Queen Victoria Hospital NHS
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 5 January 2017

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: 5 January 2017

Members (voting):

Chair	-	Beryl Hobson
Senior Independent Director	-	Lester Porter
Non-Executive Directors:	-	Ginny Colwell
	-	John Thornton
Chief Executive:	-	Steve Jenkin
Medical Director	-	Ed Pickles
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
Director of Operations	-	Sharon Jones
Head of Communications and Corporate Affairs	-	Clare Pirie
Deputy Company Secretary	-	Hilary Saunders
Governor Representative:	-	John Belsey
Deputy Director of Nursing	-	Nicky Reeves

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

	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.
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
Ginny Colwell Non-Executive Director	Nil	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
Ed Pickles Medical Director					I am a member of a group of anaesthetists (East Grinstead Anaesthetic Services) who provide anaesthetic care to patients undergoing surgery in local independent hospitals. This surgery may occasionally include NHS patients		

	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.
Steve Jenkin Chief Executive	Nil	Nil	Nil	Nil	Nil	Nil	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)							
Sharon Jones Director of Operations	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Geraldine Opreshko Director of HR & OD	Director of GO Consultants	Nil	Nil	Nil	Nil	Nil	Nil
Clare Pirie Head of Communications & Corporate Affairs	Nil	Nil	Nil	Nil	Nil	Nil	Nil
John Belsey Governor Rep	Director of Golfguard Ltd Director of Mead Sport & Leisure Ltd	Nil	Nil	Trustee of Age UK Ltd, East Grinstead & District	None anticipated although, see above	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	NA	NA	NA	NA	NA	NA	NA
Lester Porter SID	NA	NA	NA	NA	NA	NA	NA
Ginny Colwell Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
John Thornton Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
Steve Jenkin Chief Executive	NA	NA	NA	NA	NA	NA	NA
Ed Pickles Medical Director	NA	NA	NA	NA	NA	NA	NA
Jo Thomas Director of Nursing	NA	NA	NA	NA	NA	NA	NA

Register of fit and proper person declarations

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Clare Stafford Director of Finance	NA	NA	NA	NA	NA	NA	NA
Other members of the board (non-voting)							
Sharon Jones Director of Operations	NA	NA	NA	NA	NA	NA	NA
Geraldine Opreshko Director of HR & OD	NA	NA	NA	NA	NA	NA	NA
Clare Pirie Head of Communications & Corporate Affairs	NA	NA	NA	NA	NA	NA	NA
John Belsey Governor Rep	NA	NA	NA	NA	NA	NA	NA

Queen Victoria Hospital NHS
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 5 January 2017 at 10:00
Cranston Suite, East Court, College Lane, East Grinstead, West Sussex RH19 3LT

Agenda: session held in public			
Welcome			
01-17	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**Page**
02-17	**Draft minutes of the meeting session held in public on 3 November 2016 (for approval)** *Beryl Hobson, Chair*	*Approval*	1
03-17	**Matters arising and actions pending** *Beryl Hobson, Chair*	*Review*	9
04-17	**Chief executive's report** *Steve Jenkin, Chief Executive*	*Assurance*	10
05-17	**Board Assurance Framework overview** *Steve Jenkin, Chief Executive*	*Assurance*	13
06-17	**Sustainability and Transformation Plan** *Steve Jenkin, Chief Executive*	*Discussion*	14
Key strategic objective 1: outstanding patient experience			
07-17	**Board Assurance Framework** *Nicky Reeves, Deputy Director of Nursing*	*Assurance*	86
08-17	**Corporate risk register (CRR)** *Nicky Reeves, Deputy Director of Nursing*	*Review*	87
09-17	**Patient story** *Nicky Reeves, Deputy Director of Nursing*	*Assurance*	-
10-17	**Quality and governance assurance report** *Ginny Colwell, Non-executive director and committee chair*	*Assurance*	95
11-17	**Quality and governance: Proposed changes to current meeting arrangements** *Ginny Colwell, Non-executive director and committee chair*	*Approval*	97
12-17	**Quality and safety report** *Nicky Reeves, Deputy Director of Nursing*	*Assurance*	100
13-17	**6-monthly nursing workforce review** *Nicky Reeves, Deputy director of Nursing*	*Assurance*	127
Key strategic objective 2: world-class clinical services			
14-17	**Board Assurance Framework** *Ed Pickles, Medical Director*	*Assurance*	141
15-17	**Medical director's report** *Ed Pickles, Medical Director*	*Assurance*	142
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
16-17	**Board Assurance Framework** *Sharon Jones, Director of Operations and Clare Stafford, Director of Finance*	*Assurance*	147

17-17	**Financial and operational performance assurance report** *John Thornton, Non-Executive Director*	*Assurance*	149
18-17	**Operational performance** *Sharon Jones, Director of Operations*	*Assurance*	152
19-17	**Financial performance** *Clare Stafford, Director of Finance and Performance*	*Assurance*	163
20-17	**Business Planning 2017/18 – 2018/19** *Clare Stafford, Director of Finance and Performance*	*Approval*	181
Key strategic objective 5: organisational excellence			
21-17	**Board assurance framework** *Geraldine Opreshko, interim Director of Human Resources and Organisational Development*	*Assurance*	196
22-17	**Workforce report** *Geraldine Opreshko, interim Director of Human Resources and Organisational Development*	*Assurance*	197
Board governance			
23-17	**Risk Management strategy** *Nicky Reeves, Deputy Director of Nursing*	*Information*	210
24-17	**Management of Incident and Risk Policy** *Nicky Reeves, Deputy Director of Nursing*	*Approval*	232
25-17	**Audit committee** *Lester Porter, committee Chair*	*Assurance*	330
26-17	**Board Effectiveness assurance review** *Clare Pirie, Head of Communications and Corporate Affairs*	*Review*	333
27-17	**Annual approval of Board sub-committee Terms of Reference** • Audit committee • Finance and performance • Quality and governance • Nomination and remuneration *Clare Pirie, Head of Communications and Corporate Affairs*	*Approval*	336
28-17	**QVH Charity** *Lester Porter, committee Chair*	*Assurance*	-
29-17	**Draft agenda for the March 2017 business meeting** *Clare Pirie, Head of Communications and Corporate Affairs*	*Information*	355
Any other business (by application to the Chair)			
30-17	*Beryl Hobson, Chair*	*Discussion*	-
Observations and feedback			
31-17	**Feedback from key events and other engagement with staff and stakeholders** *All*	*Discussion*	-
	Questions from members of the public *We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to Hilary.Saunders@qvh.nhs.uk clearly marked "Questions for the board of directors". Members of the public may not take part in the Board discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.*	*Discussion*	-
Date of the next meetings			

Board of Directors:	Sub-Committees	Council of Governors
Public: 02 March at 10:00	**Q&G:** 12 January 2017 at 09:00 **F&P:** 16 January 2017 at 14:00 **N&R:** 19 January 2016 at 11:00 **Audit**: 22 March 2017 at 14:00 **Charity:** 30 March 2017 at 09:00 **Corp. Trustee**: 02 Nov 2017 at 14:00	**Public**: 19 January 2016 at 16:00

Queen Victoria Hospital NHS
NHS Foundation Trust

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 3 November 2016, 10.00 – 13.00, The Cranston Suite, East Court, East Grinstead RH19 3LT**	
Present:	Beryl Hobson, (BH)	Trust Chair
	Ginny Colwell (GC)	Non-Executive Director
	Ed Pickles (EP)	Medical 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:	Clare Pirie (CP)	Head of Communications and Corporate Affairs
	Sharon Jones (SLJ)	Director of Operations
	Geraldine Opreshko (GO)	Interim Director of Human Resources & Organisational Development
	John Belsey (JEB)	Governor Representative
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
Public gallery	Two members of the Council of Governors	

Welcome	
174-16	**Welcome, apologies and declarations of interest** The Chair opened the meeting and welcomed EP to his first Board meeting as medical director and JB as governor representative to the Board. She also welcomed Mr Colin Fry, joining the first part of the meeting to describe his experiences as a patient at QVH. There were no apologies and no new declarations of interest.
Standing items	
175-16	**Draft minutes of the meeting sessions held in public on 1 September 2016 for approval** The minutes of the meeting held on 1 September were **APPROVED** as a correct record.
176-16	**Matters arising and actions pending** The Board received and **APPROVED** the current record of matters arising and actions pending,
177-16	**Chief Executive's report** RT presented his final Chief Executive report prior to his departure later this month. This was a break from his traditional report and focused on the future of the foundation trust model, and the health economy in general. Amongst many of the Trust's achievements under RT's tenure, the Chair highlighted our consistent achievement of surplus, despite continuing challenges, the 'Good' rating following last year's CQC inspection and the recent 'segment 1' ranking, (under the new single oversight framework). BH was confident these achievements were due to the quality of RT's leadership and concluded by thanking RT on behalf of the Board and the organisation.
178-16	**Corporate risk register (CRR)**

	The Corporate risk register was presented to provide high level assurance that quality, performance, finance and risk were being managed effectively within QVH. The Board sought and received assurance on the following: • Risk leads would now update their area of the CRR on a regular basis, regardless of any changes in the previous reporting period, which would enhance assurance on process; • Risk ID 909 (industrial action by junior doctors) had now been de-escalated; • The risk score for ID 849 (reputational risk caused when non-QVH patients arrive at main Outpatients for Phlebotomy services) had been reduced following a review by the Director of Nursing. • Steps being taken to address concerns raised under ID 995 (Freedom of Information - potential of non-compliance with responses within the required timescale). CS explained that actions had been identified and implemented to improve the compliance processes. Performance was being monitored by the Information Governance Group.
Key strategic objective 1: outstanding patient experience	
179-16	**Board assurance framework** JMT advised that the BAF for KSO1 had been refreshed. There were no significant changes at this stage, although this might change in the coming months. There were no questions and the Board **NOTED** the contents of the update.
180-16	**Patient story** Mr Colin Fry explained that what he at first thought was a cold sore led to a full rhinectomy, meaning that he has an artificial nose. After two operations and radiotherapy at a different hospital he described the day that he came to QVH as the best day. He praised the QVH team for, without exception, making sure he fully understood the options and what would happen and for working together as a real team. He mentioned specific doctors, nurses, prosthetics experts and reception staff describing their skill, professionalism and understanding, their ability to make him feel at his ease, and the rapport he felt. Mr Fry described the operation he had at QVH and the excellent follow up treatment and showed members of the Board samples of the 'stuck on' nose he had for six months before he was ready for a more permanent prosthesis. He said that every part of QVH was spotlessly clean. The pace of the treatment had also impressed Mr Fry – he came in on a Sunday, had his operation on a Monday and went home on the Wednesday. Asked what we could have done better, Mr Fry said he could not think of anything. The Board thanked Mr Fry for taking the time to come in and to describe his experience. JMT said that we wanted to learn from patient stories but also celebrate our success. This was a profoundly positive experience built on a very negative personal starting point. For Mr Fry this was not just an episode of care but a real point of connection, and since then he has been speaking to pre-op patients about what to expect from surgery and fundraising for the charity HeadStart.
181-16	**Quality and governance assurance report**

	GC presented the regular quality and governance report. This provided information and assurance in respect of meetings and activities in September and October. Key points to note were: • One serious incident/never event reported where an injection was administered to the wrong finger. An RCA investigation was underway, which would include a human factors assessment, and • NHS Protect: an updated action plan had been submitted to the Q & GC by CS. This now contained no red standards, which GC described as a testament to the work undertaken by both JMT and CS since the initial NHS Protect report came to the Board in May. There were no further questions and the Board **NOTED** the contents of the update.
182-16	**Quality and safety** Following on from the previous Board meeting, JMT reported that there had been a further four cases of MRSA colonisation in September and October, with typing indicating that there had been transmission between the patients. Enhanced infection control measures remained in place, with additional training and surveillance by the infection control nurse being undertaken. JMT was assured that there had been good multidisciplinary engagement in the learning and actions required from the investigations. A year on from the CQC inspection, JMT was keen to encourage staff to reflect on progress of key recommendations. She was confident the Trust could now demonstrate growth and improvement on clinical and governance processes through improved quality metrics. Progress had been made on the applicable national, local and specialist CQUINS, with the Trust meeting the milestones for Q2 submission of data. A meeting had taken place with the CCG to review progress and payment of the schemes. The Trust was awaiting formal feedback but anticipating full payment for Q2. JMT warned that it was too early to make any assumptions against achieving CQUIN milestones for Quarters 3 and 4, CS added that financial provision had been made to mitigate areas where it was not expected to fully meet remaining milestones but noted any additional achievements would boost this year's financial position. Assurance was also provided in the following areas: • In respect of the fall in the scores in Outpatients for the Friends and Family Test (FFT) in August and September, assurance was provided that scoring had been skewed by the low number of responses during this period. However, this situation would continue to be carefully monitored; • The increase in potential safeguarding incidents reported was as a result of the work undertaken by safeguarding leads to raise awareness. Details were fed through from the strategic safeguarding group to the Quality and governance committee and were carefully reviewed; • Whilst the number of vacant (WTE) posts within the nursing workforce was not insignificant, there was no evidence that this was currently impacting on other quality or patient experience indicators. It would be unusual for an organisation to operate with a full establishment of staff at all times, as this would restrict flexibility to staff according to bed occupancy. GO also reminded the Board that a number of areas in the Trust had consulted on restructures and different ways of working which meant a number of posts had specifically been left vacant/covered on a temporary basis until processes were concluded. Moreover, current figures did not reflect the use of overtime by substantive members of staff. In the meantime, JMT described how vacancies were mapped and benchmarked against national specifications to provide assurance in respect of quality metrics. There were no further questions and the Board **NOTED** the contents of the report.
Key strategic objective 2: world class clinical services	
183-16	**Board assurance framework**

	EP presented the BAF for KSO2. He explained that as he had only just taken up the MD role, it would not have been appropriate to make any changes at this stage, but he would provide a detailed update in January. There were no further questions and the Board **NOTED** the latest update.
184-16	**Medical director's report** The Board commended the content of the Medical Director's report. During discussion EP highlighted the following: • In response to the CQC action plan, focus would continue on the leadership and staffing of the intensive care unit, and of the networking arrangements with other intensive care units (inextricably linked with those at BSUH); • Despite the huge amount of work undertaken already, there was still more to do in respect of consultant job planning, and plans for the coming year were outlined; • Although safe, the Trust was still unable to meet the new standards required under the seven day service initiative. Discussions were underway with NHS England on how to make the audits and aims more relevant to QVH practice and case mix, and how best to record activity; • The Board was apprised of recent success in respect of the Trust's hosting of exams for plastic surgery specialists from across the UK. This had required careful planning involving trainee surgeons, 40 examiners and 70 patients. During a review of the report, the Board sought clarification in respect of: • Human Factors Training: This was continuing with the aim of enhancing clinical performance through an understanding of the effects of team work, tasks, equipment etc., and would be monitored through the Quality and governance committee. The Board was reminded that training in theatres was part of the local CQUINS for 2017/18; • The medical devices maintenance and repair contract was significantly overspent YTD due to an inadequate medical devices inventory at the time of contract tendering. Lessons had been learnt and the Trust was meeting with the supplier to re-examine the contract, whilst at the same time exploring other options for provision. There were no further questions and the Board **NOTED** the contents of the report.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
185-16	**Board assurance framework** <u>KSO3</u> SLJ advised that although the KSO3 BAF had been refreshed, there were no further changes to report since the last Board meeting. <u>KSO4</u> CS reported that the overall BAF rating of 20 remained the same as last time. However, surplus was in line with the plan, there had been no slippage on the Cost Improvement Programme and whilst the capital plan had slipped the Trust was still in train to deliver.
186-16	**Financial and operational performance assurance report** JT presented an assurance report in respect of Finance and operational performance. Following concerns earlier in the year, diagnostic waits had improved significantly. Overall 18 week RTT performance was strong and JT felt the Trust was as much in control of this target as it could be, given the current health economy.

	JT went on to reiterate concerns regarding staff turnover. Recruitment into specialist areas was difficult, leading to agency usage above Trust targets. He noted that the Trust's ability to attract and retain high quality staff remained a challenge.
187-16	**Operational performance** Following on from the KSO3 update, the Board went on to consider the Operational Performance report, seeking additional clarification in respect of: • The Trust's achievement of 91% against the 92% 18-RTT open pathway target for August, which would enable the Trust to access the Sustainability and Transformation Fund. • There was evidence that action taken to address issues within MaxFacs (as previously reported to the Board) were improving its position in terms of managing demand and capacity; • A comparison of open pathway activity with that of 2014 showed that growth had almost doubled over the last two years. Whilst teams had worked hard to increase productivity they were still diligent in booking patients in chronological order and according to clinical urgency. In response to appeals for assurance on future activity, SLJ described how the open pathway was a true representation of activity, (which had increased by almost 100%). Whilst it was difficult to use this metric to quantify weighting, casemix was carefully monitored by the Finance and performance committee. • Cancer standards data generally arrived too late to be included in the Board papers but this appeared to be positive. SLJ reminded the Board, however, that the Trust was still susceptible to shared breaches with other trusts; • Assurance that the Trust would continue to develop its operational strategy; RT confirmed this would continue to include certain activity that could not currently be delivered by surrounding trusts; • Assurance of the protocols employed in respect of cancelled operations. There were no further comments and the Board **NOTED** the contents of the update.

188-16	**Financial performance**
	CS presented the Finance report which detailed the Trust's financial performance for the 6 months to 30 September 2016. This report had previously been considered by the Finance and performance committee before being submitted to the Board. Highlights included:
	• Delivery of the control total as at the end of Q2, (70% of which related to Finance and 30% to Performance);
	• The Trust delivered a surplus of £722k in month, £434k ahead of plan and in line with the forecast. The YTD surplus had increased to £1,184k which was on plan;
	• The Trust achieved 100% of planned Cost Improvement Programme YTD, (ie. £1.3m savings against the YTD plan of £1.3m).
	• The capital programme was £324k behind plan at the end of September, which included £255k in relation to Estates. CS explained that the principal development within Estates was the backlog maintenance programme; in this respect several business cases for works identified in the recent site-wide condition survey had now been approved, with work being initiated and planned for completion in 16/17;
	• A number of other papers had been included in this month's report including
	  • an overview of the NHS improvement guidance and timetable;
	  • an overview of the Sustainability and Transformation Fund for 2017/18 to 2018/19 and the QVH Control totals for 2017/18 to 2018/19, although these would be subject to change once the impact of the Clinical Negligence Scheme for Trusts was known. The Trust had been advised that the deadline for acknowledgement of the control total and associated conditions was 24 November. Any trusts not signing up by this date could forfeit eligibility to receive the Q1 STF in 2017/18 which would also impact the Trust's Single Oversight Framework (SOF) rating.
	  • details of the Trust's business planning approach for 2017/18 and 2018/19. CS explained that

	the timetable had been accelerated this year by three months. Although the terms of reference of the Finance and performance committee delegated authority for sign-off, she reminded the Board that all were invited to attend the next F&PC meeting on 21 November. The Board considered the implications of the update and sought assurance in respect of the directive that performance against the Agency Ceiling would be a key part of the providers' financial risk rating. RT reminded the Board that the Trust's agreement to the current Control Total had included certain provisos, and whilst the QVH would continue to report on the agency spend, safe levels of staffing would not be compromised. The Board was unanimous that any attempts to manage agency spend should not compromise quality and patient safety, but noted it was crucial to continue improving recruitment. The Chair thanked CS for her report, the contents of which were **NOTED** by the Board.
Key strategic objectives 5: organisational excellence	
189-16	**Board assurance framework** GO presented the latest KSO5 update, noting that for clarity, recent changes had been underscored. Whilst the threat of industrial action by junior doctors had receded, risks in relation to management competency of workforce planning, and staff retention in theatres and ward areas continued. On a positive note, the Trust had been successful in its funding bid for the in-house management and leadership development programme. There were no questions and the Board **NOTED** the contents of the update.
190-16	**Workforce report** GO introduced the workforce report which provided the Board with a breakdown of key workforce indicators and information linked to performance. The Board was asked to note in particular that recruitment continued to present a challenge, with recent advertising to NHS Jobs being unsuccessful. Plans to expand the current recruitment team were underway, and new ways of recruiting, including the use of social media, under consideration. After deliberation, the Board sought and received assurance in respect of: • The staff campaign for the flu vaccine - which was going well; • The current staff survey - the executive team was hopeful of a strong response rate which would provide meaningful feedback on any staff concerns. There was concern in relation to the fall in compliance with Statutory and Mandatory training and annual appraisals. The executive team described initiatives in place to address some of these concerns, including training on the appraisal process and the leadership development and wellbeing programmes, and went on to describe some of the operational difficulties which could impact on timely delivery of appraisals. Whilst acknowledging these issues, the NEDs stressed the importance of appraisals in the retention and development of staff, and looked forward to seeing an improvement in the statistics. There were no further questions and the Board **NOTED** the contents of the update.
191-16	**Equality and diversity annual report** GO reminded the Board that the Trust was required, as part of the Equality Delivery System 2 (EDS2), to publish an annual equality and diversity report, which was designed to ensure a diverse and representative workforce. GO assured the Board that, although this report was dated 2015, it reflected the same ethnicity, and current demography of the Trust.

	GO asked the Board to be aware that a significant percentage of staff were aged over 50, after which staff could choose when to retire, which could create difficulties for the organisation under certain circumstances, (eg. in the case of a single handed service). As QVH was a small trust, it was acknowledged that it might be easier to identify certain staff within groups, and care would be taken to anonymise details where appropriate. There were no further questions and the Board **NOTED** the contents of the update.
Board governance	
192-16	**Audit committee assurance report** As Committee Chair, LP presented an update on the most recent meeting. This included a description of the process undertaken in re-appointing KPMG as the Trust's external auditors. Whilst acknowledging attempts to mitigate the risk of 'threat of familiarity' following the re-appointment of KPMG, JEB sought assurance that changes in KPMG personnel also related to the Partner, not just its senior management team. CS agreed to investigate and report back **[Action: CS]** There were no further questions and the Board **NOTED** the contents of the update.
193-16	**QVH Charity assurance report** As Chair of the committee, LP had prepared a report on the recent QVH Charity committee meeting. He reiterated the need to build the Charity's income flows, and noted that any proposals arising from the strategy which could result in additional costs should be agreed within the normal budget setting process for 2017/18. During discussions, it was agreed that the deadline for submission of the funding strategy to the Charity Committee would be postponed to March 2017. There were no questions and the Board **NOTED** the contents of the update.
194-16	**Nomination and remuneration committee** The Chair reported that the Committee had convened on Friday 30 September to agree the appointment of the new Chief Executive, (subsequently approved by the Council of Governors) and also to approve the appointment of the new Medical Director.
195-16	**Annual seal report** To comply with Section 8 of the Trust's Standing Orders, the Board received and **NOTED** a report of all sealings made since the last annual report in November 2015.
196-16	**Draft agenda for January 2017 business meeting** The draft agenda for January 2017 was reviewed and its contents **NOTED** by the Board. JMT also asked the Board to note her advance apologies and that her Deputy would be representing her instead.
Any other business	
197-16	There was none

Observations and feedback	
198-16	**Feedback from key events and other engagement with staff and stakeholders** The Chair reported that the previous day she had attended the unveiling of the Guinea Pig memorial at the national arboretum in Staffordshire, and commended CP for the quality of media coverage generated for the Trust. RT noted that following his imminent departure, his involvement in the Local Workforce Action Board for the STP, and the KSS Leadership Development Programme was set to continue; he was therefore hopeful that his contact with QVH might remain.
199-16	**Questions from members of the public** There were none.

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**
3 November 2016						
1.	**192-16**	Following re-appointment of the Trust's external auditors, assurance to be provided that changes in KPMG personnel relate to the Partner, (and not just their SMT)	**CS**	Jan		**Pending**
1 September 2016						
2.	**153-16**	R & D team to be advised of Board's recommendation for the next R & D A/R to include details of QVH related publications	**EP**	Nov	**03 11 16** Board recommendations forwarded to R&D team via Clinical Lead for Research. Will be reflected in 2017 report.	**Complete**
3.	**157-16**	A report providing quality assurance in respect of new clinical support services to be submitted to Q & GC.	**SJ**	Jan	**03 11 16** SLJ to liaise with JMT as to how best to achieve.	**Pending**
4.	**161-16**	Measurements to assess how FTSU process is perceived by staff to be incorporated in next staff survey.	**GO**	March	**03 11 16** Feedback to be provided to March BoD	**Pending**

Queen Victoria Hospital NHS
NHS Foundation Trust

Chief Executive's Report					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/01/17**		**Agenda reference:**	**04-17**	
Report title:	**Chief Executive's Report**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Steve Jenkin, Chief Executive				
Appendices:	None				
Executive summary					
Purpose:	To update the Board on progress and to provide an update on external issues that may have an impact on the Trust's ability to achieve its internal targets.				
Recommendation:	For the Board 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				
	Date:	19/12/16	Decision:	Review BAF	

CHIEF EXECUTIVE'S REPORT

JANUARY 2017

WELCOME & THANK YOU

In my first chief executive's report, I would like to start by thanking my predecessor Richard Tyler for handing over the leadership baton of QVH, a hospital steeped in heritage with a strong sense of belonging, with loyal, committed and compassionate staff. In Richard's final report he talked of his "privilege and pleasure" in leading such a unique organisation as QVH. In just a few weeks I understand fully those sentiments with the strength and warmth of my welcome from colleagues and the wider community.

TRUST ISSUES

Board Assurance Framework (BAF)
Attached are the BAF front sheet and the corporate risk register.

Segmentation
Under the Single Oversight Framework, NHS Improvement (NHSI) now segment providers based on the level of support each provider needs. The framework was introduced from 1 Oct 2016 replacing the Risk Assessment Framework used by Monitor. The framework helps NHSI identify potential support needs across 5 themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability

The first formal segmentation was published by NHSI on 14 December 2016 and places us as a 2. We have organised a meeting with NHSI on 11 January for both parties to understand the data analysis concerning RTT and shared breaches.

SECTOR ISSUES

Brighton and Sussex University Hospitals NHS Trust
The chief executive and chair of Western Sussex Hospitals Foundation Trust (WSHFT) are to take over the leadership of Brighton and Sussex University Hospitals Trust (BSUH) from April 2017. BSUH in 2016 was placed in special measures for finance and quality and the priorities will be improving quality, securing financial sustainability and improving A & E performance. WSHFT is one of only five acute trusts in England to be rated Outstanding by the Care Quality Commission.

NATIONAL ISSUES

NHS Providers Conference
The health secretary announced a number of workforce related measures that are focussed on flexible working, career progression, leadership and doctors in training in his speech to delegates at the NHS Providers conference in Birmingham in November. Key announcements:

- Development of a 'skills escalator' to progress staff through entry-level apprenticeships to a nursing degree apprenticeship.

- A requirement that, by the end of 2017, all trusts must be meeting the best practice on e-rostering, as outlined in NHS Improvement's best practice guide.
- A new programme and review to encourage more clinicians to go into senior managerial roles.
- A major review of the assessment and appraisal process for junior doctors, to make it simpler and more helpful.

Care Quality Commission
The Care Quality Commission on 13 December 2016 published *Learning, Candour and Accountability*, the report of its review of the way NHS foundation trusts and trusts review and investigate the deaths of patients in England.

The Secretary of State offered the Government's initial response to the House of Commons, announcing a range of measures in response to the recommendations. For trusts, these will include:

From March 31 2017 the boards of all NHS Trusts and Foundation Trusts will be required to:

- Collect and report to NHSI a range of specified information, to be published quarterly (this requirement will be confirmed in new regulations), on deaths that were potentially avoidable and serious incidents and consider what lessons need to be learned on a regular basis.
- This will include estimates of how many deaths could have been prevented in their own organisation and an assessment of why this might vary positively or negatively from the national average, based on methodology adapted by the Royal College of Physicians from work by Professor Nick Black and Dr Helen Hogan.
- Alongside that data, trusts must publish evidence of learning and action that is happening as a consequence of that information.
- Identify a board-level leader (likely the medical director) as patient safety director to take responsibility for this agenda and ensure it is prioritised and resourced within their organisation.
- Appoint a non-executive director to take oversight of progress.
- Follow a new, standardised national framework to be developed for identifying potentially avoidable deaths, reviewing the care provided, and learning from mistakes.
- Government will ensure that investigations of any deaths that may be the result of problems in care are more thorough and genuinely involve families and carers.
- The NHS National Quality Board will draw up guidance on reviewing and learning from the care provided to people who die, in consultation with Keith Conradi, Chief Investigator of Healthcare Safety. These guidelines will be published before the end of March 2017, for implementation by all Trusts in the year starting April 2017.
- Health Education England will review the training for all doctors and nurses with respect both to engaging with patients and families after a tragedy and maintaining their own mental health and resilience in extremely challenging situations.

Steve Jenkin
Chief Executive

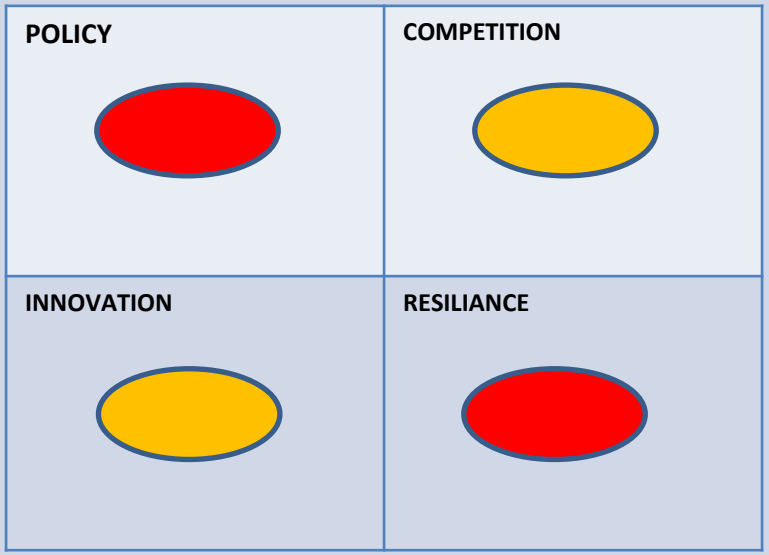
Board Assurance Framework – Risks to achievement of KSOs

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	Q 1	Q 2	Q 3
KSO 1	10	10	10	12
KSO 2	15	15	15	12
KSO 3	15	15	20	20
KSO 4	20	20	20	20
KSO 5	15	15	15	12

Future Threats



Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/01/17**		**Agenda reference:**	**06-17**	
Report title:	**Sussex and East Surrey Sustainability and Transformation Plan**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Steve Jenkin, Chief Executive				
Appendices:	1. Sussex and East Surrey STP (33) 2. Central Sussex and East Surrey Alliance Place-Based Delivery Plan				
Executive summary					
Purpose:	To inform the Board on the publication of the STP and to consider the implications for the wider health economy as well as for QVH itself.				
Recommendation:	To note the report				
Purpose: [one only]	Information	Information	Information	information	Information
Link to key strategic objectives (KSOs): [Tick which KSO(s) this recommendation aims to support]	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *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:	Board Seminar				
	Date:	01/12/16	Decision:	For information	
Next steps:	CEO and EMT colleagues are active participants in the STP Programme Board and various work-streams.				

1.	**Purpose of Report**
1.1	To inform the Board of the publication of the Sussex and East Surrey Sustainability and Transformation Plan (STP) and to consider its implications for the wider population over the next five years.
2.	**Background**
2.1	STPs are plans for the future of health and care services in England. NHS organisations in different parts of the country have been asked to collaborate to respond to the challenges facing local services. 44 STPs have been developed involving NHS organisations, local authorities and the voluntary sector.
2.2	The pressures facing local services are significant and growing, and the timescales available to develop these plans have been extremely tight. The start of the STP process was characterised by a high level of intervention from NHS England and NHS Improvement in defining geographical boundaries for the plans and identifying STP leaders.
2.3	The original purpose of STPs was to support local areas to improve care quality and efficiency of services, develop new models of care, and prioritise prevention and public health. The emphasis from national NHS bodies has shifted over time to focus more heavily on how STPs can bring the NHS into financial balance quickly
3.	**Sussex and East Surrey STP**
3.1	The Sussex and East Surrey STP (Appendix 1) was published on 25 November 2016. The Plan outlines how health and social care organisations will all work together to transform and integrate health and social care services to meet the changing needs of all of the people who live in our area.
3.2	It is a large and diverse region, with 23 organisations serving 1.7m people. There are significant challenges with waiting times and cancer outcomes, alongside a relatively older population. The STP Programme Board has established three “Place-Based” areas (Delivery plans in Appendix 2), each defined around local communities, empowered to co-design person-centred services, led by GPs with support from a wide range of professionals. The challenge is to improve the health of our communities, make it quicker and easier to access services, to deliver improvements identified by regulators and find a way to do so within a tighter budget than the health economy has faced in many years.
3.3	It is the first time that organisations have all worked together in this way and it offers a unique opportunity to bring about positive and genuine improvement in health and social care delivery over the next five years.
3.4	The STP sets out how services need to change over the next five years to achieve the right care for the population; both now and in decades to come. It will build on work already underway to transform local services; and it will help deliver the Five Year Forward View (NHS England) which sets out the national vision for health.
4.	**Case for Change**
4.1	Patients are receiving varied care across the footprint, this combined with poor health outcomes for some means that people are suffering unnecessarily. Coupled with poor patient experience and poor health for some, the financial burden across the area is growing. This can be broken down as the ‘case for change’:
4.2	Health & Wellbeing Gap – older population, longer life expectancy, complex needs (prevalence of dementia, some areas of severe deprivation, high numbers of looked after children).
4.3	Quality Gap – quality of care is inconsistent, although most people who use local services

	report positive experiences – but pressures on services, timeliness, communication, cancellations, waiting times, cancer outcomes, access to GP appointments, delayed transfers of care, demand on urgent care.
4.4	Financial Gap - across Sussex and East Surrey Health and Social Care there is a budget of £4bn; without change an anticipated shortfall in budgets of £865m, compared to what we think people will need, by 2020/21. Additionally three organisations in the area under special measures or regulatory action.
5.	**Place-Based Care**
5.1	Across the STP there is a strong history of local engagement and the development of "place-based" care. Organisations will work together to build on this work; therefore the STP is being delivered by three defined geographical areas. These are: • Coastal Care • Central Sussex and East Surrey Alliance (QVH is located within this 'place') • East Sussex Better Together
5.2	Each place has built, or is building, a model that best responds to both local health and social care needs; and in the context of the health and social care organisations in the region. However, organisations are continually working across the STP to identify areas where they can combine collective expertise and resources. Currently three STP wide priorities have been prioritised; and there are local leaders to work across the area on developing and sharing the best models of care. These are: • Urgent and Emergency Care • Frailty • Primary care
5.3	Within the Central Sussex and East Surrey Alliance place-based system, there will be 20 care hubs built around GP clusters each serving a 50k population. These care hubs will become the delivery units for a new organisational entity known as a Multi-Specialty Community Provider (MCP) which will be in place by 2020. Its aim will be to integrate community health, mental health, social care and third sector support in order to improve the care provided to the local population, improve health outcomes and drive a greater level of efficiency across the whole system.
5.4	Four clinical priorities for hubs to re-design: 1. Prevention 2. Urgent care 3. Long term condition management 4. Frail and complex patients
6.	**Progress**
6.1	A Programme Director has been appointed to support the work of the STP funded by the 23 organisations involved.
6.2	Partners will need to continue to work together to bring about the 'triple aim' of: 1. Improving the health and well-being of the local population 2. Improve the quality of local health and care services 3. Deliver financial stability for the health and care system
6.3	The publication of the STP starts off a period of engagement and consultation with local people and their respective communities. Decisions to implement changes can only take place after and with sound public engagement. There is a strong desire for communities to

	work alongside organisations and to join the STP wide conversation to co-design services that are shaped and sustained for the future.
7.	**Summary**
7.1	The STP work is a huge challenge; but there is a pressing case for change. The current health and social care system isn't setup to meet the needs of today's population. Many more people are living longer and there are more and better treatments available and this means that people want and need a different kind of care. Most people get good care in the current system most of the time; services are not always good enough - for example people sometimes wait too long and providers can't always recruit enough staff. At the same time, like many areas across the country, the health and social care economy is facing a big financial problem.
7.2	QVH is strongly placed to support both the development of community care, as reflected in our work within the Healthy East Grinstead Partnership, and a networked approach to specialist acute care as already reflected in our hub and spoke arrangements across both Sussex and Kent.

Sussex and East Surrey Sustainability & Transformation Plan

WORK IN PROGRESS

Name of footprint and no: Sussex and East Surrey (33)

Region: NHSE South

Nominated lead of the footprint including organisation/function: Michael Wilson, Chief Executive, Surrey and Sussex Healthcare NHS Trust

Contact details (email): *Michael.Wilson@sash.nhs.uk*

22nd November 2016

Our "plan on a page"

WORK IN PROGRESS

Sussex & East Surrey Sustainability & Transformation Plan

Context and challenges: We are a large and diverse region, with 23 organisations serving 1.7m people. We have significant challenges with waiting times and cancer outcomes, alongside a relatively older population. We have established three "Place-Based" areas (Delivery plans in Appendix B), each defined around local communities, empowered to co-design person-centred services, led by GPs with support from a wide range of professionals. Our challenge is to improve the health of our communities, make it quicker and easier to access services, to deliver improvements identified by regulators and find a way to do so within a tighter budget than we have faced in many years.

