Trust Board Meeting

Date and Time: Thursday 8 June 2017, 10:00 – 12:30
Venue: Hyde Park Room, 1st Floor, Lanesborough Wing

Time	Item	Subject	Action	Format
10:00 – FEEDBACK FROM BOARD WALKABOUT				
OPENING ADMINISTRATION				
10:30	**1.1**	**Welcome and Apologies** Chairman	-	-
	1.2	**Declarations of Interest** All	-	Oral
	1.3	**Minutes of Meeting held on 04.05.17** Chairman	Approve	Paper
	1.4	**Action Log and Matters Arising** All	Review	Paper
	1.5	**Update from CEO** Chief Executive	Inform	Oral
PATIENT SAFETY, QUALITY AND PERFORMANCE				
10:40	**2.1**	**Quality Improvement Plan** Chief Nurse	Assure	Paper
	2.2	**Performance & Quality Report** Director of Efficiency, Delivery & Transformation/Chief Nurse	Review	Paper
	2.3	**Referral to Treatment and Elective Care Recovery Programme** Elective Care Recovery Programme Director	Update	Paper
	2.4	**Infection Prevention Control Annual Report 2016-17** Chief Nurse	Assure	Paper
	2.5	**Adult Safeguarding Annual Report 2016-17** Chief Nurse	Assure	Paper
	2.6	**Report from Quality Committee** Chair of Committee	Inform	Paper
FINANCE				
11:20	**3.1**	**Month 1 Finance Report** Chief Financial Officer	Assure	Paper
	3.2	**Report from Finance & Performance Committee** Chair of Committee	Inform	Oral
WORKFORCE				
11:30	**4.1**	**Workforce Performance Report** Director Human Resources & Organisational Development	Inform	Paper
	4.2	**Report from the Workforce and Education Committee** Chair of the Committee	Inform	Oral
	4.3	**Staff Survey Results** Director Human Resources & Organisational Development	Discuss	Paper
	4.4	**Fit & Proper Person Policy & Procedure** Director Human Resources & Organisational Development	Approve	Paper
	4.5	**Managing Conflicts of Interests in the NHS** Trust Secretary & Head of Corporate Governance	Approve	Paper
GOVERNANCE & RISK				
11:50	**5.1**	**Report from Audit Committee** Chair of Committee	Inform	Paper
	5.2	**Annual Freedom of Information Report** Trust Secretary	Receive	Paper
12:00 - PATIENT STORY Sue Lines was recently a patient at the Trust and as well as having praise for the staff on the ward she did have some concerns around communication issues which she has kindly agreed to share with the Board.				

CLOSING ADMINISTRATION				
12:25	**6.1**	**Questions from the Public**	-	Oral
	6.2	**Summary of Actions** Trust Secretary	-	Oral
	6.3	**Any New Risks or Issues** All		-
	6.4	**Items for Future Meetings** i. Charity to attend Board (July 2017) ii. Learning from Avoidable Deaths (July 2017) iii. Update on Outpatients Programme and Business Case (July 2017) iv. PLACE Assessments (July 2017) v. Communications Strategy and Annual Plan (July 2017) vi. Children's Safeguarding Annual Report (August 2017) vii. Adult Inpatient Survey (July 2017) viii. Staff Survey Results – Action Plan (July 2017) ix. Risk Management Framework and Approach (July 2017) x. Evaluation of Overseas Visitors and Migrant Cost Recovery Pilot (August 2017)		-
	6.5	**Any Other Business** Chair	-	-
	6.6	**Reflection on Meeting** All	-	Oral
12:30		**Close**		

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

Date and Time of Next Meeting: Thursday 6 July 2017, 10:00 – 12:30

Trust Board
Purpose and Meetings

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

Trust Board Dates 2017-18 (Thursdays)		
06.07.17 10:00 – 13:00	10.08.17 10:00 – 13:00	07.09.17 10:00 – 13:00
05.10.17 10:00 – 13:00	09.11.17 10:00 – 13:00	07.12.17 10:00 – 13:00
11.01.18 10:00 – 13:00	08.02.18 10:00 – 13:00	08.03.18 10:00 – 13:00

St George's University Hospitals NHS
NHS Foundation Trust

Minutes of Trust Board Meeting in Public
4 May 2017 – From 10:00, Hyde Park Room, 1st Floor, Lanesborough Wing

Name	Title	Initials
PRESENT		
Gillian Norton	Chair	GN
Jacqueline Totterdell	Chief Executive	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Avey Bhatia	Chief Nurse	CN
Ann Johnson	Acting Chief Financial Officer	Acting CFO
IN ATTENDANCE		
Thomas Saltiel	Associate Non-Executive Director	NED
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Mark Gammage	HR Advisor to the Board	HRAB
Larry Murphy	Chief Information Officer	CIO
Sandra Shannon	Deputy Chief Operating Officer	DCOO
Alison Benincasa	Divisional Chair, CSD	DC – CSD
Tunde Odutoye	Divisional Chair, SCTN	DC – SNTC
Lisa Pickering	Divisional Chair, CWDT	DC – CWDT
Justin Richards	Divisional Chair, MedCard	DC – MedCard
Marie-Noelle Orzel	NHSI Quality Improvement Director	QID
APOLOGIES		
Jenny Higham	Non-Executive Director	NED
Andrew Rhodes	Acting Medical Director	MD
SECRETARIAT		
Fiona Barr	Trust Secretary & Head of Corporate Governance	Trust Sec
Richard Coxon	Membership & Engagement Manager	MEM

Feedback from Board Walkabout
Board members had been to visit different areas of the Trust before the meeting including Rose Centre & Surgical Day Unit; Cavell Ward & Nye Bevan Unit; Neuro ICU & Belgrave; Gordon Smith Ward & Champneys Ward; Nicholls & NNICU and Florence Nightingale Ward & Amyand Ward.

There were a number of common themes. Staff were welcoming and committed, and were very open in their discussions with the Board. There was a good focus on patient care and the wards visited were calm and well-organised.

The main issues raised by staff were infection control, and being able to challenge senior colleagues on the “bare below the elbows” policy, delays in recruitment and the vacancy control process. There were some specific estates and IT issues raised in particular wards.

Board members welcomed the opportunity to go on a walkabout and speak to staff before the start of the Board meeting though agreed that more fine tuning was needed to ensure that the visits were not rushed and there was sufficient time for structured feedback. Board members also confirmed their intention to visit community and administrative areas as part of the annual programme.

1. OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and welcomed everyone present, in particular Jacqueline Totterdell, the new CEO as well as James Friend, Harbhajan Brar and Ann Johnson who were all attending their first Board meeting. Sandra Shannon, Deputy COO, was representing operations and the apologies were as set out above.
Declarations of Interest	
1.2	The Chairman asked for declarations of interest. None were made.
Minutes of Meeting held on 06.04.17	
1.3	These were accepted as a true and accurate record of the meeting held on 06.04.17 except for some spelling errors.
Matters Arising and Action Log	
1.4	The following was noted on the Action Log: • Action reference TB.03.11.16/03 – was closed. • It was agreed that action TB.05.01.17/11, TB.09.03.17/22, TB.06.04.17/23 – 25 could be closed subject to their satisfactory consideration in the meeting. • The DCOO agreed to address action TB.09.02.17/16 and TB.09.02.17/18 • All other actions remained open. *Post meeting note: Action reference TB.09.03.17/22 was re-opened as the Board concluded that it still needed a workshop on risk to be organised.*
Update from Chair and CEO	
1.5	The new CEO thanked everyone she had met so far for making her feel so welcome and confirmed that she felt privileged to be at the Trust. Stability in the leadership team was important and she wished to reassure staff and Board members that she planned to stay long term. She had already met a number of staff and more briefings were planned. She emphasized the importance of listening to staff to understand their concerns. She would use this feedback alongside the requirements of the Trust's regulators to build a plan for recovery and prioritise work over the coming months to respond to needs of internal and external stakeholders.
1.6	The deadline for the submission of the Financial Recovery Plan to NHS Improvement was 19.05.17. Whilst the Trust had support from EY through the Financial Special Measures regime, the Plan was one which was very much developed and owned by the Trust.
1.7	The CEO closed by explaining the work needed to improve the Trust's elective care planning and delivery, noting the work still required to fully understand the position in regard to patients referred to the Trust for treatment. More work was needed on the pace and scale of the programme though some progress had been made. She agreed that the Elective Care Recovery Programme Director would provide a regular report to the Board from June.
TB.04.05.17/28	**Provide a regular report to the Board on the progress of the Elective Care Recovery Programme.** **LEAD: Elective Care Recovery Programme Director, Diana Lacey**
2. PATIENT SAFETY, QUALITY AND PERFORMANCE	

Quality Improvement Plan	
2.1	The CN presented a report on the Quality Improvement Plan (QIP) which had been developed since the last Board meeting through input with the Trust's Quality Improvement Director and the Trust's commissioners and regulators (to ensure the new approach was in line with their expectations). Over time, the intention was to combine the recovery plans for quality and finance, along with individual programmes to track identified areas for improvement in estates, IT and Outpatients to ensure there were no competing priorities. Key to the success in all areas was the involvement and engagement of staff at all levels as the plans themselves – and their outcomes – had to be owned by the staff.
2.2	The CEO explained that the Trust was commissioning an external review of governance which would start in the next few weeks. This would provide a welcome opportunity to build the internal assurance and control framework for the Trust which had become fragmented. She also advised that the programme structure which the incoming DDET would introduce would provide greater clarity of approach and lines of reporting and decision making.
2.3	The Board received the report and noted improvement on the delivery of the QIP.
Section 29a Progress Report	
2.4	The CN presented a report on the follow up to the Section 29A warning notice served on the Trust on 26.08.16 which had identified: i. Unsafe and unfit premises where healthcare was provided and staff accommodated. ii. Lack of formal mental capacity assessments and best interest decision making. iii. Governance arrangements not effective in identifying and mitigating significant risks to patients. iv. Data used in reporting and managing patients was not robust or reliable. v. More governance was needed to underpin the effective integration of End of Life Care (EoLC). vi. Arrangements for ensuring directors were fit and proper people were deficient.
2.5	In response to these concerns, the Trust had identified 21 actions that needed action to provide safe care for patients in an environment that supported staff and patients which was in line with the standards expected by the Care Quality Commission (CQC).
2.6	The evidence for compliance had been reviewed and where necessary validated by directly reviewing practice and showed that progress had been made in a number of areas. However the nature of some of the actions required (eg significant estates work) meant that full delivery of some of the actions would take longer to deliver, embed and sustain.
2.7	The Board re-confirmed its overall commitment to addressing all of the areas of concern covered in the Section 29A notice and welcomed the paper which clearly set out progress and where work was still required. The Board noted progress with compliance with the Mental Capacity Act and Deprivation of Liberties Safeguards, as well as improvement with End of Life Care, agreeing that a number of improvements had been made though more work was still required. The CEO explained that a new Recovery Board had been established particularly in response to the Trust being placed in Financial Special Measures. Whilst its current focus was the development of the Financial Recovery Plan, once this had been submitted its scope would be widened to oversee and scrutinise the Trust's financial and quality improvement programme.
2.8	The Board briefly discussed the likely timing of a re-inspection by the CQC and received the report.
Performance & Quality Report	
2.9	The DCOO presented the Performance Report advising that the Four Hour standard for

	March was 88.60% and the year ended on 91.86%. Capacity in the Emergency Department (ED) remained a significant issue and had contributed to a number of breaches (activity was 1.5% higher year to date) though plans to increase the triage area would improve flow and overall capacity within ED.
2.10	The Board was briefly updated on the Elective Care Recovery Plan (ECRP) which was reviewing and revalidating patients on elective waiting lists. A number of patients had waited in excess of 52 weeks and the impact of these long waits on their health and need for treatment was being assessed. The Board concurred that it needed to monitor the situation closely and looked forward to receiving its first detailed report in June 2017.
2.11	It appeared that there had been an increase in grade 3 and 4 pressure ulcers though the Board was reassured that this was as a result of conducting a look back exercise; there had been no material increase in the number and grade of pressure ulcers. However it did note a deterioration in MRSA compliance and the CN advised that she would present a report to the Quality Committee to understand the reasons behind this.
TB.04.05.17/29	**Provide a report to the Quality Committee on the increase in MRSA cases.** **LEAD: Chief Nurse**
2.12	The Board noted that concerns remained with the Trust's complaint handling service. The CN agreed though explained the work she was doing to examine the complaints handling process to see where improvements could be made – particularly in learning lessons and preventing recurrence of issues as well as improving the complaints handling process. She would bring a report back to the Board in due course.
TB.04.05.17/30	**Present a report to the Board on complaints handling and where improvements can be made in both the complaints handling process and learning lessons.** **LEAD: Chief Nurse**
2.13	The Board received the report.
3.Finance	
2016-17 Outturn Report	
3.1	The Acting CFO reported that the Trust's 2016-17 Revenue Outturn was a £73.9m deficit against a baseline forecast outturn of £76m (excluding £5m recycling of fines). This was a £2.1m improvement against the forecast though this was mainly due to one-off accounting adjustments and the underlying position was an in-month deficit of £6.6m. Work was still required to understand the drivers of the deficit.
3.2	The Board received the report.
Report from the Finance Committee	
3.3	The Committee Chairman expressed concern that the Trust had started the new financial year without a final budget. She also queried if a £60m cost improvement programme (CIP) for 2017-18 was realistic and achievable.
	The Executive advised that there had been a reduction in spend on agency and interim workers and a drive to fill vacant posts with substantive staff. Furthermore more controls were being introduced through the Programme Management Office to validate this year's CIPs and give greater confidence in their delivery; once CIPs were confirmed, their value was removed from baseline budgets. Considerable work was underway on analysing CIP opportunities (for both income generation and cost saving) and once this had been completed, the Executive would have more confidence in the deliverability of the CIP target for the year.
3.4	In closing, the Board concurred that staff involvement and engagement in CIP delivery was vital as these targets would only be achieved through the combined effort of staff, management and the Executive working together.

4.Workforce	
Workforce Performance Report	
4.1	The HRAB presented the Workforce Performance Report for March 2017 which showed: i. Overall agency spend for 2016-17 was £43.32m against a cap of £24.54m. The Trust was determined to operate within the agency cap and had set an internal target of £22m against an agency cap for 2017-18 (and 2018-19) of £24.54m. ii. Appraisal compliance had increased to its highest level of 80% for non-medical and 85% for medical staff. iii. Mandatory and statutory training (MAST) compliance remained at the target of 85%. iv. The reasons for gender and ethnicity disparity in Employee Relations cases was being investigated and would be reported through the Workforce & Education Committee (WEC).
4.2	The Board received the report.
Update on Leadership Strategy	
4.3	The incoming Director of HR & OD, Harbhajan Brar, presented a leadership development strategy and implementation plan to improve leadership at all levels in the Trust. He noted that leadership had been highlighted as a weakness by the CQC and the new approach focused on building for critical capabilities: i. Compassionate, inclusive leadership skills ii. Improvement skills iii. Talent Management systems, and iv. Systems leadership skills. He said it was impossible to put a value on such a programme, given the supplementary benefits (eg reduced turnover and sickness, greater staff satisfaction).
4.4	The Board welcomed the strategy and plan which had previously considered at the Workforce & Education Committee. It endorsed this leadership strategy and supported its implementation.
5. Governance & Risk	
Corporate Risk Register	
5.1	This was taken as read. It was agreed to leave this item until the second part of the meeting to discuss in more detail.
IG Toolkit Submission	
5.2	The Board was advised that the Trust maintained Information Governance (IG) Toolkit Level 2 compliance for 2016-17. However it was informed of a significant change in legislation would come into effect by May 2018 (briefing had been provided in the supporting paper).
5.3	There would be a number of far reaching changes. For example, there would be the requirement to appoint a Data Protection Officer (DPO) – this new separate role from the Senior Information Risk Owner and the Caldicott Guardian which had to report directly to the highest management level of the organisation, would not receive instructions on how to perform his or her tasks, and would be protected from disciplinary action. In addition there would be new requirements to adhere to in relation data erasure and portability between organisations.
5.4	Given the significance of the change and the scale of work required to prepare for it, the Board requested to receive a regular report on the IG Toolkit going forwards.

TB.04.05.17/31	**Receive a regular report on the IG Toolkit going forwards and progress on compliance on new IG Toolkit.** **Lead: Chief Information Officer**
Report on Use of Trust Seal 2016-17	
5.5	The report on the use of the Trust Seal from Q2 2016-17 was taken as read and accepted by the Board.
STAFF STORY Giovanni Gambaruto, Medical Devices Co-ordinator, was invited to explain to the Board how he had managed to spend £30m+ capital before the year end. He explained that whilst this had been a challenge, what had made it significantly easier had been the records that he and his team kept of the status of medical equipment in the organisation and their excellent knowledge of the clinical needs of the organisation. As they had first hand knowledge of what was needed and where, he was able to mobilise procurement very quickly. Giovanni was thanked for all his hard work and asked that the Board's thanks be passed on to his team.	
6. CLOSING ADMINISTRATION	
Questions from Public	
6.1	Leslie Robertson mentioned she had tried out one of the newly bought dental chairs in the Maxillofacial unit last week which was very comfortable. She welcomed the CEO and was also pleased to hear the feedback from the Board Walkabouts. She had been on ward inspections organised by Mary Prior, CHECK TITLE, and was disappointed with lack of progress around general refurbishment.
6.2	Hazel Ingram asked for clarification about who pays for patients' treatment if they are sent to a private facility for treatment. She was told that the NHS would pay for this if the referral had been from the NHS. She was also advised that Queen Mary Hospital was an NHS hospital (and part of St George's) rather than a private hospital.
6.3	Finally she raised concerns about children using scooters in the hospital making it very hazardous for visitors, especially the infirm. The Board agreed and the CEO said that the Executive would look into the matter.
Any other Business	
6.4	With no other items of any of any other business, the Chairman closed the meeting.

Date and Time of Next Meeting: Thursday 8 June 2017, from 10:00

Trust Board Public - 08.06.17

Action Ref	Theme	Action	Due	Revised Date	Lead	Commentary	Status
TB.05.01.17/08	**Overseas Visitors and Migrant Cost Recovery Pilot**	Board to receive an evaluation report on the pilot programme to recover costs in two clinical areas (maternity and an elective service) from overseas visitors and migrants who use NHS services but are not entitled to free care. Report to be received in June 2016.	~~TB.08.06.17~~	TB.10.08.17	~~CRO~~ CFO	Advised that this item has been rescheduled as a result of election "Purdah". The pilot study in the elective speciality will now take place after the election and we have given this an indicative timing of TB.10.08.17.	Open
TB.05.01.17/12	**Claims and Insurance**	Present an update report to the March Board meeting (09.03.17) on the Trust's insurance arrangements following the review by an external insurance specialist.	~~TB.09.03.17~~	~~TB.06.04.17~~ ~~TB.04.05.17~~ Q2	HoG	This item is still subject to an internal review though is planned for discussion at EMT in June following which it will be reported to the Board.	Open
TB.09.02.17/16	**Local Escalation Plan**	Updated Local Escalation Plan to be circulated to the Board following its approval by the CEO and Chair on behalf of the Board.			DCOO	No update available at the time of publication.	Open
TB.09.03.17/18	**Additional Payments**	Brief the Board on the implications of the changes to additional payments on income, activity and patient safety, by service line, at its next meeting.	~~Board.06.04.17~~	TB.04.05.17	DCOO	No update available at the time of publication.	Action Re-Opened
TB.09.03.17/19C	**Integrated Performance Report**	Over time, produce an Integrated Performance Report which triangulates metrics on finance, quality and performance, with qualitative and quantitative analysis, and an assessment of outturn by month and year end position.	Under Development		COO and CN	This report is subject to regular revision and review to improve the format and layout and provide the information that the Board will find useful to oversee and challenge performance. However until it fully triangulates information it is suggested that this action remains open.	Open
TB.09.03.17/21	**Board Workshop**	Organise Board workshop on risk to enable all members of the Board in identifying and agreeing strategic risks.	~~Board.06.04.17~~	Q2 2017-18	Trust Sec & CN	Action re-opened at 04.05.17 Board meeting as the Board concluded that a risk workshop still needed to be organised. At present the timing of this is being discussed with the external partner which will be supporting the Trust in it's review of governance arrangements. It is likely to be Q2.	Action Re-Opened
TB.06.04.17/26	**Staff Engagement**	Present a paper on staff engagement at the May 2017 Board meeting.	Q1 2017-18		HRAB	Timing of item under discussion - though the EMT received a briefing on an outline approach to staff engagement on 24.04.17.	Open
TB.06.04.17/27	**Staff Survey**	Present the results of the Staff Survey and the action plan to address feedback from staff at a future meeting of the Board.	Q1 2017-18		HRAB	Staff Survey Results on the agenda for TB.08.06.17. The action plan will be presented to the Board at TB.06.07.17.	Open
tb.04.05.17/28	**Elective Care Recovery Programme**	Board to receive a regular report on the progress of the Elective Care Recovery Programme.	TB - Monthly		ECRPD	On the agenda for TB.08.06.17 and a monthly report will be provided to the Board.	Proposed for Closure
TB.04.05.17/29	**MRSA**	Provide a report to the Quality Committee on the increase in MRSA cases.	QC.26.07.17		CN	Not yet due.	Open
TB.04.05.17/30	**Complaints Handling**	Present a report to the Board on complaints handling and where improvements can be made in both the complaints handling process and learning lessons.	EMT.26.06.17		CN	A paper is scheduled for presentation to EMT.26.06.17 following which it will either be presented to the Quality Committee or Board.	Open
TB.04.05.17/31	**IG Toolkit**	Receive a regular report on the IG Toolkit going forwards and progress on compliance on new IG Toolkit.	TB.06.07.17		CIO	The CIO has confirmed that the first of the regular briefings will be presented to the July Board.	Open

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	8 June 2017	**Agenda No.**	**2.1**
Report Title:	Quality Improvement Programme Update		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse & Director of Infection Prevention & Control		
Report Author:	Chris Evans, QIP Project Manager		
Presented for:	Assurance		
Executive Summary:	This paper provides an update on the status of the QIP established to support quality and innovation within practice, and move the trust to a position whereby the next CQC assessment in 2017/18 records an improved position for the five domains and the trust is, as a result, released from the special measures regime for quality.		
Recommendation:	The Board are asked to note and discuss progress of the QIP delivery and progress with reframing the QIP.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	Failure to make the necessary improvements to patient safety and care across the whole trust which is required to release the trust from special measures for patient safety and quality (CQC Assessment in 2017/18)		
Legal/Regulatory:	(ii) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; (iii) The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015; (iv) Care Quality Commission (Registration) Regulations 2009; and (v) The Health & Social care Act 2012, the NHS Provider Licence General Condition 7 – Registration with the Care Quality Commission.		
Resources:	See paper		
Previously Considered by:	N/A	**Date:**	
Equality Impact Assessment:	N/A		
Appendices:	Appendices A and B		

QUALITY IMPROVEMENT PROGRAMME UPDATE
Trust Board, 8 June 2017

1.0 PURPOSE

1.1 Update on the Quality Improvement Programme (QIP) status following the QIP Board meeting held on 30 May 2017.

1.2 Summarise development of core KPIs and reporting on outcome measures (changes/ improvements at service level – target completion June 2017).

1.3 Outline work in progress to define projects and set baseline metrics with trajectory targets (30 day, 60 day, 90 day, and 120 day, to 180 day achievements – target completion June 2017).

1.3 Highlight resource requirements in order to advance QIP implementation and delivery, aligned to Financial Recovery programme.

2.0 BACKGROUND

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

2.2 The Quality Improvement Plan forms part of NHS Improvement's enforcement undertakings and, in this regard, the trust is required to undertake a programme of work, with detailed trajectories and outcome measures which will define at which point we will be ready to: (i) provide NHSI with assurance that we have addressed the 'must do' actions to the CQC's satisfaction; (ii) is no longer considered by CQC to be inadequate in the well-led domain and overall; and (iii) has improved against all domains rated as inadequate or requires improvement when compared to the CQC's inspection findings.

2.3 Following publication of the CQC report, the Quality Improvement Plan was developed and structured into eight workstreams which delivered against set actions through the 2016/17 financial year.

2.2 During April and May 2017 the QIP has been reviewed and restructured into five programmes of work, each with revised workstreams and projects which are being further developed and re-launched across the Trust during June 2017.

3.0 ASSURANCE UPDATE & QIP PMO RESOURCES

3.1 This paper provides an update on the status of the QIP established to support quality and innovation within practice, and move the trust to a position whereby the CQC assessment scheduled for 2017/18 records an improved position for the five domains and the trust is, as a result, released from the special measures regime for quality of care and patient safety. The Board is asked to note the finalised QIP Framework in Appendix A and the exception report in Appendix B.

3.2 The delivery of the reframed QIP will require project management support within the overall PMO.

4.0 IMPLICATIONS

Risks

4.1 Failure to make the necessary improvements to patient safety and care across the whole trust which is required to release the trust from special measures for patient safety and quality (CQC Assessment in 2017/18).

Legal Regulatory

4.2 Compliance with:

(vi) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;
(vii) The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015;
(viii) Care Quality Commission (Registration) Regulations 2009; and
(ix) The Health & Social care Act 2012, the NHS Provider Licence General Condition 7 – Registration with the Care Quality Commission.

5.0 NEXT STEPS

5.1 Reporting through newly established **weekly** QIP Board oversight aligned to Financial Recovery programme timescales and reporting formats commences next week (7 June 2017), underpinning this will be bi-weekly workstream meets reviewing the progress and development of the individual projects in order to maintain grip during a period of intense work.

5.2 QIP workstreams will be fully operationalized by the end June 2017 (subject to resourcing), which will include each project having agreed ToR for its delivery, Driver Diagrams developed to inform project focus, agreed KPI/metrics for monitoring outcomes with set baselines and aspirational trajectories agreed for the next 30 day, 60 day, 90 day, 120 day, to 180 day periods.

6.0 RECOMMENDATION

6.1 The Board are asked to note and receive the assurances in this paper.

Author: **Chris Evans, QIP Project Manager**
Date: **30/05/2017**

St George's University Hospitals NHS
NHS Foundation Trust

APPENDIX A

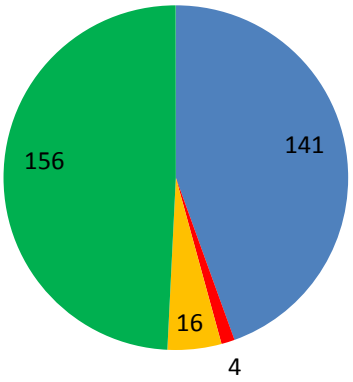
PROGRAMMES	WORKSTREAMS	PROJECTS		
Current Focus	Fundamentals of Care – Helen McHugh & TBC	Risk Assessments	Infection Control	Compassion
Safe & Effective Care (Avey Bhatia)	End of Life Care – Alison Benincasa & Katherine McGowan	Implementation	Access	Care Coordination
	Dementia, MCA & DoLs – Jeremy Isaacs, Maxine Armantrading & David Flood	MCA Compliance	Use of Bedrails	Carer Access
	Patient Safety – Renate Wendler & Helene Anderson	Observations	Sepsis	WHO Checklist
	Medicines Management – Chris Evans, Wendy Pullinger & Vinodh Kumar	Drug Omissions	Environment	Controlled Drugs
Led by Financial Recovery Plan	Patient Flow – Lisa Pickering, Tracy Holmes & Heather Jarman	Ambulatory Care	SAFER	Const. Standards
Flow & Clinical Transformation (Fiona Ashworth)	Theatres – Tunde Odutoye & Tim Price	Environment	Efficiency	
	Outpatients – Justin Richards & Gavin James	Environment	Efficiency	Communication
	RTT – Diana Lacey & Stewart Reeves	RTT		
Further informed by Deliotte Review	Floor to Board Governance – Fiona Barr & Paul Linehan	Governance	Data Intelligence	Risk Management
Quality & Risk (Andy Rhodes)	Complaints Management – Avey Bhatia & Andy Rhodes	Responsiveness	Quality Monitoring	Efficiency
	Learning from Incidents – Renate Wendler & Paul Linehan	Divisional Process	Learning	Thematic Reviews
	Clinical Records – Richard Lau & Mark Hamilton	Information Governance	Storage and Access	
Enablers	Estates Recovery Plan – Sharon Welby	Recovery Plan Delivery	QIP Delivery Support	
Estates & IT (Richard Hancock)	IT Strategy – Larry Murphy	10 Year Plan Delivery	QIP Delivery Support	
	Innovation –Larry Murphy & Richard Hancock	Infrastructure Innovations and Solutions		
Engagement & Leadership (Jacqueline Totterdell)	Leadership & Culture – Harbhajan Brar	Org. Development	IHI Programme	Leadership
	Engagement – Karen Daly, Mark Hamilton, Chris Rolfe	Staff Engagement	Pinch Point Work	Stakeholders

APPENDIX B

QIP EXCEPTION REPORT

CURRENT PROGRAMME STATUS

PROGRAMME	R	A	G	TOTAL
Safe & Effective Care	4	3	46	**53**
Flow & Clinical Transformation	0	7	34	**41**
Quality & Risk	0	1	50	**51**
Estates & IT	0	0	6	**6**
Engagement & Leadership	0	5	20	**25**
TOTAL	**4**	**16**	**156**	



Out of a total of 317 actions: 141 have been delivered (44.48%), 156 (49.21%) are on track to deliver, 16 (5.05%) are delayed but still expect to deliver, and 4 (1.26%) are at significant risk to delivery

Workstream Milestone & Deliverable	Target date	Revised completion date	BRAG Status March	BRAG Status 22/05/17	Comment
Local managers to produce a schedule of cleaning responsibility listing all items to be cleaned and to identify who is responsible for cleaning each item. Patient facing equipment generally to have one full clean daily and a clean between patients. Staff to document cleaning with signed, dated green "I am clean tape". Environmental audits to provide assurance of compliance.	01/02/2017	01/07/2017	R	Red - Overdue	The National guidance on cleaning and decontamination has been incorporated in the Trust Decontamination policy. Evidence is being sourced that the policy has been ratified and is now operational. Action flagged as red due to the initial target date for completion being missed and no evidence to date supplied to the QIP PMO to substantiate policy is operational, that environmental audits have been consistently carried out, and as such outcomes have improved in relation to equipment cleaning.
Review where Curtains or screens used to screen the beds within clinical areas to ensure they fit correctly.	31/12/2017	11/06/2017	R	Red - Overdue	There remain ten wards where inappropriate curtains are still in place, delays during the procurement phase have resulted in a revised completion date as the curtain rails are currently being adjusted to the relevant height each weekend, with work due to complete in June.
Engage with Diabetes team to lead on this programme of education and address poor insulin awareness through discussion with nursing staff as needed during ward Medication Safety Visits.	31/03/2017	01/07/2017	R	Red - Overdue	Training programme sessions initially undertaken in March, no further progress has been made in improving training levels so action flagged as red and is being challenged following the QIP Board meeting on 30 May 2017
85% compliance with VTE/anticoagulation training on MAST for all clinical staff. In addition to develop bespoke and refresher training	31/03/2017	01/07/2017	R	Red - Overdue	MAST programme developed and available for use, staff groups on MAST to be confirmed. Completion data moved to 01/07/2017 action raised at PSQB and additional action required to confirm staff groups

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality and Performance Report for Trust Board

Trust Board – 8th June 2017
Reporting period - April 2017

Excellence in specialist and community healthcare

Quality and Performance Executive Summary

Are we safe? (pages 5-11)

In April the Trust reported one patient with hospital attributable Clostridium Difficile Infection which is an improved position on the previous months . There were also two patients who acquired an MRSA Bacteraemia. Root cause analysis is undertaken for each case to ensure that any opportunities for learning are captured and appropriate actions taken to prevent similar avoidable infections in the future. Each case is also reviewed by a Consultant Microbiologist and the Director of Infection Prevention & Control.

We continue to protect our patients from 'new harms' as evidenced when benchmarking our position national Our incidents of serious harms (including never events) has reduced. However, there has been an increase in patients with grade 3 pressure ulcers within cardiology. A number of actions have been taken to support improvement in this areas with additional support from the Tissue Viability team.

Are we effective? (pages 12-15)

The Trust continues to be better than the standard for weekday and weekend Hospital Standard Mortality ratio and also HSCIC. Total bed occupancy remained above the target of 85% in April, with 86.5% of beds occupied at midnight in general and acute wards. Length of stay remains consistent. Data from Dr Foster shows the trust has a readmission rate of 9% which is above the average of 7.2% (average based on region. This is predominantly due to readmission following a non-elective spell where we are currently performing at 12.7% against an expected position of 9%, however the rate remains consistent and within upper and lower confidence limits.

Are we caring? (pages 16-19)

The number of complaints received in April has decreased however we remain below the standard for 25 day response rate. The management of complaints is currently under a review with a proposed new way forward which will focus on how we engage with complainants and learn from complaints . The Friends and Family Test recommendation rates for Inpatients, A&E and outpatients remains above locally agreed target and this coupled with good response rates provides a level of assurance for patient experience . This also needs to be triangulated with other patient experience feedback that we receive i.e. patient experience surveys.

Are we responsive (pages 20-27)

Work to improve the management of patient flow is continuing with a focus on expansion of the ambulatory care provision. The aim is to increase the number of patients who can be seen, assessed and treated on an ambulatory pathway without the need for inpatient admission. Thereby improving the patient experience as well as our ability to deliver the Four Hour Operating Standard. The performance for April has improved with 90.5% of patients attending A&E seen and discharged, transferred or admitted within four hours of arrival.

6 out of 8 cancer standards were met in March with 2ww and breast symptomatic not met. April performance is not submitted until June, however, it is predicted that 2ww will not be met. Recovery plans are in place with all relevant specialties. There has been improvement in the 62 day standard for the last three quarters and this is predicted to be met in April.

A daily review of on the day cancellations is undertaken in order to identify opportunities to avoid non clinical cancellations which should only occur in exceptional circumstances. Avoiding cancellations is essential element in improving the patient experience as well as improving theatre productivity.

Are we well-led? Pages (28-32)

Staff sickness remains above the trust target of 3%, although there has been a reduction over the last 2 months. The number of staff attending the Trust core Mandatory and Statutory Training ("MAST") topics has increased and is now above the target of 85%. The exception is Information Governance which is currently 81%. Capacity to delivery resuscitation training is currently under review.

Staff appraisal rates remain below target for both medical and non-medical appraisals and Divisions, although improved on previous months.

Individual Performance Reviews and MAST will be monitored through Divisional Performance Reviews.

Trust Overview

Effective	Mortality Indicators	Excellent	Excellent	Stable	The Trust continues perform well against the standard for weekday and weekend Hospital Standard Mortality ratio and better than national expectations
	Length of Stay	On Track	On Track	Stable	
Caring	Admitted Patient Experience	Excellent	Excellent	Stable	
	ED Patient Experience	Excellent	Excellent	Stable	
	Single Sex Breaches	Excellent	Excellent	Stable	
	Complaints	Significant	Significant	Stable	Reduction in the number of patient complaints received, improvement to be made in the timeliness of responding to complaints. This is being challenged within divisions
Responsiveness	Emergency Department Access	Significant	Significant	At Risk	ED operational target remains below the national target however performance was met against the STP target in April, achieving 90.5%. Works to be carried out in ED to improve Assessment space will generate improvements within the ED environment and performance.
	Cancer Access	Moderate	Moderate	Stable	Recovery plans and trajectories are in place and TWR is forecast to recover from June 2017. 62 Day performance remains better than national target
	Diagnostic Access	Significant	Significant	At Risk	6 week diagnostic performance continues to be a challenge and the trust is currently reporting 4.1% against the 1% target, and recovery plans are in place for modalities underperforming capacity
	Bed Capacity and Management	Moderate	Moderate	Stable	Bed occupancy remains stable. The expansion of the Ambulatory Care model will further reduce occupancy and limit short-stay admissions over the next months. The continued presence of Medically-Fit patients is impacting on Bed Occupancy as well as causing financial impact through increased premium staffing required to manage approximately 80-90 patients daily with no requirement to be within the Trust.
	Cancelled Operations	Significant	Significant	At risk	The number of patient procedures cancelled on the day has reduced in the month of April. Continued focus and improvement work is on-going.
Well Led	Staff Experience	On Track	On Track	At Risk	
	Workforce Indicators	Significant	Significant	At risk	Division have been requested to set trajectories for Mandatory and Statutory training and with improved focus appraisal rates have increased
	Safe Staffing	Moderate	Moderate	Improving	
Operational Dependencies	Activity Volumes	Moderate	Moderate	At Risk	Activity volumes are recalibrating as that activity not requiring to come to a tertiary centre is repatriated to other local Trusts, and GP referrals are following those pathways increasingly.
	Data Quality	Significant	Significant	At risk	Data Quality Project is improving overall validation, as well as delivery of training programme to improve the inputs within the PTLs, thus gradually improving the quality of data provided to management teams.

The trust is currently reviewing additional indicators for inclusion which will be incorporated in forthcoming reports

Scorecard Assessment Key

Management priority

Significant	An externally reported metric is below standard and therefore significant interventions are planned or in progress due to one or more factors
Moderate	An important internal metric is below agreed level and therefore moderate interventions are planned or in progress
Minor	Trends are adverse therefore some interventions are in place or in progress
On Track	All areas are on track
Excellent	Targets consistently met

Forecast

At Risk	Performance expected to worsen by next reporting period
Stable	Performance not expected to change significantly by next reporting period
Improving	Performance expected to improve by next reporting period

Statistical Process Control Charts

Performance against each indicator is shown as a Statistical Process Controls (SPC) chart. The purpose of these charts is to provide a simple view of performance over time, as well as an indicator of whether any variation in performance or activity is statistically important or not.
Each chart consists of four factors:

1) The run chart indicator, showing performance by month from April 2015 (blue line)
2) Average (mean) performance during the time period (green line)
3) Upper and lower control limits (UCL and LCL), which set out an expected range of variation for performance. Performance beyond these limits suggests a level of variation during the time period

In this month

	Apr-17	Compared to last Year: Same Month	Compared to last Year: YTD
The Trust received….			
 Patients Referred from Primary Care (GP)	9,777	-25.9%	-25.9%
 Patients seen following Urgent Cancer Referrals	1,207	-0.7%	-0.7%
The Trust treated….			
 Patients Attending ED	14,246	3.71%	3.71%
 Non Elective Patients Admitted	4,311	4.1%	4.1%
 Patients attending 1st Outpatient appointment	14,694	-17.2%	-17.2%
 Patients Admitted for Day case treatment	2,842	-5.9%	-5.9%
 Patients admitted for Elective treatment	1,305	2.3%	2.3%

SAFE Domain Scorecard

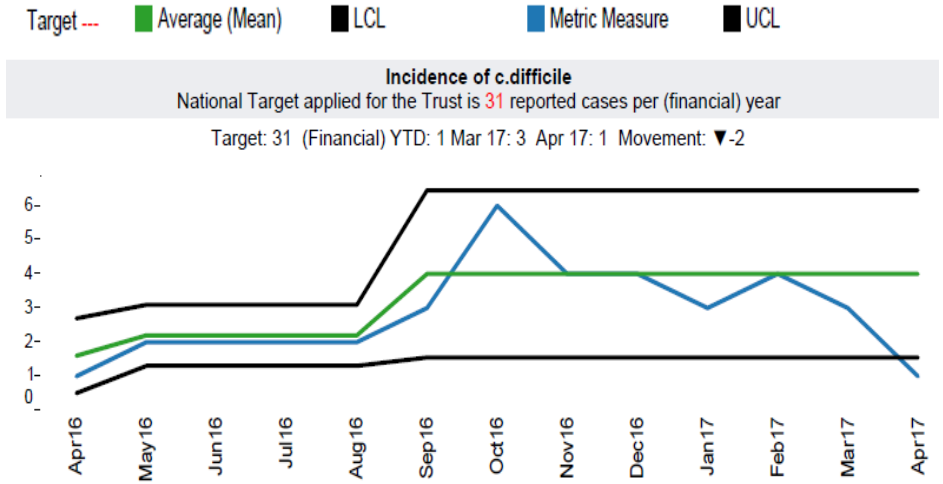
Executive Lead: Avey Bhatia, Chief Nurse

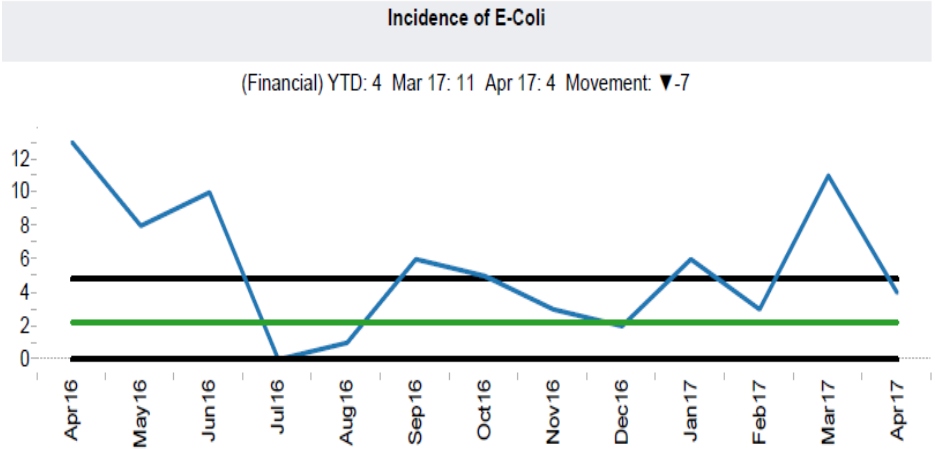
Theme	Indicator	Units	Period	Target	National or Local	Mth Rag Rating	Feb-17	Mar-17	Apr-17	Variance	YTD Total
Infection Control	Clostridium Difficile	Number	Apr-17	31	Local		4	3	1		1
	MRSA bacteraemia cases	Number	Apr-17	0	National		1	0	2		2
	Incidences of E Coli	Number	Apr-17	N/A	N/A		3	11	4		4
	Incidences of MSSA	Number	Apr-17	N/A	N/A		2	2	3		3
	Cleaning & Decontamination Audit	%	Apr-17	95%	Local		97.70%	95.43%	93.09%		93.09%
	Hand Hygeine Audit	%	Apr-17	95%	Local		96.54%	95.27%	91.45%		91.45%
Incident Reporting	Total number of serious incidents reported	Number	Apr-17	N/A	N/A		6	8	5		5
	Total number of Never Events	Number	Apr-17	0	National		1	0	0		0
	Overdue CAS Alerts	Number	Apr-17	0	National		1	1	1		1
	Maternal Deaths	Number	Apr-17	0	National		0	0	1		1
	Medication errors causing serious harm	Number	Apr-17	0	National		0	0	0		0
Harm Free Care	Number of falls per 1000 occupied bed days	%	Apr-17	<3%	Local		1.05%	1.10%	0.81%		0.81%
	Total number of patient falls*	Number	Apr-17	N/A	N/A		137	154	105		105
	Attributable Grade 2 Pressure Ulcers per 1000 occupied days	%	Apr-17	N/A	N/A		0.21%	0.14%	0.13%		0.13%
	Attributable Grade 3 & 4 Pressure Ulcers per 1000 occupied bed days	%	Apr-17	0.00%	Local		0.02%	0.02%	0.02%		0.02%
	VTE Risk Assessments Completed	%	Mar-17	95%	National		96.46%	96.25%	95.33%		95.33%
	Bed Rails Audit	%	Apr-17	95%	Local		93.12%	88.98%	96.01%		96.01%
	Percentage of Harm Free Care	%	Apr-17	95%	National		95.80%	94.35%	94.19%		94.19%
	Percentage of NEW Harm Free Care	%	Apr-17	95%	National		97.59%	98.00%	97.98%		97.98%

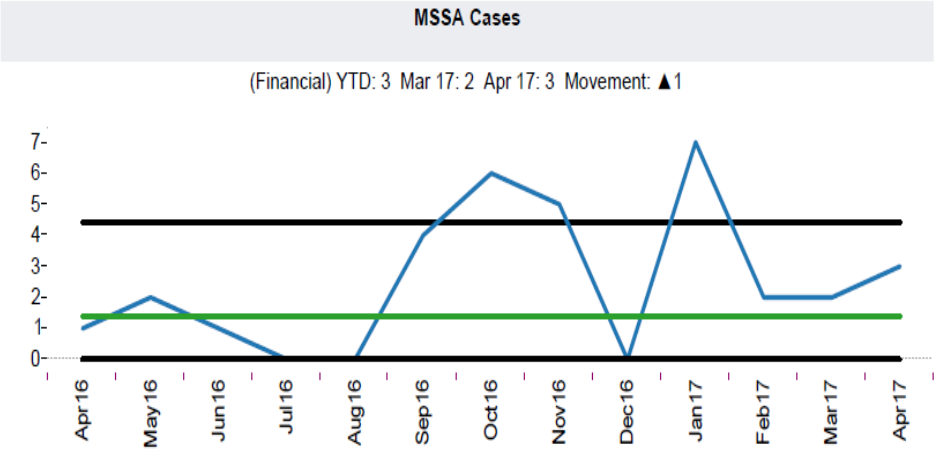
SAFE – Infection Control & Cleanliness

Briefing:

There was 1 patient reported with a hospital acquired CDifficile in April occurring on the Neuro Intensive Care Unit. The threshold for 2017/18 remains the same as previous year at 31 cases. Also in the month of April, 2 patients cases of MRSA were identified within Richmond AMU and Vernon Ward against a ceiling of zero. An urgent review of these cases is being completed for presentation to the Director of Infection Prevention and Control.







SAFE – Infection Control & Cleanliness

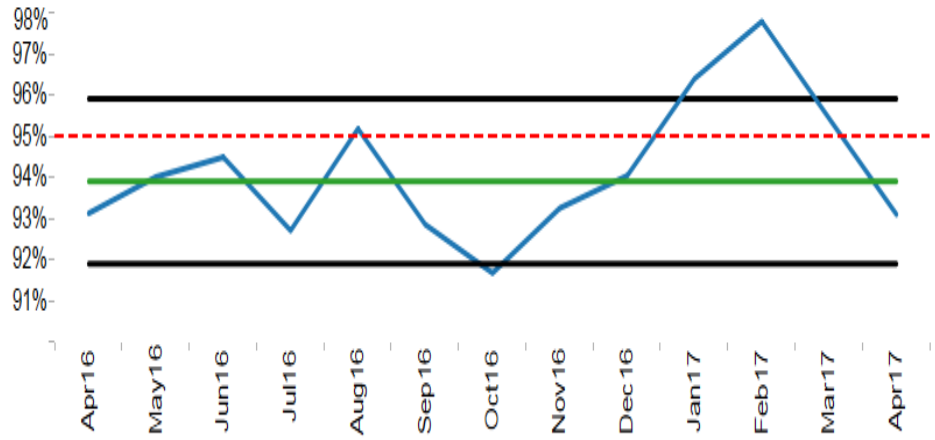
Briefing: For April the position for cleaning and decontamination has fallen below target reporting 94.2% against a target of 95%. Hand Hygiene has also dipped below target of 95% reporting 91.45% for April. An external review is expected to take place by NHS England (NHSI) and the Clinical Commissioning Group (CCG) infection control leads to review standards of practice and compliance against the hygiene code.

The infection Control team is currently recruiting a support nurse for 6 months to focus on Hand Hygiene compliance and education across professional groups.

Target --- Average (Mean) LCL Metric Measure UCL

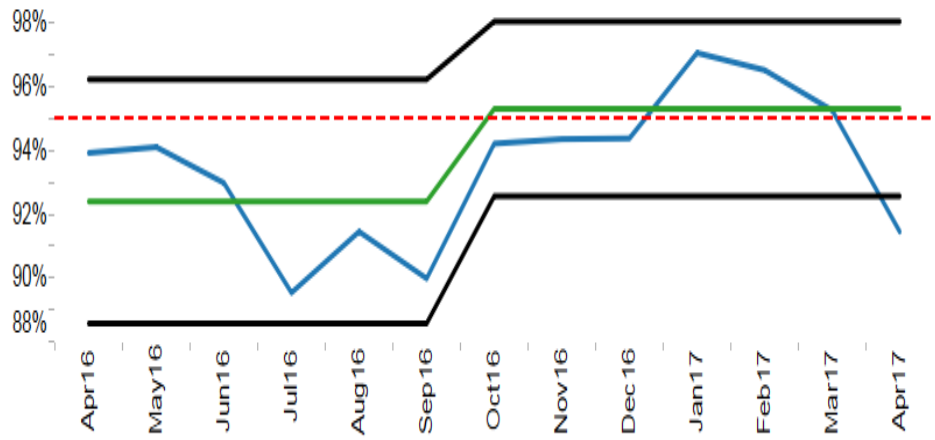
Saving Lives Audits - Cleaning and Decontamination

Target: 95% (Financial) YTD: 93.09% Mar 17: 95.43% Apr 17: 93.09% Movement: ▼-2.34%



Saving Lives Audits - Hand Hygiene

Target: 95% (Financial) YTD: 91.45% Mar 17: 95.27% Apr 17: 91.45% Movement: ▼-3.82%



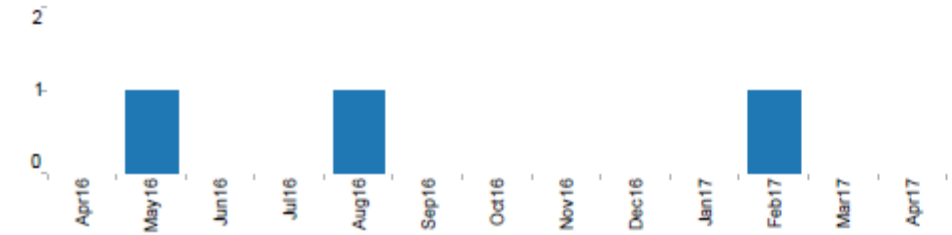
SAFE – Incident Reporting

Briefing:

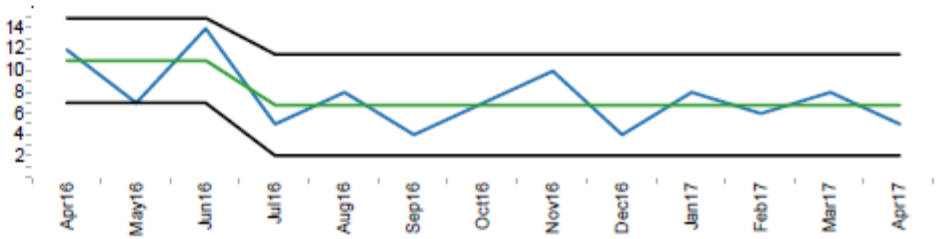
- For two consecutive month, March and April there have been no never events.
- For three consecutive months Feb-April there have been no medication errors causing serious harm to our patients.
- There were 5 Serious Incidents (SI's) declared in April 2017, all active SI's are within the deadline (none overdue)

Target --- Average (Mean) LCL Metric Measure UCL

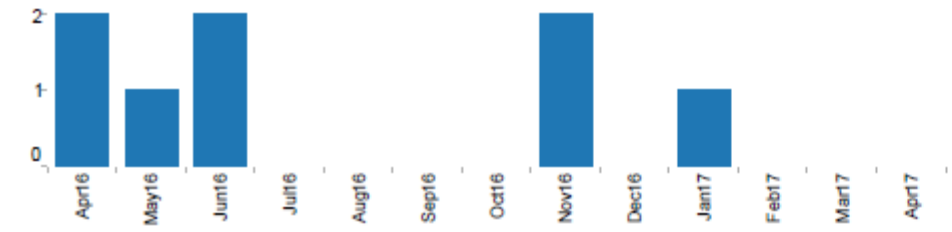
Never Events
Serious Incidents that are wholly preventable Target is zero
Target: 0 (Financial) YTD: 0 Mar 17: 0 Apr 17: 0 Movement: ▸0



Serious Incidents
Number of serious incidents reported Target is zero
(Financial) YTD: 5 Mar 17: 8 Apr 17: 5 Movement: ▼-3



Medication Errors Causing Serious Harm
Patient safety incidents of type medication error, resulting in severe harm or death reported to the National Reporting and Learning Service (NRLS) by provider. Target is zero
Target: 0 (Financial) YTD: 0 Mar 17: 0 Apr 17: 0 Movement: ▸0

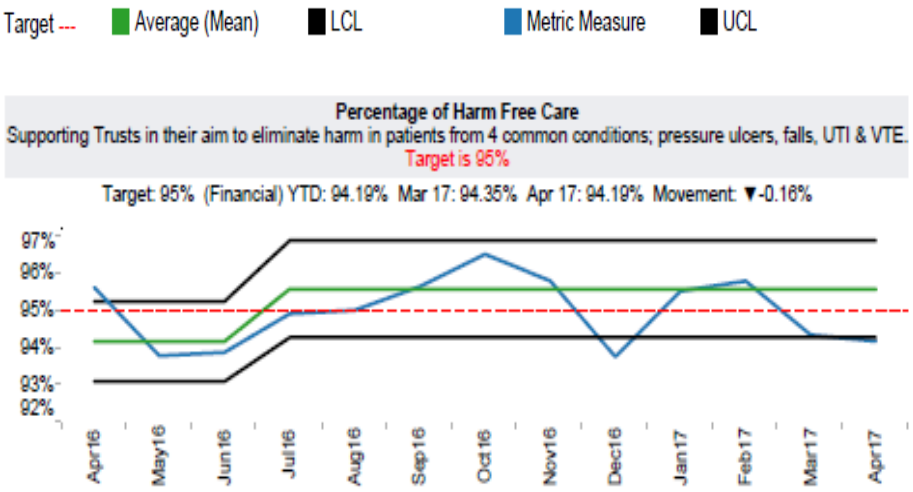


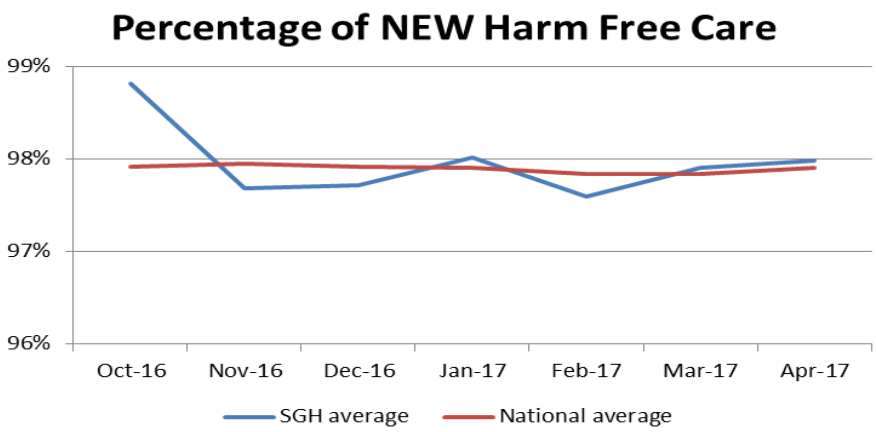
SAFE – Harm Free Care

Briefing:

We continue to protect our patients from 'new harms' as evidenced when benchmarking our position nationally.

