BOARD OF DIRECTORS MEETING (PUBLIC)

9 MAY 2018
BOARD OF DIRECTORS PUBLIC MEETING  
Wednesday 9 May 2018 2:00pm – 3:30pm  
Venue: Education Centre, 1st Floor West Wing, 250 Euston Road, London NW1 2PG

AGENDA

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<td>Oral</td>
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<td>18. Any other business</td>
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<td>Oral</td>
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<td>Questions from the public – limited to 15 minutes</td>
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<td>20.</td>
<td>Date and time of next meeting in public: Wednesday 11 July 2018</td>
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Draft minutes from the last board meeting held on 14 March 2018.docx
Board of Directors

Minutes of the meeting held in Public on Wednesday 14 March 2018

Present

Geoff Bellingan, Medical Director, Surgery & Cancer Board
Harry Bush, Non-Executive Director, Vice-Chairman
Althea Efunshile, Non-Executive Director
Gill Gaskin, Medical Director, Specialist Hospitals Board
Charles House, Medical Director, Medicine Board
Tim Jaggard, Finance Director
Marcel Levi, Chief Executive
David Lomas, Non-Executive Director
Rima Makarem, Non-Executive Director
Tony Mundy, Corporate Medical Director
Flo Panel-Coates, Corporate Medical Director
David Prior, Chairman
Caspar Woolley, Non-Executive Director

In attendance

Simon Knight, Director of Planning and Performance
Prasad Korlipora, Guardian of Safeworking Hours (in attendance for agenda items 1-9)
Cathy Mooney, Director for Quality and Safety
Ben Morrin, Director of Workforce
Rachel Stoukas, Trust Administrator (Minutes)
John Welch, Nurse Consultant (in attendance for item 7)
Bryan Williams, Director of Research and Development

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<td>BoD/18/18</td>
<td>Welcome and apologies for absence</td>
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<tr>
<td>18.1</td>
<td>Apologies noted from Kieran Murphy.</td>
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<tr>
<td>BoD/19/18</td>
<td>New declarations of interest</td>
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<tr>
<td>19.1</td>
<td>None.</td>
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<tr>
<td>BoD/20/18</td>
<td>Declarations of conflicts of interest</td>
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<tr>
<td>20.1</td>
<td>None.</td>
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<tr>
<td>BoD/21/18</td>
<td>Minutes of the last meeting held on 10 January 2018</td>
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<tr>
<td>21.1</td>
<td>The minutes were agreed as an accurate record.</td>
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<tr>
<td>BoD/22/18</td>
<td>Action tracker</td>
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<tr>
<td>22.1</td>
<td>The action tracker was noted. Items marked complete were agreed to be closed.</td>
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BoD/23/18 Matters arising
23.1 None.

BoD/24/18 Safety series presentation - sepsis
24.1 The Chairman welcomed John Welch, one of the Trust’s sepsis leads, to the meeting. John explained that a review of the process of care received by patients with sepsis carried out by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) revealed that 64% of patients received “less than good” care and there was a 27% mortality rate. The principal recommendation from NCEPOD was that all hospitals should have a formal protocol for the early identification and immediate management of patients with sepsis. The National Institute for Health and Care Excellence (NICE) also produced guidance to assist NHS Trusts on the recognition, diagnosis and early management of sepsis for all populations.

24.2 The Trust undertook a review of its own processes with a particular focus on the emergency department, being the first place that patients with sepsis presented. John explained that initial Trust practices revealed adequate protocols for the management of sepsis and a Spot it Stop campaign launched in 2017. The Board noted the sepsis pathway which detailed the steps to be taken with 48 hours of a patient’s arrival in to the ED.

24.3 The Board discussed the Trust’s mortality rate, the percentage of patients with sepsis being treated with antibiotics within one hour and the next steps. The Trust’s performance for treating patients with sepsis within one hour was gradually improving. John explained whilst the Trust was in a relatively good position for sepsis mortality in comparison to other Trusts there would be a deep dive review of sepsis deaths, analysis and validation of suspicion of sepsis data and development of the sepsis nurse role.

24.4 The Board thanked John for his informative presentation and for the hard work of the sepsis team for the care provided to patients.

BoD/25/18 Performance report
25.1 The Chief Executive introduced the month 10 performance report with a particular focus on emergency department (ED) performance, referral to treatment (RTT) incomplete pathways, cancer waits, pressure ulcers and complaints responded to within target time. The latest remedial action plans for cancer 62 day waits and ED 4 hour waits were also reviewed.

25.2 Emergency department
In January the Trust reported performance of 85.9% against a trajectory of 90.4% for the four hour standard. Reasons for not meeting the trajectory included high levels of flu and norovirus with associated bed closures and staff shortages. Key actions taken in January included working with staff to embed coordination centre processes, opening a surge area for patients who needed to be admitted in to an identified bed that was not ready yet and adding extra senior clinician support during evening periods. The ED team were working closely with Consultants to reduce the time patients wait in ED for a specialist review. Productivity within the urgent treatment centre (UTC) was also reviewed to improve efficiency and help ease the burden on other areas of the ED, particularly majors.
25.3 Harry Bush asked why the target for UTC performance was set at 95% and suggested a higher target in order to help overall ED performance. The Chief Executive and C House agreed with this and explained the daily aim is for at least 97%.

25.4 Rima Makarem asked about ED staff shortages and the use of locum junior doctors. The Chief Executive explained the ED Clinical Director had a robust plan to recruit more senior staff. The Board went on to discuss the ongoing recruitment difficulties within ED. C House explained there was a rolling recruitment programme in place. As well as senior clinicians, there was also a focus on recruiting to non-medical roles to improve the running of the department.

25.5 **ED four hour wait recover action plan**

Casper Woolley asked how the Board could be assured that the actions in the refreshed RAP would work. C House explained the managerial team in place were working hard to improve the performance and focus on getting patients seen and assessed within the 4 hour target. He stressed the team were committed to delivering improvement but were faced with many complexities including bed capacity in the Tower linked to length of stay and discharge rates.

25.6 The Board noted the recover action plan and recommended that the action to develop a business case to recruit additional Consultant posts be expedited.

25.7 The Chairman raised his concerns and those of the Non-Executive Directors. They were concerned about the impact on patients and the loss of the sustainability and transformation funding. Whilst the Board were assured there were no patient safety issues, the Chairman stressed that more urgent work was needed to improve and sustain performance. The Chief Executive acknowledged the concern and explained that ED performance was a Trust wide issue and the SDT were working across all clinical and corporate boards and divisions to improve operational performance.

25.8 **Cancer waits**

The Board reviewed the latest position and recovery action plan. The Chief Executive explained good progress had been made to clear the backlog of patients waiting for treatment and inter-transfer referrals were improving.

25.9 **Referral to treatment incomplete pathways**

In January the Trust achieved 91.1% which was only 1% off the trajectory. There had been improvement particularly across the non-compliant divisions; RNTNE, Eastman Dental Hospital and Queen Square. The Chief Executive reminded the Board that the cause of the breaches were multifactorial including patient choice and late referrals in to the Trust.

25.10 **Pressure ulcers**

During January there were six grade two hospital acquired pressure ulcers. The root cause analysis has not found any omissions in care. F Panel-Coates highlighted that the Trust had seen a reduction in pressure ulcers in January which was commendable over the winter period and she explained that the Trust was performing well compared to its peers.
25.11 **Patient experience**  
Althea Efunshile noted poor performance for collection of inpatient and outpatient feedback. F Panel-Coates acknowledged this and explained an analytic review had been carried out which looked at how the Trust collects its data, the variations across services for doing so and why some methods work better than others. It was agreed a comprehensive update should be prepared for the next meeting to aid discussion.

**Action BoD/3/Flo Panel-Coates**

25.12 **Efficiency and productivity**  
R Makarem asked what was being done to address the outpatient DNA rate in the Medicine Board. Charles House explained all departments were being asked to ensure they had robust processes in place for appointment reminders and to ensure follow-up appointment processes were accurate and efficient.

25.13 The month 10 performance report was noted. The Board acknowledged the actions being taken to improve operational performance and agreed further assurance was needed to improve the ED four hour wait target. The Board acknowledged the risk that the Trust was unlikely to receive the quarter 4 STF funding for ED targets.

**BoD/26/18 Chief executive and Senior Directors team report**

26.1 **Guardian of safe working hours quarterly report**  
The Board discussed two reports covering periods from 6 July 2017 to 5 October 2017 and 6 October 2017 to 31 January 2018. Dr Prasad Korlipara spoke to the two reports explaining that the majority of junior doctors moved to the new contract in August 2017 which explains the significant increase in numbers of exception reports. He explained that the culture of reporting had changed. Consistent feedback across all trainee groups included IT issues and lack of access to computers. The Chief Executive explained plans were in place to increase the number of laptops and computers available. He went on to explain the benefits of having an open culture across the Trust and he felt the role of the Guardian was working very well. In response to Rima Makarem’s query, Dr Korlipara confirmed the fines incurred were drawn from the budgets of the clinical divisions.

26.2 The two guardian of safe working hour reports were noted.

26.3 **Gender Pay Report**  
The Board discussed the definition of the gender pay gap noting it to be the difference between the average earnings of men and women across an organisation. The Trust gender pay analysis shows that at UCLH the mix of men and women who carry out professional roles varies and that the median average difference in pay is 9.5%. The UCLH workforce is comprised of 71% female and 29% male.

26.4 The Board reviewed the analysis of the basic hourly rate across staff groups. Female agenda for change staff were noted to have a higher rate of pay than that of their male colleagues; this was also the case for nurses and midwives, pharmacists and psychologists. Male medical and dental staff had a higher rate of pay than that of female colleagues.
Ben Morrin explained the next steps the Trust would take to address the findings including development of an action plan to address the gender pay gap issues. In addition further work will be done to ensure the Trust amends its process to ensure that female consultants are not disadvantaged by the local Clinical Excellence Awards process.

The UCLH Gender Pay Report was approved for publication on the Trust’s website.

Workforce Race Equality Standard (WRES)

The updated WRES report and Equality, Diversity and Inclusion action plan was noted. The Chairman noted he had asked the Director of Workforce to plan a future Board seminar presentation to discuss the WRES standards and plans to increase recruitment of black and minority ethnic staff (BME) as well as more women in senior management roles. Althea Efunshile suggested it would be useful for the 2018/19 corporate objectives to explicitly include an equality, diversity and inclusion measure.

The WRES report was approved.

Annual staffing(nursing) report

The Board reviewed the annual staffing report and were assured that there was sufficient nursing and midwifery staffing capacity and compliance with national safe staffing guidance.

Caspar Woolley noted the Trust did not compare well against other Trusts for the care hours per patient day (CHPPD). Flo Panel-Coates explained this was a new metric to try and measure productivity and efficiency across inpatient wards and units. UCLH reports on both registered nurses and non-registered nurses and whilst overall staffing levels have consistently remained within 2% of planned hours, registered nurse filled hours remain below 95% which are being backfilled by nursing assistants therefore when benchmarked the Trust’s CHPPD appear lower than some peers.

The Board reviewed progress against the 2017/18 corporate objectives noting good progress against objectives 1 and 6 (high quality care and world class clinical research).

The proposed 2018/19 objectives were discussed. Rima Makarem commented that year on year the number of objectives were increasing despite previous concern raised by the Board that there were too many. She also felt too many of the objectives had been Gill Gaskin as the lead and this was a concern given Gill’s role as the Electronic Health Records System (EHRS) senior responsible officer. The Chief Executive explained that EHRS was a priority for the Trust however it was still important for the Trust to focus on other ambitions including its aim to become a research hospital. He also explained it had been difficult to reduce the number of objectives owing to the Trust strategy refresh, however the SDT would certainly accept the challenge to reduce the number for 2019/20. Gill Gaskin clarified that whilst she was the lead for a number of objectives these were closely interlinked to EHRS.

The Board approved the 2018/19 annual objectives subject to inclusion of an explicit reference to equality, diversity and inclusion.
EHRS
The Board discussed the progress of the EHRS programme for the period January – February 2018 noting the programme was currently on track against plan. Harry Bush asked about the plans for end-user training. Gill Gaskin explained that following the direction setting sessions, subject matter experts had been identified and there were positive signs of clinical engagement. The recruitment for trainers would begin imminently.

David Lomas asked about progress of the delivery of the hardware. Gill Gaskin confirmed there were active plans in place with a phased programme rollout. Weekly technical meetings were taking place between Atos and Epic.

Caspar Woolley congratulated Gill and the EHRS team on the excellent progress made. He asked about the assurance process to ensure no risks or issues were missed. Gill Gaskin confirmed plans were in place to bring in external assurance assessors and three experienced people had been identified along with two additional senior clinicians from Cambridge.

The EHRS update was noted.

Refeshed Trust Strategy
Following input from patients, staff, governors and stakeholders the revised Trust Strategy was presented for approval. Some of the key changes included explicit inclusion of the Sustainability and Transformation Partnership (STP) priorities and a rewrite of the patient pathway section.

The Board approved the refreshed Trust Strategy.

Research update
The research update was reviewed. Bryan Williams outlined the keys steps being taken to get ready for the new General Data Protection Regulations (GDPR) explaining that The Health Research Agency had now issued draft guidance. Using that guidance, the Head of Risk and Regulation of the Joint Research Office has prepared a comprehensive update for investigators advising them how they should now prepare for GDPR.

The Research report was noted.

Quality and safety committee report
David Lomas introduced the Quality and Safety Committee report which highlighted key issues following the meetings held in January and February 2018. He noted a correction to the first paragraph of the report explaining it should read ‘our score of 81% for the proportion of patients reporting that they are getting enough help from staff to eat meals is below the expected target of 88%.’

The Board noted the report.

Mortality surveillance report
Tony Mundy introduced the statutory report. He explained that there was an error in section five (paragraph 5.1.3 SI471 maternal death) and clarified the last sentence of the paragraph should read “The MSG reviewed the death on 5th March and determined that it was not likely to be due to problems in care”.

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28.2 The Board noted the quarterly report which provided an update on deaths and learnings for the period July to September 2017. There were no areas of concern and the Board were assured that correct processes were in place.

**BoD/29/18 Finance and contracting committee report**

29.1 Caspar Wooley introduced the report. There had been a financial improvement and the month 10 position was £3.8m better than forecast.

29.2 In terms of 2018/19 financial planning, the draft plan had now been submitted to NHS Improvement. The Trust did not accept its control total owing to the significant loss of cardiac funding and medical undergraduate teaching funding. The Board was informed that some progress had been made with NHSI and Health Education England to reduce the loss of transitional funding for undergraduate teaching by £1.3m. However this was not sufficient to enable the Trust to accept its control total.

29.3 The FCC noted that 2018/19 would be an exceptionally challenging year and that there would need to be a strong focus on productivity and efficiency. The committee agreed the cost improvement plan target was extremely stretched. The committee therefore recommended to the Board that it support a reduction in the Board contingency from £10m to £8m.

29.4 The Board discussed the current financial position. Tim Jaggard explained that initial February figures remained positive and other financial benefits included formal confirmation that the Trust would receive its Global Digital Exemplar fast follower funding as well as income from the sale of the Eastman Dental Hospital - first tranche income would be received in the current financial year.

29.5 There was a discussion about the achievability of the 2018/19 CIP target. Tim Jaggard explained a lot of effort was being made to ensure identified Trust wide schemes would deliver on an underlying basis. Rima Makaram asked about the procurement work programme. The savings opportunities appeared low. Tim Jaggard explained the procurement team was working closely with clinical teams and suppliers to secure price reductions and product switching. He explained the Trust was hoping to implement an electronic system to assist with product assets, tracking and ordering.

29.6 The Board noted the FCC report including the 2018/19 financial planning update.

29.7 The Board approved the FCC recommendation to decrease the level of planned Board contingency from £10m to £8m in order to support a reduced CIP target in 2018/19.

**BoD/30/18 Audit Committee report**

30.1 The Board received a comprehensive update following the Audit Committee meeting held on the 30 January. Rima Makarem explained the committee continued to focus on the Trust’s readiness for GDPR and the use of procurement waivers, which still remained high. The Committee discussed that the Care Rounds internal audit had received an amber/red rating and asked for further assurance and updates on the two high priority recommendations.

30.1 The Audit Committee report was noted.
BoD/31/18  Workforce Committee report
31.1 At its February meeting the Workforce Committee focused on the strategic workforce objectives for 2017/18, in particular any issues or risks concerning delivery against targets by year end. The Committee had also been briefed on the pending NHS staff survey results for 2017. The actual results were published on 6 March 2018. Initial analysis has shown good results with no major changes to the previous year. Areas of concern included staff working extra hours and experiencing harassment and bullying.

31.2 The Board noted the Workforce Committee report including the summary of results of the NHS staff survey. The Chairman confirmed the Board would discuss the results and action plans at its next meeting.

BoD/32/18  Audit committee minutes
32.1 The minutes from the Audit Committee meeting held on the 28 November 2017 were noted.

BoD/33/18  Register of interests – annual update
33.1 The annual register of Board members’ interests was noted.

BoD/34/18  Entries in the seal register
34.1 There had been one entry in the seal register since the last report. The Board noted and endorsed the use of the Board seal.

BoD/35/18  Any other urgent business
35.1 None.

BoD/36/18  Questions from the public
36.1 Q1 – Was there any scope for the Trust to reduce its PFI costs? In response to this question T Jaggard confirmed there was no scope for this, although the Trust had been lobbying hard for a reduction. He went on to explain that it was now important for the Trust to focus on strengthening its contract management processes.

36.2 Q2 – related to a topic already covered in the meeting relating to Care hours per patient per day (see minute number 26.10)

Signed
David Prior, Chairman
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<th>Action Number</th>
<th>Date of Meeting</th>
<th>Subject</th>
<th>Action</th>
<th>Responsible Director</th>
<th>Due date</th>
<th>Comments</th>
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<tbody>
<tr>
<td>BOD/3/18</td>
<td>14.03.18</td>
<td>Performance report - Patient Experience</td>
<td>Althea Efunshile noted poor performance for collection of inpatient and outpatient feedback. F Panel-Coates acknowledged this and explained an analytic review had been carried out which looked at how the Trust collects its data, the variations across services for doing so and why some methods work better than others. It was agreed a comprehensive update should be prepared for the next meeting to aid discussion.</td>
<td>F Panel-Coates</td>
<td>May-18</td>
<td>Included within the Board papers for meeting 9.8.18</td>
<td>Complete</td>
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Quality and Safety Committee Report.doc
Report of the March 2018 Meeting

1. Safe rooms

Following two incidents where patients attempted to self-harm on the Acute Medical Unit (AMU) and T8 in May 2016 a safe room was created on the AMU for safe management of such patients in the future. QSC asked for a risk assessment to be carried out to advise whether a second safe room was required in the tower.

It was noted that that ED has a transitional assessment facility (TAF) in place for patients with mental health needs and changes have also been made to T12 (adolescent ward) to ensure that risks are minimised should a safe room be required. Based on the risk assessment and analysis QSC has been advised that the risk imposed by not having a further safe room is low.

The committee has however expressed concerns about the increasing number of patients with mental health needs presenting not just to ED but to other wards for medical care as well as the increase in violence against staff. It was acknowledged that a proportion of this is related to substance abuse however the increase in patients presenting with mental health needs was compounded by ongoing local mental health resourcing issues. The chief executive highlighted the need to have clear protocols on the care and appropriate transfer of patients with mental health needs.

2. Care Quality Commission Executive Steering Group report

The report included information on the work undertaken as part of the CQC inspection action plan from 2016, and the actions to address the recommendations from an internal audit into Improving Care Rounds (ICRs) and approve the ICR policy. It also included a review of outliers on the CQC dashboard and learning from our mock inspection of the maternity service at another trust.

3. 2018/19 Quality Account update

The committee noted the process that has been used so far to determine quality priorities for 2018/19 which are further developments of the 2017/18. The committee endorsed the proposal for the quality priorities for 2018/19.

4. Trust infection control scorecard

UCLH reported one healthcare associated Methicillin-resistant Staphylococcus aureus against a target of zero for 2017/18; this was invasive device related. The target for healthcare attributable Clostridium Difficile for 2017/18 is less than 97 cases and to date the Trust has had 62 healthcare associated cases of which 29 are in progress or being reviewed by the CCG, 31 of which have been successfully appealed and two which were due to lapses in care. The learning from managing the flu season and flu incident last year was noted and that this had led to improvements this year. Management of influenza has been good with significantly less lost bed days than last year.
5. Trust quality and safety performance

The committee discussed key performance points for January 2018. No grade three or four pressure ulcers were reported for the month. There were six grade two hospital acquired pressure ulcers, which was a significant improvement compared to the previous two months but was above our trust threshold of four. UCLH was thought to be performing well as most organisations were reporting higher numbers of pressure ulcers over the winter.

The Sir William Gower’s Unit accounted for 46 falls in January, with one patient falling 16 times and another patient falling 10 times. There were two reported falls that led to moderate harm. Reviews have not identified care or service delivery issues as contributing to these falls.

Other outliers included dose omissions and mixed sex mixed sex accommodation breaches.

6. Patient experience committee quarterly report

Overall results are positive from the recently published Picker National Patient Inpatient survey results. The trust will remain cautious about comparisons until CQC results are available in May/June.

The CQC maternity survey report was published in February. Key points are:

- Overall the trust is not statistically different from England as a whole.

- UCLH was ‘about the same’ for each of the three subsections of the survey: labour and birth, staff during labour and birth and care in hospital after birth. This is an improvement on 2015 when we were worse than expected for labour and birth.

- Thirteen theme scores were improved from 2015, and one was the same. However there were deteriorations in the overall score for the care in hospital after birth, and in the individual themes in the labour and birth section on taking concerns seriously and responding within a reasonable amount of time when attention is needed, and in the score for the length of time a partner could stay after the birth.

The division is preparing its action plan in response to the published survey.

7. Reporting concerns

The committee discussed the Dr Bawa-Garba case and the potential impact it could have on doctors’ willingness to report mistakes which will also negatively impact local effort across services to gain learning from failures.

8. Patient Safety Committee monthly update

The update covered highlights from the committee held in February. The PSC report produced following the meetings is shared across divisions to enable the dissemination of learning from incidents and failures. QSC agreed that the current format was useful for this purpose.
1. Disclosure & Barring Service (DBS) checks for contractors and Interserve Facilities Management staff

An update on findings from the KPMG audit of employment checks for contractors and IFM (Interserve Facilities Management) staff was requested by the QSC following an update in July 2017. KPMG found IFM to be fully compliant with DBS and ‘Right to Work’ requirements but overall concluded that their findings provided partial assurance that NHS Employer Standards were being met. Recommendations for improvements have highlighted health checks, fit to work confirmation, spot checks and agency staff checklists as priority areas of focus. A progress update will be provided in June to the Workforce Committee followed by update to the QSC in July.

2. Clinical Effectiveness Steering Group (CESG) quarterly report

The reported covered CESG activity for January and February 2018 which included updates from five subcommittees (Use Medicines Committee, Antimicrobial Stewardship Committee, Clinical Guidelines Committee, Organ Donation Committee, NICE Implementation Advisory Group (NIAG) and the Critical Care Collaboration Group). The NICE Implementation Advisory Group (NIAG) has agreed that a formal process to obtain assurances from divisions on their compliance with the UCLH NICE guidance implementation and monitoring policy is commenced.

A gap analysis for the National Confidential Enquiries into Patient Outcome and Death (NCEPOD) on mental health in general hospitals (January 2017) was considered; this found that of the 21 recommendations in the report, 14 are met, two are not applicable to UCLH, four are part-met and one is not-met. Action plan to address gaps is in progress and QSC has asked for a further review of the analysis. A gap analysis for NCEPOD report ‘review of the quality of care provided to patients receiving acute non-invasive ventilation (July 2017)’ was presented and did not cover all UCLH sites, The CESG therefore asked for this to be completed by May 2018.

3. Clinical Audit & Quality Improvement Committee quarterly report

The corporate clinical audit programme for 2017/18 is in progress and on track and the 2018/19 programme is under consultation.

It was noted that the British Medical Journal quality improvement portal is now closed for quality improvement projects and UCLH has submitted five projects that are at write-up stage, these will be shared once published.

An update on the new Electronic Health Records System and how it will support clinical audits was provided by an EHRS clinical lead and EHRS will be a standing item on the CAQIC agenda. Quality improvement updates at the committee have continued. Three clinical audit presentations were shared -adherence to antibiotic guidelines in the Emergency Department, National Audit of Dementia and the National Clinical Audit of Falls.

4. National maternity and neonatal safety collaborative

The trust is part of wave one of the national initiative which is aiming to reduce antenatal stillbirth rate by 20% by 2020 and 50% by 2030. Through the programme the trust has benefitted from the maternity multidisciplinary team being trained in quality improvement methodology by the Institute of Health Improvement. The local project is aiming to reduce numbers of intrapartum stillbirths after 24/40 weeks. The main work streams have been aligned to national priority areas which are looking to make improvements in safety culture, clinical practice, systems and processes and patient involvement in treatment. The project is on track and overall it has been valuable for the team to be part of wave one of the national project. QSC is to have an update in nine months.
5. Trust quality and safety performance

QSC discussed key points from the quality and safety performance report for February 2018. There were no grade three pressure ulcers (there have been none since November 2017) or grade four pressure ulcers. There were no falls with serious harm during the month of February. There were 82 falls with no harm and 18 with low harm.

Three cases of MSSA were reported in February 2018, the committee will monitor trends in coming months to assess the need for further action. The committee also considered allergy breaches and mixed sex accommodation breaches

6. Quality Account priorities

The latest version of the Quality Account priorities was shared with the committee and the final wording agreed.

7. Patient experience

A review of governance arrangements for how the ‘patient experience’ agenda is currently delivered across the trust is underway led by the Chief Nurse. Proposed changes to the governance structure will mean integration of oversight and assurance responsibilities into the Quality and Safety Committee and business as usual reporting through SDT, Clinical Boards and Clinical Quality Review Group and discontinuation of the Patient Experience Committee. Next steps include consultation with clinical boards and Board of Directors.

Cathy Mooney Director for Quality and Safety on behalf of Professor Tony Mundy, Corporate Medical Director
Research Report.doc
1. Biomedical Research Centre (BRC) Update

1.1 Major new industry partnership signed
A Respiratory Innovation Hub (RIH) is being established between UCL, UCLH and GSK. The concept for the partnership arose from the independent expert review on the BRC 2 years ago when representatives from GSK originally became interested in the BRC’s focus on clinical translation. A partnership agreement has now been signed that will enable UCL/UCLH to build on existing programmes of collaborative research in imaging and fibrosis within the framework of a novel, open innovation model in which GSK make available some of their research assets for further investigation at UCL/UCLH. The RIH is based around 3 mechanistic themes - Immunomodulation, Lung repair and regeneration and Fibrosis and remodelling; and 4 translational themes – Cell and gene therapy, Imaging, Respiratory translational science and Data sciences. An announcement about the RIH will be made to coincide with the launch event for the Research Hospital.

1.2 NIHR BioResource
UCLH BRC proposal to establish and lead a dedicated Cerebrovascular Disease (Stroke) BioResource has been well received by an independent review panel at NIHR. The concept of a new common disease theme in stroke has been accepted and the final outcome of our bid to be the National lead organisation for the NIHR Bioresource theme in Stroke is anticipated by June 2018.

1.3 End of Year 1 reviews and governance changes
To mark the end of the first year of the current BRC term a short review of BRC themes was carried out. The review meetings will form the basis of the BRC annual report which is in preparation for submission to NIHR in May. One outcome of the review meetings will be to rationalise the existing BRC Executive Committee, enlarging membership to include all 13 theme leads, so as to maximise the opportunities for interaction between all the BRC’s theme leads.

The BRC is in the process of appointing a new Theme Lead for the Healthcare Engineering and Imaging Theme. The theme will benefit significantly from the fact that the Wellcome Trust has taken the decision that the Wellcome/EPSRC Centre for Surgical and Interventional Sciences will stay at UCL following the departure of Professor Sebastian Ourselin to King’s College.

1.4 MedCity / BRCs event in Cell and Gene Therapy
The BRC played a key role in a recent meeting to showcase the capabilities and capacities of London and the Southeast in cell and gene therapies. This industry facing event was attended by over 150 people.

1.5 NIHR Policy on press releases
NIHR has written to all Heads of BRCs and other NIHR infrastructure to clarify that they will, from May 2018, regard as breach of contract any repeat failures of BRCs to ensure NIHR acknowledgement on press releases arising from BRC supported research and to notify NIHR in advance of press releases. Whilst the UCLH BRC has a good track record in this regard but we do have examples of instances where press
releases that have generated media interest have not followed this policy because of
the failure of the lead researcher to inform the BRC communications team. The
expectations of the NIHR have been cascaded to BRC Faculty to serve as a reminder
of the importance of compliance.

2. The Research Hospital

Recent progress in the implementation of the Research Hospital includes:
   a. A launch date set for 21st May. This will be a primarily external facing event for the
      media and will outline the UCLH Research Hospital vision, including the
development and application of advanced analytical methods to the Trust’s large
clinical service performance challenges.
   b. A Research Hospital brochure is in development to support the launch event and
      aid internal UCLH communications.
   c. A digital strategy to support the Research Hospital is in development
   d. The principles of the UCLH-Turing Partnership have been agreed and a
      Partnership Agreement under negotiation.
   e. Work continues on the development of AI tools to optimise scheduling at UCLH.
   f. A large time and motion study was initiated at UCLH in week commencing 23rd
      April focused on flow in the hospital.
   g. “UCL Be The Change”, a group of medical students focused on assisting with audit
      and quality improvement projects are engaged and providing students to do the
data collection to support the time and motion study.
   h. Head of Research Innovation post established to take forward implementation of
      the RH. Appointment expected in mid-May.

3. UCLH Clinical Research Facility

The staff consultation and selection process for the planned integration between the
CRF at 170TCR and the LWENC at Queen Square have been completed and the new
organizational structure became effective on 1st April 2018. The outcome of this
process has been that the integrated CRF is now managed by a single General
Manager, supported by a single QA Manager and Head of Nursing who will oversee
nursing at both sites. A key objective for the new Management Team is to put in place
systems for sharing opportunities, resource and processes across each site, and the
potential to support manage the portfolio of studies more effectively across the 2 sites.

4. UCLH Clinical Research Update

4.1 Research Recruitment Performance

Recruitment to research studies at UCLH has decreased slightly over the last year,
although the number recruited to NIHR adopted research studies has increased. In
2016/17 UCLH reported a total of 11,507 recruits to NIHR adopted research studies,
compared with 13,542 recruits to date in 2017/18. The Divisions recruiting the highest
number of participants this year continue to be Cancer and Queen Square.

Total recruitment to all studies (NIHR adopted, and non-adopted combined) in 2017/18
was 14,674 participants, in comparison with 17,620 in the previous financial year.
However, although the number of new studies approved across both years remained
consistent, nearly twice the number of studies closed in 16/17 (144 studies) than in
17/18 (76 studies), meaning that fewer studies have been open and recruiting across
the course of the year.

Recruitment upload response rates were higher than the previous average of 50%, due
to a targeted JRO exercise to contact study teams both directly and via the units to
encourage data entry onto the Edge and CPMS systems. Updates are currently still in
progress and so recruitment figures for the current year are likely to continue to
increase slightly over the next few weeks. Recruitment reporting is under review so that in 2018/19, recruitment figures will be referenced against locally determined sample size and project timelines, so that specialties and divisions can measure their progress against their own stated parameters.

4.2 Pharmacy capacity for clinical trials
Capacity for aseptic preparation of medicinal products to be used in UCLH clinical trials have recently been brought to light by the UCLH Pharmacy. Whilst it is encouraging that an immediate term solution has been identified from within the existing Pharmacy footprint it is imperative that an effective mid- to long-term solution to this issue is identified well in advance of the problem reaching a head again later this year. Even the suggestion that the Trust does not have sufficient pharmacy capacity for clinical trials carries very considerable reputational and financial risk for the organisation.

4.3 Reduction in funding to North Thames Local Clinical Research Network
The final notification has not yet been confirmed but the indicative budget for UCLH shows a reduction of £238.7k for 2018-19 representing a 5.5% reduction on UCLH allocation (£4,339k) as agreed by the North Thames LCRN Executive Group. 62% of this reduction has been delivered through natural wastage with the balance coming from a reduction on our overhead allocation.

4.4 NHS England Consultation on simplifying arrangements for research in the NHS
Work is on-going via the Shelford Group to flag up the risks of NHS England’s proposal for a single standard commercial clinical trial price for commercial contract clinical trials in the NHS. The proposal is aimed at speeding up the clinical research process in the NHS but there are significant risks in terms of under recovery of commercial trial costs from Sponsors and loss of opportunity to develop direct relationships between Trusts and the Pharmaceutical industry. At a joint meeting between Shelford and the NHSE, NIHR Clinical Research Network, NHSI and the Health Research Authority (HRA) on 23rd April, NHSE has agreed to work with the Shelford Group over the next 2 months to evidence the potential financial impact of the policy and to identify the best way to ensure Shelford Group Trusts retain control of the commercial costing process.

5. General Data Protection Regulation
The Joint Research Office continues to follow Health Research Authority (HRA) guidance for the implementation of GDPR. The HRA requires that all studies which are recruiting participants or collecting new personal information from patients after May 25th – the date the Regulation comes into force - submit a non-substantial amendment and update the information provided to participants. As the HRA produces updated guidance the JRO is making it available to clinical researchers at UCLH/UCL.

BRYAN WILLIAMS
DIRECTOR OF RESEARCH AND DEVELOPMENT UCLH/UCL
FOREWORD
Important themes in the previous period for the senior directors team (SDT) were operational performance (see further), collaboration in the North Central London Sustainability and Transformation Partnership and beyond, and development of the research hospital, next to ongoing activities including completion of the financial year 2017-2018 and submission of the plan for 2018-2019, and implementation of the Electronic Health Record System.

The Board will review and discuss the month 12 performance pack which is attached, however I would like to provide a brief update on the provisional view of our performance against the key access standards for April:

Emergency department
Overall we are reporting 83.53% against the four hour A&E target for April. Positively recent interventions in the Urgent Treatment Centre seemed to be having an effect and the last week has seen UTC performance of 98%. This week SDT agreed a new governance structure to clarify responsibility for the ED target and cross-board participation to improve our operational grip.

Cancer
The 62 day internal treatment standard should be maintained in April.

Referral to treatment
Divisions are finalising the April month end position for RTT. We expect to maintain or improve upon the 91.01% reported in March.

1. PERFORMANCE

Enclosed with this month’s performance report are the monthly updates from the Trust’s remedial action plans (RAPS) for Cancer 62 day wait and ED four hour wait. The updates are in a set template which shows:
- The latest position against our trajectory
- An overview of delivery against the RAP including a description of any amber or red actions
- A description of any new risks or emerging issues
- Key learnings from the last month

2. DIGITAL SERVICES

2.1. General Data Protection Regulation (GDPR) update

The Board will be aware that the new GDPR regulations come in to place on 25 May 2018. The SDT have been receiving regular updates on Trust readiness and some of you will have been to the deep dive session held by the Audit Committee in March. A comprehensive update on this is included later on the agenda.
2.2. Information Governance and Cyber Security Assurance

The Information Governance Toolkit (IGTK) submission for 2018 has been made at 83% against a target of 80%. Our submission in 2017 was 80% and this year’s Toolkit compliance was more challenging for an equivalent percentage, so significant progress has been achieved. Importantly there were no information or data loss breaches that needed to be reported to the Information Commissioner’s Office (ICO) over the last year. An internal audit of our IGTK reported significant assurance with minor improvement opportunities.

3. PATIENT FEEDBACK

At the last meeting the Board asked for further opportunity to review and discuss the feedback we receive from patients. The attached report provides an update on the new patient feedback system and summarises the successes and challenges for all friends and family test areas.

4. VOLUNTARY SERVICES ANNUAL REPORT

4.1 I am delighted to have the opportunity to thank all of our volunteers for the invaluable work they provide to help improve patient experience. We ended the year with 421 active volunteers who have helped in a broad range of areas. I hope the Board enjoys reading the voluntary services annual report and I am sure will join me and the SDT in thanking all our volunteers, the UCLH charity and the corporate nursing division.

5. NHS 70TH CELEBRATIONS

The NHS turns 70 on Thursday 5 July 2018. NHS England is organising a wide range of high profile activities in the run up to the day and on the day itself. The key themes and objectives for the anniversary celebrations are:

- Celebrating the work of everyday heroes (NHS staff, frontline and back office)
- An engagement opportunity, e.g. to recruit more volunteers and staff
- An opportunity to look at the impact of the NHS, past, present and future

There are also aspirations to leave a legacy – to recruit more people into research. NHS England has created a new website and logo for the celebrations – the soft launch was at NHS Expo on 11 September with a short film of frontline staff talking about their roles, the NHS now and in 70 years. UCLH contributed to this – one of our oncology dietitians features in the film with the Cancer Centre as the backdrop.

The Trust has actively engaged in the celebrations and to date has contributed two UCLH patient stories to the NHS 70th website and changed the @UCLH Twitter banner so that it includes archive pictures. There have been many other exciting activities which our staff have been involved in. Our most recent UCLH Magazine has a NHS 70th / research theme. The next exciting engagements include the NHS 70th themed Research Open Day on the 5 July, the Annual Members Meeting on 23 July where there will be an archive stand. We will also hold an NHS 70th volunteer recruitment campaign and an NHS 70th exhibition at University College Hospital and other sites. I hope the Board will be able to join staff at the key celebrations.

6. CORPORATE OBJECTIVES

6.1 Attached for the Board to review is an update on progress against the 2017/18 corporate objectives. This is the final position for 2017/18 and highlights the areas the Trust needs to improve on.
6.2 Also attached for the Board to **approve** are the final 2018/19 corporate objectives with proposed metrics to track progress against these.

### 7. NON-EMERGENCY PATIENT TRANSPORT

The SDT receives a monthly update on the revised contract and KPI performance. Below is a summary for the Board to note:

- Overall we have seen an improvement in March against the February data and the KPI performance trajectory.
- We have seen an improvement in performance especially around DNAs, which were 127 in February against 84 in March.
- We had fewer patients waiting over two hours for transport home.
- Having implemented the 2 hour prebooked transport time for the majority of outpatients there has been an improvement in patient return journeys.
- We have seen an improvement in patients’ actual ready times against expected ready times which helped the planning of outward journeys. We still have a bit of work to make this more robust specifically around cancer patients at the Macmillan Cancer Centre.
- 521 journeys were aborted for March. Two patients missed appointments for March and this has been validated against the Datix received for March.
- On the day discharge bookings caused major operational issues especially around the last weekend of the month with the bank holidays. 81% of discharges were booked on the day during March.
- We are working with the patient experience team to roll out friends and family test independent from the contract process. Health Communications will extend this to incorporate direct qualitative feedback from patients.
- Transport Quality Improvement Group- The first meeting will take place on the 24th May and will be chaired by Dr Robert Urquhart. The aim of the group will be to provide oversight and scrutiny into the implementation of quality initiatives that G4S and the Trust are required to undertake in order to deliver a patient centred service and the actions that the Trust takes to monitor and audit those initiatives.

### 8. CHANGES TO THE SCHEME OF DELEGATION / STANDING FINANCIAL INSTRUCTIONS

The Board is asked to **approve** the attached changes to the Trust SFIs. These have been reviewed and agreed at the SDT and the Audit Committee.

### 9. STRATEGIC DEVELOPMENTS

We continue to work with our partners across the North Central London to optimise services for patients. There is a review of the delivery of Orthopaedic Surgery across the sector underway, looking at the best model for elective care for this cohort of patients. We are actively contributing to this ongoing piece of work, which has good participation from all effected Hospitals and patient representatives.

We have almost completed the refurbishment of the NHNN Theatre suite, with the site becoming fully operational this summer. This will provide much better facilities for patients and staff. We are in ongoing discussions with the University in relation to their purchase of the EDH site for the creation of a world-class academic facility and are pleased that this
transaction went smoothly. We are currently in the process of finessing our understanding of what is a necessary clinical co-location on this site.

Phase 4 and Phase 5 continue to develop, with the PBT cyclotron due for delivery in June of this year. This will be a big milestone for the Trust and takes us a step closer to offering this world-class service in London.

In the summer, we will be refining our estates strategy to ensure that we continue to provide the very best care for our patients over the next 10 – 20 years.

10. FIT AND PROPER PERSONS TEST

The SDT reviewed the changes that are being made to our processes in relation to the Fit and Proper Persons Test which will ensure our compliance with the latest CQC requirements issued in January 2018. The latest guidance from the CQC includes changes which affect all new and existing board directors, board members and equivalents who are responsible and accountable for the delivery of care in relation to pre-appointment and in-post checks, management and dismissal.

11. MEETINGS OF INTEREST TO THE BOARD

On 15 March I gave a key note lecture at the international university hospital conference in Helsinki on the “The Academic Hospital of the Future”.

On 16 March gave a brief presentation at the CNMR Research in Practice conference at UCLH.

On 22 and 23 March I attended as a member the European Medical Research Council in Brussels, Belgium. Prominent item on the agenda was the position of the UK in the European Research programs after Brexit.

On 28 March I attended the launch of the Middlesex Annexe plans, organised by the UCLH charity and attended by Camden local authority planners and councillors.

On 9 April I presented a key note lecture on “The professional in the lead- leadership in the NHS” at the NIHR Leadership Conference in Ashridge.

On 12 April I gave a lecture (“The hospital perspective”) and was part of a discussion panel on Patient-based Blood management and Transfusion in Hospitals in Lisbon, Portugal.

On 14 April I gave a lecture on “Development of cancer services in the next decade” at the International Cancer Conference in Bergamo, Italy.

On 17 April I presented closing remarks at the Women’s Health Institute day at UCL.

On 23 April I participated in a discussion webinar organised by the Royal College of Physicians on “Our future Health- sustainability of the current health economy”.

On 4 May I presented at the joint British-Dutch Society of Acute Medicine Conference 2018 on the similarities and differences in the organization of acute medicine between various countries.
12. USE OF THE TRUST SEAL

The Trust Seal was used 10 times since the last Board meeting.

<table>
<thead>
<tr>
<th>Seal Number</th>
<th>Date of Entry</th>
<th>Entry Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>941</td>
<td>12 March 2018</td>
<td>Deed of Release of Rights of Light between - This Deed releases Rights of Light relating to the occupants of Flat 43, Gordon Mansions, Torrington Place, WC1E 7HG and and the site of the Royal Ear Hospital.</td>
</tr>
<tr>
<td>942</td>
<td>12 March 2018</td>
<td>Lease of Part Basement and Ground Floor New Wing and Part Ground Floor at Alexander Wing.</td>
</tr>
<tr>
<td>943</td>
<td>12 March 2018</td>
<td>Grant of Underlease of 5\textsuperscript{th} Floor West and 5\textsuperscript{th} Floor Central Communications Room, 250 Euston Road NW1 2PG to the Doctors Laboratory.</td>
</tr>
<tr>
<td>944</td>
<td>26 March 2018</td>
<td>Option Agreement for the disposal of Eastman Dental Hospital, 256 Grays Inn Road, WC1X 8LD to UCL.</td>
</tr>
<tr>
<td>945/946</td>
<td>26 March 2018</td>
<td>Leaseback of part of Eastman Dental Hospital, 256 Grays Inn Road, WC1X 8LD.</td>
</tr>
<tr>
<td>947</td>
<td>26 March 2018</td>
<td>Acquisition of Queen Square House from UCL to University College London Hospitals NHS Foundation Trust.</td>
</tr>
<tr>
<td>948</td>
<td>26 March 2018</td>
<td>Counterpart/Underlease relating to parts of the basement, 1\textsuperscript{st} Floor, 6\textsuperscript{th} floor and 9\textsuperscript{th} floor of Queen Square House, Guildford Street, WC1</td>
</tr>
<tr>
<td>949</td>
<td>26 March 2018</td>
<td>Original Lease relating to Queen Square House, WC1</td>
</tr>
<tr>
<td>950</td>
<td>26 March 2018</td>
<td>Transfer of Title of Queen Square House from UCL to University College London Hospitals NHS Trust</td>
</tr>
<tr>
<td>951</td>
<td>26 March 2018</td>
<td>Transfer of whole registered titles from UCL to University College London Hospitals NHS Trust.</td>
</tr>
</tbody>
</table>

PROFESSOR MARCEL LEVI
MAY 2018
Performance report.pdf
## PERFORMANCE REPORT TO THE BOARD OF DIRECTORS

9 May 2018

<table>
<thead>
<tr>
<th>Current issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>In March we reported 85.9% performance against a revised trajectory of 95.1% for the four hour standard. We have not met our trajectory for Q4 and so are not due to receive the STF funding. Performance in discharged pathways has remained stable however performance in the admission pathway has deteriorated from 58% to 42% in the first calendar quarter. UTC performance has been in the 90-95% range but is regularly de-stabilised due to overspill of more complex patients from majors, with a significant number requiring admission. Activity has remained stable through early January to end March period through all ED streams. Emergency admission rates have not fallen as we have moved into Spring and have remained at 350-400 per week, with ambulance conveyances rising. Conversion rates for ED attendances have been in 16-18% range.</td>
</tr>
<tr>
<td>RTT incomplete pathways</td>
<td>In March, we achieved 91.01% (down 0.44% from February). The total number of patients waiting over 18 weeks increased by 160 to 3,813. We finished the month 527 worse than our plan (including contingency). We reported five 52 week breaches in neurosurgery, and one in head and neck. Harm reviews are pending, but we are not expecting harm to be confirmed in any of these cases. A review is due this month into the cause of all 52 week breaches over the past 6 months so that any trends can be identified for improvement.</td>
</tr>
<tr>
<td>Cancer waits</td>
<td>We have agreed a trajectory to deliver overall compliance for June 2018. March’s provisional position (76.6%) is 0.4% below trajectory. Internally the provisional position is at 87%; above our plan for the month. We are tightly monitoring patients at risk of breach both in April and May, following the embedding of the changed PTL process. We reported 6 internal and 15.5 shared breaches. Each shared breach counts as half so there were 37 patients who breached overall. Of the internal breaches, one was avoidable, with the remainder being a combination of complexity and patient choice. We have refreshed our remedial action plan and we provide a more detailed assessment of our performance against the plan in the cancer update paper. The trajectory and bi-lateral action plans are available on request. Our March’s provisional 31 day first treatment standard was compliant. The urology team is providing additional sessions and are booking at 17 days, currently well within the 24 day standard.</td>
</tr>
</tbody>
</table>
We reported compliance with the two week wait standard but not the breast symptomatic standard. This was due to patient choice.

| Pressure ulcers | During the month of March there were no grade 3 pressure ulcers, but unfortunately there was one grade 4. In line with policy and practice a root cause analysis was undertaken which found that the patient was young, terminally ill and at the advanced end stage of life, they had full capacity, was independent and expressed a strong desire not to participate in pressure ulcer prevention and management strategies. A full SI investigation is also being completed awaiting chief nurse review, to investigate further.