Benefits:

Years 1-2	Years 3-4	Year 5
Quality: Waiting time targets met or exceeded, All trusts exit special measures, all GPs working in a new way, e.g. in a locality and delivering person-centred frailty models. GP appointments available more readily for all communities.	**Quality:** Each Place to have at least one walk-in primary urgent care with max 30 min wait. Hospital performance in top quartile for all measures. All services to have full mind and body integration/approach	**Quality**: patients report having full ownership of care and wellbeing for all LTCs and frailty
Performance: Delivery of agreed trajectories in year 1. Further improvement in performance in year 2.	**Performance**: Minimum constitutional targets met and improved outcomes where performance is poor e.g. lung cancer, EIP and IAPT Access delivered,	**Performance:** Prevention goals achieved, ~20% reduction in bed days per 1,000 population
Finance: Overall position improved by £147m	**Finance**: Further efficiencies of £279m delivered	**Finance:** overall position £60m deficit

Priorities:

Years 1-2: Addressing the quality and performance gap

Place based transformation:
Accountable Care: ESBT/Coastal new models in place by Year 2 with pooled budgets Y1 in ESBT. CSESA significant progress towards MCP and collaborative commissioning
Primary care: Make GP services easier to access and work better for patients, and integrate multidisciplinary teams.
Frailty (primary care): led by primary care, develop services for older people that respond to their complex needs;
New primary and community urgent care models: networked with acute hospitals, aiming to make better use of resources

Whole system: acute recovery plan (Appendix C):
Capacity review: making the best use of existing beds
Community beds: new community beds (primary care and community led in partnership with BSUH and ESHT)
Elective redesign: share resources to improve efficiency
Discharge delays: reduce blockages in the care system to free up capacity to care for those who need it most
Networked hospital care: working together on cancer, stroke, pathology and imaging, and to deliver seven day services

Years 3-4: Accelerating transformation

Place based transformation:
Accountable Care: place-based decision making and financial incentives implemented, e.g. capitated budgets
Innovation across all LTC pathways, primary care and mental health: each place empowered to drive local transformation building on best practice sharing
Workforce transformation: training for new roles and workforce productivity plans implemented and contracts to underpin community based models and deliver a motivated and engaged workforce
Mind and body care: all models to have full "holistic" approach

Provider sustainability:
Elective centre: Build on initial partnerships to deliver transformed model across whole STP footprint
Networks for DGH services: mapped patient pathways to underpin new model of acute collaboration through acute networks
Specialised integration: ensure delivery of transformational schemes to underpin future configuration around Brighton

Year 5: Embed transformation

Transformed Place based care:
Continue to transform and integrate care, led by GPs and integrated mind and body teams, with further local innovation and tailoring to deliver the needs of local populations to remain independent and healthy

Completion of:
Deliver future Brighton hospital: MTC and teaching hospital
Deliver on patient pathway integration and implications for acute sites

Supported by: Estates | Digital | Workforce | Comms & Engagement

Executive summary

WORK IN PROGRESS

This document summarises our work in progress plans to improve the quality of care patients receive, make it easier to see a GP or to use specialist services and to deliver services within the money available. It builds upon our submission of 30th June 2016, and should be seen as work in progress to guide delivery of change. We will need to co-create the detail of solutions with local communities and we will significantly expand our engagement activities to achieve this.

We are committed to working as an STP footprint as we believe this is the only way to achieve change at scale and specifically to achieve acute networking and pathways, support our tertiary services and facilitate transformation in partnership with organisations that span the whole footprint (mental health and community).

Our STP footprint shares the challenges and opportunities of the rest of the country in delivering the triple aim of STPs, with particular challenges locally due to our population demographics, performance of some providers and CCGs and our overall outcomes particularly in Cancer.

Our aspirations for longer term transformation and delivery of the 5YFV, including GP and Mental Health 5YFV will be driven by our three “places” – with each aiming for an accountable care model, and an agreed focus on three areas for next year as an STP (in addition to local priorities): frailty, urgent care and primary care transformation. We have significantly progressed our governance as an STP to enable this local work to flourish, and there has been significant movement in the development of localities or care practice groups of GPs in each of our areas. (Appendix B for delivery plans)

The added value of working as an STP across the three places is the ability to share learning and speed up transformation and to make clear links between the granular person centred care plans and our commitment to furthering acute networking for secondary services as a whole STP.

We acknowledge that despite this good progress we have some particularly acute challenges that require focus in the short term to deliver system sustainability this winter:

- Operational performance challenges in A&E and RTT, and for Cancer
- Significant financial challenges at a number of trusts and commissioners; most notably BSUH, but also ESHT, SECAmb and two CCGs

We believe that the largest opportunity to solve these issues and prepare for winter is to maximise the number of acute beds, particularly across BSUH sites, where approx. 86 have been lost in the past year, and at ESHT where there is a projected shortfall of 66 beds between the two sites. (Appendix C for recovery plans)

Our STP has brought organisations together to develop a shared plan to solve the bed shortage. These resilience plans are founded upon a mix of: opening additional capacity at RSC site through internal reconfiguration and optimisation of space, opening additional community beds at existing sites, and working in partnership with social care to deliver nursing solutions to decompress acute sites. These are in addition to whole system daily capacity management “operations rooms” that have been established by ESBT and are being designed rapidly for Brighton and catchment.

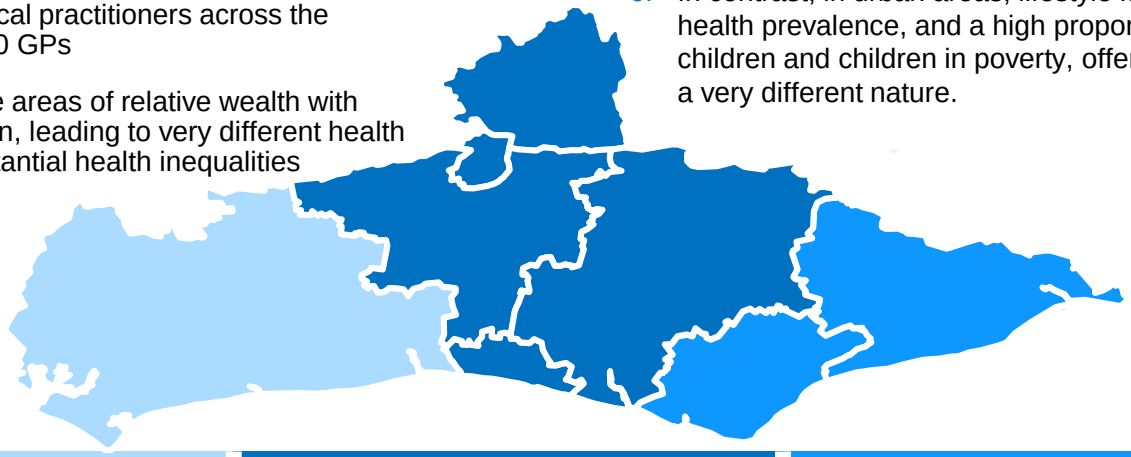
We have a history of working in acute networks e.g. vascular/stroke services and our aspiration is to build on this to design a networked future for secondary care. The detailed work for this winter has also rapidly progressed a number of medium term actions for years 2 and 3, that will link with this networking including elective care factory, balancing capacity for both daycase and elective work across sites and driving economies of scale.

We remain committed to delivering the efficiency improvements set out by the centre. However we have found that the scale of our starting performance and finance challenge raises concerns around material safety issues in relation to winter capacity. Therefore we will not be able to submit a plan that balances and meets CCG business rules in all years. We have not made this trade off lightly and are keen to discuss and test our assumptions with you, as well as to continue to work to find solutions to further close the gap.

WORK IN PROGRESS

Our sustainability and transformation footprint

1. Our footprint is home to 1.7 million people providing health and social care at a cost of £4bn
2. 23 partner organisations are involved across all health and social care sectors
3. There are over 37,000 medical practitioners across the footprint including over 1,000 GPs
4. The footprint combines large areas of relative wealth with pockets of severe deprivation, leading to very different health challenges, along with substantial health inequalities
5. We have a larger than average elderly and ageing population, which when combined with the rural areas and variable transport links makes supporting this complex and vulnerable cohort a significant challenge.
6. In contrast, in urban areas, lifestyle factors and mental health prevalence, and a high proportion of looked after children and children in poverty, offer equal challenges of a very different nature.



Coastal Care

Coastal West Sussex CCG
Sussex Community NHS Foundation Trust **(SCFT)**
Sussex Partnership NHS Foundation Trust **(SPFT)**
West Sussex County Council
Western Sussex Hospitals NHS Foundation Trust **(WSHFT)**
South East Coast Ambulance Service **(SECAmb)**
GP Providers
IC24

Central Sussex & East Surrey Alliance (CSESA)

East Surrey CCG
Crawley CCG
Horsham & Mid Sussex CCG
Brighton & Hove CCG
High Weald Lewes Havens CCG
Queen Victoria Hospital NHS Foundation Trust **(QVH)**
Surrey & Sussex Healthcare NHS Trust **(SaSH)**
Surrey & Borders Partnership NHS Foundation Trust **(SaBP)**
Brighton & Sussex University Hospitals NHS Trust **(BSUH)**
Sussex Community NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
Brighton & Hove City Council
West Sussex County Council
East Sussex County Council
Surrey County Council
First Community Health & Care
SECAmb
GP Providers
IC24

ESBT

Eastbourne, Hailsham and Seaford CCG
Hastings and Rother CCG
East Sussex Healthcare NHS Trust **(ESHT)**
East Sussex County Council
Sussex Partnership NHS Foundation Trust
SECAmb
GP Providers
IC24

Our vision for Sussex and East Surrey

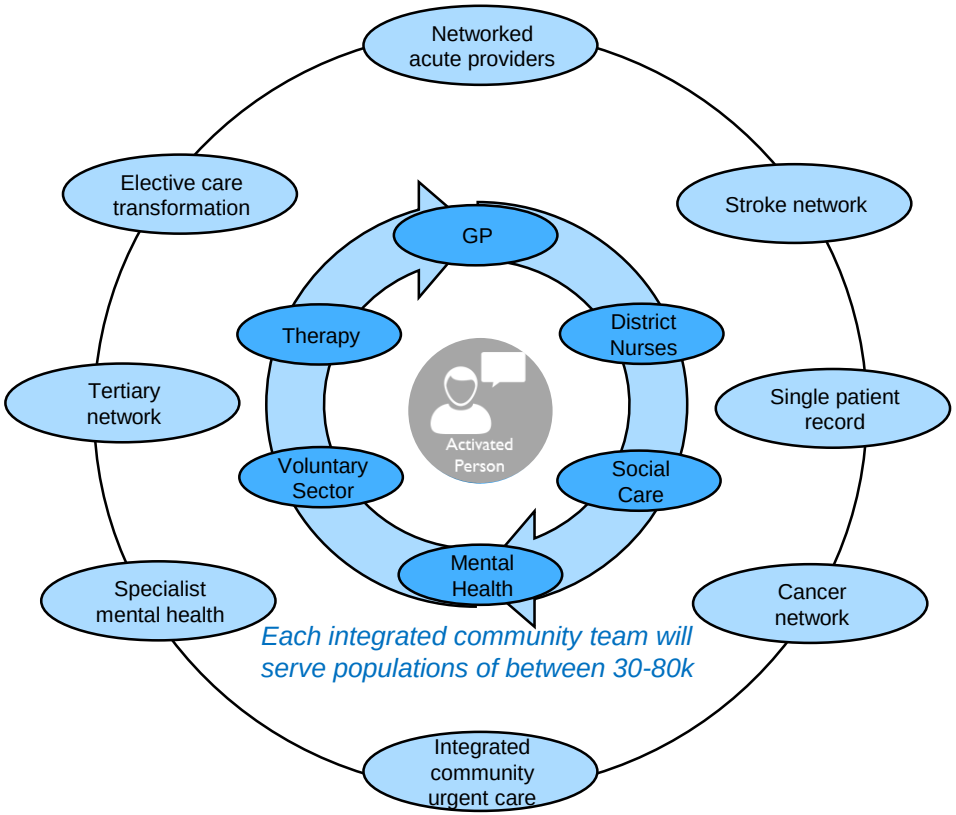
WORK IN PROGRESS

Key principles

1. Full engagement of local populations to support us in delivering the best outcomes with available resources
2. Led by place-based integrated care in our 3 “places” to be responsive to the range of needs of our population
3. Focused on prevention and proactive care through multidisciplinary locality teams supported by a shift in investment towards Primary Care and Community
4. Supported by a provider sector that collaborates to network services, share workforce, and balance capacity across the system
5. Move at pace, and support local organisations to go as fast as they can, recognising different starting points of each of the 3 Places

Our Ambition

- Our ambition is to improve population health and wellbeing by working together as an STP footprint
- Prevention and self-care is central to all of our plans to prevent illness and enable people to live well
- The care you receive will be integrated and all of the people and organisations involved will be centred around you and in communication with each other
- Where care is more specialist – this care will be provided through acute clinical networks to ensure that you receive the highest quality care that meets your needs
- We are committed to having one shared patient record – this means that you will not have to repeat your patient history each time you meet someone new



Each integrated community team will serve populations of between 30-80k

Hospital and specialist mental health services will be arranged over appropriate populations, i.e. 1m to 2m

How has the footprint responded to feedback received on the June 30th submission

WORK IN PROGRESS

	Feedback received from NHSE/NHSI in July 2016	Actions implemented since June 30th
Leadership and Governance	▪ Governance and behaviours should facilitate stronger collective leadership ▪ Streamline governance and ensure appropriate decision making can occur at pace ▪ Move quickly to address leadership issues where possible ▪ Describe and resource additional programme support arrangements and establish at pace ▪ Work closely with Kent on cross-border issues	▪ Single system leadership (SPoLs) now in place across our three "Places" ▪ Programme Board Executive created to drive STP-wide progress with agreed behaviours and principles as contained in Appendix A of this document ▪ Workstreams reviewed and enhanced to focus on delivery with Chairs in post to drive change ▪ Programme resource planning – programme director interviews held and offer made ▪ Engagement with Kent STP leaders to align plans
Transformation of local care through "Places"	▪ Provide clearer plans on how the STP will move forward to address the quality gap ▪ Clarity on how place-based plans are being developed in light of the STP ▪ Clarify engagement with local authorities in Estates discussions ▪ Ensure delivery of Primary Care five year forward view is embedded in places ▪ Stronger plans for Mental Health, drawing on the Five Year Forward View	▪ Place based delivery plans accelerated (note differing starting points) – clarity on vision, governance, resourcing, clinical models, contracting and finance, and enabling streams. ▪ Local transformation teams now present in all three places ▪ Clear future state identified for each place, with plans to deliver in Years 1&2, two accountable care models and one commissioner collaborative with an MCP ▪ Further testing of basis (including evidence base) for plans ▪ A Mental Health review panel (across the three places) has reviewed each of the place-based plans to ensure that the main priorities of the MH5YFV are in place ▪ Significant engagement of primary care colleagues in development of all place-based plans
Provider collaboration and transformation	▪ Identification of more radical solutions to close the finance gap ▪ Further develop the options for sustainable acute and specialised services ▪ Ensure compelling case for 3Ts model is developed and is consistent with the STP plans	▪ Agreement to build on existing acute networks to identify future models for networked DGH provision, building on pathways of care that integrate with place-based plans ▪ NHSE led work to assess requirements and sustainability of MTC at BSUH to report December 2016 ▪ Strategy for sustainable elective care in development, building on analysis and ensuring delivery of RTT

Overview of the challenge we face

WORK IN PROGRESS

- Patients are receiving varied care across the footprint, this combined with poor health outcomes for some means that people are suffering unnecessarily. Coupled with poor patient experience and poor health for some, the financial burden across the footprint is growing. Consequently all stakeholders need to work together to successfully improve care for all in Sussex and East Surrey.

Health & Wellbeing Gap

- The STP footprint has a growing and ageing population, with an increasing number of people suffering from long term conditions (LTCs) and in particular a significant older population living with multiple LTCs. Health is poor in some areas of the footprint, notably in in coastal towns, where pockets of deprivation across the STP lead to significantly poorer health outcomes and fewer disability free years of life lived.
- Specifically, we have gaps across the footprint relating to:
  - Smoking: above average smoking rates amongst 15 year-olds, and some localities with high adult smoking rates
  - Cancer: we perform poorly on 1-year cancer survival, driven in particular by lung cancer
  - Obesity: we have above average rates of adult obesity
  - Mental health: above-average rates of hospitalisation for self-harm

Care & Quality Gap

- We have significant problems in primary care – specifically to patients unable to book appointments within a reasonable time period, old buildings that are not fit for purpose and high vacancy openings that GP surgeries are struggling to fill.
- Within our hospitals:
  - ESHT, BSUH and SECAmb are in special measures
  - Referral to Treatment times, cancer waits and A&E 4-hour performance continue to decline, and are getting worse
  - High vacancies are resulting in very high levels of bank and agency use which is adding further pressure on finances
- Care & Quality problems also exist in other sectors, with variable performance in mental health care, issues in recruitment within social care, and capacity issues where care homes have closed.
- Care and quality issues relating to specific physical and mental health conditions include:
  1. Cancer: early diagnosis rates and poor patient experience
  2. Stroke outcomes: particularly rehabilitation and social support
  3. Mental health detection, access and outcomes
  4. Management of long term conditions (e.g., respiratory): prevention and support
  5. Support to the frail and elderly: End-of-life care, organisational and funding structures
  6. Maternity and children's services: perinatal services, complex families and poverty

Finance & Efficiency Gap

- Total allocated funds for CCGs, primary care, social care and specialised commissioning was £4bn in 16/17.
- In 15/16, the financial gap STP-wide was £127m.
- The ‘do nothing’ financial gap by 2020-21 is predicted to be £864m.
- ESHT and BSUH are in financial special measures.
- STP-wide efficiencies and new models of care must make better use of the £4bn to address this growing financial challenge.
- In November 2016, all organisations within this footprint will reforecast their financial position. This will also give a clearer indication of the system as a whole and will enable STP financial planning from a stable foundation

Transforming care through our 3 localities

Our STP is comprised of 3 'places' responsible for locally driven community and integrated care with the aim of improving health outcomes for our communities and reducing avoidable illness and health and care expenditure.

Each place is building a model that best responds to both the local health needs and context of the health and care organisations in the region, however many commonalities exist between them. Each place will oversee radical clinical transformation of LTCs, frailty, mental health, community, social care, general practice and urgent services to transform outcomes and quality.

Coastal Care

Model: Accountable care model with one capitated budget

Ambition: to take our good care and make it excellent, working together as partners to improve the health and wellbeing of the population, to improve outcomes for individuals and to deliver better value for money.

Strategic objectives:

- Enhance primary and community care and focus on population wellbeing and early intervention to reduce demand for hospital services
- Successful integration of teams and providers

Initial priorities:

- Develop Local Clinical Networks
- Tackle the challenge of the ageing population
- Redesign urgent care services
- Implement new pathways for planned care
- Carry out targeted service improvements for children to enhance physical and mental wellbeing

Predicted benefits:

- Enhanced primary care
- Sustainable community, mental health and social care provision
- Improved access to specialist expertise
- Communities engaged and developed
- Reduce spend on traditional hospital care by £44m by 20/21 (8%)

Central Sussex & East Surrey Alliance (CSESA)

Model: Multispecialty community provider (MCP)

Vision: To develop pro-active, community-centric and more integrated health system, led by primary care that promotes wellbeing, self care and care closer to home.

Strategic objectives:

- Care designed for the needs of local populations
- Successful integration of providers
- Sustainability of primary care, acute care, community and mental health care

Initial priorities:

- Improve prevention and self care
- Better access to urgent care
- Continuity of care for patients with LTCs
- Coordinated care for frail and complex patients
- System-wide higher quality and performance

Predicted benefits:

- Reduction in emergency and planned admissions
- More episodes of care in the community
- Increased quality of care and patient satisfaction
- Stable, sustainable workforce
- Sustainable primary and acute providers along with sustainable community, mental health and social care provision
- Reduce spend on traditional hospital care by £80m by 20/21 (12%)

East Sussex Better Together (ESBT)

Model: Accountable Care model with capitated funding and pooled budgets

Vision: Develop a fully integrated health and social care system, ensuring every patient enjoys proactive, joined-up care and is able to live fully within the community.

Strategic objectives:

- Improve health outcomes of the population
- Enhance the quality and experience of people's care
- Reduce the per-capita cost of care

Initial priorities:

- Pooled budget Year 1, full ACM in Year 2
- Develop new Integrated Locality Teams
- Provide streamlined points of access for health and social care services
- Develop new models for GP-led urgent and emergency care
- Increase efforts to prevent illness and to promote healthy living and wellbeing

Predicted benefits:

- Improved community health and wellbeing
- Better user experience of services
- Cost of care is sustainable and affordable
- Staff able to make the most of their dedication, skills and professionalism
- Reduce spend on traditional hospital care by £44m by 20/21 (14%)

WORK IN PROGRESS

STP-wide place-based priorities (Years 1-2)

Since June, this STP has sought to collaborate in a way that has not existed before now. Our leaders recognise we can do more for our communities, faster, if we work on the following priorities collaboratively across the three places. Whilst the models will differ according to local context, there are strong commonalities in approach.

	Urgent & Emergency Care	Frailty	Primary Care
SRO	Marianne Griffiths	Keith Hinkley	Geraldine Hoban
Case for change	Currently the STP footprint is experiencing a high number of avoidable A&E attends in part due to inconsistent opening hours across each of the three places. Links to GP services also require strengthening to deliver a 'joined-up' system.	Our STP footprint has an older than average population, and, in common with the rest of the country, services are currently fragmented and do not support people to live independently.	A lack of historic investment and significant shortages of GPs across the footprint has resulted in multiple list closures and the population struggling to access primary care in places.
Vision	For all Urgent & Emergency Care Centres to be networked and linked with an ED, and embedded in a primary care community of practice, to enable a highly responsive service and for patients to be cared for as close to home as possible.	People living with frailty to be treated proactively in a coordinated and well managed way. Patients receive care that better reflects the complexity of their needs, closer to home and in the community as much as possible.	Strengthened GP services, through locality teams (or communities of practice), that coordinate care of patients – improving access, outcomes and delivering greater value to communities from available funding.
Benefits	▪ Improved A&E performance – key underpinning action to achieve target trajectories ▪ Better support for people and their families to self-care or care for their dependents ▪ Availability of the right advice in the right place, first time; ▪ Responsive, urgent physical and mental health services outside of hospital at any time of day, every day of the week	▪ People supported to live independently for as long as possible ▪ Reduction in unplanned, avoidable admissions and reduced length of stay in acute hospital resulting in reductions (up to) 18% in total bed use within an acute care setting ▪ Substantial reduction in outpatient appointments in acute settings ▪ Patients dying in their place of choice	▪ Underpins our transformation model and is core to future delivery of integrated care ▪ Individuals supported to manage their own conditions and stay well as much as possible ▪ Improved system performance, across A&E, RTT and financial efficiency
Year 1 Priority	▪ Define operating model for UCCs, including an STP wide service specification ▪ Review current services and work with providers on rapid action plan to improve, or identify need for retendering ▪ Oversee implementation of plan to agreed timescales (within year 1/2)	▪ Implementation at pace in ESBT and learning to be shared, including proactive care, integrated locality teams and personal resilience schemes ▪ Agree STP-wide principles for implementation ▪ Coordinate with hospices, third sector and voluntary organisations	▪ Complete design of primary care models to deliver the GP 5YFV and ten high impact changes ▪ Ensure implementation trajectory to enable pace of plans – i.e. new models implemented for all practices no later than 2017/18

WORK IN PROGRESS

Our STP plan for this winter

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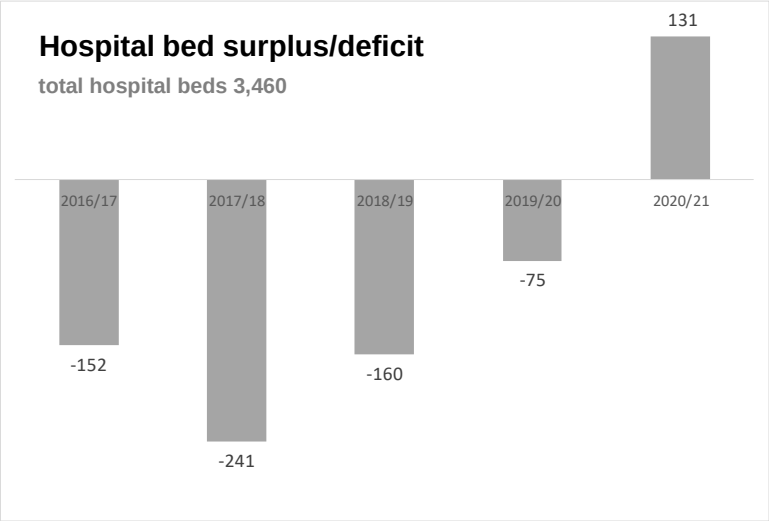


Our challenge

We have an immediate capacity shortfall (of around 3% of hospital beds) that we think will continue, and peak, next year, before our "person-centred" models begin to change the number of hospital beds needed.

There are three hospitals that will face particular pressure, Brighton (Royal Sussex County site), Eastbourne, and Hastings.

We have worked together as an STP to explore opportunities to make best use of space at existing hospitals. We have worked in partnership with social care and community providers, and have found alternative beds where patients no longer need medical care but aren't yet ready to return home.

Our solutions

We have developed an immediate action plan, summarised below, and are continuing to develop further opportunities as an STP, both to mitigate any under-delivery and to prepare for next winter.

Immediate actions:

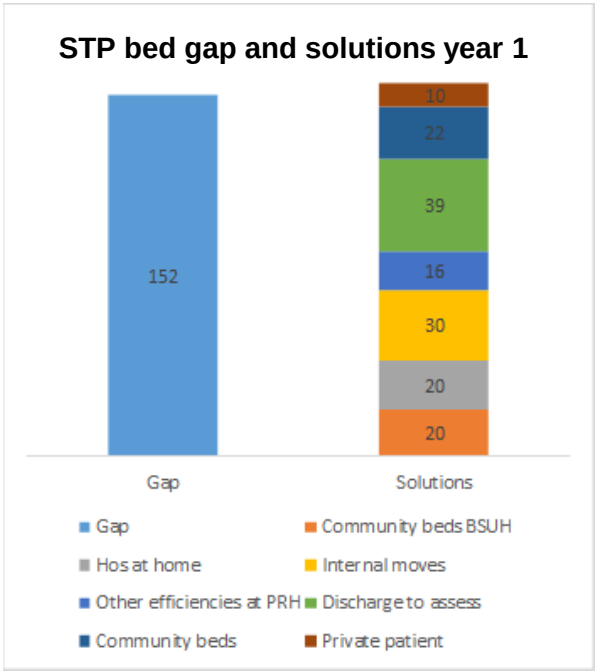
At RSC in Brighton: 20 beds at a community site: with a nursing model and active management of capacity for rapid discharge, 20 beds through "Hospital at Home" expansion: focussing on improving quality of care for this cohort of patients, rather than making them wait in acute beds for rehab, and 30 beds through internal movement of services and better use of existing estate

For Eastbourne and Hastings: 39 community beds through the "discharge to assess" programme where patients do not need to stay in hospital but don't yet have the support to live at home, 22 additional beds opened in existing community hospitals that were closed over the summer, and10 beds internal movement of services and better use of existing estate

Subsequent actions requiring further planning:

The STP will monitor fortnightly and accelerate any plans if additional risks come to light or there is any unexpected surge in demand.

The additional actions being explored include: Identification of a small number of tertiary services that could be temporarily diverted to relieve pressure, new models at the front door, conversion of non-clinical space, extension of use of community beds and building temporary beds.



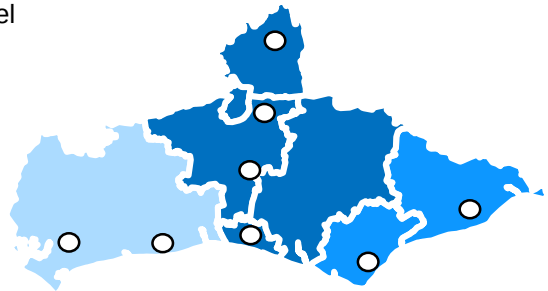
*After adjustments for unmet demand, target occupancy and winter surge capacity.
Sources: Modelling by 2020 Delivery, based on BSUH 3Ts model and EY Benchmarking 2015. Beds from national sitrep data; growth and impacts of place-based care and prevention from STP financial model

Long term provider sustainability (2-5 year plan)

WORK IN PROGRESS

Acute sector sustainability challenge

- Within our STP we have a history of collaboration and successful networking around a range of specialist and tertiary services, including vascular, stroke, cancer and others.
- We recognise that our place-based, integrated plans will mean that patients will less frequently need to travel to hospital for care, and are built upon an increase in primary care and community care capacity.
- Opportunities through improved digital technology will allow further networking of services, with doctors in one hospital able to provide support and input to the team caring for a patient in another part of the patch, however there will remain a mis-match in available capacity and local demand between our sites,
- We also have a significant financial sustainability challenge in our acute sector, which may increase if services change but the model of provision and care pathways do not evolve at sufficient pace.
- We are now considering how we work together as an STP to support individual organisations around DGH services that we believe will become unsustainable over time. This work is about extending and furthering the existing networks and collaboration across the patch.
- We recognise that this discussion also needs to link with the outcomes of the NHS England led work assessing the requirements and sustainability for an MTC at RSC in Brighton, alongside teaching and tertiary services



Our acute sustainability solutions

Short Term → **Medium Term**

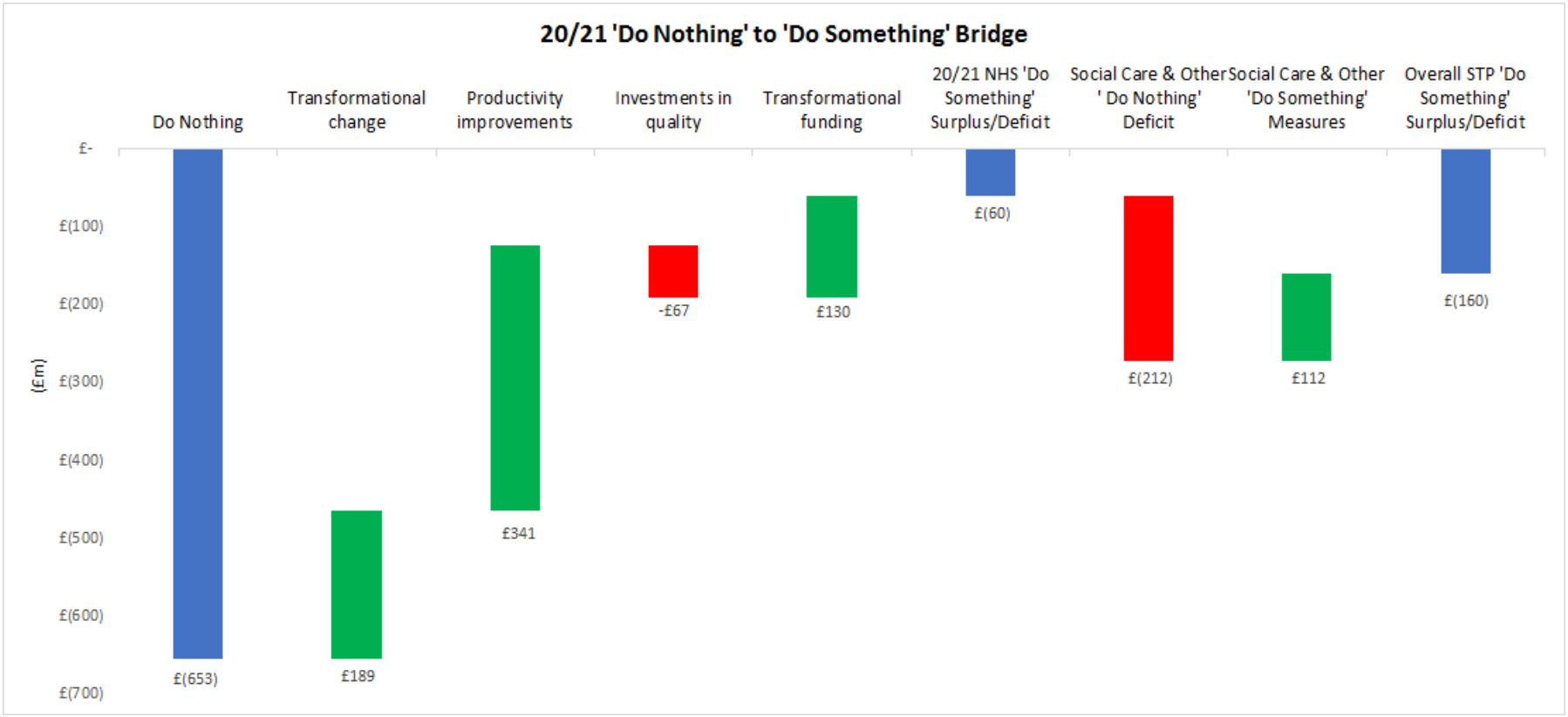
Elective care collaboration: partnership discussions are underway between hospitals
Specialised transformation: work closely with Specialised Commissioning on transformational QIPP schemes in addition to successful completion of MTC review at BSUH
Efficiency: pathology and imaging collaboration
Networks: working together to design how we will work as an STP on networked DGH services
Alignment with person-centred care: networking with local urgent care centres
for quality of care

Elective factory: further develop scope to reduce waiting times and increase efficiency
Alignment with ACO Models: our providers participate in our ACOs in different ways, but we intend to maximise access and use of services at all sites including for integrated care models
Complete the detailed design and implications of our future networked model to deliver sustainability as an STP

Brighton hospital re-development underway: working through networks with other providers and with underpinning specialised services model to support complete
Patient pathways for all sites mapped and delivered: through networks across sites and providers
Whole system performance transformed: aiming for top quartile nationally

Financial position by 2020/21

WORK IN PROGRESS



- Our financial plan includes £530m of net savings across the NHS resulting in a residual deficit of £60m
- An additional £112m of social care efficiencies have been identified. We continue to work with colleagues in LAs to understand and develop a response to financial pressures they face and how we ensure our plans effectively mitigate this too
- Our plan includes £140m of recurrent investment in quality by 20/21 to deliver the service improvements outlined in the NHS Five Year Forward View (£73m is in the “Do Nothing” position and £67m is shown above)
- In addition to a £450m transformation of the Royal Sussex County Hospital site, we are planning a number of strategic capital projects to develop the estate and digital infrastructure that our transformative new models of care need to thrive (see appendix D3)

Integrating mental health with physical health across our footprint

Our June submission highlighted the case for change across the footprint and since then we have created a Mental Health Review team to ensure each place-based plan delivers the MH5YFV . In managing the challenges of the years ahead, the **integration of mental and physical health** is at the core of our wider strategic thinking, enabling opportunities to co-design and improve access to care and treatment that is holistic, timely, of a high quality and delivered in an appropriate non stigmatising setting. The footprint is committed to ensuring that the investment identified for mental health is spent on addressing the priorities identified in the MH5YFV & Transforming Care for People with Learning Disabilities and where there are gaps in service provision and variation in practice and outcomes across Sussex and East Surrey.

Priority	Our future vision/what is going to be different?	Actions to be implemented
1. Specialist Services	Developing new models of care and integrated pathways which focus on early intervention and prevention to avoid Tier 4 inpatient admissions, support early discharge, treatment and repatriation as close to home as possible.	▪ To work with NHSE to establish Specialist Commissioning arrangements for: CAMHS Tier 4, Eating Disorders, Personality Disorders forensics & people with learning difficulties and expand perinatal mental health services ▪ To develop new evidence based pathways and models of care that support admission avoidance and reduced lengths of stay.
2. Integration of Mental Health with Physical Health	Co-designed networked operating model developed with each place based plan & local populations that connects across the wider health and social care system, embedding the principles of integrated mental & physical wellbeing and providing a seamless interface with primary, acute and out of hospital care services and a 'no wrong door approach.'.	▪ Explore New Care Models that support the integration of mental, physical and social care across the system. ▪ Co-design a connected networked model for mental health that provides a seamless interface for people of all ages and levels of ability, exploring options for integration, single point of access, co-location, estates optimisation, common & shared governance, & outcomes. ▪ Implementing Making Every Contact Count Training across the whole workforce
3. Gaps in Primary Care Provision	Improved access and availability of mental health knowledge and expertise in primary care to include early diagnosis and treatment of people with dementia & long term conditions and improved access to holistic care for people with mental health and / or a learning disability	▪ To explore evidence based approaches that support good physical & mental health and wellbeing in primary care including: increased access to IAPT across long term conditions & integrated with physical healthcare; increase in dementia diagnosis rates. ▪ Establish primary care pilots during 17/18 e.g. to co-locate integrated mental health within GP services & expand Sussex Youth service model (i-Rock) ▪ Build on Dementia Crisis team in Coastal W. Sussex and Golden Ticket in High Weald Lewes & Havens and rolling this scheme out wider across the footprint by 17/18. ▪ Build on learning of Technology integrated Health Management (Dementia) Innovation Test Bed.
4. Citizen Led Prevention and self management	We will create resilient communities and engage citizens in activities that improve awareness & understanding of the psychological determinants of ill health including factors that underpin poor lifestyle choices.	▪ Develop in-reach emotional wellbeing support to the PHSE syllabus in schools by exploring and providing actual & virtual initiatives ▪ Implementing MECC across the whole health & social care workforce ▪ Expand Recovery College & Social Prescribing models.
5. Managing Crisis Well	People experiencing mental health crises will have rapid access to a range of well coordinated community care options and high quality inpatient provision, supported by an effective Crisis Care Concordat, that will impact on the wider system by reducing pressure on acute services, reducing non elective admissions, attendances at A&E and lengths of stay and provide opportunities for estates optimisation.	In 17/18 commit to develop and invest in a range of approaches to address gaps in quality & service provision: ▪ Expand evidence based Psychiatric Liaison model ▪ Expand model of Crisis Response & Home Treatment 24/7 ▪ Implement Single Point of Access for Urgent and Crisis Care ▪ Expand out of hospital networks of support e.g. Safe Haven model & Street Triage ▪ Review quality and capacity for acute inpatient and intensive care services
6. Increase Digital maturity & Shared Digital Record	There will be full interoperability of healthcare records across the health & care system that supports people in telling their story only once. We will have developed a digitally competent workforce.	▪ Implement integrated care records through the Digital Road Map. ▪ Identify training and development needs of the workforce to embrace new healthcare technologies that create efficiencies and improve quality of care.

