Trust Board Meeting

Date and Time: Thursday 5 January 2017, 10:00 – 12:30
Venue: Boardroom H2.7, 2nd Floor, Hunter Wing

PATIENT STORY
A patient receiving care from a number of specialties in the Trust will be attending the meeting to describe his experiences.

Time	Item	Subject	Action	Lead	Format
OPENING ADMINISTRATION					
10:15	**1.1**	**Welcome and Apologies**	-	Chairman	-
	1.2	**Declarations of Interest**	-	All	Oral
	1.3	**Minutes of Meeting held on 01.12.16**	Approve	Chairman	Paper
	1.4	**Action Log and Matters Arising**	Review	All	Paper
	1.5	**Chair & CEO's Report**	Inform	CEO	Oral
PATIENT SAFETY, QUALITY AND PERFORMANCE					
10:20	**2.1**	**Quality Improvement Plan**	Assure	DQG	Paper
	2.2	**Performance & Quality Report**	Review	COO/CN	Paper
	2.3	**Overseas Visitors and Migrant Cost Recovery Pilot**	Approve	CRO	Paper
FINANCE & STRATEGY					
11:00	**3.1**	**Month 8 Finance Report**	Assure	CFO	Paper
	3.2	**Report from Finance & Performance Committee**	Inform	Chair of Committee	Oral
	3.3	**Communications Plan to support Trust's Long-Term Strategy**	Review	CEO	Paper
WORKFORCE					
11:30	**4.1**	**Workforce Performance Report**	Inform	DWOD	Paper
	4.2	**Leadership Development**	Discuss	DWOD/MD	Paper
GOVERNANCE & RISK					
11:50	**5.1**	**Information & Communications Technology Update**	Update	CIO	Paper
	5.2	**Corporate Risk Report**	Review	DQG	Paper
	5.3	**Claims & Insurance – Briefing Paper**	Inform	DQG	Paper
CLOSING ADMINISTRATION					
12.20	**6.1**	**Questions from the Public**	-	Public	Oral
	6.2	**Summary of Actions**	-	Co Sec	Oral
	6.3	**Any New Risks or Issues**		All	-
	6.4	**Items for Future Meetings** i. Local Escalation Plan (February 2017) ii. Review of Trust's Insurance Arrangements (March 2017) iii. Update on Leadership Development (March 2017) iv. Evaluation of Overseas Visitors and Migrant Cost Recovery Pilot (June 2017)		-	-
	6.5	**Any Other Business**	-	Chair	-
	6.6	**Reflection on Meeting**	-	All	Oral
12:30		**Close**			

Resolution to move to closed session
In accordance with Section 1 (2) Public Bodies (Admissions to Meeting) Act 1960, the Board is invited to approve the following resolution: "That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"

Date and Time of Next Meeting: Thursday 9 February 2017, 10:00 – 13:00

Trust Board
Purpose, Membership and Meetings

Trust Board Purpose:	The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Membership and Those in Attendance		
Members (Voting)	**Designation**	**Abbreviation**
Sir David Henshaw	Chairman	Chairman
Simon Mackenzie	Chief Executive	CEO
Ann Beasley	Non-Executive Director	
Stephen Collier	Non-Executive Director	Name/NED
Jenny Higham	Non-Executive Director (University Rep)	
Gillian Norton	Non-Executive Director	
Sir Norman Williams	Non-Executive Director	
Sarah Wilton	Non-Executive Director	
Suzanne Banks	Chief Nurse	CN
Margaret Pratt	Chief Financial Officer	CFO
Andrew Rhodes	Medical Director	MD
Thomas Saltiel	Associate Non-Executive Director	Name/NED
Executive Team		
Mark Gammage	Director of Workforce & Organisational Development	DWOD
Mark Gordon	Chief Operating Officer	COO
Richard Hancock	Director of Estates & Facilities	DE&F
Diana Lacey	Programme Director for the Elective Care (Data Quality) Recovery Programme	PD-ECRP
Iain Lynam	Chief Restructuring Officer	CRO
Paul Moore	Director of Quality Governance	DQG
Larry Murphy	Chief Information Officer	CIO
Executive Team		
Alison Benincasa	Divisional Chair, CSD	DC/CSD
Tunde Odutoye	Divisional Chair, SCTN	DC/SCNT
Lisa Pickering	Divisional Chair, MedCard	DC/MedCard
Justin Richards	Divisional Chair, CWDT	DC/CWDT
Secretariat		
Fiona Barr	Corporate Secretary and Head of Corporate Governance	Co Sec

Trust Board Dates 2016-17	
Thursday 09.02.17 10:00 – 15:30	Thursday 09.03.17 10:00 – 15:30

Trust Board (Public)
1 December 2016 – From 10:00
H2.8 Boardroom, 2nd Floor, Hunter Wing

Name	Title	Initials
PRESENT		
Sir David Henshaw	Non-Executive Director (Chair)	
Simon Mackenzie	Chief Executive	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Gillian Norton	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Margaret Pratt	Chief Financial Officer	CFO
Andy Rhodes	Medical Director	MD
Suzanne Banks	Chief Nurse	CN
IN ATTENDANCE		
Thomas Saltiel	Associate Non-Executive Director	NED
Karen Charman	Director of Workforce	DWOD
Mark Gordon	Chief Operating Officer	COO
Richard Hancock	Director of Estates & Facilities	DE&F
Iain Lynam	Chief Restructuring Officer	CRO
Paul Moore	Director of Quality Governance	DQG
Larry Murphy	Chief Information Officer	CIO
Alison Benincasa	Divisional Chair, CSD	DC - CSD
Lisa Pickering	Divisional Chair, MedCard	DC - MedCard
APOLOGIES		
Tunde Odutoye	Divisional Chair, Surgery	DC - SNTC
Justin Richards	Divisional Chair, CWDT	DC - CWDT
Jenny Higham	Non-Executive Director	NED
Fiona Barr	Interim Corporate Secretary & Head of Corporate Governance	Co Sec
SECRETARIAT		
Richard Coxon	Membership & Engagement Manager	MEM

PATIENT STORY

Karen Waterworth and her three year old son Josh joined the meeting to tell the Board about her experiences of Paediatric Intensive Care (PICU) and the paediatric services over the last four months. Her story gave the Board an insight into Josh's care following a virus which paralysed him. She was full of praise for the care Josh had received and provided some helpful feedback about what we can do better, much of it concerning communication between staff. The Chairman thanked Karen and Josh on behalf of the Board.

OPENING ADMINISTRATION

1A Welcome and Apologies

1.1	The Chairman opened the meeting and welcomed everyone. He reported that his daughter in law had given birth at St Georges's yesterday and the maternity staff had provided great quality care.
1.2	The apologies were as set out above.

1B Declarations of Interest	
1.3	The Chairman asked for declarations of interest. None were made.
1C Minutes of Meeting held on 03.11.16	
1.4	These were accepted as a true and accurate record of the meeting held on 03.11.16.
1D Matters Arising and Action Log	
1.5	The Board received the Action Log and noted that the actions were closed. There were no matters arising.
1E Chief Executive's Report	
1.6	The CEO reported that there had been two separate meetings with NHSi this week one focused on Finance and the other on Quality. He confirmed that the executive team continued to see the two as being closely linked. The income recovery work has identified a need to recruit more coders urgently to ensure we are billing for the work we undertake correctly. There have also been minor network failures recently which is the highest risk on the Trust risk register. NHSi have been kept fully informed and a formal letter is going to NHSE. There was a heating failure yesterday in the Atkinson Morley Wing (PFI building) and in St James's Wing caused by a pipe blockage. This resulted in 28 patients having operations cancelled.
1.7	The Trusts response to the Croydon tram crash on the 9.11.16 showed the organisation at its best and the CEO would like to note the Board's thanks to all staff involved for their skills and compassion dealing with all those affected.
PATIENT SAFETY, QUALITY AND PERFORMANCE	
2A Trust Quality Improvement Plan	
2.1	The DQG introduced the Quality Improvement Plan, which had been updated and expanded to address the identified compliance concerns.
2.2	The response to the Section 29A Warning Notice had been sent on the 30.11.16 and a copy of letter was circulated to Board Members immediately after submission.
2.3	There is a report being prepared into Water Safety Management including flushing to avoid legionella. This will go to Quality Committee first.
2.4	DC-CSD reported that the first collaborative palliative care meeting had taken place with CCG last week which would be discussed at EMT next week.
2B Performance & Quality Report	
2.6	The COO introduced the performance report advising that the Trust was performing positively against a number of indicators though particular challenges remained in the achievement of the Emergency Department (ED) Four Hour target, RTT and cancelled operations on the day by the hospital for non-clinical reasons. Cancer national standards had been met in September. STF trajectory standard was also met for the 62 day standard. The Trust is not meeting the RTT national standard, however, October backlog of patients waiting 18 weeks reduced further, totalling a reduction of 694 patients since August.
2.7	Daily COO-led Performance Control meetings are now established discussing issues and risks for the day, performance against key standards and activity plans.
2.8	The Chief Nurse led the Board through the quality metrics noting that: i. Mortality indicators remained better than expected. ii. Safety thermometer for was 96.65%, better than the national average of 95%.

	iii. There had been a reduction in the number of Serious Incidents (SIs) being declared Apr-Oct 2016/17: 58 compared with 90 Sis declared Apr-Oct 2015/16, this represents a 35% decrease. iv. There had been a slight increase in falls this month, attributable to a spike in Mary Seacole and Amyand. A substantial amount of work has been undertaken around policies, assessments and training/awareness. v. There had been no grade 3 or 4 Pressure Ulcers for four consecutive months. vi. There were three Trust apportioned C. Difficile cases in September with a cumulative total of 12 (Trust threshold being 31 for the year). vii. An MRSA case was reported in October which was the first this year though the investigation did not suggest a lapse in care. viii. Safeguarding children level 3 training has improved at 88% for the whole Trust, based on a manual reconciliation of data, although adult safeguarding training is below target at 83%. ix. The number of complaints were down from 91 in September to 69 in October. x. Friends and Family Test score was 93% Trust-wide. Nursing workforce fill rates were 94%. xi. On 13.12.16 there will be a Trust wide bed audit to evaluate condition of all beds and bed rails and an update will be given at next meeting.
2.9	xii. The new board report is being designed and will be presented at the January 2017 Board meeting.
2.10	The Board received the report.
2C Workforce Performance Report	
2.11	DWOD presented the Workforce Performance Report. The figures for October 2016 continue to show an increase in substantive staff which is a positive move for the Trust in both quality of care and financial terms. However the figures have yet to demonstrate an accompanying reduction in temporary staffing costs particularly agency costs.
2.12	Positive movements within the report: i. Vacancy rate for substantive staff is below average for London Teaching Hospitals at 15.75%. ii. Stability at 84.1% is in line with London Teaching Hospitals. iii. Percentage of bank to agency bookings at 42% is the highest level since June. Areas of concern with focused work in November: iv. Failure to realise reduction in temporary staff usage. v. Non medical appraisal at 67% and MAST compliance at 78%.
2.13	The Board discussed the controls that are now in place to approve the booking of agency and bank staff. There was also some discussion around recruiting staff as a collaborative setting rates with other trusts. DWOD confirmed that all options were being explored.
2.14	The Board received the report.
2D Update on the Workforce Race Equality Standards (WRES) Action Plan	
2.15	DWOD presented the action plan which addresses the deficits identified by the WRES reporting as well as those which have arisen from the Annual Staff Survey and CQC visits.
2.16	The Board approved the Action Plan

2E Report from Workforce & Education Committee	
2.17	Gillian Norton, Chair of the Workforce & Education Committee, gave an update from the last meeting and supported all the work being carried out to control agency and bank spend.
2F Referral to Treatment (RTT) Briefing	
2.18	The RTTPD presented a briefing on RTT. The Trust had commissioned a comprehensive review of the systems and processes in place to manage patients along the along the elective pathway due to a series of performance and data issues at the Trust. These reviews focused on three areas: • Referral to Treatment pathways (RTT) • Cancer pathways and • Diagnostic pathways.
2.19	The outcome of these reviews highlighted multiple operational process and technology issues that pointed to patients receiving a sub-standard level of care and potential clinical risk. In addition current mechanisms of reporting elective pathway performance statistics were viewed as fundamentally broken and on this basis the Board made the decision that the Trust should cease national reporting of RTT information.
2.20	In light of these findings we have developed and are implanting a recovery programme, led by a programme director comprising of a number of core work streams necessary for us to improve both our IT systems and our operational processes of tracking patients are seen in a timely manner.
2.21	This is a long standing problem and building blocks need to be in place to ensure accuracy of data. An elective recovery programme is taking place including a patient record validation exercise, staff training, data quality and capacity management.
2.22	The Board were told that that the issues can be fixed but will require the whole organisation to engage. Independent external experts have approved this approach and estimate the recovery will take up to two years. The data quality issues identified raises questions about our ability to record the work we are doing – which could have significant financial implications.
2.23	The Board received the report.
FINANCE	
3A Month 7 Finance Report – Including Update on Cost Improvement Programme	
3.1	The CFO presented the month 7 Finance Report. The Trust has reported an in-month deficit of £5.4m in November which is £5.2m worse than plan. Included in-month is a Non Pay overspend (£2.8m), excess pay costs of £0.1M and below plan Income £2.0m; mainly attributable to the STF (£1.5m) and RTT non-reporting penalty (£0.3m)). £0.4m of Pay, £0.2m Non Pay and £0.3m of Income in-month is cost unforeseen and outside of the control of the Trust. . The YTD deficit is £47.7m.
3.2	The forecast outturn is a deficit of £80.7m subject to a full reforecast exercise with NHSi in the coming weeks. The Board discussed on-going negotiations with commissioners regarding backdated unbilled work carried out and the loss of income due to not enough coders.
3.3	The Board received the report.
3.B Report from Finance & Performance Committee (F&PC)	
3.4	All relevant issues were covered earlier.

GOVERNANCE AND RISKS	
4A Response to NHS Improvement Enforcement Undertakings	
4.1	The CEO updated the Board on the high level action plan prepared in response to the enforcement notice received by the Trust on 01.11.16 from NHS Improvement.
4.2	The Trust agreed a number of Enforcement Undertakings as a result of being placed in Special Measures. The Trust has complied with these including submitting an interim two year estates plan with a fuller five year strategy and estates recovery plan to be submitted by 31.03.17.
4.3	The Board received the report.
4B Corporate Risk Report	
4.4	DQG presented for review the Corporate Risk Report. • The Board were asked to agree that the current level of risk exposure is tolerable or acceptable and that the risk is under sufficient control; • The Board were invited to consider and advise on any further mitigating action required to achieve control; and • To consider whether any modification is needed to the Board's risk appetite in light of current risk exposure and act accordingly.
4.5	The Board agreed the report.
4C Report from the Audit Committee	
4.6	Sarah Wilton presented the Audit Committee report from the meeting held on the 10.11.16. The Board discussed the previous independent auditors recommendations which had been agreed and signed off but had not actually been implemented. The Board expressed concern about this and also whether all the lessons of the PwC report had been embedded.
5 CLOSING ADMINISTRATION	
5A Questions from Public	
5.1	Ms Hazel Ingram asked about an orthopaedic appointment she was supposed to have had in August 2016 which had been cancelled and rescheduled three times and was now scheduled for February 2017. She sought reassurance that it would not be cancelled again and the COO agreed to look into the matter and respond to her directly.
5.4 Any Other Business	
5.2	As there were no further items of business, the Chair resolved to move to closed session and ended the meeting.

Date and Time of Next Meeting: Thursday 5 January 2017 10:00 – 15:30

Trust Board Public - 05.01.17

Action Ref	**Theme**	Action	**Due**	**Revised Date**	**Lead**	**Commentary**	**Status**
TB.03.11.16/02	Pressure Ulcer Performance	Include benchmarked Pressure Ulcer performance per 1000 bed days in January 2017 Quality Performance Report	TB.05.01.17		CN	A verbal update will be provided in the meeting.	Proposed for closure.
TB.03.11.16/03	Mortality Statistics	Undertake a deep dive into mortality statistics at the Quality Committee every six months.	QC.29.03.17		MD & CN	This action will be added to the Quality Committee Action Tracker for reporting at the March meeting.	Open
TB.03.11.16/05	Legal Arrangements	Present a report to the Board on the Trust's inusurance arrangements and overall level of litigation and clinical negligence claims.	TB.05.01.17		DQG	On the agenda as item 5.3.	Proposed for closure.

Meeting Title:	Trust Board		
Date:	January 2017	**Agenda No**	
Report Title:	Quality Improvement Programme progress report		
Executive Sponsor	Paul Moore - Director of Quality Governance		
Report Authors:	Paul Moore – Director of Quality Governance Anne O' Connor – Quality Improvement Plan Project Manager		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	In this report we provide assurance on the progress of the Quality Improvement Plan, a breakdown of the anticipated benefits for each workstream, and highlights by exception actions that are not on track or at risk of breaching implementation deadlines. As at 16/12/2016: • 16.8% of actions have completed embedded actions (Blue) • 78.0% of actions are on target (Green) • 3.2% are at risk of breaching (Amber) • 2% have breached target date for implementation (Red)		
Recommendation:	The Board is invited to note the update and actions reported by exception, and to advise on any further action required by the Board		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	All CQC Domains		
Single Oversight Framework Theme:	(i) Quality of Care (ii) Operational Performance (iii) Leadership and Improvement Capability		
Implications			
Risk:	I. Service users are exposed to unacceptable levels of harm arising from inadequate compliance with CQC fundamental standards of care; and II. The Trust fails to comply with NHSI enforcement undertakings and the provider licence.		
Legal/Regulatory:	Compliance with: (i) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; (ii) The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015; (iii) Care Quality Commission (Registration) Regulations 2009; and (iv) The Health & Social care Act 2012, the NHS Provider Licence General Condition 7 – Registration with the Care Quality Commission		

Resources:			
Previously Considered by:	Quality Improvement Board	**Date 14/12/16**	
Equality Impact Assessment:			
Appendices:	Workstream Overview Report for: (i) Personalised Care (ii) Safety Culture (iii) Governance (iv) Human Resources (v) Estates (vi) Operations (vii) Healthcare Informatics (viii) Leadership		

Quality Improvement Programme Update Report. December 2016

1.0 PURPOSE

1.1 The purpose of this paper is the ensure the Board of Directors are up to date on the progress of the Quality Improvement Plan, and to highlight to the Board by exception elements of the plan that are not on track or at risk of not meeting target dates for implementation.

2.0 BACKGROUND OR CONTEXT

2.1 The Quality Improvement Plan brings together the actions required to address the CQC compliance concerns identified following inspection in June 2016. The plan takes account of: (i) the Section 29A Warning Notice, served on the Trust in August 2016; (ii) all the 'must do' and should do' recommendations contained within the inspection reports; and (iii) a range of improvement interventions identified locally as quality priorities by the Trust.

2.2 The Quality Improvement Plan forms part of NHS Improvement's enforcement undertakings and, in this regard, the Board is required by November 2017 to: (i) provide NHSI with assurance that it has addressed the 'must do' actions to the CQC's satisfaction; (ii) is no longer considered by CQC to be inadequate in the well-led domain; and (iii) has improved against all domains rated as inadequate or requires improvement when compared to the CQC's inspection findings.

2.3 Following publication of the CQC report, the Quality Improvement Plan expanded and restructured into eight workstreams.

3.0 ANALYSIS

3.1 Although the QIP will continue to provide a 'confirm and challenge' function to support delivery of the RTT plan, it is acknowledged that the RTT Programme has separate plan and governance structure, with its own reporting arrangements to the Board of Directors. This report does not, therefore, provide assurance to the Board on the delivery of the RTT Programme.

3.2 Within the 8 workstreams involved in the QIP there are 345 actions. Of those actions: 78.0% (n=268) are on track; 16.8% (n=58) have completed embedded actions; 2.0% (n=7) have breached the target date for implementation; and 3.2% (n=11) are identified as at risk of breaching target date for implementation.

3.3 The Trust submitted its response to the Section 29A Warning Notice to the Care Quality Commission on 30/11/2016. CQC have acknowledged receipt of the Notice at a routine engagement meeting between the Trust and local CQC inspectors held on 9 December 2016. No further instructions have been received at the time of report in respect of the Section 29A actions.

4.0 IMPLICATIONS

4.1 Risks

I. The Trust continues to expose service users to unacceptable levels of harm arising from inadequate compliance with CQC fundamental standards of care;

II. The Trust fails to assure the Regulator that: (i) it has addressed the 'must do' actions to the CQC's satisfaction; (ii) is no longer considered by CQC to be inadequate in the well-led domain; and (iii) has improved against all domains rated as inadequate or requires improvement when compared to the CQC's report published in November 2016.

2.2 Legal/Regulatory

Compliance with:

(ii) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;

(iii) The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015;

(iv) Care Quality Commission (Registration) Regulations 2009; and

(v) The Health & Social care Act 2012, the NHS Provider Licence General Condition 7 – Registration with the Care Quality Commission.

5.0 RECOMMENDATION

The Board is invited to note the update and actions reported by exception, and to advise on any further action required by the Board.

Author(s): **Paul Moore – Director of Quality Governance**
Anne O'Connor – Quality Improvement Plan Project Manager
Date: **16/12/2016**

Appendix 1 Summary of QIP Workstream numbers and Ratings

QIP Workstream	Total Actions	B	R	A	G	B/G	Overall Status	Comments
Personalised Care	103	16	3	3	81	0		Risks relate to staffing levels in Paediatrics, NNU and Gwynne Holford wards. Ensuring sufficient and appropriate bed stock & bed rails availability.
Safety Culture	83	10	0	1	72	0		Most actions within this workstream are within time scales.
Governance	29	10	1	0	18	0		Risk relates to duty of candour compliance for moderate incidents.
Human Resources	28	5	1	1	21	0		Risks relate to reduction in agency staff to no more than 10% of total pay bill
Estates	38	14	2	3	19	0		Water safety management (Pseudomonas), theatre refurbishment and PPM, demolition of buildings.
Operations	44	2	0	3	39	0		Risks in relation to data reliability to report performance management and data outcome measurement – 18 weeks, cancer and diagnostics.
H/C Informatics	6	0	0	0	6	0		The 14 actions remain within time scales thus rated green.
Leadership	14	1	0	0	13	0		13 actions remain within time scales thus rated green.
RTT								Evidence presented to RTT Board for assurance. Opportunity to provide challenge at the QIP workstream.
Total	345	58	7	11	269	0		

Table 1: Summary of BRAG rating by workstream.

Overall workstream BRAG rating

Blue	Workstream completed, embedded and assured in daily practice
Red	≥ 5% actions in workstream have breached target date for implementation
Amber	≥ 20% of actions in workstream are either breached or at risk of breaching target dates
Green	< 20% of actions in workstream are either breached or at risk of breaching target dates
Blue/Green	Blue subject to CQC confirmation.

Table 2. Overall workstream BRAG rating

QIP: Timeline

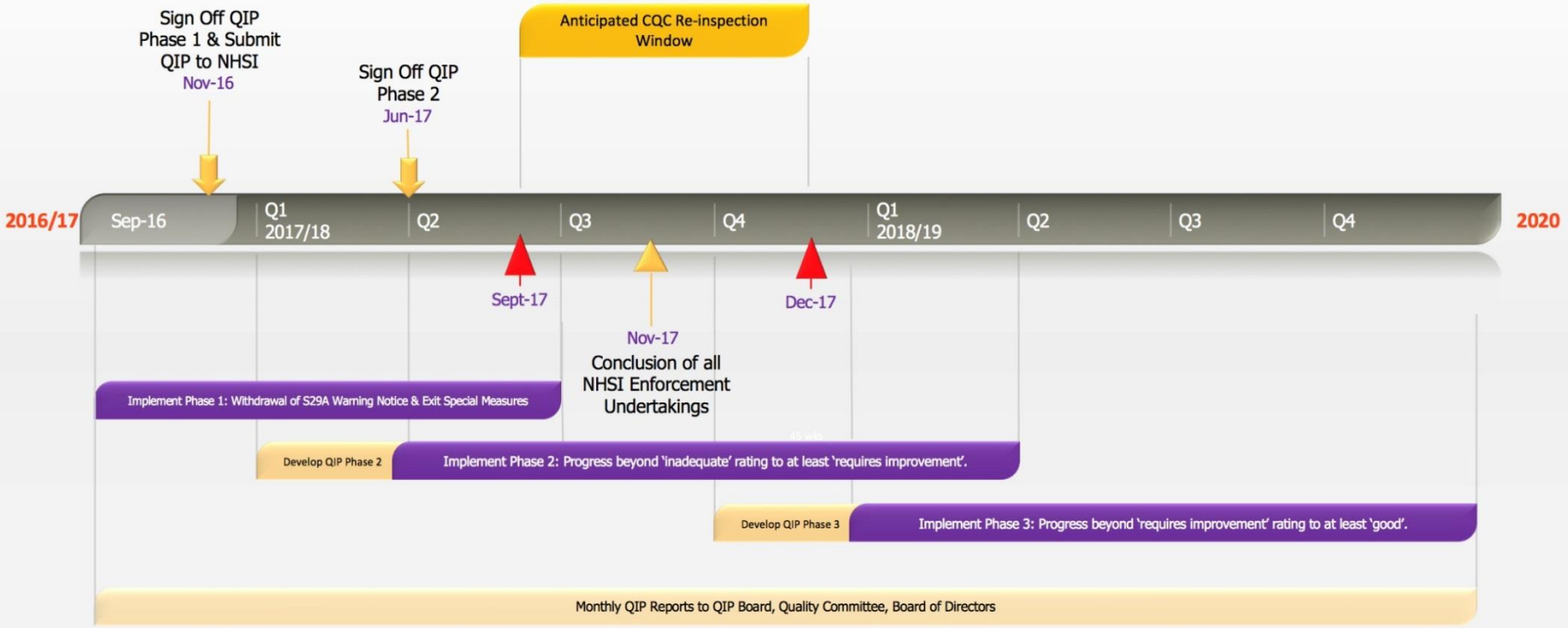
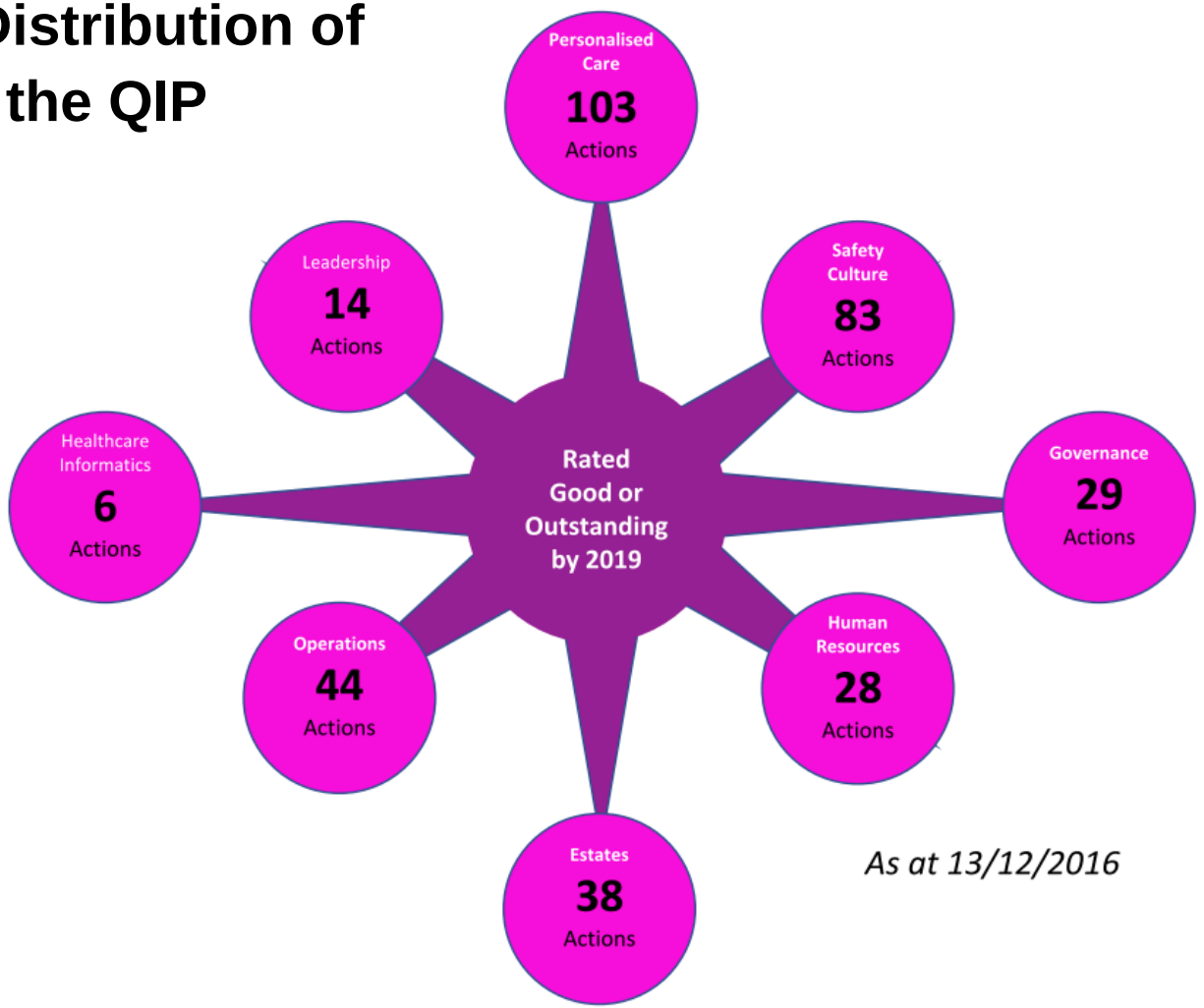
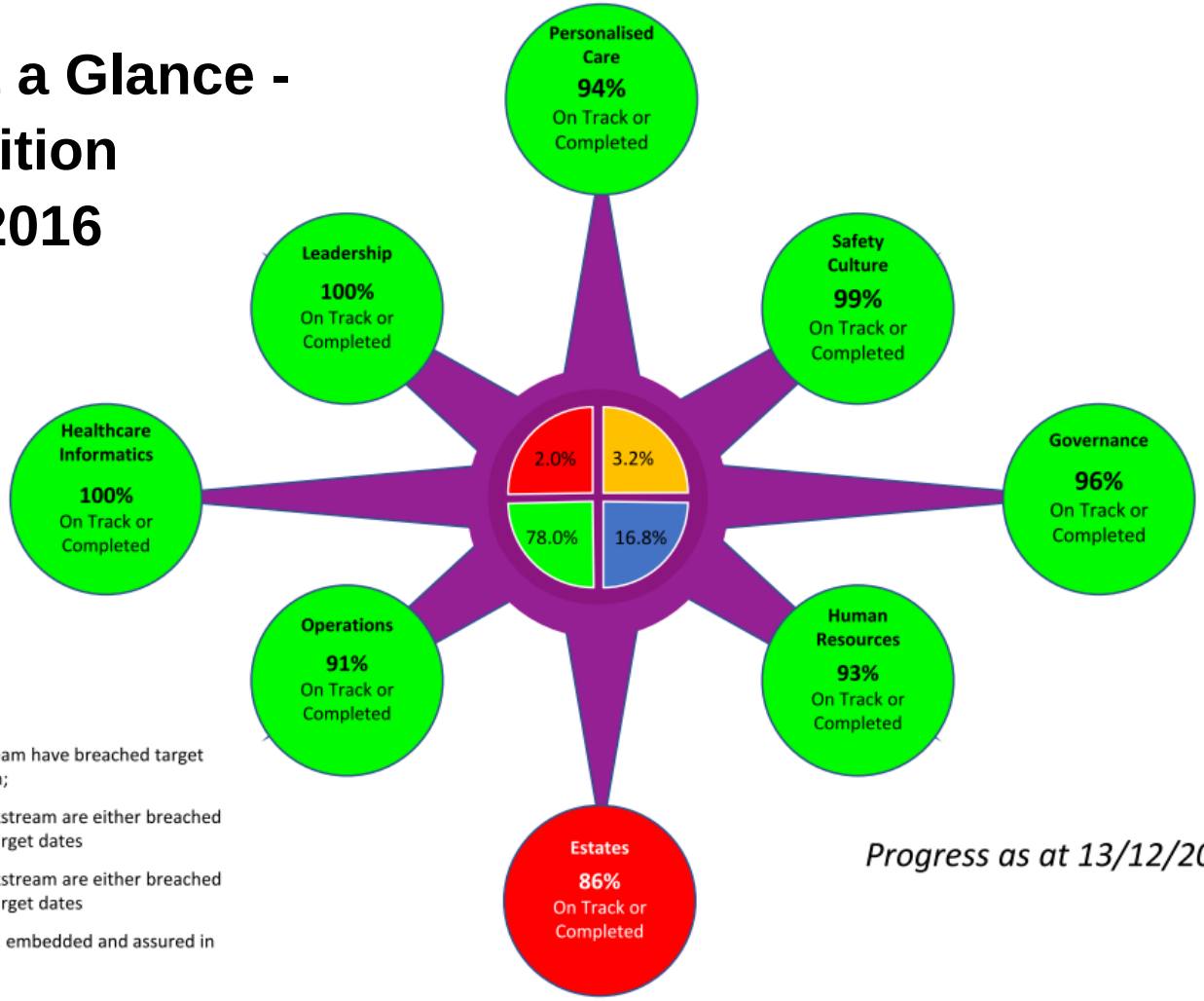


Figure 1: Distribution of Actions in the QIP



As at 13/12/2016

Figure 2: At a Glance - Overall Position December 2016



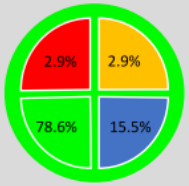
Key to Overall Workstream Rating

- ≥ 5% actions in workstream have breached target date for implementation;
- ≥ 20% of actions in workstream are either breached or at risk of breaching target dates
- < 20% of actions in workstream are either breached or at risk of breaching target dates
- Workstream completed, embedded and assured in daily practice

Progress as at 13/12/2016

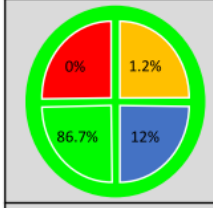
FLASH REPORT DEC 2016

PERSONALISED CARE



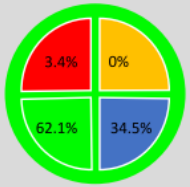
- Progress on End of Life Care
- Substantive recruitment on Gwynne Holford Ward & Paediatrics
- Roll out of MCA / DoLS training and completion
- Ligature / self harm hazards in Paediatrics, and Paediatric staffing
- Replacement and use of beds and bed rails

SAFETY CULTURE



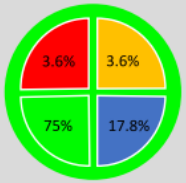
- Update of IR(ME)R Procedures
- Update of policy for reporting radiation incidents
- WHO Safer Surgery incorporated to the QIP
- EWS and Deteriorating Patient actions added to the QIP

GOVERNANCE



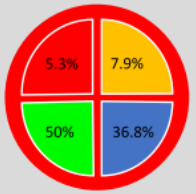
- Compliance with Duty of Candour for all qualifying moderate harm incidents

HUMAN RESOURCES



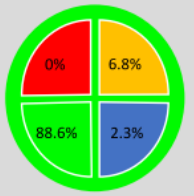
- Expansion of apprenticeship programme
- Effectiveness of bank and agency controls

ESTATES



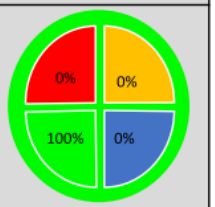
- Renal Unit relocation underway, to be concluded mid-December
- Relocation of 15% of outpatient services in LW, almost concluded
- Availability of Fire Warden on every ward and every shift in LW
- Water Safety Management – pseudomonas flushing routine
- Commencement of Theatres Refurbishment Plan

OPERATIONS



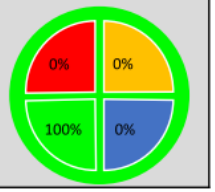
- Percentage of telephone calls answered in OPD within target
- Data management and performance reporting

HEALTHCARE INFORMATICS



- 6 actions on the QIP
- All actions on track

LEADERSHIP



- 14 actions on the QIP
- All actions on track

Quality Improvement Plan: Benefits Realisation

Workstream 1: Personalised Care

Focus area	Phase 1 Objectives (by 01/09/2017)
End of Life Care	• Establish and maintain a more integrated end of life Service between acute and community settings which maintains current high levels of patient satisfaction • Determine the benefit of the service level agreement with Trinity Hospice and, where the contract remains in place, ensure value for money is achieved • Redesign and implement pathways for end of life care, replacing the Liverpool Care Pathway • Establish and maintain a performance framework for end of life services
Gwynne Holford Ward	• Leadership on Gwynne Holford Ward is stable and staff report that they are satisfied with the leadership team on the Ward • Staff report less stress following a reduction in bed capacity to better align workload with staffing levels • Fill vacant posts and reduce requirement for agency or temporary workforce • All staff are trained and can demonstrate competence with Mental Capacity Assessments, Deprivation of Liberty safeguards and best interest decision making • Achieve zero avoidable cardiac arrests by applying controls to recognise and respond to the signs of clinical deterioration • Achieve full compliance with infection prevention and control procedures
Beds and Bed Rails	• Audit and inspection demonstrates that all beds in use are serviceable and fit for purpose. • Audit and inspection demonstrates that all beds in use have, where required, functioning, compatible and fit for purpose bed rails attached with appropriate and regularly reviewed risk assessments recorded as part of the care plan.
MCA/DoLS	• All clinical staff can articulate and demonstrate their role in the appropriate application of mental capacity assessments, deprivation of liberty safeguards and the recording of best interest decision making.
Privacy & Dignity	• Service users in inpatient settings are satisfied that all curtains used to screen patient bed areas are sufficiently low to maintain their privacy and dignity. • Service users in outpatient settings and Emergency Department are satisfied that their privacy and dignity was maintained in reception, consulting and treatment areas.
Pain Management	• Service users consistently report at least 98% satisfaction with how their pain was assessed, evaluated and managed by clinical teams • Build capacity and capability for pain management by establishing a network of link nurses on every ward and clinical area to raise awareness and spread good practice

Dementia Care	• All clinical staff can articulate and demonstrate their role in the appropriate application of dementia care in their clinical area • All clinical areas have an up to date environmental risk assessment in place to address foreseeable risks associated with caring for people with dementia or delirium, and can evidence action taken to address identified environmental hazards • Dementia and delirium performance is always reported to, considered, and action taken to improve as part of care group governance meetings

Workstream 2: Safety Culture

Focus area	Phase 1 Objectives (by 01/09/2017)
Medicines Management	• Zero breaches of medicines controls • Demonstrate enhanced governance and oversight of medicines management
Radiation Safety	• Zero breaches of ionising and non-ionising radiation protection controls • Demonstrate enhanced governance and oversight of radiation protection
Early Warning Score and Deteriorating Patient	• Zero avoidable cardiac arrests • Successful recognition and rescue of deteriorating patient
WHO Safer Surgery Compliance	• Zero surgical never events.
Clinical Records Security	• Zero breaches of confidentiality.

