St George's University Hospitals NHS
NHS Foundation Trust

Trust Board Meeting (Public)

Thursday 28th July 2016 commencing at 10am – 12.00
H2.7, 2nd Floor Hunter Wing, Boardroom 7

Item	Time	Item	Owner:	Board Action	Paper No:
Board Business					
1.		**Welcome and Apologies**	Sir D Henshaw	Apologies received from: Jennie Hall, Karen Charman, Sir Norman Williams	-
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**	Sir D Henshaw	To consider the Minutes of the previous meeting held on 30th June 16 and check for amendments and approve	TB July 16 - 01
4.		**Key Issues**	All	Board members to identify any key issues	-
5.		**Schedule of Matters Arising**	Sir D Henshaw	To discuss any matters arising from previous meetings and provide updates and review where appropriate	TB July 16 - 02
6. Patient, Safety, Quality and Performance					
6.1		**CQC update**	P Moore	To discuss the latest position regarding the CQC Inspection	TB July 16 – 03
6.2		**Performance & Quality Account**	C Siddall	To inform the Board about the latest performance and quality report.	TB July 16 - 04
6.3		**Workforce Performance Report**	-	To inform the Board about the latest position on workforce.	TB July 16 - 05
6.4		**Quality & Risk Committee**	J Higham	To inform the Board about the key issues arising from the Committee	Verbal
6.5		**RTT Update**	C Siddall		TB July 16 - 06
6.6		**Vascular IR update**	A Rhodes		Verbal
7. Finance and Performance					

Item	Time	Item	Owner:	Board Action	Paper No:
7.1		**Finance & Performance Committee**	N Carr	To inform the Board about the latest project outturn including the capital bid for information	TB July 16 - 07
7.2		**Finance & Performance Committee**	Sir D Henshaw	To inform the Board about the key issues arising from the Committee	Verbal
8. Governance and Risk					
8.1		**Risk and Compliance Report**	P Moore	To review the Trust's most significant risks and external assurances received	TB July 16 - 08
09. Items for Information					
9.1		**Capital Bid to NHSI**	N Carr		TB July 16 - 09
9.2		**Questions from the Public**	Sir D Henshaw	To note use of the Trust seal in July 2016. The seal was used on 14th July – Captsticks-Surbiton Health Centre Lease from CHP to the Trust	-
9.3		**Key reflections**	Sir D Henshaw	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	-
9.4		**Key reflections**	All	The Board to reflect on key issues	-
Date of next meeting: 1st September 2016					

St George's University Hospitals NHS
NHS Foundation Trust

Minutes Trust Board

Minutes of the meeting Trust Board of St George's University Hospitals NHS Foundation Trust, held on Thursday 2 June 2016 in Boardroom H2.5 commencing at 10am.

PRESENT

Sir David Henshaw	DH	Chairman
Sarah Wilton	SW	Non-Executive Director
Stella Pantelides	SP	Non-Executive Director
Jennie Hall	JH	Chief Nurse
Simon Mackenzie	SM	Chief Executive Officer
Iain Lynam	IL	Chief Restructuring Officer
Wendy Brewer	WB	Director of Workforce
Corrine Siddall	CS	Chief Operating Officer
Richard Hancock	RH	Director of Estates and Facilities
Alison Benincasa	AB	Divisional Chair, Community Services
Andy Rhodes	AR	Medical Director and Divisional Chair, Women and Children
Sir Norman Williams	NW	Non-Executive Director
Kate Leach	KL	Non-Executive Director
Nigel Carr	NC	Chief Financial Officer
Gillian Norton	GN	Non-Executive Director
Lisa Pickering	LP	Divisional Director of Medicine and Cardiovascular
Paul Dossett	PD	Partner, Grant Thornton, Item 8.3
Elizabeth Olive	EO	Auditor, Grant Thornton, Item 8.3

Agenda Item	Action
1. Welcome and Apologies The Chair welcomed everyone to the meeting. The Chair introduced Gillian Norton as a Non-Executive Director to the Board. Eric Morton will also be joining the board as Non-Executive Director. Apologies were received from Tunde Odutoye and Luke Edwards.	
2. Declarations of Interest There were none.	

3. Minutes

The Board considered the minutes of the last meeting held on 5 May.

Resolved that the Board**:** approved the minutes as an accurate record.

4. Key Issues

No key issues were identified for discussion.

5. Matters Arising

SW noted there were some actions that required a confirmed due date.

6 PATIENT SAFETY, QUALITY AND PERFORMANCE

6.1 Performance & Quality Report

CS reminded the board that one of the key objectives for access to the Sustainability and Transformation Fund for 2016/17 was the agreement and delivery against improvement trajectories on key access standards. The Trust had submitted the trajectories on the 18th April 2016 as detailed in last month's report. There was an opportunity to review and submit revised trajectories if required. The 62 day cancer standard and over 6 week diagnostic waiting time trajectories were resubmitted. The ED and RTT incomplete pathway trajectories were unchanged.

ED

Formal communication had been received from NHS England recognising the performance in ED and congratulating the team. CS noted the ED team is continuing to work hard, and a number of initiatives have been implemented through May. LP noted ED performance for May was 93.6% which is in line with the trajectory. However, this does not fully capture the changes implemented in ED and Medicine during the month. The board welcomed the changes implemented in the ED department.

RTT

CS noted there was very detailed action plan for RTT recovery which will need to be revised following the external MBI review due to conclude on the 17th June. The RTT action plan will be refreshed and revised following the review. The refreshed plan will be presented to the Board next month.

C Siddall
July 2016

The board were assured there were no patient safety issues or risk to patients which had not already been identified. The third review is currently on going which has raised no significant issues. The operational teams are meeting on a daily basis to review.
CS reported there were 65 patients requiring a further in depth review. 63 of those patients have been reviewed and treated, and the remaining patients would be reviewed today.

The board was concerned on the data quality issues identified in the External Audit by Grant Thornton of the Quarterly Account relating to

the inaccurate reporting of RTT and ED performance. SM said the trust needs to have reliable data in order to manage and ensure services are reliable. The trust needs to move to a standard process and way of reporting. A data quality board has been set up to get to grip with data quality issues.

SW asked how soon the data quality issues would be resolved considering the potential impact on the STP funding which was linked to meeting these targets. IL noted the work carried out in other areas was throwing light on the gravity of the challenge and fixing the fundamental quality of data would be a substantive programme which requires reliable IT and use of a single system with proper data integrity. Currently we are at the stage of finding issues. The issues to be addressed will have to be prioritised.

The board recognised there was still a considerable amount of work to do to ensure the data quality issues are resolved. The board noted the Trust was being open and transparent with the commissioners.

Outpatients
SW noted the improvement in the call centre performance. The level of call activity and the number of abandoned calls remain under target primarily due to shortage in staffing levels. The average wait time for call to be answered is 4 mins. AR reported the call centre is currently going through a transformational phase and on an active recruitment drive to fill the staffing capacity shortfall following recent vacancies which have arisen.

Quality Report
JH updated the committee on key quality indicators. In the effectiveness domain mortality HSMR performance remains significantly lower than expected; for the period March 2015 to February 2016.

The Boards attention was drawn to the national End of Life Care (EOLC) Audit. The audit indicated against benchmarks against the national performance the Trust is performing better in 4 of the 5 indicators. There are still some actions to be taken in order to ensure full compliance. JH confirmed SW had agreed to take on the role as lay member on the Trust Board with responsibility for EOLC.
An ELOC strategy will be developed and the Board will be updated in 3 months on the longer term plans.

J Hall
Sept 2016

The national audit also covered Percutaneous Coronary Interventions (PCI) data between January and December 2014 and assessed key aspects of the patterns and quality of care for PCI. The report looked at a number of key indicators and the Trust was considered to be “Almost excellent”.

Peer review audit was undertaken in this audit round to provide assurance that data submitted by specialties are in line with reported findings. The overall performance shows a drop in compliance rate for all fields in this peer reviewed audit round.

JH reported there were 13 general SIs reported in April. The proportion of patients that received harm free care in April was 95.11% which is better than the national average for the month and in line with our target of 95%. There were no MRSA Hospital acquired bacteraemias reported since September 2015. There is compliance with safeguarding children training compliance level 3 and there is an improving compliance position in safeguarding adults.
The Board noted the proposed complaints action plan.
Safe staffing remains consistent with some variation in individual areas. In April 2016 the trust achieved an average fill rate of 94.5%.

Resolved that the Board**:** noted the updates.

6.2 Workforce & Performance Report
WB introduced the workforce report noting that the vacancy and turnover rates have increased in April. 140 nurses have been recruited from the Philippines and discussions are taking place to bring the nurses through earlier than September. Further recruitment will take place from the EU where work is progressing. All the nurses will be in place by Q3 and Q4. The plan will have an impact on the CIP programme, preparation for Winter and skill mix profile.

Temporary staffing reduced in accrual. There is significant work taking place to reduce temporary staffing particularly around medical locums. There has been good progress in mandatory training compliance and the trust is meeting the trajectory for improvement. The workforce and education committee considered the action being taken on mandatory training. A detailed review will take place at the next meeting in June.

The board were previously updated on the number staff in acting up arrangements. The managers have been requested to resolve all acting up arrangement that have lasted for more than 6 months by the end of July.

SP presented the chairs report from the workforce and education committee meeting on the 31st May. The Board were asked to support the senior leadership on development and coaching/mentoring. The CEO and Chair were asked to support the programmes objectives and visibly act as sponsors.

It was noted that there would be significant reduction in the education income in 16/17 as transition funding support is gradually withdrawn. Further reduction is expected in 17/18 with transition funding ceasing completely in 18/19. The committee requested that a commercial lens is applied to this area. **W.Brewer**

6.3 Quality & Risk Committee
NW presented the key issues arising from the committee. This was his first meeting as Chair and he noted some very good work is on-going in the Trust. NW noted:

- Mortality data is very good
- Improvement in mortality in Cardiology
- End of life information is good with 4 out of 5 indicators above average
- Stroke results have improved but noted problems in capacity
- Poor performance in WHO checklist in some areas
- Plan required to address the slow turnaround time in complaints
- Radiation safety concern – reassurance measures need to be put in place and ensure they are effective
- Productivity needs to be improved in Theatre capacity
- Need to ensure compliance in mandatory training
- Appoint Governor to act as a Freedom to speak up guardian to help to improve bullying and harassment

NW reported he was confident as chair of the committee that there are processes in place to address these issues. However, further assurance is required over the audit cycle.

6.4 Urogynaecology Report
The Board on the 3 March 2016 supported the proposal for the Trust to begin a process of liaison with commissioners to understand the appetite and specification for the re-establishment of a urogynaecology service.

The service remains in suspension as the safety and governance issues have not been resolved. Wandsworth CCG have indicated that they aim to review the clinical needs of the local population in relation to urogynaecology and also the sub speciality needs to support other services at Trust and across SW London. A GP clinical lead has been appointed to work closely with the Trust on the development of any potential new service specification.

Wandsworth CCG will produce a service specification in the Autumn which must go through the formal procurement mechanism in order to re commission the service, the ability to deliver the service within the framework of the national tariff and the timescales for recruitment of new staff.

A Rhodes
June 2016

SW asked whether patients were being consulted through the process before the service specification is prepared in the Autumn considering the strong patient interest. AR agreed to take the suggestion to the commissioners leading on this.

Resolved The Board supported the on-going liaison process with Wandsworth CCG.

7. STRATEGY

7.1 Estates Strategy

RH presented the detailed paper and strategy summary presentation. The Estates strategy vision is for the Trust to be operating from a safe, reliable estate that supports the effective, efficient delivery of services in support of the Trust's operational plan. This is a short to medium term plan to address the shortcomings on site and community sites.

Further funding will be required as the majority of the 2016/17 allocation is needed just to maintain the critical services.
The additional funding will be required to make changes to the unreliable infrastructure. The final estates strategy proposals will form the basis of a business case(s) that will be used to gain funding to deliver the intended improvements.

DH noted the Sustainability and Transformation Plan (STP) process had identified the Trust as a principle site in the future. Hence the need to refurbish the estate and work is underway focussing on reducing cost, demand and throughput by increasing productivity. The STP work recognises the need to have an estates strategy which ensures the best use of all assets and meets the standards.

SW noted the Trust is co-located with the Medical School and asked for assurance that RH is liaising with colleagues on the plans. The Board were assured that meetings were taking place with good dialogue.

Resolved that the Board approved the development of a detailed estates strategy for the July Board meeting.

R Hancock
July 16

7.2 Outpatient Review

AR noted that the paper provides an update to the programme and way forward. A review of the outpatient transformation has been undertaken and a number of recommendations made and a Programme Director appointed. Meetings have also taken place with the stakeholders.

The outpatient transformation programme has been reviewed at the Outpatient Strategy Board, Executive Management Team and recommended by the Finance and Performance Committee.

The detailed Implementation Plan (DIP) ran into problems due to competing pressures. The governance structure, process and plans have been reworked and a new mechanism has been developed to delivering this plan.

The board were advised that the work to date is an analysis of the current position process and a single proposal will be developed.

Resolved that the Board approved the recommendations and appointment of Board level Senior Responsible Officer (SRO) and Clinical Responsible Owner (CRO).

8 FINANCE AND PERFORMANCE

8.1 Finance Report – Month 1

NC reported the month 1 position was an adverse variance of £1.6m. This was linked to activity issues with underperformance on SLA income which reflects loss of elective and outpatient activity due to the four days of junior doctor strikes, unachieved RTT targets and business case slippage. April also saw lower levels of non-elective activity than planned. Penalties for the month are broadly in line with plan.

The STF funding has been accrued at the full rate which is paid in arrears. Pay is broadly in line with budget. It was expected to see some mitigation in temporary staff costs given the activity underperformance. NC noted the systems need to be improved to get weekly data to divisions to provide better visibility to reassess their staffing levels in month.

The underperformance of pay CIPs is compensated through holding vacancies in some areas. There is an increase trend in the use of non clinical interims.

NC reported a broadly a clean year end with little prior year into this year. The underlying month 1 deficit after the removal of non-recurrent items was £5.3m. The cash balance was £12.9m, £0.2m less than plan. The adverse I&E performance has not been reflected in the cash position mainly by better working capital performance and capital under spend.

Resolved: that the Board noted the update.

8.2 Finance & Performance Committee

SW outlined the key messages. The committee was concerned on the shortfall at month 1 and fully support the work to understand recurrent and non recurrent items to forecast and deal with reasons for the shortfall. The SLA income was short by £2.2m in the month was a key factor particularly the lower levels of activity in outpatients than budgeted.

It was noted there were £10m CQUINs performance agreed with commissioners within the budget and the committee were keen to ensure that the mechanics to deliver are in place and are able to keep a track of performance against measures in those areas.

The committee will need to consider improvement projects at the next meeting. There are £33m of CIPs in the budget for this year across the key workstreams and the Board needs assurance through the relevant committees that all the projects are properly resourced and will deliver given the highly challenging budget agreed for this year.

Resolved: that the Board noted the update.

8.3 Annual Report and Accounts

Paul Dossett and Elizabeth Olive attended from Grant Thornton. The board were informed that the quality accounts and working papers to support the accounts were not of the standard expected. This led to significant difficulties in completing the audit with an overrun of 3 weeks.

An emphasis of matter paragraph has been included within the auditors report to reflect the material uncertainties that exist given financial challenges faced by the Trust. A note has been included in the accounts to that effect and this is reflected in the auditor's report.

As a result of the Trust's deficit of £55.1m in 2015/16 and its planned deficit of £17.2m for 2016/17, as well as due to the current level of NHS Improvement intervention at the Trust, the auditors have noted adverse conclusion on the Trust's arrangements for securing value for money.

The limited assurance procedures was completed on the Trust's quality report, and assurance was obtained that the quality report is compliant. However, the Trust was unable to provide supporting data sets for the selected indicators of RTT and 4 hour A&E wait that agree to the figures reported in the quality report. As a result, a qualified conclusion in relation to both indicators will be issued.

EO reported across the Referral to Treatment Time indicator 4 out of 25 cases failed. This resulted in an understatement of the actual RTT indicator which means the position reported is better than it actually is. In the 4 hour A&E indicator 5 out of 25 cases failed. EO noted 25 samples are a very small number of indicators to test and this would not change the reporting indicator.

The board noted great concern over the data quality issues identified and will be working to get to the bottom of those issues but these could be significant and difficult to resolve given the technical issues and culture.

EO noted that the finance function needs to address competence and capability work in the department going forward and the training needs of individuals. A key point to address in the finance function will be the culture within the team. NC noted there will be focus in these areas to address going forward.

The audit committee reviewed the report and accounts and subject to the completion of the audit recommend that the board approves. The audit committee also had the assurance to the Non-Executive Directors from the Executive Directors in the letters of representation.

Resolved: that the Board noted the report form the Audit Committee. The Board approved the annual reporting accounts and authorised the CEO and CFO to sign off the relevant documents as SRO.

9. Governance and Risk

9.1 Risk and Compliance Report

JH presented the report. She noted the most significant risks on the corporate risk register were detailed. There were two new risks relating to safeguarding have been included in the CRR. Both have resolutions going forward. Controls are developed for all risks, with a rolling programme of review by QRC.

JH confirmed the Chief Financial Officer has reviewed and confirmed that it is appropriate to close the risk on 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. A new risk will be opened and a risk assessment is also underway.

The Board asked for the risk description on RTT to be reviewed. Non-compliance of fire safety has also been reviewed by the Director of Estates and Facilities.

The CQC visit is scheduled for the 21st – 23rd June. The CQC will be on site initially undertaking open sessions with patients and relatives followed by staff sessions. JH noted there is momentum in preparing for the visit and progress has been made across a number of areas.

The board were asked to note the ofstead inspection in Children and young people with special needs in May. The final report has not yet been received.

The Chair noted the risk and compliance report was disappointing and not what was expected in a high performing Trust. A plan will be developed to get grip in governance risk and quality.
The data quality risk will need to be reviewed in light of the discussion and highlighted to the Board at the next meeting.

J Hall
July 2016

9.2 Board Assurance Statements

The Board were asked to agree the level of compliance with the two governance statements to be submitted to NHSI following the meeting. The Board agreed to statement 2 and the alternative wording was agreed for statement 1.

10 Items for Information

10.1 Annual Plan

Resolved: The final version of the plan was noted by the Board.

11. Use of the Trust Seal

The seal was not used in May.

12. Questions from the Public

Barbara Bohana asked why has the management of the Urogynaecology services failed yet again to engage patients in the plans for reconfiguration of the Urogynae services. She also asked whether the G.P providing the lead, is an expert in Gynaecology. She said patients would be bitterly disappointed to hear the process has been shelved until Autumn, and asked whether this service finally be

privatised.

DH responded that the service has been suspended in light of the reasons explained. The Trust is currently under direction from the commissioners as to whether the service should be established and the CCG are engaged in a process of redesigning the service. The question on patient involvement has been taken on board and will be passed to the commissioners. It was agreed the question will be sent to the commissioners for a response.

13. Key reflections

It was agreed that questions from the public would be taken at the start of the meeting followed by a patient story to start off the Board meeting in future.

J Hall
July 2016

Date of next meeting

The next scheduled meeting of the Board to be held in public will be 28th July 2016.

St George's University Hospitals NHS
NHS Foundation Trust

Matters Arising/Outstanding from Trust Board Public Minutes
28 July 2016

Action No.	Date First raised	Issue/Report	Action	Due Date	Responsible officer	Status at July 2016
13.	7 April 16	Workforce and Performance Report	Provide a clarification around the 35% vacancy factor reported for the SWLP	April 16	W Brewer	The vacancy issue in SWL Pathology was a result of budget realignment and has now been resolved
10	7 April 16	Key Trajectories - RTT	Written report on RTT to be submitted to the board	July 16	C Siddall	Superseded
10	7 April 16	Key Trajectories	The expectation was that the trust would be sustainably hitting all seven standards	TBC	C Siddall	A revised new trajectory with commissioners was agreed. All standards to be achieved from April 2016 with the exception of 62 days which is July 2016. In April and May the Trust continued to fail the 2 week wait standard (as well as 62 day) and additionally in May 62 Day screening standard was also not achieved.
7.4	5 May 16	Frequent A&E Attenders	Proposed new approach to facilitate alternative planned care away from Emergency Department. AB to share detailed analysis with NW	June 16	A Benincasa	TBC
7.5	5 May 16	PPI/PPE Strategy	Board agreed with the Strategy. JH to set out an action plan working with Patient representatives.	Sept 16	J Hall	
8.4	5 May 16	2015/16 Annual Plan Q4 Review and End of Year Summary	RE agreed to provide an update on the EDM and e-prescribing projects following the Board.	June 16	I Lynam	Update
6.1	2 June 16	Patient Safety, Quality and Performance (RTT)	CS noted there was very detailed action plan for RTT recovery which will need to be revised following the external MBI review due to conclude on the 17th June. The RTT action plan will need to be refreshed and revised following the review. The refreshed plan will be presented to the Board next month.	July 16	C Siddall	On Agenda

6.1	2 June 16	Patient Safety, Quality and Performance (Quality Report)	A ELOC strategy will be developed and the Board will be updated in 3 months on the longer term plans.	Sept 16	J Hall	
9.1	2 June 16	Risk and Compliance Report	The data quality risk will need to be reviewed in light of the discussion and highlighted to the Board at the next meeting.	July 16	L Murphy	Superseded by wider review conducted by Director of Quality Governance

Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

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

Paper Title:	**UPDATE FOLLOWING CARE QUALITY COMMISSION INSPECTION**
Sponsoring Director:	**Director of Quality Governance**
Author:	**Director of Quality Governance**
Purpose: *The purpose of bringing the report to the board*	*To Note*
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*	

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

1. Key messages

The CQC inspected the Trust during the week commencing 21 June 2016. The Trust is awaiting a full report and rating. The CQC found our staff to be motivated, engaged and caring. Initial feedback highlighted concerns in respect of the quality of the estate (particularly Knightsbridge and Lanesborough Wings), governance, timely access and data quality.

The Trust has taken steps to address urgent concerns brought to the Trust's attention.

2. Recommendation

To note

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?

Key risks include:

- A failure to comply with one or more fundamental standards, caused by inadequate internal control. This may result in a breach of CQC Certificate of Registration.

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

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.

UPDATE FOLLOWING CARE QUALITY COMMISSION INSPECTION OF ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

1. The CQC inspected the Trust during the week commencing 21 June 2016. The inspection was a comprehensive, announced inspection that involved 3-days of intensive inspection supplemented by a series of unannounced inspections over the following two weeks.

2. The Trust is awaiting a full report, but can share the following initial headline feedback from the inspection which has formed the basis of the Trust's response:

AREAS OF GOOD PRACTICE

- Our staff were motivated, engaged and had a good understanding of the issues within their own areas
- Our staff were caring and spoke with candour of the challenges they, and the organisation faced
- The CQC were impressed with the clinical outcomes and low caesarean section rates currently reported by the Trust
- The CQC considered that the frontline workforce was engaged with driving the improvement agenda forward if they were engaged appropriately.

AREAS OF CONCERN

- The condition of the estate within renal services and outpatients and wider estates risk management and in particular mitigation of fire risk in Lanesborough Wing
- Governance arrangements supporting the investigation of serious incidents
- Oversight and delivery of action plans at a local level
- Compliance with the Duty of Candour
- Compliance with the Fit and Proper Persons Requirement
- End of Life care in community settings – oversight and governance regarding the relationship with Trinity Hospital, and a lack of service level agreement provision
- The management of patients on Gwynne Holford Ward at Queen Mary's Hospital in respect of monitoring nutrition and hydration, and oversight of the administration of medicines to day patients receiving rehabilitation treatments
- Empowerment within Theatres. Staff not prepared to challenge colleagues on dress code which raised a question as to whether staff would be empowered to challenge in the event of a patient safety concern
- Staff were knowledgeable about the Mental Capacity Act and Deprivation of Liberty Safeguards, however there were examples where patients were restrained without appropriate safeguards in place
- Governance processes were considered weak, with a lack of accountability, and overall risk management arrangements need strengthening
- Executive portfolios need reviewing
- Data quality, IT infrastructure and unreliable performance information, combined with insufficient clinical oversight and prioritisation of referrals

AREAS REQUIRING IMMEDIATE ASSURANCE

- Estates – fire safety standards and environment of care;
- Board Assurance Framework and over-riding governance; and
- Clinical prioritisation of referrals.

IMMEDIATE ACTION TAKEN

3. The CQC subsequently notified the Trust of the possibility of enforcement action subject to receipt of urgent assurances from the Trust in respect of (i) progress to repair a leaking roof and mitigation of the risk of electric shock in Buckland Ward; and (ii) fire detection, fire separation and water treatment in Lanesborough Wing. The Trust provided urgent assurances as required, to the satisfaction of the CQC, and the Trust has subsequently been notified of the CQC's decision not to take regulatory action. Improvements will continue to be monitored by the CQC.

INITIAL RESPONSE TO CQC FINDINGS

ESTATES

4. Renal Services (Buckland Ward, Knightsbridge Wing) – the roof has been repaired. In addition we have assessed and prioritising any necessary repairs to fixed wiring installations. The entire electrical infrastructure is being tested in accordance with BS7671 wiring regulations and NIC standards.
5. The Trust ceased using those beds affected by the risk of electric shock from water ingress in Buckland Ward.
6. We are enacting a plan to relocate renal services.
7. We are continuing to test all fire alarm systems weekly.
8. We are continuing to complete the replacement of the fire detection system in Lanesborough Wing. The replacement has been completed on the Ground to Third floors with the remaining floors underway.
9. Subject to funding, we also have plans to replace the fire alarm system in St James Wing.
10. We have initiated immediate retraining on fire for all matrons and charge nurses.
11. We have commissioned an independent review of fire compliance from London Fire Brigade.
12. As part of the decant programme, starting on the fifth floor of Lanesborough Wing, we are assessing and remediating any breaches of fire compartmentation.
13. Flushing, chlorination and pasteurisation (of water pipes) continues as part of the Water Safety Plan. We have initiated Estates-led flushing routines.

GOVERNANCE

14. The Trust has appointed a Director of Quality Governance with considerable experience in addressing regulatory concerns and improving organisational governance. The Director of Quality Governance joined the team on 4 July 2016.
15. The Trust is continuing with its plans in train ahead of the CQC inspection to address the specific concerns in respect of the estate within Knightsbridge and Lanesborough Wings.
16. The Trust is developing a Board Assurance Framework, reconstructing the Corporate Risk Register alongside divisional risk registers, developing the risk management process in addition to advancing a series of proposals to enhance governance across the Trust for the Board's consideration.
17. A detailed Quality Improvement Programme (QIP) is being developed, subject to the approval and sign off by the Board of Directors, and shall be supported by a dedicated Programme Lead to drive forward the improvement required. Programme governance will follow that widely adopted by Trust's in special measures in order to assure progress and delivery. We recognise Quality Improvement Programme will expand as and when the CQC's report is published in order to address all the concerns that have come to light. The Director of Quality Governance will be Programme Director for the QIP.
18. The Director of Quality Governance has initiated a rapid review of risk management, Board assurance and overall governance arrangements, and shall report to the Board of Directors in early August. In the meantime, the Trust has reviewed the Risk Management Policy and is developing the corporate risk profile to gain greater insight into the material risks facing the organisation in the short and longer term.

19. The Director of Quality Governance has initiated a series of Good Governance Master classes to engage and involve front line teams in effective control and oversight. The master classes will run every week throughout the summer

CLINICAL PRIORITISATION OF REFERRALS

20. The Trust is taking urgent action to stabilise the risk. The Board has received and discussed the MBI report and agreed a series of urgent actions, including extending its review of data to also incorporate cancer and diagnostic pathways.
21. The action underway involves:
    (i) procuring external expertise to address the technical failures and identify patient cohorts requiring clinical review. This will quantify the scale of the problem and initiate auto-validation using specific algorithms;
    (ii) urgent staff training has taken place, together with targeted tracking of data entry errors to prevent new patients from being entered on the system without a clock start, this minimising the risk of clinical harm;
    (iii) A process for clinical review of patients where auto-validation is inconclusive, or clock stops aren't found, has been developed to evaluate the risk of patient harm and urgently recall for treatment where clinically indicated. There is a potential for a very large number of patients requiring clinical review and resources to support rapid review will be provided;
    (iv) Improving leadership and oversight of RTT, including dedicated project resource – independent of normal operations to ensure validation and clinical review is undertaken promptly;
    (v) The Trust is exploring ways to reduce demand on its systems and release capacity to cope with the validation exercise;
    (vi) A communications plan is being implemented and external stakeholders are being kept informed regularly of the position.
    (vii) An executive-led RTT Recovery Programme has been developed, with support from external stakeholders, incorporating a whole system's transformation RTT management.

ACTION/DECISION REQUIRED

22. The Board are invited to note the CQC's initial feedback, the Trust's initial response and be advised that, in due course, the Trust shall provide a regular update and assurance on delivery of the QIP as part of this meeting going forward.

Paul Moore
Director of Quality Governance
21/07/2016

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

Paper Title:	Quality and performance Report to Board Month 3 June 2016
Sponsoring Director:	Jennie Hall- Chief Nurse/ Director Infection Prevention and Control Andrew Rhodes - Medical Director Corinne Siddall – Chief Operating Officer
Authors:	Jennie Hall- Chief Nurse/ DIPC Andrew Rhodes - Medical Director Peter Riley- Infection Control Lead Corporate Nursing Team Divisional Directors Nursing/ Governance Trust Safeguarding Leads Hazel Tonge, Deputy Chief Nurse Head of Performance
Purpose:	To inform COG, Board/ QRC about Quality Performance for Month 3.
Action required by the board:	To note the report and key areas of risk noted.
Document previously considered by:	Quality and Risk Committee

Executive summary

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

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

(Note: Cancer performance is reported one month in arrears, thus May performance is reported in June)

Cancer Two Week Wait Standard

The trust did not meet the 93% standard in May with performance of 87.3%. The standard was not met due to underperformance in the following specialties: Gynaecology, Skin, Head and Neck, Haem, Breast and Urology. Key reasons cited for breaches were patient choice and capacity constraints. The trust is working with commissioners to improve communications with patients in a primary care setting.

Specialties are working to address capacity shortfalls, in particular; Gynaecology who have had increased OP capacity in place since May and Skin who have agreed additional capacity to meet summer demand. This is continually being reviewed.

Cancer 62 Day Standard

The trust did not meet the 85% standard in May with performance of 77.5%. The standard was not met due to underperformance in the following specialties: Gynaecology, Head and Neck, Lung, Upper GI, Lower GI and Urology. Key reasons cited for breaches were: patient choice, capacity constraints, delays in working-up patients, referrals being received from other trusts with no information, a number of patients being on complex diagnostic pathways, and increased demand and impact on diagnostics related to growth in referrals.

The trust is undertaking weekly conference calls with referring trusts to address key issues pertaining to quality of referrals. This also continues to be reviewed at the SWL Cancer forum. Furthermore specialty teams continue to review capacity constraints and recovery plans are in place to address key areas of challenge such as CT-colon and Gynaecology OPD and Hysteroscopy Capacity.

The Trust continues to follow the agreed recovery programme primarily focusing on enhancing PTL development, validation and improving tracking processes.

Cancer 62 Day Screening Standard
The trust did not meet the 90% standard in May with performance of 84.8%. The standard was not met due to underperformance in the modalities of Breast and Lower GI.

Underperformance was primarily due to breaches being against a low number of patients treated in comparison to previous months. The breaches were due to breast screening patients who were treated late by other providers. These were shared breaches due to the trust being the host organisation for the screening service.

RTT Incomplete Pathways Standard
The trust did not meet the 92% standard in June with performance of 88.3%. The overall waiting list size and backlog size have also increased this month.

The trust reported 6 patients waiting 52+weeks at end June. These were in the following specialties: ENT, Trauma & Orthopaedics, Gynaecology and Gastroenterology. Root cause analysis investigations are being undertaken for these patients.

RTT remains a challenge and the trust acknowledges the importance of not just reducing long waiters but achieving a position of sustainability. The RTT external review by MBI has been concluded and a findings report provided to commissioners and regulators on June 30th. In review of the report the trust is mobilising the development of a recovery plan and the trust are taking key action to address areas of leadership, governance, clinical harm and procurement of external operational and technical resource.

ED 4 Hour Standard
The trust did not meet the 95%standard in June. However great improvement and significant increase in performance has been seen since April. In June the trust achieved 94.0% within 4 hours which is an increase of 0.46% compared to May and also above the STF trajectory.

Contributing factors to ED performance were: Capacity and bed flow, delays in ED assessment and treatment, increase in the number of DTOC patients and an increase in the number of patients who were medically fit for discharge. These included patients awaiting transfer to another provider and patients going home that day. The trust is working with commissioners and external agencies to expedite this.

Analysis has also shown that in relation to performance a higher proportion of breaches are reported on a Monday and Tuesday with a higher proportion of attendances arriving on a Thursday. This is parallel to ambulance arrivals and hospital admissions. In response to this the trust are reviewing staffing models to asses if and how adjustments can be made to be in line with variation in demand. Furthermore, a review of UCC ways of working is being undertaken in light of increased workload and to identify ways in which navigation process can be further enhanced.

The trust continues to monitor progress against its recovery plan and trajectory with both external and executive oversight via the Flow Programme Board.

The trust shows the quality governance score against the Monitor risk assessment framework of 4 and the Monitor imposed additional license conditions in relation to governance remain.

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

Key Points of Note for the Board to note in relation to June 2016 Quality Performance:

The Overall position in June remains consistent with the previous two quarters in terms of the trends for the metrics with some moderate improvement across a number of indicators. Serious Incident numbers remain an area of focus in relation to themes seen and actions being taken. Routine oversight of serious incidents continues to be monitored through the Patient Safety Committee and SIDM.

Effectiveness Domain:

- Mortality performance remains statistically better than expected for the Trust. The Mortality Monitoring Committee review SHMI in detail. The committee has reviewed Group 123: Joint disorders and dislocations; trauma-related, Spinal cord injury, Skull and face fractures, other fractures, sprains and strains. 38/45 cases revealed two common modalities: 1) elderly patients that have sustained a fall 2) traumatic spinal and brain injuries. No systemic care issues were identified. Next month MMC will focus on septicaemia.
- National Audits within the report: The first report examines VTE in patients presenting in ED requiring lower limb to be immobilised with a plaster cast or discharged to be treated as an outpatient. SGH performed poorly against both fundamental written referral) and developmental standard (information leaflet given) with ED documentation being poor. Action plans have been developed and three reaudits later have improved with a further cycle at the end of July. The second examined procedural sedation audit, which showed lots of good practice particularly in terms of assessment before discharge. An action plan is in place to improve documentation and to deliver training and education to staff.
- Local audits included the local bereavement survey audit (31 responses) explored carers and relatives views about care received at EOL. 80% felt that relatives were treated with respect and dignity at all times.
- A complete review of all NICE guidance is underway. The number of outstanding items of guidance issued up to March 2016 has dropped from 71 (May) to 64 (June), 55 of these with compliance issues. The focus is on clearing the backlog and after this the Clinical Effectiveness Team will concentrate on continuing dissemination and follow up recent guidance.

Safety Domain:

- Safety Thermometer performance deteriorated 93.51 per cent, which is marginally lower than the national average for the month (94.16%). The level of PU is similar to last month with falls and catheter associated UTIs slightly lower. An increase is observed in new VTE harms, with a total of eight recorded, but currently the data is unvalidated, and will be for the trust board report.
- The number of general reported incidents in June indicates a similar trend in terms of numbers and level of harm. 12 Sis have been declared for June the Board will note the issues are across a range of clinical issues including: medication error x 2: maternal x 2; corporate x 3 (IT downtime, ventilation, and RTT – data quality); fall; unexpected death; failure to commence treatment; failure to act on adverse image results; and unavailability of medical devices/return to theatre.
- June saw a rise is the total number of pressure ulcers SIs, with two declared for acute services and community have no declared Sis. The number of grade 2 reduced, driven by 50% reduction in acute services.
- There were no MRSA Hospital-acquired bacteraemias since 23rd September 2015. In June there were two *C. difficile* episode. This makes a total of 5 against a trajectory of 31 cases.
- The trend line appears to indicate falls incidence has slightly increased over the last year, but a similar incidence of falls this month. The falls committee is being reconvened to drive the falls action plan in the QIP to include reviewing the current training of clinical staff in falls prevention and developing a framework to include e-learning packages. The policy is being reviewed and updated in line with electronic documentation. The "Safe and Effective Use of Bed rails" policy will be reviewed and updated by August 2016.
- VTE compliance from electronic records for May was 97.59% (not available for June), with safety thermometer reports 94.5 % (June) compliance. The Trust wide VTE audit for Quarter 1 showed Trust wide improvements compared to 2015/16.
- Safeguarding Adults compliance for training remains a key area of focus. The Trust is now demonstrating a compliance of 83 % for adult training, a slight improvement against last month.
- Safeguarding children compliance for children's training for May remains a focus with level 3 compliance at 93%, although community services and Medcard are only 82%and 76% compliant. There are still concerns around the accuracy of ARIS as our training database.

Experience Domain:

- In June 94% of people were extremely likely / likely to recommend the service to friends or relatives this is tabulated in the attached report. Response rate in OP are underperforming which day cases and critical care are scoring the highest.
- The complaints received for June is 78 which is a significant increase on May when 58 complaints were received. In relation to turnaround times of complaints there has been a

slight decline compared to last month with 60% responded to within 25 working days. Actions are now being put in place corporately and at divisional level to improve this performance and a Trust wide action plan is being implemented. The progress against the action plan will be presented at the September board.

- For this month a patient story features which highlights themes and learning for caring for EOL patients

Well Led Domain:

- The safe staffing return is included for all inpatient areas. The average fill rate for the Trust is 94.14% % across these areas against current staffing figures. There was a slight decrease in the number of final alerts, although community services remain highest which is related to on-going recruitment issues.
- There have been no mixed sex accommodation alerts this month.
- There have been no mixed sex breaches in June.

Ward Heat map:

The Heat map for June is included this month for both Acute and Community services.

risks identified:

Complaints performance (on BAF)
Infection Control Performance (on BAF)
Safeguarding Children Training compliance Profile (on BAF)
Staffing Profile (on BAF)

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

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

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Performance and Quality Report For Trust Board

Month 3 – June 2016

Excellence in specialist and community healthcare

CONTENTS

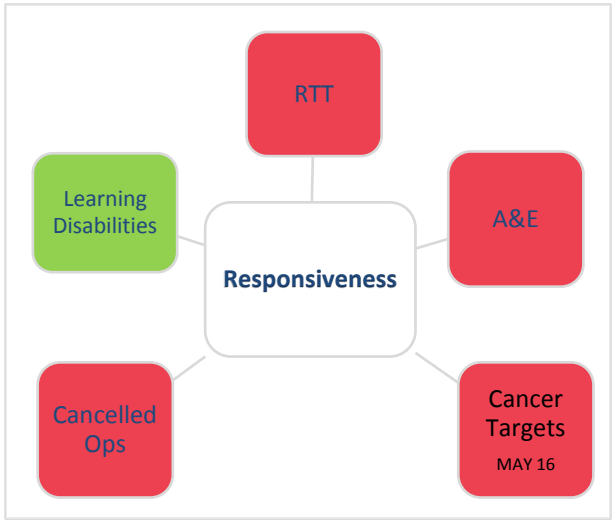
excellent / kind / responsible / respectful /

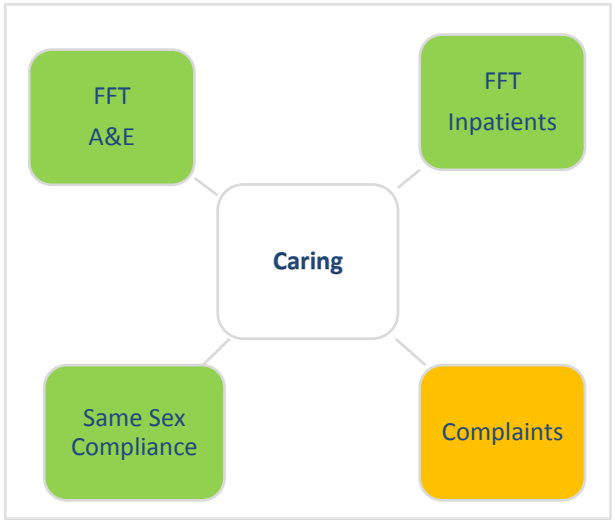
St George's University Hospitals NHS
NHS Foundation Trust

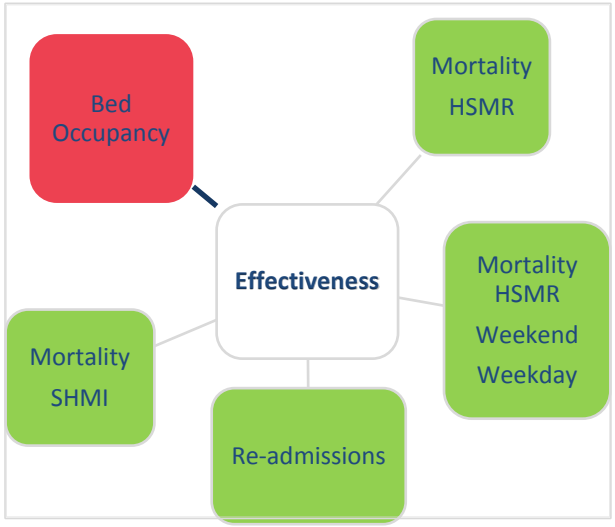
Performance against Frameworks

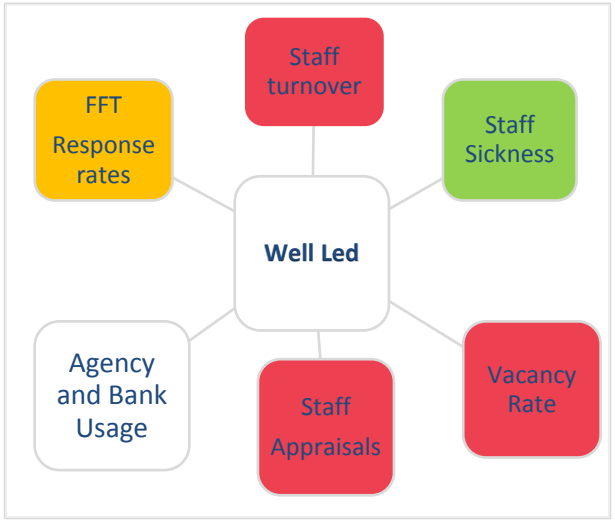
Excellence in specialist and community healthcare

1. Executive Summary - Key Priority Areas June 2016*









The above shows an overview June 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 May 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 2016/17: June 2016 Performance (Page 1 of 1)

ACCESS

Metric	Standard	Weighting	Score	YTD	May-16	Jun-16	Movement
Referral to Treatment Admitted	90%	N/A	N/A		77.10%	69.80%	-7.30%
Referral to Treatment Non Admitted	95%	N/A	N/A		89.20%	88.50%	-0.70%
Referral to Treatment Incomplete	92%	1	1		90.20%	88.30%	-1.90%
A&E All Types Monthly Performance	95%	1	1	92.40%	93.5%	94.00%	0.46%
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Q4**	**Q1**	**Movement**
62 Day Standard	85%	1	1	81.10%	82.95%	81.10%	-1.85%
62 Day Screening Standard	90%			89.50%	90.16%	89.50%	-0.66%
31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%		0	97.90%	95.89%	97.90%	2.01%
31 Day Standard	96%	1	0	97.20%	95.02%	97.20%	2.18%
Two Week Wait Standard	93%	1	1	87.50%	91.72%	87.50%	-4.22%
Breast Symptom Two Week Wait Standard	93%	1		95.00%	95.35%	95.00%	-0.35%

OUTCOMES

Metric	Standard	Weighting	Score	YTD	May-16	Jun-16	Movement
Clostridium(C.) Difficile - meeting the C.difficile objective (de minimis of 12 applies)	31	1	0	5	2	2	0
Certfication of Compliance Learning Disabilities;							
Does the Trust have mechanism in place to identify and flag patients with learning disabilities and protocols that ensure the pathways of care are resonably adjusted to meet the health needs of these patients?	Compliant	1	0	Yes	Yes	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	50%	1	0		58	54.6	-3.4
Referral Information	50%	1	0		87.6	87.4	-0.2
Treatment Activity	50%	1	0		70.8	70.9	0.1
Trust Overall Quality Governance Score					4	4	0

June 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 5 and Monitor have imposed additional license conditions in relations to governance.

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. Q1 relates to period Apr to May-16.

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 2016/17: June 2016 Performance (Page 1 of 1)

RESPONSIVENESS

Metric	Standard	YTD	May-16	Jun-16	Movement
Referral to Treatment Admitted	90%		77.10%	69.80%	-7.30%
Referral to Treatment Non Admitted	95%		89.20%	88.50%	-0.70%
Referral to Treatment Incomplete	92%		90.20%	88.30%	-1.90%
Referral to Treatment Incomplete 52+ Week Waiters	0	17	4	6	2
Diagnostic waiting times > 6 Weeks	1%		2.03%	0.99%	-1.04%
A&E All Types Monthly Performance	95%	92.4%	93.5%	94.0%	0.46%
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%		10.40%	4.34%	-6.06%
Certification against compliance with requirements regarding access to health care with a learning disability	Compliant	Yes	Yes	Yes	

Metric	Standard	YTD	Apr-16	May-16	Movement
62 Day Standard	85%	80.10%	83.10%	77.50%	-5.60%
62 Day Screening Standard	90%	89.50%	93.90%	84.80%	-9.10%
31 Day Subsequent Drug Standard	98%	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%	97.9%	100.0%	94.7%	-5.30%
31 Day Standard	96%	97.20%	98.30%	96.30%	-2.00%
Two Week Wait Standard	93%	87.50%	87.60%	87.30%	-0.30%
Breast Symptom Two Week Wait Standard	93%	95.00%	94.80%	95.20%	0.40%

EFFECTIVENESS

Metric	Standard	YTD	May-16	Jun-16	Movement
Hospital Standardised Mortality Ratio (DFI)	100		84.0	83.7	-0.30
Hospital Standardised Mortality Ratio - Weekday	100	0	84.3		-84.3
Hospital Standardised Mortality Ratio - Weekend	100	0	85.0		-85.03
Summary Hospital Mortality Indicator (HSCIC)	100	0	0.90	0.90	0.0
Emergency Re-admissions within 30 days following Elective or emergency spell within the Trust	5%		3.25%	4.19%	0.9%
Bed Occupancy - Midnight Count Generl Beds Only	85%		98.5%	97.6%	-0.9%
LOS - Elective			4.3	4.3	0.0
LOS - Non-Elective			4.4	4.4	0.00

CARING

Metric	Standard	YTD	May-16	Jun-16	Movement
Inpatient Scores - Friends & Family Recommendation Rate	60		95.10%	83.45%	-11.65%
A&E Scores - Friends & Family Recommendation Rate	46		83.10%	81.97%	-1.13%
Complaints			58	78	20
Mixed Sex Accomodation Breaches	0	0	0	0	0.0

SAFE

Metric	Standard	YTD	May-16	Jun-16	Movement
Clostridium Difficile - Varience from plan	31	5	2	2	0
MRSA Bacteramia	0	0	0	0	0
Never Events	0	1	1	0	-1
Serious Incidents	0	29	7	11	4
Percentage of Harm Free Care	95%		93.8%	93.9%	0.1%
Medication Errors causing serious harm	0	0	0	0	0
Overdue CAS Alerts	0	2	2	2	0
Maternal Deaths	1	0	0	0	0
VTE Risk Assessment (previous months data)*	95%		97.60%	97.60%	

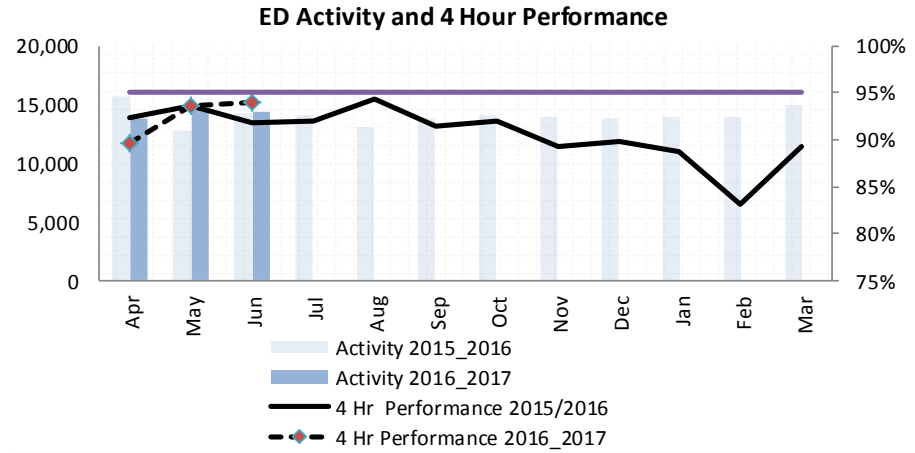
WELL LED

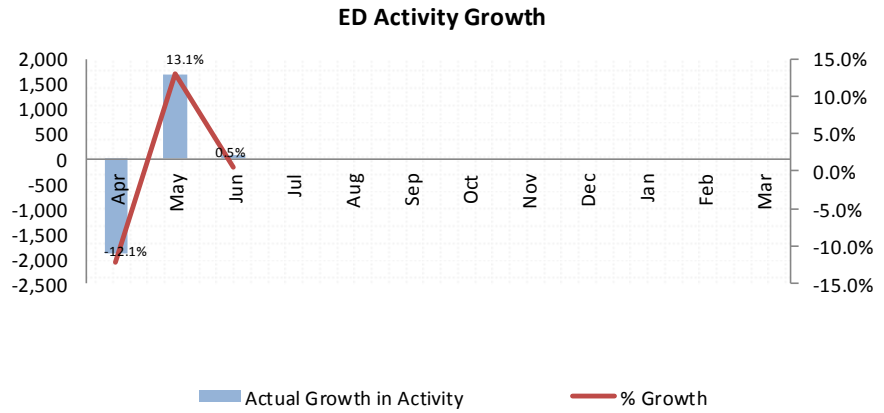
Metric	Standard	YTD	May-16	Jun-16	Movement
Inpatient Respose Rate Friends & Family	30%		30.6%	31.3%	0.7%
A&E Respose Rate Friends & Family	20%		23.0%	23.7%	0.7%
NHS Staff recommend the Trust as a place to work	58%	62.0%			
NHS Staff recommend the Trust as a place to receive treatment	4	3.78			
Trust Turnover Rate	13%		18.4%	18.6%	0.2%
Trust level sickness rate	3.5%		3.7%	3.5%	-0.20%
Total Trust Vacancy Rate	11%		19.4%	16.7%	-2.7%
% of staff with annual appraisal - Medical	85%		86.30%	86.30%	0.0
% of staff with annual appraisal - non medical	85%		69.10%	69.10%	0.0

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.

