Queen Victoria Hospital NHS
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 7 July 2016

Session in public at 10.00

The Cranston Suite
East Court
College Lane
East Grinstead
West Sussex
RH19 3LT

Queen Victoria Hospital NHS
NHS Foundation Trust

MEETINGS OF THE BOARD OF DIRECTORS: 7 July 2016

Members (voting):

Chair	-	Beryl Hobson
Senior Independent Director	-	Lester Porter *(apologies)*
Non-Executive Directors:	-	Ginny Colwell
	-	Ian Playford
	-	John Thornton
Chief Executive:	-	Richard Tyler
Medical Director	-	Stephen Fenlon
Director of Nursing	-	Jo Thomas *(apologies)*
Director of Finance and Performance	-	Clare Stafford

In full attendance (non-voting):

Interim Director of Human Resources & OD	-	Geraldine Opreshko *(apologies)*
Director of Operations	-	Sharon Jones
Interim Company Secretary	-	Chipo Kazoka
Deputy Company Secretary	-	Hilary Saunders
Governor Representative:	-	Chris Orman
Deputy Director of Nursing	-	Nicky Reeves

Queen Victoria Hospital NHS
NHS Foundation Trust

Annual declarations by directors

Declarations of interests

As established by section 40 of the trust's constitution, a director of the Queen Victoria Hospital NHS Foundation Trust has a duty:

- to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the foundation trust.
- not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.
- to declare the nature and extent of any relevant and material interest or a direct or indirect interest in a proposed transaction or arrangement with the foundation trust to the other directors.

To facilitate this duty, directors are asked on appointment to the trust and thereafter at the beginning of each financial year, to complete a form to declare any interests or to confirm that the director has no interests to declare (a 'nil return'). Directors must request to update any declaration if circumstances change materially. By completing and signing the declaration form directors confirm their awareness of any facts or circumstances which conflict or may conflict with the interests of QVH NHS Foundation Trust. All declarations of interest and nil returns are kept on file by the trust and recorded in the following register of interests which is maintained by the company secretary.

Register of declarations of interests

	Relevant and material interests						
	Directorships, including non-executive directorships, held in private companies or public limited companies (with the exception of dormant companies).	Ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or QVH.	Significant or controlling share in organisations likely or possibly seeking to do business with the NHS or QVH.	A position of authority in a charity or voluntary organisation in the field of health or social care.	Any connection with a voluntary or other organisation contracting for NHS or QVH services or commissioning NHS or QVH services.	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with QVH, including but not limited to lenders of banks.	Any "family interest": an interest of a close family member which, if it were the interest of that director, would be a personal or pecuniary interest.
Non-executive and executive members of the board (voting)							
Beryl Hobson Chair	Director: Professional Governance Services Ltd (clients include health charities and the Royal College of Surgeons)	Part owner of Professional Governance Services Ltd	Part owner of Professional Governance Services Ltd	Nil	Nil	Nil	Nil
Lester Porter Senior Independent Director	Nil	Nil	Nil	Nil	Nil	My wife and I are longstanding clients of Mazars LLP, Sutton who are our personal tax advisors, and of Mazars Financial Planning Ltd who manage our self-invested personal pension funds.	Nil

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Ginny Colwell Non-Executive Director	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Ian Playford Non-Executive Director	1. NED of Onboard Executive Ltd 2. Director/board advisor – Kingsbridge estates 3. NED – Her Majesty's Courts and Tribunals Service	Nil	Nil	Nil	Nil	Nil	Nil
John Thornton Non-Executive Director	1. Non-Executive Director: Golden Charter Ltd 2. Non-Executive Director: Osmo Data Technology Ltd	Nil	Nil	Nil	Nil	Nil	Nil

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Richard Tyler Chief Executive	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Steve Fenlon Medical Director	Nil	Nil	Nil	Nil	Nil	I work for a syndicate of anaesthetists for private patients. Occasionally the syndicate is asked to cover NHS patients.	Nil
Jo Thomas Director of Nursing	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Clare Stafford Director of Finance	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Other members of the board (non-voting)							
Chipo Kazoka Interim Company Secretary	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Sharon Jones Director of Operations	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Geraldine Opreshko Interim Director of HR & OD	Director of GO consultants	Nil	Nil	Nil	Nil	Nil	Nil

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Chris Orman Governor Representative	Nil	Nil	Nil	Nil	Eldest daughter senior manager at college of Occupational Therapists	Nil	Nil

Fit and proper person declarations

As established by regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the regulations"), QVH has a duty not to appoint a person or allow a person to continue to be an executive director or equivalent or a non-executive director of the trust under given circumstances known as the "fit and proper person test".

By completing and signing an annual declaration form, QVH directors confirm their awareness of any facts or circumstances which prevent them from holding office as a director of QVH NHS Foundation Trust.

Register of fit and proper person declarations

	Categories of person prevented from holding office						
	The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	The person has been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.
Non-executive and executive members of the board (voting)							
Beryl Hobson Chair	No	No	No	No	No	No	No
Lester Porter SID	No	No	No	No	No	No	No

Register of fit and proper person declarations

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Ginny Colwell Non-Executive Director	No	No	No	No	No	No	No
Ian Playford Non-Executive Director	No	No	No	No	No	No	No
John Thornton Non-Executive Director	No	No	No	No	No	No	No
Richard Tyler Chief Executive	No	No	No	No	No	No	No
Steve Fenlon Medical Director	No	No	No	No	No	No	No
Jo Thomas Director of Nursing	No	No	No	No	No	No	No
Clare Stafford Director of Finance	No	No	No	No	No	No	No
Other members of the board (non-voting)							
Chipo Kazoka Interim Company Secretary	No	No	No	No	No	No	No

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Sharon Jones Director of Operations	No	No	No	No	No	No	No
Geraldine Opreshko Director of HR & OD	No	No	No	No	No	No	No
Chris Orman Governor Rep	No	No	No	No	No	No	No

Priorities – 2016/17

Queen Victoria Hospital NHS
NHS Foundation Trust

	KSO 1 (JT)	KSO 2 (SF)	KSO 3 (SJ)	KSO 4 (CS)	KSO 5 (GA)
Consolidate	Systems & Processes – CQC report (CS)				
	Risk Management – CQC report (JT & SF))				
	Re-structure – complete (GA)				
	Governance – bed in post review, internal 'Well-Led' review (KA)				
Improve	Quality Improvement Strategy	OOH Trauma Paediatrics Critical Care Oral Surgery (CQC report)	Electronic Document Management	IT infrastructure	Recruitment & Retention
	Estates Improvement programme		Pathway redesign	Information capability - EKBI	Safe & Effective Care Planning
				Refinement CIP process	
	Integrated Education Strategy				
		Spoke governance			
Transform	Estates Strategy	Clinical Strategy		Productivity Programme	Leadership Development
		R&D Strategy	7 day working		

NOTE: CQC placeholders 16/17 budget setting – capital £300k; strategic reserve tbc.

Queen Victoria Hospital NHS
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 07 July 2016 at 10:00
Cranston Suite, East Court, College Lane, East Grinstead, West Sussex RH19 3LT

Agenda: session held in public		
Welcome		
109-16	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*	-
Standing items		
110-16	**Draft minutes of the meeting session held in public on 05 May 2016 (for approval)** *Beryl Hobson, Chair*	1
111-16	**Matters arising and actions pending** *Beryl Hobson, Chair*	10
112-16	**Chief executive's report, (including BAF overview)** *Richard Tyler, Chief Executive*	13
113-16	**Corporate Risk Register (CRR)** *Richard Tyler, Chief Executive*	16
Key strategic objective 1: outstanding patient experience		
114-16	**Board Assurance Framework** *Nicky Reeves, Deputy director of Nursing*	26
115-16	**Patient story: experience** *Natalie Jones, Adult Safeguarding Lead Nurse*	-
116-16	**Quality and governance assurance report** *Ginny Colwell, Non-executive director and committee chair*	27
117-16	**Quality and Safety** *Nicky Reeves, Deputy director of Nursing*	29
118-16	**6-monthly nursing workforce review** *Nicky Reeves, Deputy director of Nursing*	54
119-16	**CQC action plan** *(for information only)* *Nicky Reeves, Deputy director of Nursing*	79
120-16	**National I/P survey report 2015** *(for information only)* *Nicky Reeves, Deputy director of Nursing*	98
121-16	**Annual report for child and adult safeguarding** *(for information only)* *Nicky Reeves, Deputy director of Nursing*	120
Key strategic objective 2: world-class clinical services		
122-16	**Board Assurance Framework** *Steve Fenlon, Medical Director*	148
123-16	**Medical director's report** *Steve Fenlon, Medical Director*	149

Key strategic objectives 3 and 4: operational excellence and financial sustainability		
124-16	**Board Assurance Framework** *Sharon Jones, Director of Operations and Clare Stafford, Director of Finance*	152
125-16	**Financial and operational performance assurance report** *John Thornton, Non-Executive Director*	154
126-16	**Operational performance** *Sharon Jones, Director of Operations*	157
127-16	**Financial performance** *Clare Stafford, Director of Finance and Performance*	165
Key strategic objective 5: organisational excellence		
128-16	**Board Assurance Framework** *Richard Tyler, Chief Executive (on behalf of Geraldine Opreshko, interim Director of Human Resources and Organisational Development)*	180
129-16	**Workforce report** *Richard Tyler, Chief Executive (on behalf of Geraldine Opreshko, interim Director of Human Resources and Organisational Development)*	181
Board governance		
130-16	**Audit Committee** *Ginny Colwell on behalf of Lester Porter, Chair*	193
131-16	**Draft agenda for the September 2016 business meeting** *Chipo Kazoka, Interim Company Secretary*	194
Any other business (by application to the Chair)		
132-16	*Beryl Hobson, Chair*	-
Observations and feedback		
133-16	**Feedback from key events and other engagement with staff and stakeholders** *All*	-
134-16	**Observations from members of the public** *Beryl Hobson, Chair*	-
135-16	**Observations and feedback on the meeting** *John Thornton, non-executive director*	-

Date of the next meetings		
Board of Directors: **Public**: 01 September at 10:00	**Sub-Committees** **Q&G:** 14 July 2016 at 09:00 **F&P:** 18 July 2016 at 14:00 **Audit**: 21 September 2016 at 14:00 **Charity:** 29 September 2016 at 09:00 **N&R:** 28 July 2016 at 11:00 **Corp. Trustee**: 03 Nov 2016 at 14:00	**Council of Governors** **Public**: 25 July 2016 at 16:00

Queen Victoria Hospital NHS
NHS Foundation Trust

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 5th May 2016, 10.00 – 13.00, The Blond McIndoe Research Centre, QVH site, East Grinstead RH19 3DZ**	
Present:	Beryl Hobson, (BH)	Trust Chair
	Ginny Colwell (GC)	Non-Executive Director
	Steve Fenlon (SF)	Medical Director
	Ian Playford (IP)	Non-Executive Director
	Lester Porter (LP)	Senior Independent Director
	Clare Stafford (CS)	Director of Finance and Performance
	Jo Thomas (JMT)	Director of Nursing
	John Thornton (JT)	Non-Executive Director
	Richard Tyler (RT)	Chief Executive
In attendance:	Graeme Armitage (GA)	Director of Human Resources and Organisational Development
	Chipo Kazoka (CK)	Interim Company Secretary
	Sharon Jones (SJ)	Director of Operations
	Chris Orman (CO)	Governor Representative
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
Public Gallery:	Christine Halloway (CH)	Public governor
	Sapna Radia	Senior Registrar, Orthodontics

Welcome	
66-16	**Welcome, apologies and declarations of interest** BH opened the public session and welcomed two members of the public to the meeting. There were no apologies and no new declarations of interest. BH noted this was GA's final public board meeting before leaving the trust later this month. On behalf of the board, she thanked him for his contribution to the trust, paying particular tribute to the improvements achieved in statutory and mandatory training during his tenure.
Standing items	
67-16	**Draft minutes of the meeting session held in public on 3rd March 2016 for approval** The minutes of the public meeting held on 3rd March 2016 were **APPROVED** as a correct record.
68-16	**Matters arising and actions pending** The board reviewed the current record of matters arising and actions pending. GA advised members that an update on all matters relating to his area were contained within a separate report which should have been included in this month's papers. He went on to provide a verbal update assuring the board that these matters had now been addressed and incorporated into relevant action plans. The outstanding report was then tabled, with electronic copies to follow. In the meantime, these actions would be marked as complete. The remainder of the matters arising update was then received and **APPROVED**.

69-16	**Chief Executive's report** RT presented his regular update on progress and risks to the main internal targets. He also apprised the board of external issues likely to impact on the trust's ability to achieve those targets. Highlights included: • **CQC Report** Our inspection report published on 26th April and which confirmed that QVH had been awarded an overall 'Good'. RT reiterated this was a tremendous result. In particular, the 'Outstanding'' for care was a testament to the day-to-day commitment of our staff and should be both acknowledged and celebrated. BH echoed his comments asking that the board's thanks to staff be formally recorded. • **National issues – Year end position** A recap of the board's decision in February to reject the suggested control total of £2.6m, whilst providing a rationale for its response. At the time of writing the trust was still awaiting a detailed response to this decision. RT would continue to keep the board apprised. In the meantime, he warned that whilst QVH would be a described as a 'succeeding' organisation under current standards, there could be changes to criteria in the future. • Board Assurance Framework (BAF): The level of risk for each KSO remained unchanged from Q 4. In relation to horizon scanning, the trust remains red on policy and resilience to reflect both the uncertainty in the national policy and planning framework. However in relation to competition the position had improved from amber to green, reflecting the positive benefits of the year-end position in relation to both the CQC rating and our financial position, and the ongoing elective capacity challenges in adjacent trusts. The board requested this year's BAF be adapted to include the longer term financial view. In response, RT confirmed that the next board seminar would be dedicated to future sustainability and surpluses. However, it was acknowledged that the focus of the BAF was on all strategic goals, not just financial. The seminar format would lend itself to a more detailed discussion around these issues. There were no further questions and the Chair thanked RT for his report, the contents of which were **NOTED** by the board.
70-16	**Corporate Risk register (CRR)** RT presented the latest CRR, developed to provide assurance that risks were being identified, reviewed and updated in a timely manner. He acknowledged that, due to formatting errors, this version was not fully aligned in places making it difficult to read. It was agreed the document would be revised as soon as possible. In the meantime, the board sought and received assurance on the following: • That the CRR was an operational document, reviewed and assessed by the executive and at Quality and governance committee on a regular basis; • Key drivers were highlighted in the accompanying report's front sheet; • Current long term sickness and vacancy within the risk team was being managed effectively. Whilst noting the Audit committee was about to incorporate a new system of reviewing risks associated with each KSO on a rolling basis, it was emphasised that this was designed to test process and not content. SF asked the board to note that the report referred incorrectly to PIP breast implants. This should have read NAGOR implants and the report would be amended accordingly. There were no further questions and the Chair thanked RT for his report, the contents of which were **NOTED** by the board.

71-16	**Board Assurance Framework KSO1** There were no changes to this month's update, the contents of which were **NOTED** by the board.
72-16	**Patient story: experience** JMT highlighted the difficulties in identifying patients who were willing and able to attend board sessions to provide an insight into their experience. She was currently working with SF to explore further options. In the meantime, GC suggested that patients' complaint and plaudit letters could be used to apprise the board of their experiences. **[Action: JMT]**
73-16	**Quality and Governance assurance report** The Chair thanked LP for his chairing of the Q & G committee whilst GC had been acting in a temporary capacity as Clinical Advisor to the trust. There were no further questions and the board **NOTED** the contents of the update.
74-16	**Quality and safety report** JMT presented the Q & S report detailing the latest information and providing assurance that the quality of care at QVH was safe, effective, responsive, caring and well-led. The following areas were highlighted: • Formal acknowledgement that the CQC had now published the QVH inspection report. As the board was aware, the trust had been judged as a 'good' overall with 'outstanding' overall for care. In addition, QVH received very positive feedback from the CQC at its quality summit. The trust was now collaborating with the CQC to achieve an 'outstanding' rating. The Chair paid particular tribute to JMT and SF for leading the Quality Summit in RT's unforeseen absence; • The board was cognisant that the trust had not performed well following a recent NHS Protect assessment. This was despite an earlier self-assessment indicating overall compliance. JMT assured the board of the remedial action taken to date. Further developments would be monitored - predominantly through Quality and governance committee – although the Audit committee would be reviewing commissioning of services; • Revalidation: JMT reminded the board that all nurses and midwives now have to revalidate their professional qualification every 3 years under the new NMC guidance. The Deputy Director of Nursing and Deputy Director of Human Resources were leading on this project and initial responses appeared positive; • The draft Quality Account was on track for submission. The only data outstanding related to stakeholder comments, over which the trust had no control; • The board was asked to note an error in reporting whereby 'No Serious incidents were reported in February or March 2016' should be changed to 'One Serious Incident was reported in February and none in March 2016' The Chair congratulated JMT on the improved reporting format. The board went on to discuss matters arising from JMT's briefing including: • Assurance of steps being taken with regard to vacancy levels, noting recent improvements within Canadian Wing; • Assurance of the actions taken to improve response rates for the Friends and Family Test; • Compliance in Practice: Recognition that underperformance was identified in the incident reporting section, particularly with regard to wider communication of incidents and subsequent learning. Methods of capturing any issues relating to the non clinical environment were also discussed. • Assurance that whilst trialling a reduction in the number of ward beds open at the weekend the situation was being carefully monitored. RT noted that reduced flexibility could be reflected in this year's staff survey. However, any issues would be triangulated to retain confidence in

	safety; • Assurance that the review of medication errors by Ward Managers was appropriate to this role and part of overall development. The Chair thanked JMT for her update, the contents of which were **NOTED** by the board.
Key strategic objective 2: world-class clinical services	
75-16	**Board Assurance Framework KSO2** It was noted there was still much to do in terms of addressing gaps in controls and assurances. There were no further questions and the board **NOTED** the contents of the update.
76-16	**Medical director's report** The medical director update this month highlighted the following: • Details of the National Mortality Case Record Review Programme, organised by the Royal College of physicians to establish and roll out a standardised methodology and process for retrospective case record review (RCRR) for adult acute care deaths; • An update on work underway to resolve Critical Care and Out of Hours cover, as highlighted during the recent CQC inspection; • A breakdown of the data relating to medical and dental consultant workforce. This has changed nationally over the last fifty years, with a move towards more corporate responsibility and shorter but more specific training requirements The board went on to discuss matters arising from SF's briefing including the age demographic and gender specifics. The Chair thanked SF for his update, the contents of which were **NOTED** by the board.
77-16	**Clinical Audit Strategy** SF presented a strategy describing how the trust intended to develop and support clinical audit over the next three years, in line with its wider governance and assurance mechanisms. This had been reviewed by the Quality and governance committee and was recommended for approval by the board today. The board agreed the strategy was a well written and easy to navigate, and commended the report's author. It went on to discuss matters arising from the strategy including: • The possibility of developing links between Clinical Audit and Research and Development; • The potential for gaining assurance from an internal audit perspective; • Whilst the Best Practice policy was currently under review, methods for capturing its intent remained wide-ranging; • Assurance that outstanding actions were tracked through the Quality and governance committee; • The issue of 'Patient engagement/involvement' where it was important not to duplicate work already undertaken by the Patient Experience Group. There were no further questions and the board **APPROVED** the Clinical Audit strategy.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
78-16	**Board Assurance Framework KSO3 and KSO4** The BAF updates for KSOs 3 and 4 were presented for information. Whilst there were no material changes to KSO3, SJ highlighted changes to Cancer reporting

	standards. The board was also apprised that the slow rise in cancer referrals could affect the 18 RTT open pathway target. The board went on to consider: • The financial and operational impact of recent industrial action, noting implications for the BAF, CRR and the trust's financial risk rating should the situation continue; • The reasons behind the KSO4 current and residual risk ratings. Whilst internal control was strong, the trust had little influence over external factors. • The impact of the Sustainability and Transformation agenda on the trust's financial sustainability and the importance of QVH remaining fully engaged in the process; • The opportunities and threats arising from the 3Ts business case, with the first phase scheduled for 2020/21. There were no further questions and the board **NOTED** the contents of the update.
79-16	**Finance and operational performance assurance report** As chair of the F & P committee, JT presented the monthly report relating to delivery of financial and performance targets. He noted that business plans and underlying activity plans had progressed well, but warned of a number of uncertainties which could impact on achieving our surplus He also cautioned that, whilst some headroom had been created, further work was required in respect of Cost Improvement Plans. The board went on to discuss briefly the technicalities of implementing the Sustainability and Transformation plans and the uncertainty created by the central guidance on control totals. There were no further questions and the board **NOTED** the contents of the update.
80-16	**Operational performance** SJ presented the regular operational performance report which detailed targets, delivery and Key Performance Indicators. The board congratulated SJ on the excellent achievement to date. There were no other comments and, the board noted the contents of the update
81-16	**Financial performance** CS presented the interim (unaudited) financial position showing that the trust had delivered a cumulative surplus of £827k (£190k behind plan). The annual report and accounts had been submitted to KPMG on 21 April. No material misstatements or adjustments had been highlighted. JMT reminded the board that in 2014/15 KPMG had been unable to issue a limited opinion on the percentage of incomplete pathways within 18 weeks for patients. Once again, KPMG would be unable to offer an opinion as there was less than 12 month's of data to process. . Overall, however, JMT was assured that the external audit opinion would be supportive of the trust's position in this respect. CS presented a statement of comprehensive income for 2015/16, noting the following: • The surplus for the year was £1.5m; • An independent revaluation exercise on land buildings had been undertaken and the value of fixed assets had increased materially. • After income and expenditure adjustments, the operational surplus was £827k. This was the figure on which the trust's financial performance would be assessed by the regulator. • The cash position was currently favourable on the basis of current liquidity and debt service

	rations, although deterioration of Income and Expenditure performance or delays in payment of debt could have an adverse effect. There were no further questions and the board **NOTED** the contents of the update.
82-16	**2016-17 Business plan – for information** CS reminded the board that the process for review and sign off of the 2016-17 business plan had been delegated to the Finance and Performance committee. This report, (which was for the board to note, therefore), provided an update on the status of NHS Commissioner contracts and the revenue and capital plans submitted to Monitor on 18th April. Whilst there had been no material changes since this time, CS apprised the board of the following: • Thanks to the efforts of the Head of Commerce and her team, the trust had agreements in place with all commissioners where the value of activity planned in the year exceeded £200k. • There was still no formal contract agreement with NHS England; • Despite good performance overall, the capital planning proposal had increased by £59k to account for the carry forward from the 2015-16 capital programme; • Emerging risks in respect of CQUINS, due to a change in focus. Plans would be completed and returned to JMT, as trust lead. Delivery against milestones would be monitored and an escalation process would be agreed; • Assurance that the plan retains a financial risk rating (FRR) of 4 with an explanation of the impact of phasing. Additional detail would be included in the Finance and performance reports to aid clarity. In order to further enhance the board's engagement in the budget process, CS reminded members of the open invitation to attend the March Finance and performance committee meetings.. There were no further questions and the board **NOTED** the contents of the 2016-17 business plan.
Key strategic objective 5: organisational excellence	
83-16	**Board Assurance Framework** The BAF update for KSO5 was presented for information. GA asked the board to note specific analysis on vacancy versus absence management, and the Band 7 ward manager development programme being implemented to address recruitment and retention issues. A further initiative to address the shortage of theatre staff was to appoint an external agency to support the recruitment process. Whilst assuring the board there would be only limited financial implications, GA agreed to apprise CS of the detail before progressing further. **[Action: GA].** There were no questions and the board **NOTED** its contents.
84-16	**Workforce report** GA presented the latest report containing information on establishment figures, staff in post, bank and agency usage, sickness absence, recruitment activity and statutory mandatory training. Highlights included: • Establishment – the operational gap (the difference between staff establishments and staff in post) was 116.82 WTE posts, a decrease compared to the previous month. • The sickness absence rate had increased . However, the HR team was focusing on reducing the number of long terms sickness absence cases, which should have a positive impact on overall rates. • Improvements in appraisal rates and in statutory and mandatory training rates for bank and agency staff;

	• An appendix designed to highlight any correlation between staff vacancies and absence was reviewed, with assurance that this was monitored to identify any trends. The board sought assurance in respect of: • The accuracy of the establishment figures. Whilst these had been reviewed as part of the business planning process, a further workforce review was scheduled for June at which time more work would be undertaken on the workforce plan. The board would be updated on results in due course **[Action: GA.]** CS noted that the business planning should also be reconciled against eRostering and ESR for greater accuracy. GA was confident that with the recent appointment of a workforce analyst reporting in this area should improve. • Workforce KPIs, with an explanation provided in respect of turnover, sickness absence and annual leave optimum levels. There were no further questions. The board **NOTED** the contents of the report.
85-16	**Equality and Diversity Strategy** GA presented a three-year strategy, developed by the Equality and Diversity Group (EDG), and based on the trust's requirement to comply with Equality Delivery System 2 (EDS2) and the Workforce Race Equality Standard (WRES). This strategy has been designed to provide clarity on the targets set in relation to equality and human rights. And, also set out objectives against which the EDG would continue to monitor performance and provide updates to the board. After considering the report, clarification was sought in respect of: • Today's recommendation: GA explained that the Strategy was for the board to note, whilst the Annual Report (due in Q2) would be presented for approval; • How board members would be held to account. GA conceded this was not explicit. The Annual Plan would be developed separately with measurements and timescales and included as part of the Annual Report. **[Action: GA]** The board then went on to discuss issues of gender equality within the trust. GA noted there whilst there was some disparity, this was the norm within the health service, and reflective of the nature of the work undertaken by the trust. Whilst he was keen to avoid positive discrimination, GA conceded that more analysis could be done in auditing recruitment initiatives and profiling the type of groups the trust wished to attract. There were no further comments and the board **NOTED** the contents of the report.
86-16	**Staff survey action plan** Referring back to his earlier update, GA presented the action plan developed following the 2015 Staff Survey. After due deliberation, the following points were highlighted: • That the report's recommendation should read for the *board* to note and not the *finance and performance committee* as stated; • The first page of the action plan should read *four* key areas not *two*; • That more work was needed in order to address higher pockets of bullying and harassment; • Whilst there was no separate action plan to improve staff engagement, the board asked for this to be cross-referenced for the sake of clarity. There were no further questions and the board noted the content of the update.
Board governance	

87-16	**Annual report and accounts - delegation of authority** In the event of absence by the CEO during the annual report and account approval process, it was agreed that in accordance with paragraph 3.17 of the trust's standing orders and paragraph 2.4.9 of the standing financial instructions, arrangements would be made for the delegation of temporary short-term powers of the chief executive officer. **[Action: HS]**
88-16	**Suite of trust governance documentation for ratification** The board was recommended to approve the suite of governance documents(previously circulated by email to all members), and to which it had already indicated support. There were no further questions and the board formally **APPROVED** the suite of documents, noting that approval was retrospective, with effect from 1st April 2016.
89-16	**Changes to Constitution** The board was apprised of the completion of the QVH Constitution amendment process which it had initiated earlier in the year. BH asked the board to note that it was the Council of Governors rather than the board of directors which was accountable for the membership strategy. The recommendation contained within the report was therefore discarded.. There were no further questions and the board **NOTED** the content of the update.
90-16	**QVH Charity committee** LP presented an update on the Charity committee following its meeting on 31 March. He explained why support for staff events had been reviewed in the light of recent media coverage of this issue. It was agreed that no further staff events should be supported until advice and clarification had been received from the Charity Commission, at which point the Charity's position on this would be reviewed. There were no further questions and the board **NOTED** the content of the update.
91-16	**Audit committee** LP reminded the board that the committee had agreed to assess Mazars' (internal auditors) performance at the end of March to ensure that the recovery plan had been achieved and to review next steps, (which included the potential to end the contract). The committee was also mindful of the trust's expectation to appoint new external auditors in September 2016 and its concern not to change both internal and external auditors in quick succession. Following an improvement in performance, LP reported the committee was inclined to continue with the Mazars contract subject to key changes of personnel assigned to the contract, and to continued performance monitoring. As a consequence, the trust could now proceed with appointing new External Auditors. It was anticipated a recommendation would go before Council in July or October, depending on timescales. There were no further questions and the board **NOTED** the content of the update.
92-16	**Annual DoI/FPPT returns** The board was reminded that Directors' declarations of interest and Fit and Proper Person declarations for the 2016/17 register were now due. Electronic copies would be circulated immediately

	following the meeting. RT suggested that declarations made under the register of 'fit and proper persons' should be amended from N/A to 'Yes' or 'No', as appropriate **[Action: HS]**
93-16	**Draft agenda for July 2016 business meeting** The board noted the content of the draft agenda for July. .
Any other business (by application to the Chair)	
94-16	There was no further business.
Observations and feedback	
95-16	**Feedback from key events and other engagement with staff and stakeholders** BH had attended a recent Chairs meeting which had focused on current Sustainability and Transformation plans, and reiterated earlier comments made by RT.
96-16	**Observations from members of the public** Clarification in respect of CQC ratings was sought from the Chair, with acknowledgment that the trust had achieved a great result. There being no further business, the meeting closed at 1.05pm
97-16	**Observations and feedback on the meeting** These were taken during an informal private session of the meeting.

Chair …….. Date …….

Matters arising and actions pending from previous meetings of the Board of Directors (BoD)						
No.	**Reference**	**Action**	**Owner**	**Action due**	**Latest update**	**Status**
7 May 2016						
1.		Refresh Trust staff training in order to bring it in line NHS Protect Standard on Conflict Resolution	**JMT/ CS**	June 2016		**Pending**
2.		Updated Trust staff training (compliant with NHS Protect Standard on *Conflict Resolution*) to go in staff induction packs	**JMT/ CS**	June 2016		**Pending**
3.		Recall Trust identity badges and reissue them with time-specific expiry dates	**JMT/ CS**	June 2016		**Pending**
4.		Ensure Trust CCTV usage is compliant with NHS Protect standard on *Security* (*on premises and buildings*)	**JMT/ CS**	TBA		**Pending**
5.		Audit Committee to note that lessons have been learnt on the need to examine/challenge evidence supporting self-assessment outcomes (such as the one carried out on NHS Protect standards)	**LP**	June 2016		**Pending**
6.		Quality & Governance Committee to monitor action plan emerging from the outcome of the NHS Protect assessment	**GC**	June 2016		**Pending**
7.		Action plan from NHS Protect assessment to go to Health and Safety Committee	**JMT/ CS**	June 2016		**Pending**
8.		Action plan from NHS Protect assessment to be escalated from Health and Safety Committee to Quality & Governance Committee	**JMT/ CS**	June 2016		**Pending**
9.		Disseminate lessons learnt from form NHS Protect assessment to the rest of the organisation	**JMT/ CS**	June 2016		**Pending**
10.		Invite NHS Protect to carry out another full assessment after execution of action plan	**JMT/ CS**			**Pending**
11.		Update board on progress on STP	**RT**	Ongoing		**Ongoing**

Matters arising and actions pending from previous meetings of the Board of Directors (BoD)						
No.	**Reference**	**Action**	**Owner**	**Action due**	**Latest update**	**Status**
12.		Advise Board on issues emerging from STP process	**RT**	TBA		**Pending**
13.	**72-16**	Patient correspondence to be presented to board as a way in which to impart the 'Patient Story'	**JMT**	July		**Pending**
14.	**83-16**	Finance team to be apprised of impact of appointing external agencies for recruitment of theatre staff prior to proceeding further.	~~**GA**~~ **GO**	ASAP		**Pending**
15.	**84-16**	Board to receive further assurance of accuracy of establishment figures following workforce review in June.	~~**GA**~~ **GO**	Sept		**Pending**
16.	**85-16**	E & D Annual Plan to be developed with accountabilities, measurements and timescales and included part of the E & D Annual Report in Q2.	~~**GA**~~ **GO**	End Q2		**Pending**
17.	**87-16**	Delegation of temporary short-term powers of chief executive officer to be arranged in the event of his absence during approval of annual report and accounts.	**HS**	ASAP		**Complete**
18.	**92-16**	Declarations made under the register of 'fit and proper persons' to be amended from N/A to 'Yes' or 'No' **[Action: HS]**	**HS**	July		**Complete**
19.	**42-16**	Patient Experience Group to be tasked with monitoring action plan following 2015 national inpatient survey results	**JMT**		**05 05 16** JT confirmed this is now complete	**Complete**
20.	**43-16**	Discussion on implications of the new consultant contract to be added the board seminar programme	**KA**		**03 03 16** Board seminar programme updated. Date to be agreed by Chair and CEO in due course	**Complete**
21.	**45-16**	Additional work on internal affordability of SOC for burns services	**RT**		**05 05 16** Initial SOC submitted on 18.4. RT to continue to provide updates as appropriate	**Ongoing**
22.	**52-16**	Clarification in respect of KF27 (staff survey), to gain better understanding of question posed to staff.	**GA**		**05 05 16** Report tabled, update provided, action now complete	**Complete**
23.	**52-16**	Analysis of data (where appropriate) to ascertain areas where staff have expressed reluctance to	**GA**		**05 05 16** Report tabled, update provided, action now	**Complete**

Matters arising and actions pending from previous meetings of the Board of Directors (BoD)						
No.	**Reference**	**Action**	**Owner**	**Action due**	**Latest update**	**Status**
		report bullying, harassment or abuse in the workplace.			complete	
24.	**52-16**	Analysis of reasons for staff dissatisfaction with opportunities for flexible working.	**GA**		**05 05 16** Report tabled, update provided, action now complete	**Complete**
25.	**52-16**	Work to be undertaken this year to improve response rates for 2016 national staff survey.	**GA**		**05 05 16** Report tabled, update provided, including details of efforts to improve response rates plus launch of online version for 2016. Action now complete	**Complete**
26.	**52-16**	Formal action plan in response to 2015 staff survey to be presented to the board in May 2016	**GA**		**05 05 16** Report tabled, update provided, action now complete	**Complete**
27.	**55-16**	Discrepancy within revised N & R Terms of Reference to be addressed. BoD to be apprised of outcome via email.	**KA**		**05 05 16** BH confirmed this had been actioned prior to KA leaving the trust.	**Complete**
7 January 2016						
28.	**21-16**	Pending review of best practice at other trusts, final version of the Engagement policy for celebrity, VIP and other high-profile visitors and supporters to be ratified by the board electronically.	~~**KA**~~ **CK**	~~April 16~~ July 16	**05 05 16** To be formally ratified at July board	**Pending**
5 November 2015						
29.	**236b-15**	Executive team to review allocation of nursing staff budgets and report conclusions in 6 months' time.	**JMT**	~~May 16~~ July 16	On July agenda	**Pending**

Chief Executive's Report					
References					
Meeting title:	**Board of directors**				
Meeting date:	**7th July 2016**		**Agenda reference:**	**112-16**	
Report title:	**Chief Executive's Report**				
Sponsor:	Richard Tyler, Chief Executive				
Author:	Richard Tyler, Chief Executive				
Appendices:	None				
Executive summary					
Purpose:	To update the Board on progress and risks to key internal targets and to provide an update on external issues that may have an impact on the trust's ability to achieve its internal targets.				
Recommendation:	To note the report				
Purpose:	Information	Information	Information	Information	Information
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	External issues will be considered as part of the BAF 'horizon scanning' section.				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Executive Management Team – relevant sections only				
	Date:	20th June	Decision:	Review BAF	

CHIEF EXECUTIVE'S REPORT
JULY 2016

Changes to the Executive Team
As the Board is aware our Medical Director, Steve Fenlon, has been appointed to the post of Medical Director at Dartford and Gravesham NHS Trust. We have started the recruitment process for his successor and interviews are scheduled for the last week in July.

We have appointed Geraldine Opreshko as interim Director of HR & OD. We aim to start the recruitment process for a permanent director later in July.

Finally we have appointed Clare Pirie to the post of Head of Communications & Corporate Affairs. Clare starts on 11th July. I would like to take this opportunity to thank Chipo Kazoka for his support as interim Head of Corporate Affairs and wish him well for the future.

Sustainability & Transformation Plans
As the Board will be aware the Trust is engaged in the Sussex sustainability & transformation plan (STP). An initial submission was made to NHS England on 15th April which set out the main challenges for the Sussex footprint.

We have been fully engaged in the S&T process and the latest iteration was submitted on 30th June. Following changes in the national governance process it was determined that this iteration forms 'a plan for a plan' and as such does not require formal sign off by individual organisations. The STP leadership did hold a stakeholder event on 27th June and this was attended by a number of members of the Trust Board.

The latest iteration will be reviewed by NHS England during July and further work will then be required before the next submission in September. We will continue to keep the Board apprised of progress as more detailed proposals emerge.

2015/16 provider deficits
The total provider deficit for 2015/16 was £2.45bn with the underlying position around the £3bn mark. Board members will recall that the planned year-end deficit was £1.8bn. Recent guidance from *NHS Improvement* indicates that the aggregate planned provider deficit stands at £550m. The guidance proposes further action to reduce the planned deficit. Of particular interest to the Trust is the focus on back office and pathology consolidation, both of which were highlighted in *The Carter Review*. STP leads are being asked to develop proposals to consolidate back office and pathology services with outline plans, initially on an STP footprint, to be agreed by the end of July.

Board Assurance Framework (BAF)
Attached is the BAF front-sheet and the corporate register. The following points are worth noting.

In respect of the KSO risk scores and horizon scanning the level of risk remains unchanged from May 2016.

Richard Tyler
Chief Executive

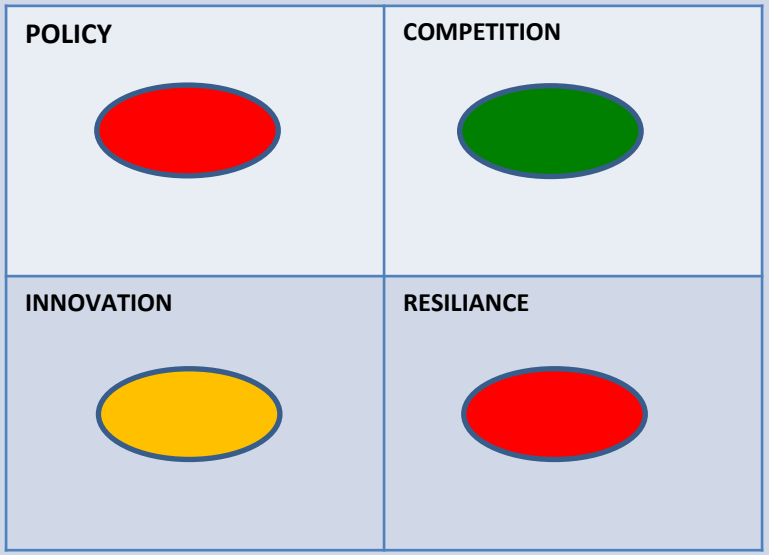
Board Assurance Framework – Risks to achievement of KSOs

KSO 1 Outstanding Patient Experience	KSO 2 World Class Clinical Services	KSO 3 Operational Excellence	KSO 4 Financial Sustainability	KSO 5 Organisational Excellence
Patients lose confidence in the quality of our services and the environment in which we provide them due to increasing patient safety incidents, a decline in care standards and a failure to maintain a modern care environment	Patients, clinicians & commissioners lose confidence in our services due to a decline in clinical outcomes, a reduction in research output and fall in teaching standards.	Patients & Commissioners lose confidence in our ability to provide timely and effective treatment due to an increase in waiting times and a fall in productivity.	Regulators lose confidence in the long-term financial sustainability of the Trust due to a failure to create adequate surpluses to fund operational and strategic investments.	Staff lose confidence in the Trust as place to work due to a failure to offer; adequate training, opportunities ; staff development; and a failure to act on the findings of the annual staff survey.

Current Risk Levels

	Q4	May	July	August
KSO 1	10	10	10	
KSO 2	15	15	15	
KSO 3	15	15	15	
KSO 4	20	20	20	
KSO 5	15	15	15	

Future Threats



Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/07/16**		**Agenda reference:**	**13-16**	
Report title:	**Monthly Risk Exception report (Reporting period of 01/06/2015 – 30/06/2015)**				
Sponsor:	Jo Thomas				
Author:	Ian Fearnley				
Appendices:	None				
Executive summary					
Purpose:	To provide high level assurance that quality and risk is being effectively managed within QVH.				
Recommendation:	The Committee is requested to note the contents of the report and the progress made.				
Purpose:	Information	Information	Information	Information	Information
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	Internal links exist from this document to the Corporate Risk Register and the BAF				
Corporate risk register:	As above				
Regulation:	NHSI and CQC requirements.				
Legal:	As above				
Resources:	None				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:	Information	

Corporate Risk Register Report June 2016

Key issues

1. Three new risks were added to the Corporate Risk Register one scored/rated as a 12 and the others were rated 9

   972: Potential for the lack of Executive leadership due to the CEO and Medical Director leaving the Trust within a short timeframe (9)

   973: Potential staff retention issues due to current nursing consultation (9)

   968: Delivery of commissioned services whilst not meeting all national standards/criteria for Burns and Paed (12)

2. Three risks had a score/grading change:

   951: Ability to Deliver Conflict Resolution Training to Required NHS Protect Standard reduced to 9

   944: Impact of reduced delivery of Risk Management functions Reduced to 8

   967: Lack of assurance of quality of care Reduced to 8

   910: Removed
   954: Removed
   935: Removed

3. The corporate risk register was reviewed at the monthly Clinical Governance Group and Quality and Governance Committee in early June

Implications of results reported

4. The register demonstrates that the trust is aware of key risks that affect the organisation and that these are reviewed by owners.

5. No specific group/individual with a protected characteristic are affected issues identified within the risk register.

6. Failure to address risks or to recognise the action required to mitigate them would be key concerns to our commissioners, the Care Quality Commission and Monitor. **Action required**

7. Continuous review of existing risks and identification of new or altering risks through existing processes.

   Link to Key Strategic Objectives
   Outstanding patient experience
   World class clinical services
   Operational excellence
   Financial sustainability
   Organisational excellence

8. The attached risks can be seen to impact on all the trusts KSOs.

Implications for BAF or Corporate Risk Register

9. Significant corporate risks have been cross referenced with the Trusts Board Assurance Framework.

Regulatory impacts

10. The attached risk register would inform the CQC but does not have any impact on our ability to comply our CQC authorisation and does not indicate that the Trust is not:
    - Safe
    - Effective
    - Caring
    - Well led
    - Responsive

11. The attached risk register does not impact on our Monitor governance risk rating or our continuity of service risk rating.

Recommendation

The Board is recommended to **note** the contents of the report.