Workstream 3: Governance

Focus area	Phase 1 Objectives (by 01/09/2017)
Risk Management and Board Assurance	• Internal audit assurance demonstrates significant improvement in risk management and Board Assurance Framework • Performance issues are escalated to the relevant committees and the Board through clear structures and processes • Management and staff are held to account for the prudent control of risk
Freedom to Speak Up	• Staff report awareness of and confidence in the Freedom to Speak Up Guardian
Complaints Handling	• >80% compliance, sustained for at least 3 months, with thresholds for response to complaints • 10% reduction in cases referred to PHSO
Serious Incident Handling	• Zero breaches of 60-working day timeline for conclusion of investigations. • Full assurance that actions cited in SI reports have been implemented as planned • 10% reduction in serious incident exposures • In the annual staff survey, staff report a strong focus on continuous learning and improvement at all levels
Quality Improvement Plan	• Exit special measures for quality • Warning Notice withdrawn by the CQC
Incident Reporting & Duty of Candour	• Zero breaches of Duty of Candour obligations for all qualifying moderate, severe and catastrophic incidents

Workstream 4: Human Resources

Focus area	Phase 1 Objectives (by 01/09/2017)
Fit & Proper Person Requirement	• Demonstrate full compliance
Equal Opportunity	• Staff report equal opportunities for pay and progression • The Trust is rated in the top 25% of Trust's within the staff survey for satisfaction with leadership
Recruitment	• Staff turnover reduced by 10% or more in a year • Vacancy rate reduced by 2% • Staff report high satisfaction with the quality of local induction
Mandatory Training	• Trust target is met for completion of mandatory training, for all subject areas

Workstream 5: Estate

Focus area	Phase 1 Objectives (by 01/09/2017)
The Estate remains serviceable at all time and fit for purpose	• Zero leaks from roofs • Certificated compliance with NIC EIC electrical standards • Defect-free renal dialysis facility operational • Renal unit move concluded • Zero fires and 10% reduction in unwanted fire signals • Unsuitable and unusable Estate decommissioned • Theatre refurbishment programme on track as planned • Contamination of the water supply from *Legionella* and *Pseudomonas* is kept at or below levels which are deemed acceptable for hospital use • Resilience in the event of interruptions to the power supply • Resilience in the event of heating / hot water failure

Workstream 6: Operations

Focus area	Phase 1 Objectives (by 01/09/2017)
Access to services and advice	• Cancelled operations for non-clinical reasons at or below national average • Zero incidents of harm involving inappropriate bed allocation or patient transfer within the Trust • Speed up response to telephone calls: calls are answered within or before contractual threshold • Service users say they are satisfied with the explanation given for any delays arising when outpatient clinics overrun
Equipment Requirements	• There is sufficient supply of cystoscopes to run a service and allow fully compliant automated endoscope reprocessing
Clinical Model	• A strategy for Neuro-Rehabilitation is agreed and being implemented • A strategy for adult community services is agreed and being implemented • Targets for the Healthy Child Programme are met
Divisional Communications	• Staff report clarity of purpose and service objectives at divisional and care group levels

Workstream 7: Healthcare Informatics

Focus area	Phase 1 Objectives (by 01/09/2017)
Access to clinical records and clinical systems for relevant staff in community care settings	• Extended remote/mobile access • Arrangements to enable temporary workforce to access clinical systems are effective and efficient • Third party providers operating out of St George's report high levels of satisfaction with their access to clinical IT systems needed to support the care of patients
Community services are equipped to meet their IT requirements to support patient care	• Migrate to Windows 7 operating system • Extended remote/mobile access
Date accuracy, validity, reliability, timeliness and relevance	• The Board are confident there has been a significant improvement, ideally a significant assurance audit opinion, in data quality across the Trust • Information and analysis is used to identify opportunities and proactively drive improvements in care • Integrated reporting supports effective decision making
Mandatory Training	• The Board are confident that data captured by the MAST recording system is accurate, reliable and fit for purpose

Workstream 8: Leadership

Focus area	Phase 1 Objectives (by 01/09/2017)
Stability of leadership	• Succession for Interim Chairman concluded • Appointment of substantive Chief Executive and Executive Directors concluded by 01/06/17 or sooner • The Board can confirm it has the experience, capacity and capability to ensure the long-term strategy is delivered
Long term strategy and vision	• All 2017/18 strategic objectives are on target to deliver by 31/03/2018 • Front line teams can articulate the vision, values and strategic goals as they apply to their services • It can be confirmed that the statement of vision and values has been translated into a credible strategy with well-defined objectives that are regularly reviewed by the Board • There is consensus on the risks to achieving the strategy, clarity at the Board on mitigation plans, and risks kept under prudent control by the Board • Staff report, within the annual staff survey, higher levels of engagement
Enabling strategies	The following enablers are delivering as planned: • Agreed clinical strategy with specific emphasis on priority services • Out of Hospital Strategy • Joint working with neighbouring providers • Education Strategy • Information Technology Strategy • Workforce Strategy • Long Term Financial Model for St George's

Appendices 1-8 Individual workstream overview reports

Personalised Care Workstream overview report

QIP Work stream Personalised Care		Executive Lead: Title: Chief Nurse Name: Suzanne Banks						
Overall BRAG	**Reporting Period:** December 2016	**Action BRAG rating analysis**					**Active Actions**	**Assurance Actions**
		B	**R**	**A**	**G**	**B/G**	**87**	**16**
		16	**3**	**3**	**81**		**Total Actions in Workstream**	
							103	

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.
Blue/Green	Blue subject to CQC confirmation.

Exception Report: Red / Amber Actions				
Action	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
Gwynne Holford 1.2.2a To stabilise the workforce on GH	**30/07/2016**		On-going vacancies for 13 Band 5 posts despite active recruitment campaigns. Stabilised usage of agency staff, those that are used are returning. 10 beds have been closed to help stabilise staffing levels and manage workload and stress levels.	**TBC**
Bed Rails 1.3.1a Ensure sufficient and appropriate bed stock and bed rails availability	**30/09/2016**		Point prevalence review of current bed, mattress and cot side stock to be undertaken 13/12/16 to prioritise bed replacement plan. This is to go before next IDDG. Did not meet original time line of 30/09/16 as original bid rejected by IDDG.	**31/03/17**
Paediatrics 1.9.3a Decrease the number of	**31/12/16**		National problem with recruiting paediatric nurses. Recruitment plan in place to try and recruit to all	**TBC**

agency staff used on the paediatric units			vacancies, particular problems with Band 7. Review of skill mix, introduction of nurse practitioner roles, discharge coordinators to release nursing time. Working with St Helier to look at sustainable plan across the region.	
1.4.1b **MCA/DoIs** Audit against compliance with the MCA, DoLs and safeguarding policy	**31/01/2017**		Returned audit results October show poor compliance. For re-audit in January following training. Amber as risk identified that compliance numbers may not significantly improve during Dec-16 and Jan-17 if staff unable to be released for training.	**31/03/17**
1.9.1b Paediatric environment s safe and suitable for caring with children and young people with mental health conditions	**31/01/2017**		Risk assessment completed. Immediate action taken for removal of ligature points. Residual works to be completed. Work currently out to tender, at risk of delay due to financing.	**31/01/17**
1.9.3b Decrease the number of agency staff on the neonatal ward	**31/03/17**		National shortage of NNU nurses. The majority of agency staff on the NICU are regular staff. Funding obtained for nursery nurses to work on SCBU which will free up trained nurses to work in HDU. Beds have been closed when safe staffing cannot be maintained.	**TBC**

Personalised Care Recommendations Regarding Delivered and Embedded Actions

	Area	Action (Number then action narrative)	Comments	Evidence
1.	EOLC	1.1.1.h Identify NED Lead for EOLC	Sarah Wilton identified and agreed as NED	To minimise the file size of this document, the evidence is retained by the QIP Programme Manager and available on request to the Board.
2.	EOLC	1.1.1i Establish an EOLC steering group to drive and lead implementation of strategy	First meeting held 23/11/16	
3.	EOLC	1.1.2a Clarify contracts and SLA's with Trinity Hospice for community EOLC Nursing	SLA signed and in place	
4.	EOLC	1.1.2b Clarify contracts and SLA's with Trinity Hospice for EOLC Medical	SLA signed and in place	To minimise the file size of this document, the

		cover		evidence is retained by the QIP Programme Manager and available on request to the Board.
5.	GH	1.2.1e Introduce ward meetings with the leadership team and staff	Taking place on a weekly basis	
6.	GH	1.2.2d To ensure safe staffing levels on Gwynne Holford by utilising the therapies for basic care e.g. washing and dressing.	Process implemented	
7.	GH	1.2.4a To achieve compliance rates ≥ 85% with MAST	Compliance achieved	
8.	GH	1.2.4b Work with the Pharmacy to deliver medicines management training		
9.	GH	1.2.7a Review and improve patient record keeping as patients move between floors.	Patients now on one floor.	
10.	GH	1.2.7b Ensure a secure space for storage of clinical records	All notes now stored together in one locked cupboard and accessed by MDT	

Safety Culture Workstream Overview report

QIP Work stream Safety Culture		Executive Lead: Title: Medical Director Name: Andrew Rhodes						
Overall BRAG	Reporting Period: December 2016	Action BRAG rating analysis						
		B	R	A	G	B/G	Active Actions	Assurance Actions
							73	10
		10	0	1	72		Total Actions in Workstream	
							83	

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.
Blue/Green	Blue subject to CQC confirmation.

Exception Report: Red / Amber Actions				
Action	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
2.1.11 Ensure consistent temperature monitoring in all areas where medicines are stored	31/12/16		Not all areas are compliant. Some areas not consistent with monitoring	31/12/16

Risk/Issue to Highlight to QIB	Mitigating Action
We have further developed the deteriorating patient action of the safety culture workstream. This includes refreshing and strengthen the EWS and escalation of deteriorating patients. The need to develop a business case for a critical outreach team, which may require additional resources, has been identified. The programme also requires more robust IT and Wi-Fi systems to support the NEWS clinical systems.	Continue to train staff in the importance of NEWS and prompt escalation of the deteriorating patient.

Recommendations Regarding Delivered and Embedded Actions

	Area	Action (Number then action narrative)	Comments/Evidence	
1.	**Medicines Management**	2.1.1b Review the fluid storage within ED major incident cupboard to ensure that no fluids are out of date	Numerous spot checks. No out of date fluids	To minimise the file size of this document, the evidence is retained by the QIP Programme Manager and available on request to the Board.
2.		2.1.1c Provide report on monthly basis identifying outliers in compliance to best practice	Audits complete, good compliance	
3.		2.1.2 Ensure medical gases are stored, prescribed and audited to meet national standards	Audited October 2016, Full compliance	
4.		2.1.3b Remove FP10 prescriptions where services do not use them. Brief leadership/ management teams on correct processes.	All areas audited and fully compliant	
5.		2.1.3c Amend the medicines management policy to changes in practice, adding to the appendices the SOP and standard template for reconciliation	Policy updated and on line	
6.		2.1.5 Compliance with administration and recording of wasted drugs in resuscitation room in ED	ED competency booklet created Checked in back to the floor Fridays	
7.		2.1.12 Review stock lists and implement optimum stock holding process	Stock lists on all areas have been reviewed and stocks reduced	
8.		2.1.13 Achieve compliance with medicines reconciliation	90-100% compliance across areas.	
9.		2.1.14 Compliance with allergy management	99% compliance on audits	
10		2.1.15 Develop and implement patient group directives (PGD's) to enable radiographers to administer medication (contrast media)	16 PGD's signed off and in use in Radiology	

Governance Workstream Overview report

QIP Work stream Governance		Executive Lead: Title: Director of Quality Governance Name: Paul Moore						
Overall BRAG	**Reporting Period:** December 2016	**Action BRAG rating analysis**						
		B	**R**	**A**	**G**	**B/G**	**Active Actions**	**Assurance Actions**
							19	**10**
		10	**1**	**0**	**18**		**Total Actions in Workstream**	
							29	

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.
Blue/Green	Blue subject to CQC confirmation.

Exception Report: Red / Amber Actions				
Action	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
3.1.8a Urgently review the mechanism to deliver Duty of Candour. Address gaps and achieve full compliance with Duty of Candour	30/09/16		We have commenced monthly reporting of DOC. We are not yet fully compliant for all qualifying moderate incidents and are reporting this. Will not go green until at least 3 consecutive months of full compliance.	28/02/17

Governance Workstream Recommendations Regarding Delivered and Embedded Actions

	Action (Number then action narrative)	**Comments**	**Evidence**
1.	3.1.1a Establish and appoint a Director of Quality Governance to lead on governance, risk management and the Quality Improvement Plan	Director of Quality Governance appointed	To minimise the file size of this document, the evidence is retained by the QIP Programme Manager and available on request to the Board.
2.	3.1.1b Undertake a rapid review of board assurance, risk management arrangements and effectiveness of the Board's assurance committees. The Director of Quality Governance will bring proposals to the Board that (i) develop policy and practice to enhance the Board's risk management capability; and (ii) sets out a new board assurance methodology centred on accountability for internal control. These proposals will be presented to the Board for consideration on 4th August	Agreed at the Council of Governors meeting 28/07/16	
3.	3.1.1c Prepare and present to Board a revised Board Assurance Framework that is aligned to organisational risk and the Board's assurance needs, and addresses more directly risk treatment plans and assurance on controls	BAF signed off by the Board . Presented to the Quality committee on 23.11.16.	
4.	3.1.1f Commence a series of 'Good Governance Master classes', delivered by the Director of Quality Governance, to engage and support the Board and divisional teams to improve governance, risk management and compliance	Total of 246 attended training as of October 2016	
5.	3.1.2a Develop and write a paper outlining the requirements for a Freedom to Speak Up Guardian (FTSUG). Appoint FTSUG	Paper to QRC and agreed. FTSUG offered and agreed, Karen Richards Wright	

6.	3.1.5c Reconstruct the Corporate Risk register with clear escalation pathways and processes to the Board	Completed. Reported to Board at each formal meeting since September 2016.	To minimise the file size of this document, the evidence is retained by the QIP Programme Manager and available on request to the Board.
7.	3.1.5d Ensure risk registers are handled through Datix Web in order to pass control to managers, speed up recording, and improve monitoring and reporting. Ensure identified risks are included on the divisional Risk register"		
8.	3.1.6b Extend current RCA training to include enhanced guidance for panel chairs/members – to include guidance around SMART actions aligned where possible to auditable measures in order to measure effectiveness of action taken.		
9.	3.1.7b Upgrade Datix system to enhance functionality and feedback mechanisms to reporters		
10	3.1.7c Appoint Datix Administrator to support enhanced training programme for staff around Datix use		

HR Workstream Overview report

QIP Work stream HR	Executive Lead: Title: Director of Human Resources Name: Mark Gammage

Overall BRAG	Reporting Period:	Action BRAG rating analysis						
		B	R	A	G	B/G	Active Actions	Assurance Actions
	December 2016						23	5
		5	1	1	21		Total Actions in Workstream	
							28	

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.
Blue/Green	Blue subject to CQC confirmation.

Exception Report: Red / Amber Actions

Action	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
4.1.4c Agree and implement new process plan for Bank and Agency/temporary staff and demonstrate reduction in the use of agency (Reduce to no more than 10% of total pay bill).	**31/03/17**		07/12 - Went live 28/11/16 - Currently only a 10% reduction. No realistic prospect of reaching target by 31/03/17. Currently undertaking a daily count of the usage of agency clinical staff.	**Unknown**
4.1.2f We will expand our apprentice programme to support work opportunities in the communities we serve and achieve over 200 placements by April 2017-18	31/03/17		Likely challenge in achieving against the target date.	31/03/2017

HR Recommendations Regarding Delivered and Embedded Actions

	Action (Number then action narrative)	**Comments/Evidence**
1.	4.1.1a Revise Fit and Proper Person Policy in discussion with, and support from, our Improvement Director	To minimise the file size of this document, the evidence is retained by the QIP Programme Manager and available on request to the Board.
2.	4.1.1b Audit all current Executive Director and Non-Executive Director personal files and identify gaps with compliance.	
3.	4.1.1c Evidence of licensed accountant on the Board	
4.	4.1.2b Board approved Workforce Race Equality Standard in place. Workforce Race Equality Standard presented to and received by the Board	
5.	4.1.2c Action plan for Workforce Race Equality Standard presented to Board	

Estates Workstream Overview report

QIP Work stream Estates		Executive Lead: Title: Director of Estates and Facilities Name: Richard Hancock						
Overall BRAG	Reporting Period: December 2016	Action BRAG rating analysis						
		B	R	A	G	B/G	Active Actions	Assurance Actions
							24	14
		14	2	3	19	0	Total Actions in Workstream	
							38	

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.
Blue/Green	Blue subject to CQC confirmation.

Exception Report: Red / Amber Actions				
Action	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
5.1.6g Divisional Directors of Nursing to ensure that there is a nominated nurse for each ward who acts as the Fire Warden and receives relevant fire awareness and evacuation preparedness training and that this is then cascaded to the wider nursing team, with lessons learned being built in	31/07/16		% total of all shifts covered on each ward ranges from 14.28%– 100%; insufficient to demonstrate compliance with a fire warden on every ward on every shift. Additional training has been arranged for some areas but not all. This was included in the S31 Letter	TBC

5.1.11e Daily flushing carried out and documented for pseudomonas	**30/11/16**		Flushing returns for November: 100% GICU 90% NICU 70% Dialysis technicians A risk assessment of the 14 areas will be conducted by Infection Control & Estates, together with the local manager to identify infrequent used outlets by the end of w/c 05/12/2016. It was also agreed that Estates could go to Trust suppliers to tender for a Trust-wide, long term solution. Presently going through Procurement.	**TBC**
5.1.3 Immediately initiate survey and inspection of fixed wiring in Buckland.	05/08/16		Infrastructures including circuits have all been tested and repaired. Outstanding area of testing is Buckland Ward - due to clinical risk - clinicians don't want power turned off as high risk patients require continuous power supply. Knightsbridge Wing will be fully decanted by end of Dec-16; all staff and patients will be relocated and this risk will be removed.	31/12/16
5.1.5 Relocate 15% outpatient services in Lanesborough Wing	30/09/16		14% relocated. Remaining 1% (BPU) will be moved to Nelson. The live date is 15 December 2016. Following this, 15% will be achieved.	31/12/16
5.1.22b The paediatric ward environment is safe and suitable for treating and caring for children and young people with mental health conditions.	31/01/17		RA has been carried out. Ligature points have been removed. Awaiting approval for funding for remedial work. Costs currently with DDN Risk that this date will not be met doe to tendering process and funding	31/01/17

Risk/Issue to Highlight to QIB	**Mitigating Action**	**Status**
5.1.11e Daily flushing carried out and documented for pseudomonas Part of the 29A Warning notice compliance requirements	A risk assessment of the 14 areas will be conducted by Infection Control & Estates, together with the local manager to identify infrequent used outlets by the end of w/c 05/12/2016. It was also agreed that Estates could go to Trust suppliers to tender for a Trust-wide, long term solution. Presently going through Procurement.	

Estates Recommendations Regarding Delivered and Embedded Actions

	Action (Number then action narrative)	**Comments**	**Evidence**
1.	5.1.1 Immediately repair known leaks to the roof on Buckland Ward, Knightsbridge Wing	Completed and confirmed to CQC in Chief Executive's Letter 07/07/2016. Cleared Gutters and drains. Vegetation pruning and removal of tree and roots.	To minimise the file size of this document, the evidence is retained by the QIP Programme Manager and available on request to the Board.
2.	5.1.2 Close beds in those areas within the Ward affected by the ingress of water and declare those areas unusable until the electrical works have been certified.	Completed and confirmed to CQC in Chief Executive's Letter 07/07/2016. Beds have now been removed, the area has been zoned off and secured, this area has been taken out of use.	
3.	5.6.1.a Continue weekly fire alarm testing, routine servicing and independent testing	Completed and confirmed to CQC in Chief Executive's Letter 04/07/2016 Work has been completed certificates supplied	Witnessed weekly testing on a Wednesday
4.	5.1.9.b Replace 2 faulty air handling units in St James Wing theatres.	Completed. Air handling units installed.	To minimise the file size of this document, the evidence is retained by the QIP Programme Manager and available on request to the Board.
5.	5.1.6.b Introduce fire compartmentation to second floor Plant Room Lansborough Wing	Completed and confirmed to CQC in Chief Executive's Letter 04/07/2016 Work has been completed certificates supplied	
6.	5.1.6.c Complete audit and replacing where necessary fire extinguishers to all locations including plant rooms	Completed and confirmed to CQC in Chief Executive's Letter 04/07/2016	
7.	5.1.6.d Upgrade fire compartmentation, including fire doors, to the vertical escape routes in Lanesborough Wing	Completed and confirmed to CQC in Chief Executive's Letter 04/07/2016	
8.	5.1.6.h Targeting high risk areas initiate a series of table top fire exercises covering two clinical areas each week.	Confirmed in Chief Executive's Letter to CQC 07/07/2016. 11/10 - This has been complete 30/09/16. This will become a rolling programme across all clinical areas.	

9.	5.1.6. j Fire Safety Advisors to meet London Fire Brigade Inspection Team and invite LFB to undertake independent inspections to provide further assurance. Fire Brigade inspecting officers Matthew Swanepoel & Carol Campbell have met with Estates. The date of the inspection is 31st August 2016		To minimise the file size of this document, the evidence is retained by the QIP Programme Manager and available on request to the Board.
10.	5.1.7 Relocate staff working in Wandle Annex and demolish this facility.	Staff have been relocated. Building is now demolished.	
11.	5.1.11. c Replace electronic monitoring (L8 Guard) with paper and department folders until suitable electronic flushing records can be resolved.		Reverted to paper based reporting in October 2016
12.	5.1.11.d Twice weekly flushing carried out and documented for Legionella		To minimise the file size of this document, the evidence is retained by the QIP Programme Manager and available on request to the Board.
13.	5.1.13 Replace ripped chairs within patient areas in ED so that they can be thoroughly cleaned.		NO ripped chairs in ED as of November 2016
14.	5.1.14 Identify the cause of the leaks in the Emergency Department and ensure repairs are made.		To minimise the file size of this document, the evidence is retained by the QIP Programme Manager and available on request to the Board.

Operations Workstream Overview report

QIP Work stream Operations		Executive Lead: Title: Chief Operating Officer Name: Mark Gordon						
Overall BRAG	**Reporting Period:** December 2016	**Action BRAG rating analysis**						
		B	**R**	**A**	**G**	**B/G**	**Active Actions**	**Assurance Actions**
							41	**2**
		2	**0**	**3**	**39**	**0**	**Total Actions in Workstream**	
							44	

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.
Blue/Green	Blue subject to CQC confirmation.

Exception Report: Red / Amber Actions

Action	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
6.1.4a Patient Access Percentage of telephone calls answered by staff in the outpatient department are within the service level agreement targets of ≥95%	01/12/16		Although there is significant improvement from 40%-93%, the Trust target of 95% has not yet been met.	**28/02/17**
6.6.1c Must do - The data used in reporting and performance management must be robust and valid. Data Management Implement standard suite of reports and dashboards for non RTT related data	**01/06/2017**		This area is to be revisited by DCOO & HOI to reflect non RTT data management (18 weeks, diagnostics and cancer)	**01/06/17**
6.6.1d Implement a programme of validation and data quality audit.	**01/08/2017**		This area is to be revisited by DCOO & HOI to reflect non RTT data management (18 weeks, diagnostics and cancer)	**01/08/17**

Risk/Issue to Highlight to QIB		Status
6.3 Neuro-rehabilitation & amputation service No response from DDN in relation to this area of the operations workstream. It has been escalated to DDO, the COO & Divisional Chair	This is a CQC Must do - Develop a strategy for the neurorehabilitation and amputation service	

Operations

Recommendations Regarding Delivered and Embedded Actions

	Area	Action (Number then action narrative)	Comments/Evidence
1.	**Equipment requirements**	6.2.1a Purchase required number of Ureteroscopes and cystoscopes.	To minimise the file size of this document, the evidence is retained by the QIP Programme Manager and available on request to the Board.
2.	**Health visiting**	6.7.2b Robust mechanisms for data collection relating to the 6 to 8 week health visiting reviews are in place.	Health visitors are not responsible for the reviews, this is a GP responsibility. The HV service will put in place a system to ensure they work with GPs to record the date of the GP reviews and submit as part of the minimum data set to NHS England. SGHT participating in a SWL information hub from April 2017. No further action to be taken

Informatics Workstream Overview report

QIP Work stream Healthcare Informatics		Executive Lead: Title: CIO & SIRO Name: Larry Murphy						
Overall BRAG	**Reporting Period:** December 2016	**Action BRAG rating analysis**					**Active Actions**	**Assurance Actions**
		B	**R**	**A**	**G**	**B/G**	**6**	**0**
		0	**0**	**0**	**6**	**0**	**Total Actions in Workstream**	
							6	

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.
Blue/Green	Blue subject to CQC confirmation.

Exception Report: Red / Amber Actions

Action	Target Completion Date	Status	Explanation for RAG rating	Expected completion date

Risk/Issue to Highlight to QIB

Rated green due to working within Target dates. However IT systems and integrity of data is a significant risk for the Trust. The CIO has agreed to further extend the plan to include "improving electronic access for clinical areas across the Trust and roll out of clinical systems programmes e.g. e-prescribing, whiteboards and NEWS" This will be included in the next iteration of the QIP V1.6	Full review currently under way.

Leadership Workstream Overview report

QIP Work stream Leadership		Executive Lead: Title: Chief Executive Officer Name: Simon Mackenzie						
Overall BRAG	**Reporting Period:** December 2016	**Action BRAG rating analysis**					**Active Actions**	**Assurance Actions**
		B	**R**	**A**	**G**	**B/G**	**13**	**1**
		1	**0**	**0**	**13**	**0**	**Total Actions in Workstream**	
							14	

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.
Blue/Green	Blue subject to CQC confirmation.

Risk/Issue to Highlight to QIB	**Mitigating Action**	**Status**
Rated green due to working within Target dates, however, a Trust strategy and a stable, substantive leadership team are fundamental for moving the Trust from an inadequate rating to good or outstanding.	Interim EMT and Chair in place. On-going recruitment of NEDS. Strategy development under way.	

Leadership Recommendations Regarding Delivered and Embedded Actions

	Action (Number then action narrative)	**Comments**	**Evidence**
1.	8.1.2 Paper and board workshop to confirm vision, clinical vision and priorities		To minimise the file size of this document, the evidence is retained by the QIP Programme Manager and available on request to the Board.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	5 January 2017	**Agenda No**	**2.2**
Report Title:	Performance and Quality Report		
Lead Director/ Manager:	Mark Gordon & Suzanne Banks		
Report Author:	S Shannon & Hazel Tonge		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:			
Recommendation:	The Trust Board is asked to receive and note the Trust Performance and Quality Board report.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of performance, quality and safety, and patient experience.		
CQC Theme:	Addresses all five key themes: Safe, effective, caring, responsive and well-led		
Single Oversight Framework Theme:	Performance against key national indicators and Quality of Care		
Implications			
Risk:	N/a		
Legal/Regulatory:	N/A		
Resources:	No additional resources		
Previously Considered by:	None	**Date**	
Equality Impact Assessment:			
Appendices:	Appendix A – Quality Paper		

Quality Report
Trust Board, 5 January 2017

1.0 PURPOSE

1.1 To provide assurance to the Trust Board of performance against: the National Risk Assessment Framework, national access standards, quality of care against core indicators and clinical effectiveness.

1.2 To highlight areas that require improvement and provides an update on actions

2.0 KEY MESSAGES

2.1 There are several key points of note for the Board in relation to November performance and quality:

Performance against key national performance indicators:

Since April 16 we have seen a significant increase in in-patient activity, particularly non elective which has remained consistently over target. In November compared to April non elective activity increased by an average of 17.2%, equating to 167 additional cases per month. In addition, elective has increased by 9.2% and day case by 8%.

On the day cancelled operations increased in November, The top 3 reasons were:

1. Major incident – tram derailment.
2. Estates issues – theatres too cold or ventilation failure.
3. Previous case over ran/ emergency took priority.

Cancelled operations are now reviewed weekly as part of the activity planning meeting to identify opportunities for improvement. A tighter escalation and tracking process has been introduced to ensure all appropriate actions are taken before cancellation. All patients cancelled were offered dates within 28 days but a number declined due to the Christmas period and will be operated on in January 17.

The preparations for managing occupancy and increased unplanned activity for the December – January period dominated the operations agenda over the past period.

NHSI had instructed Trusts to reduce Bed Occupancy levels to 85% from 19/12/16 to 16/04/17, and to reduce elective activity in order to reduce pressure on unplanned activity.

All Divisions were involved in the planning process since early November in order to maintain appropriate levels of activity by delivering a plan involving the following steps:

- Reduction of Elective Activity by 66% or below (where requiring overnight stay),
- Increased levels of Day Surgery (including booking into Main Theatres),
- Reduction of Repatriation Patients,
- All Cancer/Trauma/CPOD cases prioritised.
- Improved performance in ED by improving flow in the hospital from AMU – Specialty Beds

- Reduction of MFD (Medically Fit for Discharge) patients in hospital beds,
- Reduction of Medical Outliers.

Additionally, within the plan, the Divisions have been tasked to physically close beds from key dates between 19-24 December. This has resulted in the closure of over 120 beds. The management of these areas and their re-opening is being strictly controlled in line with requirement. This has the benefit of reducing costs of maintaining beds, as well as focussing operational management during the period on disciplined utilisation of appropriate resources.

All Divisions booked December activity from early November to fit the actions listed above at the Weekly Activity Planning meeting; notably the increased Day Surgery cases into Main Theatres.

The results have been:

1. Occupancy reduced and maintained at less than 85% since Thursday 22nd December (improved performance compared to December 2015). It has averaged at 78% for several days over the period, and is currently 82% (29 December).
2. ED Performance has improved over the period (up to 91.11% Week Commencing 19 December, and maintained at 95.7% Week commencing 26 December (including high attendance days), compensating for 2 poor performing weeks in early December.
3. Medical Outliers have been reduced to average 3 patients which is a significant reduction compared to Christmas 2015 figures (average 25-30).
4. Repatriation patients has reduced to nil waiters longer than 5 days.
5. All cancer and trauma cases have been prioritised for treatment.
6. Elective surgery has continued, including increased Day Surgery caseload over the period thus maintaining a proportion of elective income during the period.

Clinical Effectiveness

2.2 Mortality indicators remain better than expected
2.3 Raw mortality remains within normal limits
2.4 Outlier Alert Dr Foster Imperial Unit for Coronary Atherosclerosis showed no clinical concerns; although identified coding issues identified.
2.5 Participated in launch of National Mortality Case Record Review and planning local implementation
2.6 Safety Thermometer for this month was 94.85% which is slightly lower than the national average (95%)
2.7 Significant number of non or partial NICE compliance which are being monitored through PSQB

Patient Safety

2.8 There has been a reduction in Serious Incidents (SIs) declared Apr-Nov: 2016/17: 71 compared with 107 SIs declared Apr-Oct 15/16, this represents a 34% decrease.
2.9 There has been a decrease in the number of falls reported over the last month compared to the previous month and the lowest number of falls this financial year (data not individually verified). Of the 128 falls, 108 were reported as no harm, 18 low harm, and 2 moderate/severe harm (Extreme harm –Gordon Smith and Moderate harm – Community).

2.10 The rate per 1000 bed days for falls on the acute site is 3.69 (NPSA 2010 average rate per 1000 bed days for acute= 5.6) and the rate per 1000 bed days for the community site is 9.16 (NPSA 2010 average rate per 1000 bed days for community=8.6).

2.11 The post falls protocol has been redesigned to include names and bleep numbers of health care professionals who have been informed of an inpatient fall

2.12 The revised version of the multifactorial falls risk assessment (NICE compliant) is now available for ordering

2.13 Total number of Trust-apportioned episodes of *Clostridium difficile* infection was 22 at the end of November 2016. This compares to 29 at the same time in 2015. The threshold for 2016-17 is not more than 31. If the trust position is in line with 2015-16 the threshold will not be exceeded. There is a risk of the trust exceeding the threshold despite the number and rate of episodes being up to 50% lower than other comparable hospitals in London. Root cause analysis is performed for all Trust-apportioned episodes. Of those analysed so far this year, there have been no lapses in care identified i.e. no evidence of patient to patient transmission. There have been some issues with documentation of review dates of antibiotics in patients.

2.14 The trust has reported its fifth consecutive month of zero pressure ulcer serious incidents and remains on target to meet its threshold of 19.

2.15 VTE compliance via Unify reported at 95.99% (see footnote i)

2.16 A Safeguarding review of services has been commissioned by the Chief nurse

2.17 Safeguarding Level 3 children has improved at 89% for the Trust based on manual data, and adult safeguarding is 85% (on target)

2.18 A Serious Case Review is due for publication in January 2017. Any recommendations that impact on the trust will be noted and monitored through the safeguarding committee and reported to the Quality committee.

Patient Experience

2.19 Number of complaints increased significantly from 67 in October to 92 in November, with no particular changes around themes.

2.20 Complaints performance has remained the same overall in October.

2.21 Number of PALS concerns received in November remains high: 326 compared to 346 in October.

2.22 Overall FFT scores indicate 96% would recommend the Trust as a place to be cared for (December 16)

Workforce

2.23 Overall the Trust establishment fill rate is 94.27%.

2.24 The number of staffing alerts increased this month, with the community division reporting a high number. Divisions have assured that no adverse patient harm has resulted. The Community division have employed a recruitment nurses to assist in reducing vacancies and improving retention

4.0 NEXT STEPS OR TIMELINE

5.1 A new board report is being finalised in line with Operations and Governance Unit.

5.0 RECOMMENDATION

5.1 The Trust Board is asked to:

i. Receive and note the Trust Quality Board report

Date: 28/12/2016

[i] **The target for patients being assessed for risk of VTE **during** admission is set at 95%. Data is extracted from electronic records following discharge from the Trust, measuring the number of patients where a record of risk assessment has been made (either on Merlin discharge summary or via electronic assessment on iClip) against the total number of admissions.*
ST - Nursing staff collect data monthly across a range of safety indicators, including completion of VTE risk assessment, via the safety thermometer. Data is collected for all patients across the Trust on a single day of the month, representing a snapshot in time. Data is obtained from the drug chart and measures the total number of complete VTE risk assessments at the point of audit against the total number of beds occupied. Data is adjusted by HTG to exclude 'Not Applicable' recordings (these are validated by the team
There are differences in the methodology of collecting the different data streams. Data submitted to the Safety Thermometer is regularly validated by the thrombosis nursing team. The team consistently find variation in the interpretation of the audit tool across the Trust, resulting in inconsistent and sometimes inaccurate results. This problem is encountered nationally and limits the reliability and value of the data presented. The RAG ratings represented on this data sheet (from April 2015 onward) are as follows: Green >95%, Amber >90-<95%, Red <90% (this may differ to RAG ratings used in other reporting tools).

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St George's University Hospitals NHS
NHS Foundation Trust

Performance Report
For Trust Board

Month 8 – November 2016

Excellence in specialist and community healthcare

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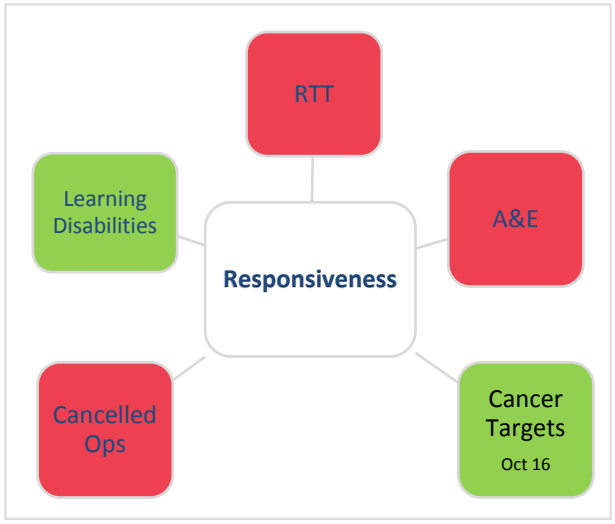
St George's University Hospitals NHS
NHS Foundation Trust

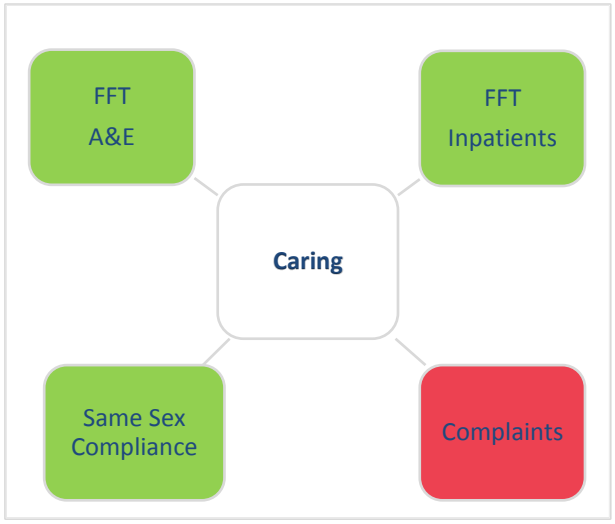
Performance against Frameworks

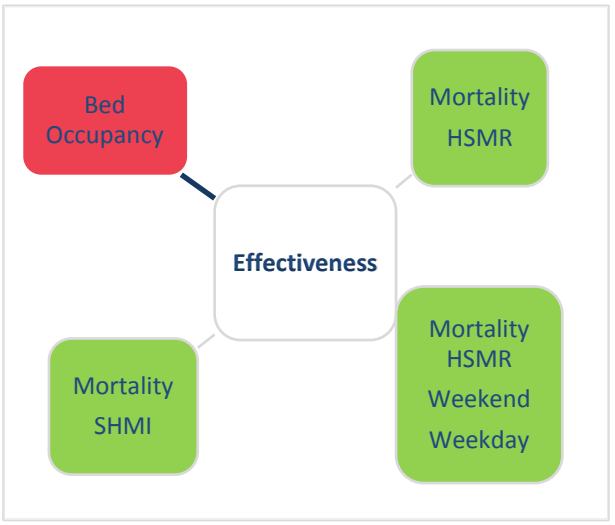
Excellence in specialist and community healthcare

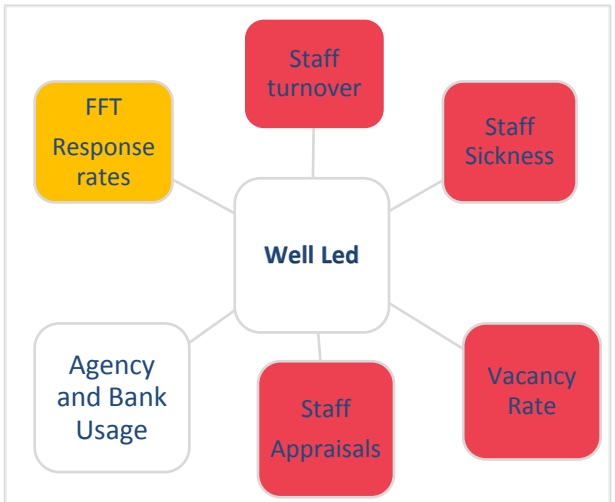
1. Executive Summary - Key Priority Areas November 2016*

St George's University Hospitals NHS
NHS Foundation Trust









The above shows an overview of November 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 October 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: November 2016 Performance (Page 1 of 1)

St George's University Hospitals NHS
NHS Foundation Trust

	Metric	Standard	Weighting	Score	YTD	Oct-16	Nov-16	Movement
ACCESS	Referral to Treatment Incomplete Pathways	92%	1	1		86.40%	86.30%	-0.10%
	A&E All Types Monthly Performance	95%	1	1	92.96%	93.20%	93.50%	0.30%
	Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Q2**	**Q3**	**Movement**
	62 Day Standard	85%	1	0	85.03%	88.46%	88.60%	0.14%
	62 Day Screening Standard	90%			92.90%	94.50%	96.00%	1.50%
	31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	0.00%
	31 Day Subsequent Surgery Standard	94%		0	97.40%	97.70%	96.00%	-1.70%
	31 Day Standard	96%	1	0	97.40%	97.10%	97.20%	0.10%
	Two Week Wait Standard	93%	1	0	91.20%	93.79%	93.20%	-0.59%
	Breast Symptom Two Week Wait Standard	93%	1		93.60%	94.50%	98.90%	4.40%

	Metric	Standard	Weighting	Score	YTD	Sep-16	Oct-16	Movement
OUTCOMES	Clostridium(C.) Difficile - meeting the C.difficile objective (de minimise of 12 applies)	31	1	0	22	6	4	-2
	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		54.7	53.2	-1.5
	Referral Information	50%	1	0		86.9	86.8	-0.1
	Treatment Activity	50%	1	0		72.5	71.6	-0.9
	Trust Overall Quality Governance Score					**2**	**2**	0

November 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. Q3 relates to October performance only.

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

MONITOR GOVERNANCE THRESHOLDS	
	Green: a service performance score of <4.0 or <3 consecutive quarters' breaches of a single metric
	Governance Concern Trigger and Under Review : a service performance score of >=4.0 or 3 consecutive quarters' breaches of single metric with monitor undertaking a formal review, with no regulatory action.
	Red: a service performance score of >=4 and >=3 consecutive quarters' breaches of single metric and with regulatory action to be taken

2. Trust Key Performance Indicators 2016/17: November 2016 Performance

St George's University Hospitals NHS
NHS Foundation Trust

RESPONSIVENESS

Metric	Standard	YTD	Oct-16	Nov-16	Movement
Referral to Treatment Incomplete	92%		86.40%	86.30%	-0.10%
Referral to Treatment Incomplete 52+ Week Waiters	0		14		
Diagnostic waiting times > 6 Weeks	1%		0.99%	0.99%	0.00%
A&E All Types Monthly Performance	95%	92.6%	93.2%	93.5%	0.30%
12 Hour Trolley Waits	0	0	0	0	0.00%
Proportion of patients not treated within 28 days of last minute cancellation	0%	12.64%	5.70%	9.80%	4.10%
Certification against compliance with requirements regarding access to health care with a learning disability	Compliant	Yes	Yes	Yes	

EFFECTIVENESS

Metric	Standard	YTD	Oct-16	Nov-16	Movement
Hospital Standardised Mortality Ratio (DFI)	100		86.7	84.1	-2.60
Hospital Standardised Mortality Ratio - Weekday Emergency	100	0	84.2	86.7	2.5
Hospital Standardised Mortality Ratio - Weekend Emergency	100	0	92.0	82.4	-9.6
Summary Hospital Mortality Indicator (HSCIC)	100	0	0.90	0.90	0.0
Bed Occupancy - Midnight Count General Beds Only	85%		96.9%	97.2%	0.3%
LOS - Elective			4.7	5.1	0.4
LOS - Non-Elective			3.9	4.1	0.20

Metric	Standard	YTD	Sep-16	Oct-16	Movement
62 Day Standard	85%	85.03%	88.28%	88.60%	0.32%
62 Day Screening Standard	90%	92.90%	92.00%	96.00%	4.00%
31 Day Subsequent Drug Standard	98%	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%	97.40%	93.8%	96.0%	2.20%
31 Day Standard	96%	97.40%	96.20%	97.20%	1.00%
Two Week Wait Standard	93%	91.20%	94.20%	93.20%	-1.00%
Breast Symptom Two Week Wait Standard	93%	93.60%	96.00%	98.90%	2.90%

CARING

Metric	Standard	YTD	Oct-16	Nov-16	Movement
Inpatient Scores - Friends & Family Recommendation Rate	60		94.2%	97.5%	3.30%
A&E Scores - Friends & Family Recommendation Rate	46		86.63%	84.40%	-2.23%
Number of complaints			67	92	25
Mixed Sex Accommodation Breaches	0	0	0	0	0.0

SAFE

Metric	Standard	YTD	Oct-16	Nov-16	Movement
Clostridium Difficile - Variance from plan	31	22	6	4	-2
MRSA Bacteraemia	0	1	1	0	-1
Never Events	0	2	0	0	0
Serious Incidents	0	68	7	10	3
Percentage of Harm Free Care	95%		96.5%	95.8%	-0.7%
Medication Errors causing serious harm	0	7	0	2	2
Overdue CAS Alerts	0	1	1	1	0
Maternal Deaths	1	0	0	0	0
VTE Risk Assessment (one monthe in arreas)	95%		96.3%	96.2%	-0.1%

WELL LED

Metric	Standard	YTD	Oct-16	Nov-16	Movement
Inpatient Response Rate Friends & Family	30%		28.1%	47.6%	19.5%
A&E Response Rate Friends & Family	20%		24.2%	21.5%	-2.7%
NHS Staff recommend the Trust as a place to work	58%	62.0%			
NHS Staff recommend the Trust as a place to receive treatment	4	3.78			
Trust Turnover Rate	13%		18.9%	18.0%	-0.9%
Trust level sickness rate	3.5%		3.6%	3.6%	0.00%
Total Trust Vacancy Rate	11%		15.0%	14.4%	-0.6%
% of staff with annual appraisal - Medical	85%		66.20%	81.10%	14.9%
% of staff with annual appraisal - non medical	85%		66.20%	65.10%	-1.1%

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

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St George's University Hospitals NHS
NHS Foundation Trust

Performance and Activity

Excellence in specialist and community healthcare

3. Monthly Headlines

Unplanned Care

AED – Due to a poor performance in early December, 4 hour performance for Qr 3 to date is slightly below target at 91.52% and 92.52% for the year to date.
Bed capacity continues to be the highest cause of 4 hour breaches followed by ED capacity and delay in treatment decisions.
The recent reduction in bed occupancy has had a positive impact on 4 hour performance to 95.7% in week commencing 26/12/16.