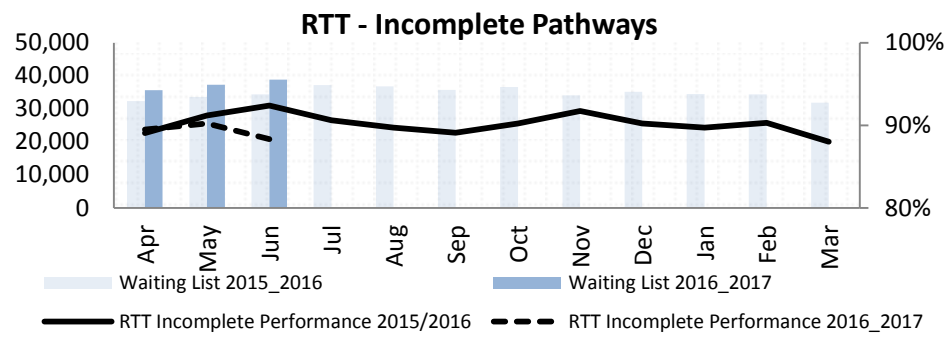
3. Trust Key Performance Areas and Activity Comparison to previous year (1 of 2)

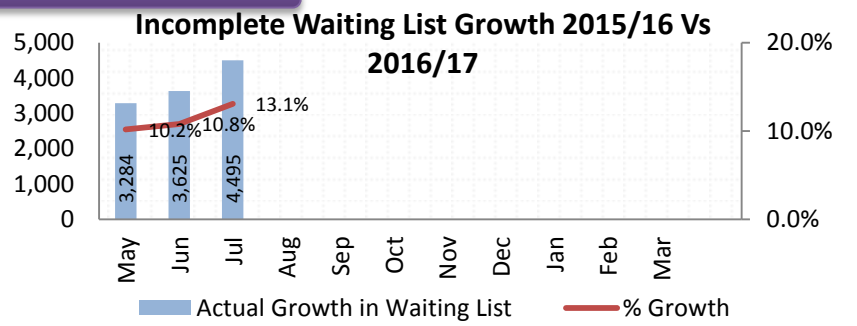
ED Performance

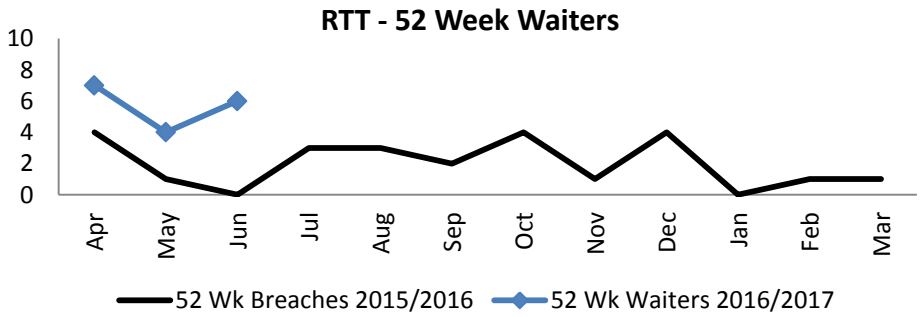


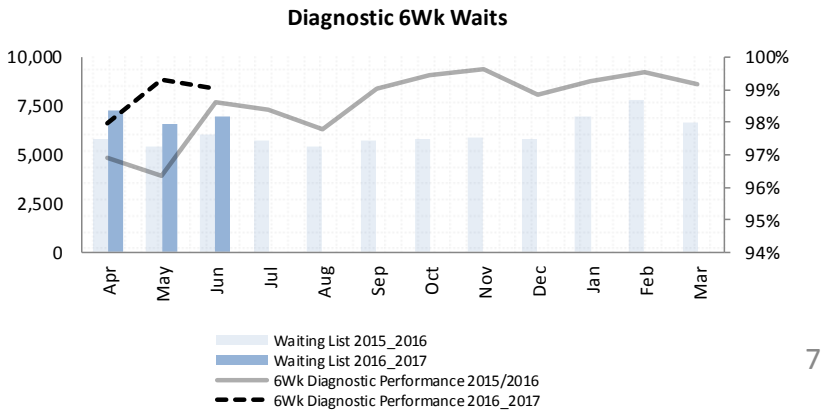


RTT & Diagnostics



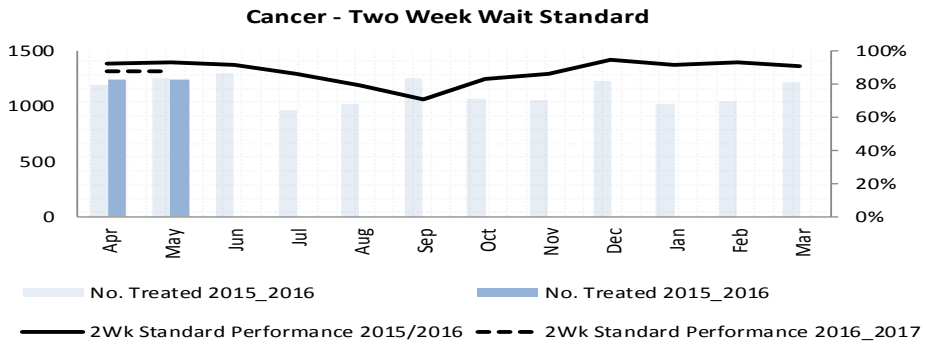


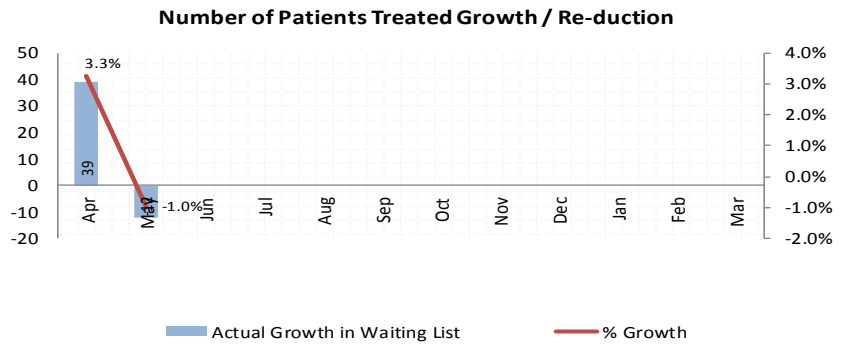




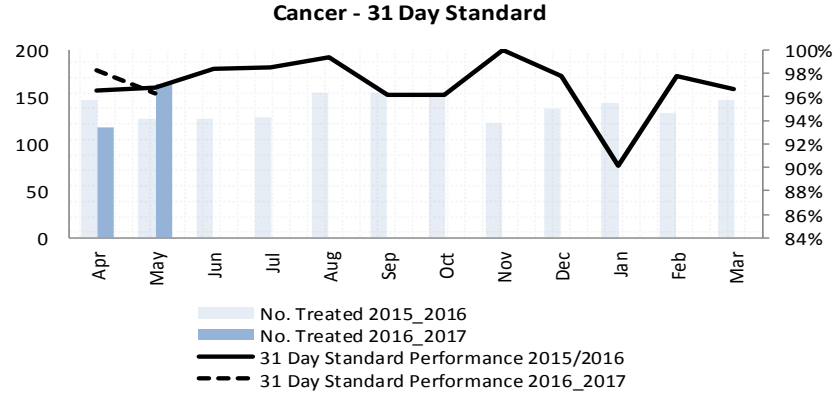
3. Trust Key Performance Indicators and Activity Comparison to previous year (2 of 2)

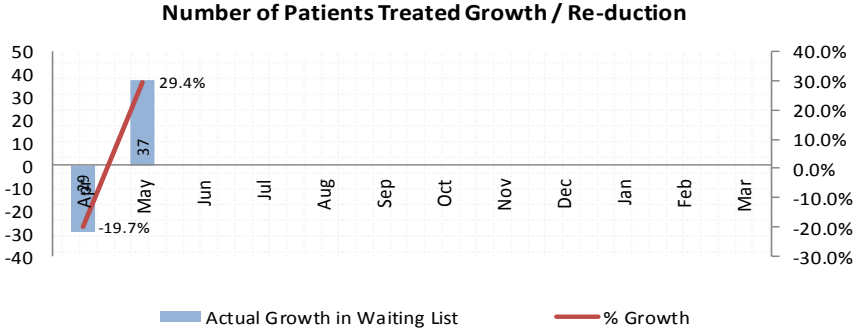
Cancer - Two Week Wait Standard



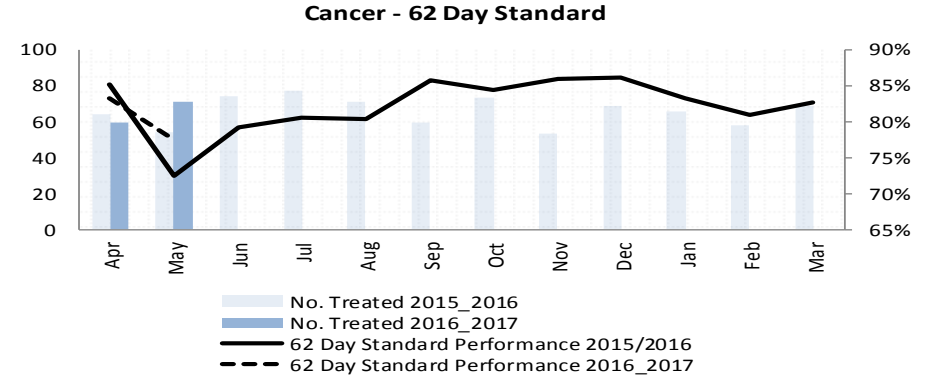


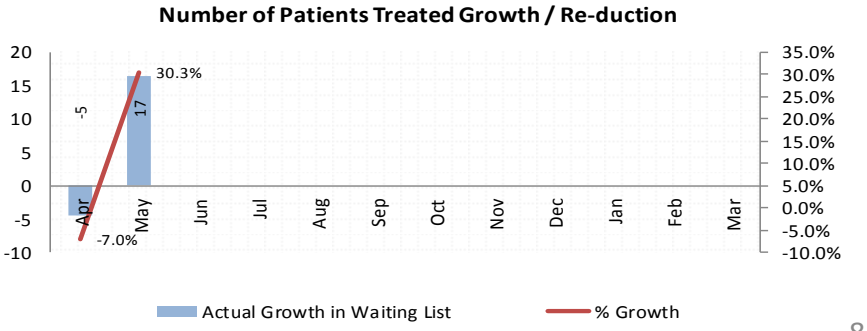
Cancer - 31 Day Standard





Cancer - 62 Day Standard





excellent / kind / responsible / respectful /

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 6) - A&E: 4 Hour Standard

Total time in A&E - 95% of patients should be seen within 4hrs							
Lead Director	May-16	Jun-16	Movement	2016/2017 Target	Forecast for Jun-16	Forecast for Jul-16	Date expected to meet standard
FA	93.54%	94.00%	⇧ 0.46%	>= 95%	R	R	TBC

Peer Performance May 2016 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
1	3	4	5	2
93.60%	92.90%	92.10%	85.10%	93.40%

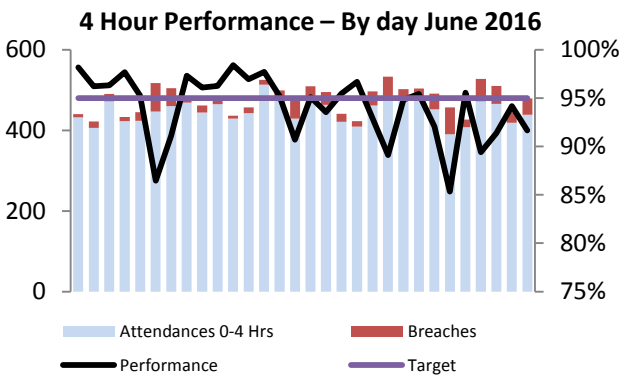
The ED target is that 95% or more of patients should be seen and discharged within 4 hours of attending the Emergency Department. Performance remains challenged against the national target being below the target at both the weekly and monthly level, however great improvement and significant increase in performance has been seen since April, and in June the trust achieved 94.% within within 4 hours which is an increase of 0.46% compared to May and also above the STF trajectory.

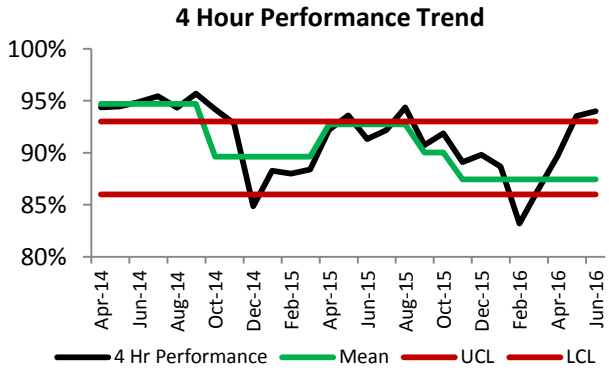
Contributing factors to ED performance were:

- Breaches were made up of delay in treatment decision (18.5%), ED Assessment (15.4%), wait for specialist opinion (14.5%), ED Capacity (12.2%), bed capacity (12.1%), clinical exception 9.3%), other breaches include mental health, transport, diagnostics and patient factors.
- Higher proportion of breaches reported on a Monday & Tuesday (up to 6% higher than the remaining days of the week.
- Higher proportion of attendances arriving on a Thursday this is parallel to ambulance arrivals and hospital admissions.
- 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 01/07/2016 there were 24 DTOC and 22 Non-DTOC patients.

Key current actions being taken are as follows:

- Review of Monday staffing to assess if staffing models require adjustment.
- A review of UCC ways of working in light of increased workload and to identify ways in which navigation process can be further enhanced.
- Analysis of the impact from opening of SAU.
- Focus on development of internal professional standard.
- The OPAL service in reaching to ED is starting end July. This will support ED performance improvement.





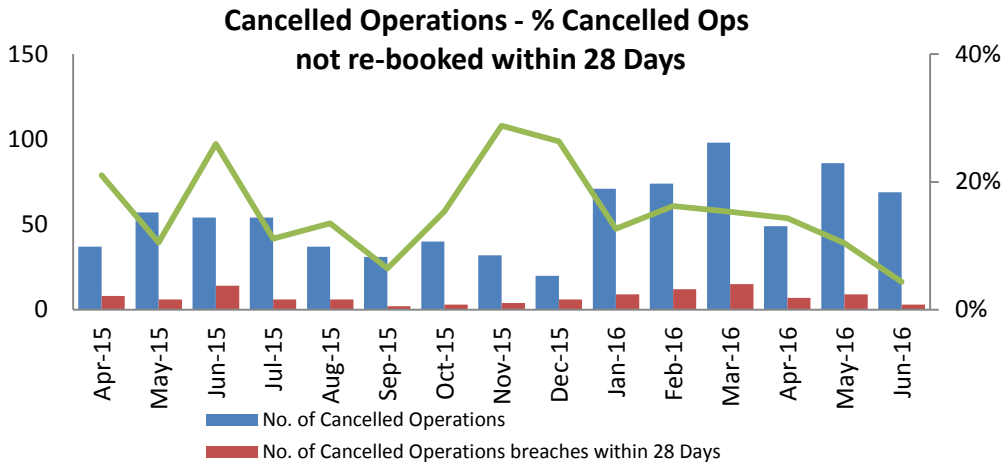
	Apr-16	May-16	Jun-16	Jul-16
STF Trajectory	88.80%	90.20%	91.50%	91.40%
Actual Performance	89.70%	93.54%	94.00%	

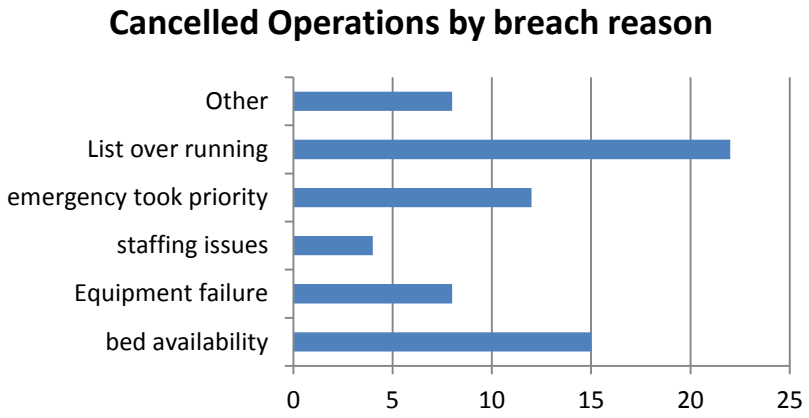
Failed National and STF target
Failed National but achieved STF target
Achieved both National and STF target

4. Performance Areas of Escalation (Page 2 of 6) - Cancelled Operations

Proportion of Cancelled patients not treated within 28 days of last minute cancellation							
Lead Director	May-16	Jun-16	Movement	2016/2017 Target	Forecast for Jun-16	Forecast for Jul-16	Date expected to meet standard
CC	10.40%	4.34%	-6.06%	0%	G	G	Jul-16

Peer Performance Comparison – Latest Available Q4 2015/16				
STG	Croydon	Kingston	King's College	Epsom & St Helier
5	2	3	4	1
23.1%	0.0%	8.7%	11.2%	0.0%





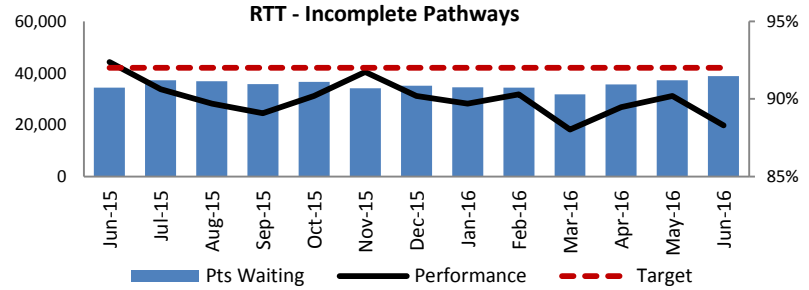
The national standard is that all patients whose operation has been cancelled for non clinical reasons should be treated within 28 days.

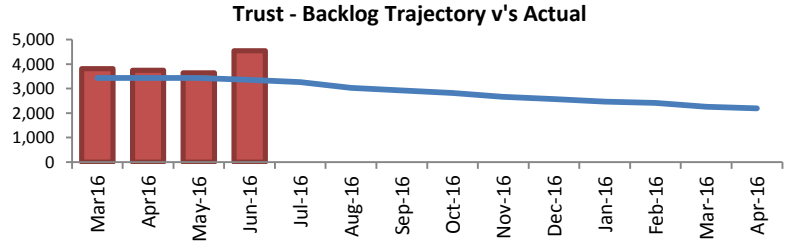
The trust had 69 on the day cancellations from 4,716 elective admissions in June. 66 of those cancellations were rebooked within 28 days with 3 patients not rebooked within 28 days, accounting for 4.34% of all cancellations. There was a decrease of 17 cancelled operations compared to the previous month. The majority of cases were cancelled due to bed availability, emergency cases, and list's over running / lack of theatre time.

4. Performance Areas of Escalation (Page 3 of 6)
- RTT Incomplete Pathways

Referral to Treatment Incomplete Pathways							
Lead Director	May-16	Jun-16	Movement	2016/2017 Target	Forecast for Jun-16	Forecast for Jul-16	Date expected to meet standard
CS	90.20%	88.30%	-1.90%	92%	R	R	Mar-17

Peer Performance April 2016 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	2	1	5	3
89.50%	95.00%	96.80%	80.70%	92.00%





The Trust has been non-compliant against RTT incomplete pathways for a number of months. June 2016 performance increased by 1.90% reporting 88.30% with the number of patients above 18 weeks increasing by 902 patients. The total waiting list size at the end of June has seen an increase by 1606 patients, There are a number of specialties shown in the table below who remain challenged with performance below target of 92%.

The number of 52 week breaches increased to 6 patients reportable in June's performance, consisting of ENT (1), Trauma & Orthopaedics (1), Gynaecology (3), Gastroenterology (1). Root cause analysis investigations have commenced.

RTT remains a challenge and the trust acknowledges the importance of not just reducing long waiters but achieving a position of sustainability. The RTT External Review by MBI has been concluded and finding report provided to commissioners and regulators on June 30th. The following actions have been undertaken:
A senior Exec Led task force has been set-up to take this forward
First Clinical Harm Review Group has taken place on 4th July with Medical Director in attendance.
We are working through the procurement phase to commission external support to support the Technical and Validation stabilisation.
Collating advice from NHSE and other Trusts on the RTT Recovery programme structure and resource requirements including the identification of work streams and our internal project plan.

	Waiting List Size						Backlog Size (18+)						Performance				
Specialty	Mar-16	Apr-16	May-16	Jun-16	Var	Var%	Mar-16	Apr-16	May-16	Jun-16	Var	Var%	Mar-16	Apr-16	May-16	Jun-16	Var%
Gen Surg	3,091	3,545	3,842	3,821	-21	-0.6%	400	410	415	440	25	6%	87.06%	88.43%	89.20%	88.48%	0.8%
Urology	1,456	1,664	1,755	1,832	77	4.6%	208	205	198	254	56	27%	85.71%	87.68%	88.72%	86.14%	1.0%
T&O	2,850	3,298	3,347	3,506	159	4.8%	577	580	567	653	86	15%	79.75%	82.41%	83.06%	81.37%	0.6%
ENT	3,105	3,516	3,829	3,798	-31	-0.9%	666	743	816	922	106	14%	78.55%	78.87%	78.69%	75.72%	-0.2%
Ophthalmology	267	271	231	263	32	11.8%	25	17	1	36	35	206%	90.64%	93.73%	99.57%	86.31%	5.8%
Oral Surgery	1,987	2,075	2,054	1,937	-117	-5.6%	42	60	59	85	26	43%	97.89%	97.11%	97.13%	95.61%	0.0%
Neurosurgery	748	904	834	903	69	7.6%	50	59	42	66	24	41%	93.32%	93.47%	94.96%	92.69%	1.5%
Plastic Surgery	1,057	1,060	1,128	1,221	93	8.8%	179	183	209	245	36	20%	83.07%	82.74%	81.47%	79.93%	-1.3%
Cardiothoracic	332	312	286	323	37	11.9%	117	103	80	77	-3	-3%	64.76%	66.99%	72.03%	76.16%	5.0%
General Medicine	630	815	865	966	101	12.4%	46	40	47	77	30	75%	92.70%	95.09%	94.57%	92.03%	-0.5%
Gastroenterology	2,233	2,559	2,708	2,835	127	5.0%	335	347	324	451	127	37%	85.00%	86.44%	88.04%	84.09%	1.6%
Cardiology	1,669	1,821	1,912	2,022	110	6.0%	114	128	124	134	10	8%	93.17%	92.97%	93.51%	93.37%	0.5%
Dermatology	2,503	2,874	3,098	3,180	82	2.9%	276	221	206	384	178	81%	88.97%	92.31%	93.35%	87.92%	1.0%
Thoracic Surgery	942	990	1,041	1,106	65	6.6%	122	73	38	71	33	45%	87.05%	92.63%	96.35%	93.58%	3.7%
Neurology	901	968	964	1,157	193	19.9%	20	15	11	27	16	107%	97.78%	98.45%	98.86%	97.67%	0.4%
Geriatric Medicine	30	22	29	38	9	40.9%	1	1	1	6	5	500%	96.67%	95.91%	96.60%	84.21%	0.7%
Rheumatology	849	978	1,021	1,022	1	0.1%	49	40	26	19	-7	-18%	94.23%	95.45%	97.50%	98.14%	2.0%
Gynaecology	2,497	3,083	3,167	3,398	231	7.5%	375	297	272	358	86	29%	84.98%	90.37%	91.40%	89.46%	1.0%
Other	4,671	4,871	5,132	5,521	389	8.0%	211	231	202	235	33	14%	95.48%	95.26%	96.10%	95.74%	0.8%
Total	31,818	35,626	37,243	38,849	1,606	4.5%	3,813	3,753	3,638	4,540	902	24%	88.02%	89.47%	90.20%	88.30%	0.7%

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

Cancer Performance								Peer Performance Latest Published May 2016				
Lead Director – CC	Apr-16	May-16	Movement	2016/2017 Target	Forecast for May-16	Forecast for Jun-16	Date expected to meet standard	STG	Croydon	Kingston	King's College	Epsom & St Helier
62 Day Wait Standard	83.10%	77.50%	⇩ -5.60%	85%	R	R	Jul-16	77.50%	83.67%	91.14%	80.77%	86.09%

62 Day Standard

The trust was non compliant against the 62 Day standard in May. There were a total of 16 reported breaches with the standard not being achieved in Gynae (1.5 breaches), Head & Neck (1.5 breaches), Lower GI (2.5 breaches), Lung (2 breaches), Upper GI (2breaches) or Urology (5.5 breaches). Contributing factors were Capacity (19%), Intertrust transfers insufficient information (44%), Complex diagnostic (31%) and patient unfit (6%).

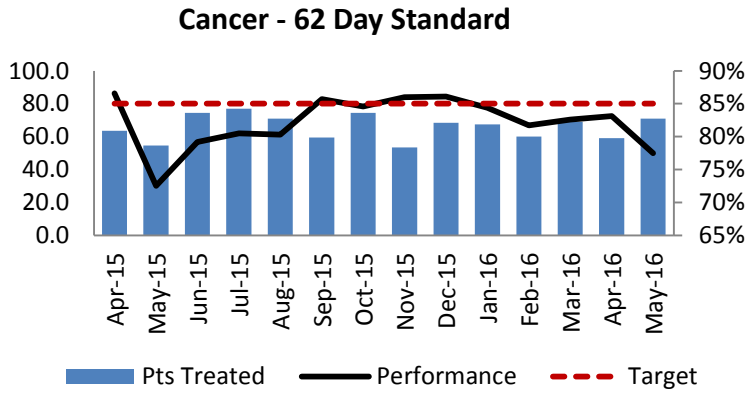
Key reasons

- The additional 2WW demand has impacted on the 62day and in particular diagnostic pathways and has further challenged diagnostic capacity
- Patients on complex diagnostic pathways have also presented challenges in being treated within 62days
- The increased growth in referrals continues to impact on capacity. Head and Neck, gynaecology and Thoracic surgery and diagnostics (CT Colon & MRI especially) continue to be challenging
- Patient choice, particularly multiple cancellations of events along the pathway
- Late ITT referrals or received with insufficient information for the Trust to be able to action next events

The Trust continues to follow the agreed recovery primarily focused on enhancing PTL development, validation and improving tracking processes. Other areas of key concerns are:

- Theatre maintenance programme
- Gynae OP and Hysteroscopy capacity
- Head and Neck Diagnostic capacity
- Lanesbourough Wing re-location

This remains an on-going priority for the Trust and significant work in relation to PTL enhancement has been undertaken which will allow for improved tracking, expediting and forecasting. Weekly tracking meetings are in place reviewing patients to assure that timely treatment plans are in place and expedited where necessary.



	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
All Types	86.13%	83.30%	81.00%	82.60%	83.10%	77.50%
Breast	100.0%	100.0%	100.0%	100.0%	90.9%	95.7%
Gynae	33.3%	84.6%	84.6%	60.0%	100.0%	57.1%
Haem	80.0%	100.0%	85.7%	92.3%	100.0%	100.0%
Head & Neck	50.0%	50.0%	77.8%	50.0%	81.8%	57.1%
Lower GI	83.3%	100.0%	75.0%	83.3%	57.1%	80.0%
Lung	75.0%	75.0%	70.6%	42.9%	45.5%	75.0%
Skin	100.0%	85.7%	66.7%	84.0%	87.5%	94.7%
Upper GI	66.7%	0.0%		0.0%	100.0%	66.7%
Urological	96.4%	90.0%	85.0%	93.1%	81.8%	72.5%

4. Performance Areas of Escalation (Page 5 of 6)
- Cancer 62 Day Screening Pathway

Cancer Performance								Peer Performance Latest Published May 2016- 2017				
Lead Director – CC	Apr-16	May-16	Movement	2016/2017 Target	Forecast for June	Forecast for July	Date expected to meet standard	STG	Croydon	Kingston	King's College	Epsom & St Helier
62 Day Screening Standard	93.90%	84.80%	-9.10%	90%	g	G	Jul-16	84.80%	-	100.00%	89.29%	-

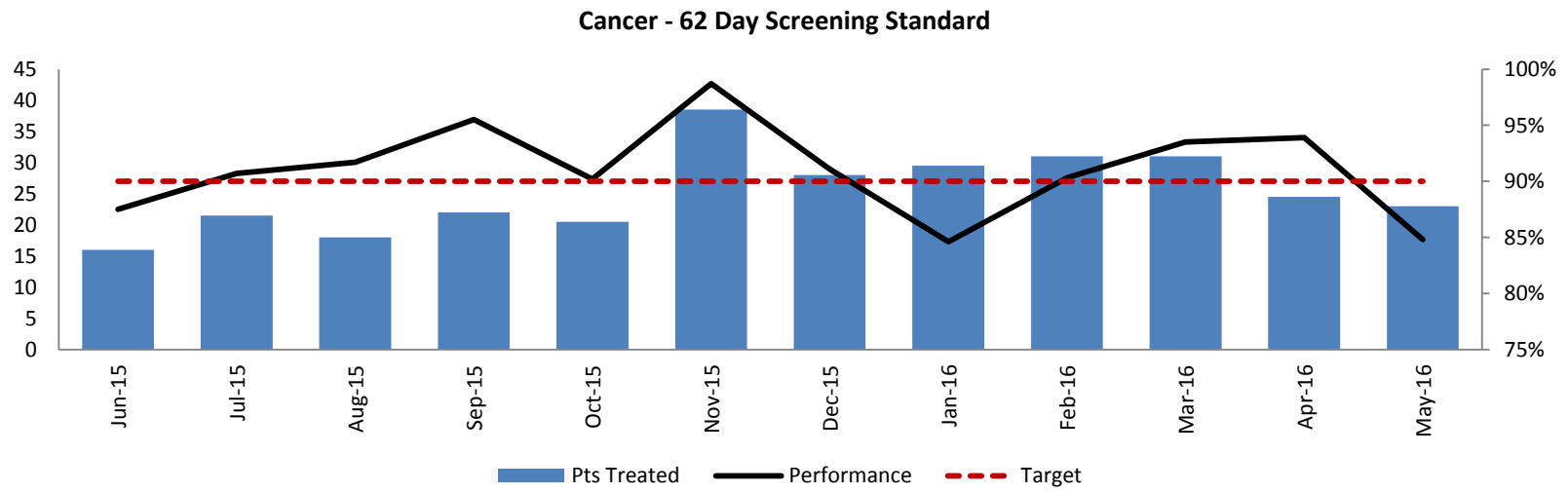
62 Day Standard Screening

The trust was non compliant 62 day screening in May.

There were a total of 3.5 reported breaches with the standard not being achieved within Breast and Lower GI.

62 Day screening underperformance is due to 3.5 breaches against a low number of patients treated of 23. The breaches were due to breast screening patients who were treated late by other providers. These were shared breaches due to the trust being the host organisation for the screening service.

	Jan-16	Feb-16	Mar-16	Apr-16	May-16
All Types	86.40%	90.30%	93.50%	93.90%	84.80%
Breast	94.4%	96.4%	94.0%	93.6%	85.3%
Gynae	-	-	-	-	100.0%
Lower GI	0.0%	42.9%	91.7%	100.0%	80.0%



4. Performance Areas of Escalation (Page 6 of 6) - Cancer Two Week Wait

Cancer Performance								Peer Performance Latest Published May 2016- 2017				
Lead Director – CC	Apr-16	May-16	Movement	2016/2017 Target	Forecast for June	Forecast for July	Date expected to meet standard	STG	Croydon	Kingston	King's College	Epsom & St Helier
14 Day GP Referral for all Suspected Cancers	87.60%	87.30%	-0.30%	93%	A	G	Jul-16	87.30%	97.24%	97.81%	93.00%	95.67%

14 Day Standard

The trust was non compliant against the two week wait target in May with performance of 87.30% against the target of 93%. There were a total of 157 reported breaches with the standard not being achieved in the following modalities: Breast (19 breaches), Gynaecology (28 breaches), Haem (3 breaches), Head & Neck (22 breaches), Skin (53 breaches), Urology (16 breaches)

Key reasons for breaches were as follows:

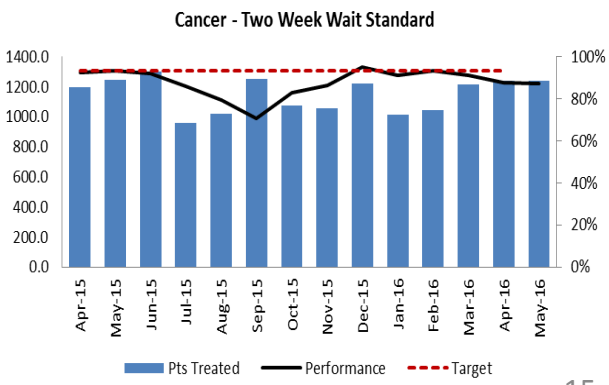
- Patient choice accounting for 59% of all breaches, this is also linked to not being able to book within the optimal booking window of 7 days
- Capacity constraints accounting for 37% of all breaches
- 18% increase in 2WW referrals across all specialties which is above forecasted growth.

This is an on-going priority area for the trust and performance is envisaged to be back on track in Q2. Weekly tracking meetings are in place support the expedition of patients where necessary.

Key actions to drive performance improvement include:

- Development of 2WW PTL has now been implemented
- Weekly and monthly dashboard developed to measure key indicators that will help drive performance – deployment in July
- Capacity/ demand in 2WW to allow booking by day 7
- Recruitment of MDT Co-ordinators to improve tracking of patients along the pathway – posts to go to Vacancy Control Panel, week commencing 25th July 2016.

	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Varience May v's Apr	June Provsional
All Types	94.84%	91.13%	93.17%	90.95%	87.60%	87.30%	-0.30%	89.17%
Breast	96.20%	97.64%	98.08%	93.67%	91.40%	91.30%	-0.10%	94.50%
Gynae	89.00%	62.38%	90.80%	73.27%	75.20%	75.20%	0.00%	97.06%
Haem	96.15%	100.00%	92.31%	100.00%	85.70%	90.00%	4.30%	93.55%
Head & Neck	95.24%	97.96%	93.08%	94.31%	82.00%	84.40%	2.40%	89.61%
Lower GI	96.90%	99.11%	93.86%	97.16%	92.40%	95.00%	2.60%	91.30%
Lung	100.0%	97.6%	96.8%	92.5%	89.40%	93.50%	4.10%	85.71%
Skin	93.47%	87.57%	85.49%	87.14%	85.20%	83.60%	-1.60%	87.43%
Upper GI	92.31%	92.68%	98.75%	91.07%	91.70%	94.80%	3.10%	71.91%
Urological	96.75%	91.38%	96.10%	96.13%	100.00%	87.90%	-12.10%	87.10%
Childrens	100.0%	100.0%	66.67%	71.43%	75.00%	100.00%	25.00%	100.00%



5. Divisional KPIs Overview 2016/17: June 16 Performance (Page 1 of 2)

Monthly View

June 2016

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	18 weeks - admitted waits (division level)	%	0	82.5	61.4	64.9	69.8
	18 weeks - incomplete waits (division level)	%	92.7	89.3	85.4	89.5	87.9
	18 weeks – non-admitted waits (division level)	%	98.1	82.3	84.4	91.7	88.5
	52 week waiters	No.	0	1	2	3	6
	A&E waits (4 hours)	%	99.7	93.3	0	0	94
	Cancelled operations re-booked within 28 days (division)	%	0	3.2	3.3	12.5	4.3
	LAS handover within 15 mins	%					44.5
	LAS handover within 30 mins	%					94.6
	LAS handover within 60 mins	No.					0
	6 week diagnostic waits	%					99
	No Trolley Waits in A&E - 12 hours	No.					0
	Urgent operations cancelled for the second time	No.	0	0	0	0	0

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

May 2016

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 week gp referral to first outpatient (breast symptoms) - (division)	%	0	0	95.2	0	95.2
	2 week gp referral to first outpatient (cancer) - (division)	%	0	0	87.3	0	87.3
	31 day second or subsequent treatment (drugs) - (division)	%	0	0	100	0	100
	31 day second or subsequent treatment (surgery) - (division)	%	0	0	94.7	0	94.7
	31 day standard from diagnosis to first treatment - (division)	%	0	0	96.3	0	96.3
	62 day urgent gp referral to treatment for all cancers - (division)	%	0	0	77.5	0	77.5
	62 day urgent gp referral to treatment from screening - (division)	%	0	0	84.8	0	84.8

5. Divisional KPIs Overview 2016/17: June 16 Performance (Page 2 of 2)

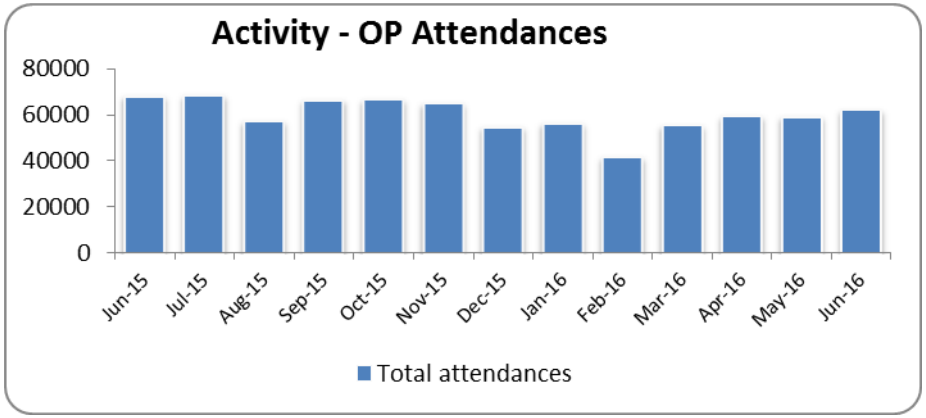
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Outcome Metrics	30 day emergency re-admissions (from elective) (division)	%	2.4	2.5	1.5	1.3	2
	30 day emergency re-admissions (from non-elective) (division)	%	31	9.7	6.2	2.3	7.1
	Average LOS (elective) (division)	Ratio	0	5.6	4	3.8	4.3
	Average LOS (non-elective) (division)	Ratio	25.1	4.1	7.3	2.7	4.4
	C-sections (applicable to women & children only)	%	0	0	0	23.7	23.7
	CAS alerts	No.					2
	Falls (ward level)	No.	26	78	34	3	141
	HSMR	Ratio					83.7
	Incidence of c.difficile	No.	0	1	1	0	2
	Incidence of e-coli	No.	0	4	1	5	10
	Incidence of MRSA	No.	0	0	0	0	0
	Maternal deaths	No.	0	0	0	0	0
	Medication errors causing serious harm (division)	No.	0	2	0	1	3
	Mixed sex accomodation	No.	0	0	0	0	0
	Never events	No.	0	0	0	0	0
	Serious incidents (division level)	No.	0	5	3	3	14
	SHMI	Ratio					0.9
	Trust acquired pressure ulcers	No.	0	2	0	0	2
	VTE risk assessment (data submitted to unify)	%					97.6
Quality Governance Indicators	Friends & family response rate	%	66	28	35.4	14.7	29.6
	Patient satisfaction (friends & family)	%	87.1	84.9	92.6	97.4	87.1
	Percentage of harm free care	%	0	88.7	98.7	99.1	93.8
	Percentage of staff appraisal (medical) - (division)	%	87.5	86.8	86.4	85.4	86.2
	Percentage of staff appraisal (non-medical) - (division)	%	66.6	70.8	77.1	63.7	68.8
	Sickness/absence rate - (division)	%	4.8	3.3	3.1	3.5	3.5
	Sickness/absence rate - (ward)	%	7	3.6	4.1	3.9	3.9
	Staff turnover - (division)	%	20.8	18.6	16.3	19.6	18.8
	Staff turnover - (ward)	%	25.5	22.7	22	16.2	20.1
	Vacancy rate - (ward)	%	16.7	22.4	28.2	12.8	20.2
	Voluntary staff turnover - (division)	%	15.5	16	13	16.1	15.4

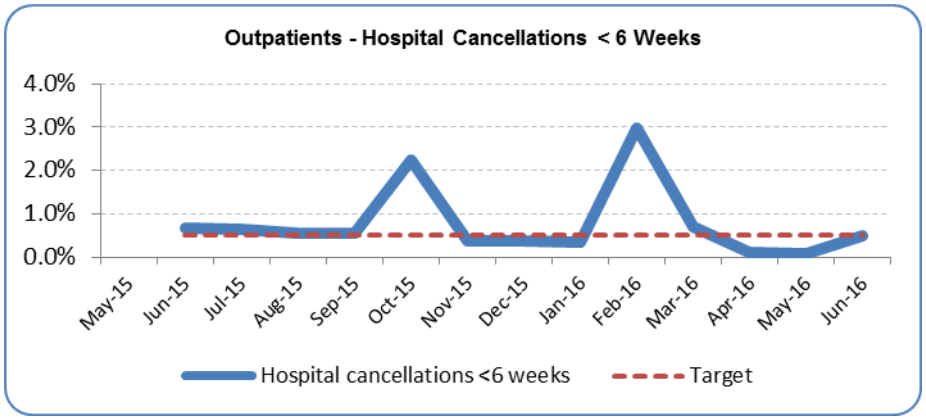
Key Messages:

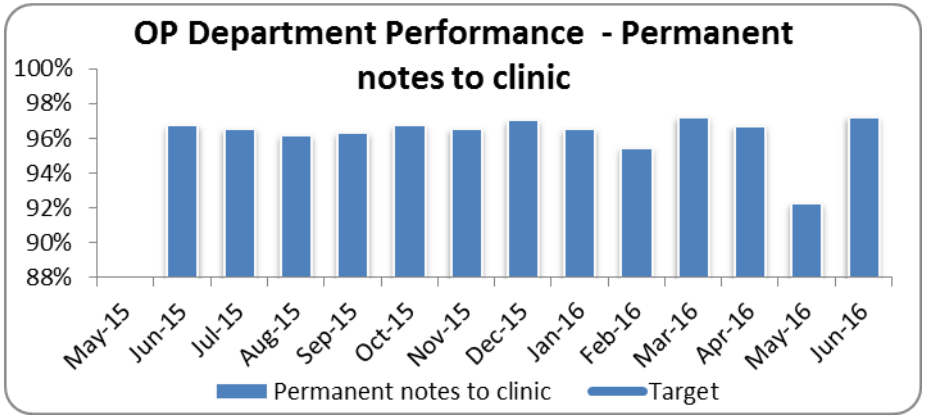
This section headed 'Access' indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution. The Access section is split into two components,. Cancer performance is reported one month in arrears.
LAS arrivals to patient handover times, continues to fluctuate. At the end of June 44.5% of patients had handover times within 15 minutes and 94.6% within 30 minutes, both of which are not within target. The trust had zero 60 minute LAS handover breach in June.

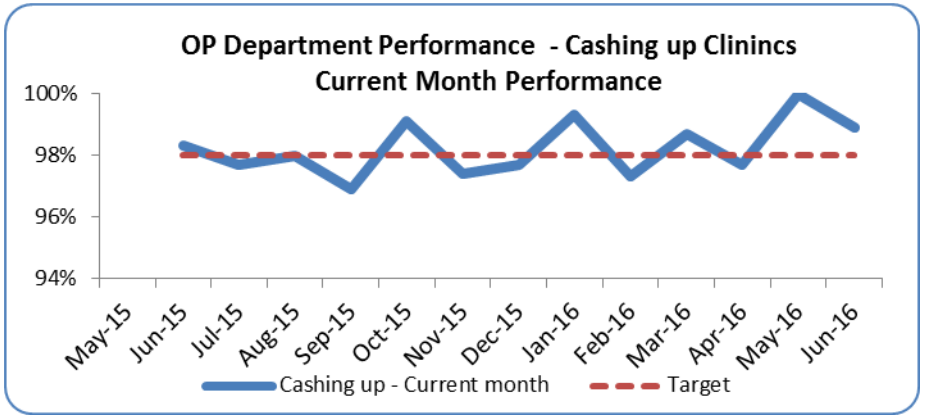
The trust has a zero tolerance policy on avoidable pressure ulcers and has placed significant importance on its prevention. In June the trust had 2 grade 3 pressure ulcer SI's and no Grade 4. All grade 3 and 4 pressure ulcers acquired in our care are investigated as serious incidents, and a. full investigation and Root Cause Analysis will be produced for each PU and reviewed at the Pressure Ulcer Strategy group, chaired by the Deputy Chief Nurse

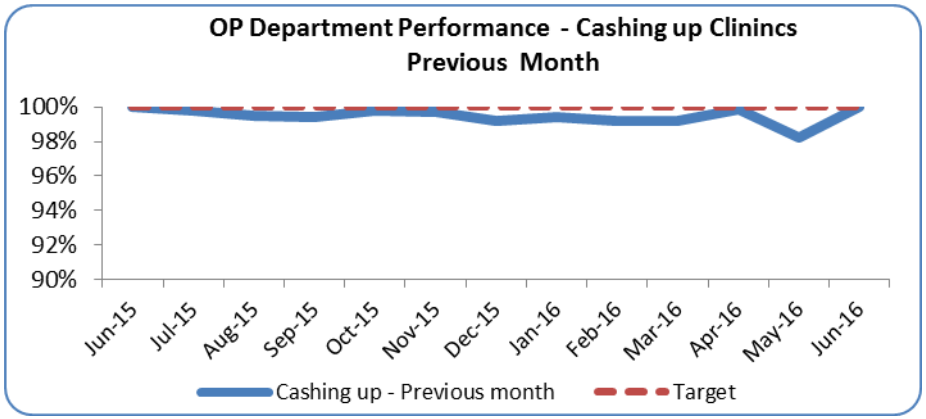
6. Corporate Outpatient Services (1 of 2) - Performance Overview

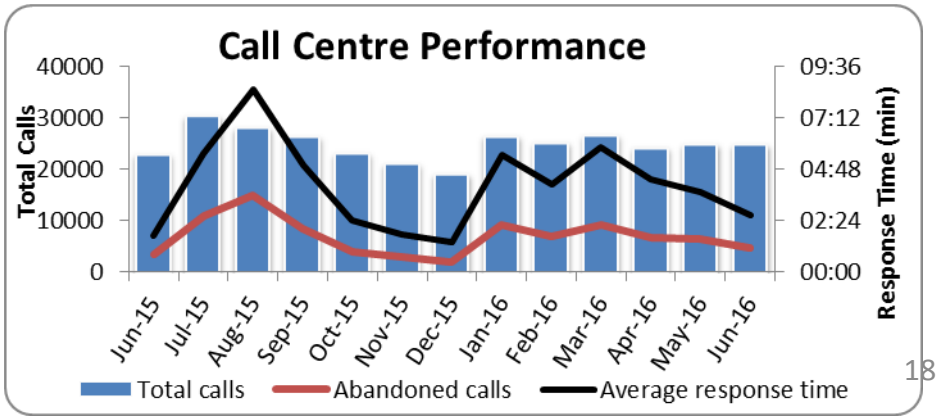












6. Corporate Outpatient Services (2 of 2) - Performance Overview

		Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Activity	Total attendances	N/A	60564	59841	68002	68277	57188	66271	66501	64863	54618	56239	41552	55261	59211	59055	61937
	Hospital cancellations <6 weeks	<0.5%	1.26%	0.74%	0.66%	0.64%	0.56%	0.54%	2.24%	0.36%	0.37%	0.35%	2.97%	0.69%	0.11%	0.08%	0.48%
OPD performance	Permanent notes to clinic	>98%	95.52%	95.54%	96.74%	96.54%	96.14%	96.31%	96.72%	96.52%	97.02%	96.50%	95.42%	97.20%	96.70%	98.35%	97.22%
	Cashing up - Current month	>98%	98.60%	98.30%	98.30%	97.70%	98.00%	96.90%	99.10%	97.40%	97.70%	99.30%	97.30%	98.70%	97.70%	99.2%	98.90%
	Cashing up - Previous month	100%	99.60%	99.70%	100.00%	99.80%	99.50%	99.40%	99.80%	99.75%	99.20%	99.40%	99.20%	99.20%	99.90%	100.00%	100.00%
Call Centre Performance	Total calls	N/A	18710	17732	22955	30426	28095	26357	23138	21082	19093	26557	25273	26674	24279	24924	24881
	Abandoned calls	<25%/<15%	1551	2237	3309	10828	15019	8253	3930	2756	1953	9084	6949	9055	6671	6362	4542
	Mean call response times	<1 m/<1m30s	01:00	01:29	01:42	05:31	08:34	04:59	02:24	01:43	01:24	05:30	04:06	05:49	04:20	03:45	02:37

Key Messages:

- Increase in activity for a third consecutive month compared to February and March. However activity in June is lower than same period last year.
- Compared to June 2015 there has been a decrease in activity of 9%
- Hospital cancellations <6 weeks maintained within target. However, increased from April and May position.
- Permanent notes to clinic has maintained improvement since February, 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 , with a some improvement in reducing the number of abandoned calls. This 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.

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Quality Report

June-2016

Excellence in specialist and community healthcare

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Patient Story

Excellence in specialist and community healthcare

8. Patient Experience
- Patient Story

The husband of deceased patient raised a number of concerns about the care his wife received at the end of her life on two wards at St George's Hospital.

"On my arrival on the ward the next day I asked at the main nurses' station what bed my wife was in, I then on walking round to the cubical found my wife sitting on a commode with the front curtains open two thirds of the way. She was in floods of tears, in agony and very distressed. There were other patients and visitors in the vicinity".

