St George's University Hospitals NHS
NHS Foundation Trust

Trust Board Meeting (Public)

Thursday 6th October 2016
9.30am – 1pm
Queen Mary's Hospital – Richmond & Barnes Rooms

Item	Time	Item	Owner:	Board Action	Paper No:
PATIENT STORY					
Board Business					
1.		**Welcome and Apologies**	D Henshaw	Apologies received from :	-
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**	D Henshaw	To consider the Minutes of the previous meeting held on 1st September 2016 and check for amendments and approve	TB Oct 16 - 01
4.		**Key Issues**	All	Board members to identify any key issues	-
5.		**Schedule of Matters Arising**	D Henshaw	To discuss any matters arising from previous meetings and provide updates and review where appropriate	TB Oct 16 -02
6. Patient Safety, Quality and Performance					
6.1		**Performance & Quality Report**	M Gordon & S Banks	To inform the Board about the latest performance and quality report	TB Oct 16 -03
6.2		**Workforce Performance Report**	K Charman	To inform the Board about the latest position on workforce and present new focused set of priorities	TB Oct 16 -04
6.3		**Report from the Quality Committee**	N Williams	To inform the Board about the key issues arising from the Committee	Verbal
6.4		**Report from the Workforce and Education Committee**	G Norton	To provide a verbal update on the key issues arising from the Committee. Workforce Performance report attached for information	TB Oct 16 -05

Item	Time	Item	Owner:	Board Action	Paper No:
6.5		**RTT**	M Gordon	Monthly update	TB Oct 16 -06
7. Transformation					
7.1		**Update on cost improvement programme**	I Lynam	Update on current position	TB Oct 16 -07
7.2		**Interim Resourcing**	I Lynam	Update	TB Oct 16 -08
7.3		**Estates Report**	R Hancock	Update and assurances against identified risks	TB Oct 16 -09
7.4		**Project Update - Gibraltar and Overseas Patients**	I Lynam	Update	TB Oct 16 - 10
8. Finance and Performance					
8.1		**Finance Report – month 5**	N Carr	To inform the Board about the latest project outturn	TB Oct 16 -11
8.2		**Finance & Performance Committee**	D Henshaw	To inform the Board about the key issues arising from the Committee	TB Oct 16 -12
8.3		**Report from the Audit Committee**	S Wilton	To inform the Board about the key issues arising from the Committee and highlight the summary findings from the External Audit report	TB Oct 16 -13
09. Governance and Risk					
9.1		**Corporate Risk Report**	S Maughan	To review the Trust's most significant risks and external assurances received	TB Oct 16 -14
9.2		**ICT Approach**	L Murphy	Approval of direction of travel	TB Oct 16 -15
9.3		**Board Assurance Framework**	L Edwards	To review the new Board Assurance Framework and provide any initial comments	TB Oct 16 -16
9.4		**Fit and Proper Person Assessment and Revised Policy**	L Edwards	For approval	TB Oct 16 -17

Item	Time	Item	Owner:	Board Action	Paper No:
9.5		**A Framework of Quality Assurance for Responsible Officers and Revalidation**	A Rhodes	To provide assurance	TB Oct 16 - 18
10. Items for Information					
10.1		**Use of the Trust Seal**	D Henshaw	To note use of the Trust seal in September 2016 – **The seal has not been used in September 2016**	-
10.2		**Questions from the Public**		Members of the public present are invited to ask questions relating to business on the agenda. Priority will be given to written questions received in advance of the meeting	-
10.3		**Key reflections**	All	The Board to reflect on key issues	-

Date of next meeting

The next scheduled meeting of the Board in public is 3rd November 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 1 September 2016 in Boardroom H2.8 commencing at 10am.

PRESENT

Sir David Henshaw	DH	Chairman
Mark Gordon	MG	Chief Operating Officer
Gillian Norton	GN	Non-Executive Director
Sir Norman Williams	NW	Non-Executive Director
Thomas Saltiel	TS	Associate Non-Executive Director
Simon Mackenzie	SM	Chief Executive Officer
Iain Lynam	IL	Chief Restructuring Officer
Suzanne Banks	SB	Chief Nurse
Karen Charman	KC	Director of Workforce
Nigel Carr	NC	Chief Finance Officer
Paul Moore	PM	Director of Quality Governance
Justin Richards	JR	Divisional Chair, Children's and Women's,
Alison Benincasa	AB	Divisional Chair, Community Services
Lisa Pickering	LP	Divisional Director of Medicine and Cardiovascular
Jenni Doman	JD	Assistant Director, Facilities
Hazel Tonge	HT	Deputy Chief Nurse
Steve Sewell	SS	Outpatient Programme Director

Agenda Item		Action
	Patient Story – Dino Bragazzi The Chair introduced Dino Bragazzi to give personal experience his story of being a patient at St George's. Mr Bragazzi had suffered right hand side body paralysis in 2005 but a diagnosis could not be found. In 2006 following an MRI scan at St Georges, he had a front lobe tumour removed in a successful operation. He felt that the care he had received throughout at St George's was fantastic and he has since made a full recovery. The only criticisms he had concerned the aftercare on discharge in 2006 did not offer sufficient support or signposting to any charity's that offer support to patients. Also, he felt there was a lack of cohesion between NHS services regarding shared information and centralised patient record. The Board thanked Mr Bragazzi for sharing his story with the Board.	
1	**Welcome and Apologies** The Chair opened the meeting and welcomed Suzanne Banks, Mark Gordon, Karen Charman and Thomas Saltiel. Apologies were received from Sarah Wilton, Richard Hancock, Andrew Rhodes,	

Jenny Higham, Chris Rolfe, Luke Edwards and Larry Murphy.

2. Declarations of Interest

No declarations of interest, pecuniary or non-pecuniary, were received.

3. Minutes

The Board considered the minutes of the last meeting held on 28 July and noted some minor amendments.

Resolved that the Board**:** approved the minutes as a true and accurate record as amended.

4. Key Issues

Key issues are covered in agenda.

5. Matters Arising

The matters arising were covered in the agenda.

6 PATIENT SAFETY, QUALITY AND PERFORMANCE

6.1 Performance & Quality Report

MG presented to performance report highlighting that performance against the cancer two week standard was 90% in June against the standard. This reflects an over the quarter and an activity plan has been put in place which will enable delivery of the standard in the future. NW asked if the Trust had any 'one stop clinics'. MG responded that currently we do not, but this needed to be considered further as it may be a more efficient model for services such as Dermatology.

MG noted that had been a major shift in the way in which we organise theatres to ensure better matching of appropriate theatre space. This will assist in clearing the backlog of operations and help increase income. Paediatrics has been the first division that has been given responsibility over booking theatre space and this will then be rolled out to our divisions. All outsourced surgery has been stopped and is now on individual exceptional basis where we have contract arrangements. The junior doctors proposed strikes will mean that planned operations will have to be cancelled and rescheduled and will have a negative impact.

NW noted the good progress that had been made and asked whether there was a lack of capacity. MG confirmed that lack of capacity was not the key issue but that capacity planning needed to be significantly improved. MG is currently spending time coaching General Managers to ensure that a standard process is followed and to ensure that they have a sufficient knowledge of the day to day delivery of their service.

HT introduced the quality element of the report. The mortality figures are within normal limits including weekend however health records

audit figures are down to 75% which is very poor with significant variation amongst divisions. A lead has been identified to improve performance and a report will be submitted to the next EMT for consideration. Infection control is performing well with no cases of MRSA in nearly a year and 2 cases of c diff in July.

There is an on-going problem around compliance with safeguarding children training. There were 50 places at last training day and only 12 staff attended. Action will be taken to ensure managers release staff for essential training and a plan will be put in place to resolve the issue.

Resolved: that the Board noted the update and next steps.

6.2 Workforce & Performance Report

KC introduced the report which showed some performance improvement in a number of areas however there remained a significant amount of work that needed to be done. The turnover rate has increased this month to 18.8%, significantly above the current target of 13%. We are looking at where we are losing people through the recruitment process such as drop outs, ensuring we know where new recruits are in the 'pipeline'. There is a '100 day' tipping point for new staff who leave because they are not happy or do not feel well supported. The key priority is to ensure that they have received a good induction and feel supported in their new role. In respect of retention of staff, after the Brexit vote a Trust wide message was sent out to all staff to say how much we value our European members of staff. We received a great response from staff and will be ensuring that we continue to support staff going forward once the result of Brexit negotiations have begun. Mast training is now over 80% against a target of 85%

The number of bank and agency staff remains broadly at the same level despite increases in overall staff levels. This raises a number of concerns including around costs and we are investigating this issue. The Trust has put in place process to manage recruitment with a short term vacancy freeze in place as revised plans are developed with all divisions including the corporate areas of the business. The focus will be to deliver a sustainable reduction in administrative staff and other non-essential staff but not clinicians. An improved monthly report will be presented to the Board from next month.

Resolved: that the Board noted the report.

6.3 RTT Report

IL presented an update report on the RTT programme. An initial contract has been awarded to Cymbio to conduct a first small sizing exercise to determine the number of patient records that will need validating. Chris Nolan has been appointed as Programme Director as he has experience of Cerner and major software projects.

A full report will be prepared for the next Board which will include the

budget required to resolve the issue.

Resolved: the Board noted the report and that a more detailed paper will be presented to the October meeting.

IL October 2016

6.4 Estates

JD updated the Board on progress against the plan in RH's absence:

- Work has now completed on theatres 5 and 6 and they are expected to open imminently.
- The Wandle Annexe has been vacated and demolition has commenced. All other marked buildings will be demolished this year.
- Some renal services for appropriate patients have been relocated in the community and the mobile dialysis unit is now on site.
- The Mortuary project phase 2 will be completed by end of September.

SM confirmed to NW that we needed to have actioned changes to the estate in response to the CQC by the 30 November and a large part of programme was underway including the theatre refurbishment. The latter had to be balanced with on-going activity. CQC are being kept informed of progress and are realistic in their expectations.

Resolved: the Board noted update.

6.5 Complaints Action Plan

HT introduced the item. The Trust had held a workshop on 19 April in relation to the poor performance on complaints. This identified 40 areas which required further work to address including the timing and quality of responses. Staff have already been provided with training including e-learning. It was noted that obvious errors and typos should be checked before given to CEO for signature.

GN asked if there was learning from complaints. HT responded that in weekly divisional meetings with complaints team, actions and themes were recorded such as communication, bookings and attitude of staff. This standard practice in many Trusts and we are looking at learning from good practice at other trusts including Leicester Hospitals.

Resolved: that the Board noted update was and agreed that monthly reports would be provided.

7. TRANSFORMATION

7.1 Outpatient Programme presentation

SS introduced the item reminding the Board that the previous report was at the June meeting. There are still many challenges across the Trust which are being prioritised but there have been some positive outcomes. In July, improvements in Dermatology outpatients led to an

increase of £35,000 in income. The call centre has dramatically improved answered calls within 60 seconds. In the next six months, referrals will get a response within days with a future appointment date. We want to ensure that patients are not given unnecessary follow up appointments.

GN asked whether we have a reasonable level of confidence in our IT systems to provide support for these changes. IL responded that we intend to use three databases across the Trust which will capable of providing what we want and these are on track to be delivered early next year.

DH noted that he had met with Dermatology team last week who wanted to try new ways of working but felt they needed to seek permission. DH informed them it is their service to manage and they don't need permission to make improvements that will benefit patient care.

FM asked about some elderly neighbours she helps who were unable to speak to someone at the call centre to cancel an appointment. SS stated that this has now greatly improved and text and letter reminders will be sent to patients nearer to appointment date when appointment booked far in advance to avoid DNAs.

Resolved: that the Board noted update

7.2 Interim Resourcing

IL presented a paper on interim resourcing. The Trust currently has 1128.38 WTE of temporary staff working here, including 61 WTE interims and 12 WTE of KPMG consultants. The KPMG consultants will be phased out by end of September.

Every interim will be reviewed over the next few weeks to ensure the role is justified and an exit date is agreed. An update will be provided once this is complete.

DH added that he was aware that there had been concerns raised about the number of interims at senior level and positions not filled substantively. However the interims were not here for just a few months but to provide stable leadership, push through a huge agenda of change and to leave the Trust in a better position. It will then be possible to attract the right people in the substantive roles going forward.

Resolved: that the Board noted update

8. FINANCE

8.1 NC summarised the report for the Board. The trust was £11.0m deficit in month 4 which was £9.0m adverse to plan. This includes £5.9m adverse variance due to the exclusion of STF income previously accrued, no longer expected to be received. The adverse variance excluding this adjustment is £3.1m.

The year to date deficit is now £16.5m which was less than £1m below the control total of £17.2m. These figures assume that we accrue the STF funding and while the guidance for Quarter 1 remains unclear we are clearly in a very challenging position.

The cash position is deteriorating given the worse revenue deficit and the trust drew down £20.9m from facilities on the 15th August. The forecast outturn is based on a revenue deficit of £53.3m.

The total forecast borrowing requirement for the year would be £107.7m, £75.2m higher than planned. This includes the emergency capital funding request of £39.1m for urgent estates investment and £36.1m extra borrowing needed to finance the higher operating deficit.

£3.8m of cost year to date relate to items outside of the Trust's initial plan regarding unforeseen, one off issues associated with the CQC, the estate, IT infrastructure, additional senior management support and Junior Doctors strike.

GN stated that she felt reassured despite the big numbers that we were facing the risks and challenges.

Resolved: that the Board noted update.

9. Governance and risk

9.1 Risk and Compliance Report

PM updated the Board on the progress of his work to review the corporate risk register (CRR). The CRR is currently being rebuilt and reassessed and is due to be completed by the 30th September. This will produce a report on which the Board can rely for assurance and decision making can rely for assurance and decision making purposes. The CRR may change as further analysis, challenge and the development of the risk profile progresses.

The Board's strategic risks are currently being assessed ahead of producing a new Board Assurance Framework (BAF) for the next Board Meeting.

TS asked about how many items had been identified as risks? PM responded that there were around 500 across the Trust but had not all yet been validated.

Resolved: that the Board noted update and that the BAF and revised risk register will be reported to the October Board.

10. Items for Information

10.1 Use of the Trust Seal

The use of the trust seal was noted.

10.2. Questions from the Public

Leslie Robertson asked MG about the gaps he had identified between general managers and clinicians in the divisions. MG responded that it was no different from any other trust and they needed guidance to be clear on individual responsibilities.

Gail Adams asked about theatre utilisation and whether work is still outsourced and a weekend list? MG confirmed that we have stopped the outsourcing of theatre work and are using weekend surgery where suitable.

Gail Adams asked if there had been any racist abuse 'Brexit' attacks on staff following the out vote? She noted that she was pleased that the Trust had reassure staff by email after the vote. KC responded she was not aware of any such attacks within the Trust but would check. We would continue to reassure and support staff as any changes to EU employment situation changes.

Gail Adams asked about the Francis Report and whether the Trust was assured that staffing levels and use of bank and agency staff are at the correct levels? HT responded that we are confident that we have the right number of staff in place with a bi-annual review. We are also developing apprenticeships for nursing staff to ensure that patients get the right care.

10.3 Key Reflections

Gail Adams stated that she liked the patient story and would also like to hear some staff stories in the future.

GN felt that it had been a purposeful meeting with a good balance of discussion. She personally felt that the Trust had a better grip on its problems.

NW stated that he had arrived with trepidation due to the big issues the Trust is facing but felt more assured that progress was being made.

11. Date of next meeting

The next scheduled meeting of the Board to be held in public will be 6th October 2016 at Queen Mary's Hospital.

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

6th October 2016

Action No.	Date First raised	Issue/Report	Action	Due Date	Responsible officer	Status at October 2016
7.5	5 May 16	PPI/PPE Action Plan	Board agreed with the Strategy. JH to set out an action plan working with Patient representatives.	Sept 16 deferred to October 16	S Banks / H Tonge	To be covered by Suzanne Banks in the Integrated Performance Report
6.1	2 June 16	Patient Safety, Quality and Performance (Quality Report)	ELOC strategy will be developed and the Board will be updated in 3 months on the longer term plans.	Nov 16	S Banks/H Tonge	
6.3	1 Sept 16	RTT Report	Detailed paper to be presented	Oct 16	M Gordon / I Lynam	**ON AGENDA**

REPORT TO Trust Board **Paper ref:**

Paper Title:	Quality Report to Month 5. August 2016
Sponsoring Director:	Andrew Rhodes- Medical Director Suzanne Banks Chief Nurse and Infection Prevention and Control Mark Gordon - Chief Operating Officer
Authors:	Hazel Tonge – Deputy Chief Nurse Sal Maughan – Head of Governance Peter Riley- Infection Control Lead Corporate Nursing Team Divisional Directors Nursing/ Governance Trust Safeguarding Leads Head of Performance
Purpose:	To inform Trust Board about Quality Performance for Month 5.
Action required by the board:	To note the new style report and key areas of emerging risk and mitigating actions noted.
Document previously considered by:	EMT, QRC

Executive summary

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.

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

- All cancer national standards met in July. STF trajectory standard was also met for the 62 day standard.
- Diagnostic waiting time's standard achieved both against the national target and STF trajectory.
- Trust is not meeting the RTT national standard and has seen an increase in the number of patients waiting 52+weeks in comparison to previous month.
- Continued non-compliance against the cancelled operations at last minute target. However, actual number of cancellations has seen a reduction in the last two months,

Points for Assurance

Cancer 14 day and 62 day standards performance on track to achieve national and STF targets for August.

Diagnostic waits greater than 6 weeks are observing a week on week reduction. Plans for additional capacity have been put in place for challenged modalities, in particular MRI and Neurophysiology.

New daily Chief Operating Officer led Performance Control meetings in place focusing on key issues and risks for the day, performance against key standards and activity plans.

New Flow Programme is being finalised to address local ED and system challenges to support performance improvement.

Emerging Risks and Mitigating Actions:

Cancer performance sustainability. In particular the 62 day standard with challenges in areas of staffing, and diagnostic capacity. Proposal for staffing have been put forward for executive approval and action plans to increase diagnostic capacity for key modalities are being implemented.

ED performance falling below STF trajectory. This is being reviewed daily at performance control meetings and throughout the day, with defined escalation and exec oversight processes in place.

RTT backlog increase. This will be addressed by the RTT recovery programme.

The trust shows the quality governance score against the Monitor risk assessment framework of 2 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 in relation to August Quality Performance:

- Mortality indicators remain better than expected
- Continued reduction in the number of pressure ulcers
- Zero MRSA cases year to date
- Poor compliance with deadlines for Serious Incident reports within the surgical division.
- Poor compliance with complaints performance within the surgical division.
- Staff not being released to undertake MAST Safeguarding training
- Significant number of non or partial compliance with NICE guidance

Points for Assurance

Mortality is significantly better than expected at 84.3. HSMR rates for emergency admissions analysed by day of admission, patients admitted at weekend and weekdays shows mortality to be better than expected at 87.2 and 83.2 respectively. In addition, raw mortality has reduced by 20per cent from June to August.

There have been two further cases of Clostridium Difficile which are trust apportioned episodes, and subject to investigation. The Trust remains below the threshold of 31 cases per annum.

The number of grade 2 pressure ulcers is continuing to show a decreasing trend for the third month in a row (35 - 23), and there have been no grade 3 or 4 pressure ulcers for the last two months.

Falls remain static with the levels of harm continuing at low or no harm.

The Friends and Family trust response for the last two consecutive months has been positive: 95% of patients said they were extremely likely or likely to recommend the service to friends or relatives

Emerging Risks and Mitigating Actions:

Some improvement in addressing the backlog of outstanding actions for NICE guidance. 47 outstanding to determine compliance within the divisions. Fully compliant with all technology appraisal evidence.

One never event had been declared (wrong site surgery), in August and the root cause analysis is underway. The Trust takes these events extremely seriously. Directorate Management Teams are working closely with the Chief Nurse and Medical Director to minimise the risk of Never Events and other serious incidents. There has been a reduction in Serious Incidents (SIs) declared April to

August: 47 compared to 70 in July 2016. There are currently four overdue SI reports within the surgical division and a 'confirm and challenge' meeting was held with the division to determine support needed to achieve these deadlines and identify learning.

MAST safeguarding training remains below target for both adults (82%) and children's (78%). There is a discrepancy' between the data from ARIS (the HR system) and that which is collected locally through manual systems. Work is underway to validate this.

The Trust is not achieving the internal target of 85% of complaints being responded to within 25 days. Each division has developed an action plan to improve compliance against the target. Confirm and challenge meetings have been set up weekly with the DDNG and DCN. There has been an increase in number of complaints received this month (95) with common themes being clinical treatment, communication and appointment delay / cancellation. In August there was a high number of PALS concerns received, an increase of 10% compared with July 16 (306) and over 31% when compared with August 2015 (257).

In August the safe staffing fill rate improved to 95.88 % for August. Requests for bank and agency utilisation continue to be risk assessed and monitored on a daily basis in the divisions.

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

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

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

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St George's University Hospitals NHS
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Performance and Quality Report For Trust Board

Month 5 – August 2016

Excellence in specialist and community healthcare

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Performance against Frameworks

Excellence in specialist and community healthcare

1. Executive Summary - Key Priority Areas August 2016*

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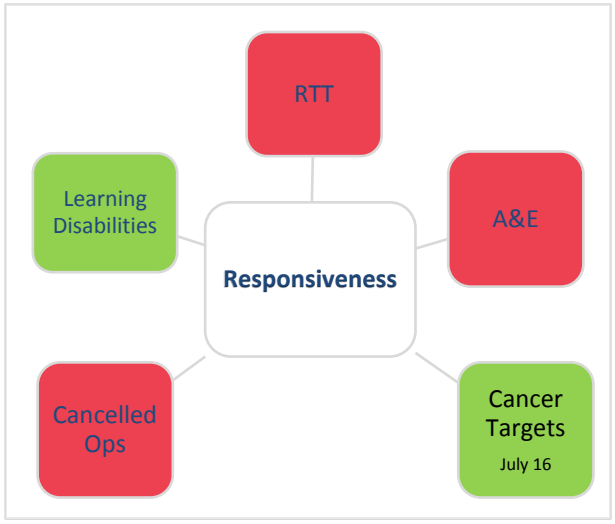

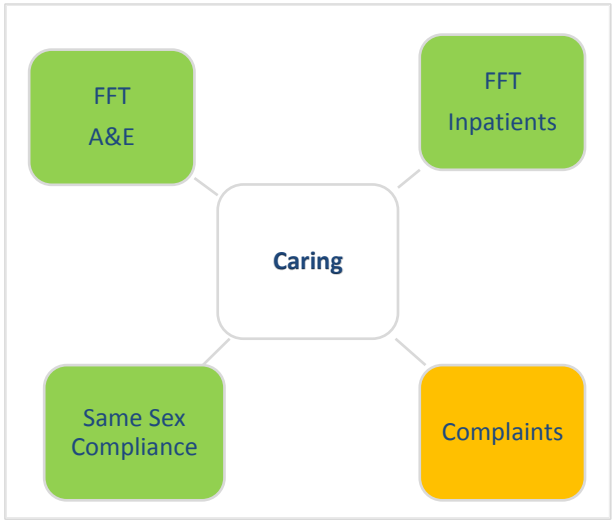

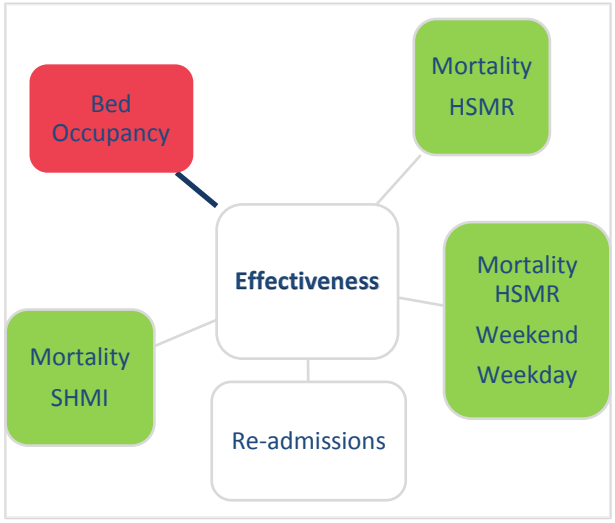

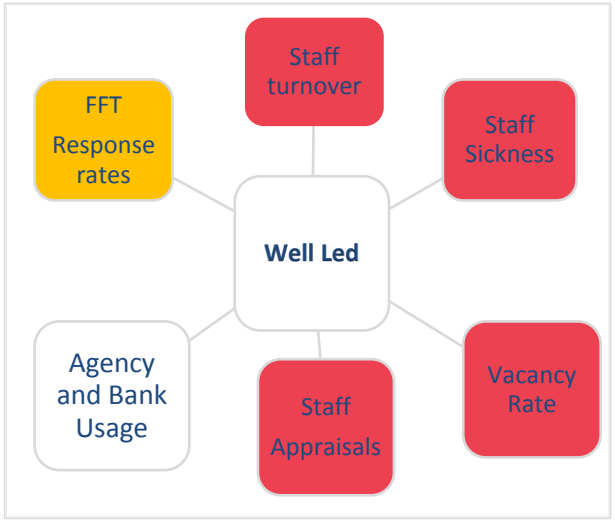

The above shows an overview of August 2016 performance for key areas within each domain and also as detailed in the Monitor Risk Assessment Framework.

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 July 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: August 2016 Performance (Page 1 of 1)

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	Metric	Standard	Weighting	Score	YTD	Jul-16	Aug-16	Movement
ACCESS	Referral to Treatment Admitted	90%	N/A	N/A		67.21%	62.30%	-4.91%
	Referral to Treatment Non Admitted	95%	N/A	N/A		81.69%	85.60%	3.91%
	Referral to Treatment Incomplete	92%	1	1		87.52%	85.61%	-1.91%
	A&E All Types Monthly Performance	95%	1	1	93.10%	94.40%	92.70%	-1.70%
	Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Q1**	**Q2**	**Movement**
	62 Day Standard	85%	1	0	83.10%	80.60%	90.20%	9.60%
	62 Day Screening Standard	90%			92.20%	91.50%	95.00%	3.50%
	31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	0.00%
	31 Day Subsequent Surgery Standard	94%		0	98.20%	97.80%	100.00%	2.20%
	31 Day Standard	96%	1	0	97.70%	97.80%	97.60%	-0.20%
	Two Week Wait Standard	93%	1	0	89.40%	88.30%	93.10%	4.80%
	Breast Symptom Two Week Wait Standard	93%	1		91.60%	90.80%	93.80%	3.00%

	Metric	Standard	Weighting	Score	YTD	Jul-16	Aug-16	Movement
OUTCOMES	Clostridium(C.) Difficile - meeting the C.difficile objective (de minimise of 12 applies)	31	1	0	9	2	2	0
	Certification 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 reasonably 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 regularly 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		53.2	52.6	-0.6
	Referral Information	50%	1	0		87.2	87.1	-0.1
	Treatment Activity	50%	1	0		71.5	73	1.5
	Trust Overall Quality Governance Score					**3**	**2**	-1

August 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 2 and Monitor have imposed additional license conditions in relations to governance.

Areas of underperformance for quality governance are:

- A&E 4 Hour Standard
- RTT (Non Reporting)

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

*Cancer Data is reported a month in arrears. Q2 relates to July-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: August 2016 Performance (Page 1 of 1)

St George's University Hospitals NHS
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RESPONSIVENESS

Metric	Standard	YTD	Jul-16	Aug-16	Movement
Referral to Treatment Admitted	90%		67.21%	62.30%	-4.91%
Referral to Treatment Non Admitted	95%		81.69%	85.60%	3.91%
Referral to Treatment Incomplete	92%		87.52%	85.61%	-1.91%
Referral to Treatment Incomplete 52+ Week Waiters	0	30	6	7	1
Diagnostic waiting times > 6 Weeks	1%		0.99%	0.84%	-0.15%
A&E All Types Monthly Performance	95%	93.1%	94.4%	92.7%	-1.70%
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%		8.93%	10.00%	1.07%
Certification against compliance with requirements regarding access to health care with a learning disability	Compliant	Yes	Yes	Yes	

Metric	Standard	YTD	Jun-16	Jul-16	Movement
62 Day Standard	85%	83.10%	81.60%	90.20%	8.60%
62 Day Screening Standard	90%	92.20%	94.80%	95.00%	0.20%
31 Day Subsequent Drug Standard	98%	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%	98.2%	96.7%	100.0%	3.30%
31 Day Standard	96%	97.70%	98.80%	97.60%	-1.20%
Two Week Wait Standard	93%	89.40%	90.00%	93.10%	3.10%
Breast Symptom Two Week Wait Standard	93%	91.60%	85.90%	93.80%	7.90%

EFFECTIVENESS

Metric	Standard	YTD	Jul-16	Aug-16	Movement
Hospital Standardised Mortality Ratio (DFI)	100		85.3	84.3	-1.00
Hospital Standardised Mortality Ratio - Weekday	100	0	88.1	83.2	-4.9
Hospital Standardised Mortality Ratio - Weekend	100	0	91.8	87.2	-4.6
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			5.00%	5.80%	0.8%
Bed Occupancy - Midnight Count General Beds Only	85%		98.5%	97.9%	-0.6%
LOS - Elective			4.2	5.2	1.0
LOS - Non-Elective			4.2	4.3	0.10

CARING

Metric	Standard	YTD	Jul-16	Aug-16	Movement
Inpatient Scores - Friends & Family Recommendation Rate	60		96.10%	95.20%	-0.90%
A&E Scores - Friends & Family Recommendation Rate	46		83.80%	85.10%	1.30%
Number of complaints			65	98	33
Complaints performance 25 days	85%		71.0%		
Complaints % within agreed timescales	100%		89.0%		
Mixed Sex Accommodation Breaches	0	0	0	0	0.0

SAFE

Metric	Standard	YTD	Jul-16	Aug-16	Movement
Clostridium Difficile - Variance from plan	31	9	2	2	0
MRSA Bacteraemia	0	0	0	0	0
Never Events	0	2	0	1	1
Serious Incidents	0	42	5	8	3
Percentage of Harm Free Care	95%		94.9%	95.0%	0.1%
Medication Errors causing serious harm	0	6	0	0	0
Overdue CAS Alerts	0	2	2	2	0
Maternal Deaths	1	0	0	0	0
VTE Risk Assessment	95%		96.90%	96.74%	-0.16%
No Safeguarding referals			85	98	
No MCA referrals			16	22	
Pressure Ulcers Serious incident - numbers of Grade 3 and 4 avoidable	19	2	0	0	0
Pressure Ulcers - grade 2	436	168	30	23	-7
Falls		1851	158	166	

WELL LED

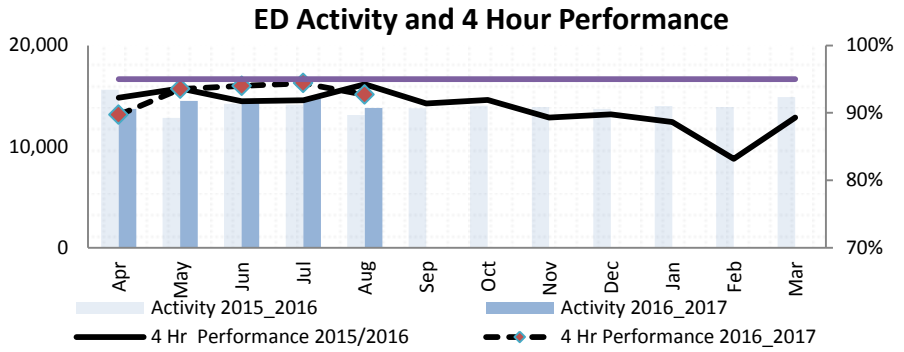
Metric	Standard	YTD	Jul-16	Aug-16	Movement
Inpatient Response Rate Friends & Family	30%		23.4%	24.7%	1.3%
A&E Response Rate Friends & Family	20%		23.4%	22.4%	-1.0%
NHS Staff recommend the Trust as a place to work	58%	62.0%			
NHS Staff recommend the Trust as a place to receive treatment	4	3.78			
Trust Turnover Rate	13%		18.9%	18.6%	-0.3%
Trust level sickness rate	3.5%		3.6%	3.4%	-0.20%
Total Trust Vacancy Rate	11%		16.7%	16.2%	-0.5%
% of staff with annual appraisal - Medical	85%		83.00%	82.50%	-0.5%
% of staff with annual appraisal - non medical	85%		71.60%	70.60%	-1.0%
Compliance MAST Level 3 adults	85%		84.00%	83.00%	-1.0%
Compliance MAST Level 3 children	85%		82.20%	76.00%	-6.2%
Compliance MAST VTE	85%		32.40%	46.00%	13.6%
Safe Staffing profile (fill rate)	95%		95.53%	95.88%	0.3%
Safe Staffing alerts			12	12	0.0

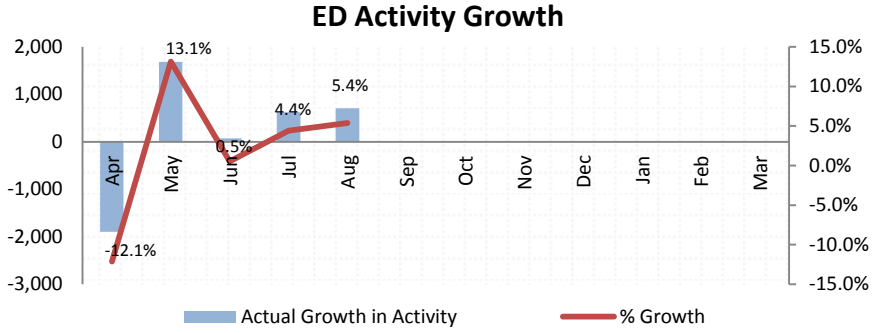
The trust continues to monitor the above key performance indicators following authorisation as a Foundation Trust. The indicators are grouped into domains parallel to that defined by the CQC. The trust is currently reviewing additional indicators for inclusion which will be incorporated in forthcoming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

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

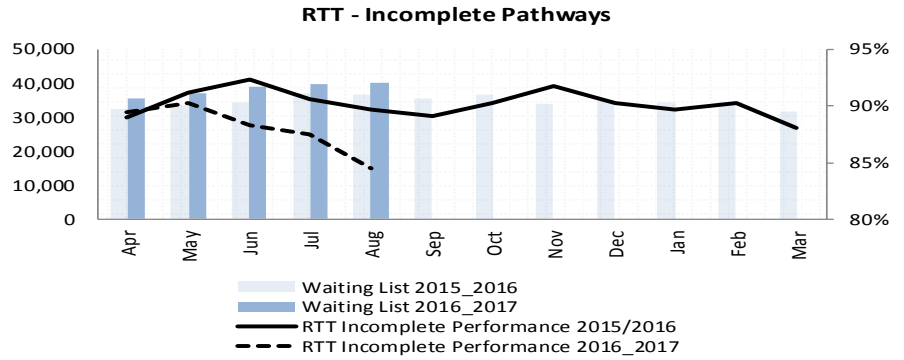
St George's University Hospitals NHS
NHS Foundation Trust

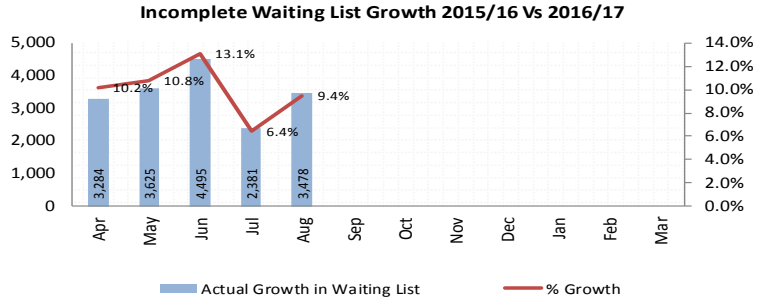
ED Performance

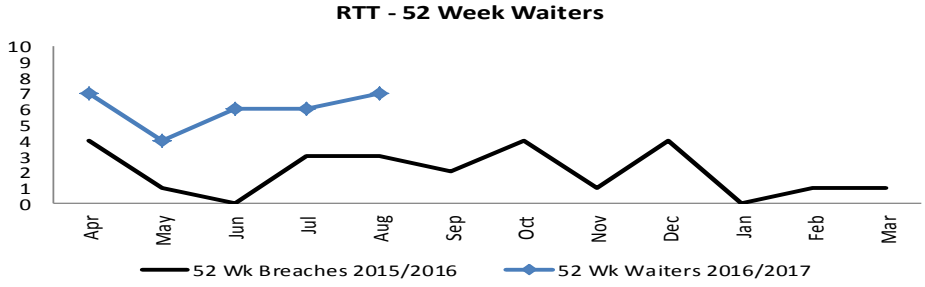


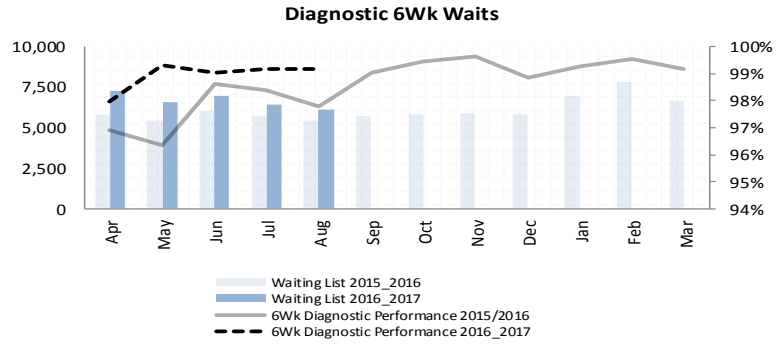


RTT & Diagnostics





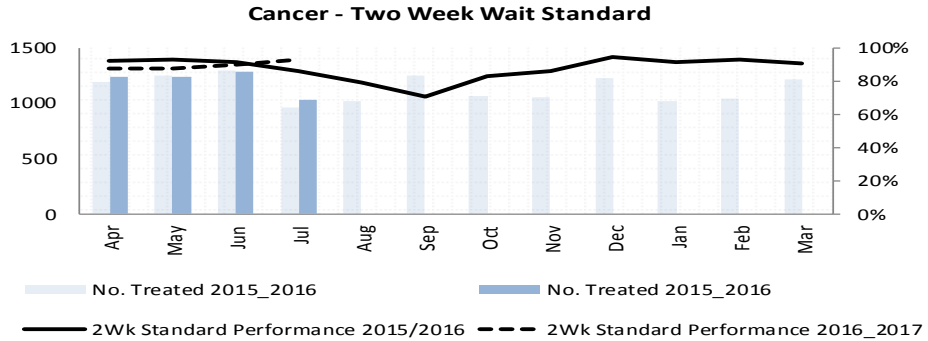


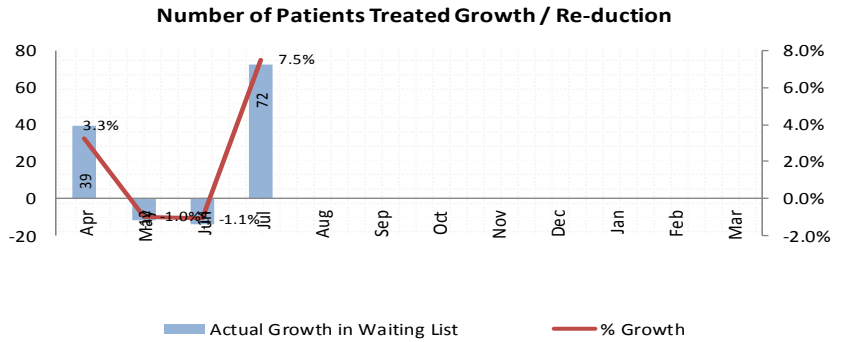


3. Trust Key Performance Indicators and Activity Comparison to previous year (Page 2 of 2)

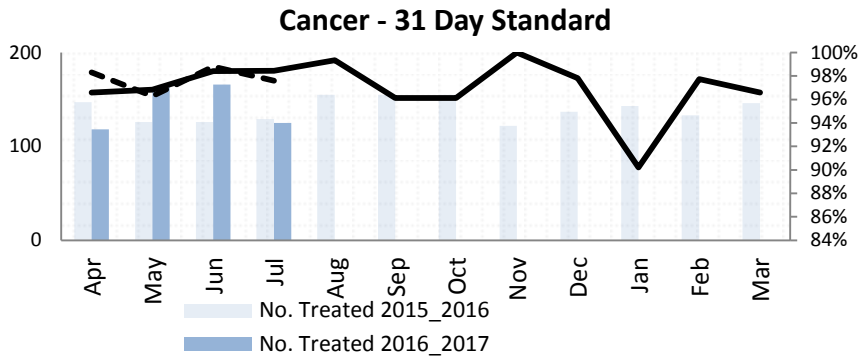
St George's University Hospitals NHS
NHS Foundation Trust

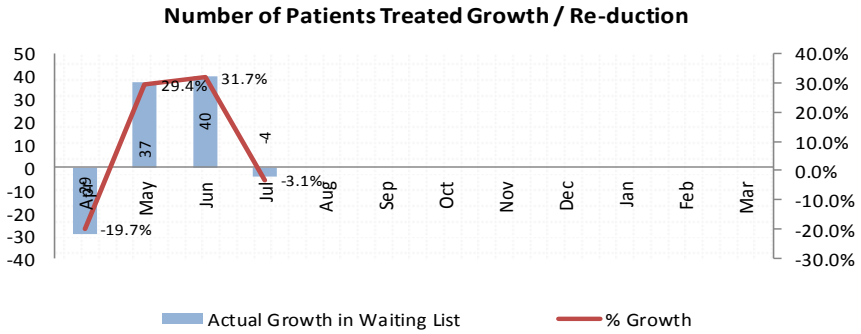
Cancer - Two Week Wait Standard



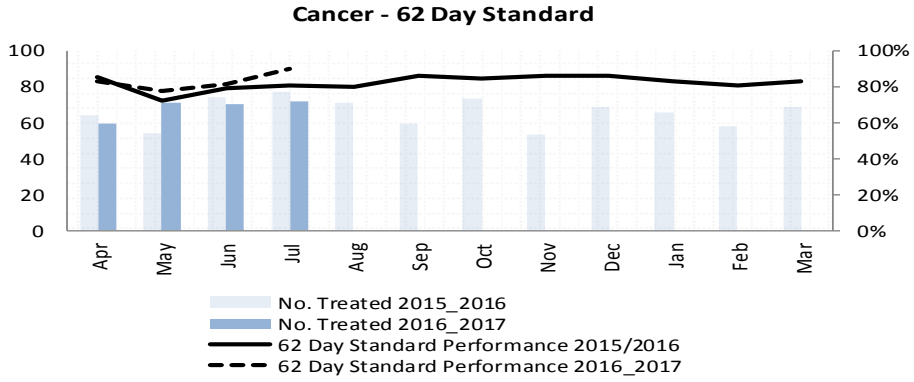


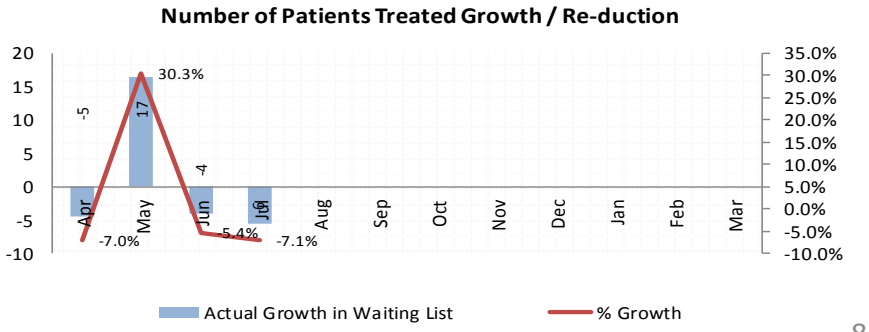
Cancer - 31 Day Standard





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 3) - A&E: 4 Hour Standard

St George's University Hospitals NHS
NHS Foundation Trust

Total time in A&E - 95% of patients should be seen within 4hrs							
Lead Director	Jul-16	Aug-16	Movement	2016/2017 Target	Forecast for Aug-16	Forecast for Sep-16	Date expected to meet standard
FA	94.40%	92.70%	-1.70%	>= 95%	R	R	TBC

Peer Performance July 2016 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
1	2	4	5	3
94.40%	94.20%	93.80%	83.50%	94.00%

Overview

In August the Trust's ED performance against the 4 hour 95% Standard was 92.70% with a total of 13,814 attendances. The Trust has met the STF trajectory in Q1 and although for August performance was 0.1% below agreed trajectory of 92.80% , remain on target for Q2. This in line with an acknowledged improvement in performance seen since April 2016.

Breach Performance

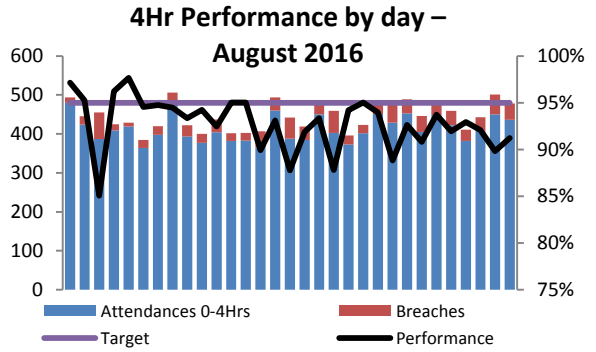
Total of 13,814 patients attended the department in August (5.4% higher than previous year) and a total of 1003 breaches. Treatment decision and wait for specialist opinion remain the highest contributing factors. An increase in the numbers of delayed transfer of care patients (DTOC) in comparison to 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 22/09/2016 there were 23 DTOC and 15 Non-DTOC patients. Overall improvements in Bed flow have focussed more attention on improved specialty support into ED to assist in the management of intense surges of patients.

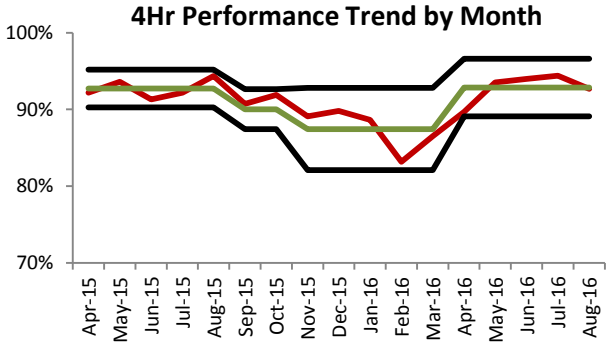
Improvements

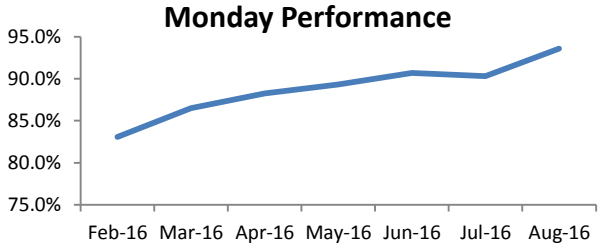
- Significant changes have been made to working systems to improve care (4-5% improvement)
- Enhanced action plan developed to maximise care and performance including the escalation policy.
- Increased engagement through consultant leads from ED to improve response rates
- Monday performance has significantly improved due to weekend process changes increasing from 83.1% to 93.6%
- Significant improvement in 15 minute LAS handover performance since April 2016 from 31% to 62% on the 19th September.

Actions

- Action plan in place for top 4 breach reasons cohorts including treatment decisions and speciality breaches
- New Flow Programme is being finalised to address local ED and system challenges
- Further reduction in LOS through roll out of SAFER Bundle with a greater focus on discharge
- Review of rotas is underway in ED as well as the RATs and urgent care systems.







4. Performance Areas of Escalation (Page 2 of 3) - On the Day Cancelled Operations

St George's University Hospitals NHS
NHS Foundation Trust

Proportion of Cancelled patients not treated within 28 days of last minute cancellation							
Lead Director	Jul-16	Aug-16	Movement	2016/2017 Target	Forecast for Aug-16	Forecast for Sep-16	Date expected to meet standard
CC	8.93%	10.00%	⇩ 1.07%	0%	G	G	

Peer Performance Comparison – Latest Available Q1 2016/17				
STG	Croydon	Kingston	King's College	Epsom & St Helier
5	2	3	4	1
4.0%	1.0%	5.3%	5.0%	2.0%

Overview

The national standard is that all patients whose operation has been cancelled for non clinical reasons should be treated within 28 days. The Trust reported a total of 50 on the day cancellations in the month of August of which 5 were not re-booked within 28 days accounting for 10% of all cancellations. There was a reduction of 6 cancelled operations compared to the previous month. The level of cancellations remain high compared with London Trusts and this remains a priority area for St George's 1) to fully utilise theatre lists, 2) Improved planning with divisions, 3) improved data quality and validation to ensure accurate and timely data, 4) Firm action plans in place to address capacity constraints. It should also be noted that due to the complex nature of many of our patients that a cancellation rate will be expected due to 'on the day' clinical reasons.

Breach Performance

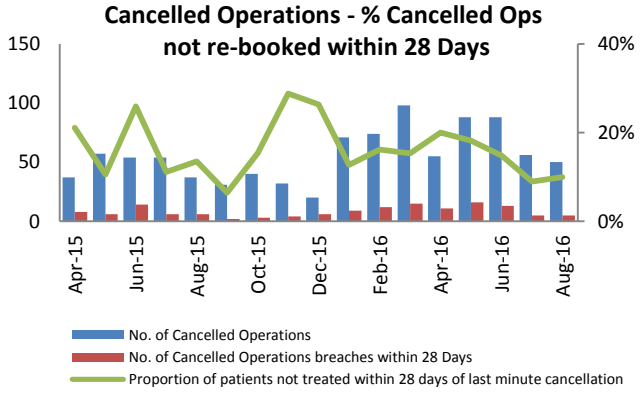
Total of 50 on the day cancellations with 5 patients not re-booked within 28 days. The highest proportion of breaches occurred within Surgery and Cardiothoracic). Cases were cancelled due to bed availability, emergency cases, and list's over running / lack of theatre time.

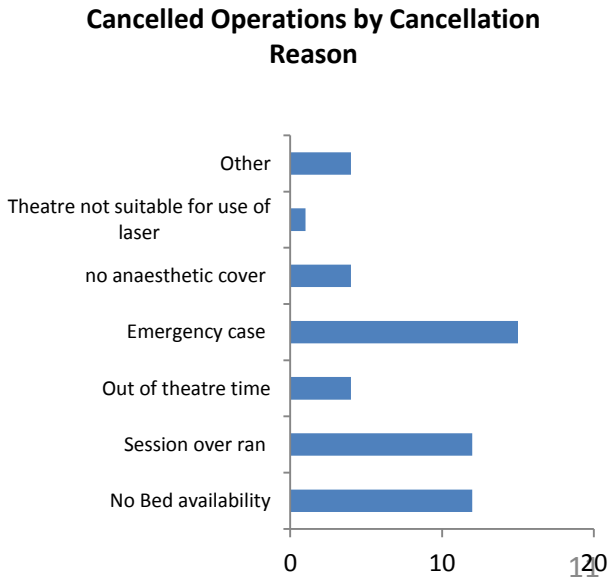
Improvements

- Fortnightly reviews of cases with Directorate leads to ensure efficient forward planning
- Daily Theatre dashboard now in operation to allow improved daily management and analysis
- General Managers now approve all cancelled operations after discussion with Clinical Director and Divisional Director of Operations
- Daily operational meetings chaired by COO with all general management teams
- Morning management focus on bed and theatre flow has led to improved throughput
- St James Theatres 5&6 back in use and operational
- In Cardiac Surgery, cardiologists have agreed to release further capacity to CTICU to increase intensive care capacity to reduce breaches.

Actions

- Improvement of Pre-Operative Assessment Routine.
- Increased booking intensity of theatre lists.





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

St George's University Hospitals NHS
NHS Foundation Trust

Referral to Treatment Incomplete Pathways							
Lead Director	Jul-16	Aug-16	Movement	2016/2017 Target	Forecast for Aug-16	Forecast for Sep-16	Date expected to meet standard
CS	87.52%	85.61%	-1.91%	92%	R	R	

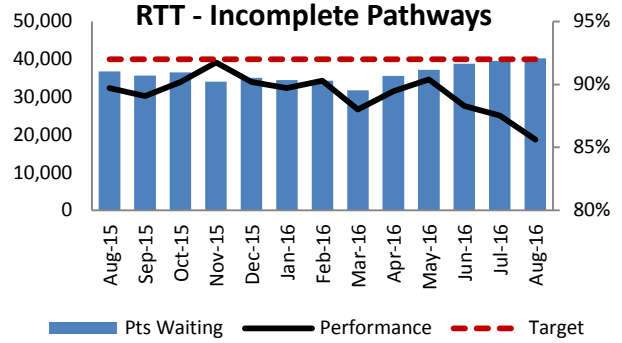
Peer Performance June 2016 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	2	1	5	3
87.52%	93.40%	96.40%	81.30%	91.50%

Overview

The Trust has been non-compliant against RTT incomplete pathways for a number of months, and recognises the significant scale of the task at hand to regain performance and sustainability going forward and there are a number of actions the Trust is taking as part of the RTT Recovery Programme to ensure this happens. August 2016 performance decreased by 3.02% reporting 84.50%, with the number of patients above 18 weeks increasing by 620 patients. The total waiting list size at the end of month has seen a slight reduction of 341 patients, There are a number of specialties who remain challenged with performance below target of 92%. The number of 52 week breaches reportable in August performance were 7, consisting of ENT (2), General Surgery (2), Gynaecology (2), Interventional Radiology (1).

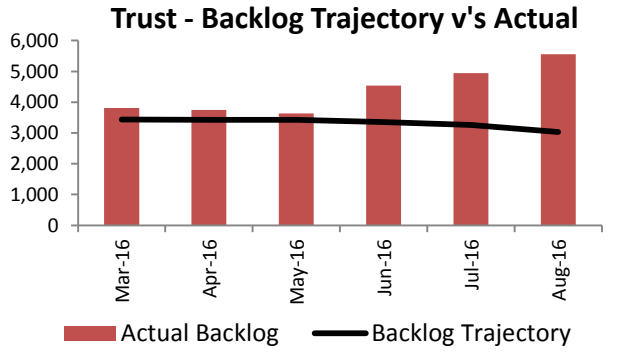
Breach Performance

The largest cohort of patients breaching 18 weeks are within ENT, followed by Trauma & Orthopaedics and General Surgery, with the number of patients within backlog increasing. There are a number of reasons for this increase including late referrals from other Trusts beyond 18 week breach date and many are sent without having been investigated thoroughly and without the correct information to support transfer. This is evidenced across a number of specialities particularly ENT. The configuration of the ENT network means that where patients require an overnight stay, the only option for treatment has been a referral to SGH. This has resulted in a significant number of patients being added to the waiting list for treatment and over time has also included day case procedures where local services have made changes to their tolerance and when the potential for overnight stay is high. In other specialities, patients in this cohort are waiting for non-complex surgery not complex tertiary work that can only be delivered at SGH.