Planned Care

18 weeks RTT
Since August there has been significant improvement in the incomplete waiting list with a reduction of 2,691 patients and a reduction in the 18 week backlog of 636 patients Backlog reduction also seen within First OP PTL (21.9%) and Admitted PTL (14.8%) (comparison made between August and November data).
52 week breaches – 10 confirmed breaches for November, a reduction of 4 since October. 4 of 10 have been treated with the remainder being treated in January. All patients had previously been offered dates for treatment which they were unable to take.

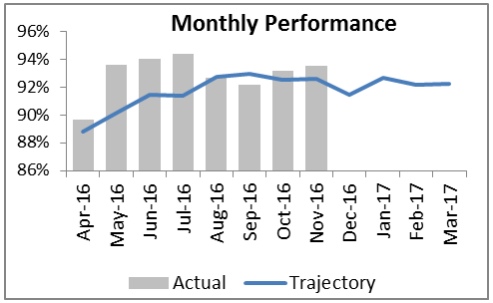
Cancer

All cancer standards achieved for October.
2ww – there continues to be high numbers of breaches in skin as a result of capacity pressures due to clinical vacancies, although the under performance in skin was offset by high performance across the other specialties. 2WW is predicted to be under standard in November. The plan to improve performance in 2WWs includes increased Capacity in Dermatology (Consultants) and Endoscopy (2 added rooms).
62 day – the standard has been achieved since July, however there has been an increase in 62 day backlog over October and November, within Upper GI and urology, (accounting for 50% of total backlog), which is likely to impact on performance when these patients are treated. However we have taken action to create added capacity for both Upper GI and Urology to enable increased treatment capability for cancer treatment.

St George's University Hospitals NHS
NHS Foundation Trust

The Sustainability and Transformation Fund Performance against Trajectory 2016/2017

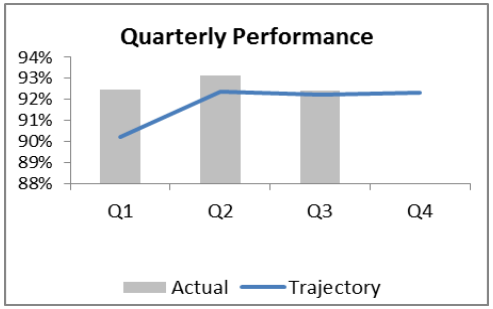
Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Attendances	13,606	14,521	14,523	14,413	13,373	14,075	14,317	14,207	14,006	14,275	14,197	15,317
Attendances<4 Hours	12,085	13,098	13,286	13,176	12,407	13,086	13,252	13,157	12,811	13,225	13,081	14,129
Breaches >4 Hours	1,521	1,423	1,237	1,237	966	989	1,065	1,050	1,195	1,050	1,116	1,188
Performance Trajectory	88.8%	90.2%	91.5%	91.4%	92.8%	93.0%	92.6%	92.6%	91.5%	92.6%	92.1%	92.2%
Performance Actual	89.7%	93.6%	94.0%	94.4%	92.7%	92.2%	93.2%	93.5%				
Meeting STF	✓ 0.9%	✓ 3.4%	✓ 2.5%	✓ 3.0%	✗ -0.1%	✗ -0.8%	✓ 0.6%	✓ 0.89%				



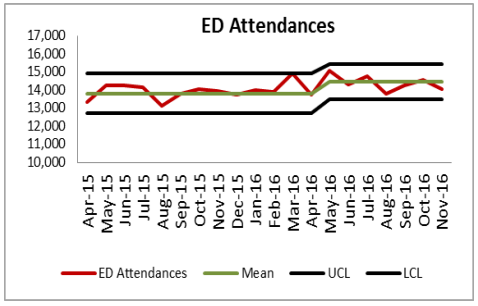
Quarterly Trajectory	Q1	Q2	Q3	Q4
Total Attendances	42,650	41,861	42,530	43,789
Attendances<4 Hours	38,469	38,669	39,220	40,435
Breaches >4 Hours	4,181	3,192	3,310	3,354
Performance	90.2%	92.4%	92.2%	92.3%

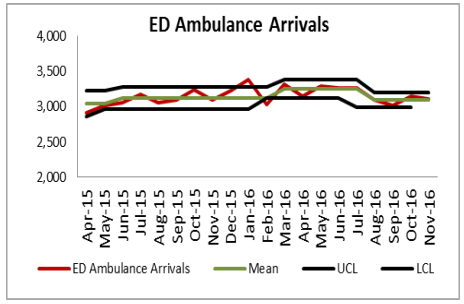
Quarterly Actual	Q1	Q2	Q3
Total Attendances	43,114	42,827	33,864
Attendances<4 Hours	39,874	39,888	31,295
Breaches >4 Hours	3,240	2,939	2,567
Performance	92.5%	93.1%	92.4%
Meeting STF	✓ 2.3%	✓ 0.8%	✓ 0.2%

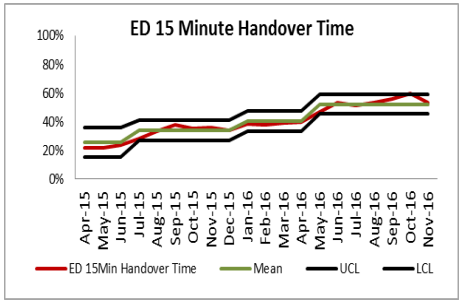
Met STF not National
Not met STF or National
Met STF and National

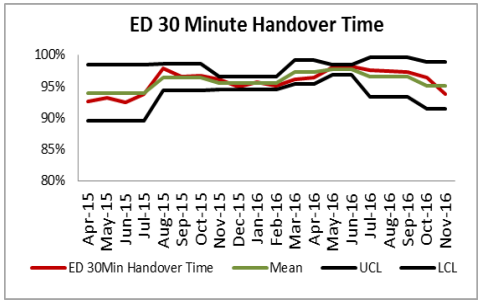


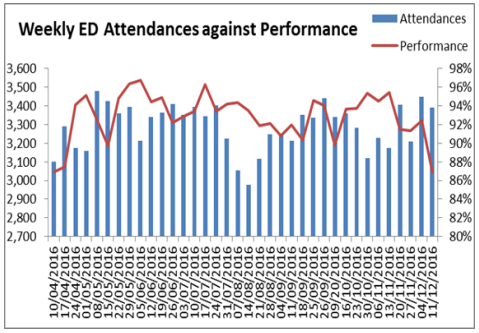
Weekly and Monthly Monitoring

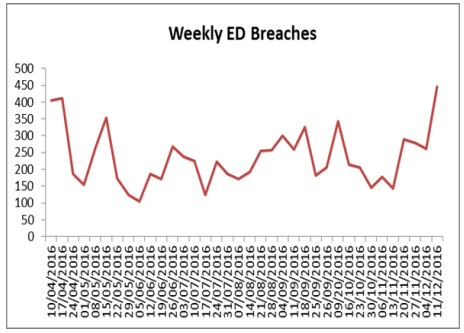


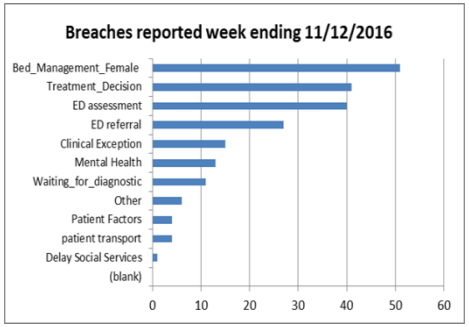


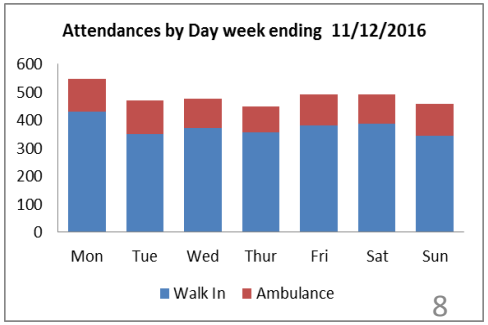












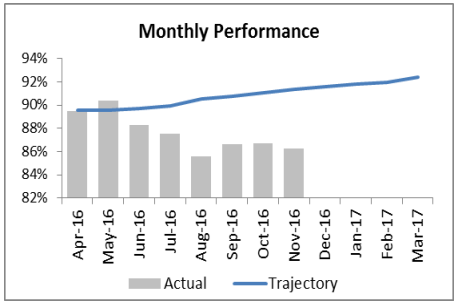
5. RTT Incomplete Pathways

The Sustainability and Transformation Fund Performance against Trajectory 2016/2017

Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Incomplete Waiting List	32,957	32,957	32,618	32,419	31,985	31,721	31,392	30,943	30,504	30,205	29,968	29,765
Total waits < 18 Weeks	29,526	29,526	29,261	29,162	28,956	28,794	28,577	28,274	27,932	27,734	27,558	27,511
Total waits > 18 Week Breaches	3,431	3,431	3,357	3,257	3,029	2,927	2,815	2,669	2,572	2,471	2,410	2,254
Performance Trajectory	89.6%	89.6%	89.7%	90.0%	90.5%	90.8%	91.0%	91.4%	91.6%	91.8%	92.0%	92.4%

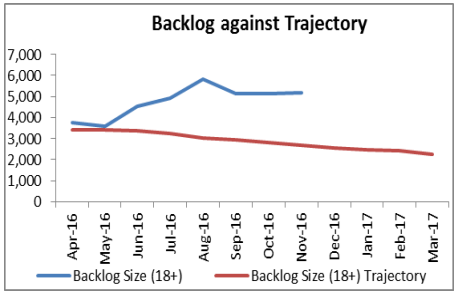
Total Incomplete Waiting List	35,626	37,243	38,849	39,573	40,299	38,635	38,594	37,608				
Total waits < 18 Weeks	31,873	33,668	34,309	34,635	34,498	33,487	33,454	32,443				
Total waits > 18 Week Breaches	3,753	3,575	4,540	4,938	5,801	5,148	5,140	5,165				
Performance Actual	89.5%	90.4%	88.3%	87.5%	85.6%	86.7%	86.7%	86.3%				
Meeting STF	✗ -0.1%	✓ 0.8%	✗ -1.4%	✗ -2.4%	✗ -4.9%	✗ -4.1%	✗ -4.4%	✗ -5.1%				

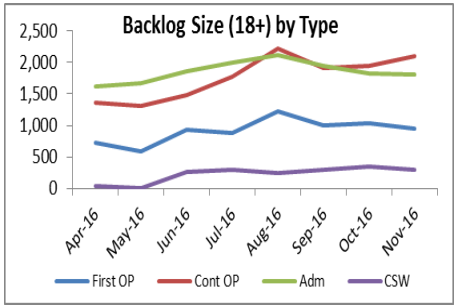
Met STF not National
Not met STF or National
Met STF and National



RTT Incomplete Backlog

	Backlog Size (18+)											
	May-16		Jun-16		Jul-16		Aug-16		Sep-16		Oct-16	
Specialty	OP	IP	OP	IP	OP	IP	OP	IP	OP	IP	OP	IP
General Surgery	212	199	226	214	305	232	493	265	370	223	385	238
Urology	102	95	155	99	150	84	171	82	172	54	172	58
Trauma & Orthopaedics	436	123	496	157	481	213	602	207	455	188	566	172
Ear, Nose & Throat (ENT)	186	623	247	675	301	695	432	745	296	740	397	676
Ophthalmology	1	0	36	0	39	0	37	0	36	0	30	0
Oral Surgery	5	54	4	81	6	109	8	152	2	63	10	106
Neurosurgery	22	18	40	26	45	18	96	31	78	32	98	26
Plastic Surgery	62	145	92	153	100	157	126	194	116	189	113	185
Cardiothoracic Surgery	9	70	12	65	6	73	6	66	3	57	10	41
General Medicine	43	1	77	0	65	0	54	0	19	0	102	0
Gastroenterology	257	60	338	113	366	132	405	106	289	74	249	65
Cardiology	35	85	73	61	94	68	125	55	122	45	118	50
Dermatology	195	0	384	0	325	0	354	0	246	0	322	0
Thoracic Medicine	38	0	64	7	108	12	76	2	69	2	62	1
Neurology	7	4	25	2	45	2	86	2	59	0	60	5
Rheumatology	26	0	19	0	26	0	36	0	37	0	70	0
Geriatric Medicine	1	0	6	0	5	0	1	0	2	0	4	0
Gynaecology	128	134	194	164	237	167	241	158	258	132	212	124
Other	147	52	197	38	243	29	336	51	576	144	341	72
Total	1912	1663	2685	1855	2947	1991	3685	2116	3205	1943	3321	1819
Monthly Grand Total	3575		4540		4938		5801		5148		5140	

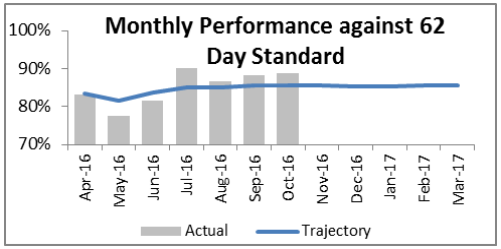




The Sustainability and Transformation Fund Performance against Trajectory 2016/2017 - 62 Day Standard

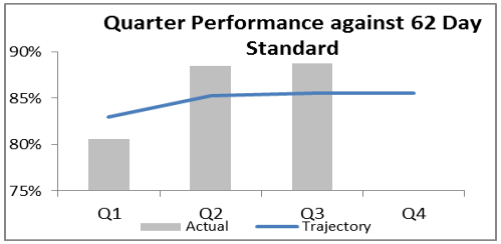
Met STF not National
Not met STF or National
Met STF and National

Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Treatments	60	60	74	74	74	63	70	63	68	68	70	70
Treatments <62 Days	50	49	62	63	63	54	60	54	58	58	60	60
Breaches >62 Days	10	11	12	11	11	9	10	9	10	10	10	10
Performance Trajectory	83.3%	81.7%	83.8%	85.1%	85.1%	85.7%	85.7%	85.7%	85.3%	85.3%	85.7%	85.7%
Total Treatments Actual	59.5	71	70.5	71.5	59.5	64	62.5					
Total Treatments within 62 Days Actual	49.5	55	57.5	64.5	51.5	56.5	55.5					
Total Breaches Actual	10	16	13	7	8	7.5	7					
Performance Actual	83.2%	77.5%	81.6%	90.2%	86.6%	88.3%	88.8%					
Meeting STF	✗ -0.1%	✗ -4.2%	✗ -2.2%	✓ 5.1%	✓ 1.4%	✓ 2.6%	✓ 3.1%					



Quarterly Trajectory	Q1	Q2	Q3	Q4
Total Treatments	194	211	201	208
Treatments <62 Days	161	180	172	178
Breaches >62 Days	33	31	29	30
Performance	83.0%	85.3%	85.6%	85.6%

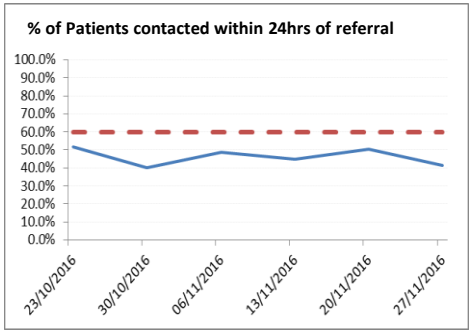
Quarterly Actual	Q1	Q2	Q3	Q4
Total Treatments	201	195	62.5	
Treatments <62 Days	162	172.5	55.5	
Breaches >62 Days	39	22.5	7.0	
Performance	80.6%	88.5%	88.8%	
Meeting STF	✗ -2.4%	✓ 3.2%	✓ 3.2%	

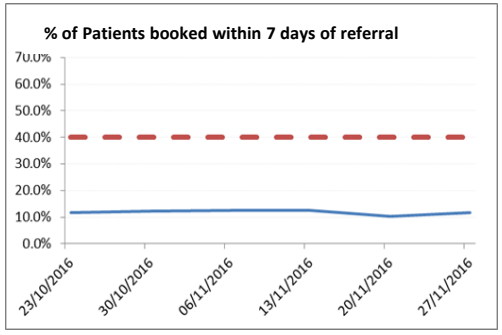


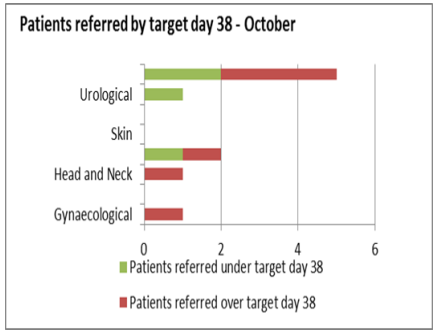
All Cancer Standards Performance Indicators

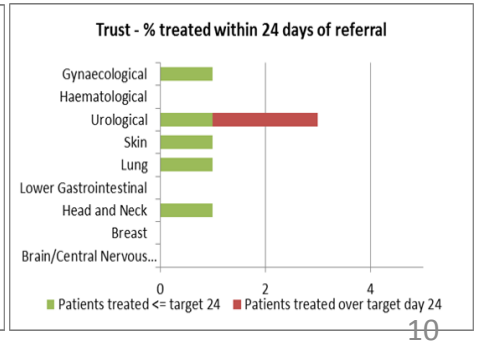
All Cancer Standards	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Trend
14 Day GP Referral (93%)	86.6%	87.3%	90.0%	93.1%	95.1%	94.2%	93.2%						
14 Day Breast Symptomatic (93%)	94.8%	95.2%	85.9%	93.8%	94.2%	96.0%	98.9%						
31 Day First Treatment (96%)	98.3%	96.3%	98.8%	97.6%	97.4%	96.2%	97.2%						
31 Day Subsequent Treatment Surgery(98%)	100.0%	94.7%	96.6%	100.0%	100.0%	93.8%	98.8%						
31 Day Subsequent Treatment Drug(98%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%						
62 Day Referral (85%)	83.2%	77.5%	81.6%	90.2%	86.6%	88.3%	88.8%						
62 Day Screening (90%)	93.9%	84.8%	94.8%	95.0%	95.8%	92.0%	96.2%						
62 Day Consultant Upgrade (85%)	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	92.6%						

Key Metrics









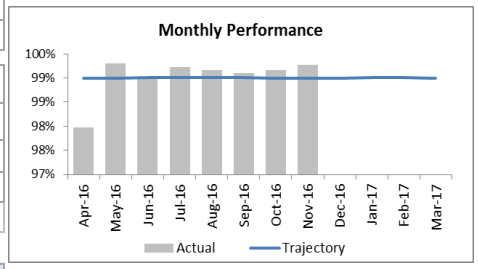
7. Summary of Diagnostic Performance

St George's University Hospitals NHS
NHS Foundation Trust

The Sustainability and Transformation Fund Performance against Trajectory 2016/2017

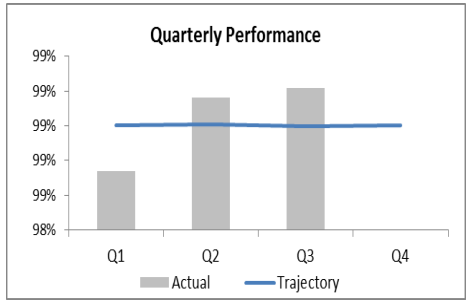
Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Waits	5,788	5,386	6,046	5,718	5,429	5,750	5,803	5,860	5,776	5,813	5,816	5,802
Total Waits <6 Weeks	5,730	5,332	5,986	5,661	5,375	5,693	5,745	5,801	5,718	5,755	5,758	5,744
Total Waits >6 Weeks	58	54	60	57	54	57	58	59	58	58	58	58
Performance Trajectory	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%
Total Waits	7,290	6,588	6,977	6,436	6,085	6,258	6,834	6,878				
Total Waits <6 Weeks	7,142	6,542	6,908	6,386	6,034	6,202	6,777	6,828				
Total Waits >6 Weeks	148	46	69	50	51	56	57	50				
Performance Trajectory	98.0%	99.3%	99.0%	99.2%	99.2%	99.1%	99.2%	99.3%				
Meeting STF	✗ -1.0%	✓ 0.3%	✓ 0.0%	✓ 0.2%	✓ 0.2%	✓ 0.1%	✓ 0.2%	✓ 0.3%				

Met STF not National
Not met STF or National
Met STF and National

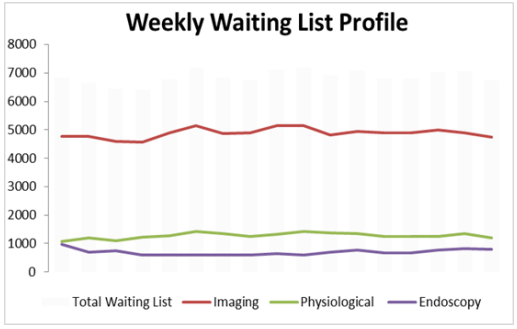


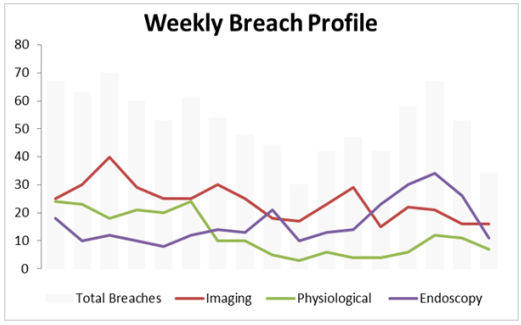
Quarterly Trajectory	Q1	Q2	Q3	Q4
Total Waits	17,220	16,897	17,439	17,431
Total Waits <6 Weeks	17,048	16,729	17,264	17,257
Total Waits >6 Weeks	172	168	175	174
Performance	99.0%	99.0%	99.0%	99.0%

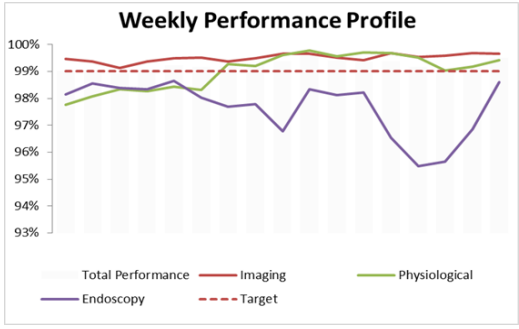
Quarterly Actual	Q1	Q2	Q3	Q4
Total Waits	20,855	18,779	13,712	
Total Waits <6 Weeks	20,592	18,622	13,605	
Total Waits >6 Weeks	263	157	107	
Performance	98.7%	99.2%	99.2%	
Meeting STF	✗ -0.3%	✓ 0.2%	✓ 0.2%	



Weekly Performance Monitoring up to 04/12/2016

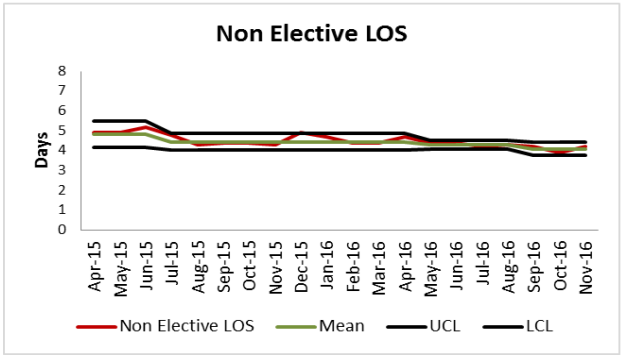


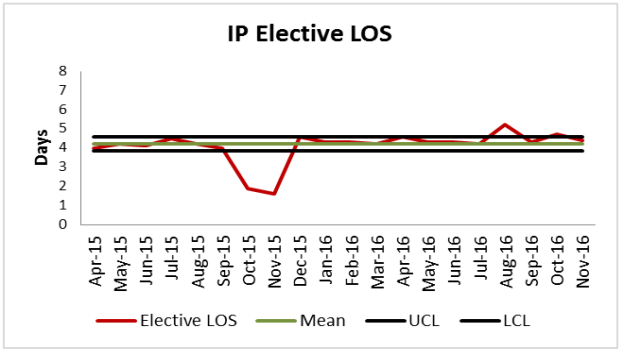


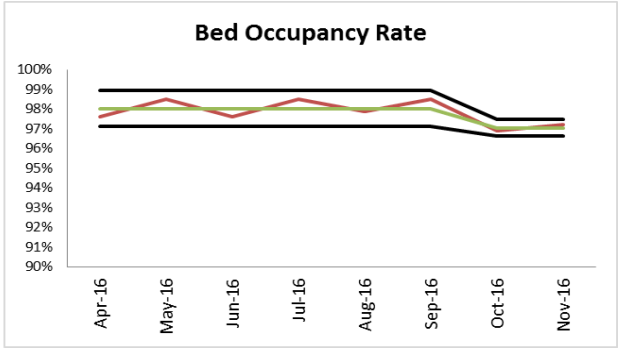


8. Operational Dependencies

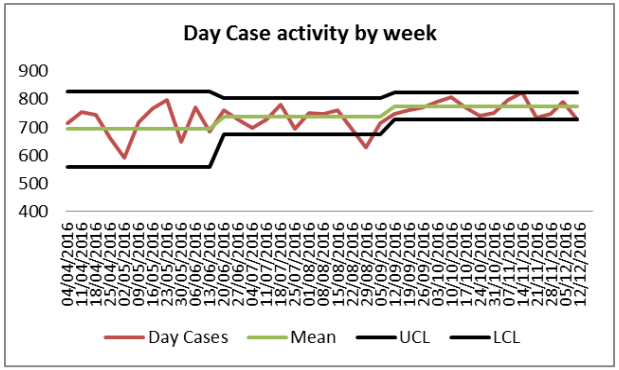
Length of Stay and Bed Occupancy Level by Month

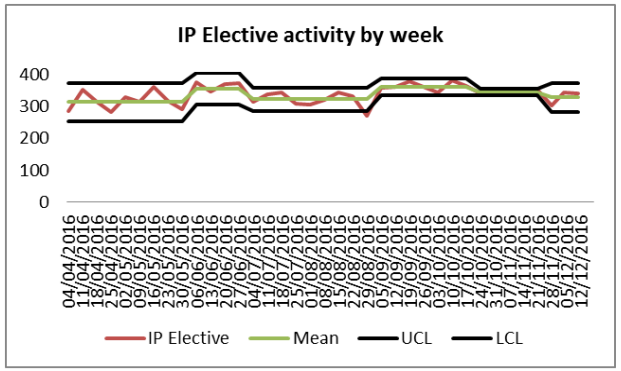


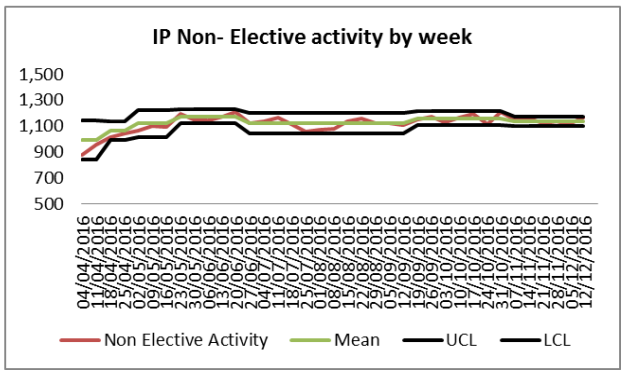




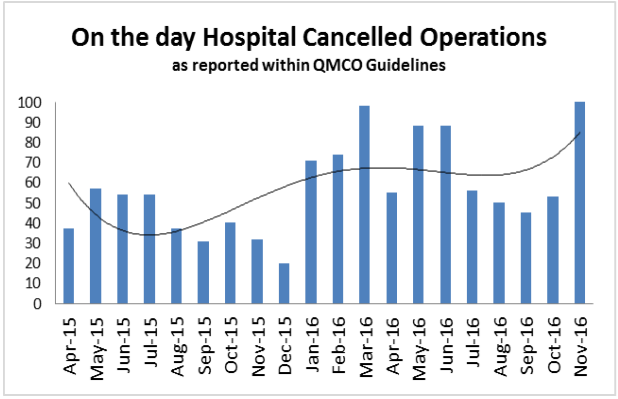
Theatre Productivity by Week

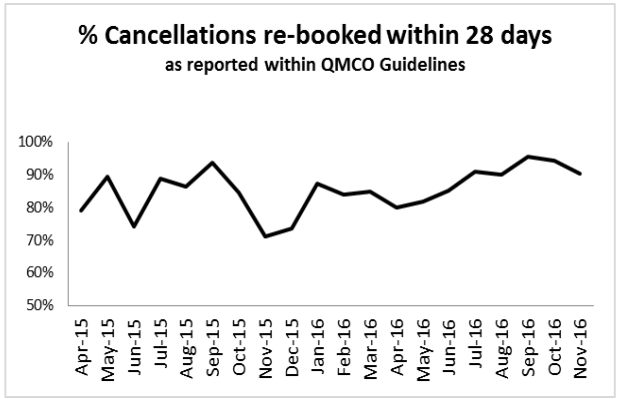


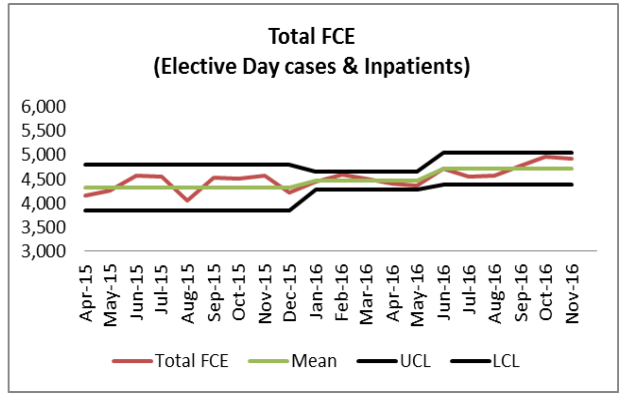




Cancelled Operations



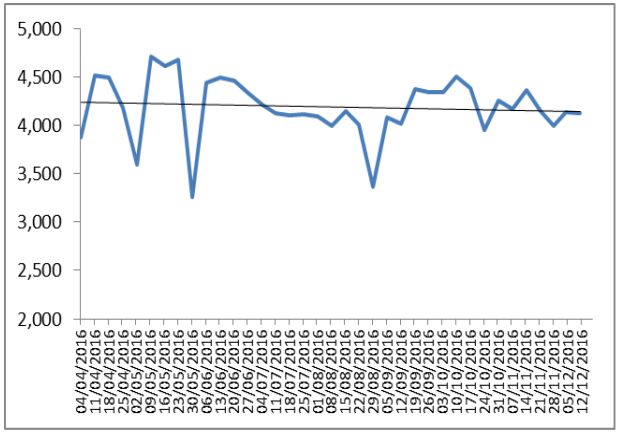


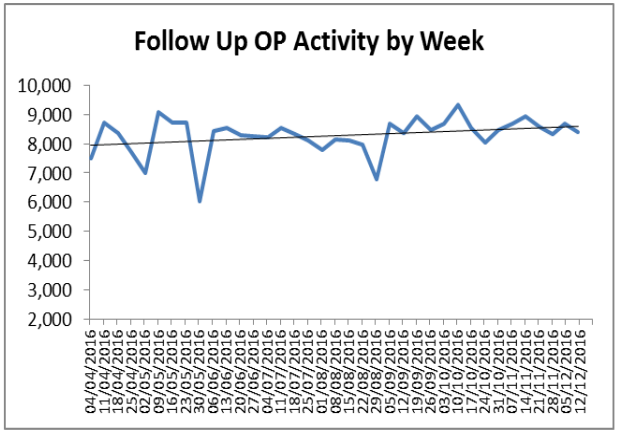


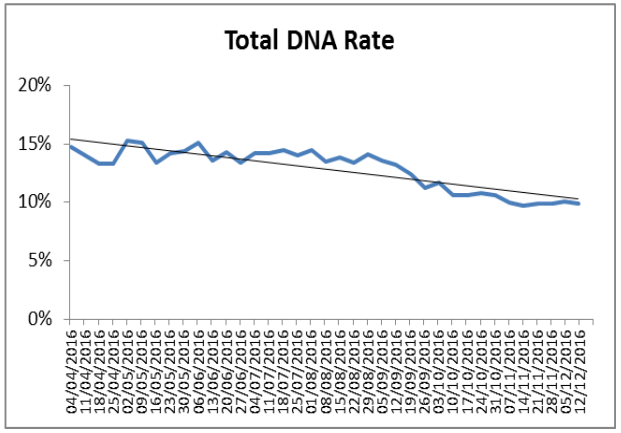
8. Operational Dependencies

St George's University Hospitals NHS
NHS Foundation Trust

Outpatient Activity







excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

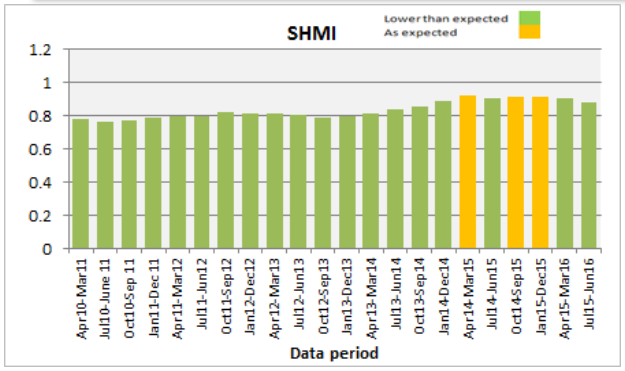
Quality Report

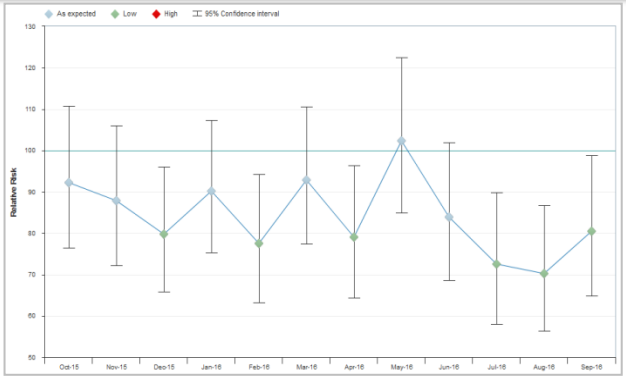
November-2016

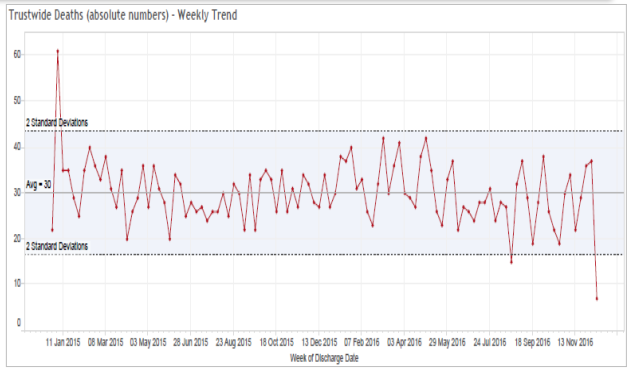
Excellence in specialist and community healthcare

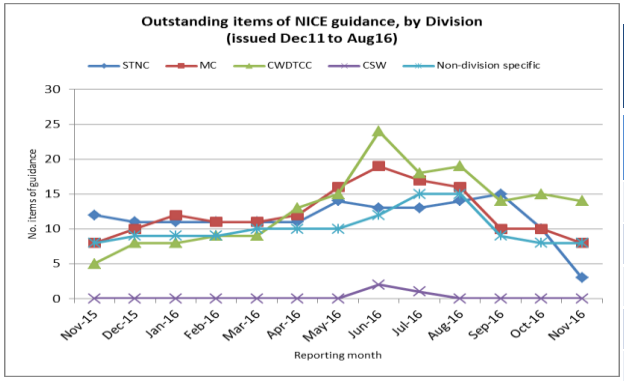
Clinical Effectiveness

St George's University Hospitals NHS
NHS Foundation Trust



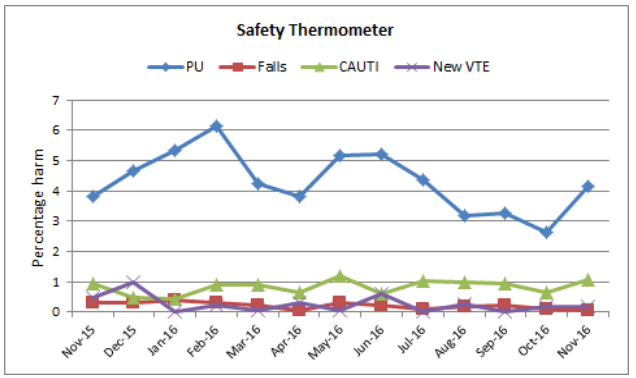






Items of NICE Guidance with Compliance Issues (Jun 2010 to August 2016)

Division	2010	2011	2012	2013	2014	2015	2016
STNC (n=17)	0	1	2	1	3	2	8
M+C (n=22)	2	0	1	1	2	9	7
CWDTCC (n=15)	3	1	1	2	4	1	3
CSW (n=0)	0	0	0	0	0	0	0
Non-division specific (n=14)	0	2	0	3	1	4	4



Mortality

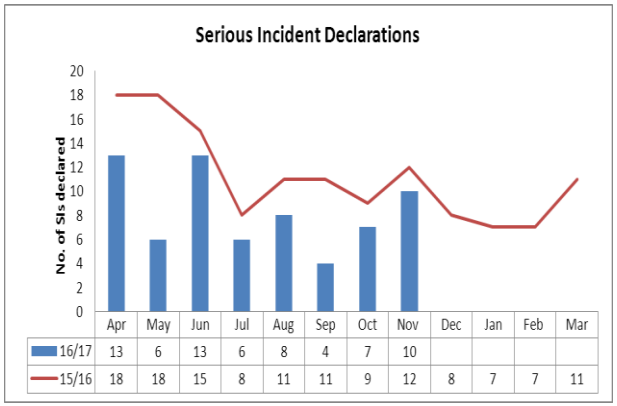
- For Oct 15 – Sep 16 HSMR is better than expected at 84.1 [weekend emergency admissions = 86.7 (better than expected); weekday emergency admissions = 82.4 (better than expected)].
- For the most recent month for which data is available (Sep 16) the HSMR is better than expected at 80.4 [weekend emergency admissions = 73.5 (as expected); weekday emergency admissions = 85.1 (as expected)].
- Latest SHMI July 15 – June 16 = 0.88 – lower than expected. One of 15 Trusts in England in this banding and identified as a repeat outlier.
- Raw mortality within usual limits.
- Key workstreams: Dr Foster Imperial Unit Outlier Alert Coronary Atherosclerosis - investigation provided assurance of no clinical concerns; identified coding issues. Participated in launch of National Mortality Case Record Review and planning local implementation.

NICE Guidance

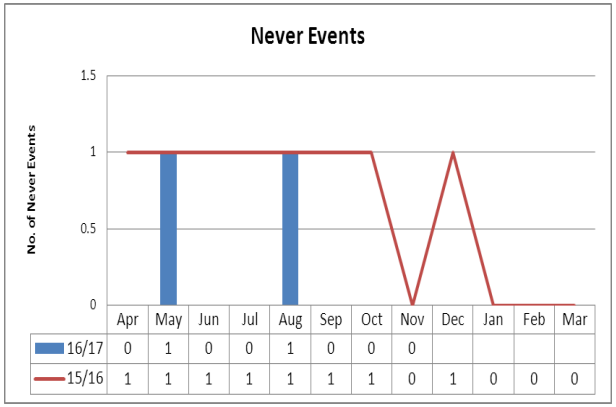
- 68 items of guidance with compliance issues that are with the Divisions for action; either to agree deviation and submit to PSQB or to devise an action plan.
- 27 items of guidance for which there has been no assessment of compliance, down from 40 last month. These have been escalated to each division for resolution.
- Monthly reports detailing the above are provided to divisions to support action and elimination of backlog.