In April the percentage of all harm free care was marginally below target reporting for all harms at 94.19% against the target of 95%.





SAFE – Falls and Pressure Ulcers

Briefing:

A total of 105 patients experienced a fall within the trust in April, although the percentage of falls per 1000 occupied bed days remains below national average.

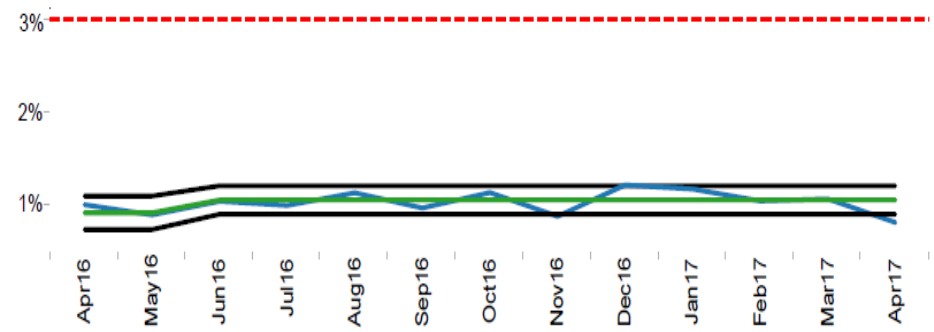
The number of patients with grade 2 pressure ulcers attributable to the trust also fell in month. All Grade 2 pressure ulcers are being investigated as Serious Incidents and the Tissue Viability team will be reviewing them as a cluster to establish any wider learning. However, this has increased slightly for avoidable grade 3 and 4 ulcers with two grade 3 pressure ulcers reported in April in Belgrave Ward and Heart Failure Unit. These have been declared as Serious Incidents for investigation and initial learning relates to poor compliance with the PUP

Target --- Average (Mean) LCL Metric Measure UCL

Falls Per 1000 Occupied Bed Days

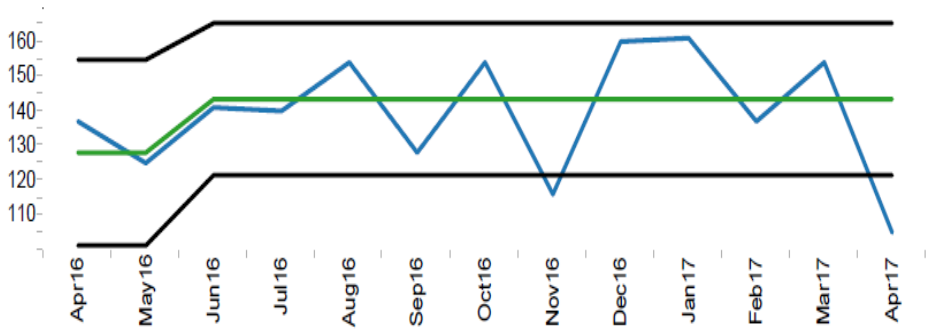
Number of Beds Occupied Per 1000 Bed Days Target is <3%

Target: <3% (Financial) YTD: 0.81% Mar 17: 1.07% Apr 17: 0.81% Movement: ▼-0.26%



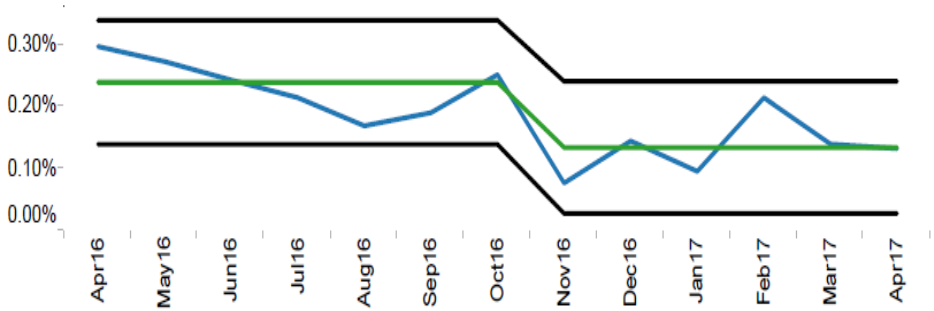
Total Patient Falls

Target: 0 (Financial) YTD: 105 Mar 17: 154 Apr 17: 105 Movement: ▼-49



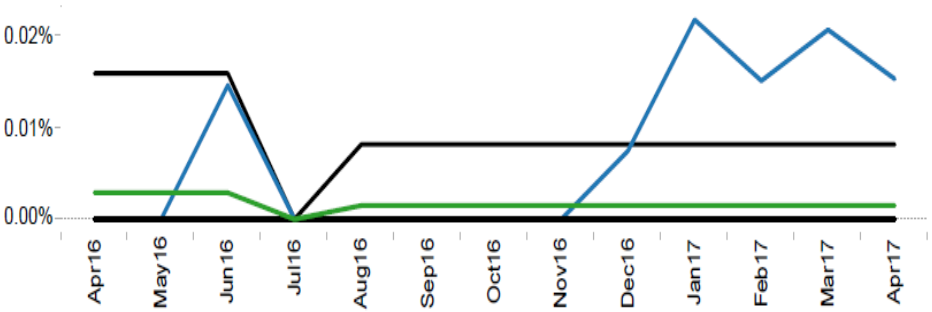
Attributable Grade 2 Pressure Ulcers per 1000 Occupied Bed Days

Target: 0% (Financial) YTD: 0.13% Mar 17: 0.14% Apr 17: 0.13% Movement: ▼-0.01%



Attributable Grade 3 and 4 Pressure Ulcer per 1000 Occupied Bed Days

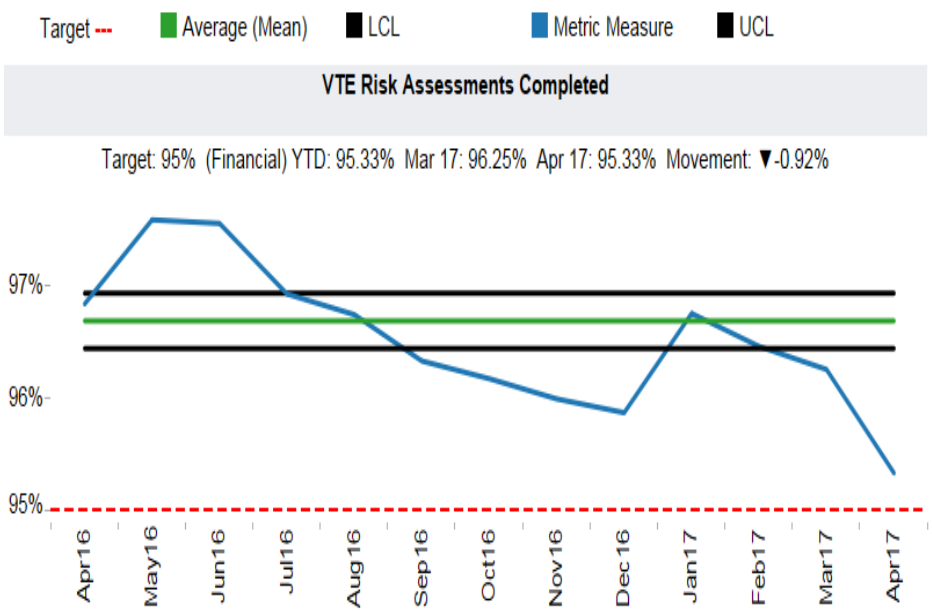
Target: 0% (Financial) YTD: 0.02% Mar 17: 0.02% Apr 17: 0.02% Movement: ▸0.00%

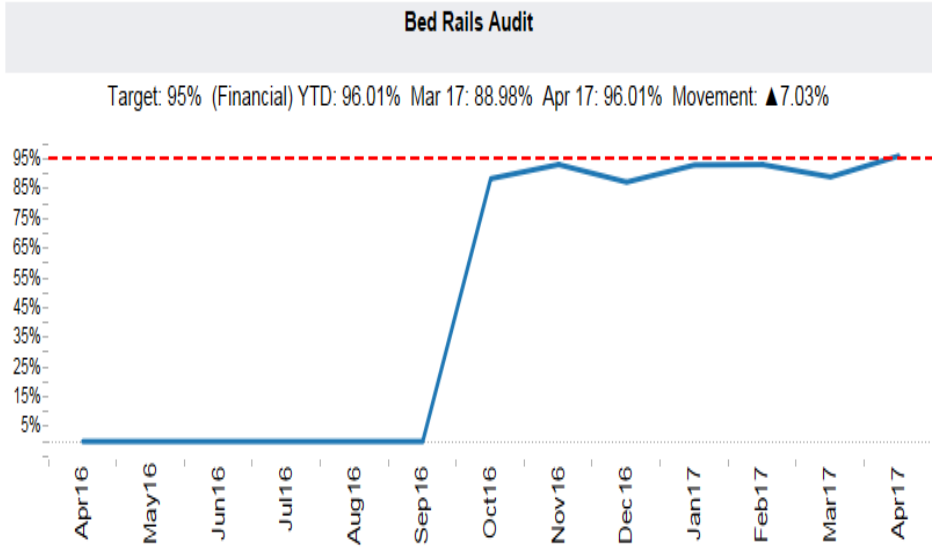


SAFE – Harm Free Care

Briefing:

- In April, 95.3% of our patients had a Venous thromboembolism (VTE) risk assessment completed. This is better than the national target of 95%.
- Monthly bed rail audits show an improvement in month, increasing from 88.98% in March to 96.1% in April. A review of the audit tool has been completed to ensure clarity of questions due to inaccurate completion of the tool. Ward Managers and Matrons for areas that have low compliance have been emailed with the results to ensure improvements with data collection and compliance with the audit. The bed rails audit has also been incorporated into the ward quality dashboard for monitoring at ward level and reporting through Divisional Meetings



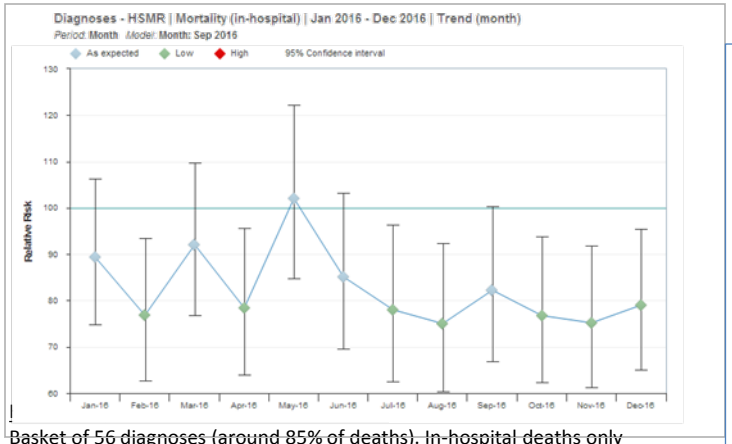


EFFECTIVE Domain Scorecard

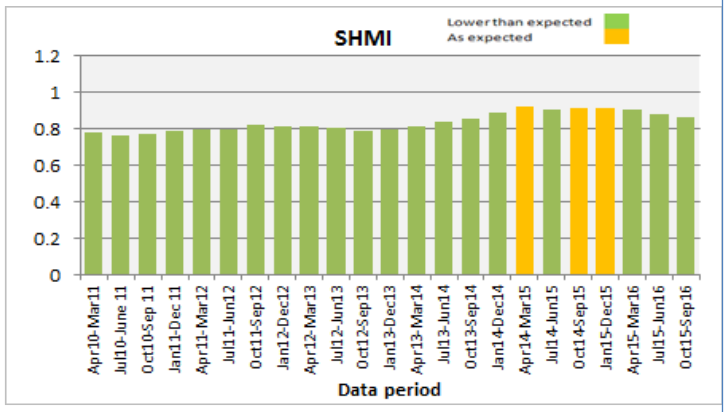
Executive Lead: Andy Rhodes, Medical Director

Theme	Indicator	Units	Period	Target	National or Local	Mth Rag Rating	Feb-17	Mar-17	Apr-17	Variance	YTD Total
Mortality Indicators	Hospital Standardised Mortality Ratio (HSMR)	%	Apr-17	100	National		83	82.5	83.5		N/A
	Hospital Standardised Mortality Ratio Weekday Emergency	%	Apr-17	100	National		79.9	79.2	80.1		N/A
	Hospital Standardised Mortality Ratio Weekend Emergency	%	Apr-17	100	National		85.6	84.2	86		N/A
	Summary Hospital Mortality Indicator (HSCIC)	%	Apr-17	100	National		0.9	0.9	0.86		N/A
Length of Stay	Length of Stay Elective	Number days	Apr-17	4	Local		3.8	3.9	4		N/A
	Length of Stay Non Elective	Number days	Apr-17	5	Local		4	4.3	3.9		N/A
Occupancy	Bed Occupancy General & Acute	%	Apr-17	<85%	Local		92.4%	91.1%	86.8%		N/A
Re-admission	Emergency Re-admissions within 30 days following an elective spell at provider	%	Apr-17	TBC	Local		5.0%	4.5%	4.0%		N/A
	Emergency Re-admissions within 30 days following an non-elective spell at provider	%	Apr-17	TBC	Local		14.3%	13.0%	12.8%		N/A

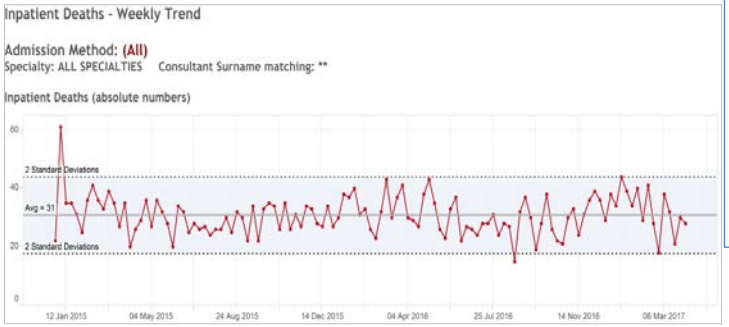
EFFECTIVE - Mortality



Basket of 56 diagnoses (around 85% of deaths). In-hospital deaths only
Adjusted for more factors, including palliative care



SHMI: summary hospital-level mortality indicator
All English acute non-specialist providers. All deaths in hospital and within 30 days of discharge



Risk-adjusted Mortality remains stable. HSMR remains better than expected: Jan 16 – Dec 16 = 82.5 with SHMI Oct 15 – Sep 16 = 0.86 – lower than expected. Raw mortality is monitored daily and remains stable within usual limits.

The committee has 'real-time' monitoring of deaths by date and by day of admission; the committee reviews all deaths following elective admission, and scrutinises all deaths in mortality signals that arise in analysis of Dr Foster data. Recent completed reviews include analysis of deaths following #NOF, crushing injury, atherosclerosis, septicaemia, and CABG (other). Reviews are triangulated with the SI process and one death from this month's reviews was investigated as an SI. There has been learning including the importance of documentation of pre-operative assessment, the challenges of discussing operative risks in extremely ill patients, and improved interaction with coding teams in cardiology and GICU to improve information. The mortality monitoring committee has independently screened 34% of all deaths for learning, and to identify areas to strengthen this year.

Learning from Deaths https://www.england.nhs.uk/ourwork/part-rel/nqb/ (published 15/3/17).

The framework stipulates that board should ensure their organisation: has board-level leaders (exec and non-exec) to take responsibility for 'learning from deaths'; has a systematic approach to identifying deaths requiring review and selecting other patients whose care they will review including vulnerable patients; adopts a robust and effective methodology for case record reviews of all selected deaths ensures case record reviews and investigations are carried out to a high quality; ensures that mortality reporting in relation to deaths, reviews, investigation and learning is regularly provided to the board (a dashboard has been provided to support reporting); ensures learning is acted on to sustainably change practice and improve care and reported in Quality Accounts (from June 2018); ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time to review and investigate deaths; offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to responding to a death;

A number of immediate priorities for the next two months have been identified, which include:

- A nominated non-executive director to provide oversight of progress;
- collect and publish quarterly information on deaths, including those deaths subjected to case record review and how many were judged to have been due to problems in care;
- training of Divisional staff in the use of the RCP structured judgement review (SJR) and the implementation of learning disability (LeDeR) review process;
- ensure that our policy on responding to deaths is clear and supports the organisation to deliver its duties and meet the new requirements;
- To review governance arrangements and processes. This is underway and as a key first step we are finalising arrangements to ensure there is a dedicated full-time resource (person) available to support the AMD for mortality to deliver this broad programme of work, both in collating the data, facilitating the reviews and dissemination of learning; this is currently being negotiated.

Through addressing these urgent actions we will develop a plan for implementation of all aspects of the guidance.

Deaths following time in hospital, England, October 2015 – September 2016

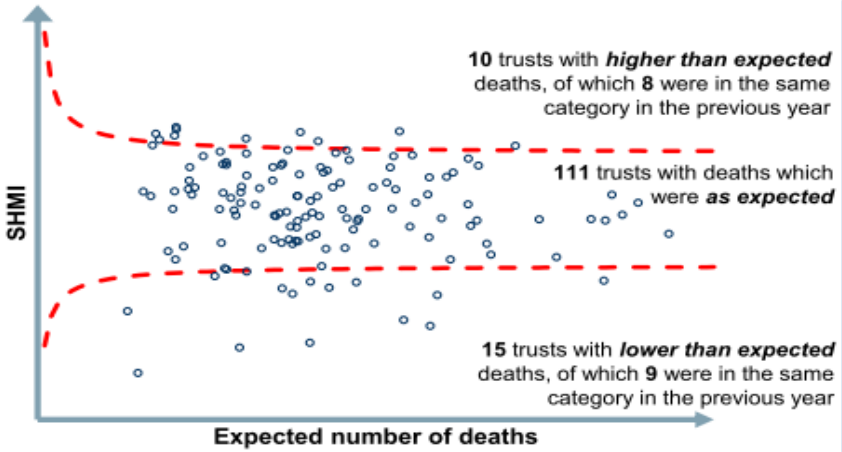
Quarterly statistics: Published 23rd March 2017

NHS Digital

This publication compares the actual number of deaths following time in hospital with the expected number of deaths, using the Summary Hospital-level Mortality Indicator (SHMI).

The expected number of deaths is estimated using the characteristics of the patients treated; age, sex, method of admission, current and underlying medical condition(s). It covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged.

Between October 2015 and September 2016, there were approximately 8.9 million discharges, from which 286,000 deaths were recorded either while in hospital or within 30 days of discharge for the 136 hospital trusts covered. This includes deaths from other causes as well as deaths related to the reason for the hospital admission.



The 10 trusts with a ***higher than expected*** number of deaths were:

- **Blackpool Teaching Hospitals NHS FT**
- **Dorset County Hospital NHS FT**
- **George Eliot Hospital NHS Trust**
- Gloucestershire Hospitals NHS FT
- Pennine Acute Hospitals NHS Trust
- **South Tyneside NHS FT**
- **Southend University Hospital NHS FT**
- **Weston Area Health NHS Trust**
- **Wrightington, Wigan and Leigh NHS FT**
- **Wye Valley NHS Trust**

The 15 trusts with a ***lower than expected*** number of deaths were:

- **Barts Health NHS Trust**
- **Cambridge University Hospitals NHS FT**
- **Chelsea and Westminster Hospital NHS FT**
- **Guy's and St Thomas' NHS FT**
- Homerton University Hospital NHS FT
- **Imperial College Healthcare NHS Trust**
- Kingston Hospital NHS FT
- London North West Healthcare NHS Trust
- Poole Hospital NHS FT
- Salford Royal NHS FT
- St George's University Hospitals NHS FT
- **The Whittington Hospital NHS Trust**
- **Torbay and South Devon NHS FT**
- **University College London Hospitals NHS FT**
- **West Suffolk NHS FT**

Trusts in **bold** were also in the same category in the same period in the previous year. 'FT' means 'Foundation Trust'.

The SHMI was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust.

It is used along with other information to inform the decision making of trusts, regulators and commissioning organisations.

The SHMI is not a measure of quality of care. A *higher/lower than expected* number of deaths should not immediately be interpreted as indicating poor/good performance and instead should be viewed as a '**smoke alarm**' which requires further investigation.

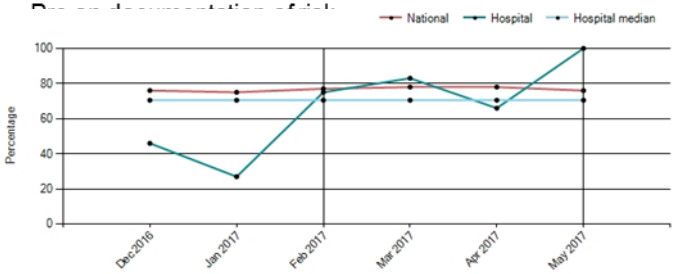
The SHMI cannot be used to directly compare mortality outcomes between trusts and it is inappropriate to rank trusts by their SHMI.

See the full release at http://digital.nhs.uk/pubs/shmioct15sep16 **0300 303 5678** **ISBN 978-1-78386-973-2**

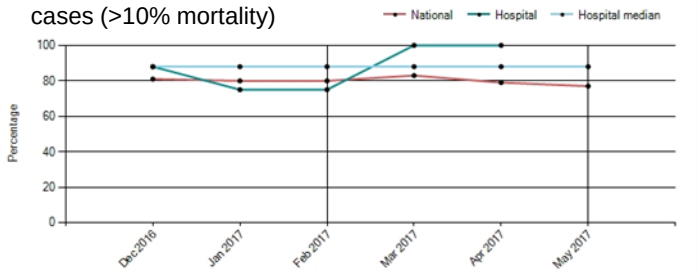
Responsible Statistician: Sally Harrison **enquiries@nhsdigital.nhs.uk**

Audit performance- Dec 16 - May 2017

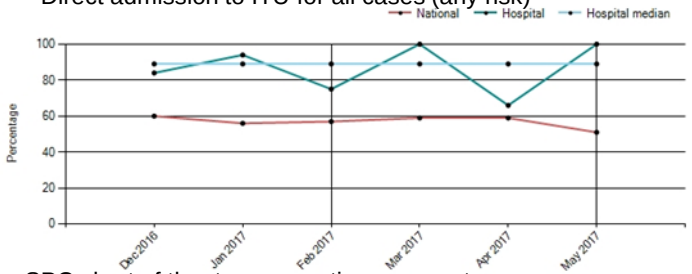
Metric	CQC domain	Year 4 (Dec '16- 15 May '17) Performance and comments
Case ascertainment- completion of audit data is assessed annually and RAG rated against HES data	Well led	Year 4 performance has improved dramatically from year 3. 70% data is filled in by clinical teams, with the remainder caught by the ITU ICNARC nurse or NELA lead anaesthetist, so total return is 100%. IT infrastructure in theatres so clinicians to access web portal is crucial to data capture and an on-going risk. Data entry burden for the clinical lead is
Pre op documentation of risk of death Patients should have objective risk scoring, to guide intra-op and post op management	Effective	There has been consistent improvement in year 4, (Y3 completion was <10%), due to changing electronic booking form and building awareness. There is emerging evidence from studies that risk assessment is a useful tool to improve teamwork and ensure patients access the correct standards of care.
Access to theatres in appropriate timescale NCEPOD urgent classification cases- access in <6 hours, NCEPOD immediate- <2 hours	Responsive	Since Dec, 78% patients have been reaching theatre in appropriate timescale. 8 patients waited longer than is clinically indicated for their surgery. Recent changes to the electronic theatre booking form should support timely access, and give some indication to the underlying cause of delays.
Consultant surgeon and anaesthetist present in theatres if >5% predicted mortality	Effective	90% cases meet this standard. This is a consistently strong area of performance for St Georges.
Cases >10% predicted mortality admitted to high dependency	Safe	GICU aim to take patients with risk of death >5%, 100% patients meeting admission internal standard. We are amongst the best performers nationally.
Length of stay	Not reported to CQC	Average LoS Dec to Mar is 20 days, median 12 days. LoS could be improved by provision of care of the elderly liaison into emergency surgery. The NELA lead and surgical governance lead have requested management assistance to provide this.
Mortality	Effective	In hosp mortality Dec 16-Mar 17 is 10.2%. (last year 10.8%) Average predicted risk of death was 21.4% (p possum). This data lags behind other measures as it is completed after discharge mainly by the NELA lead.



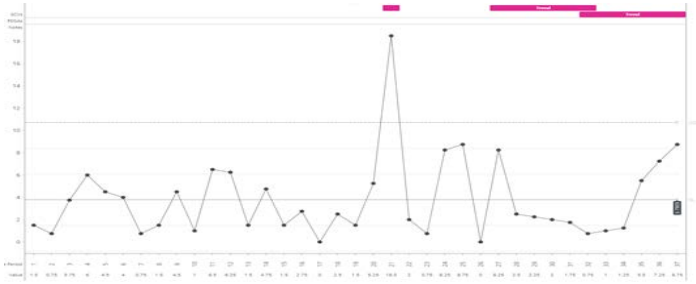
Consultant anaesthetist and surgeon present for high risk cases (>10% mortality)



Direct admission to ITU for all cases (any risk)



SPC chart of theatre access times- urgent cases

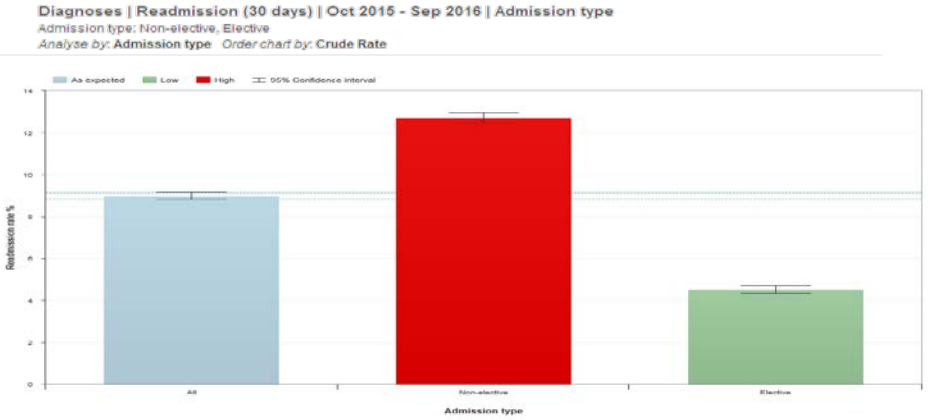


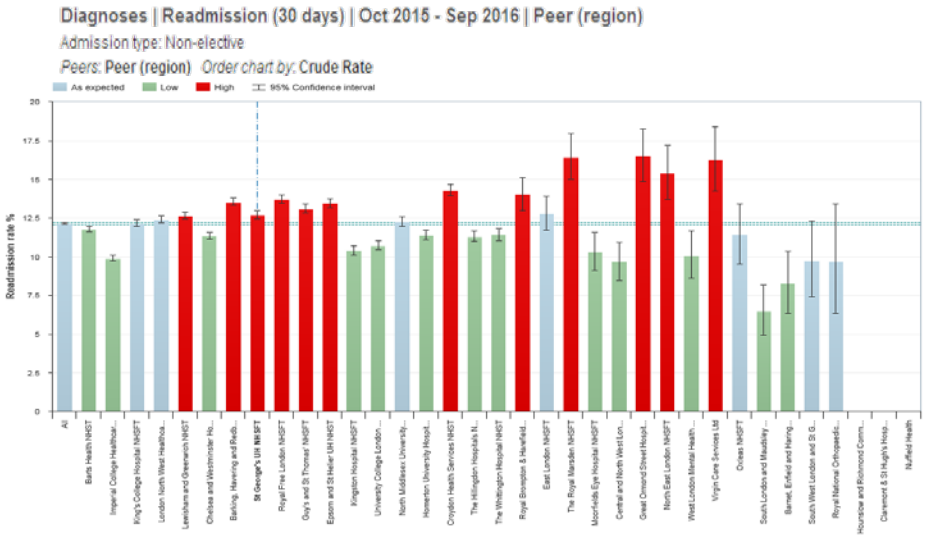
EFFECTIVE – Readmission Rates

Briefing: Data below summarises the Trusts re-admission rate within 30 days following either an emergency or elective patient spell in hospital. Data is shown over a 12 month period from November 2015 – October 2016 (as available on Dr Foster) this shows that during this period on average 9% of our patients were readmitted with in 30 days of admission.

This higher rate is predominantly due to readmission following a non elective spell where we are currently performing at 12.7% against an expected position of 9%. However this rate remains consistent and within upper and lower confidence limits. Detailed analysis shows higher readmissions rates are experienced within the diagnoses groups of Cancer, Hematologic conditions, lung disease and mental health disorders. Readmission following an elective stay is better than our expected position at 4.5%.

Admission Type	Month	Spells	Observed	Crude rate (%)	95% lower confidence limit	95% upper confidence limit
All		116,818	10,413	9.0	8.8	9.2
Non Elective Total	All	63,938	8,042	12.7	12.4	13.0
	Nov-15	5,181	675	13.1	12.2	14.0
	Dec-15	5,385	661	12.4	11.5	13.3
	Jan-16	5,228	706	13.6	12.7	14.6
	Feb-16	4,933	564	11.6	10.7	12.5
	Mar-16	5,143	645	12.7	11.8	13.6
	Apr-16	5,163	659	12.9	12.0	13.8
	May-16	5,425	666	12.4	11.5	13.3
	Jun-16	5,466	678	12.6	11.7	13.4
	Jul-16	5,377	649	12.2	11.3	13.0
	Aug-16	5,497	694	12.8	11.9	13.7
	Sep-16	5,555	735	13.3	12.5	14.3
	Oct-16	5,585	710	12.8	12.0	13.7
Elective Total	All	52,880	2,438	4.6	4.4	4.8
	Nov-15	4,439	207	4.7	4.1	5.3
	Dec-15	4,113	210	5.1	4.5	5.8
	Jan-16	4,368	204	4.7	4.1	5.3
	Feb-16	4,504	188	4.2	3.6	4.8
	Mar-16	4,368	185	4.2	3.6	4.9
	Apr-16	4,243	197	4.6	4.0	5.3
	May-16	4,159	205	4.9	4.3	5.6
	Jun-16	4,543	183	4.0	3.5	4.6
	Jul-16	4,352	205	4.7	4.1	5.4
	Aug-16	4,426	213	4.8	4.2	5.5
	Sep-16	4,598	208	4.5	3.9	5.1
	Oct-16	4,767	233	4.9	4.3	5.5

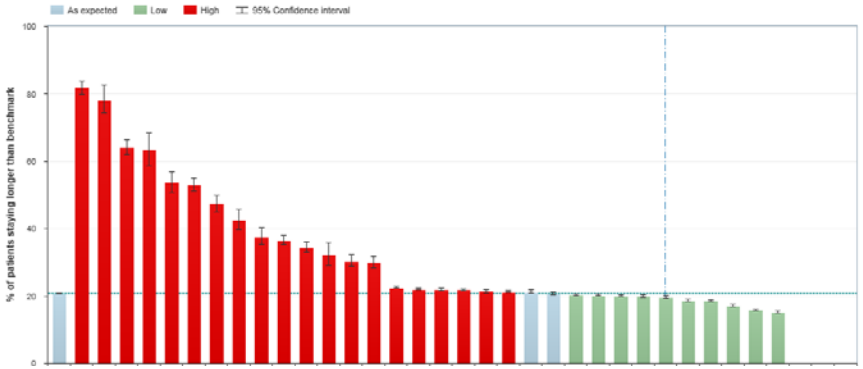




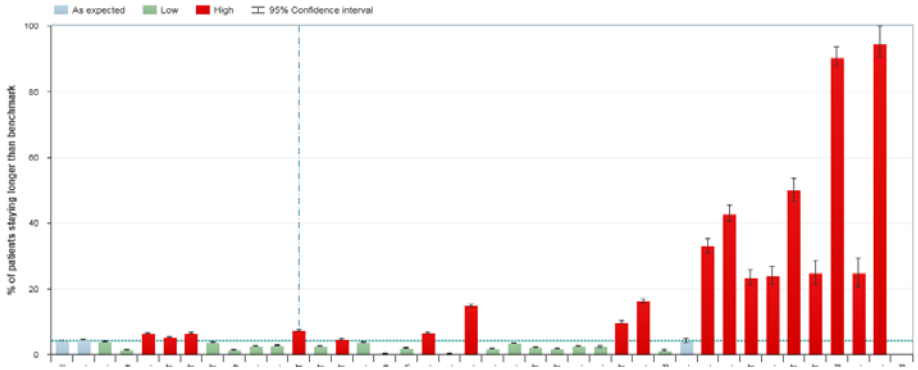
EFFECTIVE – Length of Stay

Briefing: The length of time our patients stay in hospital averaged 4.4 days for the period Feb 16–Jan 2017. This is as expected against Dr Foster benchmarking (taking into account high volume activity) and achieving well against peers. Mean LOS has seen a step change (↓) from April 2016 from 5 days to consistently reporting between 4-4.4 days (on average) Analysis against upper quartile LOS shows that 20% of patients stay longer than benchmark, this is within expected range for non elective admissions and is below other providers.
Elective Stay – Mean LOS is 4 days for the month of April and has seen a slight increase when compared to previous months however performance is comparable with our peers. When benchmarked against upper quartile St George's is higher than expected showing that 7.4% of elective patients stay longer than benchmark against an expected rate of 6.3% and is above national average. Areas above expected range include pain management, total excision of bladder and cystectomy

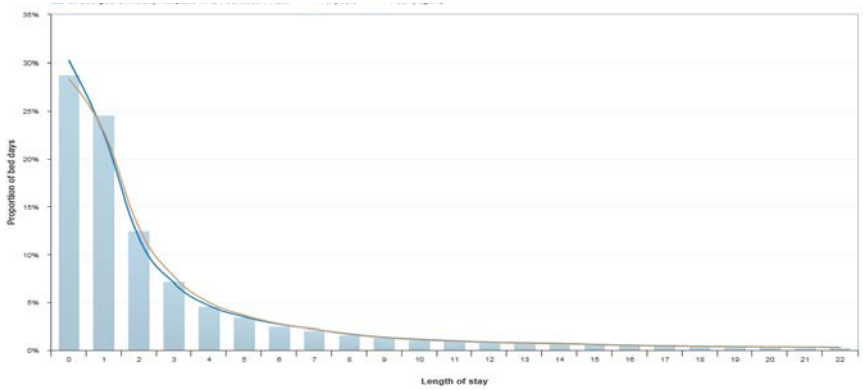
Length of Stay (upper quartile) | Feb 2016 – Jan-17 | Peer (region)
Admission Type: Non Elective



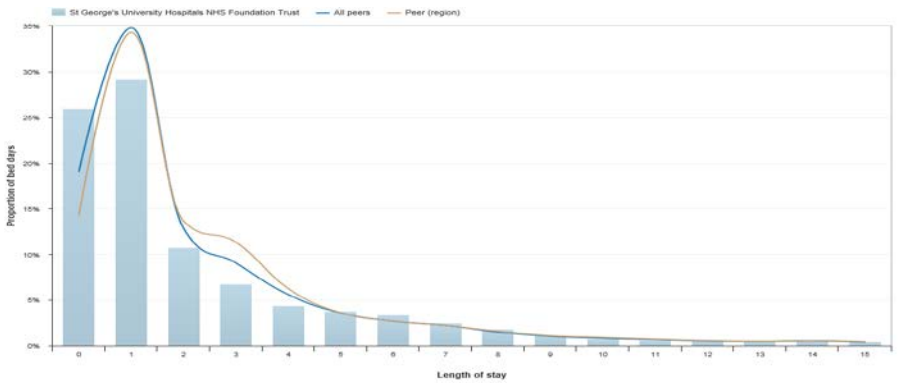
Length of Stay (upper quartile) | Feb 2016 – Jan-17 | Peer (region)
Admission Type: Elective



Length of Stay (average) | Feb 2016 – Jan-17 | Peer (region)
Admission Type: Non Elective | Proportion of Bed Days



Length of Stay (average) | Feb 2016 – Jan-17 | Peer (region)
Admission Type: Elective | Proportion of Bed Days



CARING Domain Scorecard

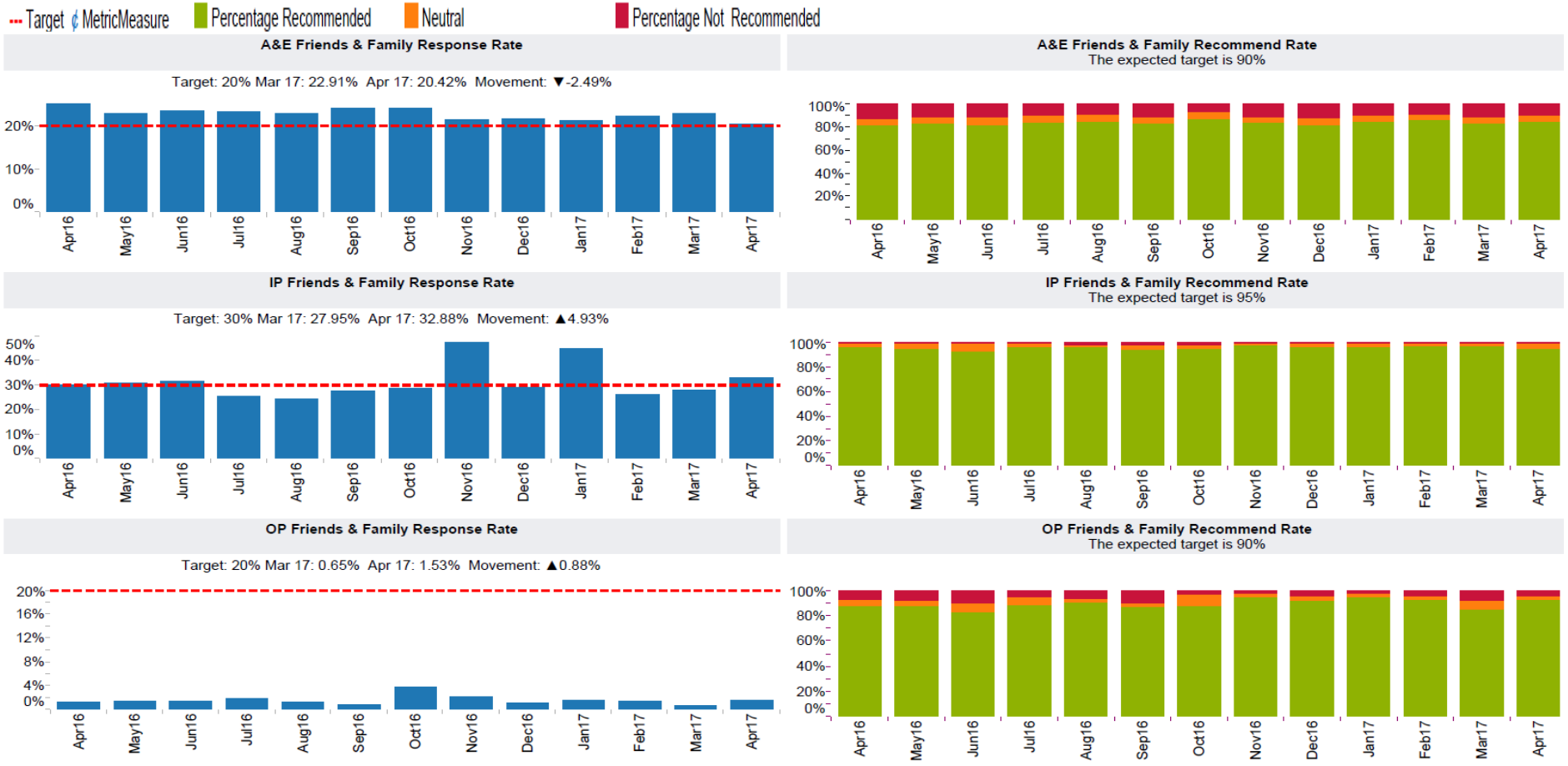
Executive Lead: Avey Bhatia, Chief Nurse

Theme	Indicator	Units	Period	Target	National or local	Mth Rag Rating	Feb-17	Mar-17	Apr-17	Variance	YTD Total
Mixed Sex Accomodation Breaches	Total Number of MSA breaches reported	Number	Apr-17	0	National		0	0	0		0
Friends & Family	FFT Response Rate A&E	%	Apr-17	20%	Local		22.43%	22.91%	20.40%		N/A
	FFT Recommendation Rate A&E	%	Apr-17	90%	Local		86.28%	82.75%	85.00%		N/A
	FFT Response Rate Inpatients	%	Apr-17	30%	Local		26.20%	27.95%	33.00%		N/A
	FFT Recommendation Rate Inptients	%	Apr-17	95%	Local		97%	97%	95%		N/A
	FFT Response Rate Outpatients	%	Apr-17	20%	Local		1.30%	0.60%	1.50%		N/A
	FFT Recommendation Rate Outpatients	%	Apr-17	90%	Local		93%	85%	93%		N/A
	FFT Response Rate Maternity	%	Apr-17	20%	Local		5%	9%	2%		N/A
	FFT Recommendation Rate Maternity	%	Apr-17	90%	Local		89%	97%	89%		N/A
	FFT Response Rate Community	%	Apr-17	20%	Local		2%	0.8%	2.8%		N/A
	FFT Recommendation Rate Community	%	Apr-17	90%	Local		96.2%	93%	95%		N/A
Complaints	Complaints responded to within 25 days	%	Mar-17	85%	Local		72.86%	59.26%			
	Number of complaints with agreed extensions	%	Feb-17	100%	Local		91.43%				
	Total Number of complaints received	Number	Apr-17	N/A	N/A		73	81	67		67
	Total number of PALS received	Number	Apr-17	N/A	N/A		346	294	299		299

CARING – Friends and Family Test

Briefing:

- The trust has set some quite challenging targets internally for the Friends and Family Survey and remains a continued area of improvement for the Trust.
- Emergency Department response rate remains above target of 20% however recommendation rate remains below target of 90% reporting 85% in April.
- Inpatient recommendation rate remains better than target. Plans are in place to further improve on this including additional tablets have been ordered due to wards reporting faults impacting on capturing of response rates. The indicator being added to the ward dashboard and will also be monitored though the hospital operations board.
- Outpatient recommendation rates by our patients are better than target however work is needed to improve the number of responses.



CARING – Friends and Family Test

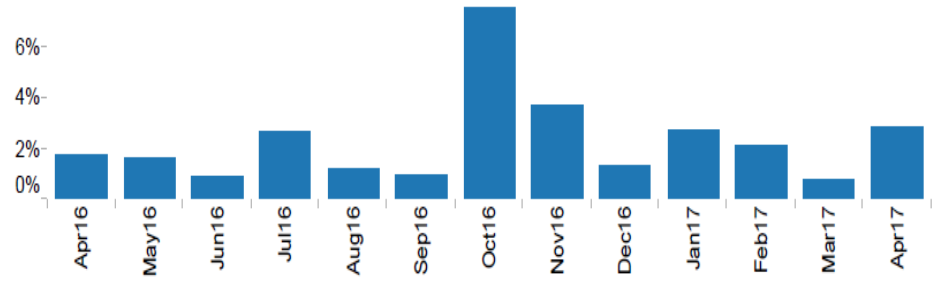
Briefing:

- Our Maternity and Community recommendation rates by our patients are better than the 90% target set.
- In order to improve response rates for community services and outpatients, the option of text messaging is being explored through the out patient transformation programme.
- Community services sample on average 300-400 patients a month, however due to the number of services users this translates to a low sample size. In October the community services will conduct a detailed patient experience survey across the services in line with the commissioning arrangements.

Target ¢ MetricMeasure Percentage Recommended Neutral Percentage Not Recommended

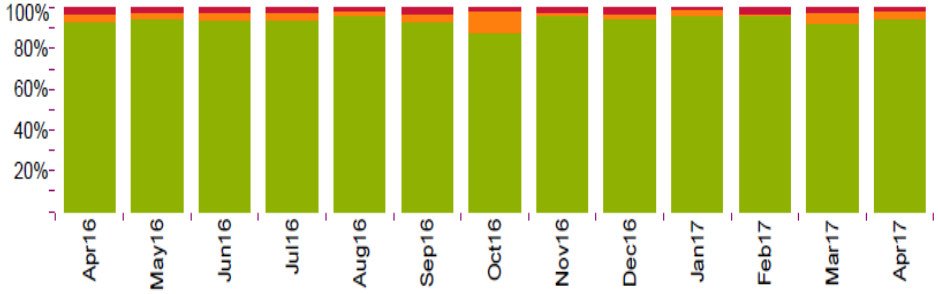
Community Friends & Family Response Rate

Target: 20% Mar 17: 0.77% Apr 17: 2.83% Movement: ▲2.06%



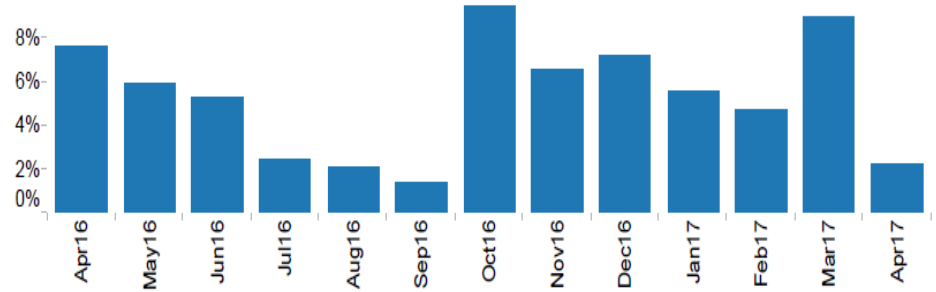
Community Friends & Family Recommend Rate

The expected target is 90%



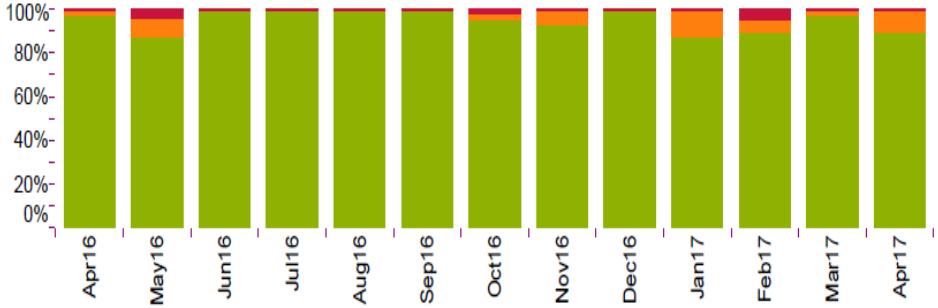
Maternity (Birth) Friends & Family Response Rate

Target: 20% Mar 17: 8.91% Apr 17: 2.23% Movement: ▼-6.68%



Maternity (Birth) Friends & Family Recommend Rate

The expected target is 90%



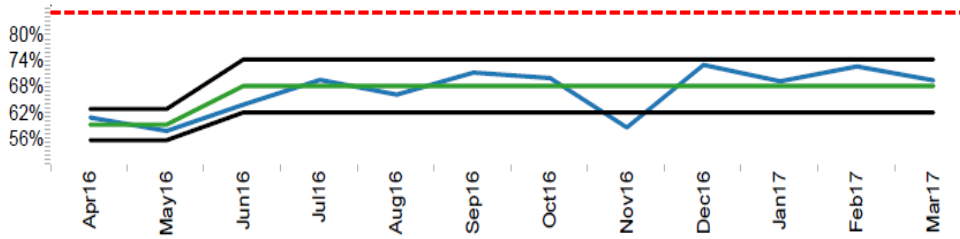
CARING – Complaints

Under review as part of Quality Improvement Plan

Target --- Average (Mean) LCL Metric Measure UCL

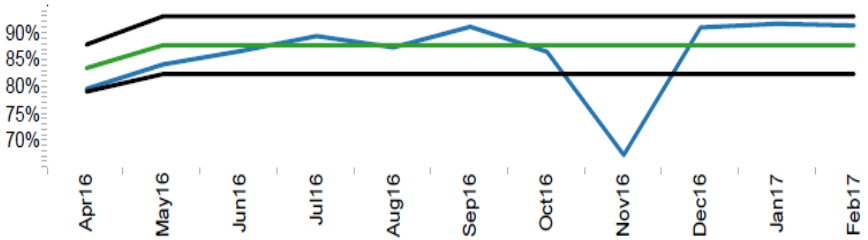
Complaints responded to within 25 days

Target: 85% (Financial) YTD: 66.22% Feb 17: 72.86% Mar 17: 69.62% Movement: ▼-3.24%



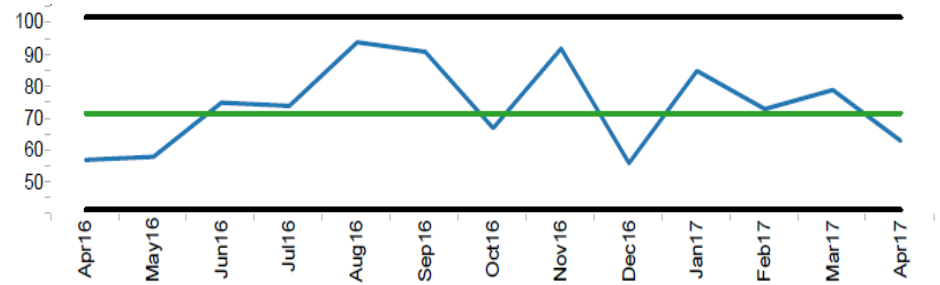
Number of Complaints With Agreed Extensions

Target: 100% (Financial) YTD: 85.91% Feb 17: 91.43% Mar 17: Movement: ▸0.00%



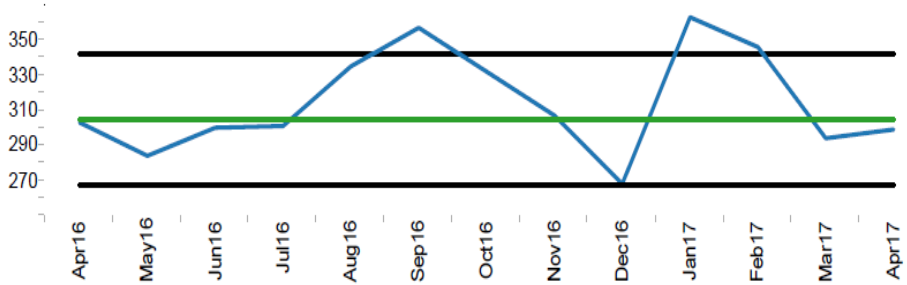
Total Number of Complaints Received

(Financial) YTD: 63 Mar 17 79 Apr 17: 63 Movement: ▼-16



PALS Received at Trust Level

(Financial) YTD: 299 Mar 17 294 Apr 17: 299 Movement: ▲5



RESPONSIVENESS Domain Scorecard

Executive Lead: Sandra Shannon, Deputy Chief Operating Officer

Theme	Indicator	Units	Period	Target	Local or national	Mth Rag Rating	Feb-17	Mar-17	Apr-17	Variance	YTD Total
Waiting Times	4 Hour Operating Standard	%	Apr-17	95%	National		90.59%	88.60%	90.50%		90.50%
	London Ambulance Handovers within 15 minutes	%	Apr-17	100%	National		51.1%	50.2%	46.0%		N/A
	London Ambulance Handovers within 30 minutes	%	Apr-17	100%	National		95.80%	97.60%	96.10%		N/A
	London Ambulance Handovers not completed within 60 minutes	Number	Apr-17	0	National		0	0	0		N/A
	Diagnostic Waits over 6 Weeks	%	Apr-17	99%	National		97.20%	97.10%	95.80%		N/A
	Number of patient procedures cancelled on the day due to non-clinical reasons	Number	Apr-17	0	National		91.00	63.00	58.00		N/A
	% of patients not treated within 28 days of last minute cancellation	%	Apr-17	0%	National		2.20%	11.10%	6.90%		N/A
							Jan-17	Feb-17	Mar-17	Variance	
	Cancer 14 Day GP Referral	%	Mar-17	93%	National		87.90%	87.90%	86.00%		89.88%
	Cancer 14 Day Breast Symptomatic	%	Mar-17	93%	National		94.00%	93.40%	87.20%		92.50%
	31 Day First Treatment	%	Mar-17	96%	National		96.40%	97.50%	96.70%		97.14%
	31 Day First Subsequent Treatment Surgery	%	Mar-17	94%	National		95.10%	100.00%	94.59%		96.91%
	31 Day First Subsequent Treatment Drug	%	Mar-17	98%	National		100.00%	99.00%	100.00%		99.67%
	62 Day Referral	%	Mar-17	85%	National		87.70%	86.60%	86.29%		84.72%
	62 Day Screening	%	Mar-17	90%	National		93.00%	96.20%	92.65%		93.31%
	62 Day Consultant Upgrade	%	Mar-17	85%	National		93.00%	97.60%	85.70%		94.38%

National submission deadline for Cancer standards is one month in arrears, therefore April performance will be submitted early June 2017

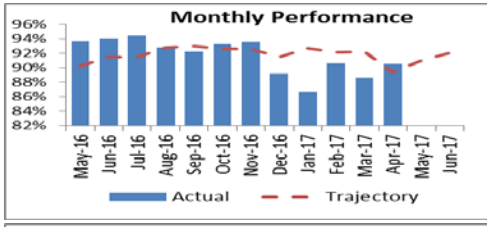
RESPONSIVENESS – Emergency Department

Briefing: Emergency Department - Much work is underway to further improve patient flow (expanding space for ambulatory care) and thus improve patient safety and experience and improve our ability to deliver our performance against the Four Hour Operating Standard. The performance for April has improved and saw 90.5% of patients attending A&E be discharged, transferred or admitted within four hours of arrival.

