Trust Board Meeting
Part 1 - Public

Date and Time: **Thursday 28 February 2019: 10:00 – 13:30**

Venue: **Board Room H2.6, Second Floor, Hunter Wing, St George's Hospital**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	**A**	**Visits to various parts of the 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 on 31 January 2019**	**Gillian Norton** Chairman	Approve	Report
	1.4	**Action log and matters arising**	**All**	Review	Report
10:35	**1.5**	**CEO's update**	**Jacqueline Totterdell** Chief Executive	Inform	Report
QUALITY & PERFORMANCE					
10:45	**2.1**	**Quality and Safety Committee report**	**Sir Norman Williams** Committee Chair	Assure	Report
10:55	**2.2**	**Integrated Quality & Performance report**	**James Friend** Director of Delivery, Efficiency and Transformation	Review	Report
11:10	**2.3**	**Cardiac Surgery Update**	**Richard Jennings** Chief Medical Officer	Assure	Report
FINANCE					
11:20	**3.1**	**Finance and Investment Committee report**	**Ann Beasley** Committee Chair	Assure	Report
11:30	**3.2**	**Month 10 Finance Report**	**Andrew Grimshaw** Chief Financial Officer	Update	Report
STRATEGY					
11:40	**4.1**	**Clinical Strategy Highlight Report**	**Ralph Michell** Head of Strategy	Update	Report
11.50	**4.2**	**NHS Long Term Plan**	**Ralph Michell** Head of Strategy	Update	Report

Time	Item	Subject	Lead	Action	Format
WORKFORCE					
12:00	**5.1**	**Workforce and Education Committee Report**	**Stephen Collier** Non-Executive Director	Review	Report
12:10	**5.2**	**Workforce Race Equality Standard 2018 Report**	**Harbhajan Brar** Director of Human Resources & Organisational Development	Review	Report
12:20	**5.3**	**Gender Pay Gap**	**Harbhajan Brar** Director of Human Resources & Organisational Development	Approve	Report
12:30	**5.4**	**Ethnicity Pay Gap**	**Harbhajan Brar** Director of Human Resources & Organisational Development	Approve	Report
12:40	**5.5**	**Guardian of safe working**	**Richard Jennings** Chief Medical Officer	Assure	Report
GOVERNANCE					
12:50	**6.1**	**UK withdrawal from the European Union**	**Andrew Grimshaw** Chief Financial Officer	Review	Report
CLOSING ADMINISTRATION					
13.00	**7.1**	**Questions from the public**	-	-	Oral
	7.2	**Any new risks or issues identified**	All	-	
	7.3	**Any Other Business**		-	
	7.4	**Reflections on the meeting**		-	
13:10	**PATIENT / STAFF STORY** Reports on the experience of a patient with cancer who attended the Trust's Emergency Department and was admitted as an outlier onto a renal ward.				
13.30	**CLOSE**				

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

Date of next meeting: Thursday 28 March 2019, 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	20.12.18	31.01.19	28.02.19	28.03.19	25.04.19	30.05.19	27.06.19	25.07.19	29.08.19

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
Richard Jennings	Chief Medical Officer	CMO
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
Sally Herne	Quality Improvement Director, NHS Improvement	QID
Secretariat	**Designation**	**Abbreviation**
Michael Weaver	Interim Head of Corporate Governance	IHCG
Jill Jaratina	Interim Assistant Trust Secretary	IATS

Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting
Part 1 (Public)
Thursday 31 January 2019, 10:00 – 13:30
Hyde Park Room, 1st Floor Lanesborough Wing, St George's Hospital

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Avey Bhatia	Chief Nurse and Director of Infection Prevention & Control	CN
Andrew Grimshaw	Chief Finance Officer	CFO
Richard Jennings	Chief Medical Officer	CMO

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	DEF
Stephen Jones	Director of Corporate Affairs	DCA
Suzanne Marsello	Director of Strategy	DS
Ellis Pullinger	Chief Operating Officer	COO

APOLOGIES		
Tim Wright	Non-Executive Director	NED
Sally Herne	NHSI Improvement Director	NHSI-ID

SECRETARIAT		
Jill Jaratina	Interim Assistant Trust Secretary (Minutes)	IATS

Feedback from Board Visits	
Members of the Board provided feedback on the departments visited which included Therapies Outpatients, Fracture Clinic, Ruth Myles Ward and Day Unit, Endoscopy, Infection Control Team, McEntee Ward, Allingham Ward, Cardiac List Planning, Benjamin Weir Ward, Frederick Hewitt Ward and Blue Sky Centre. The DDET advised that the Therapies Outpatients Unit had received its first accreditation. Staff highlighted some estates problems in the unit and they had devised a list of tasks for estates. There was a toilet blockage which had not been fixed. Staff highlighted general infrastructure problems and that one consultant room was not in use. The Chairman had asked staff about their understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) and had been encouraged by their level of knowledge. In Radiology, there were also estates	

issues. The team had resorted to painting the walls and it was noted that the temperatures were very low, particular given staff were required to be bare below the elbows. Despite this, staff were very enthusiastic and one of the team had recently won an award. It was noted that there was no recovery space in the department so patients often went to Theatres for recovery.

The CFO provided feedback on the Ruth Myles Ward. He commented that recruitment and retention of senior staff was good and staff were dedicated. The physical condition of the ward was also good but cluttered and the service was pushed to capacity. Staff had highlighted issues with ventilation. This was functional and met requirements, but staff noted that it would be difficult to maintain services if anything went wrong with the equipment which was ageing. There had been teething problems with iCLIP but this had now been resolved.

The CN provided feedback on the visits to Endoscopy and the Infection Control Team. The Endoscopy unit was clean, efficient and a soothing environment. St George's was a hub for bowel treatment and had a good reputation. Staff had demonstrated a good understanding of MCA and DoLS. Staffing on the unit was good, though would benefit from the appointment of a Practice Educator. The unit had encourtered persistent problems with its printer, and this was essential equipment as the unit printed discharge reports for its patients. The unit had achieved the external accreditation and previous concerns regarding single sex accommodation had been addressed. The Infection Control team had recruited new staff but was experiencing IT issues particularly in relation to inputting relevant infection control information onto iClip. The team also highlighted challenges with some medical staff complying with infection control practices.

The DS provided feedback on the visits to McEntee and Allingham Wards. Staff had reported that although the estates team was very responsive, there were longstanding estates issues. The Ward was planning to use money from the St George's Hospital Charity Special Purpose Funds to refurbish the ward. Medical staff reported that iCLIP could sometimes be slow and further iClip training was needed. The DS advised that Allingham Ward had a very large number of patients who were present due to social challenges rather than medical need which placed significant pressure on the service. In terms of estates, staff fed back that they believed the unit did not have enough toilets.

Stephen Collier reported on the visit to Cardiac List Planning and Benjamin Weir Ward. The group had attended a pre-meeting with the surgeons, and there had been thoughtful discussions about protocols, engagement and oversight. The CMO commented that the discussions at the Cardiac MDT had been encouraging. Benjamin Weir Ward was busy, tidy and organised with increased uptake in activity. The group had arrived in the middle of a ward accreditation assessment and they asked staff about their understansing of MCA and DoLS, with staff demonstrating good levels of knowledge. The CMO commented that improvements were needed in the comprehensiveness of documentation on the ward.

Jenny Higham provided feedback on the visit to Frederick Hewitt Ward and the Blue Sky Centre. Room temperatures in Fredrick Hewitt Ward were discussed and staff asked for the air conditioners to be serviced before the summer. Staff were complimentary about the support they received from the security team. Staff commented that the unit would benefit from having an additional cubicle.

The Chairman reflected that, overall, there were a lot of things that were positive and that the feedback had moved on a good deal recent months, particularly in relation to estates. Undoubtedly, there continued to be problems with the estate, but what had come through clearly was the generally good morale among staff.

OPENING ADMINISTRATION		Action
1.1	**Welcome, Introductions and apologies**	
	The Chairman opened the meeting and noted that Tim Wright and Sally Herne had given their apologies.	
1.2	**Declarations of Interest**	
	It was noted that there were no new declarations of interest.	
1.3	**Minutes of the meeting held on 13 December 2018**	
	The minutes of the meeting held on 20 December 2018 were agreed as an accurate record subject to three amendments: • To add Jenny Higham to the list of those present (page 1); • To substitute "radiotherapy" for "radiography" in the section on Board visit feedback (page 1); • To omit the reference to "Caroline Ward" in the section on ward accreditation in the Board visit feedback (page 2).	
1.4	**Action Log and Matters Arising**	
	The Board reviewed the action log and agreed to close those actions proposed for closure. This included the closure of action TB 20.12.2018/01 (Information Governance breach involving iCLIP cards) following assurance from the CFO that a report on the breach and actions to address future occurances would be considered by the Informatics Governance Group and the Trust Executive Committee in February 2019.	
1.5	**Chief Executive Officer's Update**	
	The CEO provided an update on the following issues: • The NHS Long Term Plan had been published earlier in the month and this had potentially wide-ranging implications for major secondary care providers like St George's. The Trust was currently considering the details of the Plan, including implications for the development of the Trust's new five year strategy. • The United Kingdom's withdrawal from the European Union had been the subject of intense speculation in recent weeks and contingency planning for the possibility of a "no deal Brexit" had been stepped-up across the NHS. The CFO had been appointed as the Senior Responsible Officer and "Brexit lead" and a small working group had been established to support the contingency planning that had recently been put in train. A new NHS London Brexit Oversight Group had been established and the Chief Nurse had been appointed as a member. • The Trust had recently commenced a new piece of work to embed the new diversity and inclusion strategy. Four groups had been established: Black, Asion and Minority Ethnic (BAME); Disability and Wellbeing; Gay, Bisexual and Transgender; and Women. Some 42% of the staff at the Trust were from BAME backgrounds but were significantly under-represented in more senior roles. The Trust was committed to addressing this and diversity and inclusion as a whole	

	was a major priority for the Trust. Sarah Wilton asked what measures the Trust was taking to prepare for the UK's withdrawal from the EU and the risks of a "no deal Brexit". The CFO advised that the Department of Health and Social Care had issued guidance for operational readiness in December and both NHS England and NHS Improvement were working with NHS organisations to ensure appropriate contingency planning was in place. The Chief Pharmacist at NHS England had recently written to all providers about the steps necessary to maintain medicines supply which had reiterated previous guidance to Trusts not to stockpile medicines. The Trust was updating its business continuity arrangements so that these were in place in the event of a "no deal Brexit". **The CFO agreed bring a paper to the February Board with an update on the Trust's work on planning for the UK's withdrawal from the EU.** Sir Norman Williams advised that he had been approached by an individual who felt there was discrimination in the NHS, and in particular insufficient BAME representation in senior posts and in relation to serious incident investigations. He added that unconscious bias was an issue which affected everyone and it would be important to address this. The DHROD advised that there were undoubtedly challenges with the under-representation of BAME staff in senior roles and this had come through clearly in the latest data in the Workforce Race Equality Standard (WRES) report. The scale of the challenge reinforced the importance of the diversity and inclusion work the Trust had recently launched. The CEO emphasised the importance of ensuring there was real impetus behind this work and stated that it would not be a tick box exercise; the Trust was committed to making a step change on diversity and inclusion. The Chairman commented that some staff had queried whether the new BAME group was making a difference, to which the CEO responded that attendance at a recent meeting had been disappointing and work was underway to ensure that future meetings were well attended. **The DHROD agreed to bring a report on the WRES to the February Board.** The Board noted the report.	**TB.31.01.2019/01** **CFO** **TB.31.01.2019/02** **DHROD**
QUALITY AND PERFORMANCE		
2.1	**Quality and Safety Committee Report**	
	Sir Norman Williams provided a summary of the key issues and discussions at the Quality and Safety Committee meeting held on 24 January 2019. Sir Norman reported that the Committee had discussed the importance of embedding the learning from clinicial audits and Serious Incidents. It had emphasised that reports needed to contain quantifiable data that provided evidence that lessons had been learned and that this had been embedded. The Committee noted a slippage in performance on the Duty of Candour completed for all incidents graded at moderate harm and above. It heard that this was a local issue that related to capacity in a division rather than a wider problem. Remedial action was being undertaken to recover performance. In relation to the CQC action plan, a total of 80 actions had been completed, althouth the Trust had missed a deadline for one red action	

	with no mitigation in place. To ensure the Trust met all of the regulatory requirements identified in the CQC inspection in March 2018, the Trust had established a weekly Executive challenge meeting to address all areas of concern and identify what additional support was needed. Sir Norman expressed concern that basic life support training compliance was at 64% and nursing staff had fed back that they do not have the time to attend training. The Trust was commissioning external training and was expected to achieve a performance of 85%. The Committee heard that training on DoLS and MCA training was progressing well. One never event and two serious incidents had been reported in January 2019 and these were currently under investigation and would be reported to the Committee in due course. The Committee noted that only one case of MRSA had been reported to date and, as a result, the Trust was one of the best performing providers in London. On the BAF, the Committee had felt that there was significant assurance for RTT reporting therefore the risk score should be revised but there was an emerging risk related to sustainability in reporting. It was noted that this would be considered later on the Board's agenda. Ann Beasley asked for an explanation on the KPI in relation to appraisal rates for nurses in ED department that had not been met and commented that the Trust could not keep moving the timeline. The CN explained that the Trust was working through the action plan and getting support. The CEO reiterated that the Trust should be able to clock steady progress and not set a blanket target and move away from RAG ratings. In relation to basic life support, the CFO asked if non-compliance was due to capacity or planning issues. The CN advised that there were a significant number of staff who did not attend their training when booked. Sir Norman Williams commented that staff would like to attend training but there were staffing gaps so they ended up covering the rotas and this prevented them from attending their scheduled training. The CN noted that rotas were planned six to eight weeks in advance. The Board noted the report.	
2.2	**Integrated Quality and Performance Report**	
	The DDET provided a summary of quality and performance and highlighted four areas: Emergency Department attendance, inpatient elective and day cases, non-elective cases and outpatients attendances and variances in the activity plan year to date. The Friends and Family response rate in the Outpatients department had doubled due to the implementation of two-way text messaging. The CN commented that the Board had expressed concerns about the increase in the number of falls and noted that these has significantly reduced and a PDSA cycle had been completed for quality improvement. The COO explained that there were 60 on-the-day cancellations for non-clinical reasons and 58 of the cancelled appointments had been rescheduled. The priority was to keep a good flow of acute and elective patients. The number of Emergency Care attendances had been reviewed in the previous week and the flow of patients out of the organisation continued to be a daily focus. The Chairman acknowledged the commendable work of the the Cancer team. The DHROD reported that the Trust vacancy rate continued to be below the target of 10%. Sickness levels had remained above target at 3.8%.	

	Non- medical appraisal had remained below target at 71.5%. Individual appraisals were being competed manually and these were progressing at a slow pace. In response to Sarah Wilton's question about when the Trust was expecting to have an electronic system of appraisal, the DHROD responded that this was in the implementation stage and it would fully start running on 1 April 2019. The electronic version would also enable quality checks. The Chairman commented that some staff members felt they could not rely on appraisals and that across the Trust completion of appraisals was a concern. The CEO pointed out that managers at all levels needed to ensure appraisals were taking place. There were opportunities to improve the appraisal process and to link these to the Trust's strategy and values. The Board noted the report.	
2.3	**Cardiac Surgery Update**	
	The CMO highlighted the key points of the Cardiac Surgery update. The CMO, CEO and Associate Medical Director for Cardiac Survery (Steve Livesey) had met the Independent Scrutiny Panel appointed by NHS Improvement on 10 January 2019 and the meeting was constructive and positive. The separate External Mortality Review Panel had so far met five times, having started its work in December 2018, and the Trust was reflecting on the feedback from the Panel. The CMO reported that he had attended an MDT meeting where he had observed reassuring audit results on consent. A Quality Summit with NHS England, NHS Improvement, the CQC and other key stakeholders, had taken place on 28 January 2019 and the Trust was receiving on-going support from Guy's and St Thomas' NHS FT and King's College NHS FT. One of the service developments in the last four weeks was the agreement to implement an improved model for the case management of all elective patients. The Board noted the risks on the risk register for the cardiac surgery service. The Chairman acknowledged the scale of the work that had been done in Cardiac Surgery in recent weeks and months to improve the service. The Board noted the report.	
2.4	**Learning from deaths Q3 Mortality Monitoring Committee report**	
	Dr Nigel Kennea, Associate Medical Director, presented the report and explained that the Trust had a well-established system for reviewing deaths. The Trust had participated in the second meeting of the Learning from Deaths London Network and work was progressing locally to design and implement the Medical Examiner system which would strengthen the work of the Mortality Monitoring Committee. Trusts were required to have this system in place from April 2019. Deaths were reviewed and linked with the risk management system and Serious Incident 72-hour reviews were carried out. The daily reviewing of deaths helped the Trust to identify issues in care. It was noted there had been an increase in the number of deaths recorded in ITU in the last two months, but no lapses in care had been identified. The Trust's Summary Hospital-level Mortality Indicator (SHMI) for July 2017-June 2018 was lower than expected and the Hospital Standardised Mortality Ratio (HSMR) for weekday emergency admissions was significantly better than expected but the weekend ratio was not	

	significantly different to that expected. Sarah Wilton asked if anything could be done to reduce the weekend mortality and whether end of life care patients who die at home are captured in SHMI and/or HSMR. Dr Kennea advised that the SHMI and HSMR related to patients who died in the hospital. Further work would be done to establish if mortality figures had gone up for particular groups and mortality for individuals who are admitted during the weekends. In response to a question from Ann Beasley on whether patients with mental health needs were contributors to mortality, Dr Kennea confirmed that other services recorded the mortality for this cohort of patients. Sir Norman Williams asked how the appointment of a medical Examiner would improve services and whether learning from Serious Incidents and the national guidelines had been embedded. Dr Kennea advised that the Trust had adopted the leader programme for patients with learning difficulties and that the Learning Disability team was exceptional. Dr Kennea explained that the Medical Examiner (ME) system was independent from the Trust's governance. The ME would review non coronial deaths, liaise with families of deceased patients and complete death certifications. This service would initially be available over 5 days for the Trust as it was difficult to commit to 7 days at present. The DS commented that patients with mental health issues typically died younger and advised that she was part of the team that was setting up a group to cater for patients with mental health issues and this group would link with the Mortality Monitoring Committee. In relation to child death reviews, the CN commented that there would be a shift in responsibilities with resource implications. The CMO thanked the Mortality Monitoring Committee for all the work they were doing in the Trust and advised that the Treatment Escalation Plan (TEP) was a key quality improvement strategy for 2019/20 and structured judgement reviews for departmental mortality monitoring would also be introduced. The Board noted the update on implementation of the 'Learning from Deaths' national framework and supported the next steps in the process. It also agreed to support the introduction of the Medical Examiner system from April 2019. The Board also took assurance that the Trust had robust processes for assessing deaths and from learning any lessons that arise from them. In addition, it noted the need for divisional teams to use this report to take learning back to their services. Finally, the Board noted the specialty areas where mortality signals are present.	
2.5	**Transformation Q3 Update**	
	The DDET introduced the report which provided the regular update to Board on the progress and impact of transformation work across the Trust. Overall, progress remained on track but there still remained some IT and operational capacity issues. The Board was asked to note that the Model Hospital information suite had been refreshed and that the Trust's Emergency Department had moved from being in the most expensive quartile nationally for cost of service delivery in 2016-17 to being in the best quartile in 2017/18. The DDET advised that performance in the Outpatients virtual clinic had declined. With regards to planned care, the	

	two-way text message reminders had increased to 400 per day. Stephen Collier asked for clarity regarding the information set out in paragraph 2.14 of the report relating to the Urgent Treatment Centre at Queen Mary Hospital. The DDET responded that there would be very minimal migration and the focus was on activity growth. The DDET pointed that the Trust had originaly been overly ambitious in setting its objectives but it now had the right level of ambition to enable the Trust to meet performance. The Board noted the report.	
FINANCE		
3.1	**Finance and Investment Committee Report**	
	Ann Beasley, Chair of the Committee, introduced the report which provided an update on the Committee's meeting held on 24 January 2019. The Committee had considered finance, IT and estates risks. In relation to capital investment, the Committee had agreed that the lack of progress in securing additional capital funding should be raised with NHS Improvement at the next Provider Oversight meeting. The Committee heard that there had been improvement in mitigating risks relating to data quality and risks associated with ongoing work to become compliant with the new data protection legislation, including GDPR. The Committee had asked that more work be done to keep the risk list in "real time" and that some of the emerging risks be added for consideration. It also asked for greater consistency in the presentation of risks to the Committee. AnnBeasley explained that the DEF had presented a paper on Dalby Ward and the Committee had welcomed the improved environment and agreed to undertake a post project evaluation in six months. In relation to emergency flow, Ann Beasley commented that the Trust should be mindful that there had been a significant increase in demand compared with the previous year which needed to be considered when reflecting on current performance levels. The Committee had heard that the procurement department had achieved a Level 1 status and it was one of the four in London and the first in South West London to be recognised in this way. The Committee also noted that cash continued to be well managed. The CN advised that NHS Improvement had requested more information on water quality and the response would be sent on 1 February 2019. With regards to the progress made on the emergency capital bid and the capital and cash scenarios, the Chairman expressed concern at the ongoing delays with the potential for reorganisation at national level to impact on the timescales for deciding on the bid. The CFO advised that there were significant national capital pressures and the Trust could not rely on the bid alone and needed to find alternative ways to resolve the capital issues. The Board noted the report .	
3.2	**Month 9 Finance Report**	

	The CFO informed the Board that the Trust was reporting a pre-PSF (provider Sustainability Fund) deficit of £44.1m at the end of December 2018, which was £17.7m adverse to plan. Within this position, income was £10m adverse to plan and expenditure was overspent by £7.7m. The Trust had planned to deliver £34.2m of CIPs by the end of December 2018 and, to date, £31.1m had been delivered, which was £3.1 behind plan. Capital expenditure of £19.7m had been incurred year to date and this was £1.5m above plan. At the end of Month 9, the Trust's cash balance was £3.1m which was better than plan by £0.1m. The Trust had secured a loan of £5.6m for January and requested £7.1m for February. It had also submitted an emergency capital bid to NHS Improvement which was currently being considered. Sir Norman Williams asked what proportion of the deficit cardiac surgery contributed and the CFO advised that the bulk of the deficit related to loss of income resulting from lower than planned activity. The Chairman expressed concern at the ongoing low levels of activity and said that making improvements for the balance of the year would be important for the outturn position at year end. The CFO added that the Trust was continuing to protect the elective flow. The Board noted the Trust's financial performance at Month 9 2018/19.	
STRATEGY		
4.1	**Clinical Strategy Highlight Report**	
	The DS introduced the report which provided an update on progress in developing the Trust's new clinical strategy. All actions committed to were on plan as of January 2019 and the remaining Board workshops for the development of the strategy had been scheduled. The plan was to bring the draft strategy to the Board for consideration and approval in March 2019 and to launch the strategy shortly thereafter. The DS advised that she had met with the Merton locality leads and was engaging with General Practitioners. The Board noted the progress in developing the clinical strategy and noted the identified issues and risks.	
4.2	**Corporate objectives 2018/19 Q3 Report**	
	The DS presented the quarterly update report on progress in delivering the Corporate Objectives 2018/19. Twelve objectives had been rated green, 11 amber, and 15 red. A total of 11 objectives had no applicable milestones for Q3. Oveall, the position at the end of Q3 was a deterioration on Q2, when 19 objectives had been rated green, 17 amber and 9 red. Sarah Wilton observed that it was a concern that the position had deteriorated with so many objectives not achieved according to the plan. The Chairman asked that the CEO for her reflections. The CEO explained that there were lessons that would be taken from 2018/19 in framing the objectives for the following year. On reflection, the Trust had set too many objectives but there was a question as to whether they were pitched at the right level and dealt with the transformational goals the Trust was committed to delivering. For next year, the business as usual items will be removed so that focus was on the strategic objectives. Priorities would be cascaded to the divisions and quarterly progress would be reported to the Trust Executive Committee. **The Chairman asked for that the Board workshop on the Premisis Assurance Model be arranged before April 2019**.	**TB.31.01.2019/3** **DEF & DCA**
GOVERNANCE		

5.1	**Audit Committee Report**	
	Sarah Wilton introduced the report which provided a summary of the key issues discussed and agreed by the Audit Committee at its meeting on 10 January 2019. The Committee had held a busy meeting and the report reflected the volume of items considered. There continued to be progress in reducing the number of overdue internal audit actions and the new arrangements by which these were reviewed by the Trust Executive Committee were working well. Currently, there were six overdue actions, with a further 54 actions not yet due. Eight internal audit reports had been completed since the previous meeting and were considered by the Committee. Two of these had received substantial assurance (Core Financial Systems; Cancer Pathway), three had received reasonable assurance (CIP delivery; Elective Care Recovery Programme; and Complaints), and three had received limited assurance (Friends and Family Test; Cyber Security; and Clinical Systems not supported by Central IT). The Committee had been assured with the levels of assurance achieved, particularly in comparison with previous years. In response to the internal audit on Freedom to Speak Up (FTSU), which had received limited assurance, the policy would be reviewd and updated to ensure that there was one comprehensive policy that addressed both FTSU and whistleblowing. The Committee had considered the internal audit plan for 2019/20 and endorsed this, noting that the plan would be further refined by the Trust Executive Committee, with a final version presented to the Committee in April 2019. The plan for the Annual report and accounts 2018/19 and timetable for production were considered and a draft report would be presented in April. The plan from the external auditors had been recommended to the Board. It was noted that the Quality and Safety Committee had asked for assurance on the content of learning from clinical audits. It was also reported that the Standing Orders, Scheme of Delegation and Standing Financial Instructions remained sufficiently robust but a more comprehensive review would be completed by July 2019. Two areas had been identified in the review of Audit Committee effectiveness and plans for each issue would be presented to the Committee for consideration. In relation to the FTSU internal audit, the Chairman emphasised the importance of having robust processes for staff raising concerns and that it was important staff knew how to raise concerns. The DHROD agreed and advised that a review of the policy would be completed by end of March 2019 and be presented to the Audit Committee in April. This would include clarification of the ownership of FTSU at Executive level, support to the designated Non-Executive Director, and routes for raising concerns. The Board noted the report and agreed the annual audit plan by the Trust's external auditor, and associated audit fees, on the recommendation of the Audit Committee.	
5.2	**Board Assurance Framework (BAF) Q3 Report**	
	The CN presented the quarter 3 report on the Board Assurance Framework and advised that the assurance ratings for the risks related to Workforce and Education Committee were not available as the Committee was not due to meet until 7 February 2019. It was noted that the risk score for Strategic Risk 8 had increased from 10 to 12 following the Board's request to the Workforce and Education Committee review the score. There was a discussion about Strategic Risk 2 and it was noted that the	

	Quality and Safety Committee had considered this and had concluded that while there was significant assurance on the controls managing risks to date, quality specifically related to referral to treatment. The Committee considered that it needed to see sustained performance for timely treatment and that the risk score should remain unchanged until that point. The Chairman asked whether Strategic Risk 4 should be scored at a higher level given the emerging risks in the external environment, particularly relating to the South West London Health and Care Partnership. Further consideration would be given to this and would be brought back through the Quality and Safety Committee, and any changes brought back to Board in the next quarterly report. The CN also noted that the Board had considered the effectiveness of the BAF at a Board workshop on 17 January 2019 and the strategic risks would be refreshed for 2019/20. For the 14 risks assigned to Board sub-Committees, the Board noted the risk scores, assurance ratings and statements from the respective Committees. For the three strategic risks reserved to the Board, the Board noted the risk rating, agreed the proposed assurance rating and agreed the proposed assurance statements. The Board also noted that **further consideration would be given to the risk score relating to the partnership aspects of Strategic Risk 4 and that this would be brought back to Board through the Quality and Safety Committee and the next quarterly report to Board**.	**TB.31.01.2019/4** **CN**
5.3	**Emergency preparedness Resilience and Response (EPRR) - Annual EPRR Assurance submissions to NHS England (London)**	
	The COO presented the report and advised that the Trust had achieved partial compliance with the EPRR core standards, with 11 areas not compliant. There was an action plan in place to achieve full compliance. Ann Beasley commented that some of the dates in the action plan were set quite far into the future (with some not due until August 2019) and asked whether, given the significance of the work, these should be brought forward. The COO responded that the Business Continuity plan was being revised on a shorter timescale, particularly with a view to contingency planning for the UK's withdrawal from the EU. The Board noted the report and that the Trust achieved partial compliance with the EPRR Core Standards and that the Trust had developed an action plan to achieve full compliance.	
CLOSING ADMINISTRATION		
6.1	**Questions from the Public**	
	The Chairman invited questions from the public and noted that a question had been submitted in advance by Lord Armstrong of Illminster, which asked the Chairman to state whether she or any members of the Board "knew that Dr. Simon Haynes was the clinical director of cardiothoracic services at Freeman Hospital, Newcastle, who "slightly hesitantly" agreed to let Mr. Sukumaran Nair carry out the fatal robotic mitral valve replacement, when he was appointed co-author of the Bewick Review in response to the NICOR alert covering the period from 2014 to 2017 when Mr. Nair was a locum at St. George's". In response, the Chairman stated that certain Executive members of the Board were aware that Professor Bewick had appointed Dr Haynes to assist him. These included the Chief Executive, the Acting Medical Director and the Director of Human Resources. She added that Professor Bewick had led the review, and the Trust's contract for undertaking the review was with Professor Bewick. Professor Bewick was recommended to the Trust by NHS Improvement and had significant experience of conducting similar reviews at other NHS	

Trusts, as well as being a former Deputy Medical Director at NHS England. The Chairman explained that Professor Bewick appointed Dr Simon Haynes to assist him with the review and Dr Haynes' role was discussed at that time with NHS Improvement. Dr Haynes had a successful track record of leading a cardiac unit from an underperforming to a high quality service, and Professor Bewick considered him to be "an outstanding clinician with a practical and pragmatic view of the service". Professor Bewick was aware of Dr Haynes' position at Newcastle and any potential conflicts of interest were considered. In his view, the robotic procedure undertaken in Newcastle had no bearing on Dr Haynes' impartiality or ability to critique the service at St George's, which was principally focused on providing insight into cardiac surgery data. The Chairman asked that the answer be sent to Lord Armstrong given that he had been unable to attend the meeting.

A member of the public asked further questions about cardiac surgery, stating that she had been dissatisfied with responses given to her questions at previous Board meetings:

- In response to the first question regarding the distinction made between an "exclusion" and a "suspension" of a medical practitioner, the DHROD explained that this was an important distinction. Only the General Medical Council had the power to suspend a practitioner from the medical register, pending a hearing of their case or as an outcome of the fitness to practise hearing. An employing Trust has no such power and cannot suspend a doctor. The DHROD further stated that an exclusion of a medical practitioner from the workplace was a temporary and precautionary measure and not a disciplinary sanction. It was used only as an interim measure while action to resolve a problem is being considered. As such, exclusions could not be permanent. National guidance made this distinction explicit, and it was important to be clear about the actions that were and were not taken.

- In relation to a second question regarding lost income and activity to the Trust during the mediation involving members of the cardiac surgery unit in December 2017, the COO explained that there was sufficient cover to provide a full emergency service to fulfil St George's status as a trauma centre. He explained that it was routine for surgery scheduling to take into consideration time for team development and that all patients scheduled to have an operation were treated, so there was no lost activity or income. In response to the question about the cost per case of cardiac surgery, the COO explained that the income for each procedure depended on the specific procedure each patient received and it was not possible to provide a generalised figure of cost per case.

