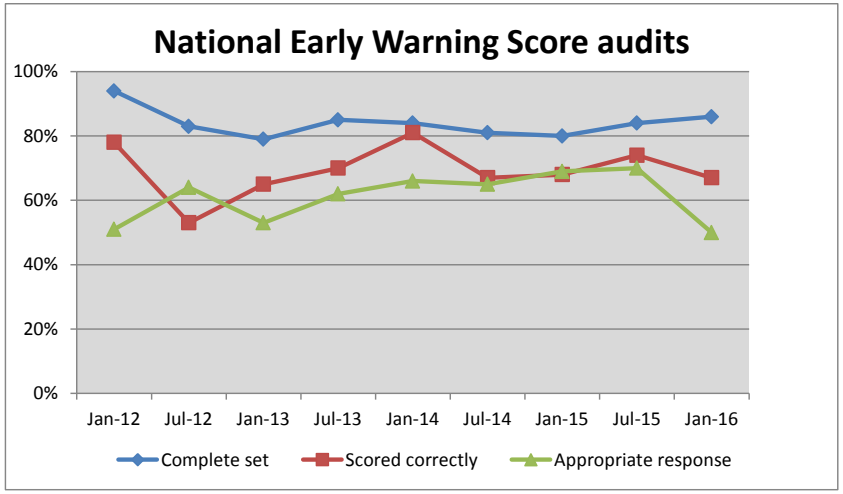
1. Infoflex to have a page with the extra NPCA data fields and BAUS data fields
2. Infoflex to be filled in at the MDT both pre and post treatment. This will work for the surgical but NOT the radiotherapy patients.

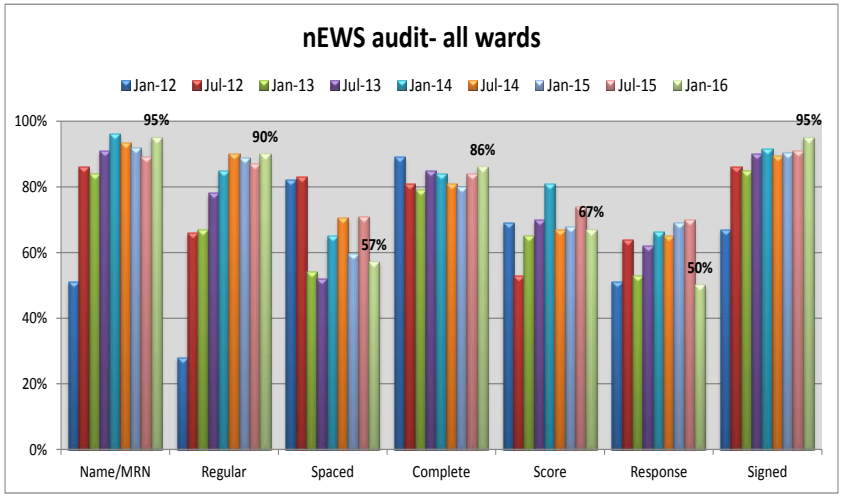
Current requirement

1. Infoflex to be our hub for these data collections and submissions to prevent double-filling.
2. The current computers and laptops in the Pathology Seminar room need to be upgraded to ensure the hardware is up to speed with our requirements and response in real time.
3. A review of the role of one of the MDT co-ordinators to support data entry and therefore better BAUS submissions too.

7. Clinical Audit and Effectiveness - Local audit

Use of nEWS Re-Audit - January 2016





In compliance with NICE guidelines to protect the deteriorating patient, St George's has used an EWS chart since 2000 and adopted the national EWS in January 2012. Audits have been undertaken on a six monthly basis and the latest cycle took place in Jan 2016. This included 29 wards (n=285) . Data for the four remaining wards, which currently record observations electronically, was unavailable.

The main markers for the success of the nEWS are (a) recording a complete set of observations; (b) scoring nEWS correctly; and (c) appropriate response to triggers. These were achieved in 86%, 67% and 50% of cases respectively in this audit against the local target of 80%.

Results overall are unsatisfactory and show a general reduction in three important indicators, evenly spaced observations, correct scoring and appropriate response. The even spacing problem is characterised by a marked diurnal variation in some areas; the results for having a correct score are particularly disappointing since IT have now rolled out the new Welch Allyn monitors that add up the observations automatically, so it would appear that staff may be using them incorrectly. The appropriate response to a high EWS score was at its lowest for many audits and will be investigated further. Lastly the wards using Cerner are not reported as there were no resources in IT to extract the data.

Individual ward results have been disseminated through the divisional structures and focus is now being placed in support of Ward managers with less than 80% compliance in any of the three main target measures to ensure that staff are adequately educated by their nEWS lead and perform monthly re-audits until compliance has reached 80% consistently. Oversight of these areas will be undertaken by the Nursing Board with presentation and assurance of improvement plans A PowerPoint presentation is already available to wards for training days and utilised in MEERKAT's training and the Harm Free Care study day. Wards scoring poorly for appropriate response should ensure staff attend this training. As there continues to be an issue with spacing, particularly at night time, more attention needs to be paid to adhering to documented regularity. Wards who are using the Welch Allyn device are encouraged to seek appropriate training.

7. Clinical Audit and Effectiveness - Local audit

Venous Access Device Care Annual Audit Report 2016

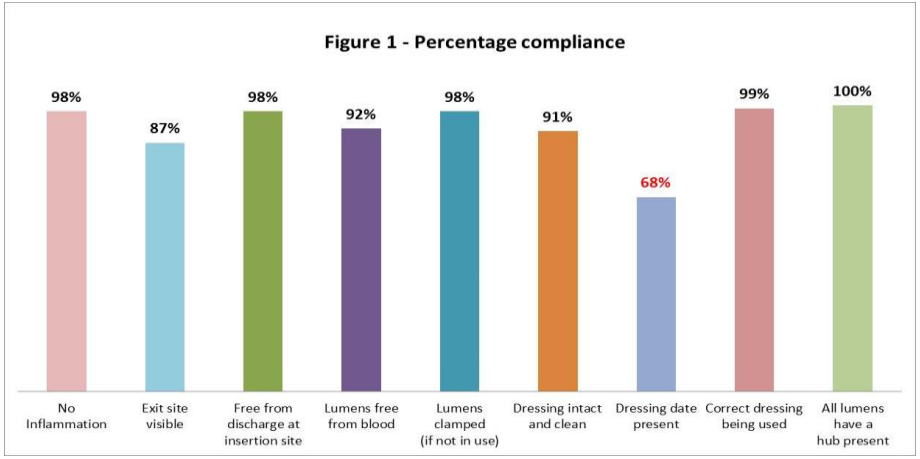


Table 1 - Performance table against last audit round	2015	2016	
Number of VAD's audited	414	456	↑
No inflammation	95%	98%	↑
Exit site visible	78%	87%	↑
Free from discharge at insertion site	-	98%	-
Lumens free from blood	93%	92%	↓
Lumens clamped (if not in use)	-	98%	-
Dressing intact and clean	77%	91%	↑
Dressing date present	68%	68%	-
Correct dressing being used	-	99%	-
All lumens have a hub present	-	100%	-
Number of bandaged PVCs not justified	-	5	-
Number of 3-way taps and/or extensions being used and not required	-	5	-

Overview

This audit was undertaken to observe current practice, to identify compliance with the Trust's guidelines in the care and management of VADs and to create the opportunity to give immediate feedback if deemed necessary in the area of VAD management.

Results - a total of 456 VADs were audited in Medicine & Cardiovascular, Surgery/Anaesthetics/Neurology and Women's & Children divisions between November 2015 and January 2016. 41 clinical services were audited in this audit round.

Demographics - more than half of the VADs documented were from the Medicine and Cardiovascular division. The most commonly used device was the peripheral venous catheter (PVC, 74%), accounting for more than half of the VADs audited. 78% (n=269) of the PVCs audited were non-ported cannulas, and 22% (n=75) of the PVCs audited were ported cannulas.

Compliance Rate - Nine questions were reviewed for compliance and eight questions scored above 80%, while compliance on "**dressing date present**" scored below 80% (Figure 1). Eight services scored 100% for this question (Heberden, Holdsworth, James Hope – Day Case, Nicholls, Norman Tanner Haemodialysis Unit, Paediatric Intensive Care, and Rodney) while 8 services scored below 50% (A&E, Brodie, Dalby, Freddie Hewitt, Gwillim, Marnham, McKissock, and William Drummond). Table 1 shows the comparison scores against the last audit round.

Patient experience of device - 82% scored above average for experience of the device used, which indicates a positive experience.

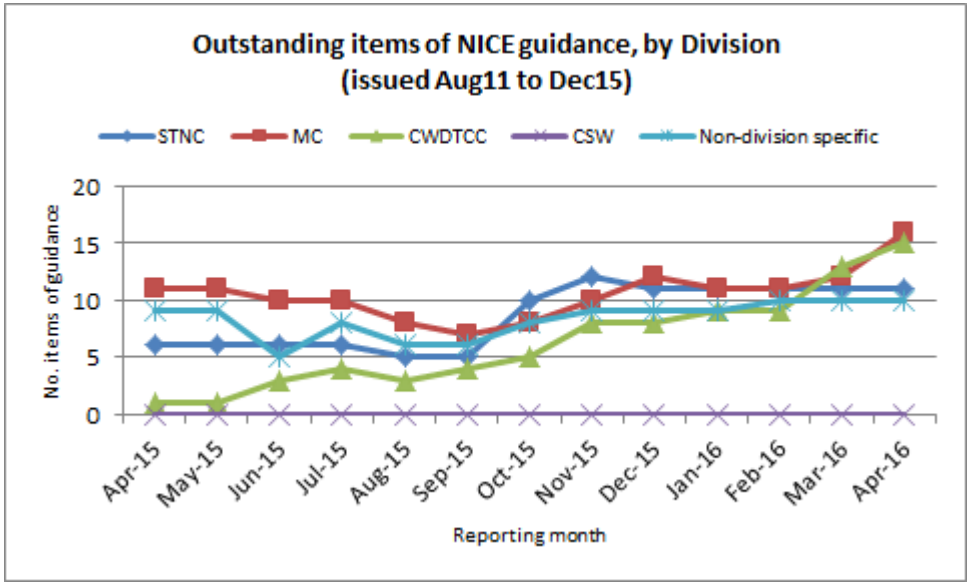
Documentation Recordings - 73% (n=308) had complete paper documentation, and 49% (n=148) had complete electronic documentation.

Reasons for VAD insertion Almost half (48%) of the VAD insertions were for the administration of fluids & medication and 24% were used for antibiotic administration. 28% were for other reasons such as Unknown (8%), Medical Procedure (8%), Bloods (5%), IV Antibiotics & Fluids (4%), Patient unstable (2%) and Medical investigation (1%).

Conclusion - overall there has been significant improvement in all areas apart from 'dressing dated' which has remained at the same level of 68%.

Action Plan - the Venous Access Team will work with the clinical areas to improve documentation of the dressing and highlight suboptimal electronic and paper documentation.

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



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

Division	2010	2011	2012	2013	2014	2015
STNC (n=9)	0	1	2	1	4	1
M+C (n=18)	2	2	4	1	2	7
CWDTCC (n=17)	3	1	1	3	6	3
CSW (n=0)	0	0	0	0	0	0
Non-division specific (n=11)	0	2	0	4	1	4

Overview

The number of outstanding items of guidance increased from 46 to 52 this month and there are currently 55 with compliance issues. For guidance issued in the first two months of the year we have already received responses from clinicians for almost 50 per cent, which is a more encouraging position.

The volume of newly issued guidance and updates received from NICE each month has contributed to the observed increase. Excluding technology appraisals and public health guidance, there was a 30 per cent increase in the number of NICE publications between September 2015 and February 2016, when compared to the same period 12 months previously (this period was selected to exclude the disruption around the Purdah period). As previously explained the audit team has continued to disseminate guidance in a timely way, but has had insufficient resource to follow-up outstanding guidance.

It is very positive to note that we are now fully staffed and a complete review of NICE guidance is underway. This will encompass following up historical items of guidance where we have not had a response as to implementation and those where full implementation has not been achieved. However, it will also look at systems for dissemination, follow-up and reporting. Through developing more efficient systems and processes we hope to eliminate the backlog and free up time to support clinicians in more timely assessment of implementation. We also aim to improve the flow of information between corporate and clinical teams. Through a critical review of our reporting at both trust and divisional level we plan to develop a process that delivers a clear and up-to-date picture of implementation and supports the assessment and management of any risks associated with partial or non-compliance.

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Patient Safety

Excellence in specialist and community healthcare

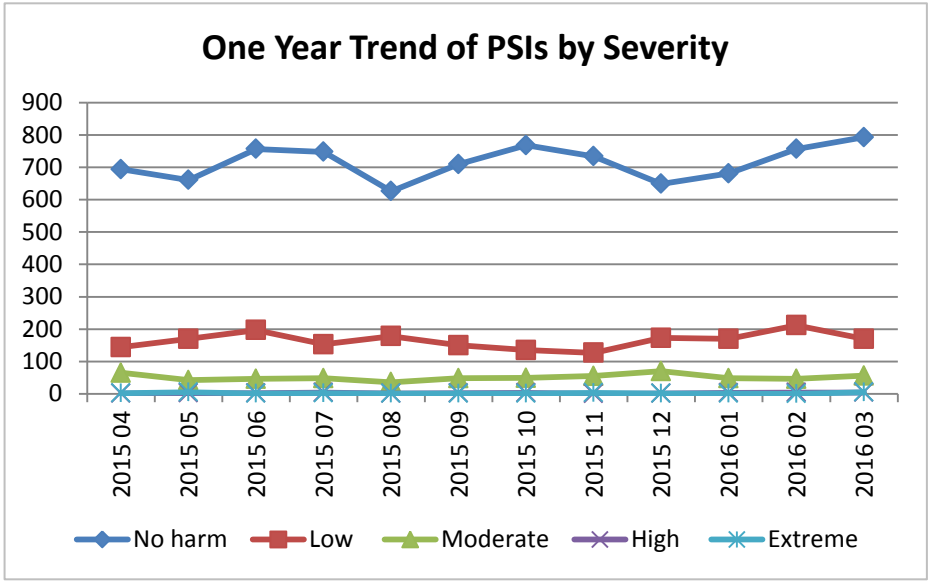
8. Patient Safety
- Incident Profile: Serious Incidents and Adverse Events

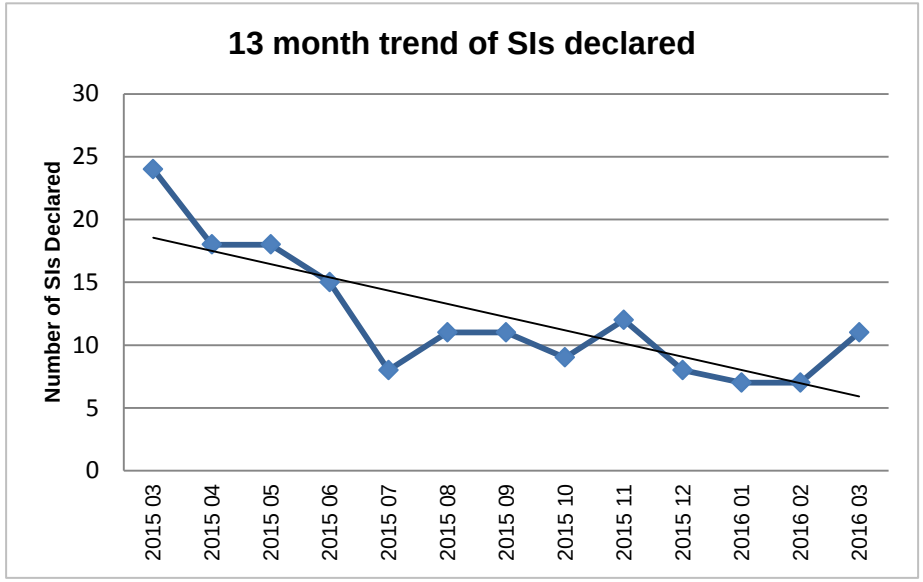
	2015/16 SIs Declared by Division (incl. PUs)				
	M&C	STN&C	CSD	C&W	Corporate
January	5	0	1	0	1
February	1 (shared C&W)	3 (1 shared with C&W)	0	5 (2 shared, 1 M&C, 1 STN&C)	0
March	4 (1 shared with Corp)	2	0	4	2 (1shared with M&C)

Table 1

Closed Serious Incidents (not incl. PUs)				
Type	January	February	March	**Movement**
Total	4	4	4	➤
No Harm	3	2	1	➘
Harm	1	2	3	➚

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.

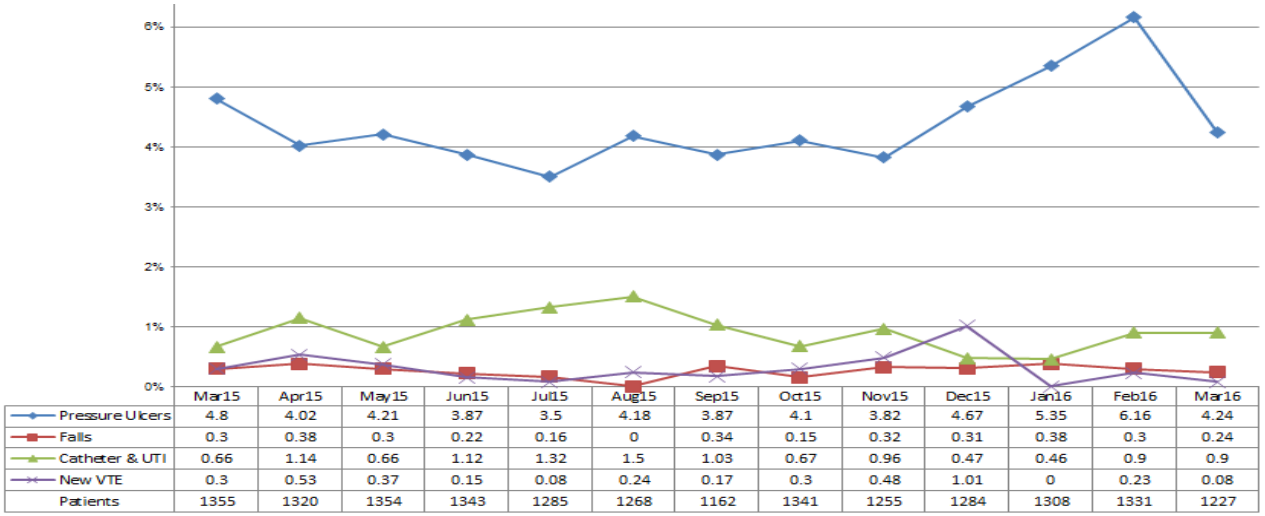
There were 11 general SIs reported in March (0 pressure ulcers) and the subjects are varied.

The 11 general SIs declared in March relate to a range of issues. They include the following categories:

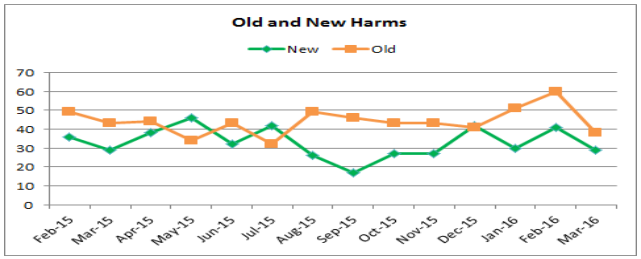
- Length of wait for an appointment
- Unexpected admission to NNU
- Maternal death (2)
- Inappropriate/wrong treatment (2)
- Patient fall
- Safeguarding (2)
- Infrastructure failure (1)

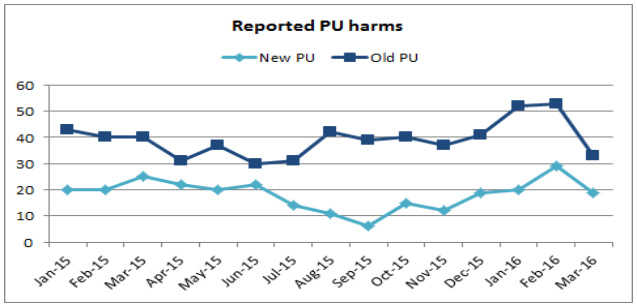
8. Patient Safety
- Safety Thermometer

% Harm Free Care							
Lead Director	January 2016	February 2016	March 2016	**Movement**	**2015/2016 Target**	**National Average March 2016**	**Date expected to meet standard**
J Hall	93.96%	92.64%	94.62%	↑	95.00%	94.08%	March 16



	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15	Jan16	Feb16	Mar16
Pressure Ulcers	4.8	4.02	4.21	3.87	3.5	4.18	3.87	4.1	3.82	4.67	5.35	6.16	4.24
Falls	0.3	0.38	0.3	0.22	0.16	0	0.34	0.15	0.32	0.31	0.38	0.3	0.24
Catheter & UTI	0.66	1.14	0.66	1.12	1.32	1.5	1.03	0.67	0.96	0.47	0.46	0.9	0.9
New VTE	0.3	0.53	0.37	0.15	0.08	0.24	0.17	0.3	0.48	1.01	0	0.23	0.08
Patients	1355	1320	1354	1343	1285	1268	1162	1341	1255	1284	1308	1331	1227





Pressure ulcers (52)

- 24 grade 2 (12 new, 12 old)
- 21 grade 3 (6 new, 15 old)
- 7 grade 4 (1 new, 6 old)

CAUTI (11)

- 5 old
- 6 new

Falls (3)

- 2 low harm falls
- 1 moderate ham

VTE (1)

- 1 new other

The safety thermometer data represents a snapshot of harms as collected by ward staff on one nationally agreed day per month. This project measures point prevalence as opposed to the number of incidents. In March 2016 the proportion of our patients that received harm free care was 94.62 per cent, which is better than the national average for the month of 94.08%.

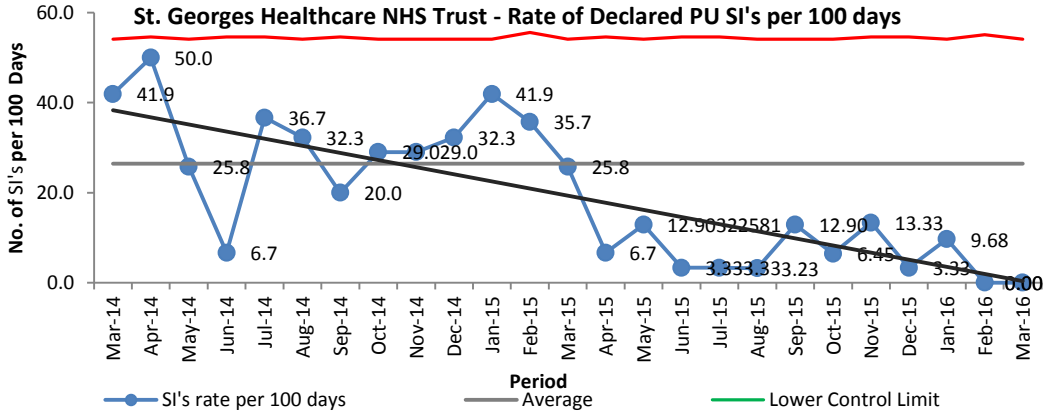
In March we reported 67 harms to 66 patients; 65 patients experienced one harm and 1 patient had 2 harms. There was a decrease in both new and old harms reported at 29 and 38 respectively. The number of pressure ulcers, both old and new, decreased this month. All other categories of harm also saw a decrease in numbers reported.

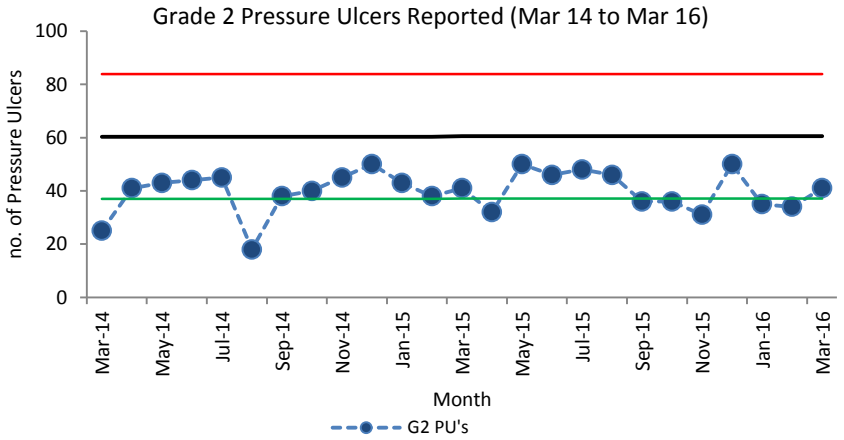
Data has been prepared for the Quality Account 2015/16, which shows that for the financial year 2015/16 we collected data on 15,478 patients, of which 94.4 per cent were free of the harms described above as measured by the Safety Thermometer. This compares with a national average of 94.2%.

8. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers										
Type	Nov	Dec	Jan	Feb	Mar	YTD April – March 2016	Movement	2015/2016 Target	Forecast March 2016	Date expected to meet standard
Acute	3	0	2	0	0	**14**			G	-
Community	1	1	1	0	0	**8**			G	-
Total All	4	1	3	0	0	**22**			G	-
Total Avoidable	4	1	3	0	0	**22**		40		-
Previous Year	8	6	8	3	2	**52**				

Grade 2 Pressure Ulcers						
Nov	Dec	Jan	Feb	Mar	Movement
11	39	20	20	25	
20	11	15	14	16	
31	50	35	34	41	
45	50	43	38	41	





Overview:

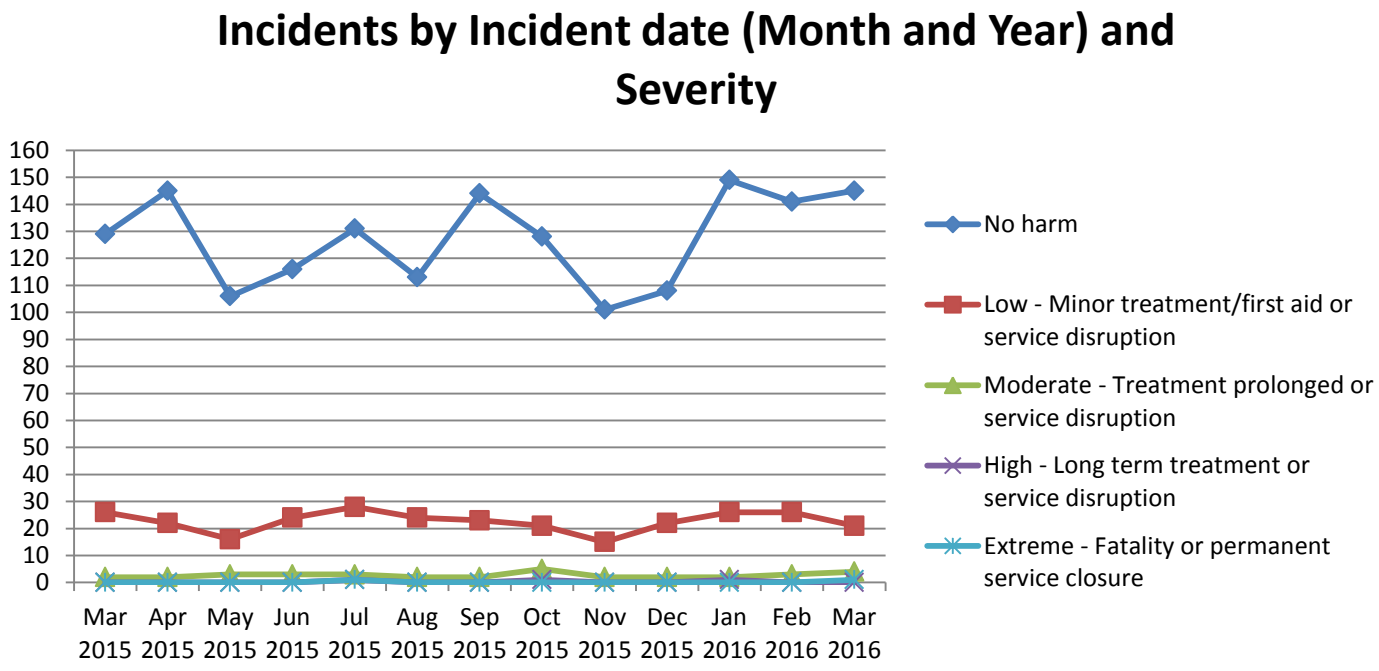
In March there were 0 pressure ulcer serious incidents reported across the trust. This brings our yearly total to 22, which means the trust has met it's target of 40 for the financial year 2015/16. There has been a 57% reduction in avoidable grade 3 / 4 pressure ulcers within the Trust during the year. There was an increase in the number of Grade 2 pressure ulcers in both acute and community services During the month and a consistent profile with the last 12 months.

Actions:

- Shortlisting for Band 7 TVN for community services underway.
- IHI project roll-out extended to Mary Seacole and Richmond Wards.
- Pressure Ulcer Prevention and Management Study Days planned for 2016.
- Snapshot audit of documentation and practice in inpatient areas currently underway.

8. Patient Safety
- Incident Profile: Falls

Falls														Falls with Harm March 2015 to 2016			
Lead Director	March 2015	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan 16	Feb	March 16	Movement	No Harm	Low	Moderate	Severe
	157	165	126	144	163	140	168	155	118	132	179	170	171	⟺	1656	294	14	2



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 no significant changes this month overall but there has been some changes within divisions (decrease in medicine and cardiac division and increase In community division). A prospective audit on the management of patients post fall is about to commence- this will provide important information on essential assessment and care and should be completed by the end of May 2016.

8. Patient Safety
- Infection Control

MRSA						
Lead Director	February	March	Movement	2015/2016 Threshold	Forecast March- 16	Date expected to meet standard
JH	0	0	⇔	0	G	-

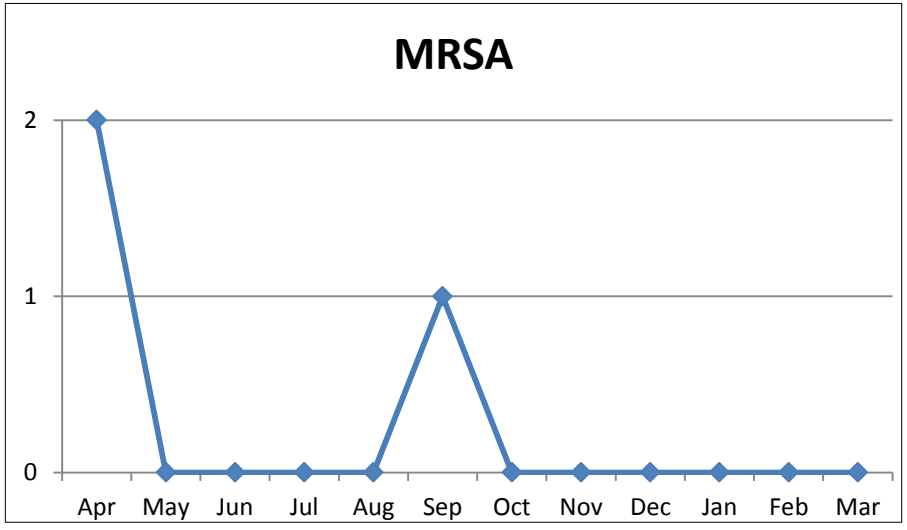
Peer Performance – YTD March 2016				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3	2	1	3	5

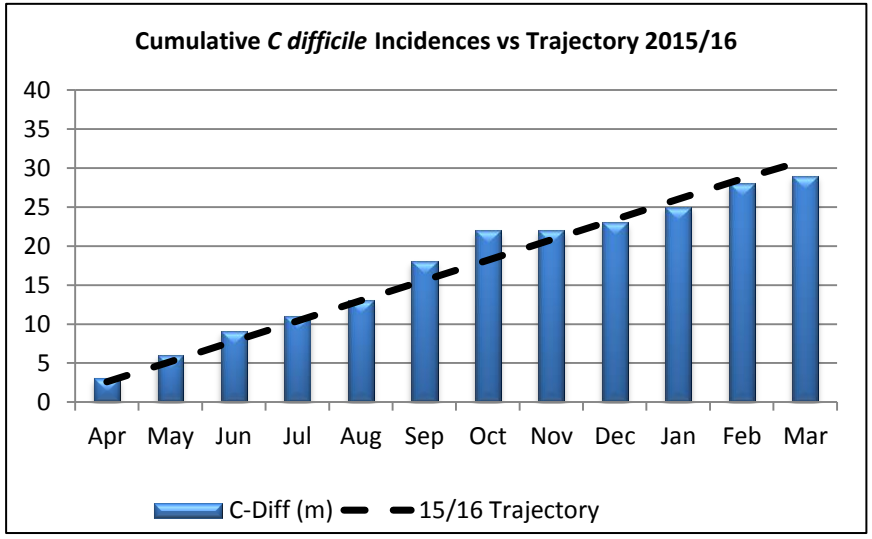
C. difficile						
Lead Director	February	March	Movement	2015/2016 Threshold	Forecast March- 16	Date expected to meet standard
JH	3	1	⇩	31	G	31/03/16

Peer Performance – YTD March 2016 (annual threshold in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
29 (31)	19(16)	18(9)	82(72)	30(39)

The MRSA bacteraemia threshold is zero. There were no MRSA Hospital-acquired bacteraemias in March. The last hospital-acquired MRSA bacteraemia was on 23rd September 2015. The Trust was non-compliant for the year 2015-16, with 3 incidents in total against a target of zero.

In 2015/16 the Trust has a threshold of no more than 31 *C. difficile* incidents. In March there was one episode. This makes a total of 29 for the FY to end March 2016 indicating that the Trust met the target. The total for 2015/16 is 24% lower than 2014/15. Nationally the numbers have risen. The threshold for 2016/17 remains at 31.





8. 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	Mar 2015	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan 2016	Feb	March
Unify2	96.27%	96.64%	96.45%	96.75%	96.56%	96.78%	97.22%	97.10%	96.8%	96.5%	96.6%	96.7%	

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	Mar 2015	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan 2016	Feb	March
Safety Thermometer	85.74%	89.83%	90.19%	95.14%	94.84%	92.38%	91.28%	93.40%	93.24%	88.56%	94.10%	90.2%	94.04%
National average	84.69%												

Comparison of data streams:

There are differences in the methodology of collecting the different data streams. Data submitted to the Safety Thermometer is regularly validated by the thrombosis nursing team. The team consistently find variation in the interpretation of the audit tool across the Trust, resulting in inconsistent and sometimes inaccurate results. This problem is encountered nationally and limits the reliability and value of the data presented. 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 Hospital Thrombosis Group is expanding its VTE champion network and working to further establish the network to drive improvement in VTE prevention across the Trust. The group hold monthly meetings with the Champions to discuss issues highlighted at HTG and listen to feedback from the Champions about clinical practice relating to VTE prevention from across the Trust. The network is multi-disciplinary with representation including doctors, pharmacists, physician's associates and midwives. The group are interested in recruiting nursing staff in addition to increasing the numbers of other staff groups already present. The aim of the network is to grow a culture of engagement with the VTE prevention programme, and embed good practice relating to VTE prevention as part of routine clinical practice. Representatives from the HTG are taking part in a working group led by Cerner UK to help co-design an improved VTE pathway for the electronic system which will support safe and effective implementation of VTE prevention guidelines.
- The Hospital Thrombosis Group has reviewed their process for disseminating learning following the occurrence of preventable hospital acquired thrombosis. A face to face meeting between HTG representatives and representatives from both the clinical and ward based teams involved will be scheduled to review the care of the patient in question within a month of the incident. This is to encourage increased engagement in learning from incidents and ensure that the learning is shared amongst the wider team.

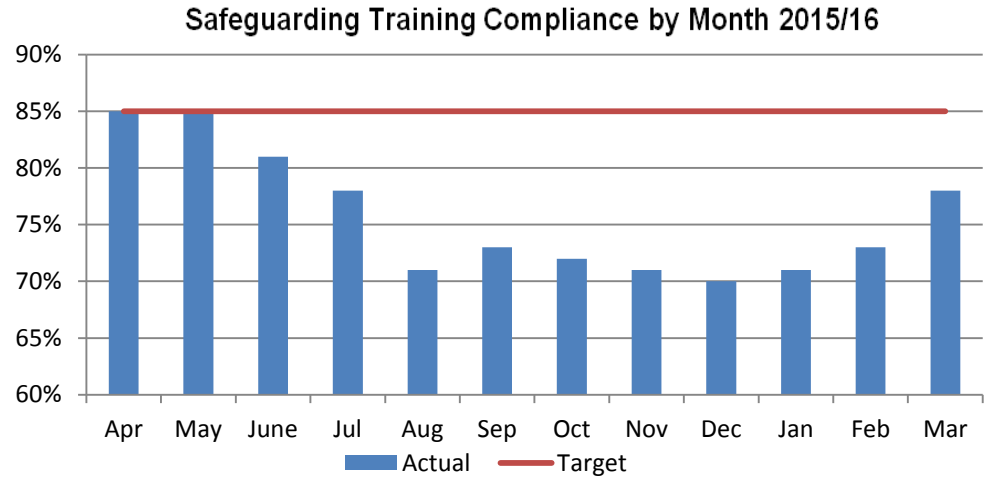
Root Cause Analysis (RCA) of Hospital Acquired Thrombosis (HAT)

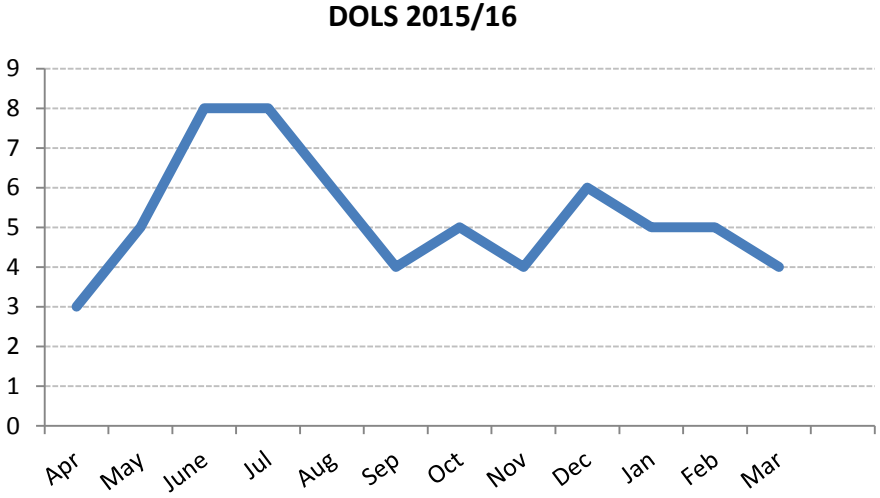
Year		2016
HAT cases identified to date (attributable to admission at SGH)		54
Mortality rate	Total	6 (11.1%)
	VTE primary cause of death	2 (3.7%)
Initiation of RCA process		100%
RCA complete		63% (34/54)
Cases where adequate prophylaxis was provided		32
Cases where inadequate prophylaxis was provided		2
Incidents jointly reviewed by HTG and clinical team		pending
Incidents investigated as SI		1

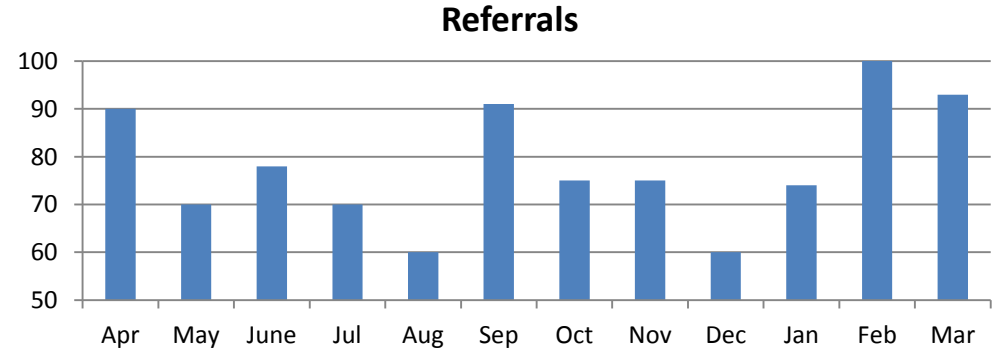
8. Patient Safety
- Safeguarding: Adults

Safeguarding Training Compliance - Adults									
Lead Director	Oct	Nov	Dec	Jan	Feb	Mar	2015/2016 Target	Forecast April 2016	Date expected to meet standard
JH	72%	71%	70%	71%	73%	78%	85%	A	

Safeguarding Adults Training Compliance by Division – Feb16				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
76%	78%	77%	79%	77%







DOLS: Since April 2014 and the Supreme Court judgement there has been a significant increase in DOLS activity which is 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. July 15 – fresh legal advice obtained around risk to organisation and patients with regard to non application of DoLs. Revised briefing paper presented for QRC July 2015.

Continue to monitor safeguarding training via ARIS and MAST steering group. Divisions to take action around low compliance

Review procedures following implementation of Care Act – Pan London procedures published Feb 2016 – local guidance to be produced Spring 2016

Roll out MCA training across trust, audit due Spring 2016

8. Patient Safety
- Safeguarding Children

Division	No. requiring training	No of staff compliant	compliant %
Children and Women's Diagnostic and Therapy Services	615	503	83%
Community Services	124	99	80%
Corporate	3	3	100%
Medicine and Cardiovascular	189	150	76%
Surgery & Neurosciences	27	26	81%
Total	**958**	**781**	81%

Training : The Safeguarding Children team are continuing to take an in-depth look at the level 3 training figures on ARIS. It remains evident that staff who are known to be compliant are not recorded as such on ARIS. The safeguarding team are working with the MAST team re correcting the data and ensuring that staff are allocated to the appropriate level of training. The latter in conjunction with department leads and HR.

Serious Case Reviews and Internal Management Reviews: Potential SCR for a Croydon child who is currently an inpatient on a paediatric ward.

Other: The Section 11 audit was completed, the results were positive. An electronic survey (Survey Monkey) was piloted successfully. The plan is to use this format again for 2017 with the aim of reaching much larger staff groups.

Multiagency MASH audit has been completed, awaiting outcome.

The restructure review continues and is led by the Chief Nurse.

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Patient Experience

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9. Patient Experience
- Friends and Family Test

Service	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average
Community Services	81% n=539	96% n=565 ^	90% n=284 v	87% n=353 v	86% n=401 v	87% n=430 ^	94% n=1213 ^	94% n=1337 –	93% n=536 v	94% n=392 ^	96% n=385 ^	94% n=327 v	91% n=6762
Medicine and Cardiovascular	95% n=808	94% n=837 v	94% n=872 –	94% n=752 –	96% n=580 ^	93% n=628 v	95% n=555 ^	95% n=649 –	96% n=513 ^	96% n=591 –	97% n=579 ^	95% n=520 v	95% n=7884
Surgery Anaethetics and Neuro	94% n=1016	96% n=1152 ^	95% n=1098 v	93% n=986 v	90% n=767 v	88% n=736 v	92% n=787 ^	90% n=709 v	91% n=642 ^	92% n=677 ^	90% n=598 v	93% n=641 ^	92% n=9809
Women and Childrens	88% n=480	92% n=474 ^	95% n=584 ^	93% n=567 v	93% n=498 –	93% n=429 –	93% n=480 –	93% n=397 –	91% n=336 v	92% n=273 ^	93% n=249 ^	91% n=278 v	92% n=5045
Trust	**87% n=2843**	**95% n=3028 ^**	**94% n=2838 v**	**93% n=2658 v**	**92% n=2246 v**	**90% n=2223 v**	**93% n=3035 ^**	**93% n=3092 –**	**93% n=2027 –**	**93% n=1933 –**	**94% n=1811 ^**	**93% n=1766 v**	**93% n=29500**

Our Friends and Family Test scores (the percentage of people who said they were “Extremely likely” or “Likely” to recommend a service to friends or relatives) are reported above by division.

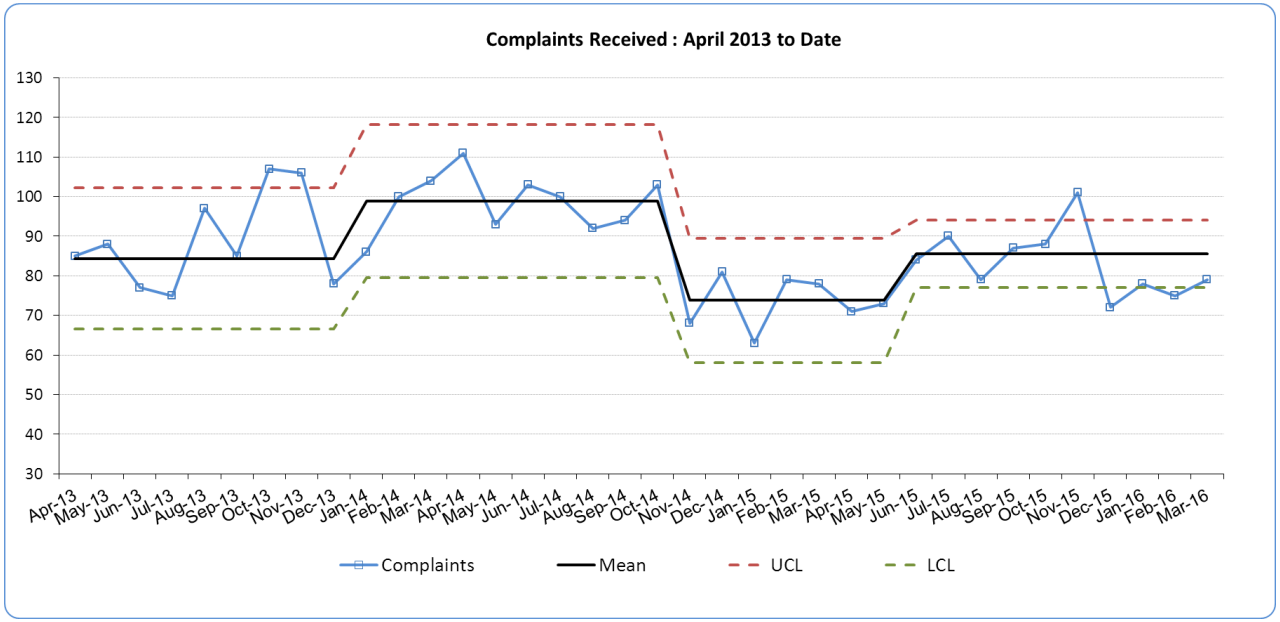
This report draws data from all patient surveys conducted on the RaTE system; including accessible versions that were created for any patient or relative that would have trouble understanding the standardised survey question.

Further breakdowns are available for services and location type.

Outpatient based services underperforms all other settings in the Trust, while Critical Care and Day case services are scoring the highest.

9. Patient Experience
- Complaints Received

Complaints Received															
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Movement
Total Number received	63	79	78	71	72	84	90	79	86	88	102	72	78	74	79	▲



Overview:

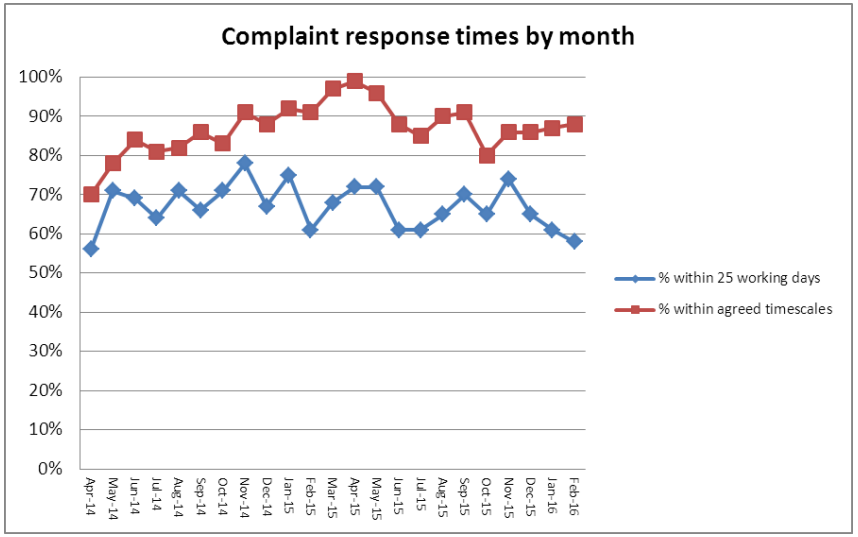
This report provides a brief update on complaints received since the last board report and information on responding to complaints within the specified timeframes for complaints received in February of 2015/2016. It also includes and update on Ombudsman referrals for the trust and some posts made on NHS Choices and Patient Opinion. The board will receive more detailed information about complaints received in quarter 4 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 4 is reached (so June 2016).

Total numbers of complaints received in March 2016

There were 79 complaints received in March of 2016, not a significant change when compared to the previous three months. The number of complaints received about the Accident and Emergency Care Group remained steady but high (9) with the top subjects being clinical treatment – diagnosis and communication. There were 4 complaints received about the Neurosurgery Care Group. Subjects were communication, information and clinical treatment. Complaints about the Obstetrics and Gynaecology Care Group remained high (8) with the majority (7) being about the Gynaecology Speciality across a number of subjects including verbal communication (around the scheduling of appointments/operations), clinical treatment and cancellation of operation.

9. Patient Experience
- Complaints Performance against targets

Performance Against Targets February 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	21	9	43%	(10) 95%
Medicine and Cardiovascular	20	12	60%	(8) 100%
Surgery & Neurosciences	22	15	68%	(2) 77%
Community Services	6	3	50%	(1) 67%
Corporate Directorates	5	4	80%	(1) 100%
Totals:	74	43	58%	(22) 88%



Commentary:
There was a further decline in performance against the first target in February 2016 when compared to January 2016. 58% of complaints were responded to within 25 working days (against the internal trust target of 85%) compared to 62% in quarter 2. Performance against the second target did not change significantly with 88% of complaints responded to within agreed timescales (against internal trust target of 100%).

Estates and Facilities Directorate was the only area which reached both targets. Children's and Women's and Medicine and Cardiovascular Divisions both improved on the second target and in Medicine and Cardiovascular 100% of complaint responses were sent out within agreed timescales.

Action plans have been in place in consistently poorly performing divisions for a period of time to improve and to deliver performance against internal standards but clearly have not achieved the impact required. A root and branch review of the Complaints process will now be undertaken to drive improvements focussing on both the local management of complaints , the process for responding to formal complaints and finally strengthening the learning from complaints, the final element has been identified as a voluntary indicator for the Quality account in 2016/17.

9. Patient Experience

- Ombudsman update & Service User comments posted on NHS Choices and Patient Opinion

Overview

In quarter 3, as in the previous quarter, St George's University Hospitals NHS Foundation Trust had a low number of referrals to the Parliamentary and Health Service Ombudsman (14). Two complaints were accepted for investigation and no complaints were upheld. The national average percentage for complaints accepted being upheld was 48%.

Below you can see how we compare to other London trusts.

Trust	Received by Ombudsman	Accepted for investigation	Fully or partially upheld
St George's	14	2	0
UCLH	25	2	1
Whittington	38	3	0
Royal Free	47	2	6
Bart's	49	13	5
Croydon	19	2	2
Guy's	27	2	0
Imperial	29	6	2

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. Below are some examples of comments/stories posted on NHS Choices and Patient Opinion since the last board report.

Anonymous gave Dentistry and Orthodontics at St George's Hospital (London) a rating of 5 stars

Maxillofacial Unit

Second time here and nothing has changed. The staff are without exception all absolutely outstanding. I lose my phobia of dentists here due to the calm professionalism of everyone; the member of staff who carried out the assessment explained everything really well and clearly giving me the information I needed to choose for example if I wanted to be sedated. The xray person was the same really calm and professional and clear. Last time I had a tooth extraction here it was so painless I didn't even realise it had been done and I have an incredibly low pain threshold. Wouldn't hesitate to highly recommend.

Visited in March 2016. Posted on 30 March 2016

Kate Mary gave Orthopaedics at St George's Hospital (London) a rating of 1 stars

Trauma & Orthopaedics Dept

I attended this dept on March 12th after a 40 minute taxi journey but then had to wait an hour and a half to see the doctor because my notes were 'lost'. A nice helpful member of staff was trying to help and told me that people were looking for them. They were found eventually and I think the member of staff said that they were on the reception desk under a pile of files and stuff. I was not happy.

Visited in March 2016. Posted on 14 March 2016

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NHS Foundation Trust

WORKFORCE

Excellence in specialist and community healthcare

10. Workforce: March 2016
- 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 March 2016. 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 March the Trust achieved an average fill rate of 94.14%, an improvement from 93.92% submitted in February. Data cleansing continues to ensure that the report is being run consistently and only relevant front line nursing roles are included. It is thought that this and a better fill rate overall has improved the March position.

Month	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Overall Fill Rate	94.4%	93.99%	95%	94.33%	93.92%	94.14%

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

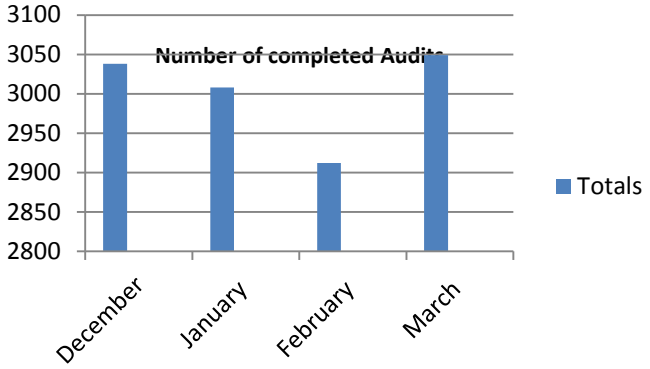
Nurses, midwives and care staff work as part of a wider multidisciplinary ward team. The demand on wards can change quickly and it will always be a clinical judgement as to whether to bring more staff in or reduce the amount the staff as per requirement.

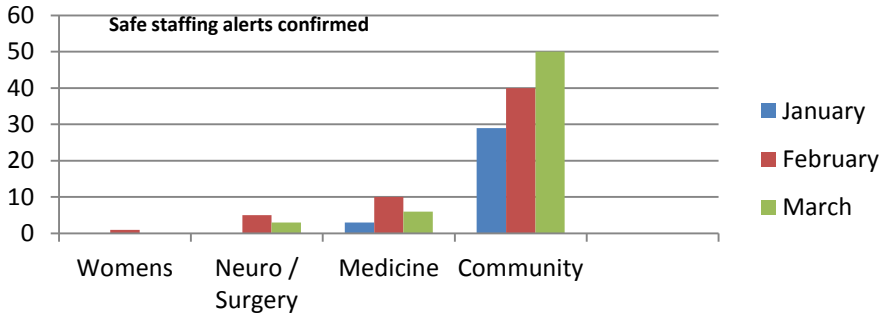
- The data does not take into account the on-going considerations for ward managers in ensuring that on each shift there is the right level of experience and expertise in the ward team.
- The nature of each ward varies. The number and type of patients seen on some wards will be relatively consistent. The number and type of patients seen on other wards will vary more dramatically, meaning that there could be greater change from the planned level and the average will be somewhere in the middle of the highs and lows of this variation.
- There needs to be the operational context of the reasons for staffing levels month on month, for example reduced demand.
- Higher than 100% fill rates relate to areas which require more staff than they are profiled for. This could be because the patients the team are looking after are exceptionally unwell or require one to one nursing or supervision called specialing.
- Lastly 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 Division of Medicine and Cardiac has carried out a review of its vacancies, triangulated with quality indicators and is taking forward a range of actions to improve staffing on the ward. Going forward Divisions have been asked to carry out a similar review of their staffing situation.
- The Trust wide Nursing/ Midwifery Workforce programme, chaired by the Chief Nurse continues including work-streams for recruitment, retention, temporary staffing, marketing and forward planning. Colleagues from HR, Finance and Divisional representation support the delivery of the programmes of work. the progress of this programme of work is reported to the Workforce and Education committee.

10. Workforce
- 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: January 3008, February 2912 and March 3049. There was a slight increase in the number of final alerts reported from 56 in February to 59 in March 2016. 50 of the alerts relate to community services. There remains an issue in staffing the tissue viability service which will remain a significant risk for another month. One new member of staff is expected to commence in post. Community services have a robust recruitment plan, unfortunately there are not enough nurses currently available to work in this area. The number of alerts reduced to a concern (ward is safely staffed but some care needs will not be completed) following on the day investigation over the post three months is January 18, February 33 and March 13. Of 3 nursing related safe staffing concerns raised on Datix system in March (reduced from 9 in February) none matched a similar entry on the RATE system.

MONTH	APR 15	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR 16
ALERTS	10	11	5	2	12	27	9	10	35	29	56	59
CONCERNS	15	18	16	17	24	14	37	13	10	18	33	13

Actions: Continue to raise the link between datix and the rate system with the nursing body with the aim to achieve greater consistency.
Risk: Retention is impacting on safe staffing as is the lack of registered nurses on the staff bank available to fill vacancies.

10. Workforce March 2016
- Safe Staffing profile for Inpatient areas

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	94.2%	#DIV/0!	99.4%	169.2%
Carmen Suite	130.9%	67.2%	99.3%	86.2%
Champneys Ward	104.6%	113.0%	101.1%	100.0%
Delivery Suite	104.0%	66.8%	107.5%	96.7%
Fred Hewitt Ward	93.7%	107.1%	96.8%	94.1%
General Intensive Care Unit	96.0%	74.7%	99.8%	79.7%
Gwillim Ward	112.4%	55.6%	99.5%	85.0%
Jungle Ward	100.1%	0.0%	#DIV/0!	#DIV/0!
Neo Natal Unit	87.8%	#DIV/0!	95.2%	#DIV/0!
Neuro Intensive Care Unit	94.4%	75.7%	97.8%	78.3%
Nicholls Ward	90.6%	87.2%	98.0%	44.4%
Paediatric Intensive Care Unit	94.6%	96.3%	97.0%	100.0%
Pinckney Ward	112.8%	64.3%	98.1%	#DIV/0!
Dalby Ward	96.5%	110.6%	99.9%	99.2%
Heberden	83.1%	102.2%	100.0%	100.0%
Mary Seacole Ward	95.5%	100.0%	98.4%	99.4%
A & E Department	93.4%	67.3%	102.2%	69.7%
Allingham Ward	87.1%	116.3%	99.1%	99.0%
Amyand Ward	80.3%	103.1%	97.5%	99.0%
Belgrave Ward AMW	94.3%	94.8%	99.4%	98.1%
Benjamin Weir Ward AMW	88.1%	74.5%	98.6%	95.9%
Buckland Ward	83.9%	57.5%	98.9%	93.8%
Caroline Ward	87.5%	79.7%	97.6%	#DIV/0!
Cheselden Ward	91.8%	110.2%	98.9%	97.7%
Coronary Care Unit	97.7%	#DIV/0!	102.1%	#DIV/0!
James Hope Ward	82.2%	90.9%	94.8%	#DIV/0!
Marnham Ward	85.7%	92.4%	96.3%	97.5%
McEntee Ward	90.1%	105.4%	99.4%	100.0%
Richmond Ward	88.8%	97.5%	97.1%	97.7%
Rodney Smith Med Ward	90.0%	94.2%	100.0%	98.9%
Ruth Myles Ward	107.7%	105.0%	100.0%	92.6%
Trevor Howell Ward	97.4%	121.8%	108.1%	75.7%
Winter Ward (Caesar Hawkins)	84.7%	102.1%	99.3%	96.7%
Brodie Ward	89.7%	89.1%	96.5%	98.4%
Cavell Surg Ward	78.7%	85.8%	97.7%	100.0%
Florence Nightingale Ward	91.2%	71.2%	99.9%	#DIV/0!
Gray Ward	83.3%	67.8%	99.9%	92.2%
Gunning Ward	89.6%	91.8%	100.0%	98.4%
Gwynne Holford Ward	87.3%	86.7%	92.8%	100.8%
Holdsworth Ward	89.1%	82.8%	100.0%	95.9%
Keate Ward	95.3%	75.5%	100.0%	100.0%
Kent Ward	85.2%	88.2%	99.1%	98.5%
Mckissock Ward	88.5%	98.3%	96.5%	96.7%
Vernon Ward	81.0%	84.8%	99.1%	100.0%
William Drummond HASU	86.5%	90.4%	92.6%	98.6%
Wolfson Centre	79.9%	100.6%	94.8%	104.3%
Gordon Smith Ward	84.5%	86.2%	100.0%	93.9%
Trust Total	91.73%	91.09%	98.84%	95.31%

Day Qual	Day HCA	Night Qual	Night HCA
91.73%	91.09%	98.84%	95.31%

Safe staffing Community Nursing Report

Service	Nov-15 Concerns	Nov-15 Alerts	Dec-15 Concerns	Dec-15 Alerts	Jan-16 Concerns	Jan-16 Alerts	Feb-16 Concerns	Feb-16 Alerts	Mar-16 Concerns	Mar-16 Alerts	Total Concerns	Total Alerts
Community District Nursing - North	1	0	0	1	0	0	0	0	0	0	1	1
Community Nursing Doddington	1	0	0	0	1	0	0	0	0	0	2	0
Community Nursing East 1 - Brocklebank	15	3	18	2	17	2	17	4	4	6	71	17
Community Nursing East 2 - Southfields and Tudor Lodge	7	1	11	2	13	0	9	0	4	2	44	5
Community Nursing North 1 - Stormont	5	0	0	0	0	2	0	0	7	2	12	4
Community Nursing North 2 - Bridge Lane and Doddington	0	0	0	0	0	0	0	0	0	2	0	2
Community Nursing North 3 - Chatfield	1	0	0	0	1	0	0	0	1	2	3	2
Community Nursing South 1 - Tooting	1	0	2	0	8	4	5	3	6	0	22	7
Community Nursing South 2 - Greyswood	11	1	5	5	4	3	2	0	3	1	25	10
Community Nursing South 3 - Balham	5	2	1	0	4	1	2	0	2	3	14	6
Community Nursing Tudor Lodge	12	3	9	2	7	7	11	5	1	0	40	17
Community Nursing West 1 - Westmoor	2	1	2	6	12	0	6	2	4	6	26	15
Community Nursing West 2 - Eileen Lecky	3	0	4	2	5	0	9	3	6	2	27	7
Diabetes Specialist Nurses	4	0	4	0	3	0	11	2	1	0	23	2
Total	68	11	56	20	75	19	72	19				95

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HEATMAP DASHBOARD
WARD VIEW

Excellence in specialist and community healthcare

March 2016

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	Ward staffing: unfilled duty hours	Falls (ward level)	Serious incidents (ward level)	Sickness/ absence rate - (ward)
COMMUNITY SERVICES	Mary Seacole	0.0	0.0	0.0	68.2	100.0	47.4	4.7	10.0	0.0	5.8
	Nightingale	0.0	0.0	0.0			15.4		7.0	0.0	2.0
	Rehab at St Johns day hospital	0.0	0.0	0.0					1.0	0.0	
MEDICINE	ALLINGHAM	0.0	0.0	0.0	100.0	91.3	35.4	-2.5	6.0	1.0	13.3
	AMYAND	0.0	0.0	0.0	89.5	100.0	8.7	2.7	4.0	0.0	5.6
	BELGRAVE	0.0	0.0	0.0	100.0	91.7	26.9	4.3	4.0	0.0	0.5
	BENJAMIN WEIR	0.0	0.0	0.0	100.0	94.4	47.4	11.3	3.0	0.0	1.1
	BUCKLAND	0.0	0.0	0.0	95.0	100.0	55.6	-4.6	2.0	0.0	0.1
	CAESAR HAWKINS	0.0	0.0	0.0	91.3	63.6	14.5	7.1	15.0	0.0	5.8
	CARDIAC CARE UNIT	0.0	0.0	0.0	100.0	94.1		10.3	0.0	1.0	1.8
	CAROLINE	0.0	0.0	0.0	100.0	95.1	40.4	12.9	1.0	0.0	1.1
	CHESELDEN	0.0	0.0	0.0	95.5	97.0	58.5	8.5	3.0	0.0	0.2
	DALBY	0.0	0.0	0.0	79.2	87.5	53.3	3.8	10.0	1.0	4.6
	EMERGENCY DEPARTMENT	0.0	0.0	0.0				2.3	3.0	0.0	3.7
	GORDON SMITH	0.0	0.0	0.0	88.9	100.0	31.4	10.8	3.0	1.0	2.4
	HEBERDEN	0.0	0.0	0.0	91.3	100.0	40.5	2.5	6.0	0.0	0.8
	JAMES HOPE	0.0	0.0	0.0			0.0	16.6	0.0	0.0	0.7
	MARNHAM	0.0	0.0	0.0	92.3	100.0	29.4	13.9	3.0	0.0	7.1
	MCENTEE	0.0	0.0	0.0	90.0	100.0	37.8	2.1	3.0	0.0	0.8
	RICHMOND	0.0	0.0	0.0	96.4	90.5	15.9	8.7	9.0	0.0	4.5
	RODNEY SMITH	0.0	0.0	0.0	85.7	95.5	47.8	4.6	3.0	0.0	5.2
	RUTH MYLES DAY UNIT	0.0	0.0	0.0	81.8	94.4	69.2	6.7	0.0	0.0	7.3
	TREVOR HOWELL	0.0	0.0	0.0	100.0	96.6	51.8	3.9	1.0	0.0	4.2

March 2016

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	Ward staffing: unfilled duty hours	Falls (ward level)	Serious incidents (ward level)	Sickness/ absence rate - (ward)
SURGERY	CAVELL	0.0	0.0	0.0	100.0	69.9	33.8	5.9	2.0	0.0	7.1
	FLORENCE NIGHTINGALE	1.0	0.0	0.0	100.0	98.2	88.1	-0.5	1.0	0.0	4.4
	GRAY WARD	0.0	0.0	0.0	96.3	91.0	68.7	16.0	2.0	0.0	2.3
	GUNNING	0.0	0.0	0.0	100.0	94.6	75.0	2.1	4.0	0.0	1.5
	GWYN HOLFORD	0.0	0.0	0.0	97.6	50.0	15.4	10.1	12.0	0.0	6.3
	HOLDSWORTH	0.0	0.0	0.0	95.6	97.2	81.8	2.1	5.0	0.0	4.1
	KEATE	0.0	0.0	0.0	100.0	100.0	64.6	16.1	1.0	0.0	4.7
	KENT	0.0	0.0	0.0	93.1	90.9	12.9	6.3	9.0	0.0	0.5
	MCKISSOCK	0.0	0.0	0.0	100.0	88.9	39.7	7.7	3.0	0.0	8.9
	THOMAS YOUNG	0.0	0.0	0.0	95.8	100.0	24.1	9.5	5.0	0.0	1.1
	VERNON	0.0	0.0	0.0	100.0	91.4	32.1	8.4	0.0	0.0	3.4
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	95.2	100.0	36.2	12.9	3.0	0.0	3.6
WOMEN & CHILDREN	CARDIOTHORACIC INTENSIV..	0.0	0.0	0.0	88.9		100.0	6.1	1.0	0.0	3.6
	CARMEN SUITE	0.0	0.0	0.0	100.0			-6.2	0.0	0.0	1.2
	CHAMPNEYS	0.0	0.0	0.0	100.0	71.4	8.0	-2.0	1.0	0.0	7.9
	DELIVERY	0.0	0.0	0.0	100.0	96.8		-3.1	0.0	1.0	5.5
	FREDDIE HEWITT	0.0	0.0	0.0			0.0	8.6	1.0	0.0	12.7
	GENERAL ICU/HDU	0.0	0.0	0.0	100.0			4.6	0.0	0.0	3.1
	GWILLIM	0.0	0.0	0.0	100.0	89.6		6.2	1.0	0.0	4.7
	JUNGLE	0.0	0.0	0.0			4.5	-1.8	0.0	0.0	0.3
	NEONATAL ICU	0.0	0.0	0.0	100.0		0.0	7.1	0.0	0.0	4.0
	NEURO ICU	0.0	0.0	0.0	84.6			5.6	0.0	1.0	1.2
	NICHOLLS	0.0	0.0	0.0		90.9	181.8	11.5	0.0	0.0	7.3
	PICU	0.0	0.0	0.0		90.9		6.0	0.0	1.0	5.1
	PINCKNEY	0.0	0.0	0.0			0.0	-2.1	0.0	0.0	3.6

11. Ward Heatmaps: CWDT

Cardiothoracic Intensive Care (CTICU)
There is a discrepancy between the heatmap and the safety thermometer report this month; with the heatmap reporting 88.9% and the safety thermometer report suggesting no data was submitted. This discrepancy has been resolved and the actual score for this metric was 100% in CTICU

Neuro Intensive Care (NICU)
The score of 84.6% relates to one patient with new grade 2 pressure ulcer.

Sickness
The staff sickness profile across the division remains fairly consistent with the exception of Freddie Hewitt ward who this month have seen an increase to 12.7%. This relates to a mix of long and short term sickness. Bi – monthly divisional meetings commenced in March 2016 to support good rota and sickness management; this meeting is facilitated by the Divisional Director of Nursing and Governance (DDNG) with ward / department sisters and matrons attending.

Friends and Family
The Friends and Family metric remains challenging in terms of the accuracy of the metric reported on the heatmap and the departmental performance. The DDNG is working with the informatics team to rectify the issues with heatmap accuracy and the local teams are now focused on improving the returns and any technical issues that are affecting data capture.

Serious Incidents
There were a total of 3 serious incidents in this month, 1 on delivery suite that relates to an unexpected admission to NNU, 1 on NICU that relates to the maternal death of a patient; this is mandated reporting and 1 on PICU relating to a safeguarding case. All incidents are currently being investigated and the learning will be fed back via the divisional governance board.

11. Ward Heatmap: MCT Division

Allingham

Falls: The ward has 6 falls that were reported in month. This has been a reduction month on month since December. These falls were low or no harm falls and 2 relate to a patient that fell twice and was specialed, 2 also relate to assisted falls.

- Serious Incidents: x 1 Patient had fall and fracture neck femur in December 2015, report completed and no learning evidenced from this
- Sickness: 4 members of staff on long term sickness,2 now returned and 2 being managed and in line with policy

C Hawkins

- FFT : The ward has shown a dip from Feb when they had 46% feedback, they are reminding the discharge and coordinator every morning to complete these as part of the board round.
- Falls – These relate to 2 patients who had multiple falls, with low and no harm. The Matron is currently reviewing all the falls to see if there is any patterns.

McEntee

- Falls: Relate to one patient who due to their clinical condition was at risk, this was managed appropriately and the patient responded.

Marnham

- Unfilled Duties: The ward managed staff across the unit and division to manage this as required.
- Falls: These falls are 3 separate patients and relate to no low harm

Rodney Smith

- Sickness is being managed with the support of HR with 1 member of staff on stage 3 and 1 on stage 1.
- Falls: 3 falls in month which were all low harm falls,

Amyand:-

- Sickness is being managed with the support of HR and includes – a LT/ST does not trigger at present
- Harm Free Care – This reduced score relates to 2 patients who had old pressure ulcers on assessment

Heberden:-

- Falls – These falls were low/no harm falls, with 3 relating to 1 patient.

Dalby:-

- Harm Free Care – This score relates to two old pressure ulcers, 2 patients with catheters/old UTI and 1 new grade 3 pressure ulcer which following assessment was deemed as unavoidable.
- Falls – The ward currently review high risk patients daily and assess the need for additional support. Matron and Ward sister reviewing documentation and falls trends.
- Serious Incident: This incident is currently being investigated by estates and relates to heating on the unit

11. Heatmap: MCT Continued

Ben Weir – Unfilled hours are due to high vacancy levels on the ward, staffing across CVT & CAG is a reviewed daily and staff moved to ensure safety. There have been 3 falls of low or no harm, all of which are being reviewed and have been managed appropriately.

Belgrave – There have been 4 falls in month all of which low or no harm, these have all been investigated and managed appropriately.

CCU – Unfilled hours are high, is due to a high band 5 vacancy rate. Recruitment to these posts is in place. Staffing is reviewed daily and staff moved where appropriate, there have been no alerts raised in month for CCU. There has been an SI declared relating to a procedure a patient underwent. This is currently being investigated

Caroline – Unfilled hours are high, this is due to vacant shifts not being filled and the high number of vacancies. Staffing is reviewed daily to ensure safety across all of our ward, there have been no staffing alerts. Recruitment is ongoing and there is an improving picture for Caroline ward as we have recruited to the majority of vacant posts.

Cheselden – There have been3 falls in month all of which are low/no harm , these have been investigated and managed appropriately.

James Hope – Unfilled hours high due to vacancy and shifts not being filled, this has not impacted upon the provision of a safe service. Friend and family has been collected but is recorded as Charles Pumphrey unit following the relocation of this unit.

Ruth Myles - The red for percentage of harm free care is - 1 x grade 3(old) and 1 x grade 2 Pressure ulcer (new) on the same long term patient. The ward has had increased level of short term sickness which is being appropriately managed.

Gordon Smith - Red for percentage of harm free care - 1 x grade 2 (new), 2 x catheters clinically needed, VTE's 38% & 61% started appropriate treatment. This has been discussed with medical team and escalated to care group leads.

Trevor Howell - VTE's 68% & 84% started appropriate treatment, this has been discussed with medical team and escalated to care group leads. 1 long term sick leave which is being managed in line with policy and HR support.

11. 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 relate to falls, sickness and ward staffing: unfilled duty hours. The areas where there have been improvements in performance are FFT satisfaction, FFT response rate, zero incidences of trust acquired pressure ulcers and zero incidents of MRSA.

There are 21 red alerts for March 2016 compared to 25 for the previous reporting period. However it should be noted that Brodie ward's data is not included in this report as there was no information on the scorecard report. It should also be noted that 2 out of the 21 red alerts are incorrect and relate to falls. The threshold for falls is incorrect for Gunning and Thomas Young wards

There is also a decrease in the overall number of alerts from 32 to 23, however again it should be noted Brodie ward's data is missing from this report, as well as the incorrect threshold for falls for 2 red indicators described above; therefore is difficult to monitor the alert trend for this period.

Cavell - 1 red indicator. This relates to sickness absence of 7.1%. 2 staff members were on long term sickness and there was one episode of short term sickness, all absences were managed as per trust policy.

Florence Nightingale – 2 red indicators. The first red indicator relates to an episode of C/Difficle. The RCA was completed and no learning was required as all medications and management of this patient was correct. The second red indicator related to sickness absence of 4.4%. This is due to one member of staff on long term sickness and one member of staff on special leave for one week. The sickness absence has been managed to trust policy.

Gunning – 1 red indicator relating to 4 falls. This amount of falls should not have triggered as the quota set for this ward is 4 per month. All falls were low harm.

Holdsworth –2 red indicators. The first red indicator was due to sickness of 4.1%. One staff member was on long term sickness and there was one episode of short-term sickness, both were managed to trust policy. One member of staff is also currently on maternity leave

The second red indicator is related to 5 falls. All falls were low harm and one patient fell twice

Keate- 2 red indicators. The first red indicator is related to unfiled duty hours of 16.1%. There are currently 4 vacancies, 1 staff member on maternity leave as well as a staff member on long term sickness. These duties were not fully filled by bank or agency.

The second red indicator is due to sickness absence of 4.7%. One staff member was on long term sickness (managed to trust policy) and one staff member was on maternity leave.

Gray- 1 red indicator due to 16% unfilled hours as vacant duties were not filled by bank or agency. A recruitment plan is in place and surgical rotations will commence in June 2016.

Vernon-No red indicators

11. Heatmap: STNC Division continued

Kent – 2 red indicators. The red indicator related to 9 falls. 8 falls were no harm and one fall was low harm.

The second red indicator related to FFT response rate of 12.9%. Staff have been reminded to capture data from friends and family of patient users on Kent ward. There will be on-going focused efforts to increase the response rate during April 2016. There have been no technical issues to explain non -compliance to discharge process.

1 amber indicator is related to Harm Free Care of 93.1%. This score was due to one fall within 72 hours and one acquired catheter associated infection.

William Drummond- 3 red indicators. The first red indicator relates to unfilled duty rate of 12.9%. These are unfilled bank and agency shifts; and staff moved from William Drummond to supplement staffing within neurosciences. WD had a band 5 vacancy factor of over 30% in March 2016 and is currently at 33% in April 2016 which will increase at the end of April with further resignations. Neurosciences have a robust recruitment plan to fill the band 5 vacancies.

The second red indicator related to 3 falls on William Drummond. All falls were low harm.

The third indicator is for sickness absence of 3.6 %. This related to one long term sickness episode; the employee has returned to work and some short term sickness absence. Sickness and absence is being proactively managed as per trust policy.

Thomas Young- 1 red indicator and 1 amber indicator. The red indicator relates to 5 falls. This data should be green. Current combined threshold is 11 (Brodie Stroke- 4, Thomas Young-7). All falls were no harm.

1 amber indicator related to FFT response rate of 24.1%. This relates to the patient cohort and did show a sustained improvement from January 2016 (there was no scorecard data for February 2016). Staff have been reminded to capture data from friends and family of patient users on Thomas Young ward. There will be on-going focused efforts to increase the response rate during April 2016. There have been no technical issues to explain non -compliance to discharge process

Gwynne Holford- 4 red indicators**.** FF response 15.4%. Problems with tablet ward level records show that only one patient was missed. The second red indicator was due to unfilled duties of 10.15%, G/Holford has a vacancy factor above 50%. Vacant duties not filled by bank and agency. The third red indicator was due to 12 falls; one patient fell 4 times, 2 falls were low harm and one related to a patient having seizure and had to be admitted for monitoring to another hospital. The fourth red indicator was for sickness of 6.3%. Two staff was on long-term sickness. All sickness managed to trust policy.

Gray and Vernon wards have really improved in their scorecard results this month, and in particular Vernon ward as this is the first month in over a year when they have not had any red indicators. Thomas Young ward has continued its focus on Falls and sickness and have reduced both significantly

CSD scorecard March 2016

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
				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	1	3	1	1	0	0
Patient Safety	Number of SI's breached	Monthly	0	0	0	0	0	0	0	0	1	0	0	0	0
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly		1	0	0	0	1	2	1	1	0	1	0	0
Patient Safety	Grade 4 Pressure Ulcers	Monthly		0	0	0	0	0	0	0	0	1	1	0	0
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly		10	7	4	12	8	13	10	11	13	10	13	18
Patient Safety	Number of moderate falls	Monthly	0	2	1	0	1	0	0	0	2	1	0	0	0
Patient Safety	Number of major falls	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Safety	Number of falls resulting in death	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Safety	MRSA (cumulative)	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Safety	CDiff (cumulative)	Monthly	31	1	0	0	0	0	0	0	0	0	0	0	0
Patient Safety	CAS ALERTS - Number ongoing- received (Trust)	Monthly	0	2	2	2	2	2	2	2	2	2	2	2	2
Patient Safety	Number of Quality Alerts	Monthly		3	5	2	9	11	4	6	7	4	7	5	5
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	85%	89.0%	86%	85%	84%	81%	81%	77%	74%	70.0%	70.0%	68.0%	79%
Safeguarding	% of staff compliant with safeguarding childrens training	Monthly	Level 1 85%	90.0%	90.0%	85%	82%	79%	88%	89%	86%	85%	89%	79%	79%
			Level 2 85%	84.0%	84.0%	82%	82%	74%	66%	67%	63%	83%	80%	85%	92%
			Level 3 85%	69.0%	69.0%	82%	90.00%	70%	85%	87%	84%	84%	84%	80%	80%
Patient Outcomes	Mortality SHMI ratio (Trus)	Monthly	<100	0.86	0.86	0.86	0.86	0.86	0.9	0.9	0.9	0.9	0.9	0.9	0.9
Patient Experience	Active Claims	Monthly		0	0	1	3	1	0	1	0	0	0	1	0
Patient Experience	Number of Complaints received	Monthly		16	18	6	5	2	5	5	5	5	4	6	9
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%	85%	100%	100%	89%	100.0%	50% (3)	
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%	92%	100%		78%	100%	67% (1)	
	FFT Score (Mary Seacole and MIU)	Monthly Mary Seacole A		97.0%	94.7%	77.7%	71.0%	97.3%	84.2%	94.4%	94.4%	100%	90%	95%	95%
Patient Experience		Monthly Mary Seacole B		81.20%	90.90%	75.00%	95.40%	90.90%	75%	90%	94%		85%		
Patient Outcomes	Catheter related UTI (Trust)			1.14	0.66	1.12	1.32	1.50	1.03	0.67	0.96	0.47	0.46	0.90	0.90
	Number of new VTE (Trust)		National 0.005	0.53	0.37	0.15	0.08	0.24	0.17	0.30	0.48	1.01	0.00	0.23	0.08
Workforce	Number of DBS Request Made	Quarterly	annually	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	206
Workforce	Sickness Rate -	Monthly	3.50%	5.72%	6.04%	6.00%	4.69%	5.75%	5.53%	5.90%	5.71%	6.00%	6.50%	6.19%	4.70%
Workforce	Turnover Rate-	Monthly	13%	19.64%	19.94%	20.40%	20.08%	21.00%	21.15%	20.75%	20.76%	21.20%	20.80%	21.59%	20.50%
Workforce	Vacancy Rate-	Monthly	11%	19.41%	19.06%	19.40%	12.60%	13.42%	12.59%	15.67%	18.50%	19.40%	18.90%	18.70%	19.40%
Workforce	Appraisal Rates - Medical	Monthly	85%	66.67%	72.73%	69.57%	69.57%	84.00%	84.00%	79.41%	81.26%	87.10%	87.10%	83.87%	88.90%
Workforce	Appraisal Rates - Non-Medical	Monthly	85%	77.25%	76.80%	75.84%	75.42%	76.02%	68.22%	64.91%	62.92%	62.40%	63.20%	63.53%	63.20%

12. Community heat map
- CSD Exception Report

- No serious incidents for March 2016
- Falls incidents increased to 21 (6 Nightingale, 4 MSA, 5MSB no/low harm, 3 in patient homes)
- Quality alerts: 5 (3 QMH/Nelson: appointments) 2 Community nursing (phlebotomy, INR testing).
- Migration of community staff to St Georges IT server near complete.
- 2 complaints breached completion target in OHC due to written response not being received by complaints dept. in time for CEO sign off. Complaints increased to 9 March 2016 (6 OHC).
- Sickness reduced due to staff returning form long term sick
- Recruitment remains challenging esp. nursing. With closure of St Georges@ Nightingale staff have been relocated to MS ward resulting in 90% staffed compared to historic significant vacancy factor

REPORT TO THE TRUST BOARD *May 2016*

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 March 2016

The workforce performance report contains detail of workforce performance against key workforce performance indicators for March 2016. The report also includes available benchmark information.

Key points to note are:

- There has been some positive movement in all of the key indicators.
- Voluntary turnover has reduced by 0.7%.
- After a lengthy period at above average rates, sickness absence has reduced to 3.6%.
- The trust continues to benchmark reasonably well against similar London trusts for sickness absence and turnover.

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?**

<u>Commentary on performance in key workforce indicators</u>

Vacancy information

The overall number of staff in post have remained static and, although the vacancy factor has reduced this is largely due to adjustments in establishments within South West London Pathology.

Turnover

Voluntary turnover has reduced by 0.7% with nursing voluntary turnover reducing by 1%. However, voluntary turnover in the allied health professionals group remains high and is of continuing concern.

Acting up arrangements

Concerns have been raised by staff about acting up arrangements in place which are felt to be unfair and which do not follow policy. In response to these concerns managers have been requested to resolve all acting up arrangements that have lasted for more than 6 months by the end of July.

Sickness absence

After an unusually long period of above average sickness absence levels, rates have now returned to slightly above average. The main reason for absence remains colds, coughs, flu and influenza. The second major reason for numbers of days lost is anxiety/stress and depression.

The trust has been pleased to be given the opportunity to develop its wellbeing programme in response to the national CQUIN. The programme will include provision of fast track musculo-skeletal physiotherapy support for staff, support for physical activity through programmes such as global corporate challenge, which begins in May, and support for mental wellbeing through the staff support service and the mental health trust IAT programme.

Agency and bank staff usage

Temporary staffing levels continued to rise in March, particularly in nursing, as escalation areas have been open in response to winter pressures.

The trust is meeting its requirements to report breaches of the agency price cap on a weekly basis. New lower capped rates were introduced from 1st April which has led to an increased number of nursing and midwifery shifts breaching in the week commencing 28th March.

The trust is being supported by Monitor to undertake a 'deep dive' review into its management of agency staffing. It is understood that the trust benchmarks well against other similar organisations.

Mandatory training and appraisal rates

The deterioration in mandatory training compliance and rates has reversed and the trust is meeting its trajectory for improvement. The workforce and education committee considered the actions being taken to turnaround performance in mandatory training at its meeting in January. Resources have been reallocated to focus on ensuring well-defined training needs analysis, accurate and trusted monitoring of compliance and easy access to training.

Appraisal rates continue to deteriorate and a revised programme is now being introduced including briefing sessions for managers. There will be a detailed review of appraisal processes at the workforce and education committee meeting due to take place in May.

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St George's University Hospitals NHS
NHS Foundation Trust

Workforce Performance Report
to the Trust Board

Month 12 - March 2016

Excellence in specialist and community healthcare

Workforce Performance Report Apr ‘15 - Mar ‘16

Contents

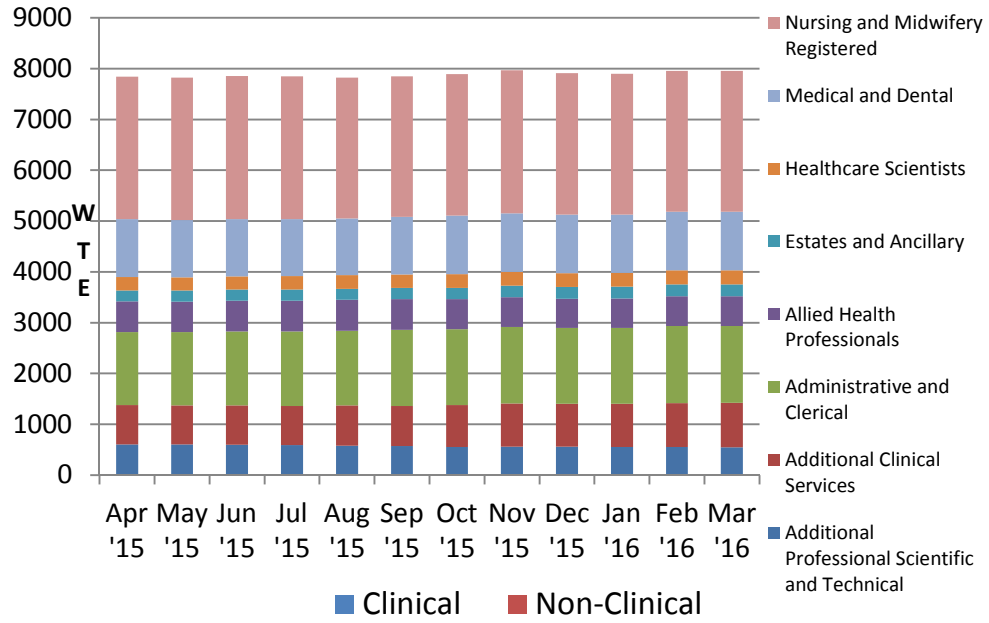
Performance Summary

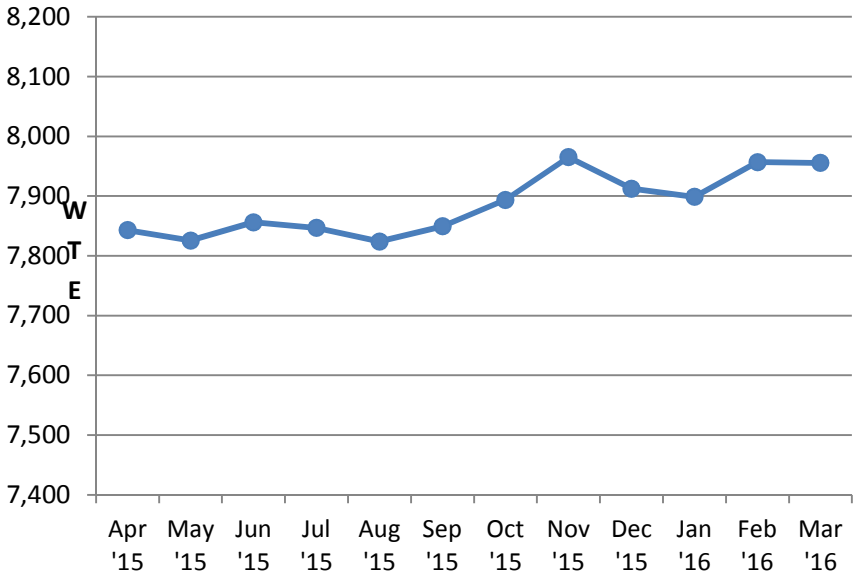
Summary of overall performance is set out below

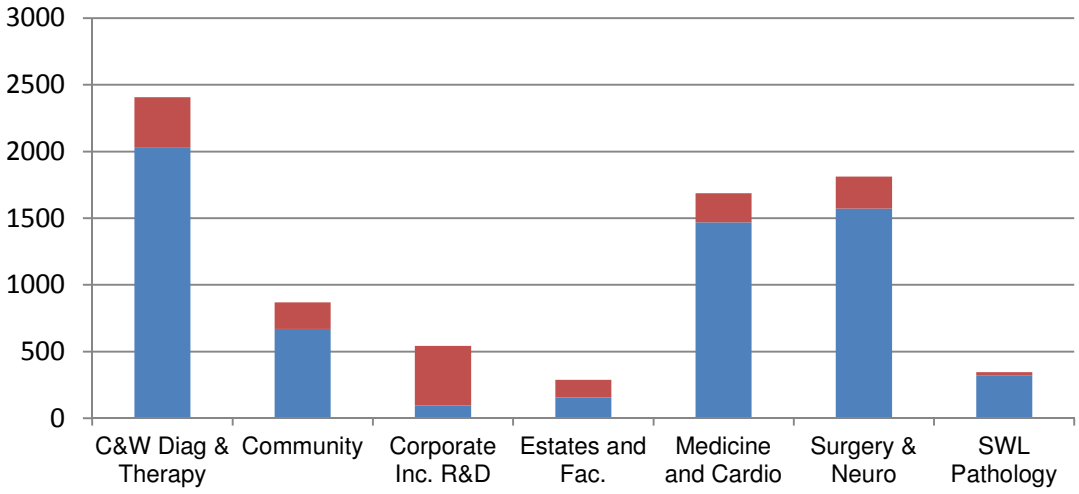
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has decreased by 0.5%	14.0%	17.0%	16.5%	↘
6	Turnover	Turnover has decreased by 0.6%	17.2%	18.5%	17.9%	↘
7	Voluntary Turnover	Voluntary turnover has decreased by 0.7%	13.9%	15.2%	14.5%	↘
8	Stability	Stability has increased by 0.3%	83.5%	82.1%	82.4%	↗
10	Sickness	Sickness has decreased by 0.7%	3.7%	4.3%	3.6%	↘
15	Temporary Staffing Usage (FTE)	Temporary Staffing Usage has increased by 0.4%	16.7%	15.7%	16.1%	↗
17	Mandatory Training	MAST compliance has increased by 6.6%	74.7%	70.2%	76.8%	↗
18	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has increased by 0.1%	75.9%	66.9%	67.0%	↗

Current Staffing Profile

The data below displays the current staffing profile of the Trust





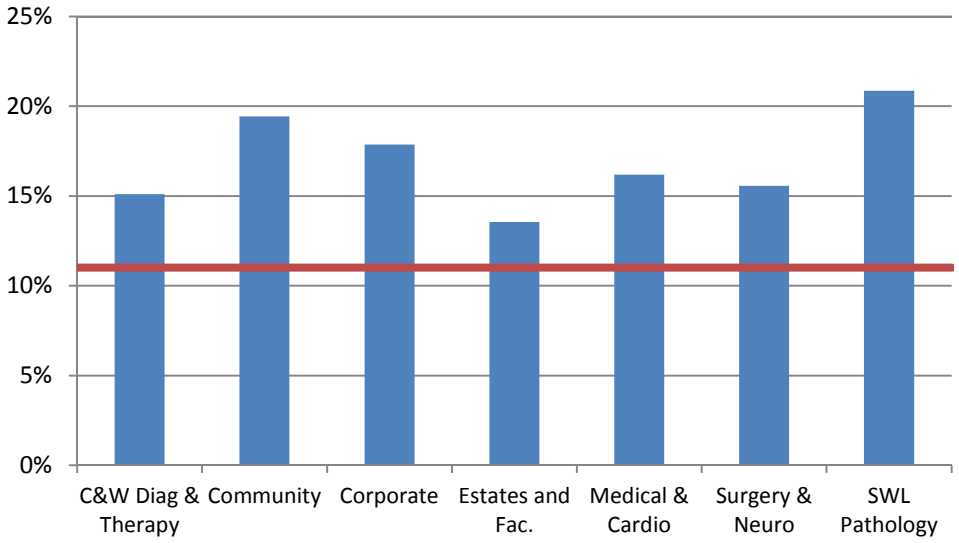


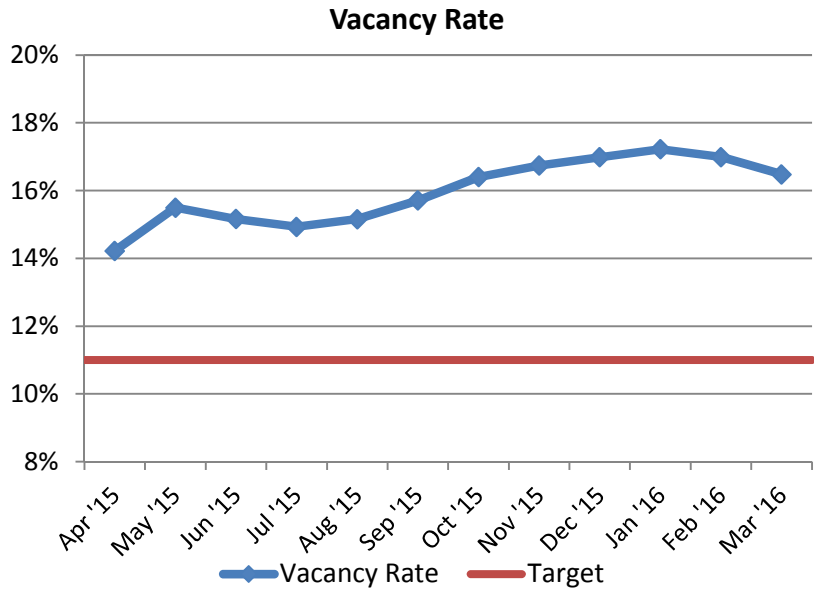
COMMENTARY

The Trust currently employs 8495 people working a whole time equivalent of 7956 which is 1 WTE fewer than February. The growth rate in the directly employed workforce since March 2015 is 113 WTE or 1.5%.

The Trust also employs an additional 456 WTE GP Trainees covering the South London area, which makes the total WTE 8412.

Section 1: Vacancies





Vacancies by Division	Dec '15	Jan '16	Feb '16	Mar '16	Trend
C&W Diag & Therapy	15.1%	16.0%	15.3%	15.1%	↘
Community	19.4%	18.9%	18.7%	19.4%	↗
Corporate	16.3%	16.9%	16.4%	17.9%	↗
Estates and Fac.	15.3%	14.3%	13.0%	13.5%	↗
Medical & Cardio	17.3%	16.7%	16.1%	16.2%	↗
Surgery & Neuro	15.9%	16.7%	14.8%	15.6%	↗
SWL Pathology	23.8%	25.4%	35.4%	20.9%	↘
Whole Trust	**17.0%**	**17.2%**	**17.0%**	**16.5%**	↘

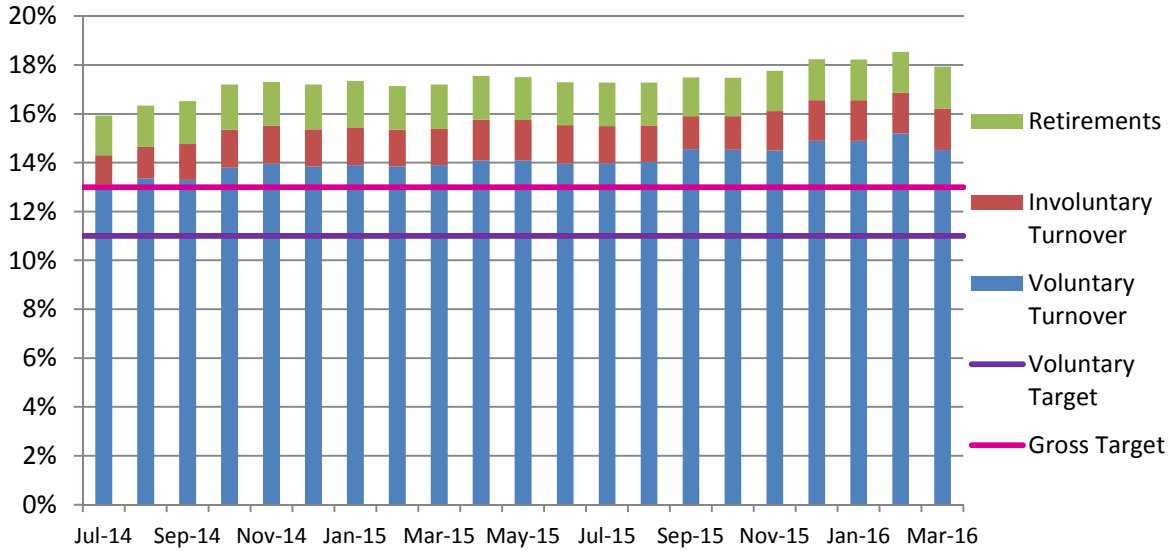
Vacancies Staff Group	Dec '15	Jan '16	Feb '16	Mar '16	Trend
Add Prof Scientific and Technic	23.9%	23.8%	20.4%	16.9%	↘
Additional Clinical Services	18.5%	19.4%	19.2%	12.8%	↘
Administrative and Clerical	18.7%	18.5%	16.4%	17.3%	↗
Allied Health Professionals	15.4%	15.3%	14.5%	14.4%	↘
Estates and Ancillary	15.8%	15.4%	13.8%	14.3%	↗
Healthcare Scientists	20.4%	20.5%	36.2%	35.3%	↘
Medical and Dental	5.7%	6.4%	5.7%	9.4%	↗
Nursing and Midwifery Registered	18.2%	18.5%	18.3%	17.9%	↘
Total	**17.0%**	**17.2%**	**17.0%**	**16.5%**	↘

COMMENTARY

The vacancy rate has decreased in March and is now 16.5%. Required adjustments to the establishment on ESR for SWL Pathology have affected the vacancy rate this month.

Section 2a: Gross Turnover

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



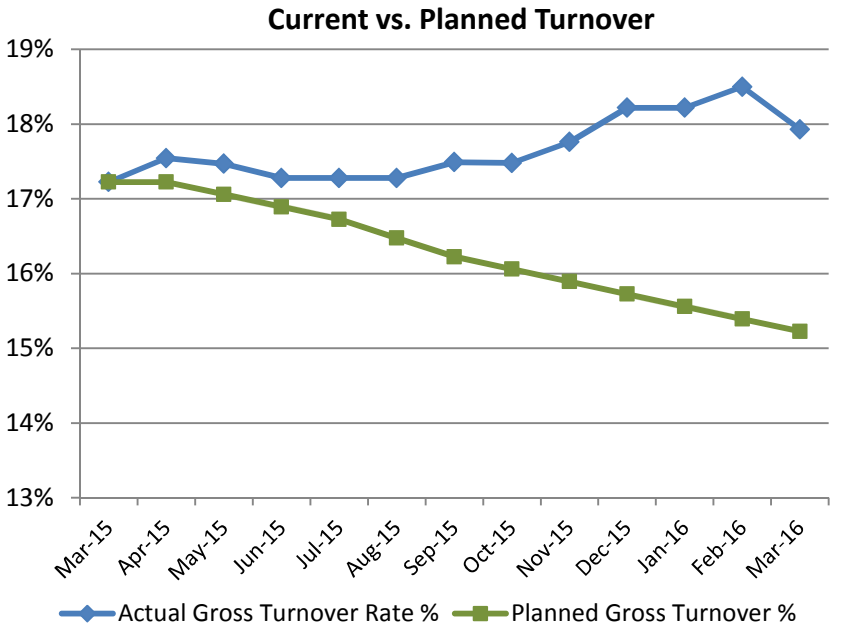
COMMENTARY

The total trust turnover rate has decreased this month to 17.9%. This is significantly above the current target of 13%. In the last 12 months there have been 1300 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	Dec '15	Jan '16	Feb '16	Mar '16	Trend
C&W Diagnostic & Therapy	19.3%	19.2%	19.3%	18.7%	↘
Community Services	21.2%	20.8%	21.6%	20.5%	↘
Corporate	21.1%	22.2%	22.3%	23.4%	↗
Estates and Facilities	15.9%	14.2%	14.5%	14.0%	↘
Medical & Cardiothoracics	19.3%	18.9%	18.9%	17.5%	↘
Surgery, Neurosciences & Anaes	13.9%	14.6%	15.1%	14.9%	↘
SWL Pathology	16.6%	17.2%	18.9%	17.7%	↘
Whole Trust	**18.2%**	**18.2%**	**18.5%**	**17.9%**	↘

	All Turnover				
Staff Group	Dec '15	Jan '16	Feb '16	Mar '16	Trend
Add Prof Scientific and Technic	21.3%	21.9%	21.5%	21.8%	↗
Additional Clinical Services	20.4%	20.6%	21.0%	18.4%	↘
Administrative and Clerical	17.7%	18.2%	18.2%	18.1%	↘
Allied Health Professionals	19.2%	19.7%	19.8%	19.8%	↔
Estates and Ancillary	8.0%	5.8%	6.1%	5.8%	↘
Healthcare Scientists	16.3%	16.5%	17.6%	17.9%	↗
Medical and Dental	11.8%	11.4%	11.1%	11.6%	↗
Nursing and Midwifery Registered	19.3%	18.9%	19.6%	18.7%	↘
Whole Trust	**18.2%**	**18.2%**	**18.5%**	**17.9%**	↘



Section 2b: Voluntary Turnover

	Voluntary Turnover					Other Turnover MAR 2016	
Division	Dec '15	Jan '16	Feb '16	Mar '16	Trend	In-Voluntary	Retirement
C&W Diagnostic & Therapy	15.9%	16.0%	16.1%	15.5%		2.0%	1.3%
Community Services	16.2%	15.3%	16.1%	15.1%		1.7%	3.8%
Corporate	17.0%	18.2%	18.3%	19.7%		1.8%	1.8%
Estates and Facilities	8.0%	7.4%	7.8%	8.2%		5.5%	0.3%
Medical & Cardiothoracics	16.9%	16.5%	16.4%	15.0%		1.3%	1.1%
Surgery, Neurosciences & Anaes	11.7%	12.2%	12.7%	12.2%		1.1%	1.6%
SWL Pathology	14.1%	14.3%	15.6%	13.7%		0.9%	3.1%
Whole Trust	**14.9%**	**14.9%**	**15.2%**	**14.5%**		**1.7%**	**1.7%**

	Voluntary Turnover					Other Turnover MAR 2016	
Staff Group	Dec '15	Jan '16	Feb '16	Mar '16	Trend	In-Voluntary	Retirement
Add Prof Scientific and Technic	15.8%	16.1%	15.7%	15.1%		5.5%	1.2%
Additional Clinical Services	17.4%	17.5%	17.5%	15.5%		0.9%	2.0%
Administrative and Clerical	13.4%	13.8%	13.8%	13.6%		2.2%	2.4%
Allied Health Professionals	17.7%	18.3%	18.4%	18.5%		0.5%	0.8%
Estates and Ancillary	4.8%	4.0%	4.3%	4.4%		0.4%	0.9%
Healthcare Scientists	13.2%	13.5%	14.6%	14.5%		0.7%	2.7%
Medical and Dental	6.0%	5.4%	5.3%	5.5%		4.5%	1.7%
Nursing and Midwifery Registered	16.8%	16.6%	17.3%	16.3%		0.8%	1.6%
Whole Trust	**14.9%**	**14.9%**	**15.2%**	**14.5%**		**1.7%**	**1.7%**

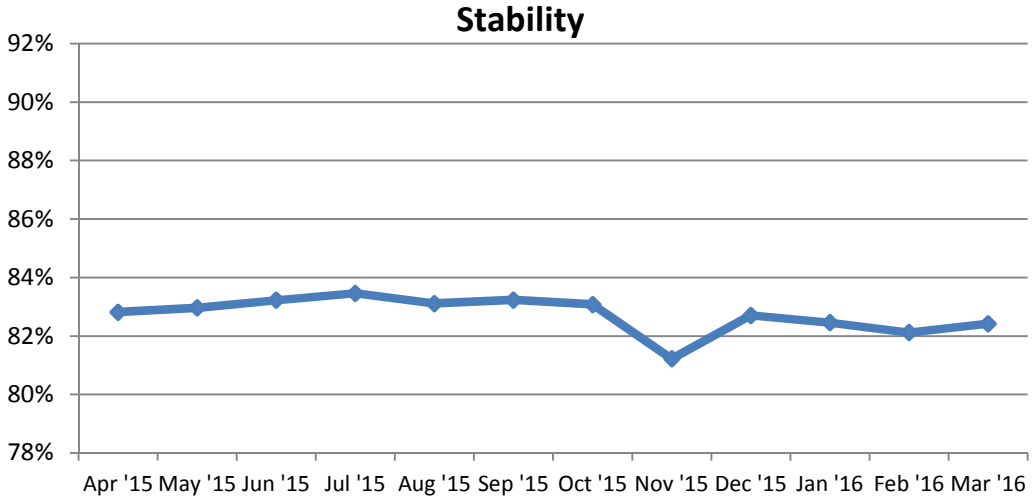
Caregroup	Staff in Post WTE	Leavers WTE	Voluntary Turnover Rate
Procurement & Materials Mgmt	37.0	11.0	28.2%
Human Resources Directorate	93.7	24.1	26.1%
SWLP Microbiology	63.0	17.3	24.3%
Offender Healthcare HMPW Services	54.9	14.0	23.9%
Chest Medicine	28.1	6.2	23.9%

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	Dec '15	Jan '16	Feb '16	Mar '16	Trend
C&W Diagnostic & Therapy	81.3%	81.8%	81.7%	82.3%	↗
Community Services	79.3%	79.1%	79.1%	79.1%	↔
Corporate	78.0%	76.0%	75.9%	78.1%	↗
Estates and Facilities	85.0%	85.9%	86.5%	87.2%	↗
Medical & Cardiothoracics	81.4%	81.9%	81.0%	81.5%	↗
Surgery, Neurosciences & Anaes	86.8%	86.0%	85.7%	85.6%	↘
SWL Pathology	89.5%	88.5%	87.0%	83.7%	↘
Whole Trust	**82.7%**	**82.5%**	**82.1%**	**82.4%**	↗

Stability Staff Group	Dec '15	Jan '16	Feb '16	Mar '16	Trend
Add Prof Scientific and Technic	73.4%	76.7%	73.8%	74.1%	↗
Additional Clinical Services	85.9%	84.7%	84.9%	86.0%	↗
Administrative and Clerical	84.6%	83.5%	83.7%	83.9%	↗
Allied Health Professionals	80.6%	80.3%	79.1%	79.8%	↗
Estates and Ancillary	89.3%	92.4%	93.2%	93.3%	↗
Healthcare Scientists	89.0%	88.3%	89.7%	88.9%	↘
Medical and Dental	90.1%	90.4%	90.2%	90.1%	↘
Nursing and Midwifery Registered	80.9%	80.2%	79.9%	80.2%	↗
Total	**82.7%**	**82.5%**	**82.1%**	**82.4%**	↗

COMMENTARY

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

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

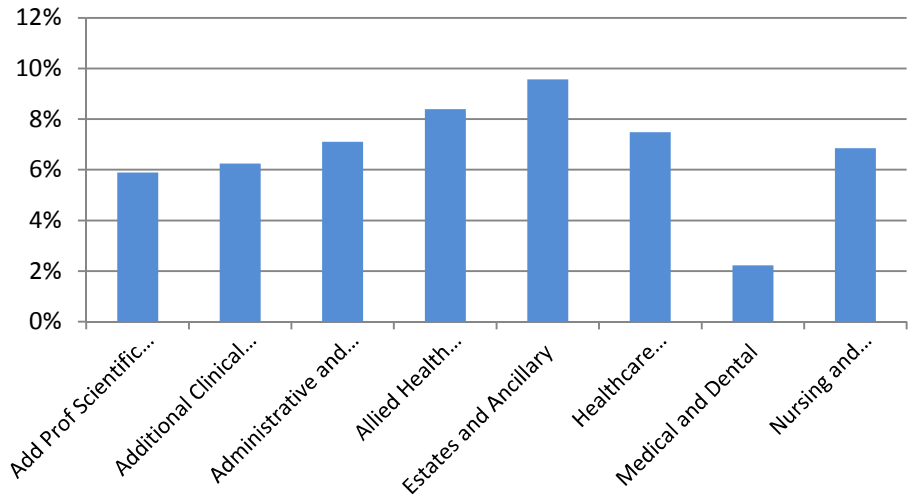
The stability rate has increased by 0.3% this month.