This month also saw increase in the number of grade 2 pressure ulcers from 6 to 9. The increase in grade 2 HAPU’s has been largely in the emergency services division, two of which were related to spinal collars and occurred on the acute medical unit. Learning has been shared with staff and the team are working on training and development around management of patients who are required to wear a spinal collar for longer than usual |

| Complaints responded to within target time (Page 15) | We were worse than threshold for patient complaint response times in March at 62.3%. Medicine board were worse than threshold at 45.5% due to clinical support reporting 0%. it is in clinical support that transport complaints are assigned. All other medicine divisions were 100% compliant. Specialist hospitals were worse than target. Paediatrics had two cases both of which were not responded to in time, one is closed and the other is still open. EDH's complaint missed target as they were unable to extend the date as they were unable to contact the patient. In surgery and cancer the surgical specialties team is working through a number of more complex complaints but a number of new complaints are being resolved quickly. |
1. Executive summaries
2. Financial Performance
3. Operational Productivity
4. Access
5. Patient Safety and Quality metrics
6. Workforce
7. Externally Reported Frameworks
### Executive Summary: Board Performance

#### Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>This Month</th>
<th>Year to date</th>
<th>LY to date</th>
<th>% Elective variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Elective variance</td>
<td>-12.1%</td>
<td>0.0%</td>
<td>23.2%</td>
<td>-9.8%</td>
</tr>
<tr>
<td>% Daycase variance</td>
<td>-3.9%</td>
<td>0.0%</td>
<td>19.5%</td>
<td>1.7%</td>
</tr>
<tr>
<td>% Non-elective variance</td>
<td>-4.6%</td>
<td>0.0%</td>
<td>-7.7%</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

### Infection

<table>
<thead>
<tr>
<th>Infection</th>
<th>This Month</th>
<th>Year to date</th>
<th>LY to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of MRSA bacteraemias</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of clostridium difficile cases reported (excluding successful appeals)</td>
<td>7</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>

### ED, RTT, and diagnostic waits

<table>
<thead>
<tr>
<th>ED, RTT, and diagnostic waits</th>
<th>This Month</th>
<th>Year to date</th>
<th>LY to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>% incomplete pathways &lt; 16 weeks</td>
<td>91.0%</td>
<td>92.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>ED, RTT, and diagnostic waits</td>
<td>91.0%</td>
<td>92.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>% diagnostic waiting list within 6 weeks</td>
<td>100.0%</td>
<td>99.0%</td>
<td>98.0%</td>
</tr>
<tr>
<td>% diagnostic waiting list within 6 weeks</td>
<td>100.0%</td>
<td>99.0%</td>
<td>98.0%</td>
</tr>
<tr>
<td>Patients waiting longer than 52 weeks</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>% patients waiting longer than 52 weeks</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>A&amp;E attendance within 4 hours</td>
<td>84.6%</td>
<td>95.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% A&amp;E attendance within 4 hours</td>
<td>84.6%</td>
<td>95.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

### Cancer waits

<table>
<thead>
<tr>
<th>Cancer waits</th>
<th>This Month</th>
<th>Year to date</th>
<th>LY to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer 62 day GP referral to treatment</td>
<td>77.0%</td>
<td>85.0%</td>
<td>91.0%</td>
</tr>
<tr>
<td>Cancer 31 day wait from diagnosis to first treatment</td>
<td>77.0%</td>
<td>85.0%</td>
<td>91.0%</td>
</tr>
<tr>
<td>Cancer 14 day referral to appointment</td>
<td>56.2%</td>
<td>55.0%</td>
<td>55.0%</td>
</tr>
</tbody>
</table>

### Workforce

<table>
<thead>
<tr>
<th>Workforce</th>
<th>This Month</th>
<th>Year to date</th>
<th>LY to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>% mandated training completion</td>
<td>90.2%</td>
<td>91.0%</td>
<td>91.0%</td>
</tr>
<tr>
<td>% mandated training completion</td>
<td>90.2%</td>
<td>91.0%</td>
<td>91.0%</td>
</tr>
<tr>
<td>Approval rate</td>
<td>96.2%</td>
<td>97.6%</td>
<td>97.6%</td>
</tr>
<tr>
<td>% patients satisfied</td>
<td>86.3%</td>
<td>87.9%</td>
<td>87.9%</td>
</tr>
<tr>
<td>Staff turnover rate</td>
<td>13.4%</td>
<td>13.0%</td>
<td>13.0%</td>
</tr>
</tbody>
</table>

### Finance

<table>
<thead>
<tr>
<th>Finance</th>
<th>This Month</th>
<th>Year to date</th>
<th>LY to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall financial rating</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Operational Performance (DfH Service Cover)</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Cash and Balance Sheet Performance (dpa)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

### Externally agreed trajectories

<table>
<thead>
<tr>
<th>Externally agreed trajectories</th>
<th>This Month</th>
<th>Year to date</th>
<th>LY to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Trajectory</td>
<td>51.0%</td>
<td>52.8%</td>
<td>55.0%</td>
</tr>
<tr>
<td>ED Trajectory</td>
<td>51.0%</td>
<td>52.8%</td>
<td>55.0%</td>
</tr>
<tr>
<td>Cancer 62 day trajectory</td>
<td>84.1%</td>
<td>84.1%</td>
<td>84.1%</td>
</tr>
<tr>
<td>Cancer 62 day trajectory</td>
<td>84.1%</td>
<td>84.1%</td>
<td>84.1%</td>
</tr>
<tr>
<td>RTT Trajectory</td>
<td>82.1%</td>
<td>82.1%</td>
<td>82.1%</td>
</tr>
<tr>
<td>RTT Trajectory</td>
<td>82.1%</td>
<td>82.1%</td>
<td>82.1%</td>
</tr>
</tbody>
</table>
## 2. Financial Performance

### 2.1 Use of Resources Rating Summary

<table>
<thead>
<tr>
<th>Area of review (metric)</th>
<th>Key Highlights</th>
<th>NHS Improvement Use of Resources Rating (UOR)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M12 actual</td>
</tr>
<tr>
<td><strong>HEADLINE FINANCIAL PERFORMANCE (Overall Rating)</strong></td>
<td>The Trust’s month 12 year-end income and expenditure (I&amp;E) performance, excluding exceptional items, is <strong>£2.9m behind</strong> plan (-£7.8m actual vs. -£4.9m plan). The Trust’s overall use of resources rating is a score of 1 (where 1 is the highest rating and 4 the lowest rating). This score has been achieved as a result of net exceptional items of +£103.2m, which results in a an overall bottom-line I&amp;E surplus of £95.4m.</td>
<td>1</td>
</tr>
<tr>
<td>1. Operational Performance</td>
<td>The Trust’s year-end revenue available for capital service is <strong>£32.5m ahead</strong> of plan (+£113.4m actual vs. +£80.9m plan). This is primarily due to additional notified indicative incentive sustainability &amp; transformation funding (STF) of £37.7m. Revenue of £113.4m is able to cover 1.50 times the Trust’s capital service (rating = 3).</td>
<td>3</td>
</tr>
<tr>
<td>a. Capital service cover</td>
<td>The Trust’s performance against the control total (which includes profit on disposal of assets), is <strong>£30.9m ahead</strong> of plan (+£26.0m actual vs. -£4.9m plan). The Trust’s adjusted month 12 I&amp;E performance (with the inclusion of notified indicative core and incentive STF) is a surplus of <strong>£76.0m</strong>, which produces an I&amp;E margin (on a control total basis) of +7.0% (rating = 1).</td>
<td>1</td>
</tr>
<tr>
<td>b. I&amp;E margin</td>
<td>The M12 I&amp;E margin (on a control total basis) of +7.0% is <strong>6.1% ahead</strong> of the planned I&amp;E margin of +0.9% (rating = 1).</td>
<td>1</td>
</tr>
<tr>
<td>c. Distance from financial plan</td>
<td>The Trust's 2017/18 spend on agency staff is <strong>£7.5m</strong>. This results in 17% of the Trust's agency ceiling (£9.0m) remaining unutilised (rating = 1).</td>
<td>1</td>
</tr>
<tr>
<td>d. Agency</td>
<td>Working capital is able to cover <strong>35 days</strong> of the Trust's operating expenses (rating = 1). At 31st March 2018 the Trust’s cash balance was <strong>£147m, £92m higher</strong> than the planned cash position of £55m. 2017/18 capital expenditure of £124m is <strong>£48m less</strong> than plan (of £172m).</td>
<td>1</td>
</tr>
</tbody>
</table>
## 2. Financial Performance

### 2.2 Income & Expenditure Summary

#### Month 12 - March

<table>
<thead>
<tr>
<th>Description</th>
<th>Budget</th>
<th>Actuals</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct income</td>
<td>197.2</td>
<td>193.4</td>
<td>-3.8</td>
</tr>
<tr>
<td>Direct costs</td>
<td>(204.8)</td>
<td>(203.8)</td>
<td>1.0</td>
</tr>
<tr>
<td>Internal trading &amp; indirect costs</td>
<td>16.7</td>
<td>16.3</td>
<td>-0.3</td>
</tr>
<tr>
<td>Contribution (EBITDA at Trust level)</td>
<td>9.0</td>
<td>5.9</td>
<td>-3.2</td>
</tr>
<tr>
<td>ITDA (before donation adj.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I&amp;E surplus/deficit before exceptional items</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control total performance (excl. STF)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net surplus/deficit</td>
<td>9.0</td>
<td>5.9</td>
<td>-3.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Budget</th>
<th>Actuals</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct income</td>
<td>17.0</td>
<td>17.8</td>
<td>0.7</td>
</tr>
<tr>
<td>Direct costs</td>
<td>(17.2)</td>
<td>(18.4)</td>
<td>1.2</td>
</tr>
<tr>
<td>Contribution (EBITDA at Trust level)</td>
<td>1.3</td>
<td>0.8</td>
<td>-0.5</td>
</tr>
<tr>
<td>ITDA (before donation adj.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I&amp;E surplus/deficit before exceptional items</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control total performance (excl. STF)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net surplus/deficit</td>
<td>1.3</td>
<td>0.8</td>
<td>-0.5</td>
</tr>
</tbody>
</table>

---

Month 12 - March

Overall Page 43 of 347
2. Financial Performance

2.3 Cash flow summary

- The Trust’s cash balance of £147m at 31st March 2018 was £92m higher than plan. This was mainly due to receipts arising from asset sales, additional 2016/17 incentive STF income, along with slower than planned in-year capital payments.
- The month 12 liquidity ratio = working capital balances of £92.4m / YTD operating costs of £98.9m = 94.8%
- The April month-end cash balance is £143m.
- The Trust’s Better Payment Practice performance shows that 59% of invoices by volume and 75% by value were paid within agreed terms in March.
- Year to date, most of the NHS late payments relate to disputed invoices from NHS organisations that take longer than 30 days to resolve.
## 2. Financial performance

### 2.4 Statement of Financial Position and Capital Programme Summary

#### Statement of Financial Position as at 31st March 2018 (£m)

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-current assets</td>
<td></td>
</tr>
<tr>
<td>Intangible assets</td>
<td>0.6</td>
</tr>
<tr>
<td>Property, plant &amp; equipment</td>
<td>798.6</td>
</tr>
<tr>
<td>PFI lifecycle fund</td>
<td>9.8</td>
</tr>
<tr>
<td>Investments</td>
<td>15.5</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td><strong>824.5</strong></td>
</tr>
<tr>
<td>Current assets</td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>17.2</td>
</tr>
<tr>
<td>Trade &amp; other receivables &lt; 1 year</td>
<td>146.5</td>
</tr>
<tr>
<td>Cash &amp; cash equivalents</td>
<td>147.1</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td><strong>310.8</strong></td>
</tr>
<tr>
<td>Current liabilities</td>
<td></td>
</tr>
<tr>
<td>Trade &amp; other payables &lt; 1 year</td>
<td>(177.4)</td>
</tr>
<tr>
<td>Tax payable</td>
<td>(16.7)</td>
</tr>
<tr>
<td>Provisions &lt; 1 year</td>
<td>(4.8)</td>
</tr>
<tr>
<td>Loans &lt; 1 year</td>
<td>(2.2)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td><strong>(201.2)</strong></td>
</tr>
<tr>
<td><strong>Net current assets/liabilities</strong></td>
<td>109.6</td>
</tr>
<tr>
<td>Trade &amp; other payables &gt;1 year</td>
<td>(242.0)</td>
</tr>
<tr>
<td>Provisions &gt; 1 year</td>
<td>(2.2)</td>
</tr>
<tr>
<td>Loans &gt; 1 year</td>
<td>(156.3)</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td><strong>533.6</strong></td>
</tr>
</tbody>
</table>

#### 2017/18 Capital Expenditure at M12 (£m)

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Programme</strong></td>
<td></td>
</tr>
<tr>
<td>Externally Funded - PDC</td>
<td>4.2</td>
</tr>
<tr>
<td>Externally Funded</td>
<td>0.7</td>
</tr>
<tr>
<td>Replace &amp; Refresh</td>
<td>13.5</td>
</tr>
<tr>
<td>Development &amp; Expansion of Service</td>
<td>3.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22.2</strong></td>
</tr>
<tr>
<td><strong>Strategic Programme</strong></td>
<td></td>
</tr>
<tr>
<td>Phase 4</td>
<td>30.5</td>
</tr>
<tr>
<td>Phase 5</td>
<td>23.2</td>
</tr>
<tr>
<td>EHRS</td>
<td>7.3</td>
</tr>
<tr>
<td>AS IS+</td>
<td>4.8</td>
</tr>
<tr>
<td>Digital Transformation</td>
<td>4.8</td>
</tr>
<tr>
<td>Proton Beam Therapy</td>
<td>16.4</td>
</tr>
<tr>
<td>Accident &amp; Emergency</td>
<td>5.5</td>
</tr>
<tr>
<td>Queen Square Development</td>
<td>7.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td><strong>M12 Accounting Additions</strong></td>
<td></td>
</tr>
<tr>
<td>PFI Lifecycle</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>124.1</strong></td>
</tr>
</tbody>
</table>
## 2. Financial performance

### 2.5 Monthly Financial Performance Summary

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Variance from Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month 1 £m</td>
<td>Month 2 £m</td>
</tr>
<tr>
<td>Income &amp; expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS clinical income</td>
<td>61.1</td>
<td>69.6</td>
</tr>
<tr>
<td>Other income</td>
<td>15.6</td>
<td>16.7</td>
</tr>
<tr>
<td>Total Income</td>
<td>76.7</td>
<td>86.3</td>
</tr>
<tr>
<td>Pay costs</td>
<td>(41.6)</td>
<td>(40.8)</td>
</tr>
<tr>
<td>Board contingency</td>
<td>(0.3)</td>
<td>(0.4)</td>
</tr>
<tr>
<td>Non-pay costs</td>
<td>(36.7)</td>
<td>(39.4)</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>(78.6)</td>
<td>(80.6)</td>
</tr>
<tr>
<td>ITDA (excl. donation adjs)</td>
<td>(6.6)</td>
<td>(6.5)</td>
</tr>
<tr>
<td><strong>I&amp;E surplus/(deficit) before exceptional items</strong></td>
<td>(1.6)</td>
<td>0.3</td>
</tr>
<tr>
<td><strong>Exceptional items (control total)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other exceptional items (included within control total performance)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Control total performance</strong></td>
<td>(1.6)</td>
<td>0.3</td>
</tr>
<tr>
<td><strong>Exceptional items (non-control total)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donations/donated asset adjs</td>
<td>0.4</td>
<td>(0.1)</td>
</tr>
<tr>
<td>Impairment losses &amp; reversals</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Core STF</td>
<td>0.7</td>
<td>0.7</td>
</tr>
<tr>
<td>Additional/incentive STF</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net surplus/(deficit)</strong></td>
<td>(6.4)</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Month 12 - March

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Weekly agency shift overrides by staff group

The Trust had no agency shifts above the price cap in March 2018.
2. Financial performance
2.6 Medicine board - Financial Performance & Agency Reporting

**Weekly agency shift overrides by staff group**

Medicine Board had no agency shifts above the price cap in March 2018.
Weekly agency shift overrides by staff group
Specialist Hospitals Board had no agency shifts above the price cap in March 2018.
2. Financial performance

2.6 Specialist hospital board - Financial Performance & Agency Reporting

Weekly agency shift overrides by staff group

Surgery & Cancer Board had no agency shifts above the price cap in March 2018.
2. Financial performance
2.7 Activity trends

- Electives (including daycases)
  - Non electives (excluding maternity)
  - Electives (excluding daycases)

- Outpatient attendances
- Clinical Income (activity only)
- Daycases
- New outpatient attendances
- Follow up outpatient attendances

Note: Prior year not set at 2017/18 tariff

Month 12 - March
2. Financial performance

2.8 Workforce trends
3. Operational Productivity

3.1 CIP Performance

### Month 12 CIP Performance

<table>
<thead>
<tr>
<th>Board</th>
<th>FY CIP Target</th>
<th>FY Actuals</th>
<th>FY Variance</th>
<th>Actuals as a % of Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine Board</td>
<td>£0'000</td>
<td>£0'000</td>
<td>£0'000</td>
<td>87%</td>
</tr>
<tr>
<td>Specialist Hospitals Board</td>
<td>6,872</td>
<td>6,004</td>
<td>(868)</td>
<td>59%</td>
</tr>
<tr>
<td>Surgery &amp; Cancer Board</td>
<td>15,092</td>
<td>8,891</td>
<td>(6,201)</td>
<td>94%</td>
</tr>
<tr>
<td>Corporate Services Board</td>
<td>15,436</td>
<td>14,573</td>
<td>(863)</td>
<td>87%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>42,000</td>
<td>33,486</td>
<td>(8,514)</td>
<td>80%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Non-Recurrent CIP</th>
<th>2018-19 Carry Forward</th>
<th>FYE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine Board</td>
<td>£0'000</td>
<td>£0'000</td>
<td>£0'000</td>
</tr>
<tr>
<td>Specialist Hospitals Board</td>
<td>1,355</td>
<td>179</td>
<td>4,827</td>
</tr>
<tr>
<td>Surgery &amp; Cancer Board</td>
<td>1,276</td>
<td>907</td>
<td>8,522</td>
</tr>
<tr>
<td>Corporate Services Board</td>
<td>2,773</td>
<td>540</td>
<td>12,340</td>
</tr>
<tr>
<td>TOTAL</td>
<td>8,308</td>
<td>2,017</td>
<td>27,194</td>
</tr>
</tbody>
</table>

### Graphs

- Trust - Actual CIP Delivery vs Plan
- Medicine Board - Actual CIP Delivery vs Plan
- Specialist Hospitals Board - Actual CIP Delivery vs Plan
- Corporate Board - Actual CIP Delivery vs Plan
- Surgery & Cancer Board - Actual CIP Delivery vs Plan

Month 12 - March

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3. Delivery of CIP

3.3 Efficiency and productivity

Trust
tower elective theatre
Queen Square theatre
Westmoreland St theatre
Cancer Centre theatre
RNTNE theatres

% Touchtime Utilisation

<table>
<thead>
<tr>
<th></th>
<th>Trust</th>
<th>Tower elective theatre</th>
<th>Queen Square theatre</th>
<th>Westmoreland St theatre</th>
<th>Cancer Centre theatre</th>
<th>RNTNE theatres</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Touchtime Utilisation</td>
<td>79.4%</td>
<td>79.0%</td>
<td>87.3%</td>
<td>79.4%</td>
<td>78.7%</td>
<td></td>
</tr>
<tr>
<td>% Opportunity for additional cases</td>
<td>21.0%</td>
<td>18.9%</td>
<td>9.9%</td>
<td>22.1%</td>
<td>16.1%</td>
<td></td>
</tr>
<tr>
<td>% 4-hour-equivalent sessions closed or unused</td>
<td>18.7%</td>
<td>9.1%</td>
<td>10.2%</td>
<td>13.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of 4-hour-equivalent sessions closed or unused</td>
<td>213</td>
<td>45</td>
<td>29</td>
<td>21</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Trust excludes Cancer Centre. Tower theatre excludes EGA, DSU & Hybrid. Queen Square excludes IMRI & Virtual.

Touch time utilisation:

Tower theatres - Surgical specialties’ performance (78.3% against a target of 90%) was affected by significant delays and cancellations resulting from inpatient and PACU bed availability in the tower. Utilisation has been fully reviewed by the project management office. GI was worse than threshold and will now have a daily huddle with Ivor Baker (theatre senior project manager) to improve start times. Paediatrics improved by 4% to 49% for March. There will be a reduction in theatre sessions for urology starting in April 2018. The same level of activity will be delivered in fewer sessions resulting in a significantly increased utilisation. EDH’s tower utilisation was worse than threshold but for a small number of patients. Women’s health were just worse than threshold at 84.4%. There have been improvements in variance against plan and forecast for gynae elective work thanks to focus on pick-up of lists and Saturday working. Work to improve utilisation and data analysis is currently ongoing through the centralised theatres project.

Westmoreland Street theatre - Utilisation for this month is just worse than threshold at 79%. This is a 2% improvement from last month. Despite that improvement this month has seen the highest percentage of potential extra cases since the metric’s inception. The surgical specialties team is focused on using all lists as efficiently as possible, with a combination of larger and smaller cases. They are using the new scheduling tool to try and ensure this is the case and utilisation is being monitored in regular meetings.

RNTNE theatres - There are weekly meetings to review future theatre lists and identify lists that are routinely under utilised. Weekly emails are sent to all surgeons showing their future theatre lists (two weeks in advance) and they aim to highlight red lists going forward.

Queen Square theatres - Queen Square division continues to use the Carter dashboard to focus on the specific areas where there is opportunity to improve and deliver more activity. For March the theatre has maintained the improvement in performance from February and is close to compliance which was last achieved in November 2017.

For March we were better than threshold for elective length of stay and just worse than threshold for non-electives. This wasn’t driven by a specific specialty but general surgery and obstetrics had an actual length of stay just worse than and these two specialties count for just under half of the total number of spells included in the calculation.
4. Access

4.1 Emergency flow

<table>
<thead>
<tr>
<th></th>
<th>This month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust threshold</td>
<td>95%</td>
</tr>
<tr>
<td>Trust actual</td>
<td>84.6%</td>
</tr>
<tr>
<td>Medicine</td>
<td>84.6%</td>
</tr>
<tr>
<td>Surgery &amp; Cancer</td>
<td></td>
</tr>
<tr>
<td>Specialist Hospitals</td>
<td></td>
</tr>
</tbody>
</table>

All A&E attendances within 4 hours | 95% | 84.6% | 84.6% |
UTC attendances within 4 hours     | 97% | 92.4% | 92.4% |
A&E to admission conversion rate   | 20% | 14.5% | 14.5% |

Tower bed occupancy

Delayed transfers of care days | 758 | 459 | 150 | 149 |
% discharges by noon           | 35.0% | 14.6% | 19.6% | 14.3% |

In March we reported 85.9% performance against a revised trajectory of 95.1% for the four hour standard. We have not met our trajectory for Q4 and so are not due to receive the STF funding.

Performance in discharged pathways has remained stable however performance in the admission pathway has deteriorated from 58% to 42% in the first calendar quarter. UTC performance has been in the 90-95% range but is regularly de-stabilised due to overspill of more complex patients from majors, with a significant number requiring admission.

Activity has remained stable through early January to end March period through all ED streams. Emergency admission rates have not fallen as we have moved into Spring and have remained at 350-400 per week, with ambulance conveyances rising. Conversion rates for ED attendances have been in 16-18% range.

A more detailed analysis of our performance against plan is available in the ED update paper.
In March, we achieved 91.01% (down 0.44% from February). The total number of patients waiting over 18 weeks increased by 160 to 3,813. We finished the month 527 worse than our plan (including contingency).

The following divisions were not compliant:
- RNTNE – 88.2% (up 0.4%). The improvement is due to continued backlog reduction in ENT. 636 patients were waiting over 18 weeks at March’s month end, 186 better than plan.
- Eastman Dental Hospital – 89 (down 1.2 %). Deterioration was mainly driven by a backlog increase in Restorative Dentistry. An initial view of data shows that referrals have remained consistent, and booking in turn has improved. A further deep dive is required to identify this cause. Planned extra capacity in March did not have the expected impact due to issues filling the lists with backlog patients at short notice.
- Queen Square – 89.2% (down 0.5%). Deterioration was driven by backlog increase in Neurosurgery. Whilst actions remain ongoing to reduce the backlog, data quality errors meant new additions to the backlog were discovered at lower week waits due to previous incorrect clock stops on the pathway. The specialty is investigating ways to improve their DQ.

We reported five 52 week breaches in neurosurgery, and one in head and neck. Harm reviews are pending, but we are not expecting harm to be confirmed in any of these cases. A review is due this month into the cause of all 52 week breaches over the past 6 months so that any trends can be identified for improvement.

We lost compliance with the six week diagnostic wait standard in March, at 98.13% . Non-compliant modalities were: MRI (95.3%, up 3.2%, 112 breaches at QS) and urodynamics (83.1%, down 4.1%, 13 breaches at QS.) The higher than normal number of breaches attributed to QS MRI were caused by loss of scanners and cancellations due to snow. The specialty has actions underway to outsource these tests in order to reduce the number of breaches for April. Despite this, improvements have been seen in number of day care MRI breaches, where booking process issues were seen to be a predominant driver for breaches.
4. Access

4.3 Access Targets – Cancer

<table>
<thead>
<tr>
<th>Target Description</th>
<th>This month (not yet validated, March)</th>
<th>Last month validated performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two week wait from referral to date seen</td>
<td>93%</td>
<td>94.0%</td>
</tr>
<tr>
<td>Two week wait from referral to date seen: breast symptoms</td>
<td>93%</td>
<td>84.5%</td>
</tr>
<tr>
<td>31-day wait from diagnosis to first treatment</td>
<td>96%</td>
<td>90.4%</td>
</tr>
<tr>
<td>31-day wait for second or subsequent treatment: surgery</td>
<td>94%</td>
<td>90.1%</td>
</tr>
<tr>
<td>31-day wait for second or subsequent treatment: drug treatments</td>
<td>98%</td>
<td>100.0%</td>
</tr>
<tr>
<td>31-day wait for second or subsequent treatment: Radiotherapy</td>
<td>94%</td>
<td>97.5%</td>
</tr>
<tr>
<td>31-day wait for second or subsequent treatment: other</td>
<td>97.7%</td>
<td>93.6%</td>
</tr>
<tr>
<td>62-day wait for first treatment from urgent GP referral to treatment</td>
<td>85%</td>
<td>60.9%</td>
</tr>
<tr>
<td>62-day wait for first treatment from urgent GP referral to treatment Internal only</td>
<td>90%</td>
<td>81.3%</td>
</tr>
<tr>
<td>Number of 104 day waits (from GP referral) Internal</td>
<td>7</td>
<td>68.2%</td>
</tr>
<tr>
<td>Number of 104 day waits (from GP referral) External</td>
<td>5</td>
<td>68.2%</td>
</tr>
<tr>
<td>% Inter trust referrals treated within 24 days of referral</td>
<td>45.0%</td>
<td>29.5%</td>
</tr>
</tbody>
</table>

* The trust threshold is an aggregate of individual clinical board thresholds

We have agreed a trajectory to deliver overall compliance for June 2018.
March’s provisional position (76.6%) is 0.4% below trajectory. Internally the provisional position is at 87%; above our plan for the month. We are tightly monitoring patients at risk of breach both in April and May, following the embedding of the changed PTL process.

We reported 6 internal and 15.5 shared breaches. Each shared breach counts as half so there were 37 patients who breached overall. Of the internal breaches, one was avoidable, with the remainder being a combination of complexity and patient choice.
We have refreshed our remedial action plan and we provide a more detailed assessment of our performance against the plan in the cancer update paper. The trajectory and bi-lateral action plans are available on request.

Our March’s provisional 31 day first treatment standard was compliant. The urology team is providing additional sessions and are booking at 17 days, currently well within the 24 day standard.

We reported compliance with the two week wait standard but not the breast symptomatic standard. This was due to patient choice.
5. Quality

5.1 Infection

We have reported 69 cases of C diff as at the end of March. 36 of these have been successfully appealed and 31 cases are under review. Two cases of C diff have been found to be lapses in care by the Trust. Therefore our worst case position currently is 33 cases against the March year to date threshold of 90.

There were one case of MSSA for March. This occurred at Queen Square in SITU. The investigation into this is on-going with multiple IV peripheral cannulas being found to have been a feature of the case.

Infection control improvement compliance was better than threshold for the trust. Medicine board were worse than threshold. The infection division was worse than target but bedside alcohol gel holders are now on ward which was reason for required improvement this month. Critical care and medical specialties were also worse than threshold.

---

<table>
<thead>
<tr>
<th></th>
<th>Trust threshold</th>
<th>Trust actual</th>
<th>Medicine</th>
<th>Surgery &amp; Cancer</th>
<th>Specialist Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of MRSA Bacteraemias</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Number of clostridium difficile cases reported (excluding successful appeals)</td>
<td>97</td>
<td>33</td>
<td>16</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Number of clostridium difficile cases due to lapses in care</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Number of clostridium difficile cases under review</td>
<td>31</td>
<td>16</td>
<td>10</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Number of clostridium difficile cases successfully appealed</td>
<td>36</td>
<td>13</td>
<td>10</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Number of MSSA Bacteraemias</td>
<td>25</td>
<td>30</td>
<td>10</td>
<td>11</td>
<td>9</td>
</tr>
</tbody>
</table>

| % - Infection control improvement compliance (this month) | 95.0% | 95.1% | 90.7% | 97.2% | 95.2% |

* The trust threshold is an aggregate of individual clinical board thresholds
We were better than threshold for harm free care. Medicine board is not achieving compliance but this is because a number of patients had acquired issues in the community.

We were better than threshold for dose omissions.

The trust was better than threshold for the VTE assessment measure. Infection was not compliant (87.5%); one patient not assessed was admitted for two hours and another for 10 hours. Four other patients have been fed back to the inpatient team to understand why they were not assessed.
5. Quality

5.3 Safety

There were 120 inpatient falls in total in March 2018. There were 90 with no harm and 27 with low harm. There were three moderate harms. One was in AMU; the patient sustained a hip fracture while walking to the toilet and is doing well after surgery. Post falls management was identified as a learning point, but this does not require further investigation. There was one on Gowers unit, a patient on day leave fell due to seizure activity while with her family and sustained a fractured ankle. There was one on Bernard Sunley, a patient fell and sustained a fractured pubic rami. As this has increased his length of stay in hospital, it has been graded as moderate.

During the month of March there were no grade 3 pressure ulcers, but unfortunately there was one grade 4. In line with policy and practice a root cause analysis was undertaken which found that the patient was young, terminally ill and at the advanced end stage of life, they had full capacity, was independent and expressed a strong desire not to participate in pressure ulcer prevention and management strategies. A full SI investigation is also being completed awaiting chief nurse review, to investigate further.

This month also saw increase in the number of grade 2 pressure ulcers from 6 to 9. The increase in grade 2 HAPU’s has been largely in the emergency services division, two of which were related to spinal collars and occurred on the acute medical unit. Learning has been shared with staff and the team are working on training and development around management of patients who are required to wear a spinal collar for longer than usual.

* falls with serious harm include severe, and death categories in Datix

---

The trust threshold is an aggregate of individual clinical board thresholds
5. Quality
5.4 Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Trust threshold</th>
<th>Trust actual</th>
<th>This month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency readmissions within 30 days</td>
<td>3.1%</td>
<td>3.6%</td>
<td>9.6%</td>
</tr>
</tbody>
</table>

% Complete vital signs collected
- Medicine: 96.0%
- Surgery & Cancer: 99.0%
- Specialist Hospitals: 100.0%

% deteriorating patients escalated according to protocol
- Medicine: 90.0%
- Surgery & Cancer: 98.9%
- Specialist Hospitals: 100.0%

Local summary hospital-level mortality indicator (1 yr rolling data)
- This month: 0.60

We were slightly worse than threshold for emergency readmissions within 30 days for February. Under performance in the medicine division was driven by the medical specialties at 9.6% and emergency services at 9.8%. This is most likely due to admissions within EAU.

We were better than threshold for vital signs observations in February. Medicine board were just worse than threshold, this was driven by Emergency services which was at 90.9%.
5. Quality

5.5 Patient Experience

We were worse than threshold for patient complaint response times in March at 62.3%. Medicine board were worse than threshold at 45.5% due to clinical support reporting 0%. It is in clinical support that transport complaints are assigned. All other medicine divisions were 100% compliant. Specialist hospitals were worse than target. Paediatrics had two cases both of which were not responded to in time, one is closed and the other is still open. EDH’s complaint missed target as they were unable to extend the date as they were unable to contact the patient. In surgery and cancer the surgical specialties team is working through a number of more complex complaints but a number of new complaints are being resolved quickly.

Inpatient FFT is made up of both inpatient and daycase areas. Data collection is via Ipad/paper for inpatient areas and text message/video messaging for daycase. The overall response rate for inpatient has improved slightly this month from 18.4% last month; this is seen across all areas. Our FFT score has fallen this month from 95.2% in February; this drop is shown in Surgery & Cancer board where the score has fallen from 95.1% last month and in specialist hospitals board where the score has fallen from 96.5%.

The response rate for ED has remained stable this month with UTC still having the highest response rate at 18%, majors at 17% and paeds at 13%. Feedback in ED is collected via text message/video messaging for majors and UTC and paper for paeds. The recommended score for ED has fallen slightly this month; this drop is shown in all areas however the main driver appears to be UTC where the score has fallen to 78.6% from 82.4% last month.

Our OP response rate has continued to remain stable for the fourth consecutive month. The recommended score has fallen slightly this month from 92.4% in February although the not recommend score has remained the same at 4.5% meaning that more patients are undecided about their care and
6. Workforce
6.1 Performance indicators

<table>
<thead>
<tr>
<th>Staff in Post (WTE)</th>
<th>N/A</th>
<th>8095.1</th>
<th>1593.4</th>
<th>2565.2</th>
<th>3091.7</th>
<th>844.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Temporary Staffing Filled via Bank</td>
<td>N/A</td>
<td>90.1%</td>
<td>86.3%</td>
<td>87.9%</td>
<td>93.7%</td>
<td>97.8%</td>
</tr>
<tr>
<td>Vacancy Rate</td>
<td>6.5%</td>
<td>8.8%</td>
<td>9.5%</td>
<td>9.9%</td>
<td>9.7%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Voluntary Turnover Rate (12m Rolling)</td>
<td>13%</td>
<td>13.4%</td>
<td>14.8%</td>
<td>12.2%</td>
<td>13.6%</td>
<td>13.4%</td>
</tr>
</tbody>
</table>

The Trust Threshold Target and Trust Actual for Turnover excludes Corporate Board.

**Staff-in-Post:** Staff-in-post levels have increased by 291 wte between month 1 and month 12 17/18. This represents a 4% increase in staffing levels over the year.

**Temporary Staffing:** % temporary staffing filled via Bank continues to increase from 89.4% in month 11 to 90.1% in month 12. Under the new contract with Bank Partners, we will be working to achieve 95% filled by bank rate in 18/19.

**Vacancy Rate:** In the last year we have recruited 1444 new staff to UCLH, of which 493 were nursing and midwifery registered staff. In September we saw high numbers of new nursing and midwifery starters at 75.8, the most new starters since November 2015. However, there have been 1256 leavers of which 444 were nursing and midwifery registered staff. As a result, we continue to have high vacancy levels in some specialities where there are recognised national shortages of skilled staff and which are becoming more challenging to fill from UK supply.

**Voluntary Turnover Rate:** We have not achieved our turnover target for 17/18. The SDT devoted time to considering this issue and have agreed a plan to take trust wide action to tackle universal areas of concern for our staff, as well as targeted interventions to identify and address the barriers to creating positive working environments. We will probe the fundamental causes of staff loss in priority professional areas and the form of incentives that would prove of greatest value to candidates, staff and us as an employer as part of this work.
### 6. Workforce

#### 6.2 Performance indicators

<table>
<thead>
<tr>
<th>Metric</th>
<th>Trust Threshold</th>
<th>This month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Medicine</td>
</tr>
<tr>
<td>Sickness absence rate (%) 12m Rolling</td>
<td>N/A</td>
<td>3.6%</td>
</tr>
<tr>
<td>All appraisals completed (Tier 1, 2 &amp; 3)</td>
<td>95% (by the end of Sep 2017)</td>
<td>96.2%</td>
</tr>
<tr>
<td>% Statutory and Mandatory training compliance</td>
<td>95%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Average time to recruit (request pack - start date) (weeks)</td>
<td>N/A</td>
<td>13.7</td>
</tr>
<tr>
<td>Average time to recruit (request pack received - unconditional offer) (weeks)</td>
<td>N/A</td>
<td>10.2</td>
</tr>
</tbody>
</table>

**Sickness absence:** Sickness rates have fallen slightly from 3.8% in month 11 and 3.6% in month 12.

**Appraisal:** We achieved the target in month 11 17/18. The 18/19 appraisal process for tier 1 staff is currently in progress.

**Mandated Training:** Compliance has fallen by 0.5% from month 11 to month 12. We continue to work with SMEs to ensure sufficient classroom capacity. Validated medical and dental honorary contract will be included in month 1, along with a requirement for clinical staff to complete duty of candour training.

**Time to recruit:** Time to recruit remained steady between month 11 and month 12. We are working to embed factual references for all recruitment episodes.
### 6. Workforce

#### 6.3 Nursing and Midwifery Detailed Workforce Dashboard

<table>
<thead>
<tr>
<th>Key Workforce Metrics &amp; Indicators</th>
<th>Medicine Board</th>
<th>Surgery &amp; Cancer Board</th>
<th>Specialist Hospitals Board</th>
<th>Corporate Board</th>
<th>UCLH Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment FTE*</td>
<td>NA 2.4 PN 5.7 RN 8a+ All</td>
<td>NA 2.4 PN 5.7 RN 8a+ All</td>
<td>NA 2.4 PN 5.7 RN 8a+ All</td>
<td>NA 2.4 PN 5.7 RN 8a+ All</td>
<td>NA 2.4 PN 5.7 RN 8a+ All</td>
</tr>
<tr>
<td>Staff in Post FTE*</td>
<td>166.3 585.0 29.7 742.0</td>
<td>211.7 969.1 42.7 1235.8</td>
<td>244.0 1092.5 50.1 1499.9</td>
<td>4.4 46.5 16.0 67.5</td>
<td>676.7 2764.1 142.1 3592.0</td>
</tr>
<tr>
<td>Vacant Posts FTE*</td>
<td>12.0 25.2 6.1 26.1</td>
<td>12 123.2 2.0 157.2</td>
<td>15.0 126.2 16.2 154.4</td>
<td>1.4 6.5 5.9 1.0</td>
<td>52.2 292.9 20.1 555.7</td>
</tr>
<tr>
<td>Starters FTE</td>
<td>2.0 3.0 0.0 10.0</td>
<td>3.0 14.0 0.0 17.5</td>
<td>4.6 11.6 0.0 16.2</td>
<td>1.0 10.0 0.0 2.0</td>
<td>11.1 34.6 0.0 45.8</td>
</tr>
<tr>
<td>Leavers FTE</td>
<td>1.0 5.2 1.0 7.2</td>
<td>1.0 3.0 0.0 11.1</td>
<td>1.5 14.3 0.0 15.0</td>
<td>0.0 0.0 0.0 0.0</td>
<td>4.4 20.0 1.0 34.1</td>
</tr>
<tr>
<td>Vacancy Rate*</td>
<td>24.9% 9.9% 20.5% 5.1%</td>
<td>12.2% 12.7% 6.9% 9.9%</td>
<td>8.5% 11.6% 29.9% 9.7%</td>
<td>31.6% 114% 34.9% 2.8%</td>
<td>4.9% 112% 21.2% 9.1%</td>
</tr>
<tr>
<td>Turnover Rate</td>
<td>10.3% 16.7% 28.7% 17.3%</td>
<td>18.2% 16.0% 6.9% 14.7%</td>
<td>20.6% 17.4% 17.3% 18.5%</td>
<td>8.3% 213% 242% 20.8%</td>
<td>17.0% 16.7% 17.6% 16.8%</td>
</tr>
<tr>
<td>Temp Staffing Usage</td>
<td>39.0% 22.2% 6.5% 26.7%</td>
<td>32.6% 16.8% 1.0% 20.2%</td>
<td>27.8% 15.8% 0.3% 19.6%</td>
<td>17.9% 4.9% 0.0% 5.1%</td>
<td>24.1% 17.1% 14.4% 21.1%</td>
</tr>
<tr>
<td>Sickness Absence</td>
<td>5.7% 4.1% 1.0% 4.3%</td>
<td>5.3% 3.6% 2.8% 4.3%</td>
<td>4.5% 4.2% 3.1% 4.2%</td>
<td>2.3% 2.1% 2.3% 2.1%</td>
<td>5.3% 3.3% 2.5% 4.1%</td>
</tr>
<tr>
<td>Flight Staffing Level by Shift</td>
<td>114.2% 96.1% 101.6%</td>
<td>124.7% 98.7% 108.7%</td>
<td>105.9% 52.1% 95.4%</td>
<td>NA NA</td>
<td>114.1% 94.3% 100.2%</td>
</tr>
</tbody>
</table>

**Notes:** The vacancy rate has decreased by 0.1% between month 11 and month 12. Over the last 12 months, we have had 403 new starters to UCLH and 444 leavers, which has resulted in a turnover rate of 16.8% for this staff group. The SDT has agreed the resourcing strategy for 18/19 and have targeted action to address the recruitment and retention challenges for this staff group.
### 7. Externally Reported Frameworks

#### 7.1 NHS Improvement Indicators – Compliance Framework

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Estimated risk</th>
<th>Weighting</th>
<th>Mar 18</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence of Clostridium difficile year to date</td>
<td>90</td>
<td>1.0</td>
<td>33</td>
<td>14</td>
<td>18</td>
<td>13</td>
<td>24</td>
<td>8 cases successfully reviewed</td>
</tr>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment - incomplete pathways</td>
<td>92%</td>
<td>1.0</td>
<td>91.0%</td>
<td>93.1%</td>
<td>90.7%</td>
<td>90.8%</td>
<td>91.3%</td>
<td>See page 8 for detail.</td>
</tr>
<tr>
<td>62 day wait for first treatment from urgent GP referral</td>
<td>85%</td>
<td>1.0</td>
<td>77.0%</td>
<td>61.0%</td>
<td>71.3%</td>
<td>74.4%</td>
<td>66.3%</td>
<td>See page 15 for detail.</td>
</tr>
<tr>
<td>62 day wait for first treatment from consultant screening service referral</td>
<td>90%</td>
<td>1.0</td>
<td>85.7%</td>
<td>69.2%</td>
<td>78.3%</td>
<td>82.8%</td>
<td>83.3%</td>
<td>See page 9 for detail</td>
</tr>
<tr>
<td>31 day wait for second or subsequent treatment: Surgery</td>
<td>94%</td>
<td>1.0</td>
<td>97.2%</td>
<td>84.9%</td>
<td>95.0%</td>
<td>94.1%</td>
<td>90.7%</td>
<td>See page 9 for detail</td>
</tr>
<tr>
<td>31 day wait for second or subsequent treatment: anti cancer drug treatments</td>
<td>98%</td>
<td>1.0</td>
<td>100.0%</td>
<td>99.1%</td>
<td>99.9%</td>
<td>99.1%</td>
<td>99.6%</td>
<td>See page 9 for detail</td>
</tr>
<tr>
<td>31 day wait for second or subsequent treatment: Radiotherapy</td>
<td>94%</td>
<td>1.0</td>
<td>99.0%</td>
<td>99.2%</td>
<td>97.4%</td>
<td>96.0%</td>
<td>97.5%</td>
<td>See page 9 for detail</td>
</tr>
<tr>
<td>31-day wait from diagnosis to first treatment (all cancers)</td>
<td>96%</td>
<td>0.5</td>
<td>98.0%</td>
<td>88.7%</td>
<td>91.5%</td>
<td>94.2%</td>
<td>92.5%</td>
<td>See page 9 for detail</td>
</tr>
<tr>
<td>Two week wait from referral to date first seen: all cancers</td>
<td>93%</td>
<td>0.5</td>
<td>94.2%</td>
<td>94.2%</td>
<td>94.3%</td>
<td>94.7%</td>
<td>93.7%</td>
<td>See page 9 for detail</td>
</tr>
<tr>
<td>Two week wait from referral to date first seen: symptomatic breast patients</td>
<td>93%</td>
<td>0.5</td>
<td>80.8%</td>
<td>92.7%</td>
<td>93.0%</td>
<td>94.1%</td>
<td>87.4%</td>
<td>See page 9 for detail</td>
</tr>
<tr>
<td>A&amp;E: Maximum waiting time of four hours from arrival to admission/ transfer/ discharge</td>
<td>95%</td>
<td>1.0</td>
<td>84.6%</td>
<td>91.1%</td>
<td>88.4%</td>
<td>85.9%</td>
<td>85.4%</td>
<td>See page 8 for detail</td>
</tr>
<tr>
<td>Single Oversight Framework</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>TBC</td>
<td></td>
</tr>
</tbody>
</table>

The new Single Oversight Framework that has been put in place by NHS Improvement, and replaces the Monitor Assurance Framework. We have been notified that we have been placed in segment two of this framework (this is of four segments; one denotes high performing, whilst four denotes formal turn-around). Our segment two status reflects non-compliance with three of the four operational standards within the framework (diagnostic waits, A&E and cancer 62 day; we are achieving the RTT standard). This puts us in the bracket of requiring targeted, but not mandated, support from NHSI.

Month 12 - March

Overall Page 66 of 347
1. Referrals and activity
2. Access
3. Patient safety and quality metrics
4. Research and development
5. CQUIN
Quarterly Review

1. Referrals and activity

**Number of referrals to UCLH per Quarter**

- GP Refs
- Non GP Refs
- Total Refs

**All Outpatient Attendances**

- Total Attendances

**Daycase and Elective Inpatients**

- Total DC & ELIP

**Non Elective Inpatients**

- Non Elective

Month 12 - March
2. Access Targets

- **62 day from GP referral target (without reallocations)**
- **A&E 4 hour wait target**
- **62 day screening target**
- **Switchboard calls answered within 30 seconds**

Month 12 - March
Quarterly Review

3.1 Infections

**MRSA - All Trust reported cases to HPA (including community acquired)**

**MRSA cases per 10000 bed days UCLH Vs London Peers**

- UCLH MRSA bed rate
- London peers MRSA bed rate
- Linear (UCLH MRSA bed rate)
- Linear (London peers MRSA bed rate)

**C. Difficile - All Trust reported cases to HPA (including community acquired)**

**C. Difficile cases per 10000 bed days UCLH Vs London Peers**

- UCLH Cdiff bed rate
- London peers Cdiff bed rate
- Linear (UCLH Cdiff bed rate)
- Linear (London peers Cdiff bed rate)

Month 12 - March
**Quarterly Review**

**3.2 Other Quality issues**

**Last minute cancellations to elective surgery**

- Graph showing cancellations to elective surgery over time with a threshold line.

**Number of Incidents**

- Graph showing number of incidents over time.

**Inpatient Falls**

- Graph showing inpatient falls over time with categories for falls with no harm, falls with harm (w/o serious harm), and falls with serious harm.

**Mortality - SHMI Relative Risk, 1 year rolling data**

- Graph showing relative risk over time.

*Month 12 - March*
### Appendix 1

### Quarterly review

#### 3.3 Other Quality issues

**30 Day Readmissions following elective admissions - All Services**

- **March 2016:** 300 readmissions
- **March 2017:** 350 readmissions
- **March 2018:** 400 readmissions

**30 Day Readmissions following non-elective admissions - All Services**

- **March 2016:** 900 readmissions
- **March 2017:** 1000 readmissions
- **March 2018:** 1100 readmissions

**7 Day readmissions - All Services**

- **March 2016:** 500 readmissions
- **March 2017:** 600 readmissions
- **March 2018:** 700 readmissions

**Emergency Readmissions with Complications within 30 Days - All Services**

- **March 2016:** 80 readmissions
- **March 2017:** 90 readmissions
- **March 2018:** 100 readmissions

---

Month 12 - March

---

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Research and Development Directorate

4.1 Research Activity Performance UCLH: March 2018

Research Activity and Performance – UCLH: March 2018

Chart 1. Number of studies approved at UCLH by Financial year and Sponsor (a)

Chart 2. Number of studies approved at UCLH by Financial year and Study types (phase) (a)

Participant recruitment UNDER REVIEW

Table 1. Number of participants recruited into research studies at UCLH, by NIHR portfolio status and Trust board

<table>
<thead>
<tr>
<th>Portfolio</th>
<th>Trust</th>
<th>Medicine</th>
<th>Specialist</th>
<th>Surgery &amp; Cancer</th>
<th>Not stated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portfolio</td>
<td>12,542</td>
<td>2,801</td>
<td>5,229</td>
<td>2,044</td>
<td>698</td>
</tr>
<tr>
<td>Non-Portfolio</td>
<td>1,132</td>
<td>115</td>
<td>547</td>
<td>264</td>
<td>206</td>
</tr>
<tr>
<td>Total recruited</td>
<td>14,674</td>
<td>2,916</td>
<td>5,776</td>
<td>2,304</td>
<td>804</td>
</tr>
</tbody>
</table>

Chart 3. Number of participants recruited into research studies at UCLH, by NIHR portfolio status

Month 12 - March
Research and Development Directorate
4.2 Clinical Research Facility (CRF)  UCLH: March 2018

**Active studies by Intensity**
- High: 63%
- Low: 23%
- Medium: 14%

**Active studies by Phase**
- Phase I: 40
- Phase I/II: 30
- Phase II: 20
- Phase III: 10
- Device: 5
- Experimental: 0

**Recruitment of Research participants**
- April: 70
- May: 60
- June: 50
- July: 40
- August: 30
- September: 20
- October: 10
- November: 5
- December: 0

**Individual patients seen each month**
- April: 200
- May: 150
- June: 100
- July: 50
- August: 0
- September: 0
- October: 0
- November: 0
- December: 0

**Intensity of studies** — This chart shows the intensity of studies conducted in the CRF in terms of staff resource intensity, as calculated by the UKCRF intensity tool. The tool calculates the WTE needed to support each clinical trial, aiding the allocation of the workforce. It provides an indication of the levels of nursing care and data entry needed.

**Number of trial participants** — This graph shows the number of individuals participating in trials at the CRF each month.

**Individual patients seen each month** — reflects the number of patients seen each month (essentially the number of visits — each patient can be seen on multiple occasions per month.)

Month 12 - March
Research and Development Directorate

4.3 UCL/UCLH Biomedical Research Centre (BRC) Activity: March 2018

UCLH/UCL Biomedical Research Centre (BRC) Activity: March 2018

RESEARCH AND DEVELOPMENT DIRECTORATE

Number of commercially sponsored trials approved to begin at UCLH in 2013/14, 2014/15, 2015/16, 2016/17 and 2017/18. For year activity shown where quarterly information not available.

Number of early phase trials approved to begin at UCLH in 2016/17 and 2017/18. For previous annual totals, please refer to chart 2 under research activity and performance two pages previous.

BRC Acknowledged Publications

Recruitment to UCL BioResource, August 2013 – March 2018 (n). The UCL BioResource continues to build on its original target of 10,000 participants with both DNA samples and phenotypic information recruited from patients/volunteers across UCLH and other UCLH hospitals. The total recruitment to UCL BioResource as of 31st March 2018 is 11,188. This data shows all activity by UCL BioResource (inc. assistance provided to GEs) plus the different sources from which participants have been recruited (UCL BioResource or via other/secondary studies).

BRC Cited academic papers (3,404) and total citations (125,033). G4 publications metrics in 2017/18 reflect a comparative performance compared to the same period in Q4 in 2016/17.

Month 12 - March

Overall Page 75 of 347
## Quarterly Review

### 5.1 CQUIN - CCG Schemes

<table>
<thead>
<tr>
<th>CQUIN Name</th>
<th>Total financial value</th>
<th>Expected Value to earn (Q4)</th>
<th>Q1 Trust Assessment</th>
<th>Q2 Trust Assessment</th>
<th>Q3 Trust Assessment</th>
<th>Q4 Trust Assessment</th>
<th>Evidence required/provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement of health and wellbeing of NHS staff</td>
<td>£320,000</td>
<td>£320,000</td>
<td>No return required</td>
<td>No evidence required</td>
<td>No evidence required</td>
<td>80%</td>
<td>Report demonstrating improvements in staff survey results and an improvement plan.</td>
</tr>
<tr>
<td>Healthy food for NHS staff, visitors and patients</td>
<td>£320,000</td>
<td>£320,000</td>
<td>No return required</td>
<td>No evidence required</td>
<td>No evidence required</td>
<td>100%</td>
<td>Report demonstrating compliance with the CQUIN.</td>
</tr>
<tr>
<td>Timely identification of patients with sepsis in emergency departments and acute inpatient settings</td>
<td>£240,000</td>
<td>£60,000</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>We achieved 98% against the 90% standard</td>
</tr>
<tr>
<td>Timely treatment of sepsis in emergency departments and acute inpatient settings</td>
<td>£240,000</td>
<td>£60,000</td>
<td>100%</td>
<td>25%</td>
<td>100%</td>
<td>100%</td>
<td>We achieved 76% against the 72.5% standard</td>
</tr>
<tr>
<td>Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.</td>
<td>£240,000</td>
<td>£60,000</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>All patients were reviewed within these timeframes.</td>
</tr>
<tr>
<td>Reduction in antibiotic consumption per 1,000 admissions</td>
<td>£240,000</td>
<td>£240,000</td>
<td>No Q1 assessment</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>Report showing reduction in anti-biotic consumption against the CQUIN targets</td>
</tr>
<tr>
<td>Working with partners to improve services for people with mental health needs in A&amp;E</td>
<td>£960,000</td>
<td>£384,000</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>Delivery has now been linked to the NCLSTP CAN work stream; evidence that A&amp;G services operational for first agreed tranche of specialties; quality standards for provision of A&amp;G met; data for main indicators provided; trajectory for roll-out of A&amp;G services to cover specialties responsible for 75% of GP referrals by Q4 2018/19</td>
</tr>
<tr>
<td>Implementing advice &amp; guidance across specialties with 75% of GP referrals</td>
<td>£960,000</td>
<td>£240,000</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>We have not achieved the CQUIN based on the ASI 4% target.</td>
</tr>
<tr>
<td>E-referrals</td>
<td>£960,000</td>
<td>£240,000</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>Delivery has now been linked to the NCL simplified discharge work stream. Evidence submitted relates to joint working with system partners to achieve the CQUIN.</td>
</tr>
<tr>
<td>Working with partners to improve discharge for patients &gt;65 years old</td>
<td>£960,000</td>
<td>£48,000</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Indicator name</td>
<td>Total financial value</td>
<td>Expected Value to earn (Q4)</td>
<td>Q1 Trust Assessment</td>
<td>Q2 Trust Assessment</td>
<td>Q3 Trust Assessment</td>
<td>Q4 Trust Assessment</td>
<td>Evidence required/ provided</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-----------------------</td>
<td>----------------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Clinical utilisation review</td>
<td>£1,271,820</td>
<td>£419,700</td>
<td>no Q1 return required</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>We will update the forecast for this indicator once we have resolved the technical issue.</td>
</tr>
<tr>
<td>Medicines optimisation</td>
<td>£676,500</td>
<td></td>
<td>return required 31/7</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Neonatal outreach</td>
<td>£378,840</td>
<td>£94,710</td>
<td>no Q1 return required</td>
<td>100%</td>
<td>75%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Haemoglobinopathy network</td>
<td>£162,360</td>
<td>£16,236</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>Evidence MDTs are in place and numbers of patients reviewed</td>
</tr>
<tr>
<td>Patient activation management</td>
<td>£514,140</td>
<td>£128,535</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>Action plan outlining activity to increase PAM across Trust</td>
</tr>
<tr>
<td>Shared decision making</td>
<td>£162,360</td>
<td>£32,472</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>Action plan outlining activity to roll out SDM across the Trust</td>
</tr>
<tr>
<td>Dose banding for intravenous chemotherapy</td>
<td>£541,200</td>
<td>£324,720</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>Evidence of agreed targets for end of year achievement</td>
</tr>
<tr>
<td>Optimising palliative therapy decision making</td>
<td>£189,420</td>
<td>£47,355</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>Report demonstrating partial achievement against target</td>
</tr>
<tr>
<td>Enhanced supportive care</td>
<td>£270,600</td>
<td>£54,000</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>Evidence against delivery of improvement targets for patients offered service</td>
</tr>
<tr>
<td>Stroke Rehab</td>
<td>£554,730</td>
<td></td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
<td>Action plan showing compliance with the requirements; baseline data collected and improvement targets met</td>
</tr>
<tr>
<td>Improving discharge</td>
<td>£554,730</td>
<td></td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
<td>Report demonstrating achievement against target</td>
</tr>
<tr>
<td>Spinal surgery networks</td>
<td>£135,300</td>
<td>£27,818</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>Evidence of use of policy to manage spinal emergencies</td>
</tr>
</tbody>
</table>

Month 12 - March
Cancer waits recovery action plan.pdf
Remedial Action Plan Monthly Update

Date of review: 19/04/2018
Forum: EAB 20/4/2018

Latest performance against revised trajectory agreed in December 17

<table>
<thead>
<tr>
<th>Trajectory</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>62 day internal (%)</td>
<td>79%</td>
<td>76%</td>
<td>81%</td>
<td>84%</td>
<td>87%</td>
<td>84%</td>
<td>87%</td>
</tr>
<tr>
<td>Internal breaches (#s)</td>
<td>9</td>
<td>10</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>62 day shared (%)</td>
<td>57%</td>
<td>49%</td>
<td>59%</td>
<td>69%</td>
<td>74%</td>
<td>79%</td>
<td>86%</td>
</tr>
<tr>
<td>Shared breaches (#s)</td>
<td>15</td>
<td>16</td>
<td>14</td>
<td>12</td>
<td>10</td>
<td>8</td>
<td>5.5</td>
</tr>
<tr>
<td>Overall (%)</td>
<td>68%</td>
<td>64%</td>
<td>70%</td>
<td>77%</td>
<td>81%</td>
<td>82%</td>
<td>86%</td>
</tr>
<tr>
<td>Overall 62d breaches (#s)</td>
<td>24</td>
<td>26</td>
<td>22</td>
<td>19</td>
<td>16</td>
<td>15</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actual / provisional</th>
<th>Actual</th>
<th>Actual</th>
<th>Actual</th>
<th>Provisional</th>
</tr>
</thead>
<tbody>
<tr>
<td>62 day internal (%)</td>
<td>88%</td>
<td>68%</td>
<td>83%</td>
<td>88%</td>
</tr>
<tr>
<td>Internal breaches (#s)</td>
<td>5</td>
<td>14</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>62 day shared (%)</td>
<td>67%</td>
<td>51%</td>
<td>49%</td>
<td>64</td>
</tr>
<tr>
<td>Shared breaches (#s)</td>
<td>9</td>
<td>15.5</td>
<td>17.5</td>
<td>15</td>
</tr>
<tr>
<td>Overall (%)</td>
<td>80%</td>
<td>61%</td>
<td>68%</td>
<td>77%</td>
</tr>
<tr>
<td>Overall 62d breaches (#s)</td>
<td>14</td>
<td>29.5</td>
<td>25</td>
<td>20.5</td>
</tr>
</tbody>
</table>

Notes: RAG rating reflects performance v trajectory rather than 85%
Shared pathways count as half each.

