## Agenda

### Meeting Title:  Board of Directors Meeting (Public)

**Date:** Wednesday 13 September 2017  
**Time:** 2:00pm  
**Venue:** Education Centre, 1st Floor West Wing, 250 Euston Road, NW1 2PG

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Board of Directors

Minutes of the Meeting held on 12 July 2017

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
Neil Griffiths, Deputy Chief Executive
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
Richard Murley, Non-Executive Director (Chairman)
Kieran Murphy, Non-Executive Director
Flo Panel-Coates, Chief Nurse
Diana Walford, Non-Executive Director
Caspar Woolley, Non-Executive Director

In attendance

Simon Knight, Director of Planning & Performance
Katie McCormack, Patient Safety Improvement Project Manager
Cathy Mooney, Director for Quality and Safety
Ben Morrin, Director of Workforce
Rachel Stoukas, Trust Administrator (Minutes)

Item | Matters covered
---|---
BoD/56/17 | Welcome and apologies for absence
56.1 | The Chairman welcomed staff and members to the meeting. All members were presents.

BoD/57/17 | New declarations of interest
57.1 | None.

BoD/58/17 | Declaration of conflicts of interest
58.1 | None declared.

BoD/59/17 | Minutes of the meeting held on 10 May 2017
59.1 | The minutes of the meeting held on 10 May 2017 were accepted as a true and accurate record.

BoD/60/17 | Matters arising / action tracker
60.1 There were no matters arising.

60.2 The action tracker was noted and completed actions would be closed. One amendment was noted to action number ABoD/3/17 – The Mortality surveillance statutory quarterly reports would be presented to the public Board meetings not the confidential meetings.

**BoD/61/17 Presentation – Safer surgery**

61.1 Katie McCormack was welcomed to the meeting. Following on from a previous presentation to the Board she outlined the ambition to improve the five surgical safety steps and involve consultants more in the surgical safety walkarounds. To date five surgeons had participated in the walkarounds with more signed up. She explained how there had been positive feedback particularly from ward staff and patients. From the surgeons perspective this was a reflective process that had helped to highlight some areas of inefficiency. However there would need to be further consideration given to whether this was the best use of consultants time and whether more emphasis could be placed on the management processes and clinical effectiveness.

61.2 The Chairman asked how learning was being shared across surgical areas. Katie explained there was one core team responsible for visiting all surgical teams to share outcomes and ideas and promote a collective process. She explained that the project had also been shared with other NHS Trusts who had commented on the innovative initiative.

61.3 T Mundy formally noted his thanks to Katie and the Patient Safety Improvement team. He stressed the project was successful because of the hard work and initiative shown by the team who had stretched the project beyond the initial expectations.

61.4 On behalf of the Board the Chairman thanked Katie for her presentation and for the positive contribution to patient safety initiatives.

**BoD/62/17 Chairman’s report**

62.1 The Chairman introduced his report. With sadness he reported that one of the longstanding hospital porters, Mr Abdulaziz (Aziz) El Wahabi had been reported as missing in the Grenfell Tower fire. On behalf of the Board the Chairman noted sincere condolences to Mr El Wahabi’s family and colleagues for their sad loss.

62.2 The Chairman recognised that there had been many national incidents in recent months and explained that morning he had met members of staff who had been working and receiving patients during the recent London Bridge / Borough Market terror incident. He recognised the effect these recent incidents have on all staff and explained the Trust was building on how it managed serious incidents ensuring lessons learnt were developed into action plans. On behalf of the Board the Chairman thanked all staff who had been working and came into work to help during the attacks.

62.3 The Chairman’s report was noted.

**BoD/63/17 Chief Executive’s report**
63.1 Fire safety and major incidents
The Chief Executive opened his report also paying his respects to the family and colleagues of Aziz El Wahabi and thanking staff that responded to the London Bridge and Borough Market attacks. He explained that additional fire safety inspections were being performed across all sites. Initial investigations had revealed a small section of cladding on a building within the National Hospital for Neurology and Neurosurgery (33 Queens Square) needed further investigation to ensure the cladding was fully fire-resistant. Once the definitive results had come back a full action plan would be formulated. The safety of patients and staff based within the building was of the upmost importance.

63.2 North Central London Sustainability and Transformation Plan
The Board were asked to consider the newly named North Central London (NCL) partners in health and care sustainability and transformation plan (STP). The revised plan is consistent with the STP shared vision to transform health and social care services in North London. The revised plan also included an additional section reflecting the NCL’s involvement in the Capped Expenditure Process (CEP). In response to financial pressure across the sector, NHS England (NHSE) and NHS Improvement (NHSI) introduced a capped expenditure process (CEP) to provide tighter controls on NHS spending. T Jaggard highlighted there had been a recent article in a national newspaper about NHS system control totals. He explained across NCL there was a collective provider gap of £61m. The Trust would continue to work closely with the sector to help bridge the gap.

63.3 Corporate objectives
The Board received and noted the final 2017/18 corporate objectives which gave details of how each objective would be measured, the rationale for each objective and list the name of the lead responsible director.

63.4 Resolution
The Chief Executive report was noted.

63.5 The Board formally endorsed the North Central London Partners in Health and Care Sustainability and Transformation plan and the commitment to work with NHSI and NHSE to produce a set of affordable NHS plans for 2017/18 as part of the CEP.

BoD/64/17 Executive Board report
64.1 Board Assurance Framework (BAF)
The 2017/18 opening position of the BAF was considered. H Bush queried if there had been any impact on the organisation following Brexit and if there should be any associated risks articulated on the BAF. B Morrin explained there had been a slight impact in terms of deterioration in employment applications from candidates from mainland Europe. This was being monitored carefully. He assured the Board that the Trust was actively engaging with European staff currently employed and support and advice offered where needed.
The Chairman asked about junior doctor vacancies and what actions were being taken to reduce the impact on clinical services. B Morrin reported that a clear framework for training roles was being introduced. He highlighted that further investment in research would also help attract candidates. C Woolley commented that this issue was on the Workforce Committee’s forward plan and they were looking at vacancy levels and how to ensure the Trust became an employer of choice. The Chairman noted the efforts being taken to address the junior doctor vacancy level and noted this would be a good topic for discussion at a future Board Strategy session.

C Woolley asked about the Trust’s position in relation to cyber security. N Griffiths confirmed the Trust was working closely with its new digital services provider and NHS Digital to mitigate the risk.

Application to the Care Quality Commission to add a new location to the UCLH registration
The Board considered and approved the application to the CQC to register the Clinical Research Facility on the 4th Floor of the 170 Tottenham Court Road as a new location.

Voluntary services annual report
The Board received the annual report noting the number of volunteers across the Trust had doubled since 2015. There were now a total of 411 volunteers. The Chairman remarked this was a fantastic achievement for the Trust and on behalf of the Board he thanked the volunteers for all their hard work.

Health and Safety Annual report
The Board reviewed the Health and Safety annual report. Like the Executive, the Board were concerned about the increase in the number of violent incidents and assaults. B Morrin explained urgent action had been taken to try and understand and manage the increase in incidents. Staff were encouraged to report incidents and were being offered enhanced support. Thorough investigations and risk assessments were being implemented and actions then taken to prevent future occurrences. The Trust had also introduced a zero tolerance policy ensuring that appropriate action is taken when patients or relatives behave in an unacceptable way.

A Efunshile had a specific query about why the reported number of staff injured while handling, lifting or carrying had seen a 17% increase between 2015/16 – 2016/17. It was agreed B Morrin would discuss the data with the Trust Health and Safety Lead and provide an update after the meeting.

Action ABoD/4/17 (B Morrin)

Annual Equality report
The Board discussed the report which sets out the Trust’s approach to equality, diversity and inclusion in meeting public sector legal duties as outlined in the Equality Act (2010). The report covered both staff and patients. Both B Morrin and F Panel-Coates stressed the Trust was fully committed to ensuring the best quality of care for patients and improving the experience of staff by ensuring a fully inclusive and diverse workforce, consistent with the population of local boroughs. Amongst the objectives for 2017/18 were a number of workforce
priorities including improving the experience of BME staff as evidenced in the Workforce Race Equality Standard and staff survey, improving the experience of disabled staff who report a significantly worse experience at work via the staff survey and improving the experience of lesbian, gay, bisexual and transsexual staff with a view to improving performance in the Stonewall Top 100 Employers Index.

64.9 The Board received and approved the Annual Equality report for publication.

64.10 Quarterly report from the Guardian of Safe Working hours
The Board received the second report, as required by the 2016 junior doctor contract. During the period of 6 January to 5 April four exception reports were made with two upheld.

BoD/65/17 Performance report
65.1 S Knight introduced the report which included the monthly updates from the Trust’s recovery action plan (RAPS) for cancer 62 day wait targets and A&E four hour wait target.

65.2 The Board reviewed the performance report and the two recovery action plans in detail. They understood that the 31 day cancer target wait had not been met during May predominantly due to a surge of external referrals from another NHS Trust. G Bellingan explained capacity issues meant the full extent of referrals could not be met within the target range. Discussions were ongoing with commissioners about this.

65.3 The 62 day cancer RAP was discussed. Whilst the Board understood the contributing issues and actions that were being taken to improve performance and cancer waiting times, concern was formally noted and the Chairman emphasised that a lot more work was needed to really drive improvement.

65.4 A&E performance was noted to have missed the 92.8% target in May. It was noted that urgent actions to improve patient care and service delivery included adding additional nurses and porters and opening up a transition ward temporarily next to A&E. C House informed the Board that there had been an increase in attendances to A&E and all effort was being taken to ensure patients received the best quality of care in a timely manner.

65.5 Theatre utilisation
Work had started on theatre utilisation improvement with Four Eyes consultancy. The work had begun at the Westmoreland Street site and the Trust was now able to track ‘touch time’ utilisation.

65.6 The Performance report was noted. The Board would monitor the RAPS for both the 62 day cancer targets and the A&E targets carefully both at formal Board meetings and in between.

BoD/66/17 Quality and Safety Committee reports
66.1 The Board received updates following the committee meetings held in May and June. D Lomas highlighted the committee were particularly focused on mandatory training performance and improvement. He also took the opportunity to thank F Panel-Coates and her teams for production of the Adult Safeguarding and Child Safeguarding Annual reports.
66.2 Resolution
The Board noted the report and the Adult Safeguarding and Child Safeguarding annual reports.

**BoD/67/17 Finance and Contracting Committee (FCC) report**

67.1 H Bush introduced the report. He highlighted the financial challenges currently facing the Trust. In particular the committee noted the corporate directorates in total were reporting a year to date shortfall against plan of £0.7m. Under achievement of cost improvement plans was highlighted as one of the main causes of the shortfall. The FCC recognised a lot of effort was being made to improve the budgetary position across the corporate directorate especially those areas with the most financial challenges. The committee would continue to monitor the financial recovery plans closely.

67.2 **Combined Costs Collection Board Assurance**
The committee had considered a report that contained information to allow the Trust to view the adequacy of the governance arrangements surrounding the Trust’s 2016/17 combined costs submission, which is a requirement from NHS Improvement for the Trust’s Board to give assurance in this area. The combined costs collection is the nationally mandated collection of cost data from NHS Trusts for delivering patient services and providing education and training of clinical placements in the NHS. The committee were fully assured of the Trust’s costing processes and recommended endorsement to the Board.

67.3 Resolution
The Board noted the FCC report and formally endorsed the committee’s recommendation to submit the final combined costs collection return.

**BoD/68/17 Audit committee report**

68.1 The Board considered the audit committee report noting the issues discussed at the meeting held on the 23 May 2017. Among the issues discussed were the External Audit Policy which sets out how the Trust might engage its external auditors for non-audit services. The Board was asked to approve a one year extension to the policy. In addition the committee annual report covering the financial year 2016/17 was received, for consideration.

68.2 Resolution
External Audit Policy – The Board approved a one year extension to the policy. Annual report of the work of the Audit Committee – The Board received the report and were fully assured of the work of the Audit Committee.

68.3 The Chairman thanked R Makarem and the committee for its hard work. He stressed the committee works well and accurately scrutinised Trust procedure and policy and he commented that the annual reporting cycle had improved immensely.

**BoD/69/17 Minutes of the Audit Committee**

69.1 The minutes from the meeting held on the 25 April 2017 were noted.

**BoD/70/17 Entries in the seal register**

70.1 The report was noted.

**BoD/71/17 Any other business**
71.1 The Chairman formally recorded his thanks to N Griffiths who was attending his last Board meeting before leaving the Trust in August. He particularly thanked him for acting up as Chief Executive during the interim period between R Naylor leaving and M Levi taking up post.

BoD/72/17 Date of next meeting in public
72.1 Wednesday 13 September 2017.

Signed .......................................................... Date ..........................................................
Richard Murley, Chairman
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<th>Date of meeting</th>
<th>Subject</th>
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<tr>
<td>ABoD/3/17</td>
<td>10.05.17</td>
<td>Presentation - learning from deaths</td>
<td>Whilst the Trust already had good procedures, there would be new practices to adopt which would improve processes across all the clinical boards. These included enhanced governance arrangements, a learning from deaths policy, training to support the new national agenda, a policy for engagement of bereaved families and carers and data collection and publication via reports to the public Board of Directors every quarter</td>
<td>C Mooney and T Mundy</td>
<td>Sep-17</td>
<td>Mortality surveillance statutory quarterly report will be presented to the confidential board meeting in September. The Mortality surveillance and learning from death policy will be attached to the Public Board meeting papers in September. 13.09.17 = Morality is included as part of the QSC report.</td>
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<td>ABoD/4/17</td>
<td>12.07.17</td>
<td>Health and safety annual report</td>
<td>A Efunshile had a specific query about why the reported number of staff injured while handling, lifting or carrying had seen a 17% increase between 2015/16 – 2016/17. It was agreed B Morrin would discuss the data with the Trust Health and Safety Lead and provide an update after the meeting.</td>
<td>B Morrin</td>
<td>Sep-17</td>
<td>K Roberts, the Trust's Health and Safety Lead has contacted A Efunshile directly and explained more about the data and reporting process. Since the report was written there has been an amendment to the Sickness Absence Policy to make the responsibilities of line managers and staff clearer in relation to the reporting of RIDDORs to ensure that we can identify and report appropriate incidents to the HSE in a timely manner. In next year's annual report we will provide a more detailed breakdown of incidents by the categories in RIDDOR so that these trends can be seen more clearly.</td>
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1. **GOVERNOR ELECTIONS**

Following elections this summer, it is a great pleasure to welcome new governors to the Council. Isaac Kohn and Brian Steve Potter have been elected as Public Governors. Martha Wiseman has been elected as Carer Governor and Donna Beck as a Staff Governor. John Green and Christine Mackenzie were re-elected as London Patient Governors.

Emma Dalton has stepped down as a Patient Governor and Wayne Sexton as a Staff Governor. I would like to thank them for their service to the Trust. Reserve governors Ann Fahey and Javed Ahmed have replaced Emma and Wayne respectively. I look forward to meeting them.

I am also pleased to welcome Kate Hall, Director of Capability Development as the stakeholder governor representing UCLPartners. Kate is a member of UCLP’s senior leadership team and the lead for the UCLP patient safety programme. She replaces Charlotte Williams who stood down in August.

2. **CLINICAL ACADEMIC TRAINING EVENT**

On 11 July, I attended a Clinical Academic training event organised by Dr Ramani Moonesinghe. The purpose of the seminar, which was attended by a number of representatives from the Trust and from UCL, was to discuss ways of improving the opportunities for doctors in the hospital to undertake research as part of their training. This was an interesting and well attended session and coincides with the drive by the Trust to create more opportunities for doctors with a research interest.

3. **PHASE 4 SITE VISIT**

On 14 July, I and a number of colleagues visited the Phase 4 site to mark the bottoming out of the dig. All those who attended were truly impressed by the works and the scale of the project – the completed building will have a larger floor area than the UCH Tower. It was also interesting to learn how Bouygues run the project and schedule day to day working. The project remains on course for completion in 2020 and work is now well underway to build out the underground part of the development.

4. **ANNUAL MEMBERS’ MEETING**

On 17 July, we held the Annual Members’ Meeting which was as usual well attended. As well as the regular reports by the Chief Executive (his first to this gathering) and the Finance Director, we had this year research presentations from Professor Rachel Batterham, Professor of Obesity, Diabetes and Endocrinology, and Professor Sam Janes, Consultant in Thoracic Medicine.

5. **RNTNEH/EDH SEMINAR**

On 28 July, I joined the Chief Executive and a number of members of the Executive Board at a seminar put on by the leadership of the RNTNEH and EDH to hear about progress with their planned move to Phase 5 development. We heard from a number of representatives of different
staff groups about the issues they were dealing with in contemplating the move (usually focussing on the consequences of the site being much smaller than their existing accommodation). It was very encouraging to see the level of thinking and preparation being devoted to the service side of the move as well as the planning of the physical environment.

6. **A&E REDEVELOPMENT - SITE VISIT**

On 16 August, I joined representatives of HMU (who own the UCH site) and the building contractors to inspect the progress of the work to fill in the ambulance bay as part of the redevelopment of the A&E Department. The work seems to be advancing well and the Trust is scheduled to take over the site at the end of the year. The extra space will clearly make a big difference to the functioning of the Emergency Department.

7. **VISIT BY ED JONES, SPECIAL ADVISOR TO SECRETARY OF STATE FOR HEALTH**

Also on 16 August, Ed Jones, Special Advisor to the Secretary of State for Health, visited UCH. I had a conversation with him about a number of the issues which the Trust faces and we had a short tour of the Bloomsbury campus.

8. **HELEN PETTERSEN**

Again on 16 August, Helen Pettersen, Chief Officer of the NCL CCG came to UCH and we had a useful discussion about our and her priorities for the STP.

9. **LUCY SALCEDO RETIREMENT**

On 18 August, Flo Panel-Coates, Chief Nurse, and I attended the retirement party for Lucy Salcedo who has retired after an amazing 44 years at the Trust working as a Midwifery Assistant. This was a wonderful occasion attended by a number of senior representatives from the Women’s Health division and many of Lucy’s current and former colleagues. It was a fitting testament for someone who has devoted such an extraordinary length of time to caring for mothers and babies in the EGA. We wish Lucy all the best for her retirement.

10. **KING’S FUND LECTURE**

On 12 September, I am due to attend a King’s Fund Seminar about the progress being made with STPs around the UK. It will be good to have the opportunity hear about developments in other parts of the country.

RICHARD MURLEY
CHAIRMAN
1. Cancer Waiting Times

The Board will recall that the Trust commissioned an external review of its 62 day wait cancer standard following ongoing non-compliance with the standard. This review has been set up with the support of NHS Improvement and started in August 2017. Whilst it is not a formal regulatory investigation the review scope has been agreed with NHSI, and they have provided the resources to conduct the review.

In preparation, a fortnightly steering group has been set up to oversee delivery of the review. I co-chair this group with Edmund King, Head of Assurance for NCEL at NHSI. The first meeting was held on 6 September.

The review has two broad work-streams; one will focus on assurance and governance, the second on operational and clinical delivery. The delivery work-stream is being led by the Clinical Lead for Cancer at Bart's Health. The initial reports are expected in mid-October; the steering group will consider how to take forward any recommendations. I will bring the outcome to the Board in November.

Although we expect the outcome of the review to offer further support to the recovery of our cancer performance the Executive are continuing to focus on improving our position. The particular areas of focus will be discussed elsewhere on the agenda. (See CEO performance report and Cancer RAP monthly update).

2. Patient Transport Services

I have previously reported the difficulties we are experiencing with our new transport provider to the Board and to our Council of Governors. We are working with G4S to improve the service; we are disappointed that this is taking longer than first anticipated.

G4S took over the service from the previous provider in November 2016. There continue to be complaints about the service, the majority of these are about long waiting times. In July the number of formal complaints was 8 out of 8111 journeys (0.1%) and in August they rose to 17 out of 7702 (0.2%) journeys.

We agreed a number of actions to improve the position and have made progress delivering the actions since the last update (Council of Governors, July 2017).

- The transport contract recovery task to finish group has been established and is meeting fortnightly. This group, chaired by Dr Rob Urquhart, Divisional Clinical Director, Clinical Support Services will provide oversight and scrutiny to the recovery of the transport contract and will address a number of transport related issues both internally and externally. The group has clinical and non-clinical staff members from each of the clinical boards. A governor has been invited to join the group.
• Patient information is being revised to be disseminated by the end of September.
• Updates were provided to staff via Insight in August on changes to the service.
• Working closely with the coordination centre programme the transport teams will improve signposting for patients and staff and implement an electronic transport booking system.
• G4S are now contacting patients by text message, where they can. A new key performance indicator (KPI) will measure their performance for providing updates to patients at one week, 24 hours and on the day of travel.
• G4S have activated GPS technology which will enable them to record data from on-board devices in all their vehicles. This will more accurately capture journey times; this will be helpful to the Trust.
• With G4S we are reviewing the current contract. We will develop more meaningful KPIs. We are much closer to proposing a workable outcome.

We decided in June that an agreement to introduce a revised contract and new KPIs would be subject to the Board being satisfied that the new arrangements would strengthen the Trust’s ability to keep performance on track and result in a better service for UCLH patients. The Board is invited to discuss how it wishes to do this once the task to finish group has completed its work.

3. UCLH Strategy Review

The Board will recall that earlier in the year we discussed taking a different approach to developing our objectives in 2018/19. To support this we are revisiting our strategy to consider whether we need to make changes to our priorities and update our strategy over the next five years.

During September we will survey our staff and invite them to give us their views on a number of questions the first of which is ‘what guides their work and decisions, and how relevant is our vision now. I will also meet with staff during my CEO roadshows at various sites in the Trust.

Following the Board Seminar in October we will engage with our Governors and external partners.

The aim is to publish a revised strategy in late 2017/early 2018 from which the organisational objectives can be developed.

4. Meetings of Interest to the Board

On 28 June, I visited the Chenies Mews Imaging Centre, with Peter Burroughs, UCLH Charity Development Director and met the Queen Square Enterprise staff, who moved there from the Heart Hospital, and saw the new MRI scanners. I also visited the UCL phenotyping research facility based in the same building.

On 28 June, I spoke at an international Digital Health Event organised by the EU and several European embassies in London.
On 29 June, I attended a UCLH/Islington-Haringey CCG roundtable discussion about the Health and Wellbeing Partnership. On 29 June I presented at the British Inherited Metabolic Disease Group Metabolic Diseases meeting on rare disease management and expensive orphan drug medication.

I attended UCLH Research Open Day (4 July) the RNTNEH/EDH Star Awards (5 July) and presented the certificates for Nursing Assistants, Exemplar Ward, Enhanced Therapeutic Centre at UCH (7 July) and at Queen Square (4 August).

On 13 July, I met Lord O'Shaughnessy, the Parliamentary Under-Secretary of State for Health, with Nick McNally and Bryan Williams. He visited the Trust to see the pioneering work of our Biomedical Research Centre (BRC) and toured the Clinical Research Facility meeting with patients and staff. Lord O'Shaughnessy also announced the awards for global health research. Professor Robert Heyderman, an expert in infectious diseases at University College Hospital and the Hospital for Tropical Diseases was awarded £6.8m to establish a research centre to study the development and prevention of pneumonia, meningitis and sepsis in young children. The centre will be based at UCL.

On 28 July, I joined a DH meeting on clinically led behavioural sciences meeting focusing on strategies to deliver change in health care institutions.

On 1 August, I was invited by Jeremy Hunt, the Secretary of State for Health to discuss cancer waiting times and improvement of compliance with cancer wait standards. I presented the plans for UCLH and the NCL-NEL sector (Cancer Alliance) and we discussed how further support from the NHS and the DH could be helpful.

In June and July I spoke at several meetings with Junior Doctors or Postgraduate trainees of various specialities about the importance of Professionals in the Lead and how they could contribute to quality improvement, performance and financial sustainability of health care systems.

5. Senior staff changes

The Board will wish to join me in congratulating Catherine Pollard on her new appointment as Executive Programme Director for the Cambridgeshire and Peterborough Sustainability and Transformation Partnership. In her short time with us Catherine significantly improved UCLH’s engagement in the North Central London STP. She will be leaving us for Cambridge at the end of September.

Gill Gaskin has been appointed as the executive lead for the EHRS programme and David Kwo, director of EHRS and Informatics will report directly to her. He will be joined by Dr Stephen Cone, consultant anaesthetist, and Dr Natasha Phillips, assistant chief nurse who have been appointed as the chief medical information officer and chief nursing information officer for the EHRS programme respectively.

Laura Churchward has been appointed as Director of Strategy. She will take up her appointment at the end of October 2017. Rishi Das-Gupta has been appointed Director of Innovation. He was previously Director of Improvement where he oversaw the delivery of uclh future. This portfolio will transfer to his new role.
6. **Fix-It Squad**

The Board might also be interested to know that I am a member of a senior 'Fix-It Squad' which has been set up for staff to call on to help unlock those problems that are stuck in bureaucratic procedures and appear impossible to resolve. It was launched in August. Staff have been invited to escalate problems to the Squad where they, their colleagues and managers have made several efforts to solve them and have been unsuccessful.

PROFESSOR MARCEL LEVI  
CHIEF EXECUTIVE  
7 SEPTEMBER 2017
Executive Board (EB) Report to the Board of Directors Meeting, 13 September 2017

1. Quarterly Report from the Guardian of Safe Working Hours

Attached at appendix 1 is the third quarterly report from the Guardian of Safe Working Hours. The report covers the period from 6 April 2017 until 5 July 2017. During this period a total of seven exception reports were raised. Six of the reports submitted were from acute medicine doctors who had had to stay late due to a combination of understaffing and heavy workloads. These exception reports were accepted and the affected doctors were given time off in lieu. Of the seven reports one was rejected because it was for a pre-approved locum shift and the doctor who raised the report was contacted and briefed on the exception reporting process. The EB did discuss that six of the exception reports were from the same division and four from one doctor. The Medical Director, Medicine Board was aware of the exception reports and confirmed actions have been taken to address the causes and themes.

The Board is asked to note the quarterly update and take assurance that sufficient criteria are being met in relation to safe working hours. Dr Prasad Korlipara, Guardian of Safe Working Hours has been invited to attend the Board to answer any questions.

2. Workforce Race Equality Standard 2017 (WRES) - appendix 2

NHS England requires all trusts to publish the Workforce Race Equality Standard (WRES) annually. The Board is asked to review UCLH performance against the nine standards. Since the last update, a Black, Asian and minority ethnic staff (BAME) Network has been established and will be launched in October in the presence of Althea Efunshile, Non-Executive Director and myself. Over the next quarter a particular focus will be to improve standard 2 'relative likelihood of staff being appointed from shortlisting’. More analysis will be undertaken to understand the current position and improve recruitment processes. The Equality, Diversity and Inclusion Action Plan 2017/18 is monitored by the Diversity and Equality Steering Group.

The Board is asked to approve the Workforce Race Equality Standard 2017 for publication.

3. Annual and Statutory Reports

EB have recently reviewed the following reports:

Nursing and Midwifery Board – appendix 3

EB considered the Nursing and Midwifery Annual Report for 2016/17. The report forms the annual update of the previous nursing and midwifery strategy (2012-16) and introduces the new Nursing Midwifery, AHP and Pharmacy Strategy, launched October 2016. It includes an update of the priorities for the first year against each of the five strategic aims.

The Board is asked to note Nursing and Midwifery Annual Report for 2016/17.
Bi-Annual Staffing Report - appendix 4

The attached report provides the Board with an overview of nurse staffing capacity and compliance using the new National Quality Board (NQB) standards (2016) and the National Institute for Clinical Excellence (NICE) safe staffing standards.

The Board of Directors is asked to:
- **Note** the work currently being undertaken and accept assurance that there is sufficient nursing and midwifery staffing capacity
- **Accept** assurance that we remain compliant with national safe staffing guidance.

Mortality Report – appendix 5

The attached report is a statutory requirement introduced in April 2017. NHS trusts are required to collect and publish, on a quarterly basis, specified information on deaths and present to a public Board meeting. This first report to the Board sets out the UCLH policy and approach. It also includes a summary of the Mortality Surveillance and Learning from Deaths Policy. From quarter 3 the Board will receive data and learning points from the review of deaths.

The Board is asked to **note** the report and the **requirements** of the Board.

4. **Capital Investment**

New approved capital schemes of interest include replacement of 22 patient care monitors within critical care areas at the National Hospital for Neurology and Neurosurgery. The replacement of these monitors minimises the risk of patient safety issues and activity levels as the current equipment was previously installed in 2008. The EB itself reviewed and approved a funding request for redevelopment of retail catering at UCH and EGA. The investment would benefit both staff and patients and would include many environmental enhancements.

A proposal to install lift wraps in UCH tower and podium to encourage stair use was also reviewed and approved. The case was developed as part of our health and wellbeing plan for 2016/17 and is designed to encourage staff and visitors alike to use the stairs and thus allow lift space to be prioritised for those who need it. This ties in nicely with our forthcoming ‘Get Active at Work Week’, which runs from 18th – 22nd September. The aim is to help staff feel well, live well and work well.

5. **Research and Development**

The attached report at **appendix 6** is a summary of UCLH research performance and of recent developments within research. Research performance is good.

6. **Strategic Developments**

Since the last Board meeting, a variety of strategic developments between UCLH and the Whittington Hospital have progressed including the launch of the ‘Abscess Pathway’ and continuation of the ‘Maternity Model’ where elective caesareans are transferred to the Whittington. In addition the Whittington Health has been appointed as the new provider for the UCLH@Home service. The current contract with Healthcare at Home ended on the 13 August 2017 and we have now entered a transition phase between
suppliers. Mobilisation plans are in place and Whittington Health will start providing the service from October 2017.

There have been positive developments within the North Central London Sustainability and Transformation Programme and I have now taken over as the SRO for the NCL planned care programme. Together with other senior directors from UCLH occupying crucial positions in the STP organisation, this provides a great opportunity for UCLH to take on a leading role in the agenda.

7. EHRS

In August 2017 the EHRS Programme Board was launched. The programme board will oversee EHRS preparation, implementation and stabilisation, and the creation of a foundation for ongoing clinical and research innovation. Membership of the board includes Executive Directors, the Directors of Innovation, Planning and Performance and Digital Services, the Chief Medical Information Officer, Chief Nursing Information Officer and Chief Research Information Officer. The attached report at appendix 7 provides a summary of the first meeting.

PROFESSOR MARCEL LEVI
CHIEF EXECUTIVE
SEPTEMBER 2017
1. EXECUTIVE SUMMARY

- No new trainees commenced on the 2016 contract and 110 junior doctors were on this contract during the reference period
- Seven exception reports were submitted by junior doctors
- No fines or work schedule reviews have been applied

2. PURPOSE OF REPORT

This Quarterly Report on Safe Working Hours within UCLH covers a period from 6 April 2017 to 5 July 2017. This is a requirement of the 2016 junior doctor contract and the aims of the report are to provide:

- a current view of working practice in relation to working hours;
- assurance that safety criteria are being met;
- highlight areas of concern; and
- seek to give confidence to junior doctors that the trust is upholding the standards set in the national terms and conditions.

3. HIGH LEVEL DATA

| Number of doctors / dentists in training (total): | 507 |
| Number of doctors / dentists in training on 2016 TCS: | 110 |
| Number of educational supervisors with UCLH: | 287 |
| Recommended amount of job-planned time: | 0.25 PAs per trainee |

4. 2016 JUNIOR DOCTORS CONTRACT IMPLEMENTATION

The schedule of implementation of the 2016 Contract has been presented in previous board reports and is listed in Appendix A. No further trainees were commenced on the 2016 contract between 6 April 2017 and 5 July 2017. The total number of trainees on the 2016 contract within UCLH was 110.

5. EXCEPTION REPORTS (WITH REGARD TO WORKING HOURS)

<table>
<thead>
<tr>
<th>Specialty Rota</th>
<th>Grade</th>
<th>No. exceptions carried over from last report</th>
<th>No. exceptions raised</th>
<th>No. exceptions closed</th>
<th>No. exceptions outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAU</td>
<td>F1</td>
<td>N/A</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>
Six of the exception reports submitted within this period were from acute medicine F1s doctors, because they had to stay late. All the exception reports were approved and time was given off in lieu. The reason given in two of the exception reports was understaffing (due to other members of the team being away) and heavy workloads. 4 exception reports were submitted by an acute medicine F1 in the same week because of excessive workload.

The exception report submitted from Neurosurgery was rejected because it was for a pre-approved locum shift. The Medical Workforce team contacted the doctor to explain the exception reporting process.

6. WORK SCHEDULE REVIEWS

No work schedule reviews were requested from 6/4/2017 to 5/7/2017

<table>
<thead>
<tr>
<th>Work schedule reviews by grade/specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
</tr>
<tr>
<td>F2</td>
</tr>
<tr>
<td>CT1-2 / ST1-2</td>
</tr>
<tr>
<td>ST3+</td>
</tr>
</tbody>
</table>

7. FINES

No fines were levied during this period

<table>
<thead>
<tr>
<th>Fines (cumulative)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at end of</td>
<td>Fines this quarter</td>
<td>Disbursements this quarter</td>
<td>Balance at end of this quarter</td>
</tr>
<tr>
<td>last quarter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>


The table below lists the vacancies in the training posts and locum usage in departments with junior doctors who have commenced on the 2016 Contract. Trainees

<table>
<thead>
<tr>
<th>SPECIALITY</th>
<th>GRADE (NO TRAINEES WHEN FULLY ESTABLISHED)</th>
<th>TRAINEE VACANCIES*</th>
<th>UNFILLED POSTS IN DEPT ** (6/7/2017)</th>
<th>LOCUM USAGE: SHIFTS (HRS) ***</th>
</tr>
</thead>
<tbody>
<tr>
<td>O&amp;G</td>
<td>ST3+ (15)</td>
<td>6-30 Apr 2017</td>
<td>May 2017</td>
<td>Zero</td>
</tr>
<tr>
<td>O&amp;G</td>
<td>GP ST1/2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Overall Page 26 of 199
<table>
<thead>
<tr>
<th>Department</th>
<th>Grade</th>
<th>Vacancies</th>
<th>Filled</th>
<th>Percentage</th>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Histopathology</td>
<td>ST3+</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>Zero – LAS post covering</td>
<td>0</td>
</tr>
<tr>
<td>Urology</td>
<td>ST3+</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>Zero – Trust Doctors covering</td>
<td>13 (52)</td>
</tr>
<tr>
<td>Urology</td>
<td>ST1/2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Zero</td>
<td>66 (587.3)</td>
</tr>
<tr>
<td>Trauma and Ortho</td>
<td>ST3+</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>One – Trust Doctors covering</td>
<td>54 (287.67)</td>
</tr>
<tr>
<td>Trauma and Ortho</td>
<td>ST1/2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Zero</td>
<td>5 (50.5)</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>ST4+</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>One – 2 Trust Drs</td>
<td>50 (535.81)</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>S1-3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>One</td>
<td>386 (3908.24)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>ST4+</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>One (sickness)</td>
<td>34 (339)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>ST1-2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Zero</td>
<td>6 (58.5)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>FY2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Zero</td>
<td>0</td>
</tr>
<tr>
<td>ENT</td>
<td>ST3+</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>Six</td>
<td>105 (1093)</td>
</tr>
<tr>
<td>ENT</td>
<td>ST1-2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>One</td>
<td>215 (2184)</td>
</tr>
<tr>
<td>ENT</td>
<td>GP ST1/2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>One</td>
<td>See ST1-2 above</td>
</tr>
<tr>
<td>General Surgery</td>
<td>ST3+</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Zero</td>
<td>40 (236.5)</td>
</tr>
<tr>
<td>General Surgery</td>
<td>ST1-2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Zero</td>
<td>72 (765.32)</td>
</tr>
<tr>
<td>General Surgery</td>
<td>FY1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Zero</td>
<td>10 (85)</td>
</tr>
<tr>
<td>Acute Internal Medicine</td>
<td>FY1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Zero</td>
<td>2 (25)</td>
</tr>
</tbody>
</table>

*The vacancy data was provided by the Medical and Dental Education Service, and refers only to training posts (FY1, and ST 1-7) and does not include trust doctors.

**Individual departments provided data on the numbers of posts that remained unfilled within their service.

***The locum usage data was supplied by Bank Partners and refers to the total locum usage (trainees and trust doctors) - the data is not provided in such a way which allows us to determine whether the locum was to fill a trust doctor or a training vacancy.

No exception reports were submitted in those departments with high levels of locum usage (including Neurosurgery, ENT, General Surgery and Urology) or those departments with several trainee vacancies (notably ENT and Obstetrics and Gynaecology). Therefore the exception reporting process did not provide any evidence to suggest that rota gaps had a detrimental impact on the safe working hours of trainees.
in these departments. This will also be discussed further in the comments section particularly with reference to the data that has just been released from the GMC trainee survey.

COMMENTS:

- The numbers of exception reports within the reference period remains very low at UCLH in comparison with similar NHS Trusts, and there have been no work schedule reviews or fines incurred.
- The numbers of vacancies in training posts that remained uncovered were relatively small across the Trust, except for Otolaryngology (ST3+). High locum usage is noted in several specialties, including Otolaryngology, Urology, Neurosurgery and General Surgery, where we know there were trust grade gaps. However, the current data available does not allow me to know whether the use of locums was to cover training or trust grade posts. The Medical Workforce Team is currently working on a joint project with Finance to address this issue, and this should enable us to have a better understanding of the impact of rota gaps from a service and trainees’ perspective.
- No new trainees commenced on the 2016 contract during the reference period. However, in anticipation of the large numbers of new trainees commencing on the 2016 contract in August 2017, the junior doctor working group (comprising the medical workforce team, guardian of safe working hours, and representatives from the Medical Education Service) have continued to meet and take a pro-active approach to ensure smooth transition in the coming months.
- Although no major issues with respect to safe working hours have been identified in most specialties, when judged by numbers of exception reports submitted, six were submitted by acute medicine F1s, including four in one week. I have discussed this situation with Dr Phil Gothard, Consultant Physician, and he felt that the exception reports could be an early barometer of departmental stress. The department has faced several difficulties over the last 6 months:
  - Early shifts for F1 doctors were erroneously not included on the departmental rota which led to reduced flexibility and capacity on the rota. This has been corrected going forward;
  - Acute Medicine had been short of six out of sixteen Registrars. There has been locum cover arranged, but the impact has still resulted in CMT level doctors frequently acting up, with increased service fragmentation, stressful team working and inefficiency. This situation was also highlighted as a patient safety issue in the recent GMC trainee survey;
  - From Dr Gothard’s perspective, a particular weakness of the rotation is that Acute Medicine does not hold the budget for Registrars. This means that they are reliant on other departments to recruit staff for this rota when there are vacancies;
  - The department has been short of an CMT level Doctor and had a problem with CMT level cover in the new Emergency Day Unit, particularly when the these doctors have been busy filling the registrar gaps; and
  - Dr Gothard has also identified vacancies in consultant leadership, which has led to lack of active management of trainees’ annual and study leave. This has resulted in trainees not taking their leave until the end of the block.
Dr Gothard informed me that there are solid recovery plans in place to resolve these identified issues. We have agreed that it would be useful for me to meet the new clinical lead that should be taking up the position in November.

- Following good attendance of the first two, the third junior doctors' forum in May was poorly attended. Engagement by the junior doctors is paramount in understanding the working conditions and for me to be able to provide assurances on safe working. To further improve communication and engagement with junior doctors I am planning to conduct a series of additional planned informal ‘drop in’ sessions to meet the juniors in their clinical areas. The importance of the junior doctors’ forum will also be emphasized in my presentations at Trust induction programme.

