St George's University Hospitals NHS
NHS Foundation Trust

2017/18 and 2018/19 Annual Plan

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1. Overview and context

1.1 2017/018 Overview

St. George's University Hospitals NHS Foundation Trust ('St. George's' or 'the Trust') is currently experiencing one of its most difficult years since moving to Tooting in 1976. The Trust is currently forecasting a deficit of £80.7m; has experienced significant leadership and senior management turnover during the last 18 months; operates primarily from a single site with buildings, environment and maintenance systems that are failing; working within an overheated market for staff that adversely affects recruitment; and has been rated as "Inadequate" in its recent CQC inspection, and as a result is in special measures. The Trust board is grappling with these complex inter-locking problems, the successful resolution of which will dominate 2017/18, 2018/19 and beyond.

The size of the financial challenge will require the Trust, over the next 15 months, to change the way care is delivered, the staff employed to deliver that care, and its relationships with partners in south west London and other tertiary centres in London. There is no quick fix, but there is a commitment and determination from the Trust to address the problems head-on, and to put in place the solutions that enables St. George's to have a successful and sustainable future.

Despite the difficult operating environment the Trust finds itself in, it continues to deliver creditable achievements, for example its commended renal service, its outstanding maternity and gynaecology services', its caring staff, and its low mortality rates. Last year's annual plan stated that *"The turnaround and transformation process that is now required will require a sustained 3 to 5 year programme coupled with sustained external support and cash resource to achieve."*, which remains the case, and the challenge for the Trust is to deliver financial balance without compromising these and other achievements.

1.2 The current year

The 2016/17 Annual Plan identified five key areas that the Trust needed to address:

1. Finding a sustainable solution to core estate and infrastructure problems
2. Addressing long term under-investment in ICT
3. Delivering access targets
4. Addressing the wider demand and capacity challenge
5. Meeting the workforce challenge

Alongside these, the challenges of continuously growing demand, the failure of financial and operational leadership which resulted in the replacement of the Trust's senior management, and a drift in quality and standards which, following the recent CQC inspection, saw the Trust placed in quality special measures, all have the potential to significantly destabilise the Trust.

Despite the challenges faced, the Trust has begun to deliver real progress on these five key areas. For example, the move of renal services out of Knightsbridge Wing, beginning the process of upgrading core support services e.g. new boilers, and improving key target performance, for example in cancer 62 day performance. Delivering the sustained improvement required by the recent CQC report will bring further impetus to the Trust to take forward these issues. However, the scale of the fix required (in terms of breadth, depth and cost to fix) means that whilst progress has been made, realistically these will remain key activities for at least the next five years.

The main Tooting hospital site continues to present challenges to the consistent and reliable delivery of core activity, as the effects of a prolonged lack of routine preventative maintenance continues to be felt. The site does not have an adequate level of heating, electrical, or IT systems, nor roof and fire integrity. The expected award of Treasury capital will allow the Trust to begin to tackle the most critical the estates problems but the Trust is at the start of that particular journey.

The Trust CIP plan for 2016/17 was £42.7m. The risk adjusted forecast outturn is for the overall CIP programme for the trust delivering £22.5m of savings, £20.2m less than plan. Reasons for the underperformance are manifold, but some of the bigger, transformative schemes which have focussed on various elements of flow, have taken longer to develop, implement, and slower to deliver savings than anticipated.

1.3 Developing 2017/18 and 2018/19 Annual Plans

The Trust is currently in negotiation with commissioners regarding activity and income for the next two years. There is a very significant difference between both sides' expectations in terms of activity in future years, which at the point of submission equates to approximately £45.5m in value (between the Trust's 17/18 initial proposal and the current offers from commissioners). The Trust has assumed that present activity trends will continue over at least the next two years, whereas commissioners are indicating that they will need to reduce activity at St. George's to be able to live within the budgets allocated to them.

Any reduction in commissioned activity will require commissioners to deliver on QIPP and other demand management projects. Given current upwards activity trends, and the level of demand management currently delivered by commissioners, the Trust regards the prospects of them achieving the level of activity reduction as low. In the absence of a clear plans from Commissioners and an identified caseload that will no longer be referred, the Trust is not prepared to reduce internal capacity and lay off (scarce) employed staff. The Trust's planning for the next two years therefore assumes that this referred activity will continue as is, and that a local income target will therefore be required to reflect the Trust view on QIPP and overall demand management delivery.

The Trust has been set control total targets of £3.5m surplus for 2017/18 and £13.3m surplus in 2018/19. The Trust has not accepted these, as it does not have the internal assurance that it can build and deliver a £74m CIP programme. It also cannot accommodate a £45.5m reduction in its SLA income, and its financial projections reflect this. However, the Trust still recognises that it does have a responsibility to manage its operating cost base in such a manner that reflects the NHSI control totals. The Trust is proposing a financial plan for 2017/18 and 2018/19 based on the following assumptions:

1. To build its financial plans from the current forecast deficit outturn of £80.7m.
2. To reject the activity and income proposals put forward by the Commissioners.
3. Activity and income will be based on the trusts original plans submitted to the Commissioners.
4. The trust secures a full PBR contract, which commissioners have recently agreed to in principle
5. The trust is paid for all the work that it has and will perform, including the items which have been previously under billed due to coding and counting errors. In this respect the plans include an income recovery amount of £25m for under billing and a local income target of £45.5m to address the proposed reduction in Commissioner funding.
6. The trust's financial plans deliver forecast outturns of £10.5m deficit in 2017/18 and break even in 2018/19, which are both around £13.5m less than the control total figure.

The Trust has recently identified that it is undertaking work for commissioners that it has not been billing appropriately for. The Trust is clear that it must be properly remunerated for the work it undertakes, and it will work with commissioners and regulators to ensure that this issue is satisfactorily addressed, and in so doing, make a material contribution to addressing the deficit at St. George's. A project board is now in place to address this issue.

Alongside the reasonable expectation to be paid for what it does, the Trust also knows that it needs to become more efficient and productive, delivering the same amount of work for fewer inputs, including staff, beds, and theatres. The trust is working to develop the CIP plan for next year, and to

date £11.5m of savings have been identified. This is a positive start in developing next year's programme, but there is a very significant way to go to deliver the scale of change, and consequent savings, required to move the trust towards financial sustainability.

The Trust has started the process of reducing its paybill, with the aim being that, over the next 15 months it will reduce by 10%. This process is at an early stage, and delivering this level of reduction, whilst maintaining quality and activity is possibly the single biggest challenge facing the Trust.

1.4 South West London STP

The South West London STP has made clear that St. George's is a fixed point in the healthcare landscape, given its status as the main tertiary provider in south west London, and the fact that it will remain a Major Trauma Centre. The Trusts emerging strategy and associated planning assumes it will broadly continue to provide the range of services as currently to the populations of south west London and Surrey. In a period of intense flux, this fixed position in the STP is welcome. However, the Trust is aware that the STP, the NHSE Specialist Service review, and its own internal requirements will mean that, over time, the mix of services on site may change, and the nature of this change will start to become apparent during 2017/18.

2.0 2017 – 2019 Activity and Capacity Plans

2.1 St. George's activity plans and SLA proposal

After many years of unbroken growth in activity and associated income, the current offers from commissioners are approximately £45.5m lower than the trust's 2017/18 SLA proposal, which excludes any additional RTT activity or counting and coding improvements. The gap comprises QIPP plans and lower levels of activity in the commissioner offers. The plans for 2018/19 will be based on a small demographic uplift to the 2017/18 plans.

The Trust's realistic initial steady-state, proposal was built bottom up based on a conservative set of assumptions, namely:

- M4 x 3 as the baseline, amended to reflect any changes anticipated for forecast outturn
- The addition of CCG recommended demographic growth rates.
- The Full Year Effect (FYE) of agreed business cases, through the impact of this was very limited.

Based on the above the following table illustrates at a "POD" Level, the 2017/18 SLA proposal to CCGs and NHSE. These figures do not include either QIPP reductions or additional 18 week activity which will be required to return the Trust to compliance as work on the RTT recovery plan is still on-going.

The activity target proposed by the Trust is in line with previous activity and expected growth rates, but the Trust does not underestimate the challenge this proposal presents to commissioners, as it is £26.7m above the 2016/17 plan.

POD	2015/16 Actual	2016/17 Plan	2016/17 Forecast Outturn	2017/18 Activity Proposal	% Activity Change 2016/17 Outturn – 2017/18 Proposal	2017/18 current proposal income (£m)
A&E	160,267	163,121	166,867	173,253	3.8%	22,297,543
Bed Days	68,058	75,932	77,554	78,045	0.6%	64,361,970
Challenges						-8,704,523
Daycase	34,088	34,387	35,064	38,107	8.3%	30,959,067
Deliveries	5,005	5,269	4,896	5,166	4.2%	16,295,187
Devices				23,691		18,110,323
Diagnostics	8,452,840	8,194,903	8,212,949	8,215,235	0.03%	25,568,688
Drugs				59,888		46,814,093
Elective	16,121	17,878	16,297	17,103	3.2%	79,732,672
Emergency	39,809	36,685	40,563	45,152	3.1%	127,512,042
Emergency short stay	4,713	7,020	7,655	4,759	1.5%	2,431,859
Other non-elective	1,790	2,266	1,863	1,901	2.4%	14,833,240
Outpatient	608,514	629,316	647,868	653,407	0.3%	112,896,869
Other Outpatients	32,206	26,616	19,047	19,195	0.6%	3,012,012
Regular Attenders	23,307	26,649	23,364	24,683	6.4%	4,691,663
Unbundled	119,222	112,146	155,396	157,170	1.2%	24,064,475
Value Fixed	62,032,210	59,160,270	61,015,308	60,910,030	0.0%	67,719,150
Variable Value	6,413,707	3,317,659	3,366,946	3,369,398	0.06%	28,064,725
Other	132,830	30,084	90,818	92,020	1.3%	64,736,968
Total	**78,144,687**	**71,968,207**	**74,015,687**	**73,933,343**	**-0.002%**	**680,661,054**

SW London CCGs have recently agreed to the principle of a full PBR cost and volume contract, with no cap, moving from an initial preference for at least some elements of the contract to be as a block. The trust and the South West London CCGs expect to be in a position to agree the finance and activity schedule and the other mandated key contract schedules by Friday 23rd December. It should be noted however that the agreed contract value is above the affordable level for SWL CCGs and they must deliver their planned level of QIPP schemes in order to hit their control total.

