Trust Board Meeting

Date and Time: **Thursday 29 March 2018, 10:00 – 13:00**
Venue: **Hyde Park Room, 1st Floor, Lanesborough Wing**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	**A**	**Visits to various parts of the Tooting site**	**Board Members**	-	Oral
OPENING ADMINISTRATION					
10:30	**1.1**	**Welcome and apologies**	**Gillian Norton** Chairman	-	Oral
	1.2	**Declarations of interest**	All	-	Oral
	1.3	**Minutes of meeting held on 22 February 2018**	**Gillian Norton** Chairman	Approve	Report
	1.4	**Action log and matters arising**	**All**	Review	Report
	1.5	**CEO's update**	**Jacqueline Totterdell** Chief Executive	Inform	Report
QUALITY					
10:50	**2.1**	**Quality & Safety Committee report**	**Sir Norman Williams** Chair of Q&S Committee, NED	Assure	Report
PERFORMANCE					
11:00	**3.1**	**Integrated Quality & Performance report**	**Executive Team**	Review	Report
	3.2	**Elective Care Recovery Programme Update**	**Ellis Pullinger** Chief Operating Officer	Assure	Report
	3.3	**NHS Improvement Emergency Care Site Visit**	**Ellis Pullinger** Chief Operating Officer	Update	Report
FINANCE					
11:40	**4.1**	**Finance & Investment Committee report**	**Ann Beasley** Chair of F&I Committee, NED	Assure	Report
	4.2	**Chairman's Actions**	**Andrew Grimshaw** Chief Financial Officer	Assure	Report
	4.3	**Month 11 Financial Report (February)**	**Andrew Grimshaw** Chief Financial Officer	Update	Report

Time	Item	Subject	Lead	Action	Format
WORKFORCE					
12:00	**5.1**	**NHS Workforce Race Equality Standard (WRES)**	**Harbhajan Brar** Director of HR&OD	Inform	Report
	5.2	**Gender Pay Gap**	**Harbhajan Brar** Director of HR&OD	Approve	Report
	5.3	**Update on Freedom to Speak Up**	**Harbhajan Brar** Director of HR&OD	Assure / Update	Report
	5.4	**NHS Staff Survey 2017**	**Harbhajan Brar** Director of HR&OD	Discussion / Update	Report
GOVERNANCE					
12:20	**6.1**	**Board Assurance Framework**	**Avey Bhatia** Chief Nurse & DIPC	Assure / Update	Report
CLOSING ADMINISTRATION					
12:30	**7.1**	**Questions from the public**	-	-	Oral
	7.2	**Any new risks or issues identified**	**All**	-	-
	7.3	**Any Other Business**	**Gillian Norton** Chairman	-	-
	7.4	**Reflection on meeting**	**All**	-	Oral
12:40	**PATIENT STORY**				
Patient Isaac shares his experience as a young adult renal patient at St George's Hospital accompanied by Marie-Louise Turner, Young Adult Worker (Transition).					
13:00	**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 of next meeting:

Thursday 26 April 2018, 10.00 – 13.00

Trust Board
Purpose, Meetings and Membership

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.

Meetings in 2018-19 (Thursdays)									
25.01.18	22.02.18	29.03.18	26.04.18	31.05.18	28.06.18	26.07.18	30.08.18	27.09.18	25.10.18
29.11.18	20.11.18	20.12.18	31.01.19	28.02.19	28.03.19				

Membership and In Attendance Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director/Deputy Chairman	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director (St George's University Representative)	NED
Sir Norman Williams	Non-Executive Director/Senior Independent Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse & Director of Infection, Prevention & Control	CN
Andrew Grimshaw	Chief Finance Officer	CFO
Andrew Rhodes	Acting Medical Director	MD
In Attendance	**Designation**	**Abbreviation**
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Kevin Howell	Director of Estates & Facilities	DEF
Stephen Jones	Director of Corporate Affairs	DCA
Suzanne Marsello	Director of Strategy	DS
Ellis Pullinger	Chief Operating Officer	COO
Mike Murphy	Quality Improvement Director – NHS Improvement	QID
Secretariat	**Designation**	**Abbreviation**
Shanaz Islam	Interim Assistant Trust Board Secretary	ATBS

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 March 2018	**Agenda No.**	**1.3 & 1.4**
Report Title:	**Trust Board Minutes and Action Log**		
Lead Director/ Manager:	Stephen Jones, Director of Corporate Affairs		
Report Author:	Shanaz Islam, Interim Assistant Trust Board Secretary		
Presented for:	Approve		
Executive Summary:	N/A		
Recommendation:	The Board is asked to approve the minutes and note the action log.		
Supports			
Trust Strategic Objective:	N/A		
CQC Theme:	N/A		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

Minutes of Trust Board Meeting

Thursday 22 February 2018, 10.00 – 13.00, Hyde Park Room, 1st Floor, Lanesborough Wing

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse and Director of Infection, Prevention & Control	CN
Andrew Grimshaw	Chief Financial Officer	CFO
Andrew Rhodes	Acting Medical Director	MD
IN ATTENDANCE		
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Kevin Howell	Director of Estates & Facilities	DE&F
Suzanne Marsello	Director of Strategy	DS
Ellis Pullinger	Chief Operating Officer	COO
Mike Murphy	Quality Improvement Director, NHS Improvement	QID
APOLOGIES		
Jenny Higham	Non-Executive Director	NED
SECRETARIAT		
Michael Wuestefeld-Gray	Interim Trust Board Secretary	TBS
Shanaz Islam	Interim Assistant Trust Secretary (Minutes)	ATBS

Feedback from Board Walkabout

Members of the Board gave feedback on the departments visited, which included: Endoscopy; Neonatal; Vernon; Holdsworth & Gunning; St James' Theatre; Paul Calvert Theatre; Trauma and Orthopaedic Fracture Clinic; Ruth Myles Day Unit; and Ambulatory Care Unit.

General observations included the clear commitment of staff to patient care, the rigour with which infection control measures were implemented, and the effective organisation and calm atmosphere across the units visited, often despite intense pressures on services. In the Endoscopy Unit, responses to the Friends and Family test had been very positive. In Vernon Ward, there was a strong emphasis on discharge and throughput of patients and this was well managed. In the Ruth Miles Day Unit, members noted that appropriate notices were in place and that fridges for storage of drugs were all secure. The resilience of staff in the Ambulatory Care Unit was noted, as were the Unit's high retention rates. In St James' and Paul Calvert theatres, all staff were bare below the elbow. A new dress code was in place which prohibited the use of lanyards for identify badges, though two consultants in Paul Calvert had refused to remove their lanyards despite challenge. The challenge was appropriately managed and the MD agreed to follow up on this.

The pressures on staff were a recurring theme across the units visited. The Ambulatory Care Unit, for example, had recently encountered recruitment challenges including a low number of applications for vacant posts. The Endoscopy Unit had also faced staffing challenges across its three sites, and while arrangements were in place to ensure the quality of services, careful consideration would need to be given to staffing in the Unit in the longer term. In Vernon Ward, members reported the high degree of reliance on bank and agency staff. In contrast to the high staff retention rates in the Ambulatory Care Unit, the Neonatal Unit had seen a high level of staff turnover. This was partly attributable to the high cost of living locally and the Chairman had been to investigate low cost home ownership options for staff with the local councils. Staff were keen to understand more about the Senior Leaders' Briefing events. The Communications team would consider how best to ensure these briefings were disseminated to staff across the Trust.

A number of estates issues were reported by members. Electronic white boards were currently out of action in the Ruth Miles Day Unit and Vernon Ward; staff were keen to see these back in operation. This pointed to a wider issue around the need to improve the Trust's IT infrastructure which was already under development. In St James' Theatre, there were issues with the front door to theatres and flooring. Flooring was also an issue for the Trauma and Orthopaedic Fracture Clinic, along with storage and access. In the Ruth Miles Day Unit, ventilation was a key concern and this had been added to the risk register. A lavatory in the Holdsworth and Gunning Wards had been out of order since late January and a commitment was made that this would be fixed promptly. A smoke seal in the Unit would also be replaced. In the Neonatal Unit, there was little overnight accommodation available to parents and consideration would be given to how best to address this for both parents and staff.

The Acting Medical Director updated the Board on the presentations by cardiac surgeons which he had attended earlier that morning along with the CEO, DHROD and Sir Norman Williams, Chair of the Quality and Safety Committee. It had been an interesting session which had highlighted the good work of the Department. Sir Norman noted that improvements had been made and that there was a clear upward trajectory in this speciality in terms of quality and performance, which was a "jewel in the crown". Sir Norman had been impressed by the training and research undertaken and with the Chief Executive's talk on teamwork, which was crucial to success.

OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and welcomed the new governors and the public. Apologies had been received from Jenny Higham, though she would be joining Part 2 of the Board. It was noted that Mike Murphy, Quality Improvement Director at NHS Improvement, would join the meeting later due to an external commitment.
Declarations of Interest	
1.2	There were no declarations of interest to note.
Minutes of Meeting held on 25 January 2018	
1.3	The minutes of the meeting of 25 January 2018 were agreed as an accurate record, subject to the following amendments: • **1.3:** The Chairman noted that the draft minutes should be circulated for review promptly following Board meetings to ensure accuracy in reporting the Board's discussions. • **3.1:** The COO clarified that medicine, children and haematology were the units that would come online in February and March 2018 and that this would help improve performance on re-booking day cancellations within 28 days.

	• **3.4:** Stephen Collier clarified his comments at the previous Board meeting, noting that in his view the Workforce and Education Committee was not meeting frequently enough and that the Committee should either meet more often or establish a sub-committee to undertake additional assurance. It was noted that this issue was under consideration. • **3.5:** Sarah Wilton noted that the End of Life Steering Group reported to the Quality and Safety Committee, but added that as the Board considers issues relating to end of life care it may be helpful for the Steering Group to report to the Board at an appropriate time.
Action Log and Matters Arising	
1.4	The Board noted that most of the actions were not yet due or had been closed because appropriate action had been taken outside the meeting. The following were noted against the actions: • **Action 35:** the Fit and Proper Person Test is reported to the Board quarterly • **Action 36:** the Charity has been invited to attend the Board in April • **Action 44:** the quarterly report is due in April • **Action 53:** was on the Board meeting agenda The Chair noted that the Action Log should be circulated with the Board minutes. There were no matters arising.
CEO's Update	
1.5	The Chief Executive reported on progress with delivery of the Trust's quality agenda in the context of continuing operational pressures. While there remained a long way to go in order to achieve the vision set out in the Quality Improvement Plan (QIP), real progress was being made and increasingly felt in many areas. This was clear from increasing hand hygiene compliance, improvements in diagnosis, reductions in the number of pressure ulcers, and the low incidence of C.difficile. Strong staff buy-in to the Trust's improvement agenda was also evident. This was encouraging and indeed essential to the successful delivery of the QIP. Significant challenges nonetheless remained and there were particular pressures on the Emergency Department which continued to impact on performance. Delivering an IT infrastructure that was fit for purpose remained a key priority. Matt Laundy, Chief Clinical Information Officer, would provide regular progress reports to the executive team and to the Trust Board to track progress. The Trust had been designated as a centre for mechanical thrombectomy in South London. The service provided was a model of best practice which other organisations were now opting to follow. The first Staff Appreciation Awards would be held on 15 March 2018. The Board noted that this was an important opportunity to recognise the excellence of staff across the Trust. The Board recognised the contribution of Martyn Willis, CEO of St George's Hospital Charity, who would step down from this role at the end of March 2018.
QUALITY	
2.1	**Quality and Safety Report**
	Sir Norman Williams, Chair of the Committee, reported on the meeting held on 13 February 2018. Highlighting the overall improvements in quality and safety delivered across the Trust in recent months, Sir Norman noted:

	i. The Committee had considered a detailed update on the implementation of the Trust's End of Life Care (EoLC) Strategy following the CQC's criticisms of the service. It noted the new governance arrangements that had been put in place to drive forward improvement and acknowledged the progress delivered to date. ii. The Committee had noted that the Trust was now compliant with Adult Safeguarding training but not yet compliant with *Prevent* training. Plans were in place to address this by August 2018. DHROD noted that the Trust had introduced a mandatory training module in relation to *Prevent*. The uptake to date had been 55% and there was a push to reach 80% in the coming months. iii. The Committee had been updated on the systems in place to provide assurance on the quality of care provided across the Trust. Measures were in place to monitor the Trust's readiness for the anticipated CQC unannounced inspection. iv. The Committee had received a report from the Deputy Chief Nurse and the National Patient Champion on the work undertaken to understand patient partnership and engagement within the Trust. Progress had been made in many areas but more was needed. The Committee had noted the work underway to improve patient engagement, the plans in place to develop a new patient engagement and experience strategy, and the wider importance of this work. v. In the past three months, there had been no never events and, for the year to date, a total of three 3 never events had been recorded. This was a significant improvement. No cases of MRSA had been reported for seven months and no cases of C.difficile for three months. Flu had been a significant challenge and had impacted on elective care and the emergency care performance targets. The MD noted that there had been 300 cases of flu and this had a domino effect organisationally with the result that the Trust was not where it wanted to be in terms of its performance against the four-hour A&E target, linked to the need to manage beds in line with infection control in relation to flu cases. The MD also noted that infection numbers were low when benchmarked against comparable organisations, and teams had worked hard to achieve this. CN highlighted that the number of falls had increased and there was a detailed analysis underway to ascertain when the falls occur and under what circumstances. vi. The Committee noted that the QIP dashboard had been refined and provided good oversight but it sought further assurance on the milestones for improvement that sat behind the dashboard. The MD noted that this was a very positive report and that a significant amount of work was being undertaken through the QIP, with teams committed to driving this forward. The Chairman thanked Sir Norman for his report, which was received by the Board.
PERFORMANCE	
3.1	**Integrated Quality & Performance Report**
	The Director of Delivery, Efficiency and Transformation gave an overview of the report. CN noted that patient experience in the Emergency Department (ED) had dropped slightly to 82.2%. Although a good rating, it was important to remain focussed on this. The Chairman queried whether all patient experience was captured sufficiently. CN noted that there were inconsistencies in some areas but these were being worked on. Patient experience was captured well in the ED. The COO reported that delivery of the four hour emergency operating standard in January 2018 was 83%. This reflected wider winter pressures and the impact of a flu outbreak. NHS Improvement would continue to monitor performance closely and would send a report shortly which would be shared with the Board following the recent visit. The CEO noted the

	importance of achieving the four hour target and of the Trust having the confidence that this could be met. Sarah Wilton asked what more could be done to sustain improvements in performance in the ED and improve patient discharge before 11 am. The COO noted that greater coordination and consistency was needed along with increased investment in new models of care, which was part of the QI process. The DDET added that a key part of the 15-point plan was to see how the fast-tracking of patient flow, which occurs with escalation plans, could be made business as usual. The Trust also needed to look at the AMU 28 bed extension on Cavell Ward, which should be discharging all patients within 48 hours but was currently doing so in five days. Sir Norman Williams asked why if numbers of patients were not increasing performance had deteriorated. The CEO noted that there is nothing specific that has been identified although changes to the estate, such as removing Dalby Ward, may have had an impact. The Chairman noted that the organisation needed to show clear action to improve performance in this area. In response to the discussion, the CEO suggested bringing a substantive paper on emergency care performance to the next meeting of the Board. **Action TB. 22.02.18/ 65 COO to bring substantive paper to the March 2018 Board meeting on emergency care performance** The COO reported that the cancer standards had been achieved for January with all eight national cancers standards met. There was continued good performance in terms of the six week access to diagnostics. Cancellations on the day were being reviewed although this had improved the previous month. The MD highlighted that there were rota gaps among junior doctors which needed to be addressed. These had the potential to deteriorate given the current caps and the move away from use of agency staff. The Chairman noted that the Trust wanted to be sure that trainees were receiving the best experience and it was mindful of the national context around ensuring appropriate support for junior doctors. In terms of the Trust's workforce, DHROD reported that sickness absence had increased in line with the seasonal flu. More broadly, there had been a focus on reducing the Trust's vacancy rate, improving recruitment and retention, and improving appraisal rates. Agency spend was ahead of the plan, with a year-end predicted position of £22m. Last year agency spend had been £42m.
3.2	**Elective Care Recovery Programme Update**
	The COO reported on the new Patient Tracking List (PTL), which had been launched on the 13 February 2018 with the aim of giving the Trust greater ability to manage patient pathways and ensure greater visibility of the capacity required to achieve the 18 week standard set out in the NHS Constitution. Staff were in the process of being trained on the PTL system. A fuller report on the PTL would come to the Board in March 2018. It was also reported that Kim Barrow, the newly appointed Recovery Director, would take up post in week beginning 26 February 2018. The MD, who co-chaired the Clinical Harm Review Group, reported that the Group was pleased with the progress made with the PTL and that a smooth transition was important. The report was received by the Board.
FINANCE	
4.1	**Finance and Investment Committee Report**
	Ann Beasley, Chair of the Committee, highlighted key issues from the report, which would be circulated with the minutes as the report had not been circulated with the Board papers. **Action TB. 22.02.18/ 66: Assistant Trust Board Secretary to circulate the report of the F&I Committee with the minutes of the Trust Board meeting**

	She noted that of the three strategic risks for which the Committee was responsible for monitoring, the Committee was still not assured of the mitigations around ICT and estates and that there would be an in depth discussion at the Committee's meeting in March 2018. The Committee had held a good discussion on risk appetite. The Committee had expressed frustration about the progress in improving A&E performance on a consistent basis. It had heard that the Trust was good at diagnosing flu and, as a result, was better placed than some other Trusts. Cancer and diagnostics were noted to be in a good position. On theatre utilisation, even though two theatres were closed for refurbishment, activity levels had been maintained. These had since re-opened but there had not been an increase in activity. This raised a number of issues including having timely pre-operative assessments. This would come back to the Committee for further consideration. The forecast year-end financial outturn deficit remained at £53m. It was noted that non-recurrent items were being used to deliver the position, and this would make next year more challenging. The Trust had not yet received confirmation that PSS funding would be given. Receipt of this funding had been included in the year-end forecast; this had been presented as a risk to the forecast to NHS Improvement. It was noted that the Trust was not yet delivering an acceptable deficit for NHS Improvement and the Trust would need to stretch itself as far as possible to achieve this. A paper was presented on Working Capital Management and Cash flow. This noted that progress in implementing the debt recovery plan had not been as swift as originally hoped. The Committee had expressed its disappointment at progress to date and requested that action was taken to recover the position. **Action: TB. 22.02.18/ 67: CFO to expedite debt recovery plan and report through the Finance and Investment Committee** The Committee had also received a report on PLICS. There was active engagement from clinicians and there had been a deep dive on vascular surgery to drive improvement and efficiencies. A business case was approved for the development of the full business case for capital investment in the electronic patient system at Queen Mary Hospital as part of the RTT Elective Care Recovery programme. The DDET noted that PLICS and GIRFT were different lenses to benchmark data. The Trust was working with NHS Improvement to focus on the fundamentals in a few core services. Stephen Collier added that there had been a helpful discussion around the budget setting process. The CEO confirmed the budget would be set by 1 April 2018.
4.2	**Month 10 Finance Report**
	The Chief Finance Officer noted that the Trust was reporting a year-to-date (YTD) deficit of £52.9m at the end of month 10, against a year-end deficit forecast of £53m. The pressures on the Trust's financial position came from a reduction in elective activity and pressure in expenditure forecasts in the clinical divisions. To date, £30.7m of Cost Improvement Plans (CIP) had been delivered, £10.7m of income and £20.m of expenditure reductions. The capital position was £4.5m under plan YTD. The capital budget had been formulated at the beginning of the year on the basis that the Trust would secure Department of Health capital of £8.4m to finance investment in ICT infrastructure but, despite an independent audit recommending approval of this bid, the Trust had not received this funding. The cash position was pressured. By the end of month 10 this was £3.8m, better than plan by £0.8m. Until the 2018/19 financial plan was locked down there would remain uncertainty around cash in the first few weeks of the coming financial year. The Board noted the Month 10 position.

STRATEGY	
5.1	**ICT Strategy**
	The Chief Finance Officer updated the Board on the work being done to ensure there was clarity about the current ICT situation and the improvement plans underway. This followed the Board Seminars on the issue in November 2017 and earlier this week. One of the strategic risks in the Board Assurance Framework related to ICT and a detailed risk assessment had been undertaken, which had identified 31 risks which needed to be mitigated urgently. Action plans were being developed and additional capital resources had been made available. Further funding was being sought from NHS Improvement. A long-term ICT Strategy was in preparation and would come to the Board for consideration in the next four-to-six months. Tim Wright noted that Trust Board had inherited a poor ICT position but progress had been made in mitigating the existing risks. Implementation of Cerner would require strong leadership from the Board and the executive team as well as capital in 2018/19. Sarah Wilton commented that the work undertaken to date to develop an ICT strategy and involve the Board had been excellent and asked whether the capital cost of the plan had been included in the budget and whether the funding was secured. The CFO said that £17-20m capital was available for next year for ICT projects, some of which had already been committed. A range of actions would be adopted including seeking funding from NHS Improvement, exploring leasing options and managed services contracts; and considering whether investment could be funded with partner organisations. The Chairman concluded that the Board regarded this work programme as a priority. It would help staff deliver better patient care as well as save resources. The Board noted the capital issue and the need to revisit this area.
GOVERNANCE	
6.1	**Committee Terms of Reference**
	The Board considered amended terms of reference for the Audit Committee, the Finance and Investment Committee, and the Quality and Safety Committee. These amendments had been developed as a result of the changes to the structure of Committees agreed by the Board at its meeting on 9 November 2017. The Board approved the changes to the terms of reference subject to the following amendments, the final approval of which was delegated to the Chair of each Committee: ▪ All terms of reference should identify Non-Executive Directors by name and members of the executive by role; ▪ Sir Norman Williams should be added as a member of the Audit Committee and be invited, though not required, to attend all meetings; ▪ A typographical error in the terms of reference for the Audit Committee was identified (in the second numbered paragraph under the heading “Financial Reporting and Accounts Review”, the text should read “All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading or inconsistent with information presented elsewhere”. ▪ The COO should be listed as a member of the Quality and Safety Committee given his responsibilities for delivery on Referral to Treatment (RTT) times. The Board noted that it would consider amendments to Trust Executive Committee, the Workforce and Education Committee, and the Nominations and Remuneration Committee at a future meeting.

6.2	**Board Assurance Framework**
	The Chief Nurse and Director of Infection, Prevention and Control presented key highlights from the Board Assurance Framework, which had been updated to reflect the decisions of the Board at its meeting on 25 January 2018. Strategic Risks (SR) 9, 16 and 17 were reserved for the Board and the changes proposed were agreed. SR 11 had been amended to reflect the discussions of the January Board. The DE&F noted that SR 13 had been reworded to add clarity and acknowledge the work already undertaken. SR 15 had been reworked with input from the MD to help clarify the Trust's ambitions in relation to research and working with stakeholders. The Board approved the proposed changes. In relation to SR1, Ann Beasley noted that the risk needed to be worded to capture fully the changes required to develop new roles and skills mix. The CN agreed to update the risk to reflect this. The MD noted that SR 5, 6 and 7 should be reviewed as the financial plan for 2018/19 was finalised. In relation to SR 6, the DDET observed that this was the joint highest rated risk in the BAF and that capacity as well as capability was key to identifying and delivering efficiencies. While the Model Hospital placed an emphasis on the latter, the Board needed to be assured on the former. No changes had been made to SR 10, but the CN asked whether the risk, as drafted, would capture staff appraisal as well as staff training. The Chairman noted that there was some anxiety around appraisal as the numbers had decreased. The Chairman noted that the Board would review the BAF again at its next meeting on 29 March 2018.
6.3	**Risk Appetite**
	The Chief Nurse and Director of Infection, Prevention and Control briefed the Board on the proposed Risk Appetite Statement 2018/19. This was intended to provide guidance for decision-makers on the Board's appetite for risk across each of the Trust's strategic objectives. The Board noted that there was a low appetite for risk in relation to: patient safety and clinical quality; patient experience; organisational performance; statutory compliance frameworks; and financial duties. A moderate appetite was assigned to reputation and workforce, the latter reflecting the need to ensure the future needs of the Trust were met. A high appetite was assigned to stakeholder relationships and involvement and to innovation and research given the opportunities that existed in both areas. The proposed risk ratings set out in the Statement were approved by the Board.
6.4	**Fit & Proper Person Regulation – Compliance**
	The Director of Human Resources and Organisational Development presented this report, the purpose of which was to give assurance to the Board on the Trust's compliance with the CQC's fit and proper persons requirements for directors. DHROD noted that the Trust was fully compliant with the fit and proper persons requirements for directors and that the data was complete. Files had been requested by the CQC in advance of their visit. NHS Improvement had requested a quarterly update on FPP compliance during 2017/18 and annually thereafter. Fit and Proper Persons (FPP) checks were still being completed in relation to the incoming Director of Corporate Affairs. DHROD had been in touch with the Disclosure and Barring Service to ensure the necessary clearance was secured ahead of the Director starting in post in March 2018 and had been liaising with CQC. Sarah Wilton asked about the "not applicable (n/a)" designation in some fields relating to the DE&F. DHROD explained that some roles require professional registration or technical

	qualifications, which do not apply in this case. DS asked the Board to note professional registration was not required for her role and that she did not hold such registration. **Action TB. 22.02.18/ 68: DHROD to give consideration to updating the FPP matrix in order to clarify which roles require professional qualifications / registrations**
CLOSING ADMINSTRATION	
7.1	**Questions from the Public**
	A member of the public asked how the Trust tracked patients on waiting lists and how patients on such lists could be assured they had not been forgotten. The COO explained that the Trust was committed to reducing waiting lists and ensuring that patients were seen within 18 weeks. Patients who had been on a waiting list for some time would receive a phone call to update them and to check that they remained fit to undergo the procedure. Another member of the public noted that his son was currently a patient at Queen Mary's Hospital and had been pleased by the care provided by staff. He asked the Board about an open dialogue initiative in cases of psychosis and schizophrenia diagnosis, which he was keen to see the Trust adopt. The CEO explained that mental health services were delivered by South West London and St George's Mental Health NHS Trust. The Director of Strategy offered to note his details and pass these on to its Medical Director.
7.2	**Any new Risks or Issues**
	No new risks or issues were identified.
7.3	**Any Other Business**
	In relation to St George's Charity, Tim Wright, a Trustee of the Charity, advised the Board that an interim CEO would provide cover following the departure of the current CEO, Martyn Willis, who was due to step down at the end of March 2018. A recruitment process was underway to make a permanent appointment. Tim Wright highlighted the importance of aligning the fundraising work and objectives of the Charity with the priorities of the Trust. The Charity would attend the Board in April 2018 to strengthen that linkage. The CEO noted that a report on the gender gap pay would be brought to the Board at its meeting in April 2018 as there was a legal requirement to publish data relating to gender pay by the end of that month. Once the Board had considered the report, it would be published externally. **Action TB.22.02.18/ 69: DHROD to bring a paper to the March Board meeting about the gender pay gap**
7.4	**Reflection on Meeting**
	The CEO noted that the QI process for A&E should come back to the Board for assurance via the Finance and Investment Committee.
	Patient Story
	The Chair welcomed Sara Watson, a patient of the Trust, and Sorrel Scott, a physiotherapist at St John's Therapy Centre. Sara was attending Board to share her experience of the Wandsworth Community Neurological Team at St John's Therapy Centre. Sara Watson had been a patient of the Trust for nearly 30 years and had been diagnosed with secondary progressive Multiple Sclerosis in 1997. A year ago, a video had been made for the Board in which Sara had been critical of her care, although this did not extend to Wandsworth Neurological Team which, for Sara, had shown the Trust at its best. Over the

	previous five years, Sara's MS had deteriorated significantly. Her main symptoms were impaired mobility, balance problems, fatigue and urological infections. A UTI and septicaemia had had a dramatic effect on her condition, causing temporary paralysis and prolonged absences from work. Sara continued to use a walking stick and walking frame. Sara said that the work of Sorrel Scott and the Neurological Community Team had enabled her to continue to work and lead an independent life. She noted that the team had worked with her in her own home to understand her needs in her daily life. Importantly, they had gained her trust which had enabled her, in turn, to be open with them. Sorrel had put together an unsupervised exercise programme tailored to her needs. The team had built up her confidence with the result that she could go outside again and use public transport confidently. An Occupational Therapist had organised handrails for her home. The team had supported her when she had been distressed about an forthcoming urological procedure, talking her through what the procedure would involve and helping her come to terms with it. Sara's sole criticism of the service was that she did not have physiotherapy on an ongoing basis, but instead only when her condition deteriorated. Given the key role exercise and mobility support play in helping her lead an independent life, Sara suggested that preventative physiotherapy would be helpful and prove more cost effective in the longer term. Likewise, regular checks, every six months, would help forestall a worsening of her condition. A programme of tailored exercise was essential as her limited mobility meant she could not use private gyms, but access to such programmes had been strictly limited. Sara said that living with MS could be isolating and frightening and never ceased to be a challenge, but the Wandsworth Community Neurological Team had helped her live independently. Sorrel Scott offered her perspective on the neurological rehabilitation services provided by the Wandsworth Community Team. The team comprised Occupational Therapists, Speech and Language Therapists, Rehabilitation Assistants, a Clinical Psychologist, a Clinical Specialist and a Clinical Nurse Assistant who together help build patients' confidence. The team focused on providing patient-centred care, and a key part of this was to work with patients to ensure early supportive discharge so people could return home as soon as possible. The team also provided neurological rehabilitation and long-term disability management. The team has around 200-230 patients, of which 16% have MS and 20-30% have had suffered a stroke. In total, the team receives about 800 referrals a year. DE&F asked Sara about the challenges she had encountered attending the hospital, for example in using transport and navigating the Trust's buildings. Sara replied that she tended to use taxis to get to the Trust. While she could get around the site, it was frustrating when disabled toilets were out of order. DS commented that a key part of the South West London Sustainability and Transformation Plan was to prevent people becoming unwell. Limiting access to tailored exercise classes would be counterproductive and she would feed this back. Sara agreed that exercise helped significantly with her MS symptoms and that it was short sighted to restrict access to this. The Chairman observed that Sara's story had set the Trust a clear challenge. She thanked Sara and Sorrel for attending and for sharing their experiences openly.

Date of Next Meeting: Thursday 29 March 2018 at 10:00

Trust Board Action Log - 29 March 2018

Action Ref	Action	Due	Lead	Commentary	Status
TB. 06.07.17/ 36	**St George's Charity -** Schedule a meeting with between the Board and the Trustees of the St George's Charity every six months.	26.04.2018	TS	Charity invited to the April 2018 Trust Board meeting.	Proposed for closure
TB.07.09.17 /44	**Medical Revalidation -** Provide interim reports on Medical Revalidation to the Workforce & Education Committee.	26.04.2018	Acting MD & Karen Daly	Due at April 2018 Trust Board.	OPEN
TB. 07.12.17/ 54	**Trust's Strategic Objectives -** Present a quarterly update on progress against the Trust's strategic objectives.	26.04.2018	DOS	Due at April 2018 Trust Board.	OPEN
TB. 25.01.18/ 64	**BAF -** The CEO requested that the Executive Team ensured that the links between the risk register and the BAF are understood by all staff over the next two months.	29.03.2018	Executive Team	Updated BAF presented at February and March 2018 Trust Board meetings.	OPEN
TB. 22.02.18/ 65	**Emergency care performance -** COO to bring substantive paper to the March Board meeting on emergency care performance	29.03.2018	COO	Paper on 15 Point Plan for Emergency Care on March 2018 Trust Board agenda.	Proposed for closure
TB. 22.02.18/ 66	**Finance & Investment Committee Report -** Assistant Trust Secretary to circulate the report with the minutes of the Trust Board meeting.	29.03.2018	ATS	Circulated alongside the papers for the March 2018 Trust Board.	Proposed for closure
TB. 22.02.18/ 67	**Debt recovery plan** - CFO to expedite debt recovery plan and report through the Finance and Investment Committee	22.03.2018	CFO	Progress update provided to the Finance and Investment Committee on 22 March 2018. Debt recovery now in line with plan.	Proposed for closure
TB. 22.02.18/ 68	**Fit & Proper Person Regulation - Compliance.** DHROD to give consideration to updating the FPP matrix to clarify which roles require professional qualifications / registrations	26.04.2018	DHROD		OPEN
TB. 22.02.18/ 69	**Gender Pay Gap -** DHROD to bring a paper to the March Board meeting about the gender pay gap.	26.04.2018	DHROD	On March 2018 Trust Board agenda.	Proposed for closure

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 March 2018	**Agenda No.**	**1.5**
Report Title:	**Chief Executive Officer's Update**		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Board Meeting.		
Recommendation:	The Board is requested to receive the report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well-led, Safe, Caring, Effective and Responsive		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A

CHIEF EXECUTIVE OFFICER'S UPDATE

The past few weeks have been exceptionally busy, with high demand for the services we provide.

The response from staff has been phenomenal, particularly at the start of March, when London and the rest of the country were hit by adverse weather conditions, including snow.

Despite the weather, we managed to keep all of our services running, and I would put this down to team-work, and many of our staff going above and beyond the call of duty, for which I am extremely grateful.

This includes Robert Holdawanski, Head Gardener at our Tooting site, who was the deserved focus of a BBC London news report about the snow, and the lengths NHS workers went to in order to minimise disruption to patients. Well done to Bob and his team, and the many others who provided support.

As well as operational pressures, we had an unannounced inspection from the Care Quality Commission (CQC) in March, more of which below. The well-led component of the inspection will take place in mid-April, for which preparations are well underway.

I would like to end this introduction to my report by formally welcoming Stephen Jones to the organisation as our new Director of Corporate Affairs. Stephen joins us from the General Medical Council, and we are delighted to now have him in post.

Care Quality Commission – unannounced inspection:

The CQC carried out an unannounced inspection of the Trust during the first two weeks of March. Whilst it was not a full-scale inspection, inspectors from the CQC did visit both St George's and Queen Mary's Hospitals.

During their inspection, the 30-strong inspection team reviewed six core services, namely medicine; surgery; emergency care; diagnostics and outpatients; children and young people; plus community inpatients. They also spent time talking to patients and staff in other areas of the Trust.

We won't receive the CQC's detailed report for a number of weeks. The staff they spoke to were approachable and happy to talk about their services, which is really positive – and the CQC commented on the caring nature of the staff we employ.

The final report will draw on the findings of the CQC's unannounced inspection, plus a broad range of information and data we shared with them in February. The inspectors also carried out interviews with staff and patients before Christmas, and the feedback from these sessions will feed into the review process as well.

We await the CQC's inspection report, but our focus must remain on making sure we continue to make progress, and get the basics right; a message we have been stressing repeatedly to staff in recent months.

Performance challenges and financial planning:

We will discuss our performance challenges, and financial planning for 2018/19, in detail at the Trust Board meeting today, but I did want to make a couple of brief observations in my report.

The performance of key services, particularly our Emergency Department at St George's, is still not where it needs to be, and we have struggled at times in recent weeks.

Our failure to meet the emergency care four hour standard is not the result of a lack of will amongst staff to make things better; staff are working as hard as they can, often to a fault.

At this time of year, we would expect to have returned to a more normal state of affairs by now; but the pressures show no immediate signs of abating. Indeed, last week saw an 8% increase in emergency attendances compared to the same time last year.

I do worry about the impact the pressures have on staff, and I will continue to support them, whilst also making sure we work as one team to tackle the problem, and ensure a more consistent level of performance, and more controlled flow of patients in and out of our services.

Against the back-drop of increased demand for our services, we are also finalising our financial plans for 2018/19. I have said to staff on a number of occasions that next year will be challenging, as we look to maintain responsive, high quality services, whilst also continuing to reduce the deficit.

For me, the incentive to deliver the required savings is intrinsically linked to our organisational aims and ambitions. We all want to invest in and improve the services we provide, but we can only do this if we first tackle the financial deficit and, in time, get back to break-even. It is only at this point that we can start to exert real control over our own future, and plan where we want to invest – and I repeat this regularly in my interactions with staff.

Staff survey results – good news, but more to do:

Our staff are the people who make the organisation tick, and we need to listen to what they are saying, and act on the feedback.

Late last year, we worked hard to ensure a high percentage of staff completed the annual NHS staff survey. I am pleased to say that the response rate was much improved on the previous year, with just over half (51%) of staff completing the survey in 2017, compared to only 40% in 2016.

Overall, the results do show we are making progress; we saw an improvement in responses to 19 questions, and a deterioration in three - with 66 staying the same, although with small improvements against a number of these.

The headline results show that more staff would now recommend the Trust as a place to work or receive treatment. This is good news, but the fact it has only risen from 3.62 out of 5 in 2016 (where 5 is positive) to 3.75 in 2017 shows there is still a long way to go - but we all know that.

