Trust Board Meeting

Date and Time: Thursday 6 July 2017, 10:00 – 13:30
Venue: Hyde Park Room, 1st Floor, Lanesborough Wing

Time	Item	Subject and Lead	Action	Format
10:00 – FEEDBACK FROM BOARD WALKABOUT				
10:40 – PATIENT STORY Two young girls who were both inpatients for a tonsillectomy at the same time made friends with one another and will talk to the Board about their experiences of being at St George's.				
OPENING ADMINISTRATION				
11:00	**1.1**	**Welcome and Apologies** Chairman	-	-
	1.2	**Declarations of Interest** All	-	Oral
	1.3	**Minutes of Meeting held on 08.06.17** Chairman	Approve	Paper
	1.4	**Action Log and Matters Arising** All	Review	Paper
	1.5	**Update from CEO** Chief Executive	Inform	Paper
ST GEORGE'S HOSPITAL CHARITY				
11:15	**2.1**	**Presentation from Trustees** Martyn Willis, Chief Executive Dr Hazel Norman (Trustee) Dr Carol Varlaam (Vice Chair) Anthony Marshall (Treasurer) Zeynep Meric Smith (Trustee)	Inform	Pres'n
PATIENT SAFETY, QUALITY AND PERFORMANCE				
11:40	**3.1**	**Quality Improvement Plan** Chief Nurse	Assure	Paper
	3.2	**Integrated Board Performance Report** Director of Efficiency, Delivery & Transformation/Chief Nurse	Review	Paper
	3.3	**Elective Care Remedial Action Plan** Elective Care Recovery Programme Director	Update	Paper
	3.4	**National Inpatient Survey 2016 Results** Chief Nurse	Discuss	Paper
FINANCE				
12:20	**4.1**	**Month 2 Finance Report** Chief Financial Officer	Assure	Paper
	4.2	**Report from Finance & Performance Committee** Chair of Committee	Inform	Oral
WORKFORCE AND COMMUNICATION				
12:50	**5.1**	**Freedom to Speak Up Guardian Report** Director Human Resources & Organisational Development	Inform	Paper
	5.2	**Staff Engagement Plan** Director Human Resources & Organisational Development	Update	Paper
	5.3	**Communications Strategy** Associate Director of Communications	Review	Paper
	5.4	**Guardian of Safe Working Quarterly Report** Medical Director	Assure	Paper
CLOSING ADMINISTRATION				
13:20	**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. Children's Safeguarding Annual Report (August 2017) ii. Evaluation of Overseas Visitors and Migrant Cost Recovery Pilot (August 2017) iii. Information Governance Toolkit Update (TBC)		-
	6.5	**Any Other Business** Chair	-	-
	6.6	**Reflection on Meeting** All	-	Oral
13:30		**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 07 September 2017, 10:00 – 13:00

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)		
		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

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

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	GN
Jacqueline Totterdell	Chief Executive	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Anna D'Alessandro	Director Financial Planning / Deputy CFO (on behalf of Ann Johnson, CFO)	DFP
Avey Bhatia	Chief Nurse	CN
Andrew Rhodes	Acting Medical Director	MD
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
Richard Hancock	Director of Estates & Facilities (Part)	DE&F
Diana Lacey	Elective Care Recovery Programme Director (Part)	ECRPD
Peter Riley	Consultant Medical Microbiologist and Infection Control (for item 2.4)	CMM/IM
Sandra Shannon	Deputy Chief Operating Officer	DCOO
Marie-Noelle Orzel	NHS Improvement (NHSI) Quality Improvement Director	QID
APOLOGIES		
Ann Johnson	Acting Chief Financial Officer	Acting CFO
SECRETARIAT		
Fiona Barr	Trust Secretary & Head of Corporate Governance	Trust Sec
Sumiya Ahmad	Senior Corporate Administrator	SCA

Feedback from Board Walkabout

Board members had been to visit different areas of the Trust before the meeting including Ruth Myles / Day Unit: Medical Records; Delivery Suite; Carmen Suite; Caroline Ward; McKissock Ward; Cheselden Ward; Vernon Ward; Frederick Hewitt; Caeser Hawkins; Holdsworth ward; Keate Ward and the Trevor Howell Day Unit.

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 remained around delays in recruitment and the vacancy control process. There were some specific estates and IT issues raised in particular wards which needed to be addressed.

The Chairman asked that the Board to Ward programme also included Queen Mary Hospital (QMH) and community services.

TB.08.06.17/32A	**Arrange a Board meeting at QMH and Board Walkabout on same day. LEAD: Trust Secretary and Chief Nurse**
TB.08.06.17/32B	**Broaden the Board Walkabout programme to include community services.**

	LEAD: Chief Nurse
1. OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and welcomed everyone present and welcomed Anna D'Alessandro, Director of Financial Planning who was attending on behalf of Ann Johnson, Acting Chief Financial Officer, and Marie-Noelle Orzel, NHSI Quality Improvement Director. The Chairman introduced Ellis Pullinger who had been appointed as the Chief Operating Officer who was in attendance and would take up post on 12.06.17. 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 04.05.17	
1.3	These were accepted as a true and accurate record of the meeting held on 04.05.17 subject to the following amendments to the patient questions in section 6.1:
1.4	Leslie Robertson, Patient Representative mentioned she had tried out one of the replacement 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. LR, as patient lead for the Patient Led Assessment of the Care Environment Audits (PLACE) had recently visited wards along with other patients as organised with Mary Prior, General Manager, Facilities and some of the issues the Board members gave from their visits today had already been highlighted. Sadly the slower pace of progress in general refurbishment was seen to be having an effect on staff morale.
1.5	Hazel Ingram, Patient Representative asked for clarification about the cost of sending the Trust's patients for care in a private hospital – for example to address long waiting lists – and if there was cross-charging between the St George's and the QMH site. These were emailed to Hazel following the meeting.
Matters Arising and Action Log	
1.6	The following was noted on the Action Log: • Action reference TB.04.05.17/28 – was closed. • The DCOO was asked to address action TB.09.02.17/16 and TB.09.02.17/18. • Action reference TB.09.03.17/21 - the Trust Sec advised that Deloitte would be supporting the Trust in the review of governance arrangements, and a risk workshop would be organised; this was being developed with the CN as the Executive Lead for risk. The CN assured the Board that in the meantime work was underway on developing a new Board Assurance Framework though the Chairman cautioned doing too much work on this without involving the NEDs and the rest of the Board. It was agreed that this was an important priority and that a date must be agreed. • All other actions remained open.
1.7	The Executive was reminded that they had to account for each action for which they had lead responsibility before the papers were prepared and circulated for the Board and that actions could only be re-dated subject to agreement with the CEO.

Update from Chairman and CEO	
1.8	The CEO said she had had a fantastic first month, having met hundreds of staff at specially organised briefing sessions, and also spending time visiting different teams and departments. Even though the scale of the challenge facing the Trust was big, she was struck by the "can-do" attitude of staff. The CEO was positive and optimistic. The current focus was on understanding the issues, and setting out key short, medium and long-term priorities and ensuring the Trust had strong and stable leadership; two new members of the Executive Team, the Chief Operating Officer and the Chief Financial Officer, would take up post in June 2017.
1.9	The CEO reported that changes had been introduced to the leadership team at QMH which was now under the direct management of the Community Services Division, with a senior member of the team based there full time as Hospital Director.
1.10	An unannounced Care Quality Commission (CQC) inspection had taken place over three days in May, checking on progress made since the Trust received its Section 29A warning notice in 2016. The final CQC report was awaited though informal feedback from the CQC team directly following the inspection was broadly positive and showed the Trust had made some good progress though there was still a lot of work to be done.
1.11	The End of Care Life Strategy had been launched in May; this was a important area of work to support patients and their families at this critical time.
1.12	The CEO reported that the recent NHS cyber attack had not affected the Trust and noted the significant amount of work undertaken by IT which had been a real team effort, and a good test of the major incident preparedness and systems.
1.13	The Annual Report & Accounts (ARA) had been signed off by the Board on 31.05.17. The Board reflected that the process must be improved and streamlined by starting the ARA earlier, identifying project leads for different sections and having a clear timeline for delivery. The CEO noted that the 2016 Terms and Conditions of Service for Doctors in Training (TCS) had been implemented at St George's in line with the national timeline. There was a requirement for an annual report on rota gaps, and the plan to reduce these gaps was required to be included in a statement in the Trust's Quality Account. The CEO reported that this had been omitted from the 2016/17 Quality Accounts. The Trust Board was also required to publish details of the Guardian of Safe Working fines in the Trust Annual accounts which had been omitted from the 2016/17 ARA. Both were reported to the Board as a matter of record.
2. PATIENT SAFETY, QUALITY AND PERFORMANCE	
Quality Improvement Plan	
2.1	The CN presented the Quality Improvement Plan (QIP) which over the past two months had been reviewed and restructured into five programmes of work, each with revised workstreams and projects being further developed and re-launched in June 2017 subject to resourcing requirements.
2.2	The QIP would be reported through a weekly QIP Board with oversight aligned to Financial Recovery Programme timescales and using the same reporting format to ensure consistency of approach. Each project would have agreed terms of reference, key performance indicators/metrics for monitoring outcomes and a clear trajectory for delivery. Progress would be checked at regular workstream meetings.
2.3	The Board received the report and noted progress with re-framing the QIP, and agreed to receive updates on progress against plan at future meetings.
Performance & Quality Report	
2.4	The DEDT reported that compliance and quality improvements had been incorporated into the report though work was still underway to produce a truly integrated performance report.

	The DEDT advised that he would circulate a proposed new format using data from the current performance report to get feedback from the Board.
2.5	The CN presented the Quality Report and reported: I. The had been two MRSA cases which were going through a root cause analysis process, and a deep dive would take place at the Quality Committee; II. The Trust had seen deterioration in hand hygiene and cleanliness results though the CN assured the Board that there was clarity on the areas which required improvement; III. Work was on-going to improve the Family and Family Test (FFT) scores particularly in Maternity and Outpatients to bring them into line with the national position; IV. The number of complaints received had decreased though performance remained below internal standard of responding within 25 days. However this had now become one of the workstreams under the Quality and Risk programme in the QIP.
2.6	The Board expressed continuing concerns with the quality of data though the MD advised that this was being addressed – largely through the work underpinning the Elective Care Recovery Programme.
2.7	The DEDT reported that performance against the Emergency Department (ED) Four Hour Standard for May was below trajectory though work was being undertaken to improve patient flow – particularly through the expansion of the ambulatory care and improvements in other internal systems. A weekly reflective session to review performance and see where improvements could be made had resulted in the national standard being met over the last three days.
2.8	Diagnostics performance remained below standard though to address this a simple demand and capacity tool had been developed; this was being tested to assess its impact in reducing the backlog and meeting demand.
2.9	The Board noted that patient referral from Primary Care had fallen in month and asked that this be monitored by the Executive, particularly given the Trust's large local income target.
2.10	The Board received the report though agreed in the future that it should contain all the workforce performance data.
Referral to Treatment and Elective Care Recovery Programme	
2.11	The ECRPD briefly updated the Board on the implementation of the elective care recovery programme (ECRP), including delivery of the 18 week referral to treatment (RTT), diagnostic and cancer access standards. The ECRP plan was being revised to tackle issues at pace, and meet key milestones with greater oversight of delivery and risk. The plan would include the resource plan and revised governance arrangements, would be submitted to NHS Improvement by 30.06.17. The ECRP plan would report into a Board Committee to ensure oversight.
2.12	The Board received the report.
Infection Prevention Control Annual Report 2016-17	
2.13	Peter Riley, Consultant Medical Microbiologist and Infection Control Doctor attended to present the report. He reported the overall performance again IPC thresholds was good though there was still work to ensure we get the basics right. The Trust was currently an outlier in Surgical Site Surveillance and though the mandatory requirement had been met further work was required. The MD noted the National Get It Right First Time Programme focused on metrics in Surgical Site infections. It had been agreed the surgical specialties would participate in the national programme and Doctors would receive mandatory training.
2.14	CMM/ICM noted that Trust had previously accepted in principle for surgical site surveillance to be expanded at the Trust following the introduction of the NICE quality standards, which required providers to undertake surgical site surveillance. A business case had been completed for acceptance by the Trust executive but due to financial

	constraints was not implemented as planned. It was agreed that the business case should be reviewed again by the Executives.
2.15	The Board approved the report and the infection and prevention control programme for 2017-18.
Adult Safeguarding Annual Report 2016-17	
2.16	The CN presented the report. She advised that Safeguarding had been an area on which she had had a priority focus since starting at the Trust given the importance of protecting vulnerable patients and keeping them safe throughout the patient pathway. The CN provided a summary of activity with regard to safeguarding adults at risk and highlighted how the Trust was responding to and reporting on allegations of abuse and neglect and work to ensure that safeguarding was integral to everyday practice.
2.17	The CQC had identified issues in the Trust organisation and response to Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) in four wards. A significant amount of work had been undertaken to raise awareness amongst staff, ensure evidence of MCA/DoLS activity was documented in patient notes, implement a new policy on MCA/DoLS and develop an audit tool to demonstrate that audits had been done and identify areas of improvement. Despite problems being identified with Gwynne Holford ward during the CQC inspection in 2016, this ward was now an exemplar in MCA and DoLS where a multidisciplinary approach had been taken which was led by a consultant. The challenge now was to implement this best practice across the Trust.
2.18	The Chairman asked on the feedback received from the Adult Social Care Lead at Wandsworth to the Trust's approach to Adult Safeguarding The CN responded that she had received positive feedback that the Trust was responsive on reporting and responding to safeguarding issues.
2.19	The Board received the report.
Report from Quality Committee	
2.20	Quality Committee Chairman, Sir Norman Williams provided a report to the Board from the last Committee meeting noting the following: I. Following the recent unannounced CQC inspection in May 2017, the final report was awaited though the initial feedback had been positive and no new areas of concern had been raised; II. Duty of Candour had improved though the Trust was still working towards full compliance and to ensure sustainable delivery at service level; III. Inpatient Family & Friends Test (FFT) survey results indicated four areas that required improvement; IV. The Committee received the Annual Adult Safeguarding Report 2016-17 and was assured to see progress with an overarching framework now in place; V. The Committee received a Mortality Monitoring Update and recognised the excellent work being undertaken by Nigel Kennea, Associate Medical Director, who was a national lead in this field. The report noted learning that needed to take place around out of ICU cardiac arrests and mortality following cardiac surgery; VI. The excellent work in Infection Prevention & Control was noted; VII. As previous comments, the Quality Account 2016-17 was poor and required work before submission which must be improved for 2017-18.
2.21	There was an erratum in the Committee Report which noted that the Trust had performed worse than the national average in the Picker Survey results FFT. The CN noted that the Trust had performed well overall however four areas had been identified that required improvement. The inpatient survey results had been received which would be presented to the Board in July.

TB.08.06.17/33	**Present the Inpatient Survey to the Board in July 2017.** **Lead: Chief Nurse**
3. FINANCE	
Month 1 Finance Report	
3.1	The Director Financial Planning (DFP) presented the report on behalf of the Acting CFO, confirming that the audited final accounts for 2016-17 were approved by the Board on 31.05.17. She advised that the Board had submitted a plan for 2017-18 to NHS Improvement for a projected deficit of £28.5m comprising a baseline budget of £88.5m deficit partially offset by a £60m Cost Improvement saving (CIP). The Month one position was a deficit of £12.2m against a plan of £6m resulting in an adverse variance of £6.2m related to unidentified CIP plans and an income shortfall of £4.9m. Pay performed favourably to budget by £1.3m.
3.2	The NEDs expressed concern that the Trust was still in the process of finalising budgets for 2017-18 and needed to start the process of budget planning for 2018-19 in the next 2 months; she also noted the encouraging reductions in agency spend. The NEDs were concerned over the significant CIP target and asked for greater visibility to understand the details. The Executive confirmed that this would be presented to the FPC as part of the update on the Financial Recovery Programme and it would also be covered at the Board meeting to review the revised Financial Recovery Plan (FRP) before it was re-submitted to NHSI. The NEDs also asked for clarification on the additional funding for capital programme for IT considering it had been six months since application. The DFP confirmed an application had been submitted for £8.6m for IT emergency funding which had been raised with NHSI who had agreed to look into this with the Treasury. However the funding had not yet been received.
3.3	The Board received the report.
Report from Finance & Performance Committee	
3.4	The Committee Chair reported that the Committee had focused on the FRP at its last meeting – in particular the development of workstreams with clear deliverables to achieve the financial targets set out in the plan. She expressed concern at the Month 1 financial performance noting that if this continued, the Trust would reach £28.5m deficit by the end of the first quarter. In closing, she strongly encouraged the Executive to do more work on the Performance & Quality Report and develop it into a robust and reliable report from which the Board could triangulate data and better understand action being taken to address variance in performance. Whilst she accepted that this was still "work in progress" with a number of improvements still to be made, she advised that this report should be a key document from which the Board could draw assurance on the Trust's performance on a range of metrics.
4. WORKFORCE	
Workforce Performance Report	
4.1	The DRHOD presented the Workforce Performance Report. I. Bank and agency usage had fallen in April and agency spend as a percentage of the total pay bill had decreased. II. Staff in post Full Time Equivalent (FTE) and establishment FTE have both fallen, however as Staff in Post (SiP) had fallen more than establishment the vacancy rate had increased slightly. III. Sickness levels had decreased to 3.2%. IV. Turnover had increased to 19.42%.

	V. Non-medical appraisal rates had increased whilst medical appraisal rates had decreased slightly. VI. MAST compliance had increased to 86%. VII. The DHROD advised that he was looking into the high rates of staff turnover.
4.2	The Board noted the report but agreed that for future meetings, the Workforce Performance Report would be incorporated into the Quality & Performance Report.
Report from the Workforce and Education Committee	
4.3	The Committee Chair Stephen Collier provided an oral updated. He advised that the committee had agreed to facilitate a workforce strategy over the next six months. The three areas identified initially as the strategic themes included: engagement, leadership & development and workforce planning with two supporting activities: regulatory compliance and HR core service. Comments were also made on the importance of also prioritising equalities work. The Committee terms of reference and strategic activities would be reset in line with achieving these.
Staff Survey Results	
4.4	The DHROD presented the report which provided an overview of the 2016 National NHS Staff Survey results and provided a brief summary of the three keys areas which needed to be addressed: employee engagement, bullying and harassment and improving equality and diversity. He confirmed that he would present the action plan to tackle these areas at the next Board meeting (TB.06.04.17/27).
4.5	The NEDs asked about the Freedom to Speak Up Guardian and how the work in this area was progressing that the HROD agreed to provide a report to the next meeting.
4.6	In closing the HROD advised the Board of an erratum in table one of the report: the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months was 33% not 27% as set out in the report.
4.7	The Board received the report.
TB.08.06.17/34	**Present a report on the work of the Freedom to Speak Up Guardian report at the July 2017 Board meeting.** **Lead: Director of Human Resources & Organisational Development**
Fit & Proper Person Policy & Procedure	
4.8	The DHROD reported that the Board had approved the Fit and Proper Person Policy and Procedure (FPPPP) in October 2016. Following an internal review of the document and the issue of further guidance by the CQC, it was proposed that the FPPPP was updated – particularly to include additional provisions to accommodate exceptional situations where an appointment was made and a new Director started within a short timescale and before the FPPPP had been completed. This change had been discussed by the Executive Directors and agreed internally with the Chairman. The proposed addition had also discussed with the CQC during the recent inspection.
4.9	The Board approved the revised policy.
Managing Conflicts of Interest in the NHS	
4.10	The Trust Sec reported that NHS England had produced new guidance for managing conflicts of interest which all Trusts were to implement from June 2017. This was extensive and far-reaching. She advised that work was now underway to set out an implementation plan to support this policy.
4.11	The Board approved the policy.

5. GOVERNANCE & RISK	
Report from Audit Committee	
5.1	The Chair of the Audit Committee reported that all five of the the Internal Audit Reports received at the last Audit Committee had Limited Assurance and the Head of Internal Audit Opinion for 2016-17 was one of Limited Assurance. The CEO advised that to continue the focus on Internal Audit, the Internal Audit Team would be invited to attend Executive Team meetings when the Internal Audit Tracker was discussed.
5.2	She advised that the Committee did not receive the regular report on breaches and waivers due to on-going staff shortages and changes in the Procurement team. The Committee considered this to be unacceptable and required full restitution of breaches and waivers reporting from September onwards.
Annual Freedom of Information Report	
5.3	The Trust Sec presented the report and noted the significant improvement in responding to FOI within the 20 day target. The FOI team were working to develop a publication scheme to improve access to information without the need for an FOI request.
5.4	The Board noted the performance of the FOI function between July 2016 and March 2017 and thanked staff for the improvement. It was agreed an annual FOI report would be provided for information at the Trust Board every June.
STAFF STORY	
Patient Sue Lines shared her story with the Board. Sue was first a patient at St George's when its neurology services were based at Atkinson Morley Hospital in Wimbledon, over 30 years ago. At the time, she was being treated for a subarachnoid haemorrhage which resulted in severe right sided paralysis. After five years of rehabilitation she could walk with a stick but never regained any function in her right arm. Sue told the Board that earlier this year she returned to St George's as an inpatient for what should have been an overnight stay following surgery to improve the mobility of her right arm – but the stay lasted 12 days. Sue was very happy with the surgeon and anaesthetist, and the surgery was straight forward. The main issues however related to the care and support received afterwards which were stressful. Though she had provided the pre-op assessment staff with a list of the things that would help her to maintain some degree of independence due to her disabilities these were not handed over to ward staff. Many of these were simple things – like putting water within reach and not on her right side or giving her bottles of water to open – but critical to her care and wellbeing. Sue was pleased that as a result of the concerns that she raised whilst on the ward changes had been made which would improve the experience for patients in the future. Sue concluded her story by saying that she will never forget the surgeon who operated on her and saved her life. She was thankful that overall St George's was a tremendously good teaching hospital. The Chairman thanked Sue for sharing her story with the Board.	
6. CLOSING ADMINISTRATION	
Questions from Public	
6.1	A member of the public asked about the implementation and enforcement of the no-smoking policy and e-cigarettes – particularly at QMH. The DE&F advised there was no official guidance on e-cigarettes though in the main this was handled in the same way as smoking (ie no smoking areas would also be no vaping areas). He confirmed that there

	should be no smoking/vaping in any part of the Trust (including QMH) though this was difficult to enforce – partly due to the size of the Trust and the resources required but also because sometimes allowing people to smoke/vape was a compassionate act, following the receipt of bad news. Further it would be difficult to issue fines without support from the Council. However, the Trust was proceeding with the installation of more signing and encouraging appropriate challenging of people smoking especially where it was close to patient areas, e.g. maternity.
6.2	The member of the public advised that patients and relatives were smoking and vaping on the wards at QMH and across on the St George's site. The Board considered this to be unacceptable and asked the DE&F to look at what could be done to address this.
6.3	Finally the member of the public advised that he had found it difficult to understand the complaints procedure and make a complaint and also expressed concerns with the FFT. The CN agreed to meet with him and look into his concerns directly.
Any other Business	
6.4	With no other items of any of any other business, the Chairman closed the meeting.
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, from 10:00

Trust Board Action Tracker - 06.07.17

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~~ Q2 2017-18	~~CRO~~ COO	Following departure of CRO, Exec Lead for this action is under investigation. Presently, the COO is overseeing this area of work and will initially provide a progress report to EMT.17.07.17, which will inform when this item will be reported to hte Board.	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	EMT.12.06.17 received and considered a paper on options for enhanced insurance and requested enquiries be undertaken to determine if DH/National Guidance was available on the procurement of enhanced insurance cover. This matter is a scheduled action for EMT.31.07.17 and will be followed through at EMT.	Proposed for Closure
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.	Sep-17		COO	As this action links to guidance issued by NHS England relating to winter resilience it is suggested that the COO presents the Local Escalation Plan for Board approval in October 2017 as part of the Trust's 2017-18 Winter Plan.	Proposed for Closure
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	COO	Since this action was agreed, it has not been possible to provide this level of detail to assess the impact of changing additional payments. However the Trust has agreed additional waiting list payments for 2017/18 and maintains a weekly tracker of activity against the commissioner Service Level Agreement.	Proposed for Closure
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. It is proposed that this note is closed.	Proposed for Closure
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 its review of governance arrangements. It is likely to be 10/08/17 or 17/08/17.	Proposed for Closure
TB.06.04.17/26	**Staff Engagement**	Present a paper on staff engagement at the May 2017 Board meeting.	~~Q1 2017-18~~	TB.06.07.17	HRAB	On the agenda for TB.06.07.17. The Staff Engagement update will also incorporate the Staff survey action plan.	Proposed for Closure
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	The staff survey results were presented at the Board at TB.08.06.17. The staff survey action plan has been incorporated into the staff engagement update at TB.06.07.17.	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. The Root Cause Analysis for each MRSA case will be presented to the Quality Committee in July.	Proposed for Closure
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 July 2017 & QC.26.07.17		CN	A revised approach to complaints management is part of the Quality Improvement Programme and will be discussed in detail at EMT and Quality Committee in July 2017.	Proposed for Closure
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.	Q2		CIO	An update will be provided to the Board once the formal guidance on the new IG Toolkit has been issued.	Open
TB.08.06.17/32A	**Meeting at QMH**	Arrange a Board meeting to take place at QMH and a Board Walkabout on the same day	TB.10.08.17		CN/Trust Sec	It is proposed that a Board meeting in August takes place at QMH. The CN will arrange the walkabout once a date is confirmed.	Proposed for Closure
TB.08.06.17/32B	**Walkabout at QMH**	Broaden the Board Walkabout programme to include community services.	TB.10.08.17		CN	Community Services has been added to the Board Walkabout Programme.	Proposed for Closure
TB.08.06.17/33	**Inpatient Survey**	Present the Inpatient survey results to the Board	TB.06.07.17		CN	On the agenda for TB.06.07.17.	Proposed for Closure
TB.08.06.17/34	**Freedom To Speak Up Guardian**	Present the Freedom to Speak Up Guardian report	TB.06.07.17		DHROD	On the agenda for TB.06.07.17	Proposed for Closure

Chief Executive's report to the Trust Board – July 2017

Since the last Trust Board meeting in June, we have witnessed the tragic events at Grenfell Tower, and there have been terrorist incidents at both London Bridge and Finsbury Park in recent weeks.

In light of the above, I wrote in my weekly message to staff recently about the importance of team work, and I think we would all agree that the way our police, ambulance and fire emergency services have jointly responded to recent events is something we can and should all be proud of.

The NHS has played a central role in managing the immediate response to these incidents, and continues to treat many of those patients directly affected. Whilst our services were not called upon to assist those patients injured in the Grenfell Tower fire, I know our teams are ready and able to help manage the response to any future incidents, should they occur.

Like many organisations, we are testing our emergency preparedness, and I am reassured by what I have seen and heard so far. I would also like to stress, for the record, that our buildings have undergone fire safety checks in recent days, and no concerns have been raised. We are not complacent, however, and will continue to take the issue of fire safety extremely seriously.

New members of the executive team

In recent weeks, I am delighted to say that we have welcomed two new members into the executive team at St George's.

Ellis Pullinger has joined as our new Chief Operating Officer from Imperial, where he was Assistant Chief Executive. Andrew Grimshaw has also joined as our Chief Financial Officer, and was most recently Acting Chief Executive/Director of Finance at London Ambulance Service.

I am delighted to welcome Ellis and Andrew to the team, and would also like to put on record my thanks to Ann Johnson, who left us last week after a short but crucial period as our Acting Chief Financial Officer.

One of my immediate aims as Chief Executive is to build a substantive executive team – and I am pleased we have been able to make quick progress in this regard.

Quality and safety review

We underwent an externally facilitated quality and safety review on 19 and 20 June. This involved teams consisting of representatives from NHS Improvement, with support from our own staff, patient representatives, and some of our Foundation Trust Governors.

This was an extremely useful exercise for everyone involved, and we are grateful to our partners for giving up their time to help us with this.

We received some informal feedback at the end of the second day. As you'd expect, this was a mixture of positives as well as things we need to improve on. For example, the review teams found improvements in labelling and cleaning of equipment, as well as staff being clear about how to report serious incidents. However, there are clearly improvements to be made – estates remain an ongoing challenge, as does compliance with all clinicians being bare below the elbow in clinical areas.

Detailed feedback will be shared with those teams involved, and we will need to take some positive action to address some of the issues raised. However, it was an important exercise in terms of assessing how we are doing, and identifying where further improvements need to be made.

Institute for Healthcare Improvement (IHI)

We also welcomed a team from the Institute for Healthcare Improvement (IHI) last week, who spent four days speaking to staff and attending lots of internal meetings; all with the aim of finding out how we approach quality here at St George's, and how we can better embed a culture of quality improvement in everything we do.

We will receive IHI's report and recommendations shortly, at which point we need to decide exactly how we want to work with them going forward.

It is clear from speaking to staff that many want to get involved in quality improvement, with the primary aim of delivering real change in their own areas for the good of patients; however, it is also clear that not everybody knows how to go about doing this, so establishing a recognised improvement methodology within the Trust is something we need to do.

I hope to be a position to provide a further update on our work with IHI at next month's Trust Board, and Dr Mark Hamilton, one of our Associate Medical Directors, will continue to link with IHI in the meantime to build on the positive start made last week.

Infection Prevention and Control

Unfortunately, we have seen an increase in confirmed cases of MRSA in recent months, with four since the start of April.

Avey Bhatia, our Chief Nurse and Director of Infection, Prevention and Control, is leading our work to help tackle the problem, in particular making sure our staff are doing everything within their powers to prevent infection from occurring.

Of course, any infection is one too many, and we don't want any patient to come to unnecessary harm as a result of being treated in our hospitals or community services – however, we have a strong track record at St George's of reducing and managing healthcare acquired infections, including MRSA, so we need to look at and truly understand the causes that are behind the recent increase in infections.

All staff are being reminded of the importance of adhering to basic standards when it comes to infection prevention and control – for example, we must ensure all patients are screened for MRSA on admission, and it is absolutely imperative that all staff are bare below the elbows in all clinical areas and when administering patient care. Compliance with core hygiene standards is not consistent across our services, and this is something we need to rectify – and quickly.

Celebrating our staff and their achievements

Finally, I want to praise the many staff doing excellent and important work around the Trust. One of my priorities as Chief Executive is to set a positive tone for the organisation – not in an artificial way, but because I do truly see excellent things happening here at the Trust, and I want our staff and teams to be recognised for the work they do.

For example, in recent weeks, our Macmillan Cancer Psychological Support Team have been nominated for an Innovation Excellence award; Nikki Parry, one of our Practice Educators, won a Learning Representative of the Year award from the Royal College of Nursing; and our surgery and theatres team were runners up at the national Rowan Hillson Insulin Safety awards in June. These are just a few examples of the external recognition our staff receive on a regular basis, which is great for them, but also the organisation as a whole.

One of the things I have enjoyed most during my first two months at St George's is presenting our Values awards. I have changed the format of our monthly Senior Leaders Briefing meeting so that they now begin with a presentation of Values awards from the previous four weeks – we did this for the first time in June, and it was a great way to start the meeting, and reminded us all that excellent things are happening at St George's on a regular basis.

Finally, I would like to take this opportunity to congratulate our Chairman Gillian Norton on her recent OBE in the Queen's Birthday Honours List. Gillian has been very supportive of me since I started in post, and the honour for her career in local government is well deserved.

Jacqueline Totterdell, Chief Executive

Dr Hazel Norman
Trustee

In the next 20 minutes we would like to:

- Demonstrate why the trust and the charity should be working closely together
- Inspire a trust NED to become a charity trustee
- Highlight some of the important contributions the charity has made over the last ten years
- Invite the trust to challenge the charity with a major fundraising campaign
- Agree future ways of working to cement the relationship between us

£20 + million of charitable contribution in 7 years…for example

St George's Hospital Charity

Trevor Howell Chemotherapy Day Unit

Main Entrance Redesign

A&E Paediatric Assessment Unit

£20 million + of charitable contribution in 7 years…for example

St George's Hospital Charity

State of the art Simulation Centre

NNU Refurbishment

£1 million professionally Curated art collection

Investment in the future

- **Professional fundraising team**: Director and team; Major Giving; Trusts and Foundations; Corporate; Communications
- **Upgraded systems:** CRM; financial accounting; financial reporting
- **Potential donors/influencers:** Captains of industry attracted but need re-energising
- **Special Purpose Funds:** Up to £6 million available for all clinical areas plus research
- **Grants:** Up to £500,000 already made available (but unused) for staff recruitment, retention, development
- **Fundraising Appeals:** Infrastructure in place to launch a major appeal of between £7 – 10 million

Public confidence in an independent charity

- **The public puts its trust in the charity to deliver added value** – we want to deliver it for St George's
- **Charity money is going unspent** – we want to spend it on St George's
- **Fundraising potential is being missed** – we want to raise funds for St George's

Five year income plan

	Financial Results				Long-Term Strategic Plan				
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	TOTAL
	Actual	Actual	Actual	Budget	Estimate	Estimate	Estimate	Estimate	5 Years
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Fundraising Income									
Major Gifts		0	70	60	90	120	150	180	**600**
Corporate		6	0	40	60	80	100	130	**410**
Community and Events		179	452	380	450	550	675	750	**2,805**
General Marketing		27	10	10	25	40	60	100	**235**
Special Purpose Funds		741	539	750	850	950	1,000	1,050	**4,600**
Development activities and events			0	50	70	100	150	200	**570**
Trusts and Foundations		85	122	152	172	202	222	252	**1,000**
Legacies	1,825	650	223	200	250	300	350	400	**1,500**
Fundraising	1,259								
Major Appeals:									
Major appeal (1) (To be agreed with the Trust. The final total may be +/-)					100	900	2,500	2,500	**6,000**
Major appeal (1) (To be agreed with the Trust. The final total may be +/-)				50	175	500	275		**1,000**
Total Fundraising Income	**3,084**	**1,688**	**1,416**	**1,692**	**2,242**	**3,742**	**5,482**	**5,562**	**18,720**
Investment Income	421	442	435	420	420	420	420	420	**2,100**
Total Income	**3,505**	**2,130**	**1,850**	**2,112**	**2,662**	**4,162**	**5,902**	**5,982**	**20,820**

What happens next?

- **Consultation -** Joint board discussions to review the MOU and agree future collaboration
- **Monthly Forum -** Re-establish monthly Joint Charity Steering Group
- **NED -** Appoint NED to charity trustee board
- **Contact -** Assign trust point of contact for the charity
- **Fundraising -** Identify trust priorities that the charity can support

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	6 July 2017	**Agenda No**	**3.1**
Report Title:	Quality Improvement Plan – update on tracking high level patient outcome measures and trajectory targets for 2017/18		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) Information		
Summary / Key points	A new framework is in place for delivering our Quality Improvement Programme which is patient outcome focussed with clear targets and / or trajectories for delivery and improvement. There are 4 programmes of work: 1. Safe and effective care 2. Flow and clinical transformation 3. Quality and risk 4. Enablers – Estates & IT Engagement and leadership In total there are 17 workstreams under these 4 programmes of work each with assigned clinical workstream lead and programme management support. This programme is fully aligned with the financial recovery plan to deliver our 'one team, one plan' approach for quality and financial special measures. The Terms of Reference for each of the workstreams are due to be fully signed off by Friday 30 June 2016. These contain the detail in terms of workstream aim, trajectory for milestones for delivery and **detailed** patient outcome measures. The Quality Delivery Board meets weekly to track progress against the milestones and progress against key performance indicators. The draft terms of reference for Learning from incidents are attached in appendix 1. We have also started to develop high level quality improvement patient outcomes measures to provide overall assurance. This dashboard (appendix 2) is still under development but provides clarity on how we shall monitor ourselves on whether we are improving our patient's safety and experience.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Effective, Caring, Responsive.		
Single Oversight Framework Theme:	Quality of Care		

Implications			
Risk:			
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Quality Delivery Board	**Date 28 June 2016**	
Equality Impact Assessment:	N/A		
Appendices:	1. Draft Terms of Reference – Learning from incidents 2. Dashboard – High level patient outcome measures		

Workstream Title:
Learning from Incidents

Sponsoring Executive:
Andy Rhodes

Aim:	For our patients, our aim at St Georges is to avoid preventable harm. Should patients be harmed, we want to make sure that we are open and honest and that as an organisation we learn from these events to stop them from happening again. For our staff, our aim at St Georges is to provide a safe environment and promote a culture where all our staff are confident to report incidents and have the skills to investigate and learn from events and feel empowered to make changes necessary to avoid them happening in the future.

Context:

The CQC inspection in June 2016 identified variations in quality of learning following clinical incidents. While the report highlighted several areas of good practice demonstrating clear timescales, processes, and outputs following an investigation, this was not consistently adopted across all divisions and specialities. This was fed back to the Trust as one of the "must do" actions post-inspection.

Following the CQC inspection the Trust has introduced a number of learning initiatives that have seen the Trust achieve its 60 day SI reporting target. Overall the number of reported adverse incidents has increased across the Trust, based on comparison with data from 2015/16. Higher and, or increased levels of incident reporting is considered as a positive indicator for effective risk management culture and systems in the NHS.

The number of SIs declared has decreased, compared with 2015/16. Observed in parallel, a decline in the number of Serious Incident (SIs) reported in 2016/17, together with an increase in the total reported incidents is a good indication that the organisation is improving from learning gained from adverse incidents.
With a focus on continued improvement the Trust has, in the past year successfully:

- Introduced Risk Management input into training programmes.
- Increased frequency of root cause analysis (RCA) training.
- Increased involvement from medical staff in following up incidents.
- Developed Monthly Governance Newsletter which is circulated to all matrons, governance leads, care group leads and other senior staff.
- Introduced quarterly analysis report – Complaints, Litigation, Incidents, PALS, Inquests (CLIPI) report and Learning from SIs.

The Trusts incident reporting system provides the following mechanisms to enable prompt feedback to staff regarding incidents:

- Confirmation email sent to staff when incidents are reported
- Email communication function, to allow shared communication regarding

incidents

- Automated feedback via email when an incident is closed on the system, providing staff with details of how an incident has been followed up – this function has recently been put into place

Whilst the focus has been on introducing new systems and processes to facilitate learning form incidents there is a need to develop the culture of reporting and learning from incidents with three key drivers to improve our programme aims being identified as:

- Corporate learning
- Divisional Learning
- Duty of Candour Reporting

It is felt that improving these areas will improve the overall quality of patient care and safety within the Trust.

1. Key Change Objectives

- **Corporate Learning**

  We want to support learning from incidents at a corporate level, learning by themes of incidents at and learning by staff group, this will help us to ensure that we are learning across the organisation and are supporting and tailoring learning to specific staff groups and areas to support incident prevention and learning from others.