- I have held informal feedback sessions with junior doctors in a number of specialties and grades (Paediatrics, Neurosurgery, F1 Medicine, F1 Surgery) and am awaiting a reply from representatives of Histopathology and Obstetrics and Gynaecology to my request for an informal meeting. These meetings have been useful in highlighting the following issues:
  - Some of the F1s did not know how to submit exception reports despite receiving their DRS4 login details, and this was rectified by the Medical Workforce Team
  - Some of the F1 and paediatric trainees expressed a reluctance to submit exception reports, because of concerns that they be viewed in a negative light or as a struggling trainee. The need to inform or seek approval from consultants to work late was also perceived as a barrier to submitting exception reports. Other trainees expressed a lack of interest in using the exception reporting system. It is essential that there are no barriers, either real or perceived, to exception reporting within UCLH when required and it is recognised that this may require a culture change among junior doctors and consultants. A member of the Medical Workforce team and I will continue to meet all consultant and junior doctors in all specialties throughout the year to reinforce this message and explain the ways in which exception reporting can help identify problems and be of benefit to patients, junior doctors, consultants and departments.

- During the production of this report, data from the GMC trainee survey covering a period from 21st March to 10th May 2017 was released. UCLH ranked 2nd in the Shelford group for overall satisfaction. The data on working hours and overall satisfaction in departments with junior doctors on the 2016 contract (with the national mean in brackets) is presented in the table below (higher score is better).

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Overall satisfaction</th>
<th>Workload</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>91.20 (83.27)</td>
<td>61.67 (46.93)</td>
</tr>
<tr>
<td>Histopathology</td>
<td>88.8 (85.57)</td>
<td>62.50 (63.78)</td>
</tr>
<tr>
<td>Medicine F1</td>
<td>87.69 (73.1)</td>
<td>36.59 (41.45)</td>
</tr>
<tr>
<td>Obstetrics and Gynaecology</td>
<td>75.54 (78.82)</td>
<td>14.42 (43.74)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>82.39 (80.05)</td>
<td>38.24 (43.00)</td>
</tr>
<tr>
<td>Surgery F1</td>
<td>62.82 (73.1)</td>
<td>34.47 (41.45)</td>
</tr>
<tr>
<td>ENT</td>
<td>89.09 (83.27)</td>
<td>52.27 (46.93)</td>
</tr>
<tr>
<td>Specialty</td>
<td>Percentage (National Average)</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td>Trauma and Orthopaedic</td>
<td>80.75 (83.27) 64.06 (46.93)</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>93.20 (83.27) 22.50 (46.93)</td>
<td></td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>70.80 (83.27) 34.58 (46.93)</td>
<td></td>
</tr>
</tbody>
</table>

- The workload data for Obstetrics and Gynaecology and Urology place UCLH as a negative outlier when compared with the national average, whereas General Surgery was a positive outlier. Of the thirteen Obstetrics and Gynaecology trainees in the GMC five reported working beyond their rostered hours on a weekly basis and a further eight on daily basis. Similarly of the five Urology trainees two reported working beyond their rostered hours on a weekly basis and three on a daily basis. It is therefore of concern that no exception reports have been submitted in these specialities. This provides a strong indication that the low numbers of exception reports in these specialities is likely to be due to the poor utilization of the exception reporting system. As this data has only recently been released, I plan to explore the issue further in the first instance by meeting the trainees and Consultants in the Urology and Obstetrics and Gynaecology departments.

- Rota gaps in Obstetrics and Gynaecology were also highlighted as a patient safety issue in the GMC trainee survey and this is thought to be due to a nationwide problem with unfilled training posts in Obstetrics & Gynaecology. Although there have been relatively few uncovered shifts in which case consultants would remain on site, the Trust recognised the negative impact of gaps and has applied for a MTI (medical training initiative) doctor through an RCOG scheme, while fellows in obstetric ultrasound will contribute one day per week to the general Obstetrics and Gynaecology rota.

Prasad Korlipara  
Guardian of Safe Working Hours  
UCLH Foundation Trust
APPENDIX A:

IMPLEMENTATION TIMELINE

October 2016: Obstetrics and Gynaecology ST3 and above

December 2016: F1 doctors (and F2 sharing rotas with F1s) taking up next appointment

Feb – April 2017: Psychiatry trainees taking up next appointments (all grades)
Pathology trainees (lab based) (all grades)
Paediatrics trainees taking up next appointments (all grades)
Surgical trainees (all disciplines) taking up next appointments (all grades)

Aug – Oct 2017: F2 doctors and GP trainees (ST1/2) taking up next appointments and sharing rotas with any of the above
Remaining trainees taking up next appointments and new starters (all grades)
EB REPORT APPENDIX 2

WORKFORCE RACE EQUALITY STANDARD (WRES) 2017

UCLH is required by NHS England to publish the third Workforce Race Equality Standard, showing performance against a number of national standards using data as at 31 March 2017. Data were submitted to NHS England in July 2017, as required. NHS England has invested £2 million in the WRES programme for the period 2015-2017 to identify and share best practice on improving recruitment practices, Board membership, disciplinary action and bullying of BME staff. The inaugural report on WRES from the NHS Equality and Diversity Council in June 2016 illustrated that there is a difference in the experience of white and BME staff in the NHS workplace. The aim of the standard is to draw attention to this, leading to improved BME staff experience and thus improved patient experience.

Since the last WRES report, UCLH has established a Black and Minority Ethnic Staff (BAME) Network which is working with Trust leads to set priorities for improvement. The BAME staff network launch will be held on 24 October 2017.

NHS England is now developing a Workforce Disability Equality Standard (WDES) which will be launched in April 2018 as disabled staff also report a significantly poorer workplace experience than non-disabled staff.

There are nine standards. The UCLH results for 2017 are detailed below.

**Standard 1: Ethnicity by staff band and staff group**
Overall, 43.3% of the overall workforce is from a BME background. The standard requires a detailed analysis of staff by ethnicity (white/BME) for each staff band, divided into three categories, listed below:

Figure 1: Ethnicity of Non-Clinical Staff

These data continue to show that for non-clinical staff, there are more BME staff than white staff employed up to and including Band 4. There are fairly equal numbers of BME and white staff at Band 5. The numbers of BME staff steadily decline from Band 6.
These data continue to show that for non-medical and dental clinical staff, there are more BME staff than white staff employed up to and including Band 3. There are fairly equal numbers of BME and white staff at Bands 4 to 6. The numbers of BME staff steadily decline from Band 7.

Figure 3: Ethnicity of Medical and Dental Staff

Ethnic representation is more balanced for medical and dental staff – 35% of trainees and career grade doctors are from a BME background whereas 27% of consultants are from a BME background. In 2016, 26% of consultants were from a BME background and 33% of trainees and career grade doctors were from a BME background.

This standard also reviews UCLH performance in recording ethnicity data on the Electronic Staff Record (ESR). In 2017 ethnicity data was not available for 3.1% of staff, a significant improvement over the position in 2016 when ethnicity data was not available for 6.6% of staff.

Standard 2: Relative likelihood of staff being appointed from shortlisting

White staff are 1.65 times more likely to be appointed from shortlisting than BME staff. In 2016, our performance had improved to a ratio of 1.34 times. It is therefore a concern that performance against this standard has worsened, despite action being taken to provide hiring managers with unconscious bias training.
A more detailed analysis of appointment and shortlisting data by staff group has been undertaken to better understand the underlying position.

Table 1: Shortlisting and Appointment Analysis by ethnicity and staff group

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>White</th>
<th>BME</th>
<th>Ethnicity not stated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Shortlisted</td>
<td>Appointed</td>
<td>Difference</td>
</tr>
<tr>
<td>Admin and Clerical</td>
<td>33%</td>
<td>43%</td>
<td>+10</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>28%</td>
<td>26%</td>
<td>-2</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>33%</td>
<td>64%</td>
<td>+31</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>46%</td>
<td>49%</td>
<td>+3</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>48%</td>
<td>60%</td>
<td>+12</td>
</tr>
<tr>
<td>Students (Nursing &amp; Midwifery)</td>
<td>20%</td>
<td>29%</td>
<td>+9</td>
</tr>
<tr>
<td>Additional Prof, Scientific &amp; Technical</td>
<td>48%</td>
<td>55%</td>
<td>+7</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>61%</td>
<td>68%</td>
<td>+7</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>56%</td>
<td>55%</td>
<td>-1</td>
</tr>
</tbody>
</table>

The difference column shows the variation between shortlisting and appointment. A positive difference shows that candidates are more likely to be appointed than would be expected, a negative difference shows candidates are less likely to be appointed than would be expected. The data show that for all staff groups (apart from Additional Clinical Services) BME staff are less likely to be appointed than white staff – the variation ranges from -1 to -27.

The position is worse for Estates and Ancillary staff (-27). This staff category includes UCLH portering and cleaning staff based at Queen Square and Westmoreland Street.

The variation for Admin and Clerical Staff is -11, for Medical and Dental staff -4, for Nursing and Midwifery variation -5 and for AHP staff -7.

Work is now underway to see whether further analysis of these data is possible. Since the WRES standard was introduced in 2015, hiring managers have been encouraged to have diverse interview panels and to attend the Interview Skills training provided by the Education Team which includes unconscious bias training. The recruitment team has had specific unconscious bias training. However, although the policy recommends that staff on interview panels should have attended the Interview Skills Training before interviewing, the take up of the training offering is low.

Divisions and corporate directorates will be encouraged to review these data and promote attendance at Interview Skills training to ensure equality of opportunity for people seeking a new role or promotion at UCLH.
Standard 3: Relative likelihood of staff entering a formal disciplinary process

BME staff are 1.39 times more likely to enter a formal disciplinary process than white staff. Our performance in this standard has improved since 2016 when BME staff were 1.63 times more likely to enter a formal disciplinary process. Analysis of these data show that staff in lower bands continue to be more likely to go through a formal disciplinary process than staff in higher bands. The Employee Relations teams reviews all requests for formal disciplinary action from managers to check that formal action is appropriate and that informal processes or mediation are being used appropriately and fairly.

Standard 4: Relative likelihood of staff accessing non-mandatory training/CPD

BME staff continue to be more likely to access non-mandatory training/CPD than white staff.

Standard 5: Percentage of staff experiencing harassment, bullying and abuse from patients, relatives or the public

Data for standards 5 to 8 relies on NHS 2016 Staff Survey data. This was gathered in October and November 2016 and published in February 2017.

More white staff than BME staff reported in the 2016 staff survey that they had experienced harassment, bullying and abuse from patients, relatives and the public in the last 12 months. The figures show that 33.4% of white staff (an increase of 1.2% from 2015) and 30.6% of BME staff (an increase of 2.2% from 2015) reported this.

Standard 6: Percentage of staff experiencing harassment, bullying and abuse from staff in the last 12 months

More BME staff than white staff reported in the 2016 staff survey that they had experienced harassment, bullying and abuse from other staff in the last 12 months. 34% of BME staff reported harassment, bullying and abuse from other staff compared with 30% of white staff.

Standard 7: Percentage of staff believing that UCLH provides equal opportunities for career progression or promotion

Significantly fewer BME staff than white staff reported in the 2016 staff survey that they believed that UCLH provides equal opportunities for career progression or promotion. 68% of BME staff believe that there are equal opportunities at UCLH for career progression or promotion (an increase from 66% in 2015) compared with 85% of white staff (unchanged from 2015).

Standard 8: Personal experience of discrimination at work from manager/team leader/colleagues

Significantly more BME staff reported experiencing discrimination at work from their manager, team leader or colleagues than their white colleagues. 16% of BME staff reported experiencing discrimination (a decrease of 2% from 2015) compared to 8% of white staff (unchanged from 2015).

Standard 9: Difference between the Board’s voting membership and the overall workforce

There was a -37% difference in ethnicity between the Board’s voting membership and the overall workforce as at 31 March 2017. This is an improvement from -44% in 2016.

BEN MORRIN, DIRECTOR OF WORKFORCE
SEPTEMBER 2017
<table>
<thead>
<tr>
<th>Reference</th>
<th>Action</th>
<th>Targets</th>
<th>Lead</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>W1</td>
<td>Review the UCLH overarching equality and diversity objectives and set new objectives for the period 2017 to 2020</td>
<td>Finalise new objectives following consultation</td>
<td>Karin Roberts</td>
<td>October 2017</td>
</tr>
</tbody>
</table>
| W2        | Complete the EDS2 grading exercise with a stakeholder event for our staff, staff representatives and staff governors and develop a comprehensive action plan | • Work with Heads of Workforce to prepare for grading exercise and prepare evidence  
• Arrange event  
• Hold consultation  
• Finalise action plan | Karin Roberts     | December 2017|
| W3        | Support the development of the Black and Minority Ethnic (BAME) Staff Network | • Support the steering group  
• Support the launch in October 2017 | Karin Roberts     | Ongoing      |
| W4        | Gain a better understanding of the staff experience across demographics | • Of our BME staff as evidenced in the WRES and staff survey;  
• Of our disabled staff who report a significantly worse experience at work via the staff survey in most key findings  
• Of our lesbian, gay, bisexual and transsexual staff with a longer-term view to improving our performance in the Stonewall Top 100 Employers Index.  
• Assess the impact of the “What is discrimination” training facilitated by the RCN | Kate Price         | March 2018    |
<p>| W5        | Equality Impact Assessments                                             | Review the Equality Impact Assessment process and documentation for policies and service | Karin Roberts     | March 2018    |</p>
<table>
<thead>
<tr>
<th>Reference</th>
<th>Action</th>
<th>Targets</th>
<th>Lead</th>
<th>Timescale</th>
</tr>
</thead>
</table>
| W6        | Reduce discrimination in the recruitment process | • Take appropriate action in identified hot spots  
• Better understand the underlying reasons for discrimination and identify actions which can reduce discrimination  
• Ensure hiring managers attend Interview Skills training | Jodie Williams working with HRBPs | October 2017 |
| W7        | Improve learning and development opportunities for staff with protected characteristics | • Offer mentoring and coaching support to staff with protected characteristics to enhance their opportunities for promotion including to director level positions  
• Review the content of the Interview Skills training programme to ensure that unconscious bias is explored  
• Ensure that all offerings embed equality, diversity and inclusion | Emma Taylor | March 2018 |
| W8        | Review the Employee Relations process to reduce potential for discrimination | • Encourage local mediation and improved training for line managers | Liz O’Hara | December 2017 |
| W9        | Improve the quality of information held on our workforce | • Further improve the recording of staff demographics relating to disability, sexual orientation and religion/belief  
• In view of ESR limitations, consider how the Trust can best record staff who have undergone gender reassignment. | Jennie Friswell | December 2017 |
Welcome and Introduction

A message from Flo Panel-Coates, Chief Nurse

I am delighted to be able to share the huge progress our staff have made in 2016/17. This report forms our annual update against the last few months of our previous nursing and midwifery strategy which ran from 2012 to 2016 and the first update against the priorities from our new joint Nursing, Midwifery, AHP and Pharmacy Strategy launched in October 2016 which will run until 2021.

It has been another busy year and as usual our teams have risen to the challenge. As a leading healthcare provider in North Central London we are always looking for ways in which we can improve our services, we have experienced the impact of this and have responded by supporting each other during those transitions, such as our reconfiguration works at Queens Square, the on-going service changes in our Emergency Department, the opening of Evergreen ward at St Pancras, the development of a plan to invest in an Electronic Health Record System (EHRS), the move to system wide thinking and working (STP), the arrival of our new CEO Professor Marcel Levi and changes in other key leadership positions, to name a few. This at a time when we have experienced nationally some of the biggest challenges to our health service and workforce such as the decision to leave the European Union, the loss of bursary funding and the reduction in post registration education funding.

Despite the distractions we have remained focused and had many achievements, as you can see within the report. The most significant is we have continued to deliver top-quality patient care, as agreed by our patients who voted us number one in London in the 2016 National Inpatient Survey and we remain an employer of choice in many areas and professions.

I hope you enjoy reading this report which has been the beginning of a very different approach, shares our progress to date and the unique contribution we make working alongside our medical directors as leaders of our clinical boards and services.

Finally, I would like to take this opportunity to thank you for your hard work, dedication and professionalism which makes a difference every day to our patients and each other.
Introduction and Background

Nursing and Midwifery Strategy

The Nursing and Midwifery Strategy 2012-16 came to an end last year and the successes have been illustrated through the previous annual reports. The Nursing and Midwifery Annual Report (2015-16) celebrated achievements against the eight key strategic aims, linked to UCLH’s vision statement.

- ‘We know that care and outcomes for patients are of a high quality’
- ‘Nurses and midwives are always caring thoughtful and intelligent’
- ‘Patients and their families feel confident in their care, and have the best experience possible throughout their whole pathway of care.’
- ‘Nurses and midwives are stewards of the NHS purse’
- ‘Nurses and midwives have a structured, coherent clinical and/or academic post graduate pathway’
- ‘Research is alive in practice’
- ‘Matrons are influential and exemplify inspirational leadership at all levels’
- ‘The sister and charge nurse is a high profile, valued and effective role’

Key Achievements: Patient Safety

The nursing and midwifery contribution to patient safety continued to be significant, delivering over 97% harm free care (Care Thermometer)

Key Achievements: Patient Experience

In 2016 UCLH retained its place as highest performing Trust in London in the National Inpatient Survey in London and continued through the new strategy to build on our PPI activities.

Key Achievements: Research and Workforce

We built on our success of 2015 and saw a reduction in use of agency staff. A number of initiatives were launched aimed at leadership development, including the Matrons Development Programme as a key objective of the 2012-16 strategy.
UCLH Nursing, Midwifery, Allied Health Professionals and Pharmacy Strategy 2016-2021

The 2015-16 Annual Report introduced the co-created Nursing and Midwifery, Allied Health Professionals and Pharmacy Strategy (NMAHPP Strategy).

The new strategy for 2016-2021 was developed following a series of events and road shows over a number of months, across all staff groups and sites. It was led by Flo Panel-Coates, Chief Nurse with senior clinical leaders in nursing, midwifery, AHP and pharmacy and with engagement from a broad representation of all staff groups.

The five year strategy was launched in October 2016 and is the first joint nursing, midwifery, AHP and pharmacy strategy. It builds on the previous achievements from the 2012-16 Nursing and Midwifery strategy to ‘be the best nursing and midwifery workforce in the NHS’. It does this by identifying high level strategic priorities for our professions which support our vision and goals.
At UCLH, nurses, midwives, allied health professionals, pharmacists and assistants to these professionals are 59% of the total workforce. Through the development of the strategy it was recognised that the challenges are similar, aspirations the same and together these professional groups are stronger.

This helped identify the title of the strategy ‘Stronger together’, to meet the growing demands requires working together and staying focused on achieving the best outcomes within our resources.

This strategy is closely aligned to our UCLH vision and strategic aims. It also addresses the national issues in the national nursing, midwifery and care staff strategy, launched in May 2016 entitled ‘Leading Change, Adding Value’.

Professor Jane Cummings, Chief Nursing Officer for England stated in her foreword for the strategy “This framework encourages us all to reach further both individually and collectively. To do this we need to focus on what is important and connect with each other so we achieve more for patients and people and also for our professions”.

At UCLH, this cannot be delivered without the day-to-day support and leadership of our excellent clinical leadership team, especially our medical directors.

Patients across UCLH receive care which is delivered compassionately and continues to be rated as high quality, safe, efficient and effective. Multi-disciplinary collaborative working is key to delivering this and despite the challenges ahead we recognise that whilst the ‘world has changed, our values haven’t’

Context – Drivers for Change

Six drivers for change identified here provide the focus and drive for the strategic aims of this strategy. Together these are essential in realising our ambition to be the organisation of choice for our professionals.
Changing health needs and increasing demands on healthcare

There are many factors which are increasing the demands on our health services such as, lifestyle changes, chronic diseases and an increasing ageing population with associated co-morbidities. At the same time there is greater emphasis being placed on health and well-being in order to impact on future generations of health service users.

To be able to meet these changing demands we have already committed to transforming what we do and how we support our patients and staff via our *uclh future* programme. The Exemplar Ward Programme is a key part of the *uclh future* transformation programme and is designed to support clinical teams to implement standard processes, reduce unwarranted variations for our patients and deliver local quality improvement initiatives in their wards and departments.

Increasing patient and public expectations

Patients and the public want care and treatment organised around them, not the services and staff. There is an expectation of high quality clinical care and a good experience. Individuals want to feel in control, to be fully informed, listened to and given easy access to our services. People want more clinician time, to be treated empathetically and be emotionally supported.

Changes in workforce requirements

There are significant workforce challenges in the NHS. This is not surprising as workforce is the largest cost in the NHS (70%...
of a typical hospital’s costs) with most of this spent on the clinical professional workforce. The right workforce is crucial to ensuring quality care is delivered whilst also ensuring the productivity and efficiency gains required to meet our financial challenges, as well as transforming services through new care models. Ensuring we minimise waste and use our resources efficiently is key. Agency caps and controls have been introduced and these will continue. There are opportunities for both skill and role development within the workforce to meet the changing and increasing demands. We will also work with partners in our health sectors, prioritising the STP’s, to train our staff for these opportunities.

Financial outlook
The biggest threat to our capacity to deliver high quality care is shortage of resources. There is a way forward, set out by the Five Year Forward View 2014 (FYFV). Lord Carter’s (2016) review of efficiency in hospitals shows how large savings can be made by the NHS; in such areas as efficient use of clinical staff, optimisation of medicines and hospital pharmacy, diagnostics – pathology and imaging, procurement, back-office functions and estates and facilities. As a pilot site for the review UCLH nursing and midwifery staff are leading the way to optimise the usage of our workforce and pharmacy is focusing initially on medicines optimisation.

Shift from organisation to system leadership
The Five Year Forward View (FYFV) sets out a clear direction for the NHS showing how the service needs to change, supporting more engaged relationships with patients, carers and the public in order to promote wellbeing and prevent ill-health. How this is achieved is complex and the way care is delivered is an important part of the solution. Another important part of the future is how the health and social care service is led. System leadership extends leaders beyond the usual limits of their responsibilities and authority and so new skills, knowledge and behaviours are required for this approach to be successful. UCLH is well represented clinically by our Medical Directors and Chief Nurse contributing as members of the North Central London Sustainability and Transformation Plan, Clinical Cabinet.

Technological advances
Technology is advancing at a fast pace and can offer many advantages to healthcare, patients and staff. UCLH have made a significant step forward during the last year with the rollout of electronic prescribing and medicines administration (EPMA) across all in-patient wards. This continues with the implementation of the co-ordination centre programme and the design and development of electronic health records system (EHRS)
Strategy within the Context of UCLH

UCLH’s five strategic aims are:

1. Provide the highest quality of care within our resources
2. Improve patient pathways through collaboration with partners
3. Support the development of our staff to deliver their potential
4. Achieve financial sustainability
5. Generate world-class clinical research

Nurses, midwives, AHPs and pharmacists’ unique contribution to UCLH strategic themes are shown below

Stronger Together – Bringing the Strategy to Life

‘Stronger together’ emerged during the co-creating events along with the importance of organisational culture and the UCLH values. Safety, kindness, teamwork and improving were identified to be important to staff. Five strategic aims have been identified for the five year strategy and there is overlap and synergy between these.
The five strategic aims:

1. NMAHPPs will provide the highest quality care within our resources
2. NMAHPPs will listen and respond to our patients and improve their pathways
3. NMAHPPs will be valued and developed to deliver their potential
4. NMAHPPs will practice in ways which manage resources and achieve financial sustainability
5. NMAHPPs will inspire, innovate and generate world class research

Enablers:

Constructive Conversations
Collaborative Working
Utilising Technology

During the process of co-creating the strategic aims, it became clear that there were three enablers instrumental in taking the strategy forward.

Developing a culture where we are confident, competent and comfortable with constructive conversations is essential and key to effective delivery of our strategic aims.

One of our Trust values is teamwork and collaborative working embraces not only teamwork and partnership working but working across systems and professional boundaries.

Technology supports transformation and patients and users of health services want more from technology to meet their needs.

These enablers are seen as opportunities to accelerate the pace of change and help deliver a more resilient and flexible workforce.

Strong leadership and professionalism is required at all levels to be able to innovate and inspire the changes and alternative approaches which will transform services and make patient pathways fit for the future.
Nursing, Midwifery, AHP and Pharmacy Objectives 2016-17

To support our strategy, annual objectives are identified for each year and will be monitored by the UCLH Nursing and Midwifery Board, which includes AHP and Pharmacy leaders. The following priorities were identified for the first year of the five year strategy (review, November 2017):

1. **NMAHAPPs will provide the highest quality care within our resources**
   - Recognising and responding to deteriorating patients
   - Reducing avoidable harm to patients
   - Reducing unwarranted variation through exemplar standardisation

2. **NMAHPPs will listen and respond to our patients and improve their pathways**
   - Maintain our patient experience
   - Improve involvement and engagement of our patients and public
   - Greater focus on the experience of our patients as customers supporting our transformation programme

3. **NMAHPPs will be valued and developed to deliver their potential**
   - Consolidate and build on the components of career pathways, including new roles and existing opportunities
   - Maintain a low vacancy rate and continue to reduce and stabilise the turnover rate
   - Reduce lost hours from clinical duties through sickness and absence and achieve a better utilisation of the workforce

4. **NMAHPPs will practice in ways which manage resources and achieve financial sustainability**
   - Ensure that expenditure is within agreed budgets and contribute to the on-going efficiency and productivity challenge of the Trust
   - Reduce unwarranted variation across the workforce
     a. Through delivery of the exemplar ward workforce efficiency pillar (e-roster)
     b. Implementations of the recommendations made by the Carter review of operational efficiency in the NHS
   - Improve discharge processes which result in an increase in discharges before 12 noon
5. NMAHPPs will inspire, innovate and generate world class research
   - Develop leaders at all levels who will drive evidence based innovations to improve patient experience and outcomes at UCLH, across our system and nationally
   - Increase the visibility of research led by NMAHPPs and strengthen structures for our clinical academic career pathway
   - Ensure all staff should take the opportunity to act as role models, mentors, teachers and coaches, so this becomes a predominant and consistent style of care, help and support

1. NMAHAPPs will provide the highest quality care within our resources

Priority 1: Recognising and responding to deteriorating patients

For the past year our efforts have continued to focus on improving the recognition, escalation and management of deteriorating patients. Sepsis, as the most common cause of deterioration, and acute kidney injury (AKI) were both brought into the wider deteriorating patients programme. The work has taken a hospital-wide approach to improvement using specific initiatives, including learning from serious incidents relating to unrecognised deterioration.

The aim of the deteriorating patient project is to improve safety huddles, National Early Warning Scores, (NEWS) escalation, the use of Situation, Background, Assessment, Recommendation (SBAR) and handovers. Over the last year we have focused on:

   - Improving NEWS scoring and vital signs recording, as the most effective tool for identifying at-risk and deteriorating patients
   - Improving the measurement and use of SBAR as a tool to improve timely and effective escalation and response
   - Improving the prompt and effective treatment of sepsis as the primary cause of deterioration

Over the last year we have seen significant increase in the accurate recording of patient observations and our staff taking the appropriate action.
Reducing Harm from Sepsis

Over the last year, we have progressed, as a Trust, with our work on implementation, education and measurement of sepsis; not just in the Emergency Department (ED) as originally planned but across the whole organisation, for both adults and children. Sepsis continues to be a patient safety priority at UCLH under the deteriorating patients programme and nursing plays a significant role.

Progress against Sepsis Improvement Project

- For children and young people, new sepsis guidelines were created and launched across our hospitals in February 2017. Paediatric Early Warning Score (PEWS) provide the basis for screening of sepsis under these guidelines, in line with our process for recognition of all deteriorating patients. Maternity-specific guidelines for sepsis were also created this year.

- A sepsis nurse was recruited to collect and report on sepsis data and to provide training and awareness activities across our hospitals.

- Trust–wide communications, ward walk rounds and poster campaigns (‘Sepsis: Spot it. Stop it’) all helped to raise awareness of sepsis. Targeted training has been designed, and is being rolled out on the wards and in the emergency department via clinical practice facilitators with support from our sepsis nurse.

- At the end of 2016/17 UCLH hosted an all-day sepsis master class aiming to share and learn from each other and hear about recent updates in sepsis care. There were 110 attendees (39 from UCLH and 71 from external organisations).
Priority 2: Reducing avoidable harm to patients

Hospital Acquired Pressure Ulcers (HAPU)

The latter part of the year saw an increase in HAPU and a sharp increase in the number of patients admitted with pressure ulcers from the community. As part of a national strategy, NHS Improvement (NHSI) requested improvement plans from every Trust aimed at reducing HAPU. In collaboration with nursing teams and the Harm Free Care Committee we have implemented a number of initiatives aimed at reducing harm from HAPU and enhancing our learning culture to sustain improvements in care.

We have seen a decrease in HAPU and severity of harm and yet continue to see a high number of patients admitted with pressure ulcers from the community. Most importantly, we have a strong commitment from teams to learn from incidents and proactively share the learning across the organisation.

<table>
<thead>
<tr>
<th>UCLH has a 5% prevalence of pressure ulcers</th>
<th>1% of pressure ulcers are hospital acquired</th>
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</thead>
<tbody>
<tr>
<td>Lower than the national average</td>
<td></td>
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Pressure Ulcer Incidence: Hospital Acquired and Imported Pressure Ulcers: 2016/17 and 2017/18

![Graph showing HAPU & Imported Pressure Ulcers: Grade 2, 3, 4, Unstagable and Deep Tissue Injury](image)
Patient Falls

Patient falls remain below the national mean of 5.6 (all falls) and 1.9 (falls with harm). The mean per 1000 beds days for the year is 4.1 and 1.0 respectively. UCLH has seen a reduction in patient falls with significant harm over the previous two years.

UCLH Total Falls with Moderate or Severe Harm

The trust has established a Falls Steering Group over the last three years, in line with NICE CG161. The steering group is multi-professional with medical, nursing and therapy leads.

Key Achievements:

- Face to face training has been implemented across the trust, with additional focus in high risk areas Falls clinic established.
- Nurse-led falls clinic has been established to support our most vulnerable patients
- A number of high risk areas have delivered successful quality improvement projects
- Multiple improvement projects in high risk areas carried out.
- Compliance and quality of Falls Intervention and Assessment Plans has improved across the trust.
- We conduct multi-professional root cause analysis of all moderate harm falls to extract the learning
Priority 3: Reducing unwarranted variation through exemplar standardisation

The Exemplar Programme is an accreditation and quality improvement programme that aims to reduce unwarranted variation across UCLH wards and departments. The programme, co-designed with staff and patients, provides a clear framework of fundamental standards that are monitored through an annual accreditation cycle.

Exemplar ward identifies five pillars with 12 standards that inform Exemplar accreditation. The implementation of these standards reduced variation across wards and departments and led to the following improvements in the quality & safety of patient care, operational efficiency and patient and staff experience:
These improvements were achieved by consistently working with ward teams in four key ways:

- **Set clear expectations**
- **Provide meaningful intelligence**
- **Recognise and celebrate success**
- **Facilitate constructive conversations**

Exemplar Ward Programme Board has produced an annual report detailing the progress against the key objectives and plans for year two.
Priority 1: Maintain our patient experience

The national metric for measuring patient experience is the Friends and Family Test (FFT). This year our FFT results were slightly below our target, with the exception of the emergency department (ED).

A new feedback system was introduced in 2016. This allows us to reach a wider range of patients and ensure we are able to capture a representative view of our services. We now collect feedback via text message and voice calls as well as electronic and paper methods. We are developing easy read paper survey options to capture the views of our hard to reach patients, such as patients with learning disabilities.

<table>
<thead>
<tr>
<th>Friends and Family Test area</th>
<th>Patients recommending in 2015/16</th>
<th>Target for 2016/17</th>
<th>2016/17 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients and day-case patients</td>
<td>97%</td>
<td>97%</td>
<td>95%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>92%</td>
<td>92%</td>
<td>91%</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
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Whilst we struggled to make the impact on the FFT and real-time survey in outpatients and in-patients, this was not so in our annual survey.

Our CQC results for 2016 show UCLH has maintained excellent performance in the inpatient national survey for 2016, achieving an overall score of 8.4/10, the top score compared to our London peers.

We performed exceptionally well in 4 areas, making the top 20% of Trusts Nationally:
- being given enough privacy when being examined or treated in ED,
- not feeling threatened by patients or visitors during their hospital stay
- being able to take own medication when needed
- Knowing which nurse was in charge of their care

This year our areas for improvement include:
- information related to planned admission dates
- help with meals,
- information following discharge from hospital

These areas of focus are consistent with national challenges.
Priority 2: Improve involvement and engagement of our patients and public

The views of patients, carers and the public matter to UCLH. Patient and Public Involvement (PPI) is one of the ways in which we can engage patients and the local community in the decisions we make, helping us to deliver our objective of providing the highest quality of care within our resources.

**PPI activities in 2016-2017**

- 476 patients listened to
- 46 patients partnered with
- 3 engagement events held
- 23 user groups

This past year has seen both large scale and smaller scale changes brought about through a range of PPI methods. We have listened to 466 patients, partnered with 46 patients, held 2 engagement events and run 23 user groups across the Trust. Some of our involvement this year includes the Improving Experience Group recruiting two new Patient Representatives to attend monthly meetings, to work in partnership with staff at both a strategic and operational level.

The Emergency Department (ED) have continued to keep patient feedback central to their re-development, by consulting patients on the signage and new route from the ED to the Elizabeth Garrett Anderson building. The National Hospital for Neurology and Neurosurgery piloted a number of user support groups throughout the year, with great success and the Cancer Patient and Public Advisory Group is in its second year and running successfully with bi-monthly meetings.

A Whose Shoes?® event held by Maternity Services in July encouraged patients and staff, through use of a board game, to ‘walk in other people’s shoes’ to gain insight into the concerns, challenges and opportunities of others through a range of scenarios and topics, and talk about how to make person-centred changes in healthcare.
The Paediatric and Adolescent Division hold weekly Breakfast Clubs on the wards, enabling patients to give feedback in a relaxed, informal environment.

Feedback postcards are collected each month, the themes from which form the content of the ‘You Said, We Did’ boards.

Over the past year, six young patients have been involved in the interview and recruitment process of new staff; the patient can help shape the staff team and provide valuable first-hand insight, so that the candidate with the right skills to suit their needs is chosen.

The team were shortlisted in the final of the Patient Experience National Network awards in March 2017 for their work involving young people in staff recruitment.

**Priority 3: Greater focus on the experience of our patients as customers supporting our transformation programme**

In the absence of a separate strategy, we agreed to align our patient experience priorities and actions to our UCLH future work programmes, and prioritise patient and public involvement and engagement. This has allowed us to focus on what matters most to our patients and the public.

3. **NMAHPPs will be valued and developed to deliver their potential**

**Priority 1: Consolidate and build on the components of career pathways, including new roles and existing opportunities**

**Internal Transfer Process**

In 2016-17 we continued to provide the nursing workforce with opportunities to seek advice and/or laterally transfer to a range of specialties across the Trust. 137 employees ranging from Nursing Assistants, Nurses and a Ward Sister have taken charge of their careers with professional support and guidance and benefitted from in-house opportunities available; developing them as professionals in specialties
chosen by them. Staffs acquire new skills and expand their clinical knowledge in a broad range of areas.

We have seen Band 6 nurses step down to band 5 roles and transfer to areas of interest due to the specific skills required for such specialist areas or to achieve a different work-life balance.

Through innovation and staff engagement, nurses are reaching their maximum potential and prospering in their professional career at UCLH whilst continuing to deliver safe and professional care.

The project is currently being trialled for Dental Nurses — a valued workforce and also a group with high turnover. We intend on applying the model to other staff groups including AHP and administrative staff.

The scheme has been showcased as ‘best practice’ across the NHS at conferences including:

- Florence Nightingale
- Capital Nurse
- NHS Employers

We are looking at the potential of partnering with other NHS organisation as a joint initiative to retain the public health nursing workforce.

Preceptorship Model

UCLH preceptorship is one of the essential components in helping new staff (preceptee) make the transition from student or internationally educated nurse to new registrant or newly qualified nurse (NQN).

Preceptorship activities have increased over 2016 - 2017:

- **60** newly qualified nurses (NQNs) &
- **63** International Nurses accessed the UCLH Preceptorship Programme.

- **121** attended the Preceptorship Development Days.

Key themes covered on the 3-day development programme include:
- Communication
- People and Personal Development
- Health, Safety and Security
- Quality and Service Improvement
Additional initiatives to enable preceptees and preceptors share experiences, problem-solve and access peer support and educational expertise include:

- Preceptorship Action Learning (PAL): every preceptee counts
- Preceptor workshop: preceptor matters

A new extended Preceptorship programme has been developed and will be in place for newly qualified and international nurses for 2017-18. The programme incorporates elements of Quality Improvement as well as a dedicated career discussion.

**International Recruitment**

The OSCE (Objective Structured Clinical Examination) is part two of the Test of Competence set by the NMC as requirement for NON-EU Overseas nurses wishing to join the register.

In 2016, 63 international nurses have successfully passed the NMC OSCE and registered with the NMC.

At present, 16 Nursing Assistants with international nurse registration have accessed the OSCE prep session aiming to register with the NMC by June 2017.

**IELTS Intensive Course & Drop-In Sessions**

All non-EU trained applicants must complete the academic version of the International English Language Test (IELTS) and need to achieve a score of 7.0 in all 4 components (reading, writing, listening & speaking) before applying to the NMC.

The IELTS Intensive Course was piloted in November 2016 in partnership with Hammersmith and West London College. 26 Nursing Assistants (NAs) completed their intensive course and are now awaiting test dates / results.

An in-house IELTS drop-in session is now on-going to provide further support to NAs.

**Supporting & developing our unregistered workforce**

Since the launch of the Care Certificate in May 2015 we have supported 538 assistants through the Care Certificate programme.

Approximately 40% of these assistants are new to healthcare and our experience survey has shown that it has been a beneficial part of their learning at UCLH.
We have also been rolling out the care certificate to existing staff across the organisation.

In May 2016 the Care Certificate programme began its rollout to our existing staff via a self-assessment model.

To date 126 assistants have completed the programme and we will continue rolling this out to each department over the coming year.

Apprenticeships

We currently have 46 Nursing Assistants on the Clinical Health Advanced Apprenticeship with training providers. This contributes 31% to the trusts overall target for Apprenticeships and has provided positive, career progressing opportunities for staff.

Supporting the Development of New Roles

The Nursing Associate is a new national role currently in pilot stages across England. UCLH are part of the second collaborative to help train individuals for this role. We are currently acting as placement providers for both an adult and children’s and young adults collaborative.

Priority 2: Maintain a low vacancy rate and continue to reduce and stabilise the turnover rate

We have continued our efforts over the last year to stabilise the nursing workforce; our vacancy rate at the end of the year was 8% and turnover had reduced to 14%. This represents a significant reduction in the number nurses, midwives and support staff choosing to leave the organisation.

In addition agency use remained below 3% for 2016/17; alongside the benefits to staff, patients and financial outcomes we remain unparalleled for our agency reduction efforts in London.

We have achieved this through a wide range of local and trust wide initiatives; key highlights include:

- national and international recruitment campaign attracting over 500 registered nurses and midwives
- extension of the transfer clinic to nursing assistants and specialist / leadership roles within nursing
• delivery of a bespoke matrons development programme

• delivery of 3 cohorts of the sisters connected programme reaching 90 sisters and charge nurses across the organisation

• roll out of enhanced therapeutic observation training for our nursing assistants an innovative programme which has reached over 130 nursing assistants (UCLH and bank staff)

• development of a Trust-wide community of practice for nurses and midwives in specialist roles

We launched an in house Deputy Development Programme in January 2017 with 20 individuals in the first cohort. The programme gives an opportunity for self-awareness and reflection with 360 feedback and Myers Briggs profiling along with sessions on skills required as a deputy.
Priority 3: Reduce lost hours from clinical duties through sickness and absence and achieve a better utilisation of the workforce

Our sickness absence reduction programme over the last year revealed sickness absence to be highest amongst our nursing and midwifery assistants.