Improvements

- Start of RTT Recovery Programme with a defined structure in place
- RTT Programme Director joined September 2016
- Enhanced Leadership and governance and clear accountability at Board level
- Review and refinement of backlog reduction plans by specialty
- Clinical Harm Review Meetings : started in June , revised proforma and service review.
- Revised Access Policy and pilot for on line RTT training.
- Backlog reduction seen within Urology and Gynae



Actions

- ENT contract in place to outsource activity to other providers
- Reviewing ENT Network and distribution of flow of referral activity for admitted and non-admitted pathways
- Next level qualitative technical review to take place
- Clinical Outcome form with revised procedure codes pilot for Gynaecology and T&O
- Prioritisation of activities into projects within programme completed.
- Roll-Out of Text Reminder Service to 11 Specialties
- Template Fix engagement and deletions progressing to revised plan

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

St George's University Hospitals NHS
NHS Foundation Trust

Monthly View

August 2016

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	A&E waits (4 hours)	%	100	92	0	0	92.7
	Cancelled operations re-booked within 28 days (division)	%	0	7.4	21.7	0	13.5
	LAS handover within 15 mins	%					50.2
	LAS handover within 30 mins	%					93.5
	LAS handover within 60 mins	No.					0
	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 July 2016

July 2016

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 week gp referral to first outpatient (breast symptoms) - (division)	%			93.8		93.8
	2 week gp referral to first outpatient (cancer) - (division)	%			93.1		93.1
	31 day second or subsequent treatment (drugs) - (division)	%			100		100
	31 day second or subsequent treatment (surgery) - (division)	%			100		100
	31 day standard from diagnosis to first treatment - (division)	%			97.6		97.6
	62 day urgent gp referral to treatment for all cancers - (division)	%			90.2		90.2
	62 day urgent gp referral to treatment from screening - (division)	%			95		95

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

St George's University Hospitals NHS
NHS Foundation Trust

Monthly View

August 2016

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Outcome Metrics	30 day emergency re-admissions (from elective) (division)	%	0	3.1	1.9	1.1	2.5
	30 day emergency re-admissions (from non-elective) (division)	%	15.1	13.8	7.8	2.7	9.1
	Average LOS (elective) (division)	Ratio	0	5.1	5.5	3.5	5.2
	Average LOS (non-elective) (division)	Ratio	9.9	4	6.9	2.8	4.3
	C-sections (applicable to women & children only)	%	0	0	0	23	23
	CAS alerts	No.					2
	Falls (ward level)	No.	19	84	50	1	154
	FFT Recommended Rate- A&E	%					85.1
	FFT Recommended Rate- Inpatient	%					95.6
	HSMR	Ratio					84.3
	Incidence of c.difficile	No.	0	1	1	0	2
	Incidence of e-coli	No.	0	1	0	0	1
	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	0	0	0	0
	Mixed sex accomodation	No.	0	0	0	0	0
	MSSA	No.	0	0	0	0	0
	Never events	No.	0	0	1	0	1
	Serious incidents (division level)	No.	0	4	1	3	8
	SHMI	Ratio					0.9
	Trust acquired pressure ulcers	No.	0	0	0	0	0
	VTE risk assessment (data submitted to unify)	%					96.7

August 2016

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Quality Governance Indicators	Friends & family response rate	%		25.8	33.1	45.5	27.4
	Number of GP Quality Alerts	No.	1	9	10	4	24
	Number of NICE Technology Appraisals	No.					5
	Patient satisfaction (friends & family)	%	100	87.6	95.8	91	89.4
	Percentage of harm free care	%	94.7	90.9	99	99.2	95.1
	Percentage of staff appraisal (medical) - (division)	%	65.2	77.6	87.5	83.2	82.4
	Percentage of staff appraisal (non-medical) - (division)	%	76.3	73	74.5	64.6	69.9
	Sickness/absence rate - (division)	%	4.5	2.5	4.1	3.3	3.4
	Staff turnover - (division)	%	21.1	17.8	16.7	19.7	18.8
	Voluntary staff turnover - (division)	%	16.6	15.4	13.4	16.3	15.5

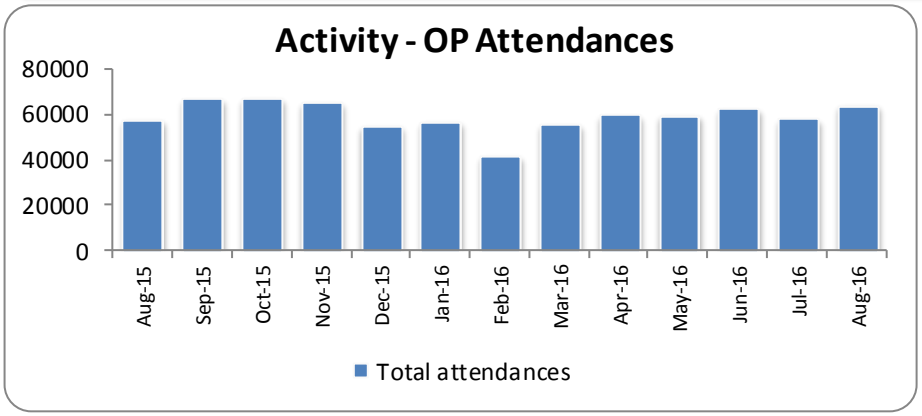
Key Messages:

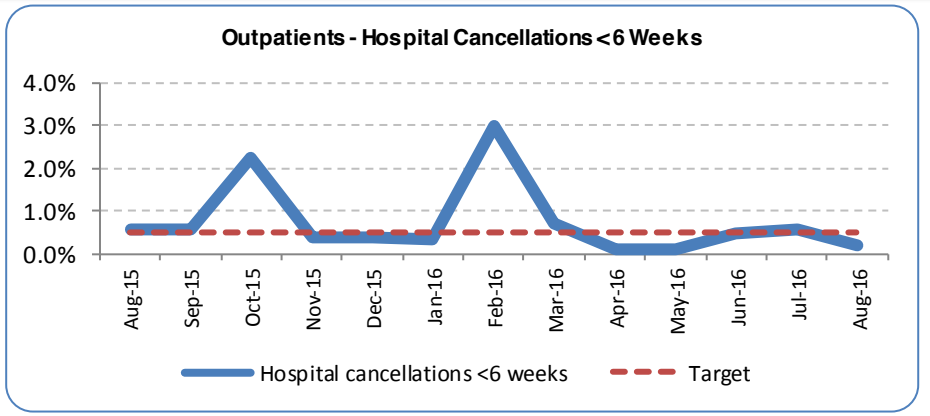
This section headed 'Access' indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution. The Access section is split into two components,. Cancer performance is reported one month in arrears.
LAS arrivals to patient handover times, continues to fluctuate. At the end of August 50.2% of patients had handover times within 15 minutes and 93.5% within 30 minutes, both of which are not within target. The trust had zero reported 60 minute LAS handover in August.

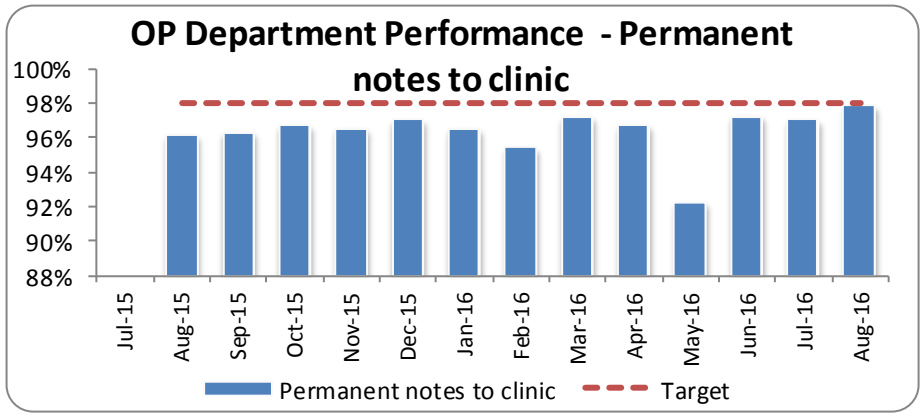
The trust has a zero tolerance policy on avoidable pressure ulcers and has placed significant importance on its prevention. In August the trust had 0 grade 3 pressure ulcer SI's and no Grade 4. All grade 3 and 4 pressure ulcers acquired in our care are investigated as serious incidents, and a. full investigation and Root Cause Analysis will be produced for each PU and reviewed at the Pressure Ulcer Strategy group, chaired by the Deputy Chief Nurse

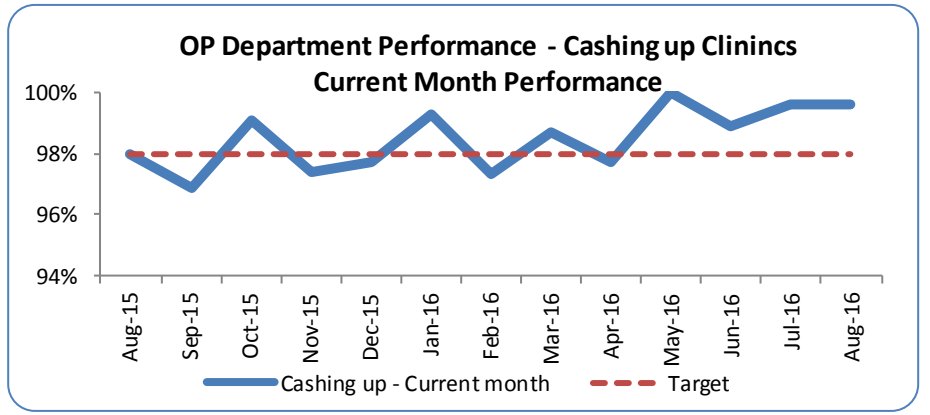
6. Corporate Outpatient Services (1 of 2) - Performance Overview

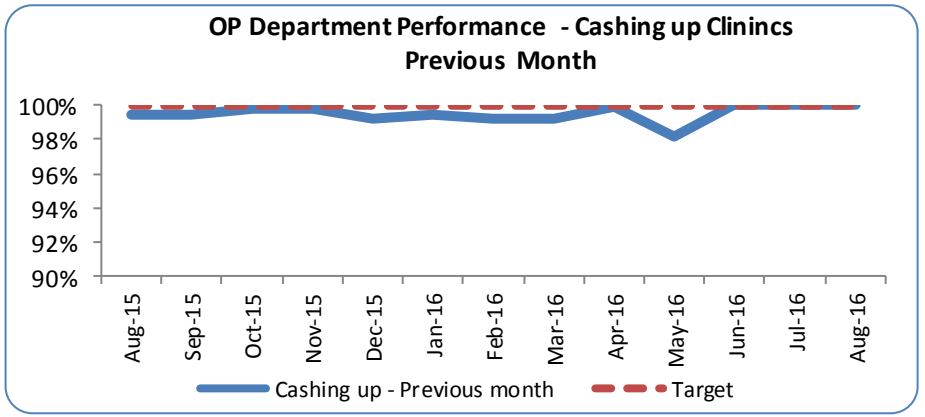
St George's University Hospitals NHS
NHS Foundation Trust

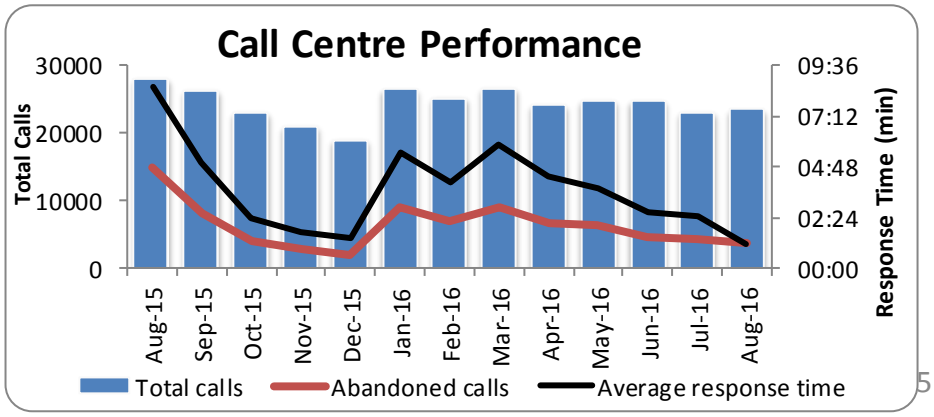












6. Corporate Outpatient Services (2 of 2) - Performance Overview

St George's University Hospitals NHS
NHS Foundation Trust

		Target	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Activity	Total attendances	N/A	57188	66271	66501	64863	54618	56239	41552	55261	59211	59055	61937	57472	63378
	Hospital cancellations <6 weeks	<0.5%	0.56%	0.54%	2.24%	0.36%	0.37%	0.35%	2.97%	0.69%	0.11%	0.08%	0.48%	0.54%	0.17%
OPD performance	Permanent notes to clinic	>98%	96.14%	96.31%	96.72%	96.52%	97.02%	96.50%	95.42%	97.20%	96.70%	92.26%	97.22%	97.01%	97.82%
	Cashing up - Current month	>98%	98.00%	96.90%	99.10%	97.40%	97.70%	99.30%	97.30%	98.70%	97.70%	100.00%	98.90%	99.60%	99.60%
	Cashing up - Previous month	100%	99.50%	99.40%	99.80%	99.75%	99.20%	99.40%	99.20%	99.20%	99.90%	98.20%	100.00%	100.00%	100.00%
Call Centre Performance	Total calls	N/A	28095	26357	23138	21082	19093	26557	25273	26674	24279	24924	24881	23186	23552
	Abandoned calls	<25%/<15%	15019	8253	3930	2756	1953	9084	6949	9055	6671	6362	4542	4185	3648
	Mean call response times	<1 m/<1m30s	08:34	04:59	02:24	01:43	01:24	05:30	04:06	05:49	04:20	03:45	02:37	02:26	01:10

Key Messages:

- Activity increased by 5,906 attendances compared to July and above same period last year.
- Percentage of Hospital cancellations <6 weeks has improved by 0.37% and has achieved the target for the month of August.
- 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 significantly improved in August. With the number of total calls remaining in line with previous months, the total of abandoned calls and the mean call response time have both achieved the target.

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kind
responsible
respectful

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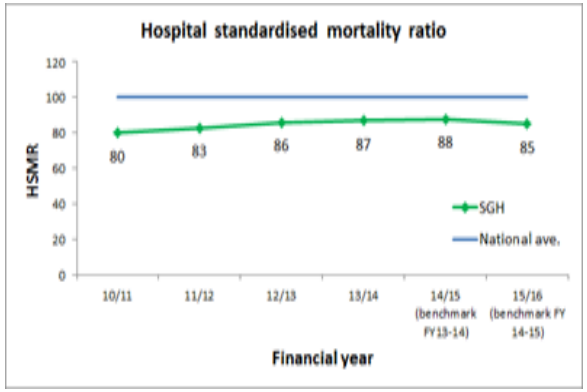
Quality Report

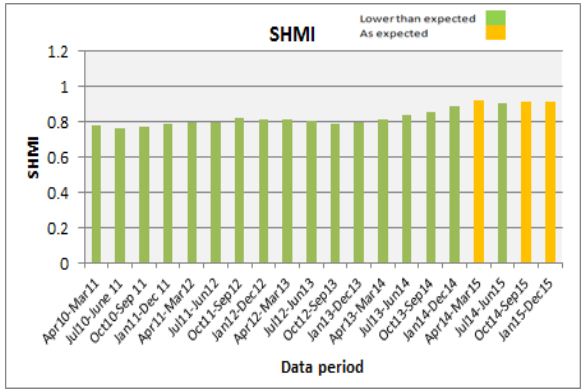
Aug-2016

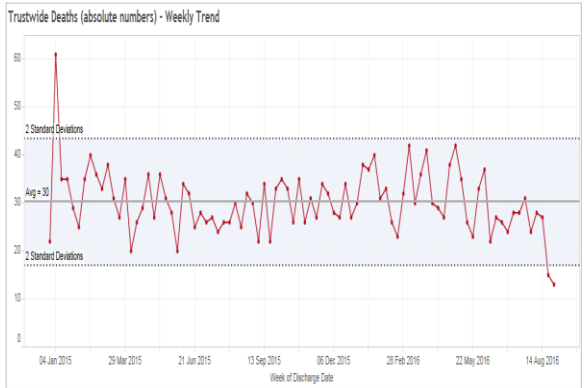
Excellence in specialist and community healthcare

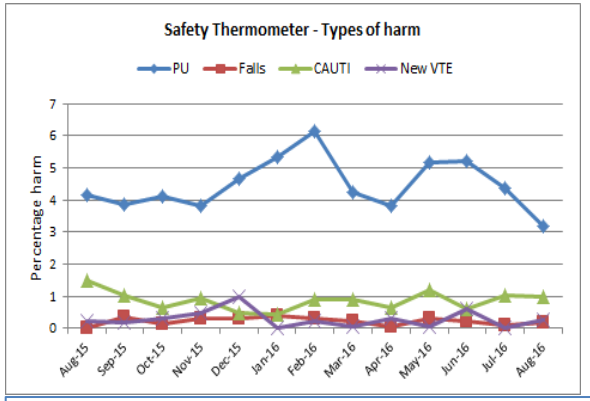
7. Clinical Effectiveness

St George's University Hospitals NHS
NHS Foundation Trust



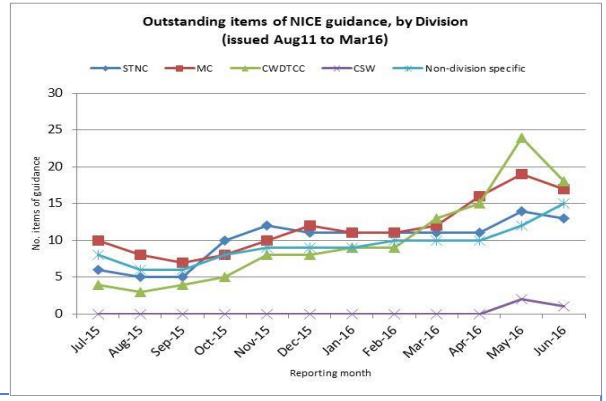






Non-compliant NICE Guidance (Jun 2010 to Mar 2016)

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
Other(n=14)	0	2	0	3	2	5	2



Mortality

HSMR remains better than expected: May15-Apr16 = 84.3 (Weekend emergency admission = 87.2 & Weekday emergency admission = 83.3)

- Latest SHMI is as expected (0.91). For the period 1st April 2015 to 31st March 2016 the SHMI is 0.90 and will be updated on the graph next month.
- Raw mortality within usual limits

NICE Guidance

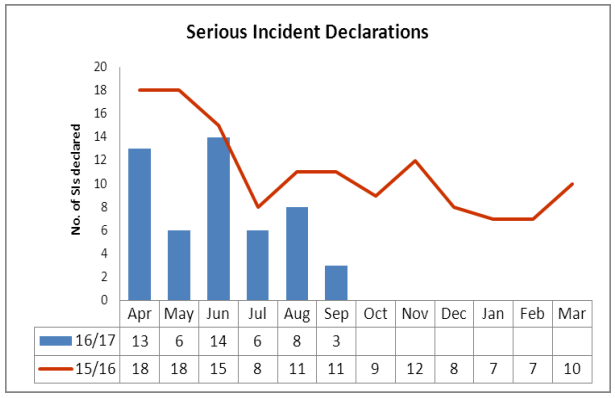
Some improvement in outstanding NICE guidance. Project underway to establish final position and eliminate backlog . Out of 107, 60 are partially compliant and 47 are waiting for confirmation from the divisions around compliance and applicability. Other" includes "non-division specific", any guidance that isn't attributed to just one division but many (e.g. smoking cessation, blood transfusion, domestic violence)

Safety Thermometer

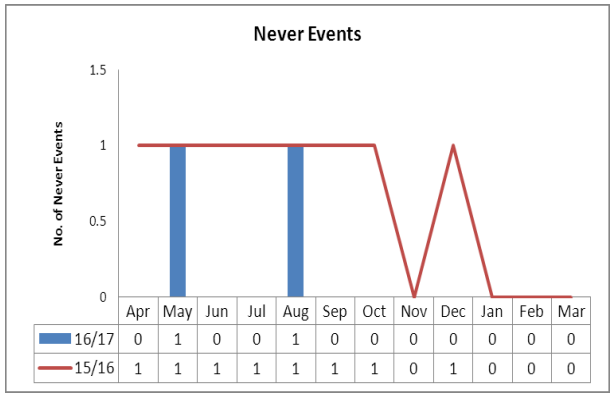
- 95.41% of patients that received harm free care - above target
- Of 52 harms (52 patients) no patients experienced more than one harm. Of these, 60% were old and non attributed to the Trust
- Number of new pressure ulcers fell for the third month
- Slight increase observed in new VTE harms, rising from zero to 3

8. Patient Safety and Quality

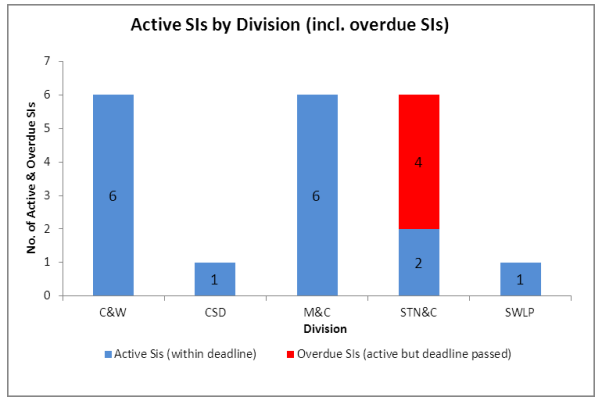
St George's University Hospitals NHS
NHS Foundation Trust

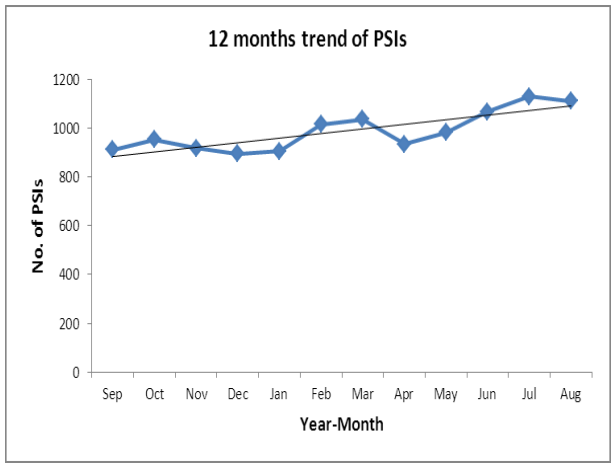


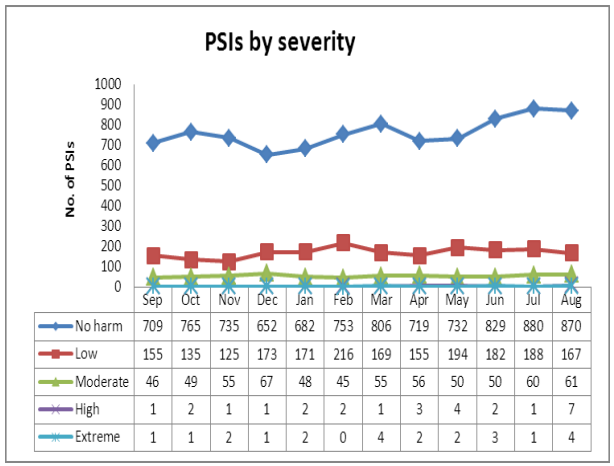
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	13	6	14	6	8	3						
15/16	18	18	15	8	11	11	9	12	8	7	7	10



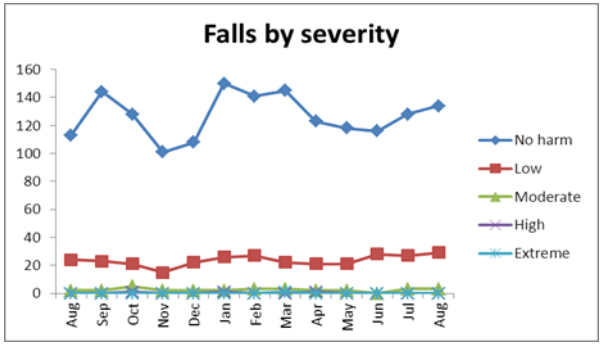
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	0	1	0	0	1	0	0	0	0	0	0	0
15/16	1	1	1	1	1	1	1	0	1	0	0	0







	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
No harm	709	765	735	652	682	753	806	719	732	829	880	870
Low	155	135	125	173	171	216	169	155	194	182	188	167
Moderate	46	49	55	67	48	45	55	56	50	50	60	61
High	1	2	1	1	2	2	1	3	4	2	1	7
Extreme	1	1	2	1	2	0	4	2	2	3	1	4



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
15/16	169	125	143	164	139	169	155	118	132	179	171	171
16/17	147	141	144	158	166							

Patient Safety Incidents (PSIs) including Serious Incidents and Never Events

One new Never Event (wrong site surgery) declared in August (2 declared year to date compared with 5, 2015/16)

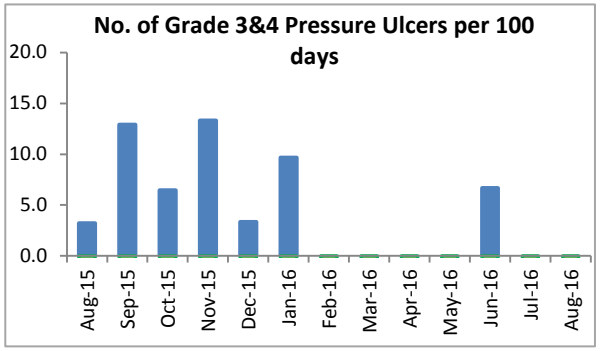
- Reduction in Serious Incidents (SIs) declared Apr–Aug: 47 compared with 70 SIs declared Apr-Aug 15/16, this represents a 32% decrease.
- Four currently overdue SI reports within Surgical Division - escalation meeting held with Execs on 15th Sept.
- The number of PSIs reported each month continues to increase as does the proportion of incidents moderate or above severity (6.5% in Aug).

Falls

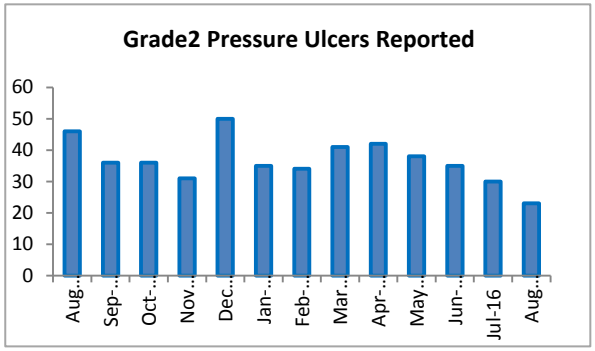
- Number of falls remains static
- Number of actions underway to support correct use of policy and best practice guidance encompassed within Trust Quality Improvement Plan (QIP)
- Falls audit planned for November
- No dedicated Falls resource

Patient Safety and Quality

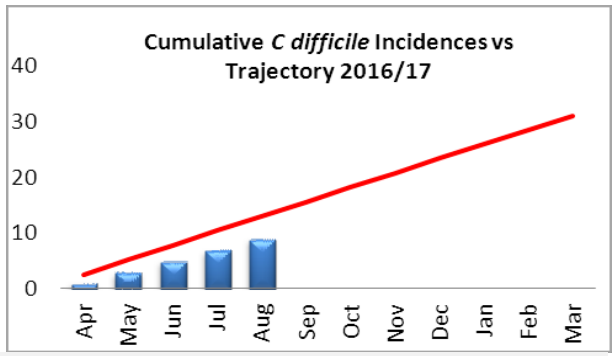
St George's University Hospitals NHS
NHS Foundation Trust



YTD	Apr	May	Jun	Jul	Aug
16/17	0	0	2	0	0
15/16	2	4	1	1	1



YTD	Apr	May	Jun	Jul	Aug
16/17	41	38	35	30	23
15/16	32	50	46	48	46



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
15/16	3	3	3	2	2	5	4	0	1	2	3	1
16/17	1	2	2	2	2							

VTE Compliance (Target >95%)											
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Unify 2: Data extracted from system on patient discharge via discharge summary or iClip											
97.22%	97.10%	96.80%	96.50%	96.60%	96.70%	97.04%	96.45%	97.59%	97.60%	96.90%	96.74%

Safeguarding Training rates (target 85%)		
Division	Safeguarding Children (manual)	Safeguarding Adults (ARIS)
CWDTCC	92%	84%
M&C	59%	80%
STNC	74%	84%
CSD	90%	87%
Corp	100%	75%
Trust	**78%**	**82%**

Infection control

- C Diff – There were two trust apportioned episodes: cumulative total is 9 = below the trust trajectory of 31 for the year. No MRSA cases.

Pressure Ulcers

- Grade 2 pressure ulcers to reduce and no grade 3 / 4 for two consecutive months
- Target to reduce grade pressure ulcers by 10% by March 2017

VTE

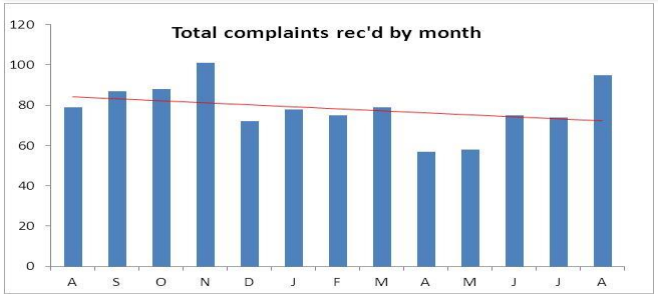
- Electronic records of assessment shows compliance of 96.74%. However, Safety thermometer data showed a discrepancy scoring 89.2% a reduction in performance since last month. This is explained by the different data collection methods, and where data is taken from. The VTE team undertake an internal audit and data from quarter 1, 2016/17 , has shown improvement on the 2015/16 average overall and shows good rates of compliance within the Trust. This reports appropriate prophylaxis is 93% (target 100%). An action plan being developed.
- VTE is overseen by the Hospital Thrombosis Group which is setting up a network to drive improvements in VTE prevention.
- Deputy Chief Nurse has met with the Hospital Thrombosis Group to review VTE programme and VTE MAST training .

Safeguarding Children and Adults & MCA training

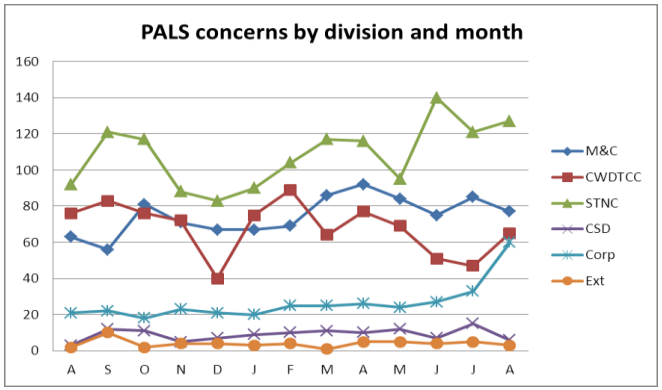
- Both safeguarding adults and children training rates below target when the data is taken from MAST. However, in July 2016, manual collection shows substantial improvement in M and C - ED at 90.32 % compared to 52.03 % on ARIS. Further work is being undertaken to improve the accuracy of data.
- Mental Capacity Act (MCA) training rollout commenced with 284 staff trained in three months.

9. Patient Experience and Nursing workforce

St George's University Hospitals NHS
NHS Foundation Trust



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
15/16	71	73	84	90	79	87	88	101	72	78	75	79
16/17	57	58	75	74	95							



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
15/16	248	227	294	302	257	304	305	264	222	264	303	308
16/17	330	289	304	306	338							

Friends & Family Test

	Apr	May	Jun	Jul	Aug	
M&C	97%	96%	95%	97%	96%	⇩
STNC	94%	95%	94%	97%	96%	⇩
CWDTCC	90%	96%	91%	93%	90%	⇩
CSD	93%	92%	94%	92%	96%	⇧
Trust	94%	95%	94%	95%	95%	⇔

Complaints Performance	% within 25 working days (target 85%)		% within 25 working days or agreed timescales (Target 100%)	
Division	June	July	June	July
CWDTCC	55%	67% ▲	(7) 90%	(5) 94% ▲
M&C	67%	83% ▲	(7) 96%	(1) 88% ▼
STNC	65%	47% ▼	(3) 78%	(4) 73% ▼
CSD	100%	83% ▼	(0) 100%	(1) 100% ◆
Corp	33%	88% ▲	(0) 33%	(1) 100% ▲
Trust	**64%**	**71%** ▲	**(17) 87%**	**(12) 89%** ▲

Complaints & PALS

- Number of complaints received continues to increase month on month since Nov 15, which has impacted on the turnaround time.
- Top themes are: clinical treatment, communication and appointment delay/ cancellation
- Complaints performance has improved overall for the second consecutive month but remains inconsistent: Further assurance has been requested by the Deputy Chief Nurse from the Senior Nursing Team with SNCT.
- Staffing problems in the Complaints and Improvements Department continue due to long term sickness and maternity leave.
- The divisions have committed to achieve targets for complaints received in September.
- High number of PALS concerns received in Aug: +10% compared with Jul 16 (306) and +31% when compared with Aug 2015 (257)which is impacting on turnaround time

Friends & family test

- Trust response for two consecutive months: 95% of patients said they were extremely likely or likely to recommend the service to friends or relatives
- Whilst M&C and STNC had seen a 1% decrease in Aug, their overall positive response rates remain >95%, CWDT is an outlier at 90%.

Nursing Workforce

- Staffing fill rates (Unify) for August 2016 are >95%
- August safe staffing date continues to reflect the challenge of safe staffing, with community reporting most alerts (n=9), with 7 alerts downgraded to concern. These did not adversely affect patient care.

10. Nursing and Midwifery Heatmap – August 2016

St George's University Hospitals NHS
NHS Foundation Trust

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	Falls (ward level)	Serious incidents (ward level)
COMMUNITY SERVICES	Mary Seacole	0.0	0.0	0.0				8.0	0.0
MEDICINE	ALLINGHAM	0.0	0.0	0.0	92.6	91.7	31.2	8.0	0.0
	AMYAND	0.0	0.0	0.0	90.6	100.0	15.5	3.0	0.0
	BELGRAVE	0.0	0.0	0.0	95.8	97.4	70.0	6.0	0.0
	BENJAMIN WEIR	0.0	0.0	0.0	96.4	94.7	34.2	1.0	0.0
	BUCKLAND	0.0	0.0	0.0	100.0	96.7	37.0	1.0	0.0
	CAESAR HAWKINS	0.0	0.0	0.0	88.9	88.5	38.8	8.0	0.0
	CARDIAC CARE UNIT	0.0	0.0	0.0	100.0	95.5	84.6	0.0	0.0
	CAROLINE	0.0	0.0	0.0	100.0	93.3	50.0	4.0	0.0
	CHESELDEN	0.0	0.0	0.0	90.9	93.8	36.0	12.0	0.0
	DALBY	0.0	0.0	0.0	87.0	100.0	24.4	5.0	1.0
	EMERGENCY DEPARTMENT	0.0	0.0	0.0		85.1	23.1	4.0	0.0
	GORDON SMITH	0.0	0.0	0.0	88.9	93.3	30.8	6.0	0.0
	HEBERDEN	0.0	0.0	0.0	73.1	85.7	37.8	8.0	0.0
	JAMES HOPE	0.0	0.0	0.0	100.0	100.0	66.9	0.0	0.0
	MARNHAM	0.0	0.0	0.0	92.9	100.0	38.2	4.0	0.0
	MCENTEE	0.0	0.0	0.0	100.0	94.7	33.9	0.0	0.0
	RICHMOND	0.0	0.0	0.0	82.9	97.3	12.6	8.0	1.0
	RODNEY SMITH	0.0	0.0	0.0	91.3	100.0	21.1	3.0	1.0
	RUTH MYLES DAY UNIT	0.0	0.0	0.0	100.0	100.0	35.0	0.0	0.0
	TREVOR HOWELL	0.0	0.0	0.0	78.9	100.0	39.7	2.0	0.0

Nursing and Midwifery Heatmap – August 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	Falls (ward level)	Serious incidents (ward level)
SURGERY	BRODIE NEURO	0.0	0.0	0.0	100.0	92.9	12.0	4.0	0.0
	CAVELL	0.0	0.0	0.0	100.0	94.7	35.0	3.0	0.0
	FLORENCE NIGHTINGALE	0.0	0.0	0.0	100.0	98.7	64.4	2.0	0.0
	GRAY WARD	0.0	0.0	0.0	100.0	87.8	74.5	5.0	0.0
	GUNNING	0.0	0.0	0.0	100.0	100.0	37.8	6.0	0.0
	GWYN HOLFORD	0.0	0.0	0.0	100.0	92.3	61.9	7.0	0.0
	HOLDSWORTH	0.0	0.0	0.0		100.0	57.1	3.0	0.0
	KEATE	0.0	0.0	0.0	94.7	95.9	55.7	2.0	0.0
	KENT	0.0	0.0	0.0	100.0	87.5	49.2	6.0	0.0
	MCKISSOCK	0.0	0.0	0.0	100.0	100.0	45.5	1.0	0.0
	THOMAS YOUNG	0.0	0.0	0.0	91.7	100.0	27.3	7.0	0.0
	VERNON	0.0	0.0	0.0	100.0	100.0	61.2	1.0	0.0
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	100.0	100.0	37.3	3.0	0.0
WOMEN & CHILDREN	CARDIOTHORACIC INTENSIV..	0.0	0.0	0.0	94.4	75.0		0.0	1.0
	CARMEN SUITE	0.0	0.0	0.0	100.0			0.0	0.0
	CHAMPNEYS	0.0	0.0	0.0	100.0	92.2	35.2	1.0	0.0
	DELIVERY	0.0	0.0	0.0	100.0	100.0		0.0	2.0
	FREDDIE HEWITT	0.0	0.0	0.0				0.0	0.0
	GENERAL ICU/HDU	0.0	0.0	0.0	100.0			0.0	0.0
	GWILLIM	0.0	0.0	0.0	100.0	88.5		0.0	0.0
	JUNGLE	0.0	0.0	0.0			93.8	0.0	0.0
	NEONATAL ICU	0.0	0.0	0.0	100.0	100.0		0.0	0.0
	NEURO ICU	0.0	0.0	0.0	100.0			0.0	0.0
	NICHOLLS	0.0	0.0	0.0		100.0	20.0	0.0	0.0
	PICU	0.0	0.0	0.0		100.0		0.0	1.0
	PINCKNEY	0.0	0.0	0.0		66.7	80.0	0.0	0.0

11. Community Nursing and Midwifery Heatmap – August 2016

St George's University Hospitals NHS
NHS Foundation Trust

Domain	Indicator	Frequency	2015/2016 Target	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	July 16
					Quarter 2 2015/16			Quarter 3 2015/16			Quarter 4 2015/16			Quarter 1 2016/17			
Patient Safety	SI's REPORTED	Monthly		2	0	1	4	1	3	1	1	0	0	0	1 (DIC)	0	0
Patient Safety	Number of SI's breached	Monthly	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly	0	0	0	1	2	1	1	0	1	0	0	0	0	0	0
Patient Safety	Grade 4 Pressure Ulcers	Monthly	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly	0	4	12	8	13	10	11	13	10	13	18	6	19	19	11
Patient Safety	Number of moderate falls	Monthly	0	0	1	0	0	0	2	1	0	0	0	1	0	0	0
Patient Safety	Number of major falls	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Safety	Number of falls resulting in death	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Safety	MRSA (cumulative)	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Safety	CDiff (cumulative)	Monthly	31	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Safety	CAS ALERTS - Number ongoing- received (Trust)	Monthly	0	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Patient Safety	Number of Quality Alerts	Monthly		2	9	11	4	6	7	4	7	5	5	3	3	4	1
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	85%	85%	84%	81%	81%	77%	74%	70.0%	70.0%	68.0%	79%	82.0%	84.0%	85%	88%
Safeguarding	% of staff compliant with safeguarding childrens training	Monthly	Level 1 85%	85%	82%	79%	88%	89%	86%	85%	89%	79%	79%	80.0%	81.0%	80%	82%
			Level 2 85%	82%	82%	74%	66%	67%	63%	83%	80%	85%	92%	66.0%	73.0%	79%	79%
			Level 3 85%	82%	90.00%	70%	85%	87%	84%	84%	84%	80%	80%	82.0%	82.0%	82%	87%
Patient Outcomes	Mortality SHMI ratio (Trus)	Monthly	<100	0.86	0.86	0.86	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	tbc
Patient Experience	Active Claims	Monthly		1	3	1	0	1	0	0	0	1	0	1	0	0	Not yet available
Patient Experience	Number of Complaints received	Monthly		6	5	2	5	5	5	5	4	6	7	1	2	5	6
Patient Experience	Number of Complaints responded to within 25 days (reporting 1 month in arrears)	Monthly	85%	78%	100%	100%	85%	100%	100%	89%	100.0%	50% (3)	71%	75%	100%	100%	100%
Patient Experience	Number of Complaints responded to within 25 days with an agreed extension	Monthly	95%	100%	100%	100%	92%	100%		78%	100%	67% (1)	50%	100%			
Patient Experience	FFT Score	Monthly Mary Seacole A		77.7%	71.0%	97.3%	84.2%	94.4%	94.4%	100%	90%	95%	95%	90.0%	85.7%	87.0%	75%
		Monthly Mary Seacole B		75.00%	95.40%	90.90%	75%	90%	94%		85%						90%
Patient Outcomes	Catheter related UTI (Trust)			1.12	1.32	1.50	1.03	0.67	0.96	0.47	0.46	0.90	0.90	0.65	1.22	0.63	0.52
	Number of new VTE (Trust)		National 0.005	0.15	0.08	0.24	0.17	0.30	0.48	1.01	0.00	0.23	0.08	0.33	0.08	0.63	0
Workforce	Number of DBS Request Made	Quarterly	annually	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	206	206 in 2015			N/A
Workforce	Sickness Rate -	Monthly	3.50%	6.00%	4.69%	5.75%	5.53%	5.90%	5.71%	6.00%	6.50%	6.19%	4.70%	4.72% Mar16	5.67%	4.89%	4.5%
Workforce	Turnover Rate-	Monthly	13%	20.40%	20.08%	21.00%	21.15%	20.75%	20.76%	21.20%	20.80%	21.59%	20.50%	20.54% Mar16	20.3%	18.74%	22.1
Workforce	Vacancy Rate-	Monthly	11%	19.40%	12.60%	13.42%	12.59%	15.67%	18.50%	19.40%	18.90%	18.70%	19.40%	19.43% Mar16	20.81% Apr 16	20.81%	25.5
Workforce	Appraisal Rates - Medical	Monthly	85%	69.57%	69.57%	84.00%	84.00%	79.41%	81.26%	87.10%	87.10%	83.87%	88.90%	88.89% Mar16	92.59% Apr 16	79.17%	70%
Workforce	Appraisal Rates - Non-Medical	Monthly	85%	75.84%	75.42%	76.02%	68.22%	64.91%	62.92%	62.40%	63.20%	63.53%	63.20%	63.25% Mar16	64.48% Apr 16	77.81%	77%

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD *October 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 for August 2016

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

Key points to note are:

- Vacancy and Turnover rates have both decreased
- Stability has therefore shown a 1.9% increase
- There is an unexplained increased use of bank and agency which will be addressed by greater controls particularly on Agency
- Any headcount reduction measures will take place from September onwards

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

Workforce Stability

Vacancy rates have decreased by 0.6% since July and Turnover by 0.3%. This is a particularly strong result for the Trust , particularly in Turnover as this is the first decrease since March 2016 from where it has been steadily rising.

Workforce stability, the percentage of staff who stay more than 12 months, has seen its first increase after a steady decline of almost 12 months.

Whilst these figures are a positive change of direction we must aspire to meet the standards of Teaching Hospitals in London. Currently that would be a vacancy rate of 15.75%, which we were achieving 12 months ago, and a stability rate of at least 84%.

Temporary Staffing Costs

With Workforce stability rising it is disappointing that temporary staffing costs have seen an increase in month of 2%. and even with seasonal factors it is higher than the same time last year. This would seem to indicate a need to improve management control of workforce rostering, annual and study leave planning. We have agreed improved measures within the Executive Management Team and the Finance and Performance Committee and the controls will be implemented from 1st October. 2016.

Staff Training and Support

The decreased MAST compliance to 79% is disappointing and reflective of a seasonal cycle. It is still 11.2 percentage points higher than the same time last year and we will continue to provide the support. We are investigating the training that staff roles have been assigned in order that we priorities those for whom the training is most relevant particularly in ALS and higher levels of safeguarding.

New Workforce Report and HR Priorities

A new concise and visually impactful workforce report was outlined to the Workforce and Education committee in September 2016 and a draft is enclosed. We will be looking to use this report from November onwards. The WEC received an update on the timlines of the HR Priority action plan presented to the Board last month and there will be a “spotlight on “ focus area in each of the monthly Board reports going forward. In November we will outline our progress on the improved recruitment process and targets for the future.

Karen Charman
Director of Workforce and OD
September 2016

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Workforce Performance Report
to the Trust Board

Month 5 – August 2016

Excellence in specialist and community healthcare

Workforce Performance Report Sep ‘15 – Aug ‘16

Contents

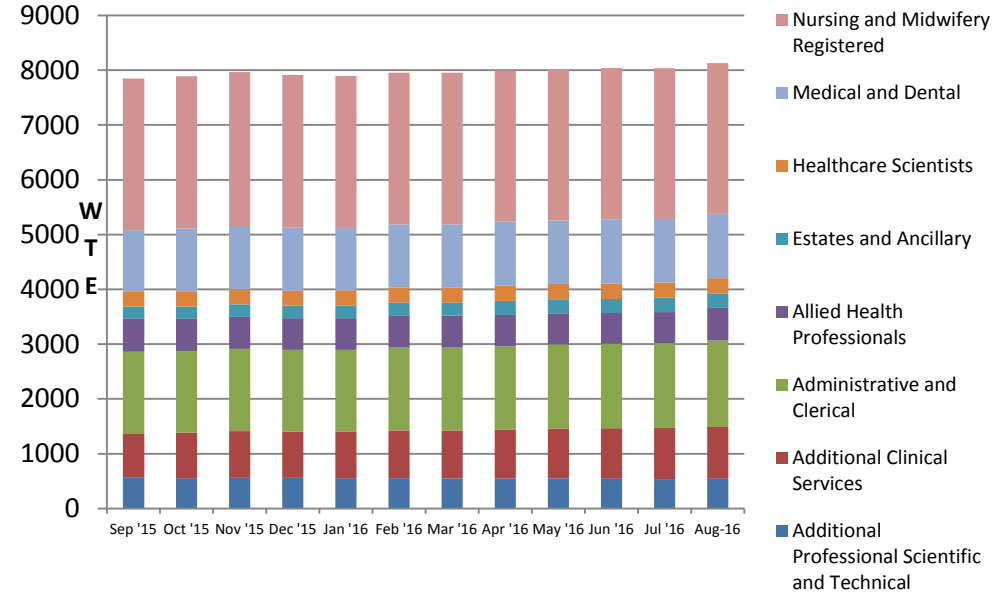
Performance Summary

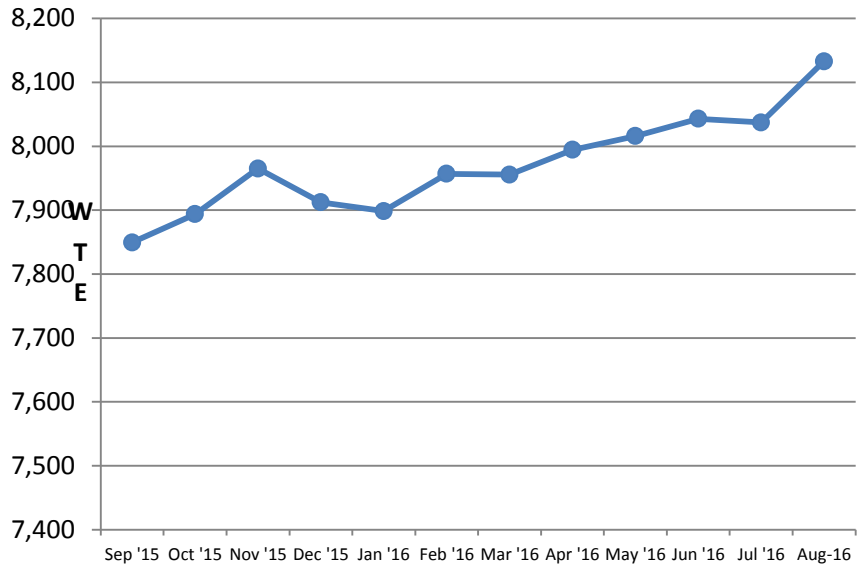
Summary of overall performance is set out below

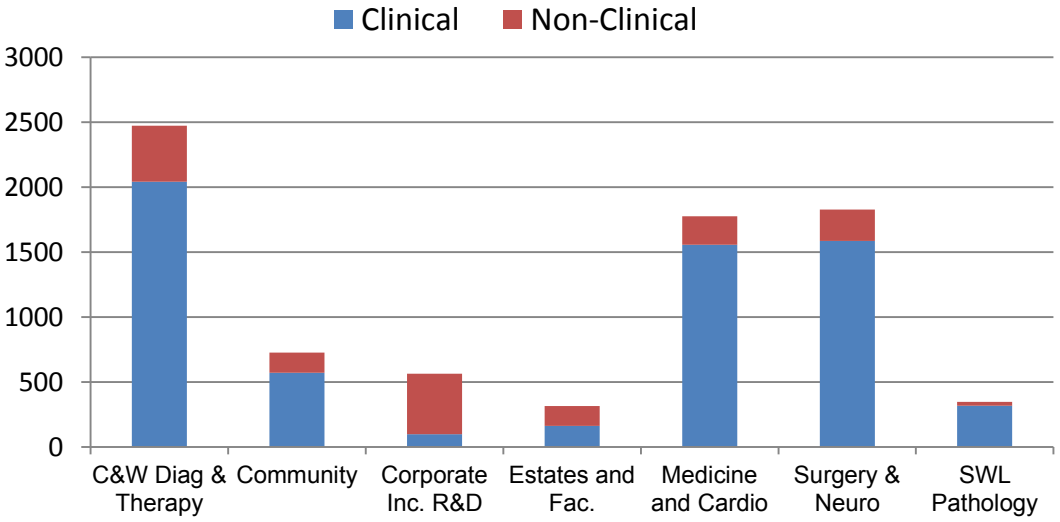
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has decreased by 0.6	15.2%	17.2%	16.5%	↘
6	Turnover	Turnover has decreased by 0.3%	17.3%	18.8%	18.5%	↘
7	Voluntary Turnover	Voluntary turnover has decreased by 0.25%	14.0%	15.4%	15.1%	↘
8	Stability	Stability has increased by 1.9%	83.1%	81.9%	83.8%	↗
10	Sickness	Sickness has remained the same	3.8%	3.4%	3.4%	↔
15	Temporary Staffing Usage (FTE)	Temporary Staffing Usage has increased by 2%	15.9%	14.9%	16.8%	↗
17	Mandatory Training	MAST compliance has decreased by 1.1%	67.8%	80.7%	79.0%	↘
18	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has decreased by 0.9%	71.5%	68.8%	67.9%	↘

Current Staffing Profile

The data below displays the current staffing profile of the Trust





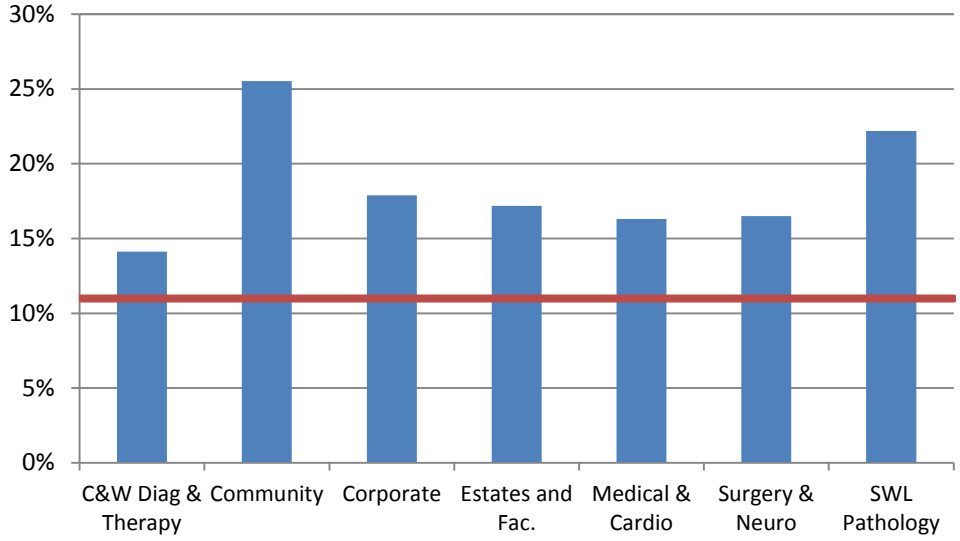


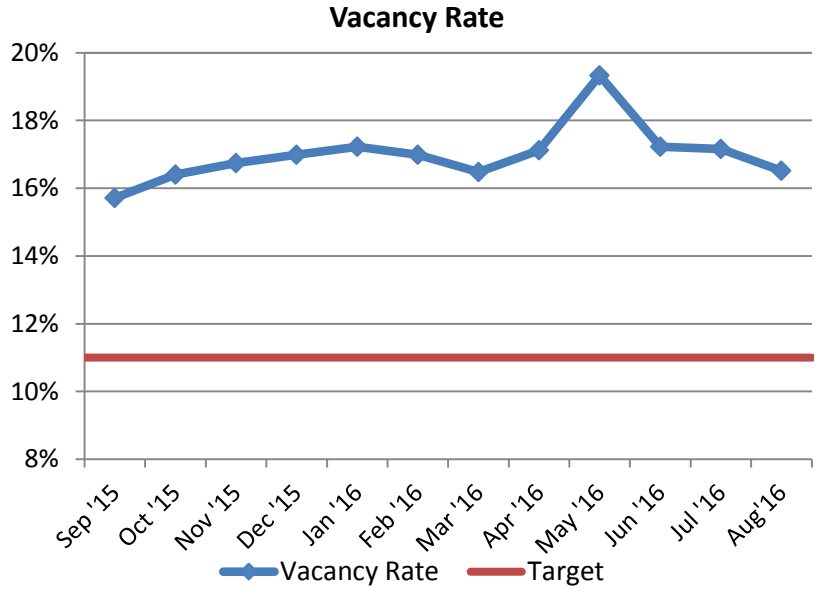
COMMENTARY

The Trust currently employs 8687 people working a whole time equivalent of 8132 which is 95 WTE higher than July.