The results are also encouraging in relation to health and wellbeing, with an increase from 3.41 to 3.49 (the higher the better) in staff feeling managers and the organisation have an interest in - and are taking action on – health and wellbeing.

There has been an increase from 27% to 33% in staff reporting good communication between senior management and staff. This is positive, and I have stressed to my executive colleagues the importance of being approachable and visible, although we could always do more.

Of course, we need to look very hard at where improvements still need to be made. For example, the number of staff experiencing harassment, bullying or abuse and harassment is still too high.

It is positive that staff feel able to speak up and report incidents such as this, and we are not alone in recognising this as a problem – but it obviously still remains a cause for concern.

I am sure members of the Trust Board have read the detailed report, which I would also urge everyone within the organisation to do.

Staff appreciation awards:

Finally, I would like to mention our first ever Staff Appreciation Awards, which took place on Thursday 15 March.

Together with Gillian Norton, our Chairman, I had the pleasure of presenting an award at the ceremony, which was held at Wandsworth Town Hall.

It was a fantastic event, and one which – I hope – we can replicate every year going forward. The staff who attended really enjoyed themselves, and rightly so; they work very hard, and it is important that we, as an organisation, reward them for their efforts.

The St George's Hospital Charity supported and organised the awards, with the help of Trust staff, and we remain grateful for their generosity, as we are the many local businesses who supported the event.

Jacqueline Totterdell
Chief Executive
March 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 March 2018	**Agenda No**	**2.1**
Report Title:	**Quality & Safety Committee report**		
Lead Director/ Manager:	Sir Norman Williams, Chairman of the Quality and Safety Committee		
Report Author:	Shanaz Islam, Interim Assistant Trust Board Secretary		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 22 March 2018.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	N/A		
CQC Theme:	All CQC domains		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Quality & Safety Committee – March 2018

Matters for the Board's attention

The Quality and Safety Committee met on Thursday 22 March 2018 and agreed to bring the following matters to the Board's attention:

1. **Hospital Acquired Thrombosis (HAT) & Venous Thromboembolism (VTE) Prophylaxis**
   Fiona Kyle, Consultant Oncologist provided an update to the Committee. Fiona is the co-chair of the Hospital Thrombosis Group which monitors a number of data streams concerning compliance with risk assessment for VTE. The Committee heard that the Trust consistently achieves VTE risk assessments in over 95% of its patients. The deep dive audits carried out by the pharmacy team supported this level of compliance and provided additional assurance that the correct action was taken when a VTE risk is identified. The purpose of the risk assessment was to prevent hospital acquired thrombosis (HAT). There had been 15 HATs attributable to admission at St George's Hospital in the year-to-date. Seven RCA investigations had been completed and none of these HATs were found to be preventable.

   The Committee was concerned to hear that there were eight RCA investigations outstanding and that it was likely they would be completed by the HAT group. The Committee observed that this is not a sustainable model.

   There had been a number of prescribing errors associated with the prescription of thromboprophlaxis. These incidents had been investigated and action had been taken to prevent recurrence. The Committee noted that the strongest control over these errors was provided by electronic prescribing.

2. **Quality Improvement Plan (QIP) Dashboard**
   The QIP Dashboard executive summary provided an overview of the KPIs against the CQC domains and each core service. In February 2018, 32 indicators were green compared with 25 in January, though there was an increase in the number of indicators that were classified as "red", from 16 in January to 19 in February. Key issues noted by the Committee were that the target for complaint response times was not being achieved; a paper would come to the Committee in April. It was noted that fewer serious incidents had been reported since December 2017 and that it looked likely that the Trust would end the year below the threshold of 96 incidents. Other red indicators relate to patient flow for in and outpatient services. There was a plan to review the QIP projects and consider any changes that needed to be made to the project plan deliverables.

3. **Integrated Quality and Performance report**
   The Committee received the report and noted that appraisal rates were below target for all staff groups and asked for this to be given some additional focus. The Four Hour Emergency Standard had been 83.5% in February 2018, compared with the national target of 95%. The cancer 62 day standard referral to treatment target continued to be a challenge; a number of steps to improve waiting times and ensure quicker access to diagnostics and treatment were being explored. The Medical Director chairs the Clinical Harm Review Panel and would bring a report on its activity to the Committee in April 2018. It was noted that the Trust's hospital mortality rate continued to be one of the best in the country. In terms of infection control, there had been 15 cases of C.Difficile over the year-to-date, below the national threshold of 31 cases. The Committee noted that there had been two recent never events and heard directly from the team involved in one

of these involving the placement of a naso-gastric tube and the actions being taken to prevent future incidents .

4. **Fundamentals of Care**
   The Senior Responsible Officer (SRO) for this work stream of the Quality Improvement Plan provided an update on the delivery of the projects within the work stream. The Committee noted that hand hygiene achieved a compliance rate of 95% and that this was to be commended. The last phase of the dress code and bare below the elbows policy would shortly be rolled out to theatres; a communications campaign would be launched around this using photographs to ensure all staff were clear about standards of dress expected.

5. **Thematic reporting: Complaints, Litigation, Incidents and PALS and Lessons Learned (CLIPI)**
   The Committee received the report and noted that the number and type of incidents had remained consistent. For the next report, the Committee asked that more detailed information be included that showed how the Trust had learned from incidents and complaints and the actions taken. It was important the Committee could be assured that such learning had taken place.

6. **Safeguarding Children**
   The Committee received an overview of the services and activities undertaken by the Trust in order to safeguard and promote the welfare of children who access its services. It recognised the steps taken to strengthen the Safeguarding Team and the Trust's commitment to partnership working. It noted the priorities for 2018/19, including in relation to meeting best practice in relation to addressing the issue of Female Genital Mutilation, and asked that the audit plan be shared with the Committee.

7. **Elective Care Recovery Programme**
   The Committee received an update on the Elective Care Recovery Programme and noted that this would be discussed further at the Trust Board on 29 March 2018.

8. **Duty of Candour**
   The Committee received a paper summarising the Trust's performance in meeting its statutory and contractual obligations under the Duty of Candour. It noted that performance in this area had been excellent and that in the coming year the focus would be on ensuring the quality of contact with patients and their families is of a high quality.

9. **Review of Quality Priorities 2017-18 and Proposed Priorities 2018-19**
   The Committee discussed and agreed in principle the proposed quality priorities for the coming year and asked for the outcome measures to be clearly defined. It also noted that the draft Quality Report would be considered at the Committee's next meeting.

10. **SWL Pathology report**
    Tim Planche, Medical Director of South West London Pathology (SWLP) attended and updated the Committee on recent work of SWLP and the new governance framework for SWLP which had been introduced in recent months. The Committee also noted that SWLP was accredited by the UK Accreditation Service (UKAS).

Shanaz Islam
Interim Assistant Trust Board Secretary
March 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 March 2018	**Agenda No.**	**3.1**
Report Title:	**Integrated Quality and Performance Report**		
Lead Director/ Manager:	James Friend, Director of Delivery, Efficiency and Transformation		
Report Author:	Kaye Glover, Performance Development Manager Emma Hedges, Divisional Performance Manager		
Presented for:	Review		
Executive Summary:	This report consolidates the latest management information and improvement actions across our quality, patient access, performance and workforce objectives. The Trust is performing positively against a number of indicators, however existing challenges continue, particularly in relation to: Four Hour Operating Standard, 62-Day Cancer Access Standards; and operations cancelled by the hospital for non-clinical reasons. The Trust has maintained positive performance improvement in Diagnostic access and continues to manage the use of agency workforce.		
Recommendation:	The Board is requested to note the report.		
Supports			
Trust Strategic Objective:	Treat the Patient, Treat the Person Right Care, Right Place, Right Time		
CQC Theme:	Safe, Caring, Responsive, Effective, Well-led		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact.		
Legal / Regulatory:	The trust remains in Quality Special Measures.		
Resources:	Clinical and operational resources are actively prioritised to maximise quality. and performance.		
Previously Considered by:	Finance & Investment Committee Quality & Safety Committee	**Date:**	22.03.2018
Appendices:	Integrated Quality and Performance Report		

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Meeting Date – 29 March 2018
Reporting period – February 2018

Excellence in specialist and community healthcare

St George's University Hospitals NHS
NHS Foundation Trust

HOW ARE WE DOING?

February 2018

Daycase and Elective Surgery operations

Actual
4,186

Target 4,460

Discharges before 11am

Actual 16.6%

Target 30%

Four Hour Emergency Standard

Actual
83.5%

Target 95%

Whole Trust Inpatient Friends and Family Test

Actual
96%

Target
95%

Outpatient First Appointment

Actual 14,958

Target 16,610

Better data, safer patients

Outpatients appointments with RTT outcome recorded

Actual
85.8%

Target
83%

Activity Summary

St George's University Hospitals NHS
NHS Foundation Trust

The table below compares activity to previous months and quarters and against plan for the reporting period

		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity against plan YTD	
		Feb-17	Feb-18	Variance	Plan Feb-18	Variance	YTD 16/17	YTD 17/18	Variance	Plan YTD	Variance
ED	ED Attendances	12,048	12,269	1.83%	13,291	-7.69%	149,495	150,531	0.69%	158,538	-5.05%
Inpatient	Elective & Daycase	4,005	4,186	4.52%	4,460	-6.15%	47,454	49,624	4.57%	50,216	-1.18%
	Non Elective	3,713	3,652	-1.64%	3,946	-7.45%	44,183	42,647	-3.48%	47,071	-9.40%
Outpatient	OP Attendances	50,959	47,990	-5.83%	49,789	-3.61%	590,455	580,118	-1.75%	567,846	2.16%

>= 2.5% and 5% (+ or -)
>= 5% (+ or -)

Source: SLAM

Executive Summary – February 2018

Patient Safety

- No Never Events reported in February. The Trust has reported three events year to date. There were four Serious Incidents declared in the month.
- In February the Trust reported one patient with hospital attributable Clostridium Difficile infection, year to date the trust stands at fourteen cases.
- No patients acquired an MRSA Bacteraemia in month, the trust total year to date is four against a ceiling of zero.
- The number of falls per 1000 bed days have reduced in February.

Clinical Effectiveness

- The Trust's mortality rates remain in the lower than expected category and shows that we are 17% lower than expected from typical hospitals and practice in this country.
- Maternity indicators continue to show expected performance.

Access and Responsiveness

- The percentage of hospital discharges before 11am have significantly improved in February reporting 16.6%, 4% higher than previous month.
- Elective and Day case activity shows a 4.52% increase compared to the same period last year.
- The Four Hour Operating Standard was not achieved in February reporting a performance of 84% of patients admitted, discharged or transferred within four hours of arrival. This was above January however below the improvement trajectory agreed with NHS Improvement who have visited the Trust and an appropriate action plan is being agreed and implemented.
- The Trust achieved five out of eight cancer standards in the month of January, continuing to achieve 14 day standard however 62 day standard continues to be a challenge with varied performance.
- The Trust has returned to compliance against the 6 week Diagnostic Access standard in December and continued to achieve this through to February, reporting 0.04% of our patients waiting greater than six weeks for a diagnostic procedure.

Patient Experience

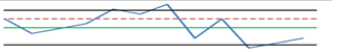
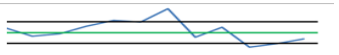
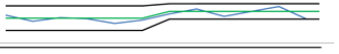
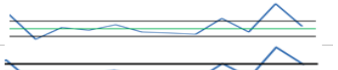
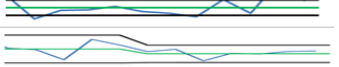
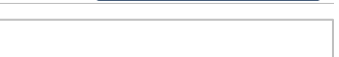
- The Friends and Family Test (FFT) recommendation rate for both inpatients and outpatients was 96% in February. This remains above threshold. Response rates are strong for inpatients but below expectations for Outpatients. The recommendation score for inpatients provides reasonable assurance on the quality of patient experience. Given the low response rate for outpatients the assurance it provides on patient experience is less significant. This is being addressed by the outpatient transformation team as part of the Quality Improvement Programme.

Workforce

- Staff sickness remains above the trust target of 3% for the month of February reporting 4%
- Non Medical appraisal rates have seen a further decline in performance within the reporting period at 66%. Medical appraisal rates have decreased to 77%, both remain below target.

Quality

Patient Safety

Indicator Description	Target	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Trend (12 months)
Number of Never Events in Month	0	0	0	0	1	1	0	0	1	0	0	0	0	
Number of SIs where Medication is a significant factor	0	0	0	0	0	1	1	1	0	0	0	0	0	
Number of Serious Incidents	8 / mth	8	5	6	7	10	9	11	4	8	2	3	4	
Serious Incidents - per 1000 bed days	N/A	0.31	0.21	0.24	0.29	0.40	0.38	0.45	0.16	0.32	0.08	0.12	0.18	
Safety Thermometer - % of patients with harm free care (all harm)	95%	94.5%	94.6%	94.3%	94.7%	93.8%	93.8%	95.7%	94.9%	95.0%	95.1%	94.9%	94.8%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	98.2%	97.7%	98.0%	97.9%	97.5%	97.8%	98.3%	98.7%	98.1%	98.5%	98.9%	97.9%	
Percentage of patients who have a VTE risk assessment	95%	96.3%	95.3%	96.2%	96.3%	95.8%	95.7%	95.4%	96.1%	96.4%	96.0%	95.4%	96.3%	
Number of Patient Falls	N/A	166	111	137	131	143	127	125	122	157	127	189	140	
Number of patient falls- per 1000 bed days	N/A	6.50	4.73	5.39	5.43	5.71	5.29	5.15	4.89	6.23	5.17	7.49	6.15	
Attributable Grade 2 Pressure Ulcers per 1000 bed days	N/A	0.78	0.72	0.28	1.16	0.92	0.63	0.74	0.28	0.64	0.53	0.63	0.66	
Number of Grade 3 & 4 Pressure Ulcers	N/A	3	2	1	0	1	1	2	0	0	0	0	0	
Attributable Grade 3 & 4 Pressure Ulcers per 1000 bed days	0.00	0.12	0.09	0.04	0.00	0.04	0.04	0.08	0.00	0.00	0.00	0.00	0.00	
Number of overdue CAS Alerts	0	1	1	1	0	0	0	0	0	0	0	0	0	

Briefing

- No Never Events reported in February, the Trust total remains at three year to date.
- The Trust declared four serious incidents in February 2018.
- The number of falls reported in February were 140 with a rate of 6.15 per 1000 bed days, the falls practitioner is looking at individual falls to identify themes and working with the Falls Group to revise the falls risk assessment tool to reflect national requirements. Of the falls reported 119 resulted in No Harm.

Quality

Infection Control

Indicator Description	Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Trend (12 months)
MRSA Incidences (in month)	0	0	2	0	2	0	0	0	0	0	0	0	0	
Cdiff Incidences (in month)	31	3	1	1	1	2	3	1	4	0	0	0	1	
MSSA	N/A	2	3	2	4	4	4	1	1	2	3	0	3	
E-Coli	N/A	11	4	2	5	9	6	8	6	2	5	5	5	

Briefing

- There was one patient reported to have suffered with a hospital acquired Clostridium Difficile Infection in February, this occurred on Pinckney ward. Clinically there was no convincing evidence of C.difficile related disease following investigation, it is recognised that you can get low-level toxin detection in children who are chronically colonised. There is no evidence of any acquisition (based on ribotypes) from any other patients and no other evidence of any lapse in care.
- C Diff threshold for 2017/18 remains the same as the previous year at 31 cases. There have been fourteen cases year to date.
- No reported cases of MRSA Bacteraemia in February. The Trust year to date total stands at 4

Quality

Mortality and Readmissions

Indicator Description	Target	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Trend
Hospital Standardised Mortality Ratio (HSMR)	<=100	82.5	82.5	83.5	81.3	82.9	79.7	81.1	80.6	81.3	81.4	82.2	80.8	
Hospital Standardised Mortality Ratio Weekday Emergency	<=100	79.9	79.2	80.1	78.2	78.9	76.4	77.4	77.2	77.5	76.6	77	77.1	
Hospital Standardised Mortality Ratio Weekend Emergency	<=100	85.6	84.2	86.0	83.5	85.4	81.3	81.8	81.2	82	83.8	84.1	83.7	
Summary Hospital Mortality Indicator (SHMI)	<=100	0.86	0.86	0.86	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	TBC	9.3%	9.5%	9.7%	9.7%	8.9%	9.0%	9.7%	10.2%	9.20%	9.38%	8.85%		

Briefing

- As in previous periods our SHMI data for the last reporting period (Oct-16 – Sept 17) remains statically lower than expected. The data shows that our mortality rate is 17% lower then expected from typical hospitals and practice in this country.
- Readmission rates following a non-elective spell observed decreased in the month of February, reporting 8.85% of patients that were re-admitted to hospital within 30 days of discharge.

Maternity

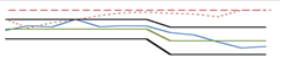
- Maternity indicators continue to be monitored and reviewed by the Divisional Governance process

Indicator Description	Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Trend
C Section Rate - Emergency and Non Elective	28%	34.1%	29.9%	29.1%	24.6%	29.5%	24.9%	30.2%	29.7%	31.9%	25.4%	23.6%	23.1%	
Admission of full term babies to neo-natal care		2	11	2	16	21	20	15	10	16	6	11	7	

Actions: All term admissions to the Neo-natal Unit are reviewed to identify any avoidable causes by the Trust's governance midwife and consultant and discussed at monthly risk and morbidity meeting. Improved incident reporting through the addition of subcategories to assist thematic reviews. Admissions to the Neo-natal Unit have decreased but we have not been able to identify a specific intervention that is driving the reduction.

Delivery

Emergency Flow

Indicator Description	Target	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Trend
4 Hour Operating Standard	95%	89.09%	90.50%	89.68%	92.12%	89.76%	90.05%	90.03%	87.97%	87.17%	84.99%	83.03%	83.50%	
Patients Waiting in ED for over 12 hours following DTA	0	0	0	1	0	0	0	0	0	1	0	0	0	
Ambulance Turnaround - % under 15 minutes	100%	50.2%	46.0%	48.4%	51.9%	48.9%	51.8%	50.9%	49.9%	49.0%	44.3%	41.0%	42.2%	
Ambulance Turnaround - % under 15 minutes (London Average)	100%	43.4%	43.7%	45.3%	47.5%	46.4%	47.0%	46.5%	45.1%	46.1%	42.1%	41.4%	42.2%	
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	53	79	72	71	53	84	71	57	82	112	180	135	
Ambulance Turnaround - % under 30 minutes	100%	97.6%	96.1%	96.7%	96.5%	97.4%	96.0%	96.6%	97.4%	96.2%	94.8%	91.3%	93.2%	
Ambulance Turnaround - % under 30 minutes (London Average)	100%	90.7%	91.8%	92.3%	93.3%	93.2%	93.1%	92.2%	91.9%	91.7%	91.6%	86.7%	87.4%	
Ambulance Turnaround - number over 60 minutes	0	0	1	1	0	1	1	0	0	0	2	3	3	

- The Four Hour Operating Standard in February was 83.5% which falls below both the national target and the improvement trajectory agreed with NHSI, however February has continued to see significant challenges with infection control from Flu.
- Ambulance performance had recently deteriorated due to challenges offloading in ED, however February performance observed a positive increase.
- Several recent initiatives have offered a protective effect on emergency flow :
    - Implementation of a Rapid Assessment and Discharge model began in late November – early analysis indicates approx. 20 more patients per day are seen, treated and discharged from the Front Door area, helping to decongest ED Majors and maintain patient flow through the department.
    - A Point-of-Care Flu test device was installed in ED in December to aid clinical and side room assessment to aid flow (POCT turnaround = 18 mins; laboratory = approx. 90 mins). More than 500 patients have been tested.
    - A Delivery Risk summit held in November 2017 identified and agreed a series of immediate remedial actions. A subsequent Risk Summit on 4 hour operating performance was held on 18/01/2018 chaired by the Chief Executive with Executive members, Senior Managers, Clinical Care Group Leads, Senior Nurses, Junior Doctors and Allied Health Professionals to review impact at specialty level. Actions included clarification of the referral pathway from ED and better visibility of specialty response time data
- Medical Admission and Ambulatory Assessment capacity have been reduced due to infection control issues and building works, with some impact on flow.

Actions

- The Unplanned and Admitted Patient Care programme, led by divisional chair for Medicine and Cardiothoracic Division and supported by clinicians throughout the Trust, aims to provide patients with alternatives to emergency admission and to accelerate discharge to reduce overall bed occupancy
- Service Improvement director for the 4 hour standard and flow commenced in early February.
- Several winter pressure schemes have been implemented with the objective of improving performance to >90% in Q4. the trust continues to struggle to deliver this performance.
- The new Ambulatory and Acute Assessment unit is due to open 5th March 2018.
- SAFER bundle is being rolled out to improve patient safety and remove delays in the inpatient journey
- Revised Trust Internal Professional Standards are in development and Escalation policies have been launched as has the 15 point plan.
- NHSI visit reviewing both performance and quality in the four hour standard, we await final feedback.

Delivery

Cancer

Indicator Description	Target	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Trend (12 months)
Cancer 14 Day Standard	93%	87.9%	86.0%	75.4%	76.6%	67.4%	80.3%	89.7%	94.0%	96.1%	97.3%	98.5%	94.8%	
Cancer 14 Day Standard Breast Symptomatic	93%	93.4%	87.2%	82.7%	84.1%	62.9%	86.9%	90.3%	98.2%	99.6%	98.0%	97.3%	95.9%	
Cancer 31 Day Diagnosis to Treatment	96%	97.5%	96.7%	96.4%	96.4%	96.8%	96.9%	96.2%	96.2%	98.1%	96.9%	97.4%	98.2%	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	100.0%	94.6%	96.4%	95.9%	94.2%	90.9%	95.8%	82.4%	94.1%	96.9%	94.3%	94.6%	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Cancer 62 Day Referral to Treatment Standard	85%	86.6%	86.3%	89.0%	87.3%	85.4%	77.8%	75.6%	76.7%	85.5%	80.8%	86.8%	77.8%	
Cancer 62 Day Referral to Treatment Screening	90%	96.2%	92.6%	92.7%	92.4%	92.5%	86.1%	92.5%	93.0%	78.4%	92.7%	93.9%	86.1%	
Cancer 62 Day Consultant Upgrade	85%	97.7%	85.7%	88.9%	100.0%	100.0%	100.0%	66.7%	100.0%	87.5%	100.0%	100.0%	33.3%	

Briefing

- The Trust continues to achieve performance against the 14 day standard, reporting 94.76%, ensuring our patients are seen within 14 days of referral.
- Cancer 62 day Standard referral to treatment continues to be challenged with varied performance reporting 77.8% in January. A total of twelve patients were treated beyond target this included reasons of referrals being received late in the pathway from other providers, pathway management delays, complex pathways and patient choice.

62 Day wait for First Treatment - GP referral to treatment (actual and internal performance)			
	Target	Actual Performance	Internal Performance
Sep-17	85%	76.7%	82%
Oct-17	85%	85.5%	100%
Nov-17	85%	80.8%	90%
Dec-17	85%	86.8%	97%
Jan-18	85%	77.8%	79%

- There is a continued focus on improving internal processes and a current action plan as part of the Elective Care Recovery Programme is in place.
- The Trust are looking at a number of patient pathways to improve waiting times and quicker access to diagnostics and treatment.
- This year there will be improved reporting within 62 day standard where the waiting times national database will record breaches that occur between each provider, the National reallocation policy will go live from July 2018.
- No Cancer patients have been cancelled due to bed unavailability during January or February

Delivery

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Brain	93%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Breast	93%	89.9%	92.3%	88.7%	84.7%	69.5%	76.4%	93.4%	94.1%	97.4%	98.4%	98.2%	96.0%
Childrens	93%	100.0%	90.0%	66.7%	80.0%	66.7%	80.0%	100.0%	100.0%	100.0%	71.4%	100.0%	87.5%
Gynaecology	93%	75.4%	87.1%	64.6%	66.7%	75.6%	93.4%	90.4%	91.1%	90.8%	95.0%	97.6%	98.0%
Haematology	93%	100.0%	95.8%	76.2%	96.9%	76.9%	95.7%	100.0%	100.0%	96.8%	100.0%	94.7%	91.7%
Head & Neck	93%	97.4%	97.9%	90.9%	84.9%	82.4%	88.0%	82.4%	90.6%	99.1%	99.4%	98.4%	100.0%
Lower Gastrointestinal	93%	95.7%	90.5%	75.1%	90.7%	44.4%	60.0%	73.9%	94.6%	97.4%	97.7%	99.3%	95.2%
Lung	93%	100.0%	100.0%	96.2%	91.1%	91.2%	95.6%	100.0%	94.1%	97.7%	100.0%	100.0%	92.3%
Skin	93%	67.7%	57.4%	29.4%	48.1%	26.9%	74.3%	96.6%	93.4%	95.0%	95.5%	97.9%	92.7%
Upper Gastrointestinal	93%	95.3%	94.2%	88.8%	96.1%	93.8%	97.6%	98.8%	98.8%	98.5%	99.0%	100.0%	89.0%
Urology	93%	95.0%	98.4%	96.1%	90.1%	82.3%	93.8%	97.0%	96.4%	93.3%	97.1%	98.9%	95.0%

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Brain	85%	-	100.0%	50.0%	-	0.0%	100.0%	0.0%	100.0%	-	100.0%	-	-
Breast	85%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	91.7%	100.0%	95.2%	100.0%	71.4%
Childrens	85%	100.0%	-	-	-	-	-	0.0%	-	-	-	-	-
Gynaecology	85%	100.0%	50.0%	100.0%	90.9%	100.0%	61.5%	100.0%	50.0%	83.3%	75.0%	67.0%	80.0%
Haematology	85%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	-	100.0%	88.9%
Head & Neck	85%	72.7%	75.0%	58.3%	85.7%	46.2%	66.7%	71.4%	87.5%	78.6%	81.8%	71.0%	100.0%
Lower Gastrointestinal	85%	66.7%	71.4%	-	62.5%	100.0%	60.0%	100.0%	66.7%	100.0%	80.0%	100.0%	100.0%
Lung	85%	78.6%	73.7%	85.7%	85.7%	64.3%	41.7%	47.4%	72.2%	72.7%	41.2%	33.0%	90.9%
Skin	85%	95.5%	100.0%	93.3%	96.4%	95.7%	100.0%	76.5%	93.8%	90.9%	91.7%	93.0%	86.7%
Upper Gastrointestinal	85%	11.1%	100.0%	100.0%	100.0%	100.0%	100.0%	77.8%	0.0%	100.0%	84.0%	100.0%	33.3%
Urology	85%	87.9%	83.9%	90.0%	67.9%	81.8%	63.0%	64.3%	77.4%	100.0%	72.7%	91.0%	60.7%

Delivery

Diagnostics

Indicator Description	Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Trend
6 Week Diagnostic Performance	1%	2.9%	4.1%	3.3%	2.2%	2.7%	2.0%	1.4%	0.3%	1.9%	0.1%	0.1%	0.0%	
6 Week Diagnostic Breaches	N/A	222	312	248	173	190	154	98	22	143	6	10	3	
6 Week Diagnostic Waiting List Size	N/A	7,678	7,550	7,442	7,843	6,988	7,751	7,184	7,072	7,534	6,440	6,884	7,232	

Indicator Description	Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Trend
MRI	1%	3.3%	2.6%	1.1%	0.6%	0.8%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	
CT	1%	0.7%	1.5%	0.5%	0.2%	0.2%	0.3%	1.2%	0.3%	0.1%	0.0%	0.1%	0.0%	
Non Obstetric Ultrasound	1%	3.0%	4.0%	2.5%	0.3%	1.1%	0.9%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	
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%	
Dexa Scan	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%	
Audiology Assessments	1%	2.5%	6.5%	10.1%	11.3%	4.6%	5.7%	4.5%	0.0%	17.4%	0.0%	0.0%	0.0%	
Echocardiography	1%	0.3%	1.2%	9.4%	2.0%	3.0%	0.3%	0.3%	0.3%	0.8%	0.0%	0.0%	0.0%	
Electrophysiology	1%	0.0%	0.0%	0.0%	75.0%	75.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	
Peripheral Neurophysiology	1%	0.5%	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.3%	0.9%	0.0%	
Sleep Studies	1%									26.8%	0.0%	0.0%	0.4%	
Urodynamics	1%	55.0%	65.5%	75.6%	64.4%	64.2%	50.6%	37.0%	16.7%	6.7%	0.0%	0.0%	0.0%	
Colonoscopy	1%	8.7%	5.7%	4.7%	0.5%	1.8%	0.0%	0.4%	1.1%	0.0%	0.0%	0.0%	0.6%	
Flexi Sigmoidoscopy	1%	8.4%	6.7%	0.0%	1.1%	4.9%	0.7%	1.5%	0.0%	0.6%	0.0%	0.0%	0.0%	
Cystoscopy	1%	2.6%	15.0%	11.5%	24.4%	14.0%	12.3%	14.7%	4.0%	1.8%	1.5%	2.8%	0.7%	
Gastroscopy	1%	4.5%	12.7%	10.0%	9.2%	11.2%	6.7%	0.8%	0.0%	0.8%	0.4%	0.0%	0.0%	

Briefing:

The Trust has continued to achieve performance in February reporting a total of three patients waiting longer than 6 weeks, 0.04% of the total waiting list, compliance has also been achieved in all modalities. The diagnostic waiting list will continue to be monitored as part of the Trust's weekly challenge meeting to ensure that the standard is maintained in all areas.

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Trend
Number of on the Day Cancellations		63	58	72	64	84	54	49	52	86	100	94	55	
Number of on the Day cancellations re-booked within 28 Days		56	54	70	54	70	43	43	34	76	67	76	48	
% of Patients re-booked within 28 Days	100%	88.9%	93.1%	97.2%	84.4%	83.3%	79.6%	87.8%	65.4%	88.4%	67.0%	80.9%	87.3%	

Briefing

- The table above shows that the number of patient procedures cancelled on the day has increased within the winter months, however February has started to see a significant shift observing a 41% decrease in the number of on the day cancelled operations for non clinical reasons.
- In Quarter 3, there were a total of 238 non clinical cancellations ,of which 74.4% were rebooked within 28 days.
- In February 55 patients were cancelled for non clinical reasons on the day of their procedure and 87.3% of these patients were re-booked within 28 days. Operations were cancelled due to bed unavailability, where an emergency case taking priority and lack of theatre time.

Actions

- Improving the Pre Operative Assessment (PAO) Process and the availability of more high risk capacity for POA
- Introducing a call to every patient before surgery to check that they are Ready, Fit and able to attend.
- At times of high non elective activity the elective patients are reviewed and their bed requirements in advance of the day of surgery
- Standard operating procedures have been introduced and a greater focus is being placed onto the booking process and list planning processes.

Patient Experience

Patient Voice

Indicator Description	Target	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Trend
Emergency Department FFT - % positive responses	90%	82.8%	85.2%	83.0%	85.2%	83.9%	85.9%	83.5%	86.4%	84.1%	86.5%	82.2%	81.0%	
Inpatient FFT - % positive responses	95%	96.7%	95.8%	97.3%	96.0%	96.6%	96.8%	96.5%	96.5%	95.7%	95.6%	94.7%	96.0%	
Maternity FFT - Antenatal - % positive responses	90%	100%		85.7%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	
Maternity FFT - Delivery - % positive responses	90%	97.0%	88.2%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	90.0%	94.1%	97.9%	95.4%	87.1%	96.4%	100.0%	92.6%	96.0%	100.0%	99.0%	90.4%	
Maternity FFT - Postnatal Community Care - % positive responses	90%	100%	100%	100%	100%	100%	98%	100%	100%	91.6%		100.0%	100.0%	
Community FFT - % positive responses	90%	93.0%	93.0%	97.6%	96.3%	94.5%	98.3%	94.1%	98.9%	95.7%	96.5%	99.2%	93.3%	
Outpatient FFT - % positive responses	90%	88.1%	92.6%	95.6%	96.6%	94.2%	96.2%	94.4%	96.3%	94.3%	98.2%	97.6%	96.1%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints Received		79	63	76	75	61	99	80	96	78	69	85	80	
PALS Received		294	299	299	234	268	170	203	185	298	262	283	234	

Briefing

- ED Friends and Family Test (FFT) – The score has decreased in February reporting 81% meaning that the percentage of patients recommending the service has decreased compared to January.
- Maternity FFT – The score for maternity care are above local threshold and work to increase the number of patients responding continues after observing a positive impact in February.
- The number of complaints received in the month of February were 80 compared to 85 in January. All complaints are now assessed for complexity when they arrive and given a response time of 25, 40 or 60 working days, the Trust is now able to report on the response times for all categories of complaints. For green (25 day) complaints received in January 48% were responded to within 25 working days against the target of 85%. For Amber (40 day) 53% were responded to within 40 working days. For Red (60 day) 100% were responded within 60 working days.

Actions: The ED management team are reviewing the results from the FFT survey for the last quarter to determine any further themes for improvement, an example being the review of staffing model to ensure response nurses are available to support high volume periods and minimise delays for patients. Complaints and PALS: A complaints handling improvement plan to address the timeliness and quality of complaint responses and which considers different models for handling complaints has been implemented.