A bespoke piece of work commenced focussing on 3 areas with the highest sickness absence rates. Engagement events took place with teams to understand pressures within the areas and plans to support staff were then created with teams.

At the end of 2016-17 sickness absence had reduced to 4%.

4. NMAHPPs will practice in ways which manage resources and achieve financial sustainability

Priority 1: Ensure that expenditure is within agreed budgets and contribute to the on-going efficiency and productivity challenge of the Trust

At the end of 2016-17 there was a surplus of £1.9 million within the nursing budget. This was predominantly surgery and cancer. Whilst this is very encouraging we are looking for more individual successes in local ward performance budgets.

Priority 2: Reduce unwarranted variation across the workforce

- Through delivery of the exemplar ward workforce efficiency pillar (e-roster)
- Implementations of the recommendations made by the Carter review of operational efficiency in the NHS

The exemplar workforce programme has reduced unwarranted variation across the workforce by creating and implementing standardised practices for the generation of rosters and prescribing of enhanced therapeutic observations.

This programme has impacted positively on the experiences of our staff, patients and carers whilst delivering over a million pounds of cost avoidance.
Key outcomes from the programme:

- Over 500 staff now working templated rosters which support health working patterns
- Time balance (difference between hours paid and hours worked) reduced from 50% to 6%
- Launch of an e-learning package to support roster creators
- Implementation of 5 week roster to ensure staff have the opportunity to plan life outside of work
- Development of enhanced therapeutic observation training for nursing assistants increasing self-reported confidence in providing enhanced care from 8% to 74%

This programme will continue in 2017/18 delivering further improvements to staff and patients whilst aspiring to have a £1.8 million impact.

In addition to the exemplar workforce programme we have adopted the Carter metrics of care hours per patient day (CHPPD) and cost per care hour (CPCH).

Whilst in their infancy both show our nursing and midwifery workforce at a trust level to be within the expected range.

We have also launched monthly reported of these metrics at ward and department level for leadership teams to review via the Carter intranet pages.

**Priority 3: Improve discharge processes which result in an increase in discharges before 12 noon**

In 2016/17 the Exemplar Programme led a project to improve pre 12 discharges across all wards at UCLH. Improvements were achieved through the implementation of a standardised approach to discharge huddles.

A ward of the week scheme was used to recognise wards that were achieving the target for pre 12 discharges.

The outcomes have been a >4% increase in pre 12 discharges and all wards at UCLH now have a daily discharge huddle.
1. NMAHPPs will inspire, innovate and generate world class research

Priority 1: Develop leaders at all levels who will drive evidence based innovations to improve patient experience and outcomes at UCLH, across our system and nationally

The centre for nursing and midwifery research (CMNR) sets the strategy for building research capability and capacity at UCLH.

In collaboration with nurses, midwives, AHP's and pharmacists; we have refreshed the strategy for the next 5 years. The new strategy builds on the strengths of our clinical specialties and workforce.

We have awarded 6 UCLH fellowships over the last years supporting nurses, midwives and AHP's to develop robust applications for postdoctoral and doctoral research grants. Three of these have completed to date with excellent outcomes; the remaining are in progress and a further bid has been placed to the charity to fund a further round of fellowships.

Priority 2: Increase the visibility of research led by NMAHPPs and strengthens structures for our clinical academic career pathway

In 2017 we hosted our 5th research in clinical practice conference which allows nurses, midwives AHP's and pharmacists across the trust to share best practice and to learn about research techniques. The event had excellent attendance with over 100 delegates attending.

This year we have developed our own UCLH research journal for non-medical researchers titled 'Connect'. We have some fantastic contributions to the first edition which will be published in the summer.
Priority 3: Ensure all staff should take the opportunity to act as role models, mentors, teachers and coaches, so this becomes a predominant and consistent style of care, help and support

Role Modelling Mentoring

The Chief Nurse, Deputy Chief Nurses and corporate nursing team mentor and coach over 20 nurses in leadership positions internally and external to UCLH.

Mentoring is viewed as an important aspect of the nursing leadership role.

NMC Revalidation

On the first of April 2016 NMC revalidation went live and now, one year later over 890 nurses and midwives at UCLH have completed a revalidation application; a requirement when renewing their place on the Nursing and Midwifery Council register. This represents around a third of our qualified workforce.

Our focus at UCLH has always been to support staff to meet the revalidation requirements in a way that feels meaningful to their professional practice. 19 ‘revalidation champions’ were recruited from across UCLH to support this philosophy in practice and staff feedback suggests we are meeting this aim; revalidation feels achievable and of value.

Between August and October 2016 Alison Finch carried out an evaluation of the experiences of nurses and midwives who have either completed a revalidation submission or have acted as a reflective discussion partner or confirmers. The evaluation analysed how revalidation has been experienced and how it impacts on individual’s sense of professionalism and continuing development. Revalidation is viewed as valuable mentoring experience and is found to build reliance and pride, personally and professionally.
Celebrating Success

Celebrating Excellence Awards

Kate Lowe
Kindness Award

Jillian Hartin
Chief Executive Award

Michelle Castello
Excellence in Education

Maria Jose Bello
International Winner

T8 Ward
Teamwork Award
International Nurses Day 2017
EXECUTIVE SUMMARY

1.1 The Chief Nurse and Heads of Nursing continue to work with our Medical Directors and Clinical Boards to ensure our wards and departments are safely staffed and to help identify further opportunities to increase efficiency and reduce costs, whilst monitoring the impact on quality and safety of care relating to the nursing and midwifery workforce.

PURPOSE

2.1 The purpose of this paper is to provide the board of directors with an overview of nurse staffing capacity and compliance with the National Institute for Clinical Excellence (NICE) safe staffing and National Quality Board (NQB) standards. It is a requirement that every Board of Directors receive a report on a six monthly basis (National Quality Board, 2016).

2.2 It provides cumulative oversight of care hours per patient day (CHPPD) and cost per care hour (CPCH) over the last 6 months. These new metrics replace the previously reported planned and actual staffing as published on NHS Choices going forward.

2.3 This is supported with an overview of staffing availability over the last 6 months and progress with assessing the acuity and dependency of patients on the ward to support the review of nursing and midwifery establishments for 2018/19.

NATIONAL NURSING AND MIDWIFERY STAFFING CONTEXT

3.1 Nationally workforce supply remains high on the agenda; NHS Digital data has shown that there were more than 86,000 vacant NHS posts in England between January and March 2017, an increase of 8,000 compared to the same period in 2016. Nurses and midwives accounted for the highest proportion of shortages. In March, there were 30,600 full-time equivalent vacancies on the NHS Jobs website, the highest total for a month since this type of data has been collected.

3.2 Although somewhat at odds with this the Home Office has launched an independent review into the impact of EU migrants on the UK economy, including whether British workers are disadvantaged by cheaper labour from the continent. The Migration Advisory Committee, tasked with drawing up the Government's immigration policy post-Brexit, will look specifically at how EU migrants affect different sectors of the UK economy and consider whether employing EU nationals leads to under-investment in certain areas of the economy, as well as the benefits and social costs of people from abroad moving to the UK.

3.3 At UCLH the vacancy rate in June was 9.6%; this represents an increase since our annual report. We are now seeing staffing pressures reported across all clinical boards and whilst the ward level data is not available board level data and local intelligence suggests that vacancy rates within the ward areas are higher than nursing in totality. In terms of Brexit we saw an unexpected peak of leavers from the European Union in January and June 2016 (following the vote to leave the EU). Since then it has
stabilised; however we are seeing a significant reduction in the number of EU staff applying for roles as reported previously.

3.4 The Department of Health has proceeded with their plans to remove the student nurse bursary for the coming academic year. UCAS reported that applications by students in England to nursing and midwifery courses at British universities fell by 23% in January 2017 compared to January 2016. We are yet to understand the impact of this on UCLH commissions for the coming year; however we will be proactively forecasting the impact of this change alongside our retention and recruitment plans. To date (August 2017) we have been advised of no reductions in places offered.

3.5 The Carter report and the NHS Five Year Forward View planning guidance make it clear that workforce and financial plans must be consistent to optimise clinical quality and the use of resources. Workforce is one of the four keys areas identified within the report that has opportunity for cost improvements. Nursing has core representation at the UCLH Carter project delivery group. Over the last year we have focused on the implementation of the NHS improvement good practice guides for ‘rostering’ and ‘specialising’. Both pieces of work have delivered over a million pounds of cost avoidance in 2016/17 and aim to do more in the current financial year.

3.6 Nursing and midwifery leaders have built on Compassion in practice to create a national nursing, midwifery and care staff framework, Leading change, adding value. This framework is aligned to the Five Year Forward View, with a central focus on reducing unwarranted variation and meeting the ‘Triple Aim’ measure of better health outcomes, better patient experience of care and better use of resources. UCLH’s Nursing, Midwifery, AHP and Pharmacy Strategy launched in 2016 captures this alongside strategic priorities at UCLH, the annual update against the closure of our previous nursing and midwifery Strategy and the first six months of our new Strategy was reported to our Senior Directors Team (SDT) meeting on 2nd August 2017

3.7 The 2015 Shape of caring report recommended changes to education, training and career structures for registered nurses and care staff. Since our last update to the board, Health Education England (HEE) has commenced a pilot of the nursing associate training scheme. UCLH is not a test site at this stage but is working collaboratively to provide placements for two pilot areas and ensure this role meets the needs of patients and providers.

3.8 On the 8th October 2015, the Nursing and Midwifery Council (NMC) approved the introduction of Revalidation, which took effect from the 1st April 2016. All registered nurses and midwives have to submit a revalidation application every three years in order to maintain their registration with the NMC. Since its launch in April 2016, 1205 nurses and midwives have submitted revalidation applications to the NMC; all have known to be accepted. The NMC have a verification process whereby small samples of registrants are contacted. We have received reports that a small number of our staff have been contacted offering assurance that the NMC’s governance framework is being seen through. We have had two staff whose registration lapsed due to failure to revalidate but there was mitigation for each. A further 456 staff are due to renew between September and March 2018. To date 45% of our current nursing and midwifery workforce have now completed revalidation as part of their three yearly NMC renewal.

4 AGENCY USAGE

4.1 Nursing and midwifery remain under the agency cap set by NHS Improvement and have done so since the caps were implemented in January 2015. This is unique in
London and particular significant as we have one of the lowest caps nationally. This has been achieved by levelling of staff across the trust sites ensuring that the nursing and midwifery workforce deployment is aligned to patient need; therefore reducing temporary staffing reliance.

5. **SETTING EVIDENCE BASED NURSING AND MIDWIFERY ESTABLISHMENTS**

5.1 The Executive Board have an agreed process for setting nursing and midwifery establishments (EB Establishment Setting Paper, 2012). As a reminder this process includes a number of important components:

- Using the Safer Nursing Care Tool (SNCT) to assess the acuity and dependency, on a daily basis for 1 calendar month across all wards. The assessment is undertaken by staff trained in the use of the tool.
- Repeating this exercise three times per year in February, June and September – to ensure validity
- External (to the Division) validation to ensure that the data collection is accurate and robust
- A multi-professional meeting with the Heads of Nursing, Finance & Workforce and the Divisional Manager to agree establishment proposals. The group ensures that where there is significant seasonality to an individual ward’s patient group; professional judgement is applied to ensure wards are not staffed beyond activity requirements. This is particularly relevant to paediatric wards.
- Professional judgement from the Head of Nursing, Medical Director and operational, financial and workforce judgement which triangulates the SNCT data and contributes towards the final proposal
- Sign off by EB before proposals are fed into the annual planning cycle and budgets

5.2 The SNCT is a NICE endorsed evidence-based tool which uses acuity and dependency to support workforce planning. Originally developed by the Association of United Kingdom University Hospitals (AUKUH) it is now hosted by and endorsed by the Shelford Group. SNCT received NICE endorsement in 2014 acknowledging that it meets the requirements set out in the NICE guideline ‘Safe staffing for adult in-patient wards’ (NICE, 2014).

5.3 The SNCT was originally developed in 2006 and updated in 2013. In the intervening years we have seen a steady increase in the demand for 1:1 specials at ward level. The capture of this detail was not included in the original development of the tool; work has begun to include this element going forward. UCLH and Sheffield Teaching Hospitals are leading this development work with 3 data sets having been collected. It is anticipated that the updated tool including the ‘1:1 specials’ element will be published later this year by the Shelford Group. This is not factored into any other existing tool or those endorsed by NICE at this time.

5.4 We have worked hard to ensure appropriate use of specials and have delivered significant cost avoidance in year. We plan to present an options appraisal for the management of specials to the SDT later this year.

6. **MEASUREMENT AND IMPROVEMENT**

6.1 The clinical and Executive Board review workforce metrics, indicators of quality and outcomes, and measures of productivity on a monthly basis – as a whole and not in isolation from each other.

6.2 This monthly oversight is consolidated by the Exemplar Ward programme which is a
multi-professional annual accreditation programme to support excellent clinical outcomes and enhanced patient and staff experience whilst reducing unwarranted variation and is aligned to the Carter recommendations. This programme:

- Measures all elements of a well-functioning ward under five fundamental pillars; quality & safety, efficiency, patient experience, staff experience and improving.
- Supports our staff to work in well-structured teams to be engaged, enabled to practice effectively and able to make changes to delivery of care to improve quality and productivity.
- Proactively seeks the views of patients, carers and staff from national and local surveys, stories, complaints and compliments.
- Measures staff engagement regularly via pulse surveys and supports the development of action plans locally to address variation in sickness absence and staff turnover. This is supported by the robust trust wide strategy and local policies and procedures that are in place to tackle bullying and harassment.

6.3 This multi-professional approach recognises the unique role of nursing and midwifery but avoids placing demands solely on any one profession and supports improvements in quality and productivity.

6.4 In 2016 all wards were assessed against the fundamental pillars as a baseline. Three wards performed so well across all pillars that they achieved the status of accreditation already. The majority of wards were satisfactory and a small number, required additional support or were in the middle of leadership changes. The assessments identified the areas that require improvement. Each ward has its own plan for improvement within this annual assessment process. The 2017 accreditation report will be published later in the year. There are a number of improvement projects which form part of a trust wide approach which include, data management, exemplar rostering, provision of specials/enhanced therapeutic care and exemplar discharge.

6.5 The staff survey in 2016 demonstrated that nurses, midwives and nursing assistants felt able to raise concerns and report incidents. This represents an improvement on the 2015 results.

<table>
<thead>
<tr>
<th>Question</th>
<th>National average</th>
<th>UCLH</th>
<th>Adult nurses</th>
<th>Other Nurses</th>
<th>Nursing Assistants</th>
</tr>
</thead>
<tbody>
<tr>
<td>% reporting errors, near misses or incidents witnessed in the last month</td>
<td>90%</td>
<td>92%</td>
<td>93%</td>
<td>93%</td>
<td>97%</td>
</tr>
<tr>
<td>Confidence and security in reporting unsafe clinical practice</td>
<td>3.66</td>
<td>3.71</td>
<td>3.87</td>
<td>3.69</td>
<td>3.84</td>
</tr>
</tbody>
</table>

Table 1. Staff survey results 2016

6.6 During the last 6 months, 179 incidents related to nurse staffing were reported, 26% of these triggered a staffing incident as defined by NICE (2014). This demonstrates an increase since the annual report published in February. All of these incidents are reported as no harm or low harm, with no adverse clinical outcome for patients however they did impact on the experience of our patients and staff. We are continuing to monitor these via the nursing and midwifery board (NMB).

6.7 In response to Sir Robert Francis’s *Speak up Review*, UCLH has implemented a Guardian Service to enhance support for staff who may wish to raise a concern and/or
seek independent review / support. Although early days feedback; from our nursing and midwifery teams has been positive.

6.8 Our compliance with Duty of Candour requirements and an annual declaration of our commitment to telling patients if a serious incident has occurred is published in our annual quality account.

6.9 The Board at UCLH ensures that they support and enable their executive team to take decisive action when necessary. Commissioners, regulators and other stakeholders are involved any decision to open or close a care environment, or suspend services due to concerns about safe staffing.

6.10 Vacancy rates within T10 Oncology and T14 North (both oncology wards within the Surgery and Cancer Board) were of particular concern. The vacancy rate in both of these areas was increasing, feedback from our medical and nursing staff was of concern and this impacted on our ability to fill RN shifts with bank and agency. The S&C Board in discussion with Medicine board colleagues made a decision based on the risk and feedback from medical and nursing staff to close T10 Oncology ward; a total of 16 beds as a temporary measure between April and October 2017. Weekly recruitment meetings remain in place within the division and a cancer specific open day was held to attract nurses into the specialism. A healthy pipeline of new staff should support the reopening of the beds during the next reporting period. This will continue to be monitored by the clinical board and via the monthly staffing report.

7 COMPLIANCE WITH NATIONAL STAFFING GUIDELINES

7.1 NICE published comprehensive guidance on nurse staffing for adult in-patient wards in July 2014 (Nice, 2014). An analysis has been undertaken of compliance against the guidance which demonstrates compliance with no exceptions. NICE also published comprehensive guidance on Safe Midwife Staffing in Maternity Settings in January 2015 (Nice, 2015). An analysis has been undertaken of compliance against the guidance which demonstrates compliance with no exceptions.

7.2 The recommendation from the Chief Nurse and Director of Workforce was there is good compliance with the new NQB standards and this remains the case. Appendix 1 provides more detail on our compliance with the revised National Quality Board standards (NQB, 2016).

8.0 PLANNED VERSUS ACTUAL STAFFING & CARE HOURS PER PATIENT DAY

8.1 All NHS provider trusts are required to publish nursing and midwifery staffing data on a monthly basis. This data shows the planned staffing hours (i.e. those that were planned in the roster) against actual staffing hours (i.e. actual hours worked by substantive and temporary staff). In addition to this the new care hours per patient day (CHPPD) and cost per care hour (CPCH) metric are now reportable monthly. Data is published on the trust internet site. This process has been in place since June 2014 and an exception report is submitted to EB every month.

8.2 Overall staffing levels have consistently remained within 2% of our planned hours. However, we have seen a steady decline in registered nurse filled hours which are being backfilled by nursing assistants within safety limits. This skill-mix adjustment is driving staffing that is in excess of plan as 1 nursing assistant is not the equivalent of 1 Registered nurse. Filling vacant RN posts remains a key focus.
Alongside this nursing assistants are deployed to support the provision of 1:1 care for patients at risk of avoidable harm and those under the mental health team (which are not part of the existing budgets). The graph below demonstrates the actual staffing fill rates over the last 6 months.

Graph 1. Published Nurse Staffing Data (data is substantive and temporary staff combined)

Over the last year we have focused our efforts on the use of nursing assistants above plan to support matrons to balance risk versus cost. This programme continues in 2017/18 aiming for a £1.8m impact. At month 3; this programme alongside exemplar rostering has delivered a cost avoidance of £346k.

The CHPPD is calculated by adding the hours of registered nurses to hours of nursing assistants and dividing the total by every 24 hours of inpatient admissions. NHS Improvement began collecting care hours per patient day formally in May 2016 as part of the Carter Programme. Whilst the data remains in its infancy the CHPPD reported at UCLH over the last 6 months is stable. This demonstrates that we are flexing our workforce in line with activity. This demonstrates that the wards with seasonal activity changes are managing their workforce as expected.

Graph 2. Published Nurse Staffing Data (data is substantive and temporary staff combined)

Whilst CHPPD is stable internally, preliminary benchmarking data suggests that at a trust level UCLH sits above the median (inclusive of critical care units). The median has
been derived from the monthly return to NHSI and includes all 134 acute providers. The Shelford trusts median is identified in grey. We continue to review and challenge unwarranted ward variation in the coming year using ward level benchmarking data available via the model hospital. This will enable us to identify individual wards that are above the national median for specialty and to investigate whether it is warranted. This will require ongoing support from the Medical Directors as well as the Chief Nurse.

Graph 3. Model Hospital, DH

8.7 Cost per care hour (CPCH) is also now reportable on a monthly basis and the CPCH reported for UCLH over the last 6 months remains stable. Benchmarking data is not yet available for CPCH but when it becomes available we will again be able to identify wards with variation against the national median for speciality. In the meantime, establishment setting has already included a skill-mix review to ensure we utilise the unregistered workforce appropriately.

9. PROGRESS WITH ACUITY & DEPENDENCY ASSESSMENT IN 17/18

9.1 The 2016/17 changes in nursing establishment were detailed in the annual report in March 2017 and approved by the Executive Board. These changes were implemented in full in April 2017 when new budgets were loaded into the system.

9.2 The EB and Nursing and Midwifery Board (NMB) continue to monitor nurse sensitive outcomes in relation to staffing and other factors (such as ward leadership) via the care thermometer. Each clinical board provides a quarterly update to NMB on any exceptions and progress with action plans that have been developed to address concerns. This ensures action plans are monitored and good practice is disseminated trust wide. The EB receives a monthly update from the NMB and has oversight of trust wide nurse sensitive indicators via the monthly staffing report.

9.3 The 2017/18 assessment to inform the budget setting for 2018/19 is approaching its third cycle, which will commence in September. When three months of acuity and dependency data has been collected this will be reported to the N&MLT and NMB. Heads of Nursing will be meeting with divisional management teams in November & December to discuss the results and feed in their professional judgement.

9.4 An options appraisal looking at the provision of staffing for 1:1 specials will be conducted in the coming months looking at current practices for providing 1:1 care for patients with mental health problems, patients at risk of falls and those with delirium (which are currently not part of the existing budgets).
10. RECOMMENDATIONS

10.1 The Board of Directors is asked to note the work currently being undertaken and accept assurance that there is sufficient nursing and midwifery staffing capacity and compliance with national safe staffing guidance.

11.0 REFERENCES

National Institute for Health & Care Excellence (2014), Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals, London, NICE
National Institute for Health & Care Excellence (2015), Safe Midwife Staffing in Maternity Settings, London, NICE
NHS England (2014), NHS Five Year Forward View
APPENDIX 1 – COMPLIANCE WITH NATIONAL QUALITY BOARD STANDARDS

1. EXPECTATION 1; RIGHT STAFF

1.1 The Executive Board have an agreed process for setting nursing and midwifery establishments (EB Establishment Setting Paper, 2012). As a reminder this process includes a number of important components:

- Using the Safer Nursing Care Tool (SNCT) to assess the acuity and dependency, on a daily basis for 1 calendar month across all wards. The assessment is undertaken by staff trained in the use of the tool.
- Repeating this exercise three times per year in February, June and September – to ensure validity
- External (to the Division) validation to ensure that the data collection is accurate and robust
- A multi-professional meeting with the Heads of Nursing, Finance & Workforce and the Divisional Manager to agree establishment proposals. The group ensures that where there is significant seasonality to an individual ward’s patient group; professional judgement is applied to ensure wards are not staffed beyond activity requirements. This is particularly relevant to paediatric wards.
- Professional judgement from the Head of Nursing, Medical Director and operational, financial and workforce judgement which triangulates the SNCT data and contributes towards the final proposal
- Sign off by EB before proposals are fed into the annual planning cycle and budgets

1.2 The SNCT is a NICE endorsed evidence-based tool which uses acuity and dependency to support workforce planning. Originally developed by the Association of United Kingdom University Hospitals (AUKUH) it is now hosted by and endorsed by the Shelford Group. SNCT received NICE endorsement in 2014 acknowledging that it meets the requirements set out in the NICE guideline ‘Safe staffing for adult in-patient wards’ (NICE, 2014).

1.3 NICE have endorsed 3 tools for setting annual establishments for adult in-patient wards. The remaining 2 tools are commercial products which rely on the SNCT methodology as the basis for the tool, however using these products would incur a cost whilst providing the same staffing recommendations.

1.4 The SNCT was originally developed in 2006 and updated in 2013. In the intervening years we have seen a steady increase in the demand for 1:1 specials at ward level. The capture of this detail was not included in the original development of the tool; work has begun to include this element going forward. UCLH and Sheffield Teaching Hospitals are leading this development work with 3 data sets having been collected. It is anticipated that the updated tool including the ‘1:1 specials’ element will be published later this year by the Shelford Group. This is not factored into any other existing tool or those endorsed by NICE at this time. We have worked hard to ensure UCLH’s use of special has not exceeded the available budget and have delivered significant cost avoidance in year.

1.5 We internally benchmark establishments aligned to patient and staff outcomes and where anomalies are identified we consult with Shelford and commission external reviews where necessary. Our work is ongoing with the Carter team to analyse benchmarking data at ward level that is now available via the model hospital. A review has been undertaken within our Haematology service and a further review of SITU/MITU is planned in the coming months.
1.6 Staffing establishments take account of the need to allow nursing, midwifery and care staff the time to undertake continuous professional development, and to fulfil mentorship and supervision roles. Core principles in determining the nursing and midwifery establishment are maintained as per previous years, namely:

- The ward sister role is supervisory and they use their time to direct care, undertake front line clinical leadership and support unfilled shifts
- The skill mix on the ward is set at a ratio 70:30 for registered nurses to nursing assistants in acute wards and 60:40 for sub-acute/rehab wards
- 22% ‘headroom’ is allocated to ward establishments to allow for annual leave, sickness, maternity leave, training and development. The RCN recommends 25% at present, however 22% is the minimum ‘headroom’ allowed with the SNCT.

1.7 The Exemplar roster programme continues to ensure ward rosters are managed within headroom and there is a continual reduced reliance on temporary staffing. This programme includes learning from the Carter Review and adoption of rolling rosters / rosters published 6 weeks in advance.

1.8 UCLH uses the CEO performance pack which is a local quality dashboard that triangulates comparative data on staffing and skill mix with other efficiency and quality metrics. Our Board papers are accessible to patients and staff working at all levels via NHS choices and the trust website. Regular executive walk-arounds are scheduled across the organisation to facilitate a strong line of communication from ward to Board, and Board to ward. Where concerns are raised in relation to staffing levels they take steps to maintain patient safety. Daily information is available to patients and the public on quality boards that outlines the number of staff are present and the names of key leaders within the clinical area alongside other quality indicators such as pressure ulcers and falls.

2. EXPECTATION 2; RIGHT SKILLS

2.1 Line managers have a responsibility ensure that staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration. Last year over 90% of our staff underwent an appraisal and all nurses and midwives who submitted revalidation applications to the NMC have had their NMC renewals accepted. We have had two staff whose registration lapsed due to failure to revalidate but there was mitigation for each. The NMC have a verification process whereby small samples of registrants are contacted. We have received reports that a small number of our staff have been contacted offering assurance that the NMC’s governance framework is being seen through.

2.2 A training need analysis is conducted annually to help identify, build and maximise the skills of staff. This forms part of the training and development strategy, which also aligns with Health Education England’s quality framework. This is underpinned by knowledge and understanding of public health and prevention, and supports behavioural change work with patients, including self-care, wellbeing and an ethos of patients as partners in their care.

2.3 All new models of care such as phase 4, 5 and 6 have a dedicated workforce work stream included in the change programme. This ensures that staff receive appropriate education and training to enable them to work more effectively in different care settings and in different ways and have the right competencies to support new models of care.
2.4 Team leaders, professional leads and sisters/charge nurses/ward managers have allocated supernumerary time to coordinate activity in the care environment, manage and support staff, and ensure standards are maintained.

2.5 We remain committed to investing in new roles and skill mix that will enable nursing and midwifery staff to spend more time using their specialist training to focus on clinical duties and decisions about patient care. Over the last 6 months we have expanded our dental nurse team, advanced nurse practitioner team and created two new consultant nurse roles. We will review the role of Allied Health Professionals to support registered roles within the Neurological Rehabilitation Unit over the next year.

2.6 We are committed to promoting equality and diversity in the nursing and midwifery workforce and to ensure that our leadership closely resembles the community it serves. The staff survey in 2016 demonstrated no significant variance in the percentage of staff experiencing discrimination at work; 18% in 2016 compared to 17% in 2015. Staff reporting they believed that UCLH provides equal opportunities for career progression or promotion remained stable at 78%.

2.7 Retention of staff remains a concern for us and in some areas, turnover rates are well above the average for UCLH. The trust wide vacancy rate for nursing and midwifery is currently 9.6% with cumulative turnover reduced to 13.9% from over 16.9% in the last two years. Whilst we recognise this is good progress when compared to peers; we continue to have high vacancy levels in some specialties where there are recognised national shortages of skilled staff and for which there is little prospect of significant improvements in UK supply.

2.8 There are a number of external factors which have a significant influence on our performance in relation to retention and recruitment of staff. The most significant of those evidenced by our local market research and staff reporting include nationally recognised shortages of staff qualified in specialty for some specialist areas; our exit from the European Union; increasing housing and transport costs; removal of bursaries for nursing and an increase in costs to sponsor international staff.

2.9 Taking the challenging context into account, our renewed approach to retention will build upon the strategic framework established successfully last year, which yielded unprecedented results for our nursing and midwifery vacancies and saw turnover fall to its lowest point in several years.

3. EXPECTATION 3; RIGHT PLACE AND TIME

3.1 The UCLH future programme utilises lean’ working principles, key deliverables for this programme are:

- The design of pathways to optimise patient flow and improve outcomes and efficiency
- Improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff.
- Supporting staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing time wasted is a key priority.

3.2 The rostering policy and nurse / midwife staffing escalation policy are in place to support those with responsibility for staffing decisions on a shift-to-shift basis. Daily monitoring of shift-to-shift staffing levels, including the use of temporary staffing solutions, is undertaken by matrons and site managers. Where staffing shortages are identified, staff utilise escalation policies which provide clarity about the actions needed to mitigate any problem identified.
3.3 Ward establishments are based on an average acuity and dependency assessment however on a day by day basis this may vary with some shifts having a higher acuity than establishment and some shifts having a lower.

3.4 The process of staff ‘levelling’ (flexing both up and down) has been embedded to address this issue and reduce reliance on temporary staffing. A twice daily assessment is undertaken by the matrons and site managers of activity and staffing numbers and a supporting tool acts as a decision aid to identify wards that may be able to release staff to support another ward.

3.5 The ability to level is closely related to the amount of vacancies a ward has and as such the process has been less successful in reducing temporary staffing spend where wards have a high number of vacancies. It has however helped to ensure safe staffing levels across the organisation as demonstrated in the monthly exception report to SDT.

3.6 To increase control over the use of temporary nursing and midwifery staff the Heads of Nursing / Midwifery for each board now oversee all agency and unfunded staffing requests. This brings additional professional judgement, rigour and challenge over the process.

3.7 As in 2016-17, reducing vacancies, turnover and improving bank fill rates remain an essential component of sustaining and improving our performance and achieving financial balance. It also remains one of the most challenging corporate tasks we face. Though our position compares favourably amongst other London trusts, we continue to have high vacancy levels in some specialities where there are recognised national shortages of skilled staff. These areas are neonates, elderly medicine, oncology and haematology, Paediatrics, Queen Square wards, midwifery, theatres and the emergency department for nursing and require different approaches to secure improvements within national context where shortages are deep and likely enduring. The current assessment centre process has recruited over 2000 excellent nurses but hasn’t been reviewed in entirety since its inception in 2012. The forthcoming planned review of the process will align our assessment to recently introduced technology and consider how we can support experienced nurses through this process.

3.8 The shortage of staff in key specialties for substantive posts is also reflected in the limitations of the temporary staffing market to supply enough suitably skilled staff to meet demand. This is despite the introduction of pay caps by NHS Improvement in November 2015 which has reduced the significant difference in pay between agency and bank workers in some groups.

3.9 Nursing and midwifery remain under the agency cap set by NHS Improvement and have done so since the caps were implemented in January 2015. This has been achieved by levelling of staff across the trust sites ensuring that the nursing and midwifery workforce deployment is aligned to patient need; therefore reducing temporary staffing reliance.

3.10 Our renewed approach to recruitment will build upon the strategic framework established successfully over the last 2 years, which yielded unprecedented results for our nursing and midwifery vacancies, of which the key components are:

- recruitment and retention aligned to the vision, values and strategy of UCLH as well as the wider North Central London Sustainability and Transformation Partnership (STP);
- campaigns designed and fronted by our staff; and
- a refreshed approach to candidate experience from attraction to on boarding.
3.11 We expect vacancies to continue to fall in the second half of the 2017/18 with the on boarding of both newly recruited international and newly qualified nurses commencing in post in October. We will need to remain focused on the for the remainder of the year.

3.12 Our workforce plan has been developed with commissioners and with Health Education England, to inform supply and demand modelling within the sector and across London. The STP is enabling us to work collaboratively with others in the local health and care system and supports the development of future care models by developing an adaptable and flexible workforce (including AHPs and others), which is responsive to changing demand and able to work across care settings, care teams and care boundaries.

3.13 We remain committed to the training of the nursing and midwifery workforce and are continuing to support Health Education England by ensuring that high quality clinical placements are available within the organisation and across patient pathways, and actively seeking and responding to feedback from trainees/students, involving them wherever possible in developing safe, sustainable and productive services.
EB REPORT APPENDIX 5

National mortality review programme

<table>
<thead>
<tr>
<th>The board should ensure that their organisation</th>
<th>Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>has an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and an existing non-executive director to take oversight of progress;</td>
<td>Executive lead is Professor Mundy Non-executive lead is Professor David Lomas</td>
</tr>
<tr>
<td>pays particular attention to the care of patients with a learning disability or mental health needs;</td>
<td>Specifically covered in the policy</td>
</tr>
<tr>
<td>has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review</td>
<td>Performance screen all deaths for review triggers. The review triggers are based on the national guidance. This is supplemented by the current arrangements for identifying deaths requiring review such as complaints and incidents</td>
</tr>
<tr>
<td>adopts a robust and effective methodology for case record reviews of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;</td>
<td>We are adopting the Royal College of Physicians ’structured judgment review’ (SJR) framework for those deaths not already addressed by the existing processes – such as complaints and incidents. All deaths of patients with a learning disability are referred to the Learning Disability Mortality Review Pilot Review Process (LeDeR)</td>
</tr>
<tr>
<td>ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur</td>
<td>Reviewers will be trained / the SJR guidance will be provided to them. Investigations for complaints and incidents will follow the current processes.</td>
</tr>
<tr>
<td>ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised;</td>
<td>Quarterly reports to the public part of the board</td>
</tr>
<tr>
<td>ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts.</td>
<td>To provide assurance that learning is acted upon and that change has occurred will require an additional focus. For example where learning has been identified and an action plan put in place assurance will need to be sought that the actions have been completed and are embedded and monitored as appropriate. Reporting in the 2018-19 Quality account will be as required.</td>
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Learning will be shared as follows:

At the end of each quarter a report including learning
will be presented to the quality and safety committee and the public part of the board of directors.

This will be distributed to medical directors, divisional clinical directors, managers and chief nurse team for local sharing in clinical teams and for presentation to specialty mortality and morbidity meetings where relevant.

It will also be shared with the commissioners through the Clinical Quality Review Group

Current processes for learning will continue: Publication in appropriate trust wide publications such as the quality and safety monthly bulletin, the monthly summary of learning from serious incidents ‘Look and Learn’ and the Safer Use of Medicines - SUMtips newsletter and the Claims and Inquests reports produced for the divisions.

A patient safety committee will be set up in October which has a key aim of sharing learning.

| Ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths; | Reviewers will be trained / the SJR guidance will be provided to them
We are currently scoping where deaths occur so that the resource is adequate |
<table>
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</thead>
<tbody>
<tr>
<td><strong>Offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death</strong></td>
<td><strong>We will invite families to raise significant concerns. Engagement with families in reviews of deaths will need to be strengthened as we currently only do this in a comprehensive way for the most significant serious incidents.</strong></td>
</tr>
<tr>
<td>Acknowledges that an <strong>Independent investigation</strong> (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved</td>
<td><strong>External reviews are already commissioned where necessary and will continue</strong></td>
</tr>
<tr>
<td><strong>Works with commissioners to review and improve their respective local approaches following the death of people receiving care from their services. Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contracts etc.</strong></td>
<td><strong>There will be regular reports to the Clinical Quality Review Group and we are likely to be working more closely with commissioners as we start to look at deaths in the community</strong></td>
</tr>
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Policy Summary

UCLH is required by NHS England to have in place a policy on how we respond to, and learn from, deaths of patients who die under our management and care, which includes:

1) How our processes respond to the death of an individual with a learning disability or mental health needs, an infant or child death and a stillbirth or maternal death.

2) An evidence-based methodology for reviewing the quality of care provided to those patients who die. UCLH has chosen to use the methodology recommended for acute trusts - The Structured Judgement Review (SJR)

3) The categories and selection of deaths in scope for case record review. These are outlined in figure 1. The policy also describes the arrangements in place at UCLH to meet the NHS England requirement to collect and publish on a quarterly basis specified information on deaths. This will be via a paper and an agenda item to a public board meeting in each quarter. This data will include the total number of in-patient deaths at UCLH (and Emergency Department deaths), and deaths within 30 days of discharge, and those deaths that UCLH has subjected to a further investigation including the SJR. Of these deaths subjected to review, we will provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

The pathway for deaths reviews is laid out in figure 1 on page one. The right hand box includes our existing processes for review of deaths. The box in the left hand side includes the deaths that will be identified for review via coding. They may or may not have been reviewed through existing mortality and morbidity processes.

1.1 In summary, the process for mortality review is as follows:

- All deaths are identified and screened for the triggers. This is to identify additional categories of deaths to be reviewed as outlined in figure 1, by the performance team.

- Deaths that meet the screening criteria as per figure 1 will be notified monthly to the quality and safety team. These include those deaths where the family have raised concerns about the care of their loved one via the bereavement team or as a result of receiving the end of life care survey and contacting the trust.

- Selected deaths via coding (left hand side box) are to be allocated to appropriate reviewers who use the methodology of the RCP SJR with a deadline for completion of the structured judgment review within 30 days.

- SJR reviewers will be asked to rate the care at various stages as per the methodology (see appendix 1 for the structure of the review) and an overall rating.

- For other death reviews (right hand side box) the investigator/SJR reviewer will be asked to rate the overall care as per the definition of death due to a problem in care.

- The findings of the SJR reviews will be entered on to the Datix mortality module once this is available.

- The findings for the other death reviews will be noted according to the type of review (e.g. serious incident summary, complaint summary).
• All the findings and learning will be collated into a report for the public part of the board of directors.

Figure 1  **Mortality review process for learning at UCLH**

### Additional categories of deaths to be reviewed
- Severe mental illness*/deaths whilst detained under the MHA
- Elective access pathway
- CQC mortality outlier notification
- All deaths where bereaved families and carers, have raised a significant concern about the quality of care provision* (other than a formal complaint)
- Death in the community within 30 days of discharge*/attendance at ED (except for the terminally ill who die in a hospice or if preferred place of death was home)
- Deaths where the patient was not under UCLH care at the time of death but where another organisation suggests that the trust should review the care provided to the patient in the past
- Sampling e.g. sepsis, diabetes, AKI, cardiac arrests, deaths out of hours

### Other potential criteria
Death following unplanned return to theatre or unplanned return to ITU.

### Structured judgement review

### Deaths judged more likely than not to have been due to problems in care

### Findings input to DATIX mortality review platform (*when available*)

### Learning shared at morbidity and mortality meetings, SUMTIPs, quality and safety bulletins, *Look and Learn*, Claims and Inquests reports. Policies, guidelines and care pathways reviewed as appropriate.