- **Divisional Learning**

  We want to work with the divisions and identify best practice and work with the governance leads to develop minimum standards for reporting and learning. Once these have been developed we will review our current position against these standards and develop action plans to achieve the minimum standards. This will support the reduction in variation between divisions in reporting and learning from incidents and how these are cascaded to the wider team

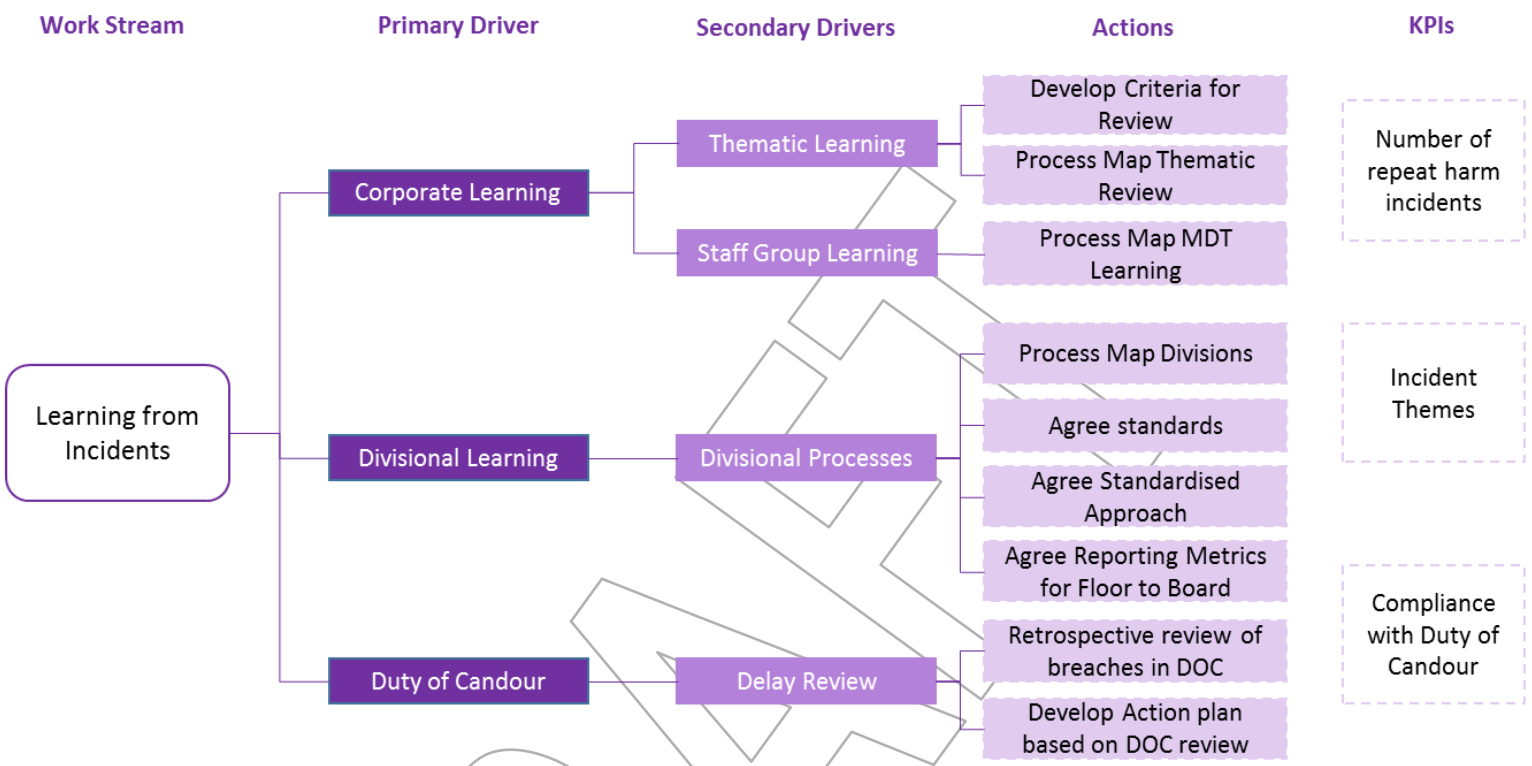
- **Duty of Candour**

  We want to make sure we are working with our patients in an open and honest way for all incidents. As part of this we want to understand why we are not achieving our 100% duty of candour compliance for moderate incidents. This will involve us learning from previous incidents where we have not met our compliance target of 10 days to identify if the issue is across the organisation or specific to a care or staff group. This will enable us to work with our staff to ensure we are open and honest with patients when errors are made or harm caused.

Our Aim

For our patients, our aim at St Georges is to avoid preventable harm. Should patients be harmed, we want to make sure that we are open and honest and that as an organisation we learn from these events to stop them from happening again.

For our staff, our aim at St Georges is to provide a safe environment and promote a culture where all our staff are confident to report incidents and have the skills to investigate and learn from events and feel empowered to make changes necessary to avoid them happening in the future.



2. Scope

In Scope:

- The reporting, investigating, and learning process for clinical incidents
- The administrative and clinical workforce for clinical governance

Out of Scope:

- Improvements to the process for incident reporting. This has already been completed via the Datix update.

3. Work stream Resources

Resource Name	Position	Workstream Role	Time Allocated to Work stream
Renate Wendler		SRO	
Angela Knibb		Project Support	
Paul Linehan		Head of Governance	
Jenny Miles		Risk Manager	

4. Meeting schedule

Learning from Incidents workstream

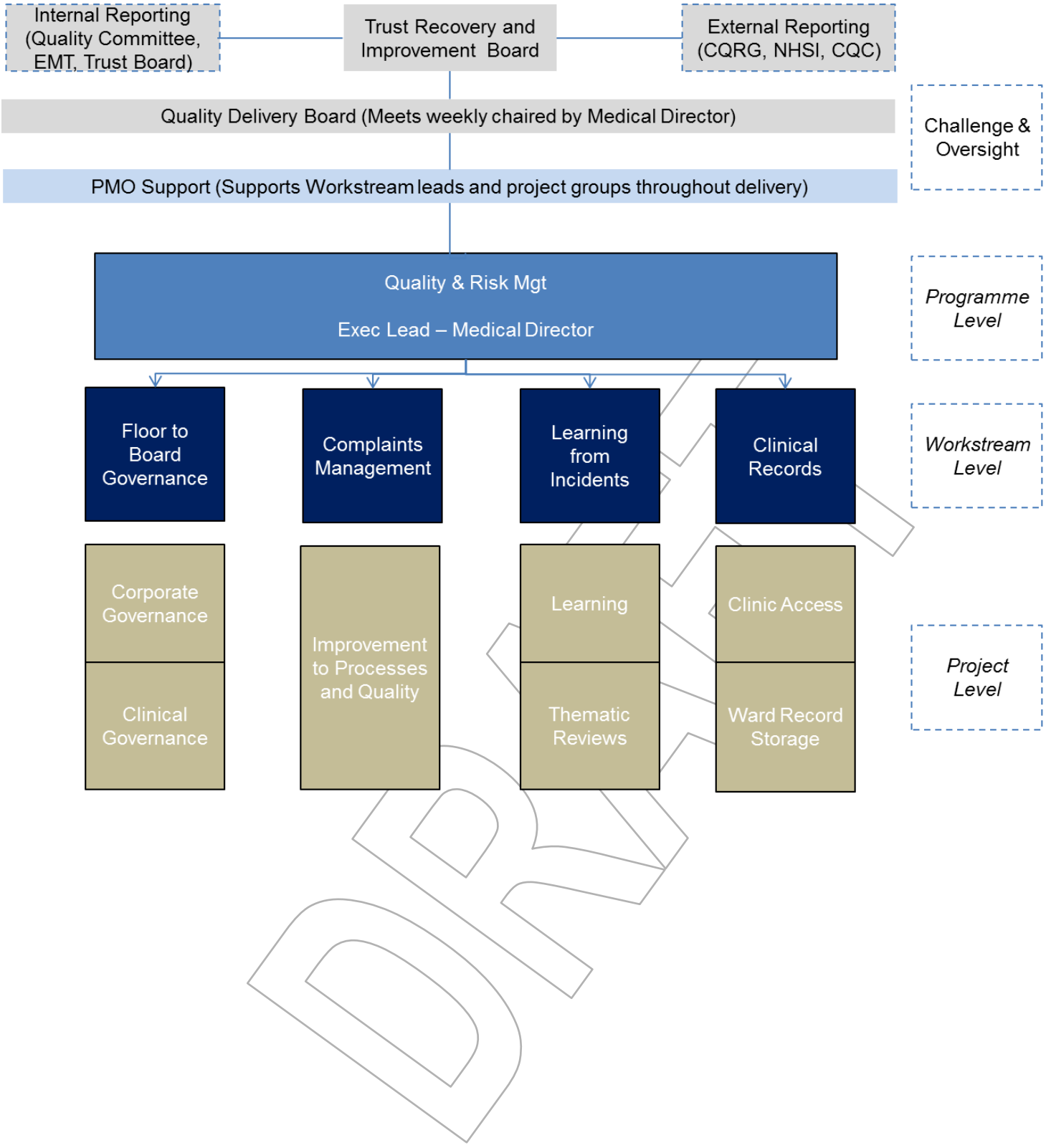
<Insert name of meeting>

- Meeting purpose: XX
- Meeting attendees: XX
- Meeting frequency: XX
- Meeting length: XX
- No. of days prior to meeting agenda is sent out: XX

5. Reporting Arrangements

- The project managers will report project progress, status and key performance indicators (KPIs) to the Learning from Incidents SRO.
- The Learning from Incidents SRO will report workstream progress, status and KPIs to the Quality Delivery Board

6. Work stream Governance Organisation & Structure



7. Work stream Implementation Plan

	Action	June	July	August	September	October	November	December	January	February	March
KPIs	Collate and validate baseline KPI data	X	X								
	Track Metric Performance		X	X	X	X	X	X	X	X	X
Corporate Processes	Establish thematic project group		X	X							
	Process Map current state thematic review			X	X	X					
	Identify gaps and develop action plans					X					
	Implementation of action plans						X	X	X	X	
	Establish Staff learning project group		X	X							
	Process Map current staff learning			X	X	X					
	Process Map new staff learning requirements					X	X				
	Identify gaps and develop action plans						X				
	Implementation of action plans							X	X	X	
	Review project aims and re-evaluate findings										X
Divisional Processes	Meet and map good practice and barriers with Governance Leads	X	X	X							
	Map improvement opportunities and design implementation project plan			X	X						
	Develop minimum standards					X					
	Develop divisional action plans to implement new standards						X	X			
	Implement new processes							X	X	X	X
	Review against new standards										X
	Hold feedback meeting to discuss project plans										X
Duty of Candour	Retrospective review of 50 duty of candour breaches	X	X	X	X						
	Identify themes and develop action plans			X	X	X					
	Implement changes					X	X	X	X	X	
	Review and revise plans										X

8. Key Quality & Operational Performance Indicators

The success of this project will be measured against the following key performance indicators:

KPI	Current Performance	National Target (if applicable)	Performance	Projected Performance at months after implementation							
				Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Number of repeat harm incidents reported			Current Performance								
			Target								
Incident themes			Current Performance								
			Target								
Duty of Candour completed within 10 working days, for all incidents graded on Datix at moderate harm and above			Current Performance								
			Target								
SI investigations >60 days			Current Performance								
			Target								

10. Quality Impact Assessment

This work stream links with the following CQC areas:

SAFE	✓
EFFECTIVE	✓
CARING	✓
RESPONSIVE	
WELL LED	✓

10. Capital Investment

There is no capital investment currently identified for this workstream which has not already been identified in the 17/18 estates capital programme

11. Implementation Risk Management Plan

The following risks to benefits capture have been identified:

Risk to benefits delivery	Risk Owner	Mitigating Actions	Key Risk Indicator to be monitored
Limited clinical engagement and ownership	Renate Wendler	Utilisation of clinical lead workshops to ensure project actions are clinically owned	Clinical attendance at workshop meetings
Insufficient administrative resource to enact change	Renate Wendler	Workforce review to be undertaken as part of project to benchmark current and future workforce models	Review resources post process review
Limited project support may impact timescales provided	Andy Rhodes	Identify project support to allow capacity for clinical lead	Project Timescales

12. Communications Plan

Clinicians and managers will be kept up to date through the following prioritised communications plan.

Communications Item	Media	Audience	Key Message	Communication Owner
Programme Objectives	Bespoke Bulletins and Face to Face Briefings	All Staff	Programme Objectives	Paul Sheringham
Progress and Project Plans	Bespoke Bulletins and Face to Face Briefings, Intranet site	All Staff	Progress and Celebration	Paul Sheringham
Highlight reports	Reports	NHS I and CQC	Progress and KPI report	Renate Wendler

13. Change Control

The steering group will approve any changes to the milestone definitions or delivery dates based on the initial recommendations of the Director as the main project customer.

14. Document Control

Version Number	Date Issued	Author of changes	Reason for version
1.0	19/06/17	P Hannah	First Draft for Comment
2.0	21/06/17	C Walton	Major revisions to draft based on comments from R Wendler, J Miles and M Orzel
3.0	26/06/17	P Hannah	Formatting amends

Version: 1.1
Last Updated: 27/06/2017

Quality Improvement Programme - Patient Outcome Measures

St George's University Hospitals NHS
NHS Foundation Trust

KEY
On/Above Trajectory/Target
Improving Trajectory/Target
Below Trajectory/Target

Aim	Indicator	Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Trend
To ensure that our patients receive effective care	Hospital Standard Mortality Ratio	<80	84.1	83.3	82.5	83.5	81.3							
To ensure our patients are safe and no not acquire infections whilst under our care	Number of MRSA bacteraemias reported	0	0	1	0	2	0							
	Number of attributable Clostridium Difficile cases reported	31 (In Year Total)	3	4	3	1	1							
To ensure our patients receive kind and compassionate care	TBC		Metric has recently commenced being collected and											
To ensure that all our patients have 'No decision about me without me'	Documentation evidencing decision making and patient, relative or carer inclusion	> of 10% each Audit Point > to 90% by April '18												
To ensure we respond to our patients needs if they deteriorate under our care	In hospital (All) Cardiac Arrest Rate/1000 Admissions	50% reduction by April '18 from baseline of 14 (April '17)	11	11	Awaiting data update									
To ensure we have safe prescribing and providing of medications to our patients	Number of moderate and serious harm related medication incidents	TBC												
To ensure we treat and care for emergency patients in a timely fashion	4 Hour Emergency Admissions Target	95%	86.6	90.6	89.1	90.5	89.7							
To ensure we provide excellent care for our patients who need an operation	Number of patients cancelled on day of surgery	< to 50 up to end June '17 < to 30 July - Sept '17 < to 20 Oct - Nov '17 < to 15 or less from Dec '17	104	91	63	56	45							
To ensure our patients have a positive experience with the care they receive from us	Friends & Family Test (Emergency Department)	95%	85%	86%	83%	85%	83%							
	Friends & Family Test (Inpatients)	95%	96%	96%	97%	95%	97%							
To ensure SGH values its staff and is a good place to work at	Staff Satisfaction Survery Results (All Areas)	TBC												
To ensure we respond in an exemplary fashion to feedback from our patients	Number of complaints that are re-opened each month	< 8%				11%	11%							
To ensure we have a culture of learning from incidents that prevents them happening again	Number of repeat (level of harm) Never Events and Serious Incidents reported	0		Awaiting data										
To ensure our staff are given all the right information to make decisions	Number of outpatient appointments where clinical notes are not available	0		Awaiting data										

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Performance Report for Trust Board

Trust Board – 6th July 2017
Reporting period - May 2017

Excellence in specialist and community healthcare

Executive Summary – May 2017

St George's University Hospitals NHS
NHS Foundation Trust

Patient Safety

- There were 6 Serious Incidents (SI's) declared in May 2017
- Patient safety thermometer- % of patients with harm free care (all harm) remained below standard at 94.5%
- In May the Trust reported 1 patient with hospital attributable Clostridium Difficile Infection and zero patients who acquired an MRSA Bacteraemia in month, however in June there has been 2 patients who developed a MRSA Bacteraemia reported which brings the trust total to 4 against a ceiling of 0. These are currently under investigation.

Clinical Effectiveness

- Mortality is lower than expected for our patient group when benchmarked against national comparators
- Maternity indicators continue to show expected performance and a constant trend

Access and Responsiveness

- The Four Hour Operating Standard was not achieved in May reporting a performance of 89.68% and not achieving the internal trajectory of 91.03%
- Six out of eight cancer standards were met in April with the exception of 2ww 14 day standard and breast symptomatic.
- Diagnostic performance remains below the 99% standard. Recovery actions have been agreed for those modalities not meeting the standard.

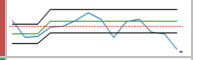
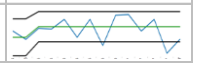
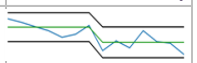
Patient Experience

- The FFT recommendation rate for inpatients was 97% in May and remains above threshold, providing a level of assurance for patient experience. ED FFT decreased to 83%

Workforce

- Staff sickness remains above trust target of 3%
- MAST Compliance and staff appraisal rates have improved

Patient Safety

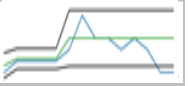
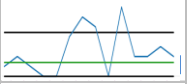
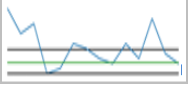
Indicator Description	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Trend
Number of Never Events in Month	0	1	0	0	1	0	0	0	0	0	1	0	0	0	
Number of SIs where Medication is a significant factor	0	1	2	0	0	0	0	2	0	1	0	0	0	0	
Safety Thermometer - % of patients with harm free care (all harm)	95%	93.8%	93.9%	94.9%	95.0%	95.6%	96.5%	95.8%	93.7%	95.5%	95.8%	94.3%	94.2%	92.5%	
Safety Thermometer - % of patients with harm free care (new harm)	95%						98.8%	97.7%	97.7%	98.0%	97.6%	98.0%	98.0%	98.3%	
Percentage of patients who have a VTE risk assessment	95%	97.6%	97.6%	96.9%	96.7%	96.3%	96.2%	95.9%	95.9%	96.8%	96.5%	96.3%	95.3%	96.2%	
Number of Serious Incidents	N/A	7	14	5	8	4	7	10	4	8	6	8	5	6	
Serious Incidents - number per 1000 bed days	N/A	0.05%	0.10%	0.04%	0.06%	0.03%	0.05%	0.08%	0.03%	0.06%	0.05%	0.06%	0.04%	0.04%	
Number of Patient Falls	N/A	139	125	142	140	155	128	154	116	161	137	154	105	125	
Number of patient falls- number per 1000 bed days	<3%	1.00%	0.92%	1.01%	1.03%	1.18%	0.95%	1.17%	0.88%	1.18%	1.05%	1.07%	0.79%	0.90%	
Attributable Grade 2 Pressure Ulcers per 1000 bed days	N/A	0.27%	0.24%	0.21%	0.17%	0.19%	0.24%	0.08%	0.13%	0.09%	0.21%	0.14%	0.13%	0.05%	
Attributable Grade 3 & 4 Pressure Ulcers per 1000 bed days	0.00%	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.02%	0.02%	0.02%	0.01%	0.00%	
Number of overdue CAS Alerts	0	1	1	1	1	1	1	1	1	1	1	1	1	1	

Briefing

- Zero Never Events reported in May
- The Trust declared 6 serious incidents in May 2017 these included:
- We continue to protect our patients from 'new harms' as evidenced when benchmarking our position nationally, however 'all harms' are below the target of 95%

Actions: The Safety Thermometer data for all harms is below the target of 95%. This was due to 83 harms being reported against 1334 patients. These harms cover Pressure ulcers, falls, Catheter Infections and VTE's. However these are harms reported prior to the patients admission to the ward area. If patients present with pressure ulcers these are reported and reviewed by the Tissue Viability team.

Infection Control

Indicator Description	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Trend
MRSA (Incidences in month)	0	0	0	0	0	0	1	0	0	0	1	0	2	0	
Cdiff Incidences (in month)	31	2	2	2	2	3	6	4	4	3	4	3	1	1	
MSSA	N/A	2	1	0	0	4	6	5	0	7	2	2	3	2	
E-Coli	N/A	8	10	0	1	6	5	3	2	6	3	11	4	2	

Briefing

- There was 1 patient reported with a hospital acquired Clostridium Difficile Infection in May occurring on Holdsworth Ward.
- C Diff threshold for 2017/18 remains the same as the previous year at 31 cases
- 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
- There were zero patients who acquired an MRSA Bacteraemia, in May with 2 incidents reported in June.

Actions: Investigation of the Clostridium Difficile case has shown no lapses in care. On review of the 2 MRSA cases whilst there were no obvious lapses in care there was learning for departments regarding screening and documentation. The policy for screening will be updated and a detailed review of all the MRSA cases is currently under way.

Both areas were placed on a period of enhanced observation by infection control to ensure clinical practices were compliant with infection control standards.

Mortality and Readmissions

Indicator Description	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Trend
Hospital Standardised Mortality Ratio (HSMR)	100	84	83.7	83.65	85.3	84.3	88.9	84.1	84.1	84.1	83.3	82.5	83.5	81.3	
Hospital Standardised Mortality Ratio Weekday Emergency	100	84.3	83.2	85.3	88.1	83.2	86.6	84.2	82.4	82.4	81.1	79.2	80.1	78.2	
Hospital Standardised Mortality Ratio Weekend Emergency	100	0.85	0.86	0.88	0.92	0.87	0.94	0.92	0.87	0.87	0.87	0.84	0.86	0.83	
Summary Hospital Mortality Indicator (SHMI)	100	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.86	0.84	
Emergency Readmissions within 30 days following non elective spell	TBC	11.0%	10.3%	10.8%	10.9%	10.5%	10.7%	10.8%	11.7%	10.7%	12.2%	11.3%	11.4%	11.8%	

Briefing

- Latest HSRM and SHMI data for the Trust shows mortality remains lower than expected for our patient group when benchmarked against national comparators
- Readmission rates following an emergency spell remain above internal threshold, predominantly within non elective spells. A data quality review is underway as there appears to be some data quality issues.

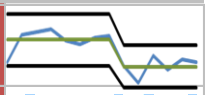
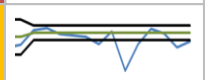
Maternity

- Maternity indicators continue to be monitored and reviewed by the Divisional Governance process

Indicator Description		May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Trend
C Section Rate - Emergency and Non Elective	28%	27.5%	23.6%	30.3%	23.0%	24.4%	26.8%	26.1%	28.4%	28.8%	29.6%	34.1%	29.9%	29.1%	
Admission of full term babies to neo-natal care		3	9	10	7	4	13	1	2	2	7	2	11	2	

Actions: C-Section-the service is reviewing the data and completing an internal audit of practice and data validation

Emergency Flow

Indicator Description	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Trend
4 Hour Operating Standard	95%	93.62%	93.98%	94.38%	92.74%	92.24%	93.21%	93.50%	89.14%	86.63%	90.59%	89.09%	90.50%	89.68%	
Patients Waiting in ED for over 12 hours following DTA	0	0	1	0	0	0	0	0	1	0	1	0	0	1	
Ambulance Turnaround - % over 15 minutes	100%	46.9%	53.4%	51.1%	53.2%	56.1%	52.1%	53.8%	49.9%	46.9%	52.4%	50.2%	46.0%	48.0%	
Ambulance Turnaround - % over 30 minutes	100%	97.9%	98.2%	97.5%	97.4%	97.2%	98.2%	97.8%	96.6%	96.4%	98.1%	97.6%	96.1%	96.7%	
Ambulance Turnaround - number over 60 minutes	0	0	0	1	0	0	0	0	0	0	0	0	0	1	

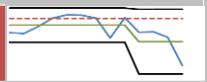
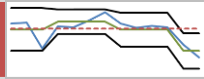
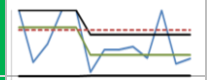
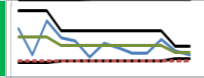
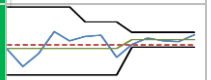
Briefing

- The ED 4hr Standard was not achieved in May 2017 with a performance of 89.68%
- Ambulance turnaround performance continues to be stable however improvements to be gained
- 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 performance

Actions

- Weekly “Communications Cell” in place to review the previous weeks performance and share lessons learned and agree actions.
- Initial assessment area has been expanded with a focus on streaming patients through to the most clinically appropriate flow, either primary care, urgency care or an ambulatory pathway.
- Daily forward look of staffing levels to ensure clinical staffing best matches time of attendances.
- A key action is to review ambulance handover processes to reduce delays in handover.
- The patient flow programme is in progress which will aim to reduce emergency admissions, reduce length of stay and reduce overall bed occupancy.
- Safer bundle is being rolled out to improve patient safety and remove non added value delays in the patient journey

Cancer

Indicator Description	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	Trend
Cancer 14 Day Standard	93%	86.6%	87.3%	90.0%	93.1%	95.1%	94.2%	93.2%	85.7%	93.3%	87.9%	87.9%	86.0%	75.4%	
Cancer 14 Day Standard Breast Symptomatic	93%	94.8%	95.2%	85.9%	93.8%	94.2%	96.0%	98.9%	94.8%	93.2%	94.0%	93.4%	87.2%	82.7%	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	100%	94.7%	96.6%	100%	100%	93.8%	98.8%	96.0%	96.0%	95.1%	100.0%	94.6%	96.4%	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	98.4%	100.0%	100%	99%	100%	100%	
Cancer 31 Day Diagnosis to Treatment	96%	98.3%	96.3%	98.8%	97.6%	97.4%	96.2%	97.2%	96.9%	96.6%	96.4%	97.5%	96.7%	95.1%	
Cancer 62 Day Referral to Treatment Standard	85%	83.2%	77.5%	81.6%	90.2%	86.6%	88.3%	88.8%	80.0%	85.2%	87.7%	86.6%	86.3%	89.0%	
Cancer 62 Day Referral to Treatment Screening	90%	93.9%	84.8%	94.8%	95.0%	95.8%	92.0%	96.2%	92.7%	92.7%	93.0%	96.2%	92.6%	92.7%	

Briefing

- All Cancer standards achieved in April with the exception of 14 Day Standard and 14 Day Breast Symptomatic
- 14 Day Standard performance in April is 75.4% against a national standard of 93%. Two week performance fell below target predominantly due to a high number of breaches within Skin (60% of all breaches) and clerical delays within the TWR office.
- In April the 2WW standard was not achieved in 8 out of 13 tumour sites. This was predominantly due to a backlog of referrals to be processed as well as clinic capacity gaps in 3 high volume tumour groups : skin, lower GI and breast. TWR office are now fully staffed

Actions

- Demand and capacity analysis has been completed to identify services where there is insufficient core capacity for 2ww patients and recovery plans developed to clear the backlog and provide sufficient core capacity with performance expected to return above standard from August 17
- Triage processes are in place to ensure patients can attend straight to test clinics where appropriate.
- A daily monitoring process is in place to ensure no backlog of referral booking builds up and to update services on clinic capacity gaps.
- Additional consultants have now been appointed for dermatology

Diagnostics

Indicator Description	Threshold	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Trend
6 Week Diagnostic Performance	1%	0.7%	1.0%	0.8%	0.8%	0.9%	0.8%	0.7%	2.2%	5.1%	2.8%	2.9%	4.1%	3.3%	
6 Week Diagnostic Breaches		46	69	50	51	56	57	50	151	372	219	222	313	248.00	
6 Week Diagnostic Waiting List Size		6,588	6,977	6,436	6,085	6,258	6,834	6,878	6,906	7,358	7,871	7,678	7,559	7443.00	

Indicator Description		May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Trend
MRI	1%	0.1%	2.9%	0.6%	2.1%	1.9%	1.0%	1.1%	1.7%	9.6%	4.3%	3.3%	2.6%	1.1%	
CT	1%	0.2%	0.2%	0.0%	0.0%	0.3%	0.0%	0.0%	0.1%	0.6%	0.0%	0.7%	1.5%	0.50%	
NON_OBSTETRIC_ULTRASOUND	1%	1.1%	0.0%	0.2%	0.2%	0.0%	0.0%	0.1%	1.0%	3.0%	1.9%	3.0%	4.0%	2.5%	
BARIUM_ENEMA	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
DEXA_SCAN	1%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
AUDIOLOGY_ASSESSMENTS	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.5%	2.5%	6.5%	10.1%	
ECHOCARDIOGRAPHY	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.3%	1.2%	9.4%	
ELECTROPHYSIOLOGY	1%	0.0%	0.0%	40.0%	0.0%	100.0%	25.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	
PERIPHERAL_NEUROPHYS	1%	0.0%	2.7%	6.4%	4.5%	3.4%	1.2%	2.6%	0.4%	0.5%	0.0%	0.5%	0.0%	0.0%	
SLEEP_STUDIES	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
URODYNAMICS	1%	0.0%	53.8%	20.0%	0.0%	50.0%	47.1%	80.0%	15.4%	0.0%	52.6%	55.0%	65.5%	75.6%	
COLONOSCOPY	1%	0.0%	2.2%	0.6%	0.0%	0.0%	2.3%	1.4%	3.6%	20.2%	5.7%	8.7%	5.7%	4.7%	
FLEXI_SIGMOIDOSCOPY	1%	0.5%	2.4%	0.6%	1.6%	1.4%	5.3%	0.0%	10.5%	20.8%	12.0%	8.4%	6.7%	0.0%	
CYSTOSCOPY	1%	4.7%	3.0%	8.9%	6.9%	11.3%	2.8%	10.6%	28.3%	14.4%	9.9%	2.6%	15.0%	11.5%	
GASTROSCOPY	1%	1.0%	0.7%	0.0%	0.0%	0.0%	4.0%	0.9%	7.2%	10.1%	3.2%	4.5%	12.7%	10.0%	

Actions

- Non obstetric ultrasound – additional sessions being provided by paediatric radiologists. Head and neck - FNAs capacity and demand analysis completed and core sessions increased. Reviewing system wide capacity to share out demand.
- Urodynamics – additional clinics to clear backlog and provide additional ongoing capacity. Longer term specialist nurse vacancy being recruited into who will be trained to perform unsupervised urodynamic assessments – 2 year timescale.
- Endoscopy – significant reduction in backlog over the last 6 weeks – additional capacity provided through waiting list initiatives. Recruitment ongoing to staff 2 additional rooms.
- Expected timescale for recovery of target is September 17

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Trend
Number of on the Day Cancellations		55	88	88	52	59	52	103	60	104	91	63	56	45	
Number of on the Day cancellations re-booked within 28 Days		39	75	83	42	56	49	88	45	92	89	56	52	43	
% of Patients re-booked within 28 Days	100%	70.9%	85.2%	94.3%	80.8%	94.9%	94.2%	85.4%	75.0%	88.5%	97.8%	88.9%	92.9%	95.6%	

Briefing

- The number of patient procedures cancelled on the day continues to decrease in the month of May reporting 45 cancellations, of which 95.5% (43) 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 top two reasons for last minute cancelled operations are: 1. lack of theatre time 2. an emergency case taking priority..

Actions

- Daily theatre briefing to confirm all theatres started on time.
- Daily monitoring and forward planning of HDU bed requirements to prevent cancellations due to lack of HDU beds. A tightened escalation process is in place to ensure all actions taken before non clinical cancellations.
- Weekly list planning meeting processes have been reviewed to tighten up optimal use of theatre sessions with a correct apportionment of trauma v elective list allocation. Cardiac surgery now allocate one session daily to emergency to minimise risks of last minute cancellations.
- A theatre transformation programme supported by Four eyes is due to commence on 28th June. This will include operational, quality and financial improvement initiatives within theatres. Reducing last minute cancellations will be a key output of this.

Patient Voice

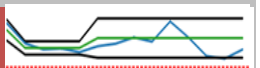
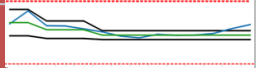
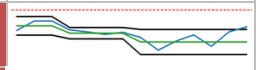
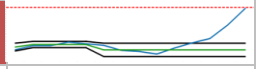
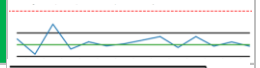
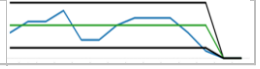
Indicator Description	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Trend
Emergency Department FFT - % positive responses	83.0%	82.0%	84.0%	85.0%	83.0%	87.0%	84.0%	82.0%	85.0%	86.0%	83.0%	85.0%	83.0%	
Inpatient FFT - % positive responses	95.0%	93.0%	96.0%	96.0%	94.0%	95.0%	98.0%	96.0%	96.0%	97.0%	97.0%	95.0%	97.0%	
Maternity FFT - Antenatal - % positive responses	100%			80.0%	No Responses						100%		85.7%	
Maternity FFT - Delivery - % positive responses	100%	100%	100%	100%	95.0%	93.0%	100%	87.0%	89.0%	93.0%	97.0%	88.2%	100.0%	
Maternity FFT - Postnatal Ward - % positive responses	94.0%	91.0%	100.0%	88.0%	96.0%	92.0%	95.0%	95.0%	95.0%	93.0%	90.0%	94.1%	97.9%	
Maternity FFT - Postnatal Community Care - % positive responses	100%	100%	95.0%	87.0%	100%	93.0%	100%	100%	100%	100.0%	100%	100%	100%	
Community FFT - % positive responses	94.9%	94.3%	94.2%	86.9%	93.2%	88.2%	96.5%	94.7%	96.6%	96.2%	93.0%	95.0%	97.6%	
Outpatient FFT - % positive responses	88.0%	83.0%	89.0%	91.0%	87.0%	88.0%	95.0%	92.0%	95.0%	93.0%	85.0%	93.0%	95.6%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints	58	75	74	94	91	67	92	56	85	73	79	63	76	

Briefing

- ED FFT – The FTT score has decreased slightly from 85% in April to 83% in May
- Inpatient FFT – The FTT score for inpatients remain above local threshold reporting 97% in May
- Maternity FFT – The FTT score for inpatients are above local threshold however improvement work to increase number of patients responding is required
- Outpatient FFT – The FTT score for outpatients has increased from 93% in April to 95.6% in May

Actions: The ED management team are reviewing the results from the FFT survey for the last quarter to determine any themes for improvement. Review of staffing model to ensure response nurse available to support high volume areas and minimise delays for patients

Workforce

Indicator Description	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Trend
Trust Level Sickness Rate	3%	4.1%	3.7%	3.5%	3.5%	3.4%	3.5%	3.6%	3.8%	3.7%	4.2%	3.8%	3.3%	3.2%	3.4%	
Trust Vacancy Rate	10%	17.0%	19.0%	17.0%	17.0%	16.0%	16.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	16.0%	17.0%	
Trust Turnover Rate* Excludes Junior Doctors	10%	18.0%	18.3%	18.6%	18.8%	18.5%	18.5%	18.5%	18.0%	18.1%	18.4%	18.5%	19.1%	19.1%	19.1%	
Total Funded Establishment			7,671	7,695	7,688	7,771	7,832	7,923	7,952	7,884	7,921	7,893	7,845	7,801		
IPR Appraisal Rate - Medical Staff	90%	82.9%	86.2%	86.2%	83.1%	82.4%	81.5%	82.2%	80.5%	76.0%	79.2%	81.3%	77.3%	82.4%	82.0%	
IPR Appraisal Rate - Non Medical Staff	90%	66.5%	68.8%	68.8%	70.8%	69.9%	69.0%	66.2%	65.6%	64.1%	67.5%	70.4%	72.8%	80.3%	78.2%	
% of Staff who have completed MAST training (in the last 12 months)			78.9%	79.6%	88.7%	79.0%	80.0%	78.3%	80.0%	79.7%	81.9%	85.0%	85.0%	85.9%	87.0%	
Ward Staffing Unfilled Duty Hours	10%	5.8%	3.6%	8.0%	4.4%	5.4%	4.8%	5.1%	5.7%	6.2%	4.6%	6.2%	4.8%	5.4%	4.8%	
Safe Staffing Alerts	0	7	10	10	13	5	5	9	11	11	11	7	2	0	0	

Briefing

- Funded Establishment has decreased by 44 posts and equates to 7,801 WTE
- Vacancy Rate across all staff group has increased to 17%
- Turnover has remained at 19.1% for all staff groups Junior doctors are excluded from the reported figures.
- Sickness has decreased to 3.4%
- MAST figures for May were recorded at 87% seeing an improvement
- Appraisal rates remain below target, with non medical remaining at a steady rate over the last 12 months. Non medical appraisal decreased in May however there has been ongoing improvement over the last 12 months.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	6 July 2017	**Agenda No.**	**3.3**
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:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	This paper provides an update on the implementation of our elective care recovery programme, including actions to return the Trust to national reporting of the standard and to deliver the 18 week referral to treatment (RTT) standard. The paper notes the issues raised in the MBI reviews of waiting list management and a recent programme stocktake, and provides details of the revised 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, including revisions to 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.		
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:	Finance and Performance Committee	**Date:**	28th June 2017
Equality Impact Assessment:			
Appendices:			

Elective Care Recovery Programme Report
Trust Board
9 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 many 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.

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

3.4 A second review of waiting list management at Queen Mary's Hospital, Roehampton identified issues specific to the Hospital that are not addressed in the original recovery plan.

4.0 ACTION TAKEN

4.1 The ECRP plan, including the governance arrangements has been revised to ensure we tackle the issues at pace, and meet key milestones, together with greater oversight of delivery and risk.

Risks

4.2 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.

4.3 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.

4.4 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 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 revised 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: **26 June 2017**

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

St George's University Hospitals

Elective Care Remedial Action Plan

June 2017

Contents

1. Context – St George's

In 2010, Cerner PAS was deployed at the St Georges site as part of the National Programme for IT. In February 2014 the Trust upgraded this system to add additional RTT functionality. However, the lack of SOPs and staff training undermined the Trust's ability to track patient pathways and report RTT data. In May 2016, the Trust commissioned MBI Health Group to conduct an assessment of root cause and remedial actions required.

Four main conclusions can be drawn from MBI's review:

• The current RTT PTLs are unfit for the purpose of managing patients through their pathways – patients are being excluded and those included are likely to have inaccurate waiting times;

• Planned patients are not managed appropriately;

• Non-RTT follow up patients are not managed appropriately; and

• RTT externally reported figures are beyond doubt inaccurate.

In July 2016 the Trust Board therefore took the decision to suspend national reporting of performance against the 18 week referral to treatment standard because the Trust could not guarantee that the data being reported was robust and accurate.

Progress has been made with our recovery plan established to address the highlighted data quality issues. Going forward, a number of actions are being taken:

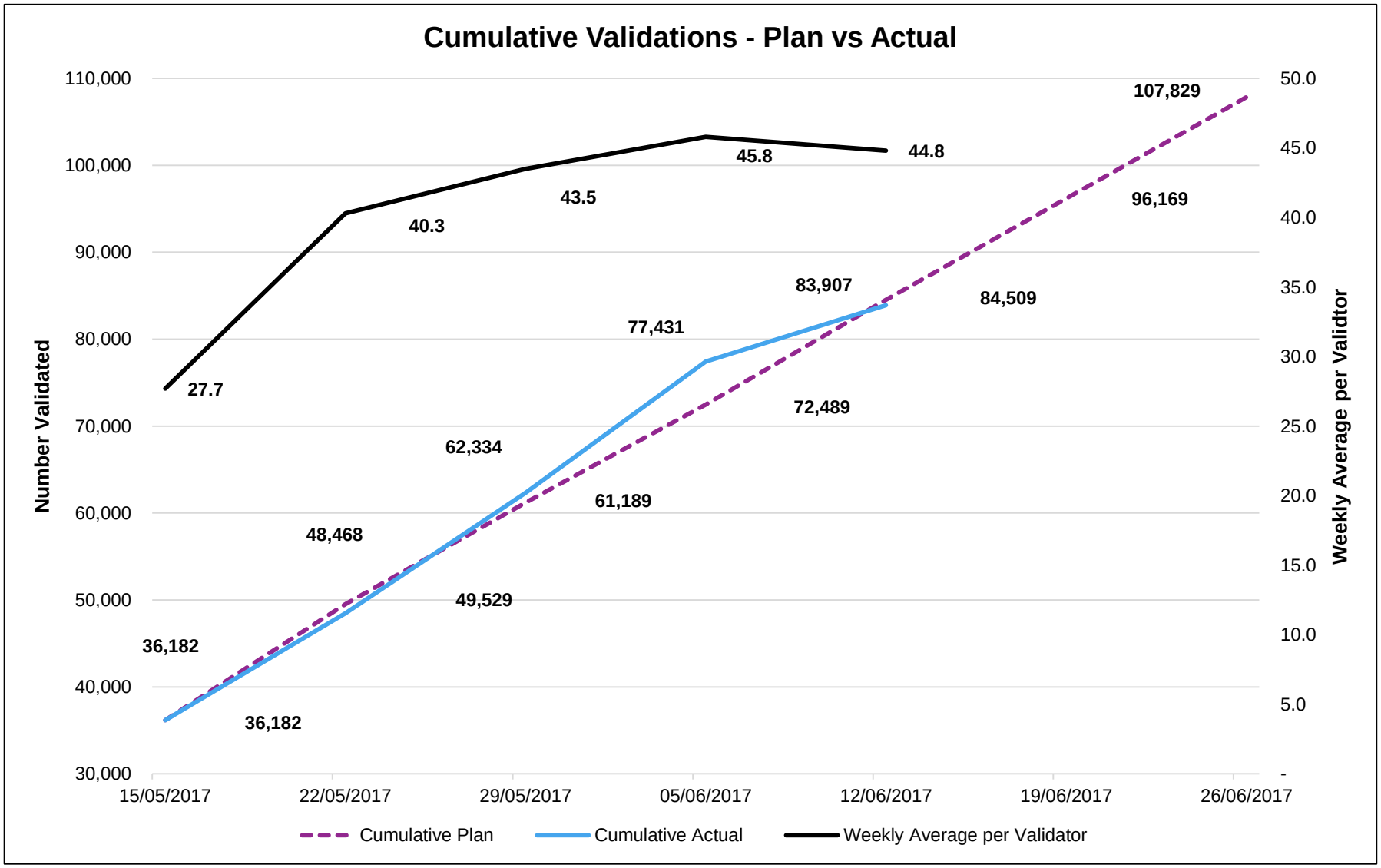
- Refreshing the key actions of the plan;
- Expanding the plan to include delivery of the RTT standard;
- Accelerating SOP Development and Training;
- Movement of Cymbio contract to phase II; and
- Strengthening the PMO to enable increased accountability and enhancing the reporting functionality of the plan to increase stakeholder assurance.