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Trend	Actions	Date Reviewed
968	20/06/2016	Delivery of commissioned services whilst not meeting all national standards/criteria for Burns and Paeds	Potential increase in the risk to patient safety Loss of income due to burns derogation	*Paeds review group in place *Mitigation protocol in place surrounding transfer in and off site of paeds patients *Established safeguarding processes in place to ensure children are triaged appropriately, managed safely *Robust clinical support for paeds by specialist consultants within the Trust *All registered nursing staff working within paediatric hold an appropriate NMC registration and are paediatric trained * Visiting consultant for paediatrics X3 sessions per week from BSUHT *Robust incident reporting in place *Serious Incidents are managed through the CGG *Named paeds safeguarding consultant in post *Strict admittance criteria based on pre-existing and presenting medical problems, including extent of burn scaled to age. *Surgery only offered at selected times based on age group (no under 3 years OOH) *Paediatric anaesthetic oversight of all children having general anaesthesia under 3 years of age.	Jo Thomas	Kelly Stevens	Compliance (Targets / Assessments / Standards)	12	4	**NEW**	To be reviewed in July following Clinical Cabinet discussions Paper to be presented at Clinical Cabinet in June 2016	20/07/2016
966	31/05/2016	Access wait times for Oral and Maxillofacial Surgery are increasing at Medway Maritime.	Significantly Increasing wait times for dental treatment (where the waits were already longer than at the QVH site) at Medway Maritime Hospital with the key driver being delays in the host Trust purchasing a new machine and then strengthening a wall on to which the new dental x-ray machine (OPG)is to be mounted. The old free standing one had broken and Trust purchased a replacement one which was wall mounted. However the purchase was made prior to an assessment of the wall being strong enough to hold the new machine	Medway Maritime have arranged for patients to attend Sittingbourne Hospital for a dental xray, however this is not always possible for all patients as the image required may need an initial consultation. If this is to occur patients are therefore taking up two appointment slots leading to further delay. Any urgent referrals can be seen at either Maidstone Hospital or at Queen Victoria Hospital	Sharon Jones	Dumiso Ncube	Compliance (Targets / Assessments / Standards)	12	2	↔	22/06/2016 This issue and a date of resolution has been raised at the last two contract meetings, followed up by regular emails and phone calls. It has now been escalated to a CEO to CEO officer conversation which took place on 21/6/16 and assurance gained 22/06/2016 Risk Reviewed by IHoR awaiting input from risk owner for an update of controls and any new actions. Email sent to risk owner on 22/06/2016	22/06/2016
949	08/04/2016	Threat to scheduling and reporting of patient waits and performance (RTT18) through system enhancement	Improved stability and detail of data from off-site locations will improve visibility of underperformance against national standards e.g. waiting time RTT18 but this will impact adversely upon reported performance. The lack of good data, along with access to their patient administration systems and so inability to include these patients on the QVH patient tracking list, is a long standing issue which is now being addressed. Medway is the main risk area as apart from a three month period in the summer of 2015, they have not been able to report their 18 RTT position since November 2014 and this has impacted upon QVH. When Medway was reporting, it was one of the worst performers in England.	1. Weekly and monthly data feeds from the offsite locations do not contain sufficient detail to correctly report Offsite RTT performance 2.Business unit managers are aware and working to gather data via manual and paper systems to assess risk as much as possible; 3.Accuracy of Onsite performance is validated and assured 4.A recovery plan will be commenced as soon as there is enough data and a trajectory agreed, this will be revised once there is more accurate data via the warehouse functionality	Sharon Jones	Rob Lock	Compliance (Targets / Assessments / Standards)	15	6	↔	22/06/2016 Risk reviewed with IHoR and IM Progress been made with East Kent to provide a data warehouse	22/06/2016
948	07/04/2016	Risk to patient care and reputation due to failing new Sussex transport provider	New provider for non-emergency Sussex transport took over on 1st April 2016 but severe problems with accessing service and delivery	Alternative and very responsive accredited PTS provider recommended by CGG and using this service to deliver PTS where Sussex is failing -Staff notified via email and QNet of issues and requirement to contact relevant staff if problems arise to be redirected to new provider. -Patients informed of issue via staff and website. -Arrangements in place with alternative provider to invoice appropriately so adequate recharges can be applied Remediation action plan established by commissioners. Weekly teleconference between provider, CCG and Coperforma. Site visits form coperforma. Situation at 23.6.16 is improving situation on all KPIs but weekly issues still arise and being addressed.	Sharon Jones	Paul Gable	Patient Safety	12	6	↔	22/06/2016 Risk Reviewed by IHoR awaiting input from risk owner for an update of controls and any new actions. Email sent to risk owner on 22/06/2016 Remediation action plan established by commissioners. Weekly teleconference between provider, CCG and Coperforma. Site visits form coperforma. Situation at 23.6.16 is improving situation on all KPIs but weekly issues still arise and being addressed.	22/06/2016
946	05/04/2016	Manual defibrillators not supported by OM potentially unreliable	1) Manual defibrillators are no longer supported by manufacturer 2) Unreliable equipment in identifying accurate rhythms	AED back up to all arrest and MET calls Defibrillators have been checked by EME and batteries are working Documented testing schedule for defibrillators in areas of use Urgent business case submitted for replacement of existing manual defibrillators.	Steve Fenlon	Clive Thomas	Patient Safety	12	4	↔	Risk reviewed with DDoN and IHoR new actions and update added. Risk to remain unchanged as actions not yet completed Business case currently being reviewed by Exec Team to ascertain level of priority for equipment	03/06/2016

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Trend	Actions	Date Reviewed
942	30/03/2016	Nagar - Breast implants	We did not register the implants at the time nor did we advise the patients that they could do so. At that time we were commissioned to replace the implants if they ruptured however this is no longer the case. This may have cost implications in regard to compensating patients for the maladministration.	Since 2008 or 09 nagor implants automatically have a warranty but prior to that they had to be individually registered. Only includes breast implants but will extend to include other implants and skin expanders at a later date Coder related concerns are to be picked up in performance meetings. ACTION: ML to clarify the current process of recording implants and confirm that the correct documentation is being used. Findings to be fed back to NR and SF.	Steve Fenlon	Mrs Nicolle Ferguson	Finance	12	4	↔	03/06/2016 Risk reviewed between IHoR and MD new action and controls added to risk register as identified New Action: The current implant register is a book held within Theatres, and further work is being undertaken in conjunction with the information Team to explore the possibility of using ORSOs to record the implants.	03/06/2016
936	08/03/2016	Eye bank facilities unfit for purpose	Preparation of MHRA licenced blood components (Autologous Plasma Eye Drops) takes place in facilities unfit for purpose. The location belongs to Blond McIndoe Research Foundation and has been turned into a workshop/cleaning store. There are no hand washing facilities in place. This is part of a wider issue with the Eye Bank facilities which are insufficient in size for the required amount of staff which has lead to recruitment issues. The BMRF building and Cleanroom Air Handling Unit has been deemed unfit for purpose by QVH Estates Department with the AHU not complying to Healthcare Technical Memorandum (HTM) specifications. A business case for replacement was submitted in 2014. Following that, interim repairs were made. The remaining plant is however still aging and this should remain on the risk register (previous risks around this area have been removed from the risk register). A PLACE inspection 08/03/2016 has highlighted the issues with the Plasma Eye Drop preparation area and internal flooring of the Eye Bank. Potential MHRA licencing issues may result.	Relocation or refurbishment required Project plan in place which include removal of carpet from clinical areas and clear demarcation for clinical and non-clinical use.	Sharon Jones	Colette Donnelly	Estates Infrastructure & Environment	12	4	↔	Trust-wide Asbestos review being undertaken in July 2016 Review of current lease before any work can commence 22/06/2016 Risk discussed with IHoR and HoE to remain unchanged but new control added together with new actions. Estates recommend that an Asbestos R&D survey be carried prior to any works being carried out.	22/06/2016
934	25/02/2016	New Burns Theatre doors not fit for purpose	The doors would appear to be installed the wrong way around; the window shutters are only accessible on the theatre side when they need to be on the outside so staff can check before entering the theatre environment The doors should open out not into theatre; since there is the potential for opening the doors and colliding with staff or equipment in theatre The doors do not appear to be aligned The doors do not stay open which means 3 staff are required to hold the doors and manoeuvre the patient/bed through The doors are heavy to push and when you push against one door to open it, the other door is also 'moving' since the two doors are in such close contact so increasing the force required to open them Sealant around the windows appears untidy and not properly finished	Awareness Reviewed by Simon wells & Mark Ripley 08/04/2016: Order placed for electrification of doors. Interim Head for Estates has agreed to fund the works Business case approved for work to commence on preparing the automatic shutter mechanism on the doors, therefore reducing the risk	Clare Stafford	Jill Ratoff	Estates Infrastructure & Environment	12	4		22/06/2016 Risk discussed with IHoR and HoE Work to start in late June or early July to fix automatic door mechanism therefore reducing the risk considerably. Risk remains unchanged as work not yet started. Once this is complete please remove for register	22/06/2016
932	19/02/2016	Current level of management competency in workforce planning	Poor long term workforce planning leading to inefficient use of resources and poor planning for service change	1. Implementation of the a new workforce planning template from February 2016 2. HR/OD supporting managers to complete the template and linking to the annual business planning process 3. Establish overall 3 year workface plan	Geraldine Opreshko	Olive Jones	Finance	12	4	↔	22/06/2016 Risk Reviewed by IHoR awaiting input from risk owner for an update of controls and any new actions. Email sent to risk owner on 22/06/2016	22/06/2016

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Trend	Actions	Date Reviewed
928	11/02/2016	Insufficient staff to cope with increased activity	Pharmacists are being pulled from other direct clinical and indirect clinical duties to help provide a dispensing service in order to keep the waiting times down. Staff are working extra unpaid which is unsustainable in the long term, increasing stress and potentially leads to increased sick leave. Guidelines and policies are not updated in a timely manner. Audits are not completed. The service is not developed e.g. inability to progress any further with electronic prescribing project due to lack of time. Staff are unable to attend CCG prescribing meetings which may make decisions that will impact adversely on the Trust. Patients may not be prescribed their correct regular medication due to a lack or untimely medicines reconciliation on admission. Patients discharged may be delayed due to dispensary staff unable to cope with inpatient and outpatient workload.	Staff currently working unpaid overtime Additional 0.6 band 7 pharmacist and band 2 assistant requested in business plan for 2016/17. (Lowest grades possible). Recruitment of band 4 technician will help to release pharmacist time for more clinical work. Going forward the Trust has a new process for business cases to ensure that the effect on all services are considered in the planning process	Sharon Jones	Judy Busby	Patient Safety	12	9	↔	22/06/2016 Risk Reviewed by IHoR awaiting input from risk owner for an update of controls and any new actions. Email sent to risk owner on 22/06/2016 23.6.16 Update. Situation unchanged. Pharmacy dept have devised prioritisation list to ensure frontline pharmacy services unaffected and dealt with over back office functions.	22/06/2016
925	28/01/2016	Information provision: Data processing and delivery is unstable, due to legacy systems	Failure of Information Services scheduled overnight processing tasks: Causes current data on patient pathway and performance to be unavailable or delayed ; impacts on service delivery and financial recovery.	1. Regular monitoring of overnight processing in the day following 2. Early intervention by login from home outside working hours 3. Remote login allows early intervention in event of scheduling failure 4. Prompt notification to affected teams when failure observed	Clare Stafford	Elin Richardson	Finance	12	6	↔	22/06/2016 Risk reviewed by IHoR need an update regarding current controls and any additional actions. Email sent to risk owner requesting an update, sent 22nd June 2016 22/06/16 - Consultation completed. 3 JD's been through banding panel and proceeding to advert. Controls remain in place. 5. Plans to replace existing legacy technology(proposal with EMT) Mobilise to create resilient data warehouse structure for data processing (EMT) EKBI predict 3 months to deliver basic solution. 31/03/2016 Update: EMT approved proposal to engage EKBI in joint work to establish a data warehouse. Project plan being agree Continue vigilance of overnight scheduling Develop staffing structures to provide resources to support development. 31/03/2016 Update: Draft structure paper completed. Cost pressure approved. All job descriptions to be completed and evaluated by A4C panel. Proceed to consultation. Anticipate 2 more Maintain record of failures to collate evidence for RCA	22/06/2016
922	14/01/2016	Recruitment and retention of medical staff Trust wide and appropriate nursing staff (in Theatres and C-Wing)	Recruitment and retention of appropriate nursing staff in Theatres and C-Wing (incls skill mix and safe staffing (Theatres vacancies=22.8 wte (15% of workforce - Agency use = 2.5%). (C-Wing vacancies = 11 wte (18% of workforce - Agency use = 4.8%). requirements) Recruitment and retention of nursing and ODP staff	1. Continual review of recruitment processes 2. HR team review difficult to fill vacancies with operational managers 3. Medical staffing team enhanced to improve recruitment to medical vacancies 4. HR attending weekly operational review meeting 5. Targeted recruitment of theatre staff to be commenced April 2016 6. Specialist agency used to supply nursing and ODA cover 7. 3.1 WTE starting in Feb and March 2016 8. E-Safe Staffing system in use for some ward areas 9. 5% cap on agency spend across the organisation 10. Exception reporting to the Board and clinical cabinet 11. Robust escalation policy in place	Jo Thomas	Nicola Reeves	Patient Safety	12	6	↔	Plan to use specialist agency to be used when recruiting staff for theatre	22/06/2016
923	14/01/2016	Lack of scientific staff	Daily operations (service delivery) within Histopathology affected by the lack of technical staff. Staff aren't able to sustain current working practices due to the increased number of specimens in Histopathology. This will adversely affect the daily operations/ turn-around times and ability to meet national KPIs. In addition, our ISO 15189 accreditation is under risk if we do not meet both these targets and their standards regarding acceptable staffing levels.	Staff currently working additional hours - unpaid - to cover extra work going through lab. Additional Band 4 healthcare scientist requested in business plan to help ease pressure.	Sharon Jones	Fiona Lawson	Compliance (Targets / Assessments / Standards)	12	9	↔	22/06/2016 Risk Reviewed by IHoR awaiting input from risk owner for an update of controls and any new actions. Email sent to risk owner on 22/06/2016 23.6.16 Situation unchanged. Failing to meet KPIs at present. Only likely to return to compliance with sustained reduced demand.	28/06/2016

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885	27/10/2015	Slips trips and falls	Covered corridors which run from main kitchen block around to new theatres in poor condition with uneven and broken surfaces. Floor finish flaking in areas where painted.	Adhoc repairs. Surface of part of corridor re painted in 2013 Civil engineering consultants engaged to undertake feasibility study. Orders raised for civil engineering consultants to undertake detailed design, prepare tender documents and supervise construction work on site. Programme developed to start work on site from January 2016	Clare Stafford	Steve Davies	Estates Infrastructure & Environment	12	6	↔	Risk discussed with IHoR and HoE to remain unchanged until new actions are completed then risk can be reduced. Resurfacing of around 40% of the worse affected area to commence in July. Not all of the area is to be resurfaced as yet just the 40% as mentioned This job is out to tender - appointment of contractor circa June 2016	22/06/2016
884	22/10/2015	Potential for Unauthorised Data Breaches	Lack of technical and physical security measures around handling of personal information.	EXTERNAL CONFIDENTIAL PATIENT INFORMATION BREACHES 1. Mail checked for visible personal details. 2. Reminders of correct postal information required placed regularly in "Q-Net" 3. E mail instruction sent to administration staff. RISK TO INFORMATION ASSETS 1. Policy & Procedures in place 2 Awareness Training undertaken by the Organisation FAILURE TO DESTROY COMPUTER HARD DISK 1. All disks currently destroyed on site only POSSIBLE IG BREACH DUE TO USE OF UNSECURED E-MAIL ACCOUNTS WHEN FORWARDING PATIENT AND STAFF INFORMATION 1. NHS e-mail accounts available and encouraged through IG training 2 Information security acceptable use e-mail policy 5) Potential loss of activity and income affecting financial liability of organisation. 5.1 Quality of work and reputation of QVH provides a strong position. 5.2 Identified areas of opportunity - H&N services and breast surgery from other trusts 5.3 Development of core reconstructive services 5.4 Contract monitoring meetings, 5.5 Programme Board overview 5.6 Business model adapted to cover lost procedures 5.7 Engagement with GP's 5.8 Compliance with low priority policy 5.9 Education and engagement with CCG leads 5.10 Engagement with the tendering process for Healthcare 6) Unencrypted Disks containing Patient Information being sent outside the Trust. 6.1 IG training in place for staff 6.2 IG policies updated Regular reminders to all staff of correct procedures when handling personal information on Q-Net IG Group to monitor and review progress against actions	Clare Stafford	Dominic Bailey	Information Governance	12	8	↔	Purchase encryption hardware for Radiology IT disposal Policy to be ratified and Contractor to be selected Implement Data Leakage Prevention Software on Trust e-mail exchange	02/06/2016
877	21/10/2015	Financial sustainability	1) Failure to achieve key financial targets would adversely impact the Monitor "Financial Sustainability Risk rating and breach the Trust's continuity of service licence. 2)Failure to generate surpluses to fund future operational and strategic investment	1) Annual financial and activity plan 2) Standing financial Instructions 3) Contract Management framework 4) Monthly monitoring of financial performance to Board and Finance and Performance committee 5) Performance Management framework including monthly service Performance review meetings 6) Audit Committee reports on internal controls 7) Internal audit plan	Clare Stafford	Jason McIntyre	Finance	20	15	↔	22/06/2016 Risk reviewed by IHoR need an update regarding current controls and any additional actions. Email sent to risk owner requesting an update, sent 22nd June 2016 1) Development and implementation of delivery plan to address forecast underperformance. Review of performance against delivery plan through PR framework with appropriate escalation policies. 2) Development of multi-year CIP/ transformational programme which complies with best practice guidelines. 3)Development and embedding of integrated business planning framework and pro	22/06/2016
882	21/10/2015	Potential loss of activity as a result of competition and / or new market entrants.	1. Loss of activity and corresponding income particularly where competitors or new market entrants gain market share for high volume / low complexity work. 2. Residual activity is complex and loss making."	1. Market analysis software purchased. 2. Business Development and Productivity Steering Group reviews opportunities. 3. Performance Review Meetings.	Clare Stafford	Jason McIntyre	Finance	12	9	↔	22/06/2016 Risk reviewed by IHoR need an update regarding current controls and any additional actions. Email sent to risk owner requesting an update, sent 22nd June 2016 1. Publish outcome data to secure pipeline of referrals.	22/06/2016
864	20/10/2015	Health Records storage	Delays in providing health records. Missing health records both on and off-site. Unsecure storage of health records. Health and Safety issues on health records retrieval.	Destruction policy in place. Some digitisation of permanent archive records. EDM strategy. Review of possible solutions including change of premises	Clare Stafford	Nicola Reeves	Information Governance	12	3	↔	Risk Review: 22/06/2016 New actions added controls remain unchanged therefore risk to remain the same Estates department currently looking for alternative site/accommodation to house medical records possibly off site EDM Post to start in September	22/06/2016
854	16/10/2015	Inefficiency in Plastics hand clinics within Outpatients causing delay in patient treatment	Patients are not seen in a timely manner, causing excessive wait times within the hand clinics. This is due to both overbooking of the outpatient appointment slots and inefficiencies within the clinic.	Matron and Nurse manager have met with Plastics Business Unit Manager. From 26/10/2015 trail with hand clinics to work in a different way. Consultant and Registrar will remain in one consulting room each, with nurse allocated to work solely with Consultant. Patients will be seen in one room, nursing staff can ensure efficient and effective patient flow occurs therefore reducing the clinic waiting times. Plastics Business Manager will address clinic template and patient pathway to ensure waiting times are reduced and to identify alternative patient follow up appointments to enhance patient flow.	Sharon Jones	Paula Smith	Compliance (Targets / Assessments / Standards)	12	6	↔	22/06/2016 Update and new actions received. Current controls in place are adequate new action identified Where possible 3 Registrars are attached to clinic Cross challenging with medical staff as to the number of patients in clinic 22/06/2016 Risk Reviewed by IHoR awaiting input from risk owner for an update of controls and any new actions. Email sent to risk owner on 22/06/2016	22/06/2016

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849	15/10/2015	Non QVH patients arriving for Phlebotomy service main Outpatients from GP practices	Trust is unaware of patient arriving from GP practices for phlebotomy services. At present unable to cope with demand within current nursing establishment. This level of service with the GP's has not been agreed with the Trust. Patient safety could be compromised.	Staff ensure patients are informed of service provision and ensure accurate recording of GP details on phlebotomy request form. Awaiting mail shot to be sent to GP Practices reminding them of the service provided at QVH.	Sharon Jones	Paul Gable	Patient Safety	12	6	↔	22/06/2016 Risk reviewed by IHoR need an update regarding current controls and any additional actions. Email sent to risk owner requesting an update, sent 22nd June 2016 Update received from risk owner: Email comms sent to Commissioners on behalf of nursing team. Ownership of risk needs to move to Outpatients nursing who manage Phlebotomy services. Evaluate impact of GP comms on Phlebotomy requests Awaiting mail shot to be sent to GP Practices reminding them of the service provided at QVH	22/06/2016
853	15/10/2015	Insufficient space in MIU to treat patients	Building footprint too small for activities of both trauma clinic and MIU walk-in patients, totalling approx. 17,000 patients per annum lack of privacy and dignity for patients as MIU pts seen in a curtained only area. Clinic patients are seen in appropriate examination rooms.	Plans are in place to move the trauma clinic to an alternative location in 2016 which will free up the required space for walk-in patients.	Jo Thomas	Nicola Reeves	Patient Safety	12	6	↔	Reviewed 22/06/2016 with DoN and Head of Risk No additional actions to note and current risk rating to remain unchanged	22/06/2016
844	13/10/2015	Medical cover out of hours	Ability of on site medical staff to function safely within the hospital at night team and ensure all patients have access to adequate medical expertise appropriate to both the needs of adults or children within a suitable timeframe; lack of understanding of the need for greater medical cover at all levels out of hours. Failure to comply with intensive care unit cover guidance; ability to assure support for junior medical and nursing staff out of hours, complying with the requirement of the 7 day services NHS standards.	Currently QVH has a skilled multidisciplinary team available 24/7. There is always a senior doctor on site (ST Anaes) however they can be pulled in more than one direction, in particular when they have responsibility for a case in theatres. Consultant advice is always immediately attendance is half an hour away. Communication with surgical leads has allowed a better time based understanding of the risks to care out of hours in particular the ability to a certain extent to control the level of activity and exposure to risk by adjusting and controlling the cases in theatres. Out of hours operating is managed according to absolute need on the background of the needs of other patients in the organisation. First assessment of the anaesthetic cover provided by consultant staff and how that links to handover ensuring patients can be clearly assessed and managed. Locum cover promised is now in place. This mitigates against the risk posed by maternity leave	Steve Fenlon	Dr Tim Vorster	Patient Safety	12	6	↔	Proposals for achieving cover OOH prepared and to be put to exec team as cost pressure 3rd June 2016 Risk Reviewed with IHoR and MD: Actions now completed and therefore removed and new controls added. Review again in one month Business case has been approved and now in discussion with peers re costing infrastructure	03/06/2016
845	13/10/2015	Lack of a robust process of managing the assessment, implementation and monitoring of national guidelines and evidence based practice	Lack of clear and communicated processes for identifying, assessing, implementing and monitoring relevant external guidelines and evidence based practice, may lead to: 1. Failure to comply with principles of clinical governance in not incorporating best clinical practice. 2. Failure to demonstrate best practice (lack of assurance) both externally (CCG, CQC and Monitor) and internally. 3. Potential harm to patient through lack of adherence to best practice. .	Monthly Clinical Audit Activity Report to the Clinical Governance Group (CGG) - details clinical audit activity against national standards/ recommendations and evidence based practice. Quarterly NICE Implementation reports presented to the CGG. Ongoing horizon scanning undertaken by the Clinical Audit & Outcomes Specialist, which includes the publication of national guidance and best practice. Ongoing participation and engagement with national Audits and NCEPOD studies. Monthly review of newly published NICE guidance, and ongoing work to assess and maintain Trust compliance. New Clinical Effectiveness Priority 2016/17- auditing of NICE guidance. this is monitored quarterly by the Quality and Governance Committee.	Steve Fenlon	Kelly Stevens	Patient Safety	12	6	↔	03/06/2016 Risk Reviewed by IHoR and MD: Risk controls discussed and as advised these are actions as yet not in place so some have been set as an action. Risk is to be reviewed again in 1 month New Action: Agree roles and responsibilities in SMT and exec team. New Action: Resource audit dept to lead this policy. Flow chart and process to be agreed with governance leads Policy being rewritten, approve through CGG and monitor through same. New NICE Implementation Policy in development. Policy for dealing with inspections, assessments, accreditations Ongoing work to embed the review of national guidance and evidence based practice in local specialty governance meetings. Ongoing work to assess all historical NICE guidelines, to ascertain a baseline of compliance NEW work to ensure national guidance and evidence based practice is reflected and embedded in local polices and guidance.	23/06/2016
907	21/09/2015	Lack of equipment for cataract surgery to support additional activity and new consultant appointment	Equipment required to support 5th consultant appointment Additional activity in theatres and specifically in Day Treatment Centre . Lack of equipment to enable productivity and utilisation of all areas to support 18 weeks RTT and demand and capacity plans	Mitigation Operating at weekends using WLI to support productivity Additional lists during the week if not utilised by other areas Business case approved Equipment purchased	Sharon Jones	Colette Donnelly	Compliance (Targets / Assessments / Standards)	12	8	↔	9/5/16 - Risk reviewed by DoN and Head of Risk, Likelihood reduced as equipment has now been ordered this now needs to be placed on the departmental risk register and removed from the corporate Head of Risk to discuss moving risk to departmental risk register with appropriate lead	13/06/2016
832	07/09/2015	Risk of harm to patients from inappropriately maintained medical devices	Potential for harm to patients if equipment used has expired its required maintenance dates and is not functioning correctly	New 3 year maintenance and repair contract with Avensys in situ since 01/06/2015. Contract management of all service/ maintenance contracts undertaken by Avensys - includes support with appraising different provider options and advice on renewal QVH Medical Devices Officer is the Head of Quality and Compliance. QVH contract manager is the Head of Quality and Compliance Near full review/ audit of all pieces of QVH equipment undertaken by the Head of Quality and Compliance and Avensys engineers. MaxFax outstanding only Ongoing monitoring and progressive checking of serviced equipment against the inventory. Ongoing monitoring and scrutiny provided by the Medical Devices Committee	Steve Fenlon	Kelly Stevens	Patient Safety	12	6	↔	Inventory almost completed and ongoing work in place for Avensys Re-audit scheduled for Nov 2015 03/06/2016 Risk reviewed with IHoR and MD: New actions added for review in one month NEW ACTION: Contract review meeting scheduled with Avensys to be held in early July 2016 QVH to further develop and maintain a collaborative working relationship with Avensys. QVH to aid in the implementation of Avensys new equipment inventory - service/ maintenance contracts storage. QVH to work with Avensys to obtain all outstanding service/ maintenance contracts inventory actions	15/06/2016

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904	24/08/2015	Medical Cover for QVH Critical Care	The QVH Medical Staffing Model does not comply with the Guidelines for Provision of Intensive Care Services (2015), with regard to out of hours cover, and no CCT in ICM. (Link to risk 844-this one specific just to ITU).	Limited clinical activity out of hours. Trauma activity controlled with the above in mind and prediction of likely conflict with all on call staff to be made aware of the risk of reducing staff availability OOH. Hospital at night handover to anticipate problems and inform plans out of hours. Greater awareness by surgical staff of the impact of operating at night on the whole hospital-hence consultant surgeon decision required. Incidents discussed at CGG	Steve Fenlon	MTURN	Compliance (Targets / Assessments / Standards)	12	4	↔	Email sent to ITU colleagues by MD to discuss the restructuring of ITU. 3Rd June 2016: Risk reviewed by IHoR and MD - No scores altered during review however new actions has been identified	03/06/2016
799	20/05/2015	Risks associated with non consultant medical staff providing services offsite	Risks associated with non consultant medical staff providing services offsite. Arisen due to lack of planning around consultant leave	1. Accompaniment by an onsite Consultant 2. Access to Consultant guidance/support 3. Agreed criteria for senior trainees and NC to undertake off site work 4. Longer term job planning to reconcile the demand and supply of suitable medical and dental staff 5. Review undertaken of non consultant medical staff work offsite - Led by medical staffing 6. Consultant access is agreed by Directorate and in line with access for trainees. 7. Policy in place in reference to allocation of staff	Steve Fenlon	Ian Fearnley	Patient Safety	12	8	↔	03/06/2016 Risk Reviewed with IHoR and MD: Some actions have now been completed and new controls added review in one month	03/06/2016
792	31/03/2015	Unable to recruit adequate dental staff for off site clinics and theatres	• Unable to treat patients within RTT 18 • More Doctors are needed to deliver services in a timely manner Feb 16 - unable to recruit dental middle grades; score increased to 12 from 10.	• Cancelling Clinics when unable to staff Some cases diverted to QVH and consultant lists	Steve Fenlon	Dumiso Ncube	Patient Safety	12	6	↔	03/06/2016 - Risk discussed with IHoR and MD no new controls added and current rating (12) remains unchanged. this is to be discussed with Execs June 2016 Rolling recruitment advertisement Consultants approached to undertake additional activity to clear the back log Reviewing Clinic templates and operating sessions to provide additional capacity	07/06/2016
789	12/03/2015	Failure to meet Trusts Medical Education Strategy	Failure to meet Trusts Medical Education Strategy	1. Funding of the non deanery clinical lead 2. Temporary education centre in place 3. Manage non LETB similar to LETB 4. Quality reviews from colleagues received 5. GMC feedback provided 6. Exit interviews undertaken with colleagues	Steve Fenlon	Geraldine Opreshko	Compliance (Targets / Assessments / Standards)	15	12	↔	Recruitment drive commenced Permanent Education Centre has had outline Board approval and funding TBA Reduced activity in some areas 03/06/2016 Risk Reviewed with IHoR and MD: continued recruitment drive in place with focus upon plastics new controls added but scores remain unchanged as still a risk to the Trust review in one month	03/06/2016
748	03/10/2014	Field safety notice FSN83000189 patient data may not be updated when exporting to 3rd party devices using auto export feature	Patient identifiable information on x-rays may not be updated in the VNA (vendor neutral archive. Studies pulled back from the VNA or pushed into a new PACS will potentially contain incorrect patient demographics.	We await the following from Philips: -An explanation as to what workflow causes this mismatch in patient data between PACS and VNA. -A description of a workflow to reduce/remove the risk of mismatched patient data between the PACS and VNA -Implement Kona across Surrey and Sussex to correct this error -Identify studies that have mismatched data -Produce and implement a fix for the identified mismatched data	Sharon Jones	Kirsty Humphry	Information Governance	12	6	↔	Discussed at CSS Mtg 05/05/2015: Current score of 12 to remain until PACS upgrade completed (due at end of May 2015) Range of information awaited from Phillips (as per controls column) Risk Discussed today between Interim Head of Risk and IG Lead: IG Lead to obtain update on previous actions. Reconcile VNA data once PACS remediation work and upgrade complete. Anticipated to begin May 2016	16/06/2016
743	09/09/2014	Harm to patients and reputational damage to the Trust as a result of the occurrence of Never Events	Harm to patients and reputation damage to the Trust as a result of the occurrence of Never Events	Risk Management and Incident Reporting Policy Completion of RCAs Never Event reporting and notification process including internal and external notifications Internal incident reviews and analysis undertaken via meetings/ committees etc Monitoring via dashboards External publishing of Never Event occurrence via NHS England RCA training provided to staff on 2 dates in April 2015 Addition of Human Factors & Non Technical Skills aspects to RCA reports from Sept 2015 to assist with ongoing analysis Human Factors CQUIN agreed and training to be developed and implemented	Jo Thomas	Ian Fearnley	Patient Safety	12	8	↔	21/06/2016 To be discussed with the Board as this is a residual risk no never events reported in last year 9/5/16 - Risk reviewed by DoN and Head of Risk: Risk reviewed and Likelihood now reduced to a possible. No never events have been reported in the last year to remain on corporate risk register as this is a corporate risk	21/06/2016
728	29/07/2014	Risk of non-compliance with best practice and regulatory requirements at spoke sites	Risk of compliance with regulatory and best practice requirements e.g. CQC, HSE, CiP assessments and audit etc. at spoke sites offering QVH services . Lack of clinical indicators and audits, lack of evidence of best practice, allocation of incidents and complaints not clear, staff training and development not recorded. Not all spoke sites on the QVH PAS system so the patient tracking list for these patients and other related activity is not visible.	Annual H&S assessments programme (monitored by quarterly H&SC). Annual infection control/decontamination reviews CQC/HSE notifications of queries relating to service provision Spokes action plan to incorporate clinical governance specified in SLAs including management and ownership of incidents, complaints, never events, policies and procedures, to ensure the quality of patient care, changes to engagement of non-consultant career grades and trainees in spokes. Plan to establish links with local risk and complaint teams and ensure lessons are embedded. Regular senior management and exec visits. Business Managers in regular contact both by phone and visiting. Quarterly contract monitoring meetings now in place and happening. Patient referrals tracked manually and information team working with EKBI to gain visibility of electronic data. robust management of the information we do have access to at the weekly PTL meeting, the access manager works closely with the admin teams at Medway and DVH and it will be resolved in the long term when the EKBI work is implemented	Sharon Jones	Kelly Stevens	Patient Safety	12	8	↔	21/06/2016 Handler changed to Kelly Stevens Head of Quality Correlation of CQC results against assessment results Focus on completion of off site spoke H&S assessments during 2015 and Trust Board reporting Ongoing monitoring via KPIs Feedback to DoNs at sites Exec and SMT visits and oversight SLA specify the governance arrangements. Annual CiP assessments to continue at spoke sites Revised programme of infection control and decontamination annual assessments in place for 2015/16	13/06/2016
727	21/07/2014	Limited on site Physician cover, need to review medical concerns of the surgical patient	Limited on site Physician cover and poor compliance with NCEPOD standards (2010) routine daily input for elderly patients having surgery; however patient population and nature of surgery differ.	Cover arrangements managed by General Manager for CSS together with MD. 24/7 phone cover and transfer available. Onsite cover available on Mon and Thurs via Mark Bayliss currently. Tej Richardson on Maternity leave until 2017 and BSUH not able to provide cover. Agency Locum Geriatrician known to BSUH engaged to start on-site cover from 18th April 2016. Telephone cover provided as part of SLA with Brighton. Patient would be transferred to Brighton (Haywards Heath) if specialised care required	Steve Fenlon	Dr Tim Vorster	Patient Safety	12	6	↔	Explore GPSI option and cover from London Trusts SASH work has not progressed as of July 15, to continue to work with BSUH but potential for tie in with community services as part of trust strategy 3/06/2016 Risk discussed with IHoR and MD: No new controls or actions in place IHoR to liaise with Risk owner for update	03/06/2016

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Trend	Actions	Date Reviewed
670	17/12/2013	Failure to maintain estates service due to limited staff numbers.	Failure to maintain estates service due to limited staff numbers, reducing resilience to cover annual leave, unplanned absences and long term vacancies.	1. Staff volunteering for additional on call duties. 2. Use of external contractors and agency staff to cover staff shortfalls e.g. lighting, storm damage and electrical failure 3. Agency staff employed to reduce deficit in lack of substantive post 4. Staff unskilled from band 3 to band 4 for on-call 5. On-call rotas now is made up of x2 band 6 and x3 band 4	Clare Stafford	Mark Johnston-Wood	Estates Infrastructure & Environment	12	6	↔	22/06/2016 Risk discussed with IHoR and HoE new controls in place and additional action added. Once new action is complete this risk may be reduced and placed onto local risk register Draft restructure paper completed and to be presented at Board in July	22/06/2016
639	10/10/2013	Support from supplier to ORSOS will cease 03/16 leaving Trust with a potential risk to electronic theatre record	Unable to record data for operations. - impact on scheduling - effect on live theatre management - ORSOS reporting including management reports.	Discussed at ICAG monthly and theatre user group. Paper back up Independent contractor will provide technical support with effect from 01/04/16 *ICAG reviewing progress of replacement each month; also Theatre User Group	Jo Thomas	Nicola Reeves	Finance	12	4	↔	*Source the new supplier 22/06/2016 Risk reviewed with IHoR and DDoN to remain unchanged until actions completed *Specification being drawn up to procure new/replacement system	22/06/2016
474	10/03/2011	Cancer target breaches	Breach in any quarter for an Oncology treatment targets for 31 and 62 day pathways resulting in delay to patient care and reduction in Monitor rating. This could also result in financial loss to Trust. Risk closed September 2015; reopened Feb 16 by Director of Operations.	1 - Cancer Data Co-coordinator issues reviewed monthly by Directorate Manager 2 - Patient tracking list for the specialties in place and produced twice a week. 3 - Cancer Data Co-coordinator communicates with staff on potential breaches. 4 - Secretaries respond to requests to bring patients forward wherever possible. 5 - Off site team leader in place to contribute and reconcile breaches. 6 - Appointments team allocate 2 week wait referrals to avoid delay. 7 - All breaches reviewed weekly by Directorate Manager. 8 - Project team established to integrate the cancer pathway. 9 - Action plan for skin cancer performance devised and implemented including process mapping sessions 10 - Cancer Outcomes Dataset report reviewed on a monthly basis by cancer team 11. Weekly review of PLT with Business Manager and Access and Performance Manager	Sharon Jones	Paula Smith	Compliance (Targets / Assessments / Standards)	12	8	↔	22/06/2016 Risk reviewed by IHoR need an update regarding current controls and any additional actions. Email sent to risk owner requesting an update, sent 22nd June 2016 22/06/2016 Review and risk updated with BUM and IHoR; Controls in place adequate with 1 new control added now developing a daily 2 week PTL review Needs additional review in September 2016 Streamline current referral pathways for all types of cancer Expand use of info flex system across Trust Ensure off site 2 week H&N cancer appointments are booked efficiently	22/06/2016

KSO1 – Outstanding Patient Experience

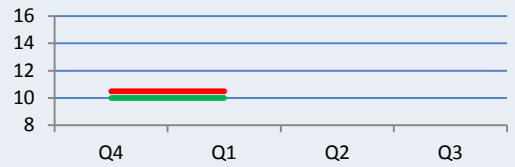
Risk Owner: Director of Nursing
Committee: Quality & Governance
Date last reviewed: 21 June 2016

Strategic Objective
We put the patient at the heart of safe, compassionate and competent care that is provided by well led teams in an environment that meets the needs of the patient and their families.

Risk
1) Trust is not able to recruit and retain workforce with right skills at the right time.
2) Patients lose confidence in the quality of our services and the environment in which we provide them , due to the condition and fabric of the estate.

Current Risk Rating 2x 5= GREEN
Residual Risk Rating 2 x 5 = GREEN

Rationale for current score
Compliance with regulatory standards
Meeting national quality standards and bench marks
Very strong FFT recommendations
Consolidated excellent performance in national inpatient survey.
Patient Safety incidents triangulated with complaints and outcomes monthly no early warning triggers, no Never Events
Affordable plan for modernisation of the estate in development
Failure to attract workforce with right skills



HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY
Burns Network Requirements resulting in burns derogation work risk in the future that patient experience may deteriorate in the short term due to transfer of services to new site /new staff /different ways of working
Nursing revalidation

COMPETITION
Patient choice if new services are available closer to home 5YFV. S&TP Surrey and Sussex group reviewing service provision, productivity and efficiency,
Integration of health and social care provision which will create new opportunities for patients and providers

INNOVATION
Patient experiences shared at public board
Ongoing work for Dementia patients, including double slots

RESILIANCE
Many services single staff member.
Nursing consultation 12 June - 12 July implement agreed changes from 1 August 2016

Controls / assurance
Programme of ongoing maintenance and remedial work
Estates work and issues monitored by the Health and Safety Group
Clinical quality standards monitored by the Quality and Governance Committee and the Joint Hospital Governance Meeting
Monthly safer nursing care metrics and CQUIN data collection
External assurance and assessment undertaken by regulatory bodies/stakeholders
Regular monitoring of FFT and patient survey results
Patient participation and feedback at the Patient Experience Group
Quality Account/CQUINS
Benchmarking of services against NICE guidance, and priority audits undertaken
Compliance in Practice (CIP) audits assessing the clinical environment
Recruitment days for specific staff groups

Gaps in controls / assurance
Development of full estates strategy and development control plan, incorporating patient expectations **CRR 670**
Quality and safety strategy being developed. BAF only
Robust clinical outcomes to be developed to ensure as effective baseline of clinical care . CRR 845, 728, DRR 746,609
Décor Improvement identified by the CQC
Lack of structured feedback from PLACE audits BAF only
Recruitment and retention strategy CRR 922
PMO approach to CQUIN Management being developed
Nursing consultation CRR 973,972

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07 July 2016**		**Agenda reference:**	**116-16**	
Report title:	**Quality and Governance assurance report**				
Sponsor:	Ginny Colwell, no-executive director and Committee chair				
Author	Ginny Colwell, no-executive director and Committee chair				
Appendices:	1. Report				
Executive summary					
Purpose:	To provide assurance to the board in relation to matters dealt with at the monthly Q & G committee				
Recommendation:	The board of directors is asked to note this report				
Purpose:	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1**:	**KSO2**:	**KSO3**:	KSO4:	**KSO5**:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Quality & Governance committee				
	Date:	09/06/16	Decision:	For information	
Previously considered by:	Quality & Governance committee				
	Date:	12/05/16	Decision:	For information	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	7 July 2016
Reference number:	116-16
Report from:	Ginny Colwell, non-executive Director and committee chair
Author:	Ginny Colwell, non-executive Director and committee chair
Appendices:	N/A
Report date:	22 June 2016

Quality and Governance Assurance report
Meetings held on12 May and 9 June 2016

1. **Infection control**
   There have been issues in regard to incomplete cleaning of theatre instruments. The company are being robustly monitored. The actions to ensure water quality in theatres were noted. There is now a water quality group to take this area forward.

2. **Safeguarding**
   The annual safeguarding report was received and the improved format noted.

3. **Patient Safety**
   The report was noted. No major incidents or particular trends.

4. **Patient Experience**
   It was noted that patients are still commenting on our food quality, mainly around choice and this will continue to be monitored by the Patient Experience Group

5. **Quality Account**
   The final draft was received

6. **CQC**
   The Action Plan was received and noted that high priority issues have been addressed. We will continue to work with the CQC to develop action to move from Good to Outstanding

7. **NHS Protect**
   The actions taken so far following our audit were noted. Following discussion and in order to ensure compliance in the future a robust way forward for monitoring was agreed.

8. **Corporate Risk Register**
   In order to focus on relevant high risk areas Ian Fearnly has suggested we separate out accepted risks. A proposal will come back to the July meeting

9. **Q&G review**
   Members have been asked to email their thoughts on how the current committee is working in order to inform discussion at the next meeting

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/07/2016**		**Agenda reference:**	**117-16**	
Report title:	**Quality and Safety Report, April and May 2016**				
Sponsor:	Jo Thomas Director of Nursing				
Author:	Jo Thomas Director of Nursing				
Appendices:	1. Safe staffing/ workforce report 2. Patient Experience report				
Executive summary					
Purpose:	To provide updated quality information and assurance that the quality of care at QVH is safe, effective, responsive, caring and well led.				
Recommendation:	The Board is asked to note the contents on the report, which reflects the quality and safety of care provided by QVH				
Purpose:		Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):		KSO2:			
		World-class clinical services			
Implications					
Board assurance framework:	No new implications for the BAF.				
Corporate risk register:	The CRR was reviewed prior to writing this report.				
Regulation:	Compliance with regulated activities in Health and Social Care Act 2014 and the CQC's Essential Standards of Quality and Safety.				
Legal:	As above				
Resources:	No changes				
Assurance route					
Previously considered by:	None				
	Date:		Decision:	For information	

Executive Summary - Quality and Safety Report, July 2016

Domain	Highlights
Safe	No hospital acquired or MRSA bacteraemia in April or May. One case one hospital acquired C Difficile in May, none in April. No Serious incident requiring investigation under NRLS Harm free care at QVH 100%, national average 93.9% (M5 data).
Effective	The full CQC action plan is submitted for information to the Board. The operational management of this will be via the Clinical Governance Group and this will be monitored via the Quality and Governance Committee.
Caring	There were ten complaints received in April and May, themes are about communication and attitude. 99% and 98% of inpatients completing the April and May FFT survey would recommend QVH.
Responsive	MIU, for April 98.75% and May 99.24% of patients were assessed and treated within 4 hours.
Nursing Workforce	M5; nursing vacancies 46.22 wte which is 20.7.% (no material changes from March data). Sickness in May has increased to 3.26% (*data source ESR*). Agency and bank usage has remained stable at 3 % and 4% respectively(M5 *data source ESR).*
CQUIN/ QA	Work has progressed on the applicable national, local and specialist CQUINS. Q1 deadlines for submission of data on UNIFY are on track. Systems have been agreed for monitoring CQUIN progress throughout the year.

Safe - Current Compliance

Domain	Current Compliance	Next Steps
Infection control	No hospital acquired MRSA IN April or May. One case of C Difficile in April. Full RCA undertaken. **May:** hand hygiene audits: 479 "moments" observed in all staff groups throughout the trust, 477 were fully compliant. Bare below the elbows observations were fully complaint at 100%. 80" hand washing" techniques observes 87 fully complaint with guidance.	RCA findings presented to Director of Infection Prevention and Control, IC Nurse , Microbiologist and CCG Lead IC Nurse. All agreed that the infection was unavoidable however there was some learning identified and following the new CCG guidance this was judged to be a lapse in care due to deviation from trust policy. It was acknowledged that this did not cause the acquisition of the C Difficile or adversely affect the patient outcome.
Medication errors	**April**: there were 12 medication related incident reported with the main trends being controlled drug and discrepancies in the measurement of them. Margret Duncombe Ward reported a total of 7 medication errors. **May:** increase in the number of medication related incidents being reported**.** 15 in total were reported. Controlled drug related issues remain high, 8 reported and 6 prescribing errors.	A trust-wide plan/standard operating procedure is currently being developed regarding the management of staff following a medication related incident. Further work will be undertaken to understand the issues impacting the measurement of controlled drugs, and what actions are required to improve and sustain performance across the organisation.
Serious Incidents	**May:** There have been **3** amber incidents reported. Two with no harm and one with minor harm. One (minor harm) relates to a case of CDIFF being identified. Another relates to CD three monthly check discrepancy found and the other relates to a wound drain been removed prematurely due to a discrepancy in the patient's documentation.	All incidents have been or are in the process of investigation. Monitoring the length of time an investigation takes is in place and this will be presented at CGG with further reporting to the Q&C.

Pressure ulcers	**April:** 3 pressure sore related incidents being reported both with a severity of minor harm. **May:** has seen no pressure sore related incidents being reported.	Each of the incidents have been investigated; one in Burns Theatre, Burns ward, main theatre and Margaret Duncombe Ward.
Falls	There were a total of 10 incidents reported for April and May relating to falls. 5 for April and 5 for May. All resulted in minor harm or no harm to the patient.	The areas reporting these incidents are Burs Ward, Maxillo Facial Unit, Margaret Duncombe Ward, Ross Tilley Ward and the Sleep disorder clinic. 1 incident reported in May happened in the car park which resulted in no harm.

Safe - Performance Indicators

Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, day case and emergency - figure /HES x 1000)	2014/15 total / average	Target	Quarter 1 2015/16	Quarter 2			Quarter 3			Quarter 4			Quarter 1 2016/17		Year to date actual
			Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
Infection Control															
MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile acquired at QVH post 72 hours after admission	1	0	0	0	0	0	0	0	0	1	0	0	0	1	1
MRSA screening - elective	96%	>95%	98%	99%	98%	98%	98%	98%	98%	97%	98%	98%	98%	96%	98%
MRSA screening - trauma	97%	>95%	97%	96%	96%	96%	96%	99%	98%	97%	95%	96%	95%	97%	97%
Incidents															
Never Events	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Serious Incidents	10		1	0	0	0	0	0	0	0	1	0	0	0	2
OOH inductions:															
All patients: Number of patients operated on out of hours 22:00 - 08:00		5	7	7	8	7	3	7	4	7	4	6	2	10	5.7
Paediatrics under 3 years: : Induction of anaesthetic was between 18:00 and 08:00		0	0	1	0	0	0	0	0	0	0	0	0	0	10.00%
Medication errors															
Total number of incidents involving drug / prescribing errors	210		15	9	11	15	12	19	19	21	16	14	12	15	178
No & Low harm incidents involving drug / prescribing errors	209		15	9	11	15	12	19	19	21	16	14	12	15	178
Moderate, Severe or Fatal incidents involving drug / prescribing errors	1		0	0	0	0	0	0	0	0	0	0	0	0	0
Medication administration errors per 1000 spells	2.2		1.1	0.6	1.3	1.4	1.7	1.9	5.9	2.6	1.9	2.8	1.9	2.5	2.1
Harm free care rate (QVH)	97%	>95%	94%	95%	100%	95%	98%	97%	96%	96%	100%	97%	97%	100%	97%
Harm free care rate (NATIONAL benchmark) - one month delay	94%	>95%	94.1%	>95%	94.1%	>95%	94.1%	>95%	94.1%	>95%	94.1%	>95%	93.9%	93.9%	
Pressure Ulcers															
Hospital acquired - grade 2	11	15	1	0	2	1	0	2	2	3	1	1	3	0	13
Hospital acquired - grade 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital acquired - grade 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VTE initial assessment	100%	>95%	100%	97%	97%	90%	98%	97%	96%	100%	96%	100%	100%	100%	97.1%
Patient Falls															
Patient Falls assessment completed within 24 hrs of admission	90%	>95%	88%	92%	67%	93%	98%	100%	100%	100%	100%	100%	100%	95%	94.3%
Patient Falls resulting in no or low harm	49	¾	4	4	3	5	3	2	1	4	1	7	5	5	44
Patient Falls resulting in moderate or severe harm or death	1	¾	0	0	0	0	0	0	0	0	0	0	0	0	0

Effective - Current Compliance

Domain	Current Compliance	Next Steps
Mortality	**April:** There were no QVH mortalities and no patients died elsewhere within 30 days of discharge **May:** There were no QVH mortalities and one patients died elsewhere within 30 days of discharge.	Mortalities to be discussed to the Joint Hospital Governance Meeting (JHGM) on Monday 11th July 2016. Work continues to embed the discussion of mortalities into local business unit and speciality governance meetings.
Transfers out	There were four emergency or unexpected transfer out in April and one in May 2016. The Trust has networks to manage all transfers out, and will monitor both the number of transfers out, and the reason for transfer.	The Trust continues to monitor transfers out to ensure that they are safe and continuity of care in maintained in conjunction with the receiving organisation.
NICE Compliance	Clinical Effectiveness Quality Priority: 20% of applicable NICE Clinical Guidelines (GLs) and Quality Standards (QSs) will be audited as the Clinical Effectiveness quality priority for 2016/17. **CG161:** Falls in older people: assessing risk and prevention **QS86:** Falls in older people **CG179:** Pressure ulcers: prevention and management **CG65:** Hypothermia prevention and management in adults having surgery Topics were identified as key hot spots which required assurance. Other key guideline are being selected and resources identified.	Ongoing work is underway to benchmark Trust compliance with guidelines: **NG45:** Routine preoperative tests for elective surgery (Apr-16) **NG46:** Controlled drugs: safe use and management (Apr-16) **QS121:** Antimicrobial stewardship.