The Trust also employs an additional 487 WTE GP Trainees covering the South London area, which makes the total WTE 8620.

Section 1: Vacancies





Vacancies by Division	May '16	Jun '16	Jul '16	Aug'16	Trend
C&W Diag & Therapy	15.1%	15.5%	14.1%	13.7%	↘
Community	38.1%	22.6%	25.5%	25.4%	↘
Corporate	20.3%	18.2%	17.9%	17.4%	↘
Estates and Fac.	9.7%	17.7%	17.2%	15.3%	↘
Medical & Cardio	18.5%	16.8%	16.3%	15.5%	↘
Surgery & Neuro	15.8%	15.7%	16.5%	16.1%	↘
SWL Pathology	22.6%	22.5%	22.2%	19.4%	↘
Whole Trust	**19.3%**	**17.2%**	**17.2%**	**16.5%**	↘

Vacancies Staff Group	May '16	Jun '16	Jul '16	Aug'16	Trend
Add Prof Scientific and Technic	14.2%	15.8%	16.7%	16.2%	↘
Additional Clinical Services	26.5%	20.8%	20.5%	19.3%	↘
Administrative and Clerical	18.8%	17.2%	16.6%	15.6%	↘
Allied Health Professionals	19.4%	18.1%	14.4%	11.6%	↘
Estates and Ancillary	11.2%	17.3%	16.8%	16.1%	↘
Healthcare Scientists	13.3%	14.1%	14.4%	14.5%	↗
Medical and Dental	10.8%	7.9%	9.1%	8.2%	↘
Nursing and Midwifery Registered	22.4%	19.9%	20.2%	20.4%	↗
Total	**19.3%**	**17.2%**	**17.2%**	**16.5%**	↘

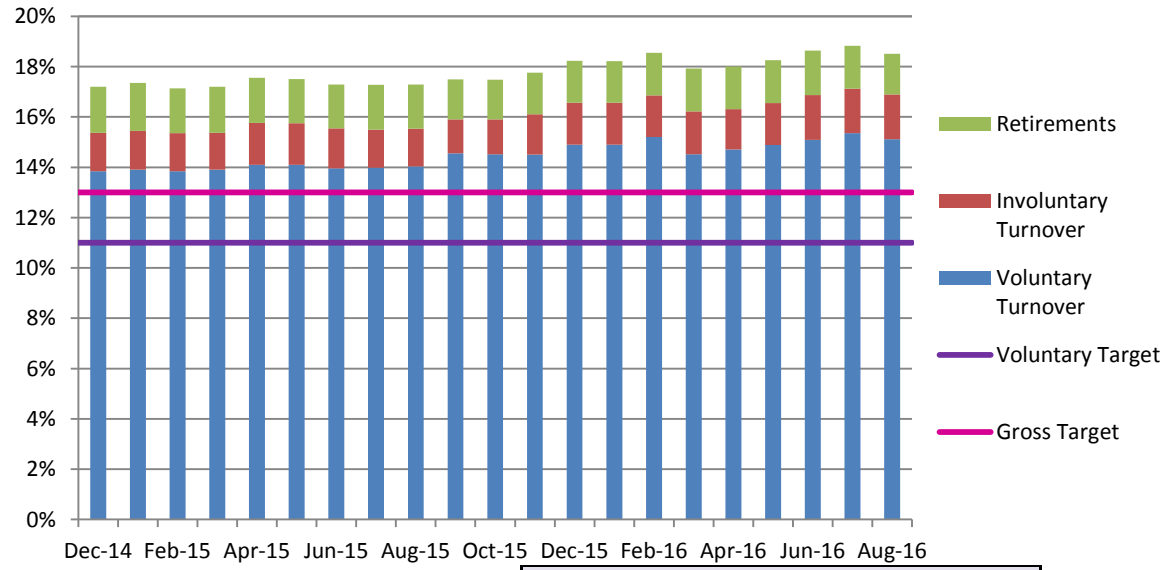
COMMENTARY

The vacancy rate decreased in August.

The Community Services Division still has some reconciliation work to be done as the reported rate is high (around 16% is more accurate). Work is on-going to reconcile ESR to the ledger to improve accuracy for September.

Section 2a: Gross Turnover

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



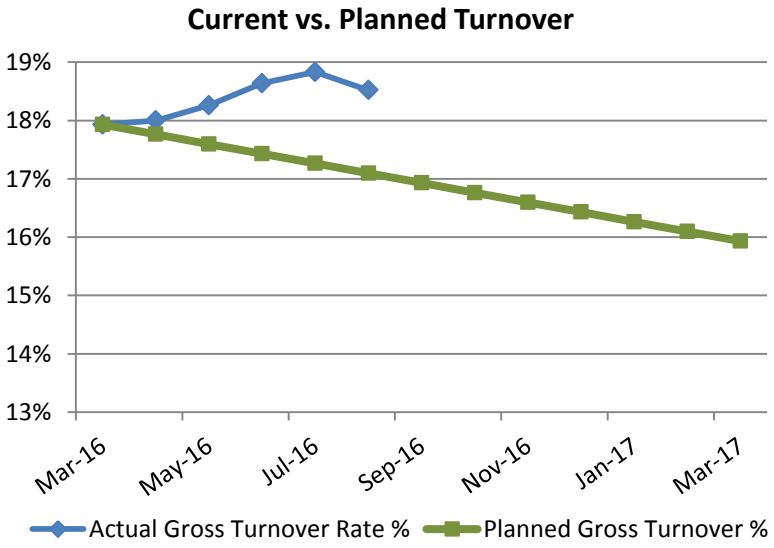
COMMENTARY

The total trust turnover rate has decreased slightly this month to 18.5%. This is significantly above the current target of 13%.

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	May '16	Jun '16	Jul '16	Aug'16	Trend
C&W Diagnostic & Therapy	19.6%	19.6%	19.9%	19.7%	↘
Community Services	21.0%	20.8%	22.1%	21.1%	↘
Corporate	20.9%	21.5%	21.1%	21.3%	↗
Estates and Facilities	11.5%	13.4%	13.6%	13.0%	↘
Medical & Cardiothoracics	18.2%	18.5%	18.6%	17.9%	↘
Surgery, Neurosciences & Anaes	15.5%	16.3%	16.3%	16.8%	↗
SWL Pathology	18.7%	19.7%	19.1%	17.2%	↘
Whole Trust	**18.3%**	**18.6%**	**18.8%**	**18.5%**	↘

	All Turnover				
Staff Group	May '16	Jun '16	Jul '16	Aug'16	Trend
Add Prof Scientific and Technic	22.2%	22.5%	23.5%	23.1%	↘
Additional Clinical Services	18.1%	18.7%	19.0%	18.7%	↘
Administrative and Clerical	17.4%	17.8%	18.0%	17.9%	↘
Allied Health Professionals	21.9%	23.0%	22.3%	22.8%	↗
Estates and Ancillary	7.8%	9.1%	9.8%	9.9%	↗
Healthcare Scientists	17.2%	18.2%	18.0%	15.5%	↘
Medical and Dental	12.2%	11.3%	11.1%	11.5%	↗
Nursing and Midwifery Registered	19.3%	19.7%	19.9%	19.4%	↘
Whole Trust	**18.0%**	**18.3%**	**18.6%**	**18.5%**	↘



Section 2b: Voluntary Turnover

	Voluntary Turnover					Other Turnover Aug 2016	
Division	Apr '16	May '16	Jun '16	Aug'16	Trend	In-Voluntary	Retirement
C&W Diagnostic & Therapy	16.0%	16.1%	16.5%	16.3%	↘	2.0%	1.3%
Community Services	15.6%	15.4%	16.7%	16.6%	↘	1.4%	3.1%
Corporate	17.2%	17.3%	17.1%	17.0%	↘	2.5%	1.8%
Estates and Facilities	8.8%	10.0%	9.9%	9.4%	↘	2.6%	1.0%
Medical & Cardiothoracics	15.9%	16.0%	16.2%	15.4%	↘	1.5%	1.0%
Surgery, Neurosciences & Anaes	12.5%	13.0%	13.1%	13.4%	↗	1.7%	1.6%
SWL Pathology	14.8%	14.7%	14.2%	12.6%	↘	0.6%	4.1%
Whole Trust	**14.9%**	**15.1%**	**15.4%**	**15.1%**	↘	**1.8%**	**1.6%**

	Voluntary Turnover					Other Turnover Aug 2016	
Staff Group	May '16	Jun '16	Jul-16	Aug'16	Trend	In-Voluntary	Retirement
Add Prof Scientific and Technic	15.5%	15.8%	16.8%	16.3%	↘	5.7%	1.2%
Additional Clinical Services	15.3%	15.6%	15.4%	15.2%	↘	1.8%	1.7%
Administrative and Clerical	13.2%	13.5%	13.8%	14.0%	↗	1.9%	2.0%
Allied Health Professionals	19.8%	21.0%	20.2%	20.8%	↗	0.9%	1.1%
Estates and Ancillary	6.1%	6.5%	7.3%	7.5%	↗	1.2%	1.2%
Healthcare Scientists	14.4%	14.3%	14.1%	12.1%	↘	0.4%	3.1%
Medical and Dental	5.7%	5.1%	5.5%	6.1%	↗	4.0%	1.4%
Nursing and Midwifery Registered	17.1%	17.2%	17.6%	17.0%	↘	0.9%	1.5%
Whole Trust	**14.9%**	**15.1%**	**15.4%**	**15.1%**	↘	**1.8%**	**1.6%**

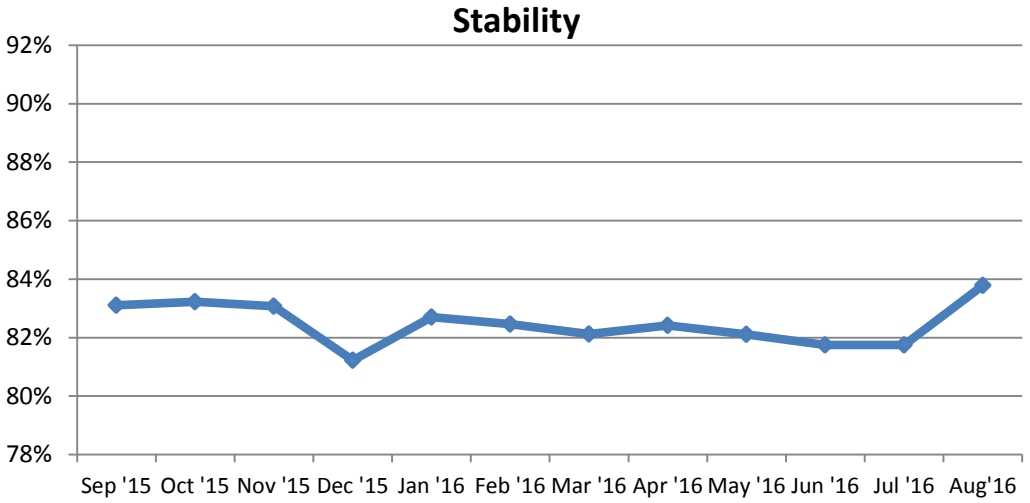
Caregroup	Staff in Post WTE	Leavers WTE	Voluntary Turnover Rate
Ops & Service Improvement	24.8	6.0	28.3%
Stroke, Neurorehab, Neurophysiology	142.2	44.2	27.4%
Medical Oncology & Palliative Care	80.3	24.2	27.1%
Chest Medicine	31.2	6.7	24.0%
Imaging	184.5	49.2	23.8%

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	May '16	Jun '16	Jul '16	Aug'16	Trend
C&W Diagnostic & Therapy	81.0%	80.1%	80.3%	81.9%	↗
Community Services	78.8%	80.7%	80.5%	82.4%	↗
Corporate	78.5%	81.5%	81.9%	83.8%	↗
Estates and Facilities	89.0%	86.5%	85.5%	89.2%	↗
Medical & Cardiothoracics	81.2%	81.5%	82.1%	83.5%	↗
Surgery, Neurosciences & Anaes	84.5%	84.2%	84.1%	85.7%	↗
SWL Pathology	81.6%	80.8%	81.4%	86.8%	↗
Whole Trust	**82.1%**	**81.7%**	**81.7%**	**83.8%**	↗

Stability Staff Group	May '16	Jun '16	Jul '16	Aug'16	Trend
Add Prof Scientific and Technic	72.0%	71.1%	73.8%	76.6%	↗
Additional Clinical Services	85.8%	85.2%	86.6%	85.7%	↘
Administrative and Clerical	83.0%	83.9%	84.0%	87.9%	↗
Allied Health Professionals	76.3%	75.4%	75.1%	76.7%	↗
Estates and Ancillary	90.8%	88.6%	87.3%	90.8%	↗
Healthcare Scientists	91.6%	90.7%	86.1%	86.0%	↘
Medical and Dental	89.1%	90.5%	90.1%	89.9%	↘
Nursing and Midwifery Registered	80.3%	80.3%	80.3%	82.1%	↗
Total	**81.7%**	**81.7%**	**81.9%**	**83.8%**	↗

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.

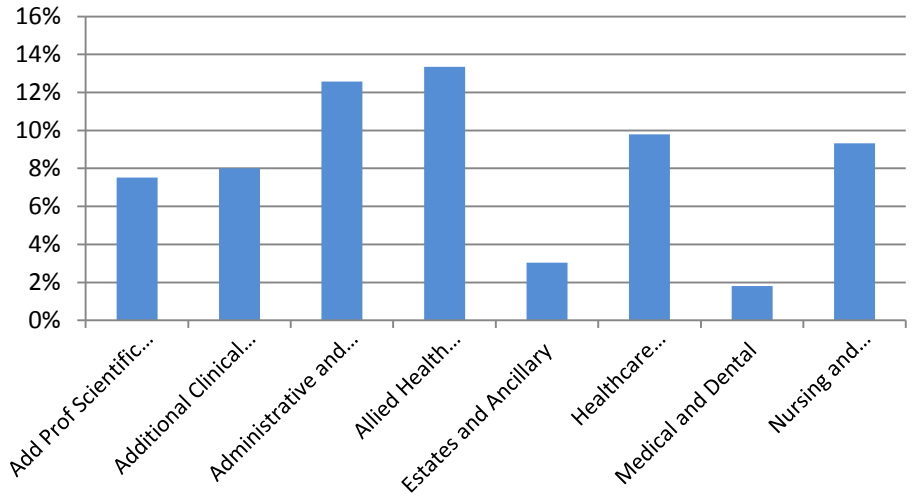
A reduction in the stability rate is of concern because of the implication that staff with longer service are leaving.

The stability rate has increased by 1.9% this month.

Over the last 12 months the stability rate has increased from 83.1% to 83.8%.

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 August 60 staff were promoted, there were 181 new starters to the Trust and 186 employees were acting up to a higher grade.

Over the last year 9.3% 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 13.3% followed by Admin & Clerical at 12.6%.

	No. of Promotions				
Division	May '16	Jun '16	Jul '16	Aug'16	Trend
C&W Diagnostic & Therapy	34	35	17	17	↔
Community Services	12	15	5	2	↘
Corporate	9	8	8	4	↘
Estates and Facilities	1	0	0	1	↗
Medical & Cardiothoracics	8	8	5	12	↗
Surgery, Neurosciences & Anaes	15	8	8	12	↗
SWL Pathology	6	2	0	12	↗
Whole Trust Promotions	**85**	**76**	**43**	**60**	↗
New Starters (Excludes Junior Doctors)	**117**	**133**	**124**	**181**	↗

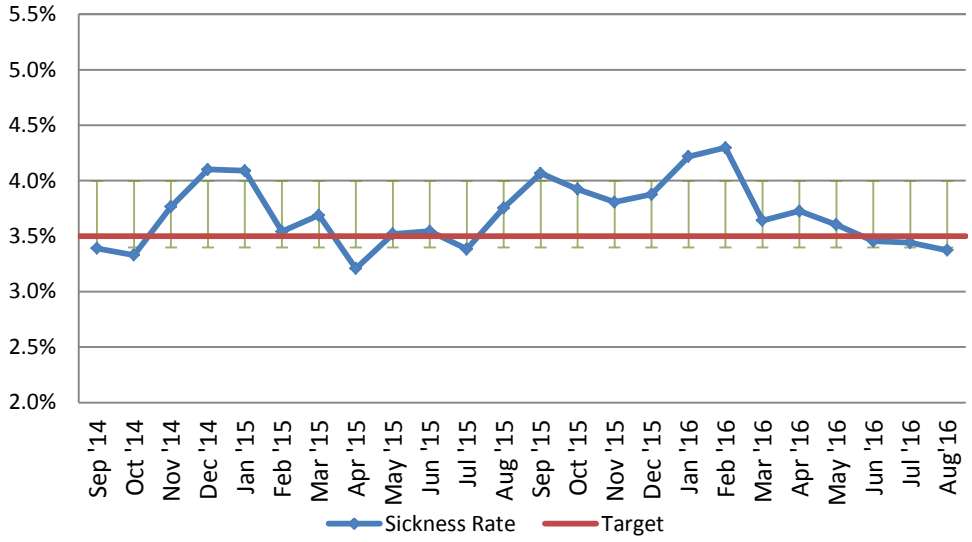
Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	2044	205	10.0%	75
Community Services	708	45	6.4%	9
Corporate	437	64	14.6%	28
Estates and Facilities	250	11	4.4%	9
Medical & Cardiothoracics	1288	104	8.1%	37
Surgery, Neurosciences & Anaes	1389	115	8.3%	21
SWL Pathology	300	52	17.3%	7
Whole Trust	**6416**	**596**	**9.3%**	**186**
New Starters (Excludes Junior Doctors)		**1564**		

	No. of Promotions				
Staff Group	May '16	Jun '16	Jul '16	Aug '16	Trend
Add Prof Scientific and Technic	1	1	1	1	↔
Additional Clinical Services	10	7	4	12	↗
Administrative and Clerical	25	27	16	13	↘
Allied Health Professionals	19	17	4	4	↔
Estates and Ancillary	0	0	0	1	↗
Healthcare Scientists	6	0	0	2	↗
Medical and Dental	0	0	0	7	↗
Nursing and Midwifery Registered	24	24	18	22	↗
Whole Trust	**85**	**76**	**43**	**62**	↗

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	465	35	7.5%	26
Additional Clinical Services	724	58	8.0%	8
Administrative and Clerical	1321	166	12.6%	69
Allied Health Professionals	532	71	13.3%	26
Estates and Ancillary	197	6	3.0%	4
Healthcare Scientists	245	24	9.8%	5
Medical and Dental	498	9	1.8%	3
Nursing and Midwifery Registered	2434	227	9.3%	45
Whole Trust	**6416**	**596**	**9.3%**	**186**

Section 5: Sickness

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



COMMENTARY

Sickness absence is at 3.4% for August, which is the same as last month. Analysis of reasons for absence this month shows gastrointestinal problems 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 August 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	May '16	Jun '16	Jul '16	Aug'16	Trend
C&W Diagnostic & Therapy	3.7%	3.5%	3.7%	3.3%	↘
Community Services	5.0%	4.8%	4.5%	4.5%	↔
Corporate	3.1%	3.2%	2.6%	3.1%	↗
Estates and Facilities	4.4%	4.4%	2.8%	3.6%	↗
Medical & Cardiothoracics	3.4%	3.3%	3.0%	2.5%	↘
Surgery, Neurosciences & Anaes	3.3%	3.1%	3.5%	4.1%	↗
SWL Pathology	2.6%	2.4%	3.0%	2.8%	↘
Whole Trust	**3.6%**	**3.5%**	**3.4%**	**3.4%**	↔

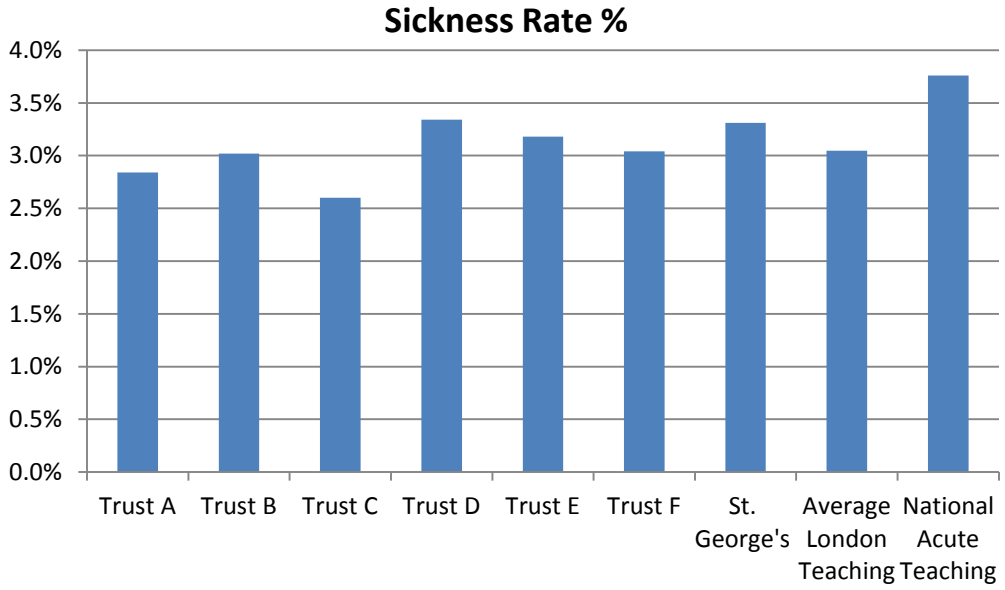
Sickness Staff Group	May '16	Jun '16	Jul '16	Aug'16	Trend
Add Prof Scientific and Technic	2.7%	2.6%	2.8%	2.5%	↘
Additional Clinical Services	5.6%	4.9%	4.8%	5.3%	↗
Administrative and Clerical	4.2%	4.0%	4.1%	4.1%	↔
Allied Health Professionals	3.0%	3.2%	2.7%	2.6%	↘
Estates and Ancillary	5.5%	6.0%	4.0%	5.1%	↗
Healthcare Scientists	1.6%	2.5%	2.3%	1.9%	↘
Medical and Dental	1.5%	1.1%	1.5%	1.4%	↘
Nursing and Midwifery Registered	3.8%	3.8%	3.8%	3.5%	↘
Total	**3.6%**	**3.5%**	**3.4%**	**3.4%**	↔

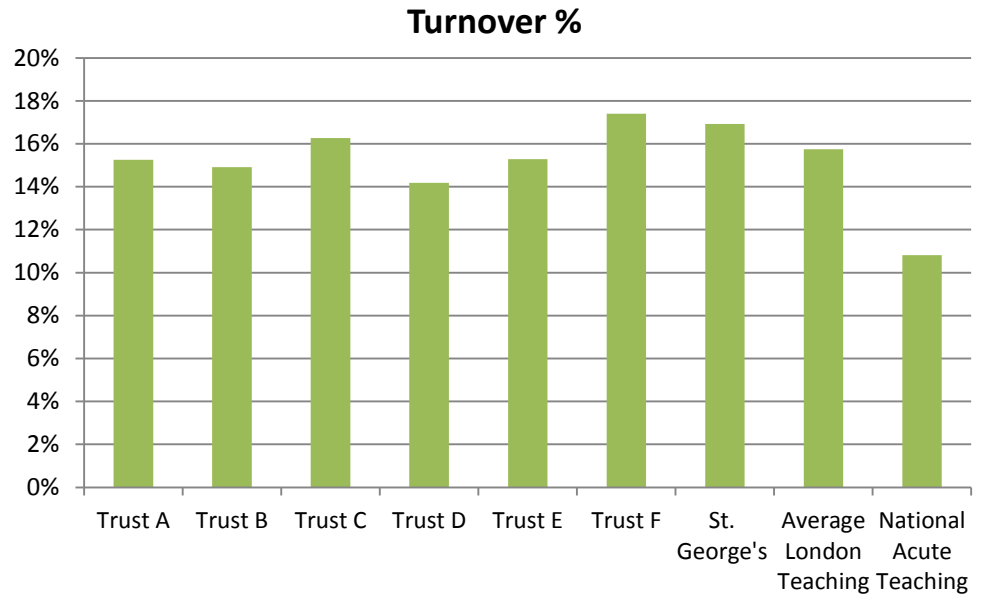
Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Energy and Engineering	50.75	158.00	10.1%	£10,167
Cancer	25.70	79.00	9.7%	£4,629
SWLP Management & Overheads	15.00	38.00	8.7%	£1,776
Offender Healthcare HMPW Services	56.63	143.35	8.2%	£8,682
Diabetes & Endocrinology	22.88	63.36	7.2%	£8,069

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S25 Gastrointestinal problems	21.29%
S13 Cold, Cough, Flu - Influenza	20.65%
S12 Other musculoskeletal problems	9.09%
S10 Anxiety/stress/depression/other psychiatric illnesses	7.74%
S16 Headache / migraine	7.34%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S10 Anxiety/stress/depression/other psychiatric illnesses	16.72%
S12 Other musculoskeletal problems	13.63%
S25 Gastrointestinal problems	11.69%
S13 Cold, Cough, Flu - Influenza	10.82%
S28 Injury, fracture	7.00%

Section 6: Workforce Benchmarking





COMMENTARY

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

Sickness data shown is from April '16 which is the most recent available. Compared to other Acute teaching trusts in London, St. Georges had a rate higher than average at 3.31%. 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 April.

The bottom graph shows the comparison of turnover rates for the same group of London teaching trusts (excluding junior medical staff). This is the total turnover rate including all 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 May). 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	15.26%	84.26%	2.84%
Trust B	14.91%	84.81%	3.02%
Trust C	16.27%	83.43%	2.60%
Trust D	14.18%	85.41%	3.34%
Trust E	15.28%	84.53%	3.18%
Trust F	17.40%	82.64%	3.04%
St. George's	16.93%	82.86%	3.31%
Average London Teaching	15.75%	83.99%	3.05%
National Acute Teaching	10.82%	88.94%	3.76%

Section 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	May '16	Jun '16	Jul '16	Aug'16	Trend
C&W Diagnostic & Therapy	1174.7	1189.6	1169.2	1172.2	↗
Community Services	687.8	504.5	529.4	570.3	↗
Corporate & R&D	64.3	70.7	70.7	51.6	↘
Medical & Cardiothoracics	1316.3	1324.9	1323.9	1323.9	↔
Surgery, Neurosciences & Anaes	1165.7	1165.7	1176.7	1186.3	↗
Total	4408.7	4255.3	4269.8	4304.3	↗

Nursing Staff in Post WTE

Division	May '16	Jun '16	Jul '16	Aug'16	Trend
C&W Diagnostic & Therapy	1007.7	1014.9	1006.3	1004.1	↘
Community Services	386.6	387.1	382.7	392.4	↗
Corporate & R&D	55.7	56.7	57.5	47.2	↘
Medical & Cardiothoracics	1040.9	1049.2	1052.8	1064.2	↗
Surgery, Neurosciences & Anaes	920.4	923.1	930.4	933.8	↗
Total	3411.4	3431.1	3429.7	3441.6	↗

Nursing Vacancy Rate

Division	May '16	Jun '16	Jul '16	Aug'16	Trend
C&W Diagnostic & Therapy	14.2%	14.7%	13.9%	14.3%	↗
Community Services	43.8%	23.3%	27.7%	31.2%	↗
Corporate & R&D	13.4%	19.8%	18.7%	8.6%	↘
Medical & Cardiothoracics	20.9%	20.8%	20.5%	19.6%	↘
Surgery, Neurosciences & Anaes	21.0%	20.8%	20.9%	21.3%	↗
Total	22.6%	19.4%	19.7%	20.0%	↗

Nursing Sickness Rates

Division	May '16	Jun '16	Jul '16	Aug'16	Trend
C&W Diagnostic & Therapy	4.1%	4.1%	4.2%	3.9%	↘
Community Services	5.7%	6.1%	6.2%	5.6%	↘
Corporate	4.2%	3.7%	5.7%	4.6%	↘
Medical & Cardiothoracics	3.6%	3.5%	2.7%	2.6%	↘
Surgery, Neurosciences & Anaes	4.4%	3.8%	4.3%	4.8%	↗
Total	4.2%	4.1%	4.1%	3.9%	↘

Nursing Voluntary Turnover

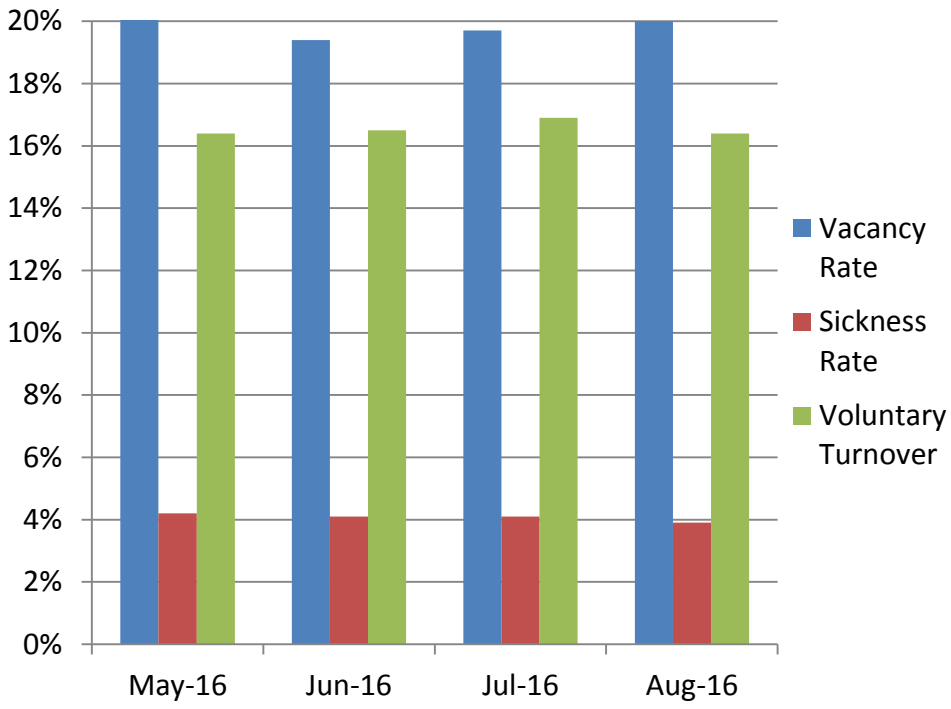
Division	May '16	Jun '16	Jul '16	Aug'16	Trend
C&W Diagnostic & Therapy	14.18%	14.51%	14.99%	15.02%	↗
Community Services	18.05%	17.35%	18.75%	16.46%	↘
Corporate & R&D	14.08%	10.21%	8.56%	13.31%	↗
Medical & Cardiothoracics	18.94%	19.13%	19.63%	18.43%	↘
Surgery, Neurosciences & Anaes	15.42%	15.87%	15.61%	15.73%	↗
Total	16.4%	16.5%	16.9%	16.4%	↘

COMMENTARY

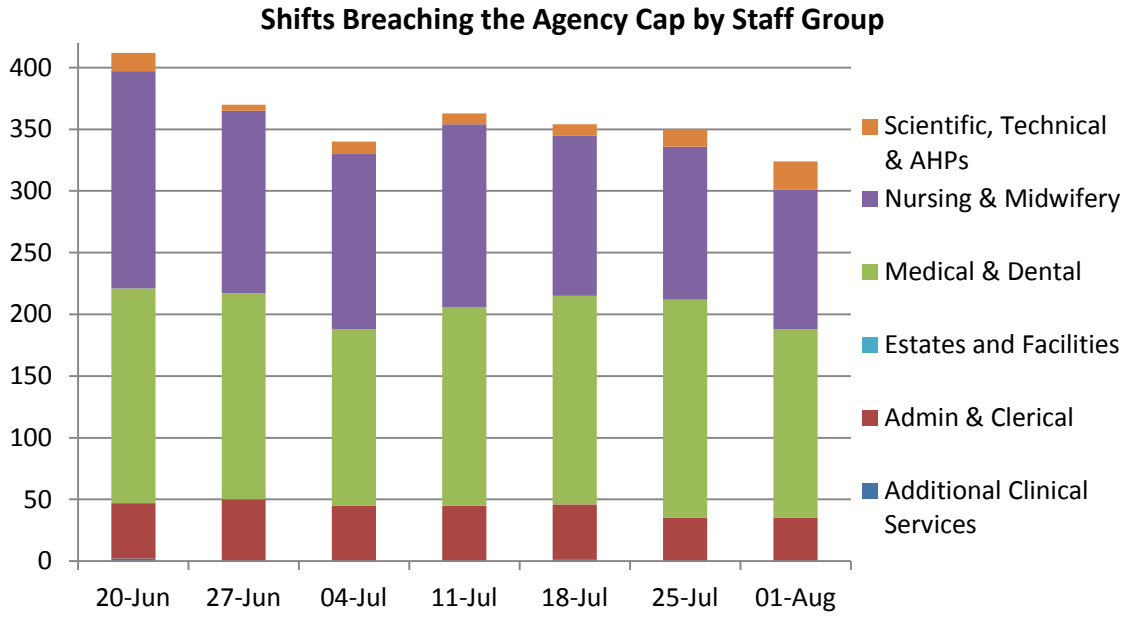
This data shows a more in-depth view of our nursing workforce (both qualified and unqualified).

The nursing workforce has decreased by 1.4 WTE in July.

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	18-Jul	25-Jul	01-Aug	08-Aug	15-Aug	22-Aug	29-Aug
Additional Clinical Services	1	0	0	0	0	0	0
Admin & Clerical	45	35	35	35	35	35	0
Estates and Facilities	0	0	0	0	0	0	0
Medical & Dental	169	177	153	176	182	182	170
Nursing & Midwifery	130	124	113	90	121	98	97
Scientific, Technical & AHPs	9	14	23	26	31	32	25
Whole Trust	354	350	324	327	369	312	292

Agency Cap Shift Breaches by Division	18-Jul	25-Jul	01-Aug	08-Aug	15-Aug	22-Aug	29-Aug
C&W Diagnostic & Therapy	68	88	85	77	59	54	49
Community Services	54	46	40	32	37	39	30
Corporate	70	60	55	55	62	69	30
Estates and Facilities	0	0	0	0	0	0	0
Medical & Cardiothoracics	114	105	84	93	103	97	96
Surgery, Neurosciences & Anaes	48	51	60	70	80	81	81
SWL Pathology	0	0	0	0	27	7	6
Whole Trust	354	350	324	327	368	312	292

COMMENTARY

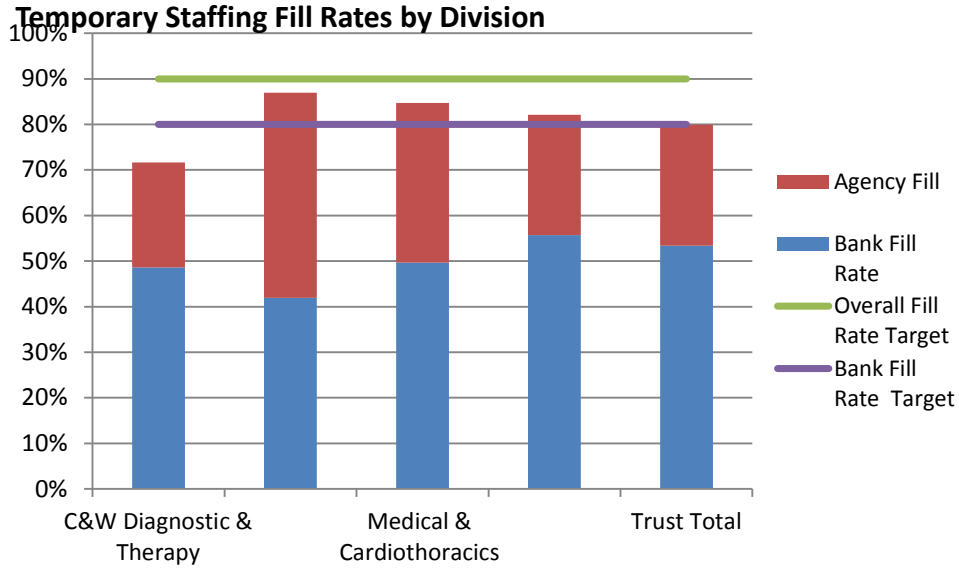
All Trusts are now required to report weekly on the number of shifts which have breached the Agency capped rates which have been set by NHS Improvement.

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.

For the week commencing 1st of August, the Medical & Cardiothoracic Division had the largest number of breaches in the Medical and Dental staff group (72). The Children & Women's Division had the highest number of Nursing & Midwifery breaches in that week (41).

Section 9: Temporary Staff Fill Rates



COMMENTARY

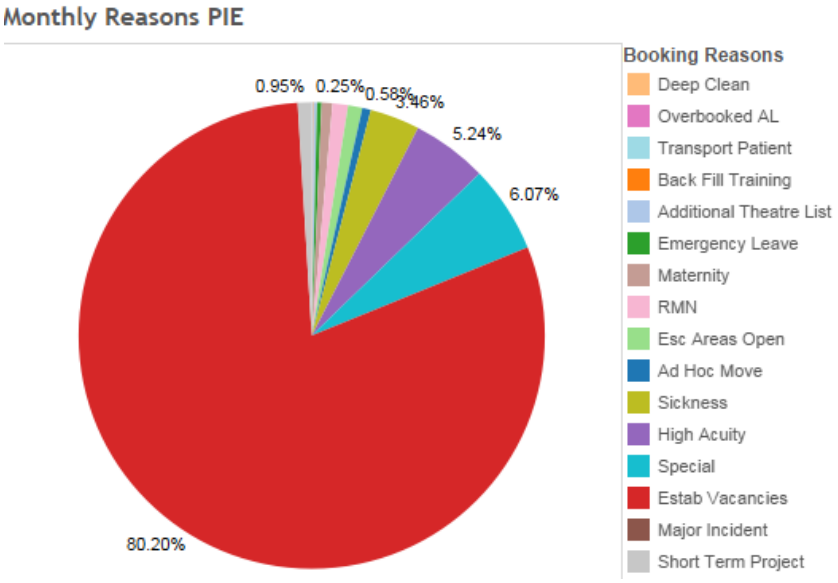
This data comes from the Trust's e-rostering system.

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 August the Bank Fill Rate was reported at 53.5% which is 0.1% higher than the previous month. The Overall Fill Rate was 79.2% which is a reduction of 0.7%. Community Services Division is currently meeting the demand for temporary staff most effectively.

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

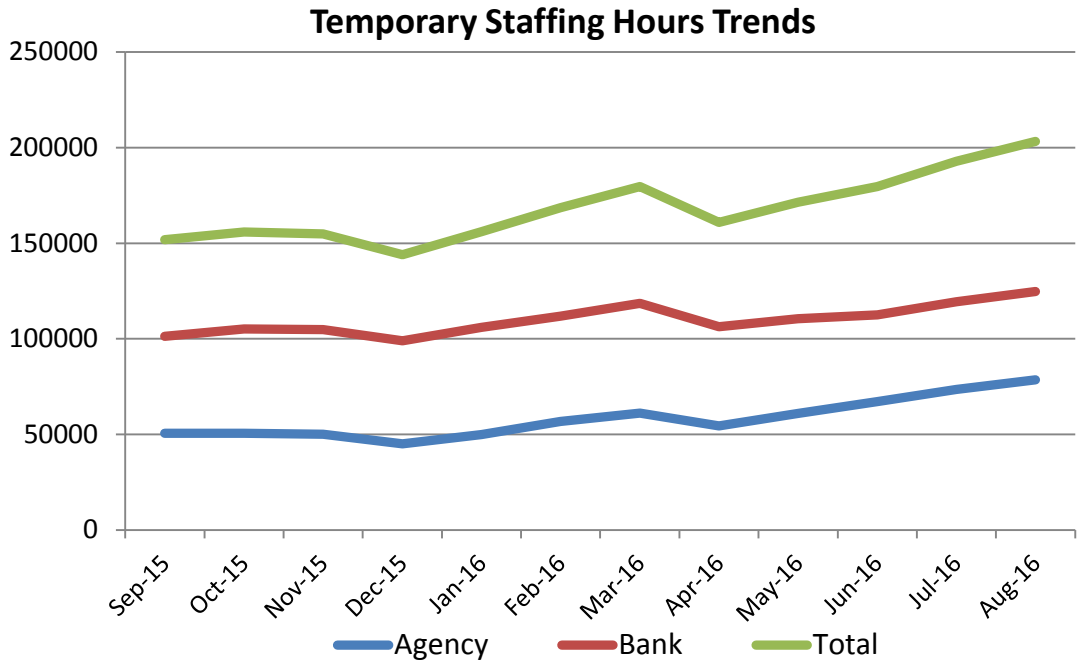
This data only shows activity requested through the Trust's bank office.



Bank Fill Rate % by Division	May '16	Jun '16	Jul '16	Aug '16	Trend
C&W Diagnostic & Therapy	53.9%	49.1%	48.6%	52.8%	↗
Community Services	46.4%	44.3%	42.0%	40.4%	↘
Medical & Cardiothoracics	47.0%	46.3%	49.7%	49.1%	↘
Surgery, Neurosciences & Anaes	56.7%	54.8%	55.7%	53.6%	↘
Whole Trust	**55.4%**	**52.8%**	**53.4%**	**53.5%**	↗

Overall Fill Rate % by Division	May '16	Jun '16	Jul '16	Aug '16	Trend
C&W Diagnostic & Therapy	76.5%	71.2%	71.6%	75.4%	↗
Community Services	86.7%	83.8%	86.9%	82.8%	↘
Medical & Cardiothoracics	83.5%	85.5%	84.7%	81.8%	↘
Surgery, Neurosciences & Anaes	79.6%	80.8%	82.1%	81.8%	↘
Whole Trust	**81.2%**	**79.2%**	**79.9%**	**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 August.

Agency hours have increased in Surgery & Neurosciences and in Children & Women's Division.

The Childrens & Women Division proportionately has the highest increase in bank hours this month. Departments with increases include Neuro Physiotherapy & Radiography.

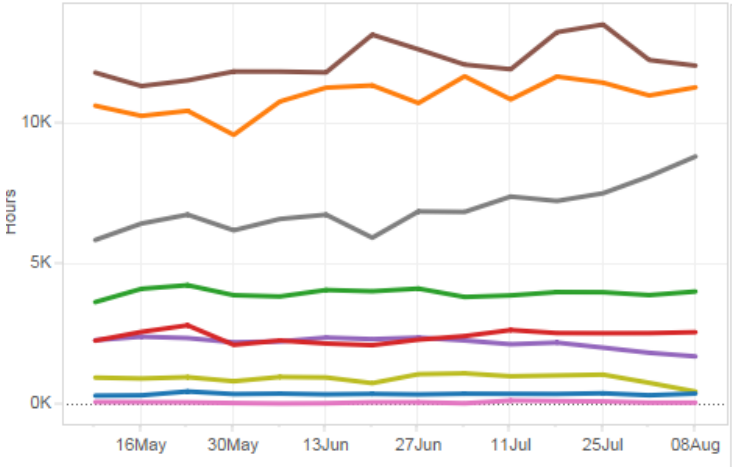
TYPE	Division	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Agency	C&W Diagnostic & Therapy	10033	11112	10724	11615	11158	14779	16404	14872	16869	19956	21545	24466
	Community Services	6421	7086	6605	6715	7298	8717	10225	8709	9108	8989	10423	10290
	Corporate	423	402	384	541	1021	793	610	866	1401	999	1089	968
	Estates and Facilities	0	4	166	322	140	176	180	361	549	321	364	187
	Medical & Cardiothoracics	24428	21792	22626	19732	23154	23159	23779	21106	24231	26734	25648	24273
	Surgery, Neurosciences & Anaes	8860	9994	9362	5953	7161	9211	9885	8584	8767	9887	11503	13891
	SWL Pathology	352	267	150	143	0	0	0	0	90	257	3013	4518
Agency Total		**50517**	**50657**	**50017**	**45021**	**49932**	**56835**	**61083**	**54498**	**61015**	**67143**	**73584**	**78592**
Bank	C&W Diagnostic & Therapy	30745	32858	31790	30886	33343	34999	32870	31037	30935	31409	31919	35655
	Community Services	8695	9149	9133	9005	9225	9796	10885	9005	8916	9340	8974	8962
	Corporate	8828	11156	9858	8426	8674	8773	9078	10249	10124	10224	10824	10861
	Estates and Facilities	8264	8506	9423	8467	8428	10122	10078	9021	9739	9914	9370	8421
	Medical & Cardiothoracics	27842	26409	28073	25363	26990	26921	29610	25231	27418	28459	32165	32678
	Surgery, Neurosciences & Anaes	16118	16265	15754	15791	18358	20155	22946	18370	19098	18549	21180	24443
	SWL Pathology	803	821	839	998	1016	1050	3063	3463	4281	4668	4879	3703
Bank Total		**101295**	**105164**	**104870**	**98936**	**106034**	**111816**	**118530**	**106376**	**110511**	**112563**	**119312**	**124725**
Temporary Staff Total		**151811**	**155821**	**154887**	**143957**	**155966**	**168651**	**179613**	**160874**	**171526**	**179706**	**192896**	**203317**

Section 11: Temporary Staffing Weekly Tracking

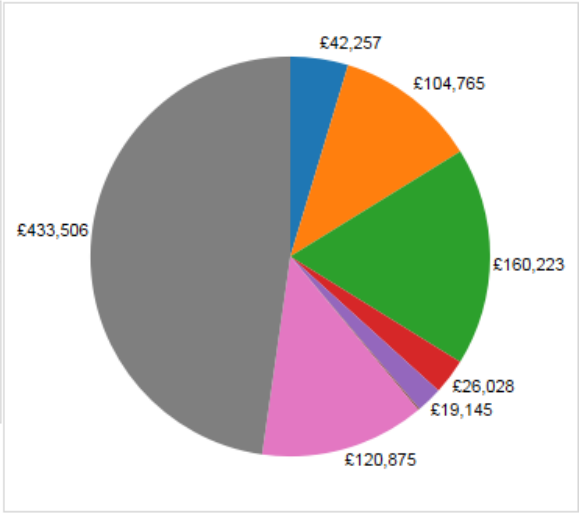
Weekly Hours Used By Division

Division	09 May	16 May	23 May	30 May	06 Jun	13 Jun	20 Jun	27 Jun	04 Jul	11 Jul	18 Jul	25 Jul	01 Aug	08 Aug
Capital Division	316	327	465	373	388	362	379	359	385	381	376	401	329	390
Children and Women's Diagnostic and..	10,659	10,295	10,476	9,618	10,809	11,303	11,384	10,753	11,708	10,882	11,698	11,481	11,023	11,314
Community Services Division	3,653	4,127	4,256	3,898	3,853	4,085	4,039	4,136	3,836	3,891	4,010	4,005	3,902	4,030
Corporate Division	2,278	2,590	2,824	2,126	2,283	2,174	2,115	2,313	2,441	2,656	2,549	2,544	2,546	2,580
Estates and Facilities Division	2,295	2,419	2,370	2,217	2,249	2,387	2,332	2,386	2,284	2,149	2,208	2,029	1,844	1,716
Medicine and Cardiovascular Division	11,839	11,360	11,560	11,880	11,876	11,846	13,193	12,670	12,126	11,960	13,281	13,556	12,289	12,089
Research & Development Division	89	83	77	52	37	44	79	80	43	141	122	110	65	66
Surgery & Neurosciences Division	5,870	6,456	6,773	6,214	6,619	6,772	5,950	6,887	6,871	7,418	7,261	7,536	8,141	8,846
SWL Pathology Division	959	928	976	830	982	966	761	1,081	1,111	1,007	1,037	1,066	773	462
Grand Total	37,957	38,585	39,777	37,207	39,098	39,938	40,232	40,664	40,804	40,484	42,541	42,725	40,912	41,491

Weekly Hours Used Trends



Weekly Spend by Staff Group



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

Total Cost

£907,999

Select Date (W/C)

08/08/2016

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	Jul '16	Aug'16	Trend
Conflict Resolution	91.2	91.0	↘
Equality, Diversity and Human Rights	84.2	83.0	↘
Fire Safety	87.2	85.0	↘
Health, Safety and Welfare	86.2	85.0	↘
Infection Prevention and Control Clinical	73.4	69.0	↘
Infection Prevention and Control Non Clinical	79.3	81.0	↗
Information Governance	81.9	77.0	↘
Moving and Handling	83.9	83.0	↘
Moving and Handling Patient	69.8	68.0	↘
Resuscitation BLS	57.5	59.0	↗
Resuscitation ILS	57.0	59.0	↗
Resuscitation Non Clinical	74.5	75.0	↗
Safeguarding Adults	84.1	83.0	↘
Safeguarding Children Level 1	82.2	84.0	↗
Safeguarding Children Level 2	80.1	76.0	↘
Safeguarding Children Level 3	71.7	76.0	↗

MAST Compliance % by Division	May '16	Jun '16	Jul '16	Aug'16	Trend
C&W Diagnostic & Therapy	78.9%	79.4%	80.0%	79.0%	↘
Community Services	82.7%	83.6%	84.9%	85.0%	↗
Corporate	78.5%	77.9%	77.8%	73.0%	↘
Estates and Facilities	68.4%	69.5%	74.4%	78.0%	↗
Medical & Cardiothoracics	76.6%	77.8%	78.5%	75.0%	↘
Surgery, Neurosciences & Anaes	77.0%	78.2%	79.4%	78.0%	↘
Whole Trust	78.9%	79.6%	80.7%	79.0%	↘

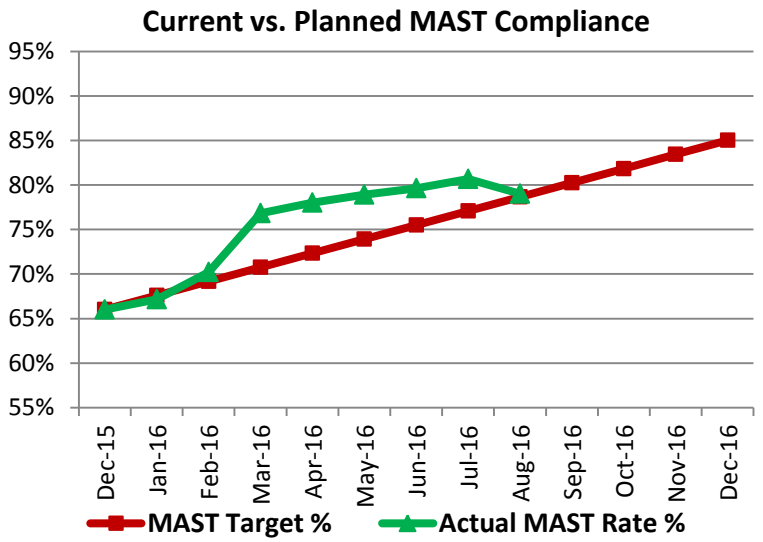
COMMENTARY

A programme of working is taking place including:

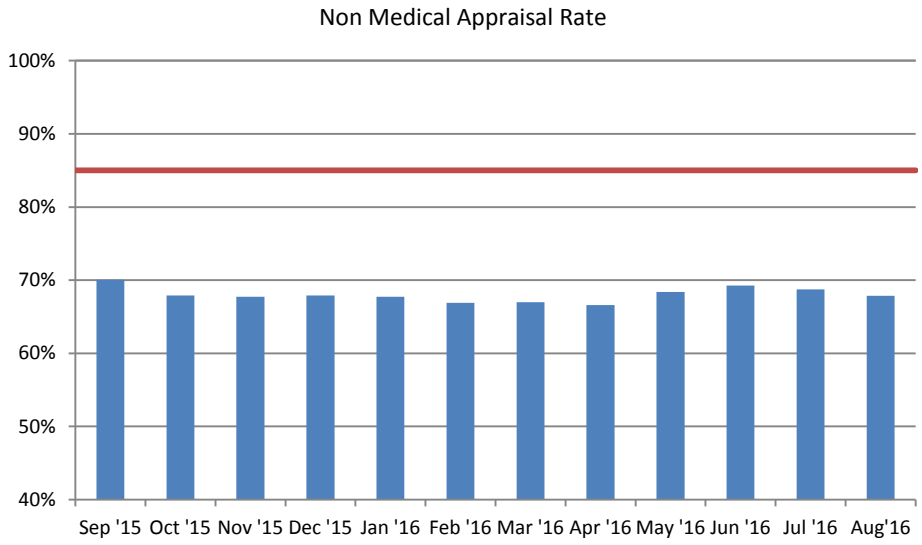
- Changing the method of delivery to on-line testing as far as possible and only training when required
- Reviewing who needs to access the training
- Reviewing the frequency of refresher periods
- Providing and accessible on-line system
- Introduced monthly meetings where divisions report on progress 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.

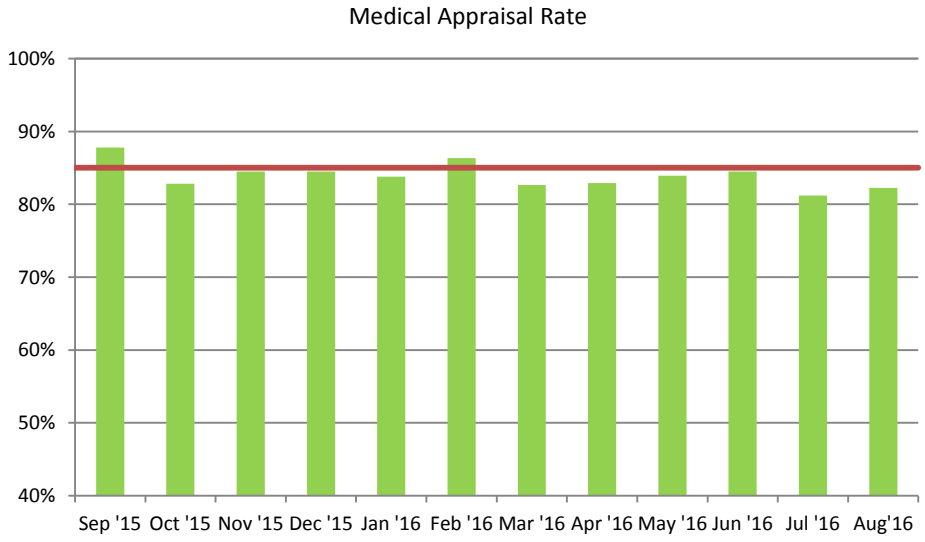
Current Issues:

- 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.