May-17 performance to date is 89.9% and currently under trajectory. The expansion of triage areas including RAT (rapid assessment triage) has now been completed and continued work to expand ambulatory care and improvement of system wide processes remain a key focus for the executive team.

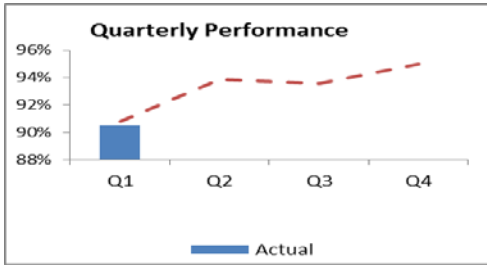
The Sustainability and Transformation Fund Performance against Trajectory

Monthly Actual	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Total Attendances	15,067	14,310	14,752	13,814	14,261	14,558	14,025	14,149	14,057	12,519	14,625	14,246
Attendances<4 Hours	14,105	13,448	13,923	12,811	13,154	13,569	13,114	12,612	12,178	11,341	12,958	12,893
Breaches >4 Hours	962	862	829	1,003	1,107	989	911	1,537	1,879	1,178	1,667	1,353
Performance Actual	93.6%	94.0%	94.4%	92.7%	92.2%	93.2%	93.5%	89.14%	86.63%	90.59%	88.60%	90.5%
Performance Trajectory	90.2%	91.5%	91.4%	92.8%	93.0%	92.6%	92.6%	91.5%	92.6%	92.1%	92.2%	89.4%
Meeting STF	✓ 3.41%	✓ 2.49%	✓ 2.96%	✗ -0.04%	✗ -0.74%	✓ 0.65%	✓ 0.90%	✗ -2.33%	✗ -6.01%	✗ -1.55%	✗ -3.64%	✓ 1.11%

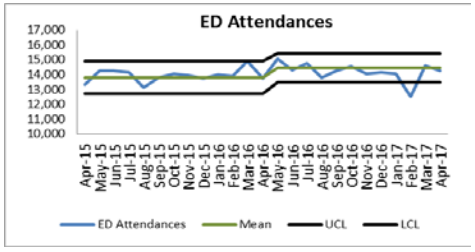


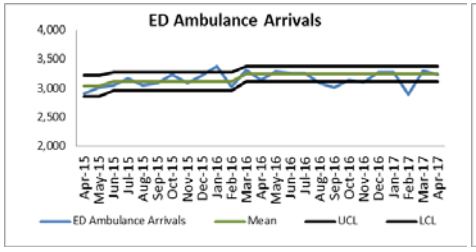
Met STF not National
Not met STF or National
Met STF and National

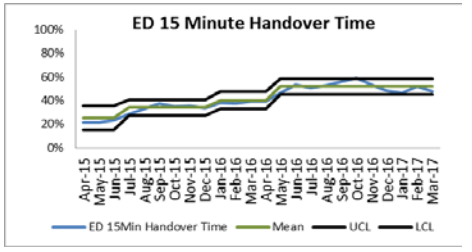
Quarterly Actual	Q1	Q2	Q3	Q4
Total Attendances	14,246			
Attendances<4 Hours	12,893			
Breaches >4 Hours	1,353			
Performance	90.5%			
Performance Trajectory	90.8%	93.9%	93.6%	95.0%
Meeting STF	✗ -0.3%			

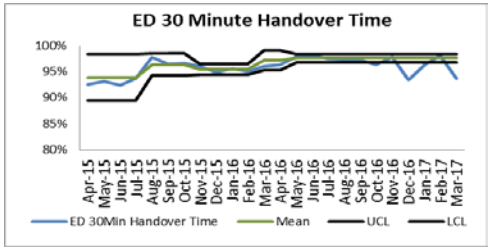


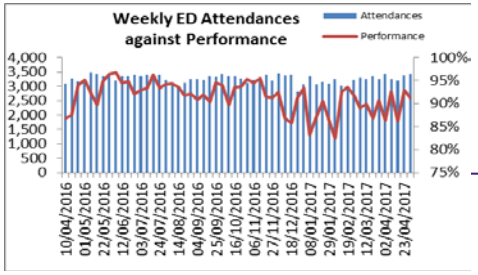
Weekly and Monthly Monitoring

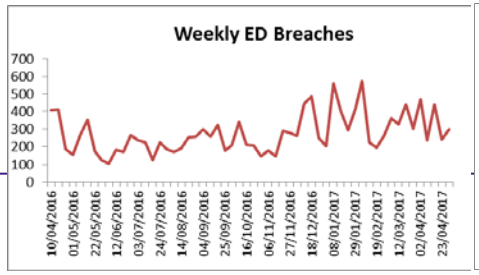


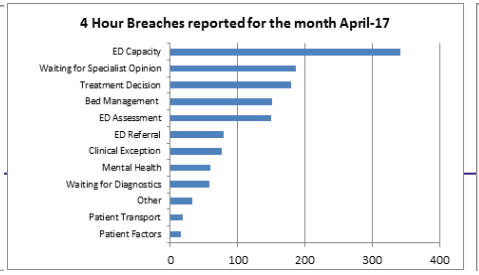


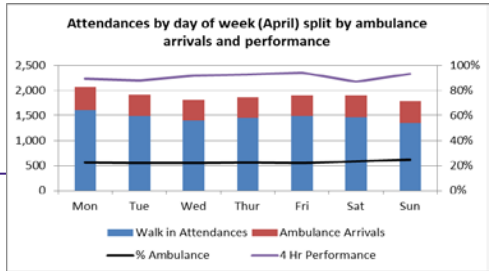












RESPONSIVENESS–Reportable On the day Cancelled Operations

Briefing:

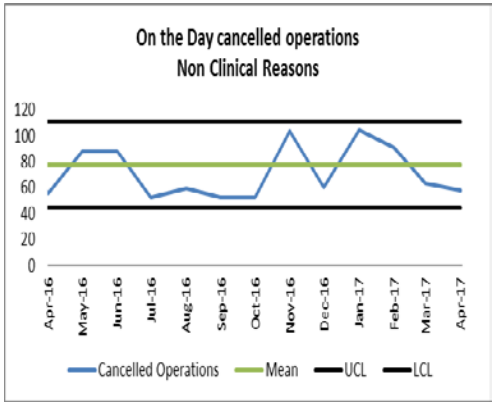
The number of patient procedures cancelled on the day continues to decrease in the month of April reporting 58 cancellations, of which 93.10% (54)were rebooked within 28 days.

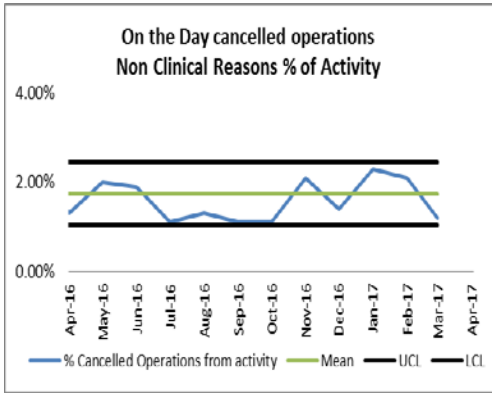
When compared with our peers, St Georges has a high number of reportable on the day cancelled operations and services are working to improve this across all areas. The majority of cancelled operations are due to an emergency case taking priority and lack of theatre time.

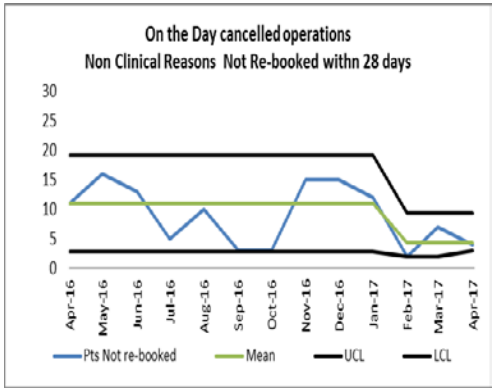
Actions:

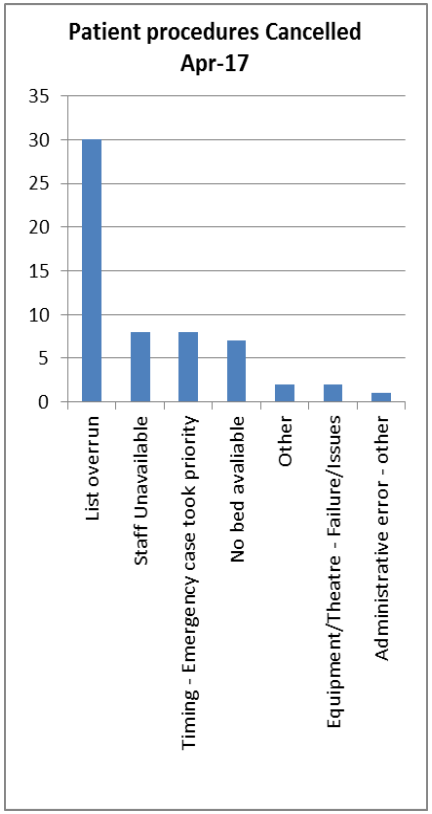
Actions are in place which include :

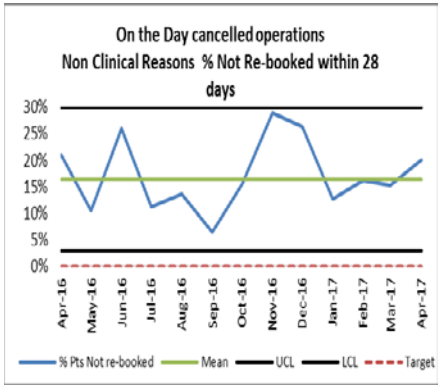
- Daily theatre briefing to confirm all theatres started on time.
- Tightened escalation process.
- Daily look back on the previous day theatre activity and confirm cancellations and reasons why .
- Weekly list planning meeting in place to ensure optimal use of theatre sessions.
- Weekly validations and 28 day re-booking of operations is monitored through the hospital operations board.
- Analysis of all cancelled operations has identified significant opportunities to further reduce cancelled operations and improve theatre efficiency. A full theatre transformation programme is also required with a daily focus on avoiding all cancellations, both reportable and non-reportable.









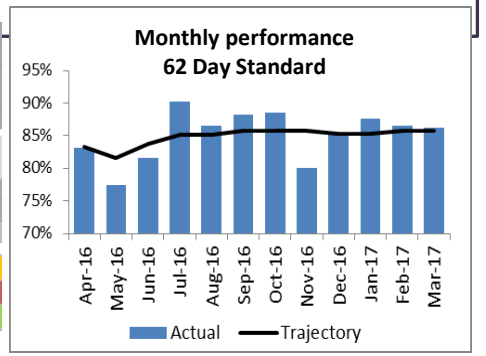


RESPONSIVENESS – Cancer

Briefing: National submission deadline for Cancer standards is one month in arrears. The latest reported position is for March for which 6 out of 8 standards were met. Standards not met were Two Week Wait where 86% of our patients were seen in two weeks against a standard of 93% and Breast Symptomatic where 87.2% of our patients were seen within 14 days . Two Week Wait Standard fell below target predominantly due to a high number of breaches within Skin (60% of all breaches) and clerical delays within the 2w office. In April 2ww performance in 8 out of 13 specialties are predicted to not be achieved due to build up of a backlog of 2ww patients. Recovery plans are developed for all specialties which includes a review of demand and capacity plans, providing additional clinics and re-booking of all patients who DNA. All vacant posts in the 2ww booking office have now been recruited to and performance standards are expected to increase in line with additional capacity and recovery plans.

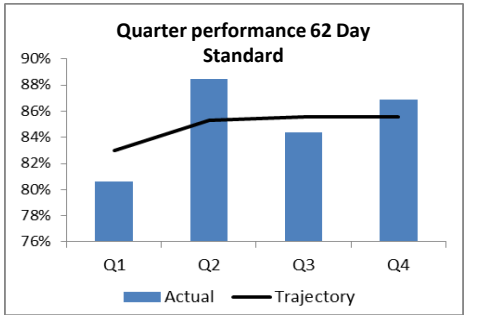
There has been an improvement in the 62 day standard for the last 3 quarters this standard and this is predicted to be achieved in April. April performance will be submitted in early June.

Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Treatments	60	60	74	74	74	63	70	63	68	68	70	70
Treatments <62 Days	50	49	62	63	63	54	60	54	58	58	60	60
Breaches >62 Days	10	11	12	11	11	9	10	9	10	10	10	10
Performance Trajectory	83.3%	81.7%	83.8%	85.1%	85.1%	85.7%	85.7%	85.7%	85.3%	85.3%	85.7%	85.7%
Total Treatments Actual	59.0	72.0	70.5	71.5	59.5	64.0	62.5	70.0	64.0	69.0	59.5	62.0
Total Treatments within 62 Days Actual	49.0	55.0	57.5	64.5	51.5	56.5	55.5	56.0	54.5	60.5	51.5	53.5
Total Breaches Actual	10.0	17.0	13.0	7.0	8.0	7.5	7.0	14.0	9.5	8.5	8.0	8.5
Performance Actual	83.1%	76.4%	81.6%	90.2%	86.6%	88.3%	88.8%	80.0%	85.2%	87.7%	86.6%	86.3%
Meeting STF	✗ -0.3%	✗ -5.3%	✗ -2.2%	✓ 5.1%	✓ 1.4%	✓ 2.6%	✓ 3.1%	✗ -5.7%	✗ -0.1%	✓ 2.4%	✓ 0.8%	✓ 0.6%



Quarterly Actual	Q1	Q2	Q3	Q4	YTD
Total Treatments	205	198	202.0	203.5	808.0
Treatments <62 Days	164	175	172.0	174.0	684.5
Breaches >62 Days	40.5	23.5	21.0	29.5	114.5
Performance	80.2%	88.1%	85.1%	85.5%	84.7%

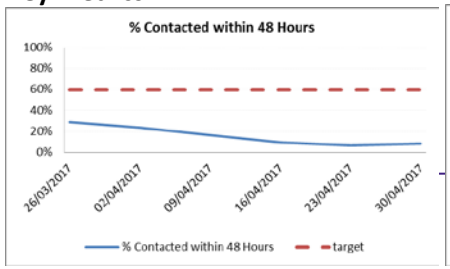
Met STF not National
Not met STF or National
Met STF and National

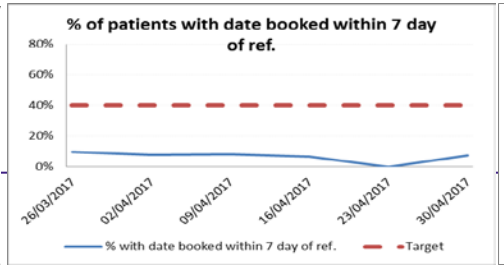


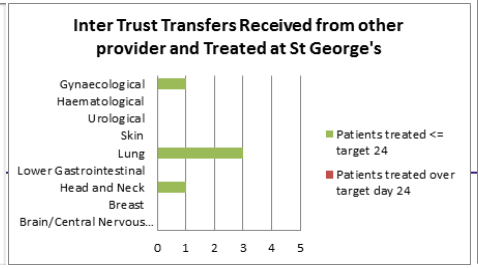
All Cancer Standards Performance Indicators

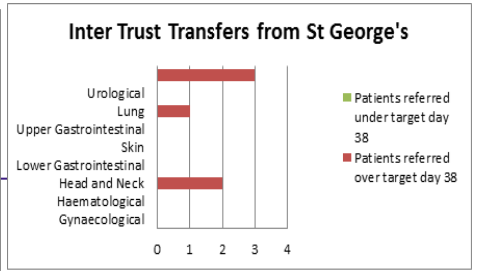
All Cancer Standards	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Trend
14 Day GP Referral (93%)	87.6%	87.3%	90.0%	93.1%	94.3%	94.2%	93.2%	85.7%	93.3%	87.9%	87.9%	86.0%	
14 Day Breast Symtomatic (93%)	94.8%	95.2%	85.9%	93.8%	93.5%	96.0%	98.9%	94.8%	93.2%	94.0%	93.4%	87.2%	
31 Day First Treatment (96%)	98.3%	96.4%	98.8%	97.6%	97.4%	96.2%	97.2%	96.9%	96.6%	96.6%	97.5%	96.7%	
31 Day Subsequent Treatment Surgery(94%)	100.0%	94.7%	96.6%	100.0%	100.0%	93.8%	96.0%	96.0%	96.3%	95.1%	100.0%	94.6%	
31 Day Subsequent Treatment Drug(98%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100%	99%	100%	
62 Day Referral (85%)	83.1%	76.4%	81.6%	90.2%	86.6%	88.3%	88.8%	80.0%	85.2%	87.7%	86.6%	86.3%	
62 Day Screening (90%)	93.6%	84.8%	84.8%	95.0%	96.2%	92.0%	96.2%	92.7%	92.7%	93.0%	96.2%	92.7%	
62 Day Consultant Upgrade (85%)	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	92.6%	87.5%	97.1%	100.0%	97.7%	85.7%	

Key Metrics









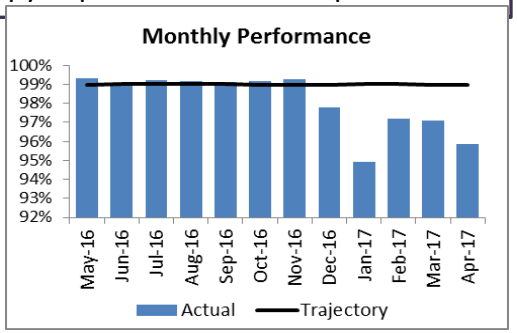
RESPONSIVENESS – Diagnostic Access

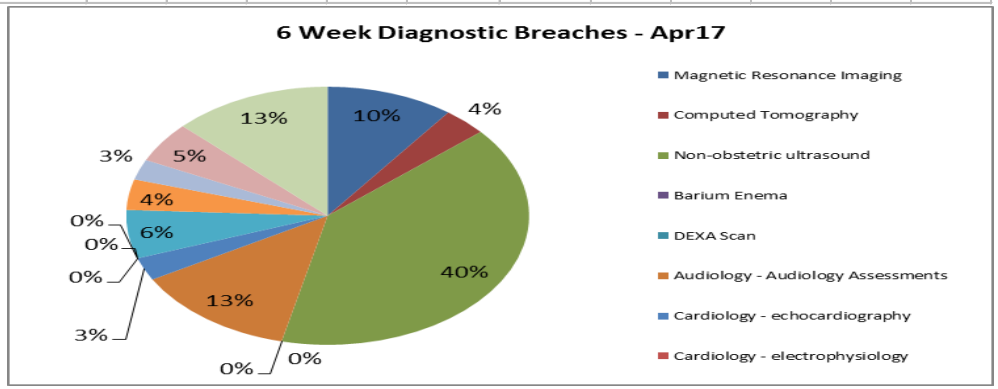
Briefing: Diagnostics 6 Week Wait – Diagnostic performance has been below national standard since December 2016. In April 313 patients did not receive their diagnostic procedures within 6 weeks, accounting for 4.1% performance against the target of 1%. Imaging accounted for 54% of the 6 week breaches mainly within Non Obstetric ultrasound, the team are completing recovery and trajectory plans and waits have seen a reduction in May. Endoscopy reported 24% of all 6 week breaches reducing significantly compared to previous month. Recovery plans are in place with additional capacity plans including additional Saturday lists for Endoscopy implemented in mid April.

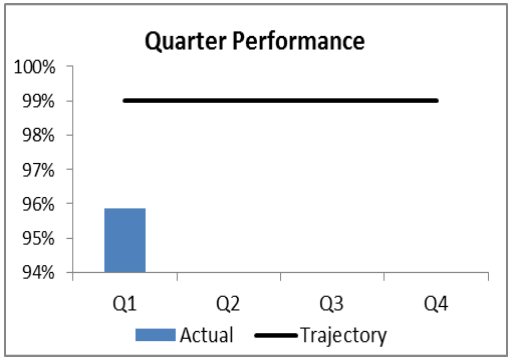
The Sustainability and Transformation Fund Performance against Trajectory

Actual	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Total Waits	6,588	6,977	6,436	6,085	6,258	6,834	6,878	6,906	7,358	7,871	7,678	7,559
Total Waits <6 Weeks	6,542	6,908	6,386	6,034	6,202	6,777	6,828	6,755	6,986	7,652	7,456	7,246
Total Waits >6 Weeks	46	69	50	51	56	57	50	151	372	219	222	313
Performance Trajectory	0.7%	1.0%	0.8%	0.8%	0.9%	0.8%	0.7%	2.2%	5.1%	2.8%	2.9%	4.1%
Meeting STF	✓ 0.3%	✓ 0.0%	✓ 0.2%	✓ 0.2%	✓ 0.1%	✓ 0.2%	✓ 0.3%	✗ -1.2%	✗ -4.1%	✗ -1.8%	✗ -1.9%	✗ -3.1%

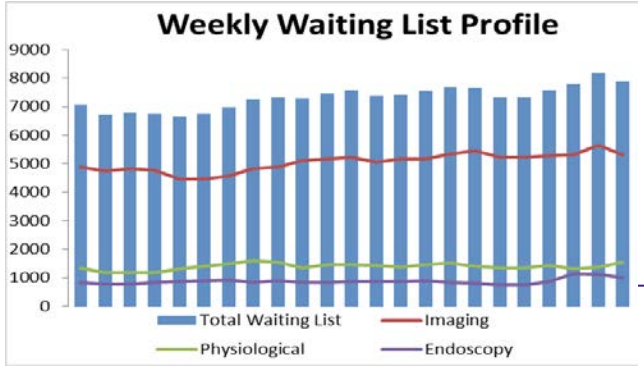
Met STF not National
Not met STF or National
Met STF and National

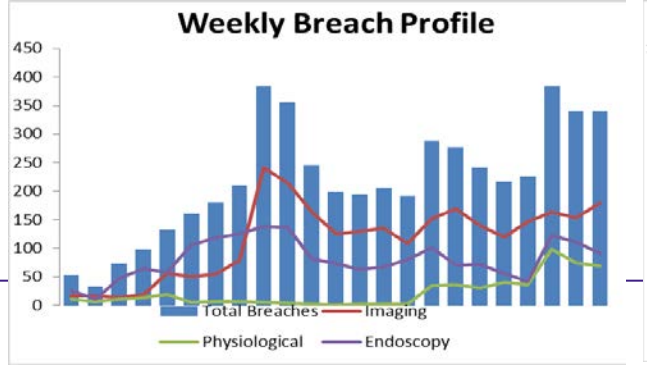


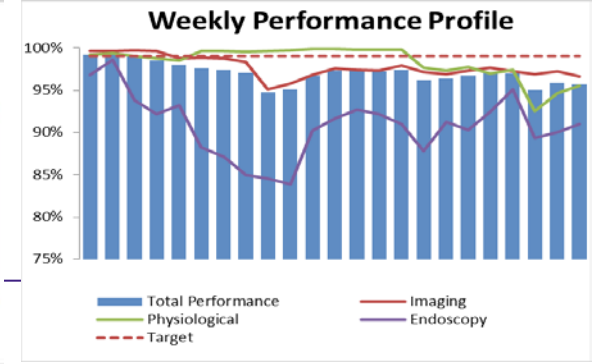




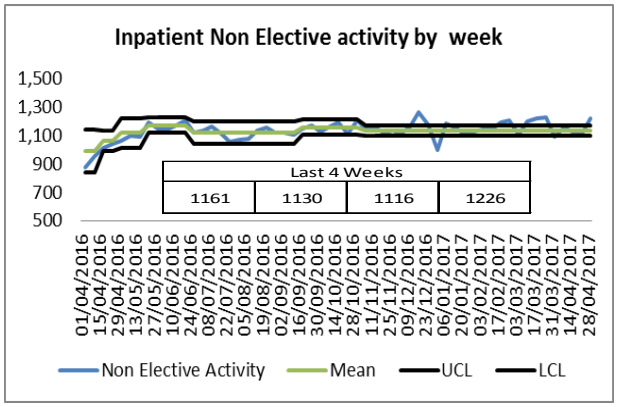
Weekly Performance Monitoring up to 12/05/2017

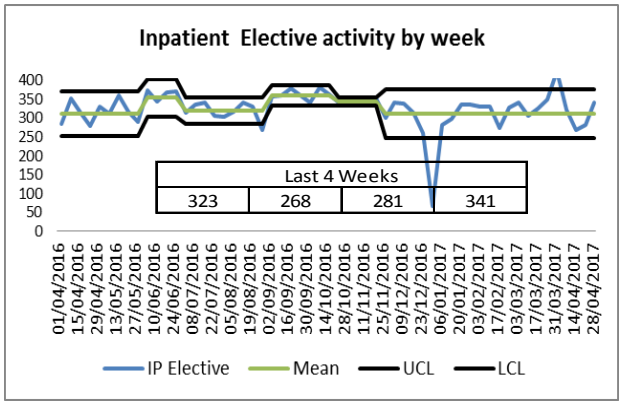


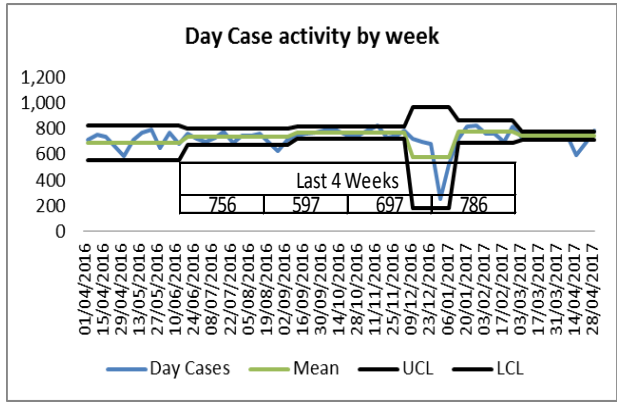


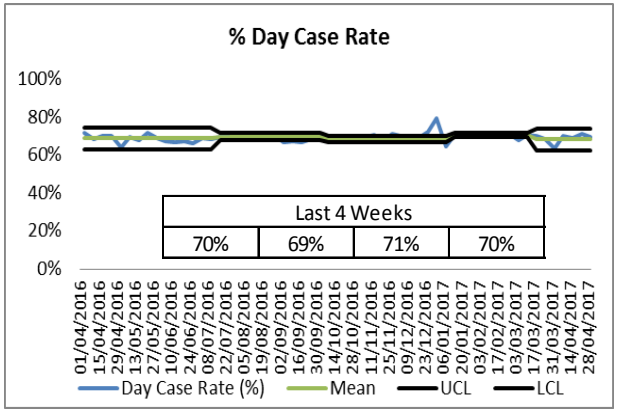


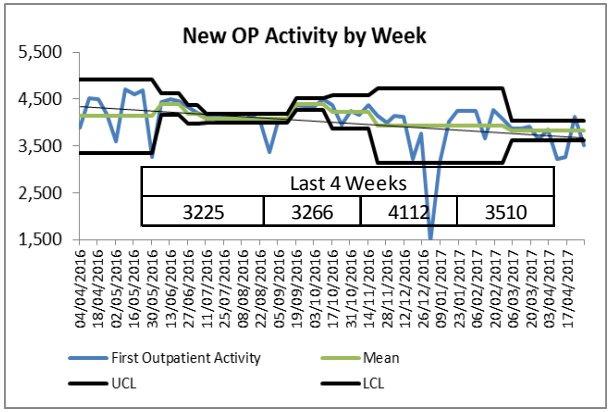
RESPONSIVENESS - Operational Trends

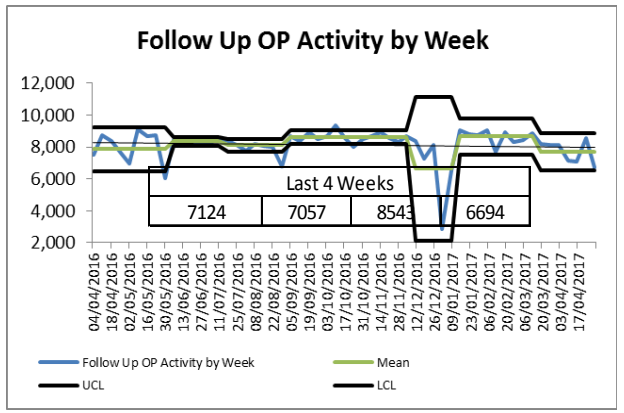


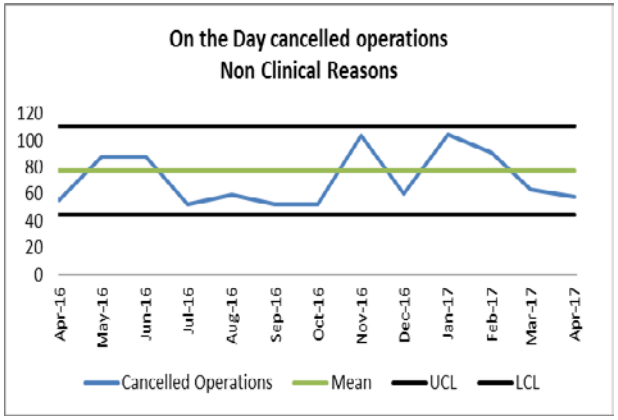


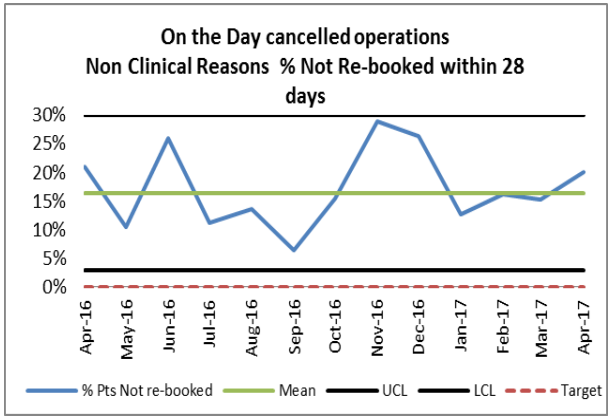


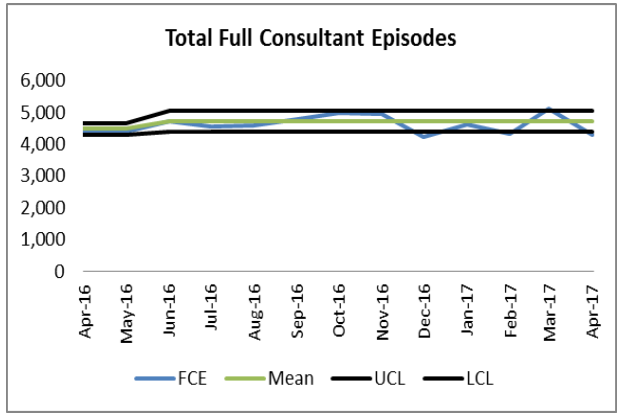




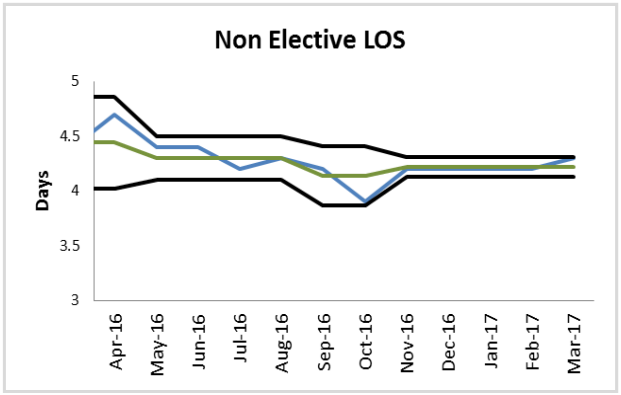


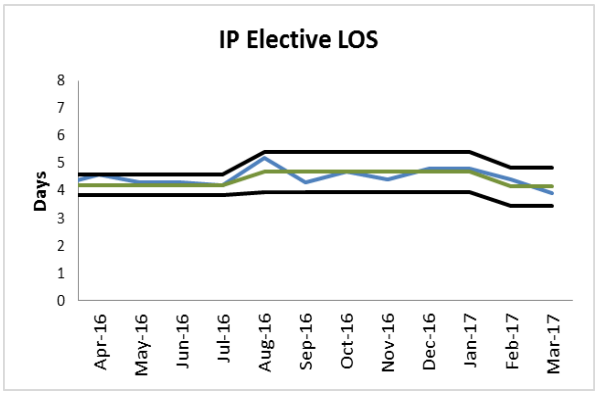


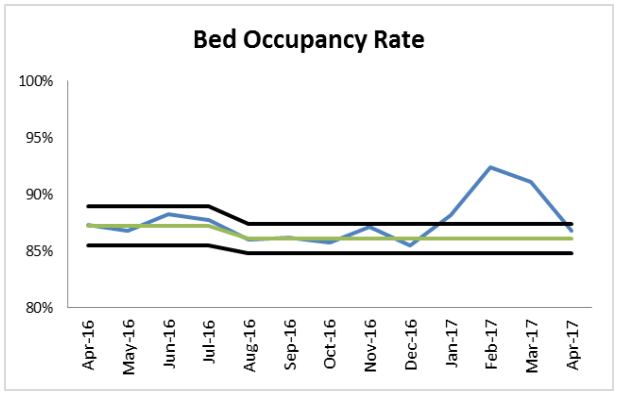


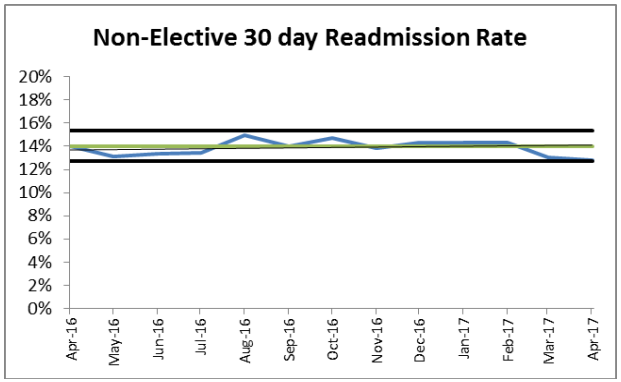


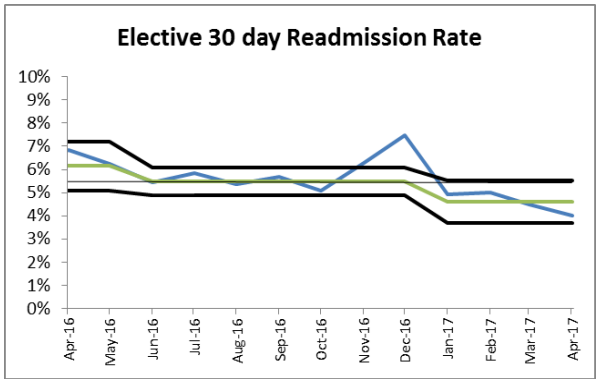
RESPONSIVENESS - Operational Trends

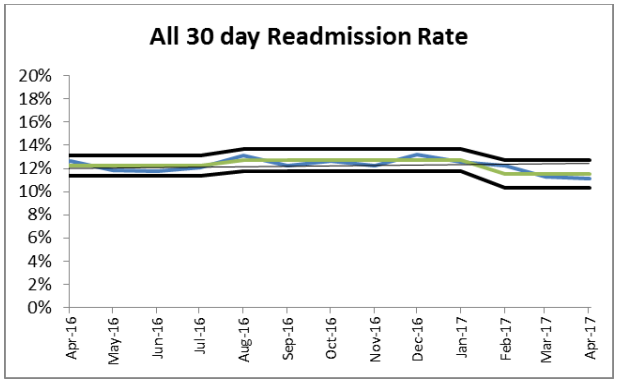


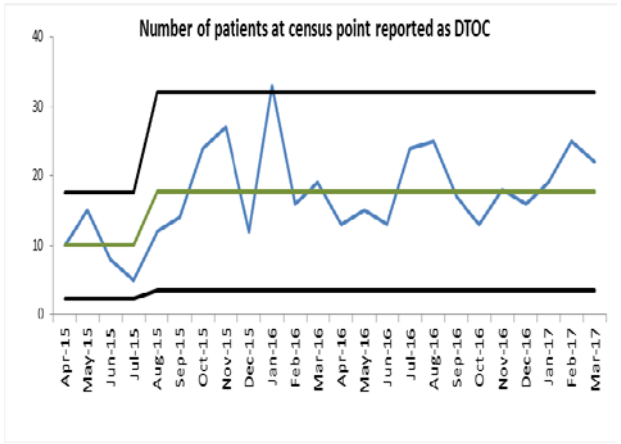


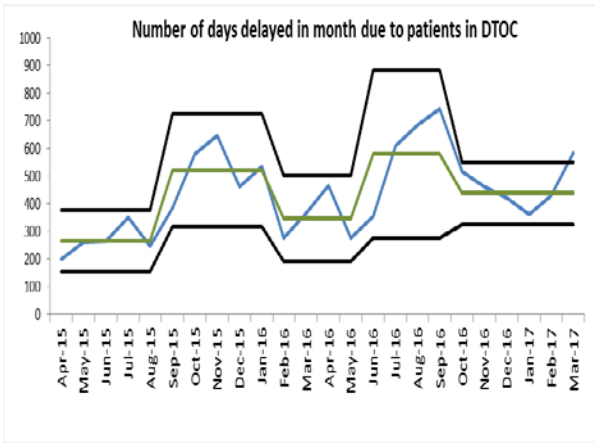


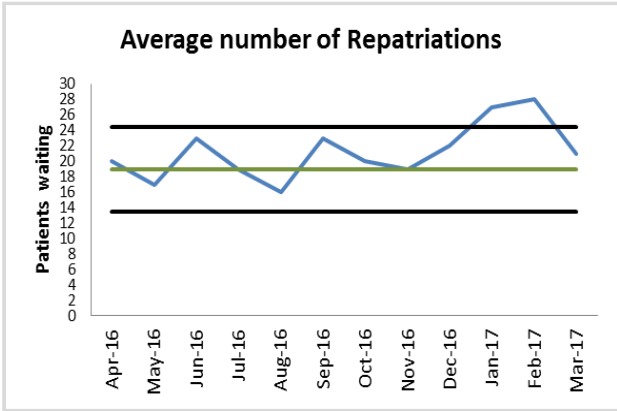




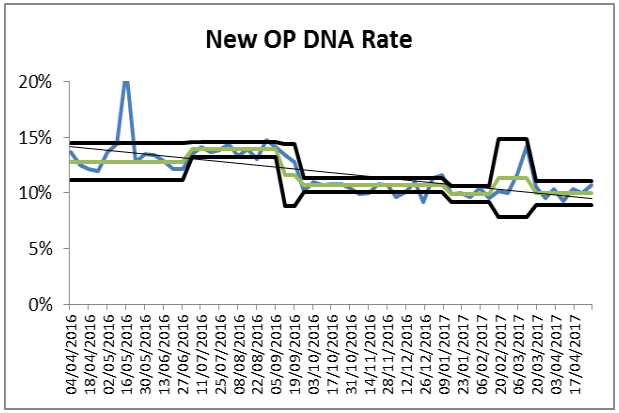


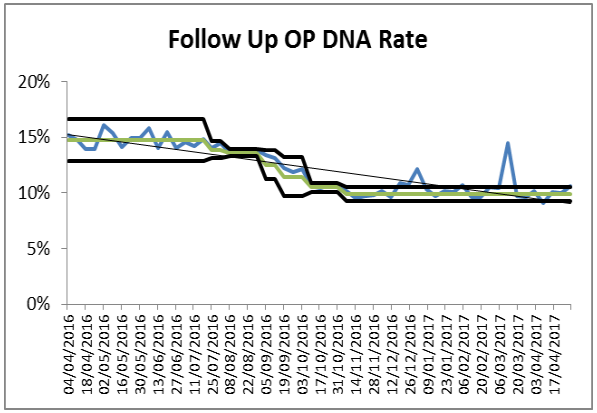


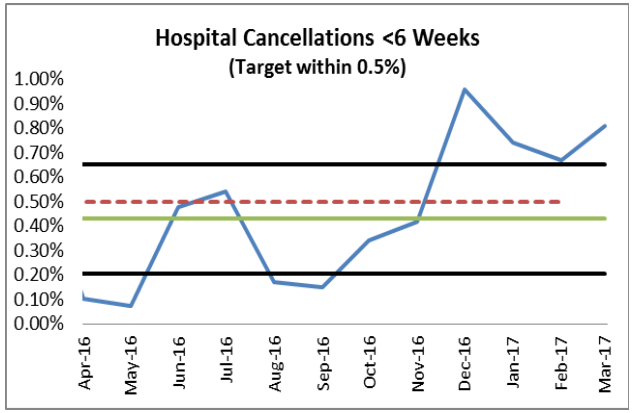


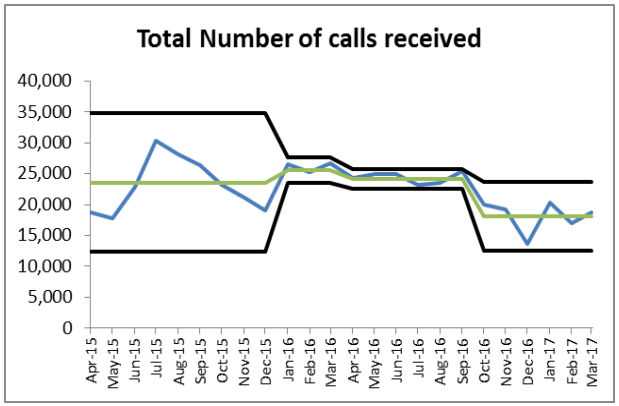


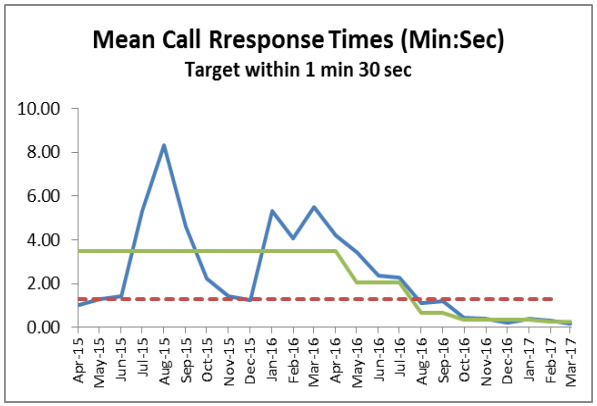
Out Patient Management

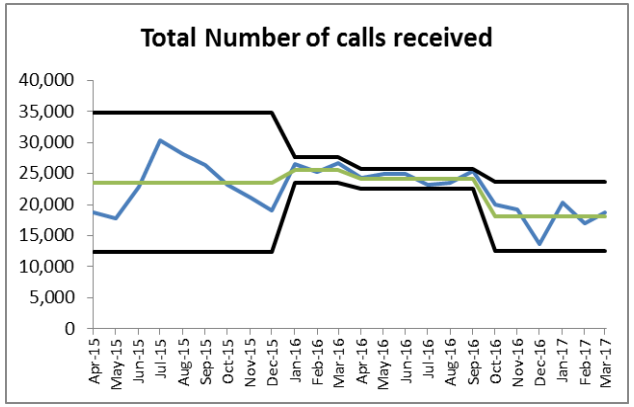


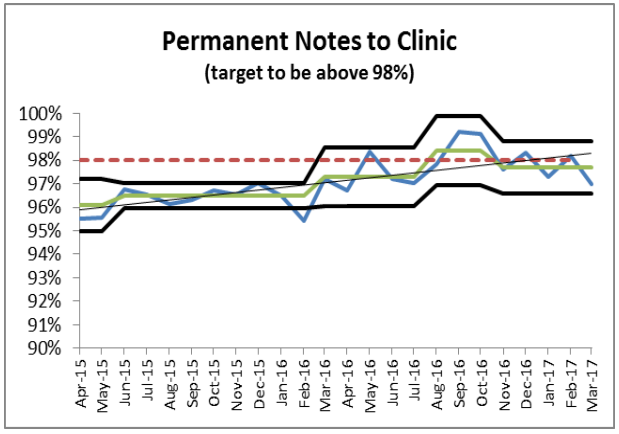


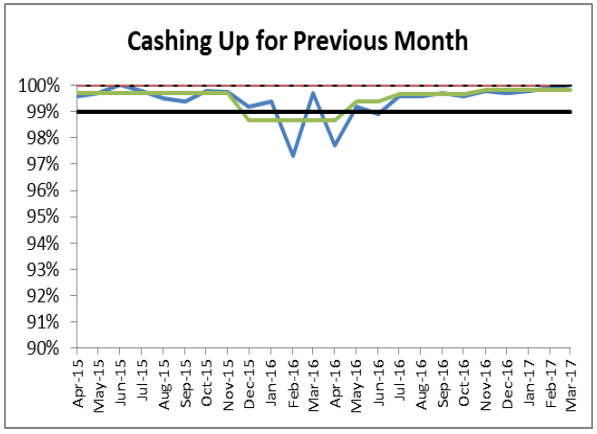












Key indicators within the outpatient service continue to improve, observing a recent reduction in patients not attending after the text reminder service was launched. Call response times continue to meet internal standards and performance has been sustained for a number of months. Hospital cancellations of patient appointments has fluctuated in recent months, this continues to be monitored through the hospital board meetings and May has seen a reduction to date

Executive Lead: Harbhajan Brar – Director of Human Resources

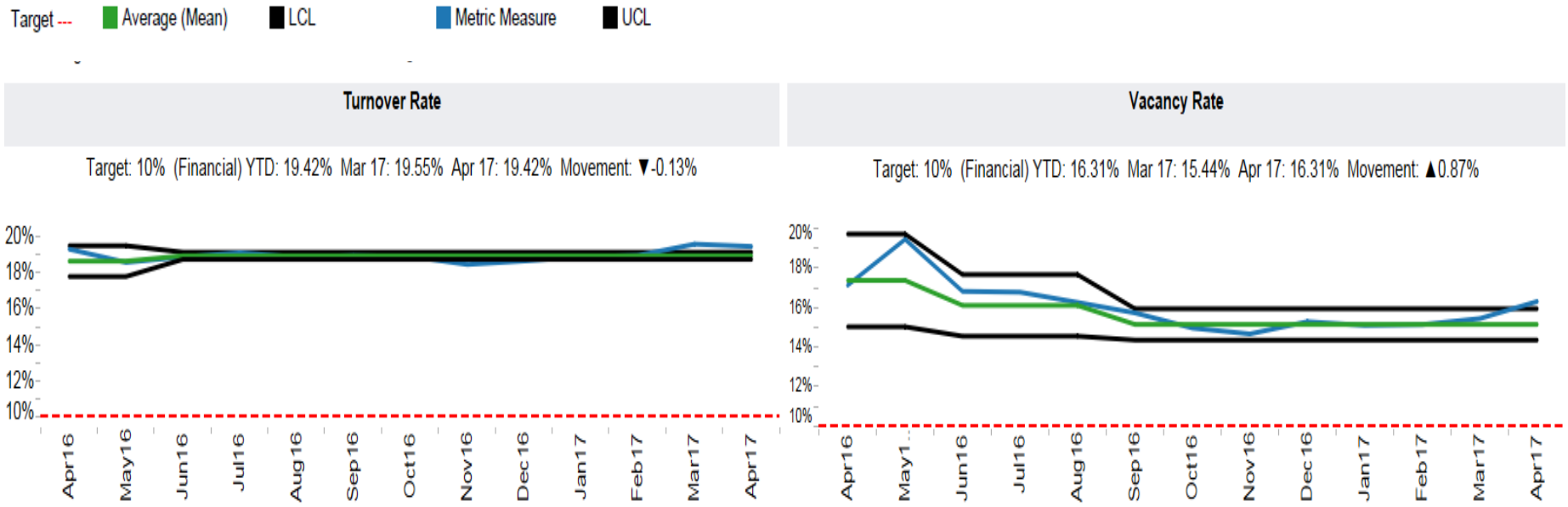
Theme	Indicator	Units	Period	Target	National or Local	Mth RAG Rating	Feb-17	Mar-17	Apr-17	Variance	YTD Total
Workforce	Trust Level Sickness Rate	%	Apr-17	3%	Local		3.78%	3.30%	3.23%		N/A
	Trust Vacancy Rate	%	Apr-17	10%	Local		15.14%	15.44%	16.31%		N/A
	Trust Turnover Rate	%	Apr-17	10%	Local		18.93%	19.55%	19.42%		N/A
	IPR Appraisal Rate - Medical	%	Apr-17	90%	Local		81.37%	77.40%	82.47%		N/A
	IPR Appraisal Rate - Non Medical	%	Apr-17	90%	Local		70.42%	72.82%	80.30%		N/A
	Ward Staffing Unfilled Duty Hours	%	Apr-17	10%	Local		6.25%	4.83%	5.46%		N/A
Safe Staffing	Safe Staffing Alerts	Number	Apr-17	0	Local		7	2	0		0

							Q1 2016/17	Q2 2016/17	Q4 2016/17	Variance	
Staff Experience	Staff Friends and Family Test Response Rate	Number	Q4	TBC	Local		655	534	403		N/A
	Staff Friends and Family Test Recommend as a place to work	%	Q4	TBC	Local		50%	36%	47%		N/A
	Staff Friends and Family Test Recommend as a place for treatment	%	Q4	TBC	Local		79%	74%	77%		N/A

WELL LED – Workforce Indicators

Briefing:

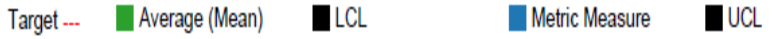
- "Turnover is based on the number of leavers as a percentage of average number of employees over a 12 month rolling period. Turnover in April was 19.42%, which indicates that on average 80.58% of staff stay with St Georges for 5 years compared to our aspiration of 10 years.
- The trust is working hard to improve the staff vacancy rate, which is currently above the target of 10%. Our vacancy rate in In April was 16.31%. Some of these vacancies are inflated due to unbudgeted vacant posts sitting in ESR which we are working with managers to remove..