Clinical audit	The new Clinical Audit Strategy 2016/17 to 2018/19 has been ratified by Board, and work is underway to meet the current year's objectives. The QVH Clinical Audit Prize Competition was held on 9th May 2016, 1st Price was awarded to project: *Setting a Standard for Head and Neck Consent* , East Grinstead Consent Collaborative.	Clinical audit continues to work with all specialties within the Trust to increase audit activity, and enhance a quality improvement culture.
CQC	The full CQC action plan has been submitted for information to the Board and this will be operationally managed via Clinical Governance Group.	The Trust will continue to work closely with CQC to ensure the areas for improvement identified are remedied. Action plan progress will be monitored on a monthly basis by the Clinical Governance Group, and assurance of action implementation and escalation of issues will be provided to Quality and Governance.

Effective - Performance Indicators

Metric	2014/15 total / average	Target	Quarter 1 2015/16	Quarter 2			Quarter 3			Quarter 4			Quarter 1 2016/17		Year to date actual
			Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
Infection Control															
Mortality	0	0	0	2	0	0	0	0	1	0	1	2	0	0	6
Readmissions															
Emergency Readmissions Within 30 Days		2.24%	1.46%	2.33%	2.34%	2.52%	1.66%	3.05%	1.75%	2.35%	2.49%	1.84%	2.03%	1.48%	1.74%
Emergency Readmissions Within 7 Days		1.21%	0.93%	1.03%	1.32%	1.50%	1.15%	1.77%	1.09%	1.10%	1.42%	1.09%	0.73%	1.01%	0.87%

Caring - Current Compliance

Domain	Current Compliance	Next Steps
Patient experience	2015 National Inpatient Survey: The survey was published in July The final response rate for Queen Victoria Hospital NHS Foundation Trust was 63%. Analysis of both the 2015 National Inpatient of the 62 question within the survey, the trust scored better than the national average in in 47 questions and worse in one.	Findings from both surveys will be reviewed by the Patient Experience Sub-group, and an action plan will be formulated to address areas for improvement. The Trust will continue to seek and learn from patient experience feedback to help improve our services.
Complaints	In April/May – Ten complaints were received. Four of these relate to attitude (two for the same department), three about medical treatment issues, two about communication of medical staff and one the late cancellation of surgery. All have been graded as minor.	All have been investigated. Chief executive, Director of Nursing and Patient Experience Manger meet monthly to review all complaints and claims.
Friends and Family Test (FFT)	**Inpatients** - In April 99% of inpatients (response rate of 38.5% - 207 patients) who completed FFT survey would recommend QVH. In May this was 98% (response rate of 49.5% - 269 patients) who completed the FFT survey would recommend us. **Outpatients** - The FFT score for out-patients in April was 94%. 2451 outpatients out of a possible 12700 completed the questionnaire either by paper, SMS or integrated voice message. The response rate for outpatients in April was 19%. In May the score increased to 95% and 2165 out of 11896 took part. This was a response rate of 18%.	The Trust action plan to improve patient experience in the outpatients department is progressing well, and continues to be monitored by The Patient Experience Group.

** Please see the patient experience exec summary in appendix 2*

Caring - Performance Indicators

Metric	2014/15 total / average	Target	Quarter 1 2015/1	Quarter 2			Quarter 3			Quarter 4			Quarter 1 2016/17		Year to date actual
			Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	
Complaints															
Complaints per 1000 spells *	4.3		1.1	3.5	0.7	2.1	2.3	3.2	4.6	3.5	1.9	3.5	1.9	4.4	2.7
Claims per 1000 spells *	1.1		0.6	0.6	0.0	2.1	1.7	1.9	1	1.4	1.3	2.1	1.3	0.0	1.1
Friends and Family Test															
FFT score acute in-patients: likely and very likely to recommend QVH	99%	>90%	99%	98%	100%	99%	98%	100%	99%	100%	100%	99%	99%	99%	99%
FFT score acute in-patients: unlikely and very unlikely to recommend QVH	0%		1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
FFT score MIU: likely and very likely to recommend QVH	95%	>90%	96%	96%	96%	94%	91%	89%	95%	93%	92%	94%	92%	95%	94%
FFT score MIU: unlikely and very unlikely to recommend QVH	3%		0%	2%	4%	3%	5%	5%	3%	4%	3%	3%	4%	3%	
FFT score OPD: likely and very likely to recommend QVH	98%	>90%	95%	94%	94%	94%	94%	95%	95%	94%	93%	94%	94%	95%	94%
FFT score OPD: unlikely and very unlikely to recommend QVH	1%		2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	
FFT score DSU: likely and very likely to recommend QVH	90%	>90%	94%	100%	100%	97%	96%	97%	97%	97%	96%	96%	96%	97%	97%
FFT score DSU: unlikely and very unlikely to recommend QVH	0%		3%	0%	0%	1%	1%	1%	0%	2%	1%	1%	1%	1%	
FFT score Sleep disorder centre: likely and very likely to recommend QVH	98%	>90%	97%	100%	93%	97%	99%	97%	98%	99%	97%	97%	96%	98%	97%
FFT score Sleep disorder centre: unlikely and very unlikely to recommend QVH	0%		0%	0%	3%	1%	0%	0%	0%	0%	0%	0%	0%	0%	
Privacy and dignity															
Mixed Sex accommodation breach	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient experience - Did you have enough privacy when discussing your condition or treatment (indicates a yes response)	97%	>90%	N/A	N/A	99%	99%	99%	99%	99%	99%	97%	97%	99%	95%	99%

* Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, day case and emergency - figure /HES x 1000)

Responsive - Current Compliance

Domain	Current Compliance	Next Steps
Compliance in Practice	Q1 2016/17 inspections commenced successfully with no changes made to the audit tool in order to baseline against the Q4 2015/16 re-launch results. Full details of strong and poor performing sections for Q1 2016/17 to be collated once all teams have been visited. Based on aggregated results, the Trust wide rating is for Q1 2016/17 to date is 'Good' (85.6%).	Q2 2016/17 inspections to commence end July 2016. Trial action plan template to support leads in addressing any department specific corrective work following each inspection. 'Quarterly focus' sections of audit tool to change in agreement with Director of Nursing. Results will be presented to the Quality and Governance Committee at regular intervals for assurance.
Incident Reporting	**April:** 136 incidents reported the common trends focusing around communication and delay in treatment. In this month three moderate incidents were reported with the rest either minor or no harm occurred. **May:** 162 incidents were reported, a small increase from April. The same themes remain communication failure and delay in treatment. One incident resulted in moderate harm whilst the rest resulted in no or minor harm.	All incidents have been or are in the process of investigation. Monitoring the length of time an investigation takes is in place and this will be presented at Q&GC. Consultants leading moderate investigations.

Nursing Workforce - Current Compliance

Domain	Current Compliance	Next Steps
Ross Tilley	7 shifts did not meet planned levels, 5 escalated due to a shortage of 1 HCA per shift, safe care achieved. 2 shifts no additional staff due to lower patient numbers. One fall, one PU in April none in May. Increase in sickness to 7%.	Trialling reduction in number of ward beds open at the weekend (10-14) which has resulted in more effective use of resources and a decrease in temporary staffing. Sickness being reviewed by ward manager and matron.
Margaret Duncombe	6 shifts did not meet planned level, 4 escalated due to a shortage of 1 staff member per shift, safe care achieved. 2 shifts no additional staff due to low patient numbers. 1 fall in April and in May, 2 PU in April none in May.	Datix information triangulated with date where rota was one nurse short, no falls or PU occurred on this shift.
Burns	9 did not meet planned levels, 2 escalated due to a shortage of 1 staff member on each shift, safe care achieved. 7 shifts no additional staff due to lower patient numbers. No falls or PU in April or May.	Some shifts were covered with staff from ITU rather than bank or agency when ITU numbers were low or zero.
Peanut	4 shifts required escalation - actual staff not meeting planned, safe care achieved by staff moving from PAU or the charge nurse covering. No falls or PU in April or May.	Charge nurse reviewing different ways of working that maintain high quality care and improve efficiencies.
Critical Care (ITU)	8 shifts did not meet planned levels- 3 escalated actual staffing did not meet planned, safe care achieved, staff from burns assisted. 5 shifts no additional staff due to low patient numbers. No falls or PU in April or May.	Datix information triangulated, no avoidable harms resulted from lower staffing template. Staff deployed more flexibly between Burns and ITU to provide cover between the 2 areas and reduce temporary staffing requirements.

Data extracted from the workforce score card in appendix 1

Nursing Workforce - Performance Indicators

1. Workforce Profile - as at 31st May 16

Staff type	Agreed WTE Establishment (as at 1 April 2016)	Number of WTE in post	Headcount	Number of vacant posts (WTE)	Percentage of vacant posts (WTE)
Nurses	222.85	176.69	211	46.22	20.74%
HCA's	86.36	76.04	91	10.32	11.95%

2. Sickness Absence Data

Staff type	Percentage of sickness absence in April 2016	Average number of sickness days per employee in Unit A in April 2016	Number of absence days lost in April 2016	Percentage of sickness absence on a 12 month rolling basis	Average number of sickness absence days per employee in Unit A on a 12 month rolling period (01.05.15 to 30.04.16)	Trend
Nurses	3.26%	0.99	218	3.45	12.98	↑
HCA's	8.27%	2.54	217	4.49	19.06	↑

3. Starters and leavers

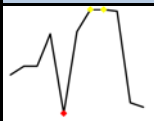
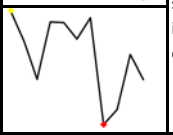
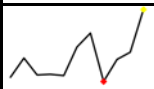
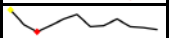
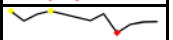
Starters	Nurses	HCA's
0 in total	0	0
Leavers	**Nurses**	**HCA's**
4 in total	3 (2.23WTE)	1 (0.76WTE)

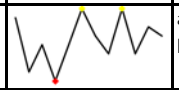
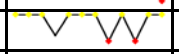
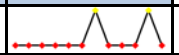
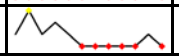
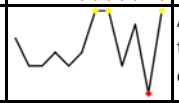
4. Nurse and HCA bank and agency usage

	Staff type	% of establishment WTE	Indicative Cost for May (Bank cost on mid pt)	Total number of hours during May
Nurses	Bank	7.65 wte = 4%	£21,296	2370.75
Nurses	Agency	4.78 wte = 3%	£24,312	
HCA's	Bank & Agency	2.12 wte = 3%	£3,707	

CQUIN - Current Compliance

Domain	Current Compliance	Next Steps
CQUIN	National CQUINS for QVH 1. Improving the health and wellbeing of NHS staff 2. Identification and early treatment of sepsis 3. Antimicrobial resistance National specialist commissioning CQUINs for QVH 1. ITU 2. Dental. In addition, the following local CQUINs have been agreed for QVH with the CCG's specialist commissioner: 1. Dementia 2. Theatre Safety Culture 3. Health and Wellbeing in therapies staff 4. NexoBrid (new drug for use in Burns).	The CQUIN schemes have been approved by the CCGs and specialist commissioners. Work is in progress to achieve the required milestones for Q1 with all data required for UNIFY Q1 submission identified. Request has been made to commissioners to review progress on all other Q1 CQUIN work.
Quality Account	Work has begun on the achievement of the three approved 3 Quality Priorities for 2016/17. 1.Safety: Decrease reporting times for incidents being uploaded onto NRLS reduce internally trust incident investigation and reporting times. Methodology agreed for calculating the incident reporting time and reports are submitted to Clinical Quality Group and Quality and Governance Committee. 2.Effectivness: Audit 20 % of applicable NICE guidance (please see effectiveness section) 3.Patient Experience: Improve walkways and Signage. Business case written and approved for capital funding to resurface the covered walks ways The Quality Account 2015/16 has been completed, laid Parliamentary and loaded onto the portal within the required timelines.	Progress of the Quality Priorities for 2016/17 will be monitored by the Trust's Quality and Compliance Committee on a quarterly basis.

CANADIAN WING 2015 / 2016	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	DoN Rating					
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies wte	9.54	9.84	9.84	10.93	8.24	11	11.76	11.76	11.7	8.6	8.45		7.5%	18%		⇧		Vacany rate stable - 5.4 WTE recruited awaiting clearance
Est = (hrs)	1550	1599	1599	1776	1339	1782	1911	1911	1911	1397.5	1373							
Temp staffing Bank	613	651	495	571	472	551	565	623.5	860	731	286		10%			⇩		Bank and agency use reduced in spite of sickness increase, improvements due to flexible deployment of staff
exc RMN Agency	621	476	294	567	564	485	586	79.5	150	411	293					⇩		
Sickness %	2.5%	3.8%	2.6%	2.7%	2.6%	4.5%	5.5%	2.2%	3.7%	4.2%	7.1%		2%			⇧		Sickness rate increase due to 4.0 WTE long term sickness, all being managed
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%		85%			⇨		
Statutory & Mandatory%	86%	88%	83.2%	93%	95%	95%	94%	93%	93%	90.0%	90%		85%			⇨		
Drug Assessments %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%			⇨		
Staff FFT Score %	_	_	_	_	_	_	_	_	_	_	_	_	_					
Budget (YTD)	24950	38816	53234	62784	81327	71598	88792	82955	79511	98162	12567	16553	<0			⇩		Budget meeting booked with finance and Dep Director of nursing
Margaret Duncombe	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Shift meets est % RN	101%	101%	98%	99%	100%	101%	98%	103%	98%	99%	102%	102%	95%			⇧		safe staffing achieved
Day HCA	100%	100%	97%	100%	98%	98%	95%	98%	100%	98%	100%	94%	95%			⇩		
Shift meets est % RN	100%	99%	98%	99%	102%	99%	96%	101%	101%	99%	100%	99%	95%			⇩		saff staffing achieved
Night HCA	97%	100%	91%	93%	94%	100%	100%	104%	93%	100%	86%	97%	95%			⇧		
Ross Tilley	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Shift meets est % RN	98.2%	98.3%	97.0%	98.1%	100%	102%	102%	96.4%	98.0%	95.9%	97.8%	100%	95%			⇧		safe stffing achieved
Day HCA	102%	98.8%	97.3%	98.6%	100%	101%	98.4%	98.6%	100.0%	98.4%	98.2%	97.8%	95%			⇩		
Shift meets est % RN	100%	96.4%	96.2%	95.2%	96.7%	95.2%	97.6%	97.6%	95.7%	98.7%	95.5%	100%	95%			⇧		safe staffing achieved
Night HCA	100%	89.7%	96.7%	100%	96.7%	93.3%	90%	97%	77.8%	86.2%	88.5%	88.9%	95%			⇨		

CANADIAN WING 2015 / 2016	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	DoN Rating					
Margaret Duncombe (&																		
Safe care	No / %												Target	Var.	RAG	Change	Trend	**Improvement Plan/Actions**
Pressure Ulcers	1	0	0	0	0	0	1	1	0	0	2	0	0			⇧		
Falls	0	0	1	1	1	0	0	0	0	0	1	1	0			⇨		
Medication Errors	7	1	4	0	4	8	5	3	8	3	6	5	0			⇩		all incidents investigated actions being taken with individuals
MRSA / C. diff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/1	0/2	0/0	0/1	0 / 0			⇩		full RCA undertaken unavoidable case
Incidents Reported (Datix)	20	6	10	18	12	10	11	9	11	9	14	16				⇧		
VTE reassessment %	85.7%	91.7%	100%	67%	100%	100%	100%	100%	100%	100%	100%	69.2%	95%			⇧		
Nutrition MUST assessment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94.1%	95%			⇧		
7 day review	100%	100%	100%	80%	100%	100%	100%	75%	100%	75%	100%	100%				⇩		
Patient numbers	160	163	138	156	159	150	125	133	117	166	166	123	N/A			⇩		
Patient FFT Score %	100%	99%	100%	100%	96%	100%	100%	100%	100%	99%	100%	99%	95%			⇩		
Ross Tilley	No / %												Target	Var.	RAG	Change	Trend	**Improvement Plan/Actions**
Pressure Ulcers	0	0	0	0	0	0	1	0	0	0	1	0	0			⇧		
Falls	1	3	1	2	1	0	0	0	0	0	1	0	0			⇧		
Medication Errors	4	2	2	3	2	3	6	6	2	5	0	6	0			⇧		All investigated actions being taken with individuals concerned.
MRSA / C. diff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/1	0/0	0/0	0/0	0/0	0 / 0			⇨		
Incidents Reported (Datix)	6	10	7	11	9	7	8	9	6	17	5	9				⇧		
VTE reassessment %	71.4%	90.9%	83.3%	30%	100%	100%	88%	100%	100%	94%	86%	82%	95%			⇧		
Nutrition MUST assessment	100%	100%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	95%			⇨		
7 day review	100%	100%	66.7%	40%	100%	50%	100%	100%	100%	75%	66.7%	N/A				⇧		
Patient numbers	210	195	188	197	192	178	188	172	156	199	148	201	N/A			⇧		
Patient FFT Score %	100%	97%	100%	99%	98%	100%	98%	100%	100%	99%	97%	98%	95%			⇧		

BURNS WARD **2015 / 2016**	**JUNE**	**JULY**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**DoN Rating**					
Safe Care	No / %												Target	Var.	RAG	Change	Trend	**Improvement Plan/Actions**
Pressure Ulcers	0	0	0	0	0	0	0	0	0	0	0	0	0					
Falls	0	0	0	0	0	0	0	0	0	0	0	0	0					
Medication Errors	0	2	2	3	1	1	1	0	0	1	1	1	0					errors investigated
MRSA / C. diff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0 / 0					
Incidents Reported (Datix)	3	7	4	3	4	9	8	3	2	3	2	7						
VTE reassessment %	100%	100%	100%	100%	100%	75%	N/A	100%	N/A	100%	100%	66.7%	95%					
Nutrition MUST assessment	100%	100%	100%	100%	100%	100%	100%	100%	N/A	100%	100%	100%	95%					
7 day review	N/A	100%	50%	N/A	N/A	100%	N/A	100%	N/A	100%	N/A	100%						
Patient numbers	23	25	22	36	31	19	20	20	20	32	44	24	N/A					
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	**Improvement Plan/Actions**
Vacancies wte	3	3	4.36	3.2	2.4	2.4	5.6	3.47	4.26	4.26	4.7		7.5%	6.8%				
Est = (hrs)	450	450	708.5	520	396.5	396.5	910	564.9	693.2	693.2	763.75							
Temp staffing Bank	168	138.5	137.5	81	80	137	128.5	303.5	303.75	356	142.5		10%	62.5%				Cover only for shifts that required additional staffing some shifts under planned template due to occupancy
exc RMN Agency	60	264	200.25	143	108	253	12	36	0	107.5	84							
Sickness %	2.7%	5.9%	4%	3.1%	2.7%	3.5%	4.7%	3.7%	5.8%	3.8%	4.2%		2%					
Shift meets est % RN	98.8%	96.6%	98.8%	100%	101.3%	97.8%	97.7%	95.3%	95.9%	95.1%	95.9%	98.8%	95%					
Day HCA	90%	87.1%	96.3%	104%	100%	105%	94.4%	94.4%	83.3%	100.0%	97%	100%	95%					
Shift meets est % RN	100%	95.7%	101.6%	98.3%	96.6%	100%	98.4%	96.8%	92.9%	93.7%	96.6%	95.2%	95%					
Night HCA	100%	100%	100%	100%	100%	300%	100%	200%	100.0%	100.0%	200%	200%	95%					
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	**Improvement Plan/Actions**
Appraisals %	97%	100%	80.5%	100%	100%	100%	97.7%	90.6%	94.0%	94.0%	94.0%		85%	-20%				
Statutory & Mandatory%	87%	78%	76.5%	93.1%	100%	100%	96.2%	91.9%	92.0%	92.0%	92.0%		85%	-1%				
Drug Assessments %	100%	100%	94%	100%	100%	100%	100%	100%	93%	93%	100%	100%	95%					
Patient FFT Score %	100%	100%	100%	89%	100%	100%	100%	100%	100%	100%	100%	99%	95%					
Staff FFT Score %	_	_	_	_	_	_	_	_	_	_	_	_	_					
Budget (YTD)	84296	132972	172048	128991	110132	115109	175359	178609	168052	154025	10530	6959	> 0					

2 wte person on mat leave
22 shifts with rn

BURNS ITU **2015 / 2016**	**JUNE**	**JULY**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**DoN Rating**					
Safe Care	No / %												Target	Var.	RAG	Change	Trend	**Improvement Plan/Actions**
Pressure Ulcers	0	0	2	0	0	2	0	1	1	0	0	0	0					
Falls	0	0	0	0	0	0	0	0	0	0	0	0	0					
Medication Errors	1	0	0	1	2	4	1	0	1	2	1	2	0					all errors investigated
MRSA / C. diff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0 / 0					
Incidents Reported (Datix)	7	8	7	14	6	17	9	9	15	5	10	9						
VTE reassessment %	100%	66.7%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%					
Nutrition MUST assessment	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	95%					
7 day review	66.7%	N/A	33.3%	N/A	100%	100%	100%	100%	67%	100%	N/A	100%						
Patient numbers	19	14	11	17	16	16	17	13	15	21	_	_	N/A					
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	**Improvement Plan/Actions**
Vacancies wte	5.6	7	6.7	5.7	4.65	4.65	3.76	4.1	4.1	3.5	2.96		7.5%					
Est = (hrs)	910	1137.5	1095	926	755.5	755.5	611	667.3	667.3	541.25	481							
Temp staffing Bank	120	264	31.5	48	31	196.5	19.5	195.5	149	244.5	6		10%					
exc RMN Agency	592.5	131.7	264	124	71	336	144	48	504	444	128.5							
Sickness %	6.3%	3.3%	1.8%	1.0%	3.5%	7.9%	3.7%	2.0%	4.2%	5.8%	3.5%		2%					
Shift meets est % RN	100%	96.1%	93.7%	95%	97.5%	96.4%	100%	100%	109%	98%	93.9%	96.8%	95%					safe staffing achieved
Day HCA	100%	100%	100%	100%	100%	100%	100%	100%	150%	100%	100%	100%	95%					
Shift meets est % RN	100%	88.3%	93.0%	85.5%	80.8%	85.7%	87.2%	98.8%	103%	95.1%	98.7%	100%	95%					safe staffing achieved
Night HCA	100%	100%	100%	100%	100%	100%	100%	100%	75%	200%	100%	100%	95%					
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	**Improvement Plan/Actions**
Appraisals %	95%	92%	96%	96%	96%	97.5%	97.5%	90%	86.5%	86.5%	86.5%		85%	-18%				vacant ward manager post
Statutory & Mandatory%	86%	78.3%	76.4%	92.1%	92%	98%	94%	92.9%	90%	90%	90%		85%	-13%				
Drug Assessments %	88%	88%	94%	100%	100%	100%	100%	100%	92%	92%	100%	100%	95%					
Patient FFT Score %	_	_	_	_	_	_	_	_	_	_	_	_	95%					
Staff FFT Score %	_	_	_	_	_	_	_	_	_	_	_	_	_					
Budget (YTD)	6357	21828	24823	34115	28032	32883	42990	37294	65547	79311	3739	28657	>0					

PEANUT WARD **2015 / 2016**	**JUNE**	**JULY**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**DoN Rating**					
Safe Care	No / %												Target	Var.	RAG	Change	Trend	**Improvement Plan/Actions**
Pressure Ulcers	0	0	0	0	0	0	0	0	0	0	0	0	0			→		No PU during 2015
Falls	0	0	0	0	0	0	0	0	0	0	0	0	0			→		No falls during 2015
Medication Errors	1	2	0	0	0	0	1	2	0	2	0	0	0			→		
MRSA / C. diff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0 / 0			→		No MRSA/CDI during 2015
Incidents Reported (Datix)	3	2	2	2	5	3	6	4	3	6	4	2				→		
Patient numbers	187	212	199	180	219	180	181	167	183	190	180	197	N/A			↑		
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	**Improvement Plan/Actions**
Vacancies wte	2	1.32	2	2.2	0	1	1.5	2.36	2.36	2.36	2.72		7.5%	7.0%		→		x1 post recruited to, start April
Est = (hrs)	325	214.5	325	357.5	0	162.5	243.7	383.5	383.5	383.5	442							
Temp staffing Bank	116.9	224.05	107.25	186	126	110	35.25	72	275.25	205.5	48.5		10%	*9%		→		
exc RMN Agency	63.75	90.7	50.75	54	91	19	12	0	12	0	0					→		
Sickness %	1.7%	4.4%	4.5%	4.0%	4.8%	2.1%	4.4%	6.2%	5.4%	5.6%	4.0%		2%	0%		→		Some long term sickness all being managed according to policy
Shift meets est % RN	100%	90.6%	100%	98.8%	101%	100%	100%	98.8%	96.2%	100%	96.3%	98.8%	95%			↑		
Day HCA	97%	100%	97.1%	97.1%	94.7%	100%	100%	97.1%	100%	100%	103%	100%	95%			↓		
Shift meets est % RN	98%	93.5%	98.3%	94.9%	95%	96.7%	95.2%	98.4%	92.7%	93.4%	94.9%	90%	95%			↓		
Night HCA	100%	100%	200%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%			→		
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	**Improvement Plan/Actions**
Appraisals %	98%	97%	84%	97%	100%	99%	100%	78.1%	91%	91%	91%		85%	-5%		→		
Statutory & Mandatory%	92%	80.9%	76.4%	91.2%	94%	94.5%	96%	94.4%	94%	94%	94%		85%	-3%		→		
Drug Assessments %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%			→		
Patient FFT Score %	100%	100%	97%	100%	100%	100%	100%	100%	100%	98%	100%	97%	95%			↓		
Staff FFT Score %	_	_	_	_	_	_	_	_	_	_	_	_	_					
Budget (K)	5937	1	2891	3480	9341	9524	7388	1657	864	9228	4314	8844	> 0			↑		

Monthly Patient Experience Report

1 June 2016 – 30 June 2016

The patient experience report aims to present a rounded picture of patient experience and provide information on all aspects of experience. Where poor experience is identified, actions are taken to ensure improvements are made and the outcomes are documented within the report. The report presents a wide range of information from different sources, including the following: complaints, claims, friends and family test and live feedback (NHS Choices/Patient Opinion).

Monthly Patient Experience Report

1 June 2016 – 30 June 2016

Performance Indicators	June
Number of new formal complaints received in the month	5
Number of complaints referred to the Ombudsman for 2nd stage review	0
Number of complaints re-opened	0
Number of claims	1

Patient Experience Headlines

Complaints

The Trust received five new complaints this month.

The Trust remains up to date with complaints management and reports.

Friends and Family Test (FFT)

For this month 269 inpatients, 2165 outpatients and 251 MIU attenders completed the FFT survey.

The inpatient response rate has increased to 49.5% (last month was 38.5%). The outpatient and MIU response rates remain consistent at 18% (19%) and 28% (27%).

Claims

There was one new claim this month.

Complaints

Open complaints: There were five new complaints opened during this period. All complaints received are acknowledged, investigated and responded to. The outcome of all complaints is recorded according to the extent to which the findings of the investigation uphold the issues raised by the complainant. When reviewing complaints trends or theme we look at the subjects and issues in all concerns raised irrespective of the outcome.

Where a complaint is not upheld, there is still the opportunity to learn about why the complainant has complained, and the need to understand the motives and feelings of the complainant.

Visiting Clinician

1. **Outpatient – Medical – Attitude of clinician –** Patient has raised concerns about the consultation that they had with clinician. Felt that the clinician was rude. **Investigating lead – Service Manager at MTW**

   Initial risk grading: **Minor** Likelihood of recurrence as**: Possible**

   Comment/Action – Complaint passed to MTW who will be investigating and responding to patient directly on this matter.

Plastics/Clinical Infrastructure/Day Surgery

2. **Day Surgery – Medical/Nursing – Communication –** The patient had asked Doctor for crutches and was told by nursing staff that these were not clinically required. **Investigating lead – Consultant/Team Leader Director**

   Initial risk grading: **Minor** Likelihood of recurrence as**: Possible**

   Comment/Action – Still undergoing investigation. Please note that investigating consultant made arrangements to see patient in clinic and met to clinically review and discuss any concerns.

Maxillofacial

3. **Trauma – Medical – Communication/attitude of staff (lack of compassion)** - Mother of patient has e-mailed the hospital over the bank holiday weekend on several occasions. Child had birthmark on cheek which has been scratched by patient and then bleed. The bleeding then continues and they are very concerned and allege that we appear not to be doing anything about the clinical situation. **Investigating lead – Clinical Director**

   Initial risk grading: **Minor** Likelihood of recurrence as**: Possible**

   Comment/Action – Patient seen as trauma and referral made to Great Ormond Street Hospital. A full review of this case has been undertaken and the clinical care and advice given was totally appropriate. However it is considered that the communication with the parents could have been improved. The consultant on call should have spoken with the parents directly about the future treatment plan for their child, this may have reassured them. Apologies given to parents regarding the staff who appeared to be uncaring or lacking in compassion. Although junior staff are empowered and encouraged to deal with patients clinical concerns, it is sometimes appropriate for staff to escalate issues and it is felt that this should have occurred on this occasion.

Plastics

4. **Inpatient - Nursing – Privacy and dignity -** Concerns raised about particular patient (prisoner) that was on Step Down Unit with other patients. Patient felt vulnerable. Also concerns about personal medication that went missing. Also concerns about some aspects of nursing care in regards the self-administration of medication. **Investigating lead – Ward Manager/Breast Care Nurses/Pharmacy**

   Initial risk grading: **Minor** Likelihood of recurrence as**: Possible**

   Comment/Action – Still undergoing investigation

Radiology

5. **Trauma – Radiology – Delayed diagnosis -** Patient raised concerns via Patient Opinion in relation to delayed diagnosis of fractured scaphoid. Patient was seen in MIU and then x-ray. **Investigating lead – Clinical Director**

   Initial risk grading: **Moderate** Likelihood of recurrence as**: Possible**

   Comment/Action – Still undergoing investigation

Closed complaints: There were five complaints closed during this period. The Trust triages all complaints in line with the Department of Health guidance to ensure that proportionate investigations take place.

Anaesthetics

1. **Anaesthetics/Pre-assessment – Medical – Cancellation of surgery –** The patient's dental surgery was cancelled on the morning of surgery just 2 hours prior to their admission. The patient was informed that the anaesthetist has asked for the patient to be further pre-assessed due to additional health issues that weren't explored. Patient would like to know why was this decision only made on the day. Patient is self-employed and had to put a lot of things in place in order to have this surgery. **Investigating lead – Consultant/Clinical Director**

   Initial risk grading: **Minor** Likelihood of recurrence as**: Possible**

   Comment/Action – The patient was not adequately pre-assessed and required an anaesthetic overview which was not noticed until the morning of the patient's surgery. Apologies conveyed that surgery was cancelled on the morning and this case has been discussed with both pre-assessment and anaesthetics team. Communication between the teams needs to be improved. **Outcome:** Upheld in part.

Plastics

2. **Inpatient – Medical – post-operative complications –** Following minor skin lesion removal patient began to bleed and had to be returned for surgery. Relative of patient wishes like to know why patient was not given antibiotic cover. Why anticoagulant medication was not suspended prior to procedure and why did a junior surgeon perform the surgery? **Investigating lead – Clinical Director**

   Initial risk grading: **Moderate** Likelihood of recurrence as**: Possible**

Comment/Action – The patient was managed and treated appropriately. It has been confirmed that antibiotic cover was administered. The anticoagulation medication was not suspended as on t his occasion this was not required. For the excision of skin lesions it is not policy to suspend anti-coagulant medications. It is understood from treating clinician that there is a lot of research showing there are higher risks associated with stopping it than allowing it to continue. Further assurance given that the surgery was performed by a competent/experienced surgeon.

Outcome: Unsupported.

Sleep

3. **Outpatient - Medical – Attitude/Communication –** Patient has raised concerns about the consultation that they had with clinician. Felt that the clinician was rude. **Investigating lead – Consultant**

   Initial risk grading: **Minor** Likelihood of recurrence as**: Possible**

   Comment/Action – Apologies given if clinician was rude however this was not his intention. Patient has other underlying issues that need to be addressed before the sleep unit cannot manage until the primary cause managed. We are looking at ways that we can develop a service with our psychological therapy unit to manage specific patients.

   Outcome: Upheld in part.

Visiting Clinician

4. See open complaint 1

Maxillofacial

5. See open complaint 3.

Parliamentary and Health Service Ombudsman (PHSO)

There have been no new cases referred to the PHSO.

Claims

There was one new claim opened this month. There are currently 63 open cases.

Incident date	Claim date	Directorate	Service	Description (allegations made within solicitors letter)	Initially Complaint	Reported as an incident
07/11/2015	20/06/2016	Maxillofacial	Medical	Partial tooth/root fragments being left in situ. This required the patient requiring further surgery under general anaesthetic.	No	No

Patient Experience – NHS Choices/Patient Opinion

In June 2016, the NHS Choices/Patient Opinion website received two feedback comments that related to care in radiology.

One of the comments has been negative (see open complaint 5) and the Patient Experience Manager has responded to all.

All reviews are seen by all staff via Qnet.

Friends and Family Test (FFT)

The detailed analysis of the FFT data was not available at the time of finalising this report.

Patient Feedback from FFT

The following are the top seven themes used by our outpatients (and the number of times) in the past months following completion of the Friends and Family surveys. Each piece of feedback received can cover a range of themes and the analysis below is based on the themes covered. This information provides the Trust with real time patient feedback analysis, both positive and negative.

Positive		Negative	
Implementation of care	975	**Implementation of care**	17
Staff attitude	802	**Staff attitude**	32
Waiting time	219	**Waiting time**	50
Communication	238	**Communication**	19
Environment	189	**Environment**	12
Patient mood/feeling	130	**Patient mood/feeling**	11
Admission	93	**Admission**	12

Report cover-page				
References				
Meeting title:	**Board of Directors**			
Meeting date:	**07/07/2016**	**Agenda reference:**	**118-16**	
Report title:	**6 Monthly Nursing Workforce Review**			
Sponsor:	Jo Thomas Director of Nursing			
Author:	Nicky Reeves Deputy Director of Nursing			
Appendices:	5 appendices			
Executive summary				
Purpose:	NHS England *Hard Truths* report requires six-monthly reviews of the nursing workforce to be presented to Boards, including an overview of nurse staffing levels. To provide information and assurance on inpatient ward and outpatient department staffing levels that facilitate the delivery of high quality care at QVH which is safe, effective, and responsive to the needs of patients. This is achieved by the use of nursing acuity tools and establishment models, flexible use of staff and most importantly professional judgement. The period of review is 1 October – 31 March 2015/16. The report also includes the impact on workforce from 2016/17 Cost Improvement Programmes which reduce the nursing workforce and the potential smaller workforce reductions, depending on the outcome of the nursing consultation. The consultation is in progress from 12 June – 12 July. The consultation has been widely circulated and has the approval of the Joint Consultation and Negotiating Committee.			
Recommendation:	The Board to note the recommendations from the 6 monthly nursing workforce review.			

Purpose:		Information	Discussion	Assurance	
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence

Implications				
Board assurance framework:	The nursing consultation has been added to KSO1 as a possible short term impact on retention of staff.			
Corporate risk register:	The nursing consultation has been added to CRR with an initial score of 9 and a residual score of 6.			
Regulation:	NA			
Legal:	As above			
Resources:	No changes			
Assurance route				
Previously considered by:	Expectative Team			
	Date:	20/06/16	Decision:	Approved, proceed to board

6 Monthly Nursing Workforce Review

Introduction

NHS England *Hard Truths* report requires six monthly reviews of the nursing workforce to be presented to Boards, including an overview of nurse staffing levels. This report provides assurance to senior managers that nursing staff are deployed to maximise the delivery of safe and effective quality patient care. This is achieved by the use of nursing acuity tools and establishment models, flexible use of staff and most importantly professional judgement.

This report does not repeat the extensive benchmarking carried out in the September 2015 paper as there have been no new seminal publications on nursing benchmarks since the last paper. This report covers staffing review from October 2015 to March 2016. It does not include perioperative and theatres workforce data or nursing roles within specialist areas e.g. pain, IPACT, Macmillan etc. The paper also outlines changes and amendments made to the nursing establishments post workforce reviews and efficiency work which is part of the cost improvement 2016/17 work stream. A quality impact assessment has been undertaken on all the nursing cost improvement schemes and these have been reviewed at Quality and Governance Committee.

The management and oversight of the nursing workforce has been scrutinised during the last 6 months and more robust processes have been implemented to improve efficiency. There is still some way to go before these processes embed and there is optimal workforce ownership and efficiency equal to the high standards of nursing care.

Safe staffing review of nursing establishments 1 October – 31 March 2016, cost improvements and nursing restructure are summarised in the table below. The individual establishment changes to wards and departments are shown in detail within the clinical areas section of this report. These changes can be accommodated by dis-establishing vacant posts; there is no requirement for redundancy. Collectively the nursing vacancies for the wards and out patients at 31 March 2016 were 23.61 wtb. Following the nursing consultation and Q2 CIP it is proposed that a further 11.03 whole time budget (wtb) which is already identified be removed subject to approval of all proposals going forwards.

Summary	Funded Establishment	Required Establishment	Variance
	w.t.b.	w.t.b.	w.t.b.
01/04/2016	224.64	213.11	11.53
CIP w.t.b reduction	-7.52	0	-7.52
Consultation w.t.b reduction	-3.51	0	-3.51
Total	213.61	213.11	0.50
a negative number denotes a deficit against the required establishment			
a positive number denotes a surplus against the required establishment			

**Rationale as to why no additional funding requests made at business planning for variance between funded and required is shown in detail in clinical areas section, full working in appendix 1.*

Nursing Framework

The nursing roster is published six weeks in advance allowing judgements to be made to which shifts must be filled using bank and agency staff. The nursing roster is reviewed and signed off by the individual ward managers initially and then further reviewed by the matron prior to publication. Trends and potential concerns such as maternity leave or long term sickness are reported and discussed with the matron in order that correct action can be identified and taken in a timely manner.

Safe staffing compliance in real-time is undertaken throughout the day with three formal review points during the day. This prospective review is undertaken by the matrons, site practitioner team, theatre floor manager and ward manger. Staff may be reallocated, temporary staff requested or the ward mangers/matron works clinically in order to maintain patient safety and experience. There is also provision for escalation to deputy director of nursing (DDN) and director of nursing (DN).

Since the last report a new process is in place for booking agency nurses. In hours this requires authorisation by DDN or DN for authorisation to book agency staff over the staffing cap and out of hours via site practitioners. The staff bank team robustly manage the process of temporary staff request, escalating as per flow chart (appendix 2). Out of hours any staffing concerns are reviewed and actions taken by the site practitioner team and/or manager on call. This process has made a modest reduction in the number of temporary staffing shifts booked and has supported compliance with booking staff, where it is safe to do so, below the agency caps introduced by NHS Improvement (NHSI) in the last financial year.

There has also been a detailed piece of work with matrons, DDN and finance to review budgets and clarify the “on costs” within the current budgets.

Acuity and Dependency

Canadian Wing, Burns Ward and ITU follow the same patient acuity tool to recognise individual patient needs and level of dependency. The Safer Care Nursing Tool (SCNT) (appendix 3) is one method used to assist senior nurses in determining optimum nurse staffing levels for inpatient wards. It provides a systematic approach at ward level to ensure patients receive the optimum nursing care they need, regardless of the ward in which they are allocated, the time of day, or the day of the week.

The Association of United Kingdom University Hospitals (AUKUH) and SNCT (appendix 4) have been adapted for use in paediatrics. This version is used in the paediatric ward and assessment unit at QVH.

The SCNT together with senior nurses’ professional judgement provide the baseline for the ward establishment per shift and a method for reviewing changes in acuity and dependency in real times. The acuity data is collected three times each day and is aligned to evidence based nurse staffing multipliers, providing recommendations for the nursing staff required per ward, based on the actual needs of the patients. Nursing workforce metrics and patient safety indicators such as pressure ulcers, falls and infection rates are monitored against this to ensure that the staffing levels enable delivery of safe care and quality patient outcomes. These indicators are also triangulated retrospectively each month by the DN to identify any emerging themes and provide additional scrutiny to the quality assurance process.

All the wards in the trust have different nurse to bed ratios in recognition of the speciality patients they care for, acuity, dependency and age. From May 2016, nationally, Care Hours

Per Patient Day (CHPPD) will become the principle measure of nursing and care support deployment following Lord Carter's report, *Operational productivity and performance in English NHS acute hospitals; Unwarranted variation*. The expectation being that it will form part of an integrated ward/unit level quality framework and dashboard encompassing patient outcomes, people productivity and financial sustainability. CHPPD will automatically be calculated by taking the actual hours worked (split into registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight. The existing e roster system allows for review of this metric and the data will be added to a new field on UNIFY daily safe staffing return.

Considerations such as skill mix and transferrable skills are the main focus and process to ensure the wards and departments are safely staffed with bank and agency staff utilised in order to maintain current staff to patient ratios together with the individual patient acuity. Future nursing workforce papers will encompass this guidance.

All the Outpatient areas are covered by a registered nurse to ensure there is leadership and guidance for the Health Care Assistants (HCA) and dental nurses. Any patient queries or concerns that cannot be addressed by the HCA are referred to the dental nurse or escalated to the nurse in charge.

Clinical Areas

MIU

MIU is open 08.00 to 22.00, staffed to 22.30 to allow staff to clear and lock down at the end of the shift. Currently MIU closes at 2000 due long term sickness and maternity leave within the Emergency Nurse Practitioners (ENP), Safe Staffing numbers have been reviewed and safe staffing has been maintained by this action. This will be reviewed in June 2016.

MIU currently provides the location and staffing resource for the trauma clinic. There are plans to relocate this clinic and ensure the staffing establishment can transfer with it to the new location.

The table below includes staffing for the trauma clinic and is calculated on 2 ENP working all day and 1 staff nurse working 1000 – 1800 (the 1000-1800 provides extra cover during busier periods).

Minor Injuries Unit	Funded Establishment	Required Establishment	Variance
	w.t.b.		w.t.b
01/04/2016	14.92	15.65	-0.73
CIP w.t.b reduction	0	0	0
Consultation w.t.b reduction	0	0	0
Total	14.92	15.65	-0.73
a negative number denotes a deficit against the required establishment			
a positive number denotes a surplus against the required establishment			

The establishment currently includes the staffing establishment for the trauma clinic and there is currently 1.0 wtb vacancy being recruited to.

There will be a review of the opening times and staff requirement post transfer of trauma clinic therefore no additional funding is required at this time.

Maxillofacial Outpatients Clinic

The unit comprises of a busy orthodontic clinic and maxillofacial outpatient clinic with a trauma service and minor oral surgery clinic. The clinic runs on a best practice staffing model of registered nurses and registered dental nurses with health care assistants and is open from 08.30 to 17.30 Monday to Friday.

Orthodontics meets the guidance for the provision of nursing staff to clinic rooms. Staff from the unit have also been to East Surrey Hospital to benchmark against an alternative clinic working and are assured that the model of care at QVH is equitable. Safe Staffing metrics have been reviewed and safe staffing has been maintained. There are 2.4 wtb vacancies.

The budget allows for the current capacity to be fully utilised 5 days per week with a degree of flexibility to respond to service demand and to offer major case pre assessment to the head and neck oncology cohort of patients. Maxillofacial staff also cover the spoke clinic at Maidstone. Maxillofacial provide approximately 39 clinics per week plus provide pre-assessment for the major head and neck cases.

Maxillofacial Outpatients	Funded Establishment	Required Establishment	Variance
	w.t.b.		w.t.b
01/04/2016	24.13	23.93	0.2
CIP w.t.b reduction	-0.2	0	-0.2
Consultation w.t.b reduction	0	0	0
Total	23.93	23.93	0.00
a negative number denotes a deficit against the required establishment			
a positive number denotes a surplus against the required establishment			

Main Outpatients

Outpatients, which include Outpatients 1, currently provide clinics 5 days per week between 08.30 and 18.00. The clinic also runs a nurse led dressing clinic on a daily basis which will also open on bank holidays to deal with post-operative wound management. OPD run approximately 60 to 65 clinics per week. Safe Staffing metrics reviewed and safe staffing has been maintained. There is 0.65 wtb vacancy.

Main Outpatients	Funded Establishment	Required Establishment	Variance
	w.t.b.		w.t.b
01/04/2016	16.4	16.2	0.2
CIP w.t.b reduction	-0.2	0	-0.2
Consultation w.t.b reduction	0	0	0
Total	16.2	16.2	0.00
a negative number denotes a deficit against the required establishment			
a positive number denotes a surplus against the required establishment			

Corneo-Plastics

The corneoplastic service comprises of 4-6 inpatient beds located on RT, and a busy outpatient department. The corneo-plastic staffing establishment will be incorporated in to the C Wing budget from the new financial year to ensure the specialist nursing resource is managed flexibly at ward level. Safe Staffing metrics have been reviewed and safe staffing has been maintained. There is 0.63 wtb vacancy.

The rota during the day shift is one RN and one HCA and one RN at night. Patient acuity is higher than that of the other inpatients on the ward due to intensive eye medications and interventions. The corneo-plastics nurse also operates an out of hour's phone line for emergency calls from patients following surgery or in some cases re-admission.

Corneo plastics outpatients is open from 08.30 to 18.00, 5 days per week with occasional Saturday cover as required. Corneo plastics deliver approximately 90 clinics per week.

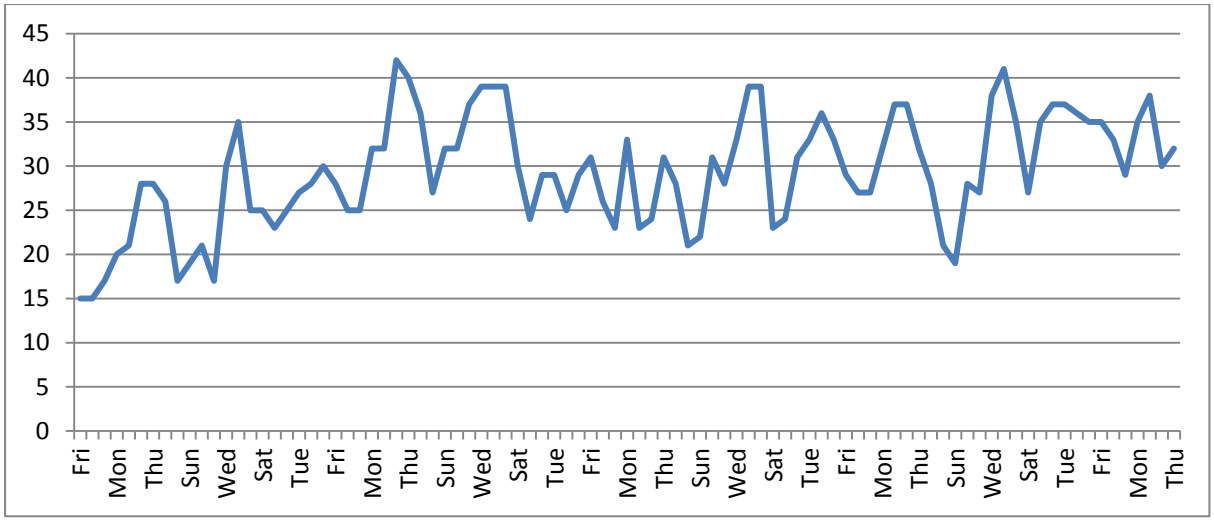
Corneoplastics	Funded Establishment	Required Establishment	Variance
	w.t.b.		w.t.b
01/04/2016	19.05	18.85	0.2
CIP w.t.b reduction	-0.2	0	-0.2
Consultation w.t.b reduction	0	0	0
Total	18.85	18.85	0.00
a negative number denotes a deficit against the required establishment			
a positive number denotes a surplus against the required establishment			

Canadian Wing

Canadian Wing (C Wing) comprises of three ward areas; Ross Tilley Ward (RT), Margaret Duncombe (MD) ward and Step Down Unit (SDU) within MD ward. This inpatient area consists of 47 beds in total, 23/ 24 beds on each ward. Staffing levels meet the Royal College of Nursing guidance (RCN 2012) of one registered nurse (RN) to 6/8 patients during the daytime and one RN to 10/11 patients at night is the benchmark.