Section 13: Appraisal





Non-Medical Commentary

The non-medical appraisal rate has decreased by 0.9% this month to 67.9%. Appraisals are still being managed closely by the appraisal project team who are monitoring progress every two weeks and scrutinising divisional plans. The Estates & Facilities Division currently has the lowest non-medical compliance rate. Appraisal completion is now linked to incremental progression for bands AFC band 7 - 9 staff. The table below lists the five care groups with the lowest non medical appraisal rate this month

Medical Commentary

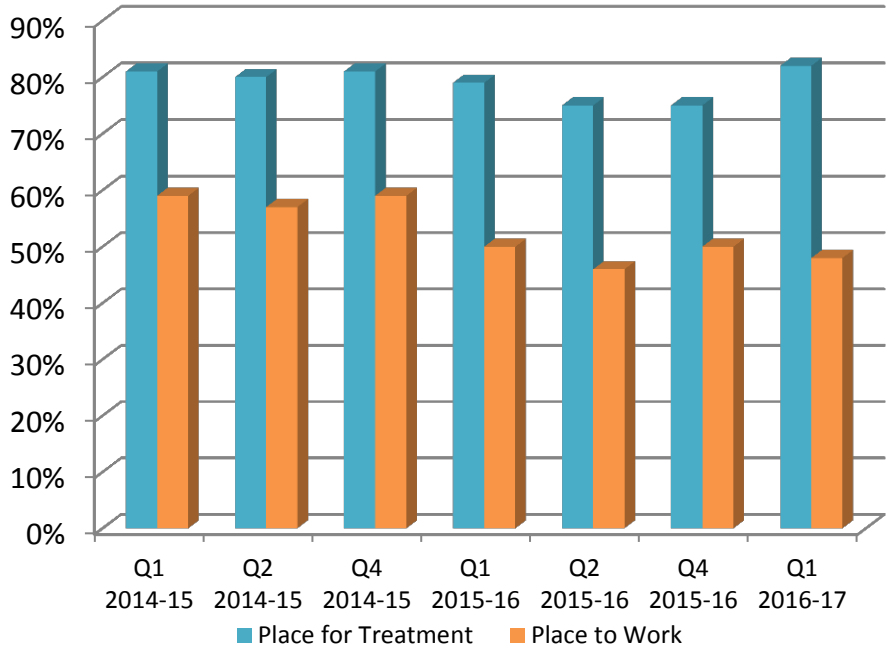
Medical appraisal rate compliance has increased this month to 81.3% which is below target.

Care Group	Non-Med Appraisal Rate	Staff In Post WTE
SWLP Central Reception	13.0%	67.27
SWLP Haematology	20.5%	58.31
SWLP Biochemistry	25.5%	55.20
Energy and Engineering	25.6%	50.75
Chief Operating Officer	29.3%	42.26

Non Medical Appraisals by Division	May '16	Jun '16	Jul '16	Aug'16	Trend
C&W Diagnostic & Therapy	63.8%	66.3%	66.9%	64.6%	↘
Community Services	66.6%	77.8%	77.3%	76.3%	↘
Medical & Cardiothoracics	70.8%	69.7%	68.9%	73.0%	↗
Surgery, Neurosciences & Anaes	77.1%	80.2%	78.2%	74.5%	↘
Corporate	64.0%	65.2%	63.3%	62.7%	↘
Estates & Facilities	64.0%	62.8%	57.8%	51.4%	↘
Whole Trust	**68.4%**	**69.3%**	**68.8%**	**67.9%**	↘

Medical Appraisals by Division	May '16	Jun '16	Jul '16	Aug'16	Trend
C&W Diagnostic & Therapy	85.4%	87.3%	86.2%	83.2%	↘
Community Services	87.5%	79.2%	70.0%	65.2%	↘
Medical & Cardiothoracics	86.8%	82.0%	79.9%	77.6%	↘
Surgery, Neurosciences & Anaes	87.5%	86.6%	84.3%	87.5%	↗
Corporate	75.0%	75.0%	100.0%	75.0%	↘
Whole Trust	**83.9%**	**84.5%**	**81.2%**	**82.3%**	↗

Section 14: Friends & Family Test



Quarter	No. of Respondents	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	655	79%	50%

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:

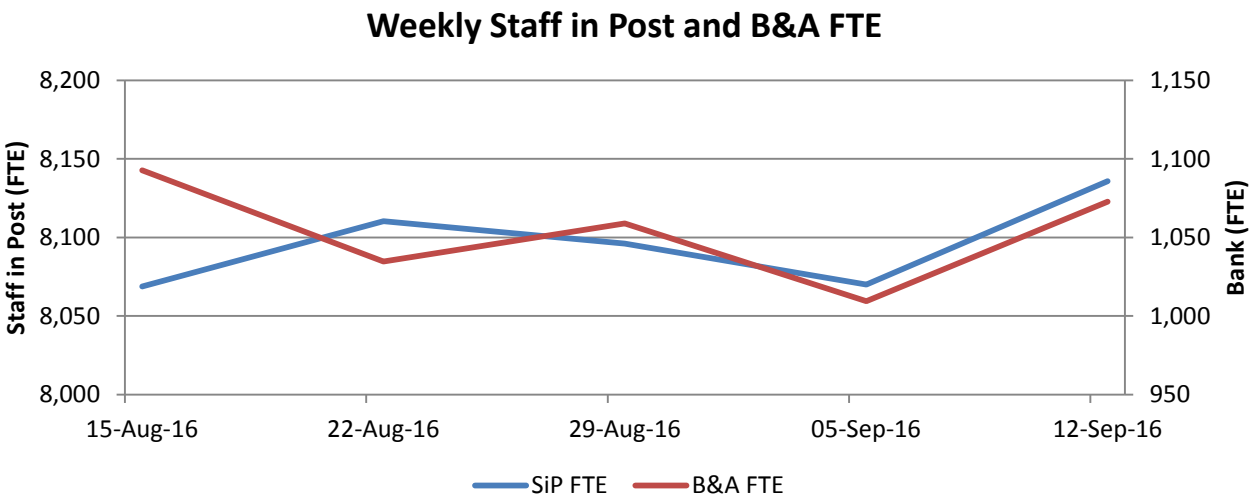
“How likely are you to recommend this organisation to friends and family if they needed care or treatment?”

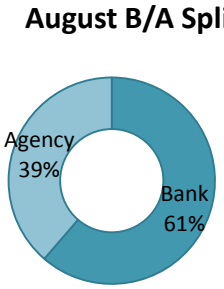
“How likely are you to recommend this organisation to friends and family as a place to work?”

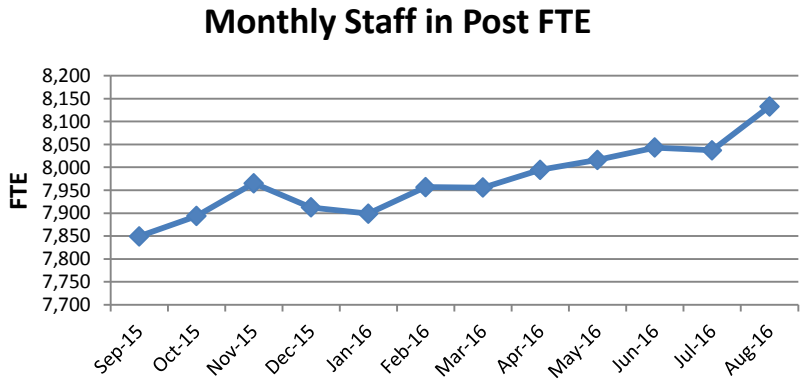
The figures show a downward trend in the percentage of staff recommending the Trust as a place to work. The percentage who recommend the Trust as a place for treatment has remained fairly stable at around 80%.

Section 1: Current Staffing Profile and Bank & Agency

The data below displays the current staffing profile of the Trust and key bank & agency data





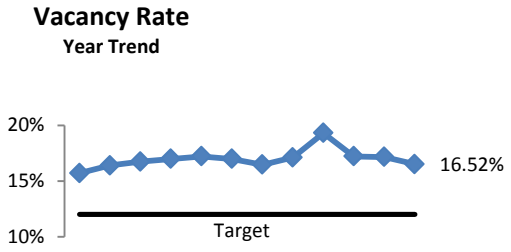


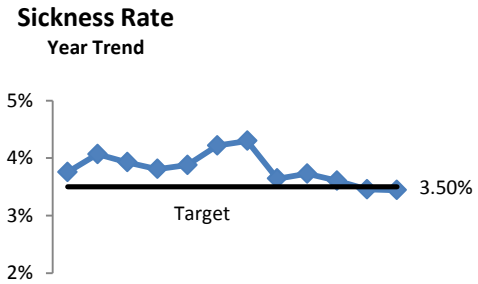
COMMENTARY

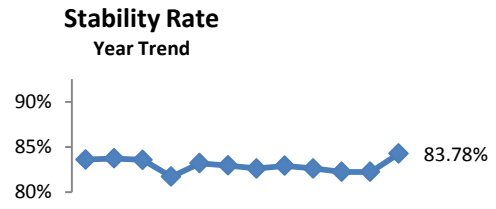
The Trust currently employs 8594 people working a whole time equivalent of 8037 which is 6 WTE lower than June. The growth rate in the directly employed workforce since July 2015 is 190 WTE or 2.4%.

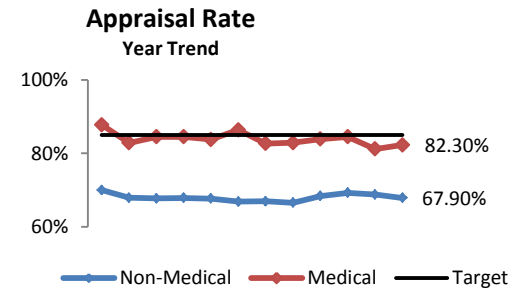
The Trust also employs an additional 435 WTE GP Trainees covering the South London area, which makes the total WTE 8472.

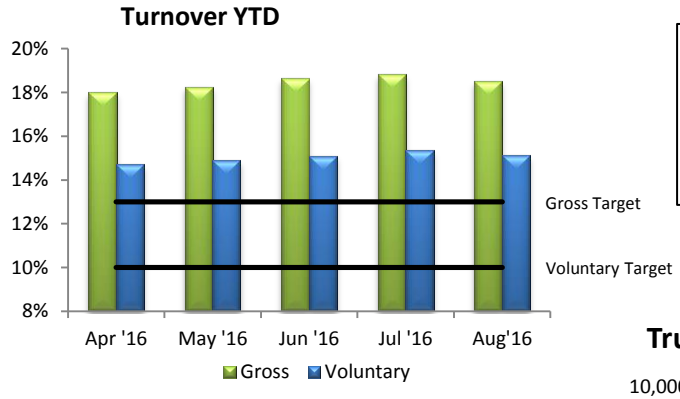
Section 2: Workforce KPI's





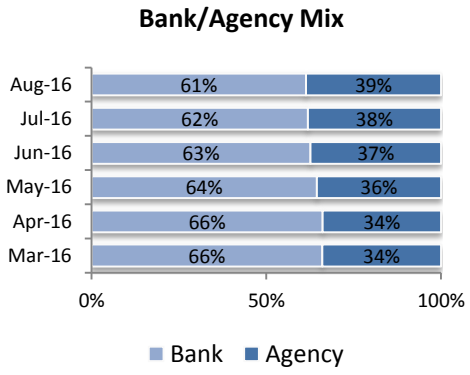


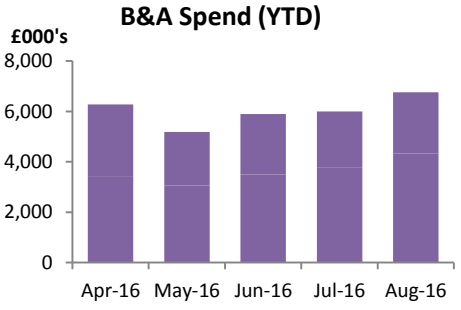


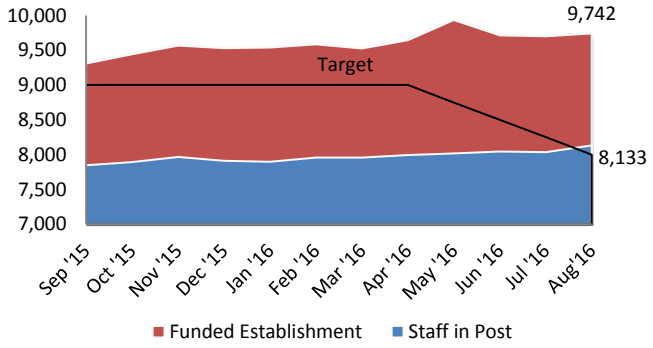


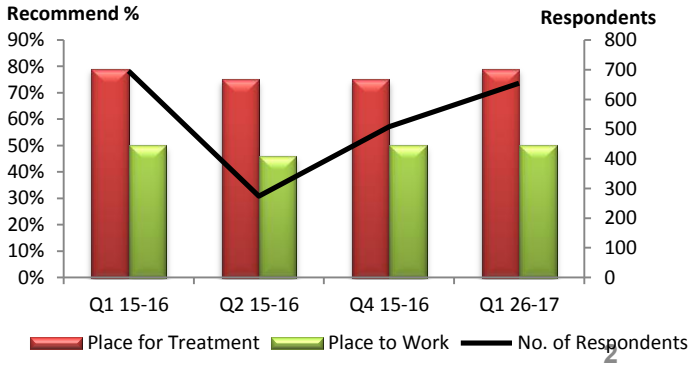
Key points:

- Vacancy has fallen by 0.6%
- Sickness has remained the same
- Turnover has decreased by 0.3%
- Voluntary turnover has decreased by 0.25%

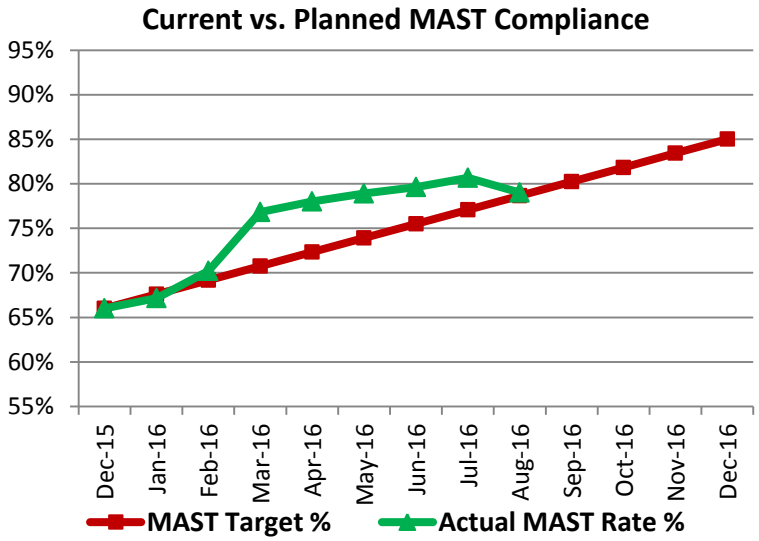








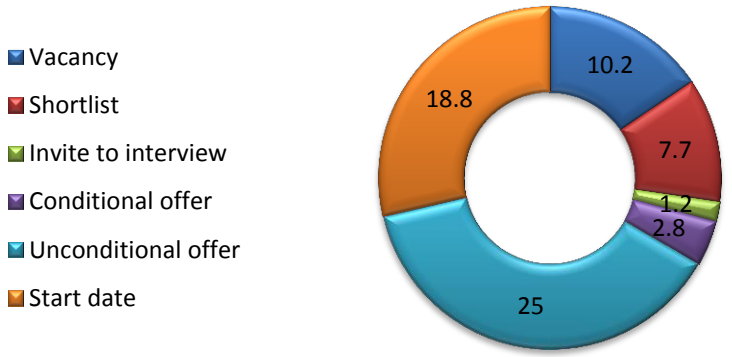
Section 3: MAST Compliance



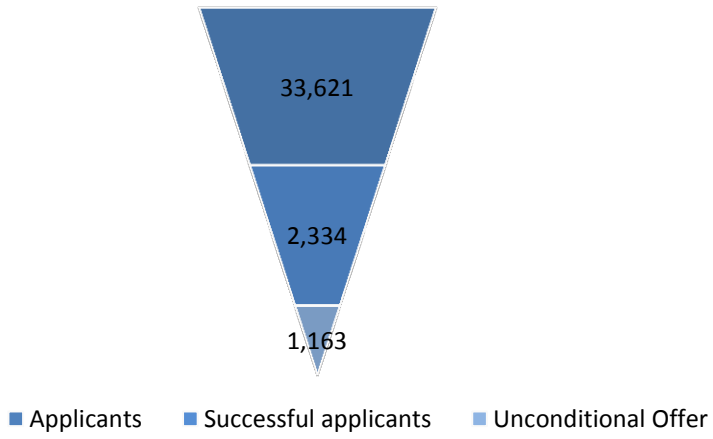
Section 4: Recruitment Pipeline

Current Pipeline (FTE)

Average days taken for key stages in Recruitment Process



Recruitment volumes to date*



Vacancy – days between completed documents received by Recruitment Team and vacancy posting
Shortlist – days that Recruiting Managers take to shortlist
Invite to interview – days between shortlisting being received from Recruiting Manager to interview invites being sent out
Conditional offer – days between interview outcome paperwork received to formal conditional offer
Unconditional offer – days between conditional offer and unconditional offer
Start date – days between unconditional offer and start date confirmed.

* When the Trac Recruitment System was implemented

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD *October 2016*

Paper Title:	Recovery Plan for Referral to Treatment (RTT) Process at St Georges University Hospitals Trust
Author:	Mark Gordon, Chief Operating Officer
Purpose: *The purpose of bringing the report to the board*	To provide the Board with an updated on the recovery plan for the Referral to Treatment (RTT) Process
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	To note the update

Aim:

To outline the key actions to be undertaken by SGUH in order to recommence national reporting of RTT Performance data, confirming competence of all staffing in management of the systems and processes, and delivery of a safe validation of patients within the current RTT pathways.

Execution: 3 Concurrent Streams

Stream 1: Immediate Data Validation of current pathways and local reporting.
Stream 2: Re-Establishment of Systems, Processes and Training.
Stream 3: Forward Management and Validation Process.

Stream 1: Immediate Data Validation of current pathways and local reporting. (COO).

- Immediate establishment of data validation, information and performance teams.
- Reconstruction of all patient data lists, and validation of current status.
- Application of immediate fixes to process issues, and retraining of key teams.
- Daily data-cleansing and triangulation of all patients on the current systems.
- Weekly Reporting internally and with Commissioners.

Tasks to Enable: Information Team, RTT and Performance Teams (18 weeks) to combine and co-locate by 05 Oct in Grosvenor Wing.

Stream 2: Re-Establishment of Systems, Processes and Training (Responsible: COO – Board).

- Re-Establish Cerner.g
- Establishment of entirely new SOPs, processes and templates for patient pathways.
- Cerner to conduct full training package for all admin/management/clinical staffs.
- Establish checks in system and regularised validation process.
- Trust-wide re-training package

Stream 3: Forward Management and Validation Process.(Programme Director to COO).

- Confirm procurement scope with Cymbio and Board sign-off.
- Commencement of pure analysis (no additions) from Cymbio.
- Weekly Report to EMT/Board.

Governance:

The Programme Board will be lead by the Trust Chairman, and will report directly to the Hospital Main Board. It will update its reporting outputs weekly in line with the current reporting cycle.

Leadership: The COO will lead the entire project, and will be responsible for all outputs.

The Weekly Board will meet at 1400 hrs on Wednesdays.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – 6th October 2016

Paper Title:	**Update from Turnaround Board**
Sponsoring Director:	**Iain Lynam, Chief Restructuring Officer**
Author:	**Jane Paice, PMO Director**
Purpose: *The purpose of bringing the report to the board*	To provide an updated position following the predicted shortfall from the CIP programme reported at the last Board.
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	**For information and to note**
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	**Turnaround Board (TAB) 21.09.16** **Executive Management Committee (EMT) 26.09.16** **Finance & Performance Committee 28.09.16**

Executive summary

This note sets out an update on the current position following a predicted shortfall for the CIP programme for the year and recovery actions to be put in place to provide new CIPs to begin the recovery process. Stretch targets have been agreed with Senior Responsible Officers (SROs) and Programme Leads (PL).

Recommendation
The Board is asked to note the position.

Key risks identified:
Failure to deliver sufficient CIP savings will significantly impact on the Trusts financial position.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	Deliver our Transformation Programme enabling the trust to meet its operational and financial targets
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	

Equality Impact Assessment (EIA): Has an EIA been carried out?
No, an EIA will be carried out as necessary on individual proposals.

Update from Turnaround Board held on 21 September 2016 and Finance & Performance Committee

1. Background

1.1. At the meeting of TAB held on 21 September 2016, it was reported that the CIP programme for the year was still showing a predicted shortfall against budget at Month 4.

1.2. It was reported that in response to this the SROs and PLs undertook to accept stretch targets per the schedule in Appendix 1.

1.3. Moving to Month 5, this shortfall had grown to £29.2m.

2. CIP Shortfall

2.1. The original CIPs in the budget were £42.7 million.

2.2. At Month 5 end, the actual CIPs delivered, as reported to PMO, are £13.5 million.

2.3. This means that we are still seeking a further £29.2 million savings in the Rest of Year (RoY) to achieve the £42.7 million full year forecast (FYF) that we reported to NHSI.

2.4. This forecast will not achieve our control total and is therefore not sufficient. Rather we need to seek a £50 million saving by the year-end to make the control total.

2.5. Therefore a stretch target of £7.3 million has been allocated to the CIPs that might reasonably have the capability to achieve the extra savings. There are also some new/additional CIPS proposed. All these allocations need to be agreed by the relevant divisional management but they indicate the direction of travel needed.

2.6. The FYF including stretch then becomes the £50 million savings needed.

2.7. PMO risk rated position at Month 5, using the M5 actuals, has determined a total CIP delivery of £23.9 million, leaving a further savings totalling £26.1 million still to be found.

2.8. Finally it should be noted that a separate major sensitivity is the divisional CIPs of £10 million, which it is still assumed will be delivered in addition to the Recovery Programme.

3. Next steps

3.1. The CIP schemes need to transact identified benefits through budgets, ensuring that all benefits are properly captured.

3.2. The quality impact assessment process has been revised which will allow a number of schemes to be processed.

3.3. At TAB, it was reported that the Executive Management Team recognised that a major effort would be necessary to address the decline in the savings anticipated to be derived from the CIP programme and to institute a set of further steps recovery steps designed to restore the total CIP for the year and catch up the present shortfall.

3.4. SROs and PLs undertook to review their programmes and develop plans to deliver further benefits.

Appendix 1

CIP Summary for TAB, EMT, FPC and Board as at Month 5					21/09/2016		
	FYE of Actual M5	ROY	FYF	Proposed Stretch	FYF including stretch	PMO Risk M5 Assessed	Still Needed
	£m	£m	£m	£m	£m	£m	£m
Theatres		5.0	5.0		5.0	4.0	(1.0)
Outpatients		2.1	2.1	0.4	2.5	2.1	(0.4)
Flow		2.0	2.0	2.0	4.0	2.0	(2.0)
Diagnostics	0.4	0.4	0.8	0.5	1.3	0.7	(0.6)
Fix Close Transfer		2.0	2.0		2.0	0.0	(2.0)
Procurement	1.9	3.3	5.2	0.8	6.0	4.5	(1.5)
Medicines Optimisation	1.4	0.6	2.0	0.2	2.2	2.0	(0.2)
Divisional CIPs	9.8	0.2	10.0		10.0	8.0	(2.0)
Nursing establishment		1.3	1.3		1.3	0.0	(1.3)
Nursing temporary staffing		1.4	1.4		1.4	0.0	(1.4)
AHP		1.3	1.3		1.3	0.0	(1.3)
nursing other		0.0	0.0	0.7	0.7	0.0	(0.7)
Medical secretaries and clinical correspondence		0.9	0.9		0.9	0.0	(0.9)
Medical workforce		1.9	1.9	1.5	3.4	0.2	(3.2)
Non-Medical workforce		3.6	3.6		3.6	0.0	(3.6)
Reducing pay costs		0.2	0.2		0.2	0.2	0.0
Spans and layers		0.5	0.5		0.5	0.2	(0.3)
SWL Bank		0	0		0.0	0.0	0.0
Workforce and Nursing Establishment	0	11.1	11.1	2.2	13.3	0.6	(12.7)
New and additional CIPs potential - requiring approval							
Repatriation of activity from Private sector		2.5	2.5	0	2.5	0	(2.5)
Private patients / mortuaries (anomalies etc)				0.5	0.5	0	(0.5)
SWLPathology				0.7	0.7	0.0	(0.7)
Total CIPs for 2016/2017	**13.5**	**29.2**	**42.7**	**7.3**	**50.0**	**23.9**	**(26.1)**

Briefing Paper on Interim Resourcing

1. Background

1.1. In a paper dated 19 August 2016, it was reported that the total number of interims was 81 WTE and the total number of KPMG consultants averaged 12 WTE in the month of July.

1.2. The number of interims has now risen but it is now becoming clear that there were a number of individuals not previously identified, such as those in SWL Pathology.

1.3. As at 16 September 2016, there were a total number of 98 WTE and work continues to resolve the exact status of five individuals within that total. The major reason for the change in overall numbers has been the rise in additional individuals to support IT plus the addition to the total of the interims deployed within SWL Pathology, which had not been included previously.

1.4. Meanwhile the total KPMG consultants, during August 2016, averaged 4.5 WTE.

1.5. As advised previously, Interim for this purpose is defined as temporary staff that are contracted to be present in the Trust for longer than one month. KPMG are the management consultants who have supported the Trust in Project Bold and its turnaround activities over the last year.

2. Interims

2.1. The 98 WTE interims comprise temporaries in the following divisions and departments: -

	Month 5	Month 4	Variance
IT and Information Management	38	27	11
"Turnaround" including PMO	28	15	13
Finance	5	7	(2)
Divisions and Operations	12	6	6
Members of the EMT	6	5	1
Procurement	2	1	1
SWL Pathology	7	20	(13)
Total	**98**	**81**	**17**

2.2. In summary 44 WTE of this total support those back office departments, which have suffered a crisis or collapse leading to a significant or complete loss of substantive staff. This includes IT, Finance and until recently Procurement (although this has now almost completed its substantive recruitment to restore the normal position.)

2.3. There are 6 WTE who are the most senior interims and who fill director level positions in the EMT. At present, the Trust cannot substantively fill these roles because of its current position.

2.4. There are 12 WTE who support the divisions and there are 16 WTE who comprise Turnaround and PMO resource.

2.5. It is recognised that a number of these roles will need to be substantively recruited, once conditions allow, and that the balance are genuinely temporary in nature. Accordingly it is intended that each and every

position will be reviewed over the next month to ensure that every interim is justified and that there is a proper target exit plan or conversion to substantive for each.

2.6. An update will be provided once this review has been completed.

3. KPMG

3.1. Although there were 16 consultants giving a total of an average 12 WTE input for each week in July 2016, this has fallen in September 2016 so that only remain 5 individual consultants contributing 3.4 WTE remain working on site.

3.2. Of these, two individuals are managing FCT CIP work streams that are due to conclude by the end of September, two hold line positions in Finance, including the role of CFO itself, and one provides part-time support to selection and sourcing of interims under the PMO.

3.3. The KPMG position will be reviewed again at the beginning of October, as is the case every month, and again prior to the end of October with a view to agree final conclusion dates for all KPMG involvement.

Iain Lynam
Chief Restructuring Officer
19 August 2016

St George's University Hospitals NHS
NHS Foundation Trust

Estates CQC Report – Board of Directors Report

Area	CQC requirement	Actions planned and assurances	Progress made to Date
Water Safety Management	CQC require us to demonstrate that we are compliant in relation to water outlet flushing across the trust and that we have robust assurances in place across our systems and processes for the avoidance of Legionella.	1) Action: Flushing regime will continue under Estates control and with Assurance: Regular reporting demonstrating robust and timely effective system for testing. 2) The main water provision plant will be replaced during H2, 2016, in GW. This will provide fresh water to adjacent buildings, bypassing the water that comes via the university. This is expected to reduce the opportunities for infection within old plumbing. 3) As additional assurance, water testing and cross-party committee DIPC/IC committee have recognised improvements across the last 18 months and will continue to monitor. 4) All results of testing are held in an electronic evidence log book and are available upon request. 5) Capital funding has been requested to enable further action to be taken to systematically remove dead legs. 6) Assurance: Emergency hand-wash basins are available to use in the event that any results return an indication of infection.	1) Replacement of aged plant is underway; we have emergency funding of £1.5m to replace the GW water plant which will reduce this risk. 2) Flushing now in the hands of the Estates team and a new flushing regime is in place, as at 15/09/2016, 100% flushing was achieved. Evidence will be sent to the Trust Board and 5 days later reported to the CQC. Water testing being carried out in accordance with HTM04, L8 and HSG274. This is imposing a strain on the Estates team and an independent alternative resource is being sourced. 3) The Estates team have also taken back in house the testing of water from the existing third party supplier (Clear Water) ensuring greater control over water quality, testing and any required treatment. 4) Dead legs are being removed as and when they are

		7) Action: Estates to establish options for permanent solutions to water safety within Richmond Ward.	discovered through existing building related project works. 5) Full pasteurisation of St. James Wing water system completed and CI02 water system was also installed on the St. James Wing water system. 6) Lanesborough Wing will be pasteurised during w/e of 1-2 Oct 2016.
Renal Services (Buckland Ward, Knightsbridge Wing)	CQC require us to demonstrate that there is robust mitigation in place to ensure patients and staffs are protected from risk of harm associated with water ingress within the electrical supply. CQC require fixed wire testing for all clinical areas within Knightsbridge Wing to be compliant. To confirm that Renal patients, specifically chronic dialysis patients, outpatient services and acute beds are moved to a more suitable environment whilst giving assurance in the interim period the risk of harm to staff and patients are sufficiently mitigated.	1) Action: Plans are in progress for Inpatients to be relocated to Champneys Ward during November 2016. 2) Assurance: Knightsbridge Wing is planned to be beyond use by Christmas 2016 and demolished ASAP in Q1 2017 through the Estates Strategy and demolition programme which is responsible for reviewing whether staff need to remain on-site or can move off-site and relocating staff accordingly. 2) In response to a clinical risk posed to relocating patients, it was agreed on 14/09/2016 with executive and clinical leads that fixed wire testing will take place after the final decant of patients to Champneys Ward to avoid having to relocate patients more than once. Other reinforcements have been built into the electrical infrastructure, to lower the overall risk. 3) A mobile dialysis unit has been placed on-site for outpatients to continue receiving dialysis treatment; this will be operational from 25/10/2016.	1) Patients at harm from water ingress near electric power sockets were immediately relocated, the bays put out of use and the electrical circuits were tested. Remedial works were carried out on the roof to reduce the water seepage in the short term. 2) The CQC return to check that this work was underway on Monday, 11th July and went away satisfied. 2) A dialysis service has been moved off-site to locations in Colliers Wood and North Wandsworth on 19/08/2016. 3) Space requirements for Kidney transplant post-op outpatients have been captured to enable the decision on

		4) Action: Establish solution for relocation of kidney transplant post-op outpatients. Meeting planned for 03/10/2016.	potential solutions.
Lanesborough Wing	CQC require assurance that systems and processes are sufficiently robust for mitigating the risks associated with both the management of fire and Legionella infections.	1) Assurance: The London Fire Brigade (LFB) are pleased with the Trusts current progress and we have signed an accord with the LFB to show we are working in partnership. There is a letter from LFB assuring they are satisfied with the fire safety of the Trust. 2) Assurance: Water safety is reported and governed through the water safety committee, the infection control committee and up through to the Quality and Risk committee. 3) Action: Desktop Ward based evacuation procedures have been designed and will be carried out on an on-going basis. 4) Action: Remedial works planned to address the main service corridor on the ground floor of Lanesborough Wing to provide a fire rated corridor. 5) All other doors are being replaced with appropriate fire doors across the Estate. 6) We will continue with the upgrade of fire compartmentalisation and ensuring fire extinguishers are present across the remaining Estate. 7) Assurance: Fire alarm in LW has had fire alarm upgrade from L2 to L1 and the assurance is that it has halved false alarm call-outs to LFB. 8) Action: Upgrades from level 2 to a level 1 fire alarm system throughout the	1) Fire extinguishers have been assessed and replaced in the Lanesborough Wing. Reporting is carried out bi-monthly to the Trusts' Health and Safety Board and an annual Fire report, based on HTM05 requirements. 2) New emergency planning liaison officer in place to address single points of failure for water flushing as of 16/09/2016. 3) There is a tender out for replacing the fire doors picked up by the audit in July 2016.

		remaining Estate is underway.	
Electrical Repairs	CQC require assurance that electrical installations are safe and compliant with relevant regulations.	1) Parts of the annual routine maintenance budget, emergency funding will be targeted on replacing the most critical infrastructure starting in LW and SJW, covering generators, switch gear and transformers. This will increase our overall electrical capacity and is a key enabler for the provision of new Theatres and adequate cooling, simultaneously reducing our electrical capacity overload. 2) Action: Fixed wire testing is underway for the remainder of the estate, estimated duration to deliver this will be 12 months and this will be put under ppm. 3) Action: A campus wide six facet survey is being procured; this will identify the areas for priority repairs. The replacement of double isolation valves will be included to reduce the risk of whole site outage. 3) Assurance: Reporting for all Utilities takes place within the Trusts relevant committees, which feed into the Risk Management committee.	1) Fixed wiring assessment completed. 2) Fixed wiring certification is being tendered.
OPD moves	CQC concerns with regards to outpatients relate to overcrowding, fire safety and renal services. Fire safety and Renal services have been addressed above. To answer the question of overcrowding, a project has been initiated to reduce patient footfall by 15% in Lanesborough Wing.	Plans are currently in place to move three services to communities: Phlebotomy: There are negotiations taking place with CCG's to repatriate Phlebotomy service to GP surgeries and community. This represents circa 3500 patients making up	All plans for relocation are currently on track for their planned deadlines. Moves will be completed by end of October 2016 which will reduce the patient footfall by 15%.

		roughly 90% of the footfall. Current plans aim for end of October 2016 for a transfer of services. BPU: Plans are in place to relocate BPU out of Lanesborough Wing to communities. Current plans aim for end of October 2016 for a transfer of services. Urology: Relocation of Urology services to take place on 17/10/2016 to Queen Mary's Hospital clinics.	
Theatres	CQC concerns related to Theatres fit for purpose and unsuitable environment fit for staff, including improvement of ventilation. Action is required to address and bring back up to required standard.	1) Project initiated with funding for design phase to refurbish Theatres 3&4 2) Once design phase completed, the business case will be submitted to IDDG for investment approval.	Project to refurbish Theatres 5&6 completed.

St George's University Hospitals NHS
NHS Foundation Trust

Name and date of meeting:

Trust Board Meeting

Document Title:

Gibraltar Health Authority Contract

Action for the Trust Board:

- To note the correction to the Annual Report and the Gibraltar contract is not yet signed
- To seek formal authority for delegated authority to sign the Service Level Agreement For the Provision of Clinical Services to the Gibraltar Health Authority for the three years to 31 March 2019

Summary:

Despite a statement in our 2015/2016 Annual Report and Accounts that the second Gibraltar contract has been signed, this is not in fact the case.

Following a legal review by Capsticks and a commercial assessment to ensure that the proposed contract will fully recover costs for the Trust, the contract is now ready to send to the Gibraltar Health Authority in its final draft form for their approval prior to signature.

The contract is expected to be signed in first two weeks of October 2016 (tbc).

With two notable exceptions, the contract is already operational.

Modest profit expectations as opportunities for volume growth are limited. An expected annual turnover in first full year of c£2m could produce profit of c£200k.

Author and Date:

Chris Burford and Jo Johnson
23 September 2016

Presented by:

GIBRALTAR HEALTH AUTHORITY ("GHA")
SERVICE LEVEL AGREEMENT FOR THE PROVISION OF CLINICAL SEERVICES

BACKGROUND

Introduction

The Performance Report dated 2 June on page 30 of the St George's University Hospital NHS Foundation Trust ("SGUH") Annual Report and Accounts for 2015/16 has a section on the Gibraltar contract that concludes;

> "The first year has been a great success, with the effective and efficient delivery of agreed services leading to positive patient feedback. Following a systematic review of service delivery in April 2016, a new three year contract *has now been signed*. This will allow GHA to centralise their services, making the patient's care pathway simpler and better supported."

However, the contract has not yet been signed; it is anticipated that it will be signed when the Minister for Health for Gibraltar visits the UK in October (date tbc but expected within the first two weeks).

The delay in signing has been to allow full review of the draft contract including a legal review by Capsticks, the Trust's lawyers and commercial assessment. The reviews have been completed and amendments agreed with Capsticks in arriving at a final draft, which following EMT approval, will be sent to GHA for their final review prior to signing.

In order to minimise disruption to the service, it was agreed with the GHA to operate under the terms of the draft contract prior to our reviews pending agreement of the final terms. Some scoping work remains to be completed on NIPT and the Plastics waiting list but otherwise the contract is already fully operational.

Summary of the contract

Contract term, three years from 1 April 2016 to 31 March 2019.

Contract involves provision of Gastroenterology, Neurology, Neurosurgery and Plastics specialities and NIPT with scope for extensions.

Care delivered either in Gibraltar or at St George's depending on clinical considerations.

Although no guaranteed minimum annual income, it is expected to generate up to £2m in the first full year.

There is agreement for an "up front" invoice of £250,000 on signing of the contract for working through a Plastics waiting list with further payment/refund from SGUH depending on actual provision.

Population of c30,000 (c90,000 including transients) and annual health care spend of £30m, so there is probably a ceiling to potential annual income for SGUH of c£5m maximum, excluding any major incidents.

Consultants are charged at £7,150 per day where locum cover required otherwise it is £5,000 per day.

Treatment at SGUH charged at NHS tariff with MFF of 21% and a management fee of 25% (10% relating to delivery of maximum RTT of 12 weeks). All travel and accommodation expenses are paid by GHA.

Income to M5 16/17 is £608k and profit after all overheads is estimated at £66k. The profit is estimated based on the actual levels of profitability to Q3 15/16 calculated with input from PLICS with an added contingency of 10% of income.

The main operational/clinical risks would be around exercising control over activities in another jurisdiction and consultant absences prejudicing activities at SGUH.

The main financial risk would be activity levels falling below the level necessary to cover overheads.

St George's University Hospitals NHS
NHS Foundation Trust

Name and date of meeting:

TRUST BOARD
6 October 2016

Document Title:

Overseas Patients Not Eligible for Free UK Healthcare

Action for the Executive Management Team (EMT):

For Information.

Summary:

This is a very complex problem that if not addressed could, from December 2016, cost SGUH c£4-5m pa as a result of non-eligible patients not being recognised as such before receiving health care. Once identified, only a small proportion of invoices sent to non-eligible patients are paid.

The Cabinet Office and Department of Health are aware of the potential cost to the NHS nationwide and are involved in a consultation process before providing revised national guidelines. Jo Johnson Head of Private and Overseas Patients is representing SGUH in this consultation.

Current Trust policy for assessing eligibility is generally not being followed and iClip system weaknesses mean that some important information is not recorded and some is recorded but then lost. A new policy will need to be developed incorporating revised national guidelines.

Work under way includes following-up on an audit that was recently carried out by TIAA on the logging of ineligible patients in the Central Booking System and, jointly with the Division, devising a pilot study in Obstetrics to ascertain what processes might be introduced to identify non-eligible women before receiving care. If this pilot study is successful the aim would be to roll it out across the hospital to safeguard all 'front door' access.

Primary care has a significant role to play in any solution. Discussions with Wandsworth CCG have been slow to get off the ground due principally to some reluctance on their part to fully engage with the issue from SGUH's perspective.

Author and Date:

Jo Johnson and Chris Burford
23 September 2016

Presented by:

OVERSEAS PATIENTS NOT ELIGIBLE FOR FREE UK HEALTHCARE

BACKGROUND

Introduction

This is a very complex problem that due to the other issues currently facing St George's University Hospitals NHS Foundation Trust ("SGUH") could get put into the "too difficult category". However, to put it into a financial context, if no action is taken, from December 2016 the cost of health care given to non-eligible patients could be £4-5m pa.

The Cabinet Office and Department of Health are aware of the potential cost to the NHS nationwide and are involved in a consultation process before providing revised national guidelines. Jo Johnson Head of Private and Overseas Patients is representing SGUH in this consultation.

The essential problem is that non-eligible patients are not recognised as such at the SGUH 'front doors', principally Central Booking System, A&E and Obstetrics. They receive treatment and then we have to play 'catch up' when they are identified as non-eligible (there are several categories of non-eligibility which makes the legal framework very complex). It can be months after the admission date before a non-eligible patient is identified as such and it is possible that some never are. Any solution would involve controlling those 'front doors'.

The hurdles that would need to be overcome to solve this problem include those of possible discrimination, the current alignment of staff/consultant incentives with volumes of activity irrespective of whether SGUH gets paid for that activity or not, safety of our staff and the role of Primary Care.

What are the current Procedures and are they being followed?

All frontline staff have a responsibility to assess the eligibility of individuals by asking the Stage 1 interview questions. This explores where they have lived legally for the last 12 months and provide proof of this. If there is any concern in relation to their eligibility, the patient should be referred to the Overseas Patient Team, so that a Stage 2 interview can be undertaken to establish their eligibility and charging category.

Current Trust policy instructs frontline staff to enter this information on iClip. However, these categories are not in place and the country of origin has been removed. When patients are entered as overseas this reverts back to NHS as soon as the next person accesses the patients' records.

In many cases, staff are not completing the initial interview questions or feel embarrassed to ask these questions. This is particularly common in the outpatient setting where waiting areas are busy and crowded or where there is automated check in.

What have we done so far?

Central Booking System

An audit was recently carried out by TIAA that confirmed the identification and logging of ineligible patients in the Central Booking System is currently weak. The recommendations of the audit report are being followed up but this is both a big task one that principally relates to reinforcing current policies rather than developing new ones.

The audit results were fed-back to the key stakeholders from data quality, central booking, outpatients, and A & E and an action plan was agreed.

Obstetrics

The Overseas Patient Team and the Division are involved in devising a pilot study to ascertain what processes might be introduced to identify non-eligible women before receiving care.

The current practice is that patients are booked in and asked to complete a booking-in form. This form asks for proof of eligibility including passport details etc. However, these forms are routinely returned to the administration staff without these eligibility details completed and administration staff do not follow up on the missing information. The form is then kept until the woman has had her baby and then sent down in batches to the Overseas Patient Team for checking. This means that most, if not all, patients have to be sent a letter asking them to bring in documentation to prove eligibility. If they do not respond to the letter they are sent an invoice for their treatment at 150% as it is assumed they are not entitled.

Issues with this process include that women have already completed their treatment pathway and incurred significant costs prior to being identified as non-eligible, that large numbers of non-eligible patients are identified by default leading to increasing verbal and physical abuse and complaints, and that blanket invoicing incurred at a cost of £25 per invoice, generates additional costs only for the invoices, in most cases, never to be paid.

The pilot recommends a new way of working at the booking in process. Administration staff would be trained to check documentation (photo ID and current utility bill) which the women will be asked to present on booking. This will be advertised widely throughout primary care in preparation. Jo Johnson has met with Dr Mike Lane from Wandsworth CCG and discussed the potential process for embedding this.

Anyone who was not able to prove eligibility would automatically be referred to the Overseas Patient Team for further investigation allowing real time management and identification of no eligible women.

The Home Office are keen to support this pilot as a way of benchmarking this process nationally. Jo Johnson has also met with Experian who are keen to work with St George's to develop an electronic eligibility tool and it has been suggested that this could be incorporated within the proposed pilot.

If this pilot study is successful the aim would be to roll it out across the hospital to safeguard all 'front door' access.

Primary Care

Primary care has a significant role to play in any solution. Discussions with Wandsworth CCG have been slow to get off the ground due principally to some reluctance to fully engage with the issue from SGUH's perspective.

E-mail correspondence between Jo Johnson and Mike Lane of Wandsworth CCG on the invitation to engage with the obstetrics pilot study is attached as Appendix 1.

The original report prepared by Jo Johnson and sent to Mike Lane is attached as Appendix 2.

The Overseas Team

We currently have an Overseas Patient Team of 4.1 wte (0.5 of which is the Manager of Gibraltar and Overseas) and the team currently includes staff with detailed knowledge of the complexities of eligibility. Their jobs would be made significantly easier if the paperwork received, particularly from Obstetrics, was completed properly.

This would also allow more time to meet Overseas patients and discuss issues of eligibility directly with them. These conversations can become quite heated and safety of our staff is a priority.

What are the current financial implications?

We currently invoice overseas patients 150% of tariff and Wandsworth CCG 75% of tariff. When/if the patient pays us the 150%, we would reimburse Wandsworth the 75%, if paid. However, when the Non EEA Incentive arrangement is withdrawn in December 2016, Wandsworth CCG will no longer be underwriting 75% of the cost of non-eligible health care; the full risk will then fall on SGUH and could cost us up to £4-5m pa because a large proportion of non-eligible patients when they are identified as such and billed for their treatment are either unable to pay or abscond before we can collect it.

We are also currently invoicing Wandsworth for Overseas patients as if they were NHS patients due to system errors in CERNER i.e. we are invoicing Wandsworth twice for the same patient. We are currently reviewing the extent of this double invoicing and Wandsworth don't yet seem to have noticed the duplication.

Unsurprisingly, we have a large amount of debt outstanding due from overseas patients running at c£4m before provisions. Our provisions assuming that Wandsworth pay their 75% in full is c£2.1m (it would increase to c£3.0m without the Wandsworth indemnity). These figures do not include any possible debt from the duplicate invoicing.

Dear Mike,

Thank you for your email and response to the paper I sent regarding overseas patients.

This initiative does not relate to private patients, this relates to the increasing number of overseas visitors who are accessing NHS who are not entitled to treatment. The problem is escalating within obstetrics and we have just been made aware that individuals who are currently offering paid assistance to women in Nigeria to have their babies for free on the NHS at St George's. St George's is targeted as it does not currently have a robust process to check eligibility. We know from feedback from other non-eligible patients that St George's is viewed as an 'easy target'.

The Trust/CCG is currently losing approximately £4.6m a year from patients who are accessing the system and are not entitled. When they are identified and billed for their treatment they are unable to pay this back or abscond before we can collect it. At present only 20% of this money is retrieved, the majority of funds have to be recovered by our debt collection partners.

We have recently undertaken some work with the Cabinet Office and with UKBA. The government are aware of the escalating problem faced by acute Trusts and are working on revised national guidance which is likely to advocate routine presentation of proof of identity and eligibility. Legislation is due to incorporate charging for A & E and ambulance services which will mean that Trust's will have to insist that this documentation is provided before care is given (unless it is an emergency/life or death situation).

There are examples of Trust's who have successfully implemented this already, one of which is Peterborough. They have worked with their partners in Primary Care to successfully implement this. The government are likely to use this example as a national bench mark.

Primary Care has to be central to this process. We recently undertook an audit which took a random sample of referrals received through central bookings from local GP's. 19 out of 20 patients selected were not entitled to NHS treatment and some of these patients had gone on to access high cost treatments such as cardiac surgery before being detected. The cost of these patients is passed onto the CCG's or NHS England as well as impacting local funding. We are acutely aware of the challenges faced by you in the community trying to obtain this information.

The problems we encounter are that patient eligibility is not checked prior to referral into our services, that patients are given an NHS number, and that patients have a registered GP and a local address. Hospital staff assume that if they have an NHS number, GP and local address that they are entitled to NHS care which is certainly not always the case. We treated approximately 6000 overseas patients last year (and probably many more who may have remained undetected). We are desperate to secure the support of our GP colleagues and work towards a process that identifies patient eligibility before services are accessed.

This is will be a blanket process for **every** woman referred or self-referred to St George's for obstetric care. No-one will discriminated against. At booking, every patient will need to show a form of photo ID or proof of their right to remain (asylum status, visa etc.). Any patient who is unable to do this will be referred to the Overseas Patient Team for specialist document screening, in liaison with the UKBA and the Home Office.

The intention is for this to become standard procedure (and what should be carried out already as part of national legislation) and will not impact booking rates. What it will hopefully do is deter organised illegal activity, reduce the numbers of non-eligible patients and make the system more streamlined.

We are also mindful that there will always be exceptions and patients may need to have access to services for clinical, ethical or moral reasons. We would advocate that patients are always treated as individuals and that each case is assessed on its own merits.

The Home Office is very keen to formally support this pilot, so it would be really helpful if we could all meet to plan a systematic approach to allow us to launch this.

Would you be happy to meet to discuss this further?

With kind regards,

Jo

Jo Johnson
Head of Private and Overseas Patients
Strategy
St George's University Hospitals NHS Foundation Trust

T: 020 8725 3883 (Please note my new number)
M:
E: jo.johnson@stgeorges.nhs.uk
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Excellence in specialist and community healthcare

From: Lane Mike (NHS WANDSWORTH CCG) [mailto:mike.lane@nhs.net]
Sent: 18 September 2016 08:07
To: Jo Johnson
Cc: Sue Hendy; Alex Stamp; Sean Briggs; Chris Burford
Subject: Re: Paper outlining current and proposed overseas obstetric process

Hello again Jo,

Further to your recent email and outline paper, I wasn't sure what your next proposed steps are.

The proposed pathway wouldn't involve primary care (other perhaps than to make them referring practices aware of what you'll be doing).

Private patient care falls outside our commissioning remit, and my only concerns would be around possible impact on NHS entitled patients.

Primary care practice registration does not routinely capture country of origin, simply patient-identified ethnicity and language of choice, and so there will be no realistic prospect of those data being offered to SGH on the antenatal referral form. You may of course wish to amend your direct booking form in order to capture this directly from women who self-refer.

You will need to be aware of the legal limitations of discrimination law- if you ask some women for proof of eligibility eg passport then you will be expected to ask it from all women.

Also, two practical issue that we have found in our local population whilst trying to check eligibility for GP registration (before last year's change to support universal registration):

- many women will have no photo ID.

- many women from certain cultural backgrounds will have no utility bill or bank account in their name, as the male head of the household will be the registrant for those services

We are also mindful that there will always be exceptions and patients may need to have access to services for clinical, ethical or moral reasons. We would advocate that patients are always treated as individuals and that each case is assessed on its own merits.

The Home Office is very keen to formally support this pilot, so it would be really helpful if we could all meet to plan a systematic approach to allow us to launch this.

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You will need to be aware of the legal limitations of discrimination law- if you ask some women for proof of eligibility eg passport then you will be expected to ask it from all women.

Also, two practical issue that we have found in our local population whilst trying to check eligibility for GP registration (before last year's change to support universal registration):

- many women will have no photo ID. (One of my GP colleagues for example has epilepsy so no driving licence and has never travelled, so no passport, and we found it very hard to get her an NHS smart card!)

- many women from certain cultural backgrounds will have no utility bill or bank account in their name, as the male head of the household will be the registrant for those services

As a commissioner, I absolutely support SGH desire to financially protect itself from non-eligible service access. I also have a commissioner duty also however to ensure that your proposals don't result in unwarranted delays, poorer clinical outcomes or SIs, that national targets eg early booking rates don't suffer, and I know our public health colleagues will share my hope that health inequalities don't increase.

You may wish to bring a paper outlining the pathway to the SGH Clinical Quality Review Group, if there is a risk that the proposals could negatively affect NHS patient care. If so, aid suggest you need a couple of paragraphs outlining:
1. Risks identified (delays, worsened patient experience etc)
2. Mitigations

Best regards,

Mike

Dr Michael Lane
FRCGP

Board Member, Wandsworth CCG
Joint Clinical Lead, Wandle LCG

London Maternity Lead, RCGP

Appendix 2

St George's University Hospitals NHS
NHS Foundation Trust

Redesigning Overseas Patient Access to the Obstetric Pathway

Background:

- The Trust is at significant risk from increasing income loss as a result of patients who are not eligible for treatment accessing high cost care. One area which represents high risk is the obstetric pathway

- In line with Department of Health Guidelines (Reference: Improving Systems for Cost Recovery for Overseas Visitors: May 2015). Current contractual arrangements for non EEA (patients outside the European Union who are not charge exempt) allow us to charge 75% of the tariff to the responsible commissioner, Wandsworth CCG. The patient is charged at 150% tariff and when this is repaid the CCG is refunded their 75% contribution. This will cease in December 2016, and the Trust will have to meet the costs without subsidy

- All patients can access a GP, as care at the point of access remains free of charge. Once registered with a GP they will be given an NHS number. This **does not** mean that they are eligible and the GP referrals do not explicitly flag whether the patient is entitled to NHS care at point of referral. A number of patients who have recently accessed the

obstetric pathway have incurred debt from previous episodes and being actively pursued to recover this

- The overseas team are provided with the Pre-registration forms for all patients accessing this service. The vast majority of these forms are incomplete and eligibility is not established at point of booking. Information gaps include registered GP, country of origin, and NHS number. Staff members do not check and sign the forms, so incomplete forms cannot be tracked to individual staff members

- There are a large volume of outstanding Pre-registration forms awaiting eligibility authentication. It is impossible to predict what percentage of this activity represents non-eligible patients and conversely what the financial impact is. These forms are delivered to the overseas team sporadically and in batches, often post-delivery.