2. Initial Focus – St George's

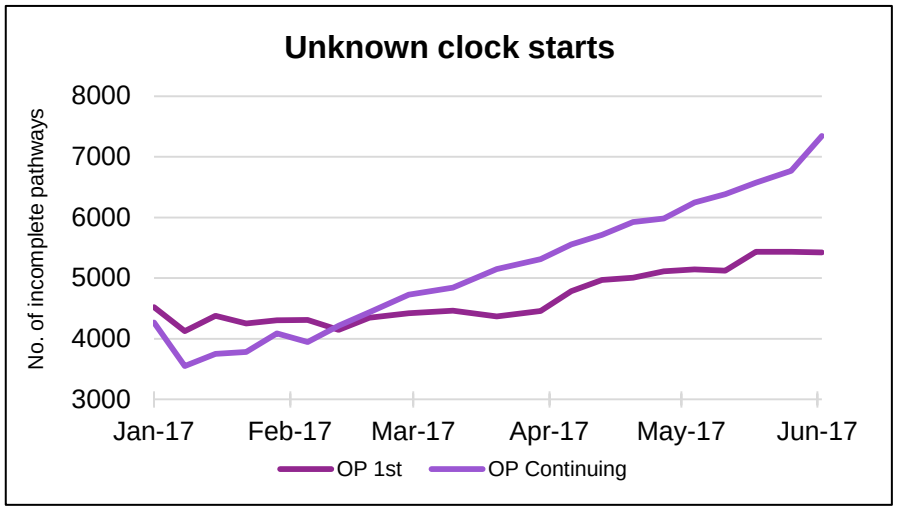
The initial focus of the recovery plan for St George's Hospital is set out below:

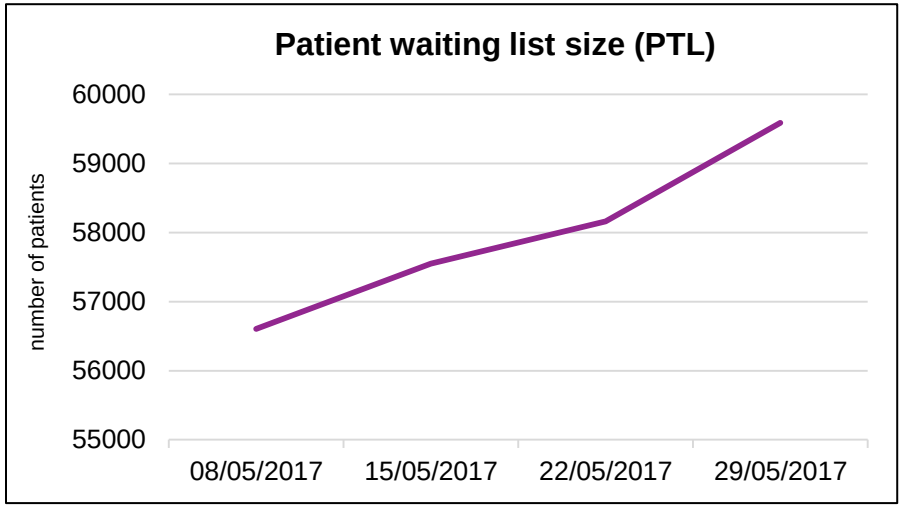
Historic Validation	► Cymbio contracted to perform historic validation of 130,000 pathways where there was an increased risk of harm to patients if treatment was delayed. ► Progress has been challenging as a result of the complexities of the data. Following review and streamlining of the process the pace has increased and the contracted volume of validations will be completed to time.
BAU Validation	► An approach to validation was agreed that over time would allow all new additions to the PTL to be validated (ensuring the accurate capture of clock starts) in addition to long wait patients that overtime would ensure validation of the entire PTL. Delay in recruiting additional staff has inhibited sufficient progress to be made.
Red Rules	► 'Red rules' script was disabled in March 2017
Deployment of Clinical Outcome Forms	► The Clinical Outcome form has been redesigned with clinical service teams, with deployment impending ► The form is being piloted in four specialties, with full rollout complete by October 2017.
Waiting List Management	► Weekly review of long-wait patients to expedite diagnosis and treatment has been established
Letter Backlog	► Letter backlog eliminated; daily review ongoing with escalation to Hospital Board by exception
Clinical Harm	► Clinical Harm Review Process established with external oversight from Dr Nicola Payne (Chair, Clinical Harm Review Panel) and CQRG.

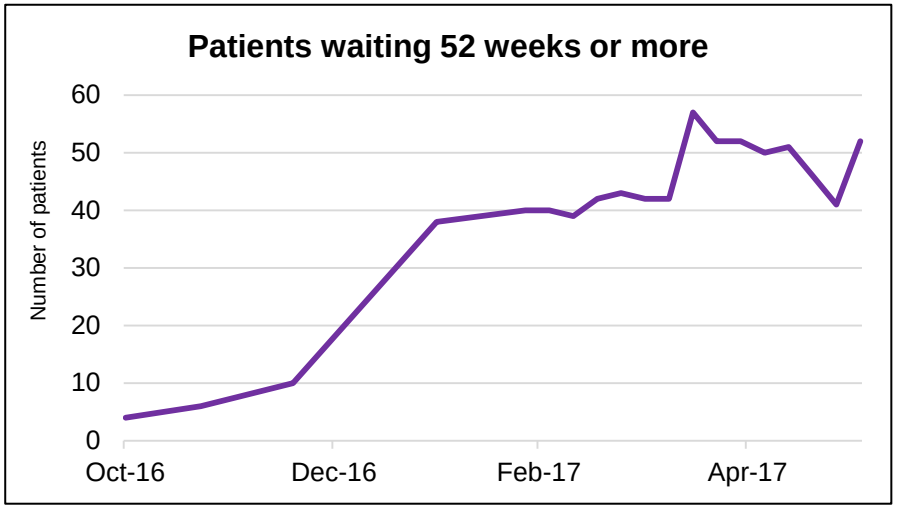
3. Cymbio Contract performance

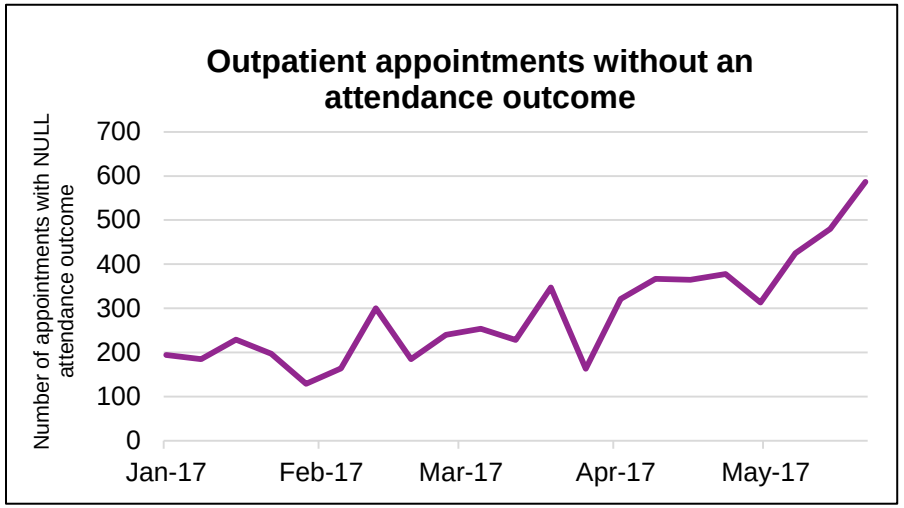


4. Key metric performance – St George's









5. Context – Queen Mary's

The MBI report highlighted significant issues on the Queen Mary's Hospital site also, and a subsequent in depth review of the waiting list management specific to Queen Mary's Hospital identified a number of issues that could potentially expose patients to avoidable harm.

The root cause of data quality issues at QMH is the IT configuration which is significantly different to the rest of the Trust. This includes a Clinicom PAS has not been upgraded to include RTT functionality.

The data quality issues arising from this include:

- An incomplete understanding of patient waiting times;
- Difficulty in determining how many patients are waiting, for how long and for what;
- Potentially a number of patients with extended waiting times;
- Clinicians may not always have access to patient information;
- Potential delays in patient pathways due to administrative processes; and
- Patients and GPs may not always be receiving important communications.

Three findings present an immediate clinical risk:

- The QMH PAS has been using an auto discharge function. The functionality has now been turned off.
- There are sometimes significant delays between a referral being received in QMH and the patient being registered on PAS. Once registered referral letters are then sent manually or in the internal post to consultant clinics at which they are triaged. There are no safeguards in place to check that triaging takes place for all patients and delays in the process can result in patients not being booked in chronological order of referral
- There is a significant backlog in clinical letter typing following outpatient appointments.

6. Initial Focus – Queen Mary's

The initial focus of the recovery plan for Queen Mary's Hospital are set out below:

Referral Receipt and Triage

- Electronic scanning of referrals. Audit in place to ensure compliance.
- Strengthening of the referral to triage process with daily reporting of KPIs to the Hospital Director and NHS Improvement. All referrals sent for triage counted in and out to ensure correct actions taken..
- Electronic solution agreed for 12 specialties where clinics are infrequent enough to make meeting the metric on referral vetting challenging.

Letter Typing Backlogs

- Redistributed staff to clear all letter typing backlogs with daily reporting to Hospital Director and NHS Improvement.
- Review of ongoing staffing requirements to ensure sufficient staff to type letters is in place sustainably.

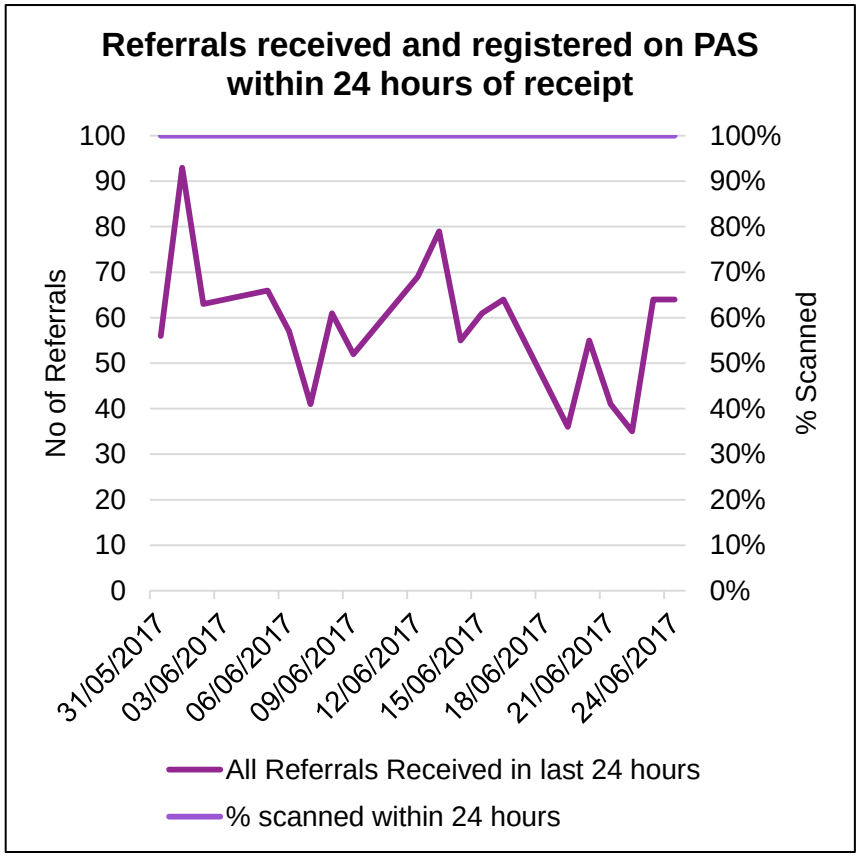
Automatic Discharge

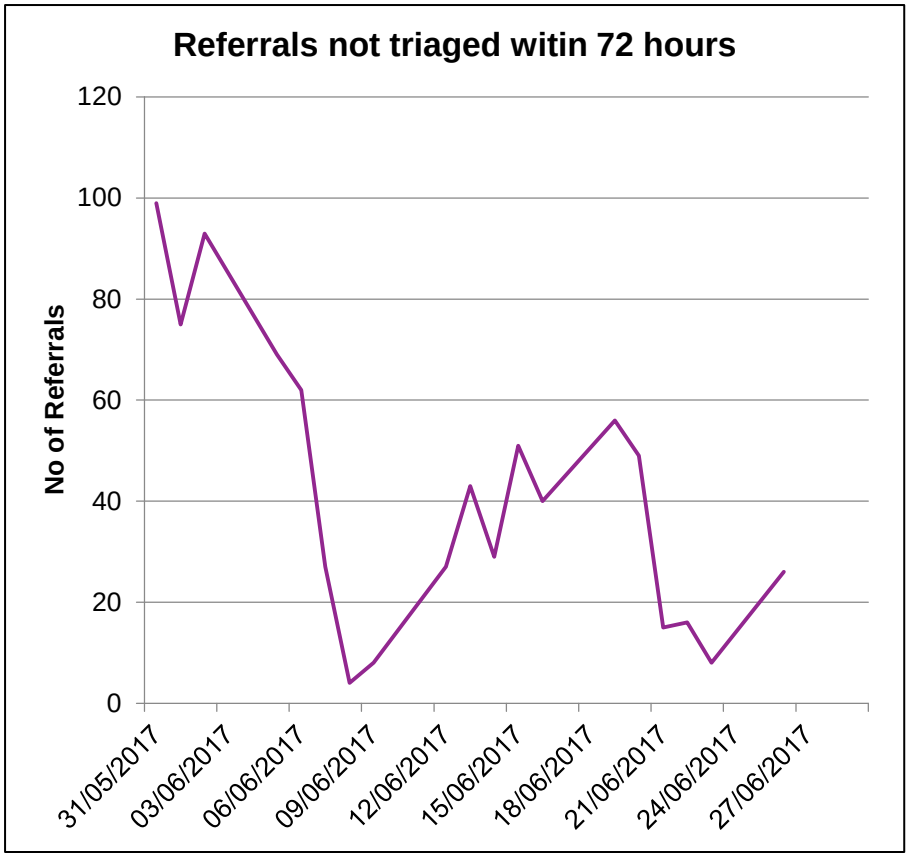
- Auto discharge function immediately switched off. An approach to assessing the appropriateness of those patients that have previously been discharged is rapidly being developed.
- Weekly report of patients who would have been discharged before removal of functionality reviewed and actioned by the validation team.
- Added 2 WTEs to immediately implement BAU validation of key patient groups, with an additional 3WTE to be appointed.

Strengthening the Leadership Team

- QMH now directly managed by one of SGH four clinical divisions, Community Services Division (CSD). QMH Hospital Director appointed and reports to the CSD Divisional Chair.
- Expert resource secured through MBI Healthgroup, additional support provided by dedicated GM.
- Weekly QMH RTT delivery group established reporting to QMH Clinical Board with responsibility for the implementation of the immediate plan to address safety issues.

7. Key Metric Performance – Queen Mary's

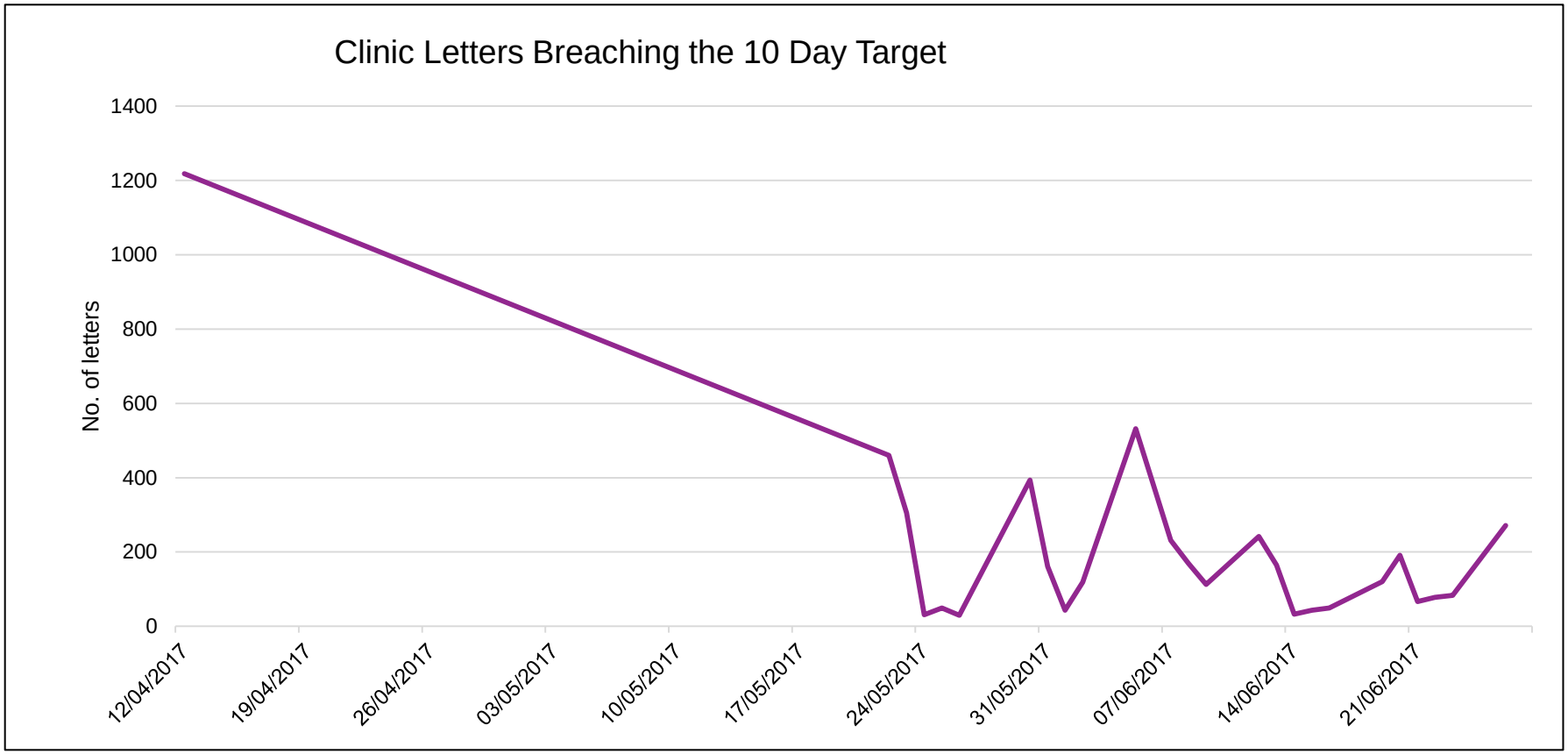




- All referrals received are being registered on PAS within 24 hours
- All referral letters received within the QMH site will be scanned and saved on a Trust drive within 24 hours from the 14th June 2017
- Currently a small data set so continual monitoring is required

- Referrals are not currently sent for vetting if the clinician is not on site
- Processes are in development to address clinicians who are infrequently on site to be able to vet within the required timeframe
- Small data set – not all clinicians represented as yet
- All referrals sent out for triaging are checked via a unique identifier to ensure all are returned

7. Key Metric Performance – Queen Mary's (contd.)



- The number of letters non-compliant with the 10 day target has decreased from the starting point, but a number still remain.
- Administrative review planned to assess workforce requirements

8. Focus of the remedial plan

Objectives

1. **Unequivocal focus on patient safety**
2. **Return to national reporting of performance against the RTT standard**
3. **Sustainable delivery of the RTT incomplete standard**

Outputs

Patient Safety & Clinical Governance

- Building ownership of access targets as a primary quality indicator
- Harm Processes
- Management of Planned & Non-RTT Follow Ups

Capacity & Demand

- Increasing run-rate
- Balanced demand and capacity plans and schedules
- Clinical variation reports

Operational Process & Training

- SOPs for all pathways
- Training Needs Assessments
- Training Modules
- Scenario-led training

Booking & Scheduling

- Template Reviews
- Chronological Booking
- Adherence to access policy

Programme Management: Pace, Grip, Assurance

Outputs

Pathway Management

- Clinic Outcome Forms
- Pathway trigger points
- Identifying bottlenecks
- Removing admin delays

Tracking & Validation

- PAS functionality
- Clean and up-to-date waiting list reports
- Validation Lists
- Unoutcomed appointments

Performance Management

- Waiting list Business Performance Rhythm
- Advanced dashboards
- Incentive alignment

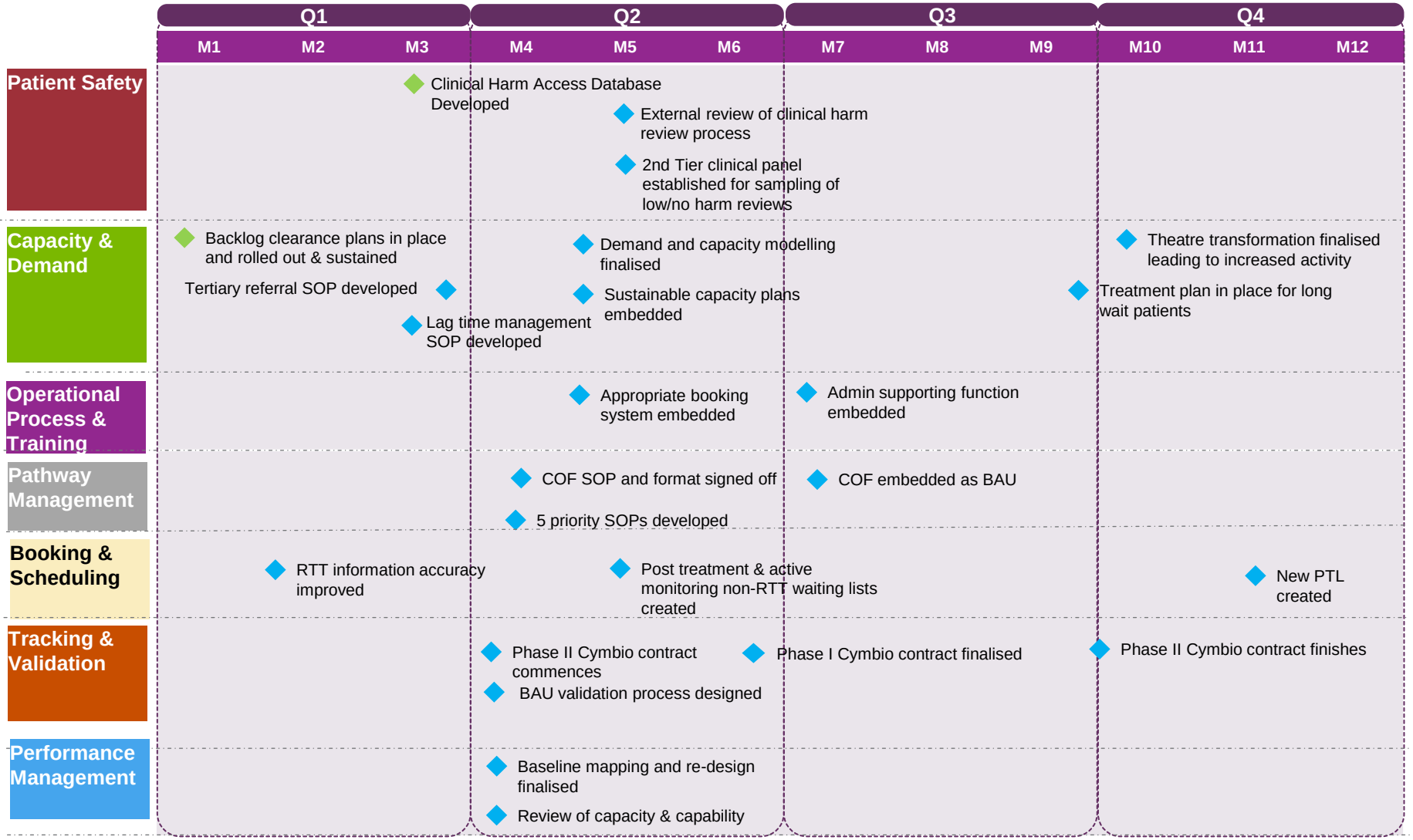
Leadership & Focus

- Governance structures
- Board reporting
- Communication Plan
- Resourcing
- External Reporting

9. Programme Structure

Objective	Outcomes	Workstream	Responsible Officer
1. Unequivocal focus on patient safety	• Accountable leadership and focus on delivering this programme incl. putting in place appropriate governance structures, Board reporting, internal and external communication plans, financial and staff resourcing and external reporting • Building ownership of access targets as a primary quality indicator • Ensuring appropriate implementation of Harm Processes at QMH • Efficient management of Planned & Non-RTT Follow Ups	Workstream 1: Patient Safety and Clinical Governance	Andy Rhodes (Medical Director)
2. Return to national reporting of performance against the RTT standard	• Putting in place supporting infrastructure incl. PAS functionality • Enabling accurate tracking and validation incl. clean and up-to-date waiting lists (PTL development and validation) and clinic outcome forms • Operational process and training in place incl. SOPs for all pathways, training needs assessments, training modules and scenario-led training	Workstream 3: Data Quality and Validation Workstream 4: SOP Development and Training	Mark Hamilton (Associate Medical Director) To be confirmed
3. Sustainable delivery of the RTT incomplete standard	• Maintaining capacity and demand in balance incl. increasing run-rate of patients treated, plans and schedules in use, and clinical validation reports in place • Efficient pathway management incl. pathway trigger points, identifying bottlenecks and removing admin delays • Clear performance management against the target incl. establishing waiting list business performance rhythm, advanced dashboards and incentive alignment • Appropriate booking and scheduling processes in place incl. template reviews, chronological booking and adherence to access policy	Workstream 2: Operations	Ellis Pullinger (COO)

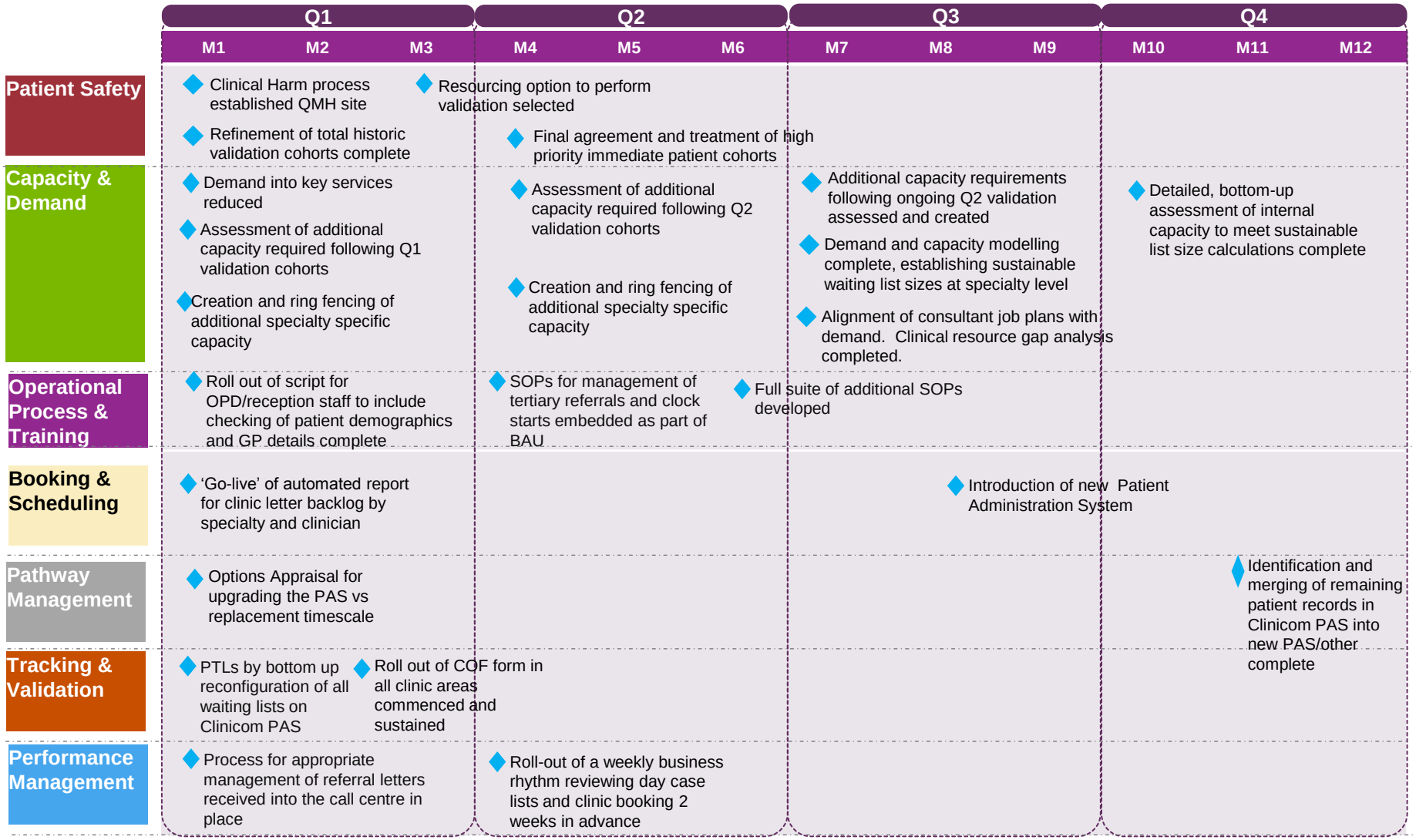
10. High Level Milestones – St George's



KEY:

- Completed
- Not yet completed

11. High Level Milestones – Queen Mary's



12. Governance & Programme Structure

The Governance structure for the programme is outlined in the diagram below.

ICT Strategy

Outpatient Transformation

Finance and Quality Recovery

13. Risks and mitigations

There are a number of key risks associated with implementing the remedial action plans; mitigating actions are in place or planned for those already identified. Existing risks will be monitored continuously, and further risks identified and action taken promptly via the Governance Structure.

Title	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls
1	Program Director	Insufficient leadership focus may result in lack of direction, prioritisation and holding to account	15	4	3	12	High	Programme Leadership strengthened Revised Programme Governance; Programme to report to Finance and Performance committee and supported by Delivery Group for each hospital site. Establishment of PMO QMH Hospital director appointed OPD GM appointed Leadership of overarching Elective Care Recovery Programme strengthened	Recent changes are not yet embedded.
2	COO	Risk of failure to deliver because of delays in recruitment process and unavailability of specialist skills	16	4	3	12	High	Additional staffing requirements have been identified in MBI reports and further review of staffing requirements to be undertaken. Expert support secured from MBI HealthCare group. Approval to expand validation team secured	Substantial funding for Elective Care Recovery Programme delivery to be agreed Validation resource not secured
3	COO/ Medical Director	Insufficient OPD and inpatients capacity leads to risk of failure to treat high volume of long waited patients and reducing wait times and increases risk of potential clinical harm	16	4	4	16	Extreme	Validation to identify long wait patients Weekly review of treatment plans for long wait patients Evaluate internal and external capacity to see patients Plan to deliver the capacity requirement Referral management Work with commissioners to implement steps to reduce demand in key services	Validation process to be finalised for QMH Agreement of funding for resources required

13. Risks and mitigations (contd.)

There are a number of key risks associated with implementing the remedial action plans; mitigating actions are in place or planned for those already identified. Existing risks will be monitored continuously, and further risks identified and action taken promptly via the Governance Structure.

Title	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls
4	COO	Lack of basic operational controls that will risk ability to increase activity run rate and improving waiting list management	15	4	3	12	High	New leadership and management in place, including weekly Trust Operational Board. Configuration of waiting list at QMH in development for completion mid July. External support for development of SOPs and training secured.	Develop and implement new standard operating procedures to deliver elective recovery
5	COO/ Medical Director	Poor engagement with clinicians and staff risks delaying implementation and delivery of the plan	12	4	3	12	High	Programme Director member of Trust Operational Board. Trust communications lead identified	Internal engagement and communication strategy to be agreed and commenced
6	COO/ Medical Director	Poor engagement with external partners and stakeholders will damage confidence in the Trust's ability to deliver and implement the plan	15	4	3	12	High	Representation of key external stakeholders on Programme Board. MBI reports shared with NHSI, CQC, SWL Alliance of CCGs and Merton and Wandsworth LDU NHSI facilitated meeting with external stakeholders to share QMH MBI report and remedial plan (13 June 2017)	External engagement and communication strategy to be agreed and commenced

Next steps

1. Develop resourcing plan, firm up programme costs and finalise budget
2. Implementation of the revised programme governance
3. Implement the enhanced reporting structure and embed new reporting tools.
4. Trust Board programme report available from August

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	6 July 2017	**Agenda No**	**3.4**
Report Title:	Results of the National Inpatient Survey 2016		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Sarah Duncan, Patient Experience Manager Robert Bleasdale, Deputy Chief Nurse		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) Information		
Summary / Key points	This report provides an overview of the Trust's results from the National Inpatient Survey 2016 (**appendix 1**) which surveyed patients who were inpatients at St George's Hospital in July 2016. The results have been published on the CQC website. The report also includes a comparison of the Trust's results over the past six years (**appendix 2**) and a comparison of results with other London Trusts (**appendix 3**). The Trust surveyed patients who had an inpatient stay at St George's Hospital in July 2016. The sample size for the audit was 1,250 patients with a response rate of 38% of eligible patients. The national CQC results demonstrate that we are "about the same" as other Trusts on the majority of questions apart from four for which we are "worse" these being: • Did you ever use the same bathroom or shower areas as patients of the opposite sex? • In your opinion, how clean was the hospital room or ward that you were in? • Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way that you could understand? • Did hospital staff discuss with you whether you would need any additional equipment in your home or any adaptations to your home, after leaving hospital? It is particularly interesting to reflect on the results over the last six years (appendix 2). These demonstrate that little progress has been made in improving the patient's experience of using our services over this time and is clearly unacceptable. Therefore the question to be answered is "what are we going to do differently over the next 1-3 years to start seeing improving responses from our patients"? Over the last couple of months we have reviewed and refocussed our Quality Improvement Plan. To really gain traction on these areas, the questions from		

	the National Inpatient Survey are being aligned to the relevant workstreams so that the right level of focus is given and tracked. This approach is the preferred way forward and the questions in the survey span every interaction that patients have with our hospitals. The results of this survey have been widely shared within the organisation and a focus group to review the results has already taken place. The results will be referred to regularly as part of the Quality Improvement Plan to ensure that this is kept live and at the forefront of care that we deliver each day.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Effective, Caring, Responsive.		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:			
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date**	N/A
Equality Impact Assessment:	N/A		
Appendices:	1. Care Quality Commission Patient Survey Report 2016 2. Comparison of Trust's results over past 6 years. 3. Comparison of results with other London Trusts		

Results of the National Inpatient Survey 2016
Trust Board 6 July 2017

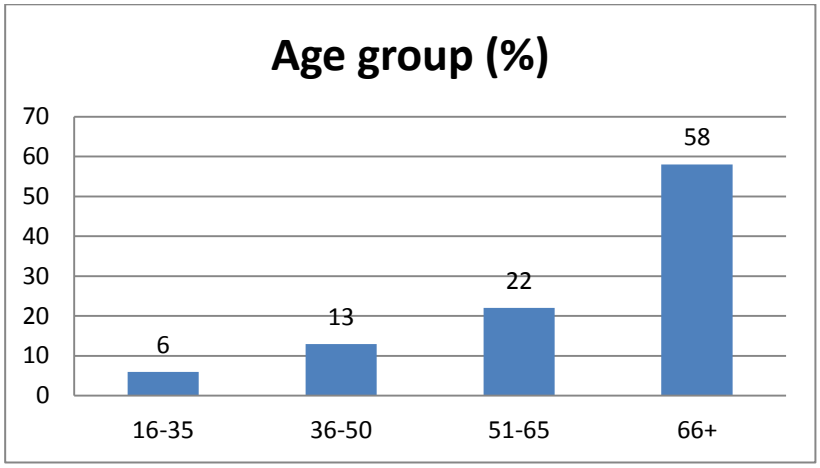
1.0 Introduction

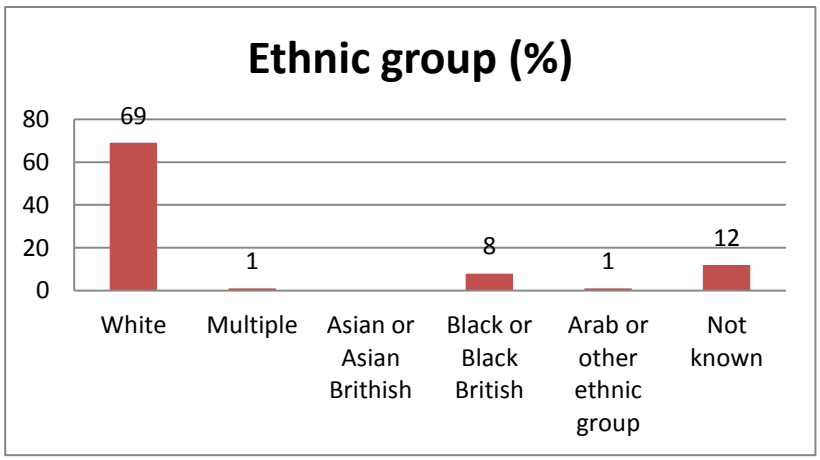
The results from the National Inpatient Survey 2016 have been published on the CQC website.

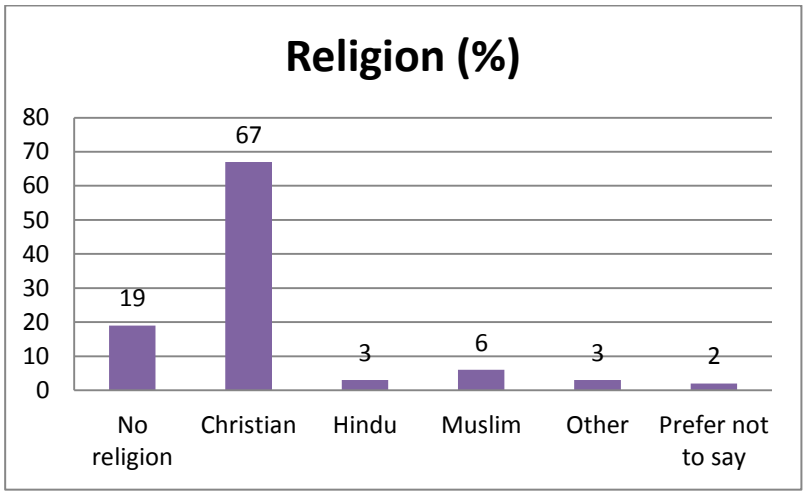
As part of the survey the Trust surveyed adult patients (over the age of 16 years) who had an inpatient stay at St George's hospital in July 2016. The sample size for the audit was 1,250 patients with 1200 patients being eligible for the survey, of which 455 returned a completed questionnaire, giving a response rate of 38%. This compares to an average of 44% response rates in all Trusts. There were 76 questions.

The demographic details of the patients who responded to the survey for St George's is as follows:

47% of respondents were male and 53% were female.







2.0 Methodology

The CQC weights the scores of each participating Trust by age, gender and route of admission. This is because it is known that people tend to answer questions in different ways depending on certain characteristics. For instance, younger respondents tend to be more critical than older respondents, females tend to be more critical than males, and emergency admissions tend to be more critical than elective admission. The weighting is applied so that each Trust, in effect, has the same age, gender and route of admission profile. This means that scores are then comparable across Trusts with different profiles. The benchmark report converts results into scores on a scale of 0 – 10. A score of 10 is the best possible score, and a higher score achieved indicates better performance. Analysis determines if the trust is performing **'better', 'worse'**, or 'about the '**same'** compared to other trusts

3.0 Overall results

The national CQC results demonstrate that we are "about the same" as other Trusts on the majority of questions apart from four for which we are "worse". It is particularly interesting to reflect on the results over the last six years (appendix 2). These demonstrate that little progress has been made in improving the patient's experience of using our services over this time and is clearly unacceptable.