Safety Thermometer

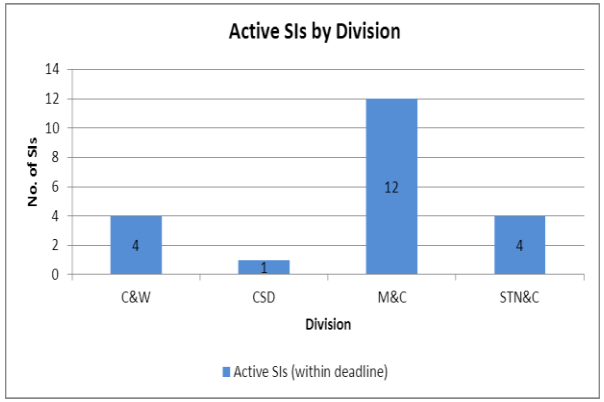
- 94.85% patients received harm free care in November. This is a decline on the previous month although in line with the national average (94.22%).
- 66 harms to 62 patients: 58 patients experienced 1 harm and 4 patient experienced 2 harms.
- 37 harms (56.1%) were old and as such not attributed to care delivered by the Trust.

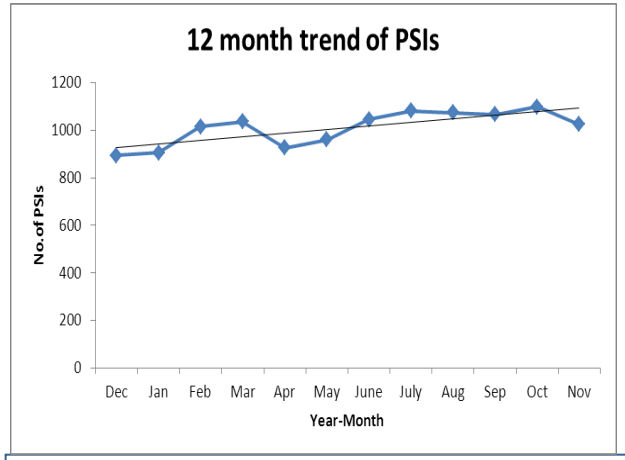


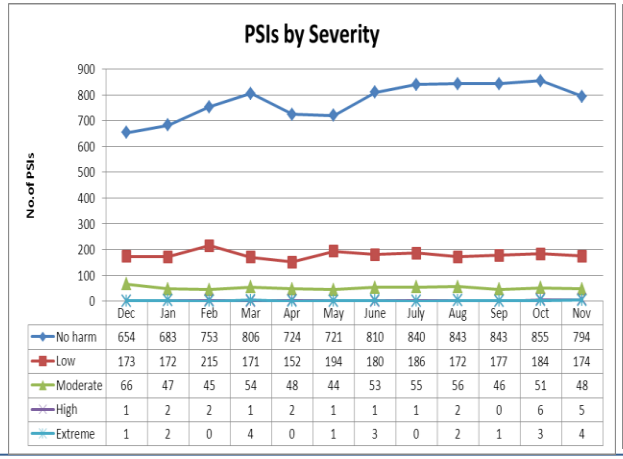
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	13	6	13	6	8	4	7	10				
15/16	18	18	15	8	11	11	9	12	8	7	7	11



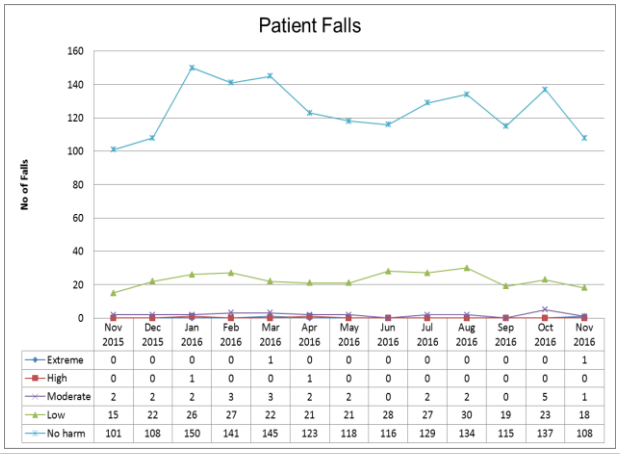
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	0	1	0	0	1	0	0	0				
15/16	1	1	1	1	1	1	1	0	1	0	0	0







	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov
No harm	654	683	753	806	724	721	810	840	843	843	855	794
Low	173	172	215	171	152	194	180	186	172	177	184	174
Moderate	66	47	45	54	48	44	53	55	56	46	51	48
High	1	2	2	1	2	1	1	1	2	0	6	5
Extreme	1	2	0	4	0	1	3	0	2	1	3	4



	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016
Extreme	0	0	0	0	1	0	0	0	0	0	0	0	1
High	0	0	1	0	0	1	0	0	0	0	0	0	0
Moderate	2	2	2	3	3	2	2	0	2	2	0	5	1
Low	15	22	26	27	22	21	21	28	27	30	19	23	18
No harm	101	108	150	141	145	123	118	116	129	134	115	137	108

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

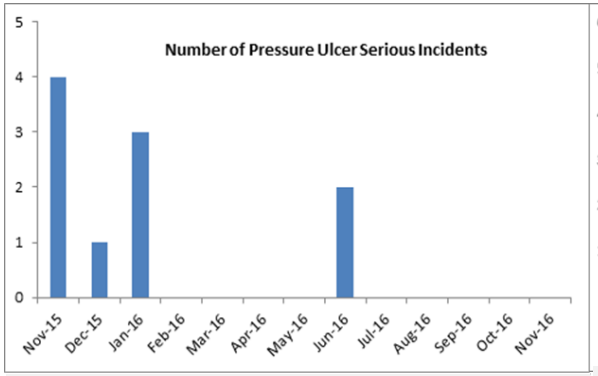
- Reduction in Serious Incidents (SIs) declared Apr-Nov 2016/17:71,compared with 107 SIs declared Apr-Nov 15/16, this represents a 34% decrease.

Falls

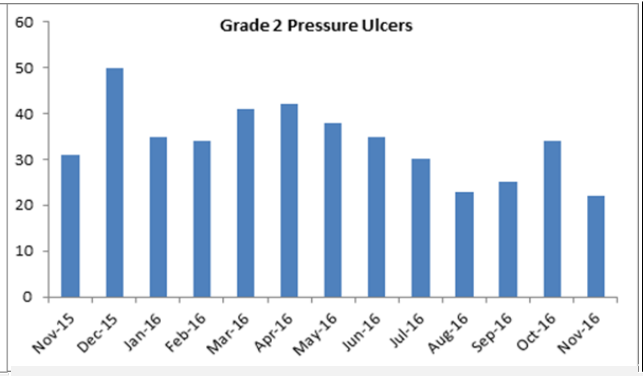
- The graph shows that there has been a decrease in the number of falls reported over the last month compared to the previous month and the lowest number of falls this financial year (data not individually verified). Of the 128 falls, 108 were reported as no harm, 18 low harm, and 2 moderate/severe harm.
- The rate per 1000 bed days for falls on the acute site is 3.69 (NPSA 2010 average rate per 1000 bed days for acute= 5.6) and the rate per 1000 bed days for the community site is 9.16 (NPSA 2010 average rate per 1000 bed days for community=8.6).

Patient Safety

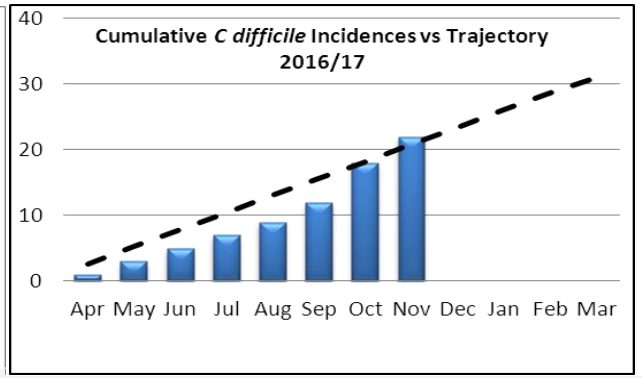
St George's University Hospitals NHS
NHS Foundation Trust



YTD	May	Jun	Jul	Aug	Sep	Oct	Nov
16/17	0	2	0	0	0	0	0
15/16	4	1	1	1	4	2	4



YTD	May	Jun	Jul	Aug	Sep	Oct	Nov
16/17	38	35	30	23	25	34	
15/16	50	46	48	46	36	36	31



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	1	2	2	2	2	3	6	4				
15/16	3	3	3	2	2	5	4	0	1	2	3	1

VTE Data Source	Dec	Jan 2016	Feb	March	April	May	June	July	August	September	October	November
Unify2 *	96.5%	96.6%	96.7%	97.04%	96.45%	97.59%	97.6%	96.9%	96.74%	96.3%	96.17%	95.99%
Safety Thermometer(ST)	88.56%	94.10%	90.2%	94.04%	95.47%	92.9%	94.5%	95.7%	89.2%	94.3%	93.9%	92.34%

Pressure Ulcers

- There was a reduction in the number of Grade 2 pressure ulcers from October to November as well as a reduction from the previous year.
- The trust also reported its fifth consecutive month of zero pressure ulcer serious incidents and remains on target to meet its trajectory of 19.

Clostridium difficile

- Total number of Trust-apportioned episodes of *Clostridium difficile* infection was 22 at the end of November 2016.

MRSA

- There has been a single episode of Trust-assigned MRSA bacteraemia in 2016-1 (target 0); this occurred in October 2016 more than one year since the previous episode

VTE

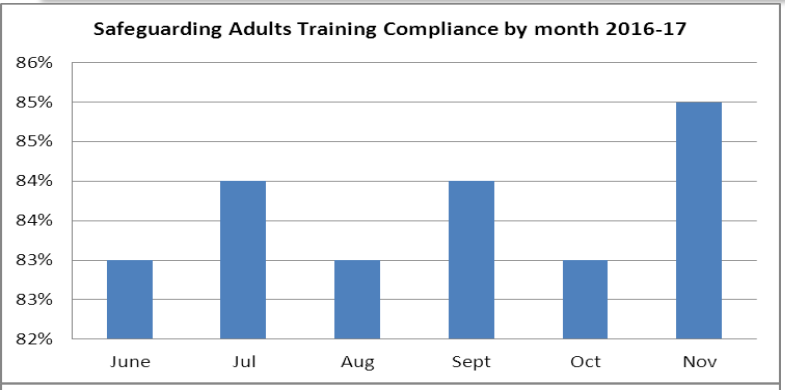
- Compliance via Unify is 95.99 %, whereas via Safety Thermometer it is 92.34% (see footnote on cover sheet)

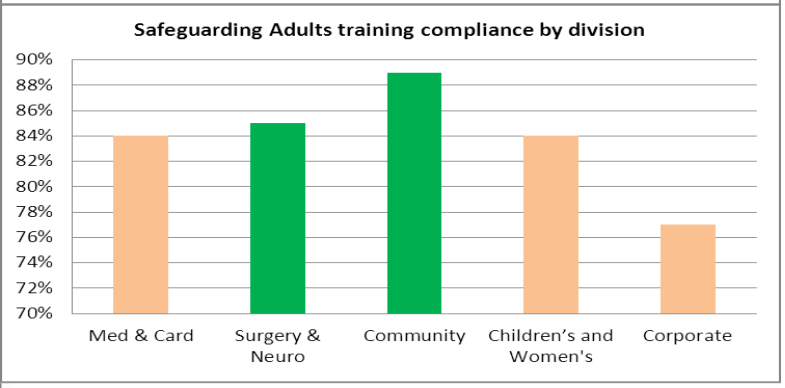
Root Cause Analysis (RCA) of Hospital Acquired Thrombosis (HAT)

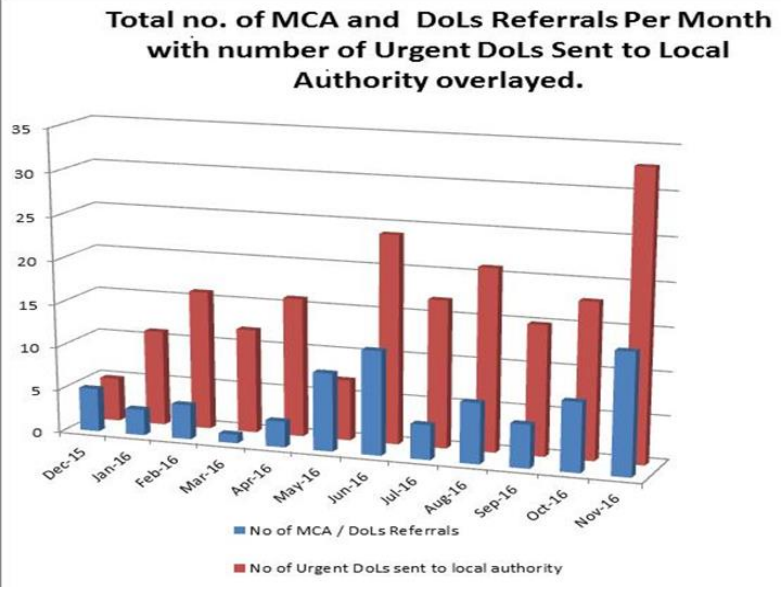
Year		2016
HAT cases identified to date (attributable to admission at SGH)		172
Mortality rate	Total	8 (5%)
	VTE primary cause of death	1
Initiation of RCA process		172 (100%)
RCA complete		105 (61%)
Cases where adequate prophylaxis was provided		90 (52%)
Cases where inadequate prophylaxis was provided		15 (9%)
Incidents jointly reviewed by HTG and clinical team		1
Incidents investigated as SI		3

Patient Safety

St George's University Hospitals NHS
NHS Foundation Trust







Safeguarding Children's Level 3 Training Compliance (Manual count)			
Division	No. of compliant Staff	No. requiring training	Compliant (%)
CWDT	605	677	89%
CSD	115	125	92%
Corporate	3	3	100%
MedCard	196	219	89%
SNTCD	25	27	93%
Overall Trust	944	1051	90%

Safeguarding Children

Training : Through a manual counting of the training data on ARIS it has become apparent that :

- There are staff on ARIS down to have level 3 - who should not be. These inevitably take up places which inevitably reduces the space available for those who should be trained.
- Staff who should have level 3 not showing on ARIS - but are being trained. This means that the training being done is not fully reflected in the system.
- The Acute safeguarding children team has added five extra dates in December to increase compliance – as the Trust target was increased to 100% by the CEO.

Serious Case Reviews and Internal Management Reviews: Case due for publication in January 2017.

Other:

The Chief Nurse has commissioned a review of the safeguarding service provision in the Trust – adults and children.

Safeguarding Adults

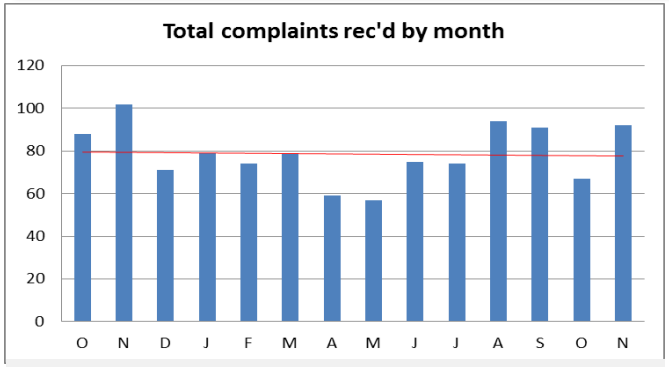
- Continue to monitor safeguarding training via ARIS and MAST steering group. Divisions to take action around low compliance. Steady increase in compliance over last 8 months
- Review procedures following implementation of Care Act – Pan London procedures published Feb 2016 – local guidance completed Spring 2016. E-Learning revised May 16. Additional training given to senior staff Oct 2016 possibly resulting in increase in referrals

DOLS & MCA

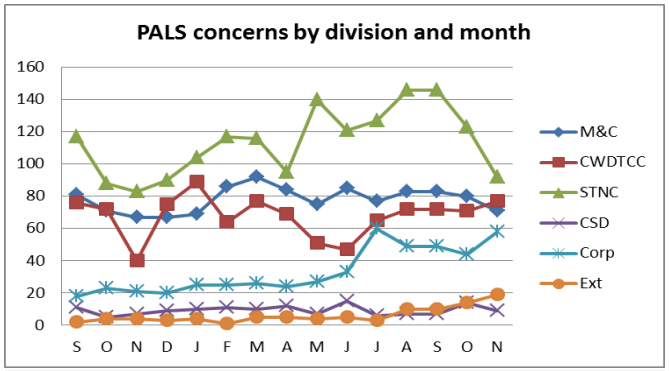
- DOLS: Since April 2014 and the Supreme Court judgement there has been a significant increase in DOLS activity which is reflected nationwide.
- New Law Society Guidance now indicates that a significant number of patients are being understandably deprived of their liberty in their best interests. This is not necessarily a reflection of poor care and treatment. July 15 – fresh legal advice obtained around risk to organisation and patients with regard to non application of DoLs.
- MCA/DoLs Guidance produced Sep 16. Working party commenced Sep 16 to address issues of training, guidance, governance, audit. CQC Sec 29 notice issued - training plan in place to address gaps in training. Initial audit completed Oct 16. To re-audit Jan 17

Patient Experience

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	94	91	67	92				



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	367	346	326				

Friends & Family Test

	May	June	July	Aug	Sept	Oct	Nov	Dec	Ave
M&C	96%	95%	97%	96%	96%	96%	98%	96%	96%
STNC	95%	94%	97%	96%	94%	95%	96%	96%	94%
CWDT	96%	91%	93%	91%	95%	92%	96%	93%	92%
CSD	92%	94%	92%	95%	85%	89%	96%	94%	91%
Trust	95%	94%	95%	95%	94%	93%	97%	96%	94%

Complaints Performance	% within 25 working days (Target 85%)				% within 25 working days or agreed timescales (Target 100%)			
Division	**July**	**August**	**September**	**October**	**July**	**August**	**September**	**October**
CWDTCC	72%	29%	50%	67% ▲	(5) 100%	(5) 64%	(9) 85%	(5) 94% ▲
M&C	88%	68%	84%	64% ▼	(2) 96%	(8) 100%	(5) 100%	(5) 100% ◆
STNC	44%	63%	73%	68% ▼	(4) 75%	(4) 75%	(3) 86%	(1) 73% ▼
CSD	83%	100%	75%	75% ◆	(1) 100%	(0) 100%	(1) 100%	(1) 100% ◆
Corp	70%	75%	57%	88% ▲	(1) 80%	(3) 100%	(2) 86%	(1) 100% ▲
SWLP	N/A	N/A	N/A	100%	N/A	N/A	N/A	(0) 100%
Trust	**72%**	**65%**	**69%**	**70%** ◆	**(14) 91%**	**(20) 86%**	**(20) 91%**	**(13) 90%** ◆

Complaints & PALS

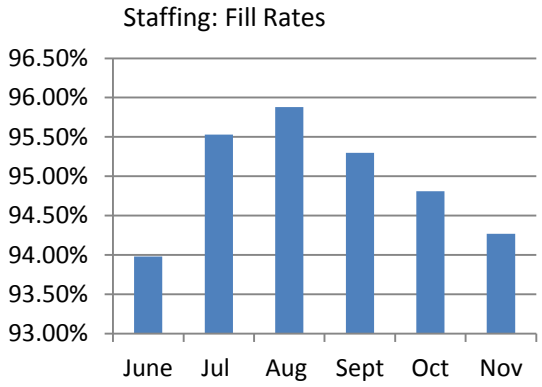
- Number of complaints increased significantly from 67 in October to 92 in November.
- Top themes are: clinical treatment, communication and appointment delay/cancellation (outpatient).
- Complaints performance has remained the same overall in October and remains inconsistent across divisions. Improvements were seen in the Children's, Women's, Diagnostics and Therapeutics Division although targets have not yet been reached and in Corporate Directorates where both targets were met. Medicine and Cardiovascular Division and Surgery and Neurosciences Division saw declines in performance. Divisions are being held to account at divisional performance meetings.
- Full time complaints vacancy has been recruited to. Complaints were sent to divisions within 2 working days in the majority of cases in November with some exceptions. Corporate team working with DDNGs to improve quality of responses to ensure focus, include actions and ensure responses are written in a more personal way.
- Number of PALS concerns received in November remain high: 326 compared to 346 in October.

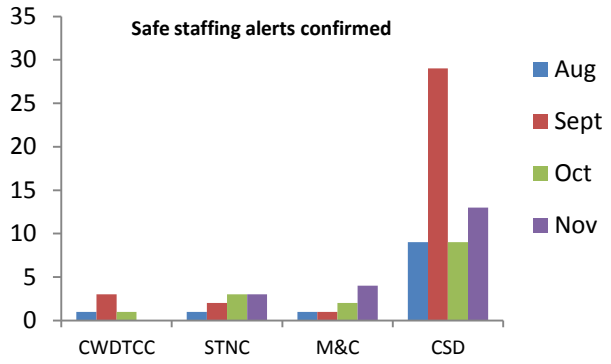
Friends & family test

- Trust response for two consecutive months: over 95% of patients said they were extremely likely or likely to recommend the service to friends or relatives

Workforce

St George's University Hospitals NHS
NHS Foundation Trust





Care hours per day (CHPPD)	JUNE	JULY	AUG	SEPT	OCT	NOV
Combined care hours per patient day	12.7	14.3	14.5	12.2	13	13
Registered nurses care hours per patient day	9.44	10.6	10.7	9.06	9.5	9.74
Unregistered nurses care hours per patient day	3.24	3.74	3.75	3.11	3.1	3.28

Key messages

Safe Staffing

- Safe staffing relies on good rostering management so that budgeted posts are filled and deployed effectively and the staff employed are available to work (e-rostering rosters to be completed 8 weeks in advance to assist in planning staffing). There has been a significant improvement in medicine and surgery divisions. The other two divisions require improvement.
- Anecdotal evidence suggests that the internal escalation process is not being utilised effectively and the safe staffing policy is not being effectively utilised. Divisions have provided assurance that staffing levels are safe and managed on a shift by shift and needs basis. To provide assurance the corporate nursing team are reviewing the safe staffing procedures.
- Community division have employed a recruitment nurses to assist in reducing vacancies and improving retention .
- Overall the Trust Fill rate is 94.27%.

CHPD

- All acute trusts with inpatient wards/units began reporting monthly care hours per patient day (CHPPD) data to NHS improvement. Over time this will allow trusts to review the deployment of staff within a speciality and by comparable ward. When looking at this information locally alongside other patient outcome measures, trusts will be able to identify how they can change and flex their staffing establishment to improve outcomes for patients and improve productivity. Guidance and support on the use of this tool will be forthcoming from NHS improvement to assist the trust in implementation.

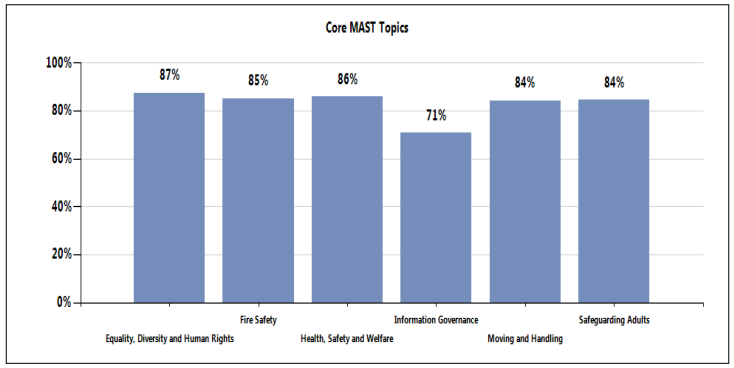
Fill Rates by Ward

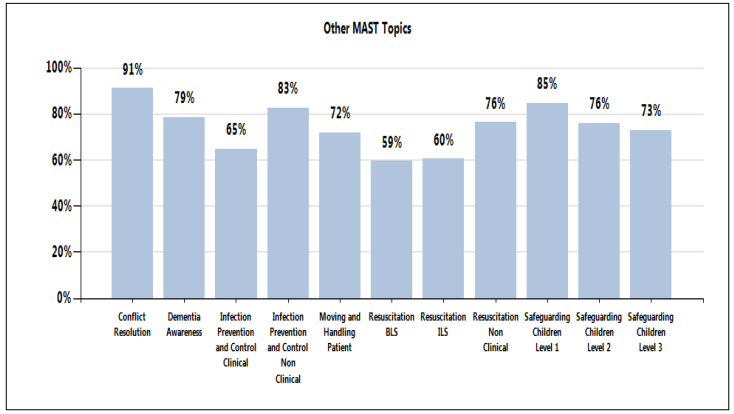
Trust Total	94.27%

Ward name	Overall %
Cardiothoracic Intensive Care Unit	98.39
Carmen Suite	96.94
Champneys Ward (being refurbished)	
Delivery Suite	96.80
Fred Hewitt Ward	91.65
General Intensive Care Unit	95.87
Gwillim Ward	94.26
Jungle Ward	83.03
Neo Natal Unit	98.16
Neuro Intensive Care Unit	90.61
Nicholls Ward	91.35
Paediatric Intensive Care Unit	93.96
Pinckney Ward	88.04
Dalby Ward	92.98
Heberden	95.81
Mary Seacole Ward	93.45
A & E Department	95.27
Allingham Ward	101.49
Amyand Ward	97.00
Belgrave Ward AMW	91.68
Benjamin Weir Ward AMW	88.97
Buckland Ward	88.45
Caroline Ward	92.43
Cheselden Ward	94.02

Ward name	Overall %
Coronary Care Unit	96.56
James Hope Ward	90.53
Marnham Ward	96.55
McEntee Ward	97.13
Richmond Ward	96.38
Rodney Smith Med Ward	98.21
Ruth Myles Ward	99.77
Trevor Howell Ward	98.28
Winter Ward (Caesar Hawkins)	94.85
Brodie Ward	92.96
Cavell Surg Ward	93.50
Florence Nightingale Ward	94.34
Gray Ward	93.50
Gunning Ward	92.61
Gwynne Holford Ward	96.73
Holdsworth Ward	92.26
Keate Ward	62.92
Kent Ward	95.86
McKissock Ward	92.24
Vernon Ward	94.39
William Drummond HASU	94.45
Wolfson Centre	95.14
Gordon Smith Ward	91.13

MAST Compliance





St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	5 January 2017	**Agenda No**	**2.3**
Report Title:	Overseas Visitors and Migrant Cost Recovery Pilot		
Lead Director/ Manager:	Iain Lynam, Chief Restructuring Officer		
Report Author:	Iain Lynam, Chief Restructuring Officer		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Approval		
Executive Summary:	Research by NHS Improvement (NHSI) suggests that trusts are not charging for overseas visitors and migrants who use the NHS and who are not entitled to use NHS services free of charge. A number of trusts have been approached to participate in a pilot to recover costs in two clinical areas: maternity and an elective service. St George's has been asked to be one of twenty trusts in the pilot.		
Recommendation:	The Board is asked to formally approve that the Trust conducts these pilots and participates as part of the wider project into overseas visitors and migrant cost recovery. An evaluation report will be presented to the Board in June 2016.		
Supports			
Trust Strategic Objective:	N/A – this is a Department of Health/NHSI initiative		
CQC Theme:	N/A – this is a Department of Health/NHSI initiative		
Single Oversight Framework Theme:	N/A – this is a Department of Health/NHSI initiative		
Implications			
Risk:	There are no specific risk implications associated with this proposal although this has been subject of questions from the public and media attention.		
Legal/Regulatory:	This pilot will be carried out in line with the Department of Health and NHSI *Overseas Visitor & Migrant Cost Recovery: Developing Best Practice* guidance.		
Resources:	There are no resource implications associated with this proposal and the Trust will benefit from support from the Cost Recovery Support Team and the Home Office Premium Service until the end of March 2017.		
Previously Considered by:	Executive Management Team Trust Board	**Date:**	September 2016 06.10.16
Equality Impact Assessment:	To be considered as part of the scope of the pilot.		
Appendix:	N/A		

Overseas Visitors and Migrant Cost Recovery Pilot
Board Meeting in Public, 5 January 2017

1.0 PURPOSE

1.1 The purpose of this paper is to seek formal approval for a three-month overseas visitors and migrant cost recovery pilot exercise firstly in Obstetrics and then in an elective service. This is a pilot led by NHS Improvement (NHSI) and the Department of Health.

2.0 BACKGROUND

2.1 The recovery of costs from overseas visitors & migrants using the health service in England remains a high priority for both Government and for the NHS.

2.2 Research by NHS Improvement (NHSI) indicates that significant numbers of patients who are overseas visitors and/or migrants are not identified within the existing NHS systems; of those that are identified and invoiced, only a small percentage of costs are recovered. The current estimate of lost revenue to St George's is c. £5m per annum.

2.2 In August 2016, the Cabinet Office met with the Trust to discuss the need to identify and recognise non-eligible patients before they receive health care.

2.2 The Department of Health and NHSI issued best practice guidance on the matter on 28.10.16: *Overseas Visitor & Migrant Cost Recovery: Developing Best Practice.* This guidance requires Board level approval for a trust to participate in a pilot project to recover costs from overseas visitors and migrants who use NHS services.

3.0 DEPARTMENT OF HEALTH/NHSI GUIDELINES

3.1 The guidelines set out that the Trust is one of a small cohort of twenty trusts that have been identified as having a significant and on-going potential for recovering lost income from overseas visitors and migrants who use NHS services.

3.2 The Trust is asked to undertake pilots in two clinical areas, maternity and one elective service; the maternity service will be obstetrics though the elective service is still to be agreed. The project requires a check of all patients, prior to them accessing services, to demonstrate their identity and UK residency. The guidelines state that asking for two forms of identification to demonstrate residency, and particularly asking for a form of photo identification, is best practice when booking in any patient for planned care.

3.3 The Trust will receive support from the Cost Recovery Support Team and the Home Office Premium Service (phone line and staff training) until the end of March 2017. In return it is required to share best practice, evaluate any new practices and processes to establish a robust evidence base that can be used by other trusts and embed successful processes into NHS 'business as usual'.

3.4 Our priority at all times will be to ensure that patients using our obstetric service at St George's continue to receive the support they need. We are confident that, by identifying patients in 'real-time', we will be in a much better position to offer patients advice and support, rather than the current situation whereby they are invoiced retrospectively. We also have a legal obligation to inform appropriate patients that charges may apply.

4.0 PILOT IN OBSTETRICS

4.1 It is proposed that the Trust commences a three month pilot in Obstetrics in January 2017. The Trust has retained an interim project manager to plan in detail and organise the pilot and to coordinate liaison with the Department of Health and NHSI. The preparatory work is well underway.

4.2 A further pilot will commence in an elective service (to be selected), once the Obstetrics pilot is under way.

4.3 In both cases there will then be a detailed evaluation once the pilots have been completed. The evaluation will identify lessons learned and how the overall "business as usual" processes can then be modified Trust-wide in future. The Board will receive a report on the evaluation of the pilots at its meeting in June 2016.

4.0 IMPLICATIONS

Risks

4.1 This paper is submitted at the request of the Department of Health and NHSI in support of their guidelines on overseas visitors and migrant cost recovery.

Legal Regulatory

4.2 This pilot will be carried out in line with the Department of Health and NHSI *Overseas Visitor & Migrant Cost Recovery: Developing Best Practice* guidance.

Resources

4.3 No additional resources are required beyond those already allocated to the pilots and central support will be made available from the NHS Cost Recovery Team and Home Office.

5.0 NEXT STEPS OR TIMELINE

5.1 The first pilot is scheduled to commence during January 2017 will last for three months; it will complete in April 2017. The second pilot will start shortly after the first is under way. An available report on lessons learned will be shared with the Board in June 2016.

6.0 RECOMMENDATION

6.1 The Board is asked to formally approve that the Trust conducts these pilots and participates as part of the wider project into overseas visitors and migrant cost recovery.

6.2 An evaluation report will be presented to the Board in June 2016.

Author: **Iain Lynam, Chief Restructuring Officer**
Date: **28 December 2016**

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	5 January 2017	**Agenda No**	**3.1**
Report Title:	Summary Finance Report- Month 08 2016/17		
Lead Director/ Manager:	Margaret Pratt		
Report Author:	Michael Armour		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	The Trust has reported an in-month deficit of £3.9m in November which is £4.4m worse than plan. Included in month is a Non Pay overspend (£3.0m), excess pay costs of £1.8m and above plan Income (£0.7m; although £1.6m of the reason is related to the RTT non-reporting penalty adjustment). £0.4m of Pay and £0.2m Non Pay is cost unforeseen and outside of the control of the Trust. The YTD deficit is £51.6m. The Trust is currently assuming a £80.7m forecast deficit.		
Recommendation:	The Trust Board notes the current Trust financial position.		
Supports			
Trust Strategic Objective:	Deliver our Transformation Plan enabling the Trust to meet its operational and financial targets.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Finance and Use of Resources		
Implications			
Risk:	**BAF Risk 6**: Failing to Deliver the Financial Plan		
Legal/Regulatory:			
Resources:			
Previously Considered by:	Finance & Performance Committee Executive Management Team	**Date**	14.12.16 19.12.16
Equality Impact Assessment:	N/A		
Appendix:	N/A		

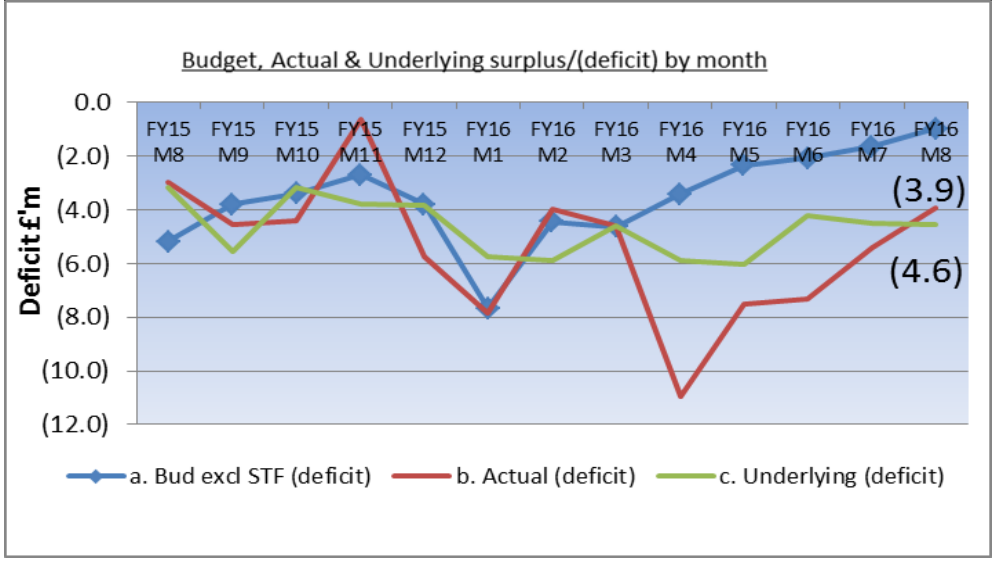
Summary Finance Report
Month 08 2016/17

Trust Board 5 January 2017

Contents

1. Financial Position for the month November 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	650.2	55.6	56.4	0.8	434.6	431.1	(3.5)
STF Income	17.6	1.5	0.0	(1.5)	11.7	0.0	(11.7)
Other Income	112.5	9.7	11.0	1.3	75.3	79.3	4.0
Overall Income	**780.3**	**66.7**	**67.4**	**0.7**	**521.6**	**510.4**	**(11.2)**
Pay	(486.6)	(40.0)	(41.8)	(1.8)	(323.6)	(329.7)	(6.1)
Non Pay	(275.8)	(23.3)	(26.3)	(3.0)	(190.2)	(208.3)	(18.2)
Overall Expenditure	(762.4)	(63.3)	(68.1)	(4.8)	(513.8)	(538.0)	(24.3)
EBITDA	17.9	3.4	(0.7)	(4.1)	7.8	(27.6)	(35.4)
Financing costs	(35.1)	(2.9)	(3.2)	(0.3)	(23.4)	(23.9)	(0.6)
Surplus/(deficit)	**(17.2)**	**0.5**	**(3.9)**	**(4.4)**	**(15.6)**	**(51.6)**	**(36.0)**
Memo: Below the Line Items	0.0	0.0	1.1	1.1	0.0	(8.9)	(8.9)



Commentary

- An in-month deficit of £3.9m is reported in November which is £4.4m worse than plan. The YTD deficit is £51.6m.
- **Forecast Outturn** (slide 3) a deficit of £80.7m which is the same as at month 7.
- **Below the line** - £8.9m of cost year to date relates to items outside the Trust's initial plan regarding unforeseen, one off costs associated with areas such as the rectification of Estates & IT infrastructure, additional senior management support, lost income from the Junior Doctors' strike, Prior Year agency cost and the RTT penalty. The reduction in month is caused by £1.6m of RTT non-reporting benefit mentioned in more detail below.
- **SLA income (not STF)** - £0.8m surplus in month and £3.5m shortfall YTD. The in-month surplus includes a benefit of c£1.6m following discussions with commissioners on the start date of the RTT non-reporting penalty. Business Case slippage in Neurosurgery (£3.1m YTD) and the impact of the RTT non-reporting penalty (£1.0m YTD) have impacted here.
- **STF Income –** There is an annual budget of £17.6m that the Trust is not expecting to receive this financial year.
- **Pay** - £1.8m overspent in month, and £6.1m YTD, as a result of unbudgeted interim staff spend and divisional vacancies covered by bank & agency. The deterioration from M07 is as a result of increased substantive costs in SWLP (£0.3m) and increased interim costs in Overheads (£0.4m).
- **Non pay**– £3.0m excess cost in month and £18.2m YTD; £14.0m (to date) of which is a consequence of non delivery of Trust CIP plans. £3.3m can be attributed to drugs cost to deliver additional Commercial Pharmacy income.
- **The M8 underlying position (excl. STF)** is a deficit of £4.6m (£4.5m in M7). The main adjustment for M8 is the 'below the line' benefit from the RTT non-reporting penalty. The deterioration since 15/16 is owing to higher: pay award & pension cost; spend on interims; soft FM costs; and costs of reactive maintenance.

2. Analysis of cash movement M08 YTD

Source and application of funds - cash movement analysis:
M08 YTD and forecast vs Plan

	Actual vs Plan YTD			Based on forecast £80.7m deficit			
	Plan YTD £m	Actual YTD £m	*Actual YTD VAR £m*	*Plan Year £m*	*Forecast Outturn £m*	*Forecast VAR £m*	Notes based on forecast £80.7m deficit
Opening cash 01.04.16	7.4	7.4		*7.4*	*7.4*		
Income and expenditure deficit	-18.1	-51.6	***-33.5***	*-17.2*	*-80.7*	***-63.5***	
Depreciation	16.4	16.2	***-0.2***	*25.0*	*25.0*	***0.0***	
Interest payable	3.4	3.3	***-0.1***	*5.1*	*5.8*	***0.7***	
PDC dividend	4.2	4.2	***0.0***	*6.3*	*5.3*	***-1.0***	
Other non-cash items	-0.1	0.2	***0.3***	*-0.2*	*0.1*	***0.3***	
Operating deficit	**5.7**	**-27.8**	***-33.5***	**19.0**	**-44.5**	***-63.5***	
Change in stock	-0.1	-0.9	***-0.9***	*0.6*	*0.6*	***0.0***	
Change in debtors	-1.2	-31.5	***-30.3***	*2.0*	*-12.0*	***-14.0***	does not assume debt targets met
Change in creditors	1.5	38.6	***37.1***	*-5.5*	*8.3*	***13.8***	
Net change in working capital	0.2	6.2	***6.0***	-2.9	-3.1	**-0.2**	
Capital spend (excl leases)	-25.6	-14.3	***11.3***	*-33.4*	*-28.9*	***4.5***	The capital cash spend forecast is reduced to £28.9m - equivalent to an underspend of £4.5m against the baseline budget excluding emergecy capital - on the basis of the YTD under spend at M08. This means no additional borrowing would be required to finance capital expenditure in year.
Interest paid	-3.2	-3.0	***0.2***	*-5.1*	*-5.6*	***-0.5***	
PDC dividend paid	-3.1	-3.1	***0.0***	*-6.3*	*-5.3*	***1.0***	
Other	-5.2	-4.7	***0.5***	*-8.0*	*-8.0*	***0.0***	
Investing activities	-37.1	-25.1	***12.1***	*-52.7*	*-47.7*	***5.0***	
WCF/ISF borrowing	27.0	49.0	***22.0***	*32.5*	*91.5*	***59.0***	The borrowing forecast excludes emergency (unapproved) capital funding as the capital cash forecast is to under spend the baseline budget by £4.5m. Therefore all the additional borrowing is to finance the higher deficit. The borrowing total does not include the £20m cash headroom requested at the beginning of the financial year.
Closing cash 31.10.13 / 31.03.17	3.2	9.7	***6.6***	3.2	3.5	***0.3***	

M01- M08 YTD cash movement
The better performance on working capital (+£6m) and cash under spend (+£11.3m) on the capital programme offset some of the adverse cash impact of the higher operating deficit (-£33.7m) and helped the Trust to restrict the increase in borrowing necessary to finance the higher revenue deficit to £22m.