- The team are then expected to check eligibility of all patients following the birth (due to the fact that this is a package tariff). As well as working closely with the Home Office and UK Border Agency to investigate high risk cases, all patients are sent a letter requesting that they provide proof of entitlement, a passport and recent utility bill, either in person or scanned and sent to the overseas e-mail address. If this letter is ignored, then the patient will be invoiced for all activity at 150% of tariff

- Each invoice costs the Trust £25 to create. Over 50% of generated invoices are then subsequently cancelled when eligibility is confirmed, which incurs additional cost. In 2015/2016 there were 1783 overseas patients identified as having accessed the obstetric pathway. Approximately 50% of this group are chargeable. In addition to the likely lost revenue, the cost implication of generating invoices for these patients was £44,575, incurred by the Private and Overseas Patient Team

- This 'blanket' billing has led to an increase of abusive phone calls and aggressive behaviour from patients and their relatives within the office. One incident at the beginning of July led to patient trying to smash the glass at the front of the office and the panic alarm being raised. We have now requested additional security to safeguard the team

- In the last month, the team have received incomplete forms relating to women who delivered in the latter part of 2015. The impact of this delay is that whilst the patient can be invoiced, the CCG cannot be charged for this activity as it falls outside the 15/16 charging period. We currently only have a 20% recovery rate from non-eligible overseas patients

- The team have requested meetings with the Obstetric Team to explore new ways of working to redesign the current pathway but the last meeting did not attract any attendees and so had to be cancelled

Implications:

- Increasing loss of income escalating in December 2016 when CCG Non EEA subsidy ends

- Patients are not identified until they have given birth rather than at the beginning of the pathway. This means that non eligible patients are able to access anti-natal care and scanning unchallenged. Some of these patients also go on to have high cost assisted deliveries +/- SCBU
- Poor debt recovery. Only 20% of this income is recovered through our debt collection partners, LRC. Overseas debt is currently running at approximately £4.6m
- St George's now has a reputation of being a 'easy target' and so numbers are likely to increase as other services tighten up their screening processes
- It is unclear what the financial implications are for patients being treated at QMH and this will need to be investigated

Solution:

- A collaborative, co-ordinated approach
- Complete redesign of booking procedure and correct use of the Pre-registration Form as a matter of urgency to negate further loss of income
- Formal roll out process and timelines
- Introduce standard procedure that means that every patient booking in has to show proof of eligibility. This should be their passport (and visa, proof of asylum etc.) and recent utility bill
- Staff to take responsibility and held accountable for the effective management of pre-registration process and form and required to sign on completion, taking ownership
- Patients who are unable to verify eligibility or where the Obstetric Team are unsure of eligibility should be sent for assessment by the Overseas Patient Team. This will allow patients to be verified **prior** to accessing the pathway
- A clear message needs to be sent out to staff and patients that we will be enforcing this and that if patients are unable to verify eligibility then they will not be able to access the service. We will need to be mindful of the ethical implications and clearly demonstrate that we assess on a case by case basis
- To involve Communications and the GP liaison service to publicise this new process
- Close liaison with GPs and Wandsworth CCG to drive this change
- Local advertising and inclusion in all patient information
- To provide a comprehensive educational programme. The Overseas Patient Team will need to work closely with the Obstetric Team reinforcing the process and monitoring competence and compliance
- Formal monthly review meetings to monitor patient numbers, collate non-eligible patients and ensure they are removed from SLAM. This review should also include an operational review to assess the overarching impact
- Monthly financial review to calculate the financial impact on the service for patient identified as non-eligible
- Responsive investigation of procedural breakdown and educational support for staff members who do not adhere

St George's University Hospitals NHS
NHS Foundation Trust

Name and date of meeting:

TRUST BOARD
[6th October 2016]

Document Title:

Summary Finance Report- Month 05 2016/17

Action for the Trust Board:

Note the current Trust financial position and forecast projection

Summary:

The Trust has reported an in-month deficit of £7.5m in August which is £6.6m worse than plan. Included is a Non Pay overspend (£3.1m), excess pay costs of £1.3m and below plan SLA Income (£2.3m; mainly attributable to the STF (£1.5m) and low activity volumes). £0.7m of Pay and £0.3m of Non Pay is cost unforeseen and outside of the control of the Trust.

The Year to date deficit is £34.9m and forecast outturn is £55.5m. These values are £19.7m and £38.3m worse than plan respectively.

Author and Date:

Nigel Carr, Chief Finance Officer

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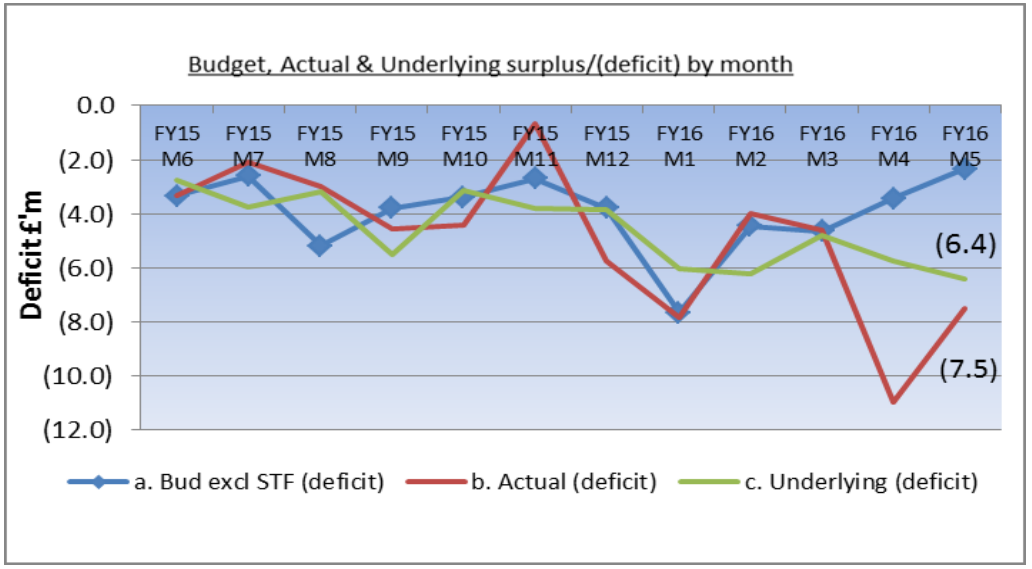
Summary Finance Report
Month 05 2016/17

Trust Board 6th October 2016

Contents

1. Financial Position for the month August 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	649.7	54.3	53.4	(0.9)	268.6	266.0	(2.6)
STF Income	17.6	1.5	0.0	(1.5)	7.3	0.0	(7.3)
Other Income	111.9	9.4	9.5	0.1	46.6	47.9	1.4
Overall Income	**779.2**	**65.2**	**62.9**	**(2.2)**	**322.5**	**314.0**	**(8.6)**
Pay	(488.3)	(40.6)	(41.9)	(1.3)	(202.2)	(204.3)	(2.1)
Non Pay	(273.1)	(22.5)	(25.5)	(3.1)	(121.0)	(129.9)	(8.9)
Overall Expenditure	(761.4)	(63.1)	(67.4)	(4.3)	(323.2)	(334.2)	(11.1)
EBITDA	17.9	2.0	(4.5)	(6.6)	(0.6)	(20.3)	(19.6)
Financing costs	(35.1)	(2.9)	(3.0)	(0.0)	(14.6)	(14.7)	(0.0)
Surplus/(deficit)	**(17.2)**	**(0.9)**	**(7.5)**	**(6.6)**	**(15.2)**	**(34.9)**	**(19.7)**
Memo: Below the Line Items	0.0	0.0	(1.0)	(1.0)	0.0	(4.8)	(4.8)



Commentary

- An in-month deficit of £7.5m is reported in August which is £6.6m worse than plan. Included is a Non Pay overspend (£3.1m), excess pay costs of £1.3m and below plan SLA Income (£2.3m; mainly attributable to the STF (£1.5m) and low activity volumes). £0.7m Pay and £0.3m Non Pay is 'Below the line'.
- **Forecast Outturn** is to achieve a £55.5m deficit. This has moved by £1.5m since M04 owing to activity shortfalls and additional agency pay costs.
- **SLA income** - £0.9m shortfall in month and £2.6m YTD. Business Case slippage in Neurosurgery and a seasonal dip in August Non Electives have contributed to this.
- **STF Income –** The cumulative under recovery of £7.3m arises as the Trust has missed its control total to date. This is expected to continue to year end.
- **Pay** - £1.3m overspent in month, and £2.1m YTD, as a result of spend on unbudgeted interim staff and extra Bank & Agency in clinical divisions to cover vacancies.
- **Non pay** – £3.1m excess cost in month and £8.9m YTD, £6.6m (to date) of which is a consequence of the shortfall in Trust CIP plans. The remaining overspend relates to drugs and pharmacy which has an offset in Commercial or SLA Income.
- **Below the line** - £4.8m of cost year to date relate to items outside the Trust's initial plan regarding unforeseen, one off costs associated with CQC inspection, the rectification of Estates & IT infrastructure, additional senior management support and lost income from the Junior Doctors' strike.
- **The M5 underlying position (excl. STF)** is a deficit of £6.4m, from £5.4m in M4. The M5 deterioration is owing to a reduction in elective & non-elective income of £0.6m and increased agency pay cost. The £11.0m actual deficit in M04 was caused by changes in approach on STF agreed with NHSI. The deterioration since 15/16 is owing to higher: pay award & pension cost; spend on interims; soft FM costs; and (unbudgeted) costs of reactive maintenance.

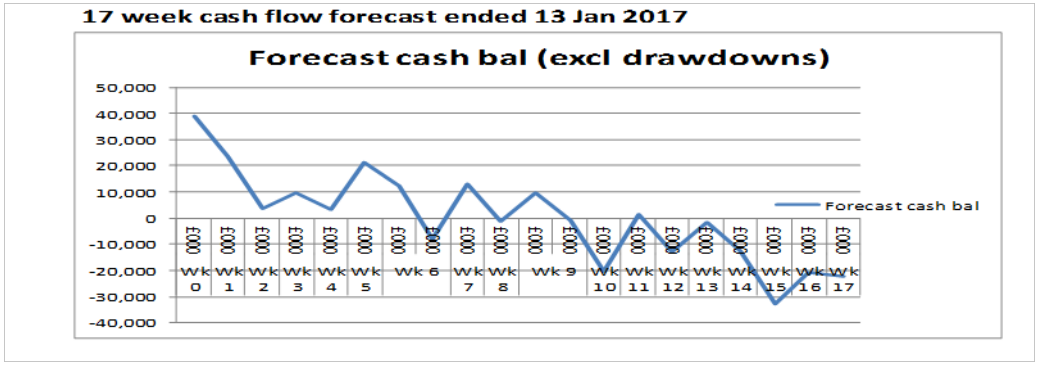
2. Analysis of cash movement M05 YTD

Source and application of funds - cash movement analysis:
M05 YTD and forecast vs Plan

	Actual vs Plan YTD			Forecast £55.5m deficit vs Plan			
	Plan YTD £m	Actual YTD £m	*Actual YTD VAR £m*	*Plan Year £m*	*Forecast Outturn £m*	*Forecast VAR £m*	Notes on forecast outturn
Opening cash 01.04.16	7.4	7.4		7.4	7.4		
Income and expenditure deficit	-17.9	-34.9	***-17.1***	-17.2	-55.5	***-38.3***	
Depreciation	10.1	10.1	***0.0***	25.0	25.0	***0.0***	
Interest payable	2.1	1.9	***-0.1***	5.1	5.9	***0.8***	
PDC dividend	2.6	2.6	***0.0***	6.3	5.3	***-1.0***	
Other non-cash items	-0.1	-0.1	***0.0***	-0.2	-0.2	***0.0***	
Operating deficit	**-3.1**	**-20.3**	***-17.2***	**19.0**	**-19.5**	***-38.5***	
Change in stock	-0.3	-0.9	***-0.6***	0.6	0.6	***0.0***	
Change in debtors	-2.4	-13.5	***-11.2***	1.8	1.8	***0.0***	does not assume debt targets met
Change in creditors	4.5	35.2	***30.8***	-5.5	-5.5	***0.0***	
Net change in working capital	1.8	20.8	***19.0***	-3.1	-3.1	**0.0**	
Capital spend (excl leases)	-16.7	-9.9	***6.7***	-33.4	-72.5	***-39.1***	includes emergency capital expenditure
Interest paid	-1.8	-1.7	***0.1***	-5.1	-5.7	***-0.6***	
PDC dividend paid	0.0	0.0	***0.0***	-6.3	-5.3	***1.0***	
Other	-3.5	-3.0	***0.5***	-8.0	-8.0	***0.0***	
Investing activities	-22.0	-14.6	***7.4***	-52.7	-91.4	***-38.7***	
WCF/ISF borrowing	18.9	20.9	***2.0***	32.5	109.9	***77.4***	includes emergency (unapproved) capital funding and additional borrowing to finance higher deficit but excludes requested £20m cash headroom
Closing cash 31.07.16	3.0	14.1	***11.1***	3.0	3.2	***0.2***	

M05 YTD cash movement

1 The cash movement table above compares the actual outturn cash movement for M01-M05 with the original plan
2 The better performance on working capital (+£19m) and cash under spend (+£6.7m) on the capital programme offset the adverse cash impact of the higher operating deficit (-£17.1m) enabled the Trust to maintain a cash balance and borrowing position at M05 ahead of plan however the trust deferred a supplier payment run from late August to September and this explains the favourable creditors variance.



M05 YTD cash movement

- Of the I&E deficit of £34.9m YTD, some costs have not impacted cash. Among these are depreciation (£10.1m) and dividend to the secretary of state (£2.6m). This generates a YTD cash operating deficit of £20.3m.
- The operating variance from plan of £17.2m in cash is directly attributable to the I&E deficit. However, the I&E report uses an internally generated plan.
- The Trust has been able to offset the worsening operating deficit with better performance on working capital (+£19m) and cash under spend on capital (+£6.7m) delivering a combined cash and borrowing position ahead of plan. However, the trust deferred a supplier payment run from late August and this partly explains the favourable creditors variance.

Forecast outturn

- The forecast cash deficit of £30.5m results from a forecast deficit of £55.5m offset by depreciation of £25m.
- The total forecast borrowing requirement for the year would be £109.9m, £77.4m higher than planned. This includes the emergency capital request of £39.1m and the £38.3m needed to finance the higher operating deficit. NB this borrowing requirement does not yet include the £20m cash headroom requested.
- Budget holders are reforecasting capital expenditure for M06 and this may reduce the capital component of the borrowing requirement.

3. M5 Forecast

M5 Desired/Planned forecast = £34.8m Deficit	Forecast submitted to NHSI at M5 = £55.5m Deficit	Straight-line forecast at M5 = £83.8m Deficit

Context

- There has been regular dialogue with NHS Improvement over the last month regarding the year end forecast which has been a completed each month since Q1 reporting.
- The Trust is being held to account against its initial gross plan of a £34.8m deficit (£17.2m minus £17.6m STF), which includes full achievement of the £42.7m CIP programme.
- A straight-line forecast of the month 5 position leads to an £83.8m deficit by year end.
- A recovery plan is being worked through in detail to provide NHSI with a full year forecast, and assurance around delivery of the forecast ahead of a Performance Review Meeting at the end of October.
- A number of supplementary recovery actions have been put into place and at month 4 the Trust reported a full year forecast deficit of £54m for the year, including full delivery of the £42.7m CIP programme. Due to the significant level of spend already incurred (and expected) on interims to address urgent concerns with the Trusts estate and IT infrastructure, it will be extremely challenging to deliver a £34.8m deficit.
- Due to the more challenging position than forecast in month 5, the forecast has been adjusted to a £55.5m deficit for month 5 with additional actions being developed to mitigate this.
- Delivery of the £55.5m deficit is expected to generate an exit run rate for 2016/17 of c£1m deficit per month (excluding STF).

St George's University Hospitals NHS
NHS Foundation Trust

Name and date of meeting:

TRUST BOARD
6th October 2016

Document Title:

Finance and Performance Committee – Month 5

Action for the Trust Board:

Note the Trusts current financial performance to date and forecast to year end.

Summary:

Month 5 financial position

Nigel Carr presented the Committee with the month 5 financial position. The Trust is reporting a £7.5m in month deficit at month 5, and £34.9m deficit year to date. This is £6.6m adverse to plan in month, and £19.7m adverse year to date.

Division	Annual Budget	M5 Budget	M5 Actual	M5 Variance	YTD Budget	YTD Amount	YTD Variance
C&W, Diagnostics, Therapies	£14,919,011	£1,515,818	£1,669,067	£153,249	£7,236,715	£7,252,041	£15,326
Medicine and Cardiovascular	-£65,729,493	-£5,802,823	-£4,953,343	£849,480	-£27,382,165	-£23,987,699	£3,394,466
Surgery and Neurosciences	-£36,241,596	-£3,267,705	-£1,969,874	£1,297,831	-£14,533,039	-£10,015,600	£4,517,439
Community Services	-£19,484,147	-£1,737,488	-£1,783,379	-£45,891	-£8,189,366	-£8,731,490	-£542,124
Overheads	£146,059,735	£12,069,343	£13,554,366	£1,485,022	£60,710,775	£64,740,463	£4,029,688
SWL Pathology	-£0	£0	-£2,006	-£2,006	-£0	-£2,006	-£2,006
Research & Development	£200,000	£16,527	£16,527	-£0	£84,308	£84,308	-£0
Reserves	-£21,383,095	-£1,940,833	£3	£1,940,836	-£1,915,995	£277	£1,916,272
Central	-£1,140,611	£32,281	£968,930	£936,649	-£761,294	£5,591,081	£6,352,375
Grand Total	**£17,199,805**	**£885,121**	**£7,500,291**	**£6,615,170**	**£15,249,939**	**£34,931,376**	**£19,681,437**

The main reasons behind the adverse variance are as follows:

- STF funding is no longer expected to be received due to the Trust not achieving its control total (£1.5m in month, £7.3m YTD)
- "Below the line" unbudgeted costs relating to urgent and unforeseen issues around the estate, IT, and senior management team (£1m in month, £4.8m year to date)
- A delay in delivery of transformation savings which were planned to start achieving from Q2 onwards (£2.4m in month, £5.2m year to date)
- Divisional shortfall in delivering elective activity and income targets (£0.7m in month, £2.4m year to date)
-

Month 5 Forecast

A high level forecast was completed at Month 5, showing a deficit position of between £53.3m and

£83.7m. £55.5m was shared with NHS Improvement, the most notable points of which being:

- £17.6m Shortfall due to lack of STF funding
- £13.2m below the line items due to unforeseen issues (RTT, Estates backlog etc.).
- Further shortfall of £7.5m due to divisions being unable to deliver in full on their income targets.
- Full achievement of £42.7m savings programme.

Recovery Plan

A recovery plan was presented covering the following:

Workforce

Karen Charman detailed the 10% headcount reduction initiative, which is forecasting to achieve £7.6m of savings up to the end of the year. Karen and Julian Barrett also spoke of the need to improve internal control, particularly around agency bookings through staff bank.

Transformation

Jane Paice presented the transformation position which showed a forecast of full delivery of the £42.7m savings. However, when this position is risk adjusted, it shows a remaining gap of £26.1m. The need for firming up plans, ensuring a clear link between savings initiative, and ensure no double counts was emphasised.

Divisional Recovery

Nigel Carr mentioned briefly that the divisions have been working on recovery plans, particularly the most financially challenged divisions of Medcard and SNCT. It was again noted the need for there to be one coherent story amongst the various savings programmes.

Cash

The total forecasting borrowing requirement for the Trust is £109.9m, based on a £55.5m deficit forecast. This is £77.4m more than the planned level of borrowing to fund the increased deficit position, as well as for urgent remedial works required on the Estates and IT infrastructure (£39.1m). A business case has been submitted to NHSI for the release of this, with no further clarity on approval of this case been given over the last month. The Trust has proceeded at risk against some of these items.

Author and Date:

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St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD *October 2016*

Paper Title:	Report to the Board from Audit Committee: 15 September 2016
Sponsoring Director:	Sarah Wilton, Non-executive Director
Author:	Sarah Wilton, Non-executive Director
Purpose: *The purpose of bringing the report to the board*	To provide the Board with a summary of the proceedings from the last Audit Committee
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	To note the update
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	N/A

Summary:

Enclosed are the key messages and draft minutes from the Audit Committee meeting held on 15 September 2016. The Board are asked to note the proceedings.

Key risks identified:
Risks are detailed within the report.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	All Corporate Objectives.
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	N/A

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

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

REPORT TO THE BOARD FROM THE AUDIT COMMITTEE MEETING ON 15 SEPTEMBER 2016

The key points which the Audit Committee wishes to bring to the Board's attention this month following its last meeting are listed below:

1. Despite considerable progress having been made, driven by our newly appointed internal audit firm TIAA, in confirming that actions arising from Internal Audits have been or are being progressed by the Trust, there remain 52 overdue actions. All Priority 1 actions, however, are now complete. We stressed the importance of implementing all these outstanding actions and requested that the Executive address this with regular oversight from EMT, to be led by the Director of Quality Governance and the Director of Finance.

   The automated on-line tracker system now implemented by TIAA should make it easier and more efficient to manage the outstanding actions. TIAA will continue to lead on this activity, which is targeted to be completed before the November Audit Committee meeting.

   We ask the Board to endorse this approach which will require the Executive to co-operate with TIAA, to take responsibility individually and severally as an Executive team for progressing and implementing agreed actions arising from Internal Audits and to report back progress to the Audit Committee in a timely and regular manner. We will report on progress in our Annual Report to the Board and at the December Board meeting.

2. The Audit Committee received an Internal Audit on Overseas Patients, completed in December 2015, which received only limited assurance. The principal assurance gaps, for which urgent remedial action is needed, related to:

   a. shortfalls in the processes for checking and documenting of immigration status and eligibility for NHS treatment
   b. delays in issuing invoices and collecting payments
   c. poor documentation of residency status

3. We received from Internal Audit an ICT review of Cyber Security Maturity Assessment. The Audit Committee is very concerned that TIAA were unable to provide assurance in this area and the Board will be briefed separately by Larry Murphy on this very important area and the urgent and medium term remedial actions in hand.

4. Two further internal audits, of the Agency Cap and of Data Quality: key performance targets, have been completed. However the Board should be aware that although these draft reports were issued for management comment and response on 26 June and 19 August respectively, TIAA are still awaiting management responses. Audit Committee asked the executive to ensure that responses are now provided quickly so that the final reports can be submitted to the November Audit Committee meeting and so that any remedial actions can be agreed and implemented as soon as possible.

5. We received a report from Counter Fraud. One case, which must remain confidential, contains some very serious allegations. Investigations are proceeding but very slowly. The Audit Committee has requested the Director of Finance to ensure that every effort now be made to speed the investigation up, so that all appropriate and necessary action can be determined and taken as soon as possible.

6. The Board is asked to note and approve the following changes to the Trust's Audit Plan for 2016/17:

    a. Transformation Programme: delivery arrangements: deferred to Q2 at Trust request
    b. Governance: Framework, Governance: Risk Management, Governance: Board Assurance Framework: all moved to Q4 at Trust request. The Audit Committee asked the Director of Quality Governance to ensure that these audits will be completed in time for the issuance of the annual Head of Internal Audit year end opinion.

7. We reviewed the External Auditor's final annual audit letter to the Board. This is attached to this report for the Board's attention. Particularly in light of the several changes in Director of Finance post-holders, the Audit Committee asked that it be updated at its next meeting with confirmation that all matters raised in the final annual audit letter will have been addressed in full before the 2016/2017 external audit commences.

8. The Audit Committee reviewed the detailed request submitted by the executive for approval of SFI waivers. The Audit Committee expressed great concern both at the volume of SFI waivers sought and the nature of many of the requests, both of which appear to suggest that the Trust's current SFI procedures and processes are not working effectively. The Head of Procurement confirmed that she is closely reviewing and updating these procedures and will report on her progress at the November Audit Committee meeting.

Sarah Wilton
Non-Executive Director
September 2016

REPORT TO TRUST BOARD ***October 2016***

Paper Title:	Corporate Risk Report
Sponsoring Director:	Paul Moore, Director of Quality Governance
Author:	Paul Moore, Director of Quality Governance
Purpose:	To highlight key risks and provide assurance regarding their management.
Action required by the committee:	The board are asked to: (i) work through each decision point highlighted in this report; (ii) consider, challenge and confirm the correct strategy has been adopted to treat reportable risk; (iii) consider any alternative approaches to treating intractable risks to which the assessment suggests the Trust is over-exposed; (iv) where required validate new significant risks identified since the last meeting and approve their admission to the Corporate Risk Register where agreed; (v) seek assurance that reportable risk is under sufficient control; and (iv) to make decisions where necessary that allow risk to be managed in accordance with the Board's risk appetite.

Executive summary

Core operational risk exposure has been grouped under the following risk areas:

- **Timely Access to Clinical Services/Patient Harm**
- **Insufficient Resilience/Unstable Critical IT/Estates Infrastructure**
- **Unsustainable Financial Position**
- **Inadequate Governance/Reputation Loss**

Risks

The Trust's overall level of exposure to core operational risk is extreme.

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

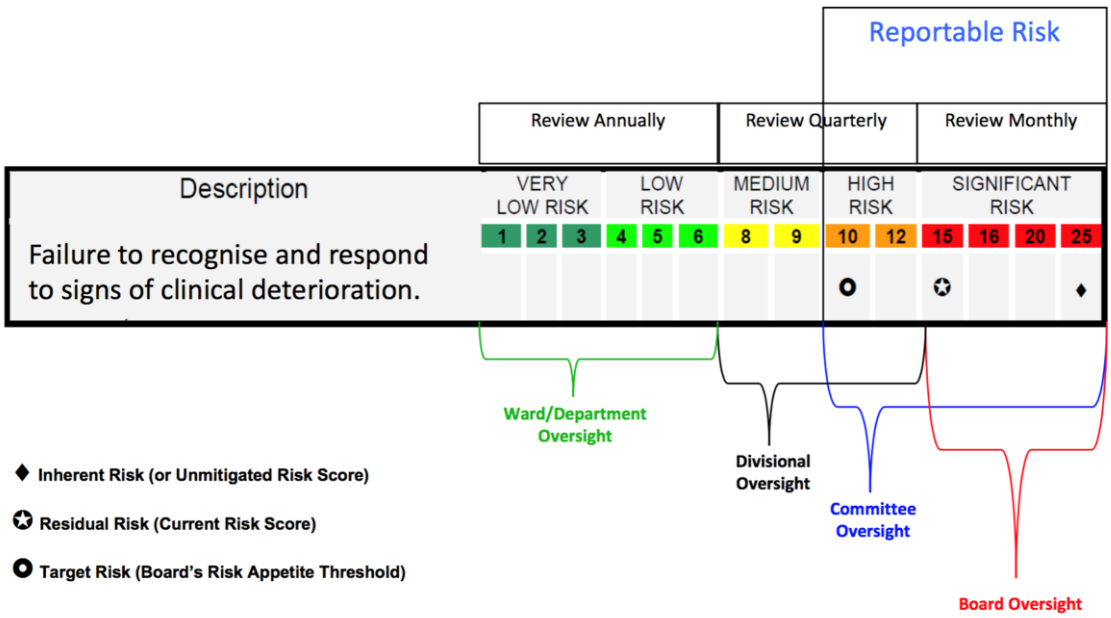
Equality Impact Assessment (EIA): Has an EIA been carried out? Yes
If yes, please provide a summary of the key findings

Contents

Risk Grading Matrix

SEVERITY MARKERS		LIKELIHOOD MARKERS*		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more CSUs; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more CSUs; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or < 1 in 1000 chance (or less) within 12 months

Risk Escalation Arrangements (illustrated)



Briefing

1. The Corporate Risk Register (CRR) has been kept under review with input from the Executive during September 2016. The CRR continues to be rebuilt and reassessed accordingly. This work remains ongoing at time of report. This follows: (i) a simplification and rationalisation of the arrangements for risk management and escalation; (ii) consideration and acceptance by the Board in August of a range of proposals to enhance governance and risk; and (iii) a decision to accelerate the migration of risk registers at divisional and corporate levels into a single electronic database within Datix. Training is being rolled out to support and assist risk register gatekeepers at divisional and corporate levels. This will allow efficient analysis, better oversight and enhanced risk escalation arrangements. Until this work is concluded, caution is advised when interpreting the CRR. The CRR may change as further analysis, challenge and development of the risk profile progresses.

   The full ~CRR is available in the reading room for reference

On The Radar

Core Operational Risk

2. The understanding of corporate risk is evolving rapidly as the Executive identify and address uncertainty ahead. Analysis and challenge during July and August 2016 has identified a range of significant/extreme operational risks, which are currently being mitigated, whose impact could have a direct bearing on requirements within NHSI's Risk Assessment Framework, ongoing CQC Registration or the achievement of Trust policies, aims and objectives should the mitigation plans be ineffective. Figure 1 illustrates using a driver diagram the primary cause, effect and potential impact of core operational risks currently on the CRR. The Board remains exposed to significant/extreme risk in the following areas:

   - **Timely Access to Clinical Services/Patient Harm**
   - **Insufficient Resilience/Unstable Critical IT/Estates Infrastructure**
   - **Unsustainable Financial Position**
   - **Inadequate Governance/Reputation Loss**

3. In due course, once divisional risk registers have been examined more closely, the Corporate Risk Register will reflect risks rated 15 or more and verified by the Risk Management Committee.

Core Strategic Risk

4. The Board's strategic risks have been assessed in preparation for the production of the Board Assurance Framework (BAF) by the 30th September. The strategic risk vectors identified for inclusion in the BAF are as follows (in no particular order):

   - **Corporate strategy not aligned to commissioning intentions or anticipated regulatory changes** (i.e. the Trust, CCGs or regulators are moving in different directions - one of the causes might be that commissioning intentions are not known to the Trust, or a lack of clarity regarding corporate strategy, other potential causes might include conflict, competition or poor stakeholder relations)
   - **Exposure to local and specialist commissioner affordability** (this is currently subject to further review)
   - **Loss of influence within and across the local health economy** (one of the potential causes might be inadequate stakeholder relationships)
   - **Addressing demand for care** (on the assumption that demand for services will continue to grow and supply-side resources continue to be stretched)
   - **Future supply, recruitment and retention of the workforce** (thereby affecting staffing levels, quality, safety and operational compliance)

- **Failure to retain critical community contracts** (one of the causes might be poor quality/performance/outcomes, or inadequate stakeholder relationships)
- **Expanding deficit and non-delivery of the financial plan** (to incorporate the combined effects of income volatility, liquidity and CIP delivery)
- **Poor or insufficient quality governance** (i.e. poor standards of care, unintended consequences of CIP, poor risk management, non-compliance with CQC)
- **Insufficient performance against contracts and KPIs** (to incorporate applicable KPIs in the NHS Outcomes Framework)
- **Poor service user experience** (inadequate user satisfaction with services for example, this has subsequently been incorporated with the quality governance vector)
- **Failure to deliver the estate improvement or backlog maintenance**
- **Prolonged and unrecoverable critical IT system down time.**

Decision Points

(a) The Board are invited to satisfy themselves that the current level of risk exposure is tolerable or acceptable and also satisfy themselves that the risk is under sufficient control;
(b) The Board are invited to advise any further mitigating action required; and
(c) To consider whether any modification is needed to the Board's risk appetite in light of current risk exposure and act accordingly

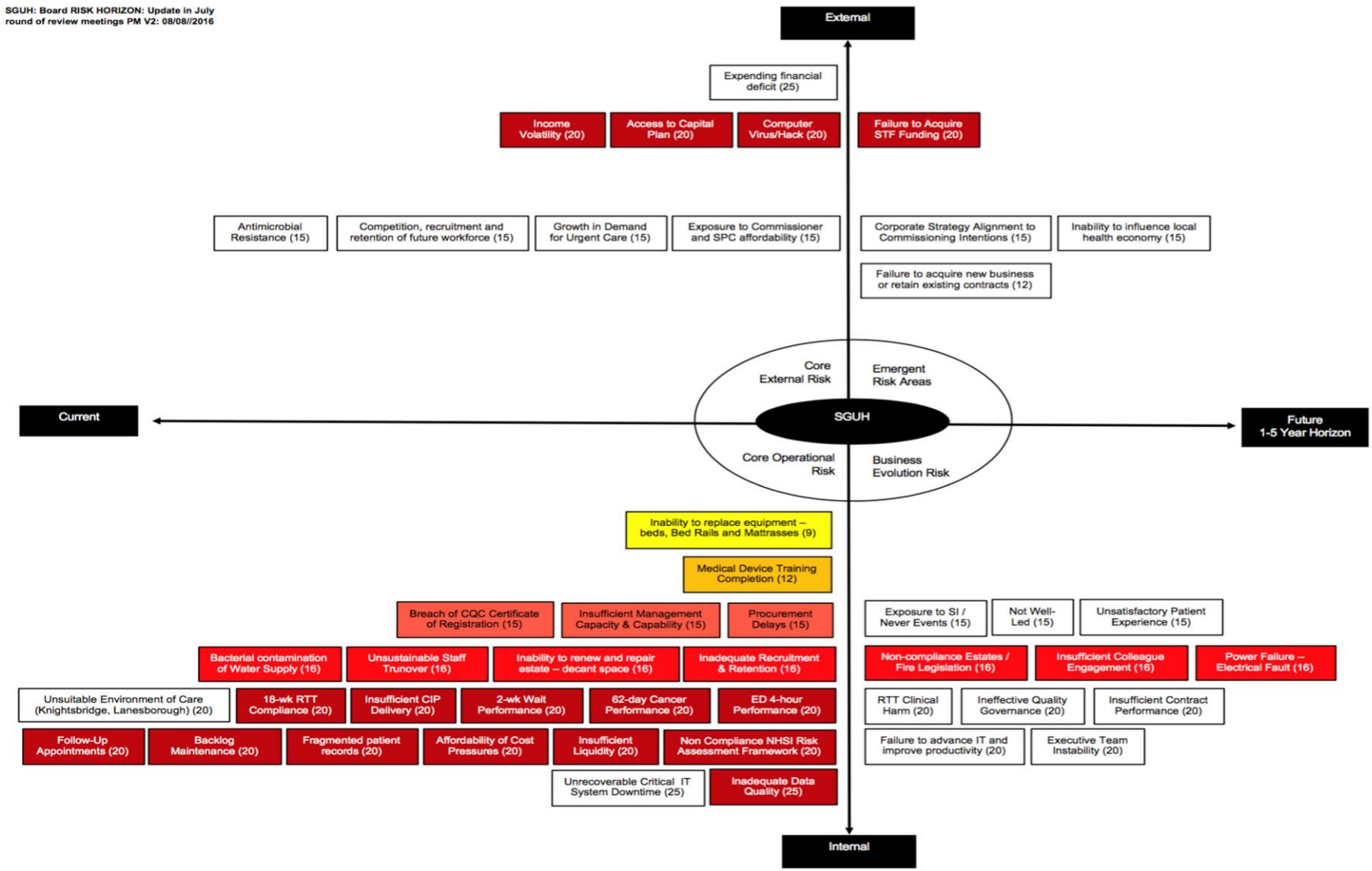
Paul Moore
Director of Quality Governance
23/09/2016

Figure 1: Core Operational Risk Drivers – SEP 2016

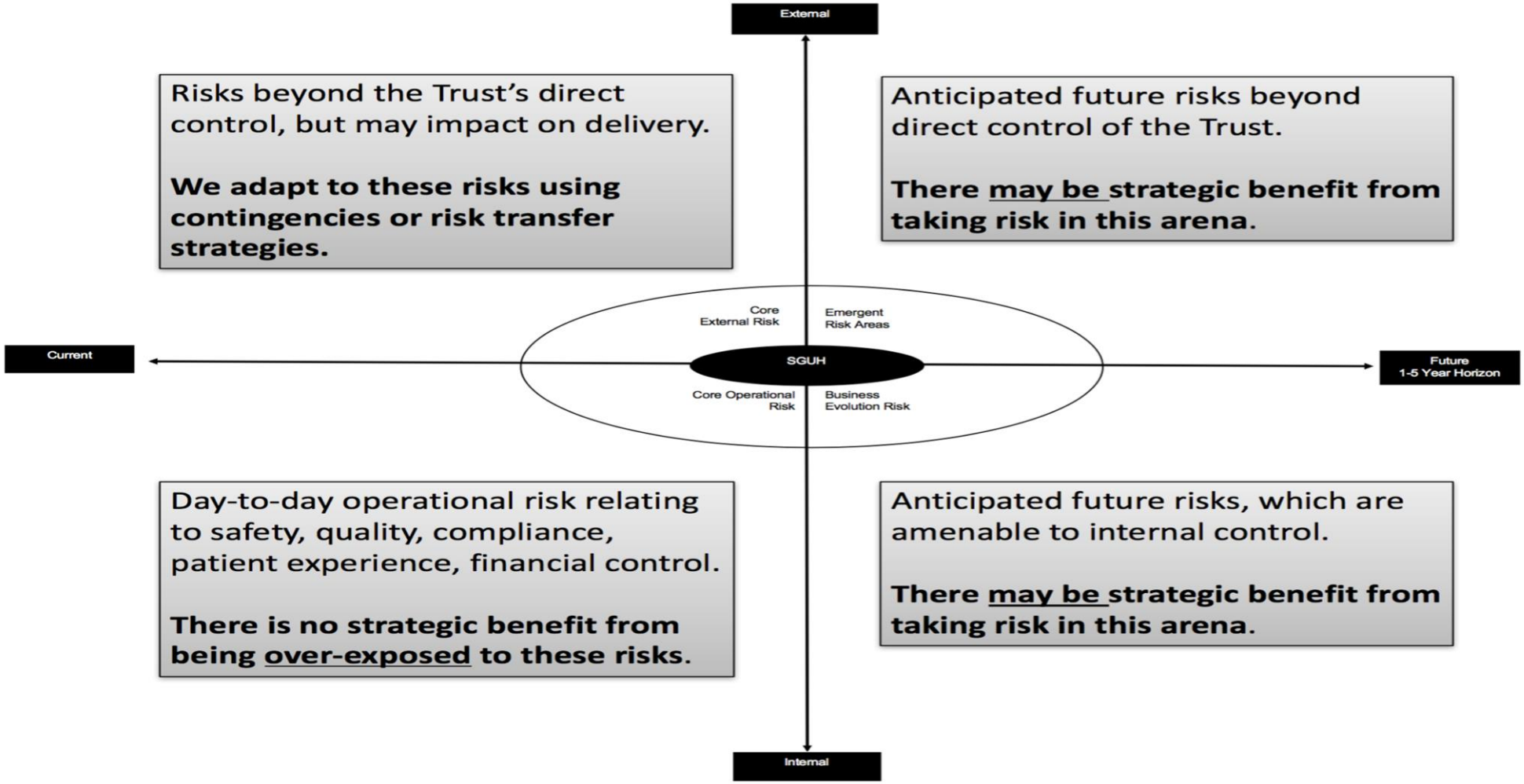
PRIMARY CAUSE	RATING	IN MONTH CHANGES	EFFECT	POTENTIAL IMPACT 16/17
Increasing 18-Week RTT backlog with potential for clinical harm	20	⬌	Timely Access to Clinical Services / Patient Harm	Continuity of Clinical Services Material Breach of Licence Conditions Integrity of CQC Certificate of Registration
Below target 2-week wait performance	16	⬌		
Below target 62-day cancer performance	9	⬇		
Failure to arrange follow-up appointments or treatments (where clinically required)	TBC			
Below target ED 4-hour performance	20	⬌		
Inadequate data quality, completeness or consistency	20	⬌		
Unsuitable environment of care (Renal Unit, Lanesborough OPD) – risk of premises closure, prosecution, fire	16	⬌	Insufficient Resilience / Unstable critical IT and Estates Infrastructure	
Potential unplanned closure of premises / non-compliance with estates or Fire legislation	16	⬌		
Bacterial contamination of water supply (Legionella, Pseudomonas)	20	⬆		
Inability to address backlog maintenance requirements	20	⬌		
IT storage: unrecoverable IT system downtime (affecting critical clinical, web and email systems)	25	⬌		
Vulnerability to computer virus or attack	20	⬌		
Inability to renew and repair clinical areas due to high bed occupancy and no decant options	20	⬆		
Power failure – electrical fault	16	⬌		
Income volatility	20	⬌	Unsustainable Financial Position in 2016/17 and beyond	
Insufficient CIP delivery in 2016/17	20	⬌		
Insufficient liquidity	20	⬌		
Lack of access to capital to address in-year IT, Estates and equipment replacement cost pressures	20	⬌		
The risk of entering special administration under the failure regime	20	⬌		
Inability to control workforce and staffing cost	TBC			
CQC rating less than 'Good' – insufficient safety, effectiveness, caring, responsiveness or not well-led	20	⬆	Inadequate Governance / Reputation Loss	
Failure to recognise, communicate and act on abnormal clinical findings	16	⬌		
Ongoing exposure to high numbers of serious incidents and never events	16	⬆		
Fragmented electronic and manual patient records	20	⬌		
Unsustainable levels of staff turnover	15	⬇		
Insufficient management capacity or capability to deliver turnaround programme	12	⬇		
Failure to secure colleague engagement	16	⬌		

⬆ = Risk Increase; ⬇ = Risk reduced; ⬌ = No change

Figure 2: Emergent Risk Horizon Scan – SEP 2016



Appendix 1: Interpreting the Risk Horizon



Corporate Risk Register - 23 September 2016

Ref	Title	Description	C	L	Rating	Risk level	Controls	Gaps in controls	Assurance	Gaps in assurance	Action Synopsis
CRR-0016	Bacterial contamination of water supply (Legionella, Pseudomonas)	There is a risk to patient safety from water-borne infection. This risk has been increased as a result of legionella being found in isolated areas in the St George's Hospital site. There are different water-bornes infections in different buildings; Legionella and Pseudomonas.	4. Major	5. Almost Certain	20	Extreme	Water testing regime in place as part of the planned preventative maintenance programme.	Until the new water plant is installed, it is not recommended to site Renal patients into GW.	Water testing and cross party committee DIPC/IC Committee have recognised improvements across last 18 months	Lack of resource constrains testing.	Monitor the testing regime and results.
							If high counts of legionella are found it is chemically treated in accordance with trust water management policy		Water safety committee report goes to ORC and Health, Safety and Fire Committee		
							Water testing being carried out in accordance with HTM04, L8 and HSG274				
							Testing regime and results kept in electronic evidence log book.(Zetasafe)	Unable to fit filters to every single tap, as not compliant models of sinks or taps in some cases. Not all mitigating actions can be applied, as PALL filters do not fit some of the sinks.	Water flushing regime has now been taken over from the clinicians by the Estates team (apart from weekends), in order that 100% water return figures can be maintained.		
							Water risk assessment completed				
							Authorising Engineer (Water Systems) appointed by trust provide independent advice and support.			September 2016 water reports highlight gaps in assurance and proposed steps to address.	Water report being presented to EMT (26/09/16), presenting actions underway and further recommended actions.
							Water responsible persons trained and certificated				
							Head of Estates Compliance in post	Capital funding is required to continue removal of deadlegs.	The Estates team have also taken back in-house the testing of water from the existing their-party supplier (ClearWater).		
							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.		The main water provision plant will be replaced during H2, 2016 in GW, this will provide fresh water to the adjacent buildings, bypassing the water that comes via the University. This is expected to reduce the opportunities for infection within old plumbing.		
							Deadlegs are removed as discovered whilst other planned work continues across the estate				
CRR-0023	Below target 2-week wait performance	The Trust are currently not achieving the 2WW performance standard for cancer. Whilst the 2WW performance was recovered in February 2016, process and capacity issues remain a risk to sustaining this, with only 25% of patients being contacted within 2 working days or receipt of referral. Identified risks are: 1.Risk of clinical or psychological harm to patients who are not seen within the access standard 2.Poor patient experience due to delays from GP referral to date 1st seen 3.Financial risk to the organisation from	4. Major	4. Likely	16	Extreme	Cancer Performance Recovery Action Plan written and agreed with the Board and the Commissioners with a trajectory of improvement to recover 2WW performance from July 2016	Patient Choice – patients choosing to be seen outside of the 14 day access standard, even when a choice of dates are offered.	Cancer KPIs are monitored weekly through the cancer performance meeting, chaired by the COO. Performance continues to demonstrate a month-on-month improvement, with a 100% increase in patients now contacted within 48 hours (15% Feb 16, to 30.7% in July 2016) and a 13% increase (6.6% to 19.9%) in patients booked within 7 days.		Improved engagement with primary care to ensure that patients are referred informed that they are on a suspected cancer pathway and available to attend at short notice.
							Cancer Programme lead appointed to oversee delivery of key actions and cancer performance recovery				

		3.Financial risk to the organisation from contract penalties where targets are not met 4.Reputational risk to the organisation						Demand and Capacity plan developed to deliver booking by day 7, to ensure that patients are offered choice.	Major Risk to the 2WW Cancer pathway is the reduction of the management team that has recovered the position in the past 6 months.			Requests to fill the Cancer pathway posts to be reiterated at Directors' Group on 22/09/16
CRR-0011	Below target ED four hour performance	Risk to patient experience and safety as a result of potential Trust failure to meet Emergency Access performance trajectory agreed with NHSE and NHSI . 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	4. Major	5. Almost Certain	20	Extreme	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 Increases in bed capacity (72 beds) Investments in patient flow schemes (£4m) including ED hot lab Integration of the hospital services		Delivered 94.11% end of April 16 Delivered 92% so far in september 2016		

							within the ED effort at the Front Door				
							Improvements in Bedflow generated by a variety of measures: establishment of integrated discharge team (IDT); reduction of medically fit for discharge (MFD)				
CRR-0021	CQC rating less than 'Good'	CQC rating of less than 'Good' due to inability to demonstrate compliance with CQC standards Risk of regulatory action and suspension of services in the event the Trust is unable to demonstrate full compliance with the CQC Fundamental Standards (safe, caring, responsible, effective, well led) 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.	5. Catastrophic	4. Likely	20	Extreme	Quality improvement plan develped to programme manage all actions identified in CQC inspection prep programme and CQC report findings	Lack of robust compliance framework in order to ensure Quality Assurance of services across all services and divisions	Licence notice section 294 received from CQC in August 2016	CQC formal report awaited - verbal feedback suggest significant issues with estates, IT infrastructure and risk management	Working to complete actions arising from CQC
							Director of Quality Governance to lead QIP work and QIP PMO in place				
							Quality Inspection programme commenced sept 2016				
							Quality improvement strategy in place				Progress QIP plan and report to QIP Board and Trust Board
							Quality Observatory (overaching care audit) looked at across the Trust to promote great visibility and reporting against 5 domains and associated Standards				
CRR-0024	Failure to meet 62-day GP referral to treatment Cancer Performance standard	Failure to meet 62-day GP referral to treatment Cancer Performance standard. The Trust are currently not achieving the 62 day referral to treatment access standard for cancer. In addition, whilst the 2WW performance was recovered in February 2016, process and capacity issues remain a risk to sustaining this, with only 25% of patients being contacted within 2 working days or receipt of referral. Identified Risk are: 1. Risk of clinical or psychological harm to patients who ae not treated within the access standard, due to potential disease progression 2. Poor patient experience due to delays in diagnostic and treatment events in pathways 3. Financial risk to the organisation from contract penalties where targets are not met 4. Reputational risk to the organisation 62 day waits are on trajectory. Q2 has consitently been ahead of the 85% tartet and is at 90.2%	3. Moderate	3. Possible	9	Moderate	Cancer Performance Recovery Action Plan written and agreed with the board and the Commissoners with a trajectory of improvement to recover performance from July 2016	The Trust is a tertiary and diagnostic centre for a number of pathways, and therefore are dependent on patients being referred from other Trust by day 38 to ensure that treatment can commence by day 62.In some pathways, particularly H & N and lung, there is poor compliance from other Trust, which puts the trajectory at risk	2 day waits are on trajectory. Q2 has consistently been ahead of the 85% target, and is at 90.2 %		Breach reallocation guidance has been agreed from Oct 2016, that allows the reallocation of a full breach when a patient is referred after day 38 in a pathway. Sector- wide Joint working groups are to be established in H&N and lung to improve the pathway and overall experience for patients on an inter-trust transfer.
							Cancer Programme lead appointed to oversee delivery of key actions and cancer performance recovery				
							RCA completed for all patients who are not treated within the 62 day standard (or 31 days from decision to treatment commencing). Any patient on a cancer pathway 95 days+ (diagnosed and not disgnosed) is assessed by a lead cancer clinician for clinical or psychological harm. All RCAS are signed off by the CEO, director of nursing and medical Director	Effectiveness of RCAs due to unclear process and tracking of competeness and actions / lessons learnt	The number of patients on an open suspected cancer over 100 days has reduced month on month to an average of 4 patients		Improved governance process to be introduces. A formal monthly clinical harm review - Board to be established from July 2016
							Weekly PTL Assurance meetings are in place, chaired by GM for Cancer Services, to expedite individual patient				

							pathways, ensuring corrective action is taken when delays are identified				
							Expansion of Bronchoscopy and Thoracic surgery capacity has increased improvement by 9.5%.				
CRR-0019	Failure to recognise, communicate and act on abnormal clinical findings	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	4. Major	4. Likely	16	Extreme	All doctors have been reminded of their responsibility for ensuring that tests that they order are followed up	The effectiveness of the SOPs is not consistent	There is no ability to track compliance through Tableau of other results at the present	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	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
							All Care Groups have developped Standard Operating Procedures to ensure that this happens	Radiology safety net not reliable as emails are not received by the appropriate staff			
							All serious incidents resulting from failure to follow up tests have been reviewed and themes reported to Divisions.	A significant proportion of results are attributed to the wrong consultant making the electrical sign off inconsistent	There is limited ability of ensuring that once results are seen, the correct actions are followed.	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	
							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).	Policy for Acting on Diagnostic test Results to be updated			
							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	not all results are reported via iClip		limited assurance as results attributed to wrong consultants	
CRR-0014	Failure to secure colleague engagement	Staff survey and medical engagement scores and results indicate a significantly reduced level of engagement amongst staff	4. Major	4. Likely	16	Extreme	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	Limited ability to influence or mitigate external factors including; London wide issues of staff turnover, turnaround and financial position	Negative Staff survey results and medical engagement score	Difficult to ascertain level of management engagement	Actions as per CRR-0025
							Support from staff side representatives and governors in engaging staff				
							MD engaging with staff		Progress against workforce action plan reports to Workforce and Education Committee		
							Staff survey open session	Levels of disengagement amongst managers make it difficult to effectively deliver the programme			
							Review bullying and harassment policy		New staff from Philippines to arrive from September 2016		
							Listening into Action				

CRR-0010	Fragmented Electronic and manual patient records	A failure of staff to document clinical information in the correct system (paper or electronic) caused by the operation of dual systems may result in inappropriate treatment. A failure of staff to review clinical information caused by a fractured clinical record may result in inappropriate clinical decision making. A failure of staff to transcribe information caused by the need to transition from an electronic process to a paper process (or vice versa) caused by the operation of dual systems may result in transcribing errors resulting in medical errors.	5. Catastrophic	4. Likely	20	Extreme	Patients outlying in live areas will remain on paper. Monitoring of incidence reports (Datix, SIs, Compliants, Feedback from GPs) for frequency and severity of incidences and to follow up with relevant areas	Under reporting of incidences Patients outlying in non-live areas will have a paper record	Organisation paused after completion of roll out to Paediatrics, Cardiac, Nephrology and Neuro which are relatively ring fenced in terms of beds therefore transitions of care within one admission from paper to electronic and vice versa are relatively less likely.	In extenuating circumstances patients may be transferred to live areas from non-live areas.	Roll out eClinical Documentation and ePMA to the remaining IP areas on St Georges Hospital site.
CRR-0008	Inability to address backlog maintenance requirements	There is a 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 capital investment within run-rate schemes. 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. 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.	4. Major	5. Almost Certain	20	Extreme	Risk assessments are 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 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 A PMO has been put in place as of September '16	Historically there has been a lack of Project management Office support to ensure robust governance is in place. A new PMO has been created in September 2016 but there will be a lead time for the identification of gaps, creation of required governance process & tools and implementation.	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. Future works procurement and prioritisation process being assembled.	Quality Impact assessment process of run rate schemes.	There is an interim Estates Strategy being presented to the EMT on the 26/09/16. It focuses on the historic underinvestment and the need to repair and replace critical infrastructure. The Trust has applied for emergency external funding to bolster the annual maintenance budget and to reduce the very high level of current risk of loss of critical infrastructure via single points of failure. A six-facet survey is being procured that will provide the Tooting campus with a thorough condition report, this will form the basis for prioritised repairs Also, 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. Require further reporting from Finance on year end cost recovery goals to enable better departmental planning and action. There is an interim Estates Strategy being currently compiled this requires input from the Clinical strategy to inform the direction of services for Estates to support.