WELL LED – Workforce Indicators

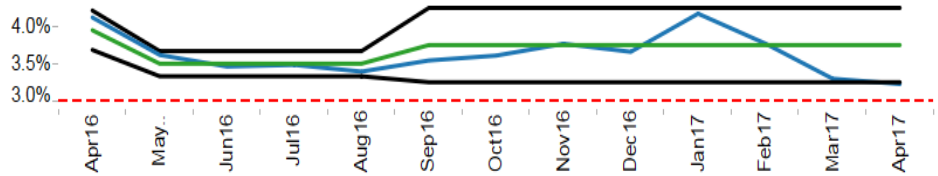
Briefing:

- Staff Sickness absence has remained fairly constant throughout last year . Although performance is not currently meeting the local target a decrease has been observed in the last 2 months .
- There were no reports of safe staffing alerts on our wards.



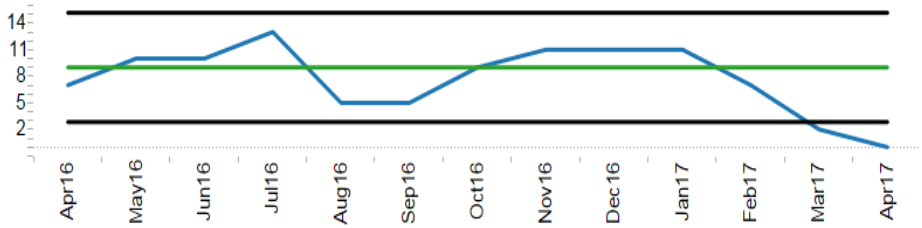
Sickness/Absence Rate

Target: 3% (Financial) YTD: 3.23% Mar 17: 3.30% Apr 17: 3.23% Movement: ▼-0.07%



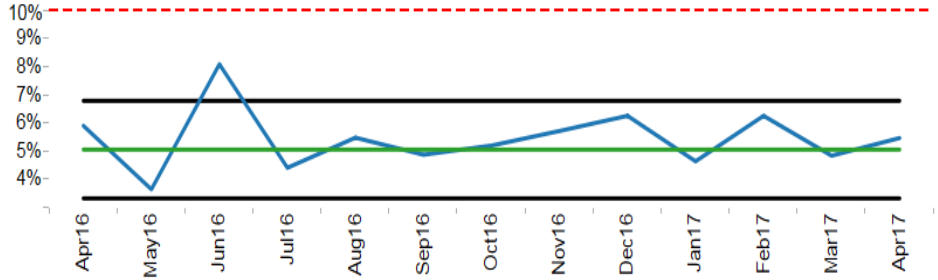
Safe Staffing Alerts

Target: 0 (Financial) YTD: 0 Mar 17: 2 Apr 17: 0 Movement: ▼-2



Ward Staffing Unfilled Duty Hours

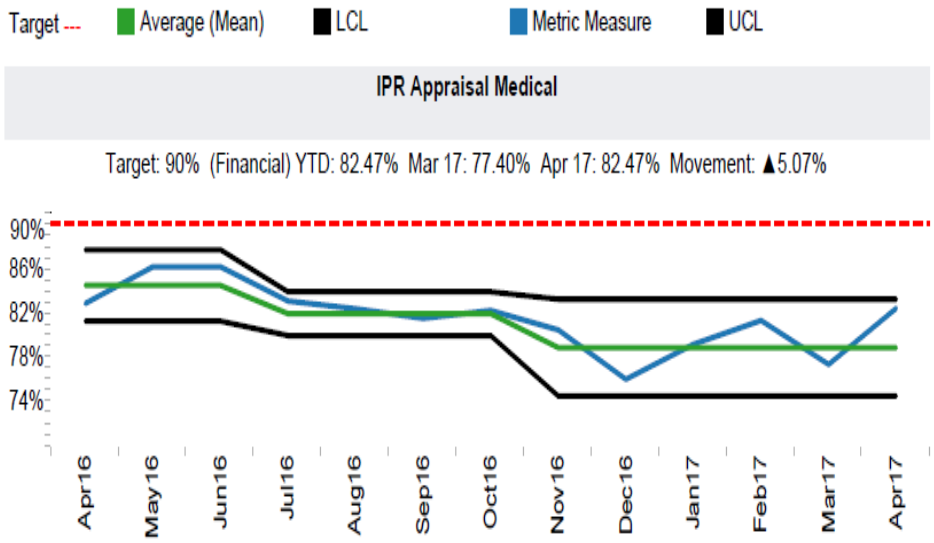
Target: 10% (Financial) YTD: 5.46% Mar 17: 4.83% Apr 17: 5.46% Movement: ▲0.63%

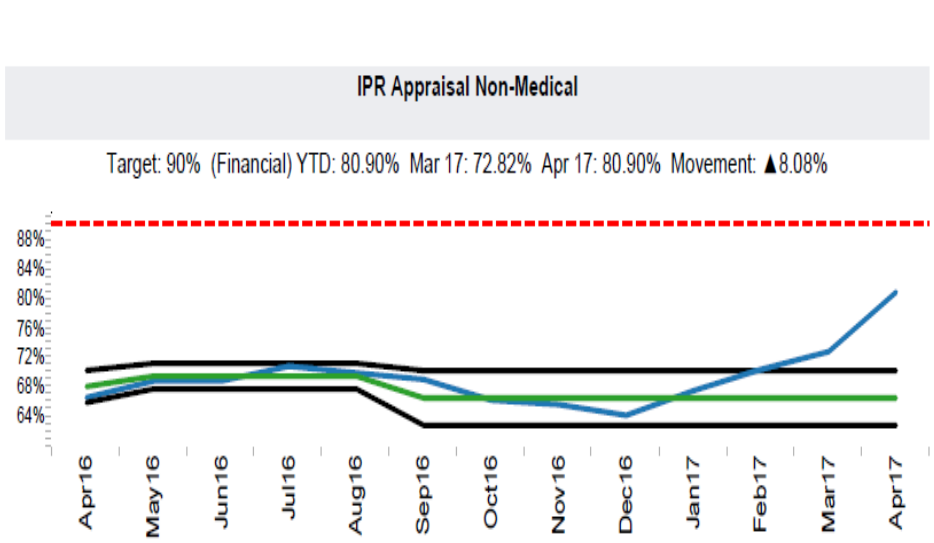


WELL LED – Workforce Indicators

Briefing:

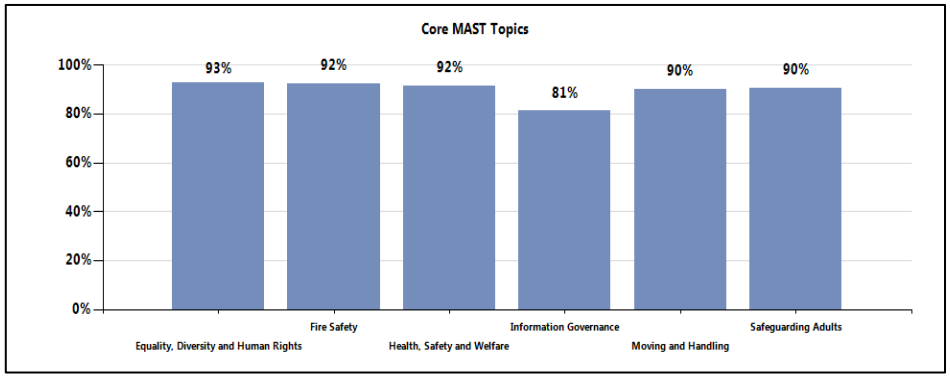
- Appraisal rates have improved in the month of April however continued focus remains to meet our internal goals.
- The recent under achievement for both medical and non-medical staff triangulates with low scores seen in the staff recommendation rates, and continued effort remains to improve staff development.

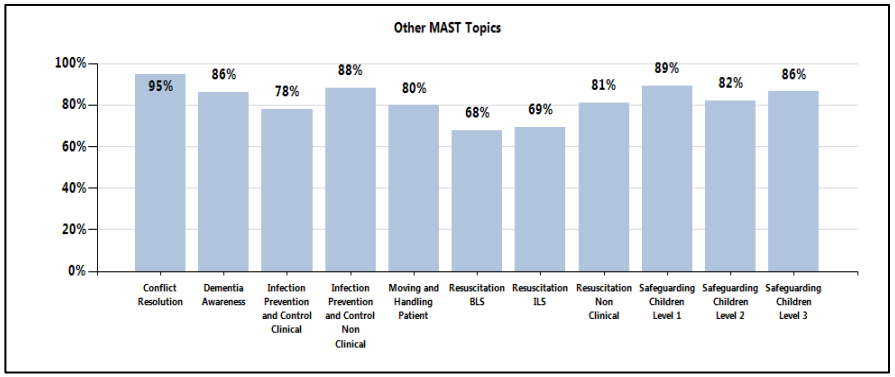




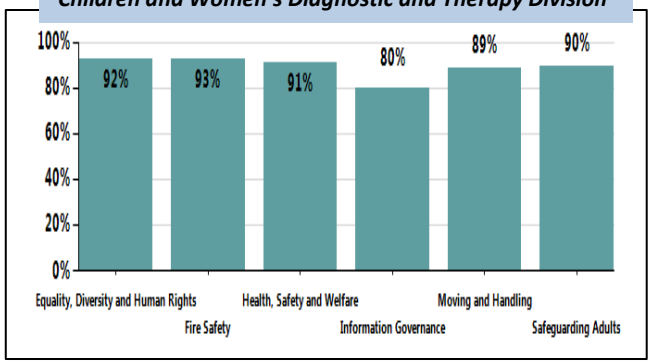
WELL LED – Workforce Indicators

Briefing:
The Trust achieved 86% compliance for Mandatory and Statutory Training in April, meeting its target and achieving the highest level of compliance the Trust has seen. There are some areas where further progress is required, most notably with resuscitation compliance, and this is being addressed.

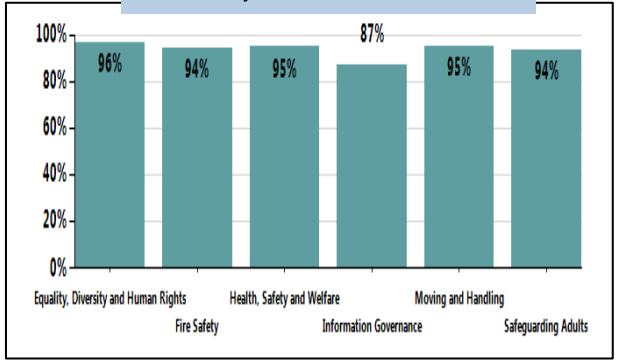




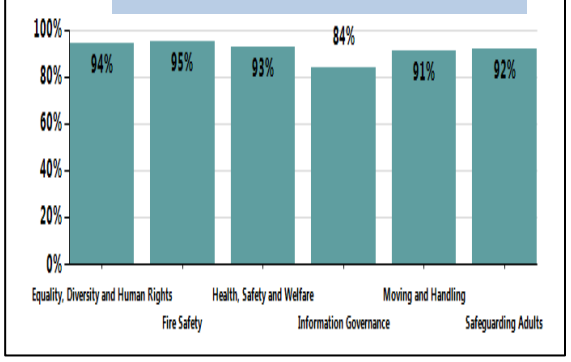
Children and Women's Diagnostic and Therapy Division



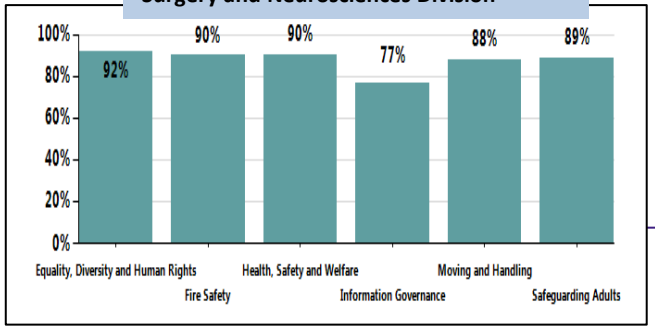
Community Services Division



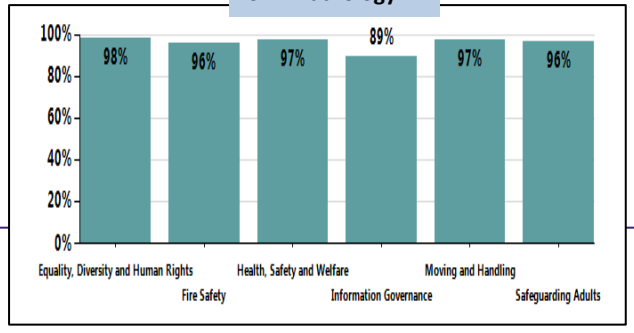
Medicine and Cardiovascular Division



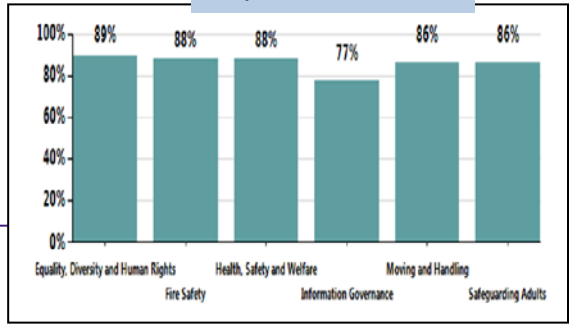
Surgery and Neurosciences Division



SWL Pathology



Corporate Division



St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	8 June 2017	**Agenda No.**	**2.3**
Report Title:	Elective Care Recovery Programme		
Lead Director/ Manager:	Diana Lacey, Director Elective Care Recovery Programme		
Report Author:	Diana Lacey, Director Elective Care Recovery Programme		
Presented for:	Update		
Executive Summary:	This paper provides an update on the implementation of our elective care recovery programme, including delivery of the 18 week referral to treatment (RTT), diagnostic and cancer access standards. The paper notes the issues raised in a recent programme stocktake, and the work in train to revise the plan - including strengthening of the leadership, governance and accountability of the programme, and timescales for completion.		
Recommendation:	The Board is asked to note the refocus of the plan, and the work in train to revise the governance, architecture and reporting arrangements for the Elective Care Recovery Programme, and the timescale for completion.		
Supports			
Trust Strategic Objective:	1. Deliver our Transformation Programme enabling the Trust to meet its operational and financial targets. 2. Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Operational Performance		
Implications			
Risk:	1. Patients may come to harm as a consequence of waiting in excess of 18 weeks for treatment. 2. A high number of patients waiting will adversely affect Trust performance against the referral to treatment (RTT) standards. 3. There will be a loss of income as the Trust will be fined for non-reporting of the RTT standard. It is anticipated that		
Legal/Regulatory:	Delivery of the programme will help the Trust to return to reporting of the referral to treatment (RTT) standard which is a requirement of the NHS Constitution. Delivery of the programme will help to address issues raised in the recent CQC report.		
Resources			
Previously Considered by:		**Date:**	5 June 2017
Equality Impact Assessment:			
Appendices:			

Elective Care Recovery Programme Report
Trust Board, 8 June 2017

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Trust Board with an update on the delivery of the Elective Care Recovery Programme (ECRP).

2.0 BACKGROUND

2.1 Following identification of a number of performance and data quality issues by the national Referral to Treatment (RTT) Intensive Support Team (IST), St George's University Hospitals NHS Trust commissioned a comprehensive review of their systems and processes that manage patients on the elective care pathway.

The comprehensive review - conducted by MBI - identified multiple operational processes and technology issues at every stage of the elective care pathway, that posed significant risks to the quality of care and safety of patients

2.2 Specifically, the Trust has a high number of 'open' patient records on its Patient Administration Systems (PAS) dating back to 2014 and possibly earlier. The Trust cannot say with certainty that these patients have been treated, or are at the correct stage of their care pathway. As a result, patients may have come to harm due to their extended wait. The Trust Board took the decision in July 2016 to suspend national reporting of RTT performance in July 2016.

2.3 The scale and complexity of the problem is great. The Elective Care Recovery Programme (ECRP) has been established to rectify the issues and return St George's to national reporting of the RTT standard.

3.0 ISSUE

3.1 A recent stocktake of the programme identified the progress made thus far, as well as the importance of intensifying efforts to resolve some of the key issues – including letter typing backlogs, development of standard operating procedures and the implementation of the new clinic outcome form.

3.2 There is a lack of clarity about demand and capacity and, as a result, the Trust's ability to reduce at pace the backlog of patients currently waiting for treatment.

3.4 The governance, and reporting arrangements need to be strengthened to provide the Board with increased oversight of ECRP delivery.

4.0 IMPLICATIONS

Risks

4.1 Not addressing the issues will increase the risk of patients coming to harm as a consequence of waiting in excess of 18 weeks for treatment.

4.2 Return to reporting against the national RTT standard will be delayed with an increased loss of income as the length of time the Trust is fined for non-reporting is extended.

4.3 Delays in ECRP delivery may adversely impact on the Trust's ability to address issues raised during the Care Quality Commission's inspection visit last year.

5.0 NEXT STEPS

5.1 The ECRP plan is being revised to ensure we tackle the issues at pace, and meet key milestones, together with greater oversight of delivery and risk. The plan, which will include the resource plan and revised governance arrangements, is to be submitted to NHS Improvement no later than 30 June 2017.

5.2 Board report against the key programme deliverables will be monthly commencing July 2017.

6.0 RECOMMENDATION

6.1 The Board is asked to note the plan, and the work in train to revise the governance, architecture and reporting arrangements for the Elective Care Recovery Programme, and the timescales for completion.

Author: **Diana Lacey, Director Elective Care Recovery Programme**
Date: **31st May 2017**

APPENDIX [insert letter]

[Insert Heading of Appendix]

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	Thursday 8 June 2017	**Agenda No.**	**2.4**
Report Title:	Annual Report of the Infection Prevention and Control Teams: 2016-17		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and DIPC		
Report Author:	Dr PA Riley, Consultant Medical Microbiologist and Infection Control Doctor		
Presented for:	Approval		
Executive Summary:	Results of mandatory, reporting of healthcare-associated infections; MRSA, MSSA, GRE and *E coli* bacteraemias, Surgical site Infection Surveillance and *Clostridium difficile* infections: two MRSA bacteraemias in 2016-17 and 36 episodes of C difficile infection – 7 lapses in care. Lowest rate of MRSA bacteraemia for a London acute teaching trust. Descriptions of other healthcare-associated infection incidents including influenza, MRSA acquisitions, norovirus, measles and tuberculosis. Details of audit activities, and teaching and training are included. The 2017-18 programme is described with a recommendation to increase surgical site surveillance across the Trust.		
Recommendation:	To approve the report and approve the infection and prevention control programme for 2017-18.		
Supports			
Trust Strategic Objective:	**High Quality Care**: To ensure consistently high quality care for patients by ensuring it is safe, effective and patient led.		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:			
Legal/Regulatory:	Compliance with Hygiene Code		
Resources:	N/A		
Previously Considered by:	Quality Committee	**Date:**	23 May 2017
Equality Impact Assessment:	No		
Appendices:	1. Annual Report of the Infection Prevention and Control Team 2016-17		

St George's University Hospitals NHS
NHS Foundation Trust

Annual Report of the Infection Prevention and Control Team

2016 – 2017

Contents

Summary

This report summarises the activities of the Infection Prevention and Control Team at St George's University Hospitals NHS Foundation Trust during the financial year 2016-17. The report also describes the Infection Prevention and Control Programme for the forthcoming year 2017-18.

The Trust-assigned MRSA bacteraemia numbers showed an improvement compared to the previous year with two Trust-assigned episodes in 2016-17. This compares to three episodes in 2015-16 and six episodes in 2014-15. There was a period of over a year between the last episode in 2015-16 and the next in 2016-17. The national threshold is zero avoidable cases. The rate of MRSA bacteraemia was the lowest for any London acute teaching trust. The number of acquisitions of MRSA colonisation fell compared to the previous year. Two clusters of MRSA colonisation were investigated on two wards during the year.

Unfortunately for the for the first time in four years the Trust did not keep the number of healthcare-associated episodes of *Clostridium difficile* infection below the target of 31 Trust-apportioned episodes for the year. This is the 3rd most stringent target for English teaching hospital trusts. At the end of the year there were 36 episodes giving a rate of 11.8 per 100,000 bed days. This is the 5th lowest for any London acute teaching trust and 7th lowest for comparable trusts in England. The median rate for all trusts in England was 13.62. Seven of these episodes were classified as lapses in care – the majority being related to inadequacies in documentation of antimicrobial treatment decisions and reviews. Nationally, no changes in targets have been made to this mandatory reporting scheme and the target for 2017-18 remains at 31 episodes.

Rates of meticillin-susceptible *Staphylococcus aureus* were the same as in the previous two years representing the median rate for acute teaching trusts in London.

Numbers of bacteraemias with glycopeptide-resistant enterococci remained low in comparison with similar trusts in London.

Two categories of surgical-site infection surveillance modules were completed and the rates of infection matched the national means. Proposals for an expansion in surgical-site surveillance are included in the programme for 2017-18.

In November the Trust participated in the European Healthcare-associated Infection Point Prevalence Survey. Preliminary results indicate that the prevalence of infection at St George's was 6.7% compared to the national average of 7%.

Influenza activity was higher in 2016-17 compared to previous years and resulted in some ward closures due to outbreaks. The uptake of influenza vaccine was the highest recorded for St George's being above the national average and the 4th highest in London. Norovirus activity was similar to previous years and resulted in closures of bays and some wards. .

There continue to be low levels of colonisation and infection with multi-drug resistant bacteria. The strong antimicrobial stewardship programme at St George's continues to support the prevention of resistance.

Actions to reduce the risk of infections in cardiothoracic surgery associated with heater-cooler units were implemented.

A small number of incidents in relation to the London-wide measles epidemic occurred and there were two episodes of staff exposure in relation to delayed diagnosis of tuberculosis

The CQC inspection of the Trust highlighted some areas for improvement in regard to Infection Prevention and Control – mainly in relation to improvements in hand-hygiene and cleaning and disinfection. The trust-wide audit programme and action plan for 2017-18 is reported and takes account of the CQQ findings.

The IPC team continues to receive support from the antimicrobial stewardship team and the vascular access team whose work over the year has helped keep the low levels of bacteraemia in the Trust.

In August 2016 Jennie Hall, the Chief Nurse and DIPC moved to a new post at NHS Improvement. Suzanne Banks took over the role in the interim until Avey Bhatia re-joined the Trust in February 2017. I would like to thank all of the above and all the other members of the infection prevention and control team, the pharmacy team, the link nurses and all others involved in infection control for their hard work during the year.

Peter Riley
Consultant Medical Microbiologist and Infection Prevention and Control Doctor

May 2017

Organisation & Management of Infection Prevention and Control in the Trust

Infection Prevention and Control within the Trust

A key part of the Trust's strategy is to emphasise that Infection Prevention and Control is the responsibility of all Trust staff, not just the Infection Prevention and Control Team. Thus, all staff are accountable for their actions with regard to infection prevention and control through their medical, nursing, therapy and managerial lines of responsibility. Infection Prevention and Control remains a standing agenda item for divisional clinical governance meetings.

The Trust as a whole is committed to participation in the DH Saving Lives Initiative and, like other Trusts, participates in the DH mandatory reporting schemes for MRSA, MSSA and *Escherichia coli* bacteraemia, *Clostridium difficile* infection, Glycopeptide-resistant enterococcal bacteraemia and Surgical Site Infection Surveillance (orthopaedics).

The Team:

It is the responsibility of the Infection Prevention and Control Team (IPCT) to provide the Trust with relevant specialist guidance and advice at every level, from senior management down to individual staff members. The team sits within the Infection Care Group which is part of the Medicine and Cardiac Division. The IPCT have direct access to the Chief Nurse who is also the Director of Infection Prevention and Control, via regular scheduled meeting and ad-hoc discussions as required. Its specific activities include:

On-going support and advice for clinical staff – regular clinical site visits, dealing with problems, outbreaks & incidents
Education of all staff groups
Drawing up policies and guidance documents (The Infection Prevention and Control Manual)
Clinical and environmental audit
Surveillance of healthcare associated infection, including participation in mandatory DH surveillance schemes
Antibiotic Stewardship ward rounds conducted by the Consultant Medical Microbiologists and antimicrobial pharmacists.

During the year 2015/16 the team consisted of:

- Professor Jennie Hall — Director of Infection Prevention & Control, & Chairman of the Infection Prevention and Control Committee – until July 2016
- Suzanne Banks — Director of Infection Prevention & Control, & Chairman of the Infection Prevention and Control Committee – August 2016 to January 2017
- Avey Bhatia — Director of Infection Prevention & Control, & Chairman of the Infection Prevention and Control Committee – February 2017 onwards

- Dr Peter Riley — Trust Infection Control Doctor

- Dr Meaghan Cotter — Deputy

- Ruth Law — Lead Infection Prevention and Control Nurse
- Selma Mehdi — Lead Infection Prevention and Control Nurse
- Jane Callaway — Senior Infection Prevention and Control Nurse

- Kristina Hager — Infection Prevention and Control Nurse
- Amelia Floresca — Infection Prevention and Control Nurse (Until August 2016)

- Melissa Farragher — Infection Prevention and Control Nurse
- Jane Goldman — Infection Prevention and Control Nurse
- Umara Adamu — Infection Prevention and Control Nurse
- Pam Bridle — Staff nurse (Bank)
- Hasan Al-Ghusein — Information Analyst

- Helen Graham — PA/Office manager

Infection Control Link Nurses

There are approximately 170 Infection Control Link Nurses in the Trust. Link Nurse meetings are held 4 times a year with 2 master classes and 2 study days. There has been good attendance, engagement & participation in the infection control agenda.

Governance of the Infection Control Team 2016-17

The work of the Infection Control Team is overseen by the Infection Prevention and Control Committee (ICC), chaired by the Director of Infection Prevention and Control (DIPC), with a membership representing the whole Trust, as well as representation from the South London Health Protection Unit (HPU). The IPCC meets every two months. The IPCC defines the infection control strategy for the Trust

The Healthcare Associated Infections Task Force met every two weeks and is also chaired by the DIPC or Infection Control Doctor. This is an operational group, which is attended by representatives from all clinical divisions, focuses on bringing about rapid interventions aimed at control of health care associated infections. It is also attended by the infection control lead for the South London Commissioning Support Unit.

The Taskforce reports to the Infection Prevention and Control Committee. During 2016-17 changes were made to the meetings structures within the Trust. The Antimicrobial

Stewardship Committee now reports directly to the Patient Safety and Quality Board as does the Infection Prevention and Control Committee.

Infection Control Team Partners

Lead Consultant for Antibiotic Stewardship

Dr Matthew Laundy

Antibiotics and Infection Management Pharmacist

Laura Whitney – Consultant Pharmacist

Venous Access Team

Headed by Jackie Nicholson Consultant Nurse

The Antibiotic Stewardship and Venous Access Teams while separately managed to the IPCT, are both involved in areas that are key to achieving better infection control, and both also attend the Infection Control Committee and work closely with the IPCT as appropriate.

Estates and Environmental Hygiene

Jenni Doman – Assistant Director, Facilities

Diagnostic Microbiology

Dr Tim Planche – Microbiology Lead - South West London Pathology (SWLP)

Infection Care Group

Dr Meaghan Cotter– Joint Care Group Lead

Prof Derek Macallan - Joint Care Group Lead

Other organisations

Dr Yvonne Young	South London Health Protection Team
Anne Lusmore	South London Health Protection Team
Sheila Loveridge	Commissioning Support Unit

Organisation and Management Community Services Division

In 2016-17 there was a single, integrated infection control team within the Trust. Currently there is one programme activity for a community infection control doctor and 1 WTE infection prevention and control nurse.

Mandatory Surveillance of Healthcare-Associated Infection:

Trusts are required to participate in six mandatory reporting schemes;

1. MRSA bacteraemia
2. MSSA bacteraemia
3. *Clostridium difficile* infection
4. Glycopeptide-resistant enterococcal bacteraemia
5. *Escherichia coli* bacteraemia
6. Surgical Site Infection Surveillance

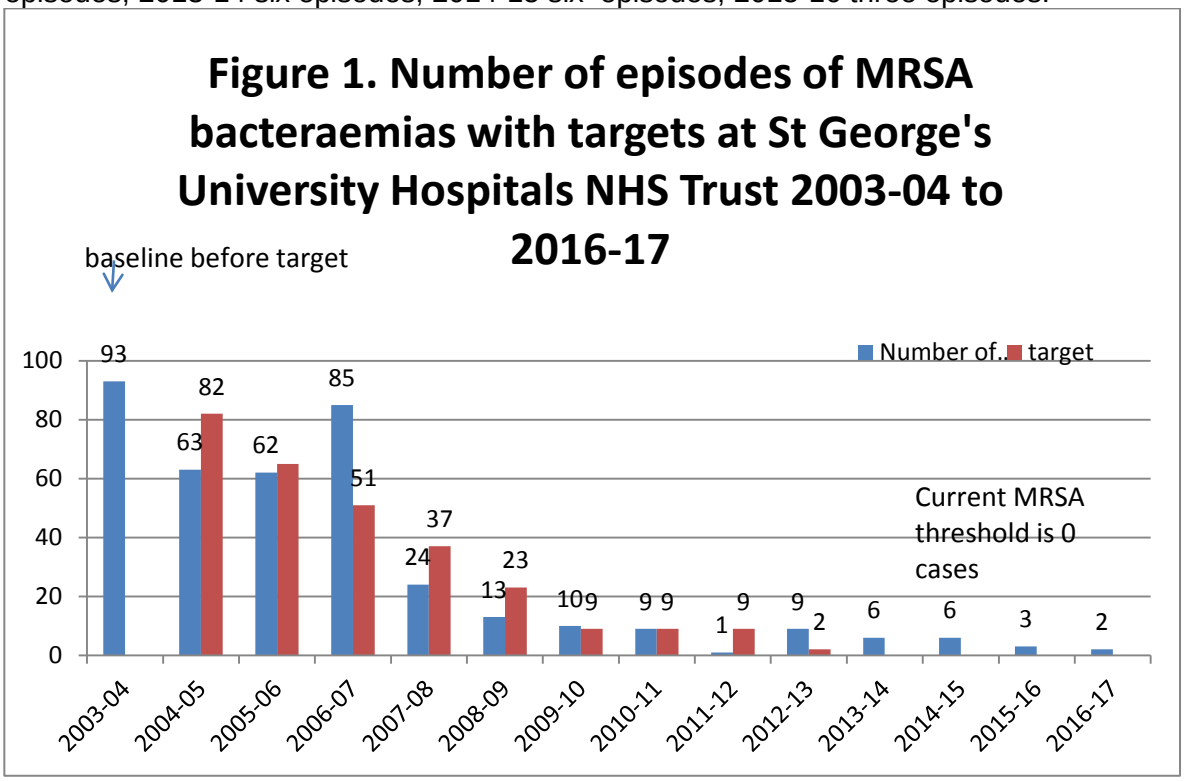
(1) MRSA Bacteraemia

Since April 1st 2001 all NHS trusts have been required to report the number of episodes of bacteraemia (bloodstream infection) with MRSA. Bacteraemias are categorised into community-acquired episodes (positive within 48 hours of admission or hospital-acquired episodes (positive after 48 hours following admission). This system is relatively crude and does not always accurately classify the bacteraemia; however it is systematic and reproducible.

All MRSA bacteraemias are initially apportioned to the organisation based on the timing of the positive blood culture The MRSA bacteraemia then undergoes a post infection review (PIR) process, the results of which are submitted to Public Health England. The bacteraemia is then assigned to the organisation deemed to be responsible. Disagreements are dealt with by an appeals process. Despite the threshold being zero **avoidable** there is no official process to label an episode avoidable or not.

In line with the government thresholds St George's has reduced the number of MRSA hospital assigned bacteraemias significantly since 2002-03. See figure 1. More recently the number of assigned episodes were as follows; 2011-12 one episode, 2012-13 nine episodes, 2013-14 six episodes, 2014-15 six episodes, 2015-16 three episodes.

Figure 1. Number of episodes of MRSA bacteraemias with targets at St George's University Hospitals NHS Trust 2003-04 to 2016-17



In 2016-17 two MRSA bacteraemia episodes were assigned to the Trust following the PIR process. This equates to a rate of 0.66 per 100,000 bed days and was the lowest rate for any acute teaching hospital trust in London and the sixth lowest of the 29 acute teaching trusts in England. During the financial years 2015-16 and 2016-17 there was a period of 13 months without a hospital-acquired episode of MRSA bacteraemia.

Table 1: Summary of Hospital Acquired MRSA Bacteraemia RCA Findings (two episodes) for 2016-17

Episode	date	Focus of infection	Location
514409	10th October 2016	Hospital-acquired pneumonia	Adult General Critical Care Unit
537924	18th February 2017	Central vascular catheter associated infection	Adult Neuro Intensive Care Unit

Lessons learnt and interventions from the root cause analyses:

Episode 514409: Patient acquired MRSA colonisation on ward. One other patient on the ward at the same time had previous history of MRSA colonisation. Possible acquisition from that patient. Not all patients on the unit had all the necessary MRSA screening swabs taken. Policy reviewed and revised and staff received further training. Apparent deficiencies in audit results were mostly due to audits not reflecting current practice. Review of audits initiated. This was the first MRSA bacteraemia acquired on GICU for over 3 years.

Episode 537924: Patient not colonised with MRSA on admission, developed a CVC associated infection. A second patient acquired MRSA colonisation on the ward at the same time. A possible common source of these infections is under investigation.

The thresholds for 2017-18 remain at zero avoidable MRSA bacteraemias permissible.

(2) MSSA Bacteraemia

From 1st January 2011, the Trust has been required to report all cases of meticillin susceptible *Staphylococcus aureus* (MSSA) bacteraemia using similar criteria and mechanisms as employed for MRSA.

There were 78 episodes in 2016-17 of which 31 were apportioned to the Trust. This compares to 91 episodes in 2015/16 with 39 of these apportioned to the Trust and in 2014-15 the numbers of episodes were 82 and 29 respectively.

There are no national thresholds for MSSA bacteraemia at present. The rate of trust-apportioned episodes for St George's is 10.2 per 100,000 bed days and represents the median rate for compared to other similar trusts in London. In the past it has been theorised that MRSA bacteraemias were additional to MSSA bacteraemias meaning measures to prevent MRSA bacteraemias would not necessarily reduce healthcare-acquired MSSA bacteraemia, though others have argued that the routes of transmission

and infection are similar. Given that only 1-2% of patients are colonised with MRSA, whereas 30% of patients are colonised with MSSA, it is not surprising that the rates of MSSA bacteraemia are proportionally higher especially since MSSA colonised patients are not given decolonisation treatment. In an attempt to understand the risk factors involved MSSA that are assessed as being clearly healthcare associated are subject to Root Cause Analysis. Vascular catheter infections are the commonest focus of infection.

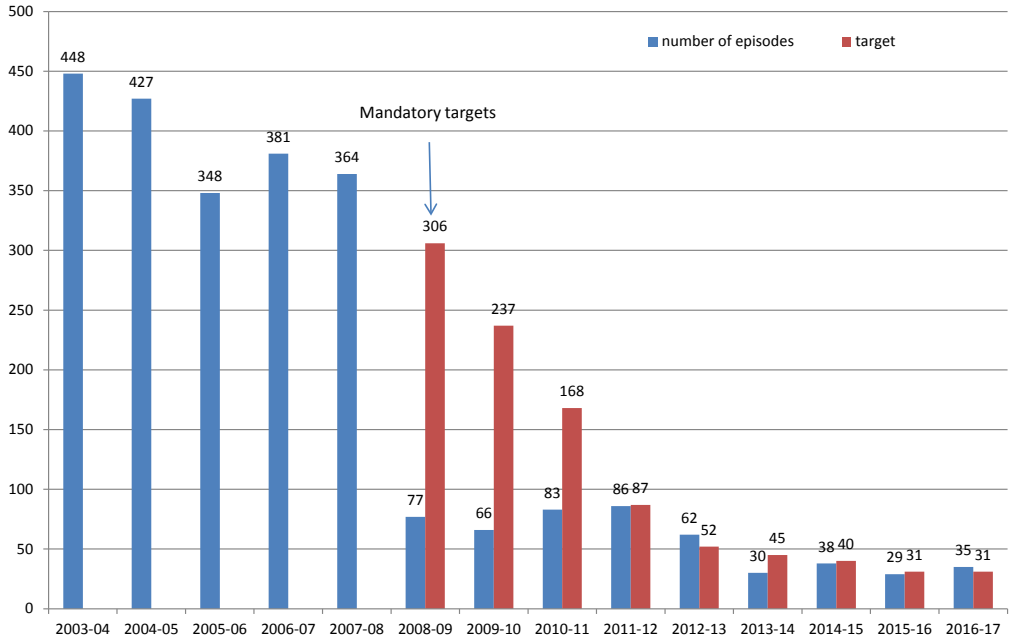
(3) *Clostridium difficile*

Clostridium difficile infection is a major cause of antibiotic-associated diarrhoea, and became widespread in UK hospitals in the late 1990s with significant increases in numbers of patients being infected. In response to this the Government announced in October 2007 a plan to reduce the number of *C difficile* infections nationally by 30% by the end of the calendar year 2010-11. The baseline that this reduction was applied to was the number of "attributable" cases in the financial year 2007-08.

The 30% reduction was for the total number of cases nationally. Some trusts already had low levels before the start of the programme in 2008-09; thus the reductions were applied differentially. That is, historically good performing trusts only needed to make a 10% improvement, whereas others with higher baselines needed to make improvements of greater than 30%. St George's was one of the latter.

St George's has significantly improved its *C. difficile* rate since then. The reduction in *C. difficile* episodes was in response to a bundle of measures introduced which has been described in detail in previous annual reports. Figure 2 indicates the reduction in numbers of episodes since 2002-03.

Figure 2. Numbers of hospital-acquired infections with *Clostridium difficile* at St George's 2003-04 to 2016-17 with targets



Each year the Trust has a target (threshold) for trust-apportioned episodes. The targets are individualised for each trust with a very wide range. The target for St George's in 2016-17 was 31 episodes equating to a rate of 10.2 per 100,000 bed days. Other London Teaching hospital trusts have targets up to 4 times higher.

Unfortunately for the first time in three years the Trust had more episodes of trust-apportioned *C. difficile* episodes than the target i.e. 36 versus a target of 31. Although this is disappointing, the rate for St George's was still lower than the majority of other London Teaching hospitals and was the 7th lowest of all 29 teaching hospital trusts in England. The best and worst performing trusts in London had rates of 8.84 and 33.6 respectively. The median rate for all trusts in England was 13.62. The lowest and highest for all trusts in England were 0 and 64.1 respectively.

Episodes that are trust-apportioned undergo RCA and all isolates of *C difficile* also undergo ribotyping to look for any evidence of cross-infection. Together, the RCA findings and ribotyping can be used to ascertain if there have been any lapses in care.

For 2016-17 analysis showed the following:

One episode was clearly a community-acquired infection but justifiable delays in obtaining a specimen meant that the timing of the diagnosis resulted in the episode being categorised as trust-apportioned.

In four episodes, despite positive cytotoxin results, *C. difficile* was not culturable from the specimen. This does not rule out infection, but does cast some doubt on whether these patients did have infection or not. It is well known that testing for *C difficile* infection is not 100% sensitive or specific.

One episode was almost certainly acquired on a ward as a result of cross infection as evidenced by the patients' isolates having the same uncommon ribotype and the patients being linked in time and location.

In five other episodes it was not possible to rule out cross-infection from one patient to another on a ward. This is because of lack of ribotyping results caused by culture-negative specimens or because the laboratory made an error and failed to ribotype the isolate on two occasions.

In six episodes there were errors in antimicrobial prescribing. In two episodes antibiotic that were given were not according to Trust protocol and approval from microbiology doctors had not been sought. Of these, one episode was prolonged prophylaxis and the other was therapeutic use of ciprofloxacin. In four episodes, antimicrobial prescribing was in accordance with the Trust policies, but there was inadequate documentation e.g. lack of evidence of reviews and/or lack of details of indications recorded.

Thus in total seven lapses in care were declared.

For three episodes it was not possible to state whether a lapse in care had taken place as a result of loss of notes in one patient and lack or ribotyping results in two patients.

(4) Glycopeptide resistant enterococcal bacteraemia

This reporting scheme started on 1st October 2003 and data have been published annually for all hospitals for a year running from October to September. St George's figures are illustrated in table 2 below with figures up to end of September 2016. There are no national thresholds. St George's has always had very low levels (more than 75% lower than some trusts) and this trend continued

Table 2: Annual numbers of GRE bacteraemias at St George's Hospital

Year	Number of patients
October 09 to September 2010	3
October 10 to September 2011	4
October 11 to September 2012	13
October 12 to September 2013	11
October 13 to September 2014	12
October 14 to September 2015	11
October 15 to September 2016	8

(5) *E. coli* Bacteraemia

All Trusts are required to report cases of *E. coli* bacteraemia using similar mechanisms as for MRSA and MSSA bacteraemia. Surveillance began in June 2011.

Typically, community acquired *E. coli* bacteraemia results from abdominal, biliary or urinary tract sepsis. Hospital acquired cases of *E. coli* bacteraemia can also be associated with urinary catheter infections. There are no national thresholds, nor does the national reporting system differentiate between trust onset and community onset so it is not possible to benchmark our data against other Trusts at the time of this report. However from April 2017 onwards, episodes will be differentiated as community-acquired or healthcare-acquired using the 48 hour rule. A 50% reduction target over a five year period will also commence and will include all episodes whatever their attribution.

There were 259 episodes in 2016-17 compared to 249 episodes in 2015-16 and 260 in 2014-15. Applying the 48 hour rule to differentiate between community-acquired and hospital-acquired episodes, 67 of those in 2016-17 were hospital-acquired compared to 63 in 2015-16 and 66 in 2014-15. As stated above it is currently it is not possible to compare the rates of hospital-acquired infection with rates from other Trusts as that information is not available, but this will change in 2017-18.

(6) Surgical Site Infection Surveillance

It is mandatory for any hospital that performs orthopaedic surgery to complete one module of the nationally organised surgical site infection surveillance service per year. The Surgical Site Infection Surveillance Service (SSISS) is organised by the Public Health England. Hospitals record data using a set of standard criteria. Infection rates are calculated on the basis of data collected during the patient's admission and include a post-discharge surveillance period that can be up to a year from the procedure date if the patient has received a prosthetic implant. This means trusts can monitor their performance against previous results and other hospitals.

Fractured Neck of Femur

The infection prevention and control team undertook surveillance of repair of fractured neck of femur. This is a mandatory module that the trust undertakes each year. We collect data for all four quarters of the year. The surgical site infection rate for fractured neck of femur was 1.3% for the calendar year 2016 which is in line with the national mean. See table 3 below. The trust will continue to monitor infection rate trends for all four quarters. The data collected for Q1 2017 has yet to be submitted, the deadline for this is June 2017.

Table 3

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2016 Q1	47	0	0.0%	0	0.0%	0	0.0%
2016 Q2	60	1	1.7%	0	0.0%	1	1.7%
2016 Q3	66	1	1.5%	0	0.0%	1	1.5%
2016 Q4	54	1	1.9%	0	0.0%	1	1.9%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

The national mean rate of infection published for cumulative data from 2011 to 2016 is 1.3%.

Coronary Artery Bypass Grafts (CABG)

The cardio-thoracic surgery team in conjunction with the infection prevention and control team undertook SSI surveillance of all CABG surgery.

Table 4

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2016 Q1	139	4	2.9%	0	0.0%	4	2.9%
2016 Q2	133	8	6.0%	1	0.8%	9	6.8%
2016 Q3	184	7	3.8%	1	0.5%	8	4.3%
2016 Q4	180	7	3.9%	2	1.1%	9	5.0%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

The national mean rate of infection published for cumulative data from 2011 to 2016 is 4.1%.

After the introduction of multiple measures following the high rates reported in the 2013-14 annual report the infection rate reduced significantly. The overall rate dropped from 9% in 2013-14 to 6% in 2014-15 and 3.6% in 2015-2016. The rate for the whole of 2016 was 4.1% in line with the national mean. SSI rates were slightly higher in quarters 2, 3 and 4 of the calendar year 2016 (See table 4 above). The Cardiac Surgery Nurse practitioner undertakes RCA for all organ space SSISs. There was no identified reason for the increase in SSIS.

Previous measures included and continue to include:

- Analysis of the cases. This did not reveal any obvious common cause such as surgeon, surgical assistants, theatres or pre-existing conditions. There was some trend towards the relation being with longer surgery although this is not unexpected.
- Establishment of a cardiothoracic infection committee consisting of cardiothoracic surgeons, cardiothoracic nurses, theatre staff, infection prevention and control team, the audit and surveillance nurse and consultant microbiologist.
- Establishment of a no touch rule for wounds and dressings for the first 2 days and now permanent use of clear dressing to allow inspection of the wound.
- Introduction of “cough locks” to prevent wound mechanical dehiscence.
- Introduction of measures to reduce inappropriate traffic through theatres.
- Weekly surgical site infections ward round with nursing, microbiology and cardiothoracic surgery consultants.

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Expansion of Surgical Site Surveillance

The results of this surveillance of post-operative infections only represent a fraction of all surgical procedures conducted in the Trust. Thirteen further modules covering other surgical procedures are available and an interest in SSI Surveillance has been shown by

other surgical teams. In order to follow up this interest, further resources are needed to expand the service as surveillance is very time consuming.

The Trust executive management team previously accepted in principle that surgical site surveillance at St Georges should be expanded especially following the introduction of the NICE quality standards QS47 which requires providers to undertake SSI surveillance and for commissioners to ensure this is performed when commissioning services from providers. A business case was completed for acceptance by the Trust executive but due to financial constraints was not implemented as planned in 2015/16 or 2016/17. This plan will be reviewed again in 2017/18.

Alert Organism Surveillance

MRSA acquisitions

The Infection Prevention and Control (IPC) team record all new MRSA acquisitions in the Trust i.e. MRSA grown from clinical samples other than blood cultures, including screening swabs. The following criteria are used to decide whether MRSA was acquired in the trust.

Acquired in the trust

- Newly positive specimen in an inpatient known to be MRSA negative on admission.
- Newly positive specimen on admission from a patient known to have been a patient in the trust in the preceding year.
- Newly positive specimen in a patient who has been admitted for greater than 48 hours.

Not acquired in the trust

- Newly MRSA positive in a swab taken less than 48 hours after admission and no admission to the trust in the preceding year.

The acquisitions are shown below since 2005-06 in table 5 and figure 3. It will be seen that numbers of acquisitions have steadily fallen since records began.

Currently all patients admitted to St George's Hospital are screened for MRSA in accordance with previous NHS requirements mandated in 2010. In 2014 new advice was published indicating that MRSA screening could be reduced to "high-risk" patients only i.e. the practice up to 2010. This new advice was reviewed at St George's and a decision was made to continue with universal screening.

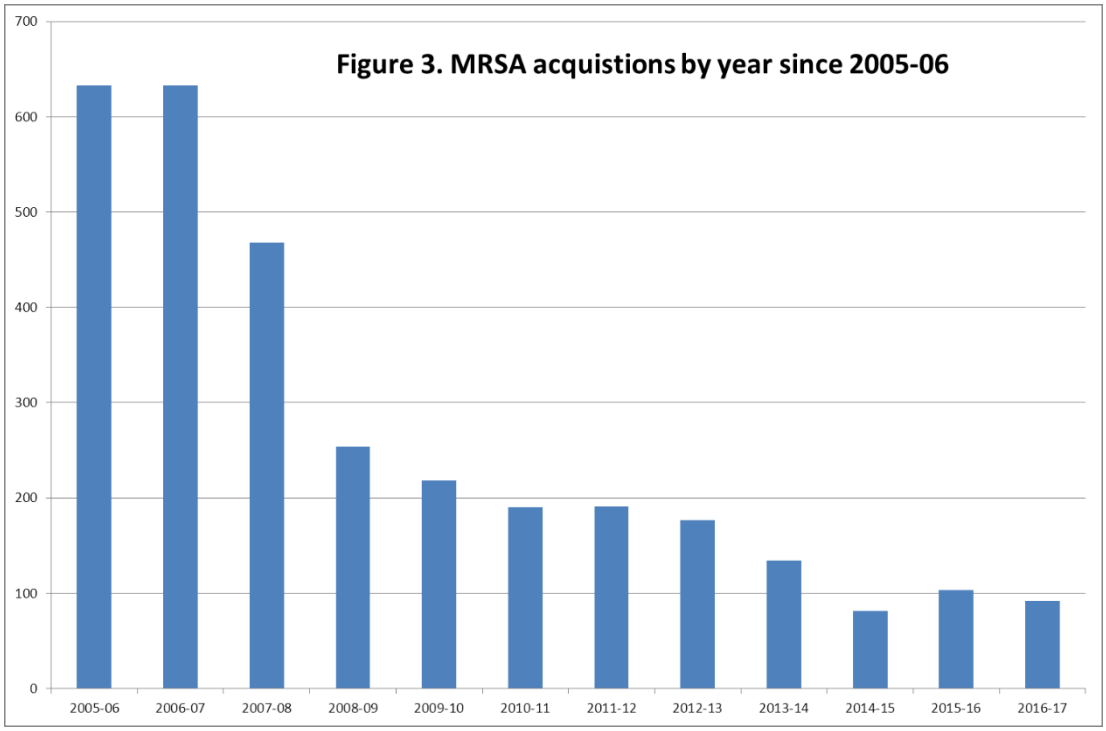


Table 5: Total number of acquisitions and percentage fall for successive years from 2005-06.