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

Over the last 12 months the stability rate has declined by 1.1% and is now at 82.4%.

Section 4: Staff Career Development

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



COMMENTARY

Staff exit survey data tells us that one of the key drivers for retaining staff is to support their development within the trust. In March 61 staff were promoted, there were 75 new starters to the Trust and 178 employees were acting up to a higher grade.

Over the last year 6.9% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the SW London Pathology Division followed by Corporate.

Managers have been asked to resolve all long standing acting up arrangements by the end of July.

Estates and Ancillary staff are seen as having the highest promotion rate on the graph (NB a small team were upgraded to bring them in line with similar staff at other Trusts) followed by the Allied Health Professionals staff group.

	No. of Promotions				
Division	Dec '15	Jan '16	Feb '16	Mar '16	Trend
C&W Diagnostic & Therapy	12	25	9	25	↗
Community Services	10	10	4	10	↗
Corporate	5	9	2	5	↗
Estates and Facilities	0	0	0	1	↗
Medical & Cardiothoracics	12	14	1	6	↗
Surgery, Neurosciences & Anaes	6	12	9	13	↗
SWL Pathology	0	1	6	1	↘
Whole Trust Promotions	**45**	**71**	**31**	**61**	↗
New Starters (Excludes Junior Doctors)	**47**	**125**	**137**	**75**	↘

Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	1999	136	6.8%	84
Community Services	827	46	5.6%	6
Corporate	425	38	8.9%	24
Estates and Facilities	259	20	7.7%	8
Medical & Cardiothoracics	1244	72	5.8%	33
Surgery, Neurosciences & Anaes	1385	87	6.3%	18
SWL Pathology	312	48	15.4%	5
Whole Trust	**6451**	**447**	**6.9%**	**178**
New Starters (Excludes Junior Doctors)		**1370**		

	No. of Promotions				
Staff Group	Dec '15	Jan '16	Feb '16	Mar '16	Trend
Add Prof Scientific and Technic	2	4	0	6	↗
Additional Clinical Services	3	5	4	2	↘
Administrative and Clerical	14	30	8	16	↗
Allied Health Professionals	11	8	3	5	↗
Estates and Ancillary	0	0	0	1	↗
Healthcare Scientists	1	2	3	1	↘
Medical and Dental	0	0	2	0	↘
Nursing and Midwifery Registered	14	22	11	30	↗
Whole Trust	**45**	**71**	**31**	**61**	↗

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	473	29	6.1%	34
Additional Clinical Services	707	41	5.8%	1
Administrative and Clerical	1311	110	8.4%	64
Allied Health Professionals	566	44	7.8%	23
Estates and Ancillary	208	19	9.1%	4
Healthcare Scientists	252	22	8.7%	5
Medical and Dental	495	12	2.4%	1
Nursing and Midwifery Registered	2439	170	7.0%	46
Whole Trust	**6451**	**447**	**6.9%**	**178**

Section 5: Sickness

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

COMMENTARY

Sickness absence is at 3.6% for March, which is a decrease of 0.7% on the previous month. Analysis of reasons for absence this month shows seasonal colds and flu to be the main reason for being off work.

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 March 2016. 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	Dec '15	Jan '16	Feb '16	Mar '16	Trend
C&W Diagnostic & Therapy	3.4%	4.3%	4.6%	4.1%	↘
Community Services	6.0%	6.5%	6.2%	4.7%	↘
Corporate	3.7%	3.4%	4.2%	3.6%	↘
Estates and Facilities	5.4%	4.7%	5.2%	4.7%	↘
Medical & Cardiothoracics	4.0%	3.8%	3.5%	2.9%	↘
Surgery, Neurosciences & Anaes	3.3%	3.8%	3.8%	3.3%	↘
SWL Pathology	3.3%	2.8%	3.6%	2.5%	↘
Whole Trust	**3.9%**	**4.2%**	**4.3%**	**3.6%**	↘

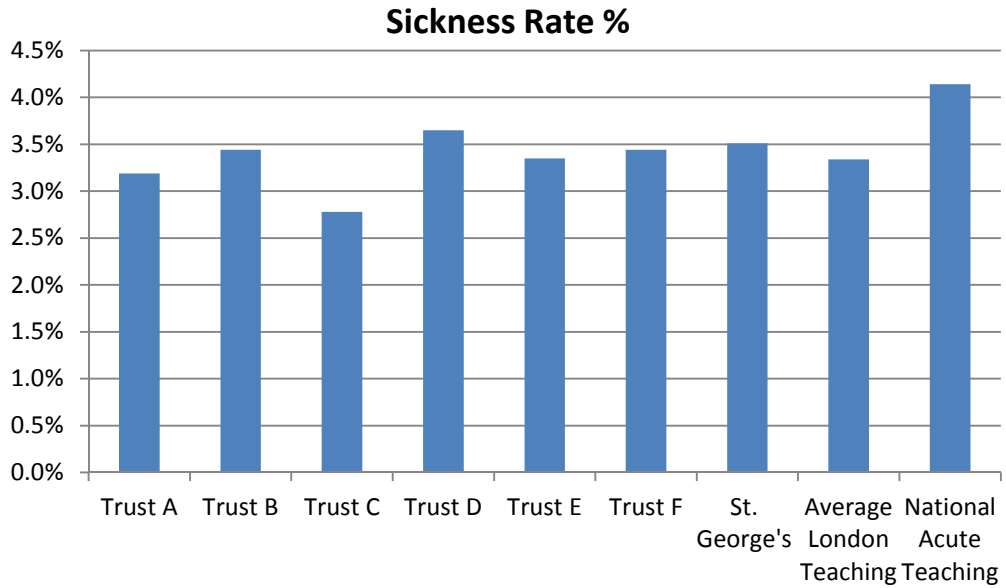
Sickness Staff Group	Dec '15	Jan '16	Feb '16	Mar '16	Trend
Add Prof Scientific and Technic	2.9%	3.4%	3.0%	3.0%	↔
Additional Clinical Services	7.4%	8.1%	6.7%	5.7%	↘
Administrative and Clerical	4.5%	4.5%	4.6%	4.9%	↗
Allied Health Professionals	3.2%	3.6%	3.8%	3.7%	↘
Estates and Ancillary	7.4%	6.2%	6.3%	5.2%	↘
Healthcare Scientists	2.4%	2.4%	2.7%	2.2%	↘
Medical and Dental	0.8%	1.3%	1.6%	1.5%	↘
Nursing and Midwifery Registered	4.0%	4.5%	5.0%	3.4%	↘
Total	**3.9%**	**4.2%**	**4.3%**	**3.6%**	↘

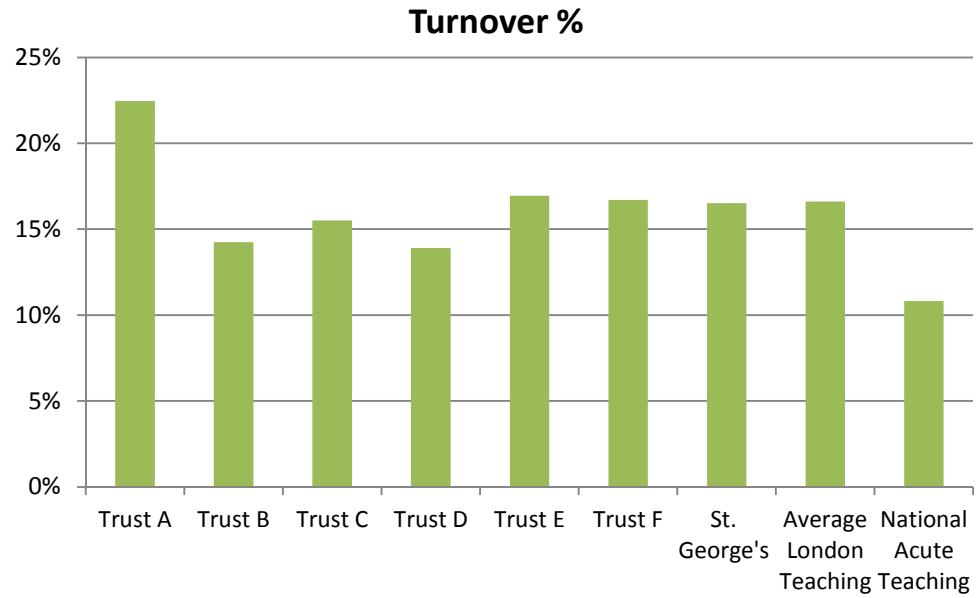
Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Energy and Engineering	53.13	171.00	10.6%	£10,642
Breast Screening	51.85	149.69	9.2%	£12,937
Offender Healthcare HMPW Services	54.93	144.00	8.3%	£11,311
Outpatients	302.77	734.63	7.8%	£36,975
Paediatric Surgery	60.95	143.73	7.5%	£15,768

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	37.85%
S25 Gastrointestinal problems	16.15%
S12 Other musculoskeletal problems	6.67%
S10 Anxiety/stress/depression/other psychiatric illnesses	5.90%
S15 Chest & respiratory problems	5.48%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S13 Cold, Cough, Flu - Influenza	23.35%
S10 Anxiety/stress/depression/other psychiatric illnesses	14.69%
S12 Other musculoskeletal problems	9.89%
S25 Gastrointestinal problems	9.50%
S28 Injury, fracture	6.78%

Section 6: Workforce Benchmarking





COMMENTARY

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

Sickness data shown is from December '15 which is the most recent available. Compared to other Acute teaching trusts in London, St. Georges had a rate slightly higher than average at 3.51%. In the top graph, Trusts A-F are the anonymised figures for this group. The Trust's sickness rate was lower than the national rate for acute teaching hospitals in November.

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 types of 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 January). Stability is also 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 5.7% lower than St. Georges.

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

Reference Group	Gross Turnover Rate %	Stability Rate %	Sickness Rate %
Trust A	22.46%	77.75%	3.19%
Trust B	14.24%	85.31%	3.44%
Trust C	15.51%	84.02%	2.78%
Trust D	13.90%	85.59%	3.65%
Trust E	16.94%	83.04%	3.35%
Trust F	16.71%	83.21%	3.44%
St. George's	16.51%	83.27%	3.51%
Average London Teaching	16.61%	83.17%	3.34%
National Acute Teaching	10.81%	88.97%	4.14%

Section 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Dec '15	Jan '16	Feb '16	Mar '16	Trend
C&W Diagnostic & Therapy	1110.4	1150.9	1152.9	1152.9	↔
Community Services	614.5	598.4	598.4	598.4	↔
Corporate & R&D	95.2	67.8	61.1	44.0	↘
Medical & Cardiothoracics	1253.7	1279.2	1279.2	1275.9	↘
Surgery, Neurosciences & Anaes	1151.0	1113.7	1094.0	1111.0	↗
Total	4224.8	4210.0	4185.6	4182.2	↘

Nursing Staff in Post WTE

Division	Dec '15	Jan '16	Feb '16	Mar '16	Trend
C&W Diagnostic & Therapy	980.6	996.4	997.7	1004.4	↗
Community Services	452.9	448.0	441.6	437.7	↘
Corporate & R&D	72.5	56.1	55.1	43.1	↘
Medical & Cardiothoracics	982.9	993.5	999.6	1003.9	↗
Surgery, Neurosciences & Anaes	909.0	903.1	904.2	908.0	↗
Total	3397.9	3397.0	3398.1	3397.0	↘

Nursing Vacancy Rate

Division	Dec '15	Jan '16	Feb '16	Mar '16	Trend
C&W Diagnostic & Therapy	11.7%	13.4%	13.5%	12.9%	↘
Community Services	26.3%	25.1%	26.2%	26.8%	↗
Corporate & R&D	23.8%	17.3%	9.9%	2.1%	↘
Medical & Cardiothoracics	21.6%	22.3%	21.9%	21.3%	↘
Surgery, Neurosciences & Anaes	21.0%	18.9%	17.4%	18.3%	↗
Total	19.6%	19.3%	18.8%	18.8%	↘

Nursing Sickness Rates

Division	Dec '15	Jan '16	Feb '16	Mar '16	Trend
C&W Diagnostic & Therapy	4.2%	5.0%	6.1%	4.7%	↘
Community Services	7.5%	8.7%	7.8%	5.2%	↘
Corporate	3.2%	2.5%	3.5%	2.6%	↘
Medical & Cardiothoracics	4.8%	4.7%	4.1%	3.3%	↘
Surgery, Neurosciences & Anaes	4.2%	4.8%	4.8%	3.4%	↘
Total	4.8%	5.4%	5.4%	4.0%	↘

Nursing Voluntary Turnover

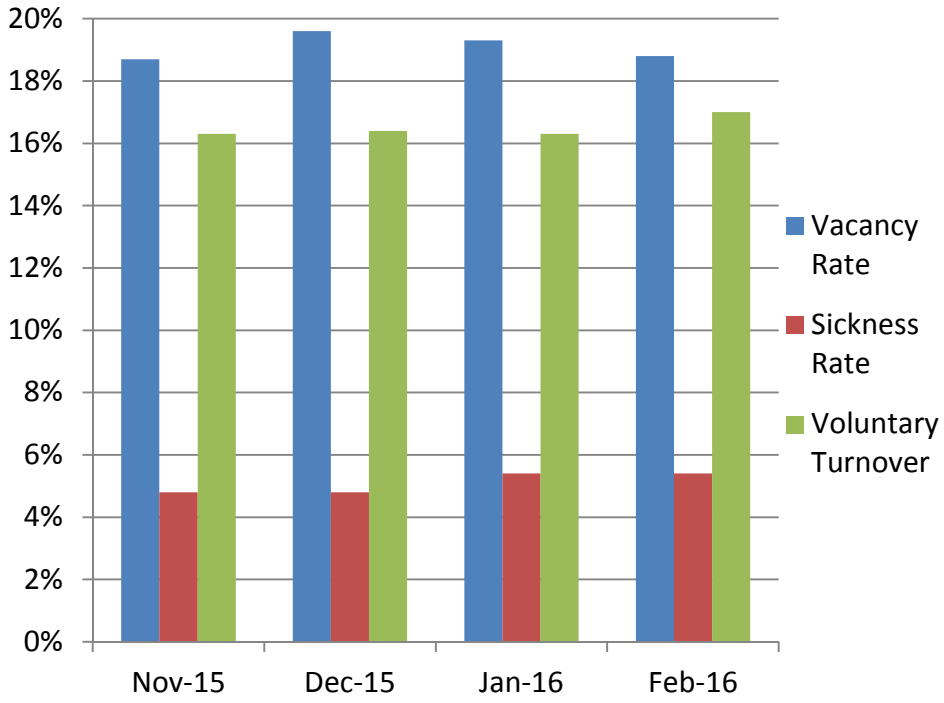
Division	Dec '15	Jan '16	Feb '16	Mar '16	Trend
C&W Diagnostic & Therapy	15.75%	15.11%	15.68%	14.07%	↘
Community Services	17.52%	16.16%	17.72%	16.82%	↘
Corporate & R&D	10.98%	12.37%	14.16%	14.64%	↗
Medical & Cardiothoracics	19.44%	19.35%	19.34%	17.96%	↘
Surgery, Neurosciences & Anaes	14.27%	14.90%	15.65%	15.03%	↘
Total	16.5%	16.4%	17.0%	15.9%	↘

COMMENTARY

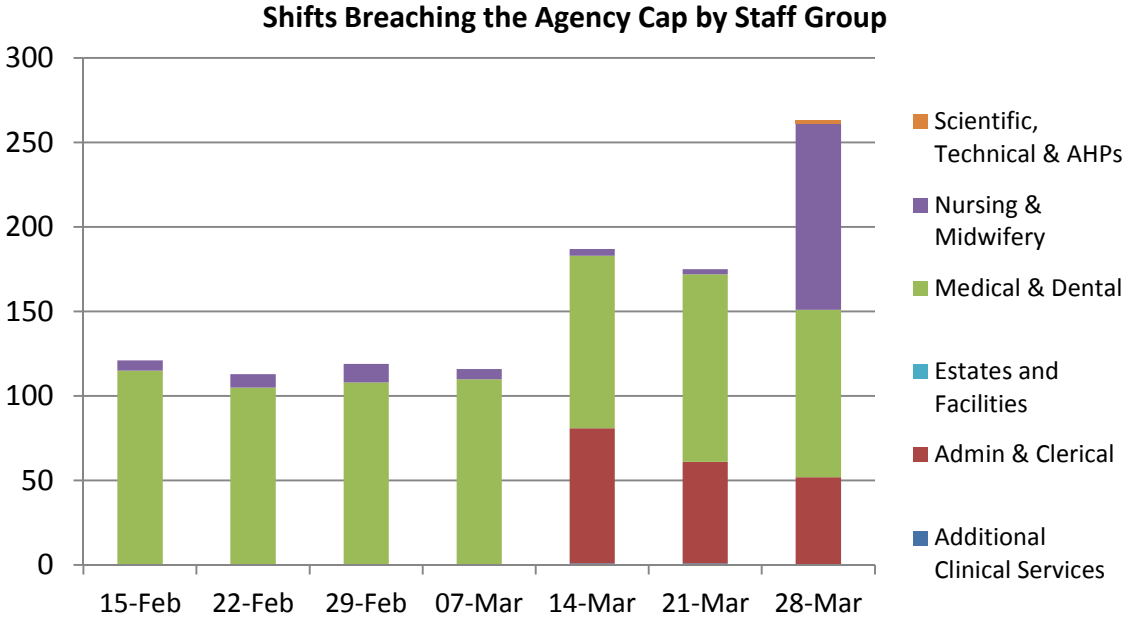
This data shows a more in-depth view of our nursing workforce (both qualified and unqualified).

The nursing workforce has decreased by 1 WTE in March.

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



Section 8: Agency Cap Monitoring



Agency Cap Shift Breaches by Staff Group	15-Feb	22-Feb	29-Feb	07-Mar	14-Mar	21-Mar	28-Mar
Additional Clinical Services	0	0	0	0	1	1	0
Admin & Clerical	0	0	0	0	80	60	52
Estates and Facilities	0	0	0	0	0	0	0
Medical & Dental	115	105	108	110	102	111	99
Nursing & Midwifery	6	8	11	6	4	3	110
Scientific, Technical & AHPs	0	0	0	0	0	0	2
Whole Trust	121	113	119	116	187	175	263

Agency Cap Shift Breaches by Division	15-Feb	22-Feb	29-Feb	07-Mar	14-Mar	21-Mar	28-Mar
C&W Diagnostic & Therapy	6	5	9	13	16	15	33
Community Services	12	12	12	15	13	21	51
Corporate	15	16	15	16	95	74	66
Estates and Facilities	0	0	0	0	0	0	0
Medical & Cardiothoracics	75	69	69	66	57	57	74
Surgery, Neurosciences & Anaes	13	11	14	6	6	8	39
SWL Pathology	0	0	0	0	0	0	0
Whole Trust	121	113	119	116	187	175	263

COMMENTARY

All Trusts are now required to report weekly on the number of shifts which have breached the Agency capped rates which have been set by Monitor.

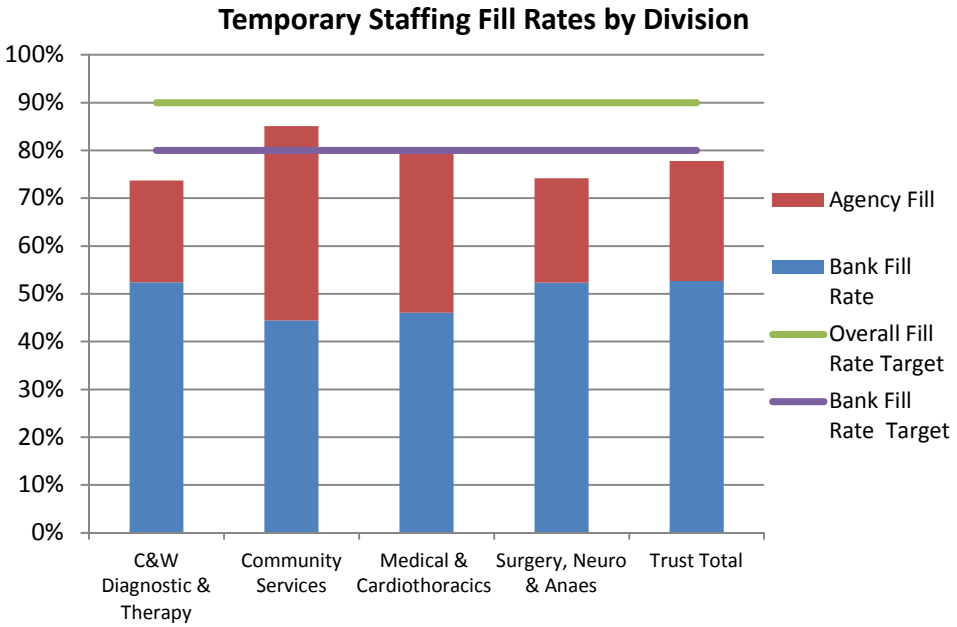
Work is on-going to stop using agencies which breach the caps where possible.

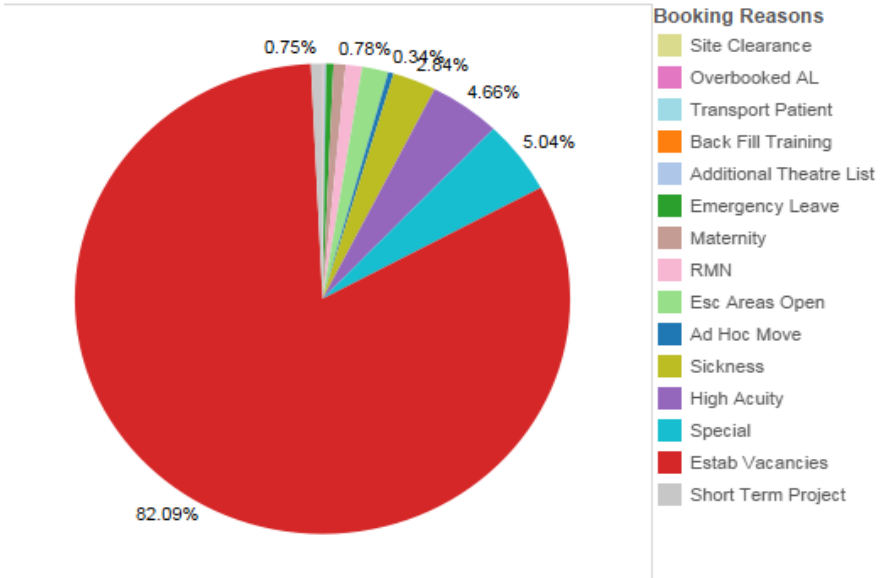
In all cases, services have confirmed there would be an adverse impact upon patient safety should the booking not go ahead.

As of the 14th of March, the Trust is now reporting breaching shifts worked by Interims that are covering vacancies.

New lower capped rates were introduced from the 1st of April which are reflected in the increased number of Nursing & Midwifery shifts breaching in the week commencing the 28th of March. The Community Services Division had the largest number of breaches in this staff group (36).

Section 9: 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 March the Bank Fill Rate was reported at 52.7% which is 2% lower than the previous month. The Overall Fill Rate was 77.8% which is a decrease of 1.8% on the previous month. The Community Services Division is currently meeting the demand for temporary staff most effectively.

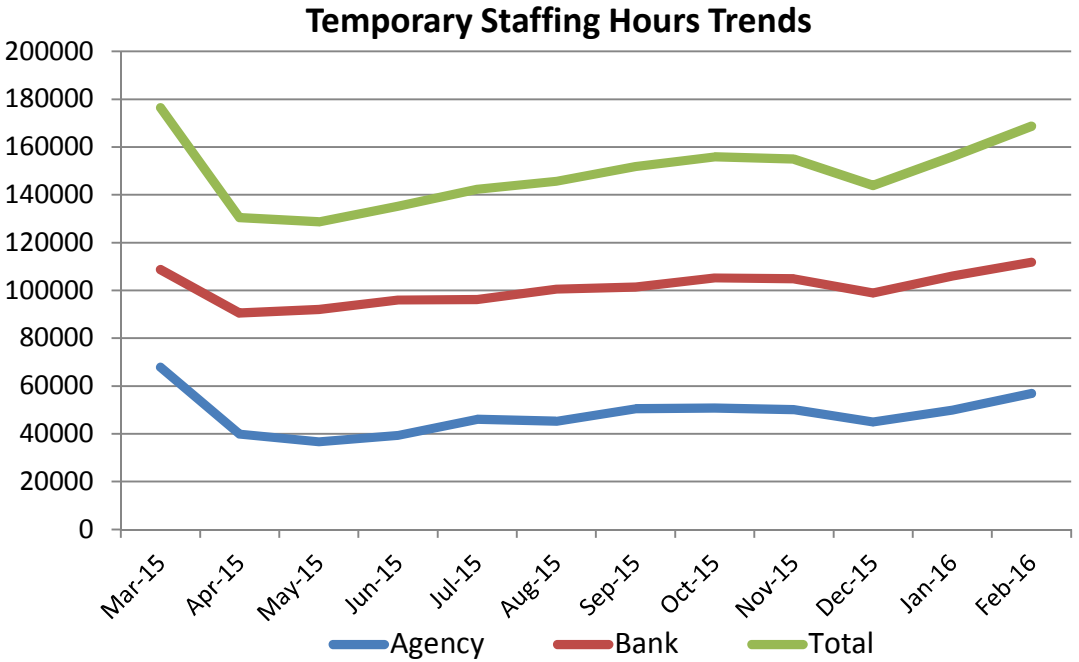
The pie chart shows a breakdown of the reasons given for requesting bank shifts in March. This is very much dominated by covering existing vacancies, specials, sickness, and high acuity patients.

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

Bank Fill Rate % by Division	Dec '15	Jan '16	Feb '16	Mar '16	Trend
C&W Diagnostic & Therapy	60.0%	63.3%	59.2%	52.4%	↘
Community Services	48.1%	48.4%	46.2%	44.4%	↘
Medical & Cardiothoracics	47.7%	46.2%	44.5%	46.0%	↗
Surgery, Neurosciences & Anaes	56.3%	51.5%	49.1%	52.3%	↗
Whole Trust	**57.6%**	**56.9%**	**54.7%**	**52.7%**	↘

Overall Fill Rate % by Division	Dec '15	Jan '16	Feb '16	Mar '16	Trend
C&W Diagnostic & Therapy	77.7%	80.3%	79.3%	73.7%	↘
Community Services	84.1%	86.9%	84.1%	85.1%	↗
Medical & Cardiothoracics	81.2%	81.2%	79.5%	79.4%	↘
Surgery, Neurosciences & Anaes	76.2%	70.9%	71.2%	74.2%	↗
Whole Trust	**80.8%**	**80.7%**	**79.6%**	**77.8%**	↘

Section 10: 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. Overall Bank & agency hours have increased across most Divisions in March.

The largest increase in agency hours is seen in the Children & Women's Division in Paediatrics and Obstetrics.

Bank hours increased greatly in Medicine and Cardiothoracics (mainly in the acute wards) as well as in Surgery and Neuro Division in Theatre Services.

TYPE	Division	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Agency	C&W Diagnostic & Therapy	9525	10750	8656	9638	9408	10033	11112	10724	11615	11158	14779	16404
	Community Services	7938	5769	5245	6077	6422	6421	7086	6605	6715	7298	8717	10225
	Corporate	1246	1331	949	529	46	423	402	384	541	1021	793	610
	Estates and Facilities	0	0	0	0	0	0	4	166	322	140	176	180
	Medical & Cardiothoracics	14492	13202	17823	20429	20348	24428	21792	22626	19732	23154	23159	23779
	Surgery, Neurosciences & Anaes	6582	5462	6386	9195	8730	8860	9994	9362	5953	7161	9211	9885
	SWL Pathology	119	204	241	228	245	352	267	150	143	0	0	0
Agency Total		**39901**	**36717**	**39299**	**46097**	**45199**	**50517**	**50657**	**50017**	**45021**	**49932**	**56835**	**61083**
Bank	C&W Diagnostic & Therapy	27789	28714	29038	25990	26657	30745	32858	31790	30886	33343	34999	32870
	Community Services	8379	7619	7704	8252	9033	8695	9149	9133	9005	9225	9796	10885
	Corporate	7424	7165	8430	7972	7206	8828	11156	9858	8426	8674	8773	9078
	Estates and Facilities	6885	7502	8178	9216	8910	8264	8506	9423	8467	8428	10122	10078
	Medical & Cardiothoracics	23755	24829	24969	26255	29728	27842	26409	28073	25363	26990	26921	29610
	Surgery, Neurosciences & Anaes	13521	13495	14553	14740	15545	16118	16265	15754	15791	18358	20155	22946
	SWL Pathology	2753	2620	3052	3751	3389	803	821	839	998	1016	1050	3063
Bank Total		**90507**	**91944**	**95925**	**96177**	**100468**	**101295**	**105164**	**104870**	**98936**	**106034**	**111816**	**118530**
Temporary Staff Total		**130408**	**128661**	**135224**	**142273**	**145667**	**151811**	**155821**	**154887**	**143957**	**155966**	**168651**	**179613**

Section 11: Temporary Staffing Weekly Tracking

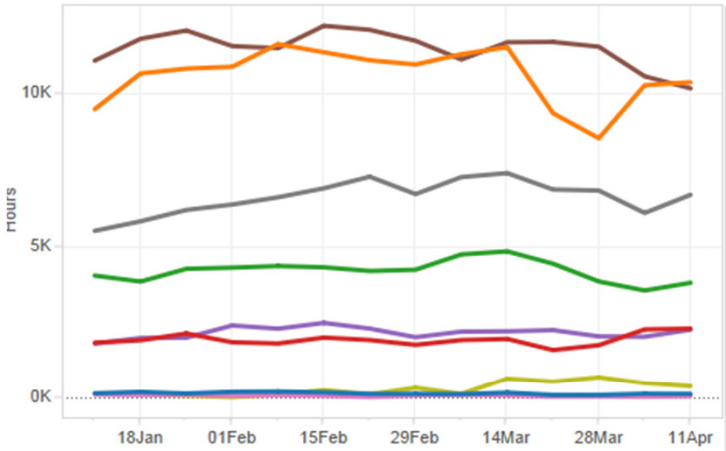
Weekly Hours Used By Division

Division	11 Jan	18 Jan	25 Jan	01 Feb	08 Feb	15 Feb	22 Feb	29 Feb	07 Mar	14 Mar	21 Mar	28 Mar	04 Apr	11 Apr
Capital Division	168	214	162	218	227	200	149	151	142	192	117	118	157	151
Children and Women's Diagnostic and T..	9,496	10,665	10,822	10,884	11,624	11,357	11,097	10,957	11,295	11,525	9,363	8,545	10,279	10,376
Community Services Division	4,051	3,856	4,273	4,311	4,364	4,323	4,202	4,243	4,744	4,844	4,441	3,859	3,564	3,815
Corporate Division	1,855	1,935	2,155	1,870	1,829	2,023	1,943	1,785	1,942	1,979	1,613	1,774	2,290	2,316
Estates and Facilities Division	1,826	2,009	2,020	2,419	2,313	2,503	2,318	2,035	2,219	2,229	2,268	2,062	2,050	2,282
Medicine and Cardiovascular Division	11,084	11,799	12,070	11,559	11,492	12,223	12,093	11,734	11,120	11,685	11,696	11,539	10,571	10,177
Research & Development Division	132	116	124	93	109	88	46	99	123	102	61	68	54	76
Surgery & Neurosciences Division	5,515	5,827	6,199	6,376	6,614	6,907	7,287	6,717	7,273	7,404	6,868	6,834	6,100	6,693
SWL Pathology Division	165	168	91	44	128	272	136	352	149	669	570	713	513	413
Grand Total	34,293	36,589	37,916	37,774	38,700	39,896	39,271	38,071	39,007	40,627	36,995	35,510	35,576	36,299

Type
- Agency
- Bank

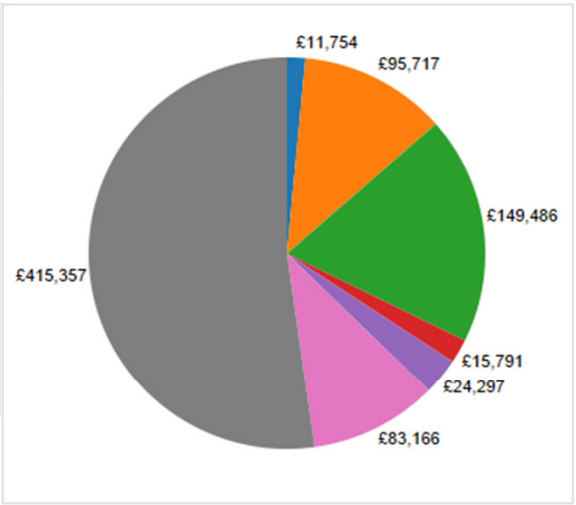
Division
- Capital Division
- Children and Women's D..
- Community Services Divi..
- Corporate Division
- Estates and Facilities Div..
- Medicine and Cardiovasc..
- Research & Developmen..
- Surgery & Neuroscience..
- SWL Pathology Division

Weekly Hours Used Trends



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



Total Cost
£795,567

Select Date (W/C)
11/04/2016

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

Staff Group
- Add Prof Scientific
- Additional Clinical Servic..
- Admin & Clerical
- Allied Health Professiona..
- Estates & Facilities
- Healthcare Scientists
- Medical & Dental
- Nursing & Midwifery

Section 12: Mandatory Training

MAST Topic	Jan '16	Feb '16	Trend
Conflict Resolution	79.4	85.4	↗
Equality, Diversity and Human Rights	78.2	80.9	↗
Fire Safety	74.2	80.9	↗
Health, Safety and Welfare	75.7	81.4	↗
Infection Prevention and Control Clinical	61.7	70.8	↗
Infection Prevention and Control Non Clinical	69.2	76.0	↗
Information Governance	65.5	81.7	↗
Moving and Handling	71.5	78.4	↗
Moving and Handling Patient	63.5	63.0	↘
Resuscitation BLS	49.1	51.1	↗
Resuscitation ILS	54.7	59.4	↗
Resuscitation Non Clinical	61.8	67.4	↗
Safeguarding Adults	72.7	78.8	↗
Safeguarding Children Level 1	72.1	77.9	↗
Safeguarding Children Level 2	73.0	77.2	↗
Safeguarding Children Level 3	68.7	68.6	↘

COMMENTARY

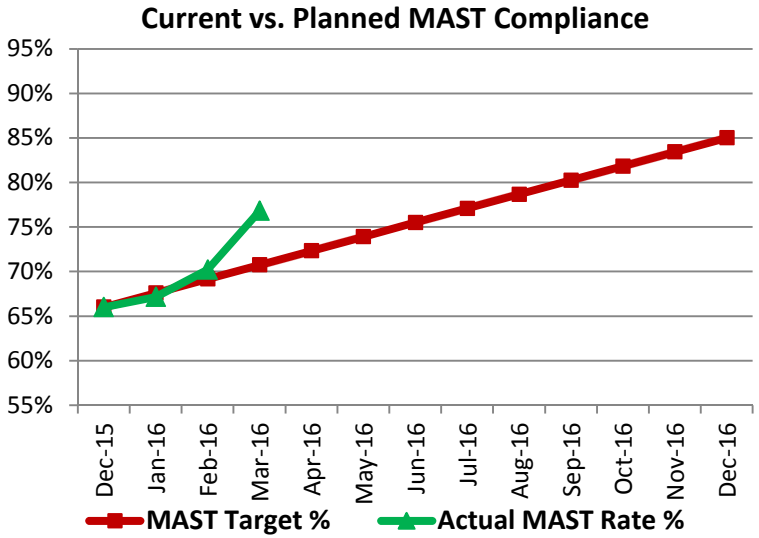
A programme of working is taking place including:

- 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.

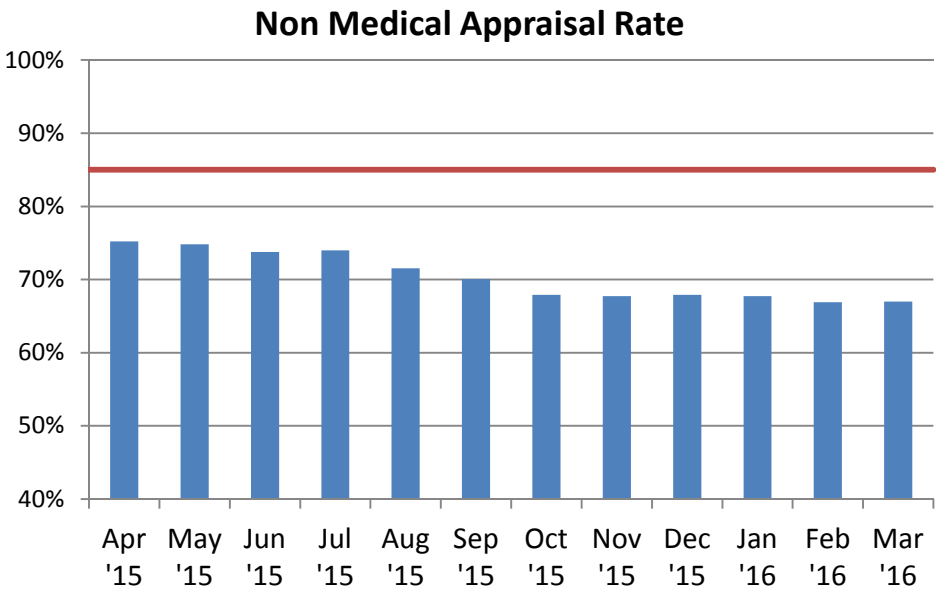
Current Issues:

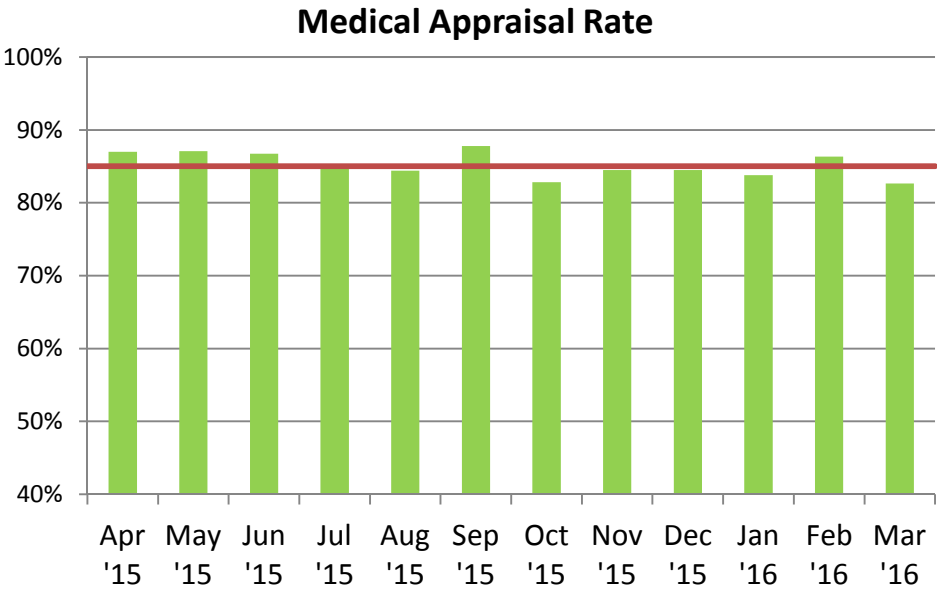
- Fall in compliance rates – largely due to staffing pressures
- Community access to Totara is on the risk register, in the interim we are visiting community sites with tablets and developing a permanent solution in parallel
- Staff unable to access training externally- Software and licencing and IG 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.

MAST Compliance % by Division	Dec '15	Jan '16	Feb '16	Mar '16	Trend
C&W Diagnostic & Therapy	67.3%	69.0%	71.9%	77.3%	↗
Community Services	65.6%	65.9%	68.4%	79.1%	↗
Corporate	65.5%	66.1%	69.5%	76.3%	↗
Estates and Facilities	62.5%	62.1%	68.6%	70.9%	↗
Medical & Cardiothoracics	63.5%	65.0%	66.9%	73.1%	↗
Surgery, Neurosciences & Anaes	64.9%	66.1%	68.4%	75.0%	↗
Whole Trust	66.0%	67.1%	70.2%	76.8%	↗



Section 13: Appraisal





Non-Medical Commentary

The non-medical appraisal rate has increased by 0.1% this month to 67%. Appraisals are still being managed closely by the appraisal project team who are monitoring progress every two weeks and scrutinising divisional plans. The Corporate Division currently has the lowest non-medical compliance rate. Appraisal completion is now linked to incremental progression for bands AFC band 7 - 9 staff. The table below lists the five care groups with the lowest non medical appraisal rate this month

Medical Commentary

Medical appraisal rate compliance has decreased this month to 82.7% which is just below target.

Care Group	Non-Med Appraisal Rate	Staff In Post WTE
Energy and Engineering	21.4%	53.13
Dermatology & Lymphoedema	26.7%	31.66
Procurement & Materials Mgmt	28.1%	37.00
Finance Directorate	36.3%	116.35
Rheumatology	46.2%	25.15

Non Medical Appraisals by Division	Dec '15	Jan '16	Feb '16	Mar '16	Trend
C&W Diagnostic & Therapy	71.8%	70.7%	68.3%	65.1%	↘
Community Services	62.4%	63.2%	63.5%	63.3%	↘
Medical & Cardiothoracics	73.7%	72.3%	72.0%	69.2%	↘
Surgery, Neurosciences & Anaes	74.0%	75.1%	75.0%	73.5%	↘
Corporate	50.2%	52.2%	56.8%	61.2%	↗
Estates & Facilities	66.1%	64.9%	63.0%	62.0%	↘
Whole Trust	**67.9%**	**67.7%**	**66.9%**	**67.0%**	↗

Medical Appraisals by Division	Dec '15	Jan '16	Feb '16	Mar '16	Trend
C&W Diagnostic & Therapy	86.0%	82.2%	85.9%	84.1%	↘
Community Services	87.1%	87.1%	83.9%	88.9%	↗
Medical & Cardiothoracics	87.7%	85.7%	90.5%	82.1%	↘
Surgery, Neurosciences & Anaes	79.9%	86.0%	84.1%	84.9%	↗
Corporate	75.0%	100.0%	100.0%	100.0%	↔
Whole Trust	**84.5%**	**83.8%**	**86.4%**	**82.7%**	↘

REPORT TO THE TRUST BOARD – 5 May 2016

Paper Title:	**Frequent Emergency Department attenders**
Sponsoring Director:	Paula Vasco-Knight, Chief Executive
Author:	Alison Benincasa, Divisional Chair, Community Services
Purpose:	To inform the Board about the proposal for an improved approach in the management of patients who attend ED on a frequent basis
Action required by the board:	For comment, to consider the proposed Trust approach and to agree a timeframe for further feedback
Document previously considered by:	N/A

Executive summary

This short paper provides the outline of a proposal for the Trust to focus initially on a relatively small number of patients to facilitate alternative planned care/support away from the Emergency Department (ED).

Wandsworth CCG has recently developed an initiative for Wandsworth GPs to actively engage with the top 500 patients who have attended ED on a frequent basis in 2015/16 (6215 times). From April 2016 Wandsworth GPs are now working with these patients on an individual basis to understand why the patient needed to use ED services. The GP and the patient will discuss and plan for alternative treatment/support solutions where appropriate. The reasons for ED attendance will also be shared with WCCG and an analysis of the reason for attendance will be undertaken to consider changes to service provision in community settings that better suit patient needs.

The Trust is keen to provide further support to this initiative. We have liaised with Homerton Hospital where there has been a successful patient focussed programme of work. The Homerton initiative adopted a multi-disciplinary approach involving professionals from acute, mental health, community, primary care, local authority and voluntary sector to identify and plan for alternative care/support. We plan to take this work forward within the Trust.

There is also recognition that there is greater potential to better support these patients if both initiatives can work alongside each other with joint working where it is of benefit to the patient. We have liaised with WCCG and Merton CCG and plan for wider joint working across health and social care.

The board is asked to note that there are additional plans to work with a wider cohort of patients to illicit an improved community response in Wandsworth and Merton in order to provide effective ED alternatives for patients. An example of this in Wandsworth is the Enhanced Care Pathway 500 (the top 500 patients at risk of hospital admission). Each patient will have a My Wandsworth Shared Care Plan that promotes health and well-being to support patients to remain safe and well cared for at home. There will be a clear and agreed service response if the patient's health deteriorates to ensure that their needs are managed in the first instance within primary and community care unless their assessed needs can only be managed in an acute setting.

Key risks identified: The need to identify clear and agreed primary and community care response to meet the needs of the patient away from an acute hospital setting.	
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? No Involvement of the patient in this initiative will be with the full knowledge and consent of the patient.	

St George's Healthcare NHS
NHS Trust

REPORT TO THE BOARD **Paper ref:**

Paper Title:	Patient and Public Involvement/ Engagement Strategy
Sponsoring Director:	Jennie Hall- Chief Nurse/ Director Infection Prevention and Control
Authors:	Jennie Hall- Chief Nurse/ DIPC Patient Representatives
Purpose:	To outline the Strategy for agreement
Action required by the board:	To request that the Board approve and support the strategy
Document previously considered by:	EMT Patient Experience Committee

Executive summary

The Patient and Public Involvement/ Engagement strategy document has been co-designed with patient representatives to provide a framework to support the strengthening of PPI/PPE work by the Trust over the next 5 years.

This is an important document to support the ambition of true partnership working with patients, their representatives and governors. Achieving this ambition takes a period of time so the document has been written to reflect that.

The strategy will need to be evaluated on an annual basis to ensure that it has a positive impact in relation to developing this work but also in supporting the delivery of excellent patient centred care where patients are at the heart of decision making.

The strategy has a vision statement and six themes to deliver that vision. The Board will note that there is a year one programme which has been outlined, that focuses on some of the building blocks of a clear structure for Patient reps and groups within the Trust alongside governors to deliver the work programme described, with training available to staff to support improve partnership working both in relation to individual patient care but also programme/ service development work. Finally to ensure that PPE/PPI activity is appropriately programmed into mainstream Trust activity.

The board is asked to support the implementation of this strategy. A programme manager will be appointed to drive this work forward through the Trust.

Key risks identified:

None at this stage

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	Regulation 9

Equality Impact Assessment (EIA): Has an EIA been carried out?
If no, please explain you reasons for not undertaking and EIA. Not applicable

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Patient and Public Involvement/ Engagement Strategy

"No decision about me without me"

Jennie Hall-Chief Nurse/ DIPC
Patient Representatives

April 2016

Vision for the Strategy:

- The vision is to develop a collaborative partnership with patient representatives, governors, volunteers and the public that takes account of the diversity of the local population to:

- Support patients to make informed and educated personal health care choices and encourage patient self-management

- Ensure that Trust decision making processes for all patient care are transparent and take account of the views of patients, their representatives and the public

- Inform, encourage and equip staff to value and support the contributions made by patient , representatives, volunteers and the public to help achieve the highest standards of care

- ~~To~~ develop a leadership and culture that values and supports PPI/E

Background:

- There are a number of key drivers to support the development of a Trust Patient and Public Involvement and Engagement (PPI/E) Strategy:
- A strong shift to put the patient and the wider public at the heart of the decision making process in health and wider public services, this is underpinned by legislation and rising public expectations
- A baseline audit of PPI/E to patient/public representation on formal committees in St Georges during 2015 showed some good evidence, but not in all directorates
- The need to ensure that Trust Governors are aligned and involved with this strategy
- A Listening into Action event in spring 2015 for volunteers and patient representatives voiced the need for more support and recognition of these roles
- There was a strong push from the Patient Reference Group to develop an overarching PPI/PPE strategy
- There is a lot of work in PPI/E going on in the trust ,but the evidence base is not strong, with variable reporting of key metrics, we are not always able to assess the effectiveness of the activity, there is weak governance in this area

- Core to the ethos of the strategy has been the partnership in developing this paper. The following were members of the working party in consultation with the Patient Reference Group:
  - Jennie Hall - Chief Nurse/ DIPC
  - Leslie Robertson - Patient Ambassador
  - Valerie Emmons – Patient Representative
  - Charlotte Lucy Ennis - Patient Representative
  - Peter West - Healthwatch Wandsworth
  - Sarah Duncan - Head of Patient Experience
  - Wilfred Carnerio - Equality and Human Rights manager
  - Peter Jenkinson – Director Corporate Affairs

Drivers for the Strategy

- **Policy**: All major policy drivers make it clear that the NHS at large and the Trust must embed good practice in patient experience . The views of patients and the public must be part of decision making.

- **Legal**: The NHS Act (2006) , Section 242 requires NHS Organisations to engage patients and the public in the:
    - planning and providing of services
    - developing and considering proposals for change
    - making decisions which effect how services operate

  The Health and Social Care Act (2012) underlines a commitment to put patients at the centre by providing them with better information, more choice and a stronger voice. "No decision about me without me".

  Other duties for the Trust to engage and involve people in are contained within the Equality Act 2010, NHS Constitution guidance, and CQC Regulation 17 (2A/E). The Trust should engage with Health Watch and other relevant organisations.

- **Strategic:** Our PPI/E strategy will link to existing Corporate priorities. It will deliver commitment across all parts and levels of the Organisation, and create a clear sense of purpose and direction for the Trust.

- **Operational**: The Patient experience and associated outcomes are central to ensuring that the Trust delivers the right services and care to the patient, and in the process makes best use of resources.

What does success for the Trust PPI/E Strategy look like?

Current Position 2016	Future Position 2020
Incomplete evidence base of PPI/E Activities	Strong evidence base of activity
Some examples of joint PPI/E activities throughout the Organisation	Systematic and two way staff , patient and public activities with a philosophy of “you said, we did”.
Inconsistent governance of activities	Integrated governance of PPI/E activities
Some public and patient engagement in service improvement	Patient and public engagement is a core part of service reviews and improvement
Some relationships with existing patient groups	Consistent and meaningful relationships with existing and new user patient groups
Some evidence for structured self management and in some clinical areas. Variable in others	Self management and self care is an established part of our care offer in all appropriate clinical services
Limited training, resources and support to staff, patients and the public to develop effective PPI/E	Improved and coordinated training, resources and support to staff , patient and the public to engage in effective PPI/E
Some use of new technologies to get feedback on PPI/E	Innovative use of technologies
Some links to other corporate strategies	Strong links to other strategies developing joint working where appropriate

What is PPI/E?

PPI/E is an approach that puts the people at the heart of care to improve service quality. There are three key activities to drive involving/engaging people in decisions about their own care and treatment in

on-going service delivery

making changes to services or redesigning care pathways

organisational decision making.

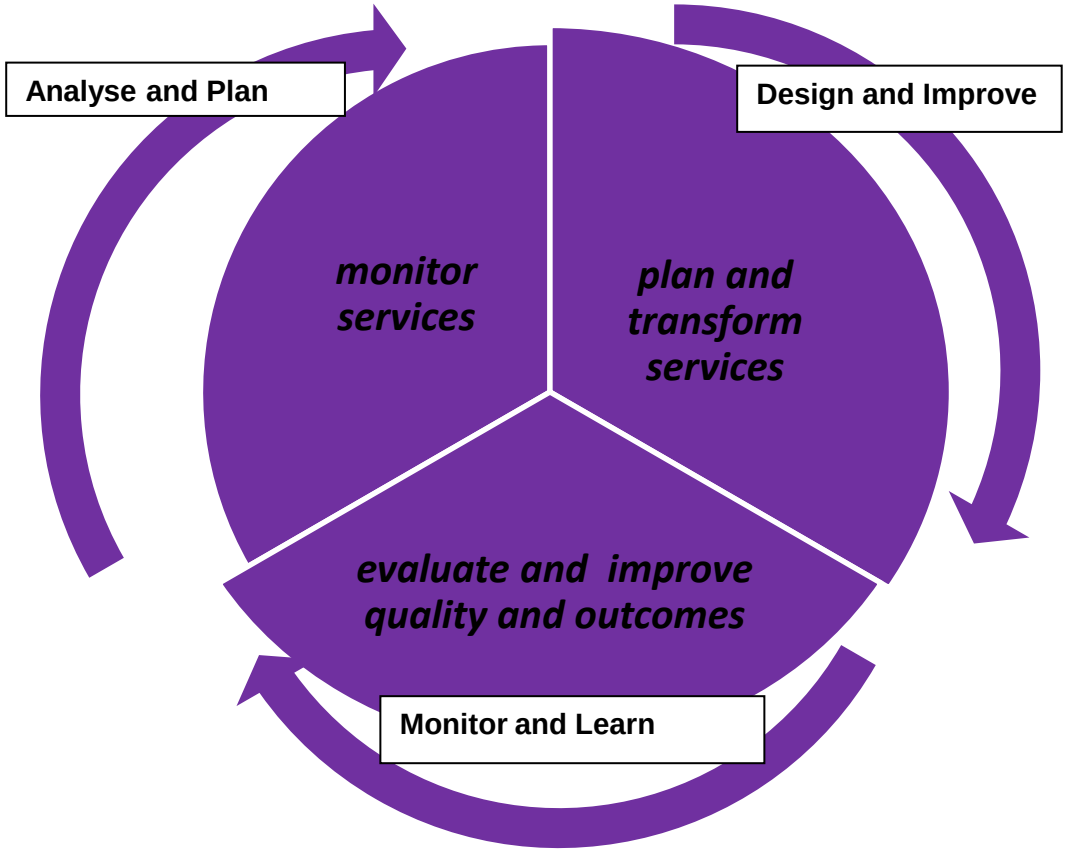
- SGH Considers "Patients and Public" to include patients, service users, carers, volunteers, people living in the areas we serve, local communities, patient groups and voluntary sector organisations .

- We can engage people as individuals or as groups. We can inform people, involve people or work in a partnership,

- As a Foundation Trust we also engage and involve our members who have a programme of work to improve patient experience. The PPI/E strategy is designed to compliment our membership and patient experience activities.

Through this strategy document, whilst involvement and engagement can be defined as separate terms we have taken them as interchangeable to help us deliver our vision .

The PPI/E Cycle: Working with patients, carers and the public to



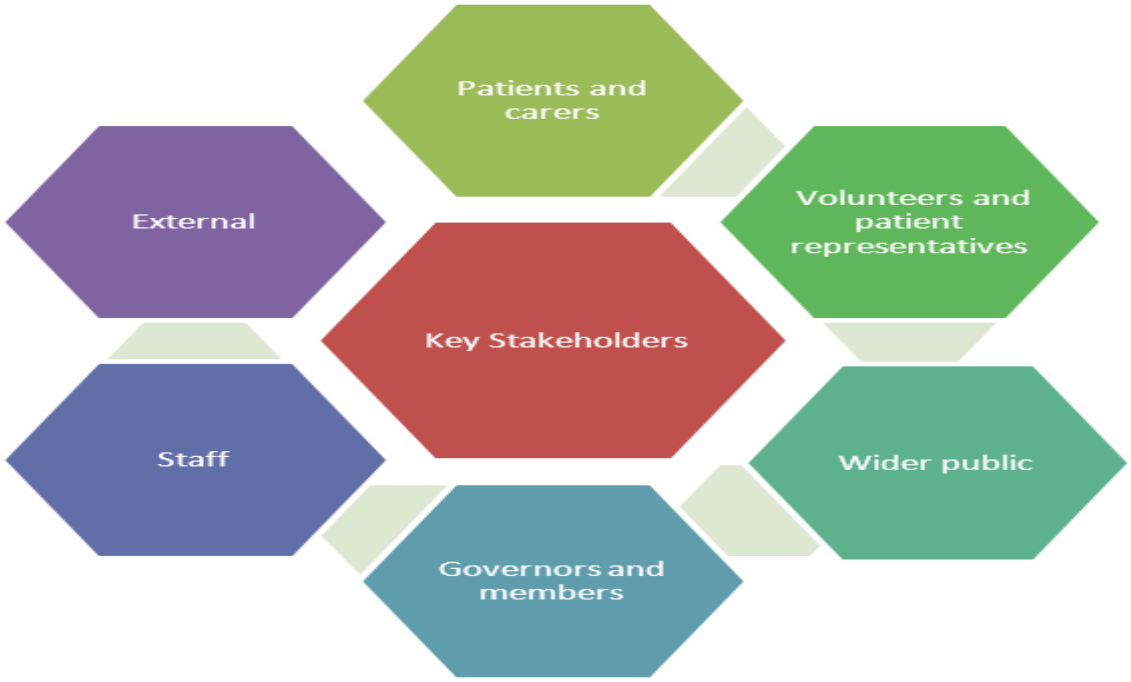
Principles that underpin effective PPI/E

- Relevant national guidance
- The values of the Trust
- Building relationships based on mutual respect and trust
- Working in partnership making the sure the contributions and experiences of everyone are valued
- Clear roles and responsibilities
- Inclusive ~~in~~ approach and actions
- Valuing the diversity of views
- Transparency and governance
- Being supported at a strategic and operational level

Infrastructure needed to support PPI/E

- Executive team support
- All stakeholders buy in
- Training and development for staff ,volunteers and patient representatives
- Financial and other resources as agreed and available
- Linking into other strategies and work-streams
- Leadership and cultural acceptance

Key Stakeholders for PPI/PPE



Stakeholders	
External	**Staff**
▪ local Health watch/es ▪ local Councils ▪ local and national Commissioners ▪ national and local support groups – condition specific ▪ local organisations and charities	▪ executive leads ▪ board and CoG ▪ divisional leads ▪ external facing committees ▪ staff leads for experience, involvement and governance ▪ staff in general ▪ training and development ▪ volunteer services and FT membership manager ▪ service improvement team/s and programmes ▪ communications

Core Themes of the Strategy

Key Elements:

Theme: Training and Development

Theme: Training and Development (T&D)			
Actions	**Measured by**	**Led by**	**Timescale**
Core training & development for volunteers & patient reps , using best practice and information from LIA event	Content agreed, number of people attending such training	Trust / PPI/E Lead	Year One
Effective training and planning PPI/E resources for staff	Identify internal and external expertise to deliver any face-to face training	PPI/E Lead	Year One
Feedback and improvement	Annual feedback to be sought from volunteers, patient representatives and staff to evaluate and improve PPI/E process and experience	Chief Nurse	Year One / Continuous Objective
On-line resources	Develop bite-size approach to in-house on-line guidance for PPI/E, measure hits and downloads	Communications Team	Year Two

Theme Two: Involvement

Actions	Measured by	Led by	Timescale
Patient Groups	Number of patient groups per division	Divisional Teams	Year One
Patient / public representation on formal committees	Record of number of patient representatives on formal committees per Directorate / Division	Company Secretary/ Chief Nurse	Year One: To build on current profile
Quality Rounds and other Inspections with public and stakeholder participation. Ensure clear procedures and processes, with standard requirements for all taking part	Annual record of such inspections with numbers of public / stakeholder / governor participation. Feedback from those taking part and records of changes made	Chief Nurse / Trust PPI/PPE Lead	To build on current Position with annual objectives for improvement
Membership Education events	Annual number of members and wider public attending each event with subject headings.	Trust Company Secretary	To potentially re-profile this action to think about lectures and role at AGM
Patient participation in self-management programmes such as DAPHNE / Bridges	Number of patients involved in such programmes annually to clinical specific conditions	Divisional Teams	Year Two
Patient and Public Involvement in Clinical trials	Annual record of number of patients and public involved in clinical trials	Director Research	Year Two or Three
Patient and public involvement in teaching education programmes	Annual record of the number of patients and public in teaching and education programmes by subject area	Education Team	Year Two or Three
Levels of involvement	Individual, health care team, organisational and methods (policies include PPI/E, staff induction/training/goals include PPI/E, meetings and committees, data systems	Head of PPI/PPE	Ongoing

Theme Three: Governance

Theme: Governance			
Actions	**Measured by**	**Led by**	**Timescale**
Develop clear guidelines for volunteers and patient representatives as to their roles and responsibilities, taking account of trust liabilities	Formal documentation to be agreed by key stakeholders and implemented	Head of PPI/PPE	Year One
Develop clear guidance for staff in valuing and supporting volunteers and representatives	Guidance to be developed for staff, agreed with stakeholders and implemented.	Head of PPI/PPE	Year One
Evidence of representation of diverse groups that reflect the trust's communities	Reports should contain evidence to the participation of a range of representation from key protected groups through all elements of this PPI/E framework. Actions undertaken to improve underrepresented groups in PPI&E activities.	Head of PPI/PPE	Years One and Two
Annual review of progress against this strategy	Bi-annual update to PIC, PRG, CoG (membership sub-committee), with annual report to the Board	Head of PPI/PPE/ Deputy Chief Nurse	Year One
Developing the evidence base	Required use of the PPI/E e-platform to record PPI/E activities in all Directorates and Divisions for inclusion in the bi-annual / annual reports.	Head of PPI/PPE	Year Two
Agree Executive sponsor/s of this strategy and operational leads. Ensure clarity within corporate and division lead activities	Agreement of executive, operational and divisional structures to support this strategy and its governance / reporting structures.	Deputy Chief Nurse	Year One
New projects build in PPI/E costings and time as part of their business case.	Specific costings for PPI/E activity measured by time and finance allocations. (use examples from CCG and new cancer PPI planned role)	All SRO for key programmes at Trust/ Divisional Level	Years One and Two

Theme Four: Engagement

Theme: Engage			
Actions	**Measured by**	**Led by**	**Timescale**
Formal consultations	Annual record of the number of consultations held with members of the public attending	Head of PPI/PPE	Year One
Service Reviews and Development	Annual record of the number of patient and public / stakeholders engaged in service reviews and development by operational / clinical area	Head of PPI/PPE	Year One
Listening into Action events	Annual record to the number of members of the public attending events based on this methodology and subject area.	Head of PPI/PPE	Year One

Theme Five: Informing

Actions	Measured by	Led by	Timescale
Use of trust websites and other platforms to inform and engage with the wider public in our services , activities and events	Number of hits on the trust website, other media outlets, and distribution of other communication platforms such as The Gazette	Communications	Year One
Patient Information leaflets available on the Trust website for general information and condition specific	Number of Patient information leaflets available on the trust website and number of hits / downloads of such information, requests for accessible information and support measured annually	Communications Team	Year One
Improve the use of effective and relevant information on public notice boards	Undertake an audit of notice boards and develop guidelines for their use. Use volunteers and other inspections to validate the information on such boards	Communications Team	Year One
Greater promotion of volunteering and involvement opportunities across the trust	Monitor number of volunteers annually and steady growth in diverse populations getting involved in service reviews and development /s within all the Trust directorates	Head of Patient Experience	Year One

Theme Six: Experience

Theme: Experience			
Actions	**Measured by**	**Led by**	**Timescale**
Use of the Friends & Family measure and other surveys done in clinical and non-clinical settings in respect of patient experience	Co-ordination of such survey information in a single annual report, ensuring that key demographics and other 'protected group' initiatives are reported as standard. Reports to be broken down to Division and Service level	Deputy Chief Nurse	? Remove as difficult to use as an outcome measure
	Consider which related measures of staff experience would support this framework as there is a direct co-relation between patient and staff experience	Deputy HR Director	Year One
Corporate and service initiatives to improve the patient experience in trust – wide and identified groups / settings	Refinement of the RATE PPI database to capture such service initiatives measured by annual report indicating Division and corporate activities	Deputy Chief Nurse	Years Two and Three
	Annual report to count number of sessions and staff attending awareness activities in groups such as Dementia, Learning Disabilities etc., related to improving the patient experience.	Deputy Chief Nurse	
Triangulation of information	Triangulation of patient experience and relevant PPI/E information to support further improvements in the patient and carer experience	Deputy Chief Nurse	Year One

Year One Plan

Agree the annual priorities for 2016	
▪ **To each priority, identify an executive sponsor and operational lead**	
Priority	**Reason**
Governance section	Focus on ensuring that governance actions are agreed and adopted, otherwise we will not be able to produce the evidence and reports that will help to embed ownership through the organisation
Training and development	Good training and support for staff to develop and evidence PPI/E, so they will be more confident in working with patients and the public. Key is feedback from the year one activities to understand and evaluate how well the strategy is working in practice.
Involvement	Once the structures for governance and training support are in place, it will be easier to encourage more involvement through the organisation. Focus in year one on Quality Inspection programme, review of service changes as part of the Transformation programme.
Engagement	Proactive Engagement activity in service changes during 2016, evaluation of success through oversight and assurance of engagement in practice.
Informing	Strengthening information to support PPI/PPE activities
Experience	Stronger understanding of outcome measures alongside process improvement
Continue to review governance and training	To support and improve all core themes

Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD ***MAY 2016*** **Paper Ref:**

Paper Title:	**Outpatients Strategy, Paper A**
Sponsoring Director:	**Rob Elek**
Author:	**Fiona McCaul**
Purpose:	**To provide an update on the Outpatient Programme**
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	**For information** *(delete as appropriate)*
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	**N/A**

Executive summary

Paper a. Key messages

- The Outpatients Programme has had key challenges in Q4, notably in IT capability and in the coordination of its delivery plans
- Key resource issues have been addressed, IT /Cerner subject matter experts are now in place and the template specialty fix has been started; new business rules have been drafted for approval
- A programme refresh is proposed in order to support the recommendations of the Outpatients Review. This will entail changes to plans, governance and bringing a greater focus onto benefits

Paper a. Recommendations

- That the Board supports these actions taken in support of the recommendations contained in April's Outpatients Review

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?

Paper a.

- There is a risk that the resources and capability required to deliver the plan and the promised benefits may not match the resources currently available
- There is a risk that it may not be possible to plan and schedule benefits in detail until a decision is made about which elements the Programme Delivery Board/OSB agree will be part of the new operating model for outpatients

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

Equality Impact Assessment (EIA): Has an EIA been carried out? (Yes / No)
If yes, please provide a summary of the key findings

If no, please explain you reasons for not undertaking and EIA.
An EIA will be carried out as part of the Outpatients Programme and will be scheduled into the updated overall plan referred to in the paper

Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD *MAY 2016* **Paper Ref:**

Paper Title:	**Outpatients Strategy Paper A.** **Update on Programme to Deliver Change in Outpatients**

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

1. Progress Update

1.1. New Business Rules for Outpatients have been produced for approval

1.2. The work to change the specialty templates has been recruited to and is now underway, started in Trauma & Orthopaedics

1.3. QMH and St. George's have adopted a common income model to encourage working across locations to allow for the development of subsequent planned changes, for example more flexible movement of consultants across locations

1.4. An evaluation of use of patient check-in booths took place and recommendations will be developed into the plans

1.5. A comprehensive DIP was completed; this included an outline of the strategic vision, briefs for the work required to deliver that intention as well as target financial benefits and an outline milestone plan

1.6. Service capacity to deliver was limited and this had an impact on progress in Q4. The range of required changes is extensive in order to achieve the RTT and other quantifiable improvements.

1.7. IT capability was a key constraint to progress in Q4

2. Programme Refresh to support the recommendations of the Outpatients Review

2.1. The outpatients review, alongside a change of programme manager provided an opportunity to carry out a programme refresh during April/May

2.2. Building on the recommendations of the outpatient review, the programme organisation proposes to make alterations to achieve a more balanced spread of ownership across all the individuals and functions whose participation is needed for completion of the tasks of the plan

2.3. There is a risk that the small number of currently active workstreams may not deliver the anticipated benefits or the full strategic intention outlined in the DIP so it is proposed that the plan will be re-scoped; the profile of resources needed to deliver the work will also be re-confirmed and an assessment made as to whether more resources will be needed along with any cost impact

2.4. A key corrective action proposed is to bring all the IT elements of the work in outpatients under programme central governance;

2.5. It is proposed that the updated plan be published in May as a single coordinated directed plan to include phasing and gates, with a clear indication of where responsibility for delivery of change lies

2.6. A second corrective proposal will be to re-confirm the benefits stretch target for the programme and increase confidence that the full range of financial and non financial benefits projected in the DIP will be delivered

2.7. It is proposed that some re-shaping of the programme now takes place in order to create focus on a number of key cornerstones around which change will be delivered

- The patient
- The operating model
- Innovation for sustainability and growth
- Information management and workflow to support outpatients

2.8. It is proposed that each part of the programme will carry its own target benefit contribution, attributable to it and clearly arising from completion of key milestones

2.9. The Programme proposes to carry out an internal Assurance Review (Gate) in May and publish a full suite of updated documentation as well as a comprehensive risk register

2.10. The programme was impacted last quarter by a high number of internal dependencies between its own parts as well as some key external dependencies, for example upon Cerner. There have also been constraints due to workforce capacity and business intelligence capability and data quality

2.11. It is proposed that programme management be tightened to make for a more resilient accelerated programme, more active management of dependencies, milestones, enablers and issues with a focus on quantifiable added value from every part

3. Recommendation

That the Board supports these actions taken in support of the recommendations contained in April's Outpatients Review

St George's University Hospitals NHS
NHS Foundation Trust

Name and date of meeting: **TRUST BOARD** **Thursday 5th May**
Document Title: **Call Centre (CBS) Performance Update**
Action for the Trust Board: To understand the reasons for the current call centre performance which has fallen over a number of months now and to support the key actions identified.
Summary: The aim of this paper is to outline the factors contributing to current performance and action plan to support improvement.
Presented by: Andrew Rhodes
Author and Date: Lucy Titheridge, General Manager Outpatients 28th April 2016

1. EXECUTIVE SUMMARY

The Board has previously been informed of issues encountered in the call centre, which have resulted in long telephone call queues and poor patient experience. Over a number of months the call centre has had a deteriorating position, and whilst this drop in performance has now stabilised, this paper aims to explain the key issues the call centre is currently facing and identify the key actions to improve performance.

2. PERFORMANCE BACKGROUND

The call centre performance has been a significant issue for the Trust over the last year and recent performance against the average time to answer patient's calls is documented below:

- January - 5 minutes 32 seconds
- February – 3 minutes 58 seconds
- March – 5 minutes 46 seconds
- April – 4 minutes 05 seconds

The original metric set in 2014 for call centre performance on time to answer call was as follows:

1) 75% of calls will be answered in 30 seconds

3. CURRENT ISSUES

The poor performance can be explained by a number of factors:

1. Demand on the call centre has increased with additional work needed for RTT and the continued lack of capacity in the specialties creating difficulties in fixing appointments. This is compounded by the system continuing to produce a high number of last minute patient cancellations together with an increased number of patient displacements occurring as result of the template fix backlog work.
2. The junior doctor strikes have had a significant impact on the call centre which takes the responsibility for cancelling and rescheduling all of the outpatient appointments that are affected.
3. A new team that individually calls patients prior to their appointment to reduce the DNA rates has been set up. This has had a knock on impact on the call centre due to the identification of patients who need to change their appointment slots.
4. The call centre currently has 18 vacancies which is having a significant impact on current performance and staff experience.
5. The call centre has seen an increase in staff sickness in some cases due to the poor staff experience and difficult working environment and, though the relevant staff

members are being managed appropriately, this has had an impact on the number of call handlers.

6. The new outpatient management team which started in March have also identified that the current call centre leadership structure has a number of weaknesses. This is being addressed.
7. The partial booking process (PB1 - no fixed appointment) takes up significant resources especially when there is little capacity to book patients.
8. The call centre has had a number of intermittent IT issues.

4. ACTIONS TAKEN / RECOMMENDATION ACTIONS:

In relation to the points above, we have identified a number of actions to resolve these issues that either falls into the transformation programme or current operational performance:

<u>Operational Performance</u>

1. A monthly outpatient operational performance group has been set up, and is being chaired by the divisional director of operations for outpatients. This meeting is focused on outpatient performance issues, and has representatives from all divisions.
2. Outpatients have created and implemented a new management structure. A call centre project manager is starting w/c 2nd May. This project manager will be looking at the structure of the call centre, specifically how it currently interacts with patients and services and St George's. The call centre will be re-structured so specialty teams have set call centre team members booking and answering patients' calls, therefore increasing ownership and accountability of the call centre. The new project manager will also be responsible for hiring a dedicated call centre manager in replacement for the previous service manager.
3. The call centre is recruiting a number of additional staff ideally with call centre experience to support the current performance issues. Outpatients has historically been very difficult to appoint to, and the General Manager is working with the HR department at St George's to put together a bespoke staffing plan that attracts more staff to work in outpatients. Currently this plan includes offering further time and funds for training and development.
4. Outpatients have agreed a new process for managing ad-hoc clinic requests that should allow services greater flexibility in setting up extra clinics, but also limit the number of last minute (within 2 week) requests that currently take place.
5. To support the number of calls that the call centre currently receives the outpatient's team plan to extend the opening hours of the call centre from 8am-8pm, and 8am – 1pm on Saturdays. This plan is dependent on recruiting extra staff but we hope to have this in place by July 2016.

6. Outpatients plan to remove the current 11 week booking cap that stops the call centre booking any new patients over 11 weeks. This causes huge additional work for the call centre and leads to poor patient experience, as they often have to wait a number of weeks for specialties to produce additional capacity. The removal of the 11 week cap has been attempted before but got stopped due to a technical Cerner issue – which results in an 18 week cap once the 11 week cap is removed. In May, outpatients are working with specialty medicine to trial the removal of the 11 week cap and have IT support to do this. If successful this will be then rolled out for all specialties.
7. In the last 2 months the call centre team have set up a DNA team that are focusing on calling patients before appointments to improve DNA rates in the Trust. In the last 2 months this has ensured the Trust have not lost close to £100k in income, but has caused additional work for the call centre. A key action for the Trust is to ensure the text messaging system goes live in the next month, and the IT team are leading on this.

Transformation Programme

1. A review of the outpatient transformation programme has led to a proposal to change the governance of the transformation programme to ensure day to day operational call centre / outpatient running is embedded into the transformation programme.
2. As part of the outpatient transformation programme fixed appointments for patients will be introduced as part of the specialty fix. If this action was rolled out more quickly this would have an instant impact on the call centre performance reducing the current workload considerably. Services are currently concerned that fixed appointments would instantly lead to an additional 10-15% demand on outpatient capacity. The transformation programme includes a review of service capacity, and services have signed up to going live with fixed appointments once this has taken place.
3. Working with services to provide a better profile for short notice leave and sharing responsibility. This specific point is being managed as part of the outpatient programme and there have already been a number of meetings with services to agree new business rules for outpatients. These business rules are now in place and agreed by all services. From these business rules outpatients have also re-written the outpatient SLA. This has been sent to all services and will be signed off at the next outpatient strategy board.

5. CONCLUSION

The purpose of this paper is to update the Board on reasons for deterioration in the call centre performance and to set clearly the key actions that will improve performance in the coming months.

Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD *5th May 2016*

Paper Title:	**Commercial Board Annual Report 2015/16**
Sponsoring Director:	**Rob Elek, Director of Strategy**
Author:	**Karen Larcombe, Deputy Director of Strategy**
Purpose: *The purpose of bringing the report to the board*	*For the Board to note the work of the Commercial Board over the last year*
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	**For information**
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	**Commercial Board**

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

1. Key messages

The attached report sets out a summary of the work of the Commercial Board during 2015/16. The report gives an overview of the role of the Commercial Board, its membership, attendance and key commercial initiatives reviewed during the year.

Given the commercially sensitive nature of the work of the Commercial Board, the attached annual report presents a brief summary of the committee's discussions and decisions only, excluding commercially sensitive information.

2. Recommendation

The Board is asked to note the work of the Commercial Board.

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 annual report does not outline any specific risks.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	**Develop additional commercial income streams**
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	

Equality Impact Assessment (EIA): Has an EIA been carried out? (No)

St George's University Hospitals NHS
NHS Foundation Trust

Annual Report of the Commercial Board 2015/16

Produced by:

Rob Elek
Director of Strategy

1. Executive Summary

The Commercial Board has had oversight of a number of key commercial and NHS income generating schemes during 2015/16 and made recommendations to the Trust Board as and when required.

The committee believes that it has satisfactorily discharged its duties as defined within its terms of reference and a survey of members is due to be carried out to see what improvements, if any, need to be made.

2. Introduction

The Commercial Board is constituted as a standing committee of the Trust Board of St George's University Hospitals NHS Foundation Trust**.**

The Commercial Board has three principal roles:

1. To provide appropriate assurance on commercial work streams
2. To act as a forum for incubation, encouragement and the sharing of best practice
3. To agree the commercial work stream income targets and ensure delivery against them.

3. Confidentiality

The committee routinely discusses commercially confidential issues around commercial schemes and initiatives, accordingly it meets in private and its minutes are confidential. However, the chair of the committee routinely provides an oral report at the public meetings of the Trust Board. This annual report presents a brief summary of the committee's discussions and decisions, excluding commercially sensitive information.

4. Membership

The committee is chaired by a non-executive director. The membership of the committee during 2015/16 comprised the following:

Core members:

- Kate Leach, Non-executive director (Chair)
- Christopher Smallwood, Chair (open invitation)*
- Miles Scott, Chief Executive
- Steve Bolam, Chief Financial Officer
- Andrew Burn, Turnaround Director
- Rob Elek, Director of Strategy
- Karen Larcombe, Deputy Director of Strategy

Additional attendees for open part of meetings:

- Divisional Directors of Operations (or nominated representative)
- Divisional Business Development Managers
- Nick Dawson, Head of Business Development

In addition to this membership, the Committee is supported by, and invites to attend other senior managers within the Trust as appropriate.

*Note – Christopher Smallwood left at the end of January 2016, and was temporarily succeeded by Sarah Wilton.

5. Committee Meetings and Attendance

The committee met 6 times during 2015-16; the meeting dates and attendance of the core members are shown below**:**

1.	**Thursday 11th June 2015**	(Chair) Kate Leach – Non-Executive Director Rob Elek – Director of Strategy Karen Larcombe - Deputy Director of Strategy Miles Scott – Chief Executive Officer
2.	**Thursday 14th July 2015**	(Chair) Kate Leach – Non-Executive Director Steve Bolam – Chief Financial Officer Andrew Burn – Director of Turnaround Rob Elek – Director of Strategy Karen Larcombe Deputy Director of Strategy Miles Scott – Chief Executive Officer
3.	**Monday 17th September 2015**	(Chair) Kate Leach – Non-Executive Director Andrew Burn – Director of Turnaround Rob Elek – Director of Strategy Karen Larcombe Deputy Director of Strategy
4.	**Monday 16th November 2015**	(Chair) Kate Leach – Non-Executive Director Rob Elek – Director of Strategy Karen Larcombe Deputy Director of Strategy Miles Scott – Chief Executive Officer
5.	**Thursday 28th January 2016**	(Chair) Kate Leach – Non-Executive Director Rob Elek – Director of Strategy Karen Larcombe Deputy Director of Strategy Miles Scott – Chief Executive Officer
6.	**Thursday 17th March 2016**	(Chair) Kate Leach – Non-Executive Director Rob Elek – Director of Strategy Karen Larcombe – Deputy Director of Strategy

The overall attendance of core members is shown below:

- Kate Leach (Chair) 6/6
- Steve Bolam 1/6
- Andrew Burn 2/5 (Joined at second meeting)
- Rob Elek 6/6
- Karen Larcombe 6/6
- Miles Scott 4/6
- Christopher Smallwood 0/4 (Had left the Trust before 5th meeting)

6. Report on activity during 2015/16

Operation of the Commercial Board

The Commercial Board has spent time during 2015/16 working out the best way to discharge its responsibilities, and as a result has reviewed its membership as well as the frequency and composition of meetings. A revised set of Terms of Reference were approved at the meeting on 16th November 2015**.** This resulted in the plan to move to monthly meetings, and the identification of a 'core membership' and others invited dependent upon the agenda.

NHS Activity Growth and Market Share Gains

A focus of the Committee has included gaining an oversight of annual planned NHS income growth, particularly to understand where marketing support would be required to deliver this. During the year the committee reviewed agreed SLAs for 2015/16, and first cut proposals for 2016/17. The new contract for services at the Nelson, worth £4.6m, was a key contributor to the income growth for 2015/16, and therefore delivery against this new contract was a key objective in year.

The first-cut SLA proposals for 2016/17 showed very modest plans for growth above demographic growth and the full year effect of 2015/16 Business Cases, with the exception of Neurosurgery (as in the previous year). This latter specialty is a key area requiring marketing effort.

Emerging marketing plans for Neurosurgery, including an analysis of market share, and key activities to increase market share, were reviewed at the meeting in November 2015.

Commercial Schemes

Non-Invasive Prenatal Testing (NIPT) – The Commercial Board supported the aspiration for the Trust to become the UK's first centre of excellence for non-invasive prenatal screening. NIPT is an advanced screening test for pregnant women, using a small blood sample rather than an invasive procedure such as amniocentisis, the test that estimates the risk of a fetus having Down's syndrome or other serious genetic disorders. The Trust partnered with a commercial company, using their test, to commence provision of this service in early December 2015, following a period of validation. Regular updates on progress were received throughout the year at the Commercial Board, noting that there

had been some unforeseen issues with rollout. The Commercial Board members were keen to ensure that the learning from this roll-out was reviewed, to embrace the learning for this, and other projects. At the Commercial Board meeting in March 2016, assurance was provided that activity would be brought back to plan, and consideration was given to future profitability and Phase 2 development.

Physitrack – regular updates were provided on the planned arrangement with an IT company to develop an app where physiotherapists demonstrate rehabilitation exercises, thereby allowing patients greater accessibility to physiotherapy regimes. The end point of discussions with the company had been agreement for St George's to have a small shareholding in the company.

Geneworks – regular updates were provided on the bespoke genetics laboratory data management system that was developed in house, including progress on a current Service Level Agreement with an existing user, and plans to consider the potential to market this service more widely. The SLA issue was resolved, but progress against the market scoping exercise has not yet been concluded.

Pharmacy services – presentations have been given to the Commercial Board on the potential to develop a number of commercial schemes in Pharmacy. Approval was given for the pharmacy service to develop two commercial schemes: a drug development and a Pharmacy Packing Unit. Both of these are still work in progress, and progress has been regularly reviewed.

Private Patient Services

Dedicated Private Patient Unit – the original plan was for a dedicated Private Patient Unit to be developed in conjunction with a private provider. Regular progress reports against this were received, but during the course of the year it became apparent that progress had stalled.

Following the Commercial Board meeting in September 2015, the Trust commissioned a strategic review of the options for private patient activity at St George's. The findings of this review were discussed at the Commercial Board meeting in January 2016, which included short-term (within 12 months), medium-term (1-3 years) and long-term (3-5 years) recommendations. It was agreed that the development of a dedicated Private Patients Unit was still the right direction of travel for the long term, and that a revised business case should be prepared. Short and medium term recommendations were also supported which included continuing to incrementally develop private services on site – see below for further details of short-term plans and progress.

Private Patient Services - Opportunities to further develop private patient services using existing facilities were regularly reviewed throughout the year, with a number of key specialties identified: Neurosciences; Cardiology; Cardiac Surgery and Dermatology. Although there have been operational issues along the way, progress is being made in the first two of these.

Overseas Activity

Overseas Chargeable patients - The implications of the national changes to the charging rules for overseas patients, that took effect in April 2015, were reviewed to ensure that the Trust adopted an appropriate strategy.

Gibraltar – the Trust has an agreement with Gibraltar to provide a range of clinical services, with both Consultants visiting Gibraltar and some patients coming to the Trust for treatment. The Commercial Board has sought assurance that an appropriate contract is in place, that income targets are being met and that there are no knock-on consequences to NHS services in the Trust.

NHS Tender Opportunities

The Commercial Board receives regular reports on NHS tender activity, including opportunities identified, tenders being pursed and those not being pursued, as well as the outcomes of tenders. In year successful tenders included: school nursing for Wandsworth; plastics services to Ashford and St Peter's; pharmacy services to Epsom and St Helier; inclusion on the childhood immunisations framework and breast screening services. There were no unsuccessful tenders, and the outcome of some tenders is still awaited. It was noted that many community tender opportunities are not explored as they are geographically removed from the Trust. After detailed work, two community tenders (Merton Community Services and Wandsworth's Community-Contraceptive and Sexual Health Service (C-CASH)) were not pursued due to the financial risk.

Other Commercial Opportunities

Education - at the Commercial Board meeting on 17th September 2015 a presentation was received on education activity and the opportunities for income generation. It was noted that the Trust has been more successful at gaining income from Health Education South London (HESL) for specific initiatives rather than the broader commercialisation of the educational offering. There is future scope here.

Estates – the Commercial Board also has an interest in plans to develop commercial estates related schemes and received periodic reports during 2015/16.

Intellectual Property

The Commercial Board was advised that there is now greater alignment between the Trust and St George's, University of London's Intellectual Property (IP) policies.

Updates are provided on any IP opportunities as they arise, and in year reports were provided on plans to capitalise on one of the Cardiologist's innovative technologies.

This annual report was approved by the Chair of the Commercial Board at its meeting on 19th April 2016.

Rob Elek
Director of Strategy

Name and date of meeting:

TRUST BOARD 5TH MAY 2016

Document Title:

Annual (Operational) Plan Q4 monitoring report

Action for the Trust Board:

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

Introduction:

The Annual Plan document was approved by the board in April with associated corporate objectives and submitted to Monitor on 15th May 2015.

Quarterly reports have been brought to the Trust Board in July, November and January 2016. The latest report both seeks to outline Q4 developments and progress, and also to make a judgement about overall delivery during the year against each of the agreed objectives.

Progress report:

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

The Q4 detailed report on our granular progress towards delivery of the annual plan is attached to this cover paper as a separate document (Appendix 1).

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

The Board requested that we also develop a critical path approach to monitoring the annual plan, highlighting those key milestones that would give assurance on delivery against these priorities. The critical path appraisal is shown on the page following the objective based dashboard.

Conclusion:

The trust set 34 corporate objectives for 2015/16:

- 20 are RAG rated as Green at quarter 4 (No change)
- 8 are Amber (-3)
- 6 are Red (+3).

Of the 6 strategic themes, 4 are RAG rated as Green, 3 at Amber and 0 Red.

Overall performance, when measured quantitatively against these objectives, would therefore be assessed as **Amber** (Amber in Q3).

However, the appraisal of the priorities articulated within the main body of the Annual Plan, how they impact on income and operational performance, and what we consider the resultant overall organisation position to be would lead to a **Red** assessment (Red in Q3).

Author and Date: Rob Elek, Director of Strategy
Tom Ellis, Head of Business Planning
29th April 2016

Annual Plan dashboard – Q4
Performance summary

Theme	Commentary		Q4 Rating
0. Overall Progress	6 themes – 3 green, 3 amber, 1 (Q1 0) red	Net change from Q2: -1 red, +1 amber	↔
	34 objectives – 20 green, 12 amber, 2 red	Net change from Q2: +2 green, -1 amber, -1 red	
1. Redesign care pathways to keep more people out of hospital	6 objectives – 4 green, 1 amber, 1 red	Net change from Q2: -1 green, +1 amber	↔
	Performance on CAHS, and working with sector partners remains strong, and is classed as green. A&E and RTT targets continue to not be met, and the trust has taken steps in Q4 to develop plans to deliver in 2016/17		
2. Redesign and reconfigure our local hospital services	5 objectives – 1 green, 3 amber, 1 red	Net change from 2: -1 amber, +1 red	↔
	Overall capacity has increased in year, but not all anticipated schemes have been delivered (remains at amber). The 5th floor scheme has slipped, overall progress now downgraded to Red. The PPU development is rated as amber as the Private Patient Strategy, which is not reliant on a new physical unit, was approved in January 2016. Nelson remains at Amber, as the trust has worked hard to deliver services at the site, but referrals from Merton GPs have remained below trajectory; SWL acute provider work progressing well (green)		
3. Consolidate and expand our key specialist services	5 objectives – 4 green, 0 amber, 1 red	Net change: +1 green, -1 amber	↑
	Renal scheme rated as Red due to problems with proposed development and likely requirement to re-think overall scheme. Cardiology beds opened in Q4, moving that objective from amber to green. MacMillan partnership work very positive and being implemented. Rehab discussions with commissioners have had positive outcome		
4. Drive research and innovation	4 objectives – 3 green, 0 amber, 1 red	Net change: +1 green, -1 amber	↔
	Main change has been the unsuccessful bid for an NIHR Clinical research facility. Other objectives remain as before – Cardiology CAG fully functional and key commercial projects progressing well (green).		
5. Improve productivity, the environment and systems to enable excellent care	9 objectives – 5 green, 4 amber, 0 red	Net change: -1 red, +amber	↔
	No change overall in the objectives apart from the downgraded of the outpatient strategy from green to amber. Flow programme continues to progress; compliance on follow-up to diagnostic tests received from Divisional chairs. Sign up to Safety funding bid unsuccessful. Please note it has not proved possible to get an update on the EDM and e-prescribing projects.		
6. Develop a highly skilled and engaged workforce championing our values	5 objectives – 3 green, 2 amber, 0 red	No change on previous quarter	↔
	No change on any RAG ratings in quarter. Leadership development programme being implemented (green), though turnover increasing; OD programme accelerating (green); values - staff feedback continues to highlight behaviours as an issue (amber); SWL shared bank programme progressing.		

Annual Plan critical path appraisal – Q4 performance summary

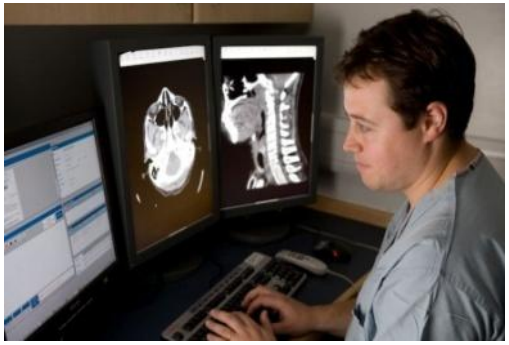
	Q1 report	Q2 report	Q3 report	Q4 report
Strategic plan	SLR	SLR	SLR	SLR
	PPE post 2013 investments	Wider scope investment review	2016/17 business planning	2016/17 annual plan
	SWL acute provider scoping	SWL APC report & Vanguard	SWL APC workshops	SWL strategy
		Radical service redesign	Strategy refresh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

Overall position				

St George's University Hospitals NHS
NHS Foundation Trust

Corporate Objectives 2015/16
Delivery Plan and Monitoring
Quarter 4 and End of Year Summary

Delivery of our 15/16 Annual Plan and Objectives



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

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

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

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

Governance: Reviewing progress

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

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

Progress Tracker – Position at Q4

RAG STATUS	QUARTER				Commentary
	Q1 Position	Q 2 Position	Q3 Position	Q4 Position	
GREEN	16	18	20	20	59% of objectives (20 / 34) have been classified as Green. Good progress made to delivering the milestones set for the quarter and the year overall. One objective have moved from amber to green – Cardiology expansion. Outpatient Strategy moved from Green to Amber.
	47 %	53%	59%	59%	
AMBER	17	13	11	8	23% of objectives (8/ 34) have been classified as amber. Key changes have been the movement of several objectives from Amber to Green in Q4, detail provided below
	50 %	38%	32%	23%	
RED	1	3	3	6	18% of objectives (6 / 34) have been classified as red. Key amongst them are delivery of targets and the delay in a number of estate projects for example the renal redevelopment project, and the children & women's hospital development.
	3 %	9%	9%	18%	

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

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Implement the new model of care in community adult health services (CAHS) **Lead:** *Chief Operating Officer*	Q4 RAG Status (↔)	• Mobilisation for the new CAHS completed • Wandsworth CCG Board have agreed to extend the CAHS contract for a period of 18months to September 2017 to align with the procurement of a Multi-speciality Community Provider (MCP) in Wandsworth	Full year RAG Status (↔)
	No specific actions for Q4		**We achieved:** ▪ Fully operationalised CAHS service from 01/04/15 ▪ WCCG agreed not to tender till 2018 ▪ On-going review and engagement ▪ Positive Board to Board **We did not achieve:** ▪ Been able to fully staff the CAHS model ▪ Deliver all the hoped for benefits, in part linked to WCCG changing the specification

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

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Complete the redesign of services for frail older people *Chief Operating Officer*	Q4 RAG Status (↔)	• MADE event supported by ECIP took place on 18th & 19th January 2016, with wide stakeholder engagement across health and social care. Commitment to develop discharge to assess model and simplify discharge processes to reduce LOS and DTOCs	Full year RAG Status (↔)
	No specific actions for Q4		**We achieved:** ▪ Secure funding from CCGs for front door frailty service ▪ WCCG & MCCG working with trust to develop integrated frailty and community geriatrician services ▪ Older Person's Advice and Liaison Service (Front Door Frailty) launched in October 2014. ▪ Funding now secured from WCCG for interface geriatrician role. Recruitment in progress for MCCG interface post (HARI) with AAC on 25th Feb 2016 **We did not achieve:** ▪ Clarity on funding of Nightingale Housie ▪ HARI funding at Nelson Health Centre ▪ Acute and community services continuing to work with CCGs to develop integrated model.

Redesign care pathways to keep more people out of hospital: 3

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Bid to provide Community Services to the residents of Merton *Director of Strategy*	Q4 RAG Status (↔)	No change – St. George's did not bid to provide community services for Merton	Full year RAG Status (↔)
	ITT outcome published. If SGH successful begin delivery of mobilisation plan		An ITT was developed in partnership with other providers, however the trust decided not to submit a bid owing to the risk profile of the specification / staffing / activity data / intermediate care provision / potential capital costs / mobilisation costs (in-year) and delivery RAG rating green as Trust has made an informed decision to withdraw from the process
Support the delivery of the Wandsworth joint health and well being strategy *Director of Strategy*	Q4 RAG Status (↔)	• The engagement with the local authority's public health department to develop new models of care continues; this will entail the use of different locations and will support the transfer of activities from acute to community based sites. • The formal cross-rail consultation process has closed, though we continue to engage and voice our concerns around the proposal to have the Northern line interchange at Balham rather than Tooting Broadway.	Full year RAG Status (↔)
	No specific actions identified for Q4		**We achieved:** ▪ Supported the HWB as requested ▪ Worked with HWB on health service options in Nine Elms ▪ Following the incomplete community sexual health tender, we are engaging with the local authorities PH department to develop new models of care. **We did not achieve:** ▪ None

Redesign care pathways to keep more people out of hospital: 4

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Develop and implement new models of care and further develop the St. George's network as per 5YFV *Director of Strategy*	Q4 RAG Status (↔) No specific actions identified for Q4	• The implementation plan for the Marsden Partners vanguard is proceeding, key risks remain around the previous LCA processes and how the vanguard will progress them, as well as the wider implications of an accountable care network for cancer in SW London. • Good engagement continues with Wandsworth GP federation around the development of a MSCP, this will accelerate following the award of the Enhanced Care Pathway tender to the federation. A positive meeting with SWL Lambeth federation was held in Q4. • The recent board strategy away day posed some key strategic questions that we will seek to develop over the coming months, in parallel to the development of the health economy strategic plan (due for submission in June)	Full year RAG Status (↔) **We achieved:** ▪ Engaged with GP for a regarding the service reconfiguration ▪ Engaged with SWLCC and SWLCAPC and the overall Health Partnership in a constructive way to the benefit of St. George's ▪ Good engagement and contribution to SWL STP, the vehicle for 16/17 development at a sector wide level **We did not achieve:** ▪ Unsuccessful Vanguard bid thought SWL APC

Redesign care pathways to keep more people out of hospital: 5

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Deliver access targets - RTT, A&E and Cancer through - Robust use of information - Aligning capacity and demand - Working in partnership with providers *Chief Operating Officer*	Q4 RAG Status (↔) Increased bed capacity either physical or through LOS reductions on-site at the Trust	• A cancer action plan has been agreed with commissioners and NHSE and is currently being implemented. The trust did not meet the proposed trajectory for February however, and a new trajectory, linked to STF funding, has been agreed from April onwards. • The trust has agreed a trajectory for each clinical service which is currently not meeting the 18 week RTT target for elective care, and will be monitored against this on a monthly basis through 2016/17. • Bed capacity has not increased significantly and LOS remains relatively unchanged	Full year RAG Status (↔) We achieved: ▪ Worked openly and transparently with commissioners on the scale of problems and plans to address ▪ Commissioned "One Version of the truth" review of A&E and begun implementation of outcomes ▪ Appointed COO to strengthen operational performance We did not achieve: ▪ The trust has not achieved its RTT and A&E standard across the year and also had problems with consistently delivering the various cancer targets

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

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Delivering additional capacity in line with clinical need *Director of Transformation / Director of Estates & Facilities*	Q4 RAG Status (↔) No specific actions for Q4.	• Recovery at Home servicer started on 18th January 2016 • Hybrid theatre build completed and opened • Nightingale re-opened in January, as opposed to November, due to hearing problems at Nightingale House.	Full year RAG Status (↔) **We achieved:** ▪ Opened the Recovery at Home service ▪ Completed and opened the Hybrid Vascular theatre ▪ Opened additional Neurosciences beds on Thomas Young and in the Neuro Gym ▪ Increased cardiac capacity with 7 additional beds **We did not achieve:** ▪ SAU, CDU3 and CICU schemes all postponed from 15/16 due to funding ▪ Slippage in AMW bed schemes due to PFI approval delays.

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

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Children's and Women Hospital *Director of Strategy*	Q4 RAG Status (↓) Board approval of OBC for Women and Children's project	• Alternative delivery solutions are under consideration for the 5th floor scheme in light of recent surveys. • Case for support for Centre for Fetal Health under development. • Discussions continue with the Marsden for the development of a "Marsden @ SGH" range of paediatric services, though this has slowed somewhat in recent weeks.. • Key meeting hosted by CEO in January re Dalby and other inter-dependencies and alternative options are under consideration.	Full year RAG Status (↓) The trust has not progressed the Children's & Women's Hospital project as it would have hoped and at this stage there is not an agreed plan in place to deliver this project
Private Patients Unit *Director of Strategy*	Q4 RAG Status (↔) Commence building work	• PP strategy completed and approved by Board • The short, medium and long term recommendations including physical capacity needs, service offer and consultant engagement are being implemented. • The long term business case is nearing completion	Full year RAG Status (↔) Significant progress during the year on developing PP and commercial work and income. However, this objective is classified as amber as it has not been possible to progress the new build with a private provider following their withdrawal from active development of the project

Redesign and reconfigure our local hospital services to provide higher quality care: 3

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Implement all Merton CCG requirements at the Nelson Health Centre *Chief Operating Officer*	Q4 RAG Status (↔) Implement final year 1 redesign changes	Activity at the Nelson continues to be under contracted volume with low levels of direct GP referrals. The trust is continuing to work with MCCG and other stakeholders to develop referral flows. Non-delivery of core expectations has led to delay in discussions about specific redesign of services	Full year RAG Status(↔) Although the Nelson opened on time and the trust has put in significant time and commitment to delivering services on site there, the volume of activity at Nelson never met projections, despite an on-going effort to increase referrals from particularly Merton GPs.
South West London Service Reconfiguration Continue to work closely with the SW London Collaborative Commissioning Programme and take a leadership role in the Acute Provider and Out of Hospital projects *Director of Strategy*	Q4 RAG Status (↔) Develop detailed proposals	• Health partnership now formed. Governance structures have been amended several times, though key work streams are now progressing. • Key risks are now around STP timescale and the acceptability in practice of the solutions developed last year. • Sutton SOC and health economy wide estates requirements need to be surfaced holistically	Full year RAG Status (↔) The trust has actively engaged with the evolving structures for south west London reconfiguration discussions, and will continue to do so with the emerging Sustainability and Transformation Plan

Consolidate and expand our key specialist services: 1

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Renal Redevelopment at St. George's *Divisional Chair MC Division*	Q4 RAG Status (↔)	With the PPU build in abeyance the OBC proposal for renal did not develop to FBC stage. Current renal unit experiencing repeated infrastructure breakdowns through Q4. The project has been reformulated, linking it opt the Fix, Close, Transfer Portfolio Optimisation Workstream, and is aiming for a new OBC to be presented to the Trust board in July 2016 to provide a new answer to the long term delivery of renal on the St. George's site.	Full year RAG Status (↔)
	Commence PPU building work including new renal wing		Despite initial good progress, with the OBC being approved at the Trust Board in April 2015, the inability to progress the preferred option of a new build as part of the PPU development, has led to the stalling of the build of a new renal unit on site. The current premises have also deteriorated during the year.
Cardiology expansion *Director of Transformation*	Q4 RAG Status (↑)	• 7 beds opened in quarter four	Full year RAG Status (↑)
	No specific actions identified for Q4		The trust had hoped for an earlier completion of the extra beds in AMW, but complications with the PFI and other internal trust delays led to a delay in the opening of the additional beds, though there were finally opened in Q4, hence the RAG status.