### Report for QSC, senior directors and public part of the board

### Annual review for the Board

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*Mandated by national policy*
UCLH RESEARCH REPORT

1. UCLH Biomedical Research Centre Update

1.1 NIHR Ministerial Visit
Lord O’Shaughnessy, the parliamentary under-secretary of state for health, made a visit with Tony Soteriou of the NIHR. The main body of the meeting was discussing how the BRC funding can help drive innovation in patient care in the NHS. After the discussions, the minister visited the CRF to see patients receiving leading edge treatments.

1.2 Health Informatics Collaborative (HIC)
The DH/NIHR has pledged a total additional £7m to support the on-going Health Informatics Collaborative for the next 12 months. The funding is subject to the 5 HIC BRCs being able to demonstrate that the additional funding (for 17/18 budgets) will be used to “pave the way” for other BRC- and non-BRC Trusts to become involved with the HIC. A full proposal for the funding is under development by the 5 HIC BRCs to be submitted to DH/NIHR in early May.

UCLH BRC will receive £1.25M additional income for the HIC.

1.3 BioResource
UCL BioResource has now surpassed its recruitment target of 10,000 participants and our current panel totals over 10,200. Recruitment continues as we now begin our second term and work towards establishing new goals and targets. The National BioResource has presented a re-structuring for the 2017-2022 funding term as a Research Tissue Bank (RTB) platform which will centralise both sample and data processing/storage under a sole ethics protocol.

Discussions are taking place with the Department of Health/NIHR about the feasibility of this change of approach.

1.4 NIHR Senior Investigators
The 11th competition round has opened and the BRC Theme Leads, with the UCL Deans, have encouraged faculty members to apply. To date there are up to nineteen people putting together their applications, the closing date is the 23rd August at 1pm. Of our 23 current NIHR Senior Investigators (including emeritus) only 2 are women. We continue to encourage female applicants from UCLH/UCL. Of the 19 potential applicants to the 11th competition round, 4 are women.

2. UCLH Clinical Research Update

2.1 Research Open Day
The fourth annual research open day at UCLH attracted hundreds of visitors on 4th July.

The special exhibition of research saw three floors of University College Hospital accommodate over 40 interactive stalls where researchers demonstrated the latest technology and techniques tackling conditions such as cancer, neurological diseases and diabetes.

Over 40 students from local secondary schools attended; they were given talks by researchers and had opportunity to ask questions such as what a normal working day is like for a researcher and which challenges they have faced. After the talks the
students went on a special tour of the Institute of Sport, Exercise and Health and saw a surgical simulation in the UCLH Education Centre. There were prizes for the best research stand and Healthcare Engineering scooped first prize with their exceptional exhibition of how technology can help medicine. Runners up were the Microbiology team who offered visitors a chance to see how clean their hands were under a special light.

2.2 Research Performance

NIHR initiation performance targets (interventional and CTIMP portfolio only): Studies obtaining NHS Permission and recruiting first patient within 70 days of submission to R&D. The line graph shows UCLH’s performance (as a percentage of studies meeting the benchmark) when compared with the other big BRC Trusts.

UCLH compares well reporting 83.9% in Q1 of 16-17 and 85.7% in Q2 of 16-17. All Trust performance has dipped in Q4 16-17. The studies subject to analysis in Q4 were only those approved via new DoH (Health Research Authority – HRA) procedures, adopted at the start of 2016/17. Previous quarters were a mix of studies from this new system and the previous system of NHS permissions. The dip reflects the controls which have been adopted by the NIHR (within this new system) to limit variability between Trusts in their interpretation and reporting of the start point for this metric. The fall in performance for UCLH between Q2 and Q3 and Q4 is less dramatic than for other Trusts – in part, due to UCLH having stayed close to the nationally prescribed definition of this start point.

Interventional studies recruiting first patient within NIHR 70 day target Q1 (14/15) – Q4 (16/17) by NHS Trust (%)

2.3 Research recruitment performance

Recruitment to research studies at UCLH has increased over the last year. In 2015/16 UCLH reported at total of 7,549 recruits to NIHR adopted research studies. The comparable figure for 2016/17 to date is 12,772 recruits. This 2016/17 performance compares to 2014/15 figures where recruitment was reported at 11,316 when a peak in recruitment was attributed to one high recruiting, low intensity study. The most recent peak in 2016/17 is attributed to an increase in almost all clinical areas and one relatively high recruiting study from Critical Care. Increases in reported recruitment (from 2015/16) are also seen from musculoskeletal studies, gastroenterology, cancer, surgical specialities and reproductive health. Total recruitment to all studies (NIHR adopted, and non-adopted combined) is similarly increasing with 13722 reported in 2015/16 and 19986 reported in 2016/17 (to date).
The generation of both sets of data relies upon the feedback from research teams. Currently the response rate (portfolio and non-portfolio) is between 52 and 58% each quarter. Initiatives are underway, supported by UCLH Planning and Performance to report adherence to reporting recruitment at specialty and board levels each quarter. The first such report is scheduled for Q2/3 2017-18.

Dr Nick McNally Managing Director, Research
EHRS Update

This paper reports on the progress of the EHRS Programme during the period July to August 2017, following the July Board’s decision to proceed with the implementation of Epic.

1 Programme Plan

The EHRS Programme Plan has a three year horizon (2017 to 2020) within which there is a go-live target of April 2019. The exact date in April 2019 will be the subject of a go-live date paper to be brought to Programme Board in January 2018. The programme plan takes into account the need for a period of stability before the move of Dental and ENT outpatient services into Phase 5, in September 2019. There are four phases leading up to go-live and one afterwards, as follows:

- Phase 0 - Groundwork: August to October 2017
- Phase 1 – Direction: November to December 2017
- Phase 2 – Adoption and Configuration: January to July 2018
- Phase 3 – Testing: August 2018 to January 2019
- Phase 4 – Training and Go-Live: February to April 2019
- Phase 5 – Stabilisation and Optimisation: May to August 2019

2 Key Milestones

The key milestones during this period are shown in Table 1 below (critical path milestones are asterisked).

<table>
<thead>
<tr>
<th>Main Area</th>
<th>Milestone</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance and Recruitment</td>
<td>*Appoint SMEs, Operational Readiness Owners and establish Working Groups, Design Decision Groups</td>
<td>30 Sep 2017</td>
</tr>
<tr>
<td></td>
<td>*Recruit programme management and development team roles</td>
<td>30 Sep 2017</td>
</tr>
<tr>
<td></td>
<td>*Complete training and certification of build team</td>
<td>31 Dec 2017</td>
</tr>
<tr>
<td>Phase 0 &amp; Phase 1 Work</td>
<td>*Complete Groundwork Questions</td>
<td>30 Oct 2017</td>
</tr>
<tr>
<td></td>
<td>*Complete Direction Sessions</td>
<td>15 Dec 2017</td>
</tr>
<tr>
<td></td>
<td>*Make scoping decisions for modules</td>
<td>31 Dec 2017</td>
</tr>
<tr>
<td></td>
<td>*Conclude 3rd party contracts for this period</td>
<td>31 Dec 2017</td>
</tr>
<tr>
<td></td>
<td>Agree guiding principles for EHRS Programme</td>
<td>8 Nov 2017</td>
</tr>
<tr>
<td>Technical</td>
<td>*Deploy non-production environment</td>
<td>14 Nov 2017</td>
</tr>
<tr>
<td></td>
<td>Complete assessment of interfaces</td>
<td>31 Dec 2017</td>
</tr>
<tr>
<td>Change Management</td>
<td>Establish change management strategy and team</td>
<td>31 Dec 2017</td>
</tr>
<tr>
<td>Communications</td>
<td>Run EHRS Launch Week</td>
<td>6 Oct 2017</td>
</tr>
<tr>
<td>Training</td>
<td>Establish core training team and prepare initial training plan</td>
<td>31 Dec 2017</td>
</tr>
<tr>
<td>PMO</td>
<td>Establish PMO: programme reports, plans, HR support, budget, risk/issues management, tools</td>
<td>31 Dec 2017</td>
</tr>
<tr>
<td>GDE</td>
<td>*Submit Fast Follower application</td>
<td>13 Sep 2017</td>
</tr>
<tr>
<td></td>
<td>*Make CUH/UCLH presentation</td>
<td>6 Oct 2017</td>
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<tr>
<td></td>
<td>*Secure first GDE payment</td>
<td>18 Dec 2017</td>
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</table>

Milestones are on the critical path if their delay would cause a delay to the overall EHRS timeline. Critical path milestones activities are discussed below. All activities have responsible individuals assigned.
3 Recruitment

The main activity during July and August has been recruitment.

- Dr Gill Gaskin (Medical Director, Specialist Hospitals Board) has taken over the role of SRO, following the departure of Neil Griffiths, Deputy CEO.
- Dr Stephen Cone has been appointed as Chief Medical Information Officer and Dr Natasha Phillips as Chief Nursing Information Officer and they will have key roles in ensuring clinical engagement in the programme.
- Dr Rishi Das Gupta has been appointed as Director of Innovation, and as part of his role will he will be a member of the core EHRS programme team, leading on Operational Readiness and ensuring that the EHRS programme fully supports and facilitates operational transformation.
- A Chief Research Information Officer post, funded jointly by the EHRS Programme and the BRC’s Healthcare Informatics Genomics/Omics Data Science theme, has been advertised, with interviews planned for 20th September.

Recruitment to programme management and development team posts (total of 130) is on-track. Of the 130, a minimum of 78 development and principal trainer posts need to be Epic certified and ready to build by early January 2018, and therefore need to start by early October, in order to commence Epic certification training. We currently have 72 individuals, a mixture of internal and some external applicants, ready to start in this timeframe and a further 10 appointable candidates with whom we are working to fill the remaining gaps. The remaining posts above these 78 are technical, change management and PMO roles. These roles do not need certification and are on-track to start this month and next.

In addition to these full-time and near-full time posts, in September we will be recruiting a large number of trusted Subject Matter Experts (SMEs) to bring their service knowledge and vision to inform the configuration of Epic for UCLH. We will also identify existing senior managers in each area to be “Operational Readiness Owners” (OROs). This is being coordinated through the trust’s senior leaders (DCDs, DMs and corporate directors) by Gill Gaskin, Stephen Cone, Natasha Phillips and Rishi Das Gupta. SMEs and OROs, supported by the core programme team, are required to (a) complete the ground work questionnaires for “Direction” sessions in December; (b) make the initial set of scoping decisions for each module; and (c) attend the Direction sessions.

Epic have appointed an Implementation Director, Greg Larson, who will be based in Bristol from October, and an Implementation Executive, Emily Tyne, based in Wisconsin, who will be in contact with the SRO on a weekly basis. Greg Larson spent five days at UCLH at the end of August, supporting us to plan the programme and learning about UCLH. A Leadership Forum in late July attended by the Epic CEO created substantial interest in the programme.

4 Governance

The Programme Board met for the first time in August and meets again on 13th September. It is chaired by Dr Gill Gaskin as SRO for the Programme, and meets as a variant of the regular Senior Director team meeting, with CEO, relevant directors and CMIO, CNIO and CRIIO as members. Epic are running an “Executive Education” session for the Programme Board on 13th September.
Two Design Decision Groups will report into the Programme Board, one focusing on clinical and operational decisions and one focusing on reporting and administration decisions, and will be established later this month. An early task will be to assist in the review of plans for existing and proposed systems that have some duplicated function in Epic.

5  Phase 0 and Phase 1 Work

The SMEs and OROs will be completing groundwork questionnaires, and making initial module scoping decisions within functional areas, by mid-November 2017, in advance of the Direction sessions in the first two weeks of December. The Direction sessions will allow our staff to make initial workflow decisions across the Epic modules. We are due to receive the final Direction schedules from Epic on 15 September. Based upon these schedules, we will send invitations in mid-October to SMEs, OROs and local department staff to attend Direction sessions in December. The Direction sessions will be held across UCLH facilities.

6  Technical

The key milestone from a technical point of view during this period is the installation of the Epic hardware platform (known as the “non-production environment”) by Atos in November 2017. This platform is needed to initially support the Direction sessions in December and thereafter to enable the systems designers to configure the Epic system starting in January 2018. This technical milestone is on-track.

A contract with Atos was signed on 28th July to cover the following elements:

- Epic hardware supply, implementation and hosting
- End user technology (mobile devices, PCs, printers, scanners, etc.)
- 3rd party applications (medical device integration, integration engine, other software such as post-coding, medical coding, drug formulary, and blood bank management)

7  Change Management

While the change management milestones are not strictly on the critical path, they are highly important in terms ensuring that we start to engage the entire organisation to prepare for changes in working practices and winning hearts and minds in terms of the transformations, catalysed by EHRS, that are envisioned. Our change management approach is based on developing leadership capacity, engaging front-line staff through SMEs and OROs, and managing the design decisions through the Design Authority and Working Groups within the agreed EHRS timeline (the programme “rhythm”).

An experienced change management lead, Lisa Hancock, is supporting the change management work on a day to day basis. We are currently making a wide sweep of face to face meetings across Clinical Boards, divisions and departments, based on existing meeting forums, to provide updates on EHRS progress and to listen to staff concerns and suggestions.

The change management plan is being developed by Ben Morrin and other senior leaders on the Programme Board. This plan will be influenced by the Epic User General Meeting (UGM) at the end of September 2017 and the wider UCLH Strategy work taking place in October 2017. Further details of this plan will be set out in future progress reports.
8 Communications

The EHRS Communications Manager is in post. The main communications event in this period is the EHRS Launch Week event scheduled for 2-6 October 2017. The event will be kicked off on the Monday with introductory sessions at each facility and talks by the CEO, the local DCD or DM and clinical representatives. On Tuesday, Wednesday and Thursday of this week, there will be Epic demonstrations of the system, visits to wards and clinical areas and face to face discussion opportunities for staff as well as EHRS information stalls at entrances. The arrangements for launch week are on-track.

As the programme develops, we will also be putting in place arrangements to engage with patients and other stakeholders.

9 Training

The Training Manager role is being recruited with interviews scheduled for 21 September 2017. There are 13 Principal Trainers being recruited to work alongside the systems designers. The Principal Trainer role is to assist with process analyses, development of training curricula, and preparation of training materials. We are already working with the Education Centre to schedule training rooms that will be needed in late 2018/early 2019.

10 Programme Management Office

The PMO Programme Manager role is in the shortlisting stage of recruitment. Programme management tools for planning, document sharing, collaborative working and resource levelling are being procured in consultation with ICT and Corporate PMO leads. The Finance Division is recruiting a Finance Manager to support EHRS in production of budget statements and help ensure that the EHRS business case costs and savings are managed over time. The one area that is off-track at the moment is the readiness of the EHRS Team offices due to delays in commissioning the remedial works needed for the office space identified. We have also not yet identified desk spaces for 48 of the 130 staff that need desk space. This matter is being progressed by senior leadership.

11 Global Digital Exemplar / Fast Follower Programme

We have been working with NHS Digital to secure Fast Follower status. After providing a well-received draft proposal, we have been asked to submit a formal application endorsed by our GDE partner, which will be followed up by a visit by NHS Digital with a presentation of our proposal on 6th October. We understand that NHS Digital will develop a process to assure our progress, and once this process is clearer we will bring a proposal to the Board for overall independent assurance and “critical friend” review.

Dr Gill Gaskin, Medical Director, Specialist Hospitals Board and EHRS Programme SRO
David Kwo, Director of EHRS and Informatics
Enclosed with this month’s performance report are the monthly updates from the trust’s recovery action plans (RAPS) for Cancer 62 day wait and A&E four hour wait. The updates are in a set template which show:

- 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 learning from the last month

This report will be brought to the trust board each month.

<table>
<thead>
<tr>
<th>Current issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>The drop in performance was due to closing a transition ward that had been open temporarily in June, located next to ED. This space had to be handed over to the re-development programme. Breaches in July were due a combination of bed, specialty and ED delays. We continue to have a ward closed in the tower (T10 oncology) due to nursing staff shortages, which has contributed to bed pressures on some days. We have also seen delays owing to middle grade doctor shortages on certain days. We are currently at risk of not achieving 90% across the quarter which is the minimum threshold required to achieve the STF monies. In order to recover the position we have enacted a daily medical director led review of performance and tower capacity. We have also put in place a pro-active process for pulling patients due to be discharged each day into the discharge lounge in order to free up bed capacity earlier in the day. A more detailed update from the RAP is attached</td>
</tr>
<tr>
<td>Referral to Treatment (RTT) incomplete pathways</td>
<td>We did not meet the RTT incomplete standard for July. Our backlog rose by 790 patients to 3,745. However, our total waiting list size reduced by 568 patients to 41,162. We believe this is because divisions have been maintaining cleaner waiting lists. This should give us a clearer view on performance challenges within these areas. All challenged reporting units have been asked to prepare recovery trajectories, due 8th September. The RTT Improvement Group will oversee delivery of these and will escalate any concerns or variance against plan to Elective Access Board. We reported 4 52 week waiters in GI surgery. These were caused by a waiting list tracking issue whereby the patients’ pathways had been incorrectly linked to diagnostic pathways and so were not appearing on the RTT PTL. Clinical harm reviews have been undertaken for all and no harm was identified. We have investigated this issue and actions have been put in place to minimise recurrence.</td>
</tr>
</tbody>
</table>
As forecast, we regained compliance with the six week diagnostic waits standard in July. Non-compliant modalities had low numbers of patients waiting and breaches: neurophysiology (98.32%, 4 breaches), urodynamics (96.81%, 3 breaches) and cystoscopy (97.06%, 1 breach).

<table>
<thead>
<tr>
<th>Cancer waits (Page 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance for July is not yet fully validated; this is the current position which may change before the final submission date.</td>
</tr>
<tr>
<td>We met our 62 day STF trajectory for June for internal pathways and predict we will meet the internal trajectory for July. Overall we achieved the STF trajectory for June.</td>
</tr>
<tr>
<td>Overall we have reported a lower number of treatments than the two previous months. We have reported a lower number of internal breaches: six. The breaches were in urology (1), breast (1), lower gastrointestinal (LGI) (3), gynaecology (1), and lung (1). Root cause analysis (RCA) investigations have been undertaken. There were avoidable delays on a number of these pathways, including access to diagnostics. A number of delays were initiated by patients.</td>
</tr>
<tr>
<td>We are progressing the external, clinically-led review of cancer waits in the trust, in order to support performance recovery. Please see Executive Board cancer recovery update for more information.</td>
</tr>
<tr>
<td>As forecast, July’s provisional position for the 31 day first treatment standard remains non-compliant. This is due to a very high number of urology surgery treatments; the number of external referrals that are being managed is impacting our ability to treat within the 31 day target at present.</td>
</tr>
<tr>
<td>We reported compliance with the two week wait standard and regained compliance with the breast symptomatic two week wait target.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% eVTE (venous thromboembolism) Risk Assessments completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>We were worse than threshold for patients being risk assessed for VTE in July. Infection had three patients who were on EAU. The paper assessments were completed but due to patients not being admitted onto the system the team were unable to complete an eVTE. Medical specialties were also below threshold as Evergreen ward did not submit data. In paediatrics there has been a worsening of performance. Junior doctors have been reminded at induction of the need to undertake eVTE screening. There is a continued monitoring of policy for screening of 13-18 year olds. Queen Square were just worse than target. The VTE report has been sent to lead clinicians for individual teams to action. Women’s health had similar performance and staff have been reminded of the importance of the assessment.</td>
</tr>
</tbody>
</table>
1. Executive summaries
2. Finance
3. Delivery of CIP
4. Access
5. Patient Safety and Quality metrics
6. Workforce
7. Externally Reported Frameworks
### Executable Summary: Board Performance

#### Activity Page 4

<table>
<thead>
<tr>
<th>Category</th>
<th>Month</th>
<th>Year to Date</th>
<th>LY to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Elective variance</td>
<td>-4.5%</td>
<td>-5.8%</td>
<td>0.2%</td>
</tr>
<tr>
<td>% Delays variance</td>
<td>-0.8%</td>
<td>-5.8%</td>
<td>3.7%</td>
</tr>
<tr>
<td>% Non-elective variance</td>
<td>2.1%</td>
<td>-7.2%</td>
<td>-5.8%</td>
</tr>
<tr>
<td>Outpatient variance</td>
<td>-3.2%</td>
<td>-5.4%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

#### Efficiency and Productivity Page 7-8

<table>
<thead>
<tr>
<th>Category</th>
<th>Month</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theatre touchtime Utilisation</td>
<td>76.7%</td>
<td></td>
</tr>
<tr>
<td>Length of stay - elective</td>
<td>4.7</td>
<td>4.5</td>
</tr>
<tr>
<td>Length of stay - non-elective</td>
<td>5.7</td>
<td>3.7</td>
</tr>
</tbody>
</table>

#### ED, RTT, and Diagnostic waits, access page 8-9

<table>
<thead>
<tr>
<th>Category</th>
<th>Month</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Incomplete pathways &lt; 1 week</td>
<td>92.5%</td>
<td></td>
</tr>
<tr>
<td>Diagnostic waiting list within 6 weeks</td>
<td>95.3%</td>
<td></td>
</tr>
<tr>
<td>Patients waiting longer than 52 weeks</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>A&amp;E attendance within 4 hours</td>
<td>80.3%</td>
<td></td>
</tr>
</tbody>
</table>

#### Cancer waits Page 10

<table>
<thead>
<tr>
<th>Category</th>
<th>Month</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer 62 day GP referral to treatment</td>
<td>96.8%</td>
<td></td>
</tr>
<tr>
<td>Cancer 31-day wait from diagnosis to first treatment</td>
<td>92.2%</td>
<td></td>
</tr>
<tr>
<td>Cancer 14 day - referral to appointment</td>
<td>92.3%</td>
<td></td>
</tr>
</tbody>
</table>

#### Finance Page 2

<table>
<thead>
<tr>
<th>Category</th>
<th>FY1</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall financial rating</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Operational performance (asset service level)</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Cash and balance sheet performance (liquidity)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Income and expenditure plan and CIP viability</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

#### Infection Page 11

<table>
<thead>
<tr>
<th>Category</th>
<th>Month</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of MRSA bacteremias</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of S. aureus bacteraemias</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of Clostridium difficile cases reported (excluding successful appeals)</td>
<td>14</td>
<td>12</td>
</tr>
</tbody>
</table>

#### Workforce Pages 16-18

<table>
<thead>
<tr>
<th>Category</th>
<th>Month</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Mandated training completion</td>
<td>95.0%</td>
<td></td>
</tr>
<tr>
<td>Appraisal rate</td>
<td>64.0%</td>
<td></td>
</tr>
<tr>
<td>Vacancy rate</td>
<td>8.5%</td>
<td></td>
</tr>
<tr>
<td>Staff turnover rate</td>
<td>10.0%</td>
<td></td>
</tr>
<tr>
<td>% Temporary staffing filled via Bank</td>
<td>92.0%</td>
<td></td>
</tr>
</tbody>
</table>

#### Externally agreed trajectories

<table>
<thead>
<tr>
<th>Category</th>
<th>Month</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Trajectory</td>
<td>91.0%</td>
<td></td>
</tr>
<tr>
<td>ED Actual</td>
<td>90.5%</td>
<td></td>
</tr>
<tr>
<td>Cancer 62-day trajectory</td>
<td>94.1%</td>
<td></td>
</tr>
<tr>
<td>Cancer 62-day actual</td>
<td>97.0%</td>
<td></td>
</tr>
<tr>
<td>RTT Trajectory</td>
<td>90.1%</td>
<td></td>
</tr>
<tr>
<td>RTT actual</td>
<td>95.0%</td>
<td></td>
</tr>
</tbody>
</table>

---

**Overall Rating:** 3
### 2. Financial Performance

#### 2.1 Financial Performance 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><strong>HEADLINE FINANCIAL PERFORMANCE (Overall Rating)</strong></td>
<td><strong>The M4 I&amp;E position, excluding donation adjls. &amp; other exceptional items, is £7.3m behind plan (-£6.7m actual vs. +£0.5m plan) (overall UOR = 3)</strong>.</td>
<td><strong>3</strong></td>
</tr>
<tr>
<td></td>
<td><strong>NHS clinical income is £0.9m behind the M4 YTD plan – (a) income from patient activity in the clinical boards is £1.7m behind plan (-£0.9m in-month), (b) income from patient activity reported corporately is £1.5m ahead of plan (+£0.9m in-month), (c) drugs, devices &amp; pass-through income is £0.7m behind plan (no in-month movement).</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1. Operational Performance</strong></td>
<td><strong>Trust’s YTD revenue available for capital service is £8.0m (rounded) behind plan (+£15.9m actual vs. +23.8m plan).</strong></td>
<td><strong>4</strong></td>
</tr>
<tr>
<td><strong>a. Capital service cover</strong></td>
<td><strong>M4 clinical board positions are:</strong> (a) Medicine is £0.5m behind plan (-£0.4m in-month), (b) Specialist Hospitals is £5.6m behind plan (-£2.3m in-month), (c) Surgery &amp; Cancer is £1.1m behind plan (-£0.8m in-month), (d) The Central and Corporate budgets within EBITDA (including R&amp;D and Education) are £0.7m behind plan.**</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Revenue of £15.9m is able to cover 0.38 times the Trust’s capital service (rating = 4)</strong>.</td>
<td></td>
</tr>
<tr>
<td><strong>b. I&amp;E margin</strong></td>
<td><strong>There are exceptional items of £5.1m reported in the M4 position – a) profit on disposal of RRO (+£4.8m), b) net capital donation adjls. (-£0.1m) &amp; c) an additional 1617 STF allocation (+£0.4m).</strong></td>
<td><strong>3</strong></td>
</tr>
<tr>
<td></td>
<td><strong>The Trust’s performance against the control total, with the inclusion of the profit on disposal of the RRO, is £2.4m behind plan (-£1.9m actual vs. +£0.5m plan). This adjusted M4 I&amp;E deficit of £1.9m produces an I&amp;E margin of -0.6% (rating = 3).</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>The overall bottom-line position is a deficit of £1.6m (£1.7m behind plan of +£0.1m)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>c. Distance from financial plan</strong></td>
<td><strong>The M4 I&amp;E margin (on a control total basis) of -0.6% is 0.7% (rounded) behind the planned I&amp;E margin of +0.2% (rating = 2).</strong></td>
<td><strong>2</strong></td>
</tr>
<tr>
<td><strong>d. Agency</strong></td>
<td><strong>The Trust’s M4 YTD spend on agency staff is £2.7m (in-month costs of £0.8m). This results in 24% of the Trust’s M4 agency ceiling (£3.6m) remaining unutilised (rating = 1).</strong></td>
<td><strong>1</strong></td>
</tr>
<tr>
<td><strong>2. Cash &amp; Balance Sheet Performance (Liquidity)</strong></td>
<td><strong>Working capital (cash + debtors - creditors) is able to cover 19 days of the Trust’s operating expenses (rating = 1).</strong></td>
<td><strong>1</strong></td>
</tr>
<tr>
<td></td>
<td><strong>At 31st July 2017 the Trust’s cash balance was £120.0m, £26.9m higher than the planned cash position of £93.1m.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>The current forecast for August month-end is a cash balance of £108m (£23m higher than plan).</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>M4 capital expenditure of £39.0m is £5.8m less than plan (of £44.8m).</strong></td>
<td></td>
</tr>
</tbody>
</table>

Month 4 - July
### 2. Financial Performance

#### 2.2 Service lines summary

#### Month 4 year-to-date

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Specialist Hospitals</th>
<th>Surgery &amp; Cancer</th>
<th>Corporate (inc R&amp;D &amp; Education)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Budget £m</strong></td>
<td><strong>Actuals £m</strong></td>
<td><strong>Variance £m</strong></td>
<td><strong>Budget £m</strong></td>
<td><strong>Actuals £m</strong></td>
</tr>
<tr>
<td>Direct income</td>
<td>65.3</td>
<td>63.8</td>
<td>(1.6)</td>
<td>140.6</td>
</tr>
<tr>
<td>Direct costs</td>
<td>(68.2)</td>
<td>(67.4)</td>
<td>0.9</td>
<td>(100.1)</td>
</tr>
<tr>
<td>Internal trading &amp; indirect costs</td>
<td>5.4</td>
<td>5.6</td>
<td>0.2</td>
<td>(19.4)</td>
</tr>
<tr>
<td>Contribution (EBITDA at Trust level)</td>
<td>2.5</td>
<td>2.0</td>
<td>(0.5)</td>
<td>21.0</td>
</tr>
<tr>
<td>ITDA (before donation adj.)</td>
<td>-</td>
<td>5.2</td>
<td>5.2</td>
<td>-</td>
</tr>
<tr>
<td>I&amp;E surplus/(deficit) before donation adj. &amp; exceptional items</td>
<td>(0.4)</td>
<td>(0.1)</td>
<td>0.3</td>
<td>(0.4)</td>
</tr>
<tr>
<td>Profit/(loss) on disposal of assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Control total performance</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Capital donations/donated asset adj.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other exceptional items</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net surplus/(deficit)</td>
<td>2.5</td>
<td>2.0</td>
<td>(0.5)</td>
<td>21.0</td>
</tr>
</tbody>
</table>

#### Month 4 in-month

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Specialist Hospitals</th>
<th>Surgery &amp; Cancer</th>
<th>Corporate (inc R&amp;D &amp; Education)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Budget £m</strong></td>
<td><strong>Actuals £m</strong></td>
<td><strong>Variance £m</strong></td>
<td><strong>Budget £m</strong></td>
<td><strong>Actuals £m</strong></td>
</tr>
<tr>
<td>Direct income</td>
<td>16.4</td>
<td>16.4</td>
<td>(0.1)</td>
<td>36.1</td>
</tr>
<tr>
<td>Direct costs</td>
<td>(17.0)</td>
<td>(17.4)</td>
<td>(0.4)</td>
<td>(25.4)</td>
</tr>
<tr>
<td>Internal trading &amp; indirect costs</td>
<td>1.4</td>
<td>1.5</td>
<td>0.0</td>
<td>(4.9)</td>
</tr>
<tr>
<td>Contribution (EBITDA at Trust level)</td>
<td>0.8</td>
<td>0.4</td>
<td>(0.4)</td>
<td>5.8</td>
</tr>
<tr>
<td>ITDA (before donation adj.)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>I&amp;E surplus/(deficit) before donation adj. &amp; exceptional items</td>
<td>(0.1)</td>
<td>(0.2)</td>
<td>(0.1)</td>
<td>(0.1)</td>
</tr>
<tr>
<td>Profit/(loss) on disposal of assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Control total performance</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Capital donations/donated asset adj.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other exceptional items</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net surplus/(deficit)</td>
<td>0.8</td>
<td>0.4</td>
<td>(0.4)</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Month 4 - July
## 2. Financial Performance

### 2.3 Clinical income summary

#### Income Variance against Plan by Division and activity type

**Activity to Jul-17: Report last updated 29/08/2017 14:36**

<table>
<thead>
<tr>
<th>Trust Summary</th>
<th>YTD Variance From Plan Activity</th>
<th>YTD Variance from Plan Value £000s</th>
<th>Total Clinical Income - Activity</th>
<th>Total Clinical Income - Drugs, devices &amp; pass.</th>
<th>Total Clinical Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1,524) (297) 960 (4,969) (8,384)</td>
<td>(1,568) (2,998) 1,408 (832) 960 2,887 (140)</td>
<td>732 (872)</td>
<td>1,514 (13)</td>
<td>1,501</td>
</tr>
<tr>
<td>Trust-wide adjustments</td>
<td>513 (3,007) (19) - 614 3,414</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Medicine Board Summary</td>
<td>(279) 16 624 (1,042) (1,625)</td>
<td>(150) (70) 799 (239) (114) 117</td>
<td>338 (246)</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Clinical Board - Medicine</td>
<td>0 0 (0) (465) (1,639)</td>
<td>- (61) (61)</td>
<td>(61)</td>
<td>- (91)</td>
<td>(91)</td>
</tr>
<tr>
<td>Clinical Support</td>
<td>0 0 (6) (10) 6</td>
<td>0 - (62) (74) (34) (170)</td>
<td>- (170)</td>
<td>- (451)</td>
<td>(451)</td>
</tr>
<tr>
<td>Critical Care</td>
<td>0 0 (6) (10) 6</td>
<td>0 0 (62) (74) (34) (170)</td>
<td>- (170)</td>
<td>- (451)</td>
<td>(451)</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>5 45 261 (126) 116</td>
<td>3 23 602 (31) 14 (199) 412 (4)</td>
<td>408</td>
<td>(66) (208)</td>
<td>(208)</td>
</tr>
<tr>
<td>Infection</td>
<td>(26) 11 119 (32) 62</td>
<td>(74) (36) (50) (7) 17 2 (149)</td>
<td>(66) (208)</td>
<td>(19) 879</td>
<td>(879)</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>(208) (40) 261 (409) (770)</td>
<td>(85) (57) 219 (135) (72) 1,028</td>
<td>898 (19)</td>
<td>879</td>
<td>(879)</td>
</tr>
<tr>
<td>Integration</td>
<td>0 0 0 0 0</td>
<td>0 - 26 26</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>MSK</td>
<td>0 0 0 0 0</td>
<td>0 - 26 26</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Pathology</td>
<td>0 0 0 0 0</td>
<td>0 - 26 26</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Specialist Hospitals Board Summary</td>
<td>(267) (48) (176) (4,009) (6,040)</td>
<td>(1,898) (302) (262) (641) 309 675 (1,564)</td>
<td>539 (1,015)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Clinical Board - Specialist</td>
<td>(233) (43) 3 (2,244) (4,698)</td>
<td>(158) (36) 5 (341) (434) 69 (886)</td>
<td>112 (774)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>EDH</td>
<td>260 (16) (18) (436) (483)</td>
<td>68 (78) (91) (109) (34) 506</td>
<td>206 (58)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>266 (12) (81) (1,643) (1,259)</td>
<td>1,266 (168) (40) (132) 886 40</td>
<td>54 (20)</td>
<td>24</td>
<td>-</td>
</tr>
<tr>
<td>Queen Square</td>
<td>(77) 3 84 329 79</td>
<td>(214) 27 128 64 51 46</td>
<td>2</td>
<td>169</td>
<td>181</td>
</tr>
<tr>
<td>RNTFEN</td>
<td>(90) (118) (164) (16) 218</td>
<td>(102) (335) (283) (122) (98) (88) (1,007)</td>
<td>(8)</td>
<td>(1,018)</td>
<td>(1,018)</td>
</tr>
<tr>
<td>Women's Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery &amp; Cancer Board Summary</td>
<td>(643) (265) 511 82 (719)</td>
<td>(26) (222) 889 48 92 (1,219)</td>
<td>(1,612) (1,450)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Clinical Board - S&amp;C</td>
<td>(614) 128 263 284 (779)</td>
<td>542 17 404 116 117 (1,052)</td>
<td>144 (737) (693)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cancer</td>
<td>(289) (224) 157 (317) (349)</td>
<td>(203) 15 129 (89) (47) (352)</td>
<td>(606) (426) (1,032)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>0 0 0 0 0</td>
<td>0 - 6 (6)</td>
<td>75</td>
<td>69</td>
<td>69</td>
</tr>
<tr>
<td>Imaging</td>
<td>(45) (169) 101 111 490</td>
<td>(508) (254) 356 (20) 33 (217)</td>
<td>(358)</td>
<td>70 (293)</td>
<td>(293)</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>0 0 0 4 (81)</td>
<td>0 - 1 (11) (26) (30)</td>
<td>(30)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Theatres &amp; Anaesthetics</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
3. Delivery of CIP
3.1 CIP update

Month 4 CIP Performance

<table>
<thead>
<tr>
<th>Board</th>
<th>Final CIP Target</th>
<th>Forecast In-year 2017-18 CIP</th>
<th>YTD Target (Inc. RED Schemes)</th>
<th>YTD Actual</th>
<th>YTD Variance</th>
<th>2016-19 Carry Forward</th>
<th>FYE</th>
<th>QIA Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine Board</td>
<td>6,872</td>
<td>£300, 885, 3,669, 869, 5,423</td>
<td>£100, 1,956, 1,759</td>
<td>(227)</td>
<td>1,246, 236, 4,411</td>
<td>45%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Hospitals Board</td>
<td>15,092</td>
<td>2,845, 6,593, 1,046</td>
<td>10,983, (4,109)</td>
<td>73%</td>
<td>4,293, 2,926, (1,367)</td>
<td>51%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery &amp; Cancer Board</td>
<td>15,436</td>
<td>1,058, 11,813, 343</td>
<td>13,213, (2,223)</td>
<td>86%</td>
<td>4,647, 4,465, (182)</td>
<td>4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate Services Board</td>
<td>4,600</td>
<td>2,289, 704, 251</td>
<td>3,253, (1,347)</td>
<td>71%</td>
<td>1,024, 644, (350)</td>
<td>5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>42,000</strong></td>
<td><strong>7,077, 22,778, 3,018</strong></td>
<td><strong>32,873, (9,127)</strong></td>
<td><strong>78%</strong></td>
<td><strong>11,550, 9,754, (2,155)</strong></td>
<td><strong>33%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Month 4 - July

Overall Page 105 of 199
3. Delivery of CIP
3.2 Productivity and financial improvement

Financial Productivity Metrics

- The metrics derive a Cost Weighted Output (weighted activity) for every £ of spend or contracted WTE. The Cost Weighted Output is calculated using 2014/15 average national reference costs for each item of activity we do.
- The adjusted cost base method reduces our actual spend from April 2016 and April 2017 to remove the effect of inflation. This is done to ensure that expenditure trends are shown on a “like for like” basis.

These metrics are still in the early stages of development due to technical complexity and should be viewed as draft. Divisional level metrics have now been developed and distributed for review and validation. This will ensure that more detailed testing can be done which will identify new areas of refinement.
### 3. Delivery of CIP

#### 3.3 Efficiency and productivity

We are working on theatre utilisation improvement with the Four Eyes consultancy at Westmoreland Street. They have put in place a programme of work to improve utilisation which includes a review of scheduling, pre-assessment and factors in theatre that reduce utilisation. We have adopted the Four Eyes methodology for measuring utilisation.

**Touchtime utilisation** is the actual session minutes used expressed as a percentage of allocated session minutes. Actual session minutes used is calculated from start of anaesthetic to the time of exiting the operating room for each patient in the session. Early starts and overruns are included in minutes used, but gaps between procedures are not. **Opportunity for additional cases** on the lists is the number of additional cases expressed as a percentage of total scheduled cases. Additional cases are the number of cases, based on average procedure times of a surgeon and list, that could be performed in the unused minutes of each list. RAG rating of both metrics will commence from next month.

**UCH tower** Utilisation is reviewed weekly through performance review and monthly theatre review chaired by the head of operations. A combination of bed pressures, patients being unfit on the day and listing problems contributed to the performance. There is an action plan in place that should deliver improvements.

**Queen Square** The division is working to ensure all data is captured accurately on OPERA, with more training for staff to help them capture data accurately and in real time.

**Westmoreland Street** Urology utilisation is being picked up through the Four Eyes review.

**Cancer centre** has not been included in the metrics. We are working on a more meaningful measure that accounts for the service planning for urgent work on elective lists and building layout that is lacking in recovery space.

**RNTNE and EDH** continue to run weekly meetings which review lists three weeks in advance to fill any gaps and ensuring equipment stock levels are maintained.

From October we will begin RAG rating the theatre metrics.