Patient Experience

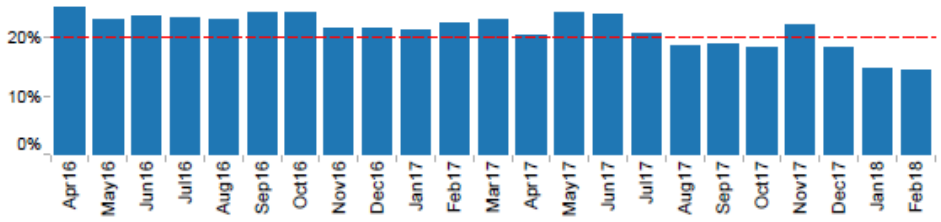
Patient Voice

CARING – Friends and Family Test

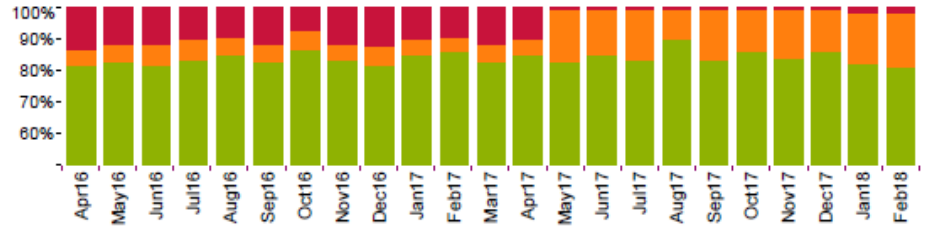
Target ¢ MetricMeasure | Percentage Recommended | Neutral | Percentage Not Recommended

A&E Friends & Family Response Rate

Target: 20% Jan 18: 14.60% Feb 18: 14.37% Movement: ▼-0.23%

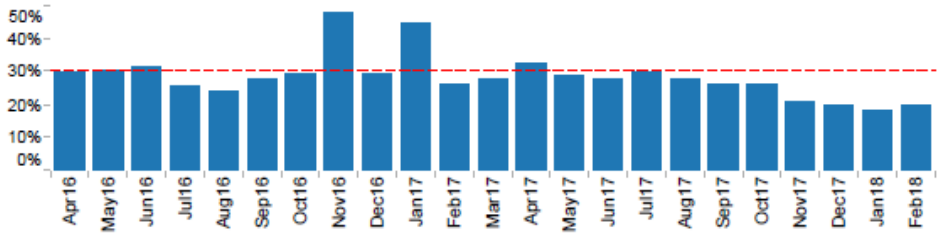


A&E Friends & Family Recommend Rate
The expected target is 90%

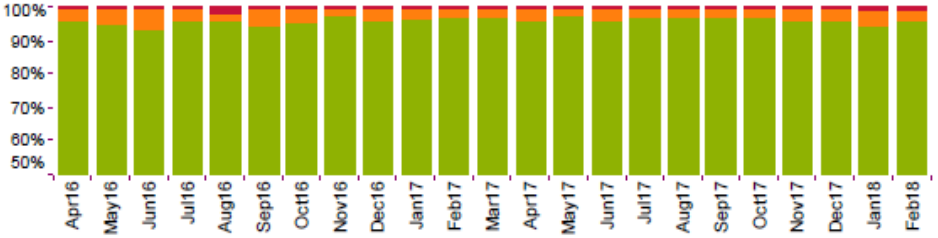


IP Friends & Family Response Rate

Target: 30% Jan 18: 18.50% Feb 18: 19.67% Movement: ▲1.17%

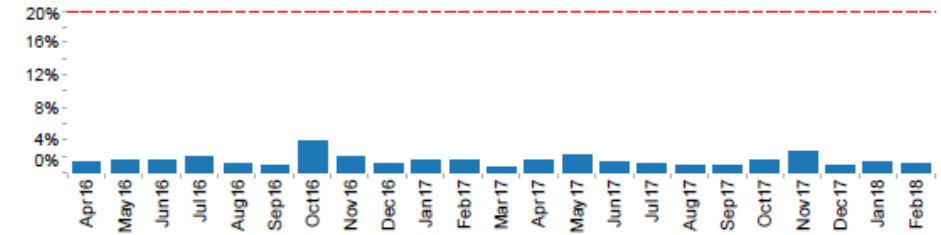


IP Friends & Family Recommend Rate
The expected target is 95%

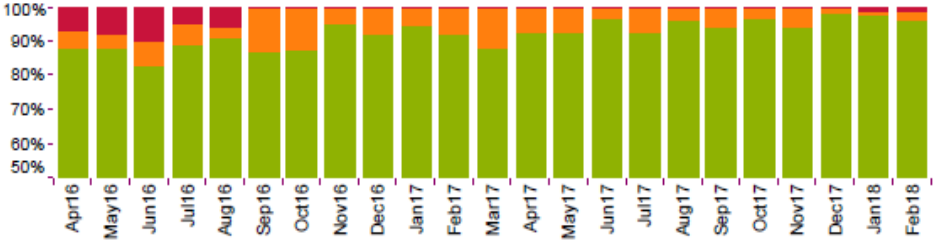


OP Friends & Family Response Rate

Target: 20% Jan 18: 1.20% Feb 18: 0.90% Movement: ▼-0.30%



OP Friends & Family Recommend Rate
The expected target is 90%



Patient Experience

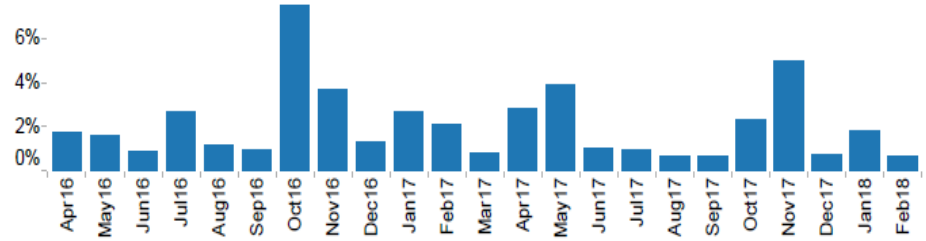
Patient Voice

CARING – Friends and Family Test

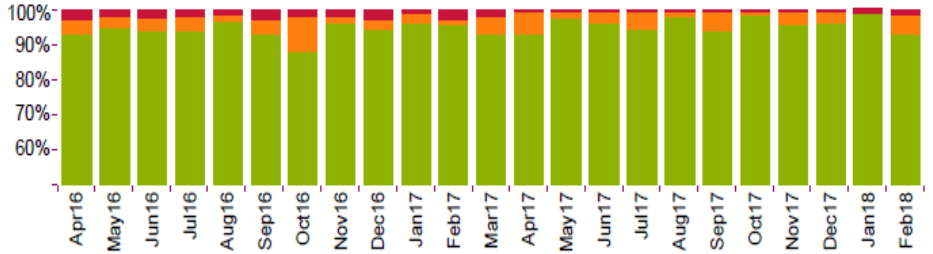
--- Target ¢ MetricMeasure Percentage Recommended Neutral Percentage Not Recommended

Community Friends & Family Response Rate

Target: 20% Jan 18: 1.80% Feb 18: 0.62% Movement: ▼-1.18%

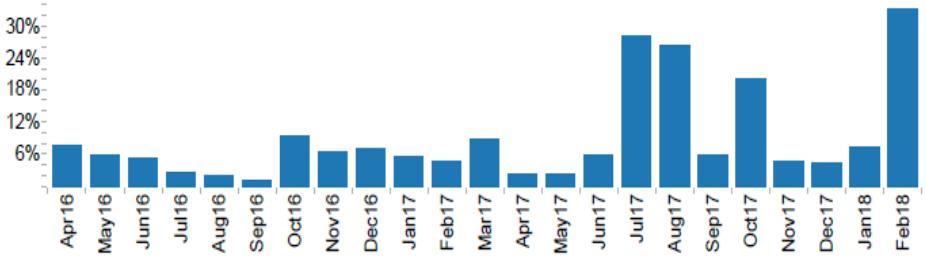


Community Friends & Family Recommend Rate
The expected target is 90%

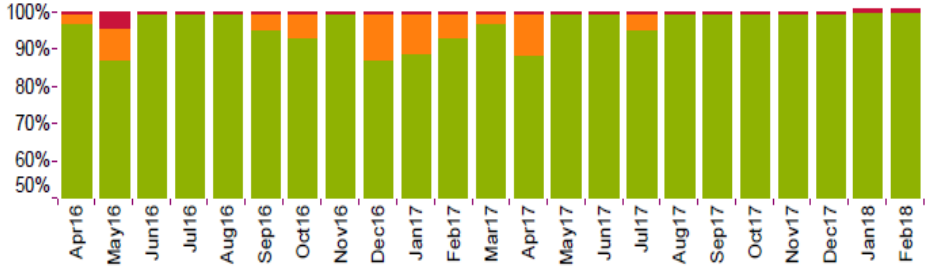


Maternity (Birth) Friends & Family Response Rate

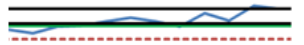
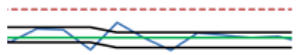
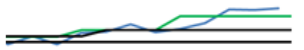
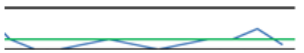
Target: 20% Jan 18: 7.30% Feb 18: 33.30% Movement: ▲26.00%



Maternity (Birth) Friends & Family Recommend Rate
The expected target is 90%



Workforce

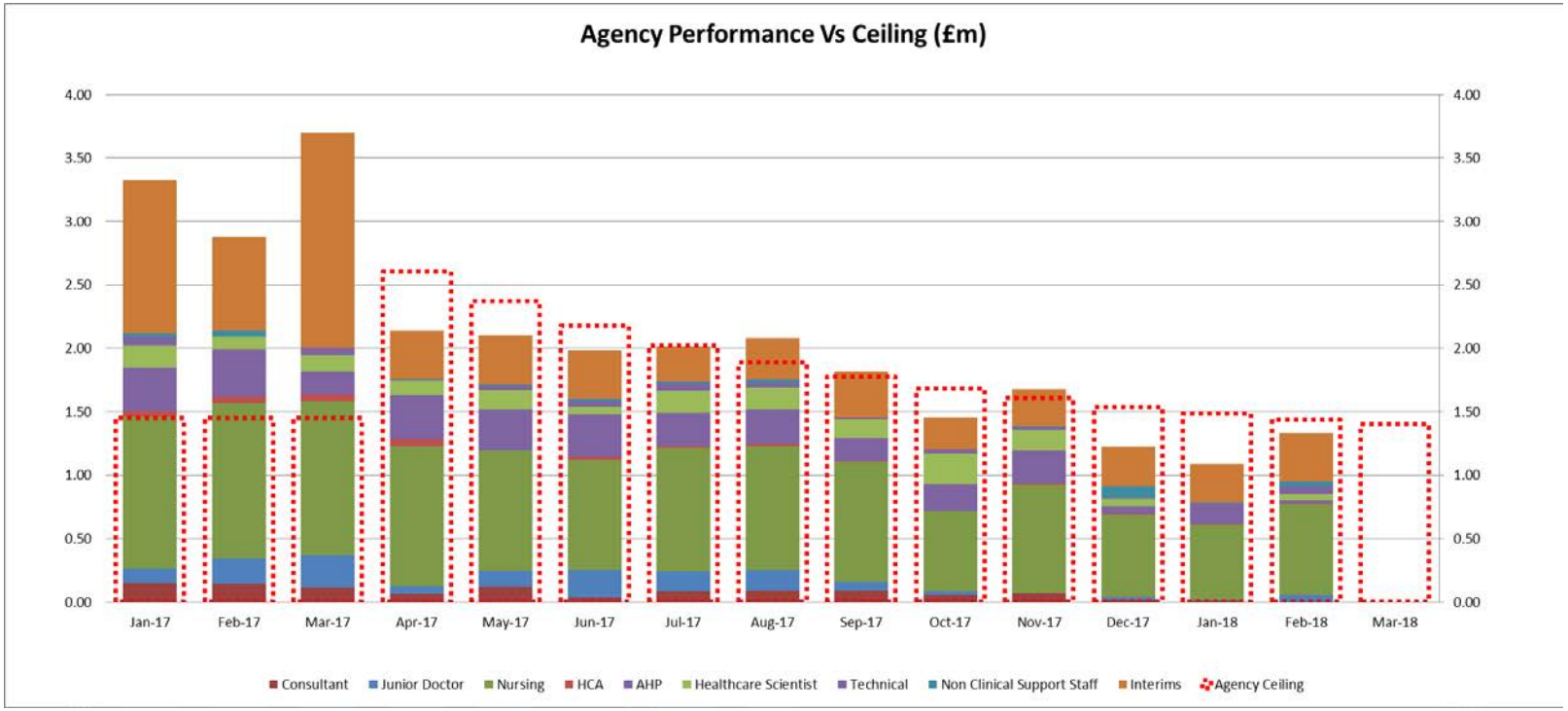
Indicator Description	Target	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Trend
Trust Level Sickness Rate	3%	3.3%	3.2%	3.4%	3.4%	3.6%	3.7%	3.6%	3.4%	3.8%	3.6%	4.1%	4.0%	
Trust Vacancy Rate	10%	15.4%	16.3%	17.0%	17.1%	16.1%	16.5%	14.8%	16.1%	12.7%	13.0%	13.4%	13.5%	
Trust Turnover Rate* Excludes Junior Doctors	10%	19.1%	19.1%	19.1%	18.8%	18.4%	19.6%	18.5%	18.5%	18.3%	18.4%	17.9%	17.6%	
Total Funded Establishment		9,798.10	9,784.10	9,924.93	9,947.77	9,878.79	9,855.40	9,794.00	9,808.00	9,470.02	9,474.19	9,514.51	9,540.06	
IPR Appraisal Rate - Medical Staff	90%	77.3%	82.4%	82.0%	74.2%	84.8%	79.0%	74.0%	80.7%	80.0%	78.9%	79.6%	76.9%	
IPR Appraisal Rate - Non Medical Staff	90%	72.8%	80.3%	78.2%	76.1%	76.1%	75.1%	79.4%	73.5%	70.2%	70.2%	67.2%	65.9%	
% of Staff who have completed MAST training (in the last 12 months)		85%	86%	87%	87%	86%	86%	85%	86%	87%	86%	87%	87%	
Ward Staffing Unfilled Duty Hours	10%	4.8%	5.5%	4.8%	5.8%	5.9%	6.5%	5.9%	6.1%	6.6%	7.8%	7.7%	7.9%	
Safe Staffing Alerts	0	2	0	0	1	2	1	0	1	2	2	4	1	

Briefing

- Funded Establishment remained in line with previous month reporting 9,540 WTE in February.
- Vacancy Rate increased by 0.1% reporting 13.5% in month.
- Sickness has remained above 3% target reporting a decrease in February to 4%.
- Mandatory and Statutory Training figures for February were recorded at 87%
- Appraisal rates remain below target, both Medical and Non Medical. Non medical appraisal rate further decreased to 66% in February and medical appraisal rate was reported at 77%.

Workforce

Agency Use



- The Trust's total pay for February was £39.96m, which is £0.04m lower than January. This is £0.57m adverse to a plan of £39.40m and £0.43m adverse to a forecast of £39.54m.
- The Trust's annual agency spend target set by NHSI is £24.5m. There is an internal annual agency target of £22.0m. For February, the monthly target set was £1.44m.
- Total agency cost in February was £1.33m or 3.3% of the total pay costs. From M1-11 2017/18, the average agency cost was 4.3% of total pay costs.
- Agency cost increased by £0.25m compared to January. In 2017/18 YTD, the Trust has performed better than the planned target by £1.73m.
- In February, there has mainly been increases in Nursing (£0.13m) and Interims (£0.09m).
- The biggest area of overspend was in AHP, which breached the target by £0.02m.
- These figures are compared to the internal target of £22.0m.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 March 2018	**Agenda No.**	**3.2**
Report Title:	**Elective Care Recovery Programme Update**		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer Kim Barrow, Elective Care Recovery Programme Director		
Report Author:	Andy Irvine, Elective Care Recovery Programme Manager		
Presented for:	Assurance		
Executive Summary:	This report provides an update on the Elective Care Recovery Programme, including key highlights of the programme, an overview of the elective care pathways training plan, and a summary of overall programme risks.		
Recommendation	The Board is asked to note the report.		
Supports			
Trust Strategic Objective:	Treat the patient, Treat the person Right Care, Right Place, Right Time		
CQC Theme:	Well-led, Safe, Caring, Responsive		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Implications			
Risk:	BAF Strategic Risk 2		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously considered by:	Quality and Safety Committee	**Date:**	22.03.2018

ELECTIVE CARE RECOVERY PROGRAMME

1. Key Highlights

Cancer	• Independent review at QMH commissioned and due to present their final report on 31 March 2018. The interim feedback has suggested that the systems and processes in place are safe but need to be refined. The specific recommendations will be part of the final report. • A new Cancer Performance Manager has started with the Trust with excellent technical knowledge of our Cancer System [Infoflex). The next version update of Infoflex is timetabled to take place during the months of May and June. • An improved approach to tracking patients has been put in place to ensure both Tooting and Queen Mary patients are part of the Multi- Disciplinary Team (MDT) coordinator work lists.
Diagnostics	• Achieved compliance in February 2018 and forecast to continue in March 2018. • The substantive Divisional Director of Operations continues to strengthen the control and grip through a confirm and challenge approach. • Work progressing on the development of a new diagnostic PTL as part of the overall programme. This is due to be completed by 31 March 2018.
Treating Patients	• The new referral treatment (RTT) incomplete and planned patient tracking lists (PTL's])are in place and continue to be used and matured by the operational teams. • New and improved reports being developed by the business intelligence team to increase the type of tools available to clinical teams • Capacity and activity draft plans have been developed with the intention of reducing the RTT backlog throughout 18/19 and treat patients more quickly.
Return to Reporting	• Data quality metrics have been agreed and are with our third part supplier to build into a dedicated tool. • Patients from our phase one validation are now being contacted and appointed where necessary. No further clinical harm has been identified during this reporting period.
Training	• All 10 RTT e-learning modules in place across all parts of the patient pathway. This is a significant step forward for the organisation. Uptake has increased over the last few weeks, which is positive. • A detailed Cerner/RTT training plan has been developed and signed off by the Trust. This will be rolled out across certain specific staff groups during Q1 of 18/19.The aim of the training will be to give clinical and administrative teams the knowledge skills and competencies required to be able to confidently and accurately manage the following: o New referrals

	○ Outpatient Pathway ○ Inpatient and Day case waiting list management ○ Inpatient and daycase admission and discharge ○ Service Staff – Elective Care Pathway monitoring and management • Over 200 staff in outpatients have been identified and targeted to undertake more core Cerner training. These are staff that have not had refresher training for a number of years and would benefit from more support by the organisation as work flows change and get updated.
Next steps	• Further implementation of maximum waiting cap for new outpatients – working to bring this cap down week on week • A real focus on training both on Cerner and RTT across the key staff groups • Sign off of specialty capacity and activity plans for 18/19 • Continue to appoint the appropriate patients from phase one validation and identify any potential harm
Risk	• Delivery of robust capacity plans that reflect demand • Sub-specialty capacity pressures in Ear, Nose and Throat and General Surgery • Standard Operating Procedure development to ensure front line staff are working to agreed rules • Training resource to train staff on the right way to process patients and RTT knowledge through e-learning packages. • Delayed Cerner implementation at QMH

2. Elective Care Pathways Training Plan

(i) Introduction

This training and development approach focuses on the design, planning and delivery of Elective Care Pathway training required to give the trust assurance in its data capture for the management and reporting of 18-week Referral to Treatment Pathways. The approach also considers the best way to ensure staff are fully equipped with the knowledge and skills to manage data on a day to day basis within the scope of clearly defined roles and responsibilities. It also considers how best to integrate the delivery of Elective Care Pathway training into the Trust's overall education and training schemes for both new starters and established staff.

This report outlines the training plan required for the trust to gain assurance on end to end elective care pathway management and provides the following details:

- scope of training;
- resource requirements;
- scheduling and delivery of the End User Training (EUT);

- development of user guides, training materials and lesson plans;
- training delivery methods

(ii) Background and Scope

The NHS constitution states that “everyone has the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible. “

Healthcare providers must ensure that patients are treated within the maximum waiting times and manage this through local systems and processes that capture the patient’s journey and timeline. This is known as 18-week Referral to Treatment (RTT) management. RTT management commences at the point of receiving a referral and is tracked through the outpatient, diagnostic, inpatient or daycase intervention and recovery phases of the patient journey. In order to manage this effectively clinical decision data must be collected at each point of the patient journey and recorded accurately on the trust’s clinical system. This enables the Trust to monitor and manage each referral, plan care in order to achieve the standards and timelines set and produce accurate reports.

Many staff are involved in the patient pathway and in documenting the care events that occur along the way. These events are predominantly part of outpatient, diagnostic or inpatient activity for which the patient attends. However, there are also care events that occur outside of an attendance that are documented as admin events.

The aim of the training will be to give clinical and administrative teams the knowledge skills and competencies required to be able to confidently and accurately manage the following:

- New referrals;
- Outpatient Pathway;
- Inpatient and Day case waiting list management;
- Inpatient and daycase admission and discharge;
- Service Staff – Elective Care Pathway monitoring and management

Training will be delivered in 2 phases:

- **Phase 1:** Focus on individual staff potentially making consistent errors (>50 in the last 6 months) in relation to Elective Care Pathway data quality. In particular, staff who are creating new pathways instead of linking to an established pathway for both Inpatient waiting list and Outpatient referrals for the same speciality.

- **Phase 2:** Focus on the staff who are entering elective care pathway data at a rate of >100 patient care events over 6 months

Training will be delivered via a combination of project and BAU resources.

Trust staff who will be delivering this training include:

- Core Project Team
- Elective Care Pathways Team (18 week Team)

- Outpatient Trainers
- Trust ICT training Team
- Data Quality (super users)
- Cerner Technical Architect

(iii) Timescales

This training will be delivered in the first six months of 2018/19 using classroom and 1:2:1 learning approaches.

(iv) Governance and Reporting

Weekly reporting will be carried out with attendance on courses being monitored daily. A number of metrics will be monitored and presented to the weekly Elective Care Recovery Delivery Group and then flow into the Divisional structure and will include:

- Attendance to Course title compared to bookings
- DNA by course title compared to bookings
- Outstanding bookings by course title
- % competency tests passed
- Competency tests passed by individuals (not for general circulation)
- Competency tests failed by individuals (not for general circulation)
- Evaluations outcome from attendees

(v) Resource

2.5 staff members have been identified as the resource to deliver this initial training plan. However, 1.5 staff members will be lost at the end of June as they migrate onto the Cerner implementation at Queen Mary's Hospital. The ECRP Director is currently working on wider options to fill this gap and open up the discussions about the wider use and involvement of core Cerner training staff from within the trust.

(vi) High Level Plan – Training

Phase One - (Focus on individual staff potentially making consistent errors)

Milestone	Start	Finish
Undertake analysis	3rd April 2018	27th April 2018
Develop a detailed training plan	16th April 2018	23rd April 2018
Develop and Sign off training materials	As above – starts on 3rd April 2018	27th April 2018
Develop KPI's / dashboard	3rd April 2018	27th April 2018
Training Sessions planned	16th April 2018	1st June 2018
Training Delivered	30th April 2018	1st June 2018

Phase Two - Focus on the staff who are entering elective care pathway data at a rate of >100 patient care events over 6 months

Milestone	Start	Finish
Develop a detailed training plan	3rd April 2018	11th May 2018
Develop and Sign off training materials	TBA when	TBA
Develop KPI's / dashboard	3rd April 2018	27th April 2018
Training Sessions planned	Provisional date 1st May 2018	25th May 2018
Training Sessions scheduled	1th May 2018	25th May 2018
Training Delivered	7th May 2018	31st August 2018

(vii) Key Risk

Securing the right capability of trainers from July 2018 onwards as the core team who initiates this will be migrating to the Cerner implementation at Queen Mary's Hospital.

3. Overall Programme Risks

Key Risks			
Risk / Cause / Impact	**RAG Score**	**Executive Owner**	**Mitigating action/s**
High numbers of errors being added to the PTL **Risk**: There is a risk that the validation burden could continue to increase until key SOPs are embedded into the organisation at the earliest opportunity to mitigate some of the causes of the cohorts which require validation. **Cause**: Incorrect entries into Cerner **Impact**: An increase in the time for the Trust to return to National Reporting and the requirement of a significantly sized validation team. Large scale validation requirement needed to continually clean the errors being made.	20	Ellis Pullinger	**Controls in place**: Strong communications on the need and consequences. **Actions**: • 'How to guides' developed to address requirements in short term • Data Quality Dashboard in place to track errors on a daily basis • Have trained 839 staff including 353 clinicians on CDOF • E-Learning training in place and mapped to 3500 staff for roll-out • Keeping PTLs clean workstream pursuing a targeted, data driven approach to 'support' and retrain' those that are consistently making the largest amount of errors – this will be monitored by refined workstream KPIs.
Insufficient outpatient and inpatient capacity to reduce RTT backlogs **Risk**: There is a risk that current capacity plans are not sufficient to reduce RTT backlogs on both SGH and QMH sites. **Cause**: Operational Planning **Impact**: An increase in the time for the Trust to return to National Reporting and the requirement of a significantly sized validation team. Excessive waiting times continue in some specialties.	20	Ellis Pullinger	**Controls in place**: Capacity planning process linked to contractual discussions **Actions**: • Development of backlog reduction plan – signed off by services • Outpatient clinic template clean-up: undefined slots • Increased outpatient new slots made available to CBS and ERS • Where necessary – outsourcing plans developed.
Adherence to Trust access policy: chronological booking and management of DNAs **Risk**: There is a risk that current capacity not being utilised effectively – particularly with regard booking patients in date order and removing patients who fail to attend. **Cause**: Booking from PTL / Process for managing DNAs **Impact**: Capacity wasteage / patients booked inappropriately.	16	Ellis Pullinger	**Controls in place**: Enhanced waiting list management, validation and review of all patients within current defined criteria **Actions**: • Launch of new Trust-wide PTL • PTL rollout to CBS and PPCs • Data Quality Dashboard tracking DNAs on a daily basis • Specialty level PTL management meetings in place
Time needed to rollout Cerner at QMH **Risk**: Trust cannot return to national reporting without an RTT compliant PAS system **Cause**: Non-RTT compliant PAS system at QMH **Impact**: The time needed to rollout Cerner at QMH will reduce the Trust's ability to strategically develop the site with other services and will limit the overall success of this Programme and the Trusts aspirations to return to National Reporting..	16	Larry Murphy	**Controls in place**: **Strong project management and robust plans to tackle the use and rollout of Cerner as well as appropriate Trust resources made available as part of the implementation phase.** **Actions**: • Engagement form the Executive team with NHSI to ensure the funding is approved for Cerner at QMH as a matter of priority (Milestone for funding approval currently missed) • 'How to guides' SOPs and revising the training approach to ensure the correct use of Cerner is incorporated into BAU training as a Programme priority and resourced appropriately
Consultant not completing the outcome functionality after training and implementation **Risk**: There is a risk that patients may be subject to harm if Consultants do not complete the outcome functionality appropriately **Cause**: patient outcome is not recorded and therefore tracked and monitored appropriately **Impact**: Patients maybe subject to harm and furthermore this creates incomplete data and erodes confidence in PTLs which in turn impacts the overall progress towards returning to National Reporting	12	Andy Rhodes	**Controls in place**: Strong leadership from the Divisions and outcomes reported as part of the governance around access **Actions:** • CDOF rollout, training and support to users across the Trust • Clinician engagement and training to be discussed with AR to drive improvement in Clinician training % and subsequent form completion • The move to Electronic Outcomes as a priority for the Trust
Identification of patients at risk of potential harm **Risk**: There is a risk that patients maybe subject to potential harm due to the current pathway challenges **Cause**: 'Dirty' PTL, non standardised processes and the incorrect use of Cerner **Impact:** Patients at potential risk of avoidable harm	9	Andy Rhodes	**Controls in place**: Enhanced waiting list management, validation and review of all patients within current defined criteria **Actions**: • Harm review criteria under review • Creation of new PTL • Introduction of CDOF and SOPs as well as revising BAU staff training

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 March 2018	**Agenda No.**	**3.3**
Report Title:	**NHS Improvement Emergency Care Site Visit**		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer		
Report Author:	Fiona Ashworth, Deputy COO and Divisional Director of Operations; Robert Rose, Service Improvement Director; Gemma Phillips, General Manager for Emergency Department and Acute Medicine		
Presented for:	Assurance		
Executive Summary:	The purpose of the report is to: • Outline the actions being taken in response to the observations and recommendations made by NHS Improvement following their Emergency Care site visit in February 2018 • Outline how the feedback and actions arising from the NHSI visit are being integrated into the existing 15 point plan to drive improvements in Emergency Care performance. • Provide assurance that the actions are sufficiently credible and robust and outline the expected impact on performance against the 4 hour Emergency Care Standard. • Outline the proposed governance structure associated with the implementation of NHSI's recommendations and to provide assurance of clear ownership and accountability of actions to improve Emergency Care Performance throughout the organisation.		
Recommendation:	It is recommended that the Trust Board considers and approves the response to the NHSI report outlined this paper. It is recommended that the governance structure to improving the 4 hour standard including unplanned care systems is considered and approved.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person. Right care, right place, right time. Build a better St George's.		
CQC Theme:	Safe, Effective, Responsive, Well-led		
Single Oversight Framework Theme:	Operational Performance, Leadership and Improvement, Quality of Care		
Implications			
Risk:	A risk assessment aligned to the actions described in this paper is being developed, as per NHSI's recommendation.		
Legal/Regulatory:	Recommendations as directed by NHS Improvement.		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee Finance and Investment Committee	**Date:**	21.03.2018 22.03.2018
Appendices:	None		

NHSI Emergency Care Site Visit to St George's Hospital
Trust Board 29th March 2018

1.0 Purpose

1.1 This paper outlines the actions being taken in response to the observations and recommendations made by NHS Improvement following their site visit to St George's Hospital on 20th and 21st February 2018.

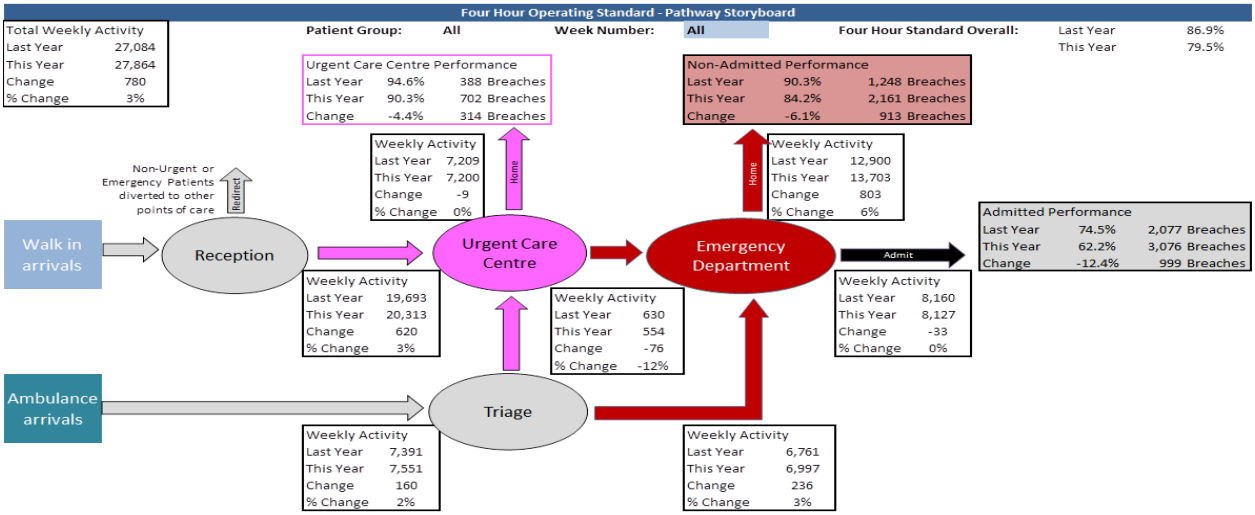
1.2 The paper highlights the key priority areas for improvement based on the feedback from NHSI and demonstrates how the actions arising in response to the NHSI recommendations have been aligned to existing plans with a focus on the immediate to medium term changes required, whilst engaging with hospital staff to facilitate a change in the organisational culture associated with the delivery of the 4 hour Emergency Care Standard.

1.3 The paper outlines the expected impact of the actions being taken on performance and outlines the trajectory for improvement against the 4 hour Emergency Care standard in 2018/19.

1.4 The paper outlines a proposed governance structure and accountability framework associated with the implementation of NHSIs recommendations and seeks to provide assurance of clear ownership and accountability of actions to improve Emergency Care Performance throughout the organisation.

2.0 Background

2.1 The Trust's performance against the 4 hour Emergency Care standard has become increasingly challenged since September 2017 and has been consistently below 2016/17 levels of performance. The Trust is currently delivering 87.57% year to date with significant variability in daily performance. In February 2018, the Trust delivered performance of 83.5%, compared to 90.69% in February 2017. March 2018 has seen a further deterioration, with current performance 75.74% as at 16th March 2018. Both admitted and non-admitted pathways performance has deteriorated significantly between 1617 and 1718 which is highlighted in the performance storyboard graphic below (Q4 to date), and reflects the concern by NHSI regarding the trusts 4 hour standard performance.



2.2 In February 2018, NHSI undertook a series of clinically led site visits to the most fragile systems for emergency care across London to review quality, patient flow and progress with a specific focus on emergency care improvement programmes, Emergency Departments (EDs), Acute Medical Units (AMUs), Ambulatory Emergency Care (AEC), inpatient wards, frailty intervention services, site management and discharge processes.

2.3 In early March 2018, the Trust received a copy of the report from NHS Improvement following their visit to St George's Hospital on 20th and 21st February 2018 which outlines 24 observations with associated recommendations for implementation, including 16 that should be addressed in the short term (within one month).

2.4 These recommendations have been cross referenced with Trust's Quality Improvement Plan (QIP) and the Four Hour Emergency Care Standard '15 Point Plan'.

3.0 Key Summary

3.1 The NHSI review has highlighted and confirmed a number of opportunities to improve the structures, processes and behaviours which are contributing to organisational performance against the four hour Emergency Care standard being delivered well below the requisite 95%.

3.2 In the report, whilst NHSI recognised that there is a clear expectation set by the executive team that emergency care is an organisational priority, it was not apparent through observations and discussions that emergency care is everybody's responsibility and a key priority is to instil this as a change in the culture across the organisation.

3.3 Whilst NHSI observed that staff are clearly passionate about the service they provide to patients, particularly within ED itself, the report identified a gap in clear leadership and ownership of Emergency Care challenges at a corporate and service level within Divisions.

3.4 This is consistent with the observations of the Service Improvement Director that, whilst staff are committed to delivering a high level patient care there is duplication of effort and an

observation of strong and conflicting series of silos within the organisation which are impeding best patient care through preventing effective patient flow.

3.5 NHSI recognised the environment and facilities in the ED for patients and staff as impressive, however noted that it was widely acknowledged by staff that recent months had proved challenging, citing staffing issues and flow as key contributory factors.

3.6 The visiting team observed a lack of emphasis on the delivery of the four hour standard and next steps required to move patients along the pathway, instead observing a focus on the prevention of extended (12 hour) waits. An organisational focus on the avoidance of 12 hour trolley waits, particularly in the early part of each day and in the context of a crowded ED can be seen to divert attention from managing emergency care pathways against the 4 hour Emergency Care standard.

3.7 In addition, there is a view at an organisational level that even when there is good flow within the organisation, ED rotas are sometimes misaligned to demand. The Emergency Care Improvement Programme (ECIP) Informatics lead is supporting the Trust in reviewing demand and capacity aligned to ED resources and rotas.

3.8 The close proximity of ED to CDU, AMU and the new Ambulatory Assessment Area (AAA) is widely acknowledged internally and noted by NHSI as an advantage, however transfers out of ED to AMU were observed to be slow, even when beds are empty and allocated to patients. Flow from AMU to inpatient wards was also observed to be slow with delays of between 1.5 to 3 hours despite overcrowding and unplaced patients within the ED.

3.9 The team observed several board rounds and spoke to nursing staff about ward processes where they found significant variation. Best practice in the implementation of the SAFER Patient Flow Bundle was not reflected on the wards that were visited.

3.10 NHSI also noted that not all wards had patients identified for discharge and found that there was poor knowledge of the departure lounge opening times which may explain variation in the number of patients utilising the facility and the number of early discharges.

3.11 Whilst the visiting team did not meet with the Transformation Team, they recognised the existence of a dedicated improvement team and Programme Management Office (PMO) and recommended that the Trust considers how many of the team are dedicated to driving improvements in emergency care and patient flow.

3.12 We have observed that a shared commitment to common goals and objectives is sometimes missing, meaning that actions in support of an agreed escalation status can be misaligned and inconsistent, with staff sometimes interpreting agreements (and in some cases instructions) differently with a lack of consequence. There is a strong need for an improvement in the alignment of patient flow activities and accountability across the organisation.

3.13 The new and expanded Ambulatory Assessment Area (AAA) and paediatric ambulatory emergency care unit present an opportunity to improve flow through the adoption of best

practice models of care but these are not yet fully established. The need to review referral pathways into the new AAA and patient flow through the unit which presents a further opportunity for improvement to patient flow and performance is a key priority.

3.14 NHSI verbally described an opportunity to improve the flow of patients via a frailty unit in place of CDU and building on the peripatetic team based in ED.

4.0 Key priority areas for improvement

In response to NHSI's observations which are consistent with the observations of the Trust's Service Improvement Director for Emergency Care over a longer period, five key priority areas for improvement have been identified:

4.1 Emergency Department Oversight

- Breach oversight is routinely undertaken by non-clinical staff. Clinical ownership and oversight of emergency care against the 4 hour standard should be implemented consistently. Non admitted patient performance should be consistently delivering at a minimum of 95%.

- The ED staffing profile alignment and focus, particularly overnight and at weekends is a concern, which coincides with poor ED Time to Treatment (TTT) performance (percentage of patients treated within 60 minutes) and consequently poor 4 hour performance. The 6 week average performance against the TTT metric at St George's is 30%. Trusts who consistently deliver 95% performance meet this key standard for 50% of patients.

- Patients over 75 years are streamed directly to ED majors as part of the Rapid Assessment and Discharge (RAD) process. This is based on evidence that ambulant patients over the age of 75 have around a 40-50% chance of admission compared to ambulant patients under the age of 75 who have around a 12% chance of admission. Due to their frailty and acuity, this cohort of frail older patients requires access to majors cubicles to ensure comprehensive assessment and appropriate disposition, the trust should consider further frailty/ OPAL provision as part of the CDU infrastructure.

- NHSI recognised the need for a frailty pathway that does not involve patients being situated in CDU, thereby improving flow through CDU and releasing capacity within the ED.

4.2 Flow from Emergency Department to short stay units (AMU/SAU)

- The SOP and access policy for the Surgical Assessment Unit should be reviewed and agreed with the Emergency Department to consider, where appropriate, direct access by ED consultants. This may offer a further opportunity to improve surgical patient flow out of ED.

- The Emergency Department has predictable pressure points in terms of capacity. Movement out of the department is impeded and currently only 30% of patients leave ED within 30 minutes of a bed being allocated, sometimes due to a lack of urgency combined with the batching of bed allocations which is then compounded by staffing challenges. This key metric should be achieved for 95% of patients, with exceptions for clinical reasons only.

- The site team is in the process of assembling a dedicated 'transfer team' to support with managing this pressure, in addition to a review of current resources. A team leader role for the patient flow co-ordinators across the ED, AMU and medicine is being be developed.

4.3 Flow from AMU to specialty wards

- The patient flow activities for AMU operate separately from the operational site team, meaning beds are allocated by one team and not consistently acted upon quickly enough by another.

- Matrons reporting the bed capacity position and number of discharges for their areas at site meetings often report a different position to that reported by bed managers even though the source of information is the same (ward managers/ discharge co-ordinators).