The table overleaf illustrates the challenge facing both the Trust and its main commissioners in arriving at a robust and deliverable contract level.

Commissioner	2017-18 St. George's proposal	2017-18 Commissioner Offer	Difference	% Difference
NHSE				
NHSE Specialist	255,499,063	235,974,279	-19,524,784	-8%
NHSE Public Health	17,237,404	16,773,117	-464,287	-3%
South West London CCGs				
Wandsworth CCG	128,562,030	118,420,000	-10,142,030	-8%
Merton CCG	68,361,987	61,592,000	-6,769,987	-10%
Croydon CCG	25,332,012	23,152,000	-2,180,012	-9%
Sutton CCG	14,979,266	13,923,000	-1,056,266	-7%
Richmond CCG	13,532,988	12,981,000	-551,988	-4%
Kingston CCG	13,203,123	13,118,000	-85,123	-1%
Other				
Wandsworth CCG Community	30,164,252	29,922,000	-242,252	-1%
Lambeth CCG	23,090,503	20,797,000	-2,293,503	-10%
Other major CCGs	24,447,820	21,743,876	-2,703,944	-1%
Totals	**614,410,448**	**568,396,272**	**-46,014,176**	

South West London CCGs have identified £17m of proposed QIPP schemes, which addresses part of the overall £45.5m gap but project plans underpinning these schemes are not well developed at this stage. In previous years CCG delivery of QIPP schemes has been inconsistent, reducing confidence that a figure of £17m figure can or will be delivered.

Initial CCG QIPP plans were received by the Trust on 16th December. There is insufficient time to properly judge the deliverability of these plans before submission, and activity and income have not been removed from the position at this moment in time. The Trust welcomes the opportunity to work with Commissioners over the coming weeks to ensure that QIPP plans developed are realistic and deliverable, at which point activity and income will be removed, as will resource from the St. George's expenditure budgets, with the aim of directly linking CCG QIPP schemes and trust CIP schemes.

CCGs have put in an anticipated £8m in challenges and fines, and the Trust is in agreement that a challenge figure will need to be included in the contract value for the coming years for the remaining national challenges (outside the STF process), automated data challenges and KPIs.

The position above is mirrored with NHSE, the Trust's single biggest commissioner, whose second offer is £235m, against a proposal from St. George's of £255m, based on forecast 2016/17 recurrent outturn. This includes £6.2m of QIPP schemes. Taking other factors into account, the current gap is £20m between St. George's and NHSE. NHSE has shared several QIPP schemes, some of which the trust has agreed, mainly around Medicines Management and device procurement savings, but none have so far been agreed that relate to activity reductions.

Where the trust does not believe that QIPP schemes will be delivered in part or in full, and where activity will over-perform if CCGs/NHSE have under-commissioned, the trust will have a Local Income Target in place as in previous years, so the trust's internal income plans will be higher than those if of commissioners.

The trust has also been investigating areas where activity has not been captured on IT systems or have not been coded accurately or in sufficient depth. In consequence, the trust has not invoiced

commissioners for all work that has been undertaken, calculated to be in the region of £25m. The trust will seek to remedy this d 2017/18 by improving its data capture and coding, and the trust's financial plan assumes that this additional income is linked to improved coding of activity already being undertaken, and does not therefore need to build in additional activity into its SLA proposal.

However, the Trust recognises that its activity and associated financial plan increases the risks around lack of sector alignment. It is further recognised that this is a risk within the plan, as commissioners will potentially cite the national counting and coding rules and notice periods, and therefore income over-performance as a result of this may be subject to challenge.

2.2 Delivering access targets

The NHS Mandate and planning guidance make clear the requirement for Trusts to meet key access targets. St. George's Major Trauma centre status, helipad, heart attack and HASU status, alongside its delivery of core local district general hospital services, has led to an increase in demand, and the acuity of that demand, on the Tooting site. This is a contributory factor, but not an excuse for, the issues the Trust has experienced in the last two years in meeting key targets. The Trust is aware that it needs to improve its performance to meet, and more importantly once met, maintain delivery of these standards.

2.2.1 18 week referral to Treatment (RTT)

The STF proposal for the Trust makes clear the expectation that St George's will meet and maintain the 18 week Referral to Treatment (RTT) standard form 1st April 2017. Following an external review of RTT data quality which identified a lack of confidence that externally reported performance figures were accurate the Trust suspended national reporting of RTT performance in June 2016. The report also identified that the existing methods of managing patient waiting lists were not fit for purpose.

An Elective Care (data quality) Recovery Programme led by a dedicated executive Director has been established to remedy this situation. The recovery programme has six work streams which will collectively ensure that historic patient records are corrected, processes are in place to ensure the accurate, complete and timely capture of data in future, and the treatment for those patients found to have had excessive waits is expedited. Due to the complexity of the challenge the Trust anticipates that it will take between nine and 12 months before it can consider a return to national reporting. The trust will therefore, not be submitting a trajectory at this moment in time, pending progress of the workstreams.

However, it is worth stating that, before the outcome of this work is known, there are a number of clinical specialties where the Trust is not currently delivering the 18 week RTT standard, and does not currently have a concrete plan to deliver the standard consistently for all specialties. The Chief Operating Officer is currently working on specialty specific activity plans, a product of which will be a better understanding of, and increasing delivery of, activity aimed at addressing 18 week RTT problems in the Trust.

The trust is not aware of any current CCG proposals to refer activity directly to the independent sector, but will work with commissioners to facilitate utilisation of appropriate facilities as and where Trust input is requested.

2.2.2 A&E 4 Hour wait target achievement

Delivery of the 4 hour target is an NHS Constitution standard and an element of the nine 'must-do's' for the NHS. St. George's Emergency Department provides non-elective care to around 450 patients

per day. The A&E aims to assess, treat, and discharge or admit 95% of patients within four hours, in line with national emergency access standards.

The Trust struggles to meet the A&E target on a consistent basis, and in response changes to capacity, process and systems have been made. Key amongst these changes are the opening of the Surgical Assessment Unit, which is taking surgical patients direct from A&E and managing their care in a more streamlined fashion, the introduction of Rapid Assessment Triage of new ambulance patients arriving in the A&E, and work on improving flow into and out of the hospital to create capacity to take A&E patients requiring admission. Initial indicators are positive, though it is too early to assess the recurrent impact of these steps.

The following proposed trajectory has been shared with, and agreed by, commissioners. This trajectory is based on a number of variables including seasonal variation and growth in activity over past three years, the 2017/18 SLA proposal, current bed state, and current performance in 2016. No adjustments have been made for commissioner demand management, QIPP or external system improvements by CCGs.

2017/18 A&E Performance Trajectory

2017 Projection	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Attendances	14,137	15,324	14,347	14,902	14,288	14,398	14,682	14,210	13,941	14,025	13,949	15,049
0-4	13,068	14,354	13,630	14,165	13,502	13,681	13,798	13,326	12,959	12,994	12,852	14,066
Breaches	1,069	971	717	737	786	717	884	884	983	1,032	1,096	983
Performance	92.4%	93.7%	95.0%	95.1%	94.5%	95.0%	94.0%	93.8%	93.0%	92.6%	92.1%	93.5%

It should be noted that the Trust continues to have problems with repatriation of tertiary patients to other Trusts in the sector, and there can regularly be 20 – 30 patients in this category in the Trust on any one day, along with a similar number waiting for discharge back to their homes or community facilities. The Trust will look to use the opportunities presented by the STP, and other formal routes, to reduce both these system bottlenecks during 2017/18.

2.2.3 Cancer Target Achievement

The Trust provides secondary and tertiary cancer services for adults and children including surgery, chemotherapy and palliative care. St. George's has made significant improvements in achieving the cancer access standards over the last year and plans to continue this improvement against all cancer standards in 2017/18. In April 2016, the following trajectory was agreed with commissioners for delivery of the cancer 62 day standard.

2016/17 62 day cancer trajectory

	Cancer - 62 Day												
	Baseline	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Numerator	9.5	10	9	11	11	11	9	10	9	10	10	10	10
Denominator	63	60	60	74	74	74	63	70	63	68	68	70	70
Performance	84.9%	83.3%	85.0%	85.1%	85.1%	85.1%	85.7%	85.7%	85.7%	85.3%	85.3%	85.7%	85.7%
	53.5	50	51	63	63	63	54	60	54	58	58	60	60

Since July 2016, the Trust has broadly achieved the 62 day performance standard, though it will miss it in November, so consistent delivery is not yet business-as-usual. Despite the increased operational focus on this and other cancer standards, the Trust is aware that it cannot yet provide the assurance that the improvement is sustainable in the longer term. Close management and monitoring of performance remains a key priority.

There are still challenges in achieving the 2 week wait and 62 day standard in some tumour groups where demand is exceeding capacity, particularly where patients are referred late in their cancer pathway from other NHS Trusts. To address this, the Trust has weekly escalation conference calls with referring Trusts to discuss shared pathways and compliance. The Trust is also reviewing systematically existing cancer pathways to remove any non-added value time and to ensure that each stage has sufficient capacity to meet the predicted levels of demand.

The Trust is a partner in the Royal Marsden Cancer Vanguard which aims to deliver the "5 Year forward view" for cancer through improved pathways and early diagnosis. In support of this, the Trust is implementing a number of pathway improvements including straight to test pathways for upper gastro-intestinal and lower gastro-intestinal suspected cancer referrals; one stop head and neck lump clinic as well as redesigning the colorectal pathway to reduce time from referral to diagnosis. Many of the changes described are in their infancy, and will take time to bed down and become business as usual, and this presents risks to on-going delivery of all cancer targets, and the Trust will be working hard to maintain improvements, taking remedial action if performance drops below required standards or agreed trajectories.