WORK IN PROGRESS

Digital transformation plan

WORK IN PROGRESS

Digital is a key enabler of our STP. In learning from the past we are proposing a multi track approach to Digital development that we believe will deliver the best outcome for the Citizen and the Health and Care professional. In parallel we are responding to feedback from NHSE on the detailed elements of our Local Digital Roadmap. With significant central finance available to support Digital Transformation we will build detailed plans to maximise benefit to citizens and staff.

Strategic approach

Digital Solutions that most benefit from scale in terms of procurement, cost, and integration capability, are implemented at STP level, not separately within each Place.

Integrate the Digital Team with the priority care pathways to support digitisation of both the professional and citizen journey

As the Place based models mature we will develop solutions by place that can best meet the business requirements. These developments will be subject to STP Digital Goverance to ensure we balance speed with efficiency

Proactively engage with Health & Care professionals.

We will explore the value of using resources more effectively at a Place and STP level to deliver the most financial and service benefit.

Priorities

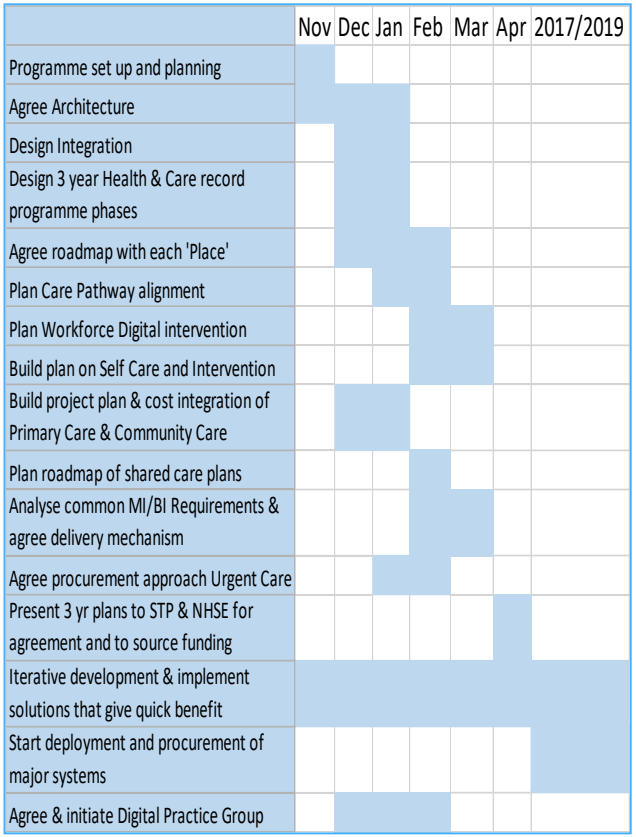
STP Wide

- Shared Digital Care Record (Physical & Mental Health, Community & Social Care).
- Urgent Care technology as part of the 111 procurement.
- Shared Infrastructure.
- Importing learning from other footprints E.g. Digitisation of Cancer Pathways.
- Supporting Workforce work stream in secondary care resource optimisation
- Health & Social Care Practice Group

Place Based

- Consolidation of Primary Care Systems and integration with Community Care Systems.
- Shared Health & Social Care, Care Plans.
- Development of operational technology to run the Place based systems . Analytics to enable Place based performance measurement.
- Prevention and self care technology
- E Consultations
- Interactions between Secondary & Primary Care

Programme Plan

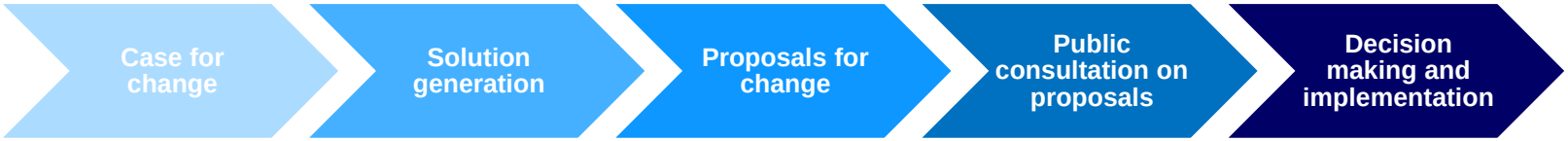


Continuing to engage our population: our patients, the public, our workforce, and our culture

WORK IN PROGRESS

- We believe passionately that public/patient engagement is not just a duty; but the pre-requisite for effective service improvement; from collectively identifying problems and designing solutions to influencing delivery and review.
- Our communications and stakeholder engagement plan is a working document that is being crafted and updated to fully exploit all existing communication channels to promote and continue an ongoing conversation with everybody who uses our services; including those people who live outside of our area.
  - It will focus on a wide range of channels to encourage wide community engagement; including digital; face to face and printed materials.
- Our primary aim is to design people-centred methods of engagement to match the needs of individual groups in the area and to ensure that we draw in views from people whose voices are seldom heard and those representing people with protected characteristics.
- In addition to the broad engagement activities we acknowledge that a number of our organisations have significant cultural issues, in some instances signalled by the CQC, and forming part of regulatory action. We will roll out an STP wide change management and performance improvement approach built on Virginia Mason principles, and catalysed by our two providers who have participated in the national pilot scheme.

Stages for STP Engagement



- We are working closely with our colleagues in health and social care, and via Healthwatch, to ensure that our plans are built on insights and conversations around patient experience and service needs and expectations.
- The heart of our approach will be centred on continuous dialogue; however we will closely monitor all emerging plans and seek legal input, and test with our overview and scrutiny committee, to ensure that we fully comply with legal guidance on more formal consultations.
- We will adopt a fully transparent and open approach to our community re all changes; not just to ensure that we adhere to the checks and balances in the system but because we truly believe this process provides us all with a unique opportunity to design a strong, effective health service that will meet both our needs and those of the generations to come.
- Everybody with an interest in our health service will be invited to join our conversation.
- We will continually update people on progress of our Comms and Engagement plan and there will be a clear audit trail of the activity that has taken place; including questions raised and responses to them.

What support do we need to ensure that we are able to deliver?

WORK IN PROGRESS

Financial

- Support transition funding to manage capacity and activity during build of 3Ts project, for BSUH and other sites in the STP
- To secure both support and agreed funding on the 16/17 BSUH and ESHT winter recovery capital ask as signalled in both organisations' recovery plans and their respective summaries contained in Appendix C of this document
- We recognise the tight position on national NHS funding. We have a number of challenged organisations in our STP. As part of the support that we require from the Centre we would propose that careful consideration is given to the overall control totals that are set in the first two years of our plan. Our goal is to achieve financial sustainability over the five year period, but given the heavy deficit position which is our starting position we will find it very difficult to achieve current control totals in the first two years.
- Guidance on how delivery of large scale transformation and long terms savings should be balanced against very challenging short term financial targets, surrounding both revenue and capital
- We would like to register the need for appropriate funding for investment in integrated care record systems for which plans will be forthcoming by the end of the calendar year

System Leadership

- Support in delivering commissioning reform as signalled in our place-based plans
- Support the STP to have the authority to deliver sustainability and improvement actions as a whole system

System Recovery

- Assistance in balancing the need of specialised commissioning with local delivery of safe care and constitutional standards, particularly in relation to the immediate challenges at BSUH and the long term vision for that site

Appendices

Glossary: Acronyms used

Acronym	Meaning
ACO	Accountable care organisation
CIP	Cost improvement programme
CSESA	Central Sussex & East Surrey Alliance
ESBT	East Sussex Better Together
MECC	Making Every Contact Count
MCPs	Multi-speciality community provider
MTC	Major trauma centre
PACS	Primary and acute care system
RSC	Royal Sussex County (Hospital site in central Brighton)
RTT	Referral to Treatment
SPoLs	Single Points of Leadership (one for each Place)
UCC	Urgent Care Centre

Contents of appendices

a) Governance

b) Place-based delivery plans – CSESA, Coastal, ESBT plans **(in separate document)**

c) Acute recovery plans **(Detailed plans contained in separate document)** –
   i. Summary BSUH Winter Sustainability Plans
   ii. Summary ESHT Winter Sustainability Plans

d) Finance

e) Workforce

f) Specialised Commissioning

g) Achieving savings through environmental sustainability

h) Summary of cancer and stroke improvement priorities

Appendix A.1: STP Governance

WORK IN PROGRESS

Programme groups

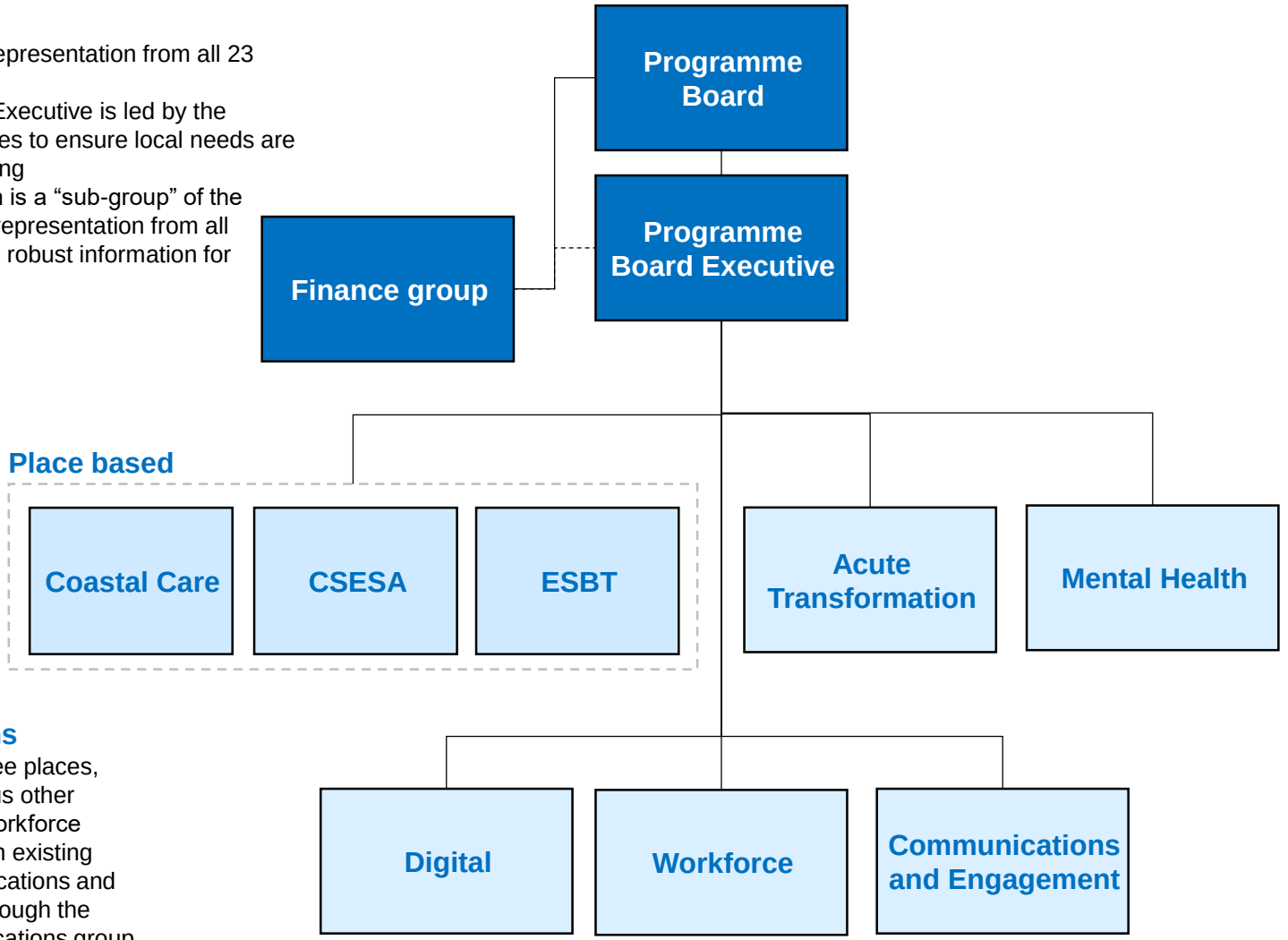
- Programme board has representation from all 23 STP organisations
- The Programme Board Executive is led by the leaders of our three places to ensure local needs are at the heart of our planning
- The Finance workstream is a "sub-group" of the programme board, with representation from all organisations, to provide robust information for planning

Core workstreams

- Each place is responsible for patient-centred care models
- Collaboration between streams are facilitated by the Programme Board and Executive

Enabling workstreams

- Membership include three places, acute, mental health, plus other "experts", e.g. HEE in workforce
- Each group have built on existing networks, e.g. communications and engagement working through the existing acute communications group



Appendix A.2:
STP Executive Group – Purpose and Principles/Behaviours

WORK IN PROGRESS

An Executive Group has been established to drive delivery of the STP.

Purpose of the STP Executive Group:

The purpose of the Sussex and East Surrey STP Executive Group is to oversee and drive the implementation of pan-STP decisions on behalf of the population served by the 23 member organisations. In addition, the group facilitates place-based progress/accelerate to achieve overall transformation of the STP footprint/5YFV triple aims.

The following principles/behaviours will apply to the model:

1. All organisations are signed up to the STP, its targets and delivery plan.
2. The **Executive Group** will deal only with those issues which are best considered on a pan-STP basis.
3. **Place-based "single points of leadership" (SPOLs)** will deal with their local place-based issues through their local governance.
4. Each member organisation retains its own Governance authority and accountability to its Board of Directors in line with current organisational form.
5. The **Executive Group** facilitate collaboration and cooperation across its membership in the interests of the population served. Where individual Boards do not agree with proposed plans, it is the responsibility of the **place-based SPOLs** to resolve locally or identify a range of options for negotiation at Programme Board.
6. Place-based responsibilities are the role of the SPOLs. Local governance should approve SPOLs to act on behalf of their Place at Executive Group.
7. Boards of all members will be responsible for agreeing recommendations and no-gos in order to support the single system leader in their decision making .
8. Decisions will not be taken that totally destabilise one partner.
9. No single organisation will halt the progress agreed by all the other place-based or STP partners.

Membership of the STP Executive Group:

Chair – Michael Wilson, *Chief Executive, Surrey & Sussex Healthcare NHS Trust*
SRO – Wendy Carberry, *Chief Officer, High Weald Lewes Havens CCG*
Coastal Care SPoL - Marianne Griffiths, *Chief Executive, Western Sussex Hospitals NHS Foundation Trust*
CSESA SPoL - Geraldine Hoban, *Accountable Officer, Horsham & Mid Sussex CCG*
ESBT SPoL - Keith Hinkley, *Director of Adult Social Care & Health, East Sussex County Council*

Siobhan Melia, *Chief Executive, Sussex Community NHS Foundation Trust*
Colm Donaghy, *Chief Executive, Sussex Partnership NHS Foundation Trust*
Dr Minesh Patel, *Chair, Horsham & Mid Sussex CCG*
Steve Emerton, *Director of Delivery, NHS England Specialised Commissioning STP South East*

Appendix B: Place-Based Delivery Plans

WORK IN PROGRESS

Please note: the Place-based Delivery Plans are contained in a separate document.

Appendix C.1: Winter sustainability plans

WORK IN PROGRESS

Please note: Winter sustainability delivery plans are contained in a separate document.

Appendix C.2:
BSUH acute winter sustainability plan 2016

WORK IN PROGRESS

Total gap at RSC site in Brighton is 66 beds. The current actions to solve this issue are:

Solution description	Beds saved*	Milestones for implementation	Risks/Implications	STP assessment of delivery risk and key mitigations
Agreement across STP has been reached that additional capacity is needed – community beds	20 (17)	10/16 - Lease agreement & pathways 11/16 – staffing complete	• Staffing • Impact of step-down beds on acute beds (not 1:1 due to ALOS)	The model will only work if sufficient focus is maintained on keeping length of stay down by getting people discharged promptly. This may need additional focus, e.g. through daily monitoring/escalation in partnership with LAs
Hospital at home	20 (15)	17/10/16 – expand capacity to 8 patients 11/16 – expand to 20 patients	• Staffing for expansion, particularly if any acceleration is required	The workforce to deliver this model overlaps with that for a number of other schemes and so will need STP-wide coordination
Moves off-site (primarily to PRH site)	4 (4) 4 (4) 8 (6) 10 (8) 2 (2) 2 (2)	Balcombe wards – 11/16 Sussex rehab beds – review staffing 10/16 Use of Allbourne – TBC Oncology SOTC bays Spinal Infusions at HWP	• Staffing • 30 day consultation for Oncology and Spinal	Risks are primarily in deliverability and thus felt to be manageable
Total solutions	**70 (58)**			
Total indicative cost^	**£1m**	^ BSUH received support from NHSE/I on 19th October 2016 for this winter recovery plan		

The STP is supportive of BSUH's plan to develop a number of additional potential solutions that will be worked up in parallel to mitigate for any slippage. These actions include: identification of a small number of tertiary services that could be temporarily diverted to relieve pressure, Hospital at Home at front door, conversion of non-clinical space, extension of use of community beds and building temporary beds. The combined scale of these actions before risk adjusting is of the order of an additional 60+ beds.
The STP will monitor fortnightly and accelerate any plans if additional risks come to light or there is any unexpected surge in demand.

* Risk adjusted number
Source: BSUH plan

Appendix C.3:
ESHT acute winter sustainability plan 2016

WORK IN PROGRESS

Total gap at ESHT is 66 beds: the current actions to resolve this are:

Solution description	Impact – on beds	Milestones for implementation	Risks/Implications	STP assessment of delivery risk
Hastings site				
Discharge to assess nursing home beds	19	Already commissioned with CCG and agreement with SC. Staffing will be covered by nursing home	• Impact of step-down beds on acute beds (not 1:1 due to ALOS) • Mitigation in ESBT "operations room"	The model will only work if sufficient focus is maintained on keeping length of stay down by getting people discharged promptly
Rye Memorial hospital	5	Beds owned by trust, staffing planning taking place 13/10	• Impact of step-down beds on acute beds (not 1:1 due to ALOS)	Risks are primarily in deliverability and thus felt to be manageable
Eastbourne site				
Discharge to assess nursing home beds	20	SC working with CCG 13/10 – beds already identified	• Impact of step-down beds on acute beds (not 1:1 due to ALOS)	The model will only work if sufficient focus is maintained on keeping length of stay down by getting people discharged promptly
Private unit beds	10	Agreement in place for beds	• Staffing – recruitment required	Requires coordinated recruitment approach
Seaford 2 beds	17	Beds owned by trust, staffing planning taking place 13/10		Risks are primarily in deliverability and thus felt to be manageable
Total solutions	**73**			
Total indicative costs	**£2.89m**			

Source: ESHT plan

WORK IN PROGRESS

Appendix D.1:
Financial challenge in intervening years

	2016/17 FOT	2017/18	2018/19	2019/20	2020/21
Do Nothing NHS Position	**£ (47,639)**	**£ (310,599)**	**£ (421,720)**	**£ (541,690)**	**£ (653,490)**
Investing for Quality‡					
Seven Day Services		£ -	£ -	£ (3,811)	£ (38,114)
Cancer Taskforce		£ (5,820)	£ (7,060)	£ (8,403)	£ (9,573)
National Maternity Review		£ -	£ (4,570)	£ (4,573)	£ (4,576)
Digital Roadmaps		£ (3,600)	£ (7,200)	£ (10,800)	£ (14,400)
Sub-total		**£ (9,420)**	**£ (18,830)**	**£ (27,587)**	**£ (66,663)**
Place-based care†					
Community – based investment		**£ (13,553)**	**£ (21,838)**	**£ (30,204)**	**£ (38,394)**
Acute Savings		£ 51,733	£ 96,434	£ 135,314	£ 171,021
Sub-total		**£ 38,180**	**£ 74,596**	**£ 105,110**	**£ 132,628**
Further Efficiencies					
Prevention		£ 6,946	£ 14,029	£ 21,243	£ 28,670
Provider Productivity		£ 64,769	£ 132,078	£ 202,242	£ 276,215
Medicines Management		£ 8,685	£ 17,736	£ 27,151	£ 36,945
Specialised Commissioning		£ 14,651	£ 26,756	£ 40,275	£ 55,734
Sub-total		**£ 95,052**	**£ 190,599**	**£ 290,911**	**£ 397,563**
CCG Surplus replenishment*		**£ (24,733)**	**£ -**	**£ -**	**£ -**
Transformational Funding		**£ 49,176**	**£ 49,176**	**£ -**	**£ 130,000**
Do Something NHS Position	**£ (47,639)**	**£ (162,343)**	**£ (126,179)**	**£ (173,257)**	**£ (59,962)**

- Despite our plans achieving significant progress by 20/21, there exists a stark financial challenge across years 2- 4 of the STP, driven by a starting deficit, increasing demand pressures and a time requirements associated with mobilising new place-based models of care
- As a result, our plan does not meet control totals for 17/18 and 18/19, but we remain committed to identifying further opportunities to improve our position and reduce the gap
- ‡Additional investments to deliver the GP Forward view (£51m by 20/21), and Mental Health Taskforce and CAMHS (£18m by 20/21) are included in the Do Nothing baseline
- †The level and phasing of place-based savings is different across the 3 places, as outlined in appendix D.2
- *The current conservative assumption a £25m non-recurrent requirement to replenish all CCG surpluses in 20/21

Appendix D.2: Capital expenditure projects by Place and category

WORK IN PROGRESS

- Each place is planning investments in it's communities to ensure the impacts on acute demand growth and population health are delivered
- Acknowledging the shortage of centrally-held capital, we are planning an innovative and diverse range of capital sources

Place	STP-wide solutions	Enabling out of hospital care	System Resilience	IM&T	TOTAL
CSESA	-	£175m	£70m	£32m	£277m
Coastal	£17m	£67.5m	£20m	£10m	£114.5m
ESBT	-	£50m	£35m	£15m	£100m
TOTAL	**£17m**	**£292.5m**	**£125m**	**£57m**	**£491.5m**

Source: Place based capital plans

WORK IN PROGRESS

Appendix D.3: Potential capital sources by project category

Category	Project	Value £m	Source	
System resilience	BGH Reconfiguration	20	PDC and DH loans	Required to ensure quality of service and outcomes are protected
	East Sussex BT alignment of acute	35		
	Western Ward Block	20		
	Pathology network	15		
	Rapid diagnostic centres	30		
	A&E reconfiguration Royal Sussex	5		
	Reconfiguration of PRH	TBC		
	TOTAL	**125**		
Enabling out of hospital care	Crawley, Horsham and Mid-Sussex Community Hubs	165	Commercial capital partnerships & commercial loans	Required to underpin new person-centred, integrated models that deliver care in community settings, reduce acute demand and improve population health
	Southlands Ambulatory hub	20		
	Littlehampton Community Hub	12.5		
	Worthing Civic Quarter Community Hub	16		
	Shoreham Community Hub	12		
	Bognor Community Hub	2		
	Durrington Community Hub	5		
	East Sussex Community Hubs	10		
	Preston Barracks community hub	TBC		
	ESBT Community hubs	50		
	TOTAL	**292.5**		
STP-wide	LDR capital projects	**57**	LDR bids	Key STP strategic enablers
	Western Radiotherapy unit	**17**	Commercial capital partnerships & commercial loans	
Total		**491.5**		

Source: Place based capital plans

Appendix E.1:
Strategic Workforce Plan

WORK IN PROGRESS

- The Sussex and East Surrey Sustainability and Transformation plan has developed a workforce strategy to deliver the transformation required to serve the needs of our population.
- The challenge for the workforce programme is to address the immediate problems and support the plans for winter pressures, whilst developing the strategic solutions for a sustainable future.
- The STP has set up a Local Workforce Action Board to lead and implement the workforce strategy to support the STP. The Board is Co-Chaired by Richard Tyler CEO of Queen Victoria NHS FT and Philippa Spicer the HEE Local Director and its membership includes representation from the new 'Places' together with clinical leadership and commissioning
- HEE is providing programme management, and resource to ensure that the actions, particularly the priorities, will be implemented. An allocation of £1.3m has been identified to support the implementation of the LWAB action plan. These funds are being are being distributed to meet the needs of the priority task and finish groups. A further allocation of £460k has been funded through the Community Education Provider Networks (CEPNs) within the STP footprint.
- N.B. The Acute recovery plans are dependent on workforce being able to support the plans that have been put together to ensure Acute sustainability through 16/17. Without a coordinated focus from both the workforce subgroup and the organisations involved, the plans are at risk. All providers are relying on the same pool of staff and so this will require coordination. That said, plans are in place with specific providers such as 130 nurses in pipeline at one provider and international recruitment being reinstated due to the success of the previous scheme.

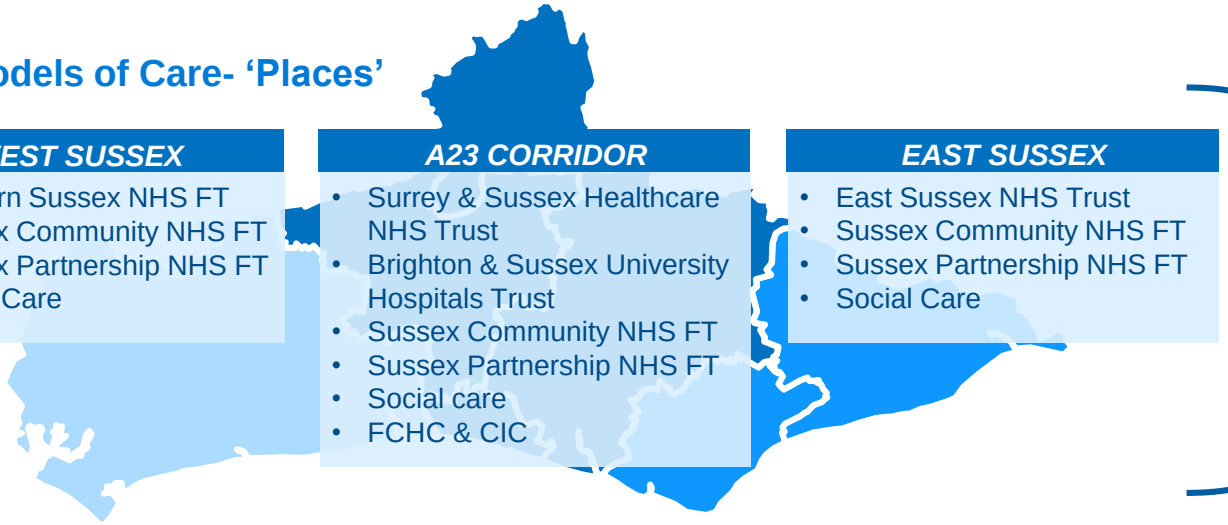
The LWAB has held several stakeholder events to develop an action plan to meet the requirements of the STP. Meetings on the 25th July and 30th September have helped to shape this work, building on existing work, identified challenges and key priority areas that have been highlighted through stakeholder engagement sessions, which have included all organisations, both health, social care, PVI, Education and Trade Unions. The plan has pulled together the actions from the June 2016 STP Submission and is grouped under five key areas within the 5YFV:

Workforce Action Plan / 5YFV	Priorities 2016/17
Prevention	MECC – Joint Programme with Public Health April 2016 – March 2017
New Models of Care	▪ Implementation of the WRaPT Workforce Repository/Planning Tool. – East Sussex Better ▪ Together and Brighton Hospital at Home. Proposal and resource agreed by STP. Mobilisation meeting on X date
System Wide – Effective & Efficient	▪ Temporary Staffing – Agency Programme in place, implementation by March 2017 ▪ Locum Spend – Trend mapping underway to report to STP December 2016 ▪ Shared Functions – Skills Passport – programme agreed
Integration	▪ Proposals from 30th September stakeholder event being developed for implementation, e.g. Shared Therapy teams to support re-enablement and Cross care pathway role
Recruitment and Retention	▪ Retention programmes: newly qualified – e.g. common preceptorship programme ▪ Mature workforce – Health and Well-being proposals. Paramedics retention ▪ Recruitment – Pre- Employment Coordinators. Prince's Trust programmes, Health and social care careers events etc.

Appendix E.2:
Strategic Workforce Programme

WORK IN PROGRESS

New Models of Care- 'Places'



WEST SUSSEX
- Western Sussex NHS FT
- Sussex Community NHS FT
- Sussex Partnership NHS FT
- Social Care

A23 CORRIDOR
- Surrey & Sussex Healthcare NHS Trust
- Brighton & Sussex University Hospitals Trust
- Sussex Community NHS FT
- Sussex Partnership NHS FT
- Social care
- FCHC & CIC

EAST SUSSEX
- East Sussex NHS Trust
- Sussex Community NHS FT
- Sussex Partnership NHS FT
- Social Care

LWAB IMPLEMENTATION PLAN BUDGET OF £1.8M provided by HEE

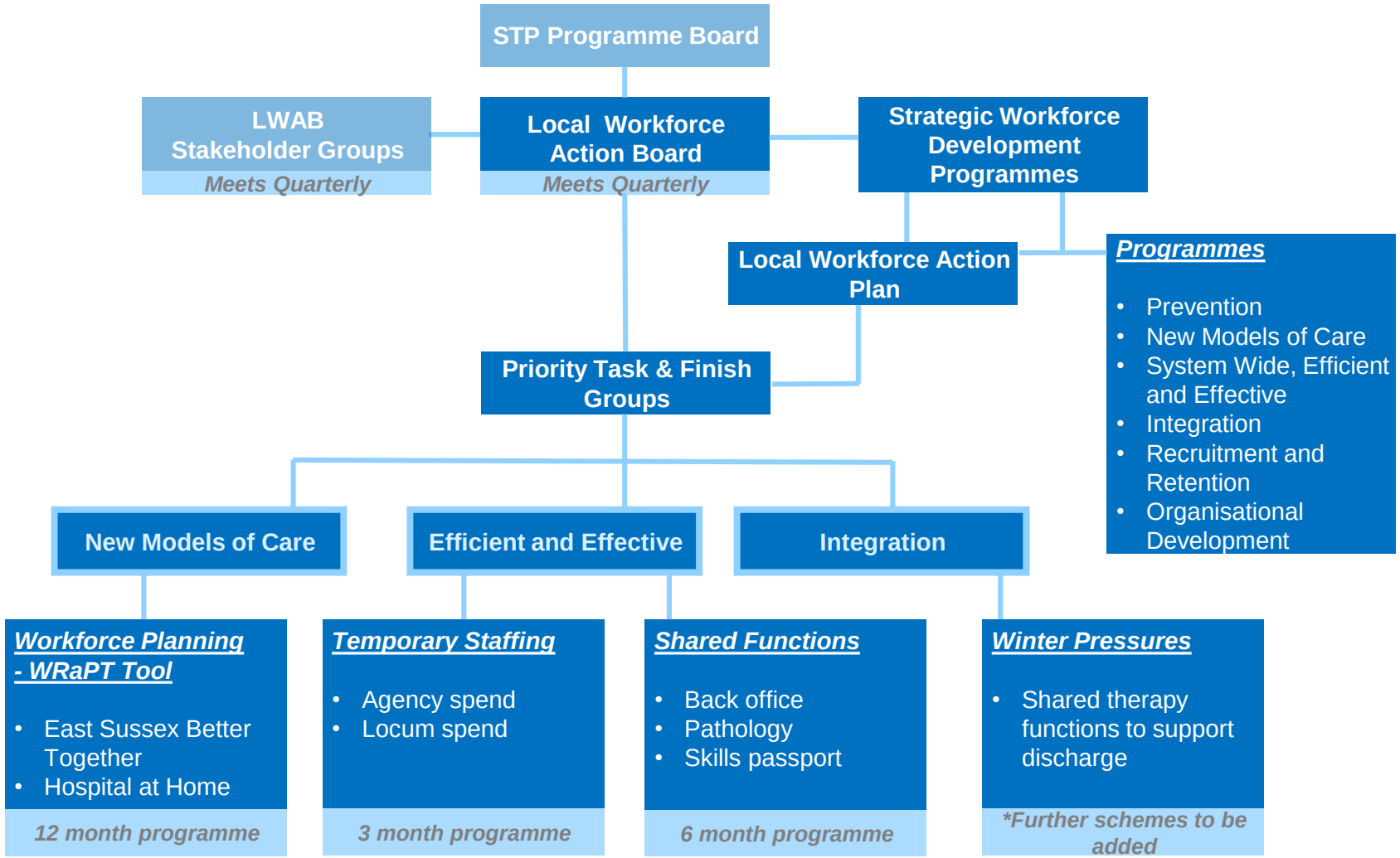
PRIORITY PROGRAMMES	**Temporary Staffing- agency and locums**		**Skills Passport**		**Winter Pressures- Shared Workforce (e.g. therapists)**			
PROGRAMMES OF WORK	Prevention	New Models of Care 'Places' WRaPT/OD	System Wide- Efficient & Effective		Recruitment & Retention		Integration	
DRIVERS	Shift to Primary & Community settings	Finance/ Pay Bill	Performance & Quality	Acute Pressures	Community Pressures	Mental Health Pressures	Primary Care Pressures	Social Care Pressures

The Workforce Action Plan is based on the need to transform the workforce for new ways of working in the future, whilst managing the immediate challenges of the workforce shortages and increased demand on services.

Diagram 1 shows the three 'places' within which the new models of care are being developed and which the workforce will need to work within. Diagram 2 shows the drivers for change and the programmes being undertaken

Appendix E.3:
Local Workforce Action Board – Governance

WORK IN PROGRESS



Appendix F.1:
Specialised Commissioning QIPP Schemes for 17/18

WORK IN PROGRESS

Transformational Schemes

Theme	Potential Transformational Schemes
Right Care	▪ Cardiology (links to pathway work below) ▪ Right care to look at work for Spec comm re MH, Neonatal and Cardiac ▪ Assessing timescales for outputs from " Getting it Right First Time" programme which may have implications for specialised services
New Models of Care	▪ Complex Cardiology pathway ▪ Cancer pathways (Inc. chemotherapy regimens) ▪ Neonatal – increasing proportion of term admissions ▪ Mental Health national 'New Models of Care- 2 pilots. Scope to roll out similar approach for CAMHS with SE as priority ▪ Assess scope for savings from current work on Vascular networks and Spinal pathways
Urgent & Emergency Care	▪ Enhanced supportive care – to reduce emergency cancer admissions
Self Care	▪ Opportunities re some neurological pathways
Prevention	▪ Secondary prevention re cardiology interventions (business case for project in preparation) ▪ Cancer ▪ Renal
CHC/Long term conditions	▪ Neuro- Rehabilitation pathways (to review scope for roll out of actions in SW)
Other productivity	▪ See Transactional schemes (on following slide) ▪ Ensuring effective planned care pathways (Inpt/ day case/ Daycase/ opt procedures
Cross Cutting Themes	▪ Critical Care – both transactional and transformational element s, focus on reducing length of stay ▪ Enhanced Supportive care (Inc. opportunities beyond cancer services) ▪ Peri-operative medicine Inc. Enhanced recovery and shared decision making with patients ▪ Repatriation – joint work with London to avoid unplanned changes of pathway but ensure appropriate, agreed pathway changes where appropriate.

Appendix F.2:
Specialised Commissioning QIPP Schemes for 17/18

WORK IN PROGRESS

Transactional Schemes

Theme	Potential Transformational Schemes
Medicines Optimisation* *Mix of full and part year effect	▪ Switch to generics and biosimilars – specific drugs to be identified together with phasing – and optimisation through ensuring more rapid take up ▪ Antifungal Stewardship – reviewing variation ▪ Starting and stopping criteria for MS drugs ▪ Intravenous immunoglobulin- best practice and reviewing database information which suggests variation in volumes being prescribed ▪ Effective prescribing of Antiretroviral Medicines – national tender ▪ Extension of SACT dose banding for chemotherapy and reducing chemotherapy wastage ▪ Home Parenteral Nutrition – recent national tender – reduction in associated costs ▪ Immunosuppressant repatriation (from CCG to NHS England for certain solid tumours) ▪ Optimising procurement opportunities ▪ Rationalise provision of aseptic units ▪ Review of outsourced pharmacies and in share arrangements ▪ Ensuring all PAS rebates secured ▪ Addressing variation in prescribing rates (links to population based prescribing work) ▪ Ensuring compliance with NICE pathways through individual patient tracking for certain high cost drugs
Reduced prostate fractionation	▪ Fye of scheme commencing Autumn 2017
Outpatients	▪ Mix of transformational and transactional elements- encouraging shift to non-face to face or lower costs appointments
Review of shared care pathways	▪ Mix of transformational and transactional elements- encouraging shift to non-face to face or lower costs appointments
Roll out of National Devices Procurement Scheme	
Continuation of CUR CQUIN	▪ To identify benefits of implementation
Price Benchmarking	
Neonatal	▪ ATAIN to follow clinical protocols to ensure consistent thresholds for referral to SCBU

Appendix G:
Achieving savings through environmental sustainability

CARE WITHOUT CARBON

A coordinated approach to carbon management within the STP

1. Context

Sussex Community NHS Foundation Trust (SCFT) has pioneered an innovative and award-winning approach to delivering sustainable, low-carbon healthcare called ***Care Without Carbon*** (CWC)**.** The CWC model successfully delivers value to the NHS by pursuing three complementary objectives:

1. **Carbon reduction** (measured in tonnes CO_2) – a measure of reduced environmental impact incorporating energy and water efficiency, waste management and travel and transport among other areas
2. **Cost improvement** – a reduction in CO_2 will almost always deliver a cost saving, for example through energy efficiency or travel avoidance
3. **Enhanced staff wellbeing** – a key focus for Lord Carter, CWC incorporates a strong staff engagement and organisational development element, aimed at encouraging behaviours that deliver not only cost and carbon savings but also help to support workforce wellbeing

The team behind CWC has developed a comprehensive approach to measuring and reporting on these outputs – most recently this has involved work with the New Economics Foundation to develop new metrics for measuring workplace wellbeing. Carbon management plans based on the CWC model are being developed for all the major provider organisations within the STP footprint and each has made commitments and plans to reduce emissions in line with NHS targets.