- In response to the question about the CQC report on cardiac surgery and the steps that had been taken to address the issues around leadership and managerial oversight, the Chairman stated that she could not add to the answers previously given. The CQC report had identified a number of problems with the service and highlighted a range of improvements that were necessary and which the Trust was addressing with the assistance of NHS Improvement. The problems within the cardiac surgery unit were longstanding, and dated back at least a decade. An entirely new Board and new Executive team were in place. A restructuring of

	clinical divisions had been undertaken. The Trust had appointed Steve Livesey to the position of Associate Medical Dircetor for cardiac surgery and this had already led to significant improvements in the service and a focused review of clinical governance across the Trust is currently being undertaken by the new Chief Medical Officer, with the support of NHS Improvement, to ensure that we have the right structures, systems and processes in place to identify issues at an early stage and learn from these. The Chairman stated that where the review identified that changes needed to be made, those changes would be implemented at pace. Another member of the public asked whether deaths in radiology related to contrast. The CMO advised that he would respond to this question outside of the meeting as he did not have the relevant information to hand.	
6.2	**Any new risks or issues identified**	
	There were no new risks or issues to note.	
6.3	**Any Other Business**	
	No other business was identified.	
CLOSING ADMINISTRATION		
6.4	**Reflection on meeting**	
	The Chairman invited Sarah Wilton, Non-Executive Director to lead reflections on the meeting. Sarah Wilton commended the quality of the Board papers received and that they had been received in good time. She asked to know where all the points raised from Board visits were recorded and emphasised the importance to staff of deomstrating that matters raised were acted on. She commented that while there had been good discussions, the Board also needed to reflect on whether it was focusing on the same issues at each meeting without moving those issues forward. The CEO noted the need to strike a balance between the role of the Board seeking assurance, maintaining strategic oversight and developing organisational culture. Ann Beasley commented that while there undoubtedly remain significant challenges for the Board to address, it was also important to take stock and reflect on the improvements made to date; the Board should celebrate these. Sir Norman observed that few of the staff he had spoken to that morning knew what was discussed at Board and asked what more could be done to promote the Board's visibility. The CEO explained that updates from the Board were communicated via her weekly newsletter to staff. The Trust's monthly senior leaders meeting also had a dedicated slot for updating managers at Band 8 upwards on the outcomes of Board meetings, and it was expected that the issues discussed were cascaded to staff at team meetings. In response to Sarah Wilton's question regardinging Board visit actions, te DCA advised that it had been agreed in the past that actions for Board walkabouts are logged by the Trust Secretariat team and a report would be presented on a quarterly basis, with the next report due in February 2019. The DCA also stated that the Trust's annual report, the preparation of which would shortly get underway, provided an opportunity to highlight areas of progress and improvement across the Trust, though it was key that this was disseminated through a variety of channels and his team were looking at this.	
PATIENT STORY		

The patient story was presented by Elizabeth Lyle, Occupational Therapist and Carolyn Romer, Consultant Midwife in Maternal Medicine and it focused on “Getting over the bump”, a joint service provided for Disability Pregnancy Parenting. A gap in service had been recognised as increasingly people with learning disabilities, physical impairments and chronic health problems were using maternity services and much more work was needed to provide high quality individualised care to disabled women. The Board heard two recorded patient stories. The first story was that of a patient who had suffered a stroke. She expreseed her thoughts before pregnancy, the difficulties she thought she would face in caring for the baby and risks to herself and to the baby. The team advised her on the equipment she could use as aids when bathing the baby and the type of car seat she could use in order to make her independent. The second story involved a patient who was a wheelchair user with spina bifida. She was very complimentary about the service. She had a positive experience during her pregnancy as she had equipment in place such as the board and bath chair during the last few months of her pregnancy. The Team had also managed to link the second patient with other teams in the community for support. Kyra Hamilton, Occupational Therapist, highlighted the service provision challenges particularly in terms of limited resources. The CEO asked about the extent to which commissioners were supportive of the service and what discussions had taken place with them about funding. The team advised that they were moving ahead on a journey to acquire some funding. The CMO commended the project and good working relationship from different specialty areas. The DHROD advised that a new group on disability had recently been established as part of the Trust’s work on dioversity and inclusion. He encouraged the presenters to get involved in its work so that the group could benefit from their experience.	

Date of next meeting: Thursday 28 February 2019 at St George’s Hospital

Trust Board Action Log Part 1 - January 2019

Action Ref	Section	Action	Due	Lead	Commentary	Status
TB 31.01.2019/01	**CEO Update**	The CFO agreed bring a paper to the February Board with an update on the Trust's work on planning for the UK's withdrawal from the EU	28.02.2019	**CFO**	On agenda	**PROPOSED FOR CLOSURE**
TB.31.01.2019/02	**CEO Update**	The DHROD agreed to bring a report on the WRES to the February Board.	28.02.2019	**DHROD**	On agenda	**PROPOSED FOR CLOSURE**
TB 31.01.2019/03	**Corporate objectives**	The Chairman asked for that the Board workshop on the Premesis Assurance Model be arranged before April 2019.	31.03.2019	**DEF / DCA**	Board workshop to be confirmed for 6/14 March 2019	**PROPOSED FOR CLOSURE**
TB 31.01.2019/03	**BAF**	Further consideration to be given to the risk score relating to the partnership aspects of Strategic Risk 4 and that this would be brought back to Board through the Quality and Safety Committee and the next quarterly report to Board	25.04.2019	**CN**	Not yet due	**OPEN**

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	28 February 2019	**Agenda No**	**2.2**
Report Title:	**Integrated Quality and Performance Report**		
Lead Director/ Manager:	**James Friend Director of Delivery, Efficiency & Transformation**		
Report Author:	Emma Hedges & Kaye Glover		
Presented for:	Information and assurance		
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, including a reduction in patient's length of stay, continued positive recommendation rate through Friends and Family survey from our inpatients, and re-booking offers to all of our patients within 28 days who had an on the day cancellation. However existing challenges continue in particular Four Hour Operating Standard and patient flow. The Trust has maintained compliance against the Diagnostic access target and achieved seven of the eight Cancer.		
Recommendation:	The Board is requested to note the report		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
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 based on the assessment of the Regulator NHS Improvement		
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Previously Considered by:	Finance and Investment Committee	**Date**	21/02/19
Equality Impact Assessment:	N/A		
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Meeting Date – 28 February 2019
Reporting period – January 2019

Balanced Scorecard Approach

St George's University Hospitals NHS
NHS Foundation Trust

OUTSTANDING CARE, EVERY TIME

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE & PRODUCTIVITY** PERSPECTIVE	Activity Summary	Bed productivity (length of stay)	Outpatient productivity (Attendances per day)	Theatre productivity (cases per session)		
OUR **PATIENT** PERSPECTIVE	Patient safety	Infection Control	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations		
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use				

St George's University Hospitals NHS
NHS Foundation Trust

HOW ARE WE DOING?

January 2019

Daycase and Elective Surgery operations

Actual
4,870

Target 5,442

Discharges before 11am

Actual 18%

Target 30%

Four Hour Emergency Standard

Actual
84.15%

Target 95%

Whole Trust Inpatient Friends and Family Test

Actual
96%

Target
95%

Outpatient First Appointment

Actual 17,766

Target 17,616

Better data, safer patients

Outpatients appointments with RTT outcome recorded

Actual
92%

Target
88%

Activity Summary

St George's University Hospitals NHS
NHS Foundation Trust

The table below compares activity to previous months and year to date 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	
		Jan-18	Jan-19	Variance	Plan Jan-19	Variance	YTD 17/18	YTD 18/19	Variance	Plan YTD	Variance
ED	ED Attendances	13,646	14,636	7.25%	14,400	1.64%	138,441	140,552	1.52%	142,133	-1.11%
Inpatient	Elective & Daycase	4,459	4,870	9.22%	5,442	-10.51%	45,436	48,168	6.01%	50,603	-4.81%
	Non Elective	3,973	4,225	6.34%	4,401	-4.00%	38,984	40,188	3.09%	42,174	-4.71%
Outpatient	OP Attendances	56,830	57,595	1.35%	59,077	-2.51%	533,395	558,315	4.67%	554,641	0.66%

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

Source: SLAM

Executive Summary – January 2019

St George's University Hospitals NHS
NHS Foundation Trust

Our Outcomes

- The area of greatest delivery challenge to the Trust remains around Emergency Flow where lower than anticipated discharges before Christmas have led to increased bed occupancy and over congestion of the Emergency Department. Whilst safety has been maintained, physical access to areas for patient assessment and treatment have been constrained.

Finance and Productivity

- Elective and Daycase activity is currently showing below plan year to date however there will be a level of post month data catch up. Daycase activity year to date continues to be above plan by 2%. Cases per session are below previous highs in Cardiothoracic, Oral & Maxillofacial Surgery however as a Trust above the same period last year. Theatre touchtime utilisation is tracked weekly and is currently performing at 79% against the 85% threshold targeted. The number of daycase procedures per working day has seen a positive increase compared to the same period last year, treating on average seventeen more patients per working day.

Our Patients

- The Trust reported two patients with attributable Clostridium Difficile infection in January, against an annual target set at 30 cases in 2018/19. The Trust is reporting twenty-seven cases year to date and is above the threshold trajectory for the period between April 2018 and January 2019.

Process

- Performance against the Four Hour Operating Standard in January was 84.2%, which was below the monthly improvement trajectory of 90%. The improvement trajectory requires the delivery of 90% performance in February 2019 and relies upon continued improvement in the experience for patients not requiring admission.
- The Trust achieved six of the seven national mandated cancer standards in the month of December, continuing to achieve 14 day standard and the 62 day standard.
- Focus remains on reducing on the day non clinical cancellations and ensuring that all patients are rebooked within 28 days, in January all of our cancelled patients were re-booked within 28 days.

Our People

- The Trust Vacancy rate threshold has been achieved in the month of January reporting 9.4% against a target of 10%
- Staff sickness remains above the trust target of 3% and has seen an increase in the month of January reporting 4.3%.
- Non-medical appraisal rates remain below target in January with a performance of 70.9% against a 90% target.
- For January the Trust's total pay was £43.32m. This is £1.34m adverse to a plan of £41.97m

Length of Stay

Non Elective Length of Stay (General and Acute Beds)

Directorate	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Discharges in the last month	Average length of Stay 2017-18	Average length of Stay 2018-19	Variance	Trend
Acute Medicine	3.4	3.5	2.8	2.9	2.7	2.6	2.7	2.6	2.6	2.5	2.5	2.7	3.1	2,736	3.0	2.7	-0.31	
Cardiothoracic	9.4	8.3	9.0	9.0	8.7	7.8	8.5	8.9	8.6	8.8	7.7	8.8	7.2	317	8.8	8.4	-0.37	
Childrens & Women	2.7	2.7	2.5	2.5	2.5	2.4	2.5	2.4	2.4	2.3	2.4	2.4	2.3	1,815	3.5	2.4	-1.12	
Neurosciences	9.4	8.7	10.6	8.9	10.6	11.6	9.4	9.6	6.6	8.8	9.6	9.8	9.1	258	9.4	9.4	-0.03	
Senior Health	9.9	9.3	8.4	11.3	10.2	11.8	7.4	12.0	7.8	7.6	8.7	11.4	11.4	61	11.5	10.0	-1.55	
Specialist Medicine	7.7	9.7	7.6	6.1	9.3	7.3	6.4	8.7	6.8	6.4	7.6	7.5	8.6	232	7.7	7.5	-0.28	
Surgery & Trauma	4.8	5.0	4.3	4.6	4.0	4.6	3.7	5.0	4.4	4.6	5.1	4.2	4.7	929	4.5	4.5	-0.01	
Therapeutics	6.1	7.5	13.2	9.8	9.8	3.6	19.2	8.3	15.7	12.0	9.8	21.1	25.5	20	11.8	13.5	1.71	
Grand Total	**4.3**	**4.4**	**4.0**	**4.0**	**3.9**	**3.9**	**3.7**	**4.0**	**3.6**	**3.6**	**3.7**	**3.8**	**3.9**	**6,368**	**4.5**	**3.8**	-0.65	

Briefing

- The non elective length of stay data is based on the patient's discharge date from the hospital.
- Over the last twelve months patients admitted to the hospital via an emergency pathway spend on average 3.9 days in a hospital bed, this includes patients with a zero length of stay. At Trust level this remains in line with National Model Hospital data.
- In the month of January Acute Medicine and Senior Health have seen a further increase in patient length of stay, however, compared to the previous year the Trust has seen an overall reduction across all directorates improving bed workflow and reducing the number of patients waiting for a hospital bed to become available from the Emergency Department.
- The implementation of a fully embedded ambulatory care unit within Acute medicine continues to enable rapid access to same day assessment, diagnostics and treatment and increased usage of the discharge lounge which has seen a 5% increase in throughput compared to December 2017 as well as a positive reduction in the number of Delayed Transfers of Care declared.

Actions

- The Emergency Department and Inpatient Clinical teams have identified a range of patient experience, quality and productivity opportunities to evolve the process embedded within iClip and these need to be the immediate priority
- One off clinical capacity is required to return the stranded patient volumes to levels where there is confidence that patients are being enabled to leave hospital in a timely manner and others admitted likewise.

Length of Stay

Elective Length of Stay (Excluding Daycase)

															Average length of Stay			
Directorate	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Discharges in the last month	2017-18	2018-19	Variance	Trend
Cardiothoracic	4.5	4.2	4.8	4.1	4.0	4.4	4.1	4.4	2.9	3.8	3.3	3.7	3.5	188	4.6	3.8	-0.76	
Childrens & Women	2.8	2.0	2.1	2.3	3.2	2.7	2.2	2.1	3.1	2.5	2.4	2.1	3.8	83	2.7	2.6	-0.07	
Neurosciences	11.9	7.8	12.7	8.7	7.3	12.8	7.1	8.9	10.0	8.0	9.3	10.6	10.3	169	10.1	9.3	-0.78	
Surgery & Trauma	4.4	3.1	3.2	3.8	4.1	3.7	3.3	4.3	3.4	3.7	3.5	4.6	4.4	383	3.9	3.9	-0.05	
Grand Total	**5.7**	**4.1**	**5.2**	**4.6**	**4.6**	**5.5**	**4.1**	**4.8**	**4.7**	**4.4**	**4.6**	**5.3**	**5.4**	**823**	**5.1**	**4.8**	-0.26	

Briefing

- Over the last twelve months patients admitted to the hospital via an elective pathway spend on average 4.8 days in a hospital bed, a reduction in length of stay has been observed compared to the previous years meaning patients can be discharged home earlier following their procedure, however an increase in length of stay has been seen in December 18 and January 19.
- The Trust has observed significant improvement within Neurosciences compared to last year reducing the length of stay of our planned patients by one day.
- Latest Model Hospital data indicates that around four beds of capacity could be released at any one time were the Trust to match peer group Daycase rates, with 1,200 fewer patients needing to stay in hospital overnight each year.
- The Theatres Teams are also working to ensure that patients with increased likelihood of being able to go home on the day of their operation are placed at the start of the Theatre list to maximise the probability that they do not need to be admitted

St George's University Hospitals NHS
NHS Foundation Trust

Outpatient Productivity

First Outpatient Attendances (average per working day)

Directorate	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	First Outpatient Attendances per working day 2017-18	2018-19	Variance	Trend
Cardiology, Cardiothoracic & Vascular Services	65	59	60	59	62	66	57	54	58	59	67	51	57	66	59	-10.7%	
Childrens Services	50	47	40	41	50	49	42	42	50	45	51	38	48	47	46	-1.8%	
Neuro	91	85	86	87	83	83	73	67	81	84	88	74	90	82	81	-1.4%	
Renal & Oncology	23	24	22	25	27	30	24	25	23	27	28	23	26	23	26	10.0%	
Specialist Medicine	151	152	148	139	153	157	142	129	144	142	150	126	146	144	143	-1.0%	
Surgery	249	248	245	265	271	300	264	253	270	279	275	257	267	256	270	5.4%	
Womens Services	81	74	69	82	85	92	89	85	89	86	90	78	85	80	86	8.2%	
T&O	51	47	54	55	56	60	62	50	55	52	55	48	53	50	55	8.6%	
Other	33	35	32	37	38	43	38	34	36	37	34	36	36	32	37	15.8%	
Total	**794**	**771**	**756**	**790**	**827**	**880**	**791**	**737**	**805**	**812**	**838**	**731**	**808**	**780**	**802**	2.8%	

Follow Up Outpatient Attendances (average per working day)

Directorate	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	FollowUp Outpatient Attendances per working day 2017-18	2018-19	Variance	Trend
Cardiothoracic & Vascular Services	119	107	98	121	116	113	107	100	117	107	124	104	103	110	111	0.8%	
Childrens Services	82	81	70	72	81	73	77	76	87	81	90	73	74	78	78	0.0%	
Neuro	112	104	107	114	113	113	109	105	122	117	123	104	118	102	114	11.7%	
Renal & Oncology	206	197	191	205	217	228	229	219	248	245	243	229	235	209	230	10.1%	
Specialist Medicine	500	489	499	500	520	501	508	477	533	509	529	481	519	482	508	5.4%	
Surgery	361	346	332	354	374	357	349	336	357	352	362	331	368	351	354	0.8%	
Womens Services	65	61	46	50	58	52	64	58	78	69	76	64	64	53	63	19.9%	
T&O	79	73	76	84	81	82	86	77	82	85	93	76	85	80	83	3.6%	
Other	86	85	74	99	98	94	89	86	97	92	91	77	87	80	91	13.2%	
Total	**1,609**	**1,542**	**1,493**	**1,598**	**1,659**	**1,613**	**1,618**	**1,534**	**1,721**	**1,656**	**1,730**	**1,539**	**1,653**	**1,545**	**1,632**	5.6%	

Briefing

- Outpatient activity year to date is above plan by 0.7%, over performing in both First and Follow up appointments driven by Children's and Women's Division and Surgical Specialties.
- Across the Directorates, First Outpatient attendances averaged 808 per working day and is above the SLA target for the month. The RAG rating applied compares to the SLA plan per working day which saw an increase in activity compared to the same period last year.
- Follow-up attendances on average remain consistent however remains above plan, meaning that the new to follow up ratios are above where we need them to be against target. This is particularly seen within Diabetes, Respiratory, Rheumatology and General Surgery where the ration is above national average. Services are reviewing the recording of particular appointments as some will be classified as outpatient procedures.
- Activity data pre October 2017/18 has been removed due to the change of contract arrangements to ensure like for like comparison.

Actions

- Two way text reminder service being extended to 400 patients per day

Outpatient Productivity

First and Follow Up DNA Rates (by month)

Directorate	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	DNA patients in the last month	Patients not attending rate 2017-18	Patients not attending rate 2018-19	Variance	Trend
Cardiothoracic & Vascular Services	9.9%	9.3%	10.3%	10.8%	10.2%	9.4%	12.2%	10.2%	9.4%	11.5%	10.9%	10.5%	10.9%	303	8.8%	10.6%	⇧ 1.8%	
Childrens Services	11.5%	12.4%	13.3%	16.0%	14.1%	12.9%	14.2%	13.1%	10.0%	11.3%	10.1%	10.9%	10.9%	327	10.4%	12.3%	⇧ 1.9%	
Neuro	9.3%	9.7%	9.2%	10.8%	10.9%	8.5%	9.5%	9.4%	10.0%	10.6%	9.6%	10.2%	10.3%	448	8.4%	10.0%	⇧ 1.6%	
Renal & Oncology	11.8%	11.2%	10.6%	10.6%	11.0%	8.1%	11.1%	11.0%	10.5%	10.4%	11.0%	10.2%	9.7%	338	10.8%	10.4%	⇩ -0.4%	
Specialist Medicine	12.3%	12.7%	11.7%	14.3%	13.1%	11.3%	11.4%	11.8%	11.6%	12.6%	13.1%	11.5%	12.3%	1,599	13.0%	12.3%	⇩ -0.7%	
Surgery	10.3%	10.1%	10.7%	12.1%	11.7%	9.0%	10.9%	10.9%	10.2%	12.1%	11.6%	10.8%	10.4%	1,376	10.9%	11.0%	⇧ 0.1%	
Womens Services	7.9%	7.2%	8.4%	8.6%	8.7%	7.3%	8.4%	9.8%	8.2%	8.7%	8.2%	7.4%	6.6%	470	9.9%	8.2%	⇩ -1.7%	
T&O	12.0%	12.6%	12.0%	11.8%	13.7%	8.4%	9.2%	11.0%	10.7%	10.4%	11.6%	10.9%	10.6%	352	9.3%	10.8%	⇧ 1.5%	
Other	10.6%	11.5%	14.0%	10.0%	9.5%	11.6%	12.9%	13.8%	12.5%	14.4%	15.4%	14.2%	12.9%	1,094	10.0%	12.7%	⇧ 2.7%	
Total	11.1%	11.2%	11.5%	12.6%	12.0%	10.1%	10.9%	11.3%	10.6%	10.5%	10.5%	10.9%	10.8%	6,307	10.2%	11.0%	⇧ 0.8%	

First and Follow Up Ratio

Directorate	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	First to FollowUp Ratio 2017-18	First to FollowUp Ratio 2018-19	Variance	Trend
Cardiothoracic & Vascular Services	1.84	1.80	1.63	2.06	1.87	1.72	1.86	1.85	2.01	1.81	1.85	2.04	1.81	1.68	1.89	⇧ 12.4%	
Childrens Services	1.65	1.74	1.76	1.75	1.60	1.47	1.86	1.82	1.74	1.80	1.77	1.89	1.53	1.69	1.72	⇧ 2.1%	
Neuro	1.24	1.23	1.24	1.31	1.36	1.36	1.49	1.57	1.51	1.39	1.40	1.40	1.31	1.24	1.41	⇧ 13.5%	
Renal & Oncology	8.77	8.07	8.67	8.38	8.08	7.64	9.75	8.89	10.77	9.08	8.68	10.13	9.17	9.02	9.06	⇧ 0.4%	
Specialist Medicine	3.30	3.22	3.38	3.60	3.40	3.19	3.59	3.71	3.70	3.58	3.53	3.81	3.57	3.35	3.57	⇧ 6.6%	
Surgery	1.45	1.40	1.35	1.34	1.38	1.19	1.32	1.33	1.32	1.26	1.32	1.29	1.38	1.37	1.31	⇩ -4.3%	
Womens Services	0.80	0.82	0.67	0.61	0.68	0.56	0.72	0.69	0.88	0.80	0.84	0.82	0.75	0.67	0.73	⇧ 10.4%	
T&O	1.56	1.56	1.40	1.51	1.44	1.38	1.38	1.55	1.49	1.63	1.69	1.59	1.60	1.60	1.52	⇩ -5.0%	
Other	2.60	2.40	2.33	2.64	2.54	2.20	2.31	2.52	2.70	2.49	2.69	2.16	2.43	2.52	2.47	⇩ -2.1%	
Total	**2.03**	**2.00**	**1.98**	**2.02**	**2.01**	**1.83**	**2.04**	**2.08**	**2.14**	**2.04**	**2.06**	**2.10**	**2.05**	**1.98**	**2.04**	⇧ 2.9%	

Briefing

- Netcall text reminder was substantially expanded in June for one way appointment reminder text messaging. A two way text reminder service was launched in late December initially for dermatology and plastic but has been expanded to include Clinical Haematology, ENT and Audiology.
- Compared to the previous year the Trust is seeing an increase in patients not attending their outpatient appointments with a number of services above threshold. For the month of January 11% of patients did not attend, this on average is 290 patients per working day.

Actions

- One way text reminders are fully live and two way is now being piloted

Theatre – Touch Time Utilisation

Theatre Utilisation

Main List Specialty	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Number of Patients in the last month
Cardiothoracic	69%	74%	64%	79%	81%	75%	74%	69%	70%	70%	73%	72%	72%	77
ENT	70%	75%	77%	75%	81%	77%	80%	84%	76%	77%	82%	78%	80%	163
General Surgery	79%	78%	77%	79%	78%	80%	82%	79%	82%	80%	82%	84%	77%	244
Gynaecology	88%	80%	82%	77%	77%	77%	83%	81%	77%	83%	87%	81%	79%	165
Neurosurgery	81%	77%	83%	76%	87%	80%	74%	84%	78%	76%	81%	80%	82%	181
Oral and Maxillo Facial Surgery	82%	76%	62%	58%	71%	73%	89%	75%	82%	63%	84%	78%	84%	30
Paediatric Dentistry	51%	46%	57%	62%	53%	50%	53%	58%	55%	56%	60%	62%	65%	46
Paediatric Surgery	79%	78%	74%	78%	82%	80%	81%	78%	75%	74%	72%	75%	76%	129
Plastic Surgery	68%	68%	69%	73%	74%	73%	77%	75%	75%	77%	74%	78%	74%	197
Renal Medicine & Surgery	77%	74%	79%	67%	76%	71%	72%	78%	61%	67%	82%	60%	66%	25
Trauma & Orthopaedics	82%	86%	80%	87%	76%	85%	84%	79%	82%	90%	85%	90%	81%	174
Urology	75%	79%	79%	77%	84%	78%	88%	84%	84%	85%	86%	81%	86%	209
Vascular Surgery	65%	75%	77%	77%	77%	76%	72%	68%	74%	76%	70%	74%	76%	54
Grand Total	**76%**	**77%**	**77%**	**77%**	**80%**	**78%**	**79%**	**79%**	**78%**	**79%**	**80%**	**80%**	**79%**	**1,694**

Theatre Average Cases per Session

Main List Specialty	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Trend
Cardiothoracic	1.6	1.5	1.5	1.6	1.6	1.8	1.8	1.5	1.3	1.4	1.5	1.5	1.5	
ENT	1.7	1.4	1.6	1.8	1.9	1.8	1.7	1.8	1.7	1.7	1.7	1.6	1.9	
General Surgery	1.7	1.8	1.9	1.9	1.9	1.8	1.8	1.7	1.7	1.8	1.7	1.6	1.8	
Gynaecology	2.3	1.9	2.5	2.4	2.3	2.3	2.7	2.6	2.5	2.6	2.5	2.9	2.7	
Neurosurgery	1.2	1.2	1.2	1.2	1.2	1.1	1.1	1.1	1.0	1.0	1.1	1.2	1.1	
Oral and Maxillo Facial Surgery	3.9	3.6	3.3	3.0	3.6	3.0	4.0	3.7	3.9	3.1	3.8	3.8	3.7	
Paediatric Dentistry	3.6	4.0	4.3	4.3	3.7	4.2	4.0	3.8	4.1	3.9	4.5	4.7	4.4	
Paediatric Surgery	2.5	2.6	2.7	2.4	2.6	2.4	2.6	2.6	2.7	2.6	2.7	2.7	2.6	
Plastic Surgery	2.0	1.9	2.2	2.2	2.0	2.0	2.0	2.2	2.2	2.1	2.0	2.0	1.9	
Renal Medicine & Surgery	1.5	1.8	1.3	1.8	1.5	1.7	1.4	1.4	1.3	1.6	1.5	1.4	1.2	
Trauma & Orthopaedics	1.7	1.8	1.5	1.6	1.4	1.6	1.6	1.5	1.6	1.9	1.9	1.8	1.9	
Urology	1.8	1.8	2.0	2.1	2.1	2.1	2.0	2.1	2.1	2.1	2.0	2.1	2.0	
Vascular Surgery	1.0	1.2	1.2	1.2	1.3	1.0	1.1	1.2	1.2	1.1	1.1	1.1	1.0	
Grand Total	**1.7**	**1.7**	**1.8**	**1.8**	**1.8**	**1.8**	**1.8**	**1.8**	**1.7**	**1.8**	**1.8**	**1.8**	**1.8**	

Briefing

Touchtime Utilisation on average for the past 12 months is at 79% against a targeted threshold of 85%. Work is on-going across all specialties to support an increase in utilisation and increase in theatre case bookings. Daily huddles are now in place to review booking targets with the patient pathway coordinators, this is having a positive impact reaching our target booking numbers and increasing Day Surgery Utilisation.

Actions

- Clinicians are reviewing their lists to verify patient order and appropriate case mix, this is linked to theatre team review identifying theatre equipment requirements, skill mix and specialist equipment to be ordered as required. A newly developed tool will be introduced to robustly look at the list planning process.
- Actions form the weekly list planning are reviewed and discussed which is further reviewed and supported by General Managers and services. All actions are reviewed in list planning the following week.
- Increase to baseline Patient Pathway Coordinator (PPC) numbers has been agreed for financial year 18/19 to provide additional bank support to the teams to streamline processes particularly around the pre-assessment pathway and build a pool of pre assessed patients.
- The booking teams (PPC) will commence using the Four Eyes Insight scheduling tool this will provide accurate activity planning information along with the ability to schedule lists at 95-105%.
- Daily Huddles with Pathway Coordinators have commenced reviewing daily booking targets and identifying on the day issues with services

St George's University Hospitals NHS
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Number of Elective Patients treated per Working Day

														Average No. of Patients per month			
Months	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**2017-18**	**2018-19**	**Variance**	**Discharges for month**
Cardiology & Cardiac Surgery	6.9	7.8	8.7	7.4	7.9	8.7	6.3	7.6	7.3	6.5	7.3	7.0	7.2	7.8	7.3	-7%	159
Clinical Haematology	0.5	0.3	0.8	0.7	0.5	0.7	0.6	0.7	0.7	0.4	0.7	0.9	0.5	0.6	0.6	10%	10
Endoscopy & General Medicine	0.7	0.6	0.4	0.9	0.5	1.2	0.4	0.5	1.0	0.5	0.6	0.7	0.7	0.6	0.7	15%	15
ENT	5.2	5.4	5.6	3.7	5.0	5.3	3.7	3.3	5.6	5.9	4.0	4.7	6.1	5.9	4.7	-20%	135
General Surgery	5.2	6.2	6.9	5.0	4.9	5.5	3.8	4.4	6.3	6.6	6.2	7.2	6.2	5.7	5.6	-2%	137
Gynae & Obstetrics	2.4	3.1	3.9	3.2	2.5	2.9	2.4	2.8	2.6	2.9	2.7	2.1	2.7	3.2	2.7	-16%	60
Max Fax & Dental	3.6	3.4	3.0	3.2	3.2	3.0	1.6	2.8	3.4	3.3	2.7	2.6	2.4	2.8	2.8	2%	52
Neuro Surgery	5.1	5.7	6.5	6.0	6.2	6.1	5.7	5.0	6.7	5.9	6.7	6.3	6.0	5.7	6.1	7%	132
Neurology	1.2	1.8	1.4	1.5	1.2	1.5	1.5	1.5	1.9	1.6	1.2	1.1	1.7	1.5	1.5	-3%	38
Oncology	0.2	0.6	0.6	1.0	0.8	0.7	0.8	0.8	0.6	0.7	0.5	0.4	0.9	1.0	0.7	-30%	19
Paediatric Medicine	0.6	0.6	0.5	1.6	0.8	1.2	0.4	1.9	0.4	0.7	0.7	0.3	0.7	0.8	0.9	5%	15
Paediatric Surgery	1.9	1.9	1.6	1.6	2.0	1.8	1.8	1.5	1.9	1.4	1.3	1.3	1.6	1.9	1.6	-16%	36
Plastic Surgery	5.1	5.9	6.4	5.0	5.6	4.8	2.3	2.0	4.1	3.4	3.9	3.1	3.9	6.1	3.8	-38%	86
Renal Medicine	0.8	1.1	1.0	1.1	1.1	1.6	1.0	1.1	1.1	1.0	1.0	0.7	0.4	1.2	1.0	-18%	8
Trauma & Orthopaedics	2.9	2.2	4.0	3.0	2.1	2.0	2.0	2.5	2.7	2.2	3.2	2.4	2.0	3.1	2.4	-22%	44
Urology	4.7	6.0	6.8	7.6	6.1	6.1	4.6	5.5	7.1	6.9	6.2	5.7	6.6	7.0	6.2	-10%	146
Vascular Surgery	2.7	3.9	3.7	3.2	3.4	2.8	2.5	2.8	2.7	2.6	2.3	1.7	2.2	2.8	2.6	-6%	47
Other	3.7	4.0	4.2	3.4	4.1	4.5	3.8	3.4	3.3	3.0	4.1	3.9	3.2	3.9	3.7	-6%	71
Grand Total	**53.6**	**60.1**	**66.0**	**58.5**	**58.0**	**60.5**	**45.2**	**50.2**	**58.9**	**55.5**	**55.2**	**52.2**	**55.1**	**61.5**	**54.9**	**-11%**	**1,212**

Briefing

- There has been a switch of activity from Elective Ordinary to Elective Daycase during 2018/19 of approximately twelve patients per day year on year.
- Theatres are ensuring that there is focused work supporting a prompt start to all theatre sessions this is linked to a weekly task and finish group, highlighting and unblocking issues for long term sustainability and change, the work from the task and finish group will be shared across all theatre services.