---

**Percentage touchtime utilisation and opportunity by site**

---

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

4.1 Emergency flow

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>This month</th>
</tr>
</thead>
<tbody>
<tr>
<td>All A&amp;E attendances within 4 hours</td>
<td>95%</td>
<td>88.2%</td>
</tr>
<tr>
<td>UTC attendances within 4 hours</td>
<td>97%</td>
<td>94.3%</td>
</tr>
<tr>
<td>A&amp;E to admission conversion rate</td>
<td>20%</td>
<td>13.5%</td>
</tr>
</tbody>
</table>

This month

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>This month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tower bed occupancy</td>
<td>90.0%</td>
<td>92.0%</td>
</tr>
<tr>
<td>Delayed Transfers of care days</td>
<td>441</td>
<td></td>
</tr>
<tr>
<td>% discharges by noon</td>
<td>10.0%</td>
<td>16.8%</td>
</tr>
</tbody>
</table>

Emergency department performance decreased from 92.1% in June. Out trajectory for July was 95%.

The drop in performance was due to closing a transition ward that had been open temporarily in June, located next to ED. This space had to be handed over to the re-development programme.

Breaches in July were due a combination of bed, specialty and ED delays. We continue to have a ward closed in the tower (T10 oncology) due to nursing staff shortages, which has contributed to bed pressures on some days. We have also seen delays owing to middle grade doctor shortages on certain days.

We are currently at risk of not achieving 90% across the quarter which is the minimum threshold required to achieve the STF monies. In order to recover the position we have enacted a daily medical director led review of performance and tower capacity. We have also put in place a pro-active process for pulling patients due to be discharged each day into the discharge lounge in order to free up bed capacity earlier in the day.

A more detailed update from the RAP is attached
## 4. Access

### 4.2 Access Targets - Referral to treatment

<table>
<thead>
<tr>
<th></th>
<th>Trust threshold</th>
<th>This month</th>
<th>Medicine</th>
<th>Surgery &amp; Cancer</th>
<th>Specialist Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>% incomplete pathways &lt; 18 weeks</td>
<td>92%</td>
<td>90.9%</td>
<td>96.2%</td>
<td>94.6%</td>
<td>88.6%</td>
</tr>
<tr>
<td>Patients waiting &gt; 52 weeks</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients waiting 40-52 weeks</td>
<td>51</td>
<td>9</td>
<td>3</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>% data quality issues on waiting list</td>
<td>5%</td>
<td>9.2%</td>
<td>15.3%</td>
<td>14.6%</td>
<td>6.2%</td>
</tr>
<tr>
<td>% Diagnostic waiting list within 6 weeks</td>
<td>99%</td>
<td>99.5%</td>
<td>99.9%</td>
<td>100.0%</td>
<td>98.7%</td>
</tr>
<tr>
<td>% Last Minute Cancellations to Elective Surgery</td>
<td>0.6%</td>
<td>2.7%</td>
<td>4.6%</td>
<td>2.2%</td>
<td>3.0%</td>
</tr>
<tr>
<td>% Cancelled Operations Readmitted Within 28 Days</td>
<td>95%</td>
<td>99.3%</td>
<td>100.0%</td>
<td>98.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Outpatient Cancellation Rate – Hospital (adjusted to include only postponed appointments)</td>
<td>5.9%</td>
<td>5.3%</td>
<td>7.4%</td>
<td>5.3%</td>
<td></td>
</tr>
</tbody>
</table>

We did not meet the RTT incomplete standard for July. Performance deterioration has been predominantly driven by decline in the following divisions:

- **Eastman Dental Hospital** – 87.5%
- **Queen Square** – 88%
- **RNTNE** – 89.3%

In addition, gynaecology (89.2%) and GI medicine (91%) were non-compliant.

Our backlog rose by 790 patients to 3,745. In addition our total waiting list size reduced by 568 patients to 41,162. We believe this is because divisions have been maintaining cleaner waiting lists. This should give us a clearer view on performance challenges within these areas.

All challenged reporting units have been asked to prepare recovery trajectories, and they are due by 8th September. The RTT Improvement Group will oversee delivery of these and will escalate any concerns or variance against plan to Elective Access Board.

We reported 4 52 week waiters in GI surgery. These were caused by a waiting list tracking issue whereby the patients' pathways had been incorrectly linked to diagnostic pathways and so were not appearing on the RTT PTL. Clinical harm reviews have been undertaken for all and no harm was identified. We have investigated this issue and actions have been put in place to minimise the risk of recurrence.

As forecast, we regained compliance with the six week diagnostic waits standard in July. Non-compliant modalities had low numbers of patients waiting and breaches: neurophysiology (98.3%, 4 breaches), urodynamics (96.8%, 3 breaches) and cystoscopy (97.1%, 1 breach).
Performance for July is not yet fully validated; this is the current position which may change before the final submission date.

We met our 62 day STF trajectory for June for internal pathways and predict we will meet the internal trajectory for July. Overall we achieved the STF trajectory for June.

Overall we have reported a lower number of treatments than the two previous months. We have reported a lower number of internal breaches: six. The breaches were in urology (1), breast (1), LGI (3), gynae (1), and lung (1). RCAs have been undertaken. There were avoidable delays on a number of these pathways, including access to diagnostics. A number of delays were initiated by patients.

We are progressing the external, clinically-led review of cancer waits in the trust, in order to support performance recovery. Please see the EB cancer recovery update for more information.

As forecast, July’s provisional position for the 31 day first treatment standard remains non-compliant. This is due to a very high number of urology surgery treatments; the number of external referrals that are being managed is impacting our ability to treat within the 31 day target at present. We anticipate a return to a compliant position by September.

We reported compliance with the two week wait standard and regained compliance with the breast symptomatic two week wait target.
5. Quality

5.1 Infection

We have reported 20 cases of C diff as at the end of July. Six of these have been successfully appealed and 13 cases are still under review. One case of C diff has been found to be a lapse in care by the Trust. Therefore, our worst case position currently is 14 cases against the August year to date threshold of 32.

We had four cases of MSSA in the trust for July. Two were in surgical specialties. One patient was on T6C. The documentation is missing in relation to the peripheral access and so the investigation into this MSSA is continuing. The other patient MSSA is still under investigation, with the source of the bacteraemia unclear. The nursing staff have been advised to improve on peripheral access documentation during huddle. Ward clerks have been advised to file appropriately according to date. There was one MSSA within Queen Square, and one within critical care, and both of these require further investigation and will be reported next month.

Infection control improvement compliance was above threshold for the trust. However the medicine board were worse than threshold. Infection were at 90% which is seen as appropriate given the quality improvement approach of the infection control metric with new demanding standards recently added to the composite measure. Medical specialties were just below threshold due to T7 environment issues.

<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>32</td>
<td>14</td>
<td>8</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Number of clostridium difficile cases due to lapses in care</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Number of clostridium difficile cases under review</td>
<td>13</td>
<td>8</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Number of clostridium difficile cases successfully appealed</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Number of MSSA Bacteraemias</td>
<td>9</td>
<td>13</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>% - Infection control improvement compliance (this month)</td>
<td>95.0%</td>
<td>95.1%</td>
<td>89.9%</td>
<td>96.5%</td>
<td>95.3%</td>
</tr>
</tbody>
</table>

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

5.2 Safety

<table>
<thead>
<tr>
<th>% Harm free care (National Safety Thermometer)</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>95.0%</td>
<td>97.1%</td>
<td>91.7%</td>
<td>97.9%</td>
<td>99.0%</td>
<td></td>
</tr>
</tbody>
</table>

| % Harm free care (Hospital acquired only)      | 95.0%           | 98.6%        | 96.4%    | 98.9%           | 99.4%               |

| Patients with preventable dose omissions      | 8.0%            | 5.1%         | 5.3%     | 6.5%            | 3.6%                |

| Dose omissions audit - % submission compliance| 100.0%          | 61.0%        | 66.7%    | 66.7%           | 55.0%               |

| % eVTE Risk Assessments completed            | 95.0%           | 92.5%        | 79.5%    | 96.3%           | 93.2%               |

We were better than the threshold of 95% for the National Safety Thermometer harm free care indicator at 97.1%. However medicine board is not achieving compliance which is reflective of a number of patients that acquired issues in the community which must nonetheless be reported against UCLH (see figures in table for hospital acquired percentage). This is driven by AMU.

We were worse than threshold for patients being risk assessed for VTE in July. Infection had three patients who were on EAU. The paper assessments were completed but due to patients not being admitted onto the system the team were unable to complete an eVTE. Medical specialties were also below threshold as Evergreen ward did not submit data. In paediatrics there has been a worsening of performance. Junior doctors have been reminded at induction of the need to undertake eVTE screening. There is a continued monitoring of policy for screening of 13-18 year olds. Queen Square were just worse than target. The VTE report has been sent to lead clinicians for individual teams to action. Women's health had similar performance and staff have been reminded of the importance of the assessment.
### 5. Quality

#### 5.3 Safety

The total number of falls in July was 87, considerably less than the 120 reported in June. This is the lowest record of falls in a month since 2013. Of the 87, the number of falls with no harm were 66 and there were 20 with low harm compared to 25 in June. Falls with moderate harm remained at one, this occurred on Molly Lane Fox – the Brain Tumour Unit with the patient sustaining a fractured tibia and fibula.

Gower’s Ward continues to have the highest number of patient falls in the Trust with a total of 12 falls however, this is a significant decrease compared to 30 in June.

As reported last month, the Queen’s Square Division falls steering group will be meeting at Gower’s ward in September to carry out a peer-to-peer review in order to explore any additional improvements.

During the month of July there were a total of four hospital acquired pressure ulcers following validation, the same as in June. There were two grade two pressure ulcers within the emergency department, one in AMU and one on T11. In addition there was an unstageable pressure ulcer in T7 and a suspected deep tissue injury in AMU.

The number of pressure ulcers remain low which illustrates the HAPU improvement plan, the in-depth root cause analysis and subsequent learning from each incident continues to have a positive impact.

---

#### Inpatient falls with serious harm

<table>
<thead>
<tr>
<th></th>
<th>Trust threshold</th>
<th>Trust actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient falls with serious harm</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Falls per 1000 bed days

<table>
<thead>
<tr>
<th></th>
<th>Medicine</th>
<th>Surgery &amp; Cancer</th>
<th>Specialist Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls per 1000 bed days</td>
<td>1.5</td>
<td>4.8</td>
<td>0.6</td>
</tr>
</tbody>
</table>

#### Falls with harm per 1000 bed days

<table>
<thead>
<tr>
<th></th>
<th>Medicine</th>
<th>Surgery &amp; Cancer</th>
<th>Specialist Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls with harm per 1000 bed days</td>
<td>0.8</td>
<td>0.9</td>
<td>0.8</td>
</tr>
</tbody>
</table>

#### % of Serious Incidents reports submitted within (60 working days)

<table>
<thead>
<tr>
<th></th>
<th>Medicine</th>
<th>Surgery &amp; Cancer</th>
<th>Specialist Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Serious Incidents reports submitted within (60 working days)</td>
<td>94.0%</td>
<td>80.0%</td>
<td>87.5%</td>
</tr>
</tbody>
</table>

#### Pressure Ulcers acquired

<table>
<thead>
<tr>
<th></th>
<th>Medicine</th>
<th>Surgery &amp; Cancer</th>
<th>Specialist Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcers acquired</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Grade three pressure ulcers acquired</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Grade four pressure ulcers acquired</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

---

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

The trust threshold is an aggregate of individual clinical board thresholds

**Note:** The graphs show patient falls per 1,000 bed days and overall patient falls, as well as pressure ulcers acquired at UCLH split by grade/category.
5. Quality
5.4 Outcomes

<table>
<thead>
<tr>
<th></th>
<th>This month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust threshold</td>
<td>3.1%</td>
</tr>
<tr>
<td>Trust actual</td>
<td>2.0%</td>
</tr>
<tr>
<td>Medicine</td>
<td>5.3%</td>
</tr>
<tr>
<td>Surgery &amp; Cancer</td>
<td>1.6%</td>
</tr>
<tr>
<td>Specialist Hospitals</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

Emergency readmissions within 30 days

<table>
<thead>
<tr>
<th></th>
<th>This month</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Complete vital signs collected</td>
<td>96.0%</td>
</tr>
<tr>
<td>% deteriorating patients escalated according to protocol</td>
<td>90.0%</td>
</tr>
</tbody>
</table>

Local summary hospital-level mortality indicator (1 yr rolling data)

<table>
<thead>
<tr>
<th></th>
<th>This month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.55</td>
</tr>
<tr>
<td></td>
<td>0.48</td>
</tr>
<tr>
<td></td>
<td>0.78</td>
</tr>
<tr>
<td></td>
<td>0.43</td>
</tr>
</tbody>
</table>

Emergency readmissions within 30 days (with PbR exclusions)

We were better than target for emergency readmissions within 30 days. Medicine board were worse than threshold at 5.3% for July. Emergency services has implemented a real-time process for identification and validation of readmissions for EDU and AMU. The five readmissions were genuine and have been sent to the clinical lead to validate.

We were compliant in achieving the threshold for vital signs observations in July. Medicine were worse than target, for infection this relates to one patient where saturations were not appropriately recorded. The patient was on continuous monitoring but it was not recorded appropriately. A reminder has been sent to the nursing team about documentation standards. Medical specialties had issues with Evergreen ward not being able to submit.
5. Quality

5.5 Patient Experience

<table>
<thead>
<tr>
<th>Complaints responded to within target time</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></td>
<td>85.0%</td>
<td>76.7%</td>
<td>100.0%</td>
<td>70.0%</td>
<td>65.5%</td>
</tr>
</tbody>
</table>

Inpatient friends and family test 96.5% 92.6%
A and E friends and family test 95.0% 81.5%
Outpatient friends and family test 93.0% 91.1%
Response rate - Friends & Family Test (IP survey) 30.0% 23.7%
Response rate - Friends & Family Test (AE survey) 20.0% 11.9%
Response rate - Friends & Family Test (OP survey) 10.0%

% of hospital appointments postponed by hospital 5.9%
Choose and book slot issues (two months in arrears) 34.9%
Patient reported being seen within 15 minutes 11.9%

We were below threshold for patient complaints response times in July at 76.7%. Surgical specialties have been working on the backlog which is now significantly reduced but has meant reduced performance for this month. In Women’s health there were seven complaints responded to, five outside of the window for varying reasons. The clinical director has reminded all clinical staff of the importance of responding on time; the division is auditing response rates in line with this. Queen Square met 11/14 complaint targets. The divisions provide daily guidance and support to our complaint investigators and are in daily contact with the central team as required.

The inpatient FFT score has fallen a little further again this month to worse than the trust target at 92.6%, with a response rate of 23.7%. The A&E response rate and scores also remain worse target at 11.9% and 81.5% respectively. The outpatient FFT score has dropped below target this month at 91.1%. However the response numbers remain high and we have now begun monitoring the response rate, which is at 10% this month.

While performance appears to be dropping it should be noted that all of the above now include automated responses through SMS/IVM and July as our first full month of this method. With the patients now being asked to feedback after leaving we had expected to see a drop in scores; patients are more likely to be honest as being asked independently, and possibly more feedback from younger patients (20s and 30s) who also tend to have higher expectations. We’re actively monitoring scores through the inpatient experience group and will be reviewing performance against peers and “best in class” to see how we perform. We continue to monitor the scores and response rates closely; IP data includes day case and we know that for inpatient data alone we reached 29% response rate this month, and we still need to ensure we are collecting data from all paediatric areas, including A&E. Once we are able to benchmark our data against others we may need to review the thresholds for all areas.
## 6. Workforce

### 6.1 Performance indicators

<table>
<thead>
<tr>
<th></th>
<th>Trust Threshold</th>
<th>This month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff in Post (Whole time equivalent)</td>
<td>NA</td>
<td>7795.8</td>
</tr>
<tr>
<td>% Temporary staffing filled via Bank (as opposed to agency)</td>
<td></td>
<td>92.0%</td>
</tr>
<tr>
<td>Vacancy Rate</td>
<td></td>
<td>6.5%</td>
</tr>
<tr>
<td>Voluntary Turnover Rate (12m Rolling)</td>
<td></td>
<td>12.5%</td>
</tr>
</tbody>
</table>

- **Staff in Post**: Staff in post has fallen by 7 WTE from 7803 WTE to 7796 WTE in month 4.

- **Temporary staffing**: The percentage of temporary staff filled by bank rose slightly from 91.3% to 92.0%. Temporary staffing usage is higher than at this time last year and rose from month 3 to month 4.

- **Vacancies**: The overall vacancy rate for the trust is 8.9%. This information is calculated from the GL. Workforce continues to work with Finance colleagues to align ESR to the GL.

- **Turnover**: Turnover rose from 12.9% to 13.5% in month 4 and is above target.

The Trust threshold target and Trust Actual for Vacancy & Turnover excludes Corporate.
6. Workforce
6.2 Performance indicators

<table>
<thead>
<tr>
<th>Establishment FTE*</th>
<th>Trust threshold</th>
<th>Trust actual</th>
<th>Medicine</th>
<th>Surgery &amp; Cancer</th>
<th>Specialist Hospitals</th>
<th>Corporate Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness absence rate (%) 12m Rolling</td>
<td>N/A</td>
<td>3.3%</td>
<td>2.9%</td>
<td>3.2%</td>
<td>3.7%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Appraisal Tier 1 &amp; 2</td>
<td>95% (by the end of July 2017)</td>
<td>64.3%</td>
<td>60.5%</td>
<td>66.7%</td>
<td>65.5%</td>
<td>61.9%</td>
</tr>
<tr>
<td>% Statutory and mandatory training compliance</td>
<td>95%</td>
<td>93.0%</td>
<td>92.0%</td>
<td>92.2%</td>
<td>92.1%</td>
<td>95.1%</td>
</tr>
<tr>
<td>Average time to recruit (request pack - start date) (weeks)</td>
<td>14.7</td>
<td>13.7</td>
<td>13.4</td>
<td>14.0</td>
<td>13.0</td>
<td>15.3</td>
</tr>
<tr>
<td>Average time to recruit (request pack received - unconditional offer) (weeks)</td>
<td>N/A</td>
<td>10.2</td>
<td>10.4</td>
<td>10.1</td>
<td>10.1</td>
<td>10.8</td>
</tr>
</tbody>
</table>

**Sickness absence:** Sickness absence rates remained the same from month 3 to month 4. Long term and short term sickness account for almost equal proportions of sickness absence.

**Appraisal:** Reported appraisal rates have improved significantly but are still below the target of 95% of staff at band 7 and above completing their appraisal by end of month 4. The Director for Education is keeping take-up under regular review. Divisions are receiving reports of late appraisals on an individual basis.

**Mandated training:** Compliance rates rose from 91.9% in month 3 to 93.0% in month 4.

**Time to recruit:** Time to recruit has improved from month 3 to month 4.
**6. Workforce**

**6.3 Nursing and Midwifery Detailed Workforce Dashboard**

### Nursing and Midwifery Detailed Dashboard - Month 4 2017/18

<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</td>
<td>NA 2-4</td>
<td>NA 2-4</td>
<td>NA 2-4</td>
<td>NA 2-4</td>
</tr>
<tr>
<td>Staff in Post FTE*</td>
<td>155.3</td>
<td>206.4</td>
<td>240.3</td>
<td>3.4</td>
<td>663.4</td>
</tr>
<tr>
<td>Vacant Posts FTE*</td>
<td>167.4</td>
<td>254.2</td>
<td>220.6</td>
<td>4.0</td>
<td>646.2</td>
</tr>
<tr>
<td>Starters FTE</td>
<td>-12.1</td>
<td>10.2</td>
<td>19.7</td>
<td>-0.6</td>
<td>17.2</td>
</tr>
<tr>
<td>Leavers FTE</td>
<td>5.0</td>
<td>5.0</td>
<td>8.0</td>
<td>0.0</td>
<td>16.0</td>
</tr>
<tr>
<td>Vacancy Rate*</td>
<td>-7.8%</td>
<td>3.9%</td>
<td>8.2%</td>
<td>-1.7%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Turnover Rate</td>
<td>11.7%</td>
<td>16.5%</td>
<td>16.8%</td>
<td>23.4%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Temp Staffing Usage</td>
<td>37.6%</td>
<td>20.5%</td>
<td>35.0%</td>
<td>4.4%</td>
<td>30.6%</td>
</tr>
<tr>
<td>Sickness/Absece</td>
<td>5.4%</td>
<td>5.4%</td>
<td>4.3%</td>
<td>4.4%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Right Staffing Level by Shift</td>
<td>124.5%</td>
<td>122.9%</td>
<td>150.1%</td>
<td>NA</td>
<td>132.4%</td>
</tr>
</tbody>
</table>

**Notes:** Establishment information (and therefore, vacancy rates) was not available for months 1 and 2 due to ESR/GL reconciliation project. The overall nursing vacancy rate is 9.9% an increase of 0.3%. This information is calculated from the GL but the rate excludes budgeted posts that are currently not being actively recruited to. Workforce continues to work with Finance colleagues to align ESR to the GL. We had 13% more leavers than starters in month 4 which has lead to an increase in the vacancy rate. Right staffing levels have fallen by 0.6% between month 2 and month 3. It is likely this trend in vacancy rates will continue until October/November as many of the newly qualified nurses we have recruited have postponed their start dates until they receive their NMC PIN. Recruitment pipeline information indicates we have 242 candidates due to start in the next few months.
### 7. Externally Reported Frameworks

#### 7.1 NHS Improvement Indicators – Compliance Framework

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Thresholds</th>
<th>Weighting</th>
<th>Jul 17</th>
<th>Q1</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence of Clostridium difficile year to date</td>
<td>32</td>
<td>1.0</td>
<td>14</td>
<td>14</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>90.9%</td>
<td>93.1%</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>64.3%</td>
<td>61.0%</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>71.4%</td>
<td>69.2%</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></td>
<td></td>
<td></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>See page 9 for detail.</td>
</tr>
<tr>
<td>31 day wait for second or subsequent treatment: Radiotherapy</td>
<td>94%</td>
<td></td>
<td></td>
<td></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>93.4%</td>
<td>88.7%</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>95.7%</td>
<td>94.2%</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></td>
<td>93.9%</td>
<td>92.7%</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>88.2%</td>
<td>91.1%</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></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.
BOARD OF DIRECTORS MEETING 13 SEPTEMBER 2017

CANCER 62 DAY WAIT RECOVERY ACTION PLAN
## Remedial Action Plan Monthly Update

### Latest position against trajectory

<table>
<thead>
<tr>
<th>Trajectory</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
</tr>
</thead>
<tbody>
<tr>
<td>62 day internal</td>
<td>67.3%</td>
<td>70.0%</td>
<td>78.0%</td>
<td>80.0%</td>
<td>85.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Internal breaches (no.)</td>
<td>16</td>
<td>15</td>
<td>11</td>
<td>10</td>
<td>7.5</td>
<td>7.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actual and Forecast</th>
<th>Actual</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal breaches (no.)</td>
<td>69.0%</td>
<td>76.2%</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>15</td>
</tr>
</tbody>
</table>

### Drivers of variance from plan

- **Provisional positive performance variance driven by reduction in breaches in July.**

## Action Plan Update

### Number of actions open by Rag status:

- **9** (Red)
- **2** (Amber)
- **25** (Green)

### Commentary on all red and amber actions

<table>
<thead>
<tr>
<th>Action Ref</th>
<th>Reason why red / amber</th>
<th>Will this impact the breach numbers?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CW and CT</td>
<td>We had planned to realise benefits from new cancer reporting system in June. The reports have been developed and the PTL is now in use. However, the report that tracks patients against pathway milestones requires near real time entry of patient events into infoflex. This is not done routinely by MDT co-ordinators. However work with the coordinators is underway to improve the capture of key milestones as they track through their PTL. All MDT coordinators have completed a time in motion study (using a nationally recognised tool). We are carrying out analysis to identify the barriers to more timely data entry and come up with plans to address these.</td>
<td>Y - 0.6/month</td>
</tr>
<tr>
<td>GI3</td>
<td>The backlog in LGI is too high. We had planned to see a reduction by end June. The GI MDT co-ordinator team is now fully recruited and tracking processes are robust. However, there continues to be high numbers of patients awaiting endoscopy. We have a backlog clearance trajectory. However, this is now behind and we are reviewing.</td>
<td>Y - 0.4/month</td>
</tr>
<tr>
<td>HN7</td>
<td>Delivery of neck lump ultrasound as first appointment pilot has been delayed due to training CNS's to request imaging at triage.</td>
<td>Y - 0.1/month</td>
</tr>
<tr>
<td>R2</td>
<td>Remote planning for radiotherapy was due to be in place by end of May 2017, this has not delivered. Revised time-frames are July/August 2017. This is being implemented by ICT. This has no direct trajectory impact</td>
<td>N</td>
</tr>
<tr>
<td>GY2WW2</td>
<td>This was to reduce median waits to 7 days by end May. This delivery date was missed. New capacity was lower than expected due to sickness. This will not impact 62 day breaches.</td>
<td>N</td>
</tr>
<tr>
<td>ITT8</td>
<td>We had planned for the NCEL ITT policy to be signed off by providers by end June. We led on developing an agreed policy for transferring patients between trusts across NCEL. Whilst most of the practices described in the policy are currently being followed, we are still awaiting sign off on one small detail from one trust. This will not impact on our ability to manage ITT pathways. We are following this up with NEL.</td>
<td>N</td>
</tr>
<tr>
<td>R1</td>
<td>Shorter radiotherapy planning time project has been slow in progress although progress is being made</td>
<td>Not at present will do beyond RAP life</td>
</tr>
</tbody>
</table>

---

Overall Page 122 of 199
Any new risks or emerging issues?

Previous risks

- The lower GI backlog continues to be high. A key driver of the backlog is now endoscopy. The team is reviewing capacity to expedite tests for these patients, and also looking at their processes to ensure that patients on the cancer PTL are visible to administrative staff when booking tests. We are developing a summary and escalation tool to enable high level visibility of key issues each week and to enable us to take action.

- Urology: patients are not getting all tests in the one-stop clinic because they refuse a biopsy under local anaesthetic. They then have to wait for a subsequent pre-assessment and biopsy date. The urology team are working to change the time and location of one-stops in order to offer pre-assessment at the one-stop and a GA biopsy within 3 days. This will commence in mid September

- Head and neck capacity for large cases in theatre: currently there is insufficient trained scrub team resource for running 2 large cases on one day. This does not impact core capacity, but does limit our ability to flex capacity in order to meet surges in demand. The theatre team are working to increase the number of head and neck trained staff.

- Urology theatre capacity: Workforce gaps in the robotic scrub teams within Urology. Advertising is underway for required posts. No response to open day held in July. Further recruitment methods are being considered to improve response to advertising

Key learning from breaches in last reported month

**Month:** July

<table>
<thead>
<tr>
<th>Tumour site</th>
<th>Issues and learning</th>
<th>New action added to RAP?</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGI (x3)</td>
<td>Patient choice and delays accessing endoscopy were the key themes</td>
<td>Y - action to implement a new patient choice policy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Action to ensure sufficient endoscopy capacity already on agenda</td>
</tr>
<tr>
<td>Urology (x1)</td>
<td>Patient choice to delay pathway - had date in time but needed bone scan before surgery</td>
<td>Y - identified dedicated slots for bone scan. Action already included on the RAP.</td>
</tr>
<tr>
<td>Breast (x1)</td>
<td>Patient choice delays in diagnostics with clinical delay at end of pathway</td>
<td>N - Already a RAP action to increase imaging capacity</td>
</tr>
<tr>
<td>Lung (1)</td>
<td>Clinical issues with obtaining a tissue diagnosis</td>
<td>N - picked up with clinical team to improve processes</td>
</tr>
</tbody>
</table>
### Actions that were closed at the last review

<table>
<thead>
<tr>
<th>Action Ref</th>
<th>Action description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HN9</td>
<td>Increase in triple imaging slots</td>
</tr>
<tr>
<td>U11</td>
<td>Dedicated Bone scan slots</td>
</tr>
</tbody>
</table>

### Future critical Actions that Impact on the trajectory

<table>
<thead>
<tr>
<th>Action Ref</th>
<th>Action Description</th>
<th>Start date</th>
<th>End date</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>U6</td>
<td>Improve management of patient choice on prostate pathway</td>
<td></td>
<td>30/10/2017</td>
<td></td>
</tr>
<tr>
<td>U8</td>
<td>Sustainable capacity for RALP that will meet surges in demand</td>
<td></td>
<td>31/10/2017</td>
<td></td>
</tr>
<tr>
<td>B2 and B3</td>
<td>Increase breast imaging capacity and improve imaging pathway</td>
<td></td>
<td>10/09/2017</td>
<td></td>
</tr>
<tr>
<td>HN6</td>
<td>Improve head and neck ITT referral pathway</td>
<td></td>
<td>30/09/2017</td>
<td></td>
</tr>
</tbody>
</table>
BOARD OF DIRECTORS MEETING 13 SEPTEMBER 2017

A&E 4 HOUR WAIT RECOVERY ACTION PLAN
Remedial Action Plan Monthly Update
ED RAP: Signed off May 2017

Date of review: 31/08/2017
Forum reviewed in: Emergency Care Recovery Board

Latest position against trajectory

<table>
<thead>
<tr>
<th>Trajectory (submitted to NHSI in May)</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Forecast</td>
<td>91.0%</td>
<td>92.8%</td>
<td>95.0%</td>
<td>95.0%</td>
<td>95.2%</td>
<td>92.6%</td>
<td>92.6%</td>
<td>90.5%</td>
<td>90.2%</td>
<td>92.5%</td>
<td>95.01%</td>
</tr>
<tr>
<td>Actual</td>
<td>90.9%</td>
<td>90.2%</td>
<td>92.1%</td>
<td>88.1%</td>
<td>88.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Subject to final validation

Drivers of any variance from trajectory
Some bed capacity pressures for medical and cancer beds (surgical bed capacity has been sufficient)
ED medical staff shortages has led to low performance on specific days
The transition space which was open in June had to be closed as this area was handed over to the ED redevelopment, this had not been factored into our trajectory so it does not explain the variance from trajectory, it is in part the reason for the deterioration in performance from June.

Action Plan Update

Number of actions open by Rag status:
- 4 red
- 3 amber
- 15 subject to final validation

Commentary on all red and amber actions

<table>
<thead>
<tr>
<th>Action Ref</th>
<th>Reason why red / amber</th>
<th>Will this impact the trajectory?</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDM2</td>
<td>CCG to develop plan with local GPs to reduce variation in A&amp;E attendances seen at practice level. This was due to be completed by end May. This was due in July. We have escalated this through the CCG.</td>
<td>N</td>
</tr>
<tr>
<td>EDM3</td>
<td>Trust to provide patient attendance data to the Camden Integrated Digital Record to enable primary care to better manage these patients. This was due at end June. It is delayed owing to issues with the trust’s integration engine. This should be resolved by end July.</td>
<td>N</td>
</tr>
<tr>
<td>ED05</td>
<td>ED team to implement point of care testing in the department. This is due for implementation by October, however, a number of milestones have slipped. This does have an expected impact on the trajectory. ECRB will review to see how it can be recovered.</td>
<td>Y</td>
</tr>
<tr>
<td>AEC1</td>
<td>ED team to review use of CDU/EDU space. The aim is to support reduction in admissions. This is due to complete at end September but interim milestones (including agreeing the model and tariffs with commissioners) have been missed. ECRB will review this to see how it can be recovered.</td>
<td>N</td>
</tr>
<tr>
<td>AEC2</td>
<td>This is the action to implement a true 48 hour model of care on AMU, it includes the strategic capacity modelling work to review potential options and benefits for a tower realignment. This is due for completion in September. However, with further clinical engagement the scope and aim of the work-stream has changed so these time-frames are not deliverable. The ECRB will agree a revised set of time-frames.</td>
<td>N</td>
</tr>
<tr>
<td>ODO6</td>
<td>CCG to undertake review of community beds and design a proposal for use of the beds. This is due for final completion at end September, but has missed interim milestones. We have escalated this to the CCG</td>
<td>N</td>
</tr>
<tr>
<td>ODO7</td>
<td>CCG to lead development of a system-wide demand and capacity model for un-planned care. This was due at end June, but has been delayed to September in order to fit with STP time-frames</td>
<td>N</td>
</tr>
</tbody>
</table>

New or emerging risks or issues

- New Issue / Risks
  - We have a high vacancy rate amongst our middle grade junior doctors which has led to shortages on certain shifts. We are filling shifts with locums where possible. We are also recruiting a number of research posts which may be more attractive posts to fill.

- Previously reported risks
  - Risk that nursing staffing vacancies will impact capacity, and that we cannot re-open the closed beds on T10 or T07 in time to meet increased autumn/winter demand, therefore continuing have high occupancy
  - Risk that we cannot find an appropriate location for a transition ward so this will lose the benefit of a recent pilot that has had a positive impact on performance
  - We have still not identified sufficient schemes to deliver our externally agreed trajectory. We will continue to work to identify further improvements

Overall Page 126 of 199
## Key learning from recent weeks

**Month:** August

### Area

<table>
<thead>
<tr>
<th>Flow</th>
<th>Issues and learning</th>
<th>New action added to RAP?</th>
</tr>
</thead>
<tbody>
<tr>
<td>New action added to RAP?</td>
<td>This has been put into normal operational practice so does not need to be added to the RAP</td>
<td>Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ED breaches</th>
<th>Issues and learning</th>
<th>New action added to RAP?</th>
</tr>
</thead>
<tbody>
<tr>
<td>New action added to RAP?</td>
<td>Y - Action added around novel recruitment of ED middle grades</td>
<td>Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bed breaches</th>
<th>Issues and learning</th>
<th>New action added to RAP?</th>
</tr>
</thead>
<tbody>
<tr>
<td>New action added to RAP?</td>
<td>Y - we have added use of a transition ward to the AMU modelling work to model this as an option</td>
<td>Y</td>
</tr>
</tbody>
</table>

### Actions that were closed at the last review

<table>
<thead>
<tr>
<th>Action Ref</th>
<th>Action Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDO3</td>
<td>Implement and track effectiveness of the nurse navigator post for front door streaming</td>
</tr>
</tbody>
</table>

### Future critical Actions that Impact on the trajectory

| Action Ref | Action Description                              | Date of expected impact | Current Status |
|------------|-----------------------------------------------|--------------------------|----------------|----------------|
| EDO6       | Improvement in specialty response times        | August                   |                |
| AEC4       | Acute frailty ambulatory pathway               | October                  |                |
| MCD1       | Revised operational policy in place            | November                 |                |
| ODO4 & ODO5| Discharge to assess implemented                | November                 |                |
| ODO1 & ODO2| Internal discharge processes and clinical utilisation review implemented                                             | November                 |                |
| EDO5       | Point of care testing in ED                    | December                 |                |
| MDC6       | Completion of ED-redevelopment                  | March                    |                |
Quality and Safety Committee report to the Board of Directors - 13 September 2017

The report below provides a summary of the QSC meeting that took place in July 2017.

1. Employment checks for agency and contract staff
QSC requested and was provided with additional assurance by the director of workforce for employment checks for non-substantive staff. Details on the systems and processes in place for carrying out employment checks for agency staff and contractors was provided and assurance given that G4S, the Trust patient transport provider is held to the provisions in the contract for employment checks and that monitoring is in place.

It is standard for checks to be written into all contracts and all external providers are held to the same standard where staff work within Trust premises or with patients in any environment. An independent audit will be carried out by KPMG on behalf of the Trust.

2. Annual claims and inquest report 2016-17
The report provided assurance of the monitoring processes in place to ensure that the Trust complies with the clinical negligence scheme for trusts (CNST)/Risk pooling scheme for trusts (RSPT). UCLH is a member of these schemes as well as the Property Excess Scheme and pays an annual subscription for its indemnity.

The total number of open claims for 2015/16 and 2016/17 has increased significantly and is in line with rising levels of national activity. The ‘time to resolution’ for UCLH CNST claims is less than the regional average and for RSPT claims is slightly above the regional average.

An internal team audit undertaken for 2016/17 showed that the majority of actions were completed within agreed timescales and records contained evidence of communication with relevant stakeholders.

The number of open inquests from deaths in the Trust has increased from 53 in 2015/16 to 61 in 2016/17. Analysis of inquest data from April 2013 to March 2017 showed that the largest proportion of inquests (199) were rated as ‘green’ (inquests where no care management issues are identified and minimal support is appropriate. The risk of litigation is unlikely) or amber (more complex issues, multiple reports required, staff support require pre and during the inquest and possible local media interest expected. There is a possibility of litigation). The Trust received one ‘Prevention of Future Death’ report in 2016/17.

3. Statutory and mandatory training update
UCLH has committed to a mandatory training completion rate of 95%. This is higher than many trusts achieve. The Trust met its 90% target in March 2016 however the current completion rate is 91.9%.

The director of education provided a status update to the committee and outlined actions aimed at helping the Trust to address key challenges and issues highlighted. It was proposed that divisional management are asked to directly report on management action taken in areas where compliance levels are unsatisfactory.
4. Quality priorities quarter one report
This report outlined progress against the safety and effectiveness priorities agreed for 2017/18. Progress against the patient experience priorities will be reported via the improving patient experience group.

4.1. Patient safety: reduce surgery related harm
A divisional clinical director and five surgeons have participated in surgical safety walkarounds with a further three signed up for future rounds. The safer surgery work was shortlisted for a national HSJ Patient Safety Award; which created wider recognition for the approach and the work undertaken to date.

4.2. Patient safety: reduce harm from unrecognised deterioration (including sepsis and acute kidney injury, [AKI])
The Trust is maintaining a mean of 98.3% vital signs completion against an expected compliance rates of 96%.

Across all three months in quarter one, 17 patients in total met the sepsis criteria from the random sample needed for the CQUIN. 13/17 (76%) received antibiotics within one hour against a target of 65%. All sampled patients received a clinical review of antibiotics within 72 hours of giving the first dose.

The appointment of the new clinical lead in August will provide more capacity and capability for improvement in AKI.

Recent work by a team at the Oxford AHSN has shown that UCLH has the lowest mortality from codes indicating a ‘Suspicion of sepsis’ amongst UCLPartners and nationally. UCLP has held the final Learning Event for the Sepsis and AKI patient safety collaboratives.

4.3. Patient safety: Reduce the harm from failure to follow up on radiology results
The Clinical Audit and Quality Improvement committee (CAQIC) have asked all divisions to declare their arrangements for specialties to have a local system in place for checking that all results have been received and read. This information is currently being reviewed and gaps are being followed up.

4.4. Continue Trust-wide learning
The quality and safety bulletin continues to publish ‘good catch’ stories for learning and robust investigation processes are increasingly being applied when trends are identified.

Improving Care Rounds (ICRs) are continuing across the Trust with a number of new leaders trained and actively leading ICRS. Staff continue to volunteer for ICRs. Where appropriate we are including additional subject matter experts such as from the workforce team. The internal auditors are in the process of scoping the review of ICR methodology and effectiveness. Findings will be used to inform a review of the ICRs and the governance processes.

During quarter one the escalation process to ensure timeliness of SI investigation and completion of reports has been reviewed and updated and is currently being implemented. The SI investigation template has been reviewed and updated to facilitate work to look at root causes and contributory factors more closely. The 60 day target remains a challenge.

4.5. Priority 3: Effectiveness – clinical outcomes; responding and learning when patients die
Responding to deaths - Mortality surveillance and learning from death policy is being finalised and was presented to QSC on 26th July 2017 for comments and endorsement. Work is underway to put in place required training and engage with relevant stakeholders to take forward requirements. Deaths that occurred in April that met the criteria are being reviewed and learning from this will inform further developments.