This survey has highlighted positive aspects of the patient experience.

- Overall: 85% rated care 7+ out of 10.
- Overall: treated with respect and dignity 81%. (Score 8.9/10)
- Doctors: always had confidence and trust 80%. (Score 8.9/10)
- Hospital: room or ward was very/fairly clean 95%. (Score 8.5/10)
- Hospital: toilets and bathrooms were very/fairly clean 91%. (Score 8.1/10)
- Care: always enough privacy when being examined or treated 88%. (Score 9.3/10)

There is however clear areas for improvement with a detailed breakdown of the results for the Trust supplied in the appendix one.

The following questions are those that we scored worse than other Trusts:

- Did you ever use the same bathroom or shower areas as patients of the opposite sex?
- In your opinion, how clean was the hospital room or ward that you were in?
- Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way that you could understand?
- Did hospital staff discuss with you whether you would need any additional equipment on your home or any adaptations to your home, after leaving hospital?

4.0 Comparison with other Trusts

It is important to understand how local Trusts have scored as it provides opportunities to share best practice from other organisations which can help to make improvements which can impact on the overall patient experience. Comparison of Trusts results is shown in appendix 3.

5.0 Response to survey and actions to improve

As part of our agreement with the Picker Institute Europe (our survey contractor) they facilitated a workshop at the Trust which was well attended by staff across a number of disciplines. Work is underway led by the Deputy Chief Nurse to address areas of concern linking these to ongoing and planned Trust initiatives within the quality improvement plan in order to ensure that change is sustained and embedded.

Whilst it is acknowledged that work needs to be completed focusing on the questions for which the Trust is worse than expected, there are also a need to reflect and have plans to address over time steady improvement in all areas to move us away from being 'average'.

The following changes are being incorporated into the Trust Quality Improvement plan so that change can be monitored and there are appropriate leads and staff representation and engagement.

1. Infection Control and Review of Cleaning on wards

   Through the infection control work stream standards of cleaning will be reviewed and provision of a decant ward to allow a deep cleaning programme, and refurbishment plan to be initiated.

   In addition to this work the contract with our cleaning providers will be reviewed to ensure it meets the needs of the organisation.

   It is envisaged that this will impact on the following questions:
   - In your opinion how clean was the hospital room or ward you were in?
   - How clean were the toilets and bathrooms that you used in hospital?

2. Implementation of SAFER bundle

This will form part of the Patient Flow work stream. However the implementation of this bundle will not only improve flow, but places the patient at the centre of their discharge planning process. Each patient should have a clear predicted date of discharge and daily senior review. The patient will be included in the discharge plans from the point of discharge using a multi-professional team. In doing so aspects of the discharge plan will be addressed improving the question 'Did hospital staff discuss with you whether you would need any additional equipment in your home or any adaptations to your home, after leaving hospital?'

It is envisaged that this will impact on the following questions:
- When you had important questions to ask a doctor, did you get the answers you could understand?
- When you had important questions to ask a nurse, did you get the answers you could understand?
- In your opinion did the staff caring for you work well together?
- Were you involved as much as you wanted to be in decisions about your care and treatments?
- Did you have confidence in the decisions made about your condition or treatment?

- How much information about your condition or treatment was given to you?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Did you feel you were involved in decisions about your discharge from hospital?
- Were you given enough notice about when you were going to be discharged?
- After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?
- When you left hospital, did you know what would happen next with your care?
- Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?

3. Review of bathrooms within clinical areas

   A review of the bathroom facilities will be completed by the Estates and Facilities department, to establish the priorities for upgrading. It is anticipated that the poor results in the question 'Did you ever use the same bathroom or shower areas as patients of the opposite sex?' is due to the delays in fixing bathroom facilities in clinical areas, resulting in patients on occasions having to share facilities.

   In addition to the plans for a ward refurbishment programme there is now daily over sight of areas that have reported facilities not working which is reported to executive level.

6.0 Conclusion

These results when reviewed over the last 6 years demonstrate that our patients receive an average experience in most areas of the services that we provide.

7.0 Recommendation

The recommendation to the board is that the questions from the National Inpatient Survey are captured and addressed via the Quality Improvement Plan workstreams to ensure detailed level of focus and tracking by the Quality Delivery Board.

Patient survey report 2016

Survey of adult inpatients 2016

St George's University Hospitals NHS Foundation Trust

Survey of adult inpatients 2016

NHS patient survey programme
Survey of adult inpatients 2016

The Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care, and we encourage care services to improve. Our role is to register care providers, and to monitor, inspect and rate services. If a service needs to improve, we take action to make sure this happens. We speak with an independent voice, publishing regional and national views of the major quality issues in health and social care.

Survey of adult inpatients 2016

To improve the quality of services that the NHS delivers, it is important to understand what people think about their care and treatment. One way of doing this is by asking people who have recently used health services to tell us about their experiences.

The fourteenth survey of adult inpatients involved 149 acute and specialist NHS trusts. Responses were received from 77,850 people, a response rate of 44%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts sampled patients discharged during July 2016[1]. Trusts counted back from the last day of July 2016, including every consecutive discharge, until they had selected 1250 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2016). Fieldwork took place between September 2016 and January 2017.

Similar surveys of adult inpatients were also carried out in 2002 and annually from 2004 to 2015. They are part of a wider programme of NHS patient surveys, which cover a range of topics including A&E services, children's inpatient and day-case services, maternity services and community mental health services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

The Care Quality Commission will use the results from this survey in our regulation, monitoring and inspection of NHS acute trusts in England. We will use data from the survey in our system of CQC Insight, which provides inspectors with an assessment of risk in areas of care within an NHS trust that need to be followed up. The survey data will also be included in the data packs that we produce for inspections. NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health will hold them to account for the outcomes they achieve. The NHS Trust Development Authority will use the results to inform quality and governance activities as part of their Oversight Model for NHS Trusts.

Interpreting the report

This report shows how a trust scored for each question in the survey, compared with the range of results from all other trusts that took part. It uses an analysis technique called the '**expected range**' to determine if your trust is performing 'about the same', 'better' or 'worse' compared with other trusts. For more information, please see the 'methodology' section below. This approach is designed to help understand the performance of individual trusts, and to identify areas for improvement.

A 'section' score is also provided, labelled S1-S11 in the 'section scores'. The scores for each question are grouped according to the sections of the questionnaire, for example, 'the hospital and ward', 'doctors', 'nurses' and so forth.

This report shows the same data as published on the CQC website (http://www.cqc.org.uk/surveys/inpatient). The CQC website displays the data in a simplified way, identifying whether a trust performed 'better', 'worse' or 'about the same' as the majority of other trusts for each question and section.

[1] 43 trusts sampled additional months because of small patient throughputs or data quality issues.

Standardisation

Trusts have differing profiles of people who use their services. For example, one trust may have more male inpatients than another trust. This can potentially affect the results because people tend to answer questions in different ways, depending on certain characteristics. For example, older respondents tend to report more positive experiences than younger respondents, and women tend to report less positive experiences than men. This could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of people.

To account for this, we standardise the data. Results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-sex-admission type profile reflects the national age-sex-admission type distribution (based on all of the respondents to the survey). Standardisation therefore enables a more accurate comparison of results from trusts with different population profiles. In most cases this will not have a large impact on trust results; it does, however, make comparisons between trusts as fair as possible.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing.

It is not appropriate to score all questions in the questionnaire as not all of the questions assess the trusts. For example, they may be descriptive questions such as Q1 asking respondents if their inpatient stay was planned in advance or an emergency; or they may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question would be Q45 "During your stay in hospital, did you have an operation or procedure?" For full details of the scoring please see the technical document (see further information section).

Graphs

The graphs in this report show how the score for the trust compares to the range of scores achieved by all trusts taking part in the survey. The black diamond shows the score for your trust. The graph is divided into three sections:

- If your trust's score lies in the orange section of the graph, its result is 'about the same' as most other trusts in the survey.
- If your trust's score lies in the red section of the graph, its result is 'worse' compared with most other trusts in the survey.
- If your trust's score lies in the green section of the graph, its result is 'better' compared with most other trusts in the survey.

The text to the right of the graph states whether the score for your trust is 'better' or 'worse' compared with most other trusts in the survey. If there is no text the score is 'about the same'. These groupings are based on a rigorous statistical analysis of the data, as described in the following 'methodology' section.

Methodology

The 'about the same,' 'better' and 'worse' categories are based on an analysis technique called the '**expected range**' which determines the range within which the trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust and the scores for all other trusts. If the trust's performance is outside of this range, it means that it performs significantly above/below what would be expected. If it is within this range, we say that its performance is 'about the same'. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, it is very unlikely to have occurred by chance.

In some cases there will be no red and/or no green area in the graph. This happens when the expected range for your trust is so broad it encompasses either the highest possible score for all trusts (no green section) or the lowest possible for all trusts score (no red section). This could be because there were few respondents and / or a lot of variation in their answers.

Please note that if fewer than 30 respondents have answered a question, no score will be displayed for this question (or the corresponding section). This is because the uncertainty around the result is too great. A technical document providing more detail about the methodology and the scoring applied to each question is available on the CQC website (see further information section).

Tables

At the end of the report you will find tables containing the data used to create the graphs. These tables also show the response rate for your trust and background information about the people that responded.

Scores from last year's survey are also displayed. The column called 'change from 2015' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2015. A statistically significant difference means that the change in the results is very unlikely to have occurred by chance. Significance is tested using a two-sample t-test.

Where a result for 2015 is not shown, this is because the question was either new this year, or the question wording and/or the response categories have been changed. It is therefore not possible to compare the results as we do not know if any change is caused by alterations in the survey instrument, or variation in a trust's performance. Comparisons are also not able to be shown if a trust has merged with other trusts since the 2015 survey, or if a trust committed a sampling error in 2015. Please note that comparative data are not shown for sections as the questions contained in each section can change year on year.

Notes on specific questions

Please note that a variety of acute trusts take part in this survey and not all questions are applicable to every trust. The section below details modifications to certain questions, in some cases this will apply to all trusts, in other cases only to some trusts.

All trusts

Q11 and Q13: The information collected by Q11 "When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?" and Q13 "After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?" are presented together to show whether the patient has ever shared a sleeping area with patients of the opposite sex. The combined question is numbered in this report as Q11 and has been reworded as "Did you ever share a sleeping area with patients of the opposite sex?" Please note that the information based on Q11 cannot be compared to similar information collected from surveys prior to 2006. This is due to a change in the question's wording and because the results for 2006 onwards have excluded patients who have stayed in a critical care area, which almost always accommodates patients of both sexes.

Q20: This question (Q20 in 2015 inpatient questionnaire), "Were hand-wash gels available for patients and visitors to use?" was removed from the 2016 survey because it was found there was very little differentiation between trusts, as well as the fact that there had been little movement over time.

Q20, Q21 and Q32: "Did you get enough help from staff to wash or keep yourself clean?", "If you brought your own medication with you to hospital, were you able to take it when you needed to?" and "Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)" are new questions in 2016 and it is therefore not possible to compare with 2015.

Q55 and Q56: The information collected by Q55 "On the day you left hospital, was your discharge delayed for any reason?" and Q56 "What was the main reason for the delay?" are presented together to show whether a patient's discharge was delayed by reasons attributable to the hospital. The combined question in this report is labelled as Q56 and is worded as: "Discharge delayed due to wait for medicines/to see doctor/for ambulance."

Q57: Information from Q55 and Q56 has been used to score Q57 "How long was the delay?" This assesses the length of a delay to discharge for reasons attributable to the hospital.

Q60: "When you left hospital, did you know what would happen next with your care?" was part of the 2015 survey and was redeveloped for 2016 (Q58 in the 2015 inpatient questionnaire).

Trusts with female patients only

Q11, Q13 and Q14: If your trust offers services to women only, a trust score for Q11 "Did you ever share a sleeping area with patients of the opposite sex?", Q13 “After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?” and Q14 "While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?" is not shown.

Trusts with no A&E Department

Q3 and Q4: The results to these questions are not shown for trusts that do not have an A&E Department.

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):
http://www.cqc.org.uk/inpatientsurvey

The results for the adult inpatient surveys from 2002 to 2015 can be found at:
http://www.nhssurveys.org/surveys/425

Full details of the methodology of the survey can be found at:
http://www.nhssurveys.org/surveys/935

More information on the programme of NHS patient surveys is available at:
http://www.cqc.org.uk/content/surveys

More information about how CQC monitors hospitals is available on the CQC website at:
http://www.cqc.org.uk/content/monitoring-nhs-acute-hospitals

Survey of adult inpatients 2016

St George's University Hospitals NHS Foundation Trust

Section scores

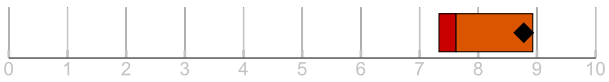
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2016

St George's University Hospitals NHS Foundation Trust

The Emergency/A&E Department (answered by emergency patients only)

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?



Q4. Were you given enough privacy when being examined or treated in the A&E Department?

Waiting list and planned admissions (answered by those referred to hospital)

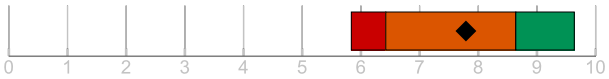
Q6. How do you feel about the length of time you were on the waiting list?

Q7. Was your admission date changed by the hospital?

Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?

Waiting to get to a bed on a ward

Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

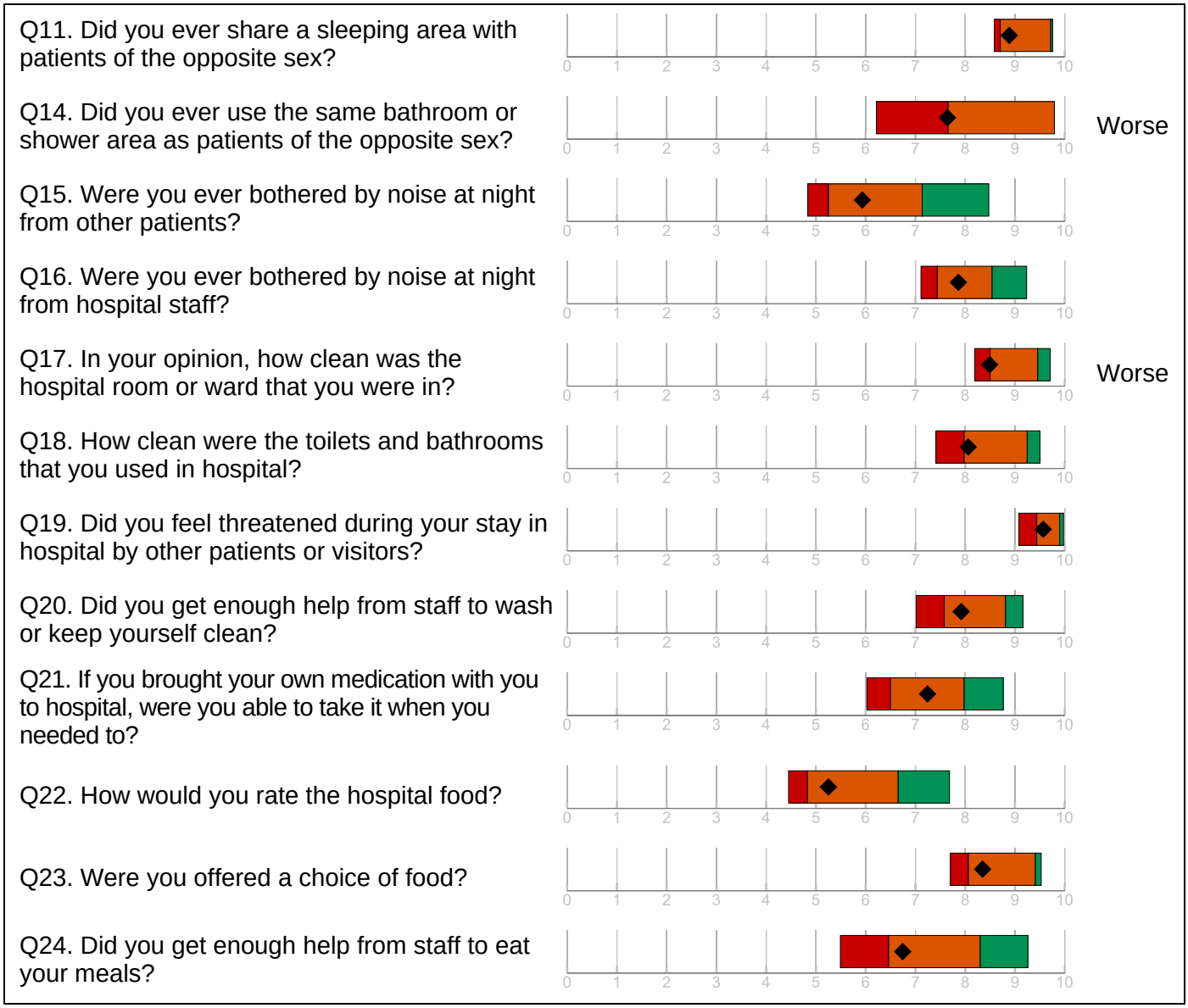


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

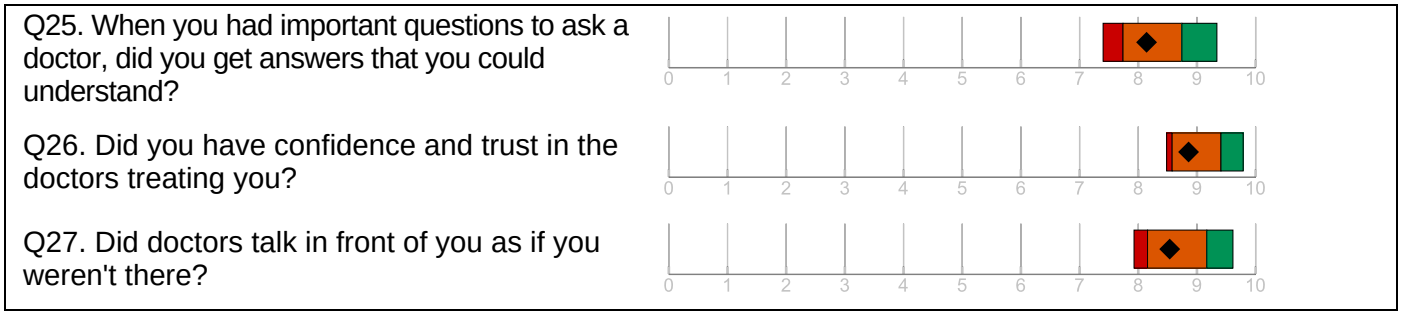
Survey of adult inpatients 2016

St George's University Hospitals NHS Foundation Trust

The hospital and ward



Doctors



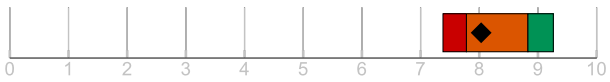
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2016

St George's University Hospitals NHS Foundation Trust

Nurses

Q28. When you had important questions to ask a nurse, did you get answers that you could understand?

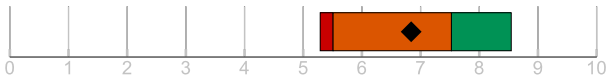


Q29. Did you have confidence and trust in the nurses treating you?

Q30. Did nurses talk in front of you as if you weren't there?

Q31. In your opinion, were there enough nurses on duty to care for you in hospital?

Q32. Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)

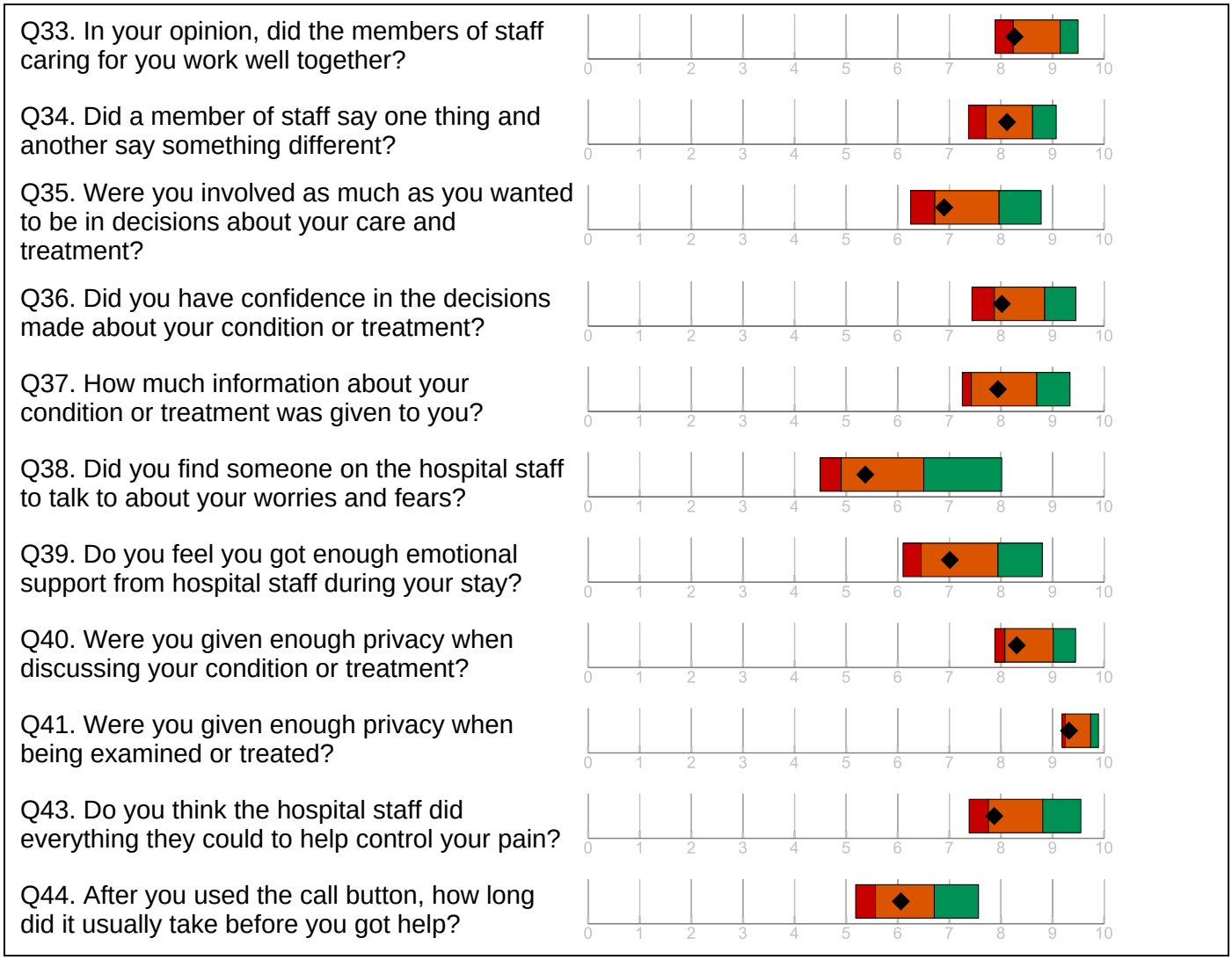


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2016

St George's University Hospitals NHS Foundation Trust

Care and treatment



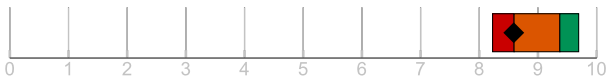
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2016

St George's University Hospitals NHS Foundation Trust

Operations and procedures (answered by patients who had an operation or procedure)

Q46. Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?



Worse

Q47. Did a member of staff explain what would be done during the operation or procedure?

Q48. Did a member of staff answer your questions about the operation or procedure?

Q49. Were you told how you could expect to feel after you had the operation or procedure?

Q51. Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?

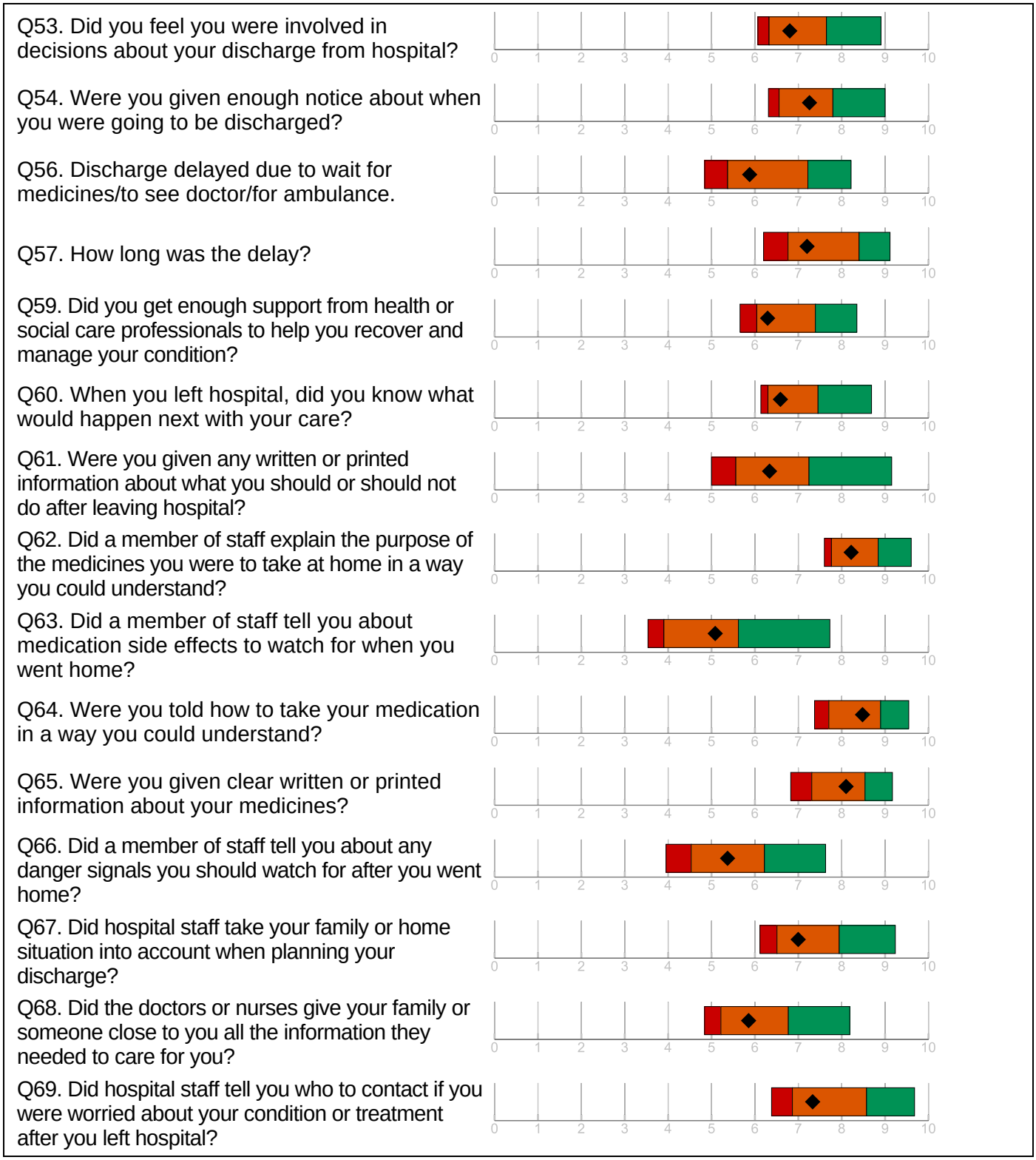
Q52. Afterwards, did a member of staff explain how the operation or procedure had gone?

Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2016

St George's University Hospitals NHS Foundation Trust

Leaving hospital



Best performing trusts

About the same

Worst performing trusts

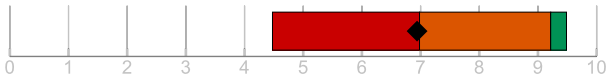
'Better/Worse' Only displayed when this trust is better/worse than most other trusts

◆ This trust's score (NB: Not shown where there are fewer than 30 respondents)

Survey of adult inpatients 2016

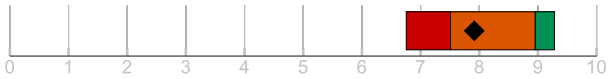
St George's University Hospitals NHS Foundation Trust

Q70. Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?



Worse

Q71. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?



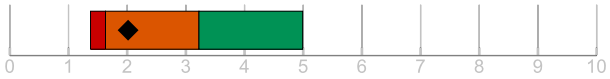
Overall views of care and services

Q72. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Q73. During your time in hospital did you feel well looked after by hospital staff?

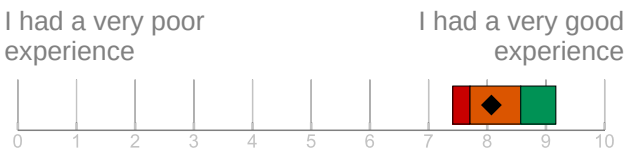
Q75. During your hospital stay, were you ever asked to give your views on the quality of your care?

Q76. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Overall experience

Q74. Overall...



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2016

St George's University Hospitals NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
The Emergency/A&E Department (answered by emergency patients only)							
S1	Section score	8.8	7.7	9.0			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.8	7.3	8.9	201	9.0	
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	8.8	7.8	9.4	216	9.1	
Waiting list and planned admissions (answered by those referred to hospital)							
S2	Section score	8.7	8.2	9.6			
Q6	How do you feel about the length of time you were on the waiting list?	8.3	6.9	9.7	198	7.9	
Q7	Was your admission date changed by the hospital?	9.0	8.2	9.7	203	8.9	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	8.9	8.4	9.6	200	9.0	
Waiting to get to a bed on a ward							
S3	Section score	7.8	5.8	9.6			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.8	5.8	9.6	438	7.3	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

St George's University Hospitals NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
The hospital and ward							
S4	Section score	7.7	7.3	9.0			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	8.9	8.6	9.8	302	9.2	
Q14	Did you ever use the same bathroom or shower area as patients of the opposite sex?	7.6	6.2	9.8	378	8.1	
Q15	Were you ever bothered by noise at night from other patients?	5.9	4.8	8.5	440	5.9	
Q16	Were you ever bothered by noise at night from hospital staff?	7.9	7.1	9.2	441	7.9	
Q17	In your opinion, how clean was the hospital room or ward that you were in?	8.5	8.2	9.7	445	8.5	
Q18	How clean were the toilets and bathrooms that you used in hospital?	8.1	7.4	9.5	414	7.8	
Q19	Did you feel threatened during your stay in hospital by other patients or visitors?	9.6	9.1	10.0	445	9.7	
Q20	Did you get enough help from staff to wash or keep yourself clean?	7.9	7.0	9.2	287		
Q21	If you brought your own medication with you to hospital, were you able to take it when you needed to?	7.2	6.0	8.8	243		
Q22	How would you rate the hospital food?	5.3	4.5	7.7	426	5.7	
Q23	Were you offered a choice of food?	8.3	7.7	9.5	434	8.2	
Q24	Did you get enough help from staff to eat your meals?	6.7	5.5	9.3	131	7.2	
Doctors							
S5	Section score	8.5	8.0	9.5			
Q25	When you had important questions to ask a doctor, did you get answers that you could understand?	8.1	7.4	9.3	408	8.3	
Q26	Did you have confidence and trust in the doctors treating you?	8.9	8.5	9.8	441	9.0	
Q27	Did doctors talk in front of you as if you weren't there?	8.5	7.9	9.6	440	8.2	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

St George's University Hospitals NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Nurses							
S6	Section score	8.0	7.3	9.1			
Q28	When you had important questions to ask a nurse, did you get answers that you could understand?	8.0	7.4	9.3	383	8.1	
Q29	Did you have confidence and trust in the nurses treating you?	8.5	8.2	9.5	447	8.6	
Q30	Did nurses talk in front of you as if you weren't there?	8.7	8.1	9.7	443	8.6	
Q31	In your opinion, were there enough nurses on duty to care for you in hospital?	7.8	6.4	9.0	443	7.6	
Q32	Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	6.8	5.3	8.5	443		
Care and treatment							
S7	Section score	7.6	7.1	8.9			
Q33	In your opinion, did the members of staff caring for you work well together?	8.3	7.9	9.5	418	8.6	↓
Q34	Did a member of staff say one thing and another say something different?	8.1	7.4	9.1	444	8.0	
Q35	Were you involved as much as you wanted to be in decisions about your care and treatment?	6.9	6.3	8.8	444	7.4	↓
Q36	Did you have confidence in the decisions made about your condition or treatment?	8.0	7.4	9.5	446	8.5	↓
Q37	How much information about your condition or treatment was given to you?	7.9	7.3	9.3	441	8.2	
Q38	Did you find someone on the hospital staff to talk to about your worries and fears?	5.4	4.5	8.0	278	5.7	
Q39	Do you feel you got enough emotional support from hospital staff during your stay?	7.0	6.1	8.8	268	7.1	
Q40	Were you given enough privacy when discussing your condition or treatment?	8.3	7.9	9.4	437	8.7	
Q41	Were you given enough privacy when being examined or treated?	9.3	9.2	9.9	438	9.4	
Q43	Do you think the hospital staff did everything they could to help control your pain?	7.9	7.4	9.5	275	8.2	
Q44	After you used the call button, how long did it usually take before you got help?	6.1	5.2	7.6	253	6.3	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

St George's University Hospitals NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Operations and procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.3	7.9	9.1			
Q46	Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	8.6	8.2	9.7	265	8.9	
Q47	Did a member of staff explain what would be done during the operation or procedure?	8.6	7.9	9.2	264	8.3	
Q48	Did a member of staff answer your questions about the operation or procedure?	8.7	8.1	9.5	238	8.6	
Q49	Were you told how you could expect to feel after you had the operation or procedure?	7.0	6.4	8.5	267	7.1	
Q51	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	8.7	8.7	9.5	232	8.9	
Q52	Afterwards, did a member of staff explain how the operation or procedure had gone?	7.9	7.2	9.0	264	7.8	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

St George's University Hospitals NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Leaving hospital							
S9	Section score	6.9	6.3	8.5			
Q53	Did you feel you were involved in decisions about your discharge from hospital?	6.8	6.1	8.9	411	6.5	
Q54	Were you given enough notice about when you were going to be discharged?	7.3	6.3	9.0	437	6.8	
Q56	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	5.9	4.8	8.2	416	6.0	
Q57	How long was the delay?	7.2	6.2	9.1	410	7.2	
Q59	Did you get enough support from health or social care professionals to help you recover and manage your condition?	6.3	5.7	8.3	236	6.6	
Q60	When you left hospital, did you know what would happen next with your care?	6.6	6.1	8.7	392		
Q61	Were you given any written or printed information about what you should or should not do after leaving hospital?	6.3	5.0	9.2	422	6.1	
Q62	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.2	7.6	9.6	327	8.1	
Q63	Did a member of staff tell you about medication side effects to watch for when you went home?	5.1	3.5	7.7	281	4.8	
Q64	Were you told how to take your medication in a way you could understand?	8.5	7.4	9.5	301	8.1	
Q65	Were you given clear written or printed information about your medicines?	8.1	6.8	9.2	302	8.1	
Q66	Did a member of staff tell you about any danger signals you should watch for after you went home?	5.4	4.0	7.6	334	5.3	
Q67	Did hospital staff take your family or home situation into account when planning your discharge?	7.0	6.1	9.2	277	6.9	
Q68	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	5.9	4.8	8.2	302	6.1	
Q69	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.3	6.4	9.7	384	7.3	
Q70	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	6.9	4.5	9.5	120	7.3	
Q71	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	7.9	6.8	9.3	234	8.2	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

St George's University Hospitals NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Overall views of care and services							
S10	Section score	5.4	4.8	6.9			
Q72	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	8.9	8.5	9.8	440	9.1	
Q73	During your time in hospital did you feel well looked after by hospital staff?	8.8	8.3	9.7	440	8.9	
Q75	During your hospital stay, were you ever asked to give your views on the quality of your care?	2.0	0.9	4.4	388	2.3	
Q76	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.0	1.4	5.0	340	2.2	
Overall experience							
S11	Section score	8.1	7.4	9.2			
Q74	Overall...	8.1	7.4	9.2	423	8.1	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016
St George's University Hospitals NHS Foundation Trust

Background information

The sample	This trust	All trusts
Number of respondents	453	77850
Response Rate (percentage)	38	44

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	47	47
Female	53	53
Age group (percentage)	(%)	(%)
Aged 16-35	6	5
Aged 36-50	13	9
Aged 51-65	22	23
Aged 66 and older	58	63
Ethnic group (percentage)	(%)	(%)
White	69	90
Multiple ethnic group	1	1
Asian or Asian British	9	3
Black or Black British	8	1
Arab or other ethnic group	1	0
Not known	12	5
Religion (percentage)	(%)	(%)
No religion	19	16
Buddhist	0	0
Christian	67	77
Hindu	3	1
Jewish	0	0
Muslim	6	2
Sikh	0	0
Other religion	3	1
Prefer not to say	2	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	90	94
Gay/lesbian	2	1
Bisexual	1	0
Other	1	1
Prefer not to say	6	4

2016 Inpatient Survey: St George's Healthcare NHS Trust

Question & Section	Score & change
The Emergency/A&E department (answered by emergency patients only)	**8.8**
While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.8
Were you given enough privacy when being examined or treated in the A&E Department?	8.8

Waiting list and planned admissions (answered by those referred to hospital)	**8.7**
How do you feel about the length of time you were on the waiting list before your admission to hospital?	8.3
Was your admission date changed by the hospital?	9.0
In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who	8.9

Waiting to get a bed on a ward	**7.8**
From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.8

The hospital and ward	**7.7**
When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?	8.9
While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?	7.6
Were you ever bothered by noise at night from other patients?	5.9
Were you ever bothered by noise at night from hospital staff?	7.9
In your opinion, how clean was the hospital room or ward that you were in?	8.5
How clean were the toilets and bathrooms that you used in hospital?	8.1
Did you feel threatened during your stay in hospital by other patients or visitors?	9.6
Did you get enough help from staff to wash or keep yourself clean?	7.9
If you brought your own medication with you to hospital, were you able to take it when you needed to?	7.2
How would you rate the hospital food?	5.3
Were you offered a choice of food?	8.3
Did you get enough help from staff to eat your meals?	6.7

Doctors	**8.5**
When you had important questions to ask a doctor, did you get answers that you could understand?	8.1
Did you have confidence and trust in the doctors treating you?	8.9
Did doctors talk in front of you as if you weren't there?	8.5

Question & Section	Score & change
Nurses	**8.0**
When you had important questions to ask a nurse, did you get answers that you could understand?	8.0
Did you have confidence and trust in the nurses treating you?	8.5
Did nurses talk in front of you as if you weren't there?	8.7
In your opinion, were there enough nurses on duty to care for you in hospital?	7.8
Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	6.8

Care and treatment	**7.6**
In your opinion, did the members of staff caring for you work well together?	8.3
Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	8.1
Were you involved as much as you wanted to be in decisions about your care and treatment?	6.9
Did you have confidence in the decisions made about your condition or treatment?	8.0
How much information about your condition or treatment was given to you?	7.9
Did you find someone on the hospital staff to talk to about your worries and fears?	5.4
Do you feel you got enough emotional support from hospital staff during your stay?	7.0
Were you given enough privacy when discussing your condition or treatment?	8.3
Were you given enough privacy when being examined or treated?	9.3
Do you think the hospital staff did everything they could to help control your pain?	7.9
How many minutes after you used the call button did it usually take before you got the help you needed?	6.1

Operations and procedures (answered by patients who had an operation or procedure)	**8.3**
Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	8.6
Beforehand, did a member of staff explain what would be done during the operation or procedure?	8.6
Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	8.7
Beforehand, were you told how you could expect to feel after you had the operation or procedure?	7.0
Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way	8.7
After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	7.9

Commentary

Of the 11 sections within the survey, the trust are positive outlier in 0 & negative outlier in 4.

Of the 65 question within the survey, the trust are positive outlier in 0 & negative outlier in 0.