Commentary

M08 YTD cash movement

- Of the I&E deficit of £51.6.m YTD, depreciation (£16.2m) does not impact cash. The accruals for PDC dividend and interest payable are added back for presentational purposes and the amounts paid for these expenses shown lower down. This generates a YTD cash operating deficit of £27.8m.
- The operating variance from plan of £33.5m in cash is directly attributable to the I&E deficit. Members will recall that the NHSI plan and Internal trust plan are phased differently
- The Trust has been able to offset the worsening operating deficit with better performance on working capital (+£6m) and cash under spend on capital (+£11.3m) enabling the Trust to contain the increase in borrowing necessary to finance the higher I&E deficit to £22m.

Forecast outturn

- The forecast operating cash deficit of £44.5m results from a forecast deficit of £80.7m offset by depreciation of £25m.
- The total forecast borrowing requirement for the year is £91.5m, £59m higher than plan. This includes £59m extra borrowing to finance the higher operating deficit. NB this borrowing total does not include emergency capital funding as the capital cash spend forecast is now to under spend the baseline budget by £4.5m.

3a. M8 Forecast

M8 Desired/Planned forecast
=
£34.8m Deficit

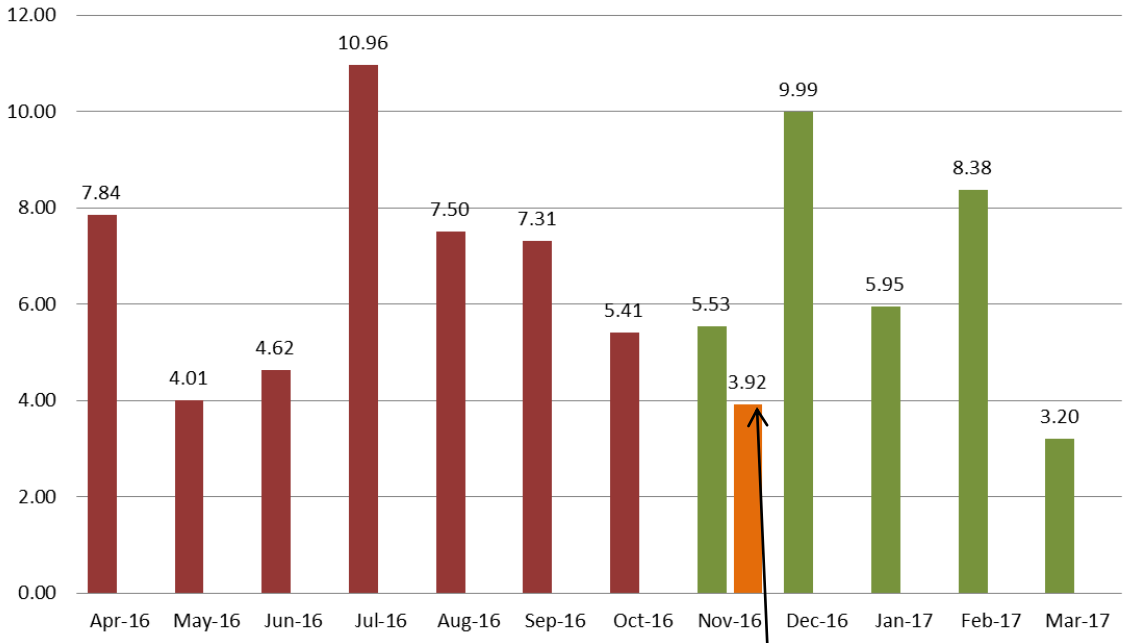
Straight-line forecast at M8
=
£77.4m Deficit

Straight-line forecast at M7 = £81.7m Deficit

Forecast submitted to NHSI at M8
=
£55.5m Deficit

- There has been dialogue with NHS Improvement over the last month regarding the year end forecast which has been 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 assumes full achievement of the £42.7m CIP programme.
- A straight-line forecast of the month 8 position leads to an £77.4m deficit by year end: an improvement from October's projected £81.7m deficit.
- A forecast of £55.5m deficit will be submitted at month 8, with a note stating the Trust's forecast has held at £80.7m (as notified to NHSI in M6). Owing to NHSI guidance, the Trust is unable formally to change its projected £55.5m deficit until Q3 reporting in January. Should the Trust wish to change the forecast outturn at that point, the governance document 'Appendix 2b' completed. Appendix 2b was shared with the Trust Board on 3rd November.
- The Trust has submitted a full reforecast to NHSI. The reforecast includes details on how to improve the £80.7m forecast outturn reported at M7.
- Divisions, and the transformation team, continue to work on recovery actions to improve the Trust's current run rate, and address the significant deficit position each month.

3b. M8 vs Forecast



Division	M8 Budget	M8 Forecast	M8 Actual	Varience to forecast
C&W, Diagnostics, Therapies	312	481	404	77
Medicine and Cardiovascular	-6,444	-6,015	-4,788	-1,227
Surgery and Neurosciences	-4,107	-3,094	-2,598	-496
Community Services	-1,729	-1,523	-1,634	111
Overheads & Other	11,487	15,685	12,534	3,151
Grand Total	**-482**	**5,534**	**3,918**	**1,615**

- M8 deficit was £3.92m against a forecast of £5.53m.
- £1.6m variance was due to a confirmed reduction in the expected fine from RTT non-reporting from £5m to £3.6m.
- A £1.5m shortfall within divisions is seen within pay as a result of failure to deliver savings at the level forecast
- This is offset by a contingency for optimism bias, as well as a provision for expenditure to address RTT and CQC issues.
- The £80.7m deficit forecast is held for the second month running, with a £4.7m provision remaining to address RTT and CQC issues.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	5 January 2017	**Agenda No**	**3.3**
Report Title:	Communications Plan to support Trust's Long-Term Strategy		
Lead Director/ Manager:	Professor Simon Mackenzie, Chief Executive		
Report Author:	Chris Rolfe, Associate Director of Communications		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Approval		
Executive Summary:	This paper summarises the key communications activity required to support publicity and promotion of the Trust's new strategy as agreed at the Trust Board in December 2016.		
Recommendation:	It is recommended that the Trust Board approves the: i. broad approach including the planned communications activity set out in the paper and at Appendix 1. ii. Minor changes to the Clinical Vision and Strategic Priorities.		
Supports			
Trust Strategic Objective:	Refresh the Trust's strategy, to develop a sustainable service model with a clear and consistent message.		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Strategic Change Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	There is a risk that if the new strategy is not effectively communicated, the priorities and plans for the organisation will not be clearly understood, either by staff or external stakeholders, resulting in confusion and a lack of clarity about what St George's and the new leadership team is trying to achieve.		
Legal/Regulatory:	There are no specific legal or regulatory implications in this paper – however, it will help address one of the issues identified by the CQC, that the Trust does not have a clear strategy.		
Resources:	The activity identified in the attached is deliverable from within existing resource – and the paper has been written with this in mind.		
Previously Considered by:	The long term strategy was considered at the Board's meeting in private in December.	**Date:**	01.12.16
Equality Impact Assessment:	N/A		
Appendix:	**Appendix 1:** Trust Strategy: St George's University Hospitals NHS Foundation Trust - Communications Plan (overview)		

Communications Plan to support Trust's Long-Term Strategy
Trust Board, 5 January 2017

1.0 PURPOSE

1.1 The purpose of this paper is to set out an integrated communications plan to raise awareness and seek buy-in for the Trust's long-term strategy.

2.0 BRIEF SUMMARY AND OVERVIEW

2.1 In the summer of 2016, the Trust Board signalled its intention to refresh the organisation's strategy in response to the challenges St George's currently faces. In December 2016, the Trust Board returned to this issue, and concluded that the existing strategy for the organisation should be updated rather than completely revised.

2.2 This decision was taken due to the immediate and pressing task of stabilising the Trust's fragile infrastructure, as well as our focus on improving quality and financial performance; all of which continues to require significant clinical and management resource. The Trust's last agreed strategy – which spans 10 years from 2012 to 2022 – was launched in 2012.

2.3 Since 2012 however, the Trust has undergone a number of changes, as has the wider NHS. As a result, the Trust Board has decided to refresh the Trust strategy, and set a new course and strategic direction for the organisation.

2.4 The operational and financial challenges St George's faces are well-documented. The Trust breached the terms of its license in 2015; was rated as Inadequate by the Care Quality Commission (CQC) in November 2016 (following their inspection of Trust services in June); and has now been placed in Special Measures by NHS Improvement. In its inspection report, the CQC also said that the Trust 'must develop a long term strategy and vision'.

2.5 At present, the Trust's new leadership is focussed on recovery, and stabilising the organisation. This involves trying to correct problems that are within our gift to solve, and managing our relationships with external stakeholders. There have been improvements in operational performance, including more efficient use of operating theatre space at St George's. We are on an improving trajectory with regard to our delivery of the emergency care target, which requires 95% of A&E patients to be treated, admitted or discharged within four hours of attending. We are also introducing greater controls on recruitment to help us reduce expenditure. But major challenges remain on a number of fronts.

2.6 In terms of the external environment, we are working with commissioners and partner organisations to play our part in tackling system-wide challenges, such as out of hospital care. We are also actively involved in developing the NHS' local Sustainability and Transformation Plan (STP), with St George's already identified as a 'fixed point', meaning that we will continue to provide the majority of local and tertiary services that we do currently.

2.7 This is the context within which the Trust will shortly announce its emerging strategy, clinical vision and key priorities for the organisation. This short paper sets out how we plan to communicate this important piece of work to staff, patients, and key stakeholders in a clear, organised, and proactive way.

3.0 AIMS AND OBJECTIVES

3.1 The purpose of this plan is to ensure that we communicate the strategy in a clear, proactive and engaging way. Delivered successfully, it will ensure that:

i. The Trust is viewed by external stakeholders as having a clear strategy, which they support and understand their role in helping us deliver;

ii. Staff are aware of the new strategy, and view it as a positive step forward for St George's. They will also understand what it does (and doesn't) mean for them as individuals, and for their teams;

iii. A copy of the strategy will be readily available in both digital and traditional (e.g. hard copy) forms. We will also produce engaging, easy to understand information to compliment the formal strategy document.

4.0 APPROACH

4.1 The approach we will take will be one which is open and honest about the strategy, and how it was developed. We will make the strategy relevant, and easy to understand; to this end, we will use digital platforms (such as You Tube video messages) as well as traditional communication channels to help publicise the strategy.

4.2 Once the initial awareness raising has been undertaken, we will ensure on-going and repeated reference back to the strategy in future communications, with both staff and external stakeholders. This will reduce the risk of accusations that the strategy has not been effectively communicated, or is not understood by staff (as evidenced previously by the CQC during their inspection in June).

5.0 KEY MESSAGES AND PRIORITIES

5.1 Messages will need to be tailored and adapted to the different audiences we need to reach. However, the over-arching key message are as follows:

i. We have developed a new strategy for St George's to help us address the challenges we face.

ii. We are confident the strategy will give everyone connected with the Trust a much clearer idea about our plans and priorities for the organisation.

iii. Our number one priority every day is to provide the best care possible for our patients; and our new strategy does not change this.

iv. We want to make St George's better again - and a clear, aspirational but realistic strategy is a crucial part of making this a reality.

5.2 To ensure the clinical vision and strategic priorities are clear and easily understood, we are proposing some minor cosmetic changes to those presented to the Trust Board in December 2016. We propose they are now as follows:

5.3 Our Clinical Vision

To provide high quality patient care for the communities we serve, and specialist services for patients with thriving programmes of education and research.

5.4 Our Strategic Priorities

- ***High Quality Care:*** *To deliver care and treatment for patients which is consistently high quality, safe, effective and person centred.*

- ***Teaching and Research:*** *To become a high quality centre for teaching and world-class research, in partnership with St George's, University of London.*

- ***Modernising our buildings and internal systems:*** *To ensure our buildings and facilities, information technology, and information and processes are sound.*

- ***Valuing our staff:*** *To lead and inspire our staff so they feel valued and recognise St George's as a good place to work.*

- ***Financial sustainability:*** *To manage our finances effectively, so they are truly sustainable.*

- ***Partnership working:*** *To work with commissioners and partner organisations to provide a range of integrated services that are aligned with our clinical vision, and which meets the needs of the communities we serve.*

6.0 INTERNAL/EXTERNAL STAKEHOLDER MANAGEMENT

6.1 The key audiences we will need to communicate with, both immediately and on an on-going basis, are as follows:

Governors:	Our Governors will need early sight of the new strategy, and the communications activity we are putting in place to support it. They will also need additional resources for when they are talking to stakeholders (e.g. detailed Q&A). Briefed properly, our Governors can be fantastic advocates for the Trust on this issue.
Staff:	Together with Governors, staff need to be the first to hear about our strategy, with bespoke communications developed for particular staff groups (e.g. senior managers will have different needs to, say, junior doctors). We also need to ensure we reach staff based in the community, who are often more difficult to communicate with.
Patients:	We treat hundreds of thousands of patients every year, most of whom live locally. The vast majority of patients simply want to have confidence that they will get high quality care at St George's whenever they need it. A small number of patients, however, will want to understand the strategy itself – and we need to provide readily accessible information in order for them to do so.
Members:	We have over 11,000 Members, so it is important they are kept informed – the majority live and work amongst the communities we serve, so need to be briefed proactively by the Trust, rather than basing their opinions on rumour or what they read in the newspapers.
Local stakeholders (in particular commissioners and Healthwatch:	This is absolutely crucial - they need to be briefed about the strategy as part of existing communications channels (e.g. our Monthly Stakeholder Briefing), not least because they are a key part of our future, and our recovery plans.
National stakeholders (including NHS Improvement and NHS England):	These key stakeholders will want to be kept informed about our plans (as is standard). They will also want reassurance that any plans to communicate our strategy do not compromise or complicate major sector priorities (e.g. Sustainability and Transformation Plans). We propose inviting both key local and national stakeholders to a facilitated workshop event at St George's before the end of March 2017 (see plan, appendix 1). This will help people engage with the strategy, and understand what we are trying to achieve.

7.0 COMMUNICATIONS ACTION PLAN AND CHALLENGES

7.1 Appendix 1 sets out the minimum level of communications activity we need to undertake to effectively raise awareness of the new strategy. Any additional proposals will need further budget/resource.

7.2 As always, there is a lot going on at St George's, and the challenges we face at present are particularly acute. The focus on delivering improvements now – for example, in relation to operational and financial performance – may make communicating seemingly abstract information to staff about a future vision difficult. However, this simply means we have to work even harder to ensure we communicate in a way that is engaging, with short, take-away messages.

7.3 The impending changes in Trust leadership – including a new Chair in early 2017– may lead some to question whether this is the right time to refresh the Trust's strategy. Our response will be that a new strategy gives much needed clarity to the organisation, and that the new Chair will continue the improvement initiatives already started.

7.4 Finally, we also need to be mindful of the changing external environment, not least the south west London Sustainability and Transformation Plan (STP). This is unlikely to result in major changes to the portfolio of services St George's currently provides. However, we will need to communicate our strategy in such a way that it is seen as cognisant of the local healthcare economy, and the potential for changes in the medium to long-term.

8.0 NEXT STEPS

8.1 Once this outline approach is agreed, the next steps are to set out a segmented and timed communications action plan and develop a suite of core communications materials to support the roll-out of the communications campaign.

8.2 The exact timescales for when information will be cascaded and communicated are yet to be agreed, but we expect the majority of activity (where achievable) to be completed by the end of January 2017.

9.0 RECOMMENDATION

9.1 It is recommended that the Trust Board approves the:

iii. broad approach including the planned communications activity set out in the paper and at Appendix 1.

iv. Minor changes to the Clinical Vision and Strategic Priorities set out at 5.3 and 5.4 above.

AUTHOR: Chris Rolfe, Associate Director of Communications
DATE: 28 December 2016

APPENDIX 1

Trust Strategy - St George's University Hospitals NHS Foundation Trust - Communications Plan (overview)*

**Dates/timescales to be added, although we anticipate the majority of activity below to be undertaken and completed in January 2017*
***This focusses on communication for all-staff. Additional bespoke communications for specific staff groups – such as junior doctors, who may not access core communication channels – will require further thought and, potentially, more resource.*

Audience	Communications Channel
Foundation Trust Governors	• Email plus detailed briefing pack and Q&A • Seminar/face to face briefing session led by members of Trust Board
Staff (all)**	• All-staff email from Chair/CEO • All-staff briefing sessions at St George's and Queen Mary's • Dedicated Senior Leaders briefing session; detailed briefing paper and Q&A for divisional teams • Dedicated intranet page with access to key messages, detailed briefing pack plus Q&A • Information in monthly Core Brief • Video message from CEO, Professor Simon Mackenzie • Four-page hard copy summary document to be professionally designed and printed – distributed to staff at all sites. To include quotations from staff/patients. • Message to consultants from Medical Director, plus consultant specific briefing session • Message to nursing staff from Chief Nurse, plus nurse specific briefing session • Posters and pull-up banners at St George's and Queen Mary's, plus community sites
Patients/public	• Dedicated strategy section and information portal on Trust website • *In focus* on strategy feature in new Trust magazine, *By George* (March 2017) • Posters and pull-up banners at St George's and Queen Mary's, plus community sites • Voxs Pops with staff and patients on website, plus via social media (Facebook/Twitter)
Local stakeholders	• Detailed briefing paper via email • Information in Monthly Stakeholder Bulletin • Invitation to stakeholder engagement event (see point 6 in document above)
National stakeholders	• Detailed briefing paper via email • Information in Monthly Stakeholder Bulletin • Invitation to stakeholder engagement event (see point 6 in document above)
Foundation Trust Members	• Email from Chair/CEO • *In focus* feature in new Trust magazine, *By George* (March 2017)

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	5 January 2017	**Agenda No**	**4.1**
Report Title:	Workforce Information Report		
Lead Director/ Manager:	Mark Gammage, HR Advisor to the Board		
Report Author:	Sion Pennant-Williams, Workforce Team		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Update		
Executive Summary:	The report provides workforce information for November 2016. Staff in post have increased and vacancies reduced although there is insufficient reduction in agency usage and spend. Turnover rates remain high. Appraisal and MAST rates of compliance are weak and some preliminary benchmarking data indicates that the Trust fairs poorly compared to other similar Trusts. The focus of the HR team will be on improving the quality of workforce data and improving grip and control as well as staff engagement.		
Recommendation:	The Board is asked to note the workforce performance report and actions outlined within it.		
Supports			
Trust Strategic Objective:	All Trust objectives		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Financial efficiency and operational performance		
Implications			
Risk:	Failure to achieve financial and other targets and manage within agreed control totals		
Legal/Regulatory:	Failure to meet NHSI control total		
Resources:	n/a		
Previously Considered by:	Regular Board report	**Date**	01.12.16
Equality Impact Assessment:	n/a		
Appendix:	Workforce Information Slides		

Workforce Information Report
Trust Board 5 January 2017

1.0 PURPOSE

1.1 To provide workforce information for the Trust Board outlining trends and explaining changes in staffing composition to support decision-making and Board assurance.

2.0 CONTEXT

2.1 Concerns have been raised about data validity and the fragility of current information reporting systems is well known. Workforce information must be accurate and reflective of the data used throughout the organisation so that there is consistency and transparency from ward to Board. Further work needs to be undertaken to assure the Board on the quality of information being used in workforce reporting.

2.2 Workforce information needs to be triangulated with other relevant information such as finance and activity data so that one common set of information is being scrutinised. Setting budgets for next year will help to ensure accurate recording of vacancies (in post against funded establishments).

2.3 Information on South West London Pathology and GP trainees will be reported separately in future. The staff in these services are employed by the Trust but via a service contract and therefore their workforce information can distort the information presented on directly employed staff.

3.0 ANALYSIS

3.1 Staff in Post. The Trust has seen an increase in the staff in post and a reduction in vacancies. The Trust supports an increase in staff in post in clinical areas where agency or other temporary staff would otherwise be deployed. However, the reduction in vacancies does not appear to be matched by a corresponding decrease in agency staff. Bank staff as a proportion of temporary staff have increased but further action needs to be taken to reduce agency usage (see paper on agency caps and control being presented to the Board).

3.2 Turnover remains high at 14% and needs to reduce to c10%. Stability[1] has increased which is a positive indicator of staff remaining for longer than 12 months, although the Trust should expect to see stability rates over 90%.

3.3 Appraisal rates are poor and worsening. This needs to be an immediate area for action by line managers.

3.4 The Family and Friends Test data indicates a poor and worsening position and forms an area of focus for the staff engagement work the Trust is supporting.

3.5 Mandatory and statutory training compliance (MAST) has not improved since June 2016. The training team are working with subject matter experts to ensure that training that has been undertaken is properly recorded. A review of training requirements is underway to ensure that training described as mandatory for each staff group is accurate and reasonable.

[1] Stability is an indication of staff 'churn' i.e. it represents the number of staff in post at the beginning of the year who remain in post at the end of the year.

3.6. Benchmarking data has been provided for three teaching hospitals in London[2]. This indicates that sickness levels and MAST compliance are worse at St George's than elsewhere.

3.7. An analysis of interim managers is provided. Each appointment is overseen and scrutinised by the Trust's CRO.

4.0 IMPLICATIONS

Risks

4.1 The risks on staff engagement feature in the Trust's risk register alongside failure of leadership. Similarly, the risks to meeting the Trust's financial control total whilst also providing safe and effective care to patients form the primary focus for the Trust.

5.0 ACTIONS

5.1 The HR team will be focussing their attention on two simultaneous programmes of work. Firstly, on grip and control; ensuring pay expenditure reduces and that the Trust has effective controls in place to maintain this. This includes reviewing the current recruitment and staff bank processes. Secondly on staff engagement; ensuring appraisal and MAST rates increase, that the organisation is 'well-led' and that the Trust values are borne out in everything that we do.

5.2 The information used by the workforce team will be reviewed to ensure it is as robust as possible given current systems and where necessary action taken to improve consistency. Budget setting for 2017/18 will support this endeavour.

5.3. RAG ratings will be agreed for key metrics for 2017/18.

6.0 RECOMMENDATION

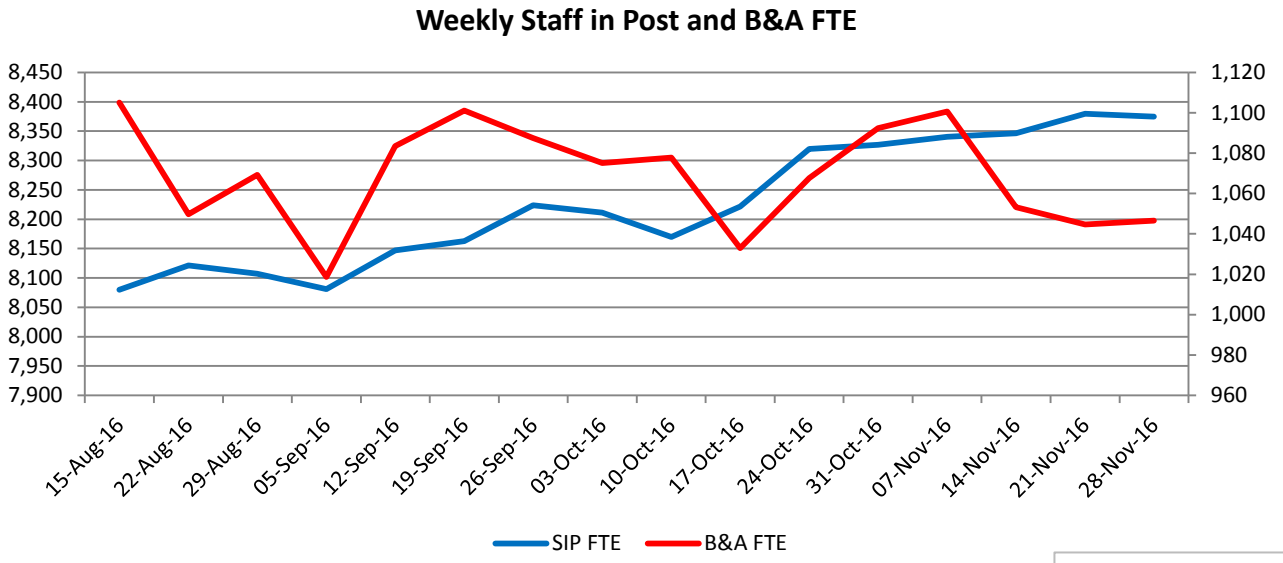
6.1 The Board is asked to note the workforce performance report and actions outlined within it.

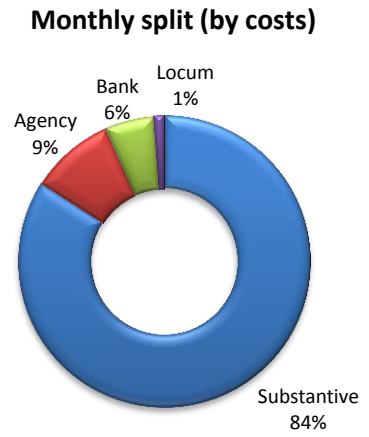
Author: **Mark Gammage, HR Advisor to the Board**
Date: **28 December 2016**

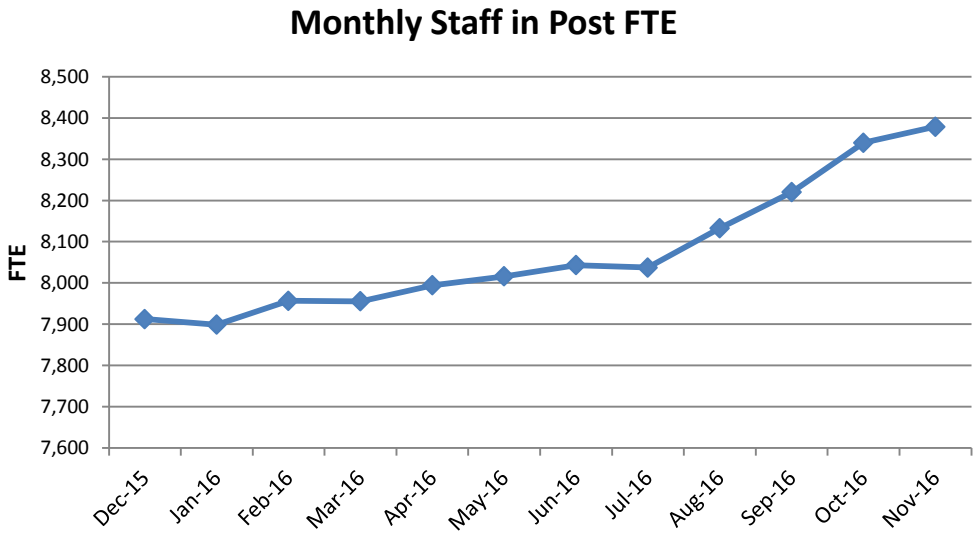
[2] Data from only three other London Teaching Hospital Trusts is currently available

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

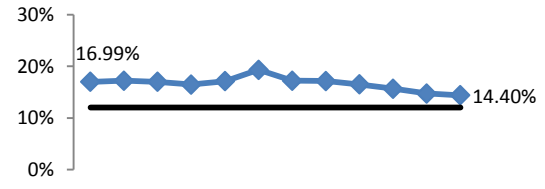
The Trust currently employs 8,941 people working a whole time equivalent of 8,379 which is 39 FTE higher than October. The directly employed workforce FTE in April 2016 was 7,912, so the growth rate is 4.81%.

This includes 426 FTE from SWL Pathology. Their FTE in April 2016 was 343, so the growth rate is 24.17%.

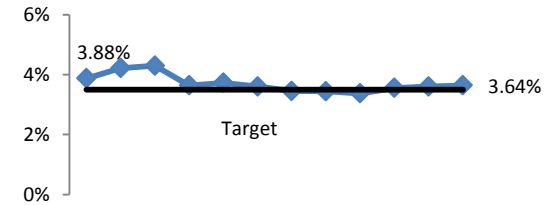
The Trust also employs an additional 481 FTE GP Trainees covering the South London area, which makes the total FTE 8859.

Section 2: Workforce KPIs

Vacancy Rate Year Trend

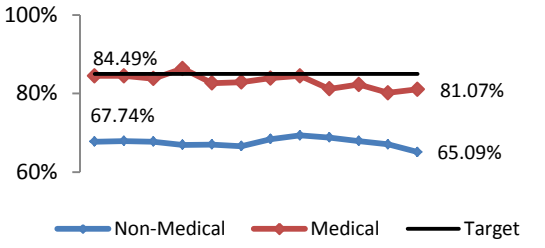


Sickness Rate Year Trend

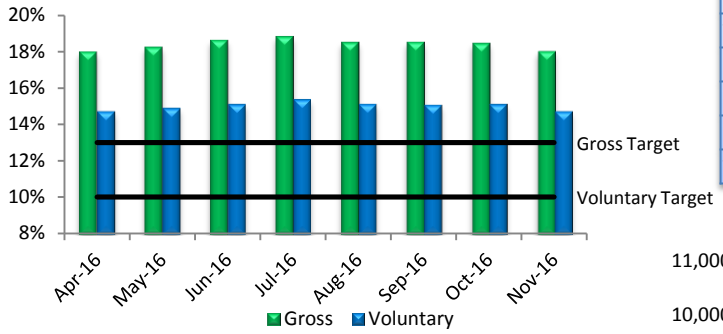


Stability Year Trend

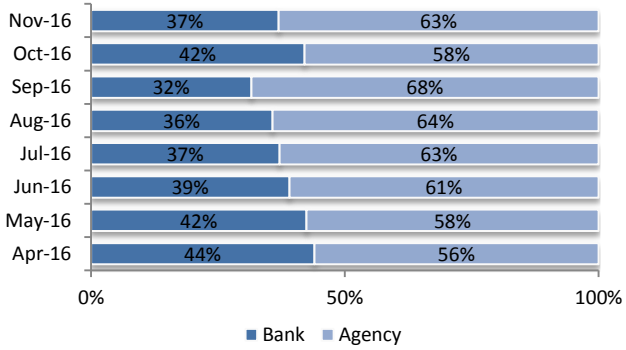
Appraisal Rate Year Trend



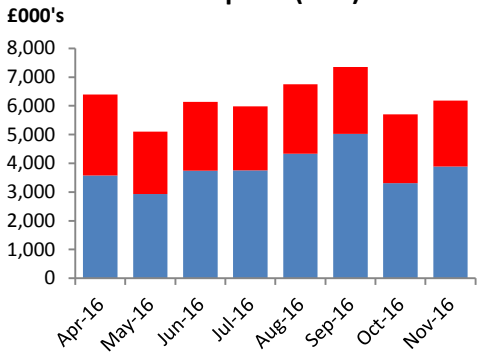
Turnover YTD



Bank/Agency Mix



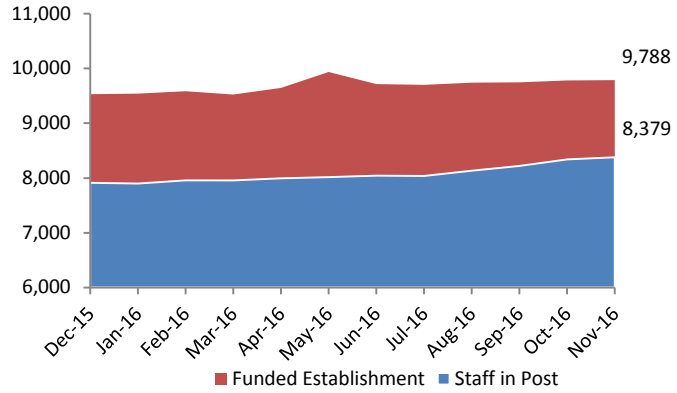
B&A Spend (YTD)



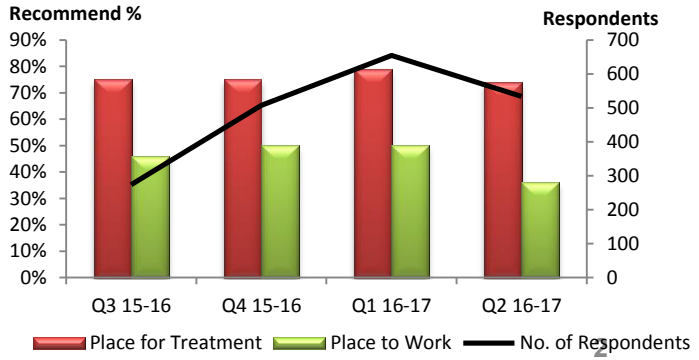
Key Points:

KPI	Change over the year	Change since last month
Vacancy	-2.59%	-0.35%
Sickness	-0.23%	0.04%
Stability	1.47%	0.02%
Gross Turnover	0.02%	-0.44%
Voluntary Turnover	0.00%	-0.38%

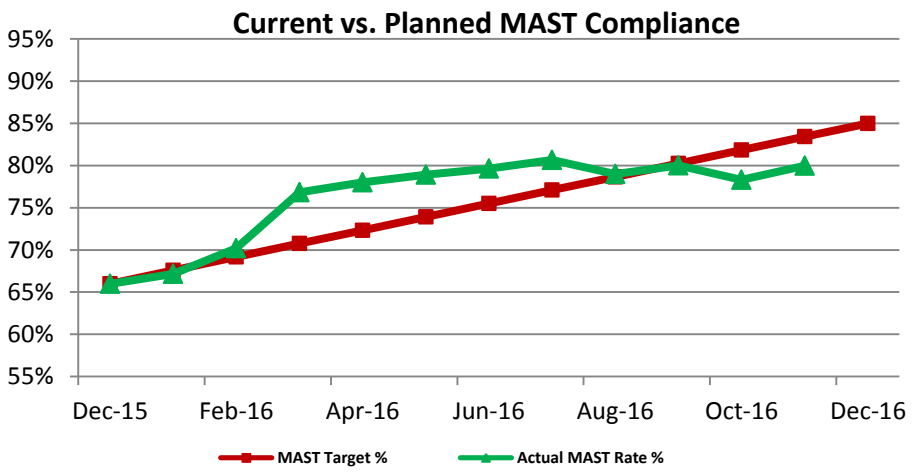
Trust Establishment & Fill Rate



Friends & Family Test



Section 3: MAST Compliance



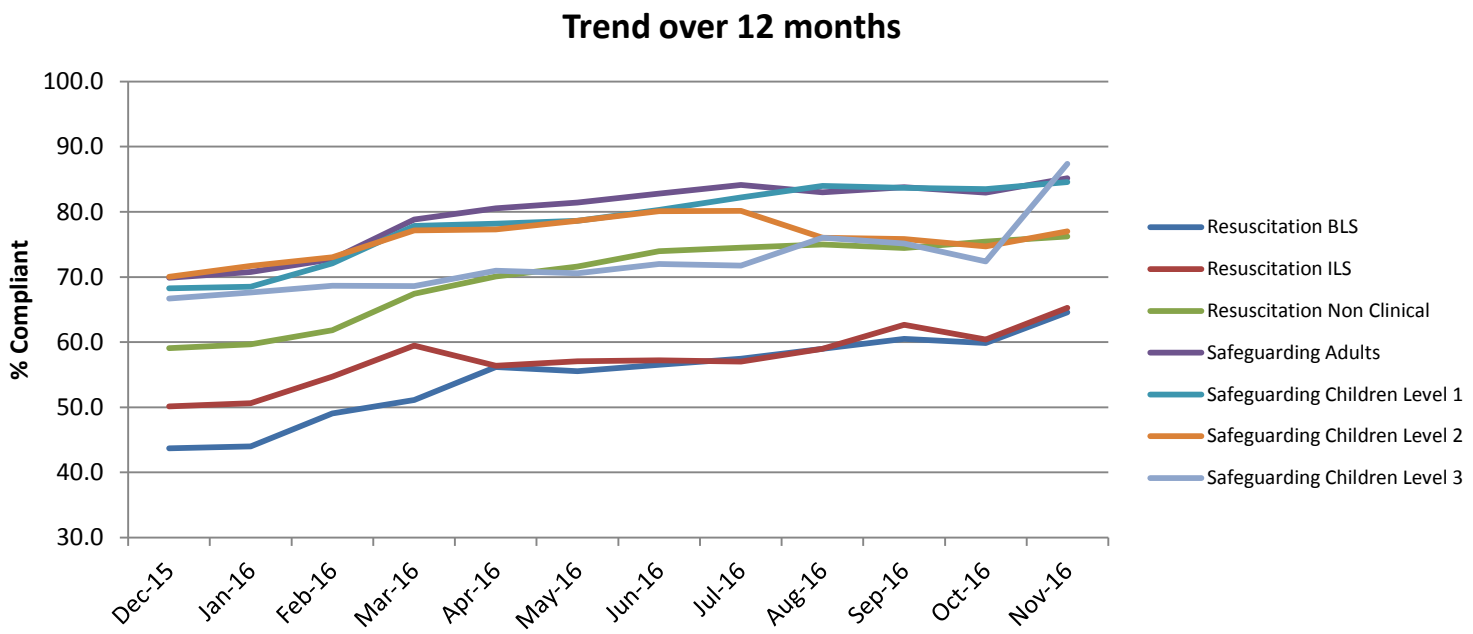
COMMENTARY

A programme of working is taking place including:

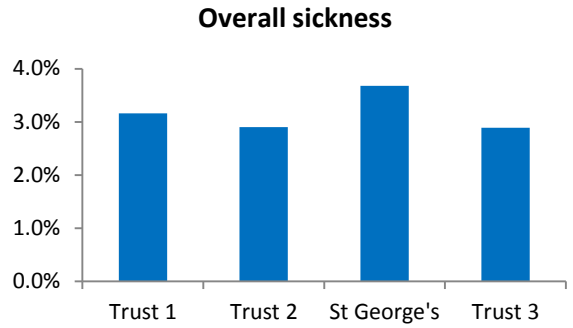
- Changing the method of delivery to on-line testing as far as possible and only training when required
- Reviewing who needs to access the training
- Reviewing the frequency of refresher periods
- Reporting compliance futures for departments so that they are proactive with compliance
- System changes so that accessibility issues are resolved.

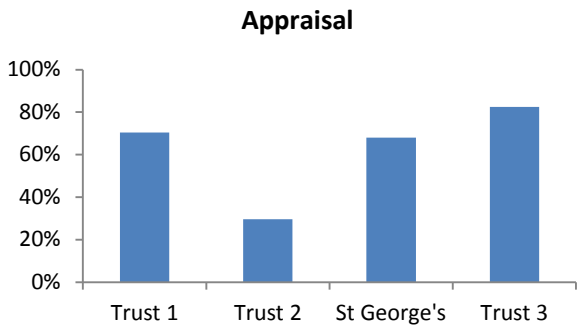
Current Issues:

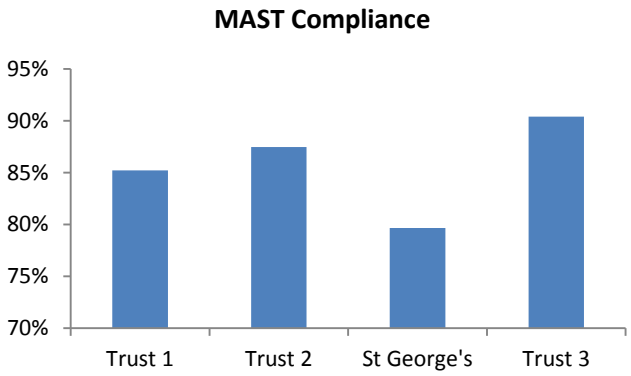
- Fall in compliance rates – largely due to staffing pressures
- Staff unable to access training externally- Software and licencing and IG issue
- Process review between Recruitment/Payroll/Education Department for new starters
- Not enough capacity to provide the training for the needs identified, particularly in resuscitation and safeguarding.
- There is currently a disconnect between actual training completed and the training being reported – this is an issue which is being focussed on.