5. Responding to deaths policy - Mortality surveillance and learning from death policy

UCLH is required by NHS England to have in place a policy, by September 2017, on how it responds to and learns from, deaths of patients who die under our management and care. This includes:
1. How our processes respond to the death of an individual with a learning disability or mental health needs, an infant or child death and a stillbirth or maternal death.
2. An evidence-based methodology for reviewing the quality of care provided to those patients who die. UCLH has chosen to use the methodology recommended for acute trusts - the Structured Judgement Review (SJR)
3. The categories and selection of deaths in scope for case record review at UCLH.

A number of challenges to implementation are being considered and consultation is underway. Further clarity was being sought from NHSI on a number of requirements.

6. CQC inspection action plan update

'Should do' recommendations from the CQC inspections from March 2016 were used to develop a number of actions plans. QSC received an update of progress against the agreed action plans. Overall, good progress is being made with implementing agreed actions set out within the Trust-level, ED, AMU, specific divisional and other action plans agreed. The monthly CQCESG has continued to monitor delivery and will be meeting again in September, when an assurance update will be presented.

7. Hospital transfusion committee report

QSC received an update and commented on the report from the chair of the hospital transfusion committee. The report included progress of the Vein to Vein project for blood transfusion, blood product collection audits, clinical incidents and a new approach to consent for blood transfusion.

8. Trust quality and safety performance

QSC noted that the number of falls had increased from 105 in April to 139 in May and that the mean number for the preceding 12 months was 128.

Since January 2017, there has been a decline in the number of SIs however this is impacted by variability in declaring incidents.

Infection control compliance was worse that the threshold for May. The Trust was close to meeting the threshold for complaints response times in May, achieving 79.3% against a threshold of 85%.

9. Infection control annual report 2016/17 and 2017/18 Plan

There were two cases of MRSA bacteraemia against a zero threshold and 29 cases of MSSA bacteraemia over the year. 90 cases of hospital-acquired Clostridium difficile (c.diff) were reported in the Trust during this period against an ambition of <97 cases. 80 cases were successfully appealed. Ten cases were classified as lapses in care which included delays in sampling and isolation. Root causes were found to be primarily associated with appropriate antibiotic usage and recurrent C.difficile infection.
The *C. diff* taskforce continued to lead on the reduction plan. As most of the actions initiated by the group also contributed to the prevention, management and monitoring of carbapenemase producing organisms the work of the group includes this.

The surveillance of surgical site infection (SSI) continues. Infection rates have not changed significantly from the previous year (2015-16) in most followed-up categories of surgery. Pseudomonas and Legionella in water continues to be monitored and managed.

10. Risk coordination board report
   June 2017 report received for information.

11. Complaints benchmarking report and update on Trust action plan
QSC received an update to the annual complaints report to provide further information on complaints benchmarking information and a redraft of the agreed improvement action plan.

We received fewer clinical, patient care and end of life care complaints compared to nationally. There was an increase of 1.4% in complaints about NHS care across the country, the Trust saw an increase in formal complaints of 6.7%, however other Shelford members had between a 25% and 83% increase for the year.

Complaints to the Ombudsman increased in all organisations and whilst 12 complaints were upheld or partially upheld for UCLH cases, this was similar to most of the Shelford Group. Due to the nature of the Ombudsman's data, it is difficult to make a direct comparison as this can span several years.

UCLH received roughly double the ‘communication’ complaints in comparison to national and London figures, and 3% more ‘values and behaviour’ complaints. It also received significantly more admission and discharge complaints and this has been linked to transport performance. QSC noted that the ‘communication’ category is very broad and that further work will be undertaken to better understand why the Trust is an outlier for this area. The Annual Complaints report is attached for the Board of Directors to note.

DAVID LOMAS
COMMITTEE CHAIR
Annual Complaints Report

April 1st 2016 – March 31st 2017

Author: Belinda Crawford, Complaints Manager
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<td>Overview of Compliance with Trust Complaints Policy</td>
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<td>Compliance with monitoring requirements</td>
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<td>Subject Analysis and Key Themes</td>
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<td>Other Lessons Learnt from Complaints Monitoring</td>
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<td>Referrals to Parliamentary Health Service Ombudsman (PHSO)</td>
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<td>Review of recommendations from 2016/17</td>
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<td>10</td>
<td>Summary Action Plan 2017/18</td>
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1. INTRODUCTION

The Trust receives and reviews a range of patient experience metrics. This report is focussed on an analysis of the formal complaints that the trust receives and is produced to comply with NHS Complaints Regulations (2009) and to share learning in order to improve patient experience. It is widely recognised that patients are concerned that making a complaint may impact on their treatment and care or will not make any difference. So it is important to reassure patients that their care should not be adversely affected by making a complaint and to ensure that opportunities to improve patient experience and learning are maximised.

We know from feedback following a complaint investigation that whilst the response does not affect the complainant’s own experience, they are grateful to know that we are keen to learn when we get it wrong: this could be at an individual, team or trust level, and to put things right.

Complaints can be made by email, letter or verbally. The vast majority of contacts come by email (see p37). Whilst the term complaint may be used, we know that often the person raising the issue wants information or action taken, such as changing an appointment to address their concerns. Whilst these are not reported through the Department of Health Complaint Report (KO41) these contacts are monitored and trends noted. There are also times when more complex issues are raised, that will require a full investigation and written response, a formal complaint.

The distinction between a ‘concern’ and a ‘complaint’ can be challenging, both are expressions of dissatisfaction and require a response. The manner in which the contact to the complaints department is handled is in accordance with the wishes of the individual raising the issue, and under the NHS Complaint Regulations (2009) should also be proportionate to the issues, and the aim is to resolve matters as quickly as possible.

In order to ensure that any complainant has adequate access to appropriate support, they are also given information about NHS Complaint Advocacy Services.

The principle on receipt of any complaint or concern is to address the issues as soon as possible. A ward to board approach exists for complaint management at University College London Hospitals NHS Foundation Trust (UCLH). All staff are encouraged to respond to concerns raised by patients and relatives as soon as they become aware of them, rather than asking them to make a complaint. All trust staff are made aware of UCLH’s expectation for staff behaviours during induction and the appraisal process. Information about dealing with complaints is also provided during induction.

At UCLH there are separate departments for complaints and Patient Advice and Liaison Service (PALS) but the two teams work closely together. PALS will escalate more serious concerns into the formal complaint process but focus on resolving concerns quickly, and the complaints team will also attempt to resolve concerns that can be addressed quickly, outside of a formal complaint response without passing patients back to PALS.

All formal complaints are logged in line with the KO41, The Information Centre for Health and Social Care Survey that all NHS agencies complete. In 2015/16 the categories and frequency of reporting changed from an annual to a quarterly return and all subjects within a complaint became reportable not just the main issue. National Figures for this year have just become available.

In 2016/17 UCLH received 772 formal written complaints at the end of financial year but this had reduced to 769 at the time of submission of the data to the annual national statistics return, compared to 712 in the previous year, this represents an increase of 6.7 per cent. When activity is considered the complaint rate also increased slightly from 0.53 to 0.56 per 1000 contacts. The National figures show an overall increase of 1.8 per cent but some individual trusts showed...
increases of 20 and up to 85 per cent (this figure may be linked to a merger and most London trust showed increases of 5-30 per cent whilst some organisations did show decreases for the year.

Complaints will often trigger improvements to our processes as staff try to learn from negative patient and relative experiences. Complaints data is shared internally with subject expert leads and committees such as medication safety, falls, pressure ulcers, nutrition, end of life steering groups amongst others so that Trust wide monitoring of these issues can take place and appropriate improvement actions can be identified and monitored by the relevant committees. Issues from complaints are discussed at local departmental and divisional meetings and actions taken where appropriate to ensure learning takes place.

The Trust has an Improving Experience Committee, a Patient Experience Committee and a Quality and Safety Committee in which data from complaints is triangulated with feedback, PALS cases or incident reports to identify trends and explore emerging themes.

Patients unhappy with the outcome of our complaints processes can ask for their complaint to be reviewed by the Parliamentary and Health Service Ombudsman (PHSO). In 2016/17 there were 96 contacts by patients or their relatives with the PHSO. Most of these were considered premature by the PHSO; the complainant had either not made a complaint to us or their concerns were still under investigation. This is a slight increase on the previous year (91 for 2015/6). Of the 96 contacts received by the PHSO, 30 were accepted for investigation, compared to 24 in the previous year, an increase of 25 per cent.

Over the past year, 12 PHSO investigations (some relating to previous years) were partially upheld (partly agreed), with the outcome being an apology, an action plan to rectify the failures that were identified and in some cases a financial settlement. Sixteen cases remain open from 2015/16 and one from 2014/15 at the time of this report.

National figures show an increase in investigations accepted by the PHSO across most of the NHS and an increase in those cases partially or fully upheld for most similar sized organisations.

Complaints and their responses are seen by members of the Trust Board including the Medical Director, Chief Nurse, Chief Executive and Chairman. Non-executive directors review complaints on a rotational basis.

Quarterly reports about patient experience, including complaints are discussed at the Improving Experience Group (IEG), the Trust’s Quality and Safety Committee (QSC) the Patient Experience Committee (PEC, and Complaints Monitoring Group (CMG). Issues and actions arising from complaints are also used and discussed within divisions and Boards to drive change and to reflect on where improvements are required.

UCLH reports on patient experience quarterly to the Camden Commissioning Group and CQRSG, and annually via this report and on request to the Care Quality Commission or other parties.

This report is limited to a review of formal complaints received up until April 2017.

It is produced in order to meet NHS Complaints regulations to ensure the Board of Directors, our commissioners and our patients are aware of all complaints-related matters.

Please note data in this report is based on the content of the complaint and not the outcome of the investigation unless specifically stated.
The purpose of this annual report is therefore to:

- provide assurance that the Trust follows its Complaints Policy and Procedures when investigating and responding to formal complaints addressed to the Trust.

- show examples of complaints which have been used to assist in learning lessons and to improve the quality of patient care during the year

- set out recommendations where further improvements could be made to both the complaints process and the use that the Trust makes of formal complaints received from patients and their representatives

2. OVERVIEW OF COMPLIANCE WITH TRUST COMPLAINTS POLICY

The trust’s complaint policy was updated in 2016, notable changes were that the UCLH Complaints Monitoring Group (CMG) terms of reference was reviewed in 2016 and the frequency of meetings was reduced to quarterly in order to prepare for the quarterly patient experience report, which uses data from complaints, Patient Advice and Liaison Service (PALS), feedback, surveys and friends and family tests (FFTs).

A monthly Improving Experience Meeting (IEG) is held, in which various sites at UCLH feedback on trends and actions noted from patient feedback, PALS and complaints.

Monthly figures on complaints are shared and monitored via the performance pack.

The Patient Experience Committee (PEC) now meets quarterly with a revised membership and is chaired by a non-executive director.

Compliance with monitoring requirements

A review of agenda for the Complaints Monitoring Group (CMG) confirms that this met quarterly


A review of the QSC minutes showed that the QSC received an update on Patient experience on a quarterly basis.
3. ANALYSIS OF COMPLAINTS RECEIVED IN 2016 / 17

Table 1. – Summary Table: complaints, response time and PHSO cases over time.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total No of Formal Complaints Received</th>
<th>Response time target met (all complaints)</th>
<th>Main Subject matter of original complaint</th>
<th>Complaints accepted for investigation by PHSO</th>
<th>Number of Complaints Upheld by PHSO</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>671</td>
<td>84 per cent</td>
<td>All Aspects of clinical treatment</td>
<td>13 (1.9 per cent)</td>
<td>0</td>
</tr>
<tr>
<td>2011/12</td>
<td>520 (↓22 per cent)</td>
<td>85 per cent</td>
<td>All Aspects of clinical treatment</td>
<td>30 (5.8 per cent)</td>
<td>0</td>
</tr>
<tr>
<td>2012/13</td>
<td>677 (↑30 per cent)</td>
<td>80 per cent</td>
<td>All Aspects of clinical treatment</td>
<td>23 (3.4 per cent)</td>
<td>2 partially upheld</td>
</tr>
<tr>
<td>2013/14</td>
<td>791 (↑17 per cent)</td>
<td>78 per cent</td>
<td>All aspects clinical treatment</td>
<td>23 (2.9 per cent)</td>
<td>2 partially upheld</td>
</tr>
<tr>
<td>2014/15</td>
<td>833 (↑5.3 per cent)</td>
<td>73 per cent</td>
<td>All aspects clinical treatment</td>
<td>22 (2.6 per cent)</td>
<td>2 partially upheld</td>
</tr>
<tr>
<td>2015/16</td>
<td>711 (↓15 per cent)</td>
<td>72 per cent</td>
<td>Clinical Treatment (main) Communications (all subjects)</td>
<td>24 (3.3 per cent)</td>
<td>6 partially upheld</td>
</tr>
<tr>
<td>2016/17</td>
<td>769 (↑8 per cent)</td>
<td>75 per cent</td>
<td>Clinical Treatment (main) Communication (all subjects)</td>
<td>30 (3.9 per cent)</td>
<td>12 partially upheld</td>
</tr>
</tbody>
</table>

As can be seen from the above table there was an increase in complaints and those referred to the Ombudsman for this year. Until Q4 there had been less complaints compared to the previous year as seen from the chart below.

**Fig 1: Number of complaints received by Quarter**

![Graph showing quarterly complaints](image-url)
An increase in complaints may not in itself be cause for concern as it is recognised that an open culture will encourage feedback and providing information on how to complain will facilitate complaints to be brought. However this sudden increase was noted and the subjects for complaints reviewed as part of the quarterly patient experience report.

We know that the NHS faced a number of challenges at this time, with significant bed pressures from emergency admissions related to a flu epidemic and outbreaks of norovirus. This may have had a knock on effect to a range of services such as elective surgery, outpatients and so may be partially related to this rise. However there was also a significant increase in complaints linked to the patient transport service for the same period and this is explored further on p 9.

There was a slight improvement in meeting response times from 72 percent to 75 percent; however there is still significant room for improvement. It should be noted that whilst there may sometimes be a delay in providing a written response, other actions may occur promptly e.g. organising a clinical appointment to assess the patient, if they are raising clinical concerns that need more immediate attention.

There was an increase in the percentage of complaints accepted by the ombudsman for investigation compared to overall complaint numbers but some of these were initially received in the previous year with further contact in 2015 / 16 to say that the scope had changed. This is explored further on page 31.

**Action:**

Continue to monitor number of complaints and trends in divisions, highlighting any emerging themes or patterns.

**Fig 2: Number of complaints by month**

Formal complaints received have ranged from 45 – 87 per month with an average of 64 compared to 59 for last year. Historically there has been a reduction noted in complaints during the summer period which was the pattern for this year. In 2015/16 Quarter four received the fewest complaints but in 2016/17 there was a significant increase for this period compared to the rest of the year.
Table 2: Comparison between Divisions over 2012 – 2017

<table>
<thead>
<tr>
<th>Division/Department</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
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<tbody>
<tr>
<td>Queen Square</td>
<td>153</td>
<td>173</td>
<td>168</td>
<td>139</td>
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<tr>
<td>Emergency Services</td>
<td>78</td>
<td>92</td>
<td>64</td>
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<td>Women's Health</td>
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<td>80</td>
<td>87</td>
<td>79</td>
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<tr>
<td>Surgical Specialties</td>
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<td>90</td>
<td>112</td>
<td>106</td>
<td>76</td>
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<tr>
<td>Gastrointestinal Services</td>
<td>51</td>
<td>54</td>
<td>66</td>
<td>59</td>
<td>38</td>
</tr>
<tr>
<td>Royal National Throat, Nose &amp; Ear Hospital</td>
<td>56</td>
<td>53</td>
<td>50</td>
<td>46</td>
<td>49</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>35</td>
<td>37</td>
<td>41</td>
<td>31</td>
<td>40</td>
</tr>
<tr>
<td>Clinical Support</td>
<td>26</td>
<td>35</td>
<td>44</td>
<td>32</td>
<td>76</td>
</tr>
<tr>
<td>Eastman Dental</td>
<td>25</td>
<td>37</td>
<td>38</td>
<td>28</td>
<td>50</td>
</tr>
<tr>
<td>Heart Hospital * Transfer to BARTS</td>
<td>21</td>
<td>37</td>
<td>35</td>
<td>16*</td>
<td>n/a</td>
</tr>
<tr>
<td>Cancer</td>
<td>16</td>
<td>21</td>
<td>31</td>
<td>29</td>
<td>34</td>
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<tr>
<td>Imaging</td>
<td>13</td>
<td>13</td>
<td>16</td>
<td>19</td>
<td>18</td>
</tr>
<tr>
<td>Infection</td>
<td>13</td>
<td>10</td>
<td>8</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>Theatres and Anaesthesia</td>
<td>11</td>
<td>16</td>
<td>15</td>
<td>6</td>
<td>11</td>
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<tr>
<td>Pathology</td>
<td>10</td>
<td>7</td>
<td>13</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Estates and Facilities</td>
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<td>8</td>
<td>14</td>
<td>4</td>
<td>7</td>
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<tr>
<td>Paediatrics</td>
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<td>5</td>
<td>14</td>
<td>15</td>
<td>17</td>
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<tr>
<td>Integration</td>
<td>n/a</td>
<td>n/a</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Critical Care</td>
<td>1</td>
<td>3</td>
<td>6</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Corporate functions : medical records/ IT/ Finance/ PALS/ Chaplaincy/ Governance</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td><strong>667</strong></td>
<td><strong>791</strong></td>
<td><strong>830</strong></td>
<td><strong>712</strong></td>
<td><strong>772</strong></td>
</tr>
</tbody>
</table>

As activity can vary between divisions and across the trust, complaints are also tracked against an activity baseline of 1000 patient contacts to allow comparison. *(This is based on performance figures for each division and clarification is being sought on whether clinical support reflects the number of PTS journeys that are made)*

Analysis shows us that despite an increase in the overall number of complaints, when activity is considered, the rate of complaints fell in many areas, notably surgical specialties and gastrointestinal services. There were small increases noted for Queen Square (which encompasses the Royal London Hospital for Integrated Medicine and services at Chalfont Hospital), Women’s Health, Royal National Throat, Nose and Ear Hospital and Eastman Dental Hospital.
Clinical Support services saw a significant increase in complaints for the year with a surge noted starting in Quarter 3. On review this was linked to a change in the provider for Patient Transport Services. Patients were experiencing long delays in collection from home or the hospital and this was discussed with the Transport team and the poor experience for patients was escalated to Board level. This increase was due to a number of factors, the previously contracted patient transport service terminated their contract without notice in July 2016 and the new transport provider experienced a number of teething problems in delivering the full aspects of the new contract.

The Improving Experience Committee and Patient Experience Committee received updates on actions being taken to improve matters but due to the significant impact on patients, the Trust declared this matter a serious incident, with an investigation carried out and an action plan developed in conjunction with the new provider. Improvements have been noted but this aspect remains under close scrutiny through the patient experience committees and further work is ongoing in this area.

In general, divisions with more surgical cases receive the largest number of complaints. This is linked to both administration issues such as waiting times, delays and cancellations, and clinical matters such as complications following surgery or outcomes as well as questions about clinical management such surgical treatment versus a conservative approach.

Complainants usually have a year to bring a complaint. Cancer services received more complaints for this year, usually relating to clinical care however some complaints related to care dating back to previous years. In cases where there has been bereavement, the trust would always try to respond to concerns about care and treatment, but in such cases the response may be affected by the passage of
time and complainants are advised of this. Such complaints are shared with the End of Life steering group and anonymised examples have been used for teaching staff about improving communication about prognosis, treatment and when discussions about resuscitation or escalation of treatment should be held.

Infection control continues to see a small number of complaints in which the complainant disputes the medical opinion and results of some tests. There has also been increased media coverage of the diagnosis of some conditions such as Lyme disease in recent year, which may have raised concerns for some patients. Further review by the PHSO has supported the clinical care and decision making by the team in the small number of cases that have been referred to them.

Paediatrics have seen a small rise in complaints, on review some of these have been linked to when staff have raised concerns to other organisations in line with Trust Safeguarding processes. However staff may not have always communicated this effectively to the parents. Such complaints have been shared with the safeguarding leads, and individual staff have received more support and training on handling difficult conversations and conflict. This is being monitored by the division.

The increase in quarter 4 resulted in an overall increase in complaints per 1000 contacts.

**Fig 4: Complaints per 1000 patient contacts for whole Trust**

![Complaints per 1000 patient contacts](chart.png)

**Grading of Complaints**

Complaints are triaged on receipt and graded, with red being the most serious. Grading is based on the content of the complaint and not on the outcome of the investigation. The chart below shows complaints by grade that entered the formal complaints process. The majority of red complaints are from relatives asking if more could have been done for their family member prior to their death.

Complaints are reviewed on receipt against any incidents that have been reported for the patient, and safety huddles are used for any potential clinical incidents. In 2017/18 Complaints about a death will be shared with the Mortality (deaths) surveillance group and the Patient Safety team. (Need reference).
The increase noted in complaints in quarter 4 was not linked to a rise in more serious complaints.

Improving Patient Safety: Triage of serious complaints

Complaints are triaged on receipt as to the seriousness of the issues raised. As part of this triage, complaints that highlight potential clinical incidents are reviewed against the clinical incident database and in 2015/16 safety huddle were introduced, in which complaints, clinical risk and safeguarding looked at the issues raised in the complaints. In 2016/17 a total of 61 complaints were reviewed in safety huddles with six being managed under complaint and safeguarding processes, four utilising the Trust's serious incident process and 19 being both an incident and a complaint.

Complaints monitoring is a standing agenda item for each divisional governance meeting, and there is evidence to support this from Divisional meeting minutes. Clinical boards have also used complaints as an example for learning across their divisions.

Trust wide issues are also highlighted as part of the monthly Quality and Safety Newsletter.

More serious complaints are shared with medical directors and heads of nursing, with amber 4 and red 5 complaint responses requiring approval from clinical directors before they are sent to complainants.

Action: Use information from complaints to inform mortality reviews in the coming year in line with CQC recommendations.
4. BENCHMARKING AGAINST OTHER ORGANISATIONS

The Health & Social Care Information Centre (which produces annual statistics on complaints) states that caution should be taken when interpreting the basic quantitative data. An organisation that has good publicity, that welcomes complaints as an opportunity to learn and to improve services, and that has a non-defensive approach in responding to complaints may be expected to receive a higher number of complaints than an organisation with poor publicity and a defensive approach in responding. Yet one might also expect its services to be of a higher quality. It is important that organisations are open about the number of complaints received, but these should not be read in isolation.

Nationally complaints about NHS care decreased by 1.4per cent, UCLH saw an increase of 6.7per cent for 2016 /17 compared to the previous year. However as can be seen from the table below, this figure varied considerably between organisations. Caution needs to be taken when looking solely at the overall number of complaints: as organisations may have improved ways to complain, may have taken over new divisions, departments or organisations or just increased activity.

Table 3 : Comparison of UCLH complaints to other key London trusts and members of the Shelford Group for 2016/17 using K041 data:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Complaints 2016</th>
<th>Complaints 2017</th>
<th>Trend</th>
<th>Resolved in 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>680</td>
<td>779</td>
<td>↑14.5 per cent</td>
<td>738</td>
</tr>
<tr>
<td>BARTS health</td>
<td>1396</td>
<td>2206</td>
<td>↑58 per cent</td>
<td>1770</td>
</tr>
<tr>
<td>Cambridge</td>
<td>519</td>
<td>503</td>
<td>↓0.3 per cent</td>
<td>346</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>344</td>
<td>628</td>
<td>↑83 per cent</td>
<td>455</td>
</tr>
<tr>
<td>Central Manchester</td>
<td>1152</td>
<td>1026</td>
<td>↓10.9 per cent</td>
<td>1227</td>
</tr>
<tr>
<td>Frimley Park</td>
<td>772</td>
<td>921</td>
<td>↑19 per cent</td>
<td>667</td>
</tr>
<tr>
<td>Kings</td>
<td>823</td>
<td>1034</td>
<td>↑25.6 per cent</td>
<td>754</td>
</tr>
<tr>
<td>GSTT</td>
<td>1122</td>
<td>1198</td>
<td>↑6.7 per cent</td>
<td>1176</td>
</tr>
<tr>
<td>Imperial</td>
<td>1164</td>
<td>1166</td>
<td>↓0.17 per cent</td>
<td>1062</td>
</tr>
<tr>
<td>Oxford</td>
<td>1047</td>
<td>1093</td>
<td>↑4.39 per cent</td>
<td>666</td>
</tr>
<tr>
<td>Sheffield</td>
<td>1148</td>
<td>1163</td>
<td>↑1.3 per cent</td>
<td>1138</td>
</tr>
<tr>
<td>Newcastle</td>
<td>627</td>
<td>541</td>
<td>↓1.4 per cent</td>
<td>486</td>
</tr>
<tr>
<td>St George's</td>
<td>975</td>
<td>903</td>
<td>↓7.4 per cent</td>
<td>934</td>
</tr>
<tr>
<td>Royal Free</td>
<td>1440</td>
<td>1545</td>
<td>↑7.3 per cent</td>
<td>1113</td>
</tr>
<tr>
<td>UCLH</td>
<td>721</td>
<td>769**</td>
<td>↑6.7 per cent</td>
<td>725</td>
</tr>
</tbody>
</table>
** Please note this data (above) is submitted at the end of April and is slightly reduced since the data was initially produced for the Trust's main annual report.

From this raw data, although UCLH has seen a significant rise above the national figure, as a Trust it has not seen the very significant rises that other Trusts have noted (25 per cent – 83 per cent). Quite why such wild fluctuations have occurred is not known at this stage but some are likely to be linked to mergers of trusts or transfer of some services.

When the themes that patients complain about is considered then UCLH is better than national and London percentage for six categories including clinical care but worse than National and London for seven, with 5 categories being better than either National or London data but not both.

However there is a problem with this analysis due to the small number of ‘other’ categories for UCLH 0.6 per cent compared to the national data 5.4 per cent and London 19.9 per cent so this ‘other’ data could have an effect on any of the subjects if it represents poor data capture.

Areas that UCLH remains a negative outlier for are often administrative in nature rather than clinical treatment or care : eg) admissions and discharges at 8 per cent (possibly linked to the number of transport related complaints for Q3 and Q4, trust administration (3.8 per cent), which would also see a large number of transport related complaints due to some of the sub categories in this section. Sadly values and behaviours (13.6 per cent) remains higher than national or London datasets but has improved slightly when compared to previous years. Further data is being sought from Shelford colleagues to understand this variation better.

### Table 4: Comparison of all subjects within a complaint as a percentage of the total Subjects for that organisation / area

<table>
<thead>
<tr>
<th>Subject</th>
<th>National</th>
<th>London</th>
<th>UCLH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment</td>
<td>26.7</td>
<td>24.6</td>
<td>17.7</td>
</tr>
<tr>
<td>Patient care</td>
<td>11.4</td>
<td>4.2</td>
<td>5.8</td>
</tr>
<tr>
<td>other</td>
<td>5.4</td>
<td>19.9</td>
<td>0.6</td>
</tr>
<tr>
<td>access</td>
<td>3.7</td>
<td>8.4</td>
<td>2.4</td>
</tr>
<tr>
<td>Admissions / discharges</td>
<td>5</td>
<td>1.5</td>
<td>8</td>
</tr>
<tr>
<td>appointments</td>
<td>6.1</td>
<td>6.7</td>
<td>7</td>
</tr>
<tr>
<td>Commissioning</td>
<td>1.9</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td>Communication</td>
<td>14.7</td>
<td>11.5</td>
<td>27</td>
</tr>
<tr>
<td>consent</td>
<td>0.3</td>
<td>1.8</td>
<td>1.3</td>
</tr>
<tr>
<td>EOL</td>
<td>0.6</td>
<td>0.5</td>
<td>0.35</td>
</tr>
<tr>
<td>Facilities</td>
<td>1.7</td>
<td>0.4</td>
<td>2.3</td>
</tr>
<tr>
<td>Integration</td>
<td>0.9</td>
<td>0.3</td>
<td>0.15</td>
</tr>
<tr>
<td>privacy</td>
<td>2</td>
<td>0.8</td>
<td>2.1</td>
</tr>
<tr>
<td>restraint</td>
<td>0.1</td>
<td>0.2</td>
<td>0.15</td>
</tr>
<tr>
<td>Staffing</td>
<td>0.4</td>
<td>1.4</td>
<td>1.2</td>
</tr>
<tr>
<td>Trust admin</td>
<td>1.9</td>
<td>0.2</td>
<td>3.8</td>
</tr>
<tr>
<td>Values &amp; behaviours</td>
<td>10.1</td>
<td>10.7</td>
<td>13.6</td>
</tr>
<tr>
<td>Waiting</td>
<td>2.2</td>
<td>5.4</td>
<td>3.2</td>
</tr>
</tbody>
</table>
Table 5: Upheld status after investigation

<table>
<thead>
<tr>
<th></th>
<th>2016/17 per cent</th>
<th>2015/16 per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Upheld</td>
<td>204</td>
<td>184</td>
</tr>
<tr>
<td>Partially Upheld</td>
<td>350</td>
<td>308</td>
</tr>
<tr>
<td>Upheld</td>
<td>187</td>
<td>232</td>
</tr>
<tr>
<td>Totals:</td>
<td>741</td>
<td>723</td>
</tr>
</tbody>
</table>

There remains considerable variance for this figure as can be seen from the figure overleaf, e.g.) St George’s NHS University Hospitals NHS Foundation Trust upholds 100 per cent of all complaints it investigates, whilst University Hospitals Birmingham NHS Foundation Trust upheld about 10 per cent however this data was felt on review to be inaccurate as it did not add up to the number of cases resolved.

UCLH upholds or partially upholds about 75 per cent of all complaints. Most trusts will be in the range of 60-80 percent for this with Royal Free NHS Foundation Trust, Newcastle Hospitals NHS Foundation Trust and Imperial College Healthcare NHS Foundation Trust being lower at 40-50 per cent upheld or partially upheld. This categorisation clearly remains subjective and should be based on the overall complaint not the main or most significant element to it.

Figure 6: Comparison of Percentage of Upheld, partially upheld and not Upheld for 2016/17

5. SUBJECT ANALYSIS AND KEY THEMES

Whilst it is possible to make a direct comparison with last year’s data, due to National changes made in complaint classification in 2015 it is not possible to directly compare the trend over a longer time.

For example whilst clinical care had previously been one category it now falls within a number of main subjects and spans a number of staff groups:

- Clinical treatment
- Patient Care
- Prescribing (medication safety)
• Values and behaviours
• Privacy and dignity

Therefore whilst clinical treatment is the main reason for a complaint, when all of the sub subjects are considered communication becomes the main topic (see fig 7 overleaf)

**Fig 7: Main subjects featured in complaints to UCLH**

From 2015 /16 more than one subject is logged and reported per complaint, therefore when all subjects and sub subjects are considered then the key subjects for 2016 /17 are illustrated overleaf, communication becomes the root cause of most complaints.

**Fig 8: ALL Subjects within complaints**
Fig 9: Top ‘10’ subjects when all components of the complaint are considered

Trends are monitored by the central complaints team and discussed at CMG. When numbers or types of complaints change significantly over time, the division is asked to account for the variation. As has already been discussed, Clinical Support management were asked to attend IEG when a sudden increase in contacts was noted in Q3 Q4 in relation to transport issues, these fall under both admission and discharge arrangements and trust policy and procedure as subjects.

We were very concerned to see this increase, which included some very poor patient experiences. This was linked to the new transport provider taking longer than expected to deliver the full service to the quality we required. We are working closely with them to improve the quality of this service. Measures already taken have included working with clinical areas to reduce transport bookings at short notice. The transport team has also been proactive in talking to patients who have had problems and ensuring future travel plans have been checked to avoid similar problems occurring. This is being monitored closely.

Access to services has been included as an eleventh subject as an upward trend in accessing British Sign Language interpretation has been noted in Quarter 4 and is currently being monitored by the IEG.

When all subjects are considered medication issues have reduced for this year and this may be linked to the introduction of electronic prescribing and a focus on reducing dose omissions as a quality initiative. It should be noted that some additional categories have been added to this dataset on request of the Trust’s Medication Safety Committee.

COMMUNICATION

It is disappointing to see communication issues continue to rise but further analysis shows that many of these complaints are linked to the administration of appointments, such as short notice cancellations. This situation is then not helped when patients cannot access the phone numbers provided on the appointment letters. A deep dive of issues linked to this from complaints and PALS...
cases was taken to the Improving Experience Committee and has been sent to the Improving Access patient team for developing an improvement strategy.

The allocation of complaints to a lead division explains the low number of complaints for some divisions, as issues such as transport or food may appear within a wider complaint but may not be the main issue raised.

Direct comparison with previous years is difficult due to the change in categories and the use of additional sub categories from April 2015.

End of year national data shows that whilst UCLH has less clinical complaints than many organisations, complaints about communication and values and behaviours account for more complaints when compared with national figures. It is not clear if this is because of the way that data is captured as UCLH does not cap the number of subjects recorded for any complaint and further work is required to understand whether the communication issues we record are recorded as administrative issues by other organisations.

**Action:** Discussion with Shelford managers about how subjects are categorised. With benchmarking planned against communication, values and behaviours and administration categories.

VALUES AND BEHAVIOURS

Generally there has been an improvement across professional groups but an increase is noted for non-clinical staff. A focus on administration staff is planned for 2017/18.

**Fig 10: Value and behaviour complaints by staff group**

What does further analysis of complaints at UCLH tell us?

There is an improvement in the number of complaints mentioning clinical staff for 2016/17 but work is ongoing. We know from many complainants that they have received care and support from the majority of staff, with many staff being singled out for particular praise but that single experiences may be the trigger for the complaint due to the distress caused by individual staff members.

Complaints about attitude or behaviours can be difficult to investigate, it maybe one person’s word against another. Often the perceptions maybe very different – we know that some patients may
have been confused, have mental health problems or be under the effect of medications. Some patients or relatives may have unrealistic expectations about how much time staff can spend with them on an individual basis and a very small minority appear to be vexatious but it is concerning that there has not been more improvement in complaints about this topic.

However the majority of complaints UCLH receive are about a single encounter with a member of staff that has left them affected enough to write in, often with the intention of avoiding it happening to someone more vulnerable than they are. Far less common are complaints about multiple care failings accompanied by a series of unsatisfactory staff encounters. Many complaints about a single staff member will acknowledge that care from other staff has been very good.

Action: End of year data will be shared with site groups and improving experience group to consider further actions

A compliments category will be added to Datix to capture any positive feedback.

### Contributory Factors from Value and Behavioural Complaints:

- Staff not introducing themselves or not wearing a visible ID badge
- Staff not robustly checking and changing patient address, GP and next of kin details – often adds to a complaint when errors are passed on – patient feels not listened to
- Lay out of some areas eg) desk location does not facilitate eye contact at reception
- Other environmental factors – department lay out etc.
- Lack of rooms for private discussions in some areas
- Patients do not understand why some patients are ‘seen ahead of them’ – e.g. in ED and multiple clinic waiting rooms and may see this as deliberate behaviour rather than streaming or triage
- Not being able to contact staff– patients often report voicemails as full, no one answering or getting transferred to lots of people. This can make some patients very angry and some staff do not seem able to make allowances for this and can terminate calls very quickly as they may feel threatened by the person on the phone.
- However some patients do expect an immediate email response and are not aware that staff are not office based and usually require three days or more to respond
- Being given a complaint leaflet rather than giving the patient time and escalating their concerns

**Actions:** These themes have been shared during teaching sessions and via periodic reports to the Trust

Appropriate attitude and behaviour of staff, and their responsiveness to patients remains a key trust priority and this message is reiterated to staff from recruitment, through induction to
development and leadership programmes. New recruits have to complete and pass a values based assessment before they are allowed to apply for a post at UCLH. Existing staff have an annual appraisal in which they consider their performance against the trust values of kindness, teamwork, safety and improving

Several caveats need to be applied to this data - more sub subjects about values and behaviours have been captured since April 2013 and in particular since April 2015 so this may also reflect better data capture rather than deterioration in staff behaviours per se.

CLINICAL TREATMENT AND PATIENT CARE

Clinical complaints continue to be reviewed closely for trends and emerging concerns, reports have been taken to the Nursing and Midwifery forums and to the medical director, divisions and boards and Quality and safety Committee.

Fig 11: Clinical Treatment and Patient Care Complaints by Division (there may be more than one issue and division per complaint)

If contact is made to the complaints team from a patient or relative whilst they are admitted, this is referred to the ward sister, matron or a consultant to arrange a meeting to try to resolve any concerns at the earliest opportunity and this usually resolved the concern.

When the subject is looked at more closely the following themes emerge, please note this is based on the content of the complaint and not the outcome

Clinical themes: Medical staff

The main reason for a complaint about medical care is that surgical outcome is not as expected - either through development of a complication, or that the outcome of the operation on their quality of life has not been as good as the patient expected. There may be elements relating to the consent process, but the response usually demonstrates that consent has included the development of the complication after surgery, suggesting that communication and patient understanding may be a root cause. Communication is the main subject for complaint when all subjects are considered, with many patients being upset by the manner in which they have been
spoken to. Complaints may be about conflicting information or insufficient information from medical (and other) staff.

Some patients may have done their own research into their condition and believe that a specific treatment or surgical procedure is indicated or that the diagnosis they have been given is incorrect.

When clinical staff do not agree they seek further clarification through the complaints process. Such complaints appear to be on the increase compared to previous years but as already discussed the categories have changed making direct comparison for this year challenging.

Missed diagnosis of a fracture is not an uncommon issue for any emergency service but when this happens clinical teams used the cases within their local governance meetings and have used them as anonymised case studies for junior doctor’s education programme

Fig 12: Comparison of Medical Staff complaints

![Comparison of Medical Staff complaints](image)

Although there is a slight reduction in complaints about clinical care for this year, medical complaints have not shown the same reduction in numbers that nursing has seen. A review of the data shows some of this may be linked to coding but further analysis is recommended.

Action: Further analysis of medical complaints is recommended to inform actions for improvement

Mechanisms for sharing medical complaint review should be established as per nursing and midwifery

Clinical: Nursing

This can vary from a single nurse’s attitude or behaviour to more complex complaints indicating failure in the overall care and support offered across an admission. A six monthly review of complaints is shared with the Trust’s Nursing and Midwifery Board.

Data from complaints in used to triangulate with other sources such as incidents, patient feedback and PALS, and is used as part of the Ward Safety Data. Each ward records the number of complaints on their local quality boards The senior nursing team and complaint’s manager monitor nursing complaints for any areas of concern such as clusters of complaints or similar clinical theme Patients often feel vulnerable at night and when staff are not supportive these are fed back to the matrons for the area. Agency / Bank staff may be perceived to be less caring / knowledgeable and recruitment has focussed on replacing temporary staff with permanent trust employees.
Table 6: Number of Complaints in which Nursing features Trend Over time

<table>
<thead>
<tr>
<th></th>
<th>All complaints</th>
<th>Nursing Complaints</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 15 16</td>
<td>171</td>
<td>30</td>
<td>17.5 per cent</td>
</tr>
<tr>
<td>Q2 15 16</td>
<td>205</td>
<td>48</td>
<td>23.4 per cent</td>
</tr>
<tr>
<td>Q3 15 16</td>
<td>197</td>
<td>41</td>
<td>20.8 per cent</td>
</tr>
<tr>
<td>Q4 15 16</td>
<td>139</td>
<td>32</td>
<td>23 per cent</td>
</tr>
<tr>
<td>Q1 16 17</td>
<td>184</td>
<td>32</td>
<td>17.4 per cent</td>
</tr>
<tr>
<td>Q2 16 17</td>
<td>183</td>
<td>32</td>
<td>17.5 per cent</td>
</tr>
<tr>
<td>Q3 16 17</td>
<td>180</td>
<td>22</td>
<td>12.2 per cent</td>
</tr>
<tr>
<td>Q4 16 17</td>
<td>225</td>
<td>26</td>
<td>11.6 per cent</td>
</tr>
</tbody>
</table>

Complaints featuring nursing are reducing over time at a time when the number of complaints UCLH received increased by 8 percent for 2016/17 compared to the previous year.