"My wife informed me that she had shocking head pain and had not been given any pain relief. I asked the nurse if my wife could be given her morphine to which the response was one of the nurses placing a hand on my shoulder and whilst laughing said "no my dear, you give paracetamol for a headache."

"I approached a nurse who was dressed in red and I told her I had noticed that since it was decided my wife was dying she was no longer receiving the care she should be or being given the dignity she was entitled to. She told me the nurses that day were agency and agreed it was unacceptable that my wife had received no basic care since the previous day. I also told her how I myself was left feeling very alone and isolated in the room at night. On one night my wife was making lots of noises whilst breathing (a loud crackling noise) and I heard this was the noise someone makes before they die and I was left very distressed."

"The nurse looking after my wife that night found it acceptable to write up false notes. The notes were written as if at the end of the night shift (patient was able to pass urine during the night, patient slept fairly well). However, because my had her accident at 01.50 hours the notes were written prior to this. The notes are also against the Nursing and Midwifery guidance as they did not have the time entered leading me to believe the intention was to write the notes up early in the shift so that at the end of the shift she would only had to add the time".

Themes

- Lack of nursing care
- Privacy and dignity
- Lack of understanding from nurses
- Lack of adequate pain relief
- Husband of patient informed patient found unconscious and sustained injuries - no explanation could be given
- Husband feels that as his wife was near the end of her life, her care was not as thorough (eg, patient not being washed)
- Nurses unaware of how to fit an air mattress
- Poor documentation in notes
- Lack of appreciation of husband and family's distress by ward staff.

Issues and actions

- Nursing staff received re-training falls risk assessments.
- Health care assistants on the ward observed by the matron re care
- Permanent ward staff attended an enhanced communications course and new staff will going forward
- Issues raised discussed at staff meeting
- Ward leaflet produced explaining the type of conditions treated on the ward and trust's expectations staff.
- Met with nurse on duty that night and highlighted the poor documentation and what is expected
- Teaching sessions on standards of documentation delivered

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Clinical Audit & Effectiveness

Excellence in specialist and community healthcare

9. Clinical Audit and Effectiveness - Mortality

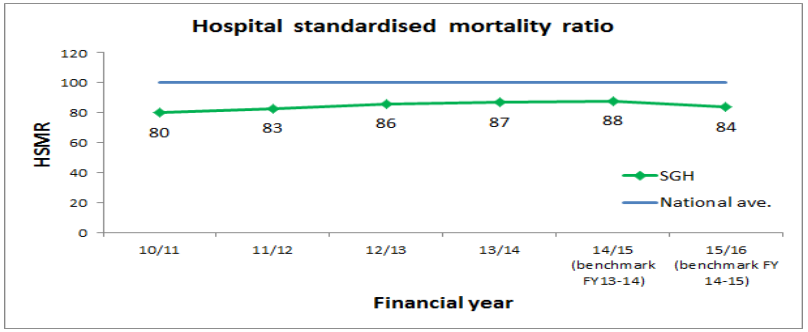
HSMR (Hospital standardised mortality ratio)							
Lead Director	April 16 (Feb15-Jan16)	May 16 (Mar15-Feb16)	June 16 (Apr15-Mar16)	Movement	2016/17 Target	Forecast March 17	Date expect to meet standard
AR	86.5	84.0	83.7	↓	<100	G	Met

SHMI (Summary hospital-level mortality indicator)				
Jul 2015 (Jan14-Dec14)	Oct 2015 (Apr14-Mar15)	Jan 2016 (Jul14-Jun15)	Mar 2016 (Oct14-Sep15)	Jun 2016 (Jan15-Dec15)
0.89	0.92	0.90	0.91	0.91

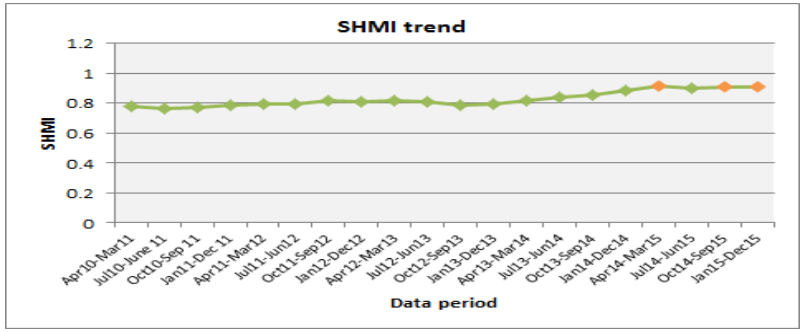
Note: Source for HSMR is Dr Foster Intelligence. Data is most recent 12 months available (updated 23/06/16) April 2015 to March 2016, and benchmark period is the financial year 2014/15. SHMI data is published by the Health and Social Care Information Centre. The last 12 month period as published on 23rd June 2016 relates to the period January 2015 to December 2015. The next publication is due in September 2016.

Overview:

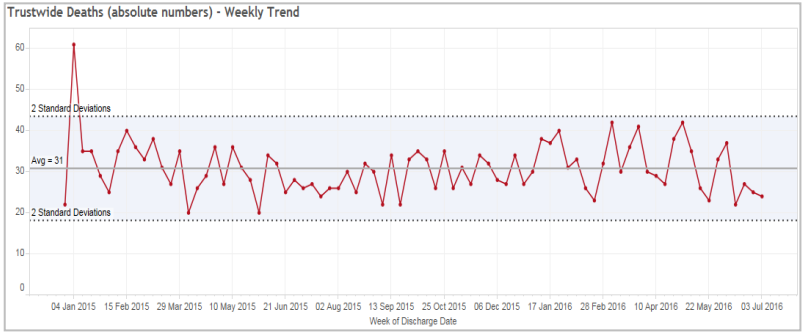
The measures that we use to monitor and understand mortality, the SHMI and HSMR, have not been updated since the last report to the Board and therefore our performance remains unchanged. The trust's most recent HSMR is 83.65, which is statistically significantly better than expected. The latest SHMI for the period January 2015 to December 2015, stands at 0.91, and is categorised as 'as expected'. Raw mortality is also considered by the Mortality Monitoring Committee (MMC) each month, and as shown by the chart alongside, our mortality continues to be within normal limits.



The SHMI is considered by the MMC following each publication and a decision made as to which, if any, diagnosis groups should be investigated. In June it was agreed that diagnosis group 2 'Septicaemia' will be closely monitored, as over the 12 months there were 70 observed deaths, compared to 64.5 expected. There has been a subsequent publication by the HSCIC on the feasibility of producing trust-level sepsis mortality data using the SHMI. In that publication our mortality for septicaemia is in line with expected; for pneumonia it is better than expected; and for UTI, as expected. This report and any required actions will be discussed at the MMC meeting in July and Dr Narani Sivayoham, who is leading sepsis work at St George's, has been invited to attend.



The MMC has also concluded it's review of the SHMI diagnosis group 123: Joint disorders and dislocations; trauma-related, Spinal cord injury, Skull and face fractures, Other fractures, Sprains and strains. The Chair reviewed a sample of 38 cases, from a total of 45. Two common modalities were identified: 1) elderly patients that have sustained a fall and 2) traumatic spinal and brain injuries, particularly following pedestrians hit by cars. 36 deaths were found to be unavoidable and 2 potentially avoidable (1 of these is attributable to St Helier). There were also 6 coding reviews conducted and amendments agreed to improve coding. No systematic care issues were identified and the review is considered complete.



9. Clinical Audit and Effectiveness - National audit

Royal College of Emergency Medicine (RCEM): VTE risk in lower limb immobilisation in plaster cast

This audit examined VTE risk assessment of adults who presented at EDs with a condition requiring a lower limb to be immobilised with plaster cast, or who were discharged to be treated as an outpatient. Standards against which practice was measured were published by the RCEM in June 2015.

Standard 1 (fundamental): If a need for thromboprophylaxis is indicated, written evidence of treatment or referral for treatment.

Standard 2 (developmental): Patient information leaflet to patients who a) develop VTE symptoms; and b) those with lower limb immobilisation.

VTE assessment:

- VTE risk assessment carried out
- VTE risk level documented
- Thromboprophylaxis indicated.

The national results found that where patients have prophylaxis indicated, very high proportions were either receiving this or being referred for treatment. However, only a small minority of patients are receiving written information outlining the risks of VTE whilst their lower limbs are immobilised. This is clearly an issue that needs addressing.

ASSESSMENT	SGH ED Results	National Median
• VTE risk assessment carried out	**2%**	**11%**
• VTE risk level documented	**0%**	**84%**
• Thromboprophylaxis indicated	**10%**	**6%**
TREATMENT		
STANDARD 1 (fundamental): If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment.	**20%**	**100%**
PATIENT INFORMATION		
STANDARD 2 (Developmental): Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation.	**0%**	**2%**

Our local ED documentation was found to be poor. Following the Care Group presentation of RCEM results, action plans were drawn up and implemented. The results show good improvements, as shown in Chart 1 below. The 4th re-audit is due at the end of this month.

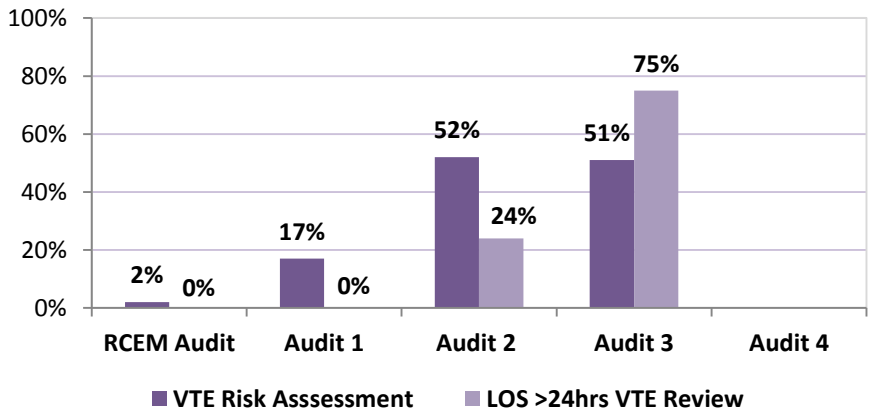
Action plan & methodology:

- Analysis of CDU patients' drug charts looking at whether they had a VTE risk assessment on admission.
- Analysis of any patients' drug charts who have stayed longer than 24 hours in CDU to see if a review of their risk was completed.

Re-audit of VTE documentation after each implemented change.
Audit Cycle 1 – education of staff (24/11/15)
Audit Cycle 2 – reminder sheet added to each CDU folder (17/02/16)
Audit Cycle 3 – Reminder column added to CDU handover sheet (08/03/16)
Audit Cycle 4 – addition of check box for VTE risk assessment on CDU admission sheet (Due 30/07/16)

Leads: Dr Nicolas Buttinger and Consultant lead Dr Neil Bhanderi

Chart 1: Action Planning & Re-audit Results



9. Clinical Audit and Effectiveness - National audit

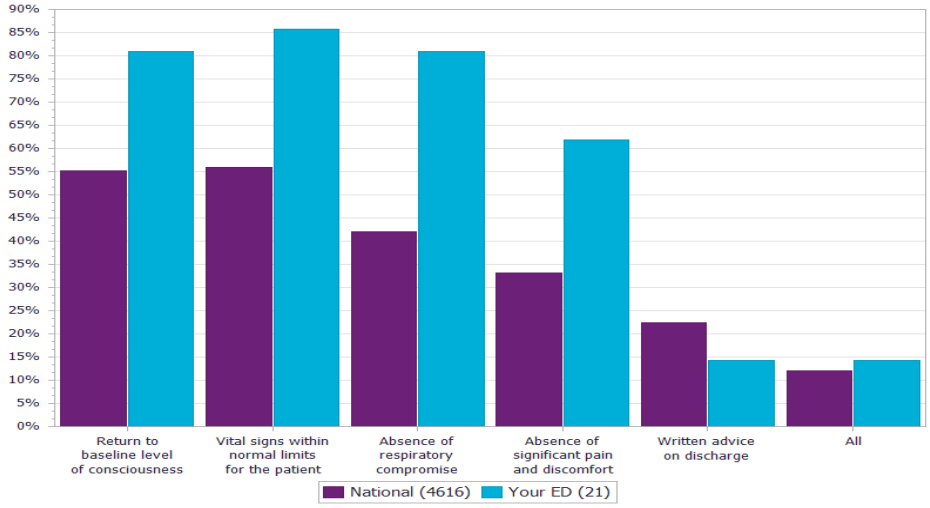
Royal College of Emergency Medicine (RCEM): Procedural Sedation audit

This national audit examines whether documented care conforms to professional standards, and aims to drive clinical practice forward by helping clinicians examine the work that they do and recognise excellence. A number of standards are fundamental (STD 1, 3,4,5 & 7a-d), whilst some are desirable (STD 2, 6 & 7e).

Results:

- **STD 1:** Document pre-procedural assessment. The standard combines criteria: a) ASA grading, b) prediction of difficulty in airway management and c) pre-procedural fasting status. SGH 0%; National median 8%. [SGH data shows a= 0% b=100% & c=100%; ASA was the only criteria not reported].
- **STD 2:** Document informed consent or lack of mental capacity. SGH 10%; National median 52%.
- **STD 3:** Procedural sedation to be in a resuscitation room or one dedicated resuscitation facilities. SGH 100%; National median 91%.
- **STD 4:** All present at sedation: a) a doctor as seditionist, b) a second doctor, ENP or ANP as procedurist, c) a nurse. SGH 27%; National median 42%.
- **STD 5:** Monitoring during procedural sedation must include: a) Non-invasive BP, b) Pulse oximetry, c) Capnography, d) ECG. SGH 93%, National median 35%.
- **STD 6:** Oxygen to be given from start of sedation until the patient is ready for discharge from the recovery area. SGH 17%; National median 47% [100% oxygen documented but only 10% report the point given. More specific documentation is needed for improved compliance].
- **STD 7:** Assessment before discharge: a) Return to baseline level of consciousness; b) vital signs in normal limits; c) No respiratory compromise; d) no significant pain and discomfort; e)written advice. SGH 14%; National median 3%, as shown in Chart 1.

Chart 1: Key results (SGH is the blue column)



Conclusion: Results show that SGH are largely above the national average, but as with the national picture there are improvements to be made and ED have presented results locally and commenced their action plan.

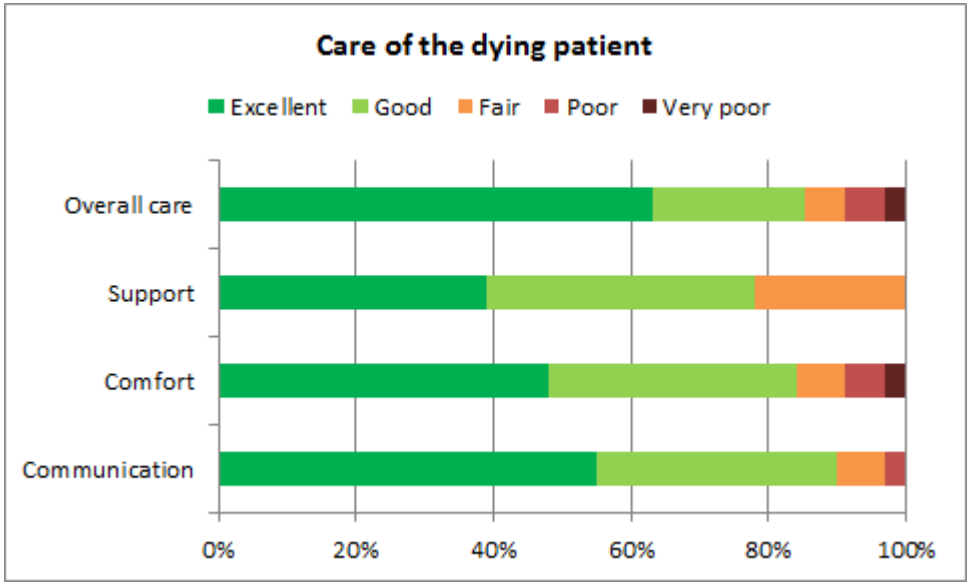
Action Plan: Led by Dr Anthony Hudson & Dr Harriet Tucker

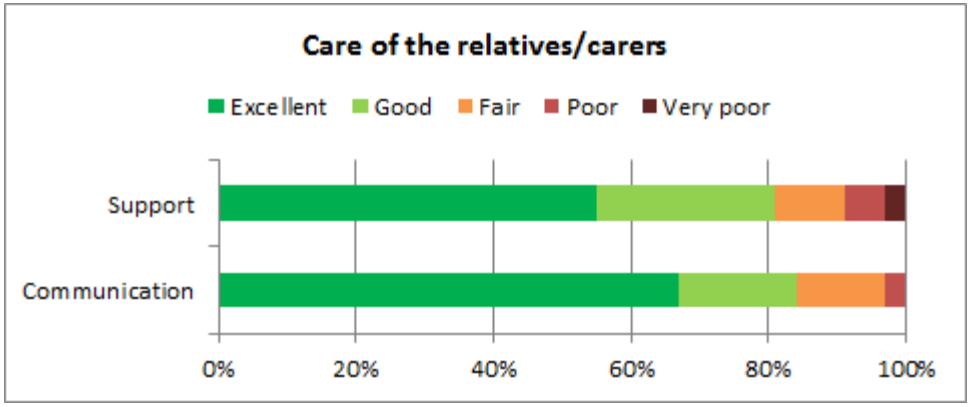
- Re-develop procedural sedation proforma.
- Create written patient information leaflet.
- Create and deliver teaching plan for doctors and nurses – to be given in formal teaching and/or after induction.
- Develop schedule for teaching and assessment of procedural sedation competencies for doctors.
- Incorporate code for 'sedation' in discharge communications – liaise with clinical informatics/IT.

9. Clinical Audit and Effectiveness - Local audit

Bereavement Survey, June 2016

The bereavement survey was undertaken to explore carer and relative's views about the care patients received at the end of life and also how well carers were treated whilst the patient was dying and in the immediate period after bereavement. Surveys were handed out in the bereavement information pack to all relatives/carers between April and June 2016. This analysis summarises the 31 responses received.





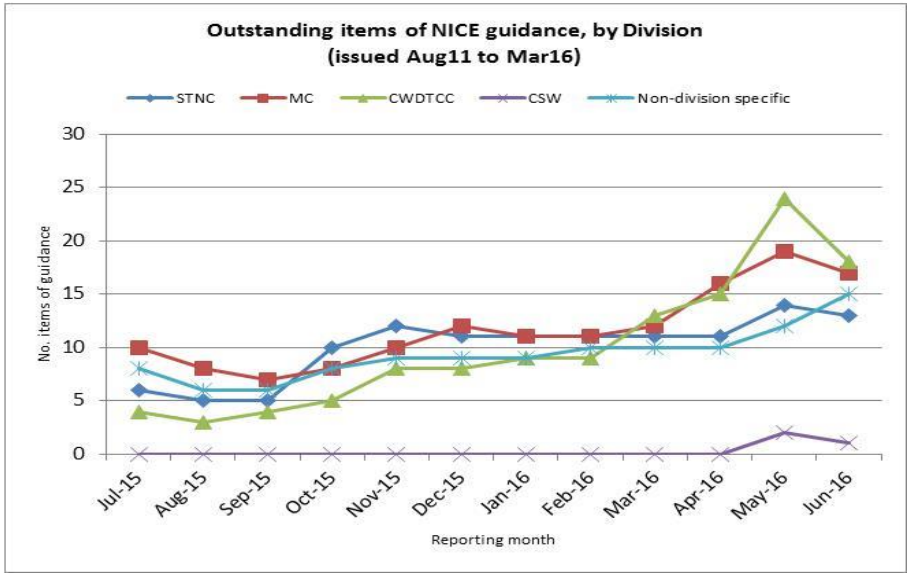
As summarised alongside, largely positive experiences were reported. The level of psychological or spiritual support offered to the patient was the only measure where just under 80% of responses were either 'excellent' or 'good'. Almost all respondents felt the patient had received all of the information and support from staff that they wished to receive, with 54% reporting needs were met completely and 42% to some extent.
It is positive to note that 80% of carers felt their relative/friend had been treated with respect and dignity at all times. However, 10% felt this did not happen all the time, and the remaining 10% did not feel that the patient was treated in this way.

Carers were also asked a number of questions about the care they themselves received. Two thirds said they had all the information and support they needed, and the same number felt communication was excellent. Three quarters of relatives felt that they were always treated with respect and dignity, and a further 23% that this happened sometimes.

Responses to questions about contact with the Bereavement Services team were very positive with everyone rating communication as excellent (56%) or good. 90% felt completely supported by the staff and that they were completely clear about the process to be followed.

Positive and negative comments have been studied to identify opportunities for learning and improvement. This has provided valuable insight and so it has been agreed that the survey will continue to run, with quarterly analysis to track progress. Furthermore, the survey has been amended so that any relative/carer that would like a response to their comments or concerns can provide their contact details. Any such instances will be reported to the End of Life Programme Board so that an appropriate investigation and response can be provided to the bereaved. This will support a positive experience and will also help us to act on any issues in a timely way.

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



Items of NICE Guidance with Compliance Issues (Jun 2010 to Mar 2016)

Division	2010	2011	2012	2013	2014	2015	2016
STNC (n=10)	0	1	2	1	4	1	1
M+C (n=18)	2	0	2	1	2	5	6
CWDTCC (n=13)	1	1	1	2	6	1	1
CSW (n=0)	0	0	0	0	0	0	0
Non-division specific (n=14)	0	2	0	3	2	5	2

Overview

A complete review of all NICE guidance issued is currently underway. The audit team has been working closely with divisional colleagues, initially in Children & Women's and Medicine & Cardiovascular divisions, to address the backlog and improve the understanding of our current position for those items with compliance issues.

During the initial stage of the review the number of outstanding items of guidance increased and this was reflected in the May numbers for both outstanding items and items with compliance issues. These numbers dropped in all except areas except the non-division specific guidance during June. There are currently 64 outstanding items of NICE guidance issued up to March 2016 and there are currently 55 with compliance issues. Many of the items with compliance issues have been reviewed recently so the focus moving forward will be to collect updates for those items that have not had their status assessed within the last few months. Encouragingly there are only 7 items of guidance awaiting reply in the period from April to May 2016 and only a further 3 with compliance issues. It is hoped that as we actively continue to chase up outstanding pieces of guidance we should see those numbers continue to drop.

Once we have cleared the backlog it is hoped that the Clinical Effectiveness department can focus on continuing to disseminate and follow up on the most recently issued guidance, bi-annually monitor guidance with compliance issues, and periodically reporting back to divisions. Through a critical review of our reporting and the flow of information between teams, we will develop a process that delivers a clear and up-to-date picture of implementation, which supports the assessment and management of any risks associated with partial or non-compliance.

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Patient Safety

Excellence in specialist and community healthcare

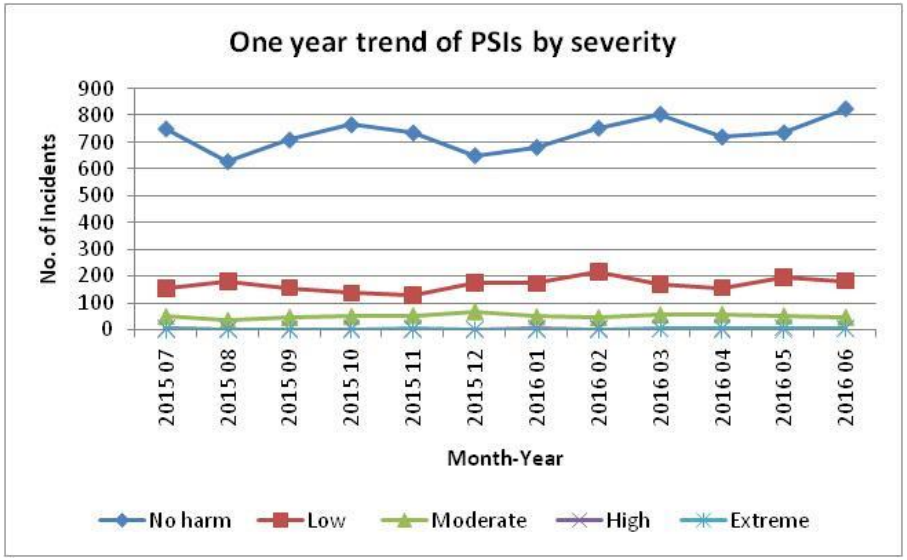
10. Patient Safety
- Incident Profile: Serious Incidents and Adverse Events

	2016/17 SIs Declared by Division (incl. PUs)				
	M&C	STN&C	CSD	C&W	Corporate
April	5	2	0	4	1
May	3 (1 shared with C&W)	1	1	2 (1 shared with M&C)	0
June	5	3	0	3	3

Table 1

Closed Serious Incidents (not incl. PUs)				
Type	April	May	June	**Movement**
Total	10	12	14	⮝
No Harm	5	4	9	⮝
Harm	5	8	5	⮟

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.

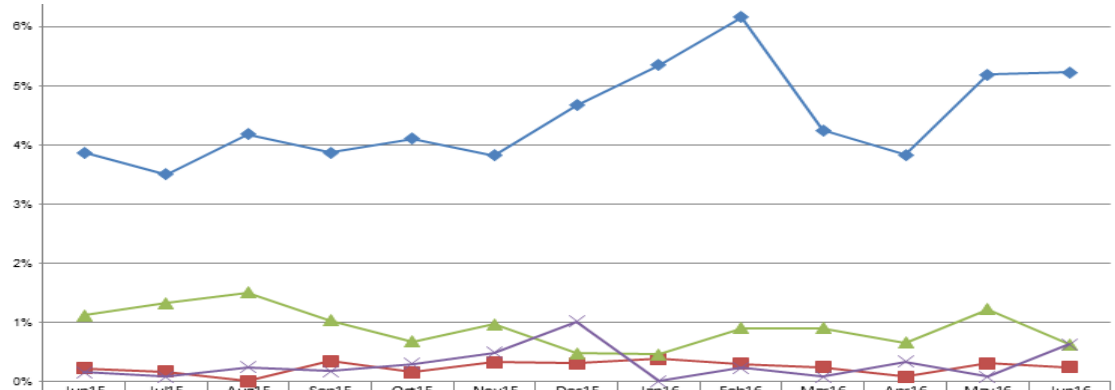
There were 12 general SIs reported in June (+ 2 pressure ulcers) and the subjects are varied.

The 12 general SIs declared in June include the following categories:

- Medication error x 2 (Omission; wrong dose)
- Maternal x 2 (Placental abruption; PPH (Contributed)
- Corporate x 3 (IT downtime; ventilation (service suspension);RTT data quality)
- Patient fall
- Unexpected death
- Failure to commence treatment
- Failure to act on adverse image results
- Unavailability of medical device/return to theatre

10. Patient Safety
- Safety Thermometer

% Harm Free Care							
Lead Director	April 2016	May 2016	June 2016	**Movement**	**2016/17 Target**	**National Average June 2016**	**Date expected to meet standard**
J Hall	95.11%	93.67%	93.51%	↓	95.00%	94.16%	March 17



	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15	Jan16	Feb16	Mar16	Apr16	May16	Jun16
Pressure Ulcers	3.87	3.5	4.18	3.87	4.1	3.82	4.67	5.35	6.16	4.24	3.83	5.19	5.22
Falls	0.22	0.16	0	0.34	0.15	0.32	0.31	0.38	0.3	0.24	0.08	0.31	0.24
Catheter & UTI	1.12	1.32	1.5	1.03	0.67	0.96	0.47	0.46	0.9	0.9	0.65	1.22	0.63
New VTE	0.15	0.08	0.24	0.17	0.3	0.48	1.01	0	0.23	0.08	0.33	0.08	0.63
Patients	1343	1285	1268	1162	1341	1255	1284	1308	1331	1227	1226	1311	1264

Pressure ulcers (66)

- 39 grade 2 (19 new, 20 old)
- 21 grade 3 (0 new, 21 old)
- 6 grade 4 (0 new, 6 old)

CAUTI (8)

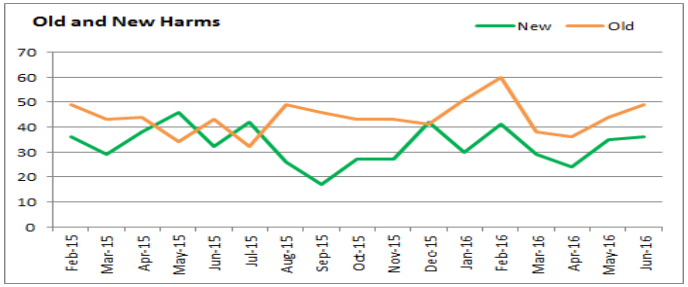
- 2 old
- 6 new

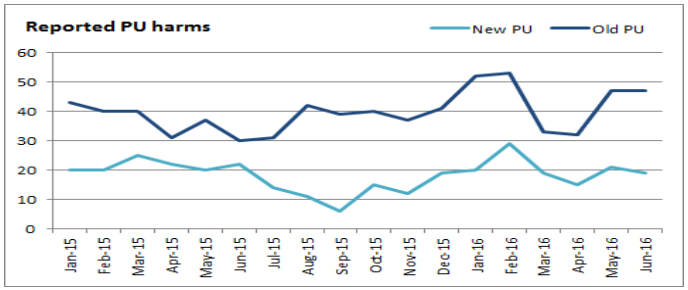
Falls (3)

- 3 low harm

VTE (8)

- 1 new DVT
- 1 new PE
- 6 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, which is reported separately.

In June 2016 the proportion of our patients that received harm free care was 93.51 per cent, which is marginally lower than the national average for the month. We reported 85 harms to 82 patients; 79 patients experienced one harm and 3 patients had 2 harms. 57.6% of harms were old.

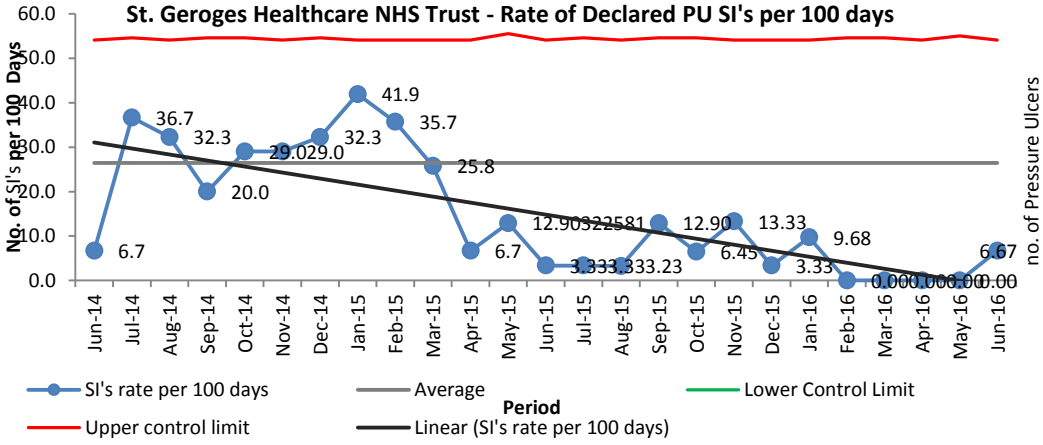
The level of PU harms is similar to the previous month and both catheter associated UTI's and falls decreased. *An increase is observed in new VTE harms, with a total of eight recorded. Seven of these are attributed to one ward that entered their data late and after validation by the VTE clinical nurse specialists. We are in liaison with the ward to determine whether these were cases of actual harm, or were entered in error. This needs to be validated.*

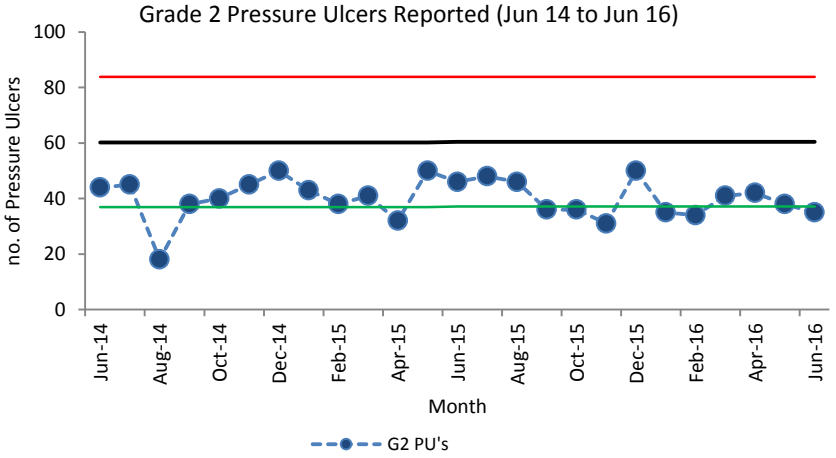
In July we begin a pilot to establish whether new harms are attributable to the ward on which they are reported. It is hoped that this will improve the usefulness of data for local teams and help to identify where improvements are required. Safety thermometer data will also be used to inform a project with the simulation team , funded by HESL. The project will use risk and audit data to align educational and training needs of teams and individuals in order to improve safety and outcomes.

10. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers										
Type	Feb	Mar	Apr	May	Jun	YTD April – March 2017	Movement	2016/2017 Target	Forecast March 2017	Date expected to meet standard
Acute	0	0	0	0	2	**2**	▲		G	-
Community	0	0	0	0	0	**0**	▼		G	-
Total All	0	0	0	0	2	**2**	▲		G	-
Total Avoidable	0	0	0	0	2	**2**		19		-
Previous Year	3	2	2	4	1	**7**	▼			

Grade 2 Pressure Ulcers						
Feb	Mar	Apr	May	Jun	Movement
20	25	27	30	15	▼
14	16	14	8	20	▲
34	41	41	38	35	▼
38	41	32	50	48	▼





Overview:

June saw a rise in the total number of pressure ulcer serious incidents, with two being declared for acute services. Community nursing achieved its fifth consecutive month with zero pressure ulcer serious incidents. There was an overall reduction in the number of Grade 2 pressure ulcer seen, this was driven by a 50% reduction in acute services.

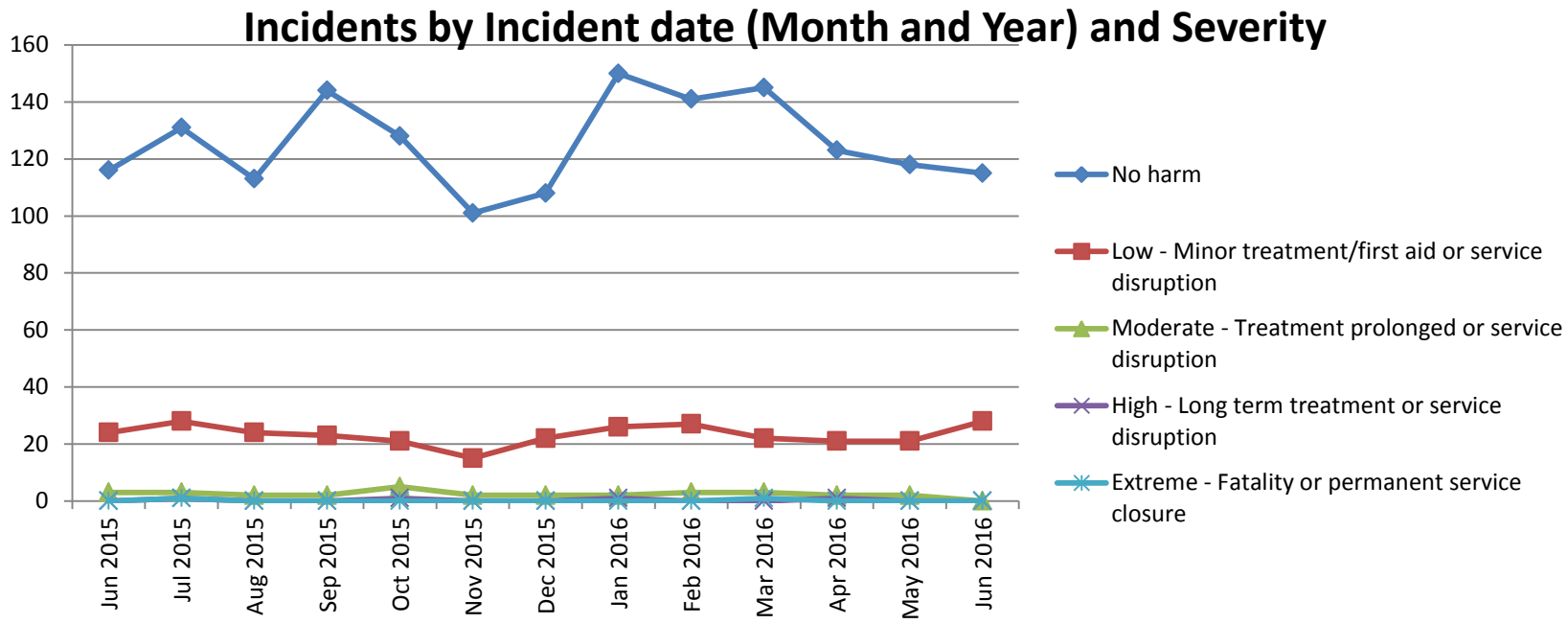
Actions:

- Recruitment of a second Band 6 Tissue Viability Support Nurse, pending checks. Recruitment of outstanding Band 7 community post on-going.
- Pressure Ulcer Strategy Group Terms of Reference to be renewed and membership reviewed.
- 2016/17 trajectory approved, target of 19 pressure ulcer serious incidents set.
- Review of audit tool, in view of trust-wide audit for pressure ulcer management.

10. Patient Safety:
- Incident Profile: Falls

Falls													
Lead Director	June	July	August	Sept	Oct	Nov	Dec	Jan 16	Feb	March 16	April	May 2016	June 2016	Movement
	144	163	140	168	155	118	132	179	170	171	146	140	143	

Falls with Harm June 2015 to 2016			
No Harm	Low	Moderate	Severe
1633	302	30	**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 a similar incidence of falls this month which may be attributed to seasonal changes. Actions include: reviewing the current training of clinical staff in falls prevention and developing a framework to include e-learning packages . The policy is being reviewed and updated in line with electronic documentation. The "Safe and Effective Use of Bed rails" policy will be reviewed and updated by August 2016. The falls committee is being reconvened to drive the falls action plan in the QIP.

10. Patient Safety - Infection Control

MRSA						
Lead Director	May	June	Movement	2016/2017 Threshold	Forecast June 2016	Date expected to meet standard
JH	0	0	⇔	0	G	31/03/17

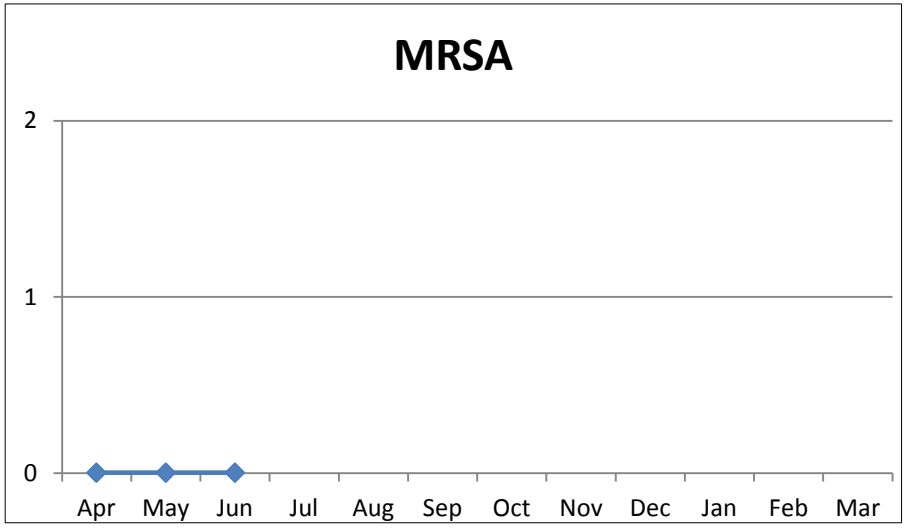
Peer Performance – YTD May 2016				
STG	Croydon	Kingston	King's College	Epsom & St Helier
0	0	0	2	3

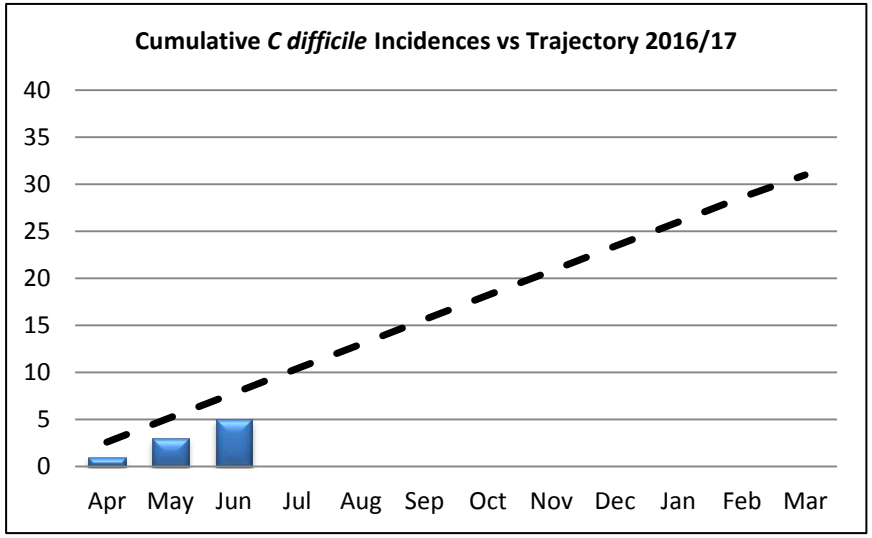
C. difficile						
Lead Director	May	June	Movement	2016/2017 Threshold	Forecast June 2016	Date expected to meet standard
JH	2	2	⇔	31	G	31/03/17

Peer Performance – YTD May 2016 (annual threshold in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
5 (31)	5 (16)	3 (9)	15 (72)	12 (39)

The MRSA bacteraemia threshold is zero. There were no MRSA Hospital-acquired bacteraemias in June 2016. The last hospital-acquired and Trust-assigned MRSA bacteraemia was on 23rd September 2015.

In 2016/17 the Trust has a threshold of no more than 31 *C. difficile* Trust-apportioned episodes. In June there were 2 Trust-apportioned episodes. This makes a total of 5 for the FY to end June 2016. This means that the Trust is currently on trajectory to achieve the target at the end of the FY 2016/17.





10. 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	June	July	August	Sept	Oct	Nov	Dec	Jan 2016	Feb	March	April	May	June
Unify2	96.75%	96.56%	96.78%	97.22%	97.10%	96.8%	96.5%	96.6%	96.7%	97.04%	96.45%	97.59%	

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. Data is adjusted by HTG to exclude 'Not Applicable' recordings (these are validated by the team). **NB. The RAG ratings for the safety thermometer changed in April 2015 to be consistent with the UNIFY targets.**

Data Source	June	July	August	Sept	Oct	Nov	Dec	Jan 2016	Feb	March	April	May	June
Safety Thermometer	95.14%	94.84%	92.38%	91.28%	93.40%	93.24%	88.56%	94.10%	90.2%	94.04%	95.47%	92.9%	94.5%

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 Quarter 1 Pharmacy-led Trust-wide audit of VTE risk assessment and prescription of appropriate prophylaxis showed Trust-wide improvement in results in comparison to the 2015/16 end of year average, across the four VTE related quality standards covered by the audit. Of particular note, targets were met consistently across the Medicine and Cardiovascular Division. There was heightened vigilance surrounding adherence to VTE prevention processes leading up to and during the CQC visit which may be reflected in these results (data collection occurred during this period). It is hoped that these high standards will continue into quarter 2.
- The next upgrade to the iClip VTE Prevention Package will be made available by Cerner by the end of July 2016. The upgrade links the VTE risk assessment with the prescribing of VTE prophylaxis within one single form/process. It is hoped that this will reduce the number of patients experiencing delays in the initiation of VTE prophylaxis following admission to the Trust.

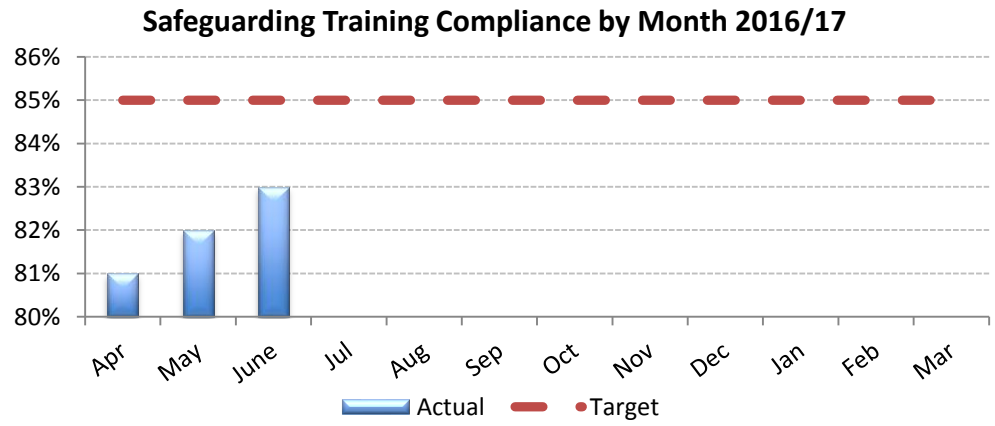
Root Cause Analysis (RCA) of Hospital Acquired Thrombosis (HAT)

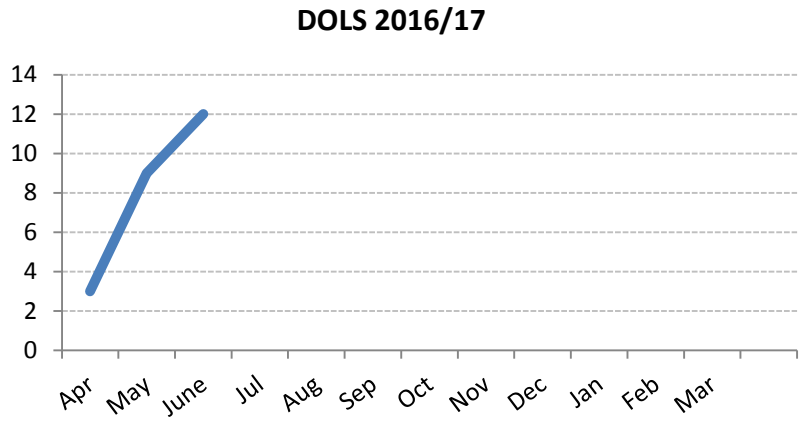
Year		2016
HAT cases identified to date (attributable to admission at SGH)		96
Mortality rate	Total	8 (8.3%)
	VTE primary cause of death	3 (3.1%)
Initiation of RCA process		100%
RCA complete		69.8% (67/96)
Cases where adequate prophylaxis was provided		60
Cases where inadequate prophylaxis was provided		7
Incidents jointly reviewed by HTG and clinical team		pending
Incidents investigated as SI		1

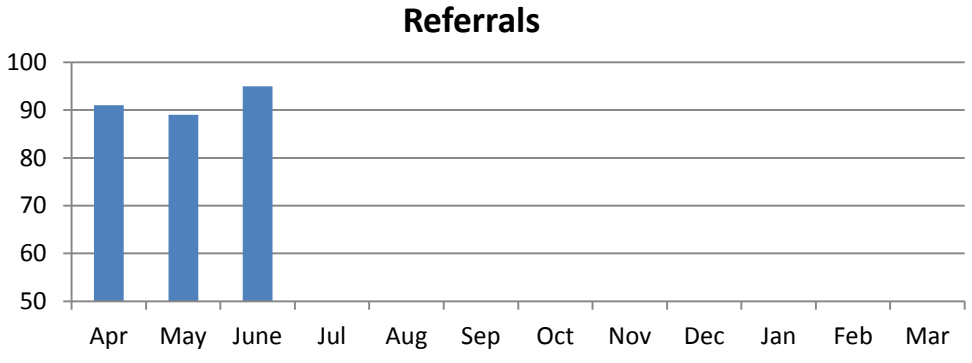
10. Patient Safety
- Safeguarding: Adults

Safeguarding Training Compliance - Adults									
Lead Director	Jan	Feb	Mar	April	May	Jun	2015/2016 Target	Forecast April 2016	Date expected to meet standard
JH	71%	73%	78%	81%	82%	83%	85%	A	-

Safeguarding Adults Training Compliance by Division – Jun 16				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
83%	83%	85%	84%	79%







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 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. Draft MCA/DoLs Guidance produced June 16. Working party to commence Sep 16 to address issues of training, guidance, governance,audit

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 completed Spring 2016. E-Learning revised May 16.

Roll out MCA training across trust, audit completed Spring 2016, training commenced May 16. Drop in sessions to continue whilst e-learning package is completed

10. Patient Safety
- Safeguarding Children

Division	No. requiring training	No of staff compliant	compliant %
Children and Women's Diagnostic and Therapy Services	537	625	86%
Community Services	93	114	82%
Corporate	2	2	100%
Medicine and Cardiovascular (ED)	197	153	76%
Surgery & Neurosciences	22	24	98%
May 2016	**851**	**918**	**93%**

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. In addition, the safeguarding team will be working with the MAST team, area department leads and HR to ensure that staff are allocated the appropriate level of training.

Serious Case Reviews and Internal Management Reviews: The Croydon Safeguarding Children Board has declared a SCR for a 4 year old boy, who presented in November 2015 with severe malnourishment. Mother and grandmother have been charged with child endangerment and are currently out on bail. A chronology and report has been requested from the Named Nurse in the acute services. There are also court proceedings between the local authority and parents; staff in the acute services have been asked to provide statements.

Other: Following an audit completed by the Wandsworth Public Health team regarding audit of FGM services at St George's, an action plan has been completed and is due to be presented to Wandsworth Safeguarding Children Board.