2.3 St. George's capacity and demand

Over the past few years the Trust's overall bed stock has risen. The Trust has no plans to add to its current bed stock, and the trend will be reversed over the coming years, due to the following key changes:

1. The requirement to refurbish a large number of wards across the Trust, reducing on a rolling basis the bed stock by 20 – 30 beds at any one time
2. The pressure on estate, IT systems and resources requiring the Trust to live within its financial means, facilitated by delivering a leaner service, putting more patients through fewer beds, theatres and other clinical areas.
3. The STP, which has an aspiration of reducing total bed numbers across south west London by 43% by 2021. This target is significantly higher than any other STP, and more work will be required to confirm its accuracy and deliverability.

This trend has already started, with the capacity & demand model taking account of the loss of Buckland Ward (following closure as a result of CQC inspection), and the removal of Nightingale House capacity. The contract for Healthcare @ Home ends in January 2017 though this is expected to be replaced by the internal programme "Discharge-to-Assess" which will seek to deliver at least the same number of virtual beds in the community. Overall during 2016/17, the trust will have reduced its total bed stock by 27 inpatient beds and 20 off site nursing beds.

The one contra to the above direction of travel is the potential impact of the STP which, as a result of any proposed reconfiguration across the sector, might mandate an increase in beds at St. George's.

The following table shows the current bed stock available to the Trust, as used in its demand and capacity modelling:

Category	Baseline Position 01/10/16
Acute ward beds adult	781
Adult ICU	67
Obstetrics	51
Paed acute	51
Neo-natal / paed ICU	51
Community / Intermediate Care / virtual community beds	129
TOTAL BEDS	**1,120**

2.3.1 Demand and Capacity Modelling – methodology and outputs

Demand and capacity modelling is an important element of developing a robust and coherent plan for the coming year. For 2017/18, the Trust's model is both straightforward and robust. Inpatient activity data is derived from the 2017/18 SLA Proposal (M4 trebled) and Average Length of Stay (ALOS) data based on the historical quarterly ALOS for Q1 2016, Q2 2016, and Q3 2015, Q4 2015. Beds are modelled as per the table above. Beds required are established through a simple calculation of ALOS/7 multiplied by the activity levels for each specialty by quarter, further split between critical care bed days and normal ward stay beds. Activity is divided between adult and paediatrics.

The specialties have been grouped together to form recognisable groups for the purpose of summarising the modelling whilst retaining their individual calculations within the model. Patients are grouped as being either elective or non-elective. Non-elective short stay patients are not included in the modelling and neither are the beds associated with the short stay units.

The model then establishes the beds required to reflect occupancy rates of 92, 95, and 97.5%, according to the normal occupancy for each clinical service. The final output shows the adult and paediatric bed requirements to meet the SLA proposal at the specified occupancy levels indicated by the specialties as being both safe and appropriate. The outputs of the model are as follows

Specialty Grouping	2016/17 Actual		2015/16 Actual	
	Q1	Q2	Q3	Q4
Cardiac	-4.25	0.03	-8.87	-2.55
Acute medicine and senior health	-39.53	-39.45	-50.15	-56.47
Vascular	-6.11	-2.32	-3.15	-3.37
Renal	0.45	1.88	4.06	4.71
Haem oncology	-2.97	1.78	-7.13	-1.46
Surgery	5.86	6.24	-8.20	0.91
T&O	-0.46	-6.32	-13.12	-9.79
Neuro	16.41	8.16	24.51	11.24
Sub-total (excluding Obstetrics)	**-30.60**	**-30.01**	**-62.05**	**-56.78**
Obstetric beds	16.82	13.30	14.10	13.17
All beds	**-13.77**	**-16.70**	**-47.95**	**-43.60**
Excluded Virtual beds - Stephen Elek	15	15	15	15
Nye Bevan reductions	11.5	11.5	11.5	11.5
Claverdale	5	5	5	5
Initial Final Position	**0.90**	**1.49**	**-30.55**	**-25.28**
Paediatrics	1.73	4.66	-2.45	-0.86

What the above table shows is that, for most services, there is a slight shortfall in capacity, but one that with business-as-usual improvements, targeted efficiency projects, and the accelerating impact of flow improvement work, should be sufficient to deliver the final, agreed SLA.

However, the outlier is acute medicine and senior health, which is between 40 and 50 beds short of meeting demand. Given the vast majority of this activity is non-elective, it is clear that unless the Trust can address this it will impact on other clinical services and their ability to deliver both their emergency and particularly their elective work. This will impact on RTT delivery, the overall Trust

casemix, and the income the trust receives. As a mitigation, the Trust will look to commissioner QIPP plans to help reduce the impact of emergency work, as well as to the Community Service Division to improve the pace of discharge, and to better support patients once discharged.

As noted above, the Trust has reduced bed capacity already during 2016/17, and this is part of the reason for the projected negative bed position in the final two quarters. However there are a number of variables that make modelling activity over the next two years particularly problematic, including:

- The outputs of the SLA negotiations and the final agreed activity figure.
- Agreeing RTT recovery, and any additional capacity needed to deliver this target (though this is complicated by the current non-reporting of 18 week figures due to our IT constraints)
- Loss of capacity through a programme of managed refurbishment of wards and clinical areas
- Potentially offset by the impacts of work to transform patient pathways, improve daycase rates and other programmes of work
- The finalisation of the Trust strategy, the NHSE Review of Specialist Services, and the outputs of the STP in terms of service configuration.

Alongside bed modelling, there are also implications in terms of capacity constraints or opportunities, in outpatients (reducing on site but better utilisation of off-site facilities including the Nelson and Queen Mary's Roehampton), theatres (a programme of refurbishment, offset by proposed changes to theatre templates and ways of working to allow the Trust to deliver more activity through fewer theatres) and diagnostics (fixed capacity of major equipment, challenges around workforce recruitment and retention) all of which are currently being addressed.

Given the shortfall in beds shown by the model, and the variables, which have both positive and negative impacts on bed occupancy, it is particularly challenging to accurately forecast demand and capacity at this stage in the planning process. The trust will be working over the coming three months to quantify and mitigate any risks to delivering the SLA.

The DCM has been shared with commissioners, and the Trust will update the model to reflect any issues identified by them.

3.0 Workforce Planning

Staff costs account for 61% of St. George's operating expenditure.

Recent years have seen a growth in workforce numbers in response to service demand and quality requirements. This growth has been a contributory factor to the deficit in recent years. The following table illustrates the changes in workforce over the twelve months to October 16, and shows a growth in Budgeted Establishment of 3.6% and of staff in post of 5.6% over that period. The increase of staff in post is a positive, in that it reduces agency and bank reliance. However, the increase in Establishment is not. The Trust is now reversing the trend on Establishment, as it seeks a re-set as a leaner, more efficient organisation.

	Staff In Post (wte)		Establishment (wte)	
Staff Group	**31-Oct-15**	**31-Oct-16**	**31-Oct-15**	**31-Oct-16**
Add Prof Scientific and Technic	552	556	714	648
Additional Clinical Services	830	998	1,028	1,187
of which Healthcare Assistants	591	666	757	827
Administrative and Clerical	1,490	1,564	1,795	1,879
Allied Health Professionals	592	607	688	674
Estates and Ancillary	223	271	276	317
Healthcare Scientists	268	291	332	327
Medical and Dental	1,156	1,225	1,209	1,282
of which Consultants	486	514	495	536
Nursing and Midwifery Registered	2,784	2,829	3,400	3,469
of which Midwives	191	194	214	221
Total	**7,895**	**8,341**	**9,442**	**9,783**

3.1 Workforce Priorities Plan

In July 2016 the revised workforce priorities plan, 'Doing it Right', was launched following discussions with staff and managers and using from information available from staff surveys, Staff Friends and Family test and exit surveys. This shorter term plan is intended to reduce turnover and vacancies, and accelerate recruitment timelines prior to a longer term strategy being developed in 2017. These feedback mechanisms identified the issues that were contributing to turnover that St. George's needed to address if it was to be able to recruit and retain the right people, with the rights skills in the right numbers. This meant focussing on some key priorities that would make a difference in a short period of time. This plan was approved by the Trust Board in September 2016 and is now being implemented.

A key workforce aim for the Trust will be to ensure that the organisation is able to meet its activity and service quality targets within available resources. The Trust is part way through a process of reducing its paybill, with the aim being that staff costs are reduced by 10%. This is a significant reduction in spend, and the clinical and corporate divisions are currently developing plans to contribute to this reduction. The savings will be generated by both actual headcount reduction, alongside the reduction in usage of bank and agency, against which the Trust is currently an outlier.

This process is at an early stage, with the plan intended to take 15 months to reach completion i.e. 31st March 2018. The Trust will need to re-engineer its processes to be able to reduce pay costs, and it will need to ensure that clinical quality, patient safety, activity are not adversely impacted by this reduction. For this reason all changes will be assessed using the Quality Impact Assessment methodology outlined in section 4.

3.2 Recruitment and Workforce Transformation

In common with many Trusts, St. George's is unable to fill all its vacancies for some key clinical roles, e.g. Radiographers, Neonatal nurses and IT specialists. Traditional recruitment routes have not provided staff in sufficient numbers, and St. George's workforce plan includes broadening entry points into nursing employment, including focussing on recruiting local people so that the Trust has a long-term sustainable workforce.

The Trust's plans include:

- The Apprenticeship for Healthcare Assistant roles supports St. George's being better placed to close the skills gap in the future. The Trust will also be piloting a 4 year nursing apprenticeship

from September 2017 as an alternative to UCAS entry. The plan for apprenticeships will mean that St. George's is offering 200 placements from April 2017 to seek to maximise return on the Apprentice Levy which comes into force from this date. A pilot cohort of nurse apprentices will offer an innovative way to offset the potential negative consequences of the withdrawal of the bursary for student nurses. A trailblazer apprenticeship in being developed in therapies for a higher level support role. Taken together the apprenticeship route offers a new, innovative, and potentially sustainable supply of new staff that the Trust can train and retain, helping address staffing shortfalls in the coming years.