Year	Total acquisitions
2005-06	633
2006-07	633
2007-08	468
2008-09	254
2009-10	218
2010-11	190
2011-12	191
2012-13	177
2013-14	134
2014-15	81
2015-16	103
2016-17	92

The majority of patients who acquire MRSA are colonised only. However it is possible that infection may develop. This can be prevented by early use of decolonisation treatment which can remove MRSA colonisation or, if given before surgery, prevent surgical site infection by reducing the MRSA bio-burden.

Decontaminating hands at the point of care and adherence to the WHO five moments for hand hygiene are essential factors to preventing the transmission of MRSA to patients. The IPC team promote the importance of hand hygiene through teaching sessions,

monthly hand hygiene audits, assessment of healthcare workers hand hygiene technique and promotion of hand hygiene day across the trust.

Wards with clusters of MRSA acquisitions

Two wards had clusters of apparent acquisitions of MRSA in 2016-17.

In December 2016 five patients on an ENT ward were identified with colonisation with a PVL producing strains of MRSA which were indistinguishable on typing. One of these five patients had been admitted already known to be colonised with MRSA and had received appropriate decolonisation treatment, but had recolonized. The typing results indicate that there was cross-infection to the other four patients. Audits showed that hand hygiene and cleaning and disinfection on the ward had been good, though the ward had been unusually busy during this time period. Following recognition of the cluster and implementation of enhanced cleaning and attention to hand-hygiene, no further episodes were detected. Whole genome sequencing of the MRSA isolate has established links to another hospital and it is possible that the index patient acquired colonisation there. This strain is identical to the MRSA isolate from a patient with bacteraemia (see section above). At the time of preparing this report, further investigations are underway.

In January 2017 five babies with MRSA colonisation were identified. Typing of these MRSA isolates revealed four different strains. Two babies had the same strain type and had been in the same room at the same time indicating that cross-infection was likely. The other three babies had unique strains and may have acquired these from other contacts e.g. mothers. Once the cluster had been identified and appropriate actions implemented no other episodes were identified. During this time there had been no deficiencies in hand-hygiene as demonstrated by audits

Other Outbreaks and Incidents

Infections associated with heater-cooler units in cardiothoracic surgery.

Heater-cooler units (HCUs) are used during cardiothoracic surgery to keep blood at the correct temperature and to cool cardioplegia solution In 2015 PHE and the MHRA alerted all trusts in England to the risk of infections associated with these units. The machines contain water which is at risk of becoming contaminated with environmental mycobacteria, in particular the species *Mycobacterium chimaera*. Some HCUs can also cause aerosols of this contaminated water to be released into the operating environment thus contaminating open wounds, surgical instruments and equipment. There is now strong evidence to show that these HCUs became contaminated at the manufacturers resulting in a world-wide problem. In the UK over 20 patients have been identified with this infection, mostly with endocarditis and worldwide there are over 100 cases reported so far, and likely to be many more. Overall the risk is still considered to be very low – in the order of 1 in 5000.

The implicated HCUs were used at St George's since 2007. Following the alert in 2015, new cleaning and decontaminating schedules were introduced and in July 2016 the suspect HCUs were replaced with an alternative model made by a different manufacturer.

Although these new HCUs contain water that can also become contaminated with bacteria, they have been shown not to produce aerosols, a property that has also been verified in tests commissioned at St George's, thus the risk to patients since July 2016 is negligible. National guidance was updated in late 2016 and St George's is following this guidance which includes enhanced cleaning and decontamination, regular water testing and a plan to remove the HCUs from the operating environment. Although the new HCUs do not produce aerosol there is still a very small risk from potentially contaminated water.

Three patients who had operations at St Georges prior to the alert in 2015 have now been identified with infection. Two of these patients were diagnosed with endocarditis and one with a sternal wound infection.

Due to the potential exposure of thousands of patients nationwide, NHS England and PHE mandated a patient notification exercise that took place in March 2017. All patients who had surgery since the start of January 2013 in hospitals where the implicated HCUs were used have been alerted to the small risk of infection, given information regarding symptoms and advice on what to do if they are concerned. Their GPs have also been informed. Thus it is possible that more episodes of infection may be identified

Influenza infections and outbreaks

The number of diagnoses of influenza was slightly higher in 2016-17 compared to the previous year. Influenza A infections started being seen in October 2016 and peaked in January 2017. 246 patients were diagnosed either in A&E or admitted with influenza A H3N2 virus and just 7 H1N1 2009 pandemic-like virus. There was 59 Influenza B confirmed patients either seen in A&E or admitted to the hospital with infection. Influenza B activity picked up in January 2017. Four wards had confirmed outbreaks of influenza A infections; these were Rodney Smith (April 2016), Belgrave (May 2016), Mary Seacole Ward (January 2017) and Gordon Smith (February 2017) resulting in a total of 100 bed days lost. 91 staff were tested across the trust and of these 9 were confirmed Influenza A positive, including some staff who had received vaccine. There were 32 hospital-acquired cases in annual year 2016-2017

Not all hospital-acquired infections are preventable. Patients with influenza can have very mild symptoms so that diagnosis is not immediately obvious and furthermore patients can be infections before symptoms start. Also vaccination does not prevent all episodes of infection. Some additional bed days were lost throughout the year due to closures for sporadic cases of influenza; however these were not for significant periods of time.

In 2016-17 there was a big increase in influenza vaccine uptake with 72.7% of patient-facing staff receiving immunisation compared to 53.7% in the previous year. The mean uptake across London Trusts was 53.1% and ranged from 21.3% to 77.6% for individual Trust. The overall rate for acute trusts in England was 64%. St George's had the fourth best uptake across London Trusts and this is up two places from last year. The uptake by nurses and doctors was 62.2% and 75.3% respectively. The uptake in other clinically qualified staff and support staff was 80.4% and 83.9% respectively. Many of the influenza immunisations at St George's are given by peer vaccinators. Peer vaccinators and Flu clinics were integral to this overall increase in vaccine uptake.

Other respiratory-viral infections

In January 2017 two babies on NNU were identified with RSV infection. One other baby had infection with metapneumovirus. Rapid interventions were introduced and no further infections occurred though the unit had to be closed to new admissions for a period of 5 days.

Norovirus Infections and Outbreaks

As in all years since 2007-08, enhanced testing for Norovirus was available for the winter months. Any patient admitted with diarrhoea or vomiting, or who developed these symptoms within 48 hours of admission is tested for Norovirus infection as are any patients where there are suspected clusters or outbreaks. In total the laboratory tested 558 patients from the trust either from A&E or inpatients (both stool and rectal swabs). Of these, a total of 50 patients were confirmed Norovirus genogroup II positive. There were 3 outbreaks within the trust: Marnham ward (April 2016), Amyand ward (May 2016) and Paediatric Intensive Care Unit (January 2017). Combined, these outbreaks resulted in 81 bed days lost. 17 staff cases were reported on PICU, however, no staff specimens were obtained.

Antibiotic-resistant *Enterobacter cloacae* on the Neonatal Unit

Since 2006 there have been intermittent episodes of colonisation and infection due to a virulent and multiply-antibiotic resistant *Enterobacter cloacae* on NNU. No episodes of either colonisation or infection with this organism were detected in 2016-17.

Pseudomonas aeruginosa cluster of colonisation infection on Neonatal Unit

A possible increase in the number of babies colonised or infected with *Pseudomonas aeruginosa* was investigated in November 2016. A possible environmental source was hypothesised. A review of water testing records and a detailed review of locations and timings of positive microbiology results in babies on the unit showed that a cluster of infections arising from water was unlikely. Water from outlets on NNU is regularly tested in accord with the requirements of the relevant HTM and *Pseudomonas aeruginosa* positive culture results from clinical specimens are now flagged as alert organisms so that possible clusters can be investigated promptly.

Multi–drug resistant *Pseudomonas aeruginosa*

Patients may be sporadically identified with colonisation and in some cases infected with a multiply-antibiotic resistant organism. In 2016-17 one patient was identified with colonisation with a multiply-antibiotic resistant *Pseudomonas aeruginosa,* designated as ST111 that was acquired during a long admission on a paediatric ward. One further patient was identified with colonisation with this organism on screening taken on admission. It is possible that this patient was previously exposed during an admission sometime in the past. This organism has been seen as a cause of sporadic infection or colonisation in individual patients as well as some clusters of infection in the past at St George's and at that time was investigated thoroughly. A set of control measures and actions were designed so that whenever an episode of infection or colonisation is

identified a thorough investigation takes place in order to determine if other patients have been affected. No evidence of colonisation or infection of other patients was found in these episodes in 2016-17, though environmental contamination of a clinical hand wash basin was discovered on the paediatric ward. This has been replaced. Further environmental screening has not detected this organism again on that ward. Regular environmental and patient screening is conducted in other wards where previous infections have occurred but this organism was not detected on these wards in 2016-17.

Carbapenamase Producing *Enterobacteriaceae* and other carbapenem-resistant organisms

These are multiply-resistant Gram-negative bacteria. No episodes of hospital-acquired infection with CPE were identified in 2016-17. Several patients with CPEs were treated in the hospital. These patients acquired their infections elsewhere and included two with NDM producing organisms acquired in Pakistan and Thailand respectively and one patient with an infection with an OXA-48 producing organism that was acquired in Spain.

This Trust does not screen all patients for CPEs but operates a programme of enhanced surveillance. All bacteria with an antibiotic resistance pattern indicative of possible carbapenamase production are investigated further. Patients at high risk are screened, for example on admission to Augmented care units, or if there is a history of inpatient stay from a high-risk location or country. Ward contacts are screened if there has been possible contact with another patient who is colonised or infected.

The Trusts reports episodes to the voluntary PHE operated CPE database as well as submitting antibiotic resistance data to the PHE. Compared to other trusts the rates of carbapenem-resistance and CPE numbers are low. This does not provide total re-assurance as other trusts have different screening and laboratory investigation protocols, so a direct comparison cannot be made. The policies and procedures at St George's are under constant review and it is likely that at some point in the near future there will be a need to expand the screening and surveillance programme.

Measles

During the year a large community outbreak of measles occurred in London. Nineteen patients with measles were diagnosed at St George's, mostly as attendees at A&E but also some inpatients. Children and adults were seen with this infection. Due to some delays in diagnosis because of unfamiliarity with the clinical presentation of measles several episodes of possible exposure to other patients took place. Measles is infectious before diagnostic symptoms appear. This resulted in some extensive tracing of patients who may be at risk of more severe infection. Only one patient, who required prophylaxis, was identified. This was a baby less than twelve months old that was exposed to another patient with measles (undiagnosed at the time) who was also attending A&E.

Candida auris

This is a multiply-antifungal resistant yeast that has caused outbreaks worldwide including several hospitals in London. Not all laboratories can easily identify this fungus, but the SW London Microbiology laboratory is able to screen as well as identify this organism accurately. So far no patients have been identified at St George's with colonisation or infection but this is likely to occur at some time in the future.

Tuberculosis

There were two episodes where a delayed diagnosis of pulmonary tuberculosis resulted in potential exposure to staff, but not to other patients. These occurred on an adult ITU and a paediatric ward in November 2016 and January 2017 respectively. Screening of staff was undertaken by Occupational Health. No staff acquisitions of infection were identified.

Community Incidents and Outbreaks

There were no incidents or outbreaks in the Community Services Wandsworth division that also includes the medical wing of HMP Wandsworth.

Saving Lives audits

The Saving Lives Programme is a set of 'Care Bundles' or High Impact Interventions (HII) for Acute Trusts that was first issued by the Department of Health in 2005. Originally a collection of five audit tools, this was expanded to eight in 2007.

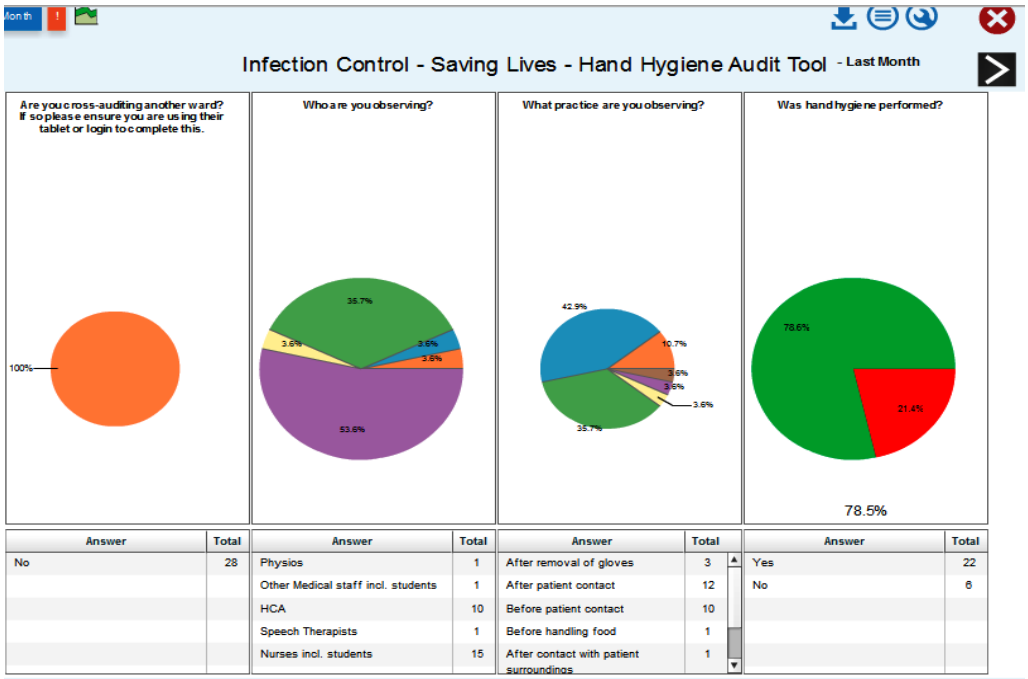
In order to streamline the number of internal audits, the Trust previously combined the Saving Lives Programme with two other mandatory Trust audits (hand hygiene and PPE) to produce a programme of ten audits that are completed as a rolling programme twice per calendar year. The current programme is shown below in table 6:

Table 6

Audit	Month	Month
1. Central venous catheter	January	July
2. Peripheral intravenous catheter	January	July
3. Renal dialysis catheter care	February	August
4. Prevention of surgical site infection	February	August
5. Ventilation associated care bundle	March	September
6. Urinary catheter care	March	September
7. Reducing the risk of *C. difficile*	April	October
8. Cleaning and decontamination of clinical equipment	Monthly	-
9. Hand hygiene observation of practice	Monthly	-
10. Isolation and PPE	May	November

Clinical areas were required to submit a minimum number of audits for each of the tools. Audits are completed on a web based system (RaTE) by the last day of the allocated month. Reports in pie chart format show a breakdown for each question allowing services to examine the audit results in more detail. These can also be downloaded for display. An example is below in figure 4.

Figure 4. Example of audit results



The data are linked to a table report on RaTE called the Saving Lives Scorecard and is updated in real time as audits are completed. This scorecard can be filtered by Division and month/year so services can check at any time to see how they are doing. Audits that have been previously agreed as not locally applicable within a ward/department are not visible on the electronic system. Please see 'Composite Scorecard' section for more detail.

Monthly audit results are displayed on the Infection Prevention and Control notice boards for departments participating in the programme. If the required level of compliance (95% for Hand Hygiene and 100% for the other audits) is not achieved, a local action plan is displayed on the notice board to raise awareness and to enhance compliance.

Results for clinical areas within the Trust directorates are presented on a monthly basis by the divisional representative at the fortnightly HAI taskforce meetings. Clinical areas that perform poorly are required to produce an action plan to address any failings within a stipulated timeframe. A trend graph is also distributed monthly by the team so services can track their direction of travel.

Staff became more familiar with entering and exporting data using RaTE, however, it is still relatively new for use with Saving Lives. Based on feedback from staff, the IPC team have also revised some of the audit tools to make them more fit for purpose.

Composite Scorecard

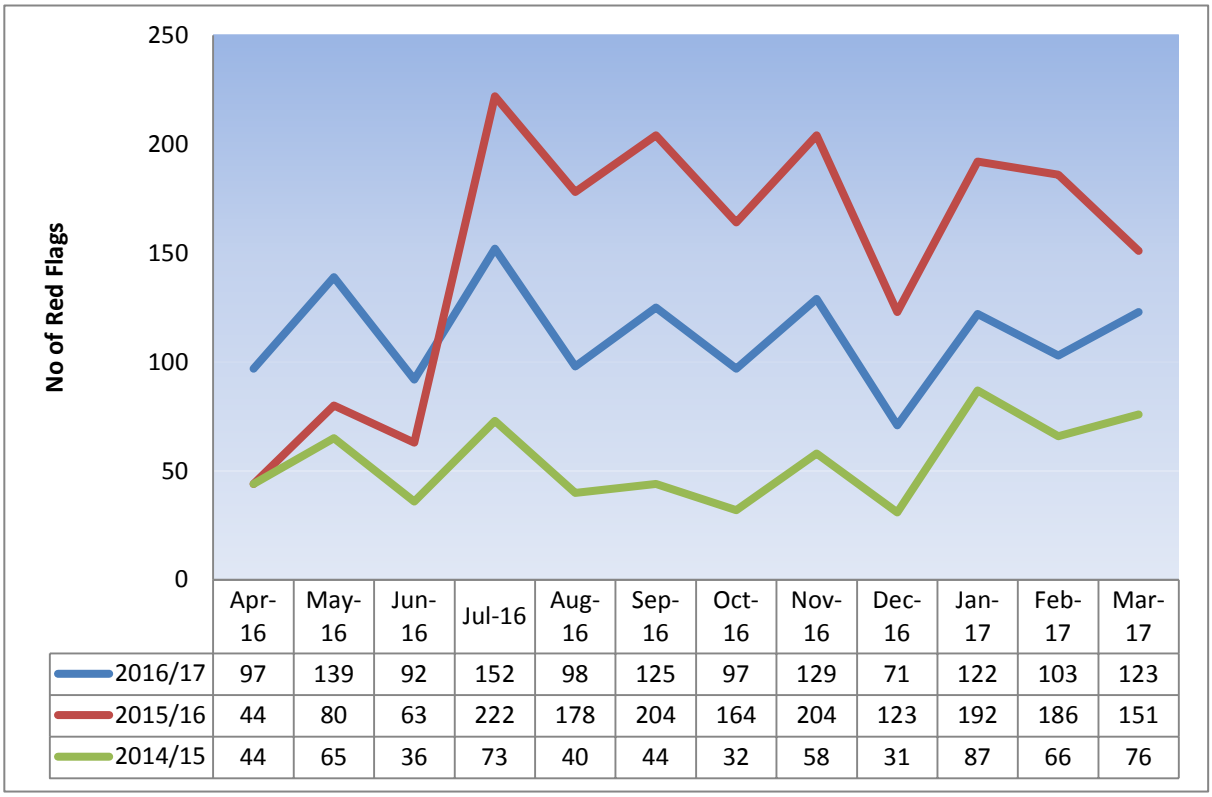
A scorecard that combines several infection prevention and control indices was first published quarterly from Apr-June 2013. Since then the scorecard is published monthly in order to give real-time feedback to the clinical areas.

The scorecard includes data on Saving Lives audits and hospital MRSA and *Clostridium difficile* acquisitions. Data on antibiotic stop dates is not included; this data is incorporated in antibiotic audit reports disseminated by the Pharmacy department.

Wards and departments are allocated a red flag depending on the number of acquired infections or results achieved in the Saving Lives audit programme. The criteria for ward/ departments being allocated red flags is as follows:
-Acquisition of an MRSA bacteraemia that occurs greater than forty-eight hours after admission and the Root Cause Analysis (RCA) demonstrates that the infection is preventable.
-Acquisition of two or more MRSA colonisations
-Acquisition of one or more *C. difficile* infections.
-Hand hygiene audit results below the required level of compliance (95%) or insufficient number of audits carried out.
-Saving Lives audit results below the required level of compliance (100%) or insufficient number of audits are carried out.

The ward/ department is required to generate and implement a remedial action plan and present the work to the HAI Taskforce as required.

Figure 5– Red flags results for 2014/15, 2015/16 and 2016/17



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
2016/17	97	139	92	152	98	125	97	129	71	122	103	123
2015/16	44	80	63	222	178	204	164	204	123	192	186	151
2014/15	44	65	36	73	40	44	32	58	31	87	66	76

Figure 5 illustrates a decline in the number of red flags in 2016-17 compared to 2015-16; this may indicate that the changeover to carrying out Saving Lives audits on RaTE has now been embedded. The fall in red flags over the years during the months of June and December may be attributed to the Saving Lives aspect of the composite scorecard. During these months only 'hand hygiene' and 'cleaning and decontamination of clinical equipment' audits are carried out.

Infection Prevention and Control Audits

The Infection Prevention and Control team undertook a programme of policy audits during the year, as part of the action plan. These included:

1. **Assessment of compliance with aspects of the trust 'Protocol for the Prevention and Management of *Clostridium difficile'*** with the aim of reducing the risk of *Clostridium difficile* (CDI) cross-infection from patient to patient. The objectives of this audit were to :

- Identify areas with high incidences of CDI.
- Establish whether patients with new onset of diarrhoea are appropriately reviewed by medical teams determining whether the likely cause is infectious.
- Review time to isolation.
- Review the infection prevention and control precautions taken when managing a CDI patient.

This audit is carried out quarterly and the results and recommendations were discussed and agreed at the Infection Prevention and Control Committee (ICC).The results and recommendations are fed back to wards and departments via the ICC.

Results indicate a decline in standards in Q2 and Q3 compared to Q1. Q4 is yet to be analysed. Further work is required to ensure full compliance.

Table 7. Compliance with Performance Parameters

Standard	Oct-Dec 2016 (Q3)	Jul-Sept 2016 (Q2)	Apr-Jun 2016 (Q1)
Was a medical review carried out?	83% ↓	86% ↑	71% →
Was the patient isolated within 2 hours of medical review?	35% ↓	50% ↓	85% ↑
Was a fluid balance chart completed?	94% ↑	93% ↑	85% ↓
Was a stool chart completed?	100% ↑	86% ↓	100% →
CDI checklist initiated?	47% ↓	77% ↑	67% ↓
Correct signage on isolation room door?	100% ↑	92% ↑	83% ↑
Isolation room door shut	94% ↑	77% ↑	67% →
PPE available?	94% ↑	85% ↓	100% →
Hand hygiene facilities available?	88% ↓	93% ↓	100% →
Patient specific commode/ toilet?	88% ↓	92% ↓	100% →
Ward commodes clean?	94% ↑	50% ↓	100% →
Chlor-clean made up in past 24 hours	94% ↑	86% ↓	100% →

Compliance
<90%
90% - 95%
96% - 100%

Reports were presented to the Infection Control Committee meeting for feedback by divisional representatives to their clinical areas.

2. Creutzfeldt -Jakob disease (CJD) Assessment Audit

The IPC Team carried out an audit of compliance with the risk assessment of patients for CJD prior to surgery or endoscopy, in accordance with trust protocol. This was presented and discussed at the ICC for action and dissemination.

A questionnaire was developed and data collected from 143 patient notes (80 elective and 63 emergency) and 11 specialities including Cardiac Surgery, Day Surgery, ENT, General Surgery, Gynaecology, Medicine, Neurosurgery, Trauma and Orthopaedics, Plastics, Urology, and Vascular Surgery. 12 wards were audited plus the Day Surgery and Endoscopy units.

Results are shown in Tables 8 and 9 below.

Table 8: Compliance Rate by Specialty for *Elective* Surgery

Speciality	**2013/14**	**2016/17**
Cardiac Surgery	54%	0% ↓
Day Surgery	89%	50% ↓
ENT	-	50%
General Surgery	81%	45% ↓
Gynaecology	100%	25% ↓
Medicine	-	33%
Neuro Surgery	100%	100%
Plastics	-	75%
Trauma & Orthopaedics	54%	67% ↑
Urology	-	63%
Vascular Surgery	-	80%

Table 9: Compliance Rate by Specialty for *Emergency* Surgery

Speciality	**2013/14**	**2016/17**
Cardiac Surgery	0%	0%
Day Surgery	–	75%
ENT	–	50%
General Surgery	75%	23% ↓
Gynaecology	–	50%
Medicine	–	25%
Neuro Surgery	60%	92% ↑
Plastics	–	100%
Trauma & Orthopaedics	0%	71% ↑
Urology	–	100%
Vascular Surgery	–	100%

(–) No data collected

- Neuro Surgery has improved – essential as operations on the brain, spinal cord and the back of the eye can carry the greatest risks for CJD.
- Plastics, Urology and Vascular achieved 100% compliance

- Cardiac Surgery do not risk assess emergency surgical patients for CJD.
- General Surgery show a substantial fall in compliance in 2016-17 compared with 2013-14.
- Trauma & Orthopaedics show a substantial rise in compliance this year when compared to 2013-14.

This report was presented to the Infection Control Committee meeting for feedback by divisional representatives to their clinical areas.

3. HCAI Point Prevalence Audit

The trust participated in the five-yearly national point prevalence study in November 2016. A total of 969 patient records across 49 wards were surveyed. Preliminary analysis showed a healthcare-associated prevalence rate of 6.7%. The provisional national mean was 7%. At the point of writing this report, the full data are not available so a direct comparison with other similar trusts or a detailed breakdown of results by clinical area is not possible. When the study was last performed in 2012 the prevalence at St George's was 9.7%.

Estates and Facilities including Environmental Cleaning

The estates and facilities team in conjunction with the nursing and infection control teams help to audit and assure the Trust of its obligation to provide a safe care environment and meet the CQC outcome requirements.

1. Monitoring and Assurance

In 2016-17 the team were part of the audit teams for the annual infection control audits and the corporate inspections which formed part of the assurance and preparations for the formal CQC visits and annual governance programmes.

These included audits across the community sites, and Queen Mary's Hospital and actions were then taken to rectify any concerns when noted.

The National Standards of Cleanliness scores across all areas continue to meet the Trust overall percentage with standards are being maintained. Any areas of non-compliance from auditing processes were rectified in the correct rectification times.

2. Main areas of development in 2016-17 through from the Estates and Facilities team were

- March 2016- new interim appointment of Director Estates and Facilities, Mr Richard Hancock
- New Estates recovery plan and Estates Strategy ratified
- Capital investment into major infrastructure works on the St. George's site
- Review of areas identified as part of CQC and Trust action for demolition (ie Knightsbridge Wing, Clare House, Bronte Annexe and House, Wandle Annexe (old chest and breast clinic) and 166 Roehampton Lane.
- Relocation of services into community of Clinics in Lanesborough wing due to capacity concerns (blood pressure units, blood test).
- New office and clinical accommodation units are on site for the relocation of services from buildings now vacated
- Water Safety improvements in both clinical and non-clinical areas
- Extension of the current Mitie contract for cleaning and catering services on the St. Georges site until May 2019.
- Significant estates works including Fire safety works; water safety including new sinks and taps in high risk areas (continuation from 2015-16)
- Review of all of the community estate and all governance process to ensure that legal arrangements and compliance
- Lifecycle plans in place for repainting of areas in AMW as part of the PFI
- Bed capacity 2 x 7 bed wards now open in AMW – Neuro Short Stay Unit and Heart Failure Unit
- Environmental Health officer visits carried out and areas scored 5/5 for food hygiene and meeting standards

- Theatre team set up to review infection control including estates and facilities concerns
- Theatres 5 and 6 in St. James Wing refurbished
- Works carried out in the community estate at Queen Mary's hospital, Tooting Clinic, Eileen Lecky Clinic.
- Orders placed for roll out of new dishwashers for all wards on the St. Georges' site.
- New contract in place for Macerators across the St. George's site.

3. Patient-Led Assessments of the Care Environment (PLACE) Programme 2016-17

The 2014 Patient-Led Assessments of the Care Environment (PLACE) is a new assessment and replaces the previous assessments known as Patient Environment Assessment Team (PEAT).

PLACE builds on the foundations of PEAT the two main differences are as follows:

1. Patients make up at least 50% of the assessment team providing a stronger voice
2. Focus on improvement with hospitals required to report publicly and say how they plan to improve

The definition of patients is:
"anyone whose relationship with the hospital is as a user rather than a provider of the services"

Assessors are recruited from patient representatives via the local Healthwatch, Residents Committees, Patient Reference Group, Patient Issues Committee and Access Committees and training on the assessment was provided by the Trust team.

The Assessment

The assessment period took place in St George's Hospital and Queen Mary's in May 2016 with dates not being shared widely.

The areas of assessment include the following four domains:

1. Cleanliness
2. Food
3. Privacy & dignity

4. General maintenance and decor

A minimum 25% of the site needs to be assessed at the St George's Hospital and 100% of Trust space at Queen Mary's Hospital.

Areas to be assessed

There no single assessment form rather there is a series of nine assessment sheets specific to each area:

1. Organisation/Hospital details
2. Organisation facilities questions
6. Organisation food questions
7. Ward assessment acute/community

3. Accident & Emergency
4. External Areas
5. Food & Hydration Assessment
8. Outpatients Departments
9. Internal Areas

Scores were as follows and a robust action plan was completed with 95% of actions being rectified in the financial year with the remaining areas requiring funding and planned for action in 2017.

St George's Hospital

Results are provided for four domains:-	
-Cleanliness (including hand hygiene)	96.42%
-Condition, Appearance and Maintenance	91.92%
- Privacy, Dignity and Wellbeing	80.16%
-Food (including service)	81.13%

Services at Queen Mary's Hospital

Results are provided for four domains:-	
-Cleanliness (including hand hygiene)	100.00%
-Condition, Appearance and Maintenance	97.85%
-Privacy, Dignity and Wellbeing	93.10%
-Food (including service)	92.08%

Environmental Hygiene

The IC team, with the cooperation of Facilities, Waste Manager and Matrons, are responsible for carrying out annual environmental audits.

A new tool was developed in 2016-17 with all members of the team to reflect the changes in the audits required. This was rolled out in 2016-17 for all areas, but see below for some details of changes that were made during the year. Actions from these audits are then fed back and rectifications actioned with the timescales and then fed back to the senior nursing team members and the IC team.

Other audits continued in relation to the National Cleanliness standards audit tools, corporate inspections; and in partnership with the infection control team other environmental audits including the *C. difficile* MDT rounds.

Estates maintenance – this has been a challenging year with the priority areas being Fire Safety, Water Safety, buildings beyond use and infrastructure.

Future plans are in place for ward refurbishment works but this will depend on funding and decant space or the closure of beds to enable these works to be actioned effectively.

Disposable curtains have been rolled out to very high and some high risk areas and the remaining wards in St. James Wing will have their tracks lowered at the beginning of 2017-18.

Further capital project works are planned for expansion of critical care areas in Atkinson Morley Wing; compliance works in outpatient areas; further assessment areas in the emergency department and the demolition of the now vacant buildings.

Further works are required to assist nursing staff with training on cleaning and food safety as a priority in 2017-18.

The site is still operating a BiCS (British Institute of Cleaning Science) accredited site and Mitie have both accredited BiCS trainers and assessors and Food Safety trainers and train their staff accordingly.

IPC Annual Environmental Audits

From 29th March 2016 the IPC environmental audit programme was merged with the trust-wide Quality Inspections being carried out in preparation for the CQC visit in June 2016. Teams were typically made up of a trust lead, clinical lead, patient representative, IPC lead and Estates (Facilities) lead. During this time, the use of the Environmental Cleanliness and Infection Control audit tool (developed in 2015 and put on RaTE) was suspended along with RAG rated, scored reports. It was requested that only key points be forwarded to the Corporate team who in turn collated the findings and sent out a report to the ward or department.

Quality Inspections organised by the Corporate Nursing team continued sporadically through October 2016 using a shortened version of the Environmental audit tool developed for 'Back to the Floor' themed visits to clinical areas - another Corporate team initiative. In October, when these stopped, the IPC team decided to review both audit tools with a view to re-launch the environmental audit programme in conjunction with the Facilities team.

The environmental audit programme using the new tool was rolled out at the beginning of January 2017 with a focus on inpatient areas. Audits were carried out electronically (entered onto RaTE), exported into a RAG rated action plan, and then circulated to the relevant senior nursing teams. This programme ran through to the end of March 2017.

Venous Access Service

The most recent vascular access device (VAD) audit is nearing completion and will be distributed in due course. For the first time the Venous Access Team completed the audit alongside practice educators for the area. Bespoke departmental results will be made available for the practice educators. This has been very advantageous in visually highlighting both good practice and areas for improvement. The new central venous catheter pack is now in use and complies with national and international guidelines. In March 2017 a new top up catheter care (TUCC) box was launched to support ward nurses with on-going care of long term lines for in-patients. The boxes are sent back to the ward areas with the patient following a VAD insertion, and contain all that is required to perform the weekly VAD dressing. This includes a step by step photo guide. The venous access team then visit the patients weekly to top up the boxes and update our VAD surveillance record. The boxes have been well received on the wards and following a pre-introduction audit, a post-introduction audit will be performed. The aim is to show improved compliance with the weekly VAD dressing.

CQC Inspection 2016

The CQC inspected St George's in the summer of 2016 and published their report in November 2016. Sadly the Trust's overall rating fell to that of inadequate and this included a rating of inadequate for safety. The inspectors reported that there was variable adherence to infection control procures with evidence that some staff ignored challenges from colleagues when their practices were observed to be inadequate. Concerns were raised in particular regard to hand-hygiene and cleaning and decontamination of equipment and low levels of completion of mandatory training, including infection prevention and control, were evident. The old estate was also flagged as a risk.

The annual programme for the Infection Prevention and Control Team (see later in this report) has actions in place as a result of these findings. The Trust is also receiving support from NHS Improvement and has received funding for temporary additional staff to support the training in particular hand hygiene.

IPC MAST, Training and Education.

1. IPC MAST Compliance

All wards and departments were encouraged to ensure that their compliance with MAST on-line training was greater than 85%. This proved to be a challenge but significant progress has been made. At present, the compliance rate for IPC clinical on-line MAST is 78% (4,266 staff) and for non-clinical it is 88% (2,292 staff). Medical and Dental staff are the least compliant group; 61% (clinical) and 50% (non-clinical).

2. Link Professional Training

A new 3–day link professional course was introduced in 2016. The aim of the course was to provide a small group of links with the knowledge and resources to be proactive in their ward or department. This was well received by attendees and is now being repeated every 6 months on a rolling basis.

3. IPC Nurse Teaching

The IPC nurses delivered trainings across the organisation throughout the year. These included trust, nurse and HCA induction, annual updates, link staff training, study days, a master class and additional bespoke training.

Hand hygiene training was delivered to all staff attending induction, utilising the Surewash machine; these use a camera, video and graphics to deliver independent hand-hygiene training to healthcare workers, measuring their performance whilst providing real-time feedback.

Face-to-face IPC updates trainings (in addition to on-line MAST):

Monthly IPC update training (1 hour session)

- General Medicine and Senior Health
- General Surgery
- Neurosciences
- Nurse Induction
- Paediatrics
- Renal
- Trauma and Orthopaedics
- ICUs

Other training / frequencies

- HCA Induction – 1 hour / 6 times yearly
- IPC Study Days – 1 day / twice yearly
- IPC Master Classes – 1 day /once- twice yearly
- Medical Students (MBBS4 Programme) – 1 hour / 4 times yearly
- Midwifery IPC update – 1 hour / every other month
- NNU IPC update – 1 hour / every other month
- Trust Induction Hand Hygiene Training – 45 minutes to one hour / weekly

Annual IPC update training (45 minutes to 1 hour session)

- Brocklebank/Doddington Health Centres- DN's
- Children Continuing Care
- Dietetic Service
- Health Visitors
- HMPW clinical staff
- Intermediate Care Day & Night Service
- Learning Disability Team
- Physiotherapists
- QMH Amputee/Neuro Therapy Team
- QMH Radiology
- QMH Wheelchair Service
- QMH Minor Injuries Unit
- St John's Therapy Centre Primary Care Podiatry, OT
- Surgical outpatients
- Theatre staff team day

As required IPC update training (30 minutes to 1 hour session)

- F1 induction
- F2 IPC teaching
- Physicians' Associates
- Cardiac Surgery
- IV Therapy
- Outbreak wards
- Wards – hand hygiene
- Norovirus training
- Influenza training
- Porters
- Phlebotomists

Training was delivered to nurses and midwives, junior medical and dental staff, medical and nursing students, healthcare scientists, therapists, estates and other ancillary staff.
The details of attendees, topics covered and venues are held on electronic staff record (ESR).

4. Study Day, January 2017

The IPC Nurses organised and ran a study day for qualified nurses and health care assistants in January 2017. This focussed on BBVs, Chickenpox and Shingles; Respiratory viruses and VHF. This was well attended and received. Lectures were provided by members of the IPC team and other invited specialists.

5. Additional events and sessions

The annual WHO Hand Hygiene Day (in May) and Infection Prevention and Control Week (in October) were observed at both St George's and Queen Mary's Hospitals. This involved the IPC nurses providing mobile hand hygiene training and stands for both staff and visitors as well as carrying out lectures. IPC company representatives were invited to attend and participated on the stands.

Antimicrobial Stewardship

Key achievements in 2016-17

Full achievement of the National Antimicrobial Resistance (AMR) CQUIN
The AMR CQUIN was introduced in 2016-17 with the aim to reduce total antibiotic consumption and broad-spectrum antibiotic use (piperacillin-tazobactam and carbapenems) and obtain evidence of clinical review within 72 hours of commencing an antibiotic.

Its rationale was to reverse previous trends, which show significant increases in both antibiotic consumption and resistance within England and thus reduce the risk of difficult to treat, multidrug resistant infections becoming increasingly prevalent.

St George's University Hospitals is one of a small proportion of Trusts in England to have achieved all 4 quality measures in the CQUIN, which has secured £750,000 of income. A particularly significant achievement is the 22% reduction in carbapenem consumption, which has saved £80,000 in drug acquisition costs. Details are shown in tables 1 and 2 below.

Part A: Reduction in antibiotic consumption per 1000 admissions
Target: To reduce consumption of the following to 1% below 2013-14 levels

	Table 1: Antibiotic Defined Daily Doses/1000 admissions						
	16-17 Q1	16-17 Q2	16-17 Q3	16-17 Q4	16-17 FY Total	Target	% Change (from 13-14)
Total Antibiotic consumption	6,467	6,474	6,625	6,392	6,395	6,881	**7%** ↓
Piperacillin-tazobactam consumption	92	84	81	79	83	85	**2%** ↓
Carbapenem consumption	105	110	108	92	102	132	**22%** ↓

Part B: Proportion of antibiotic prescriptions reviewed within 72 hours
Target: To increase the proportion to 90% by Q4.

	Table 2: Proportion of Antibiotic Prescriptions Reviewed within 72 hours			
	16-17 Q1	16-17 Q2	16-17 Q3	16-17 Q4
Trust proportion reviewed	82%	90%	90%	90%
Target	25%	50%	75%	90%

Antimicrobial Stewardship Champions
In order to improve engagement in Antimicrobial stewardship within the Divisions presentations were given to each Divisional Governance Board with a request for a

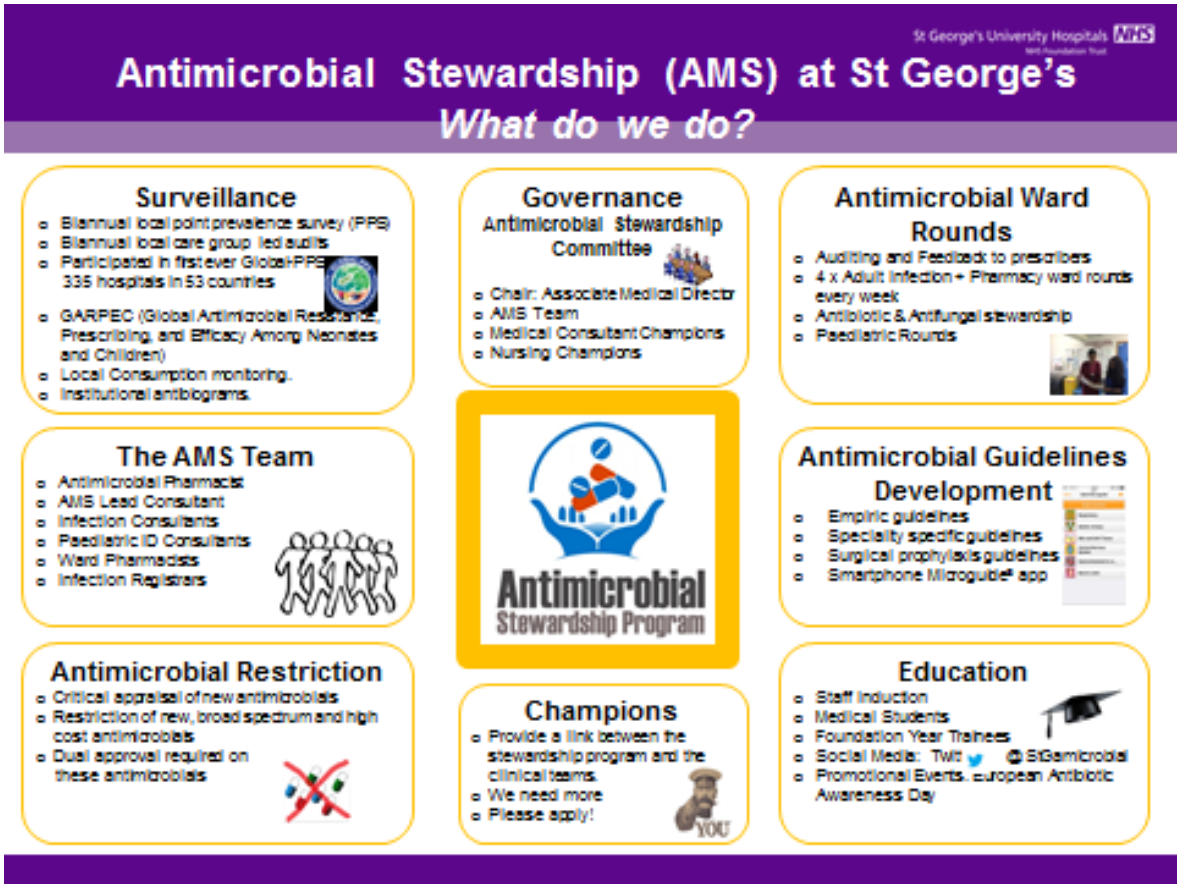
nominated antimicrobial stewardship champion in each care group. Medical consultants have been appointed from each care group resulting in improved communication and joint working with clinical staff, increased attendance at the Antimicrobial Stewardship Committee, and increased audit activity, all of which has assisted in meeting the AMR CQUIN.

Antimicrobial Usage

Most recent audit data shows the proportion of in-patients on antimicrobials has reduced below 30% (29%) for the first time since 2006. Performance against quality indicators remains stable: indication on drug chart (85%), stop/review date on drug chart (83%), appropriate prescribing (94%), protected antimicrobials used according to policy (96%). Evidence of review within 72 hours of prescription initiation has increased to 90%.

The intravenous (IV) to oral switch audit revealed a lower proportion of patients on IV antibiotics (19%) compared to the previous year (26%). However a significant proportion of patients remained on IV antibiotics despite meeting the criteria for an oral switch (23% of those on IV antibiotics), which increases the risk of healthcare-associated infections and other adverse events, increases costs and nursing time and has the potential to delay discharge. Strategies to improve compliance with this policy must be implemented in 2017-18.

Ongoing Stewardship Activities



Laboratory Support

The Infection Prevention and Control Team continues to receive excellent support from the Medical Microbiology laboratory, now part of South West London Pathology (SWLP). The laboratory provides a comprehensive service including for screening alert organisms and diagnosis of MRSA bacteraemias, *Clostridium difficile* infection, influenza and norovirus. The laboratory also has access to specialist tests including molecular epidemiology analyses by referral to the Central PHE laboratories based at Colindale and the PHE London Regional laboratory that was based at Barts and the London. This service moved to PHE Cambridge during the year 2016-17.

Support from Public Health and Commissioners

The IPC team continues to work closely and receive support from the consultants and scientists based at the South London Health Protection Team. A member of that team will usually be part of any outbreak/incident investigation team and the help and advice received at those times is invaluable.

The IPC team are also very grateful for the advice and support received from Sheila Loveridge, Infection Prevention and Control Lead and Associate Partner for Quality and Clinical Governance at the South East Commissioning Support Unit.

Trust Infection Prevention and Control Annual Action Plan: Priorities and Strategy April 2017 – March 2018

The Trust's Infection Prevention and Control Action Plan (formerly the annual programme) for 2017-18 is designed to ensure compliance with the Health Act 2006 The table below shows the priority areas for the Trust from the action plan. It may be necessary to change the programme in response to unforeseen events or other identified priorities as these arise. The full action plan is monitored on a regular basis at the HCA Taskforce meeting.

Priority area	*Actions*	*Date/Freq.*	*Outcome measures*
1.1 MRSA and MSSA Bacteraemia, *Clostridium difficile* infection	**1.1.1** Carry out **a** review of all cases at MDT panel. Ensure action plan implemented and lessons learned locally and across the organisation.	**Commence April 2017**	All cases reviewed at MDT panel. Action plan implemented and reviewed at HAI taskforce. Divisional reps/matrons attending HAI taskforce to disseminate learning
	1.1.2 Initiate Period of Increased Surveillance and Assessment when cases occur (PISA)	**Commence April 2017**	Period of Increased Surveillance and Assessment (PISA) to be carried out until standards are satisfactory.
1.2 *Clostridium difficile*	**1.2.1** Undertake a *C. difficile* re-launch across the trust	**May 2017**	Increased compliance with CDI policy.
	1.2.2 Agree additional reports to be generated and utilise CDI database to interrogate RCA data.	**June 2017**	Report(s) generated and presented to ICC
1.3 *E. coli*, *Klebsiella* and *Pseudomonas* bacteramia	**1.3.1** Review and implement new guidance when available	**March 2018**	Number of cases per annum reduced.
1.4 Carbapenemase Producing Enterobacteriaceae (CPE)	**1.4.1** Develop and implement a pragmatic local CPE action plan that reflects latest NICE and HIS approved guidance for CPE prevention and control.	**December 2017**	Identification and prevention of HAI cases, outbreaks or endemic CPE at SG trust.
1.5 *Candida auris*	Agree and finalise protocol for management of *Candida auris*	**June 2017**	Policy implemented

Priority area	*Actions*	*Date/Freq.*	*Outcome measures*
1.6 ACME software	**1.6.1** ACME to be fully functioning. Maximise the effectiveness of the ACME IPC software system to generate epidemiology reports for alert organisms.	**December 2017**	Fully functioning Appropriate reports generated
1.7 National Point Prevalence Survey on HCAI	**1.7.1** Disseminate findings of PPS to the trust. Appropriate actions taken in response to findings	**June 2017**	Trust aware of HAI rates and appropriate measures taken in response to findings.
1.8 iClip enhanced flagging	**1.8.1** Provide enhanced iClip flagging for particular alert organisms.	**June 2017**	Easy identification on admission of patients with particular alert organisms
2.1 SSI Surveillance Team	**2.1.1** Review the business case for an SSI Surveillance Team to undertake a comprehensive programme of SSI.	**June 2017**	Business case reviewed with DIPC. Decision made regarding provision for SSI surveillance within the trust.
3.1 Divisional Governance	**3.1.1** All divisions to identify IPC priorities and actions.	**May 2017**	Local ownership of IPC, improving patient outcomes Action trackers maintained for all RCAs and reported to ICC.
	3.1.2 To develop a proforma for presentation of key divisional IPC issues.	**May 2017**	Proforma developed and used by divisions
3.2 Care Quality Commission Standards	**3.2.1** Identify gaps in compliance with Key lines of Enquiry, Outcomes 12 and 15 and to work towards achieving compliance.	**June 2017**	Reviewed by IPCT Gaps and actions identified
	3.2.2 Provide assurance to the IPC committee that the trust is achieving compliance with Outcome 12 and 15.	**June 2017**	Reported to IPCC. Further necessary actions identified.
	3.2.3 Complete all relevant actions as per CQC Quality Improvement Programme (QIP)	**April 2017**	All policies up-to-date. Recommendations for nurse frequency of cleaning of equipment reviewed and incorporated into Decontamination policy.
3.3 Hygiene Code Compliance	**3.3.1 Identify gaps in Hygiene Code compliance and implement**	**May 2017**	Undertake assessment and identify gaps.

Priority area	*Actions*	*Date/Freq.*	*Outcome measures*
4.1 Policy and Best Practice Audit Programme	**4.1.1** To develop a clinical audit programme of IPC policies/protocols and best practice for 2017/18	**May 2017**	Programme agreed at ICC.
	4.1.2 To implement the programme depending on IPCT staffing levels.	**March 2018**	Programme complete - audit cycle used to drive change and improve compliance with policies/protocols and best practice.
4.2 Hand Hygiene Policy compliance	**4.2.1** To promote compliance with the Hand Hygiene policy.	**June 2017**	Improved compliance; e.g. improved HH audit scores
	4.2.2 Report EMS Gojo hand hygiene trial and training in CTICU with a view to implementation in key areas.	**April 2017**	Improved HH audit scores Report to ICC and decision taken regarding EMS Gojo package.
	4.2.3 To undertake trust-wide communications campaign for key hand-hygiene messages.	**June 2017**	Key messages communicated.
	4.2.4 Undertake additional hand hygiene audits e.g. hand-rub usage/questionnaires.	**March 2018**	Hand rub measured monthly, trends reviewed and disseminated. Additional audits identified and undertaken.
4.3 Environmental Audits	**4.3.1** Complete the revision of the environmental audits for Outpatients, Theatres and the Community.	**April 2017**	Relevant audits developed and used.
	4.3.2 Develop an electronic action plan to support the programme in order to promote efficiency by reducing manual creation and editing.	**May 2017**	Electronic action plan available and in use
	4.3.3 Audits that are ragged RED – review at taskforce to provide assurance that actions are being taken	**April 2017**	All RED audits reviewed at HAI taskforce. Improved environment and quality.
4.4 Saving Lives Audits	**4.4.1** To review current saving lives audits to ensure that they are user-friendly and appropriate.	**August 2017**	Audit tools revised, new tool for outpatients developed.
	4.4.2 To introduce a RAG rating for saving lives audits rather than a pass or fail	**August 2017**	RAG rating complete

Priority area	*Actions*	*Date/Freq.*	*Outcome measures*
4.5 PDI equipment cleaning audit	**4.5.1** Present findings with a view to funding and implementing	**June 2017**	Report to ICC and decision taken regarding PDI package.
Priority area	*Actions*	*Date/Freq.*	*Outcome measures*
4.6 Composite scorecard trends	**4.6.1** To analyse and use scorecard audit data over time more effectively by looking at different trends e.g. for hand hygiene and decontamination	**December 2017**	Highlight poor performing areas and provide support
5.1 Training Strategy	**5.1.1** Measure the training compliance of staff with direct patient contact in line with education and training strategy to ensure a well-trained work-force.	**March 2018**	IPC MAST compliance to be reported at each ICC via new proforma. Compliance of 85% or more required.
	5.1.2 Review and update online IPC MAST	**May 2017**	IPC MAST updated
	5.1.3 Develop hard copy key information messages for trust and nurse induction	**May 2017**	Key IPC message card available for all staff at trust and nurse induction.
	5.1.4 Organise training for Medical staff to attend, undertaken by IPC doctor	**June 2017**	Medical staff to comply with and promote good IPC.
5.2 Surewash Training Programme	**5.2.1** Quarterly report to be generated to review levels of compliance in clinical areas and amongst clinical groups of staff	**March 2018**	Improved hand hygiene compliance
5.3 ANTT	**5.3.1** Roll out in other areas	**April 2017**	ANTT implemented across the organisation.
6.1 Communication Schedule	**6.1.1** To review and refresh IPC schedule of Communications	**June 2017**	Trust aware of key IPC messages
6.2 Additional Communications	**6.2.1** Communicate additional IPC messages as required and celebrate any successes.	**March 2018**	Trust aware of key IPC messages
	6.2.2 Compose and circulate IPC Newsletter on a regular basis	**June 2017**	Trust aware of key IPC messages

Acknowledgements:

This report reflects the fundamental approach to infection control that operates across the Trust in being very much a team effort. Principle authors and contributors of the different sections on the annual report are as follows:

Umara Adamu
Hasan Al-Ghusein
Pam Bridle
Jane Calloway
Jenni Doman
Melissa Farragher
Jane Goldman
Helen Graham
Kristina Hager
Matthew Laundy
Ruth Law
Selma Mehdi
Jackie Nicholson
Toyin Oladutin
Annie Stewart
Laura Whitney

The Infection Prevention and Control Team would like to record their thanks to many colleagues throughout the Trust for their continuing assistance.