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

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Patient Experience

Excellence in specialist and community healthcare

11. Patient Experience
- Friends and Family Test

Service	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Average
Community Services	87% n=353	86% n=401 ↑	87% n=430 ↑	94% n=1147 ↑	94% n=1337 –	93% n=536 ↓	94% n=393 ↑	92% n=408 ↓	93% n=360 ↑	93% n=369 –	92% n=364 ↓	94% n=248 ↑	90% n=6346
Medicine and Cardiovascular	95% n=900	96% n=710 ↑	94% n=807 ↓	96% n=687 ↑	96% n=724 –	97% n=615 ↑	96% n=707 ↓	97% n=708 ↑	96% n=604 ↓	97% n=772 ↑	96% n=860 ↓	95% n=835 ↓	96% n=8929
Surgery Anaethetics and Neuro	93% n=986	90% n=767 ↓	88% n=736 ↓	92% n=787 ↑	90% n=709 ↓	91% n=642 ↑	92% n=677 ↑	90% n=598 ↓	93% n=641 ↑	94% n=820 ↑	95% n=807 ↑	94% n=1056 ↓	92% n=9226
Women and Childrens	93% n=567	93% n=498 ↑	93% n=429 –	93% n=480 –	93% n=397 –	91% n=336 ↓	92% n=273 ↑	92% n=251 –	91% n=288 ↓	90% n=305 ↓	96% n=402 ↑	91% n=335 ↓	92% n=4561
Trust	**93% n=2806**	**92% n=2376 ↑**	**91% n=2402 ↓**	**94% n=3101 ↑**	**93% n=3167 ↓**	**93% n=2129 –**	**94% n=2050 ↑**	**93% n=1965 ↓**	**94% n=1893 ↑**	**94% n=2266 –**	**95% n=2433 ↑**	**94% n=2474 ↓**	**93% n=29062**

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.

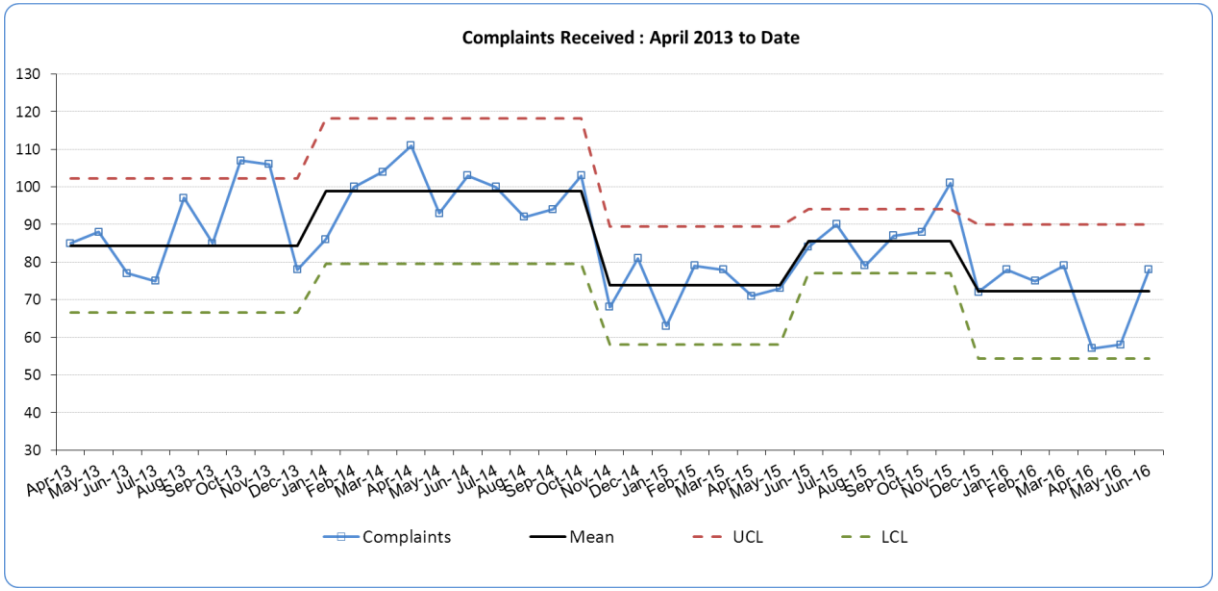
This report draws data from all patient surveys conducted on the RaTE system; including accessible versions that were created for any patient or relative that would have trouble understanding the standardised survey question.

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.

11. Patient Experience
- Complaints Received

Complaints Received														
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	Movement
Total Number received	84	90	79	86	88	102	72	78	74	79	57	58	78	▲



Overview:

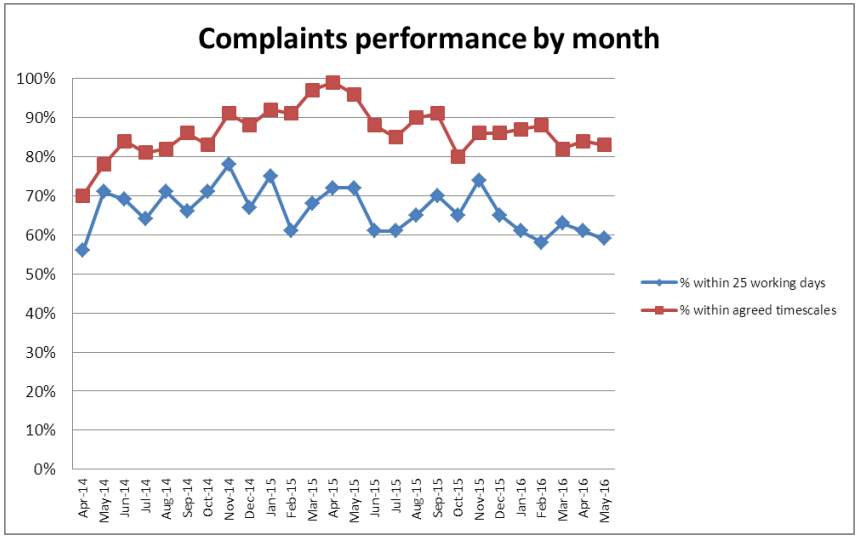
This report provides a brief update on complaints received since the last Quality and Performance report (so in June 2016) and information on responding to complaints within the specified timeframes for complaints received in May of 2016. It also includes some posts made on NHS Choices and Patient Opinion.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

Total numbers of complaints received in June 2016

There were 78 complaints received in June of 2016, A significant increase when compared to May when 58 complaints were received. The top three subjects were clinical treatment, communication and appointment delay/cancellation. The number of complaints received about the Obstetrics and Gynaecology increased significantly from 2 in May to 10 in April with 5 for each speciality. In Gynaecology three complaints were about the subject of communication or attitude, There was also a significant increase in complaints received about the Cardiovascular Directorate with 7 complaints about the Cardiology Care Group (compared to 0 in May) and 3 about the Cardiothoracic Surgery Care Group (again compared to 0 in May). Two of these three were about the subject of nursing care and this was on two different wards.

11. Patient Experience
- Complaints Performance against targets

Performance Against Targets May of 2016/2017				
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	8	5	63%	(2) 88%
Medicine and Cardiovascular	16	6	38%	(5) 69%
Surgery & Neurosciences	27	19	70%	(5) 89%
Community Services	2	2	100%	(0) 100%
Corporate Directorates	4	2	50%	(2) 100%
SWL Pathology	1	1	100%	(1) 100%
Totals:	58	35	60%	(15) 86%



Commentary:

There was no improvement in performance for complaints received in May of 2016, there was in fact a slight decline. 60% of complaints were responded to within 25 working days (against the internal trust target of 85%) compared to 61% in April. Performance against the second target did not change significantly with 86% of complaints responded to within agreed timescales (against internal trust target of 100%) compared to 84% in April.

Community Services Division and South West London Pathology reached both targets but had a very low volume of complaints to respond to. There was no significant change in performance in the other three clinical divisions when compared to April.

Update on complaints action plan

The following actions have been completed:

- The Complaints and Improvements intranet site has been updated and includes the Complaints and Concerns Policy and Procedure in which staff can find useful resources and templates to assist with complaint investigation and responses. There is also a link to Totara where staff can access the dates for "Investigating and Responding to Complaints" training and an updated complaints transcript form.

- Not strong enough

More detailed updates will be provided to the September board.

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

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

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

Anonymous *gave Trauma services at St George's Hospital (London) a rating of 5 stars*
Excellent Support/Service/advice
All the staff and trainees working at Florence Nightingale ward have been very supportive, warm and professional. The standard of care is very high and staff are friendly towards myself and other patients.

Thank you.

Visited in June 2016. Posted on 22 June 2016

Val Charles *gave Cardiology at St George's Hospital (London) a rating of 4 stars*
Catheter ablation care
I was admitted on 7 June 2016 for a catheter ablation and I was pretty scared - but I would like to say how kind everyone was from the consultant down to the cleaners and porters.

I would give St George's five stars for their service and everywhere was so clean.

Visited in June 2016. Posted on 22 June 2016

Moonbeam *gave Gynaecology at St George's Hospital (London) a rating of 1 stars*
Disgraceful staff in the admissions team.
I have never been more outraged by a health service in all my time. In admissions, nobody ever answers the phone. I have left more than 20 voicemails with the pair of admissions staff and none of them have been returned. They have lost my paperwork and forgotten to send referrals that have been promised. When I finally got someone on the phone they said they would look into my query and get back to me in 5 minutes and the never did. I am still none the wiser as to if my operation is even going ahead!

Visited in July 2016. Posted on 11 July 2016

Anonymous *gave Orthopaedics at St George's Hospital (London) a rating of 1 stars*
2nd time disappointed by FRACTURE CLINIC
First time they couldn't find my file and after waiting a long time we eventually found out where it was. Second time, i was supposed to have a Follow up appointment after my operation so i was waiting for a letter with the details of my appointment, that never came as i was never booked. In the interim, i was trying to contact with the Department so to have any kind of information but no one was picking it up. Eventually, i was booked for an appointment a week later than what i was expected as a result my recovery to be delayed and my return at my work as well. On the contrary, i was very pleased by nurses, HCA and doctors when i did have my appointment as they all were really helpful and straight forward. I hope next time will be better, thanks a lot.

Visited in July 2016. Posted on 06 July 2016

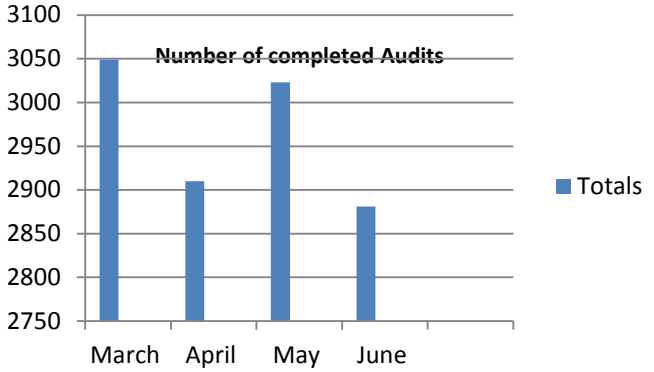
excellent
kind
responsible
respectful

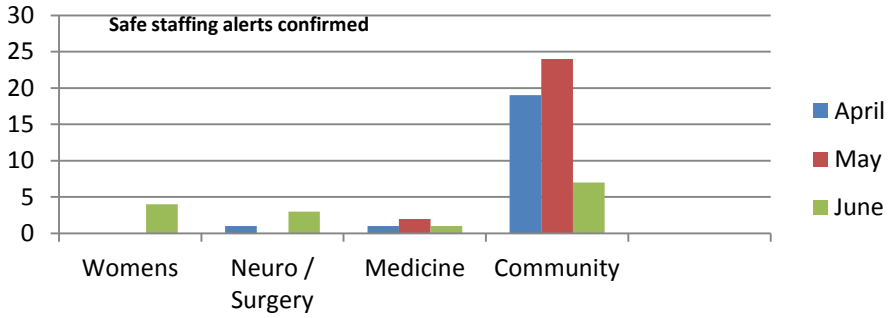
St George's University Hospitals NHS
NHS Foundation Trust

WORKFORCE

Excellence in specialist and community healthcare

12. 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: April 2910, May 3023 and June 2881. There was a slight decrease in the number of final alerts reported from 26 in May to 15 in June 2016. Community services remain with the highest number of recorded alerts (7) which is related to on-going recruitment issues. 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 April 5, May 7 and June 4. Of 6 nursing related safe staffing concerns raised on Datix system in June (4 in May) none matched a similar entry on the RATE system. Senior nurses are made aware of alerts and concerns via email at 10am.

MONTH	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	jUNE
ALERTS	5	2	12	27	9	10	35	29	56	59	21	26	15
CONCERNS	16	17	24	14	37	13	10	18	33	13	5	7	4

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.

12. Workforce – Safe Staffing alerts

Ward name	Day		Night		
	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	91.3%	100.0%	96.7%	100.0%	
Carmen Suite	127.9%	73.6%	99.9%	93.5%	
Champneys Ward	106.1%	93.9%	100.9%	99.0%	
Delivery Suite	106.3%	75.4%	107.6%	93.4%	
Fred Hewitt Ward	87.6%	79.7%	99.7%	56.1%	
General Intensive Care Unit	94.0%	73.7%	97.6%	69.3%	
Gwillim Ward	116.3%	51.1%	96.7%	80.6%	
Jungle Ward	103.7%	0.0%	#DIV/0!	#DIV/0!	
Neo Natal Unit	89.9%	#DIV/0!	96.2%	#DIV/0!	
Neuro Intensive Care Unit	91.1%	102.2%	97.3%	92.2%	
Nicholls Ward	85.1%	92.4%	93.8%	75.0%	
Paediatric Intensive Care Unit	90.6%	96.1%	96.7%	99.9%	
Pinckney Ward	107.4%	88.2%	97.4%	#DIV/0!	
Dalby Ward	95.5%	108.4%	91.3%	82.9%	
Heberden	88.1%	107.2%	97.9%	92.2%	
Mary Seacole Ward	98.0%	97.7%	87.6%	95.6%	
A & E Department	93.1%	108.6%	102.7%	86.0%	
Allingham Ward	94.7%	127.6%	93.4%	104.6%	
Amyand Ward	89.5%	104.6%	98.0%	104.1%	
Belgrave Ward AMW	97.8%	85.7%	97.2%	102.6%	
Benjamin Weir Ward AMW	82.2%	92.4%	95.0%	93.5%	
Buckland Ward	81.3%	136.0%	103.2%	189.4%	
Caroline Ward	87.7%	69.2%	94.5%	#DIV/0!	
Cheselden Ward	88.6%	100.0%	100.0%	76.9%	
Coronary Care Unit	94.0%	0.0%	97.8%	7.2%	
James Hope Ward	79.0%	91.3%	92.9%	#DIV/0!	
Marnham Ward	100.5%	80.7%	81.9%	77.1%	
McEntee Ward	92.6%	105.3%	100.0%	97.9%	
Richmond Ward	81.0%	96.5%	99.6%	92.2%	
Rodney Smith Med Ward	92.0%	95.0%	99.0%	98.9%	
Ruth Myles Ward	91.8%	83.9%	104.5%	28.6%	
Trevor Howell Ward	96.7%	88.2%	97.9%	100.0%	
Winter Ward (Caesar Hawkins)	88.3%	91.8%	96.9%	99.4%	
Brodie Ward	91.6%	84.9%	110.0%	99.9%	
Cavell Surg Ward	90.5%	95.8%	102.2%	88.2%	
Florence Nightingale Ward	98.3%	82.0%	106.9%	300.0%	
Gray Ward	80.7%	67.5%	98.1%	96.4%	
Gunning Ward	91.2%	104.3%	97.1%	113.0%	
Gwynne Holford Ward	82.0%	91.2%	97.7%	91.7%	
Holdsworth Ward	95.5%	93.0%	104.2%	100.0%	
Keate Ward	89.0%	73.3%	87.7%	59.1%	
Kent Ward	88.4%	100.1%	97.0%	90.1%	
Mckissock Ward	86.3%	88.9%	92.1%	115.3%	
Vernon Ward	77.2%	136.5%	92.3%	85.5%	
William Drummond HASU	80.6%	77.6%	94.8%	95.6%	
Wolfson Centre	74.4%	97.7%	96.9%	103.9%	
Gordon Smith Ward	86.9%	81.7%	96.9%	90.2%	
Nightingale Step Down, Off Site Facility	77.4%	109.2%	81.3%	121.5%	
Trust Total	90.97%	94.77%	97.53%	95.51%	94.14%

	Day Qual	Day HCA	Night Qual	Night HCA	Overall
	90.97%	94.77%	97.53%	95.51%	94.14%

12. Workforce:
Care hours per patient day

Overview

Every month for the past year the trust has submitted figures for the number of filled shifts for registered and unregistered staff during day and night shifts and upload this information onto UNIFY.

From May 2016, all acute trusts with inpatient wards/units began reporting monthly CHPPD data to NHS improvement. Over time this will allow trusts to review the deployment of staff within a speciality and by comparable ward. When looking at this information locally alongside other patient outcome measures, trusts will be able to identify how they can change and flex their staffing establishment to improve outcomes for patients and improve productivity.

The introduction of CHPPD for nurses and healthcare support staffing in the inpatient / acute setting is the first step in developing the methodology as a tool that can contribute to a review of staff deployment. Work has begun to consider appropriate application of this metric in other care settings and to include other health professional such as allied health professionals (AHP). As with other indicators, CHPPD, should never be viewed in isolation but as part of a local quality dashboard that includes patient outcome measures alongside workforce and financial indicators. The aim is to help ward managers, clinical matrons and hospital managers make safe, efficient and effective decisions about staff deployment.

CHPPD is calculated by adding the hours of registered nurses and healthcare support workers and dividing the total by every 24 hours of inpatient admissions (or approximating 24 patient hours by count of patients at midnight). CHPPD is reported as a total an d split by registered nurses and healthcare support workers to provide a complete picture of care and skill mix (NQB – July 16).

The data for the number of patients in a bed at 23.59 is reliant on the Iclip system being updated. For example a ward with 20 beds should never show more than 20 people in a bed at 23.59 hours. In some cases, the numbers shown were over the number of beds available. This occurs If Iclip has not been updated and patients are not discharged on time. In order to ensure the data is as accurate as possible a cap has been placed in the data collection tool to ensure the maximum number of people in a bed at midnight does not exceed the actual number of beds available. If there are less people in a bed at collection time, the data will still reflect this. We are aware that some areas may show an excess of people in a bed when they open escalation areas and this will be monitored as required.

12. Workforce:
Care hours per patient day

Ward name	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	Last Month
Cardiothoracic Intensive Care Unit	420	30.53	0.75	31.29	29.19
Carmen Suite	97	28.65	5.79	34.45	37.51
Champneys Ward	260	6.41	2.08	8.49	9.25
Delivery Suite	456	16.52	2.94	19.46	16.17
Fred Hewitt Ward	366	11.08	1.31	12.39	11.96
General Intensive Care Unit	358	36.52	0.90	37.42	37.89
Gwillim Ward	916	3.93	1.40	5.33	4.96
Neo Natal Unit	370	36.33	0.00	36.33	35.49
Neuro Intensive Care Unit	318	28.90	3.78	32.69	32.41
Nicholls Ward	423	9.35	0.89	10.23	10.22
Paediatric Intensive Care Unit	163	42.19	4.16	46.35	43.75
Pinckney Ward	349	11.56	0.94	12.51	11.88
Dalby Ward	439	6.31	7.42	13.73	10.71
Heberden	558	5.42	7.06	12.49	9.36
Mary Seacole Ward	1125	3.55	5.21	8.76	8.39
Allingham Ward	695	5.58	3.77	9.36	9.07
Amyand Ward	781	5.07	4.15	9.22	9.61
Belgrave Ward AMW	703	5.66	2.35	8.01	7.30
Benjamin Weir Ward AMW	823	4.59	1.41	6.00	5.33
Buckland Ward	520	5.58	1.76	7.33	6.97
Caroline Ward	607	5.10	1.27	6.37	6.09
Cheselden Ward	579	4.81	1.71	6.52	7.01
Coronary Care Unit	234	18.23	1.02	19.25	18.50
James Hope Ward					
Marnham Ward	779	6.33	2.91	9.24	9.50
McEntee Ward	436	5.66	2.81	8.47	9.24
Richmond Ward	1237	7.59	4.84	12.43	12.29
Rodney Smith Med Ward	575	4.89	4.45	9.34	6.29
Ruth Myles Ward	222	11.09	2.07	13.16	12.57
Trevor Howell Ward	400	7.76	3.76	11.52	10.20
Winter Ward (Caesar Hawkins)	644	4.82	2.66	7.48	6.64
Brodie Ward	600	8.11	2.72	10.83	10.41
Cavell Surg Ward	604	4.92	1.94	6.86	7.38
Florence Nightingale Ward	541	6.60	1.48	8.08	9.08
Gray Ward	717	5.26	2.24	7.50	7.05
Gunning Ward	674	4.76	2.39	7.15	6.95
Gwynne Holford Ward	309	10.87	12.19	23.06	40.88
Holdsworth Ward	470	6.32	2.90	9.22	8.76
Keate Ward	475	5.60	1.43	7.03	6.89
Kent Ward	515	6.97	6.94	13.91	12.71
Mckissock Ward	505	5.82	2.93	8.75	9.37
Vernon Ward	629	5.38	2.36	7.73	9.72
William Drummond HASU	472	10.84	2.83	13.67	13.67
Wolfson Centre	338	11.09	7.06	18.14	16.70
Gordon Smith Ward	435	7.80	2.39	10.18	10.22
Trust Total	23137	9.44	3.24	12.68	12.22

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

HEATMAP DASHBOARD
WARD VIEW

Excellence in specialist and community healthcare

Nursing and Midwifery Heatmap – June 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	Serious incidents (ward level)	Sickness/ absence rate - (ward)
COMMUNITY SERVICES	Mary Seacole	0.0	0.0	0.0	85.7	85.7	76.4	0.0	9.0
MEDICINE	ALLINGHAM	0.0	0.0	0.0	98.1	92.6	29.9	0.0	9.1
	AMYAND	0.0	0.0	0.0	88.1	96.6	27.5	0.0	5.8
	BELGRAVE	0.0	0.0	0.0	96.2	96.3	47.8	0.0	2.3
	BENJAMIN WEIR	0.0	0.0	0.0	98.4	97.0	28.3	0.0	1.4
	BUCKLAND	1.0	0.0	0.0	85.4	92.7	57.1	1.0	0.6
	CAESAR HAWKINS	0.0	0.0	0.0	89.1	91.3	29.3	0.0	1.4
	CARDIAC CARE UNIT	0.0	0.0	0.0	84.2	100.0	96.7	2.0	5.1
	CAROLINE	0.0	0.0	0.0	94.6	94.5	110.4	0.0	0.5
	CHESELDEN	0.0	0.0	0.0	83.7	95.6	38.0	0.0	1.8
	DALBY	0.0	0.0	0.0	87.5	93.8	18.3	0.0	3.8
	EMERGENCY DEPARTMENT	0.0	0.0	0.0		83.1	24.5	0.0	4.0
	GORDON SMITH	0.0	0.0	0.0	100.0	95.3	58.1	0.0	3.2
	HEBERDEN	0.0	0.0	0.0	87.5	96.8	34.9	0.0	3.2
	JAMES HOPE	0.0	0.0	0.0	100.0	97.2	73.1	0.0	1.0
	MARNHAM	0.0	0.0	0.0	94.4	94.1	36.1	0.0	3.9
	MCENTEE	0.0	0.0	0.0	97.1	100.0	37.6	0.0	4.3
	RICHMOND	0.0	0.0	0.0	94.0	96.0	42.9	0.0	5.9
	RODNEY SMITH	0.0	0.0	0.0	88.0	91.9	43.0	0.0	4.0
	RUTH MYLES DAY UNIT	1.0	0.0	0.0	100.0	95.2	50.0	0.0	4.2
	TREVOR HOWELL	0.0	0.0	0.0	97.1	97.5	49.0	0.0	6.0

Nursing and Midwifery Heatmap – June 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	Serious incidents (ward level)	Sickness/ absence rate - (ward)
SURGERY	BRODIE NEURO	0.0	0.0	0.0	94.1	100.0	72.4	0.0	3.1
	CAVELL	0.0	0.0	0.0	100.0	71.1	58.6	0.0	3.4
	FLORENCE NIGHTINGALE	0.0	0.0	0.0	95.0	96.1	88.3	0.0	9.4
	GRAY WARD	0.0	0.0	0.0	100.0	93.8	80.7	0.0	0.5
	GUNNING	0.0	0.0	0.0	100.0	97.2	74.3	0.0	1.3
	GWYN HOLFORD	1.0	0.0	0.0	100.0	85.7	73.7	0.0	8.7
	HOLDSWORTH	0.0	0.0	0.0	100.0	100.0	61.5	0.0	2.5
	KEATE	0.0	0.0	0.0	100.0	98.0	83.6	0.0	5.9
	KENT	0.0	0.0	0.0	100.0	100.0	25.8	0.0	0.0
	MCKISSOCK	0.0	0.0	0.0	100.0	96.3	42.2	1.0	10.3
	THOMAS YOUNG	0.0	0.0	0.0	96.0	87.5	24.2	0.0	1.1
	VERNON	0.0	0.0	0.0	96.0	99.1	68.7	0.0	5.3
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	100.0	96.3	47.9	0.0	2.9
WOMEN & CHILDREN	CARDIOTHORACIC INTENSIV..	0.0	0.0	0.0	94.1			0.0	3.2
	CARMEN SUITE	0.0	0.0	0.0	100.0			0.0	5.3
	CHAMPNEYS	0.0	0.0	0.0	100.0	100.0	11.1	0.0	5.3
	DELIVERY	0.0	0.0	0.0	100.0			2.0	9.7
	FREDDIE HEWITT	0.0	0.0	0.0				0.0	5.2
	GENERAL ICU/HDU	0.0	0.0	0.0	100.0			0.0	1.4
	GWILLIM	0.0	0.0	0.0	100.0			0.0	4.7
	JUNGLE	0.0	0.0	0.0		96.8		0.0	1.4
	NEONATAL ICU	0.0	0.0	0.0	100.0			0.0	3.6
	NEURO ICU	0.0	0.0	0.0	100.0			0.0	2.2
	NICHOLLS	0.0	0.0	0.0		100.0	28.6	0.0	7.2
	PICU	0.0	0.0	0.0				0.0	2.9
	PINCKNEY	0.0	0.0	0.0		100.0	33.3	0.0	1.4

13. MEDCARD Heatmap:

Marnham ward: 83.3% Harm free care which was attributed to one acquired pressure ulcer and one old and two new UTI's. The Serious Incident is currently being investigated and relates to a grade 3 pressure ulcer. Sickness is currently at 3.7% which is a reduction from previous month. This is being managed in line with policy.

Rodney Smith: 86% Harm Free Care due to two acquired pressure ulcers, two old ulcers and a new UTI. Sickness is reduced from previous months (5.4%) and te ward manager is being supported by HR to manage this.

McEntee: 87.5% Harm Free Care due to X2 new grade 2 Pressure ulcers and X1 new UTI

Amyand: Sickness was high last month due to combination of short term and long term sickness. HR advisor is informed and all the sickness were dealt appropriately in line with policy. .

Heberdon: Harm free care is 75% due to five old Pressure ulcers on admission.

McEntee: 87% harm free care. This is due to only 78% of patients had VTE assessments, this has been discussed with doctors at directorate governance. Additionally one patient was recorded as having a pressure ulcer, on review this was a moisture lesion.

Ben Weir : Unfilled hours are driven by vacancy, no staffing alerts but there have been concerns which have been monitored and managed locally. The reduction in the FFT rates for the ward is not normally seen and this has been discussed with the ward sister and nursing team.

Cheselden : 1 acquired G3 pressure ulcer which has been investigated and is awaiting review. They have scored 87% for harm free care, the harms reported were 2 old grade 3 pressure ulcers and 1 new grade 2, the care around this was investigated by the ward sister and was found to be appropriate. Sickness has also been high in Cheselden in June, this is driven by 1 staff member being on long term sick following surgery, they have returned to work and 1 other staff member is off sick for 1 week, and is being managed on stage 1 of the sickness procedure.

James Hope : sickness is up due to 1 staff member being off for an extended period, they will soon triggering long term sickness and will be managed appropriately.

13. Community Mary Seacole Heatmap:

MSW – all green with exception of sickness which is red – 5.3%

WARD	Total No of Days Sickness	Comment
MSW A	79	• Band 6 – short term sickness • Band 5 – 1 .73 wte long term sickness (both returned in July 2016) • Band 2 Admin – 0.72wte long term sickness (following surgery)
MSW B	35	• 3wte – short term sickness

13. SNCT Heatmap:

Nursing Scorecard Report- July (June's data) - STNC Division

The report focuses on areas with any red indicators or those with three or more overall indicators. The key areas where alerts are seen relate to Sickness Absence and FFT response rate. The areas where there have been improvements in performance are FFT satisfaction, Harm Free Care, Zero incidences of trust acquired pressure ulcers and Zero incidents of MRSA.

There are 7 red alerts for June 2016 compared to 20 for the previous reporting period and a decrease in overall alerts from 27 to 10. However it should be noted that this month's scorecard has not included falls and unfiled duty hours in its reporting matrix.

Surgery Directorate

Florence Nightingale – 1 red indicator which related to sickness absence of 9.4%. This is due to two members of staff on long term sickness and three episodes of short term sickness- all have been managed as per the Trust policy. One staff member who is on long term sickness has returned in July 2016 and the other staff member will return in September 2016.

Gunning – No Red/Amber indicators

Holdsworth – No Red/Amber indicators

Keate- 1 red indicator which related to sickness absence of 5.9 %. One staff member is on long term sickness and one episode of short term sickness, both of which has been managed as per Trust policy.

Vernon- 1 red indicator which related to sickness absence of 5.3%. This is due to two band 5 staff nurses being on long term sick leave. One nurse has now returned on a phased return and the other nurse remains off sick. Both are being managed in line with the sickness absence policy.

Cavell- No red/amber indicators

Gray- No red/amber indicators

13. SNCT Heatmap:

Neuroscience Directorate

Brodie -1 amber indicator. This is for 94.1% of harm free care due to a patient being admitted to the ward with an existing grade 3 pressure ulcer.

McKissock – 2 red indicators. The first red indicator related to a declaration of a Serious Incident (SI) due to an unexpected death. The patient arrested on the ward and was successfully resuscitated but died two days later on NICU due to hypoxic brain injury. A SI panel has been formed to investigate this incident.

The second red indicator related to 10.3% of sickness absence. There were three members of staff on long term sickness absence in June 2016 and there was also 56.5 hours of short term sick leave (37.5 hrs were due to planned surgery). Two of the three staff members who were on long term sickness absence have now returned on a phased basis. All sickness managed as per Trust policy.

Kent – 1 amber indicator which related to a FFT response rate of 25.8 %. This low percentage is directly related to the patient cohort (head injury patients) and on a positive update; all patients who completed this audit were 100% satisfied with their care and would recommend the service. Staff have been reminded to capture data from friends and family of patient users on Kent Ward.

William Drummond - No red/amber indicators

Thomas Young - 1 amber indicator which related to a FFT response rate of 24.2%. This score related to the patient cohort but did show a sustained improvement from previous scorecards. 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 May 2016

Gwynne Holford Ward – 2 red indicators. First red indicator related to a C. Difficile case. The Root cause Analysis has been completed and the learning has been shared with the teams. Local infection control policy has been ratified for Gwynne Holford and has been launched to the MDT.

The second red indicator related to sickness absence of 8.7%. Two nurses were on long term sick leave and there were other episodes of short term sickness absence- all managed as per Trust sickness policy.

13. SNCT Heatmap:

Summary

Overall improvements were noted in the numbers of ward that did not have any red or amber indicators- Cavell, Gray, Gunning, Holdsworth and William Drummond wards. The alerts for Harm free care and patient satisfaction have really improved for the inpatients wards in the Surgical and Neuro divisions.

Due to the cohort of our patients on the surgery and neuro wards, the majority of our red/amber flags are attributed to falls, which are not included in this month's data, therefore making it difficult to look at the month on month trends. It is also important to note that unfilled duty hours have also not been included in this month's matrix and again due to the amount of vacancies and unfilled shifts, this too would have provided more red or amber indicators.

13. CWDCT Heatmap:

Cardiothoracic Intensive Care Unit (CTICU): CTICU scored 94.1% in relation to harm free care. 12 patients were surveyed and 1 patient was found to have a single harm; a new grade 2 new pressure ulcer. There is proactive management of pressure ulcers across all of the critical care units which is reflected in the overall low numbers of grade 3 / 4 pressure ulcers.

Friends and Family: Champneys ward performance against this metric remains a cause for concern. Following senior nursing input the ward will now be looking at their wider workforce, in particular the health care assistants and ward receptionist will be supporting the team to capture this piece of useful patient feedback. There is some improvement in the overall accuracy of these metrics on the heatmap however further work is still required by the informatics team to ensure 100% accuracy of recording.

Serious incidents: There were 2 serious incidents declared on the delivery suite; these were a patient with a placental abruption and a patient with a post-partum haemorrhage. Both of these cases are currently being investigated and conclusions will be shared via the divisional governance board.

Sickness: The women's and children's directorates continue to have sickness absence rates above the trust target. There are a number of cases of long term sickness in these areas that are contributing to this; all of which are being managed in line with HR procedures. The bi – monthly divisional safe staffing and workforce meetings continue with the next one scheduled for early August.

13. Quality Scorecard :
CSD-

Domain	Indicator	Frequency	2015/2016 Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
				Quarter 1 2016/17			Quarter 2 2016/17			Quarter 3 2016/17			Quarter 4 2016/17		
Patient Safety	SI's REPORTED	Monthly		0	1 (DIC)										
Patient Safety	Number of SI's breached	Monthly	0	0	0										
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly	0	0	0										
Patient Safety	Grade 4 Pressure Ulcers	Monthly	0	0	0										
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly	0	6	19										
Patient Safety	Number of moderate falls	Monthly	0	1	0										
Patient Safety	Number of major falls	Monthly	0	0	0										
Patient Safety	Number of falls resulting in death	Monthly	0	0	0										
Patient Safety	MRSA (cumulative)	Monthly	0	0	0										
Patient Safety	CDiff (cumulative)	Monthly	31	0	0										
Patient Safety	CAS ALERTS - Number ongoing-received (Trust)	Monthly	0	2	2										
Patient Safety	CAS ALERTS - Number not completed within due date (Cumulative) Trust	Monthly	0												
Patient Safety	Number of Quality Alerts	Monthly		3	3										
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	85%	82.0%	84.0%										
Safeguarding	% of staff compliant with safeguarding childrens training	Monthly	Level 1 85%	80.0%	81.0%										
			Level 2 85%	66.0%	73.0%										
			Level 3 85%	82.0%	82.0%										
Patient Outcomes	Mortality SHMI ratio (Trus)	Monthly	<100	0.9											
Patient Experience	Active Claims	Monthly		1	Not yet available										
Patient Experience	Number of Complaints received	Monthly		1	3										
Patient Experience	Number of Complaints responded to within 25 days (reporting 1 month in arrears)	Monthly	85%	100%	2 (66%)										
Patient Experience	Number of Complaints responded to within 25 days with an agreed extension	Monthly	95%	100%	1(100%)										
Patient Experience	FFT Score (Mary Seacole and MIU)	Monthly Mary Seacole A		90.0%	86.0%										
		Monthly Mary Seacole B			86.00%										
Patient Outcomes	Catheter related UTI (Trust)			0.65	0.00 CSD										
	Number of new VTE (Trust)		National 0.005	0.33	0.00 CSD										
Workforce	Number of DBS Request Made	Quarterly	annually	206 in 2015											
Workforce	Sickness Rate -	Monthly	3.50%	4.72% Mar16	5.67%										
Workforce	Turnover Rate-	Monthly	13%	20.54% Mar16	20.3%										
Workforce	Vacancy Rate-	Monthly	11%	19.43% Mar16	20.81% Mar17										
Workforce	Appraisal Rates - Medical	Monthly	85%	88.89% Mar16	92.59%										
Workforce	Appraisal Rates - Non-Medical	Monthly	85%	63.25% Mar16	64.48% Mar17										

13. CSD Scorecard : Exception Report

- 1 x serious incidents for May (OHC DIC)
- Last reported PU Si Jan 2016
- MS B ward increase no. of falls. 5 + 3 falls from 2 complex patients. Both being specialled
- Safeguarding: ARIS data still includes services which have been transferred out of CSD- this has been flagged with the training dept. who are leading a review of data and staff profile requirements.

Workforce update: (May 2016)

Organisation	Establishment FTE	Staff in Post FTE	Vacancy FTE	Vac %	Leavers in last 12 months[1]	Total Turnover[1] %	Sickness[2] %	Non-Medical Appraisal Rate[4]	Consultant Appraisal Rate[4]
Community Services Division	**1187.56**	**735.63**	**451.93**	**38.06%**	**157.12**	**21.03%**	**4.98%**	**66.58%**	**87.50%**
Ambulatory Care Services Dir.	229.05	161.26	67.79	29.60%	28.29	18.34%	5.53%	65.42%	90.00%
Community Adult & Children Services Dir.	948.26	568.62	379.64	40.04%	126.83	21.66%	4.76%	61.44%	75.00%
Community Services Management Dir.	10.25	5.75	4.50	43.93%	2.00	27.41%	0.00%	50.00%	

- Focused action on appraisal rates led by Divisional Chair
- Recruitment activity continuous
- Safe staffing alerts reflective of unfilled vacancies and shifts – bank and agency rate >90% for nursing services.

REPORT TO THE TRUST BOARD *July 2016*

Paper Title:	Workforce report
Sponsoring Director:	Karen Charman, Director of Workforce and Organisational Development
Author:	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 June 2016

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

Key points to note are:

- There has been further negative movement in turnover and temporary staffing usage.
- The vacancy rate has decreased by 2.1%
- There has been continued progress in mandatory training compliance to 79.6%
- The trust continues to benchmark reasonably well against similar London trusts for sickness absence

Key risks identified:
Key workforce risks include:

- Failure to recruit and retain sufficient staff in relation to annual turnover rates and to safely support future increases in capacity'
- Failure to reduce the unacceptable levels of bullying and harassment reported by staff in the annual staff survey.
- Possible reductions in the overall number of junior doctors available with a possible impact on particular speciality areas.
- Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	**To develop a highly skilled and engaged workforce championing our values that is able to deliver the trust's vision.**
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	**Are services well led?**

Commentary on performance in key workforce indicators

Vacancy information

The overall number of staff in post has grown by 27 WTE, and whilst the vacancy factor has also increased. New budgets have been updated by Finance department colleagues to remove closed posts.

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. The impact of this programme of work can be seen in the reduced numbers of acting up arrangements in June.

Sickness absence

After an unusually long period of above average sickness absence levels, rates have decreased for the second month in a row to below average. The main reason for absence remains colds, coughs, flu and influenza. The second major reason being gastro intestinal episodes.

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 began in May, and support for mental wellbeing through the staff support service and the mental health trust IAT programme. These two areas represent the next two main reasons for absence. Funding in support of the CQUIN has been agreed and the staff wellbeing programme has been launched in July.

Agency and bank staff usage

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 during April.

The trust is being supported by NHS Improvement to undertake a process map and review of waste and duplications for all of the temporary staff processes. This will now form a new project under the workforce efficiency programme.

Mandatory training and appraisal rates

The deterioration in mandatory training compliance and rates has reversed and the trust is exceeding 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.

As a result of significant work in the divisions, appraisal rates have begun to improve.

Engagement score

The staff friends and family test scores, which have previously been reported through the Chief Executive's report to the board, are included in order to provide trend information. The quarter one results have seen an increase in recommendation for treatment but a further small decline in recommendation as a place to work. A revised HR priority work plan will be presented to the Board in September to seek to address the key areas of concern in this and other areas such as time to recruit, exit interviews and staff survey findings. From Q2 we will be launching a staff engagement gauge to set a baseline of current levels of engagement and review on at least a quarterly basis to measure the success of chosen interventions.

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Workforce Performance Report
to the Trust Board

Month 3 - June 2016

Excellence in specialist and community healthcare

Workforce Performance Report Jul ‘15 - Jun ‘16

Contents

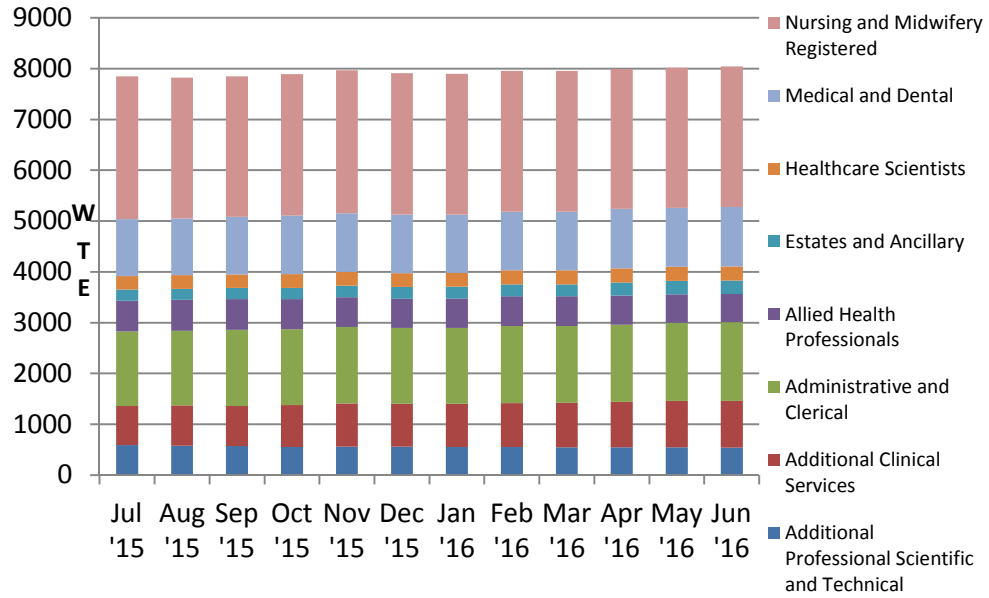
Performance Summary

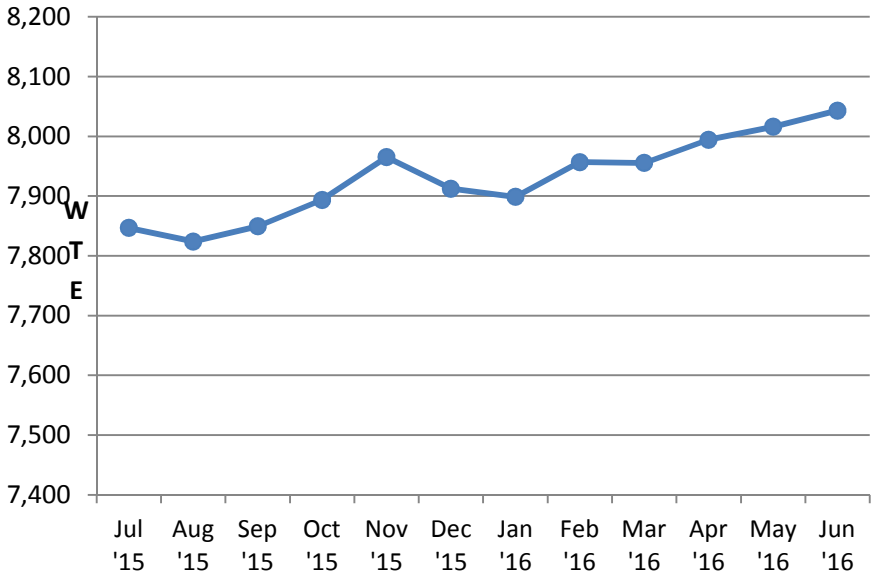
Summary of overall performance is set out below

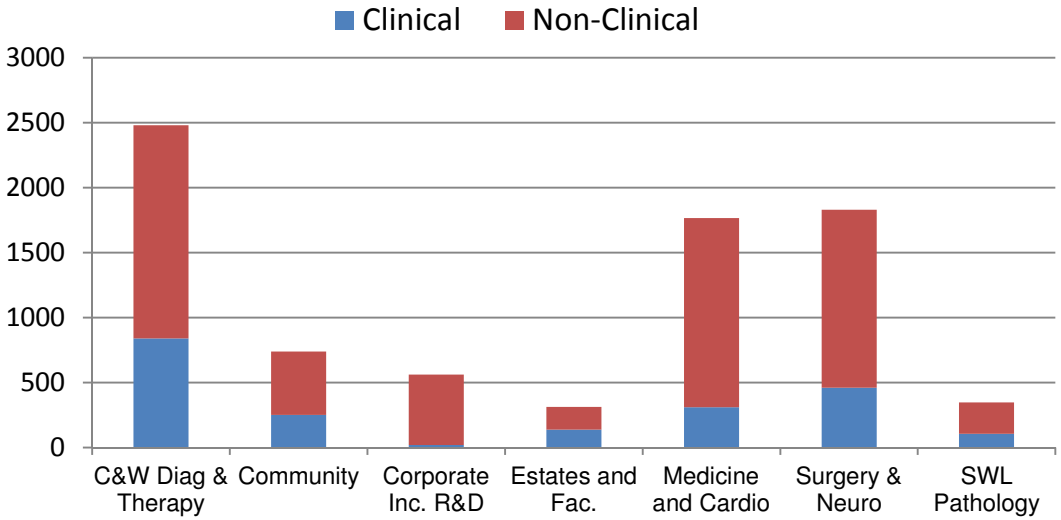
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has decreased by 2.1%	15.2%	19.3%	17.2%	↘
6	Turnover	Turnover has increased by 0.3%	17.3%	18.3%	18.6%	↗
7	Voluntary Turnover	Voluntary turnover has increased by 0.2%	14.0%	14.9%	15.1%	↗
8	Stability	Stability has remained the same	83.2%	81.7%	81.7%	↔
10	Sickness	Sickness has decreased by 0.1%	3.5%	3.6%	3.5%	↘
15	Temporary Staffing Usage (FTE)	Temporary Staffing Usage has increased by 2.1%	14.5%	13.3%	15.4%	↗
17	Mandatory Training	MAST compliance has increased by 0.7%	72.4%	78.9%	79.6%	↗
18	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has increased by 0.9%	73.8%	68.4%	69.3%	↗

Current Staffing Profile

The data below displays the current staffing profile of the Trust





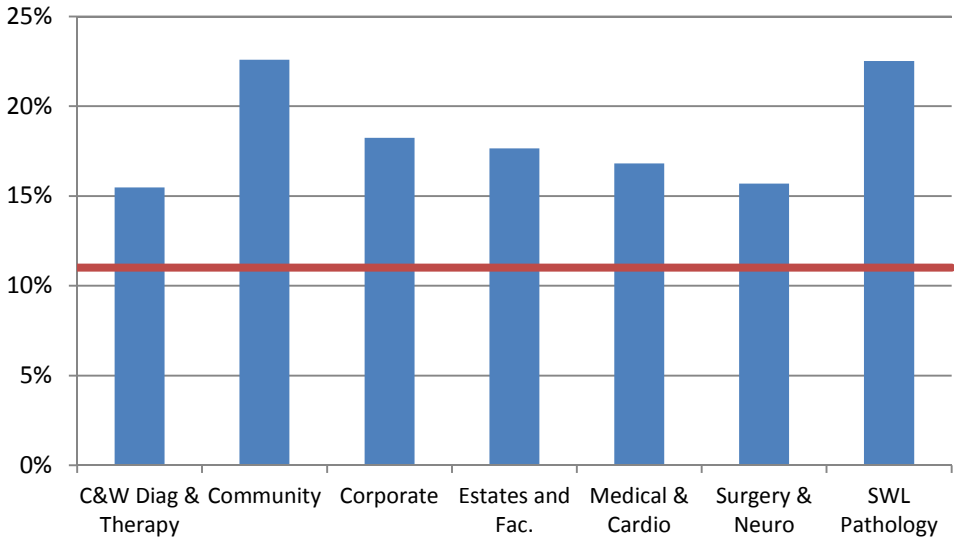


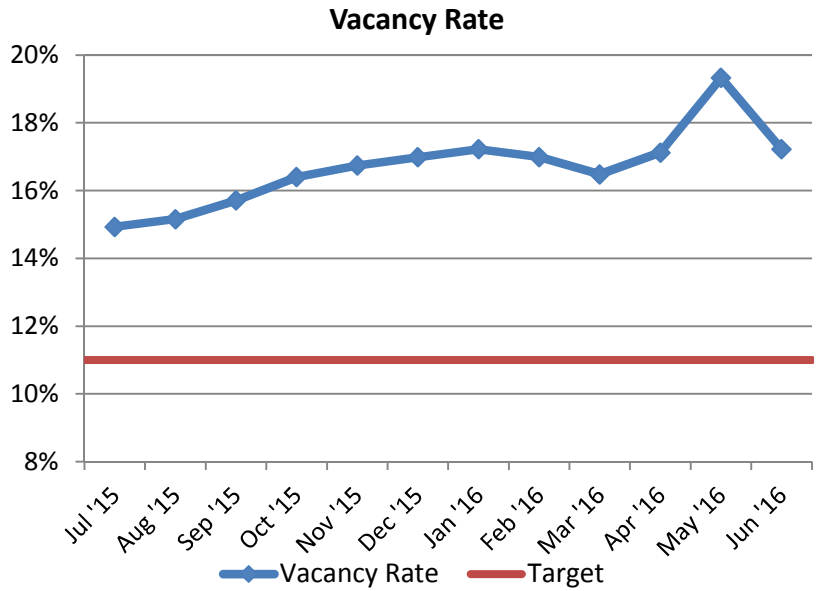
COMMENTARY

The Trust currently employs 8599 people working a whole time equivalent of 8043 which is 27 WTE higher than May. The growth rate in the directly employed workforce since June 2015 is 187 WTE or 2.4%.

The Trust also employs an additional 436 WTE GP Trainees covering the South London area, which makes the total WTE 8478.