Actions

- Agreement and plan to change Theatreman Diagnosis codes (currently SNOMED) to OPCS 4.8 codes which will support more accurate timings of theatre cases and utilisation.
- Identified data quality issues with informatics team which will identify increased theatre utilisation
- SNTC Division finance has completed service specific one pagers in conjunction to identify actions required to support SLA achievement

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Number of Patient Daycases per Working Day

														Average No. of Patients per month			
Months	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**2017-18**	**2018-19**	**Variance**	**Discharges for month**
Cardiology & Cardiac Surgery	8.0	8.9	6.9	7.5	8.4	8.3	9.2	7.7	8.4	7.6	9.5	6.8	7.2	8.5	8.1	-5%	159
Clinical Haematology	1.5	2.4	2.1	1.1	1.6	1.5	1.1	0.7	1.5	1.3	0.7	0.9	0.5	1.6	1.1	-31%	12
Endoscopy	46.2	51.2	50.4	54.1	60.3	59.8	55.3	55.2	55.3	54.2	58.6	49.4	53.3	52.8	55.5	5%	1,172
ENT	2.3	2.6	1.8	2.5	3.9	3.3	5.3	4.5	3.4	3.6	3.9	2.3	3.0	3.1	3.6	13%	67
General Surgery	4.2	4.5	3.7	4.5	4.7	5.1	5.0	4.4	4.9	4.0	4.5	3.2	4.4	4.1	4.5	8%	97
Gynae & Obstetrics	7.4	7.1	7.2	6.7	7.0	7.4	9.0	7.8	7.7	8.6	8.5	6.7	8.4	7.1	7.8	10%	185
Max Fax & Dental	2.7	3.4	2.7	3.2	3.5	3.3	5.1	3.4	4.0	3.2	3.7	2.8	4.0	3.2	3.6	12%	88
Neuro Surgery	2.7	2.9	3.0	3.4	2.5	3.2	3.5	3.1	3.3	3.1	3.4	2.9	2.9	3.0	3.1	4%	64
Neurology	23.8	21.0	20.8	23.7	23.0	26.4	24.4	22.5	23.9	29.0	27.6	23.7	27.4	22.4	25.1	12%	602
Oncology	1.5	1.2	1.1	0.7	1.1	1.1	1.0	0.9	1.1	1.0	0.8	1.0	2.1	1.6	1.1	-31%	46
Paediatric Medicine	9.0	8.3	6.8	8.5	9.4	7.2	9.6	7.6	9.2	11.3	9.6	10.7	9.8	8.3	9.3	13%	215
Paediatric Surgery	6.3	6.9	7.1	6.9	6.0	6.8	6.5	7.1	8.0	7.9	9.4	7.1	7.6	6.8	7.3	7%	168
Plastic Surgery	8.0	8.8	8.2	11.2	13.1	12.9	15.1	17.2	14.7	13.4	14.5	12.8	9.5	7.8	13.4	72%	210
Renal Medicine	3.8	3.1	2.7	4.3	4.3	4.1	3.5	4.2	4.2	3.8	2.8	3.6	2.5	3.3	3.7	14%	56
Trauma & Orthopaedics	4.2	3.8	4.4	4.4	4.9	4.7	5.8	4.0	3.5	4.0	5.3	3.6	4.8	4.1	4.5	9%	106
Urology	5.7	4.5	3.7	4.1	5.1	7.1	8.4	6.1	6.3	7.9	7.8	7.1	6.4	4.8	6.6	37%	140
Vascular Surgery	2.3	2.4	2.3	2.2	2.6	1.5	2.3	1.6	2.0	2.6	2.3	2.6	2.6	2.2	2.2	1%	57
Other	8.2	9.3	9.0	8.8	11.3	10.5	10.5	9.8	9.2	9.5	12.5	10.5	9.7	7.9	10.2	29%	214
Grand Total	**149.1**	**153.5**	**144.8**	**159.4**	**175.1**	**175.9**	**182.1**	**169.6**	**172.3**	**177.8**	**185.4**	**157.8**	**166.3**	**154.2**	**172.2**	**12%**	**3,658**

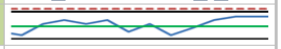
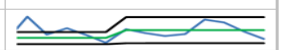
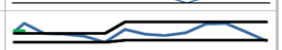
Briefing

- The number of daycase procedures per working day has seen an 11% increase compared to the same period last year, treating on average seventeen more patients per working.
- January data is showing that activity was below plan however this is expected to increase once coding has been completed.

Actions

- Bespoke scheduling manuals for Day Surgery Unit services to support activity will be rolled out to inpatient services as phase 2

Patient Safety

Indicator Description	Target	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Trend (12 months)
Number of Never Events in Month	0	1	0	2	1	0	0	0	0	0	2	0	0	1	
Number of SIs where Medication is a significant factor	0	0	0	1	0	0	0	0	0	0	1	1	0	0	
Number of Serious Incidents	8 / mth	1	4	5	4	5	2	4	1	3	5	6	6	6	
Serious Incidents - per 1000 bed days	N/A	0.04	0.18	0.19	0.17	0.21	0.09	0.17	0.04	0.13	0.20	0.26	0.26	0.25	
Safety Thermometer - % of patients with harm free care (all harm)	95%	94.9%	94.8%	94.3%	93.1%	95.3%	96.5%	94.9%	95.7%	96.3%	95.1%	95.0%	95.6%	95.9%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	98.9%	97.9%	98.5%	97.8%	98.0%	98.7%	98.5%	98.2%	99.0%	98.3%	97.7%	97.6%	98.4%	
Percentage of patients who have a VTE risk assessment	95%	95.4%	96.3%	96.0%	95.9%	95.8%	96.0%	96.9%	96.4%	96.2%	96.0%	96.2%	95.5%		
Number of Patient Falls	N/A	189	140	157	138	117	155	143	136	141	181	173	148	128	
Falls (Moderate and Above Severity)	N/A	1	2	2	3	1	1	1	1	0	1	3	1	3	
Number of patient falls- per 1000 bed days	N/A	7.49	6.15	6.05	5.77	5.01	6.70	6.11	5.91	6.26	7.40	7.50	6.32	5.23	
Acquired Category 2 Pressure Ulcers	N/A	16	13	12	2	6	10	20	15	9	12	25	13	10	
Acquired Category 2 Pressure Ulcers per 1000 bed days	N/A	0.63	0.57	0.46	0.08	0.26	0.43	0.85	0.65	0.40	0.49	1.08	0.56	0.41	
Avoidable Category 3 & 4 Pressure Ulcers	0	0	0	0	5	0	2	2	3	1	0	0	1	0	
Avoidable Category 3 & 4 Pressure Ulcers per 1000 bed days	0	0.00	0.00	0.00	0.21	0.00	0.09	0.09	0.13	0.04	0.00	0.00	0.04	0.00	
Acquired Category 3 Pressure Ulcers		9	6	6	11	4	6	5	3	2	1	3	7	7	
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Briefing

- Six Serious Incidents (SIs) were reported in January, with a total of 42 SIs year to date.
- The number of falls reported in January was 128, of the falls reported three patients sustained moderate harm.
- All grade 3 and 4 pressure ulcers that are acquired at the Trust have had a rapid response review completed. These are reviewed by a panel chaired by the Chief Nurse to establish their avoidability. In January 7 patients acquired a grade 3 or grade 4 pressure ulcer of which no cases were avoidable.

Actions

- The Falls co-ordinator is working with divisions, wards and falls champions to improve falls practice, promote best practice for falls prevention and is continuing to carry out bespoke falls education and training.
- The Trust is participating in the NHSI Pressure Ulcer Collaborative and has focused on two wards. The programme will be rolling out to other wards.

Infection Control

Indicator Description	Threshold	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	YTD Actual	YTD Threshold	Trend (12 months)
MRSA Incidences (in month)	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	
Cdiff Incidences (in month)	30	0	1	2	6	1	3	3	2	2	3	2	3	2	27	25	
MSSA	25	0	3	1	2	2	1	1	2	1	4	2	5	3	23	21	
E-Coli	60	5	5	5	1	9	6	4	3	4	2	4	3	1	37	50	

Briefing

- The C Diff annual threshold for 2018/19 is 30 cases. For 2019-2020 the time limit for apportioning healthcare onset versus community onset is 48 hours rather than 72 hours. The data collected in 2018-19 for each Trust will be used to set the new targets for these categories. In the month of January the Trust reported two cases, totalling 27 cases year to date which is above the tolerance for period April 18 – January 19.
- The Trust annual threshold for E coli is 60 for 2018-19 and year to date the Trust has reported 37 cases, 1 of which occurred in January.
- There are no National thresholds for MSSA bacteraemia at present however the Trust has set itself an internal target of a 10% reduction on last years position setting the threshold at 25 incidents for 2018/19. The Trust is reporting a total of 23 incidents in the month of January and are above threshold for the period April 18 – January 19 .

Actions

- All Cdiff cases have undergone a Root Cause Analysis (RCA) the ward has been placed on a period of increased surveillance and audit. No immediate learning has been identified
- The Trust is anticipating an NHSI collaborative to reduce E Coli infections, representation from this group includes colleagues from partner organisations and is multi professional

Mortality and Readmissions

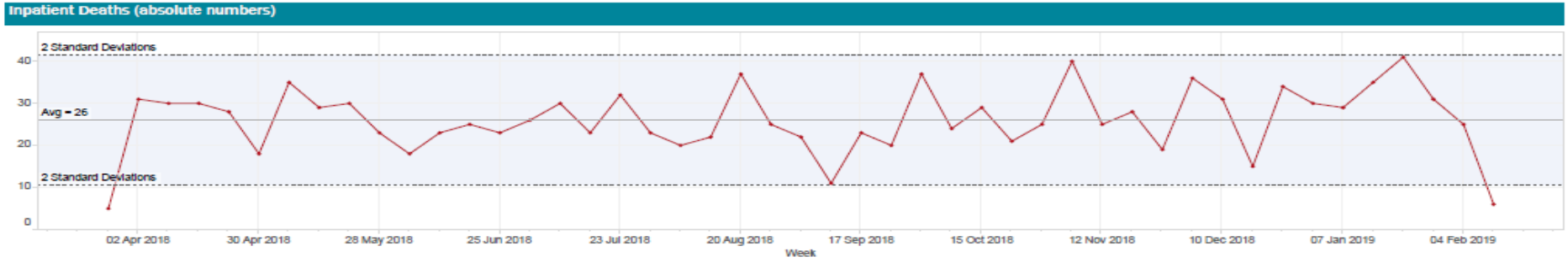
Indicator Description	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Nov-17 to Sep-18	Trend
Hospital Standardised Mortality Ratio (HSMR)	90.1	72.6	97.3	93.8	106.3	94.9	86.7	79.5	69.8	80.3	73.0	64.2	85.5	
Hospital Standardised Mortality Ratio Weekend Emergency	101.2	78.8	107.9	123.7	121.5	113.8	78.2	97.6	79.5	72.2	62.7	82.4	97.2	
Hospital Standardised Mortality Ratio Weekday Emergency	88.3	76.2	95.3	84.9	95.6	79.7	87.1	82.5	67.6	78.1	68.4	60.1	82.3	

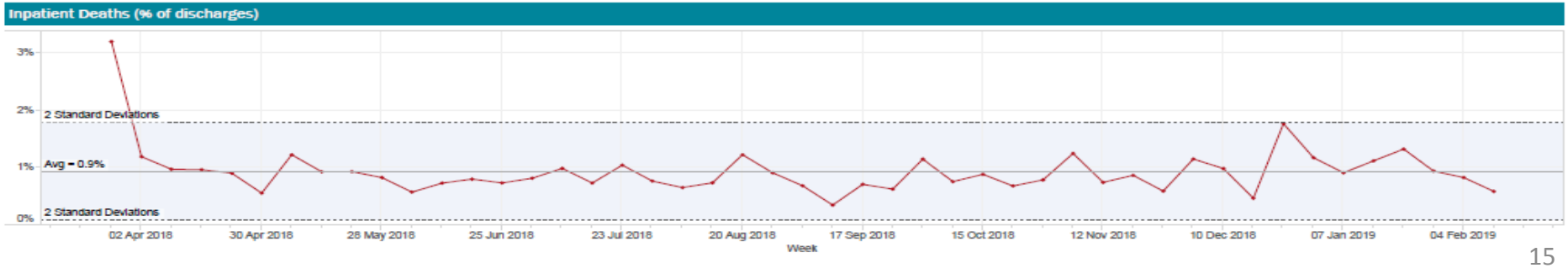
Indicator Description	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Trend
Summary Hospital Mortality Indicator (SHMI)	0.84	0.84	0.83	0.83	0.83	0.83	0.82	0.82	0.82	0.82	0.82	0.84	0.84	
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	8.9%	9.0%	9.2%	8.7%	8.8%	8.3%	8.90%	8.33%	8.24%	8.08%	7.50%	8.30%		

Please note SHMI data is reflective of the period April 2017 to March 2018 based on a rolling 12 month period (published 20th September).
HSMR data reflective of period September 2017 – August 2018 based on a monthly published position (published 22nd December).
Mortality Green Rag Rating is reflective of periods where the Trust are better than expected, non-Rag Rating is where the Trist are in line with expected rates.

Briefing

Both the Trust-level mortality indicators (SHMI and HSMR) remain lower than expected compared to national patterns. Caution should be taken in over-interpreting these signals, however as they mask a number of areas of over performance and also under performance. In particular we are aware of mortality signals in cardiac surgery, general intensive care and total hip replacement surgery that are under investigation as well as a number of more discrete diagnostic and procedure codes from Dr Foster that are reviewed monthly by the Mortality Monitoring Committee.





Maternity

Definitions	Target	Jan '18	Feb '18	Mar '18	Apr '18	May '18	Jun '18	Jul '18	Aug '18	Sep '18	Oct '18	Nov '18	Dec '18	Jan-19	Trend
Total number of women giving birth- (per calendar day -417 pm)	14 per day	13	12	13	14	14	13	13	13	15	14	13	13	14	
% of all deliveries where caesarean section occurred	<31%	23.0%	23.9%	25.3%	26.3%	28.1%	28.0%	25.1%	23.2%	23.8%	26.8%	27.5%	23.7%	29.2%	
% deliveries with emergency C-section (including no Labour)	<21%	7.7%	7.4%	8.0%	8.4%	7.8%	9.7%	6.6%	6.2%	6.5%	6.8%	8.3%	5.8%	7.4%	
Number of hours in the month that Carmen Suite closed	0											No closures			
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	4.9%	3.8%	3.4%	3.8%	3.5%	3.5%	5.1%	4.5%	3.3%	2.0%	3.6%	1.5%	2.1%	
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	2.0%	3.2%	2.1%	1.9%	2.8%	1.7%	2.4%	3.6%	1.8%	2.0%	2.6%	2.7%	2.6%	
Number of term babies (> 34 weeks), with unplanned admission to NNU		10	10	7	7	12	12	2	17	11	8	9	10	12	
Supernumerary Midwife in Labour Ward	>95%										95.16%	98.30%	100.00%	98.40%	
Number of babies born with Hypoxic Ischaemic Encephalopathy (/1000 babies)	<2/1000	1	0	0	0	2	2	0	0	0	2	1	0	1	
Number of babies still born at term (37 weeks+)	<3	1	1	0	0	1	1	1	0	0	0	1	0	1	
Number of babies still born at term (24 to 27 weeks and 6 days)	<3	1	0	4	1	0	0	1	3	2	3	2	1	1	
Number of babies born alive who die within (7 days of birth)	<3	2	4	1	1	0	1	1	3	1	2	0	3	0	
% women booked by 12 weeks and 6 days	90%	63.3%	68.6%	69.2%	60.3%	62.2%	71.0%	76.7%	81.3%	85.0%	77.9%	84.5%	86.2%	84.9%	

Briefing

- In January 421 women gave birth an average of 14 babies born daily. The overall caesarean rate was the highest seen in the year, however still within expected parameters.
- The number of women booked by 12 weeks and 6 days of pregnancy has been at its highest level in the last three consecutive months.
- The overall caesarean section rate increased to 29%, with an increase in the emergency caesarean rate seeming to drive this. The will be kept under close review.

Actions

- Based on above review, instigate a review of cases if numbers fall outside of expected norms
- Continue to monitor staffing across the service with a plan for responsive recruitment : Business case for responsive recruitment being prepared for Divisional Management Board this month.
- To verify numbers for 3rd and 4th degree tears and identify any learning to share if number is significantly lower than previous months.

Patient Experience

Patient Voice

Indicator Description	Target	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Trend
Emergency Department FFT - % positive responses	90%	82.2%	81.0%	81.4%	84.0%	85.0%	85.5%	83.7%	84.6%	83.5%	84.2%	79.2%	84.2%	82.8%	
Inpatient FFT - % positive responses	95%	94.7%	96.0%	96.3%	97.2%	97.3%	97.1%	96.7%	96.6%	96.3%	97.0%	95.5%	96.4%	96.5%	
Maternity FFT - Antenatal - % positive responses	90%	100.0%	100.0%	95.8%	100.0%	97.2%	100.0%	100.0%	100.0%	100.0%	100.0%				
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%	100.0%	100.0%	100.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	99.0%	90.4%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	90.9%	95.6%	
Maternity FFT - Postnatal Community Care - % positive responses	90%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%			100.0%		
Community FFT - % positive responses	90%	99.2%	93.3%	98.3%	97.1%	98.5%	98.3%	98.0%	98.4%	99.5%	95.6%	97.4%	96.1%	96.3%	
Outpatient FFT - % positive responses	90%	97.6%	96.1%	98.4%	97.3%	97.3%	97.4%	97.4%	97.1%	96.3%	94.9%	97.3%	95.6%	96.1%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints Received		90	80	94	96	85	79	120	96	93	90	88	78	92	
PALS Received		290	236	259	264	317	292	337	294	335	416	353	252	369	

Briefing

- ED Friends and Family Test (FFT) – In the month of January 82.8% of patients attending the Emergency Department would recommend the service to family and friends, however the response rate remains below our target of 20% .
- Inpatient Friends and Family Test (FFT) continues to be above threshold reporting 96.5% in January providing reasonable assurance on the quality of patient experience
- We continue to deliver above target against our outpatient recommend rate and although this has slightly decreased in the month of December the response rate has doubled due to the implementation of two way texting.
- Maternity and Community FFT remain above local threshold with work continuing to improve the number of patients responding,
- All complaints are assessed for complexity when they arrive and given a response time of 25, 40 or 60 working days. Complaints with a 25 day response time remain below the set trajectory of 85%, reporting in December a performance of 55%. For 40 day complaints received in November 22% were responded to within the timescale. There were three 60 day complaints received in October 2018, all achieved a response within the deadline achieving a performance of 100%. The performance is extremely disappointing. Weekly CommCell meeting is now getting feedback on divisional performance against the compliance targets, this is to balance the focus on overdue complaints which have reduced both in number and time overdue. The position for the next month has been reviewed in detail and performance is significantly improved, while this does not excuse the performance for 40 day complaints received in November it does suggest that the significant drop was exceptional.

Actions

FFT action being taken to improve response rates includes: weekly feedback to all areas on their response rate, this is published on the Quality Posters at the entrance to the area; improving the accessibility of the FFT by increasing the number of tablets and using volunteers to assist patients with the survey; scoping other opportunities to improve accessibility for example putting FFT and other patient surveys on our public website.

Complaints and PALS: The weekly CommCell is being used to maintain organisational focus on meeting both timeliness and quality standards for complaint responses.

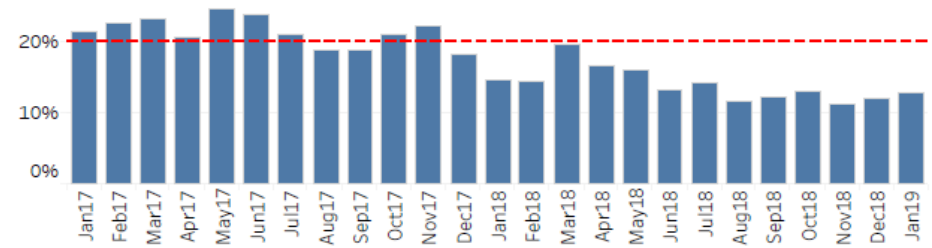
Patient Voice

CARING – Friends and Family Test

--- Target ¢ MetricMeasure Percentage Neutral

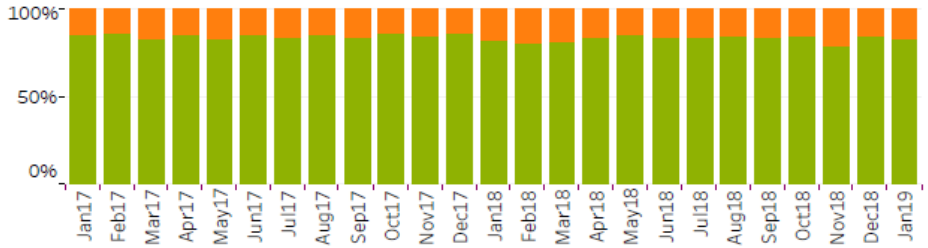
A&E Friends & Family Response Rate

Target: 20% Dec 18: 11.90% Jan 19: 12.80% Movement: ▲0.90%



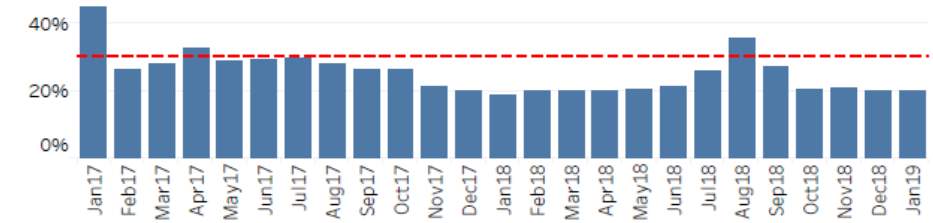
A&E Friends & Family Recommend Rate

The expected target is 90%



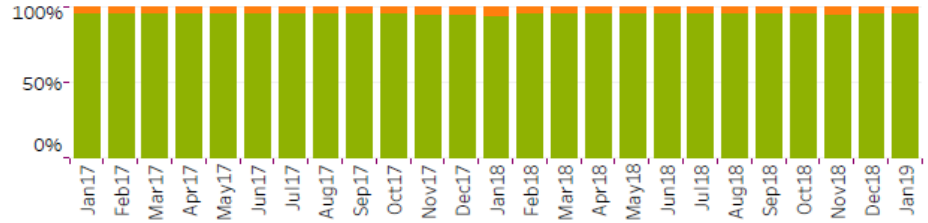
IP Friends & Family Response Rate

Target: 30% Dec 18: 20.00% Jan 19: 20.10% Movement: ▲0.10%



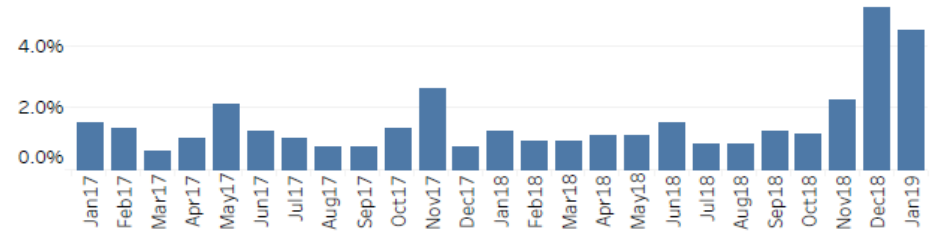
IP Friends & Family Recommend Rate

The expected target is 95%



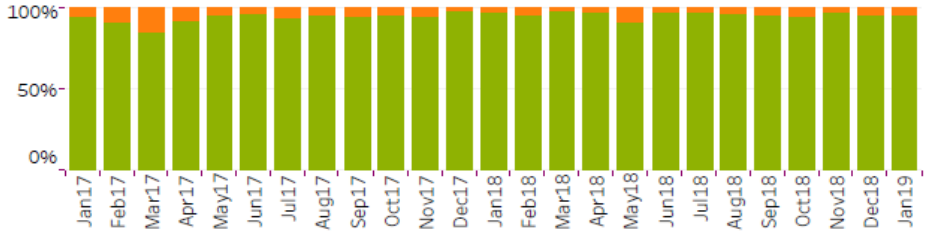
OP Friends & Family Response Rate

Target: 20% Dec 18: 5.20% Jan 19: 4.50% Movement: ▼-0.70%



OP Friends & Family Recommend Rate

The expected target is 90%

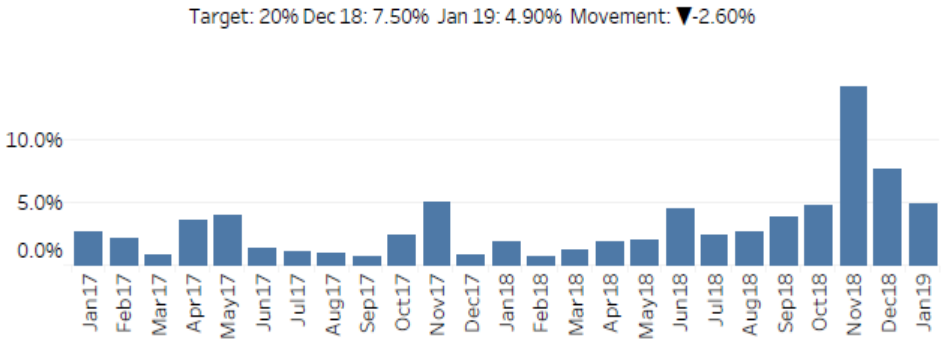


Patient Voice

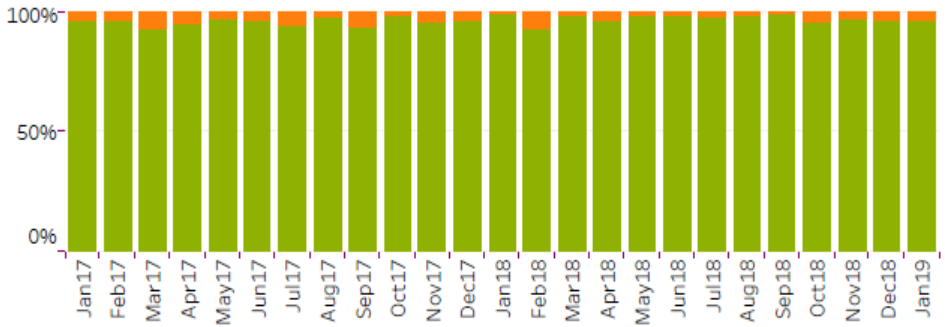
CARING – Friends and Family 2

--- Target ¢ MetricMeasure Percentage Neutral

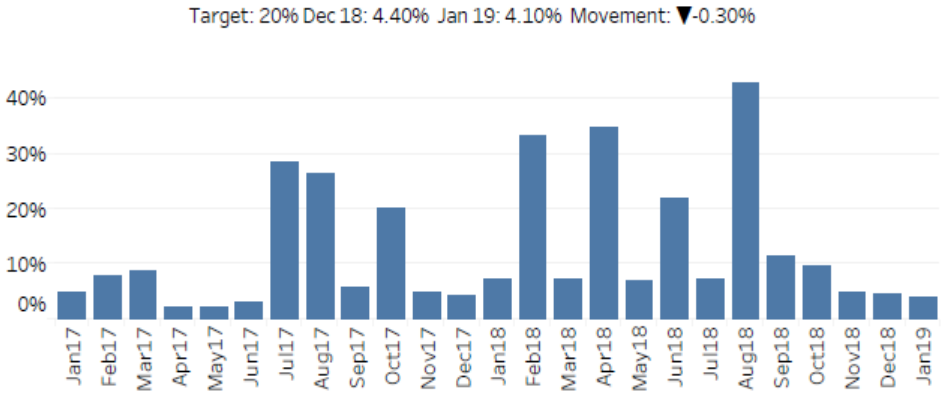
Community Friends & Family Response Rate



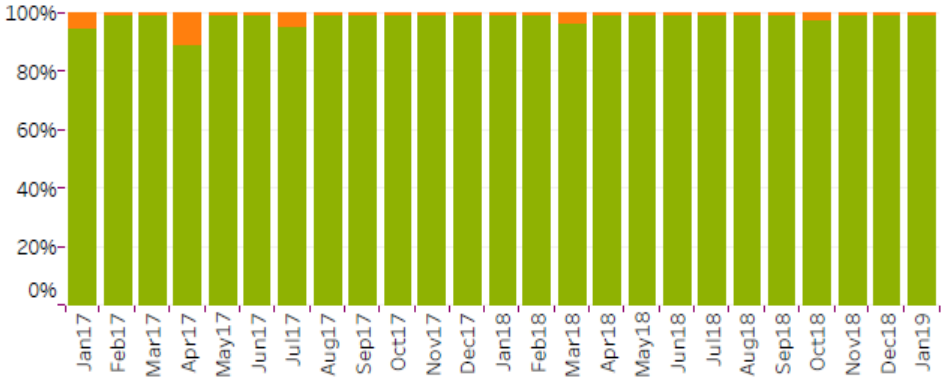
Community Friends & Family Recommend Rate
The expected target is 90%



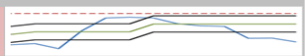
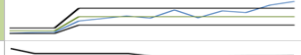
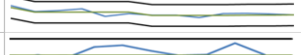
Maternity (Birth) Friends & Family Response Rate



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



Emergency Flow

Indicator Description	Target	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Trend
4 Hour Operating Standard	95%	83.0%	83.5%	81.6%	88.4%	93.3%	93.6%	93.3%	91.1%	90.3%	90.1%	85.5%	85.6%	84.2%	
Patients Waiting in ED for over 12 hours following DTA	0	0	0	2	1	1	0	1	0	1	0	1	2	0	
Time to Treatment (number of patients seen within 60 minutes)	60%	51.7%	52.2%	52.6%	61.5%	63.5%	65.5%	63.7%	70.3%	64.1%	69.5%	68.2%	74.2%	77.0%	
Admitted patients with a length of stay 7 Days or Greater		373	337	343	355	308	324	315	316	301	325	326	323	317	
Ambulance Turnaround - % under 15 minutes	100%	41.0%	42.2%	41.0%	45.0%	45.7%	43.6%	42.0%	42.3%	46.4%	42.5%	37.4%	Data not yet available		
Ambulance Turnaround - % under 15 minutes (London Average)	100%	41.4%	42.2%	41.1%	45.2%	45.7%	47.4%	46.7%	48.1%	52.6%	47.4%	46.5%			
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	180	135	105	92	65	72	67	85	109	111	138			
Ambulance Turnaround - % under 30 minutes	100%	91.3%	93.2%	94.5%	95.3%	96.8%	96.3%	96.2%	95.5%	94.1%	94.5%	93.0%			
Ambulance Turnaround - % under 30 minutes (London Average)	100%	86.7%	87.4%	87.5%	88.8%	91.9%	93.7%	93.1%	92.2%	92.5%	92.2%	91.5%			
Ambulance Turnaround - number over 60 minutes	0	3	3	10	1	0	0	0	2	3	0	3			

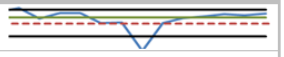
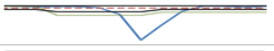
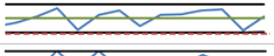
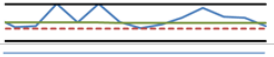
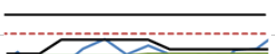
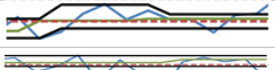
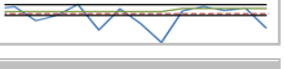
Briefing

- The Emergency Department saw more than a 7% increase in Emergency Attendances, treating an additional 30 patients per day with the increases coming in patients self-presenting , compared to the same period last year.
- The number of patients admitted via the Emergency Department has increased by 10% compared to January 2018 (15 patients per day) and more than 300 more people were admitted within four hours of arrival.
- In January, more than 1,000 patients were streamed back to Primary Care, with the percentage of all attending patients increasing to 10.6% for the month, of which 42% of patients were streamed to Wandsworth CCG and 26% to Merton CCG. Commissioner colleagues are looking to work more closely with individual GP practices to understand the root causes of this growth.
- Performance against the Four Hour Operating Standard in January was 84.2%, which whilst being below the monthly improvement trajectory of 90%, showed a positive increase compared to this time last year.
- The proportion of adult patients conveyed to the Emergency Department by ambulance who end up being admitted has fallen to 55% this month compared to 58% in January 2018 and commissioners are working to understand whether there has been a change in the effectiveness of the local Hear and Treat model. Continued improvements observed within Paediatric 4 hour performance in admitted and non admitted care in a period where attendances have increased.
- LAS Handover times are currently being validated in conjunction with Commissioners.

Actions

- The Trust has enacted an Emergency Care Enhanced Support Plan with effect from 5th February 2019 to remain in place until end March 2019. A daily midday meeting has been established to track key metrics against targets which we know to be indicators of good flow within the organisation (e.g. no. patients in the ED (target <70), time to treatment (>60% within 60mins), AMU bed occupancy (<80%), Trust-wide bed occupancy (<92.5%) and no. of patients with a Section 5 with a date that has passed (<25 patients). The output of the daily meeting includes focused actions to be carried out, with the aim of delivering real time improvements in flow and performance on a daily basis.