2. An SDMP (carbon management programme) for the STP

The STP's collective carbon footprint is estimated at 100,000 tonnes CO_2e per annum. This is primarily driven by energy consumption across the estate but it is also estimated the system produces over 10,000 tonnes of physical waste with staff driving over 20 million business miles each year. The cost of these impact s is estimated at £32M per annum and so carbon reduction presents a significant and tangible opportunity for cash-releasing savings.

Whilst individual Trusts have made commitments to reduce carbon, the STP offers an opportunity to deliver faster and more significant progress by taking a coordinated approach and achieving economies of scale in a number of key areas. As a key operational element of the STP, **a single, overarching carbon management plan will be produced** based on the CWC model, which will harmonise baselines, reporting and action planning on carbon reduction across services delivered in the STP. The plan will necessarily be closely aligned with the STP Estates Strategy and the CCGs' Local Estates Strategies and will be developed and implemented in parallel.

3. Implementation Plan

The CWC team at Sussex Community NHS Foundation Trust will lead on this work stream. Year 1 implementation plan tasks:

1. Review and merge organisational plans, creating overarching plan aligned with Estates Strategy, including harmonised baseline and targets
2. Establish five key sustainability work streams:
   - *i.* ***Utilities***: Options for driving energy & water efficiency across estate (including water industry deregulation options) and scope centralised Energy Bureau function. Investigate opportunity to create single investment vehicle to achieve cost and carbon savings across estate.
   - *ii.* ***Waste & Resources***: Assess potential for harmonised waste policy, targets and operational procedures, collective contract tendering and centralised Waste Bureau service to manage service
   - *iii.* ***Staff Travel:*** Scope opportunity for single Travel Transformation Plan to reduce staff travel time, cost and carbon across system and centralised Travel Bureau function to implement project work and support staff
   - *iv.* ***Commercial Transport*****:** Assess potential for consolidation of commercial courier services delivered by and provided to all STP organisations.
   - *v.* ***Culture****:* Assess opportunity to roll out successful staff engagement programme developed by SCFT to reduce costs, save carbon and improve workplace wellbeing
3. Assess additional resources and skills required to deliver work stream and create business case to secure necessary funding.

WORK IN PROGRESS

Appendix H.1:
Summary of cancer performance improvement priorities

Key drivers for change:

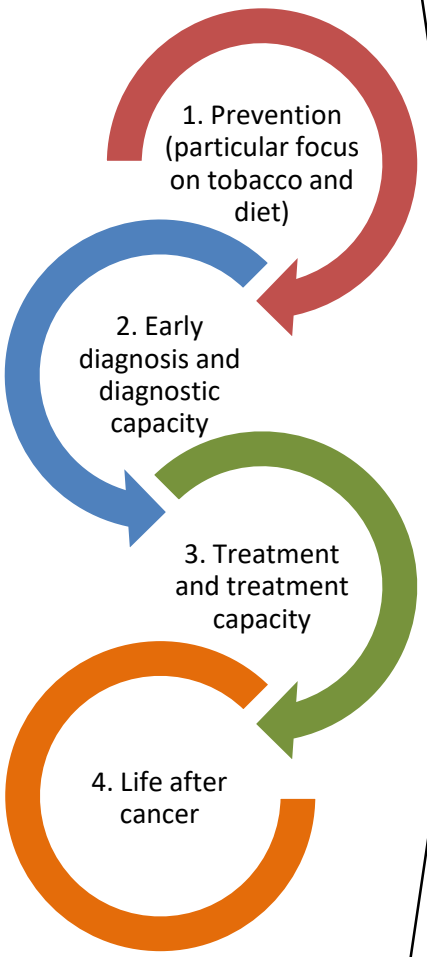
Performance:

- Poor historic one year survival rates, driven, for example, by lung cancer survival rates
- Poor historic rates of early diagnosis in particular tumour sites
- Trusts are struggling to deliver consistently on cancer waiting targets (in particular 62-day target)
- Below average patient experience of cancer services

Drivers of performance:

- High smoking prevalence in parts of the STP footprint (e.g., Brighton, Crawley, Hastings), high rates of obesity in some areas
- Growth in demand (especially for diagnostics), insufficient capacity in imaging, endoscopy, radiotherapy

Scope of end-to-end improvement initiatives:



Examples of specific improvements (detail to be developed Jul – Sept):

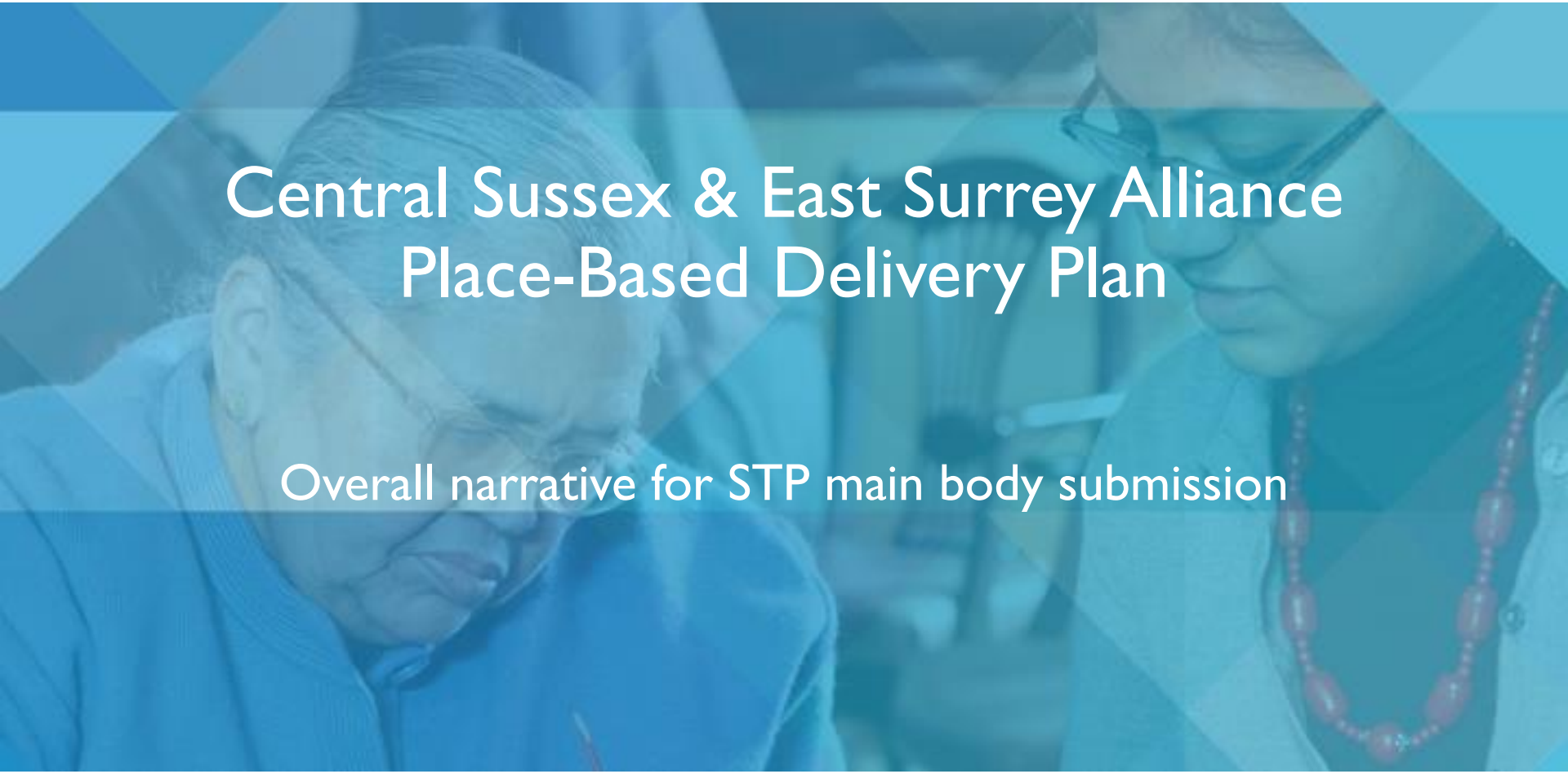
1. Development of "Rapid Access Diagnostic Centres" and pathways for symptomatic patients, ring-fenced from acute diagnostics, addressing shortfall of imaging and endoscopy capacity
2. Our "transforming care through our four localities" workstream includes a locally-driven focus on prevention and self-care in each locality, focused on tobacco, diet and exercise
3. Improving patient awareness of symptoms of potential cancers
4. Improving uptake on screening and vaccination, including:
    - HPV and cervical screening
    - Bowel screening (F.I.T. and bowel scope)
5. Exploring trial of GP direct referral for low-dose CT for patients at highest risk of lung cancer
6. Development of radiotherapy capacity (e.g., Eastbourne) and redevelopment of cancer centre as part of the 3Ts development at Brighton

WORK IN PROGRESS

Appendix H.2:
Summary of stroke performance improvement priorities

Area	Current performance of stroke services	Priorities for stroke improvements
Primary prevention of stroke	• Smoking prevalence high in parts of the STP footprint (e.g., Brighton, Crawley, Hastings) • Obesity prevalence is high in some of the same areas	• Implement the preventative activities related to tobacco, diet and exercise, that have been highlighted in the STP. This implementation to be driven via local place-based integrated care
Secondary prevention of stroke	• Detection and management of atrial fibrillation (AF) is critical to preventing strokes – performance across the STP area is currently mixed both as regards detection and management of AF • Detection and management of hypertension is important in preventing strokes – performance is poor in several CCGs	• Primary care-led implementation of actions to improve the detection and appropriate management of AF, including supporting patients to make an informed choice about which anti-coagulation is best for them, including considering of NOACs. • Improve the detection and management of hypertension
Treatment of TIAs and Acute Stroke	• Configuration of hyper-acute and acute stroke services not complete across: (1) Brighton/ Haywards Heath; (2) Worthing/ Chichester • Performance on "early assessment by specialist physician" is highly variable across CCGs	• Determine preferred configuration of hyper-acute and acute stroke services for each of (1) Brighton/ Haywards Heath; and (2) Worthing/ Chichester. The CCG Governing Bodies and HOSCs/HASC will then decide whether to implement a formal public consultation on these configurations, and, if appropriate, implement.
Rehabilitation and life after stroke	• Relatively poor performance on returning patients to their usual place of residence following stroke (4 CCGs statistically worse than peers) • Relatively poor compliance on physiotherapy and occupational therapy compliance vs targets	• For A23S and Coastal Care, Sussex Community Foundation Trust is meeting with each of the Acute Trusts and the CCGs to improve gaps in Early Supported Discharge and Community Neuro Rehabilitation.

WORK IN PROGRESS



Central Sussex & East Surrey Alliance Place-Based Delivery Plan

Overall narrative for STP main body submission

Central Sussex & East Surrey Alliance

Contents

Central Sussex & East Surrey Alliance

Executive summary

Case for change

- Continuing to **operate as we currently are is not an option**. The **funding and capacity gap** if we do nothing will become insurmountable.
- **Case mix and complexity will increase**, driving the demand for beds higher than just the total population growth. But the **acute sector is already straining to provide capacity**.
- The population is **growing**, and **growing older,** and the overall health of the population is deteriorating
- **Care quality issues** need to be addressed & **social factors** are having a direct impact on health
- Patients are not always receiving the **levels of care** that they want
- Central Sussex and East Surrey Alliance is the **right place** to deliver the future **health and wellbeing needs of its population** but the local health and social care **system is under pressure**.
- **Workforce issues**, organisations in special measures and a lack of **organisation and data integration** complicate the picture
- There are **significant organisational and infrastructure challenges** which the place-based plan needs to address

Vision & priorities

- A **less reactive**, less **hospital bed-based** system which promotes **well being**, **self care** and care at **home**. A system which places **integration** at its centre, providing care and services closer to home. **Led by primary care**, building on good work in progress, promoting **collaboration** across health and social care.

Strategic Objectives	Care designed for the local populations, including families, children & carers	Meaningful integration of providers	Sustainability of primary care	Sustainability of acute care
Priorities	Prevention and education	LTCs and EOLC managed in the community	Coordinated care for frail & complex patients	Better access to Urgent Care	Cancer, RTT and A&E targets

MCP is the right model

- The components needed to meet our strategic objectives and deliver our priorities are a **close match with the components of an MCP**
- **Primary care** services are already **moving in the MCP direction**
- **Primary care are best placed to lead** the system

The **key outcomes** are:
- Accessibility
- Continuity
- Coordination
- Workforce
- Sustainability
- Quality

The **key components** are:
- Data-driven care model
- Organisational consolidation
- Devolved finance & contracting
- MPC integrator
- Balanced workforce
- Patient at the centre

Key **needs**:
- Bottom-up integration
- Workforce without borders
- GPs are core to the model
- Full data integration

- We have strong foundations for an MCP model and we will drive delivery from care hubs
- We plan to determine the number of MCPs by 09/17, complete public consultation by 03/18 and settle on the legal construction approach by 09/18

Delivery structure

Delivery Streams	Prevention and self care	Continuity for patients with LTCs	Coordination of frail and complex patients	Improved access to urgent care
Enablers	OD & Leadership	Change Management	Workforce	IM&T	Estates

What it will take to execute

Investment in primary care is absolutely essential to the success of changing the system. Our GPs will provide **clinical leadership**, and they are at the heart of **care hubs – our engines for delivery**.

We need to address **challenges** in all areas in order to be able to deliver this whole-system change

Clinical leadership	Workforce	Change Management	Programme delivery
Technology	Estates	Investment	Contracting

Finances

Nine levers are being used to drive our model for acute savings and community re-provision

Frailty	A multidisciplinary, ambulatory approach	Non Elective admission	Ambulatory care	Long Term Conditions	Increasing patient self management
Elective Reduction	Cascade of electives to day cases to out patient to community	A&E	Improved access to urgent care	Complex Patients	Care coordination and multi-disciplinary teams
Step Down Care	Alternative setting	Outpatient Appointments	Extended primary care	PBR Excluded Drugs	Medicine Management of non PBR drugs

Our approach will reduce the projected deficit in 20/21 from £91m to £31m

Timeline

Next 6 months	Year 2	Year3	Year 4	Year 5
Strategy	*Co-design*	*Deployment & Shadow contract*	*Stabilisation & new contract*	
Service Scope defined (01/01) ◆ CSESA Strategy ◆	#MCPs defined ◆ Public consultation complete ◆	5 year MCP and acute contracts in place ◆ Delegated budgets agreed ◆	◆ MCPs live	
Programme team in place ◆ CSESA 4 year plan ◆	**Gateway #2a**: Capabilities & contract set up (shadow) Shadow delegated budgets agreed ◆	**Gateway #2b**: Capabilities & contract set up (full MCP) **Gateway #3**: Is it safe to commence?		
Gateway* **#1**: Case for Change				

Vanguard ready

We will be formally registering an **expression of interest** in joining the next wave of **Vanguard** projects.

We have:

- A credible **vision**
- A defined **care model**
- Clear **timelines**
- **Work in progress**
- Good understanding of our **financial case**

Case for change: the challenges that we face

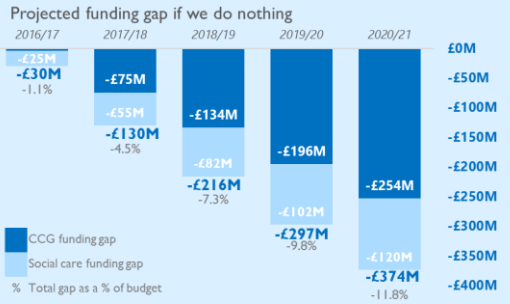
The national and local health and funding issues that must be addressed

Primary care has been underfunded for a long time

- The share of NHS funding for GPs has been cut with respect to acute over the past 10 years. As a direct result, primary care – and its workforce – are under enormous pressure.

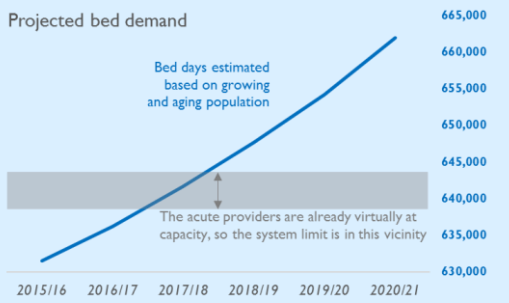
Continuing to operate as we currently are is not an option

- Over the next 5 years, the population is due to grow by an average of 0.9% per annum
- CCG spend is forecast to increase by an average 4.5% per annum, and provider spend by 5.7%.
- This increase in expenditure is forecast to result in a £5m health budget deficit in 2016 and a £254m deficit in 2020



Note: data shows position as estimated in July

- Case mix and complexity will increase, driving the demand for beds higher than just the total population growth. But the acute sector is already straining to provide capacity.



The population is growing, and growing older

- Life expectancy continues to rise. The number of people over 85 will have doubled in Surrey by 2030. In Sussex, the number of people aged 90+ is expected to increase by 50% by 2022 and over 300% by 2037. In more deprived areas this rate of increase is slower, meaning that inequality, as expressed in terms of life expectancy has, and will, continue to increase.
- As the population ages, more people will be living longer with a long-term condition or disability and many people will be living with multiple long term conditions. Many long-term conditions are strongly associated with age, but lifestyle risk factors are important, and some long term conditions are preventable. The number of people with conditions such as diabetes, coronary heart disease and chronic obstructive pulmonary disease is expected to increase over the next five to ten years. A greater number of frail patients will result in a proportional increase in of end-of-life care beds.
- Approximately 6% of the adult population in West Sussex has a diagnosis of diabetes. This is projected to increase ahead of overall population increase. Most diabetes is preventable and the risk factors understood; excess weight, smoking, poor diet, low levels of physical activity.
- It is estimated that 15%-30% of dementia is linked to cardiovascular problems. Therefore current public health interventions aimed at increasing healthy lifestyles may reduce the incidence of dementia.

The overall health of children and working age adults is deteriorating

- We have above average-smoking rates for 15 year olds and some localities have high adult smoking rate. 18% of the population in East Sussex smoke and in Brighton & Hove the prevalence of smoking is 21%; both are higher than the national figure of 17%. One in four adults drink more than the recommended daily drinking guidelines.
- There are above average levels of obesity and self harm rates of hospitalisation.

Cancer and stroke need a particular focus

- Mortality from all cancers in people under 75 years of age is significantly higher in Brighton & Hove than England and the South East, and screening uptake rates generally lower. 25% of patients in Brighton and Hove are diagnosed through emergency routes, above the national average of 20%.
- In line with national findings, we can do much to improve our levels of cancer care to an acceptable standard. Britain has the worst cancer survival rate in Western Europe.
- With 1 in 2 people born after 1960 destined to develop cancer in their lifetimes, this is a wide-ranging issue. Cancer treatment is evolving quickly but it still very costly so early diagnosis will be key.
- 1 in 5 women and 1 in 6 men over 75 will have a stroke. Our ageing population means that the volumes of strokes will continue to increase.

Patients are not always receiving the levels of care that they want

- Patient expectations continue to increase. People expect to be seen and treated more quickly and at a time and place more convenient for them.
- In Crawley, patient satisfaction rates for care inside hospital and in the community are in the lowest quartiles of performance as measured nationally. Ambition is to drive quality of these experiences up towards the national average.
- A lack of coordination across the system contributes to the poor patient experience.

Care quality issues need to be addressed

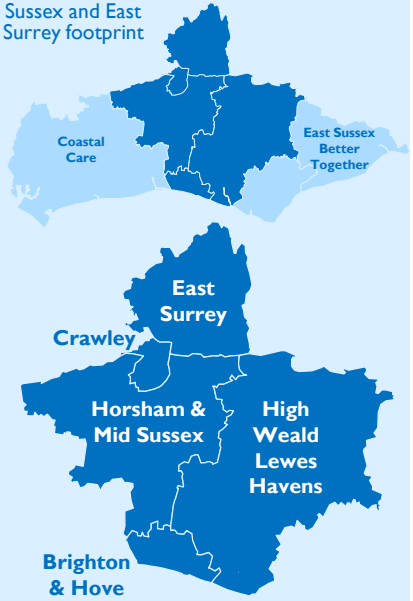
- Cancer and direct diagnostics are insufficient to meet NICE guidelines NG12
- Several other major areas of care have been identified as requiring improvement:
  - mental health detection, access and outcomes
  - LTCM prevention and support
  - support to frail and complex patients
  - maternity and children's services.

Social factors are having a direct impact on health

- Social care is also under pressure: funding levels are declining and this is a significant driver behind deteriorating health issues.
- Homelessness has increased, including rough sleeping, presenting significant risks to individuals' health and wellbeing, as well as challenges for health and social care services. For example in Brighton & Hove street services worked with 775 people during 2014/15; in November 2015, a snapshot of a single night estimated there were 78 people sleeping rough.

Case for change: understanding the CSESA place today

We have the right assets in good locations but there are a number of system challenges



1.2M	people
£1.6bn	annual healthcare spend
117	general practices
5	CCGs
4	local authorities
7	district councils
3	acute trusts
5	acute hospitals
3	hospices
5	community hospitals
2	community health trusts
2	mental health trusts
1	ambulance trust

CSESA was formed as a place-based area in August 2016

CSESA is the right place to deliver a future health and wellbeing service

- Primary care is already starting to come together at scale through in each CCG:
  - East Surrey: 4 Primary Care Networks have been established and the GP Federation selected as most capable provider of enhanced primary care services
  - Crawley: the 2 Communities of Practice are working together on introducing social prescribing
  - HMS: 4 Communities of Practice including a PCH Vanguard in East Grinstead. Exploring early shadow capitated budgets.
  - HWLH: 4 Communities of Practice pilot – Connecting 4 You
  - B&H: 6 clusters delivering services as Brighton & Hove Caring Together
- The three acute trusts are building a network where they are able to plan and deliver higher quality, sustainable services at scale. BSUH and QVH are drafting an MoU to cover short term elective capacity and strategic relationship.
- Transport links support the flow of patients up and down the corridor, provided by the A23 and M23 alongside a good rail infrastructure between London and Brighton.
- There is a wide range of inequality and diversity when looking across the footprint as a whole. There are deprived and highly affluent areas. There is also a mix of urban and rural geography. A larger place covering all of these aspects allows services to be commissioned and provided at a scale; services which are more wide-reaching and capable of delivering better outcomes for patients. Where there are currently a few people in need, a more sustainable service can be provided across a greater population.
- The wider place allows for increased partnership working, better utilisation of assets and new ways of defining and using budgets to commission services. Collaboration around the infrastructure and shared sites for health services will provide greater access to a wider range of services.
- By planning for services at this scale, we believe it will be possible to return the system back into financial balance. Capitated budgets and programme level budgeting will be possible through pooling resources. Designing services at a scale of 1-2m people with delivery localism will make it easier to invest in primary care.

But the local health and social care system is under pressure. There are significant challenges which the place-based plan must address.

- The historical under-investment in primary care has left it in a precarious state. All of the issues recognised in the GP Five year Forward View are manifested in our place.
- Recruitment and retention of clinicians is challenging: GP lists are closed and practices are closing (seven recently in Brighton) as the aging GP & nurse population retires. 17% of GPs and 39% of practice nurses are forecast to retire in the next 5 years, with no identified source of replacement.
- In our hospitals, patients are waiting too long for planned care services and are not being seen quickly enough when they attend A&E. Mandatory performance indicators such as RTT and the 4 hour A&E department standard are not being consistently met.
- As the BSUH 3Ts development progresses and decants further capacity, the broader STP will demonstrate how we will provide additional capacity in the short and long term.
- The August CQC inspection rated Brighton & Sussex University Hospitals Trust overall as Inadequate. The CQC noted that patients were not receiving the quality of care that they are entitled to expect, or within the timescales required.
- South East Coast Ambulance Trust is rated Inadequate by the CQC and has been placed into special measures.
- NHS Brighton and Hove CCG and East Surrey CCG are both rated as Inadequate. East Surrey is in special measures for its finances.
- It is not possible to access and share patient data between clinicians across organisational boundaries and patients are unable to access information about their conditions.
- There is a diverse legacy of primary and community estate with premises owned variously by GP partners, County Councils, NHS Property Services, and third party landlords including private finance initiatives.
- Whilst there is some opportunity for rationalisation and/or disposal of estate, this is outweighed by the need for substantial investment, both to address the significant local housing planned for the subsequent population growth, and to enable the shift of care from acute to primary and community settings. The development of the Royal Sussex County Hospital is a start, but will need to be accompanied by robust planning to absorb additional care, closer to home.
- Silo workforces, bound by organisational structure, result in multiple hand-offs and lack of understanding of the range of services available to patients.
- Time pressure for staff training or development and demand on services outweighing staffing levels means that stress levels are at an all-time high for many staff.
- GPs are taking on different roles as care hubs evolve and there will be a significant level of training and education required.
- In the current configuration, it is natural for organisations to compete rather than collaborate for the best interests of the patients and the system.
- The 'normal' NHS pace of change is very slow and needs to embrace digital working.

Our vision for CSESA

We will invest to develop a system of healthcare that is less reactive and less hospital bed-based. It will deliver a great start in life and continue to promote people's wellbeing, their ability to stay healthy, to self care and be cared for at home. We will bring together a system which places integration at its centre, providing more care and services closer to patients' homes and places of need. Led by primary care, we will build on the good work already in progress, promoting collaboration between all organisations working across health and social care.

Our strategic objectives

Care designed for the needs of local populations

- Uses detailed, integrated health and social care datasets based on combined GP lists to determine the changing needs of local people – as an ongoing evaluation, not a snapshot
- Applies risk stratification using real-time data and Rightcare methodology to drive proactive interventions to keep people healthy
- Identifies demographic subsets based on factors such as isolation, dependency, and deprivation to determine additional or focused services
- Applies the pay-it-forward principle to developing systems of care for children and families – especially complex ones
- Identifies and supports carers, to protect the pivotal role they play
- Maintains equality of service access and is developed in partnership with the population
- Supports patient choice to ensure dignity and quality of life
- Enables the system-wide carbon management approach

Meaningful integration of providers

- Delivers real organisational and operational integration between primary and community services
- Enables effective integration of mental health, adults and children's social care and acute services into a team around the patient
- Weaves social care tightly with healthcare to address the needs of the whole person and family
- Builds working at scale and removes existing organisation boundaries
- Formalises significant third sector support
- Uses single data systems for a seamless patient experience and real-time handovers
- Links people to a range of support services via social prescribing

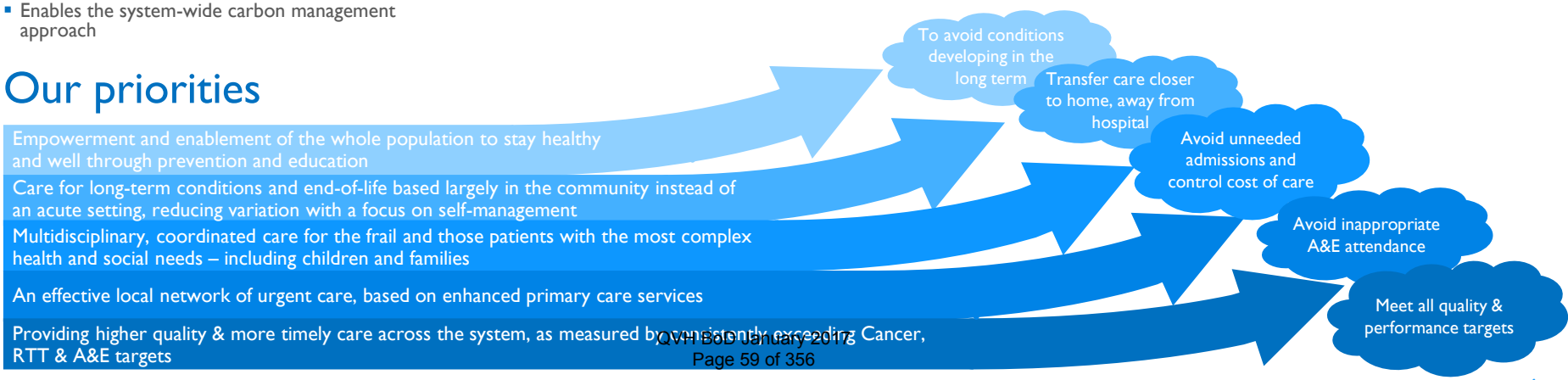
Sustainability of primary care

- Reduces people's dependence on the system and its services
- Empowers and supports front-line primary care to take a system leadership role
- Builds broader, resilient general practice at the heart of the MCP model
- Releases GP capacity through an increased use of skill mix
- Enables GPs to focus on complex patients and planned care
- Increases capacity and capabilities in primary care to enable delivery of services currently in acute – including direct cancer diagnosis and some levels of speciality current in secondary

Sustainability of acute care

- Enables acute providers to meet and exceed the constitutional quality & performance thresholds
- Transfers significant levels of activity from acute to community setting
- Reduces total healthcare spend to enable long-term sustainability
- Reduces pressure on the acute system to allow focus on specialist acute care
- Provides care closer to home and minimises the need for admissions
- Dovetails primary & community care closely with acute capability and capacity to balance supply with demand

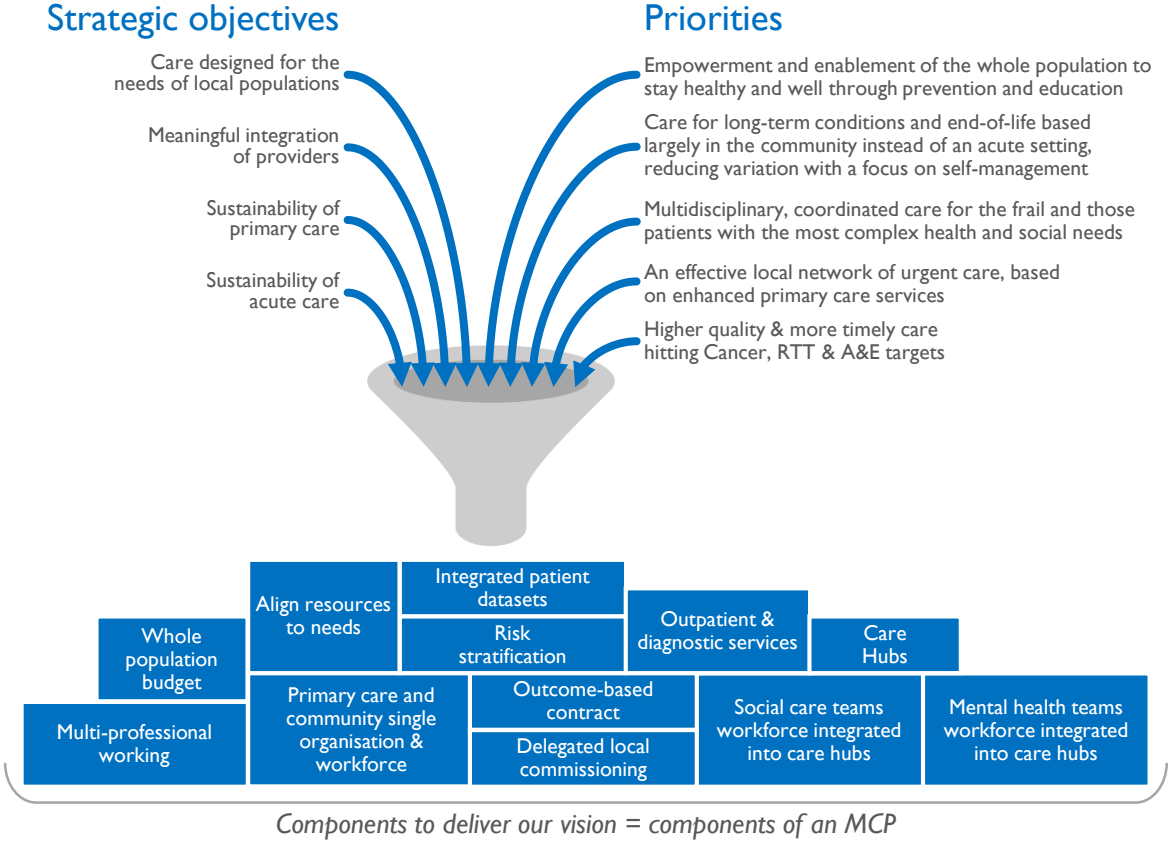
Our priorities



Why an MCP is the right model for accountable care

The current system cannot deliver the change required. There are three reasons why a multispecialty community provider (MCP) model is the best solution to both meet the local healthcare needs of our diverse population needs, and to render the system sustainable.

1 We have a shared vision which closely aligns to the MCP model and whose objectives and priorities can be met with the components of an MCP



Components to deliver our vision = components of an MCP

2 We are already building strong foundations for the MCP model

- The Brighton & Hove Caring together project already has services being delivered in integrated 'clusters'
- In Horsham and Mid-Sussex, East Grinstead have set up the Primary Care Home model with vanguard funding, and are planning to expand.
- High Weald Lewes Havens are fully co-commissioned; Brighton and Hove have recently voted to transfer to co-commissioning; Horsham and Mid Sussex are voting in October and Crawley are in discussions with GPs.
- In East Surrey, all practices are members of a Federation which has just been awarded most capable provider status for all enhanced primary care services, as a precursor to the CCG replacing individual practice LCS contracts with an umbrella contract with the Federation.

3 We have strong leadership from our primary care clinicians

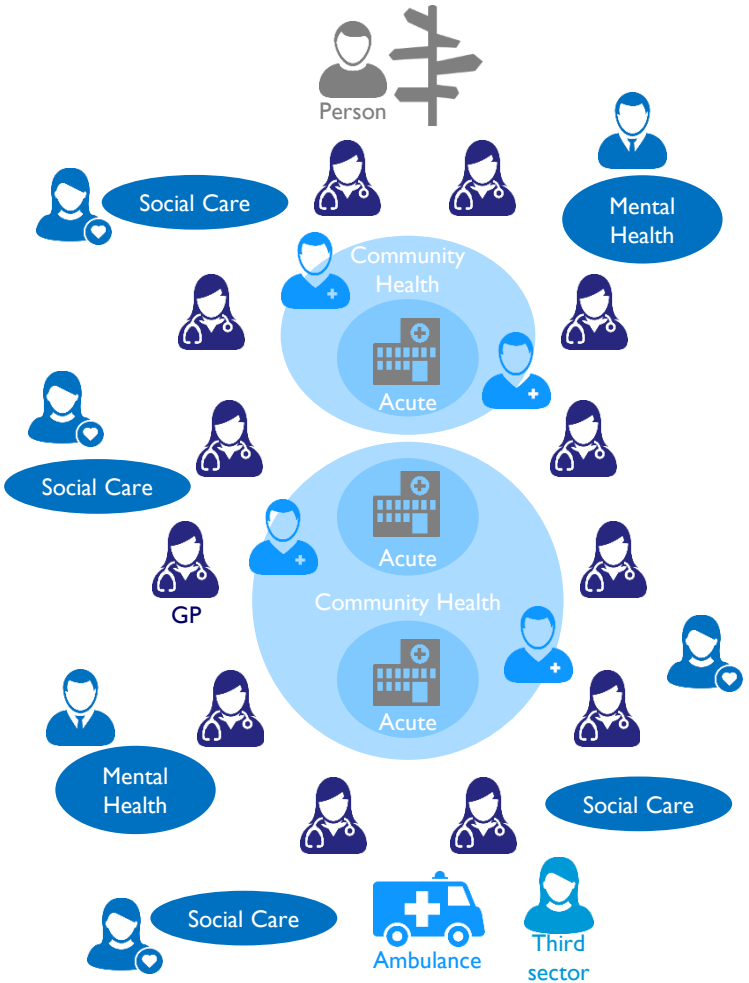
- There is very strong support from GPs across the CSESA place.
- GPs are the driving force behind change and will be providing the clinical leadership to drive the pulling of activity from the acute setting.
- Two-thirds of the workload on the system is as a result of LTCs which by their nature should be driven as a population-focused service. Primary care is best placed to coordinate that.
- We need to give the acute trusts the space to develop sustainable and networked models of care that integrate with the MCP model.