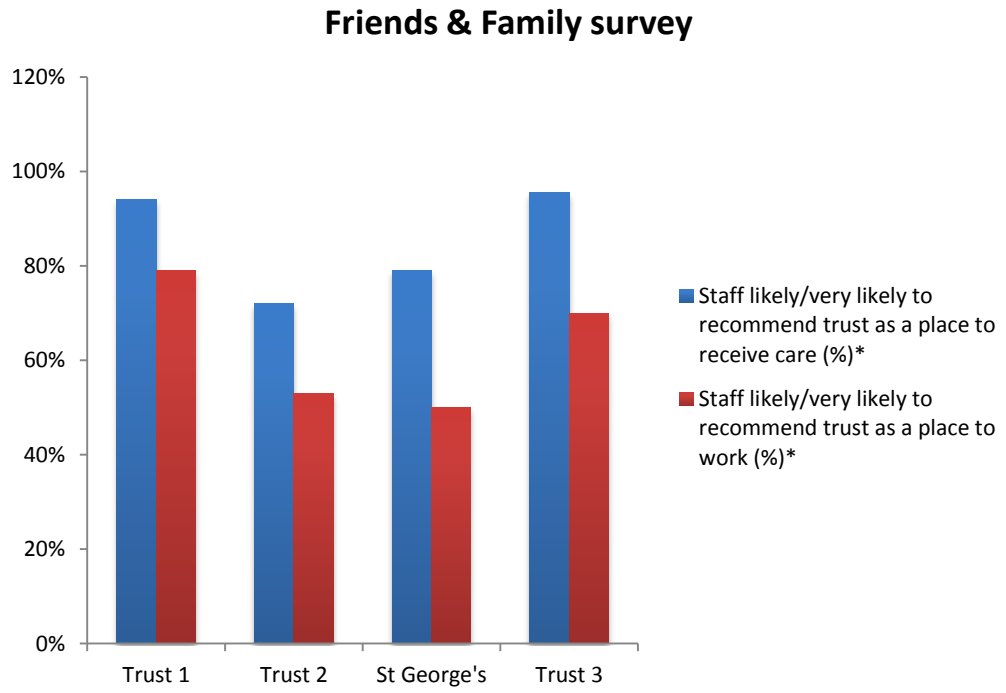
Section 4: Benchmarking







- Benchmarking against 3 other teaching hospitals within London that participated
- Data is for quarter 1
- Trust 1 has over 10,000 staff
- Trust 2 has 10,000 staff
- Trust 3 has less than 4,000 staff



Section 5: Month 8 Interim Analysis

Function	number	£'000	Notes	
CEO Office	7	1,070	*7 VSMs*	**Application of interims:** • **34 BAU backfill to** • **77 major programme interims**
Operations	11	1,148	*Includes RTT*	
IT	45	1,382	*Includes backlog*	
Estates	10	128		
Finance	7	830		
Governance	3	167		
Procurement	-	374		
Turnaround	21	2,320	*Contains Estates backlog*	**Turnaround:** **5 PMO** **6 Outpatients** **2 HR** **2 Revenue/Coding** **1 Recovery** **5 PP, overseas etc**
Sub-total	**104**	**7,419**		
SWLP	7	589		
Total	**111**	**8,008**		

Meeting Title:	Trust Board		
Date:	5 January 2017	**Agenda No**	**4.2**
Report Title:	Leadership Development		
Lead Director/Manager:	Mark Gammage		
Report Author:	Sarah James, Assos. Director of Workforce (Education) and Andrew Rhodes, Medical Director		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Discussion and Approval		
Executive Summary:	The Trust has invested insufficiently in leadership, particularly with the key cohort of leaders who need to drive the change required of the organisation. CQC rated the 'well led' domain as inadequate in 2016 and the PwC report in 2015 also demonstrated ineffective leadership and governance. There are some leadership programmes in place which need to be further evaluated and work has started to introduce a range of programmes at all levels of leadership to address some of these gaps and this needs to be completed. The Trust has been successful in obtaining funding from Health Education England South London (HEESL) and the plan is to use this money to enhance clinical leadership and our talent pipeline, in particular for Clinical Directors, Care Group Leads, Matrons and Ward Managers as well as general managers. It is proposed to supplement this with further funding from CQUINs (for Staff Welfare) to develop a comprehensive and holistic leadership programme in 2017/18. Our aim is to get to a point where everyone is effective in their current leadership position and we have a trained cohort of people in the talent pipeline. This requires a better developed plan for leadership within the organisation and a sustained and thorough approach to leadership development. A further more detailed paper will be presented to the Trust Board in March 2017 outlining these plans.		
Recommendation:	The Board is asked to: i. endorse the approach to leadership development. ii. agree to the use of the HEESL funding and to a 'roll forward' of the HEESL funding beyond March 2017. iii. receive a further, more detailed report at the March 2016 Board meeting.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Leadership and Improvement Capability		
Implications			
Risk:	Insufficient management capacity or capability to deliver our turnaround programme.		
Legal/Regulatory:	There are no specific legal or regulatory implications in this paper, although it will help to address issues raised by the CQC in its recent report.		
Resources:	Some financial support has been made available from HEESL, and more will		

	need to be drawn from the Staff Well-Being CQUIN in 2017-18. A further more detailed paper will be brought back to the Board in March 2017 with costs for a second phase. Release of leaders to attend development opportunities will be a key resource requirement.		
Previously Considered by:	This will be discussed in greater detail at the Workforce & Education Committee on 31.01.17.	**Date:**	31.07.17
Equality Impact Assessment:	Leadership programmes will be assessed for equality impact prior to commencement and on completion.		
Appendices:	**Appendix A:** Leadership Architecture 2015 **Appendix B:** Specific Leadership Requirements During Turnaround **Appendix C:** Kirkpatrick Evaluation Model **Appendix D:** Proposed Areas for Objectives for Leaders		

Leadership Development
Trust Board, 5 January 2017

1.0 PURPOSE

1.1 This paper describes the work that St George's University Hospitals NHS Foundation Trust (SGUH) has undertaken to understand the challenges it faces for the next few years and what will be needed to ensure that the leadership of the organisation has the required skills needed to take on the challenges ahead.

1.2 A vision for Trust Leadership is set out and an indication of the training and organisation development resources that will be need to support the achievement of this.

1.3 Current development plans are described with an outline of what needs to be undertaken to enhance and supplement this.

2.0 BACKGROUND

2.1 High quality quantitative and qualitative research has evidenced the link between good leadership and achievement of a positive difference to patient care, care outcomes and the experience of care[1]; there is a lot of evidence linking failure in leadership to failures in patient care too. Getting leadership right makes a very positive difference and needs careful planning.

2.2 The Rose Report[2] asserts that leadership in the NHS is at a critical tipping point, and this view was shared by the Care Quality Commission assessment of Trust leadership where the 'Well Lead' domain was rated as 'Inadequate'. Leadership was described as weak in several departments. This was not simply a Board issue. The Trust therefore needs to ensure that its current and future leaders are prepared and equipped to deal with the ever increasing complexities and pressures of today's NHS. The fact is we are much more likely to be successful by deploying tactics to ensure we 'grow our own' more effectively and that the routine development of talented individuals, linked to career progression, becomes a core part of our business.

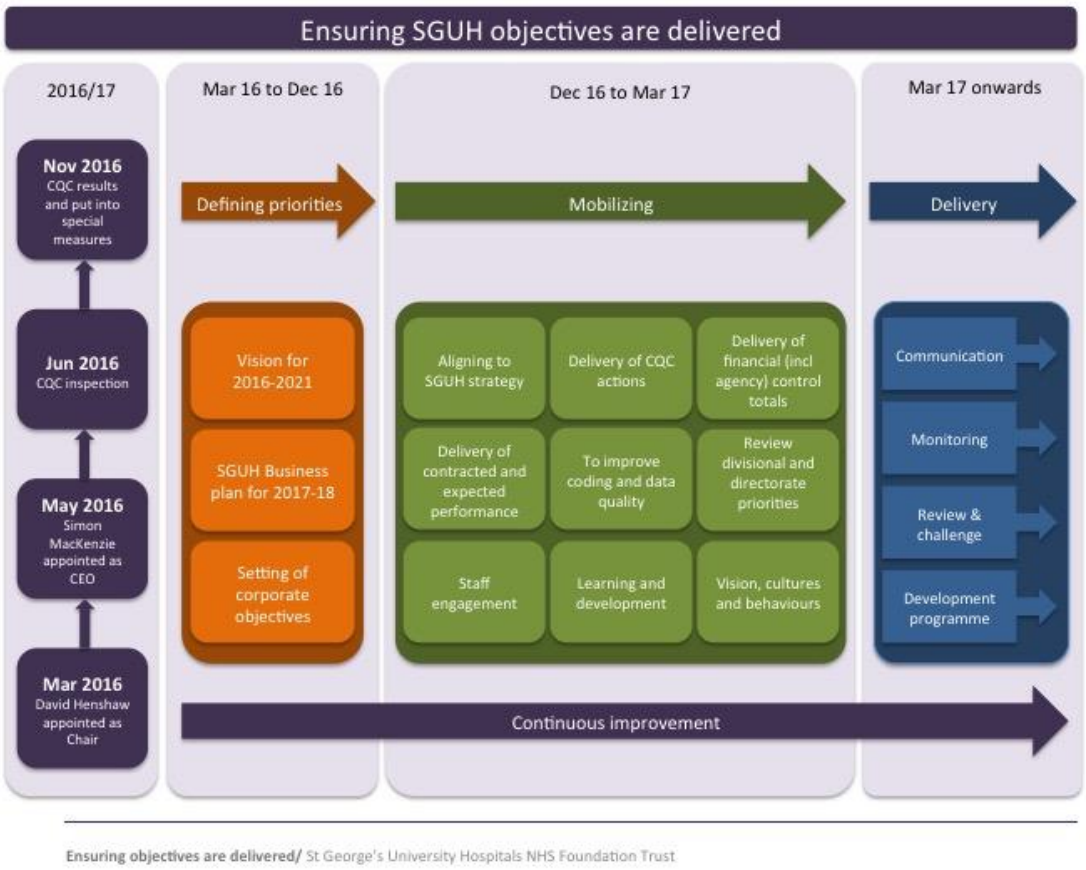
2.3 There is evidence, particularly in the NHS, which highlights the importance of collective leadership and advocates a balance between individual skill enhancement and organisational capacity building[3]. The Trust has a challenging agenda to improve quality, financial performance and access whilst improving staff engagement.

2.4 Our **vision** is for St. George's to have a cadre of credible, capable leaders who are able to ensure the organisation meets its objectives in terms of quality and safety within its resources. The overall **aim** is:

i. For leaders to find a way to deliver what we have to do
ii. To develop its existing leaders in line with Trust values and the leadership behaviours outlined in the leadership framework
iii. To develop its leaders to lead in a collaborative way across professional boundaries, departmental, divisional boundaries and organisational boundaries for the good of the patient
iv. For nurses, doctors, and general managers to understand each other's priorities
v. To prepare leaders for their next role ensuring that there is a pipeline of talent
vi. To give leaders time and headroom to lead service transformation, and find ways to bring their staff along with them.

[1] Berwick, Keogh, Michael West and Aston Business School
[2] Better leadership for tomorrow: NHS leadership review, Department of Health, July 2015
[3] West, Armitt, Eckert, West, Lee, 2015

2.5 The diagram below summarises the context within which this leadership work is being planned:



Ensuring objectives are delivered/ St George's University Hospitals NHS Foundation Trust

2.6 An interim Chairman, CEO and Executive team were appointed during 2016/17. The strategy and vision for the Trust have been redefined and corporate objectives set.

3.0 CHALLENGES FOR 2017-2019

3.1 **Delivery of CQC actions:**

i. The CQC rated SGUH as inadequate overall in November 2016 and NHS Improvement placed the Trust into special measures for quality. Serious concerns regarding leadership were raised as part of this review. Not only was the Well Led domain rated as 'Inadequate', this underlay the other concerns, including rating the Safe domain as 'Inadequate'

ii. SGUH has set up a quality improvement plan (QIP) in order to coordinate and manage the improvement actions needed following the CQC report. This QIP now needs to be delivered.

iii. In order to deliver many of the cultural issues identified there will be a need for far tighter governance and grip within the organisation that has been present previously.

3.2 **Delivery of financial and agency control totals:**

i. The Trust is under pressure from NHSI to agree financial and agency control totals for 2017/18

ii. There is an urgent need to agree with commissioners' satisfactory contracts for 2017-19

iii. The business plan for the next few years must ensure that SGUH can achieve and maintain sustainable financial balance for 2017/18. It is recognised that this is very challenging and will require transformation change to the way the organisation functions

iv. There is a need for all parts of the organisation to deliver the changes and savings required from the Trust-wide CIP programme including implementation of the Carter Review

recommendations and also the achievement of agency and budget control totals.

3.3 **Delivery of contracted and expected performance:**

i. SGUH needs to consistently meet NHS constitution performance standards over the period with a particular emphasis on:
   a. Delivery of 4 hour target to trajectory
   b. Delivery of all cancer targets each month
   c. Delivery of all RTT and diagnostic targets

ii. In order to achieve these the organisation will need to improve flow of patients with reduced length of stay

iii. Crucially the Trust will need to ensure that the hospital functions safely seven days a week

iv. These performance metrics will need to be met whilst simultaneously providing a regular maintenance programme for the estate and infrastructure.

3.4 I**mproving data quality and coding:**

i. There is recognition that data handling and information processing within the Trust is poor and this is having material impact on clinical and operational performance

ii. Due to paucity of reliable triangulated information, the Trust Board and Executive are having to make decisions based on an inadequate understanding of the problems

iii. Poor data processes translate through to inadequate booking and tracking of patients. This means that patients may be getting lost in our systems and potentially coming to harm. This has manifested in the recent non-reporting of national RTT performance metrics due to the Board's inability to trust the veracity of the data presented

iv. The poor coding and counting of clinical data results in under-recouping of income

v. New data handling processes will have to be defined and standard operating procedures described for teams to use. Training will have to be provided to ensure this happens in a reliable way

vi. Ownership of data needs to start from the shop floor so that when it becomes aggregated for presentation to the Trust Board it can be relied upon.

3.5 **Reviewing Divisional and Directorate Priorities:**

i. Divisional and directorate (and Care Group) priorities must be aligned to those of the Executive and must be designed to deliver the significant challenges described.

ii. These priority items described have been converted into a set of objectives that can be cascaded down through the leadership teams).

3.6 **Staff engagement:**

i. SGUH recognises that the staff engagement outputs as evidenced from the NHS staff survey and the medical engagement survey in 2016 are poor. These will need to change if a new way of working is to be found that will enable the turnaround of the organisation to become a reality.

ii. Staff engagement remains an issue across all professions within the organisation and at all levels within the hierarchy.

iii. Many of the staff have become cynical about the likelihood for organisational improvement and have become accustomed to mediocrity.

iv. SGUH has had a persistent problem with bullying and harrassment behaviours for a long time that it has failed to tackle.

v. A significant improvement in communications has been evidenced in 2016/17 following the appointment of an Associate Director of Communciations although it is recognsied that the *substance* of what managers and leaders do will have the most impact on staff morale.

Previous and Current Leadership Development

3.7 The Executive Management Team (EMT) agreed the architecture for leadership development in September 2015; this is shown in Appendix A. The underlying principles that were agreed were:

i. To promote a collaborative leadership approach
ii. Learning should be multi-professional, wherever appropriate
iii. Accredited, where appropriate
iv. In-place; delivered on site with joint internal and external faculty
v. Linked to Trust objectives and Quality Improvement
vi. Linked to Listening into Action
vii. For this to be developmental, not remedial
viii. Learning to be stimulating, challenging, engaging, fun.
ix. To build networks of leaders and communities of practice
x. To link to Talent Management

3.8 The Seeing Systems workshop was held for the 'Top 100' leaders in March 2016 with follow-ups in May. The aim of this work was to empower each level of leadership to perform up, rather than work down. Subsequent changes at Executive level put the Organisational Development next steps of this process on hold. A set of objectives for the Trust in Turnaround was cascaded to the 'Top 100' in November 2015 (Appendix B), together with a request that each leader complete a 360 degree leadership assessment and the offer of finding a coach or mentor.

3.9 In 2015 Monitor made funding available for some senior leaders to attend the national Nye Bevan programme, with places taken by 5 senior staff and the Trust funded a further 5 places on this and other national courses in 2016. This represents a minority of individuals and their learning has not become embedded into the culture of the organisation, re-enforcing the need for a more comprehensive programme.

3.10 The internal leadership offering has 6 levels of leadership development:

i. An Introduction to Leadership and Management (1 day) – Basic Understanding
ii. The Essentials – Leadership and Management (4 days) – Entry level roles
iii. Enhanced Leadership for Clinical Leaders – Moving into a front line role such as ward manager or consultant (2 days)
iv. Managing and Leading the Front Line (2 days) – Existing Front-line leaders
v. Managing and Leading the Service (4 days) – Senior leaders such as GMs, matrons, consultants
vi. Managing and Leading the Organisation (to be decided) – Senior leaders such as Care Group Leads, DMs, HoNs in phase 1 and general managers in phase 2.

3.11 The first five of these programmes are in place, and receiving excellent Kirkpatrick level 1 evaluations (model shown in Appendix C), with some evidence that the Paired Learning aspect of the Managing and Leading the Service programme has achieved Service Improvements. However the effectiveness of these interventions must be judged against the organisation's ability to deliver its current agenda.

3.12 The final programme focusing on leading and managing the organisation will be developed under the proposal outlined in section 4.

3.13 Those most interested in leadership development have attended to date but we now plan to work through the layers of leadership to ensure that everyone has the leadership skills required. We will also ensure that newly appointed leaders, both clinical and non-clinical are booked onto an appropriate programme within 12 months of starting work at the Trust. It is

recommended that this is mandatory and undertaken much sooner after commencing at the Trust than has historically been the case.

3.14 The intention is to refine the existing programmes in order that at least a level 3 evaluation is possible, with Quality Improvement within available resources being an integral component of each programme.

3.15 In conclusion, in spite of previous interventions and areas of good practice, the Trust have not yet established leadership development programmes and approaches which embed behaviours with the key groups of staff and this is the ultimate focus on this work.

4.0 PROPOSAL

4.1 Whilst existing leadership programmes will continue to be provided until they are fully assessed and changes made to ensure a higher level of evaluation is achieved, the Trust will be introducing a new leadership development programme for Managing and Leading the Organisation.

4.2 HEESL offered to help the Trust in a number of areas following the publication of the CQC report. One of the areas identified was leadership and £75,000 has been earmarked for this purpose from this funding. An additional amount of CPPD money will also be paid into the Learning Development Agreement funding in Q4 and this will include a further £70,000 to be used for leadership. This funding will be directed at this programme and the Board is requested to allow the 'roll forward' of this funding (£145k) into 2017/18 if it isn't all spent in 2016/17.

4.3 Given the need to focus on clinical leadership as a particular issue it is proposed to scope and develop programmes for key leadership roles focussing on Clinical Directors, Care Group Leads, Ward managers and community equivalents, and matrons in Phase 1. These roles will also be the focus of our talent management efforts in 2017. Phase 2 of the programme will follow on from this in the new financial year and will focus on leadership needs within general and service management and corporate areas. The opportunity for leaders from clinical and non-clinical backgrounds to work together as part of leadership programmes will also be explored.

4.4 A workshop will be run on 9th January 2017 for the triumvirates (the Divisional Chairs, Divisional Directors of Operations, Divisional Directors of Nursing) to agree objectives and leadership behaviours and this will be rolled out to the 'Top 100' so that there are clear objectives and standards of leadership behaviour throughout the Trust. A new proposed set of indicative areas for objectives is shown in Appendix D.

4.5 Workshops to complete training needs analyses for the next 6 layers of leadership will be completed by end February.

4.6 This new programme will include the use of the NHS 360 Leadership assessment tool both pre programme and 6 month post programme. This will provide a way of measuring changes in one-self and other observed leadership qualities. Each programme will typically include a number of modules aimed at helping those in the roles achieve their objectives, interspersed with action learning around a quality improvement project.

4.7 From experience, external organisations will charge circa £50,000 for a cohort of 15-20 people on this type of leadership development programme not including on-going costs of mentoring, coaching and action learning sets. This will result in the funds from HEESL needing to be supplemented in 2017, and a further and more complete paper will therefore be presented to the Board in March 2017.

4.8 Success will ultimately be judged on the ability of the Trust to deliver a sustained and, in places, improved quality of service to patients within existing and future resources.

5.0 IMPLICATIONS

Risks

5.1 The failure of leadership to engage with staff is on the Risk Register.

Legal Regulatory

5.2 There are no specific legal or regulatory implications in this paper, although it will help to address issues raised by the CQC in its recent report under the well-led domain. This is not the reason for putting the development programmes in place; we are putting them there because it is the right thing to do.

Resources

5.3 Funding is available from HEESL for a first round of development activity and seek the Board's approval to use it for this purpose.

5.4 Funding for on-going leadership development and a 2nd phase will be addressed in a further paper to the Board in March 2017. It is recommended that funding could be used from the Staff well-being CQUIN.

6.0 NEXT STEPS

6.1 Establish a small steering group consisting of the Medical Director, Chief Nurse, COO, a Divisional Chair, Director of HR, Associate Director of HR to ensure that the programmes are rooted in what the Trust is trying to achieve.

6.2 The training needs analysis and agreed objectives to shape the tender specifications for the programme. Procurement to commence February and programmes to be underway before April.

6.3 A thorough evaluation of existing leadership programmes to be undertaken.

6.4. A more thorough paper including the Trust's approach to leadership to be presented at the March 2016 Board meeting

7.0 RECOMMENDATION

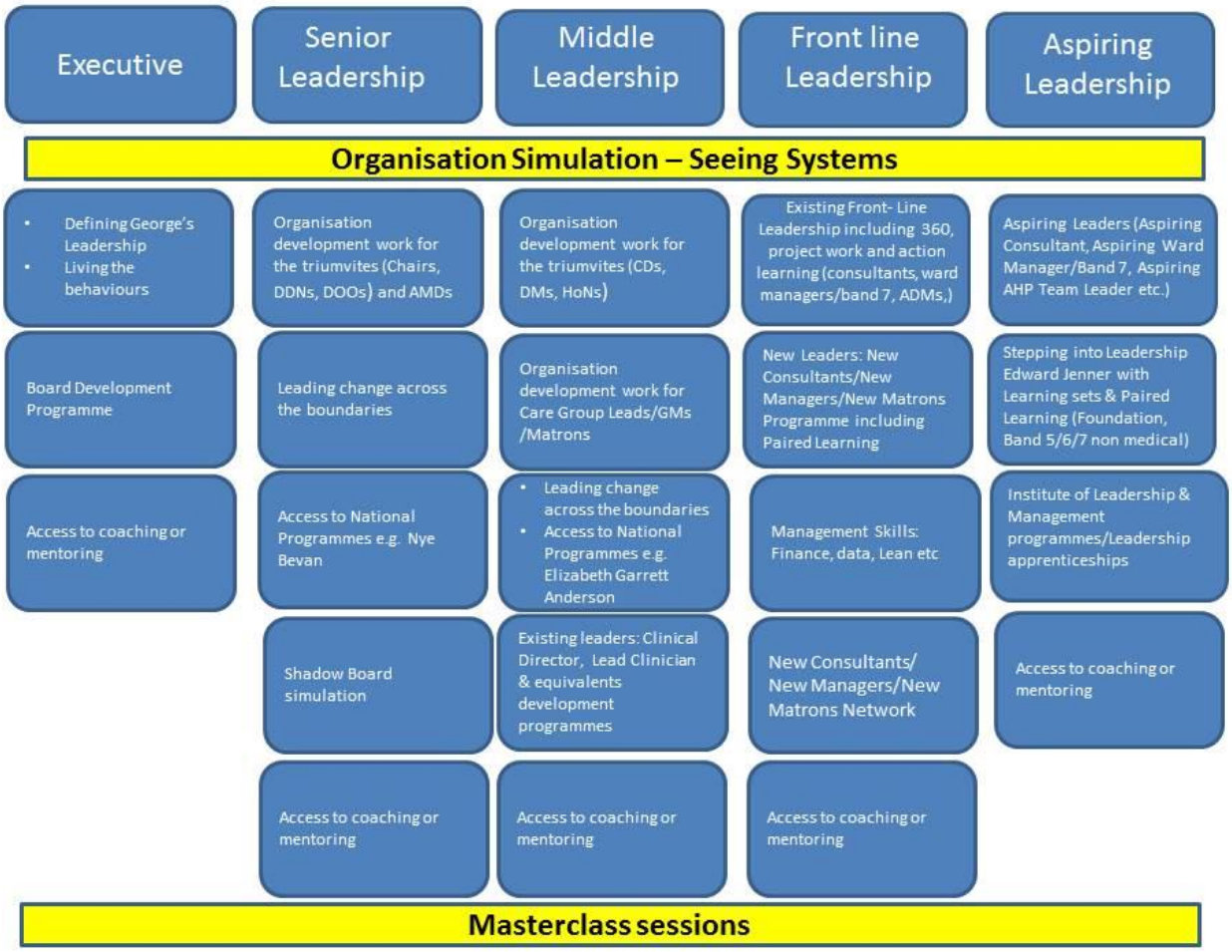
7.1 That the Board:

i. endorse this approach and the use of the HEESL funding.
ii. agree to the 'roll forward' of the HEESL funding beyond March 2017.
iii. receive a further, more detailed report at the March 2016 Board meeting.

Author: **Sarah James and Andrew Rhodes**
Date: **28.12.16**

APPENDIX A

Leadership Architecture 2015



APPENDIX B

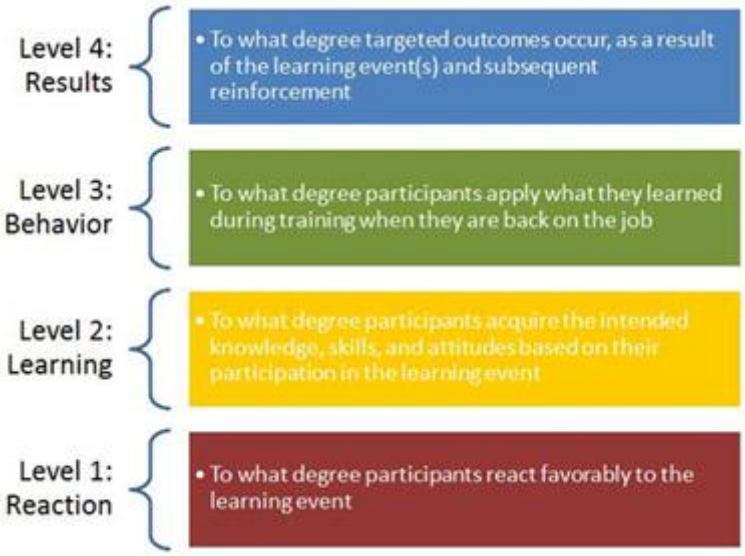
Specific Leadership Requirements during Turnaround

Provide leadership in ensuring that the trust achieves a sustainable financial position, specifically taking responsibility for delivery of agreed budget and CIP targets.	Ensure that there are processes and systems in place that prioritise and monitor safety and the quality of patient care, act to resolve alerts regarding quality or safety and ensure that the quality impact assessment process is followed.
Ensure that trust performance targets are met and, where this is challenged, take action and raise concerns appropriately.	Communicate openly, share learning, and work collaboratively with colleagues and external and internal partners, including across divisions, recognising that we are a single organisation.
Ensure that team brief is disseminated appropriately and feedback sought.	Identify ways of ensuring a greater visibility of the senior management team to all members of staff.
Set a considered tone for colleagues in how we lead and manage the organisation, including taking responsibility for ensuring reduced levels of staff turnover and for tackling poor performance and behaviour.	Ensure that staff appraisals and mandatory training are up to date for self and direct reports.
Take opportunities to lead innovation, seek out best practice and evidence of success.	

Leadership values We expect our senior leaders to demonstrate the behaviours associated with the Trust's values in the following ways.
Excellent: Lead the organisation to the highest possible standards and set a values based style for own functional area or Division
Kind: Demonstrate an empathetic leadership style.
Respectful: Demonstrate an inclusive and considered approach to leadership including acknowledging the importance of own leadership role.
Responsible: Be truthful and accept responsibility for our actions.

APPENDIX C

Kirkpatrick Evaluation Model



APPENDIX D

Proposed Area for Objectives for Leaders

Quality	Finance & use of resources	Operational performance	Strategic change	Leadership & improvement capability
Continuously improving care quality, helping to create the safest, highest quality health and care service	*Achievement of budgets and improving productivity*	*Maintaining and improving performance against core standards*	*Ensuring every area has a clinically, operationally and financially sustainable pattern of care*	*Building leadership and improvement capability to deliver sustainable services and a healthy productive workforce*

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board Meeting		
Date:	5 January 2017	Agenda No	**5.1**
Report Title:	Information and Communications Technology (ICT) Update		
Lead Director/ Manager:	Larry Murphy, CIO		
Report Author:	Peter Suter, Head of Delivery		
Freedom of Information Act (FOIA) Status:	Restricted		
Presented for:	Update		
Executive Summary:	This paper provides the Trust Board with an update on progress made on the stabilisation of the IT infrastructure and the reduction of the risk to the Trust of catastrophic IT infrastructure failure.		
Recommendations	It is recommended that the Board continues to support ICT in continuing with the current programme until completion in March 2017.		
Supports			
Trust Strategic Objective:	This supports the stabilisation of the IT infrastructure ahead of the re-commencement of Clinical Systems deployment		
CQC Theme:	This work is an enabler for further IT Infrastructure work that supports a number of CQC recommendations.		
Single Oversight Framework Theme:	This work is an enabler for a number of elements in the Single Oversight Framework, especially Finance & Use of Resources and Operational Performance.		
Implications			
Risk:	This work mitigates the risk to the Trust of major ICT failure which is Board Assurance Framework Risk 10.		
Legal/Regulatory:	N/A		
Resources:	All resources are currently in place.		
Previously Considered by:	Executive Directors	**Date:**	22.12.16
Equality Impact Assessment:	N/A		
Appendices:	None		

ICT Update
Trust Board, 5 January 2017

1.0 PURPOSE

1.1 To update the Trust board on the following:

- Current status of ICT risks and progress made on the stabilisation of the Information Technology (IT) infrastructure which mitigates the risks.
- Progress on the new Informatics Strategy that will ultimately deliver a fit for purpose Information and Communications Technology (ICT) environment for the Trust.

2.0 BACKGROUND

2.1 In August 2016, ICT set out a recovery plan based on two parallel priorities: stabilisation and the overall strategic direction of travel. Activities are currently on track and improvements are being delivered. This report builds on the update paper presented to the Board in November 2016.

3.0 IT STABILISATION & RISK REDUCTION

3.1 A programme of work to reduce the trust risk of IT failure has been running since August; progress to date has been steady however due to the delicate state of the infrastructure some areas have been purposely slowed to ensure no adverse impact as changes are made. The key projects within the programme are:

i. **Increase Computer Capacity:** Additional capacity to increase overall computing capacity has been procured, implemented, tested and is now in the live environment. In terms of objective this task is now complete; work is underway to migrate from heavily loaded old clusters to the new cluster as they require maintenance downtime.

ii. **Increase Storage Capacity:** As planned, a new contract to support existing storage has been implemented. Additional storage capacity has been procured, installed and tested successfully. In terms of objective this task is now complete, and work will now commence to migrate data in a planned manner to fully utilise the new capacity.

iii. **XP Replacement; XP: The** plan remains on track to complete the XP replacement by 31 March 2017. This specifically means that all XP machines will be identified and the majority replaced. There will be an exception list where there are technical reasons (normally old applications) that require additional time and resources to resolve effectively for the users. In each case there will be a plan and timeline for complete XP removal. To date 405 out of 820 Pcs have been replaced in the community. Plans are currently underway to survey St Georges and replacement will commence on this main site as well as St Johns and QMH from January. Additional hardware is currently being ordered to supplement the previous 750 PCs.

iv. **Network Remediation:** This is the most complex and thereby highest risk activity. The work is to stabilise the network and improve the resilience by implementing new equipment and a number of network reconfigurations. The priority of the work has been to ensure that while changes are delivered, service has been maintained. For this reason a number of changes have had to be 'backed out' as unforeseen problems have arisen, taking further re-planning and time to implement. Progress has been made, however the timescale has now been extended to end of February due to these unforeseen problems. Once the planned stabilisation has been completed there will be on-going work packages to continue to bring the network up to the required standard.

v. **Back-Up Solution:** Cloud based back up has been implemented for Exchange (email) data. For other on site data services a delay in equipment procurement has meant a later than planned implementation. It will now commence on 9 January with full completion by 31/3/17. However the risk mitigation is not linear with the biggest reduction at the start as the first phase of implementation as it takes a complete backup before the incremental feeds are fully implemented over the coming weeks. Therefore risk will be greatly reduced by the end of January.

vi. **724 Recovery:** When the network failed in June, the 724 emergency PCs did not provide the required level of resilience expected. A recovery programme has now restored 104 emergency PCs, nine are still under investigation. A business as usual (BAU) process has been implemented to ensure testing of all 724 PCs on a daily basis. Work is scheduled to implement the latest s/w upgrade of 724 and also to review end user processes to ensure clinicians are fully conversant with the 724 process.

Figure 1 below provides a visual indication of progress to-date:

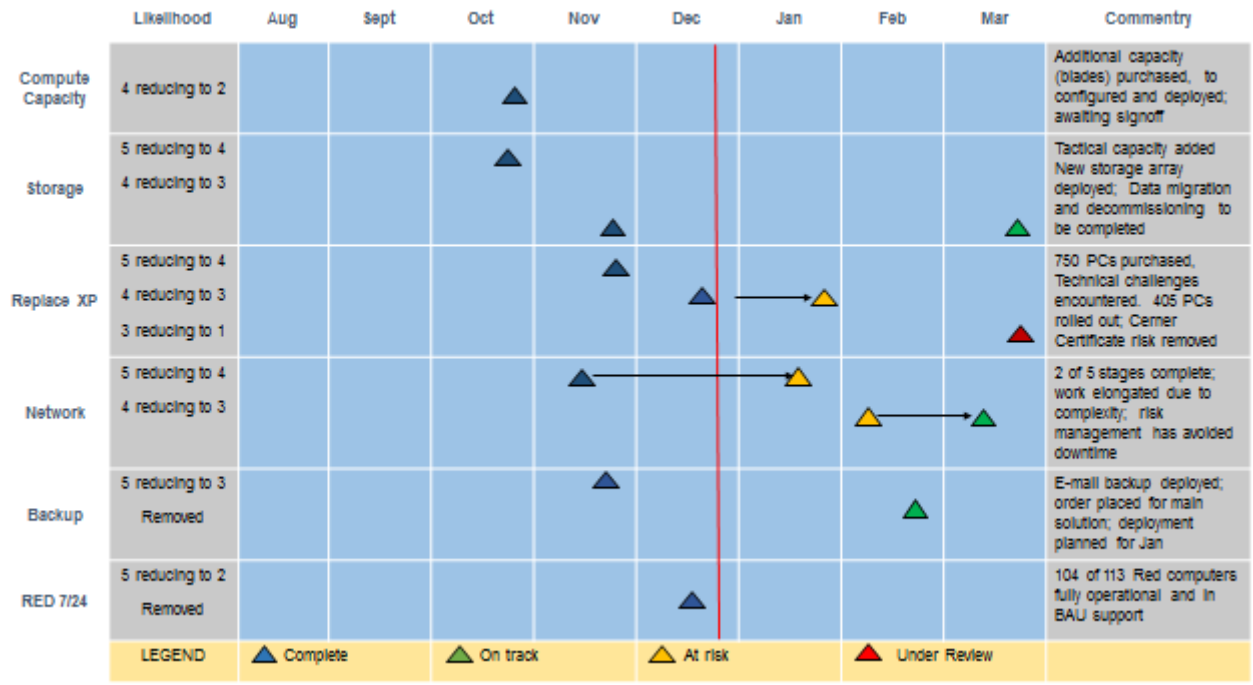


Figure 1

vii. **Risk Committee:** A deep dive' into the IT risks was conducted in conjunction with the Risk Committee and although it was agreed that the individual risks were reducing it was concluded that the combination of the above risks meant that the overall risk remained at a score of 25 (the highest possible rating). It was agreed at the risk Committee that IT would initiate a desk-top exercise with operations to manually test the IT Disaster Recovery (DR) interaction with the trust business continuity plans. IT also committed to a full test of it disaster recovery plan which is dated and risky; both of these exercises are expected to be completed by mid-February. IT has initiated a meeting in January with the outsourced supplier who is contracted to provide emergency DR equipment on site. Once clarified, the desk-top planning exercise with site operations to rehearse possible scenarios will be conducted. This will facilitate testing of the actual DR facilities.

viii. **ECR (Formally RTT) Support:** ICT have a dedicated Programme Lead who is supporting the Trust Programme providing systems and services as required. Current focus is to assist making provision for Cymbio to commence on their next segment of work.

ix. **Out Patients Support:** ICT are running four parallel activities to support the Outpatients programme in order to improve ICT systems that are used. These are EDM (Electronic Document Management), E-Triage, Dictate IT and Text Messaging. Current work plan is undertaking technical reviews, implementing tactical fixes to improve the overall user experience and process mapping to fully understand requirements in order to drive appropriate changes.

4.0 IMPLICATIONS

Legal/Regulatory

4.1 NHS England (NHSE) and NHS Improvement (NHSI) were both formally advised of the IT related incidents experienced in the Trust since June. This resulted in a meeting with NHSE and a review of several documents and plans. NHSI have also requested a private company, PSTG, to assure the remedial plans that are currently in place. An update meeting has been requested by the Wandsworth Commissioners on 4 January 2016.

5.0 NEXT STEPS OR TIMELINE

5.1 Continue risk reduction and stabilisation programme to completion.

5.2 Continue engagement with Site Ops, NHSI and NHSE to ensure all emergency scenarios are adequately covered.

6.0 RECOMMENDATION

6.1 It is recommended that the Board continues to support ICT in continuing with the current programme until completion in March 2017.

Author: Larry Murphy, CIO
Date: 22 December 2016

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	05.01.17	**Agenda No**	**5.2**
Report Title:	Corporate Risk Report		
Lead Director/ Manager:	Paul Moore		
Report Author:	Paul Moore		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	1) Core operational risk exposure areas: • Timely Access to Clinical Services/Patient Harm • Insufficient Resilience/Unstable Critical IT/Estates Infrastructure • Unsustainable Financial Position • Inadequate Governance/Reputation Loss 2) Proceedings of the Risk Management Committee held on 15/12/16 Paragraph 3.3 highlight the Risk Management Committee points of escalations to the Board		
Recommendation:	The Board are invited to consider the CRR and: • Satisfy itself that the current level of risk exposure is tolerable or acceptable and that the Board are content with the level of control achieved over those risks; • Where the Board are not satisfied, to agree further actions required to bring the risks under prudent controls; and • Consider the extent to which the Board's appetite for taking risks is adopted or if changes are needed to achieve prudent control.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Safe / Well-led.		
Single Oversight Framework Theme:	Quality of Care (safe, effective, caring, responsive). Leadership and Improvement Capability (well-led).		
Implications			
Risk:	These risks could have a direct bearing on requirements within NHSI's Single Oversight Framework, ongoing CQC Registration or the achievement of Trust policies, aims and objectives should the mitigation plans be ineffective.		
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence		
Resources:	There are no specific resource implications		
Previously Considered by:	Risk Management Committee	**Date**	15.12.16
Equality Impact Assessment:	N/A		
Appendices:	None.		

Corporate Risk Report

1.0 PURPOSE

1.1 To highlight key risks and provide assurance regarding their management.

2.0 BACKGROUND OR CONTEXT

2.1 The Corporate Risk Register (CRR) has been kept under review with input from the Executive during December 2016

2.2 The CRR continues to be rebuilt and reassessed accordingly. It is anticipated that review will be continuous in order to ensure the Board's understanding of risk is relevant and always up to date.

2.3 Training continuous to be 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.

2.4 It is anticipated that the CRR will change as further analysis, challenge and development of the risk profile progresses; and our understanding of uncertainty facing the Board's strategy emerges

3.0 ISSUE

3.1 Core Operational Risk

The understanding of corporate risk is evolving rapidly as the Executive identify and address uncertainty ahead. A range of significant/extreme operational risks have been identified and are currently being mitigated. These risks could have a direct bearing on requirements within NHSI's Single Oversight 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 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

3.2 Core Strategic Risk

The Board's strategic risks have been assessed and incorporated into the Board Assurance Framework (BAF). This was reviewed by the Board on 6th October 2016. The strategic risk vectors currently identified within 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**.

The BAF remains subject to review by the Board's committees. The company Secretary leads on the BAF

3.3 Proceedings of the Risk Management Committee

The Risk Management Committee met on 15th December 2016 to review the corporate risk register and to review in more detail reportable risk in: (i) Medicine & Cardiovascular Division, (ii) Medical Director's function, (iii) Turnaround function and (iv) Finance function.

The members felt there had been a significant improvement in the quality of risk registers and the discussion about their mitigation and options for further adaptation.

- The risk of '*onadequate data quality, completeness or consistency*' was increased from 20 to 25 following review and recognition that the current controls were not currently to be effective;
- The risk of '*ongoing exposure to high numbers of serious incidents and never events*' was reduced from 16 to 12 due to improvement in the identification and handling of serious incidents;
- The risk of '*recognising, escalating and responding to the signs of clinical deterioration*' has been added to the CRR;
- The ownership and oversight of the risk of '*insufficient cost improvement/transformation programme in 2016/17*' has been transferred to the Chief Restructuring Officer;
- Procurement of beds and bed rails. The discussion focused on the following points:
    - A paper went to IDDG during in December 2016 regarding the business case
    - A point prelevance audit took place on 13th December 2016 on every available bed on the day. It is anticipated that there will be a requirement to replace some beds and bedrails. The exact requirement is currently being analysed.
    - There are still a high number of aged bed rails which do not fit some beds correctly.
    - There are high numbers of beds with insufficient bedrails to accommodate patient need.
    - There has been a replacement of 20 mattresses with the assistance of the Estates team.
    - The Risk Management Committee considered that the risk remains extreme, but further analysis of the data will determine the exact resource implications and options to mitigate the risk. This remained ongoing at time of report.

- Epsom & St Helier Hospital are planning to buy or rent beds and the Trust will consider options join the procurement process subject to prior approval of the IDDG.

- The following anticipated potential future risks have been identified and incorporated into the Emergent Risk Horizon:

  - Loss of education and training levy
  - Out of Hospital provision of care
  - Industrial action
  - Retirements in next 3-5 years
  - Ageing workforce profile

4.0 IMPLICATIONS

Legal Regulatory

4.1 Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence

Resources

4.2 For further details on the resource implications associated with specific risk mitigations, please refer to the proceedings of the Finance & Performance Committee and Investment, Divestment Decision Group (IDDG).