Cancer

Indicator Description	Target	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	No of Patients	Trend (12 months)
Cancer 14 Day Standard	93%	98.5%	94.8%	96.7%	96.8%	93.1%	93.3%	83.0%	93.1%	95.0%	95.5%	96.3%	95.9%	96.6%	1,143	
Cancer 14 Day Standard Breast Symptomatic	93%	97.3%	95.9%	96.5%	96.8%	94.4%	79.4%	22.2%	55.2%	86.4%	97.9%	97.1%	95.4%	96.9%	260	
Cancer 31 Day Diagnosis to Treatment	96%	97.4%	98.2%	99.3%	96.5%	98.4%	99.0%	97.0%	98.4%	98.5%	99.0%	99.1%	96.5%	98.2%	171	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	94.3%	94.6%	100.0%	95.5%	100.0%	95.7%	94.1%	95.0%	96.6%	100%	96.9%	96.6%	94.6%	37	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	77	
Cancer 62 Day Referral to Treatment Standard	85%	86.8%	77.8%	80.8%	88.1%	92.3%	85.9%	89.6%	85.7%	85.7%	80.6%	87.8%	88.1%	94.8%	57.5	
Cancer 62 Day Referral to Treatment Screening	90%	93.9%	86.1%	89.1%	95.2%	80.8%	92.7%	84.6%	73.8%	91.6%	94.1%	91.8%	93.2%	82.0%	30.5	

Briefing

- The Trust met six of the seven Cancer standards in the month of December, continuing to achieve both the 14 day standard and 62 day standard.
- Performance against the 14 day standard was achieved in all tumour groups
- Performance against 62 day standard was reported at 94.8% overall, reporting a total of 3 patients treated passed the 62 day target, breaches were due to complex pathways and late hospital referrals from other providers.

62 Day wait for First Treatment- GP referral to treatment (actual and internal performance)			
Apr-18	85%	92.3%	96.7%
May-18	85%	85.9%	87.1%
Jul-18	85%	85.7%	89.4%
Aug-18	85%	85.7%	89.1%
Sep-18	85%	80.6%	85.0%
Oct-18	85%	87.8%	92.5%
Nov-18	85%	88.1%	100.0%
Dec-18		94.8%	100.0%

Actions

- There is a continued focus on improving internal processes as well as working with local providers to improve 38 day performance. Improvement trajectories have been agreed with other SWL providers to improve waiting times and quicker access to diagnostics and treatment for shared patients
- Capacity within the Breast pathway has been created within diagnostics through the addition of a new ultrasound machine at St George's Rose Centre site increasing the minimum weekly capacity by 60 slots weekly. On-going recruitment of vacant consultant posts, the creation of a new consultant post, and the introduction of a trainee position will further increase capacity by 60 slots and provide a more flexible and responsive service in the current year and a further 50 slots in year 2 once training is completed.

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	No of Patients
Brain	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	-	100.0%	-	100.0%	3
Breast	93%	98.2%	96.0%	96.5%	93.9%	94.8%	91.9%	61.2%	87.4%	97.5%	94.5%	99.4%	97.4%	98.8%	169
Children's	93%	100.0%	87.5%	100.0%	100.0%	80.0%	100.0%	100.0%	90.9%	-	100.0%	50.0%	100.0%	100.0%	2
Gynaecology	93%	97.6%	98.0%	96.8%	94.3%	94.9%	91.9%	86.1%	91.7%	90.8%	81.9%	87.8%	87.5%	95.9%	97
Haematology	93%	94.7%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	100.0%	18
Head & Neck	93%	98.4%	100.0%	97.6%	100.0%	100.0%	97.5%	92.3%	93.0%	95.6%	99.3%	99.8%	98.1%	96.0%	124
Lower Gastrointestinal	93%	99.3%	95.2%	100.0%	97.8%	94.1%	90.3%	67.5%	94.7%	98.9%	94.3%	98.1%	95.8%	94.5%	236
Lung	93%	100.0%	92.3%	100.0%	100.0%	100.0%	96.3%	90.9%	97.6%	94.7%	95.2%	100.0%	100.0%	100.0%	44
Skin	93%	97.9%	92.7%	94.8%	95.9%	94.1%	93.8%	92.7%	93.3%	92.9%	97.4%	96.6%	97.4%	97.6%	247
Upper Gastrointestinal	93%	100.0%	89.0%	97.3%	95.3%	85.2%	88.1%	89.9%	96.6%	93.9%	96.7%	98.8%	95.4%	94.1%	85
Urology	93%	98.9%	95.0%	95.1%	98.2%	81.3%	92.9%	96.5%	95.2%	93.1%	96.8%	92.4%	93.4%	96.6%	118

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	No of Patients
Brain	85%	-	-	-	-	-	-	-	-	-	-	-	100.0%	100.0%	1
Breast	85%	100.0%	71.4%	100.0%	88.9%	94.1%	84.6%	91.7%	90.9%	78.9%	100.0%	100.0%	100.0%	100.0%	12.5
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	67.0%	80.0%	77.8%	0.0%	100.0%	80.0%	100.0%	75.0%	100.0%	80.0%	90.0%	100.0%	83.3%	3
Haematology	85%	100.0%	88.9%	83.3%	81.8%	100.0%	63.6%	100.0%	100.0%	88.9%	75.0%	100.0%	100.0%	100.0%	4
Head & Neck	85%	71.0%	100.0%	83.3%	80.0%	100.0%	90.0%	75.0%	72.7%	81.8%	80.0%	100.0%	86.7%	87.5%	4
Lower Gastrointestinal	85%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	71.4%	83.3%	66.7%	88.9%	100.0%	100.0%	3.5
Lung	85%	33.0%	90.9%	57.1%	100.0%	100.0%	87.5%	83.3%	71.4%	66.7%	28.6%	50.0%	70.0%	72.7%	5.5
Skin	85%	93.0%	86.7%	100.0%	100.0%	100.0%	90.9%	100.0%	100.0%	100.0%	84.6%	92.3%	100.0%	100.0%	10
Sarcoma	85%	-	-	100.0%	-	-	-	-	-	-	-	-	-	-	0
Upper Gastrointestinal	85%	100.0%	33.3%	57.1%	66.7%	87.5%	33.3%	80.0%	100.0%	78.9%	50.0%	54.5%	100.0%	100.0%	4
Urology	85%	91.0%	60.7%	70.0%	96.7%	80.5%	84.6%	84.9%	85.7%	88.2%	92.9%	88.9%	77.8%	95.0%	10
Other	85%	-	-	-	-	-	-	-	-	100.0%	-	100.0%	100.0%	-	0

Diagnostics

Indicator Description	Threshold	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Trend
6 Week Diagnostic Performance	1%	0.1%	0.0%	0.2%	0.2%	0.2%	0.3%	0.3%	0.2%	0.4%	0.2%	0.5%	0.6%	0.5%	
6 Week Diagnostic Breaches	N/A	10	3	17	15	14	25	24	15	30	18	39	37	41	
6 Week Diagnostic Waiting List Size	N/A	6,884	7,232	7,075	7,956	7,735	7,809	7,236	6,946	7,617	7,593	7,322	6,652	7,649	

Indicator Description	Threshold	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Trend
MRI	1%	0.0%	0.0%	0.1%	0.1%	0.0%	0.4%	0.0%	0.3%	0.1%	0.2%	0.3%	0.6%	0.4%	
CT	1%	0.1%	0.0%	0.3%	0.1%	0.0%	0.3%	0.0%	0.0%	0.0%	0.2%	0.1%	0.7%	0.6%	
Non Obstetric Ultrasound	1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.1%	0.6%	0.0%	0.0%	0.0%	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%	0.0%	
Dexa Scan	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	
Audiology Assessments	1%	0.0%	0.0%	0.0%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Echocardiography	1%	0.0%	0.0%	0.0%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	
Electrophysiology	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Peripheral Neurophysiology	1%	0.9%	0.0%	0.4%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	
Sleep Studies	1%	0.0%	0.4%	0.6%	0.0%	0.0%	0.0%	1.1%	1.5%	0.0%	0.0%	7.7%	2.4%	1.1%	
Urodynamics	1%	0.0%	0.0%	9.1%	5.0%	23.9%	6.3%	26.5%	0.0%	13.9%	14.6%	10.2%	8.5%	16.3%	
Colonoscopy	1%	0.0%	0.6%	0.7%	0.6%	0.4%	0.0%	0.0%	0.0%	0.0%	0.7%	3.0%	0.0%	2.9%	
Flexi Sigmoidoscopy	1%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Cystoscopy	1%	2.8%	0.7%	0.0%	1.0%	0.8%	3.0%	1.8%	4.4%	2.6%	3.0%	4.5%	5.4%	3.2%	
Gastroscopy	1%	0.0%	0.0%	1.8%	1.0%	0.0%	0.0%	1.8%	0.0%	0.3%	0.0%	0.0%	0.6%	1.4%	

Briefing

- The Trust has continued to achieve performance in January reporting a total of forty-one patients waiting longer than 6 weeks, 0.5% of the total waiting list.
- Compliance has not been achieved within five modalities, Sleep Studies, Urodynamics, Colonoscopy, Cystoscopy and Gastroscopy
- Performance and recovery plans continue to be monitored through the weekly performance meetings.

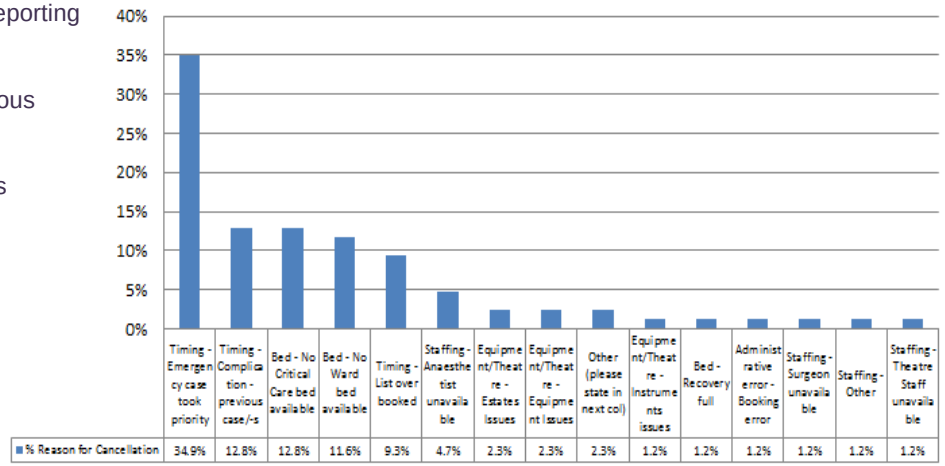
On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Trend
Number of on the Day Cancellations		94	55	86	64	87	42	54	44	55	52	53	60	86	
Number of on the Day cancellations re-booked within 28 Days		76	48	76	60	80	33	51	39	48	50	52	58	86	
% of Patients re-booked within 28 Days	100%	80.9%	87.3%	88.4%	93.8%	92.0%	78.6%	94.4%	88.6%	87.3%	96.2%	98.1%	96.7%	100.0%	

Briefing

- In January all of our on the day cancelled patients were-rebooked within 28 days reporting 100%.
- The number of on the day cancellations did increase in January compared to previous months however this was a reduction of 8.5% compared to January 2018
- Reducing cancellations has been a key focus within the improvement work streams supporting the theatre productivity programme, and we have seen a significant improvement compared to the same period last year, therefore improving patient experience.

Reason for Cancellation



Actions

- Continue to improve the Pre Operative Assessment (POA) Process and the availability of more high risk capacity for POA
- Text reminder service to be implemented within pre-assessment.
- Introduce a call to every patient before surgery to check that they are Ready, Fit and Able to attend 72 hours prior.
- At times of high non-elective activity, ensure that elective patients are reviewed, including their bed requirements, in advance of the day of surgery
- Standard operating procedures have been signed off and implemented.

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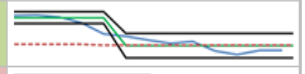
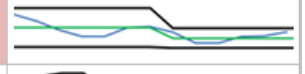
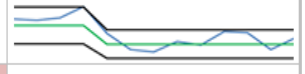
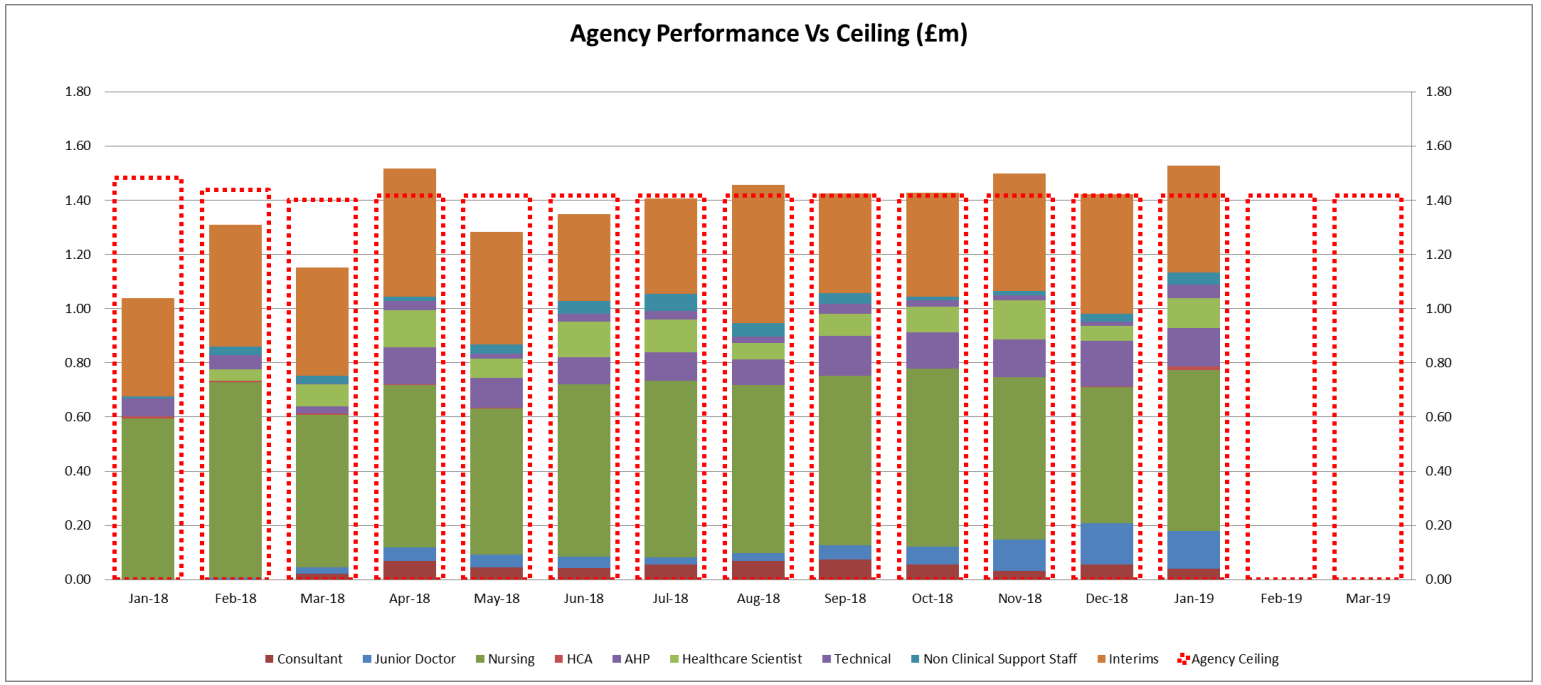
Workforce

Indicator Description	Target	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Trend
Trust Level Sickness Rate	3%	4.1%	4.0%	3.6%	3.2%	3.2%	3.6%	3.5%	3.5%	3.4%	3.7%	4.1%	3.8%	4.3%	
Trust Vacancy Rate	10%	13.4%	13.5%	13.3%	12.6%	11.3%	11.0%	10.6%	10.2%	10.4%	9.3%	8.9%	9.4%	9.4%	
Trust Turnover Rate* Excludes Junior Doctors	13%	17.9%	17.6%	17.2%	16.9%	17.0%	17.3%	17.4%	17.1%	16.6%	16.6%	16.9%	16.9%	17.1%	
Total Funded Establishment		9,515	9,540	9,497	9,469	9,318	9,242	9,239	9,160	9,180	9,165	9,171	9,196	9,229	
IPR Appraisal Rate - Medical Staff	90%	79.6%	76.9%	72.2%	81.1%	81.3%	79.9%	77.7%	Not currently provided						
IPR Appraisal Rate - Non Medical Staff	90%	67.2%	65.9%	61.6%	61.2%	63.4%	64.6%	67.6%	69.7%	69.7%	69.7%	71.8%	71.5%	70.9%	
% of Staff who have completed MAST training (in the last 12 months)		87%	87%	87%	87%	87%	87%	89%	88%	88%	88%	89%	89%	89%	
Ward Staffing Unfilled Duty Hours	10%	7.7%	7.9%	8.9%	6.5%	5.1%	4.9%	5.8%	5.5%	6.7%	6.6%	5.1%	6.1%	6.6%	
Safe Staffing Alerts	0	4	1	1	1	0	2	0	0	0	0	0	0	0	

Briefing

- The Trust Vacancy rate continues to be below the target in the month of January reporting 9.4% against a Trust target of 10%
- The Trust sickness level has remained above target of 3% and has seen an increase in sickness in the month of January reporting 4.3%.
- Mandatory and Statutory Training figures for January were recorded at 89%.
- Medical Appraisals rates are being reviewed and will not be reported this month.
- Non-medical appraisal rates remain below target with a performance of 70.9% against a 90% target.
- Percentage of Staff vaccinated against seasonal Influenza is 84% as at the 12th February 2019.

Agency Use



- The Trust's total pay for January was £43.32m. This is £1.34m adverse to a plan of £41.97m.
- The Trust's 2018/19 annual agency spend target set by NHSI is £21.30m. There is an internal annual agency target of £17.00m.
- Total restated agency cost in January was £1.53m or 3.5% of the total pay costs. For 2017/18, the average agency cost was 4.2% of total pay costs.
- For January, the monthly target set was £1.42m. The total agency cost is worse than the target by £0.11m.
- Agency cost increased by £0.11m compared to December. There has been increases mainly in Nursing (£0.09m) due to Winter and the opening of Dalby Ward, and Healthcare Scientists (£0.06m).
- The biggest area of overspend was in Interim, which breached the target by £0.09m.

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Meeting Title:	**Trust Board**		
Date:	28 February 2019	**Agenda No**	**2.3**
Report Title:	**Cardiac Surgery Update**		
Lead Director	**Richard Jennings, Chief Medical officer**		
Report Authors:	Matt Jarratt, General Manager, Cardiac, Vascular and Thoracic Surgery		
Presented for:	Assurance and discussion		
Executive Summary:	This report provides an update to Trust Board on the steps being taken to improve the cardiac surgery service following the NICOR safety alerts and the findings of the independent report by Professor Bewick (July 2018). Since the last update to Trust Board (31 January 2019) the following key developments have taken place: • A revised governance structure for cardiac surgery has been agreed by the Cardiac Surgery Steering Group. • Agreement has been reached on the terms of reference for supporting the outcomes of the Independent Mortality Review Panel, including a communications approach for the relatives of deceased patients whose cases will be reviewed through the panel. • The Independent Mortality Review Panel has continued to meet. • An audit programme has been agreed to support the audit of key governance and pathway improvements (beginning March 2019). • A 'dry-run' service inspection has taken place, with input from NHSI, in preparation for a likely CQC inspection soon. Initial feedback was positive with signs of significant improvement noted, and actions for further improvement identified. • The three extreme risks on the trust risk register were presented at the Risk Management Executive, and an agreed reduction in the risk to patient safety was made. • The financial impact of the difficulties facing the service continue to be closely monitored and managed.		
Recommendation:	Trust Board is asked to note the update on progress being made in Cardiac Surgery.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person Right care, right place, right time Champion Team St George's		
CQC Theme:	Safe, Well Led		
Single Oversight Framework Theme:	Quality of Care, Leadership and Improvement Capability		
Implications			
Risk:	As set out in the paper		
Legal/Regulatory:	The paper details the Trust's engagement with regulators on this issue.		

Previously Considered by:	Quality and Safety Committee	**Date**	21 February 2019

CARDIAC SURGERY UPDATE

1.0 PURPOSE

1.1 To update the Trust Board on progress being made with Cardiac Surgery since the last Board presentation and discussion on 31 January 2019.

1.2 Trust Board has received background context, detailing the causes leading to the current challenges facing cardiac surgery in previous submissions. This paper does not re-cover either that information or any improvements and changes made prior to 31 January 2019 2019; rather it provides a summary of the key developments that have taken place in the period since that meeting.

2.0 EXTERNAL ASSURANCES

2.1 Meetings of the independent Mortality Review Panel

2.1.1 The independent mortality review panel has continued its work.
2.1.2 It is reviewing the notes of patients who died following cardiac surgery in the period 2013-2018.

2.1.3 A plan has been agreed around the communication with the families of the deceased patents whose care is being reviewed as part of the work of the panel. A dedicated phone number (staffed by the Head of Nursing and General Manager) has been put in place (Mon-Fri 09:00-17:00) to field questions and concerns from families contacted.

3 INTERNAL DEVELOPMENTS

Since the last board update, the following key service developments have taken place.

3.1 **Pre-operative Assessment and case management**. It has been agreed that an improved model for case management of all elective patients will be implemented, including a clinical nurse specialist (CNS) led case management team supported by patient pathway coordinators, with consultant oversight. The additional posts have been developed and have been through banding, and are due for advertisement in the coming days.

3.2 **ITU/ Anaesthetic/ cardiology engagement**. An audit programme (led by the Governance lead for cardiac surgery) has been put in place to provide assurance on the strengthening of CITU engagement and improving existing pathways between cardiac surgery and CITU. This includes a daily evening call between the CTITU Intensivist on call and the Cardiac Surgeon on call to assure that all plans for patients on ITU are being enacted effectively.

3.3 **Culture and behaviour.** Key developments include the embedding of the weekly surgeons meeting, with a clear agenda and structured discussion, better formalisation of list planning and the re-establishment of the monthly care group meeting (as per the revised governance structure). The Director of Human Workforce and Human Resources is directly overseeing the behaviour work stream, and has engaged an expert in mediation and behaviour to support further

improvements in this area; this work is due to begin work in March 19.

3.4 **Mortality and Morbidity Dashboard.** The January dashboard is below. Figures for morbidity and mortality were within normal limits. There were zero deaths and zero Serious Incidents. There were two re-sternotomies for bleeding and one post-operative stroke, which have been reviewed by the AMD for Cardiac Surgery. Sadly a pre-operative in-patient died on Benjamin Weir ward this month – this is being investigated in accordance with existing protocols.

4.0 FINANCIAL POSITION - LOOK AHEAD TO 2019/20

4.1 Work is in hand to ensure that the Trust's overall 2019/20 Operating Plan is consistent with the activity and income plan within the Cardiac Surgery service.

4.0 INTERNAL ASSESSMENT

4.1 The safety of the service continues to be closely monitored by the Trust and a daily safety dashboard is seen and considered by the Chief Medical Officer and Chief Nurse. The Trust is confident in the safety of the service is currently being maintained, and this continues to involve a high level of oversight by senior individuals within the Trust.

5.0 IMPLICATIONS

Risks

5.1 There continue to be three extreme risks on the risk register for this service:

1) Losses incurred through reduced income as a result of decreased activity, and direct costs incurred through turnaround programme. (Original risk score 25, current score 20).The risk score has not been reduced within the last month.
2) Drop off in referrals and significant loss of patient and referrer confidence in the service caused by high media profile of current challenges. This impacts on the longer-term viability of the service (Original risk score 20, current score 15). The risk score has not been reduced within the last month.
3) Adverse impact on patient safety within the service, and poor adherence to Trust values on poor behaviours from within cardiac surgery team, anaesthetics, theatre staff and other key groups (Original risk score 20, current score 15). The risk score has been reduced because of the steps we have taken to improve safety within the service including the introduction of daily multi-disciplinary team meetings to discuss all planned cases, a reduction in the level of risk of cases we undertake, the introduction of new leadership, stronger governance and a more stable workforce. This was agreed at Risk Management Executive Committee on 13 February 2019.

6.0 RECOMMENDATION

6.1 Trust Board is asked to discuss and take assurance from the update on progress being made in Cardiac Surgery.

Date: 22 February 2019

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	28 February 2019	**Agenda No.**	**3.2**
Report Title:	**M10 Finance Report**		
Lead Director/ Manager:	**Andrew Grimshaw**		
Report Author:	Michael Armour & Tom Shearer		
Presented for:	Update		
Executive Summary:	Overall the Trust is reporting a Pre-PSF deficit to date of £46.0m at the end of Month 09 (December), which is £20.3m adverse to plan. Within the position, income is adverse to plan by £8.9m, and expenditure is overspent by £11.4m.		
Recommendation:	The Trust Board notes the trust's financial performance to date in January.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Finance and use of resources		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	The Finance & Investment Committee	Date	21 February 2019
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 10 (January 2019)

Chief Finance Officer

28th February 2019

Executive Summary – Month 10 (January)

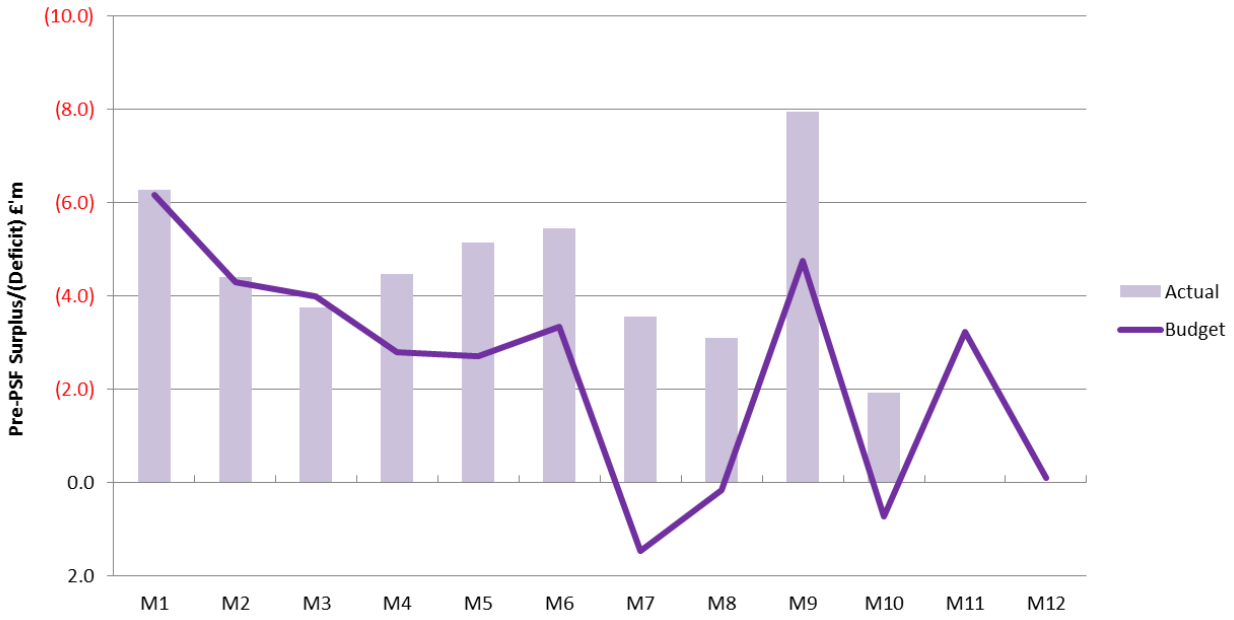
Note: All figures and commentary in this report refer to the revised Trust plan submitted to NHS Improvement on 20th June.

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	**The trust is reporting a Pre-PSF deficit of £46.0m** at the end of January, which is **£20.3m adverse to plan**. Within the position, income is adverse to plan by £8.9m, and expenditure is overspent by £11.4m. There also remains an element of income estimation in the position which will need to be validated ahead of freeze dates. **M4-10 PSF income of £7.8m** in the plan has **not been achieved** in the Year-to-date position, as the Trust continues to be adverse to the Pre-PSF plan.	£20.3m Adv to plan	£17.7m Adv to plan
Income	Income is reported at £8.9m adverse to plan year to date. Elective is the main area of lower than planned performance; with shortfalls in volume (£14.0m) being offset by pricing gains (£6.2m) in other areas. Non-SLA income is also adverse to plan, with shortfalls private patient income the major cause.	£8.9m Adv to plan	£10.0m Adv to plan
Expenditure	Expenditure is £11.4m adverse to plan year to date in January. This is caused by Non Pay adverse variance of £9.3m (although a large proportion of this is offset in Income as pass-through is over-performing). Pay is adverse to plan by £1.3m in month, where non-medical pay is not underspent (as it had been in previous months).	£11.4m Adv to plan	£7.7m Adv to plan
CIP	The Trust planned to deliver £39.4m of CIPs by the end of January. To date, £36.1m of CIPs have been delivered; which is £3.3m behind plan. Income actions of £7.9m and Expenditure reductions of £28.2m have impacted on the position.	£3.3m Adv to plan	£3.0m Adv to plan
Capital	Capital expenditure of £21.4m has been incurred year to date. This is £2.7m above plan YTD. The position is reported against the internally financed plan of £18.9m. The original £27m loan requested was reduced to £18m as per the request from NHSI in month 9. This was to recognise the timing of receipt and expected capital spend until March 2019. It is now unlikely that the Trust will receive any capital loan in 18/19.	£2.7m Adv to plan	£1.5m Adv to plan
Cash	At the end of Month 10, the Trust's cash balance was £3.6m, which is better than plan by £0.6m.The Trust received 0.5m on the last day of the month from Lambeth CCG. The Trust has borrowed £42.3m YTD which is in line with the I&E Deficit incurred. The Trust secured a loan of £7.1m for February and has requested £2.5m for March.	£0.6m Fav to plan	£0.1m Fav to plan
Use of Resources (UOR)	The Regulators Financial Risk Rating. At the end of January, the Trust's UOR score was 4 as per plan.	Overall score 4	Overall score 4

Contents

1. Month 10 Financial Performance

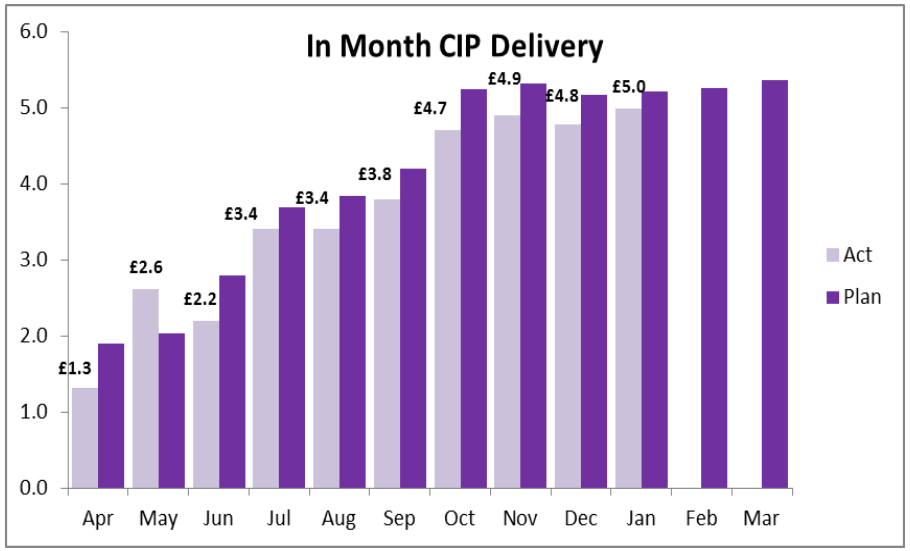
			Full Year Budget (£m)	M10 Budget (£m)	M10 Actual (£m)	M10 Variance (£m)	M10 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF	**Income**	SLA Income	662.8	57.4	57.8	0.4	0.6%	551.6	542.8	(8.8)	(1.6%)
		Other Income	159.7	13.4	14.2	0.7	5.5%	133.8	133.7	(0.1)	(0.1%)
	Income Total		**822.4**	**70.9**	**72.0**	**1.1**	**1.6%**	**685.5**	**676.6**	**(8.9)**	**(1.3%)**
	Expenditure	Pay	(509.9)	(42.0)	(43.3)	(1.3)	(3.2%)	(426.0)	(428.4)	(2.4)	(0.6%)
		Non Pay	(307.6)	(25.3)	(27.7)	(2.4)	(9.5%)	(256.9)	(266.3)	(9.3)	(3.6%)
	Expenditure Total		**(817.4)**	**(67.3)**	**(71.0)**	**(3.8)**	**(5.6%)**	**(682.9)**	**(694.7)**	**(11.7)**	**(1.7%)**
	Post Ebitda		(34.0)	(2.9)	(2.9)	0.0	0.4%	(28.2)	(27.9)	0.3	1.2%
Pre-PSF Total			**(29.0)**	**0.7**	**(1.9)**	**(2.6)**	**(366.4%)**	**(25.7)**	**(46.0)**	**(20.3)**	**(79.0%)**
PSF			12.6	1.5	0.0	(1.5)	(100.0%)	9.7	1.9	(7.8)	(80.4%)
Grand Total			**(16.4)**	**2.2**	**(1.9)**	**(4.1)**	**(187.6%)**	**(16.0)**	**(44.1)**	**(28.1)**	**(175.4%)**

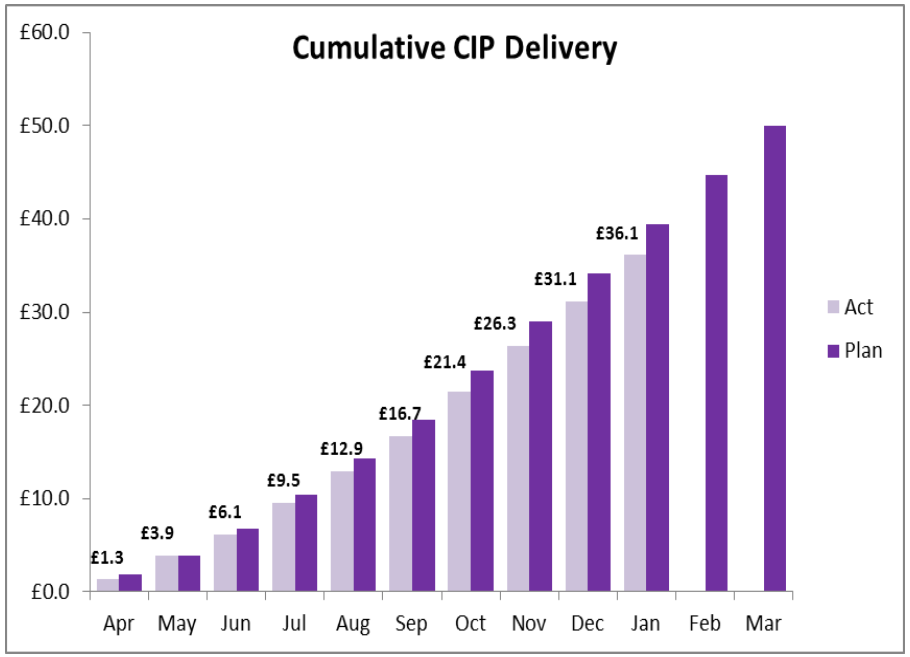


Trust Overview

- Overall the Trust is reporting a Pre-PSF deficit of £46.0m at the end of Month 10, which is £20.3m behind plan.
- **SLA Income** is £8.8m under plan. The main area of note is Elective with a material adverse variance (£7.9m), which is driven by lower than planned volumes of activity (14.0m) partially offset with increased income per case (£6.2m).
- **Other income** is £0.1m under plan, which is primarily Private patient income shortfall in Cardiology CAG.
- **Pay** is £2.4m overspent. Medical staffing overspends of £6.0m are partially offset by non-medical staffing underspends of £3.6m due to vacancies. It should be noted that within staff groups there are areas of over as well as under spending.
- **Non-pay** is £9.3m overspent, mainly owing to increased pass-through income and delay in Procurement CIP delivery.
- **PSF Income** is adverse to plan in M10 by £7.8m, as the Trust has not met the pre-PSF control total target of a £25.7m deficit.
- **CIP delivery** of £36.1m is £3.3m behind plan. The Clinical Divisions' shortfalls have been partially offset by Overheads and Central schemes. Delivery to plan is:
  - Pay £1.0m favourable
  - Non-pay £0.7m adverse
  - Income £3.6m adverse

2. Month 10 CIP Performance





CIP Delivery Overview

- At the end of Month 10, the Trust is reporting delivery of £36.1m of savings /additional income through its Cost Improvement Programme.
- This compares to an external plan to have delivered £39.4m of savings/ additional income by Month 10. Overall delivery is adverse of plan by £3.3m.
- The adverse variance to plan is due to under delivery of CIPs across all divisions as follows:
  - CWDTC - £491k
  - MedCard - £1,282k
  - SCNT - £1,800k

  primarily due to the under achievement of income and non-pay schemes.