Meeting Title:	Trust Board		
Date:	Thursday 8 June 2017	**Agenda No.**	**2.5**
Report Title:	Safeguarding Adult – Annual Report 2016-2017		
Lead Director/ Manager:	Avey Bhatia – Chief Nurse and Director of Infection Prevention and Control		
Report Author:	David Flood – Lead Nurse Adult Safeguarding Robert Bleasdale – Deputy Chief Nurse		
Presented for:	Update		
Executive Summary:	St George's University Hospitals NHS Foundation Trust has a commitment and responsibility to ensure that all patients receive safe, effective and dignified care. In particular we have a duty under CQC's Standards of Fundamental Care to ensure that those adults most at risk should "not suffer any form of abuse or improper treatment while receiving care. This includes: neglect, degrading treatment, unnecessary or disproportionate restraint and inappropriate limits on their freedom." This report provides a summary of activity with regard to safeguarding adults at risk and highlights how St George's responds to and reports on allegations of abuse and neglect and how we ensure that safeguarding is integral to everyday practice. During the year 2016-17 the team has recruited to the vacancies within the team and a review of Safeguarding was completed, in which it recommends a Head of Safeguarding oversee both the Adult and Children's Safeguarding Teams. This post is currently going through the recruitment process. 43 cases of safeguarding were referred to social service regarding care at St Georges. Only 2 cases of poor care were substantiated by Wandsworth social services. Following a review of these cases the key learning was shared with the teams and related to a lack of documentation to support decision making and skin integrity. Adult Safeguarding Training activity has continued and is above the trust target of 85%. There has been a significant rise in the number of referrals and advice regarding MCA and Deprivation of Liberty, with 244 referrals for advice regarding this in year. This has been supported by the appointment of an MCA and DOLs practitioner to support wards and deliver specific training and education. This is an area that needs increased focus following the issuing of a section 29a by the CQC in which the practice of application and documentation of MCA was raised. In response there is a rolling programme for training for high risk areas and audit questions incorporated into the quality inspection programme.		
Recommendation:	To note and approve the content of the report.		

Supports			
Trust Strategic Objective:	High Quality Care		
CQC Theme:	Caring, Responsive and Well Led		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:			
Legal/Regulatory:	Regulatory impact following the issuing of a section 29a to the trust in which MCA and DoLs was mentioned.		
Resources:	Recruitment to the vacant positions and the establishment of Head of Safeguarding		
Previously Considered by:	Quality Committee	**Date:**	23 May 2017
Equality Impact Assessment:	NA		
Appendices:			

Safeguarding Adults – Annual Report 2016/17

1. Introduction

St George's University Hospitals NHS Foundation Trust has a commitment and responsibility to ensure that all patients receive safe, effective and dignified care. In particular we have a duty under CQC's Standards of Fundamental Care to ensure that those adults most at risk should "not suffer any form of abuse or improper treatment while receiving care. This includes: neglect, degrading treatment, unnecessary or disproportionate restraint and inappropriate limits on their freedom."

This report provides a summary of activity with regard to safeguarding adults at risk and highlights how St George's responds to and reports on allegations of abuse and neglect and how we ensure that safeguarding is integral to everyday practice.

2. Safeguarding Structure and Policy

St George's utilises the Pan-London Adult Safeguarding Procedures which were revised and published in January 2016 in an attempt to provide a consistent approach and response from all agencies involved in adult safeguarding across London. These procedures were produced following the introduction of the Care Act 2014 which put adult safeguarding on a statutory footing. These procedures have been adopted by our local partner agencies and by St George's Adult Safeguarding Committee. There are named senior practitioners from each division sitting on this committee along with other key professionals such as the learning disability nurse and the lead for training and development.

St George's localised safeguarding guidance, revised in light of the Care Act, sits alongside the Pan London procedures to ensure staff respond appropriately and proportionately to safeguarding concerns.

The current resources in the Adult Safeguarding team are:

Position	Band	WTE
Adult Safeguarding Lead Nurse	8A	1 wte
Lead Nurse Learning Disabilities	7	1 wte
Learning Disabilities Nurse	6	1 wte (await start date)
MCA/DoLs Practitioner	7	1 wte (Secondment but moving to substantive)
Administrative support – (Adult and children teams)	3	1 wte (await start date)

3. Safeguarding Alerts April 2016 - March 2017

There have been a combined total of 1085 referrals in respect of safeguarding and Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS) in the period April 2016 to March 2017. This compares to a total of 971 reported in the same period last year, an increase of 11%. The increase is most likely due to the significant rise in the number of referrals around MCA/DoLS and the widening of scope of safeguarding.

Of these referrals, 307 were formally referred to and investigated (where necessary) by social services as safeguarding concerns. Excluding referrals relating to MCA/DoLS (244

for 2016/17), this represents around 36% of all contacts and is consistent with comparable figures both locally and nationally.

Year	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Number of referrals	201	502	602	825	855	971	841
Number of formal safeguarding investigations	57	133	240	294	290	322	307

N.B the figures up to and including 2015/16 included referrals in relation to MCA/DoLS. As of 2016/17 we are now recording MCA/DoLS figures separately

Breakdown of referrals by type

Neglect	225
Physical	95
Emotional	46
Discriminatory	0
Sexual	12
Institutional	0
Financial	46
Domestic Violence	29
Self-neglect	57
Discharge advice/concerns/general advice	225
Pressure Ulcer screening	102
MCA/DoLS	244
Other (including serious case reviews)	4

Breakdown of referrals by Local Authority (Excluding DoLS referrals)

Wandsworth	423
Merton	174
Lambeth	72
Croydon	47
Kingston	15
Sutton	22
Richmond	12
Surrey	22
Other	54

Summary of incidents relating to St George's Healthcare:

2 allegations related to concerns about the behaviour of family members/carers towards inpatient's at St Georges. In both cases protection plans were put in place to ensure the patient's safety and social services were notified of the details of the incidents.

With regard to formal safeguarding enquires/investigation coordinated by social services relating to care issues at St Georges, there have been 43 referrals/alerts. Of these:

- 10 cases related to pressure ulcers raised as concerns on discharge but on enquiry there was no evidence of neglect (external providers often make automatic

safeguarding referrals to social services around pressure ulcers without any definitive evidence of neglect)

- 2 cases of poor care were agreed to have been substantiated by Wandsworth social services and there has been an action plan put in place to address these concerns. These cases relate to the lack of documentation to support the care provided and checks of skin integrity.
- 2 cases remains open
- 2 cases are currently open to safeguarding adult reviews

All other cases were closed with no additional actions following initial enquiries as per Section 42 of the Care Act.

Occasionally safeguarding concerns will be raised against care provided at St George's which we have not become aware of through our systems and processes. This is rare but when this discuss occur the concerns are investigated in line with the safeguarding policy. Complaints and incidents are also reviewed and triangulated for any safeguarding concerns.

Patient Story

Mrs G was admitted to our admission ward and subsequently to one of our senior health wards with dehydration and acute kidney failure. This was her 4th admission within 2 months and was on the background of significant self-neglect. She lived with her husband who was her main carer but his own health was deteriorating and he was struggling to meet her increasing care needs. Both husband and wife continually declined any form of support at home and the ward team were particularly concerned that the cycle of readmissions would continue.

Mrs's G care was being coordinated in the community by an experienced social worker and a number of safeguarding referrals had already been made on the background of her self-neglect but without any positive outcome. There had also been multi agency meetings to discuss mitigation of risk but without engagement from Mr and Mrs G the situation looked unlikely to change

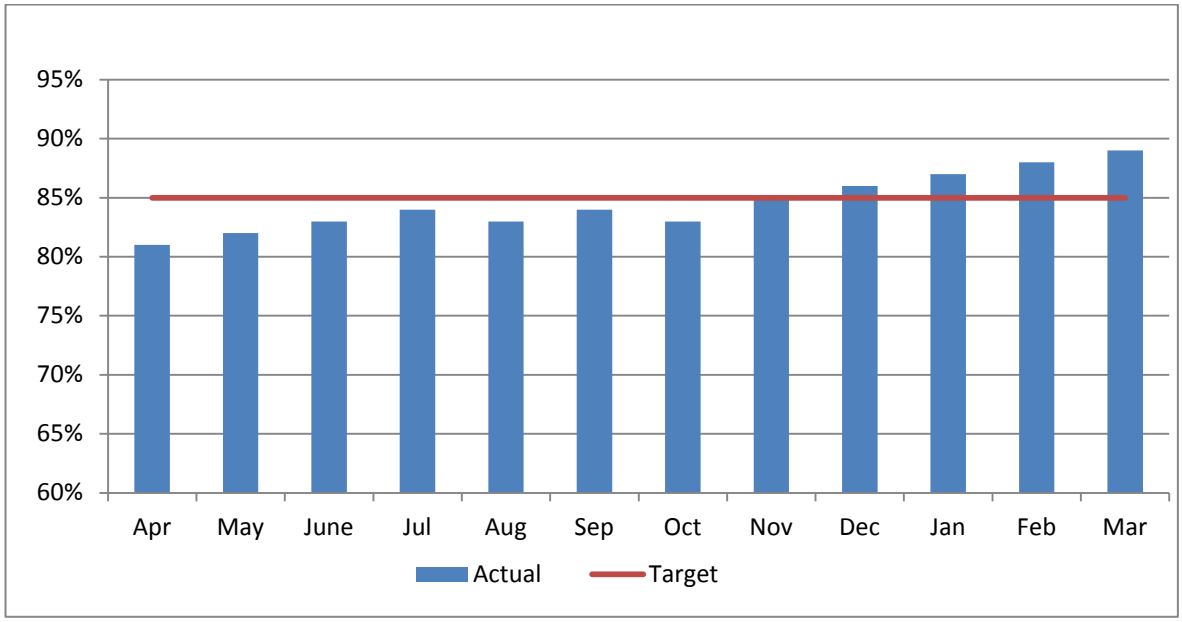
The case was taken to the multi-agency risk assessment panel where high risk cases can be presented to senior operational managers. A plan was agreed across those agencies involved that Mr and Mrs G would agree to; this was discussed with them on the ward prior to discharge. They agreed to this plan and although discharge was slightly delayed by a few days, the subsequent outcome was positive for both Mr and Mrs G. Indeed Mrs G did not have another admission for nearly 11 months

4. Partnership Working

The Lead Nurse for Adult Safeguarding is a member of both Wandsworth and Merton Safeguarding Partnership Boards. Wandsworth Borough Council is the trust's 'host' borough and there is a close and effective working relationship between the various leads within health and social care. The Deputy Chief Nurse and the Trust Safeguarding Lead attend the quarterly Safeguarding Adult Board meetings. The Trust Safeguarding Lead attends the Wandsworth Sub-Groups, one of which he chairs. There are also strong working relationships with our local CCG's around adult safeguarding and commissioning.

At a local level, the Lead Nurse for Adult Safeguarding attends strategy meetings and case conferences coordinated by local authorities following disclosures of abuse. In addition, members of the ward or community teams who may be caring for the patient at the time attend and provide information (such as medical evidence) to assist in the investigatory process.

5. Training Compliance 2016/17

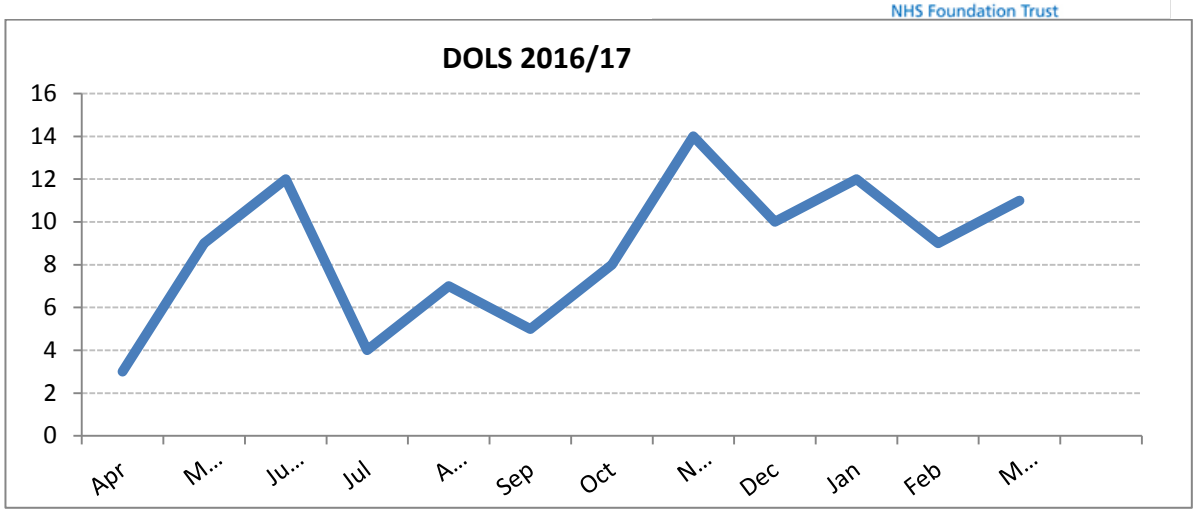


Adult safeguarding basic awareness is part of the e-MAST mandatory training of which all staff complete initially at induction and then every 3 years.

Following the introduction of the Care Act we have recently reviewed the Level 1 training and a revised assessment module was introduced last year

6. Mental Capacity Act/ Deprivation of Liberty Safeguards (DoLS)

There is a clear duty under the Mental Capacity Act (2005) that patients who lack capacity cannot be deprived of their liberty to be treated without appropriate safeguards being in place. The hospital as a 'managing authority' has a responsibility to ensure that all those patients who could potentially meet the criteria of deprivation are referred to the 'supervisory authority' (the appropriate local authority) for independent assessments. There is a requirement that any assessment or authorisation has to be reported to the Care Quality Commission.



The Supreme Court heard two Court of Appeal cases in autumn 2013 and the judgements were made public in March 2014. These judgements resulted in a new "acid test" as to whether someone is subject to a deprivation of liberty and whether the safeguards should be applied. Previous questions over "purpose", "reason", "normality" are no longer relevant. This "acid test" is: *"Is the person subject to continuous supervision and control? And Is the person not free to leave?* "If the answer to both these questions is yes, then some form of legal safeguard must be in place. In acute hospitals this would normally need to be either a DoLS (assuming lack of capacity) or an application of the Mental Health Act. In some situations where a person is ineligible for DoLS and the MHA then a direct application to the Court of Protection may be necessary.

There has been a significant rise in the number of referrals and advice around deprivation of liberty over the past 2 years. In the past year there have been 244 referrals for advice on MCA and assessment of a DoLS. However it must be noted that in the majority of these cases it is likely that some form of restriction/deprivation was in effect occurring and that if the current case law and Law Society guidance was strictly adhered to then these cases would warrant a legal safeguard under DoLS authorisations. Currently we are utilising a risk based approach in authorising the most high risk cases; this approach has been adopted following significant consultation with legal services and discussion with the wider MCA/DoLS network.

There are some specific legal challenges around how DoLS are managed and governed within acute hospitals. Below is a summary of how the urgent DoLS that St Georges have authorised have progressed. Only 36 have been formally assessed and authorised by the local authority leaving significant gaps around any legal safeguards necessary to provide care and treatment in the patient's best interests. Legal advice is very clear in this situation – the responsibility for this gap in safeguards lies with the local authority responsible for the assessments. Whilst this process is ongoing staff have a duty to continue to act in a patient's best interests where they lack capacity (including any use of appropriate and necessary restrictions).

Urgent Authorised	Assessments completed and DoLS authorised	Assessments completed but declined due to either meeting MHA criteria or capacity judged to be	Discharged or transferred before assessments completed	Capacity returned prior to assessments (as judged by clinicians)	Awaiting assessment or sign off at 31/3/17

		present			
104	36	7	42	13	6

7. CQC Inspection, Compliance and Governance

CQC visited St Georges in June 2016 and their inspection found significant issues around consistent knowledge, awareness and implementation of the Mental Capacity Act. In particular there was evidence of poor documentation around the use of restrictions such as mittens and cot sides and lack of evidence of discussion with patients and families/carers. There were no issues raised around adult safeguarding practice.

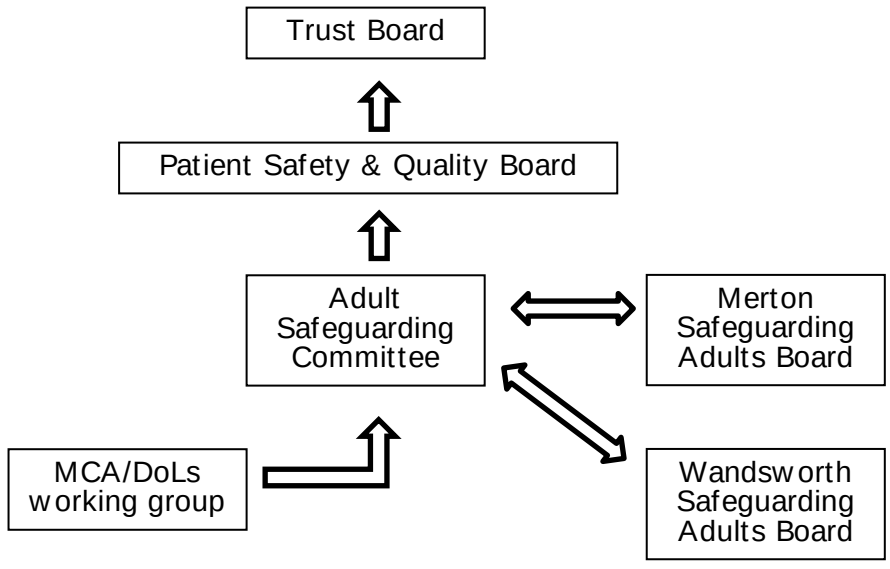
The Trust was subsequently issued a Section 29 warning notice in regard to poor practice and the use of the MCA. Since the warning notice significant training has been delivered across the Trust, in particular to the 4 wards identified in the CQC report. There is now a continued rollout of training delivered by the safeguarding lead and MCA practitioner to high risk areas with support from senior staff and practice educators.

The MCA/DOLs practitioner post, which has been a seconded post for a year, will now be made substantive and will take forward the action plan around improving the Trust awareness and implementation of the MCA. In particular external funding has been agreed to increase knowledge amongst senior staff who need enhanced understanding to help assist with complex cases.

There is now a revised MCA/DoLS policy with simplified flowcharts for staff to follow and the ability for staff to seek expert advice from the MCA/DoLS practitioner in complex cases

Safeguarding Adult Boards (SABs) are required by the Care Act 2014 to monitor and evaluate their performance and that of its members in terms of achieving its objectives and implementing its strategic plan. The London group of SABs has developed a self-assessment tool together with NHS England (London) which St Georges (along with other partner agencies) completed in February 2017. Challenge events are currently being held to provide feedback on the outcome of these audits with a view to improving practice where gaps have been identified. No significant areas of high risk were identified within the St Georges review but there are areas for improvement including more accessible resources online, a better understanding and consistent use of the MCA and improved training around Prevent. There were also areas of good practice identified including high levels of training and awareness across the organisations and good examples of effective multi-agency working.

Meeting/Governance Structure:



8. Safeguarding Review

The Chief Nurse as executive lead for Safeguarding commissioned a review of Adult and Children Safeguarding services which was presented to the Executive Management Team. This report recommended the integration of services across the acute and community services for safeguarding children and that both adult and children's services should sit under the corporate team under a Head of Safeguarding which should report to the Deputy Chief Nurse. The recommendations from the review are currently being implemented.

9. Conclusion

Where allegations or evidence of abuse comes to light whilst patients or clients are under the care of the trust, staff need to feel confident and able to ensure they respond effectively. Most importantly patients should feel safe and their care and treatment should reflect the trust values. The implementation of the Care Act has seen an impact on how adult safeguarding concerns are addressed. The widening of its scope and the revised Pan London procedures may present the Trust with challenges on how to resource the growing demands for training and assurance.

The board is asked to note this report and continue to support the adult safeguarding agenda.

REPORT TO THE BOARD FROM: Quality Committee

COMMITTEE CHAIR: Sir Norman Williams

DATE OF COMMITTEE MEETING: 23.05.17

1.0 MATTERS FOR THE BOARD'S ATTENTION

1.1 Following the recent unannounced Care Quality Committee (CQC) inspection in May 2017, the Chief Nurse advised the Quality Committee that the initial feedback had been positive and no new areas of concern had been raised.

1.2 The Committee was advised that the Trust was still working towards full compliance with the delivery of Duty of Candour. Improvements had been made though to ensure sustainable delivery at a service level, this would now be picked up at the divisional performance review meetings.

1.3 The Committee noted the Picker Survey results on the Inpatient Family and Friends Test. Further work was underway to understand where and why the Trust had performed worse than the national average and to put local action plans in place make improvements for patients and their carers.

1.4 The Committee received the Annual Adult Safeguarding Report 2016-17 and was assured to see progress with an overarching framework now in place. There had been improvements with the Trust's Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) compliance following concerns raised by the Care Quality Commission (CQC) and the policy also had been updated. The work undertaken by the Trust had been well received in a recent unannounced inspection by the CQC.

1.5 The Committee received assurance that the Clinical Audit Programme was in place and in line with the Trust's priorities. The Committee agreed to be involved in the planning and approval of the annual Clinical Audit Programme and receive regular updates on progress at meetings through the year.

1.6 The Committee received a report on Mortality Monitoring Update - Learning for Deaths and recognised the excellent work being undertaken by Nigel Kennea, Associate Medical Director, who was a national lead in this field. The Committee noted that there would be a Trust wide initiative to ensure that all patient notes were annotated to ensure the responsible consultant was easily identifiable. The committee was also informed that learning needed to take place around out of ICU cardiac arrests and mortality following cardiac surgery.

1.7 The Committee received the annual Infection Prevention Control Annual and noted good progress against the IPC targets. In particular the Committee noted:

- the rate of MRSA bacteraemia was the lowest for any London Acute Teaching Trust. the threshold for C.Difficile infection had not been met for the first time in four years though the Trust performance compared favourably to other Trusts in London. The Committee noted that the C.diff threshold was the third most stringent threshold for an English Teaching Hospital Trust.

1.8 The Committee received an oral update from the interim Head of Governance about the potential for medication errors due to dual prescribing systems (manual and electronic) being in operation at the Trust. The Committee was assured that the likelihood of prescribing errors was low due to the stringent controls in Pharmacy though noted that prescribing areas was a key area of focus of the Department of Health currently.

2.0 ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

2.1 The Committee also received reports on:

I. Consent Policy in Practice
II. Draft Quality Account 2016-17. The committee noted more work was required around the formatting of this report before submission.
III. New QIP Framework & Projects
IV. Quality Monitoring and Assurance Process

3.0 RECOMMENDATION

3.1 To receive the update from the QC.23.05.17 for information and assurance.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	TRUST BOARD		
Date:	8 June 2017	**Agenda No**	**3.1**
Report Title:	**Finance Report Month 1 2017/18**		
Lead Director/ Manager:	Ann Johnson, Interim Chief Financial Officer		
Report Author:	Anna D'Alessandro, Deputy CFO Michael Armour, Reporting Accountant		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	This report updates the Board on the financial performance for the first month of 2017/18 including actions underway as a response to under-delivery.		
Recommendation:			
Supports			
Trust Strategic Objective:	Deliver our Transformation Plan enabling the Trust to meet its operational and financial targets.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Finance and Use of Resources		
Implications			
Risk:	**BAF Risk 6**: Failing to Deliver the Financial Plan		
Legal/Regulatory:	The Trust manages its finances in line with standard accounting regulation and guidance set out by NHS Improvement.		
Resources:	N/A		
Previously Considered by:	Finance & Performance Committee	**Date**	31.05.17
Equality Impact Assessment:	N/A		
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

Finance Report Month 1 2017/18
Executive Overview
Trust Board, 8 June 2017

Final results for 2016/17

1. The audited final accounts for 2016/17 were approved by the Board on 31st May, meeting all Department of Health deadlines. There were no adjustments to the outturn previously reported to Board. Control issues and audit recommendations identified during the audit will be reviewed over the next three weeks and an action plan agreed.

Plan for 2017/18

2. The Board submitted a plan for 2017/18 to NHS Improvement (NHSI) in Q4 2016/17. The plan assumed a deficit of £(28.5)m comprising a baseline budget of £(88.5)m deficit partially offset by a £60m Cost Improvement Programme (CIP) saving. At that point, the CIP plan was underdeveloped.

3. The Trust was placed into Financial Special Measures (FSM) by NHSI on 22nd March. Under the FSM regime, NHSI has provided oversight and support to the development of a Financial Recovery Plan (FRP). The Executive team has focused the organisation heavily throughout April and May on the plan. This included putting in a management and governance structure to oversee the plan, developing a robust CIP programme, and assessing the best possible outturn for the financial year. The reforecast plan is still under development and in active discussion with NHSI.

4. Budget sign off letters have been received from all clinical divisional chairs. The letters reference risks to plans in respect of income, 'un-budgeted posts' and CIP delivery. Month One results would suggest that unbudgeted posts do not yet represent a significant risk, but that income risks may be materialising. It is too early to comment further on CIP risk as those plans are in development. We expect corporate budgets to be formally signed off by the time of the Board meeting.

Month One 2017/18 financial performance

5. Detailed M1 financial tables are attached to this report. We did not deliver the Month One financial plan, the deficit was £(12.2)m against a £(6.0)m plan. A portion of this was to be expected as £4.6m of unidentified CIPs were phased into the first month. The £1.6m non-delivery of 'baseline' budget, however, is cause for concern, and is driven by a significant £4.9m shortfall in income (8%) not fully mitigated by cost savings. The following table restates the results to separately show the 'baseline' under-delivery from unidentified CIP, and shows trend compared to last year.

Month One £m	Last year	Plan	Actual	(Adv)/ fav vs Last year		(Adv)/ fav vs plan		Key variance vs plan	Para
Income	61.5	62.4	57.5	-4.0	-6.5%	-4.9	-8%	£(1.9)m tariff or price shortfall, £(1.4)m passthrough drugs (matched with non pay underspend); £(1.6m) activity	6
Pay	-40.5	-41.9	-40.6	-0.1	0.2%	1.3	3%	£1m of the underspend is in the three main clinical divisions	7
Non pay and other	-28.7	-31.1	-29.1	-0.4	-1.4%	2	6%	£1.4 re passthrough drugs, other activity related, depreciation.	8
Unidentified CIP	0.0	4.6	0	0.0		-4.6	-100%	Unidentified CIP allocated across the full twelve months.	
	-7.7	-6.0	-12.2	-4.5	58.4%	-6.2	-103%		

6. The main reason for the year on year income reduction compared to April 2016 is that Easter fell in April 2017 (it fell in March 2016, not April). This does not wholly explain the year on year reduction, especially given an expected 1.4% increase year on year purely arising from the introduction of the new tariff, HRG4. Outside of excluded drugs, the main income shortfalls are in inpatients - the price for planned activity and the volume of emergency activity. Potential factors of the income shortfall compared to plan include:
    - Optimistic activity levels planned, particularly in non-elective.
    - Coding issues arising from the introduction of HRG4, particularly in elective, which may correct once activity is properly coded.
    - Coding issues due to annual leave during the Easter period. There was a higher level of completed activity that was not precisely coded at month-end than usual, and while an estimate was made to include in the reported income, it may have understated the price.

   Divisional and central teams are working at pace to understand the causes and the robustness of both the actual reported income and the baseline plan. This is of particular concern in Medcard, where there appear to be real reductions in non-elective acute admissions, and risks to cardiology activity linked to anaesthetics cover.

7. The pay trend both compared to budget and last year is encouraging. More work is required to understand links between workforce and activity delivered; and the developing CIP plan and underpinning workforce trajectories will necessitate further reductions in the pay bill. There are encouraging reductions in agency spend (£0.2m reduction compared to March after stripping out changes due to revised IT contracting arrangements) which will accelerate towards the end of Quarter One as interim contracts come to an end.

8. Volume sensitive non pay spend has reduced broadly in line with activity. More work is required to understand non pay spend drivers. We are particularly concerned to gain assurance that costs are captured and accrued properly in each month. This is especially

relevant for clinical consumables and drugs which are notoriously volatile and represent over half of non-pay spend.

9. The financial performance by division, separating out under-delivery between CIP and baseline issues, is summarised below.

Month one (under)/ over delivery £m	Unidentified CIP	Other	Total
CWDT	-1.3	-0.2	-1.5
Community	-0.3	-0.1	-0.4
Medcard	-1.4	-1.2	-2.6
Surgery	-1.2	-0.3	-1.5
Corporate and central	-0.4	0.2	-0.2
	-4.6	-1.6	-6.2

10. Financial performance meetings chaired by the Chief Executive were held with each clinical division over the week commencing 22nd May to understand drivers of performance and actions taken to halt and if possible reverse shortfalls. A follow up meeting with Medcard is scheduled for week commencing 29th May given the size of the baseline shortfall. The detailed report attached shows trends and actions by division. Key themes arising:

    - Baseline income shortfalls not covered by pay / non-pay savings in each division. Each team has been asked to consider its cost response in the short and longterm should the income shortfall crystallise and continue.
    - Opportunities in non-pay for further CIP savings across most areas.

11. The reported underlying monthly run rate deficit for the month is £(7.8)m, which compares unfavourably with Q4 2016/17 (£6.0 to £6.5m deficit). The key driver is the income shortfall, it is not yet clear whether this is an in-month anomaly or a recurrent issue.

Recommendation

12. The Board is asked to review the report and confirm agreement to actions/ next steps.

Appendix: Detailed Month One 2017/18 financial report

Financial Report
Month 1 (April 2017)

Board Meeting

8th June 2017

Contents

2. Financial Performance for Month 1 (April 2017)

Headline M1 Revenue Position (including CIPs)

The Month 1 (April 2017) revenue position is a £12.2m deficit, which is £6.2m adverse to plan including the unallocated CIP Plan (shown in the adjacent table).

The budget currently includes 'green' CIP savings of £5m and 'unidentified' CIP of £55m. The 'unidentified' CIP is phased in equal 1/12ths, meaning that £4.6m of the adverse variance (£6.2m) is due to CIP shortfall/non-delivery and £1.6m is adverse to baseline. The £4.6m CIP shortfall is against SLA Healthcare Income (£2.1m), Pay (£1.9m), and Non-Pay (£0.6m).

The Underlying Deficit for April is c£7.8m. This is due to the following elements: £3.1m working days adjustment/normalisation, FSM consultancy support £0.2m, ECRP/RTT costs and net fines £0.7m and CWDT & Central prior year costs £0.4m.

Income & Expenditure	April Actual 2016/17 £'m	Annual Budget 2017/18 £'m	April Budget 2017/18 £'m	April Actual 2017/18 £'m	April Variance 2017/18 £'m	April Variance 2017/18 %
SLA Income	50.8	697.0	54.7	48.3	(6.4)	(11.7%)
Other Income (excl donated)	10.7	118.0	9.8	9.3	(0.6)	(5.7%)
Overall Income	**61.5**	**815.0**	**64.5**	**57.5**	**(7.0)**	**(10.8%)**
Pay	(40.5)	(476.7)	(39.9)	(40.6)	(0.7)	(1.6%)
Non Pay	(26.0)	(332.7)	(27.8)	(26.4)	1.4	5.1%
Overall Expenditure	**(66.6)**	**(809.4)**	**(67.7)**	**(67.0)**	**0.8**	**1.1%**
EBITDA	**(5.1)**	**5.6**	**(3.2)**	**(9.4)**	**(6.2)**	**(193.2%)**
Depreciation (excl donated)	(1.9)	(22.8)	(1.9)	(1.9)	0.0	0.0%
Financing costs	(0.8)	(11.2)	(0.9)	(0.9)	0.0	4.7%
Surplus/(deficit)	**(7.7)**	**(28.5)**	**(6.0)**	**(12.2)**	**(6.2)**	**(101.9%)**

Total Income is £7m adverse to budget - £2.1m is non-delivery of CIP and £4.9m is adverse to baseline. In summary, the adverse to baseline movement in income is comprised of: £1.9m tariff (lower than average planned), £1.6m activity (lower than planned) and £1.4m pass through drugs (matched by non-pay).

SLA Income: £6.4m adverse due to **CIP of £2.1m** and **£4.3m adverse to baseline** in the following:

- **Non-elective income (£1.5m)** as a result of lower than planned average tariff for activity (£1.3m). It is important to note that un-coded activity at month 1 was very high compared to average at c20%, with this activity being priced at an average tariff of coded activity within M1. This issue is being reviewed by the income project team. Unachieved growth within Acute Medicine (£0.2m) is also leading to an adverse variance.
- **Elective income is adverse (£0.9m),** due to unachieved growth in Neuro Surgery (£0.2m), as well as cancellations due to no anaesthetic cover in Cardiac Surgery (£0.1m). Low average tariff, as per non-elective, is leading to a £0.6m adverse variance (21% un-coded activity).
- **Pass-through SLA income underperformance (£0.8m)** is offset within non-pay. **Remaining £1.1m underperformance in SLA income** is due to lower than planned activity in Outpatients (£0.3m), Diagnostics (£0.3m), Unbundled (£0.3m offset with drugs underspend), Deliveries (£0.1m), ED attendances (£0.1m).

Other Income: £0.6m adverse due to lower than budgeted recharge by SWLP (£0.2m) offset in expenditure, lower than planned private patients income (£0.2m), and other minor adverse variances (£0.2m)

Pay: £0.7m adverse although this includes **£1.9m CIP. The (non-CIP) favourable variance of £1.2m** is broadly due to reduced agency spend. The acute divisions account for £1m of this underspend.

Non-Pay: £1.4m favourable largely related to income and activity shortfalls.

3a. Children, Women, Diagnostics & Therapies I&E

Income & Expenditure	M1 LY £'m	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Variance %
SLA Income	10.8	154.8	12.2	11.0	(1.2)	(9.9%)
Other Income	2.3	39.6	3.3	3.4	0.1	1.6%
Overall Income	**13.1**	**194.4**	**15.5**	**14.4**	**(1.2)**	**(7.4%)**
Pay	(11.5)	(139.1)	(11.7)	(12.0)	(0.3)	(2.5%)
Non Pay	(2.7)	(47.9)	(4.0)	(4.1)	(0.1)	(3.6%)
Overall Expenditure	**(14.2)**	**(186.9)**	**(15.7)**	**(16.1)**	**(0.4)**	**(2.8%)**
EBITDA	**(1.1)**	**7.4**	**(0.2)**	**(1.8)**	**(1.6)**	**(948.8%)**
Post EBITDA	(0.5)	(4.2)	(0.3)	(0.3)	0.0	0.0%
Surplus/(deficit)	**(1.6)**	**3.3**	**(0.5)**	**(2.1)**	**(1.6)**	**(309.3%)**

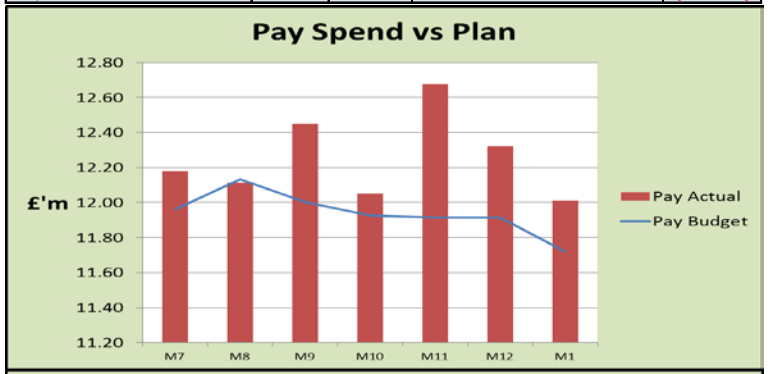
Headlines

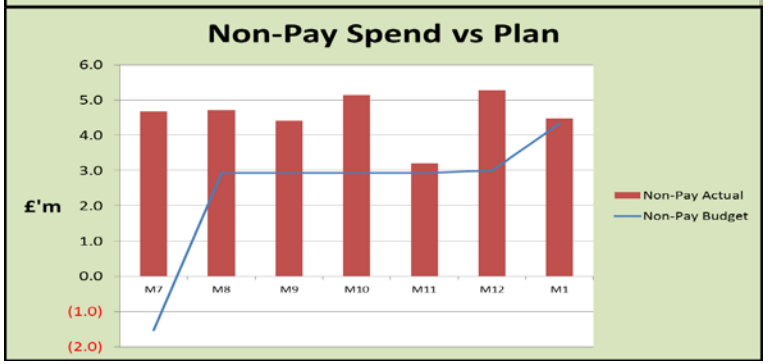
The Division's M01 financial performance is a £1.6m deficit

This is mainly due to income underperformance and the underachievement of £1.35m against the CIP target. £0.60m of the CIP is in SLA Income, £0.60m is in Pay and £0.15m is in Non Pay.

The Directorate variances in Children's (£0.7m) and Diagnostics (£0.6m) are mainly related to SLA Income.

By directorate	M1 LY £'m	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Variance %
Childrens Services	0.3	11.4	0.7	(0.0)	(0.7)	(102.5%)
Critical Care	0.2	7.3	0.5	0.4	(0.1)	(15.1%)
CWDT Division Management	(0.1)	(1.5)	(0.1)	(0.2)	(0.0)	(16.4%)
Diagnostics	(0.5)	(7.4)	(0.7)	(1.2)	(0.6)	(90.7%)
Outpatients	(1.0)	(14.9)	(1.2)	(1.2)	0.0	1.4%
Pharmacy	(0.5)	(3.8)	(0.3)	(0.3)	0.0	6.3%
Therapies	(0.8)	(7.3)	(0.7)	(0.8)	(0.1)	(18.5%)
Womens Services	0.9	19.4	1.3	1.3	(0.1)	(5.1%)
Surplus/(deficit)	**(1.6)**	**3.3**	**(0.5)**	**(2.1)**	**(1.6)**	**(309.3%)**





SLA Income includes £0.6m unallocated CIP target. £0.5m of the income underperformance is due to a lower Elective and Emergency case-mix of activity overperformance and significant levels of uncoded activity for these services which have been valued below average tariff. This has mainly affected Paediatric Services. Imaging activity performance is also affected by changes in coding of activity. Neonatal has reduced activity levels to maintain safe levels of staffing.
Other Income mainly relates to the profitable commercial pharmacy offset by drugs spend in Non-pay.
Pay spend includes £0.6m unallocated CIP target. Staff groups are underspending before CIPs £0.3m in M01. Agency spend is down significantly in nursing reflecting lower occupancy on wards and implementation of schemes to reduce usage. Agency spend has increased in Therapy services and bank usage is higher in Outpatients to cover increases in vacancies.
Non-pay £0.14m overspend includes unallocated CIP of £0.15m. There is an accrual error which will worsen the spend by £0.07m when corrected.

Actions Required

1. Code all uncoded activity before M01 Freeze and resolve recording and coding issues due to new tariff structures and other changes in process.
2. Review Pharmacy drugs issues and stock accounting including the internal trading of Pharmacy manufactured drugs products.
3. Review Consultant recharge SLA to ensure up to date with cost of service
4. Extend bank rates to save temporary staff costs and other strategies for staff retention.
5. Get SLAs agreed for all outstanding Ex-SLA income with NHS commissioners
6. Progress and deliver CIP schemes

3b. Medicine & Cardiovascular I&E

Income & Expenditure	M1 LY £'m	Annual Budget	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Variance %
SLA Income	19.2	274.3	21.5	18.1	(3.4)	(15.9%)
Other Income	1.3	14.4	1.2	1.0	(0.2)	(17.4%)
Overall Income	**20.6**	**288.7**	**22.7**	**19.1**	**(3.6)**	**(16.0%)**
Pay	(9.4)	(110.5)	(9.2)	(9.3)	(0.0)	(0.5%)
Non Pay	(7.1)	(89.2)	(7.4)	(6.4)	1.1	14.5%
Overall Expenditure	**(16.5)**	**(199.8)**	**(16.6)**	**(15.6)**	**1.0**	**6.2%**
EBITDA	4.1	88.9	6.1	3.5	(2.6)	(42.8%)
Post EBITDA	(0.4)	(3.7)	(0.3)	(0.3)	(0.0)	(0.1%)
Surplus/(deficit)	**3.7**	**85.3**	**5.8**	**3.2**	**(2.6)**	**(45.1%)**

Headlines

The Division Performance M01 is an adverse variance of £2.6m
This is mainly due to income underperformance and the underachievement of £1.41m against the CIP target. £0.82m of the CIP is in SLA Income , £0.45m is in Pay and £0.14m is in Non Pay.

The directorate variances in Acute Med (£0.8m) and Renal & Oncology (£0.7m) are related to SLA Income mainly.

By directorate	M1 LY £'m	Annual Budget	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Variance %
Acute Medicine	0.6	19.6	1.6	0.8	(0.8)	(48.5%)
Cardiology CAG	1.0	15.5	1.0	0.7	(0.3)	(31.9%)
Cardiothoracic & Vascular Services	0.0	16.4	1.1	0.6	(0.5)	(43.1%)
Emergency Department	0.5	9.5	0.8	0.5	(0.2)	(29.1%)
Medcard Management	0.0	(4.1)	(0.3)	(0.2)	0.1	27.6%
Renal & Oncology	0.4	13.6	0.8	0.1	(0.7)	(88.9%)
Specialist Medicine	1.2	14.8	0.9	0.7	(0.2)	(23.7%)
Surplus/(deficit)	**3.7**	**85.3**	**5.8**	**3.2**	**(2.6)**	**(45.1%)**

SLA Income (£3.4m adv) – Lower than planned spend on high cost drugs and devices (£1.1m adv – fully offset by non-pay savings); unachieved CIP target (£0.8m adv); shortfall in non-elective emergency admissions (£0.8m adv, see chart); cancelled lists in Cardiac, Vascular, Thoracic and Cath labs due to lack of anaesthetic cover (£0.4m adv);

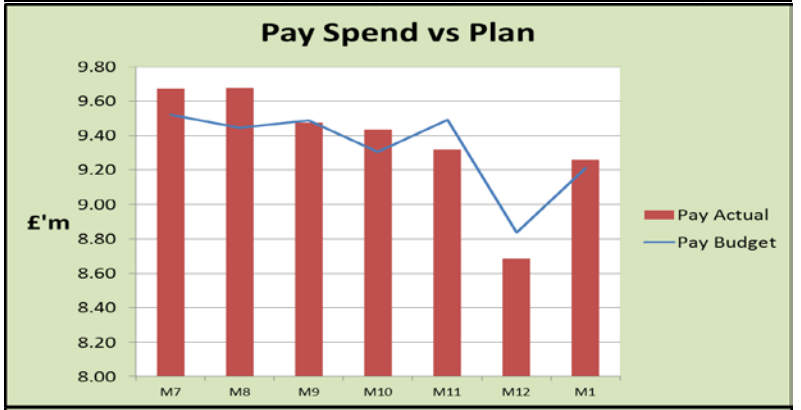
Other Income (£0.2m adv) – underperformance on private patient activity. Private patient activity has recently recommenced after a five month hold;

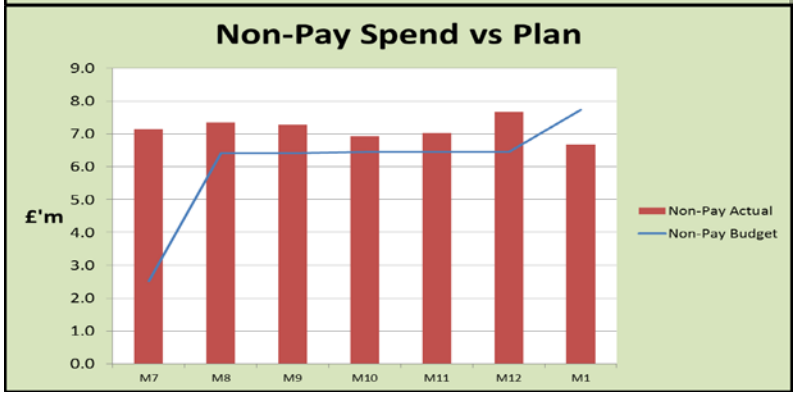
Pay (on budget) - Unachieved CIP (£0.4m adv) offset by vacancies and reduced staffing levels in Acute Medicine in response to low activity;

Non-Pay (£1.1m fav) – Offset of lower than anticipated spend on high cost drugs and devices (£1.1m fav). CIP target (£0.1m) offset by underspend on blood products linked to lower activity;

Actions Required

1. **CIP identification** – Medcard has a [c.£7m] gap between identified CIP schemes and target. PLICS data and EY support being utilised to address gap. Weekly divisional meetings to project manage delivery and identification of savings.
2. **Anaesthetic cover** – Continued lack of anaesthetic cover led to the cancelation of 23+ sessions in April. Anaesthetics addressing through recruiting additional specialist anaesthetists. Issue expected to be addressed by September;
3. **High Cost Drugs and Devices** – While cost neutral to the Trust, significant under performance to be reviewed in detail, working with pharmacy and operational teams.
4. **Other Targeted recovery actions including-** Close capacity if activity continues at current levels, Further reduction in bank and agency shifts. Review cost opportunities in funded business cases.





3c. Surgery, Neurosciences, Theatres & Cancer I&E

Income & Expenditure	M1 LY £'m	Annual Budget	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Current Month Variance %
SLA Income	13.0	186.4	14.4	12.7	(1.7)	(11.7%)
Other Income	1.6	16.8	1.4	1.3	(0.1)	(7.6%)
Overall Income	**14.6**	**203.3**	**15.8**	**14.0**	**(1.8)**	**(11.3%)**
Pay	(9.3)	(108.1)	(9.1)	(9.3)	(0.2)	(2.0%)
Non Pay	(3.2)	(42.0)	(3.5)	(3.0)	0.5	13.1%
Overall Expenditure	**(12.5)**	**(150.1)**	**(12.6)**	**(12.3)**	**0.3**	**2.2%**
EBITDA	**2.1**	**53.2**	**3.2**	**1.7**	**(1.5)**	**(46.5%)**
Post EBITDA	(0.3)	(3.5)	(0.3)	(0.3)	(0.0)	(0.5%)
Surplus/(deficit)	**1.8**	**49.8**	**3.0**	**1.4**	**(1.5)**	**(51.1%)**

Headlines

The Division Performance M01 is an adverse variance of £1.5m

This is mainly due to income underperformance and the underachievement of £1.26m against the CIP target. £0.66m of the CIP is in SLA Income , £0.48m is in Pay and £0.12m is in Non Pay.

The directorate variances in Neuro (£0.7m) and Surgery (£1.0m) are mainly related to SLA Income.

By directorate	M1 LY £'m	Annual Budget	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Current Month Variance %
Cancer	(0.1)	(1.1)	(0.1)	(0.1)	0.0	19.9%
Neuro	2.0	34.7	2.5	1.9	(0.7)	(26.6%)
Surgery	3.1	57.4	4.0	3.0	(1.0)	(25.9%)
Theatres and Anaesthetics	(3.3)	(41.3)	(3.5)	(3.3)	0.2	5.3%
Surplus/(deficit)	**1.8**	**49.8**	**3.0**	**1.4**	**(1.5)**	**(51.1%)**

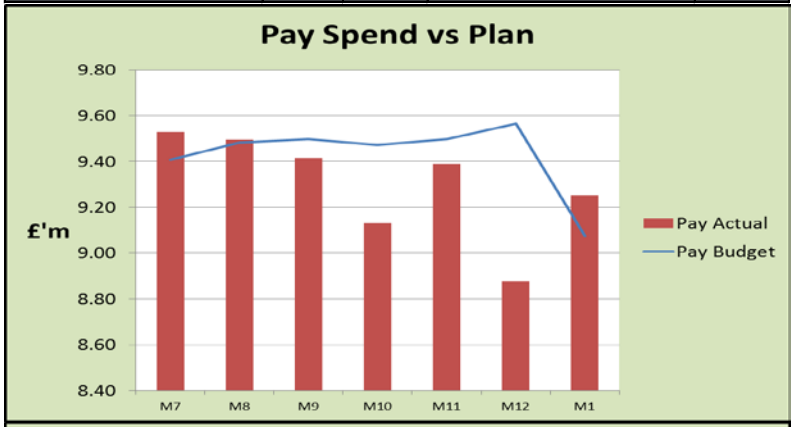
The M01 contribution £1.4m is lower than the same period last year £1.7m due to a reduction in income – Neurosurgery non electives, Surgery OP's & Surgery private patients.

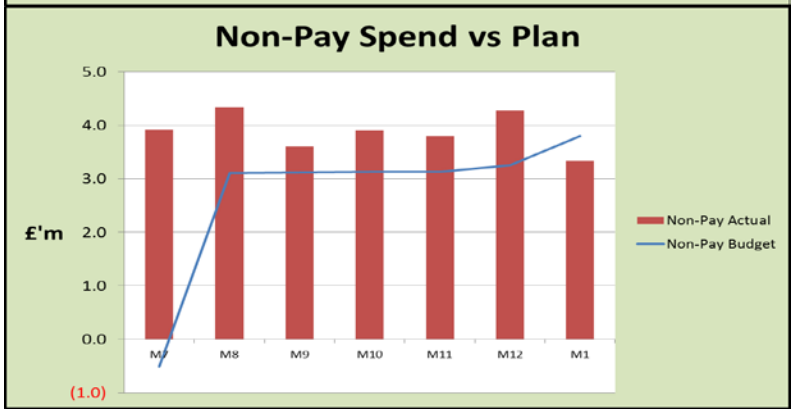
SLA income underperformance in is mainly in:

- Neurosurgery due to a reduction in activity during the Easter period, cancelled theatre sessions due to Gynaecology move, case-mix combined by a high number of un-coded activity where average tariffs are applied which lowers apportioned income until coding is resolved.
- Stroke emergency income understated as missing specialist top-up.
- T&O OP & elective income has a high no of un-coded activity and reduced no of OP appointments due to junior doctor gaps in rota.

Pay unallocated CIP gap £0.5m is partially offset by the underspend on theatre nursing (£0.2m) and ward nursing (£0.1m) where agency usage in Gwynne Holford, Nye Bevan Unit and Cavell short stay ward has reduced.

Non-pay is underspent by not sending bariatric activity to the private sector £0.2m and clinical consumables / drugs £0.3m across the division.