Consolidate and expand our key specialist services: 2

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Deliver redesigned cancer services in partnership with MacMillan *Chief Nurse & DIPC / Divisional Chair SNT Division*	Q4 RAG Status (↔) No specific actions identified for Q4	The service has continued to be developed and delivered and the arrangement has continued to be successful in Q4	Full year RAG Status (↔) A great deal of progress has been and continues to be made. The grant application to MacMillan was approved, securing £600,000 funding for the first year of a three year programme. Work streams developed include: Acute Oncology Service redesign project; Macmillan Support Worker Pilot to increase CNS availability; Values Based Standards project to improve the Surgical Pathway Experience; Patient and Public Involvement Pilot. Per the Macmillan partnership agreement, joint communications have developed a cobrand and logo and released an announcement of the partnership programme. An evaluation framework has been developed and agreed using a logic model approach.
Neurosciences Expansion *Director of Transformation*	Q4 RAG Status (↔) • Appointment of senior lecturer in neurosurgery • Deliver increased activity target for year following opening of new capacity	• Senior lecturer in Neurosurgery appointed on 11th April	Full year RAG Status (↔) The service has successfully developed this year, with additional beds being opened on Thomas Young and at QMH, and senior posts being developed and appointed to – a Professor of Neurology and Senior Lecturer in Neurosurgery

Consolidate and expand our key specialist services: 3

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Develop and implement a rehabilitation strategy Establish a 6 bedded spinal rehabilitation service in partnership with the Royal National Orthopaedic Hospital, Stanmore *Director of Transformation*	Q4 RAG Status (↔) Decision by commissioners re. support for 6 bedded unit	• Commissioners have supported the development of a 6 bedded unit, with the service due to start from Q3	Full year RAG Status(↔) • Rehab strategy groups established meeting monthly. • Cohorting of patients on new Thomas Young beds. • Discussions underway with CCG re commissioning a spinal rehab unit in partnership with RNOH. • New neuro rehab consultants in post.

Drive research and innovation through our clinical services: 1

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Continue to increase the number of patients recruited into NIHR studies excluding the impacts of large one off studies *Medical Director*	Q4 RAG Status (↔) • Improved timeline from site selection to NHS Permissions • Meet target set with CRN 4,920 • Increase no of approved studies in year	• This is the 1st year we have been collecting data on this timeline so hard to compare. The shortest timeline was 34 days; longest was 334 days (a subsequent follow up study, counting from the date of the original study site selection). It is an on-going focus. • The target was met and exceeded. 5,285 patients were recruited until the end of February and we are awaiting updated and completed recruitment for the complete FY • In 2015, the research office approved 168 new studies to be performed at St George's, a slight decrease (19 in total) from 2014. Just under 70% are adopted onto the NIHR portfolio, up from 30% in 2013, and 60% in 2014. This is an important considerations in terms of securing infrastructure funding and also ensuring more of our St George's sponsored studies apply for portfolio adoption	Full year RAG Status (↔) **We achieved:** ▪ Research Handbook launched ▪ Access to the EDGE database ▪ Website updated ▪ Exceeded the CRN target **We did not achieve:** ▪ Appointment to all vacant posts and delays in appointments in others. ▪ There were delays in recruitment to trials ▪ Research Sabbaticals Grant Scheme 2016 delayed, pending agreement of 16/17 budget re-forecasting ▪ Funding and development of the research function at the trust affected by trust turnaround process

Drive research and innovation through our clinical services: 2

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Ensure the Trust is in a position to make a successful bid for NIHR Clinical Research Facility funding *Medical Director*	Q4 RAG Status (↓) No specific actions identified for Q4	•The NIHR Biomedical Research Centre bid unfortunately did not pass the PQQ selection. Reasons cited were the volume of world class research and researchers, the track record of the University/NHS partnership and the strength of the strategic of plan. •The organisations have decided not to pursue an NIHR CRF bid in the current round because there is unlikely to be sufficient critical mass of early translational research at St George's to be successful	Full year RAG Status (↓) Bid for Bio-medical research centre unsuccessful and trust unlikely to pursue NIHR CRF bid

Drive research and innovation through our clinical services: 3

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Increase collaborations between SGUL Institutes and Trust clinical directorates through the development of further CAGs: Cardiology Neurosciences *Director of Strategy*	Q4 RAG Status (↔)	The Cardiology CAG is progressing well and a six month progress report is due to be presented to the Joint Implementation Board in April 2016. The proposal for the establishment of a Neurosciences CAG was reviewed by the Joint Implementation Board (JIB) in February 2016, and approved in principle subject to some changes to the leadership model, clarification of financial issues and clarity around vision. An updated proposal will be reviewed at the next JIB in April 2016	Full year RAG Status (↔)
	No specific actions identified		The Chief of Cardiology CAG was appointed in July 2015, and the supporting team have since been appointed including: General Manager; Lead for Research; Lead for Education; Lead for Clinical Services and a Lead for Audit & Governance. The Cardiology CAG is now fully operational. The strategic review has been completed and the CCAG is now working on its business plan across the two organisations.
Develop additional commercial income streams *Director of Strategy*	Q4 RAG Status (↔)	• The Commercial DIP is being developed • This project encompasses increasing private patient activity through an increased number of beds, improving performance against the Gibraltar contract, and the development of an offsite Pharmacy Packing Unit (PPU). • Work continues on assessing and applying as appropriate for NHS tender opportunities. We were awarded the contract for breast screening in December 2015. • Good progress continues to be made on NIPT (Non Invasive Prenatal Testing) service.	Full year RAG Status (↔)
	No specific actions identified		• Gibraltar contract signed and service being delivered. • NIPT service commenced • Commercial DIP developed • Breast Screening tender won in December 2015 • Pharmacy commercial strategy under development, with business case for initial priority in draft.

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

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Prepare plans to complete the deployment of electronic prescribing, drug administration and clinical documentation for all inpatients, operating theatres and ED on the St. George's campus in 2016/17 *Director of Transformation*	Q4 RAG Status (↔) • Cerner Code upgrade live	• No update provided	Full year RAG Status (↔) The full business case to complete the deployment on the St. George's campus was agreed by the Business Case Advisory Group on the 16th November 2015.
Implement electronic document management and electronic referral system for all new out-patient registrations at St. George's *Director of Transformation*	Q4 RAG Status (↔) No specific actions listed Q3 action: All newly registered outpatient records scanned for St. George's campus activity	• No update provided	Full year RAG Status (↔) With the exception of Neurology (which is now scheduled to take place in January 2016) newly registered outpatients records are now completed

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

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Develop and implement an Outpatient Strategy *Director of Strategy*	Q4 RAG Status (↓)	• Detailed implementation plan (DIP) finalised, though currently under review to quantify and assure delivery of project benefits • The previously highlighted absence of innovation (new models of care) and disconnect with other outpatient–related work streams will be debated at April board.	Full year RAG Status (↓)
	Agree model of care and 5 year strategy		Board approved "strategy" in Q3 – focusing on centralising the management of outpatients services and adopting a single business model across the organisation. Good progress being made on these core outcomes.
Objective to support both effective elective and non- elective flow through the organisation to improve the Patient Experience and support performance standards where applicable *Chief Nurse & DIPC*	Q4 RAG Status (↔)	Work completed in Q3 led by the SRG to understand the system profile in relation to patient flow and to agree a set of actions across Health and Social Care settings (OVOT) Flow programme realigned against OVOT and merged with Trust Programme. Mobilisation commenced in January to deliver actions following the SRG programme as part of clinical transformation for 16/17.	Full year RAG Status (↔)
	Consolidation of the programme		Flow programme developed and approved at the trust board, and specific plans also developed to help the trust meet the challenges of winter.

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

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Provide transparency on outcomes by publishing consultant level activity data, clinical quality measures and survival rates from all nationally agreed audits *Medical Director*	Q4 RAG Status (↔) • Review	On-going review	Full year RAG Status (↔) • Comply with publication of Consultant-level national audit data. Link for public viewing is on website. • Published activity data available for National Audits. • Action to continually improve learning from national audits and strengthen local data processes. • National Audit data provided in Board report. • Compliance with national mortality monitoring initiatives- we have offered to be a pilot site for new programmed
Creating Reliable processes for reducing avoidable harm - Follow Up of Diagnostic Tests - to implement a framework which will mitigate risk to an acceptable position *Medical Director*	Q4 RAG Status (↔) Consolidation	Repeat internal audit report showed that compliance remains variable.	Full year RAG Status (↔) A new Trust Policy on this including mandatory electronic sign off of radiology and histopathology was implemented in September. A report showing results not reviewed has been developed. Correct attribution of tests to consultants has caused real difficulties with implementation.

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

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Commence Sign Up to Safety Programme as element of Quality Improvement Strategy *Chief Nurse & DIPC / Medical Director*	Q4 RAG Status (↔) Begin planning for 16/17 and continue to evaluate impact of programme	The trust was not been successful in its bid to NHSLA for funding for the programme (equivalent to 10% of NHSLA premium charged). Discrete work programme in relation to sepsis are in place and continue as part of the Quality Improvement Strategy- Annual Plan. Position in Q4 as per Q3	Full year RAG Status (↔) Unsuccessful in bid for Sign Up to Safety programme but many elements taken forward in Trust Quality Improvement Strategy
Ensure delivery of safe clean environments and use of patient feedback as a vehicle for continuous improvement and adoption of best practice *Chief Nurse & DIPC*	Q4 RAG Status (↔) Implementation of actions plans, review and evaluation of data to inform further action	• Outpatient Improvement programme transferred to Outpatient Strategy objective • Feedback for divisional teams on-going on outcomes of patient feedback • Looking to triangulate information by clinical area to develop a truly informed picture of current position which can be shared with clinical teams	Full year RAG Status (↔) On-going programme in place, though challenges in the environment this year have led to classification as amber

Improve productivity, the environment and systems to enable excellent care: 5

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Evaluation of Clinical Audit results and acting on findings to ensure audit contributes to improvements for patients *Chief Nurse & DIPC*	Q4 RAG Status (↔) • Agreed Divisional Programme in place • Quarterly monitoring of Programme against Plan. • Monthly reporting to Board of Key Audits • Ensure Key Actions from Audit findings • Agree Audit Plan for 2016/17	• Audit programme is in place and monitoring of progress and outcomes has improved. We are working towards gathering a final position in terms of achievement and outcomes in Q4. • The Q3/4 position will be used to shape the audit programme for 2016/17. Subject to approval by the Patient Safety Committee, and the support of the Clinical Effectiveness and Audit Committee, it is anticipated that the programme for 16/17 will focus on 'getting the basics right' and be used to support and monitor the impact of transformation. Key audits where improvements are not demonstrated will be identified, projects reviewed and reshaped to support implementation and monitoring of improvement in 2016/17 (such as EWS, record keeping, WHO, consent). • To redesign the reporting of audit to the Board and integration into revised Integrated Performance report.	Full year RAG Status (↔) Programme in place and being delivered

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

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Develop leadership behaviours to deliver high quality *Director of HR and OD*	Q4 RAG Status (↔) • Evaluate programme delivered to date • Review LiAise role effectiveness	• Leadership development programme designed and agreed by workforce and education committee September 2015. • Assessment process for executive directors commissioned • On track for delivery of electronic appraisal system. • Senior leaders' objectives agreed and circulated. • Nursing establishment review completed for Phase 1 covering approx. 80% of the workforce. Phase 2 now in train and will conclude by end April 2016. • Turnover remains high however , focus on actions to reduce turnover through use of a variety of approaches e.g. exit interviews, training and development • Leadership academy launched and programmes in place.	Full year RAG Status (↔) Programme has had difficult first year in reflection of the challenges the trust has faced, but overall has had a successful first year
Implement an organisational development programme that supports the Divisional governance review findings *Director of HR and OD*	Q4 RAG Status (↔) • Evaluation of programme	• Organisational Development Manager in post with effect from 1st October. • Divisional leadership teams are being allocated organisational development days to meet specific team building and coaching requirements. • Development programmes are being well received by the divisions • Hay Group Executive Management team assessment completed. • Organisational development programme in place to support the transformation programme	Full year RAG Status (↔) OD Manager in post Q3. Divisional programmes well received and learning used to support transformation programme

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

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Embed the Trust values, recognise achievement and ensure staff achieve their maximum potential as well as tackling poor performance *Director of HR and OD*	Q4 RAG Status (↔) No specific actions identified	• 2 board development sessions have taken place. • Mid year review took place in November, • Review of bullying policy to be considered by W&E committee in January • Additional resources allocated to staff support service to undertake targeted interventions. • Mediation scheme established. • CQUIN funding accessed to support well being programme. Additional resources allocated.	Full year RAG Status (↔) The trust has worked hard to address issues identified but 2015 staff survey results require renewed focus in 2016
To deploy the workforce in the most efficient way possible and improve the efficiency of internal workforce departmental processes *Director of HR and OD*	Q4 RAG Status (↔) • No specific actions identified	• Benchmarking of workforce department evidences very low cost but efficiency opportunities available. • Programme of work to reduce temporary staffing usage and costs being supported by KPMG. Reduced temporary staffing costs in month 6. • Implementation of recruitment TRAC system has commenced. • TRAC in place. • New head of recruitment appointed with positive feedback. • Deep dive agency review process completed with NHSI	Full year RAG Status(↔) Against a backdrop of high turnover and vacancy rates, the trust has worked hard to improve its internal processes and believes that it has met its objective for the year

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

Objective	Actions – Quarter 4		2015/16 Summary position – Overall Q 1- Q 4 progress against planned actions
	Q4 Action	Update on Q4 progress	
Ensure the right number of skilled members of staff are available to provide the best possible quality of care *Director of HR and OD / Chief Nurse & DIPC*	Q4 RAG Status (↔)	• Nursing establishment review completed • Proposals for SW London bank in development • Turnover remains high however • Turnover plans to be monitored as part of WEG programme. • Business case for recruitment of overseas nurses has been approved, overseas recruitment trip for staff completed in March, 144 staff to arrive in October 2016	Full year RAG Status (↔)
	No specific actions identified		The trust has worked hard to address vacancy and turnover issues, though these remain problematic and are not easily addressed

SW London Acute Provider Collaborative:

Update to SWL acute trust Boards (Part 2)

20 April 2016

This update covers the key areas of the APC's work

1	Sustainability and Transformation Plan for South West London / SWL and Surrey Downs Healthcare Partnership
2	Acute configuration and networking
3	Productivity
Annex A	SWL Sustainability and Transformation Plan: Interim Submission 15 April 2016

1) Outline of the Sustainability and Transformation Plan / SWL & Surrey Downs Healthcare Partnership

Mar	Apr	May	Jun	...	Jun 17
5 April Programme Board	15 April STP submission	12 May SWL session with Simon Stevens	2 June 'final' draft circulated for comment		30 June final submission

Clinical base case	Describes current clinical position and key priorities	STP is now led by Kathryn Magson (SRO, and lead commissioner); Daniel Elkeles (acute providers); Gillian Norton (local authorities). David Bradley is the lead for the Out of Hospital Provider Forum and Cally Palmer for the Marsden.
Financial base case	Describes current financial position and 'do nothing' scenario	
Priorities for SWLSDHP		
Prevention and early intervention	Work ongoing with Directors of Public Health and other LA colleagues to identify opportunities in SWL	STP will contain where we have got to by June 2016 - work will continue to develop Pre-Consultation Business Case and implementation until June 2017
Right care in the best setting	Work through 4 sub-regional groups to look at shifting care out of the acute sector in all localities	
Configuration and clinical networking	Work ongoing through APC and the task and finish groups to model clinical networking: 6 key priorities agreed for end June	
Focus on key population cohorts	COs and CEOs have identified key population groups that the STP will focus on for activity in the first 1-2 years, where there is the greatest opportunity for clinical or quality improvement.	
Public engagement including around E&SH SOC	A public communications strategy is being developed, likely to begin in May with publication of the July 2015 APC report. This links to E&SH comms around the Strategic Outline Case on the future of the St Helier estate. Public engagement on the future of St Helier began on 19 March with two public open days at Epsom and St Helier and the SOC will be completed in June.	

South West London Acute Provider Collaborative

1) Sustainability and Transformation Plan

Delivery over the last month

- 15 April submission completed and submitted on time, following agreement of overarching narrative between Chief Executives and Chief Officers. Submission is attached as an annex to this update.
- In particular:
  - Agreement to the overall architecture for SWL: a shift to community based services through a series of community 'hubs' based in primary care and serving a population of 50,000 people
  - Agreement to the acute hypothesis for SWL: the STP is testing whether 4 acute sites can be made affordable, through a combination of productivity work, clinical networking and shift of care into the out of hospital sector
  - Agreement to the key clinical priority areas: for young people, childhood obesity and mental health; for working age adults, cancer, mental health and diabetes; and for older people frailty, dementia and end of life. Other priority areas will be addressed later in the 5 year strategy.

Upcoming milestones

22 April	Meeting with Anne Rainsberry
12 May	Meeting with Simon Stevens
16 May	Full draft of the STP to be circulated for comment. Modelling to be completed as far as possible by this date.
2 June	Final or near-final version of the STP to be circulated
30 June	Submission of the STP for SWL, including signed off financial and clinical base cases, overall strategic direction, next steps. Feedback from NHSE is that the case around acute configuration needs to be made strongly in the document.

Risks

Risk	Mitigation	Rating
Timescale is too tight to allow of all the work being completed to the required timescale in particular the modelling of configuration options	Have shortlisted priority areas for agreement by Clinical Board. Will discuss with NHSE and NHSI where it is realistic for SWL to get to, and how far it is feasible for modelling to go given the risk of being seen to pre-empt consultation	
Delay to development of Sutton Strategic Outline Case will weaken ability of STP to put forward a hypothesis for acute configuration	At present SOC is on track but political risk is always high. Epsom and St Helier are engaging closely with key stakeholders , and Acute Provider Collaborative is engaging closely with E&SH, to ensure that the two programmes remain in line and risks are clearly understood.	

South West London Acute Provider Collaborative

2) Acute configuration and networking

Delivery over the last month

Task and Finish groups have met 3 times. Clinical board have signed off the 7 priority areas to be modelled in time for the STP:

1) **UEC: Networking of emergency surgery**: to reduce cost and improve quality, emergency surgery is provided at fewer sites: a) emergency surgery is provided on 3 or 2 sites; b) emergency surgery is provided during the day only on 4, 3 or 2 sites.
2) **Planned care: All eligible activity, including cancer, pooled into four specialty areas** (orthopaedics, pelvic floor, upper abdomen, head &neck). Model consequences of locating these 'pooled' areas on 1, 2, 3 or 4 existing acute sites. Day case=local
3) **Planned care: All eligible (non day case) pelvic cancer surgery pooled onto one site** (co-located with critical care). All other specialty activity to be modelled as pooled on 1, 2, 3 or 4 sites as in previous example
4) **Maternity**: **Model no. of sites that could provide 168 hours with current obstetrician numbers**. Assume shift from obstetrician led to midwifery led care and model combinations of a) AMLUs only and b) one freestanding MLU plus AMLUs at other sites. NB the latest evidence from the Royal College of Obstetricians and Gynaecologists (academic paper on 'Births out of Hours") found no difference in outcomes between births with obstetrician consultant presence and those without. This was also the outcome of the NPEU report for the National Maternity Review so the evidence base for 168 hours is lacking.
5) **Maternity: Model a risk based network with different number of hours of consultant cover per site** depending on level of risk involved: ie make safest possible use of existing workforce and minimise no of handovers. 1 or 2 large site(s) at 168 hours, up to 4 other sites at lower levels accepting lower levels of risk. model combinations of a) AMLUs only and b) one freestanding MLU plus AMLUs at other sites
6) **Maternity: Model cost-effectiveness of standalone Midwifery Led Unit**
7) **Paeds: Networking of paediatrics**, with one longstay inpatient unit and short stay beds (PAUs) on 1, 2, 3, 4 or 5 sites: PAU length of stay of no more than 24 hours; and no more than 48 hours. Staffing model of a senior doctor until 10pm and junior doctor or nurses overnight.

Upcoming milestones

29 April	Detailed spec and stocktake of all modelling completed
16 May	Draft outputs of modelling
End May	Final results of modelling fed into STP
July	Development of further 'longlist' of other options around clinical networking – other workforce approaches, drawing on national case studies.

Risks

Risk	Mitigation	Rating
The modelling does not demonstrate sufficient savings associated with agreed site reconfiguration.	Options are relatively ambitious and further work will be done in July around areas where we could go further. However modelling for June will necessarily be non-site-specific so savings will be modelled at a theoretical level but there will not be precise agreement on site configuration	
Modelling of patient flows will prove difficult given Surrey Heartlands' view that Epsom patients should not be modelled as part of the STP	Discussions ongoing with Surrey Downs CCG	

3) Productivity

Delivery over the last month

Staff banks

- Proposals focus on developing a shared infrastructure and incentivising staff to move from agency to bank working. Proposals on shared rostering. a single shared platform for staff banks, and an agency cap have been agreed by the Directors of Workforce and Directors of Nursing. Work on developing a shared bank rate is ongoing.
- Cost/benefit analysis being finalised; papers will come to Boards in April / May.

Procurement

- Work on developing the case for a single procurement hub and short term tactical savings is proceeding on schedule with proposals due to be delivered end April

Further Carter opportunities

- Outputs of the DoFs prioritisation workshop presented to APC board. Additional prioritised schemes on Supply chain and back-office rationalisation agreed. Approch to high-level scoping of benefits for medium/longer term opportunities agreed.

Upcoming milestones

April / May	SME input to identify the opportunity for the prioritised schemes. Develop evidence base to support medium/longer term opportunities
May 6th	Workshop with DoFs to review options and benefits for key schemes for inclusion in STP
19th May	Present agreed schemes to APC CEO Challenge group for approval
13th June	Programme board sign-off of STP for circulation to individual organisations for review
30th June	STP submission

Risks

Risk	Mitigation	Rating
Productivity opportunities are not sufficiently large to meet the scale of the financial challenge	Work is ongoing to scope and maximise realistic opportunities	
Agreeing a shared bank rate is likely to be extremely difficult given the possibility of winners and losers	Modelling will capture the potential savings from agency costs as well as costs from any increases to bank rate, to identify the net position. No proposals will be put forward until the position is fully understood.	

South West London Acute Provider Collaborative

South West London STP

15 April Submission

Key information and contents

South West London Acute Provider Collaborative

Key information
Name of footprint and no: South West London - 31 **Region:** South West London **Nominated lead of the footprint including organisation/function:** Kathryn Magson, Richmond CCG **Contact details (email and phone):** Kathryn.magson@Richmond.gov.uk, 020 8734 3006 **Organisations within footprints:** **CCGs:** Croydon, Kingston, Merton, Richmond, Sutton, Wandsworth **Acute Providers:** Croydon Health Services NHS Trust, Epsom & St Helier NHS Trust, Kingston Hospital NHS Foundation Trust, St Georges NHS Foundation Trust **Community Providers:** Central London Community Healthcare, Hounslow & Richmond Community Healthcare Trust, Royal Marsden, Your Healthcare **Mental Health Providers:** South West London & St Georges MH NHS Trust, South London and Maudsley NHS Foundation Trust

Executive context

- **We face numerous challenges in SWL**:
  - Across South West London there are pockets of deprivation that are linked to poorer health and wellbeing outcomes, creating inequalities. We need to target services at hard to reach groups to ensure equity for our populations
  - We are failing to meet national and local minimum standards for urgent and emergency care in our hospitals 7 days a week, as we do not have a big enough workforce to deliver all of these services on every hospital site
  - An ageing population, and increasing numbers of people with multi-morbidity and consequent complex care needs
  - Our emergency admissions grow year on year, indicating more care could be provided in the community to keep people out of hospital and treat them closer to home
  - There is variability in the quality and accessibility of general practice, suggesting we can raise the bar through a more coordinated approach across SWL
  - We are not consistently meeting the needs of people who have mental health needs or dementia, meaning care could be better coordinated
  - Not all of our hospital estate is suitable for delivering 21st century healthcare; we must consider carefully where to invest money to bring our buildings up to standard
  - We have a projected financial deficit in 2020/21 for all SWL providers, commissioners and local authorities in the region of £800-£840m, meaning we cannot afford to continue delivering health and care as we currently do
- **We recognise that simply expanding our current model is likely to perpetuate some of these challenges, as well as being financially unsustainable. As a health economy, we want to transform services by introducing new models of care which**:
  - Deliver better health outcomes at a lower cost of provision to the system
  - Are patient centred and coordinates a wide range of services around their needs
  - Are proactive and preventative
  - Provide services at the most effective and efficient scale across the population
- **In order to tackle our challenges and transform services, we are going to focus our efforts on reducing cost, demand and throughput by**:
  - Effecting a step change in the productivity of health and social care,
  - Improving a whole system approach to prevention at individual, community and place levels across SWL, to enable the healthy choice to be the easiest choice
  - Targeted early intervention to prevent reduce and delay the need for health and social care services
  - Improving prevention and early intervention in a targeted way across SWL
  - Making sure we deliver the right care, with the right workforce, in the best setting, including having GPs coordinate more joined up care closer to home , and improving our community response to help people leave hospital sooner
  - Looking at the configuration of our hospital sites and increasing clinical networking
- **In finding solutions we intend to focus on those population cohorts at different stages of the life course where our base case has identified the most significant opportunity to reduce cost, demand and./or throughput to deliver the greatest impact on the sustainability challenge. These comprise start of life (specifically obesity and CAMHS), living well (specifically cancer, diabetes and mental ill health), end of life (specifically frailty, dementia and end of life) and people with learning disabilities.**
- **To deliver these changes, we will need to have in place robust plans for enabling services including:**
  - Embedding self care and preventative approaches within all services to prevent, reduce and delay the need for health and social care interventions
  - Considering how our organisational structures might need to change to deliver these new models of care most effectively
  - Using digital health records and other technology to help information follow the patient, and to maximise the reach of our services
  - Ensuring a workforce with the right mix of skills to deliver new models of service delivery
  - Having an estates strategy which ensures the best use of our assets and meets the standards of 21st century healthcare
  - Having an effective governance and leadership structure to develop and deliver these plans , which overcomes challenges we have faced in the past on collaborating effectively as a health economy
  - We recognise that we will need to align with other neighbouring STPs

Our health & well being challenges

In South West London, like elsewhere, cost pressures in the health and social care system are due to the inexorable rise in numbers of people with multiple long term conditions - on current trends this is becoming unaffordable. Cardiovascular disease and cancers remain the main killers, but an increasing burden of disease and suffering is also due to ill mental health.

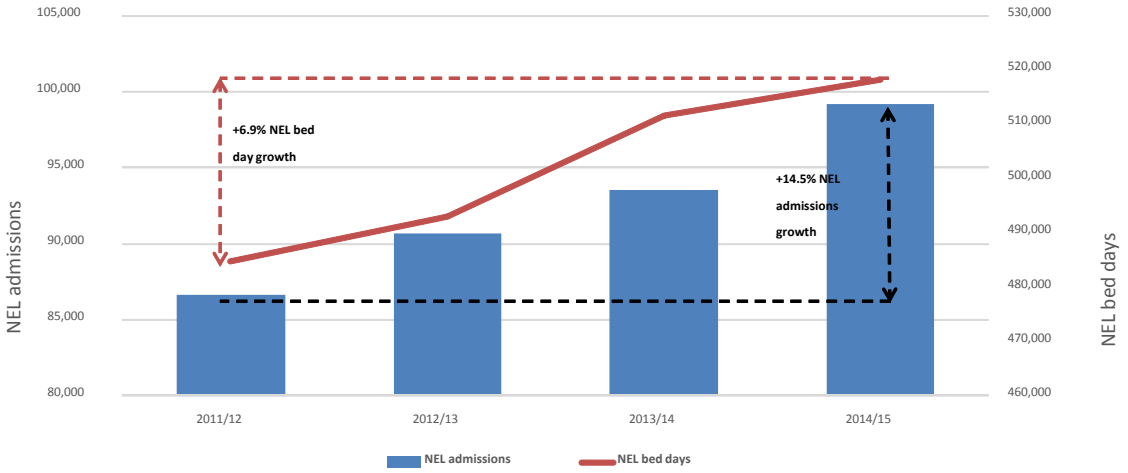
- **Across South West London there are pockets of deprivation that are linked to poorer health and wellbeing outcomes, such as life expectancy, creating inequalities.** We need to target interventions and services at hard to reach groups to **ensure equity across our population.**
- The four key behaviours that increase our risk of disease – **smoking, inactivity, poor diet and drinking too much alcohol are responsible for at least a third of ill health**, and their associated costs. The number of people adopting these behaviours in South West London is large.
- The number of people in south West London over 65 years is projected to increase from 178,000 in 2013 to 194,000 in 2018, representing a growth of 8.9% over 5 years. Unhealthy behaviours, combined with an ageing population mean the **number of people with long term ill health with continue to grow.**
- With an increasing number of older people, **the number of people living with dementia is rising** and embedding high quality dementia care into services is key. Whilst prevalence of dementia is lower than the national average, individuals with dementia experience a **longer than average Length of Stay (LoS)** if admitted to hospital, and are **more likely to be readmitted**, and are **more likely to die in hospital** than national average
- The population of **people with diabetes in South West London is predicted to increase** from around 82,000 in 2015 to 104,000 in 2025. **Diabetes currently accounts for 10% of all NHS costs.**
- **Cancer is a major cause of premature death in South West London** and across the patch screening coverage is generally below national averages. Early detection of cancer has a significant impact on survival and South West London **performance is poor against the** percentage of cancers diagnosed at an early stage - all CCGs are in the 3rd quintile or below.
- Hospital admissions for mental health conditions for those under 18 is **higher than the London average and significantly higher than national average** (127.7 per 100,000 compared to 101.9 for London and 87.2 for England).
- Preventative interventions, at all stages of life and condition, have an important role to play to **prevent, reduce and delay the need for health and social care interventions**. **Prevention in early years, to enable every child to have the best start**, with a particular focus on childhood obesity and emotional and mental well-being, given the impact on health in adulthood, will accumulate greater benefits.

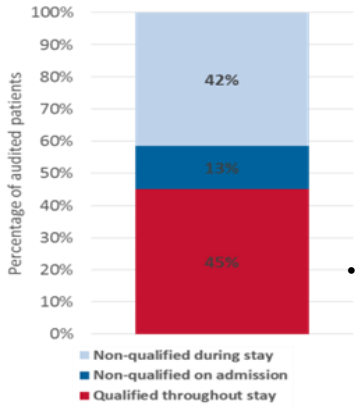
Our Care and Quality Challenges

- **We are failing to meet our minimum standards for urgent and emergency care in our hospitals 7 days a week, as we do not have a big enough workforce to deliver all of these services on every hospital site**.

- There is **variation across South West London in how coordinated primary care is for patients**, and their perceptions of accessibility (as measured by performance against the London Strategic Commissioning Framework).

- Across South West London we have seen a **14.5% increase in emergency admissions** between 2011/12 and 2014/15. Non-elective bed days have **increased by 6.9%** and bed occupancy levels have **increased from 85% to 89%** over this period.





- Evidence from an acute bed audit undertaken in 2016 also shows that **13% of patients could have avoided admission**, and a further **42% could have benefitted from early discharge to a non-acute setting**.

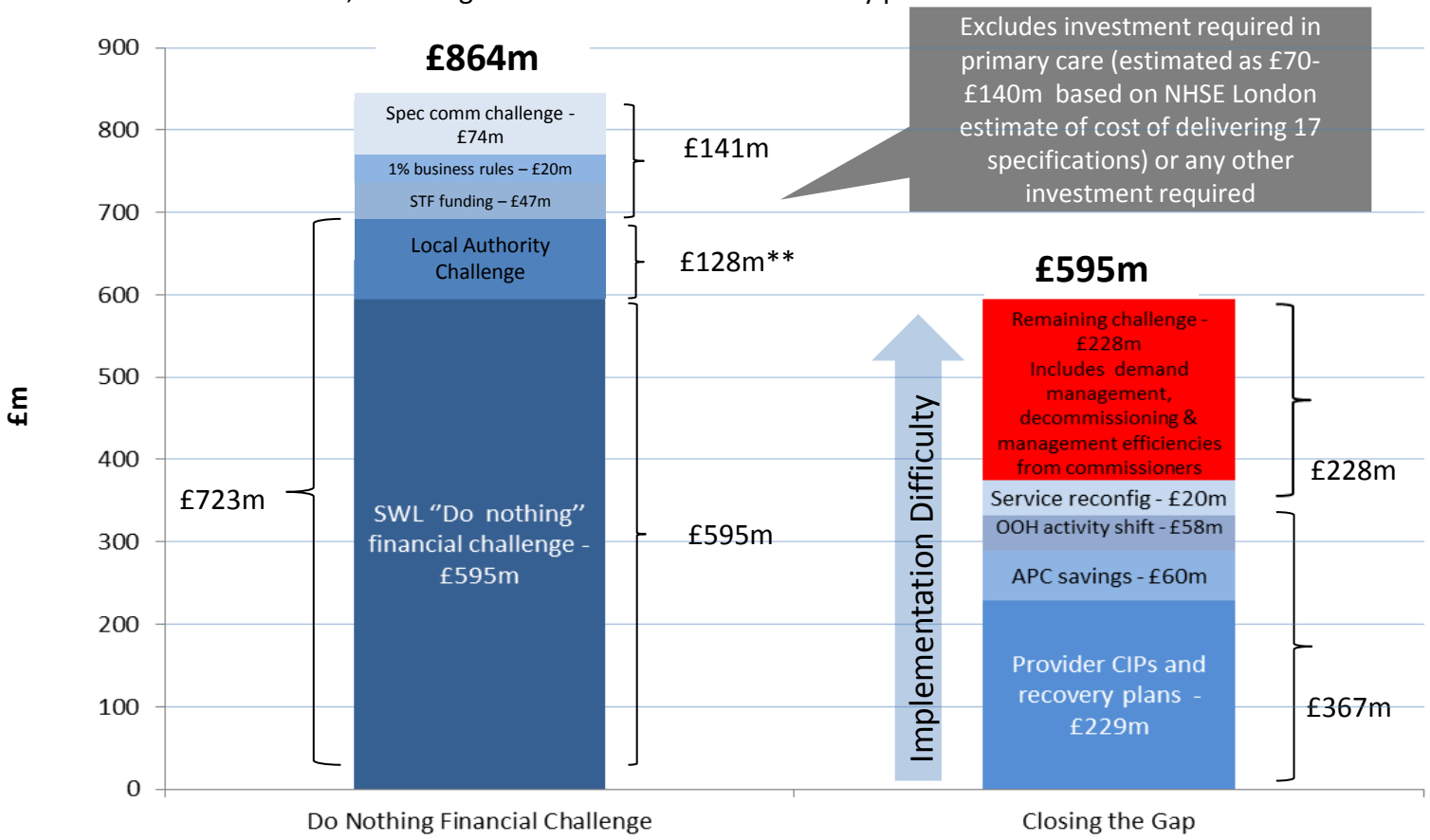
- **We are not consistently meeting the needs of people who have mental health needs or dementia, meaning care could be better coordinated.** As a whole South West London performs poorly in terms of the rate of emergency admissions for people with dementia – when measured against this, all CCGs feature in the **3rd quintile or below**.

Our financial challenge in 2020/21 and potential sources of savings

Our financial base case indicates the scale of the challenge for SWL over the coming five years and the need for a radical and transformational approach to how we deliver health and care services.

As an SPG we are committed to establishing financial sustainability across providers, commissioners, and local authorities in SWL, and collectively targeting investment into the most effective areas of care, including a shift from acute to community provision.

** Due to budgetary processes the £128m is an estimate position for 19/20 rather than for 20/21



- Estimated savings are initial high level hypotheses only – further work required to test as part of development of the STP

We have considered as a system what we want our services to look like in the future (1)

South West London Acute Provider Collaborative

We are developing **new models of care** to address these gaps and have agreed an emerging **vision and service design principles** that empower our populations and describe how core services should relate with patients, citizens and each other.

Our vision is to continuously improve the health and care of the population of South West London through the provision of patient centred care that is proactive and integrated

Service design principles

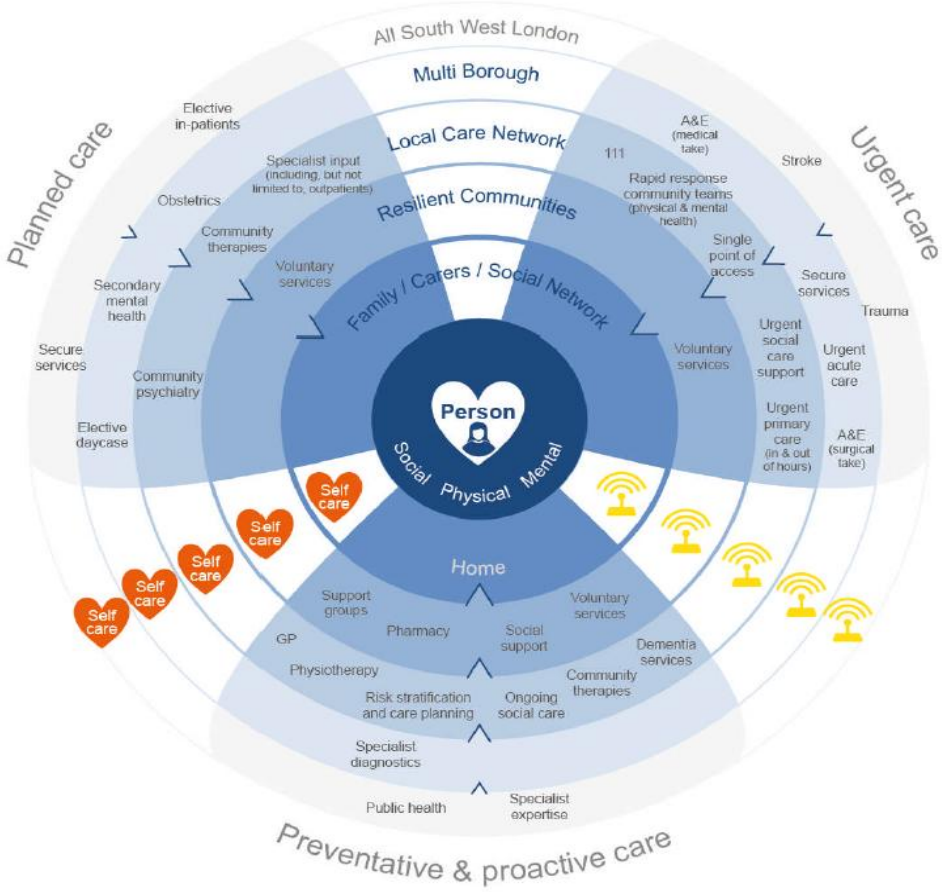
1. **Care is patient centred and holistic**
   - Inclusive and recognises the role of family, friends, communities and voluntary organisations
   - Joined up and crosses organisational boundaries, encompassing people's physical, mental and social care needs
   - Easy to navigate
2. **Care is proactive and preventative**
   - Focussed on enabling people to stay well and avoid healthcare instances
   - Prioritises early detection – people have access to early support mechanisms
   - Promotes self management - people are encouraged to take responsibility for their healthy lives
3. **Care supports the quality of life and the outcomes people value**
   - People are supported to live life as fully as possible for as long as possible
   - People are aware of the choices available and have greater control
4. **Care is financially sustainable**
5. **Our staff and care givers feel** supported and able to do their roles

Service development principles

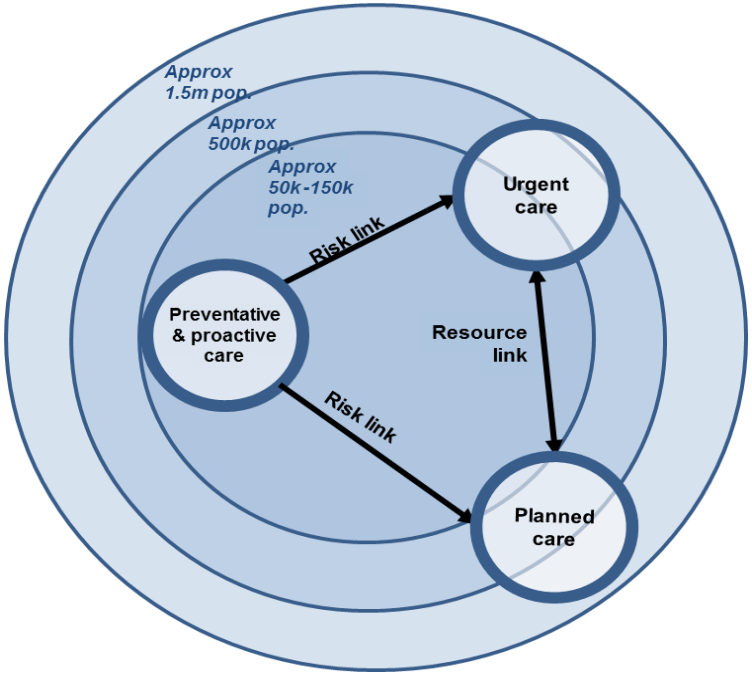
1. We focus **on better health outcomes at lower cost of provision to the system**
   - We work in partnership across all health and social care organisations including the third sector to design and deliver the solutions
   - We make better use of resources, irrespective of the organisation
   - We plan for a changing environment
2. We will rapidly adopt **evidence based care** (where possible)
3. We maximise the use of **digital technology**, for the benefit of all stakeholders

We have considered as a system what we want our services look like in the future (2)

These vision and principles have informed **our proposed service model for SWL:**



And, based on evidence from other health systems we have identified the **optimal population sizes** for the delivery of the service model through a **system architecture** that sets out three **domains of care:**

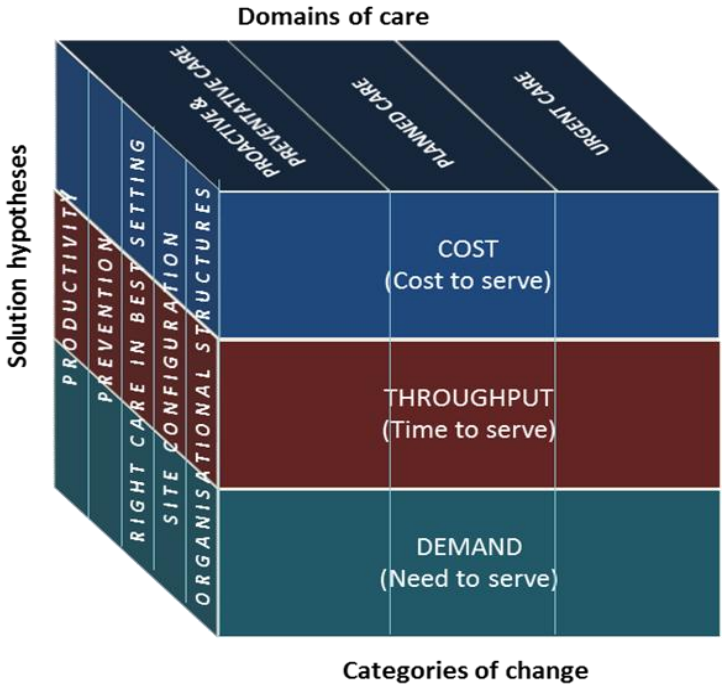


Our approach to addressing our challenges to deliver our vision

Across our three domains of care, we have identified three 'categories of change' which will have the greatest impact on delivering a clinically and financially sustainable NHS in South West London and achieving our vision.

We are developing four solution hypotheses for pulling the levers within each of these categories of change and set out on slide 10 our initial estimates how much cost these would take out of the system.

- Both providers and commissioners need to address the challenges of cost reduction, performance and operational improvement by exploring opportunities for **collaborative productivity**
- We need to focus on reducing demand by improving **prevention and early intervention**, enabling people to stay well and reduce the number of inappropriate healthcare contacts (slide 11)
- When our populations need health and social care services, we need to improve the patient journey through the system and **deliver the right care in the best setting** (slide 12)
- Improving the services we deliver in community settings also helps us to improve the quality of our acute services. We are considering how we enable the sites we have in South West London to deliver the best outcomes for the population by looking at our **site configuration and clinical networking** (slide 13)
- We recognise that there is likely to be a need to change our **organisational structures,** both commissioner and provider, to deliver these models of care (slide 15)

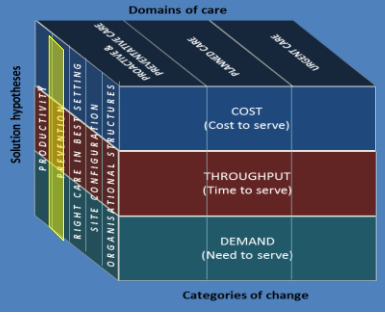


HIGHLY PRELIMINARY

Closing the Gap: Potential sources of savings attached to Do Nothing Acute Provider Collaborative three categories of change

	Type of saving	Potential savings £m	Comments	Clinical impact	Investment
Cost reduction	Provider 'do minimum' CIPs (1.5% pa) [1], additional savings from recovery plans [2,3]	219-239	• The do minimum • Probably includes most "Carter" savings • Includes financial recovery plans (both within the diagnostic and other)	Neutral	Small
	Service reconfiguration related savings	10-30	• UEC – Emergency Surgery/other network changes • Planned Care	Positive	Medium to very large
	Productivity: Acute provider collaboration savings	40-80	• Assumption not sourced from APC, details expected mid-May • Based on work done by APC in: Procurement, staff bank, SWL owner supply chain entity, medicines supply chain, corporate/administrative	Neutral	Small
	Productivity: Commissioner	?	• Work ongoing to consider what can be achieved	Neutral	Small
	Management efficiencies	?	• £45m initial high level estimate	Neutral	
Throughput	Prevention & early intervention	53-63	• Reduction in NEL admissions, A&E attendances, DTOCs • Evidence from OOH schemes suggests that costs of reprovision are expected to be a high % of gross savings, except where activity is prevented • Equivalent to 29% reduction in NEL at 70% reprovision, or 11% prevention at 20% prevention cost • There may be schemes dedicated to social care that will contribute to closing of the local authority gap	Positive	Medium to Large
Demand	Right care in the best setting	TBC	• Work ongoing to estimate likely savings from delivering care in the right settings	Positive	?
	Decommissioning	TBC	• Work ongoing to identify savings	?	?
	Potential savings sub total	**322-412**			
	Estimated residual gap	**273-183**	**For health care only before any investment requirements**		
	Local Authority	**128**	**High level estimate to 2019/20 only**		
	Estimated total residual gap	**401-311**			

Notes: [1] Average assumption of 1.5% CIPs; [2] CIPs in Do minimum baseline above 1.5% average; [3] Additional CIPs for providers for recovery not included in Diagnostic submissions
Source: SWL Financial diagnostic; APC report July 2015; 2020 Delivery analysis



Emerging Solution Hypotheses - Prevention & Early Intervention

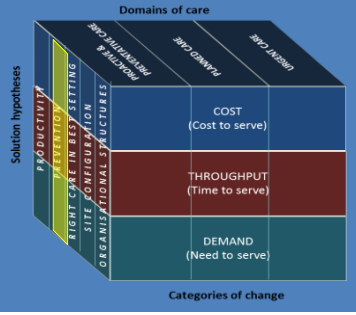
- Emerging solution hypothesis

Model of care principles have been developed as part of the System Architecture work, which sets out how the resources of the South West London health economy can best be structured to deliver the best outcomes for the population, across Preventative and Proactive care, Urgent care and Planned care. These principles have been endorsed by the Clinical Board and Programme Board.

- How we will do it

- We will use the Right Care analysis to focus on the areas which are likely to have the biggest impact to save lives and reduce elective and non-elective admissions in key clinical areas. E.g. Cancer is one of the top causes of death and SWL has poor performance of % cancers diagnosed at an early stage.
- We will embed the learnings from the Sutton and Royal Marsden vanguard value propositions
- Prevention initiatives are best delivered at a locality level and SWL CCGs and Local Authorities will work together to develop cross partner prevention plans that address nationally and locally identified challenges, building on health and wellbeing strategies. These will be coordinated through SWL plenary sessions to share good practice and ensure a coherent approach to priority areas.
- SWL Council Leaders and CCG Chairs have together identified areas where collaborating at scale can support a radical upgrade in prevention:
  - Collective management of the care home market across SW London to ensure sufficient capacity and quality of services.
  - Large-scale joint prevention initiatives targeting diabetes and living well with dementia.

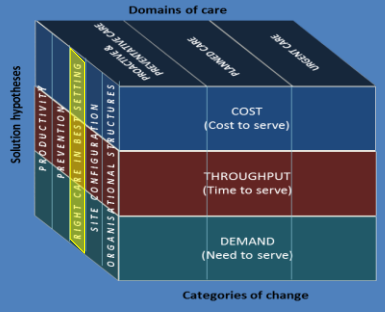
Prevention & Early Intervention



Emerging Solution Hypotheses: Right care in the best se

• Issues to resolve	• Where the current system fails to deliver effective "throughput" (i.e. effectively managing the patient journey between the current care, community and acute settings), the consequences are incurred by the urgent and planned care parts of the system which worsens patient care and experience and is more costly to the system as a whole. • We also need to improve our community response to help people leave hospital sooner
• Emerging solution hypothesis	• Care is most effectively delivered through a community/primary care model that takes account of the whole person, rather than individual conditions, and shares responsibility for health and wellbeing with the patients and their community. This requires that it combines physical and mental health care elements, significantly drives health and social care integration, and connects clinical with wider non-clinical support and assets in the community. • The provision of teams should be linked to, or incentivised by, the achievement of a set of outcomes and total system resource costs, including the delivery of urgent and planned care. • There should be clear accountability for delivery, and a single set of standards and outcomes for care to be provided across SWL.
• How we will do it	• New locality teams, responsible for providing preventative and proactive care, should be established and align with the GP practice localities already in place, providing care for circa 50,000 people. This will require skills from GPs and primary care, social care, mental health, community services, input from hospital specialists and access to diagnostics. The teams must also draw on self- care; social care; health promotion/healthy lifestyle support; and, importantly, other non-medical support from the voluntary sector/volunteering, and use of community assets, to avoid the need for costly medical interventions. • Risk stratification should be used to identify individuals with the greatest health and care needs, who should be supported by personalised care plans. • Existing GP Federations operating at scale could support the rapid delivery of this model of provision, working with a wide range of other providers. The delivery of the London Strategic Commissioning Framework for primary care will put in place certain supporting elements of this provision, including access to GPs 7 days a week • Preventative and proactive care is likely to be best commissioned and provided via a long term outcome-based capitated contract (for at least seven years) in order for providers to benefit from active interventions they make for the population. This contract should include primary care, mental health, Public Health, social care, community care and hospital expertise (such as expert opinions and diagnostics).

Right care in the best setting



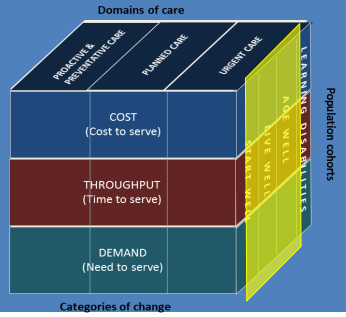
Emerging Solution Hypotheses: Site Configuration & Clinical Networking

South West London Acute Provider Collaborative

• Issues to resolve	• The current 5 acute site scenario cannot deliver the London quality standards • The number of sites in South West London should be sufficient to meet the level of need. The population of SWL plus Surrey Downs will be 1.7m in 2019-20 and is continuing to grow. According to Royal College guidance that an acute provider should serve a population of around 500,000 to support costs of 24/7 care , this would suggest that 4 acute sites with a full A&E is the most future-proof number for the geographical footprint of SWL. • There are problems with the estate on most acute sites. In particular the St Helier estate is not sustainable. • Neither reducing the 5 acute sites to 4 or 3 acute sites would close the financial gap.	Site Configuration & Clinical Networking
• Emerging solution hypothesis	• We are focussing on making the 4 site scenario work, ie four A&E sites within the geographical footprint of South West London • Four sites are likely only to be made to work if every provider and / or site does not provide every service, or provide it to the same degree of complexity. There should be significant networking and consolidation of services and work is in progress to determine how best to do this. • Providers need to focus on improving productivity if the system is going to achieve the necessary savings with a four site model • Out of hospital services need to be transformed to enable the transfer of patients to cheaper settings where appropriate	

• How we will do it	• Four sites:
	  • Acute services are likely to continue to be provided on the sites of Kingston, Croydon and St George's
	  • We will need to explore the options on how to rebuild St Helier and make it clinically and financially sustainable using the existing NHS Estate in the Epsom and St Helier catchment
	  • Services at Epsom Hospital should be configured to address the needs of the local population , which is ageing
	  • The configuration of emergency services needs to be considered in the light of the Keogh review
	• Networking: work is ongoing to model options for clinical networking including pooling of planned care and networking of specialties
	• Productivity: work is ongoing to develop shared staff banks, a single procurement hub, etc.	

The STP team will build links with other plans as they evolve. A specific link is around Epsom & St Helier University Hospitals NHS Trust, which has an acute site that is based in both the Surrey Heartlands and South West London SPG geographies. Both plans need to reflect a practical way forward for EStH to create clinically and financially viable services to be provided for the 500,000 people in its catchment. This has to take account of the differences in the strategic challenges facing each STP area.



Emerging Solution Hypotheses: Solution Development - Population Cohorts

South West London Acute Provider Collaborative

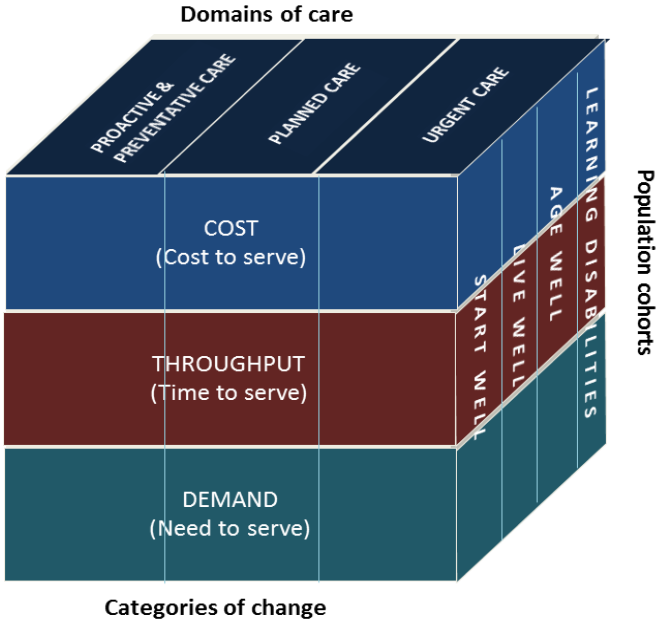
We are mindful of our commitment to deliver the national priorities, and continue to take forwards our programmes of work across each of these, including the achievement of the 17 specifications for primary care and ongoing engagement with patients, communities and staff.

However, as we develop our hypotheses, we will place additional emphasis on those population cohorts within each domain of care where our base case has identified the greatest opportunity for improving outcomes for the population of South West London through **new models of care** which will:

- Deliver cost reductions
- Optimise throughput
- Reduce demand

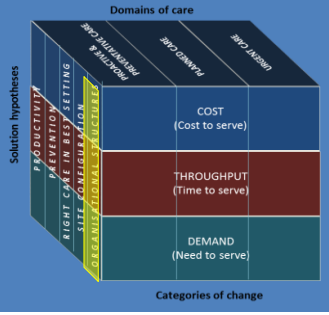
These are the proposed population cohorts on which the SWL STP will focus:

Population \ Condition/ pathway	Cancer	Diabetes	Mental Health	Frailty	Dementia	End of Life	Obesity
"Start well"			●				●
"Live well"	●	●	●				
"Age well"				●	●	●	
Individuals with Learning disabilities	End to end care management						



As the STP is developed, we will:

- Validate these areas of focus through:
  - a review of performance data
  - evaluation of their system-wide cost benefits
  - and engagement with our communities
- Identify the drivers behind significant variations in cost/demand/throughput
- Develop solutions to address these drivers, which will include our model of proactive and preventative care
- Agree measurable outcomes for each solution



South West London Acute Provider Collaborative

Emerging Solution Hypotheses – Organisational Structur

Organisational Structures

- Issues to resolve

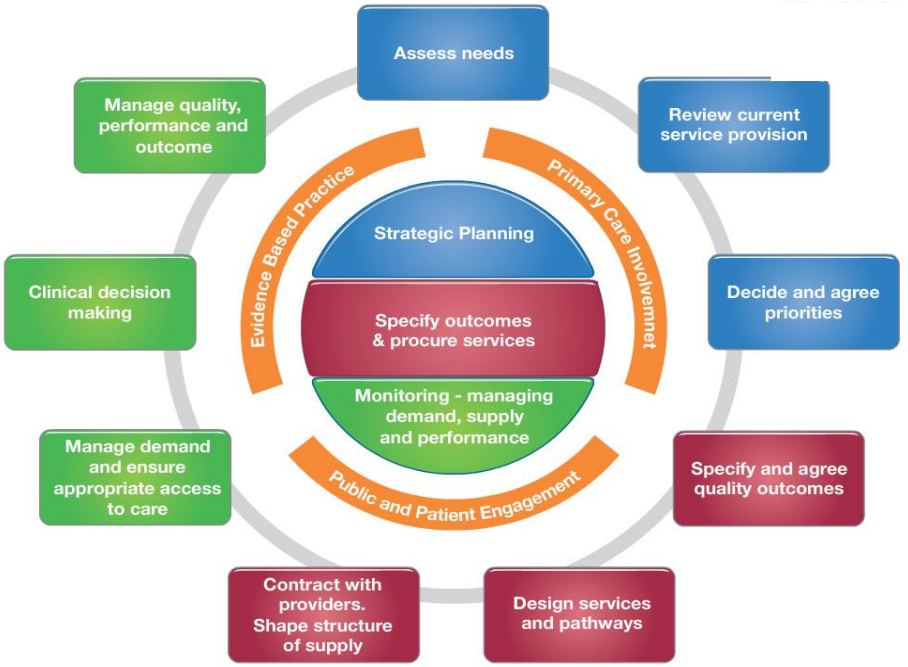
We recognise that it is likely that organisational structures will need to change to deliver these new models of care, and have discussed what these might be.

- Emerging solution hypothesis

- Place-based alliances between CCGs. The alliances will cover populations of sufficient scale for the most effective planning and delivery of care – this is likely to be around 500,000
- CCGs will play a key role in defining the outcomes required of the contract and managing performance
- These footprints will evolve over time, with alliances sharing management teams
- In time we expect budgets will be devolved
- Borough-level CCG governing bodies will be preserved for assurance, and the democratic legitimacy they represent

- How we will do it

Further discussions on this will be required as our proposals evolve, specifically in the context of how best to deliver outcome based measures across the system as a whole.



What we will need to have in place to support these changes

- The health economy in SW London has faced challenges in the past to collaborating effectively to drive transformation programmes. We have learnt from our previous attempts and have put in place new mechanisms to design and deliver an effective STP. This includes new leadership, governance, and resource structures which are detailed in the appendices.
- Delivering new models of care will require a significant focus on enablers. We have a shared commitment to:

• Digital	The creation of an interoperable health record across health and social care, building on current investments in technology. As part of our Digital Roadmap we will also explore a significant expansion of technology-enabled care to bring services to the patient and empower individuals to self-care
• Workforce	Understanding workforce requirements and implementing new roles and skill mixes, and the cultural changes required to support them. We will also work with local authorities to progress the use of public estate for key worker housing
• Estates	A system-wide approach to the public estate in SW London, and its effective utilisation to deliver new models of care

Emerging support we will require:

- Significant investment to pump prime new models of care, through :
  - Investment in the 'double running' of community response and acute hospital services as we deliver a shift to alternative settings of care other a transition timeline
  - Capital investment in estates and technology (see appendix)
- Leadership and support from national organisations to support any changes to structures that evolve over time. This might include emerging thinking from the centre as to which forms could be most effective within the health and care services in England
- To effectively move towards place-based commissioning, SWL would benefit from a comprehensive allocation of resources for the population we serve. This includes the specialised commissioning budget, giving us control over how it is spent, including the ability to invest in demand reduction schemes for certain specialised services.
- Support from the centre in relation to the political handling strategy

We have the governance arrangements in place to make key decisions and develop an STP

South West London Acute Provider Collaborative

Following agreement we are refining the membership of our Transformation Group to form an executive body for making detailed recommendations to the Programme Board / Governing Bodies for decisions.

Organisational Governance for final approval

- ALB Chief Executives
- CCG Governing Bodies NHS as commissioner
- Bipartite Oversight Group
- Provider Boards
- Local Authorities

Commissioners and Providers Groups (SWLCC, APC, OOH Provider Forum)
Local Authority Leaders & Partnership Groups
Patient & Public Engagement Steering Group

SWL & SD Programme Board
Independent Chair, 14 x CCG Chairs & COs, 4x acute CEs, 2 x acute MH CEs, 1 x LA rep, 2 x OOHospital reps, 3 x tripartite reps, 1 x NHSE (commissioner), 1 x FAC Chair, 2 x Clinical Board Chairs, 2 x PPI, 3 Programme Directors

We will explore the right mechanism for implementation of the STP; this may include establishing Committees in Common after June.

SPG Transformation Group (Executive Board)
Chair: 1 x clinical chair, 1 x CCG CO, 1 x acute CE, 1 x LA CE, 1 x MH CE, 1 x community CE, 1 x GP Fed rep, Bipartite, 1 x spec comm, 1xDoF, 3 Programme Directors

Clinical Board
Chair: 2 x independent, 7 x CCG Chairs, 10 x acute MDs & DoNs, 4 x acute MH MDs & DoNs, 2 x community MD & DoN, 3 x OOH provider leads, 1 x PPI, 1 x DPH, 1 x DASS, 1 x LAS, 1 x HESL, 3 Programme Directors

Finance & Activity Committee
Chair: SWL FD, 7 x CCG CFOs, 1 x spec comm, 9 x acute/ MH/ community DoFs, 1 x HESL, 3 x tripartite, 3 Programme Directors

SWL Technical Group

Programme Workstreams
(including clinicians and patient & public representatives)

- STP Sub-regional planning group (K & R) → CCGs/LAs
- STP Sub-regional planning group (M & S) → CCGs/LAs
- STP Sub-regional planning group (W& M) → CCGs/LAs
- STP Sub-regional planning group (C) → CCGs/LAs

We have the leadership and programme team to support collaborative development and delivery of the STP

STP leaders

- **SRO and Commissioner Lead**
  Kathryn Magson
  (Chief Officer – Richmond CCG)
- **Local Authority Lead**
  Gillian Norton
  (Chief Exec – London Borough of Richmond)
- **Provider Lead**
  Daniel Elkeles
  (Chief Exec – Epsom and St Helier University Hospitals NHS Trust)
- **Clinical Chair**
  TBC
- **Chair proactive and preventative care Provider Forum**
  David Bradley
  (Chief Executive – SW London and St. Georges MH NHS Trust)

Programme Director
Kath Cawley

Administration support

Comms & engagement

Strategic & PMO support
PWC, 2020 Delivery and CSU

Clinical workstreams

Primary Care SRO – Graham Mackenzie Clinical Lead – Nicola Jones	**UEC** SRO – Jonathan Bates Clinical Lead – Agnelo Fernandes
Proactive and preventative SRO – Adam Doyle Clinical Lead – Tom Coffey	**Maternity** SRO – Paula Swann Clinical Lead – Mike Lane
Mental Health SRO – Tonia Michaelides Clinical Lead – Phil Moore	**Planned** SRO – Tonia Michaelides Clinical Lead – Naz Javani
Children and Young People SRO – [tbc] Clinical Lead – [tbc]	**Cancer** SRO – Kathryn Magson Clinical Lead – Tony Brzezicki

Enablers

Workforce:
SRO & Clinical lead - Marilyn Plant

Estates:
SRO - Cynthia Cardozo

IM&T:
SRO - Cynthia Cardozo
Clinical Lead - Rod Ewen

Independent Chair SWL & SD partnership board
Sir Andrew Morris

Finance:

SRO Yarlini Roberts	**Finance Lead** Caroline Barker	Support from 2020 & CSU

Appendices

Governance and engagement summary

South West London Acute Provider Collaborative

Collaborative leadership and decision-making:

- SWL has a history of collaboration between CCGs, with the publication of a joint five year strategy in June 2014, risk sharing, and the formulation of an Acute Provider Collaborative to respond to the five year strategy and address the productivity challenge. CCGs have worked closely with local authorities to integrate care and deliver BCF schemes.
- In 2015, commissioners, providers and local authorities agreed a case for change and shared commitment to deliver a clinically and financially sustainable NHS in SWL. This was formalised through the establishment of the SWL & Surrey Downs Partnership (SSHP).
- The SSHP governance put in place in 2015 was refreshed in Q4 2016, to make provision for each group to contribute to the development of the STP. We have agreed an Executive Board tasked with making recommendations for the STP.
- The STP will be formally approved by the Boards and Governing Bodies of each NHS commissioner and provider in SWL ahead of submission, although some extraordinary meetings or chairs' actions maybe needed where board do not meet in June.
- The Partnership Board, which comprises representatives of all organisations involved, will explore appropriate mechanisms for the implementation of the STP that are commensurate with the scope of the plan and the different levels of delivery. This may include establishing a Committee in Common after June. Such proposals will require approval by Boards and Governing Bodies before being put in place.

An inclusive process/ engaging clinicians and staff:

- We are in a strong position in terms of early engagement in SW London. Building on extensive work already undertaken we have produced an initial communications and engagement strategy to support the publication and implementation of the STP over the course of 2016. We are proposing to evaluate and refresh the strategy at the end of 2016 as we move through the implementation phase.
- Key deliverables include:
  - Regular publication of key documents and feedback online;
  - A programme of public facing events through development and post publication – using informal and inclusive engagement methods;
  - A grassroots engagement programme supported by 7 Healthwatch organisations;
  - Regular and on-going engagement of staff across providers, CCGs, primary care, and local authorities, as well as trade union briefing sessions;
  - Use of media and social media to promote milestones and good news, including a strong focus on stories around better community-based care and opportunities presented by collaborative working; and
  - A "no surprises" approach to MP engagement, with briefings arranged for each key milestone.
- Patient and public representation is embedded throughout the development of condition or pathway specific plans within the STP, as representatives sit on each work stream group. In addition, the Partnership takes advice from a Public and Public Engagement Steering Group to ensure robust engagement.
- Clinical representation is equally embedded in the STP development process, with clinicians from across the provider spectrum included on work stream groups. Furthermore, a Clinical Board makes recommendations to the Programme Board, such as in developing our clinical base case and emerging hypotheses.

Local government involvement:

- The development of the STP has been welcomed as an opportunity for a step change in collaboration between the NHS and local authorities. A Leadership Collaboration Group has been established and met, bringing together council leaders and CCG Chairs to identify areas for joint working at scale, and to review the emerging STP.
- Local authorities are also represented on our Programme Board, Clinical Board, STP Working Group, locality groups, sub-regional groups, and certain of the condition/pathway specific work streams, e.g. IM&T.
- The South London Partnership, plus Wandsworth Council, meeting, in June is proposed as the formal approval mechanism for the STP by Local Authorities.

Agreed behaviours for developing our STP

The STP is a collaboratively-produced document, jointly owned by the whole health economy and laying out a shared vision for the future of healthcare in SW London which will then be jointly implemented. One of NHSE's required criteria for the STP is that it must be produced and signed off by CCG governing bodies, provider boards, and Local Authorities.

In order to ensure that this is a reality we have agreed the following shared behaviours:

All organisations will work together in good faith and constructively

There will be equal input into the content of the STP across commissioners, providers and Local Authorities

There will be an 'open book' approach across the health economy, including with Local Authorities

It is in the interest of all commissioners and providers to develop a solution that restores the local NHS economy to financial and clinical sustainability. To support this, all the organisations will work together to develop solutions to the challenges faced by the health economy on the basis of consensus, recognising the difficulties this may create for some individual organisations

It is possible that disagreements will arise, between sectors or between individual organisations. The expectation is that any contentious issues will be drawn out and discussed at an early stage and that organisations will engage constructively with each other to address and resolve these and aim to achieve consensus at the Programme Board

The Programme Board will seek to achieve consensus over the content of the STP and work to ensure that the STP is supported by all Programme Board members on behalf of their organisations

Our Financial Risk Management Strategy

Current Context and Arrangements

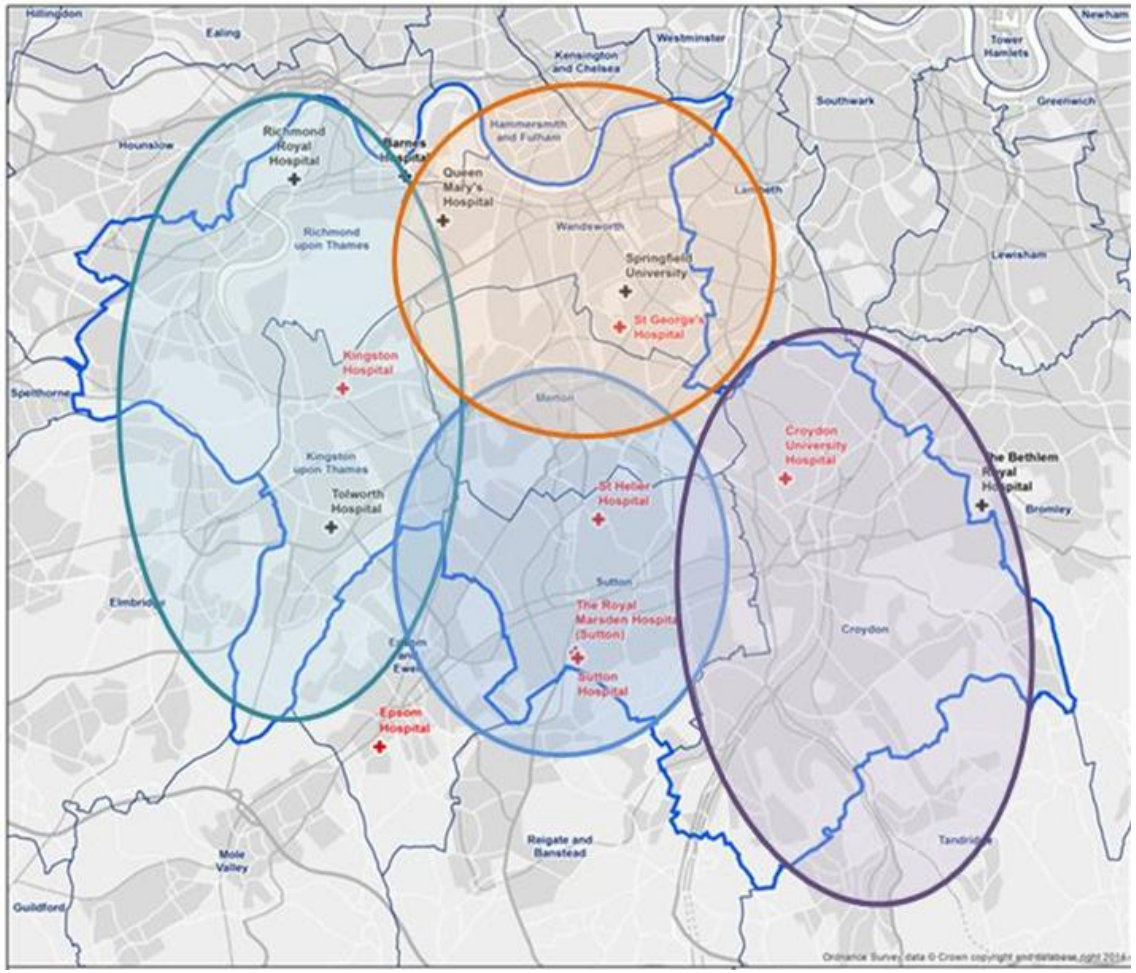
- Since establishment in April 2013, the South West London CCGs have collaborated on financial planning and financial risk management.
- To oversee such arrangements, a robust governance process was established which include a Financial Review Group whose membership included the 6 Chief Officers, 2 lay members and supported by 1 Chief Finance Officer. The Group meets monthly and has clear terms of reference that are reviewed annually.
- Across SWL CCGs there has been limited scope to pool resources, with 5/6 CCG funded below target when established. The underlying funding position has improved over time as a result of NHSE's pace of change policy on CCG allocations. The pooling of resources has been limited to the 1% non-recurrent reserve required under NHS business rules.
- A financial risk pool across SWL CCGs has been established each year since 2013/14, with a view to managing risk across at least 5 years. The areas covered were initially (i) financial support to strategic planning with the intention to reducing financial risk in the future, (ii) an in-year financial risk share arrangement to support delivery of financial control totals.
- In recent years, limited funds have been identified to invest in collective service redesign as recommended by clinical leaders in South West London (e.g. GP Online, urgent care GP). A recurrent redesign fund has not been established.
- As a minimum, the SWL CCGs will be continuing to work collaboratively to manage risk in 2016/17 through (i) maintaining funding for strategic planning and (ii) running shadow financial performance monitoring arrangements to inform any local influence over the 1% financial risk reserve.

Development of a Strategy

SWL CCGs aspire to move towards a more strategic approach to the financial management of risk associated with both in-year by longer term service redesign. Key enablers to this are:

- Place-based system budgets to allow maximum influence over the services and cost base in SWL.
- System wide financial plan that is driven by clinically agreed service redesign priorities and assumptions.
- Clarity within the system wide financial plan where transition support is required to achieve the intended outcomes for patients.

Agreed planning levels for the STP



Solution development at condition/ pathway level; Site configuration; Productivity; Enablers	• SWL Collaborative Commissioning Workstreams (CDGs &, T&F Groups) • Acute Provider Collaborative
Sub regional plans for delivering right care in the best setting	• Croydon • Kingston & Richmond • Sutton & Merton • Wandsworth & Merton
Cross partner prevention plans	• 6 CCGs working with Local Authorities

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO Trust Board *5th May* **Paper Ref:**

Paper Title:	Draft Annual Report and Accounts 2015/16
Sponsoring Director:	Rob Elek, Director of Strategy Jennie Hall Chief Nurse/ DIPC
Author:	Pippa Harper, Communications Officer Emily Sands, Communications Manager
Purpose: *The purpose of bringing the report to EMT*	Final Board submission before official submission to NHSI on 27th May 2016.
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	To provide initial comments and agree that it is compliant with the Code of Governance.
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	N/A – please see 'Next steps'.

Executive summary

All NHS foundation trusts must publish annual reports and accounts to allow scrutiny of the year's operations and outcomes. This draft also includes the quality account.

Annual report sections:

- Foreword from the chair
- Introduction from the acting chief executive
- Our vision and values
- Performance report
- Our strategy
- Accountability report, including directors' report, staff report, remuneration report
- Code of Governance and Annual Governance Statement
- Quality Account
- Financial summary

Please note some sections are awaiting content including year-end data validation. These sections have been highlighted at the beginning of the document for your information.

There are a number of statements that will need to be signed off formally by the CEO within the ARA. This will completed after the Audit Committee have signed of the accounts on 26th May. The draft is presented for initial comments. A draft will be circulated to the Board for final comments on 20th May.

As part of the ARA the board of directors is required to set out that it is compliant with the Code of Governance (page ref 87-96).

Code of Governance Statement

The draft ARA includes a statement of compliance with the NHS Foundation Trust Code of Governance

> Statement of compliance with the NHS Foundation Trust Code of Governance (page 96)
> The board of directors considers that it was compliant with the provisions of the revised NHS Foundation Trust Code of Governance. The council of governors retains the power to hold the Board of Directors to account for its performance in achieving the Trust's objectives.

St George's University Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The trust has complied with the cost allocation and charging guidance issued by HM Treasury.

NHS foundation trusts are required to provide a specific set of disclosures to meet these requirements within the Annual Report (as referenced in the *NHS Foundation Trust Annual Reporting Manual*). The trust considers that it meets these and the Board is requested to approve this.

Next steps

- Statement received from external stakeholders on the quality account (Wandsworth CCG, Healthwatches, Wandsworth OSC, Council of Governors)
- 20th May: final submission to external auditors, Grant Thornton
- 25th May: Quality and Risk Committee sign-off
- 26th May: Audit Committee sign-off
- 27th May: Final submission to NHSI and Department of Health

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?

We are required to submit the final version of the Annual Report and Accounts to the Secretary of State for Health and Monitor no later than 27th May 2016.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	Assessing and monitoring the quality of service provision

Equality Impact Assessment (EIA): Has an EIA been carried out? No
If yes, please provide a summary of the key findings

If no, please explain you reasons for not undertaking and EIA. The account is currently only in draft form.

Annual Report and Accounts 2015/16

St George's University Hospitals NHS Foundation Trust

Excellence in specialist healthcare

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

Contents page

This section is to indicate the content for inclusion yet to be received by the communications team

Chairman's foreword

Meeting with the Sir David Wednesday 4th May for guidance on content

Chief executive's statement

I would like to begin by expressing a huge thank you to all staff for the collective effort to get us to where we are today in what has been one of the most challenging years at St George's in recent times.

We began 2015/16 with significant financial and operational pressures. In early 2015 Monitor, the health regulator, became concerned with the deterioration in St George's financial position and commissioned a review into our governance and financial processes. This review included 76 recommendations. As a result of this we have worked throughout 2015/16 to ensure the trust's financial sustainability and to strengthen our systems of governance and financial management. I'm very pleased to say that we have implemented all 76 actions and have seen significant improvement as a result.

Operationally, the key issues for us last year centred on the demand for services locally and an increase in the complexity and acuity of patients' conditions. Planned operations have also been affected by the increase in emergency patients and the acuity of patients, leading to a lack of beds, the need to cancel operations and longer waiting lists. Throughout the year, we have been working closely with Monitor to resolve our operational performance issues, particularly referral to treatment times and the four hour waiting time standard in the emergency department.

It has been vitally important, no matter how strong the operational and financial pressures, to continue with our commitment to the quality of care we provide. As a board we remain fully committed to provide the highest quality of patient care. We have recently made changes to the executive team with a view to better delivery of sustained improvement to our estate management, quality, safety and efficiency.

Feedback from patients and staff is integral to understanding how well we are doing. More than 90% of patients receiving care across a range of settings have told the Department of Health via the friends and family test that they would recommend St George's as a place to receive treatment and be cared for. We have continued to receive support and positive feedback from those who enjoy watching our emergency team on Channel 4's '24 Hours in A&E'.

In the latest national staff survey results we have seen that staff have reflected the challenges of the year in relation to their own experience, but continue to recommend the trust as a place to work or receive treatment. We have taken the results of this survey seriously and are working with staff to address its key findings.

We shouldn't lose sight of the real achievements we have made over the last year. Despite the financial and operational challenges, our establishment review has ensured that our wards are safely staffed. We have opened the new Charles Pumphrey Unit for cardiology elective admissions and a new dermatology service at Queen Mary's Hospital for private patients. We are also the first major trauma centre in England to set up an innovative signposting service for major trauma patients.

We have been nationally recognised for our hard work, including receiving JAG accreditation for our endoscopy service at Queen Mary's Hospital, being the first major teaching hospital to be accredited with HIMMS stage 6 status for our clinical informatics systems, gaining a grade A for

our hyper acute stroke unit by Sentinel Stroke National Audit Programme and being approved to join the VTE Exemplar Network.

I am immensely proud of the trust and the loyalty of our staff who provide the best care they can, 24 hours a day, 365 days a year.

Finally, I would like to pay tribute to Christopher Smallwood who completed his tenure as chair in January 2016 and to Miles Scott who stepped down from his position as chief executive in April 2016. I would like to thank Sarah Wilton who became our acting chair until Sir David Henshaw took up the position of chairman in March 2016. I would also like to welcome Sir David Henshaw and the new members of our executive team to the trust.

What we do

Introduction

Everything St George's does is focused on our patients' needs. From local services to nationally leading specialties, our vision is for patients to experience the highest possible quality of care.

With over 8,500 dedicated staff caring for patients around the clock, we are the largest healthcare provider, major teaching hospital and tertiary centre for south west London, Surrey and beyond. Our main site, St George's Hospital, is one of the country's principal teaching hospitals and shares its site with St George's, University of London which trains the next generation of healthcare, science and medical students and also carries out advanced medical research.

We also share our main site with St George's, University of London and Kingston University's Faculty of Health and Social Care Sciences, which is responsible for training a wide range of healthcare professionals from across the region.

As well as acute hospital care, we provide a full range of specialist care following integration with Community Services Wandsworth in 2010. The trust serves a population of 1.3 million across south west London. A large number of services, such as cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, totalling around 3.5 million people.

We also provide care for patients from a larger catchment area in south east England for specialities such as complex pelvic trauma. Other services treat patients from all over the country, such as family HIV care and bone marrow transplantation for non-cancer diseases. The trust also has a national state-of-the-art endoscopy training centre.

A number of our services are part of established clinical networks, which bring together doctors, nurses and other clinicians from a range of healthcare providers to work to improve the quality of services for patients. These include the London Cancer Alliance, the South London Cardiac and Stroke Network and the South West London and Surrey Trauma Network of which St George's Hospital is the designated heart attack centre, hyper-acute stroke unit and major trauma centre.

This report tells the story of how St George's has performed during the year and also looks ahead to next year's priorities for providing quality, patient-centred care at a time when St George's, like many other trusts, is experiencing significant financial pressures.

Facts and figures

St George's is a vibrant, multi-faceted organisation. The following gives a flavour of the trust: its size, activity, quality and services during 2015/16. It is not an exhaustive list.

Overall, in 2015/16, the trust saw 636,766 outpatients, delivered 5,186 babies, undertook 28,413 elective inpatient and day case procedures and admitted 47,125 non-elective patients.

Our emergency department saw 151,257 patients including early pregnancy unit attendances, while Queen Mary's Hospital's minor incident unit saw 16,103 patients.

The trust has a designated large hyper acute stroke unit, which provides an extremely high quality service and received 1,930 stroke patients during 2015/16.

The trust is a major centre for tertiary services including cardiovascular, neurosciences, renal, cancer and specialised children's services for south west London and Surrey.

It is also one of four major trauma centres in London, receiving 2,205 major trauma calls in 2015/16.

We officially opened our helipad in April 2014 which strengthened our role as a major trauma centre. During 2015/16, we received 91 patients via the helipad.

Our services

As the largest healthcare provider in south west London, St George's has an important role to play in the local economy. We provide healthcare services at:

Hospitals
St George's Hospital, Tooting
Queen Mary's Hospital, Roehampton

Therapy centres
St John's Therapy Centre

Health centres
Balham Health Centre
Bridge Lane Health Centre
Brocklebank Health Centre
Doddington Health Centre
Eileen Lecky Clinic
Joan Bicknell Centre
Nelson Health Centre
Stormont Health Centre
Tooting Health Centre
Tudor Lodge Health Centre
Westmoor Community Clinic

Other settings
HMP Wandsworth

We also provide services in GP surgeries, schools, nurseries, community centres and in patients' homes.

Our clinical services are split into four divisions:
- surgery, theatres, neurosciences and cancer
- medicine and cardiovascular
- children's and women's, diagnostics, therapeutics and critical care
- community services.

The trust's tertiary and specialist services treat the most complex injuries and illnesses. Many specialist services are provided as part of clinical networks for which the trust acts as the clinical hub, for example, the trust is the inpatient centre for paediatric, ear, nose and throat, plastics and maxillofacial surgery for south west London.

The trust became one of the four major trauma centres in London in 2010 and in the same year was designated a hyper acute stroke unit. The trust's stroke service consistently receives excellent reports as part of the Sentinel audit, which shows the service to be in the top quartile nationally.

The trust was the first in London to provide primary angioplasty services 24 hours a day, treating heart attack victims with rapid stenting of the arteries around the heart, and is one of eight heart attack centres in London.

The vast majority of the trust's acute services are delivered at St George's Hospital. The trust believes this is a key strength of the organisation, bringing together the full range of acute clinical services and clinical expertise on a single site.

The diagram on the next page shows the divisional structure and the services each division delivers for the differing cohorts of patients who access St George's services.

Find out more about our services and the clinicians and healthcare professionals that provide them, on the services section of our website www.stgeorges.nhs.uk/services

Services

Flagship tertiary services	Key specialist services	Local hospital services	Support services	Community services

Service updates required – Chloe Cox

Division	Directorates	Clinical services within each directorate						
Surgery, theatres, neurosciences and cancer	Surgery and trauma	T&O	ENT	Maxillofacial	Plastics	Urology	General surgery	Dentistry
		Audiology						
	Theatres and anaesthetics	Theatres and decontamination	Anaesthetics & acute pain					
	Neurosciences	Neurosurgery and neuro-radiology	Neurology	Neuro-rehab	Pain clinic			
	Cancer	Cancer						
Medicine and cardiovascular	A&E and acute medicine	A&E	Acute medicine					
	Specialist medicine	Lymphoedema	Clinical infection unit	Rheumatology	Diabetes / endocrinology	Chest medicine	Endoscopy and gastroenterology	Dermatology
	Renal, haematology and oncology	Renal transplantation	Renal medicine	Medical oncology	Clinical haematology	Palliative care		
	Cardiovascular	Cardiology – clinical academic group	Cardiac surgery	Vascular surgery and vascular access surgery	Blood pressure unit	Thoracic surgery		
Children's and women's, diagnostics, therapeutics and critical care	Children's	Paediatric surgery	Newborn services and NICU	PICU	Paediatric medicine and community paediatrics			
	Women's	Gynaecology	Obstetrics					
	Therapeutics	Adult critical care	Therapies	Pharmacy				
	Diagnostics	Clinical genetics	Breast screening	Radiology	Laboratory haematology			
	Outpatients	Outpatients						
	Children and family	School and special school nursing	Children's continuing care	Health visiting	Child safeguarding team	Homeless, refugees and asylum seeker team		
	Community adult health	Complex and scheduled	Rapid	Access and	Specialist	Day hospitals	Elderly rehab	

	service	care	response	co-ordination	services		
Community services	Rehab and adult therapies	Specialist rehab services	Adult therapy services – physiotherapy, podiatry, dietetics	Community learning disabilities	Maximising independence		
	Offender healthcare	Primary care	Substance misuse	Inpatient care	Primary care mental health		
	Integrated sexual health	Genito-urinary medicine (GUM)	Reproductive sexual health				

Working in the community

As well as acute hospital services, we provide a wide variety of specialist care and a full range of community services to patients following integration with Community Services Wandsworth in 2010.

Children and families

School nursing: we were very pleased to win the tender to provide a school nursing service in Wandsworth for the next three years. This has a budget of £1.25m and a large number of key performance indicators (KPIs) to deliver, and we are working closely with the local authority to develop and provide a good service to all the schools in Wandsworth.

Family Nurse Partnership (FNP): starting in April 2015, this specialist national service works in partnership with the local authority to provide an intense and specific package of intervention to teenage mothers. Intervention begins in pregnancy and continues until the baby is two years old. The service is closely monitored by the national FNP unit and 45 young women have been recruited to the programme so far. Total capacity is 100.

Delivery of flu vaccine to all children in school years 1 and 2: agreement for this programme was given in late summer so mobilisation had to be quick and coordinated. The total cohort was around 7000 and the team offered vaccine to all of these children. Uptake was just over 50% which is above the London average. We were also successful in completing a tender to become part of the London immunisation framework.

Community adult health services

Community adult health services (CAHS) aim to enable patients to maintain their health and well-being so they can remain independent at home for as long as possible. They are a multidisciplinary team of doctors, nurses, therapists, social workers and support staff who work with colleagues in the broader health and voluntary sectors to provide a universal approach to patients' healthcare needs. It is now been one year since CAHS were implemented and teams have been working together in the newly designed functions of care. This has involved a great deal of change and staff have worked incredibly hard make this work, despite challenges with recruitment. The care functions provide a more accessible service to patients, in order to prevent admission to hospital, support discharges home, provide rehabilitation and support long term

conditions. Feedback from teams working in this new way has included the positive benefits of closer multidisciplinary working for both professionals and patients and their families.

Community adult health services – end of life care (CAHS – EoLC)

Community services are now providing a nurse-led end of life care service in partnership with Royal Trinity Hospice and Marie Curie. A dedicated end of life community nurse provides extra support and advice to both patients and nurses in the community, leading a team of Marie Curie health and personal care assistants offering specialised hands-on care at home. The end of life specialist nurse works closely with the Wandsworth Care Co-ordination Centre based at Royal Trinity Hospice which arranges rapid packages of care and equipment to enable patients to be cared for at home, and acts as a helpline for patients, families and professionals. The service has been operating for one year and has supported over 400 patients so far. Feedback from patients and colleagues has been very positive and has supported the centre's role in providing a rapid and sensitive service for patients and families, enabling them to feel more supported to remain at home.

Offender healthcare

HMP Wandsworth is the largest and one of the most complex prisons in the United Kingdom. Healthcare services at this busy and challenging prison are provided by a consortium for which St George's is the lead. Our key consortium partner is South London and Maudsley NHS Foundation Trust. Operationally the service provides primary care, substance misuse and mental health services at the prison through an integrated governance and management structure including an overarching integrated board.

Jo Darrow, general manager of offender healthcare services for St George's University Hospitals NHS Foundation Trust, presented at the XXXIVth International Congress on Law and Mental Health in Vienna in 2015. The conference consisted of workshop presentations from around the world including the US, Canada, Sweden, Japan, France and Pakistan. Jo was one of five presenters talking at the workshop titled "Prison Mental Health: Local Innovation and Translation". Jo's presentation, "Developing and Providing Integrated Care in One of Europe's Largest Prisons", included an exploration of the journey taken by the two large NHS trusts in creating the consortium, the successful tendering process and the subsequent successful development of an integrated governance and management structure.

The consortium is soon to enter its third year and while there is no doubt that it is a challenging environment within which to deliver healthcare services, the partnership between the large organisations involved continues to flourish.

Mothers Like Me

The innovative Mothers Like Me project won the Positive Practice Award - Innovation in Primary Care in October 2015.

To remove a child from their birth mother is likely to be the hardest decision made by the Family Court. For the child it should mean a brighter future but for the birth mother it is likely to lead to great feelings of loss, bereavement and guilt. Although birth parents are offered post adoption support, research shows that take up of services can vary.

The 18-month Mothers Like Me project (launched in January 2014) supports birth mothers of adopted babies and children in long term care placements to identify factors that contributed to this outcome and strategies and support that could help prevent it happening in future. This was a joint venture between Health and Children's Specialist Services funded by the Adoption Reform Grant with the aim of promoting the women's health and wellbeing through both individual and group support to help prevent repeated loss of their children.

The project made contact with birth mothers and listened to what support they felt they needed. A range of services was then developed including: a weekly drop in peer group session, access to community activities and training, individual assessments for psychological therapies and individual counselling sessions, making memory boxes for their children, and health screening which includes contraception advice, signposting and provision. The project has managed to engage with this hard to reach group and has had very positive feedback from the mothers involved.

Acorn Service - sexual health advice and screening for people with learning disabilities

People with learning disabilities can find it difficult to access health services, including sexual health. Working in partnership with the Wandsworth Community Learning Disability Team at the Joan Bicknell Centre, The Pearl Service at The West London Centre for Sexual Health and the London Borough of Wandsworth, the Courtyard Clinic has launched the Acorn Service which is a dedicated, easy access service for people with learning disabilities. The Acorn Service offers screening for sexually transmitted infections, contraception and information around sex and relationships.

Patients can refer themselves or can be referred by GPs, family members, carers, case workers and social workers with the patient's consent.

Research

At St George's, we are committed to innovating and improving the healthcare we offer and a key way we do this is by participating in research. Our clinical staff keep abreast of the latest treatment developments and through clinical trials, patients are offered new drugs and devices and better clinical care evolves. The key reason for our participation in clinical research is to develop new and improved clinical treatments for our patients and to realise better ways to manage illness, thereby ultimately improving the health of our local community.

St George's is a collaborating site with Genomics England for the '100,000 Genomes Project' and the genetics service has begun to recruit patients from our services to contribute data and samples to the project. St George's University Hospitals NHS Foundation Trust runs the South West Thames Regional Genetic Service which provides a specialist service to people living in South West London, Surrey and West Sussex, in 18 hospitals across the region. Initially the focus will be on rare disease, cancer and infectious disease, but our clinicians are working with the project to identify other key disease areas.

St George's, in its partnership with St George's, University of London, aims to bring new ideas and solutions into clinical practice. Clinical teams collaborate with scientists to investigate the causes of a range of diseases, to develop better methods of diagnosis and tailored treatments. There has been significant investment in new academic clinical appointments in the previous year. We look forward to a growth in research activity in neurosciences, cardiology and maternal and fetal health in 2016.

Our strong relationship with the pharmaceutical industry continues – we recruited the largest number of patients onto commercial trials in South London Clinical Research Network. This enables our clinical staff to keep abreast of the latest developments and our patients to have access to the newest treatments within clinical trials.

The cardiology clinical academic group (CAG) is a new way to manage clinical, educational and research activities through a coherent and skilled clinical group that represents both the university and the trust.

This is the first CAG to be established by the trust and university, and it is an exciting development for the whole of St George's. Patients will benefit from the best care we can possibly deliver.

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

To read more about our research projects and aims for 2016, please see page XX of the quality report.

Working with our partners

At St George's University Hospitals NHS Foundation Trust we believe in working with our partners. Here are some of our key partnerships, listed alphabetically, that help make our trust a success.

First Touch

First Touch is the neonatal charity for St George's Hospital, funding vital medical equipment, specialist nurse training and a welfare scheme for families on the neonatal unit (NNU).
The charity recruited 'ambassadors' in Tooting, Balham, Wandsworth, Wimbledon, Raynes Park and Colliers Wood to raise the profile of the charity. Actress Martine McCutcheon and her husband Jack McManus are the charity's patrons.

Full Circle Fund

The Full Circle Fund is dedicated to enhancing the quality of life of patients through pioneering supportive therapies. Based in haematology, oncology and paediatric wards, the fund's services benefit adults, babies and children with life-threatening conditions.
A range of therapies offered by the fund aim to achieve improved quality of life, a reduction of anxiety, improvements in sleeping, feelings of wellbeing and control and a reduction in the perception of pain. It works in three key areas:

- therapy – quality of life support and training programmes for patients
- research – scientific research and evaluation for better understanding of supportive therapies and survivorship
- education – informing and educating healthcare professionals and the general public about the role and benefits of supportive therapy.

Healthwatch

Healthwatch England is a national organisation that makes sure the overall views and experiences of people within health and social services are heard and taken seriously. Healthwatch Wandsworth and Healthwatch Merton give local people in the area the chance to voice their views on health and social care services. It works for the local community by helping to shape and improve the services the local communities use and by engaging with local people.

Health Innovation Network

The Health Innovation Network (HIN) is a membership organisation which is driving lasting improvements in patient and population health outcomes by spreading the adoption of innovation into practice across the health system and capitalising on teaching and research strengths.

Kingston Hospital NHS Foundation Trust

Our working relationship with Kingston Hospital NHS Foundation Trust has continued as there are a number of consultants who have appointments and commitments in both trusts.
The work covers a range of specialties and this ensures a smooth flow of patients between organisations. Both organisations participate in wider south west London clinical networks and have recently collaborated on the development of stroke and trauma services for the sector.

London Cancer Alliance

The London Cancer Alliance works collaboratively with 15 NHS provider organisations, including

St George's University Hospitals NHS Foundation Trust, plus two academic health science networks - Health Innovation Network South London and Imperial College Health Partners.
It was established in 2011 as the integrated cancer system across west and south London and serves a population of over five million.
Their vision is to provide equitable, world-class cancer care, health outcomes and patient experience, delivered through comprehensive and seamless pathways, based upon national and international standards, research and evidence.
Their mission is to work collaboratively across the integrated system to deliver safe and effective care, improve cancer clinical outcomes and enhance patients' and carers' experience and quality of life.

NHS South West London

NHS South West London brings together five clinical commissioning groups: Croydon, Kingston, Richmond, Sutton & Merton and Wandsworth. NHS South West London works with St George's University Hospitals NHS Foundation Trust on designing services to meet the specific needs of our patients.

Ronald McDonald House

Ronald McDonald House Charities keeps families together so children in hospital can get the love and comfort they need. The charity provides 'home away from home' accommodation for families with children in hospital; somewhere free to stay for as long as they need to.
The mission of Ronald McDonald House Charities is to ensure there are sufficient funds and expertise to develop and sustain free accommodation at specialist children's hospitals in the UK. The House at St George's Hospital is one of 14 across the UK. Many families travel miles from home so that their child can receive expert medical care and many have to remain in hospital for months at a time.

St George's Hospital Charity

The work of St George's Hospital Charity enhances the physical environment of our hospitals for patients, staff and visitors. They fund research and state-of-the-art equipment. Through fundraising, the charity is able to fund projects which touch the lives of the thousands of people cared for by our hospitals and local community services each year.

Some of the latest developments supported by the charity include:

- £1m of new medical equipment at St George's and Queen Mary's hospitals
- £425,000 for a major expansion of St George's neonatal high dependency unit, helping to expand high dependency capacity by four cots, increasing to 13 cots in total
- £410,000 expansion of the chemotherapy day unit following the gift of a legacy to improve cancer facilities at St George's and help more patients receive their treatments with greater privacy and dignity
- £250,000 for a patient-led initiative to improve adult wards by making them more dementia friendly
- funding towards installing a new MRI scanner for neurology patients
- two new birthing beds in the Carmen delivery suite at St George's to respond to growing need
- £70,000 for fetal monitors in the delivery suite

- an orthotic foot scanner to instantly capture a 3D image of the shape of the foot, avoiding the need for plaster casts
- force plates and rehabilitation exercise equipment to aid recovery in the Douglas Bader gym at Queen Mary's Hospital
- support for the genetics team at St George's to provide a microbiological safety cabinet for cell cultures used for genetic tests
- three balloon pumps for use for life support in emergency settings in the cardiac catheter labs and cardiac theatres
- £120,000 for four cystocopes to view the interior lining of the bladder and urethra
- £11,500 for rehabilitation equipment for hand injuries
- £104,000 for intensive care at St George's, particularly ventilators and bronchoscopes to provide breathing support

St George's, University of London

The trust's main site, St George's Hospital in Tooting, is shared with St George's, University of London, one of the country's principle medical schools. Building on centuries of joint endeavour, the university and hospital offer high quality education, training, research and clinical care. The partnership has been striving to improve and will continue to do so, using the resources and expertise available on site. This year has seen implementation of the Joint Implementation Board which has led to a number of innovations, including the planned launch of the cardiology clinical academic group. We also have joint director posts with St George's, University of London, including our medical director and interim director of estates and facilities.

South London Healthcare Networks

The trust is at the heart of several healthcare networks operating across south London, working alongside our colleagues from the NHS, private and voluntary sectors to deliver expert care to patients and their families from diagnosis to rehabilitation.
These networks include trauma, cancer, cardiac and stroke. The sharing of expertise and ability to streamline care pathways across these networks has led to consistent high quality care and improved outcomes for patients.

South London NHS Genomics Network Alliance

The South London based Genomics Network Alliance was successful in becoming a pioneering Genomic Medicine Centre, part of the ground-breaking 100,000 Genomes Project. The three-year programme, which began in February 2015, has the potential to transform the future of healthcare.
The Genomics Network Alliance serves a population of more than seven million people and is a partnership between the following London hospital trusts and universities and two of the country's biggest patient organisations:

- four NHS trusts: Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, South London and Maudsley NHS Foundation Trust and St George's University Hospitals NHS Foundation Trust.
- two universities: King's College London and St George's, University of London.
- two patient organisations: Macmillan Cancer Support and Genetic Alliance UK.
- two Academic Health Science Networks: covering South London (The Health Innovation Network) and Kent, Surrey and Sussex.
- one Academic Health Science Centre: King's Health Partners.

South West London Pathology (SWLP)

Croydon Health Services NHS Trust, Kingston Hospital NHS Foundation Trust and St George's University Hospitals NHS Foundation Trust have formed a partnership to deliver a single, integrated, high quality, NHS led pathology service to hospitals and GPs across south west London.

The partnership brings together the best of each trust's current pathology services and provides them in a co-ordinated and streamlined way. St George's University Hospitals NHS Foundation Trust is the host organisation for all the partnership's services.

London Borough of Wandsworth

St George's, NHS Wandsworth, local GPs and pharmacists and London Borough of Wandsworth work together on the Planning All Care Together (PACT) programme.

PACT puts service users, patients and carers at the heart of service delivery and uses the strengths of NHS and council services as well as the voluntary sector to design and deliver innovative approaches to care, which better meet the needs of people with long term conditions in Wandsworth.

Telehealth and telecare already support patients with long-term health conditions, helping them stay independent at home for as long as possible.

Using technology to improve our services

Information management and technology play an essential role in supporting the delivery of safe high quality care to our patients. 2015/16 saw further enhancements and new features introduced across the trust.

Integrated clinical information programme

The trust introduced more clinical content to acute clinical information systems as part of our integrated clinical information programme (iCLIP). The new clinical content to Cerner Millennium®, our main acute clinical information system, encompasses electronic integrated vital sign monitors (iVSM), electronic whiteboards and on-going consolidation and improvement of our electronic system.

St George's was recognised and accredited for its hard work in implementing clinical informatics systems within the inpatient areas of the hospital. We were the first major teaching hospital in the UK to be accredited to the Healthcare Information and Management Systems Society (HIMSS) Stage 6 (stage 7 is the highest achievable) and the first UK trust to be validated through an on-site visit. HIMSS is an international not-for-profit organisation dedicated to improving healthcare quality, safety, cost-effectiveness and access, through the best use of IT. Furthermore the organisation has been shortlisted for several national awards involving patient safety, efficiency and the innovative use of IT.

OpenRiO

OpenRio is the trust's clinical record system for the community providing a comprehensive electronic patient record supporting collaborative high quality care in a paperless environment. New functionality was introduced this year to enable community staff to view and update information in the patient's own home.

South West London Pathology

As the host organisation and hub for South West London Pathology (SWLP), St George's led the implementation of a large, complex programme of IT integration which was successfully completed in December 2015. The project connects three acute hospitals, a number of health centres and over 200 GP practices. Results are sent electronically to all requesters and are additionally available within a new portal that provides a patient centric, multi-organisational view of pathology information.

The clinical portal

Work continued in parallel with the pathology project and the South West London Portal also contains information for St George's RiO patients. The next stage of development will see the introduction of appointment data and discharge summaries from the three acute trusts and access to GP data.

GP electronic ordering

St George's rolled out electronic GP requesting for pathology tests to all GP practices across Wandsworth and Merton boroughs. GPs in Merton are also able to make radiology and cardiology requests.

Electronic document management

Electronic document management (EDM) allows paper health records to be stored electronically so that they are available to be viewed at any location where care is being delivered. This will

improve patient experience and quality of care by ensuring relevant information is always available while significantly reducing the trust's reliance on paper medical records. New referrals to the trust are now stored immediately in the EDM system instead of in a paper folder for urology, chest medicine and rheumatology. Completion of EDM deployment will enable us to move closer towards our goal of being a paper-light organisation.

Offender health

Electronic prescribing and drug administration has been implemented at HMP Wandsworth to enable transmission of drug information between prisons and replacing a complex paper process.

Our information and communications development plan for 2016/17 includes:

Deploying ePrescribing and medicines administration (ePMA) and eDocumentation

We will complete inpatient deployment of electronic clinical documentation and ePMA to all inpatient bed areas securing the safety, quality and efficiency benefits associated with the use of an electronic patient record to support improved patient care.

Technology refresh at Queen Mary's Hospital

We will bring Queen Mary's to the same level of technology enjoyed at St George's including the full range of iCLIP functionality (patient administration, ordering and resulting of diagnostic tests, clinical documentation and electronic prescribing and drug administration). Additionally, electronic document management, eTriage and DictateIT2 will be deployed.

Maternity system upgrade

An upgrade to the maternity system will go live in April 2016. This will provide improved functionality and enhanced reporting capabilities.

Benefits

The delivery of the IT strategy in 2016/17 will confer many benefits to patients and staff across St George's University Hospitals NHS Foundation Trust

Living our values

Our mission is to provide excellent clinical care, education and research to improve the health of the populations we serve. Our vision is to become an excellent integrated provider and a comprehensive specialist centre for south west London, Surrey and beyond with thriving programmes of education and research.

We are committed to keeping patients at the heart of everything that we do and our values are designed to inspire our staff to achieve this. The following values set out the standards we have set ourselves.

Excellent

- look after our patients as we would like to be looked after ourselves
- set ourselves high standards and be open to new ideas
- be professional in our approach and in our appearance
- promote and share best practice

Kind

- anticipate and respond to patients' and carers' concerns and worries
- support each other under pressure and consider the impact of our actions on others
- help people find their way if they look unsure or lost
- smile, listen and be friendly

Responsible

- have patient safety as our prime consideration
- be responsible for ensuring good patient experience
- use resources wisely
- challenge poor behaviour in others
- learn from experience including our mistakes

Respectful

- keep patients, families and carers involved and informed
- protect patients' dignity and confidentiality
- wear our name badges, introduce ourselves and address people in a professional manner
- respect colleagues' roles in patient care and experience
- value and understand the diversity of those around us

Responding to your concerns

The trust cared for over one million patients in 2015/2016. We accept that among this number of patients, the experience for some will not meet their expectations.

The trust adheres to the Parliamentary and Health Service Ombudsman's Principles for Remedy, which provides guidance on the way in which public bodies respond to complaints and concerns raised by patients and their representatives.

We are absolutely prepared to change and improve in response to feedback from patients, visitors and other stakeholders. The lessons learned and trends identified from information collected via our complaints process play an important part in improving the quality of care we provide.

In addition, our Patient Advice and Liaison Service (PALS) helps to address any problems or concerns that patients may have regarding the trust's services. PALS staff listen to the views and comments of patients ensuring that feedback is passed on. They also advise staff regarding access to interpreters, signers and other services patients may need to improve their experience. PALS staff also provide customer care training to colleagues and often assist staff when they are in need of support.

The table below lists the total number of written complaints received during 2015/16.