Action Plan Update

As agreed with NHS Improvement the RAP will be a live document. Some new actions in the work packages have been added. This means that end dates for these specific work packages have been reset.

We have made progress on key actions in the last month. These include:
- Interprovider Trust Transfer protocol has been signed off within NCL and will be kept under review to ensure it remains in line with national cancer rules
- Head of Ops for cancer performance has been advertised

Commentary on current red issues

<table>
<thead>
<tr>
<th>Action Ref</th>
<th>Issue</th>
<th>Actions to bring back on track</th>
<th>Impact on breach #s?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corp 2</td>
<td>PTL and escalation governance Delay to roll out of local PTL meeting assurance tool. This tool will provide a quarterly assessment of the items covered by local PTL meetings. It will highlight any areas for development.</td>
<td>This action is delayed. We need to finalise the criteria and we will suggest dates to CAST in May.</td>
<td>Y</td>
</tr>
<tr>
<td>Corp 4</td>
<td>Demand and Capacity analysis Standardised approach to Demand and Capacity modelling and how this can be used to support annual planning for services immediate modelling Governance cycle for demand and capacity Training programme for general managers and Information Business Partners</td>
<td>Project has slipped due to staff vacancy and absence. The project plan milestones will be reset to reflect this.</td>
<td>N</td>
</tr>
<tr>
<td>ITT2</td>
<td>ITT pathways Sector ensuring all parties have signed off bilateral action plans to improve management of pathway referrals by day 38 and treatments within 24 days - Prostate ITR date for transfer of care to be agreed - Gyneaeoncology updated MDT referral form is an outstanding action as agreement on accepting external imaging reports to progress pathway.</td>
<td>NCL Cancer Performance Leadership Group is taking lead to monitor and address. Following a further meeting between the urology teas at Royal Free and UCLH, we are undertaking analysis to determine an appropriate date. Geoff Bellingan has convened a meeting between gynae and imaging to agree further actions to be incorporated in the plan.</td>
<td>Y</td>
</tr>
<tr>
<td>Gov4</td>
<td>Refreshed terms of reference Refresh CAST ToRs</td>
<td>to CAST first week of May</td>
<td>N</td>
</tr>
</tbody>
</table>

Any new risks or emerging issues?

- Risk to urology external performance - PAH staffing issues delaying all parts of the pathway. Discussions ongoing on whether there is any assistance that we can provide to assist in managing the patients at PAH
## Key learning from internal breaches in last reported month

**Month:** February - final

<table>
<thead>
<tr>
<th>Tumour site</th>
<th>Issues and learning</th>
<th>Avoidable?</th>
<th>Learning / new action added to RAP?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology (x2)</td>
<td>Patient could not decide between treatment options and wanted thinking time</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Patient needed rebiopsy but delayed as away</td>
<td>No</td>
<td>Patient engagement is a piece of work that is being reviewed</td>
</tr>
<tr>
<td>Lower GI (2)</td>
<td>Patient delayed initial investigation by one month and then needed second test to confirm diagnosis</td>
<td>No</td>
<td>Patient engagement is a piece of work that is being reviewed</td>
</tr>
<tr>
<td></td>
<td>Complex diagnostics - clinical suspicion of cancer but biopsies not representative</td>
<td>No</td>
<td>Management of complex pathways is on RAP and allowed in tolerance</td>
</tr>
<tr>
<td>Haematology (1)</td>
<td>Complex diagnostics - sarcoma to lung to haem before diagnosis confirmed</td>
<td>No</td>
<td>No - Management of complex pathways is on RAP and allowed in tolerance</td>
</tr>
<tr>
<td>Lung(2)</td>
<td>Patient had to have treatment for metastases and recovery time before primary treatment commenced</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Delays to appointments over Christmas before able to plan for treatment</td>
<td>Yes</td>
<td>Patient engagement is a piece of work that is being reviewed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Management of complex pathways is on RAP and allowed in tolerance</td>
</tr>
</tbody>
</table>

*Note: Complexity is acknowledged within the 15% tolerance in the national 62 day standard*

### Actions that were closed at the last review

<table>
<thead>
<tr>
<th>Action Ref</th>
<th>Action description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R2</td>
<td>Reduced radiotherapy planning times from referral to treatment</td>
</tr>
<tr>
<td></td>
<td>VPN access for consultants has now been actioned</td>
</tr>
<tr>
<td>ITT1</td>
<td>ITT Policy</td>
</tr>
<tr>
<td></td>
<td>NCL have agreed protocol and now in use</td>
</tr>
<tr>
<td>CL5</td>
<td>Engagement of Nursing Teams</td>
</tr>
<tr>
<td></td>
<td>Lead Cancer Nurse has verified that all are aware and fully engaged in cancer patients pathways</td>
</tr>
<tr>
<td>OpL1</td>
<td>New Head of Ops - Cancer Performance</td>
</tr>
<tr>
<td></td>
<td>Has been advertised and closed on 11/4</td>
</tr>
<tr>
<td>ITT 3</td>
<td>Review governance arrangements for ITT’s in sector</td>
</tr>
<tr>
<td></td>
<td>Managed by sector performance leadership group and weekly sector call</td>
</tr>
<tr>
<td>ITT 4</td>
<td>Sector wide RCA’s</td>
</tr>
<tr>
<td></td>
<td>Standard operational policy now agreed</td>
</tr>
</tbody>
</table>
## GP 62 day - internal vs external referrals

<table>
<thead>
<tr>
<th>Tumour Site</th>
<th>No. (Internal)</th>
<th>Delays (External)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brain</strong></td>
<td>1</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Breast</strong></td>
<td>12</td>
<td>0.5</td>
<td>66.7%</td>
</tr>
<tr>
<td><strong>Lung</strong></td>
<td>3</td>
<td>3.5</td>
<td>40.0%</td>
</tr>
<tr>
<td><strong>Haematology</strong></td>
<td>3</td>
<td>1.5</td>
<td>66.7%</td>
</tr>
<tr>
<td><strong>Upper GI</strong></td>
<td>1.5</td>
<td>0.5</td>
<td>66.7%</td>
</tr>
<tr>
<td><strong>Lower GI</strong></td>
<td>4</td>
<td>0.5</td>
<td>66.7%</td>
</tr>
<tr>
<td><strong>Dermatology</strong></td>
<td>6</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Gynaecology</strong></td>
<td>6</td>
<td>1.5</td>
<td>75.0%</td>
</tr>
<tr>
<td><strong>Urology</strong></td>
<td>7</td>
<td>2</td>
<td>28.6%</td>
</tr>
<tr>
<td><strong>Head and Neck</strong></td>
<td>2</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Sarcomas</strong></td>
<td>1</td>
<td>0.5</td>
<td>50.0%</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td>1</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Acute Leukaemia</strong></td>
<td>1</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Testicular</strong></td>
<td>2</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Other (CUP)</strong></td>
<td>0.5</td>
<td>0.5</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>42</td>
<td>7</td>
<td>83.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>76.5</td>
<td>24.5</td>
<td>68.0%</td>
</tr>
</tbody>
</table>
Emmergency department recovery action plan.xlsx
Remedial Action Plan Monthly Update

Date of review: 18/04/2018
Forum reviewed in: Emergency Care Recovery Board (ECRB)

Refreshed RAP: In March we reported 85.9% performance against a revised trajectory of 95.1% for the four hour standard. We have not met our trajectory for Q4 and so are not due to receive the STF funding.

Performance in non-admitted pathways has remained stable however performance in the admission pathway has deteriorated from 58% to 42% in the first calendar quarter. UTC performance has been in the 90-95% range but is regularly de-stabilised due to overspill of more complex patients from majors, with a significant number requiring admission.

Activity has remained stable through early January to end March period through all ED streams. Emergency admission rates have not fallen as we have moved into spring and have remained at 350-400 per week, with ambulance conveyances rising. Conversion rates for ED attendances have been in 16-18% range.

Latest position against refreshed trajectory

<table>
<thead>
<tr>
<th>Trajectory (submitted to NHSI in May)</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refreshed trajectory agreed in December</td>
<td>88.1%</td>
<td>90.4%</td>
<td>93.0%</td>
<td>95.1%</td>
<td></td>
</tr>
<tr>
<td>Actual</td>
<td>85.5%</td>
<td>86.1%</td>
<td>85.9%</td>
<td>85.6%</td>
<td>85.9%</td>
</tr>
</tbody>
</table>

Drivers of any variance from trajectory

Patient flow is slowing down. Average decision-to-admit (DTA) to transfer times have risen through Q4 reaching 4.5hrs at the start of April (2.5hrs beginning of January). Upper quartile DTA to transfer times have been rising and have now reached 11hrs with regular near mises against the 12 hour trolley breach standard. These metrics suggest deteriorating exit block which result in not only bed breaches but reduced internal ED flow. Bed breaches themselves have risen significantly (80/week Jan 15th, 250/week April 2nd). Bed occupancy has risen throughout Q4 (rising from 92 to 95%).
### Action Plan Update

**Number of actions open by RAG status:**

<table>
<thead>
<tr>
<th>RAG</th>
<th>Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Amber</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Green</td>
<td>12</td>
<td></td>
</tr>
</tbody>
</table>

**Commentary on all red and amber work packages (identified as priority areas which have maximum impact on performance)**

<table>
<thead>
<tr>
<th>RAP ref</th>
<th>Reason why red / amber</th>
<th>Recovery actions / expected date of completion</th>
<th>Impact on trajectory</th>
</tr>
</thead>
</table>
| **EDO6** | Specialty response/referral: Following a pilot in acute medicine and surgery and agreement from cancer, haematology and orthopaedics, we have moved towards a standardised approach for this. Since December ED consultants have been able to book beds for patients they expect to be admitted. All patients will be reviewed in ED by the specialty prior to transfer to the ward. This allows the specialty referral and bed booking process to run concurrently. AMBER as number of breaches is still higher than planned. | **Action:** A proposal for a charter on how specialties and emergency medicine interact, defining responsibilities for both, is currently being developed: Completion date: May  
**Action:** Specialty review dashboard has been developed and is being circulated: w.c. 02/04/2018  
**Action:** CEO is providing bi-weekly reports to teams to ensure visibility of performance - 05/04/2018  
**Action:** Clinical Reference Group has been set up to share best practice, with aim to convene 3 meetings per annum: May 2018 | Y |
| **AEC2** | AMU improvement project - Review of AMU care model and operational practices with the aim of establishing a more effective 48 hour pathway / Optimise onward moves from AMU: AMBER due to inability to mobilise 48 hour model on AMU due to exit block from patients awaiting specialty ward beds | **Action:** Complete consultation and staffing re-design (expected completion date 01/09/2018)  
**Action:** Implement daily specialty reviews (completed & ongoing)  
**Action:** Work package to be reviewed at ECRB: ongoing | N - not included in current trajectory but will lead to fewer breaches. |
| **MDC1** | Rollout of revised operations policy (including capacity issue escalation process and bed allocation process) RED due to ongoing delays in developing full capacity protocol. Unplanned staff absence causing latest delay - interim solution now identified. | **Action:** Agree how FCP and triggers would fit with our existing dashboard: 03/05/2018  
**Action:** Agree timeline for completion:03/05/2018 | Y |
<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/05/2018</td>
<td>Undergoing reconciliation process to ensure accurate reporting is possible</td>
</tr>
<tr>
<td>30/4/2018</td>
<td>Governance structure to be approved at Senior Director Team meeting</td>
</tr>
<tr>
<td>30/04/2018</td>
<td>CUR reporting metrics and escalation process to be agreed at ECRB and established thereafter</td>
</tr>
<tr>
<td>1/5/2018</td>
<td>Key metrics to be agreed at Programme Board</td>
</tr>
<tr>
<td>30/4/2018</td>
<td>Setup weekly Operational Excellence Group to use improved visibility to drive performance</td>
</tr>
<tr>
<td>01/05/2018</td>
<td>Supplier to address issues around the reconciliation of data</td>
</tr>
<tr>
<td>10/05/2018</td>
<td>Update on current available reporting and timescales for development or additional metrics</td>
</tr>
</tbody>
</table>
### Key new learning from recent weeks

**Month:** March

<table>
<thead>
<tr>
<th>Area</th>
<th>New issues since last report and actions to address</th>
<th>RAP work package</th>
</tr>
</thead>
</table>
| **ED breaches** | **Issue:** EAU has been utilised for patients with decision to admit awaiting inpatient beds and this has caused issues around patient flow.  
**Action:** Division to ringfence EAU beds for CDU pathways to support better patient flow. | MDC1: Rollout of revised Operations Policy (development of Full Capacity Protocol) |
| **Bed breaches**| **Issue:** Significant rise in bed breaches through February and March due to the timeliness of discharges and lack of appropriate Tower bed capacity, resulting in a mismatch between admission demand and bed availability.  
**Action:** Discharge to assess work where patients are treated out of the acute setting, including daily meetings with the CCG and weekly escalations through STAR Chamber | MDC1: Roll out of revised Operations Policy  
AEC2: Optimise onward moves from AMU  
AEC3: Bed base re-alignment  
ODD5: Discharge to assess  
MDC2: Co-ordination centre  
ODD2: CUR |
|                 | **Issue:** Beds have been closed due to infection control issues. Usable medical bed capacity was high, impacting on ED performance. Numbers of patients waiting for beds has been high at times across Majors, Resus and EAU.  
**Action:** Utilisation of the 8 bed Surge area during times of heightened pressure (8pm-2am), enabled by winter funds to treat patients out of the ED for low risk patients with a bed allocated time. Currently exploring alternatives for potential surge area.  
**Action:** Additional posts have been recruited to support with embedding processes throughout the Tower wards following the launch of the electronic co-ordination centre. These include an extra matron, HCA and transfer nurse, as well as senior operational support and two pharmacists to work on AMU. |                                                                                |
Patient Feedback report to the Board of Directors Meeting

9 May 2018

This paper provides an update on our patient feedback system and follows on from the original update on the new system implantation.

The paper included:
- progress against the benefits from the business case and (all delivered except the ability to further adapt surveys for all patient groups).
- included a summary of the findings of our volunteer-led inpatient feedback review ward by ward, and
- summarised the successes and challenges for all FFT areas on a single page

The Senior Directors Team (SDT) recognised the concerns raised regarding the drop in a number of our scores and percentage of feedback.

The summary page provides a 3 month comparison of data before and after the introduction of SMS and interactive voice messaging. Unfortunately we are consistently performing below the thresholds in ED and IP/DC, though day case scores have improved. We are also reviewing our scores against peers as initial comparisons for those using similar collection methods suggest that our ED threshold is unachievable, despite continuing to pay attention to ensure we improve in important areas such as management of expectations, pain and communication.

This paper was discussed with both our Patient Experience Committee and SDT March meetings and has been updated to reflect their comments and advice.

We have continued to make good progress but there remain areas for improvement:
- Divisions/site groups are reviewing iPads to ensure hardware is in place, to improve current numbers and scores
- Consider automating Friends and Family Test (FFT) for IP– (update since the meeting has identified some pilot areas to start by July and monitor impact on returns and scores)
- Increase use of volunteers to support wards with high volumes of discharges or complex patient cohorts
- Increased focus and support to local teams looking at numbers and IVM data (for example ED waiting times in UTC improving though FFT score static or deteriorating)
- Need to develop a bespoke approach for wards with elderly or cognitively impaired patients
- Consider automating FFT for women at the birth and postnatal ward touch points
## 1. Summary of FFT areas

<table>
<thead>
<tr>
<th>FFT Collection Areas</th>
<th>Inpatients</th>
<th>Daycase</th>
<th>Outpatients</th>
<th>ED</th>
<th>Maternity</th>
<th>Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods of collection</td>
<td>iPad or paper</td>
<td>SMS/IVM</td>
<td>SMS/IVM Paper for Paediatrics</td>
<td>SMS/IVM Paper for Paediatrics</td>
<td>Paper at all 4 touch points</td>
<td>Paper via G4S Moving to agent calls</td>
</tr>
</tbody>
</table>
| Reported issues | • Delays to data reports expected by staff led to lack of engagement with system  
• Staff engagement varied – too busy to collect feedback  
• iPads broken or missing  
• Wi-Fi connection issues  
• Paper surveys – local data entry still happening and collection | None. Working well with increased response rates since introducing SMS/IVM. | None. Working well with increased response rates since introducing SMS/IVM. | • Lower response rate  
• Worse scores than with paper collection previously  
• Paediatric feedback collection reintroduced late 2017 | • Central paper collection – better since moving to EGA as bulk of returns from here  
• Varying engagement from staff  
• High burden on women – risk of survey fatigue | • Paper collection challenging with vulnerable patient group  
• Data from G4S low and therefore unreliable |
| Responses | 2017 June-Dec | Volume: 6298  
Rate: 21% | Volume: 8499  
Rate: 17% | Volume: 51,829  
Rate: 9% | A&E: 3288 (13%)  
Paeds: 502 (6%)  
UTC: 4847 (16%) | A/N: 371  
Birth: 496 (13%)  
P/N: 613  
Com:111 | Total Volume: 8637  
Total Rate: 13% | Responses: 7276 |
| | 2016 June-Dec | Responses: 7276 | Responses: 1090 | Responses: 8108 | A&E: 7281  
Paeds: 2961  
UTC: 1024 | A/N: 934  
Birth: 466 (15%)  
P/N: 780  
Com: 210 | Total Volume: 11,266  
Total Rate: 17% | Responses: 2 |
| Scores | 2017 June-Dec | 92.8 / 2.9 | 94.0/ 3.1 | 91.4/ 4.1 | A&E: 83.0 / 12  
Paeds: 96.8 / 1.4  
UTC: 81.3 / 12.8 | A/N: 94.6 / 1.9  
Birth: 97.4 / 1.2  
P/N: 94.0 / 1.9  
Com: 95.5 / 3.6 | Overall: 82.8/11.8 | Responses: 1470 |
| | 2016 June-Dec | 94.0 / 2.2 | 91.9 / 2.9 | 90.9 / 3.1 | A&E: 93.8 / 2.7  
Paeds: 97.3 / 0.8  
UTC: 93.5 / 3.3 | A/N: 93.1 / 3.0  
Birth: 96.7 / 1.1  
P/N: 93.1 / 2.4  
Com: 96.2 / 0 | Overall: 93.7/2.7 | Responses: 2 |
| Learning | • Paper best option for some patients so blended approach good but need to reduce burden on staff  
• Technical support for hardware not available/easy to access  
• Increased engagement with matrons/sisters as data improved but returns still low  
• Consider automating FFT with local survey elements via iPad/paper to reduce burden of response rates  
• Local survey option for dementia patients possible but won’t feed into FFT reporting so could worsen overall response rate  
• App coming soon to enable data collection when no Wi-Fi access | • Still reviewing survey fatigue settings  
• Need to engage across all areas to ensure all areas are making good use of the data available | • Still reviewing survey fatigue settings  
• Consultant level feedback being used in some areas – need to improve engagement with use of the data | • Rates and scores are lower than expected despite increasing paediatric data  
• Department need to continue to review the themes emerging – hoping to see an improvement from new environment and improvement of waiting times in UTC  
• Improvements noted in area of pain  
• Focus on managing expectations and communication | • Paper on all areas not working  
• Other trusts focus on birth and postnatal ward and send SMS – splitting the responses between each area  
• Suggest maintaining paper in antenatal and iPad/paper in community  
• Currently discussing options to change the approach with division | • Hard to benchmark against others  
• Freepost card tried originally with limited success  
• Contract now includes a score driven KPI with local data collection  
• New independent collection method contracted by division starting by June |
2. Review of approaches to inpatient feedback

As part of reviewing the approach we recruited a volunteer to assess what was happening in each ward across all UCLH sites. The aim was to capture the various patient cohorts, e.g. high levels of cognitive impairment needing an adapted approach, and to talk to staff about some of the challenges they face collecting feedback.

A summary of the key issues raised were:

- Technical issues – iPads not working, not charged and survey links not working
- Ward staff very busy and collecting surveys not seen as a priority
- Some patients not having cognitive skills to complete the survey/iPad not appropriate

A high-level view of each wards response was included and reviewed.

3. Other issues

Handover to Atos

The eligible patient numbers now showing in Envoy relies on a daily data extract from Carecast, sent to HC via a remote server. The ability to make real time changes for any amendments/errors with the extract has proved difficult.

The technical support for the iPads is managed locally and was not always clear to all staff. Also any changes to the iPads - such as amending the survey link when we make changes or adding new links – incurs a charge from Atos. This is impacting our ability to roll out the local survey function to more departments and so limiting our ability to achieve the full benefits Envoy offers.

Changes to the FFT question

NHS England is currently reviewing the approach to asking this question and is now consulting on what patient feedback is mandated and how. They are currently consulting on this and new guidance is expected in April 2019. We will therefore need to review any approaches in line with the new recommendations.

We are also proposing to continue with Envoy in 2019 after go-live of EHRS. This will require input to any hierarchy and data extract changes later this year.

4. Recommendations

We have continued to make good progress but there remain areas for improvement:

- Divisions/site groups are reviewing iPads to ensure hardware is in place, to improve current numbers and scores
- Consider automating FFT for IP– (update since the meeting has identified some pilot areas to start by July and monitor impact on returns and scores)
- Increase use of volunteers to support wards with high volumes of discharges or complex patient cohorts
- Increased focus and support to local teams looking at numbers and IVM data (for example ED waiting times in UTC improving though FFT score static or deteriorating)
- Need to develop a bespoke approach for wards with elderly/cognitively impaired patients
- Consider automating FFT for women at the birth and postnatal ward touch points
- Need to request a different level of service from Atos (Nick Roberts has agreed to resolve)

FLO PANEL-COATES, CHIEF NURSE
Voluntary Services annual report.ppt
We are immensely proud of our volunteer team. Together they comprise people of all ages and backgrounds and bring so many different skills to the Trust. Although diverse, the one thing that unites them all is a desire to help us do more and improve our patient experience.

During the year the volunteer service continued to grow with significant progress being made at Queen Square with a doubling of their volunteer numbers, the rolling out of new services and the beginning of a new culture of volunteering. Across the Trust we have also worked to develop new roles, increase the effectiveness and quality of volunteering, and the impact that volunteers make to our patients.

Over the next year we look forward to growing the service, further increasing our capacity to do more and improve our patient experience.

Our thanks go to everyone who has given their time to help the Trust, and to the UCLH Charity for their continuing support.

Lorraine Szeremeta Deputy Chief Nurse
Clive Pankhurst Trust Volunteers Lead
2. Impact of the volunteer program

Over the year volunteers came in over 7867 times, giving 25600 hours of their time.

This represents a growth of 47% on last year.

This time equates to an economic contribution of £261,000 (using the London Living Wage).

Volunteers helped patients 140,000 times. Of this 100,000 was basic support (an interaction under 5 minutes), 30,000 was moderate (5-30 minutes) and 10,000 was intensive.
3. Volunteer numbers

Over the year our volunteer numbers stabilised with 276 new people joining the team and 266 leavers. We ended the year with 421 active volunteers, slightly up on 2016-17 (411 volunteers). This churn is a natural part of any volunteer program, and we ask all new volunteers to commit to a minimum of 6 months (for outpatient roles) or 12 months (inpatient roles). Our 2017 leavers had each completed an average of 13 months with us.

Although there has not been growth in our overall numbers there has been significant growth in the number of hours that our volunteers give and the number of people that they help. This reflects the work that we have done to improve the effectiveness and quality of volunteering and a move towards improved retention of volunteers.

Total number of volunteers across UCLH

<table>
<thead>
<tr>
<th>Location</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCH Tower</td>
<td>145</td>
</tr>
<tr>
<td>UCH Cancer Centre</td>
<td>64</td>
</tr>
<tr>
<td>UCH EGA</td>
<td>17</td>
</tr>
<tr>
<td>Queen Square</td>
<td>73</td>
</tr>
<tr>
<td>Westmoreland Street</td>
<td>2</td>
</tr>
<tr>
<td>RNTNEH</td>
<td>7</td>
</tr>
<tr>
<td>Citybeat (Hospital Radio)</td>
<td>22</td>
</tr>
<tr>
<td>Chaplaincy</td>
<td>31</td>
</tr>
<tr>
<td>On hold</td>
<td>60</td>
</tr>
<tr>
<td><strong>Total number of volunteers</strong></td>
<td><strong>421</strong></td>
</tr>
</tbody>
</table>

New volunteers by age

New volunteers by gender:
74% of new volunteers were women, 26% men
4. Improving the hydration and nutrition of patients

Over the year we worked with the Improving Experience Team and Dieticians to better understand how volunteers can help patients over mealtimes and to improve their hydration and nutrition. The initial reaction to how volunteers could help was around providing assisted feeding. However, an information raid to better what support patients need showed that only 5% required help with assisted feeding with 31% needing help with packaging and 29% needing help with arranging their table. As such the support volunteers can give is much broader and really helps improve patient experience at mealtimes.

- Volunteers like Darrell can help with the soup rounds on T9 and 10 (S) and also go out to buy additional food and drink for patients
- The HCC funded snack trolley service on T13/14/16 enables haematology patients to access additional food as and when they need it
- Ward volunteers like Caroline can help refill water jugs and check patients are ok with their meals. This has been found to really improve the drugs rounds on T10
5. Support from external groups

In addition to our regular volunteers we are supported by 27 external charities and groups whom provide our patients with voluntary services. These varied groups range from those supporting our children's wards to specialist support groups at the Cancer Centre. During the year there has particularly been a growth in the number of musicians performing for patients such as the UCL Jazz society that play to patients at the Cancer Centre.

| AGSD-UK (Glycogen Storage Disease (GSD)) | Penny Appeal |
| Ataxia UK | RLHIM Friends |
| Bliss | Spoonful of sugar |
| Bright Futures UK | Spread a Smile |
| Chinese Association for Cancer Support | Starlight |
| Climb Family Support service | Teenage Cancer Trust |
| Contact a Family | The Mayhew Animal Home |
| Crohns Colitis Relief | UCL Fun club |
| Guildhall School of Music | UCL Hospital Connect |
| Henry Dancer Days | UCL Jazz society |
| Jos Cervical Cancer Trust | UCL Origami Club |
| League of Jewish Women | UCL Songs for Smiles |
| London Sarcoma Support Group | UK Garrison |
| Music and movememnt (Rosetta Life) | |

UK Garrison regularly invade UCLH visiting our children's wards and atrium.
6. Queen Square

With funding from the charity for a dedicated Volunteer Manager for Queen Square we have grown and embedded the service, doubling the numbers of volunteers during the year. This enabled us to increase the coverage of Welcomers and Guiders at the main entrance, and integrate volunteers onto the wards. For many wards this is a new culture and we appreciate how welcome they’ve made the volunteers. We introduced a new ward based complementary therapist service which is much appreciated and we will expand this in 2018. In addition we expanded our volunteer admin support function within the Square providing support to the specialist teams.

Funding from the Lady Samaritans has enabled us to pilot the use of ward based ‘activity boxes’ which volunteers can use to help with patients boredom busting.

'I just wished to extend a thank you to Shelia for helping to get this project off the ground for the Epilepsy service. It is in its 3rd week and without both of your help pulling it together it would not be possible to collect this valuable data.'

Claire
Over the year we worked with teams across the Trust to develop 38 new volunteer roles. 20 new roles were at UCH, 18 at Queen Square. Each role is developed to meet local need and included a significant increase for volunteers to help in admin based roles.

### 7. New volunteer roles

<table>
<thead>
<tr>
<th>Role</th>
<th>Role</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brain Tumour Unit Admin Volunteer</td>
<td>Fundraising volunteer</td>
<td>Phlebotomy OPD volunteer</td>
</tr>
<tr>
<td>8-11 Queen Square Admin Volunteer</td>
<td>Intensive Volunteer QS</td>
<td>QS Summer Placement Volunteer</td>
</tr>
<tr>
<td>Admin support (Cancer Collaborative)</td>
<td>Maternal Fetal Assessment Unit</td>
<td>Raspberry Wednesdays Club</td>
</tr>
<tr>
<td>Admin support GI Medicine</td>
<td>Medical specialties admin support</td>
<td>RLHIM Admin Volunteer</td>
</tr>
<tr>
<td>Chemo daycare support volunteer</td>
<td>Neurology ward volunteer - David Ferrier</td>
<td>Sir William Gowers Ward Volunteer</td>
</tr>
<tr>
<td>Creative volunteer (T14)</td>
<td>Neurology Ward Volunteer - Sir Jules Thorn</td>
<td>Specialist Services Admin Volunteer</td>
</tr>
<tr>
<td>Deep Brain Stimulation (DBS) Admin Support</td>
<td>NRU Ward Volunteer - Sir Jules Thorn</td>
<td></td>
</tr>
<tr>
<td>Dementia Admin Support</td>
<td>Outpatients Admin</td>
<td>T9 Ward volunteer</td>
</tr>
<tr>
<td>Dementia Clinic Volunteer</td>
<td>Paediatrics admin support (6th floor)</td>
<td>Theatres/Critical Care Admin Volunteer</td>
</tr>
<tr>
<td>Digital Media Volunteer</td>
<td>PAM Volunteer</td>
<td>Vocational Rehab Admin Volunteer</td>
</tr>
<tr>
<td>Eastman Dental OPD</td>
<td>Patient information support volunteer</td>
<td>Ward musicians (various)</td>
</tr>
<tr>
<td>Epilepsy Information Volunteer</td>
<td>Patients Anti Boredom Volunteer</td>
<td>Ward volunteer: Evergreen</td>
</tr>
</tbody>
</table>

Alexi was the first volunteer in a new ‘intensive role’. He volunteered for 3 days per week in a variety of roles designed to give experience across the Trust.

Yousra, new ward volunteer on John Young and Maida Vale, Queen Square
Developing group based volunteering enabled us to engage volunteers in different ways to support patients. This included a Wednesday morning arts group and Wednesday afternoon student group that works across UCH and Queen Square. In addition UCL Connect, a Student Society visit our care of the elderly wards.

8. Group volunteering

For Valentine’s day the groups worked with patients to make heart shaped banners with messages of support for the clinical staff who were looking after them.

Raspberry Wednesdays is a new group that is aimed at providing an easy opportunity for students to volunteer with us. They have helped with arts and befriending based opportunities across the UCH Tower and Queen Square.
We are particularly grateful to the 20+ professional complementary therapists whom come in every week to give their time to help our patients. This included both the therapists supporting patients through the Macmillan Support and Information Service and those who are managed directly by Voluntary Services. An expansion of the service enabled us to have our first therapist at Westmoreland Street and two therapists now support inpatients at the National. We also offered sessions to staff and during Get Active at Work Week we gave 20 min taster sessions to 45 members of staff at QS, WMS and UCH.

Over the year volunteers gave over 700 complementary therapy sessions to medicine inpatients in the Tower

Amanda won the 'Volunteer of the Year' UCLH Excellence Awards. In addition to helping induct the majority of new therapists she has helped to roll out new complementary therapy services to staff and supports the development of the service.
Over the year there has been an increase in the number of volunteers involved in arts based activities. These provide easy ways for volunteers to interact with patients and can make a big impact.

10. Arts and music

Over the year there has been an increase in the number of volunteers involved in arts based activities. These provide easy ways for volunteers to interact with patients and can make a big impact.

‘Last weeks session was great! We had a real party atmosphere going on in one of the bays - the piano came out and a bit of sing-song begun - quite a few Irish tunes and some Music Hall stuff. One elderly lady really joined in, prior to that was sitting alone agitated and disorientated. She was joined in song by an Irish patient who has been there several weeks. I even played Frank Sinatra on the Bluetooth speaker, rounding off with New York New York. The place just came alive. It was one of the best sessions!’

David, volunteer musician, Care of the Elderly wards

Michelle took part in a rock painting session delivered at her bedside. Sharon, who runs the arts sessions is also a member of staff and gives up her Tuesday evening as a volunteer.
11. Adding value

In addition to their regular volunteering many volunteers go above and beyond what is expected of them. The has included: finding Cantonese, Japanese and Turkish speaking volunteers to visit patients that don’t speak any English. Teaching staff at RNTNEH sign language. Working with dieticians to encourage certain patients to eat. Special PAT dog visits, befriending support for a patient and her family who were new to the country. Spending the whole day supporting anxious patients, ah hoc supporting patients with additional needs or dementia. Building giant wig wams for the chemo floor at the cancer centre, supporting conferences, marathons and fundraising events for our charities.

‘Today I was at ED from 17:00 to 22:00. I hope it’s alright that I stayed for an extra couple of hours? I promised a patient that I’d not leave until he received pain relief.’
Maria

‘A huge thanks to George Heptonstall & Helen Wynne-Griffith from the Volunteer Services. Your amazing effort in marking a special day for a family in challenging circumstances was a real inspiration. Thank you from all in UCLH’s Children’s Cancer Services’
Abu Sidhanee (Good Deed Feed)

“I have been coming here for 7 years now and I just wanted you to know that despite the reason for being at the hospital, as I walk through the automatic doors, I am delighted and hopeful when I see the warm welcome and smile that you give. I thank you. You are a credit to the hospital.”
Patient feedback about Ty, Welcomer and Guider at the National
12. Moving on: progression from UCLH

Progression is a natural part of our volunteers journey. Whilst we are very appreciative of those volunteers who stay with us for a long time the minimum requirement we ask of new volunteers is to commit for 6-12 months.

Volunteering is a two way exchange of skills and many use their volunteering here as a stepping stone to other things. We are particularly proud of the 29 people who managed to use their volunteering to find paid employment. Many students also use their volunteering to help them gain direct experience of working with patients and this can help them get into medical school.

‘I have had a truly fantastic time volunteering with you guys and I cannot thank you enough for taking me on board. You have changed the way I think about medicine, and not only helped me gain a place at medical-school but also helped me to become a better doctor in the future’

Ted, former NRU Volunteer, Queen Square

“I would like to thank you for this opportunity and also thank everyone on T11 and especially the play room staff, who have been amazing. I have had an amazing year and will cherish all that I have learnt.

Ayan

‘Thank you for giving me the opportunity to join your team. It has made me grow in confidence and feel valued as an individual and not just as a mum’

Kirsti, Queen Square admin volunteer who progressed to paid work at Mororfields
13. Plans for 2018-19

In the coming year we plan to continue to grow the number of volunteers and the impact that they make to patients. In the last year we have also been excited by development work at Queen Square and how teams have embraced volunteering and plan to continue to nurture this growth so that volunteers can make even more of a difference.

Current work to develop evening and weekend based work is still in its infancy, but is proving popular with potential volunteers. Over the year this will help us expand our ward based volunteering and provide additional support to the emergency department and maternity services.

Aims for 2018-19

1) Continue to increase levels of volunteering at Queen Square
2) Increase levels of volunteering supporting patients over evenings and weekends
3) Increase the average amount of time that volunteers give
4) Increase the amount of people applying from the local community
5) Increased development of roles that appeal to local people wanting to use volunteering as a stepping stone into work
6) Increased engagement of young people as volunteers
Corporate objectives 2017 2018 Q4
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<td><strong>1 Provide Highest Quality Care within our resources</strong></td>
<td>Align all clinical staff to work towards reducing avoidable harm</td>
<td>Tony Mundy</td>
<td><strong>Reduce harm from unrecognised deterioration (including sepsis and AKI)</strong>&lt;br&gt;- Deliver antibiotics to confirmed cases of sepsis within one hour (Q1: 65%, Q2: 67.5%, Q3: 70%, Q4 72.5%).&lt;br&gt;- Better understand how well we are recognising and treating AKI in patients who develop AKI whilst inpatients, and see where any improvement work may be needed.&lt;br&gt;- Maintain average hospital-wide vital signs compliance of 96%.&lt;br&gt;- Increase use SBAR tool when escalating to the PERRT team (10% proportional increase on 16/17)</td>
<td>Q1 target: 65% Achieved: 76%&lt;br&gt;Q2 target: 67.5% Achieved: 36%&lt;br&gt;Q3 target: 70% Achieved: 94%&lt;br&gt;Q4 target: 72.5% Achieved: 76%&lt;br&gt;...&lt;br&gt;In 18/19 we will carry out an AKI audit alongside assessment of staff awareness and process mapping. The outputs of these will form the AKI improvement plan. Achieved.&lt;br&gt;Use of SBAR/ISBARD on referral to PERRT was 64% against a target of 69% across the year. Q4 average was 69%&lt;br&gt;19 surgical safety walk rounds have taken place at Q4, above our plan to carry out 18.&lt;br&gt;The Q4 data is not available for surgical incident reporting levels yet. There have been no surgical never events in this financial year to date. We completed our baseline exercise across all specialties: 64% of specialties have reported having robust systems in place for checking and following up results. This is broken down as follows:&lt;br&gt;• 16 subspecialties responded that they have a robust system in place for picking up and acting on imaging results (including fail-safe mechanisms), and they are regularly checking that these are effective&lt;br&gt;• 30 subspecialties said that they have robust systems in place however they have not confirmed regular audits or checks of these...</td>
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| Improve how we learn from mortality, morbidity and serious incidents to sustain excellent outcomes | - Maintain current SHMI rating in top 4 of trusts  
- Implementation of learning from mortality in line with NHSI guidance  
- Undertake structured judgement review (SJR) of deaths identified by the UCLH selection tool  
- Increase percentage of SIs being investigated within 60 days (75%) | Tony Mundy | | Currently ranked 4th for SHMI.  
Learning from deaths policy been agreed and published. SJR of deaths has started. Two reports have been to the Board. Eight senior reviewers have been trained by the Royal College of Physicians and we are planning further in-house training to create an adequate pool of reviewers. |
| Improve patient experience | - Improved trust FFT ratings and national inpatient and cancer patient surveys (FFT ratings 96% for inpatients and 94% for A&E)  
- Improved use of patient stories  
- Improve patients experience of discharge – developing metric to include in our local surveys  
- Improve patients’ reported access to CNS measured in national survey | Flo Panel-Coates | | Q4 FFT ratings were:  
- 95% for both inpatients and day case  
- 82% for A&E  
We have two local questions on discharge which we monitor through local surveys. At Q4 we are performing above the benchmark:  
- patient knowing what happens after leaving: 84% against target of 75%.  
- delayed discharge: 84% against target of 60%.  
The cancer survey is reported annually. This year’s results reported significant improvement. |
| Ensure all contact with patients and GPs is timely, accurate and professional including a streamlined booking process | - 80% of GP referrals booked via ERS by October  
- Delivery of advice and guidance services for GPs across specialties that make up 35% of total GP referrals by year end  
- Progress implementation of a patient portal | Gill Gaskin | | We achieved the targets for the number of services available to GPs via e-referrals and percentage of services available on the advice and guidance service. However, we did not meet the Q4 target to reduce appointment booking issues. The APA programme is working with divisions to ensure there is sufficient capacity electronically for bookings ahead of GPs no longer referring via paper. |
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<td>Start implementation of an Electronic Health Record System and successfully implement pre-requisite systems</td>
<td>Gill Gaskin</td>
<td>Delivery of the project according to agreed milestones - Implementation of co-ordination centre tracking (as a pre-requisite to EHRS)</td>
<td>The EHRS programme is broadly on track, with mitigation plans alongside the internal team for building while builder certification is completed. The pace of work is intensive. The electronic co-ordination centre went live in December 17.</td>
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<td>Achieve hospital acquired infection targets</td>
<td>Charles House</td>
<td>Maintain current rates of C-diff per month - No MRSA cases</td>
<td>We are on track with our c-diff trajectory. We have reported 1 case of MRSA.</td>
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<td>2 Improve patient pathways through collaboration with partners</td>
<td>Work with system partners to shorten waits for patients in our emergency department and avoid admission where possible</td>
<td>Charles House</td>
<td>Deliver the A&amp;E four hour wait trajectory (this varies from 91% - 95% per month) - Maintain current conversion rate from ED (&lt;12%)</td>
<td>We missed our agreed trajectory and delivery of STF monies in Q4. Actions based on ED processes, patient flow and discharge in place to improve. Our conversion rate rose to 16.5% in Q4.</td>
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<td>Improve our patients’ experience of waiting, both from referral to diagnosis and treatment, and waiting in the building</td>
<td>Geoff Bellingan</td>
<td>Deliver national standards for diagnostic 6 week wait (99%) - Deliver national standards for 18 weeks (92%) - Improve patient perception of waiting time in outpatients (captured in our local surveys)</td>
<td>We delivered the diagnostics standard against all months, except for June and March. In both instances we narrowly missed compliance and implemented actions quickly to mitigate future months. We lost compliance with RTT in July. We had a trajectory to deliver compliance from March 18. However, we missed this, reporting 91%.</td>
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<td>Shorten waiting times at all stages of the pathways for cancer patients</td>
<td>Geoff Bellingan</td>
<td>Deliver the performance trajectory for the cancer 62 day standard (achieving 85% by September) - Deliver national standards for cancer 2 week waits (93%) - Deliver national standards cancer 31 days (96%)</td>
<td>We have been sustainably compliant with the two week wait standard and we recently regained compliance with the 31 day target. For the 62 day target we are improving across the sector and on our internal performance but have a trajectory to meet this sustainably from Q2 2018.</td>
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<td>Deliver earlier diagnosis for cancer patients across the sector through the Cancer vanguard</td>
<td>Geoff Bellingan</td>
<td>Successfully launch early diagnosis interventions to improve early diagnosis in priority areas (including lung and colorectal cancer) - Scale up the multidisciplinary diagnostic centre model across the region - Implement best practice diagnostic pathways in line with Vanguard delivery plan.</td>
<td>The NCEL sector has received some Q4 transformation funding. This includes a larger proportion for NEL, which has been achieving 62 days, and a smaller proportion to improve specific pathways across the sector such as prostate.</td>
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<td>Deliver phase 4, phase 5, ED and Queen Square development milestones</td>
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<td>Geoff Bellingan and Gill Gaskin</td>
<td>- Programmes delivered in line with project milestones</td>
<td>The multidisciplinary diagnostics centre is being celebrated.</td>
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| Work with local and specialist STP partners to develop new pathways and support preventative care for our local patients | | Laura Churchward | - Progress partnership working with the Whittington in breast, bariatric, general surgery and maternity services  
- Engage actively in STP urgent and emergency care; health and care closer to home; planned care and digital programmes  
- Provide leadership for the cancer vanguard (for North Central and North East London STPs) and better births work-streams  
- Engage in specialist STP as pathway discussions emerge  
- Engage actively in the Haringey & Islington Well-being Partnership and Camden Local Care Delivery programmes | The programmes are on track against the revised, agreed timeframes. |
| 3 Support the development of staff to achieve their full potential | Improve staff experience | Ben Morrin | - Improve staff survey results  
- Reduce turn-over rates to 12.5% | Turnover increased to 13.6% in February, which is above the trajectory. A strategy is being developed to concentrate on key retention hotspots to improve turnover in the short term, and we are working alongside STP partners to improve recruitment and retention in the long-term across the sector. |

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| Improve the quality of education and development | Ben Morrin | - Deliver plan for number of new apprentices in the trust  
- Increase number of staff on development programmes  
- 95% compliance with statutory and mandatory training | We recruited 51 staff to apprenticeship programmes against a public sector target of 188. The lower number than last year has been largely due to the procurement issues with the new apprenticeship levy and the more stringent requirement for apprentices to have 20% time away from the workplace. Our low number is in keeping with other organisations in the UK and we are confident that this will improve over the next year.  
We have met our target of over 2000 staff undertaking development programmes, largely as a result of 900 staff being eligible for the APA programme training.  
As at the beginning of April our mandatory training completion rate is 86%. This is partially low due to the introduction of all honorary contract holders being included on ESR and therefore in the reporting figures. | |

| Demonstrate that we are an employer of choice | Ben Morrin | - Sustain low vacancy rate of 6.5%  
- 95% appraisals completed by end September  
- Improve quality of appraisals as measured by staff survey  
- Deliver improvements to staff environment and facilities within the CQUIN plan | The vacancy rate at end of December was 8.5%. This is above plan due to a slowing of recruitment activity and an increase in turnover in areas facing significant national and international shortages in supply. Retention plans are being developed to improve turnover.  
We achieved 96% appraisal completion by year end and our 2017 Staff Survey results show the quality of appraisal remains high.  
Steps to improve staff facilities are progressing | |
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| Improve working conditions for junior doctors and other staff in training | Ben Morrin | - Deliver improvement plan based on GMC survey feedback  
- Evidence of engagement with dental trainees in advance of phase 5 | GMC survey results show that we fare favourably with Shelford trusts and against national averages where there has been a decrease in satisfaction nationally.  
A new junior doctors’ mess opened this year. |
| Collaborate with STP and others to design and develop the future health and care workforce | Ben Morrin | - Deliver shared staff bank  
- Deliver mechanism for shared staff contracts with partners | UCLH is tendering for our future supplier of a staffing bank. The tender allows for neighbouring trusts to commit to the same model.  
A mechanism for employment portability for UCLH and Whittington Health staff has been signed off at Executive Board level (by both) and shall shortly be launched. |
| Develop our staff to achieve transformational change | Ben Morrin | - Deliver plan for number of staff attending the institute quality improvement training  
- Deliver plan for number of staff attending the leading change training | Our plan for staff attending QI training is on target at over 350 staff this calendar year.  
The band 5-7 leader development started in September and 3 cohorts have attended this programme. |
| Achieve financial sustainability | Tim Jaggard | - Deliver agreed CIP plan  
- Deliver the trust’s control total | The Board appointed a turnaround director and has strengthened the programme management office to help UCLH deliver in-year savings and significantly improve run-rate financial performance.  
The Trust’s financial position was on plan at the end of Q3, although the underlying financial position remains weak and financial risk in 2018/19 is high. |
| Deliver clinical productivity efficiencies in line with the Carter agenda | Gill Gaskin | - Improve use of electronic rotas for clinical staff  
- Reduce in-session opportunity lost in our theatre lists to 10%  
- Develop monitoring and then improve outpatient room utilisation  
- Reduce LOS in line with agreed targets | Medirota is being rolled out across the Trust.  
We are developing outpatient room utilisation reporting but establishing a baseline capacity has been challenging. Pragmatic focus is therefore on increasing total number of attendances. |
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<td></td>
<td>Mundy</td>
<td>Research Centre project</td>
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<td>milestones</td>
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<td></td>
<td>Increase numbers of</td>
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<td>patients in early phase</td>
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<td></td>
<td></td>
<td></td>
<td>clinical trials (by 5%)</td>
<td></td>
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<td>Patient recruitment to</td>
<td></td>
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<td>early Phase clinical trials</td>
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<td></td>
<td>is comparable to previous</td>
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<td>years Number of research</td>
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<td>publications in 2017/18</td>
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<td>exceeds the total for 2016/</td>
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<td>17 and the upward trend</td>
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<td>in annual publications</td>
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<td>continues.</td>
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<td>The AboutMe project will</td>
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<td></td>
<td>implement consent for</td>
<td></td>
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<td></td>
<td>recall process across</td>
<td></td>
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<td></td>
<td>UCLH. The project is in</td>
<td></td>
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<td></td>
<td>the advanced stages of</td>
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<td>planning We have developed</td>
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<td></td>
<td>and agreed on criteria in</td>
<td></td>
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<td></td>
<td>collaboration with academic</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>colleagues. These were</td>
<td></td>
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<td></td>
<td>discussed in SDT in January</td>
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<td></td>
<td>and subsequently with the</td>
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<td>Provost and Vice-provost</td>
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<td></td>
<td>of UCL. The university has</td>
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<td></td>
<td></td>
<td></td>
<td>accepted our</td>
<td></td>
</tr>
<tr>
<td>Strategic Objective</td>
<td>Annual Objectives</td>
<td>Lead</td>
<td>Measures and deliverables</td>
<td>Q4 update</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
|                     | Work with partners, including HSL, to develop academically-linked, advanced diagnostics and embed genome testing. | Geoff Bellingan           | - Plan for improving diagnostic capability in place and agreed with partners  
- Plan delivered to time-frames  
- Use of genome testing in agreed areas | There is increasing clarity on both the cancer and rare disease local pathways to be adopted. However, there is still considerable work to do and some risk, including agreement with Bart’s Health and the NEL London group on cancer pathways and on what national/specialist work can be taken on/won. This is a complex tender. There is further risk around the pricing/finances of these, next steps in rapidly operationalising these and in the IT support that is envisaged nationally. |
|                     | Improve utilisation of our clinical research facilities                            | Tony Mundy                | - Increase activity in CRF (by 5%)  
- Increase activity in Leonard Wolfson (by 5%) | Activity volumes have increased in line with plan. Both CRF sites have specifically increased their volume of highly risky and highly intense first-in-man/phase I clinical trials.                                                                                                                                                                                                                          |
|                     | Develop and encourage research opportunities for junior doctors, nurses and all other staff across UCLH | Bryan Williams            | - Specific plan to be developed by research and development department | Junior doctors – the first cohort of research fellows has been selected, with 31 funded fellows being supported to develop research activities alongside their clinical care duties.                                                                                                                                                                                                                                                                                  |
2018 2019 corporate objectives and metrics.pdf
Report to the Board of Directors Meeting

9 May 2018

The Board are asked to review and agree the 2018/19 Corporate Objectives and proposed metrics to track progress.
## Proposed metrics for UCLH 2018/19 annual objectives

<table>
<thead>
<tr>
<th>Strategic objectives - draft</th>
<th>Coordination director lead</th>
<th>Measurement / target (where known)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provide highest quality care within our resources and increase our focus on safety</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Continue to reduce avoidable harm through our agreed safety priorities | Tony Mundy | - Reduce harm from failure to recognise and respond appropriately to deterioration  
- Maintain average hospital-wide vital signs compliance of 96%  
- Five steps to surgical safety: reduce avoidable harm from surgery and invasive procedures  
- Deliver planned programme of surgical safety walk rounds  
- No never events  
- Reduce harm from failure to follow up on radiology results  
  o % specialties who have a SOP in place  
  o % specialties who have completed an audit of their SOP |
| **Improve how we learn from mortality and serious incidents** | Tony Mundy | - Maintain current SHMI rating in top 4 of trusts  
- Increase percentage of SIIs being investigated within 60 days (75%)  
- % SJRs undertaken for deaths meeting the criteria for SJRs (denominator and numerator to be defined.)  
- Deliver 100 human factors awareness training sessions |
| **Improve patient experience** | Flo Panel-Coates | - Improve FFT ratings (FFT ratings 1% for inpatients and 2% for A&E  
- Improve inpatient and cancer patient survey ratings in national inpatient and cancer patient surveys:  
- Improve patients' experience of discharge (knowing what was happening on leaving – 3%)  
- Improve patient reported waiting times (OP) – 7%  
- Improve patients getting help with meals – 2%  
- Improve access to easy to understand written information about cancer type (5%)  
- Q1 develop thresholds  
- Q2 start reporting |
| **Work towards all contact and booking with patients and GPs being timely, accurate and professional** | Gill Gaskin | - 100% of GP referrals booked via ERS by October 2018 unless agreed otherwise with NHSE due to incomplete GP take-up  
- Complete first cycle of Admin and Patient Administration staff training |
| **Improve patient involvement in their care** | Gill Gaskin | - Complete configuration, testing, training and patient engagement for Go-Live of MyChart patient portal on 31.3.2019 |
| **Achieve hospital acquired infection targets** | Charles House | - No cases of MRSA  
- No more than 96 cases of Clostridium difficile |
| **Become a world class academic research hospital embedding research throughout the organisation and all disciplines** | | |
| **Deliver the promises of the Biomedical Research Centre bid** | Bryan Williams | - Deliver Biomedical Research Centre project milestones  
- Increase numbers of patients in early phase clinical trials (by 5%) |
| **Give as many of our patients as possible the opportunity to be part of research trial** | **Tony Mundy** | - Increase the numbers of patients in research trials (by 5%)
- Improve patients' experience in research |
| **Align medical and academic leadership at all levels in our organisation** | **Marcel Levi** | - Devise a plan for the first steps in achieving closer alignment of medical and academic leadership |
| **Develop operational research in the hospital with key partners** | **Tony Mundy** | - Establish collaboration with the Turing Institute
- Initiate operational research projects in the Trust |
| **Plan for using EHRS informatics to drive research opportunities** | **Gill Gaskin** | - Complete configuration, testing and training for Go-Live of Epic research module on 31.3.2019
- Through BRC Clinical Research Informatics Unit and Chief Research Information Officer, develop Informatics Research Strategy and Research Information Governance framework |
| **Draw up a plan for research into the health needs of our local population** | **Tony Mundy** | - Develop a plan during 2018/19 |
| **Develop and encourage research opportunities for junior doctors, nurses and other clinical staff across UCLH** | **Marcel Levi** | - Number of clinical research fellows and nurse/AHP research fellows |