Year End Forecast & Actions

- Based on the forecasting exercise, the Trust identifies £50m CIP forecast delivery which matches the 2018/19 plan, albeit with risks and opportunities.
- £46m is assessed as 'firm' delivery
- £4m is assessed as 'subject to some delivery risk' and key mitigation includes:
  - Delivery of divisional improvement actions £0.8m
  - Delivery of corporate improvement actions, primarily procurement and non-recurrent, £3.2m

3. Balance Sheet as at Month 10

	Mar-18 Audited (£m)	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Fixed assets	**377.2**	**398.7**	**379.3**	**-19.4**
Stock	**6.4**	6.4	7.8	1.4
Debtors	**112.3**	103.8	94.4	-9.4
Cash	**3.5**	3.0	3.6	0.6
Creditors	**-118.4**	-113.6	-121.8	-8.2
Capital creditors	**-15.4**	-6.6	-5.1	1.5
PDC div creditor	**0.0**	-0.1	-0.3	-0.2
Int payable creditor	**-0.7**	-2.7	-2.4	0.3
Provisions< 1 year	**-0.2**	-0.2	-0.2	0.0
Borrowings< 1 year	**-57.7**	-58.3	-57.6	0.7
Net current assets/-liabilities	**-70.2**	**-68.3**	**-81.6**	**-13.3**
Provisions> 1 year	**-1.0**	-0.6	-0.8	-0.2
Borrowings> 1 year	**-241.6**	-282.1	-277.3	4.8
Long-term liabilities	**-242.6**	**-282.7**	**-278.1**	**4.6**
Net assets	**64.4**	**47.7**	**19.6**	**-28.1**
Taxpayer's equity				
Public Dividend Capital	**133.2**	133.2	133.4	0.2
Retained Earnings	**-167.9**	-184.6	-212.9	-28.3
Revaluation Reserve	**97.9**	97.9	97.9	0.0
Other reserves	**1.2**	1.2	1.2	0.0
Total taxpayer's equity	**64.4**	**47.7**	**19.6**	**-28.1**

M01-M10 YTD Balance Sheet movement

- Fixed assets are £19.4m lower than plan due to lower capital spend than plan . It is unlikely that the Trust will receive any capital funding in 2018/19.
- Stock decreased in month by £0.3m and remains £1.4m higher than plan due mainly to increase in Pharmacy and Cardiac stock. Pharmacy stock should reduce significantly over the remainder of the year.
- Overall debtors are £9.4m lower than plan.
- Creditors are £8.2m higher than plan relating mainly to the rescheduling of the payment of NHSPS rental charges and other NHS suppliers.
- Capital creditors are lower £1.5m than plan due to lower capital expenditure . No DH capital loans has been received to date.
- The cash position is £0.6m better than plan. Cash resources are tightly managed at the end of the month to ensure the £3.0m minimum cash balance is not exceeded.
- The Trust has borrowed £42.3m YTD for deficit financing which is more than plan. The Trust will drawdown £7.1m for February and has requested £2.5m for March to finance the deficit..
- The Trust had not drawn down any capital loans to date. The capital bid for approx £27.9m was submitted to NHSI was revised down to £18.0m as per request from to submit based on ability to spend by March. It is now unlikely that the Trust will receive any capital funding in 2018/19.
- The deficit financing borrowings are subject to an interest rate 3.5%. Also borrowings for new finance leases are lower than plan due to delay in receipt of capital loan

4. Month 10 YTD Analysis of Cash Movement

	YTD Plan £m	YTD Actual £m	YTD Variance £m
Cash balance 01.04.18	**3.5**	**3.5**	**0.0**
Income and expenditure deficit	-16.7	-45.0	-28.3
Depreciation	19.6	19.6	0.0
Interest payable	8.9	8.9	0.0
PDC dividend	0.7	0.7	0.0
Other non-cash items	-0.1	-0.2	-0.1
Operating deficit	**12.4**	**-16.0**	**-28.4**
Change in stock	0.0	-1.3	-1.3
Change in debtors	10.5	17.9	7.4
Change in creditors	-6.8	3.3	10.1
Net change in working capital	**3.7**	**19.9**	**16.2**
Capital spend (excl leases)	-48.4	-31.6	16.8
Interest paid	-7.1	-7.3	-0.2
PDC dividend paid	-0.5	-0.4	0.1
Other	-0.3	-0.1	0.2
Investing activities	**-56.3**	**-39.4**	**16.9**
Revolving facility - repayment	0.0	0.0	0.0
Revolving facility - renewal	0.0	0.0	0.0
WCF borrowing - new	21.8	42.3	20.5
Capital loans	24.7	0.0	-24.7
Loan/finance lease repayments	-6.8	-6.7	0.1
Cash balance 31.1.19	**3.0**	**3.6**	**0.6**

M01-M10 YTD cash movement

- The cumulative M10 I&E deficit is £45m, £28.3m adverse to plan. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £45m, depreciation (£19.6m) does not impact cash. The charges for interest payable (£8.9m) and PDC dividend (£0.7m) 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 £16.0m.
- The operating deficit variance from plan of £28.4m.
- Working capital is better than plan by £16.2m. The favourable variance on debt comprises £2.6m favourable variance on invoiced debt and a £10m adverse variance on accrued debt. The £10.1m favourable variance on creditors relates mainly to the timing of payments for other NHS bodies. The Trust has borrowed £42.3m YTD which is in higher than the YTD . The Trust had a draw down of £5.6m loan in January and has secured £7.1m in February and requested £2.5m for March. If the March draw down is approved, cumulative working capital borrowings would be £30.1m more than the plan as expected, to fund the planned deficit. The borrowings are subject to an interest rate of 3.5% for the amounts drawn since November 17.

January cash position

- The Trust achieved a cash balance of £3.6m on 31 January 2019, £0.6m higher than the £3m minimum cash balance required by NHSI and in line with the forecast 17 week cash flow submitted last month.
- **The Trust will remain dependent on monthly borrowing from DH given the higher I&E deficit.**

5a. Capital Programme – total, internal and at risk

TOTAL - CAPITAL EXPENDITURE POSITION

Spend category	Internal Budget £000	M10 YTD budget £000	M10 YTD exp £000	M10 YTD var £000
Infrastructure renewal	5,732	5,633	5,538	95
IT	3,220	3,220	6,720	-3,500
Medical equipment	1,890	1,890	869	1,021
Major projects	5,756	5,647	5,653	-6
Other	1,108	1,048	1,371	-323
SWLP	545	544	243	301
Urgent £11.8m March 2018 projects	711	712	1,080	-368
Total	18,963	18,694	21,474	-2,780

INTERNAL CAPITAL BUDGET only

Spend category	Internal Budget £000	M10 YTD budget £000	M10 YTD exp £000	M10 YTD var £000
Infrastructure renewal	5,732	5,633	4,877	756
IT	3,220	3,220	3,233	-13
Medical equipment	1,890	1,890	869	1,021
Major projects	5,756	5,647	5,650	-3
Other	1,108	1,048	1,371	-323
SWLP	545	544	243	301
Urgent £11.8m March 2018 projects	711	712	1,080	-368
Total	18,963	18,694	17,323	1,371

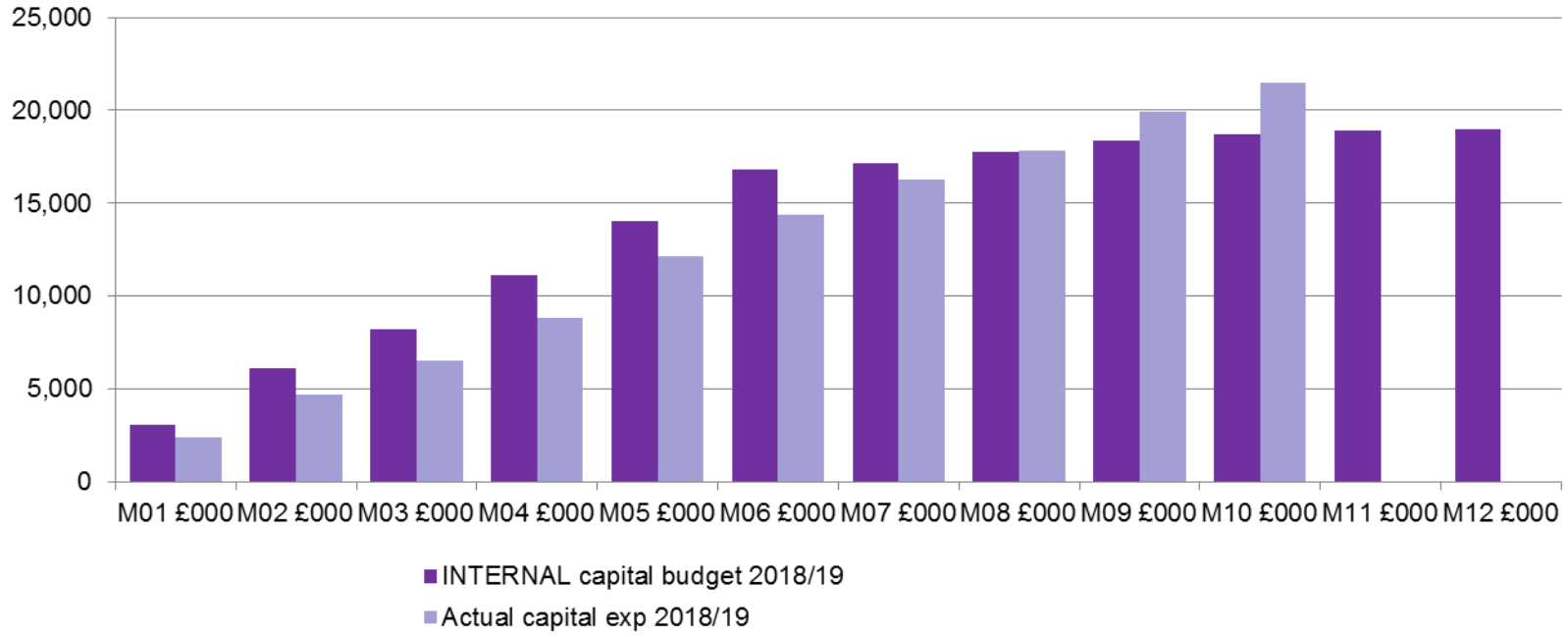
CAPITAL AT RISK EXPENDITURE only

Spend category			M10 YTD exp £000	M10 YTD var £000
Infrastructure renewal			661	-661
IT			3,487	-3,487
Medical equipment			0	0
Major projects			3	-3
Other			0	0
SWLP			0	0
Urgent £11.8m March 2018 projects			0	0
Total			4,151	-4,151

5b. Internal capital budget and expenditure M10

St George's University Hospitals NHS
NHS Foundation Trust

INTERNAL capital budget 2018/19 (excl bid - not approved) and YTD exp



- The Trust's internally funded capital expenditure budget for 2018/19 is £18.9m.
- The Trust has incurred capital expenditure of £21.4m in the first ten months of the year. This comprises £17.3m against the YTD internal capital budget of £18.7m and £4.1m expenditure incurred 'at risk' on the projects for which the Trust has submitted a bid for capital funding to NHSI. Therefore the capital programme is over spent by approx £2.8m at M10 overall. In addition to the spend at risk expenditure of £4.1m a further £1.8m has been approved.
- **The total amount spent and committed for Capital at Risk is £5.9m, therefore the Trust has now reached the limit approved of £6m.**
- The main component of the year to date under spend on internal capital relates to the biggest project – the Lanesborough wing stand-by generators project (Infra Renewal category) which is under spent by approx £700k as at M10. This project and Medical equipment are behind schedule but is forecast to come within budget and so the M10 YTD underspend represents a temporary timing difference.

6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M10 YTD)	Actual (M10 YTD)
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
Distance from financial plan	n/a	4
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%

Commentary

- 1 represents the best score, with 4 being the worst.
- At the end of January, 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. The internal Trust cap is lower than the external cap of £21.3m.
- The distance from plan score is worked out as the actual % YTD I&E deficit (6.50%) minus planned % YTD I&E deficit (2.30%). This value is -4.20% which generates a score of 4.
- Distance from plan score in this report refers to the Trust plan submitted to NHS Improvement on 20th June.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	28 February 2019	**Agenda No**	**4.1**
Report Title:	**Clinical Strategy Highlight Report**		
Lead Director/ Manager:	**Suzanne Marsello, Director of Strategy**		
Report Author:	Laura Carberry, Strategy and Partnership Manager		
Presented for:	Update		
Executive Summary:	In March 2018, the Board agreed to commence the development of a 5-year Clinical Service Strategy. This paper advises the Trust Board on the development of the 5-year Clinical Service Strategy to date (due end March 2019) and the deliverables in February 2019, outlining progress so far, next steps and the identified issues and risks, in line with the agreed process and timescales.		
Recommendation:	The Board is asked to note the progress reported and the identified issues and risks.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Safe, Effective and Well-Led		
Single Oversight Framework Theme:	Strategic Change		
Implications			
Risk:	As outlined in paper		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee	**Date:**	13 February 2019
Appendices:	Appendix 1: Clinical Strategy Development Timeline and Workstreams Appendix 2: Issues to be addressed as Clinical Strategy Development progresses		

Trust Strategy: Highlight Report

1.0 Purpose

1.1 This paper advises the Trust Board on the development of the 5-year Clinical Service Strategy to date (due end March 2019) and on the deliverables in February 2019, outlining progress so far, next steps and the identified issues and risks, in line with the agreed process and timescales.

2.0 Progress in February 2019:

2.1 All actions committed to are on plan for February 2019.

Deliverables/ Milestones for February 2019	Progress	Actions for March 2019	Completion Date/ RAG*
Overall Programme Plan (Workstream 1)	Programme Plan 'live' and ongoing progress on workstreams Project Risk Register reviewed	Delivery ongoing	On plan
Development of Options (Workstream 2)	Board Seminar on Strategy for Support Services (12 February)	N/A	On plan
Alignment, Deliverability and Prioritisation (Workstream 3)	Alignment of the different propositions and assessment of cohesion/ common themes, conflicts and likely reactions of stakeholders	Completion of deliverables to enable Board Seminar to cover Clinical Strategy Final Review (6 March 2019)	On plan
Communication and Stakeholder Engagement (Workstream 4)	Engagement Events completed in early February 2019: • Public x 3 • Staff x 4 (including 1 at Queen Mary's Hospital)	Completion of deliverables to enable feedback to Board Seminar to cover Clinical Strategy Final Review (6 March 2019)	On plan
'Into Delivery' Planning (Workstream 5)	Alignment to 2019/20 Business Planning i.e. Y1 of a 5yr Strategy Board Seminar and Challenge Sessions in early February 2019 1st draft Operating Plan submission to NHSI (12 February 2019)	Final Operating Plan submission to NHSI (March 2019)	On plan
Enablers and Interdependencies (Workstream 6)	Initial discussions with Estates, IT and Workforce to agree approach and plan	Initial Meetings planned to progress this	On plan
Production/ Publication of Strategy (Workstream 7)	Agreement on Communication and Engagement plan for launch and publication of Strategy including: • Communication with Clinical Divisions internally; • Communication and Engagement with Key Stakeholders; • Confirmation of Plain English Crystal Mark processes and timescales, and; • Proposed St George's Day launch (23 April 2019)	Board Meeting (28 March 2019) to review and sign-off Strategy Completion of deliverables to enable launch and publication of Strategy (April 2019)	On plan

** RAG rating refers to current in-month progress of the workstreams, rather than an assessment of the content covered in its entirety with its related risks.*

A Clinical Strategy Development Timeline is attached (Appendix 1) along with a description of the 7 workstreams.

3.0 Key Milestones for February 2019 onwards

- Board Seminar covering Support Services and a Cancer Services Review (12 February 2019) plus an overall Strategy Review and Triangulation (6 March 2019);
- Engagement Events for Staff (5, 6, 18 and 21 February 2019) and the Public (7, 15 and 19 February 2019).

4.0 Issues and Risks

In approaching the finalisation and publication of the Clinical Strategy, we have started to articulate and identify risks not only to the delivery of a publication but also to the implementation of the strategy.

No	Area	Description of Issue/ Risk	Mitigation	RAG
3.	Reputational (Engagement Events)	Engagement Events- brief, concise sessions. This could lead to criticisms of engagement being inauthentic and a perception of the process being too rapid.	February 2019, early invitations to stakeholders and venues landed and locked down. Communications, Divisions, Strategy and Transformation teams working together on content/ format and delivery of events. Over 600 people have attended over 30 events since July 2018.	
4.	Capacity and Engagement in Implementation of the Strategy (Clinical Divisions)	Bandwidth and breadth of challenges for Clinical and Managerial colleagues in the divisions and competing day-to-day priorities- finance, operational performance, quality standards- could lead to a lower prioritisation of strategy work leading to difficulties in implementing a strategy	High-level Implementation Plans to be agreed as part of the 2019/20 Business Planning process and will be further refined in Q1, 2019/20. Strategy Team to engage and provide support, as far as possible, but clinical expertise and input will continue to be a key input and necessary requirement and resource restraint	

5.0 Recommendation

The Board is asked to:

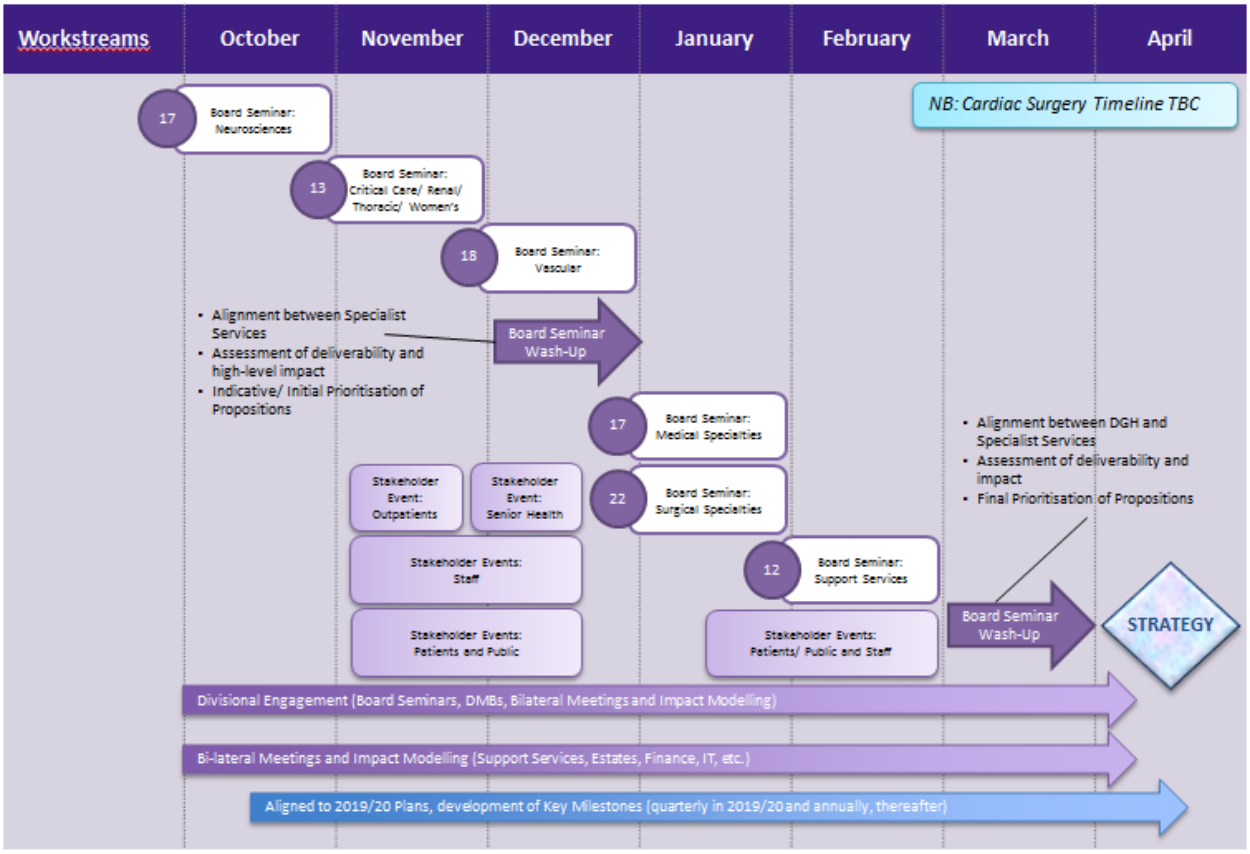
- Note the progress reported and the identified issues and risks.

Author: **Laura Carberry, Strategy and Partnership Manager**

Date: **20 February 2019**

Appendix 1: Clinical Strategy Development Timeline and Workstreams

Clinical Strategy Development Timeline



Clinical Strategy Workstreams

Workstream	Description
1. Programme Management	Programme plan, risk register, etc.
2. Development of Options	Development of options for board to consider, (e.g. as per work to date for board seminars)
3. Alignment, Deliverability and Prioritisation	Making sure that the board's preferred options align and that any conflicts/issues are visible & managed, enabling the board to prioritise where necessary, and ensuring that what goes into the strategy is realistic & deliverable (with reference to money, estates, workforce, reactions of competitors/commissioners etc.)
4. Communications and Stakeholder Engagement	In developing the strategy and then disseminating once published. Covering a) strategically important stakeholders such as commissioners, regulators and b) staff & public.
5. 'Into delivery' Planning	Development of high-level milestones over the next 5 years for implementing the strategy
6. Enablers and Interdependencies	Alignment with business planning round for 19/20, and strategies for estates, finance (medium term financial plan), IT, workforce, research.
7. Production and Publication of Strategy	Agreeing what it should look like / who it should speak to; drafting/writing it; graphic design; publishing etc.

Appendix 2: Issues to be addressed as Clinical Strategy Development progresses

These are issues that have been identified from early strategy discussions and are recorded to ensure that they are not lost during the development process. They are recorded here to ensure that they are not lost during the development process.

- The clinical strategy needs to be developed taking account of research and education priorities: meeting held with Principal of SGUL; Medical Director is a member of Strategy Project Steering Group. Medical Director to convene meeting re development of Research Strategy.
- Clinical innovation is a core part of the strategy: to be considered with each service as plans developed.
- The external environment analysis should include systems outside of SWL e.g. South London (links to specialised commissioning reviews), Surrey and Sussex: presentation to Board Strategy Seminar in July.
- Working within the SWL system at borough level with primary care, mental health and community provider colleagues within the wider health system is important: this will be picked up as the strategy work for the secondary health/ local hospital services is developed.
- Maximising the relationship with St. George's, University of London is an important partnership: meeting held with Principal of SGUL. Input to Board Seminars and links to Research Strategy.
- Include Kingston University as a key partner regarding training of nurses and other professional groups.

Meeting Title:	**Trust Board**		
Date:	28 February 2019	**Agenda No**	**4.2**
Report Title:	**NHS Long Term Plan**		
Lead Director/ Manager:	**Suzanne Marsello, Director of Strategy**		
Report Author:	Ralph Michell, Head of Strategy		
Presented for:	Update		
Executive Summary:	In January, the national NHS Long Term Plan was published. It sets out a plan for the next decade for the health service, including: • "a new service model for the 21st century": integrated local care systems, with local providers and commissioners collaborating to take responsibility for the health of (and health spending on) local populations; stronger primary/community care to prevent/manage more conditions in the community; a range of measures to reduce pressure on A&E; and transformation of outpatient services, significantly reducing the number of hospital appointments. • Action on prevention and health inequalities (e.g. smoking, obesity, alcohol, air pollution) • Progress on a number of national priorities: maternity and children's services, cancer, cardiovascular disease, stroke, diabetes, respiratory care, mental health, and short waits for planned care. • "Giving NHS staff the backing they need", with a range of ambitions on the workforce, to be set out in more detail in a workforce 'implementation plan' later in 2019 • Mainstreaming digitally-enabled care across the NHS • A range of commitments on finance, including returning NHS providers to balance, achieving cash-releasing productivity growth of 1.1% p.a., reducing growth in demand, reducing unjustified variation in performance, and making better use of capital investment/existing assets. The plan will have a number of strategic implications for St George's. This paper sets out the contents of the Long Term Plan, and the implications for St George's, in more detail.		
Recommendation:	Board is asked to note this update, and agree that the Trust should position itself accordingly in its 5 year strategy to be published in April 2019.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Safe, Effective and Well-Led		
Single Oversight Framework Theme:	Strategic Change		
Implications			

Risk:	As outlined in paper		
Legal/Regulatory:	As outlined in paper		
Resources:	As outlined in paper		
Previously Considered by:	Trust Executive Committee	**Date:**	20 February 2019
Appendices:			

The NHS Long Term Plan

1.0 Purpose

1.1 This paper summarises the recently-published NHS Long Term Plan, and sets out some potential implications for St George's.

1.2 This summary is not comprehensive in the sense that it does not cover every commitment set out in the plan. Instead it focuses on those commitments most relevant to St George's. It is structured broadly as per the chapters of the Long Term Plan itself:

- A new service model for the 21st century
- Action on prevention and health inequalities
- Progress on national clinical priorities
- Workforce
- Digitally-enabled care
- Finance
- Next steps

2.0 A new service model for the 21st century

Community care

2.1 The Long-Term Plan sets out a vision of more integrated care that builds on longstanding national policy.

2.2 The plan envisages more horizontal integration across primary care and community services, with **primary care networks** (typically covering 30-50,000 people) taking a proactive approach to managing population health. From 2020/21, these networks will assess their location population by risk of unwarranted health outcomes, and working with local community services, target support to those that need it. To provide that support, as part of "fully integrated community-based health care", expanded neighbourhood teams are expected to comprise staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers, allied health professionals, social care and the voluntary sector. GP practices in each network will enter network contracts, alongside their existing contracts, including a single fund through which all network resources will flow. Primary care networks will also be offered a new 'shared savings' scheme so that they benefit from action to reduce avoidable A&E attendances, admissions, delayed discharge and outpatient attendances.

2.3 Alongside these primary care networks the Long Term Plan commits to increasing the capacity and responsiveness of **community and intermediate care services**, and rolling out the 'Enhanced Health in Care Homes' model across the country to "all care home residents who would benefit" by 2023/24.

2.4 To support these ambitions the plan describes a national guarantee that **spending on primary and community health services** will grow faster than the NHS budget overall.

2.5 The plan does not assume that this additional investment in community and primary care will enable a reduction in **hospital capacity**. Instead its 'core assumption' is that demand for hospital services will continue on current trend, and that where local areas are able to implement the model above effectively, they will benefit from an additional 'dividend'.

Urgent & emergency care

2.6 The plan commits the NHS to embedding a **single multidisciplinary Clinical Assessment Service (CAS)** within integrated 111, ambulance dispatch and GP out of hours services from 2019/20, and fully implementing the **Urgent Treatment Centre model** by autumn 2020 (which St George's is on track to do at Queen Mary's Hospital).

2.7 Every acute hospital with a type 1 A&E department is expected to move to a "comprehensive model of **Same Day Emergency Care**" during 2019/20, with the ambition that this will increase the proportion of acute admissions discharged on the day of attendance from a fifth to a third. Acute trusts are also expected to reduce avoidable admissions through the establishment of **acute frailty services** operating for at least 70 hours a week, so that patients can be assessed and treated by multidisciplinary teams delivering comprehensive geriatric assessments in A&E and acute receiving units.

2.8 The plan sets a goal over the next two years of achieving and maintaining an average **Delayed Transfer of Care** (DTOC) figure of 4,000 or fewer delays, and over the next five years of reducing them further.

Outpatient services

2.9 The expectation is that **outpatient services will be "fundamentally redesigned"**. The Long Term Plan describes how hospital outpatient visits have nearly doubled over the past decade, arguing that "the traditional model of outpatients is outdated and unsustainable." In future it envisages better support to GPs to avoid the need for a hospital referral, online booking systems, appointments closer to home, and alternatives to traditional appointments where appropriate including digital appointments. The consequence is that "over the next five years patients will be able to avoid up to a third of face-to-face outpatient visits, removing the need for up to 30 million outpatient visits a year."

Fewer organisations, focused on population health

2.10 The Long Term Plan articulates a vision in which NHS organisations (including providers) are increasingly concerned with, responsible for, and paid for delivering, population health.

2.11 By April 2021, **Integrated Care Systems** will cover the whole country, "growing out of" the current network of Sustainability and Transformation Plans. Through ICSs, providers and commissioners will make shared decisions on how to use resources, design services and improve population health.

2.12 On the **interface between the NHS and local government**, the plan says that the NHS will continue to support local approaches to blending health and social care budgets, with further proposals for social care and health integration in the forthcoming Green Paper on adult social care. It promises a review of the Better Care Fund, to conclude in early 2019, "to ensure it meets its goals". The plan also says that the Government "will consider whether there is a stronger role for the NHS" in commissioning a range of services currently commissioned by local government: sexual health services, health visitors, and school nurses.

2.13 A range of measures will encourage **NHS providers to concern themselves with population health**. The CQC will place greater emphasis on partnership working and system-wide quality in its regulatory activity, so that providers are held to account for what they are doing to improve quality across their local area. New licence conditions for NHS providers will be consulted on, aimed at supporting providers to take responsibility for use of NHS resources across local areas and population health. Reforms to the payment system will

move funding away from activity-based payments and ensure a majority of funding is population based.