5.0 NEXT STEPS

5.1 Once divisional risk registers have concluded formal review by the Risk Management Committee, the Corporate Risk Register will also include risks rated 15 or more that have been agreed by the Risk Management Committee.

5.2 Decision Points

The Board to consider:

(i) Is the Board satisfied that it has sufficient visibility of material risk exposures?
(ii) Is the Board satisfied that the control frameworks for mitigating those material risks are sufficiently understood and complied with by management?

6.0 RECOMMENDATION

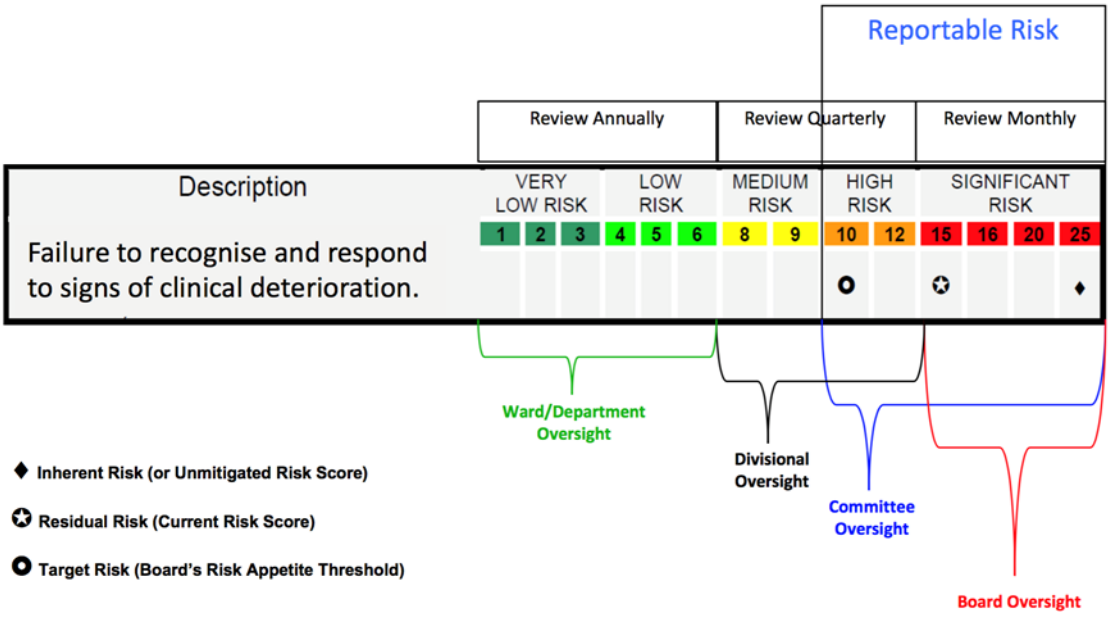
The Board are invited to consider the CRR and:

- To satisfy itself that the current level of risk exposure is acceptable and that the Board are content with the level of control achieved over those risks;
- Where the Board are not satisfied, to agree further actions required to bring the risks under prudent control; and
- To consider the extent to which the Board's appetite for taking risks is adopted or if changes are needed to achieve prudent control.

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 Arrangement (illustrated)]



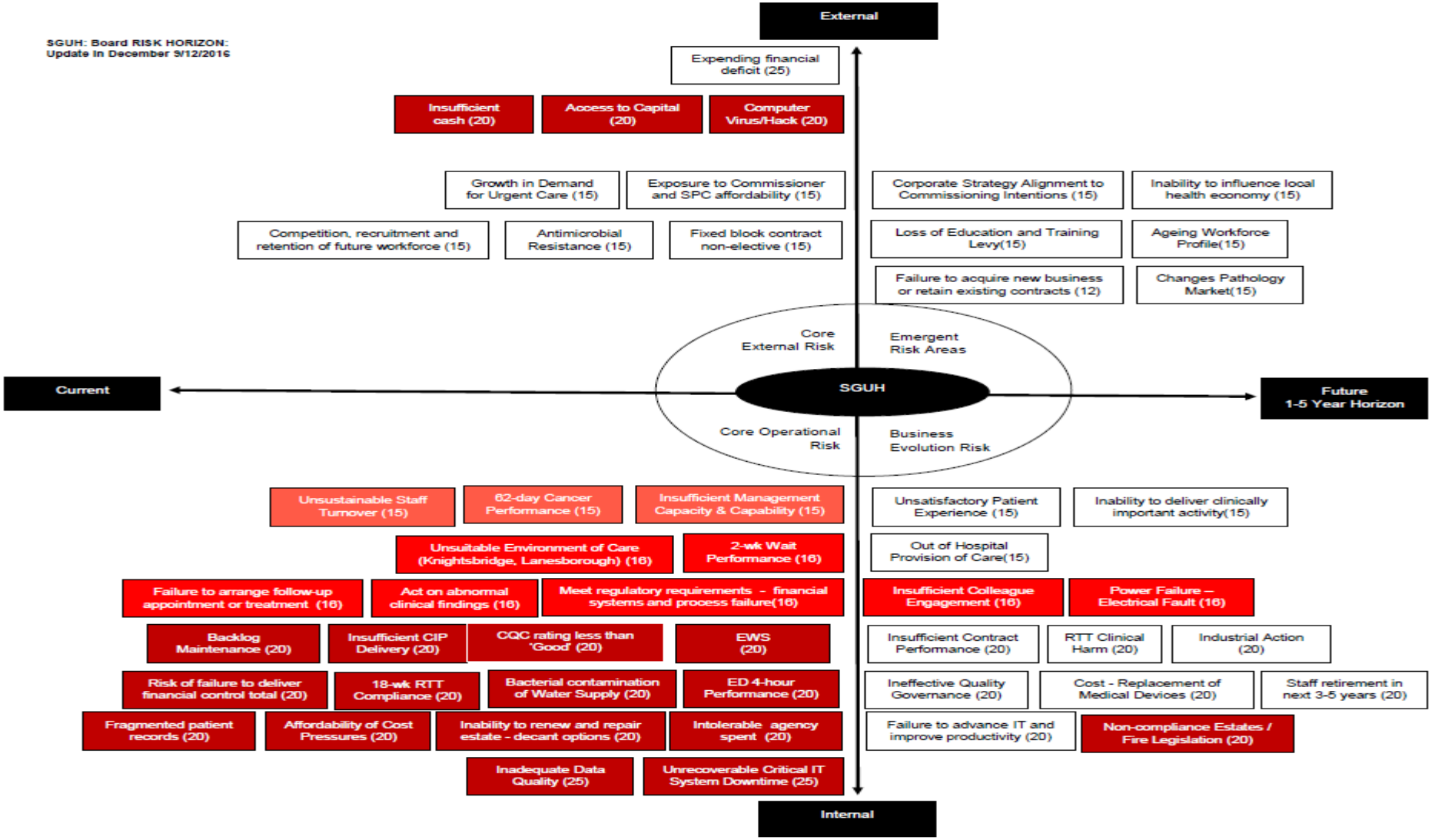
APPENDIX [B]

Figure 1: Core Operational Risk Drivers – Dec 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	15	⇔		
Failure to arrange follow-up appointments or treatments (where clinically required)	16	⇔		
Below target ED 4-hour performance	20	⇔		
Recognising, escalating and responding to the sign of deteriorating patient	20	NEW		
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	20	⇔		
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	⇔		
Insufficient CIP delivery in 2016/17	20	⇔	Unsustainable Financial Position in 2016/17 and beyond	
Insufficient cash to meet payment demand	20	⇔		
Lack of access to capital to address in-year IT, Estates and equipment replacement cost pressures	20	⇔		
Inability to control agency staffing and associated staffing costs	20	⇔		
Risk of failure to deliver the financial control total	20	⇔		
Inability to meet regulatory requirements due to financial system and process failure	16	⇔		
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	12	↓		
Fragmented electronic and manual patient records	20	⇔		
Unsustainable levels of staff turnover	15	⇔		
Insufficient management capacity or capability to deliver turnaround programme	15	⇔		
Failure to secure colleague engagement	16	⇔		
Inadequate data quality, completeness or consistency	25	↑		
↑ = Risk Increase; ↓ = Risk reduced; ⇔ = No change from previous report to Board				

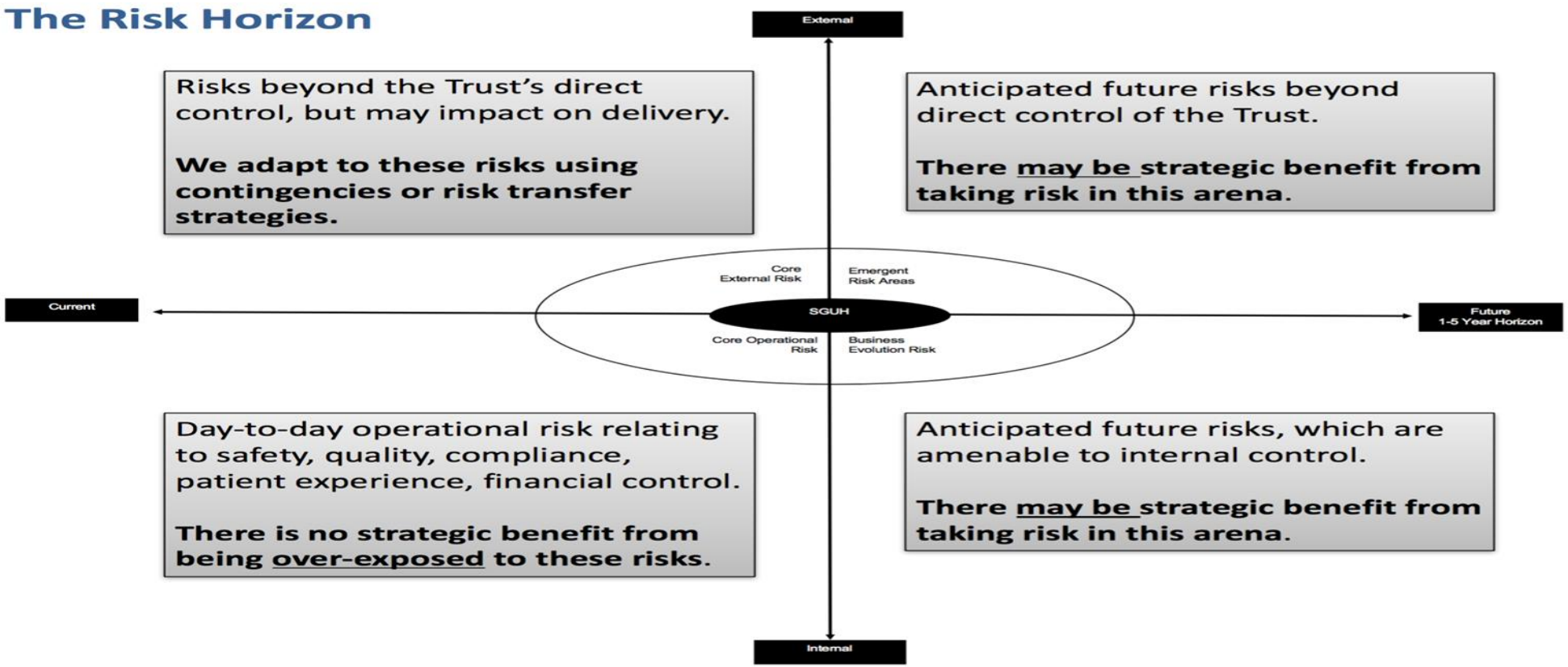
APPENDIX [C]

Figure 2: Emergent Risk Horizon Scan – Dec 2016



APPENDIX [D]

Figure 3: Interpreting the Risk Horizon



Corporate Risk Register for Trust Board January 2017

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Action Done date	Last updated
CRR-0025	Unsustainable levels of staff turnover	01/10/2015	Charman, Karen	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.	12	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 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 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		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 seek to identify gaps after first level of review	29/09/2017 01/09/2016	21/09/2016	Maria Prete* 26/10/2016 15:43:31
CRR-0022	Insufficient management capacity or capability to deliver turnaround programme	01/10/2015	Charman, Karen	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	15	3. Moderate	5. Almost Certain	15	Extreme	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	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	21/11/2016		Vanessa Davies 17/11/2016 15:31:30

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										Expanded Friends & Family test to assess staff quarterly							
										Management skills compulsory for all new starter with management posts							
CRR-0014	Failure to secure colleague engagement	01/04/2016	Charman, Karen	Enhanced risk of disengagement of staff due to changes within senior management team & a potential lack of corporate memory with interim senior team	20	4. Major	4. Likely	16	Extreme	Delivery of HR priorities plan with focus on: right staff, right time, right place, right skills	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. Break down to 10 reasons	Difficult to ascertain level of management engagement	Re-written workforce priorities programme to be launched in September 2016 including Fit for the Future campaign.	01/11/2016 30/09/2016 31/08/2016	21/10/2016	Vanessa Davies 17/11/2016 15:32:59
										Support from staff side representatives and governors in engaging staff							
										Review bullying and harassment policy	Levels of disengagement amongst managers make it difficult to effectively deliver the programme			Quarterly staff survey to commence quarter 2		21/10/2016	
										Listening into Action							
										Chair and CEO Exec briefings	Diafficulties in Managers to hold consistent team meeting ensuring staff are kept informed	Progress against workforce action plan reports to Workforce and Education Committee	Drive engagement				
										Annual staff survey				Finalising team brief by Head of Comms. This will require local cascade and feedback		17/11/2016	
										Additional quarterly survey - 'temperature check'	Nursing staff recruited from aborad not yet in post until Q4						
										Recruitment from abroad							
CRR-0021	CQC rating less than 'Good'	31/10/2010	Banks*, Suzanne	CQC rating of less than 'Good' due to inability to demonstrate compliance with CQC standards Risk of regulatory action (section 29a) 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.	15	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		CQC formal report received- significant issues with estates, IT infrastructure and risk management	Working to complete actions arising from CQC and removal of section 29a	31/10/2016 30/12/2016		Maria Prete* 23/11/2016 16:58:15
										Director of Quality Governance to lead QIP work and QIP PMO in place							
										Quality Observatory (overaching care audit) looked at across the Trust to promote great visibility and reporting against 5 domains and associated Standards	Refinement of Quality metrics to monitor performance			Progress QIP plan and report to QIP Board and Trust Board			
										Thematic Back to the florr weekly visits							
										reports to Patient Safety Quality Board / Quality Committee / Trust Board							
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						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	SOPs to be reviewed by DCs for each Care Group to ensure fit for purpose			Maria Prete* 26/10/2016 14:20:43
											Radiology safety net not reliable as emails are not received by the		endorse patients for whom they are				

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		19/07/2016	Rhodes*, Andrew		16	4. Major	4. Likely	16	Extreme	All Care Groups have developped Standard Operating Procedures to ensure that this happens All serious incidents resulting from failure to follow up tests have been reviewed and themes reported to Divisions. Radiology have strengthened their safety net system. This now includes e mail to MDT for unexpected cancer (cancer MDTs have instituted a red flag system to ensure oversight).	appropriate staff A significant proportion of results are attributed to the wrong consultant making the electrical sign off inconsistent Policy for Acting on Diagnostic test Results to be updated not all results are reported via iClip	There is limited ability of ensuring that once results are seen, the correct actions are followed.	endorse patients for whom they are not responsible, and b) results of their own patients not being received for endorsement Issues regarding the time required to comply with the new system, and the limitations of IT systems were common themes. Some of the specific issues raised could possibly be rectified by additional training, others would require system changes (either technical or in respect of workflows limited assurance as results attributed to wrong consultants	Re-audit SOPs to ensure fit for purpose Review /update policy for acting on results implement RCA recommendations	28/02/2017 01/12/2016 03/04/2017 02/01/2017		
CRR-0013	Vulnerability to computer virus or attack 'Ransom ware'	07/04/2016	Murphy, Larry	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	20	4. Major	5. Almost Certain	20	Extreme	NHS N3 gateway anti malware software Local Websense anti malware software Local Anti-virus software Regular and repeated user education and communication Firewall updates have been applied Supplier informed and anti-malware suite security controls increased. Continuous monitoring of reported infections. Replacing more vulnerable XP machines (more prone to infection)	Ransom ware infections continue to be reported Project underway to replace xp machines Unproven / out of data ICT Business Continuity plan testing	ICT systems team restoring identified corrupt files from back-ups. Minimal data loss reported Regular reports (XP Replacement project, security patching, anti-virus management, change control board) to be tabled at meetings (ICT Management tean, IG Committee)	New ransomware is created daily - the Trust is vulnerable until security patch has been created by vendor and successfully rolled out over estate Awaiting procurement of Snow (software management system) to govern ICT estate				Keith James* 28/11/2016 16:20:11
CRR-0012	Increasing 18 weeks RTT backlog on elective waiting lists with potential for clinical harm			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. impact on technical, operational/performance and clinical aspects. Issues across all non elective admitted pathways, financial cost of recovery programme						Employed 18 week manager to support National Intensive support team have undertaken a deep dive diagnostic of how best to manage and develop action plan and revised trajectory for 18 weeks New processes to manage RTT weekly (incl cancer)	there is no signed contract to provide a techical solution and validatory support there is not a database capable to	Clinical harm panel has not identified an instances of patient harm whilst on waiting lists daily review of PTLs per service	RTT backlog	project board to review and discuss next steps, confirm gaps in workstreams, leads			Maria Prete* 01/12/2016 15:29:23

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		31/05/2014	Gordon, Mark		20	5. Catastrophic	4. Likely	20	Extreme		expanding to accomodate the volume of patients requirirng clinical harm assessment				05/12/2016		
										10 work streams have been set up							
										Clinical harm panel set up , particularly to monitor waiting lists							
										Removal of late referrals from Trust RTT PTL							
											there is no documented training strategy and plan to address RTT recovery	weekly issue of RTT service performance					
										Implemetnation of RTT techincal plan and validation							
										NHSI approved elective recovery programme. Provides clarity and details key milestones and deliverables							
CRR-0011	Below target ED four hour performance	01/06/2014	Gordon, Mark	Risk to patient experience and safety as a result of potential Trust failure to meet Emergency Access performance trajectory agreed with NHSE and NHSI . This is caused by bed capacity Specialty response times to referrals, delays to assessment and referrals in the ED Mental health breaches. 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	20	4. Major	5. Almost Certain	20	Extreme	1.Emergency department actions – led by DDO and Clinical Director for ED	Lack of Interprofesional standards, to minimise delays in speciality response to the ED	Q1 Target - 90.2% Achieved- 92.49%	Continued failure to meet the 95% performance standard	Previous Days ED performance and action required to metigate performance to be incorporated into the 9.00 am meeting with GMs and COO	30/12/2016 30/12/2016		Maria Prete* 23/11/2016 16:39:34
										2.Whole hospital actions – led by Chief Nurse through 'Flow' programme							
										3.Wider system actions – led by SRG							
											Lack of visibility and accountability for speciality performance within divisions	Q2 Target - 93.37% Achieved- 93.13%					
										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							
											Vacancies within UCC ENP's impacting on performance	Q3 Target - 92.22% Achieved- 93.37%	Bed numbers are lower than in prvious years with no plans to increase bed capacity - the plan is to rely on increased throughput of remaining bed stock only	Epeciality performance data collected from ED performance to be incorporated into divisional performance reviews			
										Investments in patient flow schemes (£4m) including ED hot lab							
										Integration of the hospital services within the ED effort at the Front Door							
											Reduction in bed stock causing reduced flow of patients out of ED	Q4 Target - 92.34%					
										Improvements in Bedflow generated by a variety of measures: establishment of integrated discharge team (IDT); reduction of medically fit for discharge (MFD)							
										work to reduce attendance from frequent fliers							

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CRR-0010	Fragmented Electronic and manual patient records	14/06/2016	Murphy, Larry	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.	20	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 Lack of creation of Departmental Standard Operational Procedures (SoPs) when gaps are noticed	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. Multiple use of clinical systems in uncontrolled manner	Roll out eClinical Documentation and ePMA to the remaining IP areas on St Georges Hospital site.	31/08/2016		Keith James* 28/11/2016 16:23:54
CRR-0024	Failure to meet 62-day GP referral to treatment Cancer Performance standard	01/11/2015	Gordon, Mark	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%	12	5. Catastrophic	3. Possible	15	Extreme	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 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 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%.	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 Effectiveness of RCAs due to unclear process and tracking of competeness and actions / lessons learnt	2 day waits are on trajectory. Q2 has consistently been ahead of the 85% target, and is at 90.2 % The number of patients on an open suspected cancer over 100 days has reduced month on month to an average of 4 patients		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. Improved governance process to be introduces. A formal monthly clinical harm review - Board to be established from July 2016	31/10/2016 29/07/2016	17/11/2016 24/08/2016	Maria Prete* 20/10/2016 16:56:50
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						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 Cancer Programme lead appointed to oversee delivery of key actions	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.		07/09/2016	Maria Prete* 13/10/2016 09:57:09

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		01/08/2016	Gordon, Mark	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 contract penalties where targets are not met 4.Reputational risk to the organisation	12	4. Major	4. Likely	16	Extreme	and cancer performance recovery 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	30/09/2016 22/09/2016	17/11/2016	
CRR-0026	Inability to control agency staffing and associated staffing costs	30/09/2016	Charman, Karen	Inability to control agency temporary staffing cost. Unable to demonstrate a control on agency temporatry staffins as shown by breach of annual cap value.	16	4. Major	5. Almost Certain	20	Extreme	Completion of NHSI self-sertification No agency invoice is paid without booking number Monthly data analysis which shows reasons for reuest and rates of use by ward level - data will be used by the monthly Exec meeting All requests for agency are required to be booked throught the Central Bank Office Exec Management are briefed on which service lines are frigile and require higher agency input The Trus tis full member of South West London Bank which agree max rates across London and offer banks rates to each other Nursing rostering prepared 8 weeks in advance	No single level of sign off for agency staffing Monthly Exec oversight meeting (to start in November 2016 No formal Exec Ojectives		No known level of non compliance Not known Central Bank office performance to ensure Max bank fill & Min agency fill & best price				Maria Prete* 24/10/2016 09:15:10
CRR-0027	Risk of failure to deliver the financial control total	11/10/2016	Pratt, Margaret	The Trust is unable to deliver activity within the tariff set by NHSE and NHSI. In consequence, the Trust cannot deliver its financial control total.	20	5. Catastrophic	4. Likely	20	Extreme	Analysis and quantification of the drivers of deficit at care group level including premium workforce costs implementation of practical, realistic and deliverable plans to eliminate the drivers of deficit ensuring that contracted activity volumes can and are delivered within the tariff available Monthly divisional performance meetings to understand and challenge I&E, forecast and recovery plans Investment into Turnaround and development/delivery of Cost Improvement plans	Identification of cost drivers does not enable reduction in costs Plans are impacted by issues with the Estates CIP have not delivered System weaknesses expose the Trust to challenges and payment is not received		Although activity can be agreed, costs to deliver the activity are subject to wider market pressures. In addition, further lack of assurance exists due to the trust not delivering its control total over the past two years.	produce draft business plans for 16/17 produce final businees plans for 16/17	24/11/2016 23/12/2016		Maria Prete* 20/10/2016 11:55:30
CRR-0028	Inability to meet regulatory requirements due to financial system and			There is a significant risk that the Trusts current financial systems and processes are not sufficient enough						The finance function carries out a number of processes to ensure that the trust:	Systems and process weaknesses limit the effectiveness of the processes to accurately capture and	The trust has been audited both internally and externally. Significant regulatory breaches were not	Although no material issues have emerged to date, failure to resolve significant issues leaves the trust	Procurement workplan to address process issues across trust and within procurement to be			Maria Prete* 20/10/2016 12:08:06

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	process failure	11/10/2016	Pratt, Margaret	to meet statutory obligations, prevent fraud, mismanagement of funds or inappropriate decision making by Trust officers.	16	4. Major	4. Likely	16	Extreme	i) produces robust financial data to enable regulatory reporting (statutory and NHS) ii) identifies fraud and misappropriation of trust resources through control accounts, segregation of duties and approval hierarchy iii) budgets for, reports and forecasts financial position on a regular basis iv) collects debts and makes appropriate payments v) trains, appraises, performance manages and supports staff as they carry out duties vi) Procures goods and services following required Procurement regulations	report relevant information. i) Receivables are significantly overdue ii) A significant level of debt is written off as irrecoverable from NHS, private patrients and overseas patients. iii) Insufficient provisions on the balance sheet expose the I&E iv) Data quality is poor and not all activity is captured v) Cost improvement plans are not delivering as planned vi) Demand and capacity modelling is not clearly linked to infrastructure maintenance and activity forecast vii) Trust staff do not comply with required Procurement processes vii)Post Project Evaluations are not always carried out post investment in approved business cases	reported. No significant contractual or legal challenges have been raised by the trust suppliers No significant contractual or legal challenges have been raised by the trust employees No material fraud has been identified	exposed to future issues.	implemented Data quality action plan to be implemented	30/11/2016 30/11/2016		
CRR-0029	Failure to arrange follow-up appointments or treatments (where clinically required)	30/09/2016	Rhodes*, Andrew	Risk failure to follow up patients as clinically required . Caused by inconsistent processes and procedures for ensuring that patients receive timely and appropriate follow up appointments and/or treatment once seen in clinic May result in delayed diagnosis or treatment leading to severe personal harm	16	4. Major	4. Likely	16	Extreme	SOPs / cashing up systems Access Policy RTT project board and programme Data quality working group established within trust to address Attribution of consultant Communication to Patients & GPS	not all services have robust SOPs or processes in place to ensure follow up of patients in Outpatient clinics or following DNA. Variable processes for arranging follow up care upon discharge Clinical outcome forms @ OP not completed RTT programme has not yet made sufficient progress	Cashing up of outpatients runs at >99% RTT programme has new programme director Access policy signed off	No assurance data from RTT working group as yet SOP audits not complete	SOP audits need to be repeated and quality checked RTT programme needs to develop SOPs for processes	01/02/2017 01/02/2017		Andrew Rhodes* 22/11/2016 15:31:26

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Action Done date	Last updated
CRR-0008	Inability to address backlog maintenance requirements	25/07/2016	Hancock*, Richard	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.	20	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 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. This funding is required to underpin the initiatives to support the Estates recovery plan and strategy.	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. New Divisional project board will ensure visibility of all works. 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.	The action remains to gain line of sight to this funding in the Trust budget and to have a plan which lays out how and when the initiatives will be delivered. 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 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. Upon completion of the Six Facet Survey, a prioritised list of repairs will be produced. 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.	31/03/2017 30/11/2016 24/10/2016 31/01/2017 14/11/2016	17/11/2016 05/12/2016 24/10/2016	Rebecca Woodley 05/12/2016 12:08:12
CRR-0007	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. These repairs are monitored through the Health, Safety & Fire Committee. Regular meetings/communication with Fire Brigade to check progress.	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 is required to ensure that all staff are appropriately trained to increase rate of compliance, specifically general staff and Fire Marshalls. Fire Training for general staff is circa 80% and fire warden training, based on nominal 850 staff (10% of 8500) required is currently circa 990.	Implement action plan in period. (Fire risk assessments, training, infrastructure, governance). Monitor progress through Health, Safety & Fire Committee and via Organisational Risk Committee. A more practical, ward based training event will be delivered for future courses			Rebecca Woodley 05/12/2016 11:59:29

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		14/03/2013	Hancock*, Richard		20	5. Catastrophic	4. Likely	20	Extreme			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.		Further discussion on possible action to be taken to encourage attendance to Fire safety courses.	30/12/2016		
										Specialist fire safety resource in place to lead on the actions. Planned and reactive monitoring of fire safety.					30/12/2016		
										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	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.		Key performance indicators are required for reporting to Health safety and Fire committee, ORC and QRC.	L1 fire alarm will be installed, replacing the L2 alarm for the remaining Tooting estate.	31/07/2017 31/03/2017 31/03/2017 30/12/2016		
										Two permanent Fire Officers are in post, reporting to Head of Estates Compliance		External -London Fire Brigade are pleased with the Trusts current progress and the LFB have signed a memorandum of partnership with the Trust. A letter from LFB can be provided highlighting the current assessment of the Trust for Fire Safety.		The Fire Compartmentation works are ready to go out to tender via procurement with a project completion date of March 2017. The tender process will have a duration of 4 weeks.			
										Established “Responsible Fire Persons” email circulation list to send personal emails to ward/area managers				The replacement of Fire Doors throughout SGH is out to tender with a return date of 08-Nov. After awarding the contract, the works duration is estimated to be 3 months.			
										We have installed a new L1 Fire Alarm throughout LW.FRAs of LW undertaken in April 2016.							
CRR-0017	Inability to renew and repair clinical areas due to high bed occupancy and no decant options	30/05/2014	Hancock*, Richard	Lack of decant space for capital schemes delays the ability to deliver some large capital schemes.	16	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. The Space Policy will look to implement a Space Utilisation Group.	28/02/2017 31/08/2016		Rebecca Woodley 05/12/2016 12:17:49
										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.						
										Potential for space realisation as a result of Fixed Close Transfer work.				Review of space and potential decant areas well developed and being discussed at EMT. Tasks being undertaken by Estates and Facilities			
											Infrastructure issues for Knightsbridge Wing and						

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Action Done date	Last updated
											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.				22/09/2016	
										Re- activate the Trust Space committee to develop a Trust space strategy and assess the space issues across the Trust	Decant plan for Knightsbridge Wing to be presented for approval at the EMT on 05/12/2016						
										Project team in place to carry out Demolition programme for Knightsbridge Wing to decant and demolish before Dec '16.							
CRR-0016	Bacterial contamination of water supply (Legionella, Pseudomonas)	14/05/2014	Hancock*, Richard	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.	16	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 constraints testing.	Monitor the testing regime and results.	30/12/2016 30/12/2016 30/12/2016 28/10/2016 14/11/2016	17/11/2016	Rebecca Woodley 05/12/2016 12:13:49
										If high counts of legionella are found it is chemically treated in accordance with trust water management policy							
										Water testing being carried out in accordance with HTM04, L8 and HSG274		Water safety committee report goes to ORC and Health, Safety and Fire Committee		Water report presented to EMT (26/09/16), presenting actions underway and further recommended actions.		17/11/2016	
										Testing regime and results kept in electronic evidence log book.(Zetasafe)			September 2016 water reports highlight gaps in assurance and proposed steps to address.				
										Water risk assessment completed	Unable to fit filters to every single tap, as non-compliant model 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. As at 15/09/2016, 100% flushing of little used outlets was achieved.		All outlets in Endoscopy sampled 15/09/2016 for legionella (10 day incubation). Results from samples taken 15/09/2016 will determine which sinks will be required to be isolated if PALL filters cannot be installed and replaced with mobile wash station to minimise the risks. Estates currently have four emergency hand wash stations available and will look to hire additional units as required following results of tests taken on 15/09/2016.			
										Authorising Engineer (Water Systems) appointed by trust provide independent advice and support.							
										Water responsible persons trained and certificated		The Estates team have taken back in-house the testing of water from the existing their-party supplier (ClearWater).		Replacement of IPS Panels, Sinks, Taps and removal of dead legs, worked tendered with 6 weeks lead in time from order.			
										Head of Estates Compliance in post	Capital funding is required to continue removal of deadlegs.		The general condition of the hand was stations within endoscopy increases the possibility of failed samples due to non HTM compliant clinical sinks installed, sensor taps installed that are proven to reduce water flow, along with providing multiple surface areas for proliferation and also fitted with flexible hoses.				
										St James calorifier is decommissioned and hot water is fed via plate heat exchangers		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		Estates require full access to all ceiling voids and water services within the ward to enable a permanent solution to be identified for the poor circulation issues being experienced. Following risk assessment this work would not be			
										Detailed action plan in place being led by the Head of Estates.							

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										Deadlegs are removed as discovered whilst other planned work continues across the estate		old plumbing.		possible or safe in an occupied ward space and expected down time of Ward would be 10 days, this will be subject to findings.			
CRR-0006	Power failure - electrical fault	01/03/2016	Hancock*, Richard	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.	20	4. Major	4. Likely	16	Extreme	Temporary repairs undertaken.	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 undertaken, view is that building is beyond economic repair. Trust Board decision to vacate and demolish	30/12/2016		Rebecca Woodley 05/12/2016 11:41:39
										Fixed wiring assessment complete, repairs across Wing being enacted, will be tested to full fixed wiring standard.							
CRR-0005	Insufficient cash to meet payment demands	01/06/2016	Pratt, Margaret	There is a significant risk that the Trust will have insufficient funds to meet payment demands. The risk has emerged because i) the trust is trading at a deficit ii) unplanned income volatility cannot be managed through timely reduction in related expenditure iii) shortages of key staff groups lead to higher agency premium spend worstening the financial position iv) the trust is struggling to deliver the cost efficiencies planned v) the Trust is struggling to collect debts due to data quality and systems/process issues vi) the trust has failed to secure STFF £17.6m due to adverse performance and I&E	20	5. Catastrophic	4. Likely	20	Extreme	Short term cash flow forecast (STCFF) prepared on a weekly basis	Systems and process weaknesses impact the ability of the Trust to accurately capture and report relevant information	Some assurance provided by NHSi that the loan will be forthcoming	Backlog maintenance and costs/capital required to address the impact are still estimates	Progress to approval of the capital funding request	31/10/2016 15/11/2016 31/10/2016 30/12/2016 31/10/2016	28/11/2016	Nina Schmidt-Marino 28/11/2016 15:46:34
										Capex approved, monitored and challenged through Investment and Divestment Group (IDDG)							
										Recovery plans developed to minimise deficit	Approval of the backlog maintenance fund is still outstanding			Monitor impact of recovery on September and October financials and consider impact on forecast position			
										Monthly divisional performance meetings to understand and challenge I&E, forecast and recovery plans							
										Investment into Turnaround and development/delivery of Cost Improvement plans	Trust is spending at risk against the £39m backlog maintenance funding request						
										Targeted collection of aged debts				identify alternative schemes to close the shortfall on CIP			
										£39m backlog maintenance fund request submitted (spending at risk)	The trust continues to trade at a deficit with an increasing trend in actual pay costs and income under plan.						
										demand and capacity planning to understand capacity impacts on ability to deliver income as per plan/forecast			Backlog maintenance fund is not agreed yet				
										ITFF loan application for funds required to meet the cash requirements of the trust is underway	The cost efficiency programme at M5 has a PMO risk assessed full year forecast of £24m of the £50m target.			improve departmetnal processes to ensure robust cash collection and capture of income			
										Close relationship with NHSi relationship partner to monitor performance and requirements for							

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										funding are being met							
										Board level committees challenging divisions on recovery plans, investments, divestments	The Trust decision to increase payment terms to 60 days is impacting the ability to make savings						
										Board level committees monitoring cash position and forecast demands on cash.				review decision to increase suppolier pa7ment terms to 60 days			
										Board level support to secure maintenance funding and loan facility	The Trust has agreed the headroom funding facility but this must be agreed on a monthly basis and cannot be guaranteed					27/10/2016	
										Recovery plans, 12 month forecast, aged debtor analysis included in F&P papers each month							
CRR-0004	Insufficient Cost Improvement/Transformation Programme in 2016/17	20/07/2015	Pratt, Margaret	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 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	20	4. Major	5. Almost Certain	20	Extreme	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	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	30/12/2016 30/12/2016		Vanessa Davies 17/11/2016 13:42:42
										Detailed implementation plans 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							

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										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							
CRR-0015	Lack of access to capital to address in-year IT, Estates and equipment replacement cost pressure	20/07/2015	Pratt, Margaret	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	16	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	30/09/2016 31/08/2016 31/08/2016		Maria Prete* 26/10/2016 15:41:43
										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 management of internal resources.		Divisional monthly performance review meetings		Design and implementation of operational levels to reduce deficit			
										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							

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										Development of transformation savings schemes							
CRR-0020	On-going exposure to high numbers of Serious Incidents & Never Events	16/08/2016	Moore*, Paul	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	15	4. Major	3. Possible	12	High	Weekly SIDM meeting (attendees: Chief Nurse, Medical Director, Director of Quality Governance, Head of Governance, Risk Manager, Associate Medical Directors) to quality assure & sign off of reports ensuring action plans are robust. SIDM provides forum to identify and act upon immediate safety issues and/or request urgent reviews of practice.		Commissioner review of SI declaration process in march 2016 – 12 recommendations made for improvement.		Complete all actions on QIP plan		24/11/2016	Vanessa Davies 05/12/2016 16:39:22
										Monthly Divisional Performance mtgs provide forum for challenge services around repeat SIs and local actions to address		NHSI review of entire process in April 2016 – process found to be robust.			30/12/2016 30/12/2016		
										Quarterly thematic analysis report of SIs and learning presented to Patient Safety and Quality Board and to Quality Committee/Board							
										Monthly AMD governance newsletters pull out themes and trust wide applicable learning							
										Trust working with CCG to identify themes to focus on at CQRG to ensure learning and actions to address.		Downward trajectory for SIs declared during 2016/17. 33 SIs declared Q1 16/17 compared with 18 in Q2 16/17.		Further evaluation and CCG review of declaration process to be undertaken by Dec 16.			
										Strengthened RMC scrutiny and oversight of corporate risk register. RMC scrutiny through deep dive review of service risk registers		Demonstrable learning from SIs (NGT / pressure Ulcers)				24/11/2016	
										Review and redevelopment of senior lead risk register							
CRR-0009	IT storage: unrecoverable IT system downtime affecting critical clinical, web and email systems	25/07/2016	Murphy, Larry	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; •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	20	5. Catastrophic	5. Almost Certain	25	Extreme	On-going monitoring of infrastructure.	All issues yet to be exposed.	Some improvement in resilient and storage.	Not all issues have been uncovered	Complete and test the deployment of the full back up solution			Maria Prete* 07/12/2016 15:08:10
										Program of work in place to eliminate specific areas of risk							
										Procured two new back up facilities. Email back-up solution now completed and working.							
										Tactical data storage has been procured and deployed.	Full back-up solution procured and to be deployed; full coverage expected in Feb. 2017.			Complete the XP Replacement project			
										XP Replacement Project underway with 362 machines replaced to date (07/12/2016)							
										Quarterly Board updates on the ICT Stabilisation and Recovery Programme.	XP Replacement Project delivery slower than anticipated due to the uncovering of unknown systems and ownership.			Test Disaster Recovery Solution	31/03/2017 15/02/2017 31/03/2017 31/03/2017 14/04/2017		
										Weekly Project progress meetings and Fortnightly Project Board meetings		Fewer service desk calls relating to historical issues.	Still not fully resilient and have many single points of failure				
											Lack of detection and asset			implement detection and asset			

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											management software (used to indentify hardware/software conponenets)			management software			
										Reporting the progress and exposure, quarterly, to the Information Governance Committee							
										Service desk statistic analysis reporting (Heat Portal) for individuals back-up storage files.	Testing of the business continuity plan and full disaster recovery			Complete the deployment of long-term storage facilities			
										On-going Capacity Management to monitor usage							
										On-going maintenance of Network hardware and configuration and manage change undertaken by the IT Opertions Team							
CRR-0001	Inadequate Data Quality, completeness or consistency	22/07/2016	Rhodes*, Andrew	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 Trust (Cerner, Rio, iSoft) Delays and inaccuracies in coding activity lead to uncertainties in the validity of risk adjusted mortality and other nationally-published outcome data	25	5. Catastrophic	5. Almost Certain	25	Extreme	Governance accountability at board level. MBI report presented to Board	RTT - No agreement from NHSI to procure external provider for technical solutions	Initial clinical harm review of 1000 patient notes found no severe harm	No assurance on which data can be trusted	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		26/10/2016	Vanessa Davies 08/12/2016 14:49:05
											Use of different IT systems						
										RTT specialist at board level	Clinical Coding - Capacity of clinical teams to provide reviews			Data quality strategy paper to be presented to EMT (Mark Hamilton)			
											Clinical Coding - Insufficient interaction between clinical and coding teams						
											Clinical Coding vacancies (7.5 WTE) lead to delays in activity being coded			Business case for NHSI care pathway (Diana Lacey)	30/12/2016		
										Clinical harm board set up to review patient level records					30/12/2016		
											No validation of data through Kite Marking				30/12/2016		
											Data Quality policy not up to date			Finalise resource requirement for elective care pathway (Diana Lacey)	30/03/2017		
										Clinical Coding - policy in place agreed with clinicians	RTT - No SOPs on how to input data		Risk not able to be quantified until phase one of project complete		31/01/2017		
											Trainings not develepped / resources for trainings not identified			Develop revenue coding recovery plan (Iain Lynam)	31/08/2016		
											Leadership structure not clear				31/01/2017		
										Clinical Coding - training in place - Income generator supporting clinicians with correct coding	Inconsistent verification of data prior to be externally submitted			ICT strategy to be presented to Board and agreed (Larry Murphy)			
											No IT strategy						
										Clinical Coding - validation of data	Clinical Coding - External audit - Payment by result audit no longer run			Data Quality Policy to be updated			
											Incomplete/ inaccurate information provided/inputted						
CRR-1143	Recognising, escalating and responding to the signs of deteriorating			Risk of failure of recognising, escalating and responding to the signs of deteriorating patient. This is coused by the suboptimal use of EWS as observatins not completed correctly, not clezarly escalted or promptly responded in order to commence treatment.						Policy for Minimum Standard for Adult in-patient observation	Policy does not include the emergency response and clinical communication	Educational /support project showing quality imprvement of EWS.	Educational support project will terminate in March 2017	Policy for the Minimum standard for adult in-patient observation to be updated			Vanessa Davies 09/12/2016 09:22:11
											Trianing package - 3 different packages delivered by 3 different teams: Resus, Similation, Critical Care.						
										Education / training for recognition of deterioration package							

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		07/12/2016	Rhodes*, Andrew	This may result in avoidable death, and/or breach of CQC registration requirements.	20	5. Catastrophic	4. Likely	20	Extreme	Competency for obs included in the policy. all staff required to undertake it on an annual basis - Run by division Locum / agency staff used to ensure safer ration of staff/patients Educational /support project (currently in place) involving 3 nurses: each urse covers one area/ward showing how to identify sick patient and guide them on what needs to be done to prevent deterioration Follow up of patient once discharged from ITU EWS audit undertaken bi-annually STARR project - to promote ward-based learning across the Trust by deploying a mobile edication troupe to support local tailored needs analysis, action planning and evaluation	Training is not mandatory, It is not part of MAST, Not recorded on Totara Training package covers only qualified nurses and not HCA. HCAs are only trained on how to take obs but not reporting No emergency response team Competency is not done in all areas Locums / agency staff not knowledgeble on Trust policies despite agency contract stating requirement of knowledge of obs Local ownership of processes shortage of skills No systematic monitoring / review of incidents and therefore no learning	Negative assurance serious incidents and AI's	No funding for outreach team	Review of Locum/agency staff contract to ensure requirements (knowledge of taking obs) are clearly stated Review education package to integrate the 3 different streams and have a Care Certificate in deteriorating Adult. Deterioratin patient training package to be added to MAST Business case for outreach team Idnetify and train senior medical, nurses and HCA chanpions on each ward to lead implemntation of local EWS process embed SAFER care bundle	31/01/2017 31/03/2017 31/03/2017 31/03/2017 01/02/2017 01/02/2017 28/02/2017		
CRR-0018	Unsuitable environment of care (Renal Unit, Lanesborough OPD) - risk of premises closure, prosecution, fire	31/10/2012	Hancock*, Richard	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.	16	4. Major	4. Likely	16	Extreme	Revised estates management structure is in place this includes compliance managers. The plan is to add a dedicated compliance manager within the Facilities team Management structure which includes delegated responsibility 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 An audit on the gaps in compliance has been completed.	All recommendations from the estates action plan are not complete Until PAM is mature, the Trust will continue to have gaps in the evidence that we have met and are current with compliance standards There are up to eight different call centres, depending on what building and service a customer requires. This is planned to be rationalised A plan to rationalise as many functions into one Staff Help Centre is being worked on. Aim for delivery during 3rd quarter 2016	Authorising Engineers appointed in all HTM areas April 2016 - External H&S audit undertaken which indicates a 75% compliance (Empathy EC) Internal - Estates compliance records being assembled, ahead of external audit. NHS Estates Profession are supportive of this approach Action plans will need to be collated into a cohesive programme and regular reports will need to be submitted to the EMT and reformed	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. 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 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.	31/12/2016		Rebecca Woodley 05/12/2016 12:20:13

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										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. The Estates action plan will be further revised as higher risk items are closed	Further compliance points and actions for the PAM are being collated from interviews for external review. Initial interviews with Estates and Facilities staff for PAM are continuing, there are additional interviews in the coming weeks. 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 approx. 6 weeks. The output will be a prioritised set of actions and compliance of each will need to be identified.	QRC. 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)				

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	5 January 2017	**Agenda No**	**5.3**
Report Title:	Claims & Insurance – Briefing Paper		
Lead Director/ Manager:	Paul Moore		
Report Author:	Shanti Kelly – Legal Services Manager		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted (select using highlight)		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	Update on Trust's claims and insurance profile.		
Recommendation:	This paper is for information only.		
Supports			
Trust Strategic Objective:	1. Ensure we make the most of our buildings and estate and maximise efficiency through improving back office and corporate functions.		
CQC Theme:	Safe and Effective Care		
Single Oversight Framework Theme:	None		
Implications			
Risk:	Identification of potential estate risks related to under-insurance		
Legal/Regulatory:	None		
Resources:	Insurance Premiums and Contributions circa £14.5 Million 2015/16 (increased to (£19.5M)		
Previously Considered by:	N/A	**Date**	N/A
Equality Impact Assessment:	N/A		
Appendices:	Appendices B1 -3 - provide benchmarking data against other London NHS Acute Trusts		

Claims and Insurance
St Georges University Hospitals Board Meeting – 5th January 2017

1.0 PURPOSE

1.1 To provide a brief claims profile, nature of current indemnity schemes and premiums payable.

1.2 To provide benchmarking data against other London NHS Acute Trusts for comparison.

1.3 To provide an update on review of current insurance arrangements

2.0 BACKGROUND

2.1 The paper provides an overview of the numbers of clinical and non-clinical claims reported to the NHSLA, the indemnity schemes which cover these claims and the premiums payable for each scheme.