What will be different in an MCP

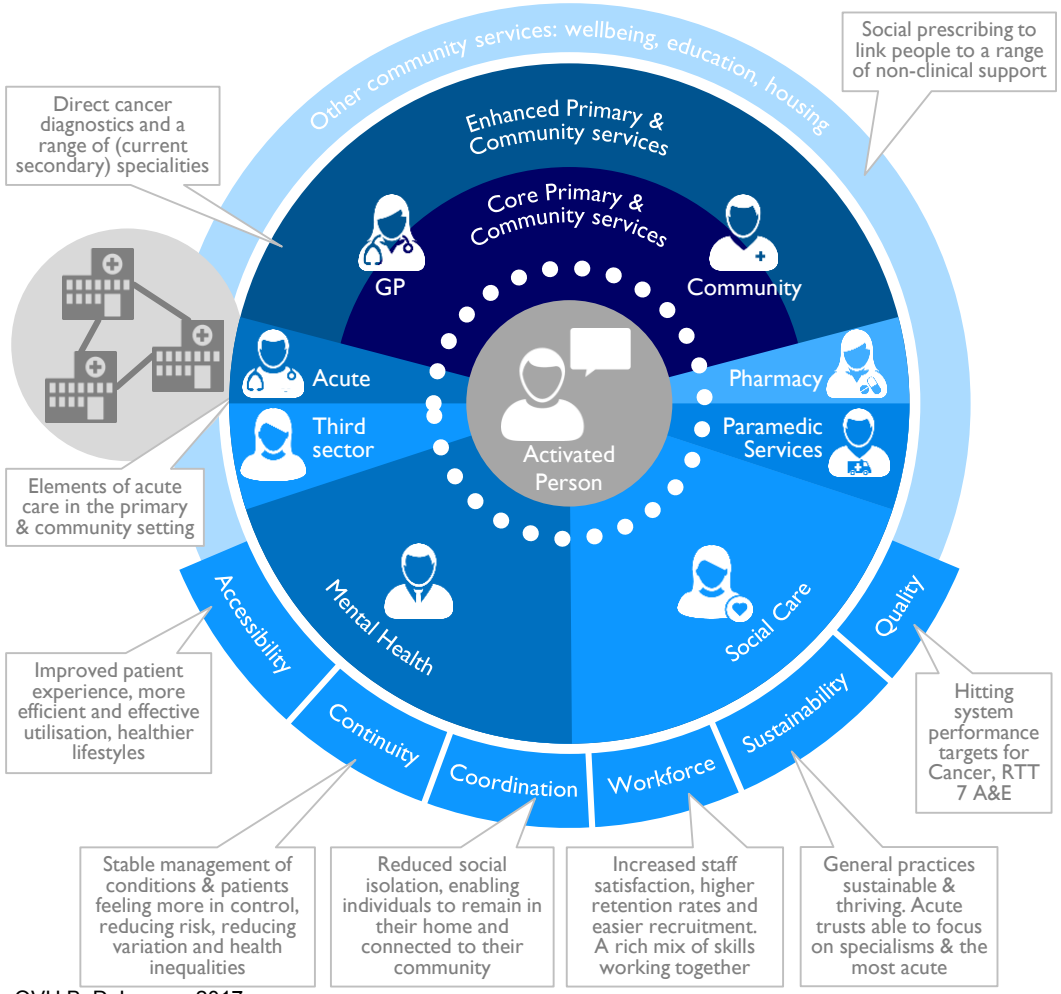
The MCP model arranges care around the person and integrates out-of-hospital services

This is today

The patient experience is very much one of disjointed organisations, with little sense of a joined-up service



This is our future



What the MCP will look like

The key differences in how an MCP will work

Organisational consolidation

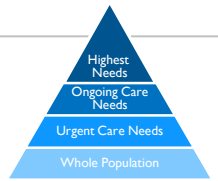
- Integrated primary and community care via networks of general practices. This may mean federations or super practices joining organisations with community providers – or it may mean a prime/subcontractor model
- Organised into 20 care hubs of 30-50k, with a minimum total population of 100k
- Mix of informal alliances, federations, or super-partnerships – working as partners, subcontractors or employees – according to the choice of local general practices
- Closely aligned mental health care and social care, with a consistent MDT structure
- Clinically-led local care hubs
- Collaborative, shared leadership and management across the MCP
- Designed-in connection to and use of the voluntary sector
- Shared estates & back office functions
- Community diagnostics and outpatient services

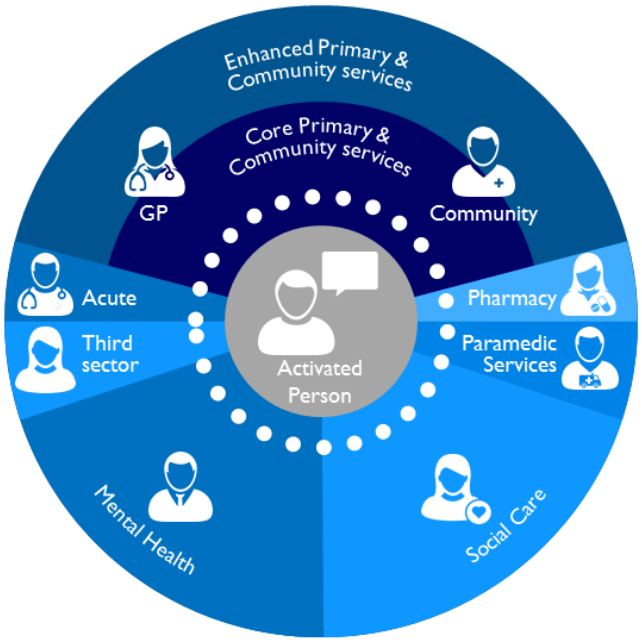
MCP Integrator

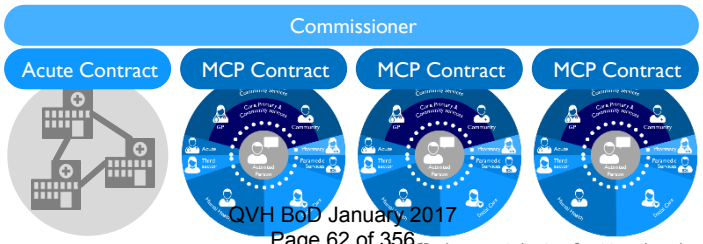
- The model will include a provider-based function to oversee all in-MCP services and respond to commissioner, effectively running delegated commissioning and taking make-or-buy decisions
- Uses dynamic analytics so that continuous data is available info to clinicians, organisations, system and used to adjust services
- Coordinates delivery, defines performance agreements, manages payments, organises networks and membership, trains practice staff

Data driven care model

- Clear and deep understanding of the population needs with risk stratification
- Prevention and care designed for segmented population
- Analytical, predictive models to target variation
- Single technology stack and integrated digital care record across primary, community, social care and acute







3 MCPs shown not indicative of anticipated number

Patient at the centre

- Better patient experience, with the patient's and population's needs determining the services and delivery in a location closer to home
- Activates patients, carers and families
- Uses digital technology to transform contact, diagnosis and treatment
- Supports the patient choice agenda, whilst working in partnership with patients and their families about the most appropriate place of care

Balanced workforce

- Locality managers
- Single workforce with a richer skill mix (GPs, nurses, paramedics, pharmacists, consultants, social prescribers, etc.)
- Redesigned jobs and workforce mobility within and MCP
- Close working with acute, even employing consultants

Devolved finance & contracting

- Broader and larger in scope, joint outcome-based contracts between the CCGs and the MCP, with separate contracts for acute
- Holding single whole-population capitated budgets, with a new performance framework. Discussions are already underway for early shadow budgets.
- Collaborative commissioning and co-design
- Greater responsibility for performance monitoring & management
- Flexibility to manage whole resource pool according to budget

We have strong foundations from which to grow our MCP

We will focus on building the care hub locality services first

- Although CSESA is a relatively new group covering a large and very diverse area, there is a great deal of work to transform services already underway and much good practice to leverage. Social care and mental health are already integrated to varying extents and we are in the process of aligning contracts.
- The parallels and cooperation across CCGs and providers are what has brought us together as a place footprint and is why leaders are aligned on an MCP model as the right answer. This will incorporate the 20 existing care hubs and will be arranged around a robustly networked acute service.
- We want to drive delivery from the care hubs upwards. We are already having conversations about how some of them could be given early delegated budgets to provide services at this local scale.
- There are three key milestones:

Determine number of MCPs
We will perform additional population modelling and compare the options for MCP configuration

Sep 2017

Hold Public Consultation
Gather patient and public feedback on the rationale for, approach to, construction of and number of MCPs

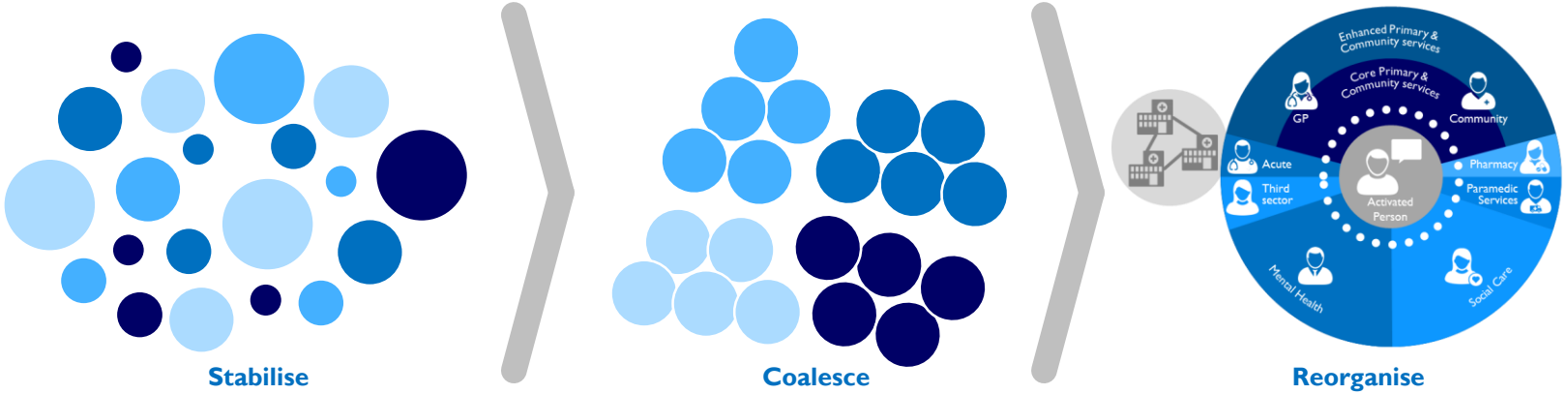
March 2018

Dates TBC subject to purdah

Decide the legal form that each MCP will take
In partnership with providers, establish whether a virtual, partially integrated or fully integrated model works best in each MCP. There is appetite for full integration.

Sep 2018

- We will build MCPs from the ground upwards, starting with establishing sustainable care hubs:



Stabilise
We will focus our immediate effort on laying the firm foundations: establishing strong, sustainable care hubs that deliver services at local scale.

Coalesce
As communities develop and stabilise, we will determine how they informally come together into large groups – taking into account national evidence and learning

Reorganise
The groups will pivot into a formal MCP structure(s) with transfer of workforce into new organisations

How our organisational capability will mature

Comparing where we are now with our ambition highlights the change that is needed

The WISH maturity model sets out 5 capability 'ladders'

- This is a framework for maturity progression for population-based accountable care
- It is a robust framework for planning out the changes that are required to move from our current set of capabilities to those needed to operate our MCP model
- Each step up each of the 5 ladders will mean a significant change to organisation, leadership, ways of working for all staff, use of technology and estates

The LGA and NHS Confederation Integration self-assessment tool will be used to help plan these changes

- This tool will be used to assess the readiness of the leadership, system and programme team for setting out on and managing the complex programme of change

Where we want to be

Where we are now

	i Population	ii Outcomes	iii Metrics and learning	iv Payments and incentives	v Co-ordinated delivery
5	**Intersections accounted for** (ie, co-morbidities)	Outcomes that **matter to people**; prioritized based on **individual goals**	Aggregated longitudinal data made **public** in cross-provider **consistent** format	**Full capitation** with guard rails on quality; differential payments for outcomes	Clinical and data **integration of provider network**; patients **co-design** care
4	**At-risk** individuals identified, using all available sources	Focus on **prevention** and **wellness**; goals adjusted based on patient **risk** level	Results shared with people in **usable** form; monitoring **built into** clinical work flow	Upside and **downside** shared savings; strong professional competition	Patients **empowered** to self-care; **care plan** and **managed transitions**
3	**Registry** of population **integrated** with EHR	**Comparable** with other providers and aligned with global **best practice**	**Real-time** and **summary** learning; results **shared** with payer and clinicians	**Upside-only** shared savings and risk for whole health; bonuses to staff	**Clinicians empowered** to adjust interventions to improve outcomes
2	**Defined** population (eg, morbidity, age, geography, payer)	Incorporation of **patient experience** into targets	**Leading clinical indicators** with **evidence link** to outcomes	**Bundled payments** with quality controls for episodes of care	Multi-disciplinary **meetings**; all team members used to **maximum potential**
1	**Holistic view** of existing funding and providers	**Basic clinical outcomes** decided at local level	**Admin-based** measures; **limited** transparency; summary evaluation only	**Pay-for-performance** bonuses **on top of** fee-for-service or block payments	**Basic electronic data-sharing** across providers
0	No identified population	No target outcomes	No metrics nor learning	Payments for activity only	Uncoordinated provision of elements of care

WISH
مؤتمر القمة العالمي للابتكار في الرعاية الصحية
World Innovation Summit for Health

The clinical approach within the MCP model

We have 4 clinical priorities

	Whole Population	Urgent care needs	Ongoing Care needs	Highest needs
Link to the wider System	Significantly increased prevention initiatives | Integration with public health | Social prescribing and signposting to social and third sector services | Tailored health coaching to encourage self-care	Networked UTC/WIC/MIUs | Broadening direct patient access to services | Diagnostic centres to provide quicker and easier access	Consultants providing advice / support working in the community to the same outcome basis as general practice | Increasing shared decision making in elective pathways | More EOLC at home/in community integrated to hospice care	Geriatricians supporting MDT-led frailty pathway | Community beds model reviewed and services optimised with emphasis on care at home but providing short term specialist support | Responsive services teams & specialist nurses supporting patients needing urgent care in their own homes, preventing admissions and immediate discharge
Locality	Targeted health education based on population data	Locality wide improvements to on the day access towards 7/7 working | Better utilisation of existing walk-in facilities	Connecting to other public services and the voluntary sector | Access to extended care hub team | LTC management through wider skill mix based around practices	Lead GP co-ordinating locality approach | Care hubs as locus of coordination | Practice collaboration in areas such as a visiting service | Integrated health & social care packages | Greater mental health involvement in MDTs
Practice	Increased focus on routine and complex patients (due to urgent on-the-day demand moving to single locality solution)	Different skill mix to enable easier access | digital access to primary care and online diversion to self-care | Load balancing supply across locality	Named primary point of contact. Increased skill mix in practice (nurse practitioners, paramedics, physician assistants etc.)	Locality care coordinators to manage the day-to-day provision of care and act as single point of contact for patients
GP	Increased role in leadership of designing and delivering local services | Increased flexibility to shift between: focussing on routine and complex patients | Providing on-the-day urgent access for locality | Roving GP for home visits		Focused attention on better outcomes/management of LTCs such as respiratory conditions & diabetes (LCS)	Lead professional as co-ordinator of care (not always GP) | Focused attention on better management of complex high cost patients (LCS)
Person	Prevention & self-care	Accessibility	Continuity	Coordination
Examples of services/ projects already in place or in progress, and ready to scale	Care hubs: East Surrey GP Federation Networks | Crawley Communities of Practice | HMS Primary Care Home vanguard | HWLH Connecting 4 You | Brighton and Hove Caring Together Social prescribing | Health coaching and patient activation | Smoking cessation | Homeless GP practice | LCS funding weighted by population need | Care without Carbon	Commitment to place-wide diagnostic centre | Paramedic practitioner Whitstable model | Roving GP | Rapid response community services and tech-enabled care link | A&E GP front door services |Trials of digital consultation channels | Pharmacy moving into community locations | 24-hour single point of access for Mental Health | Safe havens and street triage	MSK pathway | Cardiology triage and ambulatory ECG | Acute referral management | Community geriatrician | Perinatal mental health | Integrated children's mental health | CAHMS transformation plan | Golden ticket dementia service | Community transport | Enhanced nursing home care | Care homes prescribing | End of life care strategy | Tier 2&3 diabetes community service	Complex patients care coordination at practice level | Care-hub MDTs for most complex patients | Lead professional

We will deliver the clinical changes by driving delivery at a local, care hub level within an outcomes-based framework, with consistency, support and enablers managed at a programme level. The clinical work will fit into one of four delivery streams:

Delivery Streams	1. Prevention and self care	2. Improved access to urgent care	3. Continuity for patients with LTCs	4. Coordination of frail and complex patients
Enablers	OD & Leadership	Change Management	Workforce	IM&T	Estates

How our place-based plan will support sustainability of acute care

There is whole-system support for the BSUH recovery plan and building a sustainable acute network

The acute system is **under pressure across our STP**. It is particularly fragile at BSUH, . We recognise the need for **investment** in the BSUH **3Ts** programme and the **Urgent Care Centre expansion** this winter. We also recognise that there is an immediate need to invest in **more beds** as a short term measure but we aim for the place-based system to relieve significant pressure from acute starting next year. We must secure improvements in **patient flows** though the acute sector, which includes plans to **support our ambulance trust** in increasing their performance – for example, working on ambulance handover delays at A&E.

Our model will significantly increase the episodes of care in the out-of-hospital setting, in order to **decrease the demand** on all acute hospitals. Even where resilience is currently good, our plan will ensure that the increasing need and complexity bought by a changing demographic profile will be met while, only increasing activity in secondary care where this is clinically appropriate. We will be looking beyond the health system to **local authorities** and the **third sector** to bring support to a **highly integrated** system.

Our MCP model will have bring **three key benefits** in controlling demand for acute services. It will: **avoid unnecessary attendance**; or **admission**; and **accelerate discharge**

Benefit	Whole Population	Urgent care needs	Ongoing Care needs	Highest needs
Avoid attendance	▪ Increased prevention and self-care will enable people to have increasing disability free life years and, where needed, to access care early, thereby decreasing care need and cost. This is a longer term impact. ▪ Social prescribing will provide people with more rounded health and wellbeing support and will give people a wide range of options so that hospital is not the default solution.	▪ A more integrated approach to urgent care, with improved access to GPs and other local clinicians through the Clinical Navigation Hubs will avoid unnecessary use of A&E ▪ Increased community diagnostics will reduce demand on acute trust diagnostic services currently under enormous pressure such as digestive diseases. It will also detect issues earlier, reducing the amount of acute care needed to treat patients ▪ Paramedic Practitioner Whitstable model seeing patients at home will decrease conveyances ▪ Mental health safe havens will decrease the use of A&E for episodes of crisis ▪ GP on A&E front door	▪ Significant shift of LTC care into the community with specialist support. Working with NHS England in the commissioning and delivery of whole pathways involving specialist services ▪ Elective care system with shared decision making interventions focussed on outcomes ▪ A more resilient range of elective care providers ▪ Reduced barriers between primary and secondary professionals (such as Consultant Connect) ▪ Day case procedures provided by MCP ▪ EOLC with a focus on care in the place of choice will reduce need for patients to come to hospital and support rapid discharge ▪ Enhanced nursing home care will reduce reliance on 999	▪ Community-led MDTs will incorporate consultant input to decrease travel to hospital ▪ Care coordination will ensure timely and joined-up care packages at home, and provide patients with a single point of access ▪ Increasing 'Discharge to Assess' to reduce deterioration and frailty in the acute environment
Avoid admission	▪ Follows from avoided attendance above, but will be a limited impact in the short term	▪ Better integration of community health, social care and mental health led by primary care will make it easier to be able to send patients home with appropriate follow-up care	▪ Increased focus on supported self-management will reduce episodes of crisis that might have needed bed-based care	▪ Proactive integrated care will reduce episodes of crisis avoiding unnecessary bed-based care ▪ Responsive services and specialist nurses will increase treatment at home, avoiding unnecessary short stays
Accelerate discharge	▪ Not applicable		▪ Better integration will make it easier to be able to send patients home with appropriate follow-up care	▪ The integrated MDT and MCP organisation will be a single team helping patients home

Our model includes significant use of acute consultants in a community setting and therefore in time we would expect initiatives such as Hospital at Home to embed as an integral part of the MCP delivery team, led by primary care with support from acute. We will also reduce pressure on the acute saw-case units by providing procedures in the MCP. In the short term, key quick wins include increased community diagnostics and more integrated MDT teams for the most complex patients at risk of admission. Both of these will help relieve pressure from the acute setting quickly.

Timescales

	Year 1 – 2016/17 (next 6 months)	Year 2 – 2017/18	Year 3 – 2018/19	Year 4 – 2019/20	Year 5 – 2020/21
	Strategy	**Co-design**	**Deployment & Shadow contract**	**Stabilisation & new contract**	
Clinical Approach	▪ Use risk-stratification models to identify the priority service needs for 20 care hubs ▪ Determine clinical scope, priority workstreams & resource requirements ▪ Draft logic models (1 per care hub)	▪ Redesign priority pathway redesign (in 4 delivery streams) ▪ Perform full service mapping ▪ Construct business cases for Year 3 shadow running	▪ Deploy 'new' MCP services and localised delivery ▪ Complete full MCP business case(s)	▪ Stabilise MCP-based delivery ▪ Improve and extend services	
Modelling	▪ Iterate financial model & assumptions ▪ Procure & mobilise actuarial modelling ▪ Define capitated budget & delegation framework ▪ Estimate population-based budgets	▪ Build and iterate detailed actuarial model ▪ Calculate delegated budgets at granularity required in each locality	▪ Refine model using evidence from live services ▪ Readjust delegated budgets	▪ Continue to drive benefits	
Procurement & Contracting	▪ Agree contracting approach & principles ▪ Design risk/gain approach ▪ Define procurement strategy	▪ Review national MCP contract ▪ Create outcomes framework for future contracting, including metrics ▪ Create procurement plan	▪ Create 5 year MCP contract ▪ Transition delegated quality monitoring and performance to MCPs (skills, tools, people) ▪ Monitor shadow metrics	▪ Report on benefits realisation at place, MCP and care hub level ▪ MCPs monitor quality and manage performance across care hubs	
Commission reform	▪ Agree approach to leadership, management & ways of working, virtual teams ▪ Specify commissioner OD requirements ▪ Estimate resources to create, run and assure new model	▪ Design & plan commissioner changes ▪ Deploy new commissioner leadership & management structure	▪ Mobilise and transition delegated commissioning functions in MCPs: due diligence, delegation framework, op models ▪ Define future organisation form of CCGs	▪ MCPs running delegated budgets, make or buy decisions ▪ CCGs transition to new organisational form	
Organisational form	▪ Compare MCP configurations (number of MCPs) ▪ Create MCP business plan framework	▪ Complete assessment of org options ▪ Determine no. of MCPs ▪ Define transitional MCP governance ▪ Create business plan per MCP	▪ Define per-locality, multi-speed approach to new orgs ▪ Formalise new orgs		
Workforce	▪ Complete ongoing workforce analysis ▪ Create training, recruitment & retention plan ▪ Specify MCP & care hub OD requirements ▪ Design skills development programme ▪ Design MCP leadership academy	▪ Launch skills development curriculum ▪ Launch academy	▪ Embed 'one team' and 'no borders' cultural change ▪ Increase skills mix through training and recruitment		
Engagement	▪ Create internal comms & engagement plan ▪ Start internal comms & engagement ▪ Create public engagement plan ▪ Start public engagement	▪ Design public consultation ▪ Execute & analyse public consultation (subject to purdah) ▪ Continue workforce comms & engagement	▪ Continue public comms & engagement	▪ Launch event. Ongoing public comms	
Programme & PMO	▪ Agree place-based programme plan for Year 2+3 in detail ▪ Mobilise programme team ▪ Define & mobilise programme transformation governance	▪ Support local delivery to programme plan ▪ Link with overall STP enabler workstreams ▪ Assure delivery of above to plan ▪ Manage risks, issues, programme budget, stakeholder engagement, programme governance			
Milestones	Service Scope defined (01/01) ◆ CSESA Strategy ◆ Programme team in place ◆ CSESA 4 year plan ◆ **Gateway* #1**: Case for Change	#MCPs defined ◆ Public consultation complete ◆ Shadow delegated budgets agreed ◆ **Gateway #2a**: Capabilities & contract set up (shadow)	5 year MCP and acute contracts in place ◆ Delegated budgets agreed ◆ **Gateway #2b**: Capabilities & contract set up (full MCP)	◆ MCPs live **Gateway #3**: Is it safe to commence?	

* *Gateways based on proposed Dudley CCG approach*

What it will take to execute

Significant investment, time and thought will be needed to bring about this change

Investment in primary care is absolutely essential to the success of changing the system. Our GPs will provide clinical leadership, and they are at the heart of care hubs – our engines for delivery.

Investment

- **Investment** in all of the items listed here is needed, starting with **primary care**
- A **ring-fenced, pooled budget** used to fund all the above activity and the associated costs of delivery
- Tight, **centralised financial management** of budgets

Contracting

- An **outcomes framework** aligned with the national MCP contract and an agreement on **a risk/gain share** approach
- An framework for establishing **delegated budgets** to support shadow contracting, with a view to identifying early pilot delegated budgets e.g. in PCH vanguard

Leadership Development

- **Clinical leaders championing the change**, and working directly with peers to drive engagement across primary, community, secondary, tertiary, mental health, nursing, hospice, ambulance, pharmacy and other experts
- **Co-production** of service redesign engaging both workforce and patients – a coal-face integrated approach to implementing change, enabled by senior management delegation of local decision making
- Creating the **right forums and environment** to accelerate clinical dialogue at all levels – from care hubs through MCP up to governance forums – to **cut across organisational boundaries** and foster true joint working
- Continuous **clinical and patient/carer input** into service design
- **Leadership academy** to be ready in next academic year

Workforce

- Initial informal agreement to **pool workforce** where practical, via loans or secondments. Requires a **willingness to work across organisational boundaries**. **Workforce planning** needs to be performed across the **whole system**.
- Rapidly developed **training curriculum** to support Collaborative Care and Support Planning and enable us to grow the right type of resources. **Education** to upskill existing resources. This is needed to underpin both clinician and patient activation.
- **Place-wide contracts** for resource types across a variety of roles (e.g. paramedic practitioners, advance nurse practitioners)

Technology

- A fully developed **roadmap of delivery** for an **integrated digital care record**, including interim improvements to enable care hubs to operate at local scale
- **Clinical and patient/carer input** into solution design and testing
- Properly resourced **implementation team**

Estates

- **Pooling of estates** resources across the place into a single asset register, aligned with One Public Estate and combined ETTF bids
- Creation of additional space; repair, repurposing or disposal of existing space
- Use of estates for building **housing for key workers**
- **Consolidation** of estates management functions

Change Management

- A **dedicated function** for enabling the workforce, patients and public to absorb the changes
- An agreed change model for the **whole health and care system**
- A detailed and robust **comms and engagement** plan, backed up by the resources to execute it
- A new **operating and governance model**

Programme delivery

- A **single programme** plan run by a senior programme director, backed up by a team of clinical and commissioner experts, seconded subject matter experts and a lean PMO function
- Leveraging of **local care hub leadership** to deliver services within the programme timescale. Learning from local **vanguard PCH** projects.
- **Sponsorship** at the highest level and recognition that this is the single highest priority

Assumptions driving our financial model

There are a number of different levers that could be pulled in the acute setting to close the forecast financial deficit. The finance subgroup will model the impact of these levers to propose an optimal model that is both deliverable and maximises the potential savings.

Lever	Definition	Reduction assumption (worst case)	Max. saving	% saving	Cost of alternative…	…based on
Frailty	Any non elective admission for a patient over 75, with LOS <7 days	The SASH frailty business case assumes a Frailty Centre to provide a multidisciplinary approach to reducing frailty admissions; this could be implemented across all sites.	£21.2m	40%	£884 per avoided spell	Cost per patient in SASH Pendleton Assessment Unit (PAU) business case
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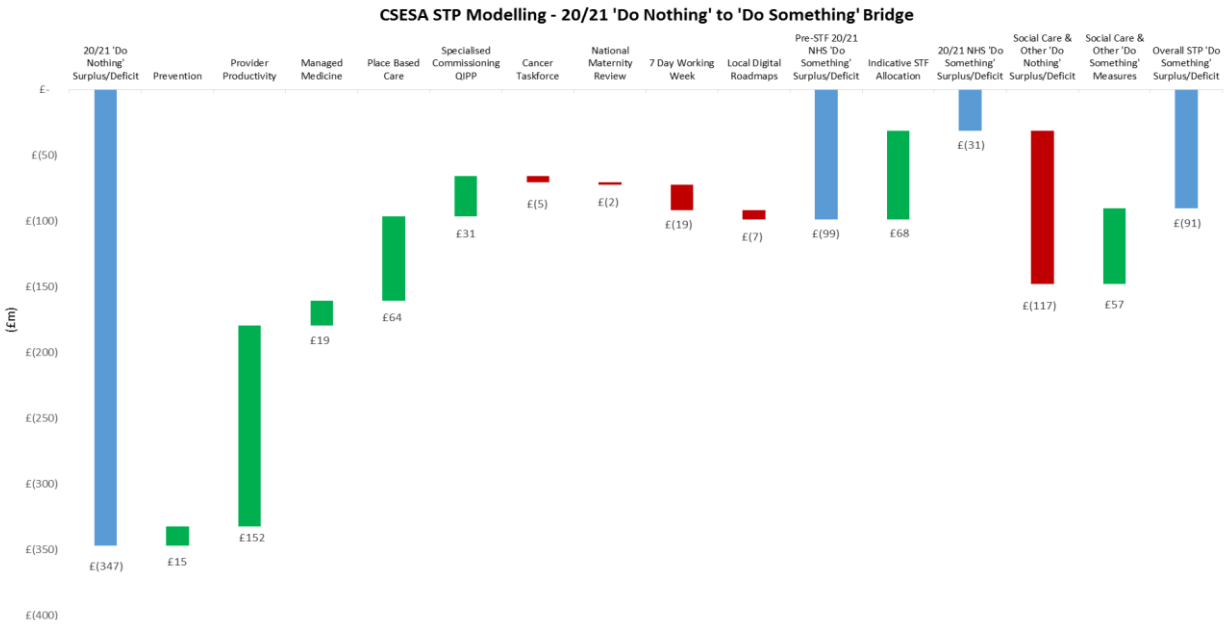
The model then de-duplicates savings by applying business logic to historical per-person data. It also assumes a benefits lag. After these adjustments the expected annual saving is:

Total annual saving expected at the end of year 5	£92m

← Indicative estimate that that there are sufficient savings available

Finance projection

By 2021 we expect to have addressed the financial gap – and improved quality and performance



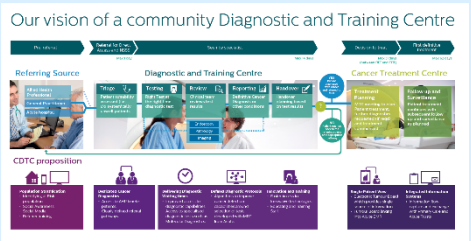
By Year 5 we will have reduced the healthcare deficit to £31m

- The current level of modelling performed indicates that there is sufficient total benefit (within the nine levers identified in our assumptions) to reduce the acute costs by 25% while being re-provided in the community at 70%; or cheaper. This is equivalent to a net saving of 7.5%.
- At this stage, the model does not take into account the one-off or ongoing investments in primary care that will be needed to enable this change to happen.
- We will undertake a more detailed modelling exercise between now and the end of March 2017. This will be done in parallel with a programme planning exercise so that firm dates can be put against benefits and costs.
- This doesn't take into account the quality and performance improvements that we expect the new model of care to bring, or the sustainable system that it will create.

- Further detailed modelling can examine whether increasing capacity out of hospital will lead to a direct corresponding reduction in bed capacity in acute. There are two reasons why this may not be the case:
  1. The immediate impact of reducing demand will be to enable the hospitals to remain safe at all times, even through winter resilience pressures
  2. A secondary impact will be to create the headroom for hospitals to absorb the additional – appropriate – demand that will occur with the demographic changes in the population, without having to open additional wards

We are assuming it will be possible for early wins to bring benefit in Year 2

- Our current model assumes a linear ramp-up of benefits over four years, starting in Year 2. This means that we expect 25% of benefits to have kicked in by March 2018. The model does not at this point specify the projects that will deliver this 25% of benefits in year 2.
- By the end of this financial year we will have drafted tailored logic models for each of the 20 care hubs in the CSESA place. These will help us to identify where to target early wins in each locality and across the place. However, there are projects that we aim to see delivering substantial benefits by the end of Year 2, for instance:
  1. We are currently exploring how to stand up one or more community diagnostic and training centres. These would supply X-ray, CT, MRI, ultrasound, bone scan and barium swallow services and address both the immediate shortfall in equipment and staffing capacity as well as the projected demand. This will significantly improve early diagnosis rates and RTT for cancer and other acute, chronic and long term conditions, which in turn will improve patient outcomes.



  2. Risk stratification will identify interventions needed for the top 2-5% of patients with long term conditions. Locality MDTs, widespread care coordination and efforts to increase patient activation can be put in place quickly to reduce the spend on the most costly percentiles whilst improving the quality of their care.