	15/16
Admissions, discharge and transfer arrangements	22
Aids and appliances, equipment, premises (including access)	14
Appointments, delay/cancellation (outpatient)	105
Appointments, delay/cancellation (inpatient)	30
Attitude of staff	67
All aspects of clinical treatment	432
Communication/information to patients (written and oral)	192
Consent to treatment	2
Patients' privacy and dignity	6
Patients' property and expenses	19
Personal records (including medical and/or complaints)	20
Failure to follow agreed procedure	1
Mortuary and post mortem arrangements	1
Transport (ambulances and other)	25
Policy and commercial decisions of trusts	1
Hotel services (including food)	11
Others	26
Total:	974

Data table on response times to be provided in second week of May – Sarah Duncan

Care Quality Commission

In line with the requirements of the Health and Social Care Act 2008 (the Act), the trust continues to be registered with the Care Quality Commission (CQC), the independent regulator of health and social care in England, without condition, to provide the following services:

- treatment of disease, disorder or injury
- surgical procedures
- diagnostic and screening procedures
- maternity and midwifery services
- termination of pregnancies
- family planning clinics
- assessment of medical treatment for persons detained under the 1983 (Mental Health) Act.

The trust has no conditions placed on it and the CQC has not taken any enforcement action against the trust in 2015/16. In order to maintain registration as a healthcare provider, the trust must demonstrate that it meets the 16 essential outcomes of quality and safety set out in the Act under the following headings:

- involvement and information
- personalised care, treatment and support
- safeguarding and safety
- quality of management
- suitability of management

During a CQC inspection, the trust is measured against the five domains of quality:

- are services caring?
- are services safe?
- are services effective?
- are services responsive?
- are services well led?

The CQC rating system has four categories - outstanding, good, requires improvement and inadequate. Trusts are given an overall rating and a range of services within the trust are also given one of these four ratings.

The trust received an overall rating of 'good' with adult critical care and some areas of maternity considered to be 'outstanding' during the trust's last inspection in February 2014. The CQC rated 62 specific standards. Out of these, four were rated outstanding, 50 were rated good and eight were in the 'requires improvement' category. None of our services were judged inadequate.

The CQC report on the trust highlighted numerous examples of commendable practice, including:

• Outstanding maternity care underpinned by information provided to women and partners and robust midwifery staffing levels with excellent access to specialist midwives

• Exceptional end of life care demonstrated within the maternity department

• Outstanding leadership of intensive care and high dependency units with open and effective team working and priority given to dissemination of information, research and training

• Excellent multidisciplinary working within and across community and acute teams

• The functioning of the hyper acute stroke unit, short term reablement and rehabilitation service

• The well led, integrated working and calm environment within the emergency department

• Multi-professional team working in neurology theatres

• Systems developed by the trust to promote the safety of children, young people and families

• An evident culture of positive learning from medicine administration errors

• Development and use of DVDs to engage staff with ongoing practice improvements.

As well as highlighting some aspects of care which required improvement the CQC also asked that we take action to ensure staff awareness and implementation of the Mental Capacity Act at Queen Mary's Hospital (QMH). The CQC noted that most staff had attended or completed training on safeguarding adults and that there was appropriate specialist input through the trust's safeguarding lead and two specialist learning disability nurses. However, varying levels of understanding of the Mental Capacity Act were identified.

During 2015/16 the trust has continued to take action to address the two issues identified by the CQC. A formal action plan was developed and approved by the trust board before being shared with the CQC. The plan set out how the trust would ensure improvements in the availability of medical records in outpatient clinics, and also set out the measures we would take to ensure that staff at QMH have a good level of understanding of the Mental Capacity Act in order to deliver safe, responsive and effective care.

There has been an improvement project in the corporate outpatient department and better availability of medical records was just one of the improvements made. This improvement is monitored on an on-going basis.

The trust designed and delivered a tailored training programme to all staff at QMH around the implementation of the Mental Capacity Act and all staff have now attended and have evaluated the training and a case note audit has shown that practice has improved.

Progress on the action plan has been presented to the trust's commissioners and the CQC on a quarterly basis and both commissioners and the CQC indicated that good progress had been made to improve quality of care where needed. The action plan was therefore closed in July 2015, with all actions in the plan still monitored by the trust on an on-going basis.

The CQC have announced that they will return to the trust on 21st June 2016 to carry out a full inspection as part of their continued announced inspection regime. The results will be available in early autumn 2016.

There is more information on the CQC within the quality report on page XXX.

Below are some of the achievements and successes at St George's over the past year. To put them

into context, they are grouped under the five questions used by the CQC.

Are we caring?

St George's opens new cancer ward

St George's was delighted to announce the opening of a new cancer ward in May 2015

The ward provides an additional 20 beds in a clean, modern environment to treat a diverse number of patient groups, including those with leukaemia, lymphoma and non-malignant conditions of the blood.

Gordon-Smith ward was officially opened by Dr Anne Rainsberry, NHS England's regional director for London. It is the second step of investment in our cancer services after the opening of the new haematology and oncology outpatients clinic last year.

The ward is named after Ted Gordon-Smith, a retired professor of haematology at St George's, University of London, who joined St George's in 1987. He was instrumental in expanding our clinical haematology service from two beds to a dedicated 13-bed transplant and haematology ward during his 25-year career at the trust.

Dr Anne Rainsberry said: "It is a great honour to open this new ward which will really improve the experience of cancer patients at St George's. Across London, we are committed to ensuring that people with cancer receive world-class care which is centred on their needs at every stage - from prevention and diagnosis, through to treatment and beyond."

New hybrid theatre at St George's Hospital to enhance patient care

St George's has opened a new hi-tech hybrid operating theatre, where state of the art imaging enables less invasive surgery which is safer for patients.

The theatre, on the first floor of St James wing, is equipped with an advanced scanner available at all times where small body parts such as veins and arteries can be visualised and surgeons can be guided to these areas.

Medical equipment like catheters or stents can then be inserted through small holes rather than the patient undergoing more invasive surgery. By minimizing the physical trauma to the patient, non-surgical interventions can improve recovery and shorten hospital stay. If the less invasive route is not successful, surgeons can convert to open surgery under one anaesthetic in a safe theatre environment.

Matt Thompson, professor of vascular surgery, said: "It's a very exciting development for the trust to have a first-class safe environment that combines an operating theatre with an interventional radiology suite. The new treatment options have the potential to enhance patient care and shorten recovery times, reducing the overall cost of treatment."

Renate Wendler, associate medical director and clinical lead for the project, said: “The development of the hybrid theatre was a real group effort. I’d like to thank all staff who worked incredibly hard to make it happen.”

The new hybrid suite is used primarily for vascular surgery and interventional radiology procedures, but has the potential to be used for other specialities such as major trauma or cardiology/cardiac surgery.

Are we safe?

Redthread youth violence intervention at St George’s

St George’s held a special engagement event in April 2015 to introduce our staff and associated community professionals to Becky and Alex, two Redthread youth workers who have joined our emergency department (ED) team.

Hundreds of teenagers fall victim to gang-related violence every year and without intervention or effective support some become trapped in a cycle of violence. Redthread are leaders in a youth violence intervention program, working closely with ED staff across London to approach victims and provide the help they need to hopefully break that cycle.

Redthread have been embedding youth workers within the major trauma centre at King’s College Hospital since 2006, St Mary’s from October 2014 and the Royal London Hospital from April 2015. And now, as part of the Mayor’s initiative to better support those who fall victim to gang violence, they have started to focus their attention on establishing a partnership with St George’s.

Becky Calnan, senior youth worker, will be based at St George’s full time, whilst Alex Melhuish will divide his time between our ED and Kings Hospital.

Their posts have been funded by the Mayor’s office, with their primary role being to work with 11-25 year olds who have presented with injuries secondary to violence or who are at risk of violence or sexual exploitation. They will be based in the ED but they will also engage with young people on both the paediatric and adult wards.

Safer test, shorter wait as new Down’s screening comes to St George’s

St George’s announced in June that it will begin offering an in-house, non-invasive prenatal test (NIPT) for pregnant women in the UK. The test helps expectant mothers to understand the risk of their unborn baby having Down’s syndrome and other serious genetic diseases.

Before this, pregnant women in the UK could only access NIPT privately, with blood samples being sent either to the US or China. Not only was this costly, but it also carried a waiting time of up to two weeks for results which are pivotal in helping parents make decisions about their pregnancies.

St George's screening test will be called 'the SAFE test' and St George's will be the only trust to offer NIPT to expectant mothers through the NHS. Based on Premaitha Health's IONA® test, the SAFE test analyses a small sample of the mother's blood to correctly identify over 99% of Down syndrome and other serious genetic disorders.

The focused service will be available to all pregnant women referred to St George's to receive further care after receiving a NHS "high risk" combined test result.

The women will have the choice to undertake either a CVS or the SAFE test – as clinically appropriate.

Are we effective?

St George's seen as an exemplar site

St George's has become the second and largest UK trust to be validated at stage six of the international acute Electronic Medical Record Adoption Model. We are the first site to be accredited following a visit by the Healthcare Information and Management Systems Society inspectors.

The speed and uptake of Cerner Millennium® since it went live in 2012 was cited as an area of good practice during the inspection. The centralised electronic patient record system now has more than 5,500 users including nurses, consultants, doctors in training and administrative staff.

As a result of this accreditation, we are the most requested Cerner site for other hospitals to visit to learn more about iCLIP and how it is used. So far this year we have had 18 enquiries and visits ranging from as far as Qatar and Australia, to London hospitals including the Royal Free and University College London Hospitals (UCLH).

The visits generate credit points from our supplier Cerner Millennium® which are then used towards training, software licenses and equipment.

Queen Mary's Hospital celebrates rich past and bright future

June 2015 marked 100 years since the first amputee patient was admitted to Queen Mary's Hospital (QMH).

To celebrate a century of care, guests were invited to a special centenary exhibition at QMH which was created by QMH Roehampton Archive and Museum Group.

Former RAF fighter pilot Sam Gallop CBE and Councillor Ravi Govindia, leader of Wandsworth Borough Council, declared the display open.

Sam Gallop, one of our most distinguished patients, lost a leg and was badly burnt in World War II. He praised the staff who treated him and encouraged current patients to seek inspiration from the achievements of the past as illustrated in the exhibition. The exhibition includes historic information and educational interactive displays for patients and visitors.

Two months later in September, the Wolfson Neurorehabilitation Centre was opened by Justine Greening, MP for Putney, Roehampton and Southfields, retired St George's neurosurgeon Henry Marsh CBE and Miles Scott.

The centre, which is the largest of its kind in London, provides specialist neurorehabilitation for adults who have acquired neurological conditions resulting in physical or psychological disabilities. Throughout a patient's stay, of typically three months, there is a strong focus on goals, challenges and getting back home.

The Wolfson was relocated from its original Wimbledon site to Queen Mary's. Now in its new home, designed with the help of service users, the centre has 36 inpatient beds.

Current patients joined 60 guests in celebrating the launch which included tours of the unit.

Are we responsive?

A look into the Recovery at Home service

The St George's Recovery at Home service provides acute care in patient's own homes and is aimed at freeing up bed space within the hospital as well as helping reduce length of stay in hospital beds and improving patient outcomes.

The service, which was launched in January 2016, has already supported over 20 patients and saved 206 acute hospital bed nights. The team consists of specially trained nurses, physiotherapists and healthcare support workers and will in the future also include an occupational therapist.

Patients remain under the care of their consultant but are transferred home where they receive acute care from Recovery at Home staff. The trust will continue to provide pharmacy and pathology services in exactly the same way as if the patient remained in the hospital. Patients are discharged from Recovery at Home only when they have recovered in accordance with their treatment plan set by our consultants. Upon discharge, a summary will be sent to the patients' GP in the normal way.

Dorothy Brown, a patient who was transferred to the service in February, has commended the service saying: "The Recovery at Home service has been brilliant and there are really friendly staff."

Nine out of ten people would recommend St George's to a friend or relative

The NHS Friends and Family Test (FFT) reached a memorable milestone in August by achieving its ten millionth piece of feedback from patients.

St George's University Hospitals NHS Foundation Trust has conducted over 40,000 surveys in the last 12 months. These have been far reaching across the trust – including inpatient wards, outpatient clinics, community and maternity services.

On average, 90.3% of people are “Extremely likely” or “Likely” to recommend the service they received to a friend or relative.

By conducting the surveys using our own real time survey system we are able to act quickly on the information we receive, and correlate it with other patient experience data such as any complaints we have received.

We are currently using the feedback to focus on the three main issues raised by patients – minimising noise at night, being clearer about the possible side effects of medication we provide, and involving our patients more in the discharge process.

Although the FFT helps identify areas such as these where improvements can be made, most of the feedback has been overwhelmingly positive across healthcare organisations and many of them report that it has provided an unexpected boost to staff morale and created many more opportunities to give well deserved appreciation to individual staff who have given excellent patient care.

Are we well led?

Macmillan and St George’s join forces to transform the experience of cancer care for people in south west London

Macmillan Cancer Support and St George’s University Hospitals NHS Foundation Trust have announced a three-year partnership which will endeavour to provide people affected by cancer who are treated at St George’s with an excellent experience of care.

Macmillan has already invested £600,000 in the first year of this innovative programme, where healthcare professionals at the hospital and in the community will work alongside patients to improve the current systems of care.

The benefits of the partnership will include:

- increased availability of cancer nurse specialists
- new ways for people affected by cancer to get involved and help shape improvements in care
- specialised training for cancer healthcare professionals which will enable them to deliver more personalised cancer care, as well as help them to empower patients to take control of their own treatment and care.

St George’s is one of the main providers of cancer services in south west London, delivering a range of diagnostic, treatment and support services to more than 4,000 new patients each year. Macmillan has an experienced track record in working with trusts around the country to shape and deliver improved cancer care.

St George's is first major trauma centre in London recognised for its anaesthetic service

The anaesthetic department at St George's Hospital has received Anaesthesia Clinical Services Accreditation (ACSA) in recognition of the excellent service it provides.

ACSA is a unique and prestigious scheme run by the Royal College of Anaesthetists (RCoA) that enables departments to demonstrate quality in key areas, including patient experience and safe care. It has received acclaim from national regulators including the Care Quality Commission.

Paul Quinton, clinical director of theatres and anaesthetics at St George's said: "We are delighted to become only the fifth anaesthetic department and the first major trauma centre in London to receive this accolade".

"Our anaesthetic department has more than 105 consultants and more than 40 trainees working in 28 theatres; as well as covering other areas including pain services, maternity and intensive care. This accreditation is testimony to their hard work, dedication and commitment to providing safe and excellent care to patients at St George's Hospital."

Dr J-P van Besouw, former president of the RCoA, stated that the process should help departments to focus on sharing best practice, clinical governance and ultimately improving patient care.

Dr Tony Turley, lead ACSA reviewer, described the department at St George's as "proactive and dynamic", adding that "there was a clear emphasis on patient safety and noteworthy clinical leadership throughout the department". Dr Turley also commented on the examples of excellent service delivery and improvement, which he said would significantly contribute to the ACSA library of best practice.

Performance report

A brief history of St George's

The original St George's Hospital opened on Hyde Park Corner in 1733. The St George's Medical School was established later on in 1868. The hospital moved from Hyde Park Corner to the Grove Fever Hospital and Foundation Hospital's site in Tooting in 1973, after the NHS was established in 1948. The university followed shortly after in 1976. Her Majesty the Queen officially opened the Tooting site – St George's Group - in 1980, which later became St George's Healthcare NHS Trust in 1993. New developments including, but not limited to, the Atkinson Morley wing, the emergency department, the helipad and the merger with Community Services Wandsworth take us up to 2015 when the trust was authorised as a foundation trust.

Now we can look back over our first full year of being a foundation trust in 2015/16. Being a foundation trust means we are regulated by NHS Improvement (as of 1st April 2016) using a different regulatory framework to the Department of Health. This brings us increased responsibility and freedom to enable us to grow and modernise our services to meet local needs, meaning we can bring new treatments and services to our patients more quickly.

We also have a council of governors which was established in 2014 as a shadow council, before becoming fully functional upon authorisation. Their first official meeting was held on 10th February 2015.

Our 21,000 strong membership represents the communities we serve as a trust. Developing this membership will increase the trust's accountability to patients, staff and the public, which will result in real benefits for all of our stakeholders.

Being a foundation trust is recognition of the high quality services and safe care we provide in our hospitals and in the community and shows that we can live up to our values; Excellent, Kind, Responsible and Respectful.

The purpose and activities of St George's

The role of St George's is to improve the health and wellbeing of patients, to support patients to become mentally and physically well, to support patients to get better when they are ill and when patients cannot fully recover, to help them to stay as well as they can to the end of their lives.

St George's works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. St George's touches lives at times of basic human need, when care and compassion are what matter most.

St George's provides an extensive range of services, available to all. Our services are designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. We have a duty to each and every individual that we serve. At the same time, we have a wider social duty to promote equality through the services we provide and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

We work within a common set of principles and values that bind together the communities and people we serve – patients and public – and the staff who work for us.

Statement from the chief executive providing their perspective on the performance of the foundation trust during 2015/16 – communications to draft based on figures once arrived. Paula Vasco-Knight to approve

Measuring our clinical and operational performance

The trust has continued to work hard in 2015/16 to drive performance improvement across the organisation in all service areas.

As a large and complex teaching trust encompassing a tertiary centre, a major trauma centre, a busy emergency department (ED) and a wide ranging portfolio of services, there are greater risks to the routine delivery of day-to-day operational and financial targets than in many other trusts.

Over the past years, St George's has met or exceeded a number of key performance areas providing both patients and commissioners continued assurance that St George's is a safe place to receive high quality clinical care. However 2015/16 was a challenging year with performance being affected against a number of targets including: ED four-hour standard, cancer two-week wait, cancer 62-day standard and 18-week referral to treatment waiting times. Significant winter pressures and a continued increase in the complexity of patients' conditions leading to an increase in unplanned admissions resulted in the trust not meeting the four-hour wait target. The trust acknowledges that operational processes as well as external improvements need to be made and a number of key work streams have been identified to enable improvement. Over the past year the trust has significantly increased ED staffing, both medical and nursing and is working internally and with external partners to ensure that actions are taken to achieve sustainable performance delivery and to improve the flow of patients through the organisation and their care pathway.

The trust has continued to meet a number of cancer targets in 2015/16. However we experienced a challenging year in regard to the two-week wait from referral to date first seen for all urgent referrals (cancer suspected) and 62-day wait for first treatment from urgent GP referral for suspected cancer, with both indicators failing to achieve the national target. The trust has implemented a number of robust action plans working with commissioners to bring performance back to target and we continue to work collaboratively with external partners and peer trusts to share lessons learnt and improve operational practices.

The trust was pleased with the improvement made from 2014/15 on infection control and mixed sex accommodation breach performance in 2015/16, however there is still improvement to be made. The trust does not underestimate the challenge in meeting increased demand on targets over the coming years with demand rising and the complexity of activity increasing, as well as being able to deliver a strong financial performance.

Within the last twelve months the trust has seen a significant increase in patients waiting from GP referral to elective treatment which has had an impact in the trust being able to meet the national 18-week performance target. There has been trust wide engagement in completing demand and capacity models and working with our external partners to identify referral levels

and ensuring capacity is in place to meet demand. The trust also has a number of key actions to ensure improvement and sustainability against the standard in 2016/17 and this area remains a high priority for the trust.

Indicator	Target	2015/16 Performance
ED: maximum waiting time of four hours from arrival to admission / transfer / discharge	>=95%	90.4%
RTT - Consultant-led Referral to Treatment Waiting Times Incomplete Pathways	>=92%	90.3%
62-day wait for first treatment from urgent GP referral for suspected cancer	>=85%	82.4%
62-day wait for first treatment from NHS Cancer Screening Service referral	>=90%	90.1%
31-day wait for second or subsequent treatment - surgery	>=94%	96.6%
31-day wait for second or subsequent treatment - anti-cancer drug treatments	>=98%	100.0%
All cancers: 31 day wait from diagnosis to first treatment	>=96%	97.1%
Cancer: two week wait from referral to date first seen for all urgent referrals (cancer suspected)	>=93%	87.4%
Cancer: two week wait from referral to date first seen for symptomatic breast patients (cancer not initially suspected)	>=93%	93.4%
C.difficile - meeting the C.difficile objective	31	29
MRSA bacteraemias (blood stream infections)	(0 with do minimis of 6)	3
Mixed Sex accomodation breaches	0	11
Emergency readmissions within 30 days following an elective or emergency spell at the trust.	5%	3%
Data completeness: community services, comprising:		
Referral to treatment information	50%	55.50%
Referral information	50%	87.70%
Treatment activity information	50%	70.30%

Updated cancer figures to be sent by end of w/c 2nd May – Imran Hussain

The trust reviews and monitors performance against key performance indicators (KPIs) via a number of forums as part of its governance processes. Dependant on the nature of the KPIs, performance is monitored, daily, weekly and monthly using a number of reporting tools and online dashboards.

Weekly performance review meetings with operational leads including executive oversight are in place to assess recent performance, escalate concerns and actions required to remediate performance and to assess the impact on the delivery of actions plans. Performance is also benchmarked against peer providers to show how the trust compares to similar size organisations and also against organisation within the local health economy.

Monthly reported performance is signed-off by both operational and executive leads. These are then reported to the appropriate sub-committees of the trust board and to trust board for scrutiny.

In addition to the internal processes performance against key national indicators is reviewed and scrutinised externally by commissioners via a number of external meetings associated with system resilience. The trust then works collaboratively with commissioners in agreeing remedial action plans for any recovery required and associated trajectories.

2015/16 – a challenging year

The trust acknowledged the scale of the financial challenge St George's was facing for 2015/16 in last year's annual report and 2015/16 has proved to be a very challenging first full year as a foundation trust.

St George's is the largest healthcare provider in south west London, with over 8,500 dedicated staff. The trust is the specialist regional centre for the 2.6 million people of southwest London and Surrey, and also provides a range of supra-regional services such as cardiothoracic surgery, neurosciences and renal transplantation for upwards of 3.5 million people. St George's is one of four major trauma centres in London (and one of only two in London currently with a helipad), a heart attack centre, and one of eight hyper-acute stroke units serving London. It is also the provider of community services for Wandsworth including at HMP Wandsworth. It is a diverse, complex and high quality organisation, authorised as a foundation trust on 1st February 2015.

St George's ended 2014/15 with a £16.8m deficit and its initial forecast deficit for 2015/16 was £46.2m resulting in the trust being in breach of its foundation trust license. This resulted in Monitor, the oversight body for foundation trusts, placing St George's into 'turnaround'. This involves outside support, in this case from KPMG, being brought into the trust to help identify and address the causes and drivers for the financial position, and begin the process of returning the organisation to financial sustainability. A key output of the turnaround process has been a revised financial forecast for 2015/16 outturn of £63m and a high level financial plan for 2016/17. All staff within the trust have worked incredibly hard to improve the financial position, while maintaining quality.

The trust's strategy was approved in late 2012 and was reflective of the trusts financial performance in the previous years, its aspiration to become a foundation trust and set out a direction for the organisation for the ten years to 2022. The current strategy remained in force during 2015/16 as the overarching framework against which corporate objectives and other trust proposals were measured and developed against.

The trust will refresh its strategy during early 2016/17. It is the expectation that much of the change to the strategy will be evolutionary as opposed to revolutionary – the needs and requirements of the patients that use the trust and the need to deliver a high quality service, seven days a week, being key to the strategy that the trust develops.

The strategy needs to be refreshed to take account of the financial challenges the trust faces, the evolving needs of the health economy and the need to take account of and begin to implement the five year forward view and the local sustainability and transformation plan (STP). These latter two documents respectively outline the direction of travel for the NHS between 2015 and 2020 and the translation of those aspirations into locally deliverable plans – the STP.

Overall performance against financial and operational targets has been mixed, and the scale of the financial challenge at the trust has been considerable and will remain so during 2016/17.

The trust has achieved a number of the key performance targets, for example:

Indicator	Target	2015/16 performance
All cancers: 31-day wait from diagnosis to first treatment	93%+	93.4%
C.difficile – number of infections per year	31	29
Emergency readmission within 30 days following an elective or emergency spell at the trust	5%	3%

However, on a number of key measures, the trust has not achieved the performance that it would wish to for its patients, key amongst them:

Indicator	Target	2015/16 performance
Emergency department: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	90.4%
18-week referral to treatment: incomplete pathways	92%	90.4%
62-day wait for first treatment from urgency GP referral for suspected cancer	85%	82.4%

The trust has agreed trajectories with commissioners and regulatory bodies for how it will ensure to improve and meet the targets set out above during 2016/17. Delivery against these targets will be a key focus for the trust in the coming year.

The trust has worked hard to meet the financial targets it has set for itself, and has ended the year at £55.1m deficit. This is over the planned deficit of £46.2m, but the trust is clear that without the significant steps undertaken during the year, the deficit position of the trust would potentially have been significantly worse. The trust has begun to develop a transformation programme to underpin a radical but financially sustainable model of healthcare for the future, which will begin to be implemented during 2016/17.

The current strategy is underpinned by two key guiding principles, values and quality. St George's has a set of values which describe the behaviours that all trust staff are expected to demonstrate in all aspects of their work, including delivery of excellent patient and client care. Patients and service users are at the heart of everything we do, and the overriding concern is to ensure that we provide all our users with the highest quality services. The trust uses the national definition of quality, which is divided into the following three domains:

- patient safety – quality care is care which is delivered so as to reduce or eliminate all avoidable harm and risk to the individual's safety
- patient experience – quality care is care which looks to give the individual as positive an experience of receiving and recovering from care as possible
- patient outcomes (clinical effectiveness) – quality care is care which is delivered according to best evidence as to what is clinically effective in improving an individual's health outcomes.

Risks to delivering the 2016/17 operational plan

The trust has a comprehensive governance process that identifies and manages risk within the trust. A number of the challenges, or actions to address those challenges, are covered by the trust's various risk registers and particularly the corporate risk register.

For clarities sake, however, the risks to the delivery of the operational plan are outlined below. We will review the contents of this plan, as it is being refined for submission in April 2016, against those registers, and update as appropriate.

The key issues and risks identified that could affect the trust in delivering this plan are as follows:

1. That the transformation programme does not deliver in its entirety. This would have:

    - operational impacts e.g. flow programme does not improve length of stay sufficiently, hindering the delivery of key access targets

    - financial impacts – with the bulk of the trusts savings programme, and ability to meet the £17.2m deficit control total, tied up in the transformation programme, any delays will have a material adverse impact on the trusts financial position.

2. That the lack of capital funding, internal or external, does not allow the trust to progress major infrastructure projects, particularly the renal re-provision and children and women's hospital.

3. That unexpected infrastructure failure forces the trust to spend additional monies on the capital programme, so risking delivery of the trusts financial targets.

4. That unexpected additional constraints on capacity mean that plans to improve access target performance as outlined in the plan are not delivered.

5. That the trust cannot agree service level agreements with commissioners that allows delivery of targets, and appropriately remunerates the trust for the work it undertakes, impacting on the financial performance of the organisation.

6. That staff turnover and vacancy rates remain unchanged or worsen, impacting on the continuity of patient care, the ability to meet the agency cap, and impact on the ability to deliver the workforce savings outlined in this plan.

That failure to meet access target trajectories, financial recovery plans or transformation plans lead to the trust not receiving the full sustainability and transformation fund allocation of £17.6m, impacting on the ability to meet the control total of £17.2m deficit.

Our strategy

St George's mission and vision

The trust agreed the following mission statement and vision when it developed and approved its strategy in 2012:

Mission

The trust's purpose

Mission

To provide excellent clinical care, education and research to improve the health of the populations we serve

Vision

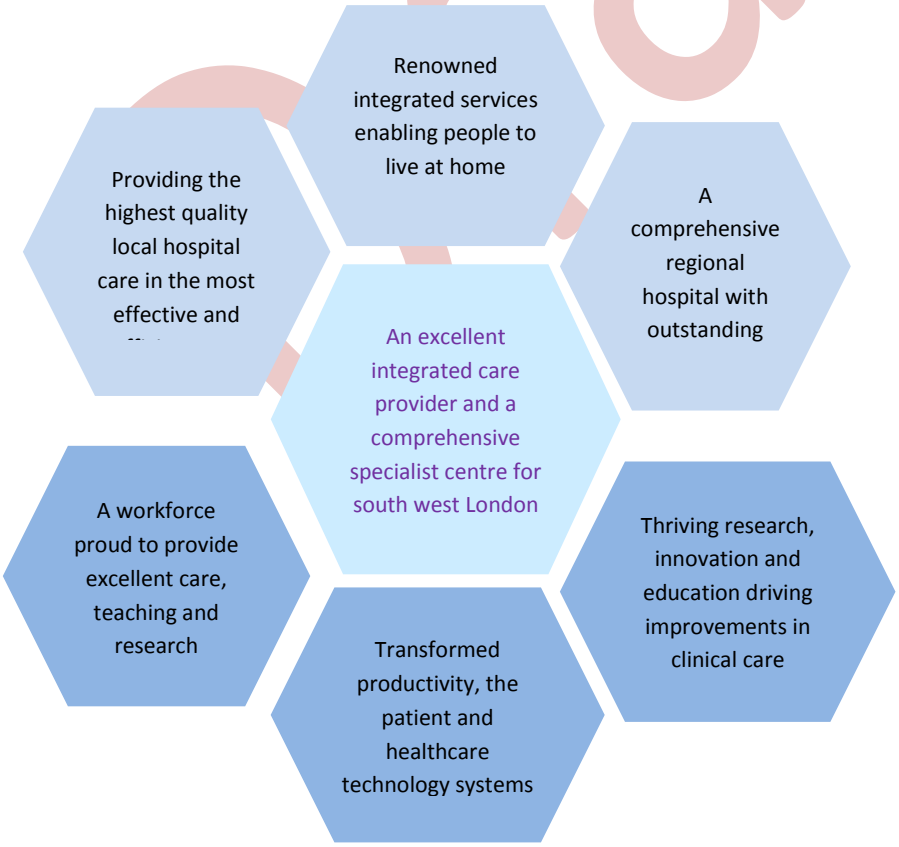
What the trust wants to be

Vision

An excellent integrated care provider and a comprehensive specialist centre for south west London, Surrey and beyond with thriving programmes of education and research

St George's strategy

The trusts strategy was developed utilising the guiding principles outlined above and is designed to move the trust towards implementing its vision and delivering its mission:



The following outlines in more detail what each of these statements mean, some of our achievements in 2014/15 to help deliver the strategy as well as some of the actions we want to take in 2016/17 to move us further forward.

Renowned integrated services enabling people to live at home

To deliver this element of the trust's strategy and vision we will redesign care pathways to keep more people out of hospital.

Evidence shows that home and community based services are safe and effective at keeping people out of hospital. We know that people prefer not to have to go to hospital. Innovations in both technology and the skills of staff mean that St George's can do more of this than ever before.

What have we done in 2015/16?

1. Worked with Wandsworth CCG to develop and implement the community adult health service model to offer patients:

- a well-led, high quality, fully integrated and multi professional community service which meets people's urgent, intermediate and on-going health care needs
- a service that operates as one, from both a clinical and a patient/service user viewpoint, that enables people to remain within their own home and avoid deterioration in their health and to be discharged home as safely and quickly as possible following an episode of acute care

2. Developed and implemented the frailty model of care, supporting older people to remain in their own homes and speeding their discharge from hospital by: -

- introducing a generic pathway for the frail older person with multiple long term conditions
- using risk prediction tools, that are applied in community and hospital settings, to target the interventions that deliver better outcomes, improved communication, co-ordination and more proactive and integrated care across professionals, teams and care settings

To provide the highest quality local hospital care in the most effective and efficient way

To deliver this element of the trust's strategy and vision we will need to redesign and reconfigure our local hospital services to provide higher quality care

We will continue to redesign local hospital services to ensure that patients have a better experience with high quality and efficient pathways into, during and back from hospital. The current configuration of hospital services in south west London is not clinically or financially sustainable, and will work closely with partners and stakeholders to determine the best solutions.

What have we done in 2015/16?

1. Delivered a number of projects that have increased the total number of beds available to patients in cardiology, neurosciences and rehabilitation medicine.
2. Worked with other hospitals, notably Croydon and Kingston, to develop a more networked model of clinical care, in for example services such as urology.

A comprehensive regional hospital with outstanding outcomes

To deliver this element of the trust's strategy and vision we will need to consolidate and expand our key specialist services

Central to St George's role as the regional hospital is the delivery of tertiary and specialist services. We have identified the services that make the most significant contribution to the mission and vision of the trust, and are seeking to develop their excellence further.

What have we done in 2015/16?

1. Built and opened a new hybrid vascular theatre, where radiology interventions and open surgery can both be undertaken, minimising risk to patients and improving patient outcomes in complex vascular surgery.
2. Created the cardiology clinical academic group, improving the links between the trust and St George's, University of London, with benefits for patients, staff and both St George's, as well as appointed to a new a professorship in neurosciences.

Thriving research, innovation and education driving improvements in clinical care

To deliver this element of the trust's strategy and vision we will need to provide excellent and innovative education to improve patient safety, experience and outcomes and drive research and innovation through our clinical services.

As a leading UK teaching hospital we aspire to improve patient safety, patient experience and outcomes through excellence in our provision of education and training for the staff, students and trainees.

Healthcare organisations with vibrant programmes of research provide higher quality clinical care and recruit, motivate and retain the best staff. We need to strengthen our focus on this agenda in the future.

What have we done in 2015/16?

1. Participated in around 200 trials with funding attached, with around 50 new trials per year undertaken by St George's bringing in over £1m of income to the hospital.
2. Developed and implemented a leadership programme seeking to develop a culture in the organisation where staff, from the top down, deliver the trust values on a daily basis.

Transformed productivity, environment and systems

St George's systems, processes and quality of the environment sometimes hinder us in the provision of consistently outstanding care. The trust must address this.

We will have a rolling improvement programme that delivers against its goals, have delivered the information, communications and technology strategy, the estates strategy, implemented the South West London Pathology service and have a well-regarded private patients unit

What have we done in 2015/16?

1. Implement electronic document management and electronic referral system for all new out-patient registrations at St George's for all bar one clinical service in the trust.
2. Provided transparency on outcomes by publishing consultant level activity data. Published activity data available for National Audits shows no mortality or complication outliers.

A workforce proud to provide excellent care, teaching and research

To deliver this element of the trust's strategy and vision we will need to develop a highly skilled, motivated and engaged workforce championing our values

The workforce is vital to the delivery of the highest quality clinical services, education and research and will need to evolve to meet future needs. We need to value our staff and ensure

they champion our values. Evidence tells us that happy staff results in happy patients.

What have we done in 2015/16?

1. Undertaken a full review of nursing to ensure the trust has the right number of nurses available on every ward and service within the organisation.
2. Undertaken a full review of outpatients, leading to a new outpatient strategy, that is designed to offer patients a better, more patient focussed outpatient experience, and in so doing, improve staff morale and job satisfaction working in outpatient services.

St George's business model

St George's is at the heart of a dynamic, fluid and fast changing healthcare environment in south west London. The six clinical commissioning groups (CCGs) that make up the south west London sustainability and transformation plan area are Wandsworth, Croydon, Kingston, Merton, Richmond and Sutton. All are co-terminus with their local authorities. The trust understands the people that it provides services to, its plans to develop and enhance those services and its position in the local health economy. These insights and judgements made by the trust inform the organisations business model.

The trust understands the population it serves and what is happening to that population. The core local population of the trust is 561,790 people (as measured in the 2011 census) who live in the London boroughs of Wandsworth, Merton and parts of Lambeth. For the specialist and tertiary services the trust provides, the catchment population increases up to 3.4 million, encompassing the five south London boroughs, Surrey and beyond and for some services the trust offers supra-regional and national services.

St George's is confident that it can provide to all its patients and service users high quality and safe care. The table below outlines the populations served by the trust and the services those populations primarily access.

Populations and services of St George's

Specialist level	Catchment population		Services provided include
	Area	Population	
Community	Wandsworth borough	310,000	▪ children and family services ▪ adult, specialist and diagnostic services ▪ older people and neuro-rehabilitation services ▪ offender healthcare at HMP Wandsworth
Secondary	44 wards across Wandsworth, Merton and Lambeth	560,000	▪ accident and emergency ▪ acute medical services ▪ full range of surgical services ▪ maternity and paediatrics ▪ diagnostics and therapies
Tertiary	South west London, Surrey and beyond	3.4 M	▪ cardiac surgery and cardiology ▪ paediatric surgery ▪ neurosurgery and neurology ▪ renal services including transplant ▪ trauma

Specialist level	Catchment population		Services provided include
	Area	Population	
National specialist centre	Primarily south east, south central and eastern England.	25M+	▪ family HIV care ▪ lymphoedema ▪ penile cancer

Based on growth estimates from the 2011 Census, the population of south west London and Surrey will increase by 330,000 over the next 10 years.

St George's, on reviewing the population it serves has made the following judgements:

1. That the population is growing, across all age groups, and that background demand for all of the services currently provided will continue to grow.
2. That the trust will experience an increasing demand for maternity and paediatric care, particularly from Wandsworth.
3. That the total number of older patients will also increase. This will bring an increase in demand for long term condition management.
4. With the increase in the number of people over 65, the demand for St George's tertiary services – cardiovascular, stroke, neurosciences, will grow.
5. That the ethnic make-up of the population will be a driver for demand for certain services over the coming years.

In response to these various different factors and clinical demands that these populations will place on St George's, the trust has developed a coherent and logical response:

- Developed a comprehensive strategy that seeks to address the needs of the various population groups that access St George's services.
- Is a major trauma centre with a state of the art emergency department, providing facilities that a young and fluid population are likely to need to access.
- There will also be significant additional people over 65 who will require relatively more cardiac, stroke and neurosciences services as well as improved management of long term conditions. St George's has expanded its cardiac and neurosciences services to meet population demand.

St George's understands the markets it operates in, the other providers in those markets and those services that it wishes to grow and develop over time. St George's:

1. has a clear understanding of who its partners are in the delivery of care, south west London district general hospitals, and more importantly who its competitors are and for what services
2. has a clear understanding of the market in those services that it wishes to grow, neurosciences for example, and who the trust is competing with in these markets
3. for stroke, major trauma and renal transplantation, has a solid market position, and is delivering on active plans, for example the helipad for major trauma, to expand capacity on site.

Important events since the end of 2015/16

In April 2016 Miles Scott, chief executive, left the trust for a secondment at NHS Improvement. Paula Vasco-Knight (former chief operating officer) became acting chief executive with immediate effect from April 2016.

The trust is also preparing for its upcoming CQC inspection in June 2016. For more information on this, please see page XX.

Going concern disclosure – Kirit Shah, finance

Equality, diversity and human rights

The trust serves the diverse local population of south west London and beyond. This population is ethnically diverse – nearly 50% of the population is from non-white British backgrounds and speaks over 300 languages. Among our staff, we are proud to reflect this with nearly 50% of our staff from different ethnic communities.

The changes in our local population are rapid and it is vitally important that all patients and staff who come into contact with us in different settings feel included, respected and valued.
By treating everyone in a fair and inclusive manner, we send a strong signal about the values of the NHS and Britain at large.

In 2014/15 we undertook our second assessment using the NHS Equality Delivery System and used the results to set our corporate equality priorities for 2015-2019. We did this in consultation with our staff and other stakeholders and the findings were approved by the board.

The results of this assessment and our equality reports can be seen at
https://www.stgeorges.nhs.uk/about/living-our-values/equality-andhuman-rights/

Information about the environmental matters, including the impact of the foundation trust's business on the environment – Richard Hancock

Our clinical services contract with Gibraltar Health Authority

In June 2015, the trust signed a contract with the Gibraltar Health Authority (GHA). The initial contract was agreed for one year, with a review in April 2016.

Gibraltar, a British Overseas Territory, has a population of approximately 30,000 residents. The GHA are dedicated to providing access to high quality, nationally bench marked clinical services and have chosen the trust to deliver these services as their preferred provider.

Clinical monitoring and treatment is delivered in two ways. Firstly by clinicians from St George's visiting Gibraltar to provide outpatient and day case treatment on a regular basis and secondly by providing treatment for Gibraltar patients at St George's.

This year has seen the appointment of a dedicated manager to operationally support the contract. The manager has played a key role in organising the delivery of appointments and admissions, as well as providing expert support to our patients and their families.

We have developed close working relationships with the clinicians in Gibraltar allowing effective collaboration and facilitating clinical excellence. This has allowed the exploration and introduction of new services to ensure residents have equal access to a wide range of specialist services.

The first year has been a great success, with the effective and efficient delivery of agreed services leading to positive patient feedback. Following a systematic review of service delivery in April 2016, a new three year contract has now been signed. This will allow GHA to centralise their services, making the patient's care pathway simpler and better supported.

The performance report was approved by the board of directors on XX May 2016 and signed on its behalf by Paula Vasco-Knight, acting chief executive.

Signature required

Accountability report

Directors' report

The board of director's primary role is to set the trust's strategic direction and objectives, ensure delivery of these within planned resources and oversee the trust's performance.

The board comprises of a chairman, six non-executive directors - including a university representative - and nine executive directors (four voting and five non-voting). One of the seven non-executive directors became a voting member of the board following authorisation as a foundation trust.

The chairman and the non-executive directors come from different professional backgrounds with a wide range of skills and experience that reflect the needs of the trust. Although members of the board, non-executive directors are not part of St George's executive management team and are effectively independent experts in their field employed to challenge the trust and provide expert leadership and guidance. They hold the executive directors to account for the day-to-day running of the trust.

The board of directors consists of:
- chairman
- five independent non-executive directors
- one university representative non-executive director
- four voting executive directors (chief executive, chief nurse, medical director and director of finance)
- four non-voting directors, who attend board meetings in advisory capacity.

The board has a scheme of delegation in place and a schedule of powers and decisions reserved to the board to ensure that decisions are taken at the appropriate level.

The chairman and non-executive directors' responsibilities include:
- contributing to the development of strategic plans to enable the trust to fulfil its leadership responsibilities for healthcare of the local community
- ensuring that the board sets challenging objectives for improving its performance across the range of its functions
- monitoring the performance of the executive team in meeting the agreed goals and improvement targets
- ensuring that financial controls and systems of risk management are robust and that the board is kept fully informed through timely and relevant information
- accountability to NHS England for the delivery of the trust's objectives and ensuring that the board acts in the best interests of its local community
- taking part in the appointment of executive and other senior staff
- ensuring that the organisation values diversity in its workforce and demonstrates equality of opportunity in its treatment of staff and patients and in all aspects of its business.

The appointment of the chairman and non-executive directors is approved by the council of governors. All board appointments are made using fair and transparent selection processes with specialist human resources input. When appointing to the board, due consideration is given to the range of

skills and experience required for the running of the trust.

Each year every member of the board has a formal appraisal to review their strengths, aspirations and learning and development needs. Each director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information.

Declarations of interest

NHS employees are required to be impartial and honest in the conduct of their business and remain above suspicion. It is the responsibility of all staff to ensure that they are not placed in a position which risks or appears to risk conflict between their private interest and NHS duties. The primary responsibility applies to all NHS staff, including the executive team and non-executive directors. Members of the board are asked to declare any interests they have before the start of each board meeting. Interests of board members have been declared within the directors' report on the following pages.

Register of interests

All staff who are either responsible for and/or involved in the requisitioning and/or purchasing of goods and services, should declare any interests they are aware of.

- Statement that the NHS foundation trust has complied with the cost allocation and charging guidance issued by HM Treasury – Dominic Sharp, FINANCE
- Details of any political donations – Dominic Sharp, FINANCE
- A statement describing the better practice code, or any other policy adopted on payment of suppliers and performance achieved, together with disclosure of any interest paid under the Late Oayment of Commercial Debts (Interest) Act 1998 – Dominic Sharp, FINANCE
- Income disclosures as required by section 43 (2A) of the NHS Act 2006 – Dominic Sharp, FINANCE
- A statement as to disclosure of auditors – Dominic Sharp, FINANCE

Non-executive directors 2015/16

All non-executive directors are independent other than Jenny Higham as she is a representative of St George's, University of London. All non-executive directors are members of the Board and the Board of Directors Nominations and Remunerations Committee.

Sir David Henshaw

Chairman
Sir David joined the trust in March 2016.

Declared interests:
To be added

Membership of Committees:
Finance and performance

About:
Sir David Henshaw has been Chair of Alder Hey Children's Hospital NHS FT since 2010. He subsequently become Interim Chair of Morecombe Bay Hospitals NHS FT, from 2012 – 2013 and from 2013-14 was Interim Chair at Dorset University Hospital NHS Foundation Trust. Prior to his time in the NHS, Sir David was Chief Executive Officer of Liverpool City Council from 1998 – 2005. During this period, in 2004, he was knighted for his services.

Sarah Wilton

Non-executive director
Acting chair between January – March 2016

Declared interests:

- Non-Executive Director, and Audit and Risk Committee Chair, at Capita Managing Agencies Limited
- Non-Executive Director, and Audit and Risk Committee Chair, at Hampden Members' Agencies Limited
- Trustee and Vice Chair at Paul's Cancer Support Centre
- Family and Adult Court Magistrate

Membership of Committees:

- Audit
- Quality and risk
- Finance and performance

About:
Sarah is a qualified chartered accountant with PricewaterhouseCoopers. She has held several senior executive positions at Lloyd's of London, delivering major change programmes including restructuring, outsourcing, efficiency and effectiveness reviews.

Before joining St George's, Sarah was a non-executive director at NHS Wandsworth where she was chair of the resources committee and a member of the audit committee and children's trust. Sarah also oversaw the integration of Community Services Wandsworth with St George's as co-chair of the joint NHS Wandsworth and St George's University Hospitals NHS Foundation Trust integration programme board.
Sarah has held non-executive director appointments at two Lloyd's agencies, Capita Managing Agency since 2004 and Hampden Agencies Limited since 2008, chairing the audit and risk committees. She is a Magistrate at Wimbledon Magistrates Court and a Trustee of the Paul D'Auria Cancer Support Centre.

Jenny Higham
Representative of St George's, University of London
Jenny started in November 2015.

Declared interests:
- Governor, Kingston University
- Director, INTO – SGUL LLP
- Deputy Chair
- London Higher Chair
- UK Higher Education Advisory Committee
- Honorary Consultant Imperial
- Visiting Professor Lee Kong Chain School of Medicine in Singapore

Membership of Committees:
- Quality and Risk Committee

About:
Jenny is the newly appointed Principal at St George's, University of London. She previously had senior roles at Imperial College and the Lee Kong Chian School of Medicine in Singapore. In addition to managerial roles, she continues clinical practice. She has been named "Mentor of the Year" at the Women of the Future Awards, been awarded a President and Rector's Award for Outstanding Contribution to Teaching Excellence and the Imperial College Medal for outstanding leadership.

Mike Rappolt
Non-executive director

Declared interests:
- Member of the Parkside Residents' Association Committee
- Various shareholdings (all under 1% of company)
- Trustee of St George's Hospital Charity

Membership of Committees:
- Audit
- Finance and Performance

About:
Mike has 40 years' of international management experience including 29 years as a management and IT consultant with PA Consulting Group, where he was a main board director for 12 years, chaired the audit committee, and from which he retired in 2001. He was a governor of Contemporary

Dance Trust for 13 years setting up and chairing the audit committee and was also a non-executive director of a small quoted IT service company for five years. He was chairman of the Wimbledon Civic Theatre Trust and a committee member of his local residents' association. Mike joined the board of St George's University Hospitals NHS Foundation Trust as a non-executive director in 2004 and he chairs the trust's audit committee. Mike is also the deputy chairman and the senior independent director for the trust.

Stella Pantelides
Non-executive director

Declared interests:
- Consulting - various financial and professional services sector firms

Membership of Committees:
- Workforce
- Finance and Performance

About:
Stella has extensive commercial and human resources experience gained through senior leadership roles in a wide range of organisational settings. She combines the running of a successful consulting company on workforce and organisational strategy with a number of public appointments, including the Judicial Appointments Commission and non-executive director on the Service Personnel Board at the Ministry of Defence.

Kate Leach
Associate Executive Director
Non-executive director

Declared interests:
- Director of Kate Leach Consulting

Membership of Committees:
- Workforce
- Commercial

About:
Kate has over 18 years' commercial experience within the pharmaceutical industry, the majority of which spent with GlaxoSmithKline. She has won many GSK and external marketing awards. As a commercial leader, Kate has held director-level positions leading a number of GSK's therapy business units including urology, HIV, vaccines and respiratory. She has a wealth of experience in commercial excellence, strategic planning, market access, branding and capability development. In addition, Kate has a proven track record launching new brands into multiple therapeutic markets.

Christopher Smallwood
Previous chairman
Christopher left the trust in December 2015.

Declared interests:
None

Membership of Committees:
- Finance and Performance
- Commercial Board

About:
Christopher has extensive NHS experience having previously been chair of Kingston Hospital NHS Foundation Trust and prior to that, chair of NHS Hounslow. He is a policy adviser to The Prince's Charities and until 2005, was economic adviser to Barclays plc, following several years as a partner at the city consultancy Makinson Cowell. Christopher has also worked at TSB Group as strategic development director and chief economist. He was economics editor of The Sunday Times and chief economist and head of financial strategy and planning for BP He has been an economic adviser to HM Treasury and a special adviser at the Cabinet Office. He was also, until recently, a member of the Competition Commission.

Professor Peter Kopelman
Representative of St George's, University of London
Peter left in November 2015.

Declared interests:
- Governor, Kingston University
- Director, INTO - SGUL LLP
- Deputy Chair & Trustee, London Higher Chair, Faculty Board, Royal Pharmaceutical Society
- South London Health Innovation Network
- South London Collaboration for Leadership in Applied Health Research and Care
- UK Higher Education Advisory Committee

Membership of Committees:
- Workforce
- Quality and risk

About:
Peter graduated from St George's in 1974 and undertook most of his junior doctor training at St George's Hospital. He was Vice Principal, Queen Mary, University of London, and Deputy Warden of the Medical and Dental School (2001-06) and Dean of the Faculty of Health, University of East Anglia (2006-08).
He has been closely involved in undergraduate and postgraduate medical education and chairs the Clinical Examining Board of the Federation of Royal Colleges of Physicians (UK) and the National Institute for Health Research Academic Careers Panel. He is a member of the UK Healthcare Education Advisory Committee. Professor Kopelman has a long-standing interest in diabetes care, nutrition and obesity, with a major research interest in obesity. He is a member of the UK Department of Health and Food Standards Agency Scientific Advisory Committee on Nutrition, the Department of Health Expert Panel on Obesity, and is Science and Innovations Foresight Obesity Project. Additionally, he is a member of the national and international committees on nutrition and academic affairs.

Dr Judith Hulf
Non-executive director

Judith left in January 2016.

Declared interests:
- Responsible Officer and Senior Medical Advisor, General Medical Council

Membership of Committees:
- Audit
- Quality and Risk

About:
Judith is the responsible officer and senior medical adviser to the General Medical Council. Prior to this she was a consultant general and cardiothoracic anaesthetist at University College London Hospital until 2009 and President of the Royal College of Anaesthetists 2006-2009. Judith has chaired many important taskforces including the Swine Flu (H1N1) Critical Care Clinical Group for the Department of Health and the Extra Corporeal Membrane Oxygenation (ECMO) sub-group. She was awarded a CBE in June 2009.

Executive directors 2015/16

Miles Scott
Former Chief Executive
Miles was Chief Executive for the full 12 month period of 2015/16, he left the trust on secondment to NHS Improvement in April 2016.

Declared interests:
- Chair of NIHR CLAHRC South London Board
- Chair of South London Clinical Research Network Partnership Board
- Vice Chair of Health Innovation Network

About:
Miles was chief executive of Bradford Teaching Hospitals NHS Foundation Trust from August 2005 to November 2011. Before joining Bradford Teaching Hospitals, Miles was chief executive of Harrogate and District NHS Foundation Trust for four years. He started his NHS career on the General Management Training Scheme in 1988 after graduating from Cambridge University with a degree in History. His career in the NHS has encompassed acute, community and mental health services, the King's Fund and Trent Regional Office.

Paula Vasco-Knight
Acting Chief Executive
Paula joined the trust in October 2015 as Interim Chief Operating Officer. She became Acting Chief Executive in April 2016.

Declared interests:
None

About:
Paula joined St George's in September 2015 as Interim Chief Operating Officer. She began her career as a nurse and still works clinically, committed to making a difference to patients, their families and communities, locally, nationally and internationally, over a 20 year period as a leader in the NHS. Paula has held a number of senior positions in different organisations, including: Chief Executive/Chief Operating Officer; Executive Director of Operations and Service Improvement; Executive Director of Nursing and Midwifery; Deputy Director of Nursing and Governance; and Senior Nurse Manager. Paula received a CBE in 2014 and honouree doctorate in Law from Exeter University.

Iain Lynam
Chief Financial Officer

Declared interests:
Partner at the Aaronite Partnership LLP
Director of Codere Finance UK Limited

About:
Iain is an experienced senior finance professional with particular expertise in corporate and financial restructuring in both the NHS and the private sector. To be added to.

Jennie Hall
Chief Nurse, Director of Infection Prevention and Control and Deputy Chief Executive

Declared interests:
- Honorary Professor, Kings College University London
- Clinical Director, South London Patient Safety Collaborative at Health Innovation Network
- Honorary Clinical Fellow of Kingston University Health and Social Sciences

About:
Jennie joined St George's in June 2014 following her post as Programme Director (London) in the Trust Development Authority. She has worked in the NHS and has provided strategic leadership at director/chief nurse level to the nursing and midwifery profession. She has broad experience in operational management including mergers. In 2012/13 she led the transaction programme for the dissolution of South London Healthcare NHS Trust which included the design and implementation of a quality and safety handover process for all corporate and clinical services.

Simon Mackenzie
Medical Director (joint post with St George's, University of London)

Declared interests:
None

About:
Simon has extensive experience in critical and intensive care, both as a practising consultant and as a clinical leader. He has driven quality and safety improvement programmes, as well as having sat on national bodies, including two years as president of the Scottish Intensive Care Society.
His previous role was medical director at University Hospitals Division NHS Lothian. NHS Lothian,

which provides services from more than ten hospitals and other community settings, also has close ties with the University of Edinburgh. As a teacher, Simon prioritises work on clinical leadership, improvement and information and data.

Martin Wilson
Director of Transformation
Former Director of Delivery and Improvement

Declared interests:
None

About:
Martin started his career as a nurse before moving into general management via the NHS Management Training Scheme. He has undertaken a number of senior roles in the acute sector and in strategic health authorities, including director of operations, QIPP and transformation at NHS North East. From 2011-2014, he worked for McKinsey and Company supporting hospitals to improve their quality and sustainability. He re-joined the NHS in 2014 as director of delivery.

Rob Elek
Director of Strategy

Declared interests:

- Director, Elek Technical & Analytical Ltd
- Senior Advisor, Physitrack Limited

About:
Prior to joining St George's Rob worked at Moorfields Eye Hospital NHS Foundation Trust as the director of strategy and business development. His key achievements include strengthening relationships with commercial and third sector organisations, developing new partnership models for the delivery of NHS patient care and leading. Rob also acted as the interim chief operating officer during autumn 2013. He recently supported the production of Monitor's new strategy development toolkit and has held senior NHS roles in strategy, major capital projects, business and commercial development. His career outside the NHS includes management consultancy and recruitment. He led the expansion of its satellite network from 13 to 23 sites. Rob also directed annual planning and business development, managed corporate functions and a new hospital project.

Wendy Brewer
Director of workforce and organisational development

Declared interests:
None

About:
Wendy joined St George's University Hospitals NHS Foundation Trust in February 2012. She has over nine years' experience working in human resources roles within the NHS; having previously worked at Lewisham Healthcare NHS Trust, Bromley PCT and King's College Hospital NHS Foundation Trust. Wendy has also worked in the mental health and charity sectors.

Richard Hancock
Interim Joint Director of Estates and Facilities (joint post with St George's, University of London)
Richard joined the trust in March 2016.

Declared interests:
To be added

About:
Richard has a lot of experience in leading and running critical infrastructure portfolios and capital projects in central government departments, the BBC (as a member of the estates board) and the NHS, where he took over the Move Programme at North Bristol NHS.

Eric Munro
Joint Director of Estates and Facilities (joint post with St George's, University of London)
Eric left the trust on Friday 1st April 2016.

Declared interests:
- Member of Executive team, St George's, University of London

About:
Eric joined the trust and university from West London Mental Health NHS Trust, where he was responsible for the large-scale redevelopment of the Broadmoor Hospital and St Bernard's Hospital. Eric has significant experience in the higher education environment as well as in the NHS.

Andrew Burn
Director of Turnaround
Andrew left the trust in March 2016.

Declared interests:
Partner of KPMG LLP

About:
Andrew Burn was appointed as the trust's turnaround director in June 2015. Andrew leads KPMG's Public Sector and Health Restructuring practice (KPMG's specialist financial recovery arm) and is a partner with over 20 years' experience of major change and turnaround situations, across the public and private sector. Andrew has worked with trusts, foundation trusts and CSU's who faced similar challenging circumstances.

Steve Bolam
Chief Financial Officer; Deputy Chief Executive
Steve left the trust in February 2016 on secondment to NHS Improvement.

Declared interests:
None

About:
Steve was appointed in September 2012. He joined the trust from Southampton, Hampshire,

Isle of Wight and Portsmouth PCTs. Steve has significant board-level experience, having previously held director level roles at Hampshire PCT, Basingstoke and North Hampshire NHS Foundation Trust and Nuffield Orthopaedic Centre NHS Trust, Oxford.

Peter Jenkinson
Director of Corporate Affairs
Peter left the trust in November 2015.

Declared interests:
None

About:
Peter joined St George's as trust secretary in June 2009 and has responsibility for corporate governance including the corporate office, communications, risk management and membership functions. Prior to taking up this post he was at Winchester and Eastleigh Healthcare NHS Trust for seven years, holding a variety of roles including company secretary, head of corporate services and head of governance. Prior to joining the NHS in 2002, Peter gained experience working in various departments of central government and in the IT industry.

Council of governors and membership

Our council of governors

Our council of governors became a full council when the trust was authorised as a foundation trust on the 1st February 2015. The council is comprised of 15 elected public governors; five5 elected staff governors and eight governors appointed from stakeholder organisations.

Role of the governors

The council of governors is responsible for the appointment of the chairman and non-executive directors, agreeing their terms and conditions, as well as the appointment of the external auditor. Each financial year, the council of governors is consulted by the board on the trust's forward plans and receives the annual accounts, auditors' report, annual report and quality report. Governors respond as appropriate when consulted by the directors on specific issues. Governors are unpaid; however they are entitled to receive reimbursement of their expenses.

Lead Governor

The council of governors select one of their elected members to be the lead governor of the council of governors. The lead governor co-ordinates communication between Monitor and the other governors. They act as the main point of contact for the chairman and the senior independent director. The lead governor at the date of this report is Kathryn Harrison.

Meetings of the council

The council held four full meetings in 2015/16.

Constituency name	Governor name	Political and financial interest	Term of office	
Public: Wandsworth	Stuart Godden	None	3	
Public: Wandsworth	Yvonne Langley	None	3	
Public: Wandsworth	Doulla Manolas	None		2
Public: Wandsworth	Felicity Merz	None		2
Public: Wandsworth	Derek McKee	None		2
Public: Wandsworth	David Kirk	None	3	
Public: Merton	Sue Baker	None	3	
Public: Merton	Anneke De Boer	None		2
Public: Merton	Sheila Eden	None		2
Public: Merton	Hilary Harland	None	3	

Public: South west Lambeth	Gail Adams	Labour party	3	
Public: Regional	Mia Bayles	Conservative party	3	
Public: Regional	Robin Isaacs	None		2
Public: Regional	Kathryn Harrison	None		2
Public: Regional	Jan Poloniecki	None	3	
Staff: Medical and Dental	J P van Besouw	None	3	
Staff: Community Services Division	Noyola McNicolls-Washington	None		2
Staff: Non-Clinical Staff	Jenni Doman	None		2
Staff: Nursing and Midwifery	David Flood	None	3	
Staff: Allied Health Prof. and Other	Will Hall	None	3	
Appointed: Healthwatch Merton	Brian Dillon	None	3	
Appointed: Merton Council	Cllr Phillip Jones	None	3	
Appointed: Healthwatch Wandsworth	Mike Grahn	None	3	
Appointed: St George's, University of London	Dr Frances Gibson	None	3	
Appointed: Kingston University	Dr Val Collington	None	3	
Appointed: Wandsworth Clinical Commissioning Group	Dr Patrick Bower	None	3	
Appointed: Merton Clinical Commissioning Group	Dr Tim Hodgson	None	3	
Appointed: Wandsworth Council	Cllr Sarah McDermott	None	3	

Governors' activities

Governors attend board meetings as observers and 'Medicine for Members' health talks where they can meet and talk with trust members. Governors are also able to attend board sub-committee meetings to observe and take part in quality inspections around the trust. The governors have been involved in the selection process for a new chairman this year and have selected a new clinical non-executive director who will take up post on 1st April 2016.

Members who wish to communicate with governors and/or directors can do so by contacting the membership office via members@stgeorges.nhs.uk

Register of governors' interests

A register of governors' interests is maintained. A copy of the latest version submitted to the council of governors is available on the trust's website or it may be inspected during normal office hours at the board secretary's office.

Communicating and engaging with our members

The trust recognises the importance of communicating effectively with members, ensuring that they are properly informed and able to participate as they choose. Communication with members must also be a two way process and mechanisms are in place to ensure that members, governors and the trust are able to engage in quality dialogue. However due to the high cost of postage and the current cost savings we have to make within the NHS, we are no longer able to post out information to our members on a regular basis. We rely on email to communicate on a regular basis with those members who want updates from us.

During 2015/16 we hosted monthly 'Medicine for Members' talks as a way for the members to learn about key health issues, such as diabetes, sepsis, tinnitus, arthritis, stroke and keeping your heart healthy. We also held a special '24 Hours in A&E' at the start of the launch of the new series where members could meet staff who feature and the production team.

All our members are invited to attend the Annual Members' Meeting in July 2016.

Membership by constituency

Staff	8,974
Public	
Wandsworth	4,066
Merton	3,034
Rest of England	4,592
Lambeth	604
Out of trust area	16
Total	12,312
	21,286

Membership Strategy

The trust's membership strategy sets out the framework that the trust will use to continue to build, manage and engage with its membership.

The objectives of this strategy are to:

- outline the definition of membership and its roles and responsibilities
- define the membership community
- identify the size of membership required and outline the strategic approaches for recruitment to, and building of, the membership
- outline proposals for the effective management of the active membership
- outline proposals for engagement and communication activities to ensure that members' views can be taken into account in the trust's decision making process
- identify the resources necessary for building and managing the membership
- identify how the membership strategy can contribute to the trust's community engagement and partnership working
- outline the mechanisms that will be used to evaluate the effectiveness of the strategy.

Managing an active membership

The trust recognises that members have a valuable role to play in the future direction of the organisation and is committed to creating and maintaining an effective engagement with its members. Members who are well informed and who feel that they are listened to are more likely to remain in long term membership and equally can be effective advocates for the trust.

Member engagement

The trust recognises that members' interests and capacity to engage with the trust will vary widely. It is the trust's strategy to ensure that members have the opportunity to participate and are enabled to do so in the way they feel is most appropriate to them.

Engagement objectives

To ensure members are fully engaged with the trust will work to:

- increase the number of informed and active members
- develop electoral processes which encourage active members to participate in the election of governors
- train and support elected governors, so that they can fulfil their roles effectively and participate in policy development and decision making processes
- develop a partnership culture between members, governors and trust management to facilitate effective working relationships.

Communication and engagement activities

The communication dialogue with members is achieved through:

- monthly e-bulletins for public members
- monthly health talks called 'Medicine for Members'
- other events including the Annual Members' Meeting
- dedicated member and governor page within the trust website
- use of social media including Twitter and Facebook
- governor meetings with members.

Appendix C2 - membership report

Membership size and movements

Public constituency	**Last year (2015/16)**	**Next year (estimated) (2016/17)**
At year start (April 1)	12,375	12,875
New members	168	
Members leaving	250	
At year end (March 31)	12,293	

Staff constituency	**Last year (2015/16)**	**Next year (estimated) (2016/17)**
At year start (April 1)	8,624	
New members	2,101	
Members leaving	1,758	
At year end (March 31)	8,967	

Patient constituency	**Last year (2015/16)**	**Next year (estimated) (2016/17)**
At year start (April 1)	0	
New members	0	
Members leaving	0	
At year end (March 31)	0	

Analysis of current membership

Public constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	9	114,834
17-21	535	28,314
22+	11,346	443,343
Ethnicity:		
White	7,170	380,440
Mixed	598	28,684
Asian or Asian British	2,424	75,326
Black or Black British	1,812	67,014
Other	289	7,464
Socio-economic groupings*:		
AB	3,761	76,421
C1	3,834	62,462
C2	1,852	23,918
DE	2,805	31,989
Gender analysis		
Male	4,932	284,898
Female	7,361	301,591

Patient constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	0	
17-21	0	
22+	0	

The analysis section of this report excludes:
- 403 public members with no dates of birth, 0 members with no stated ethnicity and 0 members with no gender
- 0 patient members with no dates of birth

General exclusions: Out of Trust Area, Suspended Members, Inactive Members
* Socio-economic data should be completed using profiling techniques (eg: postcode) or other recognised methods. To the extent socio-economic data is not already collected from

members, it is not anticipated that NHS foundation trusts will make a direct

The accountability report was approved by the board of directors on XX May 2016 and signed on its behalf by Paula Vasco-Knight, acting chief executive.

Signature required

Staff report

National staff survey

The 2015 National NHS Staff Survey took place in all NHS organisations in autumn 2015. We had an overall response rate of 31%, which is below the national average. The trust's response rate for 2015 had reduced from 2014 (39%) but the national response rate also reduced. The range of questions remains consistent from year to year, making it possible to benchmark against previous years as well as performance alongside other trusts. The survey was communicated to all staff via our internal trust communications channels including through our weekly e-newsletter, bi-monthly newsletter, staff forums. There is more information on these channels on page XX.

Our overall engagement score has decreased slightly this year and is below the national average. In 2015, the trust's top four areas of performance were reported as:

- percentage of staff feeling under pressure to attend work when they are unwell
- quality of non-mandatory training, learning or development
- quality of appraisals
- percentage of staff reporting the most recent incidence of violence.

The bottom four ranked scores were:

- percentage of staff witnessing potential harm, near misses or incident in the last month
- percentage of staff experiencing work-related stress in the last 12 months
- staff satisfaction with resources and support
- staff experiencing harassment, bullying and abuse from other staff.

Our future priorities and targets are as a result of the staff survey. The overall objective of our *Workforce* and *Staff Experience action plan 2016/17* is to develop a highly skilled, motivated and engaged workforce by addressing issues that affect the workforce, in particular the issues that affect turnover and staff experience. We will focus on:

- a return to greater earned autonomy for the front line
- clearer channels of communication
- enhanced management skills in engaging with staff in a constructive way
- freeing up time for important engagement and a focus on quality.

We will appoint a speak-up champion to supplement our Listening into Action liaison role, established to hear staff concerns and resolve them. Some of the concerns raised by our staff relate to the estate and IT infrastructure and this will be an area of focus.

We are aware that as we address our financial performance staff are continuing to provide excellent clinical services and we want to recognise this. We will ensure our values awards are well publicised so that this excellence is acknowledged. We will also be providing support and opportunities to staff to maintain their health, well-being and safety.

The *St George's as One* initiative was set up in 2015 to address some issues that arose from the 2014 staff survey, particularly in relation to staff from black and minority ethnic (BME) groups. This work will continue in 2016/17 as we roll out our successful unconscious bias to all managers who have not yet attended a session. We want to promote openness and transparency regarding appointments, acting up arrangements and promotions and we are changing this process to ensure that all staff have equal opportunities for development.

We will continue to tackle harassment and bullying towards staff by other staff members by reviewing our policy to bring it in line with successful campaigns in other NHS trusts. This will include encouraging early informal resolution of concerns rather than using the formal policy route.

Our managers will participate in a leadership development programme where all our managers will have clear objectives regarding the management of their staff. This will include encouraging open communication with staff through regular meetings and involving staff in any changes that affect them. The quality of our appraisals is good, and the new electronic appraisal system that we are introducing in 2016 will ensure that we are able to monitor the consistency and quality of appraisals.

One of our priorities is to continue the work we have done to tackle harassment, bullying or abuse from staff in the past 12 months. The trust has a comprehensive programme to prevent bullying and to identify bullying and to tackle it where it occurs. Through investigations, we are aware that members of staff have encountered bullying behaviour and we are taking formal action where such actions are known to have occurred.

The strategy to tackle bullying includes coaching and training for managers dealing with difficult staffing issues. In addition, the Listening into Action liaison role provides listening for members of staff and an opportunity to raise concerns has been established. The bullying and harassment support line run by the staff support service is still in operation.

As part of our plans to address the health and wellbeing of staff we are implementing a wellbeing strategy in order to reduce sickness absence and to enhance a sense of personal responsibility and engagement amongst staff. Last year we ran a successful Global Corporate Challenge when 15 teams took part to increase their fitness at work. We will be employing a physiotherapist to work in our occupational health service to support staff back to work following muscular skeletal absences, and assist them in maintaining good health. Weekly Pilate's sessions have proved to be a success with staff and these will continue.

Our human resources advisers ensure all line managers are fully trained to tackle workforce and employee relations issues. We reviewed all our training programmes in 2015 and managers have access to sessions on holding difficult conversations.

	2014/15	2014/15	2015/16	2015/16	Improvement/deterioration
Response rate	STG	National Average			
	39%	43%	31%	43%	Deterioration

Top 4 ranking scores	STG	National Average	Trust	National Average	
% of staff feeling under pressure to attend work when not well	56%	56%	57%	58%	
Quality of non-mandatory training learning and development	NA	NA	4.05	4.04	
Quality of appraisals	NA	NA	3.04	3.03	
% of staff reporting the most recent incidence of violence	56%		52%	52%	
Bottom 4 ranking score					
% of staff witnessing potential harm, near misses or incidents in the last month	36%	34%	37%	29%	
% of staff experiencing	41%	37%	43%	36%	

work related stress in the last 12 months					
% of staff experiencing harassment, bullying and abuse from other staff	31%	23%	33%	24%	
Staff satisfaction with resources and support	NA	NA	3.11	3.30	

Staff engagement

Our workforce is vital to the delivery of the highest quality clinical services, education and research, and will need to evolve to meet future needs. We need to value our staff and ensure they champion our values. Patients have told us that happy staff result in happy patients. Our workforce is the most important asset we have, so we understand the importance of engaging with our staff and we are constantly monitoring how well we keep them engaged and informed. In order for us to serve our patients and the public effectively, we have a number of different channels available to keep staff up to date, generate discussions and provide feedback on different issues that affect us all.

We have an active Partnership forum where we meet with our Staff Side colleagues to discuss issues of concern to staff. Our staff side representatives have been involved in the development of our approach to incremental progression and the new supporting appraisal policy.

We share and discuss the trust's performance reports and chief executive's report at the partnership forum to ensure that staff are aware of our priorities and performance.

Values awards

The values awards give staff, patients and the public an opportunity to nominate a member of staff or team that they feel demonstrates our values. Winners are awarded with a certificate and badge in a team presentation with the chief executive and they become eligible or entry into our annual awards ceremony. Photos are taken of the presentations and are communicated to all staff via our internal communications channels.

Listening into Action

We recognise that as well as listening to our patients, it is also important that we listen to our staff and involve them when we try to identify where improvements could and should be made.

We launched the Listening into Action programme in 2013 with the aim of achieving a fundamental shift in the way we work and lead by putting clinicians and staff at the centre of change for the benefit of our patients, our staff and the trust as a whole. Listening into Action has been adopted in a growing number of departments and continues to be used as a sustainable way of continuously improving our services, using the feedback we get from staff as our focus.

Essentially, Listening into Action is about:

- engaging all the right people around delivering
- better outcomes for our patients, our staff and our trust
- aligning ideas, effort and expertise behind the
- patient experience, safety and quality of care
- overcoming widespread challenges around staff engagement and morale
- developing confidence and capability of our leaders to 'lead through engagement'
- collaborating across the usual boundaries
- engendering a sense of pride.

During conversations with our staff as part of Listening into Action the idea of providing a service for staff, based on the patient advise and liaison service (PALS), was aired. A staff advisory service called LIAiSE (Listening into Action is Staff Engagement) was established as a pilot. The LIAiSE adviser provides a listening and signposting service, identifying where support is available. This has proved to be a success in busy departments such as the emergency department and been instrumental in making changes in the workplace that improves the working lives of our staff.

Team brief system

The Listening into Action Big Conversations and Staff Friends and Family Test told us that staff felt they need to understand more about their own areas of work and other areas of the trust if they are to perform effectively. Taking into account this response and to provide a communications channel to ensure that feedback from staff makes it right up to the most senior management at the trust, we introduced a team brief system.

The team brief is made up of a core brief provided by the chief executive and a local brief produced by each division or directorate. Every other month the chief executive begins the process by presenting the core brief at each divisional management board meeting and separately to divisional directors.

Those senior managers will then brief their teams and include a one-time local brief relevant to their specific clinical division or directorate. Every manager is responsible for a face-to-face team brief meeting with their staff once every other month. The team brief was introduced not communicate information downwards but to truly engage and involve staff in staff on key issues that affect the trust. Every member of staff has the opportunity to discuss and question the points being raised with line managers, who feed this information back up to the board.

We believe this process is vital to keeping staff engaged, informed and encouraged to be involved with the trust's performance. It also gives staff the opportunity to share their views so that they can be taken into account in making decision which might affect their interests as an employee. In 2016 we will be

enabling managers to free up time to hold these meetings with their staff. We host the following channels to engage with staff:

Patient safety forums

These are presented by senior members of staff, often using an example of a serious incident at the trust. Staff are encouraged to ask questions as to how we can make patients safer at the trust.

Valuing and developing our staff

In 2014 we introduced a new incremental progression scheme, initially for senior staff to establish the link between contribution and salary reward. This scheme will be extended to the majority of staff over the next 12 months following a staff engagement exercise and will be linked to a revised appraisal scheme.

All staff emails

Our all-staff email newsletter, 'eG', is issued every Thursday. Work has been undertaken to make it more appealing, such as reformatting the layout, limiting word length and including photos.

'By George!' staff newsletter

By George! is a bi-monthly publication written for staff, by staff. It contains trust news and information about different teams, as well as positive patient experiences. Hard copies are made available so trust staff who cannot easily access our intranet have access to their newsletter.

Senior leaders' meeting

The senior leaders' meeting takes place monthly. Senior managers are invited to hear the latest trust news regarding finance, quality and workforce from the executive team. It is also an opportunity for staff to ask any questions they may have to relay to their departments.

Ask Miles

Ask Miles is a monthly session that all staff can get involved in by attending or by submitting questions for the chief executive to answer. Topics include finance, quality, workforce, estates and IT among others.

Schwartz Rounds

Schwartz Rounds allow staff to discuss the highs and lows of work in a confidential, expertly facilitated environment. It is a chance for staff to talk about the emotional and social aspects of their jobs, led by a panel of employees chosen from across the trust. They have a different theme and panel at each monthly session.

Turnaround Times

This is a monthly newsletter designed to keep staff up to date as we journey towards a firmer financial footing.

Chief nurse surgery

The chief nurse surgery offers all nursing and clinical staff the chance to hear updates from our chief nurse. All clinical areas are represented so that information presented and discussed can be cascaded back to each department.

Consultants' meetings

These meetings occur monthly and provide the opportunity for consultants to find hear key updates from the medical director. They also offer consultants the chance to ask and questions or raise any concerns they may have.

Bespoke staff engagement events

The trust hosts a multitude of bespoke events each year to inform, engage and inspire staff. Such events include International Nurses' Day, CQC briefings and awareness days.

Supporting good people management

Our annual staff survey results and information from our exit questionnaires help inform our plans for strengthening line management skills which play a crucial role in motivating and developing our staff. Managers have access to a range of management development courses along with tailored support from the workforce directorate in order to embed good practice. Staff have accessed nationally provided in-house leadership development programmes, ranging from those intended for emerging leaders through to a leadership toolkit available for all staff online. We have a range of courses provided on site to develop staff.

Managers and leaders:

- appraise your staff
- band 6 leadership programme
- band 7 ward managers programme
- currently commissioning 15 credit module from Kingston University for aspiring band 7s effective people management
- conflict resolution
- ILM Level 2 in team leading
- ILM Level 3 in first-line management
- leading and motivating your team
- coaching
- new leaders programme for consultants, matrons, general managers
- paired learning for doctors and managers
- performance conversations

- responding to complaints
- resolving conflict
- seeing systems for the top 100 leaders
- tailored team diagnostics and building and helping teams in trouble

Junior doctors:

- teaching skills
- assessment and supervision in education and training
- developing authority (foundation and dental only)
- authority and impact workshop
- leadership and management (core training programme). aspiring consultant.

Faculty development:

- advanced clinical communications
- recognising postgraduate supervisors - accreditation workshop
- professional boundaries
- authority and impact workshop
- trainee in difficulty.

All staff:

- acting assertively
- AMSPAR medical terminology
- authority and impact in the workplace
- being your best
- business administration QCF L2 and 3
- effective administrator
- effective customer service
- excel with Excel
- grand rounds
- influencing for impact
- leadership and influencing skills for support staff
- manage your time with Outlook
- mediation (accredited course)
- medical terminology
- resilient thinking for peak performance
- Sage & Thyme
- Schwartz Rounds
- team development
- working with Word
- writing persuasive letters and emails
- writing effective emails and reports.

For Healthcare Support Workers (HCSW) we have a four day development programme, Qualification Credit Framework (QCF) and help with literacy and numeracy.

We support staff on salary supported courses such as the Foundation Degree which leads to a

gradual increase in banding from two - four and we also support HCSW's to complete nurse training. We developed a trust wide HCSW development pathway and also made a film to raise the profile of support workers across the trust and as an aid to recruitment.

We have introduced the Care Certificate which focuses on the induction of support workers and the assessment of their competence. The education team worked closely with corporate nursing and therapies leads to develop a robust induction and assessment of support workers which leads to the completion of the nationally recognised Care Certificate.

The trust has also been involved in responding to service needs by developing innovative bespoke courses in partnership with King's College London and Kingston University with a particular focus on mental health training for non-mental health professionals.

The trust also offers a bespoke facilitation service to teams in order to increase their effectiveness and cohesiveness. Coaching is available to managers/leaders on a one-to-one basis.

During 2014, over 700 staff members took advantage of the development opportunities available to them. This included over 200 managers who attended appraisal skills, which has resulted in an increase in the number of staff reporting that they have received a well-structured appraisal.

The trust has developed the role of the physician associate (PA) and has established a PA board with representation from PAs to ensure good educational development and raising the profile of this innovative role.

The trust has also trained nurses and midwives in: IV drug administration, venepuncture and cannulation and medicines management.

To assist all staff to access and record all development and to monitor mandatory and statutory training compliance, the trust is launching a new, web-based learning management system.

The trust has commenced a pilot group of apprentices in outpatients and plans to build on this work in the year to come. Staff on the foundation degree in healthcare practice will now achieve a higher apprenticeship award.

Workforce of the future

Simulation suite

Now in its 15th year of operation and 2nd build, St George's Advanced Patient Simulation and Skills Centre (GAPS) trains more than 4,318 doctors, nurses, medical and nursing students and other health professionals per year. It is widely recognised as one of the most innovative inter-professional healthcare simulation and skills facilities in the country and has been successful in bidding for educational contracts both regionally and nationally year on year. However, its core business is the training of St George's staff in caring for acutely ill patients by focusing on building resilience of safety within teams as well as individuals. Staff learn in multi-professional teams and reflect by engaging in multi- professional conversations about practice provoked by experiences gained in either the simulated or real clinical environment.

Simulation-based training takes place in the GAPS centre, on the wards, in the delivery suite, the emergency department, operating theatres, critical care units, the community and more recently, internationally. For the first time GAPS has delivered simulation-based training in local GP and dental practices improving team work and emergency preparedness capacity for staff to respond to life-threatening medical emergencies. This model has now been successfully transferred back into the outlying departments within the hospital setting with good effect.

GAPS is a major provider of skills training and is consistently highly rated by external participants for Acute Trauma Life Support, European Trauma Course, Basic and Advanced Surgical Skills, Care of the Critically Ill Surgical Patient and a host of other Royal College of Surgeons seconded courses. In addition, specific specialty area courses are aimed at St George's staff and these include obstetric skills and drills, tracheostomy care, advanced airway skills for anaesthetists, trans-thoracic and trans-oesophageal echocardiography skills, transfer training and critical care. The GAPS team have transferred knowledge and skills to local trainers in almost all specialities allowing in situ and ad hoc training to be delivered in response to identified risk, Serious Incidents (SIs) and individual training needs. Trainee and expert surgeons are able to use advanced computerised laparoscopic trainers and realistic anatomical part task trainers to maintain specialist skills in their field. GAPS have also designed a cardiac surgical team training course using the latest technology *Orpheus* cardiac bypass simulator to address the human factors and non-technical skills of team in cardiac theatres.

GAPS pride themselves inter-professional. These include the foundation programme, core medical trainee and final year medical school simulation days. *Acclimatisation* for healthcare staff new to the NHS is a particularly innovative new programme. It has now had 89 participants since it was launched in February 2015 and will continue to facilitate the transition of non-UK trained staff into safe and effective NHS practice. The St George's simulation *Train the Trainer* course is always oversubscribed and has been the commissioners' choice of faculty development for several years. GAPS have now trained more than 500 healthcare staff in the art of technology enhanced learning and teaching. The great strength of the centre is the teaching faculty base of more than 300 experienced clinical educators.

Despite its considerable educational output, the GAPS team is relatively small. Seven permanent centre staff includes clinical simulation specialists, technical staff, administrators and an educationalist. GAPS hosts between two and four simulation fellows, advanced specialist medical trainees who take time out from their training programmes to develop expertise in simulation- based training. GAPS staff are regular presenters at international meetings and author papers in peer-reviewed journals. Recently the simulation specialists of the GAPS team were winners of the South London Simulation Network conference as well as the head of department, Nicholas Gosling, who won the NHS Development Champion of the Year in the London Leadership awards.

Student nurses

St George's has 330 student nurses and has developed a guaranteed employment route for them in partnership with our nursing directorate and King's College London and Kingston University. This model of guaranteed employment is one of the recommendations of the Shape of Caring Review by Lord Willis (2015) with the proviso that there will be a robust period of Preceptorship.

Doctors in training

St George's is one of five lead providers across south London. It is commissioned to run training programmes by one of the three London local education and training boards (LETBs). These boards have been set up by Health Education England and are responsible for making sure that the NHS is successfully training the future workforce for our population. Lead providers have been tasked with leading educational development and innovation and managing their local training communities. St George's is responsible for a total of 13 specialty training programmes (for pan London, south London and south west London) - core medicine, core surgery, core dental, cardiothoracic surgery, clinical radiology, clinical genetics, geriatrics, gastroenterology, geni to urinary medicine, general surgery, higher anaesthetics, trauma and orthopaedics and vascular surgery.

St George's is an active member of the Confederation of South London Lead Providers (COSL), a forum which encourages the lead providers to work collaboratively and share best practice to enhance the quality of medical and dental education delivered across south London.

COSL aims to ensure that excellence in healthcare education is delivered across south London, to provide the best training.

Retention

Retaining staff is just as important as recruiting. We have focussed on retention over the last year with each division drawing up their own plans to retain their staff. The national shortage of some staff groups, particularly nursing means that we are recruiting from overseas to fill the gaps in our workforce so that our permanent workforce is not overloaded.

A formal period of preceptorship is now embedded across the trust for all newly qualified nurses. The programme consists of the following:

- six months preceptorship support
- named preceptor
- preceptorship handbook
- regular progress meetings
- four study days
- preceptee workshops.

We are currently developing an international nursing preceptorship package incorporating acclimatisation.

Sickness absence

Attendance at work is reported monthly to the trust board and at divisional management boards to ensure that staff are supported to return to work and to ensure we have as many staff available for work as possible.

Sickness absence full year 2015/16:

Staff group	%

Add Prof Scientific and Technical	3.07%
Additional Clinical Services	6.24%
Administrative and Clerical	3.86%
Allied Health Professionals	2.26%
Estates and Ancillary	5.37%
Healthcare Scientists	1.90%
Medical and Dental	0.93%
Nursing and Midwifery Registered	3.70%
Total	**3.41%**

Our workforce by contract type for 2015/16

Staff Group	Permanent	Fixed Term	Bank, Agency & Locum	Total
Add Prof Scientific and Technic	476.8	92.3	82.0	651.1
Additional Clinical Services*	723.5	88.8	0.0	812.2
Administrative and Estates	1599.9	103.9	336.0	2039.8
Allied Health Professionals	552.8	42.1	82.0	676.9
Healthcare Scientists	260.9	10.2	74.0	345.1
Medical and Dental	435.0	712.2	90.0	1237.3
Nursing and Midwifery Registered	2674.8	116.4	689.0	3480.1
Grand Total	**6716.8**	**1156.4**	**1353.0**	**9226.3**

*Temporary HCA Staff are included in Nursing and Midwifery Registered

Our workforce by gender

A breakdown of the workforce by gender at year end is set out in the table below.

	WTE		%	
Staff group	**Female**	**Male**	**Female**	**Male**
Directors	3.0	4.0	42.86%	57.14%
Senior managers (AFC 8c +)	63.6	51.0	55.48%	44.52%

All staff	5794.0	2161.6	72.83%	27.17%

From April 2015, in line with the rest of the NHS, we adopted a new Workforce Race Equality Standard (WRES). The WRES was developed to support NHS organisations in ensuring that staff from black and ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace. NHS organisations are required to demonstrate progress against a number of indicators of workforce equality in the workforce, especially at leadership levels. It is important that our staff and leaders reflect the communities in which they work, bringing diverse experiences to the table and acting as positive role models for others to follow.

Occupational health and staff support

The occupational health service supports the wellbeing of staff so that they can work safely and effectively. In 2015, a wellbeing strategy was introduced to promote healthier lifestyle choices for staff and empowering staff to manage their own health and wellbeing needs and providing the skills to champion the wellness needs of those around them.

The trust provides a staff support service to which staff can confidentially self-refer at times of particular difficulty or stress in their lives whether at work or at home.

The trust is committed to protecting the health, safety and welfare of its employees and this policy sets out the steps the trust will take to identify stress in the workplace and effectively manage stress where it occurs.

Our stress management policy outlines the responsibilities of managers and employees in tacking stress and along with the accompanying procedure and management guidelines will support managers in identifying and managing the causes and effect of stress in the workforce, and help to minimise the impact of work-related levels of stress within the organisation.

Our policy on the employment of disabled people and our recruitment and selection policy set out how we recruit people with disabilities, ensuring that a guaranteed interview is offered to any disabled candidate who meets the essential criteria for the role, and discussing any adjustments that might be required if appointed.

When an existing member of staff becomes disabled we actively seek redeployment where possible, taking advice from our occupational health department as appropriate. This may require offering additional training to a newly disabled member of staff to help them meet the requirements of their new role.

Promoting equal opportunities

The trust serves the diverse local population of south west London and beyond. In common with other major cities, London's population is ethnically diverse nearly 50% of its population from non-white British backgrounds and speak over 300 languages. Among our staff, we are proud to

reflect these changes with nearly 50% of our staff from different ethnic communities. The changes in our local population are rapid and it is vitally important that all patients and staff who come into contact with us in different settings feel included, respected and valued. By treating everyone in a fair and inclusive manner, we send a strong signal about the values of the NHS and Britain at large.

In 2014/15 we undertook our second assessment using the NHS Equality Delivery System and used the results to set our corporate equality priorities for 2015-2019. We did this in consultation with our staff and other stakeholders and the findings were approved by the board. The results of this assessment and our equality reports can be seen at https://www.stgeorges.nhs.uk/about/living-our-values/equality-and-human-rights/

Over the last few years, the trust has worked in partnership with a local school on 'Project SEARCH'. Project SEARCH is a collaboration of Cricket Green School, Action on Disability and the trust. We are a partnership that aims to put young people with disabilities into work, both within and outside the hospital. St George's supports six trainees annually. All of the trainees from 2015/16 are now in paid employment, one is working in Marks and Spencer at St George's Hospital, others are working in local schools, retail, hospitality and the theatre. The trust has employed five past Project SEARCH trainees since the programme began. In total over the past three years, 80% of our students have been employed compared to a national average of around 7% of people with learning difficulties in paid employment.

In December 2014, the trust issued 'Policy on the Employment of Disabled People' with input from staff side colleagues which includes information including:

- giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities
- continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period
- training, career development and promotion of disabled employees

The policy sets out the trust's commitment to employing people with disabilities and making appropriate arrangements for disabled applicants to be shortlisted if they meet the minimum requirement for the post. This is a well-established process; applicants are able to indicate they have a disability at the outset of the process and successful applicants can discuss any required adjustments to the role with the recruiting manager with support from the occupational health department if necessary. The policy also covers the steps that we take to retain staff in employment should they become disabled, which includes identifying any training and career development requirements for disabled staff. We monitor the responses of disabled staff through the staff survey and going forward the particular needs of disabled staff will form part of the 'St George's as One' initiative which focuses on the protected characteristics and how we ensure all staff are able to contribute equally at the trust and have their contribution valued.

As part of our duties under the Equality Act 2010, the trust collects a range of employment data to monitor diversity and inequalities. The results are published in annual workforce monitoring reports on the trust's website - https://www.stgeorges.nhs.uk/ Information about the diversity of our patient activity is now included in these reports. Equality impact assessments are undertaken

to provide assurance that corporate policies and major service developments and functions take account of diversity and are not discriminatory.

Through patient involvement and engagement activities, the trust makes effort to ensure we work in partnership with patients, carers and staff. Our Friends and Family Test now includes information on key demographics to ensure we get a cross-representation of feedback from our patients.

Counter fraud

The trust's counter fraud team is committed to providing a zero tolerance culture to fraud, bribery and corruption.

The counter fraud team are accountable to the chief financial officer and monitored by the audit committee. All concerns are professionally investigated in line with guidance from our regulators NHS Protect. Our counter fraud team consists of two accredited local counter fraud specialists.

The trust has anti-fraud and anti-bribery policies and is committed to the elimination of fraud and illegal acts within the trust and ensures rigorous investigation, disciplinary and criminal sanctions as appropriate. In the 2015/16 financial year counter fraud received 120 contacts and opened 10 full investigations, of which 11 were referred for disciplinary consideration and 1 for criminal prosecution. All fraud referrals and investigations are recorded on the NHS Protect FIRST case management system. During 2015/16 we have delivered counter fraud awareness sessions targeting all levels of staff.

A representative from the counter fraud team regularly attends the audit committee to provide an update on current or new fraud cases and actions taken as a result of those cases.

The counter fraud team have participation in the National Fraud Initiative which is data matching exercise run by the Cabinet Office. The counter fraud team have undertaken pro-active exercises including misuse of blue disabled badges and identity documents for staff. A number of these types of fraud were identified and staff disciplined accordingly.

The counter fraud team has an excellent working relationship with the Home Office and with the local Safer Neighbourhood Team.

Off-payroll engagements

Table 4B: For all off-payroll engagements as of 31 Mar 2016, for more than £220 per day and that last for longer than six months	8A1 2015/16 Number of engagements Number	Maincode Subcode	Expected Sign	Checks
No. of existing engagements as of 31 Mar 2016	26	100	+	
Of which:				
Number that have existed for less than one year at the time of	13	110	+	

reporting				
Number that have existed for between one and two years at the time of reporting	12	120	+	
Number that have existed for between two and three years at the time of reporting	1	130	+	
Number that have existed for between three and four years at the time of reporting	0	140	+	
Number that have existed for four or more years at the time of reporting	0	150	+	
Confirmation:				
Please confirm that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	Yes	160	Please select	**Pass**

Table 4C: For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2015 and 31 Mar 2016, for more than £220 per day and that last for longer than six months	8A2 2015/16 Number of engagements Number	Maincode Subcode	Expected Sign	Checks
Number of new engagements, or those that reached six months in duration between 01 Apr 2015 and 31 Mar 2016	9	100	+	
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations		110	+	**Pass**
Number for whom assurance has been requested	0	120	+	**Pass**
Of which:				
Number for whom assurance has been received		130	+	
Number for whom assurance has not been received *		140	+	

Number that have been terminated as a result of assurance not being received		150	+	Pass

*Where an individual leaves after assurance is requested but before assurance is received and instances where trusts are still waiting for information from the individual at the time of reporting this should be included within "No. for whom assurance has not been received".

Table 4D: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 Apr 2015 and 31 Mar 2016	8A3 2015/16 Number of engagements Number	Maincode Subcode	Expected Sign	Checks
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	1	100	+	Pass
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	4	110	+	Pass

All FTs must disclose the number of individuals in the capacity of a board member of senior manager having significant financial responsibility in the year. This includes both on-payroll and off-payroll engagements.

In any cases where individuals are included within the first row of this table, please set out:		Checks
Details of the exceptional circumstances that led to each of these engagements.	Appointment of a turnaround director.	Pass
Details of the length of time each of these exceptional engagements lasted.	From June 2015 to March 2016	Pass

Expenditure on consultancy –Tak Pang, finance

Exit packages – Jacqueline McCullough, HR

Remuneration report

Annual statement on remuneration

The trust has two committees, one dealing with executive pay and appointments and the other with non-executive directors.

The board of directors' nominations and remuneration membership includes the chairman and all non-executive directors. The Head of Corporate Governance acts as secretary to the committee, the director of workforce provides advice to the committee as required and the chief executive attends when appropriate.

The council of governors' nominations and remuneration committee membership includes public, staff and appointed governors and is supported by the Head of Corporate Governance.

There have been no substantial decisions regarding remuneration during 2015/16.

Remuneration policy 2015/16

The policy agreed by the relevant committees for this year is as set out below:

Executive directors

The remuneration policy for executive directors is set by the board of directors' nominations and remuneration committee.

The trust has maintained a policy of spot rates for executive director remuneration based on publicly available benchmark data and market data available through search companies. The trust is paying at median or below median market rates for its executive director group. Remuneration has been reviewed annually against the available data and in the context of any national pay awards.

In 2015/16 the trust appointed four new executive directors:

- turnaround director
- interim chief operating officer
- interim chief financial officer
- interim director of estates and facilities
- transformation director

For each new appointment the committee agreed remuneration levels against available benchmarked information.

Senior managers are paid on Agenda for Change pay scales or medical terms and conditions. Senior managers' salaries, benefits and pension entitlements are published in the trust's annual report. The trust policy on loss of office is in accordance with Agenda for Change terms and conditions.

There are no obligations on the trust which is contained in any senior managers' service contracts which could give rise to, or impact on, remuneration payments or payments for loss of office.

Chairman and non-executive directors

As a foundation trust it is for the council of governors to set the remuneration and allowances, and other terms and conditions of office, of the chairman and non-executive directors. The council of governors agreed the initial remuneration for chairman and non-executive directors at its meeting in April 2015, taking into consideration the recommendations of the council of governors' nominations and remuneration committee.

The council of governors agreed that the remuneration should be set established using the following guiding principles:

- competitive: remuneration should be competitive with comparable trusts on a comparative workload basis, so that council should be able to attract at least as good a chairman and non-executive directors as other comparable trusts;
- value for money: the total cost of the chairman and non-executive directors should be demonstrably good value for taxpayers' money in comparison with other comparable trusts;
- aligned with role: remuneration should be appropriate to the role of chairman and non-executive directors.

The council agreed that remuneration should be comparable to the market rate for the benchmark peer group (large acute foundation trusts in London) in the NHS providers remuneration survey and publicly available benchmarking data. The council agreed that given financial circumstances the remuneration for the chairman should be incremental but that for the other non-executives it should be set at a comparable level immediately.

For the chairman, the council of governors agreed to commit to achieving the mean point within the peer group range but to do so in a phased approach – to set the initial remuneration to £45,000 with effect from 1st February 2015, with a further review in autumn 2015 with a view to moving to the mean point within the peer group range from February 2016, as part of the appointment/reappointment process – as with the non-executives this to be linked to an explicit expectation of time commitment, say ten days per month.

For non-executive directors, the council agreed to set their remuneration at a spot rate, £12,000, with effect from 1st February 2015.

The council of governors considered the option of applying specific uplifts to salary for certain additional non-executive responsibilities, but noted that all non-executive directors had additional responsibilities over and above their basic role, including chairing board sub-committees, and therefore agreed that initially there should be a single rate for all non-executive directors. This could be reviewed again in future.

The council agreed that these arrangements should be subject to an annual review, informed by appraisal information and current benchmark information.

Attendance at the council of governors' nomination and remuneration committee during the year is set out below:

Governors nomination and remuneration committee 2015/16

Governor	Constituency	14/1/16	3/3/16
Ed Crocker	Public Governor	N	N
Kathryn Harrison	Public Governor	Y	Y
Mia Bayles	Public Governor	Y	Y
Fran Gibson	Appointed governor	Y	N
Hilary Harland	Public Governor	Y	Y
Philip Jones	Appointed Governor	Y	Y
Hilary Rattue	Staff Governor	N	N
Felicity Merz	Staff Governor	Y	Y
Jenni Doman	Staff Governor	Y	N
Anneke de Boer	Public Governor	Y	Y
J-P Van Besouw	Staff Governor	N	N
Sue Baker	Public Governor	Y	Y
Christopher Smallwood	Chairman	Y	Y

Severance and payments

There have been no terminations of contract for executive or non-executive directors during 2015/16.

Senior managers remuneration policy – Dominic Sharp, finance

Annual report on remuneration – Dominic Sharp, finance

The remuneration report was approved by the board of directors on XX May 2016 and signed on its behalf by Paula Vasco-Knight, acting chief executive.

Signature required

Regulatory ratings and disclosures

The trust is regulated by Monitor, to whom it submits its annual plan. Details contained within the trust's annual plan and the in-year submissions made will be the basis from which Monitor will assess and assign a risk rating for the trust. The role of ratings is to provide a judgement of performance and to indicate when there is a cause for concern for the trust.

In accordance with Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) the trust confirms that the income it receives from the provision of goods and services for the purposes of the health service in England is greater than the income it receives for any other purposes.

The trust has a number of income generating activities and the surplus these activities generate is used by the trust to fund the provision of goods and services for the purposes of the health service in England.

The trust has performed positively against some of the regulatory targets in 2014/15 although the financial performance has deteriorated. The financial position is discussed in more detail in the finance review section.

The trust has faced significant challenges in 2015/16, in particular with regards to the emergency department four-hour standard, the national two-week wait and 62-day cancer standards and the RTT incomplete pathways within 18-week standard. These are all on-going priority areas for the trust and are regularly reviewed with commissioners as part of system resilience and the trust is proactively engaging with Monitor about actions being taken to improve performance against these targets.

The trust achieved foundation trust status in Q4 2014/15. Prior to this the trust was regulated under the Trust Development Authority accountability framework and also undertook self-assessment against the Monitor risk assessment framework (RAF).

From August 2015 Monitor implemented an update to the RAF requiring foundation trusts to assign a financial sustainability risk rating (FSRR) to their current financial performance, to replace the existing continuity of service rating (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 the income and expenditure margin (the degree to which the organisation is operating at a surplus/deficit) and variance from plan in relation to the income and expenditure margin (the variance between the organisation's plan and its actual margin).

An overview of the assessment is as follows:

2015/16	Annual plan	Q1	Q2	Q3	Q4
Continuity of service rating	1	2	2	2	2
Financial sustainability risk rating	1	2	2	2	2
Governance rating		Under Review	Under Review	Under Review	Red

In 2015/16 Monitor investigated financial sustainability concerns at the trust, triggered by deterioration in the trusts financial and performance position and formal regulatory action was undertaken in two areas. This included an enforcement undertaking and additional license requirements. The trust submitted a reforecast plan for 2015/16 on 20th November and a two-year recovery plan to 2016/17 by the end of December 2015. The trust also received a regulatory notice to appoint Sir David Henshaw as Interim Chair on 15th March which was enacted. Full details of the regulatory notices can be found on the Gov.uk website.

After making enquiries, the directors have a reasonable expectation that the trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

The accounts have been prepared under a direction issue by Monitor under the National Health Service Act 2006.

Statement of the chief executive's responsibilities as the accounting officer of St George's University Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by Monitor.

Under the NHS Act 2006, Monitor has directed St George's University Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of St George's University Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.

Signature required

Paula Vasco-Knight
Acting Chief Executive Date: xx May 2016

Code of Governance

The board of directors (the board) of the trust attaches great importance to ensuring that the trust operates to high ethical and compliance standards. In addition it seeks to observe the principles of good corporate governance set out in the Monitor NHS Foundation Trust Code of Governance.

The board is responsible for the management of the trust and for ensuring proper standards of corporate governance are maintained. The board accounts for the performance of the trust and consults on its future strategy with its members through the council of governors.

The council of governor's role is to influence the strategic direction of the trust so that it takes account of the needs and views of the members, local community and key stakeholders, to hold the board to account on the performance of the trust, to help develop a representative, diverse and well-involved membership, and to help make a noticeable improvement to the patient experience. It also has to carry out other statutory and formal duties, including the appointment of the chairman and non-executive directors of the trust and the appointment of the external auditor.

Governance structure

A change to the trust's constitution was approved by the board of directors and the council of governors in February 2015 to reflect the name change of the trust. The structure was in place prior to becoming a foundation trust in shadow form and has now been operating for a year. The trust is open and transparent with the community through the public council of governor meetings, the various health events held during the year and the large amount of information available on our website.

The trust board sub-committees include:

- audit committee (more information can be found on page XXX.
- workforce committee
- nominations and remuneration committee
- quality and risk committee
- finance and performance committee
- commercial board

To see the full trust corporate governance structure – please see appendix 1 of the Annual Governance Statement.

Directors

The directors who held office during 2015/16 can be seen along with their declared interests, skills, expertise and experience from page XX. The trust has a separate chairman and chief executive. The chairman is independent.

Chairman

The trust's interim chairman is Sir David Henshaw. He is a non-executive director and chair of the council of governors. He was appointed in March 2016. Christopher Smallwood was the trust's

chairman until January 2016 when his term ended. Sarah Wilton was acting chair of the trust prior to Sir David Henshaw's appointment. The chairman and non-executive directors regularly meet, without executive directors present. The chairman conducts annual appraisals of non-executive directors and will, as part of that process, identify any personal development needs. These were completed by Christopher Smallwood prior to his departure.

Deputy chair and senior independent director

The trust's deputy chairman and senior independent director is Mike Rappolt. His appointment was ratified by the council of governors in February 2015. The senior independent director leads the annual appraisal process for the chairman and will report the outcome of that appraisal to the council of governors.

Chief Executive

The trust's acting chief executive is Paula Vasco-Knight. She joined the trust as Interim Chief Operating Officer in September 2015 and became Acting Chief Executive in April 2016. Miles Scott was Chief Executive for the full 12 month period during 2015/16. He was appointed in September 2011 as Chief Executive and left the trust on secondment in April 2016.

The board

The board of directors is made up of:

- chairman
- five independent non-executive directors
- one university representative non-executive
- four executive directors
- four non-voting directors, who attend board meetings in advisory capacity.

No executive director currently holds a non-executive role in another foundation trust or comparable organisation.

The board meets regularly and has a formal schedule of matters specifically reserved for its decision. This includes high level matters relating to strategy, business plans and budgets, regulations and control, annual report and accounts, audit, and monitoring how the strategy is implemented at operational level. The board delegates other matters to the executive directors and senior management.

Regular contact, including with the non-executive directors, is maintained between formal meetings. Board meetings follow a formal agenda, which includes a review of quality and patient care, strategy, clinical governance, operational performance and performance against quality indicators set by the Care Quality Commission (CQC), Monitor and by management, such as infection control targets, patient access to the trust and emergency department waiting times.

The directors have timely access to all relevant management, financial and regulatory information. On being appointed to the board, directors are fully briefed on their responsibilities. On-going development and training requirements for individual directors are assessed annually through the appraisal process, with the chairman leading on collective board development, which is addressed at board workshops.

The board of directors has standing orders, which set out the procedure for meetings and for recording decisions. The board of directors' standing orders allow any director to have their comments recorded in the minutes. The board of directors confirm the code of conduct on an annual basis, which includes the Nolan Principles of public life. The trust has arranged NHS Litigation Authority indemnity cover for directors.

Each board sub-committee evaluates its effectiveness on an annual basis and will raise any concerns about resources via that process. Each board sub-committee also reports to the board after each of its meetings so can raise concerns with the board through those reports.

The board agrees its financial, quality and operating objectives in public on an annual basis, following input from the council of governors. The board will then monitor progress against those objectives on a quarterly basis.

The trust has a stakeholder map including relevant third party bodies and other key stakeholders and this is actively managed to ensure effective communication and engagement with each respective stakeholder.