- The Trust has been successful in its bid to introduce the new Nursing Associate role and the pilot will be commencing in January 2017. It will provide highly skilled support to registered nurses in Neurosciences and Medicine.
- The Trust's Associate Practitioner band 4 role in Peri-operative care and Neonatal care supports workforce transformation, with a further cohort commencing in January 2017.
- St. George's continues to be the leading user of the Physician Associate role, and will continue to roll out its deployment.

One of the areas where the Trust has most difficulty in recruiting nursing staff is in HMP Wandsworth, and in response to this St. George's has developed the role of pharmacy technicians in the prison to release nursing time for nursing duties. The Trust is developing a training programme to be delivered by Occupational Therapists to Teaching Assistants and parents in both special and mainstream schools in Wandsworth. The programme will commence in January with accreditation being sought later in the year. This will help occupational therapists to set care and treatment plans, but for delivery to come 'in place'.

The Trust is continuing to provide training to our staff on mental health issues so that patients presenting with mental health issues are not only more appropriately cared for but to also reduce reliance on mental health nurse agency specials.

In addition the Trust will continue to invest in its recruitment infrastructure so that it can recruit staff as quickly as possible. The Trust has recently reviewed its recruitment process and is implementing plans to reduce the time to recruit.

3.3 Skills Development

St. George's will reinvigorate the performance management and appraisal system led by the Director of Workforce and Organisational Development so that all staff are aware of how their role contributes to delivering services. The plan includes improving the quality of line managers' skills to ensure that the Trust achieves the best out of its current workforce through development of their skills and identifying opportunities for them. Retaining key staff is a critical part of the Trust strategy as it attempts to tackle the turnover challenge facing all trusts. St. George's leadership development strategy which is being presented to the Trust Board in January 2017 will support this work and will include training for management at all levels, including clinical managers.

3.4 STP Collaborative Working

The Trust is currently part of a pilot with other trusts in South West London to introduce a Staff Bank for nursing and midwifery staff across the trust sector. The Trust is working in collaboration with neighbouring trusts that are part of the pilot to harmonise rates of pay, and will use eRostering so that all rotas are released at the same time. The ability of the trusts in the sectors to access each other's bank staff will contribute to the reduction in the use of agency staff. In addition to the current project the HR Directors will investigate how the learning from the bank project can be extended to medical and AHP staff.

The Trust will share its emerging workforce plan with commissioners and providers through the STP as appropriate to help south west London as a whole to develop sector wide plans to address shortages in key staff, as well as to identify areas where closer working will deliver benefits to all parties.

3.5 Staff Engagement

The Trust is aware from the Staff Survey and the Medical Scale Report that there is much work to do on staff engagement. St. George's will continue to support its Listening into Action service to empower staff to discover and implement their own solutions for local issues. The Trust will be continuing the work started in September 2016 to improve 'joined-up' working between Allied Health Professionals, and a separate piece of work involving stakeholders (including commissioners) to identify ways in which all staff can work together to provide excellent end of life care in support of the Trust's End of Life Care 5 year strategy.

St. George's is implementing a wide-ranging health and wellbeing programme to underpin its workforce strategy and ensure that are staff are themselves fit and well. Staff often work in pressurised situations and central to St. George's support for staff is training on resilience and stress management. The Trust has already appointed 60 staff as health and wellbeing 'champions' to ensure the benefits of a healthy lifestyle can be embrace by our staff. Finally, the Trust provides a staff support service within Occupational Health to provide expertise to staff and managers on managing pressure.

The Trust is also improving the way it communicates with staff. Recent changes include a new, twice weekly e-bulletin, plus a much shorter, user-friendly Core Brief which managers are encouraged to use when briefing their teams. Alongside this, the Trust has also introduced monthly staff briefing sessions with the Chair and Chief Executive at both St. George's and Queen Mary's Hospitals'. The Chair and Chief Executive also issue a weekly email message to staff. The Chief Executive is also now recording a short monthly video message as a way of communicating with staff in new and innovative ways.

In March 2017, the Trust will be introducing a staff app, which will give staff access to the latest Trust news and events on their mobile phones or devices. This follows a communications staff survey carried out in October 2016, in which over 50% of staff said they want to be able to access trust information on their phones.

3.6 Monitoring Progress

St. George's has further work to do to improve on its consultant job planning process, and the Trust is looking to improve this critical function over the coming year. The next round of job planning will look to ensure that job plans are aligned more closely with actual activities undertaken, building on work done earlier this year.

The Divisional workforce plans will set out how staff can be organised differently and used most effectively to deliver services. A nursing workforce project is underway to ensure maximisation of the eRostering programme to map rotas to activity and ensure the need for using temporary staffing is reduced to achieve the nursing temporary staffing spend cap and the trusts funded workforce levels. In some cases this will mean moving staff to where they are needed and in others changing shift patterns to reflect new activity. The Trust has implemented a new payment system for internal medical locums to ensure consistency of payment rates when it needs St. George's doctors to carry out additional work. This will reduce reliance on agency doctors.

Progress towards achieving the workforce strategy is monitored formally through the Workforce and Education Committee which in turn provides assurance to the Trust Board. Each Division is required to attend the Workforce and Education Committee which meets bi-monthly to confirm how they are implementing elements of the plan within their Divisions. Additionally, progress will be monitored at the monthly Divisional Performance Management meetings which are attended by key Executive Directors who can direct remedial action as necessary and risks are raised and managed through the Trust's Risk Management Committee.

4.0 Planning for Quality

There is much that the Trust does well, but much that can be improved upon, which the recent CQC inspection and report identified. Quality is a direct executive responsibility for three key Directors:

- Andy Rhodes, Medical Director
- Suzanne Banks, Chief Nurse and Director of Infection Prevention and Control
- Paul Moore, Director of Quality Governance

This triumvirate is overseeing the response to the CQC inspection report and the overall development of the quality agenda in the Trust, the deliverables of which are encompassed within the Quality Improvement Plan.

4.1 Context for Quality Improvement at St George's

In June 2016, the Trust was inspected by the Care Quality Commission (CQC). The Trust has been open with the CQC about the challenges faced at the time of inspection, in particular highlighting:

- significant financial problems
- overall condition of the estate
- fragility of the Trust's IT infrastructure and the urgent need to prevent a catastrophe arising from one or more single points of failure
- the difficulties operating in a strategic vacuum
- underlying weaknesses in organisational governance and risk management
- significant operational problems relating to RTT, cancer, A&E 4-hour performance, data quality and completeness
- and that these problems had become so normalised it was difficult for colleagues to recognise what good looks like and challenge poor practices.

The Trust was rated 'inadequate' overall following CQC inspection. The 'safe' and 'well-led' domains received an 'inadequate rating'; the 'effectiveness' and responsive' domains received a 'requires improvement' rating; and 'caring' domain received a 'good' rating. Shortly after inspection the CQC served a Section 29A Warning Notice, requiring the Trust to improve significantly in the following areas by 30/11/2016:

- Premises and equipment
- Mental capacity assessments and best interest decision making
- Organisational governance and risk management
- Fit and proper persons requirement for director's

A substantial amount of work was undertaken at pace to put right the immediate problems highlighted in the Warning Notice. This included:

- refurbishment of operating theatres, including air handling units, in theatres 5&6 in St James's Wing;
- installation of a new renal dialysis facility on site and preparations to relocate the renal unit out of Knightsbridge Wing;
- assured the flushing of low-use water outlets to help mitigate the risk of *Legionella* contamination;

- making good electrical installations in Knightsbridge Wing, providing additional generator capacity in the event of an outage and initiating a programme of fixed wire testing across the site
- demolition of Wandle Unit
- doubling boiler capacity to provide additional resilience in hot water and heating supply
- easing congestion in outpatient facilities in Lanesborough Wing
- resolving concerns regarding fire prevention and management in Lanesborough Wing
- reducing capacity on Gwynne Holford ward to improve the management of risk and enhance staffing levels
- an immediate investment of £1.3m to help stabilise IT infrastructure and avert IT catastrophe
- the production of a Mental Capacity Assessment policy and supporting training materials, targeted at those wards highlighted by CQC not compliant
- the introduction of a range of interventions to stabilise and support better governance and risk management at the Trust

The Trust's Quality Improvement Plan builds on these achievements.

4.2 The Quality Improvement Plan 2017/18

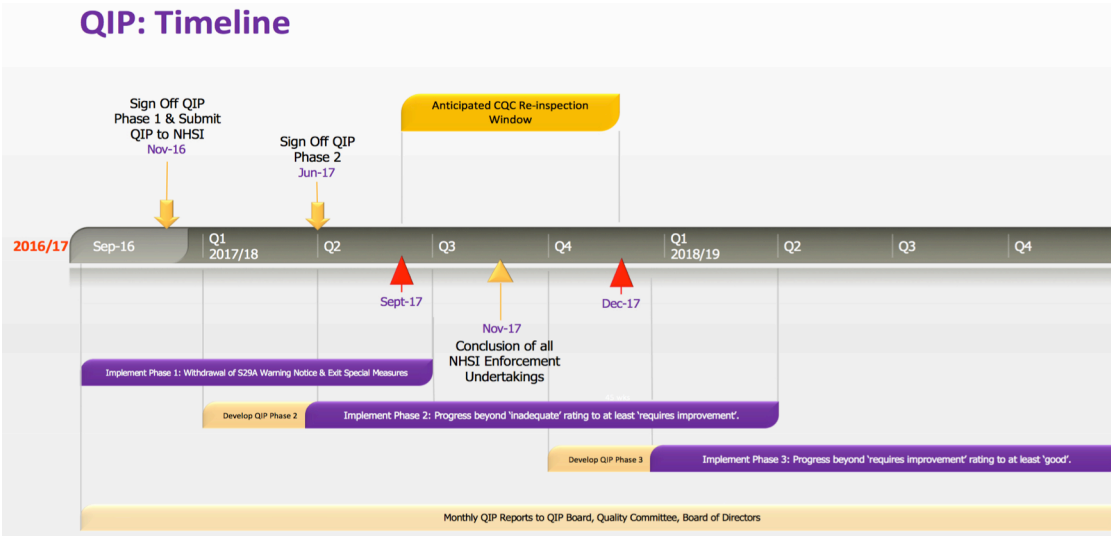
The Trust has prepared a detailed Quality Improvement Plan (QIP). This plan takes account of pre-existing compliance matters, the Section 29A matters and all the 'must do' and 'should do' recommendations from all the CQC reports which formed the basis for their judgement and rating for the Trust in June 2016. The QIP has been reviewed, challenged and approved at Quality Improvement Board, chaired by the chief Executive, and authorised on the Board's behalf by the Quality Committee, chaired by a Non-Executive Director. Updates on the Quality Improvement Plan are routinely reported to the Board of Directors.