When the complaints are reviewed for topics there is also a reduction for each of the top 8 subjects for nursing complaints for 2016/17 compared to 2015/16.

Fig 13: Comparison between 15/16 and 16/17 for Nursing Complaints

In 2015/16 patient survey data suggested a problem with care at night, on review it was found that patients were likely to be disturbed by other patients as well as experience concerns about reduced care and support. In 2016/17 there was a reduction in complaints about care at night for both midwifery and nursing. With five complaints for nursing in 2017 compared to 12 for the year before and two complaints about midwifery support at night compared to five for the previous year.

There are many committees that receive data on complaint issues that are related to clinical complaints. For example

Falls – any complaints featuring falls are shared with the Falls group and falls leads and incident reports are checked. In 2016 /17 two complaints featured falls and both had been reported as incidents at the time. This is the same as 2015/16 but remains below the six reported in 2013/14.
Pressure ulcers – any complaints featuring these are shared with the tissue viability team. There were no complaints about pressure ulcers in 2016/17 but advice was sought regarding wounds for two complainants, there was one complaint about an acquired pressure ulcer in 2015/16 but this related to care given in the previous year, there were no complaints received in 2014/15 about pressure ulcers compared to two for 2013/14.

Medication safety - a quarterly report is shared with the Trust medication safety committee and data triangulated with clinical incident reports. These complaints can be linked to medical, nursing or pharmacy staff.

Any complaint mentioning medication issues is shared with the medication safety lead and a quarterly report is shared to cross reference themes from complaints with incidents.

The trust has focussed on reducing the number of times that drugs are missed for non clinical reasons and has also introduced an electronic prescribing system to try to improve the safety of prescribing, dispensing and administering medication to patients. There has been a reduction in complaints about dose omissions since this system was introduced.

**Fig 14: Medication Related complaints 2016/17**
Learning Points: When a complaint is about an individual then this is used to direct their development and training needs. When the issue has been noted for more than one individual then the whole team will usually discuss the care provided and the complaint, and consider how they can learn from the issues raised.

In 2016/17 several wards have used a complaint as part of their ward development programme and a section on dealing with concerns and complaint handling is planned for the senior staff nurse development programme in April and July 2017.

When complaints are received teams utilise safety huddles to address immediate actions following complaints and more significant learning is discussed at local governance meetings.

Clinical cases studies have also been used for junior doctor training or discussion at local governance groups eg) unusual / atypical presentations, X-ray review and teaching.

Where a lack or conflicting information about a procedure or the potential complications has been identified as an issue this has been shared with the patient information lead and new leaflets have been developed or existing information reviewed. Examples for this year include: cystoscopy leaflets and blood test location maps.

Maternity Complaints

Complaints for Women’s health services increased slightly for this year, therefore further review of these have been carried out by Maternity Services and the complaint manager to identify themes and develop improvement plans.

Fig 15: Maternity and Obstetric related care complaints

Ante Natal Care

The department has seen an increase in complaints for the year especially in Quarter 3. On review this is largely tied to long waits in clinic and a lack of continuity in midwifery leading to complaints as women are concerned that this will be the pattern for their pregnancy. Some women have had a poor experience with phlebotomy and getting test results in a timely manner. The ante natal matron and complaints officer shared the numbers and themes from complaints in a team meeting.

Actions taken locally: These themes were brought to the Women’s Health Operational Group to ensure learning took place and that solutions were sought to improve these aspects.

Latent phase: A working group has been formed to work towards bringing about an
improvement in the experience of women in latent phase of labour. The group is focusing on 4 key areas:

- Telephone communication before admission (telephone triage)
- Communication of the diagnosis of latent phase with the woman and her family
- The use of oramorph as pain relief
- The option and place of admission

**Waiting time:** The diabetes clinic has emerged as the main source of complaints relating to waiting time. The following areas are been addressed through the outpatients programs of care working group.

- The patient pathway
- The number of clinics on a single day, with potential extension to a different day
- The role of music; which has been introduced in the waiting area.

**Values and Behaviours:** The maternal and fetal assessment unit is also working with the patient experience group to towards the “Always Event”.

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**Care during Labour**

Birth reflection meetings (midwife and obstetric) are available and occurs weekly. These after-birth reflections play a vital role in supporting women through difficult birth experiences and provide the opportunity to plan appropriately for subsequent pregnancies. There was a small cluster of complaints from partners in Q3 Q4, who did not seem prepared for the fact that their partners would be in a bay with other women. There was also a backlog in duty of candour letters which left some women confused about what to expect in relation to the review of their care. Some complaints were received connected to delay in communications about process. The backlog has now been addressed as the safety team has been strengthened with the appointment of a Risk Management midwife, who is supported by a Safety Midwife. The number of complaints remains steady.

**Pain control** – after seeing a reduction in complaints about delays awaiting epidurals during labour, this is slightly higher for this year and should be monitored. However the overall number of complaints about pain control is stable with 11 for 15/16 and 12 for 16/17. This is against activity of 6753 births (Apr 16 – Mar 17). This may also be linked to care being provided whilst awaiting a definitive bed and the senior midwifery team have reiterated that midwife led analgesia can be provided in any location.

**Post Natal Care**

In a report to NMB in 2014 complaints about midwifery care and support were largely connected to postnatal care. Women’s Health took this on board, arranged rotations for staff, focused on team and individual development and this had an impact in 2015/16. The role of the breastfeeding coordinator was strengthened and more training in this area was provided. Breast feeding complaints have reduced further from 5 in 2015/16 to 2 in 2016/17. However the overall number of postnatal complaints increased in the latter part of the year. This appears to be linked to a mismatch between the amount of support expected by the women and that provided, with an increase in complaints noted about discharges being ‘rushed’. This may be connected to the increasing demand on the service and an increase in activity year on year.
6. OTHER LESSONS LEARNT FROM COMPLAINT MONITORING

This section considers further how the trust learns from the complaints it receives.

Complaints provide valuable feedback, and should be viewed by staff and the trust as positive agents for change. This may arise from review of themes or trend analysis but on occasion issues can be identified from individual complaints which have implications for other patients, their relatives and carers, as well as the services provided by the Trust. Some of these lessons have already been shared in section 4.

Improving response times:

The trust met 75 percent of agreed response times in 2016/17, although this is an improvement compared to 72 percent in 2015/16 it is short of the 85 percent Trust target. The table on page 2 demonstrates that this has deteriorated overtime. It should be noted that performance does vary, and this is reported monthly via the quality scorecard. Some divisions consistently meet their targets and keep the complainants updated. Longest delays tend to occur with complex clinical complaints. Queen Square have reviewed their local coordination of investigations and focussed on improving response times and have recently met 100 percent of response times.

**Action:** Divisions that are not meeting response deadlines have been asked to review their local complaint handling processes and develop an action plan.

Quality checks by the division and the central complaint team and an improvement in the quality of initial responses to complainants has reduced the number of complainants sending further concerns following their complaint response (8.5 percent for 2016/17 compared to 10 percent in 2015/16).

Re contacts from complainants are now scrutinised more carefully, and direction is provided by the central complaint team to divisions on the areas to respond to. If there is nothing more to add (such as further response or meeting) then a letter explaining that local resolution has concluded and information about contacting the Ombudsman is provided following feedback that as an organisation we sometimes took too long to close the local process.

Compliance with Complaint Process

In 2016/17 Complaint Handling was audited by internal audit at UCLH.

They found that the complaint policy was easy to read and explained staff roles in the process. They also identified room for improvement:

- That response times could be improved
- That patients needed to be kept more informed about the progress of their complaint, divisions were not always making telephone calls to complainants and did not always let them know when there had been a delay in investigating their complaint.
- They noted improvements to training staff in handling complaints had been made but asked us to consider if this training should become mandatory for some groups.
- They also noted that although there was evidence of lessons being learnt and actions to improve patient experience being taken after complaint investigations this could be strengthened further.

**Actions:** An action plan has been developed in conjunction with divisions and clinical boards.
Learning and sharing learning from complaints

There is a great deal to be learned when patients or their relatives raise concerns. We use our monthly quality and safety bulletin to highlight and share that learning widely across our hospitals. We tell staff what needs to be done to prevent the concern recurring.

A complaint was received from patients’ next of kin about the death of their relative following discharge from the emergency department.

Action: This was thoroughly investigated and as a result we reminded staff they should be aware that if a patient dies on UCLH premises after recent discharge from (any) hospital the death must be referred to the coroner. We asked divisions to reinforce with staff that referrals of a death to the coroner are the responsibility of the treating clinician, and should be done by an appropriate clinician on the ward where the patient died. We provided a reminder of when a referral should be made. This includes when there are other concerning features that need to be explained to the coroner and could include where the patient was discharged from hospital and died unexpectedly soon after the discharge or if family raise concerns about care. We reminded staff that if they are unsure about whether to make a referral to the Coroner, it is recommended they discuss the matter with their clinical lead.

We received a couple of complaints in the Cancer division in which a chaperone had not been offered.

Action: We have produced a policy for staff on chaperoning. The policy requires clinical staff to explain the nature of any examinations at the earliest point possible in the consultation, ensure that patients are offered a chaperone, document the choice to have/not have a chaperone made by the patient and highlight any difficulties in obtaining a chaperone to the nurse in charge /matron/manager. In the UCH Macmillan Cancer Centre stamps for the clinical notes have been made available to make this easier for staff.

A patient with a learning disability complained that the complaint response from UCLH was difficult to read and ‘inaccessible’.

Action: We now offer an ‘Easy to Read’ version of the complaint response to patients with a learning disability. Our clinical nurse specialist for patients with a learning disability provides support with the production of Easy Read documents for complaint responses. We offer help for staff communicating with patients with a learning disabilities on the UCLH intranet.

When care does not meet our expected standards.

One complaint highlighted the importance of team working and good communication and the importance of risk assessment and escalation. An elderly patient was admitted with a history of Alzheimer’s and falls resulting in a fracture. He was transferred a number of times and was primarily being cared for as an ‘outlier’. The patient’s next of kin complained about the overall lack of care and support for him, poor pain control and weight loss during his time in hospital and about arrangements for discharge. Although the nursing staff had risk assessed the patient as high risk for nutritional problems, this was not reassessed or escalated to the nurse in charge or the dieticians in a timely manner, and there was also lack of recognition of his ongoing reduced food intake.

Action: When this was noted, escalated and a multi-disciplinary approach used, with dietician involvement, medical staff prescribing supplements, nurses encouraging the patient and family to try small amounts often, the weight loss stabilised.

This is an unusual complaint that demonstrates many risk factors / red flags that feature in the lead up to patient incidents or complaints. We reinforced with staff that they need to pay extra attention to counter the risk when they recognise multiple ‘red flags’/ risks.
RED FLAGS

<table>
<thead>
<tr>
<th>Patient Factors</th>
<th>Care delivery factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly</td>
<td>‘Outlying’ on a ward</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>Multiple transfers</td>
</tr>
<tr>
<td>Few visitors</td>
<td>Lack of escalation</td>
</tr>
<tr>
<td></td>
<td>Discharge planning did not start on admission</td>
</tr>
<tr>
<td></td>
<td>Lack of continuity of staff</td>
</tr>
</tbody>
</table>

We are introducing ‘nutrition buddies’ to each ward and a nutrition Darzi fellow is in post who has objectives connected to the nutrition screening tool assessments and ensuring patients are accurately assessed on admission, transfer and when their condition changes.

Being open when things go wrong – getting it right for patients. We shared the following messages to encourage staff in being open and honest in letters and in having difficult conversations with patients/families. They appreciate openness and transparency and this may reduce distress and anxiety when there is moderate or severe harm.

During a serious incident investigation meeting with the family concerned, under the duty of candour the patient’s father said that “he was surprised to hear the trust being so honest about the mistakes that had been made, this is not what they had expected and he was grateful that there was no attempt to sweep these issues under the carpet.”

A complainant fed back to the complaints team: “how pleased he was with the response he just received from the chief executive, with a letter. He said he was surprised that the investigation was very thorough and with the outcome. He said he has nothing but praise.”

A complainants’ feedback to the divisional manager: “Mxxx welcomed the opportunity to explain to you about the events of 19th November. We both appreciated the care and attention that has been shown in response to our complaint.”

Early Response to patient worries: We encourage staff to intervene early with a ‘phone call if a patient needs more information, or has concerns. The complaints team shared this example of a patients’ response when the division responded quickly to her concerns with a ‘phone call.

“, …I did receive a phone call last night from a senior member of staff from endoscopy which I’m very thankful for, I was able to explain the issues that occurred during my test which was all I needed to do, so it can help with further treatment. I really appreciate everything that you and the senior member of staff from the endoscopy department have done for me, thank you so much. Kind regards”.

This may have averted a formal complaint.

A relative bringing a patient with a disability to the hospital complained about disabled parking availability.

Blue badge holders wishing to park on the UCLH site must have a dispensation notice. We changed the rules to enable patients with a disability to obtain a dispensation notice before coming to the hospital. Previously, they would have to make three journeys from their car to the hospital - one to get a notice from reception staff, one to park their car and one to go back to the hospital. Now, visitors with a disability can simply park and get to their appointment. We also now employ parking attendants to ensure that disabled spaces at the hospital are used correctly at all times.
Issues with appointments: administration and process issues

Data from complaints has been used to drive improvements by divisions and also the Trust transformation programme. However unsurprisingly given the large number of outpatient appointments at UCLH, these issues continue to be raised. At the time of this report the national figure for complaints linked to appointments is 6 percent compared to UCLH 7 percent.

**Action :** Further work is planned with the access and transformation team for the coming year but divisions and specialties were asked to look at their processes in particular for managing multiple cancellations and short notice cancellations.

A patient with a rare condition had a number of problems with nurses and doctors during their care pathway

The matron met with the patient and apologised and explained how they had fed back her experience through a series of safety huddles on the ward, and presented an anonymised (confidential) version of her pathway and experience at the local governance group, so that the whole team became aware of the impact on the patient. Formal educational sessions on the patient’s rare condition were also arranged for key medical and nursing staff so that future patients would not have the same experience.

The patient was very happy with this resolution.”

7. **REFERRALS TO THE PARLIAMENTARY HEALTH SERVICE OMBUDSMAN (PHSO)**

The Parliamentary and Health Service Ombudsman (PHSO) is a free and impartial organisation that makes final decisions on complaints that have not been resolved by the NHS in England and UK governments and other public organisations. They receive 8000 complaints a year and go on to investigate about 50 percent (but will ask for medical records and complaint files on many more.) They will not usually investigate unless the organisation has completed their own investigation. In deciding to investigate they will consider:

- Whether the person been personally affected
- Whether they complained to the PHSO (or MP) within a year of the matter becoming known**
- Whether they have or has the option of a legal route**
- Whether there are signs that the organisation potentially got things wrong that has had a negative effect on the complainant that has not been put right.

Overall the PHSO upholds or partially upholds approx. 37 percent of the cases it investigates nationally, and finds that in:

- 1 in 5 of the complaints are due to poor communication
- 1 in 4 show failures in decision making
- 1 in 5 the organisation has arrived at the wrong conclusion or used incorrect guidance

The PHSO periodically releases papers, to try to share learning across the NHS. In 2016 they reviewed complaints across the NHS linked to serious harm / death. Key findings were inconsistency in quality of investigation with many cases not reported as a serious incident.

UCLH reviews all complaints it receives against incidents that have been reported and considers serious incident reporting criteria, using safety huddles or 72 hour reviews. In line with national guidance on mortality governance we have made learning from deaths a quality priority for 2016-
17. Complaints received raising concerns about deaths will be screened and will feed into this process.

Complaints to the Parliamentary and Health Service Ombudsman

In 2016/17 there were 96* contacts by patients or their relatives with the PHSO. Most of these were considered premature by the PHSO; the complainant had either not made a complaint to us or their concerns were still under investigation. This is a slight increase on the previous year (91 for 2015/6). Of the 96 contacts received by the PHSO, 30 were then investigated, compared to 24 in the previous year, an increase of 25 per cent. This data was based on the data that had been provided to the Trust over the year, however these figures changed when the PHSO provided their working data to us in June.

Over the past year, 12 PHSO investigations (some relating to previous years) were partially upheld (partly agreed), with the outcome being an apology, an action plan to rectify the failures that were identified and in some cases a financial settlement. Sixteen cases remain open from 2015/16 and one from 2014/15 at the time of this report. This makes analysis of the data challenging.

If the PHSO accept a case they may now consider no further action is needed, or may partially or fully uphold the complaint and may request an action plan, apology and possible compensation.

Table 7: PHSO cases Comparison across Shelford Groups

<table>
<thead>
<tr>
<th>Trust complaints 2016/17</th>
<th>PHSO referral</th>
<th>Cases accepted</th>
<th>Cases closed</th>
<th>Upheld</th>
<th>Partially upheld</th>
<th>Not upheld</th>
<th>Percentage upheld/ partly upheld**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham 779</td>
<td>64</td>
<td>17 (2.3 per cent)</td>
<td>27</td>
<td>0</td>
<td>12</td>
<td>14</td>
<td>45 per cent</td>
</tr>
<tr>
<td>GSTT 1198</td>
<td>66</td>
<td>9 (0.8 per cent)</td>
<td>19</td>
<td>0</td>
<td>3</td>
<td>16</td>
<td>16 per cent</td>
</tr>
<tr>
<td>Cambridge 503</td>
<td>28</td>
<td>3 (0.5 per cent)</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>38 per cent</td>
</tr>
<tr>
<td>Imperial 1166</td>
<td>72</td>
<td>14 (1.2 per cent)</td>
<td>22</td>
<td>2</td>
<td>7</td>
<td>12</td>
<td>41 per cent</td>
</tr>
<tr>
<td>Newcastle 541</td>
<td>55</td>
<td>19 (3.5 per cent)</td>
<td>24</td>
<td>1</td>
<td>11</td>
<td>11</td>
<td>50 per cent</td>
</tr>
<tr>
<td>Central Manchester 1026</td>
<td>69</td>
<td>17 (1.7 per cent)</td>
<td>32</td>
<td>3</td>
<td>7</td>
<td>18</td>
<td>31 per cent</td>
</tr>
<tr>
<td>Oxford 1093</td>
<td>27</td>
<td>12 (1.1 per cent)</td>
<td>20</td>
<td>2</td>
<td>7</td>
<td>9</td>
<td>45 per cent</td>
</tr>
<tr>
<td>Kings 1034</td>
<td>84</td>
<td>17 (1.6 per cent)</td>
<td>29</td>
<td>2</td>
<td>10</td>
<td>10</td>
<td>41 per cent</td>
</tr>
<tr>
<td>UCLH 769</td>
<td>64</td>
<td>16 (2.1 per cent)</td>
<td>24</td>
<td>2</td>
<td>10</td>
<td>7</td>
<td>50 per cent</td>
</tr>
</tbody>
</table>

** although cases may not be closed in the same year, this is the easiest way to try to compare organisations given the limited data available but does not reflect a true percentage.

It is difficult to analyse any Ombudsman data until the PHSO releases its official figures due to the number of premature or repeat cases and our local data is therefore never the same as that which
the PHSO holds, as they will count repeat contacts as ‘new’ cases whilst we would consider it the same patient / case if it relates to the same complaint. The data has been shared with the Shelford group by the Ombudsman as the official data is still not ready for release. This shows that between 16 – 50 percent of cases that were accepted by the PHSO and closed in 2016/17 were upheld for this particular group of hospitals.

Why has there been an increase in partially upheld cases, and is this a concern?

There was a backlog of PHSO investigations due to the large increase in cases accepted nationally for review since 2013, this meant that UCLH received a large batch of decisions in both 2015/16 and 2016/17 compared to previous years.

There was an overall increase in percentage of cases going to the PHSO compared to complaints received in 2016/17, but this will include cases from earlier years.

The PHSO cases are spread across the organisation and no single area emerges as a concern, but surgical cases are more common than non-surgical ones.

For action: Further exploration of PHSO data with Shelford group and monitoring of trend over coming year

Thematic review of PHSO cases:

No single division is an outlier for cases that are upheld, and many PHSO cases have spanned several divisions.

Main Themes from review of partially upheld complaints by the Ombudsman

- Inadequate communication to patient or relatives (in most cases)
- Inadequate or missing documentation (in some cases)
- Consent process has not included documented risk / benefit or various treatment options including option for no treatment (in some cases)
- Pathway delays (in some cases)
- Inadequate complaint investigation, failure to cover all issues in complaint response (in a few cases)
- Complaint Maladministration (in some cases) – responses took too long and the complainant had not been kept updated

Financial implications: financial redress was recommended in 8 out of the 12 cases partially upheld cases.

Action plans may be requested by the PHSO in response to the outcome of their investigations. It has been challenging to obtain action plans for the PHSO in a timely manner, with updates on completion of the action plans equally challenging to obtain.

Action: Review process for completion of action plans with clinical boards taking more responsibility in developing and tracking completion of these

Actions to reduce complaint maladministration findings:

Complaints team: To Provide training on complaint handling

Divisions: to ensure sufficient staff are trained in investigating and responding to complaints

Both: Consider ways to improve response times
Examples of Learning from Ombudsman's cases

A patient complained to the ombudsman about the results given to them by UCLH, when a different diagnosis was made overseas

The PHSO investigated and concluded that we had carried out tests recognised in the UK as the gold standard for making a diagnosis and these had been negative. The complaint was therefore not upheld (not agreed).

A relative was unhappy with a number of aspects of their relative's care. UCLH's investigation had already partially upheld their concerns.

The PHSO case looked at the consent process for the complex surgical procedure and recommended a review of some of the pre-operative tests and how these were documented. They also recommended improving written patient information and documentation during ward rounds. The consent process had originally been considered appropriate by UCLH. The overall case was upheld (agreed). A payment was provided to recognise the failures identified and an action plan is being developed. This will also feed into the improvement work on consent planned for next year.

A patient had been referred for a specialist opinion, but the patient was not given a definitive diagnosis

During a series of tests, some incidental findings were noted but the consultant had not recommended following these up with a further referral to another specialist team. This delayed definitive treatment for the patient. The case was subsequently discussed within the medical team and a reminder of the importance in asking the GP to consider further referrals when unexpected results are noted.

Concerns about delay in responding to an infection were raised

Although there were clinical reasons to request more tests prior to an operation, on review it was agreed that antibiotics and surgery should have been considered earlier. The report was shared with the Improving Sepsis team and used to illustrate why the campaign for prompt treatment of infection is important.

A patient was unhappy with the information they had been given prior to surgery.

The PHSO case looked at the consent process for the procedure and recommended an improvement in documenting the discussions and information given prior to consent. They also recommended reviewing written patient information and improving clarity of documentation that this had been supplied. The consent process had originally been considered appropriate by UCLH. The overall case was partially upheld (agreed). A payment was provided to recognise the failures identified and an action plan is being developed. This will also feed into the improvement work on consent planned for next year.
8. COMPLAINT MANAGEMENT AND COMPLIANCE

Board engagement

The medical directors, chairman and Chief Nurse have always played very active roles in the complaints process, in reading complaints and raising issues raised by complaints with their teams and in a variety of meetings. All complaints and responses are shared with the Chief Nurse, Chairman, and a non-executive director (on a rotational basis) and signed off by the Chief Executive. Significant complaints and all PHSO cases are also shared with the medical directors and heads of nursing. The non-executive director who chairs the patient Experience committee has had regular contact with the complaints manager.

UCLH is involved in the Shelford Complaints forum which explores best practice and shares learning from complaints management.

External Reports and Visits

The new Ombudsman hopes to visit UCLH in 2017/18. There was no CQC inspection during this calendar year.

Improving quality of responses

Whilst the majority of the complaint responses appear to satisfactorily resolve the concerns raised, there are a number of complainants who return to the Trust with additional queries, follow up questions or re-contacts for areas that require clarification. In some cases a complaint may require a full reinvestigation, especially if new information is provided.

- In 2010/11 UCLH had a 10 percent reinvestigation/ recontact rate.
- In 2011/12 UCLH continued to have a 10 per cent reinvestigation / recontact rate.
- In 2012/13 UCLH experienced a drop in reinvestigations / recontacts to 7 percent.
- In 2013/14 UCLH had a 8 percent reinvestigation / recontact rate.
- In 2014/15 UCLH had a 8.5 percent reinvestigation / recontact rate.
- In 2015/16 UCLH had an 11 percent reinvestigation/ recontact rate.
- In 2016/17 this reduced to 8.5 percent.

It is hoped that the complaints handling training provided in 2016/17 has improved the quality of responses provided to complainants but it is not possible to state this for certain. Some of the reinvestigations are logged when a meeting is planned as part of the response and it is felt that this might be affecting the data for some divisions.

A small number of complainants (6) have also re-contacted the department after receiving their response to thank us for the explanation provided and the actions the trust plan to take.

Action: Continue to monitor reinvestigation rate and complaints that go to the Ombudsman to establish themes for dissatisfaction with initial response and to establish if further improvements can be made.

Use anonymised examples of ‘best practice’ complaint responses or phrases for training purposes in one to one or group sessions.

Explore ways to establish complainant satisfaction with the process and response they receive.

Explore the criteria Shelford group use for recording reinvestigations to ensure consistency.
Education and development

The Complaints team have run a series of workshops on handling complaints, with over 100 staff receiving training.

A series of teaching materials have been developed and shared with staff.

Complaints team staff have presented at audit days as Queen square, Eastman Dental and RNTNE in 2016/17 with over 300 staff attending these sessions.

The complaints team have also had input into the Senior Staff Nurse Development programme with sessions on dealing with concerns effectively and handling more formal complaints.

**Action:** To review if complaint training should become mandatory for some staff

To provide further educational sessions on responding to concerns and complaint handling

How can we be reassured that patients and relatives know how to complain?

A leaflet explaining the complaint process and also how to contact PALS has been in use since 2008, it was last revised in February 2016.

7000 complaint leaflets were distributed in 2016/17 across the trust. More complaints and contacts were received in 2016/17.

The Trust website has an online complaints form. The complaints team assist patients in making a complaint and provide advocacy details when additional support is required.

In 2015/16 the website was checked and slight adjustments made to make it easier to make an online complaint or raise a concern.

In 2013/14 a welcome pack was introduced for all patients undergoing an elective admission. This contained a section on how to raise a concern or make a formal complaint.

In 2014/15 – stickers were added to the bedside for patients to be able to contact a senior member of staff if they had concerns about care.

Environmental walk-rounds involving wide selection of staff and governors take place, part of the checklist is to check availability of complaints forms and obtain feedback from patients.

It is hoped that this would increase feedback and awareness of how to raise a concern or to complain and the complaints team work with divisions to ensure any matter that is raised is reviewed to see if prompt actions can resolve any concern without it needing to become a formal complaint.
Working with other organisations

The 2009 Complaints Regulations require organisations to offer complainants the option of a joint response when their concerns cross the boundaries of NHS care providers.

The Trust currently asks the complainant for consent to share a complaint with another organisation. During 2016/17 the Trust received 17 complaints which required co-operation with another organisation. This is a reduction from 35 for 2015/16, after a big increase from 10 in 2013/14.

All the complaint files were reviewed against the following criteria:

- Patient consent was obtained in order to share information between organisations

Conclusion

All complaints requiring joint working across organisations were managed in line with the policy, and joint responses provided either by UCLH or via another organisation.

Audit of Complaint Process

Internal auditors looked at the complaints process this year. The audit found ‘significant assurance with minor improvement opportunities’. It highlighted that there were processes for learning lessons in place at divisional and trust-wide level. For example, the quality and safety bulletin was used to share lessons from complaints and good complaints handling practice. Areas for improvement included improving response times and communication with complainants if delay occurred.
Compliance with Complaint Process:

a) acknowledging a complaint
KPMG conducted an audit in 2016/17 that showed most contacts were acknowledged within 3 days, but that sometimes more information was needed before investigations could take place.

b) responding to a complaint
UCLH has a flexible approach to complaint response times, and seeks to negotiate the time period with the complainant wherever possible, in line with the revised NHS Complaints Guidance (2009) which removed the 25 day target.

Many issues may be resolved during the initial phone call and all divisions are encouraged to involve the complainant in determining what they are hoping to achieve from their complaint, with many immediate actions being taken. eg booking a clinical appointment, arranging a meeting

We recognise that some complaints may take considerably longer where multiple divisions or organisations are involved. Monitoring timescales is therefore based on whether the negotiated target is met.

Table 8: response times

<table>
<thead>
<tr>
<th>Year</th>
<th>Response within 25 working days or negotiated target</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/17</td>
<td>75 per cent</td>
<td>Slight improvement in performance but not meeting target</td>
</tr>
<tr>
<td>2015/16</td>
<td>72 per cent</td>
<td>Deterioration in performance</td>
</tr>
<tr>
<td>2014/15</td>
<td>73 per cent</td>
<td>Deterioration in performance</td>
</tr>
<tr>
<td>2012/13</td>
<td>84 per cent</td>
<td>Marginal deterioration in performance</td>
</tr>
<tr>
<td>2011/12</td>
<td>85 per cent</td>
<td>Slight improvement in performance</td>
</tr>
<tr>
<td>2011/10</td>
<td>81 per cent</td>
<td>Baseline</td>
</tr>
</tbody>
</table>

Adhering to the response date and providing a high quality response in the allocated time frame continues to present a challenge for some Divisions, with a reduction in meeting response times unfortunately noted for the last few years.

Where performance within divisions consistently fell below target, this is escalated to the relevant division and then medical director for comment and action. The reasons for delay are multifactorial and may include difficulties contacting the patient to discuss their complaint, notes not being available to the investigator, general workload, especially when a clinical reviewer is needed or absence or changeover of staff.

Although some of our patients indicate they are not concerned by how long their response takes, as they want to know that a thorough investigation has occurred and that we have learnt from the
issues they have raised, for others a long response time may add to their distress and anxiety. A failure to update the complainant can very distressing and is a common reason for dissatisfaction with the complaint process.

**Action**

Ensure staff agree realistic deadlines for complex complaints when speaking to complainants

Consider experimental performance metric to monitor complaints that take longer than 65 working days

Work with performance and the clinical boards to improve response times and to ensure that complainants are kept updated when delays occur.

Explore with the Shelford Group whether other approaches could be considered.

**Ensuring Equal Access**

The Trust endeavours to make the complaints process easy to access and equitable, in the following ways:

- Support is provided to complainants who wish to make a complaint but for whatever reason are unable to write in to the Trust or make the complaint themselves. Approximately complainants were supported in this way by a member of the complaints team in 2016/17, however this is probably an under representation due to data capture methods.

- Easy read complaint leaflets are available on the website and also the trust’s Clinical Nurse Specialist has been involved in supporting complainants with learning disabilities when they have complained.

- A patient with autism has shared their experiences with the clinical team in a forum led by the Trust’s CNS for Learning Disability.

- Complaints responses are translated on request and during 2016/17 only one requests for translation was received and actioned.

- All complainants are given information about accessing advocacy services via the complaint leaflet and acknowledgement letters.

- Complaints data is found alongside other data within the Trust’s Equality and Diversity report and is only summarised briefly in this section to meet NHS Complaint report guidance.

- An emerging issue has been identified with the provision of British Sign Language interpreters in Q4 and this is being monitored by the Trust and arrangements are under review to facilitate timely interpreting is available for deaf patients.

- Further analysis is provided to the Trust’s annual diversity report.

**Action**: Continue to explore ways to review complaints process to ensure equal access.
Fig 17: Complaints By Gender

![Pie Chart: Gender Distribution]

- Female: 64%
- Male: 36%
- Unknown Gender: 0%

Fig 18: Complainants by Age

![Bar Chart: Age Distribution]

- 0 to 5: 0
- 6 to 17: 0
- 18 to 25: 40
- 26 to 55: 360
- 56 to 64: 100
- 65 to 74: 70
- Over 75: 20
- Not noted: 10
Ethnicity

Ethnicity data is drawn from CDR / EPR and is linked to the patient not the complainant as per NHS guidance. This metric is now not included in KO41 returns.

Please note that where a complainant is not a patient this data is not available, eg visitor, relative etc. It is not possible to separate out ‘not stated’ from those who do not wish to provide this data, but there was an increase where no ethnicity data was provided.

Table 9: Ethnicity of patients as appearing on Carecast

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not stated</td>
<td>331</td>
</tr>
<tr>
<td>White - British</td>
<td>255</td>
</tr>
<tr>
<td>White - other white</td>
<td>67</td>
</tr>
<tr>
<td>Other ethnic category</td>
<td>32</td>
</tr>
<tr>
<td>Black African</td>
<td>18</td>
</tr>
<tr>
<td>Indian</td>
<td>15</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>14</td>
</tr>
<tr>
<td>Other Asian</td>
<td>9</td>
</tr>
<tr>
<td>White - Irish</td>
<td>6</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>6</td>
</tr>
<tr>
<td>Other Black</td>
<td>6</td>
</tr>
<tr>
<td>Pakistani</td>
<td>5</td>
</tr>
<tr>
<td>Other mixed</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Mixed white and black Carribean</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Mixed white and black African</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Mixed white and Asian</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Chinese</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

Methods of accessing the complaints process

The Trust offers a range of options for raising complaints: leaflet, letter, email, in person, by phone

Fig 18: Trend of method of contact for complainants
The ongoing rise in emails brings challenges as some people may expect an instant response and often do not include enough information to start the investigation. An automated receipt has been developed informing patients that they should receive further contact within 3 days, although the aim is always to try to respond that or the next working day.

Most written complaints are submitted independently, but provision is made to support complainants when this is not possible. For example noting their concerns made via telephone and in person, these are then sent back to the individual to confirm an accurate representation of the issues they want the trust to investigate. All complainants are provided with information about the Independent Complaints Advocacy Service as they are better placed to support patients draft complaint letters and provide independent support.

The leaflet in 2016 was changed to be for information only, not to submit their complaint as this was felt to limit space for complainants to describe their experience.

Complaints may come from advocates, solicitors, MPs, and GPs. All complaints are treated equally regardless of the source and consent is obtained when appropriate.

Letters from GPs will be shared with the Trust’s GP Enquiries team and any learning will be anonymised and shared via the GP newsletters when relevant.

**Use of initial contact sheet / telephone contact, compliance with Trust Complaint’s Policy**

As part of the monitoring of compliance with the Complaints Policy two elements were selected for the monitoring by ‘mini audit’ which reviewed a selection of complaints throughout 2016/17

- Use/completion of the initial contact sheet
- Making the initial telephone call to complainants

<table>
<thead>
<tr>
<th>Table 10: Complainant Contact Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Qtr1 and 2</strong></td>
</tr>
<tr>
<td>Evidence to support contact call was made within 5 days</td>
</tr>
<tr>
<td>Call made but after 5 days</td>
</tr>
<tr>
<td>No evidence</td>
</tr>
<tr>
<td>patient had initially raised complaint to a member of staff or had requested written response or staff had tried but could not contact so letter sent</td>
</tr>
</tbody>
</table>

It was disappointing that there was less evidence on the data base of contacting complainants to discuss their complaint for the year but due to use of temporary staffing in complaints in Q1 and Q2 this may be a data collection issue. In Q1 and Q2 the complaints team had 6 documented contacts chasing a phone call and in Q3 and Q4 this had increased to 12

However there are some challenges to making a call, many patients are not available during the day, trust phone numbers appear on mobiles as ‘withheld’, which can be off putting to some complainants and not everyone has a voicemail to leave a return contact. Staff may also not want to leave messages about complaints and would prefer to speak to the complainant. The complaints
team have encouraged staff to let them know if contact cannot be made, so that a letter can be sent offering them to recontact us and this has happened more frequently in 2016/17 than last year.

**Action:**
To amend acknowledgment letter and emails to explain about withheld numbers from trust extensions
To continue to engage with divisions to explore ways to improve contact with the complainant and use of the contact sheet or other feedback to confirm this has been actioned.
To ensure complaint team are capturing data accurately
To revise contact sheet to be more useful to divisions, not just capturing that a call has been made

9. **SUMMARY AND CONCLUSIONS**

UCLH has noted a 6.7 per cent increase in KO41 reportable complaints, against a backdrop of increased activity but this is above the overall national figure of an increase of 1.8 per cent. Staff try hard to resolve concerns at the earliest opportunity and there has been an increase in the number of contacts to the complaints team that are resolved promptly without the need for investigation. The time taken to respond to some complaints remains too long in some cases. This is supported by the audit of complaints carried out by KPMG in 2017 and action is needed to improve response times within some divisions and boards.

There is ongoing evidence that complaints are regarded by the organisation as a valuable gauge of the patient experience at UCLH. There is evidence that complaint responses regularly identify opportunities for individuals, departments, and the organisation to learn from complaints. Greater sharing of issues and solutions from all aspects of patient experience has been achieved in 2016/17 and this is supported by the internal audit in Jan – March 2017, which found evidence to support that learning was evident and changes were being implemented as a result of complaints. However opportunities exist to build on this further.

The incidence of reinvestigations and referrals to the PHSO has again increased over the past year, with an increase noted in partially upheld complaints but this remains small when compared to the overall number of complaints investigated by the Trust. This pattern is in line with most of the Shelford Group members but will be monitored in the coming year and those organisations with low PHSO referrals will be approached to see if any learning can be shared.

UCLH receives less clinical and patient care complaints than national figures, and also sees less end of life complaints. However areas for improvement from complaint data are communication, values and behaviours, administration and possibly transport but further analysis and comparison will be sought from Shelford to clarify the sub topics and confirm this is not a data capture issue.
## REVIEW OF ACTION PLAN FOR 2016 / 17

### Table 11: Review of recommendations from previous year’s annual complaints report

<table>
<thead>
<tr>
<th>Action</th>
<th>Leads</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Explore ways to improve response times</strong></td>
<td>DMs, DCDs, clinical boards, Performance and Complaints team</td>
<td>The escalation process for overdue complaints was revised. Divisions receive a weekly memo for all complaints due in the coming fortnight and the medical directors and heads of operations were made aware when complaints were significantly overdue. Periodic reports on delayed complaints have been circulated to the Trust. The performance team has monitored compliance with the clinical boards. Improvement was noted at year end (3 percent) but further work is needed to continue with this improvement.</td>
</tr>
<tr>
<td>2. <strong>Review complaints procedure in line with key reports and any legislative changes in financial year</strong></td>
<td>Complaints manager and other staff as required</td>
<td>There were no significant changes noted in this financial year so no amendments required to UCLH complaints procedure</td>
</tr>
<tr>
<td>3. <strong>Strengthen learning lessons across whole patient experience e.g.) Use of complaints data alongside other data sets such as clinical incidents and PALS for responsive reports or comparisons against key national reports</strong></td>
<td>Head of Quality and Safety, site leads, clinical boards and Complaints manager</td>
<td>This was achieved in a number of ways such as sharing lessons from complaints and Ombudsman cases via the Trust wide quality and safety newsletters. Site improvement groups use complaint data. Quarterly reviews from complaints are shared with some subject matter experts such as end of life, nutrition and medication safety. A six monthly report on issues arising from nursing care complaints is shared with the Chief Nurse and the Nursing and Midwifery Board. It was felt on review that patient experience report would remain separate from the complaint report but complaints have been integrated into the quarterly experience report that is shared Trust wide and with commissioners</td>
</tr>
<tr>
<td></td>
<td>Consider methods to evaluate complaint handling</td>
<td>Complaint manager</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>5</td>
<td>Improve training materials for staff involved in investigating complaints</td>
<td>Complaint manager</td>
</tr>
<tr>
<td>6</td>
<td>Offer governors and non-executive directors (NEDS) the opportunity to visit the complaint team</td>
<td>Complaint manager</td>
</tr>
</tbody>
</table>
## 10: SUMMARY ACTION PLAN FOR 2017 / 18

| Action                                                                 | Leads                                                                 | Date Due               |
|------------------------------------------------------------------------|                                                                      |                       |
| **1** Trust Objective : To improve patient experience                   | DMs, DCDs, clinical boards Performance and Complaints team           | April 2018             |
| Complaint team objectives aligned to this :                             |                                                                      |                       |
| a) Explore ways to further improve response times and communication to complainant |                                                                      |                       |
| b) Explore development of complaint handling training via e learning with education team and implement further face to face training for staff building on the success of 16/17 |                                                                      |                       |
| **2** Trust Objective : To improve how we learn                         | Quality and safety team, IEG, DMs DCDs, Clinical Boards             | October 2017           |
| Complaint team objectives aligned to this :                             |                                                                      |                       |
| a) Improve board and trust wide feedback following complaint investigations through Patient Safety Committee |                                                                      |                       |
| b) Improve trust wide learning from when things go wrong, and when patients die. We will do this by linking with the Mortality (deaths) surveillance group and the Patient Safety team when complaints of this nature are received |                                                                      |                       |
| **3** Review complaints procedure in line with key reports and any legislative changes in financial year | Complaints manager and other staff as required                      | As required            |
1. Introduction

1.1 This report updates the Board of Directors on the issues considered at the meeting of the Finance and Contracting Committee (FCC) on Wednesday 6th September 2017, which includes the Trust's financial position as at 31st July 2017.