- The paediatric bed base should be managed in the same way as medicine and surgery. Neurosciences and Cardiac need to remain aligned to their respective services due to the tertiary nature of these specialised services.

4.4 Exit flow from the hospital

- Discharge oversight meetings with senior input from system partners were discontinued several months ago, resulting in time consuming meetings which review but do not have representation from individuals with sufficient seniority and authority to influence the delays and expedite discharge.

- The ratio of stranded patients to DTOCs/NDTOCs is high. NHSI identified underreporting, indicating a knowledge gap within discharge co-ordination teams which is further contributing to delayed discharge. This is being reviewed.

- Best practice discharge to assess models exist for Wandsworth Social Services but are not yet in place for Merton.

4.5 Site management and operational oversight and accountability

- The site team does not currently have the organisational authority to hold services to account. The Trust is looking at ways for the clinical site management team to manage the hospital site more effectively.

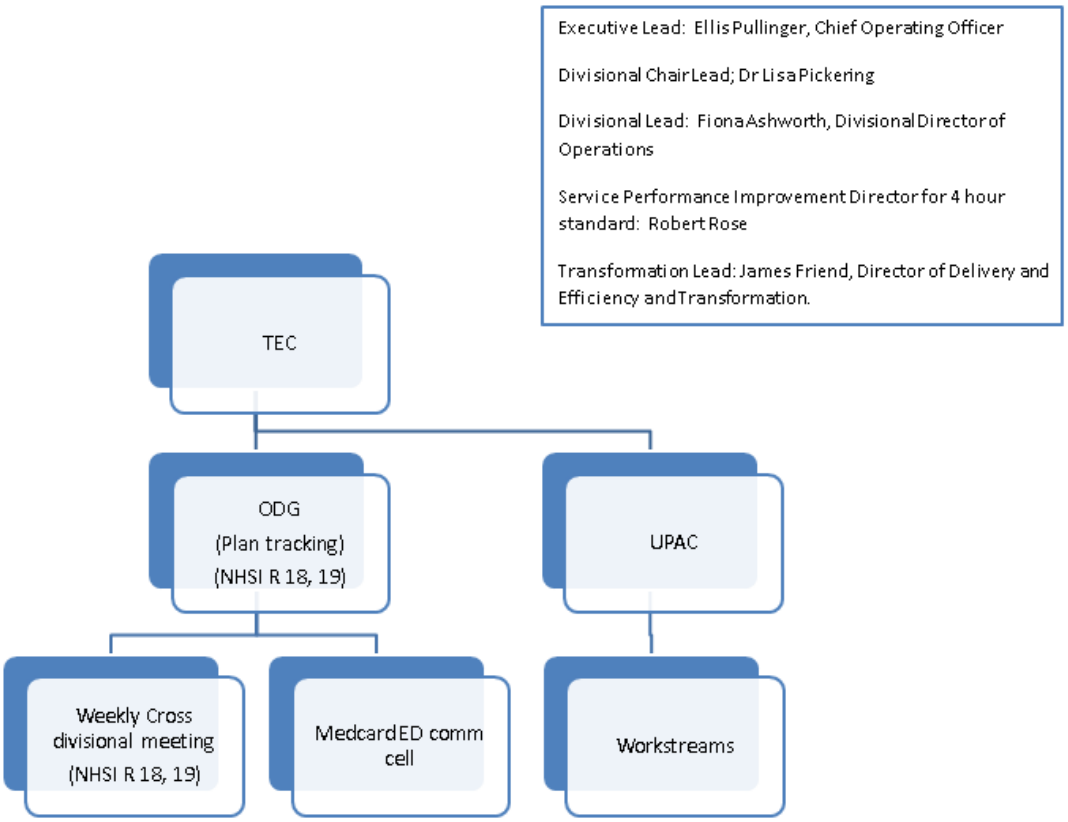
- Oversight of patient discharge sits with four different stakeholder groups: Divisions via the ward managers, divisions via the patient flow managers (differences between Medcard

and Surgery Divisions) and site operations via the bed managers. Discharge coordinators at SGH are qualified nurses, whereas at QMH they are not. Where there are staffing shortages, discharge coordinators have been observed to be called upon to perform nursing duties, leaving a gap in focus on discharge planning on the ward.

- The discharge structure and function will be reviewed with a view to aligning under one accountable officer. Without these key changes, improvement in discharge planning and flow will struggle to improve sustainably.

5.0 Proposed Governance Structure for Emergency Care Performance

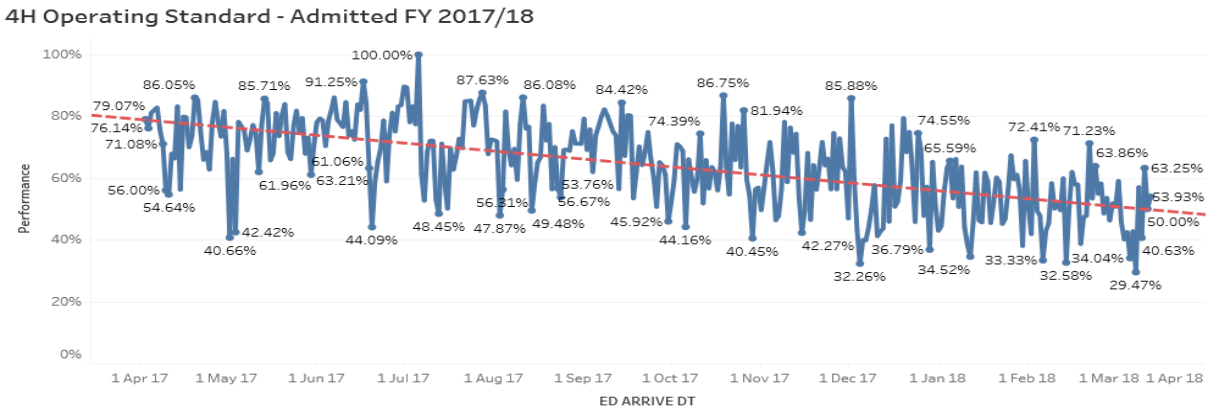
The diagram below outlines the governance structure for the oversight of Emergency Care performance improvement.

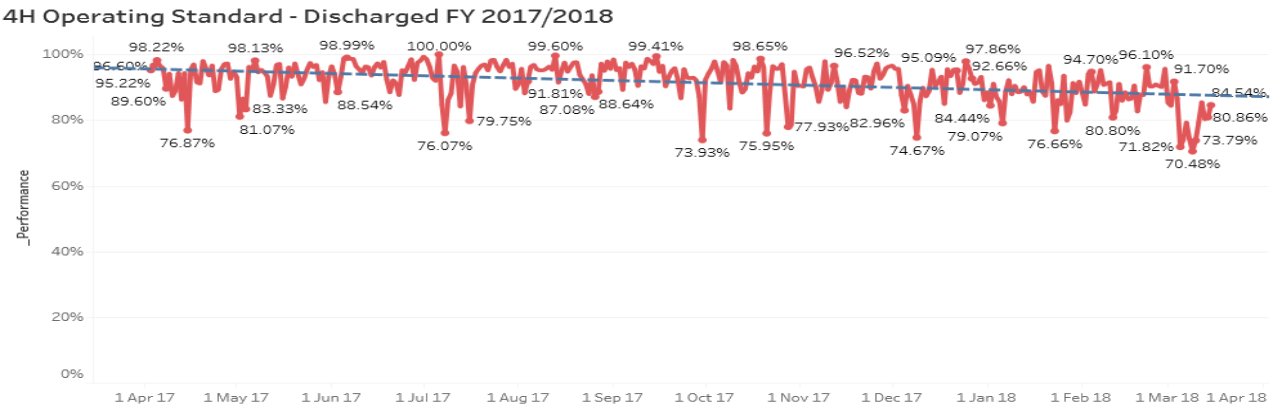


6.0 Emergency Care Performance Improvement Trajectory 2018/19

6.1 It is expected that the actions being taken will contribute to the delivery of 90% performance on average over 2018/19. The proposed trajectory will allow for the medium to long term actions to be embedded within the organisation and the cultural change needed to deliver improved performance to be effected.

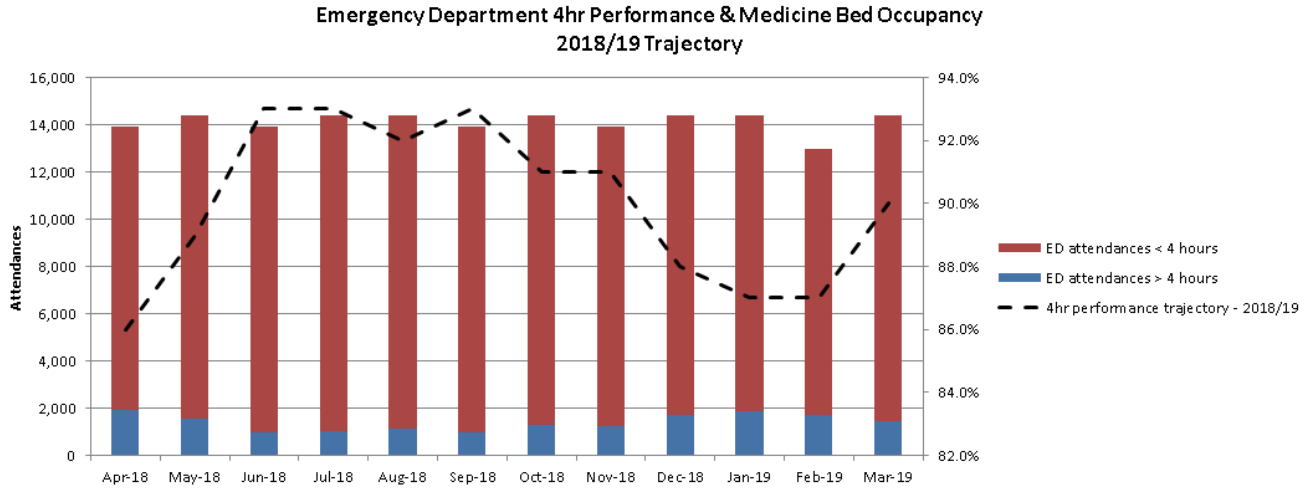
6.2 Both admitted and non-admitted 4 hour performance has seen a declining trend since April 2018, with a marked deterioration in non-admitted performance in recent weeks. This will be reviewed and addressed as part of the improvement plan and data is presented weekly to the Emergency Department communications (comms) cell meetings including senior clinical staff. The charts below summarise 2017/18 4 hour performance for admitted and non-admitted cohorts.





6.3 The Trust aspires to deliver sustainable improvements in Emergency Care performance that will ultimately enable the achievement of 95% performance against the 4 hour constitutional standard. The table below outlines the proposed quarterly trajectory for delivery against the 4 hour Emergency Care standard in 2018/19, taking into account current performance and the actions being taken to improve performance. The chart shows the trajectory on a monthly basis.

2018/19 Period	Proposed improvement trajectory
Q1	**89%**
Q2	**93%**
Q3	**90%**
Q4	**88%**



6.4 The actions described in the 15 Point Plan will largely impact on reducing breaches due to bed management and ED capacity constraints. The table below describes the impact on performance of a 10% reduction in breaches in these categories in April and May 2018 and a 20% reduction from June onwards, linked to the delivery of the proposed trajectory. This assumes ED activity will be delivered in line with the 2018/19 SLA and is based on the proportion of breaches against these categories in 2017/18.

Impact of actions on performance in line with 4 hour standard trajectory

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
Total attendances - planned 2018/19	13,920	14,384	13,920	14,384	14,384	13,920	14,384	13,920	14,384	14,384	12,992	14,384	169,360
4hr performance trajectory - 2018/19	86%	89%	93%	93%	92%	93%	91%	91%	88%	87%	87%	90%	90%
Total Breaches (adjusted)**	1764	1597	937	881	1136	804	1290	1280	1622	1546	1460	963	15,280
4hr performance trajectory - 2018/19 (Adjusted)	87%	89%	93%	94%	92%	94%	91%	91%	89%	89%	89%	93%	91%

** 10% reduction in April 2018 and May 2018 in Bed Management and ED Capacity breaches, and 20% reduction for each of the following months

** Based on proportion of breaches recorded against each breach category as at March 2018

*** Assumes ED attendances in line with 2018/19 SLA

6.5 There is an assumption, supported by the Emergency Care Improvement Programme (ECIP) that to deliver 90% performance consistently, bed occupancy should be no higher than 92.5%. The same bed occupancy level (92.5%) is linked to the optimal delivery of safe patient care. It is expected that until some of the changes described in this paper are embedded, bed occupancy is likely to remain at around 95% on average over Q1. Since December 2017, the Trust has been running at between 95-98% bed occupancy on average. It is acknowledged that when an organisation reaches 96% occupancy, it becomes extremely challenging to achieve 95% performance against the constitutional 4 hour standard.

6.6 As part of the 15 Point Plan, a detailed refresh of the demand and capacity model is being undertaken across all Divisions supported by ECIP. This will be a key part of the winter plan for 2018/19 and will have input from system partners.

6.7 There are opportunities to improve the capacity challenge, including through the inpatient processes and discharge work streams as part of the Unplanned and Admitted Patient Care Programme (UAPC).The implementation of the best practice SAFER Patient Flow Bundle need to be embedded with support from the Transformation team, with clinical sponsorship and ownership with the Divisions in order to contribute to reducing bed occupancy sustainably.

6.8 Furthermore the majority of patients attending SGH would be expected to be discharged within 7 days. After this point they become regarded as delayed or 'stranded', requiring a clinical challenge of balancing the risk of the patient remaining under our care. The number of 'stranded' patients (patients with a length of stay >7 days) is currently 289 with 89 'super stranded' patients (patients with a length of stay of >21 days). The Trust is currently reporting 23 Delayed Transfers of Care (DTOCs) and 9 Non-delayed Transfers of Care (NDTOCs).

6.9 There is further work to be undertaken on quantifying the impact of some of the actions on improvement in emergency care performance and bed occupancy within the organisation. This work is being supported by the Head of Informatics for ECIP and the Trust's Informatics team. A rapid review of review of demand and capacity across the organisation is also being undertaken, linked to emergency performance and elective care recovery.

7.0 Next steps

7.1 The 4 hour Emergency Care Standard 15 Point Plan incorporating the actions are detailed within this paper in response to our local plans and the observations and recommendations from NHSI. Links to the Trust's QIP are highlighted, with clear leads and timeframes for delivery.

7.2 The delivery of the 15 Point Plan and wider improvements in emergency care performance are being supported by the Trust's Service Improvement Director (SID). The delivery will be underpinned by the further development of dashboards.

7.3 Point 24 of NHSI's report, relating to the limited Quality Improvement capability within the organisation is being taken forward by the Associate Medical Director for Quality Improvement and Clinical Transformation, in conjunction with the Transformation team and Clinical Directors. It is anticipated that this work will address the cultural shift that is required in order to deliver sustainable improvement, with support from the Human Resources team.

7.4 The Trust has committed to hosting two further Multi Agency Discharge Events (MADEs). The next MADE, which will be preceded by a Day of Care Audit is being held on 20th March 2018 with a further MADE taking place during the week commencing 14th May 2018.

8.0 Recommendation

8.1 It is recommended that the Trust Board approves the actions outlined in response to NHSI's recommendations on Emergency Care, considers and approves the proposed governance structure and improvement trajectory for Emergency Care Performance.

	Objective	Link to NHSI recommendations	Link to QIP objectives	Actions and progress	Impact on performance	Lead/timeframe
ED operational performance improvement plan in support of response to NHSI (24) recommendations following site visit 20 and 21 February 2018						
1	Optimise flow within ED, proactively preventing breaches of the 4 hour standard	NHSI points 2 & 8.	1) Ensure flow of patients is optimised to deliver good patient care and performance 2) QIP 1,2,3,7	There is a now one GM working across ED and Acute Medicine. Together with the AGM they have a regular presence in ED. Tight oversight of patients above 3hrs and DTAs, alerting DDO and SID (in hours and tactical on call out of hours) when more than two four hour breaches occur per hour. Consultant in Charge to have oversight of non-admitted pathway and assessment times (time to treatment – TTT metric) to improve non-admitted performance. Three times daily clinical site management meetings review maximum length of time in ED, including potential 12 hour trolley breaches, but also those patients currently at 3 – 4 hours with no plan.	1. Improve non-admitted performance against 4 hour standard: Q1 – 90% Q2 – 95% Q3 – 95% Q4 – 95% 2. Improve Time to Treatment metric (treatment within 60 minutes) from current 6 week average of performance of 31%: Q1 – 35% Q2 – 45% Q3 – 40% Q4 – 40%	GM for ED & Acute Medicine, in place.

				The DDO is alerted regularly as part of escalation and personally attends ED board rounds.		
2	Prevent the use of ED escalation areas without discussion of other preventative actions. Involvement of DDO or SID in hours and tactical on call out of hours, with one hour notice of impending need to open escalation (trigger >70 patients in department).	NHSI points 2 & 4 – SBAR approach to OOH conference call and ED presence on the call. Further improvement to ED board rounds. NHSI point 5 relating to 'fit to sit'. NHSI point 17, development of frailty unit.	1) To stop impact on non-admitted flow. 2) QIP 1-7	The ED escalation areas have been opened 7 times since the 15 point plan was launched on 25 February to 5th March 2018. On each occasion this has been approved in advance by the DDO (and on two occasions the SID) and has typically been for a maximum of 2 hours to manage patient surge, rather than stretch the use of existing clinical staff. The full capacity protocol is in place and has been used to support escalation to black (OPEL 3) on four occasions since 25th February 2018.	1. Impact on performance is linked to reduction in bed management and ED capacity breaches: Q1 – 10% reduction Q2 – 20% reduction Q3 – 20% reduction Q4 – 20% reduction	General Manager for ED & Acute Medicine supported by Transformation by 1st June 2018.
3	All patients to leave ED within 30 mins of bed being allocated, with discharge summaries completed within 30 mins or bed being	NHSI point 4 relating to ED board rounds and management against 4 hour standard.	1) Optimise patient flow 2) QIP1,2,3	Patients leaving ED within 30 mins of bed allocation is subject to review at the site operational meetings held at 8.30, 1300 and 1600 daily. This in turn provides a focus for improving	1. Increase percentage of patients leaving ED within 30 minutes of a bed being made available (currently 30%): Q1 – 40%	CD and HoN for ED, supported by site team by 2nd April 2018

	allocated	NHSI Point 6 - transfer from ED to AMU NHSI point 8 - response to operational pressure in line with OPEL and escalation policy.		operational performance. Site team have established a transfer team to support outflow from ED. Operational pressures have inhibited clinical staff from consistently completing discharge summaries within 30 minutes. The focus being to avoid overcrowding the ED	Q2 – 55% Q3 – 50% Q4 – 50%	
4	Delivery of Emergency Department Inter-professional Standards (IPS) and adherence to Trust escalation policy linked to requirement for specialties to attend ED within 30 minutes of referral	NHSI point 8 – review triggers and actions align escalation policies.	1) Performance delivery 2) Adherence with escalation policy (inc. OOH). 3) QIP 1,2,7	ED to flag to divisional silver if internal operational standards not being met by medicine / surgery for example. On a day-to day basis specialty delays are raised at operational site meetings at times of exit block. Responsiveness is improving as the Trust is embracing ED operational performance as organisational care responsibility.	1. Decrease in breaches due to waiting for specialist opinion: Q1 – 5% decrease Q2 – 10% decrease Q3 – 10% decrease Q4 – 5%decrease	General Manager for ED & Acute Medicine and HoN for ED by 2nd April 2018 supported by site team.

5	AMU push for patients to go to base wards and pull from ED	NHSI point 6 relating to flow. NHSI point 9 relating to inpatient ward beds. NHSI point 7 relating to variation in ward processes.	1) Boarding in wards if there are more than 10 DTAs in ED & aim to have 10 beds by midday in AMU 2) QIP1,2,3,4,5,	Patient discharges from base wards to discharge lounge is improving. In addition, the bed manager for medicine personally details on the AMU white board the expected discharge times of patients on base wards. On 13th March; 11 patients passed through the discharge lounge by 11am and 44 by 5 pm. Typically, 5 patients pass through by 11am and 20 patients by 5pm.	Number of AMU beds available at midday: Q1 – 5 beds Q2 – 10 beds Q3 – 10 beds Q4 – 5 beds	Head of Operations and matron for AMU, by 2nd April 2018.
6	Fully embed best practice ambulatory care model and extend opening hours in line with business case by June 2018	NHSI point 10- AAA and AAA SOP.	1) QIP 1,2,3	The new and expanded Ambulatory Assessment Area (AAA) facility opened on 5th March 2018 with extended hours (phased approach). The unit operates in line with the best practice 'process' as opposed to pathway specific model, with ambulatory care as the first line approach unless patients are clinically unstable, enabling rapid access to same day assessment, diagnostics	1. Reduction in admissions to AMU compared to 2017/18: Q1- reduction of 3 admissions per day Q2 - reduction of 5 admissions per day Q3 - reduction of 5 admissions per day Q4 – reduction of 5 admissions per day	Clinical Director for Medicine, 2nd April 2018

				and treatment. .	2. Reduction in number of breaches due to bed management and ED capacity Q1 – 10% reduction Q2 – 20% reduction Q3 – 20% reduction Q4 – 20% reduction	
7	Breach validation takes place live as they occur	NHSI point 8 – revert to focus on 4 hour performance.	1) Accurate live information (clinically led) to agree appropriate actions to sustain flow, performance and optimised patient care (QIP1)	Breach validation is taking place live by a non-clinician. Currently there is inconsistent oversight by clinical staff. The emergency department are considering how best to introduce live clinical validation of breaches with the support of informatics colleagues.	No direct impact on performance due to live breach validation but will enable closer monitoring of ED position .	General Manager for ED and Acute Medicine by 30th April with support from Informatics
8	Anonymised ED operational performance is displayed in the department (not visible to patients) and the MTC comparison graph is supplemented by a SWL graph	NHSI point 8 on mind set and delivery of constitutional standard.	1) Build on improving performance ensuring patient focus. 2) Develop a framework that will be used by ED for individual	We are discussing with senior clinical colleagues where best to locate this information and what is displayed. The GM for ED and Acute Medicine is leading on this issue going this forward. Data to be presented through ED comm cell.	No quantifiable impact on performance but awareness of performance against peers and higher performing Trusts is expected to contribute to cultural change.	General Manager for ED and Acute Medicine by 2nd April 2018

			developments and delivery of both safe care and performance 3) QIP 1,2,3,4	The Medical Director and COO met with ED consultants on 2nd March to discuss the NHSI letter following site visit on 20th and 21st February 2018. This was followed by a meeting with the AMU/AAA team on 9th March which was also attended by the Chief Nurse.		
9	Performance by shift and for the 24 hour period	NHSI point 3 – staffing and shift performance & point 8 on mind set and delivery of constitutional standard. NHSI point 18 – development of emergency care KPIs and cross-organisational visibility and action through COO.	1) Further develop a performance focussed environment 2) Live plan to resolve the previous issues 3) QIP 1,2,3,4,	We are discussing with senior clinical colleagues where best to locate this information and what is displayed. The GM for the Emergency floor is leading on this issue going this forward.	No quantifiable impact on performance but awareness of performance against peers and higher performing Trusts is expected to contribute to cultural change.	Informatics team, by 30th April 2018 informatics.
10	Red hour v green hour and key issues (at every board	NHSI point 8 on mind set and delivery of	1) To understand the actions needed	The DDO for Medcard is supporting these meetings personally. Blocks to patient	No direct impact on performance. Monitoring of red to green hours at	Clinical Director for ED by 2nd April 2018

	meeting in ED)	constitutional standard.	to provide optimise flow, and performance 2) QIP 1,2,3	progress and exit from ED are identified and acted upon.	board rounds in ED are an indicator of pressure in the department and will signal the need to take actions in line with escalation policies.	
11	7.5% patients streamed to primary care (brief at the start of every day linked to board meeting)	NHSI point 21 – link to community services and GP OOH and point 18, development of KPIs for emergency care.	1) Deliver the standard agreed with CCG on optimising patient navigation 2) Patient to the right place and navigated from ED QIP 1,2,3,7	The DDO for Medcard is supporting these meetings personally.	1. Proportion of patients streamed to primary care: Q1 – 7.5% Q2 – 7.5% Q3 – 7.5% Q4 - 7.5% Impact on performance is linked to improvement in non-admitted performance (see point 1)	Clinical Director for ED and HoN for ED by 2nd April 2018
12	Increase streaming to AAA (including straight to AAA or other ambulatory service)	NHSI recommendation 10-AAA.	1) Deliver the 7.5% standard agreed with CCG on optimising patient navigation 2) Patient to the right place and	The new Ambulatory Assessment Area (AAA) was opened on 5th March 2018, 7 days a week. Hours will be extended in line with agreed business case as staff are recruited.	1. Reduction in number of breaches due to bed management and ED capacity Q1 – 10% reduction Q2 – 20% reduction Q3 – 20% reduction Q4 – 20% reduction	Clinical Directors for ED and Acute Medicine, by 30th June 2018 supported by Transformation and SID.

			navigated from ED 3) QIP 1,2,3,7			
13	Reduce breaches due to waiting for specialist opinion. All specialties to deliver minimum of 60% performance. Specialties delivering >80% performance to sustain/improve position.	Point 8 NHSI recommendation, response to operational pressure and point 19 – lack of Divisional ownership.	1) System owned performance. 2) QIP 1,2,3,	Actively contact specialities who have not delivered 80% performance and require evaluation of breaches and a plan. Use of speciality linked SPAs to ensure that the response available for weekly performance review meetings.	1. Decrease in breaches due to waiting for specialist opinion: Q1 – 5% decrease Q2 – 10% decrease Q3 – 10% decrease Q4 – 5%decrease	General Manager for ED & Acute Medicine by 2nd April 2018, supported by DDOs across all Divisions.
14	Evaluate the role of flow co-ordinator, total retrain and delivery focus (and consider impact of role- end April 2018)	NHSI point 7 &11 – recommendation on discharge planning, SAFER and red to greens in wards	1) QIP 1,2,3,7,	The alignment of discharge co-ordinators, flow co-ordinators and patient flow which is also in response to the NHSI site visit on 20th and 21st February is considered in this paper.	This is an enabler to improve effectiveness of PFC role in proactively preventing breaches of the 4 hour standard.	AGMs for ED and Acute Medicine by 30th April 2018 with Transformation /SID support.
15	Optimise discharge planning through evaluation of discharge planning team roles and best practice models as part of improving flow	NHSI point 7 & 12 NHSI – recommendation on discharge planning, SAFER and red to greens in wards. Discharge co-ordinator review.	1) QIP 4,5 & 7	Matrix management as one team through a single accountable officer is being considered. Also being considered is whether the QMH, SGH or a hybrid model is the best one for discharge co-ordinators.	1. Bed occupancy: Q1 – 95% Q2 – 92.5% Q3 – 92.5% Q4 – 95%	Head of operations supported by DDOs and Transformation team

		NHSI point 13 regarding discharge lounge and 14 regarding inpatient therapy. NHSI point 15, 16 & 22 on whiteboards and DTOCs. NHSI point 20 – demand and capacity in therapies.				
	Trust QIP Plan 1. A&E 4 hour operating standard **95%** 2. Ambulance handover time 15min **100%** 3. % of patients assessed within 15 min of arrival at A&E **100%** 4. % of Daily discharges by 11am **40%** 5. Bed Occupancy **92.5%** 6. % of wards using SAFER **90% (staged)** 7. Patient Experience (FFT) **95%**					

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 March 2018	**Agenda No**	**4.1**
Report Title:	**Finance and Investment Committee report**		
Lead Director/ Manager:	Ann Beasley, Chairman of the Finance and Investment Committee		
Report Author:	Ann Beasley, Chairman of the Finance and Investment Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 22 March 2018.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Finance and Investment Committee – March 2018

Matters for the Board's attention

The Finance and Investment Committee met on Thursday 22 March 2018 and agreed to bring the following matters to the Board's attention:

1. The Committee had a further discussion on the estates risk which had been allocated to it as part of the Board Assurance Framework, but accepted that further work was required by the estates and facilities management team before it would be in a position to properly assure itself. The Committee's discussion was not helped by the circulation of the wrong paperwork and it agreed to have a further discussion on both the estates and IT risks at its meeting in April.

2. As previously agreed following the Deloitte Governance Review the Committee continued to consider performance insofar as it impacts on activity levels and therefore income and where it presents opportunities for productivity improvements. There was a further discussion on the performance in the Emergency Department, which remains disappointing. Frustratingly, the challenges are not that there is a lack of understanding of what needs to be done, or indeed that the right actions are never undertaken, but that performance is inconsistent. Additional senior resources have been brought in to increase focus on what needs to be done. An external review has also highlighted opportunities to monitor interim targets such as the percentage of patients with a medical intervention in the first hour, which should better enable the Trust to achieve the overall 4 hour A&E standard.

3. After achieving compliance in all cancer standards last month, the Committee was concerned to note the downturn in performance in January. Discussions highlighted the fragility of underlying systems and the need to improve these so that the Trust can come to expect compliance every month. A further discussion on utilisation of theatre capacity highlighted opportunities to improve throughput within existing capacity, which need to be explored. The Committee welcomed the improvement in on the day cancellations and recognised the hard work by staff to achieve this.

4. The Committee considered the monthly finance report based on data up to the end of February and the forecast for Income and Expenditure until the end of the year. It was noted that year to date expenditure against income showed a deficit of £57.1 million, compared with a year to date deficit last month of £52.9 million. Members reflected that whilst the Year to date position had worsened, the forecast was unchanged from previous months. Members took some assurance from the actions being taken to keep the forecast out turn at (£53m) but noted the continued reliance on non-recurrent items which would have knock on implications for 2018/19. The Committee remained concerned about the risk in relation to PSS income of £7m which had previously been paid by NHSE but this responsibility had been partially transferred to CCGs without the requisite funding. The Committee noted that if this issue was not resolved satisfactorily the forecast out turn would increase to a deficit of (£60m).

5. The Trust has received recent notification that it would receive additional capital funding that needed to be spent in the current financial year. The Committee re-assured itself that adequate plans were in place to achieve this.

6. On business and financial planning for 2018/19, the Committee noted that there had been further progress in developing Green Cost Improvement Programmes but there was further work to do in relation to pay CIPs. Whilst it is clear that NHSI are still hoping

to set a more ambitious control total for the Trust, the Committee was very mindful of the need for a target that was widely believed to be achievable and thus felt that the priority must be to identify the remaining Green CIPs already built into the budget. A further workshop session will be scheduled to allow Board members to understand fully the implications of budget settlements for next year and sign off an appropriate budget.

7. The Committee welcomed the improvement in the cash position and was pleased to note the increased attention on debt recovery.

8. The Committee approved policies on credit management, Treasury actions, asset valuation and financial planning. It also noted the first iteration of the long term financial model.

9. The Committee noted the need to undertake a Committee Effectiveness Review in time for discussion at its next meeting.

10. Recommendation

The Board is recommended to receive the report from the Finance and Investment Committee on 22 March 2018 for information and assurance.

Ann Beasley
Finance and Investment Chair, NED
March 2018

BOARD MINUTE – USE OF STANDING ORDER 5.2

Chief Executive's Office
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Minute of the approval of the **SINGLE CURRENCY INTERIM CAPITAL SUPPORT FACILITY AGREEMENT for £10m** by the board of St George's University Hospitals NHS Foundation Trust.

IN ATTENDANCE

NAME	POSITION
Ms Gillian Norton	Chairman.
Ms Jacqueline Totterdell	Chief Executive

1. Standing Order 5.2

The Trust's Chief Financial Officer set out in an email to the Trust's board members dated 7th March the requirement for the proposed use of standing order 5.2 giving authority for the Chairman and Chief Executive to enter into the documents, ancillary documents and take related actions in relation to the **SINGLE CURRENCY INTERIM CAPITAL SUPPORT FACILITY AGREEMENT for £10m ("the Agreement")** with the Secretary of State for Health by the board of St George's University Hospitals NHS Foundation Trust by reason of urgency subject to later ratification of the Trust board.

As a result of the email, consultation took place with the board and Sarah Wilton and Ann Beasley being non-officer members gave their approval to the proposed action under standing order 5.2

3. INTERESTS IN PROPOSED TRANSACTIONS AND/OR ARRANGEMENTS WITH THE TRUST NAME NATURE AND EXTENT OF INTEREST

The Chairman and Chief Executive did not have any interest in the Transaction.

4. PURPOSE OF THE CHAIRMAN'S ACTION

The Trust's Chief Financial Officer explained to the Trust's board members in a covering email that the Trust needed to approve the **SINGLE CURRENCY INTERIM CAPITAL SUPPORT FACILITY AGREEMENT for £10m** no later than Wednesday 7th March 2018 in order that the Trust may secure access to the £10m capital.

The Trust's Chief Financial Officer attached the draft **SINGLE CURRENCY INTERIM CAPITAL SUPPORTFACILITY AGREEMENT for £10m.**

5. CONSIDERATION

The Chairman and Chief Executive considered the Agreement and supporting documents and the background thereto and were satisfied that:

5.1 the borrowing is consistent with the capital investment plans outlined in the Trust's capital programme (PAU) bid documents reviewed by the Trust Board and submitted previously to NHS Improvement

5.2 the Trust's Chief Financial Officer has in place detailed procedural instructions concerning the applications for the funding in relation to the Agreement;

6 RESOLUTIONS

Following consideration, IT WAS RESOLVED by the Chairman and the Chief Executive that the Agreement would be in the interests of the Trust, and IT WAS FURTHER RESOLVED pursuant to the powers under standing order 5.2 to:

6.1 approve the Agreement and the terms of the transactions contemplated by the Agreement and authorise any authorised signatory listed below to execute the Agreement on behalf of the Trust subject to such amendment as those executing the same on behalf of the Trust think fit;

6.2 authorise any authorised signatories listed below to do all such acts and things and agree and execute on behalf of the Trust all such other documents to which the Trust is a party and all other documents as may be required in order to implement the Agreement and generally to sign all such certificates and notices as those executing the same on behalf of the Trust think fit;

6.3 confirm that drawdown ("utilisation requests") to secure funding under the Agreement once the Agreement is in place may be signed on behalf of the Trust by the authorised signatories set out in Standing Financial Instructions clause 22.1.17

"*All drawdowns of borrowings "utilisation requests" must be signed/counter-signed by at least two of the following officers - the Director of Finance, the Deputy Director of Finance and an Associate Director of Finance".*

7. AUTHORISED SIGNATORIES FOR SIGNING THE AGREEMENT

The authorised signatories referred to above are:

Signatory Name	Position
Andrew Grimshaw	Chief Financial Officer
Robert Flanagan	Director of Finance - Operations

9. CLOSE

There was no further business.

07.03.18

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Ms Gillian Norton (Date)
Chairman

07.03.18

…… …….

Ms Jacqueline Totterdell
Chief Executive (Date)

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 March 2018	**Agenda No.**	4.3
Report Title:	**Month 11 Financial Report (February 2018)**		
Lead Director/ Manager:	Andrew Grimshaw, Chief Financial Officer		
Report Author:	Michael Armour, Financial Strategist Tom Shearer, Strategic Finance Manager		
Presented for:	Update		
Executive Summary:	Overall the Trust is reporting a YTD deficit of £57.1m at the end of Month 11 (February), an adverse variance to plan by £10.2m. Within the position, income is adverse to plan, which is partly offset by Pay expenditure underspend. The Trust planned to deliver £36.6m of CIPs by the end of February. To date, £36.7m of CIPs have been delivered; £12.4m of income actions and £24.3m of expenditure reductions. The Trust forecast outturn remains a £53m deficit at year end.		
Recommendation:	The Trust Board is asked to note the Trust's financial performance to date at month 11 and forecast outturn.		
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:	N/A		
Resources:	N/A		
Previously Considered by:	Finance & Investment Committee	**Date:**	22.03.2018
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 11 (February 2018)

Chief Finance Officer
Trust Board 29 March 2018.