**Operational excellence through EHRS and optimised processes**

| **Implement our Electronic Health Record System** | **Gill Gaskin** | - Delivery of the programme according to agreed milestones |
| **Embed our Coordination Centre to improve how patients move through our services** | **Charles House** | - Improve time taken for patient being declared ready to move (from ED and/or Recovery) to patient occupying a bed (baseline to be set in Q1)
- Improve time taken from request for a green bed clean to clean completed (baseline to be set in Q1)
- Improve number of confirmed discharges (date and time) identified the day before that result in a patient actually being discharged the following day (baseline to be set in Q1)
- Continue to embed Clinical Utilisation Review process to reduce the number of internal delays (i.e. non-community) by 15%, linked to CQUIN trajectory |
| **Improve our ability to interact with patients in a more customer-focussed way** | **Gill Gaskin** | - Complete configuration, testing, training and patient engagement for Go-Live of MyChart patient portal on 31.3.2019
- Complete first cycle of Admin and Patient Administration staff training
- Revise list of patient-facing phone numbers and improve call answering rates once baseline established |
| **Improve our patients' experience of waiting, both from referral to diagnosis and treatment and while waiting in the building** | **Geoff Bellingan** | - Deliver national standard for RTT (92%)
- Deliver national standard for diagnostic 6 week wait (99%)
- Improve patient perception of waiting time in outpatients (captured in our local surveys) |
| **Improve the quality and timeliness of our IT services** | **Nick Roberts** | - Ensure IT incidents are resolved within the defined SLA according to priority level |

**Improve patient pathways through innovation and collaboration with partners**
<table>
<thead>
<tr>
<th>Task Description</th>
<th>Responsible Person</th>
<th>Actions/Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with system partners to shorten waits for patients in our emergency department and avoid admission where possible</td>
<td>Charles House</td>
<td>- Deliver the A&amp;E four hour wait trajectory (this varies from 91%-95% per month)</td>
</tr>
</tbody>
</table>
| Shorten waiting times at all stages of the pathways for cancer patients         | Geoff Bellingan   | - Deliver the performance trajectory for the cancer 62 day standard (achieving 85% from Q2 onwards)  
|                                                                                |                   | - Deliver national standard for cancer 2 week waits (93%)  
|                                                                                |                   | - Deliver national standard for cancer 31 days (96%)  |
| Deliver earlier diagnosis for cancer patients across the sector through the Cancer Collaborative | Geoff Bellingan   | - Prepare to deliver earlier diagnosis (<28 day) standard ready for reporting in April 19.  
|                                                                                |                   | - Ensure cross sector metrics in place and so all providers aware of their performance against ITT requirements and actions plans in place, monitored by NCL and NEL and where needed by NHSI, to ensure delivery.  
|                                                                                |                   | - Implement best practice diagnostic pathways in line with the Cancer Collaborative delivery plan.  |
| Continue to develop our relationship with the Whittington in support of population health and prevention | Laura Churchward  | - Work positively to expand the hospital @ home programme  
|                                                                                |                   | - Develop innovative collaborative patient pathways  
|                                                                                |                   | - Progress projects in breast, bariatrics, general surgery, and maternity  
|                                                                                |                   | - Explore other areas of collaboration in finance, workforce, back office and estates, and community care  |
| Work with local and specialist STP partners to develop new pathways and support preventative care for local patients | Laura Churchward  | - Engage actively in STP urgent and emergency care; health and care closer to home; prevention; planned care and digital programmes  
|                                                                                |                   | - Provide leadership for the cancer vanguard (for North Central and North East London STPs) and better births work streams  
|                                                                                |                   | - Engage in specialist STP as pathway discussions emerge  
|                                                                                |                   | - Engage actively in the Haringey and Islington Well-being Partnership and Camden Local Care Delivery programmes  
|                                                                                |                   | - Work closely with primary care in the creation and support of integrated networks  |
| Deliver phase 4, phase 5 and ED development milestones                          | Geoff Bellingan, Gill Gaskin, Charles | - Programmes delivered in line with project milestones |
| Develop regional and national specialist services, working with our specialist partners in UCLP | Marcel Levi       | - Number of new/renewed or further developed services |
| Develop all our diverse staff to deliver their potential and foster talent     | Ben Morrin        | - Reduce vacancy rate to 8% (including corporate board)  
|                                                                                |                   | - 95% appraisals completed by end of September  
|                                                                                |                   | - Improve quality of appraisals as measured by staff survey  
|                                                                                |                   | - Deliver improvements to staff environment and facilities within the CQUIN plan  |
| Promote equality and inclusion and demonstrate we are an employer of choice    | Ben Morrin        | - To improve performance in the national staff survey results compared to the national average for acute trusts  
<p>|                                                                                |                   | - To improve the Trust's performance in the Overall Satisfaction domain in the GMC National Training Survey compared to the national mean.  |</p>
<table>
<thead>
<tr>
<th>Area</th>
<th>Responsible Party</th>
<th>Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the quality of education and development</td>
<td>Ben Morrin</td>
<td>- Deliver 85% workforce stability in line with CQC use of resource requirement</td>
</tr>
</tbody>
</table>
| Improve working conditions for junior doctors and other staff in training | Ben Morrin        | - Deliver plan for number of new apprentices in the trust  
- Increase number of staff on development programmes  
- 90% compliance with statutory and mandatory training |
| Develop our staff to achieve transformational change, particularly in research, productivity and digital programmes | Ben Morrin        | - Deliver plan to train 400 staff in quality improvement methodology  
- Complete delivery of the APA training programme and transition to BAU  
- Develop and deliver a comprehensive Epic training programme |
| Improve financial sustainability of UCLH and the wider health economy |                   |              |
| Achieve financial targets and deliver the cost improvement programme  | Tim Jaggard       | - Deliver CIP plan  
- Deliver the trust’s control total |
| Deliver clinical and non-clinical productivity efficiencies in line with the Carter agenda | Tim Jaggard       | - Introduce productivity assessment framework during Q1  
- Show improvement on more metrics than deterioration when reviewing ERIC estates and facilities benchmarking date for 2017/18 compared to 2016/17. (Q3)  
- Work with all areas of UCLH to help use the Model Hospital  
- Develop robust and appropriate operational metrics and targets in Q1. Track progress Q2-4. For example touch time theatre utilisation and length of stay. |
| Continue our leading role within the NCL and specialist sustainability and transformation partnerships (STPs) to support financial objectives | Tim Jaggard       | - SDT members to maintain leadership roles within STP, delivering STP milestones as they emerge  
- Work with partner organisations in North Central London to improve the financial sustainability of the Trust and the STP, and ensure financial incentives and payment mechanisms support these objectives |
| Improve management of commercial relationships                          | Tim Jaggard       | - Roll out best-practice contract model for contract management and communicate clearly across the organisation  
- Deliver significant value form more robust contract management, of at least £1m in 2018/19  
- Develop plans to provide a commercial and contract management support service to other NHS organisations |
| Achieve value for money from our assets and estate                    | Tim Jaggard       | - Develop revised long term financial model and estates strategy that delivers long term financial sustainability  
- Work with STP estates work-stream to support NCL-wide benefit  
- Reduce I&E impact of PFI charges to contribute towards cost improvement programme by at least £100K per year |
| Deliver more efficient use of non-pay resources                       | Medical Directors / Tim Jaggard | - Deliver pharmacy hospital transformation plan  
- Improvement as measured by a reduction in non-pay costs per weighted activity unit (WAU) when comparing 2018/19 to 2016/17  
- Deliver savings of £2,016m from the procurement CIP programme, and an additional £7.5m non-pay expenditure savings |
Proposed changes to the Standing Financial Instructions.docx
Report on Proposed Amendments to the Standing Financial Instructions and Scheme of Delegation

Board of Directors Meeting

9 May 2018

1. Introduction

The Trust has adopted Standing Financial Instructions (SFIs) and a Scheme of Delegation (SoD). Together with the Trust’s Standing Orders these provide a business and operational framework for the governance and regulation of the Trust’s business proceedings internally and for the discharging of responsibilities.

2. Purpose

The purpose of this paper is to present proposed amendments to the current SFIs and SoD.

SDT reviewed and agreed the proposed amendments to the SFIs and SoD on 7th March 2018. The Audit Committee reviewed and agreed the proposed amendments to SFIs and SoD on 20th March 2018. The proposed changes are now being presented to the Board for approval.

3. Proposal

The two main reasons for the amendments are:

- As part of the scheduled biennial review
- The imminent introduction of a new finance system, Oracle Cloud, which imposes certain system based requirements and limitations on the structure of the processes for approving procurement requests. The changes will standardise and simplify the approval process across the Trust.

The new approval framework is set out in Appendix A.

A tracked changed version of the full SFIs and SoD setting out all the amendments is also presented to the Board for approval. This document has been circulated to Board Members only.

4. Recommendation

The Trust Board to approve the proposed changes.

Following approval the updated version will be published. A detailed communications plan has been developed to manage the transition to the new structure.

Guy Dentith – Deputy Finance Director
Appendix A - Proposed Changes to Standing financial instructions.docx
Appendix A

The main development affecting the SFIs is the imminent introduction of a new finance system, Oracle Cloud, which imposes certain system based requirements and limitations on the structure of a procurement approval hierarchy.

Key changes required by the new system include:

- No facility to set up users with more than one approval level (the current SOD applies different approval thresholds for catalogue and non-catalogue spend; this is also the case for revenue and capital expenditure)
- The hierarchy takes a more linear form, with clear approval lines for each cost centre

The proposed new approval framework is outlined below:

<table>
<thead>
<tr>
<th>Role</th>
<th>Approval Limit</th>
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<tbody>
<tr>
<td>Finance Director</td>
<td>99,999,999*</td>
</tr>
<tr>
<td>Executive Directors</td>
<td>500,000</td>
</tr>
<tr>
<td>Heads of Finance</td>
<td>100,000</td>
</tr>
<tr>
<td>Level 2 Managers / DMs</td>
<td>100,000</td>
</tr>
<tr>
<td>GMs</td>
<td>50,000</td>
</tr>
<tr>
<td>Cost Centre Manager</td>
<td>25,000</td>
</tr>
<tr>
<td>Reviewer</td>
<td>0</td>
</tr>
<tr>
<td>Requisitioner</td>
<td>Any Value</td>
</tr>
</tbody>
</table>

These changes have been discussed and agreed by the Finance Leadership Team, and have been presented to, and approved by, SDT and Audit Committee.

*This limit is intended to ensure no transactions get stuck in the system without an approval route. It does not represent an approval limit, as approvals at high value will be approved in line with the SFIs, but allows POs for major contracts (such as the PFI unitary payment) to be raised and approved.
Appendix B - Updated SFIs (Track Changes - Pages 129 - 182 have been sent to Board members only
Finance Directors Report.docx
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST

FINANCE DIRECTOR’S REPORT TO THE BOARD OF DIRECTORS

9 May 2018

Brief Summary of the Report

This report updates the Board of Directors on the 2017/18 full year financial position and provides an update on the financial plan submitted to NHS Improvement on 30th April 2018.

The Board of Directors is asked to:

- Note the financial performance for the 2017/18 financial year,
- Note the changes to the financial plan submitted to NHS Improvement

1. Month 12 Position and Forecast

1.1 The March position shows an in-month operational deficit of £0.3m against a £1.0m surplus plan, an adverse position of £1.3m. The year to date position on the same basis is a £7.8m deficit, which represents an adverse variance to plan of £2.9m.

1.2 The overall control total performance was £28.7m in month, £26.0m year to date, resulting in a position £30.9m ahead of the control total for the year. Incorporating £38.1m of incentive STF in addition to £12.3m of core STF brings the year-end position (before completion of audit) to a surplus of £75.9m (excluding the impact of the reversal of impairments).

1.3 The summary financial position is shown in Table 1 below.

<table>
<thead>
<tr>
<th>Monthly Performance</th>
<th>Year-to-date</th>
<th>In-month</th>
<th>Annual Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget</td>
<td>Actuals</td>
<td>Variance</td>
</tr>
<tr>
<td>Trust</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Medicine</td>
<td>9.0</td>
<td>5.9</td>
<td>(3.2)</td>
</tr>
<tr>
<td>Specialist Hospitals</td>
<td>65.1</td>
<td>54.7</td>
<td>(10.3)</td>
</tr>
<tr>
<td>Surgery &amp; Cancer</td>
<td>11.1</td>
<td>10.8</td>
<td>(0.3)</td>
</tr>
<tr>
<td>Research &amp; Development</td>
<td>-</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Education</td>
<td>(3.2)</td>
<td>(2.6)</td>
<td>0.6</td>
</tr>
<tr>
<td>Corporate directorates</td>
<td>(174.6)</td>
<td>(176.2)</td>
<td>(1.7)</td>
</tr>
<tr>
<td>Other corporate budgets</td>
<td>156.8</td>
<td>166.4</td>
<td>9.6</td>
</tr>
<tr>
<td>EBITDA</td>
<td>64.2</td>
<td>59.5</td>
<td>(4.8)</td>
</tr>
<tr>
<td>ITDA</td>
<td>(69.2)</td>
<td>(67.2)</td>
<td>1.9</td>
</tr>
<tr>
<td>Income &amp; Expenditure before exceptional items</td>
<td>(4.9)</td>
<td>(7.8)</td>
<td>(2.9)</td>
</tr>
<tr>
<td>Other exceptional items (included within control total performance)</td>
<td>-</td>
<td>33.8</td>
<td>33.8</td>
</tr>
<tr>
<td>Performance against control total</td>
<td>(4.9)</td>
<td>26.0</td>
<td>30.9</td>
</tr>
<tr>
<td>Exceptional items (non-control total)</td>
<td>Donations/donated asset adjustments</td>
<td>-</td>
<td>(0.5)</td>
</tr>
<tr>
<td>Impairment reversals/(costs)</td>
<td>-</td>
<td>19.5</td>
<td>19.5</td>
</tr>
<tr>
<td>Core STF</td>
<td>14.7</td>
<td>12.3</td>
<td>(2.4)</td>
</tr>
<tr>
<td>Additional/incentive STF</td>
<td>-</td>
<td>38.1</td>
<td>38.1</td>
</tr>
<tr>
<td>Net surplus/(deficit)</td>
<td>9.8</td>
<td>95.4</td>
<td>85.6</td>
</tr>
</tbody>
</table>
1.4 The in-month position reflects an adverse position in the clinical boards of £0.5m. The main drivers of the in-month position within each of the clinical boards are detailed within sections 1.5 to 1.7 below.

1.5 Medicine Board reported an in-month position £0.5m worse than plan. This is driven by the Emergency Services Division (£0.4m), reflecting continued locum use and nursing pressures, combined with unidentified CIP.

1.6 Specialist Hospitals Board’s in-month position was £0.4m worse than plan. This was driven by Women’s Health (£0.7m) in-month. A number of factors have contributed to this position including consultant long-term sickness within gynaecology, unidentified CIP, ongoing staff shortages within neonatal nursing and a lower number of births than had been planned. PMO support has been allocated to the division and a recovery plan is in place.

1.7 Surgery and Cancer’s in-month position was £0.4m favourable to plan. This was driven in part by continued improvement in identification of drugs that should be recharged as well as by unused lists in theatres.

1.8 The other key adverse variances were within ITDA (£0.8m) where the estimate of profit share on investments was reduced (£1.4m), offset by a reduction in depreciation due to a movement to quarterly, rather than monthly depreciation of new assets.

1.9 Table 2 below shows the underlying position by clinical board. The full year underlying position is a deficit of £25.4m, £20.5m adverse to plan. Key non-recurrent items include profit on disposal of £30.5m and the release of Board contingency of £9.3m.

Table 2 – Month 12 Summary Financial Position

<table>
<thead>
<tr>
<th></th>
<th>M12 YTD variance as reported</th>
<th>Prior year clinical income gains</th>
<th>Balance sheet, one-off &amp; prior year adj.</th>
<th>M12 YTD underly’g variance</th>
<th>M12 YTD underly’g actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>(3.2)</td>
<td>0.1</td>
<td>(2.5)</td>
<td>(5.6)</td>
<td>3.5</td>
</tr>
<tr>
<td>Specialist Hospitals</td>
<td>(10.3)</td>
<td>-</td>
<td>(0.5)</td>
<td>(10.6)</td>
<td>54.3</td>
</tr>
<tr>
<td>Surgery &amp; Cancer</td>
<td>(0.3)</td>
<td>(0.4)</td>
<td>(2.0)</td>
<td>(2.7)</td>
<td>8.4</td>
</tr>
<tr>
<td>R&amp;D / T&amp;E</td>
<td>1.0</td>
<td>-</td>
<td>(0.8)</td>
<td>0.2</td>
<td>(3.0)</td>
</tr>
<tr>
<td>Corporate Directorates</td>
<td>(1.7)</td>
<td>-</td>
<td>(4.0)</td>
<td>(5.7)</td>
<td>(180.2)</td>
</tr>
<tr>
<td>Central Budgets</td>
<td>8.4</td>
<td>0.4</td>
<td>(7.9)</td>
<td>0.9</td>
<td>158.9</td>
</tr>
<tr>
<td>ITDA (before donation adj’s)</td>
<td>3.1</td>
<td>-</td>
<td>-</td>
<td>3.1</td>
<td>(67.2)</td>
</tr>
<tr>
<td>I&amp;E surplus/(deficit) - before exceptional items</td>
<td>(2.5)</td>
<td>-</td>
<td>(17.6)</td>
<td>(20.5)</td>
<td>(25.4)</td>
</tr>
<tr>
<td>Other control items</td>
<td>33.8</td>
<td>-</td>
<td>(33.8)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>I&amp;E surplus/(deficit) - control total basis</td>
<td>30.9</td>
<td>-</td>
<td>(51.4)</td>
<td>(20.5)</td>
<td>(25.4)</td>
</tr>
</tbody>
</table>
1.10 The graph below shows the in-month variance to plan (the red/green bars) and the cumulative variance from plan (the blue lines).

![Trust-wide 2017/18 financial performance (excluding exceptional items)](image)

1.11 The Trust’s cash balance at 31st March was £147.1m. This includes the receipt of EDH Tranche 1 (£28.6m) as well as prior year STF that had not been assumed/planned.

1.12 The Trust’s Better Payment Practice (BPP) performance showed that for the year to end of March 2018, 73% of the total value of invoices were paid within the agreed terms.

1.13 Of the £42m 2017/18 CIP target, £33.5m was delivered in-year (80% of target). The largest shortfall was in Specialist Hospitals Board (a £6.2m shortfall against a target of £15.1m, 59% delivery).

2. 2018/19 Financial Planning Update

2.1 The 2018/19 financial plan was submitted to NHS Improvement on 30th April.

2.2 Following NHSI confirmation of a reduction in the control total by £2m and of a deferral of education funding losses (£1.3m), the Trust accepted the control total of a £6.2m deficit before Provider Sustainability Funding (PSF).

2.3 The submitted CIP plan contained £42.5m of identified schemes, both local and trust-wide, against a target of £45m. Although almost all of the CIP target has been identified, there remain material risks within these plans of either delay or non-delivery. Detailed project plans have been developed and programme governance put in place for all large cross-cutting schemes. The revised governance structure in the Trust means that progress against these schemes is reviewed by the Senior Directors Team twice a month, with a rolling programme of deep-dives into Trustwide Schemes and Special Measures divisions.
2.4 PSF (previously STF) available in 2018/19 amounts to £20.7m and is being awarded on the same basis as in 2017/18. 70% (£14.5m) is available for achievement of the finance control total, the remaining 30% (£6.2m) being available for delivery of the 4-hour Emergency Department (ED) standard, if the financial control total has also been delivered.
Introduction

The purpose of this report is to set out the current recruitment and retention position at UCLH and a refreshed approach to improving our ability to attract and retain skilled staff into our hardest to fill areas which has been reviewed and endorsed by the SDT. This is the first staffing report provided to the Board of Directors and it is intentionally focused on resourcing into our substantive posts as this is one of the most challenging corporate tasks we face. In the coming financial year, it is forecast that there will be even more difficult market conditions for supply into key professional areas.

The focus of the paper is on nursing and midwifery and allied health professionals. Our medical and dental workforce strategy was considered at SDT in June 2017 and a guide to our progress on its content is at Appendix 1.

Other information concerning our staffing such as usage of bank and agency staff, length of time to hire, vacancy rates and other workforce key indicators such as sickness can be found in the CEO performance pack which is provided on a monthly basis. The Board of Directors is invited to make suggestions about content and areas of focus for future staffing reports.

Starting points

UCLH employs a workforce of 8036.5 full time equivalent staff (FTE), as at month 11, of which 18% is employed on a fixed term basis. A breakdown of FTE staff in post by professional group and by board is provided at Appendix 2.

Workforce trends

The overall trends in our establishment in terms of starters and leavers are detailed in Appendix 3. Our analysis shows that staff-in-post levels have increased by 291 FTE between month 1 and month 12 17/18 which represents a 4% increase in staffing levels over the year. However, our turnover rate has also increased to 13.4% (compared to 12.8% last year) and we have not achieved our turnover target of 13% for 17/18. Over 20% of all non-medical leavers leave within one year of service which equates to 19% of all new starters and nearly 1 in 10 new starters leave within 6 months of starting. Over half of appointees to band 5 nursing posts leave within 24 months.

We have probed a range of data including the financial ledger, the exemplar report, ESR, search response and agency usage data to ascertain those areas where resourcing is at greatest risk and in which vacancies are anticipated to remain above 10% across non-medical posts.

- Critical Care
- AMU
- GI
- Theatres and Anaesthetics
- Oncology
- Haematology
- Queen Square wards
- Neonates
• Maternity

In Allied Health Professionals; diagnostic radiography, specialist occupational therapy and physiotherapy at band 6 and 7 similarly face forecast vacancy levels at the same level.

Temporary staffing
The percentage of temporary staffing filled via Bank continues to increase from 89.4% in month 11 to 90.1% in month 12. Our overall performance in relation to temporary staff is strong; our bank fill rate is amongst the highest achieved in London, our reliance on agency staff is relatively low and our performance against the NHS Improvement (NHSI) agency rules and pay caps is amongst the best both in London and nationally.

Our new staffing bank model – also led by UCLH in the last year – allows for a similar united approach to temporary staffing which is relatively strong and from the summer should be ready to apply one of the most efficient staffing models – through direct engagement – utilised anywhere in the NHS.

Workforce planning
An integrated workforce and financial planning process is led through our clinical boards, supported by their embedded workforce and finance leads. This process ensures that workforce plans are strategically aligned, affordable and in accordance with the plans of our partners in health and social care. In developing their plans, we ask divisions to consider:

• Clinical productivity (e.g. reviewing long term bank and agency usage, improved job planning etc.)
• Workforce re-design
• Workforce benefits realisation
• Operational delivery (including seasonal fluctuation and recruitment lead-in times)

Our planning process also aligns with the workforce planning requirements of Health Education England, so we can inform commissioning decisions for future workforces. We have a strong relationship with our HEE and contribute to discussions on workforce risks, challenges and plans to ensure that any system level action required is taken in a timely fashion.

External factors influencing recruitment and retention
Ensuring stability of our workforce ahead of 2019 is essential to assure stability across our workforce in advance of EHRS’s initiation and the organisational turbulence it will involve alongside phase 4 and 5’s introduction.

There are a range of external factors that significantly impact on our ability to maintain our vacancy rate across UCLH and critically within our most hard to fill roles. Although there appears limited scope to address them quickly or without significant policy changes by national government or regulators, we are continuing to lobby on each.

Immigration from outside the EU
Since November 2017, 8 applications for certificates of sponsorship for foreign clinicians selected to join us, have been refused three times since January. This issue is not uncommon for Trusts. NHS Employers have escalated the issue with the Department of Health and Social Care and have written to the Home Secretary outlining the issue and recommending a solution.

Brexit
In 2016/17, UCLH saw an overall 50% decrease in EU starters in all staff groups and this only slightly increased in 2017/218 (Appendix 4), however we have seen a gradual decrease in the number of EU leavers (Appendix 4). The number of nurses and midwives from Europe
leaving the NMC register has increased by 67 percent, while the number joining the register from the EU has dropped dramatically by 89 percent. There is limited evidence of the impact of Brexit on AHPs; however demographic information about HCPC registrants indicate that we are most reliant on recruiting from Portugal, Italy and Greece with 42% of all registrants with an EU nationality.

**Drop in professional registration**

The Nursing and Midwifery Council (NMC) reported that in July 2017, for the first time there were more nurses and midwives leaving the register than joining it. The number of UK graduates leaving the profession has increased by nine percent (Appendix 5). The student funding reforms in 2015 shifted the funding of undergraduate nursing courses in England away from a centrally commissioned system. Universities no longer have a cap on the number of places they can offer but equally, nurses no longer have access to bursaries and have instead to take out student loans. Forecasting analysis suggests the combination of these restrictions and funding reforms will most severely impact on parts of the UK where costs of living are at their highest including the capital.

**Recruitment in 2018-19**

In 2018/19 our recruitment efforts will target those sources where we have typically proved able to compete well in NHS markets, for: newly qualified nurses, international nurses, nurses working in the private sector and nurses already in the NHS. In addition, the head of medical workforce and workforce intelligence is leading fresh initiatives to drive workforce planning and has identified new ways of working for our AHP, N&M and M&D workforce which inform our current intent for refined roles and retraining. We intend to refresh our ‘UCLH starts with u’ campaign with new staff fronting a fresh marketing approach.

**Targets**

In order to reduce the vacancies in nursing and midwifery we have considered the number of average leavers, the average growth in establishment and the target vacancy rates we wish to achieve (Appendix 6). Our relative reliance on those incoming routes over this and the last three years is detailed below.

<table>
<thead>
<tr>
<th>Recruitment Source</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19 (predicted)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FTE</td>
<td>%</td>
<td>FTE</td>
<td>%</td>
</tr>
<tr>
<td>NHS</td>
<td>382</td>
<td>55%</td>
<td>262</td>
<td>67%</td>
</tr>
<tr>
<td>Private health/social care</td>
<td>47</td>
<td>7%</td>
<td>19</td>
<td>5%</td>
</tr>
<tr>
<td>Newly qualified nurses (including staff from postgraduate education)</td>
<td>80</td>
<td>12%</td>
<td>31</td>
<td>8%</td>
</tr>
<tr>
<td>International - EU</td>
<td>59</td>
<td>9%</td>
<td>7</td>
<td>2%</td>
</tr>
<tr>
<td>International - Non-EU</td>
<td>72</td>
<td>11%</td>
<td>15</td>
<td>4%</td>
</tr>
<tr>
<td>Other (source not specified on new starter paperwork)</td>
<td>49</td>
<td>7%</td>
<td>59</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Nursing associates</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Nursing apprentices</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| Total               | 689 | 100%| 393 | 100%| 354 | 100%| 550 | 100%

Our assessment is that there is little prospect of increasing international supply (which we’ve normally regarded as the prime route to fill any non UK supply) and so our quest is to increase the number of newly qualified students we take on – early indications suggest we will. Yet current assumption is that our total forecast will still leave us with a vacancy rate of 7.5-10% for nurses and midwives. The most realistic action we can take to guard against any higher rate, is to invest in retention – as detailed in the closing section of this report. In the medium term we should look to new supply routes to offer fresh routes of registered nursing supply – so from September with £250k recently secured from HEE – we intend to welcome our first nursing associates on to a 3 year programme designed to allow for their professional registration, from 2021. Apprenticeship growth offers the most significant opportunity for high VFM selection into sub band 5 selection into all professional roles.

**International supply**
The Filipino and Indian markets offer a field of nurses for band 5 posts and the greatest opportunity to recruit into our most challenged areas. In March, the SDT endorsed two international recruitment campaigns in the Philippines and India with Kings Commercial, our contracted partner for international recruitment, in May and September 2018. Intelligence indicates that we will get 40 nurses into post for each campaign. The economic justification for recruitment is clear but only where UK sources offer no prospect of supply in the short or medium term. We intend to pilot a skype assessment process with a number of suppliers which will reduce the costs of international recruitment.

**Routes of supply for AHPs**
To date there has not been a centralised approach to international recruitment for AHP roles, however, individual services are experiencing enquiries from international candidates and have, for example, recruited from Australia and South Africa. For the first time there is a realistic prospect to recruit to AHP roles via a skype process with Drake Medox. They have offered us 28 radiographers to interview across specialties (including sonographers) of which 50% are already HCPC registered. We will also have access to interview staff across specialist occupational therapy and physiotherapy, areas which continue to have high vacancies.

**Action on remaining hot spots**
Recruitment advisors, the responsible HR business partners and head of resourcing review progress against local recruitment plans on a monthly basis. In areas where vacancy levels are in the worst quartile of the trust, the Workforce Director and Chief Nurse (for nursing and midwifery) have initiated additional in-depth reviews to learn of progress and consider flexibilities and investments that may promote swifter progress. In three of the areas where such meetings have been held since the New Year (cancer, endoscopy and neonates) progress is significant.

**Recruitment process**
The speed of our recruitment processes benchmark well against the latest NHSI and NHSE corporate benchmarks. The main area national analysis suggests we have most scope to improve relates to race equality and gender. In our latest self-assessment in January, we found that in the prior six month period, white shortlisted candidates were 45% more likely to be offered a post than black and ethnic minority candidates. In 2016, the difference had been
higher and reached 69%. UCLH is not an outlier on this metric and the causes of this variation are multi-faceted and owe to inequalities that affect candidates before they enter the job market. Nevertheless, for an organisation that has proved itself to be at the vanguard of global recruitment into research and clinical posts, we should be concerned that there is institutional bias in our resourcing approaches.

NHS trusts have commonly applied two forms of address to such a challenge: some have applied trust-wide changes which have led to a mandate of an independent BME panellist on every interview panel (RFL, East London FT, Bradford Community FT). Others have sought independent reviews by expert advisory consultancies to refine their resourcing approach. Our assessment is that neither approach is right for us; that our progress in recent years and international staff base is distinctive and that any resourcing process changes should be targeted - in areas where the workforce least well reflects London’s population. On that basis, we propose we test changes where our gender pay analysis and workforce race equality standard (WRES) results suggest the greatest imbalance in our current workforce.

Our biannual WRES report and our first gender pay report show that the representation of BME staff and female staff at the most senior grades is not representative of our overall workforce. The percentage of BME staff in posts at AfC 8C and above is between 6% and 8%, whereas the percentage of BME staff in posts at Band 6 to 8A is between 32% and 40%. The percentage of female staff at the most senior posts, is similarly unrepresentative of our overall workforce. Indeed, at VSM/director level the gender pay gap is 44.6%, i.e. female staff in these grades earn on average 44.6% less than the average male staff.

The SDT have agreed that, for any senior management posts at AfC 8B and above (so roles at around £60k+ per annum), if any internal BME and/or female candidate is shortlisted but not successful at an interview panel, the chair of the panel should complete a one-page development assessment detailing recommendations that could help the candidate secure such a post in future. For internal candidates, this would then be provided to their MD/corporate director and the Education Director so they could consider the contribution they could make to invest in that plan. Such an approach is being tested by some peers in the NHS in the coming year. We intend to design such a model following consultation internally and with fellow interested trusts, apply it from the summer, and return to the SDT with an evaluation of its impact, one year on.

**Retaining our staff**

The new workforce framework in our strategic refresh focuses on four domains for action: right staff, right way, right capabilities and right leadership. ‘Right staff’ is focused on us becoming an employer of choice by offering employees what is important to them in the workplace giving us the ability to recruit the employees that UCLH need.

Earlier data in this paper suggests that even with proactive resourcing planning there will remain areas of workforce shortage and a risk of growing turnover, for which the most compelling solutions are to focus on retention.

The SDT devoted time to considering this issue in March 2018 and have agreed a plan to take trust wide action to tackle universal areas of concern for our staff, as well as targeted interventions to identify and address the barriers to creating positive working environments. We will probe the fundamental causes of staff loss in priority professional areas and the form of incentives that would prove of greatest value to candidates, staff and us as an employer as part of this work.

Focused work is already underway to improve retention amongst our nursing and midwifery workforce through the development of new initiatives that directly address known causes of lower staff satisfaction and turnover, including:
• greater flexibility to retain the over 50’s workforce;
• development of clinical academic posts to grow the research culture amongst non-medical professionals, and
• extension of the careers clinic to provide enhanced career support.

Our overall progress to deliver the follow-through actions in relation to our staff survey results will be monitored by the retention and recruitment group. Helpful additional insight will come from near complete survey evidence from Ipsos Mori who we commissioned - with STP funding - to probe the fundamental causes of staff loss in priority professional areas and the form of incentives that would prove of greatest value to candidates, staff and us as an employer. Our intention is that the findings of that research directly inform the bids we submit to charitable sources for fresh non-pay benefits and staff environmental improvements - as detailed in the accompanying paper.

Next steps

The Board of Directors is asked to

• note and comment on our strategic approach to resourcing, and
• make suggestions about areas of focus for future staffing reports.

Kate Price
Deputy Director of Workforce
Medical Workforce Plan: Update on recruitment and retention

The junior doctor establishment has been reviewed by service and finance. Work is currently being undertaken to reflect this position on both the general ledger and ESR- this will be done by the end of the financial year. The Medical Workforce Team are in the final phase of agreeing with the clinical boards an expedited process for processing vital/urgent posts for recruitment. Funding has been agreed to support an increased establishment for the Medical Workforce Team to support rapid and focussed response to junior doctor vacancies. We are now training new members of the team and from 1st April 2018, each division will have a dedicated Medical Workforce Officer to support their recruitment and retention needs. (The funding for this team has only been agreed for 1 year.).

From 1st May 2018, trust doctor recruitment will also move to the Medical Workforce Team, which will streamline the way we manage the junior doctor establishment into one team. The team will be reviewing the trust doctor contract to bring it in line with the 2016 junior contract. We will also be looking at the way these doctors are managed in relation to revalidation and their personal and professional development and setting a standard for the trust to make our trust doctor posts more attractive. To further align the medical workforce recruitment process, the responsibility for consultant recruitment will move to Medical Workforce from 1st November 2018.

The table below illustrates the number of vacancies that are actively being recruited to at the current time:

<table>
<thead>
<tr>
<th>Board</th>
<th>Number of Vacancies Currently Actively in Recruitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Services</td>
<td>6</td>
</tr>
<tr>
<td>Critical Care</td>
<td>3</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>1</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>3</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>1</td>
</tr>
<tr>
<td>Medicine Board Central Team</td>
<td>1</td>
</tr>
<tr>
<td>Pathology</td>
<td>1</td>
</tr>
<tr>
<td>Queen Square</td>
<td>11</td>
</tr>
<tr>
<td>RNTNE Hospital</td>
<td>1</td>
</tr>
<tr>
<td>Surgical Specialities Division</td>
<td>10</td>
</tr>
<tr>
<td>Theatres and Anaesthetics</td>
<td>1</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>Grand Total</strong></td>
</tr>
</tbody>
</table>

The Medical Workforce Team will take a proactive approach to medical workforce recruitment and retention which will include:

- reviewing the medical workforce establishment and highlighting in advance where vacancies will be occurring;
• proposing and supporting new recruitment strategies to fill posts before these vacancies become an issue, including the clinical research fellowship programme initiated by Professor Marcel Levi and Chief Registrar posts;
• actively challenging areas with vacancies which are not being recruited to;
• streamlining job descriptions and adverts to ensure that they are attractive to potential candidates, whilst setting clear expectations on salary and requirements;
• monitoring all submitted EC1s for medical workforce to ensure that the basics are correct, including grade, salary information, tenure and position numbers, which will support the trust to improve its management of the junior doctor establishment and ensure that we are recruiting for the positions we need (for example, recent review of EC1s has highlighted that grades on the forms are not always consistent with the salary indicated, which if not resolved upfront will cause delays later in the recruitment process);
• providing expert advice on the terms and conditions of medical workforce to avoid miscommunication and agreements that have led to increased costs in the past; and
• Partnering with recruitment agencies to focus on recruiting to our hard to fill posts.
## Staff in Post

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Trust</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Corporate Functions</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Medical Board</th>
<th></th>
<th></th>
<th>Medication Board</th>
<th>Specialist Hospital Board</th>
<th></th>
<th>Surgery and Cancer Board</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Staff in Post FTE</td>
<td>8036.5</td>
<td></td>
<td>835.2</td>
<td></td>
<td>1585.1</td>
<td></td>
<td>3071.5</td>
<td></td>
<td>2544.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Add Prof Scientific and Technical</td>
<td>337.3</td>
<td>4.2%</td>
<td>12.3</td>
<td>1.5%</td>
<td>131.5</td>
<td>8.3%</td>
<td>118.8</td>
<td>3.9%</td>
<td>74.7</td>
<td>2.9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>991.0</td>
<td>12.3%</td>
<td>22.1</td>
<td>2.6%</td>
<td>258.5</td>
<td>16.3%</td>
<td>377.4</td>
<td>12.3%</td>
<td>333.0</td>
<td>13.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>1822.9</td>
<td>22.7%</td>
<td>617.7</td>
<td>74.0%</td>
<td>248.2</td>
<td>15.7%</td>
<td>502.4</td>
<td>16.4%</td>
<td>454.6</td>
<td>17.9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>532.8</td>
<td>6.6%</td>
<td>9.4</td>
<td>1.1%</td>
<td>140.8</td>
<td>8.9%</td>
<td>177.6</td>
<td>5.8%</td>
<td>205.1</td>
<td>8.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>165.0</td>
<td>2.1%</td>
<td>1.7</td>
<td>0.2%</td>
<td>12.4</td>
<td>0.8%</td>
<td>107.8</td>
<td>3.5%</td>
<td>43.1</td>
<td>1.7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>227.5</td>
<td>2.8%</td>
<td>6.5</td>
<td>0.8%</td>
<td>7.6</td>
<td>0.5%</td>
<td>134.2</td>
<td>4.4%</td>
<td>79.2</td>
<td>3.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>1387.6</td>
<td>17.3%</td>
<td>50.8</td>
<td>6.1%</td>
<td>268.4</td>
<td>16.9%</td>
<td>582.0</td>
<td>18.9%</td>
<td>486.5</td>
<td>19.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>2558.2</td>
<td>31.8%</td>
<td>114.8</td>
<td>13.7%</td>
<td>517.7</td>
<td>32.7%</td>
<td>1057.2</td>
<td>34.4%</td>
<td>868.6</td>
<td>34.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students</td>
<td>14.0</td>
<td>0.2%</td>
<td>0.0</td>
<td>0.0%</td>
<td>0.0</td>
<td>0.0%</td>
<td>14.0</td>
<td>0.5%</td>
<td>0.0</td>
<td>0.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Establishment trends – starters and leavers

The budgeted establishment has increased by 522 full time equivalent (fte) since March 2017 and there has been an increase of 288 full time equivalent (fte) staff in post. The overall number of staff in post has steadily increased in 2017/18. The overall trust turnover rate has increased slightly from 12.8% to 13.6%, and the nursing and midwifery turnover rate has increased from 14.2% to 16.1%.

In the last year we have recruited 1444 new staff to UCLH, of which 493 were nursing and midwifery registered staff. In September we saw high numbers of new nursing and midwifery starters at 75.8, the most new starters since November 2015. However, there have been 1256 leavers of which 444 were nursing and midwifery registered staff. Since April 2017 we have had 122 new AHP starters and 124 leavers. As a result, we continue to have high vacancy levels in some specialities where there are recognised national shortages of skilled staff and which are becoming more challenging to fill from UK supply.

Registered nurse leavers averaged 32 FTE per month in 2015/16 and 2016/17 in 2017/18 so far they have averaged 35 FTE per month. Starters averaged 56 FTE per month in 2015/16, 34 FTE per month in 2016/17 and 41 FTE per month in 2017/18. Leavers peak in autumn, around Christmas and at the end of the financial year in March. Starters meanwhile show an even stronger peak in the autumn, when our overseas recruitment campaigns have coincided with NQNs (Appendix 1).

In nursing and midwifery, nearly half of all band 5 nurse leavers leave between 1 and 2 years of service. Relocation was the predominant reason for leaving with it being cited twice as many times as any other reason (38%).

Nursing trends

The graph below shows the average number of leavers between 2015 – 2018.
The graph below shows the average number of starters between 2015 – 2018.

![Nursing Starters (Average 2015 - 2016)](image)

The graph below shows the average number of starters and leavers and cumulative difference.

![RN Starters v Leavers (Average 2015 - 2018)](image)
APPENDIX 4

Starters at UCLH

Leavers at UCLH
APPENDIX 5

Staff leaving the NMC register

<table>
<thead>
<tr>
<th>Country</th>
<th>October 2015 to September 2016</th>
<th>October 2016 to September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>26,653</td>
<td>29,019</td>
</tr>
<tr>
<td>Europe</td>
<td>2,435</td>
<td>4,067</td>
</tr>
<tr>
<td>Rest of the world</td>
<td>2,090</td>
<td>2,277</td>
</tr>
<tr>
<td>Total</td>
<td>31,178</td>
<td>35,363</td>
</tr>
</tbody>
</table>
The table below shows the estimated number of new recruits required to achieve a 7.5% vacancy rate:

<table>
<thead>
<tr>
<th>N&amp;M registered</th>
<th>Average leavers</th>
<th>Number of new starters to maintain vacancy rate (including growth)</th>
<th>Current vacancy rate</th>
<th>Target vacancy rate</th>
<th>Target number of new recruits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>400</td>
<td>500</td>
<td>8.9%</td>
<td>7.5%</td>
<td>550</td>
</tr>
</tbody>
</table>

| AHP registered | 90              | 120                                                          | 8.7%                | 7.5%              | 187                           |
UCLH STAFF SURVEY

REPORT TO BOARD OF DIRECTORS, MAY 2018

Background
The most recent NHS staff survey closed on 1st December 2017. Responses were received from 40.5% of our eligible staff (3307 individuals); further information on our response rate can be seen in appendix 1.

Reporting is made available to us via two methods; raw data for the 88 questions from our contractor Picker, and NHS England’s key findings data covering 32 summary indicators based on the survey questions. The NHS England data is published nationally and enables benchmarking against any NHS organisation in England.

UCLH is included within the ‘acute trust’ benchmarking group comprising of 92 organisations. Key findings are only made available for the 23 divisions with the highest response rates. Key findings are provided as either:

- percentage scores: this is the percentage of staff giving a particular response to one, or a series of, survey questions; and
- scale summary scores: staff responses to questions are converted into scores. The minimum score is always 1 and the maximum score is 5.

Overall, key findings for acute trusts have remained largely stable with a decline in some areas such as staff motivation at work and the overall engagement score - the engagement metric is referenced in further detail in a later section of this paper. The indicators that have been highlighted as concerns for UCLH have all either remained stable or seen a slight decline across the average for acute trusts.

The SDT has reviewed our staff survey results and agreed to:

- a programme of seven initiatives to address staff concerns;
- seek UCLH charity funding for those initiatives, as an executive priority for 2018/19;
- each line manager working in a division where the incidence of bullying and harassment and / or discrimination is above the average to being set an objective to lead credible action to improve staff experience; and
- DMs and DCDs in the identified ‘hotspot’ areas being invited to provide local action plans as to how they will prioritise and improve their staff survey results in 2018/19.

UCLH’s results

Key findings
The key findings’ results for UCLH have remained stable, with 31 key findings seeing no significant change. One metric, ‘staff motivation at work’, has decreased significantly from 3.93 in 2016 to 3.89 in 2017. This is representative of decline at a national level. Our overall results have been considered at Senior Directors Team (SDT) and a programme of actions, described later in this report, have been endorsed subject to obtaining funding.

Engagement score
Each organisation receives a summary engagement score calculated by NHS England, determined from the indicators in appendix 2. Our overall engagement score for 2017 is
3.88, compared to a national average of 3.79. This represents a drop of 0.01 in our score and compares to a mean reduction of 0.02 for acute trusts.

We continue to see a wide breadth of experience being reported by staff, which is evident through their engagement scores and not typical for peers whose results are typically more consistent. Appendix 3 provides ranked staff engagement scores by division. 73% of our divisions are reporting above national average engagement (78% in 2016). This represents seven divisions reporting a lower score than national average (four in 2016), with nine divisions seeing a drop in their score against 2016.

Top and bottom ranking scores
Our top-ranking results place us in the highest 20% against acute trusts; pleasingly nine key findings fall into this compared to seven for 2016, listed in appendix 4.

There are seven indicators for which we fall into the worst 20% of acute trusts; these have largely remained the same for the past four years and are listed in appendix 5.

Each of these indicators has been identified as a concern in the previous two surveys, having scored in the worst 20% with the exception of two that are noted in appendix 6, which were previously ‘below average’. SDT recognise that these weaker results are concerning, and in particular are aware that it is exceptional for an organisation to have such results and sustain a strong patient experience offering, and that the CQC will expect a credible response within our well-led plan. Appendix 6 provides the ranked performance of each division against these indicators.

Our response
We have undertaken thorough analysis of our staff survey results, and have looked to current credible academic research (listed in appendix 7), our peers in the NHS and the wider business community to craft our response. SDT have considered and endorsed the following programme of targeted interventions to identify and address the barriers to creating positive and inclusive working environments that allow our staff to deliver the care they aspire to. As importantly, we will work to further understand why some areas are able to demonstrate improvements and achieve results that are continuously strong, whereas others report consistently weaker scores and their management focus on staff experience appears relatively unclear and not obviously strategic.

We have seen with the implementation of the charitably-funded ‘Where do you draw the line?’ campaign that investment in staff experience can make a tangible difference. Eastman Dental Hospital in particular has seen a vast improvement in their score for percentage of staff experiencing bullying, harassment or abuse from other staff of 14%, alongside a 14% improvement in staff reporting of these incidents. The campaign has been embedded well in this area, with strong leadership from the DCD to ensure that the campaign message and dialogue around staff experience are prioritised. Similar feedback and progress is notable in Cancer – which has devoted division wide and team specific time to focus on the campaign and supporting appreciative inquiries. In areas where the campaign or an equivalent doesn’t appear to have been taken up and poorer behaviour hasn’t been consistently challenged, our results are notably weaker.
A fresh programme: seven proposals

This programme of renewed and new initiatives looks to tackle the causal themes behind poorer staff experience and engagement, with a focus on those that build a positive organisational climate, greater inclusivity and strong team environments in which staff feel safe, supported and engaged. This should allow staff to develop their capabilities, support co-workers, build resilience and have a greater perception of organisational support. We anticipate this programme will require c£1.5 million initial investment over an 18 month period, and we will in turn prioritise this theme within our pending dialogue with the UCLH charity in relation to trust wide investment in 2018/19.

1. A management development pathway:
   Many of most credible studies stress the causality between investing in line manager support and having well-functioning teams, and it is well evidenced that local management is a critical factor in determining individual experience. To apply a credible platform for management development we will first need to:
   - Standardise management job descriptions and bandings across the trust;
   - Determine a capability framework for managers;
   - Develop clear career pathways; and
   - Undertake a training needs assessment.

   Alongside this, we will explore how to best utilise the knowledge and experience of those managers supporting divisions that have scored well, and how they can provide coaching and mentoring assistance for those managers supporting lower performing areas. There are a number of associated benefits, including having standardised roles on ESR and reducing the resource needed for job matching panels. A supporting proposal from the Education Director will be presented to SDT in May which takes this initiative further and considers developing a programme that would support managers to identify and develop talent. That in turn will reflect our interest to search for, recruit and develop talent from backgrounds less well represented in our middle and senior management tiers.

2. A staff self-care wellbeing programme:
   The Royal College of Nursing recently launched their ‘Rest, Rehydrate, Refuel’ programme, highlighting the criticality of meeting these basic needs to deliver safe and effective care to patients. This follows the inclusion of promoting rest breaks, improved access to food and drink 24/7 and wellbeing support by NHS Improvement in their recommendations for junior doctors. Their campaign adopts a similar methodology to the Royal College of Anaesthetists autumn research publication on fatigue which argued that employers needed to secure far better space for staff to rest. We propose developing a UCLH branded campaign highlighting the importance of staff wellbeing and self-care, demonstrating that this is a priority for UCLH as an employer and providing the building blocks for our teams to shape healthier working relationships, improved ways of working and better patient outcomes. Given the success of a recent short-term project to provide free food to staff working at night during winter pressures we are interested to enhance the campaign approach by investigating how we may provide our staff free or lower cost food and drink at key times.

   Furthermore, we intend for this programme’s design to have a focus on the mental health of our workforce. With 41% of our staff suffering from work related stress, and only 36% believing we take positive action on health and wellbeing, we need to do more to ensure
the mental wellbeing of our staff is a priority. We are aware that a higher proportion of staff self-identify as having a disability through the staff survey than through other routes such as via the recruitment process or on ESR, and that this comprises a number of staff that do not feel confident to disclose a mental health condition to us as an employer.

3. A new phase of ‘Where do you draw the line?’
Trust-wide promotional activities will continue throughout 2018; in particular we will see ‘Where I draw the line’ interviews from our staff and marketing materials shared throughout our sites, and will work with divisions seeing improvement in their results to understand what additional activities can be rolled out. April’s leadership forum was devoted to a follow-up session to the initial launch in September 2017, and showcased case studies on what activities have been undertaken.

Using our staff survey results to identify the areas that require further support to embed the campaign, we propose the following additional measures be carried out:

- Appreciative inquiry – this is an intervention that has already seen success in areas such as GI. A number of our HR Business Partners are skilled and experienced in carrying out appreciative inquiry and we propose that they facilitate sessions with management and teams;
- Cultural observation and diagnosis – Our Staff Psychological and Welfare team has the expertise and training to undertake targeted diagnostic work to better understand the nature of the problem, and to work with the areas to create action plans; and
- Coaching and mentoring for managers – through the existing coaching and mentoring programme we propose that further support is given to aid the personal and professional development of managers. This would also link with the Consensio programme for managers, which equips individuals with the skills to identify and manage conflict, which is currently open to all managers at a band 7 and above and has received excellent feedback during this past year.

4. Focussed support for areas with relatively poor staff experience
For those areas highlighted in this year’s staff survey as reporting a poorer staff experience we propose undertaking additional diagnostic and interventional work. We intend to begin with forming a multi-disciplinary team involving HR colleagues, staff experience, OD and the Staff Psychological and Welfare service with support from our Quality Improvement team to look in further detail at our staff survey, alongside additional reporting such as exemplar ward surveys, the GMC survey, the staff friends and family test, data from our employee relations team and feedback from our guardian service.

This year’s results suggest that the following areas require additional support to improve their scores in relation to our top concerns:

- Theatres and Anaesthetics
- Emergency Services
- Critical care
- Queen Square
- RNTNEH
- Women’s Health
These areas have consistently reported lower scores and require a focussed approach to both understand why staff experience is poorer and what actions need to be taken to drive improvement. Such work should not be an external intervention but framed to support managers and contribute towards explicit divisional action plans identifying how they will prioritise and progress their staff survey results for 2018/19.

5. Modernising celebrating excellence
Celebrating excellence has proved a popular annual scheme allowing us to recognise exceptional performance in support of our values and vision. In 2016, we extended our awards programme to include an additional winter event recognising exceptional commitment during periods of demanding activity and refreshed the annual award structure, meaning that in 2017 over 20% of the organisation were involved as nominees, winners or finalists. Recognising excellence is something we should do through the year and seek to involve a greater proportion of our staff in, and so we are interested to consider the form of events that could recognise exceptional commitment through 2018/19 and SDT have committed to involve the executive and Board in playing a personal commitment in meeting staff across the hospitals to recognise their contribution.