In SDU patient acuity is higher. The patients have varying ratios of between one registered nurse to two, and one to four patients. Patient acuity as well as activity is carefully considered to determine the nurse to patient ratio; this is managed by the ward managers or nurse in charge on a shift by shift basis. Staff are flexed between ITU and SDU depending on acuity and staffing levels across the site. Safe Staffing metrics reviewed and safe staffing has been maintained. There are 6.2 vacancies on Canadian Wing however, following the implementation of the CIP measures from Q2, these posts will be dis-established leaving a vacancy of 1.59 wtb.

During the final quarter of 2016/17, a review of patient activity was undertaken. A decrease in inpatient bed days and increases in day case activity were noted. Following this analysis, changes have been made to the numbers of beds open at the weekend with 15-20 beds closed each weekend on Friday night or Saturday morning and these reopen Sunday night or Monday morning. Staffing requirements have decreased as a result and is part of the nursing efficiencies/ CIP for 2016/17.



This graph from January to April 2016 demonstrates the decrease in patient numbers seen at the weekends on C Wing.

The staffing template is established as below:

Canadian Wing	Funded Establishment	Required Establishment	Variance
	w.t.b.		w.t.b
01/04/2016	67.55	62.92	4.63
CIP w.t.b reduction	-5.42	0	-5.42
Consultation w.t.b reduction	-0.8	0	-0.8
Total	61.33	62.92	-1.59
a negative number denotes a deficit against the required establishment			
a positive number denotes a surplus against the required establishment			

There will be reduction in the budget from Q2 to deliver the CIP following the change in opening hours and ongoing review in to the skill mix and staffing requirement will continue. The current vacancy will reduce as the budgeted establishment decreases. There are other potential efficiency schemes currently being explored however these will be adjusted to ensure that the wtb at the end of August 2016 is not in deficit.

Burns Service

The burns service comprises of three discreet but co-dependant and collocated areas, Burns ward, ITU and Emergency Burns Assessment Centre (EBAC). Each area has an establishment requirement, however staff work flexibly between the areas as required in order to safely manage acuity and patients need.

ITU

The Guidelines for Provision of Intensive Care Services 2015 (GPICS) builds upon the Care Standards for Intensive Units 2013, the first step towards the development of a definitive reference source for the overall planning and delivery of UK Intensive Care services.

This document stipulates that 50% of registered nurses within the department's establishment must have post-registration award in Critical Care Nursing. QVH currently has 70% of staff that have a critical care qualification.

Level 3 patients must have 1:1 nursing and level 2 must have a minimum of 1:2, with a supernumerary Clinical Coordinator 24/7. Burns acuity is measured on a different scale to a "standard" critical care patient, a burn requiring level 3 ITU care would be graded as a B4 or 5 patient to capture the additional care hours required, often resulting in an increase in staff to patient ratio from 1:1 to 2:1 as per national burns guidance. Whilst staffing is managed flexibly through ITU, our reference cost index of 214 for Burns Critical Care for 2014/15 suggests that we are twice as expensive as the average; this is very likely to be overstated due to anomalies in the data submitted by other organisations. Removing the anomalous data reduces our index to 130. (appendix 5) For 2015/16 we hope to improve the accuracy of the Burns Critical Care reference costs by adjusting for days when there are no Burns Critical Care patients and staff are deployed elsewhere in the Trust. This should reduce the Burns Critical Care index. However, the unpredictability of the burns ITU activity, the specialist nature of our intensive care and limited scope for economies of scale operating such a small number of ITU beds will continue to inflate reference costs.

Safe staffing metrics have been reviewed and maintained. There was one exceptionally busy night which resulted in a Datix being raised regarding a patient incident and all appropriate escalation had taken place however safe staffing was achieved. There are 4.23 wtb vacancies.

ITU	Funded Establishment	Required Establishment	Variance
	w.t.b.		w.t.b
01/04/2016	21.65	22.08	-0.43
CIP w.t.b reduction	-0.75	0	-0.75
Consultation w.t.b reduction	-0.65	0	-0.65
Total	20.25	22.08	-1.83
a negative number denotes a deficit against the required establishment			
a positive number denotes a surplus against the required establishment			

There has been no request to increase the under establishment due to the flexible nature of the activity in this ward. 0.75 wtb of a vacant nursing post has been dis-established as part of the CIP programme and further posts may be disestablished if the standardisation of nursing shifts is taken forwards following nursing consultation in June 2016. There is also an opportunity for more efficient deployment of staff across ITU, HDU and Step Down unit if the 8.0 wtb staff move from Step Down to the ITU team. In addition, there are other potential efficiency schemes currently being explored however these will be adjusted to ensure that the wtb at the end of August 2016 is not in deficit.

Burns Ward/ EBAC

The Burns Care Standards stipulate that 75% of Registered Nurses must have post-registration training in a range of critical care and burn care skills. At QVH we have 62% of Registered Nurses with a Burns qualification. This will be addressed by the ward manager and funds will be reserved from the Health Education England Kent Surrey and Sussex training days allocation for 2016/17.

The level of Registered Nurses for burn patients requiring critical care must adhere to both the National Burns Care Recommendation Guidelines and the National Guidelines Associated with Critical Care which stipulates minimum staffing levels of 1:1. Burns patients not requiring critical care are cared for using a 1:3 ratio. Safe Staffing metrics reviewed and safe staffing has been maintained. There are 7.9 wtb vacancies.

At QVH burns outpatients are seen and managed through Emergency Burns Assessment Centre EBAC. This group of patients may require significant levels of nursing care due to the complexity and size of the dressings; some can take 2-3 hours. The majority of EBAC activity is managed in appointments of less than one hour.

There are other potential efficiency schemes currently being explored; however these will be adjusted to ensure that the wtb at the end of August 2016 is not in deficit.

Burns	Funded Establishment	Required Establishment	Variance
	w.t.b.		w.t.b
01/04/2016	35.73	30.04	5.69
CIP w.t.b reduction	-0.75	0	-0.75
Consultation w.t.b reduction	-1.46	0	-1.46
Total	33.52	30.04	3.48
a negative number denotes a deficit against the required establishment			
a positive number denotes a surplus against the required establishment			

0.75 wte nursing posts have been dis-established as part of the CIP programme and further posts will be disestablished if the standardisation of nursing shifts is taken forwards following the nursing consultation in June 2016. In addition 1.0 wte has been identified to contribute to the cost of the nursing restructure. There are other potential efficiency schemes currently being explored however these will be adjusted to ensure that the wtb at the end of August 2016 is not in surplus.

Peanut

Safe staffing levels for children are benchmarked by the Royal College of Nursing (RCN). This is a minimum of one RN 1:3 ratio for children aged two years and under at all times and one RN 1:4 for children aged three and over. Safe Staffing metrics reviewed and safe staffing has been maintained. There is 0.6 wte vacancy

Peanut Ward has recently undergone a change in ward manager who is actively engaged in identifying new and novel ways of addressing staffing requirements.

The medical clinical lead for paediatrics and DDN are also engaged in a piece of work reviewing activity, particularly inpatient cases with a view to making recommendations on options for service delivery and models of care delivery leading up to the transition and post burns inpatient relocation. There will be significant staffing changes as a result of the review and provision of inpatient burns service at another provider site.

The RCN guidelines and AUKUH acuity tool (appendix 2) recommend there are two registered paediatric nurses on every shift. The proposal to reduce staff during weekday night shifts to one trained paediatric nurse and one HCA is being explored by the ward manager and the deputy director of nursing. The majority of inpatients on Peanut are elective or very minor trauma and one or two patients of this dependency do not require two

trained nurses in order to achieve safe and effective care. There is no direct increase in the current quantified paediatric risks which relate to paediatric consultant cover. The site practitioners and trauma co-ordinators all hold paediatric life support courses and will continue to provide the same level of support. The Board is asked to note this proposed pilot, a detailed risk and quality impact assessment will be undertaken prior to beginning this trial which is planned to commence during Q2. There will be no reduction of night skill mix at weekend during this trial period.

The Paediatric Assessment Unit (PAU) is staffed Monday to Saturday by two staff nurses. On Mondays, Wednesdays and Fridays when consultant outpatient clinics are being held within the PAU, there is an additional healthcare assistant. This nursing establishment for PAU is within Peanut ward.

The staff on Peanut Ward provide out of hours burns assessment service following an emergency telephone triage process. All staff rotate between Peanut and PAU. In addition a rotation is now in place for Paediatric Registered Nurses to work alongside the ENP staff in MIU to provide additional paediatric clinical skills and knowledge to children treated in MIU.

Peanut	Funded Establishment	Required Establishment	Variance
	w.t.b.		w.t.b
01/04/2016	25.21	23.44	1.77
CIP w.t.b reduction	0	0	0
Consultation w.t.b reduction	-0.6	0	-0.6
Total	24.61	23.44	1.17
a negative number denotes a deficit against the required establishment			
a positive number denotes a surplus against the required establishment			

Further work on the ward establishment is planned following paediatric service review recommendations. There are other potential efficiency schemes currently being explored by the charge nurse however these will be adjusted to ensure that the wtb at the end of August 2016 is not in surplus.

Current Vacancies

Recruitment remains a challenge in maintaining the required registered nurse to untrained nurse ratios due to the location of the site, specialist nature of nursing and proximity to London trusts without paying London waiting allowance.

Improvements have been seen since the implementation of the recruitment task and finish group who have organised two recruitment days. These days resulted in offers of approximately 16 nursing and theatre staff. The group is looking at innovative ways of working rotations between QVH and Brighton to enable sharing of skills between trusts and have a positive impact on recruitment as well as improved patient experience. Utilisation of a specific recruitment agency to target recruitment for theatres has been employed and the value for money of this innovation will be reviewed.

The key initiatives in progress to further improve recruitment and retention are reducing turnover, increasing development opportunities, new career pathways within the trust and developing further targeted recruitment and open days in 2016. Additionally the recruitment

process has been streamlined alongside reviewing pay incentives and the continuation of staff engagement.

The nursing consultation commences in June 2016. The purpose of this is to improve clinical leadership and accountability with more clearly defined senior nursing roles, provide definite career development pathways and improve equity for all staff with regard to shift patterns. It is envisaged that this will have a positive impact on recruitment and retention once the new structure is embedded.

The trust enjoys a positive relationship with Brighton University and offers placements to student nurses at all stages of their training. Students rate the trust highly when evaluating the quality of the placements at QVH.

Further initiatives in place are Return to Practice for nursing, ODPs and surgical assistants and care certificates for Health Care Assistants.

The trust nursing vacancy for wards and outpatients areas as of 1 April 2016 was 20.96 wte (this excludes theatre vacancies). Vacancy rates have significantly reduced on Canadian Wing since the last workforce report. Further reductions are anticipated in Q2 following implementation of the CIPs and continued targeted nursing recruitment.

Maternity Leave

Each individual area is required to cover the vacancy left by a member of staff on maternity leave which creates a small cost pressure, this varies depending on the length of service and the amount of occupational maternity pay an individual is entitled to. Finance and nursing are working collaboratively to create a “maternity tracker” to monitor maternity leave and the cost pressure to the organisation.

Practice Development

There is no practice nurse/development nurse within the trust. The ward practice educators currently cover the trust induction and practice development courses. The DDN has oversight of the education contracts with HEEKSS. Post consultation the full education agenda will sit within the responsibility of the DDN.

Preceptorship

The Trust supports all newly qualified nurses with a preceptorship programme. A nurse preceptor is a teacher who is able to undertake the dual role of practitioner and educator. The responsibility of precepting falls in between teaching and mentoring newly qualified staff. This programme still requires development (not achieved to date due to lack of professional development post) to improve the quality of the content and standardise the approach throughout the trust.

A refreshed care certificate programme for HCA’s is currently being developed jointly with the trust organisational development team. As recognised certificate of competency and skill this initiative will contribute to consistent care standards for our patients and potentially improve retention of HCAs.

Revalidation

All nurses/midwives now have to revalidate every 3 years under the new NMC guidance. This process has been led by the DDN and the deputy director of Human Resources. During 2016 there will be 72 QVH nurses who need to revalidate, 49 of these will be in the next six months.

April	May	June	July	August	September
5	5	3	7	5	24

The senior nursing team continues to offer targeted prepare and support individual staff to successfully negotiate the revalidation process. There is a monthly drop in session for staff to find out more about the revalidation process and facilitated peer support is also available. So far, no staff have decided to retire or resign rather than go through the process of revalidation and to date, the April validators have all been through the process successfully, at this stage. This significant piece of work has been achieved with no additional resources.

Nursing Agency Caps

The previous system of monitor caps has been replaced in 16/17 by a new target applicable to all staff groups. There is a maximum ceiling allocated to each provider. At QVH our target is £1.76 million across all staff groupings. As QVH is meeting its financial target, it does not have to adhere to this ceiling however within nursing we are actively working towards only using temporary staff from framework agencies within the cap providing it does not compromise safety. NHSI have implemented a series of caps on the hourly rates agencies are able to charge, ranking from Tier 1 to 3 which is proving challenging to secure specialist nurses within this system. Nursing and Human resources are working together to create a "ready reckoner" for managers to understand how many hours of temporary staff can be "used" for every hour of vacancy.

Conclusion

Following this review there is evidence that staffing is proactively planned to ensure the right nurses with the right skills and experience are in post to care safely and effectively for our patients. Safe staffing has been maintained during the past 6 months.

Following the focused work on nursing establishment and nursing budgets as part of the budget setting there is a narrowing of the gap between funded and actual establishments to an almost neutral position of 0.5 wtb over establishment. There is still a small amount of redeployments of budget required post consultation and implementation of the Q2 CIP to ensure each area has the required budget to deliver high quality safe care.

There has been some success in targeted recruitment and a significant reduction in vacancy on C-Wing.

Quality data combined with professional judgement and clinical leadership are the cornerstone of effective staff planning and review. Credible and effective nurse staffing decisions cannot be made without this; further work is required on the use of nursing workforce information. A review of the Allocate E-roster system is planned for June with the Allocate account manager, HR director and director of nursing.

The nursing consultation provides a framework to drive the clinical leadership, accountability, improve management of nursing resource by ward managers and matrons and positively

impact on recruitment and retention. A range of measures for reviewing the impact of the consultation will be agreed once this has concluded which will include staff survey satisfaction and recommendation which is widely agreed by professionals and regulators to be an accurate measure of quality and patients satisfaction when levels are high.

Recommendations

The Board is asked to:

- note the staffing review;
- agree that no additional nursing establishment is required following this nursing review in order to maintain safe staffing levels;
- note the efficiency work streams re flexible use of inpatient beds, flexible temporary redeployment of staff;
- note the introduction of the CHPPD tool to support safe care provision;
- note the reduction in the gap from funded versus actual establishment required;
- note the pilot to reduce staffing on paediatric ward at night for a specific cohort of patients.

Appendix 1

MIU Establishment incl 22% uplift

Grade	Weekly hours per grade	Whole Time Equivalents per grade	22% Total	
Trauma Clinic	30	0.80	0.18	0.98
Trauma Clinic	22.5	0.60	0.13	0.73
Traum Clinic T	52.5	1.40	0.31	1.71
Band 5	15	0.40	0.09	0.49
Band 6	37.5	1.00	0.22	1.22
Band 7	203	5.41	1.19	6.60
Manager	22.5	0.60	0.13	0.73
Ward Clerk	98	2.61	0.57	3.19
	0	0.00	0.00	0.00
Totals	481	12.83	2.82	15.65

C Wing Establishment incl 22% uplift

Grade	Weekly hours per grade	Whole Time Equivalents per grade	22% Total	
Band 2	448.5	11.96	2.63	14.59
Band 3	0	0.00	0.00	0.00
Band 4	0	0.00	0.00	0.00
Band 5	437	11.65	2.56	14.22
Band 6	402.5	10.73	2.36	13.09
Band 7	0	0.00	0.00	0.00
SDU	276	7.36	1.62	8.98
Ward Clerk	0	0.00	0.00	0.00
	0	0.00	0.00	0.00
Totals	1564	41.71	9.18	50.88

C Wing Support Establishment incl 22% uplift

Grade	Weekly hours per grade	Whole Time Equivalents per grade	22% Total	
Discharge B 6	52.5	1.40	0.31	1.71
Ward manager	75	2.00	0.44	2.44
Resus B 7	18.75	0.50	0.11	0.61
Nutrition	7.5	0.20	0.04	0.24
Educator B 6	18.75	0.50	0.11	0.61
Educator B 7	18.75	0.50	0.11	0.61
Housekeeper	91.5	2.44	0.54	2.98
Ward Clerk	124.875	3.33	0.73	4.06
	0	0.00	0.00	0.00
Totals	407.625	10.87	2.39	13.26

*Not all roles in this chart require “backfill” @ 22% this is taken in to account in the charts within the individual areas

ITU Establishment incl 22% uplift

Grade	Weekly hours per grade	Whole Time Equivalents per grade	22% Total	
Band 2	0	0.00	0.00	0.00
Band 3	0	0.00	0.00	0.00
Band 4	0	0.00	0.00	0.00
Band 5	322	8.59	1.89	10.48
Band 6	310.5	8.28	1.82	10.10
Band 7	37.5	1.00	0.22	1.22
Band 8	0	0.00	0.00	0.00
Educator	18	0.48	0.11	0.59
	0	0.00	0.00	0.00
Totals	688	18.35	4.04	22.38

*Not all roles in this chart require “backfill” @ 22% this is taken in to account in the charts within the individual areas

Burns Ward and EBAC Establishment incl 22% uplift

Grade	Weekly hours per grade	Whole Time Equivalents per grade	22% Total	
Band 2	138	3.68	0.81	4.49
Band 3	0	0.00	0.00	0.00
Band 4	0	0.00	0.00	0.00
Band 5	285.25	7.61	1.67	9.28
Band 6	202	5.39	1.19	6.57
Band 7	37.5	1.00	0.22	1.22
Band 8	0	0.00	0.00	0.00
Ward Clerk	76.25	2.03	0.45	2.48
	0	0.00	0.00	0.00
Totals	**739**	**19.71**	**4.34**	**24.04**

Burns support roles Establishment incl 22% uplift

Grade	Weekly hours per grade	Whole Time Equivalents per grade	22% Total	
Research	15	0.40	0.09	0.49
Admin ass	24	0.64	0.14	0.78
Systems Admin	24	0.64	0.14	0.78
Technican	37.5	1.00	0.22	1.22
outreach 6	30	0.80	0.18	0.98
Outreach 7	75	2.00	0.44	2.44
Bca	12	0.32	0.07	0.39
Educator	15	0.40	0.09	0.49
	0	0.00	0.00	0.00
Totals	**232.5**	**6.20**	**1.36**	**7.56**

*Not all roles in this chart require “backfill” @ 22% this is taken in to account in the charts within the individual areas

Peanut Clinical Establishment incl 22% uplift

Grade	Weekly hours per grade	Whole Time Equivalents per grade	22% Total	
Band 2	103	2.75	0.60	3.35
Band 3	0	0.00	0.00	0.00
Band 4	0	0.00	0.00	0.00
Band 5	251	6.69	1.47	8.17
Band 6	206	5.49	1.21	6.70
Band 7	30	0.80	0.18	0.98
Play specialist	66.5	1.77	0.39	2.16
Ward Clerk	0	0.00	0.00	0.00
	0	0.00	0.00	0.00
Totals	**656.5**	**17.51**	**3.85**	**21.36**

Peanut Support Establishment incl 22% uplift

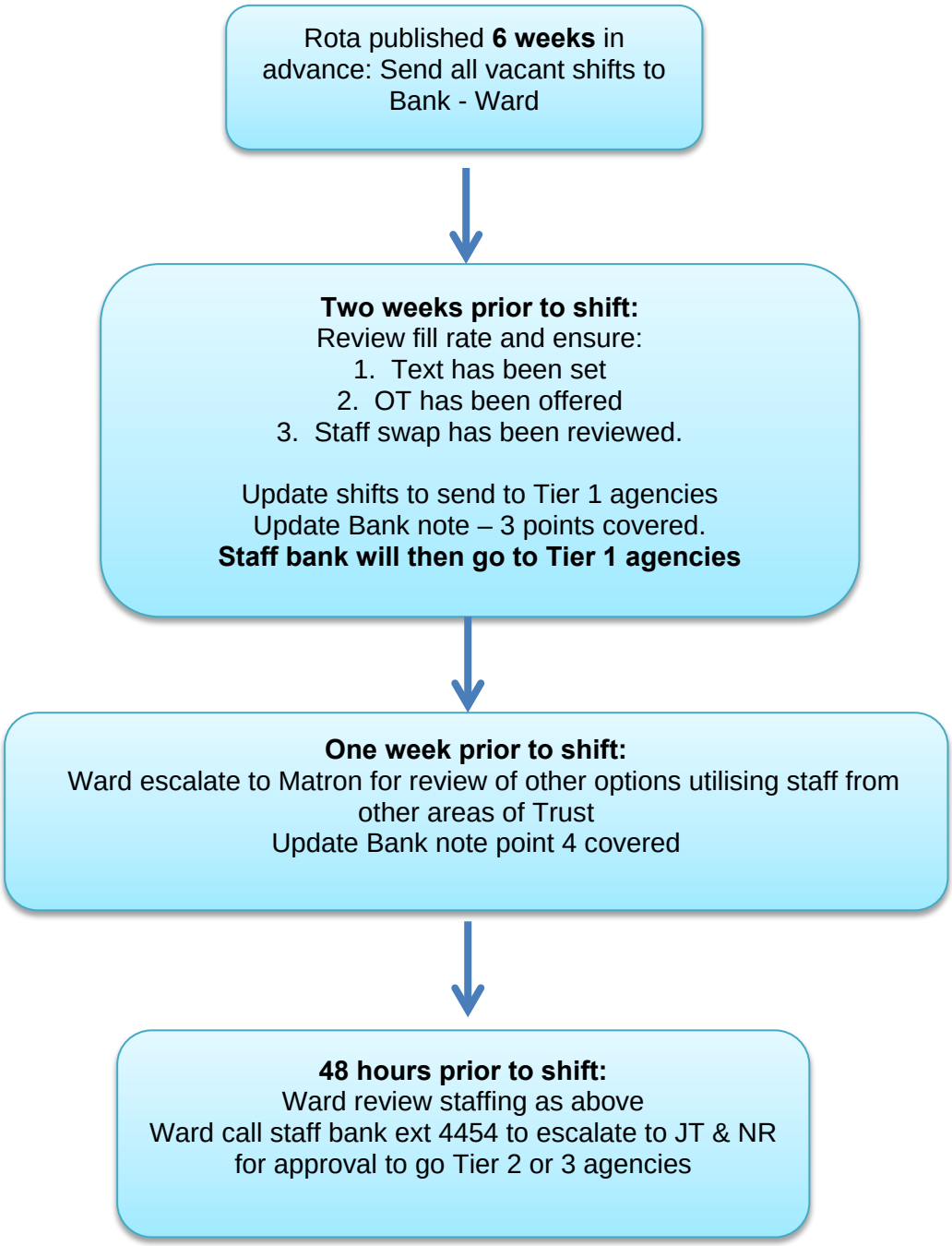
Grade	Weekly hours per grade	Whole Time Equivalents per grade	22% Total	
Band 2	0	0.00	0.00	0.00
Band 3	0	0.00	0.00	0.00
Med Sec	20	0.53	0.12	0.65
Safeguarding	0	0.00	0.00	0.00
Band 6	0	0.00	0.00	0.00
Band 7	0	0.00	0.00	0.00
Play specialist	0	0.00	0.00	0.00
Ward Clerk	65	1.73	0.38	2.11
	0	0.00	0.00	0.00
Totals	**85**	**2.27**	**0.50**	**2.77**

*Not all roles in this chart require “backfill” @ 22% this is taken in to account in the charts within the individual areas

Appendix 2

Queen Victoria Hospital NHS
NHS Foundation Trust

Rota / Bank and Agency Flow Chart



Appendix 3

Patient Acuity Tool

Levels of Care	Descriptor
Level 0	**Care requirements may meet the following:**
Patient meets normal ward care	*Surgical admission
	*May have an underlying medical coniditon requiring on-going treatment
	*Patients awaiting discharge
	*Post-operative procedure care - observations recorded 1/2 hrly initially then 4 hrly
	*Regular observations 2- 4 hrly
	*NEWS score within normal threshold
	*ECG monitoring/ Fluid management
	*O2 therapy less than 35%
	*Patient Controlled Analgesia (PCA) / Nerve Block
	*Confused patients not at risk
	*Patients requiring assistance with some activities of daily living, require assistance of one/ incontinence
Level 1a	**Care requirements may meet the following:**
Acutely ill patients requiring	*Increased level of observation and therapeutic interventions
intervention or those that are	*NEWS - trigger point reached and escalation commenced
unstable	*Post-operative care following complex surgery
	*Emergency admissions requiring immediate intervention
	*Requires continual observations/ monitoring
	*O2 therapy greater than 35% +/- chest physiotherapy 2-6 hrly
	*Arterial blood gases required intermittently, severe infection or sepsis
	*Post 24 hrs following insertion of a tracheostomy, epidural, etc
Level 1b	**Care requirements may meet the following:**
Patients who are stable but that	*Complex wound management requiring more than one nurse or takes one hour to complete
are dependant on nursing care	*TNP therapy where ward based nurses undertake the treatment
to meet most or all of the activities	*Mobility or repositioning difficulties requiring assistance of two people
of daily living	*Complex IV medication regimes - including those with long preparation or administration
	*Patient/ carers requiring enhanced psychological support due to poor disease prognosis/ poor clinical outcome
	*Facilitating a complex discharge where this is the responsibility of the ward based nurses
	*Patients requiring end of life care
	*Confused patients who are at risk or requiring constant supervision
	*Requires assistance with most or all activities of daily living
	*Potential for self harm and requires constant 1:1 observation

Appendix 4

Paediatric Patient Acuity – Peanut Ward
To be recorded 6-8am, 1-2pm, 6-8pm

Safer Nursing Care Tool – Children's and Young Person's Care Levels	
Level 0 Child/young person requires hospitalisation -needs met through normal inpatient care	***Care requirements may include the following;*** Children over 2 years of age Elective surgical admission May have underlying medical conditions requiring on-going treatment Patients awaiting discharge Post-operative/post-procedure care – observations recorded half hourly initially then 4 hourly Regular observations 2-4 hourly Early warning score within normal limits Basic fluid management Oxygen therapy less than 40% and patient stable Intravenous medication regimes – (NOT requiring prolonged preparatory/administration/post-administration care)
Level 1a Child/young person is acutely ill requiring close supervision & monitoring or is unstable with a greater potential to deteriorate -can be met through normal inpatient care	***Care requirements may include the following;*** Children under 2 years of age Children over 2 years of age with complex pre-existing medical conditions, with or without parents/carers Children with a burn of 5-9% TBSA Oxygen therapy greater than 40% +/- chest physiotherapy 6 hourly Increased level of observations and therapeutic involvement or continual observation Early warning score – trigger point reached and requiring escalation Stable nasopharyngeal airway Post-op care following complex trauma in the acute stage i.e. free flap, replant of digit, toe to hand Patient within 24 hours of returning from PICU/ITU Patient on a PCA/NCA/Epidural Emergency admission requiring immediate therapeutic intervention

	Insertion of nasogastric tube and enteral feeding Intravenous bolus of 2 or more medications

Paediatric Patient Acuity – Peanut Ward
To be recorded 6-8am, 1-2pm, 6-8pm

Level 1b Child/young person is stable but dependent on nursing care interventions/intensive therapy to meet most or all their care	***Care requirements may include the following;*** Children with burns greater than 10% TBSA Unaccompanied children Stable patient requiring 2 hourly blood sampling Post op care following complex trauma/surgery in the rehab phase Complex wound management requiring more than 1 nurse or taking more than 1 hour to complete VAC therapy where ward-based nurses undertake treatment Mobility or repositioning difficulties requiring the assistances of 2 people Complex intravenous drugs regimes –(including those requiring prolonged preparatory/administration/post-administration care) Patient and/or carer requiring enhanced psychological support due to poor disease prognosis or clinical outcome or high level of emotional support Potential for self-harm and requires constant observation High level safeguarding input Facilitating complex discharge where it is the responsibility of the ward based nurse Severe infection or sepsis Transferring an acutely unwell child to a specialist paediatric unit

Appendix 5

Reference Costs Issues for the 2015/16 Submission

1. Background

Reference Costs are the average unit costs to the NHS of providing a defined service in a given financial year.

At the end of each financial year, each trust is required to submit a Reference Costs return. These costs are prepared in accordance with national costing guidance and principles issued by Monitor. The costs are prepared at Healthcare Resource Group (HRG) level and use the Reference Cost version of the HRG4 grouper, which is different to the payment grouper currently used for income charging. The Reference Cost grouper is an indication of how HRGs will develop for income charging purposes. The main purposes of this return are as follows:

(i) To inform the setting of the Payment by Results (PbR) tariffs in future years and

(ii) To enable benchmarking between trusts primarily through the issue of the Reference Cost Index (RCI). The RCI is a measure of the relative efficiency of trusts and is calculated against an average efficiency score of 100. An index score higher than 100 indicates below average performance and an index lower than 100 indicates better than average performance.

2. 2015/16 Issues

For the 2015/16 submission the following reviews have been undertaken to further improve the quality of the costing data.

(i) Critical Care – QVH 2014/15 unit costs were twice the national average.

Currency description	Unit cost	Activity	National Average	RCI
Adult Critical Care, 4 Organs Supported	5,562	4	3,154	176
Adult Critical Care, 3 Organs Supported	5,367	77	3,474	154
Adult Critical Care, 2 Organs Supported	4,248	320	1,648	258
Adult Critical Care, 1 Organ Supported	2,205	93	1,191	185
Adult Critical Care, 0 Organs Supported	1,216	49	927	131
Average / Total	3,793	543	1,775	214

However, when the service level HRG data was published, it was evident that some organisations had submitted very low costs.

Organisation	Currency description	Unit cost	National Average	RCI
BARTS HEALTH NHS TRUST	Adult Critical Care, 0 Organs Supported	283	927	31
BARTS HEALTH NHS TRUST	Adult Critical Care, 4 Organs Supported	544	3,154	17
BARTS HEALTH NHS TRUST	Adult Critical Care, 1 Organ Supported	677	1,191	57
BARTS HEALTH NHS TRUST	Adult Critical Care, 2 Organs Supported	695	1,648	42
THE ROYAL WOLVERHAMPTON	Adult Critical Care, 2 Organs Supported	775	1,648	47
BARTS HEALTH NHS TRUST	Adult Critical Care, 3 Organs Supported	888	3,474	26
BUCKINGHAMSHIRE HEALTHCARE	Adult Critical Care, 2 Organs Supported	1,058	1,648	64
THE ROYAL WOLVERHAMPTON	Adult Critical Care, 3 Organs Supported	1,257	3,474	36

Reworking the RCIs after removing the very low costs reduced our RCI to 130. Critical Care activity for all organisations submitting Burns Critical Care was reviewed and they all generated over 10,000 bed days a year compared to QVHs 500. The relative size of the QVH unit can be expected to adversely impact on our unit cost.

(ii) Burns LSEBN – in 2014/15, Burns benefitted from LSEBN (London and South East of England Burn Network) non-patient activity related funding which reduced the Burns reference costs by £538k. This funding has now been incorporated into the patient activity contract and will no longer be eligible to set against our costs. This means that Burns unit costs can be expected to increase for 2015/16.

(iii) Burns Inpatients – in 2014/15, the following HRG generated an adverse variance against the national average of more than £100,000. NES/JB32C Minor Burn (TBSA of less than 20%) without Skin Procedure was reviewed by the Information Department and discovered to be an Emergency Burns Assessment Clinic (EBAC) procedure. These are admitted for analgesia purposes to the clinic rather than the ward and do not have a theatre procedure. They tend to be treated over several days; going home at night. An appropriate reduction in the ward cost allocation will be calculated and agreed with the relevant Business Manager.

(iv) Maxillofacial Inpatients - in 2014/15, the following HRG generated an adverse variance against the national average of more than £100,000. EL/CA80A Very Complex, Mouth or Throat Procedures, with CC Score 5 – theatre minutes for this procedure are double that of other CA80 procedures.

(v) Sleep – in 2014/15, some coding issues were identified. A quarter of the inpatient activity (500 FCEs) had been grouped to non-sleep HRGs - mental health and genetic disorders. Investigation by Information ascertained that the QVH procedure codes all look reasonable; the anomalies seem to have been created by the Reference Cost Grouper.
The allocation of Sleep costs between inpatients and outpatients needs reviewing. This will be carried out with the business manager before submission of the 2015/16 costs.

In 2014/15 the proportion of Jubilee Ward used by Sleep Studies looked low. Sleep Studies use of Jubilee Ward will be reviewed with the Business Manager before submission of the 2015/16 costs.

(vi) Botox – In 2014/15, our unit cost worked out at £25 which generated a RCI of only 12 and a very high favourable variance of £373k. We only spend £52k on activity of 2000. Facial palsy does not require a high dose and we have a procedure to allow us to do unlicensed multi-dosing. Investigation by Information ascertained that use of Botox for treating facial palsy is correctly coded as a high cost drug.

(vii) Corneo Inpatients - in 2014/15, the following HRG generated a favourable variance against the national average of more than £100,000. DC/BZ60B Very Complex, Cornea or Sclera Procedures, with CC Score 0-1 – the majority of these procedures are carried out at the Centre for Sight and therefore no theatre allocation is made. An appropriate increase in the other costs allocation will be calculated and agreed with the relevant manager.

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Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/07/2016**		**Agenda reference:**	**119-16**	
Report title:	**CQC action plan**				
Sponsor:	Jo Thomas Director of Nursing				
Author:	Jo Thomas Director of Nursing				
Appendices:	None				
Executive summary					
Purpose:	QVH is required to compile an action plan in response to the findings and recommendations from the scheduled CQC Inspection undertaken 10 -14th November 2015. This action plan was sent to the CQC within 28 days after publication of the official report as required.				
Recommendation:	The Board is requested to note the trust's official CQC action plan and the progress made to date.				
Purpose:		Information		Assurance	
Link to key strategic objectives (KSOs):	KSO1:	KSO2:			
	Outstanding patient experience	World-class clinical services			
Implications					
Board assurance framework:	KSO1: Outstanding patient experience and KSO2:World-class clinical services				
Corporate risk register:	None				
Regulation:	Compliance with CQC Essential Standards of Quality and Safety and NHS Standard Contract requirements				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	09/06/16	Decision:	For information	

CQC Inspection 10-14 November 2015 – Official Action Plan (June 2016)

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
A1	Ensure that all medication in theatre are stored appropriately	Theatres	Theatres Manager/ Chief Pharmacist **Miriam Lunney/ Judy Busby**	May 2016	**COMPLETED** New drug cupboards scheduled to be fitted in May 2016	**Y**	**Y**	**G**
A2	Review and audit concerns around unlocked drug cupboards in anaesthetic rooms	Medicines	Theatres Manager/ Chief Pharmacist **Miriam Lunney/ Judy Busby**	June 2016	**COMPLETED**	**Y**	**Y**	**G**
A3	Investigate mechanisms for benchmarking service specific and national standards across the Trust	Quality	Medical Director **Steve Fenlon**	July 2016	Exploring how we can use NICE Quality Standards (QSs) Relevant NICE Quality standards have been identified – currently arranging meetings with leads to assess compliance. Further work to be undertaken for national	**N**	**N**	**A**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
					benchmarking.			
A4	Patient information leaflets and self check-in kiosks to be made available in different languages.	Meeting individual needs	Director of Nursing and Quality **Jo Thomas**	September 2016	Action to be taken to the Quality and Human Rights Group to ascertain which languages are required. All leaflets contain information on how to request leaflets in different languages/ formats	**N**	**N**	**A**
A5	Patient Advice and Liaison Service (PALS) leaflets and posters to be clearly visible in all patient areas.	Complaints and concerns	Director of Nursing and Quality **Jo Thomas**	May 2016	All patient areas have visible PALS posters and leaflets.	**Y**	**Y**	**G**
A6	Review governance arrangements in to ensure all specialities have a governance with oversight of: - Risk and incidents - Complaints - Staffing	Governance/ Critical Care	Director of Nursing and Quality/ Medical Director **Jo Thomas/ Steve Fenlon**	January 2016	Critical Care management group meeting has been formulated and meetings held.	**Y**	**Y**	**G**
A7	All areas to review mandatory training compliance rates and increase as appropriate.	Mandatory training	Director of HR & OD **Geraldine Opreshko** (interim)	July 2016	Continued work to review and improve trust wide compliance with mandatory training.	**N**	**N**	**A**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
A8	Ensure appraisals are being undertaken across all healthcare disciplines on an annual basis	Competent staff	Director of HR & OD **Geraldine Opreshko** (interim)	June 2016 New date Aug 2016	Work is ongoing and continues to build on the improvement measures implemented in September 2015.	**N**	**N**	**A**
A9	All areas to receive training to raise awareness of the Duty of Candour and its principles - Professional responsibilities - Process - Timescales	Duty of Candour	Director of Nursing and Quality/ Medical Director **Jo Thomas/ Steve Fenlon**	July 2016	Duty of Candour training forms part of the Trust's induction training (monthly), and Junior doctors' induction which is held bi-annually (Feb and Aug).	**N**	**N**	**A**
A10	Ensure adequate OOH medical cover is in place - Monitoring arrangements for OOH provision	Medical staffing	Medical Director **Steve Fenlon**	July 2016	Formal consultation in progress to increase consultant on site anaesthetic cover in the evening till 8pm	**N**	**N**	**A**
A11	Review system in place to undertake environmental health and safety checks on an annual basis, including: - Manual handling - Environmental and ligature risk assessments	Environment and equipment	Director of Nursing and Quality **Jo Thomas**	June 2016, New date July 2016	Focus on ligature risk assessment planned for June 2016. Review of manual handling assessments is currently being undertaken	**N**	**N**	**A**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
A12	Review storage arrangements for all COSHH (Control of Substances Hazardous to health) products	Risk management	Director of Nursing and Quality **Jo Thomas**	June 2016	**COMPLETED** Checks completed to ensure correct storage of chemicals/ substances in all areas, to meet COSHH storage requirements.	**Y**	**Y**	**G**
A13	Ensure departmental risks are identified, recorded and regularly reviewed.	Risk management	Director of Nursing and Quality **Jo Thomas**	June 2016	Process for reviewing risk registers at business unit meetings is embedded. New Risk Management Policy awaiting ratification	**N**	**Y**	**A**
A14	Review the current specification of Datix: - Use of handlers - reports/access to the system, - Reports produced - tracking incidents	Risk management	Director of Nursing and Quality **Jo Thomas**	July 2016	Datix user forum scheduled from February 2016 (quarterly) New timescales and tracking of incidents in development All reports produced by the risk team are currently being reviewed with the intention of moving to a standardised format.	**N**	**N**	**A**
A15	Risk register access to be reviewed across the Trust	Risk management	Director of Nursing and Quality	December 2015	**COMPLETED** Head of Risk has met with all directors to review	**Y**	**Y**	**G**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
			Jo Thomas		corporate risks they lead on. Departmental risk registers have been reviewed by local management team and risk team. Obsolete risks closed and additional mitigating actions added, and new risks identified.			
A16	Trajectory to reduce reporting incidents to the NRLS from current 60 – 30 days' timeframe	Risk management	Director of Nursing and Quality **Jo Thomas**	July 2016	Upload to NRLS is undertaken every two weeks from March 2016 – data is only one month in arrears Algorithm to be added as appendices in new risk policy. Quality Priority for 2016/17 Trajectory to reduce internal Trust investigation timeframes. Progress will be monitored by the Q&GC	**Y**	**Y**	**G**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
A17	Mechanism for actioning and closing CAS alerts in a timely manner to be reviewed	Risk management	Director of Nursing and Quality **Jo Thomas**	July 2016	This has been added to the new draft risk management policy	**N**	**N**	**A**
A18	Reinforced awareness of individual responsibility to report all incidents. specific focus critical care and therapies	Risk management	Director of Nursing and Quality **Jo Thomas**	July 2016	Launch Datix user forum, internal Datix education session planned from February. Seeking staff views e.g. Improved incident feedback Risk management policy to be updated to include individual responsibilities	**N**	**N**	**A**
A19	Internal Audit of risk management in Q4 - Findings to be reviewed and implemented as appropriate in light of 'Delivering Excellence'	Risk management	Director of Nursing and Quality **Jo Thomas**	June 2016	Audit completed – substantial assurance given	**Y**	**Y**	**G**
A20	Ensure all areas have access to general health and safety information – paper folder and/ or electronic information	Equipment and environment	Head of Risk **Alison Vizulis**	June 2016	Information available on QNet and shared Trust folders	**Y**	**Y**	**G**
A21	Adequate facilities for patients	Environment	Associate Director	July 2016	Planning commenced to	**N**	**Y**	**A**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
	attending hand therapy clinic, and ensure privacy is maintained.	and equipment	Estates and Facilities **Mark Johnston-Wood** (interim)		relocate hand therapy clinic			
A22	Staff to be reminded that surgical scrubs should not be worn outside of the clinical environment.	Infection prevention and control	Director of Nursing and Quality/ Medical Director **Jo Thomas/ Steve Fenlon**	May 2016	**COMPLETED** Periodic reminders to be sent throughout the year	**Y**	**Y**	**G**
A23	Review processes of food ordering, to ensure that patients receive the choices they order	Meeting people's individual needs	Director of Nursing and Quality, **Jo Thomas**	June 2016	**COMPLETED** Processes in place to ensure that patients receive their choices by six monthly audit of menus	**Y**	**Y**	**G**
A24	Continual process for checking understanding and embedding of the Trust's Vision and Strategy	Vision and Strategy	Chief executive Officer **Richard Tyler**	June 2016	Monthly update at Staff Briefing, work to continue. Newly launched Compliance in Practice (CIP) inspections cover awareness of Vision and Strategy.	**N**	**Y**	**A**
A25	Review processes in place to engage staff, and increase staff feedback to	Staff engagement	Director of HR & OD	July 2016	Human Factors training has taken place with	**N**	**N**	**A**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
	help identify trends and improve staff engagement and experience.		**Geraldine Opreshko** (interim)		theatre staff prioritised for this course in May. Specific patient experience feedback sent monthly to theatre manager.			
A26	Schedule of regular patients telling their stories to Board	Patient experience	Director of Nursing and Quality **Jo Thomas**	January 2016, New date: June 2016	Enable to identifying patients willing to attend Board. Plan to potentially interview a patient following a plaudit or complaint, and this will be played to Board in July 2016.	**N**	**N**	**A**
A27	Décor in Outpatients 1 to be refreshed and updated	Environment and equipment	Associate Director Estates and Facilities **Mark Johnston-Wood** (interim)	December 2016	This is a priority, but awaiting the outcome of the 6-factet Estates survey to finalise timeline	**N**	**N**	**A**
A28	Corridors between wards and departments to be repaired and updated as appropriate.	Environment and equipment	Associate Director Estates and Facilities' **Mark Johnston-Wood** (interim)	October 2016	Target is now a Quality Priority for 2016/17 Trajectory for achievement has been formulated and will be monitored by the Q&GC	**N**	**N**	**A**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
					This is a priority, but awaiting the outcome of the 6-factet Estates survey to finalise timeline			
MIU								
A29	Schedule and undertake a regular case note audit	Records	MIU Lead **Sandra Lockyear (interim)**	July 2016	Regular case note audit to be scheduled to ensure compliance with documentation standards.	**N**	**N**	**A**
A30	Look into ways of recording and monitoring (inc auditing) treatment times after triage for each category of severity.	Accessing and responding to patient risk	MIU Lead **Sandra Lockyear** (interim)	July 2016	Work is ongoing to devise a method for capturing triage for each category of severity outside of an A&E environment.	**N**	**N**	**A**
A31	Schedule and undertake pain audits	Pain management	MIU Lead **Sandra Lockyear** (interim)	June 2016 New date July 16	Work is ongoing to review the measurement of pain scored within MIU	**N**	**N**	**A**
A32	Review mechanisms for consulting and involving staff members in decisions around strategy and the future of the service.	Vision and Strategy	MIU Lead **Sandra Lockyear** (interim)	July 2016	Updates at monthly staff briefings (undertaken by the executive team) and email correspondences as appropriate. Working	**N**	**N**	**A**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
					group in process of being convened to work with primary care to improve patient access. MIU manager invited to be part of this group.			
Specialist Burns and Plastics								
A33	Healthcare professionals to be reminded that they should change into green scrubs when entering the unit, even when in blue scrubs.	Infection prevention and control	Associate Director Estates and Facilities' **Mark Johnston-Wood** (interim)	May 2016	**COMPLETED** Periodic reminders to be sent throughout the year	**Y**	**Y**	**G**
Theatres								
A34	Ensure robust plan is in place for recruiting staff to vacancies in theatres	Nursing staffing	Theatres Manager **Miriam Lunney**	June 2016 Ongoing	Bespoke theatre recruitment day in January. Specialist recruitment plan for theatres has been compiled and work is ongoing. In addition, an external recruitment agency has	**N**	**Y**	**A**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
					been engaged, and there are plans to advertise posts on social media. Recruitment strategy will be continually reviewed to ensure the campaign and options are effective. A QVH recruitment film is also in development, and the Trust is looking at schemes for apprentices.			
Critical Care								
A35	Procedures surrounding the documentation and administration of controlled drugs to be reviewed – specific reference to verbal orders and drawing up of drugs by non-administrators of medication	Pharmacy/ controlled drugs	Director of Nursing and Quality **Jo Thomas**	December 2015	**COMPLETED** JB and JT undertaking to interactive sessions in Jan 2016 with ward leads and site practitioners to address this issue	**Y**	**Y**	**G**
A36	Communication to be sent to key nursing leads surrounding the statutory requirements of the CD register and completion	Pharmacy/ controlled drugs	Director of Nursing and Quality/ Chief Pharmacist **Jo Thomas/ Judy Busby**	March 2016	**COMPLETED** CD interactive sessions (including statutory requirements) have being completed (Feb 16).	**Y**	**Y**	**G**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
A37	Review governance arrangements in Critical Care and formulate a management Group: - Risk and incidents - Complaints - Staffing	Governance/ Critical Care	Critical Care Lead **Ken Simm**	January 2016	**COMPLETED** Critical Care management group meeting has been formulated and meetings held.	**Y**	**Y**	**G**
A38	Review arrangements for the provision of pain relief - patients are timely access to pain relief - scores are monitored appropriately - documentation provides ability to distinguish whether analgesia is effective or not	Pain management	Critical Care Lead **Ken Simm**	June 2016	New documentation for recording patient pain levels developed. Elective dressing changes are assessed against pain control regime/ tolerance and theatres booked as required following assessment. Trust is currently reviewing burns pain paperwork, and a working group has been formed to address issues. First draft of analgesia for burns dressing guidelines has been developed and will be circulated for consultation. In addition, a burns dressing checklist	**N**	**Y**	**A**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
					and observation chart is in development.			
A39	Explore ways of following up patients discharged from the unit, to understand the impact of prolonged admission.	Multidisciplinary working	Critical Care Lead **Ken Simm**	July 2016	**COMPLETED** Patient diaries in use which records patient's stay on the unit – these are shared by supported reading with a senior nurse. The Burns Support Group and psychological services also provide support for all patients after a prolonged admission.	**Y**	**Y**	**G**
A40	Explore and formulate a forward thinking strategy for the unit – what is next, and how this will be delivered.	Vision and strategy	Critical Care Lead **Ken Simm**	August 2016	Meeting with key critical care staff DoN, Medical Director and CEO to share CQC findings and identify next steps (April 2016). Separate review of mortality by anaesthetic staff, / anaesthetist being lead clinician for admitted ITU patients; develop critical care clinical	**N**	**Y**	**A**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
					governance via the now separate critical care governance meeting. Assessment of elective burns dressing change ward v theatre. New pain control charts have been developed. Acute pain pathway concept in development.			
Services for Children and Young People								
A41	Staff to be reminded that 'I am clean' stickers to be added to all pieces of equipment after cleaning,	Infection prevention and control	Paediatric Lead **Sandra Lockyear** (interim)	May 2016	**COMPLETED** Staff had feedback from DoN once report published, spot checks indicate ward compliant "with I am clean" stickers	**Y**	**Y**	**G**
A42	Ensure that equipment is not stored on the floor.	Infection prevention and control	Paediatric Lead **Sandra Lockyear** (interim)	May 2016	**COMPLETED** Shelf added in the sluice room	**Y**	**Y**	**G**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
A43	Ensure that blue bag emergency kits are checked on a monthly basis	Environment and equipment	Paediatric Lead **Sandra Lockyear** (interim)	May 2016	**COMPLETED** The blue bag emergency kit signature sheet has been moved, and is now kept with the bag (rather than the resuscitation trolley). This ensures that staff members are prompted to sign the sheet at the time of checking.	**Y**	**Y**	**G**
A44	Ensure local training records are up to date and reflect the current compliance position.	Mandatory training	Paediatric Lead **Sandra Lockyear (interim)**	July 2016	All local records are kept up to date on a monthly basis. Records are also held in the Staff Development Centre (SDC)	**Y**	**Y**	**G**
Outpatients and Diagnostic Imaging								
A45	Kitchen in rehab department to be locked when not in use, to ensure safety of staff members	Safety	Therapies Lead **Marc Tramontin**	June 2016 New date July 16	All knives and matches removed from the OT kitchen. Lock to be added – looking at the feasibility of a digital lock.	**N**	**Y**	**A**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
A46	Alarm system to be installed in the therapy and rehab department to ensure that staff are able to call for help in an emergency situation	Safety	Therapies Lead **Marc Tramontin**	April 2016	**COMPLETED** Therapies manager has undertaken a review, and mitigation is in place: Policy, access to phone Work to be continued to ascertain level of risk Within the Rehab Unit and the Main Physio / OT department there are phones in all clinic rooms where staff may be alone with patients or behind a closed door – an alert can be raised easily whether this be to switch / security / crash team / police/ fire service etc. Clinical work is undertaken in close proximity to other staff and behind curtains and an alert can be raised by shouting Both departments have	**Y**	**Y**	**G**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
					adequate fire alarms. Staff follow the Trust's Lone Working Policy and there are Therapy specific procedures. All staff are expected to notify switch and obtain an alarm. There is no alarm in the external toilets just outside main Physio / OT. These toilets have been identified as being inadequate. All patient toilets in rehab have adequate alarms.			
A47	Signposting to the use of hand gels to be reviewed, to ensure people know how and when to use it.	Infection prevention and control	Therapies Lead **Marc Tramontin**	June 2016	Infection Prevention and Control Team are reviewing location of hand gels and signposting to.	**N**	**N**	**A**
A48	All equipment to be checked to ensure it has been serviced and maintained in line with Trust policy.	Environment and equipment	Outpatients Lead **Kathy Brasier**	May 2016	**COMPLETED** Equipment inventory completed, all equipment in OPs is believed to be up to date.	**Y**	**Y**	**G**