Executive Summary – Month 11 (February)

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	The trust is reporting a deficit of £57.1m at the end of the February, an adverse variance to plan by £10.2m. Within the position, income and non-pay are adverse to plan, which is being partly offset by Pay expenditure underspend. In month, income is lower than budget, pay is higher than budget and non-pay is lower than budget.	£10.2m Adv to plan	£8.8m Adv to plan
Income	Income is being reported at £15.2m adverse to plan year to date, with an adverse movement in month of £2.4m. Included within the month 11 results are £0.9m of income relating to prior periods. There is lower than planned income of £7.8m in Elective YTD. Exclusions income is lower by £6.2m, but is offset by reduced expenditure. Non-SLA income is also under plan by £1.2m as well, although £0.8m of this is offset in SWLP.	£15.2m Adv to plan	£12.8m Adv to plan
Expenditure	Expenditure is £5.0m favourable to plan at month 11, £1.0m favourable in month. The majority of the favourable position is in pay, £5.8m YTD, with underspends seen in Nursing, Non Clinical and ST&T categories. Non-pay is £2.6m overspent, and the main drivers being IT MSA costs, RTA bad debt and the impact of the removal of tendered community services. Post-EBITDA costs are £1.9m underspent; depreciation is causing the majority of this.	£5.0m Fav to plan	£4.0m Fav to plan
CIP	The Trust planned to deliver £36.6m of CIPs by the end of February. To date, £36.7m of CIPs have been delivered; £0.1m favourable to plan. £12.4m of income actions and £24.3m of expenditure reductions are in the above actuals. The Trust has therefore over-delivered on Income CIPs by £5.7m and under-delivered on expenditure CIPs by £5.6m.	£0.1m Fav to plan	£0.4m Fav to plan
Capital	Capital expenditure of £36.3m has been incurred year to date. This is £5.3m below plan YTD. The Trust received notification on 2nd March of two new capital allocations totalling £11.849m – a PDC capital allocation £1.849m for cyber security and a DH Capital loan of £10m for equipment/IT and estates infrastructure. DH has stipulated that the Trust must spend these capital monies by the year end and therefore the Trust has activated plans to spend the PDC allocation and loan in accordance with DH instruction. As a result the Trust is now targeting to spend c£52m for the year. A working group chaired by the Chief Financial Officer confers on a daily basis to agree the investment decisions and track progress.	£5.3m Fav to plan	£4.6m Fav to plan
Cash	At the end of Month 11, the Trust's cash balance was £8.1m, which is better than plan by £5.1m. The Trust has borrowed £55.2m YTD which is £10.1m more than plan. The Trust will draw down £5.1m in March and has requested £4.7m for April. The borrowings are subject to an interest rate of 6% for the amounts drawn up to October and 3.5% for the amounts drawn since November.	£5.1m Fav to plan	£0.8m Fav to plan
Financial Risk Rating- Use of Resources (UOR)	At the end of February, the Trust's UOR score was: Capital service cover rating: Plan – 4; Actual – 4 Liquidity rating: Plan – 4; Actual – 4 I&E margin rating: Plan – 4; Actual – 4 Distance from financial plan: Plan – n/a; Actual – 3 Agency rating: Plan – 1; Actual – 1	Overall score 4	Overall score 4

1. Month 11 Financial Performance

L2 Cat	L3 Cat	M11 Budget (£m)	M11 Actual (£m)	M11 Variance (£m)	M11 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %	Full Year Budget (£m)
⊟Income	SLA Income	54.86	52.58	(2.28)	(4.2%)	616.04	601.98	(14.05)	(2.3%)	675.22
	Other Income	9.83	9.66	(0.17)	(1.7%)	106.79	105.59	(1.20)	(1.1%)	116.58
Income Total		**64.69**	**62.24**	**(2.45)**	**(3.8%)**	**722.82**	**707.57**	**(15.25)**	**(2.1%)**	**791.79**
⊟Expenditure	Pay	(39.40)	(39.96)	(0.57)	(1.4%)	(448.63)	(442.83)	5.80	1.3%	(487.80)
	Non Pay	(25.25)	(24.00)	1.25	4.9%	(289.89)	(292.53)	(2.64)	(0.9%)	(314.98)
Expenditure Total		**(64.64)**	**(63.96)**	**0.68**	**1.1%**	**(738.51)**	**(735.36)**	**3.16**	**0.4%**	**(802.77)**
⊞Post Ebitda		(2.83)	(2.46)	0.37	13.1%	(31.18)	(29.30)	1.88	6.0%	(34.02)
Grand Total		**(2.79)**	**(4.18)**	**(1.40)**	**(50.1%)**	**(46.88)**	**(57.08)**	**(10.21)**	**(21.8%)**	**(45.00)**

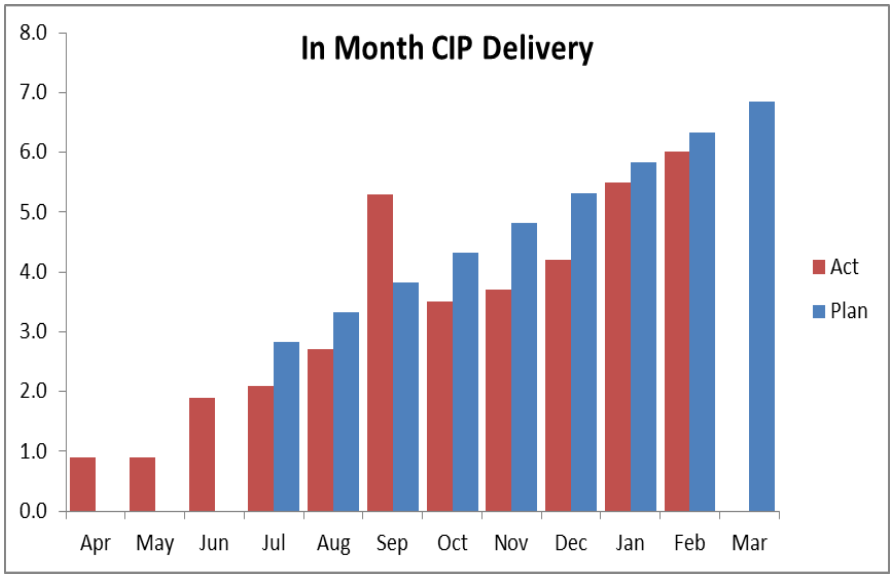
Trust Overview

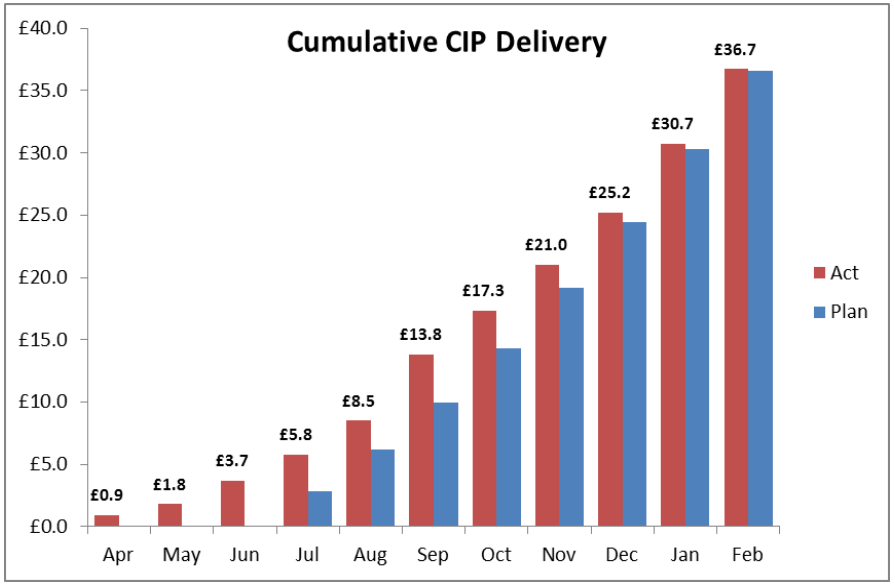
- Overall the Trust is reporting a deficit of £57.1m at the end of Month 11, an adverse variance to plan of £10.2m.
- **Income** is £15.2m adverse to plan. £6.3m of the under recovery of income is directly offset with underspends in expenditure (SLA Pass-through £5.5m, South West London Pathology £0.8m).
- **SLA Income** is £14.1m under plan, owing to shortfalls of £5.5m on pass-through, £7.8m in Elective, £4.5m higher challenges and £0.5m for Deliveries, offset by Daycase £2.8m and Outpatients of £1.9m. Smaller variances sum to £0.5m adverse. A £0.9m prior period SLA income catch-up is mainly volume.
- **Other income** is under plan by £1.2m; the key driver is lower than planned private patients income (£1.3m), partially offset by other smaller variances (£0.1m favourable).
- **Pay** is £5.8m favourable, with all major staff groups underspending with the exception of medical pay. The in month position has moved adversely to budget as a result of an increasing level of CIPs being phased into the position
- **Non-pay** is £2.6m overspent, due to expenditure on the ECRP project that was budgeted within income (challenges), offset by reduced clinical consumable expenditure.
- **CIP delivery** of £36.7m is £0.1m ahead of plan. If this were excluded from the reported position then the overall position would show an adverse variance to plan of £9.2m. The Trust has over-delivered on Income CIPs by £5.7m and under-delivered on expenditure CIPs by £5.6m.

ACTION REQUIRED

- Validate income recovery; depth of coding and reporting.
- Ensure use of staff bank when booking additional shifts.
- Reviewing discretionary spend.

7. Month 11 CIP Performance





CIP Overview

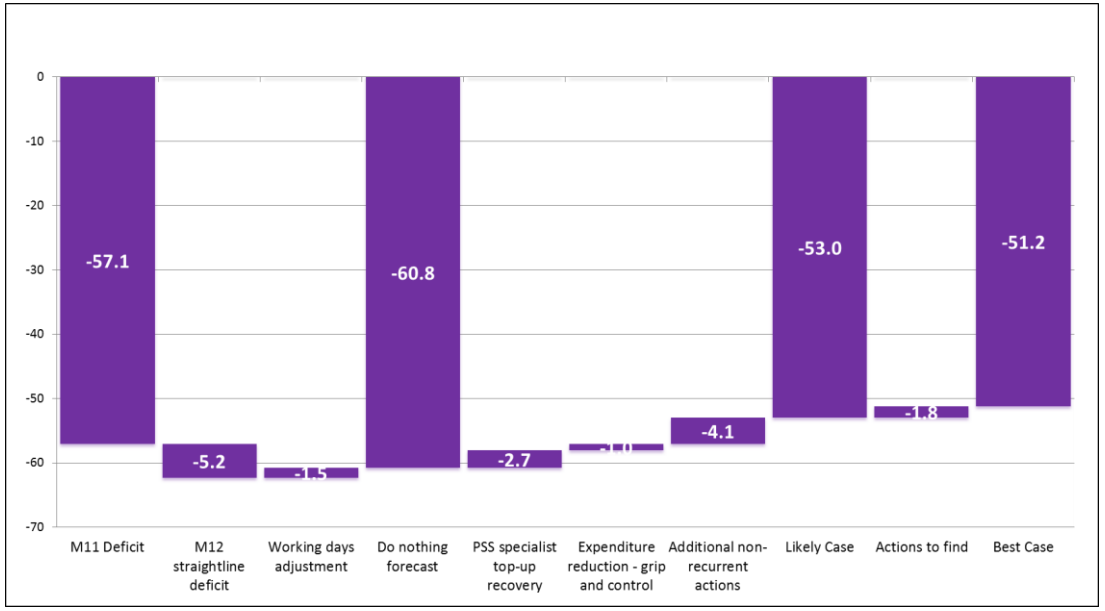
- At the end of Month 11, the Trust is reporting a cumulative delivery of £36.7m of savings . This includes a number of central initiatives which are non-recurrent in nature and have been classified as 'CIPs'
- £6.0m of savings were reported in February (including some of the non-recurrent items mentioned above)

NB - In the revised financial plan CIPs are not planned to deliver during Q1 meaning the value of the CIPs 'ahead of plan' is favourably supporting the Trust's reported bottom line. This is the reason the three graphs on the left do not show any planned delivery (blue bars) in the first three months. It is also important to note that in the revised financial plan the full year CIP target is shown as £43.5m in the graphs and variances as CIP Contingency of £3.5m is used to offset the total value.

Actions

- The Trust requires that it's original CIPs, supported by some one off actions, deliver £43.5m of savings in 2017/18 (£47m less £3.5m contingency). This is to achieve the forecast £53m year end deficit.
- The use of non-recurrent items, to achieve the 17/18 forecast outturn, has put pressure on the exit run rate of the Trust. Reducing the run rate must remain a key priority for the organisation.
- Exiting the 2017/18 financial year, with a higher than planned run rate, means that the need to find savings in 2018/19 is higher than it would otherwise have been. Achieving a balanced run rate in 2018/19 will require material reductions to WTE and these reductions will need to be articulated consistently through the CIP and Workforce plan

2017/18 Year End Forecast



- The Trust has maintained the working forecast at £53.0m.
- While further improvements have been identified, these have been required to mitigate other emerging pressures. Notably:
  - Elective income underperformance as a result of bed pressures within surgical specialties.
  - Pay run rate challenges in CWDT .
- Additional expenditure control of £1m is planned in M12, and managed through divisional run rate sessions and well as TRIG.
- £4.1m of non-recurrent actions are included within the forecast position to be delivered in M12.
- Risk associated with PSS funding from NHSE to CCGs is not included in the forecast position. The delivery of £53m deficit is dependent on both the specialist top-up element of this activity (£2.7m), and the budget transfer from NHSE to CCG's to allow payment of this activity to the Trust.

	Revised Forecast £m	Comment
Most likely	(53.0)	• Run rate pressures emerging within divisional forecasts. • PSS pressure assumed to be covered by NHSE transferring funds to CCGs. • Some non-recurrent balance sheet actions included in position.
Best	(51.2)	• As per most likely case above. • Other gains increasingly being absorbed to hold the median case.
Worst	(64.6)	• PSS income of £7m not secured from NHSE, either directly or via CCGs. • CCGs adopt aggressive approach to year end settlement. • No further run rate pressures emerge.

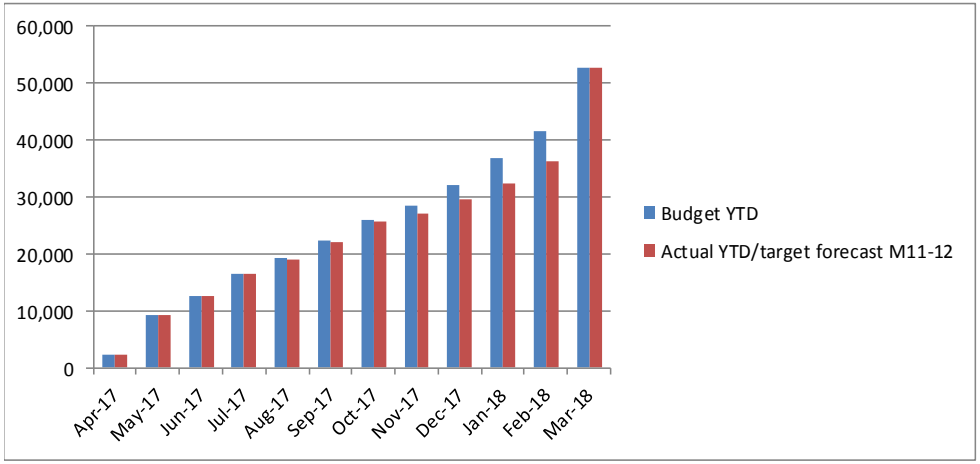
9. Month 11 Capital Programme

Capital expenditure summary M11 2017/18

Spend category	2017/18 Original Budget £000	2017/18 Revised budget £000	M11 YTD Budget £000	M11 YTD actual £000	*YTD Variance vs Revised budget*
Energy Perform Contract	**5,555**	**5,555**	**5,555**	**5,456**	*99*
Infra Renewal	**10,492**	**6,825**	**6,578**	**4,904**	*1,674*
Med Eqpt	**3,194**	**4,457**	**4,215**	**3,204**	*1,011*
Major Projs	**22,210**	**14,434**	**11,679**	**9,695**	*1,984*
IMT	**2,567**	**12,602**	**11,408**	**9,083**	*2,325*
Other	**601**	**1,634**	**1,516**	**3,535**	*-2,019*
SWL PATH	**684**	**684**	**632**	**375**	*257*
Contingency/Headroom	**1,096**	**776**	**0**	**0**	*0*
Total	**46,400**	**46,967**	**41,583**	**36,252**	***5,331***

The Trust has revised the budgets following the completion of the re-forecasting and re-prioritisation exercise in M07. Therefore IMT's revised budget is now £12.6m c/f £2.6m per the original budget

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



- The capital budget was formulated at the beginning of the year on the basis the Trust would secure DH capital of £8.4m to finance investment in IT infrastructure. Despite an independent audit recommending approval of this bid, the Trust did not receive approval from NHSI. Consequently the Trust revised the capital budgets following a re-prioritisation exercise to ensure the minimum level of IT capital investment required this year could be accommodated.
- Capital expenditure in February was £3.9m and M11 YTD expenditure is £36.3m giving rise to an under spend of £5.3m YTD against the ***revised capital budget.*** It should be noted the M11 YTD expenditure figure includes approx £1.9m of costs transferred from revenue to capital – this is subject to review.. Further revenue to capital transfers totalling £1m are included in the M12 forecast.
- The Trust received notification on 2nd March of two new capital allocations totalling £11.849m – a PDC capital allocation £1.849m for cyber security and a DH Capital loan of £10m for equipment/IT and estates infrastructure. DH has stipulated that the Trust must spend these capital monies by the year end and therefore the Trust has activated plans to spend the PDC allocation and loan in accordance with DH instruction. As a result the Trust is now targeting to spend approx £52m for the year. A working group chaired by the Chief Financial Officer confers on a daily basis to agree the investment decisions and track progress.

10a. Month 11 YTD Analysis of Cash Movement

St George's University Hospitals NHS
NHS Foundation Trust

CASH: Source and application of funds - cash movement analysis

	Plan	ACTUAL	*Actual*	Plan	***Forecast***	*Forecast*
	2017/18 YTD £m	2017/18 YTD £m	*YTD VAR £m*	2017/18 Year £m	***2017/18 Outturn £m***	*2017/18 VAR £m*
Cash balance 01.04	5.0	6.0	*1.0*	5.0	***6.0***	*1.0*
Income and expenditure deficit	-45.1	-57.9	*-12.9*	-46.2	***-51.7***	***-5.5***
Depreciation	22.5	20.0	*-2.5*	27.0	***21.6***	***-5.5***
Interest payable	6.9	7.6	*0.7*	8.6	***8.6***	***0.0***
PDC dividend	2.8	2.8	*0.1*	3.3	***3.1***	***-0.2***
Other non-cash items	-0.2	-0.2	*0.0*	-0.2	***-0.2***	***0.0***
Operating deficit	**-13.1**	**-27.7**	-14.6	-7.5	**-18.6**	***-11.1***
Change in stock	-0.6	-0.7	*-0.1*	0.4	***0.4***	***0.0***
Change in debtors	-11.4	6.5	*17.9*	-5.4	***10.2***	***15.6***
Change in creditors	13.4	3.0	*-10.4*	0.9	***-14.6***	***-15.5***
Net change in working capital	1.4	8.8	7.4	-4.1	**-4.0**	***0.1***
Capital spend (excl leases)	-36.4	-37.5	*-1.1*	-40.9	***-51.9***	***-11.1***
Interest paid	-5.8	-5.7	*0.1*	-8.0	***-7.4***	***0.6***
PDC dividend paid	-1.7	-1.7	*0.0*	-3.3	***-3.1***	***0.2***
Other	-0.3	-0.2	*0.1*	-0.4	***-0.4***	***0.0***
Investing activities	-44.1	-45.0	-0.9	-52.6	**-62.8**	***-10.2***
Revolving facility - repayment						
Revolving facility - renewal						
WCF borrowing - new	45.2	55.2	*10.1*	55.8	***60.3***	***4.6***
Capital loans	16.2	16.3	*0.1*	16.2	***27.3***	***11.1***
Loan/finance lease repayments	-7.5	-5.6	*1.9*	-9.8	***-5.2***	***4.6***
Cash balance 31.03	**3.0**	**8.1**	*5.1*	3.0	**3.0**	***0.0***

M01-M11 YTD cash movement

- The cumulative M11 I&E deficit is £57.9m* – £12.9m worse than plan. (*this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £57.9m, depreciation (£20m) does not impact cash. The charges for interest payable (£7.6m) and PDC dividend (£2.8m) 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 £27.7m.
- The operating variance from plan of £14.6m in cash is in part attributable to the lower depreciation charge.
- Working capital performed better than plan by £7.4m.
- The Trust has borrowed £55.2m YTD which is £10.1m more than plan. The Trust will draw down £5.1m in March and has requested £4.7m for April. The borrowings are subject to an interest rate of 6% for the amounts drawn up to October and 3.5% for the amounts drawn since November.
- The Trust has drawn down its £16.2m capital loan in full to finance expenditure on the NHSI-financed capital projects per the successful bid made last year. On 2nd March DO notified the Trust of £11.849m additional capital funding which needs to be spent by the year end – see Capital update paper.

Year end cash position

- The March borrowing request has been approved and February receipts were £7.9m higher than the base (worst case) scenario modelled last month. Therefore the Trust will achieve its minimum £3m cash balance on 31 March **but remains dependent on monthly borrowing from DH given the continuing I&E deficit**

12. Balance Sheet as at Month 11 2017/18

St George's University Hospitals NHS
NHS Foundation Trust

ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
Finance Department
Balance sheet FEBRUARY 2018

	Mar-17 Audited £000	Feb-18 Plan £000	Feb-18 Actual £000	*YTD Variance £000*	Explanations of balance sheet variances
Fixed assets	335,834	351,127	352,263	*-1,135*	Lower depreciation than plan
Stock	6,575	6,723	7,293	*-570*	Main targets agreed to reduce adverse YTD variance by year end
Debtors	101,837	111,522	95,311	*16,211*	Debt lower than plan but overdue debt higher than M08 Debt Redn Plan target
Cash	6,022	3,000	8,098	*-5,098*	Higher opening cash than plan and capital under spend YTD.
Creditors	-118,305	-126,153	-121,263	*-4,890*	Higher levels of creditor payments.
Capital creditors	-5,284	-2,284	-3,506	*1,222*	Timing of payments has increased capital creditors at M11
PDC div creditor	0	-1,389	-1,193	*-196*	
Int payable creditor	-259	-1,782	-2,203	*421*	Borrowing higher due to higher deficit than plan.
Provisions< 1 year	-335	-335	-197	*-138*	
Borrowings< 1 year	-55,206	-57,485	-56,675	*-810*	Lower value of finance leases - some leases extended rather than renewed
Net current assets/-liabilities	**-64,955**	**-68,184**	**-74,335**	*6,152*	
Provisions> 1 year	-988	-658	-927	*269*	
Borrowings> 1 year	-164,524	-224,904	-228,234	*3,330*	Borrowing higher due to higher deficit than plan.
Long-term liabilities	**-165,512**	**-225,562**	**-229,161**	*3,599*	
Net assets	**105,367**	**57,382**	**48,766**	*8,616*	
Taxpayer's equity					
Public Dividend Capital	129,956	129,956	131,304	*-1,348*	
Retained Earnings	-114,843	-162,828	-172,710	*9,883*	Higher I&E deficit than plan
Revaluation Reserve	89,103	89,103	89,022	*81*	
Other reserves	1,150	1,150	1,150	*0*	
Total taxpayer's equity	**105,367**	**57,382**	**48,766**	*8,616*	

15. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M11 YTD)	Actual (M11 YTD)
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
Distance from financial plan	n/a	3
Agency rating	1	1

Basis of the scoring mechanism

Area	Weighting	Metric	Definition	Score			
				1	2	3	4[1]
Financial sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

- 1 represents the best score, with 4 being the worst.
- At the end of February, the Trust had planned to deliver a score of 4 in "capital service cover rating", "liquidity rating" and "I&E margin rating", and 1 in "agency rating".
- The Trust has scored as expected in these 4 categories, with the first 3 owing to adverse cash and I&E performance.
- The "agency rating" score of 1 is due to improved control and recruitment plans to reduce agency spend within the cap. Furthermore, interim spend has reduced significantly this year due to the IT MSA, with costs now being reflected in non-pay.
- The distance from plan score is worked out as the actual % I&E deficit (8.07%) minus planned % I&E deficit (6.49%). This value is -1.58% which generates a score of 3. To score a 4, the Trust would need to have a value of -2%, which would be a YTD deficit of £60.0m, £2.9m worse than the current YTD deficit.

Meeting Title:	**Trust Board**		
Date:	29 March 2018	**Agenda No.**	**5.1**
Report Title:	**Workforce Race Equality Standard Data Analysis for St George's Hospital**		
Lead Director/ Manager:	Harbhajan Brar, Director of Human Resources & Organisational Development		
Report Author:	Donna Harding, Senior HR Advisor		
Presented for:	Discussion / Update		
Executive Summary:	This report provides the Board with analysis as to how the Trust compares at both a national and Pan London level for each of the 9 WREs indicators based on the publication of the 2017 NHS Workforce Race Equality Standard (WRES). It shows that whilst the Trust has made some (very minor) improvements, it still has a long way to go to address the issues of Race Equality.		
Recommendation:	It is recommended that the Board notes the findings of the analysis and asks the newly appointed Workforce Diversity and Inclusion Lead to produce a revised WRES action plan focusing on key actions that will start to have a 'real' impact on the position of BME staff.		
Supports			
Trust Strategic Objective:	Champion St George's, supporting our staff, listening to staff, staff engagement, equality and diversity, bullying and harassment, leadership, values.		
CQC Theme:	Well led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	Failure to address the inequalities experience by our BME staff will result in a significant component of our workforce feeling 'disengaged' and undervalued for their contributions to the safe and effective care of our patients.		
Legal/Regulatory:	The current UK legislation (Equality Act 2010) places a duty on all public sector organisations to: eliminate discrimination, harassment and victimisation in the workplace and advance equality of opportunity between people from different groups. Failure to do this puts the Trust at increased risk of legal challenge.		
Resources:	A new Workforce Diversity and Inclusion Lead has been offered the role.		
Previously Considered by:	Trust Board - Part 2.	**Date:**	25.01.2018
Equality Impact Assessment:	This report forms part of our adherence to the Equalities Act.		
Appendices:	N/A		

2017 WRES Data

St. George's University Hospitals NHS Foundation Trust

Harbhajan Brar

March 2018

WRES indicators

Indicator 1

- Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM compared with the percentage of staff in the overall workforce

Indicator 2

- Relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts

Indicator 3

- Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process

Indicator 4

- Relative likelihood of BME staff accessing non mandatory training and CPD as compared to white staff

Indicator 5

- KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

Indicator 6

- KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Indicator 7

- KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion

Indicator 8

- Q17. Percentage of staff experiencing harassment, bullying or abuse from manager/team leader or colleague

Indicator 9

- Percentage difference between the organisations' Board membership and its overall workforce

WRES data by region I

	Relative likelihood of white staff appointed from shortlisting compared to BME staff		Relative likelihood of BME staff entering disciplinary process compared to white	
	2016	2017	2016	2017
London	1.80	1.81	1.99	1.80
South	1.73	1.48	1.17	1.16
Midlands & East	1.52	1.34	1.56	1.28
North	1.28	1.54	1.42	1.27
National average	1.57	1.60	1.56	1.37

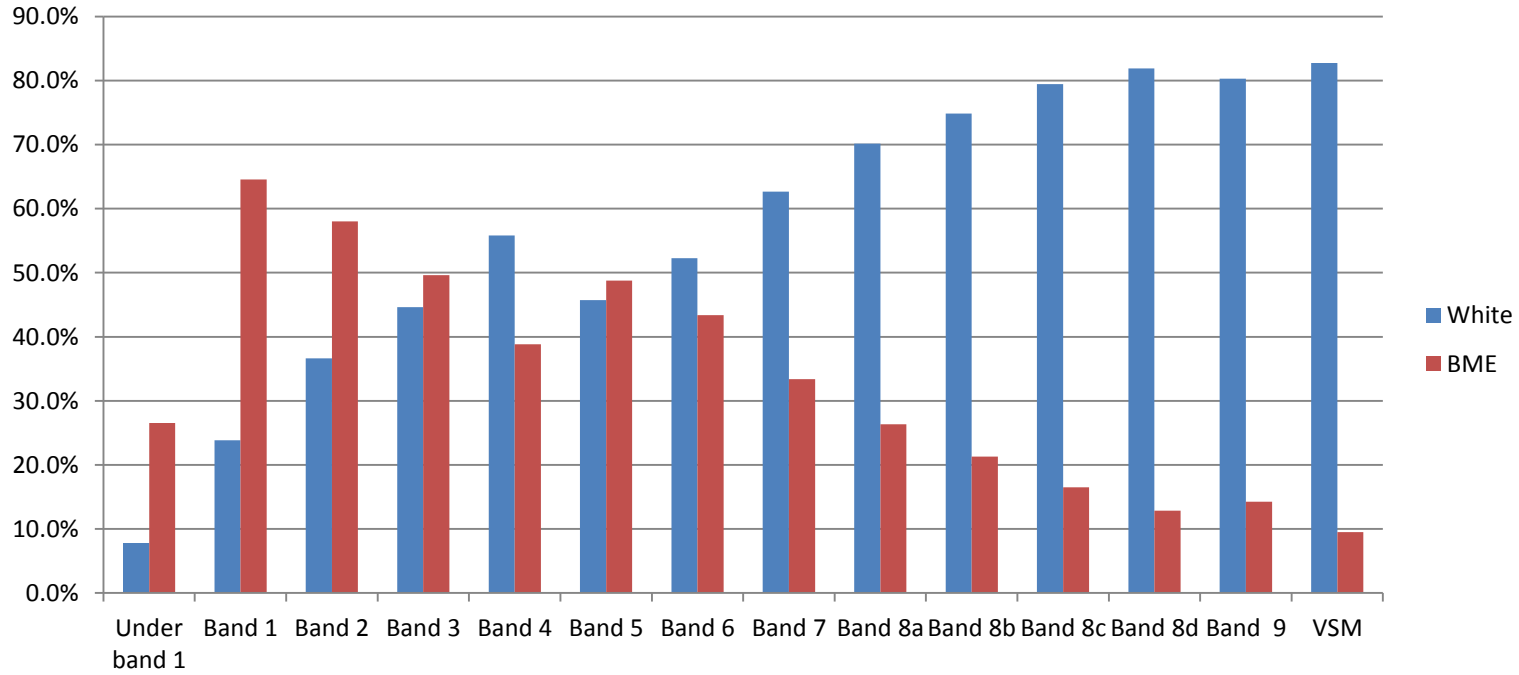
WRES data by region II

	BME staff experience harassment, bullying, abuse from patients (%)		BME staff experience harassment, bullying abuse from staff (%)		BME staff belief trust provides equal career opportunities (%)		BME staff experience discrimination at work (%)	
	2015	2016	2015	2016	2015	2016	2015	2016
London	29.6	30.0	28.7	29.0	69.2	69.7	14.8	14.9
South	29.4	29.5	26.8	24.9	76.0	78.8	13.9	12.8
Midlands & East	28.8	28.4	25.5	26.6	74.5	75.6	12.8	14.3
North	27.0	27.4	25.1	25.3	76.5	77.1	12.9	13.4
National average	28.8	28.7	26.5	26.3	73.8	75.5	13.6	13.8

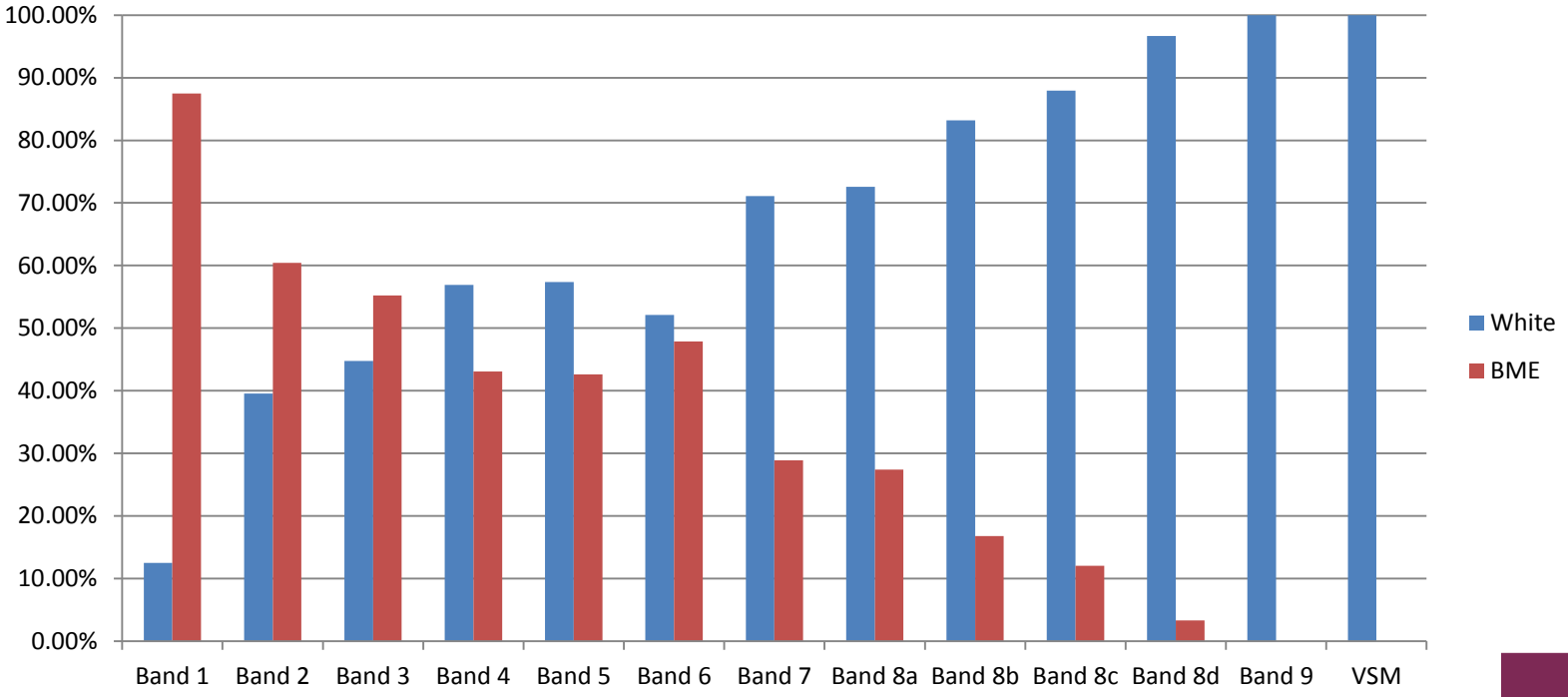
For all indicators, BME staff have a worse experience in London than the national average.