The overall goal is to achieve a 'good' or 'outstanding' rating from the CQC by 2019. There are three phases to the QIP:

Phase 1 is primarily concerned with addressing the defects found during inspection. Phase 1 is expected to conclude on or before 30th September 2017, and essentially deals with the immediate compliance concerns highlighted by CQC. The focus for Phase 1 of the QIP is mandated in accordance with NHSI's enforcement undertakings. Successful implementation of Phase 1 will lead to the withdrawal, by the CQC, of the Section 29A Warning Notice and, following satisfactory conclusion of NHSI's enforcement undertakings, lead to a recommendation for the Trust to exit special measures for quality.

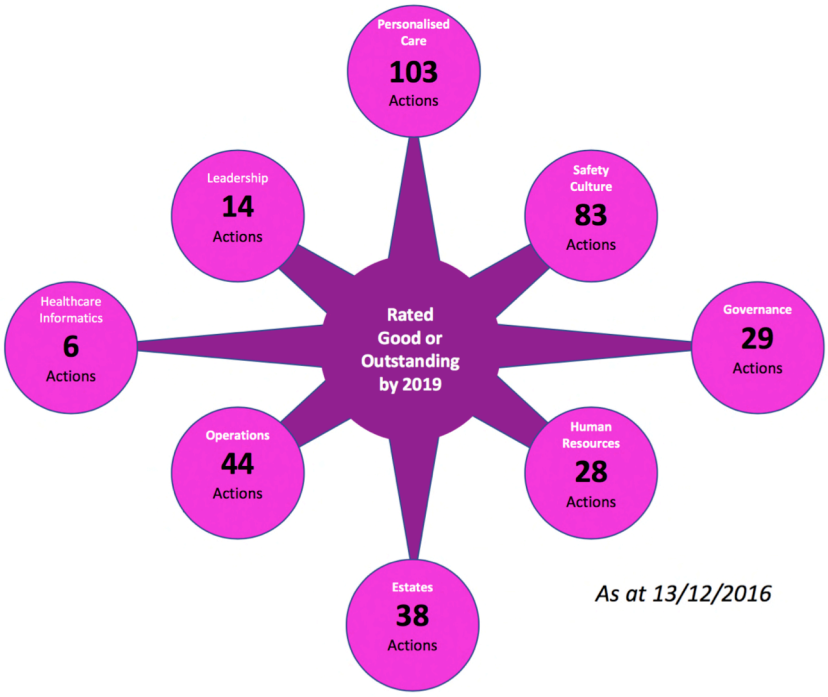
Phase 2 is primarily concerned with embedding good governance and compliance across acute and community services. It is designed to allow the progression from an 'inadequate' rating to a 'requires improvement' rating by quarter four 2018/19. It is acknowledged that elements of Phase 2 may require further evolution and refinement following completion of an independent well-led governance review required as part of NHSI's enforcement undertakings.

Phase 3 is primarily concerned with building capability, confidence and competence, allowing the progression from a 'requires improvement' rating to the restoration of an overall rating of at least 'good' by the end of 2019.



4.3 Specific QIP Workstreams

There are eight workstreams that form for Trust's Quality Improvement Plan. These are illustrated below.



The details of these plans are shown in appendix 1 of this plan, but at a high level they are:

1. **Personalised Care** – includes end of life care, privacy and dignity, pain management, dementia care
2. **Safety Culture** – covering medicines management, radiation safety, early warning scores, WHO safer surgery compliance and clinical records security
3. **Governance** – including risk management and board assurance, Freedom to Speak Up, complaints and Serious Incidents

4. **Human Resources** – covering Fit & Proper Person requirement, equal opportunities, recruitment and mandatory training
5. **Estates** – to ensure it is serviceable at all times and fit for purpose
6. **Operations** – covering access to services, requirement requirements, clinical model and divisional communications
7. **Healthcare Informatics** – including access to clinical records, data accuracy & validity, and IT systems fit for purpose
8. **Leadership** – covering leadership stability, long term strategy and vision, and delivering enabling

In addition to the above, the Trust will be appointing an Improvement Director in early 2017, who will support the Board in delivering the overall operational, quality and workforce agenda.

4.4 Governance arrangements for the Quality Improvement Plan

The Director for Quality Governance has responsibility for oversight and delivery of the QIP. Together with the QIP manager they meet with the workstream leads at a confirm and challenge meeting, held each month with the Executive lead and relevant action owners, to review progress against actions and adherence to time scales. Each action is rated according to delivery against an agreed target date as follows:

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This is backed up by appropriate evidence
Red	Has failed to deliver by target date. Off track.
Amber	Off track but confident recovery action planned will ensure delivery by target date
Green	Completed / on track to deliver by target date.

The output of the 'confirm and challenge' meetings is formally reported to the Quality Improvement Board, an executive group chaired by the Chief Executive. The QIP Board meets monthly where progress is reviewed, escalations are considered and corrective actions agreed, and evidence of delivery of actions is examined in detail. Management is held to account for the delivery of the QIP at the Quality Improvement Board.

A QIP summary report is also provided at each formal meeting of the Trust's Quality Committee, an assurance committee of the Board chaired by a non-executive director, where progress is scrutinised and the Executive held to account for delivery of the plan. In addition, progress is reported to the Board of Directors at each formal meeting thereafter.

The Trust recognises that it needs to build its Quality Improvement capacity and capability within the trust. A clinical consultant has been appointed to lead this process, and the trust is holding talks, up to CEO level, with other NHS organisations to identify a partner organisation to help St. George's to deliver this complex agenda. The QI capability will be used to both support the immediate delivery of the QIP, but in the longer term, to ensure that quality improvement capability is more of a business as usual function within the trust.

4.4 Quality Impact Assessment Process

The need for St. George's to have a robust Quality Impact Assessment (QIA) process is paramount, given the twin pressures of meeting the financial challenge the organisation faces and addressing the outputs of the CQC inspection. St George's approach to the assessment of services changes considers the Quality Impact Assessment against the three core quality domains of patient safety, clinical effectiveness and patient experience

With the goal of reducing the Trust staff pay costs by 10%, the Trust's CIP and Transformation plans will require a full and robust QIA process to ensure that any risks to service quality are appropriately understood, and that appropriate controls and mitigations are put in place.

All Trust staff accept that the extreme challenges that will impact on the range of services delivered, and more particularly, how those services are delivered. No savings scheme that has a clinical or nursing component is developed in isolation from local clinical and nursing leadership. The Trust acknowledges that a significant part of the long term answer to St. George's sustainability lies in the knowledge, ideas and insight held within our clinical services. CIP and Transformation schemes therefore have as an integral part, clinician participation. This does not mean that clinicians, nurses and other staff will always be in agreement with proposed changes – no one party has a veto in this process. However, where there is concern about proposed changes the QIA process is designed to pick up on and address these.

The following outlines the formal process that all efficiency, productivity, savings or CQC related schemes will adhere to.

- At the initial level, divisions will sign off projects (with clinical input and oversight from the Divisional Chair, relevant Clinical Directors, the Divisional Director of Nursing and Governance, the Divisional Director of Ops and others as appropriate to the scheme) subject to the saving being under £100k, and any residual risks exceeding 12 on the NHS risk matrix. Any project exceeding these limits must be signed off by the Medical Director and Chief Nurse using the standard QIA sign-off process
- The Trusts Programme Management Office (PMO) have developed a revised QIA template that facilitates an accurate description of service based risks and mitigations associated with CIP, savings and transformation projects
- No scheme can go live until completion of the full sign-off process, which includes the QIA forms appropriately signed-off.
- Responsibility for compliance with the standards for full completion of the QIA and Saving Scheme Form sign-off is the responsibility of the
    - Divisional Steering Committees for divisional projects, or
    - Programme Steering Group for the Turnaround programmes.
- The PMO will provide oversight of the project sign-off process and will undertake a quarterly review of the governance process and provide assurance reporting to the Turnaround Board
- The PMO will initiate the establishment on a weekly basis for the purpose of review and approval of all QIAs signed-off by the divisions. The purpose of this meeting is to provide executive level oversight and approvals of projects
- A process of regular review of programmes; work-streams; projects; QIAs; and risk-logs is being introduced with a requirement for Divisional Steering Committees to ensure that a regular review of QIAs and risk-logs for on-going projects is undertaken, with issues escalated to the Turnaround Board as necessary

As demonstrated, both the QIA process itself, and the governance overseeing the implementation of the QIP plan provide clear safeguards and escalation spaces to identify if care is in danger of being compromised by any process or proposal being adopted in the Trust. The Trust Board is very attuned to the clinical and quality risks inherent in addressing the scale of the financial challenge facing the organisation, and through its monthly board will monitor delivery of the Trusts QIP and financial plans in a holistic way, seeking sufficient assurance that clinical care and quality is not being compromised by delivering CIPs or the other transformation schemes the Trust needs to deliver to bring the organisation back to an operationally and financially sustainable position.

To this end baseline data collection forms part of the QIA process, and will therefore be monitored as schemes are implemented. In terms of potential cumulative impact of several schemes on a particular pathway, service, team etc., this again, should be picked up in the QIA process, and also the Divisional Management Boards will also provide a further assurance of local intelligence on cumulative impact being picked up early.