6. Regular check-ups:
The current national surveys form and centralised procedure does not allow trusts to react with timely action. Indeed, staff who choose not to complete it most commonly feedback that they don’t feel UCLH has listened and reacted to what they said.

We propose procuring a crowdsourcing platform to deliver both our staff survey and a more continuous and comprehensive programme to engage with staff, particularly in relation to specific concerns highlighted in the survey, the hotspot areas identified and to evaluate interventions taken. This data would be used to develop a thorough staff experience dashboard, alongside key metrics such as turnover, sickness absence, temporary staffing spend and patient experience scores to produce a regular set of reporting for trust managers, enabling them to open up a two-way dialogue around staff experience and develop action plans. Deep dives would be used within hotspot areas with additional activity such as focus groups, additional targeted surveys and pulse checks. New social enterprises and research units have entered the NHS market in the last year offering to provide such service inclusive of the provision of staff survey results within 48 hours of the survey closing. The base cost for such a service is not significantly more than we afford our current provider and this function is affordable within the workforce directorate’s budget for 18/19. Imperial and Barts are similarly minded to switch to such a model by this autumn.

Being able to provide improved data on staff experience will allow managers to better understand the links between ward climate and staff wellbeing, and how this impacts on patient experience and outcomes. It is critical that the experience of our staff is monitored, understood and analysed on a regular basis from team to board level, to allow for a culture in which staff feel listened to, prioritised and supported.

7. Ensuring the safety and security of our staff
Our staff survey results have highlighted that in certain areas across the trust our staff are suffering from a growing level of abuse, violence and aggression from patients. We propose undertaking a bespoke project in the areas identified (maternity, emergency
services and AMU), working with staff to ensure we have clear and practical processes that:
- highlight to patients what behaviours are unacceptable, and how these will be dealt with
- support staff to identify and handle these situations, including instances when a patient may be mentally vulnerable
- set clear guidance on how staff should manage and escalate issues with abusive patients, including removal from the hospital if necessary, to best ensure the safety of our staff; and
- identify how to manage repeat offenders

Work to develop these proposals into tangible plans is being informed by feedback gathered from senior colleagues at a dedicated leadership forum in April and from the most recent Council of Governors meeting. Leads for each proposal have been identified to take this work forward in partnership with our staff and the leads of each of our staff networks. We will mirror the successful approach we have taken to develop the bullying and harassment campaign, ‘where do you draw the line?’ by ensuring that our staff are engaged in shaping and developing each element of work so that each end-product reflects the needs and wishes of our staff.

In addition to endorsing the above proposal and seeking charitable funding to support it as an executive priority for 2018/19, SDT have agreed that:

- each line manager working in a division where the incidence of bullying and harassment and / or discrimination is above the trust average will be set an objective to lead credible action to improve staff experience; and
- DMs and DCDs in the identified ‘hotspot’ areas will be invited to provide local action plans as to how they will prioritise and improve their staff survey results in 2018/19.

Finally, in the parallel report on staffing being considered at the May Board of Directors meeting, we have set out a number of changes that we propose to test where our gender pay analysis and workforce race equality standard (WRES) results suggest the greatest imbalance in our current workforce.

An update on these actions and further plans will be provided to the UCLH Workforce Committee/the successor SDT sub group for assurance in the coming months; alongside the recruitment and retention group and Diversity and Equality Steering Group for their input.

The Board of Directors is asked to review our staff survey results, comment on our initial findings and our actions.
Appendix 1: Further information on our response rate

Our response rate of 40.5% suggests a 4.1% decrease compared to 2016, though the actual number of individuals completing the survey increased by 29. The drop in our overall percentage rate is due to changes in national guidance, resulting in eligible staff who left during the 2017 survey period being counted as non-respondents. This is in contrast to previous years, in which staff who left the trust during the survey period were removed from the eligible staff list and did not count towards the final response rate. It should be noted that this guidance affected all NHS organisations, though the average response rate for acute trusts has remained stable at 44%.
Appendix 2: Indicators used to calculate engagement

The engagement score is calculated based on our scores for the following key findings:

- Staff recommendation of the trust as a place to receive work or treatment
- Staff motivation at work
- Staff ability to contribute to improvements at work
Appendix 3: Engagement scores by division

Green – above trust average
Amber – in line with trust average (allowing for 0.03 variance)
Red – below trust average

<table>
<thead>
<tr>
<th>Division</th>
<th>2017 Engagement Score</th>
<th>2016 Engagement Score</th>
<th>2017 vs 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Nurse Division</td>
<td>4.09</td>
<td>4.12</td>
<td>-0.03</td>
</tr>
<tr>
<td>Pathology</td>
<td>4.08</td>
<td>3.96</td>
<td>0.12</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4.05</td>
<td>4.11</td>
<td>-0.06</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>4.04</td>
<td>4.04</td>
<td>0.00</td>
</tr>
<tr>
<td>Cancer Services</td>
<td>4.01</td>
<td>3.97</td>
<td>0.04</td>
</tr>
<tr>
<td>Infection</td>
<td>3.99</td>
<td>4.02</td>
<td>-0.03</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>3.98</td>
<td>3.87</td>
<td>0.11</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>3.96</td>
<td>4.03</td>
<td>-0.07</td>
</tr>
<tr>
<td>Other</td>
<td>3.95</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Critical Care</td>
<td>3.94</td>
<td>3.93</td>
<td>0.01</td>
</tr>
<tr>
<td>Performance &amp; Partnership</td>
<td>3.94</td>
<td>3.84</td>
<td>0.10</td>
</tr>
<tr>
<td>Workforce</td>
<td>3.93</td>
<td>3.98</td>
<td>-0.05</td>
</tr>
<tr>
<td>Clinical Support</td>
<td>3.87</td>
<td>3.93</td>
<td>-0.06</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>3.86</td>
<td>3.85</td>
<td>0.01</td>
</tr>
<tr>
<td>Queens Square</td>
<td>3.86</td>
<td>3.88</td>
<td>-0.02</td>
</tr>
<tr>
<td>Finance</td>
<td>3.85</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>RNTNE Hospital</td>
<td>3.82</td>
<td>3.74</td>
<td>0.08</td>
</tr>
<tr>
<td>Theatres and Anaesthetics</td>
<td>3.78</td>
<td>3.81</td>
<td>-0.03</td>
</tr>
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<td>Women's Health</td>
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<td>3.79</td>
<td>-0.01</td>
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<td>Imaging</td>
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<td>Education</td>
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<td>Eastman Dental Hospital</td>
<td>3.70</td>
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<td>-0.03</td>
</tr>
<tr>
<td>Research &amp; Development</td>
<td>3.65</td>
<td>4.03</td>
<td>-0.38</td>
</tr>
</tbody>
</table>
Appendix 4: Indicators in which UCLH scored in the highest 20% of acute trusts

- Percentage of staff appraised in the last 12 months (92% compared to a national average of 86%)
- Quality of appraisals (3.32 compared to a national average of 3.11)
- Percentage of staff reporting errors, near misses or incidents witnessed in the last month (previously scored above average; 93% compared to a national average of 90%)
- Staff recommendation of the organisation as a place to work or receive treatment (3.99 compared to a national average of 3.75)
- Percentage of staff able to contribute towards improvements at work (previously scored above average; 74% compared to a national average of 70%)
- Percentage reporting good communication between senior management and staff (39% compared to a national average of 33%)
- Percentage agreeing their role makes a difference to patients / service users (previously above average; 91% compared to a national average of 90%)
- Effective use of patient / service user feedback (3.84 compared to a national average of 3.71)
- Percentage experiencing physical violence from patients, service users of members of the public (12% compared to a national average of 15%)

UCLH has fallen out of the top 20% and into ‘above average’ for ‘fairness and effectiveness of procedures for reporting errors, near misses and incidents’ (3.79 compared to a national average of 3.73).
Appendix 5: Indicators in which UCLH scored in the lowest 20% of acute trusts

- Percentage of staff experiencing bullying, harassment or abuse from staff in the last 12 months (32% compared to a national average of 25%)
- Percentage of staff experiencing discrimination at work in the last 12 months (19% compared to a national average of 12%)
- Percentage of staff believing the trust provides equal opportunities for career progression / promotion (77% compared to a national average of 85%)
- Percentage of staff working extra hours (77% compared to a national average of 72%)
- Percentage of staff feeling unwell due to work related stress in the last 12 months (41% compared to a national average of 36%)
- *Percentage of staff experiencing bullying, harassment or abuse from patients, relatives and members of the public in the last 12 months (31% compared to a national average of 28%)
- *Percentage of staff witnessing potentially harmful errors, near misses or incidents in the past month (33% compared to a national average of 31%)

*Denotes that this indicator has moved into scoring in the worst 20% of acute trusts, from previously being 'below average'
Appendix 6: Performance against our top concerns by division

Green – above trust average
Amber – in line with trust average (allowing for 0.03 variance)
Red – below trust average

<table>
<thead>
<tr>
<th>Division</th>
<th>% experiencing bullying, harassment and abuse from staff in the last 12 months</th>
<th>% experiencing bullying, harassment and abuse from patients, relatives and members of the public in the last 12 months</th>
<th>% of staff experiencing discrimination at work in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatrics</td>
<td>14</td>
<td>Performance and Partnership</td>
<td>0</td>
</tr>
<tr>
<td>Pathology</td>
<td>16</td>
<td>Information Technology</td>
<td>8</td>
</tr>
<tr>
<td>Information Technology</td>
<td>18</td>
<td>Education</td>
<td>9</td>
</tr>
<tr>
<td>Education</td>
<td>20</td>
<td>Workforce</td>
<td>10</td>
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<tr>
<td>Performance and Partnership</td>
<td>23</td>
<td>Finance</td>
<td>10</td>
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<tr>
<td>Clinical Support</td>
<td>26</td>
<td>Research and Development</td>
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<td>Gastrointestinal</td>
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<td>Trust Average</td>
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<tr>
<td>Cancer Services</td>
<td>28</td>
<td>Pathology</td>
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<td>Chief Nurse</td>
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<td>Chief Nurse</td>
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<tr>
<td>Medical Specialties</td>
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<td>Eastman Dental</td>
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<tr>
<td>Infection</td>
<td>31</td>
<td>Theatres and Anaesthetics</td>
<td>18</td>
</tr>
<tr>
<td>Trust Average</td>
<td>32</td>
<td>Clinical Support</td>
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<td>Queen Square</td>
<td>32</td>
<td>Gastrointestinal</td>
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<td>Surgical Specialties</td>
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<td>Cancer Services</td>
<td>21</td>
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<tr>
<td>Imaging</td>
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Overall Page 216 of 347
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<td>% of staff feeling unwell due to work related stress</td>
<td>% of staff witnessing potentially harmful errors, near misses or incidents in the past month</td>
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<td>Workforce</td>
<td>49</td>
<td>Emergency Services</td>
<td>89</td>
</tr>
</tbody>
</table>
Appendix 7: Academic sources researched to develop our response

NHS England report published February 2018; *Links between NHS staff experience and patient satisfaction: Analysis of surveys from 2014 and 2015*

NHS Employers report published July 2014; *Staff experience and patient outcomes: what do we know?*

Royal College of Physicians report published March 2015; *Work and Wellbeing in the NHS: why staff health matters to patient care*

Point of Care Foundation report published 2014; *Staff care: how to engage staff in the NHS and why it matters*

NHS National Institute for Health Research report published November 2012; *Exploring the relationship between patients’ experience of care and the influence of staff motivation, affect and wellbeing*

NHS Improvement, NHS Providers and the Faculty of Medical Leadership and Management report published October 2017; *Eight high impact actions to improve the working environment for junior doctors*

Department of Health and Social Care report published August 2011; *NHS staff management and health service quality*

The King’s Fund report published 2012; *Employee engagement and NHS performance*

NHS England report published March 2018; *Employee engagement, sickness absence and agency spend in NHS trusts*
This paper reports on the progress of the EHRS Programme for the period March to April 2018.

1. Programme Plan

The programme plan showing the implementation overview for EHRS is set out in Diagram 1 below.

Diagram 1 – Implementation Overview

This diagram shows key milestones on the EHRS programme plan since July 2017 that are completed (✔) or are on track to be completed (☑) at the appropriate time in Phase 2.
We are currently ON TRACK and ON BUDGET against plan although there are risks that are being actively managed, as set out below.

2. Dashboard

The Dashboard in Table 1 shows the status of the 17 EHRS work-streams during April 2018.

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
<th>Apr-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Design</td>
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<tr>
<td>2. Build</td>
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<tr>
<td>3. Developments</td>
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<tr>
<td>4. Reporting</td>
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<tr>
<td>5. Integrated Areas</td>
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<tr>
<td>6. Interfaces &amp; Contracts</td>
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<tr>
<td>7. Technology</td>
<td></td>
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<tr>
<td>8. Testing</td>
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<tr>
<td>9. Training</td>
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<tr>
<td>10. Operational Readiness</td>
<td></td>
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<tr>
<td>11. Go-Live</td>
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<tr>
<td>12. Benefits Management</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>13. People Readiness</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>14. Communications</td>
<td></td>
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<tr>
<td>15. Programme Control</td>
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<td>16. Financial Control</td>
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<tr>
<td>17. Assurance</td>
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</table>

- Satisfactory (on track)
- Watch (up to 10% off-track)
- Serious (over 10% off-track)

3. **Design.** The workflow build phase contains four waves of workflow build ending in mid-July, each followed by a set of Adoption sessions. The clinical content build phase contains 6 cycles of clinical content design and build ending in November 2018. During March, we completed the first of the 6 clinical content design sessions.

4. **Build.** 99% of Wave 1 workflows were completed in March 2018. Build is currently behind schedule. Details of mitigations are set out in Section 4 below.

5. **Developments.** We continue to track Epic software developments in Epic’s development tracking tool. There are currently over 10 software developments in varying stages of the development cycle, including those for the Patient Administration System, Pharmacy (Willow), Ambulatory, Cancer Waiting Times, Clinical Coding and Caboodle (data warehouse). We will decide if we want to take such developments and flag if they become significant either in terms of their impact on timeline or costs.
6. **Reporting.** Last month’s Programme Board agenda included a paper on Business Intelligence/Reporting and one on Clinical Coding. We have confirmed our decision to use Epic’s data warehouse (called Caboodle) to be the main vehicle for operational and external reporting and that the current data warehouse (called URSA) will be replaced at go-live with a new, externally developed, billing processing engine at least until such time as Epic development avoids the need for a third party system.

7. **Integrated Areas.** 26 of the 27 integrated (cross-module) areas defined by Epic are either in a green (satisfactory) or amber (watch) status. The exception is “Patient Safety Surveillance Lead” where we will be confirming, by the middle of May 2018, the detail of how our Safety Surveillance function will be delivered. We already have mechanisms in place to deliver many of the tasks required during design and build (for example, the Medication Safety Committee leads have reviewed every design decision related to medication) and designated pharmacists outside of the build team are checking every medication entry in the database. We will identify areas of workflow risk for specific focus during testing and training and will put in place specific safety surveillance measures in the Go-Live period, over and above the trust’s routine quality and safety monitoring. Stephen Cone, our CMIO, holds the nationally-required role of Digital Clinical Safety Officer.

8. **Interfaces and Contracts.** The Interface team is behind schedule on pre-testing steps for interfaces due to interface staff recruitment and certification delays and an unexpected staff departure. A mitigation plan has been agreed and is being deployed including re-structuring of roles to enable certified staff to do less project management work and more interface build work. In March, the Commercial Directorate added external commercial expertise to the team to help complete Interface contracts with third party suppliers. This is recognised to be a challenging process in every implementation and our Commercial Director is closely involved.

9. **Technology.** In March, the Atos and Digital Services plan to roll-out Windows 10 devices over the next year in preparation for EHRS go-live was completed. This allows the installation of new hardware alongside retaining sufficient capability to run legacy systems until Go-Live and beyond where necessary. The technical workstream is on track. The Epic hardware platform was upgraded in February and the newer (Actual Non-Production) platform was delivered in April 2018, both on-time.

10. **Testing.** The Testing work-stream is on-track. Recruitment has commenced for 5 applications testing and 5 technical testing staff.

11. **Training.** The Training work-stream is on-track. All Principal Trainer posts have now been filled and the post-holders have started work on creating training materials. Detailed analysis has been undertaken on the options for additional “credentialled” trainers and specialist clinical trainers and for superusers and floorwalkers at Go-Live. A schedule of training time for these groups and for organisational “end-users” is being finalised and the team is working closely with the Workforce team, who in turn are in discussion with Staff Partners, on how this will be integrated into rostering and leave. This is on the agenda of the May programme board.
12. **Operational Readiness.** The Operational Readiness work-stream is on-track. The Operational Readiness Owners (largely Divisional Managers and Corporate department heads) are meeting regularly. This work-stream has the challenge of designing and embedding sound operational processes to the required timescale e.g. for outpatient scheduling. A paper on activity planning around the go-live period is being taken to the 9 May Programme Board meeting.

13. **Go-Live.** Most of the go-live readiness planning activity commences in June 2018. In April, the PMO met with Estates and Finance to assess options for locating the Go-Live Command Centre in view of UCLH’s multi-site estate.

14. **Benefits Management.** The key areas of benefit were confirmed at a Trust Leadership Forum in February. Gill Gaskin and Dr Rishi Das-Gupta, Director of Innovation, are reshaping the APA (Access and Patient Administration) and outpatients redesign work to align with EHRS design and build. A Benefits Manager is being recruited and liaising with the NHS Digital Global Digital Exemplar Team on benefits management.

15. **People Readiness.** Lisa Hancock has gathered feedback from Subject Matter Experts to help shape preparation for our Adoption and Clinical Content sessions and organised for end-to-end demos of the Epic system to be shown during Adoption 2 sessions in April.

16. **Communications.** Regular updates to Clinical Boards and Divisions continued in March and April and positive and constructive feedback was received. Gerrie Coetzen, the EHRS Communications Manager, has expanded the use of the EHRS Engagement App by Subject Matter Experts and Operational Readiness Owners. He has also assisted with the communication of key scoping decisions to the appropriate stakeholders. Survey feedback after Adoption sessions suggests a high degree of positivity about the EHRS programme amongst those attending, and some areas where we can improve our planning.

17. **Programme Control.** In March, the Programme Management Office implemented a refreshed weekly cycle of meetings to: (a) coordinate the individual work-streams; (b) review the Decisions, Issues and Risks Logs; (c) review off-track tasks on the programme plan and (d) escalate issues and decisions to the weekly Escalation Group chaired by G Gaskin. This has been helpful in resolving delays to build more rapidly.

18. **Financial Control.** The EHRS Programme is currently on-budget. Cost pressures related to build recovery are being managed against an available contingency through a financial change control process. Some additional costs are expected related to the finalisation of the scope.

19. **Assurance.** We have organised for external experts to advise the SRO and the Programme Team on preparedness at key points and stage gates of the programme timeline: between the build and testing phases, between the testing and training phases, and prior to go-live. Chris Belmont, the ex-CIO of MD Anderson, and Maurits Ros, the IT Director at Amsterdam Medical Centre, are at UCLH on 3 and 4 May to conduct a
baseline review of the programme. We have invited two senior clinicians from Cambridge to provide programme assurance from a clinical safety perspective and they have accepted the invitation.

20. Accomplishments to date

The main EHRS accomplishments during March and April 2018 were as follows:

(a) Design and Build

The EHRS Decisions Log currently has 598 decisions logged of which 68 are outstanding and waiting for decision. The Chief Medical Information Officer (CMIO), Chief Nursing Information Officer (CNIO), Chief Research Information Officer (CRIO) and Director of Innovation were instrumental in helping our 16 module teams to close down decisions needed to inform build.

(b) Adoption 2

Adoption cycle 2 was completed between 17 and 19 April with a high level of Subject Matter Expert attendance and engagement. A survey of attendees was administered and 54 attendees responded. 39 SMEs responded to the question: “how do you feel about the EHRS Programme?” and their answers are shown as follows:

Q6: Overall, how do you feel about our EHRS programme at UCLH?

The spread of respondents is set out as follows:
(c) Technical Work-Stream

The Epic hardware platform (Actual Non-Production) was delivered on 16 April 2018, as scheduled. The Windows 10 and Epic end-user devices roll-out plan was reviewed and agreed at the April Programme Board. Atos has commenced a survey of UCLH’s wifi capability and capacity to inform the extent to which our wifi infrastructure may need to be upgraded for Epic go-live.

(d) Collaboration with Cambridge University Hospitals (CUH)

A CUH team of 5 people came to visit UCLH in April for half a day to guide us through the build of Referral to Treatment (RTT) rules as part of our PAS build.

We continue to hold fortnightly meetings with representatives from GOSH to collaborate on Epic systems development and training work-streams. Currently, we are in discussion with GOSH to jointly review Emergency Care Data Set requirements and how these can be configured in Epic.

(e) Governors

On 13 April, Rishi Das-Gupta and David Kwo met with the Council of Governors to discuss the following topics as requested by the Governors: patient portal, technology, training, go-live, radiology, and Teletracking. There was a high level of support and enthusiasm for EHRS displayed amongst the Governors.

(f) Super Users

Work on the role of Super Users in testing, training and go-live has progressed and the role will be publicised in May and nominations invited.

21. Current Key Challenges

The current key challenges, and mitigations, for the EHRS programme are set out as follows:

(a) Build

We are currently approximately 3 weeks behind on the cumulative Wave 0-4 build target. However, over the past two weeks, most build teams have now stabilised their build rate at the required recovery rate. Build teams have complex jobs with competing demands
including organising meetings with subject matter experts and managing their questions and requests, working with multiple teams and Epic representatives and learning new skills, as well as delivering the actual application build. Subject matter experts are themselves juggling many priorities.

In order to catch up on build in time for testing on 23 July, a weekly Escalation Group, chaired by Gill Gaskin, has been set up to agree actions for high priority issues. The Chief Medical Information Officer (CMIO), Chief Nursing Information Officer (CNIO), Chief Research Information Officer (CRIO) and Director of Innovation have scheduled dedicated time each day to help the build teams remove build blockers alongside SMEs.

Our build recovery plan includes: weekly task plans for each builder in each team, increased team leader action and accountability, dedicated build days and quiet areas, use of additional remote Epic build staff and on-site multi-certified, ex-Epic, contractor build staff to be funded by EHRS staffing contingency, as approved by TJ and GG.

(b) Contracts

We are currently behind on the closure of interface contracts with approximately 70% of the 19 contracts in the first set due for completion by 5 May. It is likely that we will be at 50% at this time. These delays are impacting interface testing timelines.

To manage these issues, Dom Firth the Commercial Director is involved in twice weekly Contracts review meetings, alongside the technical team, to expedite contract completion. We report contracts status to Tim Jaggard and Gill Gaskin each week and escalate actions requiring executive interventions.

(c) Decisions

There have been a number of key scope decisions outstanding during this period and most of these decisions are now made.

22. Board Action

The Board of Directors is requested to note the progress being made in the EHRS Programme and is invited to make any comments or suggestions.

Dr Gill Gaskin, Medical Director, Specialist Hospitals Board and EHRS Programme SRO
David Kwo, Director of EHRS and Informatics
3 May 2018
Health and Safety Annual Report
2017 18.pdf
Report to the Board of Directors Meeting

9 May 2018

Health and Safety Annual Report

The Health and Safety Annual Report for 2017/18 provides assurance to the Board that UCLH has put in place appropriate standards to manage the risks associated with health and safety. The report outlines issues and activities undertaken during the year. It analyses health and safety-related incidents reported on Datix which have increased by 10%. There has also been an increase in the number of incidents reportable to the Health and Safety Executive (RIDDORs) with detailed analysis. It reports on the annual health and safety risk assessment process and on mandatory training compliance for related courses. It identifies as the top priority for action in 2018/19 the development of a new and innovative approach to reducing violence, aggression and abuse to which staff are subject and to improving the support offered to staff.

The Board is asked to approve the Health and Safety Annual Report.
1 Executive summary

Legislation sets minimum standards for the management of health and safety and includes the need for organisations to manage risk by undertaking risk assessments and putting in place controls to either remove or reduce risk so far as is reasonably practicable. Health and Safety at University College London Hospitals (UCLH) NHS Foundation Trust aims to meet these requirements and the report outlines issues and activities between 1st April 2017 and 31st March 2018.

The overall number of reported incidents has increased by 10%. There have been significant increases in the some incident types which are discussed in Section 3.

There has been an increase of 21% in the number of Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) reports to the Health and Safety Executive (HSE). The number of 7-day injuries has increased from 10 to 26, but the number of injuries reported in 2016/17 was unusually low and reporting 26 incidents is in line with the number of injuries reported by similar acute trusts. Specified injuries for staff and visitors and over-7 day injuries for staff must be reported to the HSE, along with specified patient injuries or deaths that have arisen out of or in connection with work activity. For example, if a patient falls out of bed and suffers a fracture and the care plan had identified the need for bed rails but these had not been provided, then this would be reportable under RIDDOR. There was one specified patient injury in 2017/18 where a patient fell when entering a lift. It was alleged that the lift car may have been out of alignment with the lobby floor and this has been investigated. With all occupational exposures, the Occupational Health team sends a root cause analysis email to line managers. The occupational health team continues to work closely with infection control and procurement to increase the use of safety devices for giving injections and other procedures that are reliant on the use of sharps.

The annual review of health and safety risk assessments ensures that divisions and corporate directorates are complying with the UCLH risk assessment process. Returns were received from all divisions and directorates. Detailed feedback is provided to divisional managers and provides advice on where improvements can be made.

Care of the back (e-learning) was completed by 89% of staff, a fall of 3% from 2016/17. Face to face moving and handling training has been completed by 82% of staff, a fall of 4% from the previous year. 88% of staff had completed mandatory fire training (no change from 2017/18).
2. Introduction

UCLH is required to ensure the health, safety and welfare of its employees, patients, visitors and members of the public. Failure to comply with the Health and Safety at Work Act 1974 and its associated regulations could lead to potential harm to the groups mentioned above and the possibility of criminal proceedings or other enforcement action.

Non-compliance may result in a breach of the requirements of Care Quality Commission (CQC), NHS Litigation Authority (NHSLA), the Health and Safety Executive (HSE) etc. leading to further action from those bodies. Serious breaches of Health and Safety legislation can also have a damaging effect on the reputation of UCLH, a loss of public confidence, increase in litigation and claims, increase in staff absence and a reduction in staff motivation.

3. Progress against the priorities identified for 2017/18

The 2017/18 Health and Safety Action Plan focussed on five priorities:

- **Reducing violence and aggression** – the Preventing and Managing Violence and Aggression (PMVA) Steering Group reviewed the content of the training programmes to better support staff. These are now delivered by an in-house PMVA trainer/adviser. He is also available to provide on-site support to our staff and provide tailored training where this is appropriate. There has been good engagement with our nursing colleagues, but we need to ensure there is wider engagement with other clinical staff groups going forward. The Health and Safety Committee continues to review all physical assaults to provide assurance that staff are supported, that incidents are thoroughly investigated and that lessons are learned.

We recognise that there is still much to do to ensure that our staff are safe and supported when in the workplace. This has been identified as the top priority for action in 2018/19 and we are currently considering new and innovative ways to progress this using a multidisciplinary team approach.

- **Reviewing the format of the health and safety quarterly incident report to incorporate RIDDOR reports** – the new simplified reporting format was introduced in November 2017.

- **Ensuring that there are processes in place to report RIDDORs to the Health and Safety Executive within the prescribed timescales** – revised processes were introduced and work well providing that divisions and departments ensure that work-related incidents involving staff sickness are reported in a timely fashion and not when the member of staff returns to work following a period of sickness. There remain some concerns about the reporting of patient incidents in a timely fashion which will be explored in 2018/19.
• **Reviewing the risk assessment audit process** – for the 2017/18 risk assessment audit all divisions and directorates received feedback reports; returns were received from all divisions and directorates.

• **Ensuring that the Health and Safety Committee is aware of and monitors all the health and safety-related risks on the UCLH Risk Register** – this new process was introduced in Autumn 2017 and will be evaluated in 2018/19.

4. **Health and Safety Incidents**

4.1 **Non-clinical Incidents - Overview**

Non-clinical incidents and near misses are reported by UCLH staff via the Datix incident reporting system. Incidents are reviewed quarterly at the Health and Safety Committee. The data can be found in Table 1. There have been significant increases in the following incident types:

- IT-related incidents (this peaked in the summer of 2017 at the time of the switch over of IT support contractors but started to reduce in the winter of 2017/18; all incidents were investigated by the Digital Services team)
- Radiation exposure incidents have increased by 67% (these are investigated by radiation physics and on-going training and guidance is provided to staff in the areas and are considered at the Radiation Protection Advisory Committee)
- Communication and confidentiality issues have increased by 64% - these include communication failures within local teams and breaches of confidentiality
- Waste disposal incidents have increased by 49% - this includes issues with sharps and incidents and these are investigated by the Capital Estates and Facilities Directorate (CEFD)
- Environment and estates issues have increased by 27% - these include cleaning-related issues, lift-related issues, floods, temperatures too hot or cold, pest infestations and broken facilities and are investigated by CEFD
- Staffing issues have increased by 19% - these are actively monitored by the Deputy Chief Nurses. Where ‘red flags’ are identified (when nursing tasks are delayed or where less than two nurses are on duty), an investigation is undertaken and appropriate action taken. UCLH staffing levels are published on the UCLH website.
- Abuse (violence and aggression) incidents have increased by 8% - the levels of violence and aggression continue to be a concern and the proposed actions to address this issue are discussed in more detail in section 4.2.

The number of fire and security incidents has fallen.

The number of sharps and splash incidents has fallen. These incidents are reported to the UCLH Trust Infection Control Committee. A quarterly high-level report is circulated to all Matrons, Divisional Clinical Directors, Medical Directors, Deputy Chief
Nurses and ward/departmental sisters and charge nurses. More detailed information is also sent to the infection control team on a monthly basis. All incidents are followed up by the occupational health team. This is discussed in more detail in section 4.4.

Table 1: Staff and public non-clinical incidents April 2017 to March 2018

<table>
<thead>
<tr>
<th>Category</th>
<th>General areas UCH/EGA</th>
<th>Corporate Functions</th>
<th>Medicine Board</th>
<th>Specialist Hospitals Board</th>
<th>Surgery and Cancer Board</th>
<th>Total 2017/18</th>
<th>Percentage</th>
<th>Total 2016/17</th>
<th>Percentage Change</th>
<th>Total 2015/16</th>
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<tbody>
<tr>
<td>Accidents/Injuries/illness</td>
<td>5</td>
<td>2</td>
<td>60</td>
<td>127</td>
<td>83</td>
<td>277</td>
<td>10.7</td>
<td>279</td>
<td>-1%</td>
<td>317</td>
</tr>
<tr>
<td>Abuse – alleged or actual</td>
<td>12</td>
<td>11</td>
<td>182</td>
<td>281</td>
<td>128</td>
<td>614</td>
<td>23.8</td>
<td>569</td>
<td>+8%</td>
<td>499</td>
</tr>
<tr>
<td>Communication and Confidentiality</td>
<td>2</td>
<td>28</td>
<td>29</td>
<td>55</td>
<td>37</td>
<td>151</td>
<td>5.8</td>
<td>92</td>
<td>+64%</td>
<td>83</td>
</tr>
<tr>
<td>Environment / Estates issues</td>
<td>36</td>
<td>4</td>
<td>35</td>
<td>96</td>
<td>35</td>
<td>206</td>
<td>8.0</td>
<td>162</td>
<td>+27%</td>
<td>230</td>
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<tr>
<td>Fire Safety*</td>
<td>38</td>
<td>7</td>
<td>18</td>
<td>44</td>
<td>31</td>
<td>138</td>
<td>5.3</td>
<td>202</td>
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<td>227</td>
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<td>15</td>
<td>16</td>
<td>18</td>
<td>59</td>
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<td>13</td>
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<td>Sharps/body fluid incidents</td>
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<td>3</td>
<td>76</td>
<td>107</td>
<td>78</td>
<td>265</td>
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<td>284</td>
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<tr>
<td>Radiation – unnecessary exposure</td>
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<td>1</td>
<td>3</td>
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<td>15</td>
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<td>9</td>
<td>+67%</td>
<td>12</td>
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<tr>
<td>Security*</td>
<td>37</td>
<td>7</td>
<td>36</td>
<td>44</td>
<td>25</td>
<td>149</td>
<td>5.8</td>
<td>161</td>
<td>-8%</td>
<td>224</td>
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<tr>
<td>Staffing Issues**</td>
<td>0</td>
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<td>143</td>
<td>340</td>
<td>166</td>
<td>653</td>
<td>25.3</td>
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<td>18</td>
<td>23</td>
<td>16</td>
<td>58</td>
<td>2.2</td>
<td>39</td>
<td>+49%</td>
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</tr>
<tr>
<td>Total</td>
<td>131</td>
<td>77</td>
<td>618</td>
<td>1136</td>
<td>628</td>
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<td>100%</td>
<td>2357</td>
<td>+9.7%</td>
<td>2563</td>
</tr>
</tbody>
</table>

* Fire and Security annual reports are available from Rod Townley, General Manager for Fire and Security
** includes ‘Staffing issues’ that have been recorded as affecting staff and patients

4.2 Violent incidents

Table 2 shows the number of incidents of assault, abuse and aggression against our staff which increased by 8% in 2017/18. This is in line with the national picture for the NHS where violence against staff is increasing year on year.

The NHS Staff Survey shows that UCLH is in the lowest (best) 20% of all acute trusts for the number of staff experiencing physical violence from patients, relatives and the public in the last 12 months but is in the highest (worst) 20% of all acute trusts for the number of staff experiencing harassment, bullying or abuse from patients, relatives
and the public in the last 12 months. UCLH has an average score for reporting violence, harassment, bullying or abuse; this is in line with the local concern that verbal assault and aggression is under-reported.

**Table 2: Abuse against UCLH staff: 2013/14 to 2017/18**

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical assault</td>
<td>104</td>
<td>105</td>
<td>98</td>
<td>140</td>
<td>146</td>
</tr>
<tr>
<td>Sexual assault</td>
<td>3</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Verbal assault</td>
<td>244</td>
<td>203</td>
<td>133</td>
<td>195</td>
<td>260</td>
</tr>
<tr>
<td>Aggression</td>
<td>95</td>
<td>156</td>
<td>235</td>
<td>200</td>
<td>194</td>
</tr>
<tr>
<td>Staff bullying</td>
<td>0</td>
<td>11</td>
<td>13</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>Racial abuse</td>
<td>7</td>
<td>7</td>
<td>16</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>453</td>
<td>489</td>
<td>499</td>
<td>569</td>
<td>614</td>
</tr>
</tbody>
</table>

There has an increase of 4.3% in the number of physical assaults. There were 146 physical assaults and 3 sexual assaults in 2017/18; the main divisions reporting such incidents were:

- Queen Square – 46 incidents
- Emergency Services – 35 incidents
- Medical Specialties – 27 incidents
- GI Services – 8 incidents
- Critical Care – 7 incidents

All physical assaults are reviewed by the Health and Safety Committee. Changes have been made to Datix to improve the quality and timeliness of investigations into physical assaults by managers and to ensure that the staff affected are offered appropriate support. Affected staff are contacted directly by the Staff Psychology and Welfare Service to ensure they are aware of support options available, but local support is variable. As part of “neighbourhood policing”, a dedicated police squad of three officers was set up in April 2017 to protect hospital staff from violent patients at UCLH, the Royal Free, the Whittington and GOSH. Our security team works closely with this team to protect our staff, but the number of police prosecutions remains low.

Table 2 shows that there is a concerning upward trend in the number of staff reporting verbal abuse/assault. This is corroborated by the information from the 2017 national staff survey results for UCLH (Key Finding 25) which show that 31% of UCLH staff have experienced harassment, bullying or abuse from patients, relatives or the public during the reporting period. The staff survey data and anecdotal evidence suggests that there is significant under-reporting of these types of incidents on Datix. There is a view that the pressures currently affecting the NHS is impacting on this increase in
aggression. 465 incidents of verbal abuse and aggression were reported in 2017/18. The main divisions reporting such incidents were:

- Queen Square – 98 incidents
- Women’s Health – 79 incidents
- Emergency Services – 51 incidents
- Cancer Services – 38 incidents
- Surgical Specialties – 34 incidents

Reducing the number and impact of verbal assaults and aggression by patients and visitors on staff will be the priority action for 2018/19.

The requirements of mandatory training were reviewed and a new form of training was introduced in April 2017, along with tailored support and training for departments. This new training is called Prevention and Management of Violence and Aggression (PMVA) training and has four levels of training. Training is conducted by a dedicated in-house trainer. The number of high risk divisions has been extended to include Paediatrics and Adolescent Services and Medical Specialties wards; training has also been made available to other groups, including receptionists and staff in the Cancer Centre. Compliance for conflict resolution training is based on a Training Needs Assessment. At the end of March 2018, PMVA training compliance was as follows:

- PMVA Level 1 (e-learning) 93.7% compliance
- PMVA Level 2 (classroom) 83.6% compliance
- PMVA Level 3 (disengagement/assault avoidance) 32.0% compliance
- PMVA Level 4 (physical intervention skills) 8.6% compliance

PMVA training at levels 2, 3 and 4 includes time to discuss verbal abuse, in particular looking at how this is as unacceptable as physical abuse. Options to de-escalate difficult situations are considered and staff are encouraged to report all incidents on Datix. The PMVA trainer works closely with the Trust Security Adviser.

There are ongoing discussions as to the level of training which is appropriate for different areas. There is a view that staff in the Accident and Emergency Department should be trained to Level 3 rather than to Level 4 which leaves security staff to manage difficult and challenging patients. Some staff have expressed concerns about the manner and level of force used to restrain patients identified as at risk of harm by clinical staff, e.g. when trying to prevent patients from leaving the department. More effective management of difficult patients and visitors will be a priority action for 2018/19.

This programme of work is overseen by the multidisciplinary PMVA steering group, with representation from nursing, security, learning and development, health and safety, occupational health and staff psychology and welfare. The group has been tasked with identifying ways of reducing the levels of violence and abuse experienced by UCLH staff and reports to the Health and Safety Committee.
In summary, current actions to reduce violence and aggression are centred on:

- Enhanced training to a wider audience of staff
- Better support for staff affected by violence and aggression
- Encouraging staff to report incidents
- Ensuring that incidents are investigated thoroughly, that risk assessments are reviewed and mitigating actions taken to prevent future occurrences
- Ensuring that there is a trust-wide approach to zero tolerance - with appropriate action being taken when patients and relatives behave in a criminal way.

5. Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR)

5.1 All RIDDOR reportable injuries are investigated by Health and Safety. Where there are identifiable failings in procedure, equipment or infrastructure, action is taken to prevent a recurrence. All RIDDOR reportable incidents are reported quarterly to the Health and Safety Committee. This includes investigation, recommendations and action plans where appropriate.

Figure 1: RIDDOR reportable incidents: 2013/14 to 2017/18

Figure 1 above shows that overall there has been a 21% increase in the number of RIDDOR reports to the HSE during 2017/18. The number of 7 day injuries was very low in 2017/18 and is now closer to pre-2016/17 levels. The number of dangerous occurrences has reduced slightly.
Table 3 RIDDOR Reports 2017/18

RIDDOR April 2016 to March 2017

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Injured while handling, lifting or carrying</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Physically assaulted by a person</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>5</td>
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<td>1</td>
</tr>
<tr>
<td>Slipped, tripped or fell on the same level</td>
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<td>1</td>
<td>3</td>
<td>10</td>
<td>3</td>
<td>10</td>
<td>4</td>
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<td>1</td>
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<tr>
<td>Struck against or hit by object</td>
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<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
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<td>Another kind of accident</td>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
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<tr>
<td>Total</td>
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Over 7 day injuries

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</thead>
<tbody>
<tr>
<td>Injured while handling, lifting or carrying</td>
<td>7</td>
<td>5</td>
<td>12</td>
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<td>6</td>
<td>6</td>
<td>4</td>
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<td>Physically assaulted by a person</td>
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<td>1</td>
<td>0</td>
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<td>0</td>
<td>1</td>
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</tr>
<tr>
<td>Slipped, tripped or fell on the same level</td>
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<td>3</td>
<td>3</td>
<td>10</td>
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<td>10</td>
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<td>1</td>
</tr>
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<td>Struck against or hit by object</td>
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<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Another kind of accident</td>
<td>1</td>
<td>1</td>
<td>1</td>
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Disease

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Dangerous Occurrences

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</thead>
<tbody>
<tr>
<td>Sharps injury, donor +ve to blood borne virus</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>16</td>
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<td>4</td>
<td>7</td>
<td>12</td>
<td>16</td>
</tr>
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<td>Exposure body fluid, donor +ve to blood borne virus</td>
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<td>4</td>
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<td>6</td>
<td>7</td>
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<tr>
<td>Total</td>
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<td>10</td>
<td>5</td>
<td>22</td>
<td>23</td>
<td>5</td>
<td>11</td>
<td>19</td>
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</tbody>
</table>

Injury to member of public taken to A&E

<table>
<thead>
<tr>
<th>Injury to member of public taken to A&amp;E</th>
<th>Corporate Functions</th>
<th>Medicine Board</th>
<th>Specialist Hospitals Board</th>
<th>Surgery and Cancer Board</th>
<th>2017/18</th>
<th>2016/17</th>
<th>2015/16</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
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<td>Contact with machinery</td>
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<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Slipped, tripped or fell on the same level</td>
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<td>4</td>
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</tr>
<tr>
<td>Struck against or hit by object</td>
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<td>4</td>
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</table>

Specified patient injuries connected with work activity

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</thead>
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<td>1</td>
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<td>4</td>
<td>1</td>
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</table>

Total number of RIDDOR

<table>
<thead>
<tr>
<th>Total number of RIDDOR</th>
<th>Corporate Functions</th>
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<th>Specialist Hospitals Board</th>
<th>Surgery and Cancer Board</th>
<th>2017/18</th>
<th>2016/17</th>
<th>2015/16</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
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<td>12</td>
<td>18</td>
<td>20</td>
<td>51</td>
<td>42</td>
<td>37</td>
<td>46</td>
<td>48</td>
</tr>
</tbody>
</table>
The deadlines for reporting RIDDOR are:
- 10 days for specified injuries (staff or public) and dangerous occurrences from the day of the incident
- 15 days for over 7 day injuries from the day of the incident.

The HSE raised the issue of late reporting of RIDDORs in late 2016 which resulted in the development of an action plan to improve the timeliness of reporting including: changes to Sickness Absence Policy, communications via Insight and a review of the Occupational Health processes for handling dangerous occurrences within the 10 day time frame. The position in 2017/18 is much improved, providing that managers ensure that incidents are reported promptly on Datix and establish if staff are absent due to a work related injury when staff first contact them. Occupational Health ensured that all 22 dangerous occurrences from 2017/18 were reported within the specified timeframe. The process for reporting patient RIDDORs will be reviewed in 2018/19.

5.2 Specified injuries

The number of reportable specified injuries has fallen since 2016/17 with only one such injury recorded in 2017/18. Specified injuries are defined as: fractures; amputations; permanent loss/reduction of sight; serious burns/scalding; scalping; unconsciousness caused by head injury or asphyxia.

The injury in 2017/18 was a bone fracture. A receptionist in a clinic tripped over a door stop and fell, fracturing their ribs. The door stop prevented a door to a computer hub room from opening too far; it was positioned approximately 250mm from the wall. The door stop was removed to prevent a further recurrence. The position of all the door stops in the department has been checked to ensure they do not present a hazard.

5.3 Injury to member of public taken to A&E

The number of injuries of members of the public taken to A&E because of a specified injury when there have been identifiable failings in procedure, equipment or infrastructure was one in 2017/18. A relative slipped in the Emergency Department, fracturing their wrist. The relative was carrying a hot drink when they slipped where the floor had been cleaned. It was found that the correct signage had been in place and the relative had walked on to the area that was still drying.

5.4 Specified patient injuries connected with work activity

Under RIDDOR, UCLH must report specified patient injuries or deaths that have arisen from identifiable failings in procedure, equipment or infrastructure. For example, if a patient falls out of bed and suffers a ‘specified injury’ and the care plan had identified the need for bed rails but these had not been provided, this would be reportable under RIDDOR.
To ensure reports are made the following actions are taken:

- Inpatient Falls Root Cause Analysis (RCA) and UCLH Serious Incident (SI) report form have been updated to include a prompt to consider RIDDOR
- The patient fall leads sign off falls that are serious incidents, ensure that RIDDOR has been considered and that appropriate incidents are notified to the Health and Safety Adviser so that they can be reported under RIDDOR.

One such incident was reported in 2017/18. This is described below:

**Passenger lift on T13(S) – Gastrointestinal Services**

A patient fell when entering a lift and suffered a fractured neck of femur. The IP had capacity to decide to leave the ward area without assistance and had been doing so on a regular basis since their admission. The IP was wheeling a drip stand at the time which may have become caught on the lift threshold and caused them to trip. The ward will continue to discourage patients from leaving the ward with drip stands. The lift may not have aligned correctly with the floor, leading to the IP stumbling.

The following actions were taken:

- Advise wards and departments of the need to promptly report building faults to the facilities provider, ensuring information is clearly displayed advising staff how to report a problem with a lift
- The patient falls root cause analysis will be revised to ensure that investigators are prompted to inform the facilities provider about any environmental issues that may contribute to an accident.

6. **Occupational exposures to blood and body fluids (sharps/needle sticks)**

**Figure 2: Number of exposures reported to Occupational Health, by quarter January to December 2017**

There were 304 occupational exposures to blood and body fluids reported to Occupational Health during 2017. This is a slight decrease on 2016 when there were 328.
There were 227 occupational exposures to blood and body fluids reported via Datix during 2017. This represents 75% (83% last year) of all those reported to the Occupational Health (OH) team during the same period (n=304). The occupational health team encourages staff to complete Datix after all incidents. There has been a very small decrease in the number of dangerous exposures reported to the HSE. 89.2% of staff have completed inoculation incident mandatory training.

**Figure 3: Number of exposure incidents: 2013 to 2017**

Detailed reports regarding occupational exposures to blood and body fluids are submitted quarterly to the UCLH Trust Infection Control Committee (TICC) and are available on the Occupational Health and Safety Insight page. Statistics are circulated to clinical managers. Managers are asked to discuss these statistics at team meetings, safety huddles and audit/governance meetings.

A root cause email is sent to the manager of the person or area (dependent on cause), after each incident, outlining the changes needed to prevent future incidents.

Significant steps have been made towards the use of safety devices where clinically suitable. Work has been done and continues to ensure sharps bins are available at the point of use. Safety engineered intravenous cannula are now in place as are safety finger prick devices. In addition needle free devices and connections have been standardised where these are compatible. Work has been done to improve wearing of face and eye protection to prevent facial splashes and more work is planned. All blood taking devices now have a safety feature.

All clinical staff are required to undertake ‘inoculation incident’ training as part of mandatory training. An email alert is sent to the OH team each time an occupational exposure to blood and body fluids incident is reported via Datix. This helps to ensure timely intervention and management.
7. Risk assessment

7.1 Annual organisational review of health and safety risk assessments for 2017/18

Each year the Health and Safety team undertakes an organisational audit of risk assessments. The aims of the audit are:

- To provide assurance of compliance with the requirement to undertake risk assessments in association with the policies listed below
- To provide assurance of compliance with the requirement for a 'suitable and sufficient' risk assessment in accordance with HSE guidance
- To identify any areas of non-compliance or other deficiencies and to develop an action plan to address these.

The following policies contained within the Health and Safety at UCLH Policy are audited:

- Falls, Slips and Trips Prevention
- Safer Handling
- Security
- Violence and Aggression
- Lone Working
- First Aid
- Control of Substances Hazardous to Health (COSHH)
- Management of Work-Related Stress

Key Results:

- A total of 573 risk assessments were returned.
- Of the 27 divisions/corporate directorates included in the audit, returns were received from all 27 (100%)
- 9 divisions/corporate directorates submitted risk assessments for **ALL** departments and **ALL** policies
- 18 divisions/corporate directorates made partial returns. The individual divisional risk assessment report will identify where there are deficiencies and makes recommendations for action.

All of the risk assessments were reviewed for suitability and sufficiency. Detailed feedback will be provided in a report to each divisional manager. Overall, there has been some improvement in the audit criteria when compared with the previous year’s audit. However this has not been sustained evenly across all divisions. More work is
required to ensure that divisional managers take on board the feedback and ensure that it is received and actioned by the staff who update the assessments. Work will be undertaken to review the risk assessment system to look at an on-line approach.

### 7.2 Display Screen Equipment (DSE) assessments

The manual handling team undertake DSE assessments in the following circumstances:

- A self-assessment identifies hazards or problems that are not easily resolved by the assessor and/or the manager
- A staff member is referred by a member of the OH team due to a health problem
- A staff member is referred by their manager due to a health problem.

All routine DSE assessments are undertaken by the DSE user and escalated as per the policy if problems are identified.

During 2017/18, 64 ergonomic DSE risk assessments were undertaken.

The individual workstation risk assessment comprises of

- Assessment of symptoms
- Workstation risk assessment
- Seated postural analysis
- Postural training and task management
- Report detailing any suggested modifications

### 7.3 Workplace risk assessments

The work environment can impact on a person’s performance in a number of different ways. These include factors that:

- Damage health (heat stress, musculoskeletal disorders)
- Reduce the individual’s ability to perform a task (poor lighting, noise, distraction)
- May cause dissatisfaction and discomfort (poor housekeeping, lack of rest and comfort facilities).

During the reporting period there were:

- 25 workplace assessments (environmental, COSHH, incident investigations etc.)
- 8 workplace visits to investigate RIDDOR reportable incidents

### 8. Health Surveillance

The occupational health team undertake routine skin surveillance for all new staff and on an ad hoc basis when staff are seen in OH. Any staff that are identified as having problems with the skin on their hands are offered alternative cleansing products,
gloves or referred for allergy testing. All cases of work-related dermatitis are reported to the Health and Safety Executive under RIDDOR but none were reported in 2017/18.

9. **Manual Handling**

9.1 **Training**

Staff who handle patients complete a half day face-to-face training session during induction, which is updated every two years. Staff who are not designated to be patient handlers complete the e-learning Care of the Back Course. The team does not currently have the capacity to train load handlers face-to-face as required by the UK Core Skills Training Framework despite an increase in resource. This is due to the increase in induction training required for new recruits. This will be risk assessed.

- 89.1% staff are compliant with Care of the Back Training (e-learning)
- 82.7% staff are compliant with face to face moving and handling training – this includes both induction and update training

Non-compliance with Manual Handling training may result in injury to staff and patients. There is potential for litigation from both parties.

All staff and managers have access to the learning portal where they can identify any outstanding training requirements for themselves and their teams. The manual handling team checks training with any member of staff reporting an incident and when attending clinical areas to assess complex manual handling issues.

The manual handling team is often invited to demonstrate particular procedures at mentor group study days. This is usually to areas where high risk procedures are carried out. A bespoke session is provided to staff on a specific procedure or piece of equipment e.g. turning a patient into a prone position for some neurological procedures and moving an unconscious patient from chair to floor.

The team also works closely with and is involved in training carried out by other specialist departments such as the Tissue Viability Team (Skin buddy days).

The manual handling adviser works alongside clinical teams to prevent falls, pressure ulcers and violence and aggression. She is involved in the procurement process for all manual handling equipment (including beds, trolleys etc.). This can involve visiting factories and show rooms to review new equipment on the market.

9.2 **Manual handling risk assessments**

The team undertakes complex manual handling risk assessments. These assessments may relate to individual members of staff, teams or areas. Staff members are usually referred via Occupational Health or management with the aim of
supporting staff to return to full functioning within their team, providing advice and supporting or aiding in redeployment. The team supports staff with various disabilities – acquired, congenital or degenerative - to remain in the workplace. Nine complex staff assessments and thirty-six office/laboratory/building-related assessments in relation to staff were carried out during 2017/18

Where there is a specific complex issue, the team undertakes a risk assessment (with the manager) and arranges for demonstration and trial of specialist equipment. The manual handling team is also involved in the assessment and management of complex patient manual handling issues. This may include bariatric, disabled and pregnant patients and those with a high risk of developing a pressure ulcer. The number of these requests is increasing year on year.

9.3 Datix reporting

There were 58 incidents related to manual handling reported via Datix in this reporting year. This is a significant decrease of 40% from the previous year and may be a consequence of improved support to managers and staff. Each form is reviewed by the Back Care Adviser to ensure that risks are minimised to staff and patients. Actions range from checking all the relevant information is in place to conducting site visits to support managers and staff to reduce risk and injuries from avoidable manual handling accidents.