Attendance at board and sub board committee meetings 2014/15

The following table sets out the number of directors meetings held during the year and the number of board committee meetings attended by each director:

Director	Trust board	Audit committee	Quality and risk committee	Nominations and remunerations committee content required from Sumiya Ahmad/Di Emmerson	Finance and performance committee	Workforce committee
Miles Scott	11/12	1/5			11/12	0/6
Christopher Smallwood (until January 2016)	9/10	n/a		2/2	8/9	0/6
Sir David Henshaw (started March 2016)	1/1			n/a	1/1	

Steve Bolam (until February 2016)	10/11	5/5			9/10	0/6
Iain Lynam (started February 2016)	1/2				2/2	
Jennie Hall	11/12		11/11		8/12	3/4
Simon Mackenzie	12/12		11/11		5/12	1/2
Eric Munro (until March 2016)	11/12		4/11		10/12	0/6
Richard Hancock (started March 2016)	1/1				n/a	
Peter Jenkinson (until November 2015)	7/8	4/5	9/11		6/8	3/6
Wendy Brewer	10/12		3/11		11/12	6/6
Andrew Burn (June 2015 - March 2016)	6/12				8/10	
Rob Elek	11/12		1/11 (non-member)		1/12 (non-member)	0/6

Martin Wilson	12/12		6/8		10/12	0/6
Paula Vasco-Knight (From October 15)	6/6				6/6	
Non-executive director						
Mike Rappolt	11/12	5/5	4/11		7/12	0/6
Sarah Wilton	11/12	5/5	11/11		11/12	0/6
Peter Kopelman (until January 2016)	6/10		7/11		n/a	2/6
Stella Pantelides	12/12		1/11		2/12	6/6
Kate Leach	9/12				1/12	5/6
Judith Hulf (until January 2016)	5/10	2/5	10/11		1/12	0/6
Jennifer Higham (from November 2016)	3/5	2/5	2/5		n/a	0/6

Governors are encouraged to attend trust board and committee meetings and are given the opportunity to ask questions or comment.

There have been several workshops or governor induction sessions where board members and governors can meet to discuss various issues. A programme of training sessions has taken place during 2015/16 for governors in areas such as finance and equality inspections on the wards.

The commercial board

The commercial board is a sub-committee of the trust board and is responsible for overseeing both the development and implementation of a trust-wide commercial strategy. The remit of the committee includes strategic growth in NHS income as well as non-NHS income. The committee also has a role in providing assurance that commercial activity is being developed appropriately. Membership comprises non-executive, corporate and divisional representatives.

Audit committee

The audit committee is a committee of the board of directors. The committee has four main roles:

1. To review and independently scrutinise the trust's systems of clinical governance, internal control and risk management. This ensures that by proper process and challenge, integrated governance principles are embedded and practiced across all St George's activities as well as supporting the achievement of the trust's objectives.
2. To review key internal and external financial, clinical, fraud and corruption and other policies, reports and assurances functions, in order to provide independent assurance on these functions to the board.
3. To review the integrity of financial statements prepared on the trust's behalf.
4. To undertake all other statutory duties of an NHS Audit Committee.

The membership of the committee is made up of three independent non-executive directors, one of whom has financial experience. In the March meeting the audit committee co-opted two members from the council of governors to sit alongside the chairman to ensure it could be constituted as an effective decision making body.

Board of directors' remuneration and nominations committee

The aims of the nominations committee are to:

- develop the remuneration framework for senior management i.e. non agenda for change executive directors.
- agree the appropriate remuneration and terms of service for the chief executive officer, executive directors and other senior managers who report to executive directors, whose remuneration is not covered by agenda for change.
- oversee all appointments to the trust board
- ensure that plans are in place for orderly succession of appointments to executive director posts.

The committee's membership is made up of the chairman and all non-executive directors.

There have been five new executive director appointments to the board during 2015/16:

- turnaround director, June 2015
- interim chief operating officer, October 2015
- chief finance officer, February 2016
- director of transformation, February 2016.
- interim director of estates and facilities, March 2016

An external search company was used in two of the four appointments.

Appointment, re-election and the nominations committee

The directors are responsible for assessing the size, structure and skill requirements of the board, and for considering any changes necessary or new appointments. For executive director appointments, the board of directors' nomination and remuneration committee, which comprises of the chairman and the non-executive directors assisted by the director of human resources and also involving the chief executive, will produce a job description, decide if external recruitment consultants are required to assist in the process and if so instruct the selected agency, shortlist and interview candidates.

For non-executive appointments, the council of governors' nominations and remuneration committee, comprising of 10 members of the council of governors, the chairman, with the company secretary in attendance, will recommend a process to the council for approval.

The council of governors approved the following appointments of non-executive directors:

- Mike Rappolt's three month extension on 14th January 2016
- Professor Sir Norman Williams three year appointment on 3rd March 2016, effective from May 2016
- Sarah Wilton's three year extension on 27th October 2015

The interim chairman, Sir David Henshaw was appointed by Monitor using their powers under section 111(5) of the Health and Social Care Act 2012 in March 2016.

The council of governors have a statutory power to appoint or remove non-executive directors. Non-executive directors are appointed for a three-year term in office. A non-executive director can be re-appointed for a second three-year term in office on an uncontested basis, subject to the recommendation of the nominations and remuneration committee and the approval of the council of governors. No non-executive director will serve longer than nine years.

Mike Rappolt has served over nine years as the board recognised the importance of continuity on the board as we prepared for foundation trust status and once we became authorised as a foundation trust, the current non-executive directors were appointed until the end of their terms or 12 months, whichever is longer (in accordance with the constitution). He was then extended until the end of April 2016 to enable the trust to complete the appointment of new non-executive directors. The council of governors will consider the appointment of non-executive directors and the process for doing so on an individual basis when their term of office comes near to an end.

Removal of the chairman or another non-executive director shall require the approval of three quarters of the members of the council of governors. The chairman, other non-executive directors, and the chief executive (except in the case of the appointment of a new chief executive) are responsible for deciding the appointment of executive directors. The chairman and the other non-executive directors are responsible for the appointment and removal of the chief executive, whose appointment requires the approval of the council of governors.

Led by the chairman, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities. The council of governors are currently conducting a review of their first year of operation with support from the company secretary.

Council of governors

The council of governors' nominations and remuneration committee is made up of 10 governors, with chief executive and company secretary only attending to support and advise.

The council of governors has met four times in the reporting period (2015/16). After each meeting of the council, the chairman will feedback any views of governors to the board at the next meeting of the board of directors.

Directors' responsibilities statement and going concern

The directors consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy (Code of Governance C.1.1).

Each director has stated that as far as they are aware, there is no relevant audit information of which the trust's auditors are unaware and they have taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the trust's auditors are aware of that information.

The trust has controls in place to mitigate the risk of bribery including register of gifts and hospitality and a Standards of Business Conduct Policy, which requires all budget holders to complete declarations of interest on an annual basis.

The directors are required under the National Health Service Act 2006 to prepare financial statements for each financial year. The Secretary of State, with the approval of the Treasury, directs that these financial statements give a true and fair view of the state of affairs of the NHS foundation trust and of the income and expenditure of the NHS foundation trust for that period. In preparing those financial statements, the directors are required to: apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury; make judgements and estimates which are reasonable and prudent; and state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements.

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the financial statements. The directors are required under the Monitor Code of Governance to consider whether or not it is appropriate to adopt the going concern basis in preparing the trust's financial statements (annual accounts). As part of its

normal business practice, the trust prepares annual financial plans. After making enquiries, the board has reasonable expectation that the trust has adequate resources to continue in operational existence for the foreseeable future. Accordingly, the board continues to adopt a going concern basis in preparing the annual report and financial statements.

Trust auditors

The council of governors are required to appoint the external auditor of a foundation trust. At its meeting in February 2015 the governors appointed Grant Thornton as the external auditor until 2017.

The trust and board of directors have also been through external evaluation in the form of the foundation trust authorisation by the Monitor assessment team.

The trust's internal audit service is provided by the London Audit Consortium, a specialist NHS Audit Consortium. The strategic internal audit plans are approved annually by the audit committee.

The audit committee reviews reports from internal audit, including:

- the internal audit risk based strategic and operational plans
- regular progress reports
- individual internal audit reports
- the internal audit annual report, and head of internal audit opinion.

The head of internal audit is a member of the audit committee and quality and risk committee. The range of areas audited during the year is included in the annual governance statement.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of St George's, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in St George's University Hospitals NHS Foundation Trust for the period April 2015 to March 2016 and up to the date of approval of the annual report and accounts.

We have included information relating to the arrangements in place to govern service quality, quality governance and quality in the annual governance statement which starts on page XXX.

The section includes:

- How the foundation trust has had regard to Monitor's quality governance framework in arriving at its overall evaluation of the organisation's performance, internal control and

board assurance framework and a summary of action plans to improve the governance of quality.

- Material inconsistencies (if any) between:
  - the annual governance statement;
  - annual and quarterly board statements required by the Risk Assessment Framework, the corporate governance statement submitted with the annual plan, the quality report, and annual report; and
  - reports arising from Care Quality Commission planned and responsive reviews of the NHS foundation trust and any consequent action plans developed by the trust.

Statement of compliance with the NHS Foundation Trust Code of Governance

The board of directors considers that it was compliant with the provisions of the revised NHS Foundation Trust Code of Governance. The council of governors retains the power to hold the Board of Directors to account for its performance in achieving the Trust's objectives.

St George's University Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Annual Governance Statement 2015/16

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust' policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of St George's University Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in St George's University Hospitals NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has an integrated governance approach to ensure decision-making is informed by a full range of corporate, financial, clinical and information governance, and ensures compliance with the five main principles of the corporate governance code: leadership, effectiveness, accountability, remuneration and relations with stakeholders. This governance framework spans from "board to ward" and is outlined in Appendix 1.

There is an established and robust governance framework, supported and maintained by a framework of committees. The trust board (the 'board') has overall responsibility for the effectiveness of the governance framework and as such requires that each of its sub-committees has agreed terms of reference which describes the duties, responsibilities and accountabilities, and describes the process for assessing and monitoring effectiveness. The board itself has standing orders, reservation and delegation of powers and standing financial instructions in place which is reviewed annually.

As the accountable officer, I support the chairman in ensuring the effective performance of the board and its sub-committees. I achieve this in a number of ways.

- Monitoring of attendance
- Maintaining an overview of the quality of the presented information, including agenda items and supporting evidence
- Requesting the attendance of representatives from across the trust as and when required
- Ensuring that there is an annual declaration of interests by the members

- Ensuring that each of the board sub-committees reviews its own performance and reports this to the board.

Senior leadership in corporate governance is provided by the head of corporate governance (trust secretary) through the corporate affairs unit. Governance is embedded across the corporate directorates and clinical divisions, led by directors or divisional chairs, thus ensuring clear responsibility and accountability across the trust.

Each division has an established and active governance structure which reports into a divisional management board and divisional governance committee; these in turn report directly into the trust-wide governance framework. This system provides central direction and oversight whilst supporting local ownership and management of objectives and risks.

The governance framework is designed to manage governance and performance in an integrated way.

The risk control framework

Risk management is embedded throughout all levels of the organisation. Risks are systematically identified via structured risks assessments and documented on local level risk registers. These are scored using a risk scoring matrix and are escalated through to divisional and corporate level as appropriate. Low scoring risks are managed locally and higher scoring risks are managed at progressively higher levels within the organisation. Risk control measures are identified and implemented to reduce the potential for harm.

Incident reporting is encouraged through staff training and is embedded throughout the organisation. Risk identified from serious incidents which impact upon patient and staff safety are identified and managed as described above.

The trust is in the process of developing a new board assurance framework (BAF) and the corporate risk register has been used as the BAF during this financial year.

Quality Governance

As an NHS trust, patients are at the heart of everything that we do and hence our mission is “to provide excellent clinical care, education and research to improve the health of the populations we serve.”

To achieve this, our vision of being an excellent integrated care provider and a comprehensive specialist centre for south west London, Surrey and beyond with thriving programmes of education and research is underpinned by the values of:

- kind
- excellent
- respectful
- responsible

Central to achieving this mission is a robust quality governance framework which is maintained to drive a quality focused agenda and promote transparency and accountability. Quality

governance is dependent on a combination of structures and processes at and below board level to lead on trust-wide quality performance. These strive to:

- ensure that required standards are achieved
- investigate and take action on sub-standard performance
- plan and drive continuous improvement
- identify, share and ensure delivery of best-practice
- identify and manage risks to quality

The trust uses the national definition of quality, which is divided into the following three domains:

- patient safety – quality care is care which is delivered so as to reduce or eliminate all avoidable harm and risk to the individual's safety
- patient experience – quality care is care which looks to give the individual as positive an experience of receiving and recovering from care as possible
- patient outcomes (clinical effectiveness) – quality care is care which is delivered according to best evidence as to what is clinically effective in improving an individual's health outcomes.

Roles and responsibilities for quality

Board members

Responsibilities for quality are shared across the chief nurse and the medical director:

- the chief nurse is responsible for clinical risk, patient safety and patient experience;
- the medical director is responsible for patient outcomes;

Chief nurse and director of infection prevention and control (DIPC)

The chief nurse has board level responsibility for professional nursing and midwifery issues and provides strong leadership to the nursing profession. She also has the role of director of infection prevention and control for the trust, and is the trust board lead for adult and children's safeguarding. risk management responsibility was moved to the chief nurse in December 2015.

The principal responsibilities of the chief nurse include the following:-

- Accountability for the delivery of safe high quality patient care as the overriding priority of the Trust, including the specific responsibility to ensure that patients, staff and other persons are protected against risks of acquiring healthcare-associated infections, through the provision of appropriate care, in suitable facilities, consistent with good clinical practice
- Developing and implementing systems to ensure, and continually improve, quality of nursing and midwifery care
- Developing and implementing systems and processes to ensure cost efficacy and value for money in relation to the nursing/midwifery service

- Ensuring there are appropriate systems (including information systems) in place to monitor quality and safety and identify areas for improvement
- As lead for improving patient experience, lead the trust with respect to complaints, taking overall responsibility for the management of complaints and performance in relation to complaints and PALS
- The nominated individual for Care Quality Commission (CQC) and is responsible for ensuring that the quality and care standards are compliant with the regulations set out by the CQC.

Medical Director

The medical director, supported by associate medical director (clinical governance) has a pivotal role, in partnership with clinical directors and care group leads, in extending the influence and understanding of medical staff in the development of the trust. His / her role and responsibilities include:

- responsibility for the formulation of safe and efficient medical staffing policy and practice
- overseeing the formulation and implementation of medical research and education policies, practise and strategies supported by AMDs for education and training and research
- the trust's Caldicott Guardian and is therefore responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing
- responsible officer for the trust.

Trust secretary

The trust secretary (head of corporate governance) is responsible for the establishment and continuous development of governance arrangements and processes, many of which are related to the achievement or monitoring of quality related performance. Through the implementation and management of a quality focused governance framework, the trust ensures that the delivery of safe high quality patient care remains the overriding priority.

Board sub-committees

The trust's governance framework sets out the trust's system of integrated governance and the mechanism by which it leads, directs and controls its functions in order to achieve its organisational objectives. The governance framework forms part of the overarching governance manual – a set of documents which set out the trust's committee and divisional management structures and the roles and responsibilities. The trust committee structure is included along with a detailed chart of feeder committees to the quality and risk committee, the formal board sub-committee with overall responsibility of quality governance.

The primary function of the trust board is to promote a quality-focused culture across the trust. This is achieved through the implementation of an effective reporting process that engages the board in understanding and improving the quality of care offered by the trust, and ensures that quality remains at the forefront of the board's agenda.

Quality and risk committee

The quality and risk committee (QRC), a sub- committee of the trust board, has been established "to steer and monitor the strategic and operational implementation of an integrated approach to quality and risk, assurance and compliance, and to ensure that high quality, safe and effective treatments and services are being provided to patients, and that risk to patients, visitors and staff is minimised."

In respect of its role in quality:

"The committee will also oversee and monitor the implementation of systems to underpin quality (including clinical governance and patient safety). It shall:

- receive assurance that the standards of patient care are continuously improved and that standards set by external agencies, including the Care Quality Commission, are met
- review, monitor and develop the trust's systems and processes for complaints and incidents management to ensure performance targets are achieved and organisational learning takes place
- ensure lessons are learnt and services improved in response to never events and serious incidents.

The main source of assurance for the QRC comes from key components of the trust's quality governance framework – the three governance committees: patient safety committee, patient experience committee and organisational risk committee. They can be considered as the fulcrum of the flow of information between the divisions and the board.

Patient experience committee and patient safety committee

The patient safety and patient experience committees are executive committees established to reduce avoidable harm and to improve the patient experience. Both of these committees are chaired by the chief nurse with membership that reflects the purpose of each committee as described in their respective terms of reference.

The divisions are represented by the divisional directors of nursing and governance, or appropriate senior clinician, from each division to ensure that the flow of governance is strong between the divisions and corporate structure of board and sub-committees.

Organisational risk committee (ORC)

An integral part of ORC's business is the strategic governance of the divisional and corporate directorate risk registers. Risk registers are essential in good quality governance as they will house the divisional and corporate directorate challenges to delivering the strategic aims of the organisation. They describe how each such challenge is being managed and the plans to further mitigate the risks.

Board initiatives

In order to promote a quality-focused culture across the trust and to ensure that the board has the leadership, skills and knowledge to effect delivery of the quality agenda, several board level initiatives have been undertaken, including:-

- introduction of incidents and complaints, at board meetings

- divisional presentations presented at public board meetings, focusing on quality aspects of different services and specialities
- introduction of quality inspections.

The board revises the trust's strategic aims and objectives on an annual basis. This enables the board to review the trust's strategic aims and affiliated actions, ensuring that they are still relevant and focused on the delivery of safe, high quality services.

The divisional management structure

The trust is structured into four clinical divisions, supported by corporate directorates. The divisions are responsible for operating a system of governance that ensures:

- evidence-based clinical practice is in place and audited
- accountability for service and financial performance
- good practice is systematically disseminated
- effective management of risk
- when adverse incidents and complaints occur they are investigated within the agreed timescales and lessons learnt disseminated and embedded
- poor clinical practice is identified and dealt with to prevent harm to patients
- leadership skills are developed within the clinical team and the organisation
- professional development programmes reflect the principles of clinical governance and support the delivery of the trust's objectives
- high quality data are collected to monitor clinical care and performance
- compliance with the Care Quality Commission standards for quality and safety, and other external standards and regulatory requirements

Each division is led by a divisional chair. The divisional chair, working together with the divisional management team, is responsible for the delivery of quality patient care; and ensuring that there is effective cross-divisional working to improve patient care pathways and working between specialties. The divisional chair is also accountable for clinical quality, performance, governance, finance, and service developments within his/her division.

The divisional chair is supported by a divisional director of operations (a full-time manager) and a divisional director of nursing and governance. Other members of the supporting management team include clinical directors, who are responsible for the delivery of clinical services for specific care groups, general managers, heads of nursing, a management accountant and a human resources manager.

Professional leadership is provided to medical staff within the divisions by the medical director and associate medical directors, through the divisional chairs, where these are doctors. professional leadership is provided to nurses and midwives by the chief nurse and director of operations, through the divisional directors of nursing and governance, the director of midwifery or chief of therapy.

Divisional management / governance boards:

Each division has a divisional management board (DMB) established to review and monitor the implementation of the division's strategies and business plans.

Each division also has a divisional governance board (DGB) established to support the DMB in ensuring an integrated approach to quality, risk and patient safety. The DGB is chaired by the divisional chair and is responsible for:-

- setting and monitoring implementation of the division's quality improvement strategy
- monitoring of all aspects of clinical governance and clinical/non clinical risk within the division and ensuring that lessons are learnt from adverse incidents or complaints and corrective action plans are put in place
- providing leadership, focus and consensus on key aspects of quality, risk and patient safety, based upon expertise within the division
- providing assurance to the board that high quality, safe, effective treatments and services are provided to patients and that risk to staff and visitors is minimised
- reviewing external sources of assurance and ensuring that compliance with regulations maintained
- ensuring evidence provided for continued compliance with CQC standards.

As well as regular reporting to and contribution from each division to patient safety committee (PSC), patient experience committee (PIC) and organisational risk committee (ORC), the divisions present six-monthly reports regarding quality related performance to the PSC and PIC and two monthly reports regarding risk as part of the risk register reviews to the ORC. These reports are presented by the divisional directors of nursing and governance and provide for the escalation of significant risks and issues up the committee structure, to the trust board, as appropriate.

Each division also reports to the quality and risk committee at least once per year on the delivery of their respective quality improvement strategy.

In accordance with the trust's performance management framework, divisions are held to account by the executive directors on a quarterly basis across a range of performance domains, one of which is quality.

Quality reporting and monitoring

A central function of the trust board is to promote a quality-focused culture across the trust. This is achieved through the implementation of an effective reporting process that engages the board in understanding and improving the quality of care offered by the trust, and ensures that quality remains at the forefront of the board's agenda.

Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual.*

The quality and performance report:

The purpose of the report is to update the board on key developments in quality. Like the quality account, the report looks at the three domains of quality and focuses on the trust's performance in these areas by looking at several indicators and performance measures i.e.-

- patient safety: including infection control, serious incident reporting, pressure ulcers, workforce and recruitment
- patient experience: including same sex accommodation, access to interpreter services, patient surveys, PALS and complaints, patient experience trackers
- clinical effectiveness: including NICE compliance, clinical outcomes including national audits, local audits and mortality monitoring

The quality performance report is now combined with **the trust integrated performance report**.

The trust performance report is presented to the finance and performance committee on a monthly basis and to board every two months. This report contains a summary of operational performance across all domains of performance, including quality metrics such as infection rates. Any quality issues identified by the finance and performance committee are referred to the quality and risk committee for further consideration. The quality metrics within the trust performance scorecard are also reviewed monthly by the quality and risk committee.

The quality improvement strategy:

The trust's quality improvement strategy was originally approved by the board in November 2010 and is refreshed annually. The strategy outlines the trust's vision for quality improvement over the next five years, detailing key priority areas and planned action to promote continuous improvement in the safety and quality of services provided by the trust. This strategy is reviewed and updated annually by the quality and risk committee.

Serious incidents:

All serious incidents are reported to the board as part of a weekly synopsis report. At each of its meetings, the board will then review in more detail selected incidents. In addition quality and risk committee will also review selected serious incidents and never events in detail, as well as receiving assurance that lessons from all serious incidents are being learnt within divisions, via the patient safety committee. The serious incident reporting to board also includes any safeguarding serious case reviews.

Care Quality Commission compliance

The trust is compliant with the registration requirements of the Care Quality Commission.

The Care Quality Commission undertook a Chief Inspector of Hospitals inspection in February 2014 which resulted in an overall rating of 'Good'. The trust received two compliance actions:

- There was a poor general understanding and implementation of the principles of the Mental Capacity Act 2005. (St George's Hospital and Queen Mary's Hospital)
- Medical records must be made available to staff working in the outpatients clinics. (St George's Hospital)

Action plans have been implemented in response to these compliance actions and monitored internally through the quality and risk committee and externally through the clinical quality review meetings with commissioners.

Risk management

The trust is committed to providing high quality care, in an environment which is safe for patients, visitors and staff and which is underpinned by the public service values of accountability, probity and openness. Robust risk management and internal control are an essential part of good governance and is integral to the delivery of this commitment. The governance committee structure shown in Appendix 1 provides an effective and robust system of risk management across the trust.

The key aim of the trust's risk management approach is to ensure that all risks to the trust's achievement of strategic objectives (whether clinical, non-clinical, information, research or financial) are identified, analysed, evaluated, treated, monitored and managed appropriately.

The system of risk management is described in the trust's risk management policy which is accessible to all staff via the trust intranet. It is based on an iterative process of:

- identifying and prioritising the risks to the achievement of the organisation's policies, aims and objectives
- evaluating the likelihood of those risks being realised and the impact should they be realised
- managing the risks efficiently, effectively and economically.

This is achieved through a sound organisational framework, underpinned by a robust policy framework, which promotes early identification of risk, the co-ordination of risk management activity, the provision of a safe environment for staff and patients, and the effective use of financial resources. It ensures that staff are aware of their roles and responsibilities and outlines the structures and processes through which risk is assessed, controlled and managed.

Risks are identified through feedback from many sources such as proactive risk assessments, adverse incident reporting and trends, clinical benchmarking and audit data, complaints, legal claims, patient and public feedback, stakeholder/partnership feedback and internal/external assurance assessments.

Key stakeholders are involved in the management of risks via patient and public involvement groups and activities, patient and staff surveys, public board meetings, the local Healthwatch groups and the local adult care and health overview and scrutiny committees.

Risks are evaluated using a recognised risk assessment tool which assesses the impact and likelihood of the risk occurring using a 5 x 5 matrix scoring system. This risk score feeds into the decision-making process about whether a risk is considered acceptable. Higher level unaccepted risks require control measures/contingency plans to reduce them to an acceptable level. Each risk has an identified owner who is responsible for reassessing and monitoring the effectiveness of the controls in place to manage and mitigate the risk; this is recorded and reported back regularly to the appropriate committees.

Risk management is embedded within the organisation through the corporate, divisional, directorate and care group structures and the reporting and feedback mechanisms are in place (as shown in Appendix 2).

the compliance unit, which includes the corporate risk and assurance department, supports staff in disseminating good practice across the organisation. Involvement in risk management activities is also included within the trust's objective setting and individual performance review of staff and the organisation's business planning process. The corporate risk and assurance department works closely with the head of patient safety to ensure a joined-up approach to improving patient safety.

The trust is developing a new board assurance framework, which will be aligned to the Trust's strategic corporate objectives. The corporate risk register has been used as the board assurance framework in 2015/16. This is a high-level document based on structured and on-going assessment of the principal risks to the trust. It describes the controls and assurance mechanisms in place to manage the identified risks.

The executive management team and the quality and risk committee (QRC) regularly review the board assurance framework, with the most significant risks being reported to each public trust board meeting. Divisional and directorate risk registers are reviewed regularly by the organisational risk committee with high-level risks being reported to the QRC.

In addition, the trust uses its assurance map to record the outcome of any external accreditation visit or statutory inspection, and assurance that actions are being taken to address any issues identified through these inspections is provided to the board.

Risk management training is is available for trust staff, relevant to their authority and duties; this includes modules within the clinical leadership programme and senior staff induction programme. Expert guidance and facilitation from the corporate risk and assurance department supports this function. Incident reporting training is part of the trust induction programme.

Principal risks identified in 2015/16

The following risks were identified by the board as being the principal risks during 2015/16, and the associated controls overseen by the executive management team and the quality and risk committee. The most significant risks on the board assurance framework are reviewed by the board at each meeting, following recommendation from the executive management team and the quality and risk committee. These risks will therefore change during the year, however risks that have remained consistently in the list of most significant risks during the year are as follows:

Ref	Description	Rating (at March 2016)
01-13	Theatre capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	20
3.7-06	Failure to meet the minimum requirements of the Monitor Risk	20

	Assessment Framework	
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
01-06	Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	20
01-07	Risk to patient safety and experience as a result of potential trust failure to meet 95% Emergency Access Standard	20
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	20

Information governance

The board is aware of the importance of maintaining high standards of information governance, including protecting the confidentiality of patients' information. The trust has appointed the director of finance, performance and informatics as the senior information risk officer and the medical director as Caldicott Guardian. The trust also has an information governance manager and a range of policies, procedures and training to ensure that staff are aware of information governance requirements.

The information governance (IG) committee oversees the completion of the information governance toolkit on an annual basis, as well as reviewing any information governance incidents. The IG toolkit rating for the reporting period was satisfactory.

One incident has been reported to the information commissioner's office (ICO) in this period. This related to serious incident investigation. The ICO undertook an investigation and there was no formal action as a result.

Data quality

The trust has an information team, reporting to the director of transformation, who oversees the quality of data. The trust has a data quality strategy, to ensure continual improvement in the quality and integrity of data. This is monitored by the data quality board, which reports to quality and risk committee on a quarterly basis.

Review of economy, efficiency and effectiveness of the use of resources

Performance is monitored monthly by the finance and performance committee and the board, via the monthly quality and performance framework. Performance is reported through a number of key performance indicators (KPIs) through the appropriate regulatory frameworks. At the end of this reporting period, March 2016, the trust was performing positively against a large number of key indicators and was pleased with the improvement made on infection control and mix sex accommodation breach performance. However there remain challenges

including the ED four hour target, cancer two week wait, cancer 62-day standard and 18-week referral to treatment waiting time's performance. This is set out in more detail in the clinical and operational performance overview on page XX. The trust financial stability rating has been rated as 2 across the reporting year reflecting the significant financial challenges that the trust faces.

Compliance with NHS Pensions Scheme regulations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality and diversity

Control measures rare in place to ensure that all the trust's obligations under the equality, diversity and human rights legislation are complied with. The trust has completed a self-assessment against the equality delivery system (EDS) standards and has agreed annual objectives to ensure continual improvement in this area.

Climate Change Act and Adaptation Reporting requirements

The trust has undertaken risk assessments and carbon reduction delivery plans are in place, in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the trust's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the quality account attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and quality and risk committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I am confident as to the effectiveness of the system described above and that conclusion is informed in a number of ways:

The head of internal audit has provided me with reasonable assurance that the internal controls are operating effectively within the fundamental financial systems, as a whole. That opinion is that overall reasonable assurance could be provided both that controls are generally sound and

operating effectively and that the internal controls are operating effectively within the fundamental financial systems.

The internal audit plan for the year included reports across the main operational areas of the trust as follows:

- **patient safety and service quality reviews:** diagnostic test follow up; infection control; capacity planning; and complaints
- **governance reviews:** board assurance framework and risk management and Care Quality Commission registration
- **financial systems reviews:** fundamental financial systems audits, cashiers, commissioner fines and challenges and capital assets
- **clinical and cost effectiveness:** service improvement programme, South West London Pathology Service and the cost improvement programme.
- **estates, facilities, IT and information:** community properties; PFI contract management; consultant attribution data quality; IT strategy follow up; network secutrity pentration testing follow up; and information governance and accreditation.
- **human resources and payroll**: payroll; bank and agency staff; mandatory and statutory training; and locums.

A range of assurances from significant assurance to limited assurance have been given. The limited assurance reports were:

- diagnostic test follow-up
- cost improvement programme
- financial reporting and budgetary control
- mandatory and statutory training
- community properties
- consultant attribution data quality
- network security pentration testing follow-up

In addition to the head of internal audit opinion, the audit committee chairman provides a written report following each committee meeting to the next meeting of the trust board, which includes significant conclusions arising from the committee's work, concerns and recommendations. A summary of the full range of internal audits undertaken in the year and the associated level of assurance are included in Appendix 3.

Executive directors and managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The board assurance framework provides me with evidence that the effectiveness of the controls used to manage the risks to the organisation achieving its principal objectives have been regularly reviewed.

The trust's committee structures ensure sound monitoring and review mechanisms to ensure the systems of internal control are working effectively.

My review is also informed by a variety of other sources of information. These include:

- the views and comments of stakeholders
- patient and staff surveys
- internal and external audit reports
- clinical benchmarking and audit reports
- mortality monitoring
- reports from external assessments, including the CQC Chief Inspector of Hospitals inspection in February 2014
- Deanery and Royal College assessments
- accreditation inspections of clinical services
- patient environmental action team self-assessments and PLACE assessments.

The trust has produced a quality account for 2015/16 and the governance system described above has been used to validate its content and the data on which it is based.

Through review of these assurances, the board has considered any issues that fall within the definition of 'significant issue' according to the requirements of this Governance Statement.

The board remains concerned with the limited assurance previously provided by internal audit in respect of the trust's compliance with fire safety. This area, and the wider estate infrastructure, will be an area of significant focus on 2016/17. An estates plan is under development and will be closely monitored.

The board is concerned with the limited assurance provided on Financial Reporting and Budgetry Control and the Cost Improvement Programme. These are critical systems for the trust and have a direct bearing on the trusts ability to address its financial performance ratings. The limited assurance provided on diagnostic test follow up and consultant attribution raise potential issues regarding the adequacy of the controls. The board and relevant sub-committees will ensure these areas and the resultant action plans are appropriately scrutinised.

The board remain concerned with the deficit position and outturn deficit of £52.1m while noting the significant progress in delivering £XXm of cost savings. PwC were commissioned to undertake a Forensic Review and Assessment of the significant deterioration of the 2014/15 financial position. The report identified 76 actions on the 31 July 2015. 62 actions have been completed and 13 have remained open and will continue to be monitored and one was not accepted. The trust has agreed recovery trajectories against key performance targets with commissioners and NHS England.

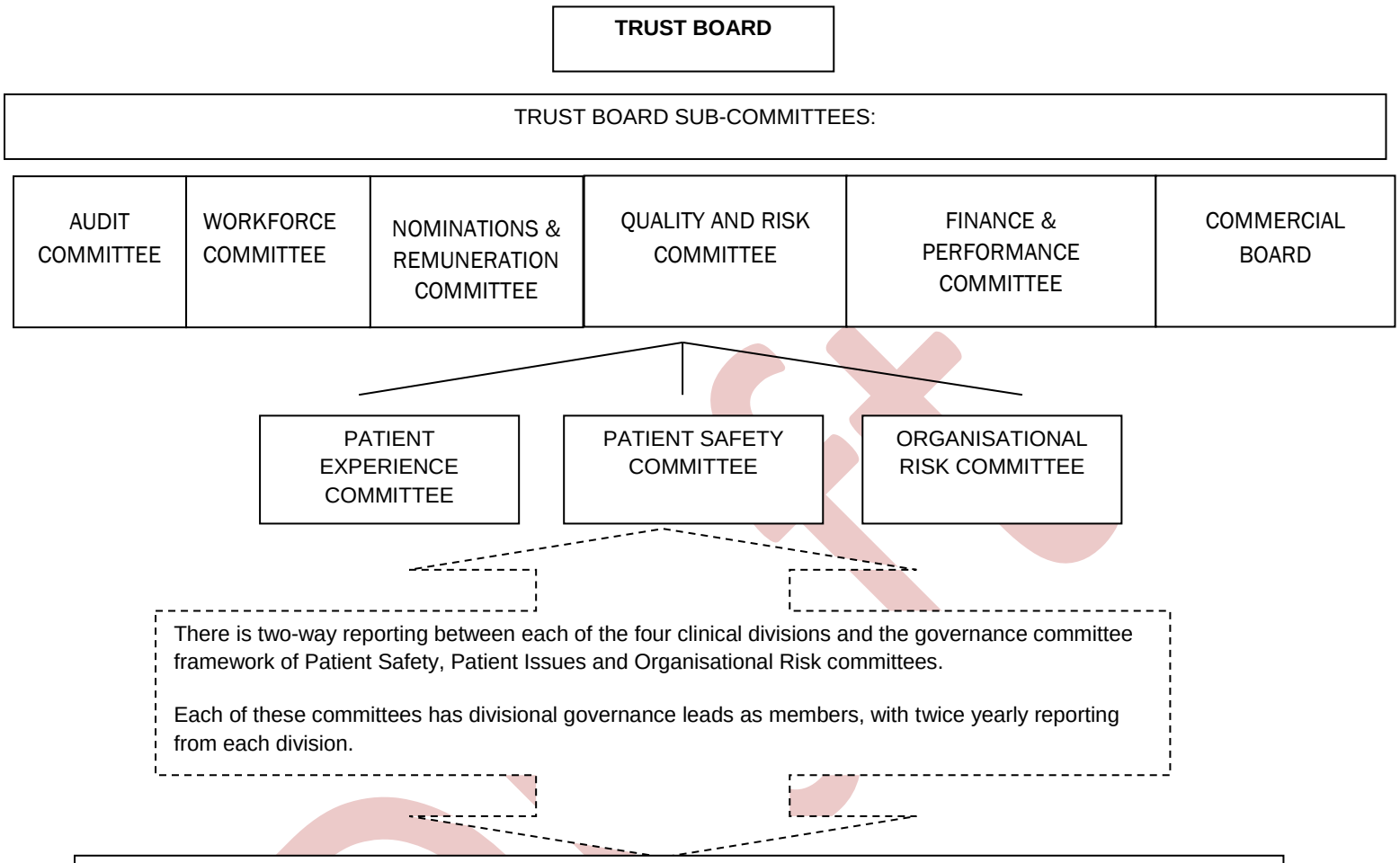
Signature required

Paula Vasco-Knight, Acting Chief Executive

St George's University Hospitals NHS Foundation Trust, May 2015

Appendix 1

Governance Framework



St George's University Hospitals NHS Foundation Trust has four clinical divisions:

WOMEN & CHILDREN, THERAPIES AND CRITICAL CARE	MEDICINE AND CARDIOTHORACIC SERVICES	SURGERY, THEATRES, NEUROSCIENCES AND CANCER	COMMUNITY SERVICES

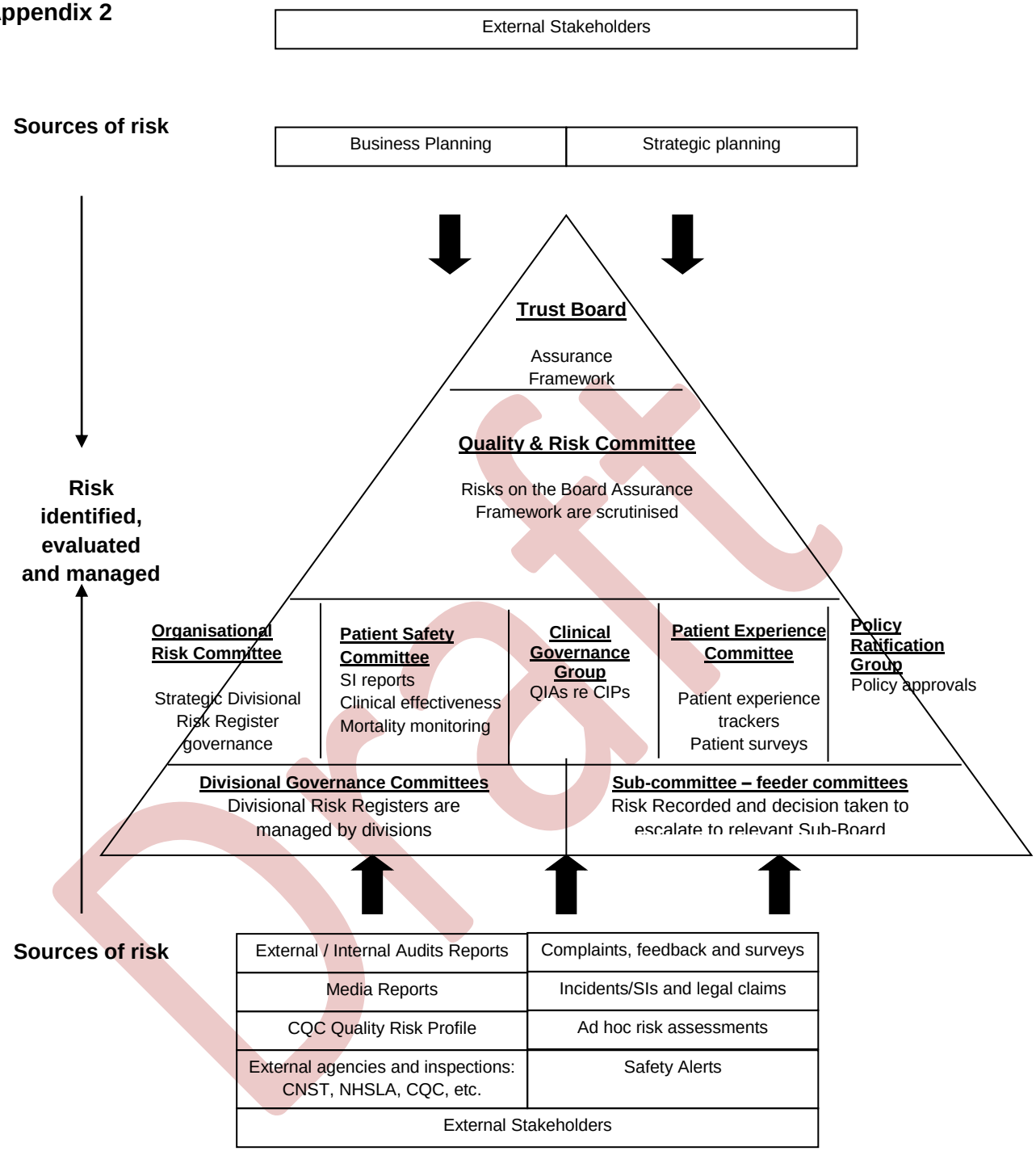
DIVISIONAL GOVERNANCE STRUCTURE:

Each of the clinical divisions has an established governance framework, at the top of which each division has a Divisional Management Board and Divisional Governance Committee.

These committees manage all aspects of governance within each division and seek and receive assurance from across their respective Care Groups.

Each of the Divisional Directors of Nursing and Governance are substantive members of the committees of Patient Safety, Patient Issues and Organisational Risk.

Appendix 2



Appendix 3 – internal audit reports issued in 2015/16

Topic	Assurance Level
Patient Safety and Service Quality	
Diagnostic Test Follow-up	**Limited**
Infection Control	**Reasonable**
Capacity Planning	**Reasonable**
Complaints	**Reasonable**
Clinical & Cost Effectiveness	
Service Improvement Programme	**Reasonable**
South West London Pathology Service	**Reasonable**
Cost Improvement Programme	**Limited**
Governance	
Board Assurance Framework and Risk Management	**Reasonable**
CQC Registration	**Reasonable**
Fundamental Financial Systems	
Financial Ledger	**Significant**
Financial Reporting & Budgetary Control	**Limited**
Accounts Payable	**Reasonable**
Income & Debtors	**Reasonable**
Cashiers	**Reasonable**
Commissioners Fines and Challenges	**Reasonable**
Capital Assets	**Reasonable**
Human Resources and Payroll	
Payroll	**Significant**
Bank and Agency Staff	**Reasonable**
Mandatory and Statutory Training	**Limited**
Locums	**Reasonable**
Estates and Facilities	
Community Properties	**Limited**
PFI Contract Management	**Reasonable**
IT/Information	
Consultant Attribution Data Quality	**Limited**
ICT Strategy Follow-up	**Reasonable**
Network Security Penetration Testing Follow-up	**Limited**
Information Governance and Accreditation	**Reasonable**

Quality report

Contents: **Page**

Chief executive's statement on quality

There is no single way to define quality, especially for such a large organisation with such a wide spectrum of services with more than one million patient contacts every year. A complex mixture of safety, clinical effectiveness and patient experience, quality is something our staff are dedicated to improving. The key questions that we ask ourselves are:

- Are our patients being treated well when they are with us?
- Are our patients free from avoidable harm?
- How can we measure this and be absolutely sure?

Our patients should be confident in the care that we provide, both in terms of specialist and local hospital services, as well as community based care in patients' homes and health centres across Wandsworth and south west London. The feedback from patients and staff is integral to understanding how well we are doing. More than 90% of patients receiving care across a range of settings have told the Department of Health that that they would recommend St George's as a place to receive treatment and be cared for through the friends and family test.

In the latest national staff survey results we have seen that staff have reflected the challenges of the year in relation to their own experience but continue to recommend the trust as a place to work or receive treatment. We have taken the results of this survey seriously and are working with staff to address its key findings.

Our Quality Account 2015/16 is full of examples of high performance and commendable practice. We remain one of the few trusts in the country to have reported lower than expected mortality rates every year since publication started. Our mean performance for harm free care was 94.4% (April 15 to March 16) against a national benchmark of 94.2%, although we did not achieve our internal target of 95%. Beneath this high level figure are reductions in the level of harm caused by pressure ulcers and VTE. In 2015/16 there was a 24% decrease in patients acquiring C.difficile whilst under our care, meaning St George's has one of the lowest rates of C.difficile in London.

We continued to focus on a comprehensive programme of clinical audit. Our community falls prevention team's early intervention service is helping reduce the burden of fragility fractures further down the line – there has been a significant increase in the number of referrals of people with osteoporosis to the service through accessing patients early. The head of the team recently presented at the Department of Health Global Progress on Safety summit in Westminster to showcase their whole systems approach to falls and fracture prevention.

We achieve these levels because the culture at St George's is to always look at how we can improve. There is a deep rooted desire running alongside clinical skill and dedication throughout the trust to always find ways to make things better for our patients even during a challenging financial climate which the trust has faced in the last twelve months.

Since the last Quality Account we have opened new facilities for patients with the commissioning of a heart failure unit, an extension of neurosurgical beds to support spinal surgery and a new neurorehabilitation unit at our Queen Mary's Roehampton site. In addition we have worked with colleagues in the CCG to implement a new community adult health service model providing care in patients' own homes.

At St George's we are committed to innovating and improving the healthcare we offer by participating in research. Our partnership with St George's, University of London, aims to bring new ideas and solutions into clinical practice. There have been important studies across both organisations including new diagnostic techniques for TB and new physiotherapy techniques for patients with lung disease. We have been active participants of the Health Innovation Network (south London) across a range of programmes.

The next year will be challenging but if we continue to work together as well as we have done over the last 12 months, I am confident that we will achieve the necessary changes and continue to improve the quality of care across the boroughs we serve.

Paula Vasco-Knight

Priorities for improvement in 2016/17

We have agreed six commitments against each domain. These priorities have been determined through a review of activity during 2015/16.

The priorities indicated below are reflected in the quality improvement strategy annual plan for 2016/17 and each element has agreed outcomes with a nominated person accountable for delivery against the priorities.

Improving patient safety

- we will create reliable processes to reduce avoidable harm
- we will establish strong multidisciplinary teams who communicate clearly across boundaries
- we will give timely and relevant feedback to teams to enable staff to be knowledgeable about patient safety
- we will promote an open and transparent culture where we listen and act on staff concerns
- we will encourage the involvement of patients in patient safety initiatives.

Improving patient experience

- we will listen to and involve people who use our services
- we will use feedback as a vehicle for continuous improvement adopting best practice where possible
- we will ensure that our patients are cared for in a clean, safe and comfortable environment
- we will ensure that our most vulnerable patients and service users are listened to and protected from harm
- we will protect patients' dignity
- we will focus on the fundamentals of care that matters to patients.

Improving patient outcomes

- we will evaluate clinical audit results and act on findings to ensure audit contributes to improvements for patients
- we will support staff to improve outcomes by provision of training and expert support
- we will communicate outcomes, promoting shared learning and prioritisation of improvement projects
- we will evidence that we are clinically effective and implementing evidence based best practice
- we will fully participate in national clinical audits and use results to improve local practice
- we will achieve best practice across all clinical areas so that patients have the best possible outcome.

Our four clinical divisions have each taken these commitments and translated them into quality improvement plans specific to their patients and services. The implementation of these plans will be overseen by our Quality and Risk Committee, which is responsible for monitoring quality at the trust.

We will be reporting on our performance against our quality improvement strategy at our (held in public) board meetings throughout 2016/17.

In last year's Quality Account we identified a number of priorities for improvement during 2015/16 to ensure that we continue to raise quality throughout the trust.

The table below indicates progress that has been made against these priorities.

Improvement priority for 2015/16	Progress as of April 2016
Create reliable processes to reduce avoidable harm. Examples of outcome measures: audit of practice against the World Health Organisation (WHO) safer surgery checklist, ward level data e.g. heat map/safety thermometer to support management action at the front line.	• We continue to conduct quarterly audits of the WHO safer surgery checklist in both theatre and non-theatre areas. This data is available at team level to support management action at the point of care. This programme will be extended to other areas that carry out invasive procedures to comply with national requirements which will be in place from September 2016. • Monthly participation in the 'classic' safety thermometer has continued across the trust and monthly reporting of the level of harm-free care by ward/clinical teams along with details of any old or new harm are communicated to clinical teams. This year the children and young person's safety thermometer has also been launched and local reporting of harms at team level is now becoming embedded. • Heat map data goes to the board monthly and is shared through the divisions. • A quality observatory has been rolled out to medicine and surgery divisions collecting data on key clinical performance.
Establish strong multidisciplinary teams who communicate clearly across boundaries through development forums for clinical governance leads.	• Regular meetings set up with the associate medical director and information sent out to support learning.
Give timely and relevant feedback to teams to	• Upgrade to Datix system to support

enable staff to be knowledgeable about patient safety.	more robust feedback. • CARE folders on wards now include learning section with local and trust wide lessons from incidents and serious incidents.
Promote an open and transparent culture where we listen and act on staff concerns through the safety forum initiative, and on-going development/monitoring in relation to the Duty of Candour.	• Duty of Candour guidance available on all wards through CARE folders. • Rolling out enhanced training around Duty of Candour.
Encourage the involvement of patients in patient safety initiatives through the roll out of the patient safety booklet/films.	• Booklet was distributed across the trust and the film placed on patientline screens. Training for staff to support patients' understanding and use of booklet.
Listen to and involve people who use our services through further improvement work in relation to the complaints function and monitoring of key metrics.	• Patient representatives involved in quality inspections to capture patient feedback. • Friends and family test feedback displayed in clinical areas, comments reflected on and action plans developed.
Use feedback as a vehicle for continuous improvement adopting best practice where possible through triangulation.	• Complaints pertinent to specific groups shared at meetings e.g. end of life care and nutrition to ensure areas for development are addressed.
Ensure our patients are cared for in a clean, safe and comfortable environment through the use of the clinical audit programme and ensuring that findings are acted upon.	• As part of the quality inspection programme, infection control and estates staff join the inspection team to provide feedback and ensure continuous improvements are made.
Ensure that our most vulnerable patients and service users are listened to and protected from harm through introduction of the dementia and delirium team and monitoring the clinical care for individual patients.	• Passports are in use for patients with dementia and learning disabilities to ensure optimum communication.
Evaluate clinical audit results and act on findings to ensure audit contributes to improvements for patients.	• Key national and local audits are reported on a monthly basis to the board as part of the quality update, helping to drive forward improvements. • Summaries of the audit programme are produced each quarter so that divisions may identify key areas for action and escalation.
Support staff to improve outcomes, promoting shared learning and prioritisation of improvement projects.	• Staff are supported to improve outcomes through the offer of regular training sessions on using clinical audit for quality improvement and also on effective data analysis and presentation. Each division has a

	dedicated resource to support them in the delivery of priority topics. Our key shared learning event is the annual clinical audit half day which this year was attended by more than 200 staff.
Evidence that we are clinically effective and implementing evidence-based best practice.	• We have just launched a project to review our approach to NICE implementation, which will help us to improve processes and provide a more complete picture of implementation. This information will help us to better identify and then manage any risks associated with non-compliance. This year we introduced new baseline assessment forms which require the evaluation of risk where full implementation has not been achieved. • Reports from confidential enquiries are prepared for the board as part of the quality update, in addition to national audits.
Fully participate in national clinical audits and use results to improve local practice.	• The reporting structures mentioned above help us to use results to improve local practice, but it is recognised that this could be strengthened and better evidenced. This will remain a key focus of the clinical audit team through the next year. • All national clinical audits are included on the annual audit programme, but it is acknowledged that there are challenges particularly in regards to data quality. These must be taken forward through local action planning. Although we participate in a number of elements of the national diabetes audit, there remain strands where we do not participate. This is being taken forward at a divisional level, with corporate support as appropriate, but remains outstanding at year end.
Aspire to achieve best practice across all clinical areas so that patients have the best possible outcome.	• Through the monitoring of national and local audits and the reporting structures detailed we endeavour to share and celebrate best practice. • We continue to build on our strong governance of mortality to ensure that a large subset of deaths are reviewed centrally and are driving the proportionate review of all deaths. Our overall mortality as measured by the HSMR remains significantly better than expected, and as measured by the SHMI our mortality is as expected or

	better than expected, depending on the 12 month period considered.

Developing the Quality Account

All NHS trusts report the same information which allows us to benchmark our performance against other trusts. This is important for not only letting us know how we are doing, but means that trusts with similar services can learn from each other.

The Department of Health (DH) and Monitor produce guidance on what should be reported in the Quality Account for NHS trusts and NHS foundation trusts.

We must comply with both Monitor's reporting requirements and those set by DH. Monitor requires us to produce an annual Quality Report which includes all of the reporting requirements of the Quality Account plus some additional requirements they have set.

Every NHS trust in the country has to report against the mandatory indicators listed below:

- Mortality rates
- Patient reported outcome measures (PROMS)
- Emergency readmissions
- Responsiveness to patients' needs
- Friends and family test for staff
- Venous thromboembolism rates (VTE)
- C.difficile rates
- Patient safety incidents

To meet both DH and Monitor's quality reporting requirements we have consolidated all the quality information into one document – the Quality Report, but for reporting purposes to DH we will call the Quality Report the 'Quality Account'.

Monitor requires the trust to report on nine voluntary indicators that reflect how we are improving patient experience, patient outcomes and patient experience. We have reported on ten this year in a bid to better reflect the services we provide and the patients we care for.

We have worked with local stakeholders to identify which indicators to include in this year's Quality Account to make sure that the areas that matter most to the people who use and provide our services are covered. These stakeholders included our staff, our council of governors, patients, local Clinical Commissioning Groups (CCGs), Wandsworth Healthwatch and Wandsworth Council.

The table below shows the voluntary indicators reported on in this document, and the indicators we will be reporting on in next year's Quality Account (2016/17). These have also been shared with stakeholders.

The voluntary indicators chosen for 2016/17 reflect some specific issues where the trust wishes to undertake a bespoke programme of work or where there is a need to continue to build on work

previously undertaken in 2015/16 to support embedding the learning in practice which is an important element of any programme. The indicators we have chosen to include fit into the three essential domains of our quality improvement strategy – improving patient safety, improving patient experience and improving patient outcomes.

Voluntary indicators in this report	Voluntary indicators chosen for next year's report (2016/17)
Patient safety • Medication errors • Patient falls • Patient safety thermometer • Offender healthcare	**Patient safety** • Medication errors • Patient deterioration • Staff learning through incident feedback • Implement learning from never events outside of theatres
Patient experience • End of life care • Complaints • Community learning disability referrals	**Patient experience** • End of life care • Complaints • Dementia and delirium
Patient outcomes • Clinical records • Sexual health in secondary schools • Clinical outcome measures in community services	**Patient outcomes** • Clinical records • Mortality

The draft Quality Account has been shared with stakeholders both for assurance and to increase understanding of the value of the report and how we record the data for each indicator. This Quality Account has been reviewed by:

- St George's Quality and Risk Committee
- St George's Audit Committee
- St George's Executive Management Team
- St George's Board
- St George's Patient Reference Group
- Wandsworth Healthwatch
- Merton Healthwatch
- Lambeth Healthwatch
- Wandsworth CCG

- Wandsworth Council Adult Care and Health Overview and Scrutiny Committee

Sharing a draft version of the report with our stakeholders has given them the opportunity to provide feedback on our performance in a formal statement. These statements are published in Annex 1. (Expected by 23rd May)

To put our performance into context we have compared our performance for all of the indicators in this report against our own performance over the last two years, and where possible and relevant, against the national average performance as published on the Health & Social Care Information Centre www.hscic.gov.uk

Testing

It is a requirement that our auditors test certain indicators to provide assurances that there is a robust audit trail.

Two indicators are mandatory. These are:

1) percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

2) percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

One local indicator needs to be selected by the trust's council of governors. For 2015/16 they have chosen XXXXX (tbc)

London Quality Standards
Why is this important

Many patients are admitted to hospital as emergencies and the treatment they receive in the first hours and days in hospital are very important. The London Quality Standards (LQS) were developed in 2011 after a review found variable, and often inadequate, involvement of consultants in the assessment and management of acutely ill patients in London. It was estimated that improved care would save 500 lives each year across the city. The standards specify the optimal way to manage patients in the crucial early period after admission. There are different standards appropriate for different groups of patients.

As part of the south west London five year strategic plan St George's agreed to progress towards meeting the full range of the LQS by the end of 2016/17. In November 2014 we participated in a peer review audit with the other acute providers in south west London. This covered the full range of LQS except for maternity. http://www.swlccgs.nhs.uk/2015/03/south-west-london-urgent-emergency-care-peer-review-visit-report/. We have continued to update this as part of our collaborative work with the other acute providers in south west London. The reporting format is slightly altered so that a standard may be reported as partially met.

How are we doing?

Our most recent report was in December 2015. In total St George's met 142 of the 176 standards in full, a further nine in part and did not meet 23. There has been improvement in most areas over the year although challenges remain, particularly around adult acute medicine, and paediatric surgery. Whilst the care required is delivered, it is not always as quickly as we would like it to be or consistently through every hour of every day. These difficulties mostly relate to competing demands on staff. It has been difficult to recruit additional acute physicians despite efforts this year.

	RED: not fully met	AMBER: partially met	GREEN: met
Adult acute medicine (22 standards)	4	2	16
Adult emergency general surgery (26 standards)	2	2	22
Emergency department (14 standards)	1	2	11
Critical care (26 standards)	1	0	25
Fractured neck of femur pathway (13 standards)	2	1	10
Paediatric acute medicine (21 standards)	6	0	15
Paediatric surgery (23 standards)	6	0	17
Urgent care centre (31 standards)	1	1	27

What are our aims?

Our aim is to continue to work towards meeting the standards by 2016/17. This is a key aim of the Acute Provider Collaborative with the other acute trusts in south west London (Croydon, Epsom and St Helier, Kingston).

Review of services

St George's is the largest healthcare provider in south west London, and one of the largest in the country. St George's serves a population of 1.3 million people across south west London. A large number of services, like cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, totalling around 3.5 million people.

Most of the services are provided at St George's Hospital in Tooting, but we also provide many services from Queen Mary's Hospital in Roehampton, health centres across Wandsworth, Wandsworth Prison and from GP surgeries, schools, nurseries and in patients' own homes.

We also provide care for patients from a larger catchment area in south east England for specialist services like complex pelvic trauma. Other services treat patients from all over the country like family HIV care, bone marrow transplantation for non-cancer diseases and penile cancer.

A number of our services are members of established clinical networks which bring together doctors, nurses and other clinicians from a range of healthcare providers working to improve clinical outcomes and patient experience. These networks include the South London Cardiac and Stroke Network and the South West London and Surrey Trauma Network, for which St George's Hospital is the designated heart attack centre, hyper-acute stroke unit and major trauma centre.

During 2015/16 we provided and/or sub-contracted 54 NHS services. We have reviewed all the data available on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2015/16 represents 100 per cent of the total income generated from the provision of NHS services by St George's University Hospitals NHS Foundation Trust for 2015/16.

The services we provide can be categorised as:

- National specialist centre

We provide specialist care to patients from across the country for complex pelvic trauma, family HIV care, lymphoedema and penile cancer.

- Tertiary care

We provide tertiary care like cancer services, neurosciences and renal services for the six boroughs of south west London and the counties of Surrey, Sussex and Hampshire.
We also provide specialist children's cancer services in partnership with The Royal Marsden NHS Foundation Trust.

- Local acute services

We provide a range of local acute services like A&E, maternity and general surgery to the people of Wandsworth, Merton, and Lambeth.

- Community services

We provide a full range of community services to the people of Wandsworth, making sure people can manage their health better by accessing the services they need closer to where they live and work and in their own homes.

Our clinical divisions

Our services are split into four clinical divisions, which all have their own clinically led divisional management boards. Each board has a divisional chair who is an experienced clinician, providing expert clinical leadership to the staff of each service so that the needs of the patients who use them are best met. Every division has a divisional director of nursing and governance who is responsible for nursing, patient experience and making sure that there are strong governance structures within their division for improving the quality of their services and safeguarding high standards of care. Each division also has a divisional director of operations who is responsible for managing the operational, business and logistical aspects of providing healthcare services. The divisional boards are made up of the clinical directors and heads of nursing who are responsible for the specialist services within their division.

Surgery, theatre, neurosciences and cancer division

Surgery and trauma clinical directorate

- Trauma and orthopaedics
- Ear, nose and throat
- Maxillofacial
- Plastic surgery
- Urology
- General surgery
- Dentistry
- Audiology

Theatres and anaesthetics clinical directorate

- Theatres and decontamination
- Anaesthetics and acute pain
- Resuscitation

Neurosciences clinical directorate

- Neurosurgery and neuroradiology
- Neurology
- Neurophysiology
- Neurorehabilitation
- Pain clinic

Cancer clinical directorate

- Cancer

Medicine and cardiovascular division

Emergency and acute medicine

- Emergency department
- Acute medicine and senior health

Specialist medicine

- Lymphoedema
- Infection department
- Rheumatology

- Diabetes and endocrinology
- Chest medicine
- Endoscopy and gastroenterology
- Dermatology

Renal, haematology and oncology clinical directorate

- Renal transplantation
- Renal
- Medical oncology
- Clinical haematology
- Palliative care

Cardiovascular clinical directorate

- Cardiology
- Cardiac surgery
- Vascular surgery
- Blood pressure unit
- Thoracic surgery

Community services

Community Adult and Children's directorate

Community Adult Health services

- Community nursing and community wards
- Intermediate care services
- Older people and neuro-therapies
- Day hospitals
- Specialist nursing
- Community learning disabilities
- Elderly rehabilitation in patient wards

Children and family services

- School and special school nursing
- Children's continuing care
- Health visiting
- Child safeguarding team
- Children's therapies and immunisation
- Homeless, refugees and asylum seeker team

Adult and diagnostic services

- Outpatient services
- Minor Injuries Unit
- Diagnostics
- Specialist rehabilitation
- Adult therapies – physiotherapy, dietetics and podiatry
- Integrated sexual health

Offender healthcare

- Primary care
- Substance misuse
- Inpatient care

Where our services are based?

Hospitals

We provide healthcare services at:
St George's Hospital, Queen Mary's Hospital

Therapy centres

- St John's Therapy Centre

Health centres

- Balham Health Centre
- Bridge Lane Health Centre
- Brocklebank Health Centre
- Doddington Health Centre
- Eileen Lecky Clinic
- Joan Bicknell Centre
- Stormont Health Centre
- Tooting Health Clinic
- Tudor Lodge Health Centre
- Westmoor Community Clinic
- Nelson Health Centre

Prisons

- HMP Wandsworth

Community

We also provide services in GP surgeries, schools, nurseries, community centres and in patients' own homes.

Find out more about our services and the clinicians and healthcare professionals who provide them on the services section of our website www.stgeorges.nhs.uk/services.

Staff friends and family test (FFT)
Staff who would recommend the trust as a place to receive treatment to friends or family

Why is this important?

One of the trust's strategic aims is to be an exemplary employer. To achieve this we must commit time, resources and effort into supporting our staff and making St George's both a great place to receive healthcare and a great place to work. Our staff are central to our success and are well-placed to judge the quality of care we provide to our patients.

How did we do?

Every year we conduct the friends and family test with our own workforce. In quarters one, two and four we give staff the opportunity to complete the survey, which comprises two questions:

- How likely are you to recommend this organisation to friends or family if they needed care or treatment?
- How likely are you to recommend this organisation to friends or family as a place to work?

Quarter three is given over to the annual national NHS staff survey.

Our scores, by quarter, are listed here:

	Staff response	Would recommend for treatment	Would recommend as a place to work
Q1	695	79%	50%
Q2	274	75%	46%
Q4	508	75%	50%
Full year	1502	76%	49%

Our aims

Our workforce is vital to the delivery of the highest quality clinical services, education and research, and will need to evolve to meet future needs. We need to value our staff and ensure they champion the trust's values. Patients have commented that happy staff result in happy patients.

We aim to further improve our scores in the friends and family staff test in 2016.

National NHS staff survey

Our 2016/17 workforce strategy action plan sets out a programme of work that will support the trust to respond to the issues raised in the national NHS staff survey. These include:

Confidence to raise concerns

The 2015 staff survey results showed that the trust had a below average score for staff agreeing that they would feel secure about raising concerns about unsafe clinical practice. The trust will be implementing the national 'Freedom to Speak Up' review. We encourage staff to raise concerns and will ensure that they receive support in doing so and feedback on the outcome of the complaint.

Tackling poor behaviour and bullying

Trust performance has remained fairly steady with 33% of staff saying that they have experienced harassment, bullying or abuse from staff in the past 12 months. The strategy to tackle bullying includes coaching and training for managers dealing with difficult staffing issues, and reviewing our policy to ensure it meets best practice standards.

Discrimination

The trust position has remained the same with regard to members of staff reporting discrimination. Of greatest concern is that 31% of black and minority members of staff report discrimination as compared to 13% of white members of staff. It is of further concern that 35% of black and minority members of staff report experiencing harassment, bullying or abuse from members of staff in the last 12 months as compared to 32% of white members of staff. Our 'St George's as One' inclusion programme was set up in 2015 to help address these issues.

Our workforce strategy explains how we aim to maximise the wellbeing of our staff and their levels of contribution and engagement. You can read the workforce strategy at: www.stgeorges.nhs.uk/about/our-strategy/strategies

Listening into Action

We recognise that as well as listening to our patients, it's also important that we listen to our staff and involve them when we try to identify where improvements could and should be made. That's why we are fully on board with the national Listening into Action staff engagement programme.

Listening into Action launched at St George's in March 2013. It's our way of working with and engaging staff at St George's. It's about achieving a fundamental shift in the way we work and lead, putting clinicians and staff at the centre of change for the benefit of our patients, our staff and the trust as a whole.

Essentially, Listening into Action is about:

- engaging all the right people around delivering better outcomes for our patients, our staff and our trust
- aligning ideas, effort and expertise behind the patient experience, safety and quality of care
- overcoming widespread challenges around staff engagement and morale
- developing confidence and capability of our leaders to 'lead through engagement' collaborating across the usual boundaries, and
- engendering a sense of collective ownership and pride.

Listening into Action complements other important projects taking place at the trust, and the change methodologies, systems and experience staff develop and gain through this programme is in many cases used to help achieve changes which are identified by Listening into Action.

We use the feedback from staff to inform our future actions and to support and enable our teams to do the very best for our patients and their families, in a way that makes us proud of our work.

Research

Why is it important?

At St George's we are committed to innovating and improving the healthcare we offer and a key way we do this is by participating in research. Our clinical staff keep abreast of the latest treatment developments and through clinical trials, patients are offered new drugs and devices and better clinical care evolves. The key reason for our participation in clinical research is to develop new and improved clinical treatments for our patients and to realise better ways to manage illness, thereby ultimately improving the health of our local community.

St George's is a collaborating site with Genomics England for the '100,000 Genomes Project' and the genetics service has begun to recruit patients from our services to contribute data and samples to the project. St George's runs the South West Thames Regional Genetic Services which provides a specialist service to people living in south west London, Surrey and West Sussex, in 18 hospitals across the region. Initially the focus will be on rare disease, cancer and infectious disease, but our clinicians are working with the project to identify other key disease areas.

St George's, in its partnership with St George's, University of London, aims to bring new ideas and solutions into clinical practice. Clinical teams are collaborating with scientists to investigate the causes of a range of diseases, to develop better ways of diagnosis and tailored treatments. There has been significant investment in new academic clinical appointments in the previous year. We look forward to growth in research activity in neurosciences, cardiology and maternal and fetal health in 2016. In the key research areas of St George's Medical School, University of London, there have important studies across both organisations.

In infection and immunity:

- New diagnostic techniques for TB.
- Pain relief in rheumatoid arthritis.
- Follow-up on babies who had meningitis.
- Looking at the ways different patients respond to antibiotics.
- Developing MRI scan techniques in cancer.
- New physiotherapy techniques for patients with lung disease.

In cardiovascular and cell sciences:

- Studies looking at cardiac problems in otherwise healthy individuals.
- Identifying new genetic influences in cardiac problems.
- New treatments for vascular dementia.
- Developing a renal inpatient nutrition screening tool.
- New ECG techniques in inherited heart conditions.

Our strong relationship with the pharmaceutical industry continues – we recruited the largest number of patients on to commercial trials in South London CRN (clinical research network). This enables our clinical staff to keep abreast of the latest developments and our patients to have access to the newest treatments within clinical trials.

Our outcomes

I. Participation:

One of the key ways of offering new treatments is through participation in clinical trials that are approved by the National Institute for Health Research (NIHR), which supports NHS and

academic institutions to deliver quality research that is patient-focused and relevant to the NHS. These studies are adopted onto the NIHR portfolio.

In the calendar year 2015, there were 198 NIHR adopted trials open and recruiting in St George's, with 7561 patients taking part. This was a decrease from 2014 where 9,021 patients took part in research. However, there were several unusual trials in both years – and having around 5,000 patients would be reasonable for 2016.

II. Approvals:

In 2015, the research office approved 168 new studies to be performed at St George's, a slight decrease (19 in total) from 2014. These range from clinical trials of medicinal products (new drugs) and medical devices, through to service and patient satisfaction studies. Just less than 70% are adopted on the NIHR portfolio, up from 30% in 2013, and 60% in 2014. Non-adopted studies include 'Proof of Concept' studies, in which our researchers and clinicians are gathering evidence that may develop into larger adopted trials, student studies and trials sponsored by commercial companies.

The approval time for studies has been a focus at St Georges in 2014. However, there are national changes in the approval system that has taken effect from 1st April 2016, meaning that approval for studies will be undertaken by the Health Research Authority, not St George's staff. Our staff will only check that we have the ability to undertake the study. Therefore, as yet, we are unclear about the extent of the impact this will have on the number of studies approved at St Georges. Our aim for 2016 is to maintain the number of studies approved and active.

III. Trials starting recruitment

In our most complex trials, we endeavour to get the study approved and the first patients recruited within 70 days of submission to the research office. We have seen a steady increase in this from 40.3% in December 2013 to 80.0% in December 2014, to 93.2% in December 2015.

IV. We intend to maintain this level in 2016. Ensuring compliance with 'Good Clinical Practice[1]' guidelines for research

All trials require one institution or company to have the legal responsibility to ensure that the trial is run safely and gathers good quality information in order to answer the research question e.g. *does a new drug lead to better outcomes compared to the standard treatment?* When we are the responsible institution (sponsor) all our trials are closely monitored by a team from the research office. When we host studies that are sponsored by other organisations or companies, we also undertake our own system of review (audit), in order to ensure best practice and optimal safety for our patients. In 2014, we aimed to audit 10% of all active trials (21 trials), and we actually reviewed 21 studies to ensure that our staff are meeting all of the regulatory and compliance requirements, and patient safety is maintained.

Our aims in 2016

I. Increase participation

[1] https://www.gov.uk/good-clinical-practice-for-clinical-trials

We intend to maintain and improve upon our patient participation rates in NIHR adopted trials at 2013 levels, understanding that 2014 and 2015 were unusual years. We hope to recruit 5,000 patients or more in 2016.

We intend to ensure that patients are made aware of the research opportunities at the trust. In order to do this we will participate in the International Clinical Trials Day on Friday 20th May 2016.

II. Approvals

In 2016, there are significant changes to the national approvals process that could affect the number of studies approved at St Georges. We intend to ensure that we maintain the number of studies approved at St Georges, at 168 with at least 70% being NIHR adopted.

III. Trials starting recruitment

We intend to continue increasing the number of trials that get up and running quickly so that the trials can be successful. We hope to achieve 90% of relevant trials recruiting their first patient within 70 days.

IV. Ensuring quality

We will continue to review 10% of all active research studies each year to provide assurance of the safety and quality of studies undertaken here.

We will continue to provide our clinicians with the opportunity to take time to develop their ideas to write successful grant applications. We will allow clinicians time to recruit patients to trials in their daily roles and support them with research staff.

Participation in clinical audits

During 2015/16, 45 national clinical audits and eight national confidential enquiries covered NHS services that St George's University Hospitals NHS Foundation Trust provides.
During that period St George's participated in 88.9% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that St George's was eligible to participate in during 2015/16 are listed in Appendix A alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 16 national clinical audits were reviewed by trust board in 2015/16. A summary of the actions agreed in response to these audits is given in Appendix B.

The reports of 14 local clinical audits were reviewed by St George's in 2015/16. A summary of the actions agreed is given in Appendix C.

Use of CQUIN payment framework

St George's University Hospitals NHS Foundation Trust's income in 2015/16 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and innovation payment framework because of the trust's contract type.

Statement from the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It regulates care provided by the NHS, local authorities, private companies and voluntary organisations that provide regulated activities under the Health and Social Care Act 2008.

The CQC registers, and therefore licenses, all NHS trusts. It monitors trusts to make sure they continue to meet very high standards of quality and safety. If services drop below the CQC's fundamental standards it can require action to be taken, impose fines, issue public warnings, or launch investigations. In extreme cases it has the power to close services down.

St George's University Hospitals NHS Foundation Trust is registered with the CQC and is licensed to provide services from each of its locations. The trust has no conditions placed on it and the CQC has not taken any enforcement action against the trust in 2015/16.

The CQC inspection framework focuses on five domains:

- Are services **safe**? *Are people protected from abuse and avoidable harm?*
- Are services **effective**? *Does people's care and treatment achieve good outcomes and promote a good quality of life, and is it evidence based where possible?*
- Are services **caring**? *Do staff involve and treat people with compassion, kindness, dignity and respect?*
- Are services **responsive**? *Are services organised so that they meet people's needs?*
- Are services **well led**? *Does the leadership, management and governance of the organisation assure the delivery of high-quality patient-centred care, support learning and innovation and promote an open and fair culture?*

The CQC rating system has four categories - **outstanding**, **good**, **requires improvement** or **inadequate**. NHS trusts are given an overall rating and a range of services within the trust are also given one of these four ratings.

How did we do?

In February 2014 the trust was subject to a full inspection using the new CQC inspection methodology against the five domains. The CQC inspected the treatment and care provided at St George's Hospital, Queen Mary's Hospital, St John's Therapy Centre and selected community services provided from other health centres in Wandsworth.

The CQC found the overall standard of care to be **good** across all sites and has awarded the trust an overall **good** rating, with some aspects of care rated as **outstanding**. St George's and Queen Mary's Hospitals both received **good** overall ratings.

The CQC rated 62 specific standards. Out of these, **four were rated outstanding**, **50 were rated good** and **eight were in the 'requires improvement' category**. None of our services were judged inadequate. The full breakdown of how our hospitals performed against each of the five CQC essential domains is available over the coming pages.

CQC statement on St George's Hospital

Service	CQC essential domain - safe	CQC essential domain - effective	CQC essential domain - caring	CQC essential domain - responsive	CQC essential domain - well led	Overall
A&E	Good	Not assessed	Good	Good	Good	Good
Medical care	Requires Improvement	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Good	Good	Good	Good	Good
ITU/CCU	Outstanding	Good	Good	Good	Outstanding	Outstanding
Maternity	Good	Good	Outstanding	Good	Good	Good
Children & Young People	Good	Good	Good	Good	Good	Good
End of Life Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Outpatients	Requires Improvement	Not assessed	Good	Good	Good	Good
Overall	**Requires Improvement**	**Good**	**Good**	**Good**	**Good**	**Good**

CQC statement on Queen Mary's Hospital

Service	CQC essential domain - safe	CQC essential domain - effective	CQC essential domain - caring	CQC essential domain - responsive	CQC essential domain - well led	Overall
A&E (Minor Injuries Unit)	Requires Improvement	Not able to rate	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not able to rate	Good	Requires Improvement	Good	Good
Community Inpatient Services	Not rated at this time	Not rated at this time	Not rated at this time	Not rated at this time	Not rated at this time	Not rated at this time
Overall	Requires improvement	Good	Good	Good	Good	Good

The audit of our community services at Queen Mary's Hospital, St John's Therapy Centre and other health centres was a pilot to help the CQC develop the methodology for auditing community services in the future. The CQC is not yet rating community services so no rating was given for the community inpatient service at Queen Mary's or for the services based at St John's and our other health centres.

The CQC reported its findings back to us at a quality summit that included representatives from:

- St George's University Hospitals NHS Foundation Trust
- The CQC
- The Trust Development Authority (TDA)
- NHS England
- Wandsworth Council
- Healthwatch Wandsworth
- Wandsworth CCG
- Merton CCG.

In its report on the trust, the CQC highlighted numerous examples of commendable practice, including:

- outstanding maternity care underpinned by information provided to women and partners and robust midwifery staffing levels with excellent access to specialist midwives

- exceptional end of life care demonstrated within the maternity department
- outstanding leadership of intensive care and high dependency units with open and effective team working and a priority given to dissemination of information, research and training
- excellent multidisciplinary working within and across community and acute teams
- the functioning of the hyper acute stroke unit, short term reablement and rehabilitation service
- the well led, integrated working and calm environment within A&E
- multi-professional team working in neuro theatres
- systems developed by the trust to promote the safety of children, young people and families
- an evident culture of positive learning from medicine administration errors
- development and use of DVDs to engage staff with ongoing practice improvements.

As well as highlighting some aspects of care which required improvement the CQC also asked that we take action to ensure staff awareness and implementation of the Mental Capacity Act at Queen Mary's Hospital. The CQC noted that most staff had attended or completed training on safeguarding adults and that there was appropriate specialist input through the trust's safeguarding lead and two specialist learning disability nurses. However, varying levels of understanding of the Mental Capacity Act were identified.

During 2015/16 the trust has continued to take action to address the two issues identified by the CQC. A formal action plan was developed and approved by the trust board before being shared with the CQC. The plan set out how the trust would ensure improvements in the availability of medical records in outpatient clinics, it also set out the measures we would take to ensure that trust staff at Queen Mary's Hospital (QMH) have a good level of understanding of the Mental Capacity Act in order to deliver safe, responsive and effective care.

There has been an improvement project in the corporate outpatient department and better availability of medical records was just one of the improvements made. This is monitored on an ongoing basis.

The trust designed and delivered a tailored training programme to all staff at QMH around the implementation of the Mental Capacity Act and all staff have now attended and have evaluated the training and a case note audit showed practice had improved.

Progress on the action plan was been presented to the trust's commissioners and the CQC on a quarterly basis and both commissioners and the CQC indicated that they assured good progress has been made to improve quality of care where needed. As such the action plan was closed in July 2015, however all actions in the plan continue to be monitored by the trust.

The CQC has announced that they will return to the trust on 21st June 2016 to carry out a full inspection as part of their continued announced inspection regime. The trust has started to prepare for the inspection, the results of which will become available in early autumn.

Data quality

The collection of data is vital to the decision making process of any organisation, particularly NHS trusts like St George's. It forms the basis for meaningful planning and helps to alert us to any unexpected trends that could affect the quality of our services.

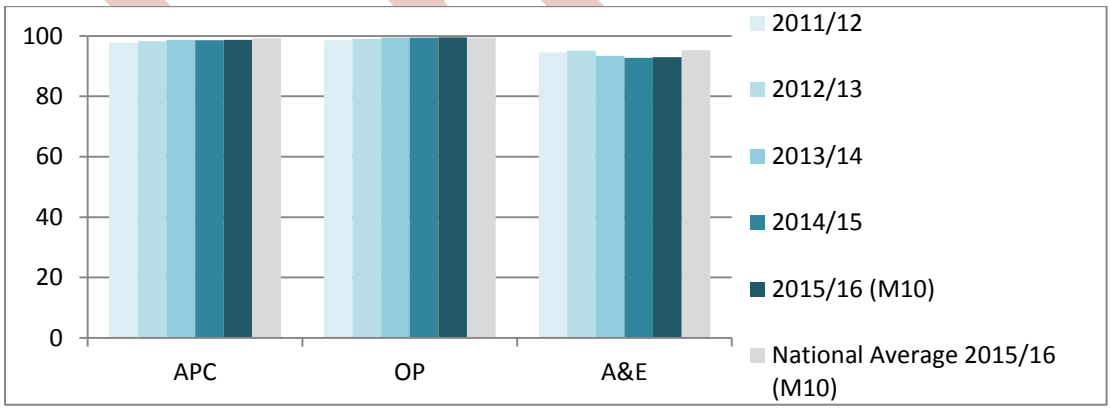
Most data is gathered as part of the everyday activity of frontline and support staff who work throughout the trust in a huge variety of settings. It is important that we accurately capture and record the care we provide and the information in this report aims to demonstrate how well we are doing this. We have been working closely with our IT suppliers this year to increase the robustness of our data capture and processing.

St George's submitted records during 2016 for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

HES is the national statistical data warehouse of the care provided by English NHS hospitals and for NHS hospital patients treated elsewhere. The body provides a data source for a wide range of healthcare analyses of the NHS, government and many other organisations and individuals.

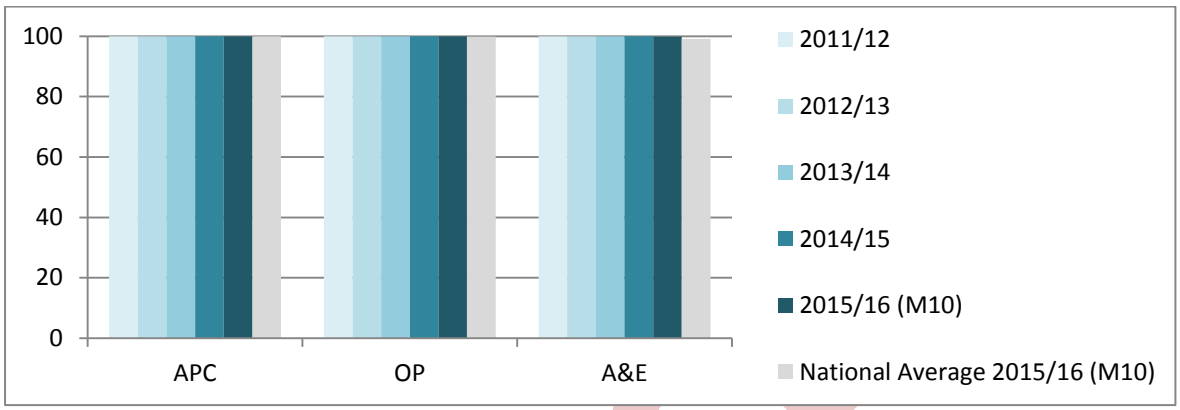
The percentage of records in the published data which included the patient's valid NHS number was:

Valid NHS no	APC	OP	A&E
2015/16 (M10)	98.7	99.5	93
2014/15	98.6	99.4	92.7
2013/14	98.7	99.4	93.4
2012/13	98.3	99	95.1
2011/12	97.7	98.6	94.5
National Average 2015/16 (M10)	99.2	99.4	95.3



Our NHS Number completeness remains good, but is behind the national average for admitted care and A&E. St George's will be taking the following actions to improve data quality. We have a data quality improvement strategy which we have developed with our commissioners that details planned improvements in the way our Patient Administration System (PAS), Cerner, accesses the national Patient Demographic Service (PDS) that should see these numbers improve next year.

The percentage of records in the published data which included the patient's valid general medical practice was:



Valid GP	APC	OP	A&E
2015/16 (M10)	99.9	99.9	99.8
2014/15	100	100	100
2013/14	100	100	99.9
2012/13	100	100	100
2011/12	100	100	100
National Average 2015/16 (M10)	99.9	99.8	99.1

Note: The data quality figures shown above are correct as at month 10 (April 2015 to January 2016 data). This is the most recent data available.

We continue to achieve exemplary scores in registered GP practice recording, where we perform better than the national average across admitted, outpatient and A&E services.

Information governance

Information governance is the term used to describe the standards and processes for ensuring that organisations comply with the laws, regulations and best practices in handling and dealing with information. Information governance ensures necessary safeguards for, and appropriate use of, patient, staff and business information.

The key objective of information governance is to maintain high standards of information handling by ensuring that information used by the organisation is:

- held securely and confidentially
- obtained fairly and efficiently
- recorded accurately and reliably
- used effectively and ethically
- shared appropriately and lawfully.

We have an ongoing information governance programme, dealing with all aspects of confidentiality, integrity and the security of information. Annual information governance training is mandatory for all staff, which ensures that everyone is aware of their responsibility for managing information in the correct way. An internal audit conducted in 2015/16 gave the trust 'reasonable' assurance that the trust is managing information appropriately and that staff are aware of their responsibilities.

Our patient administration system increased both the security and accuracy of information at the trust. All staff accessing the system use a secure and strictly authenticated smartcard which defines what they are permitted to access in the system. Virtual desktops are now in use across two thirds of the trust, increasing the security and availability of our systems. The trust has introduced a new electronic system for managing referrals improving both the accuracy and allocation of appointments. The trust is rolling out electronic document scanning across a number of areas moving away from a dependence on paper records.

How did we do?

Each year we submit scores and provide evidence to the Department of Health (DH) by using the NHS Information Governance Toolkit. The toolkit is an online system which allows NHS organisations and partners to assess themselves against DH information governance policies and standards. It also allows members of the public to view each organisation's score and compare them.

St George's University Hospitals NHS Foundation Trust information governance assessment report overall score for 2015/2016 was 73% per cent and was graded green, or 'satisfactory' according to the criteria set nationally. This is the highest grading possible, and can only be awarded by achieving an attainment Level 2 on every requirement in the NHS Information Governance Toolkit.

The information quality and records management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

You can explore the information governance scores for St George's, and other organisations, at https://www.igt.hscic.gov.uk. St George's is listed as an acute trust and our organisation code is RJ7.

Year	Information governance assessment score (per cent)	Grade
2015/16	73	Green
2014/15	77	Green
2013/14	79	Green
2012/13	79	Green
2011/12	77	Green

Clinical coding error rate

St George's University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

Improving patient safety

Reducing patient falls in the community and whilst under the care of the hospital

Why is this important?

People aged over 75 suffering falls is one of the main causes of emergency admissions to hospitals. Incidents of falls within health-care environments equally contribute to the length of stay of complex patients, as well as presenting a risk to both patients and the organisation.

Unfortunately, we will never be able to completely eliminate the risk of our patients falling. We know that even in the community one in three people over the age of 65 will fall, rising to one in two for over 80 year olds. However we also know that falling is not an inevitable part of ageing and that reversible risk factors can be addressed to reduce the risk of falling and fracturing.

The inpatient hospital population has some of the similar characteristics as the community dwelling population, and in addition there are the additional risks around acute illness and sudden change in environment which presents further challenges for those impaired by cognition/vision etc. Following the acute phase of management the patient begins their rehabilitation. An inherent part of patient rehabilitation is risk taking, which must balance the management of risk with the need to facilitate progress and enable goal attainment. We try to make sure that a multifactorial falls and bone health risk assessment is completed and that a care plan to reduce the individual's risk factors is implemented, providing a quality patient experience within a safe environment.

How did we do?

For hospital inpatient services we have:

- implemented an electronic multifactorial falls risk assessment in line with the NICE falls guidelines
- developed an interim paper-based multifactorial falls risk assessment for clinical areas that are not yet electronic
- developed and implemented a bed rails risk assessment tool which must be completed for all adult inpatients on admission to hospital
- conducted an audit of bed rail risk assessment across the trust and have implemented an action plan to improve compliance
- developed patient information leaflets on falls prevention and the use of bed rails
- been running monthly patient simulation study days to promote best clinical practice for falls and other harms.

We have participated in the National Inpatient Falls audit. The results showed that we are below the national average for falls resulting in moderate/severe harm or death per 1000 bed days (0.03 versus 0.19) and slightly below the national average for number of falls per 1000 bed days (6.12 versus 6.63).

However, the audit showed that in seven key indicators of good falls prevention, we achieved amber status for four areas (assessment of delirium, assessment of continence, call bell in reach, walking aid in reach) and red status for three areas (postural blood pressure measurement, visual assessment and medication review). An action plan to improve practice has been developed and we will be participating again in the autumn.

There has been no significant reduction in the number of inpatient falls across the trust this year.

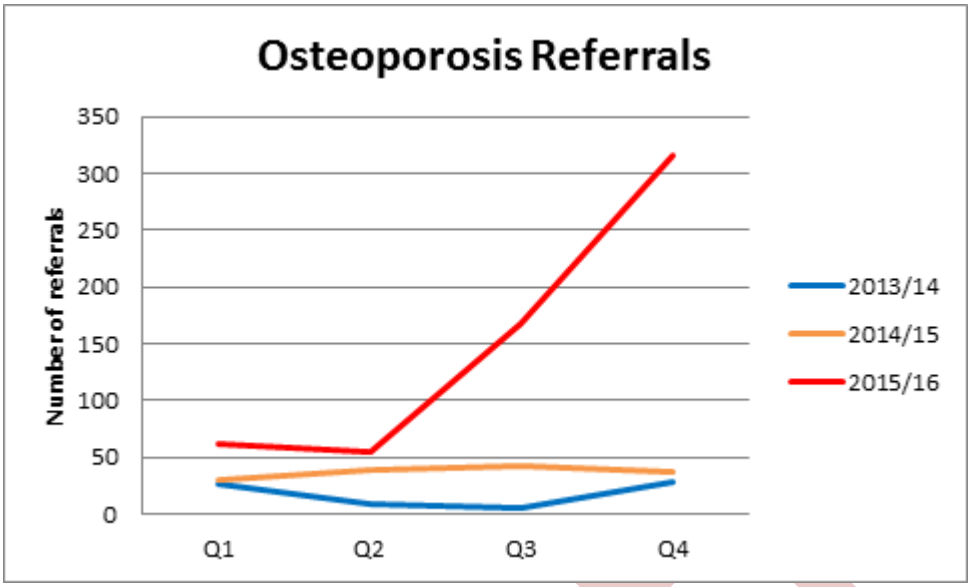
Community based services:

We have an integrated falls and bone health service (IFS&BH). This is predominantly a prevention-focused service that dovetails with other reactive community services and is fully integrated with the hospital-based sister services such as osteoporosis/orthopaedics/older people services.

Following assessment, optimisation of the patient is a clear target for the team. This requires multiple communications, influencing other health and non-health professionals and implementing a tailored treatment plan in order to address the reversible risk factors for falls and fractures. Assessments are carried out in patients' homes, health venue clinics and at satellite clinics in non-health venues such as sheltered accommodation sites. Part of the service provision is the running of 25 community based exercise groups a week – six of these with transport to ensure a fair and accessible service to all. Another arm of the service is the bone boost provision – an early prevention model targeting the population at risk of fracture https://www.youtube.com/watch?v=-dsQ1ula9hM

Building on the success of joint working with the acute-based services, further development work has continued this year:

- Development of the Denosumab PGD – an innovative work stream about skilling up the IFS&BH pharmacist and physiotherapists to provide this important injection for the prevention of fractures in community settings for more frail patients.
- Evolution of a niched falls prevention exercise group for our diabetes patients – recognising their more complex needs and a different approach.
- Development of a rapid referral service for vertebral fracture patients – a smooth pathway for immediate access to appropriate vertebral bracing support has been implemented with the orthotics department.
- Monthly integrated falls and fracture meetings between the rheumatology, renal, orthopaedic consultants and head of IFS&BH to ensure service developments and pathway improvements for fragility fracture patients especially with hip fractures.
- Monthly meetings with dexa scan technician and fracture liaison nurse with IFS&BH clinical lead to ensure effective and efficient pathway design – accessing patients early with community intervention following a diagnosis of osteopenia/osteoporosis. This early intervention prevention service will help to reduce the burden of fragility fractures further down the line. The graph below shows the significant increase in referrals through closer working together.



This year has also seen the implementation of ARCH – Active Residents in Care Homes – our joint research feasibility trial with St George's and Kingston University. This is an exciting project which will yield some important findings about the prevention of falls and fractures for this population. The clinical team for this £300k research trial funded by the CSP are all from the IFS&BH team. The trial will continue into 2016/17.

Presentations and posters:
Two clinical audit posters were presented at the trust's clinical governance day.

In addition to our integrated working within our own organisation we have also led on an integrated work stream at Kingston hospital – the falls prevention navigator role which was presented at the Chartered Society of Physiotherapy (CSP) conference in Liverpool this year. http://www.physiotherapyuk.org.uk/programme

Bernadette Kennedy, head of integrated falls and bone health, also presented at the recent Department of Health Global Progress on Safety Summit in Westminster regarding whole systems approaches to falls and fracture prevention: http://mhforum.org.uk/conferences/progress-on-safety-learning-together-event/

Our aims

- To reduce the admissions for falls and fragility fractures in Wandsworth through our community provision.
- To reduce the current rate of reported falls during an inpatient episode.
- We will continue to identify the trends and themes and implement targeted action plans through structured evaluation and benchmark ourselves against other organisations when possible.
- We aim to maintain our position as a leading falls and fracture prevention service in the country, continuing to work with our patient populations to deliver innovative services that meet individual and population needs.

Patient safety thermometer

Making sure that patients do not suffer avoidable harm is a key focus for the trust. The 'classic' safety thermometer is a quick and simple point-of-care tool for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm-free care.

Developed by the NHS for the NHS, the safety thermometer collects data on high risk areas including falls, pressure ulcers, urinary catheter-related infections and blood clots. The safety thermometer allows us to merge patient safety data across all the teams and wards in the trust, with the built-in analysis charting functions allowing us see the results straight away so we always have a clear picture of what is happening in any service at any time.

We have regular and reliable data for all of the high risk areas listed above, across all inpatient and community services. All data recorded on the safety thermometer is submitted to the Health & Social Care Information Centre with monthly national reports developed and published at www.hscic.gov.uk/thermometer . Teams can then be given feedback on the proportion of their patients who are harm-free which gives them a powerful tool for improvement.

In 2015/16 we collected data on 15,478 patients, of which 94.4 per cent were free of the harms being measured in this way. This compares with a national benchmark of 94.2%.

Next year for the 'classic' safety thermometer we will try collecting the data in a slightly different way which will help us to identify where harms have developed. This will make the data more useful to us in identifying areas where care might be improved.

A safety thermometer specific to children and young people has been developed by the national team and we have been piloting this at St George's since June. The harms that are measured include deterioration, extravasation, pain and skin integrity. The process of audit and action planning are becoming embedded. Each month a report is provided to all children's wards and they are asked to report back actions against harms.

During the year there has been a lot of work undertaken to reduce medication errors, and piloting the Medication Safety Thermometer was part of this work. See below.

Reducing medication errors

Over the years we have worked hard to develop and maintain our strong reporting culture. Following their audit of the trust in February 2014, the CQC reported that there is an evident culture of positive learning from medicine administration errors at St George's.

This year the National Reporting and Learning System has reported that St George's medication error reporting is higher than the national benchmark for reporting medication incidents.14.1% of all incidents reported involved medication for St George's in comparison to 10.3% for all acute teaching organisations. In Q1-3 of 2015/16 the trust reported 1202 medication incidents, reflecting a good safety culture. Of these incidents, 93.0% resulted in no harm, 5.6% in low harm and 1.2% in moderate harm. One medication incident (0.08%) resulted in severe harm. The most common types of error were omissions and delays to administer medication and administering the wrong dose of medication.

Degree of harm:

No harm – 93.0%
Low harm – 5.6%
Moderate harm – 1.2%
Severe harm – 0.08%

The trend of reporting medication incidents continued to increase over 2015/16, without an increase in the degree of harm. 94.9% of incidents were no harm in Q3 201/16 compared to 92.1% for Q3 of the previous year.

The pharmacy department has an intensive medication safety teaching programme for clinical staff and our pharmacy team manage a comprehensive audit programme, including auditing prescribing accuracy, medicines reconciliation, antibiotic point prevalence, medication handling and medication safety. The pharmacy medication safety team also co-ordinates medication safety monitoring visits to clinical areas to monitor medication safety issues.

During 2015/16 medication safety visits have been conducted in community services, ward and non-ward areas including radiology and endoscopy.

Implementing the early warning score indicator at HMP Wandsworth

Why is this important?

We provide all healthcare and substance misuse services to the 1,665 offenders at HMP Wandsworth, the largest prison in the UK. The Jones Unit is a six-bedded inpatient facility in the prison. The unit is a 'step-down' from a hospital ward and is used for offenders whose condition needs closer monitoring than can be provided on an outpatient basis whilst they stay in their cell. Prisoners requiring isolation are also located on the Jones unit. The unit reduces the need for unwell offenders to be transferred to St George's Hospital, freeing up beds in the hospital for other patients.

The early warning score indicator is a simple tool in a patient's observation notes used by medical and nursing staff to determine the severity of illness. A number of observations are regularly recorded on the chart which allows any deterioration to be quickly identified. The observations recorded are:

- heart rate
- respiratory rate
- blood pressure
- level of consciousness
- oxygen saturations
- temperature.

The early warning score (EWS) indicator has been used at St George's and Queen Mary's Hospital for a number of years and our aim for 2013/14 was to introduce the early warning score indicator to offender healthcare services and subsequently to devise an electronic template so that the EWS is integral to the clinical information system and to patients' medical record.

How did we do?

In 2013/14 the early waning score indicator was successfully implemented at HMP Wandsworth with all patient observation charts on the Jones unit including the indicator. All offender healthcare service staff were trained in the use of the early warning score indicator meaning that any deterioration was identified quickly.

An electronic template was also devised and put into use in quarter four of 2015/16, and the first audit illustrated that the EWS tool was used for patients on 118 occasions. This was significant as not only has it shown a significant improvement in numbers recorded, the quality of the assessments were also improved by the electronic nature of the template as it automatically calculates scores so as to remove the opportunity for error.

Our aims

Further work is required in 2016/17 to maintain a consistent approach in the use and recording of EWS, and to subsequently expand its use to cover emergency response and substance misuse observations.

Mortality

Why is this important?

The summary hospital-level mortality indicator (SHMI) is intended to be a single consistent measure of mortality rates. It shows whether the number of deaths linked to an organisation is more or less than would be expected, when considered in light of average national mortality figures, given the characteristics of the patients treated there. It also shows whether that difference is statistically significant.

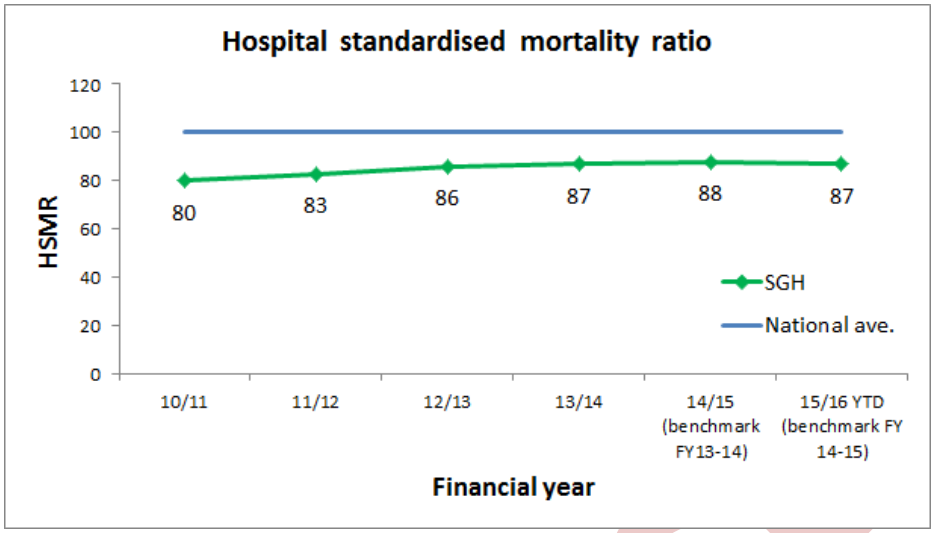
Our outcomes

Our SHMI continues to be either lower than expected, or in line with what would be expected. The table below summarises the quarterly publications for this period. As well as considering our overall position we look at this data by diagnosis group and investigate areas where mortality may be higher than expected.

Publication date	Reporting period	Ratio	Banding
April 2015	October 2013 – September 2014	0.86	Lower than expected
July 2015	January 2014 – December 2015	0.89	Lower than expected
October 2015	April 2014 – March 2015	0.92	As expected
January 2016	July 2014 – June 2015	0.90	Lower than expected
March 2016	October 2014 – September 2015	0.91	As expected

Source: Health and Social Care Information Centre

At St George's we continue to use the hospital Standardised Mortality Ratio (HSMR) in addition to the SHMI to monitor mortality. The chart below shows our performance over the last few years. With the HSMR, if our mortality matched the expected rate our score would be 100. The HSMR indicates that St George's mortality is consistently significantly better than expected.



Source: Dr Foster Intelligence

These data are reviewed by the trust's mortality monitoring committee which meets on a monthly basis. The group, which is chaired by the associate medical director for governance and has members from across the trust also considers mortality data at diagnosis and procedure level and reviews all deaths in hospital following an elective admission. By examining this range of data we are able to scrutinise our outcomes and the care we provide to patients. Where there are lessons to be learnt these are identified and acted upon and where best practice is observed this is acknowledged and shared.

Palliative care coding

As it includes all deaths, the SHMI makes no adjustment for palliative care. The Health and Social Care Information Centre publishes contextual indicators to support interpretation of the SHMI, one of which is 'the percentage of deaths with palliative care coding'. This presents crude percentage rates of deaths that are coded with palliative care either in diagnosis or treatment fields. The data displayed below shows the percentage of deaths with palliative care coding for the trust compared to the national average.

Publication date	Reporting period	St George's	National
April 2015	October 2013 – September 2014	29.0%	25.3%
July 2015	January 2014 – December 2014	28.8%	25.7%
October 2015	April 2014 – March 2015	29.3%	25.7%
January 2016	July 2014 – June 2015	29.4%	26.0%
March 2016	October 2014 – September 2015	29.6%	26.6%

Source: Health and Social Care Information Centre

Our aims

Our aim for the coming year is to further strengthen our governance of mortality and we hope to achieve a mortality ratio which is lower than expected. We will continue to expand our scrutiny of deaths and to identify opportunities for learning. We are committed to implementing the anticipated national mortality case record review programme.

Assessing risk of VTE in admitted patients

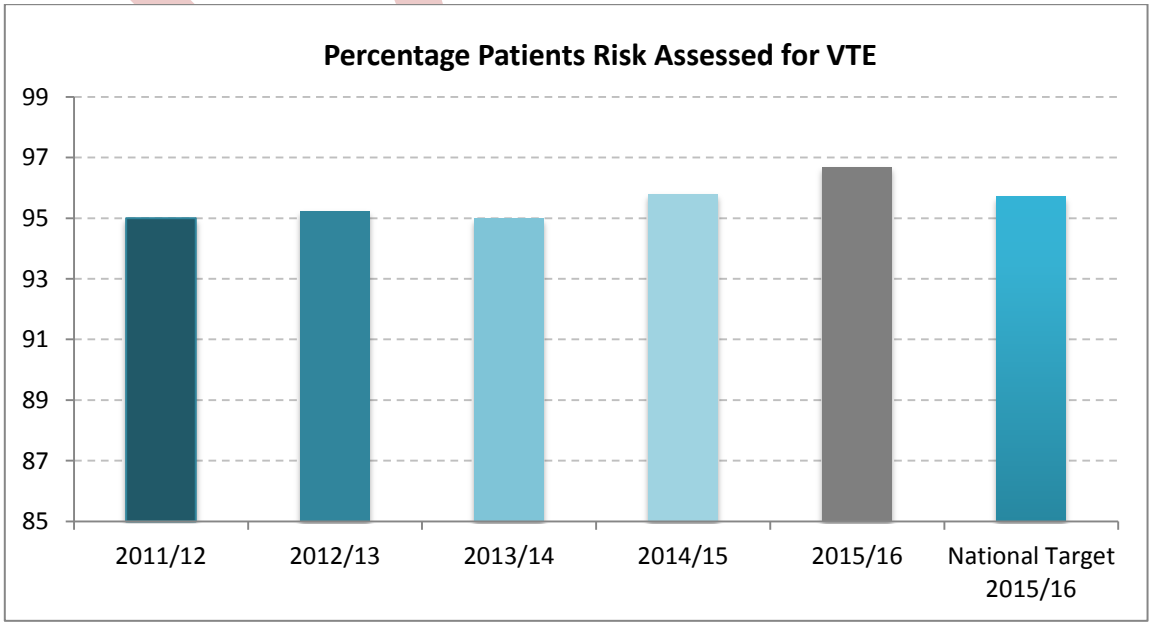
Why is this important?

Venous thromboembolism (VTE) occurs when a deep vein thrombosis (blood clot in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs) causes substantial long term health problems or death. VTE is associated with long periods of immobility and can be prevented with appropriate preventative measures at the earliest possible time according to the needs of each patient.

Risk assessments for VTE ensure that we intervene with preventative measures at the earliest possible time, it also helps us to identify any instances of deep vein thrombosis or pulmonary embolus occurring within 90 days of admission so that we can investigate and learn how to avoid these in the future.

How did we do?

Every trust in the country is required to report the number of documented VTE risk assessments being conducted on admission as a proportion of the total number of hospital admissions. In addition they are also required to report the proportion of cases where there is a documented risk assessment that appropriate thromboprophylaxis has been prescribed. In 2015/16 there were 190,362 risk assessed admissions at St George's and Queen Mary's Hospitals and of these 96.7% were given VTE risk assessments, thus exceeding the national target for VTE risk assessments of 95% and our 2014/15 performance of 95.89%.



Infection control
Why is this important?

The prevention and control of healthcare-acquired infections at St George's is a top priority. Our aim is to make our facilities as clean and safe for patients as possible. Alongside the cleanliness of our hospital, we also continue to focus on our programme of comprehensive training for staff, stringent hand hygiene and careful use of antibiotics.

Our infection control team, made up of doctors and nurses, works around the clock, monitoring infections and providing ward staff with advice on how to prevent, treat and contain the spread of infections to our patients.

Infections can spread in many different ways. For that reason we use an array of measures to stop the spread of infection to our patients. The success of these measures can be assessed in many different ways. In particular we carry out surveillance for several 'alert organisms'. One such organism is *Clostridium difficile.*

What is *Clostridium difficile*?

Clostridium difficile (*C.difficile*) is a bacterium that can cause mild to severe diarrhoea and inflammation of the bowel. *C.difficile* infection can be prevented by a range of measures, including good hand hygiene, careful use of antibiotics and thorough environmental cleaning. By monitoring the prevalence of infections acquired in hospital we can obtain information on how good we are at adhering to high standards of environmental cleanliness, hand hygiene, and isolation of infectious patients . We can also introduce better measures to reduce the risk of infection for all of our patients.