4.5 Seven Day Services

The three acute clinical divisions are required to report on progress on delivering seven day services, and their plans to meet the 4 key standards, on a monthly basis to the CEO and Executive Directors. These 4 standards are:

- **Standard 2:** All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital
- **Standard 5:** Hospital inpatients must have scheduled seven-day access to diagnostic services. Consultant-directed diagnostic tests / completed reporting will be available seven days a week
- **Standard 6:** Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions
- **Standard 8a:** All patients on the Acute Medical Unit (AMU), Acute Surgical Assessment Unit (ASU), and Intensive Therapy Unit (ITU) and other high dependency areas are seen and reviewed by a consultant twice daily
- **Standard 8b:** Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week.

Each division has undertaken a baseline assessment exercise in August 2016. Compliance against the 4 key standards has been self-assessed at a divisional level, with Surgery at 95% compliance, Children & Women's at 87.5% and Med Card at 61%. The trust has also taken part in the second national 7 day survey, and is awaiting the results from the same, which will inform St. George's 7 day work programme over the coming months.

The Trust is therefore building from a strong starting point in terms of delivering the 4 key standards, though there will be severe challenges to meet and maintain them by November 2017, particularly standard 2 across all specialties. The Trust is currently working through the clinical division's plans for meeting the November 2017 standards, and it remains the Trust aim to meet this target date.

4.6 Triangulation of indicators

As part of the Trust performance framework, St. George's undertakes monthly executive performance reviews where a series of indicators and their interdependencies in relation to performance, finance, quality, workforce, and risk are reviewed and key items for escalation are addressed. Areas of underperformance are reviewed in terms of delivery against national/internal standards, financial implications, impact on quality and patient care and experience, and workforce implications associated with it. In addition to this the impact of potential workforce issues are discussed and their impact on respective areas, both short and long term with remedial proposals for action.

Key actions from reviews are also discussed and monitored at various forums in relation to key domains, namely: Finance and Performance Committee, Quality and Risk Committee, Workforce and Education Committee and Monthly Finance and Performance Reviews.

Further triangulation and board scrutiny of key areas is undertaken at monthly Trust Board and key indicators from all domains are reported in the monthly Trust Board Performance and Quality

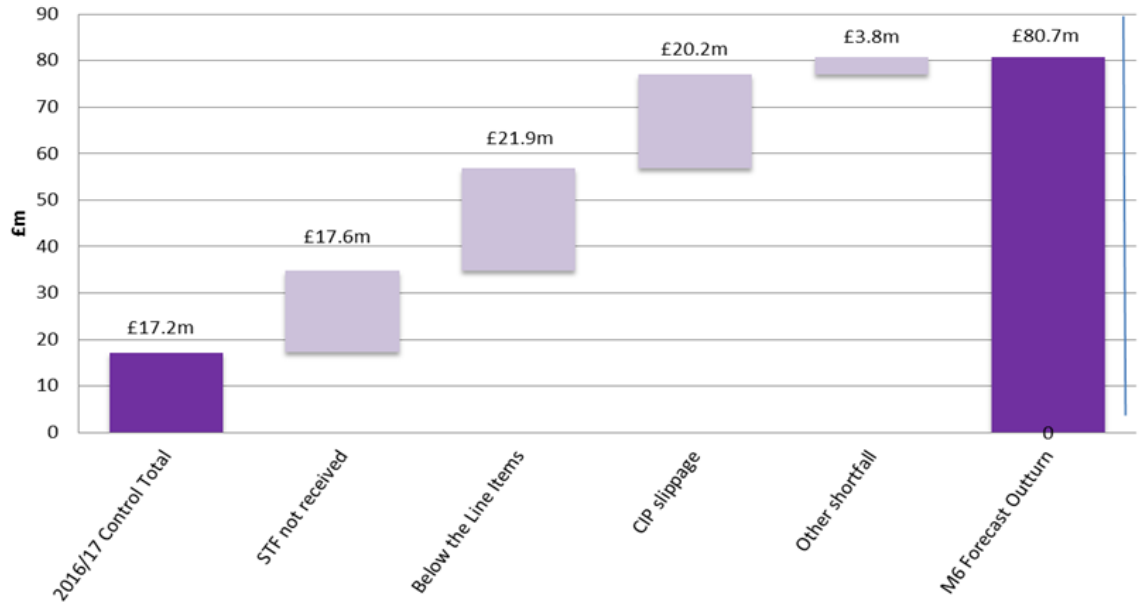
Report. The Board scrutinise indicators/performance, request further details or recovery action plans where required. Also, in relation to particular areas the board may request specific thematic analysis and forecast for future performance and any associate implications. The board will then use this data to identify key priority and development areas for the Trust for both the immediate term and strategic long term.

5.0 Financial Planning

5.1 Financial context, forecasts and modelling

The Trust was set an extraordinarily challenging financial target in 2016/17 of a deficit of £17.2m and has struggled with delivering the levels of transformational change required by the KPMG financial recovery plan. In addition, the levels of risk associated with the estate and IT infrastructure have escalated through the year; and the Trust has also had to manage the impact of both the CQC inspection; and the identified information deficiencies that led to the suspension of Referral to Treatment reporting in July 2016.

As the Trust has not been able to achieve its control total, Sustainability and Transformation Funding of £17.6m has also not been received. The Trust is endeavouring to hold its forecast deficit of £80.7m for the 2016/17. The table below highlights the main elements which have moved the forecast outturn to an £80.7m deficit from the original NHSI control total of a £17.2m deficit:



The revised forecast outturn creates the starting point for producing the proposed financial plans for the years 2017/18 and 2018/19. It needs to be noted that the trust is currently undertaking a reforecasting exercise for NHSI to indicate how the 2016/17 deficit could be pulled back to £55.5m. NHSI have indicated that they wish to work with the trust to review monthly ,and to monitor recovery actions being taken by the trust and to provide support where appropriate.

5.2 Headline Financial Plans for 2017/18 and 2018/19

NHS Improvement (NHSI) informed the trust in writing on the 1st November that the expected control totals for 2017/18 and 2018/19 would be £3.5m surplus and £13.3m surplus respectively and that the sustainability and transformation monies of £18m for each year would be dependent upon the trust accepting the proposed control totals.

Commissioners have indicated that they intend to reduce the amount of activity the Trust is commissioned to undertake in 2017/18 by approximately £45.5m compared to the Trusts proposal.

Against this background, the 2017-9 planning round has also been very challenging:

- Commissioners have sought to transfer financial and activity risk to St George's and although the Trust is likely to be able to reduce risk through PbR contracts, it will still be holding a local income target risk (i.e. outside contract)of c£45.5m;
- The Trust has identified a shortfall in its billing of £25m+ that has not been included in commissioner contracts, but is holding associated expenditure within its cost base;
- A CIP target of £73.9m (c10%) would be required to enable the Trust to hit the control total for 2017/18 of a surplus of £3.5m. This includes the potential mitigation of the additional income, and the Trust continues to press commissioners to recognise these pressures with income in 2016/17 as well as the forthcoming years.

To be confident in delivery of its control target against these financial risks, the Trust needs to have confidence in the levels of activity included in its contracts; the quantification of its RTT backlog; the demand management plans of its commissioners; and its ability to drive and deliver transformational change with an estate and IT infrastructure that are demonstrably fragile and at risk of single points of failure. Even without these impediments, 10% CIP over one year would be unrealistic compared with sector benchmarks. 4.5% is considered best in class and the Trust has never delivered more.

Board members have reflected carefully on the achievability of the control total in the light of the levels of risk, and have concluded that it would be inappropriate to commit the Trust to a control total that it would be likely to fail. The Board has always been clear that the St George's recovery plan would be a 3-4 year plan, delivered in a measured way against tough but achievable targets. The Trust is making progress against all aspects of its recovery agenda, but cannot commit to deliver a £3.5m surplus in 2017/18, rising to £13.3m in 2018/19. The Trust Board undertakes to push savings as hard as possible, but is of the view that it will struggle to achieve better than a control total of £10.5m deficit in 2017/18 and a break-even position in 2018/19, delivered via a £35m CIP plan for 2017/18, and £39.5m for 2018/19.

The Trust is proposing to set financial plans based upon the following key elements:

a. To build its financial plans from the current forecast deficit outturn of £80.7m
b. To reject the contract proposals put forward by the Commissioners
c. Activity and income will be based on the trusts original plans submitted to the Commissioners
d. The trust secures a full PBR contract, which commissioners have recently agreed to in principle
e. The trust is paid for all the work that it will perform through the application of a local income target of £45.5m to address the proposed reduction in Commissioner funding
f. The trust will recover the income shortfall of £25m attributable to historic under billing
g. The trust will receive the full allocation of the £17.9m sustainability and transformation funding for 2017/18 and 2018/19.

The Trust's thinking around adopting the proposed deficit plans is that these numbers are a product of an eighteen month run rate development from its current full year forecast outturn for 2016/17 of an £80.7m deficit.

Detailed below is a high level financial bridge showing the movement from the preceding year's financial outturn to the respective annual deficit totals:

2017/18 Control Total Challenge	£'s m
Brought forward 2016/17 opening deficit	-80.7
Identified net in year cost pressures	-29.7
Removal of previous years non-recurrent items	21.9
Sustainability & transformation funding	0
Revised operating run rate	-88.5
CIP and 10% Pay bill Reduction savings	35
Revenue Capture	25
	-28.5
Anticipated reduction in Commissioner funding in 2017/18 of £45.5m.	-45.5
Local income target required to offset Commissioner funding reduction	45.5
Sustainability & transformation funding	18
Planned Deficit for 2017/18	-10.5

2018/19 Control Total Challenge	£'s m
Brought forward 2017/18 opening deficit	-10.5
Identified net in year cost pressures	-29
Sustainability & transformation funding	-18
Revised operating run rate	-57.5
CIP and 10% Pay bill Reduction savings	39.5
	-18
Anticipated reduction in Commissioner funding in 2017/18 of £45.5m.	0
Local income target required to offset Commissioner funding reduction	0
Sustainability & transformation funding	18
Planned Deficit for 2018/19	0

Note:
(i) The above financial bridges include a full allocation of the sustainability and transformation funding for each year on a non-recurrent funding basis.
(ii) In Month 6 of 2016/17 the trust commenced an initiative to assess how much income it was losing through counting and coding errors, and how much it was therefore not appropriately billing for. The sample testing indicated that the Trust was losing around £25m per annum; this amount is being pursued with commissioners ahead of the final plan submission.