Question & Section	Score & change
Leaving hospital	**6.9**
Did you feel you were involved in decisions about your discharge from hospital?	6.8
Were you given enough notice about when you were going to be discharged?	7.3
What was the MAIN reason for the delay?	5.9
How long was the delay?	7.2
After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?	6.3
When you left hospital, did you know what would happen next with your care?	6.6
Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	6.3
Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.2
Did a member of staff tell you about medication side effects to watch for when you went home?	5.1
Were you told how to take your medication in a way you could understand?	8.5
Were you given clear written or printed information about your medicines?	8.1
Did a member of staff tell you about any danger signals you should watch for after you went home?	5.4
Did hospital staff take your family or home situation into account when planning your discharge?	7.0
Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?	5.9
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.3
Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving	6.9
Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (e.g. services from a GP,	7.9

Overall view of care and services	**5.4**
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	8.9
During your time in hospital did you feel well looked after by hospital staff?	8.8
During your hospital stay, were you ever asked to give your views on the quality of your care?	2.0
Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.0

Overall experience	**8.1**
Overall...	8.1

Key

Compared to 2015 survey
Better
About the same
Worse

Compared to other trusts	
Better	x
About the same	x
Worse	x

St George's Healthcare NHS Trust

CQC Inpatient Survey, comparison of responses for most recent 6 surveys

Question	2011		2012		2013		2014		2015		2016
While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.8	⇨	8.7	⇨	8.5	⇨	8.2	⇧	9.0	⇨	8.8
Were you given enough privacy when being examined or treated in the A&E Department?	8.7	⇨	8.8	⇨	8.8	⇨	9.0	⇨	9.1	⇨	8.8
How do you feel about the length of time you were on the waiting list before your admission to hospital?	7.8	⇨	8.3	⇨	8.5	⇨	8.2	⇨	7.9	⇨	8.3
Was your admission date changed by the hospital?	9.2	⇨	8.9	⇨	9.1	⇨	8.9	⇨	8.9	⇨	9.0
In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?	Not asked		9.4		9.1	⇨	8.6	⇨	9.0	⇨	8.9
From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.2	⇨	7.2	⇨	7.6	⇨	7.2	⇨	7.3	⇨	7.8
When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?	9.2	⇨	9.1	⇨	9.5	⇨	9.1	⇨	9.2	⇨	8.9
While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?	7.7	⇨	7.8	⇨	7.8	⇨	7.9	⇨	8.1	⇨	7.6
Were you ever bothered by noise at night from other patients?	6.0	⇨	6.0	⇨	5.9	⇨	5.6	⇨	5.9	⇨	5.9
Were you ever bothered by noise at night from hospital staff?	7.8	⇨	8.0	⇨	7.7	⇨	7.8	⇨	7.9	⇨	7.9
In your opinion, how clean was the hospital room or ward that you were in?	8.7	⇨	8.7	⇨	8.7	⇨	8.5	⇨	8.5	⇨	8.5
How clean were the toilets and bathrooms that you used in hospital?	8.1	⇨	7.9	⇨	8.1	⇨	7.9	⇨	7.8	⇨	8.1
Did you feel threatened during your stay in hospital by other patients or visitors?	9.7	⇨	9.8	⇩	9.5	⇧	9.8	⇨	9.7	⇨	9.6
Did you get enough help from staff to wash or keep yourself clean?	Not asked		Not asked		Not asked		Not asked		Not asked		7.9
If you brought your own medication with you to hospital, were you able to take it when you needed to?	Not asked		Not asked		Not asked		Not asked		Not asked		7.2
How would you rate the hospital food?	5.3	⇨	5.4	⇨	5.2	⇨	5.6	⇨	5.7	⇨	5.3
Were you offered a choice of food?	8.5	⇨	8.8	⇨	8.6	⇨	8.4	⇨	8.2	⇨	8.3
Did you get enough help from staff to eat your meals?	6.8	⇨	7.2	⇨	7.0	⇨	6.8	⇨	7.2	⇨	6.7
When you had important questions to ask a doctor, did you get answers that you could understand?	8.2	⇨	8.3	⇨	8.3	⇨	8.2	⇨	8.3	⇨	8.1
Did you have confidence and trust in the doctors treating you?	8.9	⇨	9.1	⇨	8.9	⇨	8.7	⇨	9.0	⇨	8.9
Did doctors talk in front of you as if you weren't there?	8.4	⇨	8.5	⇨	8.3	⇨	8.7	⇩	8.2	⇨	8.5
When you had important questions to ask a nurse, did you get answers that you could understand?	7.7	⇨	8.1	⇨	7.9	⇨	8.1	⇨	8.1	⇨	8.0
Did you have confidence and trust in the nurses treating you?	8.3	⇨	8.5	⇨	8.4	⇨	8.2	⇨	8.6	⇨	8.5
Did nurses talk in front of you as if you weren't there?	8.4	⇨	8.7	⇨	8.7	⇨	8.9	⇨	8.6	⇨	8.7
In your opinion, were there enough nurses on duty to care for you in hospital?	7.7	⇨	7.7	⇨	7.6	⇨	7.8	⇨	7.6	⇨	7.8
Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	Not asked		Not asked		Not asked		Not asked		Not asked		6.8
In your opinion, did the members of staff caring for you work well together?	Not asked		Not asked		Not asked		Not asked		8.6	⇩	8.3
Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	7.9	⇨	8.2	⇨	7.9	⇨	8.2	⇨	8.0	⇨	8.1
Were you involved as much as you wanted to be in decisions about your care and treatment?	7.0	⇨	7.2	⇨	7.4	⇨	7.2	⇨	7.4	⇩	6.9
Did you have confidence in the decisions made about your condition or treatment?	Not asked		Not asked		Not asked		Not asked	⇨	8.5	⇩	8.0
How much information about your condition or treatment was given to you?	7.8	⇨	8.3	⇨	8.2	⇨	8.1	⇨	8.2	⇨	7.9
Did you find someone on the hospital staff to talk to about your worries and fears?	5.6	⇨	5.2	⇧	6.0	⇨	5.4	⇨	5.7	⇨	5.4
Do you feel you got enough emotional support from hospital staff during your stay?	6.6	⇨	7.1	⇨	6.9	⇨	7.1	⇨	7.1	⇨	7.0
Were you given enough privacy when discussing your condition or treatment?	8.2	⇨	8.4	⇨	8.3	⇨	8.6	⇨	8.7	⇨	8.3
Were you given enough privacy when being examined or treated?	9.4	⇨	9.4	⇨	9.4	⇨	9.4	⇨	9.4	⇨	9.3
Do you think the hospital staff did everything they could to help control your pain?	8.3	⇨	8.3	⇨	8.2	⇨	8.2	⇨	8.2	⇨	7.9
How many minutes after you used the call button did it usually take before you got the help you needed?	6.1	⇨	6.3	⇨	6.3	⇨	6.3	⇨	6.3	⇨	6.1
Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	8.7	⇨	8.9	⇨	8.5	⇨	8.8	⇨	8.9	⇨	8.6
Beforehand, did a member of staff explain what would be done during the operation or procedure?	8.3	⇨	8.4	⇨	8.2	⇨	8.6	⇨	8.3	⇨	8.6
Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	8.4	⇨	8.8	⇨	8.4	⇨	8.8	⇨	8.6	⇨	8.7
Beforehand, were you told how you could expect to feel after you had the operation or procedure?	6.9	⇨	6.6	⇨	6.5	⇨	7.2	⇨	7.1	⇨	7.0
Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way you could understand?	8.7	⇨	8.9	⇨	8.8	⇨	8.9	⇨	8.9	⇨	8.7
After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	7.8	⇨	7.4	⇨	7.7	⇨	8.2	⇨	7.8	⇨	7.9
Did you feel you were involved in decisions about your discharge from hospital?	6.6		6.4	⇨	6.6	⇨	6.9	⇨	6.5	⇨	6.8
Were you given enough notice about when you were going to be discharged?	Not asked		7.1	⇨	7.1	⇨	7.2	⇨	6.8	⇨	7.3
What was the MAIN reason for the delay?	5.4	⇨	5.3	⇨	5.4	⇧	6.3	⇨	6.0	⇨	5.9
How long was the delay?	7.1	⇨	6.8	⇨	7.0	⇨	7.4	⇨	7.2	⇨	7.2
After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?	Not asked		Not asked		Not asked		Not asked		6.6	⇨	6.3
When you left hospital, did you know what would happen next with your care?	Not asked		Not asked		Not asked		Not asked		Not asked		6.6
Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	6.3	⇨	6.8	⇨	6.4	⇨	6.9	⇩	6.1	⇨	6.3
Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.4	⇨	8.6	⇨	8.4	⇨	8.5	⇨	8.1	⇨	8.2
Did a member of staff tell you about medication side effects to watch for when you went home?	4.6	⇨	5.0	⇨	4.6	⇨	5.3	⇨	4.8	⇨	5.1
Were you told how to take your medication in a way you could understand?	8.3	⇨	8.4	⇨	8.5	⇨	8.5	⇨	8.1	⇨	8.5
Were you given clear written or printed information about your medicines?	7.7		8.1	⇨	8.1	⇨	8.3	⇨	8.1	⇨	8.1
Did a member of staff tell you about any danger signals you should watch for after you went home?	5.1	⇨	4.7	⇧	5.6	⇨	5.5	⇨	5.3	⇨	5.4
Did hospital staff take your family or home situation into account when planning your discharge?	Not asked		7.1	⇨	7.3	⇨	7.0	⇨	6.9	⇨	7.0
Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?	5.6	⇨	5.8	⇨	6.2	⇨	6.5	⇨	6.1	⇨	5.9
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.5	⇨	7.5	⇨	8.1	⇨	7.7	⇨	7.3	⇨	7.3
Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?	Not asked		7.6	⇨	7.4	⇨	7.5	⇨	7.3	⇨	6.9
Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (e.g. services from a GP, physiotherapist or community nurse,	Not asked		8.6	⇨	7.9	⇨	8.6	⇨	8.2	⇨	7.9
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	8.8	⇨	8.8	⇨	8.9	⇨	8.8	⇨	9.1	⇨	8.9
During your time in hospital did you feel well looked after by hospital staff?	Not asked		Not asked		Not asked		Not asked	⇨	8.9	⇨	8.8
Overall...	7.9		8.0	⇨	8.0	⇨	8.0	⇨	8.1	⇨	8.1
During your hospital stay, were you ever asked to give your views on the quality of your care?	1.3	⇨	1.8	⇨	1.8	⇨	2.3	⇨	2.3	⇨	2.0
Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	4.0		2.0	⇨	2.0	⇨	2.1	⇨	2.2	⇨	2.0

Key

- Positive Outlier
- Negative Outlier
- No data available for trust
- Not asked — No equivalent question this year

- ⇧ Significantly better than previous year
- ⇨ No significant change
- ⇩ Significantly worse the previous year
- No data available*

* In a few cases the CQC didn't provide data for change significance

Appendix 4

St George's University Hospitals NHS
NHS Foundation Trust

National Inpatient Survey 2016 – comparison with other London Trusts

Survey section	Highest Trust Score (out of 10)	Lowest Trust Score (out of 10)	St George's University Hospitals NHS Foundation Trust	University College London Hospitals NHS Foundation Trust	Guy's and St Thomas' NHS Foundation Trust	Croydon Health Services NHS Trust	Epsom and St Helier University Hospitals	Imperial College Healthcare NHS Trust	Chelsea and Westminster NHS Foundation Trust
The Emergency/A&E Department answered by emergency patients only	8.9	8.1	8.8	8.9	8.8	8.1	8.6	8.5	8.8
Waiting lists and planned admissions answered by those referred to hospital	9.1	8.4	8.7	9.0	9.1	8.7	8.9	8.7	8.4
Waiting to get a bed on a ward	8.1	7.0	7.8	7.3	8.1	7.1	7.2	7.0	7.5
The hospital and ward	8.2	7.5	7.7	8.2	8.3	7.5	8.1	7.8	7.8
Doctors	8.8	8.4	8.5	8.8	8.8	8.4	8.5	8.5	8.5
Nurses	8.4	7.4	8.0	8.3	8.4	7.4	7.9	7.8	7.7
Care and Treatment	8.0	7.2	7.6	7.9	8.0	7.2	7.7	7.7	7.6
Operations and procedures answered by patients who had an operation or procedure	8.6	8.1	8.3	8.6	8.5	8.1	8.5	8.3	8.5
Leaving hospital	7.2	6.7	6.9	7.0	7.2	6.3	7.1	6.7	7.0
Overall views of care and services	6.0	5.3	5.4	6.0	5.3	5.5	5.3	5.5	5.3
Overall experience	8.4	7.6	8.1	8.4	8.0	7.6	8.0	8.2	8.1

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	6 July 2017	**Agenda No**	**4.1**
Report Title:	Month 2 (May 2017) Financial Performance		
Lead Director/ Manager:	Andrew Grimshaw, CFO		
Report Author:	Anna D'Alessandro, Director Financial Performance		
Freedomof Information Act (FOIA) Status:	Restricted		
Presented for:	Assurance		
Executive Summary:	This report updates the Committee on the financial performance for Month 2 (May 2017) including actions underway as a response to under-delivery.		
Recommendation:	The Committee is asked to receive the update and confirm agreement to next steps.		
Supports			
Trust Strategic Objective:	Deliver our Transformation Plan enabling the Trust to meet its operational and financial targets.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Finance and Use of Resources		
Implications			
Risk:	**BAF Risk 6**: Failing to Deliver the Financial Plan		
Legal/Regulatory:			
Resources:			
Previously Considered by:	Financial & Performance Committee	**Date**	28/06/17
Equality Impact Assessment:			
Appendices:	None		

Executive Summary
Month 2 (May 2017) Financial Performance

Month 2 (May) 2017/18 Financial Performance - Headlines

1. The detailed M1 financial tables are attached to this report. Against a planned deficit of £2.1M, we achieved an actual in-month deficit of £5.7M, therefore we did not deliver the plan by £3.6M. The combined M1 and M2 positions take our cumulative/YTD deficit to £17.9M, which is worse than plan.
2. The M2 shortfall to plan (£3.6M) is comprised of three key elements as shown in in **Tables 1 & 2** below:
    - The benefit of a significant amount of M1 income catch up **(Table 1);**
    - CIP shortfall/non-delivery **(Table 1)**. The unallocated/undelivered CIP is phased in equal 1/12ths, hence the £4.1M of the variance is due to this CIP shortfall. The £4.1M shortfall is against; SLA Income £2.1M, Pay £1.8M and Non-Pay £0.2M; and
    - Baseline income shortfall of £1.7M **(Table 2).**

Table 1 – M2 Financial Performance Headlines

	£M
M2 Plan Deficit	-2.1
M2 Actual Deficit	-5.7
M2 Variance (worse) to Plan	**-3.6**
Explained by:	
M1 Income catch-up M1 Flex plus	2.2
CIP non-delivery	-4.1
Baseline shortfall	-1.7
M2 Variance (worse) to Plan	**-3.6**

Table 2 – M2 Baseline Shortfall

	Pass through £M	**Other £M**	**Total £M**
Income	-0.9	-2.1	-3.0
Pay	0.0	0.6	0.6
Non-Pay	0.9	-0.2	0.7
(worse)/better	**0**	**-1.7**	**-1.7**

3. The **M2 underlying deficit is £6.9M**. The reported M2 deficit of £5.7M is adjusted for one-off items including: £2.2M M1 flex income recovery; £0.5M FSM consulting support; non-recurrent Elective Care Recovery Programme/RTT costs £0.4M; £0.4M RTT non-reporting costs and £0.2M working days adjustment. This compares to M1 underlying deficit of £5.6M and represents a £1.3M deterioration which is driven mainly by income.

Total Income (SLA and Other):

4. The £3M adverse income variance against the baseline is shown as SLA income £2.7M and other income £0.3M.
5. **Table 3** below shows the price and volume mix for M1 and M2 which have been restated for the "Flex plus" income, reported in M2 but part of M1 activity.
6. In M2, of the £2.7M adverse baseline SLA income variance, £0.6M is price (over 80% in Elective and remainder in Non-Elective), £1.2M is activity (over half in Elective, mainly in neuro and cardiac and c40% in Non-Elective, mainly Acute Medicine)
7. Against M1, price has deteriorated by a further £0.2M, volume by £0.1M and pass through drugs by £0.3M.

Table 3 – Baseline SLA Income Breakdown (M1 vs M2)

	M2		Restated M1		Difference
	£M	POD	£M	POD	£M
Price/Tariff	-0.6	-0.1M Elective -0.5M Non-Elective	-0.4	-0.1M Elective -0.3M Non-Elective	-0.2
Volume/Activity	-1.2	-0.8M Elective -0.2M Non-Elective -0.2M Outpatients	-1.1	-0.2M Elective -0.7M Non-Elective -0.2M Other	-0.1
Pass through drugs	-0.9		-0.6		-0.3
Total	**-2.7**		**-2.1**		**-0.6**

8. At M1 (April 2017) we reported that income was down compared to the same time last year. The main reasons included; Easter falling in April and hence less working/income days, coding issues arising from the introduction of HRG4, particularly in Elective, optimistic activity levels planned particularly in non-elective and c20% of un-coded activity (both in Elective and Non-Elective) at the time we reported M1 income, which may have understated price.
9. At M2 (May 2017) we recovered an additional £2.2M (M1 "Flex plus"), £1M of this was related to the introduction of HRG4+ and £1.2M was related to price given the amount of un-coded activity at M1. We are unlikely to see the same extent of an income catch-up in M2

as the HRG4+ problem has rectified itself and we have c15% of Elective and Non-Elective coded activity (compared to M1 20%).

Pay

10. M2 Pay is £0.6M is better than baseline budget. Most of this improvement is attributed to reductions in agency spend. Overall, pay is broadly flat but by M3 we need to start to see more of a concerted effort to reduce pay. In order to hit our total paybill of £476M by M12, we need to reduce pay by an average of £1.5M per month. Work continues to prepare the Trust's workforce plan which accommodates the necessary reductions in the paybill, building this into the CIP Plan and triangulating this with the activity delivered.

Non-Pay

11. Volume sensitive non-pay spend has reduced by (£0.9M) in line with income/activity. More work is required to understand non-pay spend drivers. This is being accelerated as part of the Financial Recovery Plan. We are particularly concerned to gain assurance that costs are captured and accrued properly in each month. This is particularly relevant for clinical consumables and drugs which are notoriously volatile and represent over half of non-pay spend.

CIPs

12. At M2, of the £60M CIP Plan, there are c£28M "RAG" rated CIP schemes (not including pipeline) of those,
    - c£11M Green;
    - £4M Amber; and
    - c£13M Red.
13. There is a discrepancy (c£2M) between the general ledger and the PMO database and we will be working to resolve this for M3 so there is one version of the truth. Some of this discrepancy is timing.
14. At M2, £1.7M has been identified as delivered against a plan of £3.8M implying we missed plan by c£2M.
15. Moving forward, the focus needs to be on moving each scheme along the development pipeline. Getting the red and amber schemes to green whilst continuing to firm up the pipeline ideas. This is an ongoing process and not just a one-off push.

    Big ticket items, prioritised on a "return on investment" basis are:
    - Temporary workforce
    - Procurement

- Estates

Risks and Opportunities

16. At M2, c£23M of risks have been identified (by Division) across the Trust, adjusted for the likelihood and impact of crystallisation. At present, no further opportunities over and above CIPs have been identified to mitigate the risks. We have been challenging Divisions as part of the Divisional Performance Reviews.

17. MedCard's and Surgery's risks appear to be disproportionately high. We are currently investigating this with the Division.

Table 4 – Adjusted Risks by Division

Division	Value
CSD	2,319,000
CWDT	2,808,900
Medcard	9,776,300
Overheads	2,431,000
Surgery	5,411,000
Grand Total	**22,746,200**

Most of these risks are baked into the financial position. There is c£6M of risk which is new risk largely in pay and non-pay.

Divisional Financial Performance

18. The financial performance by Division, separating out M1 income catch up, CIP and baseline impact, is summarised in **Table 5** below.

Table 5 – Divisional Financial Summaries

Divisons at M2	Plan	Actual	Var (worse)/ better	M1 Income catch-up	CIP non-delivery	Baseline	Total
	£M	£M	£M	£M	£M	£M	£M
Childrens & Womens	0.2	-1.2	**-1.3**	0.4	-1.3	-0.5	**-1.3**
MedCard	7.5	7.3	**-0.2**	0.8	-1.4	0.4	**-0.2**
Surgery	4.3	3.1	**-1.2**	1.0	-1.1	-1.1	**-1.2**
Community	1.8	1.4	**-0.4**	0.1	-0.3	-0.2	**-0.4**
Central/Corporate	-15.8	-16.3	**-0.5**	-0.1	-0.1	-0.3	**-0.5**
Total	**-2.0**	**-5.7**	**-3.6**	**2.2**	**-4.2**	**-1.7**	**-3.6**

19. Overall, against plan, Children's and Womens Division under delivered against plan by £1.3M of the £3.6M adverse M2 variance, mainly due to Pay overspend of £0.6M. However with income catch-up and CIP non-delivery the Division had a £0.5M negative impact on the baseline.

20. With M1 flex income recovery and CIP non-delivery stripped out, Surgery performed worse than other Divisions with a £1.1M adverse impact on their baseline despite having caught up M1 income more than any Division £1.1M. This will be challenged as part of the Performance Review to understand the drivers.

21. MedCard had baseline issues in M1 due to reductions in non-elective admissions and reduced cardiology activity linked to anaesthetics cover, have worked hard over the month to recover their position. At M2, MedCard overperformed on their baseline by £0.4M. This was largely due to income losses offset by upsides in both Pay and Non-Pay.

Divisional Performance Reviews

22. M2 Financial performance meetings chaired by the Chief Executive were held with all Divisions in week commencing 19th June to understand drivers of performance and actions taken to halt and if possible reverse shortfalls.

23. Key themes arising:

    - Divisions to identify and risks and mitigations to the baseline;
    - Opportunities in non-pay for further CIP savings across most areas.

Financial Report
Month 2 (May 2017)

Trust Board

6th July 2017

1. Contents

2a. Financial Performance for Month 2 (May 2017)

HEADLINES - M2 Revenue Position (including CIPs)
The Month 2 revenue position is a £5.7m deficit, which is £3.6m adverse to Plan. There is a £4.1m CIP shortfall which is against: SLA Income (£2.1m); Pay (£1.8m), and Non-Pay (£0.2m). M2 also includes £2.2m income recovered relating to M1 (flex); £1m specialist top-up income and £1.2m coding catch-up.

THE UNDERLYING DEFICIT for M2 is £6.9m. This compares to an **underlying deficit for M1 of £5.6m** and represents a £1.3m deterioration from M2: lower income (£0.9m), increased non-clinical pay (£0.2m), and increased non-pay (£0.2m).

TOTAL INCOME: £2.9m adverse (£2.1m CIP non-delivery, £0.8m is adverse to baseline). The £2.2m income catch-up (flex) is included in M2 which means an underlying **adverse baseline variance of £3m adverse.**

SLA INCOME: £2.6m adverse (£2.1m CIP non-delivery, £0.5m adverse to baseline). Excluding income catch-up from M1 (£2.2m), **M2 SLA income is £2.7m adverse to baseline** due to:

Income & Expenditure	May Actual 2016/17 £'m	Annual Budget 2017/18 £'m	May Budget 2017/18 £'m	May Actual 2017/18 £'m	May Variance 2017/18 £'m	May Variance 2017/18 %	YTD Budget 2017/18 £'m	YTD Actual 2017/18 £'m	YTD Variance 2017/18 £'m	YTD Variance 2017/18 %
Income	**64.2**	**814.2**	**68.0**	**65.2**	**(2.9)**	**(4.2%)**	**132.5**	**122.7**	**(9.9)**	**(7.4%)**
Pay										
- Medical	(11.0)	(132.8)	(11.1)	(11.0)	0.1	0.8%	(22.1)	(21.9)	0.2	1.0%
- Nursing	(14.9)	(187.0)	(15.5)	(15.0)	0.5	3.4%	(31.2)	(30.0)	1.3	4.0%
- Non Clinical	(6.9)	(86.4)	(7.2)	(7.2)	(0.0)	(0.7%)	(14.4)	(14.3)	0.1	0.9%
- STT	(7.1)	(89.8)	(7.5)	(7.3)	0.1	1.7%	(15.0)	(14.5)	0.5	3.1%
- Other	(0.0)	(2.7)	(0.2)	(0.2)	(0.0)	(11.9%)	(0.5)	(0.6)	(0.1)	(32.0%)
- CIP	0.0	22.4	1.8	0.0	(1.8)	(100.0%)	3.7	0.0	(3.7)	(100.0%)
Total Pay	**(39.9)**	**(476.3)**	**(39.6)**	**(40.7)**	**(1.1)**	**(2.9%)**	**(79.5)**	**(81.3)**	**(1.8)**	**(2.3%)**
Non Pay										
- Drugs	(7.0)	(89.5)	(7.5)	(7.3)	0.2	2.0%	(15.0)	(14.5)	0.5	3.3%
- Clinical Supplies	(6.8)	(103.6)	(8.6)	(8.1)	0.5	6.3%	(17.3)	(15.5)	1.7	10.1%
- Other	(11.7)	(139.2)	(11.6)	(11.8)	(0.3)	(2.2%)	(23.2)	(23.6)	(0.4)	(1.6%)
Total Non Pay	**(25.5)**	**(332.3)**	**(27.7)**	**(27.3)**	**0.4**	**1.6%**	**(55.5)**	**(53.6)**	**1.9**	**3.3%**
EBITDA	**(1.2)**	**5.6**	**0.7**	**(2.8)**	**(3.6)**	**484.2%**	**(2.5)**	**(12.3)**	**(9.8)**	**(396.6%)**
Depreciation (excl donated)	(1.9)	(22.8)	(1.9)	(1.9)	(0.0)	(0.0%)	(3.8)	(3.8)	0.0	0.0%
Financing costs	(0.8)	(11.2)	(0.9)	(0.9)	0.0	3.0%	(1.9)	(1.8)	0.1	3.8%
Surplus/(deficit)	**(3.8)**	**(28.5)**	**(2.1)**	**(5.7)**	**(3.6)**	**(170.2%)**	**(8.1)**	**(17.9)**	**(9.7)**	**(119.4%)**

- **Non-elective income (adverse £1m)** - £0.5m from lower than planned average tariff/price for activity. Un-coded M2 activity remains high (14%), although lower than M1 (21%). The adverse tariff variance at M1 was largely recovered (£1.2M) on coding. The remaining £0.5m is due to unachieved activity in Acute Medicine (£0.3m), and £0.2m in T&O, Urology and General Surgery
- **Elective income (adverse £0.9m)** - £0.3m due to unachieved activity in Neuro, cancellations due to a lack of anaesthetic cover in Cardiac & Thoracic Surgery (£0.3m), General Surgery & Vascular both (£0.1m). Low average price is driving a £0.1m adverse variance in M2 (16% un-coded).
- **Pass-through SLA income (underperformance £0.9m)** offset in non-pay. **Balance of £0.1m favourable:** higher than planned Day Cases (£0.3m), offset by lower Obstetrics Outpatient activity (£0.2m).

OTHER INCOME: £0.3m adverse due to lower than budgeted recharge by SWLP (£0.2m) offset in expenditure, and lower than planned PP income (£0.1m)

PAY: £1.2m adverse (£1.8m CIP, £0.6m favourable to baseline) broadly due to reduced agency spend in the Acute Divisions.

NON-PAY: £0.5m favourable (£0.2m CIP, £0.7m favourable baseline variance) due to pass-through underspends (£0.9m), offset by unbudgeted FSM consulting support (£0.3m), additional £0.1m favourable variance due to lower than planned activity.

2b. Underlying Financial Performance for Month 2 (May 2017)

UNDERLYING DEFICIT – M2 VS M1

The M2 underlying deficit is £6.9m compared to an underlying restated deficit in M1 of £5.6m. This represents an underlying deterioration of £1.3m.

The underlying position each month adjusts the actual in-month financial position to exclude material one-off items. Those one-off adjustments are shown in the adjacent table for both M1 and M2.

The first adjustment in the table translates the actual income figure to that of an 'average' month in terms of working days to allow an equal comparison/normalised position between months. For example, in M1, the position is improved to reflect the fact that Easter is a lower than average month for activity and associated income.

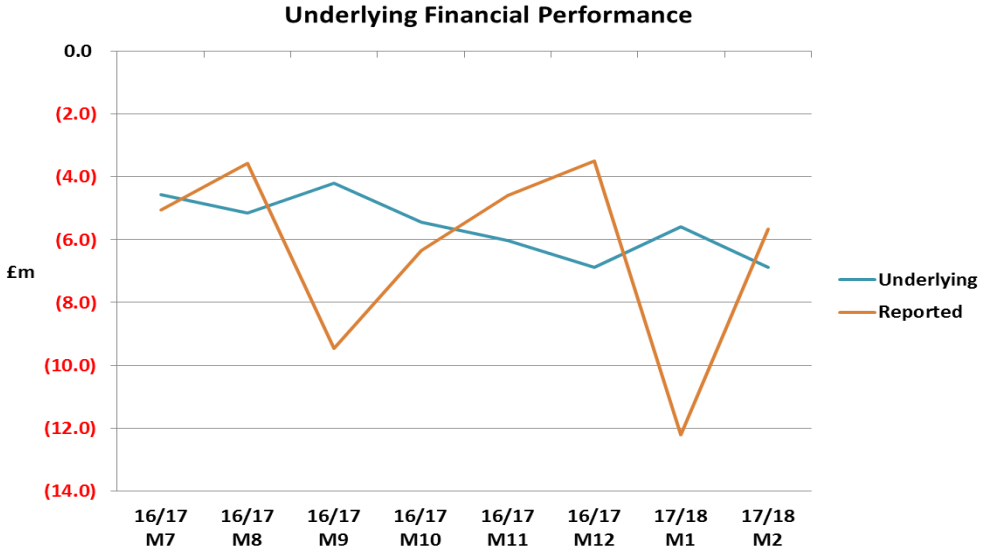
In addition to the one-off adjustments, income and expenditure is restated into the month that it was incurred or earned. The Trust recovered £2.2m of additional income from M1 reported to M1 flex. To achieve a valid underlying position, £2.2m income is added to M1 and removed from M2.

	M1	M2
Reported Deficit	**-£12.2**	**-£5.7**
Income days adjustment	£3.1	-£0.2
FSM Consulting support	£0.2	£0.5
ECRP/RTT investment	£0.4	£0.4
Prior Year costs	£0.4	£0.0
Fines related to non-reporting RTT	£0.3	£0.3
M1 reported to M1 Reported @ M2	£2.2	-£2.2
Underlying Deficit	**-£5.6**	**-£6.9**

DETAILED MOVEMENTS

The £1.3m adverse movement in the underlying financial position is due to:

- **£0.9m adverse movement in SLA Income:**
  - Elective £0.6m – lower elective income per working day, predominantly in Neuro Surgery (£0.2m), Cardiac Surgery (£0.1m), Vascular Surgery (£0.1m), Urology (£0.1m), and General Surgery (£0.1m)
  - Outpatients £0.3m – Lower activity in Obstetrics. The Division (CWDT) is looking into the possibility of missed data from Euroking. If this is the case, this income will be recovered in the M3 financial position.
- **£0.2m adverse movement in Pay:**
  - Increase in non-clinical staff costs in the Corporate Division due to new starters. This is not yet offset with an agency reduction as accounting for interims is being reviewed as the PO process not being uniformly followed.
- **£0.2m adverse movement in Non-Pay:**
  - Adverse movement in clinical consumables in Neuro.

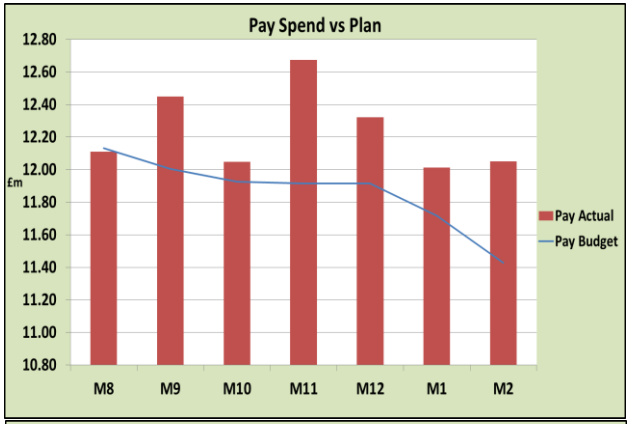


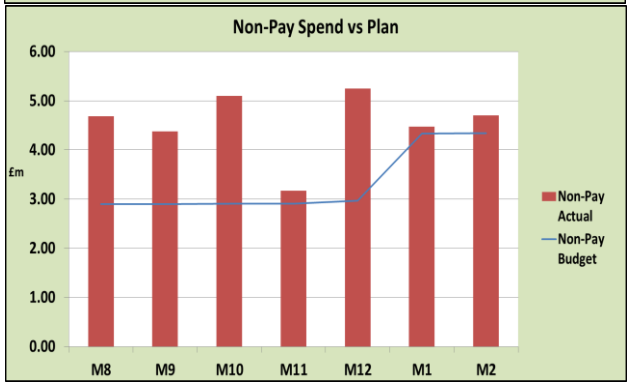
Longer Term: Over the last 8 months, the underlying position has deteriorated owing to the changes in Waiting List Initiative payments and associated income

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

Income & Expenditure	M2 LY £'m	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Current Month Variance %	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m	YTD Variance %
SLA Income	11.8	154.7	12.6	12.2	(0.4)	(3.5%)	24.9	23.2	(1.7)	(6.6%)
Other Income	3.2	39.5	3.3	3.4	0.1	2.7%	6.6	6.7	0.1	2.1%
Overall Income	**15.0**	**194.2**	**15.9**	**15.6**	**(0.4)**	**(2.2%)**	**31.5**	**29.9**	**(1.5)**	**(4.8%)**
Pay	(11.8)	(138.7)	(11.4)	(12.0)	(0.6)	(5.4%)	(23.1)	(24.1)	(0.9)	(4.0%)
Non Pay	(3.8)	(47.9)	(4.0)	(4.4)	(0.4)	(8.9%)	(8.0)	(8.5)	(0.5)	(6.2%)
Overall Expenditure	**(15.7)**	**(186.6)**	**(15.4)**	**(16.4)**	**(1.0)**	**(6.3%)**	**(31.1)**	**(32.5)**	**(1.4)**	**(4.5%)**
EBITDA	**(0.7)**	**7.6**	**0.5**	**(0.8)**	**(1.3)**	**(267.4%)**	**0.3**	**(2.6)**	**(2.9)**	**(891.3%)**
Post EBITDA	(0.5)	(4.2)	(0.3)	(0.4)	(0.0)	(0.9%)	(0.7)	(0.7)	(0.0)	(0.4%)
Surplus/(deficit)	**(1.2)**	**3.4**	**0.2**	**(1.2)**	**(1.3)**	**(881.1%)**	**(0.4)**	**(3.3)**	**(2.9)**	**(799.5%)**

By directorate	M2 LY £'m	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Current Month Variance %	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m	YTD Variance %
Childrens Services	1.0	11.4	0.8	0.4	(0.4)	(50.7%)	1.6	0.4	(1.2)	(74.9%)
Critical Care	0.7	7.3	0.5	0.6	0.1	23.4%	1.0	1.0	0.0	4.4%
CWDT Division Management	(0.1)	(1.5)	(0.1)	(0.1)	(0.0)	(14.2%)	(0.3)	(0.3)	(0.0)	(15.4%)
Diagnostics	(0.8)	(7.3)	(0.7)	(0.7)	(0.1)	(13.3%)	(1.3)	(2.0)	(0.7)	(51.7%)
Outpatients	(1.3)	(14.8)	(1.2)	(1.3)	(0.1)	(9.1%)	(2.5)	(2.6)	(0.1)	(3.8%)
Pharmacy	(0.5)	(3.8)	(0.3)	(0.5)	(0.2)	(74.5%)	(0.6)	(0.8)	(0.2)	(33.4%)
Therapies	(0.8)	(7.3)	(0.5)	(0.7)	(0.2)	(28.4%)	(1.2)	(1.5)	(0.3)	(22.8%)
Womens Services	0.7	19.4	1.7	1.2	(0.4)	(26.0%)	3.0	2.5	(0.5)	(16.7%)
Surplus/(deficit)	**(1.2)**	**3.4**	**0.2**	**(1.2)**	**(1.3)**	**(881.1%)**	**(1.9)**	**(3.7)**	**(1.8)**	**(92.1%)**





Headlines

- **The Division's M02 performance is adverse by £2.93m YTD and £1.34m in month (and £1.74m excluding £0.4m M01 income recovery)**
- **This is largely due to the underachievement of the CIP target £2.61m YTD and £1.26m in month**
- **The position excluding CIPs is £0.32m YTD. However this excludes £0.3m of Obstetrics OP activity and £0.2m cost recovery of pharmacy manufactured products which would bring the baseline position into balance.**

SLA Income includes £1.2m unallocated CIP target YTD. Obstetrics OP is £0.3m down due to a M02 submission problem now resolved. Bedday activity is down in Paeds partly to maintain safe levels of staff but over performing in Critical Care. Elective and Non elective inpatient activity and Diagnostics OP activity have lower than expected income performance . This may reflect lower casemix but the value variance from plan requires validation of coding issues following changes to the groupers that calculate the value of this activity this year.
Other Income mainly relates to the profitable commercial pharmacy offset by drugs spend in non-pay. This performance exclude s £0.2m cost recovery of finished manufactured products, to be resolved as part of the review of financial reporting of drug receipts and issues .
Pay spend includes £1.2m unallocated CIP target YTD. Staff groups are underspending before CIPs by £0.3m. Agency spend is down significantly due to the cessation of the Paeds Continuing Care services effecting nurse spend and continues to reduce in Radiology, Acute Therapy and the agency to bank scheme in Obstetrics to be implemented as a pilot in ICU.
Non-pay includes unallocated CIP of £0.3m YTD. Over spend is the commercial pharmacy drug cost matched to income performance.