Section 1: Vacancies





Vacancies by Division	Mar '16	Apr '16	May '16	Jun '16	Trend
C&W Diag & Therapy	15.1%	16.0%	15.1%	15.5%	↗
Community	19.4%	20.8%	38.1%	22.6%	↘
Corporate	17.9%	20.2%	20.3%	18.2%	↘
Estates and Fac.	13.5%	5.8%	9.7%	17.7%	↗
Medical & Cardio	16.2%	15.0%	18.5%	16.8%	↘
Surgery & Neuro	15.6%	18.6%	15.8%	15.7%	↘
SWL Pathology	20.9%	19.9%	22.6%	22.5%	↘
Whole Trust	**16.5%**	**17.1%**	**19.3%**	**17.2%**	↘

Vacancies Staff Group	Mar '16	Apr '16	May '16	Jun '16	Trend
Add Prof Scientific and Technic	16.9%	15.8%	14.2%	15.8%	↗
Additional Clinical Services	12.8%	23.9%	26.5%	20.8%	↘
Administrative and Clerical	17.3%	18.2%	18.8%	17.2%	↘
Allied Health Professionals	14.4%	17.0%	19.4%	18.1%	↘
Estates and Ancillary	14.3%	4.7%	11.2%	17.3%	↗
Healthcare Scientists	35.3%	13.8%	13.3%	14.1%	↗
Medical and Dental	9.4%	5.9%	10.8%	7.9%	↘
Nursing and Midwifery Registered	17.9%	19.9%	22.4%	19.9%	↘
Total	**16.5%**	**17.1%**	**19.3%**	**17.2%**	↘

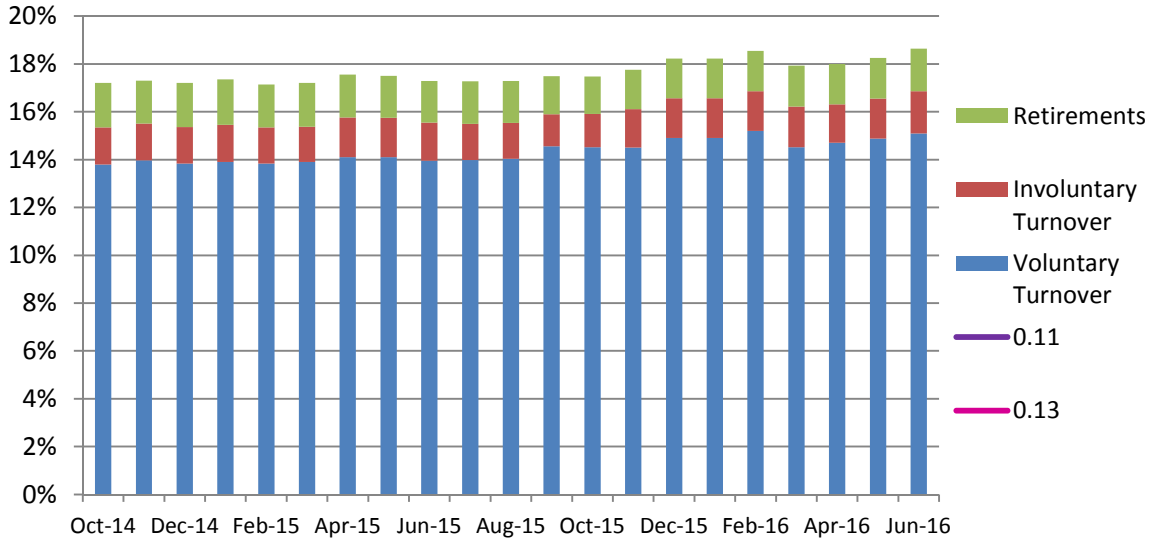
COMMENTARY

The vacancy rate has decreased in June. Updating new budgets on ESR is in progress so the reported rate is now more reflective of the true vacancy rate than May.

The Community Services Division in particular still has some reconciliation to be done as the reported rate is high (around 15% is more accurate). Work is on-going to reconcile ESR to the ledger to improve accuracy for July.

Section 2a: Gross Turnover

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



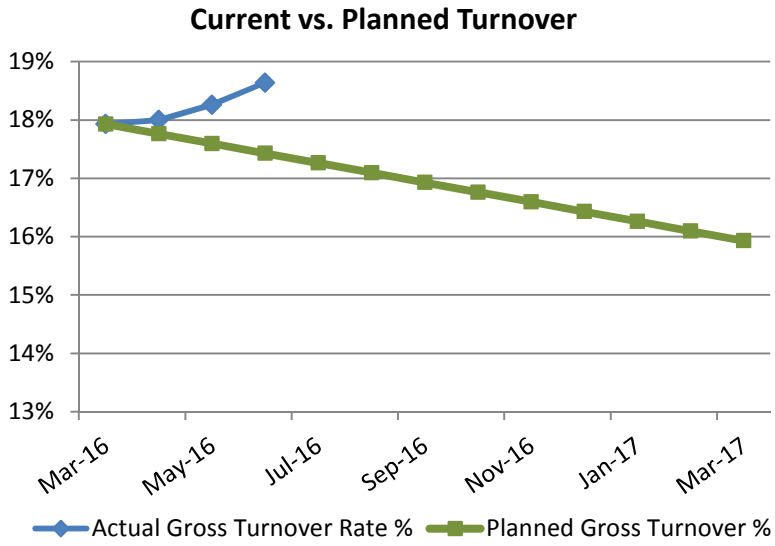
COMMENTARY

The total trust turnover rate has increased this month to 18.6%. This is significantly above the current target of 13%. In the last 12 months there have been 1365 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	Mar '16	Apr '16	May '16	Jun '16	Trend
C&W Diagnostic & Therapy	18.7%	19.2%	19.6%	19.6%	↔
Community Services	20.5%	20.3%	21.0%	20.8%	↘
Corporate	23.4%	22.0%	20.9%	21.5%	↗
Estates and Facilities	14.0%	10.9%	11.5%	13.4%	↗
Medical & Cardiothoracics	17.5%	17.7%	18.2%	18.5%	↗
Surgery, Neurosciences & Anaes	14.9%	15.4%	15.5%	16.3%	↗
SWL Pathology	17.7%	19.2%	18.7%	19.7%	↗
Whole Trust	**17.9%**	**18.0%**	**18.3%**	**18.6%**	↗

	All Turnover				
Staff Group	Mar '16	Apr '16	May '16	Jun '16	Trend
Add Prof Scientific and Technic	21.8%	21.8%	22.2%	22.5%	↗
Additional Clinical Services	18.4%	17.8%	18.1%	18.7%	↗
Administrative and Clerical	18.1%	17.2%	17.4%	17.8%	↗
Allied Health Professionals	19.8%	20.1%	21.9%	23.0%	↗
Estates and Ancillary	5.8%	6.6%	7.8%	9.1%	↗
Healthcare Scientists	17.9%	17.2%	17.2%	18.2%	↗
Medical and Dental	11.6%	12.6%	12.2%	11.3%	↘
Nursing and Midwifery Registered	18.7%	19.4%	19.3%	19.7%	↗
Whole Trust	**17.9%**	**18.0%**	**18.3%**	**18.6%**	↗



Section 2b: Voluntary Turnover

	Voluntary Turnover					Other Turnover Jun 2016	
Division	Mar '16	Apr '16	May '16	Jun '16	Trend	In-Voluntary	Retirement
C&W Diagnostic & Therapy	15.5%	15.8%	16.0%	16.1%	↗	2.1%	1.3%
Community Services	15.1%	15.1%	15.6%	15.4%	↘	1.9%	3.6%
Corporate	19.7%	18.0%	17.2%	17.3%	↗	2.1%	2.2%
Estates and Facilities	8.2%	8.6%	8.8%	10.0%	↗	2.3%	1.0%
Medical & Cardiothoracics	15.0%	15.4%	15.9%	16.0%	↗	1.3%	1.2%
Surgery, Neurosciences & Anaes	12.2%	12.6%	12.5%	13.0%	↗	1.6%	1.6%
SWL Pathology	13.7%	14.5%	14.8%	14.7%	↘	0.9%	4.1%
Whole Trust	**14.5%**	**14.7%**	**14.9%**	**15.1%**	↗	**1.8%**	**1.8%**

	Voluntary Turnover					Other Turnover Jun 2016	
Staff Group	Mar '16	Apr '16	May '16	Jun '16	Trend	In-Voluntary	Retirement
Add Prof Scientific and Technic	15.1%	15.2%	15.5%	15.8%	↗	5.5%	1.1%
Additional Clinical Services	15.5%	15.0%	15.3%	15.6%	↗	1.4%	1.7%
Administrative and Clerical	13.6%	13.2%	13.2%	13.5%	↗	1.9%	2.3%
Allied Health Professionals	18.5%	18.6%	19.8%	21.0%	↗	1.0%	1.0%
Estates and Ancillary	4.4%	5.3%	6.1%	6.5%	↗	0.8%	1.7%
Healthcare Scientists	14.5%	13.9%	14.4%	14.3%	↘	0.7%	3.1%
Medical and Dental	5.5%	5.9%	5.7%	5.1%	↘	4.6%	1.6%
Nursing and Midwifery Registered	16.3%	17.1%	17.1%	17.2%	↗	0.8%	1.7%
Whole Trust	**14.5%**	**14.7%**	**14.9%**	**15.1%**	↗	**1.8%**	**1.8%**

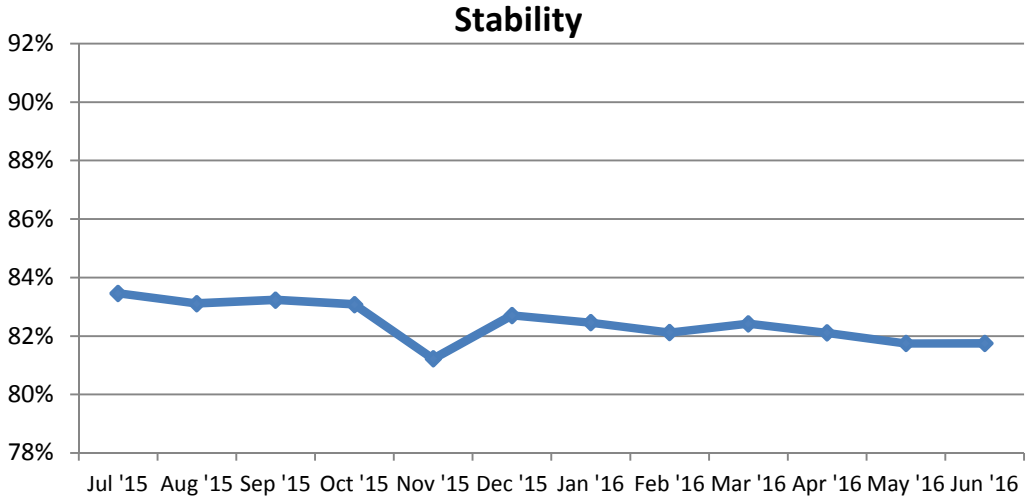
Caregroup	Staff in Post WTE	Leavers WTE	Voluntary Turnover Rate
Ops & Service Improvement	22.0	7.9	38.1%
Chest Medicine	29.1	7.5	28.6%
Medical Oncology & Palliative Care	89.8	21.7	26.7%
SWLP Microbiology	67.0	17.3	24.1%
Neonatal	154.4	33.4	23.1%

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	Mar '16	Apr '16	May '16	Jun '16	Trend
C&W Diagnostic & Therapy	82.3%	81.7%	81.0%	80.1%	↘
Community Services	79.1%	79.1%	78.8%	80.7%	↗
Corporate	78.1%	78.4%	78.5%	81.5%	↗
Estates and Facilities	87.2%	89.3%	89.0%	86.5%	↘
Medical & Cardiothoracics	81.5%	81.4%	81.2%	81.5%	↗
Surgery, Neurosciences & Anaes	85.6%	85.0%	84.5%	84.2%	↘
SWL Pathology	83.7%	81.8%	81.6%	80.8%	↘
Whole Trust	**82.4%**	**82.1%**	**81.7%**	**81.7%**	↔

Stability Staff Group	Mar '16	Apr '16	May '16	Jun '16	Trend
Add Prof Scientific and Technic	74.1%	71.5%	72.0%	71.1%	↘
Additional Clinical Services	86.0%	84.4%	85.8%	85.2%	↘
Administrative and Clerical	83.9%	84.2%	83.0%	83.9%	↗
Allied Health Professionals	79.8%	78.8%	76.3%	75.4%	↘
Estates and Ancillary	93.3%	92.1%	90.8%	88.6%	↘
Healthcare Scientists	88.9%	90.8%	91.6%	90.7%	↘
Medical and Dental	90.1%	89.6%	89.1%	90.5%	↗
Nursing and Midwifery Registered	80.2%	80.4%	80.3%	80.3%	↔
Total	**82.4%**	**82.1%**	**81.7%**	**81.7%**	↔

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.

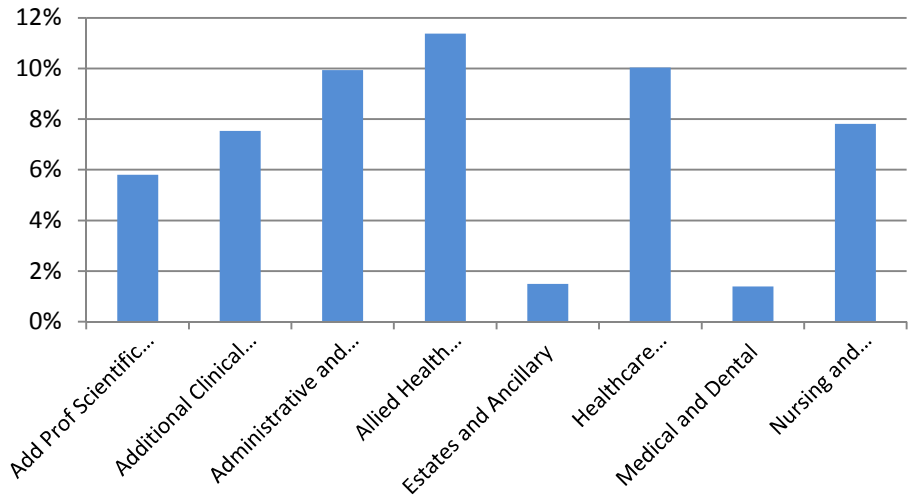
The stability rate has remained the same this month.

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

Over the last 12 months the stability rate has declined by 1.5% and is now at 81.7%.

Section 4: Staff Career Development

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



COMMENTARY

Staff exit survey data tells us that one of the key drivers for retaining staff is to support their development within the trust. In June 76 staff were promoted, there were 133 new starters to the Trust and 182 employees were acting up to a higher grade.

Over the last year 7.8% 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.

The Allied Health Professionals staff group have the highest promotion rate at 11.4% followed by Healthcare Scientists at 10.0%.

	No. of Promotions				
Division	Mar '16	Apr '16	May '16	Jun '16	Trend
C&W Diagnostic & Therapy	25	22	34	35	↗
Community Services	10	14	12	15	↗
Corporate	5	5	9	8	↘
Estates and Facilities	1	0	1	0	↘
Medical & Cardiothoracics	6	8	8	8	↔
Surgery, Neurosciences & Anaes	13	8	15	8	↘
SWL Pathology	1	3	6	2	↘
Whole Trust Promotions	**61**	**60**	**85**	**76**	↘
New Starters (Excludes Junior Doctors)	**75**	**157**	**117**	**133**	↗

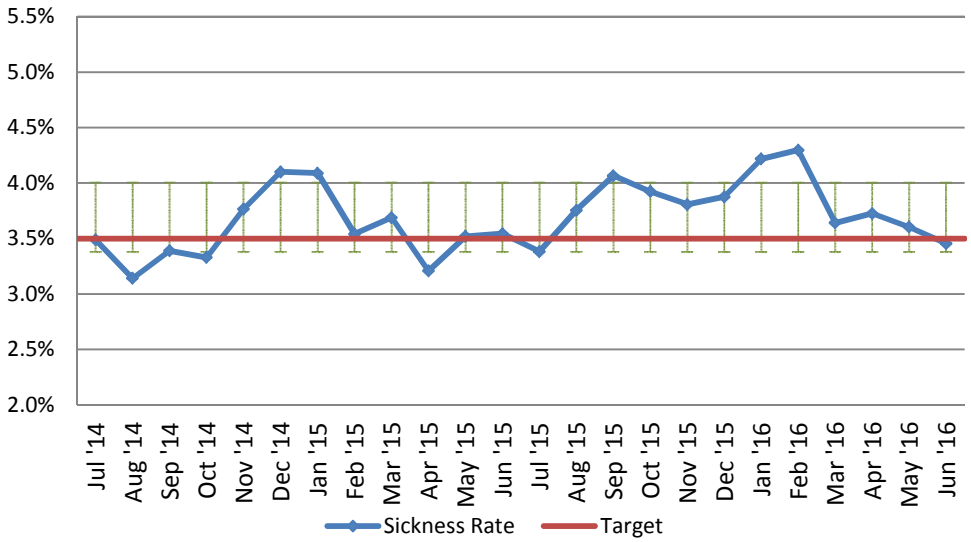
Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	2051	176	8.6%	77
Community Services	723	45	6.2%	9
Corporate	435	48	11.0%	24
Estates and Facilities	254	4	1.6%	8
Medical & Cardiothoracics	1288	82	6.4%	37
Surgery, Neurosciences & Anaes	1383	89	6.4%	20
SWL Pathology	301	55	18.3%	7
Whole Trust	**6435**	**499**	**7.8%**	**182**
New Starters (Excludes Junior Doctors)		**1481**		

	No. of Promotions				
Staff Group	Mar '16	Apr '16	May '16	Jun '16	Trend
Add Prof Scientific and Technic	6	3	1	1	↔
Additional Clinical Services	2	7	10	7	↘
Administrative and Clerical	16	15	25	27	↗
Allied Health Professionals	5	12	19	17	↘
Estates and Ancillary	1	0	0	0	↔
Healthcare Scientists	1	2	6	0	↘
Medical and Dental	0	1	0	0	↔
Nursing and Midwifery Registered	30	20	24	24	↔
Whole Trust	**61**	**60**	**85**	**76**	↘

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	465	27	5.8%	29
Additional Clinical Services	717	54	7.5%	7
Administrative and Clerical	1319	131	9.9%	58
Allied Health Professionals	536	61	11.4%	26
Estates and Ancillary	201	3	1.5%	4
Healthcare Scientists	249	25	10.0%	5
Medical and Dental	502	7	1.4%	2
Nursing and Midwifery Registered	2446	191	7.8%	51
Whole Trust	**6435**	**499**	**7.8%**	**182**

Section 5: Sickness

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



COMMENTARY

Sickness absence is at 3.5% for June, which is a decrease of 0.1% on the previous month. Analysis of reasons for absence this month shows 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 June 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	Mar '16	Apr '16	May '16	Jun '16	Trend
C&W Diagnostic & Therapy	4.1%	3.7%	3.7%	3.5%	↘
Community Services	4.7%	5.7%	5.0%	4.8%	↘
Corporate	3.6%	3.4%	3.1%	3.2%	↗
Estates and Facilities	4.7%	4.5%	4.4%	4.4%	↔
Medical & Cardiothoracics	2.9%	3.2%	3.4%	3.3%	↘
Surgery, Neurosciences & Anaes	3.3%	3.3%	3.3%	3.1%	↘
SWL Pathology	2.5%	3.9%	2.6%	2.4%	↘
Whole Trust	**3.6%**	**3.7%**	**3.6%**	**3.5%**	↘

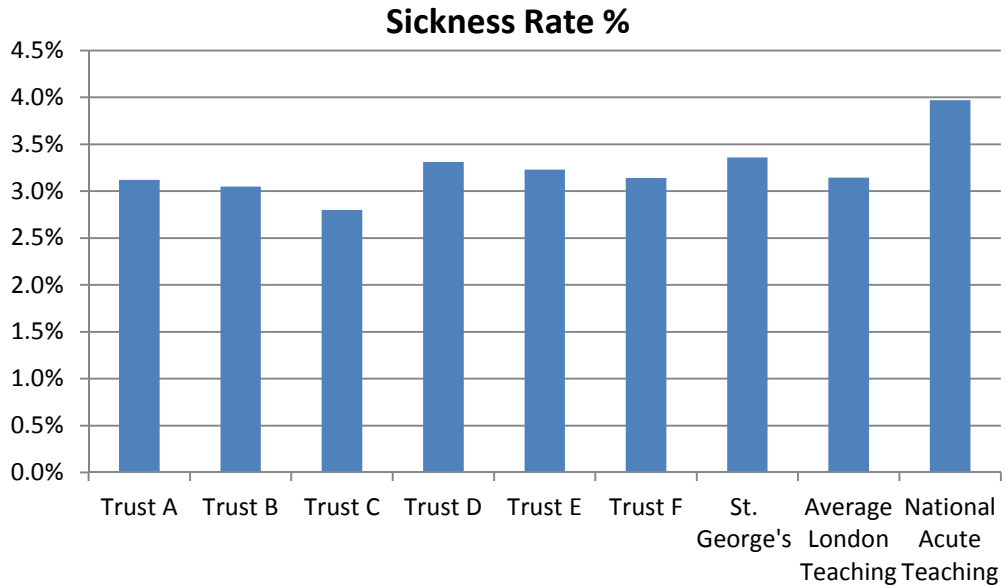
Sickness Staff Group	Mar '16	Apr '16	May '16	Jun '16	Trend
Add Prof Scientific and Technic	3.0%	2.9%	2.7%	2.6%	↘
Additional Clinical Services	5.7%	5.9%	5.6%	4.9%	↘
Administrative and Clerical	4.9%	4.5%	4.2%	4.0%	↘
Allied Health Professionals	3.7%	2.9%	3.0%	3.2%	↗
Estates and Ancillary	5.2%	5.5%	5.5%	6.0%	↗
Healthcare Scientists	2.2%	2.6%	1.6%	2.5%	↗
Medical and Dental	1.5%	1.4%	1.5%	1.1%	↘
Nursing and Midwifery Registered	3.4%	3.9%	3.8%	3.8%	↔
Total	**3.6%**	**3.7%**	**3.6%**	**3.5%**	↘

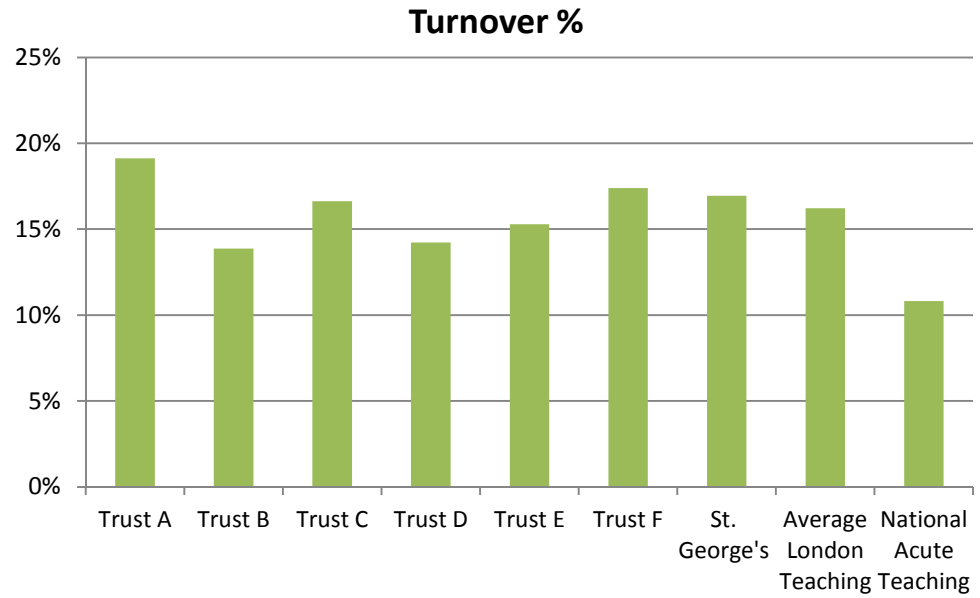
Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Energy and Engineering	50.75	128.43	8.4%	£7,925
Computing Directorate	44.67	103.37	7.5%	£7,712
Community Adult Health & IP Rehab Services	247.80	510.96	7.2%	£34,468
Offender Healthcare HMPW Services	53.63	99.98	6.4%	£7,070
Facilities Services	119.96	223.80	6.2%	£10,623

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	27.77%
S25 Gastrointestinal problems	16.69%
S12 Other musculoskeletal problems	8.83%
S10 Anxiety/stress/depression/other psychiatric illnesses	6.89%
S16 Headache / migraine	6.66%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S13 Cold, Cough, Flu - Influenza	16.13%
S10 Anxiety/stress/depression/other psychiatric illnesses	15.91%
S12 Other musculoskeletal problems	14.11%
S25 Gastrointestinal problems	9.44%
S11 Back Problems	6.14%

Section 6: Workforce Benchmarking





COMMENTARY

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

Sickness data shown is from March '16 which is the most recent available. Compared to other Acute teaching trusts in London, St. Georges had a rate higher than average at 3.36%. 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 March.

The bottom graph shows the comparison of turnover rates for the same group of London teaching trusts (excluding junior medical staff). This is the total turnover rate including all types of leavers (voluntary resignations, retirements, end of fixed term contracts etc.). St. Georges currently has higher than average turnover compared to the group (12 months to end April). Stability is lower than average. High turnover is more of an issue in London trusts than it is nationally which is reflected in the national average rate which is 6% 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	19.12%	80.69%	3.12%
Trust B	13.88%	85.66%	3.05%
Trust C	16.62%	83.08%	2.80%
Trust D	14.23%	85.36%	3.31%
Trust E	15.29%	84.54%	3.23%
Trust F	17.40%	82.67%	3.14%
St. George's	16.94%	82.89%	3.36%
Average London Teaching	16.21%	83.56%	3.14%
National Acute Teaching	10.82%	88.97%	3.97%

Section 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Mar '16	Apr '16	May '16	Jun '16	Trend
C&W Diagnostic & Therapy	1152.9	1156.9	1174.7	1189.6	↗
Community Services	598.4	598.4	687.8	504.5	↘
Corporate & R&D	63.4	64.1	64.3	70.7	↗
Medical & Cardiothoracics	1275.9	1275.9	1316.3	1324.9	↗
Surgery, Neurosciences & Anaes	1111.0	1196.7	1165.7	1165.7	↔
Total	4201.6	4292.0	4408.7	4255.3	↘

Nursing Staff in Post WTE

Division	Mar '16	Apr '16	May '16	Jun '16	Trend
C&W Diagnostic & Therapy	1004.4	993.1	1007.7	1014.9	↗
Community Services	437.7	429.6	386.6	387.1	↗
Corporate & R&D	54.1	54.7	55.7	56.7	↗
Medical & Cardiothoracics	1003.9	1019.8	1040.9	1049.2	↗
Surgery, Neurosciences & Anaes	908.0	910.7	920.4	923.1	↗
Total	3408.0	3407.9	3411.4	3431.1	↗

Nursing Vacancy Rate

Division	Mar '16	Apr '16	May '16	Jun '16	Trend
C&W Diagnostic & Therapy	12.9%	14.2%	14.2%	14.7%	↗
Community Services	26.8%	28.2%	43.8%	23.3%	↘
Corporate & R&D	14.7%	14.7%	13.4%	19.8%	↗
Medical & Cardiothoracics	21.3%	20.1%	20.9%	20.8%	↘
Surgery, Neurosciences & Anaes	18.3%	23.9%	21.0%	20.8%	↘
Total	18.9%	20.6%	22.6%	19.4%	↘

Nursing Sickness Rates

Division	Mar '16	Apr '16	May '16	Jun '16	Trend
C&W Diagnostic & Therapy	4.7%	4.0%	4.1%	4.1%	↗
Community Services	5.2%	6.7%	5.7%	6.1%	↗
Corporate	2.6%	2.7%	4.2%	3.7%	↘
Medical & Cardiothoracics	3.3%	3.9%	3.6%	3.5%	↘
Surgery, Neurosciences & Anaes	3.4%	3.9%	4.4%	3.8%	↘
Total	4.0%	4.3%	4.2%	4.1%	↘

Nursing Voluntary Turnover

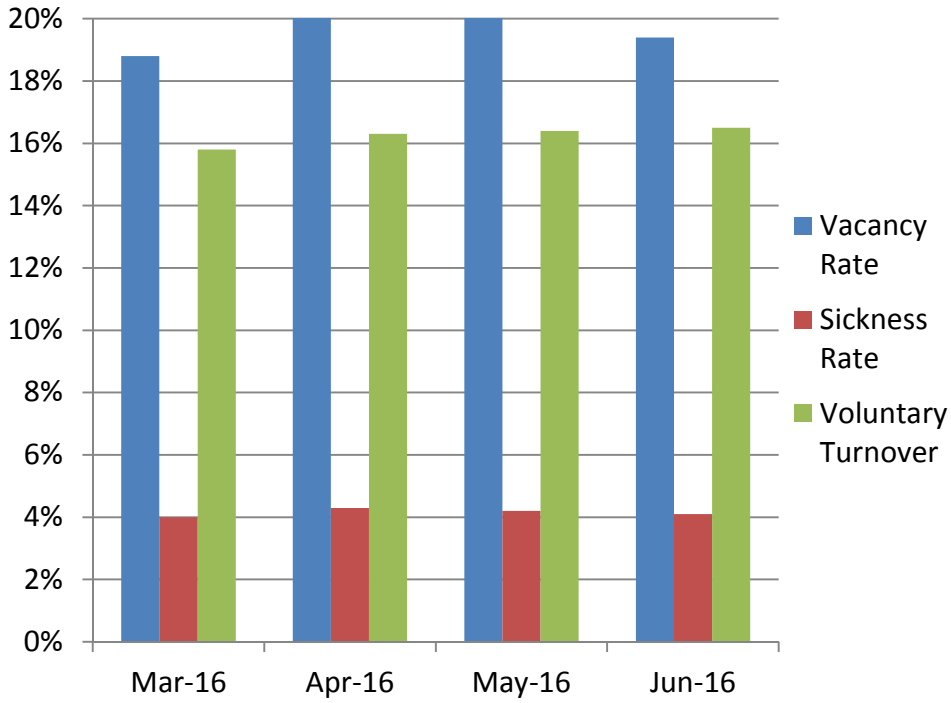
Division	Mar '16	Apr '16	May '16	Jun '16	Trend
C&W Diagnostic & Therapy	14.07%	14.50%	14.18%	14.51%	↗
Community Services	16.82%	17.08%	18.05%	17.35%	↘
Corporate & R&D	13.05%	12.36%	14.08%	10.21%	↘
Medical & Cardiothoracics	17.96%	18.41%	18.94%	19.13%	↗
Surgery, Neurosciences & Anaes	15.03%	15.74%	15.42%	15.87%	↗
Total	15.8%	16.3%	16.4%	16.5%	↗

COMMENTARY

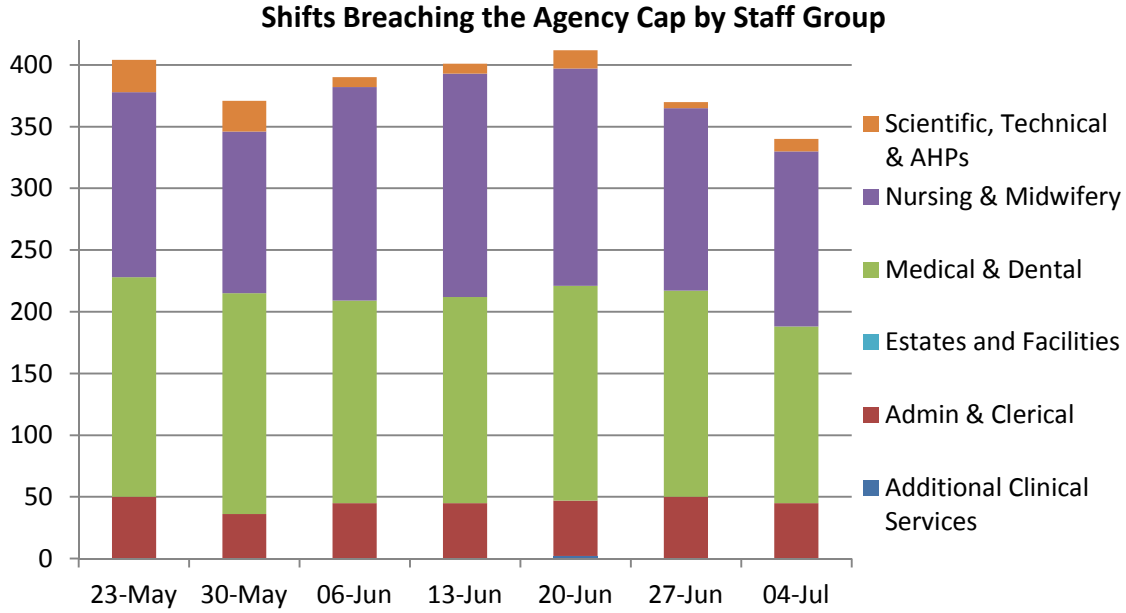
This data shows a more in-depth view of our nursing workforce (both qualified and unqualified).

The nursing workforce has increased by 19.7 WTE in June.

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	23-May	30-May	06-Jun	13-Jun	20-Jun	27-Jun	04-Jul
Additional Clinical Services	0	0	0	0	2	0	0
Admin & Clerical	50	36	45	45	45	50	45
Estates and Facilities	0	0	0	0	0	0	0
Medical & Dental	178	179	164	167	174	167	143
Nursing & Midwifery	150	131	173	181	176	148	142
Scientific, Technical & AHPs	26	25	8	8	15	5	10
Whole Trust	404	371	390	401	412	370	340

Agency Cap Shift Breaches by Division	23-May	30-May	06-Jun	13-Jun	20-Jun	27-Jun	04-Jul
C&W Diagnostic & Therapy	80	80	86	88	94	65	55
Community Services	75	69	74	79	81	69	69
Corporate	75	60	70	70	70	75	45
Estates and Facilities	0	0	0	0	0	0	0
Medical & Cardiothoracics	126	113	114	106	117	99	98
Surgery, Neurosciences & Anaes	48	49	46	58	50	62	48
SWL Pathology	0	0	0	0	0	0	0
Whole Trust	404	371	390	401	412	370	315

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 NHS Improvement.

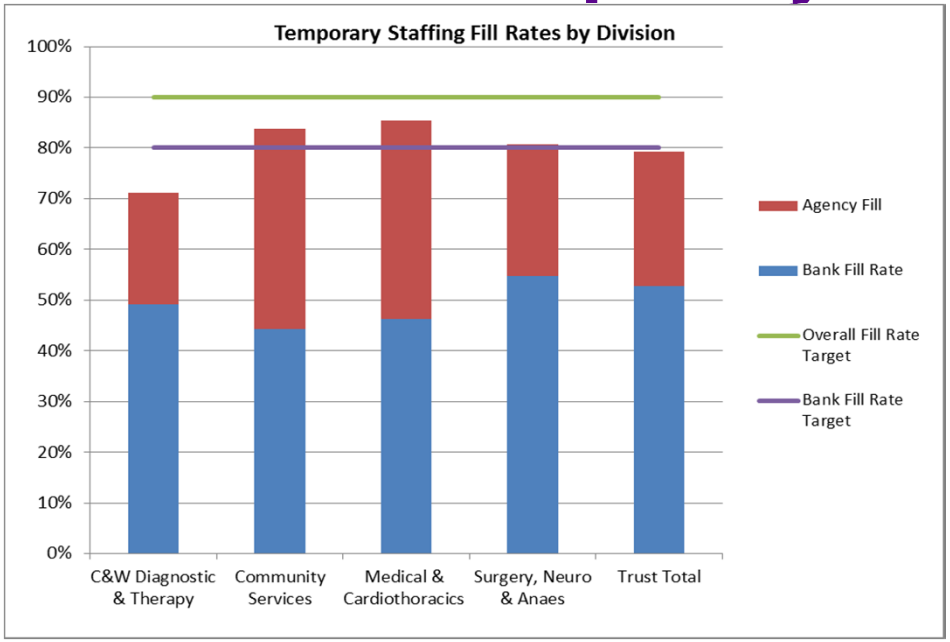
Work is on-going to stop using agencies which breach the caps where possible.

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

New lower capped rates were introduced from the 1st of April which are reflected in the increased number of breached Nursing & Midwifery shifts now being reported.

For the week commencing 4th of July, the Medical & Cardiothoracic Division had the largest number of breaches in the Medical and Dental staff group (74). The Children & Women's Division had the highest number of Nursing & Midwifery breaches in that week (55).

Section 9: Temporary Staff Fill Rates



COMMENTARY

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

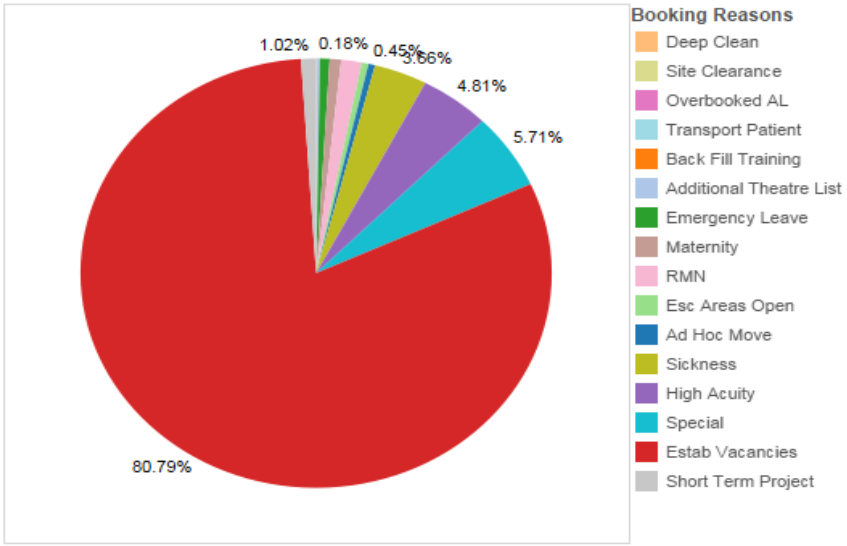
The "Overall Fill Rate" is the percentage number of requests made to the Staff Bank to cover shifts which were filled by either trust bank staff, or by an agency. The remainder of requests which could not be covered by either group are recorded as being unfilled. The "Bank Fill Rate" describes requests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

In June the Bank Fill Rate was reported at 52.8% which is 2.5% lower than the previous month. The Overall Fill Rate was 79.2% which is a decrease of 2%. The Medical & Cardiovascular Division is currently meeting the demand for temporary staff most effectively.

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

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

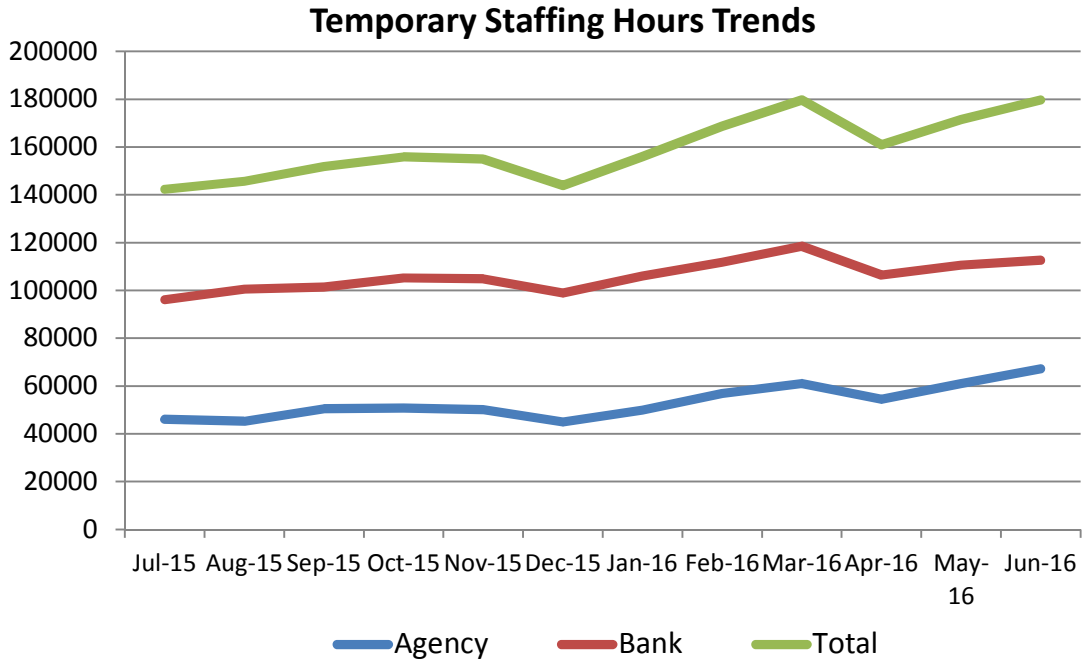
Monthly Reasons PIE



Bank Fill Rate % by Division	Mar '16	Apr '16	May '16	Jun '16	Trend
C&W Diagnostic & Therapy	52.4%	59.0%	53.9%	49.1%	↘
Community Services	44.4%	45.8%	46.4%	44.3%	↘
Medical & Cardiothoracics	46.0%	45.5%	47.0%	46.3%	↘
Surgery, Neurosciences & Anaes	52.3%	52.7%	56.7%	54.8%	↘
Whole Trust	**52.7%**	**55.1%**	**55.4%**	**52.8%**	↘

Overall Fill Rate % by Division	Mar '16	Apr '16	May '16	Jun '16	Trend
C&W Diagnostic & Therapy	73.7%	77.2%	76.5%	71.2%	↘
Community Services	85.1%	83.9%	86.7%	83.8%	↘
Medical & Cardiothoracics	79.4%	81.0%	83.5%	85.5%	↗
Surgery, Neurosciences & Anaes	74.2%	75.3%	79.6%	80.8%	↗
Whole Trust	**77.8%**	**79.0%**	**81.2%**	**79.2%**	↘

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 June.

Agency hours have increased substantially in all clinical Divisions. In the Medicine and Cardiothoracic Division this was particularly in Acute Wards and Renal. In the Children in Women's Division, increases are seen in Outpatients (Medical Records) and Diagnostics (Radiography).

The Community Services Division proportionately has the highest increase in bank hours this month. Departments with increases are Radiology and Minor Injuries.

TYPE	Division	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Agency	C&W Diagnostic & Therapy	9638	9408	10033	11112	10724	11615	11158	14779	16404	14872	16869	19956
	Community Services	6077	6422	6421	7086	6605	6715	7298	8717	10225	8709	9108	8989
	Corporate	529	46	423	402	384	541	1021	793	610	866	1401	999
	Estates and Facilities	0	0	0	4	166	322	140	176	180	361	549	321
	Medical & Cardiothoracics	20429	20348	24428	21792	22626	19732	23154	23159	23779	21106	24231	26734
	Surgery, Neurosciences & Anaes	9195	8730	8860	9994	9362	5953	7161	9211	9885	8584	8767	9887
	SWL Pathology	228	245	352	267	150	143	0	0	0	0	90	257
Agency Total		**46097**	**45199**	**50517**	**50657**	**50017**	**45021**	**49932**	**56835**	**61083**	**54498**	**61015**	**67143**
Bank	C&W Diagnostic & Therapy	25990	26657	30745	32858	31790	30886	33343	34999	32870	31037	30935	31409
	Community Services	8252	9033	8695	9149	9133	9005	9225	9796	10885	9005	8916	9340
	Corporate	7972	7206	8828	11156	9858	8426	8674	8773	9078	10249	10124	10224
	Estates and Facilities	9216	8910	8264	8506	9423	8467	8428	10122	10078	9021	9739	9914
	Medical & Cardiothoracics	26255	29728	27842	26409	28073	25363	26990	26921	29610	25231	27418	28459
	Surgery, Neurosciences & Anaes	14740	15545	16118	16265	15754	15791	18358	20155	22946	18370	19098	18549
	SWL Pathology	3751	3389	803	821	839	998	1016	1050	3063	3463	4281	4668
Bank Total		**96177**	**100468**	**101295**	**105164**	**104870**	**98936**	**106034**	**111816**	**118530**	**106376**	**110511**	**112563**
Temporary Staff Total		**142273**	**145667**	**151811**	**155821**	**154887**	**143957**	**155966**	**168651**	**179613**	**160874**	**171526**	**179706**

Section 11: Temporary Staffing Weekly Tracking

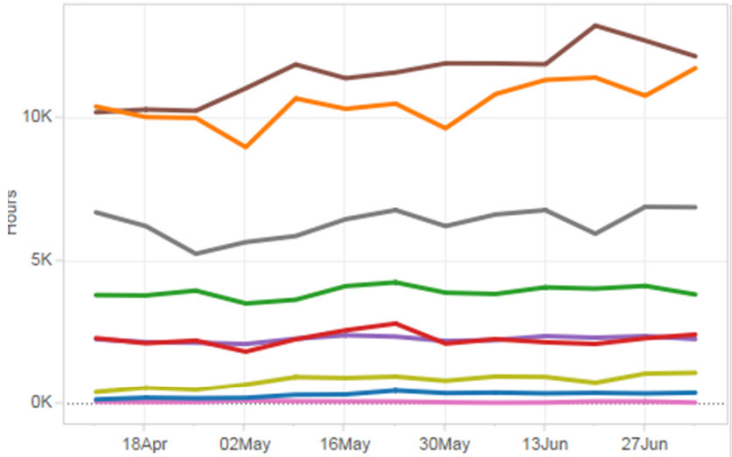
Weekly Hours Used By Division

Division	11 Apr	18 Apr	25 Apr	02 May	09 May	16 May	23 May	30 May	06 Jun	13 Jun	20 Jun	27 Jun	04 Jul
Capital Division	151	212	193	207	316	327	465	373	388	362	379	359	385
Children and Women's Diagnostic and..	10,376	10,010	9,979	8,960	10,659	10,295	10,476	9,618	10,809	11,303	11,384	10,753	11,708
Community Services Division	3,815	3,802	3,971	3,523	3,653	4,127	4,256	3,898	3,853	4,085	4,039	4,136	3,836
Corporate Division	2,316	2,139	2,231	1,846	2,278	2,590	2,824	2,126	2,283	2,174	2,115	2,313	2,441
Estates and Facilities Division	2,282	2,176	2,159	2,111	2,295	2,419	2,370	2,217	2,249	2,387	2,332	2,386	2,284
Medicine and Cardiovascular Division	10,177	10,272	10,227	11,012	11,839	11,360	11,560	11,880	11,876	11,846	13,193	12,670	12,126
Research & Development Division	76	66	65	118	89	83	77	52	37	44	79	80	43
Surgery & Neurosciences Division	6,693	6,215	5,251	5,658	5,870	6,456	6,773	6,214	6,619	6,772	5,950	6,887	6,871
SWL Pathology Division	413	568	496	694	959	928	976	830	982	966	761	1,081	1,111
Grand Total	36,299	35,460	34,570	34,128	37,957	38,585	39,777	37,207	39,098	39,938	40,232	40,664	40,804

Type
- Agency
- Bank

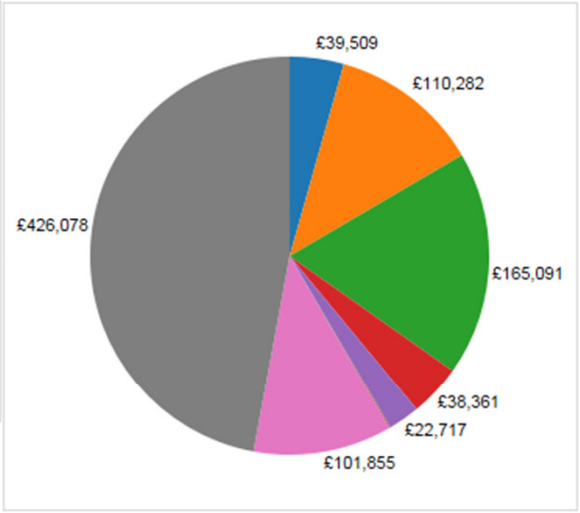
Division
- Capital Division
- Children and Women's D..
- Community Services Divi..
- Corporate Division
- Estates and Facilities Div..
- Medicine and Cardiovasc..
- Research & Developmen..
- Surgery & Neuroscience..
- SWL Pathology Division

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



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

Total Cost
£904,889

Select Date (W/C)
04/07/2016

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

Section 12: Mandatory Training

MAST Topic	May '16	Jun '16	Trend
Conflict Resolution	89.3	89.4	↗
Equality, Diversity and Human Rights	81.2	82.2	↗
Fire Safety	84.1	86.0	↗
Health, Safety and Welfare	83.9	84.9	↗
Infection Prevention and Control Clinical	75.0	74.3	↘
Infection Prevention and Control Non Clinical	76.7	77.5	↗
Information Governance	83.2	81.6	↘
Moving and Handling	81.0	82.4	↗
Moving and Handling Patient	67.6	68.7	↗
Resuscitation BLS	55.5	56.5	↗
Resuscitation ILS	57.1	57.2	↗
Resuscitation Non Clinical	71.6	74.0	↗
Safeguarding Adults	81.4	82.8	↗
Safeguarding Children Level 1	78.6	80.3	↗
Safeguarding Children Level 2	78.6	80.1	↗
Safeguarding Children Level 3	70.6	72.0	↗

COMMENTARY

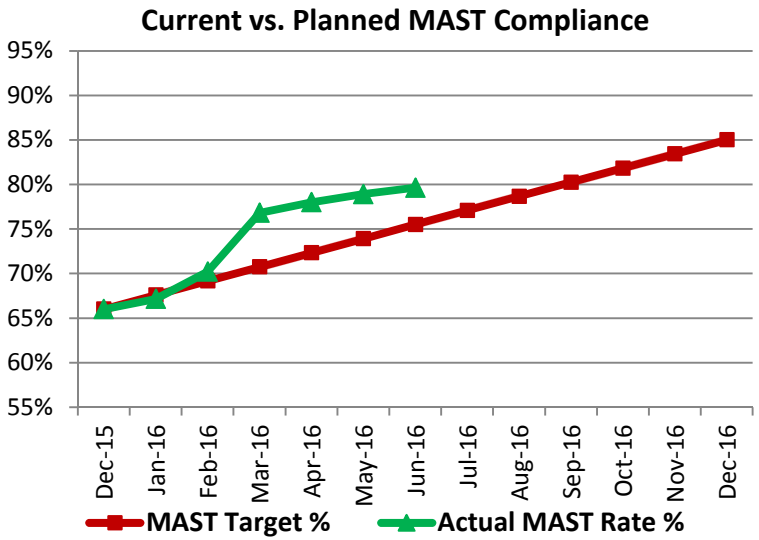
A programme of working is taking place including:

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

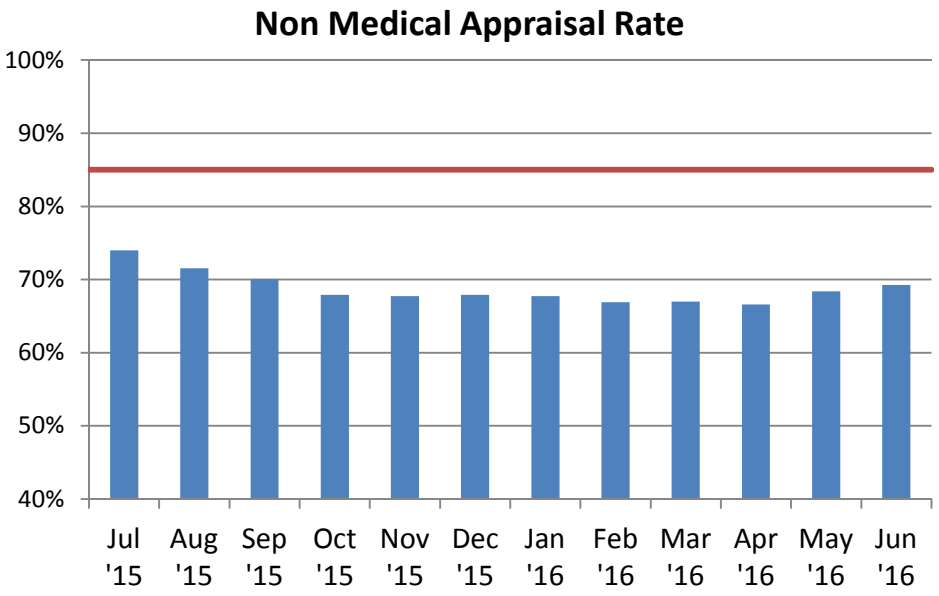
Current Issues:

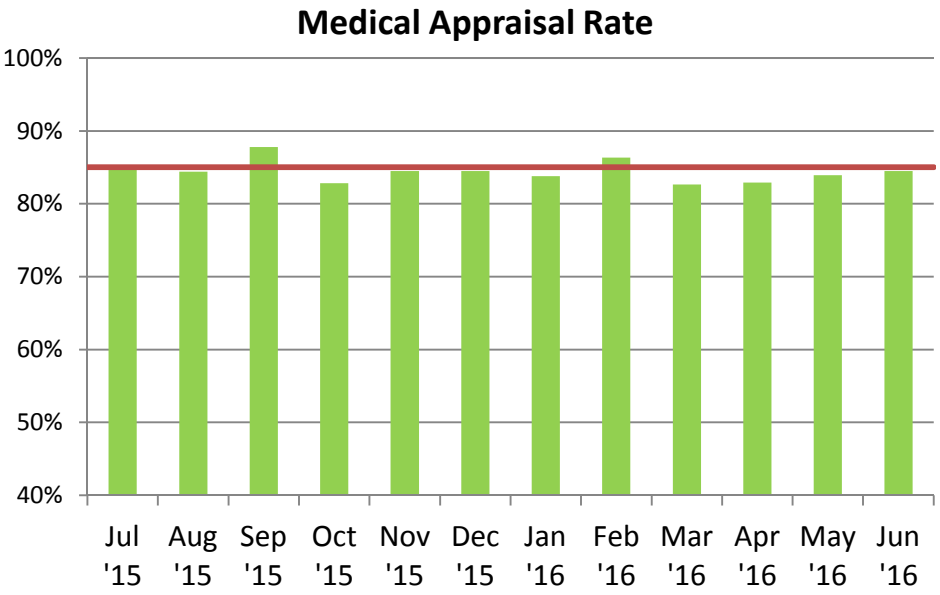
- Fall in compliance rates – largely due to staffing pressures
- Community access to Totara is on the risk register, in the interim we are visiting community sites with tablets and developing a permanent solution in parallel
- Staff unable to access training externally- Software and licencing and IG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

MAST Compliance % by Division	Mar '16	Apr '16	May '16	Jun '16	Trend
C&W Diagnostic & Therapy	77.3%	77.8%	78.9%	79.4%	↗
Community Services	79.1%	81.0%	82.7%	83.6%	↗
Corporate	76.3%	77.6%	78.5%	77.9%	↘
Estates and Facilities	70.9%	70.1%	68.4%	69.5%	↗
Medical & Cardiothoracics	73.1%	75.5%	76.6%	77.8%	↗
Surgery, Neurosciences & Anaes	75.0%	76.1%	77.0%	78.2%	↗
Whole Trust	**76.8%**	**78.0%**	**78.9%**	**79.6%**	↗



Section 13: Appraisal





Non-Medical Commentary

The non-medical appraisal rate has increased by 0.8% this month to 69.3%. Appraisals are still being managed closely by the appraisal project team who are monitoring progress every two weeks and scrutinising divisional plans. The Corporate Division currently has the lowest non-medical compliance rate. Appraisal completion is now linked to incremental progression for bands AFC band 7 - 9 staff. The table below lists the five care groups with the lowest non medical appraisal rate this month

Medical Commentary

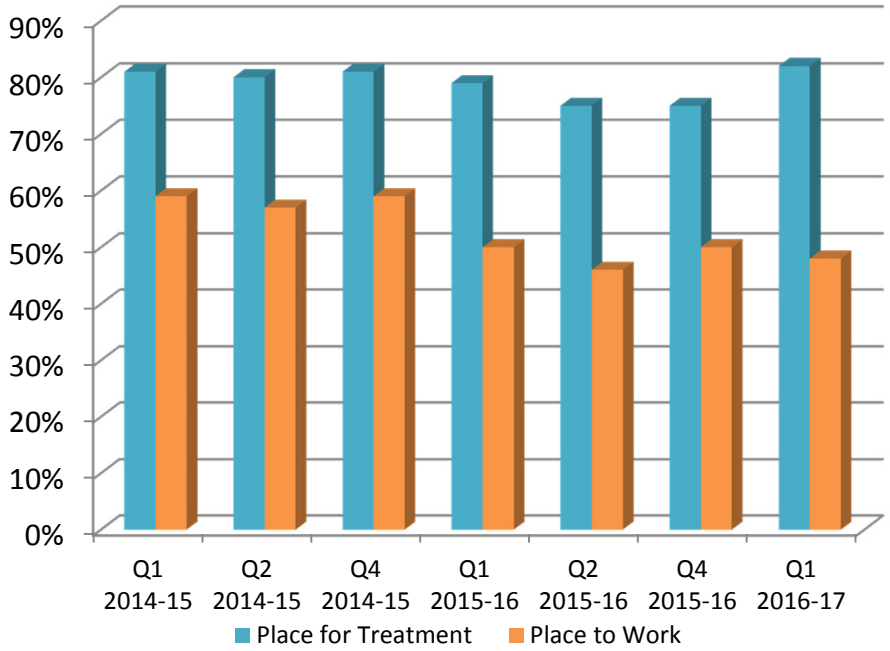
Medical appraisal rate compliance has increased this month to 84.5% which is just below target.