C.difficile is present naturally in the gut of around 3% of adults and 66% of children. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, *C.difficile* bacteria can multiply and cause symptoms such as diarrhoea and fever.

As *C.difficile* infections are often caused by antibiotics, most cases usually happen in a healthcare environment, such as a hospital or care home. Both appropriate and inappropriate antibiotic use can cause *C.difficile* infection and there is always a balance of risk in treating patients with antibiotics. A strong antimicrobial stewardship program is important to ensure appropriate antibiotic usage only. Transmission can occur from patient to patient however with good modern infection control practices this is not common, although in the past it was far more common. Older people are most at risk from infection, with the majority of cases (80%) occurring in people over 65.

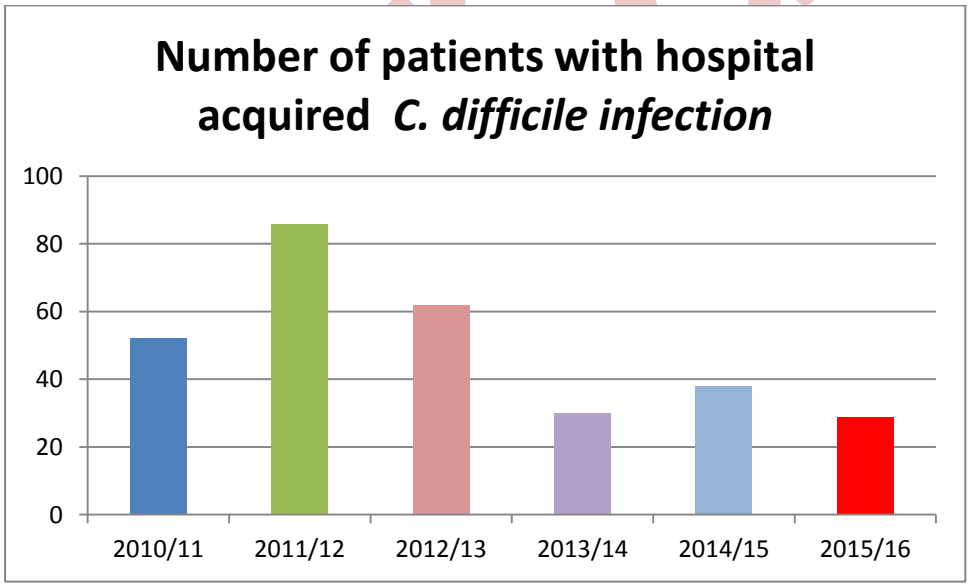
Even with stringent adherence to control measures, it is not possible to prevent all infections with *C. difficile.*

Most people with a *C.difficile* infection make a full recovery. However, in rare case the infection can be protracted and occasionally fatal.

Our *C.difficile* outcomes

In 2015/16, our aim was to have fewer than 31 hospital-acquired infections with *Clostridium difficile.* During the year 2015/16 29 patients acquired *C.difficile* whilst under our care. This represents a decrease of 24% compared to last year.

Year	Number of patients with hospital-acquired *Clostridium difficile* infection
2010/11	52
2011/12	86
2012/13	62
2013/14	30
2014/15	38
2015/16	29



Our aim

Nationally the number of infections in 2015/16 has increased. Given the national increase, the mandatory target for St George's remains at 31 but our target is to reduce the number of infections further in 2016/17.

Rate of patient safety incidents and percentage resulting in severe harm or death

Why is this important?

Modern healthcare is increasingly complex and occasionally things go wrong, even with the best practices and procedures in place.

An open reporting and learning culture is important to enable the NHS to identify trends in incidents and implement preventative action. The rate of reported patient safety incidents eg unintended or unexpected incidents which could have led, or did lead, to harm for one or more patients receiving NHS healthcare, is expected to increase as a reflection of a positive patient safety culture.

This view is supported by the National Patient Safety Agency who state "organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are".

Patient safety incidents

There were 11,216 reported patient safety incidents in 2015/16 compared to 10,187 the previous year. This shows that we continue to actively report as many incidents as we can, demonstrating that at St George's we are committed to developing good systems that enable us to learn from things that go wrong and prevent them from happening again.

Year	Number of patient safety incidents
2015/16	11,216
2014/15	10,187
2013/14	9,739
2012/13	9,084
2011/12	9,663

The number of never events declared over this period was eight.

Division	Service	Never event
Surgery	Dentistry	Retained foreign object (Dental Roll)
Surgery	ENT	Wrong Site Surgery
Surgery	Trauma & Orthopaedics	Retained foreign object
Therapeutics	Critical Care	Misplaced NG Tube
Therapeutics	Critical Care	Maladministration of insulin
Women's	Obstetrics	Retained foreign object (swab)
Community services	Dermatology	Wrong site surgery
Renal, Haematology & Oncology	Renal Medicine	Retained foreign object

Improving patient experience

Community learning disability referrals

Why is this important?

The Wandsworth Community Learning Disability Health Team (CDLHT) is a multi-professional team providing community-based health care for adults with learning disabilities. The service facilitates access to generic NHS services. Where people with learning disabilities are unable to access mainstream services they should be in receipt of specialist learning disability community services to address their complex needs.

The service is provided in the setting most appropriate to the service users' needs. This can be in their own home, place of work or education, out in the community, in an NHS facility, or at the CLDHT team base.

Our CLDHT provides a person-centred, multi-disciplinary community service to people who need a specialist learning disability service so there may be just one or several CLDHT professionals involved with a service user at any one time. Most service users have a network around them which can include family members and a range of health and social care providers. Working collaboratively with colleagues in the CLDHT and the service user's network is essential for the delivery of a quality service that meets their needs.

It is important that people referred to the service are assessed for eligibility within a four week period so we can make sure that people with learning disabilities are in receipt of appropriate care to support their complex health needs as soon as possible.

Confirming eligibility for the receipt of CHLDT services is a time-intensive process that can be delayed by things like accessing healthcare records. Once a referral is received the service user will follow the eligibility pathway, and as soon as it is established the individual has a learning disability they will be accepted by the CLDHT for the provision of specialist health services.

If the referral is for somebody who is already known to the CLDHT (for example, a re-referral) they will be accepted straight away. If the person is unknown to the CLDHT there is a three-stage process to determine eligibility. The referral can be accepted at any point where there is sufficient evidence of a learning disability.

- Review of documentation such as past assessments, IQ tests, reports, statements of educational needs.
- Initial screening test (the Initial Service Assessment Checklist – Adults or the Learning Disability Screening Questionnaire).
- IQ test (eg Wechsler Adult Intelligence Scale) and Social Functioning Assessment (eg Vineland or Adaptive Behaviour Assessment System).

To receive the CLDHT service clients must have a learning disability which is:

- impaired intelligence (a significantly reduced ability to understand new or complex information and learn new skills with an IQ of less than 70)
- impaired social functioning (a reduced ability to cope independently)
- both of which started before adulthood with a lasting effect on development.

If at any point in the eligibility process it becomes clear the person does not have a learning disability, they will be signposted to the most appropriate service. If the individual is assessed as having a learning disability but it is felt they are not in need of specialist services for their specific problem, they will be signposted to the most appropriate mainstream service.

How did we do?

2013/14 was the first year we formally reported on the rate of patients going through the eligibility pathway within 28 days of referral. Because of this we had a target that increased every quarter, with our target starting at making sure 80% of service users referred between April and June 2013 were assessed within 28 days, increasing to 95% for those referred between January and March 2014.

Ensuring eligibility is assessed and completed within 28 days is challenging due to the requirement to obtain the necessary evidence of a learning disability which can be complex.

During 2015 the CLDHT reviewed their eligibility pathway and introduced a weekly clinic to assist supporting the eligibility process with the aim to ensuring commencement on the eligibility pathway within 28 days of receipt of the referral.

The table below shows that to date during 2015/16 the target of commencing eligibility within 28 days of receipt of referral is 100% with more than 70% of assessments completed within this time frame.

COMMUNITY LEARNING DISABILITY HEALTH TEAM - QUARTERLY ACCOUNT TARGETS					
Q1 (April-June)					
Month/ Year	Total Number of Referrals received for month	Total Number of New/Eligibility Query Referrals for month	% of New / Eligibility Assessments **initiated** within month.	Total Number of Eligibility Assessments ***completed*** within month	% of Eligibility Assessments completed within month
Apr-15	30	4	100%	2	50%
May-15	40	4	100%	4	100%
Jun-15	64	9	100%	6	67%
TOTAL	**134**	**17**	**100%**	**12**	**70.58%**
Q2 (July-September)					
Month/ Year	Total Number of Referrals received for month	Total Number of New/Eligibility Query Referrals for month	% of New / Eligibility Assessments **initiated** within month.	Total Number of Eligibility Assessments ***completed*** within month	% of Eligibility Assessments completed within month
Jul-15	55	5	100%	4	80%
Aug-15	67	5	100%	4	80%
Sep-15	59	8	100%	5	63%

TOTAL	**181**	**18**	**100%**	**13**	**72%**
Q3 (October-December)					
Month/ Year	Total Number of Referrals received for month	Total Number of New/Eligibility Query Referrals for month	% of New / Eligibility Assessments **initiated** within month.	Total Number of Eligibility Assessments ***completed*** within month	% of Eligibility Assessments completed within month
Oct-15	28	2	100%	2	100%
Nov-15	31	3	100%	2	66%
Dec-15	47	6	100%	4	66%
TOTAL	**106**	**11**	**100%**	**4**	**72%**
Q4 (January-March)					
Month/ Year	Total Number of Referrals received for month	Total Number of New/Eligibility Query Referrals for month	% of New / Eligibility Assessments **initiated** within month.	Total Number of Eligibility Assessments ***completed*** within month	% of Eligibility Assessments completed within month
Jan-16	18	2	100%	2	100%
Feb-16	27	0	100%	0	0%
Mar-16	XX	XX	XX	XX	XX
TOTAL					

Complaints

Why is this important?

Last year we had more than one million appointments and inpatient stays at our hospitals and in the community. With this number of patients and appointments, we know that there will unfortunately be times when we do not meet the expectations of our patients.

We encourage our patients and their friends, family and carers to let us know when this happens so we can make the changes that are needed to improve.

As well as dealing directly with our staff, patients and their friends, family and carers can also discuss any concerns they have with our Patient Advice and Liaison Service who will work with them and the service to resolve any issues. Complaints and compliments can also be formally submitted to our complaints and improvements department. We aim to investigate and provide a full response to all formal complaints within 25 working days of the complaint being received.

The lessons learned and trends identified from information collected from our complaints process play a key role in improving the quality of our services and the way we engage with our patients and visitors.

Our outcomes

In 2015/2016 we received XXX formal complaints, compared to 1,052 complaints in 2014/15.

It is very difficult to benchmark complaints against other trusts as there is no uniform way for trusts to record complaints, meaning there is a lot of inconsistency across the NHS.

We view all types of patient feedback as positive and we are constantly looking at how we can encourage patients, carers and families to give their views.

Number of complaints

Year	Number of complaints
2015/2016	XXX (data not available until May)
2014/2015	1052
2013/2014	1083
2012/2013	825
2011/2012	1031

2010/2011	1253

Complaints response rate

We fully responded to XX per cent of complaints within 25 working days. Our target is that 85 per cent of complaints are fully responded to within 25 working days.

We fully responded to XX per cent of complaints within 25 working days or an agreed timescale. Our target is that 100 per cent of complaints are fully responded to within 25 working days or an agreed timescale.

The chart below tracks peformance throughout the year. It can be seen that whilst performance regarding responding to complaints within agreed timescales improved throughout the year to almost 100% in March, hitting the 25 working day target is proving to be a challenge in some areas. A focussed piece of work is underway to ascertain the reasons for each late response so that actions can be taken regarding any themes or areas of particular concern that are identified.

Insert graph complaint response times by month

Responding to patients' needs

Why is this important?

Patient experience is a key measure of the quality of care. At St George's, we continually strive to be more responsive to the needs of our service users, including needs for privacy, information and involvement in decisions. Every year we take part in the national inpatient survey published by the Care Quality Commission (CQC), as well as others less frequently for A&E, maternity and outpatients. The national inpatient survey is an important indicator of how all NHS trusts in the country are performing, looking at the experiences of more than 70,000 patients each year who were admitted to hospital for at least one night.

In 2013 a new measure was introduced - the friends and family test (FFT).

Friends and family test

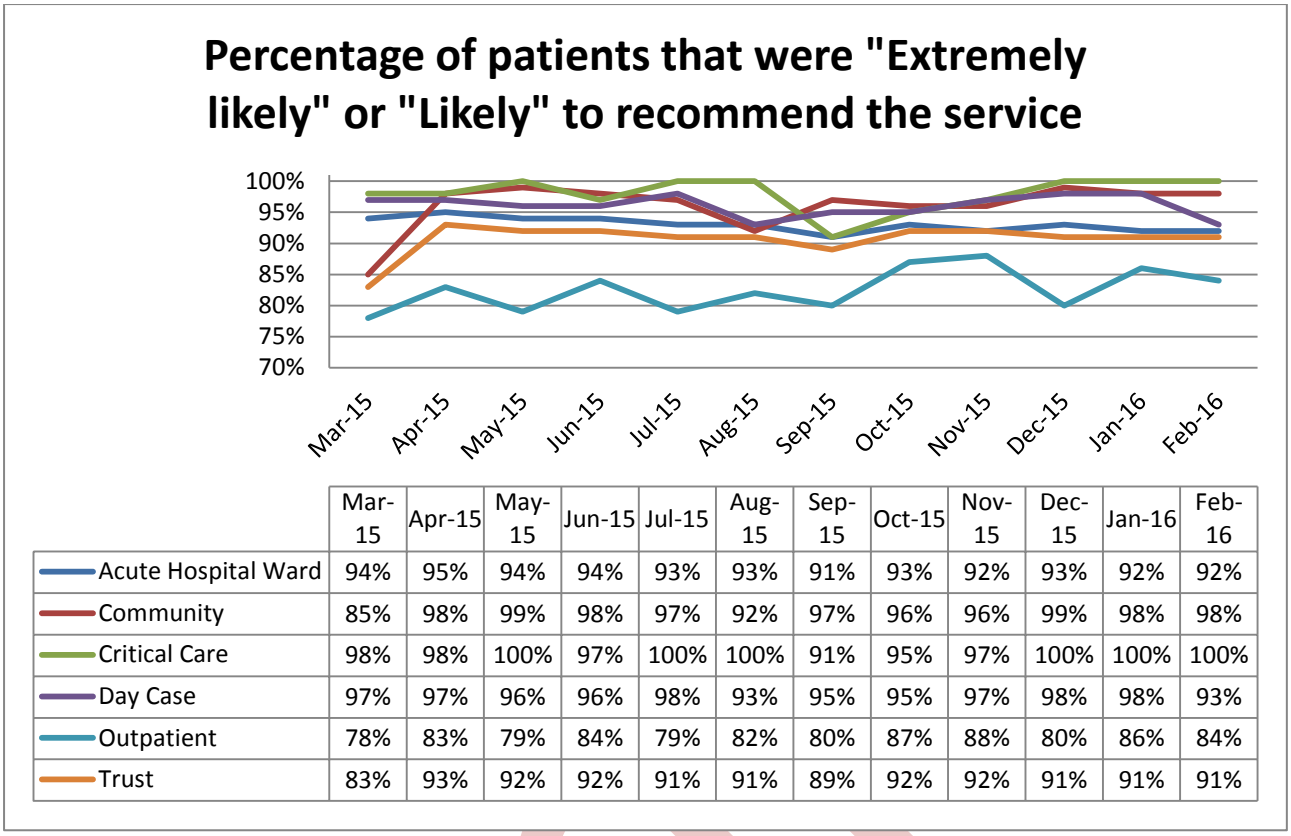
The friends and family test is a single question asked of patients on discharge about how likely they are to recommend our services to a friend or relative based on their treatment. There are six options; extremely likely, likely, neither likely nor unlikely, unlikely, extremely unlikely or don't know.

The scoring is based on the percentage of people that said they were "Extremely likely" or "Likely" to recommend our service if a friend or family member needed similar care or treatment.

The FFT has now been in place for three years, having been rolled out to A&E and inpatient adult areas for April 2013, maternity in October 2013 followed by outpatient and community services in September 2014.

The maternity survey is different from A&E and adult wards as there are four occasions or 'touch points' when women are asked to rate the service (antenatal, birth, postnatal ward and postnatal community) whereas A&E and inpatient adult areas is only once on discharge.

In addition we also have a number of other survey questions that we ask patients (anonymously) about their experience based on the national annual inpatient survey. A bespoke system allows for almost real-time feedback to enable staff to share good practice and implement any actions that may be required. We will continue to undertake national surveys but hope this process allows for more rapid feedback and action. The data below is a summary for the year outlining the additional questions with the percentage relating to positive answers.



	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Acute Hospital Ward	94%	95%	94%	94%	93%	93%	91%	93%	92%	93%	92%	92%
Community	85%	98%	99%	98%	97%	92%	97%	96%	96%	99%	98%	98%
Critical Care	98%	98%	100%	97%	100%	100%	91%	95%	97%	100%	100%	100%
Day Case	97%	97%	96%	96%	98%	93%	95%	95%	97%	98%	98%	93%
Outpatient	78%	83%	79%	84%	79%	82%	80%	87%	88%	80%	86%	84%
Trust	83%	93%	92%	92%	91%	91%	89%	92%	92%	91%	91%	91%

Staff use word clouds to display comments from patients in their clinical areas. Our word clouds give greater prominence to the words that appear most often in our survey results.

National inpatient survey

Awaiting content

End of life care

Why is this important?

Providing high quality end of life care services to all patients, who are felt to be in the last year of life, continues to be a priority for St George's. This core service currently comprises specialist palliative care input available seven days a week including a rapid discharge service; general palliative care provision from all clinical specialities; a spiritual care team led by chaplaincy; and bereavement and mortuary services. The end of life care programme board was established to take a strategic view of improving this core service in line with the five priorities set out in One Chance to Get It Right (2014), and to recognise that end of life care is everyone's responsibility. The membership of this board has recently been reviewed and an action plan developed to clarify strategic priorities. In order to deliver on this strategic view, a new end of life care operational group was developed to drive through improvements and changes at an operational level.

In recognition of the wider need across the trust for improving end of life care services to all patients in the last year of their life, we're in the process of developing a St George's end of life care strategy. The development of this strategy will include engaging key stakeholders within the trust and ensuring representation at divisional and board level.

What will we do?

Current quality improvements are focused on improving the care of dying adult patients within St George's Hospital and this includes:

- the development of a nursing daily evaluation for patients in the last hours and days of life – education and awareness sessions have accompanied the plan's dissemination
- three cohorts of staff have attended QELCA training and are sharing their learning with colleagues at St George's, we hope to send an additional three cohorts later this year
- funding has been obtained to run a 'Dying matters' week 9-13 May, to raise awareness of end of life issues with hospital staff, this will coincide with the National 'Dying Matters' events; mortuary services with recent approval to fund a £410k project to increase mortuary capacity.

These key issues have been shared with our executive management team and positive contributions by the executive team have been noted, including the appointment of a non-executive with responsibility for end of life care.

The National Care of the Dying Audit 2015/2016 results have been released and St George's is above average on most areas nationally. However we must strive to continue to improve in this area.

Sage and Thyme Foundation level communication courses are available at St George's. Unfortunately this year we lost 50% of our trained facilitators due to staff leaving the trust. This has meant a reduction in the number of courses being offered and a number of courses being cancelled at short notice. Last year we were able to offer three courses and trained 41 staff across a number of disciplines. We plan to run more courses this year and will hopefully obtain funding to train more facilitators who are outside the palliative care team.

Our aims

One of the areas within the survey where the trust needs to improve was in relation to patients' perception about the quality of communication between staff and patients particularly when patients were admitted to the trust.

It is hoped that the introduction of Sage and Thyme will improve general communication skills across the trust and positively impact the National Patient Experience survey.

Improving patient outcomes

Sexual health in secondary schools

Why is this important?

Supporting young people to grow up with a good knowledge of their sexual health and how to both protect themselves and keep safe is really important. Historically, Wandsworth has had a high teenage pregnancy rate which has halved in the last 10 years due to improved services and education.

Schools are responsible for providing sex and relationships education. St George's provides school nursing services in Wandsworth.

To improve access to sexual health advice, support and signposting, our school nursing service provides a drop-in service in secondary schools in Wandsworth. Our target is for 50% of secondary schools in Wandsworth to have sexual health support on the school grounds.

How did we do?

All 11 secondary schools in Wandsworth have a school nurse who spends up to three days a week in the school supporting pupils.

These schools also have a weekly drop-in session when pupils can see a school nurse confidentially (there is always the need however to inform pupils that if a safeguarding concern is raised this will need to be shared).

All of our school nurses have received training in sexual health and the administration of emergency contraception, with a patient group direction (PGD) and competency framework for the administration of emergency contraception developed and implemented.

Sexual health information is freely available in all secondary schools. Information is also given to pupils about The Point sexual health clinics in Wandsworth, with pupils actively encouraged to attend if they are likely to be sexually active.

Reporting period	Number of young people seen for sexual health advice	Number referred onto sexual health clinics
Q1	18	12
Q2	24	12
Q3	30	17
Q4	XX (data available at end of April)	XX

No secondary schools have agreed to the administration of emergency contraception at present.

Our aims

We have three main aims for young people in Wandsworth:

- To have quick and easy access to sexual health information in a confidential and appropriate way giving them the option to make informed choices about their sexual health.
- To be protected from harm.
- To have easy access to emergency contraception where a holistic assessment will be carried out by a school nurse. This then gives the opportunity to make sure the young person is safe and address any other health concerns.

Clinical outcome measures in community services

As previously reported, it can be very hard to report on clinical outcomes within community services as interventions can extend over a long period of time and care can focus on many different issues. Some services focus not on illness but promoting health and wellbeing. All of these factors can make it hard to measure clinical outcomes in community services and to know when best to do this. The NHS continues to work with professional bodies like the Royal College of Nursing and Chartered Society of Physiotherapy to develop the best way to measure clinical outcomes.

During 2015/16 we have continued to develop our data collection processes to enable us to effectively analyse our community services and see both where we are performing well and where we can make improvements. We have continued to participate in a national programme on community indicator development.

In addition, during 2015/16 we have worked with Wandsworth CCG to jointly develop an outcomes framework for Community Adult Health Services (CAHS). This focus was driven by the recent service redesign to ensure that it provided outcome results.

We set up processes to identify and share 40 patient care plans on a quarterly basis with the CCG as follows:

- 20 joint care plans CAHS/primary care
- 10 ongoing case management care plans
- 10 under review/surveillance care plans.

The provision of the 40 anonymised care plans per quarter was to enable CCG-led audits to ensure that appropriate plans are in place and are being followed to allow best outcomes for patients.

This was a developmental piece of work with Wandsworth CCG and we also participated in the evaluation process with the CCG. As a result of the Wandsworth CCG-led audit 'My Wandsworth Shared Care Plan' has been developed by them to support joint care provision for patients on an enhanced care pathway in 2016. The audit process also showed the number of patients with an identified key worker and the extent to which the patient had identified care/treatment goals.

Patient reported outcome measures (PROMS)

Why is this important?

Patient reported outcome measures (PROMs) assess the quality of care from the patient's perspective. Covering four procedures, they calculate health gains after surgical treatment using short, self-completed, pre- and post-operative questionnaires.

Our outcomes

The table below shows the percentage of patients who reported an increase in their health following surgery, using three scoring methods, which are explained briefly below. The range is between 0 and 100 and higher scores are better. This makes no adjustment for the type of patients treated.

For all four procedures EQ-5D™ and EQ-VAS indices measure a general view of health, and for three there is also a measure specific to the condition treated.

- EQ-5D™ is a combination of five key criteria concerning general health.
- EQ VAS assessed the current state of the patient's general health marked on a visual analogue scale.
- Condition specific measures include a series of questions specific to the patient's condition.

		Apr11 – Mar12 (final)		Apr12 – Mar13 (final)		Apr13 – Mar14 (final)		Apr14 – Mar15 (provisional)	
		SGH	Eng.	SGH	Eng.	SGH	Eng.	SGH	Eng.
Hip replacement (primary)	EQ-5D™	87.8	87.3	*100*	89.7	*86.4*	87.9	*87.5*	88.3
	EQ-VAS	57.9	63.6	*72.2*	65.5	*65.2*	64.2	*75.0*	65.3
	Specific	93.2	95.7	*95.0*	97.1	*80.8*	96.0	*100*	96.5
Knee Replacement (primary)	EQ-5D™	63.0	78.4	*68.8*	80.6	*60.0*	80.3	*66.7*	80.6
	EQ-VAS	30.0	53.8	*53.3*	54.9	*50.0*	54.6	*55.6*	55.4
	Specific	76.5	91.6	*86.7*	93.2	*80.0*	93.0	*90.0*	92.3
Groin hernia	EQ-5D™	48.0	49.9	36.4	50.2	37.8	49.7	30.0	49.9
	EQ-VAS	40.2	38.9	32.7	37.7	25.0	37.3	34.1	38.0
Varicose vein	EQ-5D™	58.2	53.2	48.6	52.7	48.3	51.8	32.4	51.9
	EQ-VAS	50.0	42.0	26.7	40.9	30.4	39.9	36.8	39.2

	Specific	81.5	83.1	79.4	83.3	71.4	82.9	74.3	82.3

Source: Health and Social Care Information Centre
Data notes: *Total questionnaire count for survey and procedure type is less than 30.*

The latest publication provides provisional data for April 2015 to September 2015. This does not allow us to make comparison to the national picture as the number of completed pre- and post-operative questionnaires is too low and is therefore not reflected in the table above.

Adjusted health gain

Adjusted average health gains have been calculated using statistical models which account for the fact that each provider organisation treats patients with a different casemix. This allows for fair comparisons between providers and England as a whole.

Data reported in the table below shows that for the majority of measures there are insufficient records for this analysis to be reported for St George's patients. This is true for all measures for the partial year 2015/16 and the period is therefore excluded from the table.

Provisional data for 2014/15 shows that for varicose vein surgery we are an outlier for two of the three measures, meaning that our patient reported outcomes are worse than the national average. For groin hernia there is only one measure available, and this shows our patient reported outcomes to be worse than the national average. The number of records is too low for analysis of hip and knee replacement outcomes. It should be noted that at St George's we perform only a small number of complex cases of knee and hip replacements, with the majority of routine cases being referred to the South West London Elective Orthopaedic Centre for treatment.

		Apr11 – Mar12 (final)	Apr12 – Mar13 (final)	Apr13 – Mar14 (final)	Apr14 – Mar15 (provisional)
Hip replacement (primary)	EQ-5D	*	*	*	*
	EQ-VAS	*	*	*	*
	Specific	Not outlier	*	*	*
Hip replacement (revision)	EQ-5D	-	*	*	*
	EQ-VAS	-	*	*	*
	Specific	-	*	*	*
Knee Replacement (primary)	EQ-5D	*	*	*	*
	EQ-VAS	*	*	*	*
	Specific	*	*	*	*

Knee Replacement (revision)	EQ-5D	-	*	*	*
	EQ-VAS	-	*	*	*
	Specific	-	*	*	*
Groin hernia	EQ-5D	Not outlier	Not outlier	*	*
	EQ-VAS	Not outlier	Negative 95% outlier	Negative 95% outlier	Negative 95% outlier
Varicose vein	EQ-5D	Not outlier	Not outlier	Not outlier	Not outlier
	EQ-VAS	Not outlier	Negative 95% outlier	Negative 95% outlier	Negative 95% outlier
	Specific	Not outlier	Negative 99.8% outlier	Negative 95% outlier	Negative 95% outlier

Source: Health and Social Care Information Centre

Data notes:
*insufficient records
- split between primary and revision procedures was not made in 2011/12

Participation

St George's is responsible for providing patients with the opportunity to complete pre-operative questionnaires. Post-operative questionnaires are sent by contractors working for the Department of Health directly to patients that have completed the initial survey. Our aim is to provide the choice of completing the questionnaire to all appropriate patients, however it is voluntary and not all patients will choose to take part.

	Apr11 – Mar12 (final)		Apr12 – Mar13 (final)		Apr13-Mar14 (final)		Apr14-Mar15 (provisional)		Apr15 – Sep15 (provisional)	
	SGH	Eng.	SGH	Eng.	SGH	Eng.	SGH	Eng.	SGH	Eng.
All procedures	**64.5 %**	**74.6 %**	**66.8 %**	**75.5 %**	**77.4 %**	**76.2 %**	**47.1 %**	**75.4 %**	**52.4%**	**73.1 %**
Hip replacement	88.2 %	82.3 %	87.0 %	83.2 %	137.1 %	85.9 %	79.4 %	85.6 %	73.9%	84.1 %
Knee replacement	101.7 %	89.3 %	127. 9%	90.4 %	137.5 %	93.7 %	131.6 %	94.8 %	125.0 %	93.4 %
Groin hernia	52.4 %	60.6 %	72.1 %	61.7 %	69.8 %	59.9 %	54.9 %	58.3 %	58.6%	56.4 %

Varicose vein	68.9 %	48.9 %	34.3 %	44.3 %	71.7 %	40.5 %	30.2 %	39.3 %	34.4%	31.6 %

Source: Health and Social Care Information Centre

Note: Participation rates of over 100% are possible for a number of reasons: an operation is cancelled following completion of the pre-operative questionnaire; surgery is carried out by a different provider; coding issues.

Our participation rate for the most recent period available (April 2015 to September 2015) is 52.4 per cent, which is below the national average of 73.1 per cent; however, for three of the four procedures our participation rate is above the national average. Local monitoring and regular reporting is in place and whenever a decline in submissions is observed this is addressed with local teams to ensure patients are provided the opportunity to participate. This work will continue to be overseen by the Patient Experience Committee.

Clinical records - driving quality improvement through the use of iCLIP data

Why is this important?

By March 2016, NHS England says that the Care Quality Commission (CQC) will measure digital maturity within healthcare settings as part of their inspection regime. In addition, by 2020, being 'paperless' will be a pre-requisite for holding an operating licence to provide publically funded healthcare.

These significant measures will mean that successfully deploying electronic clinical documentation is an even bigger priority for health care professionals and health care providers. By implementing an electronic clinical documentation system the trust will enable transformational programmes that focus on modernisation, increased patient safety and greater productivity.

National initiatives:

- Five Year Forward View – Systems that 'talk to each other' to enable different parts of the health service to work together and harness the shared benefits that come from interoperable systems.
- Patients being able to access their online records and write in them.
- NHS Paperless by 2018.
- Lord Carter report.

Local drivers:

- Risk management, patient and staff safety.
- Real time reporting.
- Transparency and accountability.
- Aligned with CQUINs and KPIs.

How did we do it?

We have deployed electronic clinical documentation and electronic prescribing and medicines management (ePMA) to 44% of the hospital. This has been supported by clinician engagement in designing and implementing the system. A comprehensive training programme was devised to support the rollout.

Interactive whiteboards

Integrated whiteboards support length of stay management and provide the ability to view the current status of all beds and additional information to support the bed managers in controlling the flow of supply and demand. They also provide a plethora of both demographic and clinical data to inform the clinician and enhance the decision making process, a medications timeline showing past, present and future medications and an events timeline giving access to clinical results: they span across all inpatient locations in the hospital.

Benefits

Enhanced patient safety is the overarching benefit which includes:

- improved access to real-time patient information
- ensuring nursing tasks are completed in a timely manner
- improved patient flow and increased capacity
- reduced length of stay
- improved access to real time clinical information eg Early Warning Scores.

Integrated vital signs monitors

The monitoring devices integrate with the trust-wide acute Electronic Patient Record (EPR) - Cerner Millennium. Vital signs are matched into the patient's clinical record and auto-calculations based on established algorithms (National Early Warning Score - NEWS) are available to provide decision support. Reference text in the electronic record directs the nurse to the NEWS document that codifies the NEWS result and described situation, background, assessment and recommendation (SBAR) communication tool actions.

Benefits

Enhanced patient safety is the overarching benefit which includes:

- keeping the nurse at the bedside whilst 'releasing time to care'
- displays Early Warning Score at the bedside with visual prompt for required escalation
- eliminates the need to transcribe results – saving time and transcription errors
- results are immediately available to clinicians across the trust via the patient's record and on the interactive whiteboard
- eliminates need to access limited number of computers, or move workstations on wheels (WOWs) around with the monitor
- improves the recording of complete sets of observations and correctly scoring the NEWS.

Clinical Exchange Platform (CEP)

Work is progressing to expand the sharing of data between acute, community and primary care through our CEP. So far there is a link established with Wandsworth GPs which gives clinicians in St George's a real time view of data from the GPs. The GPs can also access St George's information from within their EMIS system. Data shared includes certain laboratory results, medications, allergies and discharge summaries.

Benefits

Our local GPs tell us access to patients' hospital records enables them to provide better care for their patients. Including:

- access to hospital records from anywhere (so long as the GPs have the means to access their own clinical system)
- peace of mind that the built-in security and audit trail features allow access to registered patient records only and facilitate monitoring of unauthorised use
- real-time access to a range of information about their patients including appointments, discharge summaries, medications, allergies, diagnostics and problems.

Endorsing results

Endorsement of test results has always been possible in iCLIP however in 2013/14 the trust had 15 serious incidents where diagnostic tests were not reviewed or followed up in a timely or appropriate manner. To support endorsement of results iCLIP now only sends radiology and cellular pathology results for endorsement.

Benefits

- All radiology and cellular pathology results in a clinician's inbox to be endorsed ensuring the appropriate clinical interventions are actioned in a timely manner.

Offender health

E-drug administration and e-prescribing have been implemented at Wandsworth Prison to enable transmission of drug information between prisons replacing a complex paper process.

Electronic Documentation Management (EDM)

Electronic Document Management (EDM) allows paper health records to be stored electronically so that they are available to be viewed at any location where care is being delivered. This will improve patient experience and quality of care by ensuring relevant information is always available whilst significantly reducing the trust's reliance on paper medical records.

New referrals to the trust are now stored immediately in the EDM system instead of a paper folder for urology, chest medicine and rheumatology. Completion of the deployment will enable us to move closer towards our goal of being a 'paper-light' organisation.

Our aim

In 2016/17 we aim to complete the inpatient deployment of electronic clinical documentation and ePMA to inpatient bed areas.

The clinical systems programme board will continue to drive the deployment by monitoring:

- the deployment plan
- pre and post-deployment support including the use of 'champion users' and training
- risk associated with the transition from paper to electronic processes
- issue logs to identify any themes or trends that might impact patient care and safety
- future developments ie care pathways
- data captured and data quality.

Reducing hospital readmissions

Why is this important

An emergency readmission is recorded when a patient has an unplanned re-admission to hospital within 30 days of a previous discharge. Reducing the number of emergency and elective readmissions would ease the pressure on our emergency department, which is one of the busiest in the country. This would in turn create extra capacity in the hospital for elective patients and mean that less elective procedures are cancelled because of surges in emergency activity

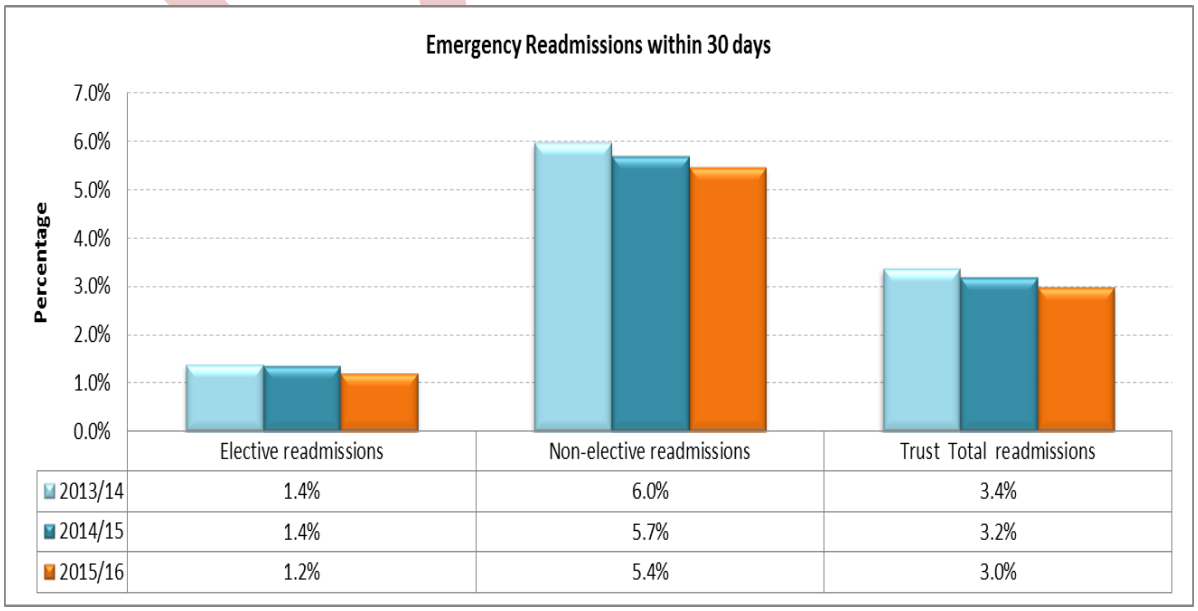
Hospitalisation is costly and re-admissions contribute to that cost however to aim for a readmissions rate of zero is unrealistic and may even indicate poor quality care, as many readmissions are medically appropriate due to an unavoidable change in condition, a medical error, adverse event that occurred during the initial hospitalisation, lack of understanding of discharge instructions, or communication following discharge. These types of avoidable readmissions are those that the trust aims to prevent or reduce.

How did we do?

Reducing emergency readmission remains one of the trusts key priorities and a continued area of focus between St George's, our partners in primary care and local councils. It is a substantial and hugely challenging task given the financial and regulatory constraints, but the potential benefits are enormous to patients.

In 2015/16, 3% of patients were readmitted to hospital within 30 days. In real terms this means that 4459 patients were re-admitted to hospital within 30 days of being discharged from their previous emergency or elective admission. This is an improved position on the previous year when 3.2% of patients were readmitted within 30 days of discharge.

*Data to Feb 16



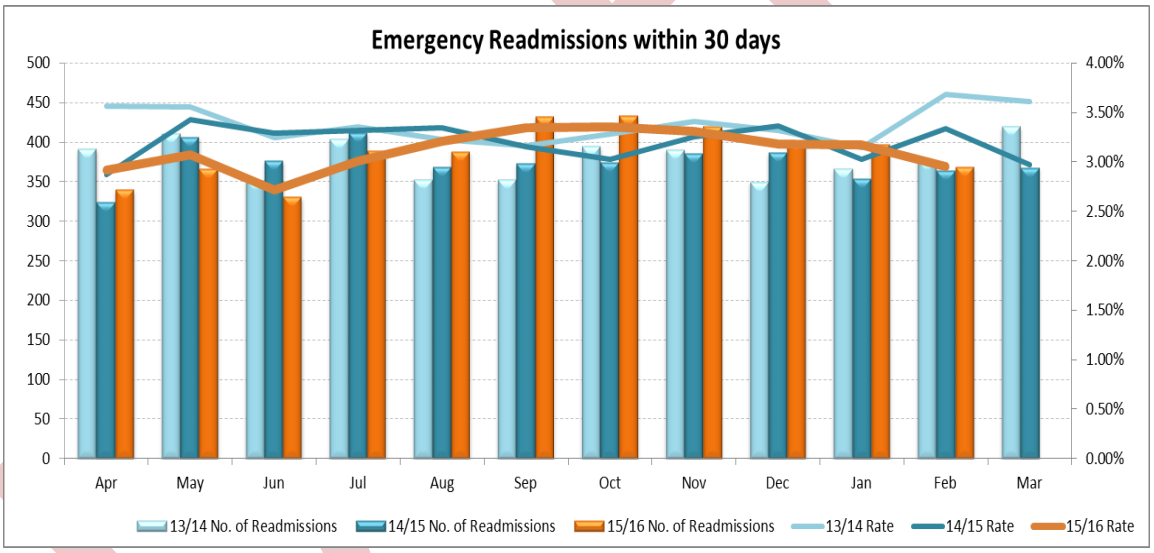
	Elective readmissions	Non-elective readmissions	Trust Total readmissions
2013/14	1.4%	6.0%	3.4%
2014/15	1.4%	5.7%	3.2%
2015/16	1.2%	5.4%	3.0%

Elective and emergency readmissions

In 2015/16, the trust had 86714 elective admissions compared to 80665 in 2014/15. Despite the increase in admissions the trust saw a reduction in the readmission rate from 1.4% in 2014/15 to 1.2% in 2015/16. For patients admitted for elective care, an important part of this process has been the pre-operative assessment, which has helped to reduce the risk of complications during and following admission.

The number of emergency patients coming to St George's increased in 2014 from 59901 in 2014/15 to 62740 in 2015/16 with the emergency readmission rate reducing from 5.7% in 2014/15 to 5.4% in 2015/16.

St George's Hospital is a regional major trauma centre, hyper-acute stroke unit and heart attack centre and treat seriously ill patients and complex cases from across south west London and Surrey, with some emergency patients coming from as far afield as East Anglia. This means that the risk of patients needing to be readmitted after leaving hospital is higher for St George's than or other acute trusts in that area.



A reduction in readmission rates overall reflects the hard work St George's has been doing around trying to ensure that our patients are not discharged before they should. It also highlights our collaborative work with GPs and community services to provide a highly responsive approach to the management of patients with chronic long term conditions in their own homes.

Our aim

In 2015/16 the trust is committed to continuing the reduction in readmissions for all patients, whether they have received emergency or elective (planned) treatment, by making sure that all discharges are properly planned and that patients are not discharged until it is safe to do so. A vital part of this is working collaboratively with community and social services to ensure that services are in place to support patients in their own home when they are ready to leave hospital. For patients admitted for elective care, an important part of this process is the pre-operative assessment, which reduces the risk of complications during and following their stay in hospital.

Performance table

	Indicator	Target	2014/15	2015/16	2016/17
ACCESS	Referral to Treatment Incomplete	92%	91.33%	90.40%	Specialty level compliance.92% achieved by all specialities
	A&E All Types Monthly Performance	95%	92.14%	90.70%	Improve performance in line with trajectory to achieve 95% target
	Indicator	**Target**	**2014/15**	**2015/16**	**2016/17**
	62 Day Standard	85%	84.70%	82.40%	Improve performance in line with trajectory to achieve target
	62 Day Screening Standard	90%	91.50%	90.10%	
	31 Day Subsequent Drug Standard	98%	100%	100%	Maintain and continue to improve target
	31 Day Subsequent Surgery Standard	94%	98.50%	96.60%	Maintain and continue to improve target
	31 Day Standard	96%	97.80%	97.10%	Maintain and continue to improve target
	Two Week Wait Standard	93%	95.93%	87.40%	Improve performance in line with trajectory to achieve target
	Breast Symptom Two Week Wait Standard	93%	96.66%	93.40%	

	Indicator	Target	2014/15	2015/16	2016/17
OUTCOMES	Clostridium(C.) Difficile - meeting the C.difficile objective (de minimis of 12 applies)	31	38	28	No more than 31 cases of Cdiff during 2016/17
	Incidents of MRSA	0	6	3	Zero MRSA incidents
	Mixed Sex Accomodation	0	16	11	Compliance to achieve the target of zero
	Never Event	0	5	8	No never events in 2016/17
	Mortality	Lower than expected	Lower than expected		Maintain lower than expected mortality rates
	Certfication of Compliance Learning				
	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	Yes	Yes	Maintain and continue to improve performance
	Does the Trust provide available and comprehensive information to patients with learning disabilities about the following criteria: - treatment options; complaints procedures; and appointments?	Compliant	Yes	Yes	
	Does the Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	Compliant	Yes	Yes	
	Does the Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	Compliant	Yes	Yes	
	Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Compliant	Yes	Yes	
	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	Yes	Yes	
	Data Completeness Community Services:				
	Referral to treatment * data is for Oct and Nov 2015	50%	55	55.5	Maintain and continue to improve performance
	Referral Information	50%	88	87.7	
	Treatment Activity	50%	70	70.3	
	Trust Overall Quality Governance Score- Concern Trigger and Under Review			4	Improve our Quality Governance score

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

Note : RTT and A&E performance reported ir avg YTD for April to Feb 2015/16 - Cancer performance reported ir YTD for April to February 2015/16

Annex 1: Statements from commissioners, Healthwatch and overview and Scrutiny Committees

Awaiting content

Wandsworth CCG

Wandsworth Council

Healthwatch Wandsworth

Healthwatch Merton

Healthwatch Lambeth

Statement from the governors

Independent auditor's limited assurance report to the Council of Governors and Board of Directors on the Quality Report

Awaiting content

Annex 2: Statement of directors' responsibilities for the quality report

Awaiting content

Appendices

Appendix A:

Participation in national clinical audits and national confidential enquiries

The national clinical audits and national confidential enquires that St George's University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2015/16, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title		Relevant	Participating	Submission rate (%) / Comment
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)		✓	✓	Ongoing
Adult Cardiac Surgery		✓	✓	Ongoing
Bowel Cancer (NBOCAP)		✓	✓	Ongoing
Cardiac Rhythm Management (CRM)		✓	✓	Ongoing
Case Mix Programme (CMP)		✓	✓	Ongoing
Congenital Heart Disease (CHD) – Adult		✓	✓	Ongoing
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)		✓	✓	Ongoing
Diabetes (Paediatric) (NPDA)		✓	✓	100%
Elective Surgery (National PROMs Programme)		✓	✓	Ongoing
Emergency Use of Oxygen		✓	✓	100%
Falls and Fragility Fractures Audit programme	Fracture Liaison Service Database	✓	✓	100%
	Inpatient Falls	✓	✓	100%
	National Hip Fracture Database	✓	✓	100%
Inflammatory Bowel Disease (IBD)		✓	✓	>75%

programme				
Major Trauma Audit		✓	✓	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance	✓	✓	100%
	Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	✓	✓	100%
	Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity)	✓	✓	100%
	Maternal mortality surveillance	✓	✓	100%
Medical and Surgical Clinical Outcome Review Programme	Acute Pancreatitis	✓	✓	100%
	Physical and mental health care of mental health patients in acute hospitals	✓	✓	Ongoing
	Sepsis	✓	✓	100%
	Gastrointestinal Haemorrhage	✓	✓	100%
National Audit of Intermediate Care		✓	x	Difficulty in participation as the Intermediate Service was changing. We will not be participating in 2016 as not relevant to the current structure.

National Cardiac Arrest Audit (NCAA)		✓	✓	Ongoing
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Pulmonary rehabilitation		✓	✓	77%
National Comparative Audit of Blood Transfusion programme	Use of blood in Haematology	✓	✓	100%
	Audit of Patient Blood Management in Scheduled Surgery	✓	✓	100%
National Diabetes Audit - Adults	National Footcare Audit	✓	x	0%
	National Pregnancy in Diabetes Audit	✓	✓	100% of consented women were audited. The consultant lead is seeking to improve the rate of consent.
	National Core	✓	✓	n = 117 Data was submitted for all patients with an insulin pump, but not for the complete cohort of diabetic patients. A working group has been established to develop an IT solution to allow full participation. Progress with implementation is monitored by the Quality and Risk Committee.
National Emergency Laparotomy Audit (NELA)		✓	✓	<50% During the year improved processes have been established to identify relevant patients for the audit
National Heart Failure Audit		✓	✓	Ongoing
National Joint Registry (NJR)	Knee replacement	✓	✓	Ongoing
	Hip replacement	✓	✓	Ongoing
National Lung Cancer Audit (NLCA)		✓	✓	Ongoing
National Prostate Cancer Audit		✓	✓	Ongoing

National Vascular Registry		✓	✓	Ongoing
Neonatal Intensive and Special Care (NNAP)		✓	✓	Ongoing
Oesophago-gastric Cancer (NAOGC)		✓	✓	Ongoing
Paediatric Asthma		✓	✓	100%
Paediatric Intensive Care (PICANet)		✓	✓	Ongoing
Procedural Sedation in Adults (care in emergency departments)		✓	✓	30% This audit round the RCEM sample size increased from the usual 50 cases to 100 cases. 30% of data were submitted due to demands on the service.
Renal Replacement Therapy (Renal Registry)		✓	✓	Ongoing
Rheumatoid and Early Inflammatory Arthritis	Clinician/Patient Follow-up	✓	✓	n = 13
	Clinician/Patient Baseline	✓	✓	n = 22
Sentinel Stroke National Audit programme (SSNAP)		✓	✓	Ongoing
UK Parkinson's Audit	Occupational Therapy	✓	x	We did not participate in these elements of the audit due to reconfiguration of the therapies service and a lack of resources
	Speech and Language Therapy	✓	x	
	Physiotherapy	✓	x	
	Patient Management, elderly care and neurology	✓	✓	100% neurology cases
Vital signs in children (care in emergency departments)		✓	✓	51% This audit round the RCEM sample size increased from the usual 50 cases to 100 cases.
VTE risk in lower limb immobilisation (care in emergency departments)		✓	✓	51% This audit round the RCEM

			sample size increased from the usual 50 cases to 100 cases.

Appendix B
National clinical audit actions undertaken

The reports of 16 national clinical audits were reviewed by the provider in 2015/16 and St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National clinical audit	Action*
National Audit of Intermediate Care 2014	The intermediate care service is currently being reconfigured as part of the Community Adult Health Service redesign. This may affect the classification of some service lines so they may not meet the inclusion criteria as an Intermediate care services in future years.
National Prostate Cancer Audit Report 2014	Results presented by Cancer Network , with St George's included in the South West London network. Data completeness - our network has shown significant improvement, scoring 77% for 2012 compared to 44% in 2006-2008. The national score is 71% in 2012 and 53% in 2006-2008. The trust carried out a self-assessment of current performance against national recommendations and met all those relevant to services provided. High-dose brachytherapy is not available in this Trust, however if this is needed, patients are either referred to Royal Marsden or University College Hospital.
National Paediatric Diabetes Audit 2013/14	1) Resources: Increased diabetes nurse specialists to 2.5WTE; increased dietician time to 1WTE and also secured 0.6WTE psychology support. Service manager in post to support improved processes of care over appointments and education activities, issuing clinic reminders and HbA1c quality control. Introduced a consultant led formal transition service for 15-19 year olds. 2) Education: Sessions at home and school, including special sessions for ethnic minorities. 3) Technology: Changes including pump use, with meter and pump downloads in clinic. Capillary HbA1c testing in clinic with quality control.
National Congenital Heart Disease Audit Report 2011/14	Data submitted to the audit is subjected to rigorous validation comprising site visits by a clinical auditor and clinician. A data quality indicator is calculated, with NICOR's expectation that units will achieve 90 per cent. St George's consistently achieves this

	standard, with our most recent score being 90.75. Analysis of all hospitals shows an upward trend in survival in the most recent 18 months. St 30 day survival is 100 per cent.
Sentinel Stroke National Audit Programme (SSNAP)	• Changes have been made to the way bed managers are alerted to ED admissions. • Work is in progress developing the stroke nurse role in ED. • More information is being added to iClip to minimise the need for paper notes. • A 7.15am morning MRI slot had been launched to reduce admissions for MRI. • Discussions with local hospitals around improving repatriations are on-going.
British Thoracic Society (BTS) Pleural Procedures Audit 2014	Three national Improvement Objectives were outlined in the report. • Written consent should be taken for greater than 95% chest drains inserted (excluding those placed in an acute emergency) • Greater than 95% of chest drains should be placed in a dedicated clean area (procedure room), away from the patient bedside. • Patients with chest drains should be nursed on wards with staff specifically trained in chest drain care, in more than 95% of cases. We have a new pleural consultant, a role which will help facilitate any changes needed in order to meet these objectives and to fully contribute to future audits. It is also hoped that this new post will enable management of some of these patients in an out-patient setting.
College of Emergency Medicine - Mental Health in the Emergency Department	• ED revising mental health risk assessment • Reinforcing good clinical documentation is an on-going piece of work in ED, and shall now include emphasis on reporting mental health. Meeting with trainees to discuss documentation. • Meeting held between ED and Psych Liaison team. Liaison team have data showing mean time from referral to being seen was 25 minutes. To improve accuracy of data Liaison team have been asked to inform ED co-ordinator when they attend to see a patient • Facilities requests have been submitted to make the necessary changes to the assessment room. Requests supported by GM.
College of Emergency Medicine - Assessing for Cognitive Impairment in	• ED clinical notes to be amended as they currently state that all patients >65 require assessment • Information to the GP will require an iCLIP modification so that

Older People	this information is transferred • Further investigation of how information can be given to carers is required and how best practice units are achieving this • Nursing input is required to ensure EWS scores are calculated and reported for all patients
National Hip Fracture Database (NHFD) Report 2015	• 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 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. • Quarterly clinical governance presentations, using timely NHFD data to monitor performance and discuss areas of shortfall.
National Audit of Inpatient Falls 2015	• Falls that result in moderate or severe harm are investigated at a divisional level • Replacing Stratify tool with a multi-factorial risk assessment tool to be used for all patients at risk of falling • Introduction of new tool to be supported by concurrent training and audited once embedded • Conducting a bed rail audit
MBRRACE-UK - Perinatal Mortality Surveillance Report Recommendations	Self-assessment conducted against national recommendations, found compliance with all but one relevant item relating to the offer of post-mortems. An audit will be conducted to explore reasons why post-mortem may not be offered and to design actions accordingly.
PICANet (Paediatric Intensive Care Audit Network) – November 2015 Annual report	Recommendations were made for commissioners and providers. Locally, actions are in place to improve our position in relation to staffing. The unit continue to recruit band 5 and 6 staff. External recruitment of Band 6 staff has proven challenging, therefore the unit are trying to grow their own staff by training and developing them.
National COPD Audit Programme: Resources and organisation of Pulmonary Rehabilitation services in England and Wales 2015	Overall we provide a robust service compliant with all the quality standards set out by the BTS. However, the overall number of referrals both nationally and locally is low compared to the number of patients who are likely to benefit from PR and the figure for the uptake of assessments by patients referred is just 69% (this is both the national figure and that for SGH) although the reason for this is not clear. Given the proven benefits of a PR service the report recommends that the pathway is reviewed and enhanced. The local results suggest that we also look at ways to encourage patients to complete their PR. To commissioners it is

	recommended that steps are taken to ensure providers have a clear, long-term funding framework that will allow programmes to recruit and retain staff with an appropriate skill and seniority mix, this is already in place for SGH and we are currently recruiting permanent staff members.
National Vascular Registry 2015 Annual Report	For indicators where it is possible to compare performance at St George's with overall results we are performing better than the national average. At St George's we are largely compliant and no specific areas have been highlighted for action by the vascular care group.
National Pregnancy in Diabetes Audit 2014	• Contacted the national project team and HQIP (Healthcare Quality Improvement Partnership) to request local unit reports (with or without benchmarking) to inform local action planning. • Improved processes for consenting women to increase the number of cases submitted by St George's. The numbers of women consenting to participate has substantially improved on the first year.
National Head and Neck Cancer Audit 2014	8 measures were identified and the trust scores were above the national and London Cancer Alliance (LCA) scores for 7. One measure which relates to patient seen by CNS prior to 1st treatment by MDT scored 50.8% which is lower than the national score (62.9%) and London Cancer Alliance score (61.3%). Discussion is currently on going as to the reasons for this and how to improve. • MDT to encourage all clinicians to refer patients to the CNS team as early in the pathway post diagnosis as possible. • CNS access to and contemporaneous entry onto Infoflex must be a priority. • If patients get diagnosis and treatment plan the same day and go to RMH (Royal Marsden) for first definitive treatment the SGH CNS's do not get to see the patients in clinic as they see the RMH doctors. In this instance the presence of the RMH CNS in the H&N clinic at St George's to register the patients as seen here prior to transfer for RT/CRT.

*Based on information available at the time of publication

Appendix C

Local clinical audit actions undertaken

The reports of fourteen local clinical audits were reviewed by the provider in 2015/16 and St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Local clinical audit	Action*
Pressure Ulcer Prevention (PUP) Audit	In total, 334 patients were audited across the trust. Assessment documentation was checked for 329 patients and 73.6% of these had an up to date assessment form, this represents a small decrease from the previous audit. All patients audited were on a pressure relieving mattress, 87% had a repositioning chart, and this was fully completed in an average of 71% of cases, which is an increase from previous audits. Communication sheets (giving ongoing information) were in progress for 35.25% of patients but only 19 (6%) had been given a patient information leaflet. Overall the audit showed that there are pockets of excellent care but also areas where improvements are required. Results were considered alongside details of PU incidents and PU training. Planned actions to facilitate improvements include targeted reviews of the wards where there appears to be most room for improvement and a recheck of some wards where there may be some lesser issues.
Venous Access Device Re-Audit 2014/15	VAD device training is currently being reviewed and practice educators plan to be attend team study days to provide this training. A section about VAD management training is to be included in the Infection control MAST training by end of May 2015.
IV Administration Audit 2014	Recommendations include using existing educational and management forums to increase knowledge of the policy and design of an e-learning tool to promote on going learning and updates of knowledge.
Protected mealtimes, nutrition and hydration audit, March – May 2015	Local action plans developed in accordance with ward results. Wards are required to enforce protected mealtimes and challenge colleagues accordingly. Ward sisters and matrons to review practice to ensure that there is a robust approach to nutritional screening and support, including the use of red trays.

Trust-Wide Consent Re-Audit 2014/15	• Legibility needs to be addressed and adoption of name stamps is recommended. • Divisions have received divisional analysis to facilitate local discussion and action planning. • The Legal Services Manager will include a summary of the key areas for action as part of a presentation on consent to the STNC division. • Associate medical director for governance to recruit a new lead to help drive recommendations and implement action plans.
WHO Surgical Checklist Audit 4th Quarter 2014/15	• Report circulated to Clinical Governance leads and findings presented at Theatre Care group meeting for discussion. • Support to be given to 3 specialties with the lowest results to understand the issues they face and help improve compliance. • Clinical lead to visit best performing areas to congratulate them and gain insight into their successful processes, which can then be shared. • Focus on improvements to Time-out checks, with target of 100% compliance at next audit round. • Matrons and team leaders to discuss findings with their local teams. • Surgeons and anaesthetists to collect data for quarter 1 2015/16.
Healthcare Records Audit Report Q1 2015/16	• Local action will be required to improve standards and to this end care group results are available alongside the trust level report • A number of measures have been recommended at trust level, particularly around the improved access to patient labels, use of clinician name stamps, patient identification stickers and dividers in ward ring folders. Where the audit revealed that there is no access to a working label printer this has been reported to divisions for local resolution.
End of Life Discharge Home Service Report	The end of life discharge service demonstrated an increased demand in the year 2014/15, and achieved a high number of patients discharged to their PPC/PPD. The palliative care team are working more closely with the ward discharge coordinators and there are proposed changes to the hospital discharge team to help fast track patients. The team are trialling a system of one CNS focusing just on fast tracks for a week at a time to provide better continuity.
Tissue Handling Audit (HTA) 2015	• Patients encouraged to fully complete the consent form, indicating consent or refusal to all the use of tissue in diagnosis and audit, teaching and research • Recommended staff are formally trained and competency assessed by implementing a training schedule to cover all activities, including information regarding legal requirements • Theatre matrons to schedule regular teaching sessions and presentations. • All new staff should be supervised to promote adherence to the protocols and SOPs, ensuring clinical competence. • All the SOPs and quarantine procedures for autologous tissues are to be reviewed by the theatre team.
Safe and Secure Handling	• Local actions were taken at the time of completing the audit and further actions are informed by considering detailed local results

of Medicines Annual Audit	and feedback • At an organisational level a number of actions are agreed to improve the audit process, thereby providing a full picture of performance and identifying best and poor practice.
Controlled Drugs Check & Stock Audit Quarter 2 2015/16	Pharmacists carried out local education and training of ward staff as issues were identified during the audit process. Furthermore, divisional reports including targeted action plans will be presented at the DGB meetings. In some areas ward pharmacists have identified the need for CD training, to include how to order CDs, entering CDs into registers and calculating the amount of medication required. A training package is being piloted on General Medicine wards in Quarter 3 to address these issues.
Healthcare Records Audit Report Q3 2015/16	The clinical audit department hope to create a report in PIEDW (iCLIP) by which to audit the quality of electronic documentation in those areas that use iClip. This is dependent on training and the format of the electronic record. Standard of documentation as reported by this audit and other data to be considered when formulating the Quality Improvement Strategy for 2016/17.
WHO Surgical Checklist Audit 3rd Quarter 2015/16	• Peer review audit will be undertaken in the next audit round (4th quarter). • This information will be included in the new theatre efficiency project led by Martin Wilson (Director for Transformation) • To continue circulating the results to Theatres Care Group and Governance leads.
Controlled Drugs Check & Stock Audit, Quarter 3 2015/16	• Pharmacists carried out local education and training of ward staff as issues were identified during the audit process. Corrective action was also taken at the time of the audit and this has been reported to divisions for ongoing support. • Where pharmacists have identified the need for CD training, to include how to order CDs, entering CDs into registers and managing stock held, mini training sessions are being held to address these issues.

*Based on information available at the time of publication

Auditor's report including certificate – Grant Thornton

Foreword to the accounts FINANCE

Statement of comprehensive income FINANCE

Statement of financial position FINANCE

Statement of changes in taxpayers' equity FINANCE

Statement of cash flows FINANCE

Notes to the accounts FINANCE

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As well as making a donation there are lots of ways you can get involved with the St George's Hospital Charity. To find out more speak to the Giving to George's team.

Telephone 0208725 4917
Email giving@stgeorges.nhs.uk
Web www.stgeorgeshospitalcharity.org.uk

Volunteer

Our volunteers perform a number of varied roles, from manning information desks, general housekeeping, administration and helping patients find their way around. If you would like to volunteer at any St George's, University Hospitals NHS Foundation Trust sites, contact the voluntary services team.

Telephone 020 8725 1452
Email zoe.holmes@stgeorges.nhs.uk

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Annual Report 2015/16 produced by St George's communications team.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – APRIL 2016

Paper Title:	2016/17 Annual Plan and APR update
Sponsoring Director:	Rob Elek, Director of Strategy
Author:	Tom Ellis, Head of Business Planning
Purpose:	The narrative plan needs to reflect the outputs of the finalised financial plan. The intention is that an updated version of the narrative plan will be completed and circulated in advance of the trust board, and that any changes to the financial plan agreed at the Trust board would then be incorporated into a finalised version of the narrative plan. Agreement of the financial plan will allow for population of the APR templates, and submission of these to NHSI. Part of the APR template is the need to self-certificate against the questions shown in section 3 below. The Trust Board will be required to make a decision on its response to each of these questions, which will need to be considered against the 2016/17 financial plan. The Trust Board is asked to note the current position and to expect a version of the narrative annual plan to be circulated in advance of the Trust Board on 5th May.
Action required by the board:	For discussion and approval
Document previously considered by:	An earlier version of this paper was presented to EMT on 25th April, and linked financial papers were discussed at Finance & Performance Committee on 27th April

1. Introduction

The trust is required to submit to NHS Improvement (NHSI) a narrative annual plan and a set of Annual Planning Return (APR) templates that detail the financial plan and other key operational parameters for the organisation for the upcoming year. This submission was initially due on 11th April, but the trust has negotiated an extension, with the expectation that the trust will submit on the 6th May. It is worth noting that all NHS bodies were given an extension to 18th April, indicative of difficulties all NHS organisations are experiencing in finalising their 2016/17 plans.

This paper seeks to outline the current position on development of the submission, and the proposed process to enable submission of the required plans etc.

2. Current status

Work is on-going to complete the financial elements of the submission. The trust accepted a control total deficit of £17.2m linked to the acceptance of the £17.6m offer of STF funding. The initial budgetary position, presented to the Finance & Performance Committee on 27th April, showed a projected £43.6m deficit, which it was agreed was not acceptable. Work is underway to finalise the financial proposals for 2016/17, to allow the trust board to approve a budgetary position that will be acceptable to NHSI and deliverable as a trust.

It should be noted that the lack of clarity on the financials is the key bottleneck in completing the narrative annual plan.

NHSI have provided feedback on the narrative annual plan submitted on 8th February. Key headlines from that feedback include:

- A challenge to the trust on the 16/17 forecast financial position and the figure we are aiming for. They note the trusts run rate has improved during 2015/16, and question whether meeting the control total deficit of £17.2m is ambitious enough. They also reference the difference between the control total and the figure the trust presented to Monitor on 28th January of a £5m deficit. Given the points noted in the paragraph above regarding the forecast financial position, resolution of the outstanding financial questions is clearly paramount
- Greater detail on the trusts Transformation Programme, and assurance on its deliverability
- A need to update with agreed trajectories for 18 week RTT, A&E and Cancer targets – these targets have been agreed with commissioners and plans to achieve them are being finalised and implemented.
- More detail on the capital expenditure, and confirmation of its sufficiency to meet the core estate issues currently impacting on patient care
- Greater detail on anticipated workforce changes, their anticipated benefits, as well as the trust position on the agency cap
- Readiness for CQC, and potential preparatory costs

The narrative annual plan is being finalised currently to not only address the points raised above, but also to update the overall document to take account of the evolving position within the trust and externally since the 8th February. It is anticipated that a final draft of the annual plan will be circulated in advance of the Trust Board meeting on 5th May, incorporating the finalised financial plan numbers. This will ensure that the narrative plan, the APR submission, and the internal trust working plans are all based on, and using, the same figures.

It should be noted that the corporate priorities remain as those considered by the board previously.

3. Board Financial Self-Certifications

As part of the approval of the APR submission, the trust board is required to self-certify against a number of questions. These are:

a) Continuity of service condition 7 – Availability of Resources – where the trust needs to confirm its position against one of the three following conditions:

- *Either* - After making enquires the Directors of the Licensee have a reasonable expectation that the Licensees will have the required resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate
- *Or* - After making enquires the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the required resources available to it after taking into account in particular (but without limitation) and distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box in section 3 below) which may cast doubt on the ability of the Licensee to provider Commissioner Requested Services
- *Or* - In the opinion of the Directors of the Licensee, the Licensee will not have the required resources to it for the period of 12 months referred to in this certificate

b) Declaration of interim and/or planned term support requirements – The trust forecast a requirement for DOH interim support or planned term support for the year ending 31st March 2017

c) Statement of main factors taken into account in making the above declaration – In making the above declarations, the main factors which have been taken into account, as stated in section 1b above, by the Board of Directors are as follows: (Trust to insert narrative)

d) Declaration of review of submitted data – The board is satisfied that adequate governance measures are in place to ensure the accuracy of data entered in this planning template (including

that any relevant flags within the template are adequately explained)

e) **Control Total and Sustainability & Transformation Fund Allocation** – The board has submitted a final operational plan for 2016/17 that meets or exceeds the required financial control total for 2016/17 and the Board agrees to the conditions associated with the Sustainability and Transformation Fund.

The above declarations are required to be signed off by both the Chair and Chief Executive. Completion of the above is only possible once the financial plan has been finalised. A process to ensure the trust can complete the self-certifications is currently being developed.

Key risks identified:

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

Risks will be identified in the plan and are noted in the paper e.g. around capacity to deliver 18 week activity.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	None – the production of the annual plan and corporate objectives will deliver a refreshed set of corporate objectives for 2016/17
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	None

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

If yes, please provide a summary of the key findings

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

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

No, not at this stage. Once they have been completed a decision will be taken in association with appropriate trust leads about whether it is required and if so how it should be progressed.

Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – 5 May 2016 **Paper Ref:**

Paper Title:	**Finance Report for Month 12 2015/16**
Sponsoring Director:	Iain Lynam, Interim Chief Financial Officer
Author:	Anna Anderson, Interim Director of Financial Performance
Purpose:	To inform the Board about the Trust's financial position at the end of March 2016
Action required by the board:	To note the report
Document previously considered by:	Finance and Performance Committee

Executive summary

This report summarises the Trust's final outturn for 2015/16.

In March the Trust had a deficit of £5.7m compared to a planned deficit of £3.8m. This reflects a number of year end balance sheet changes, impairment of capital fees relating to developments that are not expected to proceed, and GP trainee costs that had not been budgeted. Previously reported expenditure and income trends have largely continued.

The Trust finished the year with a deficit of £55.1m which is in line with the last official forecast to Monitor and £1m better than the revised budget. Internally the Trust had been forecasting to do slightly better with a deficit of £54m, before capital fee impairments of £0.6m, and it is good that the final outturn is so close to what was expected. As reported in previous months, pay budgets have continued to underspend largely because the pace of recruitment has been slower than planned. These underspends have been partially offset by continuing underperformance on SLA income, particularly for outpatients, a lower level of elective activity than planned, and higher than expected SLA penalties.

£41.5m of CIPs were achieved by the end of the year, compared to the plan of £43.1m.

The cash balance at the end of March was £7.4m, £4.4m more than plan. In addition, use of the working capital facility was £11.8m lower than expected so overall the cash position was £16.2m better than plan.

Capital spend for the year totalled £31.1m, £17m less than the revised plan which has helped with cash management.

The Trust's overall risk rating in March was again a 2.

The draft accounts have been completed and the year end audit is now in progress.

Enclosure:

Key risks identified: The need to balance financial measures with maintaining the quality of patient care. The need to improve staff morale in the light of the last staff survey and the impact of financial challenges. The impact of one off measures this year on 2016/17. The tension between reducing capital spend and addressing urgent needs for capital investment in the estate and IT.

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 12 2015/16

Trust Board 5th May 2016

1. Month 12 Headlines & Actions – Income & Expenditure

Area of Review	Metric	Key Highlights
Overall financial performance in March	Deficit of £5.7m in the month, £1.9m worse than reforecast	Performance is £1.9m worse than plan due to: • SLA Income: underperformance including higher challenges conceded • Pay overspend owing to GP trainee costs previously assumed to be 100% recoverable, national clinical excellence awards confirmed in March, and impact of a second Easter holiday in the financial year (additional anti-social hours premium) Note: pay increase due to transfer of turnaround management costs from non-pay has associated non pay reduction • 'Other' income under recovery is due to a higher income plan (£1m), GP trainee contract issue which adversely impacts income and pay (each by £0.4m) , and M12 favourable position on VAT reclaims (£0.9m).
Overall financial performance - year to date	Year to date deficit of £55.1m against plan of £56.1m i.e. £1m better	Month 12 cumulative performance is better than budget due to: • Pay underspends resulting from recruitment assumptions in the reforecast which were too optimistic • £1m more capital to revenue income than in the reforecast • The above offset SLA income under performance which continues to be below plan despite a lower reforecast plan.
Outturn vs Forecast	£55.1m deficit outturn vs internal forecast of £54m, And £55.1m forecast to Monitor	The Trust outturn is £55.1m deficit which is £1.1m greater than the internal forecast deficit of £54m reported last month. Of note is that the internal forecast did not include the impairment of capital scheme fees (£0.6m). The Trust outturn is in line with the £55.1m forecast submitted to Monitor.
Activity/Income	Income is £4.2m below plan for the year to date and £1.2m below plan in month	Actual activity across all areas other than A&E was below plan for March. In month £1.2m underperformance includes partially completed episodes adjustments (£0.8m adverse movement), 2014/15 CQUIN loss (£0.4m) notified in March. Cumulative adverse elective income reflects the junior doctor strikes, theatre closures, changes to theatre schedules and adjustment to marginal rate calculations for neuro rehab.
Expenditure- Pay	Pay budgets are £3.5m below year to date plan and £1m above plan in month	M12 pay is over budget due to transfer of £0.7m turnaround management costs from non pay to pay; impact of trainee GP costs previously assumed to be fully rechargeable (£0.4m) and a second Easter holiday in the financial year (antisocial hour premium c£0.4m) . These are partly offset by additional recharges in month. Underspend to date is due to recruitment difficulty and business case slippage.
Expenditure- Non Pay	Non pay for the year to date is £0.9m worse than plan (£1.1m better than plan in month)	The M12 favourable variance reflects a higher non-pay budget this month (£1m) and, £0.5m adverse impact of the M12 balance sheet changes (stock and bad debt provisions, net of gains on PO creditor write backs) and transfer of consultancy costs from non pay to pay for turnaround management (£0.7m). The cumulative variance reflects pass through costs which are recovered via SLA exclusions income & other income over performance).
CIP	£41.5m savings delivered to date against £43.1m plan	Of the £41.5m delivered to date £21.7m is CIPs and £19.8m is non recurrent or run rate savings. Of the £41.5m total schemes delivered this year £36.7m, or 88%, are green .

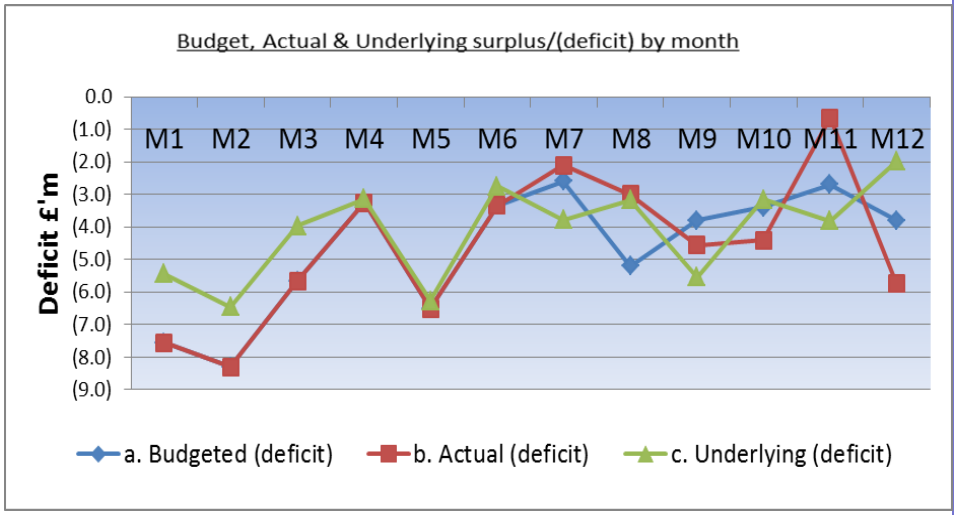
2. Month 12 Headlines & Actions – Cash and Capital

Area of Review	Metric	Key Highlights
Cash	Cash balance £7.4m	The M12 actual cash balance was £7.4m (£4.4m higher than plan) including cumulative WCF drawdowns of £40.4m. The M12 plan cash balance was £3m including cumulative WCF drawdowns of £52.2m. Therefore the overall cash position was £16.2m better than plan. The cash balance reduced by £6m in month due to the unwinding of cash measures taken before Christmas – eg deferral of CNST premiums and rental payments to NHS Property Services. The Trust received a payment on account of £7.2m from NHS England for in-year SLA over performance following a meeting in early March.
Capital	YTD spend £31.1m, £16.9m less than plan	Capital expenditure was £3.9m in March. Year to date expenditure is £31.1m which is £16.9m less than the budget – contributing significantly to the favourable cash position reported above.
Working Capital	Outturn movement -+£5m, £12.3m better than Plan	Working capital deteriorated by £1.3m in March however performance was better than forecast due to higher cash receipts from NHS debtors and significant reductions in stock. The net working capital performance for the year of +£5m compares to the plan of -£7.3m – a favourable variance of £12.3m for the year which contributed to the better performance on cash. Overdue NHS debt remains high although the Trust received £7.2m for 2015/16 SLA over performance by NHS England. Stock reduced by approx £1.6m in M12 however £0.4m of this reduction relates to a provision for obsolete/slow-moving stock,
FSRR (formally COSRR)	Rating of 2 compared to plan of 1	The Trust's financial sustainability risk rating for month 12 (March) is 2 which is ahead of plan. The rating reflects a better than planned cash balance and deficit position.

3. Overall Position for the 12 months to 31st March

Note: YTD variances reflect variances from Oct (M7)

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	615.2	52.5	51.4	(1.2)	615.2	611.0	(4.2)
Other Income	107.2	11.0	10.4	(0.7)	107.2	109.7	2.5
Overall Income	**722.5**	**63.6**	**61.8**	**(1.8)**	**722.5**	**720.7**	**(1.8)**
Pay	(462.4)	(39.5)	(40.5)	(1.0)	(462.4)	(458.9)	3.5
Non Pay	(281.7)	(25.0)	(23.9)	1.1	(281.7)	(282.7)	(0.9)
Overall Expenditure	**(744.1)**	**(64.5)**	**(64.4)**	**0.1**	**(744.1)**	**(741.5)**	**2.6**
EBITDA	(21.7)	(0.9)	(2.6)	(1.7)	(21.7)	(20.9)	0.8
Financing Costs	(34.4)	(2.9)	(3.1)	(0.2)	(34.4)	(34.3)	0.2
Surplus / (deficit)	**(56.1)**	**(3.8)**	**(5.7)**	**(1.9)**	**(56.1)**	**(55.1)**	**1.0**



Commentary

- The March deficit of £5.7m was £1.9m worse than plan and includes £1.2m net adverse impact of balance sheet changes per below:
  - £0.4m non pay gain: £1.8m Creditor/VAT write back less £1.4m stock/ bad debt write off and capital to revenue transfers
  - £1.1m income loss: £0.8m partially completed spells & £0.4m '14/15 CQUIN loss
  - £0.4m I&E charge: Capital scheme impairments (£0.6m) and disposal (£0.1m) costs less reduction in depreciation charge (£0.3m)
- The cumulative deficit of £55.1m is £1m better than plan and in line with the forecast outturn reported to Monitor last month. The variance from plan is mainly due to £1m extra capital to revenue transfers ('other' income).
- **SLA income** in March is £1.2m worse than plan mainly due to the balance sheet changes above. Cumulative adverse position reflects under performance on outpatient, elective and non elective activity, and higher income challenges than expected.
- **Other income** in M12 is less than plan due to higher M12 plan (£1m), unachieved M12 charitable income target (£1.1m) and partly offset by gains VAT reclaim income (£0.9m) and other recharges (£0.5m). Cumulative over performance reflects commercial pharmacy activity which incurs non pay overspend (drugs).
- **Pay** spend for M12 increased by £1.6m compared to the average for the first two months of this quarter and is higher than plan for the first time since the reforecast. The increase is due to turnaround management costs transferred from non pay, costs for the GP trainees not anticipated previously and, the impact of 2 Easter holidays in the financial year (higher unsocial hours).
  Cumulative pay underspend of £3.5m reflects slippage on business cases.
- **Non pay** underspend in month reflects a higher M12 budget, consultancy costs transferred to pay and adverse impact of balance sheet changes. Cumulative overspend relates to high cost drugs and commercial pharmacy over performance.
- **The M12 underlying deficit** of £2m, is an improvement on the £4m average since turnaround (i.e. M4-11). This reflects improved underlying income whilst broadly maintaining underlying expenditure trend.

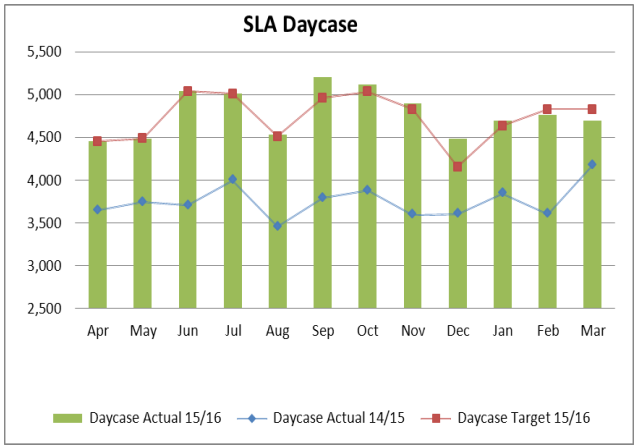
4. SLA Income for the 12 months to 31st March

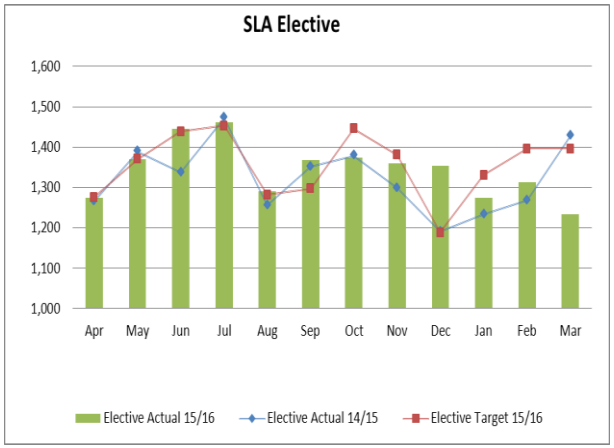
Activity	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
A&E	18.5	1.6	1.5	(0.0)	18.5	18.2	(0.2)
Bed Days	59.0	5.4	5.3	(0.1)	59.0	58.1	(0.9)
Daycase	30.6	2.6	2.7	0.1	30.6	31.1	0.6
Elective	67.1	5.7	5.6	(0.2)	67.1	65.5	(1.6)
Non Elective	121.2	10.4	10.4	(0.0)	121.2	120.3	(0.9)
Outpatients	139.1	12.2	11.4	(0.8)	139.1	136.6	(2.5)
Pass-through drugs & devices income (HCD)	67.1	13.2	14.2	0.9	67.1	69.3	2.2
SLA Programme	16.3	1.9	1.6	(0.2)	16.3	16.8	0.4
Community Block	49.7	4.2	4.1	(0.0)	49.7	49.8	0.1
Fixed Block (HIV)	12.9	(7.1)	(7.1)	0.0	12.9	12.9	0.1
Unbundled (Chemotherapy & Diagnostics)	20.8	1.7	1.8	0.0	20.8	20.8	0.0
In Patient Deliveries	11.1	0.9	0.9	(0.0)	11.1	10.9	(0.2)
Out Patient Regular Attenders	4.2	0.3	0.3	(0.0)	4.2	4.3	0.1
Challenges/Penalties	(10.3)	(1.6)	(1.8)	(0.2)	(10.3)	(12.2)	(2.0)
Other (Ex SLA)	4.4	1.0	0.4	(0.7)	4.4	3.9	(0.5)
Other Income (Capital to Revenue income)	3.6	0.0	0.0	0.0	3.6	4.6	1.0
Grand Total	**615.2**	**52.5**	**51.4**	**(1.2)**	**615.2**	**611.0**	**(4.2)**

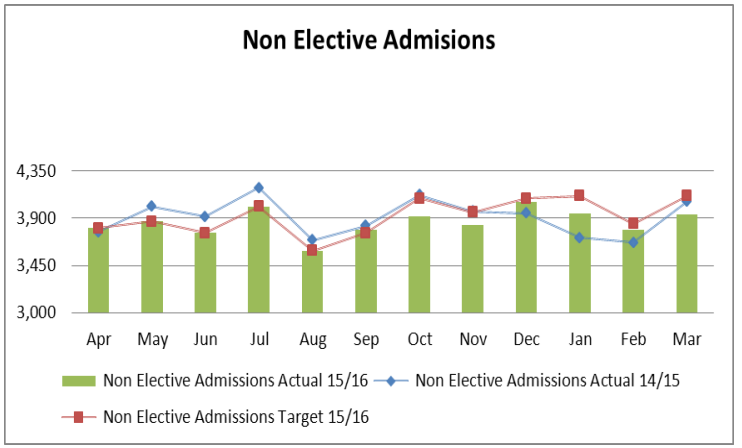
Commentary

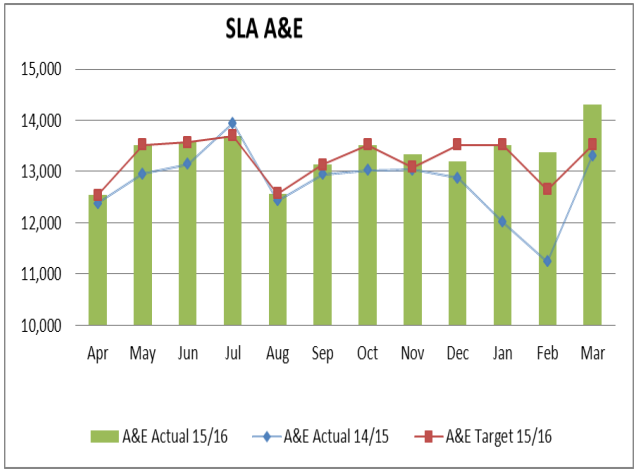
- The March income budget is £2.9m lower than February reflecting the lower number of working days in the month due to an early Easter.
- SLA income is £1.2m under plan in the month and £4.2m below plan for the year to date, despite the £1m additional capital to revenue transfer. Income for patient activity is £1.2m lower than plan in month and £5.2m lower than the year to date plan.
- Provisions for CCG challenges have increased in the month to ensure the Trust is covered adequately for penalties. This includes a £350k provision in relation to the Minimum Income Guarantee for the Nelson hospital activity.
- The Trust's final income position for the year shows a shortfall of £2.5m in outpatients and £1.6m shortfall in elective activity consistent with trends in previous months. The outpatient shortfall has been experienced trust wide whereas elective income shortfall is most noticeable in Neurosciences due to delays in proposed developments. Activity trends are shown on the next slide.

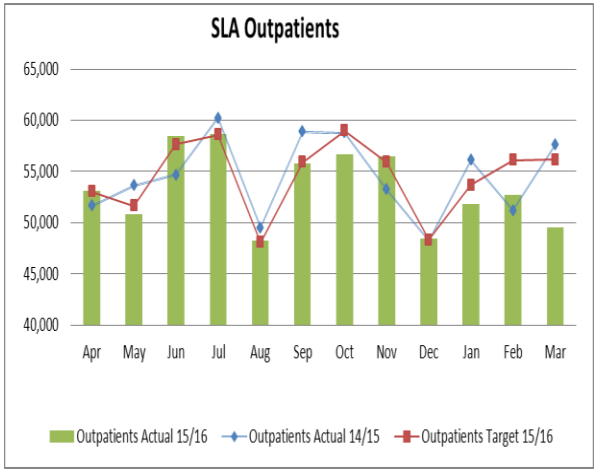
5. Patient activity compared to plan for the 12 months to 31st March











Commentary

- Actual activity for day cases, elective patients and outpatients has fallen in March whereas A&E and non elective activity has increased.
- All areas remain below plan for the month with the exception of A&E which has seen an increase in less complex patients.
- The shortfall in outpatients is mainly in T&O, Neurosciences and Plastics - this is currently being investigated by the service leads.
- A & E activity is 5% higher than last year and outpatients are 2% lower than last year.
- The Trust will begin 2016-17 with an RTT backlog which will need to be managed.

6. SLA Income by Commissioner for the 12 months to 31st March

Income	Annual Budget (£m)	Year to Date		
		Budget (£m)	Actual (£)	Better/(Worse) than Budget
NHSE Specialist	207,978	207,978	218,244	10,265
NHSE Public Health	23,434	23,434	23,356	(78)
NHSE Secondary Dental Care Services	8,708	8,708	8,519	(189)
NHSE Cancer Drugs Fund	2,882	2,882	3,921	1,039
NHSE SPECIALIST (IFR)	0	0	27	27
NHSE - HEPC	0	0	4,797	4,797
Public Health England	422	422	1,028	606
Subtotal NHSE	**243,423**	**243,423**	**259,891**	**16,468**
NHS Wandsworth CCG	148,154	148,154	149,980	1,827
NHS Merton CCG	59,410	59,410	63,510	4,100
NHS Lambeth CCG	20,155	20,155	20,788	633
NHS Croydon CCG	21,787	21,787	23,322	1,535
NHS Sutton CCG	13,799	13,799	14,034	234
NHS Kingston CCG	13,339	13,339	12,759	(580)
NHS Richmond CCG	12,003	12,003	12,335	332
SURREY CCG	20,608	20,608	21,263	656
Other CCGs	21,112	21,112	19,404	(1,708)
Subtotal CCGs	**330,368**	**330,368**	**337,395**	**7,027**
NCA	8,560	8,560	7,567	(993)
Other Trusts	1,060	1,060	1,234	175
Other Local Authority	7,261	7,261	7,667	406
Subtotal CCGs	**16,880**	**16,880**	**16,469**	**(411)**
Internal Targets: Growth, Business Cases etc	15,014	15,014	(13,350)	(28,364)
Ex SLA Income	5,935	5,935	5,984	49
Total NHS Healthcare Income	**611,620**	**611,620**	**606,388**	**(5,232)**
Additional Income				
Private & Overseas Patient	5,459	5,459	6,673	1,214
Road Traffic Accidents (RTAs)	4,182	4,182	3,689	(493)
Other Healthcare Income	237	237	240	3
Education and Training Levy Income	45,244	45,244	45,133	(111)
Other Income	55,719	55,719	58,467	2,748
Total Other Income	**110,841**	**110,841**	**114,200**	**3,360**
Total income	**722,460**	**722,460**	**720,589**	**(1,871)**

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 (Wandsworth, Merton and Croydon) contracts. The NHSE specialist over performance mainly relates to High Cost Drugs.

The Trust set an additional internal target of £26.6m, now reduced to £15m to reflect patient activity that was expected over and above agreed contract values. The Trust is below its total reforecast SLA activity targets by £5.2m year to date thus only £9.8m of the £15m internal target was achieved this year.

The actual value shown on the internal target line is mainly contract penalties (shown separately for transparency and allocated to CCG upon agreement). All other income is shown by CCG hence the negative variance on this line.

Other income* is the income that is generated by South West London Pathology, Pharmacy Income, R & D Project income, Donated Capital income and Parking Services income.

7. Pay costs for the 12 months to 31st March

1. Pay spend against budget (In month & YTD)

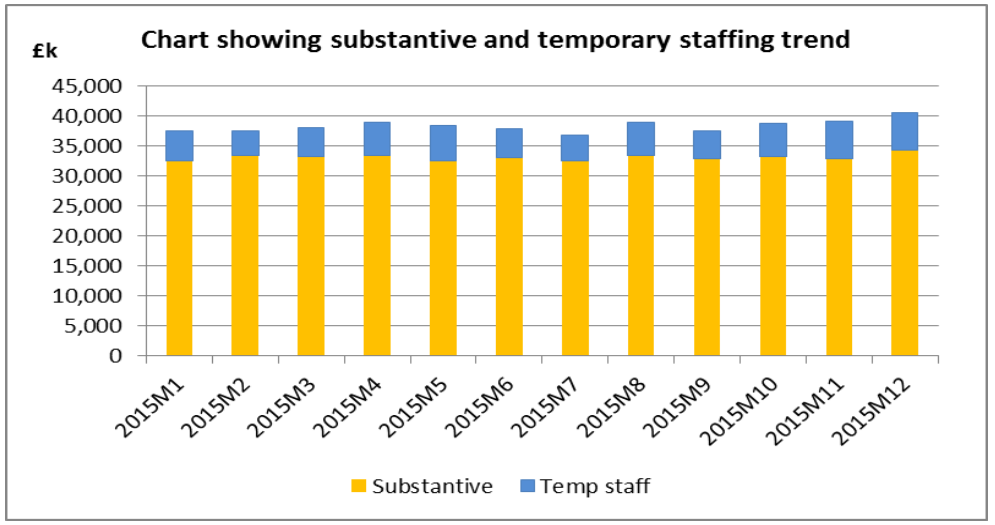
Pay Summary by Staff Type	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
Consultants	(72.5)	(6.1)	(6.5)	(0.4)	(72.5)	(73.1)	(0.6)
Junior Doctors	(50.2)	(3.9)	(4.2)	(0.3)	(50.2)	(50.5)	(0.2)
Non Clinical	(78.1)	(6.7)	(7.0)	(0.3)	(78.1)	(76.7)	1.4
Nursing	(178.8)	(15.6)	(15.4)	0.2	(178.8)	(176.7)	2.1
Scientists/Technicians/Therapists	(82.6)	(7.1)	(7.5)	(0.3)	(82.6)	(81.9)	0.7
Unallocated (Pay Provisions)	(0.2)	(0.1)	0.0	0.1	(0.2)	0.0	0.2
Grand Total	(462.4)	(39.5)	(40.5)	(1.0)	(462.4)	(458.9)	3.5

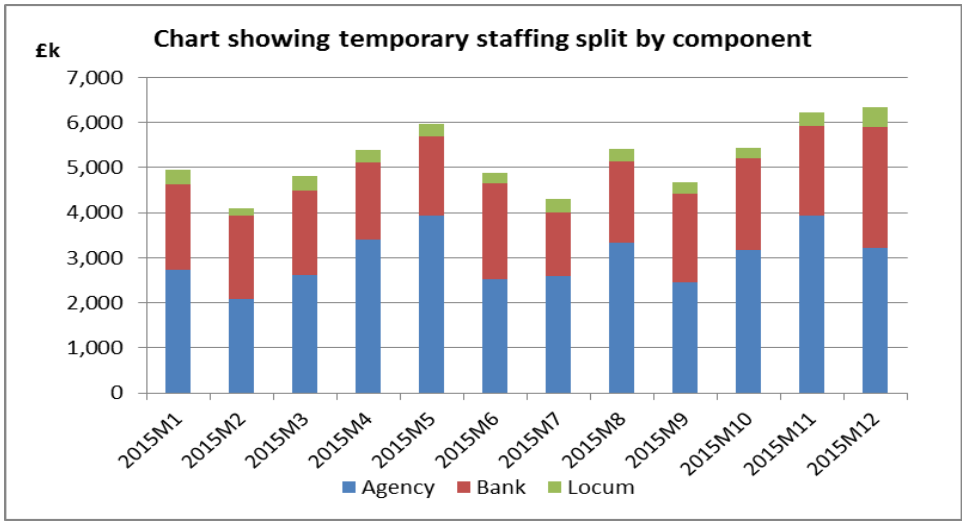
2. Monthly Pay trend by Staff-type	M1 £m	M2 £m	M3 £m	M4 £m	M5 £m	M6 £m	M7 £m	M8 £m	M9 £m	M10 £m	M11 £m	M12 £m	Total £m
Consultants	(5.8)	(5.8)	(5.9)	(6.4)	(5.9)	(6.2)	(5.9)	(6.3)	(6.2)	(6.2)	(6.0)	(6.5)	(73.1)
Junior Doctors	(4.3)	(4.2)	(4.2)	(4.2)	(4.3)	(4.0)	(4.2)	(4.4)	(4.1)	(4.2)	(4.2)	(4.2)	(50.5)
Non Clinical	(6.1)	(6.0)	(6.1)	(7.5)	(6.6)	(6.3)	(6.0)	(6.5)	(6.0)	(6.2)	(6.4)	(7.0)	(76.7)
Nursing	(14.6)	(14.7)	(15.0)	(14.1)	(14.5)	(14.6)	(14.0)	(14.9)	(14.5)	(14.8)	(15.4)	(15.4)	(176.7)
Scientists/Technicians/Therapists	(6.6)	(6.7)	(6.8)	(6.6)	(7.1)	(6.7)	(6.6)	(6.6)	(6.6)	(7.1)	(7.0)	(7.5)	(81.9)
Grand Total	**(37.4)**	**(37.4)**	**(38.0)**	**(38.8)**	**(38.4)**	**(37.8)**	**(36.7)**	**(38.8)**	**(37.4)**	**(38.7)**	**(39.1)**	**(40.5)**	**(458.9)**
Average per qtr :			**(37.6)**			**(38.3)**			**(37.6)**			**(39.4)**	**(38.2)**

Commentary

- Pay this month is £1m more than plan and cumulative pay is £3.5m less than plan.
- M12 pay of £40.5m is £1.6m higher than the £38.9m average for the first 2 months of the quarter. The increase relates to:
  - re-classification of turnaround director costs (£0.7m) from consultancy costs to pay
  - GP trainee costs (contract with Health Education England from August '15) incorrectly thought to be 100% rechargeable has £0.4m costs for the Trust (and £0.4m reduction in recharge income)
  - accounting for outstanding March shift payments as result of 2 Easter holidays in year have higher unsocial hours costs (£0.4m)
  - accounting for new national clinical excellence awards for 15/16 (£0.2m) which was only confirmed in March
  - catch-up in nurse bank accruals relating to a processing error is offset by increased recharges and reduced agency costs.
- Some of the key drivers for the increase in pay spend relate to the 6-9 months before March. This shows work needs to continue to improve systems for capturing accurate information on pay spend.
- YTD pay underspend is on nursing, non clinical, therapeutic and scientific staff groups. These reflect business case delays, use of fewer escalation beds than anticipated and recruitment challenges.

8. Pay trend for the 12 months to 31st March





Commentary

- The proportion of total pay spend relating to use of bank staff was 7% in month. This is 2% higher than the 5% reported for the last 11 months. The increase is mainly due to a catch up in nurse bank accruals relating to a processing error.

- Agency proportion of total pay spend in March at 8% is comparable to the proportion for the first two months of quarter 4 and the average since the reforecast in month 7. Of note is that the total pay spend in month is the highest it has been all year due to transfer of turnaround management costs from non-pay to pay (£0.7m) , impact of M7-12 GP trainee costs (£0.4m) and national clinical excellence awards (£0.2m).

- Department of Health caps on nurse agency spend came into effect in October and the cap for the Trust for Q3 & Q4 is 10% of total nursing spend.
- M12 actual nurse agency spend was 13%, Spend for all months since monitoring started in October has been higher than the 10% target and the transformation workforce work stream is aiming to reduce agency spend.

- Work is also in progress to avoid breaching other temporary spend controls e.g. on maximum rates of pay and use of frameworks.

- The HR team continues work to ensure all departments book agency staff via the bank office focusing on areas of low compliance. This will improve control & reduce the estimation required each month and also allow better information on headcount.

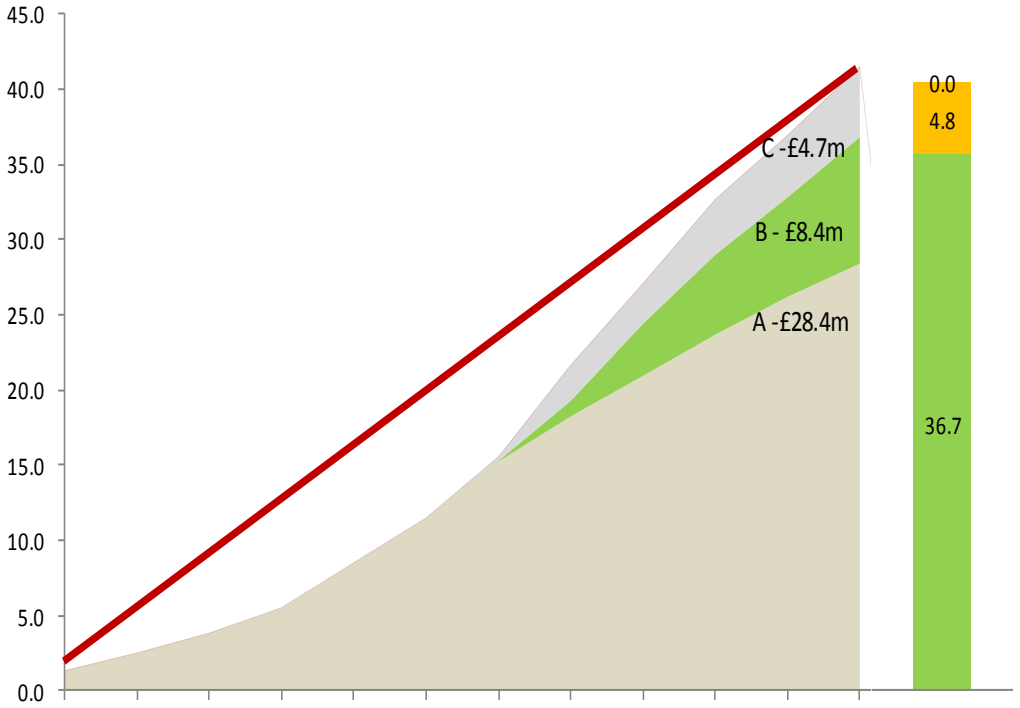
9. Non pay costs for the 12 months to 31st March

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	(97.9)	(8.6)	(7.4)	1.2	(97.9)	(94.9)	3.0
Drugs	(61.3)	(5.1)	(5.9)	(0.8)	(61.3)	(65.5)	(4.1)
Premises	(43.7)	(4.1)	(3.2)	0.8	(43.7)	(42.9)	0.8
Clinical Negligence	(15.1)	(1.2)	(1.3)	(0.0)	(15.1)	(15.4)	(0.3)
Establishment	(11.2)	(0.9)	(0.8)	0.1	(11.2)	(11.0)	0.1
General Supplies	(14.6)	(0.9)	(1.0)	(0.1)	(14.6)	(14.3)	0.4
Non Pay Unallocated	(0.0)	(0.0)	0.0	0.0	(0.0)	(0.0)	(0.0)
PFI Unitary payment	(7.0)	(0.6)	(0.6)	(0.0)	(7.0)	(7.0)	(0.0)
Reserves	(1.2)	(1.1)	0.1	1.2	(1.2)	0.0	1.2
Prior Year Costs	(1.3)	0.0	0.0	0.0	(1.3)	(1.3)	0.0
Old Year Creditor Adjustments	1.4	0.2	0.2	0.0	1.4	1.2	(0.3)
Consultancy	(7.3)	(0.6)	0.1	0.7	(7.3)	(6.5)	0.8
External Facilities	(8.2)	(1.0)	(1.5)	(0.5)	(8.2)	(8.5)	(0.3)
Other NHS Facilities	(6.4)	(0.5)	(0.5)	0.0	(6.4)	(5.8)	0.5
Other	(8.1)	(0.7)	(2.2)	(1.6)	(8.1)	(10.9)	(2.7)
Grand Total	**(281.7)**	**(25.0)**	**(23.9)**	**1.1**	**(281.7)**	**(282.7)**	**(0.9)**

Commentary

- In M12 non pay spend of £23.9m is in line with the £24m average spend for M10 and M11, and £1.1m less than plan. The variance reflects non-pay budget increase in month (£1m), transfer of non-pay costs to pay (£0.7m) and adverse impact of balance sheet year end changes (£0.4m) & other underspends:
  - Provisions for bad debt provision (£0.6m) and slow moving stock (£0.4m), capital transfer to revenue (£0.4m) are offset by PO creditors write backs (£1m)
  - £0.3m underspend against Cerner costs of £1.9m
  - £0.3m released accrual for carbon tax following confirmation the Trust 2015/16 liability is nil
- Clinical consumables underspend to date is the result of slippage against various business cases (in month underspend includes PO creditor write backs and transfer of prior month new robot costs from revenue to capital).
- Drugs overspend is driven by commercial pharmacy and high cost drugs activity and is recovered via other income and SLA exclusions income.
- Premises underspend in month reflects cost reductions for carbon emission (£0.3m), NHS property services (£0.1m), PO Capital creditor write back (£0.1m) and breast screening site rental (£0.1m).
- Reserves underspend relates to a budget adjustment for 2015/16 benefit on LDA Education income (HR income target increased and reserves non-pay increased however, actual spend for the funded projects are already within divisional reforecast budgets)
- Consultancy underspend in month relates to the transfer of turnaround director costs from consultancy to pay in month 12.
- 'Other' over spend in month includes £1m for stock and bad debt write off, and £0.4m capital to revenue transfers for IMT & major projects.

10. Trust CIP performance



Total CIP schemes reported at year end - £41.5m. Of which -
A - £28.4m forecast against £30.7m embedded in reforecast £63m deficit plan
B - £8.4m new schemes which will improve the reforecast £63m deficit plan
C - £4.7m schemes reported as CIP but are embedded in the £63m reforecast deficit plan

RAG rating of £41.5m schemes

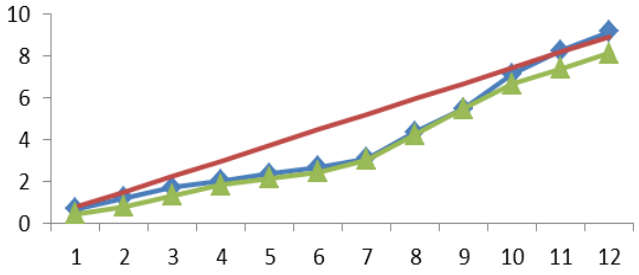
Commentary

- The original CIP target for 2015/16 was £38.1m. The chart alongside shows CIP plans and delivery against this original £38.1m target
- The Trust has delivered £41.5m of savings compared to a plan of £38.1m. Of the £41.5m delivered, £21.7m is CIPs and the balance of £19.8m is non-recurrent run rate/vacancy control savings
- The baseline forecast £63m deficit plan required delivery of £30.7m CIP embedded in the revised plan. The actual delivered against this is £28.4m as outcomes for a number of schemes have reduced.
- £8.4m CIP was added to the forecast and improved the trust position – this includes SWLEOC (£0.6m) and Mitie contract renegotiation (£2.2m non-recurrent), delays in opening winter capacity and funding from the St George's charity, as well as run rate savings.
- A further £4.7m is reported as CIP but did not impact the forecast plan as these schemes were already embedded in the trust's reforecast plan.
- Of the total £41.5m CIP reported, £36.7m is Green
- Looking to 2016/17 the extra full year effect of 2015/16 schemes is £5.2m however, this is more than offset by the loss of 2015/16 non recurring schemes of £19.8m.