10. Capital Investment Projects (CIP)

Health and safety works with the Capital Estates and Facilities Directorate to ensure involvement at an early stage of capital investment projects. The health and safety adviser sits on the Capital Works Committee, which reviews all projects, including capital equipment purchases. This ensures that health and safety is involved at an early stage of developments.

11. Policy review

During 2017/18 the clustered Health and Safety at UCLH Policy was published, along with a Health and Safety at UCLH Handbook which includes:

- Safe Handling – a policy for safer moving and handling
- Slips, trips and falls prevention (for staff, visitors and outpatients
- Control of substances hazardous to health
- Display screen equipment incorporating eye testing
- Prevention and management of work-related stress
- First aid
- Management of work-related stress
- Lone workers
- Health surveillance
- Skin management for staff (including latex)
- Sharps and other occupational exposures to blood and body fluids
- Healthcare workers with HIV, Hepatitis B and Hepatitis C
• Smoke-free environment.

12. **Current legislation**

The Health and Safety Committee is responsible for assuring UCLH that it is compliant with current legislation. It is not aware of any changes to the law that would impact on its services.

13. **Next Steps – Priorities for action in 2018/19**

It is proposed that 2018/19 Health and Safety Action Plan should focus on the following priorities:

- **Reducing violence and aggression** – this has been identified as the top priority for action. New ways of tackling this difficult issue will be explored to see what steps could be introduced to reduce the number of incidents of violence and aggression to which staff are subjected in the workplace, to improve the support provided to affected staff and to ensure that the organisation’s culture supports zero tolerance. This will build on the work initiated by the Managing Violence and Aggression (PMVA) Steering Group.

  UCLH believes it is critical that all staff are able to perform their jobs without the fear of violence. We will explore how we can better pursue legal action against offenders whenever this is appropriate; we will talk to our police team to work out how we can support criminal proceedings and explore the option of taking out a civil action. We will explore how we can improve the support provided to staff and teams looking after patients with clinical conditions which affect patient behaviour.

- **Ensuring that there are processes in place to report RIDDORs to the Health and Safety Executive within the prescribed timescales** – concerns about the reporting of patient incidents in a timely fashion to be explored.

- **Reviewing the risk assessment audit process** – examine the feasibility of moving to an online system.

- **Ensuring that the Health and Safety Committee is aware of and monitors all the health and safety-related risks on the UCLH Risk Register** – evaluate this new process.

- **Manual handling** – ensure that departments risk assess the need for load handling training

- **Under-reporting of incidents** – develop a campaign to encourage staff to report incidents on Datix, working closely with the Quality and Safety team
Report to the Board of Directors Meeting

9 May 2018

Annual Equality Report

UCLH has a statutory responsibility to publish an annual equalities report providing information about the work we are doing in relation to both patients and staff. The report covers the 2017 calendar year and provides a commentary on the achievements for 2017, along with supporting data and priorities for action in 2018/19.

Highlights for 2017 include the successful launch of our new Black and Minority Ethnic Staff Network which has engendered much positivity and excitement and the work that has been achieved to improve the care of patients with Learning Disabilities and Hearing Impairment.

The Board is asked to approve the Annual Equality Report.
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Foreword

Welcome to the UCLH Annual Equality Report for 2017. The Trust has a statutory responsibility to publish an annual equalities report which provides information about the work we are doing. The report details the equality, diversity and inclusion themes and analysis for staff and patient services for the calendar year from 1st January to 31st December 2017.

Providing top-quality patient care to all our patients is at the core of all we do. We are proud that we do this with such a diverse workforce. Once again we have chosen to publish our equality report for patients and staff as one integrated document as we feel this best reflects the close links between patient experience and staff satisfaction.

The introduction of the Workforce Race Equality Standard has given us the opportunity to focus on what we can do to ensure that our black and minority ethnic staff are treated as favourably as all other staff so that UCLH can capitalise on the best available talent, draw on the innovation we know diverse teams can bring and further recognise the diverse needs of the communities we serve. One of the highlights of 2017 has been the successful launch of our new Black and Minority Ethnic Staff Network which has engendered much positivity and excitement.

Managing staff with respect and compassion correlates with improved patient satisfaction, better patient outcomes and higher levels of patient safety.

In line with the strategic objectives of UCLH for 2017/2018 and the UCLH Equality Objectives 2017-2020, the Trust is committed to ensuring that we provide a positive patient experience for all patients regardless of their identity and protected characteristic in all our services and at all points of access.

Ambitious targets in 2017 set out an agenda encompassing our commitment to recognising the particular needs of patients with protected characteristics and the importance of recording all elements of patient disabilities. The Accessible Information Standard continues to prove a challenging requirement but, with the introduction of the Electronic Health Record (EPIC) at UCLH in 2019, the preparation and profile achieved this year will ensure that we are able to meet this requirement going forward.

We are particularly proud of the work that has been achieved for the care of patients with Learning Disabilities. A number of specialist clinical leaders have committed to creating care pathways and patient information that focus on patients holistic needs rather than just condition or treatment pathways. The needs of hearing impaired patients have continued to be recognised with a series of highly successful Deaf Awareness training session for staff at all levels of the organisation. The challenges associated with our BLS providers earlier in the year have now been successfully resolved and we are now working closely with our EPIC partners to develop a robust system of both articulating interpreting needs and booking appropriate support. We continue to work closely with our user groups who provide key insights into their experience of our services.

In creating future priorities, the views of patients, carers and a wider group of stakeholders have been key in articulating our objectives for the coming year. These priorities have been articulated under 3 key areas, improving the environment, improving
access for patients with interpreting requirements and specialist priorities which will include a wider commitment to health promotion and the needs of patients with chaotic or challenging behaviour.

We have started our formal evaluation of our progress against the Equality Delivery System 2. In 2018/19 we have a new headline objective to “Promote equality and inclusion and demonstrate that we are an employer of choice”. We are confident that this will support us to deliver our enduring vision: top-quality patient care, excellent education and world-class research.

Ben Morrin  
Director of Workforce  
Executive Lead for Staff  
Equality Diversity and Inclusion

Flo Panel-Coates  
Chief Nurse  
Executive Lead for Patient  
Equality, Diversity and Inclusion
Executive Summary and Summary of Key Findings

This report sets out the UCLH approach to equality, diversity and inclusion and meets our public sector legal duties outlined in the Equality Act (2010) in meeting the nine protected characteristics:

- Age
- Sexual orientation
- Gender reassignment
- Pregnancy and maternity
- Race including nationality and ethnic origin
- Disability
- Gender
- Marriage and civil partnership
- Religion or belief

The Public Sector Equality Duty (PSED) came into force on 5 April 2011 and supports good decision making by ensuring the Trust considers how people who have protected characteristics will be affected by our activities, helping us to deliver policies and services which are efficient, effective and accessible to all and which meet the needs of different people. We will seek to meet the aims of the PSED:

- through eliminating unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act;
- by advancing equality of opportunity between people who share a protected characteristic and people who do not share it;
- by fostering good relations between people who share a protected characteristic and people who do not share it.

UCLH has a long history of commitment to equality, diversity and inclusion with a truly diverse workforce serving an international city community. We recognise that delivering our vision requires a workforce performing at its very best who are able to be themselves whilst at work. In order to achieve this and meet both the spirit and the letter of legislation and best practice, our staff are at the heart of our work to create an accessible and inclusive organisation and working environment.

The Workforce Race Equality Standard (WRES) was introduced by NHS England in April 2015. It is now included in the NHS standard contract and requires the Trust to produce and publish an annual WRES return. The purpose of the return is to allow each trust to demonstrate progress against a number of indicators related to Black and Minority Ethnic Staff. Our action plan addresses the areas where black and minority ethnic staff are treated less favourably than white staff. There is clear evidence that patients have a better experience in organisations where workforce race equality is good. Securing tangible improvements against the standard is important to us and we thus intend to publicly report against it every six months to transparently outline our progress.

We continue to review our staff and patient-focused policies, undertaking an equality analysis assessment in line with guidance from the Equality and Human Rights Commission, and updating them accordingly.
Having a clear profile of our patients and staff helps to advance equality of opportunity and meet the needs of our patients and staff in designing our services and the workplace. Our organisational culture, based on the UCLH values of Safety, Kindness, Teamwork and Improving, fosters good relations between different groups that result in more efficient, effective and accessible patient care, improved services for the public in a workplace where they are welcomed by staff who are empowered to provide optimal care and support for all our patients.

**Summary of Key Findings for our Workforce:**

The biannual publication of the Workforce Race Equality Standard continues to highlight the need to improve accessibility of senior and leadership positions for staff from a BME background.

The characteristics of our workforce are broadly consistent with the populations of our local boroughs in terms of religion and ethnicity. We have stronger representation of females and staff from a Black and Minority Ethnic background in our workforce than in the local population. This is, in part, due to the nature of the work we undertake and the impact of international recruitment campaigns to recruit new joiners into occupations for which there is a national shortage. Staff at UCLH come from more than 120 different nations. The rich mix of our staffing helps us to better identify the needs of our staff and patients. Over four hundred staff joined us from outside the UK in 2017 and each has made a valued contribution to that has been swiftly welcomed by patients and staff alike. The number of new starters from EU nations remains at 2016 levels.

The learning and development accessed by our staff is broadly consistent with the workforce as a whole. Staff with protected characteristics have similar or better levels of access to learning and development.

We seek our senior leadership and management at UCLH to be representative of the wider workforce and the local community. There is work to do to encourage, support and develop women and individuals from Black and Minority Ethnic communities so that they are in a position to put themselves forward for more senior roles. Working with our staff networks we are identifying role models and we have made mentoring and coaching available to staff with protected characteristics to empower them to aspire to higher roles.

Our analysis of employees managed through formal employee relations processes shows that staff in lower bands are more likely to go through a formal disciplinary process than staff in higher bands. Taking the ethnicity and gender of staff in these lower bands into account, more staff than would be expected go through a formal disciplinary process with a BME background or are male. However there is a different pattern for staff going through formal processes related to the management of sickness. More female staff than would be expected from the overall workforce profile go through a sickness process.
2017 saw the conclusion of a campaign asking all staff to update their demographic details on the Electronic Staff Record (ESR). This has resulted in a significant improvement to the accuracy and completeness of demographic data held centrally on our staff.

However there is still a major discrepancy between disability data recorded on the ESR and that self-reported during the annual staff survey which will be explored though focus groups to better understand the concerns of staff in being open about disability. The year 2018 will see the introduction by NHS England of the Workforce Disability Standard which will provide a framework for UCLH to better support disabled staff.

We will also identify ways in which we can support our transgender staff members.

The section on Progress for Staff by Protected Characteristic outlines the progress against these priorities and the new set of objectives proposed for 2018/2019.

**Summary of Key Findings for our Patients:**

A set of ambitious priorities were set out last year in response to areas identified by staff and patient groups and have been tracked across the year. These included

- Further roll out of dementia friendly environment across the Trust
- Ensure that data can be collected on all protected characteristics for patients and that multiple disabilities can be recorded
- Monitor the effectiveness of the system in place to meet the needs of patients with specific communication requirements in line with the requirements of the NHS England Accessible Information Legislation (part of the Health and Social Care Act (2012)
- Further develop the teenage and young adult page on the UCLH website, including establishing a closed Facebook page.
- Further improve access and information for disabled patients to UCLH by implementing the recommendations from the DisabledGo scoping exercise.
- Development of the maternity internet portal to include links to information leaflets for pregnant women whose first language is not English, so as to ensure equal access of information for all.
- Explore in more detail why patients aged 16-24 score lower on the local inpatient survey than other age groups.

The section on Progress for Patients by Protected Characteristic outlines the progress against these priorities and the new set of objectives proposed for 2018/2019.
Introduction to UCLH

UCLH is situated in the heart of London. We are a large NHS Foundation Trust providing first class acute and specialist services in five hospital sites: University College Hospital (incorporating the Elizabeth Garrett Anderson Wing, the Hospital for Tropical Diseases, the University College Hospital Macmillan Cancer Centre, the Institute of Sport, Exercise and Health and University College Hospital at Westmoreland Street), the Eastman Dental Hospital (EDH), the National Hospital for Neurology and Neurosurgery (NHNN), the Royal National Throat, Nose and Ear Hospital (RNTNEH) and the Royal London Hospital for Integrated Medicine (RLHIM).

The Trust has a corporate board and three clinical boards (the Medicine Board, the Specialist Hospitals Board and the Surgery and Cancer Board), each led by a medical director, supported by divisional clinical directors and divisional managers and a head of nursing.

The Medicine Board has eight divisions: Critical Care, Emergency Services, Medical Specialties, Infection, Pathology, Clinical Support and Integration. The Specialist Hospitals Board has five divisions - the Eastman Dental Hospital, Queen Square, the Royal National Throat Nose and Ear Hospital, Women's Health and the Paediatric and Adolescent Services divisions. The Surgery and Cancer Board has five divisions: Cancer, Gastrointestinal Services, Surgical Specialties, Imaging and Theatres and Anaesthesia.

UCLH is one of the most complex Trusts in the UK, serving a large and diverse population. We provide academically-led acute and specialist services, both locally and to patients from throughout the United Kingdom and abroad. We balance the provision of highly-rated specialist services with acute services for the local populations of Camden, Islington, Westminster, Barnet, Enfield and Haringey.

We work in partnership with University College London (UCL) and are a founding member of UCLH Partners Academic Health Science Partnership, along with Moorfields Eye Hospital, The Royal Free London, Barts Health NHS Trust, Great Ormond Street Hospital, UCL and Queen Mary University of London. UCL Partners pools resources and expertise to produce outstanding research and deliver the benefits to patients more rapidly.

We have good links with key academic partners who train the professional staff who work across our teaching sites including London South Bank and City Universities which offer high quality training and education for nurses and allied health professionals, as well as with the UCL Medical School.

The Council of Governors provides support to UCLH to ensure that we deliver services that best meet the needs of our patients and the communities we serve. Our Council has 33 governors (twelve patient, one carer and four public governors, together with six staff representatives and ten representatives from local organisations). The Council of Governors is a valued and effective body advising UCLH on issues that are important to patients and the wider community. It works with UCLH to ensure we provide the best possible services to our patients. The governing body is not responsible for the day-to-day running of the Trust but works with the Board of Directors to produce the Trust's
future plans. It ensures that the voices of members and partners inform the Trust’s decisions. Its statutory responsibilities are described in the Trust’s constitution. UCLH has a published membership development strategy which sets out the plan governors agreed to maintain, grow and develop membership. The three strands of the strategy are reviewed each year by the governing body and are to:

- build a membership that effectively represents the population the Trust serves;
- effectively communicate with members; and
- engage and encourage member involvement.

As we serve an incredibly diverse population, with equally diverse needs, understanding the demographic context in which we operate is crucial. Data for 2017 shows that the largest age group of our local population is between the ages of 30 to 39, with the majority being female. Approximately 9.3% of our local population have a limiting long-term illness (disability). Our most represented patient ethnic group is White British at 38.9% followed by White/Any Other White Background at 10.3%. The least represented ethnic group in our patients are service users from a White/Black African mixed background representing 0.3% in total. The largest religion or belief for our local population is Christianity (22.3%) whereas 40% of staff have a Christian background.

UCLH recognises that it is extremely fortunate to have a mix of employees from a diverse range of communities, beliefs and sexual orientations. The UCLH values of Safety, Kindness, Teamwork and Improving, introduced in 2012, are at the heart of all that UCLH does. A raft of evidence shows a positive link between staff experience and that of patients and the outcome of their care. Our CQC inspection in 2016 found that the UCLH values are well embedded and welcomed by our staff and patients alike.
# Equality Delivery System 2 (EDS2)

The EDS2 is NHS England’s tool to ensure that the legal obligations of the NHS are met under the Equality Act. Implementation of EDS2 is based on achieving 18 outcomes grouped within 4 goals:

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>Better health outcomes</th>
<th>Provisional EDS2 grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Services are commissioned, procured, designed and delivered to meet the health needs of our communities</td>
<td>Achieving</td>
</tr>
<tr>
<td>1.2</td>
<td>Individual patient health needs are assessed and met in appropriate and effective ways</td>
<td>Achieving</td>
</tr>
<tr>
<td>1.3</td>
<td>Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed</td>
<td>Developing</td>
</tr>
<tr>
<td>1.4</td>
<td>When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse</td>
<td>Achieving</td>
</tr>
<tr>
<td>1.5</td>
<td>Screening, vaccination and other health promotion services reach and benefit all local communities</td>
<td>Developing</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Goal 2</th>
<th>Improved patient access and experience</th>
<th>Provisional EDS2 grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds</td>
<td>Achieving</td>
</tr>
<tr>
<td>2.2</td>
<td>People are informed and supported to be as involved as they wish to be about their care</td>
<td>Developing</td>
</tr>
<tr>
<td>2.3</td>
<td>People report positive experiences of the NHS</td>
<td>Achieving</td>
</tr>
<tr>
<td>2.4</td>
<td>People’s complaints about services are handled respectfully and efficiently</td>
<td>Achieving</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Goal 3</th>
<th>A representative and supported workforce</th>
<th>Provisional EDS2 grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Fair NHS recruitment and selection processes lead to a more representative workforce at all levels</td>
<td>Achieving</td>
</tr>
<tr>
<td>3.2</td>
<td>The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their local obligations</td>
<td>Developing</td>
</tr>
<tr>
<td>3.3</td>
<td>Training and development opportunities are taken up and positively evaluated by staff</td>
<td>Developing</td>
</tr>
<tr>
<td>3.4</td>
<td>When at work, staff are free from abuse, harassment, bullying and violence from any source</td>
<td>Developing</td>
</tr>
<tr>
<td>3.5</td>
<td>Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives</td>
<td>Developing</td>
</tr>
<tr>
<td>3.6</td>
<td>Staff report positive experiences of their membership of the workforce</td>
<td>Achieving</td>
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<thead>
<tr>
<th>Goal 4</th>
<th>Inclusive Leadership</th>
<th>Provisional EDS2 grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations</td>
<td>Achieving</td>
</tr>
<tr>
<td>4.2</td>
<td>Papers that come before the Board and other major Committees identify equality-related impacts including risks and say how these risks are to be managed</td>
<td>Developing</td>
</tr>
<tr>
<td>4.3</td>
<td>Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination</td>
<td>Developing</td>
</tr>
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Our Progress in 2017

As an effective governance infrastructure, the well-established Diversity and Equality Steering Group continues to lead the way in setting the strategic direction as well as monitoring and providing assurance of delivery of our action plan. Our progress in equality, diversity and inclusion was examined by the CQC in March 2016 as part of the well-led domain and this raised no concerns. UCLH is due to be revisited by the CQC in 2018.

In 2017, we have continued to achieve successes through different initiatives to improve staff experience, patient experience and service delivery. One of the highlights of 2017 has been the launch of the new staff network for Black and Minority Ethnic staff.

Progress for staff by Protected Characteristic

Age

The UCLH workforce profile is younger than the average for NHS acute trusts. 65% of the UCLH workforce is below 45 years of age, compared to a national average of 53%.

UCLH has made good progress in developing roles for young joiners by providing apprenticeship opportunities, although these do not have any age stipulation. The majority of our apprentices are aged between 18 and 24 and come from the London boroughs.

Since 2017, 35 apprentices have been recruited and, in addition to this, UCLH has offered existing staff an opportunity to undertake an apprenticeship qualification. There are now a total of 87 staff on these apprenticeship programmes. Sixty-seven per cent of the apprentices come from a BME background. Thirty-one per cent of the apprentices are aged under 24, sixty-nine per cent of the apprentices are aged over 25, showing that there are no age barriers to becoming an apprentice and developing new skills.

The type of apprenticeships offered during 2017 has expanded to include clinical roles (e.g. nursing assistants and Allied Health Professional assistants). The feasibility of developing undergraduate-level and master level's apprenticeship programmes is being explored.

The apprenticeship team has recently run a series of road shows and prepared a series of films for National Apprenticeship Week in 2018. The films have captured the diversity of UCLH staff undertaking apprenticeship programmes, showcasing staff at various stages of their careers. The apprentices interviewed were keen to share their journey and show that there are no barriers learning. Many of the UCLH apprentices were involved in making the films; some could be found behind the camera, others in the editing room. The videos have now been made available to all UCLH staff. Several of the apprentices involved have been invited to the annual Celebrating Excellence Award ceremony to recognise the contribution they have made.

One of the major benefits of this work has been the increased engagement with the local community which has given UCLH access to an untapped talent pool. UCLH is working alongside a local college to attract potential apprentices. UCLH also takes part in the
Social Mobility Foundation Summer School Programme which provides low income students from local schools and colleges an opportunity to gain work experience. UCLH also runs a Summer School for aspiring medical students from local schools. Social Mobility Foundation students who have completed a work experience placement at UCLH tend to go onto university. In a sample of destination data for 51 students, 29% of the aspiring students went on to study medicine, 33% to study science, 22% to study healthcare-related subjects like nutrition, dietetics, optometry, pharmacy and sports rehabilitation and 9% to study social sciences. Only 7% of the aspiring students did not go on to attend a university.

We also offer flexible working opportunities for older staff who are nearing retirement and opportunities for staff to retire and return to work so that we do not lose valuable and highly specialist skills. In 2017, a retirement policy was developed to support line managers and staff. Many staff who have retired also return to UCLH as volunteers and continue to make a huge contribution to UCLH.

**Sexual orientation**

UCLH has been working in partnership with Stonewall since 2012 and has been a Stonewall Diversity Champion since 2013.

We submitted our fifth bid to the Stonewall Healthy Lives Index in September 2017 reflecting patient care and staff priorities. There are a number of new sections in the 2017 questionnaire which have adversely impacted our performance in the index. However our action plan for 2018/19 should improve our performance in the 2018 questionnaire.

The LGBT Network group has over 75 members including straight allies and works closely with staff networks at Transport for London, Guys & St Thomas's and the London Ambulance Service. All staff are made aware of the LGBT Staff Network on the corporate induction programme where they are given a leaflet about the network and links to the intranet pages.

56 staff and friends made up the UCLH LGBT Walking Group at the London Pride March in July 2017. This was a really positive experience for all involved and UCLH already has its place confirmed for the 2018 London Pride March.

The LGBT staff network is also working closely with the Women in Leadership and BAME staff networks to arrange joint events.
The LGBT Staff Network is developing a bid to the UCLH Charity for administrative support.

**Gender**

As a Trust our female workforce exceeds that of our local and national communities. Indeed where almost all general populations have a broadly 50/50 female to male ratio our employee demographic is 71% female to 29% male representation.

Although the female workforce is 71% of the overall workforce at all grades, there is a clear change to this in higher grades. The population of very senior management sees a reversal of the representation described for lower bands.

The medical and dental in training workforce is comprised of 55% females. Forty-two per cent of the consultant workforce is female.

The Women in Leadership (WIL) Network, launched in November 2015, is continuing to progress. It holds quarterly events which support women to develop, progress and gain confidence in their abilities and careers. These events are open to both men and women and are advertised widely across the organisation to ensure a diverse range of participants from across the organisation as well as from clinicians and non-clinicians. The network receives support from the UCLH Charity.

The Women in Leadership Network has connected with the NHS London Leadership Academy Women’s Network to maximise opportunities for networking, personal development and access to inspiring speakers. One of the initiatives run through the network is the Coffee Connect networking tool which is open to all staff. This continues to connect individuals from across the organisation, to help build relationships and provide opportunities for collaborative working. Two hundred staff are currently on the list to be connected each month.

**UCLH Gender Pay Report 2017**

New gender pay reporting legislation requires employers with 250 or more employees to publish statutory calculations every year showing how large the pay gap is between their male and female employees. The regulations for public sector organisations were introduced on 31 March 2017 and our gender pay information is set out below. A separate gender pay report can be found on the UCLH intranet, the UCLH internet and on the government website.

In summary at UCLH:
- The mean gender pay gap is 15.4%
- The median gender pay gap is 9.5%

The mean gender pay gap for Agenda for Change (AfC) staff is -0.9%, i.e. the average hourly rate for female AfC employees is higher than that for male AfC employees. The mean gender pay gap for Medical and Dental (M&D) staff is 9.1%, i.e. the average hourly rate for male M&D employees is higher than that for female M&D employees. These data show that the UCLH overall gender pay gap is largely a consequence of consultant pay as the consultant workforce is 58% male and 42% female and the mean consultant pay rate is more than double the overall average pay rate for all staff.
At UCLH the only bonus payments made are Clinical Excellence Awards for consultants.  
- The mean bonus gender pay gap is 20.42%  
- The median bonus gender pay gap is 13.85%  
- 6.7% of male staff receive a bonus payment  
- 1.5% of female staff receive a bonus payment  
- 48.7% of male consultants receive a bonus payment  
- 25.7% of female consultants receiving a bonus payment  

An action plan is being developed to address the issues identified in the report.  

**Ethnicity**  
The highlight of 2017 was the launch of the Black and Minority Ethnic (BAME) Staff Network. It is anticipated that this network will have a positive impact on BAME patient and staff experience. It was officially launched on 24 October 2017 by Non-Executive Director Althea Efunshile CBE who gave a heart warming and inspiring speech on her leadership journey. Our Chief Executive, Professor Marcel Levi, welcomed more than a hundred staff to the event. Feedback for the event was overwhelmingly positive with staff keen to keep the momentum going. The BAME network has made a successful bid for support from the UCLH Charity and more events are planned for 2018, including joint events with the other staff networks.

UCLH published Workforce Race Equality Standard reports in July 2017 and January 2018. The standard has been useful in highlighting race equality as a significant issue within the organisation and has been used to develop an action plan to address key concerns. We are working closely with the BAME Staff Network on this; mentoring support is being accessed by BME staff to empower them and to ensure they are well placed to take advantage of the opportunities available. We continue to review our performance against the standard every six months. The July 2017 report highlighted an improved performance in the likelihood of appointing BME staff from shortlisting. In December 2017 white staff were 1.45 times more likely to be appointed from shortlisting than BME staff. This has improved from the position in July 2017 when white staff were 1.65 times more likely to be appointed from shortlisting than BME staff. In December 2017, BME staff were 1.34 times more likely than white staff to go through a formal ER
process, a slight improvement from the position in July 2017 when this figure was 1.39 times more likely. However, BME staff are 2.1 times more likely to go through a formal disciplinary process than their white colleagues.

Staff members from BME groups access the Staff Psychology and Welfare Service in numbers proportionate to staff numbers. These figures are monitored on a regular basis and feedback is sought from service users to ensure the quality of the service provided.

**Disability**

In preparation for the launch of the Workforce Disability Equality Standard (WDES) by NHS England in April 2019, UCLH has run a campaign in 2017 to improve the recording of demographic data for our staff. Disability includes people with mental health issues and long term conditions. However there remains a significant discrepancy in the number of staff recorded as disabled on the ESR and those who anonymously self-report they are disabled via the annual NHS staff survey and the differences in definitions on ESR and the staff survey are currently being explored by NHS England in advance of the launch of the new standard. The details of the data which will need to be collected are due to be published by NHS England in the autumn of 2018.

Our Staff Psychology and Welfare Service (SPWS) has developed and delivered workshops for managers on mental health awareness and managing stress and mental health problems in the workplace with the aim of increasing understanding about different mental health issues, how to spot early warning signs that a team member might be suffering from stress or mental ill health and the key skills to have an open conversation about mental health at an early stage. By having these conversations, showing compassion and kindness by asking staff how they are doing, this makes mental health seem like a normal concern and prevents problems becoming more severe. SPWS also runs regular seminars on managing stress and wellbeing in the workforce. 145 staff attended these workshops and seminars in 2017.

The positive mental wellbeing and engagement of our staff is crucial in delivering excellent patient care. The SPWS team has focused on raising awareness on mental health issues through articles in Insight, events on World Mental Health day and Mental Health Awareness week. Colleagues have shared their experiences of the support that has helped them when feeling unwell and what has helped them to stay at work.
Religion/Belief

In November a multi-faith team of chaplains, including volunteers, supported Inter-faith week in the UCLH atrium to promote chaplaincy. This resulted in considerable staff engagement with the chaplaincy team. Many key public figures showed their support for Inter-faith week, including Prime Minister Theresa May, Lord Bourne of Aberystwyth, Minister for Faith at the Department for Communities and Local Government, other MPs, the Mayor of London Sadiq Khan, and mayors and councillors across the country.

More activities have taken place than in any previous year since Inter-faith Week began in 2009. The hundreds of organisations that have taken part have included faith communities and inter faith bodies, non-religious belief bodies, local authorities, schools, universities and Further Education colleges, businesses, youth organisations, sports organisations, the Police and other emergency services, the Armed Services, hospitals and hospices, government departments, and many more.

The UCLH Chaplaincy Team

Following a refurbishment that included expanded facilities for Muslim women, the chaplaincy has organised Friday prayers in UCLH at lunchtime for Muslim staff and patients. We have also started a Buddhist meditation session on Tuesdays and a mindfulness session on Wednesdays. The people attending have been very grateful, but the uptake has been rather sparse.

The space within the Interfaith centre continues to be used by a large group of staff, patients and others from the local community. The team keeps utilisation under constant review and is currently finalising new way-finding systems within the centre. We support the needs of all those with faith (or none) and aim to provide a haven for quiet and reflection.

Maternity

UCLH has a number of policies to support staff taking maternity and adoption leave and offers parental support for maternity and adoption. 680 staff took maternity and adoption leave during 2017.
Other Workforce Initiatives

Reducing discrimination, bullying and harassment in the workplace

UCLH continues to build on its four-pronged strategic approach to conflict resolution. The main aim of this new approach is to improve the staff experience and to prevent bullying, abuse or violence in the workplace. Over 100 managers have completed the two-day workshop on conflict resolution skills. The content has been redesigned in response to feedback and re-launched as a one day workshop. The training equips managers with the skills to facilitate conversations with members of their teams who are in conflict quickly, informally and with confidence. The training runs alongside the successful campaign ‘Where do you draw the line?’ which invites staff to share their views on what constitutes bullying and harassment.

In 2016, UCLH launched Phase 1 of the “Where do you draw the line?” campaign to tackle conflict in the workplace. Phase 2 of the campaign was launched across UCLH in October 2017. The campaign encourages staff to seek earlier informal methods of conflict resolution and promotes the UCLH values as the behaviours that should guide our interactions with each other whilst empowering staff to speak up if any experience falls outside this.

Materials released thus far to support the campaign include:
- Portfolio of staff champions telling their stories around where they draw the line, represented via short interviews available on Insight and posters;
- The UCLH conflict resolution pathway, encouraging staff towards earlier informal methods of conflict resolution and identifying the support they can access available as a digital interactive pathway on Insight and as a poster;
- An animation video introducing the campaign and its message which is now shown to all new starters as part of our corporate induction programme.

Picture of the poster

The release of our 2017 staff survey results in March 2018 is informing a focussed approach to deliver the message of the campaign to those areas with the highest reported levels of bullying and harassment and discrimination.

A fully automated Exit Survey tool has been procured and will be implemented in April 2018. This survey tool will provide an additional measure by which we can better understand the experience of staff with protected characteristics in order to achieve our objective of improving their experience of working at UCLH.

Providing a safe environment for all our staff

Our in house conflict resolution trainer started in January 2017 and has developed a new set of training programmes for all staff, working closely with the security adviser, health and safety adviser and senior nursing staff. There are now four levels of mandatory Preventing and Managing Violence and Aggression (PMVA) training. These better support our staff to deal with awkward and aggressive patients and visitors and de-escalate difficult situations.
The Nursery for children of staff working at UCLH

Securing childcare for those of our staff who need help to gain it remains a priority for us. Our Nursery is a beacon for diversity. With an extremely diverse workforce and with children attending the nursery from all over the world, diversity is celebrated and used to enrich the experience of children and staff. The majority of our nursery places are allocated to staff who have joined UCLH from abroad and provide invaluable support to these workers.

Celebrating Excellence Awards
Over a thousand nominations were received for the 2017/18 Celebrating Excellence Awards, from which 55 individuals and teams were selected as finalists from across each of our boards and corporate departments. Finalists include clinical and non-clinical staff.

Picture

Equality Impact Assessment
The Equality Impact Assessment (EIA) process for policies has been reviewed and improved. In 2018/19 the priority will be to ensure that service developments and changes are impact assessed in a systematic way and the EIA process for policies will be audited.

Policy Review
Policies are reviewed regularly; the policies reviewed in 2017 have all been assessed to ensure they promote equality and that staff with a protected characteristic are not disadvantaged in any way.
Progress for patients by Protected Characteristic

**Age – Children and Young People**

Our children and young patient’s website was launched in 2012 and was significantly enhanced in 2015. Working closely with our patients and families our website has continued to evolve in 2017 and provides an interactive guide to our services. It includes films of patients in hospital talking about their experience, comments and advice from staff, as well as personalised journeys through the site for patients. For more information and to access this website, please follow the link: [http://www.childrenandyoungpatients.uclh.nhs.uk](http://www.childrenandyoungpatients.uclh.nhs.uk)

Priorities this year have included further developments in our use of social media via Facebook but the requirements have unfortunately been too complex to pursue. Instead, our communications team are planning opportunities for our young patients to take over Twitter and share their experiences.

The Children’s Diabetes Team continue to run the “Skype” clinics for children, young people and their families which started in March 2016. These clinics are in addition to outpatient clinics.

**Mental Health Nursing Provision - Adolescents**

A commitment to providing better care for young people with acute and on-going mental health needs resulted in the employment of two mental health support workers along with a Registered Mental Health Nurse. These roles have been successful in creating greater continuity and understanding of mental health care within the Adolescent Ward. New priorities for 2018 will include our ambition to improve provision of activity specialists for adolescents with mental health conditions and learning disabilities.

**Age - Older patients**

We continue to support older people admitted via the emergency pathway with access to review by a consultant geriatrician 7 days a week, with specialist consultant review for older people sustaining hip fractures seen within 72 hours of admission. Our acute service for mental health includes a specialist consultant for older people.

Care for older people and patients with memory deficits will continue to be one of our key priorities going forward with a focus on navigating outpatient services.

We estimate that on average 900 patients with dementia are admitted to UCLH each year. Face to face training in dementia care was introduced in 2014 and we continue to train large numbers of staff throughout the year and support John’s Campaign and the Carer’s card scheme on our elderly care wards to aid equal access to carers of older people.

The developments within our wards for older people that included pet therapy dogs and Music, Memory and Me have been very successful and will continue. Funding for an activity specialist has been agreed for the first time this year and builds on the model in children’s services where the use of ‘activities’ supports the clinical teams in delivering clinical care.

**Disability – Learning Disabilities**

Camden’s Joint Strategic commissioning plan confirms that people with learning disabilities are among the most vulnerable and socially excluded in our local society.
There is evidence that people with learning disabilities have a greater need for healthcare, both due to social concerns such as housing and poor diet as well as being more susceptible than the general population to certain health conditions. As a group they continue to have inferior access to the care they need and poorer health outcomes. It is estimated there are around 500 people known to have a learning disability in Camden and a similar number in Islington. At UCLH we see a high volume of people with a Learning Disability (LD) from across the country accessing our specialist services, particularly at the NHNN.

UCLH appointed its first LD Clinical Nurse Specialist (CNS) in November 2014. Since taking up his post, he has focused on direct patient support for inpatient areas and on improving the pathway through the Emergency Department. In partnership with the Patient Information lead he is continuing to develop the webpage specifically for patients with learning disabilities and autism. The website contains easy-read information in both leaflet and video form as well as useful contact information. There is a series of 11 films for patients with learning disabilities showing ways to access our services, which are available online at www.uclh.nhs.uk/ld and via DVD. The Welcome to EGA Wing video, was developed with the Learning Disability Team, and is on the intranet for patients with learning disabilities to watch.

UCLH is taking part in the London Learning Disability Mortality Review Pilot led by NHS England in partnership with Bristol University. It aims to ensure that robust systems are in place to appropriately review the deaths of people with learning disabilities. The pilot follows the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (2013) and the 2015 MAZARS report into Southern Health NHS Foundation Trust. Both reports highlighted that more investigations into the deaths of patients with learning disabilities is needed.

Any complaints that are received from patients with a learning disability or their families are shared with the LD CNS so that he is aware of any emerging concerns. He can also offer support to the complainant and assist the division in maximising any learning from the experience.

Disability - Sensory Impairment

The Trust has focused on meeting the NHS Accessible Information Standard which became mandatory at the end of July 2016 by working with various charities such as the British Deaf Association and The Royal National Institute for Blind People (RNIB) and other advocates.

This standard ensures that patients with disability including Sensory Impairment have equal access to our services and that the information we provide is understandable to everyone. UCLH has produced a British Sign Language (BSL) video which is supported by text and voice over to explain to patients what improvements have been made and what they can expect when they attend any UCLH site. There is also a video which explains to patients what they should do should they have any concerns. This will be made available to the general public via the UCLH website once the web based interpreting service is launched in a few months’ time.

In response to this standard, we have trained over 70 D/deaf and Sensory Loss Champions who are placed throughout the Trust. We introduced the Champions during the Deaf Awareness Week in May 2017, an awareness week which is celebrated
annually at UCLH during the month of May. Events were held throughout the week to make staff aware of the importance of providing good support to all our patients including the D/deaf and those with a Sensory Loss, and also to make patients and relatives more aware of the services we offer. This provides a great opportunity to share some of our experience of working collaboratively with other stakeholders such as Health Watch Islington, whose Chief Executive Emma Whitby joined us on the final day.

Staff were made aware of the UCL Action on Hearing Loss Library which provides educational information on D/deaf and Sensory Loss. This is situated in Grays Inn Road on the RNTNEH site and is open to staff and the public.

Following consultation with some of our D/deaf patients, the British Deaf Association and our Deaf Awareness trainers, we have produced a welcome video in BSL with subtitles, which will be made available via our website. This provides deaf and hard of hearing patients with an overview of how best to access our services and the types of communication support that are available to them.

**Gender Reassignment**

UCLH offers a pioneering highly specialist national service in the UK for children and adolescents. As the first commissioned endocrine liaison clinic by the Tavistock and Portman NHS Foundation Trust, we offer a comprehensive, multi-organisational, multi-disciplinary assessment service for those up to the age of 18. We also provide specialist physical assessments and medical interventions enabling initial stages of gender transition through hormonal reassignment and partially reversible treatments.

With a growing cohort of over five hundred young trans individuals registered and active within UCLH we are the largest UK liaison service and act as a resource and support within the NHS for newer endocrine Gender Identity Development (GID) services in Leeds and Belfast, which are to be extended to Wales and other regions of England and additionally to GPs within the wider community.

**Marriage and civil partnership**

During 2017 the Trust was able to assist in the on-site civil marriage of one terminally ill patient. The chaplains were consulted about the marriages of two other patients, but in both cases their condition deteriorated quickly and we were unable to fulfil the request in a timely manner. The chaplains, amongst others, are occasionally consulted about the possibility of individual patients getting married, both in civil and religious ceremonies.

**Pregnancy and maternity**

Maternity services have continued to ensure that our services offer high quality, family centred-care that is easily accessible, service-user driven and offers choice for all members of the diverse population we serve. The maternity service continues to develop innovative care packages to improve the quality of care and information that women receive during their pregnancy. Highlights from 2017 include:

- The Continuity of Care programme: Building on the work being done since September 2015 to improve continuity of care during a woman’s pregnancy, we undertook a recent audit of the improved care pathway. We found that 50% of women have access to continuity of care in pregnancy, and whilst there is still much to do, this is a significant improvement from previous audits. The Maternity Unit in the EGA Wing was recently successful in securing monies from the DOH Better Birth’s Call for projects to promote “Better Births and Continuity of care”. The project will involve working across different sites with our North Central London Network
Partners to promote home births for women at low risk of complications in labour. This means that any women who book at UCLH, but who live outside of the UCLH boundaries, can still choose to book a home birth with us, as the home birth teams can traverse across all sectors should the need arise for transfer into a local hospital. This will ensure that women have access to the right care, at the right time, in the right place.

- Managing waiting times: This continues to be a challenge for the outpatient services. We continue to work hard to ensure that all women have regular updates about delays in clinics every half hour, and/or the opportunity to go off site for a specified period of time if clinic appointment delays are more than 30 minutes.

- The maternity helpline is now firmly embedded into the service. This means that women are able to bypass the main hospital switchboard so they can access maternity services/advice directly. We continue to develop other ways that women can make contact with our services, in addition to an email response service, we are looking at implementing SKYPE clinics, which may be of benefit for some women who find the journey into hospital challenging.

- The antenatal booking process has now been captured in a new web based video and will support women with learning disabilities who may struggle to navigate this complicated pathway.

Our local Maternity Voices group ensures that women who use our maternity services have an audible voice about the services we provide and we will listen to what they tell us about those services and act upon anything we could do better. We remain committed to ensuring that UCLH maternity services are a real choice for all women and their families, and we are constantly trying to evaluate the services we provide to ensure they are fit for purpose.

**Ethnicity**

At UCLH, we feel passionate about making services fair and accessible to disadvantaged communities. Our multi-disciplinary team has worked hard to achieve outstanding results in this area. The African Women's Clinic offers confidential assessment, deinfibulation (opening up of the scar tissue to restore the normal vaginal opening) following FGM and support for women who have had FGM. Over the last year this service has been reinvigorated and expanded to provide increased capacity for women and their families in response to the campaign within UCLH and nationally.

The Trust has introduced a Black, Asian and Minority Ethnic (BAME) staff network this year. It is anticipated that this network will have a positive impact on BAME patient and staff experience.

**Religion or belief**

The University College Hospital chaplaincy area provides a welcome to people of faith and of no faith, for patients, visitors and staff. Following a refurbishment that included expanded facilities for Muslim women, the chaplaincy has organised Friday prayers in UCLH at lunchtime for Muslim staff and patients. This is well attended and both staff and patients have particularly appreciated not having to leave the building in colder weather. The adjacent facility at UCLH for observant Jewish patients and families continues to be well-used, and investigations into expanding this service continue.
This year we sadly were unable to celebrate a Keertan Deebar with members of the local Sikh community, staff, patients and students to pray for the hospital. We do hope that this coming year we will be able to resume this event.

The Trust is always seeking to extend its engagement with both local and London-wide world faith communities.

The chaplaincy team continues to assist in the ongoing training of nurses and nursing assistants in matters concerning the practice of some patients’ religious beliefs, particularly around diet and when patients are dying.

The space within the Interfaith centre continues to be used by a large group of staff, patient and others from the local community. The team keeps utilisation under constant review and is currently finalising new way-finding systems within the centre. We support the needs of all those with faith (or none) and aim to provide a haven for quiet and reflection.

The Patient Affairs team continue to find the dedicated bereavement suite essential to providing bereaved families a place where they can talk to the bereavement team whilst managing the affairs of their loved ones who have died. The bereavement team is confident that they have been able to deliver their sensitive services in a dignified, welcoming and comfortable space.

**Gender**

UCLH continues to place the privacy and dignity of its patients high on its agenda and offers dedicated separate inpatient clinical space for both male and female patients. When planning any new facilities, this is considered in detail and incorporated into the design of all additional clinical space. Despite increasing pressures on beds we were successful in maintaining our focus on avoiding mixed sex breaches whilst ensuring that our patients were cared for in the correct specialty and with the correct level of high dependency care preserved.
Patient Experience and Patient & Public Involvement (PPI)

Delivering high quality of care is one of UCLH’s top ten objectives and this includes maintaining our very good patient experience scores. These scores are measured through patient feedback. In 2017, 97,391 patient surveys were completed across UCLH. Patient feedback is important as it tells us what we are doing well and importantly, what we can improve. Each survey asks patients their age, gender, ethnicity, and whether they have a disability; this information allows us to monitor whether we are meeting the needs of all of our patients.

Listening to patients
We held a series of listening events to improve the way we engage with members, patients and the public. Nearly 40 people attended the first event in April. In response to feedback, a second event was held in September which 26 patients and members attended.

At both events British Sign Language interpreters and speech to text reporters were provided for deaf patients at the events to ensure that they were inclusive. A number of patients with a learning disability attended and so easy read versions of the feedback reports were published, providing accessible information for all attendees.

Patient feedback
We have a number of ways that patients can give us feedback. We already offer an electronic survey for our inpatients, which include ‘read aloud’, multiple languages, text resizer, text simplifier and colour contrast options.

Patient Information
We continue to make changes to our written patient information to improve accessibility and ensure we are meeting the requirements of the NHS England Accessible Information Standard. We now have a clearer process for staff to request alternative versions of information including easy read, audio and braille.

To help our patients, families and carers know what is available to them we have developed a poster for waiting areas and wards showing the different formats that can be requested. The poster is an easy to read format that we co-designed with advocates for patients with a learning disability.

[Image of poster]

We have now begun to roll out a core set of accessible general leaflets which are now in the process of being distributed to all our sites.

This year the patient experience team has been working with volunteers who are helping edit leaflets to support staff and improve the readability of all new and revised leaflets. One volunteer is supporting all our sites by maintaining stock in all leaflet racks, helping roll out the core leaflets and installing the new accessible information posters beside our original poster raising awareness of translations in our top 10 requested languages.

Improving the experience of patients with mental health
We have been rolling out a patient focused mental health awareness programme, delivered by Rethink Mental Illness. The programme aims to improve the provision of individualised patient care by educating staff on mental health factors that can affect a
patient’s wellbeing. It helps staff to recognise patients with physical and mental health co-morbidities and confidently support the person in distress and refer on to relevant services.

We recognised the need to support the increasing number of patients with mental health conditions coming to out outpatients departments. This is not covered by the mental health liaison services (provided by Camden and Islington) and current mental health training.
Workforce Priorities for 2018/19

UCLH has agreed a new headline objective for 2018/19 to “Promote equality and inclusion and demonstrate we are an employer of choice” – this will underpin all workforce priorities, along with the new strategic workforce framework – right staff, right way, right capabilities and right leadership.

EDS2 Grading: Complete the EDS2 grading exercise and develop a comprehensive action plan

Equality Impact Assessments: Review the Equality Impact Assessment process and documentation for service developments and changes; audit the EIA process for policies.

Improving Staff Experience:
- Improve the experience of our BME staff as evidenced in the WRES and staff survey;
- Improve the experience of our disabled staff who report a significantly worse experience at work via the staff survey in most key findings
- Improve the experience of our lesbian, gay, bisexual and transsexual staff with a view to improving our performance in the Stonewall Top 100 Employers Index.
- Roll out the “Where do you draw the line?” campaign to areas identified as hot spots

Improving the Recruitment Process and supporting the Resourcing Strategy:
- Undertake further analysis of recruitment data to understand whether there are specific areas, bands or staff groups within which a BME candidate is less likely to be appointed at interview
- Implement actions including training for hiring managers to address this
- Consider what development support can be provided to unsuccessful internal applicants for senior posts with a BME background/female by directors/professional leads
- Consider how we can involve the staff networks in providing expert advice on recruitment to very senior posts, e.g. as advisors to the governors for Non-Executive Director recruitment and as advisors to the Senior Director Team and Board of Governors for director appointments

Improving Learning and Development Opportunities:
- Offer mentoring and coaching support to staff with protected characteristics to enhance their opportunities for promotion including to director level positions
- Undertake market-research amongst BME staff at UCLH to better understand why there is a higher incidence of reporting that UCLH does not provide equal opportunities for career progression/promotion
- Consider what further action can be taken to address this from a policy and/or training perspective

Improving the Employee Relations Process:
- Roll out the new process for formal ER processes
- Audit the newly developed routes for mediation

Improving Information about our Workforce:
- Further improve the recording of staff demographics relating to disability
- In view of limitations in the ESR recording system, consider how the Trust can best record staff who have undergone gender reassignment.
Patient Priorities for 2018/19

Objectives: Review the UCLH overarching Equality and Diversity Objectives and set new objectives, harmonising with patient engagement and feedback information and meeting our ambition of delivering high quality care

Improving the Environment for patients and their families / carers
- Build on the priority recommendations from Disabled Go focusing on physical access
- Supporting the continued improvement of way-finding across the organisation
- Supporting Outpatient services to support patients with memory problems.

Improving access into our services for patients with specific interpreting requirements.
- To continue current priority ensuring that data can be collected on all protected characteristics for patients and that multiple disabilities can be recorded on the patient record.
- Ensuring that the EHRS development captures the Accessible Information Standards (AIS) requirements.
- Installation of Hearing Loops across our admin and front line services.

Supporting access to health and social care to vulnerable or marginalised groups
- Develop further activity specialist roles for both adults and adolescents whose behaviours may be chaotic or disturbed
- Supporting access to the antenatal pathway

Monitoring of Action Plans

Our priorities will be confirmed within the setting of UCLH business plans. In 2018/19, the Diversity and Equality Steering Group will monitor the action plans and will make a regular progress report to the Executive Board.
Workforce Profile

Notes: In all tables “undefined” means that staff have not answered this question. 
Definition of clinical and non-clinical staff is by occupation code using the same methodology as for the WRES report. 
Source of all data is the Electronic Staff Record (ESR).

Workforce by Band

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<th>FTE</th>
<th>Headcount</th>
<th>Percentage of headcount</th>
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</tr>
<tr>
<td>Band 8D</td>
<td>47.8</td>
<td>51</td>
<td>1%</td>
</tr>
<tr>
<td>Band 9</td>
<td>35.1</td>
<td>36</td>
<td>1%</td>
</tr>
<tr>
<td>Very Senior Manager</td>
<td>25.6</td>
<td>27</td>
<td>&lt;0%</td>
</tr>
<tr>
<td>Total</td>
<td>6439</td>
<td>6909</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical and dental staff</th>
<th>FTE</th>
<th>Headcount</th>
<th>Percentage of headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>M &amp; D in training grades</td>
<td>753.7</td>
<td>784</td>
<td>51%</td>
</tr>
<tr>
<td>SAS doctors/dentists &amp; others</td>
<td>60.4</td>
<td>97</td>
<td>6%</td>
</tr>
<tr>
<td>M &amp; D consultants</td>
<td>569.7</td>
<td>645</td>
<td>42%</td>
</tr>
<tr>
<td>Medical and dental total</td>
<td>1383.9</td>
<td>1526</td>
<td>100%</td>
</tr>
</tbody>
</table>

Distribution of workforce by band
The Board of Directors
The Board of Directors has 16 members. Five of the Board members are female and eleven are male. One Board member is from a black and minority ethnic background.
UCLH has a lower percentage of female staff than the NHS average of 79%. However the proportion of female staff at higher bands reduces significantly. This can be clearly seen in the table below. 80% of staff in bands 5 to 7 are female. The proportion of female staff steadily declines from Band 8A to below 40% for very senior managers and directors.

The percentage of female doctors in training is 55% but the percentage of female consultants is 42%.
It is only possible to analyse the workforce by male and female genders. Other genders are not recordable on the ESR as they are not part of the NHS Workforce Minimum Data Set (wMDS). This has been raised as an issue by UCLH with the national suppliers and once this is reportable then further analysis will be undertaken.
Workforce by Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>FTE</th>
<th>Headcount</th>
<th>Percentage of headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>4162.2</td>
<td>4494</td>
<td>52%</td>
</tr>
<tr>
<td>BME</td>
<td>3600.4</td>
<td>3829</td>
<td>45%</td>
</tr>
<tr>
<td>Undefined</td>
<td>202.3</td>
<td>222</td>
<td>3%</td>
</tr>
<tr>
<td>Not stated</td>
<td>20.1</td>
<td>22</td>
<td>&lt;0%</td>
</tr>
<tr>
<td>Total</td>
<td>7985.0</td>
<td>8567</td>
<td>100%</td>
</tr>
</tbody>
</table>

UCLH employs significantly more BME staff than the national NHS average of 11%. However the proportion of BME staff at higher bands reduces significantly. This is also true for medical and dental staff and there is a lower representation of people from BME backgrounds who are identified as ‘supervisors’. This is likely to be highly correlated with the grade differential.

In 2016, 6.8% staff did not have an ethnicity recorded on ESR. In 2017, following the campaign to improve the accuracy and completeness of staff demographic data, the number of staff with no ethnicity recorded has fallen to 3%.
BME staff as % of workforce by band

Clinical

Non Clinical
## Workforce by Religion/Belief

<table>
<thead>
<tr>
<th>Religion/Belief</th>
<th>FTE</th>
<th>Headcount</th>
<th>Percentage of headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Christian (including atheist)</td>
<td>2470.6</td>
<td>2613</td>
<td>31%</td>
</tr>
<tr>
<td>Christian</td>
<td>3250.3</td>
<td>3452</td>
<td>40%</td>
</tr>
<tr>
<td>Do not wish to disclose</td>
<td>893.3</td>
<td>961</td>
<td>11%</td>
</tr>
<tr>
<td>Undefined</td>
<td>1370.9</td>
<td>1541</td>
<td>18%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7985.0</td>
<td>8567</td>
<td>100%</td>
</tr>
</tbody>
</table>

The number of staff who have not declared their religion/belief or do not wish to disclose their religion/belief has reduced from 36% to 29%, of which 11% of staff have said that they do not want to disclose their religion or belief. However, this still makes it difficult to draw meaningful conclusions from these data.