Care Group	Non-Med Appraisal Rate	Staff In Post WTE
SWLP Haematology	4.4%	58.31
SWLP Central Reception	5.7%	56.27
SWLP Biochemistry	11.3%	56.40
Energy and Engineering	24.4%	50.75
Finance Directorate	40.9%	99.64

Non Medical Appraisals by Division	Mar '16	Apr '16	May '16	Jun '16	Trend
C&W Diagnostic & Therapy	65.1%	63.5%	63.8%	66.3%	↗
Community Services	63.3%	64.5%	66.6%	77.8%	↗
Medical & Cardiothoracics	69.2%	68.3%	70.8%	69.7%	↘
Surgery, Neurosciences & Anaes	73.5%	73.3%	77.1%	80.2%	↗
Corporate	61.2%	62.0%	64.0%	65.2%	↗
Estates & Facilities	62.0%	64.5%	64.0%	62.8%	↘
Whole Trust	**67.0%**	**66.6%**	**68.4%**	**69.3%**	↗

Medical Appraisals by Division	Mar '16	Apr '16	May '16	Jun '16	Trend
C&W Diagnostic & Therapy	84.1%	85.5%	85.4%	87.3%	↗
Community Services	88.9%	92.6%	87.5%	79.2%	↘
Medical & Cardiothoracics	82.1%	85.4%	86.8%	82.0%	↘
Surgery, Neurosciences & Anaes	84.9%	83.4%	87.5%	86.6%	↘
Corporate	100.0%	100.0%	75.0%	75.0%	↔
Whole Trust	**82.7%**	**82.9%**	**83.9%**	**84.5%**	↗

Section 14: Friends & Family Test



Quarter	No. of Respondants	Place for Treatment	Place to Work
Q1 2014-15	772	81%	59%
Q2 2014-15	908	80%	57%
Q4 2014-15	1112	81%	59%
Q1 2015-16	695	79%	50%
Q2 2015-16	274	75%	46%
Q4 2015-16	508	75%	50%
Q1 2016-17	197	82%	48%

The NHS Friends and Family Test (FFT) for staff has been carried out at the Trust since June 2014 and is a measure of staff engagement.

The information shown here are the responses given by our staff to the following questions:

“How likely are you to recommend this organisation to friends and family if they needed care or treatment?”

“How likely are you to recommend this organisation to friends and family as a place to work?”

The figures show a downward trend in the percentage of staff recommending the Trust as a place to work. The percentage who recommend the Trust as a place for treatment has remained fairly stable at around 80%.

Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD 28 JULY 2016 **Paper Ref:**

Paper Title:	**Referral To Treatment (RTT) Recovery Programme Update**
Sponsoring Director:	**Corinne Siddall – Chief Operating Officer**
Author:	**Corinne Siddall - Chief Operating Officer** **Larry Murphy – Chief Information Officer** **Luke Edwards - Head of Governance**
Purpose: *The purpose of bringing the report to the board*	To update the Board on the progress made with regards to the RTT Recovery Programme
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*	**Trust Board June 2016**

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

1. Key messages
Update on the current position and next steps in our Referral to Treatment process recovery programme

2. Recommendation
The Board are asked to approve the next steps as outlined in the paper

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?

- Breach of NHS Constitutional Standards
- Risk of delayed diagnosis or treatment
- Risk of breach of CQC certificate of registration

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.*	**Safety and Compliance**

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. N/A

Referral to Treatment (RTT) Recovery Programme Update

Issue

A commissioned review of RTT data and wider data quality within the organisation identified a lack of robust arrangements in place for ensuring that appropriate and timely triaging of referrals received into the organisation was undertaken. The trust only recently received the provisional assessment of RTT data quality and it raises significant issues with regards to the accuracy of the data describing RTT pathways. There is an imperative for the trust to embark on a timely assessment of this data set to determine any high-risk groups and to understand whether any patients may have come to harm as a result of these issues

Introduction

In 2010, Cerner was deployed at the St Georges site as part of the National Programme for IT. The Queen Mary Roehampton (QMH) site did not undergo any upgrade and remains on a CSC Clinicom PAS (Patient Administration System). In February 2014 the Trust upgraded this system to include, amongst other things additional RTT functionality. However, problems during implementation undermined confidence in the Trust's ability to report and track RTT data from this system. The result of this has been the development of a number of manual workarounds, which, in a review carried out by the Intensive Support Team (IST) in February 2016, were found to have a number of flaws. Some of the more significant concerns were:

- Significant numbers of unknown clock starts;
- Patients excluded inappropriately across both admitted and non-admitted pathways;
- Planned patients that do not appear to be actively managed; and
- Lack of a standardised process to book follow up appointments.

In May 2016, the Trust engaged MBI Health Group to conduct a more thorough review of these issues and recommend a way forward.

This diagnostic process clearly established that the current methods of generating, monitoring and tracking and reporting against waiting lists at the Trust are not fit for purpose. It suggested problems with how the following groups of patients were being managed, tracked and reported:

- RTT PTL;
- Planned Patients;
- Non-RTT follow-ups;
- Patients requiring active monitoring;
- Diagnostic patients outside of radiology.

These conclusions highlight risks to patients at every stage of their pathway – whether on RTT pathways or not. Due to the high number of patient pathways involved and the potential for patients being lost in the system with the possibility of harm having occurred, the Trust set up a process to resolve the data issues, re-configure the PAS system and to assess every patient pathway for potential harm.

Scale of the challenge

Given the seriousness of this issue, the Trust has moved quickly to stabilise the situation. Within one week of receiving the MBI report, it was discussed at a meeting of the Trust Board where a resolution was passed to urgently tackle the issue. Although the data reviewed to date have been those tracking the RTT pathways, the Trust has also commissioned further reviews from MBI to understand the veracity of the data behind its cancer and diagnostic pathways.

The inability of the Trust to use its PAS system as a reliable source of information is a significant problem in designing a solution going forward. Quantification of the full scale of the problem is difficult at this stage. Resolution of this problem is both expensive and technically challenging. The Trust currently has limited internal capacity or capability to undertake such a project without external expertise and assistance and this is being urgently addressed.

Immediate priorities

The scale of the challenge is large and complex. The following key areas have been identified as requiring immediate intervention:

- Technical Solution & Validation;
- Clinical Harm review process;
- Leadership and Governance;
- Increasing Capacity;
- Communication Strategy; and
- External Reporting

Technical Solution & Validation

The Trust is embarking on a procurement exercise to engage an external supplier that has the technical expertise to quickly analyse the RTT pathways and decompose them into priority cohorts. These cohorts will initially be validated using automated software algorithms and then clinically validated. The algorithmic rules will be reviewed in detail and governed by the Trust to ensure they are accurate and fit-for-purpose. A suite of Standard Operating Procedures (SOPs) will be configured from this supplier's library and localised to meet St. George's needs. When implemented and the end-users trained, a series of dashboards will be implemented to monitor activity and progress. Data entry errors will be identified, down to end-user level, which can be addressed by additional training and data correction.

This solution is designed to quantify the problem and to automatically validate patient pathways wherever possible. Where system based validation is inconclusive, or clock stops aren't found then pathways will be referred back for clinical validation to assess for potential clinical harm.

Urgent training has taken place, together with targeted tracking of data entry errors to reduce the numbers of new patients from being entered into the system without a clock start. This should minimize the risk of harm to new patients presenting after the problem was understood.

Clinical harm review process

Where the system based validation proves inconclusive, or clock stops aren't found then pathways will need to be referred back for clinical validation to assess for potential clinical harm. At this point it is likely that we will identify cases where a delay has or may materially affect a patient's prognosis or treatment options.

There is the potential for a very large number of patients to have to go through this process so ring fenced resources will be made available. Patients will be prioritized based on risk category cohorts. Clinical validation clinics will be set up to review the patients and these will be overseen by a clinical harm review panel. The overall governance of this process will be controlled through the following mechanisms:

- Clinical validation will be managed using the same validation management system that is used for the first level validation.
- Visibility of the workload and backlog of validation will be regularly reported.
- Audit trail of who validated and the outcome of the validation.

- Ensure the Trust meets its statutory and regulatory requirements around Duty of Candour

The Trust had already established a clinical harm review group and will use this process to oversee the programme. This group is based on the methodology described in the NHSE External Clinical Harm Review Handbook: guidance from London Clinical Senate Council. The purpose of this group is to:

- Consider reports of harm.
- Consider harm review processes and systems.
- Consider harm prevention.

The review panel will have an independent chair (Deputy Medical Director of NHS England) and will have representatives form SGUH operational and clinical teams, primary care and CCGs.

The group will report through the Trust governance mechanisms to the Quality and Risk Committee and then to the Board. A standardized set of reports will be developed that will be used for both internal and external reporting.

Leadership and governance

The programme will be led and owned at the executive level. It is recognised that this is a major programme and therefore a task force independent of day-to-day business as usual will be created. The Trust recognised the inadequacies in its previous governance arrangements and will therefore have in place for this the following:

- Clear Executive and NED accountability at Board level;
- The Trust is also actively seeking a Director level RTT expert;
- The Trust is appointing an RTT Clinical Lead from within the organization; and
- Executive Level data quality governance group has been established and meeting regularly
- Executive Level RTT Recovery Programme Board established

Increasing capacity

The Trust already has capacity constraints on many of its RTT pathways. This piece of work has the potential to worsen this situation by identifying more patients within previously lost pathways who will now need care and treatment. The Trust is therefore actively looking to reduce demands on its systems wherever possible and to identify areas where capacity can be increased to cope with greater demand if needed.

Communications

The problems with our RTT data will need to be clearly communicated to our staff, stakeholders and, at an appropriate time, our patients. A key part of this will be balancing the competing demands of being open and transparent with ensuring we don't cause undue concern or anxiety. We have developed a plan to ensure we clearly communicate with key audiences the scale of the problem but also, and more importantly, our recovery plan, and how we are going to tackle and overcome the issues we face. We will need to work closely with our partners and key stakeholders in tackling the problem, and engaging them early in the process will be crucial in this regard. We held a workshop with senior representatives from NHS Improvement, NHS England and local commissioners last week, and this was welcomed as a positive start to managing the problem, and being open and upfront about the challenge ahead.

External Reporting

The Trust appreciates its responsibilities both to its patients and to the wider external environment. The Trust Board resolved to suspend reporting subject to discussions with local commissioners and stakeholders and to set up a senior level task force to correct this data problem, re-implement the PAS system and to assess every patient for potential harm. Initial discussions with NHS England, NHS Improvement and local commissioners suggest that they understand and are supportive of this approach.

Next Steps

- To establish a framework to provide oversight and governance of the recovery programme that provides full assurance and governance processes demonstrating board assurance
- To provide a technical solution & validation for all referral pathways across St George's NHS Foundation Trust Hospital
- Successfully implement a clinical harm review process to identify all potential or actual harm to patients who have not previously been correctly clinically prioritised
- To provide open and transparent communications to Trust staff, stakeholders and patients
- To write a comprehensive training plan to cover all Trust staff

St George's University Hospitals NHS
NHS Foundation Trust

Name and date of meeting:

EXECUTIVE MANAGEMENT TEAM

Document Title:

M3 Finance Report

Action for the Executive Management Team:

Note the level of adverse variance against YTD budget of £4.1m which will require recovery plans at both the divisional level and trust wide level (transformation plan slippage) which will form part of wider conversations in EMT about changing the run rate in the short term

Note the YTD deficit of £16.5m which is less than a £1m below the control total of £17.2m

Note the continued breach of the Agency Cap

Summary:

Deficit of £4.6m in M3 which was £1.5m adverse to plan. YTD deficit is £16.5m which is £4.1m adverse to plan. Key features:

- *SLA income £0.6m favourable to plan, but elective income below, primarily due to poor theatre utilisation in general surgery, T&O and Neurosurgery*
- *Pay £0.9m adverse due to high spend on interims in Overhead divisions and non-achievement of CIPs*
- *Non pay £1.3m adverse due to over-performance on high cost drugs offset by underspends on clinical consumables and non-achievement of CIPs*
- *Cash is £3.5m is higher than plan*

Author and Date:

Nigel Carr, 22 July 2016

Summary Finance Report
Month 03 2016/17

Finance and Performance Committee 27th July 2016

1. Month 03 Headlines & Actions – Income & Expenditure

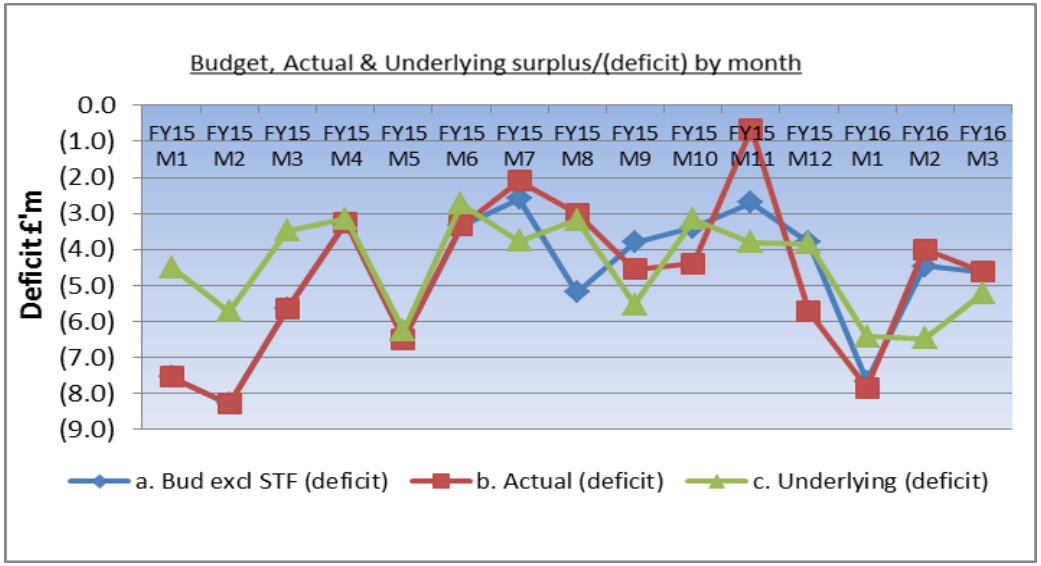
Area of Review	Metric	Key Highlights
Overall financial performance in June	Deficit of £4.6m in the month, £1.5m worse than planned	This month has seen the highest SLA income performance this year however, expenditure continues to increase as a result of pay overspends (increased use of interims and unmet CIP targets) as well as non-pay overspends attributable to reactive estates maintenance costs and, unmet CIP targets. Month on month deficit has slightly deteriorated from the £4m reported in M02 but improved against the £7.8m in M01. This month's position includes £0.3m catch-up in capital charges which was under-reported in prior months. Note: The I&E performance is reported against the internal plan. In M02 the annual plan was updated to rectify profiling errors in the original plan. See appendix 1 for a reconciliation of internal plan v original NHSI profile.
Activity/Income	SLA income is £0.6m higher than plan for June	Actual activity across all areas have performed better than last month with the exception of A&E. Non elective and outpatient income performance are much improved (the latter is due to revival of the text reminder/messaging system and tighter management of DNAs) however, elective activity is under-performing against budget. This is partly the result of downtime in theatres due to delays to planned refurbishment, and also insufficient theatre utilisation and capacity to support the beds for the Neurosciences business case.
Expenditure- Pay	Pay spend is £0.9m overspent against plan for June (YTD over spend of £0.6m)	June pay is £0.9m adverse against plan with £0.6k of the over spend attributable to Overheads division. In Corporate & Estates & facilities (Overheads division), spend on interims is increasing primarily due to non recurrent, unbudgeted projects. Overspend on clinical areas is due to unmet CIP targets. The Trust is still exceeding it's agency cap at month 3 by £1.05m in month and £2.6m cumulatively.
Expenditure- Non Pay	Non pay spend in June is £1.3m higher than plan (YTD over spend of £2.4m)	June non-pay spend is £1.3m higher than budgeted and driven by Commercial wholesale dealer pharmacy and, PbR excluded drugs activity over performance (£1.4m and £0.9m respectively) for which there are offsetting income over-performance. Excluding the above, non pay is £1m under budget in month mainly against consumables owing to SLA activity underperformance including slippage against business cases, and release of £0.2m prior year over accrual is Community services. YTD position is supported by £2.2m reserves budget.
CIP	£42.7m savings target for 2016/17.	Trust has a total turnaround target of £42.7m made up of £32.7m on central programmes and £10m in the divisions. A re-phasing has been undertaken following Q1 actuals, resulting in a current full year forecast of £34.1m against the £42.7m target.

2. Month 03 Headlines & Actions – Cash and Capital

Area of Review	Metric	Key Highlights	Actions	RAG
Cash	Cash balance £6.5m (£3.5m higher than pan)	The cash balance was £6.5m at M03 – a reduction of £1.4m in month but £3.5m ahead of plan. No drawdowns have been made from borrowing facilities so far this financial year which is £6.7m better than plan. Therefore in overall terms cash and borrowing combined are £10.2m better than plan at M03.	The Trust just has sufficient secured borrowing capacity if the planned deficit of £17.2m is met however there is only £0.8m cash headroom and the Trust has requested approx £20m cash headroom to mitigate the risks relating to the income and expenditure position. The trust is currently forecasting it will need to drawdown from borrowing facilities at the end of August.	
Capital	YTD spend £6.1m £3.4m less than plan	Capital expenditure was £2.4m in June (May £2.1m), an under spend of £1.8m in month. The year to date underspend is now £3.4m of which £1.9m relates to the energy performance contract with British Gas.	The Trust spent £3m on infrastructure renewal in 2015/16 and is planning to spend £7.2m in 2016/17. The trust submitted a bid to NHS Improvement for additional capital totalling £39.12m to address urgent risks in the estate and IT infrastructure in June. Meanwhile budget holders have been tasked with re-prioritising spend so that the highest risks are mitigated as much as possible within the existing approved capital budget.	
Working Capital	+£16.6m YTD, £10.1m better than YTD plan	Working capital in June improved by £3.7m due to lower supplier payment runs, the continued benefit of deferring the NHSL CNST premium and a reduction in stock. These factors have more than offset the impact of the revenue deficit. The overall working capital performance is £10.1m better than plan YTD – and this has contributed to the higher cash balance and lower borrowings compared to plan at M03.	The Trust needs to continue to maintain the longer supplier payment terms and secure reductions in overdue debt to protect its working capital position in 2016/17 and help to minimise borrowing.	
FSRR	Rating of 1 compared to plan of 1	The Trust's financial sustainability risk rating for month 3 (June) is 1 which is in line with plan. The rating reflects a I&E variance of 2.1% compared with an NHSI expectation of 1.3%. The liquidity score is now a 1 (in line with plan) as the effect of the in month deficit impacts on net current assets.	Actions to deliver a more favourable variance against year to date plan in the coming months will allow this rating to improve. Draw down of working capital loan in future months will improve this position.	

3. Overall Position for the month June 2016

Income & Expenditure	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £m	Year to Date (YTD) Budget £'m	Year to Date (YTD) Actual £'m	Year to Date (YTD) Variance £m
SLA Income	667.5	58.5	59.1	0.6	164.9	163.3	(1.6)
Other Income	111.1	6.3	6.7	0.4	27.8	28.2	0.4
Overall Income	**778.6**	**64.8**	**65.8**	**1.0**	**192.6**	**191.5**	**(1.1)**
Pay	(486.2)	(40.2)	(41.0)	(0.9)	(120.9)	(121.4)	(0.6)
Non Pay	(274.6)	(24.9)	(26.2)	(1.3)	(75.4)	(77.8)	(2.4)
Overall Expenditure	(760.8)	(65.1)	(67.3)	(2.2)	(196.3)	(199.2)	(3.0)
EBITDA	17.8	(0.3)	(1.5)	(1.2)	(3.6)	(7.7)	(4.1)
Financing costs	(35.1)	(2.9)	(3.1)	(0.2)	(8.8)	(8.7)	0.0
Surplus/(deficit)	**(17.2)**	**(3.2)**	**(4.6)**	**(1.5)**	**(12.4)**	**(16.5)**	**(4.1)**



Commentary

- Deficit of £4.6m is reported this month and is £1.5m adverse from plan. Note: YTD profiled ledger deficit plan is lower/more ambitious (£2m) than the deficit plan submitted to NHSI (see appendix 1).

- **SLA income** this month is £0.6m favourable against plan. Month on month income is £5.6m higher than M2 as this month, cumulative STF funding of £4.4m has been transferred from Other Income to SLA income. Excluding STF income, the increase on May income is £1.2m which reflects increases in excluded drugs, outpatient and non-elective income this month.

- **Other income** in June is £0.4m favourable against plan due to commercial pharmacy over performance which is masking private patients & overseas patients under-performance. Month on month performance excluding £4.4m STF moved to SLA income, is improved due to commercial pharmacy activity.

- **Pay** spend this month is £0.9m adverse to plan. Actual spend month on month is £1.2m more than reported last month.
- The £0.9m adverse position in month relates to clinical divisions which are £0.5m over spent due to unachieved CIP targets, £0.6m over spend in Overheads due to spend on interim staff, with the overspends partly mitigated by £0.2m credit on Central due to dropped accrual now in relevant divisions.
- Total agency (including interim) spend continues to exceed NHSI cap.

- **Non pay** overspend in month of £1.3m comprises of overspends on high cost drugs (pass through cost) which is offset by underspends against consumables, and unmet CIP targets.

- **The M3 underlying deficit** of £5.2m, is £1.2m improved position from the last two months average, although still adrift from plan. Average monthly underlying deficit since turnaround (i.e. FY 2015 Mth4) is £4.5m.
- The M03 improvement is due to improved underlying income which is £2m higher than average since turnaround. Costs since turnaround are also much higher due to pay award & pension cost increases, spend on interims, soft FM costs and reactive maintenance.

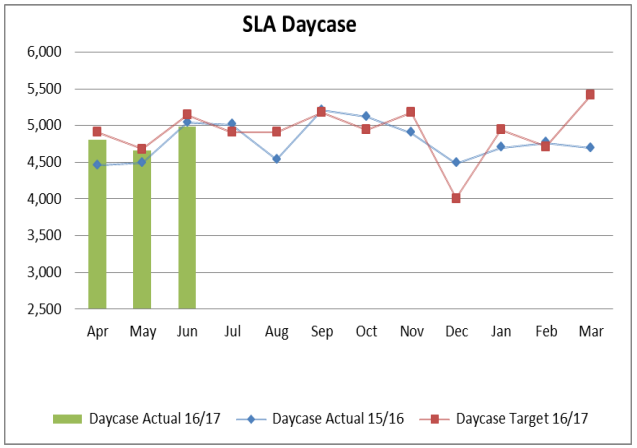
4. SLA Income for the month June 2016

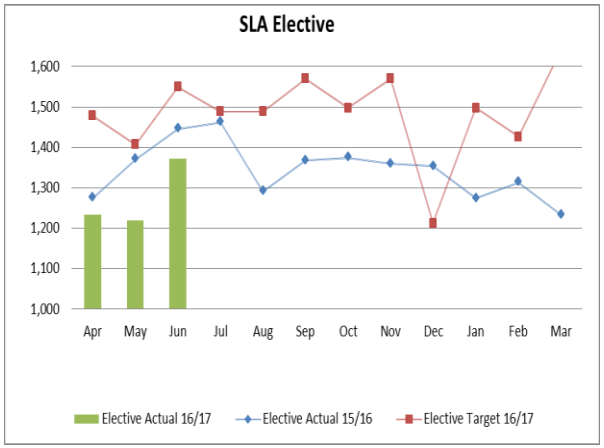
Activity	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
A&E	19.9	1.6	1.6	(0.0)	5.0	4.9	(0.1)
Bed Days	63.3	4.9	5.2	0.3	15.0	15.6	0.6
Daycase	30.4	2.6	2.6	(0.0)	7.6	7.7	0.1
Elective	74.2	6.4	5.5	(0.8)	18.4	16.4	(2.0)
Non Elective	131.3	10.6	11.4	0.8	32.7	32.4	(0.3)
Outpatients	112.2	9.5	10.3	0.8	27.8	28.0	0.2
Fixed Block (HIV)	47.9	3.4	3.4	0.0	12.1	12.1	0.0
Pass through Drugs income	47.4	3.9	4.8	0.9	11.8	13.3	1.4
Pass-through devices/programme	39.3	3.8	2.7	(1.1)	9.5	8.7	(0.8)
Diagnostics	26.1	2.3	2.2	(0.1)	6.6	6.5	(0.0)
Unbundled (Chemotherapy)	23.4	2.0	2.1	0.1	5.7	5.5	(0.2)
Community Block	18.0	1.5	1.5	0.0	4.1	4.1	0.0
In Patient Deliveries	13.5	1.1	1.1	(0.0)	3.4	3.1	(0.2)
Out patients - Regular Att.	4.9	0.4	0.4	(0.0)	1.2	1.2	(0.1)
Challenges/Penalties	(9.2)	(0.8)	(0.7)	0.1	(2.3)	(2.2)	0.1
CQUIN	(2.2)	(0.2)	0.0	0.2	(0.6)	0.0	0.6
Other (Ex SLA, Unallocated CIP, OT)	26.9	5.4	4.9	(0.5)	6.9	5.9	(0.9)
Grand Total	**667.5**	**58.5**	**59.1**	**0.6**	**164.9**	**163.3**	**(1.6)**

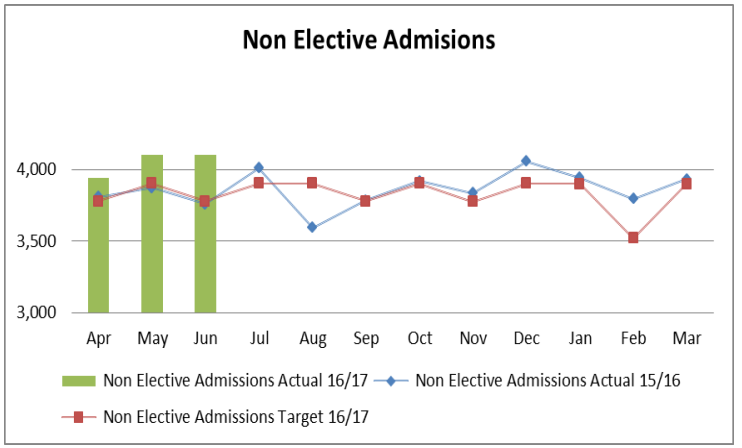
Commentary

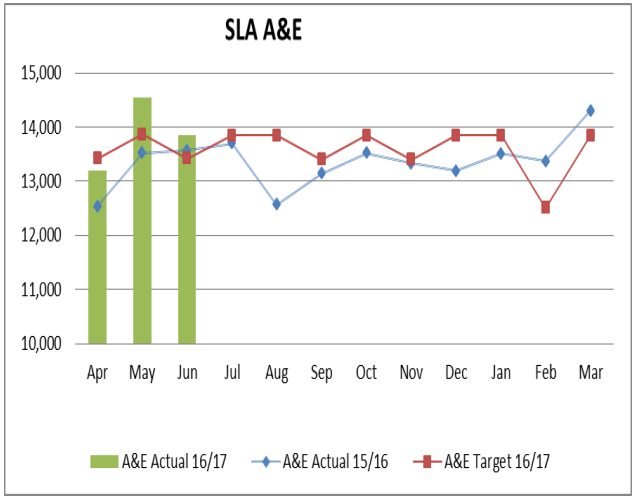
- SLA income is £0.6m under plan in the month and £1.6m under plan year to date.
- The main areas of YTD underperformance are within Elective(£2m), Non Elective (£0.3m) and other (£0.9m)
- The in month Elective shortfall of £0.8m is being driven by General Surgery (£131k) ,Trauma & Orthopaedics (£283k) and Neurosurgery (£232k) and relate to poor theatre utilisation as well as delays to theatre refurbishments.
- The 'Other' category is made up of items outside of the main SLA with Commissioners - these ex-SLA items are generally for projects funded by the department of health and/or commissioners over a pre-defined period.
- Non Elective and Outpatient income has increased during the month along with pass through drugs income which will be matched by expenditure.

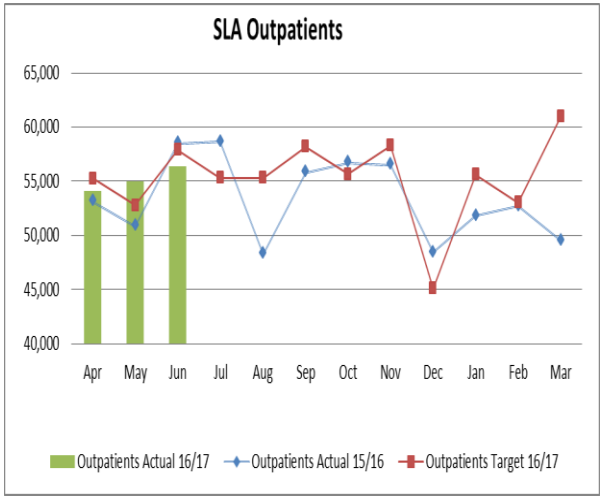
5. Patient activity compared to plan for the month June 2016











Commentary

- Actual activity across all areas have performed better than last month with the exception of A&E.
- Day case activity is performing at the planned level for the month.
- The shortfall against budget in Elective is mainly within Urology, Vascular and Neurosurgery. The downtime in theatres has contributed to this and there has been insufficient theatres capacity to support the beds for the Neurosciences business case.
- Non Elective activity has performed above target especially in General Medicine due to reduced length of stay and increased throughput.
- A & E activity is also above plan and is 5% higher than last year.

6. SLA Income by Commissioner for the month June 2016

Income	Annual Budget (£m)	Year to Date		
		Budget (£m)	Actual (£)	Better/(Worse) than Budget
NHSE Specialist	232,563	56,940	55,019	(1,921)
NHSE Public Health	17,158	4,321	4,203	(119)
NHSE Secondary Dental Care Services	8,956	2,238	2,109	(130)
NHSE Cancer Drugs Fund	3,833	958	881	(77)
NHSE SPECIALIST (IFR)	4	1	0	(1)
NHSE - HEPC	5,962	1,491	2,635	1,144
Public Health England	1,044	261	333	72
Subtotal NHSE	**269,520**	**66,210**	**65,179**	**(1,031)**
NHS Wandsworth CCG	150,822	37,625	38,017	392
NHS Merton CCG	66,207	16,459	17,381	922
NHS Lambeth CCG	22,058	5,484	5,590	106
NHS Croydon CCG	24,087	6,000	6,336	336
NHS Sutton CCG	13,862	3,454	3,924	470
NHS Kingston CCG	13,100	3,267	3,369	102
NHS Richmond CCG	12,823	3,244	3,189	(55)
SURREY CCG	22,288	5,548	6,090	542
Other CCGs	21,336	5,312	4,922	(390)
Subtotal CCGs	**346,581**	**86,393**	**88,819**	**2,425**
NCA	8,940	2,219	2,316	97
Other Trusts	1,249	308	260	(48)
Other Local Authority	14,077	3,519	3,472	(47)
Subtotal CCGs	24,266	6,046	6,048	**1**
Internal Targets: Growth, Business Cases etc				
Local Income Targets	14,277	3,497	145	(3,352)
Ex SLA Income	21,703	5,472	5,200	(272)
Provisions	-9,172	-2,293	-2,190	103
Other	330	-433	117	549
Total NHS Healthcare Income	**667,505**	**164,893**	**163,316**	**(1,577)**
Additional Income				
Private & Overseas Patient	6,399	1,594	1,449	(144)
Road Traffic Accidents (RTAs)	4,213	1,053	941	(112)
Other Healthcare Income	171	43	81	39
Education and Training Levy Income	40,526	10,131	10,104	(28)
Other Income	59,758	14,923	15,598	675
Total Other Income	**111,066**	**27,744**	**28,173**	**430**
Total Income	**778,571**	**192,637**	**191,490**	**(1,147)**

Commentary

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

The Trust is showing an underperformance against NHSE especially within Elective (Neurosurgery £782k and Trauma & Orthopaedics £481k)

The Trust is over performing on local CCGs, the most significant of which is Merton CCG.

Overall, the Trust is below the total planned income targets by £1.1m year to date.

Within the internal target section, the local income target represents activity which commissioners were not prepared to commission upfront.

Ex SLA is for block funding outside of the main SLA and provisions represent the budget we have set aside for challenges (see slide 7)

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. Provision for SLA Penalties & Challenges for the month June 2016

Annual Plan	Category	Actual £'000 M1	M2	M3	YTD	Budget YTD	Better/(worse) than Budget
(26)	Cancer	(3)	(24)	(180)	(207)	(7)	(201)
0	Cancelled operations	0	(6)	(3)	(9)	0	(9)
0	Mixed sex accomodation	0	(0)	0	0	0	0
0	MRSA	(10)	0	10	0	0	0
0	Never events	(2)	0	0	(2)	0	(2)
(1,366)	Readmissions to SGH	(43)	(185)	82	(146)	(342)	196
(210)	Readmissions critical care	(7)	(28)	17	(18)	(52)	34
(1,108)	Readmissions to other	(35)	(150)	(92)	(277)	(277)	0
(2,710)	**National terms**	(100)	(393)	(166)	**(659)**	(678)	19
(1,028)	Follow up ratio	(131)	(131)	(104)	(366)	(257)	(109)
(594)	Follow up ratio QMH	(21)	(20)	(19)	(60)	(149)	89
(507)	DC to OP adult	(42)	(42)	(59)	(143)	(127)	(16)
(66)	DC to OP paeds	(5)	(6)	2	(9)	(16)	7
(11)	NHS Number	(4)	(2)	(5)	(11)	(3)	(8)
(1,119)	High Cost Drugs	(95)	(102)	(4)	(201)	(280)	79
(476)	Automated challenges	(46)	(47)	(26)	(119)	(119)	0
0	Minimum Income Guarantee	0	0	0	0	0	0
(750)	NHSE General Challenges	(22)	(103)	(25)	(150)	(188)	38
(750)	Qtrly CCG Challenges	(128)	3	(25)	(150)	(188)	38
0	Unmatched radiology	(17)	(23)	(83)	(123)	0	(123)
(1,160)	Ad hoc challenges	(83)	74	(190)	(199)	(290)	91
(6,461)	**Local terms**	(594)	(399)	(538)	(1,531)	(1,615)	84
(9,172)	**Total**	**(694)**	**(792)**	**(704)**	**(2,190)**	**(2,293)**	**103**

Commentary

The budget for SLA national penalties and local contract challenges is £9.1m for the year and £2.3m YTD.

The June numbers are pro rated from month 2 actuals where the data is available (national penalties, local KPIs, automated challenges and HCDs). Penalties (except HCDs, automated, cancer, NHSE general challenges , and quarterly CCG challenges) have now all been allocated to divisions and will be discussed in monthly performance reviews.

The 16/17 national penalties for cancer relate to 14 day and 31 day standard RTT waiting times. The trust achieved the 31 day target and therefore there were no breaches over threshold. There were 138 breaches of the 14 day standard, resulting in a penalty for M1 & M2.

The main areas contributing to the high value of the follow up ratio challenge were ED, Maxillofacial, and Renal Medicine. We have now agreed new ratios for 16/17 that will be implemented prior to M4 and which will reduce these penalties.

An audit of emergency readmissions has resulted in a reduction of the threshold from 12.3% to 4.55%. Consequently there will be a lower penalty in the month 4 challenges.

8. Pay costs for the June 2016

1. Pay variance by Staff Type	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
Consultants	(77.2)	(6.4)	(6.6)	(0.2)	(19.2)	(19.4)	(0.2)
Junior Doctors	(52.8)	(4.4)	(4.6)	(0.3)	(13.1)	(13.3)	(0.2)
Non Clinical	(87.0)	(7.3)	(7.4)	(0.1)	(21.8)	(21.5)	0.3
Nursing	(195.9)	(16.3)	(15.5)	0.8	(48.6)	(46.3)	2.3
Scientists/Technicians/Therapists	(89.5)	(7.4)	(6.9)	0.5	(22.1)	(21.0)	1.1
Other (CIP)	16.6	2.3	(0.0)	(2.3)	4.1	(0.0)	(4.1)
Unallocated (Pay Provisions)	(0.4)	(0.7)	0.0	0.7	(0.1)	0.0	0.1
Grand Total	(486.2)	(40.2)	(41.1)	(0.9)	(120.9)	(121.6)	(0.7)

2015/16 → 2016/17

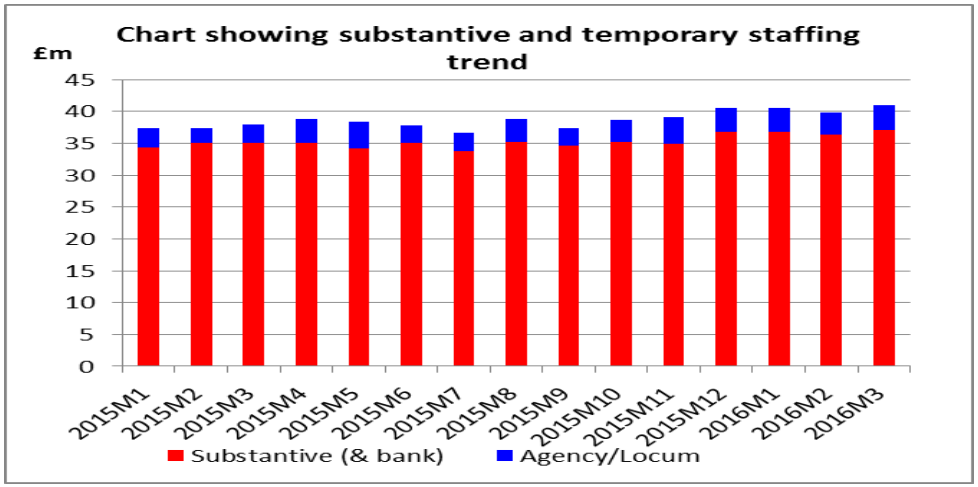
2. Monthly Pay trend by Staff-type	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Consultants	(5.8)	(5.8)	(5.9)	(6.4)	(5.9)	(6.2)	(5.9)	(6.3)	(6.2)	(6.2)	(6.0)	(6.5)	(6.3)	(6.5)	(6.6)
Junior Doctors	(4.3)	(4.2)	(4.2)	(4.2)	(4.3)	(4.0)	(4.2)	(4.4)	(4.1)	(4.2)	(4.2)	(4.2)	(4.3)	(4.4)	(4.6)
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)	(7.1)	(6.9)	(7.4)
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)	(15.9)	(14.9)	(15.5)
Scientists/Techn & 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)	(6.9)	(7.1)	(6.9)
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)**	**(40.5)**	**(39.9)**	**(41.0)**
Average per qtr :			**(37.6)**			**(38.3)**			**(37.6)**			**(39.4)**			**(40.5)**

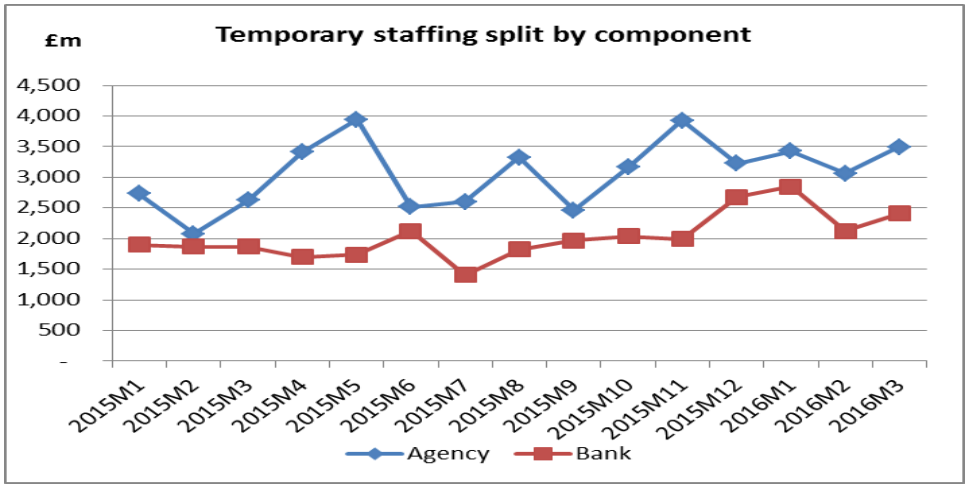
3. Pay trend by employment-type	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Substantive	(32.4)	(33.3)	(33.2)	(33.4)	(32.4)	(32.9)	(32.4)	(33.4)	(32.7)	(33.2)	(32.9)	(34.2)	(33.9)	(34.3)	(34.7)
Agency	(2.7)	(2.1)	(2.6)	(3.4)	(3.9)	(2.5)	(2.6)	(3.3)	(2.5)	(3.2)	(3.9)	(3.2)	(3.4)	(3.1)	(3.5)
Bank	(1.9)	(1.9)	(1.9)	(1.7)	(1.7)	(2.1)	(1.4)	(1.8)	(2.0)	(2.0)	(2.0)	(2.7)	(2.8)	(2.1)	(2.4)
Locum	(0.3)	(0.2)	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)	(0.3)	(0.2)	(0.2)	(0.3)	(0.4)	(0.4)	(0.4)	(0.4)
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)**	**(40.5)**	**(39.9)**	**(41.0)**
Average per qtr :			**(37.6)**			**(38.3)**			**(37.6)**			**(39.4)**			**(40.5)**

Commentary

- Pay cost this month is £0.9m (2.2%) higher than the June plan and £0.7m (0.5%) higher than cumulative plan.
- The overspend in the month shows that the budgeted savings target is not being fully achieved. The achieved proportion of the savings target is delivered via run-rate savings (includes business case slippages) as most of the target is still unallocated.
- The pay trend over the last 5 quarters (table 2) shows average quarterly spend is increasing as both the result of increased pay costs due to pay award & increased pension costs' as well as significant increase in non clinical agency/interim staff spend which is masking a modest overall reduction in clinical agency spend trend.
- Part of the improved trend in clinical agency spend reflects improved accuracy following separately costing accrual for qualified and unqualified nursing staff as well as impact of the on-going implementation of the rates cap.
- The significant increase in non-clinical agency spend is in 'Overheads' where interim staff are working on unbudgeted projects.

9. Pay trend for the 13 months to 30th June 2016





Temporary spend trend	2015M1	2015M2	2015M3	2015M4	2015M5	2015M6	2015M7	2015M8	2015M9	2015M10	2015M11	2015M12	2016M1	2016M2	2016M3
Bank %	5%	5%	5%	4%	5%	6%	4%	5%	5%	5%	5%	7%	7%	5%	6%
Average/qtr - Bank			5%			5%			5%			6%			6%
Agency %	7%	6%	7%	9%	10%	7%	7%	9%	7%	8%	10%	8%	8%	8%	9%
Average/qtr - Agency			7%			9%			7%			9%			8%

Commentary

- The proportion of total pay spend relating to use of bank staff shows a slight increase in the last 2 quarters which reflects the increase seen in booked bank hours.
- Agency proportion of total pay spend this month shows a 1% increase month on month however, trend at 8% is comparable to 2015/16 overall average of 8% (and 8% average for each half) . Agency bookings for 'overhead' staff is markedly increased due to use of interims to support various transformation work-streams and CQC inspection, and to cover vacant Trust management (including executive management) positions.
- Department of Health caps on nurse agency spend came into effect in October 2015 and for 2016/17, NHS Improvement has set the Trust an agency spend target to reduction spend from 2015/16's £36m to £23m this year.
- Agency cost has increased in June from £3.06 last month to £3.49m thus, the Trust continues to exceeded the cap/target – by £1.05m in month and £2.6m cumulatively. Divisional performance against the target is shown in appendix 2.
- Discussions with NHSI are on-going regarding some new factors affecting the Trust spend which should be factored into the cap - mainly transformation costs.