2.14 The Long Term Plan also talks about **CCGs becoming "leaner, more strategic organisations"**, and says that each ICS will "typically involve a single CCG". It states that NHS Improvement will take "a more proactive role" in supporting **collaborative approaches between trusts**, including formal mergers.

2.15 In the longer term, the NHS Long Term Plan raises the **possibility of legislative change** to "support more rapid progress". The legislative changes floated include giving trusts new duties to promote the health of their local population and the sustainability of the local NHS system; enabling NHS foundation trusts to create joint committees with others (e.g. local commissioners as part of ICS arrangements), removing the Competition and Markets Authority's duties to intervene in NHS provider mergers, freeing up NHS commissioners to decide the circumstances in which they should use procurement, and increasing flexibility in the NHS pricing regime.

Implications for St George's

2.16 These changes will present a number of opportunities and risks for St George's, in terms of our role in the local health system and our model of care.

2.17 Key opportunities might include:

- Growing potential to collaborate with our system partners to prevent or manage illness amongst our local population, backed up with increasing financial and regulatory incentives.
- The STP, and in future potential ICS, will continue to grow in importance as a forum for shared decision-making. As the largest trust in South West London, St George's will continue to have an important leadership role in helping shape the future of our local health economy.
- Support from commissioners and regulators for some of the changes to our model of care that the Trust is already pursuing: for instance, transforming our outpatient service offering, providing more 'same day emergency care', offering 'digitally-enabled care' across our services, and improving our acute frailty capacity. The Trust has been developing its strategy for the coming five years cognisant of these national priorities.
- The potential to pursue our ambitions in a more integrated provider and commissioner landscape, and therefore a less complex partnership environment.

2.18 Key risks might include:

- Pursuing the ambitions in the long-term plan in the context of limited financial resource, both for the Trust and the wider health economy in South West London.
- Pursuing the ambitions in the long-term plan in the context of a changing provider and commissioner landscape, with the potential risk of this organisational/partnership change diverting attention from those ambitions. The Trust is likely to see greater integration between primary and community care, built around primary care networks; and it is possible that national support for more collaboration or mergers between commissioners and providers will make itself felt in South West London.

2.19 The Trust will need to reflect these implications appropriately in its 5-year strategy to be published in April.

3.0 More NHS action on prevention and health inequalities

3.1 The plan sets out a range of measures to improve prevention and tackle health inequalities. On prevention, the plan focuses on smoking, obesity, alcohol, air pollution, and antimicrobial resistance.

3.2 Whilst most of these measures will be primarily for the Trust's partners in South West London to pursue (such as public health, primary care or community services), some will have a more direct impact acute trusts:

- By 2023/24, all **people admitted to hospital who smoke** will be offered NHS-funded tobacco treatment services, and this model will be adapted for expectant mothers/their partners to make available a new 'smoke-free pregnancy pathway'
- A new version of **hospital food standards** will be published in 2019, strengthening the requirements and including substantial restrictions on foods high in fat, salt and sugar
- Hospitals with the highest rate of **alcohol dependence-related admissions** will be supported to fully establish Alcohol Care Teams
- Continued implementation of the Government's five-year action plan on **Antimicrobial Resistance**

3.3 The plan also sets out **measures to tackle the health inequalities** experienced by poorer communities, vulnerable mothers, people with severe mental illness, people with a learning disability or autism, rough sleepers, carers, and people with gambling problems. Of particular relevance to the Trust are the following:

- NHS England will continue to target a higher share of funding towards geographies with high health inequalities.
- All local health systems will be expected to set out during 2019 how they will specifically reduce health inequalities by 2023/24
- An enhanced and targeted continuity of carer model will be implemented in maternity services, to improve outcomes for the most vulnerable mothers and babies – by 2024, 75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period
- Further investment in meeting the needs of rough sleepers, e.g. to reduce A&E attendances and the number of hospital bed days occupied by homeless people
- Tackling preventable deaths amongst people with a learning disability or autism, including NHS staff receiving information and training on supporting these patients.

<u>Implications for St George's</u>

3.4 The Trust will need to continue to play its part in tackling health inequalities and improving public health, paying particular attention to the support we offer our patients who smoke, mothers at greater risk of health inequalities in maternity services, and groups of patients who use our services who might need additional support such as the people with a learning disability or autism, the homeless, or alcohol-users.

3.5 Whilst Wandsworth and Merton are relatively wealthy boroughs compared to others in England, they are still marked by significant health inequalities. In Wandsworth, life expectancy in the most deprived areas is 9.3 years lower for men and 4.5 years lower for women than in the borough's least deprived areas. In Merton, life expectancy is 9.4 years lower for men and 9.3 years lower for women in the 30% most deprived wards compared to the 30% least deprived. Our local population is also diverse, with high numbers of people from the BME communities where the Long Term Plan envisages greater continuity of care through pregnancy – for instance, 29% of the overall population in Wandsworth and 37% of

the population of Merton are from BME backgrounds. 52.7% of the population of Tooting is from a BME background.

4.0 Further progress on national clinical priorities

4.1 The Long-Term Plan sets out a number of national priorities for further progress over the next decade:

- Children and young people
- Cancer
- Cardiovascular disease
- Stroke care
- Diabetes
- Respiratory disease
- Adult mental health services
- Short waits for planned care

Children and young people

4.2 A key implication for St George's is that the plan commits the NHS to a range of actions in **maternity and neonatal** services. These include "accelerating action" to achieve a 50% reduction in still birth, maternal mortality, neonatal mortality and serious brain injury by 2025, rolling out and expanding the Saving Babies Lives Care Bundle, supporting the development of specialist pre-term birth clinics for women with heightened risk of pre-term birth, ensuring every trust in England is part of the National Maternal and Neonatal Health Safety Collaborative, continuing to offer more women continuity of care throughout pregnancy, birth and the postnatal period, improving access to perinatal mental health care, improving access to postnatal physiotherapy, redesigning and expanding neonatal critical care services, and enhancing care coordination in neonatal critical care networks.

4.3 The plan points to the opportunity to better **support children in primary or community care settings, reducing the number of unnecessary A&E attendances**, and says that "local areas will design and implement models of care that are age appropriate, closer to home, and bring together physical and mental health services". It says that from 2019/20, clinical networks will be rolled out to improve quality of care for **children with long-term conditions** such as asthma, epilepsy and diabetes. It also says that over the next five years, **paediatric critical care and surgical services** will evolve, optimising access to specialised and non-specialised services through paediatric networks.

4.4 The plan also commits the NHS to significant investment in **child and adolescent mental health services (CAMHS)**, further progress on supporting children and young people with a learning disability/autism, and improvements in childhood immunisation.

Cancer

4.5 The Long Term Plan sets a new ambition that by 2028, the proportion of **cancers diagnosed at stages 1 and 2** will rise from around 50% to around 75% nationally.

4.6 Screening programmes will be modernised and age thresholds lowered in some cases. The Bowel Cancer Screening Programme will use a new and improved test (Faecal Immunochemical Test, or FIT), and the starting age for screening will be lowered from 60 to 50. HPV primary screening for cervical cancer will be implemented across England by 2020. Lung health checks piloted in Liverpool and Manchester will be extended, and more mobile lung CT scanners will be deployed.

4.7 Primary care networks (described above) will be required to help improve early diagnosis of patients in their neighbourhoods by 2023/24, and a new faster diagnosis standard will be introduced from 2020 to ensure patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from a GP or from screening.

4.8 There will be a "**radical overhaul of the way diagnostic services are delivered**". From 2019, Rapid Diagnostic Centres will be rolled out across the country, building on pilots focused on patients with non-specific symptoms but "in time" playing a role in the diagnosis of all patients with suspected cancer. Sir Mike Richards has been asked to lead a review of cancer screening programmes and diagnostic capacity, making initial recommendations by Easter 2019 and final recommendations in the summer of 2019. The plan says that NHS capital settlement, to be negotiated in the 2019 Spending Review, will support investment in new equipment, including CT and MRI scanners. The way diagnostic services are organised will also be reformed, with a focus on pathology and imaging networks.

4.9 The £130 million **upgrade of radiotherapy machines** across England will be completed, reforms to how radiotherapy is paid for will support further equipment upgrades, and a more networked approach to radiotherapy will lead to improved outcomes.

4.10 The use of **molecular diagnostics** will be extended. Over the next ten years, the NHS will routinely offer genomic testing to all people with cancer for whom it would be of clinical benefit, and from 2019, the NHS will begin to offer all children with cancer whole genome sequencing.

4.11 The plan says that the NHS "will develop and implement networked care to improve outcomes for **children and young people with cancer**, simplifying pathways and transitions between services and ensuring every patient has access to specialist expertise".

4.12 Finally, cancer patients will be offered more **personalised care** (including needs assessment, care plan) and after treatment patients will move to a follow-up pathway that suits their needs and ensures they can get rapid access to clinical support where they are worried that their cancer may have recurred.

Cardiovascular disease

4.13 The long-term plan sets out a number of improvements in cardiovascular disease aimed at **primary care** (such as greater access to echocardiography, early detection of high blood pressure, raised cholesterol and atrial fibrillation).

4.14 It also sets out some **improvements in acute hospital settings**, where St George's has been a pioneer in establishing the country's first dedicated heart failure inpatient unit. Specifically, the plan sets out improvements in rapid access to heart failure nurses for patients admitted to hospital but not on a cardiology ward. Finally it envisages scaling up cardiac rehabilitation, aiming to avoid 50,000 acute admissions over 10 years.

Stroke care

4.15 The plan commits the NHS to centralising **hyper-acute stroke care** across the country, as has been done in London. It proposes to drive up use of **thrombolysis** and mechanical **thrombectomy** (such that the c. 20% of patients who could benefit from thrombolysis do so, and c. 10% of stroke patients benefit from thrombectomy) – this is a field where again St George's has been a national leader, setting up the country's first and only 24/7 thrombectomy service.

4.16 There are commitments to modernising the **stroke workforce**, with a focus on cross-specialty and in some cases cross-profession accreditation of particular competencies, including a new credentialing programme for hospital consultants from a variety of disciplines who will be trained to offer mechanical thrombectomy.

4.17 From 2020, the plan commits to improving **post-hospital stroke rehabilitation** models, making more use of integrated and high-intensity rehabilitation.

4.18 The plan also envisages, with regards to **diagnostics**, greater use of CT perfusion scans, improved access to MRI scanning, and the potential use of artificial intelligence in the interpretation of CT and MRI scans to support decisions on suitability for thrombolysis and thrombectomy.

Diabetes

4.19 The Long-Term Plan commits to supporting improvements in **self-care and primary care** (expansion of structured education, digital self-management tools, flash glucose monitors, diabetes treatment targets in primary care), but it also says that the NHS will ensure that "all hospitals in future provide access to **multidisciplinary footcare** teams and **diabetes inpatient specialist nursing teams**", and commits that by 2020/21, all pregnant women with type 1 diabetes will be offered **continuous glucose monitoring**.

Respiratory disease

4.20 On respiratory disease, the plan focuses on supporting better diagnosis of respiratory conditions in primary care, expanding access to pulmonary rehabilitation, medicine reviews by pharmacists in primary care networks, and ensuring that patients identified with community acquired pneumonia in ED can be cared for safely out of hospital by receiving nurse-led supported discharge services.

Adult mental health

4.21 The Long-Term Plan makes a range of commitments on adult mental health services, backed up by a pledge that mental health will receive a growing share of the NHS budget. Of particular relevance for St George's are the commitments to:

- Expand access to **IAPT services** (psychological therapies), with a focus on those with long-term conditions
- Expand services for people experiencing a **mental health crisis**, such that a 24/7 community-based mental health crisis response for adults and older adults is available across England by 2020/21
- Ensure that no acute hospital is without an **all-age mental health liaison service in A&E** and inpatient wards by 2020/21, and that at a growing proportion of these liaison services meet a core set of standards (50% by 2020/21, 70% by 2023/24, 'working towards 100% coverage thereafter).
- Specific **waiting time targets for emergency mental health services**, with a clinical review of standards making recommendations on this in 2019/20.
- Reducing **inappropriate ambulance conveyance to A&E for patients with mental health conditions**, introducing mental health nurses in ambulance control rooms to improve triage and improving mental health training for ambulance staff.

Short waits for planned care

4.22 The Long Term Plan says that "the local NHS is being allocated sufficient funds over the next five years to grow the amount of **planned surgery** year-on-year, to cut long waits, and reduce

the waiting list", with "the phasing of this improvement… determined annually through the planning guidance process". The plan sets out commitments that anyone who has been waiting for six months will be reviewed and given the option of faster treatment at an alternative provider, and that an incentive system will be reintroduced under which hospitals and CCGs will both be fined for any patient who breaches 12 months.

4.23 The NHS National Medical Director is undertaking a **Clinical Standards Review**, which will make recommendations in spring 2019/20, and this will include consideration of the impact that outpatient transformation will have on referral to treatment (RTT) performance – given that two thirds of RTT 'clock stops' are outpatient appointments, and that the long-term plan's ambition is to avoid the need for up to one third of outpatient activity.

4.24 On **separating elective and emergency care sites**, the Long Term Plan also says that the NHS will "continue to back hospitals that wish to pursue" the model of managing complex, urgent care on a 'hot' site, separate from planned services provided on a 'cold' site where capacity can be protected to reduce the risk of operations being postponed when more urgent cases come in.

Implications for St George's

4.25 The Trust will have a leading role to play in addressing many of the national clinical priorities in the Long Term Plan, such as cancer, stroke and maternity/children's services – often building on existing work such as our efforts to improve continuity of care during pregnancy through the Maternity Transformation Programme, or our involvement in the West London Cancer Alliance. Elsewhere, following the Trust's decision to cease being the major provider of local community services, our role is likely to be as a partner to other local organisations (such as with South West London and St George's Mental Health Trust on mental health; or with primary care on diabetes and respiratory disease). An important part of the Trust's 5 year strategy will be to set out our own clinical priorities, in the context of these national priorities and those of our local partners. Individual specialties (e.g. maternity services, cancer, paediatrics) across the Trust will need to review the commitments in the Long-Term Plan to ensure they are taking appropriate action where necessary.

4.26 Key opportunities for the Trust could include:

- The potential for the Trust to play a leading role in improving outcomes for children and young people (including through our maternity/neonatal services).
- The potential for the Trust to play a leading role in improving outcomes for cancer patients, particularly in relation to the ambition to diagnose more cancers at an earlier stage. The national push for early diagnosis aligns to feedback the Trust has had from local GPs, as part of the development of our clinical strategy for the next five years, that local primary care colleagues would like more access to diagnostics from St George's. The South West London Health and Care Partnership is currently developing a cancer strategy which may also support these ambitions.
- The potential for the Trust to act as a key partner, alongside other organisations in South West London, in improving outcomes for patients with diabetes, respiratory disease, or cardiovascular disease. For instance, in these areas there is likely to be scope for the Trust to offer training and support for GPs (e.g. to enable greater access to echocardiography in primary care; to support better management of diabetes patients in the community). The national plan gives some recognition to the importance of supporting people with long-term conditions such as diabetes who also experience mental health problems, and improving access to emergency mental health services (where currently, for instance, many children

have to wait in our emergency department for a CAMHS assessment), and there may be opportunities for the Trust to work with South West London St George's Mental Health Trust to improve outcomes for those patients.

4.27 Key risks could include:

- The potential reorganisation of hyper-acute stroke care, where any changes across London or Surrey have the potential to impact on St George's
- The impact of the review of Clinical Standards, where the Trust will need to keep a watching brief on developments which could have a significant impact on the organisation
- The risks associated with seeking to achieve ambitious improvements in patient outcomes when revenue and capital funding is limited

5.0 Workforce

5.1 With the HEE budget yet to be set by Government, the Long-Term Plan commits to a **"workforce implementation plan"** later in 2019, but sets out a number of ambitions in the meantime. These include:

- Increasing the number of undergraduate nursing degrees, reducing attrition from training and improving retention, with the aim of improving the nursing vacancy rate to 5% by 2028
- Developing specific recommendations for allied health professionals (AHPs), in particular those in short supply (paramedics, podiatrists, radiographers, speech and language therapists).
- Examining further options to further grow the number of medical school places
- Testing a range of new incentives in the field of medical training to "accelerate the shift from a dominance of highly specialised roles to a better balance with more generalist ones"
- Measures to increase the number of doctors working in general practice
- New arrangements to support NHS organisations in recruiting overseas
- An expectation, following agreement of the HEE training budget, that investment in continuing professional develop will increase
- Support from NHSI to trusts to deploy electronic rosters or e-job plans
- Investment in scaling up successful volunteering programmes across the country, aiming to double the number of NHS volunteers over the next three years

<u>Implications for St George's</u>

5.2 Whilst some workforce measures in the Long-Term Plan could have a more immediate impact on the Trust (for instance, NHSI support for deployment of electronic rosters or e-job plans), much of the impact on St George's is likely to depend on the detail set out in the 'workforce implementation plan' later in 2019, and the Trust will need to keep a watching brief on developments here.

1.0 Digitally-enabled care

1.1 The Long-Term Plan sets out an ambition that "digitally-enabled care will go mainstream across the NHS". It envisages digital transformation focused on:

- **Empowering people** (for instance, the NHS App will create a standard online way for people to access the NHS; women will be able to access their maternity record digitally, support will be given to the development of a range of apps to support particular conditions, patients with long-term conditions will have access to their health record via the NHS app, patients will be able to incorporate information into their own personal health records).

- **Supporting health and care professionals** ("we will ensure that health and care professionals have the tools they need to efficiently deliver safe and effective patient care… and support the workforce to develop the digital skills they need")
- **Supporting clinical care** (for instance, the NHS app and its browser-based equivalent will enable people to follow a simple triage online to help them manage their own health needs or direct them to the appropriate service; patients will have more access to 'virtual' GP and outpatient appointments; and all providers will be expected to advance to a "core level of digitisation" by 2024, covering clinical operational processes across all settings, locations and departments, with robust modern IT infrastructure services for hosting, storage, networks and cyber security).
- **Improving population health** (for instance, deploying population health management solutions to help Integrated Care Systems understand the areas of greatest health need)
- **Improving clinical efficiency and safety** (for instance, pathology networks, exploiting the potential of artificial intelligence, leading to quicker test turnaround times and improved access to more complex tests; diagnostic imaging networks enabling the rapid transfer of clinical images from care settings to the relevant specialist to interpret).

Implications for St George's

1.2 The Long-Term Plan presents opportunities for the Trust in the sense that it could presage commissioner/regulator support for some of the digital infrastructure priorities the Trust is keen to pursue, such as digitising a range of clinical operational processes, and enabling more 'virtual' interaction with patients. A key risk will be the availability of capital to deliver some of these opportunities, with the NHS's capital budgets to be determined via the Spending Review later in 2019.

7.0 Finance

7.1 The Long Term Plan sets out five 'tests' that the NHS will need to meet to ensure taxpayers' investment is used to maximum effect:

- The NHS will return to **financial balance** (with all organisations in balance by 2023/24)
- The NHS will achieve cash-releasing **productivity growth** of at least 1.1% per year
- The NHS will **reduce the growth in demand** for care through integration and prevention
- The NHS will **reduce variation** across the health system, improving providers' financial and operational performance, and
- The NHS will make better **use of capital** investment and its existing assets to drive transformation

7.2 To support the NHS to meet these five tests, **the way providers are paid will change**. The majority of funding will move away from being activity-based to being population-based; the CQUIN framework will be reformed to make it simpler, more impactful and easier for providers to implement; the marginal rate for emergency tariff and the emergency readmissions rule will be removed; and an updated Market Forces Factor will be phased in over the next five years. Integrated Care Systems (ICSs) will become the level of the system where commissioners and providers make shared decisions about financial planning and prioritisation, and in 2019/20 each STP or ICS will be allocated a 'system control total' - an aggregate required income and expenditure position for providers and CCGs within the local system, with individual organisations able to make changes to their own positions so long as they are net-neutral within the system. Beyond 2019/20, the plan commits to introducing further financial reforms to support ICSs to deliver integrated care. A new Financial Recovery Fund (FRF) will support organisations to reduce their deficits, and as a result of this funding the plan envisages the number of trusts reporting a deficit in 2019/20 to be reduced by more than half, and by 2023/24 no trust to be reporting a deficit. The FRF will mean the end of the control

total regime and Provider Sustainability Fund for all trusts that deliver against their recovery plans by 2021 at the latest.

7.3 The Long-Term Plan sets out a number of **priority areas for improved efficiency** and productivity, including: reducing bank and agency costs; procurement savings through aggregation of volumes and standardising specifications; delivering pathology and imaging networks; reducing inappropriate spend on medicines; reducing administrative costs (including £400 million from providers by 2023/24); improving use of land, buildings and equipment; reducing use of clinically ineffective interventions; improving patient safety to reduce the costs associated with patient harm; and tackling fraud.

7.4 There is a commitment to setting out **reforms to the NHS's capital regime** alongside the 2019 Spending Review, which will include the NHS's long-term capital allocation. These reforms will be aimed at removing the fragmentation of funding sources, and reducing the short-termism of capital decision-making and the uncertainty for local health economies.

Implications for St George's

7.5 Whilst there are a number of areas in which the Long-Term Plan sets out a direction of travel which could have a positive impact on the Trust (such as the less stretching assumptions on productivity, the recognition of the need to invest to deliver savings, and the end of the control total/Provider Sustainability Fund regime), much of the impact on St George's will depend on the detail of the measures outlined above - fundamentally the Trust will continue to face an extremely challenging central task of eliminating its deficit over the coming years.

8.0 Next steps

8.1 The plan describes **2019/20 as a 'transition year'**, with every NHS organisation expected to agree single year operating plans. During this transition year, the Spending Review will set out details of the NHS capital budget and funding for education and training, as well as the local government settlement to cover public health and social care. A 'national implementation framework' and the Clinical Review of Standards will be published.

8.2 During 2019, local health systems will receive five-year indicative financial allocations for 2019/20 to 2023/24, and be asked to **produce local plans** for implementing the commitments set out in the Long Term Plan. These local plans will then be brought together in a detailed national implementation programme in the autumn.

8.3 In South West London, the local STP intends to produce its five year plan partly on a "bottom up" basis, building on borough-level "local health and care plans" plans due to be published shortly. The STP also intends to hold a clinical strategy event in April 2019.

8.3 In **Merton and Wandsworth, "local health and care plans"** are currently in the process of being developed, having been initiated before the publication of the national Long-Term Plan. The emerging priorities in these local plans were set out to Board in January, but in headline terms focus on ensuring that local people "start well", "live well" and "age well", with workstreams as set out below:

	Merton	Wandsworth
Start well	CAMHS, children's community services, pathways to adulthood	Childhood obesity, risky behaviours, CAMHS
Live well	East Merton Health and Wellbeing, diabetes/long-term conditions/prevention, primary mental health (IAPT), primary care at scale	Integrating physical and mental health resources, major chronic disease - diabetes
Age well	Dementia-friendly Merton, integrated locality teams, intermediate care and rapid response, support to care homes	Isolation, dementia, health and social care integration

8.4 Some of these local priorities clearly align to the NHS Long-Term Plan; elsewhere priorities set out in the national Long Term Plan are not currently priorities in the emerging local health and care plans (e.g. cancer).

8.5 St George's will be publishing a clinical service strategy for the Trust in April, and will take account of both the national Long-Term Plan and these local priorities as we do so.

9.0 Recommendations

9.1 Board is asked to note this update, and agree that the Trust should position itself accordingly in its 5 year strategy to be published in April 2019.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	28 February 2019	**Agenda No.**	**5.1**
Report Title:	**Workforce and Education Committee Report**		
Lead Director/ Manager:	**Harbhajan Brar, HR & OD Director**		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Information		
Executive Summary:	This paper sets out the key issues reviewed and agreed by the Committee at its meeting on 7 February 2019, including commenting on assurance to the Board on key risks allocated to the Committee.		
Recommendation:	The Board is asked to receive this report		
Supports			
Trust Strategic Objective:	Valuing our staff		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Board Assurance and Risk management		
Implications			
Risk:	Keys risk identified via the BAF and Trust Risk Register		
Legal/Regulatory:	None. Key legal/regulatory risk covered in the Workforce and Education Committee reports		
Resources:	None.		
Previously Considered by:	Workforce and Education Committee	**Date:**	7th Feb 2019
Appendices:	None		

1. Committee Chair's Overview

The Committee has changed its focus.

With the prospect of a CQC re-inspection ahead; the continuing gain in the confidence of the HR and organisational developments team; and the momentum that we are seeing around delivery of the wider improvement agenda, we have shifted the approach of the Committee. We are consciously now placing relatively more emphasis on the assurance role that we have, and relatively less on our co-production role in helping shape Trust policies. The nature of the discussion has changed as a result. The consequence is that we can move more crisply over a tighter agenda, and reduce the overall time required for the meeting. February's was the first such meeting and initial indications are that this has been well received by Committee members, and even with a shortened meeting time we are able to ensure time for deep discussion on the critical issues.

The areas of focus at this month's meeting have been: evaluating the effectiveness of the Trust's sickness absence policies and assessing compliance with these; reviewing the current status of appraisal processes across medical and non-medical staff; and critiquing proposals brought to the Committee for comment, around apprenticeships and induction.

We also reviewed draft reports on pay gaps (gender and ethnic) and drew a number of conclusions about levels of progress being achieved by the Trust, and also how the communication of this could be helped. Whilst it is not a legal requirement, members of WEC agreed that we should recommend to the Board that we publish our Ethnic Pay Gap report alongside the Gender Pay Gap report. We spent some time reviewing the latest report on Safe Working, and agreed a set of carry-forward actions which will help maintain the general progress the Trust is seeing on this.

We had a very helpful update on workforce planning in relation to Brexit, and received a detailed breakdown of staff composition by geographical origin - with confirmation that almost 16% of our nursing and midwifery staff are of EU origin. I have included the relevant table as an Annex to this Report. We also spent some time reviewing the four Trust-level risks that the Committee monitors and agreed a re-framing of those risks in a way that reflects our deeper understanding of the contributing elements to each risk.

We had very good attendance at the Committee from support functions and from the operational divisions. I would thank all of those who made the time to attend, particularly given the experience they bring and their insight and willingness to contribute, and to comment on what happens in practice within SGH.

2. Key points:-

Board Assurance

The Board tasked the committee with reviewing the way that three **Trust-level risks** allocated to the Committee were described. We agreed a refresh of the wording used, reflecting our clearer understanding of the contributing elements of each risk. These will come back to the Board as a part of a separate paper.

Given that our **sickness absence** rate continues to trend at between 3% and 4% (representing a notional annual cost to the Trust of up to c £15 m) we wanted assurance that this was being tightly managed. We reviewed a detailed paper from Jacqueline McCullough setting out the Trust's policies on managing sickness absence, both short-term and long-term. This summarised the way the policy is intended to work, set out two case studies demonstrating the positive effects of using the policy, and referenced a (substantial) assurance review (undertaken by TIAA in December 2017) of the way absence is managed in practice. We also noted that across the Trust we currently have under active

management 200 cases of short-term sickness absence, and 60 cases of long term sickness. The experience of those present was that the culture within the Trust was one of active (and rapid) intervention where sickness absence is experienced. The main challenge is whether all instances of one-day absence in non-rostered areas are being captured, but the overall view of the meeting was that they were and that this was reflected in the number of cases being actively managed. The Committee's conclusion was that we had received assurance that sickness absence is being actively managed within an appropriately focussed policy structure, which is known and applied.

We had in an earlier meeting expressed concern at the relatively low uptake of **appraisals** and as a result agreed that completion of all relevant appraisals should be a gating issue for each manager's salary award from April this year. This has since been communicated to all managers, and there has clearly been a renewed interest in use of the Trust's appraisal process – which has highlighted some shortfalls in the process which now need to be fixed. We reviewed two papers. Hasan Cagirtgan (Head of Corporate Training) and Brian Kilpatrick (MAST and e-learning Manager) reported back on the current position - non-medical appraisal rate reported to be at 71.5%, but some data clearly not being captured. They drew attention to a problem that had been identified in the capture of accurate information on completed appraisals. We agreed their detailed and helpful proposal that the TOTARA system be used to notify and record (in real time) appraisal data. They have assured us that this aspect of the TOTRA upgrade can and will be up and running by the end of February.

On the medical and dental side, Claire Low updated us on the implementation of the new 'Licence2Practice' ('L2P') appraisal management system. To date, 800 of our 880 connected doctors are now using the system, with the remainder to be up and running by the end of March. Appraisal completion rates are rising steadily, and when these are fully reported from the L2P system (rather than from ESR) we anticipate seeing a further uptick. The three medical practitioners present attested to the functionality, and ease of use of L2P. This represented very good progress from the unsatisfactory situation first brought to us by our Responsible Officer, Miss Karen Daly, and her commitment to getting this sorted out for the benefit of our doctors is much appreciated.

Strategic Themes

Theme 1 - Engagement

Harbhajan Brar updated us on the initial indications of results for SGH from the NHS Staff Survey. The final response rate achieved was 54%, a solid improvement over last year's 51.7%. The results remain embargoed so I will not comment further, other than to report that there was a useful discussion within the Committee on challenges facing the Trust. Two clear themes stood out. First, we are in the 'hard yards' of organisational change. Anticipation remains high, but delivery lags behind. This can be demoralising. Second, with the current numbers of patients being seen and treated the Trust is an incredibly busy and pressured environment. With patients as our priority, other things are sometimes put on hold or slowed, with the result that change on the ground is not delivered as rapidly as originally contemplated. The Committee discussed ways of addressing these factors, and their impact on staff wellbeing and perception. We will return to this once the survey's full results are available. We will also be looking at the those results extremely carefully, given the slight downturn in the results of our Q2 Friends and Family survey.

Alison Benincasa summarised the good progress being made on the Staff Engagement Plan, with all work-steams now well under way.

Over 90% of staff have self-declared their position on a number of characteristics: ethnicity, 97%+; disability, 90%+; religious belief, 92%+; sexual orientation, 92%+. This does at least indicate a degree of trust in the system that manages the information provided. The reduction

in our vacancy rate to sub-10% has been maintained. On our flu campaign, staff uptake percentage reached 82.3% - which is an excellent result.

We approved a welcome and well thought-through proposal from Hasan Cagirtgan to improve the relevance and sharpness of the Trust's induction programme for new joiners. The content of that session, and the associated written materials provided, are the first exposure many new joiners have to day to day life within the Trust, and represent an opportunity to create engagement and a strong and positive impression of the Trust as a place to work. We noted that this paper would need formal TEC sign off.

The Trust has commenced a review of practices, systems and policies to ensure they are accessible and bias free for people with disabilities and LGBT staff. The Trust is putting together a portfolio of evidence to the Stonewall Workplace Index to assess the Trust's relative position as an inclusive employer.

Theme 2 – Leadership and Progression

We reviewed draft reports on pay gap analysis - gender and ethnic that had been prepared by Sion Pennant-Williams. Both of these were considered in detail. In summary, whilst there is much that gives us comfort about what has been achieved so far, there are clear areas where work is still required. However, the two reports do present a very clear picture of what has been achieved at St George's (as at March 2018) and Sion's very helpful commentary helps point the way forward. There are some communication opportunities arising from the analysis which we can discuss at Board.

Theme 3 - Workforce Planning

The recruitment pipeline is functioning well and we have achieved good outcomes from our Nursing Open Days at St George's and Queen Mary's, with a number of offers of employment made.

We reviewed and supported a set of proposals from Mark Riley, Hasan Cagirtgan and Sarah James to ensure the Trust made greater use of the Apprenticeship Levy that it pays (£2.1 m p.a.), and which would help ensure a pipeline of staff. The proposals made clear that there was much that could be done within the Trust and without reference to external parties. We agreed that continuing as we are – underachieving for the Trust and for potential apprentices - was not an option and that we should assertively adopt the recommendations put forward. The recent introduction of the Mammography Apprenticeship Programme which the Trust has initiated for 15 individuals was cited as an example of what could be achieved. We noted that this paper would need formal TEC sign off.

We have now moved **all** non-medical staff onto Allocate, our e-rostering system. On the medical side, we are planning to move **all** medical staff onto Allocate Medics e-rostering by the end of March 2020.

The content of the Clinical Excellence Award procedure, the Acting Down Policy, the Annual Leave policy and the job planning framework are currently under discussion with the Trust's LNC (Chair, Miss Farida Ali).

Theme 4 – Compliance.