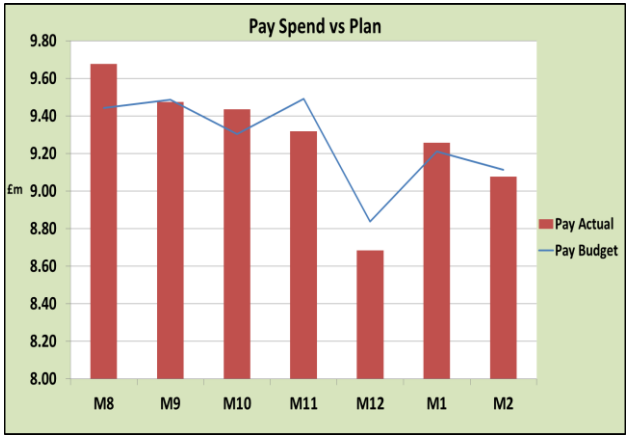
Actions Required

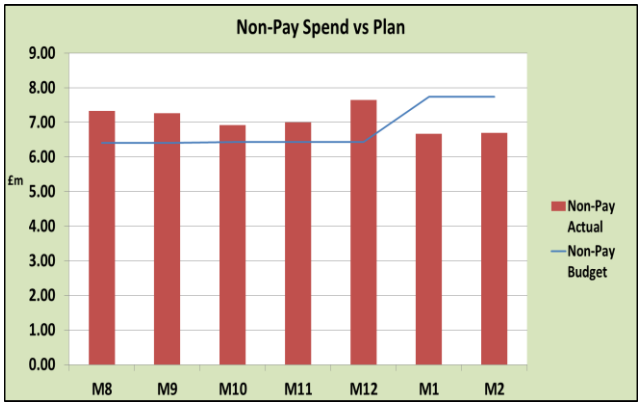
1. Validate the SLA income underperformances are not affected by changes to grouper matching of activity to tariffs
2. Complete the review of Pharmacy drugs receipts, issues and stock accounting including internal trading of manufactured drugs products
3. Review Consultant recharge SLA to ensure up to 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	M2 LY £'m	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Current Month Variance %	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m	YTD Variance %
SLA Income	20.6	274.3	23.1	22.0	(1.1)	(4.9%)	44.6	40.1	(4.5)	(10.2%)
Other Income	1.3	14.4	1.2	1.1	(0.1)	(10.2%)	2.4	2.1	(0.3)	(13.8%)
Overall Income	**21.9**	**288.7**	**24.3**	**23.1**	**(1.2)**	**(5.1%)**	**47.0**	**42.1**	**(4.9)**	**(10.4%)**
Pay	(9.2)	(109.9)	(9.1)	(9.1)	0.0	0.4%	(18.3)	(18.3)	(0.0)	(0.1%)
Non Pay	(7.5)	(89.2)	(7.4)	(6.4)	1.0	14.0%	(14.9)	(12.8)	2.1	14.2%
Overall Expenditure	**(16.7)**	**(199.2)**	**(16.5)**	**(15.5)**	**1.1**	**6.5%**	**(33.2)**	**(31.1)**	**2.1**	**6.3%**
EBITDA	**5.2**	**89.5**	**7.8**	**7.6**	**(0.2)**	**(2.2%)**	**13.8**	**11.1**	**(2.8)**	**(20.0%)**
Post EBITDA	(0.4)	(3.7)	(0.3)	(0.3)	(0.0)	(0.1%)	(0.6)	(0.6)	(0.0)	(0.1%)
Surplus/(deficit)	**4.8**	**85.9**	**7.5**	**7.3**	**(0.2)**	**(2.3%)**	**13.2**	**10.4**	**(2.8)**	**(21.0%)**

By directorate	M2 LY £'m	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Current Month Variance %	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m	YTD Variance %
Acute Medicine	0.6	19.6	1.7	1.4	(0.3)	(16.9%)	3.3	2.2	(1.0)	(32.0%)
Cardiology CAG	1.3	15.5	1.3	1.2	(0.1)	(7.5%)	2.3	1.9	(0.4)	(18.1%)
Cardiothoracic & Vascular Services	0.6	16.4	1.4	1.3	(0.1)	(5.6%)	2.4	1.9	(0.5)	(21.9%)
Emergency Department	0.7	9.5	0.8	0.7	(0.2)	(18.1%)	1.6	1.2	(0.4)	(23.3%)
Medcard Management	0.0	(4.1)	(0.3)	(0.2)	0.1	26.1%	(0.6)	(0.5)	0.2	26.8%
Renal & Oncology	(0.2)	13.6	1.2	1.5	0.3	28.9%	2.0	1.6	(0.4)	(19.6%)
Specialist Medicine	1.0	15.4	1.4	1.4	0.0	2.0%	2.3	2.1	(0.2)	(8.1%)
Surplus/(deficit)	**4.1**	**85.9**	**7.5**	**7.3**	**(0.2)**	**(2.3%)**	**13.2**	**10.4**	**(2.8)**	**(21.0%)**





Headlines

Medcard is £2.8m adverse to plan YTD driven by CIP target (£2.8m). Position includes activity shortfalls (£1.6m adv) which are offset by underspends against baseline budgets for pay (£0.9m fav) and non-pay (£0.7m fav), excluding High Cost Drugs and Devices.

In Month Variances

SLA Income (£1.1m adv) – Lower than planned spend on high cost drugs and devices (£0.8m adv – fully offset by non-pay savings); unachieved CIP target (£0.8m adv); lower than planned non-elective emergency admissions (£0.4m adv); shortfall in elective activity in Cardiac, Vascular, Thoracic and Cath labs (£0.4m adv) partially driven by lack of anaesthetic cover , offset by benefit from recoding of Month 1 activity (£0.9m fav) and over performance on outpatient activity in Specialist Medicine (£0.2m fav);

Other Income (£0.2m adv) – underperformance on private patient activity.

Pay (on budget) - Unachieved CIP (£0.4m adv) offset by vacancies and reduced staffing levels due to bed closures;

Non-Pay (£1.0m fav) – Offset of lower than anticipated spend on high cost drugs and devices (£0.8m 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	M2 LY £'m	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Current Month Variance %	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m	YTD Variance %
SLA Income	13.2	186.3	15.7	15.2	(0.5)	(3.5%)	30.1	27.9	(2.2)	(7.4%)
Other Income	1.2	16.8	1.4	1.4	(0.0)	(1.8%)	2.8	2.7	(0.1)	(4.7%)
Overall Income	**14.4**	**203.2**	**17.1**	**16.6**	**(0.6)**	**(3.4%)**	**33.0**	**30.6**	**(2.4)**	**(7.2%)**
Pay	(9.1)	(108.1)	(9.0)	(9.4)	(0.3)	(3.8%)	(18.1)	(18.6)	(0.5)	(2.9%)
Non Pay	(2.9)	(42.0)	(3.5)	(3.8)	(0.3)	(7.8%)	(7.0)	(6.8)	0.2	2.6%
Overall Expenditure	**(12.0)**	**(150.1)**	**(12.5)**	**(13.1)**	**(0.6)**	**(4.9%)**	**(25.1)**	**(25.4)**	**(0.3)**	**(1.3%)**
EBITDA	**2.4**	**53.1**	**4.6**	**3.4**	**(1.2)**	**(25.7%)**	**7.9**	**5.2**	**(2.7)**	**(34.3%)**
Post EBITDA	(0.3)	(3.5)	(0.3)	(0.3)	(0.0)	(0.5%)	(0.6)	(0.6)	(0.0)	(0.5%)
Surplus/(deficit)	**2.1**	**49.6**	**4.3**	**3.1**	**(1.2)**	**(27.5%)**	**7.3**	**4.6**	**(2.7)**	**(37.1%)**

By directorate	M2 LY £'m	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Current Month Variance %	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m	YTD Variance %
Cancer	(0.1)	(1.1)	(0.1)	(0.1)	0.0	10.6%	(0.2)	(0.2)	0.0	15.3%
Neuro	2.0	36.6	3.3	2.8	(0.5)	(14.6%)	5.8	4.7	(1.2)	(19.8%)
Surgery	3.3	53.6	4.3	3.6	(0.6)	(14.8%)	8.3	6.6	(1.7)	(20.2%)
Theatres and Anaesthetics	(3.1)	(39.6)	(3.1)	(3.2)	(0.1)	(2.8%)	(6.6)	(6.5)	0.1	(1.5%)
Surplus/(deficit)	**2.1**	**49.6**	**4.3**	**3.1**	**(1.2)**	**(27.5%)**	**7.3**	**4.6**	**(2.7)**	**(37.1%)**

Headlines YTD M02 position

- **The Division Performance M02 is an adverse variance of (£1.2m), YTD M02 (£2.7m)**
- **This is mainly due to underachievement of (£1.3m) against the SLA income CIP target, (£0.7m) Elective Neurosurgery SLA income under performance mainly due to activity shortfall and (£0.6m) Emergency SLA income under performance across the division due to 50% activity shortfall & 50% case mix / price**
- **The pay deficit is on the CIP gap (£1.0m) offset by £0.5m under spends on ward nursing and theatre staff.**

The M02 contribution £3.1m has £1.0m of SLA income relating to M01 due to applying the correct tariff to previously un-coded activity and including the specialist top-up.

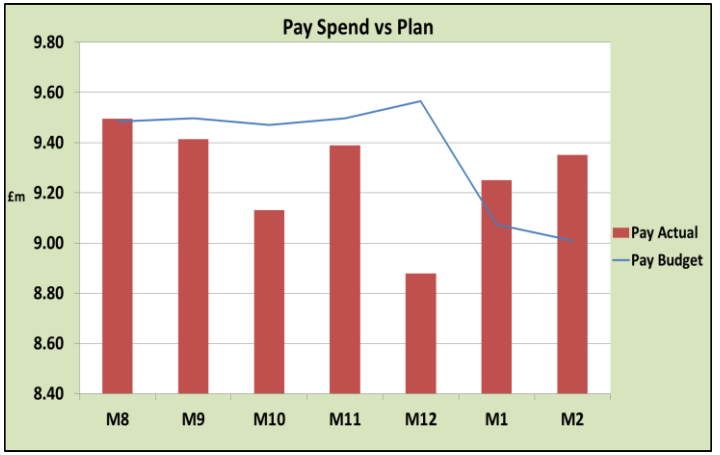
The M02 SLA income deficit is (£1.7m), which excludes £1.0m income from M01 and rechargeable high cost drugs £0.2m

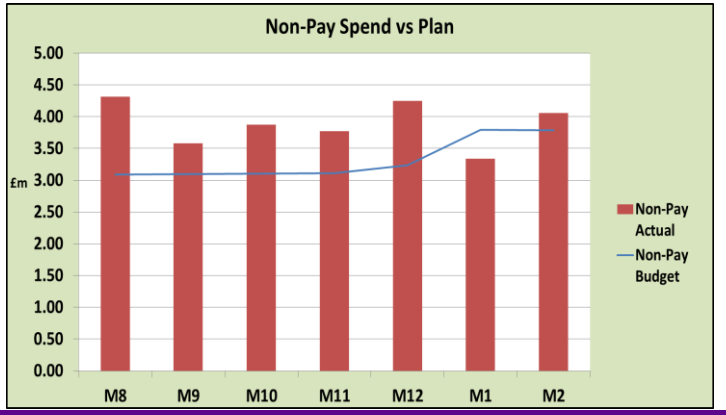
- Unallocated CIP target (£0.7m)
- Neurosurgery elective activity under performance 163 target v's 121 performed valued at (£0.5m) . There were cancelled theatre sessions due to lack of Anaesthetic cover and the Gynaecology move.
- Neurosurgery emergency deficit (£0.1m) due to case mix and Other Non-elective deficit (£0.1m) on case mix and volume.
- Surgery emergency deficit - T&O (£0.1m) 16 cases and ENT (£0.1m) 38 cases
- Surgery directorate OP deficit across Urology, T&O and Head & Neck Care Groups (£0.1m)

Pay unallocated CIP gap (£0.5m) is partially offset by the underspend on theatre nursing £0.1m and ward nursing £0.1m.
Non-pay is overspent on 16/17 ENT private sector invoices £(£0.1m) and high cost drugs rechargeable to Commissioners (£0.2m)

Actions Required

1. Remove unbudgeted posts or identify cost mitigation strategies if the posts are deemed to be essential
2. Identify mitigation plans to ensure SLA targets are met during the theatres refurbishment programme
3. Planned Theatre sessions to be handed back so other SDUs can use any spare capacity.

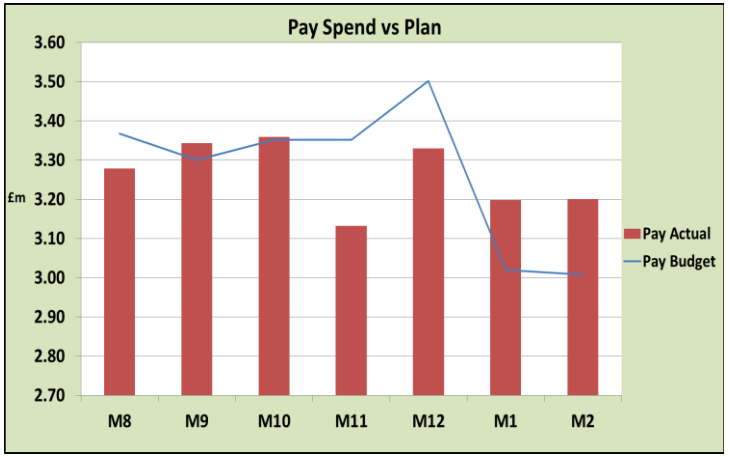


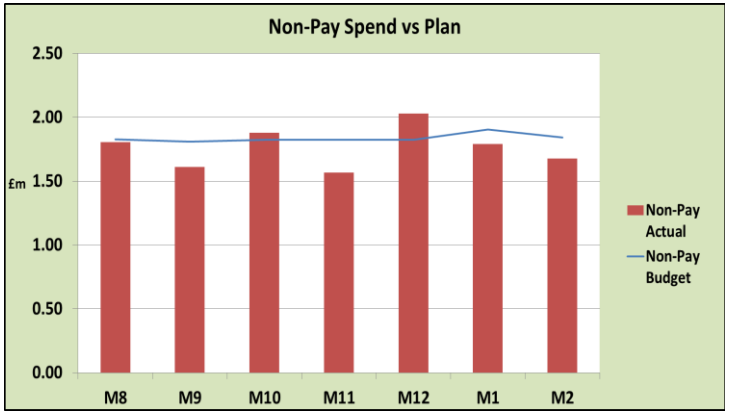


3d. Community Services I&E

Income & Expenditure	M2 LY £'m	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Current Month Variance %	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m	YTD Variance %
SLA Income	7.0	79.2	6.6	6.2	(0.4)	(5.5%)	13.0	12.4	(0.6)	(5.0%)
Other Income	0.1	0.9	0.1	0.1	0.0	49.2%	0.2	0.1	(0.0)	(5.1%)
Overall Income	**7.1**	**80.2**	**6.7**	**6.3**	**(0.3)**	**(5.1%)**	**13.2**	**12.5**	**(0.7)**	**(5.0%)**
Pay	(3.1)	(36.2)	(3.0)	(3.2)	(0.2)	(6.4%)	(6.0)	(6.4)	(0.4)	(6.2%)
Non Pay	(1.4)	(22.1)	(1.8)	(1.6)	0.2	9.1%	(3.7)	(3.4)	0.3	7.5%
Overall Expenditure	**(4.5)**	**(58.3)**	**(4.8)**	**(4.8)**	**(0.0)**	**(0.6%)**	**(9.7)**	**(9.8)**	**(0.1)**	**(1.0%)**
EBITDA	**2.6**	**21.9**	**1.8**	**1.5**	**(0.4)**	**(19.9%)**	**3.5**	**2.7**	**(0.7)**	**(21.5%)**
Post EBITDA	(0.0)	(0.3)	(0.0)	(0.0)	(0.0)	(0.2%)	(0.1)	(0.1)	(0.0)	(0.1%)
Surplus/(deficit)	**2.6**	**21.5**	**1.8**	**1.4**	**(0.4)**	**(20.2%)**	**3.4**	**2.7**	**(0.7)**	**(21.9%)**

By directorate	M2 LY £'m	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Current Month Variance %	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m	YTD Variance %
Ambulatory Care Services	1.2	5.9	0.5	0.6	0.0	9.3%	0.9	1.0	0.1	8.3%
Community Adults & Children	1.3	14.4	1.2	1.0	(0.2)	(15.7%)	2.3	2.0	(0.3)	(14.3%)
Community Services Management	0.1	1.2	0.1	(0.1)	(0.2)	(278.6%)	0.2	(0.3)	(0.5)	(242.1%)
Surplus/(deficit)	**2.6**	**21.5**	**1.8**	**1.4**	**(0.4)**	**(20.2%)**	**3.4**	**2.7**	**(0.7)**	**(21.9%)**





Headlines

- **The Division is reporting a deficit for the year to date of £0.7m, 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 £0.5m which is in Pay (£0.4m) and Non Pay (£0.1m)**

Income underperformance on relates to:-

- The level of bed day income, which is £0.1m 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 level of Rehabilitation OPs in the Orthotic and Prosthetic service, which is also £0.1m lower than planned. Opcare, which provide this service, has assured the Division that activity will return to planned levels and that the backlog will be addressed.
- The lower levels of activity in the Brysson Whyte Elderly Rehab Day Unit and the Podiatry AQP service
- The Lower levels of in-patient amputee patients has reversed this month as expected.
- There is also underperformance against HIV high cost drugs of £0.3m, which is matched by lower non pay drugs expenditure

Pay is overspent due to the impact of the Pay element of the CIP target and the challenges of delivering the run rate targets in CAHS and PLD in particular.

Actions Required

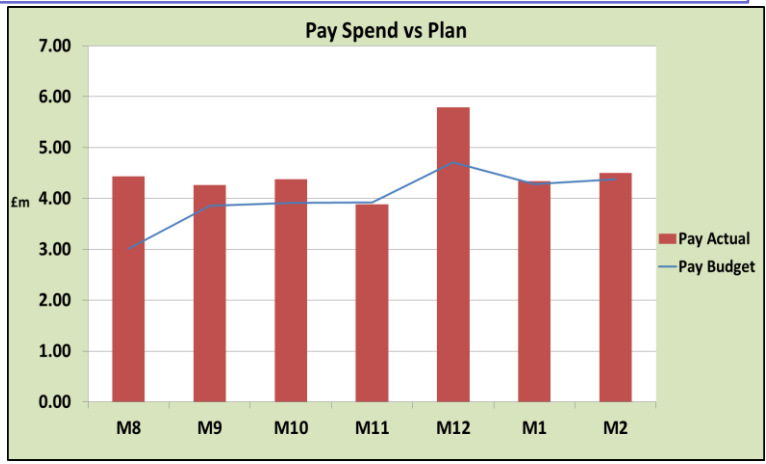
1. Continue to develop CIPs to convert its £1.1m of pipeline and red rated schemes to green and continue to identify schemes to address the £1.3m shortfall.
2. Develop and agree Care Group level plans to deliver pay run rate savings requirements.

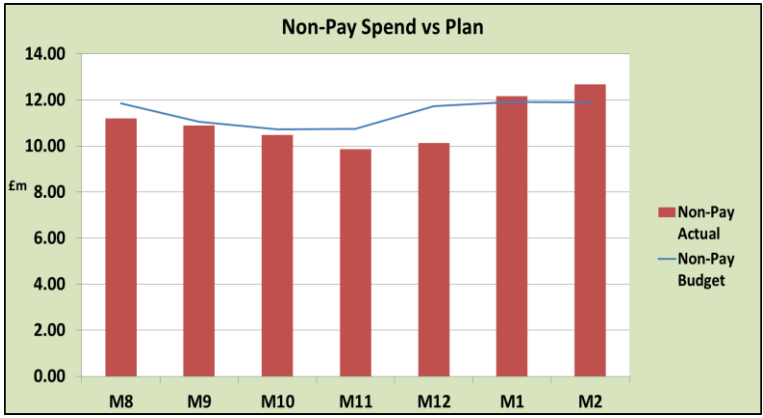
3e. Corporates and Estates & Facilities I&E

Income & Expenditure	M2 LY £'m	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £'m	Current Month Variance %	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m	YTD Variance %
Corporate Directorates										
Chief Executive & Governance	(0.2)	(7.4)	(0.9)	(1.3)	(0.5)	(58.5%)	(1.6)	(2.4)	(0.8)	(47.0%)
Chief Operating Officer	(0.3)	(3.5)	(0.3)	(0.3)	0.0	10.4%	(0.6)	(0.5)	0.1	17.8%
Human Resources Directorate	(0.3)	(10.3)	(0.8)	(0.8)	0.1	7.4%	(1.7)	(1.6)	0.2	8.8%
Ops & Service Improvement	(0.7)	(4.4)	(0.4)	(0.4)	(0.1)	(19.4%)	(0.7)	(0.9)	(0.2)	(24.9%)
Pathology - STG	(1.3)	(15.8)	(1.4)	(1.6)	(0.2)	(14.9%)	(2.7)	(3.0)	(0.3)	(11.6%)
Strategy	(0.1)	(0.2)	(0.0)	(0.0)	0.0	94.1%	(0.0)	0.0	0.1	124.2%
Quality Governance Directorate	(1.7)	(24.3)	(2.0)	(2.1)	(0.1)	(2.6%)	(4.1)	(4.1)	(0.0)	(1.1%)
Nursing Directorate	(0.1)	(1.5)	(0.1)	(0.1)	0.0	13.5%	(0.3)	(0.2)	0.0	11.3%
Finance and Procurement	(0.9)	(10.4)	(0.9)	(0.9)	(0.0)	(5.3%)	(1.7)	(1.7)	0.0	0.4%
IT, Informatics & Telecomms	(1.5)	(22.3)	(1.9)	(1.8)	0.1	3.0%	(3.7)	(3.6)	0.1	3.4%
Total Corporate	(7.1)	(100.2)	(8.6)	(9.3)	(0.7)	(8.0%)	(17.2)	(18.0)	(0.8)	(4.9%)
Estates & Facilities										
Energy & Engineering	(0.9)	(11.0)	(0.9)	(0.9)	(0.0)	(3.0%)	(1.8)	(1.9)	(0.1)	(5.4%)
Estates	(1.1)	(10.5)	(0.9)	(1.1)	(0.3)	(29.2%)	(1.8)	(2.2)	(0.5)	(25.7%)
Estates Community Premises	(1.4)	(17.4)	(1.5)	(1.4)	0.0	0.3%	(2.9)	(2.9)	0.0	0.3%
Facilities Services	(0.4)	(4.5)	(0.4)	(0.2)	0.2	47.1%	(0.7)	(0.6)	0.2	22.2%
Hotel Services	(1.5)	(15.5)	(1.3)	(1.3)	0.0	0.4%	(2.6)	(2.6)	(0.0)	(1.2%)
Medical Physics	(0.3)	(2.4)	(0.2)	(0.7)	(0.5)	(248.6%)	(0.4)	(0.9)	(0.5)	(120.7%)
Project Management	(0.1)	(0.3)	(0.0)	(0.0)	(0.0)	(15.5%)	(0.1)	(0.1)	(0.0)	(64.4%)
Rates	(0.2)	(2.4)	(0.2)	(0.2)	(0.0)	(1.7%)	(0.4)	(0.4)	(0.0)	(1.7%)
Total Estates & Facilities	(5.8)	(63.9)	(5.3)	(5.9)	(0.6)	(11.4%)	(10.7)	(11.6)	(0.9)	(8.7%)
NHSI Surplus/(deficit)	**(12.9)**	**(164.2)**	**(13.9)**	**(15.2)**	**(1.3)**	**(9.3%)**	**(27.9)**	**(29.6)**	**(1.8)**	**(6.4%)**

Headlines

- **The Division is reporting a deficit for the year to date of £1.8m, which is driven by the underachievement of the divisional CIP target (£0.7m), higher than expected Energy costs, cost of EY and SLAM underachievement in Pathology.**
- **The CIP target is currently in the 'Chief Executive' line in Corporates (£0.3m) and in the 'Estates' line in Estates & Facilities (£0.4m).**





Corporate Directorates £0.8m Adverse M02.

- A CIP target contributed £0.3m and currently sits in the Chief Executive & Governance budget.
- Additional EY costs £0.3m.
- IT continues to work on improving the Trust's IT services.
- Pathology income is lower than plan by £0.3m in month and £0.32m ytd mainly in SLAM.
- Ops & SI higher expenditure due to interims. This is being reviewed as part of the re-structure.

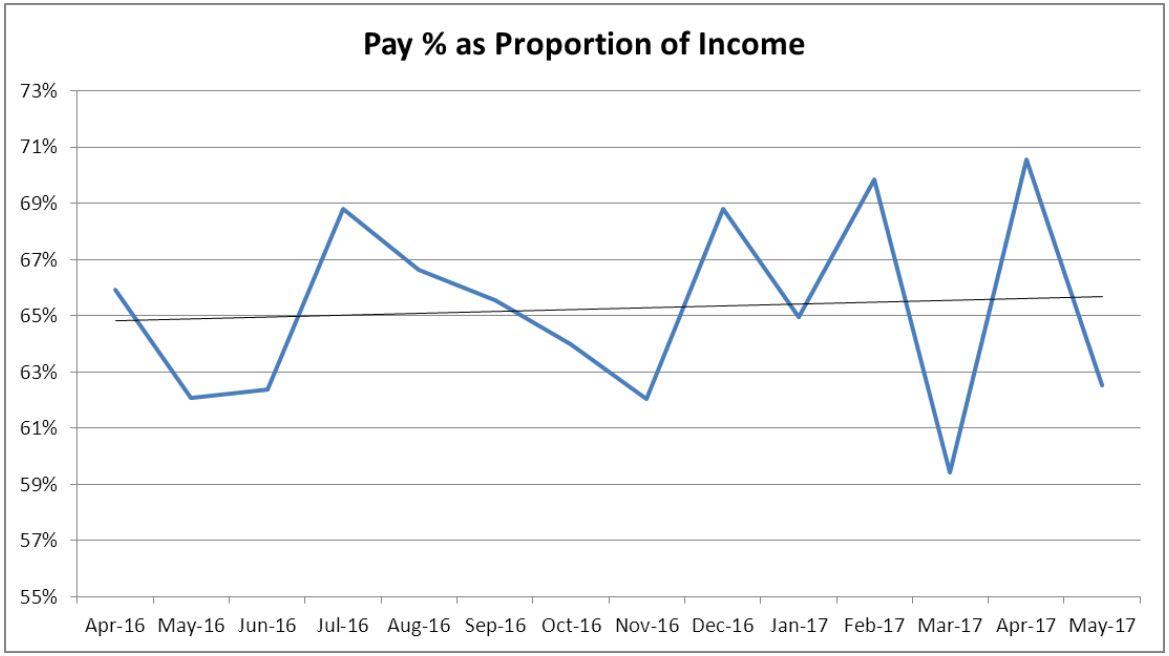
Estates & Facilities £0.3m Adverse M01.

- A CIP target of £0.4m contributed to the deficit.
- Higher Energy costs of £0.2m ytd. It is expected that costs will reduce now that buildings have been closed down and staff relocated. Offset by non-pay surpluses in Engineering.
- Medical Physics equipment cost £0.5m to be recharged to clinical divisions.
- 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 much higher than budget.

4. Pay trend



Commentary:

- **Pay** as a percentage of income has slightly increased throughout the year, largely due to Non Clinical expenditure. The profile can be quite uneven in nature owing to the seasonal nature of SLA elective income

Medical

- Expenditure has decreased due to a reduction in WLI payments as a result of reduced rates

Nursing

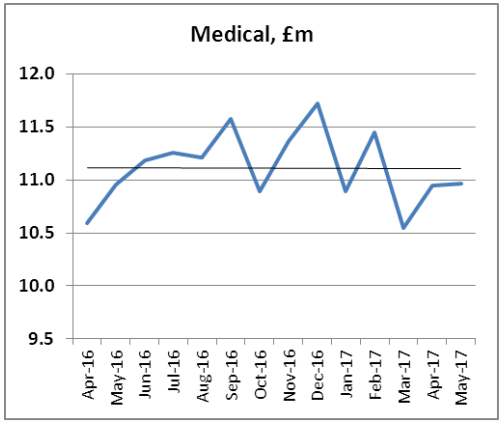
- Expenditure has decreased due to improved control on agency usage

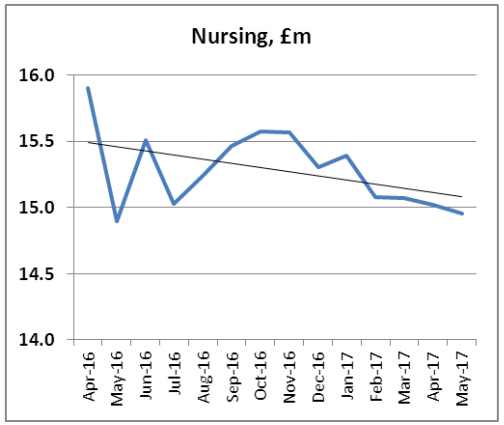
Non Clinical

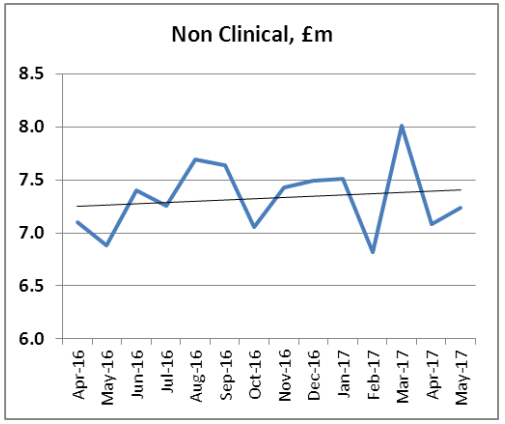
- Expenditure has increased due to continued usage of interims

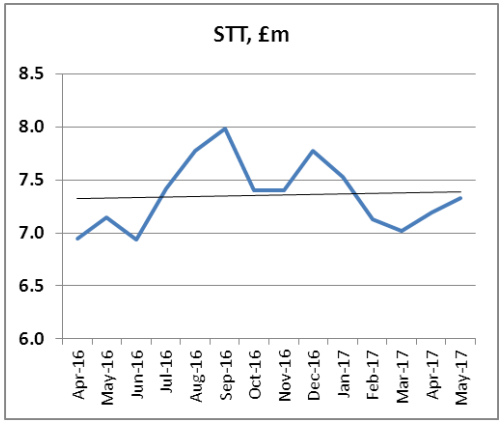
STT

- Expenditure has increased due to increased demand for clinical support services

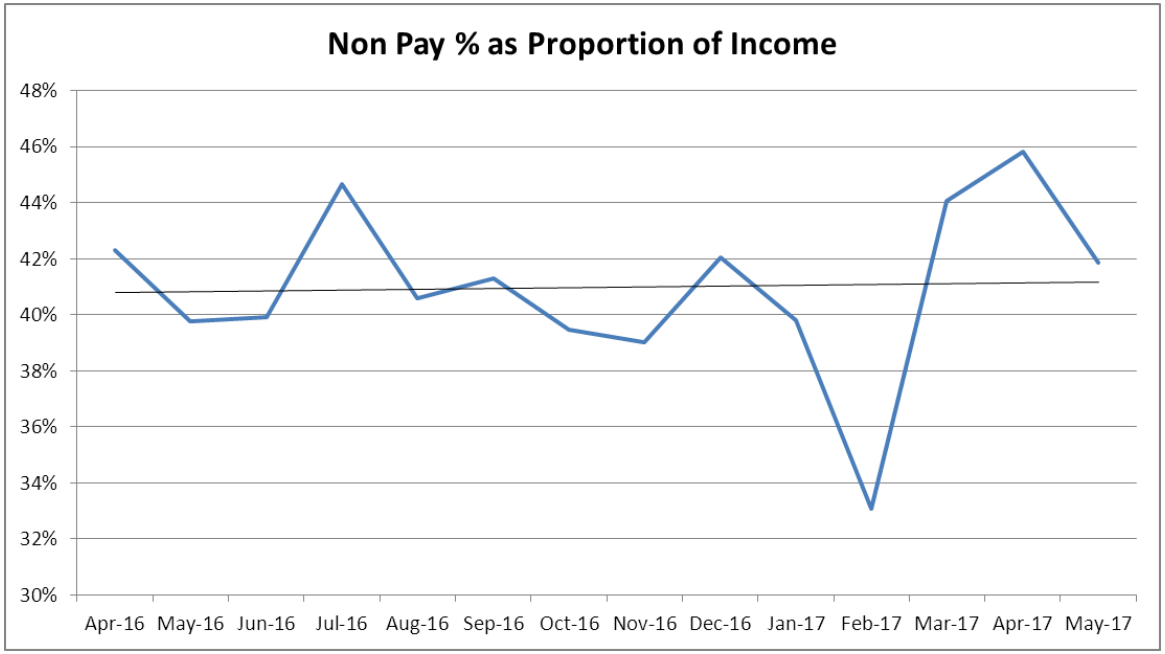






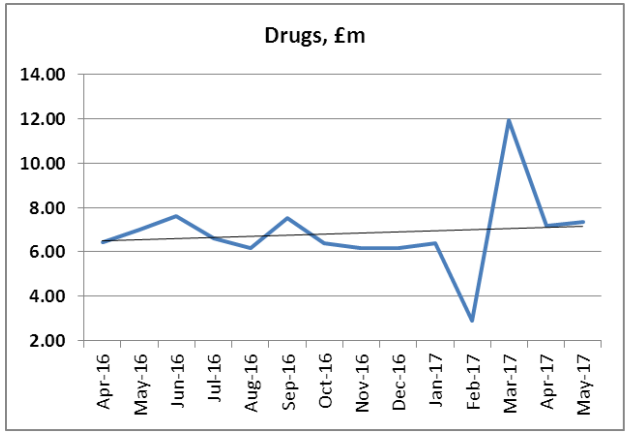


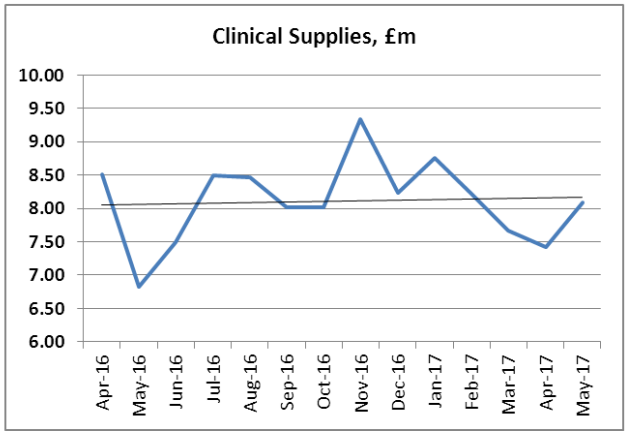
5. Non Pay trend

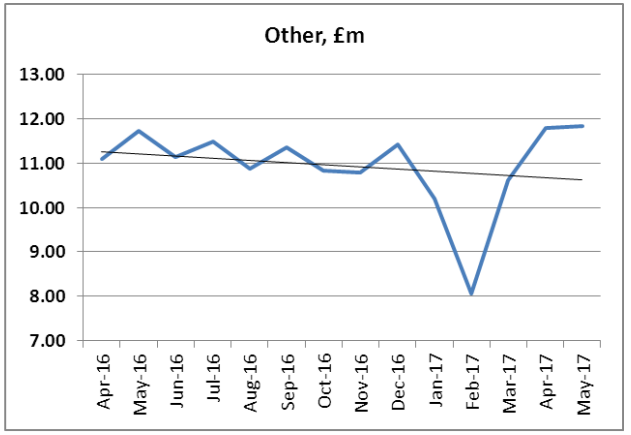


Commentary:

- **Non Pay** has tended to be c41% of Total Income, although in M11 this reduced significantly owing to a VAT reclaim in Commercial Pharmacy in M11 that related to prior year expenditure. In M12 expenditure increase considerably to reflect a year end stock adjustment for drugs. M1 was higher still as Income was very low, despite reduced costs
- **Drugs** costs have stabilised at M2, following the changes seen in previous months mentioned above.
- **Clinical Supplies** tend to be rather uneven in trend terms. Costs in Medcard and Surgery divisions were lower in M1, although they have increased again in M2.
- **Other Non Pay** improved in M11 owing to reduced depreciation cost and SWLP costs (the latter of which was have been offset by reduced income).







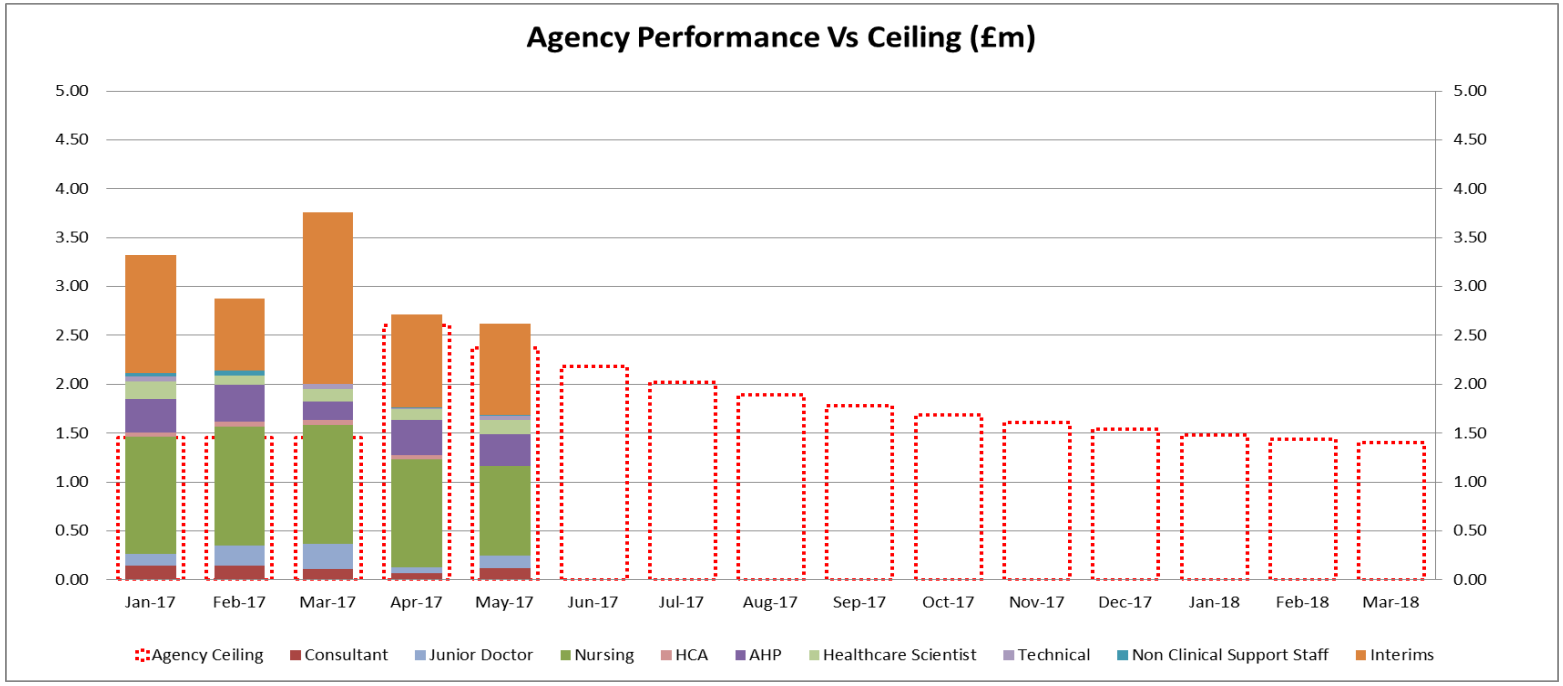
6. Other Income

Other Income Type	M2 Last Year £'m	Annual Budget £'m	Current Month				Year to Date			
			Budget £'m	Actual £'m	Variance £'m	Variance %	Budget £'m	Actual £'m	Variance £'m	Variance %
Provider to Provider	6.1	65.1	5.4	5.2	(0.2)	(3.0%)	10.9	10.4	(0.5)	(4.5%)
Education Income	3.3	37.7	3.1	3.1	0.0	0.0%	6.3	6.2	(0.1)	(1.2%)
R&D income	0.1	0.5	0.0	0.1	0.1	152.4%	0.1	0.1	0.0	21.9%
Private & Overseas patients	0.4	6.6	0.6	0.5	(0.1)	(9.2%)	1.1	0.9	(0.2)	(15.8%)
Road Traffic Accidents	0.3	3.9	0.3	0.3	0.0	0.1%	0.6	0.6	0.0	0.1%
Other	0.5	3.9	0.3	0.2	(0.1)	(32.1%)	0.6	0.5	(0.1)	(15.4%)
Grand Total	**10.8**	**117.6**	**9.8**	**9.5**	**(0.3)**	**(2.7%)**	**19.6**	**18.8**	**(0.8)**	**(4.2%)**

Commentary:

- Other Income is adverse to plan in May by £0.3m, and £0.8m year to date.
- P2P is £0.2m adverse in-month and £0.5m YTD. £0.1m of the in-month and £0.3m of YTD variation relates to SWLP, and therefore has offsetting favourable cost variances. Pathology & Energy Income in the Overheads division are also low at £0.1m in-month and £0.2m YTD.
- Private Patients is primarily underperforming owing to Cardiology CAG (£79k in-month and £164k YTD).

7. 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	0.12											0.18
Junior Doctor	0.12	0.20	0.26	0.06	0.13											0.19
Nursing	1.20	1.22	1.21	1.10	0.91											2.02
HCA	0.04	0.05	0.05	0.05	0.00											0.05
AHP	0.34	0.37	0.18	0.35	0.33											0.68
Healthcare Scientist	0.18	0.10	0.13	0.12	0.15											0.26
Technical	0.06	0.00	0.06	0.00	0.04											0.04
Non Clinical Support Staff	0.03	0.05	0.00	0.01	0.01											0.02
Interims	1.21	0.74	1.75	0.95	0.94											1.89
Total Agency Cost	**3.32**	**2.88**	**3.76**	**2.71**	**2.62**											**5.33**
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	4.98
Variance	**1.87**	**1.43**	**2.31**	**0.11**	**0.25**											**0.35**
Total Pay Cost	41.32	40.47	40.72	40.59	40.73											81.32
% Agency Cost of Pay	8.0%	7.1%	9.2%	6.7%	6.4%											6.6%
% Planned Agency	3.5%	3.6%	3.6%	6.4%	5.8%											6.4%

Commentary:

Agency has reduced in May, but is further adverse to the agreed ceiling (£0.25m in month and £0.35m YTD).