Indicator 1: Ethnicity of NHS staff in London Trusts by AfC bands - 2017

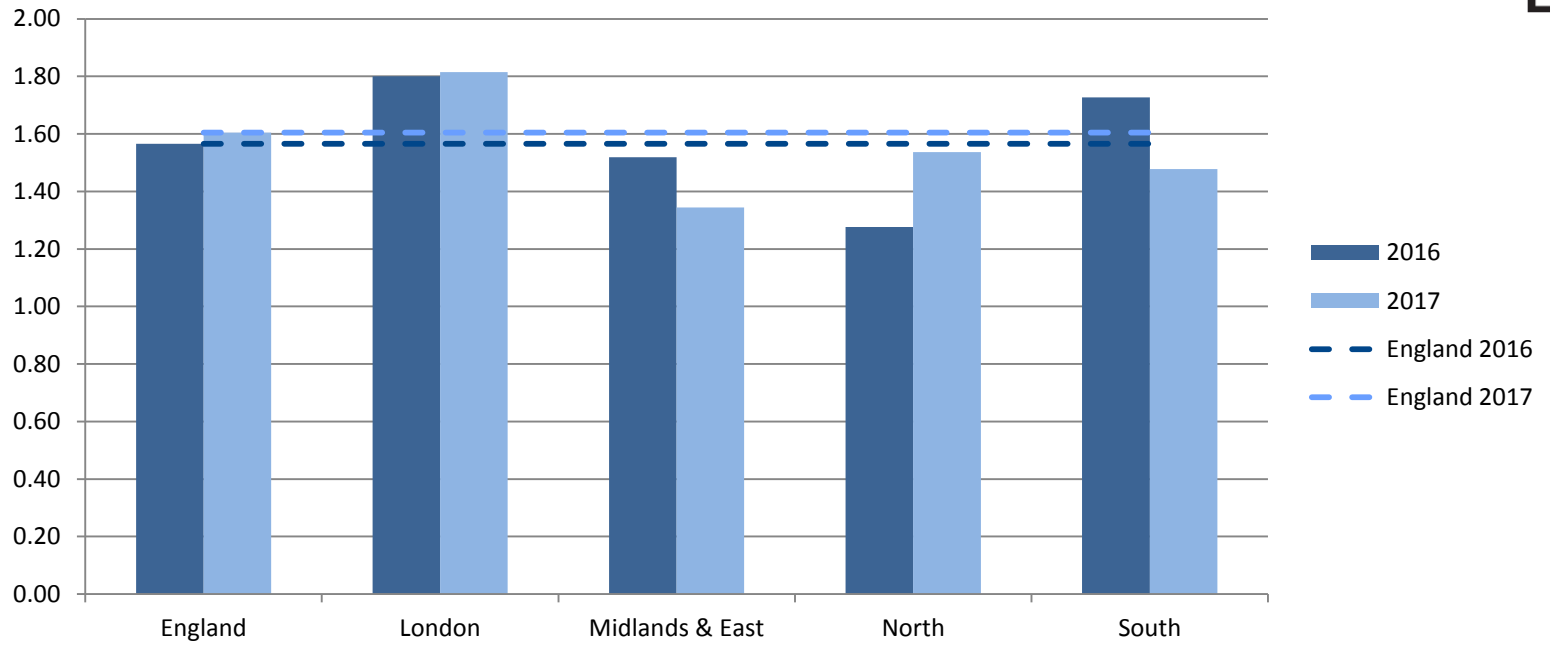
(Data source - National ESR)



Indicator 1: Ethnicity of NHS staff at St George's Hospital by AfC bands - 2017

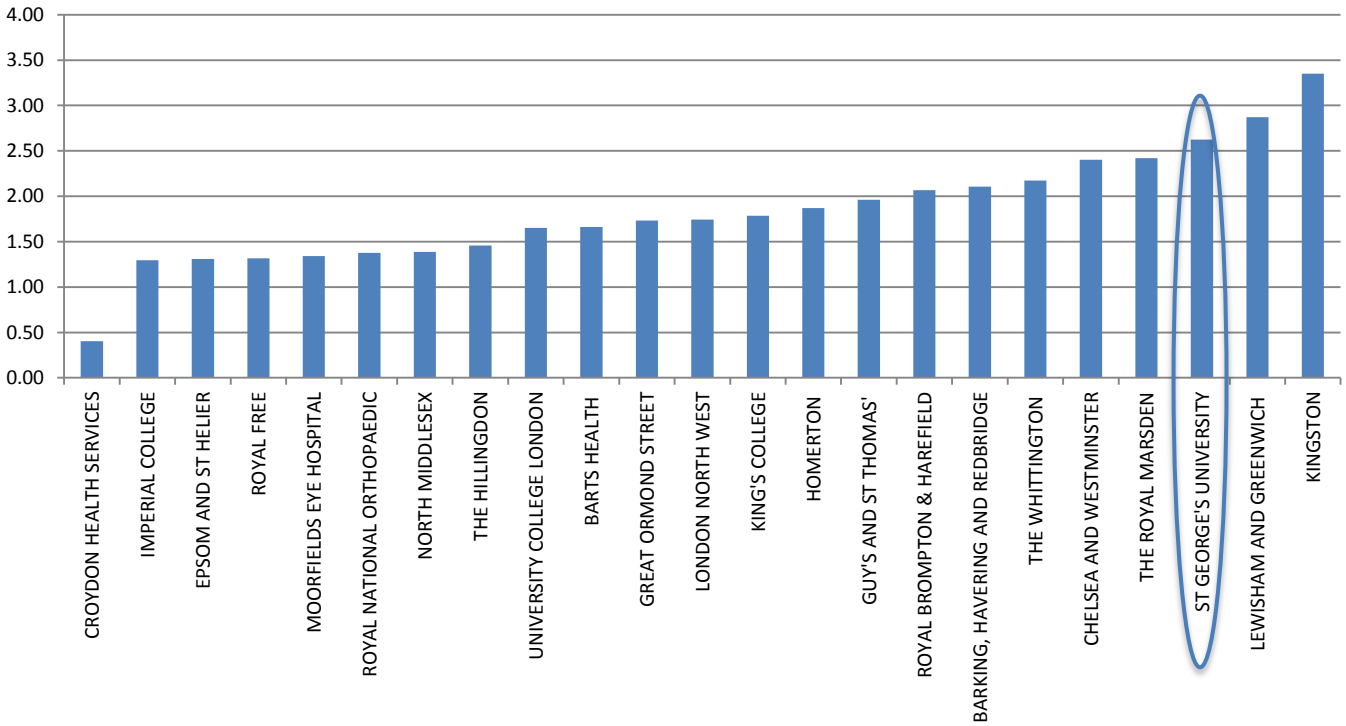


Indicator 2: Relative likelihood of white staff being appointed from shortlisting compared to BME staff by region - 2016 : 2017



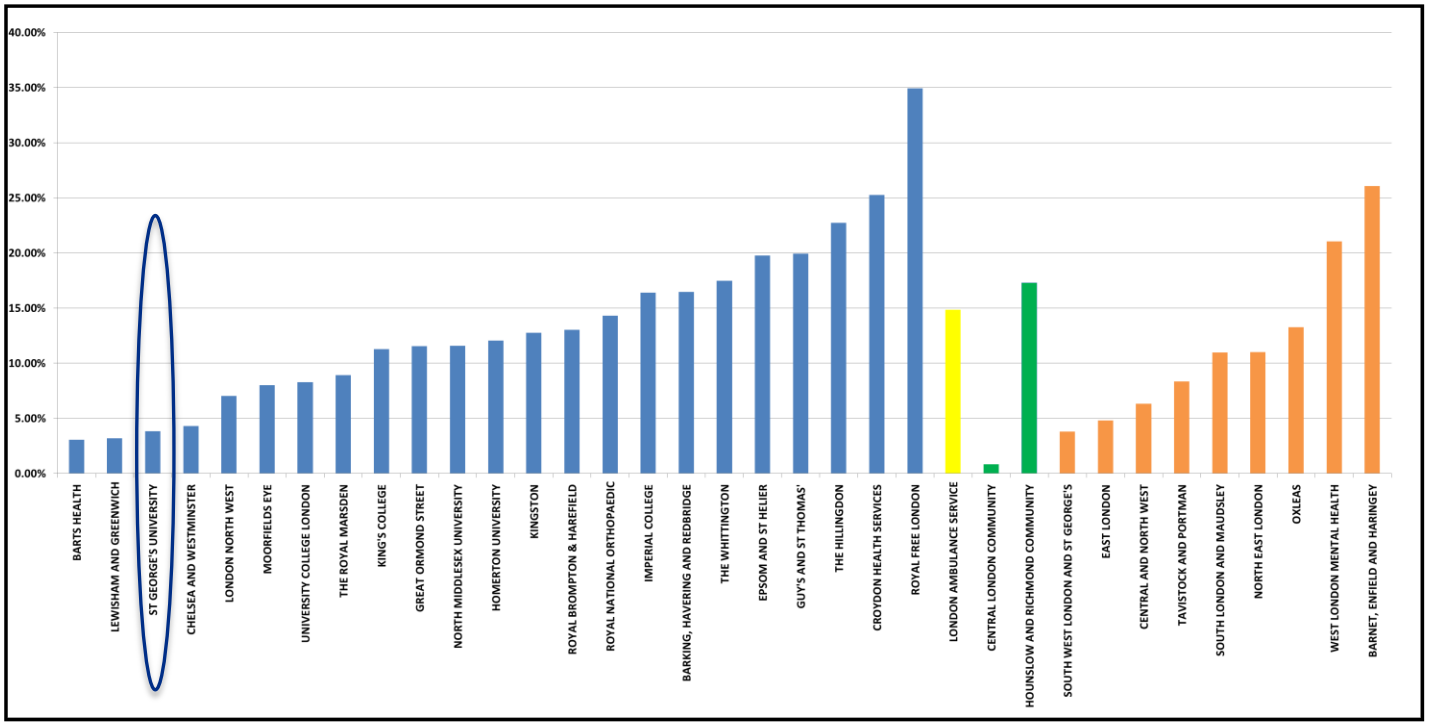
The relative likelihood of white staff being appointed from shortlisting compared to BME staff is highest in London.

Indicator 2: Relative likelihood of white staff being appointed from shortlisting compared to BME staff



The relative likelihood of white staff being appointed from shortlisting in Acute Trusts compared to BME staff ranged from 0.4 for Croydon Health Services to 3.35 for Kingston Hospital.

Indicator 2: Likelihood of BME staff being appointed from shortlisting



The likelihood of BME staff being appointed from shortlisting ranges from 0.84% for Central London Community to 34.93% for Royal Free London.

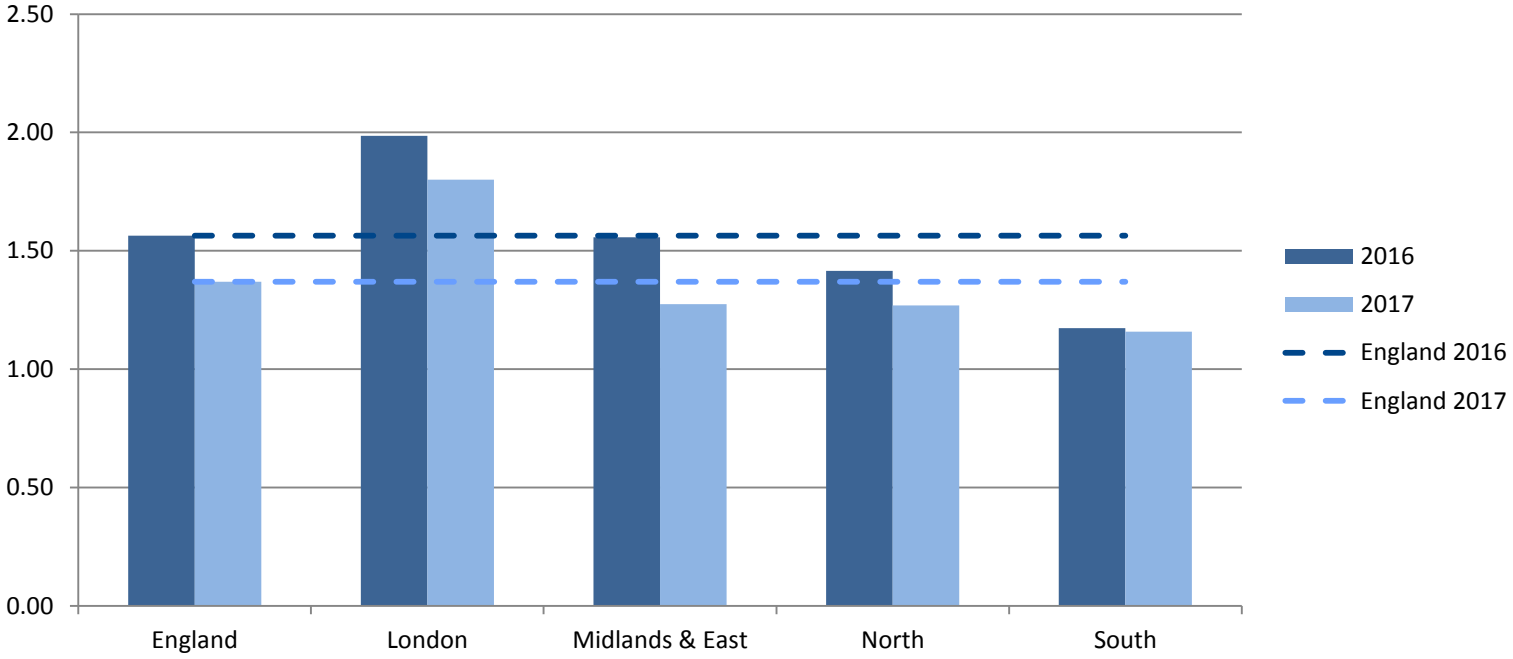
Acute Trusts

Ambulance Trusts

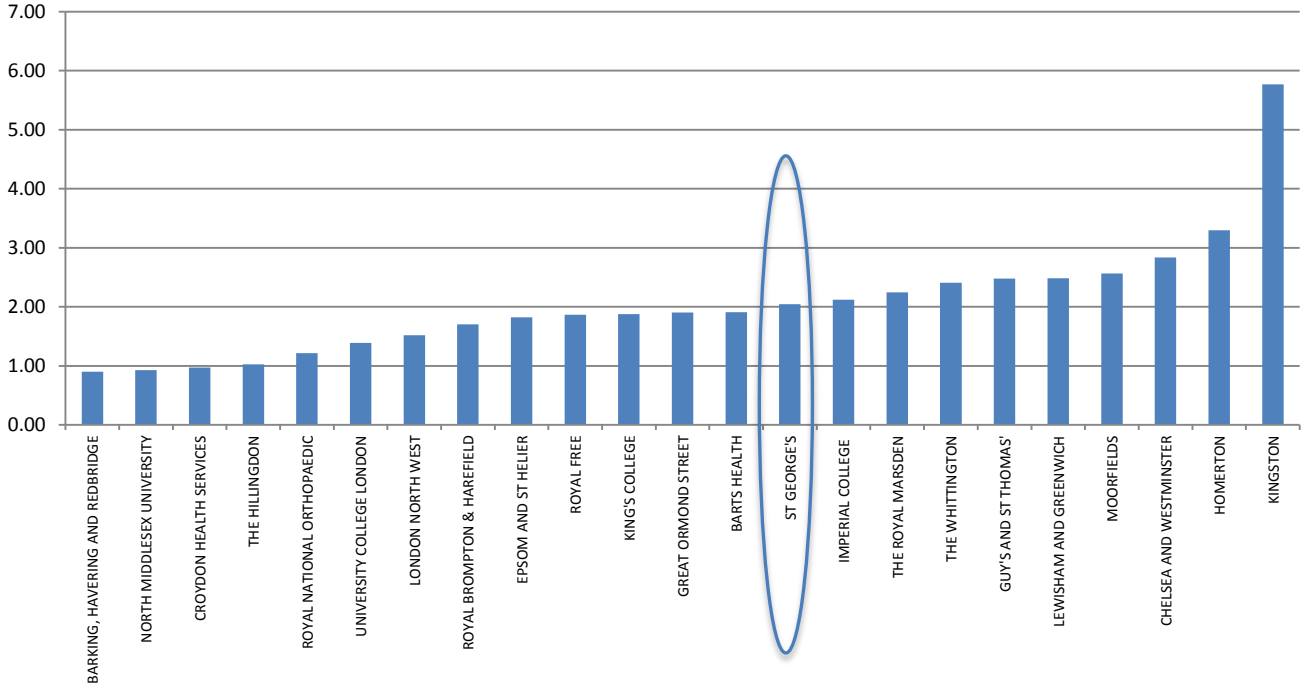
Community

Mental Health

Indicator 3: Relative likelihood of BME staff entering formal disciplinary process compared to white staff by region - 2016 : 2017

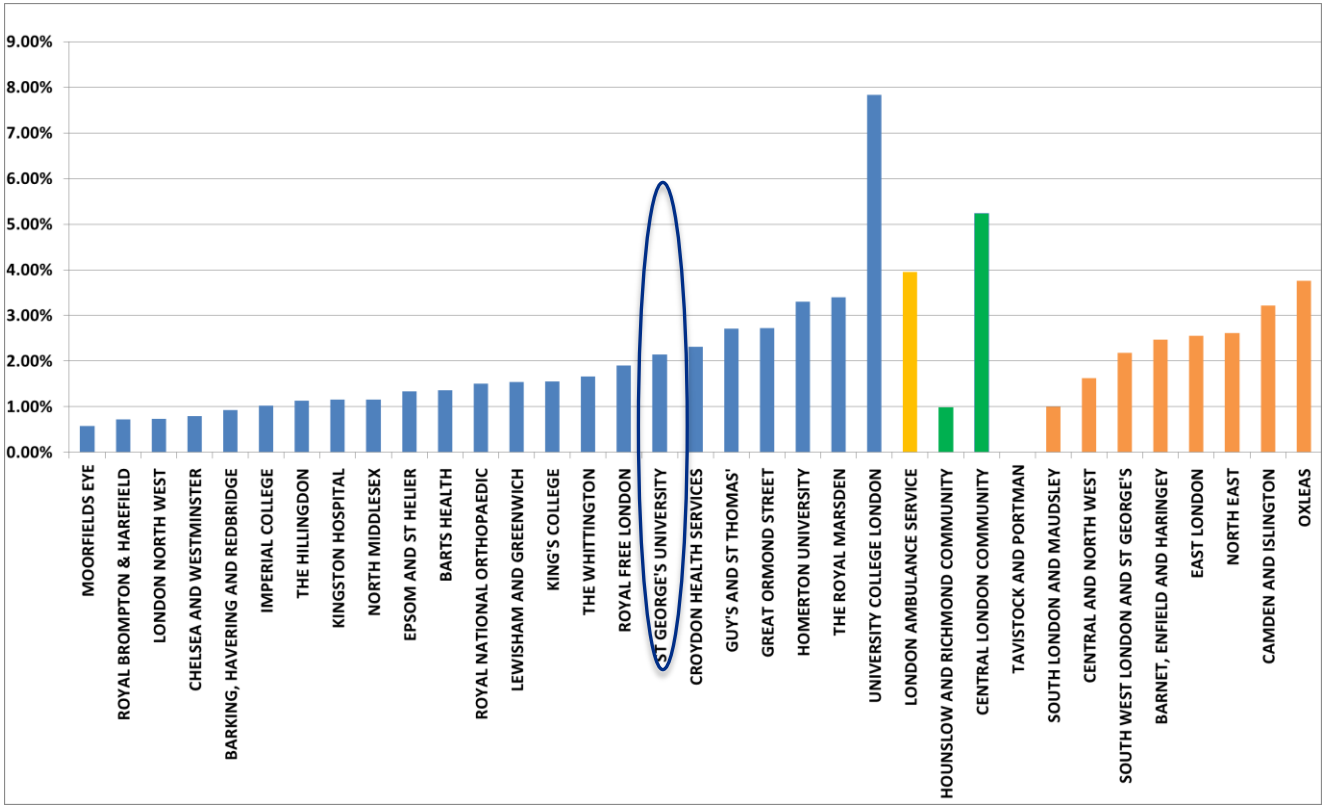


Indicator 3: Relative likelihood of BME staff entering formal disciplinary process compared to white staff



Relative likelihood of BME staff entering formal disciplinary process in Acute Trusts compared to white staff ranged from 0.9 for Barking Havering and Redbridge to 5.78 for Kingston Hospital.

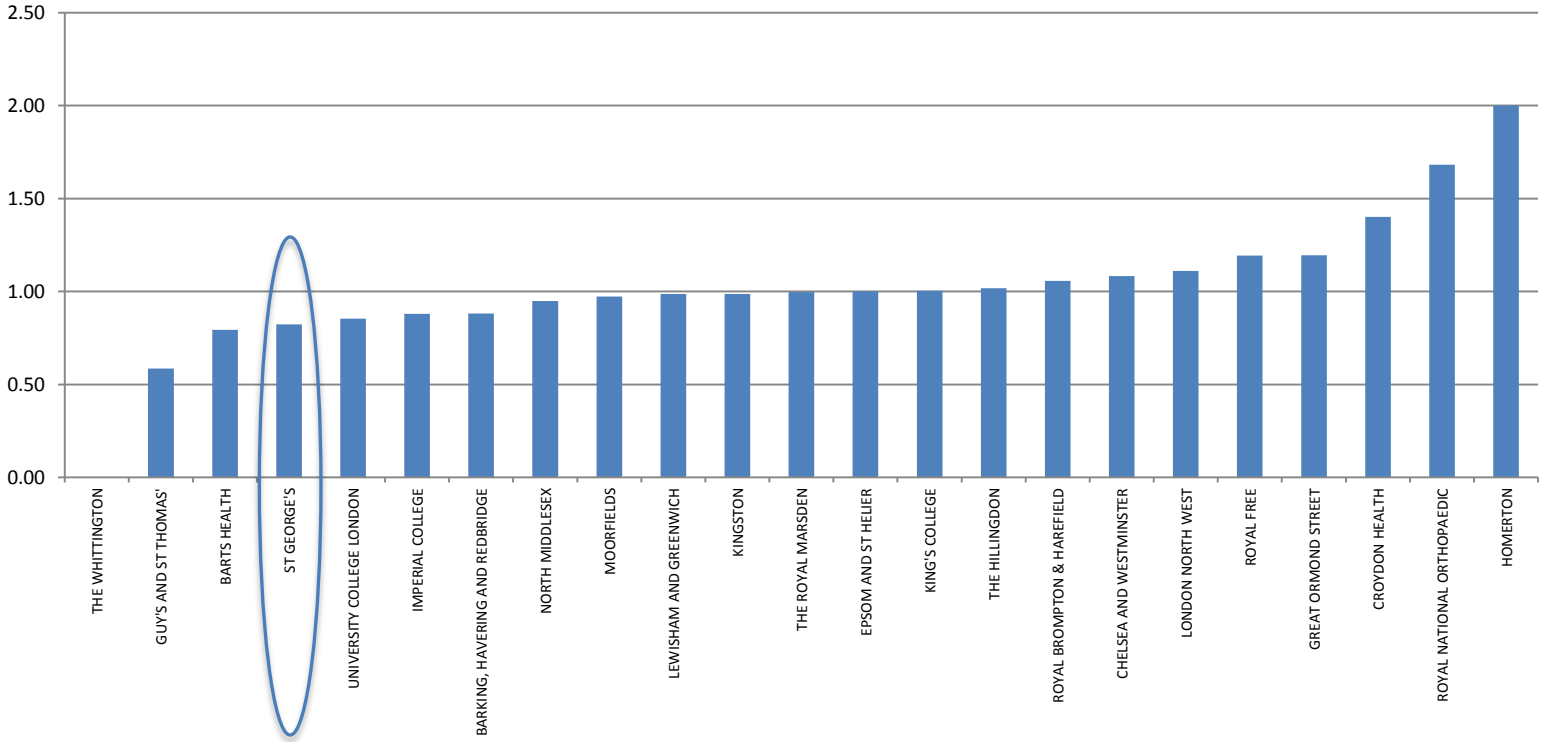
Indicator 3: Likelihood of BME staff entering the formal disciplinary process



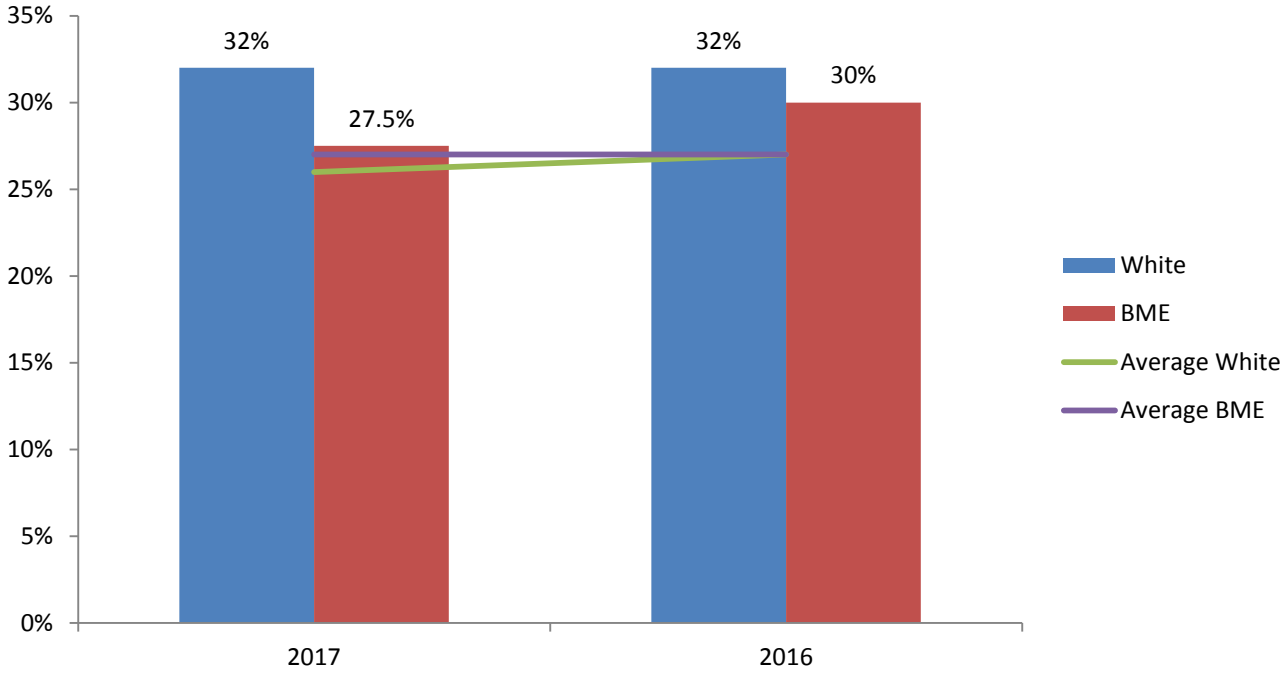
The likelihood of BME staff entering formal disciplinary process in Acute Trusts ranged from 0.57% for Moorfields to 7.83% for University College London.

Acute Trusts
Ambulance Trusts
Community
Mental Health

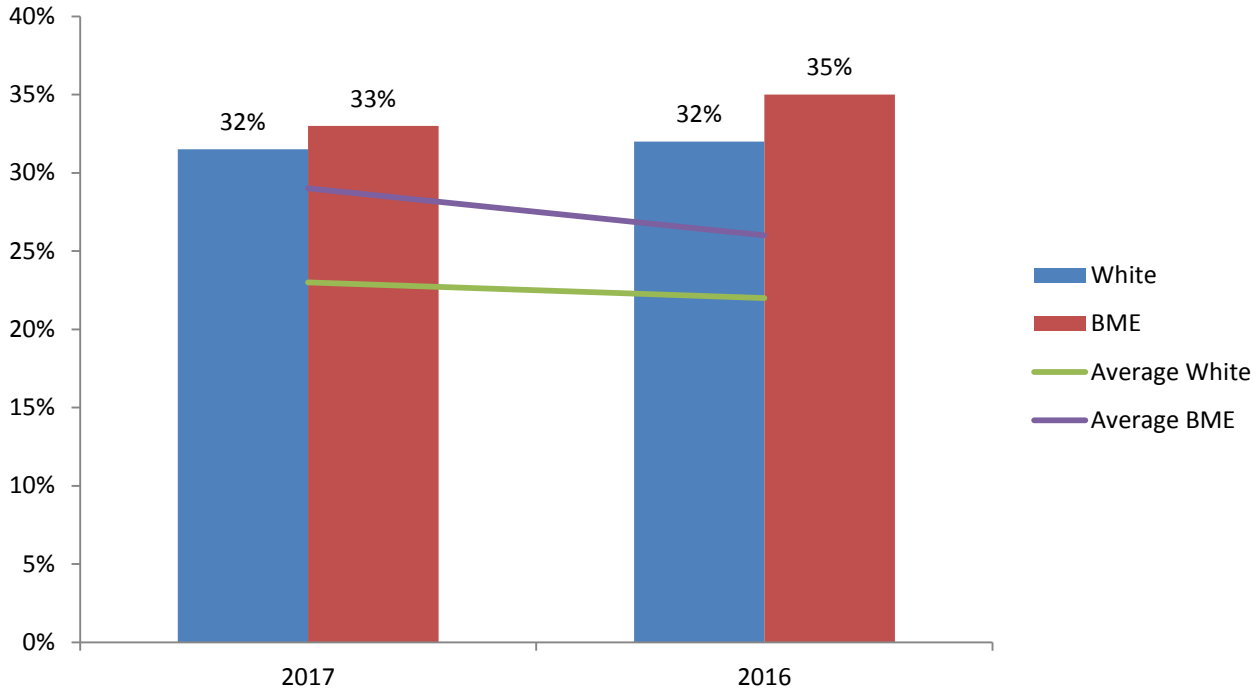
Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD – St George's Hospital - 2016: 2017



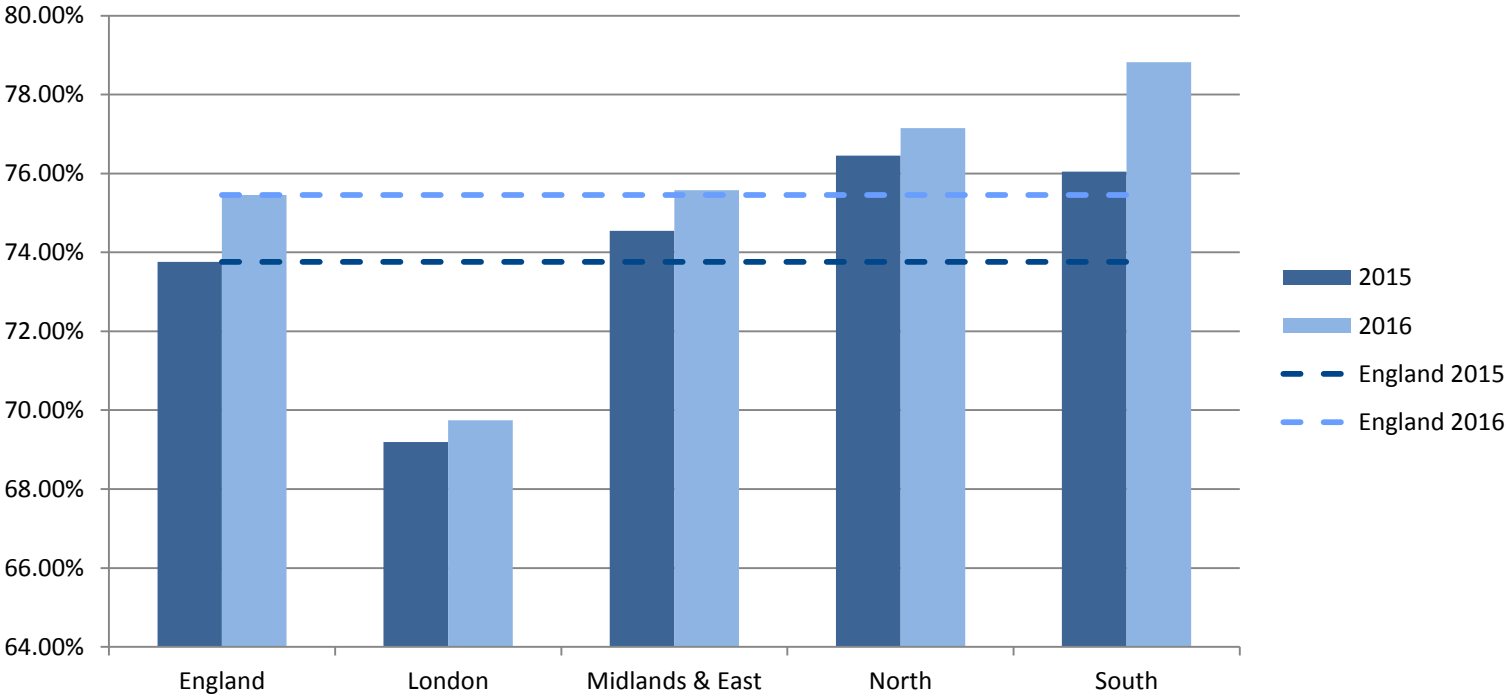
Indicator 5 KF 25: % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months – St George's Hospital - 2016: 2017



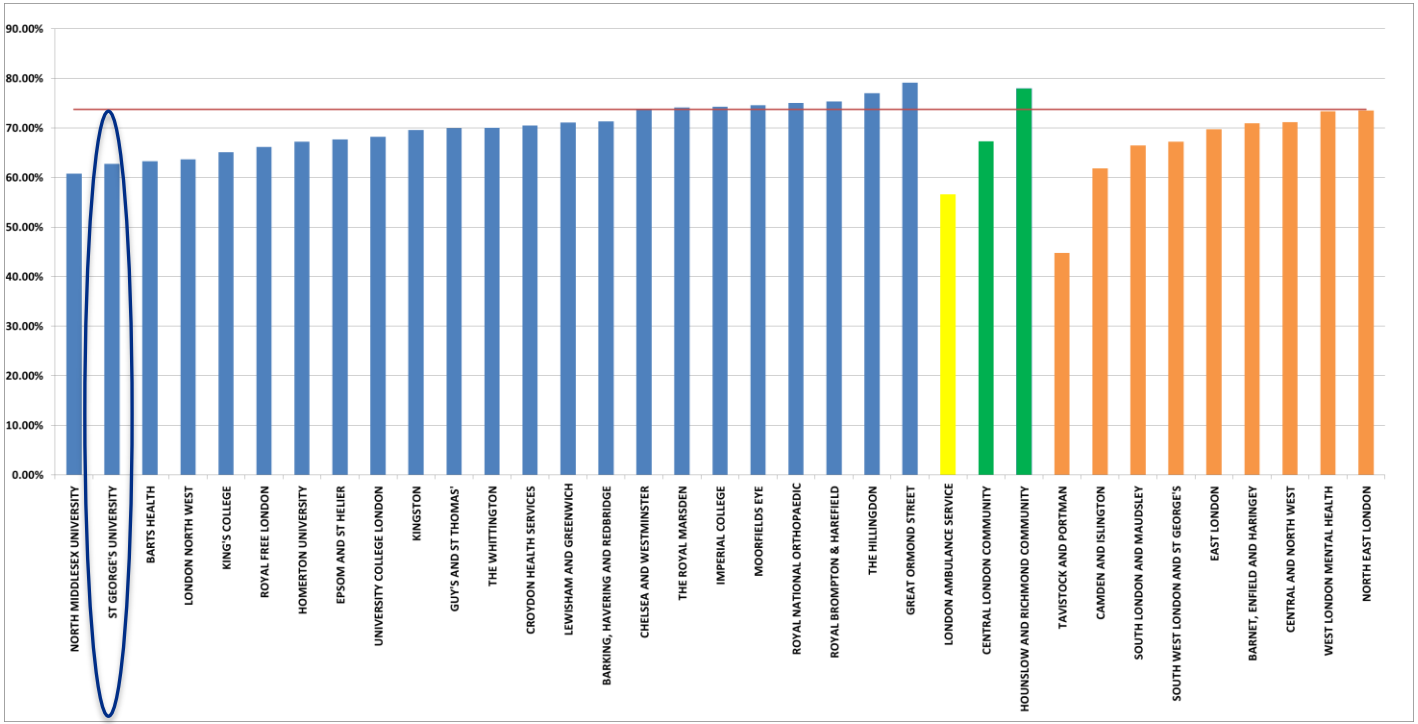
Indicator 6 KF 26: % of staff experiencing harassment, bullying or abuse from staff in last 12 months - St George's Hospital - 2016: 2017



Indicator 7 KF 21 Percentage of BME staff believing trust provides equal opportunities for career progression by region - 2015 : 2016



Indicator 7 KF21 Percentage of BME staff believing their trust provides equal opportunities for career progression



The percentage of BME staff believing their trust provides equal opportunities for career progression ranged from 44.74% for Tavistock and Portman to 79.09% for Great Ormond Street.