CRR-0017	Inability to renew and repair clinical areas due to high bed occupancy and no decant options	Lack of decant space for capital schemes delays the ability to deliver some large capital schemes.	4. Major	5. Almost Certain	20	Extreme	Detailed decant plans will sit under the Trust's Estate Director working with the Turnaround Director.	No aggregated view of impacts of several decisions not to proceed or to delay works	Documented risk assessments received by Project boards and reviewed when business cases approved	Financial position may mean potential inability to finance mitigating actions	A review of space and potential decant options have taken place and a proposal will be discussed at the EMT. The Space committee needs to continue to develop the space strategy and assess space issues and location of decant space.
							Risk assessments undertaken for each project.	Short term planning brings forward new priorities that unbalance existing plans.			
							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.		Capital project delivery is reviewed through CPMG, Project Programme Boards and IDDG.		
							Mitigating Action - The Trust received Planning permission (temp up to 5 years) for the new Wandle annex – 4 storeys c 5000m2.	Modular development to move transactional staff out of clinical areas and release space for redevelopment not in 'shrunk' capital plan.			Review of space and potential decant areas well developed and being discussed at EMT. Tasks being undertaken by Estates and Facilities
							Potential for space realisation as a result of Fixed Close Transfer work.	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			
							Potential to identify rental office space offsite for non-clinical staff relocation to free up space for priority requirements		Impact of turnaround 'collision of priorities' now mitigated by combined planning between Estates and Turnaround leads.		
							Re- activate the Trust Space committee to develop a Trust space strategy and assess the space issues across the Trust	Demolition plan for Knightsbridge Wing to be presented for approval at the EMT on the 26/09/16			
							Project team in place to carry out Demolition programme for Knightsbridge Wing to decant and demolish before Dec '16.				
CRR-0001	Inadequate Data Quality, completeness or consistency	Poor Data Quality within the current methods of generating, monitoring, tracking and reporting against waiting lists The current RTT PTLs pose a risk to patient safety as planned patients and Non-RTT follow up patient are not being managed appropriately & RTT and DM01 externally reported figures are inaccurate The failure to attribute consultant activity appropirately. this is an issue that affetcts all patients and has resulted i a failure to endorse results that may mean missed diagnosis of disease. This has an effect on clinical documentation, coding of activity and discharge processes The risk to patient is compounded by the fact that 3 different systems are used within the	5. Catastrophic	4. Likely	20	Extreme	DQ governance group has been established which meets on a weekly basis. Member of the group are CEO, CIO, COO, MD	2WTE not enough to provide both maintenance and ownership. Senior oversight layer needs strengthening	Director of governance appointed to ensure robustness governance within the organisation, commencing in July 2016	Delays in procurement	Risk meeting with commissioners, NHSI (week commencing 27/6/16) Action Plan to be present to EMT for approval Ensure DQ governance group is connected to DQ Board
							Governance accountability at board level. MBI report presented to Board		Procurement process for external IT company to reconfigure IClip		
							RTT specialist at board level	Validation of data is not robust			
							2 WTE in Information Department to support production of PTLs		External company will create SOPs for system	Risk not able to be quantified until phase one of project complete	
							Clinical harm board set up to review patient level records	Use of 3 different systems (cerner, Rio, iSoft)			
							work with external partners on training		External company will create dashboards to provide assurance of progress		

		Trust (CErner, Rio, iSoft)					/ use of IT system				
CRR-0002	Income volatility	Income Volume Risk that the trust fails to meet its activity targets (and income budget) due to loss of clinical capacity from unplanned theatre downtime and estates failure 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, clinical staffing availability, 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: Unplanned theatre downtime Estate is fragile and prone to failure 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 Performance against access target trajectory (RTT – A&E) Outsourcing to increase capacity is costly and not sustainable CQUIN 85% target not achieved	5. Catastrophic	4. Likely	20	Extreme	Recovery plans from Divisions Intensive support team and transformation resource in place to support implementation Monthly divisional performance meetings Weekly activity dashboard reviewed by Executives Business planning process – development of annual capacity plan, agreeing service volumes, capacity utilisation rates and identifying capacity requirements Investment and divestment group (IDDG) for approval of all investments in capacity Recovery action plans being developed Monthly divisional performance meetings enhanced to link financial performance to activity stats Negotiations continue with Commissioners to identify additional capacity re RTT. Board/F&P will be apprised of actions at each meeting. Transformation plans / capacity and flow programme Monitoring of monthly CQUIN performance		Reporting of performance against planned SLA income and activity targets Live activity tracking via tableau and reviewed by Exec weekly on activity dashboard OMT, EMT, TAB and Trust board oversight of Flow and Capacity plans and delivery	Integrated demand and capacity model outputs to confirm capacity requirements	Implementation of recovery plans
	Insufficient Cost Improvement/Transformation Programme in 2016/17	Cost Improvement/Transformation Programme slippage - The Trust does not deliver transformation cost improvement programme objectives •Until detailed implementation plans have been fully developed, agreed and resourced to be implemented, as well as allocated / owned by the Divisions, there is a high risk of slippage. •£6m unallocated target included in the 16/17 budget. Until this target is fully					Turnaround Board ("TAB") to oversee FY16/17 Transformation programme, driving and delivering a robust programme for 2016/17 and subsequent years through regular review meetings Detailed implementation plans	Documentation of comprehensive programme processes	Non Executive Director and NHSI observation of performance of TAB and holding workstreams to account in terms of both financial targets and milestone achievements		•Allocation of unallocated targets

CRR-0004		allocated and has a detailed plan for delivery, it remains high risk •Risk of double count between transformation schemes and divisional CIP plans •Capacity constraints may prevent delivery of those improvement plans dependent on increased activity •Some savings identified may only be non-recurrent	4. Major	5. Almost Certain	20	Extreme	developed and continually updated to manage the quantitative and qualitative aspects of each programme					
							PMO managing Transformation programme		Benefits tracking carried out by Finance and subject to Internal Audit			
							Divisional finance managers signoff financial scoping for each scheme					
							Change control form to be submitted for each change in financial savings targets		Extensive governance across workstreams and divisions is in place ensuring ownership and accountability, with a report into the Turnaround Board every month			
							HR sign off WTE impacts on each scheme					
							QIA sent to Medical Director and Chief Nurse on each scheme		Finance review the financials for every scheme to ensure its validity and its link back to the budget			
							Divisional steering groups, meet fortnightly and approve all schemes	Robust benefits tracking process			Identify and propose alternative schemes to recover shortfalls	
							Workstream fortnightly steering groups developing opportunities which are appropriately tagged to prevent double counts		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			
							Demand and Capacity Model used to assess deliverability of additional activity					
							PMO strengthened with additional experienced resource		Budget allocation from central budgets to divisional budgets approved by DDOs			
							Divisional involvement in the development and challenge of detailed implementation plans and allocation of targets by division					
							Detailed analysis and allocation of £6m unallocated target		Output of DCM reviewed by TAB			
							Reforecast of transformation programme savings and alternative schemes within the programmes proposed to recover shortfalls					
	Insufficient liquidity	Cash flow and working capital – cash balances will be depleted due to adverse I&E performance and capital overspends, and as a result the trust will require more working capital facilities than planned The 2016/17 plan is for a deficit of £17.2m having taken account of the underlying financial position going into 2016/17. There are significant risks to the planned deficit including the delivery of the cost reduction programme and the receipt of £17.6m sustainability and transformation					Short term cash flow forecast (STCFF) prepared on a weekly basis		STCFF included in F&P papers and sent to FD each week		Progress and conclude funding requests to ensure funding is received	
							Rolling 12 month cash flow forecast prepared on a monthly basis		12 month forecast included in monthly F&P report and board reports			
							Capex spend monitored and challenged through Investment and Divestment Group (IDDG)		Outputs of IDDG are reported up to board level so that the board can monitor spend levels			
							Recovery actions planned at trust wide and divisional level in order to reduce					

CRR-0005		funding. The sustainability and transformation funding is conditional on the achievement of certain operational and financial performance targets. The planned deficit results in only £0.8m of headroom in the cash flow forecast at year end. If the planned deficit is not achieved, and/or sustainability and transformation funding is not received, or other financial targets are not achieved, the trust may run out of cash and will need access to further WCF and/or other funding	5. Catastrophic	4. Likely	20	Extreme	deficit ITFF funding application plan Targeting collection of aged debtors £39m additional Estates and IT backlog funding request submitted. If no approval received, no funds will be spent £30m headroom facility application has been submitted Support from NHSI on all funding applications to ITFF Receipt of £17.6m Sustainability and Transformation funding (STF) in order to improve the cash position		Recovery plans and actions reported to FD and included in F&P papers Plans submitted to NHSI for review and approval Aged debtor reports included in F&P reports to show progress on collection of aged debts Estates and IT capex funding and additional headroom facility requests submitted and being considered Regular meetings held with NHSI to confirm their support for STG proposals and funding requests. Any evidence which shows they are not in support of the funding proposals will be escalated to the board We are monitoring releases from NHS which stipulate criteria that must be met to receive the funding. Any indications that we are not meeting the criteria will be escalated to the board		
CRR-0022	Insufficient management capacity or capability to deliver turnaround programme	Risk of inadequate management capacity to ensure required support and engagement with turnaround programme whilst also delivering business as usual. 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	3. Moderate	4. Likely	12	High	Programme management approach to the requirements of turnaround. Regular staff and senior team leader briefings Communication messages are designed to be honest in order to engage staff Clarity to reassure staff around financial position of trust and believe they can contribute to recovery Expanded Friends & Family test to assess staff quarterly Management skills compulsory for all new starter with management posts	No plan in place to ensure cascading of information to all staff	increase in partecipation 80% report SGH good place to be cared		Explore mandate team brief with Comms and EDs to be presented to EMT
	IT storage: unrecoverable IT system downtime affecting critical clinical, web and email systems	A failure to maintain and invest in the IT infrastructure for a lengthy period (7+ years) caused by a lack of funding in IT has resulted in an 'end of life' infrastructure that is likely to fail and result in catastrophic implication for the Trust in terms of corporate and clinical systems failures. The specific areas of risk within the infrastructure are;	c	iin			On-going monitoring of infrastructure. A plan to reduce/eliminate XP from the environment has been proposed	Implementation of plan is dependent on funding. Capital funding not approved for	Paper has been submitted for funding ICT Hardware has been ordered and funding approval granted	Uncertainty of funding	

CRR-0009		•Data backup facility outdated and unreliable •IT data storage capacity at limit, high risk to operational viability of the Trust •Computer hardware in clinical areas slow, old and unreliable •High numbers of XP computers in IT estate. Core Trust systems will not be able to be accessed from XP PCs from December 2016	5. Catastrophi	5. Almost Certa	25	Extreme		2016/17.			
							Engaged 3rd Party support company and increased level of IT support for disasters until full corrective action is taken.		ICT Program of work undertaken to address xp legacy, back up issues and compute capacity		
CRR-0015	Lack of access to capital to address in-year IT, Estates and equipment replacement cost pressure	The Trust faces higher than expected costs due to:- unforeseen service pressures loss of SRG and Education funding, with related costs not being removed impairment of assets Underinvestment in prior years resulting in urgent work to address backlog maintenance, stabilise the IT infrastructure, implement improvements required by the CQC and address RTT data quality issues The trust needs to adapt to changes in service/funding arrangements, for example the loss of funding in specific areas such as SRG schemes and Education. There is a high risk that unfunded resource will be required to support capacity and delivery. Unforeseen impairment of assets may have a negative impact on I&E Premium costs related to the supply of scarce resources eg cost of agency nurses due to nursing staff shortages – risk that these costs will not be appropriately monitored and controlled	4. Major	5. Almost Certain	20	Extreme	Enhanced monthly divisional performance meetings	Workforce and financial plans do not explicitly reflect the level and premium costs of agency staffing	Monthly financial reporting of performance to the Board		Implementation of transformation savings schemes
							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 NSHI.				
							IDDG has assumed 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.		Identification and review of cost pressures through the Business Planning cost pressure review process.		Weekly monitoring of headcount tracker by Executives
							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.				
							Necessary additional I&E investments to be met by an increase in divisional CIP				
							Impairment risk monitored by F&P and external accounting guidance sought				
							Reduced use of external capacity by better capacity planning and		Divisional monthly performance review meetings		Design and implementation of operational levels to reduce deficit

							management of internal resources.				
							Transformation programmes have identified controls to mitigate premium agency spend				
							Detailed Agency expenditure tracking and redevelopment of headcount tracker				
							Weekly monitoring of headcount tracker by Executives				
							Development of transformation savings schemes				
CRR-0020	On-going exposure to high numbers of Serious Incidents & Never Events	On-going exposure to high numbers of Serious Incidents and Never Events as a result of a failure to implement learning from previous incidents to prevent occurrence, poor standard of care This may result in severe harm or death and/or breach of CQC registration	4. Major	4. Likely	16	Extreme	Weekly SIDM meeting (attendees: Chief Nurse, Medical Director, Director of Quality Governance, Head of Governance, Risk Manager, Associate Medical Directors x 2) has oversight of declaration process and quality assurance/final sign off of reports and action plans	Clinical capacity and capabilities within Divisions to produce timely, high quality reports	Commissioner review of SI declaration process in march 2016 – 12 recommendations made for improvement.	Not possible to benchmark accurately against other Trusts	Complete all actions on QIP plan
							SI performance log circulated to Divisions weekly	Stronger cross divisional learning from SIs required	NHSI review of entire process in April 2016 – process found to be robust.		
							Quarterly reports upon numbers and themes presented to Patient Safety and Quality Board and to Quality Committee/Board	Head of Patient Safety role (previously had wide remit for dissemination of learning and thematic analysis) vacant since Nov 2015	Current trajectory for SIs declared up to 16 Aug 16 – 43 (-34% prev ytd – 65)		Report progress upon actions on QIP plan to CCG/CQRM
							Review of SI process (Including Never Events) underway and is encompassed within the Trust Quality Improvement Programme(QIP) Plan – reported through QIP board	4 x Patient Safety Coordinator roles currently vacant	All actions on QIP plan on track at end of Aug 2016.		
							Monthly reporting to Wandsworth Clinical Quality Review Group				
	Potential unplanned closure of premises / non-compliance with estates or Fire legislation	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). Ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)					The Director of Estates and Facilities commissioned a fire assessment, initially of the LW during April 2016. This provided a prioritised repair list.	Comprehensive surveys and assessments of compartmentation.	Internal - Reporting on fire risk assessments to Health, Safety and Fire Committee and escalate any issues to the Organisational Risk Committee.	Further effort needed to ensure that all staff appropriately trained to increase rate of compliance - •General staff •Fire Marshalls	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 for the main LW 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.
							These repairs are monitored through the Health, Safety & Fire Committee.				

CRR-0007			4. Major	4. Likely	16	Extreme	Regular meetings/communication with Fire Brigade to check progress. Specialist fire safety resource in place to lead on the actions. Planned and reactive monitoring of fire safety. Fire risks assessments (FRAs) prepared by Fire Safety Specialists (the last one via International Fire Consultants – IFC – in April 2016) and issued to the Director, Estates & Facilities, Head of Estates and Compliance Managers Two permanent Fire Officers are in post, reporting to Head of Estates Compliance Established "Responsible Fire Persons" email circulation list to send personal emails to ward/area managers We have installed a new L1 Fire Alarm throughout LW.FRAs of LW undertaken in April 2016.	All remaining main blocks have been assessed for Fire Safety and there is a plan for the whole site to have an upgraded L1 alarm by 31/03/17.	A new fire alarm, independent fire risk assessments and fire safety audits• 90%+ of all senior nursing staff have been retrained on the existing Fire Awareness training during July 2016. External -London Fire Brigade are pleased with the Trusts current progress and week commencing 12/09/16 we are signing a memorandum of partnership with the LFB. A letter from LFB can be provided highlighting the current assessment of the Trust for Fire Safety.	Key performance indicators are required for reporting to Health safety and Fire committee, ORC and QRC.	A more practical, ward based training event will be delivered for future courses Further discussion on possible action to be taken to encourage attendance to Fire safety courses. L1 fire alarm will be installed, replacing the L2 alarm for the remaining Tooting estate.
CRR-0006	Power failure - electrical fault	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. The aged electrical panel had a catastrophic failure, affecting the estate in the following two ways a) Knightsbridge Wing, which needed to be evacuated and temporary repairs were required. b) The affect on the wider Tooting estate needed to be understood. The electrical infrastructure has reached the end of its useful life.	4. Major	4. Likely	16	Extreme	Temporary repairs undertaken. Fixed wiring assessment complete, repairs across Wing being enacted, will be tested to full fixed wiring standard.	Temporary wiring repair will only keep the panel operational for the short term. Does not address deficiencies in building infrastructure. The Knightsbridge Wing will be vacated as part of the Demolition project and will be put beyond use by Dec '16. The temporary repairs have been completed and can be evidenced; these repairs could not be carried out in the Buckland ward due to the disruption to critically ill patients, the CQC are being made aware of this.	To provide adequate assurances the electrical services in Knightsbridge wing to be refurbished and tested to BS 7671 and where appropriate additional circuits and accessories fitted to HTM 06.	Building is due to be decanted and demolished by Q1 2017.	Wiring assessment completed, repairs underway as a precaution until a total relocation of all staff and services can be completed. Six facet survey has been undertaken, building is beyond economic repair. Trust Board decision to vacate and demolish
CRR-0003	Risk of entering special administration under the failure regime	Loss of STF Funding – that the trust does not meet the operational and financial targets necessary for receipt of £17.6m sustainability and transformation funding •100% receipt of £17.6m STF funding built into the FY16/17 Financial Plan. •Terms for receipt of funds conditional on: o70% - achievement of financial control total £-17.2m o30% - achievement of RTT, ED, and Cancer targets	atastrophic	4. Likely	20	Extreme	Monthly reporting to F&P and Board Divisional performance meetings Refresh of performance trajectories in hand and will be advised to the Committee and Board Reforecast of financial plans for M3 will be reported, with analysis of risk, to Committee's next meeting Agency staff cap performance shared		Close scrutiny and monitoring of performance against STF targets		Monitoring of performance against STF targets •Implementation of recovery plans

			5. C			Extreme	with divisions and directorates. Data cleanse exercise to ensure performance against cap is accurately reported. Scrutiny of performance and action plans via monthly performance meeting.				
							Recovery action plans				
							Discussion with NHSI regarding alternative support where STF withheld				
CRR-0012	Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	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.	5. Catastrophic	4. Likely	20	Extreme	Employed 18 week manager to support	Identified system wide gap of £12-14m of activity requird to deliver RTT sustainability	Clinical harm panel has not identified an instances of patient harm whilst on waiting lists	RTT backlog	
							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)				
								Some cnacellations in routine elective surgery due to bed pressures	daily review of PTLs per service		
							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				
								Some cancelled patients are not able to be rebooked within 28 days target	weekly issue of RTT service performance		
							Removal of late referrals from Trust RTT PTL				
							Implemetnation of RTT techincal plan and validation				
	Unsuitable environment of care (Renal Unit, Lanesborough OPD) - risk of premises closure, prosecution, fire	Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with E&F guidance and legislation (HSE & HTM) Until the Premises Assurance Model (PAM) compliance is completed, there are gaps in the mandatory and statutory estates compliance documentation.	jor	ely		ne	Revised estates management structure is in place this includes compliance managers. The plan is to add a dedicated compliance manager within the Facilities team	All recommendations from the estates action plan are not complete	Authorising Engineers appointed in all HTM areas	Full compliance reports not yet available. Only an external audit/cold-eye review would provide the total exposure risk. A super-set of compliance could then be developed and maintained via the Health, Safety and fire Committee.	An external audit would define the gaps and prioritise the fixes. 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.
							Management structure which includes delegated responsibility	Until PAM is mature, the Trust will continue to have gaps in the evidence that we have met and are current with compliance standards	April 2016 - External H&S audit undertaken which indicates a 75% compliance (Empathy EC)		
							An assessment into all the varied control and logging systems across all Trust suppliers and locations. Planet FM system (the estates helpdesk and job request system) is being upgraded to allow compliance to be monitored	There are up to eight different call centres, depending on what building and service a customer requires. This is planned to be rationalised	Internal - Estates compliance records being assembled, ahead of external audit. NHS Estates Profession are supportive of this approach	A Six-Facet Survey is being commissioned to provide a site-wide condition report of the Tooting estate. This will output a prioritised set of actions and complinace of each will need to be identified.	
							An audit on the gaps in compliance has been completed.	A plan to rationalise as many functions into one Staff Help Centre is being			

CRR-0018			4. Ma	4. Lik	16	Extre		worked on. Aim for delivery during 3rd quarter 2016	Action plans will need to be collated into a cohesive programme and regular reports will need to be submitted to the EMT and reformed QRC.			
							The Trust will move to the Estates Profession agreed standard of Premises Assurance Model (PAM) to provide the compliance governance going forward. This has started and all compliance points have been identified, collected and evidenced.	Further compliance points and actions for the PAM are being collated from interviews for external review	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.	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, activity funded and being installed)		
							The Estates action plan will be further revised as higher risk items are closed	A Six-Facet survey is being commissioned by week commencing 03/10/16, to provide a site wide condition report of the Tooting estate. This will take apporx.6 weeks. The output will be a prioritised set of actions and compliance of each will need to be identified.				
CRR-0025	Unsustainable levels of staff turnover	Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost. 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. 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 Larger financial expenditure as agency therapists and Locume Agency Doctors.	5. Catastrophic	3. Possible	15	Extreme	There is a workforce priority plan which has an underpinning action plan. Aproved by the Board in Sept 2016		Workforce plan has been rewritten and focuses on current needs of SGH. To be reviewed in Sept 2017		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	
							The workforce and education committee meets bi-monthly, supports the delivery of the plan and monitors its milestones.					
							There is a concise 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 and it will also take a monthly focus on key issues on recruitment					
							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				seek to identify gaps after first level of review	
							A workforce planning meeting takes place weekly, chaired by the Director of Workforce and Education with the purpose of aligning workforce information reduction in costs and developing an annual plan.					

							A medical workforce group meets every tuesday led by the Medical Director. This group will report to the workforce and education committee				
							Executive team reviews SIP headcount number weekly				
CRR-0013	Vulnerability to computer virus or attack 'Ransom ware'	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	4. Major	5. Almost Certain	20	Extreme	NHS N3 gateway anti malware software Local Websense anti malware software	Ransom ware infections continue to be reported	ICT systems team restoring identified corrupt files from back-ups.		
							Local Anti-virus software				
							User education and communication				
							Firewall updates have been applied		Minimal data loss reported		
							Supplier informed and anti-malware suite security controls increased.				
							Continuous monitoring of reported infections.				

Name and date of meeting:

TRUST BOARD MEETING
6TH OCTOBER 2016

Document Title:

IT Approach

Action for the Executive Management Team:

This paper is presented to the Board for information, approval and support of the approach to:

- The stabilisation and recovery of ICT that results in a reduction of the risk exposure due to IT failure; including the plan to commence the use of cloud technology for e-mail backups
- The plan to procure a strategic business partner to support ICT in the planning and implementation of the long term ICT solution

Summary:

The paper:

- Provides a summary of the approach to the stabilisation and recovery of ICT which includes the risk exposure and a milestone plan to mitigate these risks along with a proposal to backup the Trusts e-mail using cloud storage.
    - ICT is recommending the use of Microsoft Azure cloud storage to provide the backup solution for the Trusts e-mail; this has been approved by the Trusts Caldicott Guardian, Information Governance Officer and the CIO / SIRO (Senior Information Risk Owner)
    - **N.B.** Microsoft Azure and Microsoft Azure Government comply with the Minimum Acceptable Risk Standards for Exchanges (MARS-E) for information security regulations for health-based exchanges under the Patient Protection and Affordable Care Act (ACA) of 2010. Azure has achieved approval for handling and storage of UK government data up to OFFICIAL status, including OFFICIAL SENSITIVE across a number of services. Government guidance recommends that health records are treated as OFFICIAL/OFFICIAL SENSITIVE.

- Provides an overview of the strategic direction being pursued by the ICT Department to deliver the much needed long-term ICT platform of the future. ICT is currently procuring a Strategic Business Partner to assist in the creation of a 5/10-year ICT strategy and subsequently support its delivery. This partner is expected to assist in raising the level of intelligence within the ICT Department.

Author and date:
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29th September 2016

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1. ICT RECOVERY APPROACH

The approach taken to the ICT recovery is based on two parallel priorities:

1) The stabilisation of the existing technical platform (ICT infrastructure) to allow the Trust to operate on a safe and sound technical environment for the next two/three years
2) The creation and delivery of a 5/10-year ICT Strategy to ensure the long-term ICT solutions enable the Trust to achieve a paperless and digital operating environment and take advantage of future technical innovation.

1.1 ICT Stabilisation (Risk Reduction)

The approach to stabilisation is based on the reduction of risk. The initial risks, as referenced in the ICT Risk Register and summarized in the Trust Corporate Risk Register, have been assessed and the following action plan implemented:

1. Risk IT0011 – Computing capacity. Additional processing power has been purchased and being implemented. The work is scheduled to be completed by the 1st week in October. This will reduce the likelihood risk rating from 4 to 2.
2. Risk IT0037 – Storage capacity. This was approached in two phases – firstly some immediate 'life support' implemented in late September. This reduced the likelihood risk rating from 5 to 4 (brought forward by one month, originally scheduled for October). The second phase will be implemented during November in order to reduce the risk rating to 3. This does however require a detailed review by the Technical Design Authority.
3. Risks IT0025 & 38 – XP Replacement. 750 PCs have been ordered, a further 1,200 will be required. There will be a rolling programme to the end of the financial year to implement these. The risk will be progressively reduced from 5 to 1.
4. Risks IT0025 & 15 – network. New network switches and significant reconfiguration work is in progress. Initial work will reduce the risk from 5 to 4 in October and then down to 3 in January.
5. Risk IT0015 & 39 – Backup. Currently there is not 100% coverage on backups. Remedial work will reduce the risk from 5 to 3 in December and eradicate by February. Important to note that key clinical systems (Cerner & RIO) are hosted off site and are outside the scope of this risk.
6. Red 724 PCs. During the network failure in June it was found that the 724 disaster recovery systems did not work. Work continues to restore this, reducing the risk to 2 in October and removing it by November.

Figure 1 below provides a high level view of the timeline for resolution of the aforementioned risks / issues and an indication of the risk reduction.

Figure 1

The deployment of all clinical programmes of work has been frozen to allow the infrastructure to be stabilised and reduce clinical risk from implementing further systems on an unstable platform. In reality this freeze is formal recognition of what has already happened as the main programmes are neither properly funded or resourced, and have not been for some time. There will inevitably be some exceptions, however these will be scoped, resourced and have proper project controls implemented. A full clinical programme will be considered as part of the overall ICT Strategy, as described below.

Until recently only 1 ICT Engineer was on call outside of normal working hours. An ICT Duty Manager system has been implemented in order to provide additional support and guidance. This commenced on September 5th.

There are a number of ICT applications (EDM, e-Triage, Dictate IT and others) that are inadequately supported and acting unpredictably which results in poor user experience. With the infrastructure stabilisation work now in progress, these applications are being prioritised for detailed assessment; any issues uncovered will be planned into phase 2 of the stabilisation programme.

Business continuity: In parallel with the ICT stabilisation, the Trust will need to review and test its Business continuity arrangements. These are the plans and processes to maintain a safe clinical service in the event of a partial or total ICT failure, as well as other potential business failures.

ICT is currently reviewing its Disaster Recovery capability; initial findings indicate that it is inadequate. This is also being included in the next stage of the stabilisation programme.

1.2 Risk Reduction: Use of cloud storage

As previously reported, ICT are currently working through a series of actions to stabilise the ICT infrastructure. One of the risks relates to backup, that is; the current inability to fully backup Trust data.

Risk IT0039 – Backup. Currently there is not 100% coverage on backups. Remedial work will reduce the risk from 5 to 3 in December and eradicate by February. Important to note that key clinical systems (Cerner & RIO) are hosted off site and are outside the scope of this risk.

Part of the solution is to quickly implement alternate backup arrangements for Exchange Data (e-mail). Theoretically, e-mails should not contain any patient data; however, a cautious approach is being taken on the assumption that this may not be the case. The plan is to install a solution where the exchange data is securely encrypted and stored in 'The Cloud'. The purpose of this paper is to advise the Board and seek support for this approach. It is important to note that this approach is only part of the overall backup solution. There is other work ongoing to implement backup facilities for non-Exchange data and will form part of the overall backup strategy.

1.2.1 Cloud storage

Cloud storage is simply the provision of data storage at a remote location, accessed over a network. There are two types of cloud, Private and Public. In a private cloud the hardware is dedicated to the organization, while in a public cloud it is shared, requiring particular attention be given to the security boundaries between organizations. It is now common practice for data to be stored in this way; public clouds are secure, cost effective mechanisms for data storage.

Clarification: Public Cloud vs Private Cloud

Generally speaking, a public cloud consists of a service or set of services that are purchased by a business or organization and delivered via the Internet by a third-party provider. These services use storage capacity and processor power that is not owned by the business itself. Instead, this capacity (in the form of servers and datacenters) can be owned either by the primary vendor (e.g. an online storage/backup company) or by a cloud infrastructure vendor.

A private cloud is essentially an extension of an enterprise's traditional datacenter that is optimized to provide storage capacity and processor power for a variety of functions. "Private" refers more to the fact that this type of platform is a non-shared resource than to any security advantage.

The Azure cloud, provided by Microsoft is well implemented, stable and secure. It is a commercially available public cloud and therefore any given user does not have dedicated hardware, but benefits from a dedicated 'partition' of the hardware, at a reduced cost. Access to our data will be over the Internet, but it is important to note that the data placed onto the Azure cloud will be **encrypted** 'at source' – i.e., before it leaves our network. Microsoft, nor any other organization, will have the encryption key, and as such will not be able to read any data. The location of St George's data is important, and appropriate controls will be in place to ensure that our data never leaves the UK/Ireland. The fact that the data is encrypted in the cloud is a level of security over and above how it is currently stored in St. George's.

Benefits

- **Immediate** method of improving the backup solution and reducing risk
- **Secure encrypted data** held within backups – a improvement on current situation
- Flexibility for future options – particularly if not continuing on site with Exchange (e.g. NHS Mail)
- Cost effective – circa £13k for two years, hardware can also be re-used
- Opportunity to start to use and experience Cloud services
- More secure than current data center

- Increased throughput capacity on internal backup solution
- Implementation will be via a proof of concept to ensure that the solution is compliant before full implementation

Risk

- Reputation – the term 'Cloud' is often misunderstood. There is a risk that external parties do not appreciate the secure nature of this solution and conclude that St. George's are simply putting data on 'The Internet'; this however is not the case due to the security levels of the Azure solution.

1.2.2 Compliance

Microsoft Azure and Microsoft Azure Government comply with the Minimum Acceptable Risk Standards for Exchanges (MARS-E) for information security regulations for health-based exchanges under the Patient Protection and Affordable Care Act (ACA) of 2010. Azure has achieved approval for handling and storage of UK government data up to OFFICIAL status, including OFFICIAL SENSITIVE across a number of services. Government guidance recommends that health records are treated as OFFICIAL/OFFICIAL SENSITIVE.

Microsoft make the following declaration regarding ISO/IEC 27001; the international acceptance and applicability of ISO/IEC 27001 is a key reason why certification to this standard is a foundation of Microsoft's approach to information security. In 2009, the company received its first ISO/IEC 27001 certification for Microsoft Cloud Infrastructure and Operations (formerly Global Foundation Services), which provides datacenters and networking for Microsoft cloud services. Currently, Microsoft's cloud infrastructure and services are audited once a year for ISO/IEC 27001 compliance by the British Standards Institution (BSI), an accredited certification body, providing independent validation that Microsoft has implemented security controls end to end.

The proposed solution has been reviewed and approved by:

a) The Caldicott Guardian
b) CIO / SIRO
c) The Information Governance Officer.

1.2.3 Costs

The cost of this solution is £13,600 for two years. Costs for further years would be approx. £3000 per annum, if required. It is within the £1.3M allocated for immediate ICT Stabilisation.

Recommendation: It is recommended that the Board support the approach to move the Trusts Exchange Data into the secure Azure cloud in order to relieve the immediate risk of lack of data backup.

2. ICT STRATEGY

Without strategic direction the ICT Department will continue to implement short term tactical repairs that will ultimately cost more, deliver less benefit and continue to drive poor user experience. To fully address ICT recovery, St. George's must take a step back and assess the longer term vision and strategy for its ICT solutions.

At the EMT meeting of May 23, 2016 it was agreed that the general approach to the ICT Strategy would be one of 'Strategic Partnering'.

In line with this approach the ICT Department will initiate a procurement process, following Board approval, to procure a Strategic Business Partner (SBP). This SBP will be an intermediate partner to assist the Trust in creating a 10/15-year ICT Strategy. The intention is to continue this engagement following approval of the ICT Strategy into the delivery of some (or all) of the Strategic Programmes likely to result from the approval of the Strategy and subsequent business cases.

Initial engagement with the Trusts Procurement team has commenced and it is anticipated that an SBP will be in place by early December 2016. A Strategy and a supporting Strategic Outline Business Case (SOC) will be developed immediately and are expected to be approved by EMT and the Trust Board in Q4 this financial year.

Figure 2 below provides an indication of the SBP procurement and the completion of the ICT Strategy.

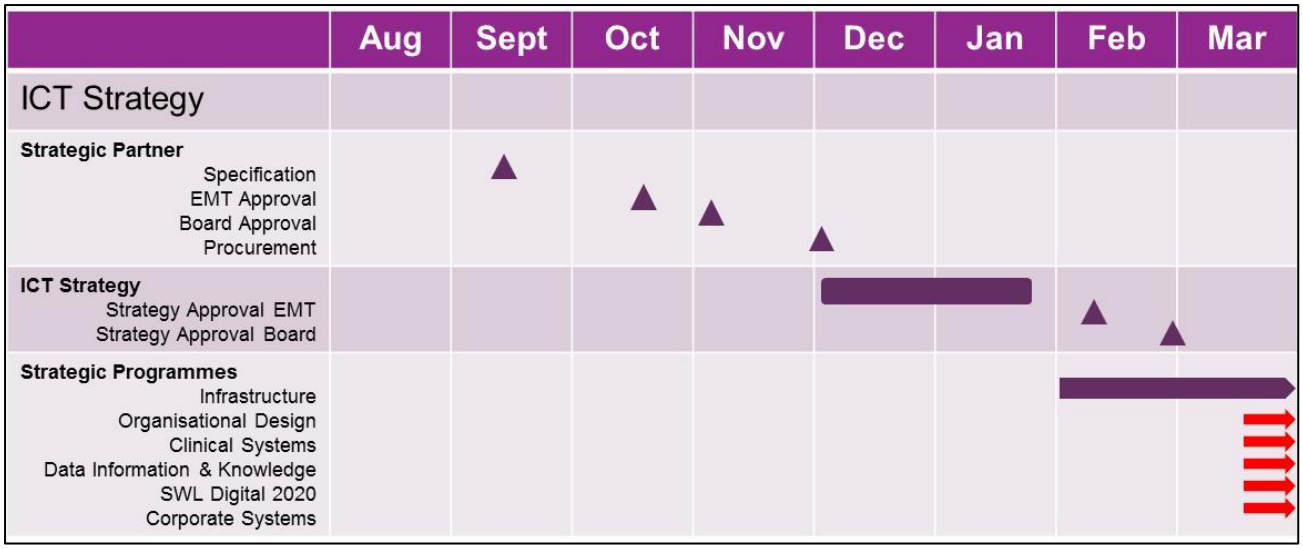


Figure 2

A modern ICT strategy, for a Trust like St. George's, typically results in the launching of several programmes of work. These programmes are likely to include:

- Infrastructure programme (all ICT hardware – network (wired, wireless and mobile), end-user-devices (desktop, laptop, tablets, telephony (mobile and fixed)), datacentre and hosting, support services, storage, compute); to improve, replace and upgrade infrastructure to a 21st century platform capable of supporting the Trust for the foreseeable future
- Organisational Design programme; address all aspects of the ICT organisation; process, operating model, organisation, structure and skills
- Clinical Systems programme (all clinical systems across the Trust – both Acute and Community); rationalisation, integration and interoperability of these applications
- Data, Information & Knowledge programme; review the Trusts data strategy and requirements; BI (Business Intelligence) needs and plan to move towards knowledge management and Big Data in the medium (3/5 years) future
- SWL (South West London / Digital 2020); this may be consumed within other programmes; a number of initiatives are already underway with local partners to meet the requirements of the NHS 2020 Digital Initiative.

- Corporate Systems programme; assess the current state of corporate / back-office systems and plan the strategic way forward over a number of years. This is likely to overlap with other programmes.

The list above is not exhaustive and other programmes may be identified as the Strategy is developed. *Figure 3* below provides an indicative timeline for the commencement of these programmes.

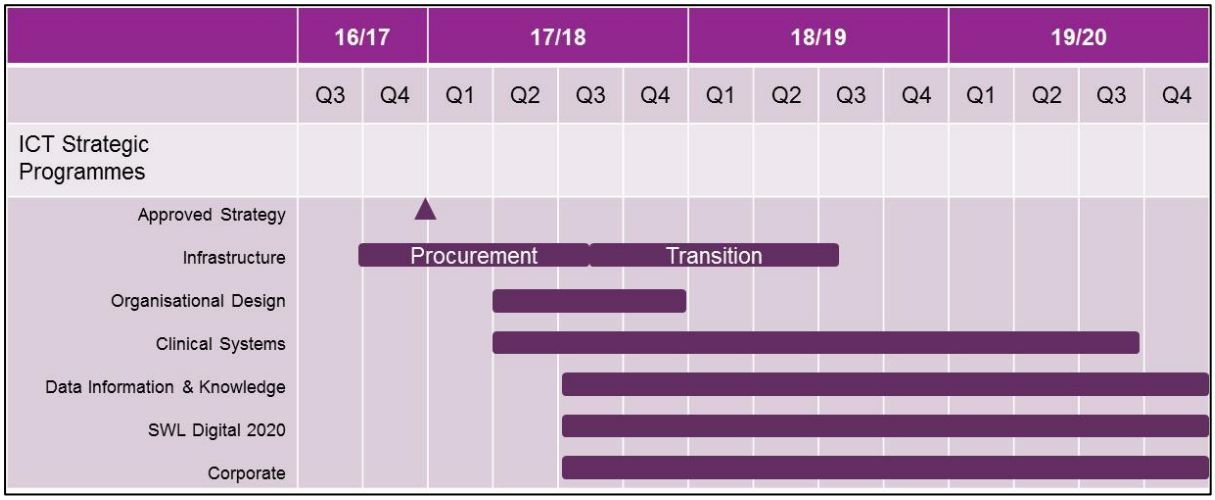


Figure 3

Recommendation: It is recommended that the Board support the approach being taken by the ICT Department to deliver the ICT strategy and the long-term ICT platform of the future.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO BOARD - 6th October 2016

Paper Title:	**Board Assurance Framework**
Sponsoring Executive Director:	**Paul Moore**
Author:	**Luke Edwards**
Purpose:	**For Decision**
Action required by the board:	That the Board: • **Considers** the initial draft of the new Board Assurance Framework and provides any specific comments noting the further work identified; • **Agrees** that the new framework is sufficient to meet the Board's assurance needs; • **Agrees** that the Board Assurance Framework should be introduced as a key assurance tool from November.
Document previously considered by:	**EMT 19/09 & 22/09**

Executive summary

The CQC raised concerns that the lack of board assurance framework (BAF) and wider governance arrangements, in their current format, were not sufficiently robust to ensure that the board and executive had oversight of the risks which were likely to impact on the organisations ability to provide safe and effective care.

A programme of work has been undertaken to develop a BAF for 2016/17 over the last two months. The draft BAF is attached at the annex. As noted in the Corporate Risk Report the BAF has been developed using the strategic risk vectors and these are aligned with the corporate objectives set out in our 2016/17 Business Plan. The framework describes each risk; the causes and the impact and quantifies the current level of the risk and acceptable level. Executive leads for each risk have identified the key controls and assessed their current effectiveness; identified the lines of assurance using the three lines of defence methodology previously discussed by the Board; and identified the gaps in assurance. An overall assessment of the control effectiveness and assurance rating is provided for each strategic risk vector.

The emerging picture the BAF describes is that the current level of risk is high or very high for 7 of the 10 strategic risks, internal controls need substantial strengthening and assurance is negative in 4 domains including: our people; finance; quality governance; and IT. Actions have been identified to strengthen the controls and assurance position in key areas.

There remains further work to finalise the BAF including reviewing the extent to which commissioner affordability is a strategic risk for the trust in 2016/17 and developing the controls we have in place around key risks including for example managing our demand.

The Board is asked to:

- **Consider** the initial draft of the new Board Assurance Framework and provide any specific comments or feedback;
- **Agree** that the new framework is sufficient to meet the Board's assurance needs; and

- **Agree** that the Board Assurance Framework should be introduced as a key assurance tool from November.

The BAF will be represented to the Board for formal approval next month reflecting the Board's comments and then updated monthly. Key actions will be tracked and regularly reviewed from this point forward. It will be presented to the Risk Committee and QC.

It is anticipated that, over time, the CRR and BAF processes will converge to minimise duplication between these processes.

Key risks identified:
The BAF will strengthen the Boards approach to governance.

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.*	**Well led domain**

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

St George's University Hospitals NHS
NHS Foundation Trust

Board of Directors Assurance Framework

For the Board's 2016/17 Corporate Objectives

DRAFT

BOARD ASSURANCE MAP: SUMMARY

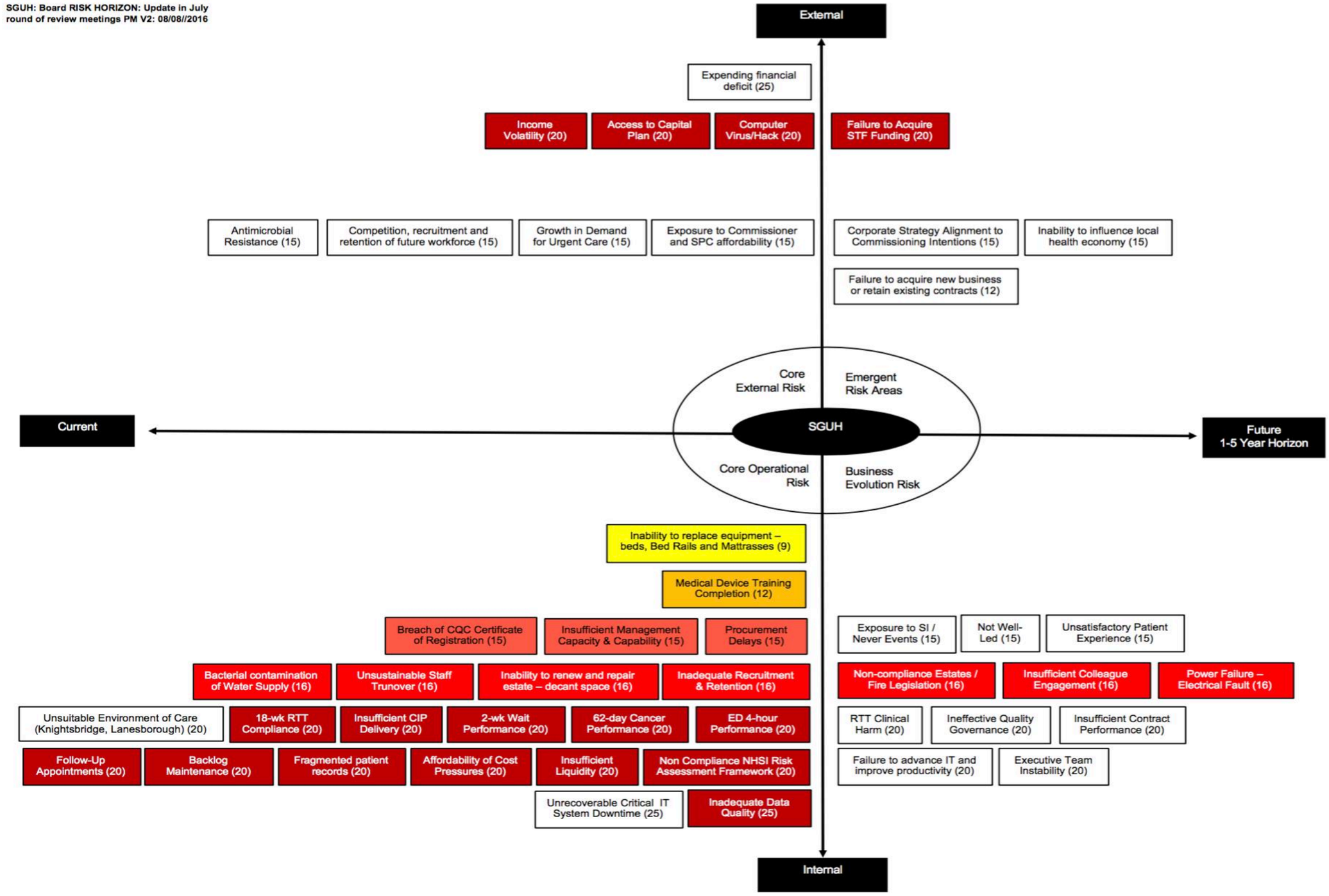
No.	BAF Risk	Corporate Objective	Strategic Risk Exposure	Primary Lead EXEC	Initial score S x L	Today's score S x L	Acceptable S x L	Committee Oversight	Internal Control Effectiveness	Adequacy of Board Assurance
1	Commissioning Intentions	Deliver our Transformation Programme enabling the trust to meet its operational and financial targets	Corporate strategy is not aligned with commissioning intentions	CEO	12	12	8	BOARD		Assurance is inconclusive
2	Health Economy Influence	Refresh the trust's strategy, to develop a sustainable service model with a clear and consistent message	Stakeholder relationships. Ability to influence within and across the local health economy	CEO	16	16	8	BOARD		Assurance is inconclusive
3	Demand for Care	Ensure the trust has an unwavering focus on all measures of quality and safety, and patient experience	Demand exceeds capacity to deliver safe and effective services	COO	20	20	15	FINANCE & PERFORMANCE		Assurance is inconclusive
4	Our People	Ensure our workforce is supported and motivated, and that they understand, and are engaged with, the challenges facing the organisation	Supply, recruitment, retention and motivation of colleagues	DW&OD	20	20	10	WORKFORCE		Assurance is negative
5	Community contracts	Refresh the trust's strategy, to develop a sustainable service model with a clear and consistent message	Acquisition of new business and retaining existing contracts	COO	15	15	10	FINANCE & PERFORMANCE		Assurance is inconclusive
6	Financial Plan	Deliver our Transformation Programme enabling the trust to meet its operational and financial targets	Delivery of the Financial Plan	CFO	25	25	15	FINANCE & PERFORMANCE		Assurance is negative
7	Quality Governance (inc. Patient Experience)	Ensure the trust has an unwavering focus on all measures of quality and safety, and patient experience	Unsafe or poor quality care. CQC intervention	DOG	20	20	10	QUALITY COMMITTEE		Assurance is negative
8	Performance	Deliver our Transformation Programme enabling the trust to meet its operational and financial targets	Operational failure adversely impacts on strategy execution	COO	20	20	15	FINANCE & PERFORMANCE		Assurance is positive
9	Estates	Ensure we make the most of our buildings and estate and maximise efficiency through improving back office and corporate functions	Failure to improve the estate or deliver backlog maintenance	DOE&F	25	25	10	QUALITY COMMITTEE		Assurance is inconclusive
10	Information technology	Ensure we make the most of our buildings and estate and maximise efficiency through improving back office and corporate functions	Operational failure to maintain core systems	CIO	25	25	10	FINANCE & PERFORMANCE		Assurance is negative

GUIDANCE

An overview of how risk relates to strategy at St George's University Hospitals NHS Foundation Trust 2016/17

	Risk categories	Relationship to Trust strategy	Approaches we use to control the risk	Example tools we use to gain confidence that risks are controlled to an acceptable level
i	Preventable, undesirable, operational risks. (Routinely fed into Ulysses on the front line).	There is no strategic benefit from taking these risks. We may prevent or cost-efficiently minimise their occurrence.	Prevention: Proactive identification and preparation. Culture. Internal control systems. Detection: Active monitoring and mitigation of risk in proportion to threat level. Contingency: business continuity plans designed to recover from a foreseeable failure/situation	Mission & value statements. Policy, procedure, training, segregation of duties; restricted access; defined levels of authorisation; record keeping; reporting. Risk maps and registers. Strategic risk register (identifies risks scored 15+) Board assurance framework. Internal audit & clinical audit. Conversation and other communications.
ii	Strategy execution risks, which the Trust accepts as a result of the Board's strategic choices.	Taking these risks is essential for achieving strategic objectives. We may reduce the likelihood and impact in cost-efficient ways.	Detection: Risk monitoring linked to strategy review meetings and resource allocation. Contingencies: Cost and time reserves to support problem solving.	Risk horizon scanning workshops. 'Delphi' method of expert review to agree a risk score. Risk 'heat map'. Strategic risk register (identifies risks scored 15+) Board assurance framework. Expert review of planning assumptions. Select Committees (i.e. an assurance committee meeting for a select purpose, to examine one topic in greater detail). Conversation and other communication.
iii	External risks which are hard to predict or manage, because although we may influence the environment, we cannot control it.	We cannot control the occurrence of such risks, but can prepare for them and thus reduce the impact.	Contingency: Escalation procedures. Emergency response planning. Contingency planning. Insurance.	What if ?' scenario workshops. Give due regard to high impact, low probability events ('HILPs'). Risk 'heat map'. Strategic risk register (identifies risks scored 15+) Board assurance framework. Conversation and other communication.

RISK HORIZON SCAN: SUMMER 2016



RECOMMENDED SCORING MATRIX

South West London and St George's NHS
Mental Health NHS Trust

SEVERITY INDEX		LIKELIHOOD INDEX*		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Divisions; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Divisions; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or < 1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Board Assurance Framework 2016/17.

Date on which data valid	30/09/2016

St George's University Hospitals NHS
NHS Foundation Trust

Corporate objective	Deliver our Transformation Programme enabling the trust to meet its operational and financial targets
Risk description:	The Trust's corporate strategy is not aligned with commissioner or stakeholder intentions. Caused by unknown commissioning intentions, poor stakeholder relationships or conflict, a lack of trust between the Trust as its stakeholders. This may result in a lack of political or stakeholder capital to underwrite the Trust's appetite for taking risk, a failure to acquire new or retain existing business, entering the 'success regime' alongside others within the SWL health economy, the CCGs inability to pay for services or risk to continuity of mandatory services.

BAF risk no	1	Scores	Initial	Today	Acceptable
Risk owner	CEO	S(4) x L(3)	12	12	8

Range of potential outcomes	Outlying clinical KPI performance, clinical outcomes and safe care	Worse than peer KPI performance, clinical outcomes and safe care	Compliant In line with peer	Better than peer KPI performance, clinical outcomes and safe care	Exemplar KPI performance, clinical outcomes and safe care	Outcome trajectory	Overall Assurance Rating	Committee Oversight
Current position			*				Assurance is inconclusive	BOARD

Control No	Control description	Gaps in control	Control Effectiveness	Assurance from first line of defence (**front line evidence** *of control effectiveness*)	Assurance from second line of defence (**management evidence** *of control effectiveness*)	Assurance from third line of defence (**independent evidence** *of control effectiveness*)	Gaps in assurance position	Further Action Planned
GUIDANCE NOTES	**DEFINE PRECISELY EACH CONTROL BEING USED TO MITIGATE THE RISK OF FAILURE. THIS IS KNOWN AS INTERNAL CONTROL** (Examples might include relevant policies, procedures, SFIs, clinical pathways or protocols, training, processes, systems of work, detection systems (such as complaints, incident reporting, monitoring budgets, contingency plans in the event of a problem etc.). **BE AS PRECISE AS POSSIBLE TO DEMONSTRATE HOW THE OBJECTIVE IS DELIVERED AND THEREFORE HOW THE RISK IS ROUTINELY MITIGATED.**	**IT IS QUITE NORMAL TO HAVE GAPS IN CONTROL. IN THIS BOX STATE THE UNDERLYING WEAKNESS IN EACH CONTROL (IF THERE IS A WEAKNESS).** Examples might include shortfall in completion of training, factors beyond the control of the Trust, performance not on track, poor compliance with procedures or policies etc. **AWARENESS OF GAPS IS A SIGN OF STRENGTH = BOARD INSIGHT AND LEADS TO BETTER DECISION MAKING**	How effective is this control? Select from one of the following options: (i) **Effective** (this control is working as intended); (ii) **Not Effective** (this control cannot be relied upon); or (iii) **Not Yet Tested** (the effectiveness of this control is not yet known).	WHAT EVIDENCE - **FROM SERVICE LINES** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include ward/department-level data, service line reports.	WHAT EVIDENCE - **FROM CORPORATE MANAGEMENT** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include corporate reports - Directors' reports, output from EMC review or DPR, Clinical Audit, management checks/visits/observations.	WHAT EVIDENCE - **FROM INDEPENDENT SOURCES** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include internal or external audit reports, patient/staff surveys, CQC intelligent monitoring or investigation, Healthwatch, assurance from Commissioners, Deanery reports or reviews commissioned from any other third party	GAPS IN ASSURANCE ARE SELF EVIDENT WHEN USING THIS METHODOLOGY - IF THERE IS NO EVIDENCE THEN THERE IS A GAP IN KNOWLEDGE AND THUS A GAP IN ASSURANCE. REASSURANCE IS ASSURANCE WITHOUT EVIDENCE - IT REPRESENTS A BELIEF AND IS NOT SUFFICIENT FOR EFFECTIVE GOVERNANCE. **IN THIS BOX OUTLINE ANY GAPS IN KNOWLEDGE OF THE EFFECTIVENESS OF A CONTROL. USE INTELLIGENCE FROM HERE TO BUILD YOUR INTERNAL AUDIT PROGRAMME FOR THE MONTHS/YEAR AHEAD** **AWARENESS OF GAPS IS A SIGN OF STRENGTH = BOARD INSIGHT AND LEADS TO BETTER DECISION MAKING**	OUTLINE THE STEPS BEING TAKEN OR PLANNED TO IMPROVE THE DESIGN OR IMPLEMENTATION OF A CONTROL, OR ADDRESS A GAPS IN ASSURANCE. **IT MAY NOT BE NECESSARY TO APPLY ACTION TO EVERY GAP IN CONTROL OR ASSURANCE; SOME CONTROL WEAKNESSES OR GAPS IN KNOWLEDGE ARE INEVITABLE AND TOLERABLE. HOWEVER, ACTION IS REQUIRED WHERE A GAP IN CONTROL OR ASSURANCE IS NOT ACCEPTABLE AND COULD, IF NOT ADDRESSED, COMPROMISE THE DELIVERY OF OBJECTIVES OR THE BOARD'S CONFIDENCE IN DELIVERY OF ITS STRATEGY.** **ASSIGN TO AN EXECUTIVE DIRECTOR AND INCLUDE EXPECTED COMPLETION DATE.**
1	The strategic landscape is emergent as the STP processes for specialist commissioning and South West London are not yet finalised. The trust is actively engaged in discussion but the has limited influence.	The strategic landscape is emergent as the STP processes for specialist commissioning and South West London are finalised. Engagement is positive but the trust has limited influence and Commissioners confidence in our ability to deliver commitments is low because of historical failure.	Effective	The Trust engages with local and specialist commissioners through a range of mechanisms and has recently agreed a revised framework. Engagement on the STP processes for local and specialist commissioning is lead by the CFO and the internal strategy development work is closely aligned through the CEO	The Board regularly discusses the strategic landscape both at the main Board and also at regular Board strategy sessions.	Executive regular meetings with Commissioners in each of the Boroughs and with NHS England by CEO and COO	Assurance that the emergent trust strategy is fully aligned with the STP process	**Clarify primary lead for commissioner engagement (CEO)**
2	The Board's strategy flows from those commissioning priorities is translated into core operational objectives, divisional priorities and reflected in annual plans.	Divisional and recovery business plans have not been fully agreed	Not Effective	Directorate performance is reported on and responded to against plan	Regular reporting takes place through Operations to EMC, F&P and Board	Regular meetings with Commissioners in each of the Boroughs and with NHS England	There is limited assurance that the plans are integrated	**Divisional plans to be agreed by end September (COO)**
3	The performance management framework encapsulates the Board's Strategy and core operational objectives. Performance against these priorities is examined at Divisional Performance Review. Adjustments are made to in-year priorities as commissioning intentions and requirements emerge.	A performance management framework is in place including regular performance management meetings however the wider PMF needs to be review to ensure it is fit for purpose. Performance plans are regularly re-baselined	Effective	Evidence of scheduled performance management meetings and divisional and care group level	Performance management reports		The effectiveness of the current performance management framework is untested	**Effectiveness of performance management framework reviewed (COO)**
4	The Finance Department sense and capture shifts in Commissioner intentions, and anticipates changes based upon service reviews, public health priorities, regulatory concerns and reports to EMT, F&P and Board.	Integration of these Intentions into individualised Business Plans for each Service Line/Directorate	Effective	Directorate management plans are updated according to any changes that are informed to Board, F&P and EMC	Regular reporting takes place through finance to EMC, F&P and Board	Regular meetings with current partners and service users groups in each of the Boroughs and with NHS England	None	
		Overall Control Effectiveness	75.0%					

Board Assurance Framework 2016/17.