In building up the financial plans for 2017/18 and 2018/19 the following assumptions have been adopted.

Income

1. Activity is at 2017/18 and 2018/19 prices respectively.
2. Provision for in year NHSE income challenges at 2016/17 levels (excluding non-recurrent RTT challenges).
3. Both private patients and other income held at 2016/17 levels.
4. Non patient care income is taken at approximately 4% less than 2016/17 levels, due to a reduction in education income (tariff and volume)
5. The amount that Commissioners have indicated that they are intending to reduce the annual funding by has been offset by the introduction of a local income target, including £25m of income associated with revenue capture. This £25m is included in the income plan, but no adjustment has been made to activity
6. No income is assumed from the Charity, but the Trust will be exploring options for charitable support, particularly for capital equipment purchases, over the course of the year.

Pay Costs

1. Pay is based on the baseline of Month 6 forecast outturn.
2. The forecast outturn pay costs have been adjusted to remove the 2016/17 non-recurrent costs elements relating to IT infrastructure and maintenance backlog, additional COO and Governance posts, Executive Team premium costs, and the premium relating to interims.
3. The pay cost run rate has been increased to reflect the expected annual pay inflation factor (2%), the anticipated apprentice levy, and cost pressures.

Non-Pay Cost Pressures

1. Non-Pay is based on the baseline of Month 6 forecast outturn.
2. Outturn run rate adjusted for expected price inflation.
3. Prior year non recurrent costs excluded relating to CQC inspection, RTT data quality costs and prior year supplier invoice payments carried forward into 2016/17.
4. The non-pay cost base line has been uplifted to take account of inflation (2%), cost pressures and the normal annual cost contingency factor.

CIP and 10% Pay bill Reduction Plans

1. The achievement of the proposed plans will rely heavily upon the delivery of the expected CIP and 10% pay bill reduction savings which for 2017/18 and 2018/19 are £35m and £39.5m respectively.
2. The plan includes a 10% monthly pay bill reduction by the end of 2017/18, with the full year effect contributing to the achievement of a breakeven position in 2018/19.
3. The trust is planning to meet the agency cap of £24m for both years.
4. A key part of the CIP delivery will be via savings to be delivered through potential theatre and ward closures, alongside these schemes detailed divisional savings plans are under development between the Trust PMO, Divisions and Divisional Heads of Finance.
5. The table below shows the current thinking around the headline split of the CIP for both years.

CIP for 2017/18 - 2018/19 Planning						
Headline	**Description**	**Sub-totals**	**Total 2017/18**		**Sub-totals**	**Total 2018/19**
Clinical Transformation:			**12.50**			**14.11**
	Theatres	5.27			5.95	
	Outpatients	2.28			2.57	
	Flow	4.56			5.14	
	Diagnostics	0.00			0.00	
	Fix Close Transfer	0.39			0.45	
Medicine Optimisation			**0.71**			**0.80**
Back Office			**1.75**			**1.96**
Procurement			**4.42**			**5.00**
Workforce Efficiency:			**15.62**			**17.63**
	Nursing workforce	3.77			4.26	
	Medical workforce	2.67			3.01	
	Clinical Admin	1.24			1.40	
	Non-medical workforce	5.08			5.73	
	AHP	1.82			2.05	
	other	1.04			1.18	
TOTAL			**35.00**			**39.50**

5.3 Delivering Carter opportunities

The Trust has invested in a new Procurement Service which became fully resourced in Q2 2016/17. The new service has focussed on delivery of the Carter recommendations and is an active and successful user of Purchase Price Index and Benchmarking data since its launch last month, identifying opportunities for reducing cost via collaboration (via LPP etc.) and direct re-negotiation of contracts to bring pricing in line with the best performing acute providers. The establishment of a culture of controls and compliance has commenced within the procurement and purchase to pay environments, driving spend to fewer providers and reducing off contract expenditure. Further detailed collaborative work is underway with SWL partners to progress opportunities to reduce costs and improve efficiency.

The trust has helped lead the way with the consolidation of pathology services, with South West London Pathology, a partnership vehicle between St. George's, Kingston, and Croydon Hospitals which came into being during 2015. Savings have been considerable and broadly in line with the original business case projections. The trust is continuing to explore opportunities for back office consolidation with other providers in south west London and will look to deliver savings from these projects during the two year period of this plan, though at this stage, no concrete plans are in place.

5.4 Cash flow and financial support

In 2016/17 the trust maintained the improvements in cash management made in 2015/16 e.g. through longer supplier payment terms and credit control actions to reduce overdue debt.

However the higher income and expenditure deficit than original plan has required higher borrowing than plan. The trusts forecasting exercise is projecting an £80.7m deficit, however it is currently conducting a re-forecasting exercise with the aim of meeting the NHSI target deficit figure of £55.5m. Meeting this lower target would result in the trust projecting a total borrowing requirement for £109.9m in 2016/17 including £39.12m for emergency capital monies – as set to in the forecast outturn submitted to NHSI at M07.

The trust's forecast cash balance on 31 March 2017 is £3.4m after loan drawdowns of £109.9m

The trust' projected borrowing requirement for 2017/18 is £87.6m comprising £63.3m to finance the planned revenue deficit and working capital and £24.4m further capital loans to finance emergency capital investment necessitated by urgent priorities identified in the estate and IT infrastructure.

5.5 Capital Planning

The trust has identified a number of very urgent priorities for capital investment in the estate infrastructure and IT infrastructure. The current inadequate standard of fire safety, buildings fabric and network resilience requires significant investment to meet the required minimum standards. Accordingly the trust submitted to NHSI an initial emergency capital bid in June 2016 for £39.12m for estate and IT capital monies.

The trust has refined the bid since June and was submitted in November 2016. This final version requests emergency capital monies of approx. £63.5m. In order to maintain consistency with the NHSI M07 return forecast outturn, £39.1m of this emergency capital is assumed to be received and spent in 2016/17, leaving the balance of £24.4m to be received and spent in 2017/18.

The capital planning and prioritisation process is as follows:

- Clarification on the available funding for the capital programme was given based on the forecast deficit for this year and next.
- Emergency capital investments identified and included in the submission week ending 24/11.

- The master list is checked to ensure all items were captured and risk assessed, with risk description and mitigation should the item not be prioritised.

Based on the above, the trust has undertaken the trust is looking to invest in the following major programmes during 2017/18.

- **IM&T** – Major areas of investment are around basic infrastructure renewal – improving network capacity and resilience, implementing changes to the trusts main PAS system and electronic document management and prescribing systems, which improve patient safety.
- **Infrastructure Renewal** – Major expenditure on generator renewal and fire safety projects, lift upgrades, standby generators, water management and theatre refurbishment
- **Energy Contract** – the trust will complete the renewal of its energy centre, the plant that supplies the energy to the main site. This project is financed by a secured loan from the London Energy Efficiency Fund (LEEF).
- **Major projects** – Completing the demolitions programme, re-location of renal services, refurbishment and replacement of the cath labs.
- **Medical equipment** –funded by finance leases where appropriate and a combination of emergency capital and internal capital.

The trust is exploring ways of better using assets, including:

- Exploring a managed equipment solution to the catheter laboratories upgrade that is required in the coming year
- Extending asset lives where risk is low
- Reviewing the community estate currently owned and managed by the trust, and looking to reduce the total number of bases within the community, whilst still delivering a high quality community service.

6.0 The South West London Sustainability & Transformation Plan

Delivery of the aspirations of the emerging Sustainability and Transformation Plans (STPs) are one of the 9 'must-do's' of the NHS for the next two years. St. George's is very supportive of the aims and aspirations of the South West London STP. The guidance makes it very clear the importance of individual organisations plans for the coming two years being clearly linked to the STPs plans, and the Trust recognises that the successful delivery of the STP is part of the solution for St. George's long term viability and health.

The STP is clear that a "no-change" scenario is not viable either clinically or economically, with the sector facing a deficit of £828m p.a. by the end of 2020/21. The STP's plan, at a high level, is to:

1. Set up locality teams, providing integrated care, for populations of circa 50,000
2. Increase capacity in the community, by using workforce differently, to reduce hospital admissions and deliver more care in the community
3. Review acute hospital configuration to meet changing demand and deliver high quality care
4. Address both mental and physical needs in an integrated way
5. Introduce new technologies to deliver better patient care
6. Make best use of acute staff through clinical networking and redesigning clinical pathways
7. Review specialised services in south London

At the moment the STP is still a work in progress, with detail underpinning how the above are to be delivered still being developed. However, the Trust is making progress on contributing to, or implementing and delivering programmes of work that will directly feed into the delivery of these goals. Key amongst these are:

6.1 Locality Teams

Central to the STP model is the transformation of community based models of care to ensure that people receive their care and treatment in the most appropriate setting based on their needs. St George's is fully supportive of this approach and recognises the benefits of the anticipated reduction in A&E attendances and emergency admissions and the increase in timely discharge from hospital.

St George's is the community provider for Wandsworth and is well advanced in developing the STP Locality Team model of care. The Trust has been working with the CCG for 5 years in developing integrated community teams working on a locality basis around GP practices. The Trust has shown that this model is successful in Wandsworth albeit for up to 200 patients (50 patients per locality) whereas the STP aspiration is for locality teams to support care and treatment for 50,000 patients. In 2017/18 onwards the Trust is are looking to develop locality team working further with the enhanced care pathway 500 initiative providing an MDT approach for patient's care, all overseen by a Consultant Geriatrician.

The Trust is also working collaboratively with Merton's new community provider, CLCH, as many of our patients are discharged to Merton, to seek standardisation between our two main boroughs, where practical and sensible. This is with particular reference to home first: discharge to access, an initiative which will see a reduction in the number of inpatient beds.