The Trust's annual agency spend target set by NHSI is £24.5m. There is an internal annual agency target of £22.0m. For May, the monthly target set was £2.37m.

Total agency cost in May was £2.62m or 6.4% of the total pay costs. In Q4 2016/17, the average agency cost was 8.1% of total pay costs. Agency cost in May decreased by £0.09m compared to April.

In 2017/18 YTD, the Trust has overspent against the planned target by £0.35m, mainly caused by excess interim cost. The process for accruing for interim costs is being reviewed in time for M3 reporting as the current procedure may lead to overstatement.

8. Cash Summary

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

		Actual M02 vs Plan M02		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	-12.6	-18.1	***-5.5***	**-28.5**
Depreciation	4.5	4.0	***-0.5***	**27.0**
Interest payable	1.2	1.2	***0.0***	**7.5**
PDC dividend	0.6	0.6	***0.0***	**3.8**
Other non-cash items	0.0	0.0	***0.0***	**-0.2**
Operating deficit	**-6.3**	**-12.3**	**-6.0**	**9.6**
Change in stock	-0.5	-0.5	***0.0***	**0.6**
Change in debtors	-0.5	5.7	***6.2***	**1.8**
Change in creditors	1.5	13.7	***12.2***	**-6.0**
Net change in working capital	0.6	18.9	18.3	**-3.6**
Capital spend (excl leases)	-8.4	-9.6	***-1.2***	**-40.7**
Interest paid	-0.7	-0.7	***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	-9.1	-10.3	-1.2	-52.3
WCF/ISF borrowing	8.5	0.0	***-8.5***	**38.0**
Capital loans	5.4	6.0	***0.6***	**16.2**
Loan/finance lease repayments	-1.1	-0.7	***0.4***	**-9.9**
Closing cash 31.05.17 / 31.03.18	**3.0**	**7.7**	***4.7***	**3.0**

M02 YTD cash movement

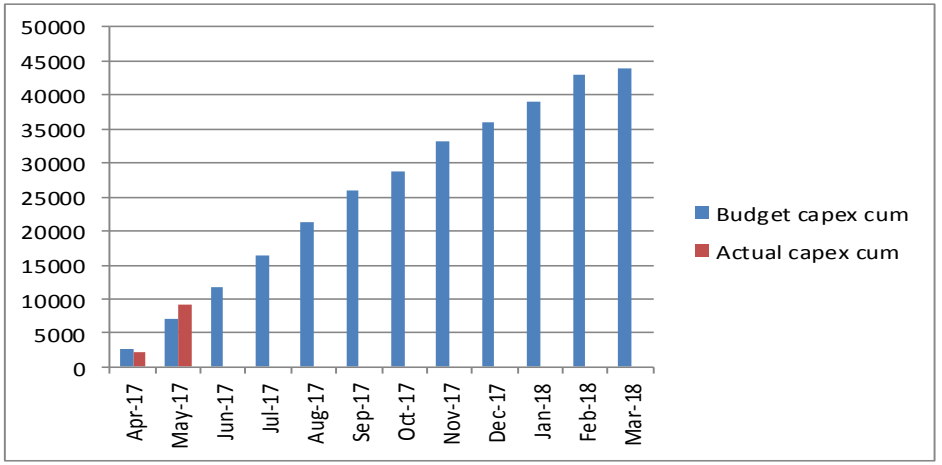
- The cumulative M02 I&E deficit was £18.1m.
- Within the I&E deficit of £18.1m (including £0.2m donated depreciation that sits outside the control total), depreciation (£4m) does not impact cash. The charges for interest payable (£1.2m) and PDC dividend (£0.6m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating deficit" of £12.3m.
- The operating variance from plan of £6m 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 (+£6.2m) and creditors (lower payments to suppliers (+£12.2m) delivering a working capital boost better than plan for the first two months of £18.3m.
- The Trust did not need to borrow from working capital facilities in the first two months due to the working capital performance above however the Trust has submitted a request to NHSI to borrow approx £11m in July. This borrowing requirement is consistent with our plan. The 2017/18 planned deficit of £28.5m necessitates borrowing of approx £38m from working capital facilities over the course of the year.
- The Trust drew down £6m in May from its £16.2m capital loan to finance expenditure on the NHSI-financed projects.

9. Capital Programme Summary

Capital expenditure summary M02 2017/18

Spend category	2017/18 Budget	M02 YTD Budget £000	M02 YTD actual £000	*M02 YTD Variance*
Infra Renewal -EPC	**4,875**	**2,050**	**1,721**	*329*
Infra Renewal	**11,172**	**691**	**827**	*-136*
Med Eqpt	**6,284**	**743**	**2,037**	*-1,294*
Major Projs	**16,642**	**1,305**	**2,005**	*-700*
IMT	**2,567**	**2,312**	**2,478**	*-166*
Other	**601**	**19**	**42**	*-23*
SWL PATH	**684**	**0**	**0**	*0*
Contingency	**1,047**	**0**	**0**	*0*
Total	**43,873**	**7,120**	**9,110**	***-1,990***

Capital prog. 2017/18 - budget & actual expenditure - cumulative



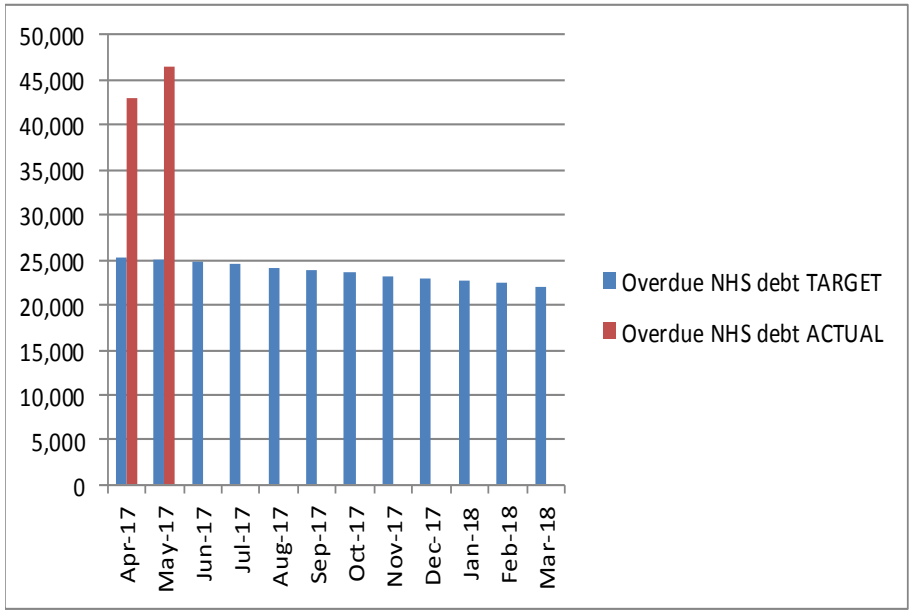
- The capital budget for 2017/18 is £43.8m. Actual capital expenditure in 2016/17 was £33.8m. The 2017/18 budget includes DH capital loan financing of £16.2m.
- Capital expenditure in May was £6.9m and is almost £2m ahead of plan YTD. The May total includes a one-off purchase of beds totalling £1.3m (medical equipment) and expenditure on the demolitions programme for which the budget is profiled later in the year.
- 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 budget.***
- The Trust is preparing bids for to secure additional, unbudgeted STP capital monies to finance estates infrastructure projects (SJW standby generators, SJW theatres refurbishments) and also new MRI scanners and the upgrade of the Cardiac cath labs.

10. Debt management – M02 overdue debt

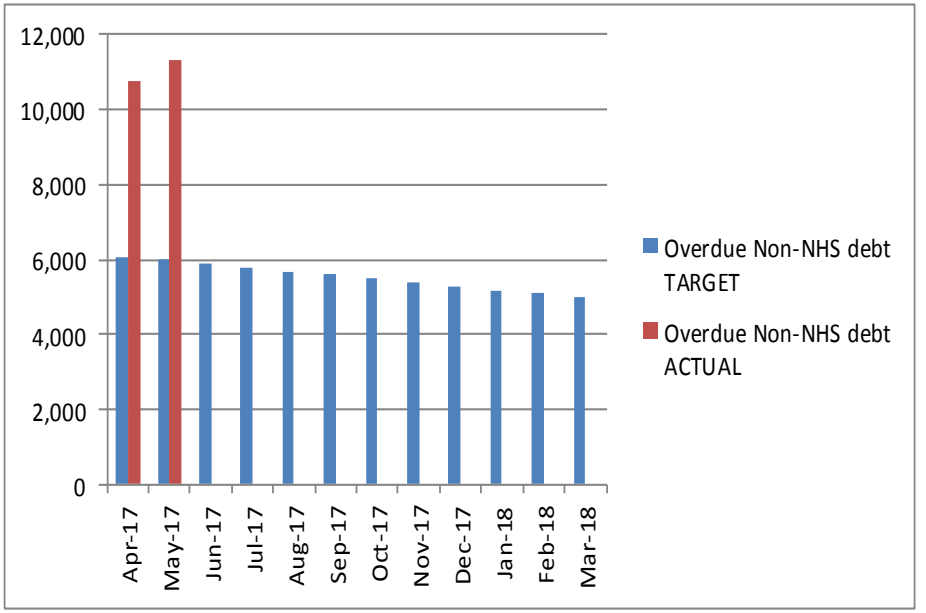
- NHS *overdue* debt increased by approx £3.4m in May to a total of £46.4m. 2016/17 SLA over-performance debt for SWL CCGs and NHSE is outstanding. The Trust expects to secure settlement of these debts by the end of July. NHS current debt reduced by £6.5m in May and so overall NHS debt reduced in the month by approx £3.1m.
- Non-NHS overdue debt increased by approx £0.5m in month mainly in respect of local authority debt for GUM services. The Trust expects to collect this overdue debt by the end of June.

- *NB: The Trust's 2017/18 cash flow plan includes a reduction in overall debt (current plus overdue) of £1.8m over the year and therefore reductions in debt in excess of this value will enable the Trust to reduce its borrowing requirement, ceteris paribus. On the grounds of prudence the cash flow plan does not assume the 'stretch' targets for overdue debt below are achieved.*

Overdue NHS debt: performance vs 'stretch' targets 2017/18



Overdue non-NHS debt: performance vs 'stretch' targets 2017/18



11. Balance sheet as at month 02 2016/17

Balance sheet MAY 2017

	May-17 Plan £000	May-17 Actual £000	*Variance £000*	**Explanations of balance sheet variances**
Fixed assets	344,023	340,975	*3,049*	Reduction in land & buildings valuation in March after Plan figures submitted
Stock	6,087	7,048	*-961*	Year end stock higher than 16/17 plan: movement since y/e in line with 17/18 plan.
Debtors	101,466	96,085	*5,381*	Lower accrued debt and higher receipts for invoiced debt
Cash	3,001	7,750	*-4,749*	Cash higher - better working capital performance YTD
Creditors	-107,801	-131,958	*24,157*	Deferred payment run in May (cyber attack(
Capital creditors	-7,069	-4,734	*-2,335*	
PDC div creditor	-634	-633	*-1*	
Int payable creditor	-936	-760	*-176*	
Provisions< 1 year	-512	-335	*-176*	
Borrowings< 1 year	-57,111	-55,781	*-1,330*	
Net current assets/-liabilities	**-63,509**	**-83,318**	*19,809*	
Provisions> 1 year	-728	-988	*260*	
Borrowings> 1 year	-175,619	-169,364	*-6,255*	Lower drawdowns to due to better working capital performance
Long-term liabilities	**-176,347**	**-170,352**	*-5,995*	
Net assets	**104,168**	**87,304**		
Taxpayer's equity				
Public Dividend Capital	129,956	129,956	*0*	
Retained Earnings	-123,946	-130,065	*6,118*	Higher I&E deficit than plan
Revaluation Reserve	97,008	86,262	*10,746*	Reduction in valuation of land & buildings in March after plan submission.
Other reserves	1,150	1,150	*0*	
Total taxpayer's equity	**104,168**	**87,304**		

12. Borrowings analysis at M02

Borrowings summary - MAY 2017

	Lender	Description	Interest rate fixed/variable	Interest rate pa	Term	Repayment terms	Maximum Facility value £000	Borrowings repay<1 yr at 31/05/17 £000	Borrowings repay>1 yr at 31/05/17 £000	Borrowings at 31/05/17 £000
	Loans									
1	Dept of Health	Capital loan	Fixed	2.20%	25 yrs	Repayable in bi-annual instalments	-14,747	-1,201	-18,347	-19,548
2	Dept of Health	Working capital loan	Fixed	1.38%	15 yrs	Repayable in bi-annual instalments	-15,000	-999	-12,003	-13,002
3	Dept of Health	Working cap facility	Variable: base rate+1%	1.50%	5 yrs	100% repayable on 18/04/20	-25,000	0	0	0
4	Dept of Health	Working cap facility	Variable: base rate+3%	3.50%	5 yrs	100% repayable Sept 2020	-64,272	0	-64,272	-64,272
5	Dept of Health	Interim revenue support facility	Variable: base rate+1%	1.50%	2 years	100% repayable March 2018	-48,700	-48,700	0	-48,700
6	Dept of Health	Interim revenue support facility	Variable: base rate+1%	1.50%	2 years	100% repayable March 2020		0	-15,073	-15,073
7	London Energy Effic. Fund	Capital loan	Fixed	1.50%	10 yrs	Repayable in bi-annual instalments	-13,303	-1,478	-9,608	-11,086
	Loans - total							-52,378	-119,303	-171,681
	Leases									
8	Blackshaw Health. Servs PLC	PFI scheme	Implicit rate	7.50%	35 yrs	Repaid monthly in unitary charge	N/A	-1,004	-43,489	-44,493
9	Various lessors	Finance leases	Implicit rates	3%-7.5%	Various	Repaid quarterly or annually	N/A	-2,399	-6,572	-8,971
	Leases - total							-3,403	-50,061	-53,464
	Total Borrowings							-55,781	-169,364	-225,145

Notes

1 DH capital loan £14.747m approved in 2014 for bed capacity projects, hybrid theatre, surgical assessments unit etc.

2 Working capital loan £15m: approved in January 2015 on licensing of Foundation Trust status to boost working capital resilience. Drawn down in full in March 2015.

3 Working capital facility £25m approved in January 2015 on assumption of Foundation Trust status. Drawn down in tranches July - Sept 2015 inclusive.
This facility was repaid in full on 15th February 2016 using funds drawn from the interim revenue support facility (see no. 5). The facility is no longer available - as advised by NHSI July 2016.

4 Working capital facility £19.6m approved in September 2015 to provide cash support for period October 2015-January 2016 inclusive pending agreement of interim revenue support funding.
This facility was repaid on 15th February 2016 using funds drawn from the interim revenue support facility (see no. 5). **This facility was re-opened and the trust used this facility to borrow from August 2016 to February 2017. The additional borrowing required to finance the higher revenue deficit in 16/17 was drawn mainly under this facility and the facility limit was increased by DH on a month by month basis. The Trust borrowed £64.2m under this facility to M11. A new loan facility was instituted for March.**

5 Interim revenue support facility £48.7m approved in February 2016.
The Trust has utilised this facility in full.

6 New interim revenue support facility loan £15.073m approved by the Trust board and DH in March for the March 2017 drawdown of £15.073m.

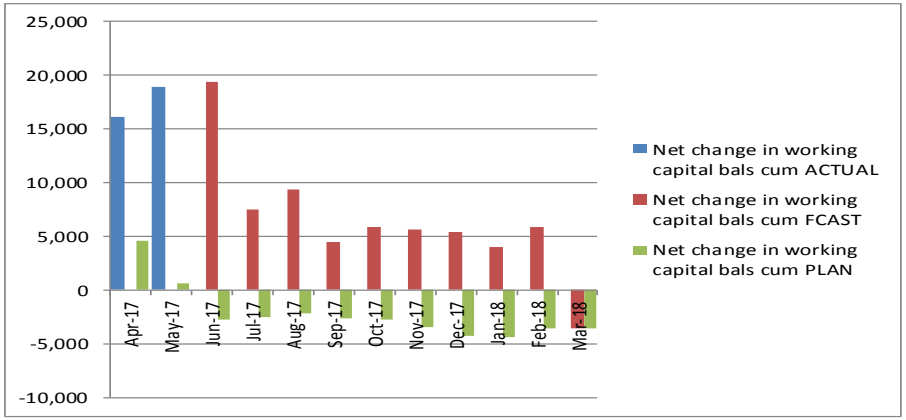
7 London Energy efficiency Fund loan for the energy performance contract.

8 AMW PFI building is accounted as on-balance sheet. The 'borrowing' figure for the lease represents the capital value of the building, fixtures and fittings encompassed in the PFI contract.

9 Finance leases for medical equipment. The capital value of new finance leases represents capital investment and is reported as such in the capital programme.

13. Working Capital – cumulative position at M02

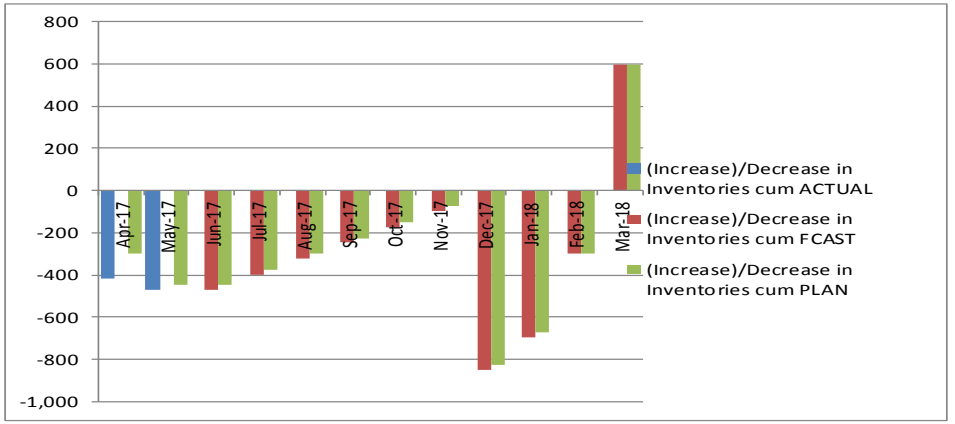
Change in all working capital balances 2017/18 actuals vs plan



£18.3m BETTER than Plan YTD.

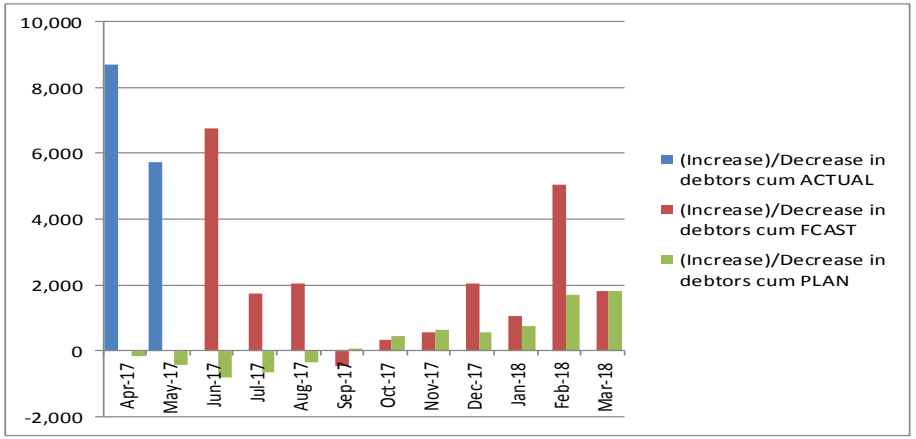
Other 3 graphs on this slide break down this movement by inventories, debtors and creditors.

Change in inventories (stock) 2017/18 actuals vs plan



Inventories change is in line with Plan YTD.

Change in debtors 2017/18 actuals vs plan



£6.2m BETTER than Plan YTD

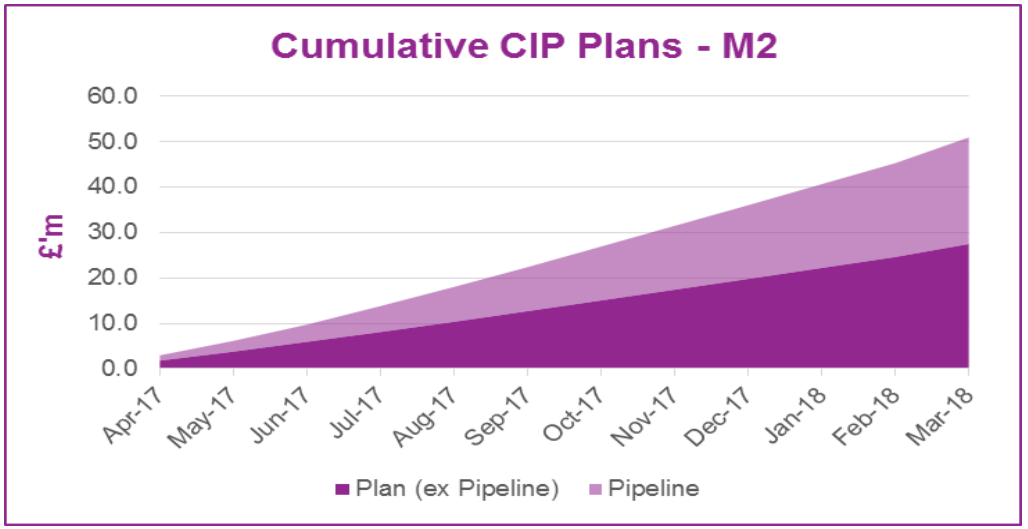
Lower level of accrued debt due to lower over-performance and collection of current invoiced debt.

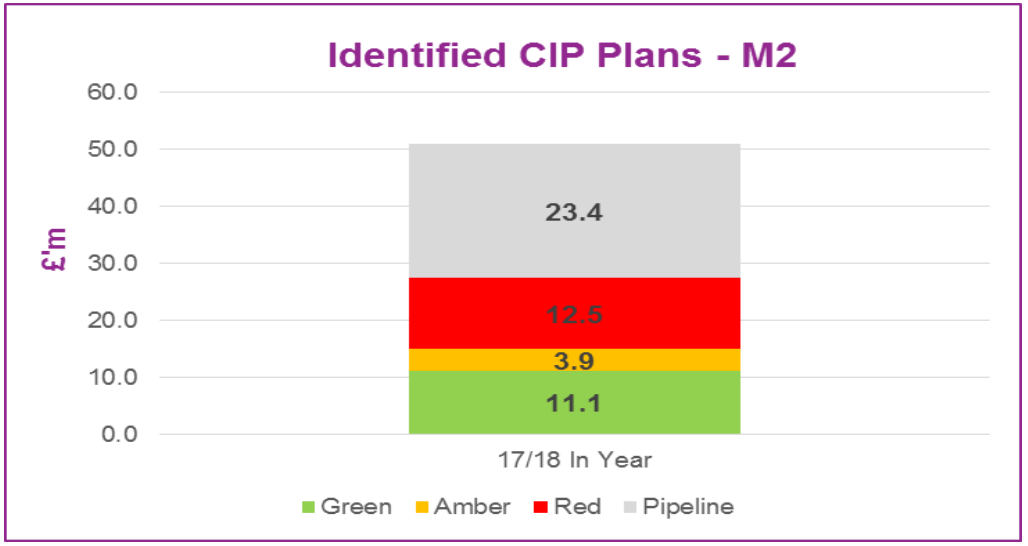
Change in creditors 2017/18 actuals vs plan

£12.1m BETTER than Plan.

The supplier payment scheduled for the end of May was deferred to the first days of June due to the IT security measures implemented to counter the NHS cyber attack.

14a. Cost Improvement Plans - Overview

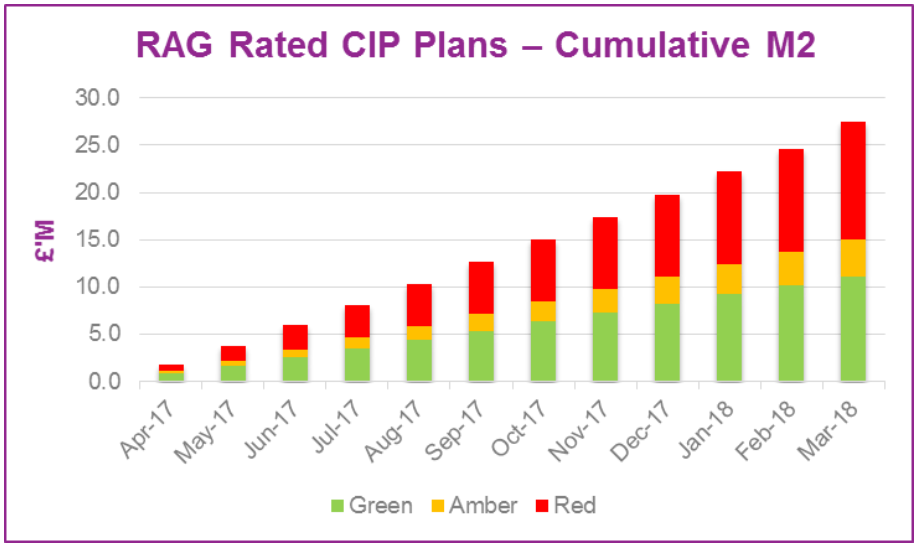


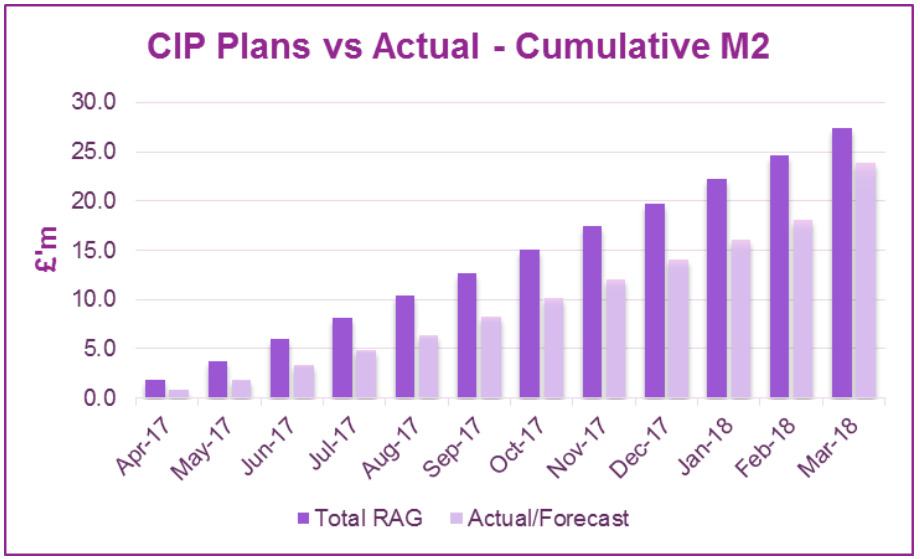


Commentary:

- At the end of Month 2 the Trust's CIP Tracking Databases show £50.9m in total of CIP plans.
- £27.5m of these plans have been 'RAG' rated and the remaining £23.4m are schemes which form the 'Pipeline'.
- The £27.5m is currently made up as follows:
    - Green - £11.1m
    - Amber - £3.9m
    - Red - £12.5m
- The finance ledger and previously agreed plan with NHSI shows a total CIP target of £60m. This has been devolved to Divisions as per the table below:

14b. Cost Improvement Plans - Progress





Commentary:

- The £27.5m of 'RAG' rated CIP plans (RAG rated plans exclude 'Pipeline' schemes) have been phased in line with their expected delivery in the Divisional CIP Trackers. This is shown in the graph opposite.
- The year to date plan value (£3.8m) is currently split as follows:
  - Green - £1.7m
  - Amber - £0.5m
  - Red - £1.6m
- As at Month 2 £1.7m has been recorded as delivered against the RAG rated plans, producing an adverse variance of £2.1m.

Division	Year to Date		
	Plan (£m)	Actual (£m)	Var (£m)
Corporate	0.77	0.49	-0.01
Estates & Facilities	0.36	0.00	-0.31
MDCD	1.45	0.54	-0.81
SCNT	1.70	0.40	-0.56
CWDT	1.80	0.31	-0.38
CSD	0.08	0.08	0.00
Total	**3.79**	**1.71**	**-2.07**

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	6 July 2017	**Agenda No.**	**5.1**
Report Title:	Update on Freedom to Speak up Guardian/LIAiSE		
Lead Director/ Manager:	Harbhajan Brar		
Report Author:	Karyn Richards-Wright		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other – for information		
Executive Summary:	Update on the integration of the Freedom to Speak up requirement and the LIAiSE role since December 2016		
Recommendation:	This paper is provided for information and to assure the Trust Board that it is compliant.		
Supports			
Trust Strategic Objective:	Supporting our staff, listening to staff, staff engagement, equality & diversity		
CQC Theme:	Freedom to speak up, safe & effective; engagement and leadership		
Single Oversight Framework Theme:			
Implications			
Risk:	Non compliance, no freedom to speak up guardian		
Legal/Regulatory:	Compliance with guardians office		
Resources:	Publicity material, not resourced other than covering from existing budget		
Previously Considered by:	n/a	**Date:**	
Equality Impact Assessment:			
Appendices:			

St George's University Hospitals NHS
NHS Foundation Trust

Update on Freedom to Speak up Guardian
Board 06.07.17

1.0 PURPOSE

1.1 The purpose of this report is to update the Board on the Freedom to Speak up/LIAiSE service and assure the Board of compliancy.

2.0 BACKGROUND

2.1 Following the 2015 review and subsequent report into the failings in Mid-Staffordshire, it was recommended that all NHS trusts appoint Freedom to Speak up Guardians (FTSUG).

2.2 Our Freedom to speak Guardian is Karyn Richards-Wright.

2.3 The Freedom to Speak Guardians have a key role in helping to raise the profile of 'raising concerns' and to 'provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled'.

2.4 The Freedom to Speak Guardians doesn't get involved in investigations or complaints, but help to facilitate the raising concerns process where needed, ensuring organisational policies are followed correctly.

2.5 Our Freedom to Speak Guardian is also one of our LIAiSE Advisers, as both roles are about supporting our staff whenever they have concerns. We have combined both roles as we have sought to harness and build upon the success of the LIAiSE service, promoting the profile of raising concerns, and to give our staff the reassurance and confidence that they are listened to. Through the LIAiSE work, the guardian does a lot of work with whole teams, which helps to identify areas of concern or issues that need to be addressed with managers. The combined role ensures that we are taking a proactive rather than reactive position

2.6 At present there are no live Freedom to Speak up cases.

3.0 Current Engagement with staff

3.1 The Guardian has advertised the Freedom to Speak up service on the intranet via eG You in which it has been arranged with the comms team to be run at least fortnightly.

3.2 The Guardian attends Trust Induction and speaks to new starters, providing them with information about the role of the Guardian. From July we will extend this to include the monthly Doctors induction. The Guardian also operates a drop in clinics (combined with the LIAiSE clinics) in the community areas. The Guardian attends St John's Therapy Centre, Tooting Health Clinic, Doddington Health Centre, Tudor Lodge and QMH on a fortnightly basis.

3.3 There is a programme of meetings planned over the next 6 months, whereby the Guardian will meet with Trust staff, so they are fully aware of the role and how to approach her.

3.4 Over time we are hoping create a network of Guardians/Freedom to Speak up Champions at this Trust who can support staff in speaking up when necessary.

3.3 Ensuring that staff have quick access to a guardian/LIAiSE Adviser is crucial to ensuring that staff feel supported and get the help, support and guidance when required. We know from

feedback that had staff not received the support from the Guardian/LIAiSE Adviser they would have resigned.

3.4 The Guardian/LIAiSE role supports Trust's strategic objectives and regulatory framework, by ensuring that staff are supported, listened to and engaged with, thereby seeking to create a culture of transparency.

4.0 IMPLICATIONS

Risks

4.2 Should the Guardian not be in place and accessible to staff, the risk of staff feeling unable to speak with their line manager about patient safety concerns could have serious consequences to the safety of patients.

5.0 RECOMMENDATION

5.1 The current Guardian recommends that the Trust:

I. Continues to publicise the role of the Guardian, including how the access the Guardian.

II. Seeks to develop a network of champions/recruit more guardians.

Author: **Karyn Richards-Wright Freedom to Speak Up Guardian**
Date: **27.06.17**

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	6 July 2017	**Agenda No**	**5.2**
Report Title:	Staff Engagement Plan 2017/2018 in response to the NHS Staff Survey 2016/ 2017		
Lead Director/ Manager:	Harbhajan Brar, Director of Human Resources and Organisational Development		
Report Author:	Alison Benincasa, Divisional Chair Community Services Moji Adetoye, Divisional Human Resources Manager		
Presented for:	Update and endorse		
Executive Summary:	This report is submitted to provide an update on the development of the Staff Engagement Plan 2017/2018 in response to the NHS Staff Survey 2016/ 2017. One of the initial action points agreed by the Trust following the release of the 2016 Staff Survey was to establish a working party led by an independent senior manager to address three key areas for improvement identified in the NHS Staff Survey 2016: - Addressing Bullying and Harassment - Improving Staff Engagement - Improving Equality and Diversity The working party, led by the Divisional Chair for Community Services, was made up of staff side representatives and a range of staff from across the Trust. The working party met weekly over a four-week period and developed a number of improvement initiatives from analysis of the available literature and conversations with staff within various services. In addition, the working party reviewed the Workforce and Staff Experience plan 2016/2017 and selected actions to be carried over to 2017/2018. The working party tested out their ideas with staff from across the Trust at two Café style events held on 21 and 23 June 2017. Lunch was provided and staff had the opportunity to discuss ideas/initiatives under the key areas for improvement outlined above. The working party also engaged the services of Pinchpoint Communications (external staff engagement company) who assisted with pulling the themes into the proposed action plan included in appendix 1.		
Recommendation:	The Trust Board is asked to review and endorse the evolving Staff Engagement Plan 2017/2018.		
Supports			
Trust Strategic Objective:	Ensure the Trust has unwavering focus on all measures of quality and safety, and patient experience		
CQC Theme	Well Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (well-led)		

Implications	
Risk:	Failure to deliver the Staff Engagement Plan may result in reputational damage; loss of confidence in the organisation; and perceived failure of leadership to engage staff
Legal/ regulatory	There are no specific legal or regulatory implications
Resources:	The resource implications associated with this proposal will be developed as the staff engagement plan evolves
Previously considered by	N/A
Equality impact assessment:	N/A
Appendices:	Appendix 1: Staff Engagement Plan 2017 - 2018

Staff Engagement Action Plan 2017 – 2018
In response to the NHS Staff Survey 2016 - 2017

1.0 Purpose

This report sets out the approach to the development of the Staff Engagement Plan 2017-2018 in response to the NHS Staff Survey 2016 – 2017.

2.0 Background

The results of the NHS Staff Survey 2016 were a difficult read for the Trust. The initial action points agreed by the Trust following the release of the 2016 Staff Survey included further analysis of the results to enable a full understanding of the key issues and to establish a working party led by an independent senior manager to address three key areas for improvement:

- Addressing Bullying and Harassment
- Improving Staff Engagement
- Improving Equality and Diversity

A summary of the further analysis undertaken was outlined in reports presented to the Executive Management Team on 24 April 2017 and the Trust Board on 11 May 2017, this included reviewing the data via divisions, directorates and professional groups such as nursing, medicine and therapies. Verbatim comments provided by staff were also reviewed and the most common themes were identified. Following this the working party was established which consisted of staff side representatives and staff from across the Trust.

3.0 Approach

The group held four meetings between 23 May 2017 and 14 June 2017 and took the following approach to devise the Staff Engagement Plan 2017 – 2018:

1.0 Reviewed all previously supplied information with a focus on ‘what this mean for me, our staff and our services’.

2.0 Held discussions in relation to the three key areas for improvement and generated ideas/ initiatives.

3.0 Created an action plan template and collated all ideas/ initiatives under the three improvement areas.

4.0 Reviewed the 2016/2017 Workforce and Staff Experience action plan to determine any on-going action points or any actions to be brought forward into 2017/2018.

5.0 Each member selected their top 5 ideas under each improvement area.

6.0 Adopted a quality improvement approach to the top 5 ideas for each area of improvement and split ideas into primary and secondary drivers.

7.0 Provided an open invitation for staff to test out the ideas of the working party and to assist in prioritising the practical action points to be taken.

8.0 Two events were held, 'Would you like to join us for lunch?', where Harbhajan Brar Director of HR and Workforce and Alison Benincasa, Divisional Chair for Community Services invited staff to café style events; one at the St George's hospital site on Wednesday 21 June 2017 and the other at St John's therapy centre in Battersea on Friday 23 June 2017 for staff in the community. 85 staff joined us to test the ideas developed by the working party and share their views.

9.0 Following these events Sarah Pinch, from Pinchpoint Communication helped us to gather all of our thoughts in to our Staff Engagement Plan (included in appendix 1).

4.0 Next Steps

1.0 The developing Staff Engagement Plan 2017 - 2018 to be approved by the Trust board to enable further work to be undertaken to confirm actions to be taken, by when and by who.

2.0 The clinical and corporate divisions to take forward the actions as appropriate and address key areas going forward

3.0 The Staff Engagement Plan 2017 - 2018 to be publicised widely through the organisation so that staff know that their views have been heard and taken seriously

4.0 Divisions to devise 2 or 3 local action points (if not done so already) to add to the Staff Engagement Plan 2017 - 2018

5.0 The working group to continue to work together to monitor and support the delivery of the plan and continue to promote and develop future initiatives and to include staff who indicated at the café style events that they wanted to be involved

6.0 The delivery of the Staff Engagement Plan 2017 - 2018 to be monitored at the Divisional boards with the support of the working group

7.0 The working group via the Workforce and Education Committee to update the Trust Board

Authors : Moji Adetoye, Divisional Human Resources Manager
Alison Benincasa, Divisional Chair, Community Services

Date: 27 June 2017

APPENDIX 1

Staff Engagement Plan 2017 - 2018

1.0 Introduction

Work undertaken by the King's Fund in 2012 made a clear link between excellent patient care and a NHS team who feel valued, listened to and involved in the future of their hospitals, and their work.

St George's has had some disappointing staff survey results.

Staff have continued to say they do not feel listened to.

This plan seeks to change that, through clear ideas, doing things differently and sticking to a plan. Many of the ideas in this plan have come from the staff.

2.0 What staff have told us

The Trust has some very real issues, it is in financial and quality special measures; and the staff survey identified three main areas for work:

1. Improving staff engagement
2. Addressing bullying and harassment
3. Improving equality and diversity

(Key themes from the staff survey)

- Put it on paper. Make it **official.** Get the message to the right people.
- Build a **relationship** with me.
- Have a **stable, visible** leadership team; get out and about.
- More emphasis on **you said, we did.** Include a you said we did notice board in key areas on and off site. Change the message on a monthly basis.
- Keep us aware of changes going on in the department and **acknowledge problems frankly.**
- My manager is fine, **it's those higher up** who are not doing enough/enabling change/empowering my manager.
- Have a better understanding of the care we provide. **Spend time in the clinical areas and** be innovative, supportive and visionary rather than reactive.
- Actually **come and speak to us**, in the four years I have been here I have not met with my manager once nor has she set foot in the department.
  (Verbatim comments from PPC staff engagement survey)
- Ensure higher managers **don't ignore bad behaviours** in middle management
- Top down autocratic management styles throughout organisation. **People not listening.** Attitude of some staff poor. **Lack of respect.** Attitude of if something goes wrong, stop doing it rather than learn.

- **Please listen to us** and don't determine our futures without engaging with us.
- **Come and talk to staff** – do not rely on the messages that are managed upwards.
- **Empower staff** to be involved in procurement to make practical savings.
- Should be supported to have **more power to make changes** to improve quality and care by driving standards of care expected from staff despite their positions
- **Stuck in treacle**. So many changes, no accountability…no organisational memory – Groundhog Day – repeating same stuff and not moving forward
  (Verbatim comments from post it note exercises with Chief Exec)

3.0 Three key areas and four themes

3.1 What do we want to do?

We want to engage staff, so we can improve these three key areas:

1. Improving staff engagement
2. Addressing bullying and harassment
3. Improving equality and diversity

3.2 How do we want to do it?

1. Regular, actively listening is vital.
2. Consistency and stability in leadership and engagement
3. Empower staff at every possible level
4. Led by example, be brave
5. Be honest.