Governance

An adjusted governance model will be needed to oversee this period of transformation

- To launch the **integrated system** that our vision sets out, correct **governance is essential** to have decisions made by the groups with the appropriate legal authority to do so.
- Decisions need to be **binding**, made at the **right level** and the **right pace**. This will require clear roles and responsibilities, with engagement from the right stakeholders in the right forums at the right time.
- Moving to a single health and social care governance model across 5 CCGs and 4 local authorities will be a **complex task** and will take time to negotiate. This design and deployment work will be undertaken by the Change workstream of the programme and therefore an end-state solution is not set out here.
- In this submission, we define instead a proposed model of **governance** to **oversee the programme** and the **transition** to a new model. This is based on a set of **guiding principles**

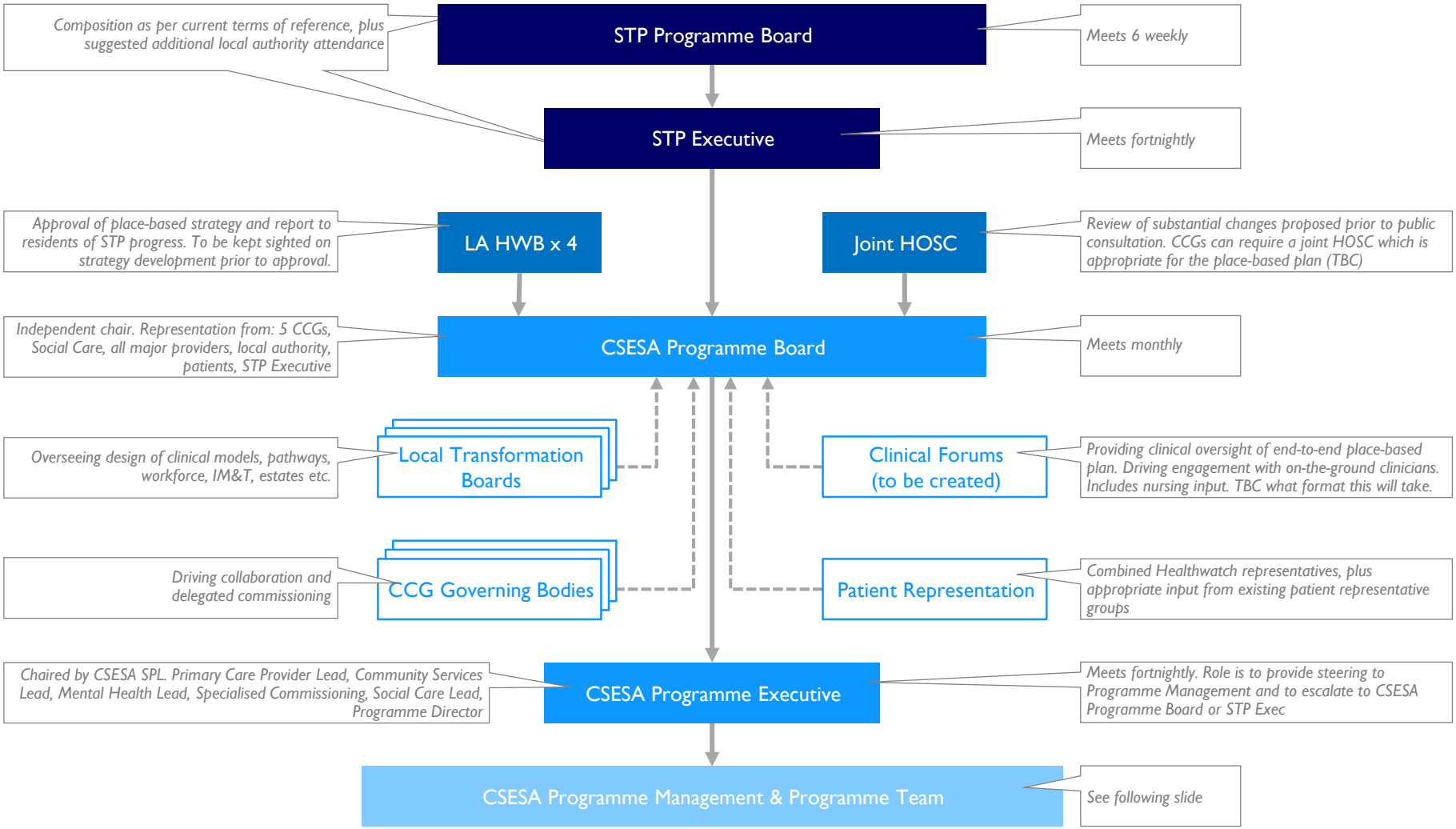
- Note that A common case for change, a common set of principles, a common MCP approach and common governance will not necessarily result in a singular outcome in terms of organisational form or local delivery model

Principles of Governance

- ✓ *Shared leadership*
- ✓ *Parity between board members*
- ✓ *Representation of all major providers*
- ✓ *Shared ownership of the board and accountability to communities*
- ✓ *Openness, transparency, inclusiveness*
- ✓ *Joined up governance to avoid repetition*
- ✓ *Programme board independent chair*
- ✓ *Democratic representation to provide public accountability*
- ✓ *The public will be engaged throughout and consulted appropriately*
- ✓ *Place-based programme aligns strategic direction across 'place'*
- ✓ *Seeks integration, sharing and efficiencies across place-based themes*
- ✓ *Works with the leadership of the other two places to align across borders and avoid repetition or competition*
- ✓ *Delivers consistent messages to STP Programme Board & individual organisations sovereign governance arrangements*
- ✓ *Delivers place-based messages alongside local strategy to the 4 HWB's to enable an aligned strategic view across the whole of the local health and care economy*
- ✓ *Local HOSCs continue to review proposals for substantial change in context of place based plans*
- ✓ *Single financial statements*
- ✓ *Single published view of estates*

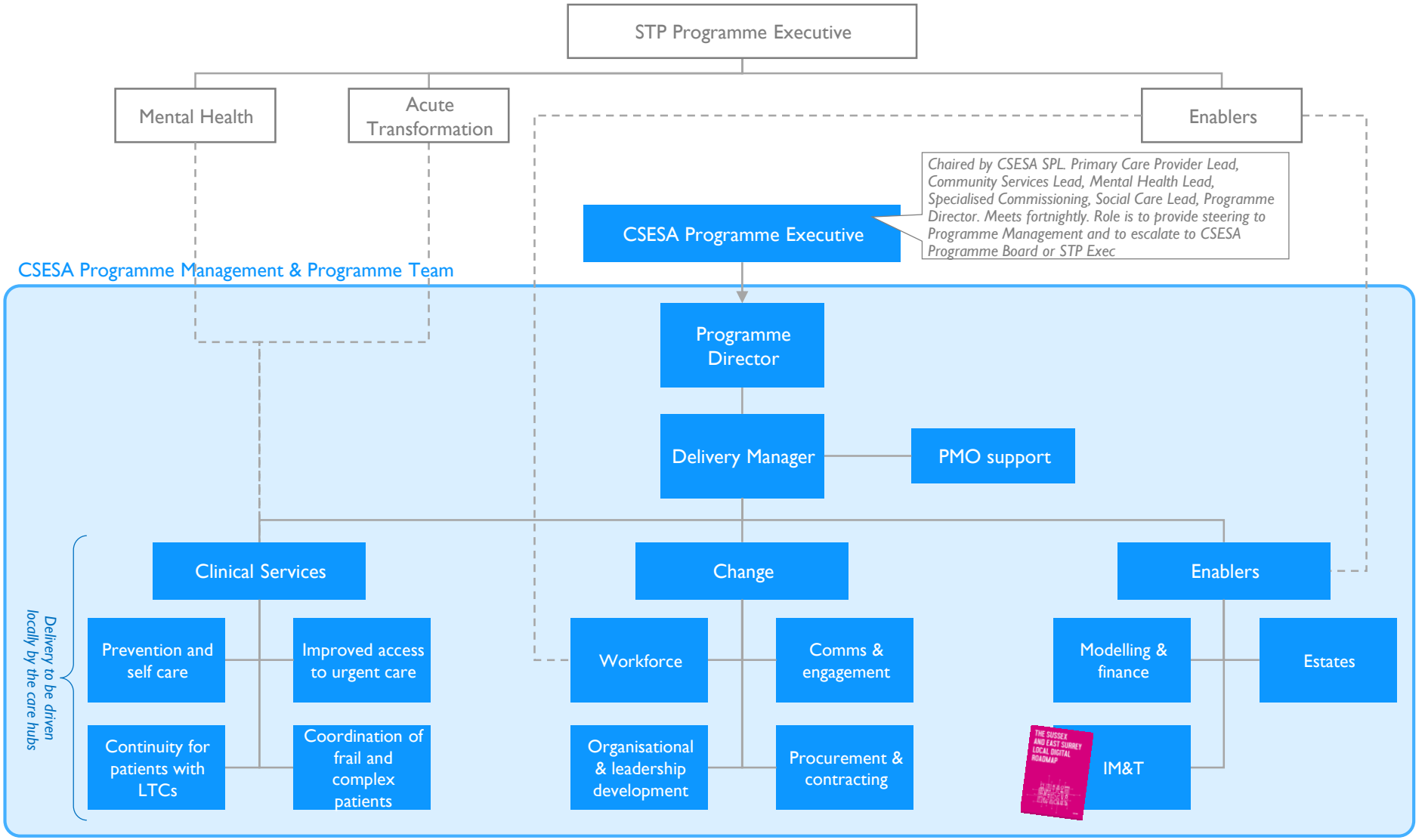
Programme and transition governance model

The **governance** here is that needed to oversee the **journey**, not the end state



Delivery programme structure

A robust, dedicated **programme team** to **deliver** the plan



In conclusion

The Central Sussex and East Surrey Alliance has a strongly held vision in common and we are already moving in the same direction

- We will transform our model of care: from one that is reactive, often crisis-triggered and heavily acute-focused – to one that promotes wellbeing, provides early detection and diagnosis and empowers people to manage their health more effectively within their communities. Primary care will lead the delivery of an effective and sustainable new care model. Practices will work in a more co-ordinated way with each other around natural geographies, embracing a wider skill mix. They will integrate with community health, mental health, social care and voluntary services.
- Each of the five CCGs have already established their respective care hubs. All 20 care hubs are in the process of integrating care around their local populations. We are also beginning to evidence the impact of more proactive, community-based care on utilisation of acute care - albeit in a narrow cohort of patients or geographical patch. Working together across the CSESA footprint, we will drive a level of efficiency, scale and pace for our clinical redesign programmes and organisational development. As we move to our MCP model we will consolidate pathways into and out of our acute providers more effectively. We will also have greater impact by working together on key enablers such as workforce requirements, interoperable digital care records and estates.
- We have set out an ambitious programme to realise fully operational, legal MCP entities by 2020. This will be underpinned by robust benefits realisation of the new care models, delegated population based budgets and reform of the commissioner landscape.
- We will now actively engage more fully with patients, clinicians, our public and key stakeholders, and in particular our local authority colleagues.
- We have a credible vision, a defined care model, clear timelines, demonstrable work in progress and a good understanding of our financial case. This puts us in a strong position to register an expression of interest for the next wave of vanguard funding.

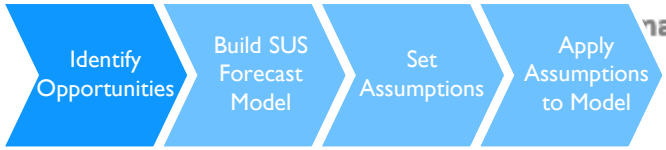
Appendix A

Financial Modelling

Modelling Approach

Identify Opportunities	We have identified a number of activity groups that could potentially be moved out from the Acute setting. Each of the activity groups have been linked to discrete episodes with SUS data to enable us to understand the scope in terms of spells, bed days and tariff.
Build SUS Forecast Model	We have developed a sophisticated model that extrapolates historical SUS data into the future, using granular population growth data and historical trends.
Set Assumptions	Against each opportunity, we have identified the size of the opportunity, the extent to which Acute activity could be reduced and what it would cost to either reduce or re-provision the activity in a community / primary care setting.
Apply Assumptions to Model	The "before" and "after" SUS forecasts are compared to understand the impact of the opportunities in terms of bed days, spells and total spend.

We have identified 9 opportunity areas



Lever	Definition
Frailty	Any non elective admission for a patient over 75, with LOS <7 days
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Lever	Definition
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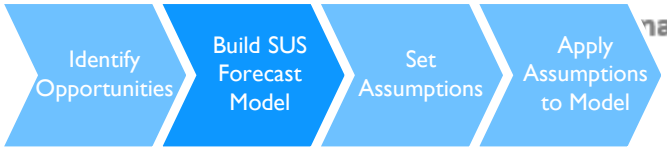
A&E	All Type 1 A&E activity, excl. UCC
First Outpatient Appts.	All first OP appointments

Lever	Definition
Long Term Conditions	As per CCG Docobo risk stratification definition
Complex Patients	As per CCG Docobo risk stratification definition
PBR Excluded Drugs	All spend associated with PBR-X drugs

We have built a sophisticated model



Our model extrapolates out episode-level SUS data out to 2020

Demographic Growth and Demographic Change

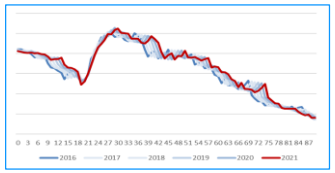
- Using granular ONS population data, we have extrapolated out episode-level FY2015/16 SUS data out to FY2020/21. This equates to 4,000,000 rows of data in the model, and is built on MS SQL-Server.
  - For example, if a CCG has an aging population, then the demand for services that the elderly will consume will grow at a faster rate than other services.
  - Similarly, as the elderly tend to have longer lengths of stay, the bed day demand will also increase.

Non Demographic Growth

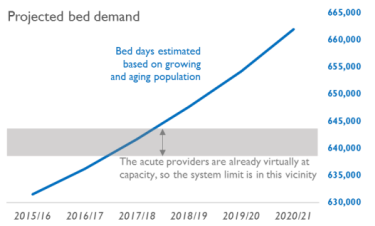
- Patient's expectations are increasing, as are advances in medical treatment. This has lead to longer term trends in activity that are, in many cases, over and above the demographic change.
- We have applied 3-year growth trends at POD / CCG level to the data.

Activity x Population Growth by Year and age band x 3yr historical Trend = Future Demand

Age	Gender	Specialty	HRG	Cost
0	M	560	PA57Z	£1,088
37	F	560	PB03Z	£981
68	M	560	PB03Z	£1,088
52	M	501	NZ08C	£1,088



CCG	POD	3 Yr. Trend
09D	A&E	2.05%
09D	DC	0.67%
09D	EL	2.90%
09D	NEL	-1.21%
09D	NELNE	-1.21%
09D	NELSD	-1.21%
09D	NELST	-1.21%
09D	OP	3.60%



We set the levels for our assumptions

The Directors of Finance for the 5 CCGs agreed the levels of saving and the cost of the alternative

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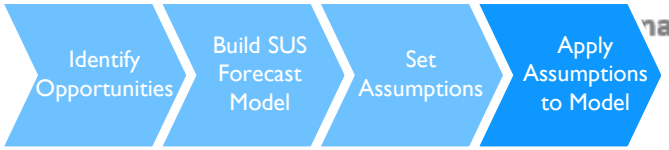
Total annual saving expected at the end of year 5 £92m ← Indicative estimate that that there are sufficient savings available

The model enables users to test the impact of different assumptions



- The front end of the model is built in Excel (see following slide) and takes a summary feed from the SUS Forecast model.
- The summary feed totals activity and cost by a variety of dimensions including CCG, POD, Site, Year, and, importantly, allocates flags against the each row according to which opportunities the data applies to.
- Within the Excel model, we can assign multiple opportunities to each episode.
  - For example, a 75 year old non elective admission could be subject to multiple opportunities, but in reality that episode can only be saved once.
  - The model ensures that double counting is minimised by applying business logic to each episode; this ensures that for opportunities are that mutually exclusive, only the opportunity that has the greatest impact is applied.
- The CCGs and Providers can then apply different assumptions to the model, and instantly see the impact. These assumptions are:
  - Year-by-year scale to which Acute activity can be reduced by each opportunity
  - Unit cost of re-provisioning or avoiding Acute activity
- As the model is built up from granular data, it is possible to view the impact of the opportunities by multiple dimensions:
  - CCG, Site / Trust, POD etc…

A quick overview of the Excel model

1 Do Nothing view, aligned with 2020Delivery financial model

2 Opportunities, and extent to which activity could be reduced

Do Nothing

	In Patient, Out Patient and A&E	*Baseline*	*Do Nothing*	-->	-->	-->
	CCG	**2016**	**2017**	**2018**	**2019**	**2020**
	NHS BRIGHTON & HOVE CCG	£ 120.8m	£ 122.3m	£ 123.6m	£ 124.9m	£ 127.5m
	NHS CRAWLEY CCG	£ 66.4m	£ 67.4m	£ 68.4m	£ 69.4m	£ 71.2m
	NHS EAST SURREY CCG	£ 96.0m	£ 96.1m	£ 96.1m	£ 96.2m	£ 97.3m
	NHS HORSHAM AND MID SUSSEX CC	£ 112.3m	£ 115.7m	£ 118.8m	£ 122.1m	£ 126.6m
	NHS HIGH WEALD LEWES HAVENS CC	£ 81.4m	£ 82.8m	£ 84.1m	£ 85.3m	£ 87.4m
	NON PBR DRUGS (CCG)	£ 19.2m	£ 20.1m	£ 21.0m	£ 22.0m	£ 23.2m
	OTHER ACUTE ACTIVITY	£ 53.4m	£ 59.8m	£ 67.2m	£ 74.2m	£ 81.2m
	ACUTE - NON NHS	£ 66.0m	£ 67.8m	£ 69.6m	£ 71.4m	£ 73.8m
SUS	SPECIALIST	£ 59.1m	£ 62.6m	£ 66.0m	£ 69.6m	£ 73.6m
Non SUS	SPECIALIST (Non SUS)	£ 165.3m	£ 178.1m	£ 192.4m	£ 207.7m	£ 225.8m
	NON PBR DRUGS (SpecComm)	£ 37.0m	£ 40.2m	£ 42.1m	£ 44.1m	£ 46.2m
	TOTAL	**£ 876.8m**	**£ 913.0m**	**£ 949.2m**	**£ 987.0m**	**£ 1,033.8m**

	Levers	**Spend (2016)**			**2017**	**2018**	**2019**	**2020**
2	Frailty	£ 19.3m	40%	*Patient is over 75, LOS < 7, NEL*	10%	20%	30%	40%
3	Elective Reduction	£ 296.3m	10%	*PCD is EL, DC or Out Patient*	3%	5%	8%	10%
4	Step Down Care	£ 8.1m	50%	*Age > = 75, Excess Bed Days*	13%	25%	38%	50%
5	Non Elective Admission	£ 19.7m	30%	*NEL, LOS < = 1*	8%	15%	23%	30%
6	A&E	£ 26.2m	30%	*HRG in VER07Z, VER08Z, VER09Z, VER11Z; no*	8%	15%	23%	30%
7	First Outpatient Appointments	£ 47.4m	5%	*First OP*	1%	3%	4%	5%
8	Long Term Conditions	£ 2.9m	50%	*HRG in Diabetes, Pulmonary, Arthritis or A*	13%	25%	38%	50%
9	Complex Patients	£ 35.6m	30%	*Previous CCG analysis (see tab)*	8%	15%	23%	30%
10	PBR Excluded Drugs (CCG)	£ 19.2m	20%		5%	10%	15%	20%
11	PBR Excluded Drugs (SpecComm)	£ 37.0m	20%		5%	10%	15%	20%

3 Ramp-up profile of opportunities

Do Something - based on Levers

	In Patient, Out Patient and A&E	*Baseline*	*Do Something*	-->	-->	-->
	CCG	**2016**	**2017**	**2018**	**2019**	**2020**
	NHS BRIGHTON & HOVE CCG	£ 120.8m	£ 119.0m	£ 116.9m	£ 114.7m	£ 113.5m
	NHS CRAWLEY CCG	£ 66.4m	£ 65.5m	£ 64.4m	£ 63.2m	£ 62.7m
	NHS EAST SURREY CCG	£ 96.0m	£ 93.4m	£ 90.6m	£ 87.8m	£ 85.9m
	NHS HORSHAM AND MID SUSSEX CC	£ 112.3m	£ 112.5m	£ 112.2m	£ 111.9m	£ 112.6m
	NHS HIGH WEALD LEWES HAVENS CC	£ 81.4m	£ 80.5m	£ 79.3m	£ 78.1m	£ 77.6m
	NON PBR DRUGS (CCG)	£ 19.2m	£ 19.1m	£ 18.9m	£ 18.7m	£ 18.6m
	OTHER ACUTE ACTIVITY	£ 53.4m	£ 59.8m	£ 67.2m	£ 74.2m	£ 81.2m
	ACUTE - NON NHS	£ 66.0m	£ 67.8m	£ 69.6m	£ 71.4m	£ 73.8m
SUS	SPECIALIST	£ 59.1m	£ 61.3m	£ 63.4m	£ 65.5m	£ 67.9m
Non SUS	SPECIALIST (Non SUS)	£ 165.3m	£ 178.1m	£ 192.4m	£ 207.7m	£ 225.8m
	NON PBR DRUGS (SpecComm)	£ 37.0m	£ 38.2m	£ 37.9m	£ 37.5m	£ 36.9m
	[Complex Patients]	£ - m	-£ 2.7m	-£ 5.6m	-£ 8.7m	-£ 11.9m
	TOTAL	**£ 876.8m**	**£ 892.5m**	**£ 907.2m**	**£ 922.2m**	**£ 944.6m**
	Acute Savings	**£ - m**	**-£ 20.5m**	**-£ 42.1m**	**-£ 64.8m**	**-£ 89.2m**

4 View of Acute spend once opportunities have been implemented

Assuming no savings
Assuming no savings
Assuming no savings
Complex patients are calculated separately, in lieu of Docabo data to merge with SUS

5 Cost of reducing / re-provisioning each opportunity

Prevention / Reprovisioning Costs

	Lever	**2016**	**2017**	**2018**	**2019**	**2020**
	Frailty	£ - m	£ 0.7m	£ 1.4m	£ 2.2m	£ 2.9m
EL	Elective Reduction	£ - m	£ 0.6m	£ 1.2m	£ 1.9m	£ 2.6m
DC	Elective Reduction	£ - m	£ 1.1m	£ 2.2m	£ 3.4m	£ 4.5m
OP	Elective Reduction	£ - m	£ 1.1m	£ 2.3m	£ 3.5m	£ 4.9m
	Step Down Care	£ - m	£ 0.7m	£ 1.3m	£ 2.0m	£ 2.7m
	Non Elective Admission	£ - m	£ 0.5m	£ 0.9m	£ 1.4m	£ 1.9m
	A&E	£ - m	£ 2.0m	£ 4.0m	£ 6.2m	£ 8.4m
	First Outpatient Appointments	£ - m	£ - m	£ - m	£ - m	£ - m
	Long Term Conditions	£ - m	£ 0.0m	£ 0.1m	£ 0.1m	£ 0.2m
	Complex Patients	£ - m	£ 0.7m	£ 1.5m	£ 2.3m	£ 3.2m
	PBR Excluded Drugs (CCG)	£ - m	£ - m	£ - m	£ - m	£ - m
	PBR Excluded Drugs (SpecComm)	£ - m	£ - m	£ - m	£ - m	£ - m
	TOTAL	**£ - m**	**£ 7.4m**	**£ 15.0m**	**£ 23.0m**	**£ 31.2m**
	Net Savings	**£ - m**	**-£ 13.2m**	**-£ 27.1m**	**-£ 41.9m**	**-£ 58.0m**
			Net Total (across all years)			**-£ 140.2m**

	Levers		**Unit Cost**	**Units**	
	Frailty		£ 884	*per admission reduced*	*Based on SASH bus case*
	Elective Reduction	EL	£ 981	*per elective reduced*	*Avg cost of Day Case*
	"	DC	£ 450	*per day case reduced*	*Avg cost of OP1 + 2xOP2*
	"	OP	£ 40	*per out patient appointment saved*	*Estimate*
	Step Down Care		£ 150	*per excess bed day saved*	*Estimate*
	Non Elective Admission		£ 320	*per admission reduced*	*Based on OP1 cost*
	A&E		£ 90	*per attendance saved*	*Based on Crawley average*
	First Outpatient Appointments		£ 40	*per attendance saved*	*Estimate*
	Long Term Conditions		£ 204	*per admission reduced*	*Self care*
	Complex Patients		£ 884	*per admission reduced*	*Specialist unit*
	PBR Excluded Drugs (CCG)		£ -	*per £ saved*	*Estimate*
	PBR Excluded Drugs (SpecComm)		£ -	*per £ saved*	*Estimate*

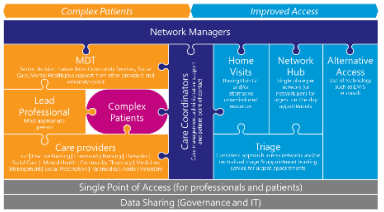
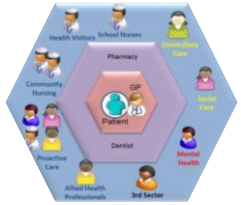
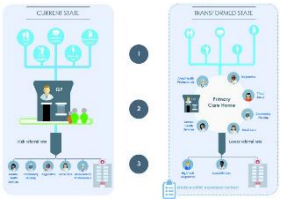
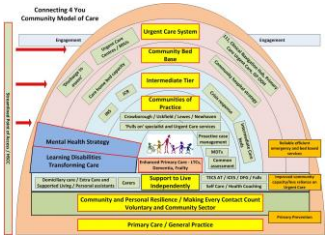
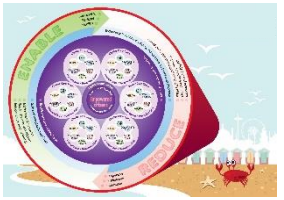
6 Net impact to financial position

Appendix B

Existing primary care development projects

How each CCG is currently developing primary care

All 5 CCGs are already taking steps to integrate primary care at scale

CCG	# Care Hubs / practices	Development Project Name	Current status summary	Model
East Surrey	4 Networks / 18 general practices	Primary Care Networks	There is a GP Federation – Alliance for Better Care Ltd – representing all practices which has worked with the CCG and other partners to co-develop new models of care that can be used to both drive the establishment of the networks and improve access to urgent care and the coordination of the most complex patients, including integrated models with social care, mental health and community services. The CCG has awarded a preferred provider contract to the federation for enhanced primary services, and is now determining how best to invest in the new model.	
Crawley	2 Communities of Practice / 12 general practices	Communities of Practice	In 2016/17 the CCGs are jointly developing enhanced primary healthcare teams, bringing together community nursing teams and multi-disciplinary proactive care teams into one integrated team based around communities of practice in the communities. Care will be designed around complex patients supported by the enhanced multidisciplinary teams and focused on early intervention, living well at home and avoiding unnecessary use of the hospital with specialist care in the community. They will test and widen new skills and roles for enhanced primary care teams, including for example increased use of pharmacists, community paramedics and advanced nurse practitioners. They will work more closely with the third sector. There will be a much stronger focus on empowering and supporting patients and their carers, to give them the knowledge, skills and confidence to manage their own condition. In East Grinstead, HMS CCG are running a vanguard pilot of the Primary Care Home model.	
Horsham and Mid Sussex	4 Communities of Practice / 23 general practices	Communities of Practice & Primary Care Home (PCH)		
High Weald Lewes Havens	4 Communities of Practice / 20 general practices	Connecting 4 you	Established four localities to develop 'Communities of Practice' to deliver integrated primary, community and urgent care services. Developing networks in the four localities to identify and deliver bespoke and agreed local priorities to improve primary care sustainability, access and outcomes. Launching the redesigned MSK, diabetes and dementia pathways, and OOH / urgent care plans. Improving care for the frail elderly and vulnerable population. A review of the services provided in primary care for people with learning disabilities. Further developing pathways for standardised approach to LTCs. Provision of responsive and children's services. High Weald is part of a pioneer site for maternity choice	
Brighton & Hove	6 Clusters / 44 General practices	Brighton & Hove Caring Together	B&H CCG have moved 5,000 patient pathways per year from hospital to community and primary care settings and contained growth in demand for hospital services - over the past five years A&E attendance has remained stable and emergency hospital admissions have decreased. To do this, they grew our crisis response services and run award-winning public communications campaigns. They use risk stratification, deliver proactive care through the clusters, deploy care coaches and health trainers, and launched 'My Life' website.	

Appendix C

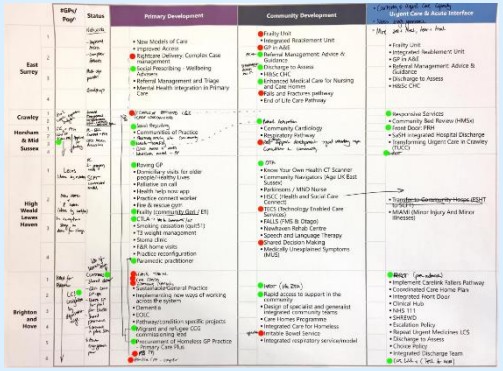
Parties involved in developing this plan

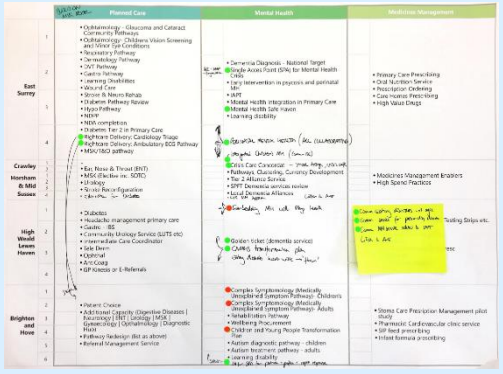
Workshops

Most content was generated through three workshops. Remaining content was established through a mixture of one-to-one conversation, and frequent review of iterated document drafts by all parties.

CCG integration leads

- Directors worked together to identify which projects and plans from each CCG could be easily shared and re-used across the place – and which areas of development needed collaborative thinking



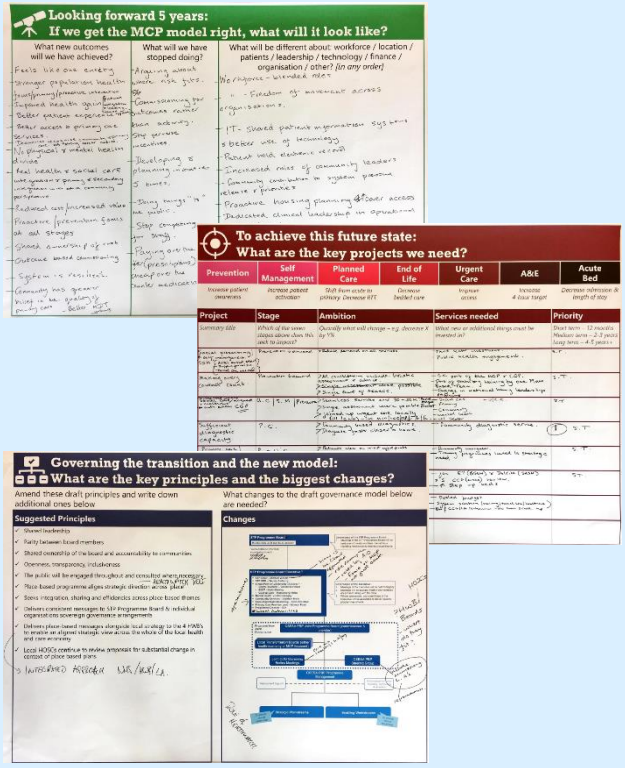


Providers

- Leaders of the following organisations worked on the place's vision, priority projects and governance
- **CCGs**: All 5
- **General practice**: ABC (East Surrey GP federation)
- **Acute**: Surrey and Sussex Healthcare, Queen Victoria Hospital, Brighton and Sussex University Hospitals
- **Community health**: First Community Health Care, Sussex Community Foundation Trust
- **Mental health**: Surrey and Borders Partnership, Sussex Partnership
- **Paramedic services**: SECAmb
- **Local authority**: West Sussex County Council, East Sussex County Council, Brighton and Hove County Council
- **Health education**: Kent, Surrey & Sussex Leadership Collaborative
- **Patients**: Healthwatch Surrey, Brighton & Hove

GPs

- A group of GPs and practice managers drawing from CCG clinical chairs, CCG clinical leads, GP federations and interested GPs discussed an early draft of the place based plan; and what it will take to drive engagement from primary care in this change



KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing
Committee: Quality & Governance
Date last reviewed: 14 December 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 **4 (C) x 3 (L) = 12 Amber**
Residual Risk Rating 4 (C) x 2 (L) = 8 Yellow

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,
Affordable plan for modernisation of the estate in development
Failure to attract workforce with right skills
National shortages of nurses and practitioners in theatres and ITU

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 completed.

Controls / assurance
Ongoing estates maintenance and remedial work, monitored at Estates & Facilities Steering Group
Clinical quality standards monitored by the Quality & Governance Committee and the Joint Hospital Governance Meeting ,Monthly safer nursing care metrics
External assurance and assessment undertaken by regulatory bodies/stakeholders
Regular monitoring of FFT and patient survey results, Patient membership on the PEG,
Quality Account/CQUINS, PMO approach to CQUIN management post appointed
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
Nursing Consultation
Local media recruitment plan for critical care and review of roles
Sub group for theatre workforce/recruitment

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
Vacancies in critical care and theatres

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**05/01/17**		**Agenda reference:**	**08-17**	
Report title:	**Corporate Risk Register (Reporting period of 01/10/2016 – 31/10/2016)**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Alison Vizulis, Head of Risk				
Appendices:	None				
Executive summary					
Purpose:	For assurance that risks are being identified, reviewed and updated in a timely manner				
Recommendation:	The Board is requested to note the Corporate Risk Register information and the progress made.				
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:	Internal links exist from the Corporate Risk Register to the BAF				
Corporate risk register:	This document				
Regulation:	Compliance with regulated activities in Health and Social Care Act 2014 and CQC essential Standards of Quality and Safety.				
Legal:	As above				
Resources:	No additional resources required to produce the report				
Assurance route					
Previously considered by:	The Corporate Risk Register was considered by the Clinical Cabinet , Quality and Governance Committee, Audit Committee and Executive Management Team in December 2016.				

Corporate Risk Register Report – October 2016 Data

Key issues

1. **Two new risks were added** to the Corporate Risk Register between 01/10/2016 and 31/10/2016 with a score of 12+ as below:

Risk register	Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
Corp	4x3=12	1003	Information Technology Network Outage - Risk that a power outage within the Trust will result in the IT network taking up to 60 minutes to fully restore network connectivity after the power is restored. The impact could be loss of connectivity to all IT services and systems on-site and access to and from off-site.	Incident review preparation for IM&T Group with IT Manager Discussed with Director of Finance
Corp	4x3=12	1004	Information Technology Server Software Operating System - Windows 2003 Server operating system is no longer supported by Microsoft as of July 2015. 17 out 140 servers are currently using unsupported operating system	Incident review preparation for IM&T Group with IT Manager Discussed with Director of Finance

2. **Two risk scores (12+) were changed** during October 2016, as below:

Risk Register	Risk ID	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore	Committee where change(s) agreed/ proposed
Corp	909	Forthcoming industrial action by junior doctors - Potential Impact on Patient Safety	4x3=12	3x3=9	Changes to doctors strikes	Discussed with Medical Director and at CGG & Q&GC
Corp	909	Forthcoming industrial action by junior doctors - Potential Impact on Activity	4x3=12	3x3=9	Changes to doctors strikes	Discussed with Medical Director and at CGG & Q&GC

3. **Two risks scoring 12+ was closed** during October 2016

- 983: Lack of Anaesthetic Consultants - Duplicate risk of 971 (3x4=12)
- 885: Slips trips and falls - Covered corridors which run from main kitchen block around to new theatre as in poor condition with uneven and broken surfaces. Floor finish flaking in areas where painted - Mitigations in place e.g. Estates resurfacing works (3x4=12).

4. The corporate risk register was reviewed at the monthly Clinical Governance Group and Quality & Governance Committee in early September 2016.

Implications of results reported

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

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

7. 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

8. 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

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

Implications for BAF or Corporate Risk Register

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

Regulatory impacts

11. 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

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

Recommendation

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

Trust Board - October 2016 Corporate Risk Register

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Trend	Residual Rating	Actions	Notepad	Date Reviewed
1003	14/10/16	Information Technology Network Outage	Risk that a power outage within the Trust will result in the IT network taking up to 60 minutes to fully restore network connectivity after the power is restored. The impact could be loss of connectivity to all IT services and systems on-site and access to and from off-site.	1. The Data Centres are protected with uninterrupted power supplies (UPS). 2. Each Data Centre is feed from a separate electricity feed and a separate generator. 3. Some key areas are protected using UPS's e.g Theatres.	Clare Stafford	Nasir Rafiq	Information Management and Technology	12	New	4	Communicate to departments to update their Business Continuity Plans in light of risk. 31/12/2016 Use existing UPS's to protect the network in keys areas. 31/01/2017 Investigate costs of UPS protection to cover the entire network - 31/12/2016 Investigate and implement reboot process of the network devices so that key areas are prioritised - 31/01/2017	New risk	14/10/16
1004	14/10/16	Information Technology Server Software Operating System	Windows 2003 Server operating system is no longer supported by Microsoft as of July 2015. 17 out 140 servers are currently using unsupported operating system.	1. Internet access has been restricted or limited access is provided external support or so that application can function correctly. 2. Up-to-date antivirus software has been installed with continuous updates. 3. No access to the servers for users, only access to the application. 4. The network is protected by firewalls 5. Full nightly backups of the entire operating system where the server is virtualised. 6. Project plan has been produced to upgrade the servers.	Clare Stafford	Nasir Rafiq	Information Management and Technology	12	New	8	A detailed plan to upgrade servers with dates of migration from software supplier 31/12/2016 All unsupported operating systems to have the latest updates installed - 31/12/2016 Controls to be put in place to restrict the software suppliers from carrying out upgrades until fully testing and compatibility assurance is provided 31/12/2016	New risk	14/10/16
995	07/09/16	Potential non compliance with Freedom of Information request responses including 20 day response timescale	Risk of Freedom of Information request responses complying with legislative timescales. 1) Responses may not also cite appropriate exemptions 2) Process may not give executive lead oversight and sign-off 3) Responses may not be provided within 20 working day limit	Datix used for all requests Handlers emailed with requests within 1 working day of receipt Executive leads aleterted in some cases FOI lead chases late responses	Clare Stafford	Dominic Bailey	Compliance (Targets / Assessments / Standards)	12	↔	6	Targetted work identified and implemented to improve compliance and processes Ongoing monitoring via IGG		03/10/16
977	18/07/16	Failure of Cleanroom Air Handling Unit	Loss of Temperature control in cleanroom. Unable to prepare graft material if temperature control fails completely	No controls in place. Condensers will need to be replaced	Clare Stafford	Colette Donnelly	Estates Infrastructure & Environment	15	↔	6			13/10/16
976	13/07/16	Difficulty to Recruit Lead Infection Control Nurse Vacancy	Lead Infection Control Nurse vacancy (long-term) may impact upon the Trusts provision of infection control, and management of HAIs. To assist with vacancy 1 x part-time secondment has concluded. Several previous recruitment attempts to fill this vacancy have failed. Increased HAI MRSA colonisation rates/occurences have been reported in July and August.	Four days per week Infection Control Nurse. Part-time Microbiologist (SLA Provision) in place two days a week. Ongoing monitoring of HAIs through dashboard and other reporting. DIPC reviews all RCAs for MRSA. Negotiations with another local provider to buy in a lead Infection Control Nurse.	Jo Thomas	Miss Sarah Prevett	Patient Safety	12	↔	8			18/10/16
971	28/06/16	Anaesthetic Department currently understaffed by at least 2 whole time equivalents since a 20% increase in general anaesthetic	1) Patient safety - decreased flexibility to run to assistance if there is a life threatening problem in another theatre. We would normally have at least on trainee doubled up on a list, giving the ability for the 'spare' anaesthetist to leave their patient in safe hands and go and help in an emergency. We are regularly running days without this safety net. 2)Patient safety - on long head and neck cancer lists the anaesthetists can be responsible for a patient non-stop for 12 to 18 hours. Lack of anaesthetic staff occasionally leads to this being done by a single anaesthetist without backup or breaks. 3)Patient safety one anaesthetist can be tasked with giving anaesthetic input in 3 different theatres - this risks a hurried and distracted approach and also risks theatre downtime if a list has to be halted while this anaesthetist is finishing of a case in another theatre. 4)Corporate risk - it is likely that we will have to cancel lists at short notice - when the scheduling of anaesthetic is so short, it only takes one person being off sick to disrupt the smooth running of theatres. 5)Corporate risk - theatre efficiency suffers because there is seldom a 'spare' anaesthetist to help out either putting a patient on or taking them off the table. List often have to stop to allow the anaesthetist to go and see a staggered admission rather than have the ability for someone to go and see them concurrently. 6)Wellbeing risk - the department is stretched and relying on good will to carry out day to day activity. It is currently stressed and the supply of good will is potentially waning. Ability for anaesthetists to take their full leave entitlement, is severely at risk.	Flexible workforce who will come in and cover when they can on days off. PA who juggles list placement to maximise efficiency. Finance to go through the anaesthetic budget to see if there are funds available to advertise for additional staff. A sketched business case was put in the budget but we are now asked to resubmit a formal business case Agreed at Perioperative Services Meeting 12/09/2016 to combine with Risk ID983 (Duplicate Risk) From ID983: 1 x locum appointment made 1 . locum appointment being requested to support second post holder Business case being prepared to support the additional workload and future proof the service	Dr Edward Pickles	Dr Tim Vorster	Patient Safety	12	↔	6	NEW RISK NO ACTIONS AS YET		10/10/16
968	20/06/16	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	Jo Thomas	Kelly Stevens	Compliance (Targets / Assessments / Standards)	12	↔	4	To be reviewed in July following Clinical Cabinet discussions Paper to be presented at Clinical Cabinet in June 2016 Paediatric review group met in August, paper to private board in September 2016.		18/10/16