6.2 Acute Sector Reconfiguration

The STP identifies that up to 55% of patients in hospital beds do not need to be in them, either because they could have been better treated outside of an acute setting, or having been treated, they could have been discharged earlier. The STP states that the sector will need to reduce its acute footprint, whilst increasing its provision of community support and step down facilities, and it states that "*difficult decisions about the configuration*" will have to be made. The STP has an aspiration to move 43% of inpatient work outside of the acute sector. This is significantly higher than any other STP area. The trust will work with the STP to test the deliverability and achievability of such a transfer out of acute units, and will work with other Trusts within the sector to implement and deliver the final, agreed figure for bed reduction.

In addition to this, none of the four Trusts are consistently delivering NHS Constitution standards for A&E, elective surgery or cancer, nor delivering 7 day services. The STP states that it does not feel it will be able to deliver the 7 day standard across the five acute sites given the inability to recruit or pay for sufficient workforce.

The central premise of the acute reconfiguration element of the plan is to reduce from five acute sites – St. George's, Croydon, Kingston, St. Helier and Epsom Hospital's – to four. In reducing from five to four the sector will be able to meet key clinical quality standards alongside delivery robust 7 day services. Both St. George's and St. Helier sites have major estate problems with St. George's identifying a requirement of £295m over the coming five years. Despite this the STP states that *"The only site which we believe is a "fixed point" is St. George's Hospital….since it provides hyper-acute stroke, major trauma and other services which are served by highly specialist equipment an estates, which be very expensive to re-provide elsewhere in south west London*", and that the NHSE review of specialised services is unlikely to change the fundamentals of this.

6.3 Specialist Commissioning

As referred to above, the specialist commissioning challenge, identified as £99m by the STP, will be addressed through the Specialist Commissioning Review. This review is proposed to be completed by the end of December 2016. St. George's is one of three Trusts – along with Kings College and Guys & St. Thomas's – providing tertiary care to patient of south London. In addition, St. George's

also provides much of the tertiary care to Surrey. At this stage the Trust does not anticipate significant change to the mix of services commissioned by NHSE on site, given, for example, the range of services required to deliver its function as a Major Trauma Centre. However, the Trust is not complacent about the review, will work constructively with it, and will ensure that the outcomes are implemented in a safe and sustainable way.

6.4 Delivering for frail, elderly people

The Trust is in the process of redesigning the unplanned care pathway for frail older patients with a view to admission avoidance in addition to the introduction of a new Rapid Access Clinic 5 days a week based at QMH from October 2016. Frail, elderly patients are to be assessed in the Emergency Department and short stay wards and redirected towards alternative community pathways where clinically appropriate. Delivery should enable able all appropriate patients to receive care in a community environment.

6.5 Getting the model of care right

St. George's has an important role to play in the delivery of networked services. The Trust, for many specialties, often has the largest consultant workforce in south west London. This puts the Trust in a position to both be part of the answer in terms of networked models of care, and to also benefit from the skills and expertise of the workforce working elsewhere in south west London. To this end, it will work closely with the other three Trusts on implementing the 2016 "Better Births – National Maternity Review", as well as looking to ensure that networked arrangements for paediatrics offer safer, more consistent care for all children. St. George's, as a major provider of maternity and paediatric services will obviously play a pivotal role in developing these programmes of work.

6.6 Closing the financial gap and capital requirements

As noted, the financial gap in the health economy will be £828m by 2020/21. Many of the ways to close that are detailed above. Alongside the reduction in acute beds days of 44%, the STP is aiming for circa 20% reduction in outpatient appointments and a 13% reduction in elective surgical activity. Though the detail of these has to be worked out, they will undoubtedly impact on St. George's, either through a reduction in capacity on site, or through taking more work on site to facilitate other reconfiguration changes.

The STP notes that *"All acute sites have areas of capital which they must urgently address in respond to requirement from the CQC or as part of ensuring that their sites are fit for purpose."* St. George's has begun this process, but it will take up to the full five years of the STP to bring the estate up to an appropriate condition.

7.0 Foundation Trust Membership and elections

As St George's gets more established as a Foundation Trust, so its confidence in how best to work with its Governors and Members has grown.

Throughout 2016/17, it has developed stronger working relationships between the Council of Governors and the Board of Directors. All Governors have a standing invitation to attend Board or Committee meetings (except the Remuneration Committee) including meetings that are held in private. This provides a great opportunity for the Governors to observe the Non-Executive Directors (NEDs) and build an evidence base against which they can assess the NEDs' performance at the end of the year. Governors simply need to provide prior notification of planned attendance through the Membership Office and time is built in to these meetings for the Governors to ask questions or make comments.

There are two joint Council-Board events in the 2016/17 programme – one was held in July 2016 and one is planned following the Governor elections in February 2017. The Governors had a very successful Away Day with the NEDs in November 2016 and structured time is being built into the Governor programme in 2017/18 to ensure that the Governors and NEDs can meet on a regular basis. The Lead Governor is invited to attend the Board strategy away days and feedback to the rest of the Governors.

Governors with a DBS check and who have been trained have also been involved in mock CQC inspections – particularly important in a year when St George's has been the subject of considerable regulatory scrutiny. The Quality Inspection programme, led by the Chief Nurse, is being reinstated in the Trust and interested Governors will also be invited to participate. St. George's is striving to ensure that Governors are offered training to enhance their role and encourage them to attend Governwell Governor networking events and courses.

The terms of office for seven elected Public Governors and two elected Staff Governors (32% of the Council of Governors) will expire at the beginning of February 2017 and already the Trust has started to publicise the vacancies amongst the Membership and hold workshops for those interested to learn more about the Governor role. The Trust anticipates that the majority of existing Governors will stand for re-election but in case they are not successful, it is already gearing up to induct and train new Governors.

Member numbers grew by 6% over the year. In November 2016, there are 21,664 Members in total, comprising 12,297 public and 9,347 staff. The increase of 1,281 new Members was due to increases in staffing numbers at St George's throughout 2016. However with the work planned to "right size" the organisation and reduce the paybill, it is highly likely that this will result in fewer staff members by the end of 2017/18.

The Trust has an active programme of events for Members throughout the year, with topics ranging from dementia to organ donation which is a great way for the Governors to engage with the Membership. There is a monthly 'meet your Governor/Membership recruitment' stand in the main reception area at the Tooting hospital site where Governors can help recruit new Members and engage with existing Members and Members receive a monthly ebulletin to update them on news from around the Trust. The Trust magazine will be re-launched by our communications team before the end of the year and Members will be able to collect a printed copy when they visit any of our sites or view on the Trust website.

This year's Annual Members Meeting was attended by 80 people and the average turnout at Membership events is 35. Given the Trust's financial position, rather than spending money trying to recruit new Members, it is instead seeking to build greater awareness and understanding of the hospital amongst the current Membership. The cost of running the Council of Governors and the Membership Office every year is £100,000 and as with all other areas of cost within the Trust, the Membership team regularly reviews how money could be saved or used more efficiently.

Appendix 1- Detail of the Quality Improvement Plan

1. Personalised Care

The personalised care workstream is led by the Chief Nurse and is the largest workstream in the QIP. Personalised care has 103 interventions planned that address a combination of pre-existing actions prior to inspection, a range of 'must do' and 'should do' recommendations following CQC inspection, and matters required by the Section 29A Warning Notice. The areas of focus include:

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
Paediatric Care	▪ To achieve zero suicides, attempted suicides or absconds for children and young people identified as at risk of self-harm ▪ All Paediatric inpatient areas have an up to date risk assessment in place to address foreseeable risks for caring with children and young people at risk of self-harm ▪ Vacant posts in paediatrics filled ▪ Achieve BAPM compliance in NNU

2. Safety Culture

The safety culture workstream is the second largest workstream in the QIP and is led by the Executive Medical Director. Safety culture has 83 interventions planned that address a combination of pre-existing actions prior to inspection, a range of 'must do' and 'should do' recommendations following CQC inspection, and matters required by the Section 29A Warning Notice. The areas of focus include:

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 ▪ Success recognition and rescue of deteriorating patient
WHO Safer Surgery Compliance	▪ Zero surgical never events.
Clinical Records Security	▪ Zero breaches of confidentiality.

3. Governance

The governance workstream is led by the Director of Quality Governance and has 29 interventions planned that address a combination of 'must do' and 'should do' recommendations following CQC inspection, as well as matters required by the Section 29A Warning Notice. The areas of focus include:

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

4. Human Resource

The human resource workstream is led by the Director of Workforce and Organisational Development and has 28 interventions planned that address 'should do' recommendations following CQC inspection, as well as matters required the Section 29A Warning Notice. The areas of focus include:

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

5. Estates

The Estates workstream is led by the Director of Estates & Facilities and has 38 interventions planned that address a range of immediate actions required by CQC post inspection alongside a combination of 'must do' and 'should do' recommendations following CQC inspection, as well as matters required by the Section 29A Warning Notice. Delivery of significant improvement to the Estate is particularly challenging and in cases, is dependent upon access to capital and the ability of services to vacate premises to enable works to be undertaken. The areas of focus include:

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

6. Operations

The operations workstream is led by the Chief Operating Officer and has 44 interventions planned that address and combination of 'must do' and 'should do' recommendations following CQC inspection. The areas of focus include:

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	▪ An agreed strategy for Neuro-Rehabilitation is agreed and being implemented ▪ An agreed 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

7. Healthcare Informatics

The healthcare informatics workstream is led by the Chief Information Officer and currently has 6 interventions planned that address 'should do' recommendations following CQC inspection, although this workstream is being developed further to help address IT requirements arising out of interventions planned elsewhere in the QIP (such as electronic vital sign monitoring and recording system to support EWS and deteriorating patient actions; access to clinical systems for temporary workforce). It is envisaged that there will be an expansion of the range of interventions under this workstream in due course. The current areas of focus include:

Focus area	Phase 1 Objectives (by 01/09/2017)
Access to clinical records and clinical	▪ Extended remote/mobile access ▪ Arrangements to enable temporary workforce to access clinical

systems for relevant staff in community care settings	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

8. Leadership

The leadership workstream is led by the Chief Executive and currently has 14 interventions planned that address 'must do' recommendations following CQC inspection. The current areas of focus include:

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 terms 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