2.2 The paper also provides a summary of the commercial (non-NHSLA) policies that the Trust has in place.

2.2 The Trust may have un-insured risks or may be under-insured in some areas following on from achieving its Foundation Trust (FT) status . A formal review of existing insurance arrangements is a necessary exercise to ensure adequate insurance is in place.

3.0 OPTIONS APPRAISAL

3.1 An on-going review of the Trust's Insurance requirements will report in March setting out options for the Boards considerations

4.0 IMPLICATIONS

Potential under-insurance of estate or significant increase in insurance premium to mitigate this risk

Risks

4.1 Should the Trust lose a building due to a catastrophic fire it would not be insured for rebuilding costs in excess of £1,000,000

Legal Regulatory

4.2 None.

Resources

5.0 NEXT STEPS

Specialist review of the Trust's Insurance requirements is in progress with a report and options appraisal to the Board in March 2017.

6.0 RECOMMENDATION

6.1 For information and noting.

Author: **Shanti Kelly**
Date: **20 December 2016**

Current Claims and Insurance profile

Introduction

The **NHSLA** is special Health Authority (established in 1995) and has two key functions:

1. Risk management in NHS Trusts (**CNST, RPST, LTPS, PES**)
2. Management of claims and litigation (defence of NHS Trusts in membership of schemes)

CNST

The Clinical Negligence Scheme for Trusts (**CNST**) is a pay-as-you-go scheme which provides indemnity for clinical negligence claims against members. Each year, money is collected from the members of the scheme to cover the estimated total cost of claims and scheme expenses to be paid during that year. Each member's CNST contribution is determined by splitting the total amount to be collected between members according to their relative size, their activity levels and their recent history of claims (claims experience). An NHS Trust's contribution is calculated as a weighted average of three elements:

- A risk based contribution, based on the organisation's size and activity levels
- A contribution based on paid claims experience over the preceding five years
- A contribution based on known outstanding claims

RPST

The Risk Pooling Scheme for Trusts (RPST) contributions are split into two parts: the Liability to Third Parties Scheme (**LTPS**) and the Property Expenses Scheme (**PES**). Both LTPS and PES operate on a pay-as-you-go basis and indemnify members for employer's liability, public liability, professional indemnity and property claims.

Each member's RPST contribution is determined in a similar way to CNST and, each year, money is collected from the members of the scheme to cover the estimated total cost of claims and scheme expenses to be paid during that year.

Claims profile

- Clinical claims

According to the 2016 NHS Litigation Authority CNST scorecard, the Trust has reported **182 clinical claims** to the NHS Litigation Authority (NHSLA) with an incident date between 01/04/2011 and 31/03/2016. The total value of these claims is estimated at **£52,829,708**, which includes settled and open cases.

- Non-clinical claims

In respect of non-clinical claims, the Trust has reported 85 claims to the NHS Litigation Authority with an incident date between 01/04/2011 and 31/03/2016. The total value of these claims is estimated at £1,146,576, which includes settled and open cases.

- Scorecards

The NHSLA scorecards provides a useful breakdown of these claims by specialty, value and volume. A Safety and Learning Service was developed by the NHSLA to support its members to build a safety and learning culture to prevent and reduce harm as well as the cost of claims. Arrangements are being made with the Safety and Learning lead from the NHSLA to attend

the Trust in February 2017 to assist with the analysis of the scorecards to enable learning from claims where appropriate.

Indemnity for clinical and non-clinical claims

The Trust is a member of the NHSLA's risk pooling schemes for clinical and non-clinical claims. The cost of claims are met through members' contributions on a pay as you go basis – over time, members pay in broadly what is paid out on their behalf.

Contributions from members are assessed actuarially in advance each year, based upon a range of factors, including type of trust or organisation; specialties offered; number of clinical staff employed and the organisation's claims history. The total contributions collected from members equate to the anticipated expenditure in the following year. Further reserves are not held, allowing the money to be available for ongoing patient care. Table 1 below provides a comparative analysis of NHSLA contribution levels (2015/16) between SGUH and neighboring NHS Trusts.

Table 1. Comparative Analyses NHSLA Contributions (2015/2016)

NHS Trust Name	NHSLA Contribution
Kingston Hospital NHS Trust	£4,763,720.25
Epsom and St Helier University Hospitals NHS Trust	£7,199,502.35
Royal Surrey County Hospital NHS Foundation Trust (The)	£9,834,703.78
University College London Hospitals NHS Foundation Trust	£12,302,128.66
St George's Healthcare NHS Trust	£14,338,724.17
Guy's and St Thomas' NHS Foundation Trust	£15,098,531.94
Frimley Health NHS Foundation Trust	£19,888,532.67
Imperial College Healthcare NHS Trust	£25,581,736.62
King's College Hospital NHS Foundation Trust	£33,257,494.71
Barts Health NHS Trust	£34,665,021.28
Grand Total	**£176,930,096.43**

The average NHSLA contribution across the 10 NHS Trusts included in Table 1 above is £17.6M. SGUH with an NHSLA contribution of £14.3M is significantly below the average level of the comparator group for gross contributions.

In the year 2015/16 NHSLA paid out a total of £14.6M in damages and payments relating to incidents arising from SGUH. This sum was almost equal to the total contributions (£14.3M) paid to NHSLA by SGUH for this period. Table 2 below provides a comparative analysis of NHSLA damages and payments made (2015/16), between SGUH and neighboring NHS Trusts.

Table 2. Comparative Analyses NHSLA Total Payments and Damages (2015/2016)

NHS Trust Name	Sum Damages and Payments
Royal Surrey County Hospital NHS Foundation Trust (The)	£8,382,401.50
University College London Hospitals NHS Foundation Trust	£9,668,943.92
Guy's and St Thomas' NHS Foundation Trust	£10,390,575.88
Kingston Hospital NHS Trust	£11,396,835.50
Epsom and St Helier University Hospitals NHS Trust	£12,412,060.52
St George's Healthcare NHS Trust	£14,555,168.60

Frimley Health NHS Foundation Trust	£15,383,693.70
King's College Hospital NHS Foundation Trust	£19,874,856.02
Barts Health NHS Trust	£22,211,430.06
Imperial College Healthcare NHS Trust	£24,142,917.98
Grand Total	**£148,418,883.66**

The 2015/16 average number of clinical incidents reported to NHSLA and considered to have the potential to give rise to a claim was 0.5 per 1000 admissions across all 10 comparator NHS Trusts (Table 3). The SGUH average was 0.6 per 1000 admissions; 20% higher than the average. This is an interesting finding when viewed against the Trust's lower than average NHSLA contributions (Table 1.); and average damages and payments profile (Table 2.), in that it may indicate that the Trust has effective and efficient systems for managing (defending) claims and also that there is significant potential to reduce SGUH's risk profile by reducing the number of CNST incidents to average values.

Table 3. Comparative Analyses Sum of Clinical Negligence Scheme for Trusts (CNST) Combined Rate of Incidents per 1000 Patient Admissions (2015/2016)

NHS Trust Name	Sum of CNST Combined Rate/1000 Admissions
Royal Surrey County Hospital NHS Foundation Trust (The)	0.334693562
University College London Hospitals NHS Foundation Trust	0.376293509
Kingston Hospital NHS Trust	0.428620809
Imperial College Healthcare NHS Trust	0.492314425
Guy's and St Thomas' NHS Foundation Trust	0.514325278
Frimley Health NHS Foundation Trust	0.558876286
King's College Hospital NHS Foundation Trust	0.592632243
Barts Health NHS Trust	0.597351028
St George's Healthcare NHS Trust	0.604523854
Epsom and St Helier University Hospitals NHS Trust	0.650082784
Grand Average	**0.514971**

The NHSLA schemes are described as follows:

1 **Clinical Negligence Scheme for Trust (CNST)**

- This scheme indemnifies the Trust against all clinical negligence claims and associated litigation costs.
- The Trust's CNST premium for 2016/17 is **£19,464,809**
- Cover is unlimited, and there is no excess payable by the Trust under this scheme.

2 Liabilities to Third Parties Scheme (LTPS)

- This scheme covers non-clinical claims, including:
  - Employers' Liability
  - Public and Products Liability
  - Directors' and Officers' Liability
  - Professional indemnity
- The LTPS premium for 2016/17 is **£353,632**

- Cover is unlimited.
- There is an excess of £10,000 for each Employer's Liability claim and £3000 for each Public Liability claim.

3 Property Expenses Scheme (PES)

- This scheme covers first party losses for damage to buildings and contents from events such as fire, theft and water damage. PES also offers business interruption expense cover arising from property damage.
- The PES premium for 2016/17 is **£29,472**
- Cover is limited to £1 million per claim. There is an excess of £20,000 for each claim.

Benchmarking data

The attached 'APPENDICES B1 - 3' provides comparative information with other London Trusts relating to numbers of claims reported to the NHSLA in 2015/16, premiums paid in 2015/16 and total payments made on behalf of each Trust in 2015/16.

Commercial (i.e. non-NHSLA) insurance policies

Additionally, the Trust also has three commercial insurance policies:

1 **Motor Fleet** - covers trust vehicles.

- Premium for 2016/17 is **£13,178**

2 **Commercial combined** - covers Business Interruption and Public and Products liability

- Premium for 2016/17 is **£3,972**

3 **Engineering Inspection** - covers statutory inspection of plant.

- Premium for 2016/17 is **£13,120**

Top-Up Cover

As a Foundation Trust we can choose whether or not to retain our membership of the NHSLA Schemes or to source all our insurance needs from commercial providers. There are very many benefits to continue with our membership of the NHSLA Schemes, and few, if any, disadvantages. However, the Trust needs to consider 'top up' cover in relation to the LTPS and PES schemes.

LTPS - to consider if top-up cover is required for:

- Any Income Generation Activities that is excluded by LTPS
- Directors & Officers Liability - The LTPS scheme covers Directors and Officers of the Trust in respect of activities falling under the definition of "relevant function" (i.e. the provision of

healthcare). However, activities undertaken by FT Directors that fall outside the "relevant function" role are not covered by LTPS. So if the Board is making commercial decisions, it will need to consider top-up insurance to cover commercial liabilities.

- Clinical Trials are not covered under LTPS.
- Travel cover for all employees whilst the employees are travelling on Trust business.
- PPU activities - in essence, this would fall within the definition of "relevant function" so will be covered under LTPS, however, there may be related commercial decisions/activities which may not be covered under LTPS

PES - to consider if top up cover is required for:

- Property Damage – The PES policy covers losses up to £1 million. The Trust should consider top-up cover for losses above £1 million.
- Business Interruption – Loss of NHS income (which is not covered under PES) and 'Top up' to the loss of profit cover for income generation activities.

Willis Towers Watson

A thorough review of the Trust's current insurance arrangements is overdue. With this in mind, Willis Towers Watson, previously known as Willis Ltd., have been instructed to undertake a review of the Trust's existing insurance programme and advise on areas where additional insurance cover may need to be considered.

Willis helped design and manage the NHSLA's risk pooling schemes on behalf of the NHSLA from its inception for many years so they are hugely knowledgeable and experienced in advising Trusts on the extent of cover provided under the NHSLA Schemes, and the gaps in cover that Trusts, particularly FTs, may need to consider.

Willis was instructed by the Trust in November 2016. A pre-risk questionnaire is currently being completed by the Trust which will inform the process. The review is expected to be completed by end of February 2017 with appropriate recommendations for the Trust to consider.

Number of claims notified in 2015/16

Claims Data	CNST No. of Claims	CNST No. of Incidents	CNST Total Matters	RPST No. of Claims	RPST No. of Incidents	RPST Total Matters	Admissions 2015/16	CNST Claims Rate/1000 Admissions	CNST Incidents Rate/1000 Admissions	CNST Combined Rate/1000 Admissions	RPST Claims Rate/1000 Admissions	RPST Incidents Rate/1000 Admissions	RPST Combined Rate/1000 Admissions	All Claims/Incidents Combined (CNST & RPST)
Barts Health NHS Trust	131	8	139	44	*	45	232694	0.56	0.03	0.60	0.19	#VALUE!	0.19	0.79
Epsom and St Helier University Hospitals NHS Trust	59	5	64	13	0	13	98449	0.60	0.05	0.65	0.13	0	0.13	0.78
Frimley Health NHS Foundation Trust	86	19	105	12	0	12	187877	0.46	0.10	0.56	0.06	0	0.06	0.62
Guy's and St Thomas' NHS Foundation Trust	71	7	78	25	0	25	151655	0.47	0.05	0.51	0.16	0	0.16	0.68
Imperial College Healthcare NHS Trust	89	10	99	19	0	19	201091	0.44	0.05	0.49	0.09	0	0.09	0.59
King's College Hospital NHS Foundation Trust	119	5	124	35	0	35	209236	0.57	0.02	0.59	0.17	0	0.17	0.76
Kingston Hospital NHS Trust	26	5	31	10	0	10	72325	0.36	0.07	0.43	0.14	0	0.14	0.57
Royal Surrey County Hospital NHS Foundation Trust (The)	26	0	26	5	0	5	77683	0.33	0.00	0.33	0.06	0	0.06	0.40
St George's Healthcare NHS Trust	67	5	72	19	0	19	119102	0.56	0.04	0.60	0.16	0	0.16	0.76
University College London Hospitals NHS Foundation Trust	56	*	60	20	0	20	159450	0.35	#VALUE!	0.38	0.13	0	0.13	0.50

NOTES

CNST = Clinical Negligence Scheme for Trusts - which covers clinical negligence claims in relation to incidents taking place after 1 April 1995

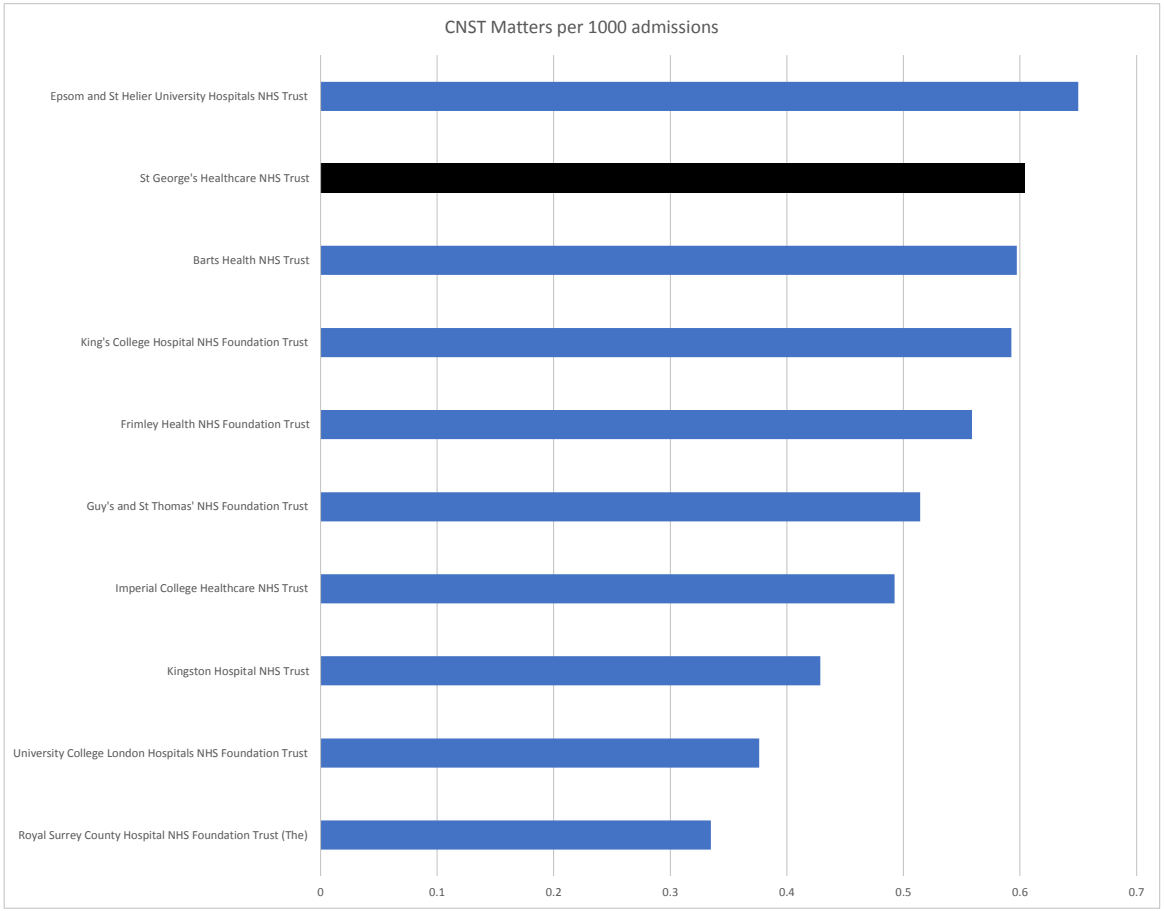
CNST Incidents - where a patient has indicated that they may be contemplating a claim and the trust therefore notifies the NHSLA. However, a formal claim may only be made many months later, or not at all, hence the “incident” never becomes a “claim”.

RPST = Risk Pooling Schemes for Trusts - which cover non-clinical liabilities such as public and employers’ liability claims under the Liabilities to Third Parties Scheme (LTPS) and "first-party" losses such as property damage and theft under the Property Expenses Scheme (PES).

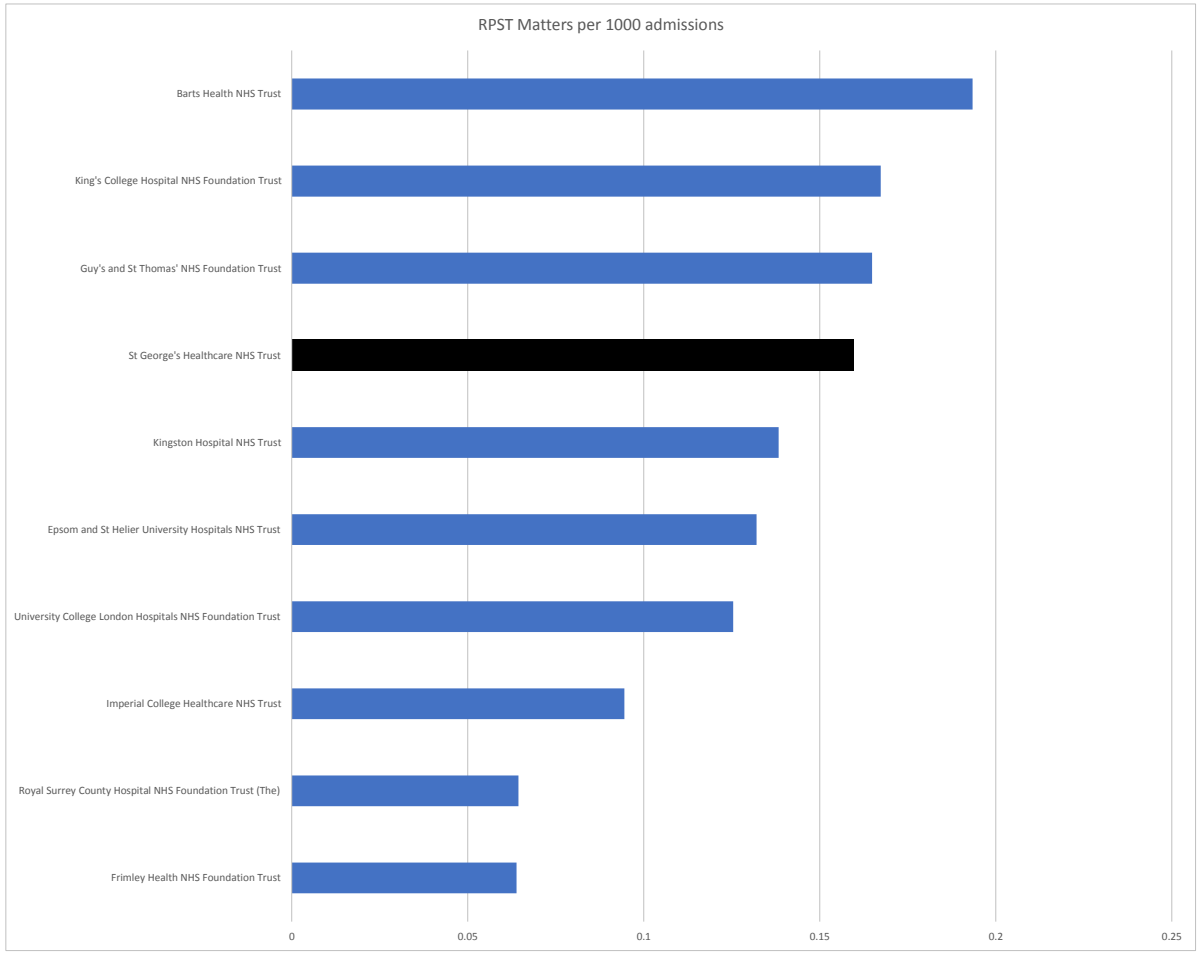
Where the number of claims/potential claims received was fewer than five, it is indicated with an * in order to protect the confidentiality of individual patients

Admissions: Courtesy of Hospital Providers: HES 2015/16

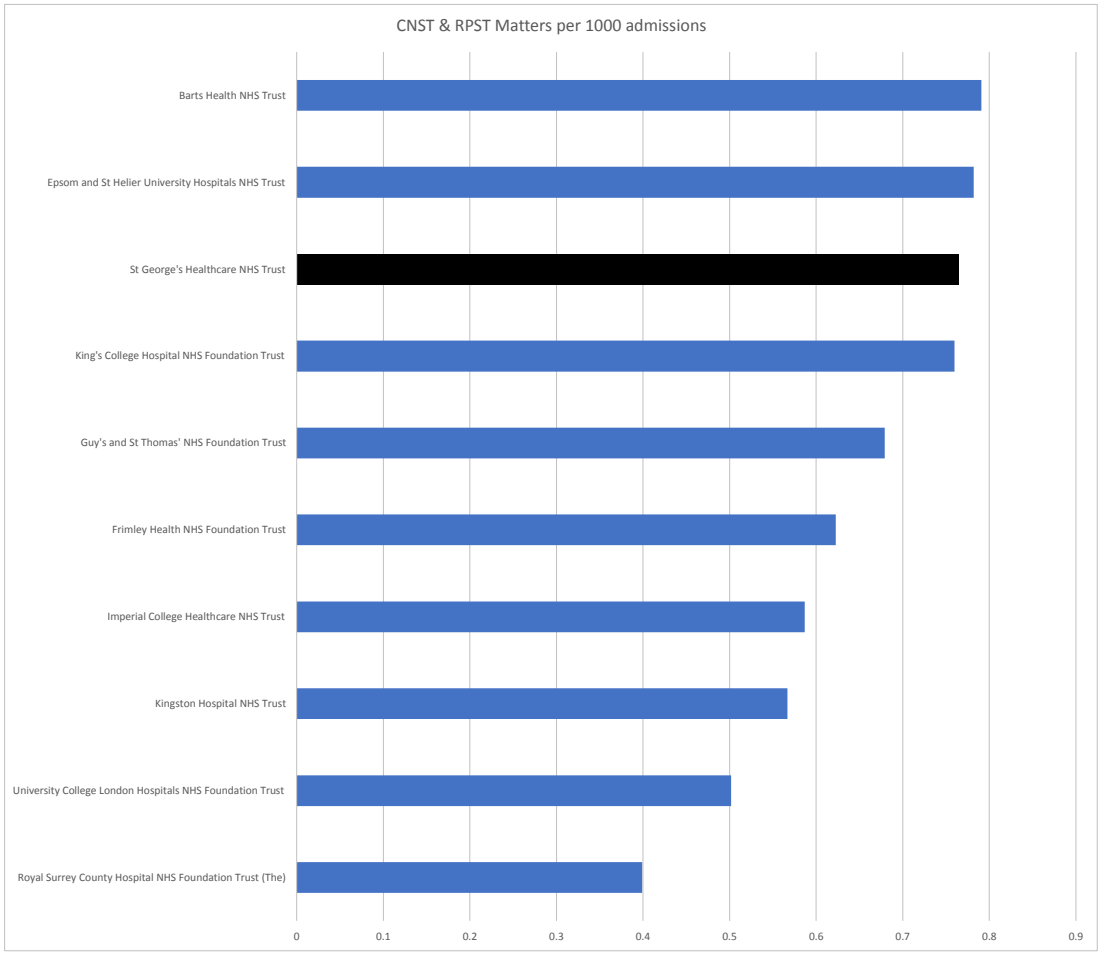
Row Labels	Sum of CNST Combined Rate/1000 Admissio
Royal Surrey County Hospital NHS Foundation Trust (T	0.334693562
University College London Hospitals NHS Foundation T	0.376293509
Kingston Hospital NHS Trust	0.428620809
Imperial College Healthcare NHS Trust	0.492314425
Guy's and St Thomas' NHS Foundation Trust	0.514325278
Frimley Health NHS Foundation Trust	0.558876286
King's College Hospital NHS Foundation Trust	0.592632243
Barts Health NHS Trust	0.597351028
St George's Healthcare NHS Trust	0.604523854
Epsom and St Helier University Hospitals NHS Trust	0.650082784
Grand Total	**5.149713777**



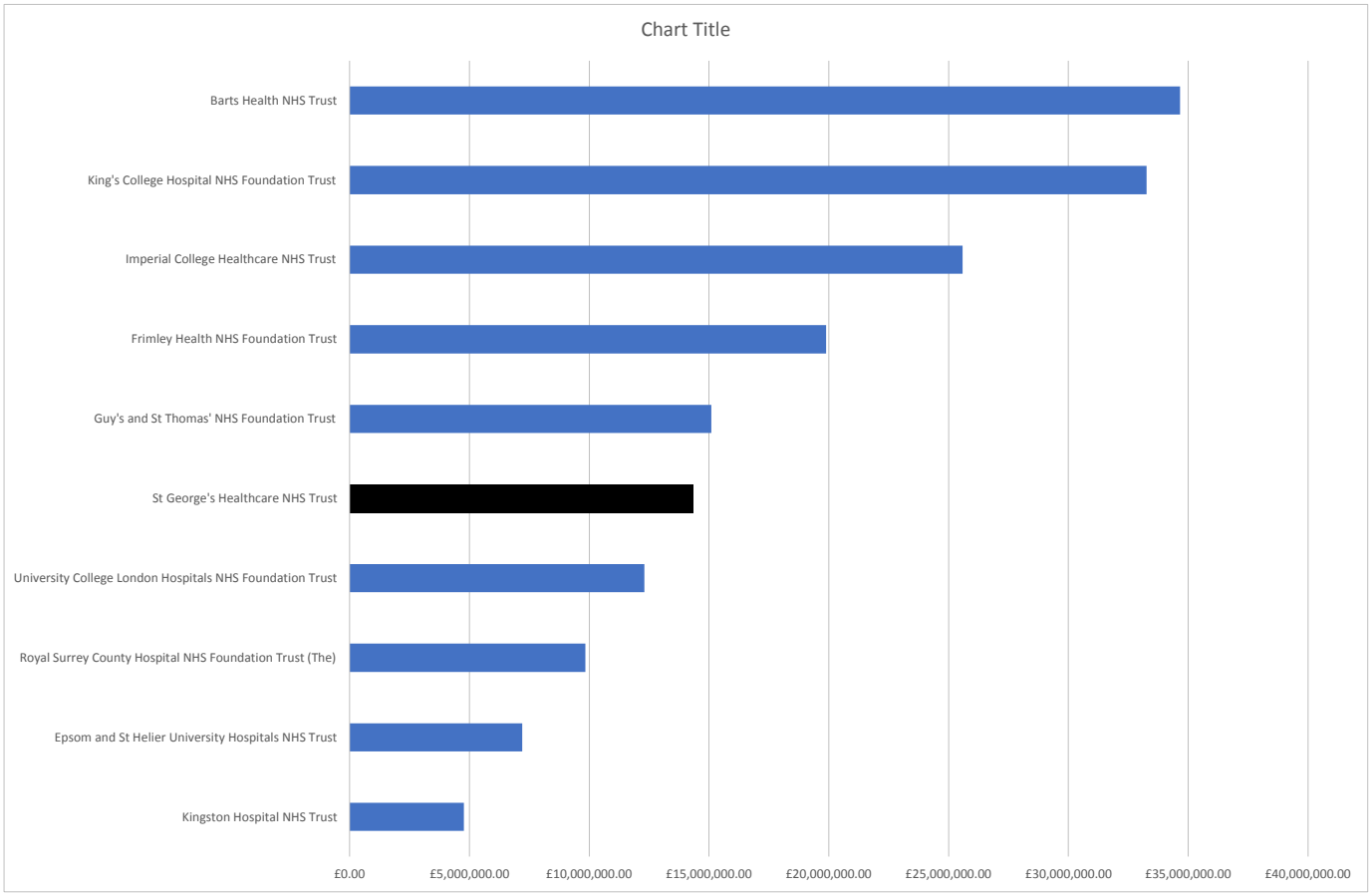
Row Labels	Sum of RPST Combined Rate/1000 Admissi
Frimley Health NHS Foundation Trust	0.063871576
Royal Surrey County Hospital NHS Foundation Trust (T	0.064364147
Imperial College Healthcare NHS Trust	0.094484587
University College London Hospitals NHS Foundation T	0.12543117
Epsom and St Helier University Hospitals NHS Trust	0.132048065
Kingston Hospital NHS Trust	0.138264777
St George's Healthcare NHS Trust	0.159527128
Guy's and St Thomas' NHS Foundation Trust	0.164847845
King's College Hospital NHS Foundation Trust	0.16727523
Barts Health NHS Trust	0.193387023
Grand Total	**1.303501548**



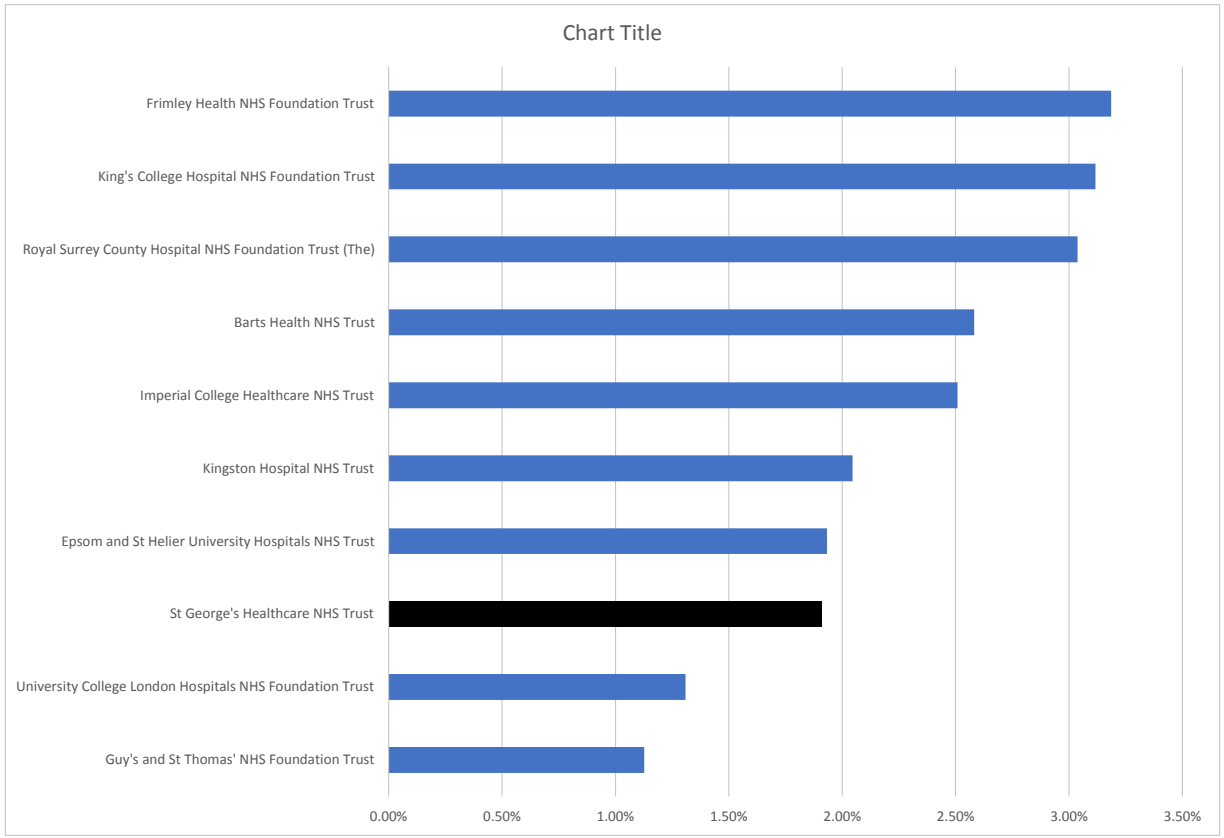
Row Labels	Sum of All Claims/Incidents Combined (CNST & RPS
Royal Surrey County Hospital NHS Foundation Trust (Th	0.399057709
University College London Hospitals NHS Foundation Tr	0.501724679
Kingston Hospital NHS Trust	0.566885586
Imperial College Healthcare NHS Trust	0.586799011
Frimley Health NHS Foundation Trust	0.622747862
Guy's and St Thomas' NHS Foundation Trust	0.679173123
King's College Hospital NHS Foundation Trust	0.759907473
St George's Healthcare NHS Trust	0.764050982
Epsom and St Helier University Hospitals NHS Trust	0.782130849
Barts Health NHS Trust	0.790738051
Grand Total	**6.453215324**



Row Labels	Sum of Grand Tota
Kingston Hospital NHS Trust	£4,763,720.25
Epsom and St Helier University Hospitals NHS Trust	£7,199,502.35
Royal Surrey County Hospital NHS Foundation Trust (T	£9,834,703.78
University College London Hospitals NHS Foundation T	£12,302,128.66
St George's Healthcare NHS Trust	£14,338,724.17
Guy's and St Thomas' NHS Foundation Trust	£15,098,531.94
Frimley Health NHS Foundation Trust	£19,888,532.67
Imperial College Healthcare NHS Trust	£25,581,736.62
King's College Hospital NHS Foundation Trust	£33,257,494.71
Barts Health NHS Trust	£34,665,021.28
Grand Total	**£176,930,096.43**



Row Labels	Sum of %
Guy's and St Thomas' NHS Foundation Trust	1.13%
University College London Hospitals NHS Foundation T	1.31%
St George's Healthcare NHS Trust	1.91%
Epsom and St Helier University Hospitals NHS Trust	1.93%
Kingston Hospital NHS Trust	2.05%
Imperial College Healthcare NHS Trust	2.51%
Barts Health NHS Trust	2.58%
Royal Surrey County Hospital NHS Foundation Trust (T	3.04%
King's College Hospital NHS Foundation Trust	3.12%
Frimley Health NHS Foundation Trust	3.19%
Grand Total	**22.75%**



APPENDIX B2

Contribution 2015/16 (£'s)

Member Name	CNST	LTPS	PES	Grand Total	2015/16 Income	%
Barts Health NHS Trust	£33,846,750	£708,488	£109,782	£34,665,021	##############	2.58%
Epsom and St Helier University Hospi	£6,836,701	£343,890	£18,911	£7,199,502	£372,591,000.00	1.93%
Frimley Health NHS Foundation Trust	£19,546,160	£310,694	£31,678	£19,888,533	£624,188,000.00	3.19%
Guy's and St Thomas' NHS Foundatio	£14,455,501	£552,415	£90,616	£15,098,532	##############	1.13%
Imperial College Healthcare NHS Tru	£25,068,085	£459,405	£54,246	£25,581,737	##############	2.51%
King's College Hospital NHS Foundat	£32,725,374	£475,401	£56,719	£33,257,495	##############	3.12%
Kingston Hospital NHS Trust	£4,542,989	£206,317	£14,414	£4,763,720	£232,810,000.00	2.05%
Royal Surrey County Hospital NHS Fo	£9,664,449	£150,597	£19,658	£9,834,704	£323,748,000.00	3.04%
St George's Healthcare NHS Trust	£13,953,099	£353,632	£31,993	£14,338,724	£750,953,000.00	1.91%
University College London Hospitals N	£11,888,119	£343,132	£70,878	£12,302,129	£940,272,000.00	1.31%

Row Labels	Sum of All Damages and Paymen
Royal Surrey County Hospital NHS Foundation Trust (Tl	£8,382,401.50
University College London Hospitals NHS Foundation Tı	£9,668,943.92
Guy's and St Thomas' NHS Foundation Trust	£10,390,575.88
Kingston Hospital NHS Trust	£11,396,835.50
Epsom and St Helier University Hospitals NHS Trust	£12,412,060.52
St George's Healthcare NHS Trust	£14,555,168.60
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Barts Health NHS Trust	£22,211,430.06
Imperial College Healthcare NHS Trust	£24,142,917.98
Grand Total	**£148,418,883.66**