Ref	Action	Area	Responsibility	By When (end of)	Update on progress/ status	Completed (Y/N)	Evidence (Y/N)	RAG
A49	All prescription pads to be stored securely	Medicines	Outpatients Lead **Kathy Brasier**	May 2016	**COMPLETED** Spot check undertaken post CQC visit in main outpatients – all prescription pads are securely stored in the safe or locked cupboard (keys are held by the trained nurses only).	**Y**	**Y**	**G**
A50	Storage of patient records to be reviewed to ensure that are locked away at all times.	Records	Outpatients Lead **Kathy Brasier**	May 2016	**COMPLETED** Spot checks undertaken post CQC visit in main outpatients – all notes stored securely	**N**	**Y**	**G**
A51	Formal records to be kept for all supervision meetings	Competent staff	Therapies Lead **Marc Tramontin**	June 2016	Therapies department is reviewing the feasibility of completing formal records for all supervision meetings.	**N**	**N**	**A**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/07/16**		**Agenda reference:**	**120-16**	
Report title:	**National Inpatient Survey Report-QVH**				
Sponsor:	Jo Thomas				
Author:	Nicole Ferguson				
Appendices:	NA				
Executive summary					
Purpose:	The National Inpatient Survey 2015 is for information purposes. • Overall, QVH scored better than other trusts across all ten relevant sections of the survey. • QVH scored significantly better than other trusts on 46 of the 62 questions asked, about the same on 12 and worse than average on only one. • Areas where QVH scored particularly highly were the questions about the hospital's nurses, care and treatment, leaving hospital and patients' overall views of care and services. QVH was the top scoring trust in the South and achieved the top scores in the country for 15 of the questions, including questions around: • The emotional support patients received from hospital staff to aid their recovery after leaving hospital • Staff providing a quiet environment at night • Staff working well together • Being involved in decisions around care and treatment and confidence about decisions made by staff • Privacy, respect and dignity • Providing sufficient information and getting answers to important questions that were easy to understand • Whether staff did all they could to control pain • Whether there were enough nurses on duty • Opportunities to feed back. The only question on which QVH scored worse than average was about the **choice of hospital food**. The hospital has been making improvements to the quality and choice of food for patients and this score had improved from the previous survey but remains a priority for the coming year.				
Recommendation:	The Board is requested to receive the National Inpatient Survey 2015 for information.				
Purpose:	Assurance	Assurance	Assurance	Assurance	Assurance
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence

Implications				
Board assurance framework:	None			
Corporate risk register:	None			
Regulation:	None			
Legal:	None			
Resources:	None			
Assurance route				
Previously considered by:	NA			
	Date:	dd/mm/yy	Decision:	

Patient survey report 2015

Survey of adult inpatients 2015

Queen Victoria Hospital NHS Foundation Trust

Survey of adult inpatients 2015

Making patients' views count

NHS patient survey programme
Survey of adult inpatients 2015

The Care Quality Commission

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

Survey of adult inpatients 2015

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

The thirteenth survey of adult inpatients involved 149 (one trust was excluded from the national results due to errors when drawing their sample) acute and specialist NHS trusts. Responses were received from 83,116 people, a response rate of 47%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts sampled patients discharged during July 2015[1]. Trusts counted back from the last day of July 2015, including every consecutive discharge, until they had selected 1250 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2015). Fieldwork took place between September 2015 and January 2016.

Similar surveys of adult inpatients were also carried out in 2002 and annually from 2004 to 2014. They are part of a wider programme of NHS patient surveys, which cover a range of topics including A&E services, children's inpatient and day-case services, maternity services and community mental health services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

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

Interpreting the report

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

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

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

[1] 43 trusts sampled additional months because of small patient throughputs.

Standardisation

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

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

Scoring

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

It is not appropriate to score all questions in the questionnaire as not all of the questions assess the trusts. For example, they may be descriptive questions such as Q1 asking respondents if their inpatient stay was planned in advance or an emergency; or they may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question would be Q43 "During your stay in hospital, did you have an operation or procedure?" For full details of the scoring please see the technical document (see further information section).

Graphs

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

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

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

Methodology

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

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

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

Tables

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

Scores from last year's survey are also displayed. The column called 'change from 2014' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2014. A statistically significant difference means that the change in the results is very unlikely to have occurred by chance. Significance is tested using a two-sample t-test.

Where a result for 2014 is not shown, this is because the question was either new this year, or the question wording and/or the response categories have been changed. It is therefore not possible to compare the results as we do not know if any change is caused by alterations in the survey instrument, or variation in a trust's performance. Comparisons are also not able to be shown if a trust has merged with other trusts since the 2014 survey, or if a trust committed a sampling error, in 2014. Please note that comparative data is not shown for sections as the questions contained in each section can change year on year.

Notes on specific questions

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

All trusts

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

Q31: "In your opinion, did the members of staff caring for you well work together?" is a new question in 2015 and it is therefore not possible to compare with 2014.

Q53 and Q54: The information collected by Q53 "On the day you left hospital, was your discharge delayed for any reason?" and Q54 "What was the main reason for the delay?" are presented together to show whether a patient's discharge was delayed by reasons attributable to the hospital. The combined question in this report is labelled as Q54 and is worded as: "Discharge delayed due to wait for medicines/to see doctor/for ambulance."

Q55: Information from Q53 and Q54 has been used to score Q55 "How long was the delay?" This assesses the length of a delay to discharge for reasons attributable to the hospital.

Q56, Q57 and Q58: "Where did you go after leaving hospital?", “After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition? and “When you transferred to another hospital or went to a nursing or residential home, was there a plan in place for continuing you care?” are new questions in 2015 and it is therefore not possible to compare with 2014.

Q58: This question does not contribute to the Section score for 'Leaving hospital' (Section 9), though is displayed for trusts where 30 or more respondents answered this question. In the instances where 30 or more respondents answered this question, the question score is displayed for the trust. If the row for Q58 is blank, this means that less than 30 responses were received for this question.

Trusts with female patients only

Q11, Q13 and Q14: If your trust offers services to women only, a trust score for Q11 "Did you ever share a sleeping area with patients of the opposite sex?" and Q14 "While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?" is not shown.

Trusts with no A&E Department

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

Further information

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

The results for the adult inpatient surveys from 2002 to 2014 can be found at:
http://www.nhssurveys.org/surveys/425

Full details of the methodology of the survey can be found at:
http://www.nhssurveys.org/surveys/833

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

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

Survey of adult inpatients 2015

Queen Victoria Hospital NHS Foundation Trust

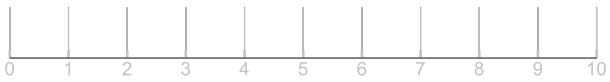
Section scores

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

Survey of adult inpatients 2015
Queen Victoria Hospital NHS Foundation Trust

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

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



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

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

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

Better

Q7. Was your admission date changed by the hospital?

Better

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

Waiting to get to a bed on a ward

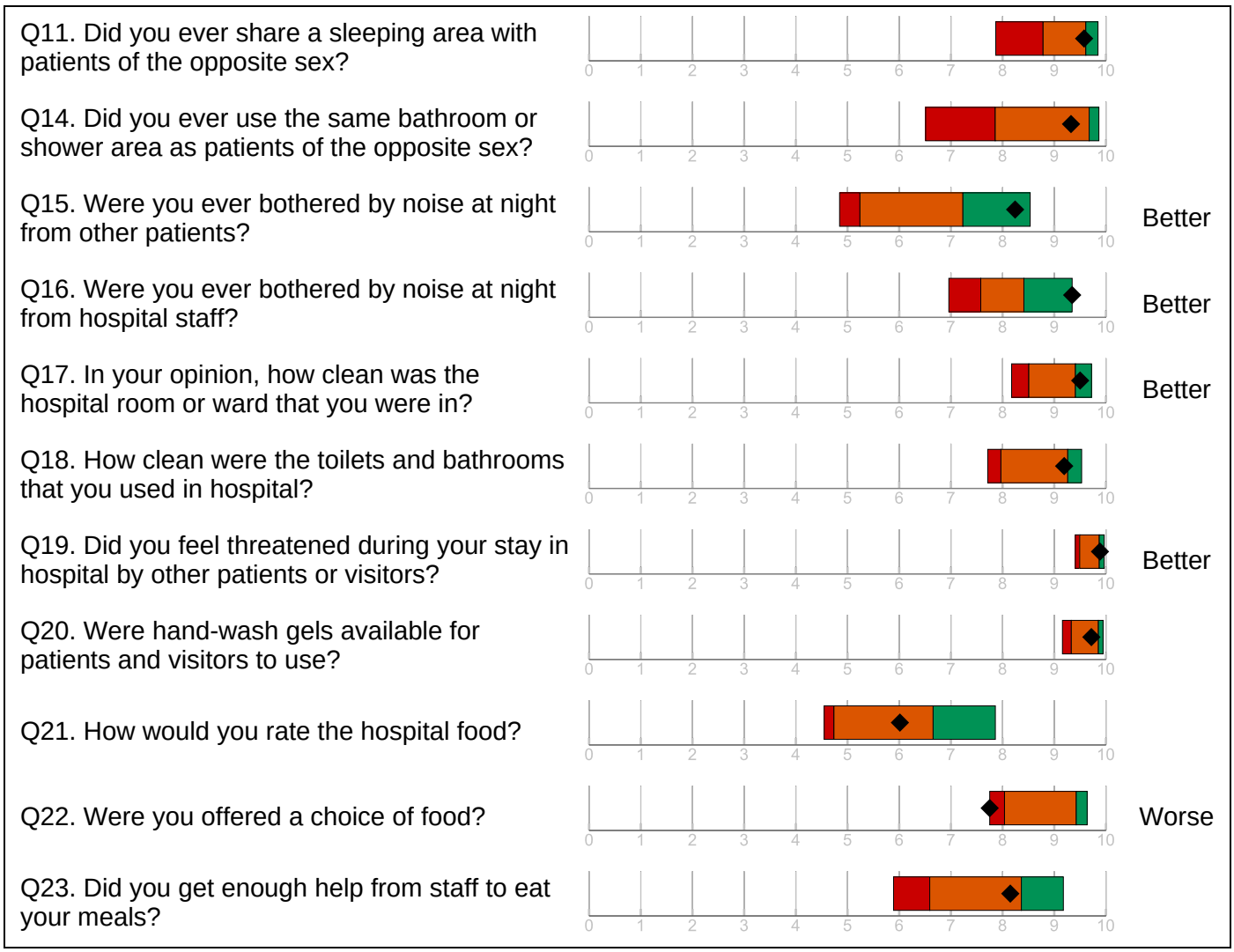
Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

Better

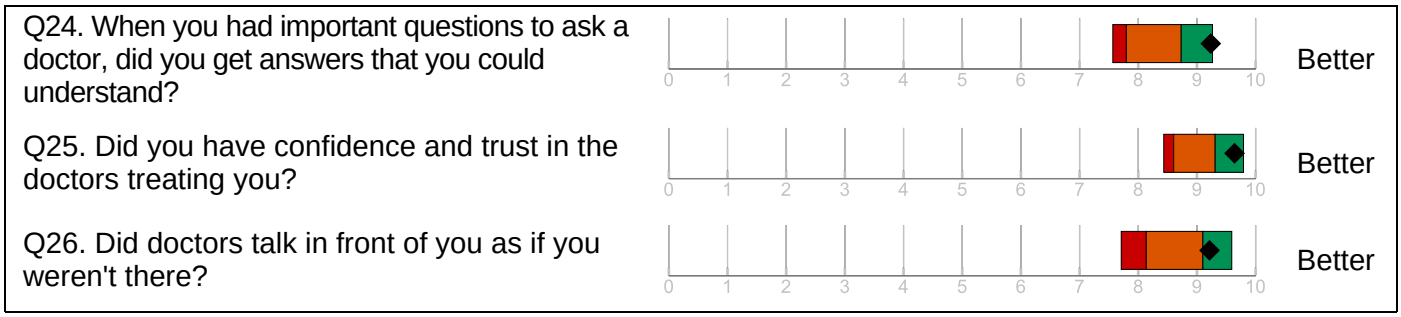
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

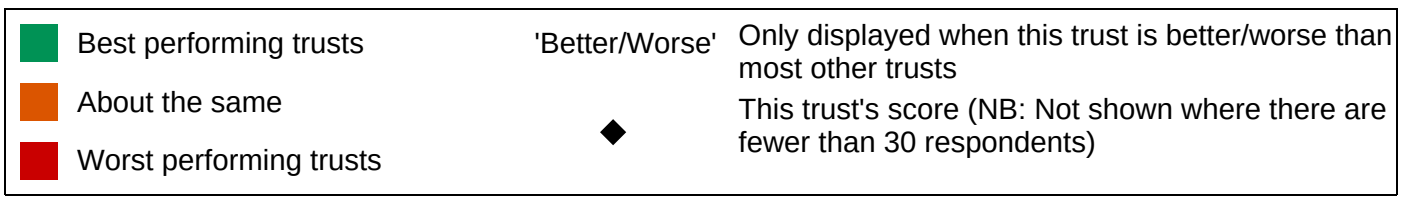
Survey of adult inpatients 2015
Queen Victoria Hospital NHS Foundation Trust

The hospital and ward



Doctors

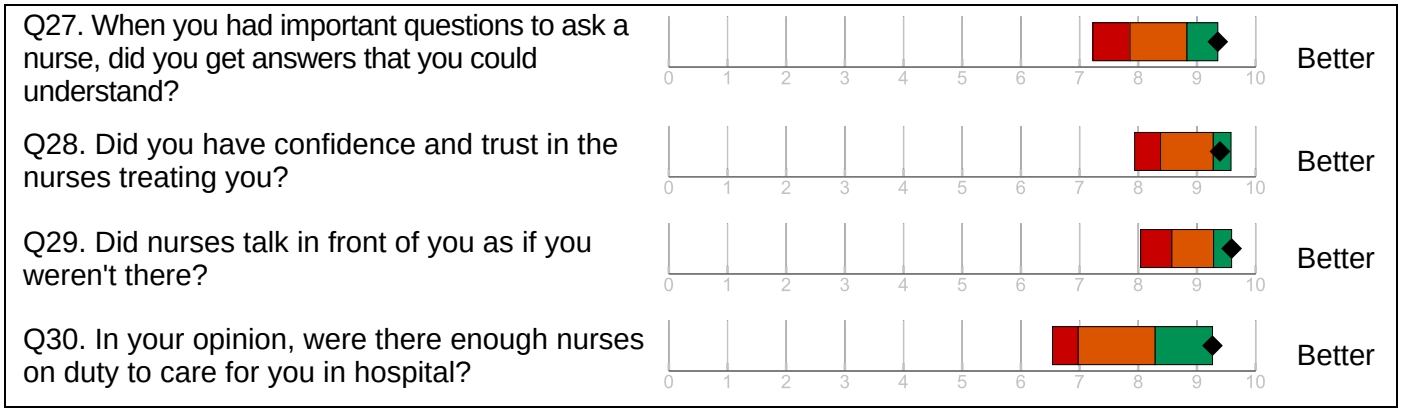




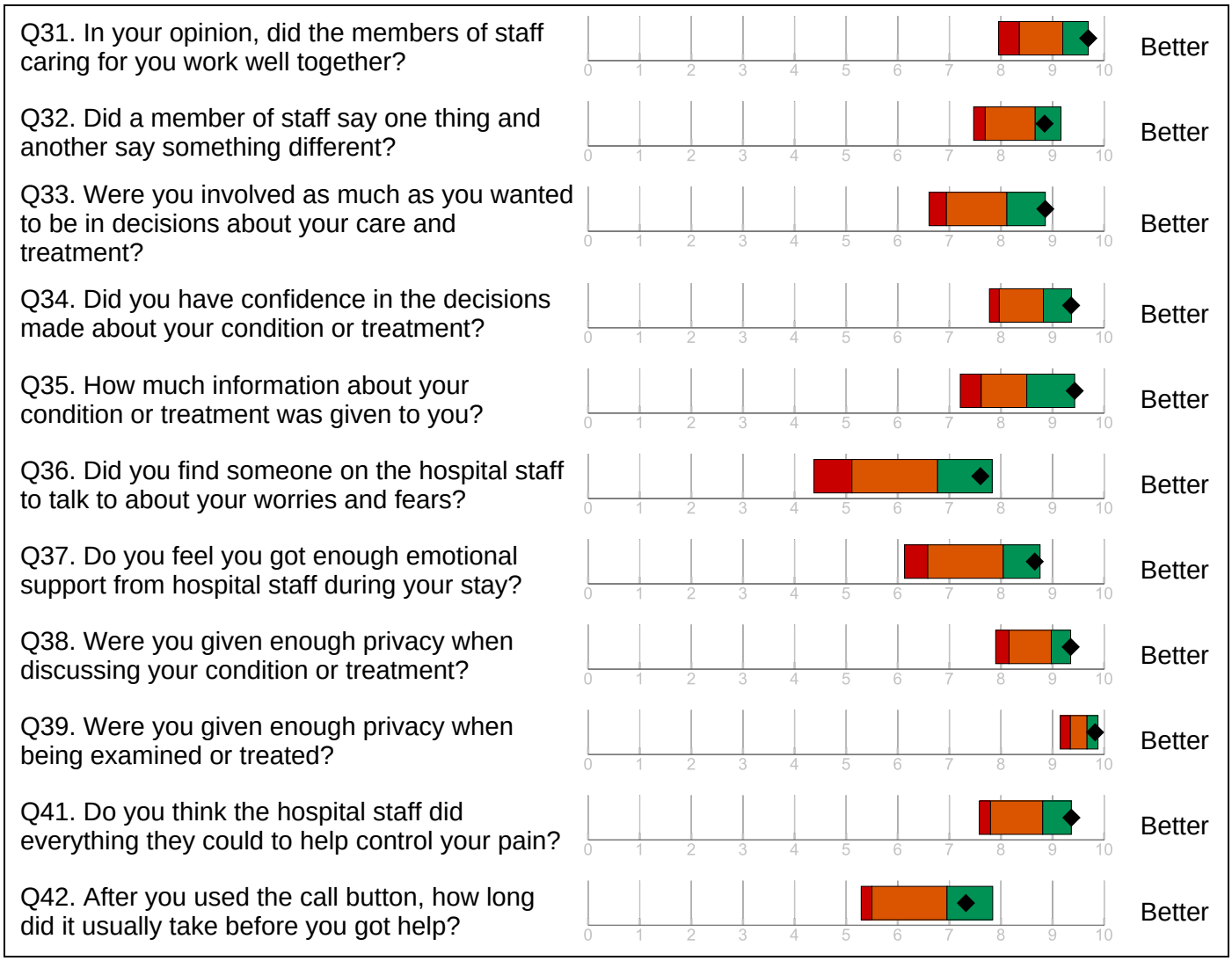
Survey of adult inpatients 2015

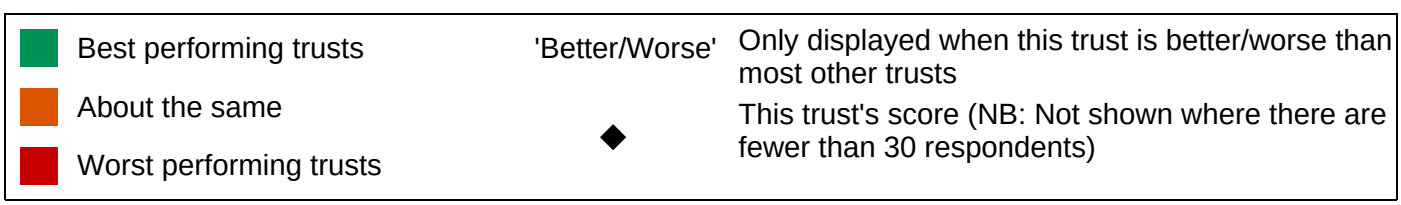
Queen Victoria Hospital NHS Foundation Trust

Nurses



Care and treatment

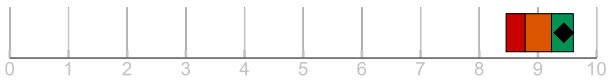




Survey of adult inpatients 2015

Queen Victoria Hospital NHS Foundation Trust

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

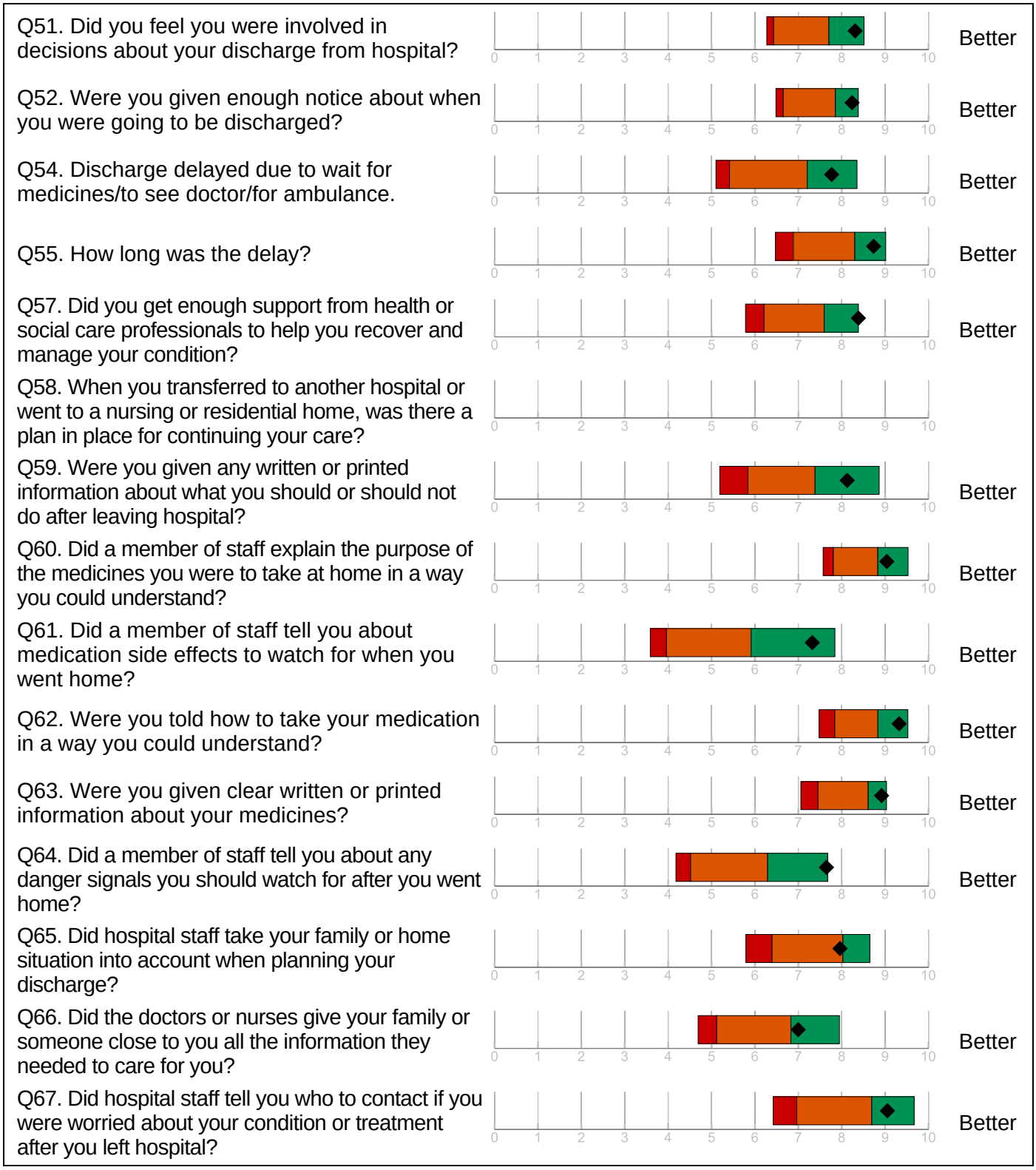
Q44. Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?		Better
Q45. Did a member of staff explain what would be done during the operation or procedure?		
Q46. Did a member of staff answer your questions about the operation or procedure?		
Q47. Were you told how you could expect to feel after you had the operation or procedure?		Better
Q49. Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?		
Q50. Afterwards, did a member of staff explain how the operation or procedure had gone?		Better

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

Survey of adult inpatients 2015

Queen Victoria Hospital NHS Foundation Trust

Leaving hospital



Best performing trusts

About the same

Worst performing trusts

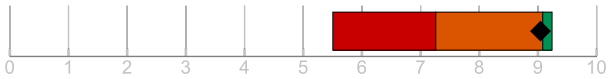
'Better/Worse' Only displayed when this trust is better/worse than most other trusts

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

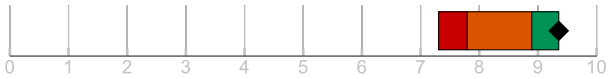
Survey of adult inpatients 2015

Queen Victoria Hospital NHS Foundation Trust

Q68. Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?



Q69. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?



Better

Overall views of care and services

Q70. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Better

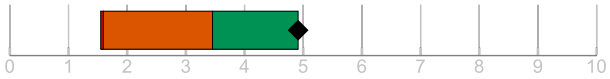
Q71. During your time in hospital did you feel well looked after by hospital staff?

Better

Q73. During your hospital stay, were you ever asked to give your views on the quality of your care?

Better

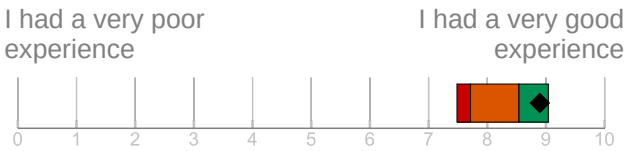
Q74. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Better

Overall experience

Q72. Overall...



Better

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

Survey of adult inpatients 2015

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
The Emergency/A&E Department (answered by emergency patients only)							
S1	Section score	-	7.9	9.4			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	-	7.5	9.3			
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	-	8.1	9.5			
Waiting list and planned admissions (answered by those referred to hospital)							
S2	Section score	9.4	8.2	9.5			
Q6	How do you feel about the length of time you were on the waiting list?	9.2	6.9	9.4	434	8.9	
Q7	Was your admission date changed by the hospital?	9.6	8.5	9.9	442	9.3	↑
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.3	8.2	9.5	435	9.2	
Waiting to get to a bed on a ward							
S3	Section score	9.1	6.5	9.6			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	9.1	6.5	9.6	560	9.6	↓

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
The hospital and ward							
S4	Section score	8.8	7.7	9.1			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	9.6	7.9	9.8	487	9.8	
Q14	Did you ever use the same bathroom or shower area as patients of the opposite sex?	9.3	6.5	9.9	489	8.9	
Q15	Were you ever bothered by noise at night from other patients?	8.2	4.8	8.5	555	8.9	↓
Q16	Were you ever bothered by noise at night from hospital staff?	9.3	7.0	9.3	559	8.8	↑
Q17	In your opinion, how clean was the hospital room or ward that you were in?	9.5	8.2	9.7	562	9.7	
Q18	How clean were the toilets and bathrooms that you used in hospital?	9.2	7.7	9.5	551	9.3	
Q19	Did you feel threatened during your stay in hospital by other patients or visitors?	9.9	9.4	10.0	560	10.0	
Q20	Were hand-wash gels available for patients and visitors to use?	9.7	9.2	9.9	525	9.7	
Q21	How would you rate the hospital food?	6.0	4.5	7.9	458	5.7	
Q22	Were you offered a choice of food?	7.8	7.8	9.6	531	7.5	
Q23	Did you get enough help from staff to eat your meals?	8.1	5.9	9.2	140	8.0	
Doctors							
S5	Section score	9.4	8.1	9.5			
Q24	When you had important questions to ask a doctor, did you get answers that you could understand?	9.2	7.6	9.3	494	9.3	
Q25	Did you have confidence and trust in the doctors treating you?	9.6	8.4	9.8	558	9.5	
Q26	Did doctors talk in front of you as if you weren't there?	9.2	7.7	9.6	551	9.3	
Nurses							
S6	Section score	9.4	7.5	9.4			
Q27	When you had important questions to ask a nurse, did you get answers that you could understand?	9.4	7.2	9.4	505	9.1	
Q28	Did you have confidence and trust in the nurses treating you?	9.4	7.9	9.6	558	9.3	
Q29	Did nurses talk in front of you as if you weren't there?	9.6	8.0	9.6	560	9.5	
Q30	In your opinion, were there enough nurses on duty to care for you in hospital?	9.3	6.5	9.3	559	9.5	

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
Care and treatment							
S7	Section score	8.9	7.2	8.9			
Q31	In your opinion, did the members of staff caring for you work well together?	9.7	8.0	9.7	542		
Q32	Did a member of staff say one thing and another say something different?	8.8	7.5	9.2	560	9.0	
Q33	Were you involved as much as you wanted to be in decisions about your care and treatment?	8.9	6.6	8.9	556	8.6	
Q34	Did you have confidence in the decisions made about your condition or treatment?	9.4	7.8	9.4	560	9.3	
Q35	How much information about your condition or treatment was given to you?	9.4	7.2	9.4	557	9.3	
Q36	Did you find someone on the hospital staff to talk to about your worries and fears?	7.6	4.4	7.8	291	7.6	
Q37	Do you feel you got enough emotional support from hospital staff during your stay?	8.7	6.1	8.8	315	9.0	
Q38	Were you given enough privacy when discussing your condition or treatment?	9.4	7.9	9.4	560	9.3	
Q39	Were you given enough privacy when being examined or treated?	9.8	9.1	9.9	559	9.7	
Q41	Do you think the hospital staff did everything they could to help control your pain?	9.4	7.6	9.4	265	9.3	
Q42	After you used the call button, how long did it usually take before you got help?	7.3	5.3	7.8	240	7.3	

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
Operations and procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.9	7.8	9.2			
Q44	Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	9.4	8.5	9.6	423	9.6	
Q45	Did a member of staff explain what would be done during the operation or procedure?	8.9	8.0	9.4	421	9.2	
Q46	Did a member of staff answer your questions about the operation or procedure?	9.1	8.1	9.5	376	9.3	
Q47	Were you told how you could expect to feel after you had the operation or procedure?	7.9	6.4	8.4	427	7.4	
Q49	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	9.3	8.3	9.6	384	9.6	
Q50	Afterwards, did a member of staff explain how the operation or procedure had gone?	8.8	6.8	9.2	430	8.5	

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
Leaving hospital							
S9	Section score	8.4	6.1	8.4			
Q51	Did you feel you were involved in decisions about your discharge from hospital?	8.3	6.3	8.5	541	7.7	
Q52	Were you given enough notice about when you were going to be discharged?	8.2	6.5	8.4	559	8.2	
Q54	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	7.8	5.1	8.4	544	7.9	
Q55	How long was the delay?	8.7	6.5	9.0	544	8.9	
Q57	Did you get enough support from health or social care professionals to help you recover and manage your condition?	8.4	5.8	8.4	264		
Q58	When you transferred to another hospital or went to a nursing or residential home, was there a plan in place for continuing your care?	-	6.1	8.8			
Q59	Were you given any written or printed information about what you should or should not do after leaving hospital?	8.1	5.2	8.9	555	8.5	
Q60	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	9.0	7.6	9.5	381	9.3	
Q61	Did a member of staff tell you about medication side effects to watch for when you went home?	7.3	3.6	7.8	286	6.4	
Q62	Were you told how to take your medication in a way you could understand?	9.3	7.5	9.5	329	9.4	
Q63	Were you given clear written or printed information about your medicines?	8.9	7.1	9.0	356	9.3	
Q64	Did a member of staff tell you about any danger signals you should watch for after you went home?	7.6	4.2	7.7	368	7.1	
Q65	Did hospital staff take your family or home situation into account when planning your discharge?	8.0	5.8	8.6	263	7.6	
Q66	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	7.0	4.7	7.9	280	6.9	
Q67	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	9.1	6.4	9.7	531	9.5	
Q68	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	9.0	5.5	9.2	98	8.8	
Q69	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	9.4	7.3	9.4	228	9.1	

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
Overall views of care and services							
S10	Section score	7.1	5.0	7.1			
Q70	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.7	8.5	9.7	562	9.7	
Q71	During your time in hospital did you feel well looked after by hospital staff?	9.6	8.3	9.7	562	9.7	
Q73	During your hospital stay, were you ever asked to give your views on the quality of your care?	4.1	0.8	4.1	456	2.9	↑
Q74	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	4.9	1.5	4.9	384	3.9	
Overall experience							
S11	Section score	8.9	7.5	9.0			
Q72	Overall...	8.9	7.5	9.0	537	9.2	↓

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015
Queen Victoria Hospital NHS Foundation Trust

Background information

The sample	This trust	All trusts
Number of respondents	567	83116
Response Rate (percentage)	46	47

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	46	47
Female	54	53
Age group (percentage)	(%)	(%)
Aged 16-35	8	6
Aged 36-50	17	10
Aged 51-65	33	24
Aged 66 and older	42	60
Ethnic group (percentage)	(%)	(%)
White	93	90
Multiple ethnic group	1	1
Asian or Asian British	3	3
Black or Black British	0	1
Arab or other ethnic group	0	0
Not known	4	5
Religion (percentage)	(%)	(%)
No religion	22	15
Buddhist	1	0
Christian	70	78
Hindu	1	1
Jewish	1	0
Muslim	1	2
Sikh	1	0
Other religion	3	1
Prefer not to say	3	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	95	94
Gay/lesbian	1	1
Bisexual	1	0
Other	0	1
Prefer not to say	3	4

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/07/2016**		**Agenda reference:**	**121-16**	
Report title:	**Annual report for child and adult safeguarding**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Natalie Jones, Adult Safeguarding Nurse Specialist, and Pauline Lambert, Paediatric Safeguarding nurse				
Appendices:					
Executive summary					
Purpose:	QVH is required to demonstrate that it has safeguarding leadership and commitment at all levels of the organisation and that it is fully engaged and in support of local accountability and assurance structures. The effectiveness of safeguarding systems is assured and regulated by a number of mechanisms. These include: • Internal assurance processes and board accountability • Partnership working with WSSCB and WSSAB • External regulation and inspection by Care Quality Commission (CQC) and Monitor • Local safeguarding peer review and assurance processes • Effective contract monitoring This report has been shared with and approved by members of QVH Safeguarding Strategic Group.				
Recommendation:	The Board is requested to receive the Safeguarding Annual Report Adults & Children.				
Purpose:	Assurance	Assurance	Assurance	Assurance	Assurance
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	As above				
Corporate risk register:	As above				
Regulation:	As above				
Legal:	As above				
Assurance route					
Previously considered by:	Quality & Governance Committee				
	Date:	9 June 2016	Decision:	Annual Report was received.	

Queen Victoria Hospital NHS
NHS Foundation Trust

Queen Victoria Hospital NHS Foundation Trust (QVH) Safeguarding Annual Report 2015-16

Document Control

Executive sponsor: **Jo Thomas, Director of Nursing and Quality, Executive Board Lead for Safeguarding**
Authors: **Natalie Jones Adult Safeguarding Named Nurse, Pauline Lambert Paediatric Safeguarding Named Nurse, Dr M Z (Oli) Rahman Paediatric Safeguarding Named Doctor**
Date: **May 2016**
Type: **Annual Report**
Version: **FINAL**
Pages:
Status: **Public. Written and prepared for the Trust Board**
Circulation: **QVH Trust Board**

Content:

1.	**Purpose of Report**
1.1	The Board as the overarching leadership mechanism for QVH need to assure themselves that the organisation has effective safeguarding arrangements in place for children, young people and vulnerable adults.
1.2	QVH is required to be registered with the Care Quality Commission (CQC). In order to be registered, QVH must assure that those who use the services are safeguarded and that staff are suitably skilled and supported. As a Foundation Trust, QVH is licensed with Monitor which is conditional upon registration with the CQC. QVH are required to demonstrate that they have safeguarding leadership and commitment at all levels of the organisation and that they are fully engaged and in support of local accountability and assurance structures :i.e. with West Sussex Safeguarding Children Board (WSSCB) , West Sussex Safeguarding Adults Board (WSSAB) and relevant commissioners. QVH must ensure a culture exists where safeguarding is every bodies business and poor practice is identified and tackled. QVH must have in place effective safeguarding arrangements to safeguard vulnerable children and adults. These arrangements include: safe recruitment, effective training for staff, effective supervision arrangements, working in partnership with other agencies, identification of a Named Doctor and Named Nurse for safeguarding children, they should also have a Named Nurse for adult safeguarding. The named professionals have a key role in promoting good professional practice within QVH, supporting local safeguarding systems and processes, providing advice and expertise, and ensuring safeguarding training is in place. They work closely with QVH Director of Nursing, West Sussex Designated Professionals, WSSCB and WSSAB.
1.3	The effectiveness of safeguarding systems is assured and regulated by a number of mechanisms. They include: • Internal assurance processes and Board accountability • Partnership working with WSSCB and WSSAB • External regulation and inspection by Care Quality Commission (CQC) and Monitor • Local safeguarding peer review and assurance processes • Effective contract monitoring
1.4	QVH Board members review monthly safeguarding metrics and receive an annual safeguarding report which is provided so the Board can be assured that the Trust is undertaking its safeguarding duties and responsibilities, and delivering its statutory safeguarding responsibilities safely and effectively. The Board should critically appraise the QVH safeguarding report by making sure patient safety, staff activity, governance arrangements and safeguarding data are transparent and clear so that they can confirm they are assured.

2.	**Safeguarding legislative frameworks and national safeguarding agenda.**
2.1	**Safeguarding Adults:** The arena for safeguarding adults has changed dramatically over the last 12 months with the introduction of the Care Act (2014). It places a series of new duties and responsibilities on local authorities. It is a major step forward in safeguarding adults who are experiencing or are at risk of abuse or neglect, and are unable to protect themselves. It replaces the 'No Secrets' guidance published in 2000. The Care Act (2014) recognises that safeguarding individuals requires multi agency responsibility and partnership working. As an organisation, QVH follows the Sussex Safeguarding Adults policy & procedures document published in April 2015, as this provides an overarching framework to coordinate all activity undertaken where a concern relates to an adult experiencing or at risk of abuse or neglect. It is available online, with hard copies available on request. This document is reviewed and updated by the West Sussex Safeguarding Adults Board.
2.2	**Safeguarding Children:** *'The welfare of the child is paramount'* principle was enshrined in the Children Act 1989 and has driven the development of systems and arrangements used to safeguard and/or protect children since that time. Section 11 of The Children Act 2004 places a statutory duty on all NHS organisations to ensure that services are designed to safeguard and promote the welfare of children. Working Together to Safeguard Children and Young People Guidance (2015) states clearly that for services to be effective, a child centred approach is essential in the delivery of health care and this should be underpinned by a clear understanding of the needs and views of each child. As an organisation QVH continues to follow Sussex Child Protection and Safeguarding Procedures when required, staff are also supported by access to a range of internal QVH policies, standards, procedures and systems which promote the delivery of safe care and support for children and their families.
2.3	**Saville Investigation Update 2015** In October 2012, the Secretary of State for Health appointed Kate Lampard, a former barrister, to undertake an independent review of the investigations that were undertaken by the Department of Health and the NHS into the matters relating to four NHS Trusts and the late Jimmy Saville. This was to provide assurance that all investigations had established the truth and had robustly protected the interests of the patients concerned. On 26 June 2014, twenty-eight reports and a separate assurance report were published including fourteen recommendations, thirteen of which were accepted in principle. QVH reported on the fourteen recommendations with the position of compliance at QVH. Some remedial actions were identified, where required these have been monitored and updated by the QVH Risk Manager. The DH released a report *Update on the Themes and lessons learnt from Jimmy Saville NHS investigations* in November 2015, which was reviewed by QVH Risk manager and the Paediatric Safeguarding Named Nurse. No additional actions for the organization were identified.

2.4	**Modern Slavery Act 2015** The Modern Slavery act received royal assent during March 2015, it encompasses human trafficking, forced labour and domestic servitude. QVH staff are made aware of these issues during training and via eLearning opportunities. Staff are encouraged to discuss any such concerns with their manager, supervisor and/or the safeguarding team, so that appropriate risk assessment and relevant actions can be taken when required.
2.5	The safeguarding agenda continues to evolve and develop as understanding, learning and further challenges emerge over time. See Appendix A for overview of the current breadth of the safeguarding agenda. The QVH Safeguarding Strategy 2015 supports progressive response to the changing landscape framing the delivery of healthcare services at QVH. Appendix E provides an overview of QVH safeguarding documents and information available for staff or the public via the Website or QNET as appropriate.

3.	**Internal assurance processes and Board Accountability.**
3.1	As an organisation we are committed to the protection and prevention of abuse & neglect for all vulnerable people whilst in the care of Queen Victoria Hospital NHS Foundation Trust (QVH). We continue to review and strengthen systems, methods and arrangements for managing episodes where we might be considering or suspect abuse/neglect has occurred either within the organisation or prior to admission. Staff are provided with support to manage any concerns identified. Protecting the vulnerable is a key component of our trust objectives – focussing on quality and patient experience - we work alongside partner agencies to promote the safety, health and well-being of people who use our services.
3.2	QVH has robust safeguarding governance arrangements in place, which are led and supported by a team of specialist safeguarding clinicians. See Appendix B for QVH safeguarding governance chart. The QVH governance structure provides transparent lines of accountability, clear partnership connections with internal QVH meetings which are in place to scrutinise practice and systems. The safeguarding team comprises of; • Jo Thomas , Director of Nursing and Quality, Executive Board Lead for Safeguarding • Natalie Jones , Named Nurse for Safeguarding Adults (in post January 2016) • Dr M Z (Oli) Rahman, Named Doctor Safeguarding Children (via BSUH SLA) • Pauline Lambert, Named Nurse Safeguarding Children (in post November 2015) • Debra Yeoh, Nurse Specialist Safeguarding Children • Katy Fowler , Nurse Specialist Safeguarding children The purpose of this team is to ensure all staff including volunteers understand their safeguarding responsibilities and are supported to undertake these. This is achieved through case discussions, advice, practice review and audit; provision of training; provision of policy, procedures and guidance.