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Trend	Residual Rating	Actions	Notepad	Date Reviewed
				*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.								
949	08/04/16	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.Business unit managers are aware and working to gather data via manual and paper systems to assess risk as much as possible; 2.Accuracy of Onsite performance is validated and assured	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 3.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 To gain access to offsite PAS systems	08/08/2016 Risk reviewed with IM Lead additional action added - No further changes at this stage Update from risk owner A request was made to Medway for all patients on the specialty 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. QVH Performance & Access Manager has visited to Medway throughout June and will continue to visit fortnightly. She has 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. She is also supporting the QVH Medway based admin team with this work. This is a longstanding issue to resolve and will take a significant amount of work and capacity from the operations team to resolve 13/09/16 Reviewed in IM&T meeting	13/09/16
946	05/04/16	Manual defibrillatorsnot supported by OM potentially unreliable	1) Maunual defibrillators are no longer supported by manufacturer 2) Unreliable equipment in identifying accurate rhythm's	AED back up to all arrest and MET calls Defibirillators 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.	Dr Edward Pickles	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		18/10/16
942	30/03/16	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.	Dr Edward Pickles	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. ML to clarify the current process of recording implants		14/10/16
936	08/03/16	Eyebank 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 builiding 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	Mark Johnston-Wood	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 addedd together with new actions. Estates recommend that an Asbestos R&D survey be carried prior to any works being carried out.	14/04/2016: Agreed at Estates and Facilities Steering Group to change Executive Lead from DoF to DoO - Actioned 14/04/2016	13/10/16
934	25/02/16	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 complete please remove register		18/10/16

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932	19/02/16	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 workfoce plan 4. Nursing consultation implemented in August 2016 offers a clear career pathway now for nursing staff 5. Recruitment adverts include CQC ratings & inpatient survey findings to reinforce the type of organisation and current success to potential candidates.	Geraldine Opreshko	DHOHR	Staff Safety	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 owneron 22/06/2016		22/06/16
928	11/02/16	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 an 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 or untimely medicines reconciliation on admission. Patients discharge 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. New work requests are prioitised.	Sharon Jones	Judy Busby	Patient Safety	12	↔	9	23.6.16 Update. Situation unchanged. Pharmacy dept have devised priortisation list to ensure frontline pharmacy services unaffected and dealt with over back office functions. 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 owneron 22/06/2016 20.7.16 Tasks to be prioritised. No new work to be taken on without assessment of priority. Risk assessments to be completed if necessary. Recruit to vacant positions.		20/10/16
925	28/01/16	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 5. Hard copy of medical record available if patient requiring imminent treatment	Clare Stafford	Elin Richardson	Finance	12	↔	6	22/06/16 - Consultation completed. 3 JD's been through banding panel and proceding to advert. Controls remain in place. 5. Plans to replace existing legacy technology(proposal with EMT) - Completed - Contract in place with EKBI 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 agre Continue vigilance of overnight scheduling - Ongoing and completed 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. Report on Datix as incidents and maintain record of failures to collate evidence for RCA	08/08/2016 Risk reviewed with IM Lead - not further changes at this stage 22/06/2016 Risk reviewed by IHoR need an update regarding current controls and any additional actions. Email sent ro risk owner requesting an update, sent 22nd June 2016 13/09/16 Reviewed in IM&T meeting 01/11/16 Reviewed by Head of Commerce with Patient Safety Risk Officer	01/11/16
922	14/01/16	Recruitment and retention of medical staff Trustwide 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 retenton 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 12. Nursing Consultation 13. Implementation of the a new workforce planning template from February 2016 14. HR/OD supporting managers to complete the template and linking to the annual business planning process 15. Establish overall 3 year workforce plan 16. Planning recruitment campaign in local news papers to attract staff specifically for theatres and ITU (August 2017 - Vacancy rates in Cwing below 10% - High vacancies remain in theatres and ITU)	Jo Thomas	Nicola Reeves	Patient Safety	12	↔	6	Plan to use specialist agency to be used when recruting staff for theatre		18/10/16
923	14/01/16	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 owneron 22/06/2016 23.6.16 Situation unchanged. Failing to meet KPIs at present. Only likely to return to compliance with sustained reduced demand.		20/10/16
884	22/10/15	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 by porters. 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 for all staff upon request and encouraged through IG training 2 Information security acceptable use e-mail policy in place 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 - Head and Neck services and breast surgery from other trusts 5.3 Development of core reconstructive services 5.4 Contract monitoring meetings,	Clare Stafford	Dominic Bailey	Information Governance	12	↔	8	Contractor to be selected 25/07/2016 HoR & IG Lead reviewed risk - IG Lead to obtain update from radiology Purchase encryption hardware for Radiology IT disposal Policy to be ratified at July 2016 IGG Implement Data Leakage Prevention Software on Trust e-mail exchange	25/07/2016: Encryption technology for radiology not procured. IT asset disposal policy to be re-drafted and considered by IGG onTuesday 2nd August 2016. Propose that data leakage prevention software is activated (02/08/2016) 28/09/2016: Technical issues following trial - logged call with support	04/10/16

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Trend	Residual Rating	Actions	Notepad	Date Reviewed
877	21/10/15	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 ro risk owner requesting an update, sent 22nd June 2016 1) Development and implementation of delivery plan to address forecast underformance. 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		22/06/16
882	21/10/15	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 opportunties. 3. Performance Review Meetings. 4. Actively angaging with providers and commissioners to develop new opportunities	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 ro risk owner requesting an update, sent 22nd June 2016 1. Publish outcome data to secure pipeline of referrals.		30/09/16
864	20/10/15	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 posible solutions including change of premises	Jo Thomas	Nicola Reeves	Information Governance	12	↔	3	25/07/2016 - HoR discussed risk with IG Lead - Executive Team exploring alternatives 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 possibley off site EDM Post to start in September 2015		18/10/16
854	16/10/15	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 challanging 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 owneron 22/06/2016		18/10/16
853	15/10/15	Insufficient space in MIU to treat patients	Building footprint too small for activities of both trauma clinic and MIU walk-in patients, totalling aprox 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 Business case for relocation approved ten weeks work plan awaiting identification of a contractor to start the work.		18/10/16
844	13/10/15	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	Dr Edward Pickles	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 andtherefore removed and new controls added. Review again in one month Business case has been approved and now in discussion with peers re costing inferstructure	05/09/2016 - Risk owner contacted by HoR for update on risk as part of risk review process.	03/06/16
907	21/09/15	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 equiptment 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		10/10/16
904	24/08/15	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	Dr Edward Pickles	Sandra Lockyer	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 alterations during review however new actions has been identified	18/10/2016 Risk reviewed at C/Care meeting	18/10/16
799	20/05/15	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	Dr Edward Pickles	Dr Edward Pickles	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	05/09/2016 - Risk owner contacted by HoR for update on risk as part of risk review process.	03/06/16
792	31/03/15	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	Dr Edward Pickles	Ruth Barton-Anderson	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		04/10/16

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Trend	Residual Rating	Actions	Notepad	Date Reviewed
789	12/03/15	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	Geraldine Opreshko	Dr Edward Pickles	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 contolrs added but scores remain unchanged as still a risk to the Trust review in one month	02/11/2016 Risk reviewed with Medical Director - No changes	02/11/16
748	03/10/14	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) IG Lead reviewed with Head of Radiology 25/08/2016- No change Reconcile VNA data once PACS remiation work and upgrade complete. Anticipated to begin May 2016	IGG to Review Risk Score at September 2016 meeting (06/09/2016) Reviewed in RPC meeting 13/09/16 28/09/2016: No further updates - next meeting scheduled for 7th October 2016 30/09/2016: Update from PACS Manager: Technical issue is with Philips, requires for the VNA and SQL servers to be upgraded. Philips to provide reconsolidation tool to identify the mismatches. Lengthy process therefore completion date is 31 March 2017.	20/10/16
728	29/07/14	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 visiblity 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	Dr Edward Pickles	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	05/09/2016 - Risk owner contacted by HoR for update on risk as part of risk review process.	18/10/16
727	21/07/14	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 Onsite cover available on Monday, Wednesday and Thursdays from July 21st 2015, return of Tej Richardson for 1.5 days per week, Dr Simon returns to SASH and Tej picks up the rehab clinic, Mark Bayliss will be retained giving 3 day per week cover and working to get further physician input Agency locum finishing but available for short term cover Telephone cover provided as part of SLA with Brighton. Geriatrics Clinic covered by Locum Geriatrician from SASH, to be covered by Tej Richardson WEF 21st July Patient would be transferred to Brighton (Haywards Heath) if specialised care required	Dr Edward Pickles	Paul Gable	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 contolrs or actions in place IHoR to liaise with Risk owner for update	23/07/2014 - Risk reviewed with AK Plastics Consultant - Updated to reflect all comments. MD (SF) has met with Head of Geriatrics at ESH and decision is agreed in principal for the SLA to proceed asap. Scoring agreed as correct at 3 x 3=9 - AV 24/07/2014 - Risk Assessment uploaded to "Documents" - MS 05/09/2016 - Risk owner contacted by HoR for update on risk as part of risk review process.	03/06/16
670	17/12/13	Failure to maintain estates service due to limited staff numbers.	Failure to maintain estates service due to limted 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	Steve Davies	Estates Infrastructure & Environment	12	↔	6	22/06/2016 Risk discussed with IHoR and HoE new contolrs 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		13/10/16
474	10/03/11	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 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 22/06/2016 Risk reviewed by IHoR need an update regarding current controls and any additional actions. Email sent ro risk owner requesting an update, sent 22nd June 2016 Streamline current referral pathwaysfor all types of cancer Expand use of infoflex system across Trust Ensure off site 2 week H&N cancer appointments are booked efficiently	Text in full from Risk Assessment Form: Impact on reputation, ratings, possible financial implications, delayed treatment for patients, increased time spent on achieving targets and rectifying problems. When the cancer co-ordinator is absent there is insufficient cover resulting in an increased risk of breaches. Cancer data co-ordinator must refer to 18 separate sources of information in order to report to the DH. These sources include MDT, coding, off-sites, PAS, patient centre, waiting list form, inter-Trust communication, patient notes, etc. Inadequacy of PAS to reconcile the RTT18 week demands and the oncology demands. (It must be borne in mind that the trust will always incur oncology breaches due to patient requests and adverse circumstances, eg, weather.) Existing controls - Oncology PTI issued weekly by cancer data co-ordinator requiring action by specialities. Cancer data co-ordinator proactively liaising with staff on potential breaches and on-going training. Secretaries respond to requests to bring patients forward wherever possible. Ongoing process reviewing. Recruitment of off-site team leader to contribute to the reconciling of off-site oncology breaches. Appointments team allocate all 2 week wait referrals to avoid delay. Proposed action: Cancer data co-ordinator meeting with directorate manager and head of commerce 23.2.11. Local access policy is being created - awaiting final contributions and approval. Initiation of a project team to look at integrating the cancer pathway into the everyday processes of the Trust from receipt of referral to treatment of patient - multidisciplinary team including consultants. A process mapping of both skin cancer pathway and cancer data is being planned after which an action plan to resolve issues will be developed and implemented.	14/10/16

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Quality and Governance Committee**				
Meeting date:	**05 January 2017**		**Agenda reference:**	**10-17**	
Report title:	**Quality and Governance Assurance Report**				
Sponsor:	Ginny Colwell, NED and Committee Chair				
Author:	Ginny Colwell, NED and Committee Chair				
Appendices:	1.				
Executive summary					
Purpose:	To provide assurance to the board in relation to matters discussed at the Quality and Governance Committee in November and December 2016				
Recommendation:	The Board is asked to **NOTE** the contents of this report				
Purpose:	**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:	Quality and Governance Committee				
	Date:	08/12/16	Decision:	For information	
Previously considered by:	Quality and Governance Committee				
	Date:	10/11/16	Decision:	For information	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 5th January 2017
Reference number: 10-17
Report from: Ginny Colwell, Chair
Author: Ginny Colwell, Chair
Appendices: N/A
Report date: 19 December 2016

Quality and Governance Assurance
Meetings held on 10th November and 8th December 2016
Areas of particular note

1. A paper proposing changes to current meeting arrangements is presented under item 11-17.

2. During a discussion on patient safety issues, further assurance was sought in respect of a potential major incident;

3. Policies update: The committee was presented with a report detailing which policies were overdue for approval. Of a total of 223 policies, only 36 are currently outstanding/require review in December 2016;

4. The following documents were received by the committee:

- Annual risk report, (the committee requested additional information on external benchmarking)
- Patient experience
- Risk management strategy (to be presented to the Board under item 24-17)
- Corporate risk register (to be presented to the Board under item 08-17)
- Update on CQC action plan
- Clinical governance group
- Nursing advisory group
- Health and Safety
- Information management
- Safeguarding

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**5 January 2017**		**Agenda reference:**	**11-17**	
Report title:	**Quality & Governance: proposed changes to current meeting arrangements**				
Sponsor:	Ginny Colwell, Committee Chair and Non-Executive Director				
Author:	Ginny Colwell, Committee Chair and Non-Executive Director Jo Thomas, Director of Nursing				
Appendices:	None				
Executive summary					
Purpose:	The purpose of this paper is to outline proposed changes to the Quality and Governance Committee (Q&GC) to improve appropriate assurance to the Committee and the Board, as well as promoting effective quality and governance engagement throughout the organisation. It is proposed to start the new arrangements from April 2017, with a review scheduled for April 2018.				
Recommendation:	The Board is asked to **APPROVE** this recommendation				
Purpose:	**Approval**				
Link to key strategic objectives (KSOs):	**KSO1**: *Outstanding patient experience*	**KSO2**: *World-class clinical services*	**KSO3**: *Operational excellence*	**KSO4**: *Financial sustainability*	**KSO5**: *Organisational excellence*
Implications					
Board assurance framework:	KSO 1 and KSO2 are presented at every Q&GC and all 5 KSO at each public board				
Corporate risk register:	CRR is presented and reviewed at every Q&GC				
Regulation:	NA				
Legal:	NA				
Resources:	No additional resources required as a result of this proposal				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date: 08/12/16		**Decision**:	Recommended for approval	
Next steps:	If approved by the Board, the new regime will be implemented from April 2017 and reviewed after 12 months				

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	05 January 2017
Agenda item reference no:	11-17
Sponsor:	Ginny Colwell, committee Chair and non-executive director
Author:	Ginny Colwell, committee Chair and non-executive director
Date of report:	19 December 2016

Quality and governance
Proposed changes to current meeting arrangements

Purpose

1. The purpose of this paper is to outline proposed changes to the Quality and Governance Committee (Q&GC) to improve appropriate assurance to the Committee and the Board, as well as promoting effective quality and governance engagement throughout the organisation. It is proposed to start the new arrangements from April 2017, with a review scheduled for April 2018.

Background

2. The Board is aware that following a governance review two years ago it was agreed that Q&GC, (then Quality and Risk), should move to a monthly meeting to provide timely assurance to the Board. Since then the organisation has consistently achieved the quality matrix and also received a Good rating from the Care Quality Commission. In order to move from 'good' to 'outstanding' committee members believe that increased local engagement with clinicians and their teams is required.

Proposal

3. It is proposed that the Q&GC continues to undertake monthly Q&G assurance activity but to move formal committee meetings to alternate months, scheduled in the month before the Board. The other months would be used to engage local clinical teams during their routine quality and governance activity.

4. The new format seeks to provide greater assurance to the Quality and Governance Committee, and subsequently to the Board.

5. Initially, the Committee considered retaining monthly Q&GC meetings and establishing a rolling programme of various clinical teams to attend the meetings. However, as many national enquires have suggested, culture is key to good governance and high quality care. Accordingly it was agreed that instead the Q&GC should observe clinical teams in their own Q&G meeting.

6. Q&GC members would attend local specialty/departmental services governance meetings, with clinical team meetings receiving a visit at least once a year. The visit would be carried out by an executive director or a non-executive director, with one other members of the committee. The meetings are being planned at the moment and it is anticipated that each Q&GC member will carry out two local visits a year as a minimum.

7. Where appropriate, committee members will be invited to provide feedback at the end of a meeting. However, they will not be expected to actively participate in the meeting apart from where an issue requiring action is identified.

8. After each meeting, Q&GC members will be asked to complete an agreed feedback template, with a summary of their observations presented to the next scheduled Quality and Governance Committee meeting. A simple rating will be applied, aligned to the CQC's ratings of *outstanding, good, requires improvement* and *inadequate*. The feedback will be circulated to the relevant manager and any recommendations followed up via the executive route and through the performance meetings.

Benefits

9. It is anticipated that this model will:
   - strengthen and raise awareness of the governance processes across the Trust
   - provide insight into local governance processes
   - improve engagement between committee members and frontline staff
   - allow Committee members to observe the interactions/culture of the various teams
   - support identification of potential local risks/areas of weakness
   - support assessment of multidisciplinary attendance and engagement
   - ensure that patient safety, aspects of clinical effectiveness and patient experience are considered at a local level.

Next steps

10. The Quality and Governance Committee has agreed the proposed way forward and seeks the Board's approval for the proposed changes. If agreed the Terms of Reference will be changed to reflect the new meeting frequency, and proposed arrangements.

Recommendation

The Board is asked to approve the proposed change to the Quality and Governance Committee.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	**05/01/17**	**Agenda reference:**	**12-17**		
Report title:	Quality and Safety Report, October and November 2016				
Sponsor:	Jo Thomas, Director of Nursing and Quality				
Author:	Jo Thomas, Director of Nursing and Quality				
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 **Y**		Assurance **Y**	Review **Y**
Link to key strategic objectives (KSOs):	KSO1: **Y**	KSO2: **Y**			
	Outstanding patient experience	*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:	NA				
Next steps:					

Executive Summary - Quality and Safety Report, January 2017

Domain	Highlights
Safe	One never event occurred in October 2016 (a retained foreign object) and an investigation and detailed route cause analysis (RCA) is currently underway. Findings and learning will be disseminated across the Trust; and shared with the Clinical Commissioning Group (CCG), Care Quality Commission (CQC) and NHS Improvement (NHSI).
Effective	The CQC have published their report on *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* (December 2016) and formulated any recommendations and actions to be taken forward. The Trust contributed to the findings of this report via a CQC information request in July 2016.
Caring	There were five new complaints in October and three in November relating to two main themes of attitude/communication and treatment. 98% and 97% of inpatients completing the October and November FFT survey would recommend QVH.
Responsive	MIU performance continues to perform better than national indicator. In October 99.56% of the 806 patients and in November 99.76% of the 807 patients were assessed and treated within 4 hours.
Nursing Workforce	M8 total nursing, theatre practitioner and HCA vacancies are 74.74 WTE, (20.99%) however this does not reflect the reduction of 15 wte from the nursing consultation and Q2 CIP. Sickness in M8 has increased to 4.33 % from 3.84% for nursing , decrease in HCA sickness to 2.63% from 3.78% . Agency usage has increased to 4.64% from 3.9% and bank usage bank has increased to 3.17% from 2.6%. (data source M8 ESR).
CQUIN/ QA	All CQUIN milestones for Q2 have been approved by the CCG and specialist commissioners for payment of the schemes.

Safe - Current Compliance

Domain	Current Compliance	Next Steps
Infection control	No further cases of hospital acquired MRSA in October or November. MRSA screening compliance for the Trust has improved with figures now 98% compliant in both elective and trauma admissions.	Work continues to remind all staff of the importance of complying with infection control policies and procedures to ensure safe care for all patients.
Medication errors	**October:** Eight patient safety medication related incidents were reported with no harm. **November:** Thirteen patient safety medication related incidents were reported, all with no harm.	Work is ongoing to reduce the occurrence of medication errors across the Trust, whilst still encouraging a reporting culture. An e-learning training package for the nursing team is in development (expected June 2017). Errors themes are reviewed on a monthly basis, and targeted supported where hotspots arise.
Serious Incidents/ Never Event	**October:** One never Event occurred at the Trust (a retained foreign object). **November:** One Serious Incident was reported on STEIS in November 2016, and an investigation is currently being undertaken.	Work continues to identify, disseminate and embed learning from incidents, serious incidents and Never Events to eliminate reoccurrence; and will form a key objective in the Trust's new Risk Management Strategy.
Pressure ulcers	**October:** There was one reported grade 2 pressure ulcer in main theatres. **November:** There was one reported grade 2 pressure ulcer in ITU.	A re-audit of Trust compliance with NICE CG179: Pressure ulcers: prevention and management is currently being undertaken, which also looks at the use of the Purpose T risk assessment tool, and pressure relieving aids.

Falls	**October:** There were two reported falls which occurred in the Margret Duncombe and Ross Tilley. **November:** There were three reported patient falls which occurred in Margret Duncombe, Ross Tilley, ITU	Trust compliance with the completion of the patient falls assessment within 24 hours of admission remains above 95% over this period (October 100% and November 96%).

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)	2015/16 total / average	Target	Quarter 3	Quarter 4			Quarter 1 2016/17			Quarter 2			Quarter 3		12 month total/ rolling average
			Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	
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	1	0	0	0	1	0	0	0	0	0	0	2
MRSA screening - elective	98%	>95%	98%	97%	98%	98%	98%	96%	95%	96%	94%	96%	96%	98%	97%
MRSA screening - trauma	97%	>95%	98%	97%	95%	96%	95%	97%	95%	95%	93%	93%	95%	98%	96%
Incidents															
Never Events	0	0	0	0	0	0	0	0	0	0	0	1	1	0	2
Serious Incidents	3	0	0	0	1	0	0	0	0	0	0	0	0	1	2
OOH inductions:															
All patients: Number of patients operated on out of hours 22:00 - 08:00		5	4	7	4	6	2	10	2	2	7	5	0	4	3.8
Paediatrics under 3 years: : Induction of anaesthetic was between 18:00 and 08:00		0	0	0	0	0	0	0	1	0	0	1	0	0	0.2
Paediatric transfers out (<18 years)			0	1	1	1	1	1	1	3	0	1	0	1	11
Medication errors															
Total number of incidents involving drug / prescribing errors	191		19	21	16	14	12	15	6	12	12	9	8	13	157
No & Low harm incidents involving drug / prescribing errors	191		19	21	16	14	12	15	6	12	12	9	8	13	157
Moderate, Severe or Fatal incidents involving drug / prescribing errors	0		0	0	0	0	0	0	0	0	0	0	0	0	0
Medication administration errors per 1000 spells	2.5		5.9	2.6	1.9	2.8	1.9	2.5	2.1	0.5	0.7	2.3	1.8	5.3	2.5
Harm free care rate (QVH)	97%	>95%	96%	96%	100%	97%	97%	100%	93%	97%	91%	91%	97%	96%	96%
Harm free care rate (NATIONAL benchmark) - one month delay	94%	>95%	94.1%	>95%	94.1%	>95%	93.9%	93.9%	94.2%	94.3%	94.2%	94.1%	94.2%	94.3%	
Pressure Ulcers															
Hospital acquired - grade 2	11	15	2	3	1	1	3	0	1	0	2	2	1	1	17
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	98%	>95%	96%	100%	96%	100%	100%	100%	97%	100%	100%	100%	97%	96%	98.5%
Patient Falls															
Patient Falls assessment completed within 24 hrs of admission	94%	>95%	100%	100%	100%	100%	100%	95%	95%	94%	100%	98%	100%	96%	98.1%
Patient Falls resulting in no or low harm (all falls)	40		1	4	1	7	5	5	9	4	0	3	2	5	46
Patient Falls resulting in moderate or severe harm or death	0		0	0	0	0	0	0	0	0	0	0	0	0	0

Effective - Current Compliance

Domain	Current Compliance	Next Steps
Mortality	**October:** There were no QVH mortalities and one patient died elsewhere within 30 days of discharge. **November:** There were one QVH mortality and two patients died elsewhere within 30 days of discharge.	The Trust will review the CQC's Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England (December 2016) and formulated any recommendations and actions to be taken forward. Evidence for this report was collected via a CQC information request, which QVH participated in, that explored how NHS acute, community healthcare and mental health trusts investigate deaths and learn from their investigations.
Transfers out	There were four emergency or unexpected transfer out in October, and two in November 2016.	Details of the Trust's transfers continue to be disseminated across the via the monthly Clinical Indicators Report

Antimicrobial Stewardship	A Trust antimicrobial stewardship assurance framework has been developed to ensure that the Trust complies with the main National antimicrobial stewardship recommendations. A daily review (Monday – Friday) of all antimicrobial prescriptions is carried out across the Trust by pharmacists, and a weekly antimicrobial stewardship round is undertaken by antimicrobial pharmacist in conjunction with the microbiologist. The WHO World antibiotic awareness week in November 2016, was marked with an awareness of usage and prescribing across the Trust.	Progress against implementation of the improvement plan actions continues to be monitored by the Medicines Management Optimisation and Governance Group (MMOGG) on a quarterly basis. The plan will also be presented to the Quality and Governance Committee (Q&GC) in January to ensure oversight. Work continues on CQUIN data collection and an audit of adherence to surgical prophylaxis guidelines is planned for December 2016.
NICE Compliance	Benchmarking of Trust compliance has been completed for: **NG24:** Blood transfusion (Nov 15) - **partially compliant** **QS130:** Skin Caner (Sept 16) - **partially compliant** Work is in progress to revisit all NICE Interventional Procedure guidance (IPGs) deemed relevant to the Trust, to ascertain whether the procedures are undertaken at the Trust. Where undertaken, further work will review whether the procedures are undertaken in accordance with the stipulated recommendations. For an update of the Clinical Effectiveness Quality Priority: 20% of applicable NICE Clinical guidance, please see: CQUIN and Quality Account Priorities section.	Work continues to revisit all historical NICE guidelines to assess their relevance, and the Trust's compliance against the recommendations. All NICE Medical Technologies (MTG) and Diagnostics Technologies (DTG) guidance is reviewed by the Medical Devices Group on a quarterly basis - next meeting December 2016. In potential instances where QVH may be found to be non-compliant with a guideline, the rationale for such will be scrutinised at the Clinical Governance Group (operational meeting) and the Quality and Governance Committee to ensure agreement, or a decision taken, around any action to be taken to achieve compliance

Clinical audit	Data has commenced on QVH's contribution to the National Head and Neck Cancer Audit (HANA) - Saving Faces audit.	Meetings have been scheduled with the specialty Audit and Governance Leads to start audit planning for the new financial year (2017/2018). All audits will be scheduled on the Trust's Clinical Audit Programme which is monitored by the Clinical Governance Group on a quarterly basis.
CQC	Work continues to work on the CQC improvement plan following the scheduled inspection in November 2015. The majority of actions have now been completed; and the plan was presented to the Quality and Governance Committee in December 2016 to ensure oversight of the implementation status of actions.	Going forward, a structured framework for reviewing the Trust's compliance against the CQC's Fundamental Standards of Quality and Safety will be formulated; and a drive to raise awareness of the standards that each person has the right to expect in hospital. This is including, but not limited to: person-centred care; dignity and respect; safety; safeguarding from abuse; duty of candour and good governance.

Effective - Performance Indicators

Metric	2015/16 total / average	Target	Quarter 3	Quarter 4			Quarter 1 2016/17			Quarter 2			Quarter 3		12 month total/ rolling average
			Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	
Mortality															
QVH Mortalities	6	0	1	0	1	2	0	0	0	0	0	0	0	1	5
Readmissions															
Emergency Readmissions Within 30 Days	1.87%	2.24%	1.75%	2.35%	2.49%	2.18%	2.11%	2.15%	2.14%	2.46%	3.02%	2.64%	1.91%	2.08%	2.27%
Emergency Readmissions Within 7 Days	1%	1.21%	1.09%	1.10%	1.42%	1.16%	0.73%	1.01%	1.04%	1.11%	1.34%	1.81%	1.02%	1.11%	1.16%
Paediatric safeguarding															
Paediatric safeguarding cases*			26	18	28	20	19	26	20	14	20	12	25	17	220
Allegations against staff			0	0	0	0	0	0	0	1	1	0	0	0	2
Safeguarding adults															
Adult Safeguarding cases*				2	2	1	0	6	6	7	10	6	7	4	51
Allegations against staff				0	0	1	0	0	0	0	1	0	0	0	2
Female genital mutilation (FGM) Risk Assessments undertaken				1	0	0	0	0	0	0	0	0	0	0	1
DoLS Applications				0	0	0	1	2	0	0	0	0	1	0	4
Prevent Referrals				0	0	0	0	0	0	0	0	0	0	0	0
Infection control audit															
Hand hygiene audit %			99%	99%	99%	99%	100%	99%	99%	99%	99%	99%	99%	99%	99%
Bare below the elbows %			100%	99%	95%	99%	100%	100%	100%	100%	100%	100%	99%	99%	99%
Trust Cleaning %			90%	90%	90%	90%	88%	88%	88%	92%	92%	92%	91%	91%	90%

*Concerns are reported via internally processes, and then referred on to the appropriate external agency

Caring - Current Compliance

Domain	Current Compliance	Next Steps
Patient experience	Following the National Inpatient Survey 2015 an action plan of the areas where improvements could be put in place has been distributed to the relevant areas. The action plan displays those questions where the trust are either significantly worse or about the same as other trusts or where there has been a significant change compared to the 2014 survey.	The action plan will be presented to the joint Hospital Governance Meeting in January 2017 and will be monitored by the Patient Experience Group (PEG).
Complaints	In October/November - eights complaints were received. Two of these relate to delays in being given an appointment, two relate to clinical care/communication, one relates to missing part of a health record, delay in arrival of patients prosthetic, missing personal possessions and the last being to an individual's needs not being met (these have all been graded as minor).	All complaint responses are personal and individualised needs of the individual to ensure that their experience is listened to. The Trust continues to ensure that positive feedback and plaudits are provided to the teams and shared across the Trust. A selection of plaudits and feedback messages will be added to the Quality Account 2016/17.

Friends and Family Test (FFT)	Inpatients: In October 98% of inpatients (response rate of 48%, n=313) who completed FFT survey would recommend QVH. In November this was 97% (response rate of 44% (national target is 40%) n=276) who completed the FFT survey would recommend QVH. Outpatients: The FFT score for out-patients in October was 95%. A total of 2099 outpatients out of a possible 129240 completed the questionnaire either by paper, SMS or integrated voice message. The response rate for outpatients was 16% (national target is 20%). In November the score slightly less at 94% and 1485 out of 7791 took part. This was a response rate of 19%.	The Trust's response rate has improved from September 2016, and work continues to encourage more patients to compete the survey

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

Caring - Performance Indicators

Metric	2015/16 total / average	Target	Quarter 3	Quarter 4			Quarter 1 2016/17			Quarter 2			Quarter 3		12 month total/ rolling average
			Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	
Complaints															
Complaints per 1000 spells *	2.7		4.6	3.5	1.9	3.5	1.9	4.4	3.5	0.0	4.6	2.3	3.0	2.0	2.9
Claims per 1000 spells *	1.1		1	1.4	1.3	2.1	1.3	0.0	0.7	0.0	0.0	0.0	0.6	0.7	1.0
Friends and Family Test															
FFT score acute in-patients: likely and very likely to recommend QVH	99%	>90%	99%	100%	100%	99%	99%	99%	98%	99%	98%	98%	98%	97%	99%
FFT score acute in-patients: unlikely and very unlikely to recommend QVH	0%		0%	0%	0%	0%	0%	0%	0%	1%	1%	0%	0%	0%	0%
FFT score MIU: likely and very likely to recommend QVH	94%	>90%	95%	93%	92%	94%	92%	95%	94%	94%	96%	97%	96%	97%	95%
FFT score MIU: unlikely and very unlikely to recommend QVH	3%		3%	4%	3%	3%	4%	3%	2%	5%	5%	2%	2%	3%	3%
FFT score OPD: likely and very likely to recommend QVH	95%	>90%	95%	94%	93%	94%	94%	95%	94%	94%	94%	94%	95%	94%	94%
FFT score OPD: unlikely and very unlikely to recommend QVH	2%		2%	2%	2%	2%	2%	2%	2%	3%	3%	3%	2%	2%	2%
FFT score DSU: likely and very likely to recommend QVH	97%	>90%	97%	97%	96%	96%	96%	97%	97%	97%	96%	94%	98%	98%	97%
FFT score DSU: unlikely and very unlikely to recommend QVH	1%		0%	2%	1%	1%	1%	1%	1%	2%	2%	3%	0%	0%	1%
FFT score Sleep disorder centre: likely and very likely to recommend QVH	97%	>90%	98%	99%	97%	97%	96%	98%	97%	98%	100%	94%	96%	96%	97%
FFT score Sleep disorder centre: unlikely and very unlikely to recommend QVH	1%		0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%
Privacy and dignity															
Mixed Sex accommodation breach	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Patient experience - Did you have enough privacy when discussing your condition or treatment (indicates a yes response)	99%	>90%	99%	99%	97%	97%	99%	95%	91%	92%	94%	100%	100%	100%	97%

* 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	Current Q3 inspections are currently being undertaken and current compliance sits at 82.1% (rating of 'Good'). Early analysis indicates that the new lines of enquiry relating to Information Governance will require improvement. Improvements have been made to the Trust's Datix system to capture and ensure the dissemination of lessons learned. This areas was identified as a hot spot from previous inspections.	Work to remedy underperformance in the new Information Governance section is currently being undertaken in conjunction with the Trust's Information Governance Lead. The next round of inspections (Q4) will commence at the end of January 2017.
Incident Reporting	**October:** 163 incidents were reported in October 2016. 88 were Patient Safety with one recorded as major harm and the rest were minor or no harm. The main themes for patient safety incidents in October were lack of resources (staff, equipment, facilities, etc.) and medication errors. **November:** 136 incidents were reported in total, 80 were patient safety, all of which were minor or no harm. The main themes for patient safety incidents in November were drug errors (administering) and Communication.	The Trust's Risk Management and Incident Reporting Policy was approved by the Quality and Governance Committee in December 2016, and will be presented to Trust Board in January 2017 for ratification. This policy underpins the newly updated Risk Management Strategy, which will also be tabled at the January 2017 meeting for information.

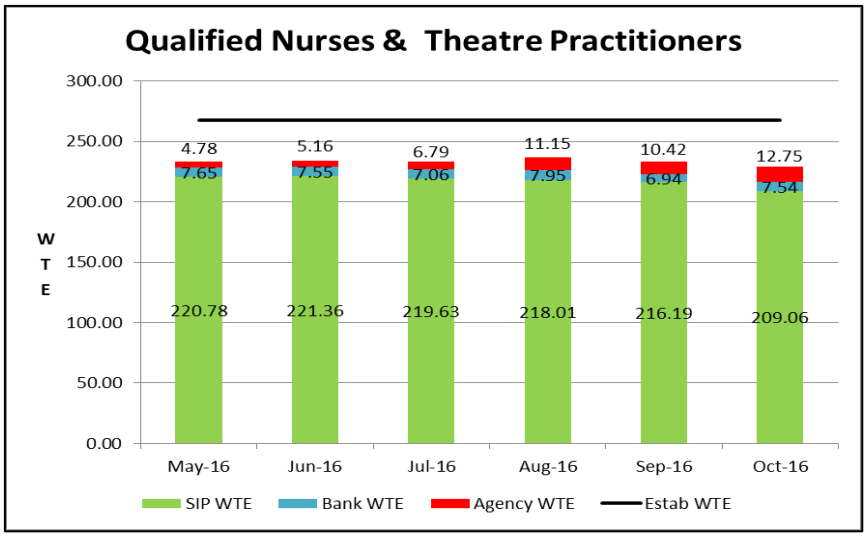
Nursing Workforce - Current Compliance

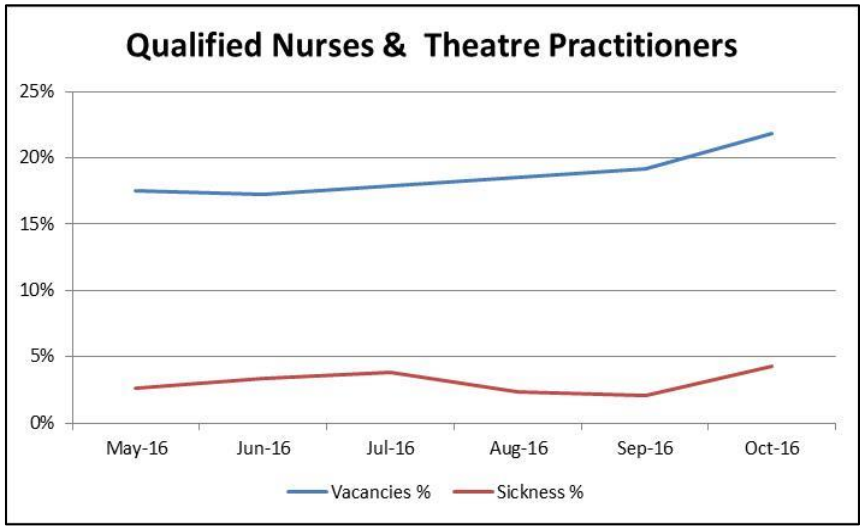
Domain	Current Compliance	Next Steps
Ross Tilley	Four shifts did not meet planned levels, all escalated. Reasons for not meeting planned staffing levels were staffing adjusted to bed occupancy, vacancy and short notice sickness. There were 2 Datix linked to a shift where there was reduced staff one not related and one fall (no harm) which may have had an indirect link.	Continue to staff according to bed occupancy and acuity. All dates where escalation re staffing required have been triangulated with Datix safety incidents, ward FFT scores and complaints information no incidents or harms align with these dates
Margaret Duncombe	Seven shifts did not meet planned level, all escalated safe care achieved. Reasons for not meeting planned staffing levels were staffing adjusted to bed occupancy, vacancy and short notice sickness.	Flexible use of staff continues as per comment for Ross Tilley . The increase in sickness on Cwing is being actively managed and additional scrutiny of quality indicators has been undertaken.
Burns	11 shifts did not meet planned levels, all escalated , safe care achieved. Reasons for not meeting planned staffing , vacancy and short notice sickness. Decrease in sickness in M8	Some shifts were covered with staff from ITU rather than bank or agency where safe to do so. All dates where escalation re staffing required have been triangulated with Datix safety incidents, ward FFT scores and complaints information no incidents or harms align with these dates
Peanut	12 shifts required escalation, safe care achieved. Reasons for not meeting planned staffing , vacancy and short notice sickness. Decrease in sickness in M8. One shift was escalated to Deputy DoN due to staffing levels and a safe alternative plan put in place to cover the night shift.	Shifts where escalation required have been triangulated with Datix safety incidents, complaints information and ward FFT scores. No incidents or harms align to these dates.