As previously reported, the HSE inspected the Trust in early November to assess the Trust's position on manual handling, and on the management of violence and aggression. The formal report back has now been received, in which the HSE identified 5 material breaches. This is disappointing. It paints an embarrassing picture of, frankly, confusion and lack of attention to process. The particular instance cited by HSE is a policy (implemented in 2011) on Violence

and Aggression ('V&A') which is internally inconsistent, poorly thought through, and which appears not to mandate risk assessments in clinical areas. The policy review process appears to have been unstructured - delegated to an internal taskforce which has failed to achieve the required timescale for that review. Whilst, rightly, this is all now being tightly gripped by the Trust (and Kevin Howell's very thorough paper gave us complete assurance on that fact, and on the maintenance and use of lifting equipment) it raises two larger questions (1) the process by which all other standing policies are routinely checked for relevance and consistency of content, and (2) how the Trust ensures periodic reviews of policies are undertaken on a timely basis. These wider questions are something that now needs to be pursued at Trust level.

As reported in December, the Trust has appointed a new Guardian of Safe Working, Dr Serena Haywood. Serena introduced her first report (and thanked her predecessor Dr Sunil Dasan). Serena was clear that her appointment will allow a shift of focus in this area, building on the achievements that Sunil had led. Sunil had clearly established the role, and helped develop a medical culture in which exception reporting is seen as important and a positive step which enables the Trust to receive early notice of, and then fix, issues around medical rostering. Serena aims to hold on to that, and overlay increased focus on medical staff wellbeing, effective planning and support systems, and individual resilience through sensible management of resources. A doctors' rest area would be a real contributor in this, and this should be supported by the Trust.

Serena's overall assessment was that the general trend is of continuing reduction in breaches, although cardiology is a developing hot-spot due to the knock-on impact of changes to the cardiac surgical caseload and the difficulty in recruiting to cardiology posts. We had a constructive discussion on how this could be addressed, and medical members and the operating division representatives present will take this forward.

The Trust's OH team is actively undertaking Tuberculosis contact tracing of staff who could have been affected by a ventilation failure on McEntee.

Happy to take questions on any of the above at the Board meeting.

Stephen J Collier
12 February 2019

ANNEX – EU STAFF

Staff Group	British Staff	EU Staff	Other Staff	Total Staff	% of EU Staff
Add Prof Scientific and Technic	447	69	123	639	10.80%
Additional Clinical Services	578	128	362	1,068	11.99%
Administrative and Clerical	1,478	100	180	1,758	5.69%
Allied Health Professionals	542	35	122	699	5.01%
Estates and Ancillary	188	46	57	291	15.81%
Healthcare Scientists	247	44	77	368	11.96%
Medical and Dental	998	128	232	1,358	9.43%
Nursing and Midwifery Registered	1,573	425	719	2,717	15.64%
Grand Total	**6,051**	**975**	**1872**	**8,898**	**10.96%**

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	28 February 2019	**Agenda No**	**5.2**
Report Title:	**Workforce Race Equality Standard (WRES) 2108 Report**		
Lead Director/ Manager:	**Harbhajan Brar; Executive Director, HR&OD**		
Report Author:	Celia Oke; Workforce Diversity and Inclusion Manager		
Presented for:	Review		
Executive Summary:	This report 1) Provides the Board with an overview of the NHS Workforce Race Equality Standard (2018) findings that were published in January 2019. 2) Shows where we are as a Trust against the national WRES indicators. In summary, whilst were are beginning to show improvements on most WRES indicators, especially in the areas of recruitment, access to training and the composition of our Board, the data shows that we still have much more to do to address race inequalities. A detailed report on progress made to date against the key targets set in our Diversity and Inclusion Strategy will be tabled at the next Workforce and Education Committee (WEC) in April 2019.		
Recommendation:	To note the finding of the 2018 WRES report.		
Supports			
Trust Strategic Objective:	Build a better St George's Champion team St George's		
CQC Theme:	Well Led		
Implications			
Risk:	Not applicable		
Legal/Regulatory:	Equality Act 2010; Employment Rights Act 1996		
Previously Considered by:	N/A	**Date**	
Appendices:	N/A		

1. Purpose

1.1 The purpose of this paper is to:-

1) Provide the Board with an overview of the NHS Workforce Race Equality Standard (2018) findings that were published in January 2019.

2) Shows where we are as Trust against the national WRES indicators.

2. 2018 WRES

2.1 The NHS Workforce Race Equality Standard (2018 Data Analysis Report) reports on data from the period April 2017 to March 2018 and therefore uses data taken form our 2017 NHS Staff Survey Result.

National and Regional Findings

2.2 The key findings from the report are:-

Analyses of WRES data between 2016 and 2018 show continuous improvement across the range of workforce indicators.	Across the 231 NHS trusts in England, there were just eight BME executive directors of nursing.
BME staff make up 19.1% of the workforce in NHS trusts. Across NHS trusts, there were 10,407 more BME staff in 2018 compared to 2017.	White applicants were 1.45 times relatively more likely to be appointed from shortlisting compared to BME applicants, a reduction from the 1.60 ratio in 2017.
The proportion of BME staff in very senior manager (VSM) positions increased from 5.7% in 2017 to 6.9% in 2018. This is still significantly lower than the proportion of BME staff (19.1%) in NHS trusts.	BME staff were 1.24 times relatively more likely to enter the formal disciplinary process compared to white staff. There have been year-on-year improvements on this indicator since 2016.
The percentage of BME staff reporting the experience of discrimination in the last 12 months increased from 13.8% to 15.0%. In contrast, 6.6% of white staff reported the experience of discrimination at work.	71.5% of BME staff believed that their trust provides equal opportunities for career progression or promotion. This is lower than the response in 2016 (75.5%). In contrast 86.6% of white staff believe that their trust provides equal opportunities for career progression or promotion.
The net number of BME board members increased. There were 11 more executive BME board members across NHS trusts in 2018 compared to 2017. Overall there was one extra non-executive board member across NHS trusts.	A sustained increase in BME nurses, health visitors and midwives in AfC bands 6 and above. There has been an increase of 2,224 from 2017.

2.3 When we compare our St George's data with the national data from the 2018 WRES report, it shows that we still have much more to do to address race inequalities.

WRES Indicator	St George's	London	All Trusts in England
2. Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants	1.59	1.63	1.45
3. Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff	2.04	1.77	1.24
4. Relative likelihood of BAME staff accessing non mandatory training and CPD compared to White staff	1.1	0.98	1.15
5. Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	28.4%	30.4%	29%
6. Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months	31%	30%	28%
7. Percentage of BAME staff believing that Trust provides equal opportunities for career progression or promotion	63%	68%	72%
8. Percentage of BAME staff personally experiencing discrimination at work from a manager/team leader or other colleagues	18%	16%	15%
9. BAME board membership	12.5%	15.6%	7%

2.4 The position across all London Trusts is clearly adverse when compared to the national position, and work is underway at a pan-London level to address specific indicators, such as the likelihood of BAME staff entering into formal disciplinary processes compared to white staff.

2.5 We have examined our 2017 data and compared it to our 2018 return and we can see some (marginal) progress being made on a number of the WRES indicators. We have improved on 6 out of the 8 indicators and have stayed the same on one and deteriorated on another.

WRES Indicator	2017	2018
2. Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants	**2.6**	**1.59**
3. Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff	**2.05**	**2.04**
4. Relative likelihood of BAME staff accessing non mandatory training and CPD compared to White staff	**0.8**	**1.1**
5. Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**27.5%**	**28.4%**

WRES Indicator	2017	2018
6. Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months	**33%**	**31%**
7. Percentage of BAME staff believing that Trust provides equal opportunities for career progression or promotion	**63%**	**63%**
8. Percentage of BAME staff personally experiencing discrimination at work from a manager/team leader or other colleagues	**20%**	**18%**
9. BAME board membership	**5.3%**	**12.5%**

2.6 It is worth noting that the 2018 WRES report uses data prior to the approval of our current Diversity and Inclusion Strategy and it is hoped that the delivery of key D&I targets will start to have a positive impact addressing the inequalities that this report highlights.

3. Next Steps

3.1 A detailed report on progress made to date against the key targets set in our Diversity and Inclusion Strategy will be tabled at the next Workforce and Education Committee (WEC) in April 2019.

Author: Celia Oke, Workforce Diversity and Inclusion Manager

Date: 19th February 2019

Meeting Title:	**Trust Board**		
Date:	28 February 2019	**Agenda No**	**5.3**
Report Title:	**Gender Pay Gap report**		
Lead Director/ Manager:	**Harbhajan Brar, Director of Human Resources and Organisational Development**		
Report Author:	Sion Pennant-Williams, Workforce Intelligence Manager		
Presented for:	Approve		
Executive Summary:	This paper has been discussed in some detail at the February Workforce & Education Committee. The gender pay gap as at the 31st March 2018 (the snapshot date for reporting) is 13.61% mean and 4.96% median. The 4 pay quartiles show a higher proportion of males in the highest and lowest pay quartiles, despite the workforce being predominantly female. The mean pay gap has decreased since the previous year. The pay gap has narrowed in most of the difference pay grades, though it has increased in the overall medical pay grades. Further examination of the medical pay grades shows that the gap has decreased slightly at Consultant level, and increased at Foundation and Junior Doctor levels. The mean gender pay gap for bonuses is 12.25% and the median is 17.19%. Bonuses (via Clinical Excellence Awards or CEAs) were paid only to Consultants, and more CEAs were paid to male Consultants than to female Consultants. It is worth formally noting that our Gender Pay Gap report has been recognised by NHS employers as an example of good practice		
Recommendation:	The Trust Board is asked to approve its publication on the Trust's external website.		
Supports			
Trust Strategic Objective:	Build a better St George's		
CQC Theme:	Well led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	n/a		
Legal/Regulatory:	Equality Act 2010 (Gender Pay Gap Information Regulations 2017)		
Resources:	n/a		
Previously Considered by:	Workforce and Education Committee	**Date**	7 Feb 2019
Equality Impact Assessment:	The purpose of this paper was to identify gender pay inequalities.		
Appendices:	n/a		

Workforce Information report

1.0 PURPOSE

1.1 Provide initial findings of the gender pay gap.

1.2 Generate discussion as to how to respond to these findings.

2.0 BACKGROUND

2.1 As per the new legal requirement, the first Gender Pay Gap report, based on a snapshot date of 31st March 2017 was produced and published in 2018. St George's are now obligated to submit another report based on a snapshot date of 31st March 2018.

3.0 ANALYSIS

3.1 There is a mean pay gap of 13.61% and median pay gap of 4.96% between male and female staff.

3.2 Female employees are under-represented in the Upper Pay Quartile, and also in most of the higher-paid payscales.

3.3 The pay gap lies mainly within the medical staff group which has the highest pay gap at both consultant and non-consultant level.

3.4 The mean pay gap has narrowed since 2016/17. This is true in most of the grades, however there are some where the gap has increased in favour of males and even reversed when previously it was favourable to females and is now favourable to males.

3.5 There is a mean pay gap for bonuses of 12.25% and median pay gap of 17.19% between male and female staff.

3.6 1.11% of all female staff are paid bonuses compared with 4.98% of all male staff.

3.7 Only consultants were paid bonuses in the form of Clinical Excellence Awards and Distinction Awards.

4.0 IMPLICATIONS

Risks

4.1 Reputational risk
Impact on staff turnover, higher dissatisfaction levels on staff surveys and FFT
Negative impact on customer care

5.0 ACTIONS

5.1 None

6.0 RECOMMENDATION

6.1 Approve the publication of the attached report on the on the Trust website

Gender Pay Gap Reporting 2017/18

Introduction

The Equality Act 2010 (Gender Pay Gap Information Regulations 2017) requires all 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 2018.

St George's University Hospitals NHS Foundation Trust employs over 8,500 staff in a number of staff groups, including administrative, medical, nursing, and allied health roles. All staff except for medical and Very Senior Management (VSM) are on Agenda for Change payscales, which provide a clear process of paying employees equally, irrespective of their gender.

What is the gender pay gap?

The gender pay gap is the difference between the average hourly earnings of men and 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 they are a man or a woman. Instead the gender pay gap highlights the imbalance of 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 could be lower.

What do we have to report on?

The statutory requirements of the Gender Pay Gap legislation is that each 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 female employees when added up separately and divided 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 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 2018) are included. Bank staff who worked a shift on the snapshot date are included. Consultant Additional Programmed Activities (APA's) are included, as are Clinical Excellence Awards (CEA's). The calculations exclude overtime pay and expenses.

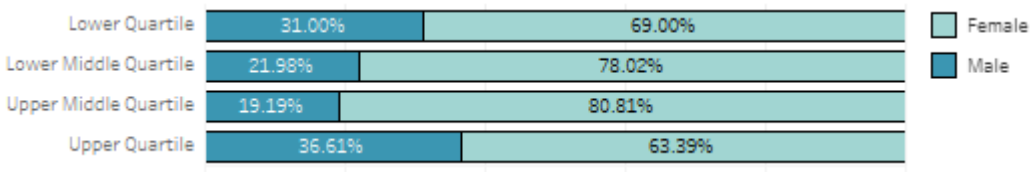
Employees who are on half or nil absence or maternity leave, hosted staff (e.g. GP Trainees) and agency staff have not been included.

Background

We first reported on the Gender Pay Gap in March 2018 based on snapshot data from 31st March 2017. The findings were:

- Our mean pay gap was 13.94%
- Our median pay gap was 2.11%
- Our mean bonus pay gap was 15.05%
- Our median bonus pay gap was 15.36%

The total workforce was comprised of 73% female and 27% male. The pay quartile split was as follows:

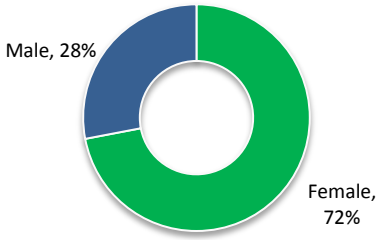


Further analysis of this data revealed that although most of the higher bands had a higher proportion of males than the overall Trust composition, the gender gap lay primarily within the Medical & Dental staff group, specifically the Consultant role. If this staff group was excluded from the calculations then the pay gap would actually have been in favour of females.

The only bonuses that were paid were to Medical Consultants. It was noted that although 56% of Consultants were male, 65% of bonuses had been paid to males whereas 44% of Consultants were female and just 35% of bonuses had been paid to females.

Trust Gender Profile (based on headcount)

St George's University Hospitals NHS, as is typical of any NHS Trust, has a higher proportion of females to males in its workforce – of the 8,778 staff counted as part of the gender pay gap reporting, 6,290 were female compared to 2,488 male:



Gender Pay Gap

Mean gender pay gap– 13.61%
(2016/17 – 13.94%)

Median gender pay gap – 4.96%
(2016/17 – 2.11%)

The above figures show that the mean hourly pay for males is £3.06 higher than that of females, which is a gap of 13.61%. Male median pay is £0.92 higher than females, which is a gap of 4.96%.

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 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 4.96% the median gap is less extreme, it is the mean pay gap of 13.61% that needs to be examines in more detail.

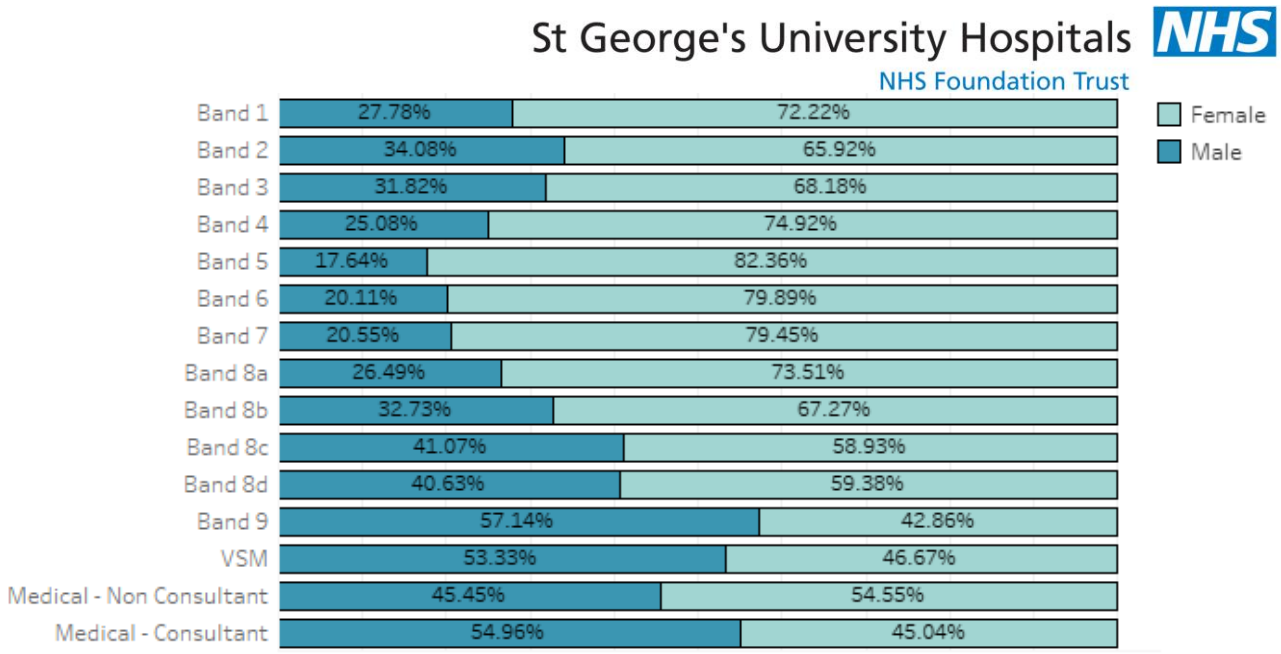
As the quartile figures in the chart above show that there is a higher percentage of males in both the upper and lower quartile than in the others, it is worth examining the gender composition and pay gaps in each individual band. This is set out in the table below, with the higher average pay by gender highlighted in green.

Grade	No. of male staff	No. of female staff	Male average Hourly Rate*	Female average Hourly Rate*	Difference	Gap[†]	2016/17 Gap[†]
Band 1	5	13	10.27	10.36	-0.09	-0.87%	-1.12%
Band 2	456	882	11.32	11.44	-0.12	-1.03%	-1.52%
Band 3	196	420	11.86	11.74	0.12	1.00%	0.64%
Band 4	154	460	12.70	13.07	-0.37	-2.90%	-2.07%
Band 5	266	1,242	16.26	16.43	-0.17	-1.06%	-1.39%
Band 6	296	1,176	19.95	20.33	-0.38	-1.89%	-1.04%
Band 7	224	866	22.81	22.94	-0.12	-0.55%	-1.32%
Band 8a	98	272	26.94	26.70	0.24	0.90%	1.78%
Band 8b	36	74	31.94	31.49	0.45	1.39%	1.62%
Band 8c	23	33	36.02	36.03	-0.01	-0.02%	3.65%
Band 8d	13	19	43.55	42.99	0.56	1.28%	1.70%
Band 9	8	6	50.29	52.23	-1.94	-3.86%	-12.62%
VSM	8	7	69.61	67.08	2.53	3.63%	23.27%
Medical - Non Consultant	320	384	27.55	25.58	1.98	7.17%	4.05%
Medical - Consultant	310	254	47.92	46.04	1.89	3.94%	4.33%

*refers to the mean hourly rate

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

Gender split by band – based on headcount:



This shows that on average females earn more in most pay bands than males – the only bands wehre males earn more is in band 3, band 8a, band 8b, band 8d, VSM (very senior management), and medical roles (both Consultant and non Consultant).These are mainly the higher paid bands, and it is also in these higher bands where the proportion of males is higher when compared to the proportion of the Trust overall (28% males to 73% female). In the highest paid bands - band 9 and VSM - there are more males to females. However there have been positive changes since the previous year. The pay gap has narrowed in bands 8a and above, and in the case of band 8c it has reversed, from 3.65% favourable to males to 0.02% favourable to females. In the case of VSM the pay gap, whilst still favourable to males, has reduced from 23.27% to 3.77%. The proportion of males to females in the VSM pay grade has also become more even, with females making up 47% of the pay grade compared with 38% in 2016/17.

The gender pay gap has narrowed in most pay grades, but the marginal reduction in the overall average pay gap is partly due to the fact that in the grades where the gap was favourable towards females, it has narrowed more in favour of males. Overall it is still in favour of females, but the gaps in these individual grades are now nearer 0% than in 2016/17. However, like the previous year, the main pay gap lies within in the medical staff group. This group has high numbers of employees and the second and third highest difference in hourly rates (the highest is VSM, bu this only consists of 15 employees). If medical staff are removed from the calculations, the gap is reversed and females get paid more than males by 2.59%.

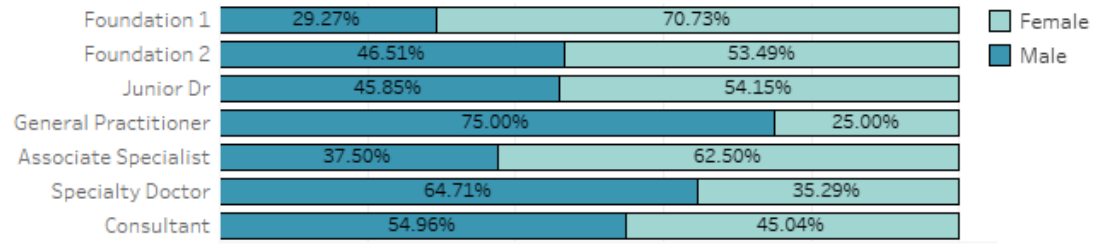
Medical Staff

Medical staff group comprises of all trainee to Consultant roles. The pay gap for Medical staff as a whole is is 11.43% (up from 9.24% last year) - males get paid on average £3.85p/h more than females. The proportion of male to female staff is roughly 50/50, and the staff group is comprised of over 1,200 employees.

Role	No. of male staff	No. of female staff*	Male Hourly Rate*	Female Hourly Rate*	Difference*	Gap	2016/17 Gap
Foundation 1	12	29	14.78	14.61	0.16	1.11%	-0.41%
Foundation 2	20	23	18.16	17.89	0.26	1.45%	-0.09%
Junior Dr	271	320	28.59	26.80	1.78	6.24%	2.91%
General Practitioner	3	1	23.71	23.70	0.01	0.03%	0.99%
Associate Specialist	3	5	41.29	40.21	1.08	2.63%	2.37%
Specialty Doctor	11	6	30.41	30.70	-0.29	-0.95%	12.73%
Consultant	310	254	47.92	46.04	1.89	3.94%	4.33%

*refers to the mean hourly rate

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



Consultants

St George's had 564 consultants in post on 31st March 2018. It was noted in the 2016/17 report that Medical Consultants are one of the highest paid roles in the Trust, and are eligible to receive clinical excellence awards (CEAs) and Additional Programmed Activities (APAs) which are consolidated into the basic pay calculations.

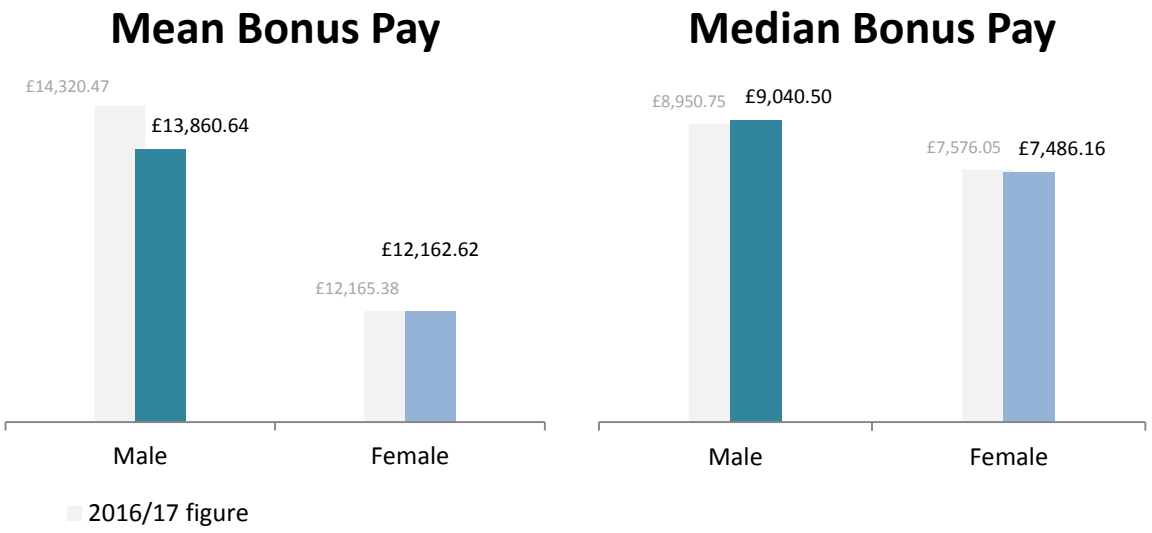
There are more male consultants than female (respectively 55% male to 45% female). Male Consultants were paid on average £2.08 p/h more than female Consultants, however the gap has narrowed slightly and in 2017/8 they were paid £1.89 more than their female counterparts, a pay gap of 3.94%. Whilst this is still high, it at least suggests that the Trust could be moving in the right direction, though with just 2 years worth of data available it is unknown yet if this is a trend.

Non-Consultants

There are some stark differences in the figures since 2016/17. The pay gap for both year 1 and year 2 foundation doctors has reversed, and is now favourable towards males. Interestingly the proportion of females to males in Foundation 1 doctors has changed from 41% male to 59% female to 29% male to 71% female. Whilst this bodes well for the future if more females are entering the profession it does not explain why females are now paid less. However further examination on the additional payments to this role shows that males were paid more night duty and extra session payments than females, so male Foundation Doctors are on average doing more overtime than female Foundation Doctors.

We have nearly 600 junior doctors, and they are the most numerous of the medical roles.This year the pay gap has increased this year from 2.91% to 6.94%. This means that male junior doctors are paid an average of £1.78 p/h more than female junior doctors. The proportion of females to males is 54% to 46%, so there are slightly more females in the role, however similar to the Foundation doctors males were paid for more extra sessions than females. More females work part-time due to childcare commitments, and there are restrictions around the amount of overtime that part-time junior doctors can work.

Bonuses



Mean gender pay gap – 12.25%
(2016/17 15.05%)

Median gender pay gap – 17.19%
(2016/17 15.36%)

The only bonuses paid in the time frame (1st April 2017 to 31st March 2018) were to Medical Consultants, in the form of CEA's and distinction awards.

Out of the 195 bonuses paid in the period, 70 were to females – out of the total amount of female employees in the Trust this is 1.11%. In comparison 125 were paid to males, which is 4.98% of the total male employees in the Trust. These are marginally more positive numbers than in 2016-17, where 1.08% of female employees and 5.28% of males were paid a bonus.

When compared with the proportion of male Consultants to female Consultants, 64% of bonuses were paid to males when they make up 55% of the role. 36% were paid to females, who make up 45% of the role.

Out of the 195 bonuses paid in the period, 186 were Clinical Excellence Awards. 14 of these were national level, and out of these 5 were awarded to females and 9 to males. The more well-paid national CEA's have tended to be awarded after 9 years of a Consultant receiving local CEAs, and as the Consultant role has traditionally been male dominated then it is not surprising that more males are paid these than females. The proportion of male and female consultants being paid CEAs by age range shows that this is an issue that won't be resolved in the near future:

Age Range	Female	Male
31-40	80%	20%
41-50	36%	64%
51-60	35%	65%
61-70	33%	67%

It is encouraging however that in the youngest age range there are more females being paid CEAs than males. Trusts are also now obligated to monitor both rates of application and rates of success in relation to protected characteristics and highlight this in the CEA annual report. This should see the number of female Consultants applying for and being paid CEA's increase. In years to come older male consultants in receipt of CEAs will retire. Both these factors should gradually contribute to the reduction of the pay gap.

Comparison

To date only 7 other Trusts have submitted their 2017/18 data so there is not enough data to complete this analysis yet.

Progress and next steps:

As highlighted in the 2016/17 report there is a higher prominence of males in the higher paid roles compared with the overall gender profile of the Trust, however there have been a number of high profile female appointments that have gone some way to redress the balance and greatly reduce the pay gap at these levels. The pay gap has also narrowed in many areas. However there is still a significant pay gap at Consultant level and males are still paid more in bonuses than females.

- Target female employees to take advantage of recent initiatives such as the Leadership Academy, which would help them develop the skills and encourage them to apply for more senior positions
- Whilst the medical Consultant role has traditionally been male dominated, this is changing which is evidenced in the higher proportion of females to males in the Junior Doctor roles. As these trainees qualify, a lot of them will eventually become Consultants, which help balance out the male to female ratio.
- Encourage existing female Consultants to apply for CEAs – this will be monitored in accordance with the new rules from the British Medical Association regarding CEAs.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	28 February 2019	**Agenda No**	**5.4**
Report Title:	**Ethnicity Pay Gap report**		
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:	This paper has been discussed in some detail at the February Workforce & Education Committee. The ethnicity pay gap as at 31st March 2018 (the snapshot date for reporting) is 11.04% mean and 5.77% median. The 4 pay quartiles show a higher proportion of white employees in the highest pay quartile, and a higher proportion of BAME staff in the lowest pay quartile. When looking at the ethnicity pay gap of the individual ethnic groups, the largest pay gap affects Black/Black British employees who are paid on average £5.10 an hour less than white employees, comprising of a mean pay gap of 23.78%. This is primarily due to a lack of Black/Black British employees in the higher pay bands of the admin and clerical staff group.		
Recommendation:	Whilst it is not yet a legal requirement, WEC has recommended that the Trust publish its Ethnicity Pay Gap report as good practice and in the interest of transparency alongside the Gender Pay Gap report on the Trust's external website.		
Supports			
Trust Strategic Objective:	Build a better St George's		
CQC Theme:	Well led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	n/a		
Legal/Regulatory:	Equality Act 2010		
Resources:	n/a		
Previously Considered by:	Workforce and Education Committee	**Date**	7 Feb 2019
Equality Impact Assessment:	The purpose of this paper is to identify ethnicity pay inequalities.		
Appendices:	n/a		

St George's University Hospitals NHS
NHS Foundation Trust

Workforce Information report
Trust Board 28th February 2019

1.0 PURPOSE

1.1 Agree to publish on the Trust external website

2.0 BACKGROUND

2.1 This report was viewed and discussed by the Workforce & Education Committee on the 11th October and reviewed again at WEC on the 7th February.

2.2 This was initially not intended for publication however to complement the WRES action plan and the wider work being done around diversity and inclusion it would benefit the Trust to be as open as possible about where pay gaps lie between the different ethnic groups.

2.3 As the first draft of the 2017/18 Gender Pay Gap report is being discussed, with a deadline to publish by 31st March, the Board is being asked whether it is agreed that the Trust publish the Ethnicity Pay Gap report on the external website at the same time.

3.0 ANALYSIS

3.1 There is a mean pay gap of 11.04% and median pay gap of 5.77% between white and BAME staff.

3.2 BAME employees are over-represented in the lower pay quartiles and under-represented in the higher pay quartiles.

3.3 There is a pay gap in favour to white staff for all the different ethnic groups except that of Chinese/Other.

3.4 The largest pay gap is between white staff and Black/Black British staff – this discrepancy is mainly found within the admin and clerical staff group.

4.0 IMPLICATIONS

Risks

4.1 Reputational risk
Impact on staff turnover, higher dissatisfaction levels on staff surveys and FFT
Negative impact on customer care

5.0 ACTIONS

5.1 None

6.0 RECOMMENDATION

6.1 To publish on the Trust external website alongside the 2017/18 Gender Pay Gap report.

Ethnicity Pay Gap 2017/18

1. Background

In 2018 the Trust was for the first time required to produce figures for the gender pay gap. This showed that for the year 2016/17 men were paid on average £3.07 more than their female counterparts, and also that female staff were under-represented in the upper pay quartile.

Figures for 2017/18 are currently being collated and although not yet required to do so, we have also collected the same figures for ethnicity. This will likely be a requirement in future years so looking at the figures now could help us pre-emptively identify if there is a pay gap between white and black, Asian and minority ethnic (BAME) employees.

2. What we are reporting on

The figures are produced in the same format as the gender pay gap figures, and so we have calculated:

- The mean basic pay gap
- The median basic pay gap
- The proportion of white and BAME staff in each quartile pay band

The mean pay gap is the difference between the pay of all white and BAME employees when added up separately and divided by the total number of white and BAME employees in the workforce.

The median pay gap is the difference between the pay of the middle white employee and the middle BAME employee, when all of the employees are listed from the highest to the lowest paid.

Though part of the gender pay gap reporting, this report does not include figures for the bonus pay gap i.e. the difference in how many white and BAME staff receive bonus payments.