	A Non-Executive Director who is chair of Quality and Governance Committee is working to support scrutiny of the agenda with 'Safeguarding' identified as a discreet responsibility. Across QVH paediatric safeguarding and adult safeguarding link staff from all services attend either or both safeguarding steering groups to share practice, discuss clinical issues, access information, review learning and to share practice improvement across the organisation. The Joint Hospital Governance Group provides a more wide reaching audience where safeguarding discussions are also undertaken, such as sharing learning from the *'Myles Bradbury Investigation'* (CUH, 2015)and how this might be applied in QVH.
3.3	**<u>Safeguarding adults clinical activity</u>** The Safeguarding Adult Named Nurse receives notification of any suspected safeguarding incidents involving adults via the DATIX reporting system. The lead responds to each Datix report. The response may be in the form of advice or it may trigger further investigation. This activity allows the lead to maintain oversight of all safeguarding adult referrals to social care. The table in Appendix C provides details of the monthly safeguarding adult incidents reported on DATIX for the past year.
3.4	**<u>Safeguarding children clinical activity</u>** The Paediatric Safeguarding team receive reports of any safeguarding children concerns which occur within QVH via a centralised email address. Follow up by Specialist Paediatric Safeguarding Nurses provides support for staff managing these situations as well as a means to scrutinise case management and follow up outcomes with statutory partners when required. The team are currently working closely with the Orthodontic and Max-Fax department to capture their safeguarding situations information more fully. Safeguarding children incidents are reported on the DATIX system when the level of harm indicates the need for referrals to social care or police. Analysis of information provided is returned directly to the staff member reporting concerns or situations requiring referral. All dog bite injuries are referred to the police under requirement of the Dangerous Dogs Act. The paediatric safeguarding team have a secure Access database and log information about any concerns raised. This provides a mechanism for quality assurance of cases and easy access to data for audit purposes. See Appendix C for overview of paediatric safeguarding activity during the past year. The Access data base is not supported by IT service, so alternative ways to capture this data for the longer term are being explored.
3.5	The safeguarding team are working closely with the QVH Evolve/EDM Project Team to develop appropriate systems on the Electronic Document Management system which will be implemented across QVH in the coming months. This provides an opportunity to look at different ways to present and capture safeguarding information.
3.6	QVH place great importance on ensuring patients have an excellent experience. The trust continues to develop ways to engage and listen to patients, collecting views, comments and ideas from them, their families and carers which then form future plans to further improve

	patient experience. In 2014/15 QVH saw a number of national surveys at the hospital including cancer, paediatric and in-patient services. Survey results help us focus on what really matters to patients to improve their hospital stay. 99% of QVH patients recommend the trust to friends and family. QVH safeguarding team have produced information for families about: QVH safeguarding children and young people, along with information about attendance with dog bite injuries in the first quarter of 2016. Both these leaflets should be available for the public once they have been approved by the patient information group during May or June 2016. Posters encouraging patients and their families to talk to clinical managers, PALs and the safeguarding team if they have any concerns about staff behaviour are ready to be rolled out across the organisation during 2016.
3.7	**<u>Safeguarding Learning and Development</u>** Driving improvement in safeguarding practice is a continuous process and as such has to be reviewed, evaluated and adapted over time. A summary of training evaluations are not available this year, a training evaluation summary will be included in next year's report. **Adult Safeguarding Training:** QVH Adult Safeguarding learning and development strategy was ratified during March 2016. This framework is aligned with the core skills framework document, and more recently has been reviewed to comply with the national guidance from the NHS England Safeguarding Adults: Roles and competences for health care staff – intercollegiate document. Staff training data for level 2 Safeguarding Adults is currently at 40%, a new format for this has only been implemented during March 2016. Level 2 training compliance should rapidly improve in the coming year. **Paediatric Safeguarding Training:** QVH Paediatric safeguarding learning and development strategy was ratified during March 2016. This framework is aligned to national guidance. It provides transparent QVH expectations for staff including the Board with regard to paediatric safeguarding training and development. The list of staff requiring level three training and options for completing this are being adjusted. This has impacted on training data percentages for level 3 during February and March 2016 which has dipped below 80%. Level 3 training data should be back above 80% by the end of June 2016. See Appendix C for overview of paediatric training levels over the past year. Medical staff paediatric safeguarding level 2 and level 3 competencies are also reviewed on a regular basis. Medical posts in January 2016 included: • Consultants = 60 • Trainee doctors = 81 • Medical bank/locum = 17 • **Total = 158, Plus Visiting OPD Consultants = 33** We currently have: • 149 doctors competent at level 2, • 16 doctors competent at level 3.

	• **Total = 165** We have 16 doctors who need level 2 updates (of which two are visiting consultants, and 5 are bank doctors). There is a small disparity between numbers of doctors working in QVH and those who have completed competencies due to some visiting OPD consultants completing their competencies in another organisation. Those requiring level 2 update as well as those not captured on QVH competencies data base are being followed up by the QVH Medical Education team. Bank staff are expected to be fully up to date with all mandatory training requirements. HR have confirmed they are removed from the bank staff list if non- compliant. Provision of supervision and support for specialist safeguarding staff is provided by West Sussex Designated professionals who are employed by Clinical Commissioning Groups. Trust policy requires that provision of specialist safeguarding advice and support to QVH staff is accessed on a case by case arrangement from safeguarding team members when needed.
3.8	**Safeguarding audit** Audit of service efficacy is an integral element of the work of the Safeguarding Team. During 2015-16 one Paediatric Safeguarding audit was undertaken. In 2014 Peanut ward introduced a Trauma Proforma for the assessment and clerking of paediatric patients with maxillofacial and plastics trauma and burns injuries. The audit reviewed the use of the safeguarding components of the Trauma Proforma in practice; including the safeguarding children screen checklist. Random samples of 99 QVH paediatric records were audited between November 2015 and January 2016. Recommendations include: raising awareness of assessment and recording requirements to all clinicians who are clerking paediatric patients. Ensuring all relevant family information is recorded at the point a child is admitted to Peanut ward. Re-structure of the Proforma will be taken forward with clinicians to improve ease of use and better understanding of what is required. There will be a re-audit 6 months after implementation of Proforma changes. The audit programme for 2016-17 has been agreed and will focus on assessment of the implementation of NICE CG89 When to suspect child maltreatment (Paediatric Safeguarding) and NICE PH50 Domestic Violence and Abuse quality standards (Adult and Paediatric Safeguarding).
3.9	**Safeguarding case reviews** **Adult safeguarding case reviews:** Safeguarding Adults Board responsibilities include: overseeing the performance and monitoring of all safeguarding work relating to adults at risk in West Sussex, including agreeing to set up serious case reviews when required. QVH has not participated in any West Sussex adult safeguarding case reviews during 2015-16.

	Safeguarding Children case reviews: **Serious Case Reviews (SCRs).** When a child dies or is seriously harmed, including death by suspected suicide, and abuse or neglect is known or suspected to be a factor in the death, West Sussex safeguarding Children Board (WSSCB) is required to conduct a Serious Case Review into the involvement of organisations and professionals in the lives of the child and the family. The purpose of a Serious Case Review is to establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard children, identify what needs to be changed and, as a consequence, improve multi-agency working to better safeguard and promote the welfare of children. **Child Death Reviews.** The WSSCB is also required to conduct a review of every child death to identify whether there are any lessons to be learned to prevent child deaths in the future. **Other types of reviews.** The WSSCB carry out a range of learning activities in order to understand how to improve safeguarding. This includes reviews into individual cases and reviews of practice across areas of safeguarding. QVH has not participated in any West Sussex safeguarding children reviews during 2015-16.
3.10	**Safeguarding policies, procedures and guidance for QVH staff and patients** The Safeguarding Team develop a plethora of guidance for the organisation, staff and patients in the form of policy, procedures, protocol, guidelines and leaflets. For a list of what is in place for QVH please refer to Appendix E. All documents are placed on the Website or QNET. All documents have been systematically reviewed and updated in collaboration with relevant services and governance groups.
3.11	**Local peer review and assurance processes** QVH has a case peer review system in place in the Burns Unit. Meetings to discuss paediatric cases and adult cases occur every Monday (except Bank Holidays). These meetings review injury mechanism and explanation, treatment, risk assess, discuss any safeguarding issues and agree actions required. Adult safeguarding steering group was set up in October 2015 and was not meeting regularly until appointment of the current Named Nurse. A meeting was held in February 2016 where-by the terms of reference were updated, training and development updates, national guidance changes, were all discussed. Link staff from 5 departments of QVH, have agreed in-put to this group. Paediatric safeguarding incidents are captured on Datix and in incident reports which are reviewed in the Paediatric Governance Group and Paediatric Safeguarding Steering group. There are 18 paediatric safeguarding link staff identified from teams and services across the hospital who are members of the steering group. The purpose of these groups is to strengthen communication and dissemination of safeguarding information and practice across the organisation.
3.12	**Safer recruitment** QVH work to ensure that those working or in contact with children are safely recruited and

	Human Resource processes take account of the need to safeguard and promote the welfare of children. Making sure that we do everything we can to prevent appointing people who pose a risk to children is an essential part of safeguarding practice and QVH recruit staff and volunteers following safer recruitment procedures. All staff at the Trust are employed in accordance with the NHS pre-employment check standards.
3.13	**<u>Allegations against staff</u>** The Director/Deputy Director of Human Resources would manage the Trust response to any allegations against trust staff. *'Allegations against staff'* procedures are followed. When required investigations are co-ordinated by West Sussex County Council. There was 1 allegation made against QVH staff caring for an adult during 2015-16. This was investigated by the Deputy Director of Nursing; the Named Nurse for Safeguarding Adults was not involved. The final report was discussed between the parties, and no safeguarding issues raised. This case was referred to West Sussex County Council (WSCC), however it was subsequently closed by them.
3.14	**<u>Staff Survey 2015</u>** The survey is carried out every year across all NHS trusts. In total, 453 QVH staff completed the survey between September and December 2015. This is a response rate of 50%, which is about average for acute specialist trusts. QVH's scores are compared with the other 17 acute specialist trusts in England because they tend to have more positive staff satisfaction scores than general acute trusts. QVH scored more positive results than average on the key findings around: • Staff recommending the trust as a place to work or receive treatment • Staff satisfaction with the quality of work and patent care they are able to deliver • Staff motivation and feeling that their role makes a difference for patients • Effective team working, resourcing and support • Work-related stress and the trust's support for staff health and wellbeing • Receiving appraisals and opportunities for career progression • Confidence in reporting unsafe clinical practice • Effective use of patient feedback. This indicates that QVH culture gives staff confidence to report unsafe practice.

4.	**Partnership working with WSSCB and WSSAB**
4.1	The delivery of effective safeguarding is dependent on multiagency working. Strategic work is often set by the children and adult Safeguarding Boards in West Sussex and translated into work streams which are monitored by QVH Strategic Safeguarding Group or QVH Safeguarding Team to ensure relevant inclusion for the trust. The section below summarises safeguarding systems in place and practice developments taken forward by the Trust with the support of partners in other agencies.

4.2	**<u>WS safeguarding adults network</u>** This group is chaired by the designated Nurse for safeguarding adults from Coastal West Sussex CCG. The Adult Safeguarding NHS Professionals group meet quarterly. These meetings include all adult safeguarding leads across Sussex, including Safeguarding Adult's Board representation. Since coming into post QVH Safeguarding Adults Named Nurse attends these meetings.
4.3	**<u>WS safeguarding children NHS professional group and networks</u>** This group is chaired by the West Sussex designated Nurse for safeguarding children. The group meets quarterly. The group is attended by all West Sussex NHS Trust Named Nurses and provides a forum which can share learning from practice, inform and influence the WSSCB. Representatives from QVH attend regularly and raise awareness of QVH issues and safeguarding practices.
4.4	**<u>Mental Capacity Act (MCA)& Deprivation of Liberties (DOLs)</u>** The MCA DOL safeguards apply to anyone: aged 18 and over, who suffers from a mental disorder or disability of the mind – such as dementia or a profound learning disability, who lacks the capacity to give informed consent to the arrangements made for their care and / or treatment, and for whom deprivation of liberty (within the meaning of Article 5 of the ECHR) is considered after an independent assessment to be necessary in their best interests to protect them from harm. The safeguards cover patients in hospitals, and people in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements The MCA/DoLS role for QVH now sits with the Adult Safeguarding Named Nurse. Staff training for implementation of this has been incorporated into the Level 2 Safeguarding Adults sessions, and is outlined in the Adult Safeguarding Learning and Development Strategy 2015-16. Trust MCA and DOLs Policies are up to date and are in line with National guidance & Legislation. Level 2 training uptake was at 40% at the end of March 2016, with the aim to increase uptake to over 80% by March 2017.
4.5	**<u>Prevent</u>** Prevent is the Government's strategy to stop people becoming involved in violent extremism or supporting terrorism, in all its forms. Prevent works within the non-criminal space, using early engagement to encourage individuals and communities to challenge violent extremist ideologies and behaviours. The Department of Health produced guidance several years ago which linked the Home Office '*Prevent* Strategy' to the safeguarding agenda. A practical approach has been agreed to support the delivery of '*Prevent*' in the trust, with lead responsibility sitting with the Adult Safeguarding Named Nurse. Learning around the basic *'prevent'* strategy is included in all existing mandatory adult and child safeguarding training sessions, practical advice is detailed in the *'Prevent'* Delivery Plan, and can be accessed by staff on Q-Net.

	During 2016 clinical staff are required to undertake a nationally directed mandatory training (as a one off session*) Workshop to Raise Awareness of Prevent* (WRAP). The roll out of this workshop will commence in June 2016 and be completed by the end of the year. This will be in addition to other adult and child safeguarding training sessions. The session to be delivered is a specified national programme devised by the home office for delivery into healthcare settings.
4.6	**<u>Domestic violence and abuse (DVA)</u>** The publication of the Nice Guidance 'Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively' (February 2014) has provided a steer for West Sussex and other areas in the region to work effectively together to offer quality, timely responses for people experiencing abuse, and to think about engaging victims and perpetrators as early as possible. The provision of specialist support services for victims of domestic violence and abuse (DVA) is available in the community. Staff are informed of any changes to information about specialist services via the QNET, through training and safeguarding supervision. Consideration and assessment of potential domestic abuse continues to be included in all safeguarding training provided in-house by QVH. Newly published NICE DVA standards were used to self-assess QVH practice, we assessed ourselves as compliant. The standards will be used during August 2016 to audit staff practice across QVH we will then triangulate results with QVH self-assessment assumptions. Results will be shared in relevant QVH governance groups and reported in next year's annual safeguarding report. There will also be development and dissemination of a '*Staff who are experiencing Domestic Abuse Policy'* during 2016, it will be developed in conjunction with HR.
4.7	**<u>Child Sexual Exploitation (CSE)</u>** The publication of the Jay (Rotherham) and Coffey (Manchester) Reports raised the profile of Child Sexual Exploitation (CSE) across the UK. There was nothing specific from these reports that required follow up by QVH. However, CSE is always discussed in Level 1 and 2 safeguarding children training sessions. The need to further develop and promote services which protect children and young people from the risks posed by perpetrators of CSE has seen continued engagement with WSSCB. QVH staff have access to WSSCB CSE risk assessment tools and guidance on the QNET intranet. They can also access more detailed training via WSSCB and via approved eLearning programmes.
4.8	**<u>Female Genital Mutilation (FGM)</u>** Understanding of FGM and mandatory reporting duty is incorporated into QVH mandatory safeguarding training for staff. DH/NHS approved and recommended FGM e-Learning packages are also available to staff to enhance their knowledge and understanding of this subject. The Safeguarding Team provide practical advice and support to clinical staff regarding the management of potential FGM cases when required, based upon current national DH and NHS multi-agency guidance.

	FGM guidance and information, with particular regard to risk assessment, mandatory reporting and recording, can be accessed by staff via the Trust QNET Safeguarding page. Within QVH one FGM risk assessment was undertaken on an adult patient during the last year, when the transferring hospital raised concerns regarding this. The ward staff and psychology therapies team managed the assessment safely and sensitively with support from the adult safeguarding lead. No referral or further actions were required once a full assessment had been completed.

5.	**External regulation and inspection by CQC and Monitor**
5.1	**<u>WSSCB Section 11 audit</u>** Improving the way key people and bodies safeguard and promote the welfare of children is crucial to improving outcomes for children (up to their 18th birthday) under the age of 18 years) Section 11 (s11) of the Children Act 2004 places a statutory duty on key organisations to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children. QVH is required to complete a Sussex wide Section 11 self-assessment audit tool every two years for the WSSCB. The QVH Safeguarding Team updated the self-assessment audit tool during March 2016 and now awaits feedback from WSSCB on the self-assessment, evidence provided and action plan produced (see Appendix F). Some issues identified in the current self-assessment action plan include: • Volunteers guidance to be produced and circulated • Review and update Paediatric Safeguarding Steering Group Terms of Reference • Roll out 'information sharing and who to tell' posters for patients across QVH • Develop Service User leaflets on Safeguarding children at QVH and mandatory reporting of dog bites to Police. • Safeguarding accountability structure to be reviewed and updated • Strengthen input into WSSCB learning and Improvement subgroup with QVH representation • Develop with HR *staff experiencing DVA policy*
5.2	West Sussex safeguarding standards and compliance reporting is completed on a quarterly basis by Paediatric Safeguarding Named Nurse and the Adult Safeguarding Named Nurse on behalf of QVH. Any safeguarding issues or concerns would be captured and reported to the Board alongside the Board's monthly safeguarding metrics.
5.3	**<u>Contract monitoring -Sussex Clinical Commissioning Groups (CCG's) Safeguarding Standards</u>** CCG's as commissioners of local health services need to assure themselves that the organisations from which they commission services have effective safeguarding arrangements in place. A self-assessment tool is completed annually and contributes to providing evidence of assurance in conjunction with assurance site visits and submission of audits as part of an audit programme. There is overlap between this report and the Section

	11 self-assessment for WSSCB. CCG exception reports are provided by QVH in April, July, October and January of each year. The only areas of concern raised during the last year were: • Transfer of information from MIU on paediatric attendances to Surrey was problematic; an updated process was agreed with Surrey services. • Strengthening QVH child abduction management with a new procedures policy – was drafted and ratified by the QVH Clinical Governance Group.
5.4	**<u>CQC inspection and monthly reporting</u>** QVH CQC overall - good rating. In the report summary form the CQC it said: there were effective and robust systems and protocols in place to protect patients from harm, and staff contributed to an incident-reporting culture. There were opportunities for learning from results of investigations. Two areas that have been followed up from the CQC report by the QVH safeguarding team include: • Ensure that departmental risks are identified, recorded and regularly reviewed (see section 6). • Staff were aware of their requirements under the Mental Capacity Act and a colour coded flow chart was available to support staff. Training was made available; however training levels were not meeting the trust target in some areas (see Section 4.4). Monthly CQC reporting via the Deputy director of Nursing over the last year: • No specific paediatric safeguarding concerns were raised during the last year. • No specific adult safeguarding concerns were raised during the last year.

6.	**Safeguarding Risks**
6.1	There are currently no corporate risks identified in relation to adult or paediatric safeguarding. There are 2 adult safeguarding departmental risks. There are 4 paediatric safeguarding departmental risks. These are listed below:
6.2	Adult safeguarding, need to increase percentage of staff who have completed level 2 adult safeguarding training (risk rating 9) Nursing and Quality department
6.3	Adult Safeguarding Named Nurse limited resources for QVH (risk rating 9) Nursing and Quality department
6.4	Children who are not brought for appointments (risk rating 9) Peanut ward, Orthodontics, OPD –Paediatric department
6.5	Potential abduction/disappearance of a child (risk rating 9) Nursing and Quality department
6.6	Peanut ward risk management of child tagging system (risk rating 9) Paediatric Department

6.7	Paediatric safeguarding unsupported *IT Access Data Base* (risk rating 9) Nursing and Quality department

7.	**Conclusions and assurance**
7.1	All health care at QVH is patient centred and QVH works closely with partners to ensure effective safeguarding is achieved for all vulnerable patients. QVH continuously strives to develop and support its staff to achieve the best outcomes for vulnerable patients. QVH promotes a culture where staff are able to raise concerns and to whistle blow without fear, this is evidenced in the staff survey. QVH also promotes feedback from patients and encourages them to raise concerns about anything they see and are worried about.
7.2	The arena for safeguarding adults has changed dramatically over the last 12 months with the introduction of the Care Act (2014). Training for staff is being transformed and staff understanding of what is required of them is more established. Paediatric safeguarding systems in QVH have been well established for many years. They continue to be strengthened. There is a transparent overview of what is in place and of paediatric safeguarding activity occurring in the organisation. Safeguarding governance arrangements have become more robust during the last year.
7.3	QVH has a range of internal assurance processes in place. An overview of adult and paediatric safeguarding activities in QVH are in place. QVH staff training programmes for adult and paediatric safeguarding have been reviewed and strengthened. Areas to improve training update have been identified and are being managed. QVH has an overview of all relevant safeguarding information and documents, which are systematically developed, reviewed and/or updated. Five safeguarding departmental risk assessments are in place.
7.4	QVH has local external regulation undertaken by the CCGs, WSSCB and WSSAB. Monitor ensures QVH are registered with the CQC. A Care Quality Commission (CQC) inspection occurred during 2015. The report published in 2016 identified two areas that the safeguarding team have worked on to improve, i.e. reporting of departmental risks and increase uptake of MCA training.
7.5	Local safeguarding peer review and assurance processes are in place.

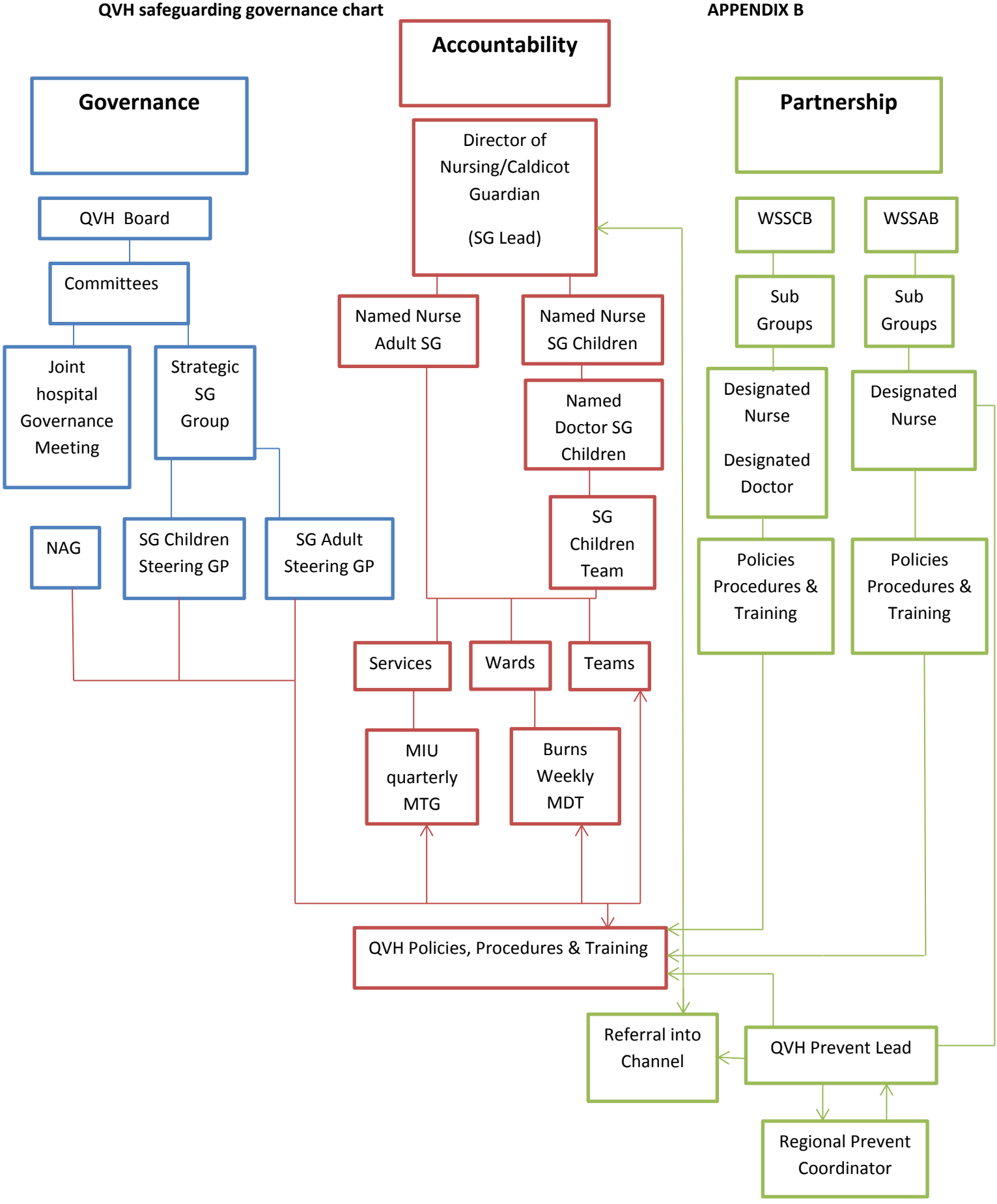
	Safeguarding specialist clinicians are well supported by the Director of Nursing, Deputy Director of Nursing and the West Sussex Designated Professionals. QVH staff are guided and supported by a team of specialist safeguarding clinicians.
7.6	Partnership working with WSSCB and WSSAB is in place. A number of practice developments have been implemented in the last year including: management of CSE, DVA, FGM and roll out of the national Prevent training workshop is planned from to occur from June 2016 onwards and will be completed within 6 months.
7.7	Effective contract monitoring is undertaken through audits and regular exception reporting to WSSCB, WSSAB, CCGs and the CQC.
7.8	**The QVH safeguarding team present this report to provide assurance to the Board that the Safeguarding agenda is robustly overseen and managed within the trust and with partners.**

The Safeguarding Agenda **APPENDIX A**

The Safeguarding agenda is far reaching and continues to evolve over time as new learning and challenges are presented.

QVH safeguarding governance chart

APPENDIX B



Safeguarding adults clinical activity
APPENDIX C

Adult's attendances in 2015-16 (Information routinely passed to GP and/or referrer)

OPD = 147,638

Inpatients = 16,260

Month	QVH cases of concern	QVH referrals to Social care	Deprivation of Liberty Safeguard applications	% Staff Trained (overall) L1	% Staff Trained (overall) L2
April 2015	1	0	0	73%	
May 2015	0	0	0	75.57%	
June 2015	5	2	0	76.31%	
July 2015	1	0	0	79.60%	
August 2015	2	1	0	80.56%	
September 2015	0	0	0	88.82%	
October 2015	3	2	0	92.70%	
November 2015	2	1	0	92.46%	
December 2015	0	0	0	92.33%	
January 2016	2	2	0	80%	
February 2016	2	2	0	90%	
March 2016	1	1	1	92%	40%
Totals	19	11	1		

Safeguarding children clinical activity
APPENDIX D

Children attendances in 2015-16 (information routinely passed to GP, HV/school nurse and/or referrer)

OPD = 17,570

Inpatients = 2,585

Month	QVH cases of concern	Referred to social care before QVH	QVH referrals to Social care	Dog Bites referred to Police	% Staff Overall Trained L1	% Staff Overall Trained L2	%Staff Overall Trained L3
April 2015	26	3	2		75.06%	64.48%	85%
May 2015	15	1	3		77.51%	66.44%	80.95%
June 2015	10	3	1		75	63	67
July 2015	10	1	1		81	71	67
August 2015	18	1	4		81	71	67
September /October 2015	28	4	2		91.96	86.34	81.25
November 2015	15	4	2		91.91	88.49	83.33
November /December 2015	26	6	2	1	91.91	88.49	83.33
January 2016	18	7	1	2	94.56 Bank 73.19	93.07 Bank 88.49	84.09
February 2016	23	5	4	2	93.14 Bank 78.85	90.82 Bank 66.67	76.09
March 2016	22	1	2	2	92.94 Bank 82.21	89.33 Bank 68.16	75.61
Total =	211	36	24	7 partial year			

Policy, procedures and guidance for QVH, staff and patients **APPENDIX E**

QVH SAFEGUARDING DOCUMENTS AND INFORMATION 29.4.2016

1	Item	Date	Location	Actions
1.1	QVH assurance statement	2015	Website	
1.2	QVH safeguarding strategy	2016	Website	Finalised, add to website
1.3	QVH QNET	2016	Intranet	Ongoing review and update as required by QVH safeguarding leads
1.4	Sussex Child Protection and Safeguarding Procedures	2016	Link via QNET	Ongoing review and update as required by WSSCB
1.5	QVH safeguarding annual report	2015-16		Drafted May 2016
1.6	QVH and BSUH Paediatric SLA	2016 updated		Copy with Deputy Director of Nursing
1.7	QVH Safeguarding Strategic Group terms of reference	2015		Held by PA for Director of Nursing
1.8	QVH Managing allegations against staff	2015	QNET	
1.9	QVH Whistle blowing policy	2015	QNET	
1.10	QVH Patient experience strategy			Mentioned in Patient experience report
1.11	QVH Handling complaints policy	2014	QNET	
1.12	QVH producing user information policy	2015	QNET	
1.13	QVH Interpreting policy	2013	QNET	
1.14	QVH supervision support guidance	2014	QNET	
1.15	QVH Recruitment and selection policy (includes Checking and DBS)	2015	QNET	
1.16	QVH Risk management and incidents policy	2014	QNET	
1.17	QVH Consents policy	2015	QNET	Includes Gillick competence/Fraser Guidelines –staff development re implementation of Fraser guidelines offered by Named Doctor
1.18	QVH Information security policy,-Patient photographic	2015	QNET	

	and video recording			
1.19	QVH Chaperone Policy		QNET	Add children's section
1.20	QVH information governance policy	2015	QNET	
1.21	QVH Health records policy	2012	QNET	Update
1.22	QVH support for staff experiencing DVA policy/guidance			To be developed during 2016 HR with safeguarding team
1.23	QVH JD and person specification template	2016	QNET	
1.24	QVH Restrictive Physical Interventions and Therapeutic Holding Policy	2016	Waiting to be added to QNET	Child section expanded and EQIA completed
1.25	QVH Abduction or suspected Abduction of an Infant/Child Policy	2016	QNET	Finalised May 2016

QVH SAFEGUARDING CHILDREN AND YOUNG PEOPLE

2	**Item**	**Date**	**Location**	**Actions**
2.1	QVH Child Protection and Safeguarding Policy and Procedures	2015	QNET	Review and update of Policy and SOPs underway, to be reviewed at Safeguarding Strategy group during 2016
2.2	QVH Paediatric Safeguarding Learning and Development strategy Plus appendix A level 3 development options	2016	QNET	Approved by Safeguarding Strategy group March 2016
2.3	QVH paediatric safeguarding steering group terms of reference	2015		To be reviewed and updated during 2016
2.4	QVH safeguarding children Trauma Proforma and child protection record	2014		Following audits in 2015. To be reviewed during 2016
2.5	QVH Safeguarding children newsletter	Quarterly	QNET	December March June September
2.6	QVH trainee doctor paediatric safeguarding guidance	Updated 2016	QNET	
2.7	QVH safeguarding children leaflet for all staff	2016 Draft	QNET	

2.8	QVH safeguarding children volunteers guidance	2016	QNET	Leaflet being produced to circulate to all volunteers
2.9	QVH Peanut missing children risk assessment	2016	Overseen by Paediatric Governance Group	
2.10	QVH children not brought to appointments risk assessment	2016	Overseen by Paediatric Governance Group	
2.11	QVH Potential abduction/disappearance of an infant/child risk assessment	2016	Overseen by Paediatric safeguarding steering Group	
2.12	QVH Paediatric safeguarding unsupported Access data base risk assessment	2016	Overseen by Paediatric safeguarding steering Group	
2.13	QVH NMC examples of revalidation forms- completion for safeguarding practice	2016	QNET	
2.14	QVH posters for patients • Information sharing • Do you need to tell us something	2016	QVH site	Circulate when approved Contact information coordinator
2.15	QVH leaflet for patients • Dog bites	2016 draft	WEBSITE	Circulate when approved Contact information coordinator
2.16	QVH leaflet for families • Safeguarding children and young people	2016 draft	WEBSITE	Circulate when approved Contact information coordinator
2.17	QVH safeguarding children staff guidance	2016	QNET	

QVH SAFEGUARDING ADULTS

3.	Item	Date	Location	Actions
3.1	QVH Safeguarding Adults Policy	2016		Awaiting ratification (to add to Q-Net)
3.2	QVH Safeguarding Adults	2016		To add to QNet

	Learning & Development Strategy			
3.3	QVH Adult safeguarding, MCA/DoLS Steering Group Terms of Reference	2016	Q-Net	
3.4	QVH *Prevent* Delivery Plan	2016	Q-Net	
3.5	QVH Safeguarding Adults Leaflet (For all staff including volunteers)	2016	Q-Net	
3.6	QVH Examples of Revalidation Forms	2016 (DRAFTED)	Q-NET	To be added to Qnet
3.7	QVH Mental Capacity Act 2005 Policy & Procedures	2015	Q-Net	
3.8	QVH Deprivation of Liberty Safeguards Policy	2015	Q-Net	
3.9	QVH uptake of adult safeguarding level 2 training risk assessment	2016	Overseen by Adult safeguarding, MCA/DoLS Steering Group	

Queen Victoria Hospital NHS
NHS Foundation Trust

TITLE: Safeguarding Strategic Group

2016-17 work plan for group based on Safeguarding Strategy Objectives, which contribute to achieving key strategic objectives of the trust:
Outstanding patient care

- World class clinical services
- Operational excellence
- Financial stability
- Organizational excellence

Strategic Objective	QVH initial assessment	Rating (RAG)	Action Required	Timescale	Implement-ation Lead	Progress/ comments
1. To provide senior and Board leadership	QVH require: • Lead Board Director • Nominated Non-Executive Board Director • Paediatric Safeguarding Named Nurse • Paediatric Safeguarding Named Doctor • Adult Safeguarding Named Nurse • MCA & DOLs lead • Prevent lead	Green	Review allocated specialist resources in coming year	Ongoing	Director of Nursing & Quality	Safeguarding team in place No vacant posts Departmental risks in place KPIs to Board Annual report to Board
2. Senior leadership responsibility and lines of accountability for safeguarding arrangements are clearly outlined to employees and members of QVH,	QVH require: • Safeguarding Accountability and communication document on Website • Safeguarding Strategy on website • Safeguarding QNET page	Green	Sustain systems Annual review and update training	Ongoing	Director of Nursing a & Quality with Named	Website and QNET update 2016 Quality assurance processes in place Policy review and updates Training uptake data and evaluations scrutinized

	as well as to external partners.	• Safeguarding Policy, standards, protocols, guidance • Information for staff • Information for patients • Safeguarding training strategy and program in place		program Use Evolve/EDM safeguarding section as new system rolled out		professionals	monthly
3.	QVH contribute to the work of West Sussex LSCB and SAB and their strategic Business Plans and priorities, and provide support to ensure that the Boards meet their statutory responsibilities.	QVH require; • Regular representation at LSCB • Regular representation at SAB • Completion of Section 11 self-audit • Monthly reports to CQC • Bi-monthly reports to LSCB and SAB • Quarterly reports to CCGs • Quarterly reports to NHS England – *prevent* coordinator	Green	Overlap between reporting requirements – manage and sustain effectively Regular representation at LSCB and SAB Regular updates from NHS England – optional teleconferences		Director of Nursing a & Quality with Named professionals	Safeguarding Children Section 11 self-assessment updated March 2016
4.	QVH support their safeguarding leads to contribute to and influence the work of the LSCB and SAB subgroups and other national and local safeguarding implementation networks.	QVH require; • Named professionals involvement in specific subgroups • Supervision from designated professionals for named professionals • Attendance at West Sussex networks • Attendance at Regional Networks	Green	Paed SG Named Nurse to join Improving Practice group		Director of Nursing a & Quality with Named professionals	Supervision in place

DELIVERING THE STRATEGY

Ensure all aspects of safeguarding work and practice are considered and incorporated into all QVH services.
Service developments take account of the need to safeguard all patients and are informed by service users and quality impact assessments.
Processes in place to disseminate, monitor and evaluate outcomes of all case review recommendations and actions.
Ensure there are effective arrangements in place to share information when required.
Safeguarding training and systems compliance will be monitored by safeguarding leads.
QVH will demonstrate it is meeting its statutory requirements via annual reporting and an audit programme.

KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Committee: Quality & Governance
Date last reviewed: 21st June 2016

Strategic Objective
We provide world class services evidenced by clinical and patient outcomes. Our clinical services are underpinned by our high standards of governance, education innovation.

Current Risk Rating **3 x 5 = RED**
Residual Risk Rating 2 x 5 = GREEN

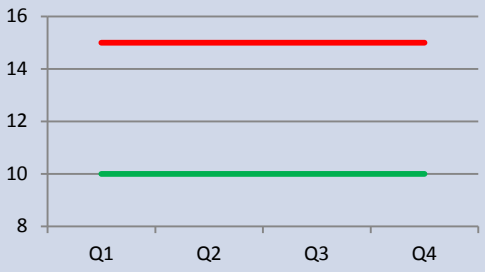
Rationale for current score
QVH governance: Sustainability of ITU, defining and meeting standards for OOH care and deliver on CQC action plan
Dental middle grades
Loss of LETB posts
Internal governance resource
Lack of NIHR engagement/research investment

HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY
National Standards:
ITU Burns Paediatrics NICE etc
Deanery training posts
NIHR
Seven day services
Medical contract negotiations
CQC action plan

COMPETITION
Positive:
Horder. BMRF collaboration
Private patients
Negative:
Spoke repatriation
Consultants electing part time/ retiring early/forming LLPs

Risk
Patients, clinicians & commissioners lose confidence in our services due to decline in or inability to obtain external assurance or publish clinical outcomes, a reduction in research output and fall in teaching standards. Quality of care may suffer by failure to deliver clinical governance standards.



INNOVATION
Efficient job planning
Efficient theatre/OPD use
Optimum OOH care
Education and simulation training
Innovation, alliance BMRF and universities
Outcomes publication
Human factors training

RESILIANCE
Loyalty and engagement of workforce
Shared burns care, other networks
Appointment of CDs and governance leads
Demand strong
CEA incentives
Management support for operational initiatives
Single points of failure with specialist staff
Response to clinical demand

Controls and assurances:
Clinical governance group and leads
Revising clinical indicators
NICE reconciliation and implamentation
CQC action plan; ITU actions include ODN/ICS
Spoke visits service specification EKBI data management
CDs and consultant staff aware of risks OOH and management

Gaps in controls and assurances:
Limited extent of reporting /evidence on internal and external standards – CRR - 845, 728 (DRR – 791, 548)
Limited data from spokes/lack of service specifications – CRR - 799, 728
Scope delivering and monitoring seven day services (OOH) – CRR - 844, 727, 918
Plan for sustainable ITU on QVH site-CRR 904, 844

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/07/2016**		**Agenda reference:**	**123-16**	
Report title:	**Medical director's report**				
Sponsor:	Steve Fenlon, Medical director				
Author:	Steve Fenlon, Medical director				
Appendices:	NA				
Executive summary					
Purpose:	For information				
Recommendation:	The board is recommended to note the contents of this report				
Purpose:	Approval	**Information**	**Discussion**	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1:	**KSO2:**	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	**World-class clinical services**	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	Yes				
Corporate risk register:	No				
Regulation:	No				
Legal:	No				
Resources:	No				
Assurance route					
Previously considered by:	N/A for Board of Directors only				
	Date:		Decision:		

Board of Directors July 2016: Medical director's update

Quality and Compliance

Engagement events with the local STP continue and workforce is a separate stream of this work. HEKSS are considering future workforce developments to meet the aims of the Five Year Forward View, themes include reducing the number of highly specialised roles in nursing and medicine to enable a more generic flexible workforce to work across roles within providers and even across providers in the STP. A key theme to address performance in acute care seeks to prevent patients attending A&E for primary care needs by diversion into other primary care providers such as community pharmacists. In addition, more acute care could be provided in the home or community by extended paramedic training and greater use of allied health professionals to support care packages. None of these ideas is new, but it is hoped the STP will help to drive them; most importantly describe how these new roles evolve the necessary responsibility and support network to make decisions about patient's treatment.

Research and Education

The trust hosted its annual research day on 27th June with guest speakers from Oxford and Tokyo, together with several research presentations representing QVH, BMRF and UOB on a host of research topics linked to tissue healing and translating laboratory research into clinical practice. There was excellent multi-disciplinary attendance at the event

The project to describe and create a research hub on the QVH site uniting all the interested parties is currently underway and managed by an external company with experience of similar ventures. The QVH charitable funds are providing essential support to this work.

Medical and dental staffing: The consultant workforce

The process for appointing a Medical Director from the QVH medical staff has begun and the interviews are likely to be end of July. Representation from the board will include the Chief Executive, Director of Nursing, a Non-executive director and the Trust Chair. There has been a good response from the consultant workforce following advertisement on 27th June.

Job planning with the revised policy from May 2016 has started for all consultants and aims to more closely link the service need to team job planning. It is possible further changes will be needed to the process following the next contract announcement, but work continues meantime.

Job plan revisions for consultant anaesthetists are completed as part of the out of hours urgent care improvement and will come into place in August. This is one of the key actions from the CQC action plan, and a current risk on the corporate risk register. In addition to achieving better compliance, it is expected this change which converts 'on-call' time to 'on-site' time will improve the effectiveness of the out of hours service for patients and the quality of training for junior doctors.

The debate over seven day services continues at national level, few disagree with the motives and need for improving out of hours urgent care, most question the ability to deliver with existing resources in light of the far-reaching need for change right through the pathway into community services. A key driver is to maintain continuity of patient discharge back in to the

community to enable acute providers to meet their targets around safety and performance, in particular for A&E.

Doctors in training contract

The BMA are currently balloting their members (closing date 1st July) on the revised contract for junior doctors and if agreed implementation is likely end of this year. The contract will include the principle of the European Working Time Directive, though most doctors are opted out of the 48 hour week. QVH will undergo the formal appointment of an independent guardian to oversee implementation compliance with the contract, breaches are managed by a system of enhanced rates of pay to the individual doctor, fines and a review of rotas. The independent guardian reports to the GMC/GDC the Local Education training board, Health Education England (NHS), the CQC, and the organisation's board of directors. It is not clear who of these has primary control, though trainee doctors still have recourse to their union if they disagree with the Guardian's management.

Consultant contract

No further details of negotiations at time of writing.

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Committee – Finance & Performance Committee
Date last reviewed - 20th June 2016

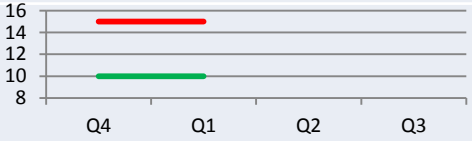
Strategic Objective
We provide streamlined services that ensure our patients are offered choice and are treated in a timely manner.

Risk
Patients & Commissioners lose confidence in our ability to provide timely and effective treatment due to an increase in waiting times and a fall in productivity.

Current Risk Rating 3 x 5 = RED
Residual Risk Rating 2 x 5 = GREEN

Rationale for current score

- Impact of new rules and no longer can use pauses on the admitted pathway will impact upon our performance particularly due to our small denominator;
- Theatre utilisation/productivity;
- Case mix;
- Coding;
- Design & deliver key IT projects;
- Knowledge management/information/benchmarking



HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY

- National Policy changes to access targets e.g. Cancer & complexity of pathways, QVH is reliant on other trusts timely referrals onto the pathway;
- NHS Tariff changes & volatility;

COMPETITION

Negative

- Spoke sites begin to repatriate routine elective work & so loss of activity & associated income;

Positive

- Neighbouring trusts requiring additional elective capacity;

INNOVATION

- Spoke sites offer the opportunity for further partnerships

RESILIANCE

- Reputation as a centre of excellence – can capitalise on our brand & market position.

Controls / Assurance

- Regular access meeting reviews and forward plans activity/booking- includes Cancer;
- National Cancer Breach Allocation Guidance has changed and has a fairer allocation of the breach for shared breaches where a referral is later than day 38;
- Patient Access Manager – new role and joined the Trust on Sept 21st;
- Monthly business unit performance review meetings in place with a focus on exceptions, actions and forward planning;
- Finance and Performance Committee in place;
- PTL accessible by all relevant managers;
- Performance Dashboard in place;
- Business Planning meetings and cycle put in place from Sept 15 for 16/17

Gaps in controls / Assurance

- Not all spoke sites on QVH PAS so access to timely information can be limited; - 728 , 799
- Shared pathways for cancer cases with late referrals from other trusts; - DRR
- Demand and capacity modelling with benchmarking requires further development for each speciality; - DRR
- Late referrals for 18RTT from neighbouring trusts, two of which are in special measures and others with severe pressures; - DRR
- Productivity information and programme required for theatres;

KSO 4 – Financial Sustainability

Risk Owner: Director of Finance & Performance
Committee: Finance & Performance
Date last reviewed: 20th June 2016

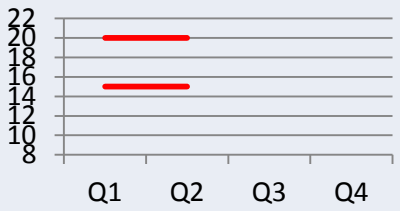
Strategic Objective
We maximize existing resources to offer cost-effective and efficient care whilst looking for opportunities to grow and develop our services

Risk
Loss of confidence in the long-term financial sustainability of the Trust due to a failure to create adequate surpluses to fund operational and strategic investments

Current Risk Rating 4 x 5 = RED
Residual Risk Rating 3 x 5 = RED

Rationale for current score (at Month 2)
- Surplus - (1.2%)
- CIP slippage - (21%)
- Capital Plan slippage – (23%)
- Sustainability Risk Rating - 4

Rationale for forecast
- Sustainability Risk Rating (4)



HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY
- NHS Sector financial landscape
  - Regulatory Intervention
  - Autonomy
- Tariff - Consultation ongoing
- Commissioning intentions
- New NHS contract
- Revised Monitor risk rating methodology
- 5YFV & Sustainability and transformation plans

COMPETITION
- Spoke-site activity repatriation
- New entrants into existing market
- Ability to capture new activity streams
- Strategic alliances \ franchise, chains and networks

INNOVATION
- New workforce models and strategic partnerships designed to address resilience issues internally and support the wider health economy
- Using IT as platform to support innovative solutions and new ways of working

RESILIENCE
- Small teams that lack capacity, agility , technical and back-up support.
- Systems and processes that cannot support real-time decision making.
- Aging, deteriorating estate
- Limited resources to invest
- Impact of industrial action

Controls / Assurances
- Performance Management regime in place
- Standing Financial Instructions
- Contract monitoring process
- Performance reports to the Trust Board
- Finance & Performance Committee in place Q2 FY16
- Audit Committee and reports - internal control 2015/16
- Internal Audit Plan including main financial systems and budgetary control.