1.2 The Board of Directors is asked to:
- Note the financial performance for the first four months of the 2017/18 financial year, and associated financial issues,
- Note the adoption of the strengthened approach to financial recovery and the proposed use of Board contingency to fund the additional investment in turnaround support.

2. Financial Performance

2.1 The July in-month position (before donation adjustments and other exceptional items) showed a deficit of £0.7m, £2.9m worse than plan. The overall reported year-to-date position before donation adjustments is a £1.9m deficit (£2.4m adverse variance against plan) includes £4.8m from the disposal of the Trust’s share of its joint venture, Radiology Reporting Online (RRO). Excluding this exceptional item the underlying year-to-date deficit is £6.7m, an adverse variance to plan of £7.3m.

2.2 The Committee noted that the overall picture was driven by unidentified or under-delivery of CIP as well as other specific financial challenges in the five divisions currently within the special measures and enhanced monitoring process.

The month 4 financial position is set out in Table 1 below:

<table>
<thead>
<tr>
<th>Month 4 financial performance</th>
<th>Year-to-date</th>
<th>In-month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget £m</td>
<td>Actuals £m</td>
</tr>
<tr>
<td>Trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>2.5</td>
<td>2.0</td>
</tr>
<tr>
<td>Specialist Hospitals</td>
<td>21.0</td>
<td>15.6</td>
</tr>
<tr>
<td>Surgery &amp; Cancer</td>
<td>2.7</td>
<td>1.5</td>
</tr>
<tr>
<td>Research &amp; Development</td>
<td>-</td>
<td>0.1</td>
</tr>
<tr>
<td>Education</td>
<td>(1.1)</td>
<td>(1.0)</td>
</tr>
<tr>
<td>Corporate directorates</td>
<td>(67.2)</td>
<td>(68.8)</td>
</tr>
<tr>
<td>Other corporate budgets</td>
<td>65.2</td>
<td>56.0</td>
</tr>
<tr>
<td>EBITDA</td>
<td>23.2</td>
<td>15.4</td>
</tr>
<tr>
<td>ITDA</td>
<td>(22.7)</td>
<td>(22.1)</td>
</tr>
<tr>
<td>I&amp;E before exceptional items</td>
<td>0.5</td>
<td>(6.7)</td>
</tr>
<tr>
<td>Exceptional items (control total)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Profit on disposal of RRO</td>
<td>-</td>
<td>4.8</td>
</tr>
<tr>
<td>Performance against control total</td>
<td>0.5</td>
<td>(1.9)</td>
</tr>
<tr>
<td>Exceptional items (non-control total)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donations/donated asset adjus</td>
<td>(0.4)</td>
<td>(0.1)</td>
</tr>
<tr>
<td>Additional 1517 STF</td>
<td>-</td>
<td>0.4</td>
</tr>
<tr>
<td>Net surplus/(deficit)</td>
<td>0.1</td>
<td>(1.0)</td>
</tr>
</tbody>
</table>

Table 1 – 2017/18 month 4 financial position

2.3 The Committee also noted the following key features of the year-to-date position:

  a) No release of Board contingency.
b) The application of agreed contractual payment terms for North Central London activity above plan (and mirrored internal marginal rate application across all activity).

c) Sustainability and transformation funding (STF) of £3.2m, which had been accrued into the position to reflect full achievement of financial and operational targets at the end of Q2.

d) A further allocation of STF relating to the 2016/17 financial year, which was made after the submission of final accounts.

The Committee noted that as NHS Improvement adjusted the Trust’s control total performance by this amount; it would be shown as an exceptional item for the purposes of in-year reporting.

2.4 The Committee noted that at month 3 the Trust had adjusted its 2017/18 year-end forecast, reported to NHS Improvement. This was as a result of the approval of the EHRS business case, which was expected to have a revenue impact in 2017/18 of around £10m. The Committee noted that the Trust expected to fully mitigate this increased cost through the profit on disposal of RRO (£4.8m) and Global Digital Exemplar (GDE) “fast follower” funding (£5m).

As the GDE funding was not yet confirmed as revenue, the forecast had been adjusted downwards by this £5m, which, together with an additional £5.2m loss of Q4 STF as a direct result of this, meant that the forecast showed a total shortfall of £10.2m against the control total.

The Committee noted that if the Trust received formal confirmation of the GDE £5m being paid as revenue in 2017/18, then the forecast position would revert to assuming achievement of the Trust’s £9.8m surplus control total.

2.5 The Committee noted that the forecast still assumed a significant recovery of the operating position, through identification of CIP, mitigation of risks (including £4.5m assumed PFI support and risk to performance-related STF) and maintaining control of cost pressures. This would, however, require the whole organisation to focus on financial turnaround and recovery, with all areas needing to maintain and/or improve their run-rate financial performance.

2.6 The Trust’s cash position at 31st August 2017 (month 5) was £105m, which was £20m higher than the planned cash balance of £85m. This was mainly due to year-to-date operating receipts, including £29m of 2016/17 STF, that were significantly better than plan.

3. Other Financial Issues

3.1 The Committee was presented with an additional pack of trend information that had been developed to help build further understanding of current trust-wide financial performance, comparing performance to prior periods as well as to plan.

The Deputy Finance Director explained that this information had been adjusted in order to present a comparable picture, for example, by removing significant non-recurrent items and adjusting for inflation and tariff impacts.

The Committee noted that whilst the information did not, at this level, provide answers as to specific issues it did help provide a useful indication of areas to probe and analyse further.

3.2 The Finance Director drew the Committee’s attention to a briefing from NHS Providers outlining:

a) A set of proposed changes to the Single Oversight Framework (SOF), which outlined the factors under each of five themes that trigger NHS Improvement to consider a support need and to risk assess NHS trusts, and

b) The confirmed changes to the final Use of Resources (UoR) Framework, which had now been issued.
The Finance Director pointed out that whilst much of the SOF framework remained unchanged, the changes to the UoR Framework could result in a more significant impact. The Finance Director explained that the new UoR assessment would use key metrics to assess financial efficiency, including DNA rates, staff retention rates and reference cost based measures such as ‘doctors cost per weighted activity unit (WAU)’.

The Committee noted that whilst they were concerned about some aspects of the new framework, particularly the emphasis on “cost per WAU” that relied upon the accuracy of national reference cost data; the Trust should take immediate steps to implement a process of measuring and reporting performance against the initial set of financial efficiency/productivity metrics and to work towards delivering and demonstrating progress against these.

4. Financial Recovery Update

4.1 The Committee received an update on the measures that have been taken to-date in order to improve financial performance, including the role of the finance PMO, and the special measures and enhanced monitoring process.

4.2 The Committee recognised that the recent decline in the Trust’s financial position needed to be addressed and that a strengthened approach to recovery should be adopted in order to deliver a significant improvement in financial performance in a sustainable way.

4.3 The Committee agreed to the implementation of a package of turnaround support that involved:

a) A turnaround director, reporting directly to the Chief Executive and working as part of the Executive Team, providing assurance to the FCC and the Board. The turnaround director would lead a combined PMO, focusing on rapid improvement in the financial forecast/run rate for divisions/corporate directorates in special measures or enhanced monitoring, as well as overseeing delivery of the trust wide schemes.

b) A consolidation of PMO resources, refocused on opportunities with direct financial benefit or on financial risk.

c) Further strengthening of the PMO to enable it to provide sufficient 'on the ground' support as well as effective monitoring and tracking of progress and issues.

d) Refinements to governance and accountability structures and overall management of the Trust's financial performance programme.

e) External targeted support to specific areas where insufficient capacity was preventing progress or where targeted additional support would be likely to generate significant return.

f) Communications support, if required, in order to ensure that the messages around the programme were appropriately communicated.

g) Investment to improve internal processes that were agreed to be causing blockages to financial improvement.

4.4 The Committee was also presented with an estimated cost of the additional investment, including cost of the turnaround director and the approximate cost of additional consultancy and interim support in targeted areas.

The Board of Directors is asked to note the proposed use of Board contingency to fund the cost of the additional investment in turnaround support, the value of which would be confirmed in the coming weeks.
The Workforce Committee held its latest meeting on 5 September. The Committee adopted a new three-part structure for its session which it intends to apply for each of its remaining meetings this financial year:

i) an opening review of performance against our six annual objectives for the year (for workforce and education

ii) a review of a new proposed framework for future workforce strategy for the trust and

iii) a deep dive into one of the themes of that prospective strategy.

2. In year performance against annual objectives for 2017/18

The Committee began its September session by reviewing performance against each of the six annual objectives that support our strategic priority to support the development of all our staff.

We focussed on sub-objectives that were at risk or for which it was felt a new initiative could help into 2018/19. The following notes detail the key observations made by the committee per such area.

i) Improve staff experience

The committee discussed forecast challenges this autumn and winter for staff as UCLH faces growing financial and service challenge. Executive members clarified their intention to encourage leaders to focus on sustaining and improving staff experience. The imminent launch of the second phase of the ‘where do you draw the line?’ campaign would be one part of that effort.

ii) Improve the quality of education and development

We discussed progress on apprenticeships, where take up was below target. The Director of Education detailed action in progress to further enhance take up and alliances with training and education partners to allow further opportunities for new apprentices.

iii) Demonstrate that we are an employer of choice

The Workforce Director clarified that he shortly intended to write to the Department of Health to ask that we be able to publish our 2017 staff survey results this year. Normally the annual survey results are not released for 3-5 months after the survey period, which limits their value.

The committee were interested in discussing ways in which the appraisal system could be improved in 2018/19 inclusive of its relationship with talent management
and leadership development. We intend to return to give this area further consideration.

iv) Improve conditions for junior doctors and staff in training

The GMC survey is one of the main sources of feedback from our junior doctors in training posts. This year the Trust received 41 red flags (negative outliers) and 41 green flags. The Trust is required to respond to negative outliers when there are 3 or more outliers in one programme, when the outlier is in a key domain (clinical supervision, clinical supervision out-of-hours, educational supervision, workload and overall satisfaction) or when the same domain in a programme has been negative for three years running. Health Education England’s approach to negative outliers has changed this year, with more visits being undertaken in response to the negative outliers. Programmes which have had 3 or more negative outliers are clinical oncology, obstetrics and gynaecology, intensive care medicine, neurology and neurosurgery. Dr Prvulovich, UCLH’s Director of Postgraduate Medical Education will meet with our Trust Liaison Dean on Thursday 7th September to discuss the Trust’s results and to confirm which areas might be visited in due course.

v) Collaborate with STP and others to design and develop the future health care workforce

The Committee were assured of credible progress on each of the projects that UCLH is leading on behalf of the STP. The staffing bank procurement process is expected to get to a preferred provider decision by end of September.

vi) Develop our staff to achieve transformational change

There was recognition of the investment being put into change training for managers in preparation for EHRS. In later committees, non-executive colleagues expressed interest in understanding the wider investment in change management envisaged in preparation for EHRS.

3. Strategic workforce framework

The Committee reviewed the emerging framework that executive colleagues have worked up for future strategic workforce priorities. The purpose of the framework is to help think about future objectives; to allow our future strategy to translate into credible action; and to allow a fresh credible basis to meet our future organisational strategy into and beyond 2018/19.

The model has four simple components: right staff; right capabilities; right way; and right leadership. It shall be developed through further engagement with the Executive and colleagues in coming weeks.

In discussion, the Committee stated:

i) they felt confident in the emerging model and the draft descriptors of its four components;

ii) more thought needed to be given to how we could better balance our interest in responding to future staff’s needs of us as an employer e.g. through more flexible employment offers;

iii) they understood Senior Directors’ wish to further test and enhance the model in coming months; and

iv) in the meantime, it should prove a helpful model to test the Trust’s readiness for forecast challenge and opportunities.
4. Right leader

The Committee then focussed on ‘right leader’ to consider how we may best strengthen our focus on leadership. Since the Board seminar session on workforce in June, executive colleagues had taken forward work to refine our leader model although it has now been agreed that the model essentially serves our purposes well and does not need any significant change. However, the emphasis on maintaining focus on the relationship axis whilst ensuring the task axis is attended to should be continued and even strengthened, and the Committee encouraged communication of ‘Why’ the particular tweaks to emphasis were being made at this time.

Executive Members of the committee had met with Professor Michael West, Senior Responsible Fellow for Leadership at the Kings Fund, in August to test our emerging thinking and outline the leadership skill development we wished to prioritise. This meeting was positive and encouraging in that our thinking is in line with best practice.

In discussion, the Committee encouraged:

i) a review of our selection process for senior leader positions, to be discussed in more depth during the right staff session;
ii) the development of the current appraisal process to identify leaders of the future in order to develop them appropriately;
iii) a renewed and deliberate emphasis on the relationship axis of the UCLH leader model;
iv) we establish processes for the ongoing review of leader capability within UCLH; and
v) we consider pathways to enable staff to progress to senior leader positions.

5. Next sessions

The Committee is scheduled to hold its next sessions on 15 November, 12 December and 5 February. Our November meeting shall focus on ‘right staff’, including action proposed to focus on high priority recruitment challenges and the form of initiative to aid retention and experience that may warrant enhanced investment into 2018/19.

CASPAR WOOLLEY

CHAIR, WORKFORCE COMMITTEE

7 September 2017
The Audit Committee (AC) met on 25 July to consider the following important matters.

1. **Internal Audit (IA) Reports 2017/18**
   
   The AC reviewed a progress report from IA which set out the timetable of reports expected for the coming year. Three reports - core financial controls, local risk registers, and patient experience/safety data - were in progress.

   It also noted that IA had been focusing on the delivery of outstanding recommendations from previous action plans and, jointly with the Trust, was putting in place new escalation steps to improve implementation. One specific area related to an audit of the Serious Incident process. The AC noted that actions had been partially delivered and that training and time was required to ensure all actions could be embedded effectively.

2. **Counter Fraud**
   
   The AC reviewed the Local Counter Fraud Specialist’s (LCFS) progress report. The report drew attention to the awareness sessions being undertaken in the Trust. It also welcomed the close liaison with UCLH staff noting that LCFS were working closely with the IT team to publish messages about email scams and cyber prevention. This was a known area of risk and had been prioritised in the annual workplan.

   LCFS had also produced a Fraud Spotlight document on overseas visitors and had completed a proactive exercise to help prevent fraud in this area. The AC noted that this work will be taken into account as the Trust prepares for any proposed new changes relating to eligibility for NHS treatment.

   The AC also reviewed a helpful NHS Benchmarking Report on Fraud; this reassured AC members that the UCLH fraud heat map was focussing on the right issues.

3. **Raising Concerns**
   
   The AC received an annual update report on raising concerns, previously known as whistleblowing, from the Ben Morrin, Director of Workforce. Since the last update in July 2016 the Trust has fully implemented an independent guardian service which enables staff to raise issues confidentially and seek guidance from a trained mediator or councillor. The AC noted there were eight ways for staff to raise issues including the standard options of raising them with the UCLH employee relations team or via the Care Quality Commission. The value of the various options will be assessed.

   Seven issues had been raised with the Trust compared to 11 in the previous year; all were investigated. However a separate report from the guardian service advised that 30 issues had been raised between June 2016 and May 2017. This demonstrated the value of a confidential service. In noting the report the AC commented that more use could be made of the service; it suggested additional marketing was needed to enable more staff to benefit from its service.

   The AC noted that many of the 30 issues were recorded as bullying and harassment. It was advised that the guardian service was helping UCLH to gain a better understanding of bullying and harassing behaviour in its widest sense and, was helping staff and managers to reflect on their different experiences of the same incident. A further ‘where do you draw the line’ campaign was being planned to pick up a number of those issues. The AC welcomed this approach.
4. Risk and Assurance

4.1 Finance Metrics Report
The AC considered a quarterly report on financial control. It discussed the metrics on creditors, purchase orders, and agency staff. It noted that there had been a reduction in creditors due to the resolution of historic issues between UCL and UCLH mostly relating to honorary contracts and salary recharges. The AC requested a further update on the recharge process to better understand the complexity of this issue and whether it could be made simpler.

On purchase orders, the AC noted that steady progress was being made to ensure that invoices received had a purchase order. Compliance was inconsistent. AC was advised that an exception list was being developed; this could help improve compliance. The list would be presented to the AC with the next report.

On agency spend the AC noted the positive impact of the agency controls which had resulted in a reduction in agency spend; this was a continuing downward trend.

4.2 Fire Safety
Following the Grenfell Tower Fire the AC requested a presentation and report on fire safety from Tracey Middleton, Deputy Director of Capital Investment and David Smart, Fire Safety Manager to gain a better understanding on how fire risk is managed.

Fire risk assessments were undertaken in all buildings across the UCLH estate. Any issues subsequently identified as moderate or high priority i.e. requires urgent attention were dealt with. The London Fire Brigade also undertakes annual audits of UCLH premises.

The AC was advised that all buildings had fire detection and fire evacuation procedures in place; these differ depending on the age of a building and what it is used for. The AC also noted learning from fire incidents. Following the inappropriate discharge of a sprinkler in the Cancer Centre the fire strategy for the phase 4 project will implement a double value sprinkler system which will enable the service to protect valuable equipment in the event of a fire in the building.

The AC was pleased to note the priority given to fire safety which it agreed demands close attention in UCLH as well as in the NHS as a whole.

5. Other assurance matters

5.1 Bad Debt Report
The AC considered a report on bad debt from Paul Sutton, Accounting and Treasury Manager. It was advised that the majority of the debt was aged – pre 2014-15 - and all avenues for chasing the debt had been exhausted. In a number of cases the individuals concerned had died.

In May the AC had been advised that targets were being set to better manage each type of debt, it would keep this under review through the finance metrics report.

5.2 Data Quality Report
The AC reviewed a report from Simon Knight, Director of Performance and Planning which provided an update on the recommendations following the IA in relation to data quality strategy and governance and a UCLH assurance audit by the elective access team.
On data quality governance a new Information Steering Group is being established. Its role will include monitoring data and information quality standards and undertaking root cause analysis of any serious or persistent data problems. In noting the report the AC commented that progress wavered. The AC was re-assured that continued training would further reduce errors however, it was EHRS that would bring the real benefit.

The AC also noted that a revised Information Assurance and Data Quality Policy was waiting approval. The changes to the policy will support better data collection.

5.3 Budget Holders Survey
The AC reviewed a helpful Budget Holders benchmarking survey undertaken by IA across UCLH and IA’s client base. The findings identified known areas of weakness for example budget holder training and the AC was advised that the finance team had already put in place a plan to improve the position. Actions included developing consistent budget performance information in an online accessible format; this was currently being piloted with a clinical division.

On training, a new regular programme has been developed to cover understanding finance within UCLH and the sector, cost and income drivers, and effective resource allocation management. The first session was delivered in July,

The AC asked for an update on the training outcomes at a future meeting.

5.4 Waivers report
The AC reviewed a quarterly report on waivers from Jacqueline Hunter, Procurement Programme Director. The report provided analysis of the number and reason for the waivers.

In January the AC had sought assurance that procurement challenged waiver requests, in particular where sole provider or continuity benefit was cited as the reason for the use of supplier. The AC was pleased to note that this challenge had reduced the number of approved waivers. The AC acknowledged that the Trust was unlikely to reduce the number of waivers to zero, but anticipated that the procurement challenge would continue to bring the number down. The next report would focus on the underlying waiver position.

The AC also supported the procurement team’s initiative to revise the waiver documentation and improve guidance to UCLH staff about how to procure services appropriately.

Rima Makarem
Audit Committee Chair
AUDIT COMMITTEE (AC)

Minutes of the meeting held on Tuesday 23rd May 2017

Present:
Audit Committee Members
Rima Makarem Non-Executive Director and Chair (RM)
Harry Bush Non-Executive Director (HB)
Diana Walford Non-Executive Director (DW)

Non-Members
Marcel Levi Chief Executive (ML)
Richard Murley Chairman (RMu)
Tonia Ramsden Director of Corporate Services (TR)
Tim Jaggard Finance Director (TJ)
Guy Dentith Deputy Director of Finance (GD)
Craig Wisdom Deloitte, External Audit (CW)
Julian Reeve Deloitte, External Audit (JR)
Hannah Wenlock RSM, Counter Fraud (HW)
Gemma Higginson RSM, Counter Fraud (GH)
Jack Stapleton KPMG, Internal Audit (JS)
Arran Rose KPMG, Internal Audit (AR)
Rachel Maybank Associate Director of Communications, For Item 5b (RMy)
Maria Adisesiah Deputy Director for Quality, For Item 5d (MA)
Cathy Mooney Director of Quality & Safety, For Items 5d, 9, 10 (CM)
Simon Knight Director of Planning & Performance, For Items 5d, 9, 10 (SK)
Mairi Bell Chief Accountant; Minutes

Matters Covered

1. Apologies for Absence
Apologies received from Althea Efunshile (AE).

2. Minutes of the Meeting held on 25th April
The minutes were agreed.

3. Matters Arising
AC agreed to close the following MA as complete:

MA 356, 368, 377, 384, 385, 387
Matters Covered

4. External Audit

4a. Audit Report (ISA 260)

CW presented the ISA 260 report, noting that this had been completed several days ahead of the previous year, with the expectation that final points would be closed off prior to the scheduled signing.

CW highlighted conclusions on the key risks, focussing particularly on revenue recognition. CW noted that the Trust erred on the side of caution in determining the bad debt provision levels, noting the provision had decreased since the previous year largely due to a better age profile. CW concluded that the provision was a comfortable level materially, but was on the prudent side. CW added when considering average levels of provision, the prudency could depend on an individual Trust’s financial position. CW confirmed that UCLH had consistently applied the policy on provisions, with no change from the previous year.

HB asked about fraud risks within valuation and capital spend. CW replied that auditors were required to assess significant risks, and this included fraud risk, but that the inherent risks in this area were not increased in respect of fraud.

CW highlighted the property valuation exercise, noting that a good piece of work had been done in the prior year and rolled forward to apply to the current year, with Deloitte valuers agreeing with the assumptions underpinning the valuation, and this was not more prudent or aggressive than in previous years. RM asked about the RNTNEH area and TJ replied that this was a leased rather than owned site, and that the rebuild value was based on the Phase 5 footprint.

CW noted no issues on capital expenditure.

CW spoke about management override of controls, noting this had been mentioned in prior AC meetings, with a risk of presenting information in the wrong way. CW confirmed that TJ and UCLH had been very transparent, particularly regarding the treatment of one-off items such as the prior period adjustment and the grant money from Royal Free FT.

RM noted the treatment of the RFH grant had been done on the basis of instruction from NHSI. CW replied that the auditors had noted the direct instruction from NHSI in their reporting. TJ added that this was a sustainability issue with no impact on the accounts, and related to the distinction between revenue and capital grant income. TJ noted that ongoing financial implications included additional PDC costs in future years.

CW concluded that from an audit perspective there was no accounts disclosure issue other than a judgement regarding recoverability, and that overall it was a good judgement to make.

Concluding on management override of controls, CW noted that the key point was the transparency of the organisation and that no behaviour indicating override or aggressive transactions had been noted.
Matters Covered

HB asked how some Trusts had managed to do better than UCLH on STF funding. TJ replied that this had been done on a % basis and that these were probably smaller Trusts with core STF lower as a % of income.

CW commented on legacy accruals, noting that while a significant balance remained, management was working through these and they would be expected to come down further in future years.

CW confirmed that there was clean opinion on VfM and that although more consideration had been given to data quality issues there was comfort that overall VfM was being achieved.

CW noted that there were no high priority audit recommendations made, and that minor recommendations would be reported to the next audit committee. CW added that there were no audit adjustments or disclosures, with very few adjustments to numbers.

CW commented on the audit opinion, referring to previous discussion on the inclusion of observations and findings. CW noted that previously the decision had been not to include this, but that most organisations were now including this. CW highlighted the only comment of note, on page 32. TJ added that these comments would be going to the public domain and that the organisation needed to be comfortable with this. AC agreed that this should be included in the report.

ACTION – report minor audit recommendations to the next AC

4b. Audit Report on Quality Account

CW presented the auditor’s limited report on the quality account, noting that the report had been reviewed for consistency and content, with review of mandated indicators RTT 18 weeks and A&E 4 hours, along with a governor selected indicator of 6 week diagnostic. CW noted that there was a lack of green on the dashboard, but observed the level of red was less than the prior year.

RM noted that the audit report didn’t capture the comparison to the prior year or the improvements made, although there was a note in the quality account itself to highlight this. CW replied that due to the limited scope of the audit and small sample size, the audit response had to be cautious, but that the improvement had been conveyed as much as possible. CW added that the sample sizes were determined by auditing standards, with a maximum size of around 24. CW noted that the audit approach had focussed on risky areas, and it was hard to judge if this was representative of the whole population. ML suggested that the sample size was too small for a 95% confidence level. RM noted the amount of work which had been put into the improvements made so far and wondered how much more resource would be required to really change the picture.

HB asked how this compared to other Trusts. CW replied this was about average. HB asked if others had more green. CW replied most were mostly amber, with some green,
Matters Covered

but this was generally related to size and complexity of the organisation. TJ noted that other Trusts had better IT systems to work with.

CW noted that the indicator for A&E was hard not to qualify, and auditors couldn’t be comfortable as there was no audit trail for changes to the source data, and suggested that a field could be added so that validation could be seen on the system. DW noted that internal audit had reported similar findings in this area.

RM asked whether the sample size could be expanded, and CW replied that the sample size could end up increasing exponentially, but that auditors were unconvinced the errors were isolated. CW agreed to consider the wording used in the report.

CW observed that 6 week diagnostic data was linked to RTT processes, and although improvement could be seen, errors were still being found in the data. CW added that in comparison to the previous year, the number and type of errors had reduced. RM noted that it would be helpful to note the factual position.

HB queried a comment suggesting UCLH had not acted on a recommendation made by Deloitte in the previous year regarding the timing of reporting. CW acknowledged there had been an active decision not to change the process. RMu added that data was still being reported in 1 month blocks as required. DW suggested a wording change. CW replied that the scope of this was tightly controlled, and there was an underlying risk that figures could be distorted.

RM asked about finding 2, and if the inclusion of irrelevant data mattered, as long as relevant data was there. CW replied that the inclusion of irrelevant data would impact on the calculation. RM asked whether the rating would move to Amber-Green if findings 2 and 3 improved. CW suggested that if 2 and 3 were dealt with, then data analytics could be used to help the Trust improve.

RMu asked if finding 1 was a non-compliant process rather than an error. CW agreed to consider the wording, and noted there were no contentious disagreements on findings.

RM suggested SK and Emilie Perrie attend September’s AC to update on data quality.

**ACTION** – EP/SK to come to September AC and update on ED data quality

4c. Management Letter of Representation

The management letter of representation was presented. RMu asked if this had been to EB and TR confirmed that it had, with no comments received.

5. Annual Report and Accounts

5a. Guide to Purpose and Destination of Documents
Matters Covered

GD presented a short briefing note outlining the documents presented to AC as part of the Annual Report and Accounts process, and highlighted the approvals and signatures required.

5b. Annual Report

RMy presented the final version of the Annual Report noting changes made since the draft presented to April’s meeting. HB confirmed comments had been provided to TJ regarding the Finance Director’s report. TJ replied that these had been considered and incorporated, and that a finance consistency check had been undertaken.

5c. Annual Governance Statement

GD presented the final version of the Annual Governance Statement (AGS), summarising changes since the presentation to April’s AC meeting, including an update to ED data quality findings.

5d. Quality Report

CM and MA attended to present the final Quality Account. MA advised that two versions were presented – a clean, final version and a version showing the changes made since the previous presentation to AC. MA noted some additional minor corrections made since the submission of AC papers.

DW asked about the wording of the last paragraph of the Chief Executive’s statement, noting this wasn’t clear. CM replied that this was Deloitte’s wording. CW noted that the wording had been suggested in the context of duty of care. HB suggested a wording change.

HB provided a final reviewed version with marked typing errors to CM and MA.

AC discussed some further minor changes to wording.

5e & f. Annual Accounts, and Commentary including changes since April AC

GD presented the final financial statements to AC, including an updated commentary. GD highlighted the key change from April’s AC meeting regarding the inclusion of £3.5m of bonus STF funding, notified late in the process. GD noted an additional £0.2m of bonus STF funding notified to the Trust shortly before the submission of final AC papers. GD confirmed that these changes to income had been fed through to the Annual Report where relevant. GD advised AC that full details of line by line changes could be found in Appendix 2.

RMu asked about the £9.8m impairment. GD explained this came from the land & buildings valuation and was a significantly smaller change than in previous years. TJ added that the impairment would reduce the PDC charge payable in future years.
Matters Covered

6. Annual Review of Non-Audit Services and Policy

RM confirmed that the policy had been reviewed and that AC remained happy with the policy.

7. Audit Committee to Recommend Accounts to Board

AC recommended the Accounts to the Board.

8. Recommendation of Approval of Statements on Trust Licence

TR advised that the documents had been circulated to EB and recommended approval. AC approved the statements.

9. Risk Report

CM presented the Risk Report, noting this summarised two RCB and 1 EB meetings, with table 2 presenting an audit trail of these discussions.

CM noted that risk 102077 would be kept as red, and the risk rating reduced when action taken. RM asked about the background to this action. ML replied that this related to leadership issues and a move of the safety system for blood transfusions, but that there was now new leadership in place and this would be kept under review. DW observed this issue had not previously been heard about and ML replied that it had been going on for some time. CM added that the score had been lower but had been escalated as it was not being dealt with. ML added that attention had increased due to a recent incident. RMu commented that an unidentified red risk was worrying.

RM noted that for the CQC visit, the focus had been on red and high amber risks, and asked how low amber and green risks were now being dealt with. CM replied that housekeeping of reports was being reviewed, following on from the KPMG audit work. ML added that risks which had been amber for a long time should maybe be red. CM noted that review dates were being monitored. RMu observed that the blood transfusion issue was an error of judgement rather than omission. CM replied that the judgement of experts was relied upon.

CM highlighted clustered risks in the Surgery & Cancer Board, where it was red rated to that Board but not overall, and noted this had been given a specific mention in the Trust wide risk on finance. TJ added that targets were expected to be met, and that this was a risk rather than a problem.
CM noted section 2, where risks identified were shown down to moderate and low risks, and advised that the risk team were looking at how to integrate these to monthly performance packs. TR noted that the estates team had been challenged to review risks and establish if these were really health and safety / fire risks. TJ commented that this would come back to the organisation’s risk appetite, and capacity for significant investment. DW noted that health and safety fines were now unlimited.

10. Board Assurance Framework

SK presented the Board Assurance Framework (BAF) noting it was similar to the version seen by the Board in May, with comments incorporated. SK added that the risk on cyber security had been updated following discussion with David Hill, and that changes to estates details had also been made.

RMu noted that there had been discussion around having a risk around causing harm to patients. CM replied that this had been discussed at RCB and was likely to be on the Trust Risk Register. SK added that the BAF focussed on risks to delivery of the Trust’s strategic objectives. RM suggested considering the human factor in cyber security controls. SK agreed to take this back.

HB asked if the Trust had been lucky to escape impact from the recent ransomware attack. ML replied that the response had been good, but the organisation was probably lucky not to have been one of the first Trusts affected. SK added that there had been time to close down systems safely and apply patches. DW asked if there was a risk to equipment. ML replied that some was supported by old systems, for example the Blood Analyser system, which couldn’t be patched, and where electronic results had to be temporarily stopped.

**ACTION** – SK to consider adding human factor risk in cyber security controls (BAF)

11. Audit Committee Annual Report (Draft)

TR presented a draft of the AC Annual Report, noting that this had been brought forward in order to go to Board before September. TR asked for feedback on the report.

HB queried the inclusion of Trust risk appetite, and whether this had previously been put to the side. RM replied that it served a purpose, but that the Committee would not spend significant time on it.

12. Counter Fraud Annual Report 2016-17 (Draft)
Matters Covered

GH presented the counter fraud annual report for 2016-17, highlighting an updated risk profile compared to March 2016, confirming proactive work done in the year and the status of reactive investigations. GH noted that Appendix B was new to AC members, with the full 2016-17 self-review tool presented to AC, a new requirement. GH added that there was an overall green rating in each of 4 key areas and overall. GH observed there were 2 ambers within the ratings and that actions had been agreed for these.

RM asked about findings and disclosures in the Pharmacy review. GH replied that management actions were still to be agreed and would be followed up next year. TJ added that there were still some manual processes which the organisation was working to improve to reduce opportunities for fraud.

13. Audit Committee Work Programme 2017-18

The work programme was noted.

Date of Next Meeting
9am, Tuesday 25th July 2017,
Chairman/CEO Meeting Room, 2nd floor central, 250 Euston Road
BOARD OF DIRECTORS MEETING – 13 September 2017

Entries in the Seal Register since the last Report to the Board

1. This report updates the Board on the use of the Seal since the July Board meeting.

2. The table below provides a list of the documents sealed. Property transactions are approved in advance by the Board. All documents have been authorised by one executive and one non-executive member of the Board.

3. The Board is asked to note Seal 883-884. A major redevelopment is taking place opposite the pathology laboratories on Whitfield Street. HSL and the Trust objected to the road closures required during the refurbishment which would have had an operational impact on the Trust’s services. The issue was mutually resolved. Due to the urgency of the issue it was not possible to inform the Board in advance that the Deed would be signed under Seal. The Deed was signed and sealed by the Chief Executive and Vice Chairman.

4. RECOMMENDATION

That the Board NOTES and ENDORSES the use of the Board Seal for the listed transactions.

Tonia Ramsden
Trust Secretary

<table>
<thead>
<tr>
<th>Number</th>
<th>Date of Entry</th>
<th>Entry Details</th>
<th>Supporting Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>872</td>
<td>26 July 2017</td>
<td>Lease between University College London and University College London Hospitals NHS Foundation Trust</td>
<td>This relates to part of the 1st, 2nd, 3rd and 4th floors The Rockefeller Building, 21 University Street, London WC1E 6JJ - the areas occupied by UCLH Cellular Pathology. The occupants will relocate to Whitfield Street towards the end of 2018.</td>
</tr>
<tr>
<td>873</td>
<td>26 July 2017</td>
<td>Lease between University College London Hospitals NHS Foundation Trust and University College London Hospitals Charity.</td>
<td>This document assigns a lease for a top flat at 47 Wimpole Street.</td>
</tr>
<tr>
<td>874-877</td>
<td>26 July 2017</td>
<td>Sub-Contractors Deed of Warranty between University College London Hospitals NHS foundation Trust and EES (London) Ltd.</td>
<td>This relates to the redevelopment of the Proton Beam Therapy and above ground in-patient facilities at Grafton Way and Huntley Street, London WC1E 6DB</td>
</tr>
<tr>
<td>878</td>
<td>9 August 2017</td>
<td>Deed of Release of Right of Light between University College London Hospitals NHS Foundation Trust and named leaseholders.</td>
<td>This Deed releases Rights of Light relating to occupants of Paramount Court, benefiting the Rosenheim building and the site of the former Odeon Cinema, Tottenham Court Road.</td>
</tr>
<tr>
<td>No.</td>
<td>Date</td>
<td>Description</td>
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<tr>
<td>879</td>
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<tr>
<td></td>
<td>2017</td>
<td>Hospitals NHS Foundation Trust and named leaseholders.</td>
<td></td>
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<td></td>
<td>2017</td>
<td>Hospitals NHS Foundation Trust and named leaseholders.</td>
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</tr>
<tr>
<td>883-884</td>
<td>9 August</td>
<td>Neighbourly Matters Deed between;</td>
<td>This Deed enables the objection to a road closure to support a redevelopment planned by Derwent London be withdrawn.</td>
</tr>
<tr>
<td></td>
<td>2017</td>
<td>i. University College London Hospitals NHS Foundation Trust,</td>
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<td></td>
<td></td>
<td>ii. West London and Suburban Property Investments Ltd,</td>
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<td>iii. 80 Charlotte Street Ltd, Derwent London Whitfield Street Ltd,</td>
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<td>iv. Whitfield Street Properties Ltd,</td>
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<td>v. Sonic Healthcare Holding Company,</td>
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<td>vi. The Doctors Laboratory Ltd,</td>
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<td></td>
<td></td>
<td>vii. University College London Hospitals NHS Foundation Trust, HSL(FM) LLP and The Doctors Laboratory Ltd,</td>
<td></td>
</tr>
<tr>
<td>885</td>
<td>4 Sept</td>
<td>Deed of Release of Light Agreement between University College London Hospitals NHS</td>
<td>This Deed releases Rights of Light relating to occupants of Paramount Court, benefiting the</td>
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<tr>
<td>Code</td>
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</tr>
<tr>
<td>886</td>
<td>4 Sept 2017</td>
<td>Lease of premises between University College London Hospitals NHS Foundation Trust and Normans News Limited</td>
<td>This document renews the current lease for the Hospital Shop in the UCH Atrium.</td>
</tr>
<tr>
<td>887-889</td>
<td>4 Sept 2017</td>
<td>Sub-Contractors Deed of Warranty between Dortek Doors; University College London Hospitals NHS foundation Trust and McLaughlin &amp; Harvey Ltd.</td>
<td>This Deed relates the refurbishment of the operating theatres at the National Hospital for Neurology and Neurosurgery and the provision of specialist doorsets.</td>
</tr>
<tr>
<td>890-892</td>
<td>4 Sept 2017</td>
<td>Sub-Contractors Deed of Warranty between Stothers (M&amp;E) Ltd; University College London Hospitals NHS foundation Trust and McLaughlin &amp; Harvey Ltd.</td>
<td>This Deed relates the refurbishment of the operating theatres at the National Hospital for Neurology and Neurosurgery and the provision of MEP works.</td>
</tr>
<tr>
<td>893-895</td>
<td>4 Sept 2017</td>
<td>Sub-Contractors Deed of Warranty between Andrew Gault T/A Gault Engineering; University College London Hospitals NHS foundation Trust and McLaughlin &amp; Harvey Ltd.</td>
<td>This Deed relates the refurbishment of the operating theatres at the National Hospital for Neurology and Neurosurgery and the provision of steelworks.</td>
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