## Workforce by Disability Status

<table>
<thead>
<tr>
<th>Disability</th>
<th>FTE</th>
<th>Headcount</th>
<th>Percentage of headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled</td>
<td>119.2</td>
<td>128</td>
<td>1.5%</td>
</tr>
<tr>
<td>Not disabled</td>
<td>7688.0</td>
<td>8247</td>
<td>96.3%</td>
</tr>
<tr>
<td>Not declared</td>
<td>145.9</td>
<td>156</td>
<td>1.8%</td>
</tr>
<tr>
<td>Undefined</td>
<td>32.0</td>
<td>36</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7985.0</td>
<td>8567</td>
<td>100%</td>
</tr>
</tbody>
</table>

Following the staff data campaign, only 2.2% of staff have not answered this question on the Electronic Staff Record. In 2016, 40% of staff had not answered this question. The number of staff who define themselves as disabled has doubled from 0.7% to 1.5%, however this is still significantly lower than those declaring themselves anonymously on the staff survey to be disabled or have a long-standing illness or health problem. The staff survey also asks staff if UCLH has made adequate adjustments to enable them to carry out their work. In 2017, 70% of staff felt this had happened, compared with 73% in 2016. The development of the Workforce Disability Equality Standard by NHS England will provide a framework for these data to be explored in more detail and will hopefully encourage more staff to report a disability.
## Workforce by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>FTE</th>
<th>Headcount</th>
<th>Percentage of headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;19</td>
<td>15.7</td>
<td>16</td>
<td>0.2%</td>
</tr>
<tr>
<td>20-29</td>
<td>1723.6</td>
<td>1752</td>
<td>20.5%</td>
</tr>
<tr>
<td>30-39</td>
<td>2514.8</td>
<td>2703</td>
<td>31.6%</td>
</tr>
<tr>
<td>40-49</td>
<td>1970.3</td>
<td>2148</td>
<td>25.1%</td>
</tr>
<tr>
<td>50-59</td>
<td>1367.6</td>
<td>1479</td>
<td>17.3%</td>
</tr>
<tr>
<td>60-69</td>
<td>370.2</td>
<td>435</td>
<td>5.1%</td>
</tr>
<tr>
<td>70+</td>
<td>22.8</td>
<td>34</td>
<td>0.4%</td>
</tr>
<tr>
<td>Total</td>
<td>7985.0</td>
<td>8567</td>
<td>100%</td>
</tr>
</tbody>
</table>

The largest proportion of staff falls in the 30-39 age group (31.6%) with 77.2% of staff aged between 20 and 49. This pattern is typical for London trusts.

**Analysis of the workforce by age**

![% Workforce by Age](chart.png)
### Workforce by Marriage/Civil Partnership

<table>
<thead>
<tr>
<th>Marriage/civil partnership</th>
<th>FTE</th>
<th>Headcount</th>
<th>Percentage of headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>2882.5</td>
<td>3207</td>
<td>37.4%</td>
</tr>
<tr>
<td>Civil partnership</td>
<td>72.9</td>
<td>78</td>
<td>0.9%</td>
</tr>
<tr>
<td>Legally separated</td>
<td>44.0</td>
<td>48</td>
<td>0.6%</td>
</tr>
<tr>
<td>Divorced</td>
<td>226.3</td>
<td>243</td>
<td>2.8%</td>
</tr>
<tr>
<td>Widowed</td>
<td>31.5</td>
<td>36</td>
<td>0.4%</td>
</tr>
<tr>
<td>Single</td>
<td>4014.3</td>
<td>4193</td>
<td>48.9%</td>
</tr>
<tr>
<td>Not declared/undefined</td>
<td>713.6</td>
<td>762</td>
<td>8.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7985.0</td>
<td>8567</td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### Workforce by Sexual Orientation

<table>
<thead>
<tr>
<th>Sexual orientation</th>
<th>FTE</th>
<th>Headcount</th>
<th>Percentage of headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual</td>
<td>5529.0</td>
<td>5870</td>
<td>68.5%</td>
</tr>
<tr>
<td>LGB total</td>
<td>289.3</td>
<td>299</td>
<td>3.5%</td>
</tr>
<tr>
<td>Gay</td>
<td>177.7</td>
<td>184</td>
<td>2.1%</td>
</tr>
<tr>
<td>Lesbian</td>
<td>41.1</td>
<td>42</td>
<td>0.5%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>70.5</td>
<td>73</td>
<td>0.9%</td>
</tr>
<tr>
<td>Do not wish to disclose</td>
<td>775.2</td>
<td>838</td>
<td>9.8%</td>
</tr>
<tr>
<td>Undefined</td>
<td>1391.5</td>
<td>1560</td>
<td>18.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7985.0</td>
<td>8567</td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

3.5% of staff have declared that they are gay, lesbian or bisexual. However in 2017 7% of staff declared they were LGB in the staff survey, the same figure as for 2016.

The number of staff who had not declared their sexual orientation had fallen from 34% to 28%, of which 9.8% had made a positive declaration that they did not wish to disclose their sexual orientation.
Employee Relations Cases

This section sets out the number of staff entering formal disciplinary processes during the 2017 calendar year and analyses these data by ethnicity, gender, disability and band.

<table>
<thead>
<tr>
<th>Type of Process</th>
<th>2017 Closed</th>
<th>2017 Live</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disciplinary</td>
<td>36</td>
<td>50</td>
<td>86</td>
<td>15.4%</td>
</tr>
<tr>
<td>Appeal</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>1.1%</td>
</tr>
<tr>
<td>Tribunal</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>0.7%</td>
</tr>
<tr>
<td>Grievance</td>
<td>8</td>
<td>10</td>
<td>18</td>
<td>3.2%</td>
</tr>
<tr>
<td>Harassment</td>
<td>10</td>
<td>9</td>
<td>19</td>
<td>3.4%</td>
</tr>
<tr>
<td>Managing performance</td>
<td>18</td>
<td>10</td>
<td>28</td>
<td>5.0%</td>
</tr>
<tr>
<td>Probation</td>
<td>12</td>
<td>5</td>
<td>17</td>
<td>3.1%</td>
</tr>
<tr>
<td>Sickness</td>
<td>326</td>
<td>53</td>
<td>379</td>
<td>68.1%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>418</td>
<td>139</td>
<td>557</td>
<td>100%</td>
</tr>
</tbody>
</table>

All ER Processes including disciplinary and sickness cases by ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2017 Closed</th>
<th>2017 Live</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>210</td>
<td>92</td>
<td>302</td>
<td>54%</td>
</tr>
<tr>
<td>White</td>
<td>192</td>
<td>42</td>
<td>234</td>
<td>42%</td>
</tr>
<tr>
<td>Not stated or not defined</td>
<td>16</td>
<td>5</td>
<td>21</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>418</td>
<td>139</td>
<td>557</td>
<td>100%</td>
</tr>
</tbody>
</table>

Disciplinary Cases Only

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2017 Closed</th>
<th>2017 Live</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>21</td>
<td>40</td>
<td>61</td>
<td>71%</td>
</tr>
<tr>
<td>White</td>
<td>15</td>
<td>8</td>
<td>23</td>
<td>27%</td>
</tr>
<tr>
<td>Not stated or not defined</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>36</td>
<td>50</td>
<td>86</td>
<td>100%</td>
</tr>
</tbody>
</table>

Sickness Cases Only

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2017 Closed</th>
<th>2017 Live</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>155</td>
<td>28</td>
<td>183</td>
<td>48%</td>
</tr>
<tr>
<td>White</td>
<td>158</td>
<td>24</td>
<td>182</td>
<td>48%</td>
</tr>
<tr>
<td>Not stated or not defined</td>
<td>13</td>
<td>1</td>
<td>14</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>326</td>
<td>53</td>
<td>379</td>
<td>100%</td>
</tr>
</tbody>
</table>

Sickness cases are broadly in line with the overall staff breakdown. However the position for BME staff undergoing formal disciplinary action has worsened since 2016 from 56% to 71%.

Overall the position has slightly improved with BME staff being 1.34 times more likely to be subject to a formal ER process. However the position for disciplinary cases only shows that BME staff are 2.27 times more likely to be subject to a formal disciplinary process. The Employee Relations team continues to closely monitor referrals and has revised the pathway for mediation.
All ER Processes including disciplinary and sickness cases by gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>2017 Closed</th>
<th>2017 Live</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>319</td>
<td>89</td>
<td>408</td>
<td>73.2%</td>
</tr>
<tr>
<td>Male</td>
<td>99</td>
<td>50</td>
<td>149</td>
<td>26.8%</td>
</tr>
<tr>
<td>Total</td>
<td>418</td>
<td>139</td>
<td>557</td>
<td>100%</td>
</tr>
</tbody>
</table>

Disciplinary Cases only

<table>
<thead>
<tr>
<th>Gender</th>
<th>2017 Closed</th>
<th>2017 Live</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>22</td>
<td>25</td>
<td>47</td>
<td>55%</td>
</tr>
<tr>
<td>Male</td>
<td>14</td>
<td>25</td>
<td>39</td>
<td>45%</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>50</td>
<td>86</td>
<td>100%</td>
</tr>
</tbody>
</table>

Sickness Cases only

<table>
<thead>
<tr>
<th>Gender</th>
<th>2017 Closed</th>
<th>2017 Live</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>254</td>
<td>38</td>
<td>292</td>
<td>77%</td>
</tr>
<tr>
<td>Male</td>
<td>72</td>
<td>15</td>
<td>87</td>
<td>23%</td>
</tr>
<tr>
<td>Total</td>
<td>326</td>
<td>53</td>
<td>379</td>
<td>100%</td>
</tr>
</tbody>
</table>

For disciplinary cases male staff are much more likely to be subject to formal disciplinary action, compared to the organisational workforce profile. The position is reversed for sickness cases where female staff are more likely to be subject to formal sickness action, compared with the overall workforce profile.

All ER processes including disciplinary and sickness cases by disability

<table>
<thead>
<tr>
<th>Disability</th>
<th>2017 Closed</th>
<th>2017 Live</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not disabled</td>
<td>332</td>
<td>123</td>
<td>455</td>
<td>82%</td>
</tr>
<tr>
<td>Disabled</td>
<td>20</td>
<td>4</td>
<td>24</td>
<td>4%</td>
</tr>
<tr>
<td>Not stated or not defined</td>
<td>72</td>
<td>6</td>
<td>78</td>
<td>14%</td>
</tr>
<tr>
<td>Total</td>
<td>424</td>
<td>133</td>
<td>557</td>
<td>100%</td>
</tr>
</tbody>
</table>

Disciplinary Cases only

<table>
<thead>
<tr>
<th>Disability</th>
<th>2017 Closed</th>
<th>2017 Live</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not disabled</td>
<td>28</td>
<td>48</td>
<td>76</td>
<td>80%</td>
</tr>
<tr>
<td>Disabled</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Not stated or not defined</td>
<td>12</td>
<td>6</td>
<td>18</td>
<td>19%</td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>55</td>
<td>95</td>
<td>100%</td>
</tr>
</tbody>
</table>

Sickness Cases Only

<table>
<thead>
<tr>
<th>Disability</th>
<th>2017 Closed</th>
<th>2017 Live</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not disabled</td>
<td>250</td>
<td>50</td>
<td>300</td>
<td>79%</td>
</tr>
<tr>
<td>Disabled</td>
<td>15</td>
<td>2</td>
<td>17</td>
<td>4.5%</td>
</tr>
<tr>
<td>Not stated or not defined</td>
<td>61</td>
<td>1</td>
<td>62</td>
<td>16.5%</td>
</tr>
<tr>
<td>Total</td>
<td>326</td>
<td>53</td>
<td>379</td>
<td>100%</td>
</tr>
</tbody>
</table>
Disabled staff are more likely to be subject to formal ER processes than non-disabled staff. The position for sickness action shows that disabled staff are three times more likely than non-disabled staff to be subject to formal sickness action and this will be explored in 2018.

### All ER processes including disciplinary and sickness cases by pay band

<table>
<thead>
<tr>
<th>Pay Band</th>
<th>2017 Closed</th>
<th>2017 Live</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Band 2</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>0.9%</td>
</tr>
<tr>
<td>Band 3</td>
<td>13</td>
<td>8</td>
<td>21</td>
<td>3.8%</td>
</tr>
<tr>
<td>Band 4</td>
<td>174</td>
<td>75</td>
<td>249</td>
<td>44.7%</td>
</tr>
<tr>
<td>Band 5</td>
<td>42</td>
<td>19</td>
<td>61</td>
<td>11.0%</td>
</tr>
<tr>
<td>Band 6</td>
<td>66</td>
<td>16</td>
<td>82</td>
<td>14.7%</td>
</tr>
<tr>
<td>Band 7</td>
<td>22</td>
<td>8</td>
<td>30</td>
<td>5.4%</td>
</tr>
<tr>
<td>Band 8</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>1.3%</td>
</tr>
<tr>
<td>Band 9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Medical/dental</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>0.5%</td>
</tr>
<tr>
<td>Band not stated</td>
<td>90</td>
<td>9</td>
<td>99</td>
<td>17.7%</td>
</tr>
</tbody>
</table>
| **Total** | **418**     | **139**   | **557**     | **100**%

### Disciplinary Cases only

<table>
<thead>
<tr>
<th>Pay Band</th>
<th>2017 Closed</th>
<th>2017 Live</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Band 2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>Band 3</td>
<td>1</td>
<td>5</td>
<td>6</td>
<td>7.0%</td>
</tr>
<tr>
<td>Band 4</td>
<td>13</td>
<td>24</td>
<td>37</td>
<td>43.0%</td>
</tr>
<tr>
<td>Band 5</td>
<td>4</td>
<td>5</td>
<td>9</td>
<td>10.5%</td>
</tr>
<tr>
<td>Band 6</td>
<td>4</td>
<td>9</td>
<td>13</td>
<td>15.1%</td>
</tr>
<tr>
<td>Band 7</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3.5%</td>
</tr>
<tr>
<td>Band 8</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>Band 9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Medical/dental</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Band not stated</td>
<td>11</td>
<td>5</td>
<td>16</td>
<td>18.6%</td>
</tr>
</tbody>
</table>
| **Total** | **36**      | **50**    | **86**      | **100**%

### Sickness Cases only

<table>
<thead>
<tr>
<th>Pay Band</th>
<th>2017 Closed</th>
<th>2017 Live</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Band 2</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>0.8%</td>
</tr>
<tr>
<td>Band 3</td>
<td>11</td>
<td>1</td>
<td>12</td>
<td>3.2%</td>
</tr>
<tr>
<td>Band 4</td>
<td>141</td>
<td>37</td>
<td>178</td>
<td>47.0%</td>
</tr>
<tr>
<td>Band 5</td>
<td>34</td>
<td>8</td>
<td>42</td>
<td>11.1%</td>
</tr>
<tr>
<td>Band 6</td>
<td>60</td>
<td>4</td>
<td>64</td>
<td>16.9%</td>
</tr>
<tr>
<td>Band 7</td>
<td>14</td>
<td>3</td>
<td>17</td>
<td>4.5%</td>
</tr>
<tr>
<td>Band 8</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>1.0%</td>
</tr>
<tr>
<td>Band 9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Medical/dental</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0.5%</td>
</tr>
<tr>
<td>Band not stated</td>
<td>57</td>
<td>0</td>
<td>57</td>
<td>15.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>326</strong></td>
<td><strong>53</strong></td>
<td><strong>379</strong></td>
<td><strong>100</strong>%</td>
</tr>
</tbody>
</table>
Staff on band 6 or below are most likely to be subject to formal ER processes with 75% of cases affecting staff on these bands. These are the pay bands with a predominance of BME staff. 43% of formal disciplinary cases involve staff on Band 4. There has been a change since 2016 with an increase in Band 4 staff being disciplined and a fall in the number of staff on Bands 3 and 5 being disciplined.

As part of our action plan in 2017, managers have undertaken training in unconscious bias. In 2018/19 we will consider what steps can be taken to reduce the number of formal ER cases, e.g. by encouraging more informal action being taken by line managers and whether additional steps need to be introduced to review the outcome of an ER investigation before a case goes to a hearing.
Non-Mandatory Training

An analysis has been undertaken of staff undertaking non-mandatory training at UCLH during 2017. Most medical and dental continuous professional development is not be included in these figures as staff record these on their own training portfolio.

- Of those undertaking training, 74.9% were females, compared with 71% of the workforce.
- 2.67% declared that they were disabled.
- An analysis by pay band showed that:
  - 19.3% to 16.1% were on Band 4 or below (an increase from the 2016 position of 16.1%)
  - 66.8% on bands 5 to 7 (the same as in 2016)
  - 10% were on band 8A or above.
- 47.3% were from a white background and 50.1% were from a BME background, showing that BME staff are slightly more likely to undertake training than their white counterparts.

### Non-Mandatory Training

<table>
<thead>
<tr>
<th>Gender</th>
<th>Female</th>
<th>Male</th>
<th>Not stated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>74.9%</td>
<td>25.1%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>White</th>
<th>BME</th>
<th>Not stated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>47.3%</td>
<td>50.1%</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disability</th>
<th>Disabled</th>
<th>Not disabled</th>
<th>Not stated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.67%</td>
<td>95.9%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Heterosexual</th>
<th>Lesbian/Gay</th>
<th>Bisexual</th>
<th>Not stated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>73.0%</td>
<td>2.1%</td>
<td>1.2%</td>
<td>23.7%</td>
</tr>
</tbody>
</table>

### By Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20 years</td>
<td>0.47%</td>
</tr>
<tr>
<td>21-30 years</td>
<td>22.4%</td>
</tr>
<tr>
<td>31-40 years</td>
<td>30.1%</td>
</tr>
<tr>
<td>41-50 years</td>
<td>29.4%</td>
</tr>
<tr>
<td>51-60 years</td>
<td>16.0%</td>
</tr>
<tr>
<td>61-70 years</td>
<td>1.6%</td>
</tr>
<tr>
<td>&gt;70 years</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

### By Band

<table>
<thead>
<tr>
<th>Band</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1/2</td>
<td>2.4%</td>
</tr>
<tr>
<td>Band 3</td>
<td>3.9%</td>
</tr>
<tr>
<td>Band 4</td>
<td>13.0%</td>
</tr>
<tr>
<td>Band 5</td>
<td>21.1%</td>
</tr>
<tr>
<td>Band 6</td>
<td>24.0%</td>
</tr>
<tr>
<td>Band 7</td>
<td>21.7%</td>
</tr>
<tr>
<td>Band 8</td>
<td>10.0%</td>
</tr>
<tr>
<td>Not stated</td>
<td>1.1%</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>2.7%</td>
</tr>
</tbody>
</table>

Overall Page 290 of 347
## NHS Staff Survey Results 2017

### Key Finding 2016

<table>
<thead>
<tr>
<th>Category</th>
<th>BME</th>
<th>White</th>
<th>Male</th>
<th>Female</th>
<th>Disabled</th>
<th>Non-disabled</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Respondents</strong></td>
<td>3277</td>
<td>3307</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Overall staff engagement</strong></td>
<td>3.89</td>
<td>3.89</td>
<td>3.96</td>
<td>3.86</td>
<td>3.90</td>
<td>3.91</td>
</tr>
<tr>
<td>KF1 place to work or receive treatment</td>
<td>3.99</td>
<td>3.99</td>
<td>4.09</td>
<td>3.94</td>
<td>4.02</td>
<td>3.99</td>
</tr>
<tr>
<td>KF2 satisfaction with patient care</td>
<td>3.96</td>
<td>3.94</td>
<td>4.18</td>
<td>3.78</td>
<td>3.92</td>
<td>3.94</td>
</tr>
<tr>
<td>KF3 role makes a difference to patients</td>
<td>91</td>
<td>91</td>
<td>94</td>
<td>90</td>
<td>90</td>
<td>92</td>
</tr>
<tr>
<td>KF4 staff motivation at work</td>
<td>3.93</td>
<td>3.89</td>
<td>4.00</td>
<td>3.85</td>
<td>3.88</td>
<td>3.93</td>
</tr>
<tr>
<td>KF5 recognition and value by managers</td>
<td>3.51</td>
<td>3.52</td>
<td>3.58</td>
<td>3.50</td>
<td>3.54</td>
<td>3.53</td>
</tr>
<tr>
<td>KF6 good communication with senior management</td>
<td>39</td>
<td>39</td>
<td>43</td>
<td>38</td>
<td>41</td>
<td>39</td>
</tr>
<tr>
<td>KF7 able to contribute to improvements</td>
<td>73</td>
<td>74</td>
<td>73</td>
<td>75</td>
<td>76</td>
<td>74</td>
</tr>
<tr>
<td>KF8 satisfaction with level of responsibility and involvement</td>
<td>3.90</td>
<td>3.89</td>
<td>3.95</td>
<td>3.89</td>
<td>3.92</td>
<td>3.92</td>
</tr>
<tr>
<td>KF9 effective team working</td>
<td>3.77</td>
<td>3.76</td>
<td>3.80</td>
<td>3.76</td>
<td>3.79</td>
<td>3.77</td>
</tr>
<tr>
<td>KF10 support from immediate managers</td>
<td>3.74</td>
<td>3.76</td>
<td>3.80</td>
<td>3.75</td>
<td>3.79</td>
<td>3.77</td>
</tr>
<tr>
<td>KF11 % appraised in past 12 months</td>
<td>93</td>
<td>92</td>
<td>91</td>
<td>93</td>
<td>92</td>
<td>92</td>
</tr>
<tr>
<td>KF12 quality of appraisals</td>
<td>3.29</td>
<td>3.32</td>
<td>3.65</td>
<td>3.14</td>
<td>3.28</td>
<td>3.37</td>
</tr>
<tr>
<td>KF13 quality of non-mandatory training/development</td>
<td>4.07</td>
<td>4.10</td>
<td>4.18</td>
<td>4.06</td>
<td>4.07</td>
<td>4.11</td>
</tr>
<tr>
<td>KF14 satisfaction with resourcing and support</td>
<td>3.30</td>
<td>3.27</td>
<td>3.41</td>
<td>3.18</td>
<td>3.30</td>
<td>3.25</td>
</tr>
<tr>
<td>KF15 flexible working patterns</td>
<td>52</td>
<td>51</td>
<td>53</td>
<td>51</td>
<td>50</td>
<td>52</td>
</tr>
<tr>
<td>KF16 % working extra hours</td>
<td>77</td>
<td>77</td>
<td>72</td>
<td>82</td>
<td>78</td>
<td>78</td>
</tr>
<tr>
<td>KF17 % suffering work-related stress</td>
<td>39</td>
<td>41</td>
<td>39</td>
<td>42</td>
<td>36</td>
<td>42</td>
</tr>
<tr>
<td>KF18 % pressure to attend work when unwell</td>
<td>53</td>
<td>51</td>
<td>49</td>
<td>52</td>
<td>46</td>
<td>53</td>
</tr>
</tbody>
</table>
The results of the staff survey continue to show that our disabled staff report a worse experience in the workplace for most key findings and this will need to be explored in 2018. Once again 14.5% of those completing the staff survey declare that they are disabled, compared with the data recorded on ESR which tells us that only 1.5% of staff report that they are disabled.

The results for BME staff relating to discrimination, equal opportunities and harassment and bullying and physical violence from staff continue to raise clear concerns which are being addressed by initiatives led by the staff experience team and also locally in divisions. However, BME staff satisfaction in most other areas is extremely positive. BME staff are the most engaged staff group and also have the highest score for recommending UCLH as a place to work or receive treatment.
Recruitment and selection data

In 2017 UCLH received 36,457 applications for jobs. Of these, 14,369 applicants were shortlisted and 1,996 applicants were offered jobs with UCLH. On average there are more than 18 applicants for each job advertised with more than 7 applicants being shortlisted for interview.

There are more applications from female staff than male staff. Female staff are more likely to be shortlisted than their male counterparts but male staff are more likely to be appointed than female staff.

There are more applications from BME staff than from white staff (62.5%) but white staff are 1.45 times more likely to be appointed than their BME counterparts. There has been an increase in the percentage of jobs offered to BME applicants since 2016.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Applications %</th>
<th>Shortlisted %</th>
<th>Offered %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>32.3</td>
<td>22.0</td>
<td>30.2</td>
</tr>
<tr>
<td>Female</td>
<td>67.4</td>
<td>77.7</td>
<td>69.6</td>
</tr>
<tr>
<td>Not stated/I do not wish to disclose</td>
<td>0.3</td>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Applications %</th>
<th>Shortlisted %</th>
<th>Offered %</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>34.5</td>
<td>41.0</td>
<td>47.2</td>
</tr>
<tr>
<td>BME</td>
<td>62.5</td>
<td>55.6</td>
<td>50.0</td>
</tr>
<tr>
<td>Not stated/I do not wish to disclose</td>
<td>3.1</td>
<td>3.4</td>
<td>2.8</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Applications %</th>
<th>Shortlisted %</th>
<th>Offered %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual</td>
<td>86.7</td>
<td>77.9</td>
<td>89.4</td>
</tr>
<tr>
<td>Gay/lesbian</td>
<td>2.4</td>
<td>2.8</td>
<td>2.1</td>
</tr>
<tr>
<td>Bisexual</td>
<td>0.9</td>
<td>0.5</td>
<td>0</td>
</tr>
<tr>
<td>Do not wish to describe or disclose</td>
<td>7.7</td>
<td>7.6</td>
<td>8.5</td>
</tr>
<tr>
<td>Not stated</td>
<td>2.3</td>
<td>11.2</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transgender</th>
<th>Applications %</th>
<th>Shortlisted %</th>
<th>Offered %</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>35.7</td>
<td>37.7</td>
<td>48.0</td>
</tr>
<tr>
<td>Yes</td>
<td>0.4</td>
<td>0.3</td>
<td>0.5</td>
</tr>
<tr>
<td>Do not wish to answer this question</td>
<td>1.1</td>
<td>1.3</td>
<td>0.8</td>
</tr>
<tr>
<td>Not stated</td>
<td>62.8</td>
<td>60.7</td>
<td>50.7</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

The TRAC recruitment system allows people who have undergone gender reassignment to be recorded but this cannot be recorded on ESR.
### Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Applications %</th>
<th>Shortlisted %</th>
<th>Offered %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>1.3</td>
<td>0.8</td>
<td>1.3</td>
</tr>
<tr>
<td>20 - 29</td>
<td>43.8</td>
<td>37.9</td>
<td>38.2</td>
</tr>
<tr>
<td>30 - 39</td>
<td>29.4</td>
<td>31.6</td>
<td>36.9</td>
</tr>
<tr>
<td>40 - 49</td>
<td>16.1</td>
<td>18.7</td>
<td>16.8</td>
</tr>
<tr>
<td>50 - 59</td>
<td>83.4</td>
<td>10.0</td>
<td>6.3</td>
</tr>
<tr>
<td>60 - 65</td>
<td>0.9</td>
<td>0.9</td>
<td>0.4</td>
</tr>
<tr>
<td>65+</td>
<td>0.1</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Not stated</td>
<td>0</td>
<td>0</td>
<td>0.1</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

### Religion/belief

<table>
<thead>
<tr>
<th>Religion/belief</th>
<th>Applications %</th>
<th>Shortlisted %</th>
<th>Offered %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atheism</td>
<td>9.8</td>
<td>10.8</td>
<td>14.7</td>
</tr>
<tr>
<td>Buddhism</td>
<td>1.2</td>
<td>1.1</td>
<td>0.8</td>
</tr>
<tr>
<td>Christianity</td>
<td>46.2</td>
<td>39.9</td>
<td>47.1</td>
</tr>
<tr>
<td>Hinduism</td>
<td>6.7</td>
<td>6.6</td>
<td>4.9</td>
</tr>
<tr>
<td>Islam</td>
<td>17.8</td>
<td>13.4</td>
<td>12.6</td>
</tr>
<tr>
<td>Jainism</td>
<td>0.2</td>
<td>0.1</td>
<td>0.4</td>
</tr>
<tr>
<td>Judaism</td>
<td>0.5</td>
<td>0.7</td>
<td>0.8</td>
</tr>
<tr>
<td>Sikhism</td>
<td>1.1</td>
<td>1.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Other</td>
<td>5.4</td>
<td>4.1</td>
<td>6.2</td>
</tr>
<tr>
<td>I do not wish to disclose</td>
<td>10.8</td>
<td>11.0</td>
<td>10.3</td>
</tr>
<tr>
<td>Not stated</td>
<td>0.3</td>
<td>11.2</td>
<td>1.1</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

### Disability

<table>
<thead>
<tr>
<th>Disability</th>
<th>Applications %</th>
<th>Shortlisted %</th>
<th>Offered %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4.1</td>
<td>4.5</td>
<td>3.5</td>
</tr>
<tr>
<td>No</td>
<td>94.0</td>
<td>93.0</td>
<td>93.9</td>
</tr>
<tr>
<td>I do not wish to disclose</td>
<td>1.3</td>
<td>1.2</td>
<td>1.4</td>
</tr>
<tr>
<td>Not stated</td>
<td>0.6</td>
<td>1.3</td>
<td>1.2</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

**UCLH is a disability confident employer - if an applicant declares on their application form that they have a disability and they meet the minimum criteria for the position, then they will be guaranteed an interview.**

### Guaranteed Interview Scheme

<table>
<thead>
<tr>
<th>Guaranteed Interview Scheme</th>
<th>Applications %</th>
<th>Shortlisted %</th>
<th>Offered %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2.8</td>
<td>2.9</td>
<td>2.2</td>
</tr>
<tr>
<td>No</td>
<td>1.2</td>
<td>1.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Not stated</td>
<td>96.0</td>
<td>95.6</td>
<td>96.4</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
All recruitment team members have received unconscious bias training to reduce discrimination in the recruitment and selection process and training is also available to hiring managers. There is a project ongoing to increase our understanding of the data so that we can take the appropriate actions to improve our performance. A new training package for hiring managers is being developed in the light of best practice.

In addition, in 2018/19 we will consider how we can involve the staff networks in providing expert advice on recruitment to very senior posts, e.g. as advisors to the governors for Non-Executive Director recruitment and as advisors to the Senior Director Team and Board of Governors for director appointments. We will also explore the feasibility of providing director-level feedback to any internal shortlisted BME and/or female candidate who is unsuccessful at interview for a senior management role to allow a dedicated development plan to be prepared which will be sponsored by their director or professional lead.
Patient Data

Equality Monitoring Information on our Patients

Please note that the information provided in this section of the report only relates to our compliance with the first aim of the general equality duty that refers to eliminating discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Equality Act (2010).

Our patients by age

<table>
<thead>
<tr>
<th>Age Range</th>
<th>0-19</th>
<th>20-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60-69</th>
<th>70-79</th>
<th>80-89</th>
<th>90+</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data</td>
<td>129,197</td>
<td>148,807</td>
<td>249,676</td>
<td>184,160</td>
<td>210,251</td>
<td>199,274</td>
<td>151,032</td>
<td>59,310</td>
<td>7,612</td>
<td>1,339,319</td>
</tr>
</tbody>
</table>

The largest age group of our patients/service users who accessed our services in different ways between December 2016 and November 2017 is 30 to 39 years at 18.64% (n249,676). In each month from December to April there was quite a large variance with big dips in December and April which is consistent with Christmas and Easter. May through to November was fairly stable with a slight decline through the summer and a marginal increase later in the year. The following chart illustrates the breakdown of our service users by age over the last few months.

Our patients by disability

Our records show that 9.3% (n124, 179) of our patients report they are disabled. We also record the type of disability when our patients come into contact with us. Please see Appendix 3 for more information on the types of disability of our patients.
The chart below depicts the breakdown of disabled patients who used our services in 2017 by month. The proportion of disabled patients seems to have been very similar each month and only increased in numbers when the total patient number increased.

Our Gender Reassignment Information
UCLH provides gender reassignment services as part of the Urology Directorate. The service is currently not taking any more patients in order to concentrate on the care and support of those already being treated.

Service users by marriage and civil partnership
The following chart illustrates the 2017 trends by month for this protected characteristic. It highlights that about half of our data for this category is unknown.
Pregnancy and maternity information
We had 98,617 patients who accessed our maternity services between December 2016 and November 2017, the highest proportion of which were White British at 21.2% (n20,947), followed by Any Other White Background at 15.1% (n14,870) and Any Other Ethnic Group at 15.1% (n14,870). 1.8% (n1805) of our maternity patients declared themselves as having a disability. However, a large proportion of this data remains undefined (51.6%). 19.3% of our maternity patients reported they were married or in a civil partnership. The largest proportion of our maternity patients declared themselves as Christian in religion at 7.4%. However, again a large proportion of this data remains undefined (79.3%).

Our patients by race/ethnicity
Data on race/ethnicity is classified according to the breakdown used in the 2001 census. Our most represented patient ethnic group is White - British at 38.9% (n520, 420) followed by White - Any Other White Background at 10.3% (n138, 090). The least represented ethnic group in our patients are service users from a White and Black African mixed background representing 0.3% (n4, 541) in total. A significant proportion of race/ethnicity data for our patients has been undefined at 21.6% (n289, 745).

The following chart depicts the 2017 trends for our service users by race broken down by months. It shows that although the number of patients has fluctuated, the proportion of different ethnicities has remained relatively stable. A breakdown of information on our patients’ race/ethnicity can be found at the beginning of this appendix.
Our Patients by Religion or Belief
56.4% of our patient data on religion or belief is undefined. 22.3% (n298,797) of patients for whom we hold this information identified themselves as Christian.
The following chart illustrates the 2017 religion or belief trends by month.

We are working on improving our reporting systems to decrease the undefined data in order to ensure that this protected characteristic is being captured properly. This would help us to identify the needs of people from different religious or belief backgrounds in terms of their care, treatment and preferences when they come into contact with us.

Our patients by gender
Most of the people who accessed our services in 2017 were female at 59.5% (n797,202). Compared to our local population, this is slightly higher as the percentage of females in North Central London is 52%. It has been suggested that women access health services more than men. This figure may be in line with this suggestion. In 2007, according to The State of Equality in London Report 2008 published by Greater London Authority, 51.1 per cent (3,834,500) of London’s population was female (women and girls), which means there are over 164,100 more women and girls than boys and men in London.
The chart below illustrates the trends for patients by gender over the last year.

**Unknown = no answer**

**Our patients by sexual orientation**
Data for patient sexual orientation is not currently being recorded. We are putting plans in place to include this protected characteristic in future.
Patient Experience

1. INPATIENT SURVEYS

National Surveys
Every year, we commission the Picker Institute Europe to undertake independent research on our inpatients. The results of this research are then published in an annual Inpatient Survey report. These annual surveys are required by the Care Quality Commission (CQC) for NHS acute trusts in England.

Our latest survey is based on a sample of consecutively discharged inpatients who attended the Trust in July 2016. The report of this survey was shared with us in January 2017. We, like all trusts, use a standard methodology and standard questions, as specified by the NHS Patient Survey Co-ordination Centre, based at Picker Institute Europe. The questionnaire reflects the priorities and concerns of patients and is based upon what is most important from the patient’s perspective.

Key findings
Of the 1689 inpatients who were asked to complete our Inpatient Survey in 2016, 603 responded, giving a response rate of 35.7%. The demographics of respondents are outlined below:

Gender: 47% male, 54% female
Age Range: 13% were aged 16-39; 24% were aged 40-59; 25% were aged 60-69 and 39% were aged 70+
Ethnic Background: 84% White, 2% Multiple ethnic group, 7% Asian/Asian British, 6% Black/Black British, 1% Arab or Other ethnic group (11% not known).

There is no information available on the experiences of patients by demographics as this was not part of the Picker analysis in 2016.

Local inpatient survey
In addition to the annual survey carried out by Picker Institute Europe, we give our patients the opportunity to complete a survey when they are discharged from UCLH, giving us real time feedback.

This survey consists of questions which are based on the national inpatient survey results and includes the Friends and Family Test (FFT) question. This allows us to track our progress in real time and highlights areas that are performing well, and areas that need improvement.

Key findings
11,452 local inpatient surveys were completed in 2017. The demographics of respondents are outlined below:

Gender: 53% male, 47% female
Age Range: 10% were aged 0-15, 9% were aged 16-24; 14% were aged 25-34; 14% were aged 35-44; 15% were aged 45-54; 15% were aged 55-64; 13% were aged 65-74; 8% were aged 75-84; 3% were aged 85+
**Ethnic Background:** 69% White, 5% Multiple, 10% Asian/Asian British, 10% Black/Black British, 6% Other Ethnic Group.

FFT scores by demographic group (1st Jan 2017 to 31st Dec 2017)

<table>
<thead>
<tr>
<th>Gender</th>
<th>FFT % recommended score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>94%</td>
</tr>
<tr>
<td>Female</td>
<td>92%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>FFT % recommended score</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>92%</td>
</tr>
<tr>
<td>25-34</td>
<td>92%</td>
</tr>
<tr>
<td>35-44</td>
<td>92%</td>
</tr>
<tr>
<td>45-54</td>
<td>94%</td>
</tr>
<tr>
<td>55-64</td>
<td>95%</td>
</tr>
<tr>
<td>65-74</td>
<td>95%</td>
</tr>
<tr>
<td>75-84</td>
<td>92%</td>
</tr>
<tr>
<td>85+</td>
<td>95%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic Background</th>
<th>FFT % recommended score</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>94%</td>
</tr>
<tr>
<td>Asian</td>
<td>91%</td>
</tr>
<tr>
<td>Black</td>
<td>92%</td>
</tr>
<tr>
<td>Multiple</td>
<td>91%</td>
</tr>
<tr>
<td>Other</td>
<td>91%</td>
</tr>
</tbody>
</table>
2. **ENSURING EQUAL ACCESS TO COMPLAINTS**

UCLH recognises that inequality of access to the complaints process may be influenced by educational background, cultural issues and language, disabilities and learning difficulties. Therefore, we endeavour to make the complaints process easy to access, including providing support to complainants who wish to make a complaint but are unable to do so in writing or make a complaint themselves. Approximately 34 complainants were supported to make a verbal complaint this way in 2017. Other methods of support include directing all complainants to the NHS Complaints Advocacy Service (Voiceability or Pohwer) for further support, offering complaints translation services, the use of sign language and Type Talk, producing complaints leaflets that can be translated into different languages on request and advertising the availability of Type Talk service provided by the Royal National Institute for the Deaf on the Trust’s website.

Information about how to make a complaint or raise a concern includes an easy read format developed by Camden Easy Read Group and the team refer any complainant with learning difficulties to the LD CNS for additional support.

Over the last few years there have been a number of initiatives to improve awareness of how to raise concerns or complain about care. An updated leaflet on raising a concern or making a complaint was revised in 2016. Information about complaints and access to advocacy services has been improved on the Trust website and is included in the patient admission pack (The Welcome Pack) which was launched in 2013. This pack includes a handy leaflet explaining who to contact with concerns and how to complain if a complainant still has issues that have not been addressed.

In 2015 a call for concern number was introduced. This is available at every bedside and puts patients or their relatives in touch with a senior nurse.

If the area of concern is one that can be addressed without using the formal complaints process, then UCLH staff and the complaints team will try to facilitate this and will check this approach has resolved any concern. Standards for complaint responses have been in place since 2014 with greater clinical involvement; all departments now use clinical staff to respond to clinical areas of concern either directly or in conjunction with managers.

**Monitoring**

Each division within UCLH has a monthly governance meeting, at which complaints and Patient Advice and Liaison Service (PALS) data is considered alongside other indicators of quality care such as patient survey data, infection, falls, pressure ulcers, clinical incidents, and staffing information. The ward quality boards display the number of complaints. A scorecard is available for each ward and complaints are part of the Performance Book which is reviewed across the organisation each month. Trends across complaints, PALS and patient experience are discussed at a quarterly complaints monitoring group and an integrated report developed and circulated each quarter. Site specific groups have also been set up to review all aspects of patient and staff experience and to feed into a trustwide Improving Experience Group (IEG).

A patient experience report which triangulates evidence between complaints and other quality measures is presented every quarter to the IEG, and then shared with the Patient.
Experience Committee (PEC) or the Trust’s Quality and Safety Committee (QSC) and in turn with the commissioners.

An Annual Complaints Report is produced and is taken to the QSC, the PEC and the Trust Board and is available on the Trust website.

Complaints and PALS data are used in the revalidation process for medical staff and can be used for other healthcare professionals, in line with post Francis recommendations.

The focus is on resolving concerns at the earliest opportunity but complex complaints can take much longer to investigate.

The Chief Executive or his deputy signs off all complaint responses. The Chief Nurse and Chairman see all complaints and non-executive directors review all complaints and their responses on a rotational basis. The Trust Board receives a summary of the QSC minutes and has used anonymised complaints in their discussions. The outgoing Chairman and complaints manager held a rotational complaints forum in the divisions on issues and themes arising from complaints and how we can improve.

A criticism by Sir Robert Francis was that complaints were not shared with Subject Matter Experts, e.g. falls at Mid Staffordshire were all managed by individual departments, and with no central team, so no one person had an overview for the whole Trust. At UCLH we ensure that subject matter experts are copied into complaints relating to their area of expertise, e.g. the falls lead is copied into every complaint referencing a fall. Complaints that may indicate safeguarding issues or serious incidents are discussed in a safety huddle and passed to the safeguarding lead as appropriate. When complaints are received, there is evidence that learning takes place and that there are processes in place for continual improvement in complaints handling and learning lessons.
Complaints by Protected Characteristic

Age and Complaints
In the reference period, UCLH received 841 formal complaints an increase on the previous year of 170 complaints. This is explored in the annual complaint report. The largest patient age group making complaints is aged 26 to 55 years. The chart below illustrates this in further detail. When a complaint is made by a visitor, relative or carer, we do not have access to age and so this is not recorded.

When complaints are received in which the age and potential frailty of a patient are a factor they are shared with the care of the elderly nurse consultant and safeguarding lead to ensure awareness of issues and consideration of other measures or processes. The importance of making an allowance for age during admission and discharge planning has been shared via range of trust work streams and included in the quality and safety newsletter when appropriate.

Hearing Impairment
14 Hearing impaired patients brought concerns to the attention of complaints over this period. 9 of these were linked to the availability of interpreters. There were changes to the national contract for BSL interpreting services to bring payment in line with other translation services in 2017. Whilst this was being implemented a shortfall in the number of interpreters arose. A second service was contracted during this period, and after the adoption of the new contract complaints have since reduced. Other issues included appointment booking process, access to specialist hearing aids, clinical care and communication when outpatients are running late.

Sight Impairment
Eight complaints were received from patients with visual impairment, but no complaints were directly linked to their disability, rather they were about overall experience and care.

Learning Disability
Four complaints or contacts were received, mainly from the next of kin or an advocate. Concerns raised included changing appointments which confused the patient, transport delays and attitude of some members of staff in two areas. These complaints have been shared with the learning disability lead and the new LD CNS and teaching sessions have been offered to areas in which complaints were received.
**Mobility impairment**
Twenty-three complaints were received from patients identified as having mobility impairment. The majority of complaints have been linked to Transport issues such as delays or the type of vehicle provided. The contract with the Trust’s Transport provider has been reviewed as a result of poor patient experience and we hope this will reduce this issue going forward. Other issues have been linked to communication around appointments and clinical care but there were no formal parking complaints from wheelchair users for this period.

**Mental health**
Five complaints were linked to mental health concerns. Examples of the issues raised included care in the emergency department prior to being transferred to another hospital, the process used to detain a patient against their will and the support given for mental health needs when admitted with other clinical problems.

**Cognitive impairment**
There were two complaints linked to cognitive impairment in which communication with the patient and family members was raised by family members. The complaints team has undergone dementia awareness training and escalates any concerns about vulnerable patients to the safeguarding lead and care of the elderly team in addition to any department directly involved.

**Gender Reassignment and Complaints**
Data on gender reassignment is recorded in terms of complaints, but the number is too small to be reported as individual complainants could be identified.

**Marriage and Civil Partnership and Complaints**
Data on marriage and civil partnership is not currently being recorded in terms of complaints.

**Pregnancy and Maternity and Complaints**
Maternity complaints are reviewed within the Women’s Health division and action plans developed when appropriate.

**Race/Ethnicity and Complaints**
The Trust recognises the importance of knowing a patient/complainant’s ethnicity, especially where translation or advocacy services are required. We have received the most complaints from White British service users. This is, however, proportionate to our patient profile and the community we serve.

However, this does not mean forgetting those whom English is not their first language or those who may feel they do not know how to complain. The data is dependent on the patient’s electronic record and so we are unable to capture the ethnicity of non-patients, we also know many patients do not wish to provide ethnicity or other demographics and so the second largest group of complaints by race remains undefined.

Of note is that the annual complaints return to the Department of Health (KO41) no longer contains ethnicity as a mandated category.
### Number of formal complaints filed by ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>White - British</td>
<td>301</td>
</tr>
<tr>
<td>White - other white</td>
<td>67</td>
</tr>
<tr>
<td>White - Irish</td>
<td>11</td>
</tr>
<tr>
<td>Indian</td>
<td>22</td>
</tr>
<tr>
<td>Other Asian</td>
<td>16</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>16</td>
</tr>
<tr>
<td>Black African</td>
<td>16</td>
</tr>
<tr>
<td>Other Black</td>
<td>9</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>7</td>
</tr>
<tr>
<td>Other mixed</td>
<td>6</td>
</tr>
<tr>
<td>Pakistani</td>
<td>5</td>
</tr>
<tr>
<td>Mixed white and black Caribbean</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Chinese</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Mixed white and black African</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Other ethnic category</td>
<td>33</td>
</tr>
<tr>
<td>Not stated</td>
<td>223</td>
</tr>
</tbody>
</table>

*Undefined = answer given does not fit any pre-defined category
**Unknown = no answer given

### Number of PALS complaints filed by ethnicity

![Bar chart showing number of complaints by ethnicity](chart.png)

### Complaints relating to ethnicity / culture or religion

In 2017 there were five complaints specifically relating to ethnicity, religious or cultural beliefs. These were primarily concerns that staff had modified their care or practice purely as a result of the patient’s ethnicity, culture or religion. In most cases patients were concerned that they had been made to wait longer. The response explained that the waiting area contained...
patients for several clinics and that the order that people arrive in is not necessarily the order that patients are seen in due to a number of factors. In the emergency department the length of wait is linked to the clinical urgency of the patient and so the order that patients arrive is not necessarily the order in which patients are seen. Two families were upset that the coroner had not respected their religious beliefs following death. Apologies were given but UCLH staff explained that as an organisation we have to comply with the coroner’s legal requests. A leaflet is being developed to explain the role of the coroner in some deaths and the legal constraints that can be associated with this.

We arranged the translation of one complaint over this period, with other complainants being offered the service but declining it.

**Gender and Complaints**

**Number of formal complaints filed by gender**

<table>
<thead>
<tr>
<th></th>
<th>Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>535</td>
</tr>
<tr>
<td>Male</td>
<td>280</td>
</tr>
</tbody>
</table>

**Complaints by Gender**

![Gender of Complainants](image)

There were no complaints in 2017 about patients receiving care in a mixed sex ward.

**Sexual Orientation and Complaints**

Similarly to the above, this data is recorded under some subjects in terms of complaints but due to the very small number of complaints is not shared. No complaints were upheld for any discrimination related to this characteristic.
3. ACCESS TO INTERPRETING SERVICES AND LANGUAGE-LINE SOLUTIONS

At UCLH we are committed to ensuring that all our patients including our limited English speakers and people who have a disability or sensory impairment, have equal access to our services.

We are committed to ensuring that the new Electronic Health Record will capture this information but we have also made the identification of communication needs a priority across the next 2 years and beyond.

We work very closely with a renowned Interpreting provider Language Line Solutions (LLS). LLS provides the full range of communication support for our limited English speakers and D/deaf and sensory loss patient. It is part of Health Trust Europe Consortium which helps ensure the Trust to meet a high-quality service and standard.

From January to December 2017 the Trust made over 15,416 Face to Face interpreting requests. Our Face to Face spend was £627,390. The divisions that accessed most telephone interpreting services were Women’s Health and Accident & Emergency. The divisions which were the largest users of Face to Face interpreting services were The Royal National Throat Nose & Ear Hospital, The National Hospital for Neurology & Neurosurgery and the UCH Macmillan Cancer Centre.

UCLH News, the magazine for members and staff, is currently produced quarterly and the articles are translated into Bengali, Chinese and Turkish. Large print word document versions are sent to those members with a visual impairment.

Recording communication needs, disabilities and sensory impairment
We are aware that our current patient information system is not able to record multiple disabilities. We are working with our new provider (EPIC) to ensure that this important information is flagged in our new electronic patient record system. Sharing information with other departments will allow the correct level of communication support for all patients. The system will also flag a reminder to the staff booking the appointment to ensure that an interpreter is booked and will take out the dependence on individual staff. We are also working with our interpreting provider LLS to introduce Video Interpreting for both BSL patients and limited English speakers.

We are very grateful to our patients who feed back their experiences and thoughts on how we can be more responsive. This learning is invaluable and has helped us to direct change and innovation.

SignLive
Sign Live is a web based video interpreting service for BSL patients which will be rolled out over the coming months. It will provide instant access to a BSL Interpreter, 8am to 8pm, Monday to Saturday. This will complement the existing Face to Face service. Staff can access the service by using existing IT equipment and the Trust internet, or using 3G or 4G where there is coverage. Sign Live can also be used as a back-up when BSL interpreters are not available. BSL patients may also use SignLive to contact the hospital.
4. OUR COUNCIL OF GOVERNORS AND UCLH MEMBERSHIP

The Council of Governors provides support to the Trust to ensure that we deliver services that best meet the needs of our patients and the communities we serve. Our Council has 33 governors, (12 patient, one carer and four public governors, together with six staff and 10 representatives from local organisations. The 23 public, patient and staff governors are elected by their membership constituencies. The Council of Governors is chaired by UCLH’s Chairman who also chairs the Board of Directors. Governors represent the views of their members. For more information on our Council, please see: http://www.uclh.nhs.uk/aboutus/FT/GB/Pages/Home.aspx

The UCLH membership strategy will be revised in 2017/18 and will focus on engaging with members and encouraging involvement. The strategy will be aligned to the patient and public engagement strategy and the volunteers’ strategy to maximise engagement and involvement with patients and the public.

This year governors chaired five Members Meet health seminars on a range of topics popular with members, including the stroke service and dementia research. There was also a listening event which included a session on the annual forward plan. These engagement sessions give an opportunity for members to talk about what’s on their mind and for governors to meet with members, follow up concerns and communicate any issues to the Board.
Types of Disability

The types of disability recorded for our patients were as follows:

- Asthma
- Blind/visual impairment
- Deaf/hearing impairment
- Deafblind
- Dementia
- Dyslexia
- Dysphasia
- Dyspraxia
- Epilepsy
- Impaired mobility
- Learning disability
- Mental health problems
## Abbreviations and Acronyms

This includes a list of abbreviations and other terms that may have been used in the report. We encourage you to see clarification if you find any of the terms unfamiliar.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>BSL</td>
<td>British Sign Language</td>
</tr>
<tr>
<td>CCCC</td>
<td>Camden Chinese Community Centre</td>
</tr>
<tr>
<td>CNS</td>
<td>Clinical Nurse Specialist</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>D&amp;E</td>
<td>Diversity and Equality</td>
</tr>
<tr>
<td>DESG</td>
<td>Diversity and Equality Steering Group</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>EA</td>
<td>Equality Act</td>
</tr>
<tr>
<td>EAs</td>
<td>Equality Analysis</td>
</tr>
<tr>
<td>EB</td>
<td>Executive Board</td>
</tr>
<tr>
<td>EDC</td>
<td>Equality and Diversity Council</td>
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<td>EDH</td>
<td>Eastman Dental Hospital</td>
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<tr>
<td>EHRC</td>
<td>Equality and Human Rights Commission</td>
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<tr>
<td>EIA</td>
<td>Equality Impact Assessment</td>
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<tr>
<td>ER</td>
<td>Employee Relations</td>
</tr>
<tr>
<td>ESR</td>
<td>Electronic Staff Record</td>
</tr>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td>GEO</td>
<td>Government Equalities Office</td>
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<tr>
<td>GID</td>
<td>Gender Identity Development</td>
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<td>HTD</td>
<td>Hospital for Tropical Diseases</td>
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<td>KPI</td>
<td>Key Performance Indicator</td>
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<td>LD</td>
<td>Learning Disabilities</td>
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<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual and Transgender (Transsexual)</td>
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<tr>
<td>LINks</td>
<td>Local Involvement Networks</td>
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<td>NHNN</td>
<td>National Hospital for Neurology and Neurosurgery</td>
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<td>NHSCIC</td>
<td>The National Health and Social Care Information Centre</td>
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<td>PALS</td>
<td>Patient Advice and Liaison Service</td>
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<td>PHSO</td>
<td>Parliamentary and Health Service Ombudsman</td>
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<td>POP</td>
<td>Productive Outpatient Programme</td>
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<td>PSED</td>
<td>Public Sector Equality Duty</td>
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<td>QS</td>
<td>Queen Square</td>
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<td>QSC</td>
<td>Quality and Safety Committee</td>
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<td>RCN</td>
<td>Royal College of Nursing</td>
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<td>RLHIM</td>
<td>The Royal London Hospital for Integrated Medicine</td>
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<td>RNTNEH</td>
<td>Royal National Throat Nose and Ear Hospital</td>
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<td>ToR</td>
<td>Terms of Reference</td>
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<td>UCH</td>
<td>University College Hospital</td>
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<td>UCL</td>
<td>University College London</td>
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<td>UCLH</td>
<td>University College London Hospitals NHS Foundation Trust</td>
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<td>UCLP</td>
<td>UCL Partners Academic Health Science Partnership</td>
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<td>WDES</td>
<td>Workforce Disability Equality Standard</td>
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<td>WRES</td>
<td>Workforce Race Equality Standard</td>
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1. Summary

The Trust is governed by a number of documents including its Constitution. A paper is attached which sets out proposed amendments to the Constitution.