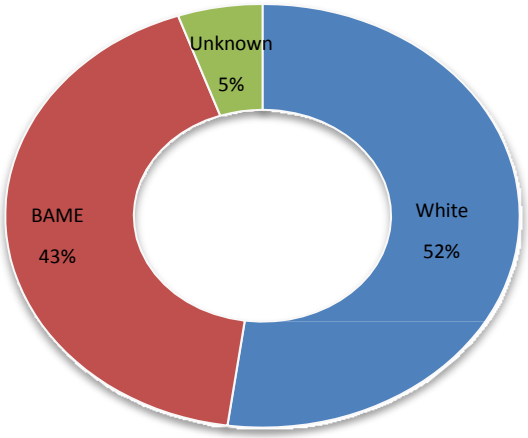
3. Who is included?

All staff who were employed by St George's and on full pay on the snapshot date (31st March 2018) are included. Bank staff who worked a shift on the snapshot date are included. Consultant Additional Programmed Activities (APA's) are included, as are Clinical Excellence Awards (CEA's). The 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 have not been included.

4. Trust Ethnicity Profile (based on headcount)

At the snapshot date St George's University Hospitals NHS had 4,580 white staff and 3,370 BAME staff. There are also 468 staff whose ethnicity is unknown.



Whilst the Trust has a 97% complete set of ethnicity data for substantive staff, there are a number of gaps for bank staff which the pay gap data includes. The data set for 2017-18 is therefore only 95% complete.

5. Ethnicity Pay Gap

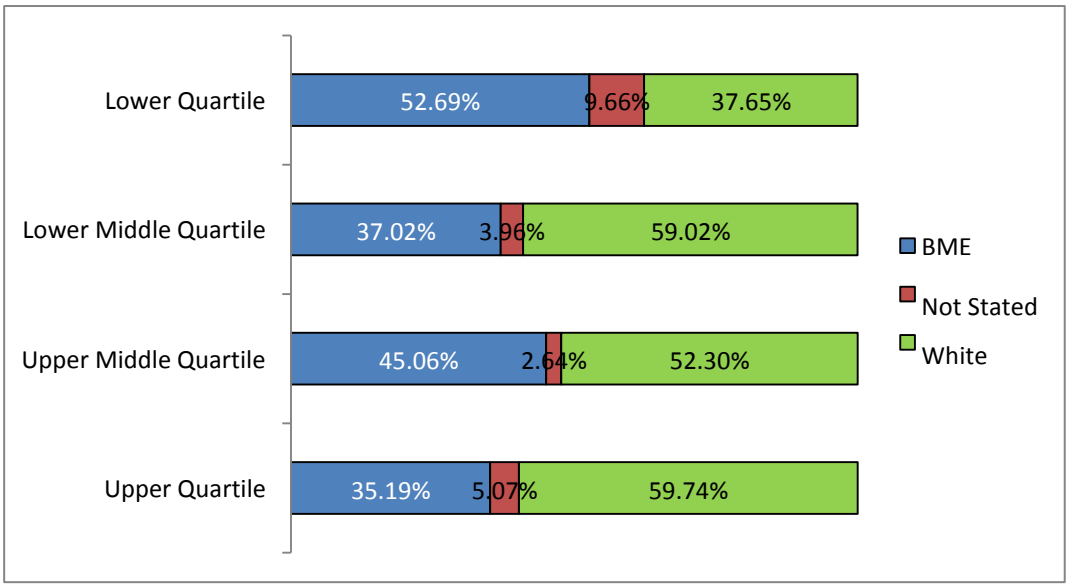
Ethnicity	MEAN Hourly	MEDIAN Hourly Rate
White	21.46	18.71
BME	19.09	17.63
Difference	2.37	1.08
Pay Gap %	**11.04%**	**5.77%**

The mean hourly pay for white staff is £2.37 higher than that of BAME staff, which is a gap of **11.04%**, the median pay for white staff is £1.08 higher than BAME staff, which is a gap of **5.77%.**

The median figure is usually considered the more representative figure; however what it does not take into account is small numbers of higher paid employees that could be skewing the data. The mean figure does highlight this, so although at 5.77% the median pay gap is the more favourable to the organisation, it is the mean pay gap of 11.04% that needs to be examined in more detail.

6. Pay Quartile Split

6.1. By Quartile



Given that BAME staff comprise of 42.49% of our workforce, they are clearly over-represented in the lower pay quartile and under-represented in the upper pay quartile. However there is fair representation in the upper middle pay quartile, which potentially offsets the imbalance in the upper pay quartile – without this we may have had a much larger pay gap.

6.2. By grade

Grade	No. of White staff	No. of BAME staff	White Hourly Rate	BAME Hourly Rate	Difference	Gap
Band 1	3	12	£10.49	£10.35	£0.14	1.32%
Band 2	463	766	£11.44	£11.56	-£0.13	-1.10%
Band 3	259	316	£11.88	£11.93	-£0.05	-0.44%
Band 4	312	262	£13.25	£12.88	£0.37	2.79%
Band 5	818	632	£15.89	£17.13	-£1.24	-7.80%
Band 6	744	695	£19.31	£21.27	-£1.96	-10.14%
Band 7	741	321	£22.87	£23.18	-£0.31	-1.34%
Band 8a	259	96	£26.57	£27.20	-£0.64	-2.39%
Band 8b	84	23	£31.89	£31.02	£0.86	2.71%
Band 8c	49	7	£36.08	£35.67	£0.41	1.12%
Band 8d	29	3	£43.50	£40.45	£3.05	7.00%
Band 9	12	1	£51.76	£47.79	£3.97	7.66%
VSM	13	2	£67.60	£73.78	-£6.18	-9.14%
Medical	710	464	£36.41	£34.44	£1.97	5.41%

If we break the figures by band it shows that the pay gap is in favour of BAME staff in bands 2, 3, 5, 6, 7, 8a, and VSM. In fact BAME staff in the VSM group are paid on average £6.18 more than their white counterparts, however they only make up 7.5% of this group and so are vastly under- represented and this does not make much different to the overall pay gap.

6.3. By different ethnic groups

Number of staff:

Asian/Asian British – 1,609 (18.33%)

Black/Black British – 1,380 (15.72%)

Chinese/Other – 421 (4.8%)

Mixed Race – 320 (3.65%)

Not Stated – 468 (5.33%)

White/White British – 4,580 (52.18%)

Ethnicity	Mean Hourly Rate	Median Hourly Rate
White/White British	21.46	18.71
Asian/Asian British	20.62	19.11
Difference	0.84	-0.40
Pay Gap	3.93%	-2.13%
Black/Black British	16.36	13.96
Difference	5.10	4.75
Pay Gap	23.78%	25.40%
Chinese/Other	22.31	21.07
Difference	-0.85	-2.35
Pay Gap	-3.96%	-12.57%
Mixed Race	18.95	16.30
Difference	2.52	2.41
Pay Gap	11.72%	12.89%

Looking at the figures broken down by the different ethnic groups can help identify if any groups are particularly affected. There is a small pay gap between Asian/Asian British staff (which is actually in favour of this group is looking at the median figure) who comprise of 18.33% of the workforce.

But it is the second largest BAME group – Black/Black British – which has the largest pay gap at 23.78%. This means that white employees get paid on average £5.10 an hour more than black employees.

A recent report in the news[1] stated that black doctors and nurses in the NHS are paid much less than white doctors and nurses, however when we break the figures down by staff group we can see that in St George's this is not the case, in that our medical and dental staff have the smallest pay gap (0.16%):

Staff Group	No. of White/White British staff	No. of Black/Black British staff	White/White British Hourly Rate	Black/Black British Hourly Rate	Difference	Gap
Add Prof Scientific and Technic	327	84	£19.16	£16.38	£2.78	14.51%
Additional Clinical Services	282	321	£12.67	£12.24	£0.43	3.39%
Administrative and Clerical	925	343	£17.41	£13.30	£4.10	23.58%
Allied Health Professionals	537	30	£20.48	£18.14	£2.34	11.42%
Estates and Ancillary	159	57	£13.17	£12.56	£0.62	4.69%
Healthcare Scientists	161	48	£23.67	£22.98	£0.69	2.90%
Medical and Dental	711	34	£36.49	£36.43	£0.06	0.16%
Nursing and Midwifery Registered	1478	453	£19.97	£19.83	£0.14	0.70%

Whilst there is a pay gap between white doctors and nurses and black doctors and nurses, it is minimal at less than 1%. However there is a large gap in the admin and clerical staff group, where white employees get paid on average £4.10 more than white employees comprising a pay gap of 23.58%. This is primarily where the overall pay gap lies, so it is worth looking at the pay differences of this staff group by pay band:

Band	No. of White/White British staff	No. of Black/Black British staff	White/White British Hourly Rate	Black/Black British Hourly Rate	Difference	Gap
Ad hoc	4	3	£6.98	£6.98	£0.00	0.00%
Band 1	1	1	£10.03	£10.03	£0.00	0.00%
Band 2	190	101	£11.25	£10.66	£0.59	5.23%
Band 3	137	83	£11.59	£11.52	£0.07	0.58%
Band 4	229	90	£13.21	£12.75	£0.46	3.48%
Band 5	89	22	£15.35	£16.08	-£0.73	-4.75%
Band 6	61	13	£18.82	£19.62	-£0.80	-4.23%
Band 7	72	16	£21.83	£21.66	£0.17	0.78%
Band 8a	50	11	£26.44	£26.61	-£0.18	-0.67%
Band 8b	24	2	£32.92	£30.28	£2.64	8.02%
Band 8c	32		£36.17		£36.17	
Band 8d	15	1	£43.31	£41.96	£1.35	3.12%
Band 9	8		£53.44		£53.44	
VSM	13		£67.60		£67.60	

[1] https://www.theguardian.com/society/2018/sep/27/black-medics-in-nhs-paid-thousands-less-than-white-medics

It is clear that the pay gap is primarily because of severe under-representation of black staff at senior level, with only 3 at band 8b or above. Considering that Black/Black British staff are our second most populous BAME group, and that admin and clerical staff make up 66% of all roles at 8c and above, this will be where a large part of our ethnicity pay gap comes from.

7. Conclusion

We have already identified and reported in the Workforce Race Equality Standard (WRES) that BAME staff are under-represented at the higher bands, so it should come as no surprise that we have a pay gap in favour of white staff.

However the data suggests that the pay gap disproportionately affects Black/Black British staff who make up 16% of our total workforce. The implication is that the cause of the pay gap may run deeper than simply under-representation in the higher pay bands.

8. Recommendation

The Trust is about to launch its WRES strategy. The findings of this report should assist in ensuring that the Trust's WRES strategy and action plan is targeted at helping address the ethnicity pay gap.

It is therefore recommended that the Committee support more detailed analysis of the position, with the results informing the content of the WRES strategy and action plan.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	28 February 2019	**Agenda No**	**5.5**
Report Title:	**Guardian of Safe Working Report**		
Lead Director/ Manager:	**Dr Richard Jennings**		
Report Author:	Dr Serena Haywood, Guardian of Safe Working		
Presented for:	Assurance		
Executive Summary:	This paper summarises progress in providing assurance that doctors are safely rostered and enabled to work hours that are safe and in compliance with Schedules 3, 4 and 5 of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016. Rota gaps have reduced to 46 with active recruitment in most departments. However, trainee doctors continue to submit reports with 56 exceptions related to working hours /conditions in this quarter with 9 due to lack of opportunity to attend teaching. Fine money disbursement is on hold which the trainee doctors are surveyed. A new Guardian of Safe Working was recruited into position 1st December 2018.		
Recommendation:	The Trust Board is asked to receive and note the Guardian of Safe Working's report and act to prevent any further working time breaches		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Safe		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:	Failure to ensure doctors are safely rostered and enabled to work hours that are safe risks patient safety and the safety of the doctor. Failure to ensure doctors are safely rostered and enabled to work hours that are safe risks overtime payments and fines being levied		
Legal/Regulatory:	Compliance with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016		
Resources:	Funding for overtime payments, fines and service changes arising from work schedule reviews Additional PA allocation in consultant job plans for time taken to personalise work schedules, resolve exception reports and perform work schedule reviews Administrative support for the role of Guardian		
Previously Considered by:	None	**Date**	03/02/2019
Equality Impact Assessment:	N/A		
Appendices:	A, B		

Guardian of Safe Working Report
Workforce and Education Committee 03/02/2019

1.0 PURPOSE

1.1 This paper provides assurance to the Board on the progress being made to ensure that junior (aka trainee) doctors' working hours are safe and to highlight all fines and work schedule reviews relating to safe working hours.

1.2 This report also includes information on all rota gaps on all shifts

2.0 BACKGROUND

2.1 The Guardian of Safe Working is a senior appointment made jointly by the Trust and junior doctors, who ensures that issues of compliance with safe working hours are addressed by the doctor and/or Trust and provides assurance to the Board that doctors' working hours are safe.

2.2 As the Trust is the Lead Employer Organisation for General Practice training across South London the Guardian will receive reports for all of the doctors under its employment from Guardians in host organisations.

2.3 The Guardian reports to the Board through the Workforce and Education Committee of the Board, as follows:

i. The Workforce and Education Committee will receive a *Guardian of Safe Working Report* no less than once per quarter on all work schedule reviews relating to safe working hours. This report will also include data on all rota gaps on all shifts. The report will also be provided to the LNC.
ii. A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps will be included in a statement in the Trust's Quality Account, which must be signed off by the Trust chief executive. This report will also be provided to the LNC.
iii. Where the Guardian has escalated issues in relation to working hours, raised in exception reports, to the relevant executive director, for decision and action, and where these have not been addressed at departmental level and the issue remains unresolved, the Guardian will submit an exceptional report to the next meeting of the Board.
iv. The Board is responsible for providing annual reports to external bodies, including Health Education South London, Care Quality Commission, General Medical Council and General Dental Council.

2.4 There may be circumstances where the Guardian identifies that certain posts have issues that cannot be remedied locally, and require a system-wide solution. Where such issues are identified, the Guardian will inform the Board. The Board will raise the system-wide issue with partner organisations (e.g. Health Education England, NHS England, NHS Improvement) to find a solution.

2.5 The Guardian is accountable to the Board. Where there are concerns regarding the performance of the guardian, the BMA or other recognised trade union, or the Junior Doctors Forum will raise those concerns with the Trust Medical Director. These concerns can be escalated to the senior independent director on the Board where they are not properly addressed or resolved. The Senior Independent director is a Non-executive director appointed by the Board to whom concerns regarding the performance of the Guardian of Safe

Working hours can be escalated where they are not properly resolved through the usual channels.

3.0 ANALYSIS

3.1. Fines

No fines were levied from 1st October 2018-31st December 2018

3.2. Exception Reports

115 exception episodes have been reported in the period 1st October 2018-31st December 2018 on the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016. 56 were eligible (>14 days since reported incident for form submission being the main reason for exclusion). St George's is the lead employer of GP trainees across South London and 0 exception episodes have been reported by this cohort of doctors in training

3.3 The Breakdown was as follows

Division	Number of exceptions	Breakdown
Medicine and Cardiovascular	24	2 Gastroenterology 9 Acute Medicine (in addition) 2 AMU 2 Haematology 2 Senior Health 2 Endocrinology 0 ED 5 Respiratory 0 cardiology
Children's, Women's, Diagnostics and Therapeutics	18	0 Obstetrics and gynaecology 3 Paediatrics 6 Neonatal medicine 9 Paediatric surgery
Surgery, Theatres, Neurosciences and Cancer	12	8 General Surgery 2 Plastic Surgery 0 urology 0 ENT 0 Renal transplantation 0 neurosurgery 2 plastics 0 Trauma and orthopaedics 0 Cardiothoracic surgery
Community		1QMH rehab 0 psychiatry

3.4 A further breakdown shows:

Forty seven exceptions related to working hours /conditions. Nine, all reported by one the paediatric surgical trainee were related to lack of opportunity to attend teaching. Full details available in **Appendix A.**

3.5 Work schedule reviews

No work schedule reviews took place from 1st October 2018-31st December 2018

3.6 Rota gaps

Rota gap information is shown in Appendix B. This lists vacant trainee, clinical fellow and trust doctor posts across St George's. This does not include vacant physician assistant or other advanced practitioner posts. This data shows that there are **46** vacancies across St George's from 624 posts which remains similar to other vacancy levels but a significant decrease from the 69 reported in March 2018.

3.7 Junior Doctor Forum

The Junior Doctor Forum (JDF) continues to meet monthly. To date it has not spent the £9,322.49 accrued to date in fine monies. Consideration has been given to using this money to refurbish the Doctors' Mess plus to purchase a managed teleconferencing solution to widen participation in the JDF. However, this is subject to further discussion and a survey result is due in February 2019.

4.0 IMPLICATIONS

4.1 Risks

There is a risk that the significant reduction in exception reporting reflects a poor reporting culture due to pressure not to exception report rather than an actual improvement in rotas. This was reflected in 2 comments in the latest GMC foundation doctor survey.

Doctors are regularly working outside of work schedules in General Surgery, Acute Medicine, and Neonatal Medicine (specifically the post natal wards). Time off in lieu and/or overtime payments will be required (and in many cases already granted or paid) unless service changes are made to reduce doctors working hours. Moves have already been made to change the way doctors are supported and work in neonatal medicine. Of particular concern are the current additional hours being worked in cardiology due to rota gaps that will feature in the next report - urgent action is required to prevent fines being levied in the forthcoming weeks due to potential breaches of the 48 hour average working week limit. The Guardian has discussed this in person with the trainees and department lead for cardiology. The changes within the cardiothoracic department is having a direct effect on cardiology workload and in combination with rota gaps, the trainee body are under considerable pressure (exception report summary in the next report).

4.2 Legal Regulatory

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

4.3 Resources - cost pressures from fines

Funding for overtime payments represents a cost pressure. Following work schedule reviews, additional staff may be required to bring doctors working hours into safe limits and to bring their hours into line with their work schedules. If actual working hours cannot be brought into line with work schedules, then basic pay for staff may need to increase. This represents a further cost pressure. Lastly, fines may be levied if unsafe working practices continue.

4.4 Resources – educational supervision

Educational supervisors require the 0.25 PA allocated in their job plans per trainee and new job planning needs to take this into account. Personalising work schedules, resolving exception reports and performing work schedule reviews are additional tasks for educational and clinical supervisors. Over 50% of exception reports continue to breach the 7 day timescale for resolution by supervisors. Education is provided by Claire Houghton (GOSW admin support) to the educational supervisors and the majority of exception reports have note from the GOSW to encourage swift resolution. This also means that the trainee can be offered TOIL wherever possible as close to the exception as possible.

5.0 NEXT STEPS

5.1 Supporting trainees to exception report

The GMC F1 survey were anonymous so no direct action can be taken but the Guardian will run more training with the trainees on exception reporting and liaise with educational supervisors about enabling trainees to report. The GMC Regional Liaison Advisors have offered to support this.

5.2 Cardiology

On-going liaison with cardiology, medicine and surgery to track how rota gaps are being filled and that trainees are also getting the education and rest they are entitled to.

6.0 RECOMMENDATIONS

6.1 The Board are asked to note this report and consider the costs associated with overtime payments and fines and the potential future costs and service changes associated with the outcomes of any future work schedule reviews so it is in everyone's interests that departments monitor closely the working pattern of their trainees.

6.2 The Board are asked to consider the issue of rota gaps due to medical vacancies and strategies to address these ahead of the guardian's next report in April 2019.

6.3 The Board are asked to continue to consider the additional activities for educational and clinical supervisors and the impact on the current round of consultant job planning.

6.4 The Board is reminded that changes in one department can affect the running of another and this has implications for trainees.

Author: **Dr Serena Haywood** **Date:** **03/02/2019**

APPENDIX A

Summary of exception reports by specialty

1st October 2018-31st December 2018

General Surgery (Upper & Lower GI surgery, excluding Transplant surgery)

12 exception reports raised between 2 F1 trainees.
4 general surgery
8 vascular surgery
10 were overtime and were all paid as overtime. 2 were described as 'needing support'.
The longest anyone worked in excess of their rotated hours was 2 hours 30 mins in a shift but most were 1 extra hour on no more than 2 consecutive days.
Comments included 'very busy and understaffed general surgical on call' and 'Low staffing on general surgical on-call, ward registrar; resulting in back log of tasks and having to do the SHO role'. The educational supervisor has been contacted to comment and the next ES for this trainee was contacted to ensure they had a smooth transition into the next post (paediatrics)

There were no fines of work schedule reviews.

General Medicine (Acute Medicine, Senior Health, Gastroenterology, Respiratory Medicine).

There was a total of 24 exception reports all at F1 level.

9 - general medicine of which
2 (1 and 4 hours - post take leaving late – paid as overtime)
2 medicine - on call 4 and 3.45 extra hours -paid
1 of 1 hour - paid,
1 1.15 hours – paid
1 for 3 hours required to work after shift – paid
1 robin cohen 1 hour post take – paid ,
1 1 extra hour due to volume of work at premium hour - paid .

5 - respiratory - 1 at 1.30 hours -paid as overtime, one trainee reporting 4 times (1.3, 1.45, 1.3 hours and one education) - all overwork paid

2 endocrine 1 trainee reported 2 occasions not being able to go to her education sessions because of work load. The educational supervisor is aware of this and has offered TOIL and the department is looking at this issue.

2 AMU - 2 - zero day on 2x bank holiday - agreed to take in the next job which is Endo and agreed with ES
2 gastro - 1 trainee 1.15 and 0.45 staying late - paid
2 Senior health - 2 at 1 hour post take - overtime pay

1 rehab – 1 hour rehab and paid

Paediatrics

3 Paeds - 2 overtime reports (2.45 and one 1.45) and one 2 hours
9 Paeds Surgery - all one trainee not getting to morning teaching. Surgeons will offer alternative teaching
6 Neonatal Medicine 2 (2.30 and 5 hours), 3 (2, 2, 2 2.5) and 1 (2.3) - all paid or TOIL and new rota and greater consultant supervision on postnatal ward and work on independent working

Appendix B

Current medical Vacancies at of 30/01/2019

Speciality	Grade	Expected (as per allocate)	Number of Trainees	Number of Trust doctors	Jan-19	GAPS	Notes
Renal Medicine	F2/ST1/2	**6**	6	0	5	1	1x post being advertised closes 22/01
Renal Medicine	ST3+	**6**	6	0	4	2	
Renal Surgery	All	**5**	2	3	5	1	1x post in offer, awaiting confirmation of start date.
Emergency Med	F2	**14**	14	0	14	0	
Emergency Med	CT3	**10**	7	3	10	0	
Emergency Med	GP	**10**	6	4	10	0	
Emergency Med	ST4+	**10**	9	1	10	0	
Emergency Med	CF	**15**	0	15	15	0	
Cardiology	ST1-2	**7**	4	3	5	2	Interview 23/01
Cardiology	ST3+	**13**	11	2	11	2	2 x offered posts / awaiting start dates
Oncology	ST1-2	**4**	4	0	2	2	1 x awaiting start date
Oncology	ST3+	**5**	4	1	4	1	Post still in shortlisting - chased to complete
Haematology	st1-2	**2**	2	0	2	0	
Haematology	ST3+	**8**	7	1	8	0	
Acute / Gen Medicine	F1/F2	**19**	19	0	19	0	
Acute Medicine	ST1-2	**15**	11	4	12	3	
Acute Medicine	ST3+	**20**	15	5	19	1	In offer, awaiting start date
General Medicine	F2 ST1-2 (CMT's)	**27**	21	6	26	1	Includes Gastro, Chest, Geriatrics, AMU, Endo
General Medicine	ST3+	**12**	12	0	10	2	x 2 geriatric posts in shortlisting

Speciality	Grade	Expected (as per allocate)	Number of Trainees	Number of Trust doctors	Jan-19	GAPS	Notes
Cardiac Surgery	F2/ ST1-2	**6**	6	0	4	2	2 x offered posts / awaiting start dates
Cardiac Surgery	ST3+	**8**	0	8	6	2	1 x in offer, awaiting start date
Thoracic Surgery	ST3+	**4**	3	1	2	2	Being advertised due to close 31/01
Dermatology	ST3+	**6**	3	3	6	0	
Microbiology/ID	ST3+	**11**	11	0	11	0	
Palliative Medicine	F1	**1**	1	0	1	0	
Vascular Surgery	F2	**1**	1	0	1	0	
Vascular Surgery	ST3+	**6**	2	4	5	1	Being advertised due to close 05/02
Total		**251**	**187**	**64**	**227**	**25**	

Speciality	Grade	Expected (as per allocate)	GAPS	Notes
Adult Critical Care	F1	3	0	
Adult Critical Care	F2/ST1/2	**39**	1	
Adult Critical Care	ST3+	**24**	2	
GUM	F1	**1**	0	
O&G	F1	**2**	0	
O&G	ST1-2	**3**	1	
O&G	ST3+	**16**	1	
O&G	CF	**10**	0	
Neonates	F1	**1**	0	
Neonates	ST1-3	**11**	0	
Neonates	ST4+	**9**	0	
Paed Surgery	ST3+	**7**	0	1x senior CF to be replaced
Paeds General	F1	**2**	0	
Paeds General	ST1-2	15	0	
Paeds General	ST4+	**9**	2	1 x being advertised
Psychiatry	F1	**2**	0	
Radiology	ST1	**5**	0	
Radiology	ST2-3	**12**	0	
Radiology	ST4+	**22**	2	2 x mat leave / in shortlisting
Total		**190**	**9**	

GP Trainees

Scheme	Specialty	Vacancies Jan-19
St George's	Emergency Medicine	3
	Neurology	2
	Paeds	1
Bromley	Obs & Gynae	1
	Emergency Medicine	1
King's	Emergency Medicine	1
Kingston	Paeds	1
	Psychiatry	1
GSTT	GIM - Diabetes (2) / Frailty (2)	0
	Genito-urinary Medicine	1
Greenwich	Emergency Medicine	0
	Paediatrics	0
	GP Practice	0
Lewisham	Urology	0
	Acute Internal Medicine	2
Croydon	Obstetrics & Gynaecology	0
	Emergency Medicine	0
Bexley&Sidcup	Emergency Medicine	1
	Obstetrics and Gynaecology	1
St Helier	Geriatric Medicine	0
	Acute Internal Medicine	0
	General Psychiatry	0
	Geriatric Medicine	0
	Cancer Medicine	0
	Emergency Medicine	1
TOTAL		17

Speciality	Grade	Expected (as per allocate)	Number of Trainees	Number of Trust doctors	Jan-19	GAPS	Notes
Neurosurgery	F2, ST1/2	**9**	0	9	9	0	
Neurosurgery	ST3+	**16**	7	9	16	0	
Neurology	ST1-2	**9**	5	4	9	0	
Neurology	ST3+	**16**	16	0	15	1	
General Surgery	F1	**9**	9	0	9	0	Includes F1 Lower GI, Upper GI, Plastics, Paeds Surgery, Renal Transplant, T&O
General Surgery	ST1-2	**13**	11	2	12	1	Interviews on 25/10
General Surgery	ST3+	**12**	12	0	10	2	
Plastic Surgery	F2	**1**	1	0	1	0	
Plastic Surgery	ST1-2	**5**	5	0	5	1	awaiting shortlisting
Plastic Surgery	ST3+	**11**	8	3	11	0	1
MaxFax	ST1-2	**7**	4	3	7	0	In shortlisting, awaiting interview
MaxFax	ST3+	5	5	0	5	0	
Ophthalmology	F1	1	1	0	1	0	
Urology	F2	**1**	1	0	2	-1	
Urology	ST3+	**8**	4	4	8	0	
Anaesthetics (Gen)	ST3+	**8**	8	0	7	1	
Anaesthetics (N/C)	ST3+	**8**	6	2	8	0	
Anaesthetics (Obs)	ST3+	**8**	6	2	6	2	Out to advert
Anaesthetics (PICU)	ST3+	**8**	8	0	6	2	2 x interviews on 28/11
Anaesthetics	CT1-2	**2**	2	0	2	0	
ENT	ST1-2 / F2	8	6	2	7	1	1 x post out to advert
ENT	ST3+	7	7	0	7	0	
T&O	ST1-2	**2**	2	0	2	0	
T&O	ST3+	**16**	7	9	13	2	1 x offered post / awaiting start date
T&O	CF	**5**	0	5	5	0	
TOTAL		**195**			183	12	

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	28 February 2019	**Agenda No.**	**6.1**
Report Title:	**Exiting the European Union**		
Lead Director/ Manager:	**Andrew Grimshaw, CFO**		
Report Author:	Andrew Grimshaw, CFO		
Presented for:	Note		
Executive Summary:	The paper provides an overview of the actions that have been taken by the NHS in general and the Trust specifically in relation to the UK exiting the EU on 29th March 2019.		
Recommendation:	To note the actions taken.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	Failure to be in a position to respond to issues that could arise from a no deal EU Exit.		
Legal/Regulatory:	N/A		
Resources:	As noted in the paper.		
Previously Considered by:	Trust Executive Committee	**Date:**	20 February 2019
Appendices:	N/A		

Trust Board, 28th February 2019
UK withdrawal from the European Union

Introduction

This paper provides a brief summary of the key actions that are being taken to address issues that may result from a "no deal" exit from the European Union (EU). The paper covers actions by the NHS in general and the Trust specifically.

The issue

A "no-deal" exit from the EU could result in the disruption of the flow of goods, services and people between the UK and EU. In order to address this risk the UK Government has been taking steps to ensure key services are prepared for this eventuality and can maintain effective and safe service provision.

The nature of the disruption that the government is seeking to avoid would be;

- Shortages of supplies; medicines, clinical and non-clinical consumables.
- Workforce issues relating to EU staff working in the NHS.
- Data sharing and processes.

Actions led by the Department of Health and Social Care (DHSC)

The DHSC issued guidance to all trusts in December 2019, and held a briefing session for all Trust "EU exit" leads in London on the 14th February. The key messages from the DHSC;

1. The Department with the support of NHSE, NHSI and Public Health England have set up a National Operational Response Centre to lead on identifying and defining actions in relation to any potential issues that may cause disruption to the delivery of health and care services in England. A structure has been created in each of the English regions to support this.
2. Specific steps have been taken to build an additional 6 weeks supply of good into existing supply chains through work with both suppliers and NHS Supply chain. The guidance to all individual NHS organisation not to build extra stocks remains in place.
3. Put in place additional capacity to support the flow of goods into the UK. Goods destined for the NHS will be given priority within this capacity.
4. Assurance was given at the meeting on the 14th February that the DHSC expected these contingencies to remove risk to the effective operation of the supply chain.

Actions required of NHS organisations.

The DHSC has requested individual NHS organisations take the following actions in respect of EU Exit;

1. Appoint a senior executive as EU Exit lead. The Chief Finance Officer has taken this role.
2. To review action cards to assure that organisations are prepared. The Trust has formed an EU Exit Group lead by the CFO to complete this. The Group includes the Director of HR & OD, the Director of Delivery, Efficiency & Transformation, the Head of Pharmacy, the Head of Procurement, The Chief Information Officer and the Associate Director of Communications. The Group has reviewed the Action Cards and is satisfied that the Trust has addressed, or is in the process of addressing all of the issues raised by the DHSC.
3. To be prepared to work collaboratively with other NHS organisations to provide mutual aid and support if needed. For example, Pharmacy leads have been asked to be prepared to share medicines if local shortages develop. Systems are in place within SWL to do this.
4. To not increase the duration of prescriptions. This is seen as unnecessary as the supply chain is expected to maintain the effective supply of goods to the NHS.

5. To review and understand the sources of goods and services, and the impact EU Exit may have. The Head of Procurement has reviewed all material lines of supply, and has not identified any areas of concern that are not already been addressed nationally.
6. As noted above, individual NHS organisations have been asked not to stockpile goods locally. Such an action would be likely to distort supply chains and act to create the shortages.
7. Support EU citizens working within the NHS. The Trust is aware of the numbers of EU nationals working in the Trust. Any changes in numbers employed will be monitored closely and actions identified to address any issues that emerge.
8. Understand data flows from the EU. A no deal EU Exit could disrupt these given current GDPR rules. A review of all systems is underway by the ICT Department. To date no material issue shave been identified.
9. At the meeting on the 14th February the DHSC indicated that a national reporting system would be instigated to ensure effective oversight of any issues that may arise from a no deal EU Exit.
10. Ensure Business Continuity Planning processes are ready to respond if any issues arise. The Trust is working through scenarios provided by the DHSC to test this.

Timeline

At the meeting on the 14th February, the DHSC indicated that NHS organisations should be prepared for a potential no deal EU Exit on the 29th March, but also that the impact of this may not be felt immediately. As such, organisations should maintain the ability to monitor and respond to events over the coming months. National and Regional Teams are adopting this stance.

Summary

It is possible that the UK could exit the EU without a deal. This scenario could potentially impact on the effective operation of the NHS if effective preparation is not in place.

The DHSC has led a national response to support supply chains, and has requested individual NHS organisations establish groups to prepare for this eventuality as a precaution.

St Georges has engaged proactively with the actions requested, and will maintain operational preparedness to respond to issues if they emerge.

Action

The Trust Board is requested to note this paper.

Chief Finance Officer
February 2019.