Actions Required

1. Work with the income team to understand the pricing variance
2. Remove unbudgeted posts or identify cost mitigation strategies if the posts are deemed to be essential by end May
3. Confirm mitigation plans to ensure SLA targets are met during the theatres refurbishment programme by early June

3d. Community Services I&E

Income & Expenditure	M1 LY £'m	Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Variance %
SLA Income	6.9	79.4	6.4	6.1	(0.3)	(4.4%)
Other Income	0.1	1.2	0.1	0.1	(0.0)	(34.6%)
Overall Income	**7.0**	**80.6**	**6.5**	**6.2**	**(0.3)**	**(4.8%)**
Pay	(3.9)	(36.2)	(3.0)	(3.2)	(0.2)	(5.9%)
Non Pay	(2.6)	(22.5)	(1.9)	(1.8)	0.1	6.0%
Overall Expenditure	**(6.5)**	**(58.8)**	**(4.9)**	**(5.0)**	**(0.1)**	**(1.3%)**
EBITDA	**0.6**	**21.9**	**1.6**	**1.3**	**(0.4)**	**(23.3%)**
Post EBITDA	(0.0)	(0.3)	(0.0)	(0.0)	(0.0)	(0.0%)
Surplus/(deficit)	**0.5**	**21.5**	**1.6**	**1.2**	**(0.4)**	**(23.7%)**

Headlines

The Division is reporting a deficit for the year to date of £0.4m, which is driven by the net impact of underperformance against income targets, underachievement of the divisional CIP target and the challenges of continuing to deliver the pay run rate requirements set on the basis of the previous year's M06 Out-turn forecast position.

The CIP programme underachievement is £0.26m which is in Pay (£0.20m) and Non Pay (£0.06m)

Income underperformance on relates to

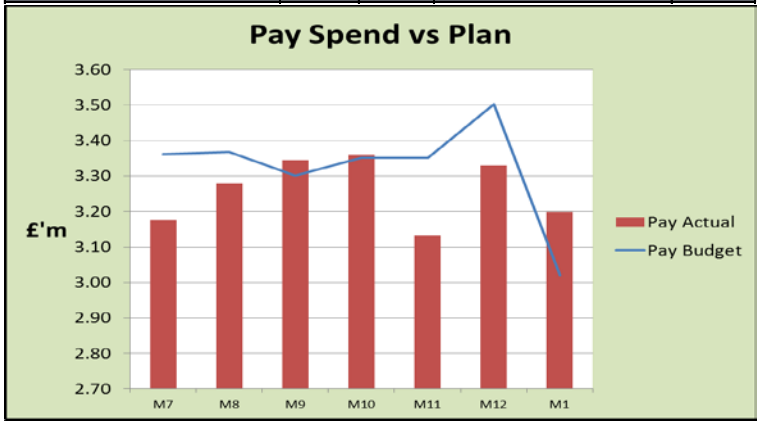
- Lower levels of in-patient amputee patients discharged in the month. These patients have relatively high lengths of stay and this level of variance is typical of the effect of the fluctuation in the number of patients discharged each month
- The level of bed day income, which is £0.09m lower than planned as a result of the number of vacant beds on Mary Seacole Ward. The demand for beds is lower due to the restrictions placed by Merton CCG on referrals of their patients to the ward. The income loss is partly offset by the reduced level of nursing pay expenditure to staff the beds.
- The lower levels of activity in the Brysson Whyte Elderly Rehab Day Unit as reported under SLA Other.
- There is also underperformance against HIV high cost drugs of £0.11m, which is matched by lower drugs expenditure

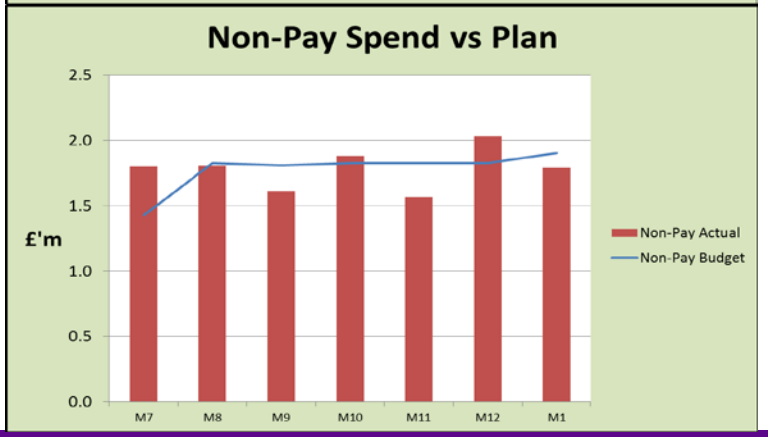
Pay is marginally overspent due to the challenges of delivering the run rate targets in CAHS.

Actions Required

1. Plan for tender losses including cost reduction within division and wider organisation and procurement challenge.
Continue to develop CIPs to convert its £1.8m of pipeline and red rated schemes to green and continue to identify schemes to address the shortfall.
2. Work with other divisions to identify opportunities to utilise surplus capacity on Mary Seacole ward
3. Develop and agree Care Group level plans to deliver pay run rate savings requirements.

By directorate	M1 LY £'m	Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Variance %
Ambulatory Care Services	(0.7)	5.8	0.4	0.4	0.0	7.1%
Community Adults & Children	1.3	14.2	1.1	0.9	(0.1)	(12.7%)
Community Services Management	(0.1)	1.5	0.1	(0.1)	(0.3)	(218.9%)
Surplus/(deficit)	**0.5**	**21.5**	**1.6**	**1.2**	**(0.4)**	**(23.7%)**





3e. Corporates and Estates & Facilities I&E

			Current Month			
	M1 LY £'m	Annual Budget £'m	Budget £'m	Actual £'m	Variance £'m	Variance %
Corporate Directorates						
Chief Executive & Governance	(0.3)	(6.9)	(0.8)	(1.1)	(0.3)	(34.5%)
Chief Operating Officer	(0.4)	(3.5)	(0.3)	(0.2)	0.1	25.1%
Human Resources Directorate	(0.5)	(10.7)	(0.9)	(0.8)	0.1	10.2%
Ops & Service Improvement	(0.6)	(4.4)	(0.4)	(0.5)	(0.1)	(30.4%)
Pathology - STG	(1.0)	(15.2)	(1.4)	(1.5)	(0.1)	(8.3%)
Strategy	(0.1)	(0.2)	(0.0)	0.0	0.0	154.3%
Quality Governance Directorate	(1.8)	(24.3)	(2.0)	(2.0)	0.0	0.3%
Nursing Directorate	(0.1)	(1.5)	(0.1)	(0.1)	0.0	9.0%
Finance and Procurement	(1.1)	(10.6)	(0.9)	(0.8)	0.1	5.9%
IT, Informatics & Telecomms	(1.3)	(22.3)	(1.9)	(1.8)	0.1	3.7%
Total Corporate	(7.1)	(99.7)	(8.6)	(8.8)	(0.2)	(1.9%)
Estates & Facilities						
Energy & Engineering	(0.9)	(11.0)	(0.9)	(1.0)	(0.1)	(7.7%)
Estates	(1.1)	(10.5)	(0.9)	(1.1)	(0.2)	(22.2%)
Estates Community Premises	(1.4)	(17.4)	(1.5)	(1.4)	0.0	0.4%
Facilities Services	(0.4)	(4.5)	(0.4)	(0.4)	(0.0)	(2.7%)
Hotel Services	(1.3)	(15.5)	(1.3)	(1.3)	(0.0)	(2.7%)
Medical Physics	(0.2)	(2.4)	(0.2)	(0.2)	0.0	7.3%
Project Management	(0.0)	(0.3)	(0.0)	(0.1)	(0.0)	(113.3%)
Rates	(0.2)	(2.4)	(0.2)	(0.2)	(0.0)	(1.7%)
Total Estates & Facilities	(5.5)	(63.9)	(5.3)	(5.6)	(0.3)	(6.0%)
NHSI Surplus/(deficit)	(12.6)	(163.6)	(13.9)	(14.4)	(0.5)	(3.5%)

Headlines

The Division is reporting a deficit for the year to date of £0.5m, which is driven by the underachievement of the divisional CIP target (£0.4m) and higher than expected Energy costs.

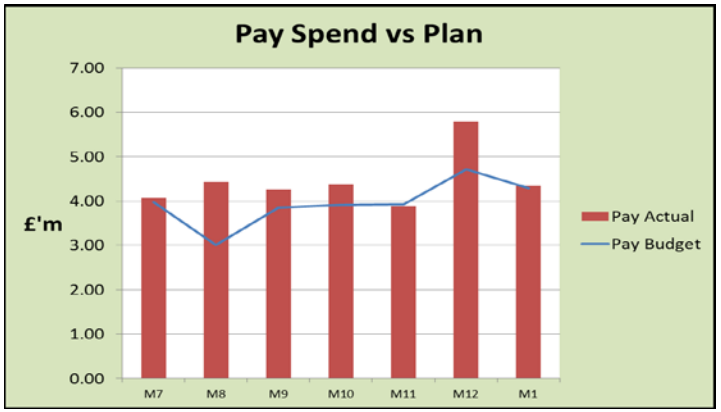
The CIP target is currently in the 'Chief Executive' line in Corporates (£0.2m) and in the 'Estates' line in Estates & Facilities (£0.2m).

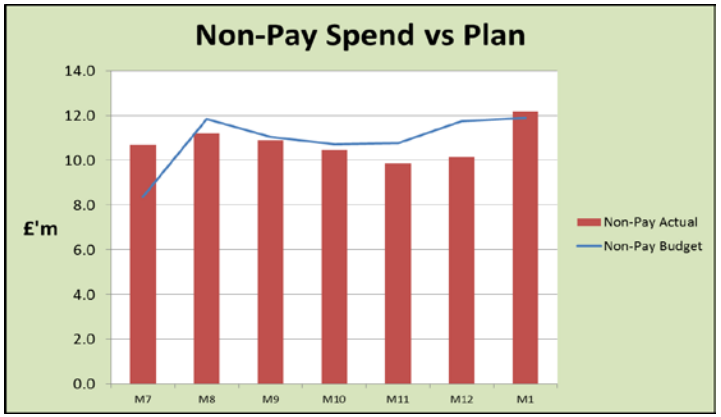
Corporate Directorates £0.2m Adverse M01.

- A CIP target contributed £0.2m and currently sits in the Chief Executive & Governance budget.
- Interim costs have reduced since March due to increased IR35 compliance and are expected to reduce further for M2/M3.
- Pathology income is lower than plan by £0.06m Haematology costs £0.04m higher
- Ops & SI costs are higher in month owing to the cost of interims; this will reduce to reflect the new structure.

Estates & Facilities £0.3m Adverse M01.

- A CIP target of £0.2m contributed to the deficit.
- Higher Energy costs of £0.1m relate to both March and April. It is expected that costs will reduce now that buildings have been closed down and staff relocated.
- CIP schemes to achieve the £2.4m target include £1.6m from reviewing all contracts with Procurement starting with Engineering Maintenance Contracts and £0.5m from the decant of the GUM clinic.

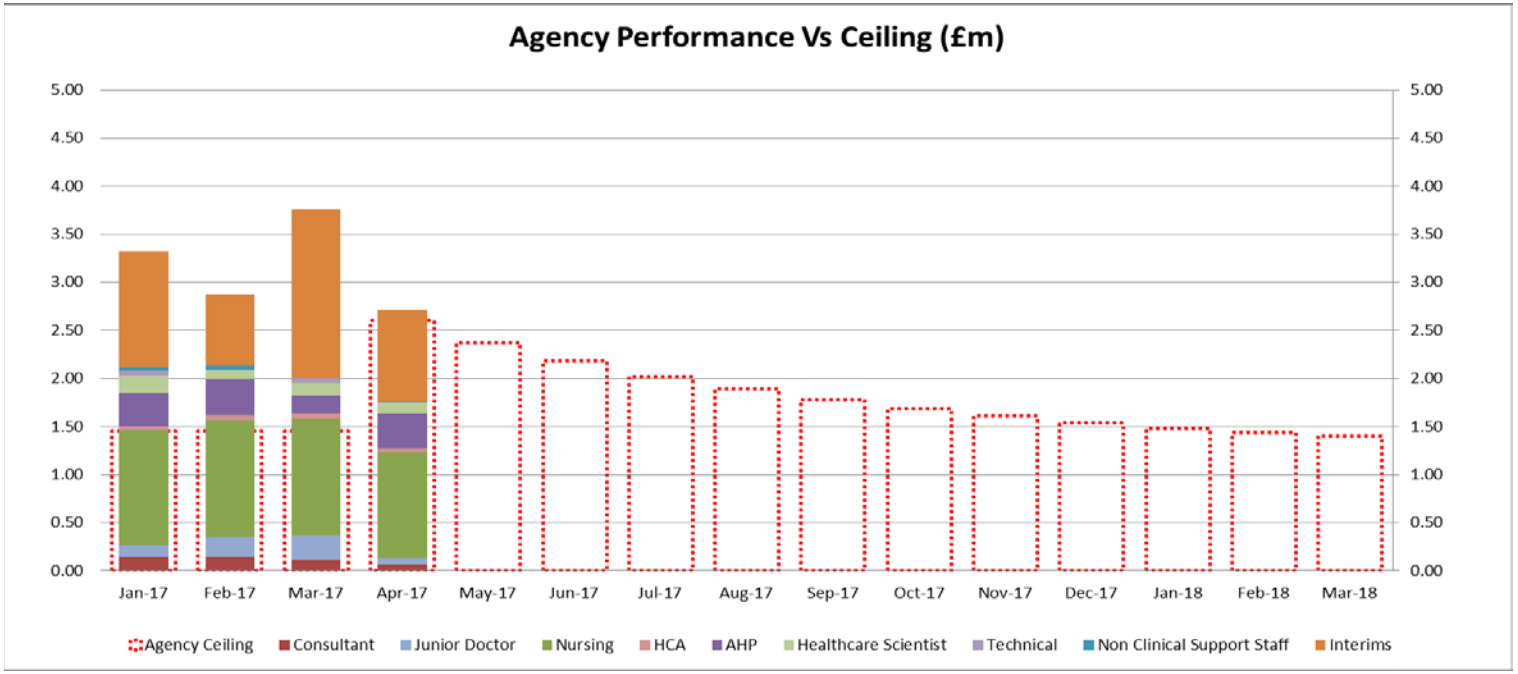




Actions Required

1. Corporate Areas to reduce budgets due to loss of CAHS and Sexual Health Service.
2. Transformation restructure to result in budget savings.
3. Estates to agree the Moorfields SLA for Rent and Service Charge.
4. Estates to review Community Premises costs in light of the CAHS loss.
5. Corporate CIP Target to be agreed on how to allocate to Corporate Services and remove from CEO.
6. IT to clarify cost of the Managed Service Agreement as this is potentially higher than budget.

4. Agency Cap performance



	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Type of Staff	**Jan-17**	**Feb-17**	**Mar-17**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**YTD**
Consultant	0.15	0.14	0.11	0.06												0.06
Junior Doctor	0.12	0.20	0.26	0.06												0.06
Nursing	1.20	1.22	1.21	1.10												1.10
HCA	0.04	0.05	0.05	0.05												0.05
AHP	0.34	0.37	0.18	0.35												0.35
Healthcare Scientist	0.18	0.10	0.13	0.12												0.12
Technical	0.06	0.00	0.06	0.00												0.00
Non Clinical Support Staff	0.03	0.05	0.00	0.01												0.01
Interims	1.21	0.74	1.75	0.95												0.95
Total Agency Cost	**3.32**	**2.88**	**3.76**	**2.71**												**2.71**
Agency Ceiling	1.45	1.45	1.45	2.61	2.37	2.18	2.02	1.89	1.78	1.68	1.60	1.54	1.48	1.44	1.40	2.61
Variance	**1.87**	**1.43**	**2.31**	**0.11**												**0.11**

Total Pay Cost	41.32	40.47	40.72	40.59												40.59
% Agency Cost of Pay	8.0%	7.1%	9.2%	6.7%												6.7%
% Planned Agency	3.5%	3.6%	3.6%	6.4%												6.4%

Commentary:

The Trust's agency spend target set by NHSI is £24.5m pa. The Trust's internal target is £22.0m. For April, the monthly target was £2.61m.

Total agency cost in April was £2.71m or 6.7% of the total pay costs. In Q4 2016/17, the average agency cost was 8.1% of total pay costs. Agency cost in April decreased by £1.05m compared to March, £0.8m of this reduction a result of changes in IT contracting arrangements

In 2017/18 YTD, the Trust has overspent against the planned target by £0.11m, in the Corporate Directorate. However, in April there has been a decrease in Interims (£0.80m) as IT staff moved into a consortium arrangement.

Compared to March, Medical staff decreased by £0.25m and Nursing/HCA by £0.18m (both owing to reduced activity) and STT increased by £0.11m (to cover vacancies in CWDT).

5 Cash M1 2017/18

Source and application of funds - cash movement analysis:
2017/18 outturn vs Plan

	Actual M01 vs Plan M01			2017/18
	Plan YTD £m	Actual YTD £m	*Actual YTD VAR £m*	***Plan Year £m***
Opening cash 01.04.17	5.0	6.0	*1.0*	***5.0***
Income and expenditure deficit	-8.6	-12.3	***-3.7***	***-28.5***
Depreciation	2.3	2.0	***-0.3***	***27.0***
Interest payable	0.6	0.6	***0.0***	***7.5***
PDC dividend	0.3	0.3	***0.0***	***3.8***
Other non-cash items	-0.2	0.0	***0.2***	***-0.2***
Operating deficit	**-5.6**	**-9.4**	***-3.8***	**9.6**
Change in stock	-0.3	-0.4	***-0.1***	***0.6***
Change in debtors	-0.2	8.7	***8.9***	***1.8***
Change in creditors	5.0	7.8	***2.8***	***-6.0***
Net change in working capital	4.6	16.1	***11.6***	**-3.6**
Capital spend (excl leases)	-2.7	-3.1	***-0.4***	***-40.7***
Interest paid	-0.3	-0.3	***0.0***	***-7.4***
PDC dividend paid	0.0	0.0	***0.0***	***-3.8***
Other	0.0	0.0	***0.0***	***-0.4***
Investing activities	-3.0	-3.4	***-0.4***	***-52.3***
WCF/ISF borrowing	0.0	0.0	***0.0***	***38.0***
Capital loans	2.7	0.0	***-2.7***	***16.2***
Loan/finance lease repayments	-0.4	-0.1	***0.2***	***-9.9***
Closing cash 30.04.17 / 31.03.17	3.3	9.3	***5.9***	**3.0**

M01 cash movement

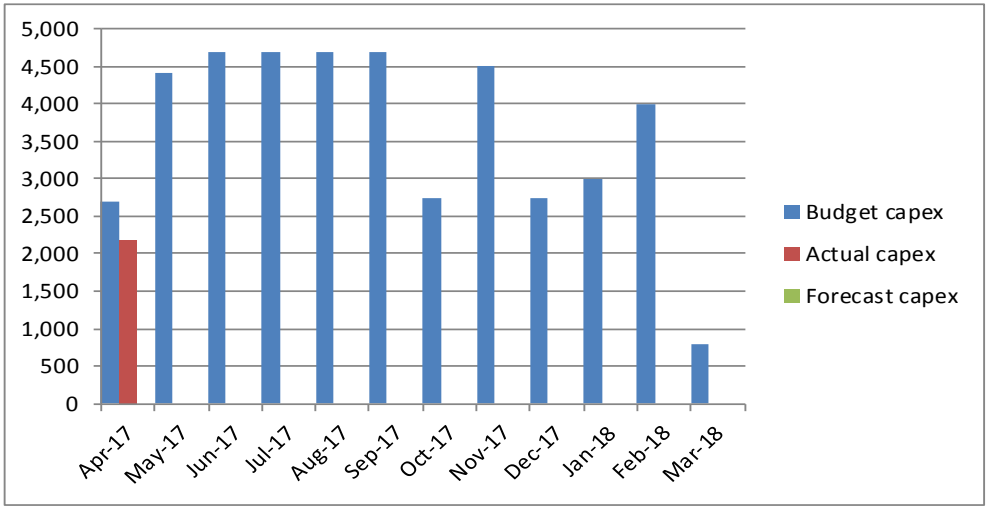
- The M01 I&E deficit was £12.3m.
- Within the I&E deficit of £12.3m, depreciation (£2m) does not impact cash. The charges for interest payable (£0.6m) and PDC dividend (£0.3m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating deficit" of £9.4m.
- The operating variance from plan of £3.8m in cash is directly attributable to the higher I&E deficit.
- The Trust was able to more than offset the higher operating deficit with better performance on debtors (+£8.9m) and creditors (lower payments to suppliers (+£2.8m) delivering a working capital boost for the month of £11.6m in total.
- In accordance with plan the Trust did not need to borrow from working capital facilities due to the receipt of Q1 LDA monies in early April. However it should be noted that the 2017/18 planned deficit necessitates borrowing of approx £38m from working capital facilities over the course of the year.
- The Trust did not need to draw down in April from its capital loan however has drawn £6m under thus loan since month-end.

6. Capital programme M01

CAPITAL PROGRAMME 2017/18 - BY SPEND CATEGORY

Row Labels	2017/18 Draft budget total £000	2017/18 Draft budget total £000	2017/18 Actual M01 YTD	16/17 YTD variance
Infra Renewal -EPC	**4,685**	**289**	13	276
Infra Renewal	**11,201**	**692**	236	456
IMT	**2,622**	**162**	569	-407
Med Eqpt	**6,234**	**385**	374	11
Major Projs	**16,855**	**1,041**	972	69
Other	**484**	**30**	18	12
SWL PATH	**1,638**	**101**	0	101
Grand Total	**43,719**	**2,700**	2,182	518

Capital 2016/17 - budget and actual expenditure per month



- The Trust's planned capital expenditure for the year is £43.7m which has not yet been formally approved by the regulator. The IMT budget has been formulated on the expectation that the Trust will secure further DH capital funding of approx £9.6m to finance extensive investment in the IT infrastructure. In the event the amount secured is lower then the Trust will have to consider re-structuring the programme in order to ensure critical IT risks are addressed within the existing capital resources. Whilst the funding available nationally for capital is constrained, Steve Russell of NHSI recognises the requirement for capital to support the Trust to exit Financial and Quality Special Measures. Board and Committee will be kept updated on progress.
- Capital expenditure in April was £2.2m against the budget of £2.7m, an underspend of £0.5m. The spend category table above shows the under spend relates mainly to infrastructure renewal.
- The Trust is financing £11.2m of capital expenditure this year with the DH capital loan of £16.2m secured in March (the Trust spent £5m 'at risk' in 2016/17 on urgent CQC-related investments).

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	8 June 2017	**Agenda No**	**4.1**
Report Title:	Workforce Information Report		
Lead Director/ Manager:	Harbhajan Brar, Director of Human Resources and Organisational Development		
Report Author:	Sion Pennant-Williams, Workforce Intelligence Manager		
Presented for:	Update		
Executive Summary:	This report provides workforce information for April 2017. Bank and agency usage has fallen in April and agency spend as a percentage of the total pay bill has decreased from 8.93% to 6.75%. Staff in post FTE and establishment FTE have both fallen, however as SiP has fallen more than establishment then the vacancy rate has increased slightly. Sickness levels have decreased to 3.2%. Turnover has increased again this month to 19.42% gross turnover and 16.08% voluntary turnover. Stability rates have also decreased, and non-medical appraisal rates have increased slightly whilst medical appraisal rates have decreased slightly. MAST compliance has increased to 86%.		
Recommendation:	The Board is asked to note the workforce performance report and actions outlined within it.		
Supports			
Trust Strategic Objective:	All Trust objectives		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Financial efficiency and operational performance		
Implications			
Risk:	Failure to achieve financial and other targets and manage within agreed control totals		
Legal/Regulatory:	Failure to meet NHSI control total		
Resources:	n/a		
Previously Considered by:		**Date**	
Equality Impact Assessment:	n/a		
Appendices:	Appendix 1 - Workforce Information slides		

Workforce Information Report
Trust Board, June 2017

1.0 PURPOSE

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

2.0 CONTEXT

2.1 The data is for the whole Trust but excludes SWLP and the GP Trainees that we host for other Trusts.

3.0 ANALYSIS

3.1 The staff in post in April has reduced by 44.9 wte, and funded establishment has decreased by 12.5. Vacancy levels have increased by 0.4% to 16.31%. The expected reduction in establishment as a result of setting budgets for 2017/18 has not yet happened as the ESR system has not yet been updated.

3.2 Bank & Agency usage has fallen in month, and agency spend as a percentage of total pay costs has decreased from 8.93% to 6.75%.

3.3 Sickness levels have continued to decrease and are now at 3.23%. Stability has fallen to 83.64%, however this is still 2.09% higher than it was in April 2016.

3.4 Non-medical appraisal compliance has increased slightly to 80.3%. After making significant improvements in the appraisal rates recently there is now a concern that they will begin to plateau and not increase any higher. Focus will remain on highlighting the importance of carrying out an appraisal and trying to engage staff more with the process.

3.5 MAST compliance has increased to 86% resulting in the Trust meeting its current target compliance for the year.

3.6 Recruitment trajectories are currently being developed to be able to identify how many new starters we are likely to employ in the future.

3.7. The recruitment data provided on slide 4 is currently under review whilst we get clarity from the Trac recruitment system providers as to how the information is determined. Close examination of the data pulled from the system has shown that certain factors may skew the 'Average days taken for key stages in Recruitment Process' figures and so we need to ascertain whether this is a process or system issue.

4.0 IMPLICATIONS

Risks

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

5.0 ACTIONS

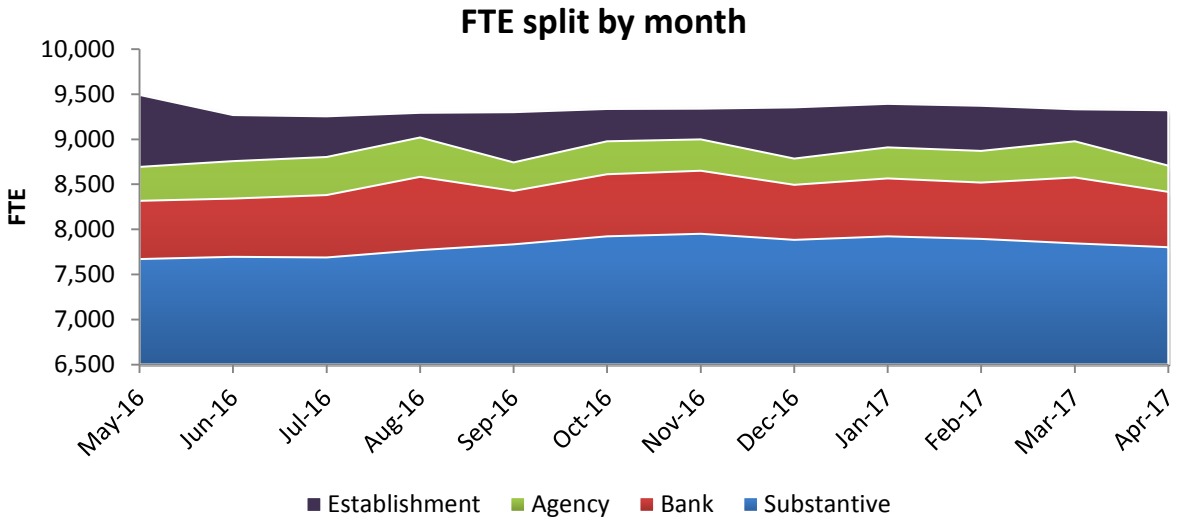
5.1 None

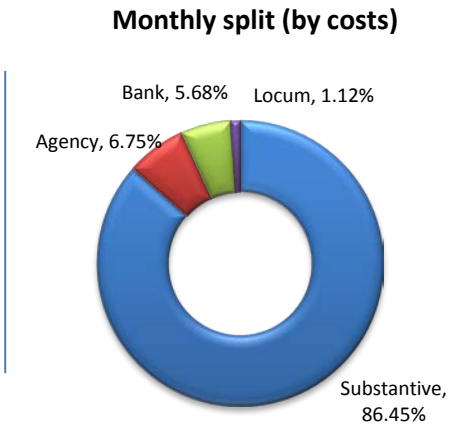
6.0 RECOMMENDATION

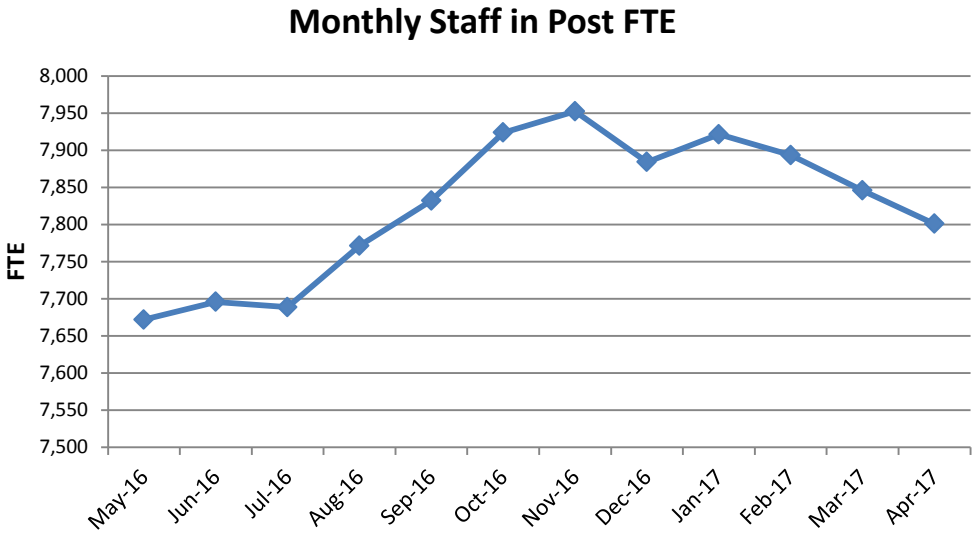
6.1 The Board is asked to note the workforce performance report and actions outlined within it.

Section 1: Current Staffing Profile and Bank & Agency

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







COMMENTARY

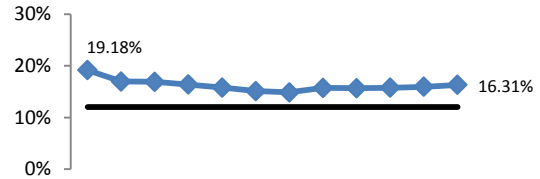
Staff in post has reduced by 44.9 FTE, funded establishment has also reduced by 12.5 FTE.

Agency spend as a percentage of the total pay bill has decreased from 8.93% to 6.75%.

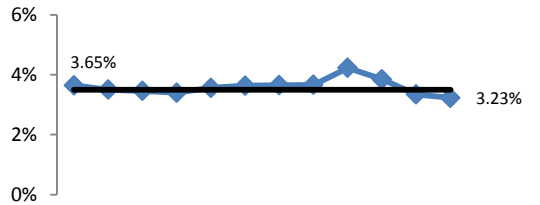
This month FTE split:
Substantive: 7801.00
Bank: 615.11
Agency: 289.37
Establishment: 9321.39

Section 2: Workforce KPIs

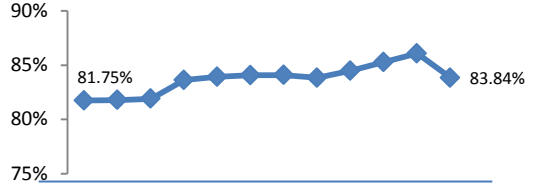
Vacancy Rate Year Trend



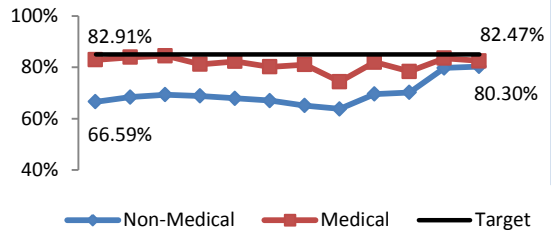
Sickness Rate Year Trend



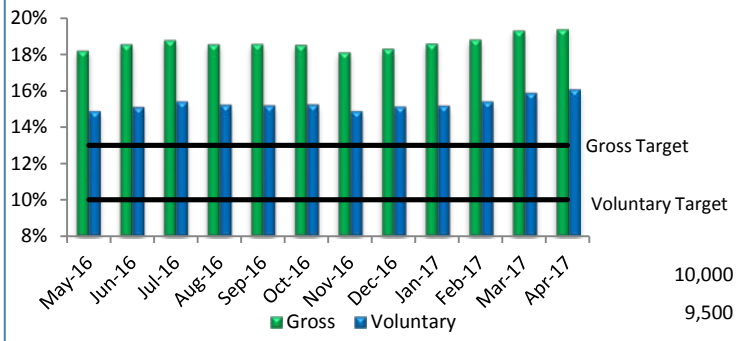
Stability Year Trend



Appraisal Rate Year Trend

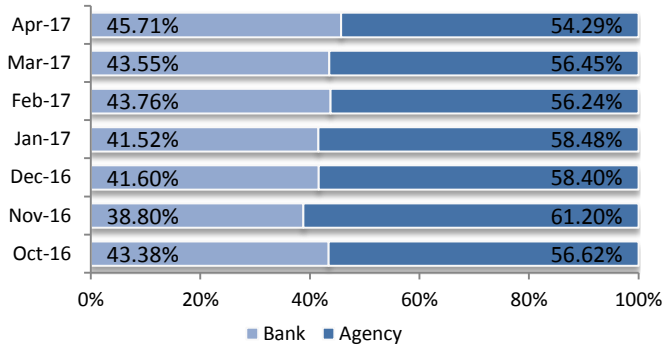


Turnover YTD

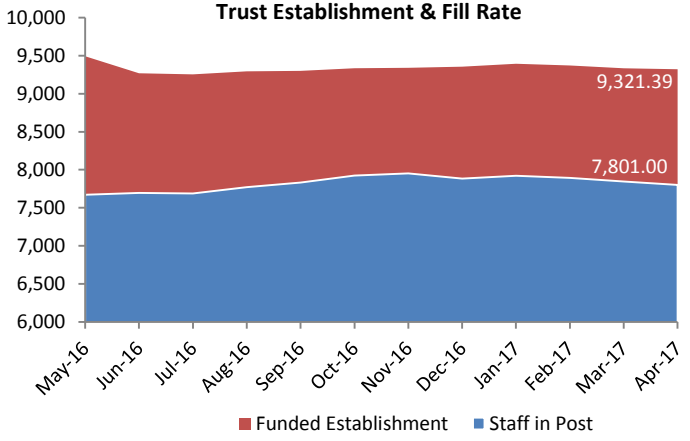


KPI	Change over the year	Change since last month
Vacancy	-2.87%	0.37%
Sickness	-0.42%	-0.11%
Stability	2.09%	-2.24%
Gross Turnover	1.19%	0.07%
Voluntary Turnover	1.20%	0.20%

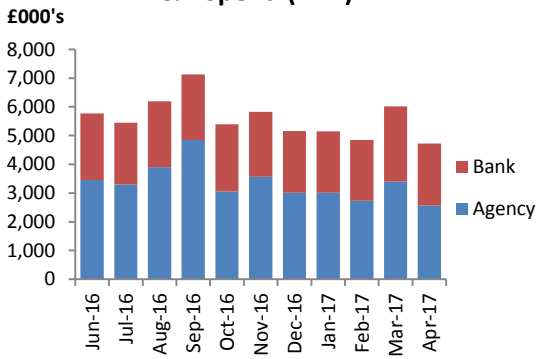
Bank/Agency Mix*



Trust Establishment & Fill Rate

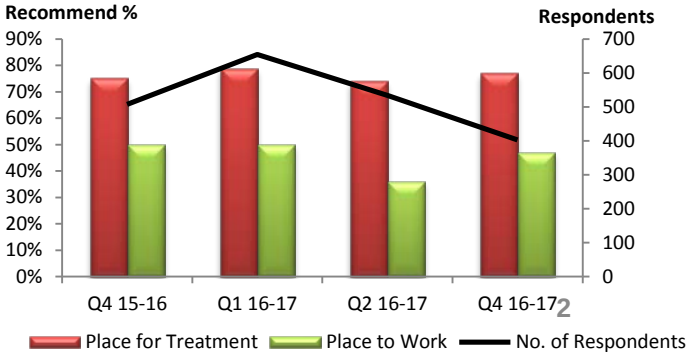


B&A Spend (YTD)*

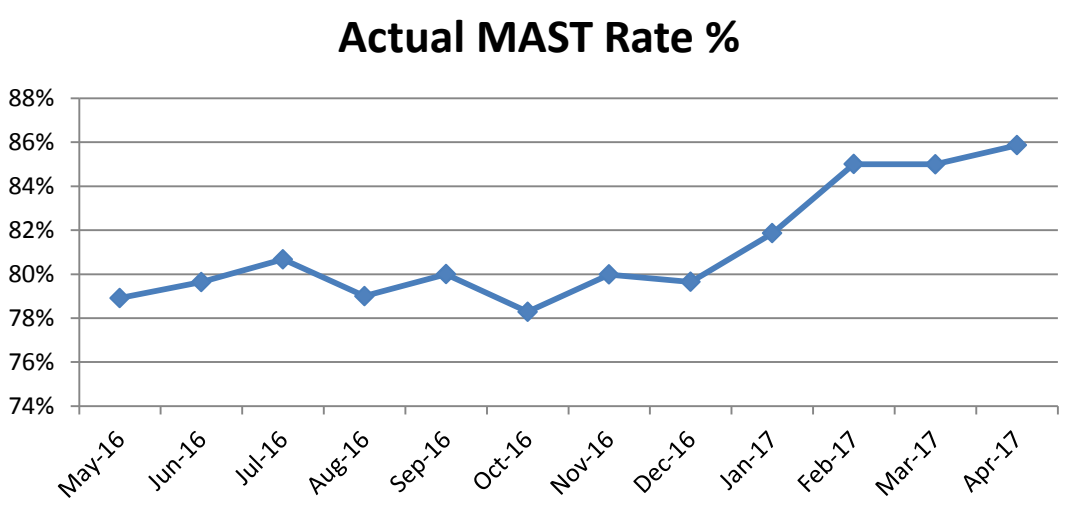


* Does not include SWLP or Central costs

Friends & Family Test



Section 3: MAST Compliance



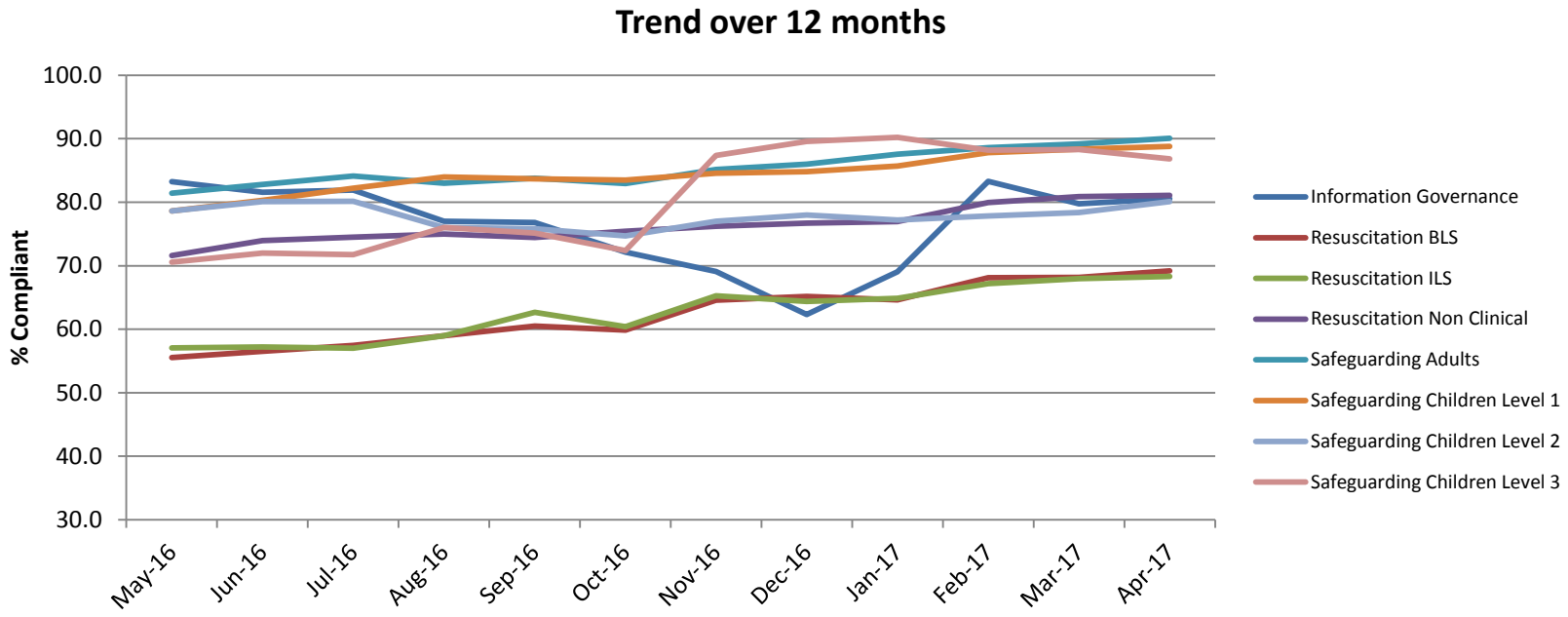
COMMENTARY

A programme of working is taking place including:

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

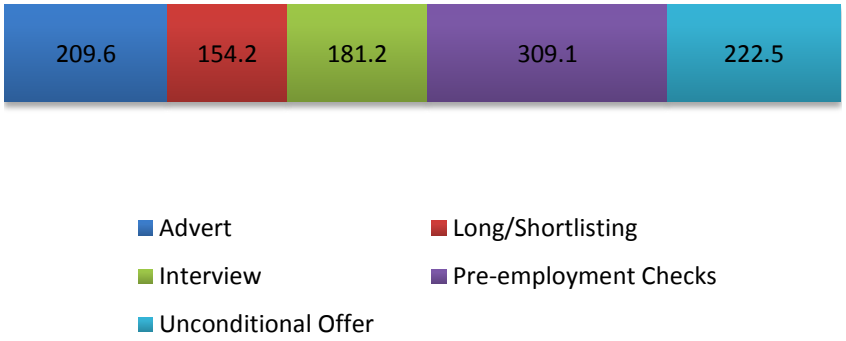
Current Issues:

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



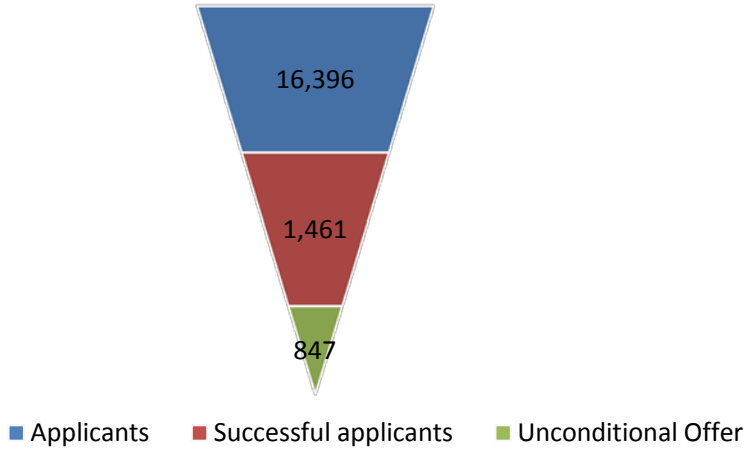
Section 4: Recruitment Pipeline

Non Medical Current Pipeline (FTE)

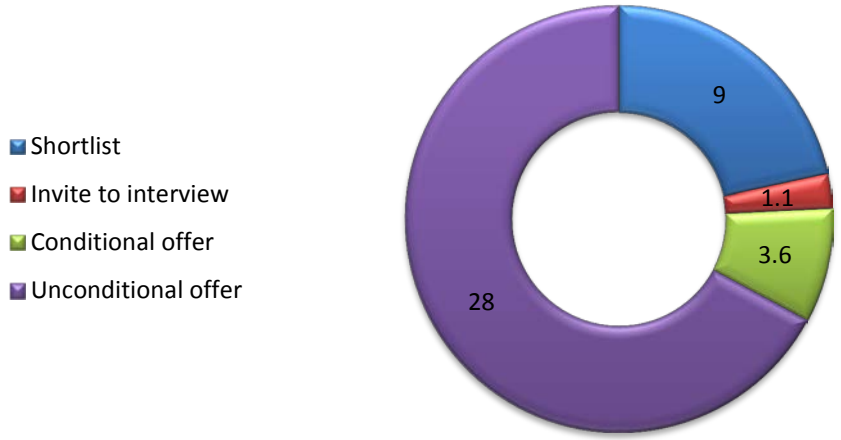


* Data is a snapshot from the end of April

Non-Medical Recruitment volumes (over 6 months)



Average days taken for key stages in Recruitment Process (over 6 months)



Shortlist – days that Recruiting Managers take to shortlist
Invite to interview – days between shortlisting being received from Recruiting Manager to interview invites being sent out
Conditional offer – days between interview outcome paperwork received to formal conditional offer
Unconditional offer – days between conditional offer and unconditional offer

NB: Reporting from the Trac system is relatively new to the Trust and so the figures are intended as a guide only at this stage as they may not be wholly accurate. These reports are highlighting gaps in housekeeping within the Trac system which potentially affect these reports and so Medical recruitment is being removed for the time being

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	8 June 2017	**Agenda No.**	**4.3**
Report Title:	National NHS Survey 2016		
Lead Director/ Manager:	Harbhajan Brar, Director of Human Resources & Organisational Development		
Report Author:	Moji Adetoye		
Presented for:	Discussion & Update		
Executive Summary:	This paper provides an overview of our 2016 National NHS Staff Survey results and provides a brief summary of the 3 keys area that the Trust would want to focus on in developing a Trust action plan.		
Recommendation:	That a detailed staff survey action plan be bought to a future Trust Board with a clear timetable of action that focuses on three key areas of; employee engagement, bullying and harassment and Improving Equality and Diversity.		
Supports			
Trust Strategic Objective:	Valuing our staff – An engaged workforce is going to be crucial in helping us to tackle the quality and financial leadership challenges the Trust faces		
CQC Theme:	Are services at this Trust well led		
Single Oversight Framework Theme:			
Implications			
Risk:	Failure to fully engage staff poses a great risk to being able to prove quality services.		
Legal/Regulatory:			
Resources:	A Staff Survey Working Party has been established and is Chaired by Alison Benincasa and has been tasked to produce a draft action plan by the end of June.		
Previously Considered by:	SMT	**Date:**	24.04.17
Equality Impact Assessment:	This support the delivery of Equalities Strategy		
Appendices:			

National NHS Staff Survey 2016
Trust Board – 8 June 2017

Introduction

1. The embargo on the National NHS Staff Survey results was lifted on Tuesday 7th March 2017 and the reports were formally released to the public. This year (2016) 3,463 questionnaires were completed out of 8,581 eligible staff at the Trust thus achieving a response rate of 40.4%. This is an improvement on last year (2015) when our response rate was 31%. The average response rate for Picker 'Acute Community' organisations was 42.3%.

2. In summary, the Trust performed slightly better than in 2015 but our scores were still lower than the national average for combined acute and community Trusts. Our top 4 ranking and bottom 4 ranking scores are summarised in the table below.

Table 1: Top Four and Bottom Four Ranking Scores 2016

	2015/16		2016/17		
	St George's	National Average	St Georges	National Average	Improvement/ deterioration
Response rate	31%	43%	40.4%	42.3%	Improvement
Top 4 ranking scores					
KF13. Quality of non-mandatory training, learning or development	4.05	4.04	4.10	4.07	Improvement
KF12. Quality of Appraisals	3.04	3.03	3.19	3.11	Improvement
KF18. % of staff feeling under pressure to attend work when not well	57%	58%	53%	55%	Improvement
KF29. % of Staff reporting errors, near misses or incidents witnessed in the last month	88%	90%	91%	91%	Improvement
Bottom 4 ranking scores					
KF19. Organisation and management interest in action on health and wellbeing	3.33	3.59	3.41	3.61	Improvement
KF14. Staff Satisfaction with resourcing and support	3.11	3.72	3.15	3.28	Improvement
KF26. % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	27%	24%	32%	23%	Deterioration
KF10. Support from immediate line managers	3.58	3.72	3.63	3.74	Improvement

3. As stated in the March 2017 report presented at EMT one of our initial action points is to provide further data analysis on the staff groups such as nursing and medicine and a review of the verbatim comments that staff provided (90 pages in total) to consider the key themes and to add further detail to the quantitative aspects of the survey.

4. The report stated that a working party was to be established led by an independent senior manager to devise a corporate action plan to include the three key action points mentioned below

- Addressing Bullying and Harassment
- Improving Staff Engagement

- Improving Equality and Diversity

At the same time the divisions should review their divisional/directorate data to enable them devise 2 or 3 local action points that will be added to the corporate areas set out above.

5. This paper outlines the initial outputs from the data analysis and a brief summary of the areas to be covered under each of these priorities for consideration by the working group.

Bullying and Harassment

6. A study into bullying and harassment (B&H) in the NHS by the National Institute for Health Research states that in order to make a real difference to organisational culture, it is important that at a senior level there is a clear commitment to tackling poor behaviour.

Detailed Analysis

7. In the 2016 Survey, 32% of staff at the Trust reported abuse from other staff and the national average for combined community and acute Trusts was 23%. The staff group with the highest percentage of staff experiencing bullying and harassment from other staff was the nursing staff group at 42% and this was closely followed by the maintenance and ancilliary staff group at 41%. 37% of staff in the Corporate Division reported experiencing harassment, bullying or abuse from other staff and this is the highest across all the divisions of the Trust.

8. 29% of staff reported experiencing harassment, bullying or abuse from patients, relatives and members of the public, whilst the average for combined acute and community Trusts was 26%. The highest staff groups experiencing bullying and harassment from patients was the nursing at 40%, Occupational therapy at 39%, closely followed by Radiography at 38%. The highest divisions experiencing B&H from patients included Medicine and Cardiovascular at 40% and Community Services at 32%.

9. B&H has been a regular feature on yearly Staff Survey action plans over the last 5 years. The Trust has implemented a significant and wide range of initiatives through the years. A summary of the variety of initiatives is attached at *appendix 1.* However, the initiatives have not resulted in the significant change required. The percentage of staff experiencing staff on staff bullying and harassment has dropped by 1% between 2015 and 2016 surveys.

10. We believe that a fundamental change is required and as such recommend that the Trust replicates the London Ambulance Service successful case study of appointing a B&H specialist to provide training sessions across the organisation and at the same time address related issues which could be anything from - what might seem as minor communication issues between colleagues to perceptions of unfair treatment by management. There are a number of initiatives linked to this. *See Appendix 2*

Staff Engagement

11. The overall staff engagement score is an important score used by the CQC and it represents the employee's perceived ability to contribute to improvements at work, their willingness to recommend the organisation as a place to work or receive treatment and the extent to which they feel motivated and engaged with their work. The Trust overall engagement score this

year is 3.70 out of 5. The overall engagement score in 2015 was 3.71 and the national average for combined acute and community Trusts this year is 3.80 out of 5.

12. In relation to the staff groups Medical and Dental staff scored 3.27 and Maintenance/Ancilliary staff scored 3.33 in recommending the Trust as a place to work or receive treatment, these are the lowest scores of all the staff groups. The staff group that scored the highest in recommending the Trust as a place to work and receive treatment is the Nursing and Healthcare assistants. The division with the lowest score was Corporate with 3.30.

13. The radiography staff group scored the lowest at 3.59, closely followed by maintenance and ancilliary staff 3.60 in staff motivation at work. The staff group with the highest motivation score was the nursing staff group at 4.14 out of 5.

14. The maintenance and ancilliary staff scored the lowest of the staff groups with only 51% stating that they are able to contribute towards improvements at work. The physiotherapy staff group scored the highest with 85% being able to contribute towards improvements at work.