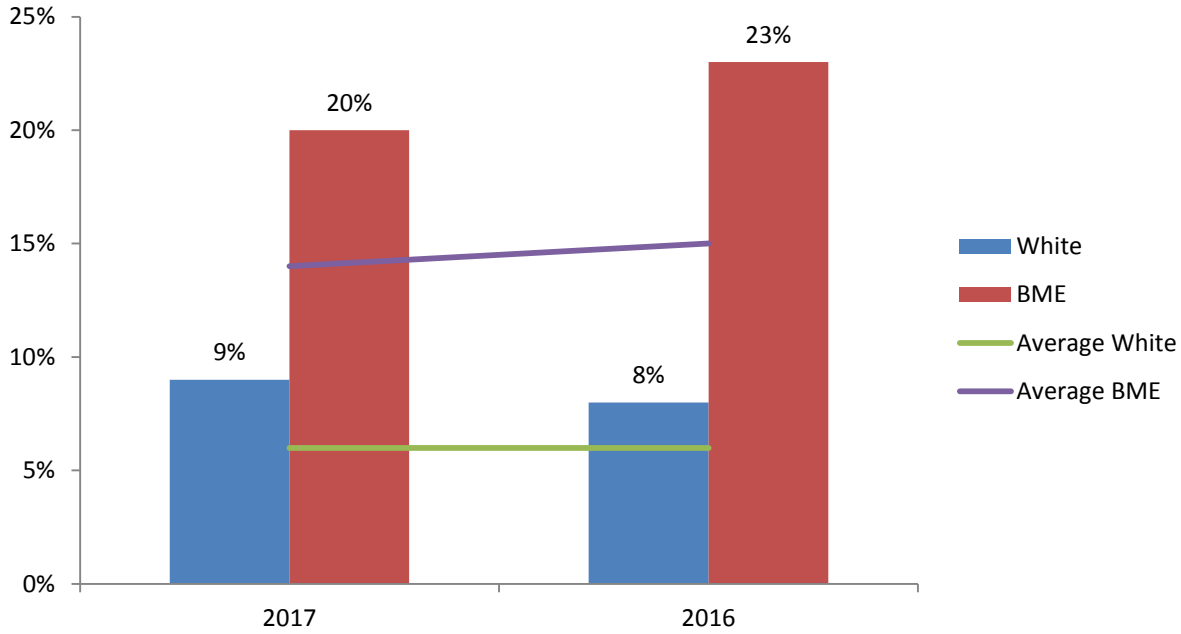
Acute Trusts

Ambulance Trusts

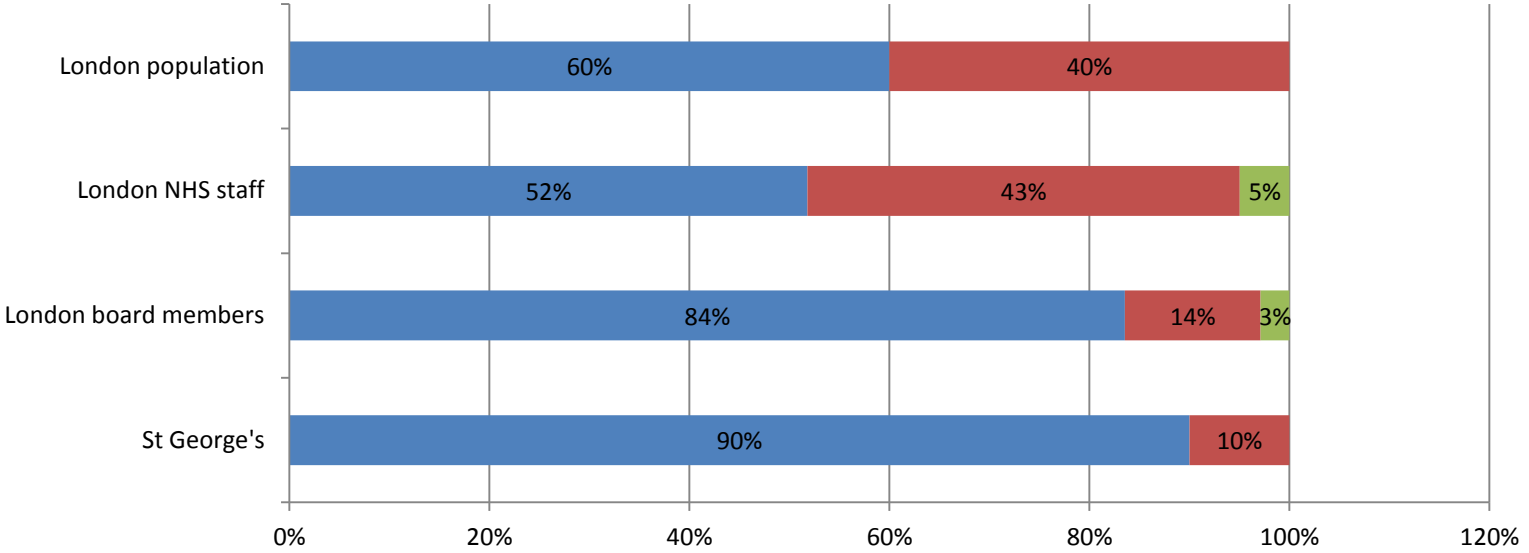
Community

Mental Health

Indicator 8 Q17: In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues - 2016 : 2017

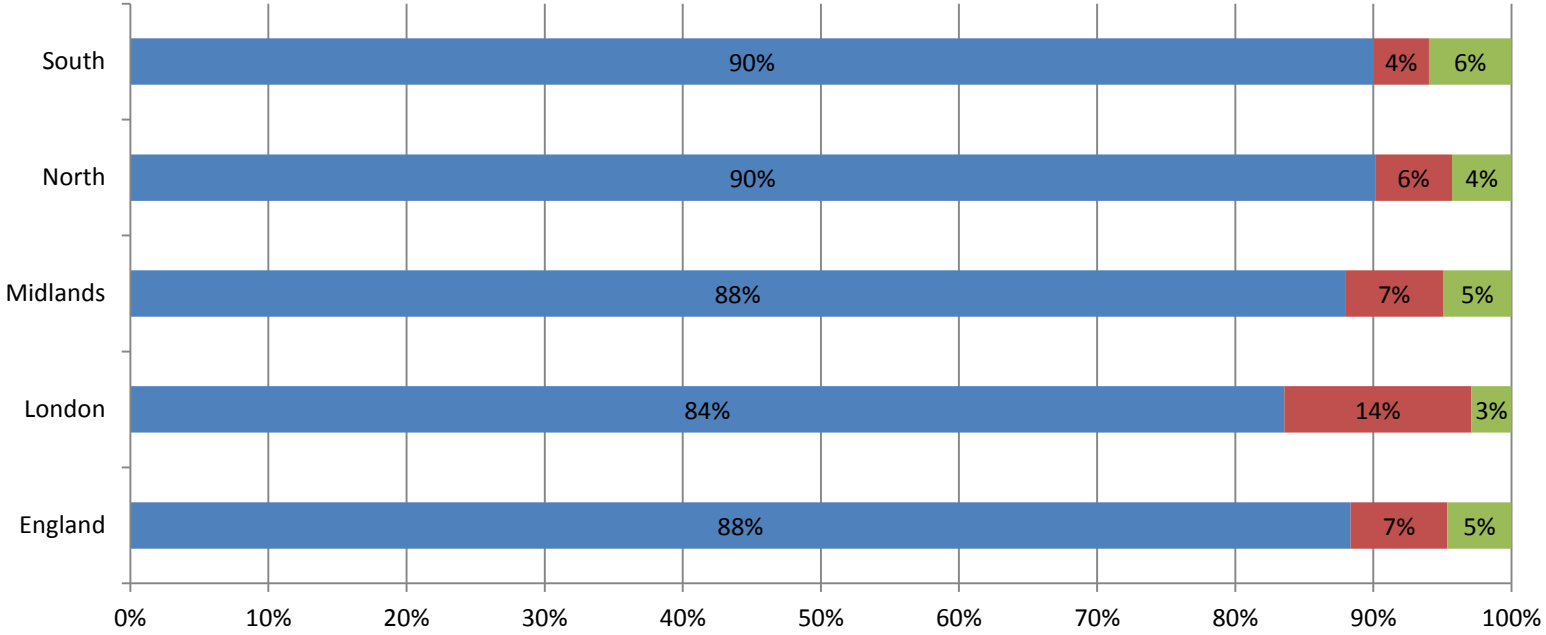


Indicator 9 Ethnicity make-up of London population, NHS trust staff and board membership – 2017

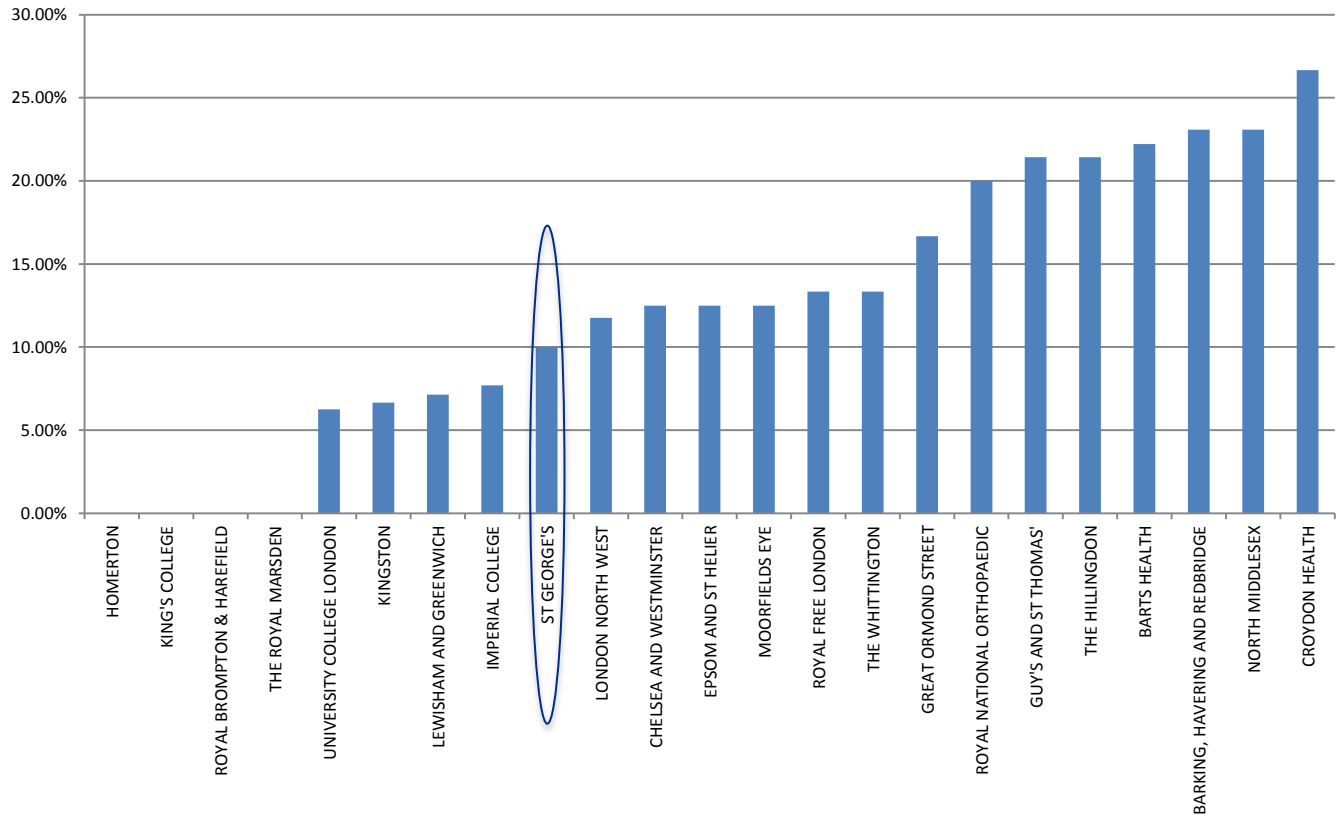


There is a higher % of BME people working for London NHS Trusts compared to the London population. BME staff are however significantly under represented at Board level.

Indicator 9: NHS trust board ethnicity by region – 2017



Indicator 9: Percentage of BME Board members



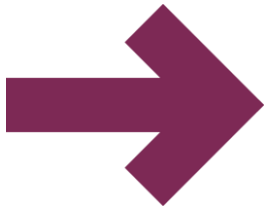
The percentage of BME Board members ranged from 0% to 40% for East London against a London BME population of 43%

Acute Trusts

The strategic approach, 2017/18, for St George's Hospital

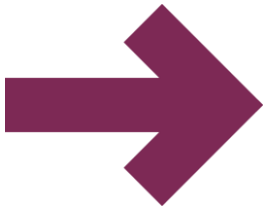
Collaborative project between: London Equality & Diversity Leads Network, London HR Directors Network, and national WRES team:

1. Focus on issues that require most attention (Indicators 1, 2, 3, 6, 8 and 9)
2. Agree standardised auditing and review measures
3. Implement and monitor impact of models of better practice / toolkits
4. Identify and address root causes
5. Evaluation, learning and sharing replicable good practice (academic partner)



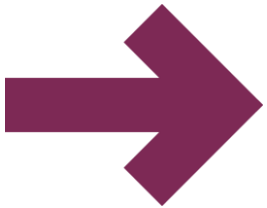
Ten steps to support WRES implementation at St George's Hospital

1. Complete and publish our annual WRES data return
2. BME staff to be involved in discussions with D&I Manager regarding the data
3. Take steps to implement action plan produced in 2017 - work-stream leads provide monthly reports to D&I Manager on actions taken
4. D&I Manager to have meaningful discussions on proposed actions in relation to key emerging issues
5. Board member to be responsible for the WRES (and equality)



Ten steps to support WRES implementation at St George's Hospital

6. Formalise arrangements for BME staff group to meet HR leads regularly
7. D&I Manager to continue working on producing robust workforce ethnicity monitoring
8. Staff survey lead to ensure BME staff are supported to complete the NHS staff survey
9. HR leads to embed and make mainstream workforce race equality, and equality in general, via DMBs
10. D&I Manager to link with other peer organisations to share learning and replicable good practice



St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 March 2018	**Agenda No.**	**5.2**
Report Title:	**Gender Pay Gap**		
Lead Director/ Manager:	Harbhajan Brar, Director of Human Resources and Organisational Development		
Report Author:	Sion Pennant-Williams, Workforce Intelligence Manager		
Presented for:	Approval		
Executive Summary:	St George's gender pay gap as at 31st March 2017 (the snapshot date required for reporting) is 13.94% mean and 2.11% median. The 4 pay quartiles show a higher proportion of males in the highest and lowest pay quartiles, despite the workforce being predominantly female. If we exclude the medical workforce, the gender pay gap is reversed and, across the rest of the workforce, on average, females get paid more than males by 3.45%. This implies a material gender pay gap within the medical workforce, and more detailed analysis has been undertaken of this and is set out in the Report. Bonuses (via Clinical Excellence Awards or CEAs) were paid only to Consultants, and more CEAs were paid to male Consultants than to female Consultants. This is more complex than it appears, as relatively more male consultants applied. The success rate of male and female consultants who do apply for CEAs is broadly the same. Similar questions arise in relation to payments for Additional Programmed Activities. Further work is required, and proposed actions are set out in the Report.		
Recommendation:	The Board is asked to approve this paper for before it is published on the Trust's external website.		
Supports			
Trust Strategic Objective:	N/A		
CQC Theme:	Well-led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	Without supporting narrative external organisations can make their own assumptions on the gender pay gap.		
Legal/Regulatory:	The Trust is required by law to publish the gender pay gap by 30 March 2018.		
Resources:	No additional resources required.		
Previously Considered by:	N/A	**Date:**	N/A
Equality Impact Assessment:	The purpose of this paper was to identify gender pay inequalities.		
Appendices:	N/A		

GENDER PAY GAP REPORT

Data stated is as at 31 March 2017, unless otherwise indicated

1. Summary and Proposed Actions

This is the first Gender Pay Gap Report from St George's University Hospitals NHS Foundation Trust ('St George's' or 'the Trust') which, as at 31 March 2017 had some 9,000 staff, 73% of whom were female.

The analysis we have done to prepare this Report identifies a 'mean' and a 'median' gender pay gap, which clearly requires investigation and, where appropriate, correcting.

St George's takes no comfort from the fact that, ranked against other NHS Trusts and Foundation Trusts which have published their respective pay gaps, it is in the upper quartile on gender fairness. There is clearly further work to be done to improve things for all staff.

The measured position on the gender pay gap for the 12 months to 31 December 2017 is as follows:-

- **Median gender pay gap, 2.11% in favour of male employees**
- **Mean gender pay gap, 13.94% in favour of male employees**

It is critical to emphasise this does not mean that a male and a female staff member doing equal work receive different levels of pay. Rather, the above statistics are driven largely by (i) the distribution of males and females within different parts of the workforce, and (ii) the pay of the medical workforce which has an amplified effect on statistics relating to the total workforce.

Within this, two dominant themes stand out. First, looking at the totality of the workforce, male staff are both disproportionately represented in the lowest and the highest earnings quartiles. The reasons for this are complex and need to be clearly understood if corrective action is to be successful. Second, if the medical workforce is excluded, the gender pay gap is reversed and becomes one which favours female staff. In fact analysing pay across all staff except medical staff creates a mean gender pay gap of 3.45% in favour of females, and a median gap of **15%** in favour of females. The clear implication is that the gender pay gap across the medical workforce is sufficient to reverse the female positive gender pay gap across the remainder of the Trust's workforce, and generate the overall results set out in the bullet points above.

Analysis of gender pay across the medical workforce reveals a complex distribution. For early years' medical trainees there is a gap in favour of female doctors, but at more senior non-consultant levels the gap switches to one in favour of male doctors. The reasons for this are multiple, but we propose a programme of work to investigate these and help inform adjustments to our employment practices to ensure fairness across all stages of medical career development.

At Consultant level, the gender pay gap is real, and favours male consultants. The mean gender pay gap for consultants is 4.33% in favour of male consultants. At first sight the data suggests that this is largely attributable to the impact of Clinical Excellence Awards and Additional Programmed Activities. It is a fact that in the past a relatively smaller proportion of female consultants than male consultants put themselves forward for such awards. The deeper question is why this is the case. We intend to review the internal processes and support offered to consultant staff to ensure that they are gender-neutral, and create a supported environment in which female consultants are as willing to apply as male consultants.

We intend to report back on all the actions we identify in this Report.

2. Introduction

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 (***the Regulations***) require public sector organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31st March of each year, and each organisation is duty bound to publish information on their website. This report captures data as at 31st March 2017, unless otherwise indicated.

St George's employs circa. 9,000 staff in a number of disciplines, including: administrative; nursing; allied health; and medical roles. All staff except for the eight Very Senior Managers (VSMs) are on either Agenda for Change or national contract pay-scales, which provide a clear process of paying employees equally, irrespective of their gender or ethnicity.

What is the gender pay gap?

The **gender pay gap** is a defined term in the Regulations and means the difference between the average hourly earnings of men and those of women. This is not the same as **equal pay**, which is concerned with men and women earning equal pay for the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because of gender. Instead the gender pay gap highlights any imbalance of average pay across an organisation. For example, if an organisation's workforce is predominantly female yet the majority of senior positions are held by men, the average female salary would be lower than the average male salary.

What do we have to report on?

The requirements of the Regulations is that each public sector organisation must calculate the following:

- The mean basic pay gender pay gap
- The median basic pay gender pay gap
- The proportion of males and females in each quartile pay band
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of both males and females receiving a bonus payment

Definitions of pay gap

The **mean pay gap** is the difference between the pay of all male and all female employees when added up separately and divided respectively by the total number of males, and the total number of females in the workforce.

The **median pay gap** is the difference between the pay of the middle male and the middle female, when all male employees and then all female employees are listed from the highest to the lowest paid.

Who is included?

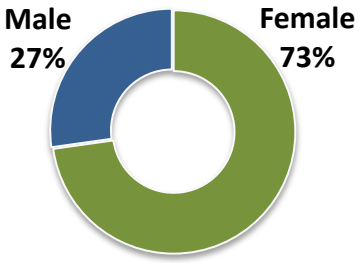
All staff who were employed by St George's and on full pay on the **snapshot date** (31st March 2017) are included. Bank staff who worked a shift on that date are also included. For Consultants we include within 'pay' those payments made for Additional Programmed Activities (APA's), as well as Clinical Excellence Awards (CEA's). All calculations exclude overtime pay and expenses.

Employees who are on half or nil absence or maternity leave, hosted staff (e.g. GP Trainees) and agency staff are not included.

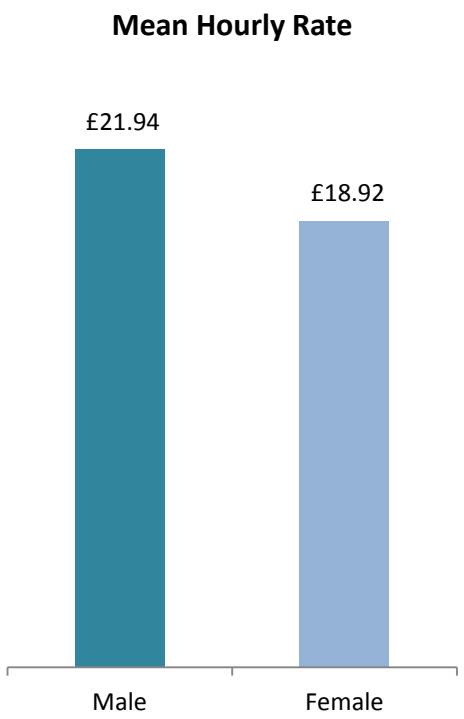
3. Results for St George's University Hospitals NHS Trust

Trust Gender Profile (based on headcount)

St George's is typical of any NHS Trust, it that it has a higher number of females than males in its workforce – of the 8,906 staff counted as part of the gender pay gap reporting, 6,482 were female compared to 2,424 male:



Gender Pay Gap



Mean gender pay gap– 13.94%

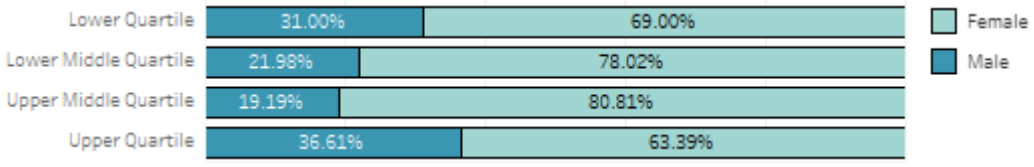
Median gender pay gap – 2.11%

The above charts show that the mean hourly pay for males is £3.07 higher than that of females, a gender pay gap of 13.94%.

They also show that median pay for males is £0.38 higher than females, a gender pay gap of 2.11%.

We are also required to split the workforce into quartiles (blocks of 25%) split by pay and show the proportion of males and females in each quartile. The results of this split are shown below. In broad terms this shows that compared to the position across the workforce as a whole, where males represent 27% of the workforce there are relatively more males in the highest and the lowest pay quartiles, (31% and 37% respectively).

Pay quartile split:



What does this mean?

The figure for the median pay gap is usually considered to be more representative of gender pay gap across the workforce. However what it does not take account of is a small numbers of higher paid employees that could be skewing the data at the mean (or average) level. The mean figure does highlight this, so although at 2.11% the median pay gap is less extreme, it is the mean pay gap of 13.94% that needs to be examined in more detail.

As the quartile figures in the chart above show that there is a higher percentage of males in both the upper and the lower quartile than in the others, it is worth examining the gender composition and pay gaps in each individual band. This is set out in the table below, and for ease of reference we have highlighted in green where the higher average pay is to be found (male or female cohort).

Grade	No. of male staff	No. of female staff	Male average Hourly Rate*	Female average Hourly Rate*	Difference[f]	Gap[f]
Band 1	4	17	£10.19	£10.30	-£0.11	-1.12%
Band 2	501	954	£11.04	£11.21	-£0.17	-1.52%
Band 3	193	474	£11.73	£11.65	£0.08	0.64%
Band 4	133	450	£12.71	£12.97	-£0.26	-2.07%
Band 5	280	1,426	£16.03	£16.25	-£0.22	-1.39%
Band 6	274	1,214	£19.85	£20.05	-£0.21	-1.04%
Band 7	223	906	£22.21	£22.50	-£0.29	-1.32%
Band 8a	100	269	£26.62	£26.14	£0.48	1.78%
Band 8b	33	73	£31.52	£31.01	£0.51	1.62%
Band 8c	21	32	£36.84	£35.49	£1.35	3.65%
Band 8d	11	20	£42.28	£41.56	£0.72	1.70%
Band 9	5	4	£48.06	£54.13	-£6.07	-12.62%
VSM	5	3	£87.70	£67.29	£20.40	23.27%
Medical – non Consultant	321	371	£26.94	£25.85	£1.09	4.05%
Medical - Consultant	294	233	£48.03	£45.95	£2.08	4.33%

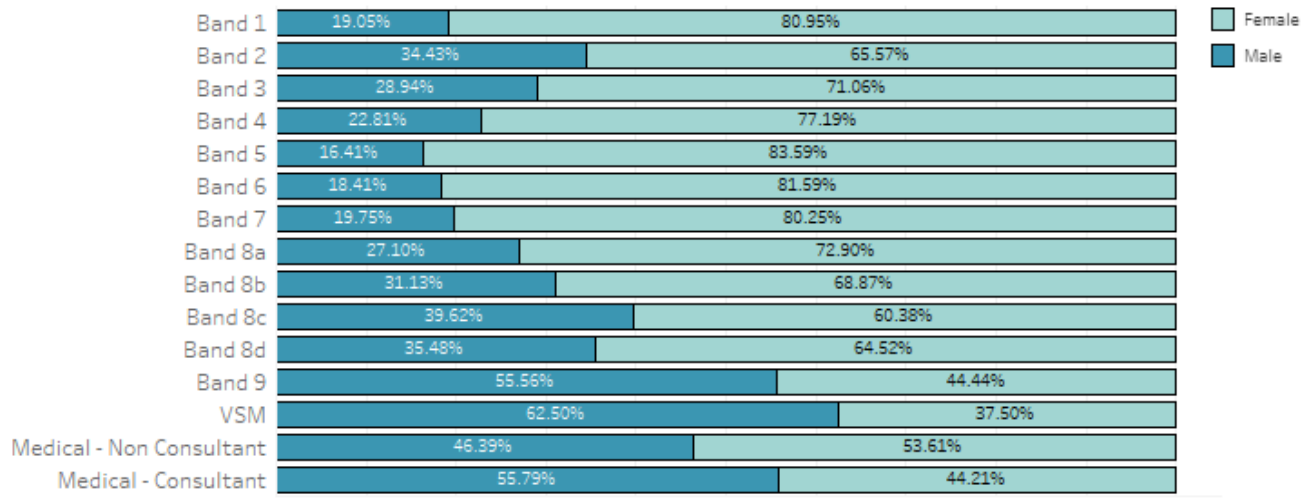
**refers to the mean hourly rate*

[f] negative values mean that the difference and the gap are favourable to females

The above table shows that, on average, females earn more in most pay bands than males - the only bands where males earn more is in band 3, band 8, VSM (very senior manager), and medical roles (both Consultant and non Consultant).

We have also analysed the proportion of males and females across each of the above bands, and the results of this are shown in the bar chart below.

Gender split by band – based on headcount:



4. Specific Focus Areas

Seniority and gender

We saw on the page above that on average, females earn more in most pay bands than males - the bands where males earn more are bands 3, 8, VSM (very senior management), and medical roles. Of note is that these are the higher paid bands, and it is also in these higher bands where the proportion of males is higher, especially when compared to the proportion of the Trust overall (27% male to 73% female). In the highest paid bands - band 9, VSM and Medical - there are more males than females.

The issue of more males than females in higher paid bands is certainly one that deserves to be highlighted, and may suggest the need for a corrective action. This will be further reviewed by the Trust. We will report back on this in our next Report.

Very Senior Managers

It is also interesting to note that the actual pay gap for bands 8a through to 8d, and the number of employees it affects, is comparatively small – typically 1.6% - 3.7%. However, for VSM staff the gap is considerably larger, at **23.3%,** meaning that on average males get paid £20.40 per hour more than females. Whilst this dataset involves only eight employees (three of whom are female) the very significant gender pay gap meant that this required immediate review. The results of that review suggested that the analysis undertaken at 31 March 2017 reflected a point in time where the Trust had a small number of more highly paid male VSMs.

Preliminary analysis of the position as at 28th February 2018 suggests that for the VSM cohort of staff currently in the Trust, the gap has been significantly reduced, to 2.29%, with females now employed in 47% of VSM roles. This reflects the impact of the recruitment processes introduced by the new Trust management team, but also the lag impact of the changes already made. We will report in more detail on this when we review all data to 31 March 2018.

Medical staff

One other significant feature of the data at 31 March 2017 is that if all Medical staff are removed from the calculations, then the gap is reversed and, across the rest of the workforce, on average, females get paid more than males by 3.45%. This prompted us to undertake a rapid review of the position of St George's medical workforce,and why it appeared to have a material gender pay gap.

Medical staff group comprises a large group, from trainees to those with Consultant roles. The pay gap for Medical staff as a whole is 9.24% - males get paid on average £3.24 per hour more than females. Equally, this is a staff group where males outnumber females, and it is comprised of over 1,200 employees. We have therefore segmented this large group into two separate cohorts: consultants, and non-consultants.

Consultants

St George's had 527 consultants on staff at 31 March 2017. These individuals tend to undertake some of the highest paid roles in the Trust, and on top of their salary are in some cases eligible to apply for and receive clinical excellence awards (CEAs). They are also entitled in some cases to payments for Additional Programmed Activities (APAs). These are consolidated into the basic pay calculations.

If we split this staff group by gender, we will see that the number of male Consultants is higher than the number of females (respectively 56% male, 44% female). The **mean pay gap for Consultants is 4.33%** which equals to £2.08 per hour, whilst the median pay gap is 2.93%, which equals £1.33 per hour. The detail is set out in the table below:

	No. of male staff	No. of female staff	Male Average Hourly Rate*	Female Average Hourly Rate*	Difference[i]	Gap[i]
Mean Pay Gap	294	233	£48.03	£45.95	£2.08	**4.33%**
Median Pay Gap	294	233	£45.42	£44.09	£1.33	**2.93%**

It is likely that this gap is, in part, driven by the slightly higher number of male consultants who have applied for and received CEAs, and who are in receipt of APAs. Whilst St George's experience is that broadly the same proprtion of female consultants who apply for CEAs receive an award, there does appears to have been a lower level of application from female Consultants than from male consultants in the past. It may be that specific targetted support would help remove the gap in this area. This will therefore be a focus for our future work, and we will progress this with our consultant workforce and anticipate reporting on this in our next full Report.

Non-Consultants

As at 31 March 2017 St George's had 692 non-consultant doctors on staff. These comprised 321 male doctors (46% of total) and 371 female doctors (54% of total). What is also clear is that as doctors careers develop, there appears to be a higher attrition of female than male doctors, such that in the more senior grades taken together (specialty doctor; associate specialist; and general practitioner) male doctors are the majority.

The data suggests that in the early years of training, the gender pay gap is in favour of female doctors. As careers develop, the data shows that the pay gap reverses and moves to favour male doctors. At the Specialty Doctor level, the mean gender pay gap reaches 12.7% in favour of males, amongst the highest in the Trust.

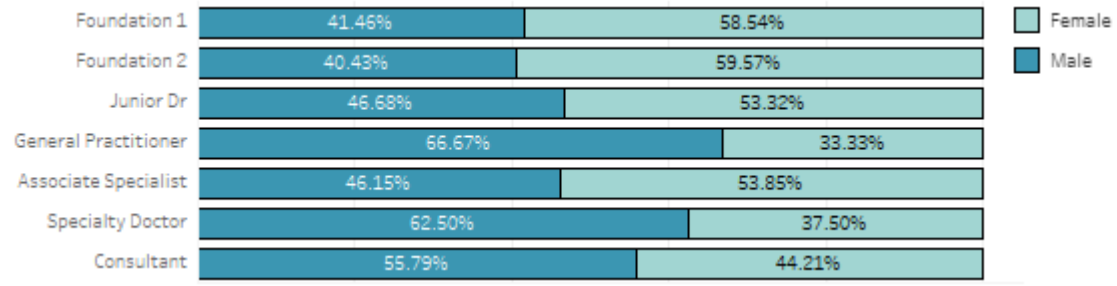
This potentially raises complex issues around career progression, family-friendly policies, and career support to our female doctors. This is an area we intend to investigate and report back on in our next full Report.

Role	No. of male staff	No. of female staff	Male Average Hourly Rate*	Female Average Hourly Rate*	Difference[1]	Gap[1]
Foundation 1	17	24	£15.39	£15.45	-£0.06	-0.41%
Foundation 2	19	28	£17.95	£17.96	-£0.02	-0.09%
Junior Dr	267	305	£27.85	£27.04	£0.81	2.91%
General Practitioner	2	1	£23.71	£23.47	£0.24	0.99%
Associate Specialist	6	7	£40.67	£39.71	£0.96	2.37%
Specialty Doctor	10	6	£31.98	£27.91	£4.07	12.73%

**refers to the mean hourly rate*

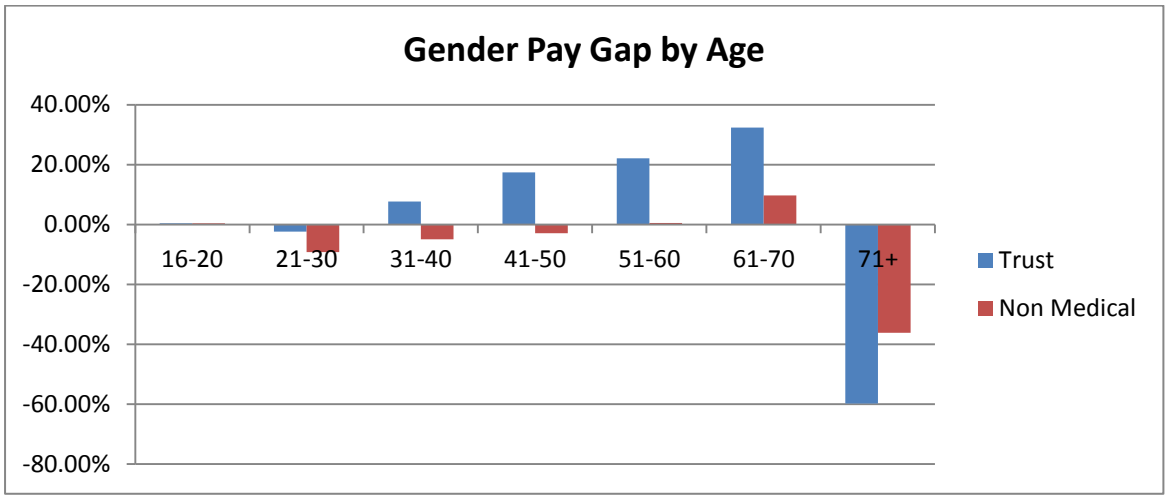
[1] *negative values mean that the difference and the gap are favourable to females*

Gender split by Medical role – based on headcount:

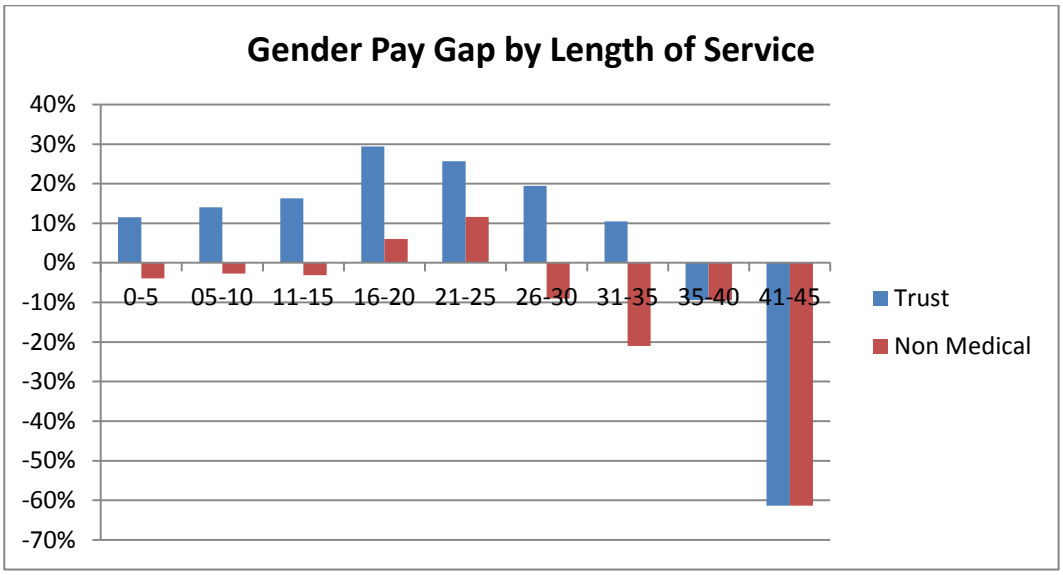


Age and length of service

If we examine the gender pay gap by age range of employees we can see that whilst in the 21-30 age range the gap is in favour of females, as the employees get older the pay gap increases in favour of males. At the 71+ age range the gap swings dramatically the other way – this is due to the number of male employees in this age range tending to be employed in lower pay ancillary roles, whilst within this age cohort there are still a number of female qualified nurses in bank roles. If we remove medical staff from the calculations then the trend is still present, yet more subdued as between the ages of 21-50 females on average earn a higher hourly rate than males.



The gender pay assessed against length of service (see chart below) also shows that (excluding medical staff), the gap is only in favour of males in the 16-20 and 21-25 year groups. This suggests that promotions and career development could potentially favour female employees rather than male employees. There are no medical staff with 35-45 years of service, and so the gap is not influenced by Consultants with long service, who would have initially been on the 'old' Consultant contracts and advanced up the increment points. The gender pay gap in favour of women in the 41-45 years of service grouping is very high, this is due to the males in this group mainly being employed in bands 2 and 3 whilst the females are in bands 6 and 7.