4. Action plan

The action plan is in three parts, based on the key improvement areas from the NHS staff survey. Some of what the action plan contains has already been acted upon.

4.1 Improving staff engagement

a. **Recruit engagement champions,** from those staff who have already said they want to be involved; ask for their help in connecting the leadership of the organisation with front line staff, provide some training and support.

b. **Monthly executive visits** to different departments, wards and offices; dates and locations to be published, never to be cancelled, no agenda, informal.

c. **Monthly meet the executive directors.** To be held with no agenda, for staff to come to meet the directors and ask any questions. Note: These will be managed by the communications team and will broadly follow the format of 'meet the CEO session'.

d. **Teamtalk**. Informal breakfast meetings with the Chair and Chief Executive, for a cross section of staff at different locations, lasting an hour. Note: This has already been organised, with the inaugural session taking place on the 9th August.

e. **Publish you said, we did every month.** Online and offline. Engagement champions to help keep information boards up to date, with clear information.

f. **Relaunch Listening into Action (LiA).** Local LiA champions, who run local events with central support; Identify a local trainer to induct staff; use LiA to celebrate good news.

g. **Relaunch staff awards, linked to behaviours.** Set up a task and finish group to revitalise the staff awards, tie the awards back to the three key areas and based on the Trust values and behaviours

h. **Ensure team meetings are taking place.** Monitor this through appraisals and HR Business partners. Ask key questions at executive walk around and drop in sessions.

i. Use **welcome and thank you cards**. Ensure every new starter feels welcome and existing staff feel thanked, make them available across the executive team and to all with management responsibilities.

4.2 Addressing bullying and harassment

a. **Tackle poor behaviours.** Role model behaviours at all levels, use the appraisal system more effectively. Set up a hotline for staff to report poor behaviours to HR business partners.

b. **Introduce 360° reviews** for all middle managers and above.

c. **Commit very clearly, to the Trust's values.** Involve staff in the development of behaviours that are acceptable and those that are not, as part of a refresh of the Trust's existing values and behaviours – and ensure that staff are recruited, appraised, rewarded and managed against them; consistently.

d. **Introduce positive event reporting** and use the same rigorous process, to learn from the positive events, as we do to learn when things go wrong.

e. Consider a **charter of behaviours** as part of the refresh of values – how the executive team promise to behave and they make a public commitment and how mangers promise to behave, and they commit to it publicly too.

4.3 Improving equality and diversity

a. **Roll out values based recruitment**, using very clear behaviours and empower managers to be confident in not recruiting, because of poor behaviours. Have an executive champion.

b. **Commit to improve understanding,** and **ensure compliance** with all relevant policies at all levels, work through very senior leaders, clinical and non-clinical to ensure they understand their responsibilities to adhere to the policies and to implement them.

c. **Have strong, consistent leadership and empower all staff in equality and diversity.** Have champions, ensure high visibility of diverse staff, gender, age, sexuality, race, job role, length of service, unsung heroes. Have a highly visible campaign when the values are refreshed, that clearly shows a 'new way' at St George's.

d. **Have a board level champion, who is visible and active in this role, not a paper based exercise.** Someone who is brave and will speak out positively about the benefits of equality and diversity.

e. **Launch a pilot mentoring scheme.** Include reverse mentoring, and provide support for those who want to be part of the scheme.

f. **Tell our story,** powerfully and positively; make equality and diversity part of the story of St George's recovery.

5. Next Steps

A clear timescale will be confirmed for each set of actions.

The action plan will be published on the intranet and sent to all those staff who gave their contact details at the lunch time events held on 21 and 23 June 2016 and want to remain involved.

All staff will receive a monthly update, and regular updates will be provided to the Board for monitoring.

6. Conclusion

There is a desire for change, staff are looking for actions now and this plan clearly sets out several actions.

Change for some issues will take time, but there is a desire to see that some key things have changed, in the short term; especially relating to leadership and changing the culture around unacceptable behaviours.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board Meeting		
Date:	6 July 2017	**Agenda No.**	**5.3**
Report Title:	Communications Strategy – 2017/18		
Lead Director/ Manager:	Chris Rolfe – Associate Director of Communications		
Report Author:	Chris Rolfe – Associate Director of Communications		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	The attached summarises a communications strategy and approach for the remainder of the current financial year (2017/18). The high level aims of the strategy are to: - Help tackle our quality, financial and performance challenges - Rebuild confidence in St George's - Be positive, and celebrate what we do - Ensure staff are engaged, and feel part of Team St George's We propose five key objectives to help us deliver these aims, all of which are supported by a series of deliverables, which are detailed in the attached. The objectives are as follows: - *Narrative:* Develop a single, compelling narrative for the organisation - *Staff communication:* Improve existing internal communications channels, including increase in two-way communication - *Engaging campaigns:* Provide communications support for major organisational campaigns, initiatives and plans - e.g. Quality Improvement Plan, Elective Care Recovery Programme - *Stakeholder engagement:* Drive, manage and oversee an engagement programme with local and national stakeholders - *Celebrate our success:* Celebrate our successes internally, amongst staff, and in mainstream and social media The strategy also sets out how we will measure and evaluate associated communications activity, so we can regularly assess the aims and objectives we have set ourselves.		
Recommendation:	Agree communications strategy and approach.		
Supports			
Trust Strategic	Ensure the Trust has an unwavering focus on all measures of quality and		

Objective:	safety, and patient experience.
CQC Theme:	Well-led
Single Oversight Framework Theme:	Leadership and Improvement Capability (well-led)
Implications	
Risk:	Failure to deliver this strategy may result in reputational damage; loss of confidence in the organisation; and perceived failure of leadership to engage and inspire staff.
Legal/Regulatory:	There are no specific legal or regulatory implications
Resources:	There are no specific resource implications associated with this proposal.
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard and Freedom of Information Act.
Appendices:	Appendix 1: Communications activity - table summary of where we were, where we are, and where we want to be Appendix 2: Insight – copy of summary activity report issued to Executive Management Team each month Appendix 3: Channels - summary of existing communications channels (internal and external)

23 June 2017

St George's University Hospitals NHS Foundation Trust

Communications strategy – 2017/18

Contents:

1) BACKGROUND

1.1 An effective communications strategy will enhance and protect the reputation of any large, complex organisation. It will also act as a key enabler for how the business is run, and how its people respond to change.

1.2 This is particularly true of St George's, given the quality and financial challenges we face; our recent history of leadership changes; and the on-going need for clarity about who we are, and what we want to achieve.

1.3 Measuring the effectiveness of communications can be difficult, and open to interpretation. However, there is evidence to suggest Trust communications has improved in recent months.

1.4 We know that effective communication has helped to improve the response rate to two major Trust-wide campaigns this year. For example, 40% of staff responded to the NHS staff survey in 2016 (compared to 30% in 2015); and the percentage of staff attending for flu immunisation was 72% in 2016, a significant increase on the 52.8% vaccinated in 2015.

1.5 In June 2017, CQC inspectors said that staff had commented on improved communications from the Trust Board. In addition, the latest Staff Friends and Family Test (January-March 2017) found that 36% of staff agreed that the Trust Board provided clear direction for the organisation, and communicates it effectively; compared to 30.3% between July-September 2016.

1.6 However, there is clearly a huge amount still to do; both internally, with our staff, but also with our key stakeholders externally. We are a long way from

where we need to be, even though improvements have been made. The baseline and starting point for communications activity (as set out in appendix 1) was relatively low.

1.7 This strategy builds on recent improvements by setting new objectives for the rest of this year (up to March 2018). We have a new leadership team, who bring a fresh and positive outlook to the organisation - and this needs to be reflected in how we communicate.

1.8 Developing a communications strategy for the remainder of the year may appear a short-term approach but, until a long-term strategy for the organisation has been agreed, it is almost certainly the right one. A long-term communications strategy, linked to a wider organisational strategy, will be developed for 2018 onwards.

1.9 In the meantime, we can – and will – deliver further improvements to the way in which we communicate; and articulating how we do this is the purpose of this paper.

2) SCOPE

2.1. This paper sets out a communications strategy for the remainder of the coming year (2017/18) only.

2.2 It does not cover GP liaison, nor Foundation Trust Membership - although we work closely with the teams directly responsible for communicating with these audiences. The same applies to Governors, for whom the membership office are the lead.

2.3 Also outside the scope of this document is the organisation's emerging staff engagement strategy. We are, however, closely involved with this work, and are also involved in the organisation's response to the latest NHS staff survey results.

2.4 Finally, this strategy does not (formally) cover patient and public involvement (PPI), even if our patients, and the communities we serve, will engage with and respond to external communications activity.

3) INSIGHT/ANALYSIS

3.1 In the past year, we have improved the way in which the Trust communicates, and how the communications team operates. It is too early to assess the long-term impact of these changes, although some real progress has been made.

3.2 In terms of staff communications, we know from surveys carried out in September 2016 and April 2017 that improvements have certainly been made. For example, in September 2016, 57% of staff found it very easy or fairly easy to find out what's going on at the Trust; this had increased to 65% in April 2017.

3.3 Our media profile remains strong, due primarily to the Channel 4 documentary series *24 Hours in A&E*. We have secured notable media successes, including national coverage of our stroke and paediatric services; this includes front page stories in the Evening Standard on two separate occasions, reaching two million people in the process (*Girl 'brought back to life' by revolutionary new stroke treatment, 20 October; Baby becomes youngest to survive major surgery, 1 March*).

3.4 We have also secured positive coverage in local media, particularly in the Wandsworth Guardian. However, we need to take a more strategic approach to our media outreach, and aim for greater exposure of our key services; and the recent appointment of a new Media Manager will help in this regard.

3.5 We have introduced a monthly Stakeholder Bulletin which goes to 200 key stakeholders including local MPs, councils, CCGs, Healthwatches and neighbouring Trusts. Readership is good, with an average read rate of 50 per cent.

3.6 In the past year, we have moved from briefing stakeholders reactively to proactively – we now brief them in advance about emerging issues or impending announcements, such as leadership changes or stories that may attract media attention. Our relationship with local Overview and Scrutiny Committees has also improved. We brief them proactively about Trust business, and scrutiny officers now have a single, named contact to liaise with in the communications team.

3.7 We have also restructured the communications team, and transformed the mix of internal and external channels at our disposal. This includes the introduction of a weekly message to staff from the Chief Executive; twice-weekly bulletins; a new staff app, *MyGeorge*, and regular face to face forums between senior and front-line staff. A summary of the changes we've made are summarised in appendix 1.

4) AIMS

4.1 The high level aims of this communications strategy are to:

1) **Help tackle our quality, financial and performance challenges**

2) **Rebuild confidence in St George's**

3) **Be positive, and celebrate what we do**

4) **Ensure staff are engaged, and feel part of Team St George's**

4.2 So why have we chosen these aims?

4.2.1 *Help tackle our quality, financial and performance challenges*

Unfortunately, the uncertainty caused by repeated leadership changes; the CQC's inspection report published in November; and 'special measure' status for both finance and quality have all had a negative impact on perceptions of the Trust.

Restoring confidence in the organisation means addressing our quality, financial and performance challenges for the benefit of staff, and the patients we treat. An effective communications strategy will serve as both an enabler in this regard, but also as a way of demonstrating grip and traction, as well as celebrating progress.

4.2.2 Rebuild confidence in St George's

Given the challenges outlined above, we need to rebuild confidence in St George's, and the services we provide. This means positioning St George's as a trusted partner, and as an organisation that consistently delivers what it says it will. We also need to ensure we have a strong voice locally, given the emerging importance of the south west London sustainability and transformation plan (STP). This communications strategy is designed to cement and protect St George's status as a major teaching hospital, and provider of local services and tertiary specialities.

4.2.3 Be positive, and celebrate what we do

There is a pervading sense (certainly amongst staff, and the consultant body in particular) that St George's, given its status, has always 'batted beneath its average', and doesn't 'sell' itself as successfully as other Trusts do.

There is a historical context to this, although we have worked hard in recent months to celebrate good news in mainstream and social media, plus internally with staff. However, there is clearly more work to do; not only in terms of improving morale, but positioning St George's as a centre of excellence for specialist services, both nationally and internationally.

We also need to set a more positive, optimistic tone for the organisation. We have a proud history. There is a huge affection for St George's locally, and people want us to succeed. Of course, there are challenges, and we need to be honest about the problems that remain; but this shouldn't stop us being optimistic or forward-thinking.

4.2.4 Ensure staff are engaged, and feel part of Team St George's

Many staff regard St George's as a special place to work, but the past 12 to 18 months have been challenging for our staff. Indeed, only 36% of staff surveyed for the FFT during July and September 2016 said they would recommend the Trust as a place to work. This is now up to 47% (January-March 2017), but is still far below where we should expect, or want, it to be.

By communicating effectively with our staff, in new and innovative ways, we can ensure they are kept fully informed about what is happening at the Trust. As important, we can ensure they feel valued, listened to, and wanting to be part of the

improvement journey we all feel is necessary at St George's. This must be true of everybody at the Trust – be they hospital or community based.

Our staff are our greatest asset, but we need to make them feel like they are. This is why equipping our managers with the skills and collateral to communicate effectively with their own teams is a key part of this strategy; research shows that this relationship has the potential to be more powerful than any corporate communication channels at our disposal.

5) OBJECTIVES

5.1 In order to meet these aims, we have set ourselves achievable and measurable communications objectives for the remainder of the year, which to some extent build on work either ongoing, or recently started.

5.2 Each objective is supported by a series of deliverables, all of which are designed to I) help us deliver the objectives we have set for ourselves and/or II) to improve the communications tools and techniques at our disposal.

5.3 The objectives are set out below, together with the associated deliverables. Once this paper has been agreed, we will set out the detailed actions required, and associated timescales for delivery; although some activity is already underway.

A) *Narrative:* Develop a single, compelling narrative for the organisation

Deliverables

- Develop over-arching narrative, supported by a clear statement of priorities and enabling strategies
- Develop set of supporting key messages, which are in turn tailored for different audiences (both internally and externally) to enhance understanding and buy-in
- Produce range of engaging digital and paper communications collateral to help support and embed narrative and key messages
- Develop brand and visual identity to support narrative and organisational ambition
- Ensure greater visibility of executive team and senior managers/clinicians as part of embedding the narrative, particularly internally amongst staff

B) *Staff communication:* Improve existing internal communications channels, including increase in two-way communication

Deliverables

- Improve quality and read-rates for existing staff internal communications channels

- Increase face to face and two way communication opportunities with staff

- Develop short and long-term plan for Trust intranet (see also Gaps and risks)

- Launch new monthly magazine for staff, *By George*, to complement our improved (and existing) digital communication channels

- Develop action plan and toolkit to improve the way in which managers brief their teams

C) *Engaging campaigns:* Provide communications support for major organisational campaigns, initiatives and plans - e.g. Quality Improvement Plan, Elective Care Recovery Programme

Deliverables

- Identify key organisational projects requiring communications support/input

- Develop bespoke communication plans, all of which link to organisation's single, compelling narrative

- Use creative, innovative communications tools and techniques to reach different audiences, including traditionally hard to reach groups (such as junior doctors and consultants)

- Regularly measure and evaluate success of campaigns, and adjust/amend approach as appropriate

D) *Stakeholder engagement:* Drive, manage and oversee an engagement programme with local and national stakeholders

Deliverables

- Undertake stakeholder mapping exercise to ensure we are targeting key influencers, and to identify gaps that may exist

- Nominate named individuals to establish links with key stakeholders as part of 'buddying arrangement'

- Hold quarterly engagement events for key stakeholders, plus more regular bespoke activity for local MPs (including tours of services and meetings with clinicians)

- Regular blogs/opinion pieces from members of executive team/senior clinicians

E) *Celebrate our success:* Celebrate our successes internally, amongst staff, and in mainstream and social media

Deliverables

- Deliver programme of positive local, regional, trade, national and international media coverage (print, online and broadcast)

- Ensure greater and more effective use of social media channels, particularly Facebook, Twitter and LinkedIn, to celebrate successes and convey improvement journey

- Extend use of video, graphic and interactive content via internal and external communications channels

- Fully leverage reputational benefits of Channel 4 documentary series 24 Hours in A&E, and other filming projects underway

6) SUMMARISING OUR APPROACH

6.1 We need to deliver a step-change in the way we communicate, which involves setting a more positive, optimistic tone for the organisation.

6.2 This is particularly important for our 9,000 staff who, anecdotally, are tired of senior colleagues 'talking the organisation down'. This has created the perception that we don't want to acknowledge success, or the achievements of individuals/teams.

6.3 Many staff also value regular and easy access to the executive team and senior leaders – so we need to increase the number of organised and impromptu opportunities for them to do so. We have already introduced Non-Executive/Executive Director walk-abouts before each Trust Board meeting, but there is more we can and will do.

6.4 Externally, the focus needs to be on ensuring we continue to communicate proactively with our stakeholders, on a regular basis, about the issues that matter to them. Many of the organisations we work with – both locally and nationally – have a vested interest in how we are performing in particular areas - e.g. the Elective Care Recovery Programme – so we need to use communications tools and techniques to demonstrate grip and control of difficult issues.

6.5 We also need to be proud of the services we provide, which in practice means opening our doors to local stakeholders on a regular basis – including partners, such as Healthwatch, plus key influencers, such as local MPs. A greater willingness to actively engage with our stakeholders – including

facilitating meetings with our clinicians, and organising visits/tours of our services - will help to build and foster supportive relationships.

6.6 In all communications activity, we need to explore opportunities for being more creative, and combine traditional written/face to face methods of engagement with greater use of new technologies – such as video, social media, blogs, apps etc. We are doing this already, but we need to build on the progress we have made to reach new audiences, who increasingly access information in new and diverse ways.

7) MONITORING AND EVALUATION

7.1 To ensure our communications objectives are being met, we need to monitor and evaluate the effectiveness of message cut-through, internal/external campaigns, and the communication channels we use.

7.2 We can use existing surveys to monitor progress, and intend to use the following two key metrics to help assess the effectiveness of internal communications activity:

- **Staff Friends and Family Test – carried out 2nd and 4th quarter annually**

  - Question: The Trust Board and Executive Team provide clear direction for the organisation and communicates this effectively (latest score: 36% agreed, January-March 2017)

- **Staff Communications Survey – carried out 2nd and 4th quarterly annually**

  - Question: How easy do you find it to get information about what's going on in the Trust (latest score: 65% found it very easy or fairly easy, April 2017).

7.3 We also plan to set up a focus group made up of 10-15 staff from across the organisation. This will meet on a six monthly basis (coinciding with our staff communications survey), and enable us to get qualitative feedback about how we are communicating, and where staff feel improvements can be made.

7.4 We already produce a monthly report for the Executive Management Team, called Insight (see appendix 2), which provides an overview of read-rates for internal/ external communications channels we are currently able to measure, plus media and social media activity.

7.5 From August, a quarterly report to the Trust Board (Insight Quarterly) will look at trends and read-rates across our internal/communications channels (listed in appendix 3), plus the effectiveness of particular campaigns carried out during the course of the year.

7.6 Measuring the effectiveness of external communications activity, particularly with stakeholders, is more challenging. We plan to carry out in-depth phone calls or face to face interviews with a small number of stakeholders on a six

monthly basis, in order to understand how effectively we are communicating, and/or what additional information they wish to receive from the Trust. We will also conduct a survey by email via our monthly stakeholder bulletin.

8) GAPS AND RISKS

8.1 The risks of not effectively delivering this communications strategy are self-evident, but include reputational damage; loss of confidence in the organisation; and perceived failure of leadership to engage and inspire staff.

8.2 There are also some issues and gaps which, whilst unlikely to prevent delivery of the above, can make day to day delivery of communications activity challenging and time-consuming.

They include:

Staff: We have one Digital Media Officer responsible for graphic design, intranet and website. Work and requests are prioritised effectively, but this limited resource can adversely impact on our ability to always deliver a timely response, or to deliver any of the three to the high standard we would aspire to with additional resource.

Organisational strategy: The current absence of an agreed Trust strategy or set of organisational priorities can make conveying a simple, compelling message challenging at times. Staff want clarity about what they are doing, and what the Trust's aims and ambitions are; and look to corporate communications to convey this message. However, the new executive team are setting a clearer direction of travel, and agreeing a single, compelling narrative for the organisation is one of the aims of this communications strategy – so definite progress is being made.

GP liaison and Foundation Trust membership: Both GP liaison and Foundation Trust membership sit outside the remit of the communications team. This is not a problem in itself, but given the importance of consistency of messaging, we just need to ensure the communications team continues to link closely with both teams; given the importance of GP communications in particular to our reputation, and by extension the views of patients using our services.

Business as usual: Given the challenges we face, a significant amount of time and energy is spent on issues management (internally and externally), as well as media handling. This is important, and a key part of business as usual, and protecting the reputation of the Trust – however, it can (at times) impact on our ability to deliver broader improvements to the way in which we communicate.

9) NEXT STEPS

The next steps are as follows:

- Agree communications strategy and broad approach at EMT and Trust Board
- Develop detailed action plans for each deliverable, together with timescales

- Submit *Insight Quarterly* to Trust Board every three months, plus regular updates as appropriate at EMT and weekly executive directors meeting.

10) APPENDICES

Appendix 1: Communications activity - table summary of where we were, where we are, and where we want to be

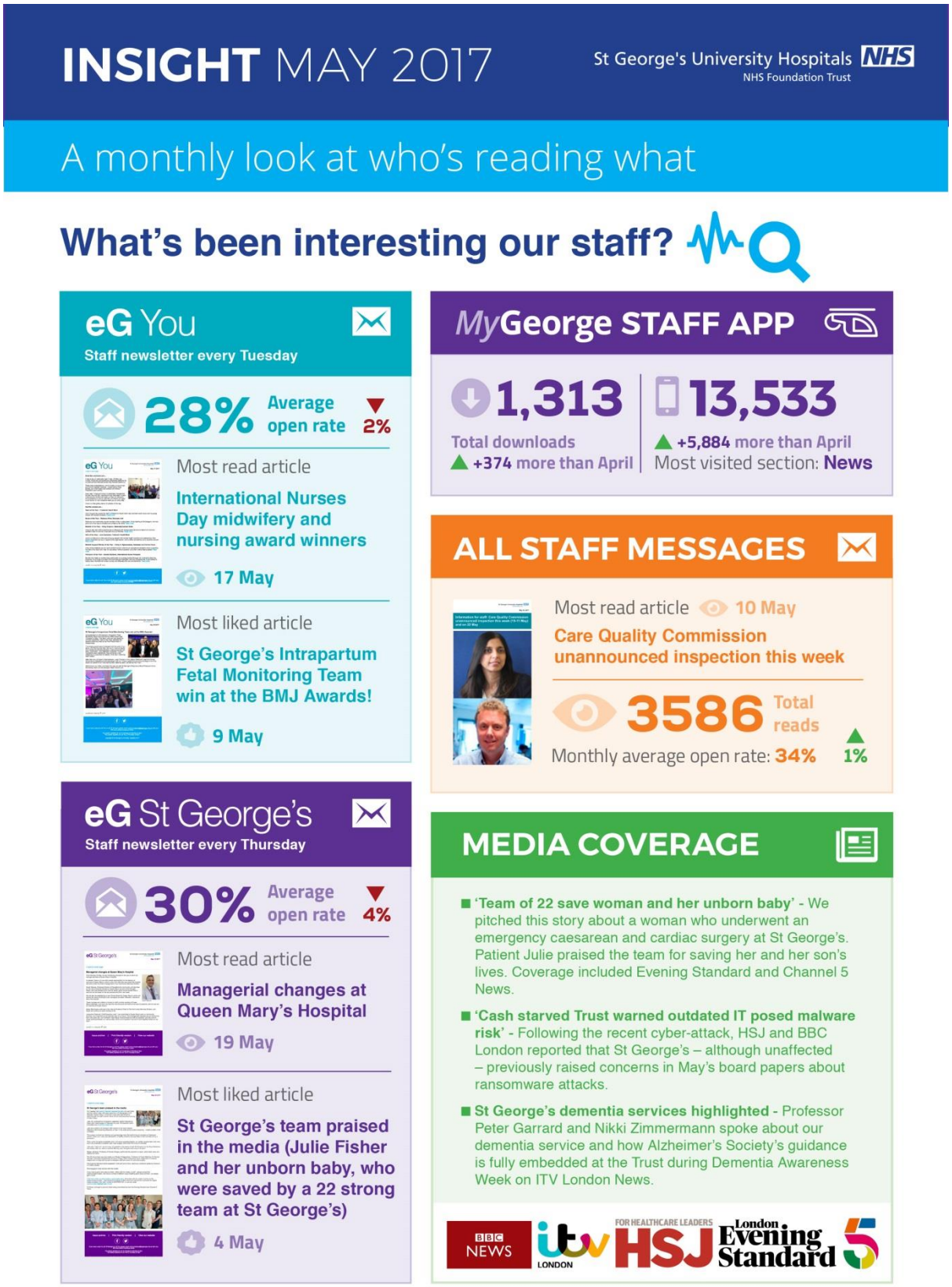
Appendix 2: Insight – copy of summary activity report issued to Executive Management Team each month

Appendix 3: Channels - summary of existing communications channels (internal and external)

Appendix 1: Communications activity - table summary of where we were, where we are, and where we want to be

WHERE WE WERE	WHERE WE ARE	WHERE WE WANT TO BE
Team of 7 people; lack of clarity around team roles/responsibilities	Team of 8 people; new team structure; clearer roles and responsibilities	Build capability within existing team; embed new structure; greater information sharing
Lack of trusted and consistent internal communication channels; overuse of all-staff emails	Trusted and more consistent internal digital channels, with fewer all-staff emails	Richer and higher quality content for existing internal digital channels, linked to Trust strategy and objectives
Intranet outdated and difficult to update	New word-press platform launched; but main intranet still outdated and difficult to update	New intranet with in-built mobile capability
Staff unable to access information outside office hours	New *MyGeorge* app launched in March 2017; 1400 downloads to date	New intranet with in-built mobile capability
No channel of communication with key local/national stakeholders	Monthly stakeholder bulletin launched in August 2016	An extensive stakeholder engagement programme, combining digital and face to face communications and face to face engagement
No pre-emptive briefings for commissioners/regulators on reputational issues	Trusted relationships with commissioner/regulator communication leads; systems and processes in place as part of 'no surprises culture'	Continue to build relationships with commissioner/regulator communication leads, particularly given growing influence of STP
Below average response rate to national campaigns and surveys; e.g. NHS flu programme, NHS staff survey	Improved response rate to national campaigns and surveys; e.g. NHS flu programme, NHS staff survey	Secure year on year improvements, and above average response rates, to national campaigns and surveys
Poor executive visibility, and absence of consistent engagement opportunities	Executive visibility still poor; improving significantly under new leadership team	Visible and accessible executive team, with roles and responsibilities clearly understood
Inability to measure impact of communications channels	Internal communications survey every six months; read-rates available for digital communications channels; however, no systemic interrogation of results to inform/improve our approach	Use qualitative and quantative data to influence communications activity; build measurement and evaluation into all communications activity
Two Trust magazines, By George (for staff) and Gazette (for patients and public); both produced at irregular intervals	New monthly magazine for staff, *By George*, to launch July 2017	Embed new monthly magazine, *By George*, and ensure consistent delivery and high quality content
Home to 24 Hours in A&E; sporadic proactive media coverage	Home to 24 Hours in A&E; sporadic proactive media coverage	Home to 24 Hours in A&E; develop programme of proactive media coverage linked to Trust strategy
Backlog of patient information requests	Backlog cleared; requests managed within agreed timescales; consistently high quality	Undertake audit of existing patient information; review
Communications strategy agreed, but not linked to day to day priority setting	Communications plan and priorities set, and progress reviewed at weekly team meetings.	Communications strategy linked to wider organisational strategy

Appendix 2: ***Insight – copy of summary activity report issued to Executive Management Team each month (see attachment)***



What's been interesting the public?

TWITTER

13,932
Total followers

201 New followers in May

▲ **+53%** increase on followers compared to April

Top tweet

"Excited for the return of #24HrsAE? Find out what you can expect in tonight's episode."

4,625 impressions, **22** retweets and reactions, **31** likes

FACEBOOK

6,077
Total followers

108 New likes in May

▲ **+151%** increase on likes compared to April

Monthly reach: **121,452**
▲ **+58,517** more than April

Monthly engagement: **17,975**
▲ **+10,622** more than April

Top post

"Congratulations to the Fetal Monitoring Team at St George's - they won a British Medical Journal award last night for Clinical Leadership Team of the Year. Edwin Chandraharan from the team is pictured below, along with Rosie Heffernan with the prestigious award and a team photo - well done all!"

13,700 reach, **199** likes and reactions, **13** comments, **30** shares

LINKEDIN

6,029
Total followers

157 New followers in May

Top post

"St George's has been awarded one of seven new research grants to advance our understanding of epilepsy. Epilepsy Research UK has funded the 12-month pilot scheme - 'recording brain activity using electrodes placed in the nose' - at St George's to assess a new minimally invasive method to monitor brain activity."

3,920 impressions, **33** clicks
52 interactions

PATIENT INFORMATION


48 hour GP review for children who have attended ED or been admitted to hospital with wheeze or asthma

51 leaflets published **+35** more than April

DESIGN & WEB

2 New Trust web hubs

11 Posters designed

TRUST PUBLIC WEBSITE

508,395 Total page views

98,803 Total visitors

2m7s Average visit duration

Most read news article: **1,918** reads

Team of 22 save woman and her unborn baby at St George's

Total monthly news reads: **15,264**

Top user search: **map**

Appendix 3: Channels - summary of existing communications channels (internal and external)

Internal

Weekly Message from the Chief Executive (introduced June 2016)
A weekly message from the Chief Executive, emailed to all-staff, that i) updates on organisational priorities and ii) offers personal reflections on news, events and successes. Hard copies are printed and distributed to wards and clinical areas via the post-room. Chief Executive Jacqueline Totterdell's message to staff is read by, on average, 3,400 staff each week.

Monthly meet the Chief Executive sessions (introduced June 2016)
Monthly engagement forums, open to all-staff, which begin with a short presentation from the CEO, followed by questions from staff. Held monthly at St George's, and bi-monthly at Queen Mary's. All staff are welcome to attend, and there is no need to confirm attendance in advance. The number of people attending range (on average) from 30-80 people.

eG-You (Tuesday) and eG-St George's (Thursday)
Twice weekly staff newsletters distributed via email, and produced in Newsweaver. eG-You focusses on staff and their achievements/well-being, whilst eG- St George's updates staff on key corporate information, and issues affecting the entire organisation. Both newsletters have print friendly option. Both *eG-You* and *eG-St George's* are ready by approximately 2,500 staff each week.

Senior leaders' meeting
The senior leaders' meeting takes place monthly. Approximately 200 senior managers are invited to hear the latest Trust news direct from the CEO, as well as members of the executive team. It is also an opportunity or staff to ask any questions they may have so they can relay the answers to their departments.

Core Brief (introduced November 2016)
This is produced monthly, and is a briefing document on key Trust issues for managers to use when updating their staff at team meetings.

MyGeorge (launched March 2017)
An internal communications survey carried out in October 2016 showed that 50% of staff wanted to be able to access Trust information on their mobile. A new staff app – developed by the communications team –launched in March 2016, and gives staff access to the internal communication channels above, plus key information about the Trust (essentially, an online handbook for staff).

By George (*July 2017*)
The new By George will re-launch in July as a monthly, staff only magazine. It will be professionally designed and printed, and distributed to wards and departments. It will focus on celebrating staff awards and achievements, as well as keeping people informed about what is happening at the Trust.

Medical Directors bulletin (launched in June 2016)
The Medical Directors bulletin is issued by Professor Andy Rhodes to the consultant body approximately once every two weeks, and provides an update and personal reflections on key issues facing the Trust. The Medical Director also organises monthly briefing sessions for consultants. Our new Chief Nurse – Avey Bhatia – produces a weekly message for senior nursing staff.

Intranet
Our current intranet is unreliable, unresponsive, and is no longer used by a number of staff. However, it is still popular with some. We have built a temporary news platform that launched in March 2017 – but this is a work-around and sub-optimal at best.

External

Monthly Stakeholder bulletin (launched August 2016)
Our monthly stakeholder bulletin is produced in Newsweaver, and sent to over 150 of our key partners and stakeholders. It includes an introduction from our CEO, plus Trust news, events and key updates. Copies are available to view on our website: https://www.stgeorges.nhs.uk/about/publications/stakeholder-bulletin/

Website
Our Trust website is visited by 100,000 people every month, who collectively view over 500,000 pages. Our homepage is updated at least twice a week with news and updates.

Social media
Our three main channels are Facebook, Twitter and LinkedIn. We have 6,000 followers/likes on Facebook; 14,000 followers on Twitter; and 6,000 connections on LinkedIn.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	6 July 2017	**Agenda No**	5.4
Report Title:	Guardian of Safe Working Quarterly Report		
Lead Director/ Manager:	Harbhajan Brar, Director of HR and Stephen Collier, Non-Executive Director		
Report Author:	Dr Sunil Dasan, Guardian of Safe Working		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	The Guardian of Safe Working's second quarterly report summarises progress in providing assurance that doctors are safely rostered and work hours that are safe. 238 trainees are now employed on the 2016 TCS. The number of exception reports in General Surgery has reduced from the last quarter. Exception reporting in Medicine has increased with the risk of breaches in working time limits. There is currently no robust data available on rota gaps related to unfilled shifts.		
Recommendation:	The Trust Board are asked to note the lack of robust data on rota gaps.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Safe		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:	Lack of robust systems to collect data on rota gaps risks lack of oversight of areas where doctors working hours may be unsafe. Current rosters in Medicine may be unsustainable and risk fines being levied.		
Legal/Regulatory:	Compliance with the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016		
Resources:	Additional time in job plans for educational and clinical supervisors may be required to ensure exception reports are dealt with in a timely manner. Lack of timely resolution of exception reports may result in overtime payments.		
Previously Considered by:	Workforce and Education Committee	**Date**	01/06/2017
Equality Impact Assessment:	N/A		
Appendices:	Appendix A: Current Medical Vacancies (as of 18/05/2017)		

Guardian of Safe Working Report
Trust Board Meeting 6 July 2017

1.0 PURPOSE

1.1 This paper provides assurance to the Board on progress being made to ensure that doctors' working hours are safe

1.2 This report asks the Board to consider the issue of rota gaps and how robust data on unfilled shifts can be collated and reported

2.0 BACKGROUND

2.1 The 2016 Terms and Conditions of Service (TCS) for Doctors in Training have been implemented at St George's in line with the national timeline. To date 238 trainees are employed on the TCS with the remaining 262 due to transfer by October 2017.

2.2 The Guardian of Safe Working's first quarterly report (covering the period from October – January 2017) detailed the 115 exception episodes where working hours or breaks were outside the agreed work schedules. This triggered one fine in General Surgery for a breach of the 72 hour working time limit and reviews of work schedules in four specialties. These work schedule reviews have now concluded.

2.3 The Guardian of Safe Working has continued to monitor exception reports from trainees and the results for the last four months are presented in this, the second quarterly report.

3.0 ANALYSIS

3.1 86 exception episodes were reported in the period 18 January 2017 – 17 May 2017 by the 238 trainees on the 2016 TCS. This compared with 115 exception episodes from the 50 trainees on the 2016 TCS during the last quarter as part of the phased implementation.

3.2 This reflects a reduction in reporting in General Surgery. In Medicine, there has been an increase in reporting. As many of the medical rotas have an average working week of over 47 hours, there is risk that a lack of timely time off in lieu will trigger a breach of the 48 hour working time limit over the forthcoming few weeks and thus incur a fine.

3.3 Four breaches of the 13 hour shift length limit occurred in Obstetrics & Gynaecology, however no fines were incurred. There has been no reporting from other doctors in the surgical specialties or paediatrics /neonates.

3.4 A small number of reports highlighted missed breaks. The Guardian of Safe Working has been working with a team from Guy's & St Thomas's NHSFT to promote the HALT campaign at St George's. This campaign encourages staff to take breaks to promote wellbeing and prevent safety incidents related to overworking. This has been rolled out at medical inductions since April and via a newsletter to all trainees and supervisors.

3.5 Issues persist with Educational and Clinical supervisors failing to complete exception reports in a timely manner. IT compatibility issues, lack of Educational supervisor time and unfamiliarity with the system have all contributed to this. An agreement was reached with the Medical Director and Divisional Chairs to deal with the exception report backlog. It was agreed that overtime payments would be made for all overdue exception reports submitted before 1 April 2017.

3.6 Robust data on unfilled shifts has been unavailable since the implementation of the TCS. A list of current medical vacancies is shown in Appendix A.

4.0 IMPLICATIONS

Risks

4.1 The lack of timely time off in lieu in Medicine may result in working hours limits being breached and fines being incurred.

4.2 The lack of data on rota gaps due to unfilled shifts risks a lack of oversight of areas where doctors working hours may be unsafe.

Legal Regulatory

4.3 Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.

Resources

4.4 Personalising work schedules, resolving exception reports and performing work schedule reviews are additional tasks for educational and clinical supervisors which will need further consideration in their job plans.

4.5 Funding for overtime payments represents a cost pressure. Lack of timely resolution of exception reports is currently being escalated through divisional chairs. If this escalation fails to ensure timely completion of reports, then overtime payments will be necessary.

5.0 NEXT STEPS

5.1 To work with General Medicine to ensure timely time off in lieu in order to prevent a working hours breach and a fine.

5.2 To trial a system of positive reporting to manually collect data on rota gaps from June 2017.

5.3 To continue with roll out of HALT campaign.

6.0 RECOMMENDATION

6.1 The Board are asked to note the lack of robust data on rota gaps.

Author: **Dr Sunil Dasan**
Date: **19/05/2017**

APPENDIX A

Current Medical Vacancies (as of 18/05/2017)

Specialty	Grade	Number of Vacancies
Respiratory	FY2	1
Gastro-Hepatology	ST3+	1
Heart Failure	Clinical Fellow	1
Renal Medicine	Clinical Fellow	1
Vascular	Clinical Fellow	1
Vascular	ST1/2	1
ENT	ST3	1
Cardiac/Neuro Anaesthetics	ST3 LTFT	1
Cardiac/Neuro Anaesthetics	ST3	1
General/Vascular/H&N Anaes	ST3 LTFT	1
Paediatric Anaesthetics	ST3	1
PICU	ST3	4
Academic unit /Upper GI Surgery	ST3	1
Vascular Surgery	ST3	1
Maxillofacial Surgery	ST3	1
Trauma & Orthopaedics	ST3+	1
Neurosurgery	ST1/2	1
GUM	Associate Specialist	1
Obstetrics & Gynaecology	Clinical Fellow ST1/2	1
Paediatric Neurosurgery	Clinical Fellow ST1-3	1
Neonates	Trust Doctor ST4+	1
Radiology	Trainee	3
General ICU	Clinical Fellow ST3+	2
Cardiac Anaesthetics (Critical Care Rotation)	Clinical Fellow ST3+	1
Cardiac Anaesthetics	Clinical Fellow ST3+	1
Total		31

	GP Trainees	*These posts may have been filled locally
Scheme	Specialty	Number of Vacancies
St George's	Emergency Medicine	1
	Neurosurgery	1
Bexley & Sidcup	Geriatric Medicine	1*
	Old Age Psychiatry	1*
	Emergency Medicine	1*
	Acute Internal Medicine	1*
	Obstetrics & Gynaecology	1*
Bromley	Emergency Medicine	1*
Croydon	Cancer Medicine	1*
	Geriatric Medicine	1*
	General Psychiatry	1*
Lewisham	Palliative Medicine	1*
Greenwich	General Medicine	1*
	Paediatrics	1*
	General Psychiatry	2*
Guys & St Thomas'	Emergency Medicine	1*
	GUM	1*
King's	Geriatric Medicine	1*
	Acute Internal Medicine	1*

	General Surgery	1*
	Paediatrics	2*
Kingston & Roehampton		0
St Helier	Acute Internal Medicine	1*
	Geriatric Medicine	1*
Total		25