10. Non pay costs for June 2016

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	(100.9)	(8.5)	(7.4)	1.0	(25.1)	(22.8)	2.3
Drugs	(29.6)	(3.8)	(3.5)	0.3	(7.5)	(9.7)	(2.2)
Drugs - Excluded (pass-through)	(40.5)	(2.2)	(4.1)	(1.9)	(10.1)	(11.3)	(1.2)
Premises	(46.3)	(3.9)	(4.1)	(0.2)	(11.5)	(11.8)	(0.3)
Clinical Negligence	(20.4)	(1.7)	(1.7)	(0.0)	(5.1)	(5.1)	(0.0)
Establishment	(11.0)	(0.9)	(0.7)	0.2	(2.8)	(2.7)	0.0
General Supplies	(17.9)	(1.7)	(1.5)	0.3	(4.9)	(4.9)	(0.0)
Non Pay Unallocated	(0.5)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)
PFI Unitary payment	(7.1)	(0.6)	(0.6)	0.0	(1.8)	(1.8)	0.0
Other non pay	(5.7)	0.1	(0.8)	(1.0)	(1.0)	(2.1)	(1.0)
Consultancy	(3.6)	(0.3)	(0.5)	(0.2)	(0.9)	(1.4)	(0.4)
Diagnostic tests/services	(26.4)	(2.2)	(2.2)	(0.0)	(6.6)	(6.7)	(0.1)
Other NHS Facilities	(5.3)	(0.3)	(0.4)	(0.1)	(1.3)	(1.3)	(0.0)
External (non NHS) Facilities	(8.5)	(0.9)	(1.0)	(0.0)	(2.5)	(2.9)	(0.3)
Unallocated CIP	0.1	(0.3)	0.0	0.3	0.0	(0.1)	(0.1)
Reserves (inc central CIP target)	20.7	0.0	0.0	(0.0)	(1.3)	0.0	1.3
Old Creditors adjustments	1.2	0.1	0.1	0.0	0.3	0.3	0.0
VAT reclaims	0.0	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)
Unallocated creditors	0.0	0.0	0.1	0.1	0.0	(0.2)	(0.2)
SWLP reporting Offset	27.0	2.2	2.2	(0.0)	6.7	6.8	0.0
Grand Total	**(274.6)**	**(24.9)**	**(26.2)**	**(1.3)**	**(75.4)**	**(77.8)**	**(2.4)**

Commentary

- June spend is £1.3m over plan while cumulative non pay is £2.4m over plan. The YTD adverse variance is driven by adverse variances on pass through drugs and on commercial pharmacy over activity and, matched by income over-performance. There are unachieved non –pay CIP targets.
- Clinical consumables underspend in month is mainly in R&D (£0.6m) which is reflected in the income performance and, release of £0.2m prior year over-accrual for rehab/therapies equipment. YTD under spend is mainly in Surgery & Medicine divisions which have the most SLA activity under-performance (after excluding pass through income over-performance).
- Drugs overspend to date is in part due to commercial pharmacy activity over-performance (£1.2m overspend has offsetting income over performance) and overspends in Medicine & Cardiology where marginal cost for increased activity plan has yet to be fully funded.
- Reserves YTD favourable position owes to contingency release of £1.9m & CQUIN expenditure reserves of £0.3m supporting the Trust position to date. This is increasingly being eroded by unachieved, unallocated central CIP target (£0.9m YTD).

11a. CIP programme £'000

Transformation Schemes and Div. CIP FY16/17	£'000													
	Actual			Forecast										
M3 Position before changes - as per Approved Budget	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	TOTAL	Budget	Variance
Diagnostics	-	-	101	89	89	89	89	89	89	89	89	89	898	988	(90)
Flow				213	213	213	265	132	239	239	236	239	1,991	2,375	(384)
Outpatients				-	-	-	-	-	-	-	-	-	-	-	-
Theatres Transformation				117	147	176	205	234	264	293	293	293	2,022	2,169	(147)
CLINICAL TRANSFORMATION	**-**	**-**	**101**	**419**	**448**	**478**	**559**	**455**	**592**	**621**	**618**	**621**	**4,911**	**5,532**	**(621)**
Corporate Efficiency (Back office)				4	4	4	4	4	4	4	4	4	38	50	(13)
Procurement	83	189	132	423	503	501	519	523	689	702	743	756	5,764	6,000	(236)
CORPORATE EFFICIENCY	**83**	**189**	**132**	**427**	**507**	**505**	**524**	**528**	**693**	**706**	**747**	**760**	**5,802**	**6,050**	**(248)**
Private Patients				28	22	8	62	64	61	64	85	85	479	445	35
Service Sustainability				316	420	258	142	279	362	362	362	362	2,863	3,026	(162)
PORTFOLIO OPTIMISATION				**344**	**442**	**266**	**205**	**343**	**423**	**426**	**447**	**447**	**3,343**	**3,470**	**(127)**
Medical Secretaries and Clinical				27	27	27	-	-	-	-	-	-	82	163	(82)
Medical Workforce Review				-	92	92	92	228	228	364	364	364	1,823	1,823	-
Nursing Establishment	6	6	6	172	284	284	284	284	284	284	284	284	2,466	2,621	(155)
Nursing temporary staffing	(8)	45	45	69	69	69	156	156	193	245	245	245	1,531	1,492	38
Reducing Pay Costs		9	9	278	278	279	279	302	303	303	303	303	2,646	3,139	(493)
Spans and Layers				-	-	-	56	56	111	111	111	111	555	555	-
South West London Bank				19	19	19	19	19	19	19	19	19	171	171	-
WORKFORCE EFFICIENCY	**(1)**	**61**	**61**	**566**	**770**	**770**	**886**	**1,045**	**1,138**	**1,326**	**1,326**	**1,326**	**9,273**	**9,965**	**(692)**
Infrastructure				(68)	(43)	(43)	-	-	-	-	-	-	(153)	(430)	278
INFRASTRUCTURE	**-**	**-**	**-**	**(68)**	**(43)**	**(43)**	**-**	**-**	**-**	**-**	**-**	**-**	**(153)**	**(430)**	**278**
Medicines Optimisation	100	139	103	169	169	169	169	169	169	169	169	169	1,860	1,831	29
DIVISIONAL IMPROVEMENT INCL MEDICINES	**100**	**139**	**103**	**169**	**169**	**169**	**169**	**169**	**169**	**169**	**169**	**169**	**1,860**	**1,831**	**29**
Divisions	321	517	487	833	833	833	833	833	833	833	833	833	8,825	10,000	(1,175)
DIVISIONS *	**321**	**517**	**487**	**833**	**833**	**833**	**833**	**833**	**833**	**833**	**833**	**833**	**8,825**	**10,000**	**(1,175)**
Stretch												6,282	6,282	6,282	-
STRETCH TARGET				-	-	-	-	-	-	-	-	6,282	6,282	**6,282**	**-**
TRUST TOTAL	**503**	**906**	**884**	**2,691**	**3,127**	**2,979**	**3,174**	**3,372**	**3,847**	**4,082**	**4,140**	**10,438**	**40,144**	**42,700**	**(2,556)**

11b. CIP programme £'000

Month 3 updates (incl Stretch allocation)	Stretch alloc	Actual			Forecast									TOTAL
		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	
Diagnostics		-	-	-	(18)	(18)	(18)	(18)	(18)	(18)	(18)	(18)	(18)	(165)
Flow		-	-	-	-	-	-	-	-	-	-	-	-	-
Outpatients		-	-	-	-	-	-	-	-	-	-	-	-	-
Theatres Transformation	1,848	-	-	-	(117)	275	323	375	346	316	159	159	159	1,995
CLINICAL TRANSFORMATION	**1,848**	-	-	-	**(136)**	**257**	**305**	**357**	**327**	**298**	**141**	**141**	**141**	**1,830**
Corporate Efficiency (Back office)		-	-	-	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(38)
Procurement		-	-	-	-	-	-	-	-	-	78	78	78	234
CORPORATE EFFICIENCY		-	-	-	**(4)**	**(4)**	**(4)**	**(4)**	**(4)**	**(4)**	**74**	**74**	**74**	**197**
Private Patients		-	-	-	-	-	-	-	-	-	-	-	-	-
Service Sustainability	655	-	-	-	(316)	(420)	(253)	(136)	(272)	(26)	414	933	894	817
PORTFOLIO OPTIMISATION	**655**	-	-	-	**(316)**	**(420)**	**(253)**	**(136)**	**(272)**	**(26)**	**414**	**933**	**894**	**817**
Medical Secretaries and Clinical Correspondence		-	-	-	(27)	(27)	(27)	-	-	-	-	-	-	(82)
Medical Workforce Review	90	-	-	-	-	-	-	-	-	(0)	30	30	30	90
Nursing Establishment		-	-	-	(166)	(278)	(110)	(110)	(110)	(110)	(87)	(87)	(87)	(1,143)
Nursing temporary staffing		-	-	-	(26)	(26)	4	0	18	(9)	(40)	(28)	(16)	(123)
Reducing Pay Costs		-	-	-	(262)	(262)	(262)	(258)	(281)	(281)	(278)	(278)	(278)	(2,440)
Spans and Layers		-	-	-	-	50	50	(19)	(19)	(75)	(28)	(28)	(28)	(97)
South West London Bank		-	-	-	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(171)
WORKFORCE EFFICIENCY	**90**	-	-	-	**(500)**	**(563)**	**(364)**	**(406)**	**(411)**	**(494)**	**(422)**	**(409)**	**(397)**	**(3,966)**
Infrastructure		-	-	-	43	43	43	-	-	-	-	-	-	128
INFRASTRUCTURE		-	-	-	43	43	43	-	-	-	-	-	-	**128**
Medicines Optimisation		-	-	-	(23)	(23)	8	24	24	24	24	24	24	105
DIVISIONAL IMPROVEMENT INCL MEDICINES		-	-	-	**(23)**	**(23)**	**8**	**24**	**24**	**24**	**24**	**24**	**24**	**105**
Divisions		-	-	-	-	-	-	-	-	-	346	316	513	1,175
DIVISIONS *	-	-	-	-	-	-	-	-	-	-	**346**	**316**	**513**	**1,175**
Stretch		-	-	-	-	-	-	-	-	-	-	-	(6,282)	(6,282)
STRETCH TARGET		-	-	-	-	-	-	-	-	-	-	-	(6,282)	(6,282)
		-	-	-	-	-	-	-	-	-	-	-	-	-
TRUST TOTAL	**2,593**	-	-	-	**(937)**	**(711)**	**(266)**	**(166)**	**(336)**	**(202)**	**576**	**1,078**	**(5,034)**	**(5,996)**

11c. CIP programme £'000

Transformation Programmes FY16/17 3+9 REFORECAST POSITION	Stretch alloc	Actual M1	Actual M2	Actual M3	Forecast M4	Forecast M5	Forecast M6	Forecast M7	Forecast M8	Forecast M9	Forecast M10	Forecast M11	Forecast M12	TOTAL	Original Board	Variance
Diagnostics		-	-	101	70	70	70	70	70	70	70	70	70	733	988	(255)
Flow					213	213	213	265	132	239	239	236	239	1,991	2,375	(384)
Outpatients					-	-	-	-	-	-	-	-	-	-	-	-
Theatres Transformation	1,848					422	499	580	580	580	452	452	452	4,017	2,169	1,848
CLINICAL TRANSFORMATION	**1,848**	**-**	**-**	**101**	**284**	**705**	**782**	**915**	**782**	**890**	**762**	**759**	**762**	**6,741**	**5,532**	**1,209**
Corporate Efficiency (Back office)		-	-	-	-	-	-	-	-	-	-	-	-	-	50	(50)
Procurement		83	189	132	423	503	501	519	523	689	780	821	834	5,998	6,000	(2)
CORPORATE EFFICIENCY		**83**	**189**	**132**	**423**	**503**	**501**	**519**	**523**	**689**	**780**	**821**	**834**	**5,998**	**6,050**	**(52)**
Private Patients					28	22	8	62	64	61	64	85	85	479	445	35
Service Sustainability	655				-	-	5	6	7	336	776	1,295	1,256	3,680	3,026	655
PORTFOLIO OPTIMISATION	**655**	**-**	**-**	**-**	**28**	**22**	**13**	**68**	**71**	**397**	**840**	**1,380**	**1,341**	**4,160**	**3,470**	**689**
Medical Secretaries and Clinical Correspondence								-	-	-	-	-	-	-	163	(163)
Medical Workforce Review	90				-	92	92	92	228	228	394	394	394	1,913	1,823	90
Nursing Establishment		6	6	6	6	6	175	175	175	175	198	198	198	1,323	2,621	(1,298)
Nursing temporary staffing		(8)	45	45	43	43	73	156	175	184	204	217	229	1,408	1,492	(85)
Reducing Pay Costs			9	9	16	16	17	21	21	21	25	25	25	206	3,139	(2,933)
Spans and Layers					-	50	50	36	36	36	83	83	83	458	555	(97)
South West London Bank														-	171	(171)
WORKFORCE EFFICIENCY	**90**	**(1)**	**61**	**61**	**66**	**207**	**407**	**480**	**634**	**644**	**905**	**917**	**929**	**5,308**	**9,965**	**(4,657)**
Infrastructure					(25)	-	-	-	-	-	-	-	-	(25)	(430)	405
INFRASTRUCTURE		**-**	**-**	**-**	**(25)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(25)**	**(430)**	**405**
Medicines Optimisation		100	139	103	145	145	177	193	193	193	193	193	193	1,965	1,831	134
DIVISIONAL IMPROVEMENT INCL MEDICINES		**100**	**139**	**103**	**145**	**145**	**177**	**193**	**193**	**193**	**193**	**193**	**193**	**1,965**	**1,831**	**134**
Divisions		321	517	487	833	833	833	833	833	833	1,179	1,149	1,346	10,000	10,000	0
DIVISIONS *	**-**	**321**	**517**	**487**	**833**	**833**	**833**	**833**	**833**	**833**	**1,179**	**1,149**	**1,346**	**10,000**	**10,000**	**0**
Stretch														-	6,282	(6,282)
STRETCH TARGET					-	-	-	-	-	-	-	-	-	-	**6,282**	**(6,282)**
															-	
TRUST TOTAL	**2,593**	**503**	**906**	**884**	**1,754**	**2,416**	**2,713**	**3,008**	**3,037**	**3,645**	**4,658**	**5,218**	**5,404**	**34,147**	**42,700**	**(8,553)**

A re-phasing has been undertaken following Q1 actuals, resulting in a current full year forecast of £34.1m against the original £42.7m.
The slippage relates to actual delivery in the first three months of the year and three programmes are on-hold pending re-scoping and resource allocation: AHP Establishment, Clinical Administration and Corporate Efficiency
Further review of existing programmes and identification of new schemes expects the programme to return to the original £50m target.
Risks: The focus on recruitment of the right calibre resource and strictly adhering to delivery timescales is essential.

CIP PROGRAMME £'000

Transformation Programmes FY16/17	Stretch	Actual			Forecast										Original	Variance
3+9 REFORECAST POSITION	alloc	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	TOTAL	Board	
Diagnostics		-	-	101	70	70	70	70	70	70	70	70	70	733	988	(255)
Flow					213	213	213	265	132	239	239	236	239	1,991	2,375	(384)
Outpatients					-	-	-	-	-	-	-	-	-	-	-	-
Theatres Transformation	1,848					422	499	580	580	580	452	452	452	4,017	2,169	1,848
CLINICAL TRANSFORMATION	**1,848**	**-**	**-**	**101**	**284**	**705**	**782**	**915**	**782**	**890**	**762**	**759**	**762**	**6,741**	**5,532**	**1,209**
Corporate Efficiency (Back office)		-	-	-	-	-	-	-	-	-	-	-	-	-	50	(50)
Procurement		83	189	132	423	503	501	519	523	689	780	821	834	5,998	6,000	(2)
CORPORATE EFFICIENCY		**83**	**189**	**132**	**423**	**503**	**501**	**519**	**523**	**689**	**780**	**821**	**834**	**5,998**	**6,050**	**(52)**
Private Patients					28	22	8	62	64	61	64	85	85	479	445	35
Service Sustainability	655				-	-	5	6	7	336	776	1,295	1,256	3,680	3,026	655
PORTFOLIO OPTIMISATION	**655**	**-**	**-**	**-**	**28**	**22**	**13**	**68**	**71**	**397**	**840**	**1,380**	**1,341**	**4,160**	**3,470**	**689**
Medical Secretaries and Clinical Correspondence								-	-	-	-	-	-	-	163	(163)
Medical Workforce Review	90				-	92	92	92	228	228	394	394	394	1,913	1,823	90
Nursing Establishment		6	6	6	6	6	175	175	175	175	198	198	198	1,323	2,621	(1,298)
Nursing temporary staffing		(8)	45	45	43	43	73	156	175	184	204	217	229	1,408	1,492	(85)
Reducing Pay Costs			9	9	16	16	17	21	21	21	25	25	25	206	3,139	(2,933)
Spans and Layers					-	50	50	36	36	36	83	83	83	458	555	(97)
South West London Bank														-	171	(171)
WORKFORCE EFFICIENCY	**90**	**(1)**	**61**	**61**	**66**	**207**	**407**	**480**	**634**	**644**	**905**	**917**	**929**	**5,308**	**9,965**	**(4,657)**
Infrastructure					(25)	-	-	-	-	-	-	-	-	(25)	(430)	405
INFRASTRUCTURE		**-**	**-**	**-**	**(25)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(25)**	**(430)**	**405**
Medicines Optimisation		100	139	103	145	145	177	193	193	193	193	193	193	1,965	1,831	134
DIVISIONAL IMPROVEMENT INCL MEDICINES		**100**	**139**	**103**	**145**	**145**	**177**	**193**	**193**	**193**	**193**	**193**	**193**	**1,965**	**1,831**	**134**
Divisions		321	517	487	833	833	833	833	833	833	1,179	1,149	1,346	10,000	10,000	0
DIVISIONS *	**-**	**321**	**517**	**487**	**833**	**833**	**833**	**833**	**833**	**833**	**1,179**	**1,149**	**1,346**	**10,000**	**10,000**	**0**
Stretch														-	6,282	(6,282)
STRETCH TARGET					-	-	-	-	-	-	-	-	-	-	**6,282**	**(6,282)**
															-	
TRUST TOTAL	**2,593**	**503**	**906**	**884**	**1,754**	**2,416**	**2,713**	**3,008**	**3,037**	**3,645**	**4,658**	**5,218**	**5,404**	**34,147**	**42,700**	**(8,553)**

A rephasing has been undertaken following Q1 actuals, resulting in a current full year forecast of £34.1m against the original £42.7m.
The slippage relates to actual delivery in the first three months of the year and three programmes are on-hold pending re-scoping and resource allocation: AHP Establishment, Clinical Administration and Corporate Efficiency
Further review of existing programmes and identification of new schemes expects the programme to return to the original £50m target.
Risks:
The focus on recruitment of the right calibre resource and strictly adhering to delivery timescales is essential.

12. Divisional Summaries for June 2016 - KEY HEADLINES

Area of Review	Key Highlights
Medicine & Cardiovascular	The division's £5.4m contribution in month though under plan by £0.4m, is an improvement on the monthly contributions of £3.7m and £4.8m reported for M01 & M02 respectively. Cumulative divisional performance reports adverse variance of £2.1m. The position is due to adverse expenditure variance as a result of unmet savings targets and a gap in the drugs budget which has yet to be fully resolved. Recovery plans are being developed for all divisions. The annual budgets currently include £4.9m unallocated pay CIPs and £1.2m unallocated non pay CIPs. The division will need to identify specific schemes to deliver these targets.
Surgery, Neurosciences Theatres & Cancer	The M3 contribution of £2.6m is £0.5m less than planed however, month on month contribution for the division has improved against £1.7m and £2.1m reported for each of the last two months. YTD position is £2.1m adverse from plan mainly as a result of under performing SLA income due to unachieved RTT targets and business case slippage. Some of the income underperformance is mitigated by expenditure under spends however, the underspend is not commensurate with the income shortfall. Included in the division's position are costs for the medical outliers in surgical beds (26 beds). Annual budgets currently include £2.8m unallocated pay CIPs and £0.7m unallocated non pay CIPs, as well as £0.3m vacancy factor to achieve in order to ensure the funded establishment is not exceeded.
Community Services	The division's contribution of £1.4m is £0.2m higher than plan for June and is largely due to pay underspends over and above the pay CIP target due to continuing recruitment difficulties in the CAHS service. The annual budgets currently include £1.2m unallocated pay CIPs and £0.3m unallocated non pay CIPs, as well as £1.7m vacancy factor.
Children, Women & Diagnostics	M3 deficit of £1.2m is in line with plan while YTD position is £0.2m adverse from plan. Income over-performance owes to commercial pharmacy activity and has offsetting non-pay overspends. The YTD adverse position is due to pay overspends attributable to unmet CIP targets. The annual budgets currently include £2.6m unallocated pay CIPs and £1.2m unallocated non pay CIPs plus, £1.7m vacancy factor.
Overheads	Overheads deficit in June is £0.9m adverse from plan and driving 60% of the Trust's M03 adverse variance. The M03 position comprises of adverse variances of £0.5m and £0.4m on Corporate services and Estates & facilities respectively. Corporate services overspend is mainly due to increasing spend on interims, while Estates & Facilities adverse variance owes to reactive maintenance & CQC related costs, loss-making retail catering service and unachieved hotel services CIPs.

Medicine & Cardiovascular - Divisional I&E for June 2016

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							
A&E	20.0	1.6	1.6	(0.0)	5.0	4.9	(0.1)
Daycase	11.3	1.0	1.0	(0.0)	2.8	2.9	0.0
Elective	25.4	2.2	2.1	(0.2)	6.4	6.6	0.2
Pass-through devices/programme	23.3	1.9	1.6	(0.3)	5.6	5.0	(0.6)
Pass through Drugs income	30.4	2.5	3.0	0.5	7.6	8.7	1.1
Non Elective	68.2	5.6	5.7	0.1	17.0	16.8	(0.2)
Other (UB, DG, RA,FV, Provisions)	24.6	2.1	2.4	0.3	6.1	6.0	(0.1)
Outpatients	40.8	3.6	4.0	0.4	10.2	10.5	0.2
	244.0	20.6	21.3	0.7	60.7	61.1	0.5
Other Income	18.6	1.7	1.5	(0.3)	4.7	4.1	(0.5)
Overall Income	**262.6**	**22.4**	**22.8**	**0.4**	**65.3**	**65.3**	**(0.1)**
Pay							
Consultants	(22.0)	(1.9)	(1.9)	(0.1)	(5.5)	(5.2)	0.2
Junior Doctors	(19.1)	(1.6)	(1.7)	(0.2)	(4.7)	(5.0)	(0.3)
Non Clinical	(8.7)	(0.7)	(0.7)	0.0	(2.2)	(2.2)	0.0
Nursing	(60.1)	(5.0)	(4.9)	0.1	(14.9)	(14.7)	0.2
Other (Unalloc CIPs & vacancy factors)	4.9	1.0	0.0	(1.0)	1.2	0.0	(1.2)
Scientists, Technicians, Therapists	(6.1)	(0.5)	(0.5)	0.0	(1.5)	(1.4)	0.1
Pay Unallocated (Gen pay prov)	(0.3)	(0.7)	0.0	0.7	(0.1)	0.0	0.1
	(111.4)	(9.3)	(9.8)	(0.5)	(27.6)	(28.5)	(0.9)
Non-Pay							
Clinical Consumables	(39.2)	(3.3)	(3.1)	0.2	(9.8)	(9.3)	0.5
Drugs	(11.6)	(2.3)	(1.2)	1.1	(3.0)	(3.8)	(0.8)
Drugs - PbR Excluded	(24.3)	(0.9)	(2.4)	(1.5)	(6.1)	(6.8)	(0.8)
Establishment	(1.5)	(0.1)	(0.1)	0.0	(0.4)	(0.3)	0.1
General Supplies	(0.5)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
Other	(3.9)	(0.3)	(0.4)	(0.1)	(1.3)	(1.5)	(0.2)
Premises	(0.3)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)
	(81.2)	(6.9)	(7.2)	(0.3)	(20.7)	(21.9)	(1.2)
Overall Expenditure	**(192.6)**	**(16.2)**	**(17.0)**	**(0.8)**	**(48.4)**	**(50.4)**	**(2.0)**
EBITDA	**70.0**	**6.1**	**5.8**	**(0.4)**	**17.0**	**14.9**	**(2.1)**
Financing Costs	(4.5)	(0.4)	(0.4)	(0.0)	(1.1)	(1.1)	(0.0)
Surplus / (deficit)	**65.5**	**5.8**	**5.4**	**(0.4)**	**15.8**	**13.7**	**(2.1)**

Commentary

June contribution of £5.4m is a continued improved position compared to the previous two months but still adverse from plan by £0.4m. Income is better than plan by £0.4m and expenditure is overspent by £0.8m.

Income is £0.4m better than plan in month 3.
The division reports over performance largely against all outpatient activity which is due to tight management of DNA, extra clinics and the revival of text messaging/reminders.
Elective activity is down in the month due to theatre list cancellations and underperformance of bone marrow transplants (BMT) activity compared to plan.

Pay is overspent by £0.5m due to non achievement of red and amber CIP schemes 80% allocated to pay budget in June.
Medical staff overspend is due to extra clinics and waiting list initiatives.
Nursing underspend is due to vacancies linked to business case not yet fully recruited.

Non-pay is overspent by £0.3m largely reported under drugs but in part due to 20% CIP allocation yet to be achieved. The in month variance has worsened in the drugs PBR excluded line and improved the variance in drugs non excluded due to budget alignment still in progress. The division is investigating budget alignment to understand the clotting factor budget allocation. Drugs budget issues are to be fully resolved in the re-forecast exercise underway.

Surgery, Neurosciences, Theatres & Cancer - Divisional I&E for June 2016

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	7.9	0.5	0.6	0.1	1.9	1.9	0.0
Daycase	14.2	1.2	1.1	(0.1)	3.6	3.3	(0.2)
Elective	44.2	3.8	2.9	(0.9)	10.9	8.4	(2.5)
Pass-through devices/programme	7.2	0.7	0.3	(0.4)	1.8	1.4	(0.3)
Pass through Drugs income	6.0	0.5	0.7	0.2	1.5	1.9	0.4
Non Elective	55.4	4.6	5.0	0.4	13.8	13.3	(0.5)
Other (UB, DG, RA,FV, Provisions)	5.5	0.3	0.4	0.1	0.9	1.0	0.1
Outpatients	37.8	3.3	3.3	0.1	9.4	9.4	0.0
	178.2	14.9	14.5	(0.5)	43.8	40.7	(3.1)
Other Income	15.5	1.3	1.2	(0.1)	3.9	4.1	0.2
Overall Income	**193.7**	**16.2**	**15.7**	**(0.5)**	**47.6**	**44.8**	**(2.9)**
Pay							
Consultants	(28.3)	(2.4)	(2.4)	0.0	(7.0)	(7.1)	(0.0)
Junior Doctors	(16.4)	(1.4)	(1.4)	(0.0)	(4.1)	(4.2)	(0.1)
Non Clinical	(10.2)	(0.8)	(0.8)	0.0	(2.5)	(2.4)	0.1
Nursing	(50.5)	(4.2)	(3.9)	0.3	(12.5)	(11.5)	0.9
Other (Unalloc CIPs & vacancy factors)	3.1	0.5	0.0	(0.5)	0.8	0.0	(0.8)
Scientists, Technicians, Therapists	(10.6)	(0.9)	(0.9)	0.0	(2.7)	(2.6)	0.1
	(113.0)	(9.2)	(9.4)	(0.2)	(28.0)	(27.8)	0.2
Non-Pay							
Clinical Consumables	(24.2)	(2.0)	(1.8)	0.2	(5.9)	(5.2)	0.7
Drugs	(3.5)	(0.3)	(0.3)	(0.0)	(0.9)	(0.9)	(0.1)
Drugs - PbR Excluded	(5.9)	(0.5)	(0.6)	(0.2)	(1.5)	(1.8)	(0.3)
Establishment	(0.4)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	(0.0)
General Supplies	(0.3)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)
Other	(5.4)	(0.7)	(0.6)	0.2	(1.4)	(1.3)	0.2
Premises	(0.8)	(0.1)	(0.0)	0.0	(0.2)	(0.1)	0.1
	(40.5)	(3.6)	(3.4)	0.2	(10.0)	(9.5)	0.5
Overall Expenditure	**(153.5)**	**(12.8)**	**(12.7)**	**0.0**	**(38.1)**	**(37.3)**	**0.8**
EBITDA	**40.2**	**3.5**	**3.0**	**(0.5)**	**9.6**	**7.4**	**(2.1)**
Financing Costs	(3.9)	(0.3)	(0.3)	(0.0)	(1.0)	(1.0)	(0.0)
Surplus / (deficit)	**36.2**	**3.1**	**2.6**	**(0.5)**	**8.6**	**6.4**	**(2.1)**

Commentary

The division's £6.4m contribution to date is £2.1m below plan. The M03 contribution of £2.6m although below plan, is significantly better than the £1.7m & £2.0m in M01 & M02 respectively.

SLA Income – Elective and non-elective income is lower than plan year to date largely due to:

- 4 days Junior Doctor's strikes in April,
- Theatre closures due to refurbishment & unplanned closures
- RTT targets which are phased to start in April but are currently not resourced
- Slippage on the Neuro Business case.

Emergency income has improved in month on Neurology Strokes and higher case-mix in Urology and T&O.

Other income – YTD, other income is over performing on private / overseas patients particularly in Plastics and ENT.

Pay – The YTD £0.2m underspend [1%] is driven by significant underspends in nursing across all 3 directorates which is offset by £0.8m unallocated CIP and vacancy factor.

Non-Pay – Clinical consumables continues to under spend due to lower than planned elective surgery particularly in Neurosurgery and T&O. The Drugs overspend relates to high cost drugs which are offset by income over performance.

The key issues and actions are:

- Improve coding of all SLA activity across the division
- Improve list planning and utilise weekend capacity for
- reallocated weekend sessions from weekdays.
- Continue to develop CIP's to reduce the unallocated target.

Community Services - Divisional I&E for June 2016

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	4.2	0.3	0.3	(0.0)	1.0	1.0	(0.0)
Elective	1.2	0.1	0.1	(0.0)	0.3	0.3	(0.0)
Pass-through devices/programme	4.9	0.4	0.4	0.0	1.2	1.2	0.0
Other (UB, DG, RA,FV, Provisions)	50.8	3.7	3.6	(0.1)	12.8	12.6	(0.2)
Outpatients	10.3	0.9	0.9	(0.0)	2.6	2.5	(0.0)
Pass through Drugs income	9.3	0.8	0.9	0.1	2.3	2.4	0.1
	80.8	6.2	6.3	0.1	20.3	20.1	(0.2)
Other Income	1.4	0.1	0.1	(0.0)	0.4	0.3	(0.1)
Overall Income	**82.2**	**6.3**	**6.3**	**0.0**	**20.6**	**20.4**	**(0.2)**
Pay							
Consultants	(1.7)	(0.1)	(0.1)	0.0	(0.4)	(0.5)	(0.0)
Junior Doctors	(2.3)	(0.2)	(0.2)	(0.0)	(0.6)	(0.6)	0.0
Non Clinical	(6.1)	(0.5)	(0.4)	0.1	(1.5)	(1.3)	0.2
Nursing	(23.7)	(2.0)	(1.7)	0.3	(6.1)	(5.2)	0.8
Other (Unalloc CIPs & vacancy factors)	2.9	0.3	0.0	(0.3)	0.9	0.0	(0.9)
Scientists, Technicians, Therapists	(9.1)	(0.8)	(0.7)	0.1	(2.3)	(2.1)	0.2
	(40.1)	(3.2)	(3.1)	0.1	(10.0)	(9.6)	0.4
Non-Pay							
Clinical Consumables	(8.4)	(0.7)	(0.5)	0.2	(2.1)	(1.7)	0.5
Clinical Negligence	(0.0)	(0.0)	0.0	0.0	(0.0)	0.0	0.0
Drugs	(0.5)	(0.0)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)
Drugs - PbR Excluded	(8.5)	(0.7)	(0.9)	(0.2)	(2.1)	(2.3)	(0.2)
Establishment	(0.9)	(0.1)	(0.1)	(0.0)	(0.2)	(0.2)	0.0
General Supplies	(0.1)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Other	(4.2)	(0.3)	(0.2)	0.1	(1.0)	(1.2)	(0.2)
Premises	(0.2)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)
	(22.8)	(1.8)	(1.8)	0.1	(5.6)	(5.5)	0.1
Overall Expenditure	**(62.8)**	**(5.1)**	**(4.9)**	**0.2**	**(15.7)**	**(15.2)**	**0.5**
EBITDA	**19.4**	**1.2**	**1.4**	**0.2**	**4.9**	**5.2**	**0.3**
Financing Costs	(0.2)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Surplus / (deficit)	**19.2**	**1.2**	**1.4**	**0.2**	**4.9**	**5.2**	**0.3**

Commentary

The in month divisional contribution is £1.4m which is £0.2m better than budget. The Year to date contribution is £0.3m better than budget.

Income – The in month position is break-even against plan while cumulative income is £0.2m adverse from plan. The YTD variance is due to School Nursing contract KPI provisions (£0.1m) plus, underachieved AQP and QMH Day hospital income.

Pay – The in month position reflects the same trends as the year to date position. The YTD budget includes in 'pay other' a vacancy target of £0.5m and an unidentified CIP target of £0.3m.
The major under-spending areas include; CAHS nursing and clerical staff, Health Visiting services and Learning Disabilities services. These areas have high levels of vacancies which are not being filled at present through temporary staffing.

Non-pay – The in month break-even position reflects an overspend in pass through HIV and GUM drugs (£0.2m) off-set by an underspend in Rehab & therapies equipment which is due to release of prior year over-accrual. The YTD position is a slight underspend against the budget.

Actions

- Work with Contracts to agree the remaining Local Authorities contracts.
- Continue to develop Divisional CIPs to reduce the unallocated target.
- Undertake Divisional forecasting for 16/17.
- Understanding and reflect the financial risks of contract KPIs within the community contracts.

Children, Women, Diagnostics & Therapies - Divisional I&E for June 2016

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	51.2	4.1	4.3	0.2	12.0	12.7	0.6
Daycase	4.9	0.4	0.5	0.1	1.2	1.5	0.3
Elective	3.6	0.3	0.5	0.2	0.9	1.2	0.3
Pass-through devices/programme	0.4	0.0	0.0	0.0	0.1	0.1	0.1
Pass through Drugs income	1.7	0.1	0.2	0.1	0.4	0.4	(0.0)
Non Elective	9.0	0.7	0.7	(0.0)	2.2	2.3	0.1
Other (UB, DG, RA,FV, Provisions)	46.5	4.1	3.6	(0.5)	11.6	10.7	(0.9)
Outpatients	24.5	2.0	2.1	0.1	5.9	5.6	(0.3)
	141.7	11.7	11.9	0.2	34.4	34.5	0.2
Other Income	28.6	2.3	3.1	0.9	7.2	8.6	1.5
Overall Income	**170.3**	**14.0**	**15.0**	**1.0**	**41.5**	**43.2**	**1.6**
Pay							
Consultants	(18.9)	(1.6)	(1.6)	(0.0)	(4.7)	(4.9)	(0.2)
Junior Doctors	(14.0)	(1.2)	(1.2)	(0.0)	(3.5)	(3.4)	0.1
Non Clinical	(16.5)	(1.4)	(1.3)	0.2	(4.3)	(3.9)	0.4
Nursing	(56.2)	(4.6)	(4.5)	0.1	(13.9)	(13.7)	0.2
Other (Unalloc CIPs & vacancy factors)	4.3	0.3	0.0	(0.3)	1.1	0.0	(1.1)
Scientists, Technicians, Therapists	(40.3)	(3.3)	(3.2)	0.1	(9.8)	(9.6)	0.2
Pay Unallocated (Gen pay prov)	(0.2)	(0.0)	0.0	0.0	(0.0)	0.0	0.0
	(141.7)	(11.8)	(11.8)	0.0	(35.1)	(35.4)	(0.3)
Non-Pay							
Clinical Consumables	(14.9)	(1.3)	(1.3)	0.1	(3.7)	(3.5)	0.2
Drugs	(13.9)	(1.2)	(1.9)	(0.8)	(3.5)	(4.9)	(1.4)
Establishment	(1.0)	(0.1)	(0.1)	0.0	(0.3)	(0.2)	0.0
General Supplies	(0.5)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
Other	(2.5)	(0.1)	(0.4)	(0.3)	(0.6)	(1.1)	(0.5)
Premises	(2.0)	(0.2)	(0.2)	(0.0)	(0.5)	(0.5)	(0.0)
Drugs - PbR Excluded	(1.8)	(0.1)	(0.2)	(0.1)	(0.4)	(0.4)	0.1
	(36.7)	(3.0)	(4.1)	(1.0)	(9.2)	(10.7)	(1.5)
Overall Expenditure	**(178.3)**	**(14.8)**	**(15.8)**	**(1.0)**	**(44.3)**	**(46.1)**	**(1.8)**
EBITDA	**(8.0)**	**(0.9)**	**(0.8)**	**0.0**	**(2.7)**	**(2.9)**	**(0.2)**
Financing Costs	(6.6)	(0.5)	(0.6)	(0.0)	(1.6)	(1.6)	(0.0)
Surplus / (deficit)	**(14.6)**	**(1.4)**	**(1.4)**	**0.0**	**(4.4)**	**(4.6)**	**(0.2)**

Commentary

The division has a YTD June deficit of £4.6m, which is £0.2m worse than plan. In month deficit of £1.4m is in line with plan.

Income – SLA income has over performed £162k YTD overall and £151k in month. Activity is over performing in Adult and Paeds ICU bed-days, Elective, Day case and Non-Elective services. Outpatient underperformance is due to under coding of Antenatal (£283K). In Other, Deliveries is under £217k YTD, Breast screening activity is underperforming and Imaging activity target has increased for the Diagnostics DIP scheme £941k (£167k YTD) which has a net savings benefit of £562k for 2016-17. Also income CIP targets £278k YTD.

Other Income has over-performed by £1.6m YTD which is the pharmacy Wholesale Dealer License and Pre-pack activity (which has a related drugs over spend in non pay).

Pay is overspent by £0.3m YTD (in balance in M03). Staff groups are reporting underspends. This is offset by £0.33m old year costs for agency and disputed medical recharges, and £0.64m YTD unallocated CIPs target. Therapy had a catch up of agency invoices above accruals of £150k in M03.

Non pay is £1.5m overspent YTD. Drugs overspend of £1.4m is driven by the Wholesale Dealer License. 'Other' non pay overspend reflects unallocated CIPs £0.5m.

Actions / Risks

Community Therapy services risks. SLAs to be agreed for out of borough children. Penalty risk of pay underspends against establishment based SLAs not reflected in M03 position.

Overheads - Divisional I&E for June 2016

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
Corporate Directorates							
Chief Executive & Governance	(22.4)	(2.0)	(2.4)	(0.4)	(5.7)	(6.2)	(0.4)
Executive Director of Nursing	(3.8)	(0.2)	(0.2)	(0.0)	(0.7)	(0.6)	0.1
Finance, Performance & IT	(28.0)	(2.3)	(2.4)	(0.1)	(6.9)	(7.1)	(0.2)
Human Resources Directorate	(3.3)	0.1	0.1	0.0	(0.8)	(0.7)	0.0
Service Improvement	(8.4)	(0.7)	(0.7)	0.0	(2.1)	(2.0)	0.1
Pathology - STG	(14.3)	(1.5)	(1.6)	(0.1)	(3.6)	(3.9)	(0.4)
Strategy	(0.9)	(0.0)	(0.0)	0.0	(0.2)	(0.2)	0.0
Chief Operating Officer	(2.5)	(0.2)	(0.3)	(0.0)	(0.6)	(0.9)	(0.3)
Total Corporate	(83.6)	(6.9)	(7.5)	(0.5)	(20.6)	(21.6)	(1.0)
Estates & Facilities							
Energy & Engineering	(11.2)	(0.9)	(1.2)	(0.3)	(2.8)	(3.0)	(0.2)
Estates	(10.5)	(0.5)	(0.9)	(0.3)	(2.6)	(3.0)	(0.4)
Estates Community Premises	(17.2)	(1.4)	(1.4)	0.0	(4.3)	(4.3)	0.0
Facilities Services	(4.3)	(0.4)	(0.4)	(0.0)	(1.1)	(1.2)	(0.1)
Hotel Services	(14.1)	(1.4)	(1.2)	0.2	(3.9)	(4.0)	(0.1)
Medical Physics	(3.0)	(0.3)	(0.2)	0.1	(0.7)	(0.7)	0.0
Project Management	(0.3)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	(0.0)
Rates	(2.1)	(0.2)	(0.2)	(0.0)	(0.5)	(0.5)	(0.0)
Total Estates & Facilities	(62.7)	(5.2)	(5.6)	(0.4)	(16.1)	(16.9)	(0.8)
Total Overheads	**(146.3)**	**(12.2)**	**(13.1)**	**(0.9)**	**(36.7)**	**(38.5)**	**(1.8)**

Overheads Summary

For month 3, the Division reports £13.1m deficit which is £0.9m adverse from plan. Cumulative position is £38.5m deficit against a £36.7m plan and £1.8m adverse variance

Corporate (£0.5m adverse M03 & £1.0m adverse YTD)
Variances for the departments are explained below:

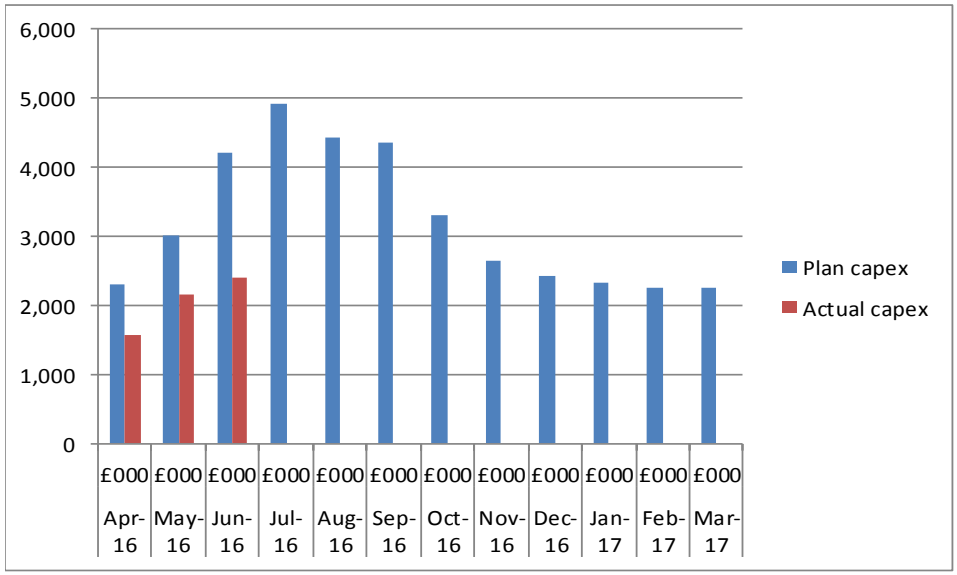
- Chief Exec & Governance: £0.4m adverse due to continued high interim costs and CQC costs £0.3m. Also unallocated CIP £0.1m which relates to corporate as a whole
- Finance: IT costs higher due to interim cover thus over spend reflects premium paid for interim staff. The Information department interims high in month.
- Service Improvement: This is favourable for the year to date as Transformation recruitment to cover substantive vacancies is still in progress.
- Pathology: Adverse variance YTD relates to £0.2m income under performance and £0.2m pay overspend.
- Chief Operating Officer: Break-even in month. YTD over spend relates to costs for planned care and RTT.

Estates & Facilities (£0.4m adverse M03 & £0.8m YTD)

- Energy & Engineering: CQC costs £0.1m and reactive maintenance costs for lifts and heating £0.2m.
- Estates: Overspend due to CIP not achieved on soft FM. Annual value for this CIP scheme (re: MITIE) is £1.2m and not expected to deliver.
- Hotel Services : Benefit in month as soft FM CIP scheme (re: MITIE) budget was transferred from Hotel services to Estates management per above.

13. Capital programme M03

Capital programme 2016/17 - budget and actual expenditure per month



Capital programme 2016/17 - budgetary position by category

Exp category	**Total Budget £000**	Budget M03 YTD £000	Actual M03 YTD £000	*Variance M03 YTD £001*
IMT	**5,172**	1,327	536	*791*
Infra Renewal	**7,221**	1,534	512	*1,022*
Infra Renewal EPC	**10,589**	2,538	636	*1,902*
Major Projs	**8,301**	2,895	3802	*-907*
Med Eqpt	**5,005**	1,190	449	*741*
Other	**2,009**	10	15	*-5*
SWL PATH	**183**	55	166	*-111*
Grand Total	**38,480**	**9,549**	**6,116**	***3,433***

- The budget for 2016/17 includes 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 opening capital budget. As at M03 £0.3m of this sum had been allocated.
- Capital expenditure in June was £2.4m and year to date expenditure is £6.1m, an under spend of £3.4m. The table above shows the YTD under spend relates mainly to the energy performance contract (£1.9m) and infrastructure renewal (£1m). The over spend on major projects reflects a timing difference with the budget profile for the SJW theatre project which will reverse over the next three months.
- The trust submitted a bid to NHS Improvement for additional capital totalling £39.12m to address urgent risks in the estate and IT infrastructure in June. Meanwhile budget holders have been asked to re-prioritise spend so that risks are mitigated as much as possible within the existing £38.4m capital budget.
- IMT have prepared a request to use £1.3m of the contingency budget to expedite highly urgent investment in the trust's IT infrastructure which may not be addressed by this re-prioritisation process

14. Cash balance and WCF drawdowns vs plan M03

Cash balance

	Actual	Actual	Actual	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	30-Apr	31-May	30-Jun	31-Jul	31-Aug	30-Sep	31-Oct	30-Nov	31-Dec	31-Jan	29-Feb	31-Mar
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
2015/16 Plan cash	13,094	4,767	3,000	3,000	3,000	3,000	3,000	3,000	3,000	6,209	3,000	3,000
Actual/forecast cash	12,922	7,885	6,566									
Cash bal fav / (adv) variance to plan	-172	3,118	3,566									

Working Capital Facility - drawdowns within cash balance above

	Actual	Actual	Actual	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	30-Apr	31-May	30-Jun	31-Jul	31-Aug	30-Sep	31-Oct	30-Nov	31-Dec	31-Jan	29-Feb	31-Mar
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Plan drawdown cumulative	0	0	6,667	13,141	18,931	25,616	26,159	27,012	30,960	30,960	30,994	32,455
Actual drawdown - cumulative	0	0	0									
WCF cum drawdowns fav / (adv) variance to plan	0	0	6,667									

Overall Cash + borrowings fav / (adv) variance to plan	**-172**	**3,118**	**10,233**									

Secured unused borrowing capacity as at 30/06/16

	Facility	Drawn at 30/06/16	Secured borrowing capacity
	£000	£000	£000
linterim Revenue Support Loan	48,700	40,396	8,304
Working Capital Facility	25,000	0	25,000
Total	**73,700**	**40,396**	**33,304**

- The M03 actual cash balance was £6.5m which is £3.5m higher than plan.
- No drawdowns have been made from borrowing facilities so far this financial year and so borrowings are £6.7m better than plan.
- LEEF loan impact: The cash balance at 30 June includes £10.8m unexpended LEEF loan for the energy performance contract and so the cash balance excluding the LEEF loan would be: -£4.3m
- **CASH RISK**
- The Trust has sufficient secured borrowing capacity ***if the planned deficit of £17.2m is met however there is only £0.8m cash headroom (£33.3m borrowing capacity - £32.5m planned borrowing requirement) and so the Trust is seeking additional borrowing facilities to provide*** approx £20m cash headroom to mitigate the risks relating to the receipt of the £17.6m sustainability and transformation funding (which is assumed in the £17.2m deficit plan) and the delivery of the 2016/17 CRP targets.

15. Analysis of cash movement M03 YTD

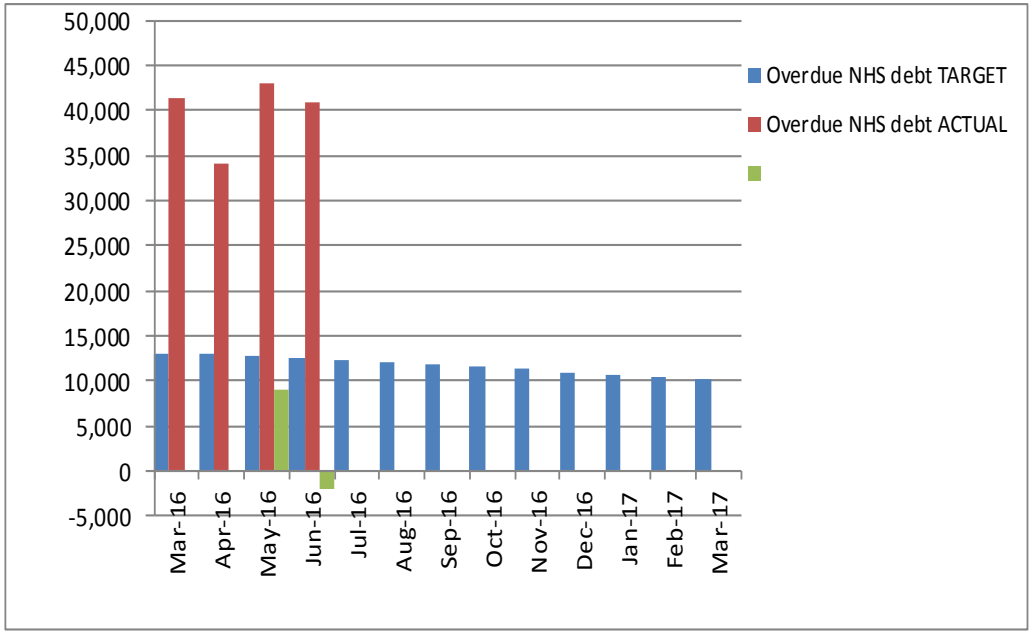
	Actual vs Plan YTD		
	Plan YTD £m	Actual YTD £m	Actual YTD VAR £m
Opening cash 01.04.16	7.4	7.4	
Operating surplus/-deficit	-6.9	-8.9	**-2.0**
Sale proceeds - asset disposals	0.0	0.0	**0.0**
Operating surplus/-deficit after disposals	**-6.9**	**-8.9**	**-2.0**
Change in stock	-0.5	-0.9	**-0.4**
Change in debtors	-1.8	-2.9	**-1.1**
Change in creditors	8.8	20.4	**11.7**
Net change in working capital	6.5	16.6	**10.1**
Capital spend (excl leases)	-8.5	-6.5	**2.0**
Other	-2.3	-2.1	**0.2**
Investing activities	-10.8	-8.6	2.1
WCF/ISF borrowing	6.7	0.0	**-6.7**
Closing cash 31.05.16	3.0	6.6	3.6

- The cash movement table above compares the actual outturn cash movement for M01-M03 with the original plan.
- The better performance on working capital (+£10.1m) and cash under spend (+£2m) on the capital programme offset the adverse cash impact of the higher operating deficit (-£2m) enabling the Trust to maintain a cash balance at M03 £3.6m ahead of plan and to delay drawdown from borrowing facilities until August.