15. There has been no change in comparison to last year in the 'staff motivation at work' and 'staff ability to contribute towards improvements at work' but there has been a decrease in the staff recommendation of the Trust as a place to work or receive treatment this score has dropped from 3.66 in 2015 to 3.61 this year. This is an area for focus on improvement.

Equality and Diversity

16. The staff survey provides analysis on each question with responses split by White and Black and Minority Ethnic (BME) staff. The results for the key questions that are required for the Workforce Race Equality Scheme (WRES) showed that when asked if they believed that the organisation provides equal opportunities for career progression or promotion, 83% of White staff and 63% of BME staff agreed. There was no difference in the score for White staff from last year but the score for BME staff had increased from 59% to 63%. This marked difference in scores for White and BME staff is greater than the average score for comparator Trusts where the score is 88% and 75% respectively.

17. A similar stark difference in scores was reflected in the response to the question on whether employees had experienced discrimination from manager/team leader or other colleagues; 9% of white staff responded 'yes' (8% in 2015) compared to 20% of BME staff (23% in 2015).

18. There was some difference in scores across staff groups with Maintenance/Ancillary staff and Healthcare Assistants most likely to experience discrimination at work (29% and 25% respectively). Medical and Dental staff (12%) were least likely to report discrimination at work. Maintenance staff were also most likely to respond negatively to the question asking whether the organisation provides opportunities for career progression/promotion (61%) whereas Physiotherapists (91%) and Occupational Therapists (98%) were most positive. Overall, our results were worse than average when compared to combined Acute/Community Trusts.

19. We know from information from our Exit Questionnaires and new starters' survey that opportunities for training, development and promotion in the Trust are both main attractions for new employees and affect our ability to retain staff. The action plan will include work around how we ensure staff have equal access to these opportunities.

Verbatim comments

20. The survey provides staff with an opportunity to add in any additional comments they would like to make. We received around 750 comments and an analysis of these showed the most common themes to be:

- The impact of reduced staffing levels
- Low morale
- Leadership and Management
- Finance
- IT (poor systems and the impact on work)

Next Steps

21. The staff survey results are in the main not encouraging and there is much work to do. It would not be possible to make progress on every area of concern, therefore, the Staff Survey Action Plan Working Party is asked to confirm that we have identified the correct areas for targeted action. A detailed action plan will be developed with input from the Working Party to support this targeted work and publicised widely through the organisation so that staff know their views have been heard and taken seriously.

Appendix 1: Actions taken to address bullying and poor behaviour

Over the past five years actions have included:

	What we did
Embed Values and Behaviour policy:	All teams to display values poster
	Team and Care Group meetings to include focus on the values as an agenda item and give examples of how it can be **implemented** within their areas of work
	All staff & managers to challenge poor behaviour wherever found – inc. consultant colleagues
	Termination form to be amended - to make exit interview information a mandatory requirement (e.g. if the interview has not been carried out with HR manager or line manager, a contact email address must be supplied - form rejected without this information)
	Exit interview template to be created to standardise the data we are collecting
	Exit interview template data to be shared with Care Group's quarterly and discussed openly in team meetings
Strengthen leadership and line management	
	Managers to undertake Leadership Framework
	GM's and HoNs to be provided with a list of all managers who have attended internal training courses so that gaps in training can be identified
	All managers to ensure that MAST and appraisal figures are at 85% - data to be circulated ranking all cost centres/GM areas by compliance
	Unconscious bias training to be rolled out to Band 7 staff
	Staff 'drop in centres' to be held once a month (targeted areas if required)
Raise Staff Awareness:	
	Develop ‘Values/Expectation Workshops’ for staff to develop a charter of expected behaviours with teams
	All teams to display Harassment & Bullying posters and leaflets (available from Heather Beeston)
	Point staff to Harassment & Bullying policy, which is actually called "Dignity at Work Policy". This needs to be circulated by GM's and HoN's to promote awareness
Provide feedback	

	Anonymised case studies to be prepared by HR monthly and shared with GMs and HoN's. These should then be shared at team meetings to highlight that action does happen when concerns are raised
	Real time data on bullying and harassment to be provided i.e. number of cases reported in division quarterly so targeted action plans can be developed in areas of concern
	Promotion of staff value awards - make nomination process easier
General	Undertaking a staff survey to understand reported bullying and harassment better (the results are set out in the section above)
	Updating and re-publicising the harassment and bullying policy.
	Establishing a formal reporting process as part of our clinical incident reporting process, including providing feedback to staff.
	Taking formal disciplinary action.
	Re-establishing the bullying and harassment support line
	Using mediation where appropriate.
	Providing whole group training exercises including the use of the clinical simulation centre to develop team building skills and to review critical incidents
	Providing training to all line managers on the management of bullying and harassment cases.
	Clear statements and communication from the Chief Executive that bullying is not acceptable within St George's.
	A focused approach of support for specific areas where evidence indicates that there are problems (
	A re-launch of the Trust's values linked to the Listening into Action programme.
	LiAise post has been made permanent allowing members of staff the opportunity to raise their concerns. This appointment has been developed from listening to the views of staff members through our Listening into Action programme.
Agreed EMT actions 2015	The Executive Management Team (EMT) publicly stated a commitment that members are willing to implement. . • All members of staff are expected to behave according to the Trust's values. No-one is exempt. There will be no intrinsic or explicit rewards for those who behave badly. • Our overall approach will be to provide support to those who cannot manage their poor behaviour in order to

	enable an improvement, through interventions such as coaching and mediation. However, for those who are not able or willing to improve, or whose behaviour is very serious, we will take appropriate action, such as dismissal, referral to the GMC, NMC or other professional body. • We will ensure that all members of staff know what support is available and we will ensure that we underpin our commitment with sufficient resources. • We will make these commitments known to staff.
	In 2015 we: • Restated the board and EMT's commitment to tackling poor behaviour and bullying no matter who is at fault. • Undertook a review of why the majority of allegations of bullying are not upheld and what alternative methods of resolution and support might be available when individuals raise concerns. • Ensured that the values are a fundamental part of the leadership development programme. • Found out what the Royal Free and GSTT have done to reduce the incidence of bullying and learn from them. • Established an in-house pool of accredited Mediators, and to provide training and support to those staff members undertaking the mediation role • Extended the Unconscious Bias workshops to middle clinical and non-clinical managers • Changed the publicity for the Dignity at Work policy by displaying new-style posters focussed on individual behaviour.
From Staff Survey feedback meeting 2016	In 2016 • Roll out unconscious bias training to all managers including those who have not attended to date. • Shorten recruitment time process • Challenge all acting up arrangements in excess of 6 months and remove those that breach the policy through confirming staff in post or other fair process. • Remove corporate meetings from Fridays and free up time for managers to engage with staff. • Introduce WOW awards or similar.

APPENDIX 2: Tacking Harassment and Bullying Case Study: London Ambulance Service (pdf)

NHS Employers

FEBRUARY 2017

TACKLING BULLYING AND HARASSMENT

LONDON AMBULANCE SERVICE

ORGANISATIONAL PROFILE

- 70 main stations
- 5,000 staff
- Sickness absence rate in December 2015 - 5.4 per cent and December 2016 - 5 per cent
- Turnover rate in December 2015 - 13.5 per cent and December 2016 - 9.5 per cent
- Serves a population of more than eight million people
- Dispersed workforce with most spending their working time in ambulances or fast response cars

THE SUMMARY

In 2015, London Ambulance Service (LAS) became the first ambulance trust to be placed in special measures by the Care Quality Commission (CQC) and concerns were raised about bullying and harassment. The trust took immediate action and recruited a bullying and harassment specialist, nominated a non-executive director sponsor and setup an HR and OD committee. A phased action plan was developed and progress is reported on a monthly basis to the non-executive director which keeps resource, energy and focus on initiating cultural changes throughout the organisation.

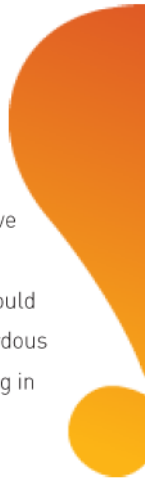
CHALLENGES

Work demands and pressures are high across the NHS, which can cause the atmosphere to become frantic. To address this, the bullying and harassment specialist bought training sessions to different areas of the organisation to reach as many people as possible; addressing everything from what could seem minor communication issues between colleagues to perceptions of unfair treatment by management. Time was taken at the end of each session to talk about the work that LAS is doing to tackle bullying and begin to change the culture.

STEPS THE TRUST IS TAKING

Bullying and harassment awareness workshops were created to equip employees with practical tools to help make the workplace more respectful. The sessions explore the difference between robust management and bullying, discuss 'banter' and how it can tip into harassment, and explain practical ways to ensure cultural sensitivity.

Round table sessions LAS commissioned an external specialist company, Total Conflict Management, which specialises in mediation skills, to train 50+ members of staff to become facilitators of round table conversations. Since the training, LAS has seen an increase in dialogue at all levels within the organisation. Twelve sessions have been requested by staff so far, and early anecdotes from staff say they have been helpful in getting people communicating.



A day in the life of events LAS has held three day in the life of events over the past twelve months, which over 120 employees attended. Teams open themselves up to visits and questions for over a week to encourage colleagues to spend time in services that they would not normally interact with, such as control rooms, legal services, NHS 111 and the hazardous area rescue team. Employees have seen this as a meaningful way to break down working in silos.

Training staff in investigating bullying and harassment allegations. To provide consistency in the speed and quality of the investigations and of the reports provided, the trust trained 70 staff to undertake investigations into bullying and harassment allegations, and seek a timely resolution.

HR training bespoke training was provided to the HR team through specific workshops covering issues such as, legal aspects of bullying and harassment, round table skills for HR managers and skills in investigating bullying and harassment investigations.

OUTCOME

LAS has begun to change culture and people are encouraged to have early conversations so that issues can be addressed quickly.

The Bullying and Harassment policy name has changed to Respect and Dignity at Work policy. Respect and Dignity ambassadors have been piloted in the organisation to help support staff and colleagues and, if successful, this trial will be rolled out. Staff have commented that they like the concept of reducing conflict as early as possible using peers, versus a formal approach, and are willing to attend training to offer this skill. The trust has held 61 workshops to explore bullying within the workplace and discuss solutions which over 750 staff have attended.

Staff turnover has improved, and the number of employees who would recommend LAS as a place to work has increased in recent friends and family test results.

TOP TIPS

- Recruit a board lead to fully support your agenda – this impact will go a long way to improve the culture in your organisation.
- Changing the policies around bullying and harassment to reflect dignity and respect is a good place to start but role modelling is even more important at all levels within the organisation to effect long term culture change.
- Engage with staff and ask their opinions and views on culture on an on-going basis, staff will tell you what is working and what is not, within the organisation.

FURTHER INFORMATION

For further information please contact Cathe Gaskell on Cathe.Gaskell@lond-amb.nhs.uk or email healthandwellbeing@nhsemployers.org

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	8 June 2017	**Agenda No.**	**4.4**
Report Title:	Fit and Proper Person Policy and Procedure		
Lead Director/ Manager:	Harbhajan Brar, Director of Human Resources & Organisational Development		
Report Author:	Fiona Barr, Trust Secretary & Head of Corporate Governance		
Presented for:	Approval		
Executive Summary:	The Board approved the Fit and Proper Person Policy and Procedure in October 2016. However, since then it has made some small changes in line with its own internal review of the document and further guidance issued by the Care Quality Commission (CQC) at the end of May 2017.		
Recommendation:	The Board is asked to approve the revised policy.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (well-led)		
Implications			
Risk:	Whilst the CQC cannot prosecute for a breach of this regulation or any of its parts, there is a risk that it can take regulatory action if the Trust is found to be non-compliant.		
Legal/Regulatory:	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5. The intention of this regulation is to ensure that people who have Director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role.		
Resources:	There are no specific resource requirements associated with amended policy.		
Previously Considered by:	Executive Directors	**Date:**	May 2017
Equality Impact Assessment:	Included in the policy.		
Appendices:	Appendix 1 - Fit and Proper Person Policy and Procedure		

Fit and Proper Person Policy and Procedure
Board, 8 June 2016

1.0 PURPOSE

1.1 The purpose of this paper is to draw to the Board's attention small changes which have been made to the Fit and Proper Person Policy and Procedure (FPPP) and to seek approval for the revised FPPP.

2.0 BACKGROUND

2.1 The fit and proper persons requirement for Directors came into force for all care providers on 01.04.15 though the fit and proper persons requirement for directors came into force for NHS bodies on 27.11.14.

2.2 The introduction of a statutory fit and proper persons requirement for Directors was an important step towards ensuring the open, honest and transparent culture that was lacking at Mid Staffordshire NHS Foundation Trust. The failures at Winterbourne View Hospital revealed that there were no levers in the system to hold the "controlling mind" of organisations to account. The fit and proper persons requirement for Directors plays a major part in ensuring the accountability of Directors of NHS bodies.

2.3 The Trust put in place a FPPP in 2016 which received Board approval on 06.10.16.

2.4 During a recent inspection by the Care Quality Commission (CQC), the Trust's compliance with its FPPP was examined as this has been the subject of previous regulatory action.

3.0 CHANGES TO THE FPPP

3.1 An internal review of the FPPP revealed that Directors had started in post before all the checks in the FPPP had been completed. The Trust had been in a very unusual position of having a great deal of change and instability in the leadership team and in some cases had to take rapid action to appoint or replace members of the Board in the interests of the continued safe running of the organisation or to ensure that Licence requirements were fulfilled.

3.2 As a result, it was proposed that additional provisions were included in the FPPP to accommodate exceptional situations where an appointment is made and a new Director starts within a short timescale and before the FPPR process has been completed. This change was discussed by the Executive Directors and agreed internally with the Chairman. The proposed addition was also discussed with the CQC during the inspection.

3.3 The proposed addition is as follows:

Members of the Board will not be able to commence in post unless the FPPR have been met. However, there may be exceptional circumstances where, in the interests of the efficient running of the organisation and/or to ensure that the requirements of our licence are fulfilled, a director may start work before all components the FPPR has been met. The Chairman is the responsible officer for making an informed decision regarding the course of action to be followed, and will confirm their authorisation for the Board member to start prior to the FPPR being met.

Please note commencement of appointment is subject to the expectation of the appointee successfully meeting the FPPR and if he or she does not then the appointment may be terminated with immediate effect.

3.4 Furthermore at the end of May 2017, the CQC updated the guidance which underpins Regulation 5 to make it explicit that it expects providers to establish whether a Director/potential Director is on the children's and/or adults safeguarding barred list and whether they are prohibited from holding the office in question under other laws such as the Companies Act or Charities Act, and to undertake an enhanced Disclosure and Barring Service (DBS) check. The FPPP has been strengthened to reflect this.

3.4 Finally in line with all new policies a new standard paragraph has been inserted in the Executive Summary of the FPPP.

4.0 IMPLICATIONS

4.1 The implications are set out on the front sheet.

5.0 NEXT STEPS

5.1 The Trust will continue to monitor compliance with the FPPP and clearly document any instances where a Director is required to start in post before all of the necessary fit and proper person checks have been completed.

5.2 Furthermore, as there is a requirement to complete an annual declaration confirming that post holders continue to be compliant with the fit and proper person requirements and declare any conflicts of interest, this will be undertaken in spring each year so it can be reported in the Trust's Annual Report and Accounts.

6.0 RECOMMENDATION

6.1 The Board is asked to approve the revised policy.

Author: **Fiona Barr, Trust Secretary & Head of Corporate Governance**
Date: **02.06.17**

APPENDIX 1

Fit and Proper Person Policy and Procedure

The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This procedural document has been equality impact assessed to ensure fairness and consistency for all those covered by it regardless of their individual differences and the results are shown in Appendix B.

Policy Profile			
Version:	1.1		
Author:	Head of Corporate Governance		
Executive sponsor:	Director of Workforce and Organisational Development		
Target audience:	**Board Members**		
Date issued:	October 2016		
Review date:	October 2019		
Consultation			
Key individuals and committees consulted:	Human Resources	**Dates**	Sept 2016
	Communications	**Dates**	Sept 2016
Approval			
Approval Committee:	Executive Management Team		
Date:	19 September 2016		
Ratification			
Ratification Committee:	Board		
Date:	6 October 2016		
Ratification Committee:	Board		
Date:	8 June 2017 TBC		

Document History			
Version	**Date**	**Review date**	**Reason for change**
1.0	Sept 2016	Sept 2019	Created as a stand-alone policy
1.1	May 2017	Sept 2019	Amendment to allow for interim approval and start of appointment subject to completion of FPPR and updated guidance from CQC about completing an enhanced DBS check.

Contents

Executive Summary

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

The Trust's policies set out the organisation's standards and intentions, and are written with the aim of being as clear and comprehensive as possible. However, we operate in a dynamic and evolving work environment and attention should be paid to the spirit of the policy as well as the letter. Policies by themselves cannot guarantee effective behaviour or the delivery of key objectives. While they are designed to support the Trust, and the people working within it, our success depends on continuous, high quality effort by everyone the policy covers, and alongside this policy you should read any guidance or supporting documentation that relates to this policy to help you do this.

Fit and Proper Persons Requirement (FPPR) Policy and Procedure

1. Scope

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

2. Purpose

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

3. Introduction

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

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

4. Meeting the Requirements of Regulation 5

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

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

- Are of good character
- Hold the required qualifications and have the competence, skills and experience required for the relevant office for which they're employed

- Are able, by reason of their physical and mental health, after any required reasonable adjustments if required, capable of properly performing their work.
- Can supply relevant information as required by schedule 3 of the act, ie documentation to support the FPPR.
- Not have been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity).
- Are prohibited from holding the office in question under other laws such as the Companies Act or Charities Act.

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

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

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

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

Members of the Board will not be able to commence in post unless the FPPR have been met. However, there may be exceptional circumstances where, in the interests of the efficient running of the organisation and/or to ensure that the requirements of our licence are fulfilled, a director may start work before all components the FPPR has been met. The Chairman is the responsible officer for making an informed decision regarding the course of action to be followed, and will confirm their authorisation for the Board member to start prior to the FPPR being met.

Please note commencement of appointment is subject to the expectation of the appointee successfully meeting the FPPR and if he or she does not then the appointment may be terminated with immediate effect.

Implementation of FPPR for Existing staff and On-going Fitness

5.1 Implementation

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

The standards are:

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

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

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

- Search of insolvency and bankruptcy register
- Search of disqualified directors register
- The Director completes a self-declaration form (Annex A)
- An appropriate media and social media search is conducted

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

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

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

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

5.2 On-going Fitness

The annual appraisal process will provide an opportunity to discuss continued "fitness", competence and how the post holder role displays the Trust values and behaviour standard including the leadership behaviour expected. The CEO will be responsible for appraising the

Executive Directors, whilst the Chairman will be responsible for appraising the Non-Executive Directors. The CEO will be appraised by the Chairman. The Chairman will be appraised through the agreed appraisal process, including where the Chairman is appointed by NHSI using their regulatory powers.

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

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

5.3 Concerns regarding an Individual's Continued FPPR Compliance

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

The Trust reserves the right to suspend a Director or restrict them from duties on full pay / emoluments (as applicable) to allow the Trust to investigate the matters of concern. Suspension or restriction from duties will be for no longer than necessary to protect the interests of service users or the Trust and/or where there is a risk that the Director's presence would impede the gathering of evidence in the investigation.

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

Responsibilities

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

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

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

Responsibility of the Chief Executive:

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

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

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

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

Appendix A

Fit and Proper Persons Test

Declaration Form

Objective

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

Requirements

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

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

Declaration

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

Are there any issues that you would like to disclose:

Yes: ☐ No: ☐

Signed ……..

Date ……

Role ……

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

Signed……..

Appendix B

EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
Fit and Proper Person Policy and Procedure	Governance	L Edwards	Now a stand-alone policy	Sept 2016

1.1 Who is responsible for this service / function / policy?
HR and Trust Secretary

1.2 Describe the purpose of the service / function / policy? Who is it intended to benefit? What are the intended outcomes?

- The policy applies to all Board members including all interim and associate members of the Board.
- All Board members should be appointed through this process
- Providing greater clarity on the process for new appointments and the annual process
- Clarifying the accountabilities and in particular that the Trust Secretary is accountable for the overall process

1.3 Are there any associated objectives? E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives

Strengthened policy put in place.

1.4 What factors contribute or detract from achieving intended outcomes?
None

1.5 Does the service / policy / function / have a positive or negative impact in terms of race, disability, gender, sexual orientation, age, religion or belief and Human Rights? Details:
[see Screening Assessment Guidance]
No

1.6 If yes, please describe current or planned activities to address the impact.
No

1.7 Is there any scope for new measures which would promote equality?

1.8 What are your monitoring arrangements for this policy/ service

1.9 Equality Impact Rating [low, medium, high]- see guidance notes 3.1 above

Low

2.0. Please give you reasons for this rating

No impact on equality

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Board		
Date:	8 June 2017	**Agenda No**	**4.5**
Report Title:	Managing Conflicts of Interests Policy		
Lead Director/ Manager:	Fiona Barr, Trust Secretary and Head of Corporate Governance		
Report Author:	Fiona Barr, Trust Secretary and Head of Corporate Governance		
Presented for:	Approval		
Executive Summary	NHS England has produced new guidance for managing conflicts of interest and requires that all Trusts implement this from June 2017. This paper presents a draft policy for approval.		
Recommendation:	The Board is asked to approve the new policy on Managing Conflicts of Interest.		
Supports			
Trust Strategic Objective:	**Valuing our staff**: To develop leadership that inspires staff and ensures they feel valued, and value the Trust as a place to deliver care.		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Leadership and Improvement Capability		
Implications			
Risk:	Without full declarations of interests there is a risk staff with responsibilities for making financial or service decisions could either be involved in decisions from which they should be excluded; or make decisions that are subject to challenge because an undeclared interest is deemed, rightly or wrongly, to have unfairly influenced a decision.		
Legal/Regulatory:	As above.		
Resources:	As the scope of the Managing Conflicts of Interest Policy is quite extensive, the responsibility for maintaining registers and seeking regular declarations from staff will be shared between Central and Divisional teams.		
Previously Considered by:	N/A	**Date**	
Equality Impact Assessment:	This is based on a model policy provided by NHS England.		
Appendix:	**Appendix 1:** Draft Managing Conflicts of Interest Policy		

New Draft Conflicts of Interests Policy
Board, 8 June 2017

1.0 PURPOSE

1.1 This paper sets out the proposed approach to managing conflicts of interest in the Trust.

2.0 BACKGROUND

2.1 It is important that all members of staff know what is expected of them regarding the conduct of business in the NHS. Currently the Trust's Standards of Business Conduct Policy includes specific requirements regarding the Registers of Gifts and Hospitality, and Interests.

2.2 From June 2017, a contract variation requires all NHS trusts to comply with NHS England's guidance on the management of conflicts of interests. This guidance:

i. Introduces common principles and rules for managing conflicts of interest
ii. Provides simple advice to staff and organisations about what to do in common situations
iii. Supports good judgement about how interests should be approached and managed
iv. Sets out the issues and the rationale behind the policy.

2.3 Regardless of employment type, all staff who work for the Trust have a duty to operate with the high standards of probity and not to put themselves in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.

2.4 To this end, the Trust must advise staff of their obligations and duties, regularly obtain declarations and manage breaches of the policy.

3.0 THE NEW POLICY

3.1 The Managing Conflicts of Interests Policy models the NHS England policy as this provides a practical interpretation of the guidance to help organisations with implementation.

3.2 Whilst it replaces the Trust's Standard of Business Conduct Policy in full, the Policy does not materially change the existing process for making a number of declarations. Instead it makes it much clearer where conflicts of interest may arise – and this covers areas not included in the currently included in the Standards for Business Conduct Policy.

4.0 IMPLEMENTATION AND COMPLIANCE

4.1 Work is underway to set out an implementation plan to support this Policy and early thoughts have been shared with the Executive Management Team on how a Trust of this size might manage the process to capture declarations of interest from staff. More work will be done on this in the coming weeks. This includes an awareness campaign of roles and responsibilities as well as developing the framework by which interests, gifts and hospitality can be captured and maintained.

4.2 In addition to a clear framework and method for capturing interests, gifts and hospitality, there needs to be a clear means of identifying, reporting and managing breaches – including taking action with staff who have deliberately breached the Policy and ensuring that lessons are learned from breaches which have occurred. This is also the subject of more work in the coming weeks.

5.0 IMPLICATIONS

5.1 These are set out on the front sheet.

6.0 RECOMMENDATIONS

6.1 The Board is asked to approve the new policy on Managing Conflicts of Interest.

Author: **Fiona Barr, Trust Secretary & Head of Corporate Governance**

Date: **2 June 2017**

Appendix 1

Managing Conflicts of Interests in the NHS

Policy Profile			
Version:	1.0		
Author:	Michael Wuestefeld-Gray, Corporate Governance Advisor		
Executive sponsor:	Fiona Barr, Trust Secretary & Head of Corporate Governance		
Target audience:	All Staff		
Date issued:	June 2017		
Review date:	June 2019		
Consultation			
Key individuals and committees consulted	Model Policy Produced by NHSE	**Dates**	Aril 2017
	EMT Members	**Dates**	May 2017
		Dates	
Approval			
Approval:	Board		
Date:	8 June 2017 – TBC		
Ratification			
Ratification:	Board		
Date:	8 June 2017 – TBC		

1 Policy Summary

It is important that all members of staff know what is expected of them regarding the conduct of business in the NHS. This policy includes specific requirements for the management of conflicts of interests.

It is the responsibility of all Trust employees to act neutrally and be impartial in the execution of their duties. Therefore they must ensure that they are not placed in a position of conflict between their NHS duties and any other interests. The primary responsibility applies to all staff, but agents and contractors acting on behalf of the Foundation Trust are similarly required to declare any interests.

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.

The Trust's policies set out the organisation's standards and intentions, and are written with the aim of being as clear and comprehensive as possible. However, we operate in a dynamic and evolving work environment and attention should be paid to the spirit of the policy as well as the letter. Policies by themselves cannot guarantee effective behaviour or the delivery of key objectives. While they are designed to support the Trust, and the people working within it, our success depends on continuous, high quality effort by everyone the policy covers, and alongside this policy you should read any guidance or supporting documentation that relates to this policy to help you do this.

2 Introduction

St George's University Hospitals NHS Foundation Trust (the Trust), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients.

These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

This policy sets out some guiding principles covering the management of conflicts of interests. It does not provide for every eventuality and, therefore you should not hesitate to seek advice from your Line Manager or the Trust's lead for managing conflicts of interests.

The Trust is a public body and as such has a duty to ensure that:

- All its business dealing are conducted to the highest standards of openness, honesty and probity;
- The interests of the Trust and its patients come first; and
- Public funds are properly safeguarded.

In particular, staff should ensure they do not:

- Abuse their official position for personal gain or to benefit their family or friends;
- Misuse any financial procedures of the Trust for personal gain;
- Wilfully neglect to perform their duty or wilfully misconduct themselves;
- Perform a relevant function or activity improperly;
- Remove items of Trust property without authorisation; and
- Seek to gain advantage or further private or business interests in the course of their official duties.

Staff are expected to comply with this policy and ensure they:

- Abide by the rules regarding conflicts of interests;
- Inform their line manager if they suspect interests have not been declared or are not being properly managed.

One of the objectives of this policy is to ensure that staff are aware of their responsibilities and when doing business they take appropriate action to ensure they do not engage in any corrupt activities that could damage the reputation of the Trust.

It is important to note that none of the requirements in this policy contradictor conflicts with an individual's rights as set out in the Trust's Whistleblowing Policy nor is anything contained in this policy deemed as overriding the Trust's legal duty to comply with the Freedom of Information Act.

As a member of staff you should…	As an organisation we will…
• Familiarise yourself with this policy and follow it. Refer to the guidance for the rationale behind this policy https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf • Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent • Regularly consider what interests you have and declare these as they arise. If in doubt, declare. • **NOT** misuse your position to further your own interests or those close to you • **NOT** be influenced, or give the impression that you have been influenced by outside interests • **NOT** allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money	• Ensure that this policy and supporting processes are clear and help staff understand what they need to do. • Identify a team or individual with responsibility for: o Keeping this policy under review to ensure they are in line with the guidance. o Providing advice, training and support for staff on how interests should be managed. o Maintaining register(s) of interests. o Auditing this policy and its associated processes and procedures at least once every three years. • **NOT** avoid managing conflicts of interest. • **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners

3 Purpose

In June 2017 a variation to the Standard contract will be introduced under General Condition 27 to give effect to NHS England's guidance on managing conflicts of interests.

This imposes a requirement on Foundation Trusts to follow that guidance and, where necessary, develop additional local systems to improve on it.

This policy will help our staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations.
- Supports good judgement about how to approach and manage interests

4 Key terms

A 'conflict of interest' is:

> "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

A conflict of interest may be:

- Actual - there is a material conflict between one or more interests
- Potential – there is the possibility of a material conflict between one or more interests in the future

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

5 Interests

Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit* from the consequences of a decision they are involved in making. Examples include:
  - a director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
  - A shareholder (or similar ownership interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
  - Secondary employment; receipt of secondary income from another organisation
  - In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role.

- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing

* This may be a financial gain, or avoidance of a loss.

their professional reputation or promoting their professional career. This may, for example, include situations where the individual is:

- An advocate for a particular group of patients;
- A member of a particular specialist professional body (although routine GP membership of the British Medical Association (BMA) or a medical defence organisation would not usually by itself amount to an interest which needed to be declared);
- An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE);
- A medical researcher.

- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career. This could include, for example, where the individual is:

  - A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation;
  - Suffering from a particular condition requiring individually funded treatment;
  - A member of a lobby or pressure group with an interest in health.

- **Indirect interests:**
  This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a health and social care (as those categories are described above) for example:

  - Spouse / partner
  - Close relative e.g., parent, grandparent, child, grandchild or sibling;
  - Close friend;
  - Business partner.

6 Staff

At the Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

6.1 All staff are responsible for complying with this policy including declaring

interests.

6.2 Line Managers are responsible for ensuring staff are aware of and familiarise themselves with this policy. They should also provide advice and support to staff may have an interest to declare.

6.3 The Trust Secretary is responsible for ensuring that the systems for reporting and recording conflicts of interests (including the collation and publication of registers and the audit of systems and processes) are operating effectively.

6.4 The Executive Management Team is responsible for ensuring the divisions and teams in the Trust comply with this policy.

6.5 The Audit Committee will receive audits of conflicts of interests and gifts, sponsorship and hospitality annually and make recommendations for the improvement and management of systems for the coming 12 months.

6.6 The Trust will ask its auditors to review its processes and policies around the management of interests at least once every three years.

6.7 Clinical Staff must declare their private practice

7 Staff Required to Make a Declaration

Having interests is not in itself negative; but not declaring and managing them is. Therefore the Trust will ask annually the following categories of staff to declare interests:

- Executive and non-executive directors
- All members and regular attendees at board sub-committees and management committees
- Members of the Council of Governors
- All staff at Agenda for Change band 8b and above
- All staff working in accounts payable, procurement, the Trust PMO, pharmacy, and the Trust's corporate office.
- Any staff who are involved in a decision on how taxpayers' money will be spent e.g. those involved in tenders, or in the commissioning or purchasing of goods, medicines, devices or equipment.
- All doctors who are employed as consultants

In addition **clinical staff** should declare all private practice on appointment, and/or any new private practice when it arises including:

- where they practise (name of private facility)
- what they practise (specialty, major procedures).
- when they practise (identified sessions/time commitment)

8 Identification, declaration and review of interests

8.1 Identification & declaration of interests (including gifts and hospitality)

All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Declarations should be made:

- On appointment with the organisation.
- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

A declaration of interest(s) form is available on the Trust's Policy Hub or from the Trust Secretary

Staff should also make a declaration of interests at any meeting where and agenda item relates to an area where they have a material or potential interest. This will allow the Chair to make a decision on how this will be handled, in line with that meeting's terms of reference or, if the terms of reference are silent on conflicts of interest, in line with this policy.

When an interest is declared it will be reviewed by the declaring person's line manager or, if the line manager is unable or not an appropriate person to make a decision, by the appropriate divisional chair. On a case by case basis a decision will be made if it is a material interest, or a potentially material interest. If so, the next step is to make a decision on how that interest will be managed and record the interest and its management arrangements in the Trust's Register of Interests.

8.2 Proactive review of interests

We will ask staff required to make a declaration to review declarations they have made and, as appropriate, update them or make a nil return annually, but we also require staff to proactively declare any interests if their circumstances change or they become aware of an interest that they have not previously declared.

9 Records and publication

9.1 Maintenance

All declared interests that are material will be promptly transferred to the register by the Trust Secretary. The register will be maintained and updated as interests are declared.

9.2 Publication

Interests will be recorded in a Register of Interests that will be held by the Trust Secretary. The register will be published but will only contain the details of Board

Members and all staff with declared interests at band 8d and above. This is in line with national guidance. All other interests will be summarised anonymously.

If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact The Trust Secretary to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

9.3 Wider transparency initiatives

The Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These "transfers of value" include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

Further information about the scheme can be found on the ABPI website:
http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

10 Management of interests – general

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making
- removing staff from the whole decision making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context-specific, and The Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

11 Management of interests – common situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

11.1 Gifts

- Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value.
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6* in total, and need not be declared.

Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined.
- Staff should not ask for any gifts.
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the Trust, not in a personal capacity. These should be declared by staff.
- Modest gifts accepted under a value of £50 do not need to be declared.
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

11.1.1 What should be declared

- Staff name and their role with the organisation.
- A description of the nature and value of the gift, including its source.
- Date of receipt.
- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.2 Hospitality

Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of 'traditional' working hours. As a result, staff will sometimes appropriately receive

* The £6 value has been selected with reference to existing industry guidance issued by the ABPI: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted, and be mindful that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviour.

Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement. Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event. Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors – these can be accepted if modest and reasonable but individuals should always obtain approval from their line manager and declare these.

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75* - may be accepted and must be declared.
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
    - offers of business class or first class travel and accommodation (including domestic travel)
    - offers of foreign travel and accommodation.

11.2.1 What should be declared

- Staff name and their role with the organisation.
- The nature and value of the hospitality including the circumstances.
- Date of receipt.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

* The £75 value has been selected with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx

11.3 Outside Employment

- Staff should declare any existing outside employment on appointment and any new outside employment when it arises.
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

11.3.1 What should be declared

- Staff name and their role with the organisation.
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.4 Shareholdings and other ownership issues

- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.
- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

11.4.1 What should be declared

- Staff name and their role with the organisation.
- Nature of the shareholdings/other ownership interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.5 Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are

ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.

- Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

11.5.1 What should be declared

- Staff name and their role with the organisation.
- A description of the patent.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

11.6 Loyalty interests

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

11.6.1 What should be declared

- Staff name and their role with the organisation.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.7 Donations

- Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on

behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

11.7.1 What should be declared

- The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

11.8 Sponsored events

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit the organisations and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the organisation's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.
- Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff arranging sponsored events must declare this to the organisation.

11.8.1 What should be declared

- The organisation will maintain records regarding sponsored events in line with the above principles and rules.

11.9 Sponsored research

Research is vital in helping the NHS to transform services and improve outcomes. Without sponsorship of research some beneficial projects might not happen. More broadly, partnerships between the NHS and external bodies on research are important for driving innovation and sharing best practice. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage. There needs to be transparency and any conflicts of interest should be well managed.

- Funding sources for research purposes must be transparent.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- Staff should declare involvement with sponsored research to the organisation.

11.9.1 What should be declared

- The organisation will retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
    - their name and their role with the organisation.
    - Nature of their involvement in the sponsored research.
    - relevant dates.
    - Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.10 Sponsored posts

Sponsored posts are positions that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the Trust, particularly in relation to procurement and competition.

The sponsorship for a post should be approved in line with the Trust's Scheme of Delegation and only following advice from HR. Sponsored posts will not be permanent posts and a review of the arrangements and the delivery of the role must be done periodically, at least annually.

There should be written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. For the duration of the sponsorship, auditing arrangements should be established to ensure this is the case. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.

Staff in the sponsored post must act in the best interests of the Trust and abide by the rules and guidance set out in this and the Conflicts of Interests policies, applying them to the sponsoring organisation in the same way as they should for any other organisation. Sponsorship should be declared on the Trust's Register of Interests.

- External sponsorship of a post requires prior approval from the organisation.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

11.10.1 What should be declared

- The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

11.11 Clinical private practice

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises* including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.†
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

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* Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

† These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

11.11.1 What should be declared

- Staff name and their role with the organisation.
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

12 Management of interests – advice in specific contexts

12.1 Strategic decision making groups

In common with other NHS bodies The Trust uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

The interests of those who are involved in these groups should be well known so that they can be managed effectively. These include the staff set out in section 7, above.

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation's register(s).
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

12.2 Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

13 Dealing with breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

13.1 Identifying and reporting breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to their line manager or the Trust Secretary.

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Ever individual has a responsibility to do this. For further information about how concerns should be raised can be found in the Trust's Whistleblowing Policy or by speaking to the Freedom to Speak Up Guardian.

The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

7.4. Following investigation the organisation will:

- Decide if there has been or is potential for a breach and if so the what severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

13.2 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for

staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
    - Informal action (such as reprimand, or signposting to training and/or guidance).
    - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

13.3 Learning and transparency concerning breaches

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published as part of reporting to the Board at least annually or as appropriate, or made available for inspection by the public upon request at the Trust's discretion.

14 Review

This policy will be reviewed by the date set out on the front sheet unless an earlier review is required. This will be led by the Trust Secretary.

15 Associated documentation

- Freedom of Information Act 2000
- ABPI: The Code of Practice for the Pharmaceutical Industry (2014)
- ABHI Code of Business Practice
- NHS Code of Conduct and Accountability (July 2004)
- The NHS England guidance on which this policy is based can be found here: https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf
- The Information Commissioner's guidance on which the policy approach to publication of the Register of Interests is based can be found here: https://ico.org.uk/media/1220/definition-document-health-bodies-in-england.pdf
- Hospital Consultants' Terms and Conditions: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf
- Competition and Market Authority Guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/NonDivestment_Order_amended.pdf

REPORT TO THE BOARD FROM: Audit Committee

COMMITTEE CHAIR: Sarah Wilton, Non-Executive Director

DATE OF COMMITTEE MEETING: 25.05.17

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

ACTION TRACKER

1. We had been assured that the Executive would address the action tracker robustly with at least quarterly oversight from EMT, and reasonably good progress now seems to be being made to provide the necessary assurance that all significant Internal Audit recommendations are completed within the agreed timeframe. However the Committee was very concerned that eleven Priority 1 recommendations remain outstanding beyond the agreed deadlines, and that several deadlines have simply been put back. It was agreed that deadlines for completing these recommendations can in future only be put back by agreement with the CEO.

2. We ask the Board to continue to endorse the approach which requires the Executive to co-operate with TIAA, to take responsibility individually and severally as an Executive team for progressing and implementing agreed actions arising from Internal Audits and to report back progress to the Audit Committee in a timely and regular manner. The Committee expects that all outstanding and overdue actions and recommendations will be complete by its next meeting in September.

INTERNAL AUDIT

3. The Audit Committee received Internal Audit Reports on Information Governance Toolkit, Governance Framework, Board Assurance Framework, Payroll and Facilities Management: all of which received only limited assurance. The Committee stressed to the Executives responsible that all actions arising from these audits must be completed within the agreed timescales.

4. The Head of Internal Audit confirmed that, as previously advised, his annual HOIA opinion for the Trust's Annual Report could only be one of limited assurance. The Audit Committee noted its understanding of the position, but reminded the Executive that the Trust must move to a position, through its recovery plan, to ensure that the HOIA opinion for 17/18 must be one of at least reasonable assurance.

EXTERNAL AUDIT AND ANNUAL REPORT AND ACCOUNTS

5. The External Auditors reported on the completion of their audit for the year noting that while improvements had been made since last year in the production of the Annual Report and Accounts and the Quality Account, the Trust's financial and accounting control environment is still very poor by comparison with similar Trusts and that major and urgent effort is needed to address these issues. The report from the auditors setting out matters identified in the course of their audit was discussed in detail and the Executive committed to addressing all matters promptly.

6. The significant and detailed year end accounting, audit and disclosure issues addressed in detail were:

    a. Going Concern: as discussed at the recent 31 May Board meeting approving the accounts

b. Director and executive emoluments: Audit Committee sought and obtained confirmation that all required disclosures are to be made, despite the existence (of which the NEDs were not previously aware) of 'non-disclosure' clauses in four interim executives' contracts
c. All detailed queries which had arisen from the accounts workshop were confirmed to be complete or in the course of being completed
d. Arrangements for the signing of the accounts and the letters of representation were still to be finalised by the DFO and CEO.

7. The Committee noted its concern that, at this final stage of approval, a considerable amount of detailed editing, re-wording, cross-checking and corrections were required to all the documents requiring Audit Committee approval, and that the narrative style and presentation and formatting of the documents was not yet of a satisfactory standard.

8. Subject to completion of these matters, many of which needed to be addressed with the Board on 31 May, the Audit Committee recommended approval of the Annual Report and Accounts and the Quality Account (which had been previously reviewed and approved in principle by the Quality Committee).

COUNTER FRAUD

9. The progress on several cases was discussed and noted. Progress on one long outstanding matter continues to be slow and Audit Committee asked for the necessary steps, which include assistance being provided by TIAA, to be taken to expedite this enquiry.

10. The Committee was very concerned to note the Counter Fraud team's report that because of weaknesses in the Trust's time/hours recording systems the risk of potential and actual fraud relating to claims for hours worked was significant: the Head of Counter Fraud was asked to take this up urgently with the Director of HR and OD.

11. The Committee is still not, adequately assured that the the learning from completed cases is being appropriately disseminated so that the risk of similar frauds occurring can be reduced; the Committee Chairman has met separately with the Counter Fraud lead to discuss how this should be improved and will continue to take this forward with the new DFO on appointment.

WHISTLEBLOWING

12. The Director to HR and OD attended to update the Committee on whistleblowing. He confirmed that an updated policy is being finalised along with better mechanisms to support staff who wished to whistle-blow or speak up. He also provided assurance that five current cases were being appropriately dealt with – the detail of these cases will be discussed as necessary in the WEC. The DHROD agreed to report back to the Committee in September with the updated policy and to provide assurance that the Trust has in place an effective system to deal with and support whistleblowers.

CLINICAL AUDIT PLAN

13. Kate Hutt attended to present the 2017/18 Clinical Audit Plan which had been approved by PSQB in April 2017 and the Committee commended the plan. She agreed to liaise with Internal Audit to ensure that national and corporate priorities are effectively included within both Internal and Clinical Audit plans, without duplication. It was also agreed that the reporting of the Clinical Audit programme should be overseen through Quality Committee, with Audit Committee receiving twice yearly updates for assurance.

BREACHES AND WAIVERS

14. The Committee did not receive the necessary report on breaches and waivers at this meeting, owing to the ongoing staff shortages and changes in the Procurement team. The

Committee considered this to be unacceptable and requires full restitution of breaches and waivers reporting from September onwards.

COMMITTEE EFFECTIVENESS

15. The Audit Committee Chairman urged the Executive to improve on its production of papers for Committee meetings, noting that it was not acceptable for the Secretariat and the Committee to receive late papers or no papers at all. While she accepted that the Executive team is currently very stretched, the Committee considers it to be essential to have full, clear and concise papers circulated at least five working days in advance of each Committee meeting to support good governance and decision making.

Sarah Wilton
Chair: Audit Committee
June 2017

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	8 June 2017	**Agenda No**	**5.2**
Report Title:	Freedom of Information Annual Report		
Lead Director/ Manager:	Fiona Barr, Trust Secretary and Head of Corporate Governance		
Report Author:	Nii Turkson, Corporate Administrator Michael Wuestefeld-Gray, Interim Corporate Governance Advisor		
Presented for:	Receive		
Executive Summary	719 Freedom of Information (FOI) requests were received in 2016/17. This is approximately 10% more than were received in 2015/16. However, performance improved from 34% of requests responded to in 20 working days or less in June 2016, to 86% in March 2017. During this period average response times fell from 28 working days to 12 working days. Underpinning this improvement was a new FOI policy that significantly tightened response timescales and approval routes. A training course on FOI for divisions and local FOI leads was also provided. Going forward in 2017/18 continued performance improvement is anticipated through the development of the Trust's publication scheme and closer working with divisions to identify repeated requests and document publication timescales.		
Recommendation:	The Board is asked to note the performance of the FOI function between July 2016 and March 2017 and consider the impact of the FOI improvement plan instigated in January 2017. It is proposed that the FOI Annual Report is provided for information at the Trust Board every June.		
Supports			
Trust Strategic Objective:	Partnership working: To meet the needs of our patients through joint working with commissioners and other partners to provide integrated and well-aligned services.		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Leadership and Improvement Capability		
Implications			
Risk:	Failing to respond to requests within 20 working days could harm the Trust's reputation, or invite regulatory action by the Information Commissioner.		
Legal/Regulatory:	Breaching the Freedom of Information Act could result in the Information Commissioner imposing directions on the Trust to comply with the 20 working day standard, which would make further breaches contempt of court. Although this has not occurred, deliberately withholding information is a criminal offence that can be punished by a term of imprisonment.		
Resources:	N/A		
Previously Considered by:	N/A	**Date**	
Equality Impact Assessment:	We rigorously enforce a policy of treating all FOI requests equally. Following receipt, the FOI allocates each one a reference number and we remove any reference to the requestor's personal details to minimise unconscious bias when collating the information for the response from colleagues within the Trust.		

St George's University Hospitals NHS
NHS Foundation Trust

Freedom of Information Report
Trust Board
8 June 2017

1.0 PURPOSE

1.1 This report sets out the performance of the Trust's statutory Freedom of Information (FOI) function during 2016/17. Please note that prior to June 2016 there are only incomplete data.

2.0 BACKGROUND

2.1 The Freedom of Information (FOI) places a duty on the Trust to release information requested within 20 working days unless an exemption to disclosure can be applied.

2.2 The Trust recognises the spirit of the Act which is to be open and transparent about what we do and how we do it. The Act provides an important route for engagement with the Trust's stakeholders and helps the Trust understand what they are interested in.

2.3 The FOI Act requires 100% of requests to get a substantive response within 20 working days Anecdotally NHS Trusts in London tend to average 85% which is the Information Commissioner's tolerance threshold for performance.

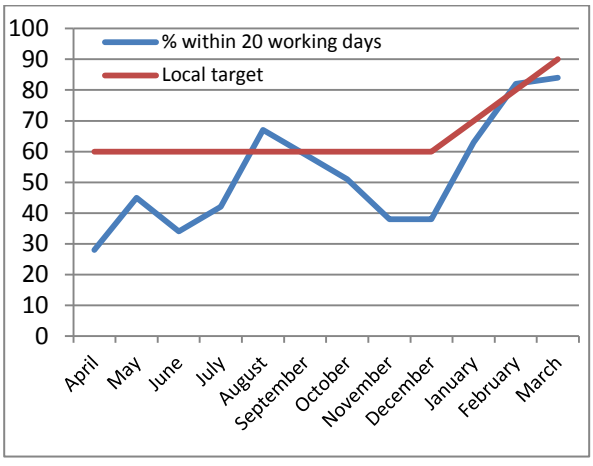
3.0 PERFORMANCE IMPROVEMENT ACTION

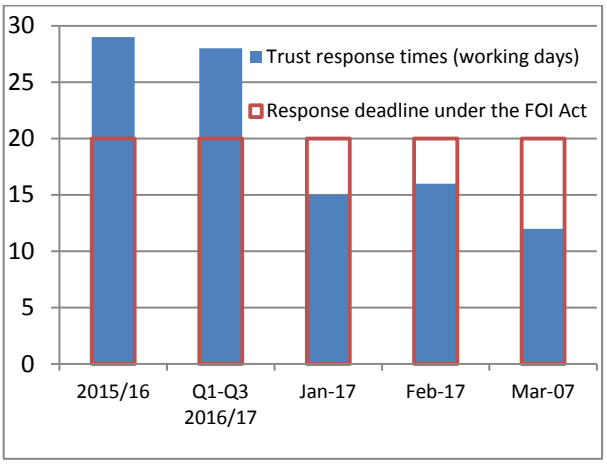
3.1 During 2016/17, improvements were implemented including regular reporting of FOI performance, improved guidance for divisions and the identification of FOI leads within directorate responsible for collating data locally to respond to FOI requests.

3.2 In Q4, tighter performance standards were to improve response rates. A new FOI policy was developed, and training provided to the people and teams closely involved in providing data for responses. Reporting of performance began to the Information Governance Committee and Board Level FOI champion was identified.

4.0 ANALYSIS OF PERFORMANCE

4.1 The charts below highlight performance in terms of responses within 20 working days; and average response times:





4.2 The Trust continues to improve toward a local target of 90% or higher compliance. The FOI team has an ambition to reduce average response times to below 10 working days.

5.0 ANALYSIS OF REQUESTS

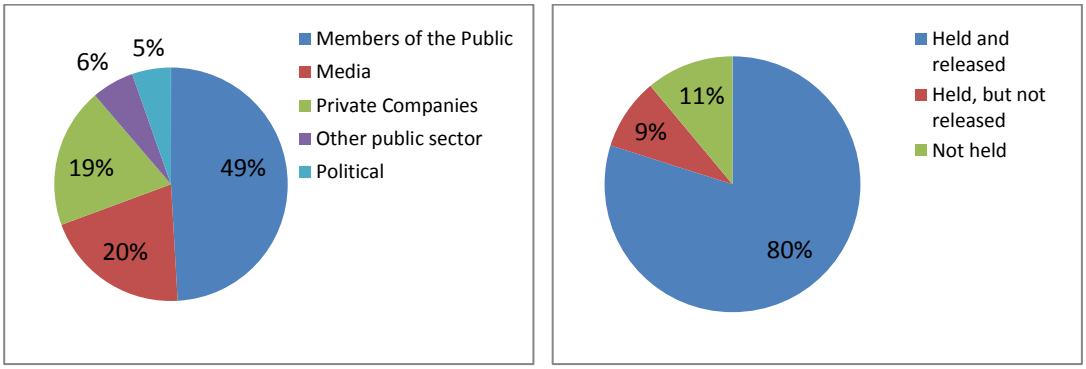
5.1 Systematic data reporting of the origin and outcome of requests only began in January 2017 so the data below are for Q4 2016/17.

5.2 The top five areas for requested information were:

i. IT systems
ii. Agency spend and staffing
iii. Car parking charges
iv. Private patients
v. Medical records

5.3 There was also interest in mental health attendance, orthotics, emergency admissions and waste management, as well as employment references and staff policies.

Request Source and Outcome:



5.4 Almost half of FOI requests originated from members of the public though a fifth were from the media and 19% from private companies.

5.5 On some occasions information was held, but not released due to an exemption under the FOI Act to releasing the information. The exemptions used were:

i. Section 12: responding would take longer than the time allowed under the Act.
ii. Sections 21 and 22: the information was already, or shortly would be in the public domain.
iii. Section 41: releasing the information would be an actionable breach of confidence.
iv. Section 43: the information was commercially sensitive.

6.0 PLANS FOR 2017/18

6.1 The FOI team will work with divisional FOI leads to further improve performance and ensure that all divisions maintain the high standards of compliance.

6.2 Development of the Trust's publication scheme to improve access to information without the need for a formal FOI response, reducing the burden on clinical teams.

7.0 RECOMMENDATION

7.1 The Board is asked to note the performance of the FOI function between July 2016 and March 2017 and consider the impact of the FOI performance improvement plan instigated in January 2017. It is proposed that the FOI Annual Report is provided for information to the Trust Board every June.

Author: **Nii Turkson, Corporate Administrator; Michael Wuestefeld-Gray, Interim Corporate Governance Advisor**

Date: **18 May 2017**