A working group was established to review the Constitution, it met in June 2017 and again in April 2018.

Membership changed during the period. Group members included Governors; John Bird, David Coulter, John Green, Annabel Kanabus, John Knight, Diarmid Ogilvy, Diana Scarrott, Wayne Sexton, and Claire Williams. Diana Walford, Non-executive director and David Prior, Trust Chairman chaired the respective meetings.

The Chief Executive was advised of any notable changes as they were proposed, and the Board was consulted on key changes such as the proposal to increase the number of Non-executive directors. The Audit Committee considered a similar report at a meeting on 24 April 2018.

Any changes to the Constitution must be approved by both the Board of Directors and the Council of Governors. The Council will consider a report at its meeting in July.

2. Recommendation

The Board is asked to discuss and approve the proposed changes to the Constitution set out in the attached paper. The key amendments are listed in section 3 and section 5 of the attached report. A tracked change version of the Constitution is also included for Board members only.

The Board is also asked to note that a Code of Conduct for Governors is being developed; this along with updated Council of Governors Standing Orders will be presented to the Council meeting in July.

Additionally, the Board is asked to note our advisors will undertake a general review of the Constitution when a further review is commissioned and propose alterations to further improve understanding.

Prepared by Tonia Ramsden,
Trust Secretary for

David Prior
UCLH Chairman
Proposed Changes to the Constitution of University College London Hospitals NHS Foundation Trust

A Paper for Decision

1. Since the last review of the Constitution in 2016 a number of changes have been discussed, which, if approved need to be reflected in the Constitution.

2. A number of these changes were presented and discussed at an Informal meeting of the Council in July 2017 by Diana Scarrott the Lead Governor at that time.

3. The table below sets out the list of proposed of changes and the reason for the proposal.

<table>
<thead>
<tr>
<th>Current position and proposed change</th>
<th>Reason</th>
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<tbody>
<tr>
<td><strong>Issues relating to Members</strong></td>
<td></td>
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<tr>
<td>a Annex 3 – The Patient Constituency</td>
<td></td>
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<tr>
<td>Current: The Non-London patient</td>
<td>Out of London better describes the geographical area in which a member lives; the other geographical patient constituency is London.</td>
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<tr>
<td>constituency is defined as the area outside the electoral wards within the 32 boroughs of London and the City of London</td>
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</tr>
<tr>
<td>Proposal: To rename the Non-London patient constituency Out of London</td>
<td></td>
</tr>
<tr>
<td>b Annex 5 – Model Election Rules (15.3)</td>
<td>Elected governors most often have surnames starting with a letter towards the first half of the alphabet. A random order recognises the possibility of inequity against candidates with surnames that start with letters towards the end of the alphabet. The random order will be determined by an independent election administrator for example the Electoral Reform Services.</td>
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<tr>
<td>Current: The election rules state that the statements of candidates standing for election must be listed in alphabetical order by surname.</td>
<td></td>
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<tr>
<td>Proposal: Amend the rules to state that candidates standing for election be published in a random order by surname.</td>
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<tr>
<td><strong>Reference to Model Election Rules</strong></td>
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<tr>
<td>We also need to amend paragraph 8.3.2 which refers to the model election rules at the time of Trust Authorisation.</td>
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<tr>
<td><strong>Proposal:</strong> A straightforward statement should be made - the model election rules are attached at Annex 5</td>
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<tr>
<td>c Annex 4 - Composition of the Council of Governors</td>
<td>In the recent past NHSE (London) has not been in a position to nominate a governor to the Council. Allocating an additional seat to the public constituency provides another opportunity for local people to influence healthcare in their area. UCLH also engages with NHSE (London) in a number of other forums.</td>
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<tr>
<td>Current: There are 33 seats on the Council, 23 elected and 10 appointed seats. One of the appointed seats is allocated to NHS England (London).</td>
<td></td>
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<tr>
<td>Proposal: Allocate the NHSE (London) seat to the public constituency. This would increase the number of public seat to five and the</td>
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| **d** | **Section 8.4 - Governors term in office**  
**Current:** The terms of office for governors is for three years, following which governors are eligible for re-election at the end of that period. Governors cannot hold office for more than six continuous years without having an interval of up to two years before holding office again for a further term or terms.  
**Proposal:** Amend the total term governors can hold office to nine years; that is three terms of three years. This would be a total aggregate period of nine years which means the terms can be consecutive or interrupted.  
*The rule would also apply to appointed governors.*  
The original desire of UCLH was to achieve a balance of experienced and new governors on its Council and to refresh the Council at regular intervals. This is best done if the number of terms in office a governor can serve is limited. The current Constitution is ambiguous. It fails to specify the total number of terms an individual can serve as a governor consequently, an individual, if re-elected, can serve unlimited terms in office subject to appropriate breaks. In governance terms unlimited terms are poor practice. Good Councils should refresh the range of experience and backgrounds of its governors to bring different perspectives and inject new ideas and thinking into the Council. Governors on the group expressed a view that three terms was a reasonable period to both allow an individual to make an effective contribution to the Council and to enable the more experienced governors to support new governors in their role. |
| **e** | **Section 9.1 - Board of Directors**  
**Current:** The Board comprises the Chairman and up to seven non-executive directors and the Chief Executive and up to seven executive directors.  
**Proposal:** To increase the number of non-executive directors to nine in total including the Chairman i.e. the Chair and up to eight non-executive directors.  
Best practice is to have a balance or majority of independent non-executive directors on the Board. Increasing the number of non-executive directors to nine will ensure UCLH has at least seven independent NEDs at the Board when you exclude the Chairman and the NED nominated by UCL. The current number of executive directors in post is seven including the Chief Executive; currently there are no plans to recruit to the vacant post. |
| **f** | **Additional reference**  
Make reference to the Senior Independent Director  
*It is good practice for a Board to have a Senior Independent Director. The Constitution will make an appropriate reference to the position. The Chairman will bring a recommendation on this position to a future meeting.* |

4. The Board is asked to note that with regard to the proposal to limit the number of terms a governor can serve in office to nine (item e above) any change will not be implemented until the current seat becomes available.
5. Other proposed amendments are to:
   i. **Make the Constitution gender neutral.** This will be adopted as a general principle for key governance documents including Standing Orders.
   ii. Revising the reference to Monitor in the definition section of the Constitution to:
       
       Monitor: means the corporate body known as Monitor as provided by section 61 of the 2012 Act. Since April 2016 Monitor is part of NHS Improvement.
   iii. **Update Board of Directors disqualification criteria set out in Paragraph 9.11.** This will be replaced with the fit and proper persons regulations. The fit and proper persons test regulates people who have director level responsibility to carry out their role. A clause will be included within the rules to allow the Chair to use their discretion to make it possible for a non-executive director to sit on the Board of UCLH and another NHS Board where it would be appropriate. A similar view may be taken about governors on foundation trust councils of governors.
   iv. **Simplify language where it is reasonable to do so.** In doing this our advisors will ensure that an amendment does not change how the rules of the Constitution are applied.

6. DAC Beachcroft LLP, the Trust’s legal advisors, has been consulted on the changes and has provided an amended Constitution with tracked changes which **has been circulated to Board members only.**

7. Where an amendment is made that relates to the powers and duties of the Council any change needs to be approved by the Trust’s members. DAC Beachcrofts have confirmed that none of the above amendments require members’ approval.

8. The Board is asked to discuss and approve the proposed changes to the Constitution specified above and in the amended Constitution.

9. Changes to the Constitution approved by the Board cannot be implemented until the Council of Governors has also approved amendments to the Constitution.

Tonia Ramsden
Trust Secretary
Since the Board last received a report the Audit Committee (AC) has met on two occasions, on 20 March and 24 April. The minutes of the 20 March are included on the agenda. This report summarises the important matters from those meetings:

1. **Internal Audit (IA)**
   
   1.1. **IA Assurance Reports 2017/18**
   
   In March the AC received and reviewed two assurance reports, in April it received one report. All three reports had amber/red ratings of partial assurance with improvements required. The reports were on The Well Led Framework: domain six – data quality, Interserve Facilities Management (IFM) recruitment management, and MSK partnership contracts. The latter two reports had high priority recommendations. Recommendations had been accepted by management. The action plans in place were highlighted in reports. The AC discussed all three reports.

   1.2. **Interserve Facilities Recruitment Management**
   
   The review focused on the pre-employment checks undertaken by IFM such as criminal records and occupational health assessments. IFM are required to comply with NHS standards. In May 2016 the Trust completed an IFM employment checks audit which identified weaknesses in the processes followed. After that audit IFM updated their policy and compliance improved.

   The 2018 report highlighted some good practice including that in all reviewed cases the DBS check had been completed. However, the AC noted some areas for improvement, this included ensuring that all appropriate occupational health checks were completed. Spot check random audits will be carried out to provide assurance in this area of work and an IFM compliance administrator is being appointed.

   The AC will invite the UCLH Deputy Director of Workforce to a future meeting to better understand what the Trust expects from its contractors as well as how pre-employment checks are managed for UCLH staff.

1.3. **Well-Led Framework: domain six – data quality**

   The review provided a general comment on whether any areas of non-compliance within the framework had been identified, if action plans were in place to deliver compliance, and whether high level information was being effectively processed, challenged and acted upon.

   A number of areas of good practice were identified including that each detailed prompt within the framework had a responsible lead, and that performance reports were tailored to include indicators relevant to each Trust committee. Key areas for improvement related to extracting data and the need to consistently identify actions where indicators are rated amber or red.

   The AC also noted that current performance information was not future focused, and it was therefore pleased to note that a paper had been presented to senior management which set out how the performance team would provide tools and prompts for divisions to understand demand/capacity gaps with a view to improve future performance and resilience in relation to access and activity targets. This will be in place later this year.
1.4. **MSK partnership contracts**

The MSK service review looked at how well UCLH is monitoring the performance of subcontractors who deliver the integrated musculoskeletal service to Camden residents. The review identified that processes appear robust but more work is required to ensure they are effectively implemented. The AC noted that contracts novated to the Trust from the CCG when UCLH took on the service and that work continues to ensure new contracts are signed; KPIs are also being revised.

The AC noted that a more general review of contract management was planned; part of that review would consider how well Trust contracts had delivered their stated objectives.

1.5. **Head of Internal Audit Opinion**

At its March meeting the AC noted the draft Head of Internal Audit (HOIA) Opinion for 2017/18 which was one of ‘significant assurance with minor improvement opportunities’. IA referred to one partial assurance report relating to Care Rounds and advised that this did not impact on the opinion that there is generally a sound system of internal control at UCLH.

2. **Internal Audit Plan 2018/19**

The AC discussed and reviewed the draft IA operational plan for 2018/19. The plan included a range of assurance and compliance audits. AC suggested some amendments to ensure the plan appropriately reflected the high risk areas; the plan was subsequently reviewed by the Senior Directors and approved.

3. **Counter Fraud**

The AC reviewed the Local Counter Fraud Specialist’s (LCFS) quarterly progress report for 2017/18 and an annual workplan for 2018/19. The report drew attention to a procurement review which had looked at how well the controls in place could mitigate the risk of fraud and bribery. Overall the results were positive. The AC noted that a procurement policy was being developed which would address areas of weakness.

The fraud and bribery risk assessment planned for this year has been completed and the register to strengthen the Trust’s ability to evaluate, mitigate and monitor risks from fraud is being finalised.

The annual workplan set out the areas of focus for the coming year. It included a continuing focus on the risk from cyber fraud. A greater focus will be also be placed on providing information to raise awareness and mitigate against other emerging risks such as timesheet fraud.

The AC approved the plan noting that it was NHS Counter Fraud Authority compliant.

4. **Management Assurance Reports**

4.1 **Data Quality Metrics Update**

The AC received an update report on data quality metrics. The report provided an assessment of the existing controls and assurances in place for the leading key data and information used by the Board to monitor the performance of the Trust. The AC noted that, in general, the main gap was around auditing data.

The AC noted that improvements had been made since last year with one measure deteriorating.

The AC sought further assurance on the process of assessment which in some cases appeared not to fit with what was understood to be the position on the ground. It was proposed that Internal Audit review the process to provide further assurance. In addition the AC noted that an information and assurance policy was being developed and a Trust-wide group to review data quality was being established.
4.2 Clinical Audit Report

Dr David Walker, Chair of the Clinical Audit and Quality Improvement Committee (CAQIC) presented the Annual CAQIC Report for 2017/18. The AC was reminded that a key priority was to build Trust priorities into both clinical audit work and other quality improvement (QI) projects.

The AC was advised that the Trust had 100 percent participation in mandatory national audits and that the quality of audits was improving. It also noted that in 2016/17 the Trust had secured 17 licences with a medical journal, one for each clinical division, to publish and showcase the work UCLH was doing in the coming year. At the end of the year 14 projects had been registered and five had been written up.

The report advised that while the focus of work would always remain on audit, more time at meetings was being dedicated to Quality Improvement. The AC suggested that the QI work could be promoted more in future reports.

The AC was also pleased to note that the CAQIC from March 2018 would consider EHRS as a standing item; this would enable contribution to the build of the clinical audit system.

4.3 Cyber Security and General Data Protection Regulations Update

Nick Roberts, Director of Digital Services provided an update on cyber security and a progress on how well the Trust was embedding GDPR.

The key focus for cybersecurity is currently patching of servers, which was not yet complete at the time of the meeting. External funding had been received to help with this. The AC also discussed business continuity and resilience issues. Cybersecurity remains a regular agenda item for the Committee. On GDPR, the AC noted that a data inventory was being undertaken to identify data flows in and out of the Trust. The AC was pleased to note that the information governance (IG) team was working with the EHRS project team to ensure that any issues identified would be resolved when Epic was implemented. The AC was advised that the main area of concern was consent and this was the main focus of work. The executive team were now receiving regular reports on GDPR. The AC asked for a further update on GDPR at its next meeting and recommended that the Board as a whole received training in this area.

5. Finance Metrics Report

AC reviewed a finance metrics report noting the continuing work to reduce the amount of debt. Proportionally the largest debt remained with other NHS organisations although this was reducing.

The AC also noted the improving trend in aged creditors; this was expected to further improve.

6. Annual Accounts and Reporting Requirements 2017/18

The AC received and discussed a draft copy of the Annual Report and Going Concern Statement. AC suggested changes for management to consider including, in the Going Concern Statement, the potential uncertainty of the NHS finance environment.

The AC reviewed the Annual Governance Statement (AGS) process and a draft version of the AGS with a summary of the evidence to support the statement. AC provided comments to management and noted there were no never events to be reported in the AGS.

The AC noted a report on the Quality Account and that the final report would be sent to external stakeholders for comment.
AC received and reviewed the draft unaudited accounts, briefing reports from management on the sale of the Eastman Dental Hospital. The draft commentary on all the key accounting judgements made by management were reviewed; these will be reviewed again when the final accounts are presented to the AC.

The AC also reviewed a paper which set out the work that had been undertaken to assess how well the Trust meets the requirements for the annual report in respect of ensuring that services are well-led. An action plan had been developed; an update on how the actions were being delivered would be presented to the Board.

The final versions of the above documents will be presented at the May meeting.

7. Other matters

7.1 Q3 Progress Report

Deloitte reported on their Q3 Audit and the continuing work. Included in the report was a note on the quality report, specifying that the two mandatory indicators selected for testing were RTT and A&E four hour waits. The AC also received an early draft of the management letter of representation which was subsequently circulated to Board members.

7.2 Constitution Review

The AC considered a report setting out amendments to the Constitution which will be presented to the Board and Council for approval. The AC was generally supportive with the exception of one proposed amendment. It felt that for effective good governance a governor should not be able to serve nine continuous years in office and proposed that there be a break of two years if a governor serves six continuous years in office. This is not dissimilar to the current Constitution. This adjustment achieves the objective of removing the possibility of governors serving unlimited terms in office and fixes the number of terms a governor can serve as nine years. This adjustment to the proposal will be raised at the Board.

Rima Makarem
Audit Committee Chair
May 2018
AUDIT COMMITTEE (AC)

Minutes of the meeting held on Tuesday 30th January 2018

Present:
Audit Committee Members
Rima Makarem Non-Executive Director and Chair (RM)
Harry Bush Non-Executive Director (HB)
Althea Efunshile Non-Executive Director (AE)

Non-Members
Guy Dentith Deputy Director of Finance (GD)
Tim Jaggard Finance Director (TJ)
Gemma Higginson RSM, Counter Fraud (GH)
Charlotte Rimmington RSM, Counter Fraud (CR)
Craig Wisdom Deloitte, External Audit (CW)
Neil Thomas KPMG, Internal Audit (NT)
Arran Rose KPMG, Internal Audit (AR)
Pat Robinson Accounts Receivable Manager (PR), For Item 4.2
Cathy Mooney Director of Quality and Safety (CM), For Items 5.1, 7
Cassie Zachariou Head of Communications (CZ), For Item 6.1
Rachel Maybank Associate Director of Communications (RM), For Item 6.1
Shirley Parker Trust Risk Manager (SP), For Item 7
Jayne Foley Head of Records and IG (JF), For Items 4.5, 5.4
Ade Oduntan Information Governance Manager (AO), For Items 4.5, 5.4
Adrian Buckingham Deputy Director of Procurement (AB), For Item 4.3
Alex Gregg Head of Planning & Performance (AG), For Item 4.4
Mairi Bell Chief Accountant; Minutes

Matters Covered

1. Apologies for Absence
Apologies received from Tonia Ramsden (TR).

2. Minutes of the Meeting held on 28th November
The minutes were agreed.

3. Matters Arising
AC agreed to close the following MA as complete:
4 Other Reports

4.1 Finance Metrics Reports

GD presented the regular update on Finance Metrics, noting that some significant payments had been received in January, after the cut-off date for the report data. GD noted that the level of aged debt was moving down, with commissioning debt very low, however NHS providers remained an area of concern. GD noted that deals on historic debtors and creditors were being investigated with some key counterparts in this sector, although it had been found that intra-NHS debt was often not a priority for other providers with financial difficulties. GD added that discussions had been held with the main organisation making up the non-NHS debt, and that these discussions indicated a deal on historic debt was feasible and being pursued.

GD noted that the reduction in debtor days of paying patients was largely driven by approved write offs being transacted on the system in December.

GD highlighted an improving trend in aged creditors following settlement of some large items, with some further large settlement expected in January.

RM asked when the Oracle migration was expected to take place. TJ replied that this had been expected to be April but may be moved back to June, although UCLH was pushing to retain the April transfer date.

GD noted that clearance of historic items as a result of migration would be expected to have an adverse impact on the BPPC measurement. TJ confirmed this, noting that performance on BPPC declines as old invoices are cleared. TJ added that the calculation would be reviewed to establish whether the pharmacy invoices should be included.

GD noted that the PO compliance figure had been recalculated to be based on the status of all invoices processed, including those through sub-systems such as pharmacy, which had led to an overall increase in reported compliance, although performance was still short of the target.

GD noted that agency spend was continuing to show a downward trend and was on track to meet the target for the year. GD noted that consultancy spend was seeing an increase due to the costs of turnaround work.

**ACTION** review inclusion of Pharmacy invoices in BPPC – GD?

4.2 Credit Control Strategy Update
Matters Covered

GD introduced the report on Credit Control Strategy and introduced PR to the meeting. GD advised that the existing credit control policy had been updated following discussion at the November meeting, and was attached for review and comment, along with a detailed on MA 422 (Lessons Learned). GD noted that action had been undertaken to expand on the responsibilities of the business within the policy. PR added that this had been clarified, particularly in section 5 of the policy with full details of what the business should do. PR noted that it was important to ensure proper approval was in place ahead of any billing.

RM asked how the policy would be rolled out. PR replied this would be circulated to all Finance Managers and other individuals who requested billing, with details of how things will be done. PR added that some users had also been visited face to face to resolve queries. PR advised that the request form had been standardised and updated to ensure all information was captured in one place, e.g. including a box for PO number. AE queried how the business would respond to this. PR replied that it would be helpful to actually reject invoices which would be problematic, where historically credit controllers have spent time resolving queries after billing. PR also noted that the forms clearly requested full customer contact information, an area often incomplete previously, and that access to this information was shared across the team.

RM asked if checks were carried out to confirm the validity of contact details. PR replied that these details were typically obtained by the business. RM noted that private companies check this, and that the front desk would need to be tightened up. PR confirmed the level of checking carried out by private providers, and this included extensive queries on level of insurance cover to ensure full payment would be received ahead of treatment. TJ added that the newly formed Private Patients Board would be looking at this process.

RM asked if there were IT solutions which could assist. PR replied that other companies send XML files to insurance companies, and that this could be done with an extract from the current system, which was being discussed with IT. PR also noted that this had been discussed in principle with a main insurance provider to establish feasibility. The provider indicated future direction was towards fully electronic billing.

4.3 Procurement Waivers

AB attended to present the regular update on Procurement waivers, introducing himself.
Matters Covered

as the new deputy director of procurement and supply chain. AB noted the 2017 calendar year had been analysed and that the number of waivers had remained constant over this period, with less movement that would have been desired. AB noted that new guidance was being developed in this area to turn waivers into compliant procurement processes. AB noted that there had been a culture of allowing waivers.

AB advised that procurement business partners were now linked into Boards and would be investigating waiver requests made in their areas on a regular basis. AB noted that only two waivers had been rejected in 6 months.

AE commented that the consistency in numbers was very interesting. AB replied that the list was full of one offs, and there did not appear to be multiple uses of the same company.

RM asked if there was one BP per Board and AB confirmed that there were 4 in total and outlined the areas of responsibility.

RM asked if there would be a retrospective review of waivers. AB replied that it was most useful to review new ones, to establish if everything had been caught, and that efforts in reviewing should reduce over time. AB observed that it could be difficult to negotiate with sole suppliers.

RM noted that £12.5m had been waived and asked what reduction would be expected in an ideal system. AB replied that the current level did feel too high, although it did include some high cost waivers where nothing would have been done differently. AB added that educating users to plan ahead for procurement work was key to success. AB added that it was hard to quantify any possible reduction in waiver use, although in theory it could be reduced by 20 to 30%.

4.4 Data Quality Update

AG presented the update on data quality, advising AC that the data quality policy had now been published and the information steering group had had its second meeting. AG noted that for ED it was proposed to accept the limitations of the current processes as there was not impact on patient care or reporting, as validation from the paper record was used.

AG also noted that reporting for RTT and diagnostics was moving to true month end reporting from the end of February. AG added that the refresher training on e-learning was now catching people at the end of their first year.

AG noted an update on RTT pathway identification since submission of the paper, noting that there was no systematic way to get the required information, and that this had been established with NHS Digital. AG advised that a manual process was set up with the contact centre. RM asked if this had to be manual unless it was externally fixed. AG confirmed this was the case and that it was an NHS wide issue.
Matters Covered

RM observed that there were two key sources of error; the system, which couldn’t be fixed, and people getting things wrong. RM asked what EHRS was expected to resolve, and if key inputters were involved in EPIC implementation. AG confirmed there was a working group for EHRS covering information and data which included clinical and operational users. RM asked if EPIC would resolve the data quality issues. AG replied that there would still be some residual issues, but that other implementers of the system had seen about 75% of issues resolved. HB asked how the organisation would keep up with identifying new issues. AG advised that the audit cycle was starting up again, and this would involve ongoing monthly sampling of the data, which had already picked up some issues, but that surprise findings were not expected.

CW commented that it was acceptable to accept the risk of paper versus electronic recording, but that testing would still have to be undertaken for the quality accounts and reported. CW added that the outstanding query raised previously on missing case notes in A&E would be followed up as part of the Q3 audit.

AG noted that the feedback from the first outputs of EPIC would be expected to come to either the September or November AC meeting and would be part of the data quality update.

TJ asked about assurance on this before switch on. AG agreed this was a sensible suggestion. RM suggested this could be incorporated into the 18-19 Internal Audit plan and this would be fed back.

**ACTION** – consider how to add data quality to IA 18-19 plan – who?

4.5 GDPR Update

JF and AO attended to give an update on progress towards the GDPR requirements. JF noted that a key focus was privacy impact assessments and that these were being requested, as demonstrated in the IG toolkit work. JF added that a review of contracts was also underway to identify those with the highest risk and impact.

JF noted that AO was working on a comms plan, with something expected on the Intranet shortly.

JF noted that the data inventory, a study of data in and out, would be the focus of the next month’s work. JF added that the IG team were working with the EHRS project team to identify data flows. JF noted that EPIC was expected to resolve some current issues, and that the IG team was working through gaps with the EHRS team. JF noted that an NCL wide IG meeting had taken place and had been very helpful to see how other organisations were handling the requirements.

JF noted that GDPR was also being reported monthly to SDT, and noted that the biggest concern was around handling consent.
5. Internal Audit Progress Report

NT introduced the Internal Audit progress report confirming that four reports had been finalised since the November meeting and were included for review. HB asked what was actually being looked at in the facilities report and NT confirmed that this was looking at recruitment checks by the third party provider, and was an addition to the plan in response to several reported incidents.

HB also asked about the proposed scope of the review of the MSK service. NT replied that the scope was still being agreed. HB suggested the scope should cover how well this recently set up service was performing against its agreed framework. TJ commented that the scope would cover specific points on data quality, performance and billing and capture lessons learned from the process, particularly if further services are to be set up this way in future. TJ added that the audit would cover both strategic and transactional processes. HB asked whether this would cover whether the service was actually working. TJ replied that if working it would be expected to reduce costs across the whole MSK pathway and that there was a broader question of overall effectiveness. HB suggested that maybe this should be reviewed next year, and proposed that QSC should look at outcomes.

5.1 Care Rounds Report

NT introduced the finalised report on Care Rounds, noting that this had received an Amber-Red rating. NT added that the audit had required specialist expertise, and had considered areas such as whether the care rounds process was effective in generating change. NT observed that the audit had concluded a lot of good work was being done, but that there was not a clear process to convert observations into change delivery. NT added that a number of points were recurring in care round reviews, despite processes being in place and that findings needed to be fed back directly to individuals involved.

AE commented that there didn’t appear to be sufficient assurance that the recommendations would lead to the necessary changes and asked what the auditors’ view of this was. NT replied that setting the right recommendations had been difficult, and noted that making this more formal had been discussed with the service, but that this had been discounted to avoid duplicating CQC requirements and the risk of reducing a current high level of engagement in taking part in care rounds assessments.

HB noted that findings could be at ward or Trust level, and asked how this would be dealt with. NT replied that an executive steering group was in place with representatives from all clinical Boards and that findings were cascaded down from this group.

RM asked if the audit rating had been a surprise. NT replied that there was a lot of activity being undertaken, so there was some disappointment and frustration that results were not coming through from this.
HB commented that the findings from the audited rounds did not make good reading. NT replied that the reporting was by exception so only negative findings were reported. HB queried what would be found on other rounds and asked if the process should just be normal ward management. NT noted that the care round visit would only ever give a snapshot of events and could change from day to day.

CM noted that the rating had not been a surprise as the team had requested internal audit look at this area. CM noted that the policy had been written ahead of the audit, and discussions needed to be focussed on what the next steps were. CM added that medical directors had different approaches to this.

CM observed that care rounds were done, and on re-visit, no changes had been made. CM added that there was no issue in getting people engaged to complete care rounds and that this was intended to be a supportive visit and to encourage sharing. CM noted that feedback sessions were held afterwards reporting back findings to people involved.

AE asked how recurrence of issues could be avoided. CM replied that the solution to this wasn’t yet known, and this was the reason to try to build it into processes. CM noted that the recommendation around collating themes and feeding back centrally was an important one.

AE asked when revisits took place. CM replied that a quality and safety audit would take place about 3 months later and it would be checked that this was happening.

HB asked about the specific findings from ED/AMU on the internal audit check. CM replied that there were substantial improvements in reporting and risk and morale had also improved, with improved local leadership. HB asked if these types of findings would be seen on other wards. CM replied that this was unlikely and was more linked to leadership, with the ED more stable now. CM added that the next CQC executive steering group would be focussed on ED.

5.2 Safeguarding Report

AR introduced the Safeguarding report, noting this had received an Amber-Green rating. AR noted that the report had compared UCLH policy to the NHS framework and that the process was robust with controls in place. AR noted that there was no formal timeline on classroom training. RM observed that courses may not always run at the time required.

SP noted that Datix had been updated to ensure accurate reporting of safeguarding. AR added that all referrals had been made properly.
5.3 Sickness Report

NT introduced the final report on sickness management, noting that this had received an Amber-Green rating, which was higher than management expected, following some senior management concerns that sickness may be being underreported. NT noted that the fieldwork had been targeted towards areas reporting low levels of sickness and that no systematic underreporting had been observed. NT observed that this audit had taken a long time to complete, largely driven by issues around the location of information required, which had been factored into the recommendations made.

RM commented that the rating felt generous given the issues around documentation and failures to comply with process. NT responded that the auditors were still comfortable with the rating, and that a lot of information was obtained from ESR and e-rostering.

HB commented that the sickness management system appeared to work in general, but did not appear effective to manage issues of persistent sickness, although this was probably a small percentage of overall sickness. HB asked if self-certification for 7 days was normal. NT replied that this was for 7 calendar days. HB also queried how the policy around annual leave interacted with sickness and whether annual leave could be taken in the middle of sickness absence. NT replied that this was covered with the sickness absence and attendance policy. HB noted that there did not seem to widespread awareness of this.

TJ expressed surprise at the rating, but noted that underreporting was hard to find evidence of and agreed that the risk was lower in areas using e-rostering. TJ asked how NT approached the unknown data. NT replied that there had been some comparison of sickness levels between areas with and without e-rostering, and that 2500 reported incidences had been reviewed to establish potential underreporting areas. NT added that in these areas, a number of interviews had been carried out.

TJ asked how this was managed in other Trusts. NT noted there was a mix of ESR and manual processes, but that there was a particular challenge at UCLH in managing the data flows between clinical boards and central HR teams.

5.4 Information Governance Toolkit Report

The final report on the IG toolkit was presented, noting an Amber-Green rating. JF noted that the intention had been to target those key areas best supporting GDPR, and that the audit was based on those. JF noted that some pieces of work on the toolkit were due to be completed before submission on 31st March, and that recommendations made had been agreed with the auditors.

RM asked if level 3 would be achieved in the March submission. JF replied that March was the aim but that some areas may be missed. RM further asked what were the main GDPR gaps and risks ahead of May. JF replied that all high level contracts were being
Matters Covered

reviewed and that there may be some gaps in data flows, but that compliance would be able to be demonstrated and that UCLH was in line with other NHS organisations.

HB observed that the IA report suggested this process was not as good as previously thought. JF replied that there was a preference to overstate the position and the audit acted as a useful sense check. RM suggested a deep dive in GDPR would be useful in March. AO commented that getting the data inventory right was key to success here.

6. Annual Report and Accounts

6.1 Annual Report

RM and CZ presented the proposed timetable and draft structure for the production of the annual report. RMy advised that it was proposed to produce a plain pdf version of the annual report only, dropping the extensive design work done in previous years. RMy confirmed this would significantly reduce the risk of transposition errors in the design phase, and save two weeks of intensive graphic design work. RMy confirmed this meant there would be no pictures in the final version. RMy confirmed that the final version could then be submitted after signing.

HB asked if there were more iterations than last time. RM added that AC should see the draft when RMy and CZ were happy with it and that the Board normally saw a version later in the production process. CZ confirmed there should be a good draft for AC review by March. HB noted that it was important to record changes clearly, and that this had happened well last time.

RM asked if there was change to the content. CA replied that there were minor changes only, and that the FT ARM had been issued without consultation. RM noted that the structure was working well.

6.2 Accounting Updates

GD presented an update on accounting changes since the previous year, as noted in the Foundation Trust Annual Reporting Manual (FT ARM) and the Department of Health Group Accounting Manual (DH GAM). GD advised that most of the changes were minor, with only a couple considered to require further work, including a new disclosure on costs of fee charging services, and clarification of central expectations on the provision for impaired receivables. HB asked if this was a change. GD replied that there was a change to the wording and CW added that the wording was more explicit this year, although there was no change to the accounting process. CW noted the potential link to management override of controls, and noted the potential difficulties caused in the agreement of balances exercise. TJ noted that this made ‘commercial’ type discussions potentially challenging.

GD highlighted the areas of audit risk. CW confirmed these hadn’t changed in the months since first presented. GD also highlighted high value items including the sale of the RRO joint venture stake, and the proposed sale of the Eastman Dental Hospital.
Matters Covered

CW noted that there was some complexity around the EDH sale which would require additional disclosure. RM asked if the first tranche of EDH would be sold this year. TJ replied that the final documents were not yet signed, but that the sale was important to both partners. TJ confirmed that Deloitte had been asked for a specific opinion on the accounting treatment of the sale.

HB asked about the potential impact of IFRS 15. CW replied that this was most likely to affect grant income, and was most complex with ACO structures for the NHS. CW noted that most trusts were using standard terms and conditions for contract revenue from commissioners.

7. Risk Report and Board Assurance Framework

CM and SP attended to present an updated risk report and board assurance framework. CM noted that there had been 3 meetings since the last update to AC, with the key updates being that the RCB was now looking at all red and high amber rated risks.

RM observed that the current red risks were more like problems, as they were already happening and suggested splitting them out to resolve this. AE noted that the risk 2209 was a particular issue for governors. CM replied that the wording in how the risks were reported was poor. TJ suggested rewording the risk of patient harm, noting that red risks were reputational. RM suggested rewording as a wider risk that harm to staff and patients may arise from anti-social behaviour. SP added that boards had been asked to review and tighten descriptions.

RM commented that ED and 62-day measures were reviewed constantly and queried how they would turn from current issues to risks. CM noted that CQC might expect to see this recorded. TJ suggested rewording around the risks of continued non-delivery.

RM commented on the risks which didn’t appear to have been reviewed. CM agreed this was a concern and that people often forgot as there was no reminder from the Datix system. SP noted that for high risks, on the BAF as well, the review often resulted in no change to the reported risk, but that in future Datix would be updated to be clear the review had been done.

RM asked if there was anything capturing risks around EPIC implementation and who would be monitoring this. CM replied that the policy describes how this type of risk would be captured, if it was highly rated by the project team. RM asked about risks around change management for this project. CM replied that this would come from the project team. TJ added that some was captured strategically in the BAF.

HB commented that some risks appeared to have been entered several years ago and had remained unchanged, with no expected target date for mitigation. CM replied that Datix only allows one target date to be entered.

AE asked what the process was to assess mitigating actions. CM replied that this should be done at clinical boards first, then at RCB and that the board risk leads were very engaged.
Matters Covered

CM asked if table 7 on page 15 was helpful to the committee. RM replied that it was, and suggested adding an update column as well.

8. Audit Committee Work Programme 2017-18

The work programme was noted.

Date of Next Meeting

9am, Tuesday 20th March 2018, Chairman/CEO Meeting Room, 2nd floor Central, 250 Euston Road
AUDIT COMMITTEE (AC)

Minutes of the meeting held on Tuesday 20th March 2018

Present:
Audit Committee Members
Rima Makarem Non-Executive Director and Chair (RM)
Harry Bush Non-Executive Director (HB)

Non-Members
Guy Dentith Deputy Director of Finance (GD)
Tim Jaggard Finance Director (TJ)
Tonia Ramsden Director of Corporate Services (TR)
Gemma Higginson RSM, Counter Fraud (GH)
Craig Wisdom Deloitte, External Audit (CW)
Julian Reeve Deloitte, External Audit (JR)
Neil Thomas KPMG, Internal Audit (NT)
Jack Stapleton KPMG, Internal Audit (JS)
Cassie Zachariou Head of Communications (CZ), For Item 8.1
Simon Knight Director of Planning & Performance (SK), For Item 4.1
Alison Glover Head of Clinical Governance & Risk (AG), For Item 8.6
Victoria Sloggett Risk Systems & Development Manager (VS), For Item 8.6
Nick Roberts Director of IT (NR), For Items 4.5, 4.6
Mairi Bell Chief Accountant; Minutes

Matters Covered

1. Apologies for Absence
Apologies received from Althea Efunshile (AE)

2. Minutes of the Meeting held on 30th January
The minutes were agreed subject to a small change to wording in 4.2.

3. Matters Arising
AC agreed to close the following MA as complete:
MA 402, 413, 416, 417, 419, 420, 421, 422, 423, 427, 418, 424, 426, 415
Matters Covered

4 Other Reports

4.1 Data Quality Update

SK attended to present the annual update on Data Quality confirming the annual refresh of the key indicators had been completed. SK advised that overall 9 areas of data quality had improved, with 7 remaining static and 1 (6 week diagnostics) showing a deteriorating position.

RM asked what assurance could be had that self-assessment of data quality was being done properly. By way of example, she referred to appraisals data quality, which was assessed as ‘green’ by all standards despite known issues with accuracy and timeliness. RM noted this was also the case for ED. SK suggested that internal audit could review the process to give further assurance, and suggested the scrutiny of the indicators may not be firm enough.

HB added that in some cases the colour rating did not match the narrative. SK commented that the data in year had been accurately reported, noting that there had been a problem with appraisals, which the data had highlighted, allowing it to be resolved and reported in an improved indicator position. RM suggested that if that were the case, the timeliness indicator shouldn’t be green. SK agreed to review the definitions of timeliness and refresh the data.

NT commented on the overall approach, noting that alternatives were to do nothing, or to impose a much more involved monitoring regime, as seen in some other trusts. NT added that internal audit work would look at underlying data streams and try to identify areas where there were system links, and establish if there were concerns. NT offered to share with SK examples of data quality assurance processes from other trusts.

TJ advised being clearer with self-assessing directors about what green means and how the data would be used by the Board. RM noted that any observed data trend should be reliable for influencing Board decision making.

ACTION – NT to share other Trusts’ data quality assurance processes with SK

4.2 Finance Metrics

GD presented the regular update on Finance Metrics, noting that significant work had been done since the last update. GD highlighted a significant temporary spike in commissioning debt, and advised the underlying on-account payment for overperformance had been settled in March. GD noted that some deals had been done with other NHS organisations to resolve areas of historic debt in both directions, but confirmed there was more work to do in this area. TJ suggested reporting back in a couple of months to demonstrate progress in this area.
Matters Covered

GD confirmed that work was being undertaken with the top 10 non-PO suppliers to improve PO compliance. HB asked when the target was likely to be met for PO compliance. TJ noted that there could be a temporary adverse impact of the upcoming Oracle move, but suggested an action plan to address the remaining areas of non-compliant spend.

GD highlighted the agency spend, noting that UCLH remained comfortably within the annual cap level for 2017/18. TJ noted that the proposed cap for 2018/19 was significantly more challenging to achieve, particularly with the increased agency requirements of the EHRS implementation, which was difficult to separate out in the reporting.

**ACTION** – report back on work to resolve historic intra-NHS debt positions
**ACTION** – report back on progress and work undertaken to ensure PO compliance

4.3 Debt Write Off

GD presented an update on proposed debt write off, noting that debts to be written off were very aged and many dated from a period known to have data quality issues within the billing. HB asked about the profitability of the private patient work, and whether the write off impact was factored in to the tariff charged for the work. TJ noted that profitability could be a subjective measure, particularly in the allocation of overhead costs, and suggested that reviewing current trends in the billing and debt would be a useful process.

HB reiterated that the profitability did need to be better understood, and noted that even with improved systems a level of write off would be anticipated. TJ noted that some pricing could not be changed even with a better understanding of the underlying position.

**ACTION** – review the profitability of this work and if this is covered in the tariff.
**ACTION** – review the debt trend in this area

4.4 Review of SFIs and SOD

GD presented the scheduled review of the Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD), drawing particular attention to a change proposed to approval levels in the SoD as a result of the forthcoming finance system change. GD confirmed that the revisions to approvals had been designed to provide a balance between control and autonomy for the business. GD noted that the proposed changes would be reviewed 3 months post implementation.
RM queried the role of the General Manager. GD replied that these were the managers 1 level below Divisional Managers, with each clinical division having at least one at this level. TJ noted there was a need to empower managers at this level, and that they were requisitioning within approved limits.

HB commented on the wording of Section 4.9 regarding tender evaluations and consideration of price and quality. TJ confirmed that this was intended to be about obtaining best value for money for the organisation. TJ agreed the wording could be updated.

GH noted a number of points of review from a Counter Fraud perspective and agreed to feed these in.

**ACTION** – provide updated wording to section 4.9 on tender evaluations

### 4.5 GDPR Update

NR attended to present the update on information governance and progress towards achieving GDPR compliance. NR updated the committee on the final preparation for the annual IG Toolkit submission. NR noted that the planned submission had been to achieve a target of 80% of indicators, an improvement on the prior year, but that the final submission had overachieved this, with a submission made at 83%. NR highlighted achievement in specific areas linked to the incoming GDPR requirements, noting overachievement in a number of these areas.

NR described the process to map and understand the organisation’s data flows, noting over 2000 data flows identified. NR added that in the current year there were no data breaches or loss of data.

NR noted that a risk based approach was being applied to GDPR, and that work in this area was closely aligned with the work of the EHRS team.

NR had held a deep dive session on GDPR with AC non-executive directors in the week prior to the AC meeting and was preparing to give an update to the Board on AC’s recommendation.

### 4.6 Cyber Security Update

NR presented an update on Cyber Security and patching work.

NR updated on progress around cyber security, noting that £180k of external funding had been secured to make improvements, and that this was likely to be used to replace or decommission old servers.
HB asked how long it would take to complete the outstanding patching required for full compliance. NR replied that partial patching was done, but it was not yet comprehensive, although the organisation’s external firewall was known to be robust.

HB asked about business continuity and recovery plans at UCLH. NR replied that the organisation was good at short term business continuity, where individual systems could be operated in standalone modes, but that for a period longer than a couple of days, the organisation would be expected to struggle, although it could call on a much larger resource from the IT provider.

5. Internal Audit

5.1 Internal Audit Progress Report and Draft Head of Internal Audit Opinion

NT introduced the Internal Audit progress report advising that two further reviews had been completed and were presented for discussion. NT also highlighted the inclusion of the draft head of Internal Audit opinion (HAO) noting this was expected to be an overall rating of significant assurance with minor improvement opportunities, and this was not expected to be adversely affected by the four reviews still to be completed.

RM asked about the overdue recommendations on Serious Incidents, and asked NT if this felt like a reasonable delay. NT confirmed that it was reasonable and noted the work being done by the service in this area, with significant discussion around how to incorporate the proposed changes and come up with a sustainable solution for the future.

5.1 Recruitment Report

JS introduced the finalised report on recruitment within the IFM contract, noting that this had focussed on recruitment checks, particularly occupational health, following several reported incidents. JS noted the review had found that checks around DBS and right to work were largely ok, but that there were recommendations around other checks being made. JS added that recommendations made had been agreed with both the Trust and the external provider. NT added that missing due dates would be completed shortly and agreed that the final action plan could be circulated for review out of session.

HB asked why nothing had been done previously if the issues were already known. NT replied that questions had been raised on the contract, and that no improvement had been seen. JS added that the serious incidents described were a recent issue.

**ACTION** – bring back finalised plan for implementing recommendations on recruitment checks
5.2 Well-Led Framework Report

JS introduced the well-led framework report, noting an exercise had been undertaken by CM’s team to review each key line of enquiry in the well-led framework, with actions being put in place to address amber-red and red items. NT noted that the performance reports used by the Trust were not sufficiently future orientated, showing a 12 month performance only.

RM asked how many targets the process had been applied to. NT replied that this was the lead indicators only. TJ added that there was agreement to ensure performance indicators were in place for each area with targets mandated.

5.3 Draft Internal Audit Annual Plan 2018/19

NT introduced the draft internal audit annual plan for 2018/19, confirming that in depth meetings had taken place with the majority of SDT members, to review and refresh the existing five year plan.

RM commented on the proposed review of Digital Readiness, querying whether change management and the human factor were sufficiently captured within the scope. NT replied that this would be the focus of the 2017/18 review, and the 2018/19 review was a placeholder in this area.

RM asked if the IG Toolkit review would now include GDPR. NT confirmed that it would, and that cyber security was also more high profile within the review. NT added that this review was scheduled for September, in order to review the process following the submission at 6 months.

RM queried the scheduling for the year, noting that no audits were expected to be undertaken before June, with a surge of audits planned for September and October. RM suggested a better balance could be achieved. NT agreed to review this.

HB queried the proposed review on Social Media, and whether this was the best use of audit resources. NT replied that issues had been found in this area when reviewing other Trusts, and noted that UCLH was probably not making best use of these processes. TR observed that this was an important area for members. TJ added that the communications processes could be quite out of date.

HB also suggested that overseas visitors may have undergone sufficient review already. TJ confirmed this review had been scheduled late in the year, so that in year review could be undertaken with changes to this proposed audit if required.

HB suggested that it would be worthwhile to look at medical recruitment, in particular the junior doctors’ contract. TJ agreed that this could be a beneficial review.
Matters Covered

NT advised that the audit plan was structured to include reviews in four key areas – finance, governance, risk and data, and that other locally specific reviews were added to these core reviews to build the overall plan. JS noted that specific input from the Chief Nurse was still to be factored into the final plan.

RM proposed that the final plan come back to the following committee meeting for approval.

ACTION – consider which reviews could be started earlier during April-May

ACTION – bring final IA plan to next AC meeting for approval

6 External Audit

CW presented the Q3 report for external audit, advising that work was proceeding in line with plans. CW drew attention to a section in the paper around the proposed EDH sale, noting that external audit were in agreement with management’s proposed accounting treatment and were completing review work of final legal documents. CW added that the Board needed to understand the rationale for the deal structure and would need to be comfortable that the deal was obtaining value for money for the organisation, and that it was not stepping into the area of management override of controls. TJ asked if the wider Board would appreciate this. HB replied that it would.

CW commented that risks were continuing to be monitored, but that no additional significant risks were expected to be identified. CW added that on the quality account, audit indicators would again be RTT and A&E, and the extent to which issues would be found was unknown at this point, but that there was a risk this would be qualified.

CW noted that AC needed to challenge management to ensure that actions weren’t being taken purely to meet targets in relation to the control total, although CW added that there was no evidence this was the case to date.

RM asked how use of resources was defined. CW replied that the auditors looked at VfM arrangements, and more holistically at the organisation. CW added that the review was focussed on arrangements to secure VfM, and was not commenting on VfM achieved.

RM asked about the CQC use of resources measures identified on page 24 of the Deloitte paper. TJ advised that an update on this had been given to the Finance Committee and this could be circulated to give more information.

CW highlighted the draft management representation letter. TR agreed to circulate this to the executive.

ACTION – circulate information presented to Finance Committee on CQC metrics
Matters Covered

7. Counter Fraud

7.1 Counter Fraud Progress Report

GH presented the Counter Fraud progress report, highlighting progress on current local proactive exercises, noting particularly good results from the procurement review. GH added that the Trust wide fraud and bribery risk assessment (FBRA) had been completed and the associated risk register was currently being finalised.

GH updated on two current reactive investigations currently going through prosecution processes. TJ emphasised that one of these was an important test case as it alleges that a consultant was undertaking private work on NHS time. HB asked how the subject could have committed the alleged offence. TJ noted that there was a degree of flexibility in the consultant contracts but that there was no evidence that work had been made up in other time.

RM observed an increase in HR-type fraud cases. GH noted that there was usually an increase around the Christmas period, and that there was confidence in processes for identifying and escalating concerns within the Trust.

GH noted that the Counter Fraud Authority had issued provider standards with a return due on these on 1st April. GH confirmed this would be included in the annual report coming to Audit Committee in the next couple of months.

RM asked what happens to employees under investigation if fraud cases were not progressed. GH replied that these cases are internally investigated by Employee Relations and that counter-fraud are involved in discussions. TJ noted that in some cases the investigations could be delayed due to resource constraints internally.

7.2 Counter Fraud Draft Annual Plan 2018/19

GH presented the proposed annual plan for Counter Fraud for 2018/19. RM observed that the workplan appeared to be straightforward. GH confirmed that she would be bringing to the AC the results of the FBRA undertaken recently.

TJ noted that there had been a benchmarking exercise reviewing proactive counter fraud days across the Shelford group of Trusts and that UCLH was reviewing the planned counter fraud days for 2018/19 as a result of this. GH advised that any changes to the draft plan would be brought back to AC.
Matters Covered

8. Annual Report and Accounts

8.1 Annual Report

CZ presented the first draft of the Annual Report. RM observed that the overall tone focussed on what the organisation was good at, and did not sufficiently address some of the issues experienced in year, such as the difficulties with the patient transport process.

HB commented on the ordering of the report, noting that the opening sections did not give enough of a sense of the challenges faced. CZ suggested that the overview from the Chairman and CEO would help to pull this together. HB replied that it was also needed in the main body of the report.

HB requested that track changes be used to review future drafts of the annual report.

The committee discussed presentation of some of the key indicators, including staff survey results and A&E targets, and suggested wording around these should be reviewed.

8.2 Annual Governance Statement Drafting Process

GD presented the process overview for drafting the annual governance statement (AGS). GD noted that there were no major changes to requirements, but that new guidance had been issued on identifying significant incidents, although this was not inconsistent with the current process. GD advised that the draft AGS text would be presented to the next AC. HB requested that track changes be used to highlight changes in the text from the previous year.

8.3 Going Concern Statement

GD presented the proposed wording for the going concern statement, setting out the reasons supporting the statement. RM advised that the committee was happy with the proposed statement, but agreed on a minor rewording to the final bullet point regarding uncertainty in the wider NHS finance environment.

8.4 Losses and Special Payments

GD presented the annual update on losses and special payments, setting out the costs for the year with comparison to the previous year. GD noted that the volume and value had reduced from the previous year and advised that processes were locally reviewed following losses to support continued improvement. HB noted that there was a significant reduction in travel reimbursements and that compensation for loss of personal effects was small for the size of the organisation.
Matters Covered

8.5 Accounting Update – Sale of EDH

GD presented a report setting out the accounting treatment of the sale of the EDH site, noting that detailed accounting advice had been obtained from Deloitte regarding the transaction and that this advice was included as an appendix. GD advised that negotiations were at an advanced stage, with a couple of minor points to resolve.

HB asked about the timing of recognition of conditional payments associated with the sale. GD noted that when these were considered to be highly probable then they would be recognised in line with accounting standards.

CW noted that proposed disclosure text for the accounts had been agreed. HB requested that this transaction be clearly highlighted in the accounts commentary report. TJ noted that sign off was set for the following week pending resolution of the remaining minor issues.

8.6 Quality Account Process Update

AG and VS attended to present an update on the process for producing the annual quality report. AG briefly updated on the process followed so far. RM asked about the local governor’s indicator. VS advised that CM was in contact with governors regarding this. CW observed that selection needed to be as soon as possible. TR confirmed that options had been sent out the previous week. TJ asked if the options were easily auditable and TR agreed to share the list.

8. Audit Committee Work Programme 2017-18

The work programme was noted.

Date of Next Meeting

9am, Tuesday 24th April 2018, Chairman/CEO Meeting Room, 2nd floor Central, 250 Euston Road