11. Trust CIP performance - divisions

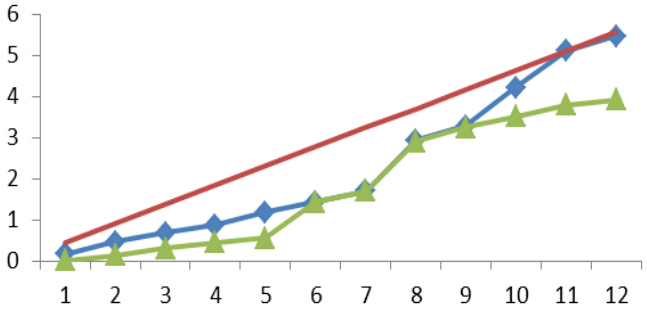
Children and Women

£9.1m schemes have been developed against the £8.9m target so the gap has been closed. At year-end, £235k more than plan has been saved. Green schemes are 88.7% of the total.



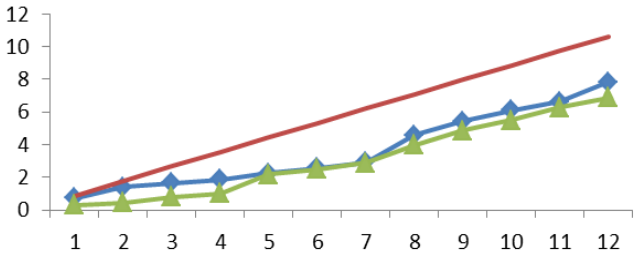
Community Services

£5.5m schemes have been developed against the £5.6m target, £0.1m under. Green schemes are 71.7% of the total.



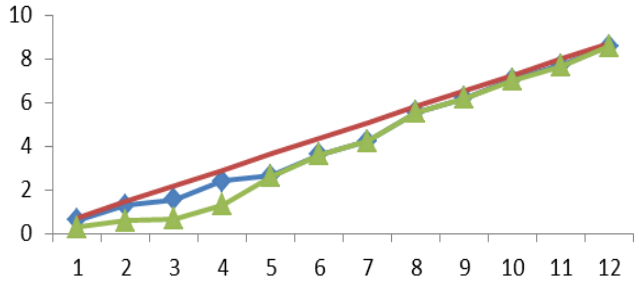
Medicine & Cardiovascular

£7.8m schemes have been developed against the £10.6m target. Year-end underperformance is £2.8m. Green schemes are 87.7% of the total.



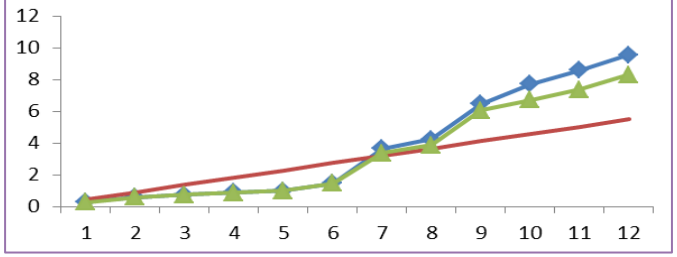
Surgery and Neurosciences

£8.6m schemes have been developed against a £8.7m target. Year-end savings are £0.1m above plan. Green schemes are 100% of the total.



Overheads

£9.6m schemes have been developed against a £5.5m target. For the year, £4.1m more than plan has been saved. Green schemes are 86.7% of the total. Corporate functions have closed the gap with the schemes submitted recently. Estates & Facilities have closed the gap through run rate savings and renegotiation of the Mitie contract.



Commentary

- Divisional targets are based on the original £38.1m target phased in 1/12s.
- Overhead departments' performance has improved significantly.
- The biggest forecast shortfall is £2.8m in Medicine.
- Focus is now on the 16/17 programme

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

12. Divisional Summaries for the 12 months to 31st March KEY HEADLINES

Area of Review	Key Highlights
Medicine & Cardiovascular	M12 included a budget adjustment with nil impact on variance - depreciation budget increased to match revised M12 costs. The outturn contribution is £0.6m less than forecast mainly as a result of higher depreciation charges (£0.7m). The division's contribution in month and cumulatively is £0.5m less than plan. The adverse movement in March is due to increase in penalty charges (£0.2m), back-pay costs (£0.2m) and loss of an NHSE funding which was conditional on having recruited the relevant staff (£0.1m)
Surgery, Neurosciences Theatres & Cancer	M12 included a budget adjustment with nil impact on variance - depreciation budget increased to match revised M12 costs. The outturn contribution is £0.5m less than forecast due to less than anticipated SLA income (£0.3m) and higher depreciation charges (£0.4m). The M12 contribution of £1m is £0.3m lower than plan and the cumulative contribution is £0.5m lower than plan. The cumulative position is driven by income underperformance due to increase in penalties, impact of theatre closures and junior doctor strikes, and delays to the Neuro gym business case. Some income under performance is mitigated by expenditure underspends reflecting delays to the business case, reduced use of the private sector and higher 'other' income than planned (private patient/overseas & Gibraltar income).
Community Services	There were no budget adjustments to the division in M12. The outturn contribution is £0.5m more than forecast due to higher than anticipated income for HIV drugs and benefit of M12 VAT reclaim adjustment. The division's contribution was £1m better than plan in March and £2.7m better than cumulative plan. The better than expected M12 position is due to £0.5m higher HIV drugs income and M12 VAT reclaims related to orthotics. The favourable cumulative position reflects recruitment difficulties (CAHS service) and better income than planned.
Children, Women & Diagnostics	M12 included a budget adjustment with nil impact on variance- depreciation budget increased to match revised M12 costs. Outturn deficit of £10.2m is £0.2m higher than forecast due to increased depreciation charges in M12. M12 deficit is £0.2m lower than plan and is driven by favourable SLA and commercial pharmacy income. The cumulative deficit is £1.7m lower than reforecast due to higher than planned commercial pharmacy activity contribution and pay underspends which reflect low uptake of planned additional outpatient clinics, and slower recruitment of scientific/therapeutic staff vacancies.
Overheads	M12 included budget adjustments with nil impact on variance- depreciation budget reduced to match revised M12 costs and budget reduction to reflect the MITIE M12 benefit. Outturn is £1.4m better than forecast deficit due to MITIE benefit (£0.5m), various income gains and lower than anticipated costs, Overheads M12 deficit is £0.1m better than plan - comprises of £0.9m overspend on corporate and £1m Estates & Facilities (E&F) underspend. Corporate overspend is mainly due to a £0.8m impact of GP trainees costs while the E&F underspend relates to costs coming in lower than reforecast (Cerner, transport & Medical physics) as well as various income gains (car parking collections and Medical school recharges).

Medicine & Cardiovascular - Divisional I&E for the 12 months to 31st March

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	1.5	1.5	(0.0)	17.4	17.3	(0.1)
Daycase	11.8	1.0	1.1	0.1	11.8	12.1	0.3
Elective	23.8	1.9	2.2	0.2	23.8	23.9	0.1
Pass-through drugs/devices/programme	48.2	4.4	4.5	0.0	48.2	49.4	1.3
Non Elective	64.6	5.5	5.7	0.2	64.6	65.2	0.6
Other	17.7	1.5	1.4	(0.1)	17.7	16.8	(0.9)
Outpatients	35.6	3.1	2.9	(0.2)	35.6	34.9	(0.7)
	218.9	18.8	19.1	0.2	218.9	219.6	0.7
Other Income	17.7	1.4	1.2	(0.3)	17.7	17.0	(0.8)
Overall Income	**236.7**	**20.3**	**20.3**	**(0.0)**	**236.7**	**236.6**	**(0.1)**
Pay							
Consultants	(19.7)	(1.7)	(1.9)	(0.2)	(19.7)	(20.0)	(0.2)
Junior Doctors	(18.3)	(1.2)	(1.2)	0.0	(18.3)	(18.3)	(0.0)
Non Clinical	(8.7)	(0.7)	(0.7)	0.1	(8.7)	(8.4)	0.3
Nursing	(53.9)	(4.7)	(4.5)	0.2	(53.9)	(53.4)	0.5
Scientists, Technicians, Therapists	(5.3)	(0.5)	(0.4)	0.0	(5.3)	(5.0)	0.3
Pay Unallocated	(0.0)	(0.0)	0.0	0.0	(0.0)	0.0	0.0
	(106.0)	(8.8)	(8.7)	0.1	(106.0)	(105.1)	0.9
Non-Pay							
Clinical Consumables	(38.9)	(3.5)	(3.7)	(0.2)	(38.9)	(39.4)	(0.5)
Drugs	(31.5)	(2.8)	(3.0)	(0.3)	(31.5)	(32.6)	(1.1)
Establishment	(1.6)	(0.1)	(0.2)	(0.1)	(1.6)	(1.7)	(0.2)
General Supplies	(0.4)	(0.0)	(0.0)	(0.0)	(0.4)	(0.4)	(0.0)
Other	(5.1)	(0.5)	(0.5)	0.0	(5.1)	(4.6)	0.5
Premises	(0.3)	(0.0)	(0.1)	(0.0)	(0.3)	(0.3)	(0.0)
	(77.9)	(7.0)	(7.5)	(0.6)	(77.9)	(79.1)	(1.2)
Overall Expenditure	**(183.9)**	**(15.8)**	**(16.2)**	**(0.5)**	**(183.9)**	**(184.2)**	**(0.4)**
EBITDA	**52.8**	**4.5**	**4.0**	**(0.5)**	**52.8**	**52.3**	**(0.5)**
Financing Costs	(5.2)	(1.0)	(1.0)	(0.0)	(5.2)	(5.2)	(0.0)
Surplus / (deficit)	**47.6**	**3.5**	**3.0**	**(0.5)**	**47.6**	**47.2**	**(0.5)**

Commentary

The outturn contribution is £47.2m, £0.5m less than reforecast target of £47.6m. In month contribution is £0.5m less than plan which is mainly due to increase in penalties in M12 (£0.2m), medical back-pay (£0.2m) and loss of NHSE income due to lack of recruitment (£0.1m).

Income in M12 is in line with the plan and £0.1m less than cumulative plan. Income position includes £1.3m over performance on pass through drugs/devices which is matched by non pay overspend against these budgets. Income position excluding income for pass through drugs and devices is £1.4m less than the reforecast and comprises :

- £0.9m under performance on 'Other' relates to income challenges/fines and include NHSE fines for new to follow up ratios that were not anticipated in the reforecast, as well as penalties for underperformance on the ED 4hr wait target.
- £0.7m under performance on outpatient income due to lower than expected activity, an increase in DNA rates, and the move of retinal screening service to the private sector
- £0.6m favourable position against non elective income due to non-block activity over performance
- £0.5m 'other' income under performance reflects RTA activity.

Pay spend is slightly under plan in month and £0.9m lower than cumulative plan due to less specialling costs than expected and, ED underspends as a result of lower than expected availability of temporary staff during the winter period.

Non-pay spend in M12 is £0.6m higher than plan and £1.2m higher than planned cumulatively. This is due to high cost drugs & devices spend which are offset by additional income.

Forecast Outturn is £0.6m worse than the £48.2m FOT due to the £0.7m increase in depreciation charges.

Surgery, Neurosciences, Theatres & Cancer - Divisional I&E for the 12 months to 31st March

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	5.2	0.5	0.4	(0.1)	5.2	4.9	(0.3)
Daycase	14.2	1.2	1.2	(0.0)	14.2	14.1	(0.1)
Elective	39.1	3.4	3.0	(0.4)	39.1	37.3	(1.7)
Pass-through drugs/devices/programme	11.5	0.8	1.0	0.2	11.5	12.4	0.9
Non Elective	49.5	4.3	4.3	(0.0)	49.5	48.4	(1.1)
Other	1.8	0.1	(0.1)	(0.2)	1.8	0.5	(1.3)
Outpatients	32.5	2.9	2.4	(0.5)	32.5	31.2	(1.3)
	153.8	13.3	12.2	(1.1)	153.8	148.9	(4.9)
Other Income	15.9	1.3	1.5	0.2	15.9	17.0	1.1
Overall Income	**169.8**	**14.6**	**13.7**	**(0.9)**	**169.8**	**165.9**	**(3.8)**
Pay							
Consultants	(26.7)	(2.3)	(2.3)	0.0	(26.7)	(26.5)	0.2
Junior Doctors	(15.4)	(1.3)	(1.2)	0.1	(15.4)	(15.5)	(0.1)
Non Clinical	(9.3)	(0.8)	(0.7)	0.1	(9.3)	(9.2)	0.1
Nursing	(43.7)	(3.9)	(3.8)	0.1	(43.7)	(42.6)	1.1
Scientists, Technicians, Therapists	(11.0)	(0.9)	(1.0)	(0.1)	(11.0)	(10.8)	0.1
	(106.2)	(9.2)	(8.9)	0.2	(106.2)	(104.7)	1.5
Non-Pay							
Clinical Consumables	(22.0)	(1.9)	(1.7)	0.2	(22.0)	(20.6)	1.4
Drugs	(9.0)	(0.7)	(0.9)	(0.1)	(9.0)	(9.5)	(0.4)
Establishment	(0.4)	(0.0)	(0.0)	(0.0)	(0.4)	(0.4)	(0.0)
General Supplies	(0.3)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	0.0
Other	(3.9)	(0.5)	(0.4)	0.1	(3.9)	(3.2)	0.7
Premises	(0.8)	(0.2)	(0.0)	0.2	(0.8)	(0.6)	0.2
	(36.5)	(3.4)	(3.1)	0.4	(36.5)	(34.6)	1.9
Overall Expenditure	**(142.6)**	**(12.6)**	**(12.0)**	**0.6**	**(142.6)**	**(139.3)**	**3.3**
EBITDA	**27.1**	**2.0**	**1.7**	**(0.3)**	**27.1**	**26.6**	**(0.5)**
Financing Costs	(4.3)	(0.7)	(0.7)	(0.0)	(4.3)	(4.3)	(0.0)
Surplus / (deficit)	**22.8**	**1.3**	**1.0**	**(0.3)**	**22.8**	**22.3**	**(0.5)**

Commentary

The division has delivered a net contribution of £22.3m for the 15/16 financial year which was £0.5m below plan and forecast of £22.8m.

Income - Elective income is significantly lower than plan largely due to theatre closures and delays to the implementation of the Neuro Gym business case. Delays to the purchase of equipment has impacted upon ENT activity following the day unit reconfiguration. Outpatient income underperformed within T&O due to a delay in the approval of the consultant business case and in Neurology due to an overstated income target in the reforecast. Underperformance in Plastics is currently being investigated.
Other SLA income is £1.3m worse than cumulative plan due to higher challenges and fines than in the reforecast.
'Other' (non SLA) income over performed on private and overseas patients, and Gibraltar contract.

Pay – M12 shows £0.2m underspend and £1.5m underspend cumulatively. This is mainly on ward nursing due to delays to business cases, implementation of the nursing establishment review, non-recurrent CIP's and, lower than expected winter costs.
Pay within theatres was underspent on nursing and operating department practitioners (ODP's) largely due to the theatre downtime.

Non-Pay – In month is £0.4m underspent and £1.9m less than cumulative plan. This relates to:

- lower clinical consumables in Neurosurgery due to lower activity than planned
- delays to business cases
- non pay controls and greater clinical engagement in T&O
- less use of the private sector for General Surgery

Community Services - Divisional I&E for the 12 months to 31st March

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	1.2	0.1	0.1	(0.0)	1.2	1.1	(0.1)
Bed Days	5.6	0.5	0.4	(0.1)	5.6	5.3	(0.3)
Exclusions	17.5	9.4	9.8	0.5	17.5	17.9	0.5
Other	50.4	(3.9)	(4.1)	(0.1)	50.4	50.5	0.1
Outpatients	24.2	2.1	2.0	(0.1)	24.2	24.3	0.2
	98.8	8.2	8.3	0.1	98.8	99.2	0.5
Other Income	1.9	0.2	0.5	0.4	1.9	2.5	0.5
Overall Income	**100.7**	**8.3**	**8.8**	**0.5**	**100.7**	**101.7**	**1.0**
Pay							
Consultants	(2.4)	(0.2)	(0.2)	0.0	(2.4)	(2.3)	0.0
Junior Doctors	(2.7)	(0.3)	(0.2)	0.1	(2.7)	(2.4)	0.3
Non Clinical	(7.6)	(0.7)	(0.6)	0.1	(7.6)	(7.2)	0.3
Nursing	(24.1)	(2.2)	(2.1)	0.1	(24.1)	(23.7)	0.4
Scientists, Technicians, Ther	(10.1)	(0.9)	(0.9)	(0.0)	(10.1)	(9.9)	0.2
	(46.8)	(4.2)	(3.9)	0.3	(46.8)	(45.6)	1.3
Non-Pay							
Clinical Consumables	(9.4)	(0.8)	(0.2)	0.6	(9.4)	(9.0)	0.4
Drugs	(11.8)	(1.0)	(1.0)	0.0	(11.8)	(11.6)	0.2
Establishment	(1.2)	(0.1)	(0.1)	0.0	(1.2)	(1.1)	0.1
General Supplies	(0.1)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
Other	(8.6)	(0.7)	(1.1)	(0.3)	(8.6)	(8.9)	(0.3)
Premises	(0.7)	(0.1)	(0.1)	(0.0)	(0.7)	(0.8)	(0.0)
	(31.9)	(2.7)	(2.5)	0.3	(31.9)	(31.4)	0.5
Overall Expenditure	**(78.7)**	**(6.9)**	**(6.4)**	**0.5**	**(78.7)**	**(77.0)**	**1.7**
EBITDA	**21.9**	**1.4**	**2.4**	**1.0**	**21.9**	**24.6**	**2.7**
Financing Costs	(0.3)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	(0.0)
Surplus / (deficit)	**21.7**	**1.4**	**2.4**	**1.0**	**21.7**	**24.4**	**2.7**

Commentary

The in month divisional position is a surplus of £2.4m which is £1m better than budget due to improvements in both income and expenditure. The cumulative position is £2.7m better than budget.

Income – The in month favourable income position against the budget is £0.5m. This relates to a £0.4m HIV drugs income increase and the release of the LDIP provision £0.1m. The year to date income position is £1m favourable due to increases in QMH activity against the budget (£0.5m), HIV drugs (£0.4m) over performance and, escort and bed-watch funding (£0.3m).

Pay – The in month variance in nursing and non-clinical pay of £0.3m continues the trend shown in the year to date position. There remains recruitment challenges mainly within the CAHS services, health visiting and school nursing.

Non-pay – The in month underspend of £0.3m relates to orthotics VAT benefit £0.4m partially off-set by month 12 invoices relating to the Nelson from Moorefield's and Merton CCG . The year to date variance of £0.5m comprises of an underspend in orthotics, prosthetics and special seating mainly relating to VAT reclaims.

Actions

- Improve the Divisional forecasting for 16/17.
- Continue to understand the impact on the budgets for 2016/17.

Forecast - The outturn contribution for the division is £0.5m better than forecast. This is mainly related to the HIV drugs income and VAT reclaims benefit.

Children, Women, Diagnostics & Therapies - Divisional I&E for the 12 months to 31st March

C&W, Diagnostics, Therapies

Income & Expenditure	Annual Budget	Current Month			Year to Date		
		Budget	Actual	Better/(Worse) than Budget	Budget	Actual	Better/(Worse) than Budget
	£m	£m	£m	£m	£m	£m	£m
SLA Income							
Bed Days	48.2	4.5	4.5	0.0	48.2	47.9	(0.3)
Daycase	4.6	0.4	0.4	0.1	4.6	4.9	0.3
Elective	4.2	0.4	0.4	0.1	4.2	4.2	0.0
Pass-through drugs/devices/programme	2.3	0.1	0.2	0.1	2.3	2.3	0.0
Non Elective	8.4	0.7	0.6	(0.1)	8.4	8.5	0.1
Other	25.7	2.1	2.3	0.2	25.7	26.4	0.7
Outpatients	38.4	3.4	3.4	(0.0)	38.4	37.9	(0.6)
	131.8	11.5	11.8	0.3	131.8	132.0	0.3
Other Income	21.5	1.9	2.2	0.3	21.5	24.5	3.0
Overall Income	**153.3**	**13.5**	**14.1**	**0.6**	**153.3**	**156.6**	**3.3**
Pay							
Consultants	(16.8)	(1.4)	(1.6)	(0.2)	(16.8)	(17.4)	(0.5)
Junior Doctors	(12.9)	(1.1)	(1.1)	0.0	(12.9)	(12.8)	0.0
Non Clinical	(14.2)	(1.2)	(1.1)	0.1	(14.2)	(13.5)	0.7
Nursing	(52.2)	(4.4)	(4.4)	(0.0)	(52.2)	(52.0)	0.2
Scientists, Technicians, Therapists	(34.9)	(3.2)	(3.1)	0.1	(34.9)	(34.1)	0.8
	(131.0)	(11.3)	(11.3)	(0.0)	(131.0)	(129.8)	1.2
Non-Pay							
Clinical Consumables	(13.0)	(1.2)	(1.1)	0.1	(13.0)	(13.0)	0.1
Drugs	(8.8)	(0.6)	(1.0)	(0.4)	(8.8)	(11.6)	(2.8)
Establishment	(0.7)	(0.1)	(0.1)	(0.0)	(0.7)	(0.7)	0.0
General Supplies	(0.5)	(0.1)	(0.1)	0.0	(0.5)	(0.5)	0.1
Other	(2.7)	(0.2)	(0.4)	(0.2)	(2.7)	(3.1)	(0.5)
Premises	(1.5)	(0.2)	(0.1)	0.1	(1.5)	(1.2)	0.3
	(27.3)	(2.3)	(2.7)	(0.4)	(27.3)	(30.1)	(2.8)
Overall Expenditure	**(158.3)**	**(13.6)**	**(14.0)**	**(0.4)**	**(158.3)**	**(159.9)**	**(1.5)**
EBITDA	**(5.0)**	**(0.1)**	**0.1**	**0.2**	**(5.0)**	**(3.3)**	**1.7**
Financing Costs	(6.9)	(0.9)	(0.9)	(0.0)	(6.9)	(6.9)	0.0
Surplus / (deficit)	**(11.9)**	**(1.0)**	**(0.9)**	**0.2**	**(11.9)**	**(10.2)**	**1.7**

Commentary

M12 deficit is £0.2m better than plan and cumulative deficit is £1.7m better than reforecast.
The £10.2m outturn deficit is slightly worse than the £10m forecast . This is due to increased depreciation costs of £0.4m (matched by an increase in budget). The position excluding depreciation improved by £0.2m against forecast and reflects net improvement of SLA income over expenditure.

Income – SLA income is £0.3m better in month due to unbundled activity (£0.1m) and lower Penalties (£0.1m). Income is £0.8m better than forecast due to PICU bed day, imaging O/P and unbundled activity and women's antenatal activity. Other income is also better than forecast due to additional funding for paediatric phlebotomy and pharmacy wholesale dealer license income better than expected over the Easter holiday.

Pay outturn is £0.4k worse than forecast mainly in children's and critical care nursing and women's.
Pay is underspent compared to the TRP budget by £1.2m and is in balance in M12. Outpatient budget underspends have contributed to the non clinical and nursing variances reported as additional planned capacity has not been used by specialties. The underspend on the scientist line largely reflects the slower than expected pace of recruitment for therapists.

Non pay – spend is £0.2m worse than forecast with higher consumables spend in critical care, drug spend in children's and consultancy and training costs in therapy for which the Trust has received LDIP funding as confirmed by contracts dept. The drugs overspend of £2.8m mainly relates to pharmacy commercial operations (£2.5m) referred to above. A lower budget profile in the reforecast for Paediatric drug issues has worsened the variance.

Actions / Risks

- Pharmacy Lab outstanding repairs are a risk to income

Overheads - Divisional I&E for the 12 months to 31st March

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
Corporate Directorates							
Chief Executive & Governance	(22.4)	(1.9)	(1.8)	0.1	(22.4)	(22.9)	(0.6)
Executive Director of Nursing	(4.9)	(0.4)	(0.3)	0.1	(4.9)	(4.5)	0.4
Finance, Performance & IT	(24.5)	(0.6)	(0.6)	(0.0)	(24.5)	(24.7)	(0.2)
Human Resources Directorate	(4.8)	(0.4)	(1.3)	(0.9)	(4.8)	(5.8)	(1.0)
Service Improvement	(1.9)	(0.2)	(0.1)	0.1	(1.9)	(1.4)	0.5
Pathology - STG	(11.8)	(0.7)	(0.9)	(0.2)	(11.8)	(12.0)	(0.2)
Strategy	(1.5)	(0.1)	(0.3)	(0.1)	(1.5)	(1.6)	(0.1)
Total Corporate	(71.7)	(4.4)	(5.3)	(0.9)	(71.7)	(73.0)	(1.2)
Estates & Facilities							
Energy & Engineering	(11.1)	(1.1)	(0.3)	0.7	(11.1)	(10.1)	1.0
Estates	(12.0)	(1.2)	(1.4)	(0.2)	(12.0)	(12.2)	(0.2)
Estates Community Premises	(16.4)	(1.4)	(1.4)	0.0	(16.4)	(16.6)	(0.2)
Facilities Services	(4.7)	(0.4)	(0.3)	0.1	(4.7)	(4.5)	0.2
Hotel Services	(11.7)	(0.7)	(0.6)	0.1	(11.7)	(11.3)	0.5
Medical Physics	(2.2)	(0.2)	0.1	0.3	(2.2)	(2.0)	0.3
Project Management	(0.4)	(0.0)	(0.0)	(0.0)	(0.4)	(0.4)	0.0
Rates	(2.1)	(0.2)	(0.2)	0.0	(2.1)	(2.1)	0.0
Total Estates & Facilities	(60.6)	(5.2)	(4.2)	1.0	(60.6)	(59.0)	1.6
Total Overheads	**(132.3)**	**(9.5)**	**(9.5)**	**0.1**	**(132.3)**	**(132.0)**	**0.3**

Overheads Summary

At year end, Overheads deficit of £132m is £0.3m better than reforecast. M12 outturn is £1.4m better than the FOT of £133.4m deficit due to MITIE M12 benefit (£0.5m), various income gains and less than anticipated costs, which have offset £0.8m adverse impact of the GP trainee costs.

Corporate

Reported variance for each department is below:

- Chief Executive : Underspend is due to lower costs of turnaround (Easter break) and income agreed for NHSE secondment post working on the SWL Provider collaborative.
- Nursing: Costs of the nursing review less than anticipated.
- Finance: Lower than reforecast cost for the Cerner project (£0.3m) offset by provision in procurement for slow moving stock (£0.4m)
- HR: The deficit in month is the costs of GP trainees to the Trust which comprises additional £0.4m pay costs and £0.4m recharge income reduction. Previous advice from HR indicated these costs were rechargeable to Health Education England (HEE) but this advice was changed in M12.
- Service Improvement: The costs of the recovery at home scheme have been lower at the start than anticipated.
- Pathology £0.2m adverse due to activity reconciled to SWLP and loss of education income

Estates & Facilities

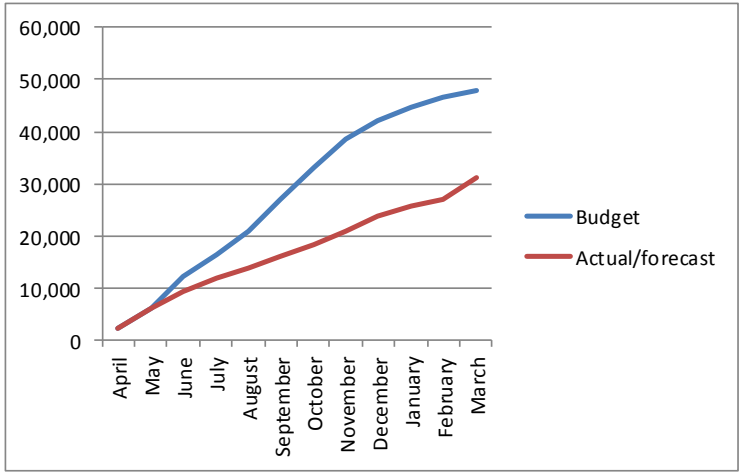
Favourable variance in the month of £1m due to :-

- Trust carbon tax confirmed as zero and accrual released (£0.3m)
- Additional income following final agreement with the Medical School (SGUL) on energy recharges (£0.2m)
- Medical Physics review of costs showed additional prepayment required (£0.2m)
- Additional car parking income collected (£0.1m)
- Transport costs lower than anticipated following contract review by General manager (£0.1m)

13. Capital

- The 2015/16 capital programme budget was reduced from £56.7m to £48m in June 2015. 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.

Budget and actual cumulative capital expenditure 2015/16 at M12



Summary cap exp by spend category	Budget £000	YTD Actual £000	YTD Var £000
Infrastructure renewal	9,680	3,990	5,690
Medical equipment	12,412	9,454	2,957
IMT	6,526	4,860	1,665
Major Projects	18,137	12,113	6,024
Other	772	601	171
SWL Path	500	57	443
Total	48,027	31,076	16,951

- Capital expenditure in March was £3.9m – higher than previous months due to the installation (as forecast) of the new MRI scanner in AMW and of the equipment for the new hybrid theatre. This equipment is leased. The capital expenditure total for the year is £31.1m, £16.9m less than budget.
- The Trust deliberately slowed down capital expenditure during the year where appropriate to support the cash position.
- The underspend within Major Projects relates mainly to the decision to slow expenditure on the surgical assessment unit, endoscopy project and CCU2 projects. The slippage on these projects is included in the draft capital budget for 2016/17.
- The under spend on the capital programme enabled the Trust to agree with Monitor and DH a capital to revenue transfer which was processed in February – improving the reported I&E deficit for 2015/16 by £4.6m.

14. Cash balance and WCF drawdowns vs plan

Cash balance

	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual
	31-Mar £000	30-Apr £000	31-May £000	30-Jun £000	31-Jul £000	31-Aug £000	30-Sep £000	31-Oct £000	30-Nov £000	31-Dec £000	31-Jan £000	29-Feb £000	31-Mar £000
2015/16 Plan cash (May 2015)	n/a	14,200	6,187	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000
Actual/forecast cash	24,179	14,188	7,925	7,265	6,175	6,097	8,258	12,846	9,252	15,236	22,036	13,374	7,397
Cash bal fav / (adv) variance to plan	0	-12	1,738	4,265	3,175	3,097	5,258	9,846	6,252	12,236	19,036	10,374	4,397

Working Capital Facility - drawdowns within cash balance above

	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual
	31-Mar £000	30-Apr £000	31-May £000	30-Jun £000	31-Jul £000	31-Aug £000	30-Sep £000	31-Oct £000	30-Nov £000	31-Dec £000	31-Jan £000	29-Feb £000	31-Mar £000
Plan drawdown (May 2015)	0	0	0	2,138	6,991	14,625	24,483	29,807	34,900	42,544	47,618	49,892	52,185
Actual drawdown - in-month						7,909	9,420	1,256	0	10,140	0	0	4,000
Actual drawdown - cumulative	0	0	0	0	7,671	15,580	25,000	26,256	26,256	36,396	36,396	36,396	40,396
WCF cum drawdowns fav / (adv) variance to plan	0	0	0	2,138	-680	-955	-517	3,551	8,644	6,148	11,222	13,496	11,789

Overall Cash fav / (adv) variance to plan	0	-12	1,738	6,403	2,495	2,142	4,741	13,397	14,896	18,384	30,258	23,870	16,186

- The **cash balance** table above compares the actual cash balance and WCF drawdowns with the May plan.
- The M12 actual cash balance was £7.4m which is £4.4m ahead of plan. Cumulative WCF/ISF drawdowns to 31st March are £40.4m which is £11.8m lower than plan.
- LEEF loan impact: The cash balance includes £11.6m unexpended LEEF loan for the energy performance contract and so the cash balance excluding LEEF would be: -£4.1m.
- The cash balance reduced by approx £6m in March as the reversal of cash management actions taken before Christmas took effect– most significantly the payment of deferred CNST instalments £2.8m, £7m rental charges to NHS Property Services and the £3.4m dividend payment.
- The Trust must maintain a minimum cash balance of £3m at month-end under the terms of its ISF borrowing facility.
- The drawdown of £4m interim support funding in March brought cumulative WCF/ISF borrowings to £40.4m for the year - £11.8m lower than the May Plan.
- The Trust's secured borrowing capacity for 2016/17 is £33.3m comprising the remaining balance of the ISF loan £8.3m (£48.7m - £40.4m) plus the Trust's working capital facility of £25m.

15. Analysis of cash movement YTD and year end forecast

Cash movement M12 2015/16

	Outturn vs Plan		
	Plan Outturn £m	*Forecast Outturn £m*	*Forecast VAR £m*
Opening cash 01.04.15	*24.2*	*24.2*	
Operating surplus/-deficit	*-21.6*	*-32.2*	**-10.6**
Sale proceeds - asset disposals	*2.5*	*0.2*	**-2.4**
Operating surplus/-deficit after disposals	**-19.1**	**-32.1**	**-13.0**
Change in stock	*0.9*	***0.9***	**0.1**
Change in debtors	*-3.0*	***7.7***	**10.7**
Change in creditors	*-5.2*	*-3.6*	**1.6**
Net change in working capital	-7.4	5.0	**12.3**
Capital spend (excl leases)	*-45.6*	*-25.5*	**20.1**
Other	*-1.3*	*-4.6*	**-3.3**
Investing activities	*-46.9*	*-30.1*	**16.8**
WCF/ISF borrowing	*52.2*	*40.4*	**-11.8**
Closing cash 29 Feb / 31 Mar	3.0	7.4	**4.4**

- The cash movement table above compares the actual outturn cash movement for the year with the original plan
- The better performance on working capital (£12.3m) and under spend (£20.1m) on the capital programme more than offset the adverse cash impact of the higher operating deficit (-£13m) enabling the Trust to reduce its borrowing requirement for the year by £11.8m.
- The Trust received a high level of aged debt receipts from NHS bodies in March and reduced its drawdown requirement for March from £8.2m to £4m.
- Total WCF/ISF borrowing for 2015/16 was £40.4m, £11.8m lower than the Plan submitted to Monitor in May.

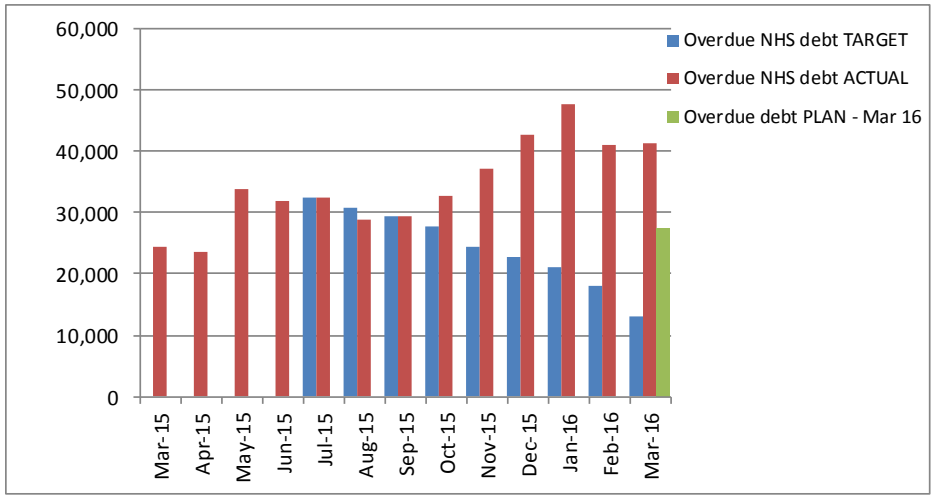
16. Debt management

- 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.
- NHS overdue debt reduced was broadly unchanged in March and remains significantly behind the 'stretch' targets. The Trust has been pursuing a 'hit list' of key overdue debts with CCGs and received approx £7.2m from NHSE in late March in respect of in-year SLA over-performance. It should be noted the overdue debt targets below are 'stretch' targets and on the grounds of prudence the year end cash forecast did not assume they were met.
- The Trust continues to press NHS England to agree a payment on account arrangement for 2016/17 over performance similar to the arrangement already in place with SWL CCGs.
- The Trust reduced overdue non-NHS debt below the target level – over-performing by £2.4m against target.

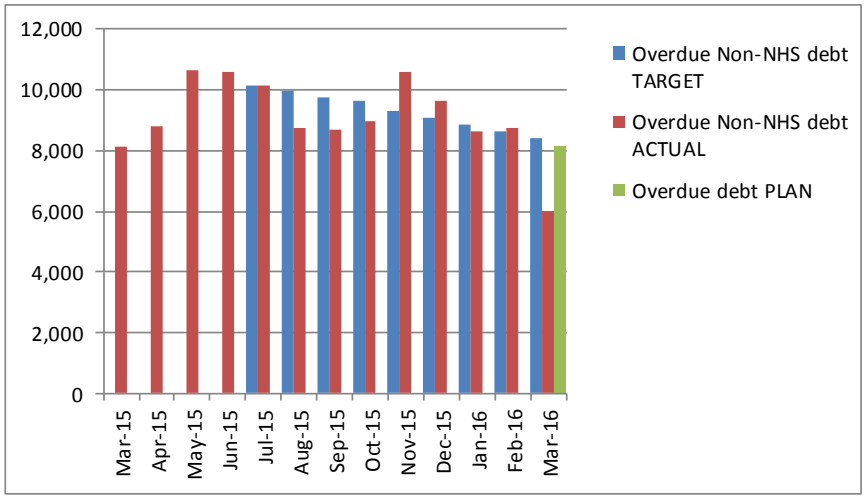
Debtor days	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
NHS income debtor days	18	19	19	19	19	20	22	22	31	29	27	27	26
Non-NHS income debtor days	205	202	219	229	205	199	198	191	256	205	205	227	192
DWP/CRU debt	981	987	1000	1029	1078	1019	1038	1080	1084	1072	1212	1266	1316
Overseas patient income	807	789	769	753	761	740	677	793	810	778	690	682	657

Debtor days = debt by average daily income for last 12 mths

Overdue NHS debt: performance vs stretch reduction targets



Overdue non-NHS debt: performance vs stretch reduction targets



17. Balance sheet as at month 12 2015/16

ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
Finance Department
Balance sheet March 2016

	Mar-16 Plan £000	Mar-16 Actual £000	*Variance £000*	**Explanations of balance sheet variances**
Fixed assets	360,075	338,386	*21,689*	Much lower capital expenditure than plan - so lower fixed assets
Stock	6,300	6,236	*64*	Pharmacy reduced stock by £0.7m in M12. Includes provision of £0.4m for central store stock.
Debtors	78,233	67,568	*10,665*	Debt balancves lower than Plan - high level of NHS receipts in last quarter.
Cash	3,000	7,397	*-4,396*	Lower capex, and better working capital performance has enabled Trust to finance the higher deficit and borow less than planned. Year end cash bal was £4.4m better than Plan.
Creditors	-81,944	-83,534	*1,590*	Longer supplier payment terms since July.
Capital creditors	-3,476	-2,933	*-543*	
PDC div creditor	0	0	*0*	
Int payable creditor	-315	-264	*-51*	
Provisions< 1 year	-602	-512	*-90*	
Borrowings< 1 year	-60,091	-6,360	*-53,732*	(NB: WCF is classified as non-current liability c/f Plan)
Net current assets/-liabilities	**-58,896**	**-12,402**	*-46,493*	
Provisions> 1 year	-1,181	-1,058	*-123*	
Borrowings> 1 year	-93,229	-131,314	*38,086*	Includes £40.4m ISF borrowings (£52.2m per Plan)
Long-term liabilities	**-94,410**	**-132,372**	*37,963*	
Net assets	**206,770**	**193,612**		
Taxpayer's equity				
Public Dividend Capital	133,761	129,520	*4,241*	£4.6m PDC capital repaid re: capital to revenue transaction. Also £0.36m received for capex.
Retained Earnings	-29,502	-37,005	*7,503*	Higher I&E deficit than plan
Revaluation Reserve	101,360	99,947	*1,413*	
Other reserves	1,150	1,150	*0*	
Total taxpayer's equity	**206,770**	**193,612**		

18. Borrowings analysis at M12

ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
Finance Department

Borrowings summary - MARCH 2016

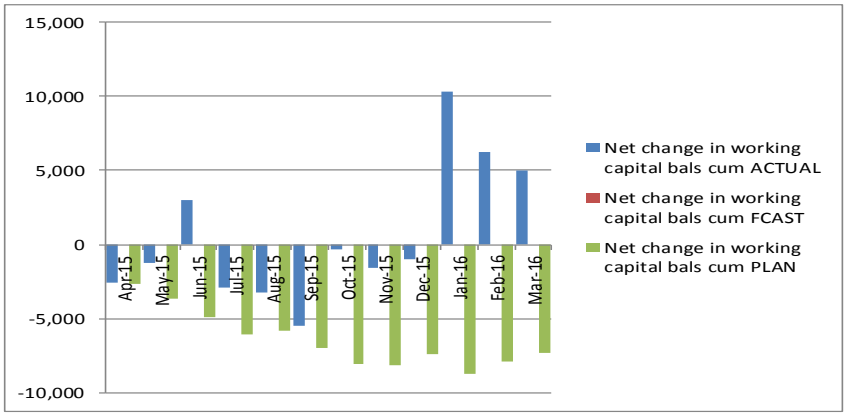
	Lender	Description	Interest rate fixed/variable	Interest rate pa	Term	Repayment terms	Maximum Facility value £000	Borrowings repay<1 yr at 31/03/16 £000	Borrowings repay>1 yr at 31/03/16 £000	Borrowings at 31/03/16 £000
	Loans									
1	Dept of Health	Capital loan	Fixed	2.20%	25 yrs	Repayable in bi-annual instalments	-14,747	-601	-13,850	-14,451
2	Dept of Health	Working capital loan	Fixed	1.38%	15 yrs	Repayable in bi-annual instalments	-15,000	-999	-13,002	-14,001
3	Dept of Health	Working cap facility	Variable: base rate+1%	1.50%	5 yrs	100% repayable on 18/04/20	-25,000	0	0	0
4	Dept of Health	Working cap facility	Variable: base rate+3%	3.50%	5 yrs	100% repayable on 21/09/20	-19,600	0	0	0
5	Dept of Health	Interim revenue support facility	Variable: base rate+1%	1.50%	2 years	100% repayable March 2018	-48,700	0	-40,396	-40,396
6	London Energy Effic. Fund	Capital loan	Fixed	1.50%	10 yrs	Repayable in bi-annual instalments	-13,303	-1,478	-11,086	-12,564
	Loans - total							-3,078	-78,334	-81,412
	Leases									
7	Blackshaw Health. Servs PL	PFI scheme	Implicit rate	7.50%	35 yrs	Repaid monthly in unitary charge	N/A	-928	-44,658	-45,586
8	Various lessors	Finance leases	Implicit rates	3%-7.5%	Various	Repaid quarterly or annually	N/A	-2,330	-8,346	-10,676
	Leases - total							-3,258	-53,004	-56,262
	Total Borrowings							-6,336	-131,338	-137,674

Notes

1 DH capital loan £14.747m approved in 2014 for bed capacity projects, hybrid theatre, surgical assessments unit etc.
2 Working capital loan £15m: approved in January 2015 on licensing of Foundation Trust status to boost Trust's working capital resilience. Drawn down in full in March 2015
3 Working capital facility £25m approved in January 2015 on assumption of Foundation Trust status. Drawn down in tranches July - Sept 2015 inclusive.
This facility will be repaid in full on 15th February 2016 when the drawdown is made from the recently approved interim revenue support facility (see no. 5)
4 Working capital facility £19.6m approved in September 2015 to provide cash support for period October 2015-January 2016 inclusive pending agreement of interim revenue support funding for 2015/16.
This facility will also be repaid in full on 15th February 2016 when the drawdown is made from the recently approved interim revenue support facility (see no. 5)
5 Interim revenue support facility £48.7m approved in February 2016.
The Trust drew down £36.396m from this facility on 15th February 2016 and repaid the amounts drawn under the working capital facilities per 3. and 4. above as set out in the paper approved by the board on 4th February.
6 London Energy efficiency Fund loan for the energy performance contract.
7 AMW PFI building is accounted as on-balance sheet. The 'borrowing' figure for the lease represents the capital value of the building, fixtures and fittings encompassed in the PFI contract.
8 Finance leases for medical equipment - eg major diagnostic equipment. The capital value of new finance leases represents capital investment and is reported as such in the capital programme.

19. Working Capital – cumulative position at M12

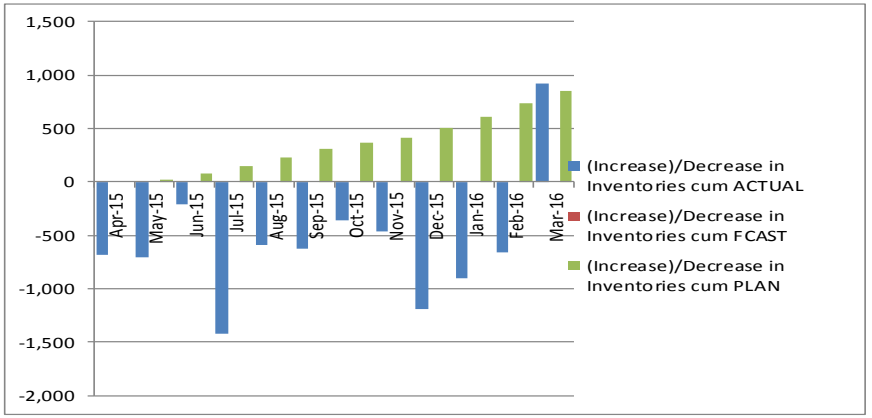
Change in all working capital balances 2015/16 actuals vs plan



£12.3m BETTER than Plan. Working capital bals deteriorated by £1.3m in M12 but performance for the year was better than plan by £12.3m

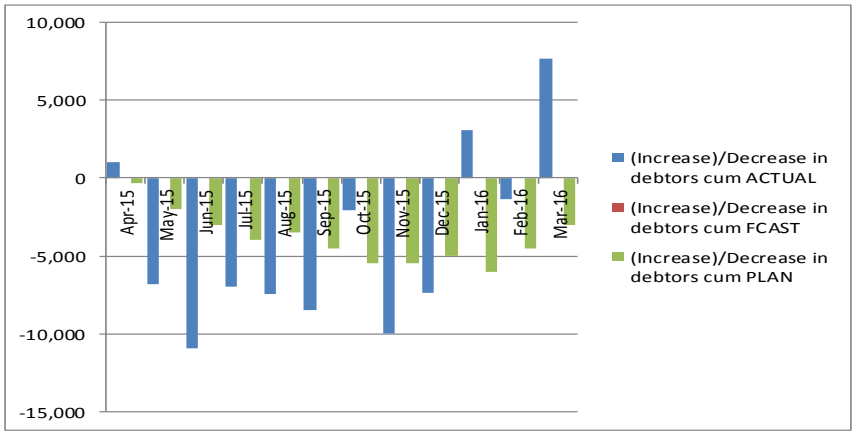
Other 3 graphs on this slide break down this movement by inventories, debtors and creditors.

Change in inventories (stock) 2015/16 actuals vs plan



£0.1m BETTER than Plan. Stocks reduced by £1.6m in M12 - mainly due to tight control at year end by pharmacy (£0.7m reduction). This reduction also includes the provision of £0.4m for obsolete/slow-moving central store stock.

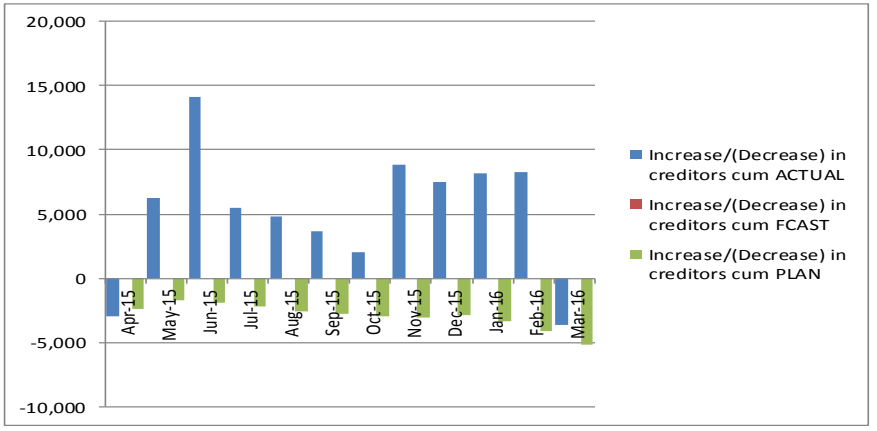
Change in debtors 2015/16 actuals vs plan



£10.6m BETTER than Plan. Debtors (invoice and accrued debt) reduced by £9m in M12 NHSE paid £7.2m for 2015/16 SLA over-performance following escalation.

NHS *overdue* debt was broadly unchanged from February's level and remains over the stretch target. Non-NHS debt though reduced to £2.4m below the target level in March.

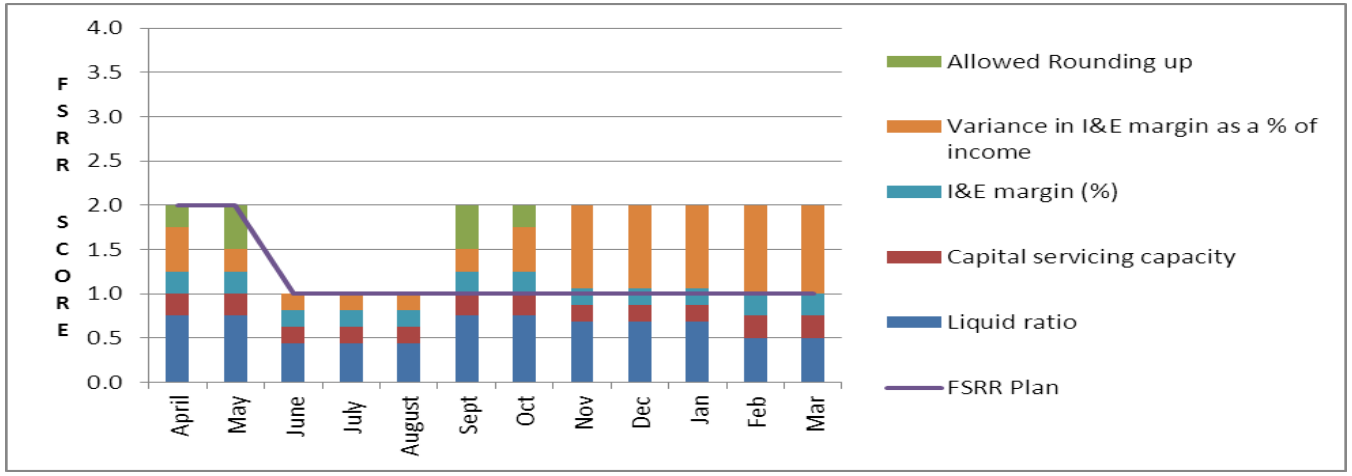
Change in creditors 2015/16 actuals vs plan



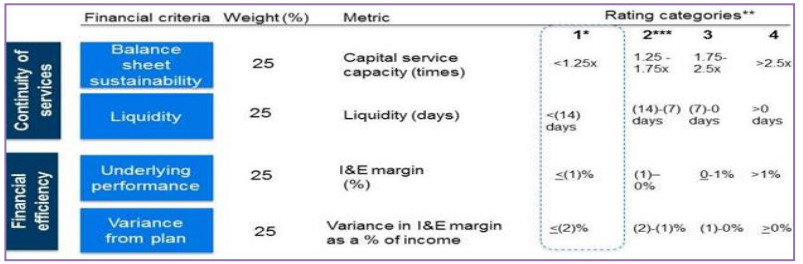
£1.6m BETTER than Plan. Overall level of creditors reduced markedly in M12 (as forecast) due to the payment of CNST premiums, NHSPS rental charges and the PDC dividend in March. The Trust continues to pay approved invoices to the new standard terms.

20. Financial Sustainability Risk Rating (FSRR)

2015/16 ACTUALS	Month											
Metric Scores (4 best, 1 worst)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Liquid ratio	3	3	2	2	2	3	3	3	3	3	2	2
Capital servicing capacity	1	1	1	1	1	1	1	1	1	1	1	1
I&E margin (%)	1	1	1	1	1	1	1	1	1	1	1	1
Variance in I&E margin (%)	2	1	1	1	1	1	2	4	4	4	4	4
Weighted Average	1.8	1.5	1.3	1.3	1.3	1.5	1.8	2.3	2.3	2.3	2.0	2.0
Overriding Score (with rounding)	2	2	1	1	1	2	2	2	2	2	2	2
2015/16 PLAN	2	2	1	1	1	1	1	1	1	1	1	1



Threshold details:



	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%

In March the Trust achieved a score of 2 for its risk rating which is ahead of the planned rating of 1. Ratings for capital servicing and I&E margin are in line with planned scores of 1 and variance and liquidity metrics are both better than plan.

Following the change in definition of the risk rating, Monitor has confirmed that the plan value from June should be a 1, reflecting performance in 2014/15 .

The deterioration in net current assets has moved the Liquid ratio metric to a 2.

The I&E variance of +0.1% as a percentage of income to date is within the range for a score of 4 due to improved performance against the I&E plan to March.

Report to the Board from Finance & Performance Committee: 27 April 2016

For a second consecutive month, several papers for this meeting had either been circulated very late or at the meeting. This is clearly unsatisfactory and the executive is urged to ensure that the agreed deadlines for F&P papers must be met from May onwards in order to ensure that this Board Committee is able effectively to meet its terms of reference. The Committee recognises that additional senior interim resources are now being added to the team to address this.

Mike Rappolt has retired. The F&P Committee now has only two NED members because a new NED with financial experience has yet to be appointed. The quorum for this committee is for two NEDs to be in attendance, so there is an urgent need to appoint a replacement for Mike Rappolt. The Interim Chair has this in hand, in liaison with the governors' nominations committee.

2015/2016 outturn

The draft accounts show an I&E deficit of £55m against the c£56m agreed with Monitor in January. It has been agreed that the 14/15 accounts will not be re-opened.

2016/2017 budget

Unfortunately this is not yet finalised. A Board-approved budget is due to be submitted to NHSI on 11 May 2016.

Based on extensive and detailed Trust-wide 'TRP 2' budgeting work in Q3 and Q4, with support provided by KPMG and the outcome challenged by F&P and Board, to establish a sound 2016/7 forecast, the Board approved in January a 16/17 budget incorporating our STP proposal for £17m STP funding over the year. We submitted in February to Monitor ('the APR submission') the detailed STP return reflecting, in summary, a £72m run-rate I&E position for the year, less £50m (net of expenses) of validated but not yet fully resourced improvement plans, with some additional small adjustments, arriving at a c£17m net deficit. This was supported by detailed validation and recommendation from the turnaround director and his KPMG supporting team. Since January, NHSI have continued to press us to improve the proposed position further eg by reflecting the current positive staff cost variances.

However, this F&P Committee was presented with papers showing a reforecast deficit for 16/17 of £26.8m, and a draft budget deficit of £43.6m, without cash flow or transformation project analyses.

F&P agreed:

* that a very considerable amount of additional detailed work is needed to conclude a 16/17 budget which can be discussed and challenged in detail, and then approved for NHSI submission by the Board, reconciling to the January 2016 submission. Particular focus is needed urgently to determine:

    * what asset sales, if any, are appropriate and capable of being concluded in 16/17

* proposed additional I&E (and capital) spend needed to deal with rectifying IT and estates maintenance backlogs

* realistic, achievable but stretching Improvement Plans, based on the detailed programme of £50m developed with KPMG support over recent months

* final contracting with commissioners and consequent adjustments to activity

* recoverability of the agreed £17m STP funding over the next 4 quarters

* that there is an urgent need for all Trust budget holders for 2016/17 to be determined and to have clear and agreed budgets in place for the year which they 'own' and for which they are held accountable.

F&P noted that the Trust's cash flow forecasts and the loan and facility arrangements currently in place reflect the 2016/17 forecasts submitted to Monitor in January. F&P sought and received the CFO's assurance at this meeting that all the conditions of these arrangements continue to be fully met. However, should the 2016/17 forecasts change then clearly the loans and facilities now in place will be insufficient and will need to be renegotiated.

F&P welcomed a positive update from the procurement team and the feedback from divisions that important procurement processes are now much improved. The team is now fully staffed, but requires further urgent improvements in Aggresso to improve effectiveness and control.

F&P welcomed confirmation that a board-level interim head of IT will join on 3 May.

Performance

Paula Vasco-Knight reported on the developing trajectories and plans to achieve significant and sustainable improvements in cancelled operations, cancer waits, RTT and ED. She and her team are working closely with CCGs and also with a 'deep-dive' investigation into RTT which has been requested by NHSI.

Sarah Wilton

2 May 2016

St George's University Hospitals NHS
NHS Foundation Trust

FY16/17 Budget Board Sign Off

5 May 2016

Contents

Board Resolution

Recommendation

The Board are asked to:

1. APPROVE the budget for FY16/17 with a planned deficit of £17.2m
2. APPROVE the submission of the budget for FY16/17 to Monitor; and,
3. AGREE to give delegate authority to the Chief Executive and the Chief Finance Officer to approve any amendments to the plan prior to the submission date.

Executive Summary

Headlines	
£17.2m deficit	• The final budget has been aligned with the control deficit set by Monitor of £17.2m. There is a risk that NHSI revises the 16/17 control totals for all Trusts but the Trust has on balance more downside risk than upside risk
Consistency with TRP2	• Whilst the Trust has moved away from the process used for TRP2, many of the assumptions, especially for the pay and non pay costs are broadly consistent. The baseline deficit (before STF and Transformation savings) is £71m, which is close to the TRP equivalent deficit of £72m
The previous draft deficit of £42m has been reduced using top down measures	• The approach taken to reduce the deficit has been to challenge all costs over and above the level of funded development ie only the growth and business cases agreed to be funded by the CCGs / NHSE has been allowed to have cost budgeted for it. We have sought to minimise the level of unfunded development. On this basis, we have reduced costs by £20m and the balance of £6m (being the difference between the previous deficit budget and the control total sought by NHSI) has been added to in year transformational savings as an unallocated target.
Reduced level of transformation savings	• The net in year savings of £35.5m, comprising gross benefits of £42.2m and one off costs of implementation of £6.7m is significantly reduced from the savings envisaged in TRP2
Excludes any major estates improvements or IT infrastructure spend	• This budget represents a baseline budget for 16/17 and excludes any provision for addressing the significant issues within the Estates and IT infrastructures which have yet to be assessed and any impact on services required to be relocated
No asset disposals	• No asset disposals have been included in this budget
Limited liquidity headroom	• Whilst the funding of a deficit of this size is within the Trust's existing finance facilities, there is only £0.8m of headroom and the Trust will need to consider additional facilities to manage any operational under-performance and slippage in the delivery in the transformation programme

Key assumptions

Main I&E items				
Area	**Inflation**	**v FY15/16**	**Basis**	**Revision since TRP2**
SLA income	c.2% demographic growth	5.9% increase	Based on agreed contractual position with CCGs and NHSE	Removal of all national fines resulting in £9m of local fines
Other income	4.3% MADEL and 1.1% SIFT	2.6% decrease	The year on year reduction reflects the non recurrence of cap to rev income in 15/16 of £4.5m, reduced education income of £3m and reduced charitable income of £2m	Increased non recurring income in 15/16
STF Income	n/a	n/a	£17.6m negotiated support. Full value budgeted without provision of performance conditionality which has yet to be issued	Not originally budgeted in TRP2
Pay	2.5%	7.3% increase	2.5% inflationary increase represents increased national insurance costs, drift and pay rises.	A pay underspend in 15/16 has been followed through into 16/17. Only fully funded growth has been matched with equivalent pay costs
Non pay	4.5% drugs, 1.2% other	5.2% increase	TRP non pay run rates adjusted for known cost pressures	CNST mandatory increase has been £4m higher. Non pay marginal costs provided for unfunded growth
Other	3.1% capital costs	1.5% increase	Asset revaluation is assumed to be nil.	

Key assumptions (cont'd)

Other assumptions

Area	Assumption
Contingency and provisions	A general £7.5m contingency is included – no change on TRP2. This was originally included to cover unbudgeted estates costs for managing backlog maintenance, additional implementation costs for the transformation programme and actual costs for growth where marginal cost had been disallowed
Savings	Gross in year savings of £42.2m are included with a net benefit of £35.5m after implementation costs of £6.7m – see separate slide. TRP2 was based on PIDs but over the last quarter, DIPs have been developed with lower gross savings and higher implementation costs.
Fines and penalties	£9m of fines and penalties are incorporated into the position.
System resilience	Since TRP2, all SRG income of £6.6m has been lost and therefore all associated costs have been removed. Approximately £3.5m of capacity and flow initiatives have been agreed with CCGs and full costs for these have been included

Capacity and flow assumptions	£m
Costs included in forecast	
Recovery at home	1.7
SAU	2.6
Main capacity and flow costs	**4.3**

Key assumptions (cont'd)

Other assumptions

Area	Assumption
Outsourcing	The TRP assumes £7.8m of outsourcing, an increase of £1.4m from FY15/16. However, this includes £1.7m in respect of Healthcare at Home so the like for like position is a £0.3m decrease on FY15/16.
Demand and capacity (DCM)	The forecast contains the following activity assumptions:

Activity type	2014-15	2015/16	2016/17	% increase
AE	153,297	160,267	163,742	2.2%
DC	45,058	57,395	59,149	3.1%
EL	15,867	16,121	18,020	11.8%
NE	46,868	46,312	46,667	0.8%
OP	653,831	640,820	666,142	4.0%
	914,921	**920,915**	**953,720**	**3.6%**

Further work is required to assess the capacity risks using the Demand and Capacity Management model of the above activity growth rates and the flow improvements from the transformation programme.

Working capital	Working capital is budgeted to deteriorate by £3.1m reflecting a risk that supplier terms of 60 days may be eroded, offset by an improvement in stock and debtors.
Capex	Capital expenditure 16/17 is £38.4m comprising £30m per the comprehensive ranking and evaluation process carried out in December and January plus £8.4m slippage in 2015/16 since this process was completed.

Key assumptions (cont'd)

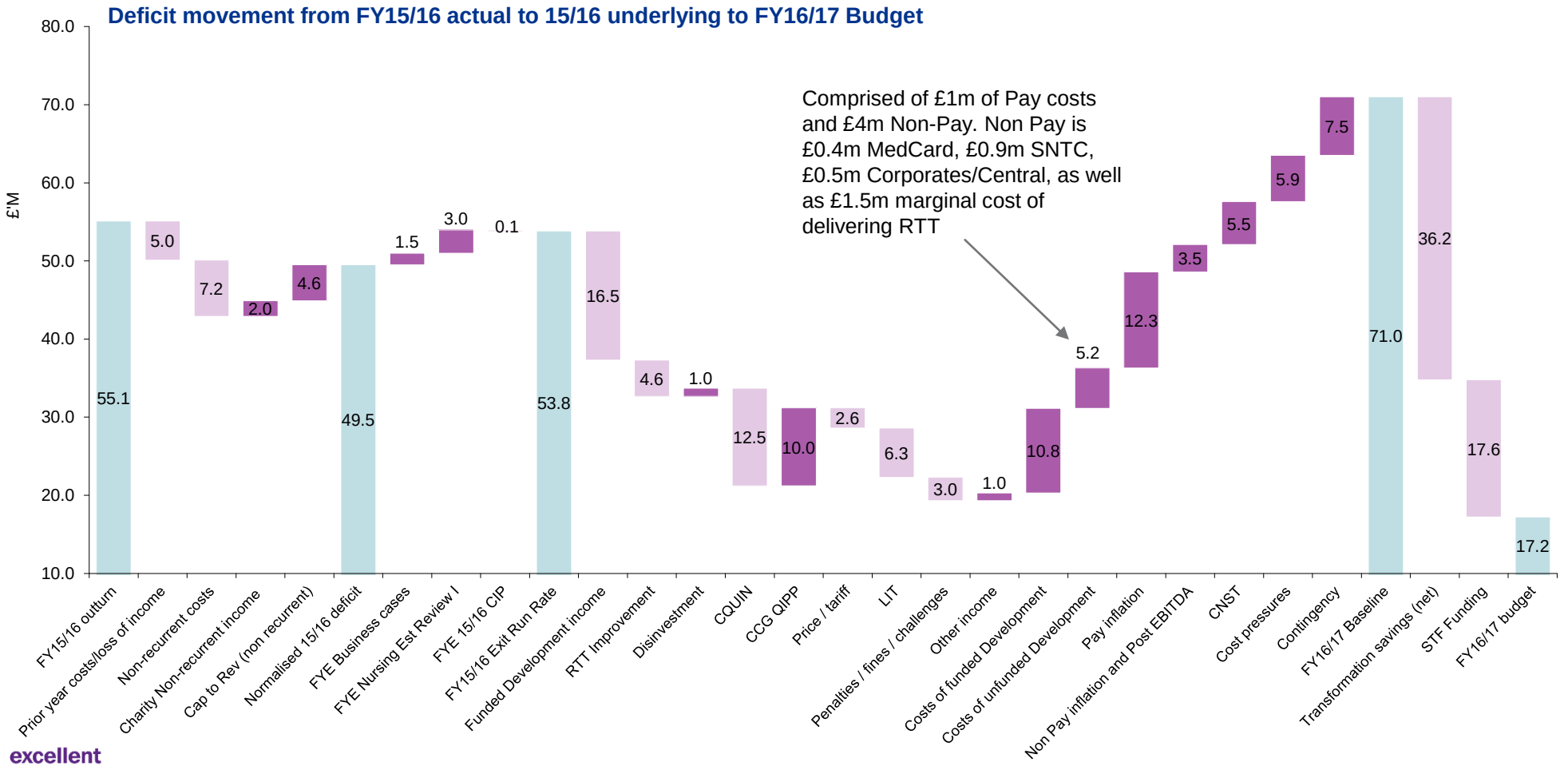
Pay

Assumption	%	
Pay award	1.0%	National pay award as confirmed by Chancellor, assumed applicable across all pay costs
Pension/NI Impact	1.6%	Changes to the NI rules around defined benefit pension schemes come in to effect from 1 April 2016. The estimated impact of this to relevant pay costs is 1.85%. This assumed to apply to c.87% of pay costs.
Incremental drift	(0.1)%	Under agenda for change there are progression spine points within grades. Based on the current staffing profile, levels of staff attrition and future staff recruitment, the inflationary impact in to 2016/17 is estimated to be a deflation of 0.1%, this is estimated to apply across 75% of pay cost.
Risk provision	0.2%	Although a large amount of analysis has gone into the above inflation estimates, there is still room for differences when the actual position for 2016/17 pay cost and work force is known at the granular level. Overall 0.8% is incorporated in the final pay inflation assumption to cover risk. This amounts to £3.6m.
Overall pay inflation	**2.5%**	**The overall pay inflation assumption for the Trust amounts to £12.3m.**

Assumption	Comment
Attrition	Nursing is currently in a net attrition position. Overall attrition is assumed to remain consistent with FY15/16 levels at c.17.5% into FY16/17.
Sickness	Forecast to remain consistent with FY15/16 levels at 3.5% into FY16/17.
Training days	Assumption is consistent with FY15/16 forecast position.
Maternity	Assumption is consistent with FY15/16 forecast position.

FY15/16 actual to FY16/17 Budget

The forecast benefit from the Transformation Programme and STF is budgeted to be eroded by the net increase in operating income of £34m being more than offset by increases in the cost base of £51m



excellent
kind
responsible
respectful

FY16/17 Budget summary

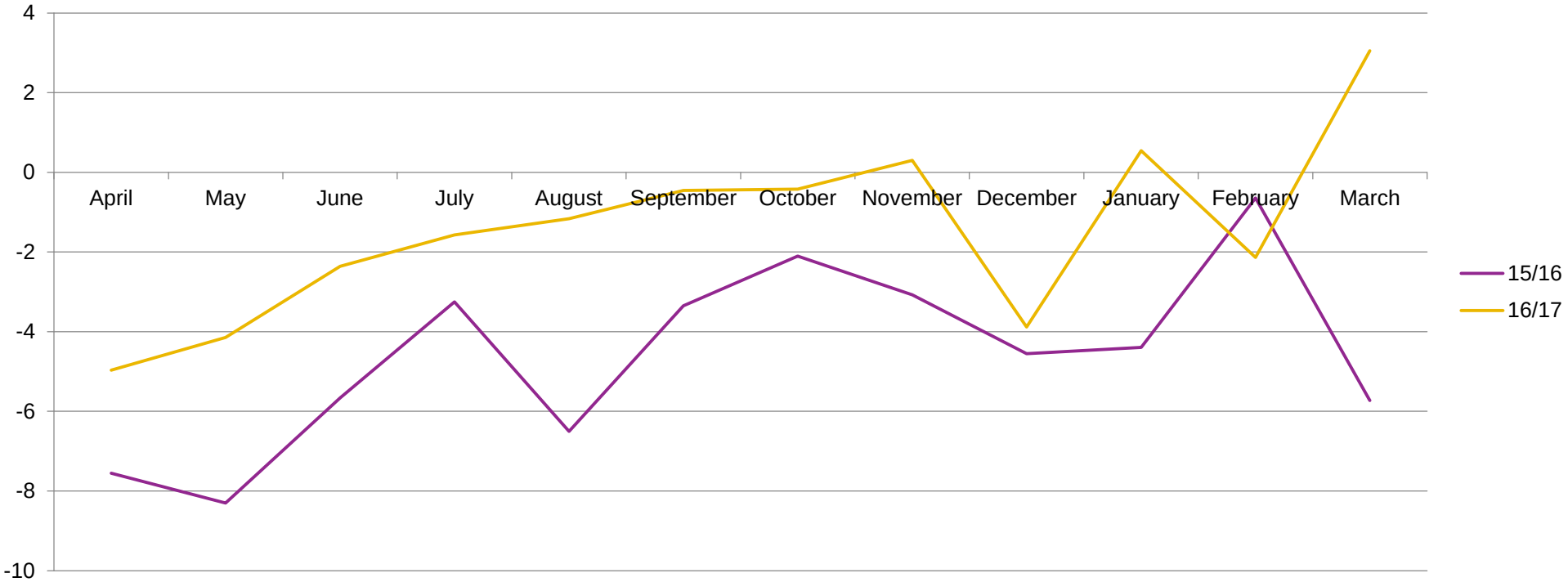
£'m	FY14/15 actual	FY15/16 actual	FY16/17 budget	FY15/16 to FY16/17	%
SLA income	-603.6	-611	-647.1	-36.1	5.58%
Other income	-61	-109.7	-106.9	2.8	-2.65%
Pay	418.9	458.9	474.9	16.0	3.37%
Non Pay	230.3	282.6	294.6	12.0	4.06%
Other	32.1	34.3	35.2	0.9	2.54%
Deficit	**16.8**	**55.1**	**50.7**	**-4.4**	**-8.72%**
STF			-17.6		
Pay Award			12.3		
Cost Pressures			13.4		
Cost Reductions			-5.5		
Savings			-36.1		
Net Deficit			**17.2**		

£'m	FY14/15 actual	FY15/16 actual	FY16/17 budget	FY15/16 to FY16/17	%
MedCard	-52.6	-47.2	-56.7	-9.5	16.75%
STNC	-26.2	-22.4	-23.9	-1.5	6.13%
CSD	-26.3	-24.4	-24	0.4	-1.63%
CWDT	9.5	10.2	10.2	0.0	-0.10%
Corporate	112.4	139.0	145.1	6.1	4.23%
Deficit	**16.8**	**55.1**	**50.7**	**-4.4**	**-8.77%**
STF			-17.6		
Pay Award			12.3		
Cost Pressures			13.4		
Cost Reductions			-5.5		
Savings			-36.1		
Net Deficit			**17.2**		

The £38m budgeted improvement in the 16/17 deficit comprises:

- £4m improvement in the financial positions in the clinical and corporate divisions
- Receipt of £17.6 of STF funding
- £12.3m pay award (not allocated to divisions)
- £13m of cost pressures made up of
  - £7.5m General contingency
  - £1.6m SAU
  - £1.0m costs to deliver the CQUINs
  - £1.0m of marginal cost for RTT growth
  - £0.8m international recruitment
  - £1.5m other
- Cost reductions comprise reductions required around two areas of specific income loss which have yet to be analysed back into the divisions:
  - £3.0m loss of education income
  - £2.5m loss of SRG funding (excluding CWDT)
- With the exception of the corporate division, none of the clinical divisions are budgeting for a significant deterioration in their financial position.

FY16/17 Phased budget



- The budgeted phasing for 16/17 continues the underlying improvement trend for 15/16
- March 17 is budgeted to be a significant monthly surplus
- The underlying trend in 15/16 resulted in a deficit in March 2016 of £2.1m but the budgeted deficits in April and May 2016 are forecast to be significantly worse than the March 2016 underlying position due to prudent phasing of cost assumptions as well as the pay increases on 1 April

Transformation Programme

Latest view of transformation workstreams

	STRETCH	PID (TRP2)	DIP	Latest	*Var. to PID*	Explanation
WEG	25.0	12.2	10.5	10.0	*(2.2)*	£1m of cost omitted from PID (assumed held centrally); £1.2m reduction in estimated gross benefits
Clinical Transformation (excl Outpatients)	10.0	7.4	6.9	5.5	*(1.9)*	Flow - Nightingale SLA income excluded (£1.5m); Theatres benefit reduced (£0.8m); reduction in implementation costs.
Portfolio Optimisation (Incl Outpatients)	15.0	7.3	3.7	3.5	*(3.8)*	£2m of Outpatients benefit now excluded (national fines savings, now excluded from income); Commercial/PP (£1.9m) cannot be delivered (capacity needed for RTT).
Divisional CIP	10.0	13.4	11.6	10.0	*(3.4)*	No PID; estimate included £2.8m already in TRP2
Corporate	4.0	0.5	0.5	(0.1)	*(0.6)*	IT run rate/outsourcing (£0.4m, not achievable) - never had detailed plans. Finance restructure was in TRP. Estates restructure not proceeding.
Procurement	6.0	6.0	6.0	6.0	*0.0*	
Medicines Optimisation	2.0	1.8	1.8	1.8	*0.0*	
Infrastructure	3.0	1.5	(0.8)	(0.5)	*(2.0)*	Estates run-rate (£400k) and other savings now excluded; Mitie (£344k) saving was baked into TRP2.
Total (zero asset disposals)	**75.0**	**50.1**	**40.2**	**36.2**	***(13.9)***	
Stretch target to be identified				6.0		
Budgeted benefits				**42.2**		

Phasing

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Benefits phasing	0.7	1.5	1.9	3.0	3.5	3.3	3.9	4.1	4.6	5.2	5.2	5.3	42.2
Per quarter		4.1			9.9			12.5			15.7		
% per quarter		10%			23%			30%			37%		

excellent
kind
responsible
respectful

Capex

Capex: 2015/16 vs 2016/17

Category	Actual 2015/16 £000	**Draft budget 2016/17 £000**
IMT	4,860	**5,172**
Infra Renewal EPC	1,015	**11,556**
Infra Renewal	2,975	**7,892**
Major Projects	12,113	**6,804**
Med Equipment	9,454	**4,843**
Other	601	**2,031**
SWL Pathology	57	**183**
Total	**31,075**	**38,480**

Analysis of draft capital budget 2016/17

	Contracted £000	Charity £000	Essential £000	**Total £000**
IMT	2,617		2,554	**5,172**
Infra Renewal	671		7,221	**7,892**
Infra Renewal EPC	11,556			**11,556**
Major Projs	3,047	660	3,096	**6,804**
Med Eqpt		1,048	3,795	**4,843**
Other			2,031	**2,031**
SWL PATH			183	**183**
Grand Total	17,891	1,708	18,880	**38,480**

- A risk evaluation and ranking process was carried out by the Investment, Divestment and Disinvestment Group. Steve Bolam, Eric Munro, Andrew Burn and the DDOs participated in the process. The resulting opening draft 2016/17 draft capital programme (£30.028m) was then endorsed by the Executive Management Team (EMT) in February.
- The figures now include the carry forward for 2015/16 slippage arising since the risk evaluation and ranking process was completed and the updated total budget is £38.4m.
- There is a contingency of £2m included within the overall capital programme. This is included within the spend category “Other” and is currently unallocated.
- The £38.4m total includes capital value of new finance leases £3.6m

Cash

	2016/17 Q1 £000	2016/17 Q2 £000	2016/17 Q3 £000	2016/17 Q4 £000	2016/17 Total £000
Cash balance b/fwd	**7,397**	**3,000**	**3,000**	**3,000**	**7,397**
Income and expenditure deficit	-11,468	-3,188	-4,005	1,461	-17,200
Interest receivable	-6	-6	-6	-6	-24
Interest payable	1,219	1,282	1,305	1,307	5,113
PDC dividend	1,561	1,563	1,563	1,563	6,250
Depreciation	6,025	6,175	6,325	6,475	25,000
EBITDA	**-2,669**	**5,826**	**5,182**	**10,800**	**19,139**
Non-cash income	-45	-45	-45	-47	-182
Interest paid	-1,105	-1,400	-1,099	-1,503	-5,107
PDC dividend paid	0	-3,124	0	-3,126	-6,250
Operating surplus/-deficit less int and divs paid	**-3,819**	**1,257**	**4,038**	**6,124**	**7,600**
Change in stock	-450	225	250	575	600
Change in debtors	-2,800	850	500	3,250	1,800
Change in creditors	5,762	-2,300	-2,000	-6,962	-5,500
Net change in working capital	**2,512**	**-1,225**	**-1,250**	**-3,137**	**-3,100**
Provisions used	**-68**	**-68**	**-68**	**-68**	**-270**
Interest received	6	6	6	6	24
Capital spend (pymts) - internal capital	-8,466	-12,068	-7,164	-5,678	-33,376
Net cash inflow/-outflow from investing activities	**-8,460**	**-12,062**	**-7,158**	**-5,672**	**-33,352**
Interim support funding requirement (ISF)	7,625	14,020	6,314	4,524	32,482
Loan repayments	-1,040	-500	-1,040	-500	-3,079
PFI finance lease repayment	-232	-232	-232	-232	-928
Other finance lease repayment	-915	-1,190	-605	-1,040	-3,750
Net cash inflow/-outflow from financing	**5,438**	**12,098**	**4,437**	**2,753**	**24,725**
Cash balance c/fwd	**3,000**	**3,000**	**3,000**	**3,001**	**3,000**

Cash assumptions and risks

1. Trust incurs I&E deficit of £17.2m in 2016/17 - NO ASSET SALES
2. Capital expenditure 16/17 is £38.4m (comprising £30m per M07 evaluation process + £8.4m slippage since M07
3. Energy Performance Contract accounts for approx £11.6m of capital expenditure.
4. Finance lease funded capital expenditure is £3.6m (included in £38.4m above).
5. No external capital loans taken out in year.
6. Capital expenditure weighted to first two quarters (61% spent by 30/09) to address infrastructure renewal priorities.
7. Net working capital movement in year -£3.1m - improvement in stock (£0.6m) and debtors (£1.8m) offset by deterioration in creditors (-£5.5m) due to trading deficit and a prudent assessment of potential erosion of the 60 day supplier payment terms implemented in 2015/16.
8. Trust would require WCF/ISF drawdowns totalling approx £32.5m to finance the deficit, loan repayments and restricted capital programme which is equivalent to the total of secured borrowing capacity available.
9. Secured borrowing capacity as at 1st April 2016 is £33.3m

<u>10. Cash risk.</u>

On the basis of the above assumptions, the Trust would require approx £32.5m ISF borrowing for the year, almost exhausting its secured borrowing capacity of £33.3m. The I&E position contains significant risk in respect of CIP delivery and the £17.6m Sustainability and Transformation funding which is conditional on the Trust's achievement of specific financial and performance objectives.

Therefore the Trust's current assessment is that additional borrowing facilities of approx £20m should be sought in 2016/17 to provide sufficient resilience to manage these risks to the cash position.

Balance sheet

Forecast Statement of Financial Position ("Balance sheet") 2016/17

	Mar-16 Actual £000	Mar-17 Forecast £000	*Movement £000*	**Explanations of balance sheet movements 2016/17**
Fixed assets	337,204	350,866	*13,662*	
Stock	6,238	5,638	*-600*	Reduction in stock following full roll-out and compliance for central store stock system
Debtors	67,568	65,768	*-1,800*	Includes cash benefit of better performance for collection than 15/16
Cash	7,395	2,998	*-4,397*	Cash balance includes total draw WCF/ISF drawdowns of approx£33m for year.
Creditors	-83,534	-78,034	*5,500*	Higher non-pay expenditure and projected partial erosion of 60 days terms
Capital creditors	-2,933	-4,433	*-1,500*	Dependent on Cerner contract (work performed in 16/17 not paid until 17/18)
PDC div creditor	0	0	*0*	
Int payable creditor	-264	-270	*-6*	
			0	
Provisions< 1 year	-512	-242	*270*	
Borrowings< 1 year	-6,359	-5,174	*1,185*	
Net current assets/-liabilities	**-12,401**	**-13,749**	*-1,348*	
Provisions> 1 year	-1,058	-1,058	*0*	
Borrowings> 1 year	-131,315	-160,829	*-29,514*	Includes projected ISF drawdown of £32.4m.
Long-term liabilities	**-132,373**	**-161,887**	*-29,514*	
Net assets	**192,430**	**175,230**		
Taxpayer's equity				
Public Dividend Capital	129,520	129,520	*0*	
Retained Earnings	-36,722	-53,922	*-17,200*	I&E deficit £17.2m for the year.
Revaluation Reserve	98,482	98,482	*0*	
Other reserves	1,150	1,150	*0*	
Total taxpayer's equity	**192,430**	**175,230**		

Risks

Area	Risk Description	Potential Impact
Plan Delivery	The 16-17 Plan is not achieved. The financial plan could be destabilised by “must-dos” including patient safety, leading to slippage on recovery plans, pressure on cash; and non-achievement of in-year plans. **Mitigations:** Focussed strengthening of management capacity and capability to assure delivery Continuing emphasis on the continuing need to proceed at pace to deliver change; Continuing dialogue with stakeholders to ensure shared approaches to challenges.	Key stakeholders lose confidence in the Trust and its leadership team.
Income and Activity	Expenditure reductions and regulatory risks impact on the Trust’s ability to deliver planned activity. The Trust has insufficient capacity to deliver expected levels of activity. **Mitigation:** Careful balancing of income and expenditure priorities to ensure that activity is delivered. Continuing dialogue with stakeholders including support to commissioner QIPP plans (demand management.)	Strategic Transformation and other budgeted income funding are not achieved. The financial plan is not achieved.
Expenditure	Efficiency programmes will not be sufficient to deliver savings assumed within budgets. Staff do not buy in/ understand the requirement to deliver agreed expenditure budgets. Risk that the expenditure budgets after efficiency gains are seen as incompatible with the achievement of income targets; and/or central/local savings targets are double counted, giving the Board a false sense of assurance. **Mitigations:** Minimise risk of double counting by devolving financial targets to divisional levels; Stronger performance management and follow-through of actions; Increase assurance through robust data quality; tight management of vacancies and staff costs.	CIP targets are not achieved. The expenditure plan is not achieved.

Risks (cont'd)

Area	Opportunity Description	Potential Benefit
Regulatory Risk	The financial plan is not accepted by NHS Improvement. Care Quality Commission, Royal Colleges and other regulators may require additional investment NHS Improvement may increase controls over agency and premium costs, leading to staffing constraints. **Mitigation:** Raise awareness within divisions and develop locally-owned mitigation plans; Develop active communication plans for stakeholders and patients about responses to risks and mitigating actions; More robust performance management to promote improved ownership and mitigations.	The Trust does not achieve its income target. The Trust is required to invest more than its budgeted expenditure plans (capital and/ or revenue) The Trust is unable to manage within the cash resources available. The Trust's financial plan is not achieved.

St George's University Hospitals NHS
NHS Foundation Trust

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NHS Foundation Trust

REPORT TO TRUST BOARD ***May 2016***

Paper Title:	Risk and Compliance report for Trust Board incorporating: 1. Corporate Risk Register 2. External assurances
Sponsoring Director:	Jennie Hall, Chief Nurse/DIPC
Author:	Sal Maughan, Head of Risk/ Governance
Purpose:	To highlight key risks and provide assurance regarding their management.
Action required by the committee:	The board are asked to: - *Discuss and make recommendations* around the current risk profile as set out in the report to ensure this reflects the range of current risks to the organisation, including its external environment

Executive summary
Key messages:

Corporate Risk Register (CRR):

- The most significant risks on the CRR are detailed.
- There are currently two new risks under risk assessment
- Controls are developed for all risks, with a rolling programme of review by QRC

Assurance:

- Details of external assurances are included within the report
- The Trust is currently preparing for re-inspection by the Care Quality Commission in Q1 2016/17.

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 ↓↑
01-13	Theatre capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	**5**	**4**	**20 →**
3.7-06	Failure to meet the minimum requirements of the Monitor Risk Assessment Framework	**4**	**5**	**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 →**
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	**5**	**4**	**20 →**
5.1-03	Business continuity risk and risk to patient safety as a consequence of failure to adequately plan for junior doctors' strikes	**5**	**4**	**20 →**
A520-04	Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	**4**	**5**	**20 →**
5.1-06	Impact upon capacity to deliver quality core services and transformation programme due to disengaged workforce	**4**	**5**	**20 →**
3.13-05	Working capital – the trust will not be able to secure the working capital necessary to meet its current plans	**5**	**4**	**20↑**
3.18-05	Cost pressure – the trust faces higher than expected cost	**4**	**5**	**20↑**
05-07	Risk to the success of the turnaround and the transformation programme in the event that there is a lack of engagement across the workforce	**5**	**4**	**20 NEW**
05-06	Risk of loss of Trust data due to malware known as 'Ransom ware'	**4**	**5**	**20 NEW**

1.1 New risks proposed for inclusion on the CRR

1.1.1 Two new risks have been included and detailed controls are included at Appendix 2:

- 05-06 Risk of loss of Trust data due to malware known as 'Ransom ware'
- 05-07 Risk to the success of the turnaround and the transformation programme in the event that there is a lack of engagement across the workforce

1.1.2 There are two risks previously identified which are currently undergoing risk assessment:

- Resource and capacity to support women of non-child bearing age subject to FGM (Corporate Nursing)
- Resource and capacity to support Safeguarding Adults (DOLS) agenda: escalated via Patient Safety Committee (Corporate Nursing)

1.1.3 There is one risk previously identified for inclusion which, following further consideration is no longer believed to be a risk

- Transformation programme associated risks - Translation into contracts (Chief Financial Officer): The rationale for not including this risk is as follows: current contract for 2016/17 has been agreed excluding the benefit of transformation projects on NHS Clinical Income. A small number of projects are being reviewed by the Assistant Director of Finance-Contracts to assess whether these could be included as contractual variations in-year.

1.2 Changes to risk scores

1.2.1 Two risks score have been increased and seven risks score have been reduced. The rationale is included at Appendix 1.

Table two: increased risk scores

Ref	Risk	Previous	Current
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**	**20**
3.13-05	-Working capital – the trust will not be able to secure the working capital necessary to meet its current plans	**10**	**20**

Table three: Reduced risk scores

Ref	Risk	Previous	Current
A610-O6	The trust will not attain the nationally mandated target of 95% of all staff receiving annual information governance training	**15**	**12**
01-19	Clinical impact of delays in procurement and/or authorisation of medical supplies and equipment	**20**	**15**
A533-O8	Reconfiguration of healthcare services in SWL result in unfavourable changes to SGHT services and finances	**12**	**10**
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	**20**	**16**
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	**16**	**9**
01-06	Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	**20**	**10**
01-07	Risk to patient safety and experience as a result of potential trust failure to meet 95% Emergency Access Standard	**20**	**16**

1.3 Risks proposed for closure

Two risks have been proposed for closure, the rationale is included at Appendix 1:

Table four: closed risks

Ref	Risk
3.15-05	**Income Tariff Risk** – that national and local tariffs do not deliver the required income
3.14-05	**Working capital –** the Trust will require more working capital than planned due to: Adverse in year I&E performance Adverse in year cashflow performance

1.4 Summary of risks by score and domain

There are 56 risks on the CRR of which 37 are extreme (a score of 15 or above). Of these extreme risks, 13 sit within the domain of Quality and seven within Finance and Operations. Of the total risks on the CRR, 66% relate to Quality.

Fig 1&2: CRR Risks by score and domain

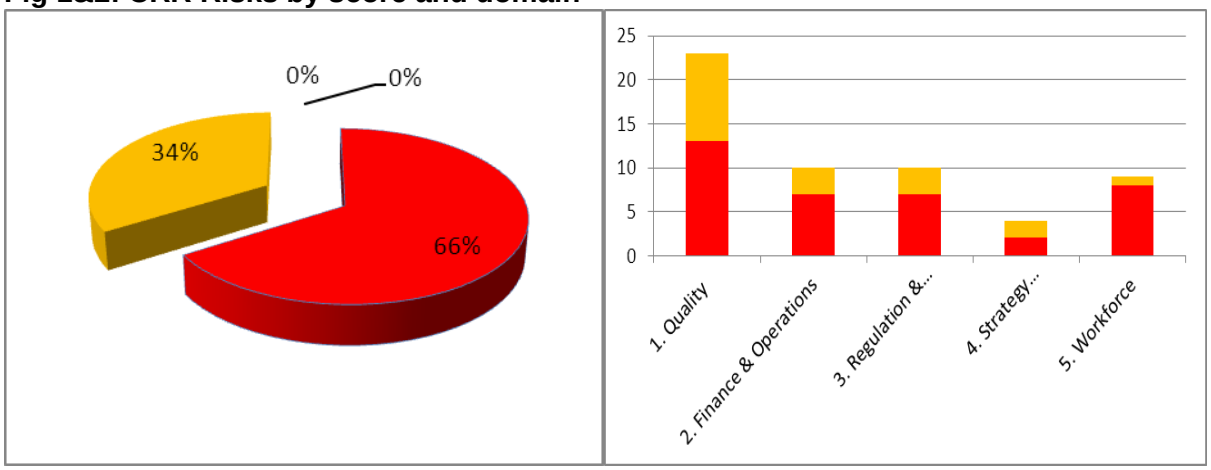

Table five: CRR Risks by Domain

	15 or above (Extreme)	8-12 (High)	4-6 (Mod)	0-3 (low)	Total
1. Quality	13	10	0	0	23
2. Finance & Operations	7	3	0	0	10
3. Regulation & Compliance	7	3	0	0	10
4. Strategy Transformation & Development	2	2	0	0	4
5. Workforce	8	1	0	0	9
Total	**37**	**19**	**0**	**0**	**56**

2. Assurance map

2.1 Care Quality Commission (CQC) – preparation for inspection

The Trust will undergo a full announced inspection by the CQC on 21st – 23rd June 2016. A core delivery team is in place with work stream and core service leads reporting to a weekly steering group meeting. A project team is also in place to support the readiness project with support from the KPMG team. Identified work stream leads are in place for Governance, Quality, Communications, Estates and Environment, ICT, HR and Medicines Safety.

The first formal information request was provided to the CQC on 8th March and a second, more detailed information request was returned to the CQC on 19th April 2016 with over 2000 documents provided. The Chief Nurse met with CQC Inspection Manager on 22nd April where it was confirmed that all eight core services across the acute site will be inspected and four core services within the community. These are detailed in table six:

Table six

Core services acute	Core services community
Urgent and emergency care Medical care (including care of the elderly) Surgery Maternity Children's and Young People OPD and Diagnostics End of Life Care Critical care	Community inpatients Community Nursing (health-visiting) Children's and young people End of Life Care

An external assessment by KPMG was undertaken in March and findings were presented to the Trust board and the wider organisation on 14th April. A full report is being finalised which contains a number of recommendations which will be triangulated with the overall programme plan.

2.2 External assurance and third party inspections: Feb-Mar 2016

2.2.1 Sterile Services Department Accreditation

The Sterile Services Department Inspection- ISO 9001 took place on the 29th Feb – 4th Mar 2016. The inspection covered two areas:

- Procedure for Stock Control
- Procedure for process validation

Two minor non-conformities were identified which related to product verification data and infrastructure / environment issues. Information upon corrective actions to address the non-conformities was provided. The external company (Interk) who carried out the inspection accepted the provided information and approved the accreditation. The certificates for ISO 9001:2008 and ISO 13485:2012, were received.

2.2.2 Information Governance Toolkit

The Information Governance Toolkit is an online system which allows organisations to assess themselves or be assessed against Information Governance policies and standards.

St George's IG Assessment Summary Report (self-assessment) was published on 30th March 2016 and was given an overall score of 73%; the grade is considered satisfactory.

2.3 External assurance – final reports

2.3.1 Local Supervising Authority (LSA) Annual Audit of Statutory Supervision

The LSA Audit occurred on 24th February 2016. The team of auditors included LSA Support Officer, two supervisors of midwives (SOM) from two London trusts and a lay auditor.

The evidence tabled by SGH met requirements outlined in the London LSA Tool for the Statutory Supervision of Midwives 2016, and was submitted two weeks prior to the audit. The evidence related to the statutory framework as outlined in the NMC Midwives' Rules 2012.

- The past: Unit Profile and Action plan from 2015 Audit
- The present: SOM team innovations for 2015 including the Birth Reflections Clinic
- The future: Impact analysis of removal of Statutory Supervision for women and midwives.

Summary of outcomes from the Annual Audit Report:

Summary of Outcomes	Rating
Rule 4 - Notifications by Local Supervising Authority	Met
Rule 6 - Records	Met
Rule 7 - The Local Supervising authority midwifery officer	Met
Rule 8 - Supervisors of Midwives	Met

2.3.2 Cervical Screening QA Visit

The cervical screening service for the acute trust (Cytology, Colposcopy and Histology) underwent a QA Visit as part of a three yearly cycle. The visit occurred on 19th Jan 2016 and the Trust has received the final report.

The QA team identified no immediate concerns; however 18 recommendations were made, the three high level issues are detailed below and all other actions to address are contained within an action plan.

Level	Theme	Description of Recommendation	Action/response
High	Governance and Accountability	Clarity is required as to the role of the HBPCs and governance of South West London Pathology	Organogram already confirmed and in place
High	Service continuity	Review clinical capacity to improve the number of women requiring treatment for high grade CIN within 4 weeks after receipt of diagnostic biopsy report	Information requested by NHSE but Trust has been informed on 28/04/16 that although measuring against, the Trust will not be penalised as not clinical
High	Service continuity	To ensure appropriate succession planning for the consultant cytopathologists	Plan ready to be put in place once post becomes formally vacant

2.4 External assurance – future inspections

2.4.1 Patient Led Assessment of the Care Environment (PLACE)

Inspection expected in May 2016 and preparations are underway.

2.4.2 OFSTED Inspection

From 1st May 2016, Ofsted and CQC will start to carry out inspections regarding services efficacy in identification, meeting needs and improving outcomes for children and young people with special educational needs and or disabilities. It is expected that the London Boroughs will be the first to be inspected. The Trust has been gathering the initial information ahead of the inspection as directed by WCCG. The final framework for the inspection is expected by the end of April 2016.

2.4.3 Environment Agency (EA) – Environment Permitting Regulation (EPR 2010)

EA inspects the safety of working environments and compliance with Trust radioactive materials permits and compliance with EPR 2010. An inspection is expected on 19th May 2016 and the trust is fully prepared for this visit.

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. There are an increasing number of risks to patient safety and experience identified arising from issues related to estates management and IT infrastructure.

The overall long-term risk profile for the trust continues to be driven by the continued financial and operational pressures faced by the trust and the transformation programme

There have been no significant issues highlighted as a result of external inspections or reviews, however an extensive preparation project ahead of CQC inspection in June 2016 is underway, supported by a small team from KPMG; this encompasses an intensive internal inspection programme which will be triangulated with external inspection findings on an on-going basis.

Appendix 1: Executive Overview of Corporate Risk Register

Domain: 1. Quality

Strategic Objective/Principal Risk	Lead	Start date	Sept 2015	Oct 2015	Nov 2015	Jan 2016	Mar 2016	Apr 2016	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	CS	11/2012	20	20	20	20	20	**16**	↓	New controls have been put in place which have reduced the risk
01-13 Theatre capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	CS	11/2014	25	20	20	20	20	**20**	→	
01-15 Adult critical care capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	CS	11/2014	16	16	16	16	16	**9**	↓	New controls have been put in place which have reduced the risk
A513-O1: Failure to achieve the National HCAI targets for MRSA and C Diff	JH	05/2010	12	12	12	12	12	**12**	→	
01-02 Lack of established process for use, provision, decontamination and maintenance of pressure relieving mattresses	RH	07/2013	9	9	9	9	9	**9**	→	
01-03 Lack of embedded process for use, provision and maintenance of bed rails	RH	01/2014	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	05/2014	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	05/2014	12	12	12	12	12	**12**	→	
01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	CS	05/2014	20	20	20	20	20	**10**	↓	New controls have been put in place which have reduced the risk

01-07 Risk to patient safety and experience as a result of potential trust failure to meet 95% Emergency Access Standard	CS	06/2014	20	20	20	20	20	**16**	↓	New controls have been put in place which have reduced the risk
01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	SM	07/2014	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	RH	10/2014	12	12	12	12	12	**12**	→	
01-11 Risk to patient safety and experience where full permanent sets of medical records are not available for scheduled outpatient appointments	CS	06/2015	16	16	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	07/2015	20	20	16	16	16	**16**	→	
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.	RH	07/2015	16	16	16	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.	RH	07/2015	12	12	12	12	12	**12**	→	
01-19 Clinical impact of delays in procurement and/or authorisation of medical supplies and equipment	JH	11/2015			20	20	20	**15**	↓	Improvement in the procurement/availability of equipment
01-20 Potential risk to staff and patient safety in the event of a failure of the Trust to meet its requirement of IR(ME)R or other IRR requirements.	SM	01/2016					12	**12**	→	
01-21 Patient care is compromised and incorrect prescribing occurs because General Practitioners receive draft copies of discharge summaries	SM	03/2016					15	**15**	→	
01-22 Potential risk to patient safety due to a failure to ensure all Trust policies are up to date and available to all	LE	03/2016					16	**16**	→	

staff										
01-23 Patient Safety risk due to electrical infrastructure in Knightsbridge Wing in danger of major failure. A recent large failure of an electrical panel caused the wing to be evacuated	RH						16	**16**	→	

Strategic Objective/Principal Risk	**Lead**	**Start date**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**Jan 2016**	**Mar 2016**	**Apr 2016**	**In month change**	**Change/progress**
1.2 Patient Experience									↓↑	
A410-O2: Failure to sustain the trust response rate to complaints	JH	04/2009	16	16	16	16	16	**16**	→	
02-01 Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)	SM	07/2013	16	16	16	16	16	**16**	→	

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	**Lead**	**Start date**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**Jan 2016**	**mar 2016**	**Apr 2016**	**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	NC	07/2015	20	10	10	10	10	**20**	↑	No growth identified
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	NC	07/2015	20	20	20	20	20		**Closed**	Proposed closure pending finalisation of approach to risk 3.13-05
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	NC	07/2015	20	20	20	20	20		**Closed**	Propose to close as new tariffs have been agreed, have either secured new

										tariffs or not. To be reviewed as new planning process for new tariffs for 2017/18
3.16-05 Market Share risks – that the trust loses market share, negatively impacting on the trusts activity and income.	NC	07/2015	20	10	10	10	10	**10**	→	
3.17-05 Cost Improvement Programme slippage - The Trust does not deliver its cost improvement programme objectives	NC	07/2015	20	15	15	15	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	NC	07/2015	16	16	16	16	16	**20**	↑	Reassessment of pressures.
3.19-05 Cash-flow Risks – Cash balances will be depleted due to: - Delays in receipt of SLA funding from Commissioners - Capital overspends	NC	07/2015	12	16	16	16	16	**16**	→	
3.20-05 Income Volume Risk (Capacity) – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.	NC	07/2015		20	20	20	20	**20**	→	
3.21 Transformation resources are of insufficient capacity and/or capability to deliver the expected benefits in 16/17	MW	03/2016					16	**16**	→	

Strategic Objective/Principal Risk	**Lead**	**Start Date**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**Jan 2016**	**Mar 2016**	**Apr 2016**	**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:	CS	05/213	20	20	20	20	20	**20**	→	

3.8 – 06 Low compliance with new working practices introduced as part of new ICT enabled change programme	MW	06/2013	16	12	12	12	12	**12**	→	
3.9 – 06 Risk of inappropriate deployment of e-prescribing and electronic clinical documentation	MW	07/2014	12	12	12	12	12	**12**	→	

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	Start date	Sept 2015	Oct 2015	Nov 2015	Jan 2016	Mar 2016	Apr 2016	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	10/2010	5	5	15	15	15	**15**	→	
A537-O6:Confidential data reaching unintended audiences	SM	10/2010	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	10/2011	15	15	15	15	15	**12**	↓	New controls in place which have contributed to the increased number of trained staff
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)	RH	03/2013	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	RH	10/2012	16	12	12	12	12	**12**	→	
03-03 Lack of decant space will result in delays in delivering the capital programme.	RH	05/2014	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.	RH	05/2014	16	16	16	16	16	**16**	→	
03-05 Trust wide risk to patient, public and staff safety of Legionella	RH	05/2014	12	12	12	12	16	**16**	→	

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	08/2015	20	15	15	15	15	**15**	→	
03-07 Risk of regulatory action or penalties upon the Trust in the event of a failure to comply with the legislative requirements of the Freedom of Information Act (2000)	LE						15	**15**	→	

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	**Lead**	**Start Date**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**Jan 2016**	**Mar 2016**	**Apr 2016**	**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	09/2010	12	12	12	12	12	**10**	↓	Reassessment of controls

Strategic Objective/Principal Risk	**Lead**	**Start Date**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**Jan 2016**	**Mar 2016**	**Apr 2016**	**In month change**	**Change/progress**
4.4 Provide excellent & innovative education to improve patient safety, experience & outcome									↓↑	
05-07 Risk to the success of the turnaround and the transformation programme in the event that there is a lack of engagement across the workforce	RE	05/2016						**20**	**NEW**	

Strategic Objective/Principal Risk	**Lead**	**Start date**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**Jan 2016**	**Mar 2016**	**Apr 2016**	**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	03/2013	8	8	8	8	8	**8**	→	

Strategic Objective/Principal Risk	**Lead**	**Start date**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**Jan 2016**	**Mar 2016**	**Apr 2016**	**In month change**	**Change/progress**
4.6 Improve productivity, the environment & systems to enable excellent care									↓↑	
05-06 Risk of loss of Trust data due to malware known as 'Ransom ware'	MW	07/04/2016						**20**	**NEW**	

Domain: 5. Workforce

Strategic Objective/Principal Risk	**Lead**	**Start date**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**Jan 2016**	**Mar 2016**	**Apr 2016**	**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	05/2010	16	16	16	16	16	16	→	
A516-O4: Possible reductions in the overall number of junior doctors available with a possible impact on particular specialty areas	WB	11/2012	9	9	9	9	12	12	→	
A520-O4: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	WB	05/2010	16	16	16	16	20	20	→	
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	11/2015	16	16	20	20	20	20	→	
5.1-02 Risk of inadequate management capacity to ensure required support and engagement with turnaround programme whilst also delivering business as usual.	WB	12/2015			15	15	15	**15**	→	

5.1-03 Business continuity risk and risk to patient safety as a consequence of failure to adequately plan for junior doctors' strikes	WB	12/2015				20	20	**20**	→	
5.1-04 Risk of inability to retain adequately staffing levels arising from a shortage of agency staffing resulting from the national introduction of a cap on agency rates for nurses and locum doctors	WB	12/2015				16	16	**16**	→	
5.1-05 Lack of success of the transformation programme without sufficient organisational support	WB	03/2016					16	**16**	→	
5.1-06 Impact upon capacity to deliver quality core services and transformation programme due to disengaged workforce	WB	04/2016					20	**20**	→	

JH	Jennie Hall	Chief Nurse (DIPC)	RH	Richard Hancock	Director of Estates & Facilities
SM	Simon Mackenzie	Medical Director	RE	Rob Elek	Director of Strategy
CS	Corinne Siddall	Chief Operating Officer	WB	Wendy Brewer	Director of Human Resources
NC	Nigel Carr	Director of Finance	MW	Martin Wilson	Director of Transformation
LE	Luke Edwards	Head of Corporate Governance			

Appendix 2 – New Risks

Principal Risk	05-06 Risk of loss of Trust data due to malware known as 'Ransom ware'				
Description	A large increase in the computer malware known as "Ransom ware" is affecting Trust computer data. There is a high risk that data that has been affected will be lost if the affected files are not identified and restored within a short time frame.				
Domain	**4.Strategy Transformation & Development**			**Strategic Objective**	**4.6 Improve productivity, the environment & systems to enable excellent care**
Score	**Original**	**Residual**	**Updated**	**Exec Sponsor**	Martin Wilson
Likelihood	4			**Date opened**	07/04/2016
Consequence	5			**Date closed**	
Score	20				
Controls & Mitigating Actions	NHS N3 gateway anti malware software Local Websense anti malware software. Local Anti-virus software. User education and communication.			**Assurance**	ICT systems team restoring identified corrupt files from back-ups. Supplier informed and anti-malware suite security controls increased. Continuous monitoring of reported infections. Minimal data loss reported
Gaps in controls	Ransom ware infections continue to be reported			**Gaps in assurance**	
Actions next period:	Increase logical security of anti-malware applications. Trust wide comms campaign educating users not to open suspect or unexpected attachments in email.				