Date on which data valid	30/09/2016

St George's University Hospitals NHS
NHS Foundation Trust

Corporate objective	Refresh the trust's strategy, to develop a sustainable service model with a clear and consistent message		
Risk description:	Inability to influence key stakeholders.	Caused by a failure to communicate effectively; poor stakeholder engagement or co-ordination; and/or unsatisfactory clinical outcomes or performance.	May result in a loss of stakeholder confidence; inability to exploit opportunities and steer the Trust towards success.

		Scores	Initial	Today	Acceptable
BAF risk no	3				
Risk owner	CEO	S(4) x L(4)	16	16	8

Range of potential outcomes	Outlying clinical KPI performance, clinical outcomes and safe care	Worse than peer KPI performance, clinical outcomes and safe care	Compliant In line with peer	Better than peer KPI performance, clinical outcomes and safe care	Exemplar KPI performance, clinical outcomes and safe care	Outcome trajectory	Overall Assurance Rating	Committee Oversight
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1	The Chief Executive, or directors on his behalf, prioritise attendance at a range of external meetings and engagement events to manage engagement effectively during turnaround and improve and develop stakeholder relationships.	The Trust prioritises meetings with key external stakeholders, and views these relationships as important. However, this is not done consistently, and there is currently a lack of capacity to track this effectively and ensure quality engagement.	Effective	Lead accountabilities have been identified to ensure that key meetings e.g. TOG, STP and OSC meetings are managed effectively.	Regular contact is maintained with regulators, MPs, Councils, CCGs and Healthwatch through 1:1 meetings or written correspondence	Annual Report includes statements from Healthwatch, commissioners and Overview and Scrutiny Committees	There is limited assurance that we are engaging in a structured way with external stakeholders. We also don't have complete assurance that information communicated, or knowledge accrued, is shared within the organisation, or even amongst the executive team.	**Key senior external meetings mapped and prioritised by end November (Trust Secretary, Nov -16)**
2	An Executive Director lead is assigned as the primary point of contact and key relationship manager for each Borough/CCG, and intelligence/concerns are routinely fed back into the Executive Team Meeting in order to develop and agree a response, and adapt in a manner that promotes successful relationships	Relationships with external stakeholders are managed primarily by the Chair, Chief executive and communications team. There is not currently a lead Executive Director for each Borough.	Not Effective	The Chief Executive meets Borough leads at the monthly Quality Oversight Group	The Chief Executive meets CCG leads, NHSE at the monthly Quality Oversight Group and also has a weekly teleconference or meeting with CCG Chief Officers	Annual Report includes statements from Healthwatch, commissioners and Overview and Scrutiny Committees	The responsibility for engaging with key stakeholders needs to be shared more widely amongst members of the senior team. This will help with capacity, but also ensure the wider team are aware of the views (and demands) of external stakeholders.	**Once the new Board is established, we will consider investing in a CRM (Customer Relationship Management) tool to co-ordinate our contact and relationship with external stakeholders. We will also consider the possibility of nominating an executive director who is the lead person for each Borough. (CEO)**
3	The Trust holds a list of key stakeholders and has an established mechanism for engaging with them. This is updated on a regular basis.	The communications team keeps an up to date list of key external stakeholders, which is regularly updated. The communications team produces a monthly stakeholder briefing which is agreed with the Chair and Chief Executive. The communications team also speak and meet with communications counterparts at external organisations (where appropriate) to share information and ensure a joined up approach. As well as the monthly stakeholder update, we also produce and circulate ad hoc briefings on urgent and pressing matters.	Effective	Key stakeholder engagement events e.g. OSC are actively discussed at EMT and Executive Directors sessions	We produce a monthly stakeholder bulletin to ensure our external stakeholders are kept informed about what is happening at the Trust	The communications team briefs their counterparts on urgent and pressing matters, separate to the monthly written stakeholder briefing.	Limited assurance that we are targeting our effort at key stakeholders.	**We have yet to undertake a detailed stakeholder mapping exercise. This will be completed by the end of December 2016 (Director of Communications/Trust Secretary)**
4	The Trust has established a Council of Governors who represent the Trust's members. Consulting members and helping the governing body is used as an engagement vehicle to further raise the Trust's profile externally, but also for the early detection of concerns or problems at a local level that may indicate strain on stakeholder relations.	An established membership function is in place and an existing membership and engagement strategy. However the Trust is failing to deliver an increase in membership in line with the strategy	Effective	The Council of Governors have an established Membership and Engagement Working Group and strategy and An outline action plan has been developed for 2016/17 Governors are increasingly engaged in the Trust business and therefore more able to represent member interests however engagement with the Trust's 12,000 membership remains limited.	Governors prepare an Annual Statement as part of the Annual Report. An annual evaluation of effectiveness is conducted by the Governors	NHSI has clear guidance in place on engagement with membership Number of candidates and turn out in elections	Effectiveness of action plan to improve membership engagement is untested	**Delivery of 2016/17 membership action plan by April 17 including early milestones (Trust Secretary)** **Effective management of elections in spring 2017 (Trust Secretary)** **Governors awayday planned 9 November (Trust Secretary)**
		Overall Control Effectiveness	75.0%					

Board Assurance Framework 2016/17.

Date on which data valid	30/09/2016

St George's University Hospitals NHS
NHS Foundation Trust

Corporate objective	#REF!		
Risk description:	The demand for services exceeds capacity to deliver them in a safe and clinically effective manner.	Growth in demand for services, underlying inefficiencies in core operations, and/or insufficient productivity.	This may result in significant operational instability, poor compliance with key performance targets, and/or inadequate outcomes for service users. In the worst case may lead to a breach license conditions.

		Scores	Initial	Today	Acceptable
BAF risk no	4				
Risk owner	COO	S95) x L(4)	20	20	15

Range of potential outcomes	Outlying clinical KPI performance, clinical outcomes and safe care	Worse than peer KPI performance, clinical outcomes and safe care	Compliant In line with peer	Better than peer KPI performance, clinical outcomes and safe care	Exemplar KPI performance, clinical outcomes and safe care	Outcome trajectory	Overall Assurance Rating	Committee Oversight
Current position			*				Assurance is inconclusive	FINANCE & PERFORMANCE

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GUIDANCE NOTES	**DEFINE PRECISELY EACH CONTROL BEING USED TO MITIGATE THE RISK OF FAILURE. THIS IS KNOWN AS INTERNAL CONTROL** (Examples might include relevant policies, procedures, SFIs, clinical pathways or protocols, training, processes, systems of work, detection systems (such as complaints, incident reporting, monitoring budgets, contingency plans in the event of a problem etc.). **BE AS PRECISE AS POSSIBLE TO DEMONSTRATE HOW THE OBJECTIVE IS DELIVERED AND THEREFORE HOW THE RISK IS ROUTINELY MITIGATED.**	**IT IS QUITE NORMAL TO HAVE GAPS IN CONTROL. IN THIS BOX STATE THE UNDERLYING WEAKNESS IN EACH CONTROL (IF THERE IS A WEAKNESS).** Examples might include shortfall in completion of training, factors beyond the control of the Trust, performance not on track, poor compliance with procedures or policies etc. **AWARENESS OF GAPS IS A SIGN OF STRENGTH = BOARD INSIGHT AND LEADS TO BETTER DECISION MAKING**	How effective is this control? Select from one of the following options: (i) **Effective** (this control is working as intended); (ii) **Not Effective** (this control cannot be relied upon); or (iii) **Not Yet Tested** (the effectiveness of this control is not yet known).	WHAT EVIDENCE - **FROM SERVICE LINES** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include ward/department-level data, service line reports.	WHAT EVIDENCE - **FROM CORPORATE MANAGEMENT** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include corporate reports - Directors' reports, output from EMC review or DPR, Clinical Audit, management checks/visits/observations.	WHAT EVIDENCE - **FROM INDEPENDENT SOURCES** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include internal or external audit reports, patient/staff surveys, CQC intelligent monitoring or investigation, Healthwatch, assurance from Commissioners, Deanery reports or reviews commissioned from any other third party	GAPS IN ASSURANCE ARE SELF EVIDENT WHEN USING THIS METHODOLOGY - IF THERE IS NO EVIDENCE THEN THERE IS A GAP IN KNOWLEDGE AND THUS A GAP IN ASSURANCE. REASSURANCE IS ASSURANCE WITHOUT EVIDENCE - IT REPRESENTS A BELIEF AND IS NOT SUFFICIENT FOR EFFECTIVE GOVERNANCE. **IN THIS BOX OUTLINE ANY GAPS IN KNOWLEDGE OF THE EFFECTIVENESS OF A CONTROL. USE INTELLIGENCE FROM HERE TO BUILD YOUR INTERNAL AUDIT PROGRAMME FOR THE MONTHS/YEAR AHEAD** **AWARENESS OF GAPS IS A SIGN OF STRENGTH = BOARD INSIGHT AND LEADS TO BETTER DECISION MAKING**	OUTLINE THE STEPS BEING TAKEN OR PLANNED TO IMPROVE THE DESIGN OR IMPLEMENTATION OF A CONTROL, OR ADDRESS A GAPS IN ASSURANCE. **IT MAY NOT BE NECESSARY TO APPLY ACTION TO EVERY GAP IN CONTROL OR ASSURANCE; SOME CONTROL WEAKNESSES OR GAPS IN KNOWLEDGE ARE INEVITABLE AND TOLERABLE. HOWEVER, ACTION IS REQUIRED WHERE A GAP IN CONTROL OR ASSURANCE IS NOT ACCEPTABLE AND COULD, IF NOT ADDRESSED, COMPROMISE THE DELIVERY OF OBJECTIVES OR THE BOARD'S CONFIDENCE IN DELIVERY OF ITS STRATEGY.** **ASSIGN TO AN EXECUTIVE DIRECTOR AND INCLUDE EXPECTED COMPLETION DATE.**
1	The delivery of services in the Trust has been altered in the past months. Service quality has been improved in order to ensure that visibility is enabled over operational performance over all key aspects of delivery in RTT, ED, Cancer, and Theatres Utilisation.	RTT Pathway. The Trust does not have sight of its RTT pathways and therefore cannot accurately report them. This is due to poor implementation of an IT system, coupled with a lack of training of staff. The Trust has put a plan in place to rectify this risk, coupled with an ongoing capability to reduce future RTT risks by managing with firm control on a daily basis.	Not Effective	Daily Performance Control Data is now collated, coupled with Service Line plans that can point to improvement in Unplanned Care, RTT, Cancer and Theatres Utilisation.	At least 2 x Executive Directors of the Board are present daily at the main performance meetings.	NHS IST and NHS Information have both commended the approach to delivering daily performance controls in order to improve quality of services.	The process will continue to be challenging due to the ongoing nature of unstable IT systems. The key aspect of the stabilisation will be the validations of the numbers of patients who may require further treatment, as well as the training requirements for all staff who need to utilise the systems.	**The current project will generate significant improvements in the management of RTT, and reduce the reliance on excessive human capital to counter the negative impacts of failing IT implementation. (COO)**
2	Active management of A&E attendance by working with commissioners to reduce unnecessary non elective admissions and pressures on A&E	Requires significant action by commissioners to ensure appropriate pathways are put in place Pilot not yet in place so model remains untested	Not Yet Tested	Evidence of data analysis into around 600,000 attendances representing 230,000 patients has identified nearly 2,500 patients attending A&E more than 10 times	Papers to Board and EMT updating on progress	None at present	Update will be required to EMT on progress	**First phase action plan due to commence in October (COO)**
		Overall Control Effectiveness	0.0%					

Board Assurance Framework 2016/17.

Date on which data valid	30/09/2016

St George's University Hospitals NHS
NHS Foundation Trust

Corporate objective	Ensure our workforce is supported and motivated, and that they understand, and are engaged with, the challenges facing the organisation
Risk description:	Failing attract, recruit, retain and motivate the workforce. Caused by acute shortages in the supply of specialist practitioners; poor organisational reputation; poor employee engagement or satisfaction; unsatisfactory work-life balance; cost of living in London; leadership style and capacity. Inability to deliver corporate strategy; unplanned expenditure arising from an over reliance on a temporary workforce; poor clinical outcomes or performance; poor patient experience; CQC intervention if staffing levels fall below minimum requirements.

BAF risk no	5	Scores	Initial	Today	Acceptable
Risk owner	DW&OD	S(5) x L(4)	20	20	10

Range of potential outcomes	Outlying clinical outcomes and harm	Worse than peer clinical outcomes & harm	In line with peer	Better than peer clinical outcomes and harm	Exemplar clinical outcomes and harm	Outcome trajectory	Overall Assurance Rating	Committee Oversight
Current position			*				Assurance is negative	WORKFORCE

Control No	Control description	Gaps in control	Control Effectiveness	Assurance from first line of defence (front line evidence *of control effectiveness*)	Assurance from second line of defence (management evidence *of control effectiveness*)	Assurance from third line of defence (independent evidence *of control effectiveness*)	Gaps in assurance position	Further Action Planned
GUIDANCE NOTES	**DEFINE PRECISELY EACH CONTROL BEING USED TO MITIGATE THE RISK OF FAILURE. THIS IS KNOWN AS INTERNAL CONTROL** (Examples might include relevant policies, procedures, SFIs, clinical pathways or protocols, training, processes, systems of work, detection systems (such as complaints, incident reporting, monitoring budgets, contingency plans in the event of a problem etc.). **BE AS PRECISE AS POSSIBLE TO DEMONSTRATE HOW THE OBJECTIVE IS DELIVERED AND THEREFORE HOW THE RISK IS ROUTINELY MITIGATED.**	**IT IS QUITE NORMAL TO HAVE GAPS IN CONTROL. IN THIS BOX STATE THE UNDERLYING WEAKNESS IN EACH CONTROL (IF THERE IS A WEAKNESS).** Examples might include shortfall in completion of training, factors beyond the control of the Trust, performance not on track, poor compliance with procedures or policies etc. **AWARENESS OF GAPS IS A SIGN OF STRENGTH = BOARD INSIGHT AND LEADS TO BETTER DECISION MAKING**	How effective is this control? Select from one of the following options: (i) **Effective** (this control is working as intended); (ii) **Not Effective** (this control cannot be relied upon); or (iii) **Not Yet Tested** (the effectiveness of this control is not yet known).	WHAT EVIDENCE - **FROM SERVICE LINES** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include ward/department-level data, service line reports.	WHAT EVIDENCE - **FROM CORPORATE MANAGEMENT** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include corporate reports - Directors' reports, output from EMC review or DPR, Clinical Audit, management checks/visits/observations.	WHAT EVIDENCE - **FROM INDEPENDENT SOURCES** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include internal or external audit reports, patient/staff surveys, CQC intelligent monitoring or investigation, Healthwatch, assurance from Commissioners, Deanery reports or reviews commissioned from any other third party	GAPS IN ASSURANCE ARE SELF EVIDENT WHEN USING THIS METHODOLOGY - IF THERE IS NO EVIDENCE THEN THERE IS A GAP IN KNOWLEDGE AND THUS A GAP IN ASSURANCE. REASSURANCE IS ASSURANCE WITHOUT EVIDENCE - IT REPRESENTS A BELIEF AND IS NOT SUFFICIENT FOR EFFECTIVE GOVERNANCE. **IN THIS BOX OUTLINE ANY GAPS IN KNOWLEDGE OF THE EFFECTIVENESS OF A CONTROL. USE INTELLIGENCE FROM HERE TO BUILD YOUR INTERNAL AUDIT PROGRAMME FOR THE MONTHS/YEAR AHEAD** **AWARENESS OF GAPS IS A SIGN OF STRENGTH = BOARD INSIGHT AND LEADS TO BETTER DECISION MAKING**	OUTLINE THE STEPS BEING TAKEN OR PLANNED TO IMPROVE THE DESIGN OR IMPLEMENTATION OF A CONTROL, OR ADDRESS A GAPS IN ASSURANCE. **IT MAY NOT BE NECESSARY TO APPLY ACTION TO EVERY GAP IN CONTROL OR ASSURANCE; SOME CONTROL WEAKNESSES OR GAPS IN KNOWLEDGE ARE INEVITABLE AND TOLERABLE. HOWEVER, ACTION IS REQUIRED WHERE A GAP IN CONTROL OR ASSURANCE IS NOT ACCEPTABLE AND COULD, IF NOT ADDRESSED, COMPROMISE THE DELIVERY OF OBJECTIVES OR THE BOARD'S CONFIDENCE IN DELIVERY OF ITS STRATEGY.** **ASSIGN TO AN EXECUTIVE DIRECTOR AND INCLUDE EXPECTED COMPLETION DATE.**
1	Fit for the Future - bringing all staff benefits and support under one cohort and recognised programme	Current HR targets are not being met	Not Yet Tested	There is a range of information available at service line level including: Workforce Statistics; 100 day Interviews; and Exit Interviews	Pulse Survey will provide regular information about the current position for the Board and Executive	There is a range of independent evidence available: Annual Staff Survey; Governors; FFT including additional 10 questions	The Fit for the Future Brand is only just launched. There will be base line information available Sep 2016.	**Continue to develop ideas, soft benefits and incentives for staff. Relook at benefits of staff briefing and two way cascade. KC**
2	Recruitment Process - continue to implement TRAC and derive benefits from the applicant tracking system. Use the MI drawn from TRAC to identify and use targeted action to address problems in the recruitment life-cycle, e.g. Hiring managers allowing shortlisting times to drift elongating time to hire and losing higher calibre candidates to other competitor in the labour market.	Use TRAC MI to address gaps in compliance with the recruitment process and timetable and take targeted action to address the shortfalls. Escalate repeated failures of compliance with senior management as appropriate.	Effective	TRAC reporting provides for the first time useful first line of defence monitoring. Managerial culture of compliance requires further and on-going work. TRAC is assisting with control effectiveness as it provides MI and reporting throughout the recruitment lifecycle	Meetings and reports with Divisional Directors and hiring managers on recruitment issues used as the second line of defence, utilising TRAC reporting from the first line of defence.	Reports on recruitment process have been produced for CQC to demonstrate both improvement in the recruitment process and also provide a gap analysis to promote continuous improvement	No gaps given the MI and actions derived from TRAC	**TRAC reporting to HRD and Trust Board to monitor time to hire and any associated problems within the recruitment lifecycle. Hiring Managers to utilise TRAC reporting to identify time frames and shorten the time to hire process. Provide quarterly reporting. JMcC**
3	Targeted Management Training	A full TNA hasn't yet been conducted to establish the full extent of the need.	Not Yet Tested	Attendance records are kept on Totara for all leadership and management development programmes. Each programme is evaluated to Kirkpatrick's 1st level as a minimum.	The need has been articulated, and new Effective People Management and Change Management Programmes designed, as well as an Induction specifically for new managers. A development programme for new leaders (on a multi-disciplinary basis) has been running for a year. HR Statistics in terms of turnover, sickness and HR issues in targeted areas.	Annual staff survey, Friends and Family. Answered Exit questionnaires.	Those who haven't attended voluntarily and not targeted.	**New managers will be routinely booked onto courses SJ**
4	Managing Staff Shortages This is achieved by using the workforce planning process to identify any gaps in the workforce that are hard to recruit to; areas where retention is low. Corporate nursing - international recruitment, recruitment fairs, open days, apprentices, development programmes e.g. HCA to nurses; radiographers to sonographers etc. Role development, divisional turnover plans	The workforce planning element of business planning is left until the end of the process. Workforce planning will include the plans for addressing gaps but the emphasis is placed on making the numbers of staff meet the budget rather than the complete process. Managers can be disengaged from the process. International/national labour market, high cost of living in London, supply from educational institutions. The vacancy freeze and the VCP process	Effective	Monthly reports are prepared for the Divisional Management boards which highlight the KPIs related to workforce effectiveness (vacancy levels; turnover rates) so that trends can be spotted. Turnover for nursing staff is available through Tableau. Managing Staff Shortages. The risk of failure is not being able to recruit to vacancies and cover unplanned absences. The Trust employs Recruitment and Retention nurses in the divisions to help reduce the vacancy rates, Recruitment and Retention Premia (RRP) is being used where there are difficulties in recruiting to positions that are in competition with the private sector etc. All KPI information is available at cost centre level.	Reports on key workforce issues are considered monthly by the Board and EMT Annual reports from the exit questionnaires.	Benchmarking against other appropriate Trusts	The gap is that although information is available it is not always used to inform decisions.	**The HR Managers will work with the Divisions to plan more effectively using the information available. They can liaise with the other parts of the HR Directorate (principally recruitment) to plan effective recruitment campaigns for hard to recruit to posts. The HR Advisers can work with identified areas** **An Independent review of temp staffing is required to identify further gaps.**
5	Cost of Agency. Continue to increase the size of the Staff Bank in order to increase the fill rate for Bank staff rather than agency staff. Reach agreement with agencies on rates charged to the Trust.	The specialties that charge the highest rates are in hard to recruit to staff groups. There is a shortage of these staff nationally so they are equally as hard to appoint to the staff bank. We are exceeding the agency cap	Not Effective	Monitor the levels of registrants on the bank to measure increase in numbers and identify areas where cover levels are particularly low. Fill rates will show the change towards bank from agency	Divisional budget setting due to tighter planning controls. Reduction in Agency Pay	Reports from NHSI comparing other Trusts and how they breach the agency cap?	We cannot create a temporary (bank) workforce where it does not exist. Our best efforts may not allow us to recruit enough bank staff.	**Work with departments in order to increase the number of our own staff who work through the staff bank. Continue to negotiate with agencies to reduce the rates charged. Place additional internal controls on use of bank. JMcC/JH**
		Overall Control Effectiveness	60.0%					

Board Assurance Framework 2016/17.

Date on which data valid	30/09/2016

St George's University Hospitals NHS
NHS Foundation Trust

Corporate objective	Failure to retain critical community contracts (adult community, sexual health & health visiting)		
Risk description:	Unsatisfactory service user experience.	Caused by inadequate organisational focus, failure to engage commissioners effectively, insufficient data	This may result loss of revenue and income generating services and not provide the Trust with the strategic platform to manage the local system

BAF risk no	6	Scores	Initial	Today	Acceptable
		S(5) x (3)	15	15	10
Risk owner	COO				

Range of potential outcomes	Retain Contracts	Retain some contracts	Considerable Uncertainty	Lose most contracts	Lose Contracts	Outcome trajectory	Overall Assurance Rating	Committee Oversight
Current position			*				Assurance is inconclusive	**FINANCE & PERFORMANCE**

Control No	Control description	Gaps in control	Control Effectiveness	Assurance from first line of defence (**front line evidence** *of control effectiveness*)	Assurance from second line of defence (**management evidence** *of control effectiveness*)	Assurance from third line of defence (**independent evidence** *of control effectiveness*)	Gaps in assurance position	Further Action Planned
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1	Ensure Executive has clear information on the tender process/time scales/sign off to prevent problems occurring during the tender process. This will mitigate the risk of not producing a compliant bid on time.	Trust has significantly less corporate business development capability than comparable NHS and commercial organisations. The organisation does not have a commercial board.	Effective	Project plans at team level	Agreed plan for the work to return to EMT at regular intervals. Supporting DMB papers and Div F&P papers	Associate Non Executive Director with commercial expertise will be approached to provide external assurance and advice on the bid	The extent to which the tenders are subject to an appropriate assurance process.	**An internal timeline for the tender submission process will be produced which identifies key milestone and executive sign-off, for discussion at EMT on Sept 19 2016. (COO)**
2	Ensure CSD has an identified a tender, clinical, financial lead for each of the three tenders and planned the resource requirements to undertake the tender submission	The Trust is not well practiced in responding/ submitting multi million pound tenders. This could lead to unexpected/unplanned barriers that will need to be solved speedily to ensure submission of a compliant bid	Not Yet Tested	Evidence that staff roles have been identified	Issue identified in key papers. Work review by finance and other key corporate functions	None	Testing the resilience of the team to respond to changes	**Identify the executive team lead for ensuring that the organisation submits three strong tender bids. (COO)**
3	Internal and external communication strategy to ensure commissioners are assured that there is senior organisational focus, that staff are fully engaged in the process and patients are aware of the changes	The Trust does not have a well established executive to executive relationship with the commissioners leading the tenders. This could be perceived by commissioners as a lack of organisational commitment.	Not Yet Tested	Communication plan will be put in place	EMT papers, DMB papers, Div F&P papers	Feedback from commissioners	Impact and effectiveness of communication strategy	**Plan for ensuring commissioners are aware of organisational and executive commitment to submitting a strong tender bid. (COO)**
		Overall Control Effectiveness	33.3%					

Board Assurance Framework 2016/17.

Date on which data valid	30/09/2016

St George's University Hospitals NHS
NHS Foundation Trust

Corporate objective	Deliver our Transformation Programme enabling the trust to meet its operational and financial targets		
Risk description:	Failing to deliver the financial plan.	Caused by the combined effects of income volatility, insufficient liquidity or insufficient identification and delivery of CIP.	Year end deficit; unsustainable or unsafe clinical services; a significant deterioration in the COSRR under NSHI's RAF; and in the worst case entering 'Special Administration'.

BAF risk no	7	Scores	Initial	Today	Acceptable
Risk owner	CFO	S(5) x L(5)	25	25	15

Range of potential outcomes	Significantly exceed Control Total	Control Total exceeded but run rate reduced	Control total achieved	Break even	Surplus of operating income	Outcome trajectory	Overall Assurance Rating	Committee Oversight
Current position	*						Assurance is negative	**FINANCE & PERFORMANCE**

Control No	Control description	Gaps in control	Control Effectiveness	Assurance from first line of defence (**front line evidence** *of control effectiveness*)	Assurance from second line of defence (**management evidence** *of control effectiveness*)	Assurance from third line of defence (**independent evidence** *of control effectiveness*)	Gaps in assurance position	Further Action Planned
GUIDANCE NOTES	**DEFINE PRECISELY EACH CONTROL BEING USED TO MITIGATE THE RISK OF FAILURE. THIS IS KNOWN AS INTERNAL CONTROL** (Examples might include relevant policies, procedures, SFIs, clinical pathways or protocols, training, processes, systems of work, detection systems (such as complaints, incident reporting, monitoring budgets, contingency plans in the event of a problem etc.). **BE AS PRECISE AS POSSIBLE TO DEMONSTRATE HOW THE OBJECTIVE IS DELIVERED AND THEREFORE HOW THE RISK IS ROUTINELY MITIGATED.**	**IT IS QUITE NORMAL TO HAVE GAPS IN CONTROL. IN THIS BOX STATE THE UNDERLYING WEAKNESS IN EACH CONTROL (IF THERE IS A WEAKNESS).** Examples might include shortfall in completion of training, factors beyond the control of the Trust, performance not on track, poor compliance with procedures or policies etc. **AWARENESS OF GAPS IS A SIGN OF STRENGTH = BOARD INSIGHT AND LEADS TO BETTER DECISION MAKING**	How effective is this control? Select from one of the following options: (I) **Effective** (this control is working as intended); (ii) **Not Effective** (this control cannot be relied upon); or (iii) **Not Yet Tested** (the effectiveness of this control is not yet known).	WHAT EVIDENCE - **FROM SERVICE LINES** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include ward/department-level data, service line reports.	WHAT EVIDENCE - **FROM CORPORATE MANAGEMENT** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include corporate reports - Directors' reports, output from EMC review or DPR, Clinical Audit, management checks/visits/observations.	WHAT EVIDENCE - **FROM INDEPENDENT SOURCES** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include internal or external audit reports, patient/staff surveys, CQC intelligent monitoring or investigation, Healthwatch, assurance from Commissioners, Deanery reports or reviews commissioned from any other third party	GAPS IN ASSURANCE ARE SELF EVIDENT WHEN USING THIS METHODOLOGY - IF THERE IS NO EVIDENCE THEN THERE IS A GAP IN KNOWLEDGE AND THUS A GAP IN ASSURANCE. REASSURANCE IS ASSURANCE WITHOUT EVIDENCE - IT REPRESENTS A BELIEF AND IS NOT SUFFICIENT FOR EFFECTIVE GOVERNANCE. **IN THIS BOX OUTLINE ANY GAPS IN KNOWLEDGE OF THE EFFECTIVENESS OF A CONTROL. USE INTELLIGENCE FROM HERE TO BUILD YOUR INTERNAL AUDIT PROGRAMME FOR THE MONTHS/YEAR AHEAD** **AWARENESS OF GAPS IS A SIGN OF STRENGTH = BOARD INSIGHT AND LEADS TO BETTER DECISION MAKING**	OUTLINE THE STEPS BEING TAKEN OR PLANNED TO IMPROVE THE DESIGN OR IMPLEMENTATION OF A CONTROL, OR ADDRESS A GAPS IN ASSURANCE. **IT MAY NOT BE NECESSARY TO APPLY ACTION TO EVERY GAP IN CONTROL OR ASSURANCE; SOME CONTROL WEAKNESSES OR GAPS IN KNOWLEDGE ARE INEVITABLE AND TOLERABLE. HOWEVER, ACTION IS REQUIRED WHERE A GAP IN CONTROL OR ASSURANCE IS NOT ACCEPTABLE AND COULD, IF NOT ADDRESSED, COMPROMISE THE DELIVERY OF OBJECTIVES OR THE BOARD'S CONFIDENCE IN DELIVERY OF ITS STRATEGY.** **ASSIGN TO AN EXECUTIVE DIRECTOR AND INCLUDE EXPECTED COMPLETION DATE.**
1	Income is reviewed at all levels of the organisation from budget holder to Trust Board. This includes a weekly assessment of income. A report is produced for the Finance & Performance Committee and subsequently the Trust Board which highlights current performance against plan, forecast performance against plan the significant risks associated with achieving the plan.	There are a number of key gaps: - Data reliability/accuracy: information assurance is weak - Timeliness of data availability and accuracy of clinical coding - Information may not be used to support operational delivery	Not Effective	Financial reports to the Trust Board have been routinely produced and have received scrutiny as to whether they are effective. Content of the reports are reviewed at least annually. Income reports are scrutinised as part of the divisional performance management meetings	Minimal changes required from Finance & Performance Committee prior to presentation of the reports to Trust Board	There is limited independent assurance but new finance NED will bring an additional level of independent challenge. NHSI is closely scrutinising income position	There are assurance gaps around: accuracy of clinical coding; utilisation of data and the flow through of greater activity into income and use of financial data and divisional/care group level.	**Further action is planned to:** **- improve clinical coding, and action plan has been agreed. CFO [date]** **- pre coding will be introduced (COO)** **- review the activity to income information flow. CIO/COO [date]**
2	Expenditure is reviewed at all levels of the organisation from budget holder to Trust Board. This includes a monthly provision of data to all budget holders. A report is produced for the Finance & Performance Committee and subsequently the Trust Board which highlights current performance against plan, forecast performance against plan the significant risks associated with achieving the plan.	There are a number of key gaps: - Management information is not user friendly and prevents effective budget management - There is a culture of non compliance with controls - The controls around the agency cap are weak	Not Effective	Financial reports to the Trust Board have been routinely produced and have received scrutiny as to whether they are effective. Content of the reports are reviewed at least annually. Income reports are scrutinised as part of the divisional performance management meetings, by finance depts. and commissioners. The trust has developed/is developing recovery plans for divisions and the corporate areas to reduce expenditure and has improved recruitment controls	Board Reports will monitor recovery plans closely and weekly reports will be provided to Executive Directors. Financial performance and workforce costs will be closely monitored through divisional and corporate performance meetings.	A budget maturity survey will be conducted by Internal Audit NHSI is closely scrutinising expenditure position	There is no assurance that recovery plans will be adhered to and this is currently untested.	**A recovery plan has been put in place and actions are routinely monitored**
3	The capital budget is closely monitored and regularly re-prioritised against emerging requirements through the capital programme board. Discussions are on going with NHSI around releasing further capital to address single point of failure risks.	The key control gap is that additional capital expenditure is pending approval from NHSI and spending is currently proceeding at risk	Not Yet Tested	Financial reports to the Trust Board include an analysis of the capital position. IDDG is increasingly reviewing the capital budget and re-prioritising spend.	Evidence that capital spend is being reviewed against emerging priorities and starting to be triangulated against the risk register	NHSI is closely scrutinising the capital funding position and bids for additional capital	Major capital projects are subject to cost/time overruns and have impacted activity/income levels	**Further action is planned to secure the capital from NHSI** **Further assurance is required around delivery of the capital plan**
4	The Trust has an established CIP programme which is managed and monitored through the transformation/turnaround board	There are a number of key gaps: - current forecast savings from the CIP programme are not sufficient to deliver the savings requirement - there is no contingency available to deal with unexpected or unforeseen cost pressures - the capacity and capability of the organisation to deliver the CIP programme is untested - the controls are limited and there may be insufficient accountability for delivery	Not Effective	Financial reports include CIP performance.	The Board receives regular reports on key turnaround programmes	An Internal Audit will be conducted into the programme in quarter 2.	The CIP programme savings programme has slipped significantly and is not currently projected to deliver the required level of savings	
5	The trust manages the cash position closely and is in active discussion with NHSI to improve the facility. Action is being taken to improve the debt position and ensuring staff are not overpaid.	The current total forecast borrowing requirement for the year is around £107m in month 4, £75m greater than planned. The trust is seeking to secure additional draw downs to manage the cash position by end September	Effective	Financial reports include a detailed analysis into the cash position	EMT papers on cash management and managing down the debt position	Internal audit of core financial controls. External audit report	The external audit has highlighted significant weakness in the core financial controls.	
		Overall Control Effectiveness	20%					

Board Assurance Framework 2015/16.

Date on which data valid 31/08/2016

St George's University Hospitals NHS
NHS Foundation Trust

Corporate objective	Ensure the trust has an unwavering focus on all measures of quality and safety, and patient experience
Risk description:	Failing to provide safe, high quality and a satisfactory experience of care for service users. Caused by poor compliance with safety critical procedures; inadequate care planning; inaccurate patient-level risk assessment; inadequate clinical engagement; demand or workload pressures; inadequate staffing levels; demotivated or unhappy colleagues; insufficient training and/or supervision; service user engagement and compliance with treatment. Severe harm or death to service user(s); loss of public/stakeholder confidence; and/or a breach of CQC registration regulations.

BAF risk no	Scores	Initial	Today	Acceptable
Risk owner DOG	5(5) x (L4)	20	20	10

Range of potential outcomes	Suspension of CQC Registration	Inadequate Compliance Warning / Enforcement Undertakings in place	Requires Improvement	Good	Outstanding Overall	Outcome trajectory	Overall Assurance Rating	Committee Oversight
Current position		*				↓	Assurance is negative	QUALITY COMMITTEE

Control No	Control description	Gaps in control	Control Effectiveness	Assurance from first line of defence (**front line evidence** *of control effectiveness*)	Assurance from second line of defence (**management evidence** *of control effectiveness*)	Assurance from third line of defence (**independent evidence** *of control effectiveness*)	Gaps in assurance position	Further Action Planned
GUIDANCE NOTES	**DEFINE PRECISELY EACH CONTROL BEING USED TO MITIGATE THE RISK OF FAILURE. THIS IS KNOWN AS INTERNAL CONTROL** (Examples might include relevant policies, procedures, SPIs, clinical pathways or protocols, training, processes, systems of work, detection systems (such as complaints, incident reporting, monitoring budgets, contingency plans in the event of a problem etc.). **BE AS PRECISE AS POSSIBLE TO DEMONSTRATE HOW THE OBJECTIVE IS DELIVERED AND THEREFORE HOW THE RISK IS ROUTINELY MITIGATED.**	**IT IS QUITE NORMAL TO HAVE GAPS IN CONTROL. IN THIS BOX STATE THE UNDERLYING WEAKNESS IN EACH CONTROL (IF THERE IS A WEAKNESS).** Examples might include shortfall in completion of training, factors beyond the control of the Trust, performance not on track, poor compliance with procedures or policies etc. **AWARENESS OF GAPS IS A SIGN OF STRENGTH = BOARD INSIGHT AND LEADS TO BETTER DECISION MAKING**	How effective is this control? Select from one of the following options: (i) **Effective** (this control is working as intended); (ii) **Not Effective** (this control cannot be relied upon); or (iii) **Not Yet Tested** (the effectiveness of this control is not yet known).	WHAT EVIDENCE - **FROM SERVICE LINES** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include ward/department-level data, service line reports.	WHAT EVIDENCE - **FROM CORPORATE MANAGEMENT** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include corporate reports - Directors' reports, output from EMC review or DPR, Clinical Audit, management checks/visits/observations.	WHAT EVIDENCE - **FROM INDEPENDENT SOURCES** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include internal or external audit reports, patient/staff surveys, CQC intelligent monitoring or investigation, Healthwatch, assurance from Commissioners, Deanery reports or reviews commissioned from any other third party	GAPS IN ASSURANCE ARE SELF EVIDENT WHEN USING THIS METHODOLOGY - IF THERE IS NO EVIDENCE THEN THERE IS A GAP IN KNOWLEDGE AND THUS A GAP IN ASSURANCE. REASSURANCE IS ASSURANCE WITHOUT EVIDENCE - IT REPRESENTS A BELIEF AND IS NOT SUFFICIENT FOR EFFECTIVE GOVERNANCE. **IN THIS BOX OUTLINE ANY GAPS IN KNOWLEDGE OF THE EFFECTIVENESS OF A CONTROL. USE INTELLIGENCE FROM HERE TO BUILD YOUR INTERNAL AUDIT PROGRAMME FOR THE MONTH/YEAR AHEAD** **AWARENESS OF GAPS IS A SIGN OF STRENGTH = BOARD INSIGHT AND LEADS TO BETTER DECISION MAKING**	OUTLINE THE STEPS BEING TAKEN OR PLANNED TO IMPROVE THE DESIGN OR IMPLEMENTATION OF A CONTROL, OR ADDRESS A GAPS IN ASSURANCE. **IT MAY NOT BE NECESSARY TO APPLY ACTION TO EVERY GAP IN CONTROL OR ASSURANCE; SOME CONTROL WEAKNESSES OR GAPS IN KNOWLEDGE ARE INEVITABLE AND TOLERABLE. HOWEVER, ACTION IS REQUIRED WHERE A GAP IN CONTROL OR ASSURANCE IS NOT ACCEPTABLE AND COULD, IF NOT ADDRESSED, COMPROMISE THE DELIVERY OF OBJECTIVES OR THE BOARD'S CONFIDENCE IN DELIVERY OF ITS STRATEGY.** **ASSIGN TO AN EXECUTIVE DIRECTOR AND INCLUDE EXPECTED COMPLETION DATE.**
1	A new **Policy Hub** is available which provides employees with access to all policies, standard operating procedures, approved clinical guidelines, clinical pathways and other 'control documents' which direct employees to undertake their duties in a particular way. **Policies, procedures and guidelines are searchable**. **An archive of control documents is maintained** and retained for the statutory period.	The corporate oversight of the quality of policies is weak An archive is maintained however it is likely to be incomplete due to problems maintaining the site. There is no current functionality within the site to track usage	Effective	Informal feedback has been positive from launch and end users can contact the corporate team to report any problems or issues with the site including technical.	253 policies were on the Hub however 83 (33%) require review and 2 new policies are under development as of July 2016 A list of current policies, expiry dates is maintained in a single register and actively managed	There has been no external assurance conducted		Further development of the policy hub is underway and a programme to ensure that all policies are up to date has been commenced. (Trust Secretary) User count functionality will be added to the site [TS Sept]
2	**Mandatory training** is provided and completed by colleagues to ensure safety-critical controls are implemented. MAST is provided both via face to face and e-learning packages Reports upon compliance are available via the intranet for all staff to access.	Compliance by topic, service and individual is available via the ARIS system There are capacity issues which impact on provision of Manual handling and Resuscitation. Release of staff is problematic due to current staffing constraints. Reconciliation between manual records and electronic records means accuracy of reporting is compromised. Problems with information flows at induction to enable training team can ensure new staff have access to e-learning	Not Effective	No info available from staff survey	MAST training by topic is evaluated pre and post training and is available to all in evaluating training modalities. Trust compliance overall is currently 79% against a target of 85% and 78% against a target of 95% for Information Governance.	Last internal audit report received in August 2015 and gave limited assurance with 9 recommendations, two of these are still outstanding. Trajectory for recovery is very positive - increase from 65% in April to 79% end of August.		Review resus training capacity and resource (HRD) Targeting of lowest compliance department to provide focused support (HRD) HR Mgrs. and Divisions reviewing 3 months following staff inductions those staff who still haven't completed MAST (HRD)
3	To keep risk under prudent control at all times, **risk is proactively identified, evaluated, treated, reported and reviewed**. Risk registers are recorded and maintained in a single Datix database and accessed by trained risk register gatekeepers. A risk escalation mechanism is in place to govern the movement of risk between the Ward/Dept. and Board. Good Governance Masterclasses are rolled out to engage and support front line teams to improve their capacity to handle risk.	Risk Management is operating at a low-level of maturity - predominantly reactive and retrospective. Insufficient anticipation of future risks, including external risks which may impact on objectives. Corporate Risk Register requires substantial development (identified in July 2016). The Trust is exposed to very high number of significant/extreme risk as at July 2016. The quality of risk registers is not meeting required standards. Details on control and further action is not always clear, and scoring unreliable for decision-making purposes. There are now staff trained within each division to manage risks and act as 'gatekeepers', in total there are 24 divisional/corporate directorate staff trained as at end Aug 16. The identified areas which do not have risks captured on the Datix system are Turnaround/PMO and the Clinical Research Facility.	Not Effective		Risk Management Policy reviewed and updated in July 2016. New scoring methodology and risk escalation mechanism introduced. Corporate Risk Register reviewed and updated, but more work is needed to incorporate risk to all access targets. Six good governance masterclasses have been held so far, dates are on-going. To date a total of 208 staff have attended. Datix has been upgraded to the latest version.	Most recent internal audit of Risk Management March 2016: Reasonable Assurance. 3 recommended actions - now undertaken. The CQC identified concerns about risk management in respect of the Renal Unit and Lanesborough OPD Estate, and also the absence of a BAF. Trust subject to regulatory intervention: CQC Warning Notice Section 29a matters.		Monitor closely the implementation of the Risk Management Policy, risk grading matrix and use of the risk escalation mechanism. (DQG) Increase oversight and challenge of risk registers through the Risk Management Committee - Chaired by the CEO. All Divisions and Corporate Functions shall be reviewed regularly as part of a rolling programme. (DQG) Extend the roll out of the Good Governance Masterclasses - reaching out into other locations in addition to SGUH - and continue with events up to
4	**Incident Reporting and Learning**: employees are able to report incidents and near misses. Reports are evaluated by management, investigated and prompt action taken to reduce risk. There is an open culture wherein colleague are free to report without fear or punishment. Trends are analysed and controls strengthened to enhance learning and minimise risk for patients, staff, contractors and visitors. Serious incidents are thoroughly investigated and action monitored closely. Staff are able to report anonymously and confidentially (Whistle blowing).	Up to date Serious Incident Policy and Adverse Incident Reporting Policy both in place. Incidents are not reviewed by management within timescales set out in policy - current backlog still exists. Main issues raised by users of Datix around large circulation lists and lack of clarity as to lead reviewer responsibilities. New Datix server procured in July 2016 and regular data back ups undertaken. Several hours of unplanned downtime in the last 12 months across on 30 June/1st July (overnight) and planned downtime to upgrade to new server on 28 July. New server will prevent unplanned downtime but in the event of this a BCP is in place to revert to paper reporting.	Not Effective	NHSI Learning from Mistakes league March 2016 Trust rated as poor reporting culture - red flags in following areas: Fairness and effectiveness of procedures for reporting errors, near misses and incidents Staff confidence and security in reporting unsafe clinical practice Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. Whistleblowing procedure used twice in 2016/17. Feedback on whistleblowing process collated by Head of Corporate Affairs.	Currently 2360 incidents either in review (1138) or awaiting a review (1222) (avg 1200 reported per month). Significant reduction in misplaced NG tube incidents following targeted actions arising from SIs. Number of significant harm pressure ulcers significantly reduced following thematic analysis and implementation of actions in response to PU SIs/incidents. HESL report November 2015 critical of lack of management response to incidents reported by Vascular and IR trainees. No flags or concerns highlighted through NRLS benchmarking	last audit of Incident reporting system undertaken in April 2014: Overall Reasonable Assurance. Main criticisms have been encompassed in on-going work within QIP plan. Formal feedback from CQC inspection June 2016 awaited but early feedback critical of delay in STEIS notifications and allocation of SI panels within STNC division. Trust now using most current version of Datix (version 14). Trust subject to regulatory intervention: CQC Warning Notice Section 29a matters.		Deliver detailed actions encompassed within the Quality Improvement plan by end of Sept 2016 (DQG) Roll out training and focus groups following upgrade to Datix system (DQG)
5	**Complaints:** service users are able to report their concerns, complaints and compliments. The Trust responds quickly to any concerns identified and takes action promptly to minimise risk and improve services for patients.	Poor compliance with timescales for response Poor quality of response Increasing numbers of complaints failure to identify/implement lessons learned Fragility of central complaints team due to long term sickness impacting upon performance Complaints training provided by central team but not attended	Not Effective	Weekly complaints team meetings with services to trouble shoot Tracker report monthly to board and overseen by DGBs	Performance reports continue to show the Trust is not meeting its targets for responding to complaints within 25 working day, and not meeting revised targets agreed with the complainant. Complaints now forming part of quality and performance reviews with Divisions. Improved quality of response due to decreasing no. of CEO rejections (June 18% reduced to 6% in Aug).	Most recent audit of complaints handling March 2016: Limited Assurance. Four recommended actions underway currently. Eight final reports received following PHSO referrals for independent review in 2015/16: Five not upheld, two upheld and one partially upheld and were reasonable. Recommendations made in upheld/partially upheld cases.	No formal benchmarking available. Unable to ascertain until November if trajectories and improvements contained within Divisional action plans are met and position improved.	Action plan both corporate and by Division is underway - to be included in the QIP (DQG) Revised reporting format to Patient Safety and Quality Board to be developed. (DQG) Peer review planned by a similar sized NHS Trust before end of 2016 (Chief Nurse/DQG)
6	The Trust has a mechanism to **receive and rapidly act upon safety alerts received from the Central Alerts System**.	Central Alert System Policy up to date and in use. Processes well embedded and roles and responsibilities clearly defined and understood. One historical alert breached regarding intrathecal devices - now to be closed in line with to NHSE guidance that not possible to close until alternate device available on market. Regular reports to PSC and Commissioners.	Effective	Assurance to Risk Management Committee September 2016. 1 alert outstanding, all others addressed.				Amend reporting template to new PSQB to demonstrate continued compliance.
7	The Trust **complies with all NICE clinical guidelines, technology appraisals and interventional procedures guidance**. Any deviation from compliance is authorised on behalf of the Board of Directors by the Patient Safety & Quality Board. All new NICE guidance is triaged and escalated to clinical teams by Clinical Audit team. Technology appraisals are subject to a rapid response process and are referred to the Medicines Risk Mgmt. Committee.	NICE Policy overdue for review (Sept 2015) . Issues of non-compliance are often complex and are often due to their being multiple stakeholders No process in place currently to approve deviation from guidelines Adherence to NICE guidance is driven by service provision and resource.	Not Yet Tested	Some NICE guidance is evaluated by commissioners and others audited as part of National clinical audit program i.e. Fractured NOF. There is no central data held on which guidelines have been audited by care groups	there have been 821 NICE pieces of guidance received since 2010; StG are compliance with 655. Of the 145 outstanding 34 were received in the last quarter and are in the process of being followed up. For the remaining 111, work is ongoing with divisions to address and risk assess those non or partially compliant	CQC found process to be robust in 2014.		

8	There is a Quality Improvement Programme (QIP) in place to address identified weaknesses in respect of CQC compliance and Key Lines of Enquiry. The QIP addresses legacy action plans alongside findings fed by the CQC immediately after inspection in June 2016. The Trust has established a temporary governance arrangement known as the Quality Improvement Board to oversee delivery of the QIP. The Quality Improvement Board shall report to the Board via EMT, QRC F&P and Workforce committees.	The QIP will require updating and expanding following release of the CQC's June 2016 inspection report. The Trust has been advised that the CQC will service a Section 29A Improvement Notice (this had not been served at time of writing - 22/08/2016) Withdrawal of candidates means recruitment to PMO support for the QIP requires conclusion. Quality Improvement Board will meet for the first time in September.	Effective	QIP programme in place (but will need updating following release of the CQC's July 2016 inspection for St George's)	As at 22/08/2016 there were 164 actions across 10 work streams in the QIP. Of these: 88% (n=144) are on track as planned (Green); 6% (n=10) are behind schedule (Amber); 1.2% (n=2) are overdue (Red); and 4.8% (n=8) are embedded BAU.	Trust subject to regulatory intervention: CQC Warning Notice Section 29a matters.		**The QIP requires development following release of CQC report and Improvement Notice, and will require formal approval by the Board** **Need to conclude recruitment to temporary PMO Support**
		Overall Control Effectiveness	42.9%					

Board Assurance Framework 2016/17.

Date on which data valid	30/09/2016

St George's University Hospitals NHS
NHS Foundation Trust

Corporate objective	#REF!
Risk description:	Failing to achieve key performance targets mandated in the NHS Outcomes Framework and local contracts. Caused by surges in demand, acute staffing difficulties, closure of beds, ineffective patient flows, delayed discharges. This may result in breach of license conditions; failure to acquire new commissions or retain existing contracts with CCGs.

BAF risk no	9	Scores	Initial	Today	Acceptable
Risk owner	COO	S(5) x L(4)	20	20	15

Range of potential outcomes	Outlying clinical KPI performance, clinical outcomes and safe care	Worse than peer KPI performance, clinical outcomes and safe care	Compliant In line with peer	Better than peer KPI performance, clinical outcomes and safe care	Exemplar KPI performance, clinical outcomes and safe care	Outcome trajectory	Overall Assurance Rating	Committee Oversight
Current position		*					Assurance is positive	FINANCE & PERFORMANCE

Control No	Control description	Gaps in control	Control Effectiveness	Assurance from first line of defence (front line evidence *of control effectiveness*)	Assurance from second line of defence (management evidence *of control effectiveness*)	Assurance from third line of defence (independent evidence *of control effectiveness*)	Gaps in assurance position	Further Action Planned
GUIDANCE NOTES	**DEFINE PRECICELY EACH CONTROL BEING USED TO MITIGATE THE RISK OF FAILURE. THIS IS KNOWN AS INTERNAL CONTROL** (Examples might include relevant policies, procedures, SFIs, clinical pathways or protocols, training, processes, systems of work, detection systems (such as complaints, incident reporting, monitoring budgets, contingency plans in the event of a problem etc). **BE AS PRECISE AS POSSIBLE TO DEMONSTRATE HOW THE OBJECTIVE IS DELIVERED AND THEREFORE HOW THE RISK IS ROUTINELY MITIGATED.**	**IT IS QUITE NORMAL TO HAVE GAPS IN CONTROL. IN THIS BOX STATE THE UNDERLYING WEAKNESS IN EACH CONTROL (IF THERE IS A WEAKNESS).** Examples might include shortfall in completion of training, factors beyond the control of the Trust, performance not on track, poor compliance with procedures or policies etc. **AWARENESS OF GAPS IS A SIGN OF STRENGTH = BOARD INSIGHT AND LEADS TO BETTER DECISION MAKING**	How effective is this control? Select from one of the following options: (i) **Effective** (this control is working as intended); (ii) **Not Effective** (this control cannot be relied upon); or (iii) **Not Yet Tested** (the effectiveness of this control is not yet known).	WHAT EVIDENCE - **FROM SERVICE LINES** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include ward/department-level data, service line reports.	WHAT EVIDENCE - **FROM CORPORATE MANAGEMENT** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include corporate reports - Directors' reports, output from EMC review or DPR, Clinical Audit, management checks/visits/observations.	WHAT EVIDENCE - **FROM INDEPENDENT SOURCES** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include internal or external audit reports, patient/staff surveys, CQC intelligent monitoring or investigation, Healthwatch, assurance from Commissioners, Deanery reports or reviews commissioned from any other third party	GAPS IN ASSURANCE ARE SELF EVIDENT WHEN USING THIS METHODOLOGY - IF THERE IS NO EVIDENCE THEN THERE IS A GAP IN KNOWLEDGE AND THUS A GAP IN ASSURANCE. REASSURANCE IS ASSURANCE WITHOUT EVIDENCE - IT REPRESENTS A BELIEF AND IS NOT SUFFICIENT FOR EFFECTIVE GOVERNANCE. **IN THIS BOX OUTLINE ANY GAPS IN KNOWLDGE OF THE EFFECTIVENESS OF A CONTROL. USE INTELLIGENCE FROM HERE TO BUILD YOUR INTERNAL AUDIT PROGRAMME FOR THE MONTHS/YEAR AHEAD** **AWARENESS OF GAPS IS A SIGN OF STRENGTH = BOARD INSIGHT AND LEADS TO BETTER DECISION MAKING**	OUTLINE THE STEPS BEING TAKEN OR PLANNED TO IMPROVE THE DESIGN OR IMPLEMENTATION OF A CONTROL, OR ADDRESS A GAPS IN ASSURANCE. **IT MAY NOT BE NECESSARY TO APPLY ACTION TO EVERY GAP IN CONTROL OR ASSURANCE; SOME CONTROL WEAKNESSES OR GAPS IN KNOWLEDGE ARE INEVITABLE AND TOLERABLE. HOWEVER, ACTION IS REQUIRED WHERE A GAP IN CONTROL OR ASSURANCE IS NOT ACCEPTABLE AND COULD, IF NOT ADDRESSED, COMPROMISE THE DELIVERY OF OBJECTIVES OR THE BOARD'S CONFIDENCE IN DELIVERY OF ITS STRATEGY.** **ASSIGN TO AN EXECUTIVE DIRECTOR AND INCLUDE EXPECTED COMPLETION DATE.**
1	Achievement of 95% Target. The delivery of the ED target has required focus on the activity and posture of the remainder of the hospital, and how it supports the delivery of bedflow throughout the Trust. In order to improve this, we have established a new means of delivering Site Control including Daily Performance Review, Assurance that the SAFER Bundle is being delivered via Board Rounds, Early Ward Rounds, and Effective Discharging via criteria-lead discharging. Further we have integrated the Community Division Team into the Daily process in order to establish a more compliant means	The main gap in control is the hospital operation at night. This has been mitigated by focus on a new 'Hospital at Night' programme. This is in its embryonic stage as at September 2016, however should be effective before the winter period.	Effective	Daily Performance Control Meetings. Weekly ED Action Meetings.	Weekly COO Performance Report EMT Board	London ED Results	Nil	**Full Unplanned Care Plan to Issue September 15 2016 incorporating improvements in SAFER, Rotas, Speciality Assistance in ED, Discharge of Medically Fit, Repatriations, Admission Avoidance of Frequent Attenders**
2	Delivery of Target Pathways at 2WW, 18 Week, 62 Days. Each service has provided a detailed plan on how it will tackle its current breaching backlog, as well as ongoing activity. The Trust has sufficient capacity to meet its ongoing demand, and deliver strong performance, however residual behaviours and practices will continue to pose a risk to sustained performance at the appropriate standard.	The main gap in control for the ongoing delivery of operational performance will be in the areas of Estate, IT, CSSD Equipment. Further gaps in control are those areas where we do not effectively control the demand referred to the hospital whereby certain Trusts will refer to SGUH significantly down the patient pathway, therefore reducing the ability for the hospital to act, and treat patients before the pathway has breached. The controls are being put in place to effectively manage demand at first receipt.	Not Effective	Daily Performance Control Meetings. Weekly ED Action Meetings. CCG Liaison - Monthly.	Weekly COO Performance Report EMT Board	South London Area CCG TRIPARTITE Meetings - NHSI - CCG - Trust	Nil	**Meetings planned for worst performing services to ensure the local Network supports services: for example ED Meeting on 15 September focussed on delivery of the ENT referrals in South London in a coordinated manner that issues demand to the most appropriate centres, rather than a lack of control that is epitomised in the current ENT structure with a large backlog in SGUH's returns.**
		Overall Control Effectiveness	50.0%					

South West London and St George's NHS
Mental Health NHS Trust

Board Assurance Framework 2016/17.