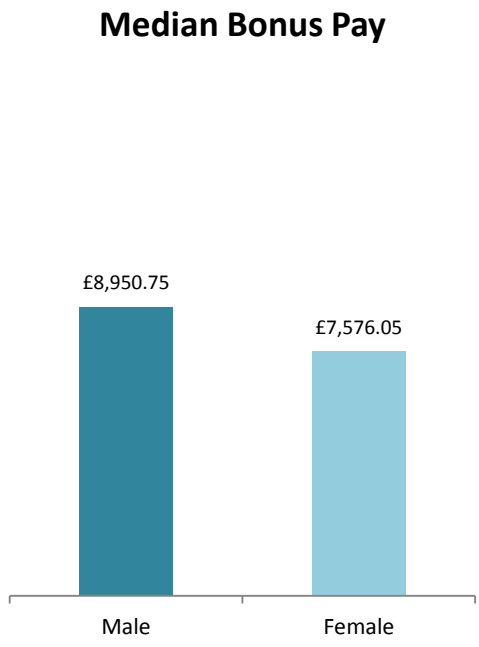


5. Bonuses

The only bonuses paid in the time frame covered by this Report (1st April 2016 to 31st March 2017) were to Medical Consultants, in the form of CEAs and distinction awards. There were 198 bonuses paid in the period, 70 were to female consultants and 128 were to male consultants. When compared with the proportion of male Consultants to female Consultants, 65% of bonuses were paid to male consultants when they make up 56% of all consultants, and 35% were paid to female consultants, when female consultants make up 44% of all consultants.

When these payments are related to all employees of the Trust - out of the total number of female employees in the Trust this represents 1.08% receiving a bonus. In comparison, 5.28% of the total male employees in the Trust received a bonus.

Mean gender pay gap, bonus – 15.05%



Median gender pay gap, bonus – 15.36%

5. Comparison with other NHS Trusts and Foundation Trusts

The mean gender pay gap at St Georges is lower than that of the public sector economy, which is 17.7%. At the time of writing this report only 30 other NHS Trusts had published their gender pay gap - 23 of the 30 reported a higher mean pay gap than St Georges, and 26 of the 30 reported a higher median pay gap. However, that is no reason for complacency and a set of actions is being progressed as a consequence of the issues identified in this Report (see below).

6. Issues identified and next steps

This report has highlighted a number of issues, amongst them:

- the higher proportion of males in higher paid (upper quartile) roles;
- the higher proportion of males in lower paid (lower quartile) roles;
- the higher levels of bonus paid to male consultants than to female consultants;
- the apparent attrition of female doctors at the pre-Consultant stage;
- a potential need to provide support to female consultants so as to encourage applications for CEAs, and provide practical support in the process;
- the need for a review of the way in which Additional Programmed Activities are made available to ensure equality of access to all consultants

Equally, though, the snapshot date of the data used to complete this Report is 31st March 2017. Since then we have made several senior and high profile appointments of female senior leaders and clinical leaders, including our Chief Executive and Chair. We expect that process of appointing purely on merit to continue, and will continue our policy of growing talent from within and providing leadership training for all managerial staff to enable them to expand their career horizons.

Within our medical workforce, whilst the Consultant role has traditionally been male dominated, this is changing - evidenced by the higher proportion of females to males in the Junior Doctor roles. As these trainees qualify and move into Consultant roles, that imbalance will be eroded and ultimately disappear. The Trust wants to ensure that it actively supports that shift.

We will report back in more detail in our next full Report in March 2019.

Sion Pennant-Williams
Workforce Intelligence Manager
March 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 March 2018	**Agenda No.**	**5.3**
Report Title:	**Update on Freedom to Speak Up**		
Lead Director/ Manager:	Harbhajan Brar, Director of Human Resources & Organisational Development		
Report Author:	Karyn Richards-Wright, Freedom To Speak Up Guardian		
Presented for:	Assurance / Update		
Executive Summary:	Update on the Freedom to Speak Up function between January and December 2017.		
Recommendation:	The Trust Board is asked to note the work that the Freedom to Speak Up Guardian has undertaken to date.		
Supports			
Trust Strategic Objective:	Champion St George's, supporting our staff, listening to staff, staff engagement, equality and diversity, bullying and harassment, leadership, values.		
CQC Theme:	Well led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	Non-compliance, patient safety compromised.		
Legal/Regulatory:	All NHS trusts and NHS foundation trusts are required by the NHS contract (2016/17) to nominate a Freedom to Speak Up Guardian.		
Resources:	Role currently undertaken as a FSUG and LIAise role.		
Previously Considered by:	N/A	**Date:**	N/A
Equality Impact Assessment:	N/A		
Appendices:	N/A		

Update on Freedom to Speak Up

1.0 PURPOSE

1.1 The purpose of this report is to update the Board on the Freedom to Speak Up/LIAiSE service between January and December 2017 and to 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 Up Guardian is **Karyn Richards-Wright.** – (see Annex B)

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 Up Guardian does not investigate concerns, but helps to facilitate the raising concerns process where needed, ensuring organisational policies are followed correctly, liaising with HR and investigating officers and feeding back to the complainant.

2.5 Our Freedom to Speak Up Guardian is also our LIAiSE Adviser, 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 service, 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.

3.0 RESOURCES

3.1 There are currently two Freedom to Speak Up Champions in place to support the function and the Guardian with plans to increase this considerably.

3.2 Some trusts have taken the step to fund a full time post for the Freedom to Speak Up Guardian role. We currently include the Freedom to Speak Up function in the LIAiSE Adviser role.

3.3 In May 2018, a 27-month study evaluating the implementation of the Freedom to Speak up Guardian role will commence. The overall objective of the project is to

better understand different ways of implementing the role (e.g. part-time or full-time, single or numerous Guardians) and the interface of the role with other functions (e.g. patient safety, governance, HR) and how these impact, or not, on the role and on NHS staff freedom to speak up.

4.0 WHAT WE HAVE DONE TO DATE

The Guardian advertises the Freedom to Speak Up service on the intranet via eG You (fortnightly), there are flyers in most if not all wards and departments throughout the Trust and our community sites, the Guardian's details are also on the My George mobile app.

4.1 The Guardian attends the weekly Trust induction to speak to new starters about speaking up; the Guardians flyers are also enclosed in the Doctors monthly induction packs. A Freedom to Speak Up podcast was completed in March 2018 and is due to be rolled out to all staff and placed on the intranet in the next few weeks. The Guardian also works closely with staff support services and both services signpost people to the other as required.

4.2 The Guardian is also working with HR to ensure that all relevant policies and staff letters reflect the role of the Guardian and how staff can access the service.

4.3 The Guardian offers drop in clinics once a month in our community areas.

5.0 ACTIVITY TO DATE

5.1 In 2017/2018, there were five cases in total (none in the first quarter one, one in the second quarter and four in the third quarter).

5.2 Of the five cases three related to bullying and harassment and in one case the complainant felt that they had suffered a detriment by raising a concern. They have since left the Trust. The Guardian is aware that two staff members have contacted the CQC prior to speaking with the Guardian due to reporting incidents to managers and being unsatisfied with the response namely a perceived failure to act on the concerns.

6.0 LEARNING

6.1 The Guardian works closely with complainants to gain feedback relating to the experience of speaking up. The Guardian also maintains close links with other Guardians through a buddy system and attends all of the regional and national conferences.

6.2 The Guardian reviews cases after completion to identify learning and if possible work with the managers or teams involved to identify and address issues that could have been handled differently.

6.3 The Guardian reviews and applies learning from case reviews conducted by the Guardian's office thus ensuring that as a trust we are also taking on learning from other NHS trusts. Please see Appendix A attached for Guardian's review of the

Northern Lincolnshire and Goole NHS Foundation Trust and what learning can be applied here.

6.4 The Guardian has raised concerns relating to the trust ensuring that Freedom to Speak Up concerns are investigated and the complainant fed back to in a timely manner i.e. within four weeks of the concern and a maximum of twelve weeks. This is imperative to ensure that staff feel supported and listened to. This will also help to minimise staff feeling that they have no choice but to raise concerns externally. Whilst this is of course their right, the Guardian has received feedback that in the two cases the Guardian is aware of, this action was taken because of concerns that complaints were not taken seriously internally.

7.0 IMPLICATIONS

Risks

7.1 The role of the Guardian and champions is crucial to ensuring that staff have timely access to an independent, impartial source of advice and support. Should this not happen there is a potential risk that staff will feel unable to raise the issue within their department and this could have serious consequences to the safety of patients and wellbeing of staff. There is also the potential risk to the trust if staff feel their only recourse is to raise their concerns externally

7.2 Legal Regulatory

All NHS trusts are required by the NHS contract (2016/17) to nominate a Freedom to Speak Up Guardian.

8.0 RECOMMENDATION

8.1 The Guardian recommends that the Trust:

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

II. Seeks to supplement the network of champions. With increased divisional representation.

III. Encourages managers to work closely with the Guardian and champions to ensure that investigations are completed and feedback given within the agreed good practise guidelines. This will mitigate the issues escalating and further reassure staff that the trust is working actively to resolve issues.

Karyn Richards-Wright
Freedom To Speak Up Guardian
March 2018

APPENDIX A

Summary of lessons learnt and the application of these at St George's University Hospitals NHS Foundation Trust following the Northern Lincolnshire and Goole NHS Foundation Trust Case Review February 2018

The Freedom To Speak Up Case Review at Northern Lincolnshire and Goole NHS Foundation Trist identified 8 main findings. I (the Freedom To Speak Up Guardian at St George's) have numbered these below and then indicated how these findings relate to St George's:

1. **Evidence of poor speaking up culture in the Trust where issues raised by staff were not always responded to according to good practice, including where staff had raised serious safety issues.**

There are instances where issues raised by staff are not responded to in accordance with good practice. We need to make sure that concerns are acted on promptly and that we as a Trust can evidence this. Managers and senior leaders need to be clear about their responsibilities in this regard and need to be familiar with the good practice guidelines and compliance. Delays and lack of communication are a primary concern for me at present. There have been cases where some staff, frustrated into believing their concerns are not being taken seriously, have taken their concerns externally to the CQC.

2. **Evidence of bullying in the Trust, including existence of a bullying culture within specific teams, that made staff fear the consequences of speaking up.**

Results from the 2016 staff survey showed that bullying was a concern and as a result the staff engagement plan has identified bullying as one of the three areas that are being tackled. The 2017 results are currently embargoed however early indicators are that bullying is again a concern in the 2017 staff survey results and will need to be addressed accordingly.

3. **Evidence that the quantity of ring fenced time provided to the Freedom To Speak Up Guardian, as well as the number of individuals in the Guardian team overall, was insufficient to meet the needs of all staff.**

At present there is one Guardian, supported by two Champions. I am making efforts to recruit more Champions and will be actively progressing this throughout the year with recruitment campaigns. In relation to ring fenced time and meeting the needs of all staff, there is at present no weekend access to a Guardian or Champion and the number of Champions needs to increase to support the Guardian role and provide requisite support within Divisions.

4. **The reports submitted by the Freedom To Speak Up Guardian to the Trust Board lacked the necessary detail and content to ensure that the Board had sufficient information about the speaking up policies, procedures and culture at the Trust.**

The Guardian has been asked to submit one report to the Board since being in post (December 2016). The Guardian will review guidance from the Guardian's office and ensure that all requested

reports contain the required detail and information to ensure that the Board has a good overview of the number of cases, themes and how these issues have been responded to by the Trust.

5. **There was no specific training for staff on either how to speak up, or for managers on how to handle matters raised by staff according to the policies and processes of the Trust.**

At present, I attend weekly inductions for new staff and introduce the role to new starters and hand out contact cards. Freedom To Speak Up is advertised fortnightly in eG-You. I also regularly go into departments and speak to staff and promote the service. There is no specific speak up training for staff. I plan to attend a forthcoming senior leaders' briefing to present the function to managers. I also plan to have discussions regarding running speak up sessions for staff and will liaise with HR in relation to training for managers around handling matters raised by staff who speak up.

6. **The Trust's speaking up policy did not meet national minimum standards as set out by NHS Improvement.**

The Trust's whistleblowing policy has recently been updated (January 2018) in line with minimum standards. However, it should be noted that there is an ambiguity around the wording in the policy which "places an improper restriction on speaking up and is not in accordance with good practice" regarding staff speaking up to bodies outside the Trust only if they have fully exhausted internal procedures. Upon reviewing the revised policy I would like Annex A to be amended as some of the wording could be construed as placing an improper restriction on speaking up which is clearly not the intention.

7. **The Trust's bullying and harassment policy needed improvement to ensure it met the standards set out in guidance by NHS Employers.**

I am aware that the Dignity at Work policy has recently been updated however on review there is no mention of the Guardian role or Freedom To Speak Up function in the policy. The Trust should review all policies to ensure the Guardian role and Freedom To Speak Up function are mentioned in all relevant policies and not just the whistleblowing policy.

8. **The Trust did not have a systematic approach to measure the effectiveness of its speaking up policies, processes and culture.**

At present, the Trust does not have a systematic approach on measuring the effectiveness of speaking up. The Guardian notes the recommendations and will work with the senior leadership team to ensure that appropriate measures to monitor speaking up processes and culture within the Trust are implemented in accordance with good practice.

<u>Additional Recommendations to be implemented at St George's following review findings:</u>

The Guardian has further identified recommendations in the review that should be implemented at St George's namely:

- The Trust must ensure that all HR policies and procedures meet the needs of staff who speak up, and that the policy or procedure is in alignment with good practice in relation to

Freedom to Speak Up **including letters to suspended staff** that accurately state their eligibility to access their Guardian or Champion.

- The Trust should ensure that, where a member of staff is going through a disciplinary process that also encompasses potential patient safety issues or similar matters they have raised, it continues to provide that member of staff with all appropriate support to speak up about those matters and also takes all appropriate steps to maintain staff confidentiality.
- The Trust should ensure that in accordance with its own policies and procedures and in accordance with good practice, all managers and leaders responsible for handling speaking up concerns provide feedback to every individual who raises an issue, including any actions they intend to take in response.
- The Trust should take steps to address bullying behaviour, including training for all staff relating to awareness and handling such behaviour.
- The Trust should provide all staff with mandatory, regular and updated training on speaking up. This training should be in accordance with national Guardian's office guidance and the Trust should monitor that it is effective.
- The Trust should take all steps to identify which staffing groups feel particularly vulnerable when speaking up, why this is the case and how those groups can be supported to speak up freely and are protected from any detriment for having done so.
- The Trust must ensure that all existing and new staff are aware of the contents of its revised whistleblowing policy.
- The Trust must ensure that all investigations into the alleged conduct of staff who have previously spoken up also seek to identify whether such allegations are motivated by a desire to cause detriment because that staff spoke up and, where such evidence is found, take appropriate action. This should include amending the Trust disciplinary procedure to require such action.
- A communications and engagement strategy should be developed to promote the Freedom To Speak Up Guardian and Champion roles, and to evaluate the impact they are having, in the longer term. This should include strategies to provide feedback on actions taken in response to speaking up and actions to tackle barriers to speaking up.
- Staff leaving the Trust should be given the option of an exit interview with the Guardian should they so wish to raise any issues and highlight areas of concern which may have prompted the individual's decision to resign.
- The Guardian should be given access to data relating to serious incidents and resignations so that work can be done to identify issues within areas that have a high incident or vacancy rate.

Karyn Richards-Wright
LIAiSE Adviser and Freedom To Speak Up Guardian
February 2018

St George's University Hospitals NHS
NHS Foundation Trust

BE THE ONE
WHO MAKES A DIFFERENCE
STAND UP SPEAK UP

Do you have concerns?
Do you need to speak to someone for confidential advice and support?
You will be supported and are encouraged to raise a concern about risk, malpractice or wrongdoing.

Examples include but are not restricted to:
unsafe patient care • unsafe working conditions • inadequate induction or training for staff • lack of or poor response to a reported patient safety incident • a bullying culture

"We all have a responsibility to raise safety issues for the benefit of patients and staff alike"

Your Freedom to Speak up Guardian is **Karyn Richards-Wright**
Karyn can be contacted in confidence on
020 8725 4001/ 07775 020247
or via email karyn.richards-wright@stgeorges.nhs.uk

Freedom to Speak Up Guardian

109300

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 March 2018	**Agenda No.**	**5.4**
Report Title:	**NHS National Staff Survey 2017**		
Lead Director/ Manager:	Harbhajan Brar, Director of Human Resources & Organisational Development		
Report Authors:	Donna Harding, Senior HR Advisor Nina Michel, HR Advisor		
Presented for:	Discussion / Update		
Executive Summary:	The purpose of this report is to provide the Trust Board with an overview of our 2017 NHS Staff Survey Results, showing where there has been movement, both positive and negative, when compared to the 2016 results. The report also provides an initial data analysis indicating the areas of focus for 2018/19, in particular looking at: ▪ Addressing personal development ▪ Increasing organisational development interventions ▪ Management development **Next Steps** ▪ A detailed corporate action plan to be developed with input from the Working Party. ▪ Divisions to review their divisional/directorate data and devise 2 or 3 local action points to be added to the corporate action plan. ▪ The action plan to be publicised widely through the organisation so that staff know that their views have been heard and taken seriously.		
Recommendation:	It is recommended that the Board notes the findings of the analysis and the areas for focus for the Staff Engagement group.		
Supports			
Trust Strategic Objective:	Champion St George's, supporting our staff, listening to staff, staff engagement, equality and diversity, bullying and harassment, leadership, values.		
CQC Theme:	Well led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	Failure to address the finding of the 2017 staff survey will result in a significant component of our workforce feeling 'disengaged' and undervalued for their contributions to the safe and effective care of our patients.		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Board - Part 2	**Date:**	25.01.2018
Equality Impact Assessment:	N/A		
Appendices:	Appendix 1: Actions taken to address bullying and harassment, staff engagement and equality and diversity.		

National NHS Staff Survey 2017

Introduction

1. The embargo on the National NHS Staff Survey results was lifted on Tuesday 6th March 2018 and the National NHS Staff Survey reports were formally released to the public.

2. This year (2017) 4,312 questionnaires were completed out of 8,375 eligible staff at the Trust thus achieving a response rate of 51.5%. This is a significant improvement on last year (2016) when our response rate was 40.4%. The average response rate for Picker 'Acute Community' organisations was 43%.

3. In summary, the Trust performed significantly better than in 2016 and our scores were higher than the national average for combined acute and community Trusts. Our top 5 ranking and bottom 5 ranking scores are summarised in the table below:

Table 1: Top Five and Bottom Five Ranking Scores 2017

	2016/17		2017/18		
	St George's	National Average	St Georges	National Average	Improvement/ deterioration
Response rate	40.4%	42.3%	51.5%	43.0%	Improvement
Top 5 ranking scores					
KF13. Quality of non-mandatory training, learning or development	4.10	4.07	4.11	4.06	Improvement
KF12. Quality of Appraisals	3.19	3.11	3.19	3.11	No Change
KF18. % of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their line manager, colleagues or themselves	53%	55%	53%	53%	No Change
KF29. % of staff reporting errors, near misses or incidents witnessed in last month	91%	91%	90%	91%	Deterioration
KF24. % of staff/colleagues reporting most recent experience of violence	68%	67%	71%	67%	Improvement
Bottom 5 ranking scores					
KF19. Organisation and management interest in and action on health and wellbeing	3.41	3.61	3.49	3.41	Improvement
KF14. Staff satisfaction with resourcing and support	3.15	3.28	3.22	3.27	Improvement
KF26. % of staff experiencing harassment, bullying or abuse from staff in last 12 months	32%	23%	30%	24%	Improvement
KF10. Support from immediate line managers	3.63	3.74	3.65	3.76	Improvement
KF9. Effective team working	3.67	3.78	3.67	3.74	No change

4. One of the immediate actions following the publication of the survey results is to provide further data analysis on each of the staff group, such as nursing and medicine and to review the verbatim comments that staff provided (617 in total) to consider any key themes that we need to focus in the coming year.

Actions taken since the 2016 Staff Survey

5. Following the 2016 survey, a Staff Engagement working party was established (July 2017). This was led by Alison Benincasa and was tasked with developing a sustainable Staff Engagement Plan that primarily focused on three key target areas; reducing the levels of Bullying and Harassment; improving Staff Engagement and improving Equality and Diversity, all of which were designed to improve the way that we work with each other. See Appendix 1 for actions taken to date.

Area of focus from the 2017 Staff Survey

6. This paper outlines the initial outputs from the 2017/18 data analysis and provides a brief summary of the new areas to be covered in addition to the three on-going priorities outlined above.

The three additional areas that will be considered by the Staff Engagement working party are:-

- Addressing Personal Development
- Increasing Organisational Development Interventions
- Management Development

Personal Development - Appraisal Process

7. The main areas across the Trust which were Score < 3% below benchmark in the 2017 survey under "**My personal development**" were:

- Appraisal/review definitely helped me improve how I do my job
- Clear work objectives definitely agreed during appraisal
- Appraisal/performance review: training, learning or development needs identified

8. With an overall score of 3.19 out of 5 for the quality of appraisals, (down 0.01 from last year's survey) it is clear that the Trust has not improved in this area. However, it is important to note that despite a score of 3.19 the Trust is still above the National 2017 acute and community Trust score for quality of appraisals which stands at 3.11 out of 5.

9. It is also important to consider the written feedback from Managers that the current appraisal process is complicated and that finding the paperwork can be a difficult and there are calls for it to be moved to an online system. Within the Trust, many managers have stated that they 'do not have time to complete the appraisals for their staff members' and that the system to confirm it has been completed is flawed and often does not report accurately the outstanding appraisals.

10. As case study from NHS direct, shows that they also had a large number staff who did not find their appraisal process as being helpful. It led to them simplifying the appraisal process, using an online appraisal system that made the appraisal more of an on- going event than just a yearly occasion - encouraging staff to feel confident in using the online system to keep everything up to date.

Your Organisation - Organisational Development Interventions

11. The overall Trust staff engagement score went up from 3.70 in 2016 to 3.75 in 2017. The national average for combined acute and community trusts is 3.78, which indicates that whilst there is room for improvement, the Trust is doing some good work in relation to making their staff feel more engaged.

12. The main areas across the Trust which were Score < 3% below benchmark in the 2017 survey under "**Your Organisation**" were:

- Would recommend organisation as place to work
- Patient/service user feedback collected within directorate/department

13. The Trust score for recommending St Georges as a place to work is 3.74 out of 5, which is an increase of 3.61 from 2016. The national average score for combined acute and national Trusts was 3.75, with the best score being 4.18.

14. The friends and family test has echoed that there has been an overall increase in the number of staff who would recommend the Trust as a place to work, with it increasing from 74% to 77% over the last year.

15. How the Organisation acts on concerns raised by patients/ service users remains below the benchmark figure and as a main concern, much like the 2016 survey. It is well documented that in order for staff to feel engaged they want to feel that they have a voice and are heard.

16. Effective use of patient/ service user feedback collected within the directorate/ department also remained an area where the Trust scored below the benchmark with a score of 3.70 compared to the best 2017 score of 3.93. The 2016 result was 3.69, so there shows little change.

Your Manager – Management

17. The main areas across the Trust which were Score < 3% below benchmark in the 2017 survey under "**Your Managers**" were:

- Immediate manager encourages team working
- Immediate manager gives clear feedback on my work
- Immediate manager supportive in personal crisis
- I know who senior managers are

18. The 2017 staff highlights that staff feel that there is more concern for them between their immediate manager than the Senior managers within the Trust. Although "I know who senior managers are" still scores on the < 3% below benchmark, there is an improvement to the figures from 2016.

19. These figures show that there needs to be some improvement in staff and the immediate managers relationship and it would be hoped that by having restarted the HR training "Passport to effective people management" in January 2018, that this will give Manager's the toolkit to be able to hold these feedback conversations and know what support that they can offer.

Staff Groups

20. The below table shows the staffing groups response rate and the area which was the highest scores on the < 3% below benchmark. This has been compared to the 2016 survey and is detailed below:

Staff Group	Number of Respondents	Main area of concern 2017	Main area of concern 2016
Allied Health Professionals	608	Your Organisation	Your Managers
Scientific and Technical/Healthcare Scientists	463	Your Managers	Your Organisation
Medical and Dental	416	Your Organisation	Your Managers
Nurses, Midwives and Nursing Assistants	1420	Your Health, Wellbeing and Safety at Work	Your Health, Wellbeing and Safety at Work
Other Groups (admin and clerical)	944	Your Personal Development/ Your Managers	Your Personal Development/ Your Managers

21. Nursing and midwifery were the highest group of respondents with their main concern within the area of Your Health, Wellbeing and Safety at work.

Verbatim comments

22. The survey provides staff with an opportunity to add in any additional comments they would like to make. We received around 617 comments and an analysis of these showed the most common themes to be:

Theme	
Working Conditions	Environment Equipment Retention and Turnover Recruitment processes Career Development Motivation and Morale

	Pay Flexible working Worklife Balance
Management Development	Senior Management
	Line Management
	Change Management
Living the Values	Bullying and Harassment
Reward Strategies	Recognising long service and pay)
Diversity and Inclusion	Fairness/Opportunity
Health & Wellbeing	Change Management
	Staff Support/Stress & Anxiety
Strategic Direction	Communication

The Staff Engagement Group, as well as TEC review the verbatim comments that staff provided and consider any key themes that we need to focus in the coming year.

Next Steps

23. The staff survey results are in the main encouraging in terms of there being an emphasis on individual and organisation development, but there is much work to do in the day to day operational areas, in particular within the theme of working conditions. It would not be possible to make progress on every area of concern, therefore, the recommendation to the Staff Survey Action Plan Working Party is to confirm that we have identified the correct areas for targeted action.

2.4 An updated action plan can be developed with input from the Working Party to support this targeted work and publicised widely through the organisation so that staff know their views have been heard and taken seriously.

Appendix 1: Actions taken to address Bullying and Harassment, Staff Engagement and Equality and Diversity

Over the past year actions have included:

	What we did
Addressing Bullying and Harassment	Publicised where staff can get support.
Tackling Unhelpful Behaviours – Role model behaviours at all levels; commit very clearly to the Trust's values	▪ Values Based Recruitment training for all staff. ▪ Set out expectations at induction and discuss and reinforce at 1:1s and appraisal. ▪ Introduced 360º reviews for all middle managers and above. ▪ Development Centres between March and June 2018 for top 250 leaders; each manager will receive a 360º review including self-reflection and peer feedback. ▪ Promoted awareness of internal bullying and harassment helpline and LIAiSE (Listening into Action is Staff Engagement). ▪ Review and promote the Trust Values Policy.
Introduce Positive Event Reporting – use the same rigorous process, to learn from positive events, as we do to learn when things go wrong	▪ Wider roll out of Greatix across the Trust. ▪ Showcase our successes via ByGeorge. ▪ Case studies of best practice promoted via ByGeorge and other communication routes.
Improving Staff Engagement	See Staff Survey Results and Friends & Family results.
Recruited Engagement Champions – from staff who have offered to be involved; ask for their help in monitoring the delivery of our plan; to keep involved and to generate on-going ideas to connect the leadership of the Trust with front line staff	▪ Asked staff to take part in the 'Would you like to join us for lunch' events. ▪ Set up monthly review meetings and invite the staff who attended for lunch and who want to remain involved, our 'engagement champions', to attend. ▪ Feedback on the findings of the review meetings to the workforce and education committee.
Out and About with the Executive Team – visits to different area each month, publish plan, never cancel, no agenda, informal; Team Talk with the Chair and Chief Executive, for a cross section of staff	▪ Identified areas to be visited a month in advance and publish plans. ▪ Communications facilitate invitations to attend Team Talk. ▪ Create an email free Friday – the last Friday of the month.
Relaunched Listening into Action (LiA) – hold Big	▪ Organised and delivered Big Conversations in September and October 2017.

Conversations x4; use LiA to celebrate good news; revitalise staff awards, tied into the 3 key focus areas and based on the Trust values and behaviours	▪ Implemented greater use of Greatix. ▪ Increase visibility of values awards. ▪ Review and refresh annual long service awards event.
Improving Equality and Diversity	Appointed an D&I Lead. Create Tableau data reports.
Rolled out Values Based Recruitment – 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.	▪ Established an Executive champion for 'recruiting the best.' ▪ Updated our recruitment paperwork to support structured application. ▪ All recruiting managers to attend values based recruitment training.
Commit to Improving Understanding – and ensure compliance with all relevant policies at all levels, working with senior leaders, clinical and non-clinical to ensure they understand their responsibilities to adhere to the policies and to implement them	▪ Set our expectations at induction. ▪ Discuss and reinforce at 1:1s and appraisal. ▪ Policies reinforced at 1:1s and appraisal.
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 high visible campaign when the values are refreshed, that clearly shows a 'new way' at St George's	▪ Identified a Board level lead (non-Executive Director) and an Executive lead. ▪ Board and Executive lead to attend at least 4 staff engagement events per year. ▪ The 2017/18 Workforce Race Equality Standard (WRES) Action Plan has been agreed by the Board and on the intranet and internet. ▪ WRES working party meetings taking place on a monthly basis. ▪ Diversity and Inclusion Manager appointed.
Tell our story, powerfully and positively – make equality and diversity part of the story of St George's recovery	▪ Developed communication strategy and track its delivery. ▪ Engagement Plan launched in Quality Improvement week. ▪ Printed document supported by posters and leaflets. ▪ Section on intranet now live. ▪ Communications strategy in place.

Donna Harding, Senior HR Advisor
Nina Michel, HR Advisor
March 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 March 2018	**Agenda No**	**6.1**
Report Title:	**Board Assurance Framework (BAF)**		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Elizabeth Palmer, Director of Quality Governance		
Presented for:	Assurance / Update		
Executive Summary:	This paper attaches Board the summary page of the Board Assurance Framework, which has been updated following the Board review in February. The wording of strategic risk 1 has been changed as discussed and agreed at February Board. The Board has asked to be updated monthly on: • any significant change in risks contributing to a strategic risk and therefore assurance statements and • assurance available in month on the effectiveness of the controls if there has been any material change The Quality and Safety Committee (22 March) reviewed the risks assigned to it and agreed the current assurance rating remains. The Finance and Investment Committee (22 March) requested that all risks assigned to it be presented at the next meeting in April for comprehensive discussion.		
Recommendation:	The Board is asked: • To note the changes made to SR1 following discussion at February Board. • To note that the risk appetite has been added.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability		
Implications			
Risk:	The strategic risk profile		
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence		
Resources:	N/A		
Previously	Finance and Investment Committee	**Date**	22.03.2018

Considered by:	Quality and Safety Committee		
Equality Impact Assessment:	N/A		
Appendices:	Appendix 1 BAF summary sheet		

Appendix 1

Board Assurance Framework
March 2018

BOARD ASSURANCE FRAMEWORK OVERVIEW										QUARTER 3
Strategic Objective	Risk appetite	Strategic Risk		Quarterly Assurance Rating Q1	Q2	Q3	Q4	Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score
Treat the patient, treat the person	*Moderate*	*SR1*	We are unable to develop new roles, changes in skill mix and innovative ways of working that address the long term staffing (supply) requirements of the Trust as well as address the immediate recruitment and retention issues, which could result in care which is below the minimum standard.			Partial		The Committee recognised a lot of activity going on in the recruitment space, but with turnover remaining at around 18%, the Committee was only able to give limited assurance on this risk. The Committee noted the on- going work in the areas of Bank and agency was well as the significant reductions in the number of overall vacancies.	Director of HR and OD	Workforce and Education Committee	16
	Low	*SR2*	Our processes for admitting, reviewing, treating, discharging and following up both elective and non-elective patients on their pathway are not timely or robust, resulting in poor, delayed or missed treatment.			Limited		The Committee recognises the significant improvement in management of our waiting lists and the launch of the new Patient Tracking List (PTL), but assurance remains limited recognising the scale of the task and the significant work still to do.	Chief Operating Officer	Quality Committee	16
	Low	*SR3*	We do not have effective, accessible and widely utilised learning and improvement methodologies, resulting in care which is below local and national standards and best practice.			Partial		The Committee is assured that the Quality Improvement Plan (QIP) for learning is being delivered and achieving key objectives but a number of key indicators in the QIP dashboard are yet to be met.	Chief Nurse	Quality Committee	12
Right care, right place, right time	*Low*	*SR4*	Our pathways are not well integrated with, or supported by the key external organisations that make up the local health economy to enable us to manage demand or patient flow effectively, resulting in poor or delayed care for our patients.			Limited		The Committee notes that the controls and assurances are cross referenced to SR17 and the increase in director level capacity to build and develop relationships within the local health economy.	Medical Director	Quality Committee	8
Balance the books, invest in our future	*Low*	*SR5*	Financial efficiency, forecasting and accountability is not seen as a priority for service managers or our wider workforce, resulting in overspending, poor budgetary management which could lead to poor service delivery and regulatory action.			Partial		The Trust needs to ensure that when staff take on roles with financial responsibility they are adequately trained to fulfil the role. Some controls need to be aligned more closely with operational requirements to ensure the smooth procurement of goods and services.	Director of Finance	Finance and Investment Committee	16
	Low	*SR6*	We do not understand our business sufficiently to identify and implement efficiency and improvement opportunities			Limited		Divisions still lack the capacity and capability to fully understand efficiency opportunities in their business	Director of Efficiency and Transformation	Finance and Investment Committee	20
	Low	*SR7*	We do not have a clear and effective business planning cycle to enable clear, timely and realistic plans and trajectories. This results in the Trust having incomplete plans and management action becoming reactive.			Limited		The Trust currently does not have in place a medium term financial and operational plan.	Director of Finance	Finance and Investment Committee	15
Champion team St George's	*Low*	*SR8*	Establishing a positive, supportive culture which is allied to accountability for delivery is not seen as a priority, with the result that our organisational culture is either negative/punitive or does not foster accountability amongst our workforce.			Partial		Increasing participation of staff in the staff survey and increased engagement in events across the Trust.	Director of HR and OD	Workforce and Education Committee	10
	Moderate	*SR9*	Due to a failure to develop and implement an effective communications strategy our staff feel disengaged, uninformed and unvalued.			Partial		The Board recognises the communication strategy and its delivery over the past year. A key assurance on its impact, the annual communication survey, will be available in April 2018. The Board asked for assurances concerning the staff engagement strategy to be mapped to this risk (xref SR8).	(CEO) Director of Corporate Affairs	Board	12
	Low	*SR10*	We do not provide accessible training in the right place at the right time for our staff, in order to ensure that they are able to do their jobs effectively, resulting in staff dissatisfaction and poor care for patients.			Partial		Compliance with mandatory and statutory training steadily improving, high compliance with appraisal and professional development planning.	Director of HR and OD	Workforce and Education Committee	9
	Moderate	*SR11*	We fail to develop our future leaders and we fail to provide clarity to them about their roles and accountabilities, which leads to low job satisfaction, high turn-over and on-going instability amongst our senior leaders.			Partial		We have put a (Kings Fund) development centre in place for our top 250 leaders. In addition we are reviewing our operational structures and developing a performance management framework to fully clarify roles, responsibilities and accountabilities.	Director of HR and OD	Workforce and Education Committee	9
Build a better St George's	*Low*	*SR12*	Our IT systems are unreliable, unstable and do not support us to provide excellent care or provide us with the information and analysis required to manage the Trust effectively.			Limited		The workshop held in December highlighted the need for more assurance on improving clinical systems and achieving a resilient infrastructure.	Chief Information Officer (CIO)	Finance and Investment Committee	20
	Low	*SR13*	Our estate is poorly maintained and underdeveloped, resulting in buildings which are not fit for purpose and may be closed by the regulator, impacting delivery and risking patient safety.			Limited		Although progress has been made on improving our estate including investment in refurbishments there remains a significant amount of work to do. Our new Director of Estates and Facilities (joined January 2018) is undertaking a full review of statutory compliance to prioritise the next areas of focus.	Director of Estates and Facilities	Finance and Investment Committee	15
	Low	*SR14*	We are unable to secure the investment required to address our IT and estates challenges and as a result are unable to transform our services and achieve future sustainability.			Limited		Reporting deficits for the last years has stressed the Trust's working capital and limited it's ability to secure external finance.	Chief Executive	Board	16
Develop tomorrow's treatments today	*High*	*SR15*	We fail to see an improvement in our research activity and profile with consequence impacting on the reputation of the Trust.			Partial		Our research portfolio underperforms against similar sites. We are developing our strategy with SGUL and the Charity but there remains a risk that our research impact does not increase to where we want it to be.	Medical Director	Quality Committee	12
Build a better St George's	*Moderate*	*SR16*	We do not have a clearly articulated and deliverable strategy underpinned by widely communicated and owned supporting delivery plans, resulting in an inability to take strategic decisions as an organisation, leading to difficulty in identifying clincial service priorities and consequently a lack of engagement in the future success of the Trust amongst our workforce.			Limited		The Board recognises that a key action to address this risk has now been delivered with the arrival of the new Director of Strategy in January 2018. Funding has been agreed for a team but this will not be fully in place until July 2018. The strategy process is in development.	(CEO) Director of Strategy	Board	12
	Moderate	*SR17*	A lack of strong, productive relationships with our key external stakeholders may result in a lack of alignment of the plans across the local health economy with our priorities and an inability to provide a source of collaborative leadership for the STP.			Limited		The Board recognises that the additional director capacity needed to build and develop external relationships is now in place but this is new (January 18) and assurance about the impact on this risk is not yet available.	Chief Executive	Board	12