Principal Risk	05-07 Risk to the success of the turnaround and the transformation programme in the event that there is a lack of engagement across the workforce				
Description	Any transformation process or process of cultural and organisational change is dependent upon the workforce being engaged. A failure to ensure support systems for staff, through leadership and management actions and behaviours may result in derailment of the transformation programme or may limit the success.				
Domain	**4. Strategy Transformation & Development**			**Strategic Objective**	**4.4 Provide excellent & innovative education to improve patient safety, experience & outcome**
	Original	**Current**	**Update**	**Exec Sponsor**	Rob Elek
Consequence	5	5		**Date opened**	1.5.2016
Likelihood	4	4		**Date closed**	
Score	20	20			

Controls & Mitigating Actions	Engagement programme developed encompasses a number of actions to increase staff engagement across the trust in the short term in preparation for wider transformation change programme. Transformation change campaign has been developed about getting staff ready for the challenges and changes that the transformation programme will bring. Change campaign encompasses an organisational wide aspect and segment level (job role) aspect.	**Assurance**	Chair has signed off the engagement programme. Campaign to TAB on 15th February.
Gaps in controls	Overall budget and resource requirement not yet formally approved to support the campaign. Current resource to support project is limited. Success of project not solely within control of project/campaign team and is dependent upon wider management engagement and behaviours.	**Gaps in assurance**	No established KPIs/or framework to measure success Because there has been no opportunity to yet fully implement controls and roll out campaign, risk remains high
Actions next period:	Secure funding and resource for project Develop of measurement and analysis framework/KPIs		

Appendix 3 – Full Corporate Risk Register– detailed controls

Quality Domain: 1.1 Patient Safety

Principal Risk	**01-12 Bed capacity** for adult G&A beds may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience				
Description	Root cause: Requirement for high activity volumes in order to meet patient and commissioner needs, and to deliver income margin as part of Trust Cost Improvement Programme. Unlimited demand on A&E which impacts on increase in emergency admissions & capacity for elective admissions affecting 28 day rebook timeframes. Delayed patient repatriation to host hospitals block beds for emergency/elective activity. 14.2% increase in emergency admissions in patients over 70 Challenges in both delivering addition capacity and releasing capacity through flow, to agreed timelines Impact: Potential for commissioner challenges and financial penalties due to breach of ED and RTT targets Potential subsequent impact on patient pathways & patient safety. Adverse reputation				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	Update April 2016	**Exec Sponsor**	Chief Operating Officer, Corinne Siddall
Consequence	5	4	4	**Date opened**	01/11/2012
Likelihood	5	5	4	**Date closed**	
Score	25	20	16		
Controls & Mitigating Actions	**Controls:** Appointed Chief Operating Officer Flow programme in place with 10 work streams Undertaken a deep dive diagnostic into all major performance areas which has resulted in action plans with performance trajectories Current programme of bed-remodelling designed to ensure correct distribution of beds in order to increase efficiency of bed use leading to greater flow and reduced bed occupancy rates New ways of managing flow have been introduced			**Assurance**	Negative assurance: - 4 hour operational standard performance cross ref CRR risk 01-07 - RTT backlog of patients- cross ref CRR Risk 01-06 Flow programme dashboard provides real-time analysis of performance against targets External assurance: ALOS benchmarking will provide insight into areas of strong and weak patient flow

	with changes to way sin which site management team operate and three times daily safety huddles focussing on timely discharge Implementation of safety professional standards and sue of the Escalation of full hospital protocol Work with SRG to produce system-wide solutions		
Gaps in controls	Ability to deliver agreed additional capacity schemes to agreed timelines remains a challenge	**Gaps in assurance**	
Actions next period:	Realisation of new physical bed capacity New integrated demand & capacity model being developed for 5 year view by KPMG		

Principal Risk	**01-13 Theatre capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience				
Description	Requirement for high activity volumes in some specialities in order to meet patient and commissioner needs in particular to deliver 18 week RTT standards, and to deliver income margin as part of Trust Cost Improvement Programme. Potential for commissioner challenges and financial penalties Adverse reputation				
Domain	**1.Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	Update April 2016	**Exec Sponsor**	Chief Operating Officer, Corinne Siddall
Consequence	5	5	5	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	4	4	4	**Date closed**	
Score	20	20	20		

Controls & Mitigating Actions	**Controls:** Appointed Chief Operating Officer Flow programme in place with 10 work streams Undertaken a deep dive diagnostic into all major performance areas which has resulted in action plans with performance trajectories Current programme of bed-remodelling designed to ensure correct distribution of beds in order to increase efficiency of bed use leading to greater flow and reduced bed occupancy rates New ways of managing flow have been introduced with changes to way sin which site management team operate and three times daily safety huddles focussing on timely discharge	**Assurance**	Negative assurance: - RTT backlog of patients- cross ref BAF Risk 01-06 - Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014 - Cancelled elective surgery Aug 15 due to loss of air pressure and ventilation Internal assurance: Internal theatres capacity plan and tactical implementation plan Approved by Executive Management Team. Reported to Finance and Performance committee. Internal audit report has not provided a formal level of assurance but has set out that the current approach to capacity planning and plans that are underway to address identified capacity gaps will provide a reasonable level of assurance once these are fully implemented. 6 of the 13 Day Surgery Unit extended day, (including reallocating sessions of activity from main theatres) Theatres dashboard in use – enables tracking of theatres throughput and utilisation External assurance: Participation in System Resilience Group that has reviewed Trust's capacity plans. Additional funds secured through SRG 1 elective RTT funds.
Gaps in controls	Maintenance of theatres behind plan for a number of years, leading to a materialised risk that theatres will break down Urgent plans being developed.	**Gaps in assurance**	Admitted backlog of over 18 week waiters greater than sustainable. Non-admitted backlog numbers not being reduced at planned rate. Theatre performance data dashboards not yet fit for purpose with divisional clinical teams.
Actions next period:	1. Go live with new DSU & paediatric CEPOD timetable 2. Continue installation of new hybrid theatre 3. PPM, remedial works and theatre upgrade plan to be completed & considered by EMT 4. Cardiac 4 business case to be reviewed and approved 5. Secure additional off site theatre and bed capacity through other providers		

Principal Risk	**01-15 Adult critical care capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience				
Description	Requirement for high activity volumes in some specialities in order to meet patient and commissioner needs in particular to support emergency services and deliver 18 week RTT standards. Also any shortage in critical care capacity will impact on trust's ability to deliver income margin as part of Trust Cost Improvement Programme. Potential for commissioner challenges and financial penalties and adverse reputation				
Domain	**1.Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	Update April 2016	**Exec Sponsor**	Chief Operating Officer, Corinne Siddall
Consequence	4	4	3	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	5	4	3	**Date closed**	
Score	20	16	9		
Controls & Mitigating Actions	Appointed Chief Operating Officer Flow programme in place with 10 work streams Undertaken a deep dive diagnostic into all major performance areas which has resulted in action plans with performance trajectories Current programme of bed-remodelling designed to ensure correct distribution of beds in order to increase efficiency of bed use leading to greater flow and reduced bed occupancy rates New ways of managing flow have been introduced with changes to way sin which site management team operate and three times daily safety huddles focussing on timely discharge			**Assurance**	Negative assurance: - RTT backlog of patients- cross ref BAF Risk 01-06 Internal assurance: Internal audit report has not provided a formal level of assurance but has set out that the current approach to capacity planning and plans that are underway to address identified capacity gaps will provide a reasonable level of assurance once these are fully implemented. External assurance: ICNARC benchmarking analysis provided to adult critical care monthly showing delays in discharging patients to acute beds due to bed occupancy pressures. New process for managing critical care escalation in place with additional escalation and cardiac beds shows improvement hence risk score revised to reflect this.
Gaps in controls				**Gaps in assurance**	
Actions next period:	Building works on CCU & Thomas Young to enable creation of 3 additional CTITU, 1 CCU & 4 Neuro HDU beds				

Principal Risk	A513-O1: Failure to achieve both National HCAI targets for MRSA and C Diff

Description	The HCAI target for MRSA is set at 0 cases (zero tolerance) and 31 cases for *C. diff* for year 2016/17. Failure to achieve both may adversely affect the Trust's reputation resulting in a loss of patient & public confidence in the Trust and risk of patient harm.				
Domain	**1.Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Apr 2016**	**Exec Sponsor**	Jennie Hall
Consequence	4	4	4	**Date opened**	31/05/2010,
Likelihood	4	3	3	**Date closed**	
Score	16	12	12		

Controls & Mitigating Actions	Infection Control score card used to monitor monthly progress, monthly review at HCAI taskforce Regular communications sent to support practice and raise awareness to ensure staff adhere strictly to diarrhoea protocol and other infection prevention and control issues. Divisional action plans presented to the taskforce as required Zero Tolerance statement on the Trust intranet Bi-monthly antimicrobial steering group chaired by Medical Director Consultant level information circulated on a regular basis RCA required for each infection (MRSA, MSSA & *C.diff*) Infection Control Policy in place Weekly line care rounds & *C.diff* rounds on-going. Competence assessment document for taking blood cultures in place Best practice visit to Southampton, Royal Free and west Hertfordshire Aseptic non-touch technique roll-out in AMW Chloraprep single use applicators being adopted across the organisation for insertion and ongoing care of lines. Cannulation packs in place in many areas of the trust New Surewash hand hygiene training machines in use at	**Assurance**	End of 2015/16 performance: • C Diff 2015/16 had **29 cases**. The date of the last one: **23rd March 2016** (target 31) • MRSA 2015/16 had **3 cases**. The date of the last one: **29th Sept 2015** (target zero) Infection control action plans reviewed by internal audit in September 2016 giving reasonable assurance. Peer review of infection control nursing team (By Barts & the London Trust) recommendations implemented Bi-weekly taskforce meeting and bi-monthly Infection Control Committee meeting. Scorecard and line care rounds presented/discussed at taskforce. Regular reports to the Patient Safety Committee, EMT & Trust Board Agreed Clinical Pathway in place for the decontamination of nasoendoscopes , work to be concluded regarding the long term framework for the decontamination of this equipment

	trust induction and across the organisation. Analysis and actions in relation to latest audit of line care undertaken.		Daily quality rounds, as part of CQC preparation undertaken by IC team.
Gaps in controls	Decontamination of nasendoscopes Timely completion of RCA reports	**Gaps in assurance**	
Actions next period:	Continual revision of infection control action plan Increasing number of consultants champions for infection control. Trust wide environmental audit to re-commence using improved audit tool. Focus on areas where IPC and cleaning inspections demonstrate need to improve. Saving Lives and Environmental audits to be carried out on RaTE to streamline and improve efficacy of process. Refresh Communications strategy		

Principal Risk	01-02 Risk to patient safety arising from variable provision of Pressure Relieving Mattresses out of office hours (Monday to Friday 0900 – 1700)				
Description	Delivery and collection of Pressure Relieving Mattresses is only staffed Monday to Friday 0900 – 1700. Out of hours delivery by porters results in variable availability, especially when stock runs out over weekends due to lack of collection. Potential factor in increased numbers of patients sustaining pressure ulcers and infection. (Cross Ref A513-O1)				
Domain	**1.Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Apr 2016**	**Exec Sponsor**	Richard Hancock – Director E&F
Consequence	3		3	**Date opened**	11/07/2013
Likelihood	4		3	**Date closed**	
Score	12		9		
Controls & Mitigating Actions	Additional initial resources approved at EMT. 32 new PRMs, 200 new top covers. PRM are being cleaned following manufacturer's procedures between patients. Out of hours delivery significantly improved by change to access for portering staff, but stock does run out on occasions since there is no weekend collection and cleaning service.			**Assurance**	Improved monitoring of availability and delivery times. Most recent data showing improved delivery times, achieving an average since April 2014 of 99.5 % delivery in under 4 hours within 0900-1700 weekdays. Stock availability has been improved out of hours due to altered access for porters, but stock does run out occasionally. We have figures on the out of hours availability; these will be reviewed and presented in the next assessment. Mattresses are being cleaned following manufacturers guidance, and Decontamination of PRM contaminated or identified as potentially

	Implementation of an electronic requesting of PRMs has been rolled out across the Trust and this has resulted in a more efficient service. This also allows the monitoring of turnaround times.		contaminated is by off-site decontamination.
Gaps in controls	The known gap is in the out of hours delivery. A business case for new mattresses across the Trust has been approved and is out to OJEU tender. The selection will end in June and the Trust aims to select a winning bidder by end of June. This will upgrade our stock over a 7 year rollout period. Ideally facilities to handle mattress cleaning need to be upgraded but due to lack of funds this will not be possible in the near future.	**Gaps in assurance**	We have no figures on the out of hours delivery delays.
Actions next period:	Review of collected data for out of hours availability. Due to the ongoing mattress tender it is suggested that the staffing requirements are reviewed after July 2016 once the new mattress system is in place.		

Principal Risk	01-03 Risk to patient safety arising from bed rails not being available to be deployed when required on beds which have removable rails.				
Description	The Trust has around 700 beds without in-built bed rails, and if rails are required there may be a delay in fitting these if an available set cannot be located. This delay may be from a few minutes to hours, with the risk of a fall being significant for some patients even with a few minutes delay, and the resulting harm can be extreme. In addition rails provided may not always fit for purpose, since they are specific to each bed model, and not always correctly applied. There is a dedicated bleep and support for rails provision, repair and fitting during office hours, with cover by porters out of hours, which is of necessity less specialised and they may not be able to find suitable rails. Absence of programmed maintenance potentially results in faulty equipment, though incorrect fitting of rails is considered to be a more important factor. The above factors have been identified by the Trust as contributing to patients sustaining harmful or fatal falls.				
Domain	**1.Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Apr 2016**	**Exec Sponsor**	Richard Hancock – Director E&F
Consequence	3		3	**Date opened**	1.1.2014
Likelihood	4		3	**Date closed**	
Score	12		9		
Controls & Mitigating Actions	Likely additional resources required approved at EMT, and additional rails have been purchased. Also a staff bank technician and a bleep provided to deal with delivery and maintenance requirements.			**Assurance**	

	Mitigating Actions If demand exceeds supply additional rails will be rented or purchased urgently. Review of training and risk assessment tool underway by falls Lead, Consultant Physio.		
Gaps in controls		**Gaps in assurance**	
Actions next period:	Continue to monitor availability and Datix reporting. "New beds" business case finalised and submitted to IDDG. The business case includes the replacement of all Trust beds with ones with integrated side-rails over a 17 year period; i.e. a rolling replacement program. The business case was approved but needed further clarification on the methodology of procurement – i.e. choice between buying or leasing. This will be clarified by the end of April 2016.		

Principal Risk	01-04 There is a potential 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.				
Description	Risk of staff not having required knowledge to safeguard children due to the required safeguarding children training not consistently being undertaken. Staff may not recognise a potential safeguarding issue, putting a vulnerable child at risk of harm.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Apr 2016**	**Exec Sponsor**	Jennie Hall
Consequence	4	4	4	**Date opened**	1.1.14
Likelihood	3	3	3	**Date closed**	
Score	12	12	12		
Controls & Mitigating Actions	As of March 2016 level 1 training is delivered at induction by the Training and Development Department. All other level 1 is delivered via eMAST. Level 2 is delivered via eMAST and face to face sessions Level 3 is delivered as face to face sessions. A review by the safeguarding team of current training and a 'deep dive' into the data has revealed some anomalies in the data on ARIS. The availability of access to MAST training for new staff in the community remains an issue. All managers have been contacted by the Safeguarding Nurse and the DDNG for CWDT&CC reminding them of their obligations under Section 11. Divisional training performance is reported at the quarterly performance			**Assurance**	. Safeguarding Children Training Compliance Level 1 1972 78% Level 2 2868 77% Level 3 951 74% Findings from the safeguarding review are being reviewed by the Chief Nurse – as yet it is not clear what the implications from this will be in respect of training.

	reviews. As a result of the manual cleansing of data and feedback from various departments it has become apparent that not all staff are allocated the correct level of training via ESR on joining the trust.		
Gaps in controls	The ARIS system data is not accurate and this has been confirmed by a manual exercise to check the data shown. A Datix has been completed to highlight this.	**Gaps in assurance**	Data is not robust
Actions next period:	The safeguarding children training compliance action plan is being implemented and reviewed at trust-wide Strategic SGC committee. Continue to target level 3 training. Trajectory set and shared with commissioners Plan is for the safeguarding team to meet with the MAST team and HR with department leads to clarify the levels staff require in line with the Intercollegiate Document and Skills for Health.		

Principal Risk	01-05 Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the Trust				
Description	Risk escalated from Surgical divisional risk register: A number of services continue to decontaminate equipment locally:- • ENT- Nasendoscopes • Gen Surg- Anal probes • Cardiac- TOE probes • ITU - Bronchoscopes The practice is no longer compliant with new guidance. The risks relate to the environment, process and tracking of equipment, which currently place staff and patients at potential risk of chemical toxicity and cross contamination.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Update Apr 2016**	**Exec Sponsor**	Jennie Hall
Consequence	4	4	4	**Date opened**	31.5.2014
Likelihood	3	3	3	**Date closed**	
Score	12	12	12		
Controls & Mitigating Actions	The Decontamination Committee oversee maintenance of relevant standards/guidance in line with local departmental experts. All areas now have an interim Tristal wipe system in place with appropriate training and tracking. Drying cabinets have been locked and a new escalation policy is in place to prevent further instruments from being			**Assurance**	Cardiac compliant with Tristal wipe system until such a time that the new reprocesser is operational and the service move to full centralisation On-going issues requiring estates input escalated via Trust Decontamination meetings, organisational risk and decon reports and individual communication with the estates department- awaiting a timeline and plan of works

	quarantined due to poor /no tracking. Solutions are being worked through for each area in terms of longer term plans and progress towards full centralised decontamination		An increased number of nasendoscopes already operational and more being business planned for. ENT to present a timeline and proposal for full centralisation of nasendoscopes. This paper will also include assurance in relation to the current interim Tristal wipe system.
Gaps in controls		**Gaps in assurance**	A further audit is being undertaken to assess if changes in practice are fully imbedded. The outputs from the audit being monitored by the Infection control committee
Actions next period:	ITU will tighten up their practice in relation to Bronchoscopes: a written process to be put in place. The rationale of the indicative cost pressure of the funding to lease an additional washer processor (1K per month) to enable decontamination to be carried out centrally has been drafted and to be signed off by each division. Explore long term solution to provide alternative centralised decontamination services which will entail a full business case and capital build		

Principal Risk	01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists				
Description	Risk to patient safety and patient experience as patients waiting greater than 18 weeks on elective waiting lists. Possible impact that patient's condition deteriorates. Specific issues regarding cardiothoracic surgery waiting lists in particular.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Updated Sept 2015**	**Exec Sponsor**	Chief Operating Officer, Corinne Siddall
Consequence	5	5	5	**Date opened**	31.5.2014
Likelihood	4	4	2	**Date closed**	
Score	20	20	10		
Controls & Mitigating Actions	Employed 18 week manager to support National Intensive support team have undertaken a deep dive diagnostic of how best to manage and develop action plan and revised trajectory for 18 weeks New processes to manage RTT weekly (incl cancer) Weekly meeting to monitor implementation of recovery action plan to ensure patients are treated in line with the plan Clinical harm panel set up , particularly to monitor waiting lists			**Assurance**	Negative assurances Identified system wide gap of £12-14m of activity required to deliver RTT sustainability Some cancellations in routine elective surgery due to bed pressures Some cancelled patients are not able to be rebooked within 28 days target RTT backlog Clinical harm panel has not identified an instances of patient harm whilst on waiting lists
Gaps in controls				**Gaps in assurance**	

Actions next period:	1. Move to use of patient tracking lists for booking all outpatient appointments in sequential order

Principal Risk	01-07 Risk to patient experience and safety as a result of potential Trust failure to meet Emergency Access performance trajectory agreed with NHSE and NHSI				
Description	Should the Trust recurrently fail to meet agreed trajectory Emergency Access Standards there would be a risk to: - *Patient experience whereby patients would not be treated or transferred within four hours* - *Patient safety – delays in patients receiving ED or specialist senior clinical input* - Risk of regulatory action including from commissioners and regulators - Trust reputational damage of failure to deliver the agreed trajectory				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Updated April 2016**	**Exec Sponsor**	Chief Operating Officer, Corinne Siddall
Consequence	4	4	4	**Date opened**	1/6/2014
Likelihood	5	5	54	**Date closed**	
Score	20	20	2016		
Controls & Mitigating Actions	CEO SRO for overall flow programme Flow programme in place across the organisation ECIP team working with the Trust to improve ED and AMU management of flow Trust and CCG Joint Investigation Action Plan developed covering capacity, pathway improvement and performance management in three areas: 1. Emergency department actions – led by DDO and Clinical Director for ED 2. Whole hospital actions – led by Chief Nurse through 'Flow' programme 3. Wider system actions – led by SRG Progress in delivering action plan regularly reviewed: • ED action plan via ED Senior team meeting weekly • Whole hospital actions via OMT fortnightly • Wider system actions via System Resilience Group			**Assurance**	Delivered 94.11% end of April 16

	performance meeting monthly • Overall the plan is reviewed with the CEO and Director of Delivery and Improvement on a fortnightly basis Continued close and pro-active working with ECIST ED dashboard and operational standards agreed, finalised and in place 4. Increases in bed capacity (72 beds) 5. Investments in patient flow schemes (£4m) including ED hot lab		
Gaps in controls		**Gaps in assurance**	
Actions next period:	Continue implementation of improvement plan (particularly focussed on whole hospital and wider system actions)		

Principal Risk	01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results				
Description	Should the Trust fail to ensure robust mechanisms for the timely and appropriate follow up of all diagnostics tests undertaken and critical test results eg blood tests , cell path and radiology this may result in adverse impact upon patient care in terms of delays in treatment				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update**	**Exec Sponsor**	Simon Mackenzie
Consequence	4	4		**Date opened**	16.7.14
Likelihood	4	4		**Date closed**	
Score	16	16			
Controls & Mitigating Actions	• All doctors have been reminded of their responsibility for ensuring that tests that they order are followed up. • All Care Groups have been asked to develop Standard Operating Procedures to ensure that this happens. • All serious incidents resulting from failure to follow up tests have been reviewed and themes reported to Divisions.			**Assurance**	Whilst actions have been taken as described, and most Care Groups have SOPS in place, there have been further instances of serious incidents due to failure to follow up test results. This indicates that significant risk continues. Internal reporting via PSC and externally through CQRM Internal audit report received - principal finding: - If there's an effective safety net in place – Safety net not reliable as emails are not received

	• Radiology have strengthened their safety net system. This now includes e mail to MDT for unexpected cancer (cancer MDTs have instituted a red flag system to ensure oversight). • Project group set up including IT, operations and service improvement to improve process of results endorsement on Cerner and roll its use out in Trust. EMT has agreed that from Sept 2015 all radiology and histopathology will be endorsed in Cerner and this will be monitored. Policy for Acting on Diagnostic test Results ratified		- That SOPs are in all areas – Associate Medical Director Data : Out of 40 areas that should have SOP , 21 had SOPs recorded, 3 using Trust wide one, 16 had no SOP recorded - 6/14 actions from an overarching review have been implemented Findings is of 'limited assurance' with a number of recommended actions
Gaps in controls	Some SOPs are outstanding and the effectiveness of others has not been verified. Radiology safety net not reliable as emails are not received by the appropriate staff A significant proportion of results are attributed to the wrong consultant making the electrical sign off inconsistent	**Gaps in assurance**	Some Care Groups have not developed SOPs and implementation is not confirmed.
Actions next period:	Update consultant lists to ensure selection of correct care episodes (CCIO) IT HR Information services to produce consistent consultant list OPD & IT to ensure current consultant attribution of the tests		

Principal Risk	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				
Description	Competence in the use of Medical Equipment is a personal responsibility of professional staff, many of whom are professionally registered and presentation of evidence of their maintenance of competency is part of the registration renewal process. The Trust has a responsibility to ensure that it has processes for identifying staff authorised to use equipment, and for identifying the training needs of staff related to Medical Equipment. This may be being carried out by local supervisors and managers, but the Trust needs assurance through having visibility of the training needs and the degree to which those needs have been met. There is currently no system to identify and report Trust wide medical equipment training needs, and to report the degree of compliance with those needs. This has the risk that the Trust cannot show that it has good management of staff with proper consideration of their competence and training needs relating to Medical Equipment. This was the subject of an audit in 2013.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Apr 2016**	**Exec Sponsor**	Richard Hancock – Director E&F

Consequence	3		3	**Date opened**	1-10-2014
Likelihood	4		4	**Date closed**	
Score	12		12		
Controls & Mitigating Actions	Many areas, particularly high acuity areas, have training and some records. For some equipment there is well controlled training linked to authorisation (eg glucometers, blood gas meters). The Trust has a policy of equipment standardisation where possible, and this is linked to organised training on implementation (e.g. Smart pumps, glucometers, defibrillators, anaesthetic machines, patient monitors etc.). The training requirements are also considered during the preparation for capital equipment purchases. The Trust has recently introduced the new training module in the Equip software and this will, once rolled out, be able to record the TNA in each clinical area. This has been trialled in PICU successfully.			**Assurance**	Centralised records for glucometer training, and records of training for major standardisation projects. Records for some areas can be inspected (e.g. GICU), anaesthetics. Professional staff work under responsibility to maintain their professional competence, and to work within that competence, with many groups submitting evidence to satisfy continuing professional development requirements and within this many should be prompted to consider their competence with medical equipment that they use. This means that the extent of competence will be wider than the availability of records, and this gives some assurance of safety, though positive records are what are needed.
Gaps in controls	The majority of areas cannot show records for all staff for all equipment training needs. There is an issue on the rollout of the Equip software due to the limited number of VDI licences. It will cost around £3 million to resolve this issue fully			**Gaps in assurance**	
Actions next period:	The next action is to pursue the following proposal: the agreement between IT and medical physics is to ask the clinical users who have no VDI access to request such access through IT and hence the licenses will be redistributed to the people that need them for the training. It is hoped that there are enough licenses for all clinical users.				

Principal Risk	01-11 Risk to patient safety and experience where full permanent sets of medical records are not available for scheduled outpatient appointments				
Description	There is a risk to patient safety where full permanent sets of medical records are not available to clinicians for scheduled outpatient appointments. This may also adversely impact upon patient experience. The Trust target is to achieve >98% of all permanent notes available in clinic.				
Domain	1.Quality			**Strategic Objective**	1.1 Patient Safety
	Original	**Residual**	**Update**	**Exec Sponsor**	Paula Vasco-Knight & Rob Elek
Consequence	3	4	4	**Date opened**	1 Jun 2015
Likelihood	4	4	4	**Date closed**	
Score	12	16	16		

Controls & Mitigating Actions	Trust wide outpatient improvement programme focus on medical records availability Exec Director spot checks on Medical records and outpatients Trust outpatient strategy developing recommendations for board on Trist strategy towards medical records usage and storage EMT quality risk session held on medical records availability Perfect week held w/comm 11th May Recommendation developed around electronic document management regarding what to scan, what to shred. Developed with DMBs. Proposal coming to EMT for approval, with intention to decrease volume of notes stored and therefore increase availability of notes electronically to clinic. Electronic document management roll out plan agreed with all new: new patients to be on EDM notes by Oct 2015 and all patients on EDM notes by July 2016 Medical Director and Divisional Chairs to agreed Trust policy on retention periods and volume of history of clinical correspondence which should be scanned into EDM in order to accelerate EDM roll out and to reduce volume of medical records retained.	**Assurance**	Report on availability of notes produced and circulated: Data reported to QRC and Board through Quality and performance report. Data reported externally on a monthly basis to commissioners. Reduced performance in Q4 with improvement in May 2015: Jan - 94.05% Feb - 90.12% Mar - 91.32% Apr - 90.45% May - 95.54%. June – 96.74% Jul 96.54% CQC compliance action plan closed by Commissioners Risk score increased to align with divisional risk in the interim until solution achieved.
Gaps in controls		**Gaps in assurance**	
Actions next period:	Continue EDM implementation Outpatient Strategy to be reviewed by Trust Board		

Principal Risk	01-18 – Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products				
Description	Kiosks are old and are breaking down on a daily/weekly basis Trust virus scanner impacts on system responsiveness Loss of Connectivity which results in gaps to Cold Chain records Current version not compatible with Windows Operating System 7 and there is no possibility of development of functionality to system Loss of System leads to unrestricted access to blood fridge and incomplete cold chain records				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update**	**Exec Sponsor**	Simon Mackenzie/Jennie Hall
Consequence	4	4		**Date opened**	1.7.2015
Likelihood	5	4		**Date closed**	

Score	20	16			
Controls & Mitigating Actions	Blood Track upgrade testing completed. All fridge kiosks have the new software installed and configured and will be switched into live on Thurs 27-Apr starting at 9am. Upgrade is planned for the day period and will entail about 2 hours downtime. Contingency plans will be put in place during this time (manual logging of units).			**Assurance**	.
Gaps in controls				**Gaps in assurance**	
Actions next period:	Relevant users to be informed at the beginning of week commencing 25 April 2016 of what the plans are. Planned Go live 27th Apr 2016				

Principal Risk	01-16 There is a potential risk to the quality and safety of patient care in the event the Estates and Facilities team are unable to complete required estates works in a timely way due to the impact of run rate schemes.				
Description	In order to achieve identified savings targets, the Estates and Facilities Department has to reduce labour and materials expenditure on its planned and reactive maintenance service.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update**	**Exec Sponsor**	Richard Hancock – Director E&F
Consequence	4		4	**Date opened**	1 July 2015 (Identified by ORC)
Likelihood	5		4	**Date closed**	
Score	20		16		
Controls & Mitigating Actions	Revised estates permanent management structure is in place including Maintenance Manager. Health and Safety management function closely involved in maintenance service. Planet FM system (the estates helpdesk and job request system) is being upgraded to allow prioritisation and work backlog to be monitored. Works procurement and prioritisation process implemented in September 2015.			**Assurance**	Works procurement and prioritisation process being assembled. Action plan being monitored and progress updates to the Operational Management Team. This risk is monitored via the Health, Safety & Fire Committee and overseen by the Organisational Risk Committee.
Gaps in controls	The action plan will be further developed as higher risk items are closed.			**Gaps in assurance**	Quality Impact assessment process of run rate schemes. QFS assessment still to be completed in advance of CQC inspection
Actions &	Asset and PPM programme being developed for all estates assets.				

timescale:	Staffing levels have increased to undertake additional works for CQC and other urgent works. Materials and services procurement issues with appropriate response times.

Principal Risk	01-17 There is a potential risk to the quality and safety of patient care in the event that required works cannot be undertaken due to capital funding decisions not to fund such projects.				
Description	Reduction of the scale of the Trust's capital programme means that not all of the Trust's high priority projects can be funded at the time they are needed.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Apr 2016**	**Exec Sponsor**	Richard Hancock – Director E&F
Consequence	4		4	**Date opened**	1 July 2015 (identified via ORC)
Likelihood	4		3	**Date closed**	
Score	16		12		
Controls & Mitigating Actions	Risk assessments undertaken for each project. Monitored through the Capital Programme Monitoring Group (CPMG) & Project Programme Boards and the Investment, Divestment and Disinvestment Group (IDDG). Engage with the department early in the capital scheme and jointly agree how this can be managed.			**Assurance**	Monitoring of project and maintenance activity through project/programme boards and Divisional Governance Boards. IDDG has representation from all Divisions and quality and safety of patient care is the highest prioritisation for all capital projects.
Gaps in controls	Lack of Project management Office support to ensure robust governance is in place.			**Gaps in assurance**	Quality Impact assessment process of schemes
Actions & timescale:	Preparation of new 5 year capital programme by July 2016 with prioritisation from quality and safety leads. Review of Knightsbridge condition survey to be completed. Capital programme to be reviewed in line with condition surveys				

Principal Risk	01-19: Risk to patient safety arising from delays and/or failures to ensure the correct medical equipment is available				
Description	Risk to patient safety due to problems with interface between wards and departments and finance/procurement/supply chain which in turn results in a failure to ensure the correct medical equipment is in the right place at the right time. Escalated through the Quality Fundamental Standards group, incident reporting and escalated concerns to managers.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Update Apr 2016**	**Exec Sponsor**	Jennie Hall

Consequence	5	5	5	**Date opened**	1 Nov 2015
Likelihood	4	4	3	**Date closed**	
Score	20	20	15		
Controls & Mitigating Actions	Clinical products procurement group set up – chaired by Assoc medical director More robust reporting categories introduced on Datix to allow closer monitoring Quality Fundamental Standards (QFS) Group regular agenda item with regular attendance and reports from Finance/procurement QFS email alert group in place and extended to include finance/procurement staff Regular trust communications through eGazette to update staff			**Assurance**	High turnover staff in procurement Incidents still being reported with no reduction in volume or frequency Recent further delays in supplies due to manufacturers not wishing to adhere to new 60 day terms of payment
Gaps in controls	Processes for procurement still not robust No second/alternate suppliers lists Critical list of equipment still not agreed			**Gaps in assurance**	High turnover staff in procurement Often clinical staff too busy to report as an incidents and info/feedback can get lost
Actions next period:	Commence work on alternate suppliers list Review TOR and scope of Clinical products procurement group Gain clarity around roles and responsibilities in procurement/supply chain with a dedicated 'trouble-shooting' role put in place to resolve urgent issues Communications to all staff around what to do out of hours and under normal circumstances				

Principal Risk	01-20 Potential risk to staff and patient safety in the event of a failure of the Trust to meet its requirement of IR (ME) R or other IRR requirements.				
Description	Recent issues identified by HESL visit and subsequent risk summit have revealed that governance process across the trust for ensuring the requirements of IRMER (Ionising Radiation (Medical Equipment) Regulations) are not robust. Should plans to address this be inadequate this may place patients and staff at risk of higher levels than necessary of exposure to radiation.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update**	**Exec Sponsor**	Simon Mackenzie
Consequence	4	4		**Date opened**	01/2016
Likelihood	4	3		**Date closed**	
Score	16	12			
Controls & Mitigating	Action to address failings and issues highlighted by the HESL visit and the subsequent risk summit are being managed through an overarching project board with the following			**Assurance**	Monthly reports to the Joint Oversight Group – chaired by Wandsworth CCG and attended by NHSE/Monitor and other CCG commissioner representatives.

Actions	work streams: Safety and Governance (Chair Head of Risk/AMD) Behaviour (Chair Dep Dir HR) Training (Chair AMD – Educ) Operational (Chair Consultant Surgeon) Project board chaired by Medical Director and delivery groups meet weekly – attendance defined at DDO/Div Chair level. Additional Medical Physics resource secured for 3 months to carry out compliance checks across all areas using radiation All areas have updated RPS folders Over 100 Radiology, radiography and nursing staff form StG, QMH and Nelson trained in IRMER Regs on 21st April – second training date in May.		Internal reporting through EMT Weekly highlight reports from work stream delivery groups All areas now reviewed with minor gaps identified addressed – with the exception of one area where RPS provision is not in line with IRR/HSE and requires a further RPOS to be identified and trained. External invited review by Royal Colleges of radiology/Surgeons took place in March 2016, awaiting report External Director of Medical Physics commissioned to carry out a review/mock CQC style inspection across April/early May.
Gaps in controls	Concerns about resources and time scale of review	**Gaps in assurance**	No clear map of areas across Trust using ionising radiation across Trust hence unable to provide full assurance that all areas have robust governance around radiation procedures Gaps in governance structures around radiation protection revealed and need for wider governance/ committee review
Actions next period:	Review of Radiation policy IRMER procedure on intranet Second IRMER training day to take place External review against CQC standards to be undertaken		

Principal Risk	01-21 Patient care is compromised and incorrect prescribing occurs because General Practitioners receive draft copies of discharge summaries				
Description	When draft discharge summaries are saved in Merlin, a copy is sent electronically to the GP. The GP may therefore believe that the patient has left hospital when they are still an inpatient. This can generate unnecessary work. More seriously, the GP may take action including changing prescriptions based on this information rather than the final version				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Update**	**Exec Sponsor**	Simon Mackenzie
Consequence	3	3		**Date opened**	March 2016
Likelihood	5	5		**Date closed**	
Score	15	15			

Controls & Mitigating Actions	IT fix to prevent draft summaries being sent until after discharge has been implanted into Merlin. This would prevent GPs trying to contact patients who were still awaiting discharge. Tests carried out on 25/04/2016	**Assurance**	Negative assurance: Data taken from Tableau in Jan 2016: 33.5% Fully completed and sent to GP's 7.8% Partially completed 58.7% Not completed
Gaps in controls	IT fix will not prevent duplicates	**Gaps in assurance**	
Actions next period:	Accelerate move to Cerner discharge summaries which do not have this problem. Priority areas Medicine, Medicine of the Elderly		

Principal Risk	01-22 Potential risk to patient and staff safety resulting from a failure to ensure Trust processes and procedures are followed due to significant numbers of Trust policies being out of date				
Description	Policies and Procedures are available on the staff intranet to deal with issues related to patients, staff, major incidents, health and safety and community services, amongst other concerns. Most policies should be reviewed at regular intervals but many are out of date. As a result, external bodies such as CQC or Monitor could potentially find that some policies or procedures that are currently available to staff are in fact out of date or do not cover current legislation or good practice.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Update**	**Exec Sponsor**	Luke Edwards
Consequence	4	4	4	**Date opened**	1-3-2016 (escalated from Corporate Affairs Risk Register)
Likelihood	4	4	4	**Date closed**	
Score	16	16	16		
Controls & Mitigating Actions	Monthly Policy Ratification Group meeting to review and approve all new policies and policy updates - chaired by Head of Governance/Chief of Staff Plan and recovery trajectory agreed at PRG meeting on 22nd March 2016. Project Officer now in place to support project to recover position and develop new system Critical clinical policy list now in place			**Assurance**	Oversight by Quality & Risk Committee Executive Management team appraised of significant number of out of date policies – and plan to recover position – linked to CQC preparation. Intranet site now unable to support updates to policies and needs rebuild.
Gaps in controls	Corporate Administrator post with responsibility for oversight and management of policy catalogue shortly to become vacant No named job title/ lead for policies.			**Gaps in assurance**	

	No formalised process of alerting and ensuring timely review Outstanding community policy catalogue requires full integration into Trust catalogue		
Actions next period:	Progress 3 month project now project officer in place Map current position against critical policies ahead of CQC inspection Complete build of intranet		

Principal Risk	01-23 Patient safety risk due to electrical infrastructure in Knightsbridge Wing in danger of major failure. A recent large failure of an electrical panel caused the wing to be evacuated.				
Description	The aged electrical panel had a catastrophic failure and the wing was evacuated. Temporary repairs have been undertaken while a permanent replacement panel is being manufactured and installed. The electrical infrastructure has reached the end of its useful life.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Updated Apr 2016**	**Exec Sponsor**	Richard Hancock – Director E&F
Likelihood	5		4	**Date opened**	1.3.2016
Consequence	4		4	**Date closed**	
Score	20		16		
Controls & Mitigating Actions	Temporary repairs undertaken. Replacement panel manufacture is underway.			**Assurance**	To provide adequate assurances the electrical services in Knightsbridge wing to be tested and refurbished to BS 7671 and where appropriate additional circuits and accessories fitted to HTM 06.
Gaps in controls	Temporary repair will only keep the panel operational for the short term. Does not address deficiencies in infrastructure.			**Gaps in assurance**	Building was due to be decanted and demolished, therefore little expenditure on electrical infrastructure in recent years.
Actions next period:	Replacement electrical panel has been delivered and is awaiting installation. Building and infrastructure condition survey has been completed to indicate condition of infrastructure and remedial actions required to utilise the building with a life expectancy of circa 5 years. This survey and the works required are being reviewed.				

Quality Domain: 1.2 Patient Experience

Principal Risk	A410-O2: Failure to sustain the Trust response rate to complaints		
Description	Risk of failure to deliver a sustained ability to turnaround of complaints within agreed timescales, also to maximise the learning from complaints. Negative impact on the Trust's reputation and loss of patient and public confidence		
Domain	**1.Quality**	**Strategic Objective**	**1.2 Patient Experience**

	Original	Residual	Update Apr 16	Exec Sponsor	Jennie Hall
Consequence	4	4	4	**Date opened**	30/04/2009
Likelihood	4	4	4	**Date closed**	
Score	16	16	16		

Controls & Mitigating Actions	Weekly spread-sheet detailing care group response times circulated. Included as a measure within the divisional performance scorecard. Complaints workshop held on 19 April 2016 to review how the complaints process is working from beginning to end and the governance/reporting/performance management. Greater oversight of complaints by DDNGs Regular reporting via PEC, QRC & Trust Board. Implemented a risk rating system to identify high risk complaints. Trust performance reviewed by PEC every 2 months Reported to TB monthly.	**Assurance**	Monthly oversight of performance by Trust Board and through Divisional Governance Boards. Commenced review of progress of Complaint actions to provide additional assurance about actions being completed. To be further progressed in Quarters one and Two
Gaps in controls		**Gaps in assurance**	A further review will be undertaken to look at the complaints function to support an improvement in response times and learning from complaints.
Actions next period:	Action plan to be developed following complaints workshop in April 2016. All divisions to revise their action plans for improvement in response times as current action plans are not yielding desired results. Revise survey of complainants to obtain feedback in line with new CQC requirements upon complaints handling as previous survey had very poor response rate.		

Principal Risk	02-01 Risk of diminished Quality: patient safety, patient experience and patient outcomes, as a result of Cost Improvement Programmes (CIPs)
Description	As Cost Improvement Programmes continue to be rolled out, there is a potential risk that inadequate identification, monitoring and mitigating actions will fail to ensure that quality of care is preserved. CIPs include run-rate schemes and service improvement projects

Domain	**1.Quality**			**Strategic Objective**	**1.2 Patient Experience**
	Original	**Residual**	**Updated**	**Exec Sponsor**	Jennie Hall/Simon Mackenzie
Consequence	4	4		**Date opened**	01/07/2013
Likelihood	4	4		**Date closed**	
Score	16	16			

Controls & Mitigating Actions	All combined schemes must have a Quality Impact Assessment (QIA) (5x5 risk scoring). The QIA has been updated following recommendation by KPMG. Combined schemes are subject to local governance scrutiny and approval, at care group, directorate and divisional level; overseen by Divisional triumvirate including Divisional Chair, Divisional Director of Operations and Divisional Director of Nursing & Governance. TQGG (Transformation Quality Governance Group) chaired by Medical Director, runs monthly and reviews the overall risk across the programme. A signoff log captures all schemes and ensures that signoff is obtained from across the division as well as from the Medical Director and Chief Nurse if the scheme is above £20,000 or a 5x5 risk of 12. Divisions will put significant risks onto divisional risk registers for management through the divisional risk processes. TQGG reports exceptional risks to QRC. Divisions make a self-declaration on management of schemes not presented to TQGG.	**Assurance**	Positive assurance: External scrutiny of process by commissioners. KPMG issued QIA template Sign-off log with evidence of challenge Evidence that this mechanism has led to review and modification or rejection of proposals **Internal – quantitative assurance:** Weekly quality oversight Quality KPIs – via Quality report Mortality monitoring **Internal – qualitative** Complaints/concerns/AIs/SIs – thematic review Risk register reviews at ORC **External – quantitative** HSCIC data including mortality KPIs reported to commissioners via Quality report **External – qualitative** CQC (Incl Intelligent Monitoring)/ Monitor Reports CQR – Commissioner
Gaps in controls	Potential that not all risks are recognised and that 5x5 risk scoring application is inconsistent across divisions. Reliance upon divisions recognising clinical risks Insufficient mitigations & increased pressure to deliver CIPs may result in less rigorous application of QIA process. Not picking up cross Trust schemes adequately It is possible that cumulative impact of schemes might not be recognised Decisions largely anticipatory. No sense of real terms impact of a schemes – needs to be linked to consequence of implementing Oversight of interdependency of schemes inadequate – need to understand the cumulative impact : - Of short term schemes which by default ensure for longer	**Gaps in assurance**	Quality measures often lagging indicators hence risks may not be identified in a timely manner

	- Of cross divisional/services schemes Timeliness of identification of risks -requires enhanced quality oversight		
Actions next period:	Continued oversight by TQGG and refinement of TQGG process Transformation programme leads to come to TQGG Development of a KPI dashboard to support review of cross trust impacts from schemes Include feedback from re-established Quality inspections Larger themes will allow higher quality QIAs and assessment		

Finance & Performance Domain 2.1 Meet all financial targets

Principal Risk	**3.13-05 - Working capital** – the Trust will not be able to secure the working capital necessary to meet its current plans				
Description	The Trust's current income and expenditure plans will require more cash than can be met from the current loan/ working capital facility arrangement				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update Apr 2016**	**Exec Sponsor**	Nigel Carr
Consequence	5	5	5	**Date opened**	20/07/15
Likelihood	4	2	4	**Date closed**	
Score	20	10	20		
Controls & Mitigating Actions	Working Capital Management, reporting and forecasting • Monthly Cash flow forecasts report the impact of the Trust's financial performance on the Trust's cash position **Distressed Trust Regime** • The current provider management regime allows for FTs to seek interim Support when in financial difficulty. • Such support is defined within Secretary of State's guidance under section 42A of the National Health Service act 2006 (Section 42A Guidance - https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts). It is			**Assurance**	No identified assurance

	used to provide transitional financial support to an FT or NHS Trust in financial difficulty where it is necessary to support the continued delivery of services for a period during which an assessment of the underlying problem is carried out and a Recovery Plan is developed which forecasts a return to a financially sustainable position. **Mitigating Actions:** Minimising Support requirement • Through the cost pressure process, the Trust is endeavouring to ensure that increases in the requirement for new revenue expenditure are minimised – in progress – managed by Investment Divestment and Disinvestment Group (IDDG) • The Trust is reviewing its working capital management processes to maximise liquidity; extending creditor payment terms to 60 days; setting targets for debt reduction; and plans to reduce stock.		
Gaps in controls	As yet there is no application for interim financial support	**Gaps in assurance**	
Actions next period:	Update financial plan to F+P in April 2016 and Trust Board (TB) May 2016		

Principal Risk	**3.16-05 Income Volume Risk (Market Share)** – that the trust loses market share, negatively impacting on the trusts activity and income.
Description	A key determinant of Trust overall financial position is the level of income that the trust receives for the volume of clinical work that it undertakes. Income is received from NHSE (the single biggest commissioner of St. George's activity) and CCG's, of which Wandsworth, as our local commissioner is the biggest. The other south west London CCG's and Surrey form the core of other CCG income. There is the potential for the income position for the trust to worsen due to a range of factors linked to the likely volume of work referred to the Trust. Key issues are: ▪ Competition with other providers. Activity and associated income/contribution will be lost due to competition from other service providers resulting in reductions in market share in areas that St. George's, for financial or strategic reasons, wishes to grow activity in. For example, Cardiology going to GSTT from SWL and Surrey, or Neuroscience activity going to inner London providers.

	▪ That the impact of potential decommissioning of services will reduce the trusts market share and hence income. ▪ That the trust makes a nuanced judgement about which services to tender for (or not e.g. Merton community services) and then actively aims to win all those services which are tendered				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update Apr 2016**	**Exec Sponsor**	Nigel Carr
Consequence	5	5	5	**Date opened**	20/07/15
Likelihood	4	2	2	**Date closed**	
Score	20	10	10		
Controls & Mitigating Actions	**Controls** ▪ Engagement with, and development of good and positive relationships with all main commissioners to help ensure that St. George's remains referral unit of choice in south west London ▪ Commercial board oversight of understanding of market share, competitors for services, tendering exercises and development of marketing plans. ▪ Development of GP liaison role to market to individual referrers ▪ Development of marketing plans for individual services e.g. Cardiology ▪ Benchmark for quality and performance to understand how the St. George's service compares to competitors ▪ On-going improvement in service quality, to maintain market share and encourage patients to actively choose St. George's. ▪ Divisional annual business plans to identify threats in the market, and how the service will respond to those issues ▪ Investment Divestment and Disinvestment Group (IDDG)– reviewing all tender submissions ▪ Decision to enter tender process for each invitation received, based on current strategic and service fit and financial contribution/profitability.			**Assurance**	▪ On-going market share monitoring via SLAM and Dr. Foster data. ▪ Business planning processes to identify risks and market strategy ▪ Limited evidence of material reductions in referred activity and apparent shortage of capacity to deliver current demand for services

	Mitigating actions: ▪ Develop deliverable and measurable action plans in response to any significant loss of market share, focusing on reclaiming lost referrals ▪ To develop action plan to develop new markets, focussing on Surrey referrals and south west London activity currently going out of sector. ▪ Cost removal – assuming that substitute activity cannot be grown to detail where cost will be taken out ▪ Lost service Line Tenders: TUPE of all staff involved. Identification of any potential substitution activity that retained assets – staff or facilities – can undertake service lines are lost in tender process • Fix, close transfer workstream. Reviewing service position, market share and profitability'		
Gaps in controls	▪ Lack of highly developed marketing plans for many services ▪ Absence of routine market share analysis	**Gaps in assurance**	▪ Absence of routine market share analysis reporting
Actions next period:	▪ Fix, close, transfer – process ongoing		

Principal Risk	**3.17-05 Cost Improvement Programme slippage -** The Trust does not deliver transformation cost improvement programme objectives				
Description	▪ Opportunities for savings schemes are not identified ▪ Opportunities to save are not sufficiently developed to deliver the value required ▪ Savings identified within schemes are overoptimistic / savings are double counted ▪ Savings are redeployed ▪ Savings schemes are not delivered as planned or are delivered late ▪ Capacity constraints prevent delivery of activity plans ▪ Savings identified are only non-recurrent				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update Apr 2016**	**Exec Sponsor**	Nigel Carr

Consequence	5	5	5	**Date opened**	20/07/15
Likelihood	4	3	3	**Date closed**	
Score	20	15	15		
Controls & Mitigating Actions	Controls ▪ Turnaround Board to oversee Trusts response to 2016/17 financial challenge by taking a lead role in developing, driving and delivering a robust Transformation programme for 2016/17 and subsequent years ▪ Benchmarking St. George's services to ensure that opportunities are found ▪ Role of PMO in managing Transformation programme. ▪ Rigorous PID development to support projects to be delivered ▪ Divisional finance managers signoff financial scoping for each scheme ▪ HR sign off WTE impacts on each scheme ▪ QIA sent to Medical Director and Chief Nurse on each scheme ▪ Divisional steering groups, meet fortnightly and approve all schemes ▪ Workstream fortnightly steering groups developing opportunities which are appropriately tagged to prevent double counts			**Assurance**	▪ Extensive governance across workstreams and divisions is in place ensuring ownership and accountability, with a report into the Turnaround Board every month ▪ Finance review the financials for every scheme to ensure its validity and its link back to the budget ▪ Finance must sign off a milestone on every scheme stating that they have seen the step change / impact in the financial position when they start to record actuals
Gaps in controls	▪ A significant proportion of the schemes are insufficiently identified leaving a significant problem for 2017/18			**Gaps in assurance**	
Actions next period:					

Principal Risk	**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				
Description	▪ The Trust has to meet costs of unforeseen changes in service requirements for example the on-going and evolving understanding of meeting requirements associated with Francis Report outcomes or other compliance requirements. The cost of meeting new and existing service standards are higher than expected. ▪ Inflationary cost pressures are greater than expected e.g. changes in energy prices, impact of incremental drift etc. ▪ Premium costs related to the supply of scare resources e.g. cost of agency nurses due to nursing staff shortages				
Domain	**2.Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update Apr 2016**	**Exec Sponsor**	Nigel Carr
Consequence	4	4	4	**Date opened**	20/07/15
Likelihood	4	4	5	**Date closed**	
Score	16	16	20		
Controls & Mitigating Actions	**Controls** ▪ Business Planning Process and Business planning steering group - the expected impact of cost pressures on financial performance is considered and robust provisions are made for future increases in cost in line with high level Guidance from Monitor. ▪ IDDG taking role of managing cost pressures ▪ Contingency Reserves are set aside in line with NHS Guidance at 1% of Turnover ▪ EMT and Business Planning Steering Group oversight of the business planning process. ▪ Monitoring of cost pressures in-year through the financial reporting regime. New pressures are identified as early as possible and the financial impact is reported to the Finance and Performance			**Assurance**	Monthly financial reporting of performance to the Board Identification and review of cost pressures through the Business Planning cost pressure review process.

	committee. ▪ Vacancy control panel ▪ Costs are based on data from robust historical costing systems including PLICS and Reference Costs which have been calculated in line with national guidance. **Mitigating actions** ▪ Reduced use of external capacity by better capacity planning and management of internal resources. ▪ Detailed Agency expenditure tracking ▪ The Trust has a number of actions it can deploy to recover its financial position if it is adversely affected by cost pressures, e.g. vacancy freezes, controls on discretionary expenditure, etc.		
Gaps in controls	Workforce and financial plans do not explicitly reflect the level and premium costs of agency staffing.	**Gaps in assurance**	
Actions next period:	▪ Completion of 2016/17 Reforecasting process and 2017/18 business planning process ▪ Paper to F+P in April 2016 and Trust Board in May 2016		

Principal Risk	**3.19-05 Cash-flow Risks –** Cash balances will be depleted due to: Delays in receipt of SLA funding from Commissioners Capital overspends				
Description	The Trust's cash balances will be significantly depleted due to delays in receipt of commissioner funding. Risk is currently greater due to high level of over-performance above agreed SLA values assumed in the Trust's plans and recent data quality issues				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update**	**Exec Sponsor**	Nigel Carr
Consequence	4	4	4	**Date opened**	20/07/15
Likelihood	3	4	4	**Date closed**	

Score	12	16	16		
Controls & Mitigating Actions	**Working Capital Management** • The Trust Cash Position is reported to the Board each month as part of the finance report, including detailed cash flow statements and 2-3 year cash projections. • Changes in debtors, stock and creditors reported and explained within finance report to Finance and Performance Committee and Board. • Trust has set month-end cash balance target against which cash performance is measured: £5m minimum in line with the terms of the current working capital facility. • SLA interim invoicing – as above. **Contract Documentation** • SLAs include special clause for interim invoicing of over-performance in advance of freeze date - enhances cash flow. **Controls:-Capital Expenditure Management** • Capital Programme Monitoring Group (CPMG) oversees the planning and monitoring of the annual and five year capital programme, which reports to IDDG which report to Executive Management Team • Monthly capital finance reports on funding and expenditure are submitted to the CPMG for review and forecasts updated. The Finance and Performance Committee and Trust Board receive a summary financial report on the capital programme as part of the finance report and significant variances and changes to plan explained. • Maintain reasonable and prudent capital cash flow projections based on detailed returns from capital budget holders commensurate with agreed funding and ensuring they are updated regularly to reflect changes in project timescales and in the receipt of external funding. **Mitigating actions:** **Manage Working Capital** • Improve Debt Collection	**Assurance**	Detailed monitoring and forecasting of cash flow and agreed debt through Finance and Performance Committee. HDD3 working capital reviews Previous track record in managing capital programme within plan Capital programme has underspent against the 2015/16 budget.

	• Delay payment of creditors / manage balances with major creditors e.g. SGUL • Reduce stock levels e.g. extend scope of consignment stock to deliver one-off improvement in liquidity – subject to VFM and affordability tests (i.e. higher unit costs) • Delay capital investments in line with reduced funding		
Gaps in controls	Contract with NHSE likely to include unidentified QIPP leading to over performance on contract maybe c£1m per month & cash flow problems	**Gaps in assurance**	Data quality risks: Potential new data challenges from commissioners which have not yet surfaced Whilst resource focused on ensuring recording of data may limit capacity to understand scope of problem to treat and ensure no recurrence Future issues with data capture occurring or being revealed by subsequent Cerner system upgrades
Actions next period:	• Seek to agree payment for over-performance in the contract with NHSE • Agree loan draw down with DH to ensure no cash flow risks from major loan funded projects • Cash management review by external audit • Further escalation through NHSE • Resolve outstanding data quality problems delaying payment		

Principal Risk	**3.20-05 Income Volume Risk (Capacity and Trajectory)** – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.
Description	A key determinant of Trust overall financial position is the level of income that the trust receives for the volume of clinical work that it undertakes. The delivery of activity is dependent upon the availability of the necessary capacity in terms of beds, theatres, clinics, critical care and diagnostics. There is the potential for the income position for the trust to worsen due to a range of factors linked to the likely volume of work delivered by the Trust. Key issues are: ▪ The availability of clinical capacity in terms of beds, theatres, clinics, critical care and diagnostic services ▪ The length of stay of patients and flow of activity through the hospital and its impact on bed, theatre and clinic utilisation, especially patient repatriation. ▪ The level of investments made by Commissioners in supporting the Trust's flow and capacity plans ▪ The delivery of the Trust's flow and capacity plans ▪ Impact of Estate problem and maintenance programme ▪ Impact of industrial action on clinical capacity ▪ Performance against access target trajectory (RTT – A&E) where S+F funding is at risk

Domain	2.Finance & Operations			Strategic Objective	2.1 Meet all financial targets
	Original	Residual	Update Apr 2016	Exec Sponsor	Nigel Carr
Consequence	5	5	5	Date opened	30/09/15
Likelihood	4	4	4	Date closed	
Score	20	20	20		

Controls & Mitigating Actions	**Controls** ▪ Business planning process – development of annual capacity plan, agreeing service volumes, capacity utilisation rates and identifying capacity requirements ▪ Benchmarking and monitoring of capacity related performance measures: i.e. capacity availability, productivity and length of stay ▪ Business Case Assurance Group (BCAG) and the business case process for approval of all investments in capacity ▪ OMT, EMT, TAB and Trust board oversight of Flow and Capacity plans and delivery **Mitigating actions:** ▪ Transformation plans / capacity and flow programme	**Assurance**	▪ Reporting of performance against planned SLA income and activity targets ▪ Live activity tracking via tableau ▪ Development of integrated demand and capacity model with scenario capabilities
Gaps in controls	▪ Integrated demand and capacity model	**Gaps in assurance**	Integrated demand and capacity model outputs to confirm capacity requirements
Actions next period:			

Principal Risk	3.21 Transformation resources are of insufficient capacity and/or capability to deliver the expected benefits in 16/17
Description	The transformation programme is expected to deliver improvements in quality and £50m of in year cost improvements through 6 key work areas and 22 projects. Delivery of this complex trust wide programme requires

Domain	2.Finance			Strategic Objective	Deliver our Transformation Programme enabling the trust to meet its operational and financial targets
	Original	Current	Update	Exec Sponsor	Martin Wilson, Director of Transformation
Consequence	4	4		Date opened	1/3/2016
Likelihood	5	4		Date closed	
Score	20	15			

Controls & Mitigating Actions	Detailed implementation plans have been developed for each element of the transformation programme, including the resource requirements of each project. An overarching transformation resource plan has been developed, which sets out the quantity, skills and timescales for required resources together with proposed sourcing strategy (secondments, interims, recruitment etc.). Dedicated HR and KPMG resources have been secured to source the required individuals. The resourcing risks are being mitigated by pursuing parallel sourcing routs (including secondments, KPMG consultants and interims) for some key roles. Appropriate handover periods are arranged where there is a transition between individuals. A twice weekly executive level Resource Gap Group has been established to oversee the sourcing of individuals within the resource plan and to take any mitigating actions required.	**Assurance**	Programme area and/ or project level assurance meetings were held with Board, divisional and Monitor representatives to test assumptions and implementation readiness of all detailed implementation plans. KPMG has provided independent quality assurance throughout their development. The DIPs and overall resource plan together with the financial impact has been approved by Turnaround Board, Finance and Performance Committee and the Board. The resource plan has been submitted to NHS Improvement as part of the business case approvals process.
Gaps in controls		**Gaps in assurance**	Capability of individuals and project teams to deliver transformation programme is not expressly assured currently.
Actions next period	Continue implementation of resource plan. Exception reporting via steering groups to Turnaround Board and where necessary Finance and Performance Committee.		

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

Principal Risk	3.7-06 Failure to meet the minimum requirements of the NHSI Risk Assessment Framework may result in reputational damage or regulatory action.				
Description	There is a risk to patient safety and the Trust's reputation should it fail to perform against the Access Metrics set out by NHSI Performance Framework particularly in relation to:- 18 weeks- A&E Waits (4 hours)- Cancer waits (TWR, 31 & 62 day targets).Individual risks, controls and actions to mitigate are set out in Divisional risk registers				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.2 Meet all performance targets**
	Original	**Residual**	**Update Nov 15**	**Exec Sponsor**	CEO, Paula Vasco-Knight
Consequence	4	4	4	**Date opened**	30/05/2013
Likelihood	4	5	5	**Date closed**	

Score	16	20	20		
Controls & Mitigating Actions	Chief Operating Officer appointed Weekly monitoring of ED, RTT and Cancer undertaken at Access board – now established Agreed trajectory with NHSE and NHSI and commissioners in place			**Assurance**	Positive assurance •Internal audit Following a period of joint investigation with commissioners, remedial action plans have been agreed for performance improvement in ED and RTT. Contract query notice served for cancer performance. Tripartite meeting with NHSE & Commissioners held and a recovery plan presented. Weekly performance recovery meetings in place both internally and a separate meeting being chaired by commissioners Clinical Quality Review meeting and contract performance meetings are held monthly with commissioners where performance and remedial action is further scrutinised
Gaps in controls	Absence of risk forecasting which is in development			**Gaps in assurance**	
Actions next period:	• Recruit to staff new capacity • Continue to implement joint I investigation actions • Implement cancer recovery plan • Cancer PTL development • Waiting list improvement programme –				

Principal Risk	3.8-06 Low compliance with new working practices introduced as part of new ICT enabled change programme				
Description	Partial adoption of new working practices could lead to inconsistencies in management of patient care. Failure to conform to new operational procedures could lead to decrease in organisational efficiency.				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.2 Meet all performance targets**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Martin Wilson
Consequence	4	4	4	**Date opened**	02/06/2013
Likelihood	3	3	3	**Date closed**	

Score	12	12	12		
Controls & Mitigating Actions	Each project within ICT programme is:- Managed using PRINCE methodology- Has a clinical lead- Reports to clinical systems programme board- Has individual risks and issues register managed on-going Director of FPI is SRO and sits on programme board. Regular programme board reports to Executive Management team Programme board highlight reports to EMT include RAG status and provides assurance project on track – this reporting mechanism promotes transparency and challenge Chief Clinical Information Officer in post 18 Champion Users seconded to support deployment Mitigating actions centre upon phases of engagement:- Involve clinical staff/health care groups in system design- Healthcare groups involved in implementation- H/care groups involved in endorsement of new working practices Weekly (Monday) i-clip meeting now takes place and all issues fed back live Lessons learned during pause period are documented and were reported back to Clinical Systems programme Board in Oct 15			**Assurance**	Programme Board highlights reports to EMT to include RAG status and provides assurance project on track. Chief Information Officer in post 18 Champion users seconded to support development Now over-arching clinical governance in place, including clinically led gateway review of ICT clinical programme 15 of the secondments have ended with clinical champions returned to their substantive roles External post implementation benefits review to be completed by Nov 2015 and supported by HSCIC, papers presented to CSPB, EMT and trust board with the findings Consolidation programme progress to be reported to October CSPB Recommendations on completion of deployment to be made to October CSPB meeting Bi weekly report on discharge summaries and VTE sent to speciality leads Revised diagnostic results endorsement policy adopted by the Trust with new process implemented from mid-September 2015
Gaps in controls	Ensuring full and representative health care professionals' input into key areas Some constraints of operating within national programme for IT framework			**Gaps in assurance**	
Actions next period:	Development of process for transition of clinical information projects into business as usual via the ICT Service Improvement Programme.				

Principal Risk	3.9-06- Risk of inappropriate deployment of e-prescribing and electronic clinical documentation				
Description	There is a risk that if e-prescribing and electronic documentation is inappropriately deployed this will have an adverse impact on patient care and clinical continuity.				
Domain	**2. Finance & Performance**			**Strategic Objective**	**2.2. Meet all performance targets**
	Original	**Residual**	**Update July 2015**	**Exec Sponsor**	Martin Wilson
Consequence	4	4	4	**Date opened**	1.7.14
Likelihood	3	4	3	**Date closed**	
Score	12	16	12		

Controls & Mitigating Actions	Funding for additional back office support identified, this will help clear the backlog of calls currently logged on HEAT Staff recruitment process now in place Communications being update regularly at meetings and via the intranet Projects team for deployment activity now in place	**Assurance**	Reporting on progress of project to Clinical Information Systems Programme Board On-going modification of deployment plan in response to lessons learned from early adoption means project is flexible and responsive to ensure success. Deployment model broadly successful but sustainability to end point currently not viable Early indications are that in areas where deployment has taken place quality has improved as well as revealing/creating challenges to existing practice Deployment system paused until 2016/17 which brings further risk of operating dual systems for longer than planned Clinical systems Programme Board will be reviewing options for completion of deployment in order to make a recommendation to EMT in Nov 2015 Risk lowered as active monitoring of Datix and SIs has revealed no significant variation between areas where e-doc has been deployed
Gaps in controls	Lack of IT back office support, impacting on ability to turn calls around in a timely way IT business as usual (BAU) team and projects team not fully resourced Turnaround time for identified issues – to reduce the time	**Gaps in assurance**	None identified

	that equipment is reported as faulty in line with a service level agreement Further changes in senior leadership within IT, for example staff leaving the trust		
Actions next period:	Delete all accounts for staff no longer working at the trust, if the staff member is then appointed to the Bank re-instate their role Request a Dump the Junk initiative specifically aimed at IT equipment Stock take of all current equipment		

Regulation & compliance Domain: 3.1 Maintain compliance with all statutory & regulatory requirements

Principal Risk	A534-07:Failure to demonstrate full compliance with the CQC Fundamental Standards				
Description	Lack of a sufficiently robust approach to self-assessment and subsequent actions to ensure compliance may lead to a CQC inspection finding of non-compliance. Improvement and/or enforcement action imposed by the CQC with associated reputational risk and risk. Ultimate risk of loss of licence to operate certain services.				
Domain	**3. Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory and regulatory requirements**
	November 15	**Residual**	**Update Apr 2016**	**Exec Sponsor**	Jennie Hall
Consequence	5	5	5	**Date opened**	31/10/2010
Likelihood	3	3	3	**Date closed**	
Score	15	15	15		
Controls & Mitigating Actions	Trust Quality inspections programme underway, increased in March 2016. Divisions and services self- assessment against the CQC KLOE as part of Quarterly return process. Internal Audit completed in relation to compliance with Trust CQC framework. Oct: Quality Fundamental standards meeting established, chaired by Chief Nurse/Deputy Chief Nurse with clear programme of meetings to review each fundamental standard and regulation across a rolling programme, Regulation leads established for each regulation. All concluded with one being finalised. Risk profile understood with actions to be taken forward. Quality Improvement strategy in place, for sign off by the			**Assurance**	Chief Inspector of Hospitals inspection report published 24th April 2014, with overall rating of 'Good'. Two compliance actions identified. All actions on compliance action plan completed and presented to commissioners and CQC in June 2015. Commissioners closed the action plan in July subject to the on-going monitoring around two actions reverting to business as usual monitoring. Actions remain open until re-inspection by CQC in June 2016 GAP analysis undertaken against recently inspected trusts to highlight key areas of focus for STG Assurance to Board through programme Updates. Includes KPMG external assessment of 50 clinical areas. Feedback correlates with the risk profile understood within the Trust, high priority actions agreed and programme to drive actions forward through CQC prep or the longer term QIS annual plan.

	Board in May 2016. Response to staff survey 2015 with programme of work Roll out of Quality Observatory following pilot in Medicine to all of the Trust to provide local assurance in practice against CQC standards. CQC preparation project underway for visit by CQC 21st - 23rd June 2016. Led by Chief Nurse/ Head of Governance and CQC project lead and supported by KPMG clinical team on site 4 days per week		
Gaps in controls	Agreement of QIS for 16/17 Agreement of plan for staff survey response in 16/17.	**Gaps in assurance**	Testing of KLOE by pathway through internal challenge process.
Actions next period:	Completion of actions for CQC visit. Working to complete actions arising from CQC Internal audit report		

Principal Risk	A537-06:Confidential data reaching unintended audiences				
Description	Inability to control all electronic methods of data transfer (USB sticks, laptops, e mails etc.). Also paper records vulnerable to loss and left unsecured. Data loss /paper can result in data reaching unintended audiences (e.g. public), loss of reputation, SUIs and restrictions from information commissioner including financial fines.				
Domain	**3. Regulation & compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory and regulatory requirements**
	Original	**Residual**	**Updated**	**Exec Sponsor**	Simon Mackenzie
Consequence	5	4		**Date opened**	31/10/2010
Likelihood	3	3		**Date closed**	
Score	15	12			
Controls & Mitigating Actions	Policies on data protection, information security, medical records and corporate email reviewed and disseminated through IG training, MAST, Trust Induction and Trust Intranet. Technical controls - All Trust laptops encrypted. USB port blocking implemented. Trust known devices whitelisted. Encrypted USB sticks			**Assurance**	Reduction in recent incidents involving data loss. On-going monitoring of any new removable storage devices with a view to blocking all such devices when greater assurance obtained that there is no clinical risk. CQC report at inspection Feb 2014 provides assurance of compliance on inspected wards in relation to secure storage of patient records.

	distributed and available to Trust. Non encrypted USB sticks read only. Encrypted external drives available. Roll out of Remote access 2 factor authentication complete. Electronic data management project in progress [paper light environment, RFID tracking]. Reviewed medical storage – updated guidance and auditing practice. On-going communication to staff on IG matters through eG IG Manager has now commenced and will continue monitoring "High" alerts in the external email monitoring software prompting email notices to members of staff Monitoring of sensitive data being sent from non-secure commercial email accounts – in progress. Letters to those staff who repeatedly deviate from guidance and Trust policy are being sent.		RFID case-note tracking. is being audited locally with improving results month on month
Gaps in controls	No method of control of stopping paper records being removed.	**Gaps in assurance**	Recent quality inspection identified unsecured notes in clinical areas.
Actions next period:	Web based email (e.g. Gmail, Hotmail) traffic is being monitored – "high risk" flagged email is being further investigated for potential policy breaches. Division to ensure all wards keep notes securely		

Principal Risk	A610-06: The Trust will not attain the nationally mandated target of 95% of all staff receiving annual information governance training				
Description	Failure to reach the target will result in an 'unsatisfactory' score for the IG toolkit submission for the Trust.				
Domain	**3. Regulation & compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory and regulatory requirements**
	Original	**Current**	**Updated**	**Exec Sponsor**	Simon Mackenzie
Consequence	3	3		**Date opened**	31/10/2011
Likelihood	5	4		**Date closed**	
Score	15	12			
Controls & Mitigating Actions	Information governance is a mandatory module in Trust induction training, MAST training and Cerner Training. E-Learning platform for MAST. Review of attendance at HR and Workforce and IG Committee. Management procedures to follow up of non-attendance in place.			**Assurance**	As reported on central Trust system IG training compliance at 80% as at end of March 2016 MAST training committee established

	New e-learning and e- assessment modules have gone live and continues to roll out. IG Manager continuously monitoring IG training compliance. All new staff receive training at Induction Face to face drop in session arranged for delivery throughout session		Inclusion of MAST training to monthly performance review meetings with Divisions in addition to Appraisal rates
Gaps in controls	Possibility that financial pressures will reduce focus on training due to run-rate controls – currently being monitored Temporary staff not requested to complete training	**Gaps in assurance**	Lack of reliability on central mandatory training reporting system hence true percentage trained could differ from that reported. Uncertainty around numbers of temp staff who require training
Actions next period:	Review of possible withdrawal of IT access to staff who have not undergone training		

Principal Risk	03- 01 Risk of premises closure, prosecution and fines as a result of non-compliance with fire regulations in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)				
Description	Ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)				
Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Residual**	**Updated Apr 2016**	**Exec Sponsor**	Richard Hancock – Director E&F
Likelihood	5		4	**Date opened**	14/03/2013
Consequence	4		4	**Date closed**	
Score	20		16		
Controls & Mitigating Actions	Robust action plan in place being led by the fire safety team and monitored through the Health, Safety & Fire Committee. Regular meetings/communication with Fire Brigade to check progress. Specialist fire safety resource in place to lead on the actions. Planned and reactive monitoring of fire safety. Fire risks assessments (FRAs) prepared by Fire Safety Specialists and issued to space/premises managers Head of Estates Compliance in post			**Assurance**	Internal Reporting on fire risk assessments to Health, Safety and Fire Committee and escalate any issues to the Organisational Risk Committee. Fire risk assessments and fire safety audits • FRAs undertaken are at 91% with the remaining being undertaken in the next month. • The annual staff fire training stands at 75% with further training dates available via the intranet.

	Two permanent Fire Officers in post reporting to Head of Estates Compliance Established "Responsible Fire Persons" email circulation list to send personal emails to ward/area managers There are responsible persons identified for all individual areas subject to FRAs.		• Fire warden training is at 85% with further training dates available via the intranet. External LFEPA regularly visit usually on a quarterly basis Internal Audit Fire safety Update Report Aug 2015: 7 out of 13 previous recommendations partially implemented, four fully implemented and two not implemented. Fire Warden training records loaded onto MAST (Totara) in December 2015. Fire Marshall training increased from 27 to 77% in the last 6 months.
Gaps in controls	Comprehensive surveys and assessments of compartmentation.	**Gaps in assurance**	90% all staff appropriately trained to increase rate of compliance • General staff • Fire Marshalls Key performance indicators are required for reporting to Health safety and Fire committee, ORC and QRC.
Actions next period:	Implement action plan in period. (Fire risk assessments, training, infrastructure, governance). Monitor progress through Health, Safety & Fire Committee and via Organisational Risk Committee. An IFC interim audit has been completed and the actions/recommendations enclosed will be implemented in relation to the management of Fire Risk. The revised Fire Safety Policy has been forwarded to the ratification panel.		

Principal Risk	03-02 Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation				
Description	There are gaps in the mandatory and statutory estates compliance documentation.				
Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Residual**	**Updated Apr 2016**	**Exec Sponsor**	Richard Hancock – Director E&F
Likelihood	4		4	**Date opened**	October 2012
Consequence	4		3	**Date closed**	
Score	16		12		

Controls & Mitigating Actions	Revised estates permanent management structure is in place this includes a compliance manager. Management structure which includes delegated responsibility Planet FM system (the estates helpdesk and job request system) is being upgraded to allow compliance to be monitored. Head of Estates Compliance in post An audit on the gaps in compliance has been completed. There is a planned programme in place to close the gaps in compliance. The Estates action plan will be further revised as higher risk items are closed.	**Assurance**	External H&S Executive – issue with electrical outlets on Richmond ward has resulted in a notice of contravention of the health and safety act (actions underway). Authorising Engineers appointed in all HTM areas April 2016 - External H&S audit undertaken which indicates a 75% compliance (Empathy EC) Internal Estates compliance records being assembled. Action plan being monitored and progress updates to the Operational Management Team. This risk is monitored via the Health, Safety & Fire Committee and overseen by the Organisational Risk Committee. Internal audit review findings: whilst some progress has been made with the remaining agreed actions, overall progress has been slower than desired in key areas.
Gaps in controls	All recommendations from the estates action plan are not complete	**Gaps in assurance**	Full compliance reports not yet available.
Actions next period:	To ensure that regular updates are provided to the committees monitoring this risk. Staff training undertaken IRO asbestos, Legionella, H&S Infection Control, Contractor Management (including Risk Assessments & Method Statements). Planned Maintenance activities being developed for assets. Premises Assurance Model being undertaken for Trust.		

Principal Risk	03-03 Lack of decant space will result in delays in delivering the capital programme.				
Description	Lack of decant space for capital schemes delays the ability to deliver some large capital schemes.				
Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Residual**	**Updated Apr 2016**	**Exec Sponsor**	Richard Hancock – Director E&F
Likelihood	4		4	**Date opened**	May 2014

Consequence	4		4	**Date closed**	
Score	16		16		
Controls & Mitigating Actions	Risk assessments undertaken for each project. Space surveys are undertaken on an annual basis to provide room usage data to enable the project manager to work out a plan. Monitored through CPMG, programme monitoring Boards and IDDG. Detailed decant plans will sit under the Trust's Development Control Plan Mitigating Action: The Trust received Planning permission (temp up to 5 years) for the new Wandle annex – 4 storeys c 5000m2. Plan in progress to vacate existing chest and breast clinic building as no longer fit for occupation. Re- activate the Trust Space committee to develop a Trust space strategy and assess the space issues across the Trust			**Assurance**	Documented risk assessments received by Project boards and reviewed when business cases approved Capital project delivery is reviewed through CPMG, Project Programme Boards and IDDG.
Gaps in controls	Short term planning brings forward new priorities that unbalance existing plans. Impact of turnaround Modular development to move transactional staff out of clinical areas and release space for redevelopment not in 'shrunk' capital plan. Infrastructure issues for Knightsbridge Wing and Lanesborough Wing has resulted in the need to identify alternative space or decant space as a matter of urgency			**Gaps in assurance**	Financial position may mean potential inability to finance mitigating actions
Actions next period:	The new space committee should be mobilised as a matter of urgency with first meeting taking place in early May 2016 with a priority to develop the space strategy, assess the Trust space issues and requests. This will form the basis to find and agree the location of a decant space. Review of space and potential decant areas being undertaken by Estates and Facilities				

Principal Risk	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.
Description	Delay to the ability to deliver the capital programme and maintenance activity as a result of spaces not being handed over to projects and maintenance as a result of capacity issues.

Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Residual**	**Updated Apr 2016**	**Exec Sponsor**	Richard Hancock – Director E&F
Likelihood	4		4	**Date opened**	May 2014
Consequence	4		4	**Date closed**	
Score	16		16		
Controls & Mitigating Actions	Risk assessments undertaken for each project. Monitored through the CPMG & Project Programme Board. Engage with the department early in the capital scheme and jointly agree how this can be managed. Potential for space realisation as a result of Fixed Close Transfer work. Potential to identify rental office space offsite for non-clinical staff relocation to free up space for priority requirements Capital and capacity planning process			**Assurance**	Monitoring of project and maintenance activity through project/programme boards and Divisional Governance Boards. CPMG
Gaps in controls	No cumulative view of impacts of several decisions not to proceed or to delay works			**Gaps in assurance**	Improving governance and prioritisation in advance of forthcoming financial year through new IDDG group (merger of Capital programme group and Business case Advisory Group)
Actions next period:	To improve robust monitoring of project and maintenance activity. Estates and end users developing agreed access to areas for remedial works, including CQC items.				

Principal Risk	03-05 Risk to patient safety as a result of legionella infection.				
Description	There is a risk to patient safety from legionella infection. This risk has been increased as a result of legionella being found in isolated areas in the St George's Hospital site.				
Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Residual**	**Updated Apr 2016**	**Exec Sponsor**	Richard Hancock – Director E&F
Likelihood	4	3	4	**Date opened**	14 May 2014

Consequence	4	4	4	**Date closed**	
Score	16	12	16		
Controls & Mitigating Actions	Water testing regime in place as part of the planned preventative maintenance programme. If high counts of legionella are found it is chemically treated in accordance with trust water management policy. Water testing being carried out in accordance with HTM04, L8 and HSG274 Testing regime and results kept in electronic evidence log book.(Zetasafe) Water risk assessment completed Authorising Engineer (Water Systems) appointed by trust provide independent advice and support. Water responsible persons trained and certificated Head of Estates Compliance in post St James calorifier is decommissioned and hot water is fed via plate heat exchangers Detailed action plan in place being led by the Head of Estates.			**Assurance**	Water testing and cross party committee DIPC/IC Committee have recognised improvements across last 18 months Water safety committee report goes to ORC and Health, Safety and Fire Committee
Gaps in controls				**Gaps in assurance**	Specify why it remains as a three whilst dead legs removal is ongoing
Actions next period:	Monitor the testing regime and results. Capital funding for water deadleg removals continuing				

Principal Risk	03-06 There is a risk of regulatory action should the Trust fail to ensure compliance with its HTA licence in relation to the mortuary				
Description	The mortuary functions as a hospital and a public mortuary. And has capacity for 87 adult bodies including 6 bariatric fridge spaces. The expansion of hospital activity together with increasing local (Wandsworth & Merton) population has resulted in increased numbers of deceased requiring mortuary storage. This is compounded by an increase in the average length of stay of deceased patients within the mortuary. This has resulted in the Trust having to use temporary storage fridges due to a lack of capacity. At unannounced inspection in July 2015, the Human Tissue Authority (HTA) found temporary storage inadequate. Failure to correct the issues identified within required timescales may result in the Trust licence for post mortems and storage of the deceased to be revoked and the mortuary closed.				
Domain	**3. Regulation and Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Current**	**Update Apr 2016**	**Exec Sponsor**	Chief Nurse/DIPC (Jennie Hall)

Consequence	5	5	5	**Date opened**	27.8.2015 – escalated from Division
Likelihood	5	4	3	**Date closed**	
Score	25	20	15		
Controls & Mitigating Actions	Task and finish group set up which oversaw programme of work to address all required actions from HTA visit. Actions now closed with the exception of 2. Capital projects managing provision of bespoke additional accommodation outside the current footprint but within the lower ground floor of Jenner wing within the security cordon of the current cellular pathology department. Business case completed for additional storage. Length of stay monitored and reported (via OMT & Datix)			**Assurance**	Internal Reports to DGB/DMB via DDNG Reports to EMT via CN Report to OMT monthly re LOS Weekly capacity oversight by CN, External: Weekly reports to the HTA on progress Critical HSE report March 2015, HTA inspection July 2015 critical with several concerns raised – task and finish group ensured all actions addressed and return HTA inspection in Dec 2015 confirmed good compliance with one outstanding issue to be taken forward in 16/17
Gaps in controls	Inability to exert significant influence on wider system – i.e. Coroner to expedite removal of deceased.			**Gaps in assurance**	Confirmation individual undertaking DI role from July onwards. Agreement of Freezer Expansion Business Case.
Actions next period:	Completion of 2 actions in relation to business case and programme plan and governance roles.				

Principal Risk	03-07 Risk of regulatory action or penalties upon the Trust in the event of a failure to comply with the legislative requirements of the Freedom of Information Act (2000)				
Description	The provisions of the Freedom of Information Act stipulate that any questions asked of the Trust under the Act must receive a response within 20 days. A lack of timely response from Trust-wide staff in relation to each request results in a late submission. Respected instances could lead to penalties or regulatory action being taken against the Trust				
Domain	**3. Regulation and Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory and regulatory requirements**
	Original	**Current**	**Update**	**Exec Sponsor**	Luke Edwards
Consequence	5	5	5	**Date opened**	1-3-2016 (escalated from Corporate Affairs Risk Register)
Likelihood	3	3	3	**Date closed**	
Score	15	15	15		

Controls & Mitigating Actions	One dedicated person coordinating requests received and temporary resource secured from 29th March until additional substantive post in place. Policy in place.	**Assurance**	Current backlog of overdue requests over 250 as at 24.3.2016. Two requests for internal review by applicants whose request has been overdue No reporting or escalation mechanism by which to performance monitor divisional responses. Divisional response rates poor and a lack of understanding of importance of timely response to either re-direct or provide requested info.
Gaps in controls	Senior corporate Administrator responsible for FOI currently covering vacant team in role means less focussed time upon FOI process Manual system with no automated capacity to manage requests	**Gaps in assurance**	No formal oversight by a Trust Committee hence level of risk and route of escalation is not clearly defined
Actions next period:	Explore electronic workflow solutions which would automate reminders and produce performance and status reports Explore possible ways to increase awareness amongst divisional staff in order to create a higher profile Develop formal monthly report for each division of outstanding requests Recruit to substantive post		

Strategy, transformation & development Domain: 4.2 Redesign & configure our local hospital services to provide higher quality care

Principal Risk	A533-08: Reconfiguration of healthcare services in SWL result in unfavourable changes to SGHT services and finances
Description	The NHS is in a period of sustained financial challenge. Much of the NHS's reform and modernisation agenda is articulated in the "Five Year Forward View" (FYFV). A key vehicle for the implementation and delivery of the 5YFV are sector wide plans called "Sustainability & Transformation Plans" (STPs) which cover the 6 south west London CCG's, the three other acute trusts, mental health trusts and also Local Authorities and other health and social care providers. The STP will outline the proposed configuration and change in clinical service delivery in south west London over the coming five years. All STPs' nationally are required to submit their plan by end June 2016, with 2016/17 being the first year covered in the 5 year plan. St. George's will work with CCG's, and particularly other acute providers in the sector – Epsom & St. Helier, Kingston and Croydon – in developing plans for sector wide reconfiguration. St. George's is a fixed point in the health economy, but at a time of great change, and with limited funding within the local health economy, the risk is that: ▪ St. George's services will be affected dis-advantageously by the recommendations falling out of the STP ▪ That decisions affecting other hospitals in south west London will require St. George's to amend its direction of travel, or to accommodate services on site that it is not currently planning to

<table>
<tr><td></td><td colspan="5">▪ That the overall uncertainty in the health economy engendered by the STP makes the development and implementation of a strategies and plans that clearly benefit St. George's more difficult to undertake due to the requirement to work within a STP framework

The effect of the above would be:
1. To have a negative impact on the trusts financial position
2. To slow or stop proposed service change at SGUH leading to negative operational, clinical or financial outcomes</td></tr>
<tr><td>Domain</td><td colspan="3">4. Strategy, transformation & development</td><td>Strategic Objective</td><td>4.2 Redesign & configure our local hospital services to provide higher quality care</td></tr>
<tr><td></td><td>Original</td><td>Current</td><td>Update</td><td>Exec Sponsor</td><td>Rob Elek</td></tr>
<tr><td>Consequence</td><td>5</td><td>5</td><td></td><td>Date opened</td><td>30/09/2010</td></tr>
<tr><td>Likelihood</td><td>5</td><td>2</td><td></td><td>Date closed</td><td></td></tr>
<tr><td>Score</td><td>25</td><td>10</td><td></td><td colspan="2"></td></tr>
<tr><td>Controls & Mitigating Actions</td><td colspan="3">Controls
▪ Senior representation on all STP bodies and groups, including on the overall approving body for the STP, to ensure that St. George's position is appropriately understood and represented
▪ Development of new trust strategy to inform STP submission and drive St. George's developments
Mitigations
▪ Savings programmes to ameliorate any loss engendered by STP driven decisions
▪ Access to support funding available through the STP funding
▪ Beneficial outcomes of the STP process offsetting negative impacts</td><td>Assurance</td><td>▪ Business Planning Steering Group to take a role in internal oversight of evolving STP discussions

▪ Regular reports back to EMT and Trust board on development of the STP and implications for St. George's to inform and formulate trust position</td></tr>
<tr><td>Gaps in controls</td><td colspan="3">None currently identified – programme at too early a stage to be able to judge</td><td>Gaps in assurance</td><td>None currently identified – programme at too early a stage to be able to judge</td></tr>
<tr><td>Actions next period</td><td colspan="5">▪ Development of internal STP governance
▪ Communication and engagement internally with STP process and requirements of individuals to support St. George's submissions
▪ Engagement through working groups in process and influencing of process</td></tr>
</table>

Strategy, transformation & development Domain: 4.5 Drive research & innovation through our clinical services

Principal Risk	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.				
Description	Although SGH has a Research Strategy, this is not embedded as a driver for research across the Trust. It is a high level document that does not set out how research will be embedded. •Track record in research relatively weak •St. George's brand is not strong in research. •Service demands restrict the ability to develop research at St George's (Historical differences in approach) •Loss of opportunities for research and development. •Inability to sustain research infra-structure and governance.				
Domain	**4. Strategy Transformation & Development**			**Strategic Objective**	**4.5 Drive research and innovation through our clinical services.**
	Original	**Current**	**Updated**	**Exec Sponsor**	Simon Mackenzie
Consequence	4	4		**Date opened**	28/02/2013
Likelihood	3	2		**Date closed**	
Score	12	8			

Controls & Mitigating Actions	• AMD for Research working with the Dean of Research and Enterprise. Regular joint meetings between SGUL and SGHT execs. • Research strategy implemented • CLRN Funded PAs for research active consultants within Divisions • Annual Plan for research strategy in place& monitored by research committee • Working with Information team, to integrate research data • Agreement of Divisional Scorecards – and introduction onto DMB or similar agenda • Implementing the Research Board • - Interim direction in place Joint working between SGUL Institutes and SGH NHS	**Assurance**	• Agreed Trust KPIs for research. • Increased levels of recruitment to NHR trials - both on raw and weighted figures. We have had a 40% increase in weighted recruitment • Research KPIs reviewed at TB and EMT • MHRA has signed off compliance with clinical trials • Increase in number of studies approved • Independent report of JREO recommendations accepted
Gaps in controls	• No system or guidance for prioritisation towards studies that contribute to NIHR recruitment (high-impact	**Gaps in assurance**	

	studies.) • There are capacity gaps for the JREO to in support developing research-interested consultants to initiate getting studies up and running • Lack of integration of research data in Trust information systems • Reduced funding for research		
Actions next period:	Implementation of JREO changes Apply for funding for NIHR and/or CRF Appointment of JREO Director		

Workforce domain: 5.1 Develop a highly skilled & engaged workforce championing our values

Principal Risk	A518-04:Failure to reduce the unacceptable levels of bullying & harassment reported by staff in the annual staff survey				
Description	Expectations placed on staff continue to rise in the light of increased clinical activity and tougher standards. Pressure felt by managers and staff often results in inappropriate behaviours. Quality of patient care negatively affected				
Domain	**5. Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Residual**	**Updated Mar 2016**	**Exec Sponsor**	Wendy Brewer
Consequence	4	4	4	**Date opened**	31/05/2010
Likelihood	4	3	4	**Date closed**	
Score	16	12	16		
Controls & Mitigating Actions	Staff are knowledgeable about the Stress Management policy & Dignity at Work: Bullying & Harassment policy. We have a H&B helpline that staff can use supplemented by access to the Staff Support and mediation service. Support is offered to managers on how to develop inter-personal skills through Leadership Development Programmes. Conflict resolution training is offered as part of induction. Regular contact with Staff side reps who raise issues on concern. Annual reports to the Organisational Risk Committee.			**Assurance**	Report outlining further work to be undertaken presented to Executive Management Team and Overview and Scrutiny Committee in July 2014. Updated analysis to go to EMT in June 2015 Elevated risk on CQC Intelligent Monitoring Report in May 2015 Staff survey results in relation to bullying and harassment show resulted a

	The Friends and Family test for staff has been launched on a trial basis which will allow us to be aware of areas where there is an increase in pressure. Unconscious bias training for senior managers have taken place Posters on harassment and bullying have been publicised across the organisation. Appointment of Senior HR Managers to take the lead around bullying Extended unconscious bias training to bands 7 (key line managers. Divisions have developed and continue to implement plans in response to staff survey The Listening into Action programme alongside work on the Trust's values will focus on action around harassment and bullying. Senior HR Advisor reviewed all work underway and benchmarked against other Trust – amendments to the policy to be made as a consequence		positive impact of recent work Feedback received from individuals directly as a result of Trust wide emails provide cause for concern Repeated concern raised externally (CQC) regarding PICU
Gaps in controls	None identified	**Gaps in assurance**	Discussions have developed and are continuing to implement plans in response to bullying
Actions next period:	Director of HR is developing an Embedding our Values programme for use across the organisation. The Effective People Management course will be revised to include an additional session on managing difficult conversations to assist managers in tackling issues effectively without being seen as harassing/bullying the member of staff. Amendments to policy – will include recommendations around leadership of the Carter review that CEO leads on Bullying and Harassment.		

Principal Risk	A516-04: Possible reductions in the overall number of junior doctors available with a possible impact on particular speciality areas				
Description	Inability to recruit and retain the appropriately skilled workforce to deliver our strategy				
Domain	**5. Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Residual**	**Updated March 2016**	**Exec Sponsor**	Wendy Brewer
Consequence	4	3	**3**	**Date opened**	30/11/2012
Likelihood	4	2	4	**Date closed**	

Score	16	6	12		
Controls & Mitigating Actions	Workforce Utilisation Plan reviewed monthly by the Trust Board. The surgical 24/7 group continues to meet regularly to review progress. ANP and PA posts have been established in most divisions to replace the work previously done by junior doctors. A training and education plan is under development for the PAs and ANPs. Able to appoint to these posts and see them as part of the staffing establishment in the future Review of medical establishment undertaken			**Assurance**	Positive assurance received via regular review within divisions. No real reduction in numbers to date. Known and anticipated reductions in junior doctor numbers will be included in business planning guidance and information for 14/15 business planning round. Medical workforce Planning group has been established
Gaps in controls	None identified			**Gaps in assurance**	Impact of new doctors' contract will be highly controversial and it is possible this will negatively affect the numbers of junior doctors wanting to work at the Trust – the impact is as yet unknown
Actions next period:	Establishment review - workforce efficiency: part of structural review Each of the divisions will consider workforce implications as part of the business planning round. Any particular difficulties in recruiting to vacancies will be identified and action plans produced. On-going assessment of how we begin to fill the gaps when junior doctors no longer are available				

Principal Risk	A520-04: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)				
Description	Loss of momentum caused by inability to release staff for training. Managers unable to ensure staff attending or undertaking eMast				
Domain	**5. Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Residual**	**Updated Mar 16**	**Exec Sponsor**	Wendy Brewer
Consequence	4	3	4	**Date opened**	31/05/2010
Likelihood	3	4	5	**Date closed**	
Score	12	12	20		
Controls & Mitigating Actions	1. eMAST in place across the Trust. All managers are currently engaged in achieving compliance with target (all managers receive monthly reports on Core MAST take up and take action accordingly). New e-learning package being implemented and a new system for recording MAST will help ensure that all compliance			**Assurance**	1. MAST policy Regular reports to ORC. Mandatory training rates to be reported on an individual subject basis in line with National Framework recommendations. 2. Uptake of eMAST training reports presented to ORC. 3. A report regarding the transition to the national framework has been presented to the Workforce Committee.

	activity is recorded. 2. eMAST training in place 3. Quarterly Mandatory training governance meeting includes Chief Nurse, Medical Director and Director of HR/OD to review content and staff cohorts of mandatory training 4. Implementation of new e-learning package and reporting systems. 5. Plan in place to deliver: • easy access to training • Well defined TNA • Accurate and trusted monitoring		4. New subjects have been added to the requirements, which has had an impact on overall numbers but provides assurance that all nationally recognised mandatory items are now included in St George's mandatory training. 5. Internal Audit report received
Gaps in controls	Lack of capacity to deliver identified training – in particular face to face sessions e.g. Manual handling, Resus and Child safeguarding Level 3 Can't release the new e-learning system in Community	**Gaps in assurance**	
Actions next period:	New MAST Steering Group set up as task force to address continued risk to non- compliance with target Include mandatory training in the regular workforce meetings with Divisions as well as appraisal rates. Recovery trajectory managed through Workforce and education committee – 75% compliance by June and 85% by December - to be reported to Trust Board and Workforce education Committee		

Principal Risk	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				
Description	NHS Trusts in London have traditionally had high turnover rates for some staff groups (mainly nursing) and most recently this has been increasing at St. George's. We are also increasing capacity in the Trust, often to areas where we have identified staffing as hard to recruit to, and the combination of these factors has meant that supply has outstripped demand, resulting in a heavier reliance on temporary staff. The impact is particularly significant in relation to band 5 nurses, where there is a very high volume of recruitment and in some specialist areas such as oncology, paediatrics and theatres. We are reporting staffing fill of 90%~+ in Safe Staffing reports but the difficulties in staffing create pressures in terms of being able to deliver their services.				
Domain	**5. Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Director of Workforce and Organisational Development Chief Nurse for nursing workforce
Consequence	4	4	4	**Date opened**	10/2015
Likelihood	3	4	5	**Date closed**	

Score	12	16	20		
Controls & Mitigating Actions	There is a workforce strategy which has an underpinning action plan. This plan is refreshed each year. The overarching objectives and progress is reported to the board. The workforce and education committee meets bi-monthly, supports the development of the plan and monitors its implementation. There is a monthly workforce information report to the board that identifies key trends against the workforce key performance indicators including turnover, vacancy rate and bank and agency usage. The report includes detail of bank fill rates. The monthly quality report to the board includes detail regarding the nursing workforce including a tracker of SAFE nursing staffing compliance and of staffing alerts that have been reported. The nursing recruitment and retention board is chaired by the Chief Nurse and meets on a 3 weekly basis to steer a programme of work to ensure recruitment and retention of the nursing workforce. A workforce planning meeting takes place weekly, chaired by the Director of Workforce and Education with the purpose of aligning workforce information and developing an annual plan. A medical workforce group is being formed, led by the Medical Director. This group will report to the workforce and education committee. Workforce plans form part of the annual business planning round.		**Assurance**	In response to the increases in turnover, the workforce strategy action plan has been refocused for 2015/16. Divisions have been asked to produce plans to reduce turnover that take into account the information available through exit survey data and the detail of turnover patterns within the division. These plans will be presented to the committee in July. There have been some areas that have reduced vacancy rate and turnover significantly such as paediatrics. This directorate has undertaken a focused piece of staff engagement work that has resulted in reduced turnover and vacancies. A business case for overseas recruitment for nursing has been approved by EMT. The nursing board, with the support of HESL, have agreed to recruit all student nurses currently on placement in the trust in the summer of 2015. (Approximately 100 nurses). A simplified process for internal promotion and movement has been introduced in response to feedback from the exit questionnaire data. The nursing and workforce leadership teams met with HESL to review the trust's submission for nursing commissions on 26th June. The trust was assured that the submission was considered to be of high standard. The trust will work with HESL on some suggested approaches such as identifying overseas qualified nurses working as health care assistants already working for the trust and providing a HESL supported nursing conversion course. A planned trajectory for turnover was presented to the trust board in May. Turnover has stabilised but remains at high levels. KPMG are providing support to the workforce planning group to speed the process for reconciling ESR and ledger workforce

			information. The nursing workforce staff-in-post has grown by 134.3 WTE since September 2014. KPMG have produced a detailed weekly tracker analysing staff in post movements. The workforce and education committee: • Routinely review turnover plans form divisions review progress with the workforce plan including progress with reconciling the ledger to ESR. • Review progress on the nursing recruitment plan.
Gaps in controls		**Gaps in assurance**	The workforce information on ESR and on the ledger needs to be resolved. KPMG have set a deadline to the finance team for end of July. The nursing recruitment plan needs to be reviewed against current activity and capacity plans. A process will be developed to ensure that the workforce plan is updated as activity and capacity plans change. This process will be managed through the workforce planning group.
Actions next period:	Business case approved to recruit 150 nursing staff from Philippines. Complete medical establishment review – now underway Routine review of turnover plans form divisions at workforce and education Committee		

Principal Risk	5.1-02 Risk of inadequate management capacity to ensure required support and engagement with turnaround programme whilst also delivering business as usual.		
Description	There is a risk to both effective engagement and support of the turnaround programme delivery where management capacity is insufficient to support the programme whilst delivering business as usual. Similarly, a risk to service delivery may arise if core business is not prioritised appropriately.		
Domain	**5. Workforce**	**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our**

					values
	Original	**Residual**	**Update Mar 2016**	**Exec Sponsor**	Wendy Brewer
Consequence	3	3	**3**	**Date opened**	30/11/2015
Likelihood	5	5	5	**Date closed**	
Score	15	15	15		
Controls & Mitigating Actions	Programme management approach to the requirements of turnaround. Regular staff and senior team leader briefings Communication messages are designed to be engaging and positive Monthly Chief Nurse open forum launched Nov 2015 Leadership programme launched Plan to recruit additional staffing to support transformation			**Assurance**	
Gaps in controls	None identified			**Gaps in assurance**	
Actions next period:	Communications to be developed in follow up to Nov Senior team leaders meeting to reassure staff around financial position of trust.				

Principal Risk	5.1-03 Business continuity risk and risk to patient safety as a consequence of failure to adequately plan for junior doctors' strikes				
Description	Patient safety and experience may be negatively affected if the trust fails to adequately plan for junior doctor strikes. This may impact upon waiting times and ability to meet performance targets.				
Domain	**5. Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Residual**	**Update Mar 2016**	**Exec Sponsor**	Wendy Brewer
Consequence	5	5	**5**	**Date opened**	1/12/2015
Likelihood	5	4	4	**Date closed**	
Score	25	20	20		
Controls & Mitigating Actions	Planning meetings underway for strikes – led by Chief Operating Officer. All Divisional plans from previous industrial action planning in December 2015 are being reviewed in preparation for new dates.			**Assurance**	Divisional representatives are satisfied their plans are robust. Agreement with the BMA that their members will leave the picket line to provide help should there be an issue of patient safety.

	Plans have been put in place for consultants and junior doctors not taking part in strike action to cover strike periods in order to maintain safe services. Where there is insufficient cover services will be cancelled. Decisions around whether to limit or cancel elective services and outpatient clinics are being communicated to patients but will remain under review in case the industrial action is called off at the last minute		Strike action has been managed with no perceivable negative impact on business continuity
Gaps in controls	Future strike dates planned for January and February 2016. Limited ability to influence response to national agenda	**Gaps in assurance**	Uncertainty around effectiveness of actions until fully tested
Actions next period:	Continue on-going planning in relation to the recently announced industrial action dates. Risk remains given uncertainty around further strike action		

Principal Risk	5.1-04 Risk of inability to retain adequately staffing levels arising from a shortage of agency staffing resulting from the national introduction of a cap on agency rates for nurses and locum doctors				
Description	The cap on agency rates introduced in December 2015 may mean the trust is unable to secure sufficient locum workforce to ensure safe and effective service provision.				
Domain	**5. Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Residual**	**Update Mar 2016**	**Exec Sponsor**	Wendy Brewer
Consequence	4	4	**4**	**Date opened**	1/12/2015
Likelihood	4	4	4	**Date closed**	
Score	16	16	16		
Controls & Mitigating Actions	Response to the national consultation Trust is currently modelling the impact of the cap to understand where we are likely to breach the capped rates in February and April 2016. Staff Bank Manager is liaising with LPP, Procurement and key agencies that we use to establish if they will provide staff at below the capped rate; this will allow us to revise			**Assurance**	The areas of concern have been identified and work is underway to agreed new rates with key agencies. Our plans to recruit out substantive staff to the Staff Bank is having some success which will increase our bank fill rate.

	our estimate of where the breaches will occur. We have contacted all managers to encourage them to ask their substantive staff to join the Staff Bank as a means of us reducing reliance on agency staff. Staff Bank recruitment plan for 2016 developed and being implemented.		
Gaps in controls	Limited capacity to influence national agenda	**Gaps in assurance**	It is not known at this stage if the medical locums agencies will be prepared to reduce their rates sufficiently.
Actions next period:	Staff Bank manager will continue to work with key stakeholders to influence the agencies to reduce their rates Monitor are visiting to carry out a deep dive into trust agency use.		

Principal Risk	5.1-05 Lack of success of the transformation programme without sufficient organisational support				
Description	If Exec Directors and Divisional leadership teams are not engaged and supportive of the transformation programme it will not succeed.				
Domain	**5.Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Current**	**Update required**	**Exec Sponsor**	Wendy Brewer
Consequence	4	4		**Date opened**	1/3/2016
Likelihood	5	4		**Date closed**	
Score	20	16			
Controls & Mitigating Actions	There is a detailed organisational development programme to support the transformation programme Plan of work in place to develop the required support/resource : 1. Ensure Exec team are positively leading engagement and communications around change 2. Embedding leadership development 3. Support for individual teams			**Assurance**	Board Development programme in place. Reports to Turnaround board and Workforce and education Committee.
Gaps in controls	Resource in the OD team to support the work plan may not be sufficient as it is difficult to anticipate the full extent of what of required for whole programme at this stage.			**Gaps in assurance**	Gap in terms of resource will be identified as the programme develops.

Actions next period:	Detailed session with workforce efficiency programme lead, OD lead and KPMG to identify all resource needed Continue to review the plan		

Principal Risk	5.1-06 Impact upon capacity to deliver quality core services and transformation programme due to disengaged workforce				
Description	Staff survey and medical engagement scores and results indicate a significantly reduced level of engagement amongst staff				
Domain	**5.Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Current**	**Update**	**Exec Sponsor**	Wendy Brewer
Consequence	4	4		**Date opened**	1/4/2016
Likelihood	5	5		**Date closed**	
Score	20	20			
Controls & Mitigating Actions	Delivery of workforce action plan for 16/17 themes focus upon: - Staff feeling able to report concerns - Pressure felt by staff - Engagement & communication with leaders - Appraisal - Fairness - Bullying Support from staff side representatives and governors in engaging staff			**Assurance**	Negative Staff survey results and medical engagement score Progress against workforce action plan reports to Workforce and Education Committee
Gaps in controls	Limited ability to influence or mitigate external factors including; London wide issues of staff turnover, turnaround and financial position Levels of disengagement amongst managers make it difficult to effectively deliver the programme			**Gaps in assurance**	Difficult to ascertain level of management engagement
Actions next period:	Staff survey open session Review bullying and harassment policy Recruit from Philippines to alleviate staffing pressures				