Date on which data valid 16/09/2016

Corporate objective	Ensure we make the most of our buildings and estate and maximise efficiency through improving back office and corporate functions
Risk description:	Failure to provide a suitable environment of care in all patient-facing areas and locations. Caused by insufficient backlog maintenance, inadequate response to concerns or requests for works, lack of access to capital, lack of decant options to enable remedial works to be carried out. This may result in unsatisfactory service user experience, harm to patients or staff, and in the worst case formal intervention by CQC, HSE, Environmental Health.

BAF risk no	11	Scores	Initial	Today	Acceptable
Risk owner	DOE&F	S(5) x L(5)	25	25	10

Range of potential outcomes	Endangerment to staff and patients/Formal external intervention	Inadequate service user experience/ Enforcement Undertakings	Requires Improvement but stable	Good	Outstanding Overall	Outcome trajectory	Overall Assurance Rating	Committee Oversight
Current position	*						Assurance is inconclusive	QUALITY COMMITTEE

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1	**Safety Management -** Health and Safety is controlled through the formation of policy, enabled through publication on the Trust's intranet and training carried out across the Trust. Mast Health and Safety training is carried out during induction and is refreshed every 3 years. All Health and Safety policies are kept up to date and are published on the intranet. Health and safety information is cascaded and communicated through the Trust's committee structures. The Health, Safety and Fire committee acts provides the consultative framework for escalation of non clinical risk from the front line staff to the Risk Management committee.	There are a number of key gaps: 1) resource availability for training is a big challenge and staff take up of provided training is inconsistent unless mandated 2) links to policies on the intranet fail on a consistent basis 3) not all equipment has been maintained in line with the equipment manufactures specifications as required under legislation 4) single point of failure for H&S policy making and communication. The organisation has no competent person cover for the Head of Health and Safety.	Not Effective	Line Managers are kept briefed of training undertaken by staff members. Policies are made visible to all on the intranet. H&S checklists are completed by wards and departments.	Numbers of staff completing training is reported and monitored through the Health, Safety and Fire committee and the Executive Management Team; any issues are addressed back through the divisional reporting lines. Policy reporting and communication takes place across all the Trust committees. Additional scrutiny takes place at the new Risk Management Board. H&S checklists are reviewed and updated annually.	Reporting is sent to the Health and Safety Executive where required to ensure compliance. Recent HSE investigations within the Trust have not produced enforcement notices.	There is only limited evidence that non clinical risks are routinely escalated in the correct manner through the Health, Safety and Fire committee. There is evidence through adverse incident reports and that Trust policies on Health, Safety and Welfare and NHS plans such as the Summer planning document are not routinely followed. There is a lack of auditable evidence within the corporate directorates of engagement with Trust Health and Safety policies and audits. Initial audits suggest that not all lost time incidents are being recorded as industrial injuries on the Health assure database	**1) The Health, Safety and Fire committee agenda and terms of reference are being reviewed in light of the recent changes to the governance structure. This will result in an updated governance system for non clinical risk. This will be completed by November 2016.** **2) A new Safety management quarterly report will be presented to the RMC in October 2016. This will detail a plan regarding closing the gaps in assurance. 3) A new Health and Safety risk assessment document will be presented to the RMC in October 2016 . This will aim to provide clear information and action regarding non clinical risk. 4) The updated Health, Safety and Welfare E-MAST module for staff who manage other staff will be launched within the next quarter.** **All actions owned by Zac Briggs.**
2	**Fire Safety Management** - Fire Safety management is in place through a policy that was established in June 2016 and ratified through the Trust's Ratification Panel. Fire safety training is undertaken from new starters as part of their induction, Fire Warden training through to annual refresher courses. Two Risk Assessors have been hired to carry out required training and this has greatly improved what we are delivering, to ensure alignment with HTM05 and the Fire safety Act 2005. £5m capital spend has been requested to alleviate the issues for 2016/17.	There are a number of key gaps: 1) resource availability for training is a big challenge and staff take up of provided training is usually poor unless mandated 2) remedial works on significant findings of fire assessment needed 3) aging estate and estate infrastructure	Not Yet Tested	Upgrades from level 2 to a level 1 fire alarm system is underway, which has halved the false alarm call outs to London Fire brigade. Doors are being replaced with appropriate fire doors across the estates. Assessed and replaced all fire extinguishers in the Lanesborough Wing, work will continue across the estate.	Reporting is carried out bi-monthly to the Trusts' Health and Safety Board and an annual Fire report, based on HTM05 requirements to provided. We are reporting on the number of Senior Nursing staff who have undertaken the Fire training to the Trust Board and CQC. Desktop evacuation procedures are carried out on an ongoing basis. Legal advice has been taken to understand current position and to assess further steps E&F need to take.	The London Fire Brigade (LFB) are pleased with the Trusts current progress and week commencing 12/09/16 we are signing an accord with the LFB to show we are working in partnership. Letter from LFB with current assessment of the trust for Fire Safety.	Staff are not attending planned training slots.	**1) Carry out the remedial works planned to address the main service corridor on the ground floor of LW to provide a fire rated corridor.** **2) Estates and Facilities will set up ward based scenario Safety and Fire training.** **3) Continue with the upgrade of fire extinguishers, fire compartmentalisation and fire extinguishers across the estate.** **All actions will be carried out through to 31/03/17 and are owned by Neil Fogg.**
3	**Utilities -** Utilities are reported and governed through the various Trust committees. To address gaps, capital has been requested or is in the process of being requested for modernisation and replacement of drainage across some of the aged estate.	There are a number of key gaps: Electricity 1) Aged electrical distribution system on HV and LV 2) Fixed wire testing hasn't been undertaken for the whole of the estate Steam distribution 3) Need to replace sections of aged steam main and installation of double isolation valves for safety Gas 4) The provision is needed to carry out business continuity for gas failure, possibly utilisation external resource for speed. Drainage 5) The sewage and drainage system is aged and in need of replacement in certain areas. Heating	Not Yet Tested	Regular reporting is carried out consistently and made available to the appropriate committee. There are committees for all the Utilities.	Reporting for all Utilities takes place within the Trusts relevant committees, which feed into the Risk Management committee.	Risks and mitigations are reviewed with both the CCGs and NHSI	Under investment over a number years has led to the gaps SGUH now has.	**Electricity** **1) Parts of the annual routine maintenance budget and emergency funding will be targeted on replacing the most critical infrastructure starting in LW and SJW, covering generators, switch gear and transformers. This will increase our overall electrical capacity and is a key enabler for the provision of new Theatres and adequate cooling, simultaneously reducing our electrical capacity overload.** **2) Fixed wire testing is underway for the remainder of the estate, est. duration to deliver this will be 12 months and this will be put under ppm.** **Steam distribution** **3) A campus wide six facet survey is being procured, this will identify the areas for priority repairs. The replacement of double isolation valves will be included to reduce the risk of whole site outage.** **Gas** **4) Due to internal staffing constraints and to provide 360 cold eye review of existing plans we will be engaging with a 3rd party.** **Drainage** **5) Started a drain clearance regime ahead of autumn and spring and as we develop the south side of the estate, enlarged drainage of all sorts, will be brought into the site.** **All actions owned by Neil Fogg**
4	**Heating Management** - Heating is run with an aged infrastructure, we suffered failure in heating during last winter across parts of the Tooting estate. New British Gas performance contract set over a 15 year period to replace central boiler plant by Autumn 2017.	There is a key gap here: 1) Aging 50 year old infrastructure is moving under a new contract with Centrica, which is not currently delivering in a timely manner	Not Yet Tested	Regular reporting is carried out consistently and made available to the appropriate committee.	Reporting for heating takes place through the Health, Safety and Fire committees and follow the trust governance processes.	Risks and mitigations are reviewed with both the CCGs and NHSI	Under investment over a number years has led to the gaps SGUH now has. It should be noted that the rented boilers are not as robust as our fully owned ones, they are small powerful units designed to be switched on for quick bursts.	**1) Existing boilers are being refurbished, taking place up to August 2017. E&F have rented further boilers which will be in place by week ending the 16/10/16. This will provide up to 5 working boilers to support heating across the estate, as it requires two for the heating to be operational. To address the delivery from Centrica, there are dedicated resources in place to monitor and keep the Centrica team on track, along with Quarterly meetings with the Centrica board.** **The action is owned by Neil Fogg**

5	**Water Safety Management** - Water safety is reported and governed through the water safety committee, the infection control committee and up through to the Quality and Risk committee. Water testing is carried out in line with plans and to understand impacts of water treatments, such as flushing on water quality. New hires in place to address single points of failure for water flushing as of 16/09/16.	There are a number of key gaps here: Water 1) Issue of Legionella across various sections of the estate, requiring replacement of aged plants and removal of dead legs 2) Water flushing regime has not been recorded, as required 3) Water bore hole extraction is limited and will not support expansion of the hospital without an increased extraction agreement	Not Yet Tested	Regular reporting is carried out consistently and made available to the appropriate committee.	Reporting for water safety takes place through the water safety committees and follow the trust governance processes. Legal advice has been taken to understand current position and to assess further steps E&F need to take.	Risks and mitigations are reviewed with both the CCGs and NHSI	Under investment over a number years has led to the gaps SGUH now has. Where properties are leased (such as parts of the community estate) the resolution of water borne infections are under the control and management of the landlord/s. Details and evidence of which must be provided to Estates and Facilities.	**1) Replacement of aged plant is underway, we have emergency funding of 1.5m to replace the GW water plant this and the removal of dead legs will reduce this risk.** **2) Flushing now in the hands of the Estates team and a new flushing regime is in place. Evidence will be sent to the Trust Board and 5 days later reported to the CQC.** **3) Estates will monitor amount of water being extracted, if this looks like it is getting closer to capacity then we will apply for an extraction. If extension not provided we may have to apply to Thames Water.** **All actions to be owned by Neil Fogg.**
6	**Business Continuity -** Business Continuity plans are documented and are subject to the Customers contingency requirements e.g. dependent on whether there is a requirement for patients to be moved or services to be diverted. The boiler house have two stand by boilers so if SGUH lost steam E&F would still be able to provide Steam to the site.	There are a number of key gaps here: 1) Not all areas have full detailed continuity plans which are needed to provide insight to the viability and direction of the Estates and Facilities business continuity plans. In some cases other areas continuity plans refer only to Estates and Facilities for business continuity. 2) Continuity plans are not sustainable in all cases and may only be relevant for a 48 hour period, if longer plans are required then sustainability needs to be explored. 3) There is currently no Emergency Planning and Liaison Officer at SGUH.	Not Effective	Plans are created and submitted to divisional leads.	Business continuity plans are submitted for review to the Trust board.	Business continuity plans are submitted and signed off independently. Risks are reviewed with SGUH by the CCGs and NHSI	There are assurance gaps with respect to sustainability of the business continuity plans.	**1) Review of all Estates and Facilities business continuity plans to check for sustainability Short, Medium and Long term.** **2) Review all departments business continuity plans to ensure requirements are well understood and alignment to overall Estates and Facilities Business Continuity plans.** **3) Recruitment for an Emergency Planning and Liaison Officer is currently underway with a view to being imminently filled.** **All actions to be owned by Neil Fogg and are due by December 2016.**
7	**PAM and related controls -** Estates and Facilities (E&F) appointed NIFES in June 2016 to assist in the collection of data for the PAM assessment. A number of overview sessions have been held with E&F staff in July and with the senior management team in August.	There is a key gap here: 1) Further interviews need to be conducted with staff to ascertain the necessary information to progress the PAM assessment. This will be reliant on staff availability and the exigencies of the Trust.	Not Yet Tested	Attendance at overview sessions and interviews planned.	Attendance at overview sessions and interviews planned.	Independent review carried out and recommendations made.	The PAM actions are yet to be confirmed and agreed.	**1) Interviews will be conducted around the trust to provide the necessary information and complete the scoring for the PAM. On completion of this NIFES will provide a list of outstanding /recommended actions. Following this Estates and Facilities will be able to provide budget costs (capital and revenue) to complete the outstanding/recommended actions to raise the PAM to a suitable level (good/outstanding.** **All actions to be owned by Neil Fogg and are due by December 2016.**
8	**Investment -** Investment is divided up across Estates and Facilities, through alignment to overall strategies and to deliver agreed capital investments.	There are a number of key gaps here: 1) Whilst emergency capital has been requested from NHS Improvement the finances are yet to be fully made available. Controls and improvements of any gaps across Estates and Facilities are dependent on this funding. 2) There is limited visibility of all change underway across the Trust making it difficult to understand any overlaps, duplication in dependencies and conflicts (with respect to the order of delivery and/or over/under stating benefits). 3) Change control has not been rigorously applied in the past and so past requests have impacted ability to deliver to time and cost.	Not Yet Tested	Spend is monitored within the individual projects and departments. This is reported on a regular monthly basis through the governance boards.	All new capital spend is approved through the Investment Divestment Disinvestment Group (IDDG), capital spend is then monitored through the monthly Capital Programme Monitoring Group.	Independent audits are carried out annually across the Estates and Facilities group.	Attendance at the IDDG and the CPMG differs, visibility of outputs may not be available to attendees of both meetings. Assurance across portfolios needs to include cross dependencies. Benefits need to be aside across the wider Trust portfolio of change.	**1) Implementation of a robust Change Control process, by November 2016. Action owned by Sharon Welby.** **2) Enterprise picture of change made visible and interdependencies with other Trust projects understood by November 2016. Action owned by Sharon Welby.** **3) Continue with change required to mitigate the risks identified across SGUH Estates and Facilities which is wholly dependent on the funding required and only in part received. Action owned by Richard Hancock.**
		Overall Control Effectiveness	0.0%					

Board Assurance Framework 2016/17.

Date on which data valid	30/09/2016

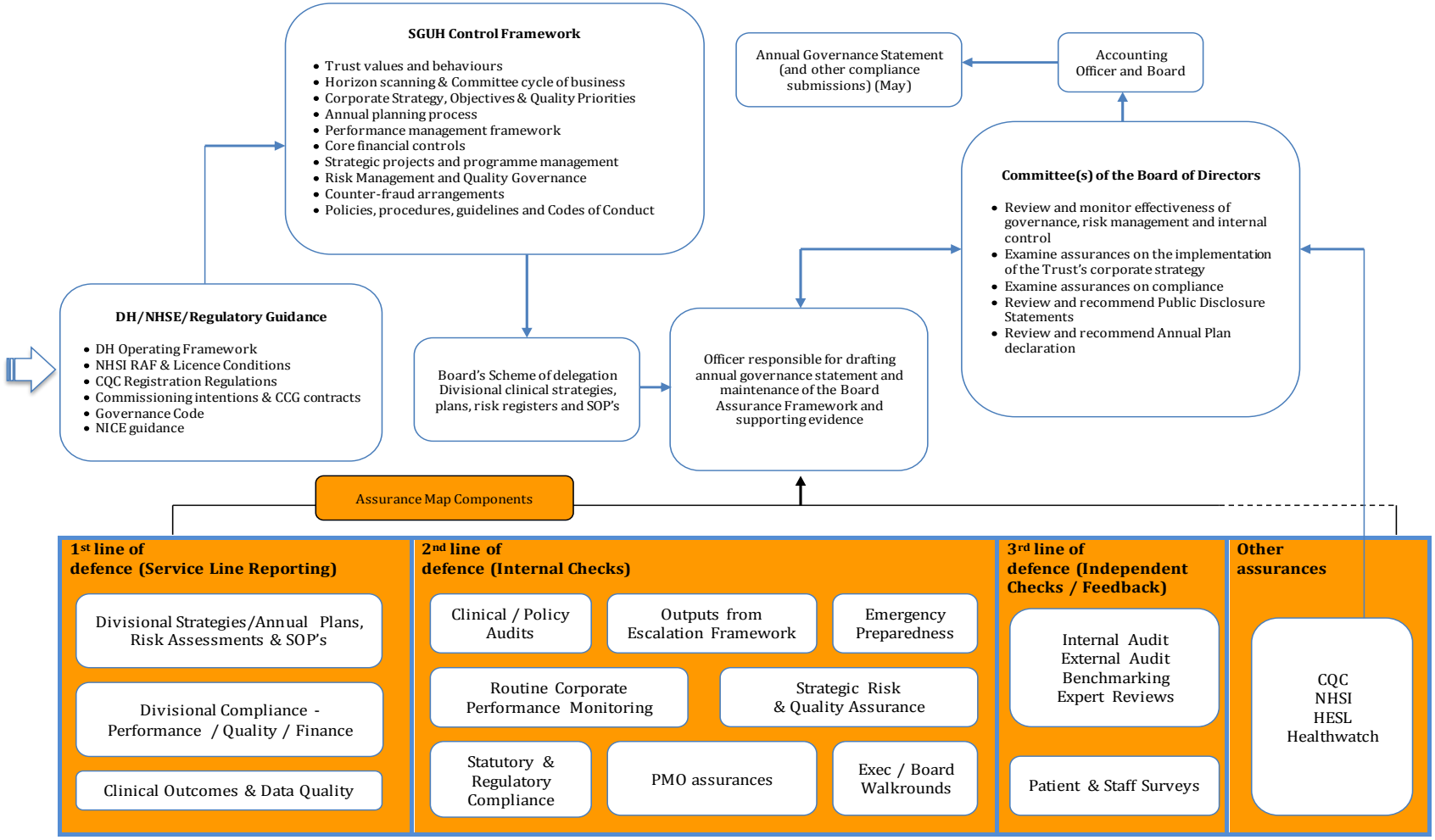
St George's University Hospitals NHS
NHS Foundation Trust

Corporate objective	Ensure we make the most of our buildings and estate and maximise efficiency through improving back office and corporate functions		
Risk description:	Prolonged and unrecoverable critical IT system down time.	Caused by ageing IT infrastructure, IT infrastructure unfit for current Trust needs, lack of access to capital, poor staff compliance, insufficient resilience plans, failure to capture back up.	This may result in immediate and widespread operational instability, failure to capture and report data, failure to maintain a patient record, inability to treat patients in a timely way.

BAF risk no	12	Scores	Initial	Today	Acceptable	Range of potential outcomes	IT enabling rapid transformation	IT supporting transformation	IT stable and consistent	IT system has limited system resilience	IT failures regularly occur	Outcome trajectory	Overall Assurance Rating	Committee Oversight
Risk owner	CIO	S(5) x L(5)	25	25	10	Current position					*		Assurance is negative	FINANCE & PERFORMANCE

Control No	Control description	Gaps in control	Control Effectiveness	Assurance from first line of defence (**front line evidence** *of control effectiveness*)	Assurance from second line of defence (**management evidence** *of control effectiveness*)	Assurance from third line of defence (**independent evidence** *of control effectiveness*)	Gaps in assurance position	Further Action Planned
GUIDANCE NOTES	**DEFINE PRECISELY EACH CONTROL BEING USED TO MITIGATE THE RISK OF FAILURE. THIS IS KNOWN AS INTERNAL CONTROL** (Examples might include relevant policies, procedures, SFIs, clinical pathways or protocols, training, processes, systems of work, detection systems (such as complaints, incident reporting, monitoring budgets, contingency plans in the event of a problem etc.). **BE AS PRECISE AS POSSIBLE TO DEMONSTRATE HOW THE OBJECTIVE IS DELIVERED AND THEREFORE HOW THE RISK IS ROUTINELY MITIGATED.**	**IT IS QUITE NORMAL TO HAVE GAPS IN CONTROL. IN THIS BOX STATE THE UNDERLYING WEAKNESS IN EACH CONTROL (IF THERE IS A WEAKNESS).** Examples might include shortfall in completion of training, factors beyond the control of the Trust, performance not on track, poor compliance with procedures or policies etc. **AWARENESS OF GAPS IS A SIGN OF STRENGTH = BOARD INSIGHT AND LEADS TO BETTER DECISION MAKING**	How effective is this control? Select from one of the following options: (i) **Effective** (this control is working as intended); (ii) **Not Effective** (this control cannot be relied upon); or (iii) **Not Yet Tested** (the effectiveness of this control is not yet known).	WHAT EVIDENCE - **FROM SERVICE LINES** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include ward/department-level data, service line reports.	WHAT EVIDENCE - **FROM CORPORATE MANAGEMENT** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include corporate reports - Directors' reports, output from EMC review or DPR, Clinical Audit, management checks/visits/observations.	WHAT EVIDENCE - **FROM INDEPENDENT SOURCES** - IS AVAILABLE TO DEMONSTRATE HOW EFFECTIVE THE CONTROL IS IN PRACTICE? Examples might include internal or external audit reports, patient/staff surveys, CQC intelligent monitoring or investigation, Healthwatch, assurance from Commissioners, Deanery reports or reviews commissioned from any other third party	GAPS IN ASSURANCE ARE SELF EVIDENT WHEN USING THIS METHODOLOGY - IF THERE IS NO EVIDENCE THEN THERE IS A GAP IN KNOWLEDGE AND THUS A GAP IN ASSURANCE. REASSURANCE IS ASSURANCE WITHOUT EVIDENCE - IT REPRESENTS A BELIEF AND IS NOT SUFFICIENT FOR EFFECTIVE GOVERNANCE. **IN THIS BOX OUTLINE ANY GAPS IN KNOWLEDGE OF THE EFFECTIVENESS OF A CONTROL. USE INTELLIGENCE FROM HERE TO BUILD YOUR INTERNAL AUDIT PROGRAMME FOR THE MONTHS/YEAR AHEAD** **AWARENESS OF GAPS IS A SIGN OF STRENGTH = BOARD INSIGHT AND LEADS TO BETTER DECISION MAKING**	OUTLINE THE STEPS BEING TAKEN OR PLANNED TO IMPROVE THE DESIGN OR IMPLEMENTATION OF A CONTROL, OR ADDRESS A GAPS IN ASSURANCE. **IT MAY NOT BE NECESSARY TO APPLY ACTION TO EVERY GAP IN CONTROL OR ASSURANCE; SOME CONTROL WEAKNESSES OR GAPS IN KNOWLEDGE ARE INEVITABLE AND TOLERABLE. HOWEVER, ACTION IS REQUIRED WHERE A GAP IN CONTROL OR ASSURANCE IS NOT ACCEPTABLE AND COULD, IF NOT ADDRESSED, COMPROMISE THE DELIVERY OF OBJECTIVES OR THE BOARD'S CONFIDENCE IN DELIVERY OF ITS STRATEGY.** **ASSIGN TO AN EXECUTIVE DIRECTOR AND INCLUDE EXPECTED COMPLETION DATE.**
1	Failure to comply with new working practices introduced as part of new ICT enabled change programme	Ensuring full and representative health care professionals' input into key areas. No sustainable funding has been identified, no clear plan for 2016/17 including ingoing funding of project team	Not effective	Multiple real time reports available including VTE, discharge, medication scanning which are review through the trust quality structure. Indications are that in areas where deployment has taken place quality has improved as well as revealing/creating challenges to existing practice	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. Communications being updated regularly at meetings and via the intranet Project team in place – support live areas to measure the use of the system and to drive optimisation of clinical care.	None	Deployment model broadly successful but sustainability to end point currently not viable	**Development of process for transition of clinical information projects into business as usual via the ICT Service Improvement Programme.** **Confirm IT priorities for 2016/17. (CIO)** **Determine ownership and BAU processes and resources for maintenance and management of the system post live.** **The introduction of electronic clinical systems may expose poor practice which will need to be recognised and addressed by the relevant governance processes. (CIO)**
2	Firewall	Current vulnerabilities of firewall place Trust internal information assets at *risk* A failure to protect against the threat of computer malware known as "Ransom ware" may affect Trust computer data resulting in a loss of Trust data if the affected files are not identified and restored within a short time frame. The risk amplified by data storage limitations on Trust network.	Not effective	1. Helpdesk Logs 2. Tested network back-ups NHS N3 gateway anti malware software Local Websense anti malware software. Control: Local Anti-virus software upgraded Mitigation: User education and communication regularly published. Mitigation: New N3 Firewall with Intrusion prevention procured and in implementation phase Mitigation: New backup solution in early stages of procurement Mitigation: Websense upgrade or patching under review	1. ICT reports 2. IT Service Desk reports 3. Change Control Board reports. 4. Anti virus reports and Websense reports. 5. Intrusion Prevention System reports.	Supplier management.	Ransom ware infections continue to be reported Websense is out of date and needs to be patched or upgraded IT backup solutions are inadequate.	**Increase logical security of anti-malware applications.** **Trust wide comms campaign educating users not to open suspect or unexpected attachments in email.** **Purchase and implement new backup solution.** **Implement new firewalls and Intrusion prevention** **Upgrade or patch web sense. (CIO)**
4	The ICT processing Infrastructure does not maintain BAU	1. The ICT processing Infrastructure lacks capacity to maintain BAU 2. Services and fragmented	Not effective	1. Helpdesk Logs 2. Computer Speed 3. ICT Complaints	1. ICT reports 2. IT Service Desk reports	1. 3rd Party reports 2. Increase in funding		**By November 2015 ICT expects to run to expected parameters. (CIO)**
		Overall Control Effectiveness	0.0%					

BOARD ASSURANCE MODEL



Adapted for St George's University Hospitals NHS Foundation Trust from HM Treasury 'Assurance Frameworks' by Paul Moore

Adequacy of Assurance	Control Effectiveness
No assurance provided	Effective
Assurance is positive	Not Effective
Assurance is negative	Not Yet Tested
Assurance is inconclusive	

1	The Chief Executive, or directors on his behalf, prioritise attendance at a range of external meetings and engagement events to raise the profile	Competing priorities sometimes result in directors' being unable to attend and unable to send a deputy.
2	An Executive Director lead is assigned as the primary point of contact and key relationship manager for each Borough/CCG, and intelligence/concerns are routinely fed back into the Executive Team Meeting	Time constraints during the EMC occasionally impede the ability to feed back and reflect on the specific issues highlighted informally by CCGs and other stakeholders.
3	The Trust undertakes stakeholder mapping and implements a system of customer/stakeholder	A number of stakeholder lists exist and have various owners and contributors.
4	The Trust actively promotes clinical research and encourages colleagues to present/publish their findings at national and international events in	
5	The Trust has established a shadow Council of	There is no membership function and no proactive

Effective	A Customer Relationship Management pilot is currently underway with the Kingston and Richmond directorate to improve stakeholder	Regular contact is maintained with MPs, Councils, CCGs and Healthwatch through 1:1 meetings or written correspondence	A review of stakeholder relationships is currently being carried out by the Henley Business School and stakeholder interviews are underway.
Effective	Trustwide stakeholder meeetings are captured on Forward Look which is discussed at every EMC. HOSC and CCG board agendas are scrutinised for mental health items and then attended if	A Customer Relationship Management pilot is currently underway with the Kingston and Richmond directorate to improve stakeholder relationship intelligence.	A review of stakeholder relationships is currently being carried out by the Henley Business School and stakeholder interviews are underway.
Effective	Discussions have been taking place at OLG followed by individual meetings with DMTs to	A review of all known stakeholder lists is underway and being merged into a single	A review of stakeholder relationships is currently being carried out by the Henley Business School
Effective	Services are pro-active in being involved in national or international events e.g. presenting at conferences as far a field as Japan. The trust regularly hosts	The Trust communications team use media releases to promote the excellent work that is taking place - any number of these examples can be seen on the public website or	A review of stakeholder relationships is currently being carried out by the Henley Business School and stakeholder interviews are underway.
Not Effective	The shadow Council of Governors meet and	The Trust executive are reviewing portfolios as	A review of stakeholder relationships is currently

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD *October 2016*

Paper Title:	Fit and Proper Person Assessment and Revised Policy
Sponsoring Director:	Karen Charman
Author:	Luke Edwards
Purpose:	This note provides the Board with positive assurance that the assessment has been completed for the current Board and the files have been reviewed to ensure they are up to date and the necessary documentation is held on file. . A revised policy has also been developed sets clearer expectations and requirements.
Action required by the board:	To: • Note the current assurance around the fit and proper person assessment of the Board • Approve the revised policy
Document previously considered by:	EMT have approved the revised policy.
Executive summary The CQC have identified that an area of concern was that 'the trust was not fully discharging its duties under the Fit and Proper Persons requirements as set out in the Health and Social Care Act. This papers set out the work that has been undertaken to confirm compliance with the requirements of the regulation and approve the revised and strengthened policy.	
Key risks identified: Failure to demonstrate compliance with the regulation is subject to regulatory action.	
Related Corporate Objective:	**To develop a highly skilled and engaged workforce championing our values that is**

Reference to corporate objective that this paper refers to.	**able to deliver the trust's vision.**
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	**Are services well led?**

Consideration

1. The intention of the regulation is to ensure that people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out the role. The introduction of the FPPR imposes an additional requirement on directors. It is the ultimate responsibility of the chair of the NHS body to discharge the requirement placed on the provider, to ensure that all directors meet the fitness test and do not meet any of the 'unfit' criteria. In addition to the usual requirements of good character, health, qualifications, skills and experience, the regulation extends to individuals who are prevented from holding the office (for example, under a director's disqualification order) and significantly, excluding people who: "have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or providing a service elsewhere which, if provided in England, would be a regulated activity".

2. To meet the requirements of Regulation 5, a provider has to:

   - Provide evidence that appropriate systems and processes are in place to ensure that all new directors and existing directors are, and continue to be, fit , and that no appointments meet any of the unfitness criteria set out in Schedule 4, part 2 of the regulations
   - This means that directors should be of good character, have the required skills, experience and knowledge and that their health enables them to fulfil the management function. None of the criteria of unfitness should apply, which include bankruptcy, sequestration and insolvency, appearing on barred lists and being prohibited from holding directorships under other laws. Directors should not have been involved or complicit in any serious misconduct, mismanagement or failure of care in carrying on a regulated activity
   - Make every reasonable effort to assure itself about an individual by all means available.
   - Make specified information about board directors available to CQC

<u>Compliance</u>

3. The CQC identified that we did not fully comply with the regulation and internal weaknesses in the way the process was being managed. An exercise has been undertaken with HR colleagues to review the position, identify any key gaps and ensure that the information is appropriately retained on file which can be easily reviewed by the CQC on request. This confirms that the current Board at end September are compliant with the regulation and the relevant evidence is now held on file. We have identified as part of this process that we need to renew Sarah Wilton's DBS clearance and this is currently being undertaken. This is detailed at Annex A (Executive Director) and Annex B (Non-Executive Directors)

4. The processes are now in place to ensure that any new appointments are compliant with the regulation including the appointments.

Revised Policy

5. A revised policy has been developed and this will strengthen the approach going forward to ensure compliance is maintained. It makes a number of changes including:

    - Making this a stand-alone policy as opposed to an appendix of an existing policy;
    - Being clear that no director should be appointed without this process being completed, unless in exceptional circumstances and at the direction of the Chair;
    - Being clear that this applies to all interim and associate members of the board in line with the regulation;
    - Clarifying that executive search companies if used should undertake the employment and reference checks for us and provide the evidence for us to retain on file;
    - Providing greater clarity on the process for new appointments and the annual process;
    - Providing greater clarity around the process where concerns are raised particularly in view of recent incidents and where records for Non-Executive Directors are held;
    - Strengthening the test to include an appropriate media and social media search conducted by communications colleagues as is routine in other trusts;
    - Clarifying that we may discuss issues or a case with the regulator;
    - Clarifying the accountabilities and in particular that the Trust Secretary is accountable for maintaining the overall process with support from HR and communications rather than splitting accountability between the Trust Secretary and HR.

6. The revised policy is included at Annex C for approval.

Luke Edwards
Head of Corporate Governance

APPENDIX 1: REVIEW OF FIT AND PROPER PERSON TEST REQUIREMENTS FOR NEW EXECUTIVE DIRECTOR LEVEL APPOINTMENTS SINCE JANUARY 2016[1]

Name	Employment history and references	Essential Qualifications	Occupational Health	Right to work	Identity Check	DBS/Criminal Conviction Checks	Search of insolvency and bankruptcy register	Search of disqualified directors register	Complete
Simon Mackenzie CEO	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nigel Carr CFO	✓	✓	✓	✓	✓	✓	✓	✓	✓
Larry Murphy CIO	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Hancock Estates	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mark Gordon COO	✓	✓	✓	✓	✓	✓	✓	✓	✓
Iain Lynam CRO	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Rhodes MD	✓	✓	✓	✓	✓	✓	✓	✓	✓
Karen Charman HR Director	✓	✓	✓	✓	✓	✓	✓	✓	✓
Paul Moore Governance	✓	✓	✓	✓	✓	✓	✓	✓	✓

APPENDIX 1: REVIEW OF FIT AND PROPER PERSON TEST REQUIREMENTS FOR ALL NON EXECUTIVE DIRECTORS

Name	Employment history and references	Essential Qualifications	Occupational Health	Right to work	Identity Check	DBS/Criminal Conviction Checks	Search of insolvency and bankruptcy register	Search of disqualified directors register	Complete
David Henshaw	✓	✓	✓	✓	✓	✓	✓	✓	✓
Norman Williams	✓	✓	✓	✓	✓	✓	✓	✓	✓
Thomas Saltiel	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gillian Norton	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sarah Wilton	✓	✓	✓	✓	✓	Renewal required	✓	✓	
Jenny Higham	✓	✓	✓	✓	✓	✓	✓	✓	✓

Fit and Proper Person Policy and Procedure

Executive Summary

To outline the procedure for ensuring that Board Level appointments are compliant with the Fit and Proper Persons test and the responsibilities for ensuring compliance.

Fit and Proper Persons Requirement (FPPR) Policy and Procedure

1. Scope

This policy and procedure applies to all board appointments i.e. executive and non-executive directors. This includes permanent, interim and associate positions.

2. Purpose

The purpose of the procedure is to ensure the Trust complies with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons Requirement.

3. Introduction

Regulation 5 has been introduced as a direct response to the failings at Winterbourne View Hospital and the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust, which recommended that a statutory fit and proper person's requirement be imposed on health service bodies. This policy outlines the application of this test for new appointments and existing postholders. Where the Trust engages an interim at a senior level equivalent to the posts above, the same process FPPR test will apply whether they are employed or registered as an external worker.

Where an interim is sourced by an agency the recruitment agency will be made aware of the FPPR process and must confirm that they have undertaken the employment history and reference checks. Executive search companies will provide relevant evidence to the Trust to be retained on file.

4. Meeting the Requirements of Regulation 5

The introduction of the fit and proper person's requirements (FPPR) places the ultimate responsibility on the chair to discharge the requirement placed on the Trust, to ensure that all relevant post holders meet the fitness test and do not meet any of the 'unfit' criteria. Further detail is provided in the CQC Guidance for NHS Bodies: Fit and Proper Persons: Directors, November, 2014 and can be found here.

The Trust will make every reasonable effort to assure itself about existing post holders and new applicants and to make specified information about board directors available to CQC on request. Individuals who fall into the categories above must satisfy the chair that they:

- Are of good character
- Hold the required qualifications and have the competence, skills and experience required for the relevant office for which they're employed
- Are able, by reason of their physical and mental health, after any required reasonable adjustments if required, capable of properly performing their work.
- Can supply relevant information as required by schedule 3 of the act, ie documentation to support the FPPR.
- Not have been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity).

In accordance with schedule 4 part 1 of the act a person is deemed "unfit" if

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

In accordance with part 2 of the Act a person will fail the good character test if they

- Has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence.
- Has been erased, removed, struck off a register of professionals maintained by a regulator of health care of social work professionals

Members of the Board will not be able to commence their role unless the FPPR have been met.

Implementation of FPPR for existing staff and on-going fitness

5 (i) Implementation

The NHS Employment Check standards apply to applications for NHS positions, including permanent staff, staff on fixed-term contracts, volunteers, students, trainees, contractors, highly mobile staff, temporary workers (including locum doctors), those working on a Trust bank, and other workers supplied by an agency. The checks are intended to provide assurances that staff working in the NHS are appropriately registered, qualified, experienced, and do not pose a risk to patients. NHS providers are required to show evidence of their compliance with these standards as part of the Care Quality Commission's regulatory framework.

The standards are:

- Identity Checks – reducing the risk of employing illegal workers and impersonators
- Right to Work in the UK check
- Professional Registration (where appropriate) and Qualification Checks
- Criminal Record and Barring Checks – reducing the risk of employing criminals
- Employment History and Reference Checks – reducing the risk of employing staff with unsuitable or unsatisfactory employment records
- Work Health Assessments – reducing the risk of employing staff that are not correctly immunised.

These checks will be conducted for all new Board Members, including where they are interim or associate positions.

In addition to the NHS pre-employment checks the following checks will be carried out:

- Search of insolvency and bankruptcy register
- Search of disqualified directors register

- The Director completes a self-declaration form (Annex A)
- An appropriate media and social media search is conducted

The process for assurance includes a check of personal files to ensure there is a complete employment history and where there are any gaps or omissions the post holder will be asked to provide a written explanation for this. Where the Trust has no record of mandatory qualifications or mandatory professional registration the individual will be asked to produce the original for inspection and verification.

If any issues arise as a result of any of process an interview may be conducted by the Chair or their nominated Deputy (normally the Trust Secretary and/or Director of Human Resources). Further documentary evidence may be required from the Director to support this process and should be provided on request.

This declaration and all associated documentation regarding the fit and proper persons test will be retained on the individual's personal file by the Director of Human Resources & Organisational Development for both Executive and Non-Executive Appointments

The Chairman will be notified of any issues of non–compliance and is the responsible officer for making an informed decision regarding the course of action to be followed.

5 (ii) On-going fitness

The annual appraisal process will provide an opportunity to discuss continued "fitness", competence and how the post holder role displays the Trust values and behaviour standard including the leadership behaviour expected. The CEO will be responsible for appraising the Executive Directors, whilst the Chairman will be responsible for appraising the Non-Executive Directors. The CEO will be appraised by the Chairman. The Chairman will be appraised through the agreed appraisal process, including where the Chairman is appointed by NHSI using their regulatory powers.

There is an annual requirement for post holders to complete a further form of declaration confirming that they continue to be a fit and proper person and declare any conflicts of interest. Confirmation of compliance will be published in the Trust's Annual Report. This will be undertaken in spring each year.

Individuals will be required to make the Trust aware as soon as practicable of any incident or circumstances which may mean they are no longer to be regarded as a fit and proper person, and provide details of the issue, so that this can be considered by the Trust using the Fit and Proper Persons Requirement Disclosure Form Existing post holders (Appendix 1).

5 (iii) Concerns regarding an individual's continued FPPR compliance

Where matters are raised that cause concerns relating to an individual being fit and proper to carry out their role the Chairman will address this in the most appropriate, relevant and proportionate way on a case by case basis. Where it is necessary to investigate or take action the Trust's current processes will apply using the Trust's capability process (managing performance or sickness absence), Disciplinary procedure or afforded a similar process to this if the potential discontinuation could be due to 'some other substantial reason'. There may be occasions where the Trust would contact the regulator for advice or to discuss a case directly.

The Trust reserves the right to suspend a Director or restrict them from duties on full pay / emoluments (as applicable) to allow the Trust to investigate the matters of concern. Suspension or restriction from duties will be for no longer than necessary to protect the

interests of service users or the Trust and/or where there is a risk that the Director's presence would impede the gathering of evidence in the investigation.

Should there be sufficient evidence to support the allegation(s), then the Trust may terminate the appointment of the Director with immediate effect, in line with the Trust's Disciplinary policy. Where an individual who is registered with a professional regulator (GMC, NMC etc.) no longer meets the fit and proper person's requirement the Trust must inform the regulator, and also take action to ensure the position is held by a person meeting the requirements. Directors may personally be accused and found guilty by a court of serious misconduct in respect of a range of already prescribed behaviours set out in legislation. Professional regulators may remove an individual from a register for breaches of codes of conduct.

Responsibilities

Responsibilities of the Chair:
The CQC requires the Trust Chairman to:

- Confirm that the fitness of all new directors has been assessed in line with the regulations.
- Declare in writing that they are satisfied that they are fit and proper individuals for that role.

Responsibilities of Board Members:
Board members have a responsibility to comply with these requirements.

Responsibility of the Chief Executive:
The Chief Executive will request a search of the Insolvency and Bankruptcy Register and the Disqualified Directors Register should be conducted annually at the time of appraisal and the outcome recorded.

Responsibility for the Trust Secretary:
The Trust Secretary has responsibility for ensuring these checks are carried out for the Chair and Non-Executive Directors. The Trust Secretary will also have responsibility for ensuring compliance with the overall policy and providing the Board with appropriate assurance of that fact.

Responsibility of the Director of Human Resources:
The Director of Human Resources has responsibility for ensuring these checks are carried out for the Chief Executive and Executive Directors and retaining the relevant files for all Board members including NEDs.

Responsibility of the Associate Director of Communications
The Associate Director of Communications will have responsibility for ensuring the media and social media searches are carried out at the request of the HR Director and/or Trust Secretary.

Annex A

Fit and Proper Persons Test

Declaration Form

Objective

The Fit and Proper Persons Regulation came into force in March 2015. The aim of the regulation is to ensure that all board level appointments of NHS Foundation Trusts have a process in place to ensure those individuals appointed are fit and proper to carry out their role. The test applies when a new director is appointed. This is known as Regulation 5. Regulation 5 is in addition to the existing general obligation for health service providers to ensure they employ individuals who are fit for the role and to demonstrate that 'nominated individuals' have necessary qualifications, skills and experience. This self-declaration form is to be completed by all new Directors.

Requirements

The requirements of the fit and proper persons test are set out below:

1. the individual is of good character,
2. the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed,
3. the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed,
4. the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and
5. none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

Declaration

I understand the requirements of the Fit and Proper Persons Test identified above and I can confirm that I am not aware of any issues that would raise any concerns regarding my appointment. If I become aware of any issues that may raise concerns or that the Trust will need to consider, I will immediately inform the Trust of the relevant details.

Are there any issues that you would like to disclose:

Yes: ☐ No: ☐

Signed ……..

Date ……

Role ……

If you have any issues to declare please set these out below:

Signed……..

Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

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

Paper Title:	A Framework of Quality Assurance for Responsible Officers and Revalidation
Sponsoring Director:	Dr Andrew Rhodes
Author:	Ms Karen Daly – **Responsible Officer** Nicola McDonald – **Revalidation Support Officer (Medical HR)**
Purpose: *The purpose of bringing the report to the board*	To provide assurance that doctors working in the designated body remain up to date and fit to practise.
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	**For decision** *Agree an annual statement of compliance to submit to the higher level Responsible Officer at NHSE(London)*
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	None

Executive summary

At the time of submitting the Annual Organisation Audit (AOA) to NHSE, the Trust reported 81.5% of doctors as having completed an appraisal between 1/4/15-31/3/16 compared to 62.7% for 1/4/14-31/3/15.

1. Key messages

In April 2016 medical revalidation entered its fourth year. Due to the phased implementation of revalidation submissions across England, this means that a much smaller number of doctors are scheduled to revalidate over the next two years which provides an opportunity to focus more closely on the requirement for all doctors to undertake a professional appraisal every year, irrespective of the date of their next revalidation, as well as improving the quality of appraisal.

2. Recommendation

The Board are asked to accept this annual report, which follows an annual audit submitted to NHS England in May 2016, covering the period 1 April 2015 to 31 March 2016. The Board are asked to approve the "statement of compliance" confirming that St George's University Hospitals NHS Foundation Trust is in compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

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?

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations

As a Designated Body, St George's University Hospitals NHS Foundation Trust and its Responsible Officer (RO) have statutory responsibilities that are monitored by NHS England.

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

Enclosure:

Related CQC Standard: *Reference to CQC standard that this paper refers to.*	
Equality Impact Assessment (EIA): Has an EIA been carried out? (Yes / No) **If yes, please provide a summary of the key findings** **If no, please explain you reasons for not undertaking and EIA.**	

St George's Healthcare NHS
NHS Trust

Appendix A:

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

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

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
				15 Oct 2010
1.1 Who is responsible for this service / function / policy?				
1.2 Describe the purpose of the service / function / policy? *Who is it intended to benefit? What are the intended outcomes?*				
1.3 Are there any associated objectives? *E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives*				
1.4 What factors contribute or detract from achieving intended outcomes?				
1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability (physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Region or belief and Human Rights				
1.6 If yes, please describe current or planned activities to address the impact.				
1.7 Is there any scope for new measures which would promote equality?				
1.8 What are your monitoring arrangements for this policy/ service				
1.9 Equality Impact Rating [low, medium, high] **2.0. Please give your reasons for this rating**				

Annex E – Statement of Compliance

Designated Body Statement of Compliance

The board/executive management team – [delete as applicable] of St George's University Hospitals NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments:

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments:

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments:

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments:

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments:

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments:

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments:

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments:

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Comments:

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments:

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Contents……1

Executive Summary

The annual organisation audit submitted to NHS England recorded 766 doctors with a prescribed connection to St George's University Hospitals NHS Foundation Trust NHS Trust as at 31st March 2016. This has increased by 67 from last year's annual organisation audit. The figure does not include Doctors in Training, who are recorded by Health Education South London. The annual organisational audit recorded the appraisal rate for all doctors with a prescribed connection as 81.5%. This was calculated from the record of appraisals kept by the Revalidation Team. There are discrepancies between this and the monthly appraisal rate recorded by the Workforce Information Team which in March was 82.66%. This is because the Workforce Information report does not currently include most Trust grade, Honorary, 0 hours or Clinical Academics that we are responsible for as a Designated Body, but does include some Consultants who whose Designated Body is elsewhere.

Purpose of the Paper

As a Designated Body, St George's University Hospitals NHS Foundation Trust and its Responsible Officer (RO) have statutory responsibilities that are monitored by NHS England. The purpose of this paper is to satisfy the Board that the Trust works within a Framework of Quality Assurance in order to confirm to NHS England that that the Trust is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and confirm by submitting a signed Statement of Compliance.

Background

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

Provider organisations have a statutory duty to support their RO in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations.
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors.
- Confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors.
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Governance Arrangements

- All doctors are sent regular reminders from the Revalidation Support Officer (RSO) that their appraisal is due. Each month, Care Group Leads, Clinical Directors and Divisional Leads are also sent an update of who in their department is outstanding an appraisal.
- The GMC automatically contact Doctors in relation to their revalidation including updating their Designated Body details and provide 4 months' notice when their revalidation is due. The RSO maintains a record of Doctors who are due to revalidate, ensuring that they have provided the required documentation and triangulation of Data is provided to the RO in order to make a recommendation to the GMC.
- The whole list of doctors on the GMC database (GMC Connect) is checked and updated monthly by the RSO. In addition to this, there is regular communication with the University to ensure accurate records are held for both organisations.
- The RSO contacts Honorary Doctors and 0 hours Doctors to ensure that their connection to the Trust is valid.
- New starters are sent information on appraisal and revalidation at recruitment stage and the RSO also contacts new starters to identify their appraisal date.

Medical Appraisal

Appraisal and Revalidation Performance Data

Each month, the Workforce Information team produce a medical appraisal report that includes details of the number of doctors in each Division and the number of complete/incomplete appraisals. The report mainly includes Consultants, some, but not all Trust grade doctors, but does not include Honorary, 0 hours or Clinical Academics that the Trust is responsible for as a Designated Body. The report is available on Tableau where HR Managers and non-Medical Divisional Managers can access to cascade to the Medical Divisional Leads for review.

The RSO uses their own records to include all other Doctors that are not included in the report. This record is used to produce quarterly appraisal reports and the annual organisation audit to NHS England.
It is also used to identify who is due due/overdue an appraisal so that individual reminders can be sent as well as escalating overdue appraisals and concerns of non-engagement within Divisions and to the RO.

The RSO records reasons for delayed/missed appraisal and escalates to the RO as appropriate. The RO accepts maternity leave, career break or long term sick leave as a valid reason for delayed/missed appraisal which is the case for a minimum number of doctors. The RO does not accept that appraisals are delayed or missed due to any other reason such as workload.

Appraisers

The RSO continues to review the list of trained appraisers to ensure that all appraisers listed are active and have received appropriate training in order to continue. In order to do this we need to ensure that the Trust maintains a pool of skilled appraisers with an appropriate specialty mix, although it is not essential for each doctor to have an appraiser from the same specialty. The Trust has commissioned an external company to deliver 2 New Appraiser Workshops, 1 of which took place in June 2016 where 18 new appraisers received training. The next will take place in September 2016 where a further 20 are invited to attend. The company will also provide an e-learning package for refresher training that will be mandatory for all current appraisers to complete in order for them to continue as an appraiser. This will be rolled out by the end of 2016.

Quality Assurance

The current process for quality assuring appraisal is that each individual appraisal folder is reviewed by both the RSO and the RO prior to a revalidation recommendation being submitted to the GMC. The RO completes a revalidation checklist for each recommendation that is made. This provides assurance that:

- The appraisal “inputs” provided are available and appropriate.
- The appraisal “outputs” i.e. agreed PDP, appraisal summary and output statements are complete and to an appropriate standard
- Key items identified within the appraisal “inputs” as needing discussion during the appraisal are included in the appraisal “outputs”

Access, Security and Confidentiality

Doctors should use the Medical Appraisal Guide (MAG) Model Appraisal Form for their annual appraisal. The instructions within the MAG reminds Doctors to take care to abide by local confidentiality, data security and information governance protocols and in particular, to remove all personally identifiable data. Once the MAG is agreed by appraiser and appraise, it is sent to the RSO to keep on file and only shared with the RO and others as appropriate.

Clinical Governance

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

Revalidation Recommendations

- The number of recommendations between April 2015 and March 2016 totalled 292.
- 291 Recommendations were submitted on time.
- 1 recommendation was submitted late due to admin error.
- The number recommendations to revalidate totalled 207.
- The number of recommendations to defer totalled 85.
- There were no recommendations of Non Engagement.

Recruitment and engagement background checks

The Trust has a Medical Staffing Team that carry out the 6 NHS Employment Check Standards that outline the type and level of checks employers must carry out before recruiting staff into NHS positions. These include:

- Right to work
- Identity
- Employment History/References
- Professional Registration
- Work Health Assessment
- Criminal Records

Responding to Concerns and Remediation

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

Risk and Issues

Over the last year, there has been some improvement on the issues that were identified in the previous year's report; however there are some that are a work in progress as follows:

Policy and Guidance

- Ambiguity remains in relation to the appraisal process and documentation that non-training Junior Doctors and other non-Consultant grade doctors should use and who can carry out their appraisal
- NHS England has changed the criteria for reporting complete/incomplete/missed appraisals. Appraisal must be completed within the 3 months preceding the appraisal due date
- Although new starters are provided with general information on appraisal and revalidation, it is clear that some doctors require on-going support and information, particularly those who have recently been awarded a CCT, as well as doctors arriving from overseas.

Appraisal and Revalidation Performance Data

The RSO currently use an Excel spread-sheet to record completed appraisals. This makes it extremely difficult to produce the quarterly and annual audits that NHS England requires.

Quality Assurance

The Trust needs to improve the quality of medical appraisal to comply with national regulations for medical appraisal and revalidation, including the statutory duty of the Trust as a Designated Body and of the RO to make recommendations to the GMC about a doctor's revalidation status.

Quality assessment of appraisal inputs (supporting information and reflection provided by Doctor) and outputs (agreed PDP, appraisal summary and statements provided by appraiser) only takes place shortly before revalidation when the RO reviews the portfolio. This is time consuming and not sustainable now that there are several years to review (in the first year only a single appraisal was required, from April 2018 it will be 5).

This is inadequate for 2 reasons: firstly because the RO cannot do anything about a poor quality appraisal several years ago and has to make a recommendation on information which is sub-optimal and secondly because concerns about an individual doctor may not be drawn to the RO's attention in sufficient time to allow corrective action.

There is also no mechanism for monitoring and managing the performance of appraisers including appraisal calibration events and feedback from Doctors on their appraisers

Clinical Governance
Triangulation of the information held by the risk, governance and complaints bodies need to take place.

Corrective Actions, Improvement Plan and Next Steps

A panel of 3 from NHS England (London) visited the Trust in March 2016 as part of the Higher Level RO Independent Verification Process (Quality Review). They identified some areas of good practice and acknowledged the improvements already made, however did make some recommendations for development, mainly around quality assurance. Their report can be found at Appendix 1 and our action plan at Appendix 2.

In summary, we need to:

- Update the Medical Appraisal Policy which will be done this year. This will clarify that all doctors with a prescribed connection to the Trust must use the MAG and be appraised by a trained appraiser. It will also confirm that doctors will be allocated an appraisal month so their due date will be by the end of that month.
- Ensure that the register of trained appraisers is updated and that only fully trained appraisers undertake appraisal
- Proceed with New Appraiser training workshops as required to maintain an adequate ratio of trained appraisers to doctors
- Proceed with appraiser refresher e-learning for all current appraisers
- Provide more support to doctors and appraisers - Appraisal and Revalidation page on intranet with FAQ's and links to information from external/governing bodies
- Procure an appraisal/revalidation management system
- Continue to work with Divisions to ensure that the responsibilities for delivery of appraisal are understood and fulfilled.
- Implement a quality assurance process for appraisal inputs and outputs including recruitment of Appraisal Leads with enhanced training for quality assurance and governance of appraisal
- Implement a quality assurance process for appraisers including formal feedback from Doctor to their appraiser (likely to be part of appraisal/revalidation management system)
- Establish an medical appraisal and revalidation advisory group for triangulation of data to support the RO with making recommendations

Recommendations

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

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