Gaps in controls / assurances
- Development and delivery of a quality led sustainable CIP incorporating identification, implementation, monitoring, quality impact and governance arrangements. Focus in theatres productivity. **CRR 877**
- Budget Setting and Business Planning Processes (including capital programme) incorporating risk identification and mitigation. **CRR 877 (DRR 879)**
- Structure, systems and process redesign and enhanced cost control. **(DRR 880)**
- Income/ activity – retention, capture and coding **CRR 879, 882**
- Monitoring and delivery of Capital Programme
- Capital investment in relation to backlog maintenance

Queen Victoria Hospital NHS
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Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**7 July 2016**		**Agenda reference:**	**125-16**	
Report title:	**Finance and Performance (F&P) Committee: assurance report**				
Sponsor:	John Thornton, Non-Executive Director and Chairperson of the F&P Committee				
Author:	John Thornton, Non-Executive Director and Chairperson of the F&P Committee				
Executive summary					
Purpose:	Assurance				
Recommendation:	The board is asked to note the contents of this report				
Purpose:		Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):			KSO3:	KSO4:	KSO5:
			Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	The trust has continued to achieve a Monitor financial sustainability risk rating (FSRR) of 4.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Not applicable.				

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 7 July 2016
Reference no: 125-16
Report from: John Thornton, committee chair
Report date: 21 June 2016

Finance and performance assurance report

NHS Improvement Control Total update

Following the Board's decision not to accept its original control total, NHSI has now proposed a reduced total. A response on whether to accept or reject this figure had to be sent to NHSI by 21 June.

It was therefore agreed that the full Board should be invited to F&P to discuss and make a decision on this proposal. The QVH Chair led a discussion on the issues and a decision was made to accept the proposal with a number of caveats.

A more detailed minute of the discussion and decision will be provided separately.

Due to this important discussion the normal F&P meeting was curtailed and focussed on key performance issues as a background to the control total debate.

1. Operational performance

It was accepted that overall performance against KPI's is under control and monitoring systems are improving.

Discussion took place on areas of current concern in diagnostics and the ongoing issues with Medway particularly around the MaxFax service provided at Medway maritime. Committee was assured that the team were doing all they could to steadily improve this situation.

There is an ongoing issue with our ability to meet some cancer wait time standards. It was accepted that the team are carefully monitoring the situation but that due to the small numbers involved and the reasons for breaches, it will be a constant battle for QVH to meet these standards.

2. HR performance

In the absence of an HR representative the content of the report was noted. It was recognised that the changes requested at the last meeting had been made.

The Chair commented that Statutory and |mandatory training numbers continued to decline

3. Financial performance

Patient activity income was below plan for the month and as a result the surplus achieved was also below plan. After two months the surplus is only 50% of budget and the underlying trading position is weaker if nonrecurring items are excluded.

Following discussion it was accepted that we shouldn't overreact to one month’s numbers and there could still be a number of adjustments. But it was also accepted that the trust needed to start to identify additional interventions now to address any shortfall.

4. IT Infrastructure Improvement Programme

Programme is almost complete and there are no major issues. A closing paper will be come to July F&P.

The team under Clare's leadership were again thanked for the huge effort that has gone into this project and commended on the quality of the outcome.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	20/06/16		**Agenda reference:**	126-16	
Report title:	**Operational Performance**				
Sponsor:	Director of Operations – Sharon Jones				
Author:	Business Managers				
Appendices:	1. Operational Performance report				
Executive summary					
Purpose:	To offer assurance as to current operational performance				
Recommendation:	To note the report				
Purpose:	Approval	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: x	KSO2: x	KSO3: x	KSO4: x	KSO5: x
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	To give assurance and confidence the controls are adequate				
Corporate risk register:	To give assurance and confidence that risks are mitigated				
Regulation:	Links to the Monitor Risk Rating				
Legal:	N/A				
Resources:	N/A				
Assurance route					
Previously considered by:	N/A				
	Date:	dd/mm/yy	Decision:		

Report to: Board of Directors
Meeting date: 20 June 2016
Reference number: 126-16
Report from: Sharon Jones, Director of Operations
Author: Business Managers
Report date: 13 June 2016

Operational Performance: Targets, Delivery and Key Performance Indicators

Key Messages

Key Performance Indicators

1. Diagnostic Waits

In May the trust achieved 98.74% trust wide against the target of 99% of patients having their diagnostics completed within 6 weeks of referral. Therefore, the trust failed the target by 0.26%.

Two breaches occurred in radiology due a delay in availability of specialist Sialography. This has now been resolved.

There are also capacity problems within the sleep study diagnostic tests for those who require a full set of sleep diagnostics. Six breaches occurred in May. This is due to unforeseen staffing issues due to long term sickness compounding maternity leave vacancies. Sleep technicians are a hard to source group via an agency and there have also been some framework issues that the trust has now resolved. Two staff members are now available to provide cover, however, they are junior and less experienced than those who are absent and are undergoing the required training to ensure they are fully competent. However, this means they can only manage one patient a day at present rather than two. It is anticipated that the sleep issue will remain during June and so pressure will remain on this target for June.

2. Monitor 18 RTT Open Pathway Target

The Trust achieved 92.05% against the 92% target for April; and is currently reporting 92.46% for May with final submission date after validation 17 June.

The target is an aggregate target, however we are working to ensure that all specialities move towards achieving the open pathway target to minimise fines. This is via a mix of validation and streamlining pathways;

April breakdown of open pathways:

RTT Speciality	Over 18 Weeks	Under 18 Weeks	Total No of Pathways	Performance
Corneo	37	1314	1351	97.26%
Maxillofacial	363	3138	3501	89.63%
Plastics	245	2471	2716	90.98%
Cardiology	2	58	60	96.67%
Rheumatology		41	41	100.00%
Other - Sleep Sciences	13	616	629	97.93%
QVH	**660**	**7638**	**8298**	**92.05%**

May (position on 13.06.16):

RTT Speciality	Over 18 Weeks	Under 18 Weeks	Total	Performance
Corneo	32	1484	1516	97.89%
Maxillofacial	374	3160	3534	89.42%
Plastics	231	2543	2774	91.67%
Cardiology	6	72	78	92.31%
Rheumatology		50	50	100.00%
Other - Sleep Sciences	7	663	670	98.96%
QVH	**650**	**7972**	**8622**	92.46%

3. Elective day cases

Year to date the weekly average of elective day cases has been 188; in May activity was 203; 230; 242; and 198 respectively.

4. Elective/In-patient activity

Year to date the weekly average of elective in-patients has been 75; in May this was 65; 71; 102; and 60 respectively.

5. Medway PTL:

QVH provides maxillofacial (Max Fax) services at Medway Maritime Hospital. The service model is that this is our activity undertaken by our surgeons. All other clinical staff including anaesthetists, nursing staff, access to all diagnostics and information systems are provided by Medway. The admin staff are QVH employed. This is a longstanding arrangement held via a service level agreement.

The QVH service based at Medway uses their PAS system which is not visible at QVH. The QVH admin staff based at Medway do not have access to a patient tracking list (PTL). This means that the QVH based Access & Performance team also do not have any oversight of the waiting lists at Medway. Medway have not been able to report on 18RTT for a considerable period of time and as QVH uses their systems, this has applied to QVH. Due to this a backlog has built up of 18RTT patients, which appear to be predominately in speciality code 140 (oral surgery):-

Current backlog figures

- A request was made to Medway for all patients on the speciality code 140 (oral surgery) to be sent to QVH;
- When this arrived, it showed significant data quality issues, with duplicate entries, patients on 2WW and patients who had already been treated. The QVH access team validated this data file;
- A subsequent file was requested but this showed even more data quality issues, with clock start dates ranging back a hundred years;
- The QVH performance and access manager has visited to Medway on 13 June and spent time with the Medway informatics team, reviewing their patient lists and explaining what we require. A new data file will be sent to us but we still expect some data issues to be present;
- This is a longstanding issue to resolve and will take a significant amount of work and capacity from the operations team to resolve.

Addressing the Max Fax backlog:

- Current referrals will be dealt with by the team at Medway;
- The backlog of referrals prior to 31 March 2016 will be dealt with separately by providing additional capacity where possible. Whilst planning work is underway, this will not be finalised until there is more confidence in the data.

6. Cancelled operations

- There were 8 non-urgent operations cancelled on the day in May – 4 elective operations; 2 hand trauma; and 2 trauma patients.
- 3 of these cancellations were due to time issues; 3 due to other emergencies; and 2 due to equipment.
- There was one 28 day breach after the non-urgent cancellations in May within maxillofacial – a root cause analysis will be completed into how this breach occurred;
- There was one urgent cancellation on the day in May and this patient was operated on the next day.

7. Monitor cancer standards

Below is the trust's performance for April 2016:

Month	Target	Standard	Total	Breaches	Performance
April	2WW GP referral to first seen (urg. susp. cancer)	93%	174	29	83.3%
April	62day GP referral to first treatment	85%	17.5	3	82.9%
April	62day Consultant upgrade to first treatment	85% (local)	0	0	
April	31day Decision to first treatment	96%	56	3	94.6%
April	31day Decision to subsq treatment (surgery)	94%	32	1	96.9%

8. Decision to First Treatment breach analysis for April 2016:

- There were 29 breaches of the 2 week wait target in April – a full analysis is being completed of these patients to ascertain exactly how this occurred;
- The majority of breaches are within maxillofacial and it appears that these breaches were not escalated up via the management structure. This is being investigated

Reporting Month	Tumour Type	Wait Days	Breach reason
Apr-16	Head & Neck	15	Patient not contactable to offer OPA within target.
	Head & Neck	15	Patient accepted appointment outside of 14-day target.
	Head & Neck	15	OPA booked outside of 14-day target as no earlier appointments available.
	Head & Neck	15	Consultant not available to run clinic, patient given next earliest available appointment.
	Head & Neck	15	No appointment slot available at Queen Victoria or Medway Hospital therefore appointment booked at Darrent Valley Hospital at the earliest available.
	Head & Neck	15	Patient declined offered OPA at Queen Victoria Hospital and requested appointment at off-site clinic at Medway Hospital.

Reporting Month	Tumour Type	Wait Days	Breach reason
	Head & Neck	16	Consultant not available to run clinic, patient given next earliest available appointment.
	Head & Neck	16	Consultant not available to run clinic, patient given next earliest available appointment.
	Head & Neck	16	Consultant not available to run clinic, patient given next earliest available appointment.
	Head & Neck	17	OPA offered day 4 of the 14 day pathway but cancelled by Hospital. Patient not seen within target.
	Head & Neck	19	No appointment slot available at Queen Victoria or Medway Hospital therefore appointment booked at Darrent Valley Hospital at the earliest available.
	Head & Neck	19	Patient offered appointment within target but declined.
	Head & Neck	20	No capacity for patient to be seen within target
	Head & Neck	20	No appointment slot available at Queen Victoria or Medway Hospital therefore appointment booked at Darrent Valley Hospital at the earliest available.
	Head & Neck	20	No appointment slot available at Queen Victoria or Medway Hospital therefore appointment booked at Darrent Valley Hospital at the earliest available.
	Head & Neck	21	No appointment slot available at Queen Victoria or Medway Hospital therefore appointment booked at Darrent Valley Hospital at the earliest available.
	Head & Neck	21	Patient cancelled OPA and rebooked outside of the 14-day target.
	Head & Neck	22	Patient requested appointment at off-site clinic which caused a delay in being reviewed within target.
	Head & Neck	22	Patient offered OPA at Queen Victoria Hospital within target as there was no capacity at Darrent Valley Hospital but patient declined.
	Head & Neck	22	Patient on holiday from 10.04.16 to 21.04.16 = 9 days of the 14-day pathway. Patient could be seen before breach.
	Head & Neck	23	Consultant not available to run clinic, patient given next earliest available appointment. Accepted appointment cancelled by patient. Patient accepted OPA outside of 14-day target
	Head & Neck	23	OPA offered after target date due to capacity issue.
	Head & Neck	24	Patient to be seen at Maidstone off site clinic due to capacity.
	Head & Neck	26	No appointment slot available at Queen Victoria Hospital - appointment booked at Darrent Valley Hospital at the earliest available.
	Head & Neck	26	Outpatients' capacity inadequate.
	Head & Neck	35	Patient offered 24.03.16 but declined. Accepted OPA outside of breach which was then cancelled due to registrar being called to ward. A further OPA date was then offered at an off-site clinic which was declined for a later date.
	Skin	15	Patient not seen within target.
	Skin	19	Patient declined opportunity to be seen within target - appointment offered day 6 of the pathway. Patient also away for 5 days that fall within the 14-day target.
	Skin	31	Patient cancelled OPA and rebooked outside of the 14-day target.

9. 62 day Referral to First Treatment breach analysis for April 2016:

Reporting Month	Tumour Type	First seen Trust	Treating Trust	Wait Days	Breach reason	Accountability
April-16	Skin	Queen Victoria NHS Foundation Trust	Queen Victoria NHS Foundation Trust	66	Patient consented to treatment but required a Mental Capacity Assessment due to cognitive impairment. Patient also required GA admission due to mobility issues.	1
	Head & Neck	Queen Victoria NHS Foundation Trust	Queen Victoria NHS Foundation Trust	69	Patient required thinking time which took 9 days of the cancer pathway causing a breach.	1

	Head & Neck	Queen Victoria NHS Foundation Trust	Maidstone & Tunbridge Wells NHS Trust	84	Standard treatment would have been surgery but patient assessed as unsuitable due to comorbidities	0.5
	Haematological	Queen Victoria NHS Foundation Trust	Maidstone & Tunbridge Wells NHS Trust	91	Patient initially referred under Head and Neck but diagnosed with lymphoma. Multiple investigations required and slides sent for 2nd opinion prior to definitive treatment plan being agreed with the patient.	0.5

10. 31 day Decision to First Treatment (surgery) breach analysis

Reporting Month	Tumour Type	Wait Days	Breach reason
Apr-16	Skin	43	Specialist requirements - patient has a pacemaker and required anaesthetist input for procedure.
	Skin	38	Patient surgery not scheduled within target
	Skin	36	DTT not agreed within target

11. Actions within Cancer

- A review of how 2 week wait patients are currently tracked has been undertaken and the team will develop a specific separate 2 week wait PTL that is issued daily initially – so all referrals can be closely monitored to prevent further breaches;
- The specific issues in Max Fax are being investigated;
- There is a standard operating procedure in relation to not booking past breach dates – this will be re-circulated to all teams.
- Liaison with management teams off-site to improve processes for joint pathways;
- Contacting individual trusts when an immediate breach has occurred due to unavailability of visiting consultant or any other reason, raising our concern and asking them to review systems;
- Liaise with health records manager regarding the cancer administration team having full access to all oncology referrals.

12. Activity plan and business unit specific operational and performance issues

- Business unit specific updates are given below;
- A business manager of the day process is working well, with the business manager being a clear point of escalation for any issues.

13. Oral Surgery business unit

- Activity in May was marginally below that in April across the business unit however the income in May is 3% (£30,000) better than the previous month. This is driven in the main by increased day case activity (up 50 units of activity) and a richer case mix in non-elective activity.
- Reductions in activity and income was seen the outpatient procedures both in orthodontics and oral maxillofacial surgery. This was partly due to leave being undertaken over the two May bank holidays to which staff took additional leave.
- The head and neck oncology activity from Brighton and Sussex University Hospitals has started to flow albeit a little slowly and a follow-up meeting has been held to refine the

processes for booking the theatre lists for Mr Sim Lew-Gor – ENT Head and Neck Consultant (BSUH).

14. Plastics business unit

- The focus for the business unit continues to be on reducing the backlog of patients with long waits and achievement can be seen by a higher percentage of patients being seen and treated within 18 weeks – improved achievement against the open pathway target of 92% in May;
- An in-depth review of referrals into the hand service is under way as referrals have dropped across the past two years but there was also a significant step-change downwards in August 2015 which has not recovered to date – the analysis will establish if any particular geographical area has seen a decrease in referrals to this service;
- The business unit continues to undertake some "see and do" clinics with consultants in skin to ensure an efficient pathway for patients;
- A first meeting of a project group to manage the dermatology tender for West Kent is planned for early July.

15. Second trauma theatre

- The second trauma theatre opened in October 2015;
- Activity within trauma, since opening of second trauma theatre, continues to be monitored on a very regular basis;
- Inductions after 10pm were 3 cases in October; 7 in November; 4 in December; 7 in January 2016; 4 in February; 6 in March; 2 in April and 9 in May;
- In April 2014, 345 trauma patients were operated on; in April 2015 there were 329 trauma patients were operated on but in April 2016 only 292 trauma patients were operated on;
- In May 2014, 329 trauma patients were operated on; in May 2015 there were 351 patients and in May 2016 this has increased to 368 patients operated on.

16. Eyes

- The business unit has continued to work with some constraints in March but have increased their output against plan this month;
- The Centre for Sight work has now moved back to East Grinstead, this continues to give limitations with our capacity but is closer for our surgeons to travel to, enabling us to increase the number of patients we can treat in the allocated time;
- The patients that require treatment at Centre for Sight do not presently get treated within 18 weeks due to lack of lists at this venue and volume of patients. The eye business unit achieves its 18 week pathway overall. Work is being undertaken to see whether some of this work could be repatriated to the QVH site;
- The first list in the day treatment centre (DTC) took place on 4 April. There are some restraints with regard to workforce over the summer period as the service currently as 3 clinical fellows instead of 5. We were unsuccessful in two recruitment rounds as there were no suitable candidates. The unit is working on mitigation plans to support the services until we return to our full complement in September.
- The number of cataract referrals has decreased significantly since January/February. The business unit continues to work on plans to close the gap by analysing why we have had the

decline in referrals. A number of meetings with CCG and chief operating officers from BSUH, SASH, and ESHT took place on 9 June to assess the opportunity of undertaking long waiting cataracts for other trusts.

17. Sleep services

- The data for March shows that the service is in line with the activity plan and is ahead of plan for day cases and outpatients;
- However, there have had some further cancellations in overnight patients due to IT issues. This has meant cancellation on the night when the patients are here. The sleep department are working with IT and an external company to resolve this;
- The sleep department remain challenged with staffing levels. A senior member of staff is off sick which reduces the ability to treat some of the complex patients. A technician who accepted a band 6 post has now rescinded their acceptance. The sleep department are interviewing next week for this post;
- Mitigation plans are in progress. The service has a positive history of successful remedial plans for unforeseen issues and the team are confident we can continue to deliver the agreed plan for next financial year.

18. Clinical Support services

- AQP Community Urology is functioning well with all outpatient procedures now migrated from theatres to outpatients. There remains some issues with GP awareness of this service and uptake, however further QVH communications and GP surgery visits are planned;
- The radiology department has now taken over the management of diagnostic imaging services in High Weald Lewes and Havens on behalf of Sussex Community Trust. The service continues to play an active role in improving the service with reduced waiting and reporting times. The next stage involves transfer of data to QVH information system (RIS) and development of a potential Peacehaven site.
- The recent increase in MSK physio waits has been reversed with locum staff and ongoing recruitment. It is currently under 6 weeks for non-urgent referrals and reducing.

19. MIU

The trust MIU performance in May was 99.25%.

20. Link to Key Strategic Objectives

- Outstanding patient experience
- Operational excellence
- Financial sustainability

21. Implications for BAF or Corporate Risk Register

Risks associated with this paper are already included within the corporate risk register.

22. Regulatory impacts

Currently the performance reported in this paper does not impact on our CQC authorisation or the current Monitor governance risk rating which remains as ‘Green’.

23. Recommendation

The committee is recommended to note the contents of the report.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	20 June 2016		**Agenda reference:**	127-16	
Report title:	**Finance Report M2 May 2016**				
Sponsor:	Clare Stafford, Director of Finance and Performance				
Author:	Jason McIntyre, Deputy Director of Finance				
Appendices:	Finance Report M2 May 2016				
Executive summary					
Purpose:	The report details the trust's financial performance for the 2 months to 31 May 2016. The trust delivered a surplus of £92k for the month; £133k lower than planned. The cumulative surplus is £123k which is £130k less than plan.				
Recommendation:	The committee is asked to note the contents of this report.				
Purpose:		Information		Assurance	
Link to key strategic objectives (KSOs):			KSO3:	KSO4:	
			Operational excellence	Financial sustainability	
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	The Trust has continued to achieve a Monitor financial sustainability risk rating (FSRR) of 4.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance and performance committee				
	Date:	20/06/16	Decision:	For information	

Queen Victoria Hospital NHS
NHS Foundation Trust

Finance Report
May 2016

Executive Director: Clare Stafford

Contents

Queen Victoria Hospital
NHS Foundation Trust

Summary Actual Position – YTD M02 2016/17

Queen Victoria Hospital NHS Foundation Trust

Table 1 - Monitor Plan Performance

Financial Performance	2016-17	May 16-17			Year to Date 2016-17		
Income and Expenditure	Annual Plan £k	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	Actual £k	Budget £k	Variance (Favourable/ (Adverse))
Patient Activity Income	62,122	5,283	5,368	(86)	10,235	10,392	(157)
Other Income	4,504	705	356	349	1,120	726	394
Pay	(42,565)	(3,596)	(3,556)	(40)	(7,093)	(7,100)	7
Non Pay	(19,107)	(1,945)	(1,588)	(357)	(3,428)	(3,052)	(376)
Operational EBITDA	**4,953**	**447**	**580**	**(133)**	**833**	**965**	**(132)**
as a %	*7.4%*	*7.5%*	*10.1%*	*-2.7%*	*7.3%*	*8.7%*	*-1.3%*
Financing	(4,275)	(356)	(356)	1	(711)	(713)	2
Current Year Surplus / (Deficit)	**678**	**92**	**224**	**(133)**	**123**	**253**	**(130)**
Surplus (Deficit) %	1.0%	1.5%	3.9%	-2.4%	1.1%	2.3%	**-1.2%**

Note: Financing costs consist mainly of depreciation, dividend and loan interest.

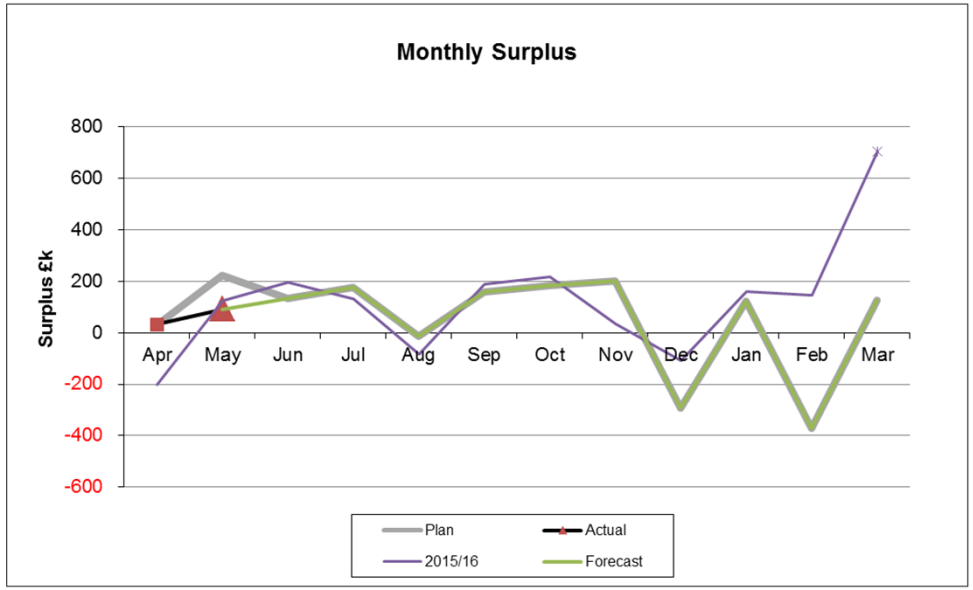
Summary

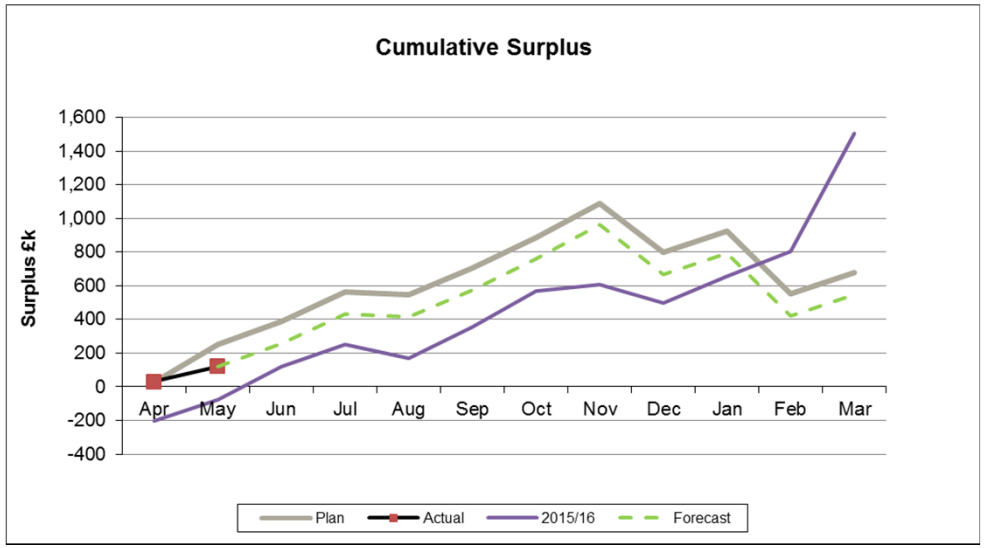
- The Trust delivered a surplus of £92k in month compared to £31k last month, increasing the YTD surplus to £123k, £130k below plan.
- Patient activity income was £86k lower than planned in month. The underlying position for the year to date is a deficit of £101k after adjustments for non recurrent items; 2015/16 coding gains and last months industrial action.
- Other income includes the release of £370k deferred income for the Electronic Document Management project (EDM) which offsets EDM expenditure.
- Pay expenditure is £40k overspent in the month of which £23k relates to EDM and £13k for RMN nursing pass-through expenditure which is offset by clinical income. The balance is due to agency premium and Cip slippage partially offset by vacancies.
- The non pay variance includes £314k of EDM with other overspends primarily on clinical supplies and equipment maintenance.
- The financial sustainability rating remains at 4.

Actions

- The Trust needs to develop and implement additional interventions to recover current underperformance to ensure delivery by the end of the year.

Surplus Trend Position – M02 2016/17





Summary

- The in month surplus is £92k against the Monitor plan of £224k.
- The monthly financial profile reflects the impact of working days, seasonal variation, bank and school holidays. In addition the M1 profile was amended to reflect the impact of planned industrial action.

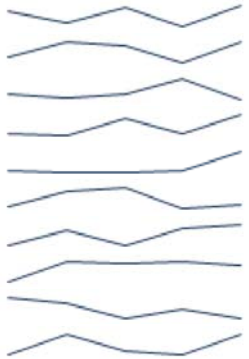
Activity Performance by POD : M02 2016/17

Queen Victoria Hospital NHS
NHS Foundation Trust

Table 1 - Month 2 comparison to previous year average by Point of Delivery (POD)

Activity Performance		Month 2 (May)		
POD	Currency	PY Average Acty	M02 Act Acty	Acty Var
Minor injuries	Attendances	979	920	(59)
Elective (Daycase)	Spells	984	1,023	39
Elective	Spells	313	302	(11)
Non Elective	Spells	414	445	31
XS bed days	Days	66	133	67
Critical Care	Days	69	44	(25)
Outpatients - First Attendance	Attendances	3,521	3,768	247
Outpatients - Follow up	Attendances	10,269	10,492	223
Outpatient - procedures	Attendances	2,166	1,512	(654)
Other	Other	2,628	2,930	302

Table 2 - M2 Point of Delivery (POD) trend analysis

Activity Performance		2015-16			2016-17		
POD	Currency	M10	M11	M12	M01	M02	Trend
Minor injuries	Attendances	889	820	905	799	920	
Elective (Daycase)	Spells	988	1026	1017	975	1023	
Elective	Spells	313	306	312	342	302	
Non Elective	Spells	378	367	427	379	445	
XS bed days	Days	75	72	68	75	133	
Critical Care	Days	34	92	106	25	44	
Outpatients - First Attendance	Attendances	3429	3670	3449	3698	3768	
Outpatients - Follow up	Attendances	10080	10601	10548	10596	10492	
Outpatient - procedures	Attendances	2218	1974	1476	1793	1512	
Other	Other	2643	2922	2692	2629	2930	

The tables above analyses patient activity levels by comparing in month activity to last year's average monthly performance and reports recent activity trend. The detailed SLAM plan by Point of Delivery (POD) and service line is currently being refined.

- There was an increase in minor injuries attendances in month – but this is still below £37k below the YTD plan principally due to a reduction in opening hours; reduced from 8am to 10pm to 8am to 7.30pm due to staffing issues. It is anticipated that normal opening hours will be resumed early July.
- Elective activity has decreased in may (40 spells) and is £20k less than plan YTD. This is concerning as the previous months activity reflected cancellation due to industrial action and is largely within Oral & maxillofacial and plastics
- Emergency activity has increased in month, however this is still below YTD plan by £101k which is offset partially by coding gains. On the basis of historical trends there is a gain from coding when activity is fully coded.
- Critical Care days have increased and there are 32 days that are being accrued for as work in progress which are not included in the above table.
- Total activity was higher in month but still behind the indicative plan.
- An adjustment has been included with clinical income to reflect estimated gain from coding, outpatient procedures and material work in progress i.e. critical care.

Financial Position by Business Unit – M02 2016/17

Queen Victoria Hospital NHS Foundation Trust

Variance by type: in £ks	Activity Income	Other Income	Pay	Non Pay	Position	Total Year To Date		
performance against financial plan	YTDV	YTDV	YTDV	YTDV	Annual Budget	Actual	Budget	Variance
Operations								
1.1 Plastics	(221)	3	(6)	(13)	24,769	3,906	4,143	(237)
1.2 Oral	(140)	(1)	9	22	6,940	1,041	1,152	(111)
1.3 Eyes	(3)	(5)	7	(22)	3,516	563	586	(23)
1.4 Sleep	40	(0)	(12)	11	1,946	366	326	40
1.5 Clinical Support	(55)	23	18	31	(1,749)	(274)	(291)	17
1.6 Other Med & Admin	(0)	-	29	1	(234)	(9)	(39)	30
Operations Total	**(380)**	**20**	**45**	**30**	**35,189**	**5,594**	**5,878**	**(284)**
Nursing & Clinical Infrastructure								
2.1 Clinical Infrastructure	(74)	(5)	39	(86)	(18,027)	(3,144)	(3,017)	(127)
2.5 Director Of Nursing	-	16	16	14	(1,245)	(161)	(207)	46
Nursing & Clinical Infrastructure	**(74)**	**11**	**55**	**(72)**	**(19,272)**	**(3,305)**	**(3,224)**	**(81)**
Corporate Departments								
3.1 Non Clinical Infrastructure	-	15	(2)	7	(4,587)	(751)	(772)	21
3.2 Commerce & Finance	2	0	(22)	30	(1,761)	(299)	(309)	10
3.4 Finance Other	295	362	(24)	(343)	(5,799)	(514)	(803)	289
4.1 Human Resources	-	(6)	(4)	(12)	(885)	(170)	(148)	(22)
5.4 Corporate	-	-	(40)	(8)	(1,695)	(332)	(284)	(49)
6.1 Research	-	(8)	(3)	17	(109)	(12)	(18)	6
6.2 Clinical Audit	-	-	2	(23)	(404)	(88)	(67)	(20)
Corporate Total	**297**	**364**	**(93)**	**(333)**	**(15,240)**	**(2,166)**	**(2,402)**	**235**
QVH Total	**(157)**	**394**	**7**	**(375)**	**678**	**123**	**253**	**(130)**

Summary

- Activity Income: There is material underperformance within Plastics and Oral service lines.
- Other Income: Clinical support is showing a positive variance from an increase in histology and radiology income. The £362k positive variance within finance is largely a result of income for the EDM project which is fully offsetting expenditure variances.
- Pay:
  - In general vacancies offset sickness and maternity cover.
  - Agency costs have increased in May within clinical and non clinical staffing groups. The YTD agency overspends and being offset by vacancies in other areas.
- Non Pay:
  - Clinical Infrastructure – Theatre overspends on clinical supplies/consumables.
  - Finance Other– This reflects the EDM spend on IT licence fees and maintenance etc.
  - Clinical Audit – Increased costs of medical equipment repairs and maintenance.

CIP - M02 2016/17

Queen Victoria Hospital NHS
NHS Foundation Trust

Table 1 - Performance by category £k	YTD CIP Plan	YTD Actual	YTD Variance
Revenue Generating schemes	147	102	(46)
Non pay - Drugs	24	18	(6)
Non pay - Other	34	29	(5)
Non pay - Supplies	31	31	-
Pay	127	107	(20)
Grand Total	**364**	**287**	**(77)**

Table 2 - Performance by area £k	YTD CIP Plan	YTD Actual	YTD Variance
Clinical Infrastructure & Nursing	107	97	(10)
Clinical Support	34	27	(7)
Corporate	75	55	(20)
Eye	49	6	(43)
Oral_Maxfax	6	10	3
Plastics	73	73	(0)
Sleep	20	20	-
Grand Total	**364**	**287**	**(77)**

CIP Programme

- The CIP target for the Trust is £3.1m There is currently £0.25 of unidentified savings.
- At M2 the Trust has achieved savings of £287k which represents 9% of total annual target. There is slippage of £77k YTD.
- Key driver for the under performance are :-
  - DTC cataract activity behind plan by £42k year to date. This is due to a reduction in patients referral and reduced waiting list.
  - Corporate agency savings are £20k less than planned.

Actions

- Business units need to identify further scheme to mitigate current underperformance.

Balance Sheet –M02 2016/17

Queen Victoria Hospital NHS
NHS Foundation Trust

Balance Sheet at: Month 2 2016/17	2015/16 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	43,837	43,524	43,649
Other Receivables	-	-	-
Sub Total Non-Current Assets	43,837	43,524	43,649
Current Assets			
Inventories	439	433	430
Trade and Other Receivables	5,315	6,194	7,593
Cash and Cash Equivalents	7,285	7,033	5,483
Current Liabilities	(7,311)	(7,523)	(7,560)
Sub Total Net Current Assets	5,728	6,137	5,946
Total Assets less Current Liabilities	49,564	49,661	49,595
Non-Current Liabilities			
Provisions for Liabilities and Charges	(572)	(606)	(572)
Non-Current Liabilities >1 Year	(7,378)	(7,378)	(7,378)
Total Assets Employed	**41,614**	**41,676**	**41,645**
Tax Payers Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	20,234	20,297	20,266
Revaluation Reserve	9,143	9,143	9,143
Total Tax Payers Equity	**41,614**	**41,676**	**41,645**

NB Analysis is subject to rounding differences

Summary

- Net current assets increased by £191k in Month 2.
- The cash balance has increased and trade receivables reduced as NHS England contract invoices have now been paid.
- The non-current liability of £7.4m is the loan from the Department of Health; with repayment of £0.8m of the principal due in year.

Issues

- Sufficient cash balances need to be generated by the Trust to provide liquidity, service the capital plan and to meet the requirements of Monitor's Financial Sustainability measures.

Actions

- Further details of actions taken to ensure robust cash management processes are outlined on the debtor and cash slides.

Capital – M02 2016/17

Capital Programme	2016/17 Plan £000s	YTD Plan £000s	YTD Spend £000s	YTD Variance £000s	Full Year Forecast £000s	Full Year Variance £000s
Estates projects						
Backlog maintenance	550		-		550	-
Education and Wellbeing Centre	250		-		250	-
Trauma Centre (Jubilee proposal)	140		-		140	-
Car parking - general	100		-		100	-
Other projects	646		2		646	-
Estates Total	**1,686**	**26**	**2**	**24**	**1,686**	-
Medical Equipment	**354**	**156**	**81**	**75**	**354**	-
IT Equipment & Software						
Infrastructure Improvement Programme (IIP)	400		336		400	-
Electronic Document Management (EDM)	600		6		600	-
Other projects	82		-		82	-
IT Total	**1,082**	**367**	**342**	**25**	**1,082**	-
Total capital spend	**3,122**	**549**	**425**	**124**	**3,122**	**-**

Summary

- The capital programme has been developed through the 2016/17 business planning process via the Capital Planning Group and with senior management and Board approval.
- The largest element of the Estates programme is backlog maintenance, the content of which will depend upon the outcome of the site-wide condition survey that is now under way. The Education and Wellbeing Centre is a joint project with external bodies and will commence in the second half of the year.
- No major medical equipment purchases are planned for 2016/17.
- Most of the 2016/17 IT programme consists of the remainder of the Infrastructure Improvement and Electronic Document Management projects which started in 2015/16. The infrastructure project will be completed in June 2016.
- Both the main IT projects are subject to a VAT review which is likely to result in substantial refunds. HMRC's decision is awaited.
- Capital YTD expenditure is £425k, 23% behind plan.
- The full year forecast is that the plan will be achieved.

Issues

- Achievement of the annual plan is largely dependent on the Estates programme, which is currently at the planning stage.
- The IT programme is progressing and delays are not expected.

Risks

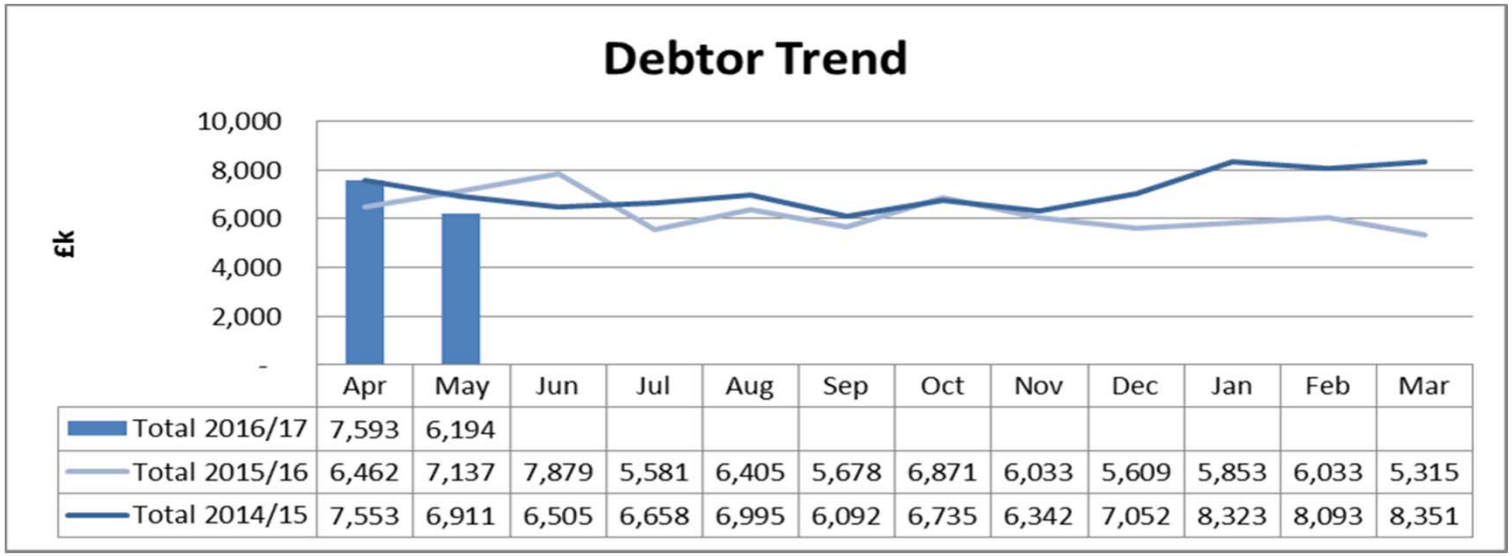
- Planning delays in the Estates programme could put the achievement of the plan at risk.

Actions

- Progress will be actively monitored by the Capital Planning Group.

Debtors – M2 2016/17

Queen Victoria Hospital
NHS Foundation Trust



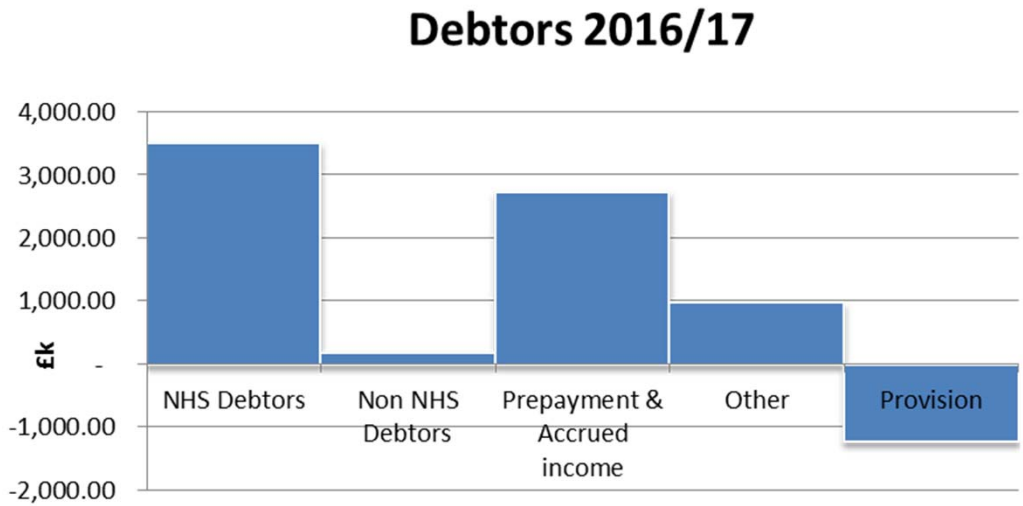
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total 2016/17	7,593	6,194										
Total 2015/16	6,462	7,137	7,879	5,581	6,405	5,678	6,871	6,033	5,609	5,853	6,033	5,315
Total 2014/15	7,553	6,911	6,505	6,658	6,995	6,092	6,735	6,342	7,052	8,323	8,093	8,351

Summary

- The debtor balance decreased by £1.4m (18%) from month 1.
- The month 2 debtor balance of £6.2m is on par with the average monthly balance in 2015-16. This is largely due to the recovery of large balances with commissioners outstanding at the prior month end.
- M2 there is £2.0m of accrued income for activity over-performance and NCAs which is an increase of £0.4m compared to the previous month.

Actions

- The financial services team are continuing to pilot a new interface to input invoices directly on to commissioners' ledgers, mitigating risk to cash and debtor balances from invoices lost in transit.



Cash – M2 2016/17

Queen Victoria Hospital NHS
NHS Foundation Trust

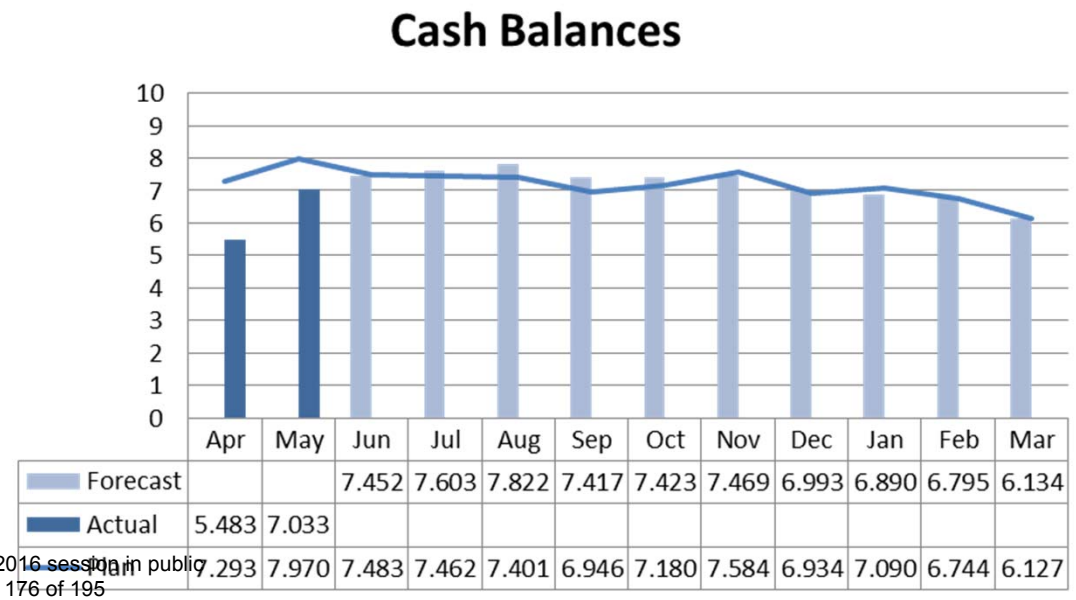
Cash Balance	Actual (£m)		Forecast (£m)									
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Opening Balance	7.285	5.483	7.033	7.452	7.603	7.822	7.417	7.423	7.469	6.993	6.890	6.795
Receipts from invoiced income	3.576	6.771	6.595	5.807	5.807	5.700	5.700	5.700	5.700	5.700	5.700	5.700
Receipts from non-invoiced income	0.172	0.209	0.100	0.100	0.100	0.100	0.100	0.100	0.100	0.100	0.100	0.100
Total Receipts	3.749	6.980	6.695	5.907	5.907	5.800	5.800	5.800	5.800	5.800	5.800	5.800
Payments to NHS Bodies	(0.640)	(0.427)	(0.500)	(0.500)	(0.500)	(0.500)	(0.500)	(0.500)	(0.500)	(0.500)	(0.500)	(0.500)
Payments to non-NHS bodies	(1.608)	(1.669)	(1.852)	(1.836)	(1.768)	(1.718)	(1.874)	(1.834)	(1.858)	(1.983)	(1.974)	(1.974)
Net payroll payment	(1.901)	(1.881)	(1.920)	(1.920)	(1.920)	(1.920)	(1.920)	(1.920)	(1.920)	(1.920)	(1.920)	(1.920)
PAYE & NI payment	(0.839)	(0.900)	(0.900)	(0.900)	(0.900)	(0.900)	(0.900)	(0.900)	(0.900)	(0.900)	(0.900)	(0.900)
Pensions Payment	(0.562)	(0.554)	(0.600)	(0.600)	(0.600)	(0.600)	(0.600)	(0.600)	(0.600)	(0.600)	(0.600)	(0.600)
PDC Dividends Paid	0.000	0.000	0.000	0.000	0.000	(0.567)	0.000	0.000	0.000	0.000	0.000	(0.567)
Commercial Loan Repayment	0.000	0.000	(0.504)	0.000	0.000	0.000	0.000	0.000	(0.498)	0.000	0.000	0.000
Total Payments	(5.550)	(5.431)	(6.276)	(5.756)	(5.688)	(6.205)	(5.794)	(5.754)	(6.276)	(5.903)	(5.894)	(6.461)
Actual Closing Balance	5.483	7.033										
Forecast Closing Balance			7.452	7.603	7.822	7.417	7.423	7.469	6.993	6.890	6.795	6.134

Summary

- The in month cash position is favourable on the basis of current liquidity and debt service ratios.
- The cash balance at the end of M2 has an adverse variance of £937k against plan, a 52% improvement on prior month. This is due to delays to payment of two invoices raised to NHS England which have been agreed to be paid and late payment of West Kent CCG's month 2 block invoice. These invoices will be paid in June, the forecast balance has been adjusted for this.