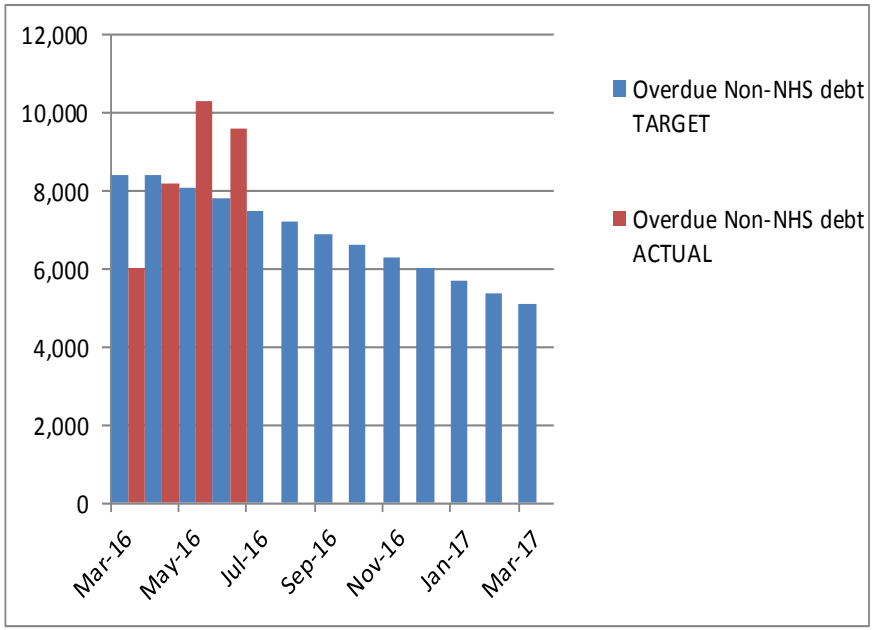
16. Debt management

- NHS overdue debt reduced in June by approx £2.1m.
- Non-NHS debt overdue debt also reduced in June - by approx £0.7m.
- The debt owed by the Medical School reduced by £0.7m in June.
- The trust expects to resolve the outstanding 2015/16 position with key commissioners including NHSE in July. This should result in as marked reduction in overdue debt
- The trust raised the Q1 invoice for sustainability and transformation funding of £4.4m in June. Although this is not yet overdue there is a risk this debt will become overdue following the response from NHS Wandsworth CCG is that it cannot be paid until formal guidance is issued by DH.
- **It should be noted the overdue debt targets below are 'stretch' targets and on the grounds of prudence the cash flow plan for the year does not assume they are met.**

Overdue NHS debt: performance vs stretch reduction targets



Overdue non-NHS debt: performance vs stretch reduction targets



17. Balance sheet as at month 03 2016/17

	Jun-16 Plan £000	Jun-16 Actual £000	*Variance £000*	**Explanations of balance sheet variances**
Fixed assets	340,766	337,290	*3,476*	Lower capital expenditure than plan - so lower fixed assets
Stock	6,687	7,118	*-431*	Pharmacy increased stock after big reduction made for year end.
Debtors	69,368	83,079	*-13,711*	Challenges provision £13.1m re-classified to creditors
Cash	3,000	6,565	*-3,565*	Cash higher than plan despite higher I&E deficit: better performance on working capital and under spend on capital expenditure
Creditors	-92,296	-116,520	*24,224*	Challenges provision £13.1m re-classified from debtors
Capital creditors	-2,933	-2,582	*-351*	
PDC div creditor	-1,561	-1,561	*0*	
Int payable creditor	-336	-325	*-11*	
Provisions< 1 year	-512	-512	*0*	Re-classification compared to plan - see non-current provisions below.
Borrowings< 1 year	-6,530	-6,208	*-322*	
Net current assets/-liabilities	**-25,113**	**-30,946**	*5,833*	
Provisions> 1 year	-991	-1,058	*68*	Re-classification compared to plan - see current provisions above.
Borrowings> 1 year	-136,701	-129,330	*-7,371*	Includes £40.4m ISF borrowed in 2015/16.
Long-term liabilities	**-137,692**	**-130,388**	*-7,304*	
Net assets	**177,962**	**175,956**		
Taxpayer's equity				
Public Dividend Capital	129,520	129,520	*0*	
Retained Earnings	-51,190	-52,794	*1,604*	Higher I&E deficit than plan
Revaluation Reserve	98,482	98,080	*402*	
Other reserves	1,150	1,150	*0*	
Total taxpayer's equity	**177,962**	**175,956**		

18. Borrowings analysis at M03

Borrowings summary - JUNE 2016

	Lender	Description	Interest rate fixed/variable	Interest rate pa	Term	Repayment terms	Maximum Facility value £000	Borrowings repay<1 yr at 30/06/16 £000	Borrowings repay>1 yr at 30/06/16 £000	Borrowings at 30/06/16 £000
	Loans									
1	Dept of Health	Capital loan	Fixed	2.20%	25 yrs	Repayable in bi-annual instalments	-14,747	-601	-13,549	-14,150
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	-10,347	-11,825
	Loans - total							-3,078	-77,294	-80,372
	Leases									
7	Blackshaw Health. Servs PL	PFI scheme	Implicit rate	7.50%	35 yrs	Repaid monthly in unitary charge	N/A	-943	-44,411	-45,354
8	Various lessors	Finance leases	Implicit rates	3%-7.5%	Various	Repaid quarterly or annually	N/A	-2,187	-7,625	-9,812
	Leases - total							-3,130	-52,036	-55,166
	Total Borrowings							-6,208	-129,330	-135,538

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 was repaid in full on 15th February 2016 using funds drawn from the interim revenue support facility (see no. 5). The facility remains available.

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.
This facility was repaid on 15th February 2016 using funds drawn from the interim revenue support facility (see no. 5). This facility is not currently available.

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. A further £4m was drawn in March 2016.

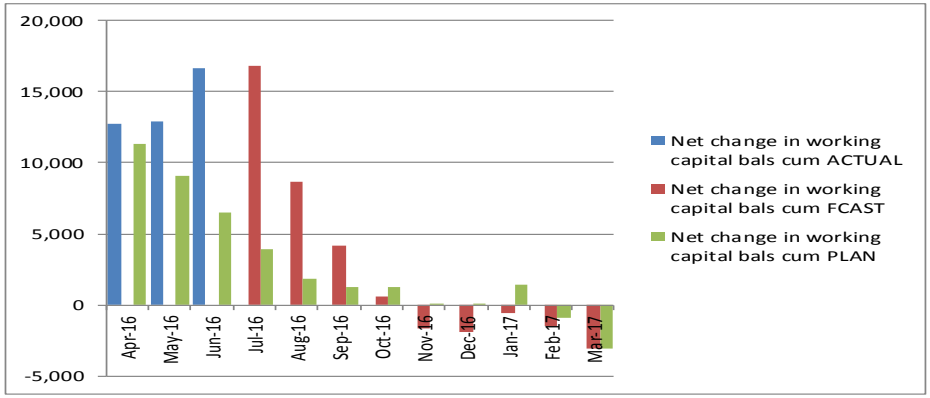
6 London Energy efficiency Fund loan for the energy performance contract.

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.

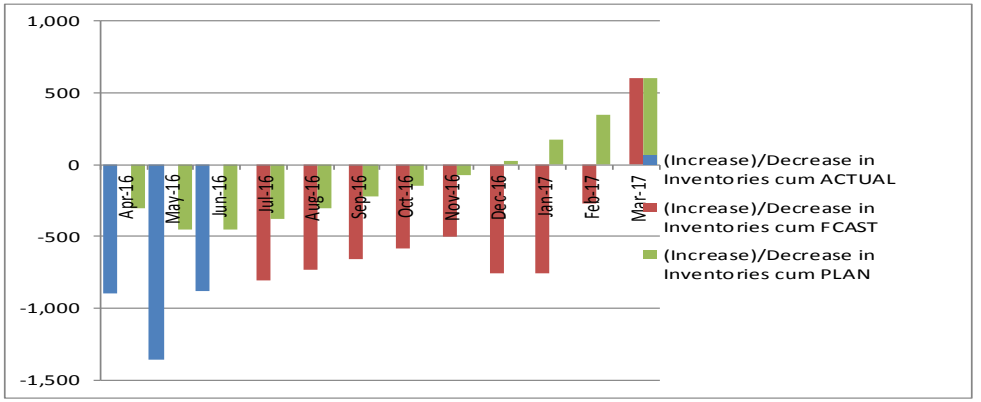
19. Working Capital – cumulative position at M03

Change in all working capital balances 2016/17 actuals vs plan



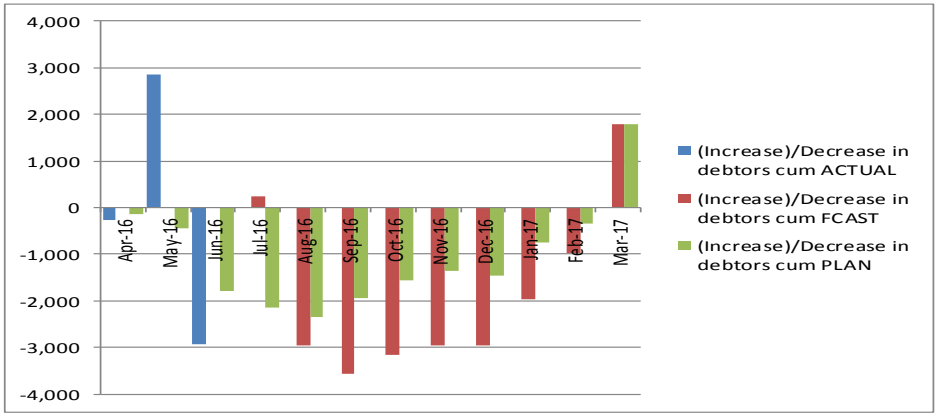
£10.1m BETTER than Plan YTD.
Other 3 graphs on this slide break down this movement by inventories, debtors and creditors.

Change in inventories (stock) 2016/17 actuals vs plan



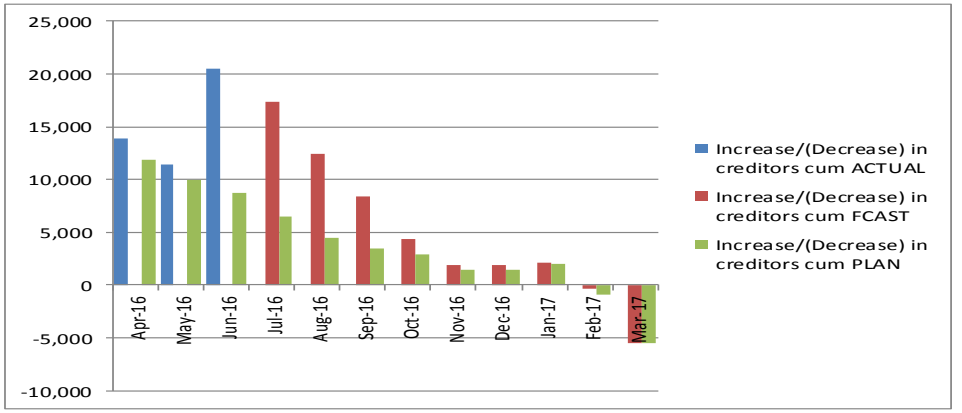
£0.4m WORSE than Plan YTD. Stock increased by Pharmacy after significant year end reduction. However stock reduced in M03 by £0.5m.

Change in debtors 2016/17 actuals vs plan



£1.1m WORSE than Plan YTD.
Total debt balances increased by £3.2m in month and are £1.1m worse than plan YTD however the M03 increase includes the £4.4m Q1 invoice for sustainability and transformation funding raised before month-end.

Change in creditors 2016/17 actuals vs plan

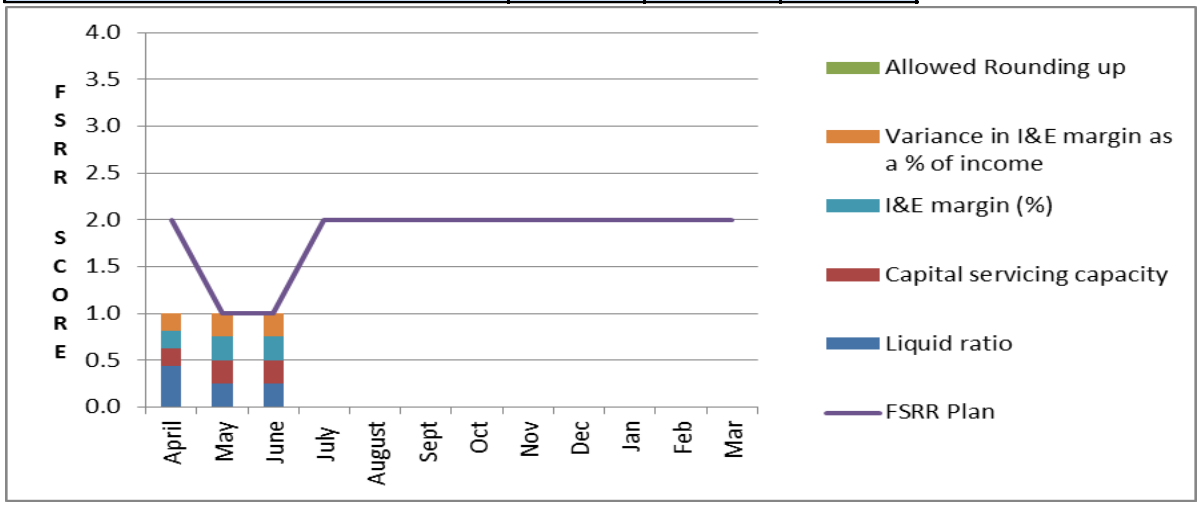


£11.6m BETTER than Plan.
Lower payments to suppliers in April and May. Trust has re-negotiated deferral of CNST premiums with NHSLA again this year ("payment holiday" in Q1). Also NHSPS rental payments not made due to late invoicing by supplier.

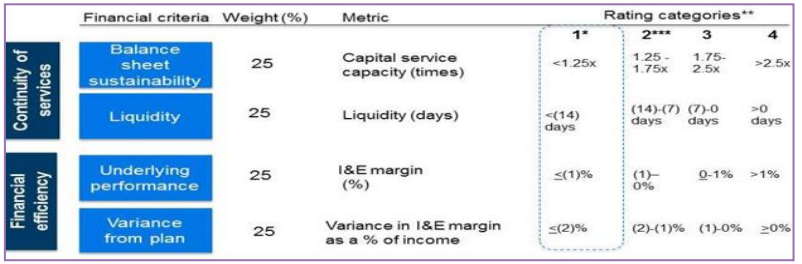
20. Financial Sustainability Risk Rating (FSRR)

2016/17 ACTUALS Metric Scores (4 best, 1 worst)	Month April	Month May	Month June
Liquid ratio	2	1	1
Capital servicing capacity	1	1	1
I&E margin (%)	1	1	1
Variance in I&E margin (%)	1	1	1
Weighted Average	1.3	1.0	1.0
Overriding Score (with rounding)	1	1	1

2016/17 PLAN	2	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 June the Trust achieved a score of 1 for its risk rating which is in line with plan.

Ratings for capital servicing, I&E margin and liquidity are in line with planned scores of 1,1 and 1 respectively.

The Liquidity score has deteriorated due to the net current asset position (as per plan).

The Variance against plan for April is 2.1% of Income. The NHSI plan reflects an expected variance of 1.3% based on last year's performance against the original plan submitted. The expected score for this metric is a 2, actual score is a 1.

NOTE ON INTERNAL PLAN V NHSI PLAN:

Against the NHSI plan to June (rather than the internal plan, outlined in Appendix 1) , the trust variance score was 1.0%, which would give a rating of 2, and be very close to a 3. The rating of 2 would not change the overall FSRR, however a 3 would allow the trust to record a total FSRR rating of 2.

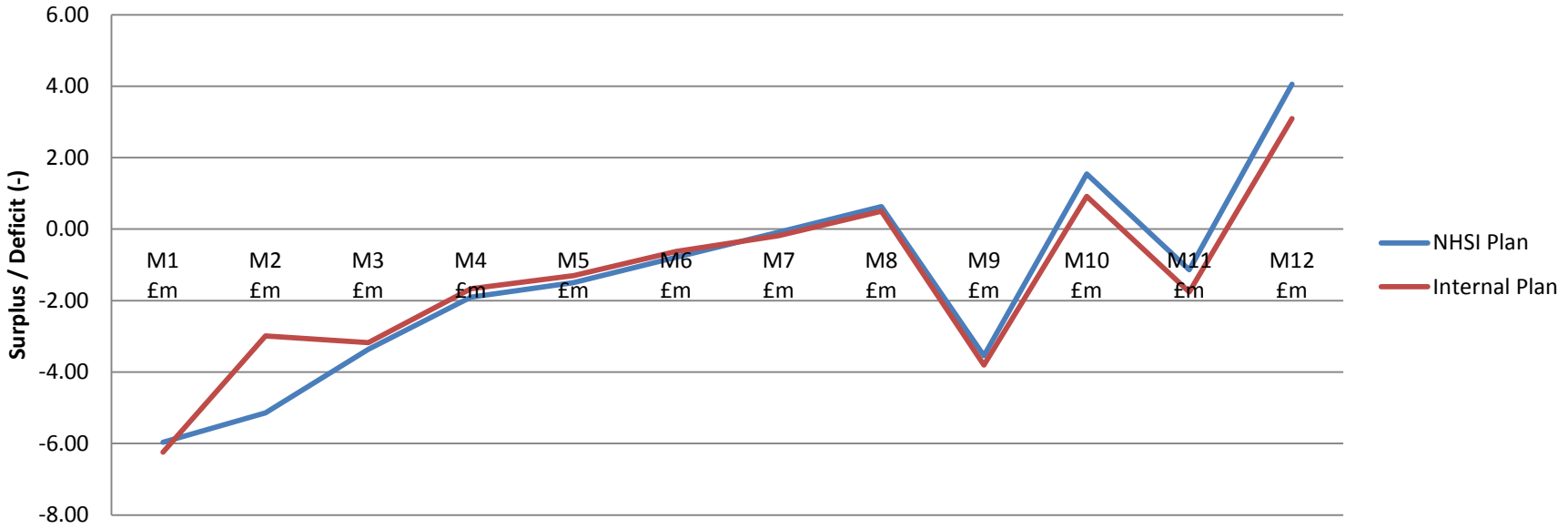
Appendices

Appendix 1: Budget Profile réconciliation NHS Improvement vs. internal (ledger) Plan

Appendix 2: Total agency spend against NHSI target: 30th June 2016

Appendix 3: Agency spend against NHSI target reported by staff group

Appendix 1: Budget Profile reconciliation – NHSI vs. Internal (ledger) Plan



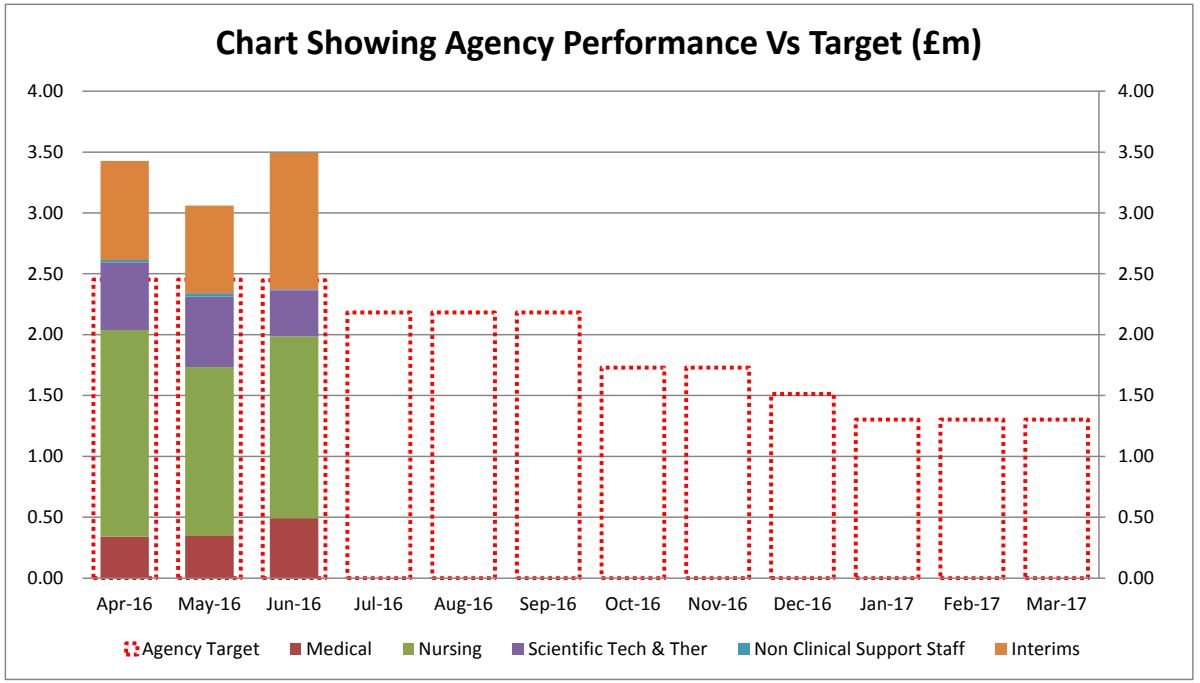
Surplus/Deficit (-)	M01 £m	M02 £m	M03 £m	M03 YTD £m	M04 £m	M05 £m	M06 £m	M07 £m	M08 £m	M09 £m	M10 £m	M11 £m	M12 £m	Total £m
NHSI Plan	-5.96	-5.14	-3.36	-14.47	-1.90	-1.50	-0.79	-0.09	0.63	-3.55	1.54	-1.14	4.06	-17.20
Internal Plan	-6.24	-2.99	-3.17	-12.40	-1.67	-1.30	-0.62	-0.19	0.50	-3.80	0.92	-1.76	3.09	-17.23
Variance	**-0.27**	**2.15**	**0.19**	**2.07**	**0.23**	**0.20**	**0.17**	**-0.10**	**-0.13**	**-0.25**	**-0.62**	**-0.62**	**-0.96**	**2.04**

Commentary

- The plan submitted to NHSI was a planned deficit of £14.5m YTD at month 3. The Trust's current internal planned deficit at month 3 is £12.4m YTD.
- The key reason for the difference is that the removal of SRG and education costs were back ended in the NHSI plan, and have been phased in equal 12ths when moved into the divisions at month 3 (£1.4m difference YTD).
- Income from the Family Planning block contract was phased in M1-3 in error, instead of M1-12). This has been corrected in month 3.
- In addition, divisions have made more minor adjustments to phasing to more accurately reflect the expected timing of income and expenditure (£0.4m). These will be kept to a minimum going forwards.

Appendix 2: Total agency spend against NHSI target: 30th June 2016

PERFORMANCE AGAINST AGENCY SPEND TARGET



	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Type of Staff	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**	**YTD**
Medical	0.34	0.35	0.49										1.18
Nursing	1.70	1.39	1.50										4.58
Scientific Tech & Ther	0.55	0.58	0.38										1.51
Non Clinical Support Staff	0.02	0.03	0.01										0.06
Interims	0.81	0.72	1.12										2.65
Total Agency Cost	**3.43**	**3.06**	**3.49**										**9.98**
Agency Target	2.45	2.45	2.45	2.18	2.18	2.18	1.73	1.73	1.51	1.30	1.30	1.30	7.35
Variance	0.98	0.61	1.05										2.63

Total Pay Cost	40.54	39.87	41.03										121.44
% Agency Cost of Pay	8.5%	7.7%	8.5%										8.2%
% Planned Agency	6.0%	6.0%	6.0%	5.3%	5.3%	5.3%	4.2%	4.2%	3.7%	3.2%	3.2%	3.2%	4.6%

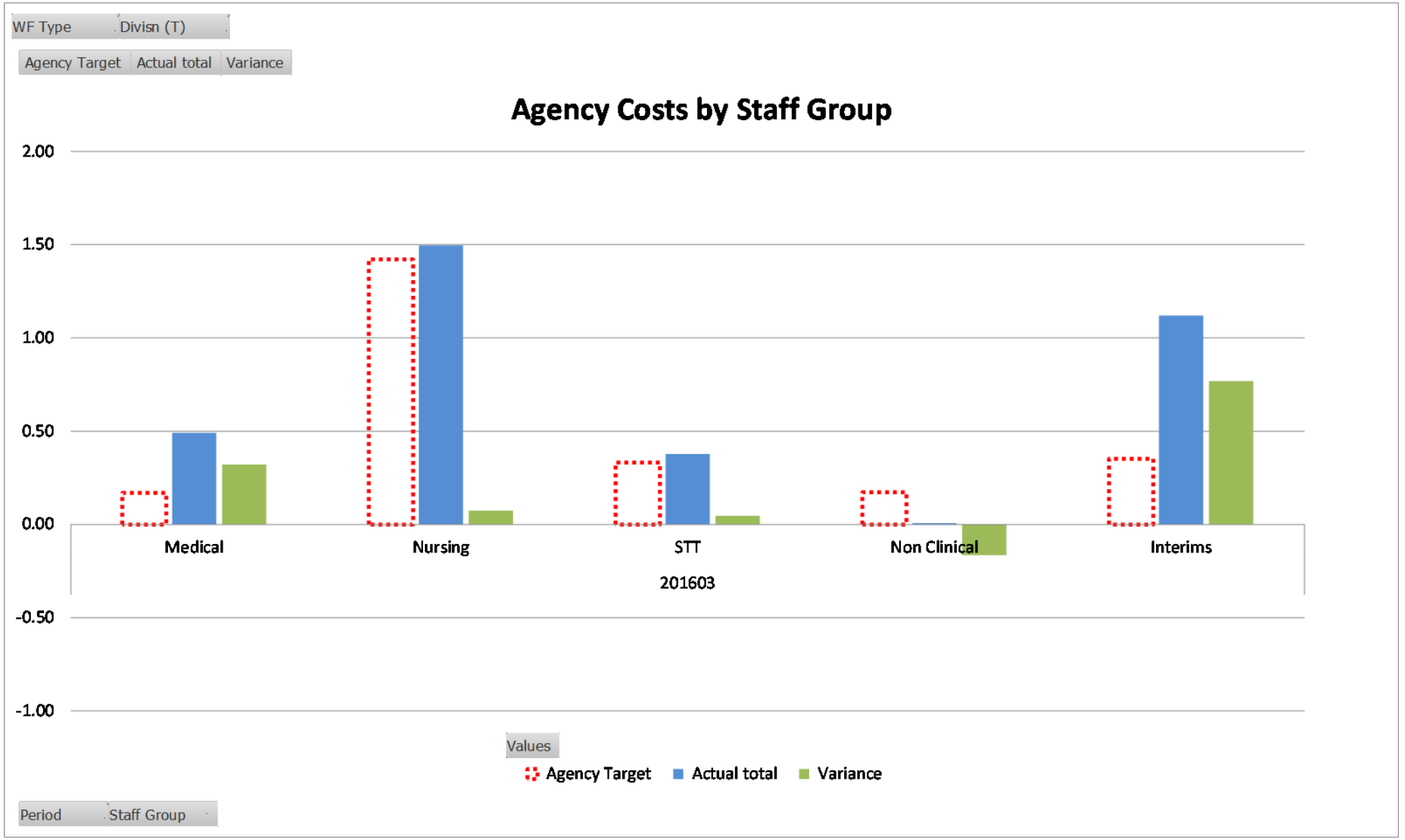
Commentary

The Trust's annual agency spend target set by NHS Improvement is to reduce agency costs from £36m to £23m.
For June the monthly target set was £2.45m.

Total Agency cost in June was £3.49m or 8.5% of the Total Pay costs. In 15/16 the Trust Agency % was 7.9%, and the target for 16/17 is to reduce to 4.6%.
Agency cost increased by £0.4m compared to May. Overall YTD we have exceeded the planned target by £2.631m.
The biggest area of overspend was the use of Interim contractors which exceeded planned target by £0.77m, primarily for Transformation and executive management cover.
Nursing and Medical cover increased in month while Other Non Clinical was below the monthly targets.

There is currently discussion with NHSI seeking to revise the Agency Ceiling Target for the Trust in light of new factors affecting our spend.
Appendix 3 on the next slide shows performance against the cap reported by staff group.

Appendix 3: Agency spend against NHSI target reported by staff group



St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD ***July 2016***

Paper Title:	Risk and Compliance report for Trust Board incorporating the Corporate Risk Register
Sponsoring Director:	Paul Moore, Director of Quality Governance
Author:	Maria Prete, Risk Manager
Purpose:	To highlight key risks and provide assurance regarding their management.
Action required by the committee:	The board are asked to: 1. *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.
- Management of CRR process under review

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

Preamble

1. The Director of Quality Governance joined the Trust on 4th July 2016. He has initiated the mechanism for a root and branch review of risk management practices, reporting and the quality of risk registers.

2. The Director of Quality Governance has met with risk owners and observed and challenged the review of risks, with a view to understanding the nature of the risks facing the Trust, and how to improve the quality of the corporate risk register for use by the Board and organisation as a whole.

3. Risk owners have been challenged to review the risk exposure and apply a focus on (i) risk treatment; and (ii) the use of relative frequency to evaluate probability. This has resulted in a number of changes which are listed in the report below. However, observation of the Organisational Risk Committee, which met on 13 July 2016, appeared to indicate that some existential threats, taken at face value from divisional risk registers, were not escalated and migrated to the Corporate Risk Register, and thus it is unclear if the Board are sighted on these potential threats (examples include ICT storage and Windows 7 migration).

4. This report continues to follow the conventions previously adopted by the Board. Proposals to develop the risk management system will be put before the Board in August, and agreement can be reached on the most appropriate way to present risk information to the Board. It is acknowledged and anticipated that:

   (i) the mechanism for handling risk registers will require substantial development to make them efficient and fit for reporting – this will include incorporating all risk records into Datix to aid analysis, timely updating and reporting;
   (ii) a more robust escalation mechanism is required, and shall be put in place for the next report, to ensure the Board are sighted on all significant risk exposures from within and across divisions; and
   (iii) the Board's Corporate Risk Register report will require development to help focus the Board on the material risk exposures and the decisions required by the Board to keep these risks under prudent control at all times.

5. At the time of report a number of risks were in the process of being updated and thus the pre-existing position is reported to the Board.

Paul Moore
Director of Quality Governance
21/07/2016

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. A detailed CRR is included at Appendix 2:The rating is based on the extent of current controls being applied to the risk (the residual risk).

Table one: highest rated risks

Ref	Description	C	L	Rating ↓↑
01-06	Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	5	4	20↑
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	5	4	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→**
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→**
05-06	Risk of loss of Trust data due to malware known as 'Ransom ware'	**4**	**5**	**20 →**

1.1 New risks proposed for inclusion on the CRR

1.1.1 There is one risk identified which is currently undergoing risk assessment:

- Meeting Cancer performance requirement (Operating Officer)
- IT structure: Storage, network, computer power and backup (ICT)

1.1.2 There are three risks previously identified for inclusion which, following further consideration will not be escalated to the Corporate Risk Register but will be placed on the Corporate Nursing risk register:

- 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)
- Risk to patient safety due to lack of compliance with Mental Capacity Act (MCA) (Corporate Nursing)

1.2 Changes to risk scores

1.2.1 Two risks score have been increased and six risks score have been reduced. The rationale is included at Appendix 1.

Appendix 1: Executive Overview of Corporate Risk Register
Domain: 1. Quality

Strategic Objective/Principal Risk	Lead	Start date	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	July 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	16	16	8	↓	Remove from CRR. To be held on Operation risk register
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	20	20	20	20	20	12	↓	Remove from CRR. To be held on Operation risk register
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	9	9	9	→	Remove from CRR. To be held on Operation risk register
A513-O1: Failure to achieve the National HCAI targets for MRSA and C Diff	JH	05/2010	12	12	12	12	12	12	→	Remove from CRR. To be held on the Corporate Nursing risk register
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	→	Remove from CRR. To be held on the Corporate Nursing risk register
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	→	Remove from CRR. To be held on the Corporate Nursing risk register
01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	CS	05/2014	20	20	20	10	10	20	↑	
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	CS	06/2014	20	20	20	16	16	20	↑	

01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	AR	07/2014	16	16	16	16	16	12	↓	
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	6	↓	Remove from CRR. To be held on Operation risk register
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	15	10	↓	Remove from CRR. To be held on the Corporate Nursing risk register
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.	AR	01/2016			12	12	12	4	↓	Remove from CRR. To be held on Medical Director risk register
01-22 Potential risk to patient safety due to a failure to ensure all Trust policies are up to date and available to all staff	LE	03/2016			16	16	16	6	↓	Remove from CRR. To be held on the Corporate Affairs risk register Policies have been updated and uploaded onto intranet
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	16	16	→	

Strategic Objective/Principal Risk	Lead	Start date	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	July 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	12	↓	Remove from CRR. To be held on the Corporate Nursing risk register
02-01 Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)	AR	07/2013	16	16	16	16	16	16	Proposed for closure	All CIP schemes are individually assessed and approved by the Executive Medical Director/Chief Nurse. Where necessary risks shall be reflected as individual risks to give greater visibility.

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	Lead	Start date	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	July 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	10	10	10	20	20	20	→	
3.16-05 Market Share risks – that the trust loses market share, negatively impacting on the trusts activity and income.	NC	07/2015	10	10	10	10	10	10	→	Remove from CRR. To be held on the Finance risk register
3.17-05 Cost Improvement Programme slippage - The Trust does not deliver its cost improvement programme objectives	NC	07/2015	15	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	20	20	20	→	
3.19-05 Cash-flow Risks – Cash balances will be depleted	NC	07/2015	16	16	16	16	16	16	→	

due to: Delays in receipt of SLA funding from Commissioners Capital overspends										
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	20	→	
3.21 Transformation resources are of insufficient capacity and/or capability to deliver the expected benefits in 16/17	IL	03/2016			16	16	16	16	Proposed for closure	Risks are reflected within individual risks

Strategic Objective/Principal Risk	Lead	Start Date	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	July 2016	In month change	Change/progress
2.2 Meet all operational & performance requirements									↓↑	
3.7- 06 Failure to meet the minimum requirements of the NHSI Risk Assessment Framework may result in reputational damage or regulatory action.	CS	05/213	20	20	20	20	20	20	Proposed for closure	Risks are reflected within individual risks
3.8 – 06 Low compliance with new working practices introduced as part of new ICT enabled change programme	LM	06/2013	12	12	12	12	12	12	→	
3.9 – 06 Risk of inappropriate deployment of e-prescribing and electronic clinical documentation	LM	07/2014	12	12	12	12	12	12	→	

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	Start date	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	July 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	15	15	15	15	15	15	→	
A537-O6:Confidential data reaching unintended audiences	AR	10/2010	12	12	12	12	12	9	↓	Remove from CRR. To be held on Medical Director risk register
A610-O6: The trust will not attain the nationally mandated target of 95% of all staff receiving annual information	KC	10/2011	15	15	15	12	12	10	↓	Remove from CRR. To be held on HR risk register

governance training										
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	12	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	16	16	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	15	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	15	8	↓	Remove from CRR. To be held on the Corporate Affairs risk register

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	Lead	Start Date	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	July 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	SM	09/2010	12	12	12	10	10	10	→	Remove from CRR. Risk assessment to be re-undertaken once the strategic objectives have been finalised

Strategic Objective/Principal Risk	Lead	Start Date	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	July 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	IL	05/2016				20	20	20	Proposed for closure	Risk is considered within 5.1-02

Strategic Objective/Principal Risk	Lead	Start date	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	July 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.	AR	03/2013	8	8	8	8	8	8	Proposed for closure	Risk has been mitigated

Strategic Objective/Principal Risk	Lead	Start date	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	July 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'	LM	07/04/2016				20	20	20	→	

Domain: 5. Workforce

Strategic Objective/Principal Risk	Lead	Start date	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	June 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	KC	05/2010	16	16	16	16	16	12	↓	Remove from CRR. To be held on HR risk register

A516-O4: Possible reductions in the overall number of junior doctors available with a possible impact on particular specialty areas	KC	11/2012	9	9	12	12	12	12	→	Remove from CRR. To be held on HR risk register
A520-O4: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	KC	05/2010	16	16	20	20	20	8	↓	Remove from CRR. To be held on HR risk register
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	KC	11/2015	20	20	20	20	20	16	↓	
5.1-02 Risk of inadequate management capacity to ensure required support and engagement with turnaround programme whilst also delivering business as usual.	KC	12/2015	15	15	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	KC	12/2015		20	20	20	20	10	↓	Remove from CRR. To be held on HR risk register
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	KC	12/2015		16	16	16	16	12	↓	Remove from CRR. To be held on HR risk register
5.1-05 Lack of success of the transformation programme without sufficient organisational support	KC	03/2016			16	16	16	12	→	Remove from CRR. To be held on HR risk register
5.1-06 Impact upon capacity to deliver quality core services and transformation programme due to disengaged workforce	KC	04/2016			20	20	20	16	↓	

JH	Jennie Hall	Chief Nurse (DIPC)	RH	Richard Hancock	Director of Estates & Facilities
AR	Andrew Rhodes	Medical Director	RE	Rob Elek	Director of Strategy
CS	Corinne Siddall	Chief Operating Officer	KC	Karen Charman	Interim Director of Workforce & OD
NC	Nigel Carr	Director of Finance	IL	Iain Lynam	Chief Restructuring Officer
LE	Luke Edwards	Head of Corporate Governance	SM	Simon Mackenzie	CEO

Appendix 2: Full Corporate Risk Register– detailed controls

Quality Domain:

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 Apr 2016**	**Next Update July 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. 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.			**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 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 April 2016**	**Next Update July 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. **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.			**Assurance**		
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	01-06 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 July 2016**	**Next Update Aug 2016**	**Exec Sponsor**	Corinne Siddall, Chief Operating Officer
Consequence	5	5		**Date opened**	31.5.2014
Likelihood	4	4		**Date closed**	
Score	20	20			
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:	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 July 2016**	**Next Update Aug 2016**	**Exec Sponsor**	Corinne Siddall, Chief Operating Officer
Consequence	4	5		**Date opened**	1/6/2014
Likelihood	5	4		**Date closed**	
Score	20	20			

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 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	**Assurance**	Delivered 94.11% end of April 16
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 July 2016**	**Next Update August 2016**	**Exec Sponsor**	Andrew Rhodes, Medical Director
Consequence	4	4		**Date opened**	19.7.16
Likelihood	4	3		**Date closed**	
Score	16	12			

Controls & Mitigating Actions	• All doctors have been reminded of their responsibility for ensuring that tests that they order are followed up. • All Care Groups have been asked to develop Standard Operating Procedures to ensure that this happens. • All serious incidents resulting from failure to follow up tests have been reviewed and themes reported to Divisions. • Radiology have strengthened their safety net system. This now includes e mail to MDT for unexpected cancer (cancer MDTs 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. • Policy for Acting on Diagnostic test Results ratified	**Assurance**	• Compliance with Trust Policy can now be tracked through Tableau, which records numbers of unendorsed radiology and cellular pathology test results on iCLIP and the numbers of tests ordered/not ordered using iCLIP. The number of unendorsed results on Tableau is steadily increasing. • There is no ability to track compliance through Tableau of other results at the present. • There is limited ability of ensuring that once results are seen, the correct actions are followed.
Gaps in controls	• The effectiveness of the SOPs is not consistent. • 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**	The feedback from consultants completing the audit indicates compliance issues. Whereas for some consultants the system seems to work satisfactorily, for many it does not. The main issue raised was in respect of correct attribution of patients to consultants. This results in consultants being a) required to endorse patients for whom they are not responsible, and b) results of their own patients not being received for endorsement. Issues regarding the time required to comply with the new system, and the limitations of IT systems were common themes. Some of the specific issues raised could possibly be rectified by additional training, others would require system changes (either technical or in respect of workflows).

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 Apr 2016**	**Update July 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.			**Gaps in assurance**	

	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		
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	01-16 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 April 2016**	**Update July 2016**	**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 & timescale:	Asset and PPM programme being developed for all estates assets. 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 April 2016**	**Next Update July 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	01-23 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 April 2016**	**Next Update July 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 &	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

Mitigating Actions			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.		

Finance & Performance Domain:

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 April 2016**	**Next Update July 2016**	**Exec Sponsor**	Nigel Carr, Chief Financial Officer
Consequence	5	5		**Date opened**	20/07/15
Likelihood	4	4		**Date closed**	
Score	20	20			
Controls & Mitigating Actions	Working Capital Management, reporting and forecasting • Monthly Cash flow forecasts report the impact of the Trust's financial performance on the Trust's cash position **Distressed Trust Regime** • The current provider management regime allows for FTs to seek interim Support when in financial difficulty. • Such support is defined within Secretary of State's guidance under section 42A of the National Health Service act 2006 (Section 42A Guidance - https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts). It is used to provide transitional financial support to an FT or NHS Trust in financial difficulty where it is necessary to support the continued delivery of services for a period during which an assessment of the underlying problem is carried out and a			**Assurance**	No identified assurance

	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	**3.17-05 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 April 2016**	**Next Update July 2016**	**Exec Sponsor**	Nigel Carr, Chief Financial Officer
Consequence	5	5		**Date opened**	20/07/15
Likelihood	4	3		**Date closed**	
Score	20	15			
Controls & Mitigating	Controls ▪ Turnaround Board to oversee Trusts response to 2016/17 financial challenge by taking a lead role in			**Assurance**	▪ Extensive governance across workstreams and divisions is in place ensuring ownership and accountability, with a report into the Turnaround Board every month

Actions	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		▪ 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

<table>
<tr><td></td><td colspan="5">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</td></tr>
<tr><td>Domain</td><td colspan="3">2.Finance & Operations</td><td>Strategic Objective</td><td>2.1 Meet all financial targets</td></tr>
<tr><td></td><td>Original</td><td>Residual April 2016</td><td>Next Update July 2016</td><td>Exec Sponsor</td><td>Nigel Carr, Chief Financial Officer</td></tr>
<tr><td>Consequence</td><td>4</td><td>4</td><td></td><td>Date opened</td><td>20/07/15</td></tr>
<tr><td>Likelihood</td><td>4</td><td>5</td><td></td><td>Date closed</td><td></td></tr>
<tr><td>Score</td><td>16</td><td>20</td><td></td><td colspan="2"></td></tr>
<tr><td>Controls & Mitigating Actions</td><td colspan="3">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 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</td><td>Assurance</td><td>Monthly financial reporting of performance to the Board
Identification and review of cost pressures through the Business Planning cost pressure review process.</td></tr>
</table>

	▪ 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 and 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 April 2016**	**Next Update July 2016**	**Exec Sponsor**	Nigel Carr, Chief Financial Officer
Consequence	4	4		**Date opened**	20/07/15
Likelihood	3	4		**Date closed**	
Score	12	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.	**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.

	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 • 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 April 2016**	**Next Update July 2016**	**Exec Sponsor**	Nigel Carr, Chief Financial Officer
Consequence	5	5		**Date opened**	30/09/15
Likelihood	4	4		**Date closed**	
Score	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:**			**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

	▪ Transformation plans / capacity and flow programme		
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	3.8-06 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 April 2016**	**Next Update July 2016**	**Exec Sponsor**	Larry Murphy, Chief Information Officer
Consequence	4	4		**Date opened**	02/06/2013
Likelihood	3	3		**Date closed**	
Score	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**	
	Original	**Residual April 2016**	**Next Update July 2016**	**Exec Sponsor**	Larry Murphy, Chief Information Officer
Consequence	4	4		**Date opened**	1.7.14
Likelihood	3	3		**Date closed**	
Score	12	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 Progarmme 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 hs 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 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	**Gaps in assurance**	None identified
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:

Principal Risk	**A534-07**: Risk of certification and registration suspension if the Trust fails 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 July 2016**	**Next Update Aug 2016**	**Exec Sponsor**	Jennie Hall, Chief Nurse & Director of Infection Prevention and Control
Consequence	5	5		**Date opened**	31/10/2010
Likelihood	3	3		**Date closed**	
Score	15	15			
Controls & Mitigating Actions	Trust Quality inspections programme 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			**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

	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 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 visit took place on 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		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.
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:	Working to complete actions arising from CQC		

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 April 2016**	**Next Update July 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.			**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

	Fire risks assessments (FRAs) prepared by Fire Safety Specialists and issued to space/premises managers Head of Estates Compliance in post 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.		undertaken in the next month. • The annual staff fire training stands at 75% with further training dates available via the intranet. • 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 April 2016**	**Next Update July 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 April 2016**	**Next Update July 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 April 2016**	**Next Update July 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 April 2016**	**Next Update July 2016**	**Exec Sponsor**	Richard Hancock, Director E&F
Likelihood	4	4		**Date opened**	14 May 2014
Consequence	4	4		**Date closed**	
Score	16	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 freezer storage capacity				
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	**Residual July 2016**	**Next Update Aug 2016**	**Exec Sponsor**	Jennie Hall, Chief Nurse & Director of Infection Prevention and Control
Consequence	5	5		**Date opened**	27.8.2015 – escalated from Division

Likelihood	5	3		**Date closed**	
Score	25	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. Insufficient deep freeze storage for number of long stay cases.			**Gaps in assurance**	Confirmation individual undertaking DI role from July onwards. Agreement of Freezer Expansion Business Case. Mortuary currently has freezer capacity of 5 spaces
Actions next period:	Deep freeze storage units to be built in Mortuary by end of September 2016 Deep freeze storage units to include at least 5 bariatric spaces				

Strategy, transformation & development Domain:

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 April 2016**	**Next Update July 2016**	**Exec Sponsor**	Larry Murphy, Chief Information Officer
Likelihood	4	4		**Date opened**	07/04/2016
Consequence	5	5		**Date closed**	
Score	20	20			
Controls & Mitigating	NHS N3 gateway anti malware software Local Websense anti malware software. Local Anti-virus software.			**Assurance**	ICT systems team restoring identified corrupt files from back-ups. Supplier informed and anti-malware suite security controls increased.

Actions	User education and communication.		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.		

Workforce domain:

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 July 2016**	**Next Update Aug 2016**	**Exec Sponsor**	Karen Charman, Director of Workforce & Organisational Development
Consequence	4	4		**Date opened**	10/2015
Likelihood	3	4		**Date closed**	
Score	12	16			
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.			**Assurance**	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. 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 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. KPMG have produced a detailed weekly tracker analysing staff in post movements The weekly tracker system has been implemented Business case approved to recruit 150 nursing staff from Philippines.		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. New weekly tracker system has helped meeting KPI 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. 150 nursing staff due to arrive from September 2016 onward
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. 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:	Workforce plan to be rewritten and focused on current needs of St Georges so risk to be redrafted with new actions and deliverables for 1st September		

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 April 2016**	**Next Update Aug 2016**	**Exec Sponsor**	Karen Charman, Director of Workforce & Organisational Development
Consequence	3	3		**Date opened**	30/11/2015
Likelihood	5	5		**Date closed**	
Score	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 Communications to reassure staff around financial position of trust.. Monthly Chief Nurse open forum launched Nov 2015 Leadership programme launched Additional staff in post			**Assurance**	
Gaps in controls				**Gaps in assurance**	
Actions next period:					

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 June 2016**	**Next Update Aug 2016**	**Exec Sponsor**	Karen Charman, Director of Workforce & Organisational Development
Consequence	5	5		**Date opened**	1/12/2015
Likelihood	5	4		**Date closed**	
Score	25	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. 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	**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. Strike action has been managed with no perceivable negative impact on business continuity
Gaps in controls	Limited ability to influence response to national agenda	**Gaps in assurance**	Uncertainty around effectiveness of actions until fully tested Uncertainty around further strike action
Actions next period:	Continue on-going planning in relation to the recently announced industrial action dates.		

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	**Residual July 2016**	**Next Update Aug 2016**	**Exec Sponsor**	Karen Charman, Director of Workforce & Organisational Development
Consequence	4	4		**Date opened**	1/4/2016
Likelihood	5	4		**Date closed**	
Score	20	16			

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 Interim MD engaging with staff Staff survey open session Review bullying and harassment policy Listening into Action	**Assurance**	Negative Staff survey results and medical engagement score Progress against workforce action plan reports to Workforce and Education Committee New staff from Philippines to arrive from September 2016
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:	Re-written workforce priorities programme to be launched in September 2016 including Fit for the Future campaign. Quarterly staff survey to commence quarter 2		

Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD - 28 July 2016 **Paper Ref:**

Paper Title:	**Funding application for critical Estates and IT infrastructure backlog maintenance**
Sponsoring Director:	**Nigel Carr**
Author:	**Nigel Carr**
Purpose: *The purpose of bringing the report to the board*	*Information*
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*	**F&P**

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

1. Key messages

- An application was made to NHSI on 10 June 2016 for further financial support amounting to £39.1m to fund additional capex spend (over and above the current budget of £38m) in respect of backlog maintenance where there is either a risk of failure or the conditional of the infrastructure is becoming unsafe
- The composition of the request is made up as follows:
  - £6.7m high risk backlog estates projects
  - £12.8m vacating and removing out of date building stock (Wandle, Knightsbridge)
  - £5m demolishing Clare & Bronte and expanding car park
  - £5m revising clinical service capacity and location
  - £9.6m ICT infrastructure stabilisation

2. Recommendation

- The Board is asked to note that whilst NHSI may take up to 3 months to approve the request, no commitments will be made until the funding is agreed.
- Discussions are being held with NHSI to support critical expenditure over the next 3 months pending approval of the main facility

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?

High risk of infrastructure failure leading to loss of capacity and adverse impact on patient services

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	**n/a**
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
If yes, please provide a summary of the key findings

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