Actions

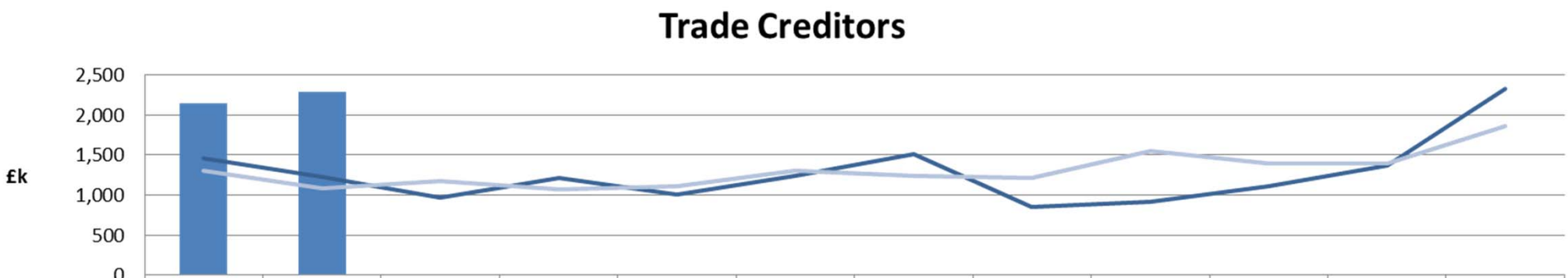
- The Trust will continue to review short term cash flow on a daily basis to manage liquidity and inform decision making.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Forecast			7.452	7.603	7.822	7.417	7.423	7.469	6.993	6.890	6.795	6.134
Actual	5.483	7.033										
Plan	7.293	7.970	7.483	7.462	7.401	6.946	7.180	7.584	6.934	7.090	6.744	6.127

Creditors – M2 2016/17

Queen Victoria Hospital NHS
NHS Foundation Trust



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	2144	2283										
2014/15	1460	1225	970	1219	1007	1242	1516	858	920	1113	1374	2332
2015/16	1302	1082	1173	1066	1111	1308	1236	1220	1551	1400	1399	1864

Summary

- Trade creditors at month 2 is £2.3m compared to an average of £1.3m during 2015-16. This is due to large value invoices arising from capital projects falling due in M3.
- The Trust's BPPC percentage has decreased in month by 1%, NHS invoice payments remain significantly behind target, due to late authorisation of invoices.
- The total volume of invoices paid has decreased in month by 2% (34 invoices), and decreased in value by £196k (8%).
- Savings from prompt payment discounts taken in month amounted to £1k, in line with plan.

Better Payment Practice Code (16/17) May	2015/16 Outturn # Invs	2015/16 Outturn £k	Current Month # Invs	Current Month £k	YTD # Invs	YTD £k
Total **Non-NHS** trade invoices paid	17,369	22,558	1,424	1,844	2,843	3,699
Total **Non NHS** trade invoices paid within target	14,769	19,071	1,136	1,412	2,308	3,086
Percentage of Non-NHS trade invoices paid within target	**85%**	**85%**	**80%**	**77%**	**81%**	**83%**
Total **NHS** trade invoices paid	893	4,538	63	296	165	777
Total **NHS** trade invoices paid within target	632	3,289	48	196	112	538
Percentage of NHS trade invoices paid within target	**71%**	**72%**	**76%**	**66%**	**68%**	**69%**

Actions

- All non purchase order invoices will be sent for approval via online invoice approval by 30th June.
- The Financial Services function are undertaking a review of the authorised signatories list to provide assurance on accuracy and completeness of the dataset, communications will be sent to heads of services by 30th June.

Appendices

Appendix 1: Financial sustainability risk rating – QVH Calculation M02 2016/17

Financial sustainability risk rating	Description	Regulatory activity
4	No evident concerns	None
3	Emerging or minor concern potentially requiring scrutiny	Potential enhanced monitoring
2*	Level of risk is material but stable	Potential enhanced monitoring
2	Material risk	Potential investigation (see Chapter 5)
1	Significant risk	Likely investigation (see Chapter 5) Potential appointment of contingency planning team

*Weighted average, rounded to nearest number, across the components of the financial sustainability risk rating.

Month 2 2016/17 :Monitor's financial sustainability risk rating

Continuity of Services:

	Metrics	Measure	Rating	Weighting	Score
Balance Sheet sustainability: Capital Servicing Capacity	**£ks**				
Operating surplus	833	3.42	**4**	25%	**1.00**
Financial obligations (year to date)	244				
Liquidity (days)					
Cash and equivalents held	5,704	33	**4**	25%	**1.00**
Operating Costs (per day)	175				

Financial efficiency:

I&E Performance - Margin (%)					
Surplus (deficit) year to date	123	1.08%	**4**	25%	**1.00**
Income year to date	11,355				
Variance from plan - I&E Margin					
Actual surplus margin	1.08%	-1.19%	**2**	25%	**0.5**
Plan surplus margin	2.27%				
FSRR (rounded)					**4**

Summary

- These calculations are based on the existing methodology introduced in 2015-16.

KSO5 – Organisational Excellence

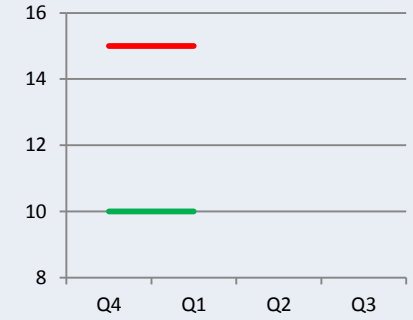
Risk Owner: Director of HR & OD
Committee: Finance & Performance Committee
Date: 20th June 2016

Strategic Objective
We seek to maintain and develop a strong professional and caring culture through clear standards, high expectations and exemplary leadership

Current Risk Rating 3 x 5 = RED
Residual Risk Rating 2 x 5 = GREEN

Rationale for current score
Capacity planning & workforce modelling
Seven day services
Junior doctors contract
Additional corporate restructuring

Risk
Staff lose confidence in the Trust as place to work due to a failure to offer; a good working environment; fairness and equality; training and development opportunities ; and a failure to act on feedback to managers and the findings of the annual staff survey. Insufficient focus on recruitment and retention across the Trust leading to an increase in bank and agency costs and having longer term issues for the quality of patient care



HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY
Consultant contract negotiations
Junior doctor contract negotiations
CQC recommendations
Tariff changes impacting on overall staffing costs

COMPETITION
More private sector competition, lower cost for same quality
Competitors becoming more agile and responsive i.e. delivering services through new job roles and responsibilities

INNOVATION
National terms and conditions can prevent flexibility to address local issues e.g. retention of skilled nursing staff
Workforce systems need to become user friendly to benefit from self service

RESILIANCE
High turnover in some nursing specialties vs lack of turnover in corporate functions
Adapting to changes in service delivery i.e. new ways of working

Controls and Assurances
Developing long term workforce planning (3 years) for FY16/17 and linking to business planning process – includes skills mix/safe staffing reviews
Leadership programme designed for Business Units / corporate services
Workforce strategy to be implemented by Q4 FY15/16
Further action and deadline set for non-permanent staff training compliance
Implementing a Board approved staff survey action plan
HR/OD metrics revised to support the Business Units
Specific analysis on vacancy vs absence management and Band 7 ward manager development - linked to addressing recruitment and retention issues
Performance review meetings to identify and address identified staffing shortfalls
HR support to corporate functions to implement successfully re-structures

Gaps in controls and Assurances
Current level of management competency in workforce planning
Continuing resources to support the development of staff
Continuing retention problems in theatres and ward areas and medical staff in Max Facs

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/07/2016	**Agenda reference:**	129-16		
Report title:	**Workforce Report – June 2016 (April and May 2016 data)**				
Sponsor:	Geraldine Opreshko, Interim Director of HR/OD				
Authors:	Jill Dale, ESR and Workforce Intelligence Manager, Geraldine Opreshko, Interim Director of HR/OD				
Appendices:	A: Workforce Report				
Executive summary					
Purpose:	The Workforce and OD report for June 2016 provides the Board of Directors with a breakdown of key workforce indicators and information linked to performance. This report incorporates a number of presentational changes to enhance clarity and focus.				
Recommendation:	The Board are asked to note the report.				
Purpose:		Information	Discussion	Assurance	
Link to key strategic objectives (KSOs):	✓ KSO 1	KSO2:	KSO3:	KSO4:	✓ KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	Trust reputation as a good employer and ensuring there are sufficient and well trained staff to deliver high quality care				
Corporate risk register:	Recruitment and retention being addressed along with sickness absence and bank and agency usage.				
Regulation:	N/A				
Legal:	N/A				
Resources:	Managed by HR/OD with support from Finance and Operations				
Assurance route					
Previously considered by:	Finance & Performance Committee				
	Date:	20/06/16	Decision:		

Human Resources & Organisational Development

Workforce Report – June 2016

Reporting Period: May 2016

1.1 Overview

The June 2016 Workforce Report incorporates a number of presentational changes to previous reports which the Board will hopefully find clearer. This has been work in progress and over the next couple of months we will continue to refine the presentation of data and information.

The notable changes are as follows:

- The introduction and summary on the following page (p3) provides a concise at a glance summary of the workforce KPI's and now includes a trend summary so that not only is there a comparison to the previous month but also the last quarter. This will support easier and timely identification of trends. Some areas do not have KPI's and this will be consulted on in the coming weeks to develop them.
- We are now providing indicative figures for May 2016 sickness absence in the June report, a month ahead of previous reports. Due to cut off dates it is an indicative figure in this report and maybe subject to slight change which will be shown as a final figure in the next month's report, and so on in subsequent months
- On page 4 we look at staff in post versus budgeted WTE. We have tended to report the difference between staff in post and budgeted WTE as a vacancy rate. However, this can be misleading as at any one time we will have a number of posts being actively recruited to (59 in May) and also posts that are covered by bank and/or agency shifts (43.9 in May). Therefore in future reports we will look to further refine the way that this is reported
- In future reports we will build in the previous months comparator data for bank and agency usage to help with trend analysis
- We are now actively involved in Health Education Kent Surrey and Sussex Procurement Hub working collaboratively to further reduce agency rates where we pay over cap and how we can make our bank more attractive to a temporary workforce
- Financial data is now excluded as this is covered in the finance report
- On page 9 we now use sickness absence benchmarking data for other specialist hospitals rather than based on geography as large acute hospitals have a different workforce profile. This also means the Trust is compared with the same benchmark group as the NHS Staff Survey
- Earlier reports have shown a large percentage for 'other' as a reason for sickness absence (p9). This is not helpful when trying to manage sickness absence and identify staff and manager support needs. We have now restricted the use of this category for recording absence on ESR and e-roster which will help give us a clearer indication of reasons for absence. Over the coming weeks we will focus on developing wellbeing initiatives to address the highest causes of absence.
- The compliance rates for appraisal in particular appear to have dropped. Business Units have been asked to refocus their efforts to considerably improve on this position over the summer period.
- The 2016/17 establishment whole time equivalent (WTE) is being reviewed by Finance and the Business Units through the business planning process and a further piece of workforce planning is underway with the Business Managers to identify gaps and challenges.

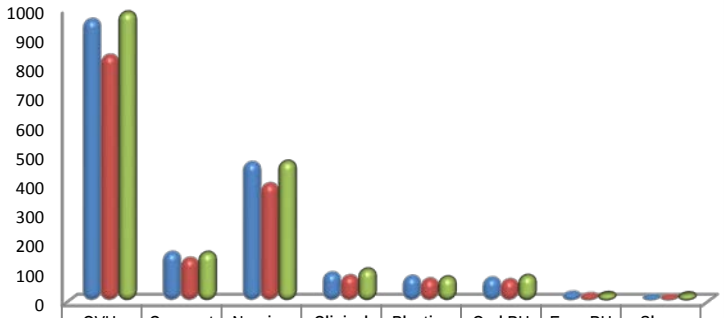
1.2 Summary

Trust Workforce KPIs	Primary Data Source	Definition/Measure	Workforce KPIs (RAG Rating)			**Jan-16**	**Feb-16**	**Mar-16**	**3 month Trend**	**Apr-16**	**Compared to Prev Mth**	**May-16**	**Compared to Prev Mth**
Establishment WTE	Finance	Establishment is the pay budget of the Trust, described in numbers of posts (WTE). Whole Time Equivalent is the method of counting posts to reflect the contracted hours against the standard full-time hours e.g. full-time 1.0 WTE				968.13	968.13	968.13		963.92	▼ *Note 3	963.92	◄►
Staff In Post WTE	ESR	Staff in Post WTE describes the permanent and fixed term staff i.e. substantive employees directly employed by the Trust reflecting contracted hours against the standard full time hours				851.36	841.99	851.31		850.12	▼	841.75	▼
Vacancies WTE	ESR	The vacancy WTE is the difference between the substantively employed staff and the budgeted establishment, measured in WTE				116.77	126.14	116.82		113.80	▼	122.17	▲
Vacancies %	ESR	The vacancy Percentage is the difference between the substantively employed staff and the budgeted establishment expressed as a percentage of the Establishment	>12%	8%<>12%	<8%	12.1%	13.0%	12.1%		11.8%	▼	12.7%	▲
Agency WTE	Healthroster	Fill by Agency Workers expressed as a WTE of hours worked				4.5	16.5	19.5		13.0	▼	15.4	▲
Bank WTE *Note 1	Healthroster	Fill by Bank Workers expressed as a WTE of hours worked				27.4	30.2	37.2		29.8	▼	28.5	▼
Trust rolling Annual Turnover % (Excluding Trainee Doctors) *Note 2	ESR	Turnover is cumulative, and is the number of staff (FTE) leaving in last 12 months divided by the average number of staff in post now and 12 months previously, as a percentage.	>=12%	10%<>12%	<10%	15.4%	15.4%	15.4%		16.9%	▲	17.1%	▲
Monthly Turnover	ESR	Current month leavers WTE divided by the Current month staff on post, expressed as a percentage				2.3%	1.5%	1.0%		2.1%	▲	1.0%	▼
Stability %	ESR	Stability is the number of staff (headcount) with more than one year's service, divided by the current number of staff in post, as a percentage	<70%	70%<>85%	>=85%	83.3%	82.9%	83.8%		82.0%	▼	99.1%	▲
Sickness Absence %	ESR	Sickness is the number of WTE days lost due to sickness divided by the number of WTE days available, as a percentage for the period.	>=4%	4.%<>3%	<3%	3.2%	3.7%	3.6%		3.2%	▼	***3.0%*** ***indicative***	
Statutory & Mandatory Training (Permanent & Fixed Term)	ESR	Mandatory Training is reported as the number of employees compliant with individual competences at month end, as a percentage of the number of employees required to be compliant with each competence	<70%	70%<>80%	>=80%	91.7%	90.5%	89.9%		88.6%	▼	87.3%	▼
% staff appraisal compliant (Permanent & Fixed Term)	ESR	Appraisals is reported as the number of employees who have had an appraisal in the last twelve months at month end, as a percentage of the total number of employees	<70%	70%<>85%	>=85%	80.6%	81.2%	81.2%		78.3%	▼	77.5%	▼

*Note 1 - does not include extra hours worked by medical staff within establishment or overtime worked by all staff groups
*Note 2 - Turnover has been recalculated to exclude rotational trainee doctors from January 2016 onwards
*Note 3 - April Establishment not available in April data reporting period, amended to reflect 2016/17

2. Establishment, Staff in Post and Vacancies

Budgeted Establishment /Staff in Post WTE & Headcount



	QVH	Corporate	Nursing & CI	Clinical Sup BU	Plastics Bu	Oral BU	Eyes BU	Sleep BU
Budgeted Establishment	963.92	168.8	476.21	98.43	86.31	80.98	31.43	21.76
Staff in Post WTE	841.75	148.52	403.72	88.52	77.59	75.11	26.53	21.76
Headcount	989	168	480	111	84	89	29	28

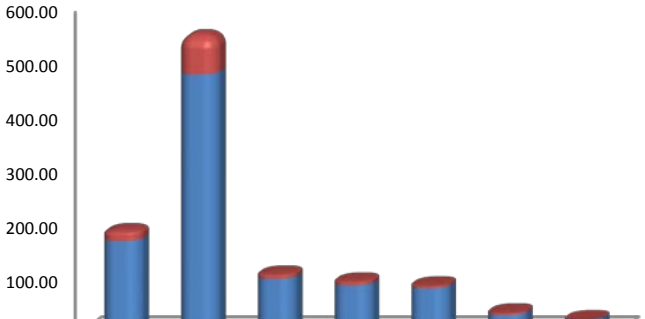
Summary

1.1 Establishment: This is the figure agreed at the start of the financial year for Trust.

1.2 Staff in post: the headcount is **989,** the WTE staff in post is **963.92**, there is a gap of **122.17 WTE (12.67%)** which is the difference between the budgeted establishment (2016/17) and the staff in post WTE (see gap chart below).

1.3 Vacancies: The current gap is **122.17** WTE. The highest gap is Nursing Staff in Nursing & Clinical Infrastructure with 20.74% followed by Eyes at 15.59%.

Staff in Post/Unfilled WTE



	Corporate	Nursing & CI	Clinical Sup BU	Plastics Bu	Oral BU	Eyes BU	Sleep BU
Number of vacancies	20.28	72.49	9.91	8.72	5.87	4.9	0
Staff in Post WTE	168.80	476.21	98.43	86.31	80.98	31.43	21.76

Vacancy Rate – number of 'vacancies' compared to budgeted WTE establishment per Business Unit

Business Unit	Gap as % of establishment	Number of vacancies (WTE)	Comparison to last month
Corporate	12.01%	20.28	▼
Nursing & Clinical Infrastructure (overall)	15.22%	72.49	▲
o **Nursing staff**	20.74%	46.22	▼
o **HCA's**	11.95%	10.32	▼
Clinical Support BU	10.07%	9.91	▲
Plastics BU	10.10%	8.72	▲
Oral BU	7.25%	5.87	▼
Eyes BU	15.59%	4.90	▼
Sleep BU	0.00%	0.00	▼
QVH Total	**12.67%**	**122.17**	▲

3. Recruitment Activity for May 2016

Total number of Posts Advertised	27, (35.03 WTE)
Total number of Job Offers	37
Number of Candidates in the Recruitment Process (as at May 2016) – job offers made, candidates not yet started	59

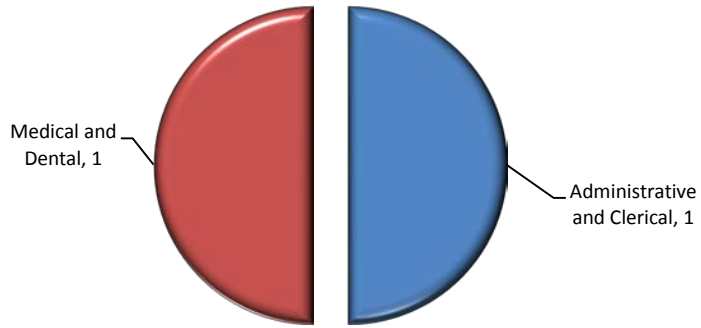
Recruitment Summary
Non-Medical Recruitment Summary: In May 2016 27 posts (35.03 WTE) posts were advertised, most of which were in the Nursing and Clinical Infrastructure department. During May there were 59 applicants in the recruitment process (job offer made, but candidate not yet started). Although the number of posts advertised is not particularly high, much of the recruitment activity is getting candidates through the recruitment clearance process, assuring all the NHS pre-employment check standards have been met. Activity in the period June – August is expected to follow the season trend with a dip in activity.

Business Unit	**Number of (New) Non-Medical Posts Advertised during reporting period**	**Number of Non-Medical Candidates in the Recruitment Process (as at 2016) –** job offer made candidate not started
Corporate	2 (2.00 WTE)	8
Nursing and Clinical Infrastructure	15, (25.96 WTE)	37
o **Nursing Staff**	5, (4.60 WTE)	9
o **HCA's**	1, (0.80 WTE) Apprentice	16
Clinical Support	7, (4.40 WTE)	8
Plastics Business Unit	0	0
Eyes Business Unit	0	4
Sleep Business Unit	1 (1.00 WTE)	0
Oral Business Unit	2, (1.64 WTE)	2
Total (QVH Overall)	27, (35.03 WTE)	59

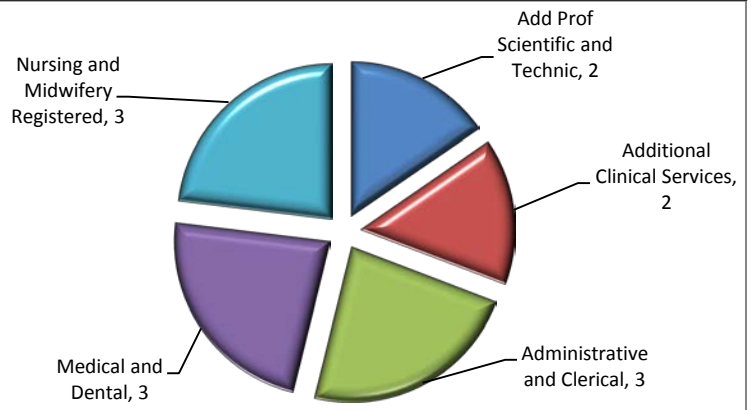
Medical and Dental Recruitment
This month there have been a number of fixed term junior doctor (non-deanery) posts advertised for commencement in September 2016 and February 2017 as planned. In Ophthalmology, two short-terms gaps at Senior Fellow level are expected in June and July due to early resignations of two Fellows. These gaps are planned to be filled by an NHS Locum with the other post currently being advertised.
Medical Locums
Looking forward, one agency locum will be used to cover a Registrar in Plastic Surgery for a period of one month to cover a short-term vacancy. Rates are in line with NHS Monitor agency rate caps. One agency Consultant Locum is covering the maternity leave of a visiting Consultant from BSUH in Clinical Support Services. Rates are in line with NHS Monitor agency rate caps. In Oral and Maxillofacial, one locum, who left in March is being replaced by another, to support the service at Medway whilst longer term plans.

4. Turnover – Starters and Leavers

Number of New Starters (Headcount) by Staff group for May 2016



Number of Leavers (Headcount) by Staff group for May 2016



Business Unit	Starters (WTE)	Leavers (WTE)
Corporate	1.00	0.61
Nursing and Clinical Infrastructure	0.00	4.29
o **Nursing Staff**	0.00	2.23
o **HCA's**	0.00	0.76
Clinical Support	0.00	1.20
Plastics Business Unit	0.88	0.00
Eyes Business Unit	0.00	1.00
Sleep Business Unit	0.00	0.00
Oral Business Unit	0.00	2.00
QVH Total	**1.88**	**9.10**

Turnover Summary

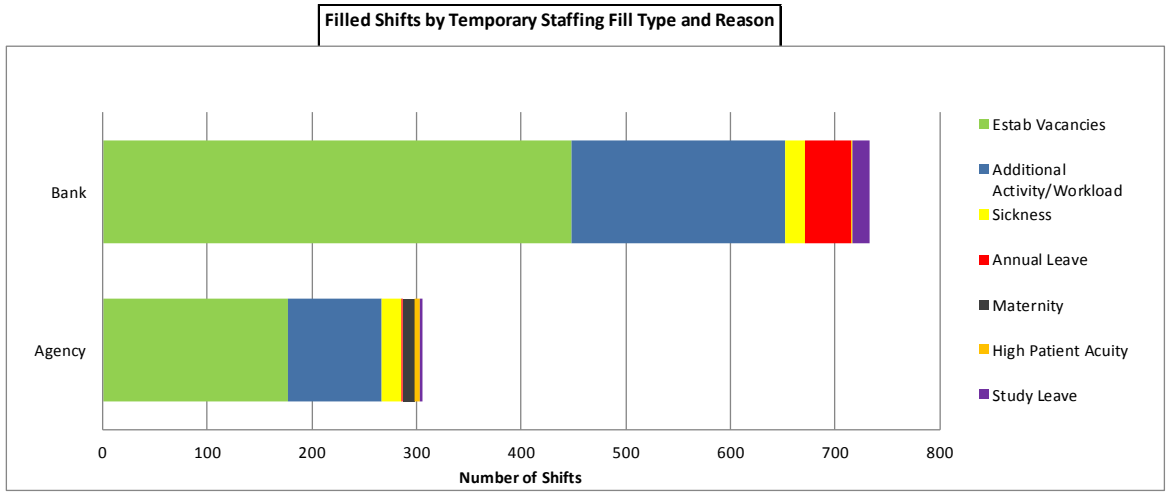
Turnover rate – for the month of May the turnover rate (excluding rotational trainee doctors) is 1.0**%** for Permanent/Fixed term staff.

Turnover rate for 12 months (Period: 1st May 2015 to 30th April 2016) is ***17.1%*** for Permanent/Fixed term staff. This figure is higher than we would expect or want. We will undertake further analysis and report at a future Board.

5. Bank and Agency Usage – May Activity Data

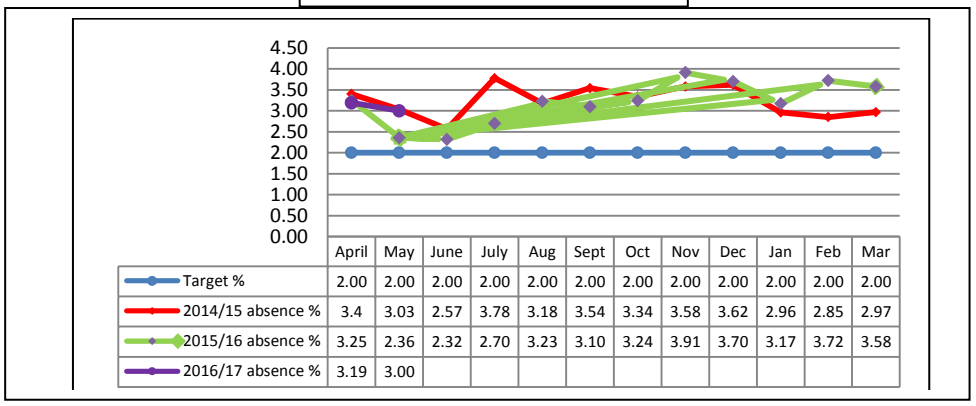
By QVH Business Unit	Current Month Agency usage in WTE	Current Month Bank usage in WTE	Current Month Agency & Bank in WTE	Previous Month Agency & Bank in WTE	Current Month compared to last month
Corporate	6.50	3.7	10.2	9.1	▲ Agency ▲ Bank
Nursing and CI	5.10	14.5	19.6	21.3	▲ Agency ▼ Bank
Clinical Support	2.90	1.7	4.6	4.2	▲ Agency ▼ Bank
Plastics Business Unit	0.00	3.4	3.4	2.9	◄► Agency ▲ Bank
Eyes Business Unit	0.0	2.4	2.4	2.3	◄► Agency ▲ Bank
Sleep Business Unit	0.9	1.3	2.2	2.8	▲ Agency ▼ Bank
Oral Business Unit	0.0	1.5	1.5	0.2	◄► Agency ▼ Bank
QVH Total	**15.40**	**28.5**	**43.9**	**42.8**	▲ Agency ▼ Bank

By Staff Group	Current Month Agency usage in WTE	Current Month Bank usage in WTE	Current Month Agency & Bank in WTE
Qualified Nursing	4.7	7.7	12.4
HCAs	0.0	2.1	2.1
Other Clinical e.g AHP & ST&T	3.7	0.8	4.5
Non-Clinical	7.0	17.9	24.9
QVH Total	**15.4**	**28.5**	**43.9**



6. Sickness Absence

Sickness Absence – April 2016



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Target %	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
2014/15 absence %	3.4	3.03	2.57	3.78	3.18	3.54	3.34	3.58	3.62	2.96	2.85	2.97
2015/16 absence %	3.25	2.36	2.32	2.70	3.23	3.10	3.24	3.91	3.70	3.17	3.72	3.58
2016/17 absence %	3.19	3.00										

Sickness Absence % and costs by Business Units

Business Unit	Sickness Percentage	Current month compared to last month
Corporate	2.02%	▼
Nursing and Clinical Infrastructure	4.69%	▼
Clinical Support	3.46%	▼
Plastics Business Unit	1.15%	▲
Eyes Business Unit	0.55%	▲
Sleep Business Unit	5.23%	▼
Oral Business Unit	2.41%	◀▶
QVH Total	**3.19%**	▼

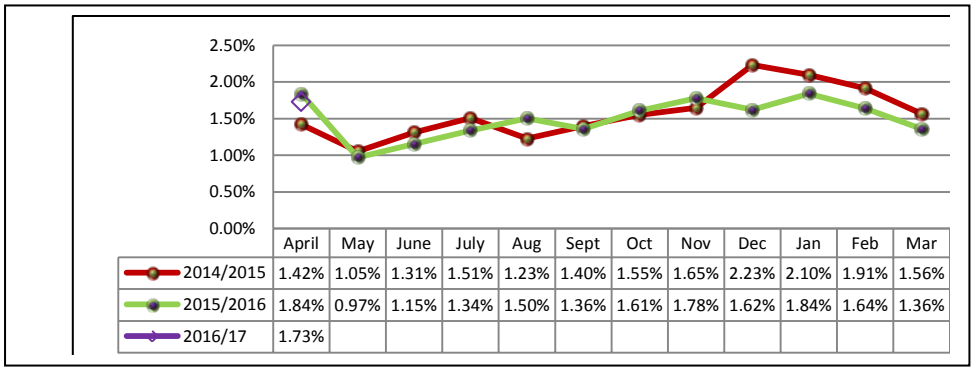
Short term Sickness Absence

Short Term sickness for April was **1.73%** which is an increase from last month. Managing sickness absence has improved in line with Policy in conjunction with the work of the HR Business Associates. We anticipate a decrease in short term sickness absence in line with the yearly trend for the last quarter.

Long term Sickness Absence

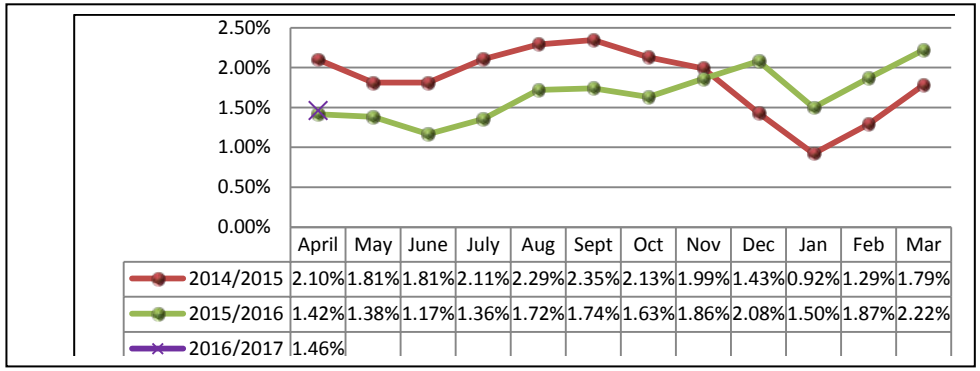
The long term sickness absence rate for April was **1.46%** which is a decrease from last month.

Sickness Absence – Short Term



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2014/2015	1.42%	1.05%	1.31%	1.51%	1.23%	1.40%	1.55%	1.65%	2.23%	2.10%	1.91%	1.56%
2015/2016	1.84%	0.97%	1.15%	1.34%	1.50%	1.36%	1.61%	1.78%	1.62%	1.84%	1.64%	1.36%
2016/17	1.73%											

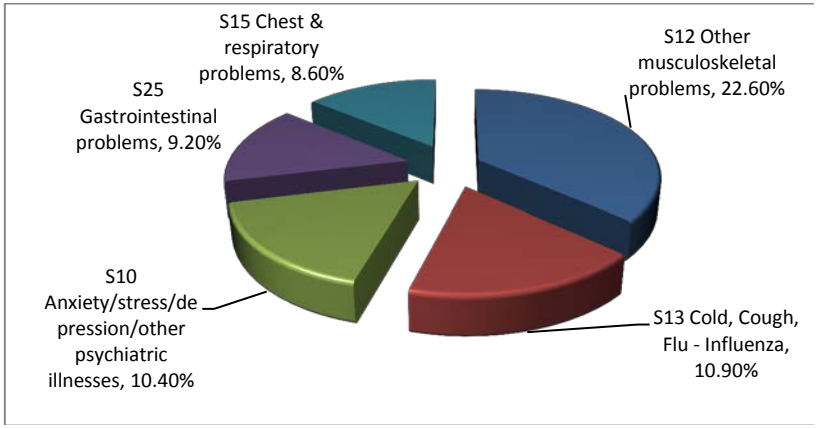
Sickness Absence Long Term



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2014/2015	2.10%	1.81%	1.81%	2.11%	2.29%	2.35%	2.13%	1.99%	1.43%	0.92%	1.29%	1.79%
2015/2016	1.42%	1.38%	1.17%	1.36%	1.72%	1.74%	1.63%	1.86%	2.08%	1.50%	1.87%	2.22%
2016/2017	1.46%											

6.1 Sickness Absence Reasons

Top 5 sickness absence reasons for April 2016



Health & Wellbeing

- 33 management referrals were received in May 2016 by Team Prevent (Occupational Health).
- Of these:
  - 60% were for musculoskeletal disorders including injury and fractures (MSD)
  - 12% were for mental health problems
- There were 71 immunisations and blood test events
- There were 3 needle stick injuries
- 2 people were referred for physiotherapy
- 20% did not attend their appointment (25 people)

6.2 Sickness Absence Benchmarking Data – Sickness percentage rates for February 2016 (*Source: Health & Social Care Information Centre)*

Specialist Hospital	Region	Rate
Alder Hey Children's Hospital	North West	5.91%
Birmingham Children's Hospital	West Midlands	3.79%
Birmingham Women's Hospital	West Midlands	4.86%
Christie Hospital, Manchester	North West	3.77%
Clatterbridge Cancer Centre	North West	4.08%
Great Ormond Street Children's Hospital	London	2.72%
Liverpool Heart & Chest Hospital	North West	3.44%
Liverpool Women's Hospital	North West	4.91%
Papworth Cardiothoracic Hospital	Cambridgeshire	3.92%
Robert Jones & Agnes Hunt Orthopaedic Hospital	Shropshire	3.19%
Royal Brompton & Harefield Cardiothoracic Hospital	London	2.36%
Royal Marsden Cancer Hospital	London	3.26%
Royal National Orthopaedic Hospital	London & Middlesex	3.01%
Royal Orthopaedic Hospital, Birmingham	West Midlands	5.01%
Sheffield Children's Hospital	North East	4.76%
Velindre Cancer Centre, Cardiff	Wales	3.84%
Walton Centre for Neurology & Neurosurgery	North West	5.38%

Sickness Absence Summary

The overall sickness absence rate at QVH for April was **3.19%.** This is a decrease from last month. The sickness % for April is lower compared to the same month in 2014/15. The indicative sickness absence rate for May 2016 is 3.0%

Highest reason for absence recorded: Other musculoskeletal problems
Highest first day absence: Monday
Number of one day sickness absence episodes: 63
Number of long term sickness absence cases (20 working days or more) 8

When comparing the sickness absence rates for February 2016 for the 18 Specialist Hospitals in the benchmark group, the QVH rate of 3.72% is below the group average of 3.84% and is the 7th lowest sickness absence rate.

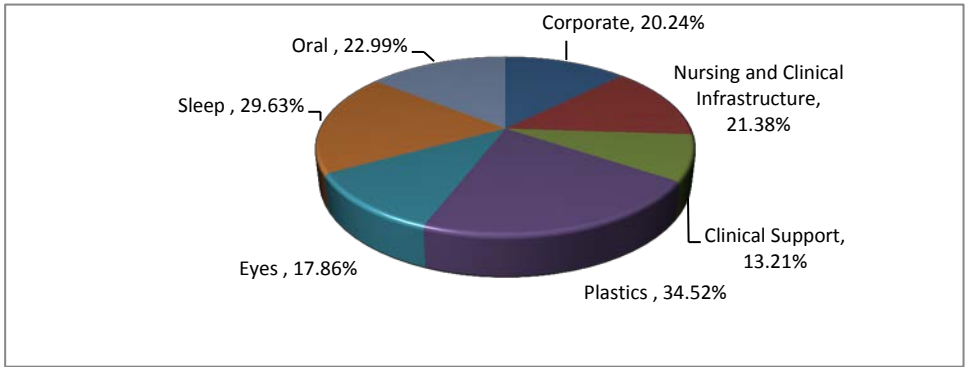
7. Training, Education and Development

Appraisal Compliance Rate as at 1st June 2016

Area	Permanent & Fixed Term Staff APPRAISAL % Compliance	Current month compared to last month
Corporate	*79.76*	▼
Plastic surgery	*65.48*	▼
Oral	*77.01*	▼
Sleep	*70.37*	▲
Eyes	*82.14*	▼
Clinical Support	*86.79*	▼
Nursing	*78.62*	▲
QVH Overall	*77.55*	▼

QVH PDR compliance target - 85%
Green - 85% & higher
Amber - 70-85%
Red - 0-69.99%

Outstanding Appraisals% as at 1st June 2016

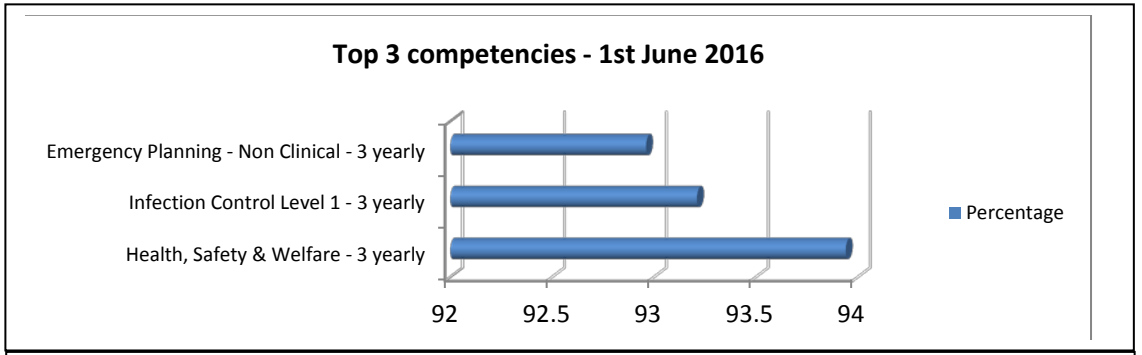


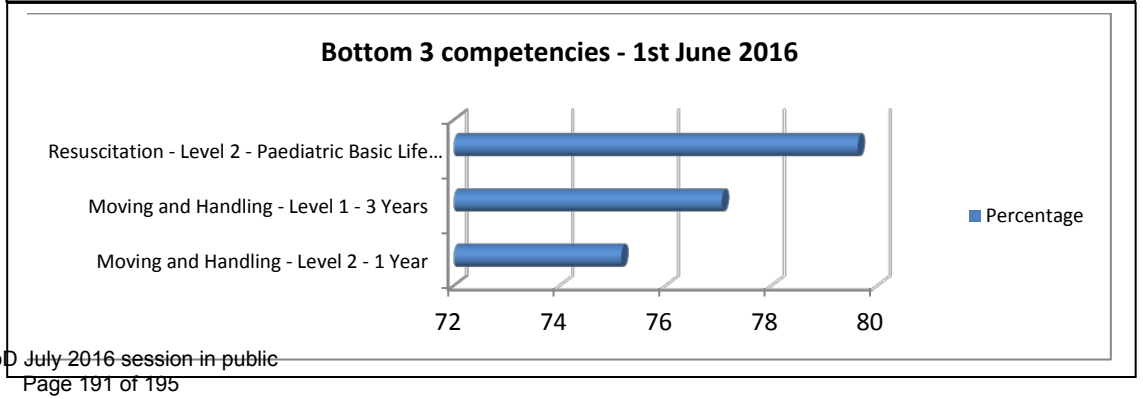
7.1 Statutory & Mandatory Compliance Rates

QVH Staff Compliance for 18 competencies as at 1st June 2016 INC Appraisal

Area	Permanent & Fixed Term Staff % Compliance	Current month compared to last month
Corporate	*86.65*	▼
Plastic surgery	*83.87*	▼
Oral	*85.74*	▼
Sleep	*89.97*	▲
Eyes	*92.56*	▼
Clinical Support	*92.12*	▼
Nursing	*86.77*	▼
QVH Overall	*87.27*	▼

QVH Overall compliance target - 80%
Green - 80% & higher
Amber - 70-79%
Red - 0-69.99%





7.2 Learning and Development – Medical Education

Medical Education Summary

Educational activities in May

- Hosted regional core plastics teaching day 5 May – excellent feedback from attendees
- Very popular CPD evening meeting for all staff – Professor Venkat Ramakrishnan presented on efficiency in breast reconstruction
- Two days of human factors training for theatres staff – also very well received, one half day of follow up training remains to be delivered in July
- Hosted managing complaints training day (funded by HEKSS) for Staff Grade/SAS doctors from around the region – positive feedback from attendees
- Work underway on creation of wet lab with funding from charitable funds

Upcoming developments

- Joint QVH Educators meeting to discuss integrated education proposals: 1 July
- Hosting regional anaesthetics post FRCA teaching day and plastic surgery pan-Thames teaching day
- Local Faculty Group and Local Academic Board meetings to assure educational governance taking place June/July
- GMC national training survey results due July 2016

Statutory and Mandatory Training Compliance

- Compliance rates for permanent staff remain high and plans are in place to ensure that this continues
- Bank staff are problematic (figures are worse this month due to the temporary addition of a number of ENT doctors working in the community to the bank – this will improve shortly)
- Changes to the requirements for training in conflict resolution are being rolled out

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 7th July 2016
Reference number: 130-16
Report from: Lester Porter, Chair
Author: Lester Porter, Chair
Appendices: N/A
Report date: 29th June 2016

Audit committee
Meeting held on 22nd June 2016

1. The first KSO risk discussion took place led by the Director of Nursing which allowed much greater time to focus on the key risks - including gaps in controls and assurance - to delivering Outstanding Patient Experience. It was agreed that greater priority should be given to completing development of a quality strategy to ensure QVH continues to deliver demonstrably superior service to competing organizations. After lengthy discussion the committee was also assured of the effort being put behind both recruitment and, increasingly, retention of staff.

2. An update on the performance of the internal auditors, Mazars, was provided by the Finance Director. The committee can assure the board that their performance has improved markedly since the last quarter following various changes to the Mazars team, and that the implementation of current year plans is on track. No change to the current internal audit arrangements is proposed therefore.

3. The backlog of actions due to be implemented from the 2014/15 and 2015/16 internal audit recommendations is now being actively managed and has been significantly reduced.

4. As a result of item 2 above, the tendering of the external audit contract can now proceed with the intention of appointing auditors from this autumn who will undertake the audit of the 2016/17 accounts.

5. The committee reviewed and approved the proposed presentation on Audit Issues by KPMG to the Council of Governors on the 25th July.

6. The assurance level of all reports provided to the committee were Substantial with the exception of the report on *Freedom of Information* processes where a Limited assurance opinion was provided. Work is now under way to address a number of weaknesses in responsiveness, and in logging and reporting processes.

7. There were no new incidents of Whistleblowing in the last quarter.

Queen Victoria Hospital NHS
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 01 September 2016 at 10:00
Cranston Suite, East Court, College Lane, East Grinstead, West Sussex RH19 3LT

Agenda: session held in public		
Welcome		
-16	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*	-
Standing items		
-16	**Draft minutes of the meeting session held in public on 07 July 2016 (for approval)** *Beryl Hobson, Chair*	paper
-16	**Matters arising and actions pending** *Beryl Hobson, Chair*	paper
-16	**Chief executive's report, (including BAF overview)** *Richard Tyler, Chief Executive*	paper
-16	**Corporate Risk Register (CRR)** *Richard Tyler, Chief Executive*	paper
Key strategic objective 1: outstanding patient experience		
-16	**Board Assurance Framework** *Jo Thomas, Director of Nursing*	paper
-16	**Patient story: experience** *Jo Thomas, Director of Nursing*	-
-16	**Quality and governance assurance report** *Ginny Colwell, Non-executive director and committee chair*	paper
-16	**Quality and Safety** *Jo Thomas, Director of Nursing*	paper
16	**Emergency Preparedness Resilience & Response and Business Continuity Annual Report** *Jo Thomas, Director of Nursing*	paper
Key strategic objective 2: world-class clinical services		
-16	**Board Assurance Framework** *Steve Fenlon, Medical Director*	paper
-16	**Medical director's report** *Steve Fenlon, Medical Director*	paper
-16	**R & D annual plan** *Steve Fenlon, Medical Director*	paper
-16	**Consultant re-validation annual update** *Steve Fenlon, Medical Director*	paper

Key strategic objectives 3 and 4: operational excellence and financial sustainability		
-16	**Board Assurance Framework** *Sharon Jones, Director of Operations and Clare Stafford, Director of Finance*	paper
-16	**Financial and operational performance assurance report** *John Thornton, Non-Executive Director*	paper
-16	**Operational performance** *Sharon Jones, Director of Operations*	paper
-16	**Financial performance** *Clare Stafford, Director of Finance and Performance*	paper
Key strategic objective 5: organisational excellence		
-16	**Board Assurance Framework** *Geraldine Opreshko, interim Director of Human Resources and Organisational Development*	paper
-16	**Workforce report** *Geraldine Opreshko, interim Director of Human Resources and Organisational Development)*	paper
Board governance		
-16	**Charity Committee** *Lester Porter, committee Chair*	paper
-16	**Nomination & Remuneration committee** *Beryl Hobson, Chair*	paper
-16	**Draft agenda for the November 2016 business meeting**	paper
Any other business (by application to the Chair)		
-16	*Beryl Hobson, Chair*	verbal
Observations and feedback		
-16	**Feedback from key events and other engagement with staff and stakeholders** *All*	verbal
-16	**Observations from members of the public** *Beryl Hobson, Chair*	verbal
-16	**Observations and feedback on the meeting** *Clare Stafford, Director of Finance*	verbal

Date of the next meetings		
Board of Directors:	**Sub-Committees**	**Council of Governors**
Public: 03 November at 10:00	**Q&G:** 08 September 2016 at 09:00 **F&P:** 19 September 2016 at 14:00 **Audit**: 21 September 2016 at 14:00 **Charity:** 29 September 2016 at 09:00 **N&R:** 27 October 2016 at 11:00 **Corp. Trustee**: 03 Nov 2016 at 14:00	**Public**: 20 October 2016 at 16:00