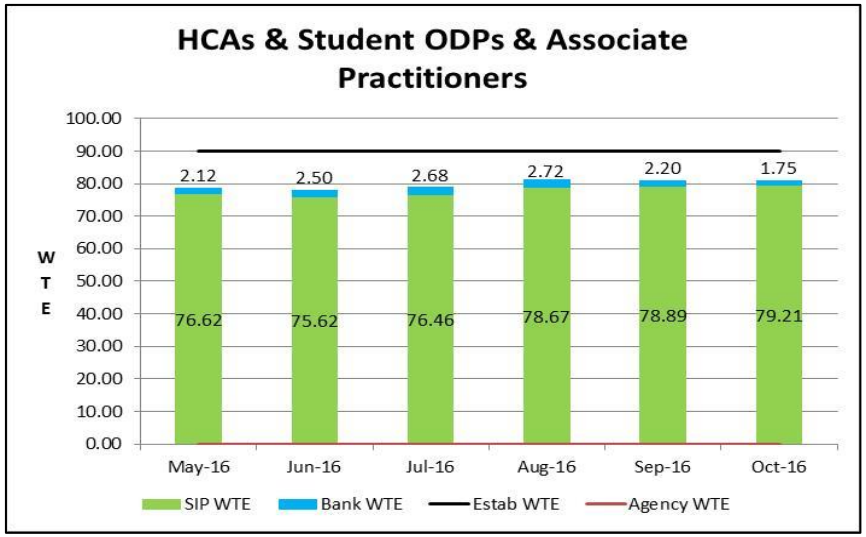
Critical Care (ITU)	Six shifts did not meet planned levels ALL escalated, safe care achieved. Vacancy rates remain high in the unit however bed occupancy remains low at 50 %.	Following triangulation with Datix safety incidents, and complaints no incidents align to these shifts. Adverts have been placed internally, nationally and in local press. In the meantime there is line booking of agency staff to assist with continuity of care. There are substantive and bank staff currently being processed via recruitment. High vacancy in this area adds risk to the quality of care mitigation is in place led by HoN and ward matron. This increased risk has been reflected in KSO1 of the BAF

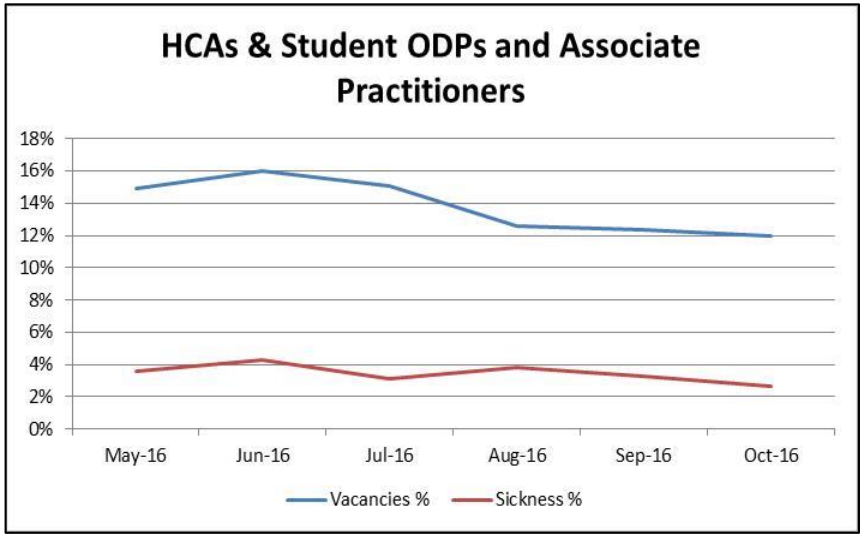
Data extracted from the workforce score card in appendix 1

Nursing Workforce - Performance Indicators







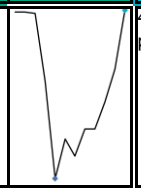
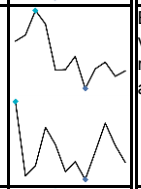
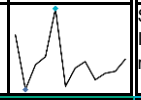
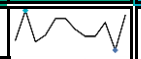
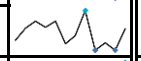
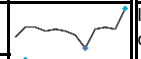
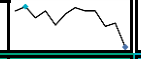
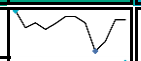
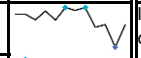
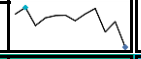


CQUIN and Quality Account Priorities - Current Compliance

Domain	Current Compliance	Next Steps
CQUIN	All CQUIN schemes milestones for Q2 have been approved by the CCGs and specialist commissioners.	Work continues with the national and local (specialist) CQUIN implementation plans, to ensure achievement of the Q3 milestones.
Quality Account	Work continues on the achievement of the three approved 3 Quality Priorities for 2016/17: **1**. **Safety:** The average duration of investigations for no and minor harm incidents in October and November (Q3 – part) continues to be 3-5 days, which surpasses the Trust target of 10 working days. **2. Clinical Effectiveness:** 20% of applicable NICE Clinical Guidelines (GLs) and Quality Standards (QSs) will be audited: **CG138:** Patient experience in adult NHS services: improving the experience of care for people using adult NHS services, and **QS15:** Patient experience in adult NHS services **3. Patient Experience:** Improve walkways. Replacement and additional lighting is being installed around the Trust car parks and walkways to improve lighting levels and security of patients, visitors and staff.	The Trust has procured the services of a contractor for phase 2 of the walkway resurfacing project (resin bonded paving), and the work has been scheduled to be undertaken the last week in December, when the foot traffic in this area is expected to be much lighter in volume. The Trust wayfinding audit has now been completed and we await the final report which is due early January 2017.

BURNS ITU 2016 / 2017		DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DoN Rating					QVH
Staff Utilisation							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies	WTE	3.76	4.1	4.1	3.5	2.96	4.44	4.44	5..24	9.3	7.11	9.11	8.26	7.5%					Targetted recruitment for ITU in progress.
Est =	(hrs)	611	667.3	667.3	541.25	481	721.5	719	848	1511.3	1155	1480	1342						
Temp staffing exc RMN	Bank	19.5	195.5	149	244.5	6	43	12	68	19	79	8	64.7	10%					
	Agency	144	48	504	444	128.5	166	24	148.5	400.5	40	310	115						
Sickness	%	3.7%	2.0%	4.2%	5.8%	3.5%	3.2%	2.8%	2.1%	0.5%	1.4%	1.5%	1.7%	2%					
Shift meets est %	RN	100%	100%	109%	98%	93.9%	96.8%	97%	92%	101%	92%	96%	96%	95%					
Day	HCA	100%	100%	150%	100%	100%	100%	100%	200%	100%	100%	113%	100%	95%					
Shift meets est %	RN	87.2%	98.8%	103%	95.1%	98.7%	100%	82.0%	101%	96%	79%	87%	81%	95%					
Night	HCA	100%	100%	75%	200%	100%	100%	100%	100%	100%	100%	100%	100%	95%					
Training / Appraisal							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals	%	97.5%	90%	86.5%	86.5%	86.5%	87%	90%	76.2%	76%	41.2%	21%	57%	85%					Improvement plan requested, new ward matron appointed
Statutory & Mand.	%	94%	92.9%	90%	90%	90%	90%	85.4%	88%	90%	78.4%	83%	86%	85%					Target of 100% set
Drug Assessments	%	100%	100%	92%	92%	100%	100%	95%	95%	95%	100%	100%	100%	95%					
Staff FFT Score	%	_	_	_	_	_	_	_	_	_	_	_	_	_					
Budget	(YTD)	42990	37294	65547	79311	3739	28657	27162	25017	31804	28789	24244		<0					RMN increased
Safe Care							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	G2+	0	1	1	0	0	0	1	0	1	0	1	0	0					
Falls	With harm	0	0	0	0	0	0	0	0	0	0	0	1	0					
Medication Errors	All	1	0	1	2	1	2	0	3	1	0	1	1	0					
C. Diff		0	0	0	0	0	0	0	0	0	0	0	0	0					
MRSA		0	0	0	0	0	0	0	0	0	0	0	0	0					
Incidents Reported (Datix)	Patient Safety	9	9	15	5	10	9	4	8	11	9	12	8						
VTE reassessment	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	66.7%	80%	N/A	95%					
Nutrition assessment (MUST)	Initial	100%	100%	67%	100%	100%	100%	100%	100%	0%	100%	80%	N/A	95%					
	7 day r/v	100%	100%	67%	100%	N/A	100%	100%	100%	100%	50%	100%	N/A						
Patient numbers		17	13	15	21	_	_	_	_	_	_	_	_	N/A					
Patient FFT Score	%	_	_	_	_	_	_	_	_	_	_	_	_	95%					See 'Burns Ward' for monthly combined score.

BURNS WARD 2016 / 2017		DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DoN Rating					
Staff Utilisation							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies	WTE	5.6	3.47	4.26	4.26	4.7	7.23	3.54	4.54	6.51	2.2	4.4	4.4	7.5%					
Est =	(hrs)	910	564.9	693.2	693.2	763.75	1174	573	735	1057	82.5	715	715						
Temp staffing exc RMN	Bank	128.5	303.5	303.75	356	142.5	223	180	225	160	72	N/A	74.25	10%					Reduced bank and agency reflects staffing to activity
	Agency	12	36	0	107.5	84	174	41	36	46.5	30	69	57.5						
Sickness	%	4.7%	3.7%	5.8%	3.8%	4.2%	5.5%	3.1%	2.2%	1.4%	1.8%	2.2%	2.0%	2%					
Shift meets est %	RN	97.7%	95.3%	95.9%	95.1%	95.9%	98.8%	100%	94%	100%	100%	96%	95%	95%					Reduced HCA cover at night reflects bed occupancy
Day	HCA	94.4%	94.4%	83.3%	100%	97%	100%	94%	90%	96%	88%	98%	100%	95%					
Shift meets est %	RN	98.4%	96.8%	92.9%	93.7%	96.6%	95.2%	93%	98%	100%	100%	100%	97%	95%					
Night	HCA	100%	200%	100%	100%	200%	200%	100%	100%	100%	100%	100%	100%	95%					
Training / Appraisal							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals	%	97.7%	90.6%	94%	94%	94%	94%	82%	76%	80%	N/A	66%	N/A	85%					Improvement plan requested
Statutory & Mand.	%	96.2%	91.9%	92%	92%	92%	92%	89.6%	92%	93%	N/A	88%	N/A	85%					Target set for 100%
Drug Assessments	%	100%	100%	93%	93%	100%	100%	93%	93%	93%	100%	100%	100%	95%					
Staff FFT Score	%	–	–	–	–	–	–	–	–	–	–	–	–	–					
Budget	(YTD)	175359	178609	168052	154025	10530	6959	20282	21387	11789	10663	14951		<0					
Safe Care							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	G2+	0	0	0	0	0	0	0	0	0	2	0	0	0					
Falls	With harm	0	0	0	1	0	0	0	0	0	1	0	0	0					
Medication Errors	All	1	0	0	1	1	1	0	1	1	1	0	1	0					
C. Diff		0	0	0	0	0	0	0	0	0	0	0	0	0					
MRSA		0	0	0	0	0	0	0	4	0	0	0	0	0					
Incidents Reported (Datix)	Patient Safety	8	3	2	3	2	7	4	4	5	9	3	6						
VTE reassessment	%	N/A	100%	N/A	100%	100%	66.7%	100%	50%	50%	100%	100%	100%	95%					Feedback given to ward matron
Nutrition assessment (MUST)	Initial	100%	100%	N/A	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%					
	7 day r/v	N/A	100%	N/A	100%	N/A	100%	100%	100%	100%	100%	100%	100%						
Patient numbers		20	20	20	32	44	24	69	59	55	65	43	62	N/A					
Patient FFT Score	%	100%	100%	100%	100%	100%	99%	100%	94%	100%	100%	100%	94%	95%					Review requested

CANADIAN WING 2016 / 2017		DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DoN Rating					QVH
Staff Utilisation							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies	WTE	11.76	11.76	11.7	8.6	4.16	5.96	5.18	6.42	6.42	7.66	9.16	11.85	7.5%					4 staff oofered posts and currently progressing through recritment process
Est =	(hrs)	1911	1911	1911	1397.5	676	968	841	1043	1043	1245	1488	1925						
Temp staffing exc RMN	Bank	565	623.5	860	731	286	292	420	112	299	364	227	280	10%					Bank and agency usage less than the wte vacancy includes cover for higher sickness rates in month. All managed appropriately at this time.
	Agency	586	79.5	150	411	293	108	178	57	245	440	289	172.5						
Sickness	%	5.5%	2.2%	3.7%	4.2%	7.1%	2.4%	3.5%	3.9%	2.8%	3.2%	3.3%	4.0%	2%					Sickness being managed as per policy. Includes sickness due to surgery and recovery. Improvement plan requested.
Margaret Duncombe							***Safe Staffing***							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Shift meets est %	RN	98.4%	103%	98.2%	99.2%	102%	102%	100%	99%	99%	101%	97%	102%	95%					
Day	HCA	94.8%	98.1%	100%	98.3%	100%	93.8%	96%	103%	92%	94%	92%	98%	95%					
Shift meets est %	RN	95.9%	101%	101%	99%	100%	99.1%	97%	90%	100%	101%	100%	111%	95%					lower staffing levels at night reflect bed occupancy
Night	HCA	100%	104%	93.1%	100%	86.1%	97%	103%	100%	100%	85%	88%	65%	95%					
Ross Tilley							***Safe Staffing***							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Shift meets est %	RN	102%	96.4%	98.0%	95.9%	97.8%	100%	100%	98%	89%	92%	99%	99%	95%					
Day	HCA	98.4%	98.6%	100%	98.4%	98.2%	97.8%	100%	91%	94%	90%	98%	105%	95%					
Shift meets est %	RN	97.6%	97.6%	95.7%	98.7%	95.5%	100%	99%	100%	93%	94%	86%	94%	95%					lower staffing levels at night reflect bed occupancy
Night	HCA	90%	97%	77.8%	86.2%	88.5%	88.9%	83%	90%	96%	71%	82%	55%	95%					
Training / Appraisal							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals	%	100%	100%	100%	100%	95%	96%	100%	100%	100%	100%	100%	100%	85%					
Statutory & Mand.	%	94%	93%	93%	90%	90%	92.9%	92.9%	87%	72%	83%	N/A	83%	85%					Target of 100% set
Drug Assessments	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97.5%	100%	95%					
Staff FFT Score	%	–	–	–	–	–	–	–	–	–	–	–	–	–					
Budget	(YTD)	88792	82955	79511	98162	12567	16553	9059	7991	11692	13962	27912		<0					

CANADIAN WING 2016 / 2017		DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DoN Rating					QVH
Safe Care		No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Margaret Duncombe (& Step Down)																			
Pressure Ulcers	G2+	1	1	0	0	2	0	0	0	1	0	0	0	0					
Falls	With harm	0	0	0	2	1	1	0	0	0	1	0	1	0					
Medication Errors	All	5	3	8	3	6	5	2	3	6	2	1	1	0					
C. Diff		0	0	0	0	0	1	0	0	0	0	0	0	0					
MRSA		0	0	0	0	0	0	0	0	0	0	0	0	0					
Incidents Reported (Datix)	Patient Safety	11	9	11	9	14	16	5	9	12	13	11	8						
VTE reassessment	%	100%	100%	100%	100%	100%	69.2%	90.9%	100%	80%	100%	100%	90.9%	95%					
Nutrition assessment (MUST)	Initial	100%	100%	100%	100%	100%	94.1%	100%	100%	100%	100%	100%	100%	95%					
	7 day r/v	100%	75%	100%	75%	100%	100%	75%	100%	100%	100%	100%	100%						
Patient numbers		125	133	117	166	166	123	137	112	162	157	173	158	N/A					
Patient FFT Score	%	100%	100%	100%	99%	100%	99%	97%	99%	96%	98%	98%	98%	95%					
Ross Tilley														Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	G2+	1	0	0	0	1	0	0	0	0	0	0	0	0					
Falls	With harm	0	0	0	1	1	0	0	1	0	1	0	0	0					
Medication Errors	All	6	6	2	5	0	6	4	4	3	4	6	4	0					
C. Diff		0	1	0	0	0	0	0	0	0	0	0	0	0					
MRSA		0	0	0	0	0	0	0	0	0	0	0	0	0					
Incidents Reported (Datix)	Patient Safety	8	9	6	17	5	9	15	8	9	15	10	9						
VTE reassessment	%	88%	100%	100%	94%	85.7%	82.4%	100%	100%	100%	100%	100%	100%	95%					
Nutrition assessment (MUST)	Initial	100%	100%	100%	100%	100%	100%	100%	100%	100%	94.1%	100%	83.3%	95%					
	7 day r/v	100%	100%	100%	75%	66.7%	N/A	100%	N/A	100%	100%	100%	N/A						
Patient numbers		188	172	156	199	148	201	218	240	191	207	210	207	N/A					
Patient FFT Score	%	98%	100%	100%	99%	97%	98%	98%	99%	100%	99%	98%	97%	95%					

PEANUT WARD 2016 / 2017		DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DoN Rating					
Staff Utilisation							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies	WTE	1.5	2.36	2.36	2.36	2.72	1.34	3.74	2.74	2	2	2	2.6	7.5%					some vacancy being held to implement chnages to night shidt pattern
Est =	(hrs)	243.7	383.5	383.5	383.5	442	217	607	445	325	325	325	325						
Temp staffing exc RMN	Bank	99.5	104.5	275.25	205.5	48.5	15.5	40	95	68	231	90.5	216.25	10%					
	Agency	12	0	12	0	0	0	12	12	4	34	34.5	46						
Sickness	%	4.4%	6.2%	5.4%	5.6%	4.0%	5.7%	7.6%	2.1%	2.4%	3.3%	7.3%	2.6%	2%					increase in short term sickness has resulted in higher usage of bank and agency
Shift meets est %	RN	100%	98.8%	96.2%	100%	96.3%	98.8%	98%	101%	97%	98%	96%	102%	95%					
Day	HCA	100%	97.1%	100%	100%	103%	100%	94%	88%	94%	104%	92%	93%	95%					
Shift meets est %	RN	95.2%	98.4%	92.7%	93.4%	94.9%	90%	93%	98%	95%	98%	90%	88%	95%					
Night	HCA	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%					
Training / Appraisal							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals	%	100%	78.1%	91%	91%	91%	91%	81%	89%	94%	N/A	66%	75%	85%					
Statutory & Mand.	%	96%	94.4%	94%	94%	94%	93%	91%	90%	92%	N/A	84%	79%	85%					Target set at 100%
Drug Assessments	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%					
Staff FFT Score	%	_	_	_	_	_	_	_	_	_	_	_	_	_					
Budget	(YTD)	7388	1657	864	9228	4314	8844	11878	13516	16305	12903	16973		<0					
Safe Care							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	G2+	0	0	0	0	0	0	0	0	0	0	0	0	0					
Falls	With harm	0	0	0	0	0	0	0	0	0	0	0	0	0					
Medication Errors	All	1	2	0	2	0	0	1	2	0	1	1	1	0					
C. Diff		0	0	0	0	0	0	0	0	0	0	0	0	0					
MRSA		0	0	0	0	0	0	0	0	0	0	0	0	0					
Incidents Reported (Datix)	Patient Safety	6	4	3	6	4	2	3	5	4	3	6	2						
VTE reassessment	%	_	_	_	_	_	_	_	_	_	_	_	_	95%					N/A
Nutrition assessment (MUST)	Initial	_	_	_	_	_	_	_	_	_	_	_	_	95%					N/A
	7 day r/v	_	_	_	_	_	_	_	_	_	_	_	_						
Patient numbers		181	167	183	190	180	197	188	235	213	216	226	202	N/A					
Patient FFT Score	%	100%	100%	100%	98%	100%	97%	99%	100%	98%	96%	97%	98%	95%					

Queen Victoria Hospital NHS
NHS Foundation Trust

Monthly Patient Experience Report

1 November 2016 – 30 November 2016

Performance Indicators	Nov	Oct	Sept	Aug	Jul
Number of new formal complaints received in the month	3	5	4	7	0
Number of complaints referred to the Ombudsman for 2nd stage review	0	0	0	0	0
Number of complaints re-opened	0	1	0	0	0
Number of complaints closed	2	3	1	2	5
Number of complaints upheld	1	2	1	1	1
Number of complaints upheld in part	1	0	0	1	3
Number of complaints unsupported	0	1	0	0	1
Number of new claims	1	1	0	0	4
Number of closed claims	1	0	0	2	0

Complaints

Open Complaints

There were three 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.

Maxillofacial – Off-Site Medway

1. **Outpatient – Appointments – Delayed appointments/waiting list -** Patient referred for MOS at Medway and advised that waiting time is 38 weeks. Patient finds this totally unacceptable and wants to know why referral was accepted. **Investigating lead – Business Unit Manager**

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

   Comment/Action – Apologies given and assurance given that we have put steps in place to improve the service and reduce the waiting time.

Maxillofacial - Inpatient

2. **Inpatients – Medical/Nursing – Clinical care/attitude** - lack of information and follow-up emergency post op care. Attitude of staff. **Investigating lead – Clinical Director/Matron**

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

   Comment/Action – Case still under investigation.

Plastics - Outpatient

3. **Patient Safety – Risk** - Debit card holder with debit card inside had gone missing from consultation room. The doctor involved was certain that the item was inside their jacket and left the jacket inside the room where they were seeing the patient. They then left the room and when they returned the debit card was missing. Debit cards cancelled and police were called on advice of Site Practitioner. **Investigating lead – Patient Experience Manager**

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

Comment/Action – No evidence to indicate that patient had taken the property. The doctor had seen two other patients prior to noticing the card missing. Personal possessions were in room during these consultations. Personal letter of apology being sent to the patient from the clinician involved.

Closed Complaints

There were two 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.

Clinical Infrastructure

1. **Outpatients/Inpatient – Medical/Nursing – Delay in treatment/Attitude (uncaring)** - Delayed treatment plan and delay in decisions being made in relation to lower limb surgery. During last admission patient alleges that nursing staff appeared uncaring towards patient's situation. I**nvestigating lead – Consultant/Medical Director/Head of Nursing**

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

   Comment/Action – There has been a delay however this is due to the complexities of this patient's medical history. Apologies given if nursing staff were uncaring towards the patient. Patient has been referred to London hospital for second opinion. **Complaint Upheld in part.**

2. **Referrals - Admin – Referrals processing -** Delay in processing 2 week cancer referral letter resulting in patient seeking private treatment. I**nvestigating lead – Service Manager**

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

   Comment/Action – There was a delay in offering this patient an appointment due to lack of capacity within the clinic. This resulted in the patient having treatment privately. As a gesture of goodwill and ex-gratia payment of £900 to cover the cost of having private treatment.

Parliamentary and Health Service Ombudsman (PHSO)

There have been no new cases referred to the PHSO during this period.

Claims

There was one claim opened this month.

Incident date	Claim date	Speciality	Service	Description (allegations within solicitors letter)	Complaint	Incident
01/10/2015	17/11/2016	Plastics	Medical	Very limited and vague information. Alleged failure to remove expander port resulting in removal of breast implant.	No	No

Patient Experience – NHS Choices/Patient Opinion

In November 2016, the NHS Choices/Patient Opinion website received two comments relating to the prosthetics department and MIU.

Superb Prosthetics Department

This is just a short note to say how pleased I am with the QVH Prosthetics Department. I've been under thie care of these staff and the eye clinic since being involved in an explosion in Iraq in 2007. Nothing short of amazing from my Dr and his team to the staff in Prosthetics. A massive thankyou to member of staff who made my first prosthetic eye and to other member of staff who has just finished my latest one. This member of staff is a credit to the team, extremely patient and their attention to detail is superb. Thankyou!

Visited in November 2016. Posted on 07 November 2016

Kind and brilliant

We saw here that the hospital closed at 8. Dashed there only to find out it actually closed at 7:30. We got there at 7:40. The nurses were so kind. They let me in anyway. Cleaned out my cut from a sharp knife. And dressed it. So kind. I couldn't have done it. It's my right hand. Lovely souls.

Visited in November 2016. Posted on 26 November 2016

Friends and Family Test (FFT)

October – Inpatients: In October 2016, 98% of patients said that they would recommend us. Out of the 652 patients eligible to complete the questionnaire 313 did, which is an improved response rate of 48%.

November - **Inpatients:** In November 2016, **97%** of patients said that they would recommend us. Out of the 629 patients eligible to complete the questionnaire 276 did, which is an improved response rate of 44**%.**

October – Outpatients: In October 2016 this very slightly improved to 95% said they would recommend that area. 2099 out of 129240 completed the survey giving a response rate again of 16%.

November – Outpatients: In November 2016 the recommendation has gone down very slightly to 94%. 1485 out of 7791 completed the survey giving a much improved response rate of **19% (target is 20%).**

October – MIU: In October the score was 96% with 197 out of 913 patients completing the survey. The response rate was again of 22%.

November – MIU: In November the score was 97%. 118 out of 439 patients completed the survey. The response rate has improved to **27% (target is 20%).**

October – Day Surgery: For October 2016 the score was 98%. 381 patients out of 948 completed the survey, which is a response rate of 40**%**.

November – Day Surgery: In November again 98% of the patient said that they would recommend us. 240 out of 556 completed the survey, which is a response rate of **43%.**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/01/2017**		**Agenda reference:**	**13-17**	
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:	The National Quality Board workforce paper: Right staff with the right skills in the right place at the right time and NHS England Hard Truths report requires 6 monthly reviews of inpatient areas to demonstrate safe care and evidence based review and deployment of resources to provide quality care,. The report covers the 6 month period from 1 April 2016 to 31 October 2016 and reviews all impatient areas, MIU and outpatient areas. It reviews the impact of 2016/17 cost improvement programme and nursing consultation as well as the sustained challenges of vacancies particularly in ITU (mirrors national shortages in this area).				
Recommendation:	The Board is asked to note the review and the increase in vacancies and the potential higher risks associated with this				
Purpose		Information		Assurance	
Link to key strategic objectives (KSOs):	KSO1: **Y**	KSO2: **Y**	KSO3: **Y**	KSO4: **Y**	KSO5: **Y**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	The BAF has been reviewed and KSO1 score adjusted to reflect the higher risk to the organisation with the level of nursing vacancies. Current score is 12 residual score is 8.				
Corporate risk register:	The CRR and the departmental risk registers reflect workforce challenges for nursing and medical staff.				
Regulation:	Compliance with regulated activities in Health and Social Care Act 2014 and CQC Essential Standards of Quality and Safety.				
Legal:	As above				
Resources:	No additional resources required to produce the report				
Assurance route					
Previously considered by:	EMT December 2016				
	Date:	19/12/16	Decision:	Noted	
Previously considered by:	Board of Directors, previous 6 monthly nursing workforce report July 2016				
	Date:	07/07/16	Decision:	Noted	
Next steps:	NA				

Queen Victoria Hospital NHS
NHS Foundation Trust

6 Monthly Nursing Workforce Review – January 2017

1. Purpose

This report provides the Board with the required six monthly review of safer staffing at Queen Victoria Hospital and fulfils the requirements of the National Quality Board (NQB) expectations that all NHS organisations present six monthly reports on nurse staffing levels in the inpatient areas (theatres are not included).

2. Background

Following the Francis Public Inquiry Report and the Governments response to the Inquiry Recommendations – "Hard Truths" there has been significant national focus on nurse staffing levels and ensuring these are fit for purpose. The report highlights the importance of safe staffing and refers to the NQB guidance 'How to ensure the right people with the right skills are in the right place at the right time'. Lord Carter's report, 'Operational productivity and performance in English NHS acute hospitals; Unwarranted variation' focusses on care hours per patient day (CHPPD) as a key measure of nursing and care support deployment. The trust submits this national data set monthly (example in Appendix 1).

The benefits of having appropriate staffing levels are well evidenced and align with the Trust's key strategic objectives;

- Outstanding patient experience
- World class clinical services
- Operational excellence
- Financial sustainability
- Organisational excellence

The data in this report is based on information available on 1st November 2016.

3. NQB expectations

Recommendation	Current Position
Boards take full responsibility for the quality of care to patients and as a key determinant of quality take full and collective responsibility for nursing care and care staffing capacity and capability	The Board has a process in place for setting and monitoring nursing levels. The Board receives six monthly nursing workforce reports and an update on staffing levels and quality at every public board.
Processes are in place to enable staffing establishments to be met on a shift to shift basis	Nursing acuity and capacity is reviewed three times per day in the ward areas. This information is presented at the twice daily bed meeting where senior clinical and operational staff manages the patient flow for electives and trauma. Nursing and care staff can be reallocated at the start or during a shift Local escalation process is embedded. Heads of Nursing are visible in the clinical areas. Daily oversight of planned versus actual staffing levels by Director or deputy Director of Nursing.
Evidence based tools are used to inform nursing and care staffing capability and capacity	All ward areas use safer nursing care tool- acuity and dependency tool. Application of specialty specific national guidance to support

	establishments and professional judgement
Clinical and managerial leaders foster a culture of professionalism and responsiveness where staff feel able to raise concerns	Datix reporting system is established and used. 'Tell Jo' – confidential email to DoN. Trust policies eg Whistleblowing. Compliance in practice ward visits and clinical Fridays undertaken by DoN.
Multi-professional approach is taken when setting nursing and care staffing establishments	This is the third six monthly workforce review undertaken by the DoN in conjunction with the executive management team (EMT). Changes to establishments have been made only after consultation with EMT and trust staff.
Nurses and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties	There is 22% uplift within the ward establishments to cover sickness, mandatory and statutory training and leave. Ward matrons are accountable for their budgets and have monthly meeting with the HoN and finance. All ward matrons have supervisory time to undertake management duties.
At each public board an update on workforce information, staffing capacity and capability is discussed six monthly with a nursing establishment review	The DoN provides updates on workforce in the quality report at every public board and there is a 6 monthly review of nursing workforce
Information is clearly displayed about nurses and care staff on duty in each ward on each shift.	All ward areas have status boards in public areas stating expected number and actual number of nurses and care staff on duty. When there are variations on this, the ward matron will review and escalate via agreed processes to ensure safe staffing maintained. The DoN will review this escalation and triangulate with safer care metrics and complaints data to ensure staffing levels allow provision of quality care
Providers take an active role in securing staff in line with workforce requirements	Recruitment days for general and theatre staff have taken place in the last 12 months. Staff are supported to undertake specialist modules for development and enhanced care. Director of HR reviewing recruitment processes. Part of the theatre productivity work has a workforce subgroup. Different recruitments campaigns have been instigated in the last 4 months. This has results in increased interest in post however the trust is experiencing difficulty in recruiting to some posts mainly in Theatres and ITU (significant national shortages in these areas).
Commissioners actively seek assurance that the right people with the right skills are in the right place at the right time with the providers with who they contract.	DoN meets monthly with the CCG Chief Nurse. Staffing levels discussed at these meeting. The commissioners are aware of the nurse staffing levels and the actions the trust is taking to optimise recruitment and retention.

4. Benchmarking data

RCN and NICE guidance advises one registered nurse (RN) to 6/8 patients during the daytime, NICE guidance advises not more than 8 patients during the day time and one RN to 10/11 patients at night as the national benchmark for a "general ward".
The RCN guidance advises on the ratio of RN:HCA at 65:35 for a general ward. Add the QVH ward ratios . C-Wing has a ratio of 65:35 with paediatrics being higher at 80;20 due to requirements of national staffing guidance. Burns ward and ITU do not qualify as general wards and are not included in this benchmarking.

At QVH patients on C-Wing, including the Step Down Unit, and Burns ward require a higher nursing ratio than a general ward due to the specialty requirements and the complexity of the case mix and acuity. There is separate guidance for Paediatric and intensive Care Units (ICU).

Canadian Wing, Burns Ward and ITU use the same evidence based patient acuity tool (appendix 2) to assess individual patient needs and level of dependency. This Safe Nursing Care tool (SNCT)) tool was developed by the Association of United Kingdom University Hospitals (AUKUH). A version of SNCT has been adapted for use in paediatrics and this is used on Peanut Ward at QVH (appendix 3).

The average benchmark that Trusts allocate for uplift costs in ward budgets is 22% (covers annual leave, some sickness allowance and mandatory training). QVH ward budgets also use this national average of 22% backfill costs.

The Chief Nursing Officers 'Strategy for England' outlines the importance of ward matrons having time to lead. All inpatient and outpatient nursing leads have at least one day per week of supervisory time (this is increased pro- rata depending on the size of the ward team).

5. Updates since last report

The acuity data is still collected three times each day. Staff can be redeployed at the start of or during a shift to another area depending on capacity and acuity. Careful consideration of the transferrable skill set and speciality knowledge of staff is given to make the best use of the resources available so that the wards and departments are safe. If resources cannot be redeployed bank and agency staff are utilised in order to maintain safe provision of care.

The nursing consultation concluded on 12 July 2016 and a final version with some changes was circulated to trust staff on 20 July 2016. Key changes:

- New ward matron role has been implemented (1 wte vacancy currently)
- Standardisation of shift has been achieved (fye saving of 192k)
- Decrease of 15 wte
- SDU management to move to ITU ward matron

A multidisciplinary working group chaired by the Deputy DoN has been set up to safely plan and implement the SDU changes.

A new system for sign off of nursing agency is in place. Agency rates above the cap can only be authorised by the deputy or DoN. Agency use is reviewed weekly by the DoN.

New to this report is the inclusion of the Outpatient areas.

6. Establishment review findings

The Deputy Director of Nursing undertook the six month reviews with the HoN and ward matrons for each ward and outpatient area. These reviews have been presented to the DoN for further review and quality assurance.

The baseline assessments for these areas show the trust meets the NICE and RCN guidance (Appendix 2 and 3) However these evidence based tools will not necessarily have taken into account roles such as discharge co-ordinator or level of therapy resource available so professional judgment is an important part of setting the correct staffing levels.

A variety of information is considered when making professional judgements and this includes Datix/incident reports, safe staffing metrics, budget, and discussion with the Heads of Nursing and the Ward Matrons.

The site practitioners monitor nurse staffing across the whole site in real time with HoN review twice a day and the Deputy and DoN monitor planned staffing levels against actual on a daily basis (ITU example in appendix 4)

The tables below show the 6 monthly review finding:

Non-inpatient areas

Department	Current wte Establishment	Establishment required post 6 month review	Number of wte in post 1/11/16	Number of vacant posts	% of vacant posts
MIU	14.92	14.92	14.16	*0.76	5%
Main OPD	16.2	15.70	14.20	*2	12%
Corneo OPD	18.84	18.84	17.84	1	5%
Maxfac OPD	23.93	22.33	20.50	*3.43	14%

** 2.8 wte of the vacant posts are currently being held and will form part of the 2017/18 CIP subject to approval and quality impact assessment*

In patient areas

Department	Current wte Establishment	Establishment required post 6 month review	Number of wte in post 1/11/16	Number of vacant posts	% of vacant posts
C-Wing	62.32	59.59	50.28	*12.04	19%
ITU	20.09	20.09	12.50	7.55	37%
Burns ward	32.76	30.15	28.06	*4.70	16%
Peanut ward	25.21	24.41	22.61	*2.6	10%

***5.94 wte of the vacant posts are currently being held and will form part of the 2017/18 CIP subject to approval and quality impact assessment*

The key area of concern from this review is ITU. Previous recruitment has not resulted in staff being retained in this area. A variety of reasons have been identified, including not enough general ITU experience, promotion and new career choices.

The Guidelines for Provision of Intensive Care Services 2015 (GPICS) state 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.

The ward matron has identified different ways to utilise HCAs and a targeted recruitment campaign has been run in November and December to attract qualified nurses, HCA and a practice educator. Currently there are two substantive RNs, one bank RN and one HCA being processed with start dates for the New Year. This equates to 2.5 wte and leaves a vacancy of 5.05wte (25%).

The majority of the vacancy is being covered by agency staff who regularly work on the unit. There are 3 beds in ITU however due to a decrease in emergency burns admissions bed occupancy is currently running at 1.5 beds per month.

7. Recruitment and Retention

There has been an increase in vacancy rates since the last report. The majority of these vacancies are in theatres however there is also a significant increase in vacancies in ITU and turnover remains higher than the national average (trust turnover rate 16.9% November 2016).

The current number of vacancies in the wards and non-inpatient areas is 34.08 wte from a total establishment of 214.27 which is 15.9% (*data source general ledger and E Roster*).

Changes in recruitment adverts and targeted approaches have increased the responses to some post such as the Lead Infection Control Nurse but not others.

The increase in vacancies has not impacted negatively on patient satisfaction scores (Complaints, Friends and Family Test) however there has been sustained scrutiny of nursing workforce metrics and review of Datix (appendix 5) and patient safety indicators such as pressure ulcers, falls and infection rates to look for any other early warning indicators relating to staffing levels or changes in quality and safe provision of care.

Whilst no actual unsafe incidents have been identified there is regular escalation to ward matrons, site practitioners and HoN and staff are regularly redeployed which is a risk to staff satisfaction and standards of care.

There has been a small increase in complaints (three complaints in 3 months) sighting nursing – communication/attitude issues. These have been investigated by the ward matron and patient experience manager and reviewed by the DoN and no direct correlation with actual staffing levels has been identified.

The risks associated with prolonged vacancies have been added to departmental risk registers, CRR and the BAF risk rating for key strategic objective – Outstanding Patient Experience has been increased to reflect the increased risk to sustaining an outstanding patient experience.

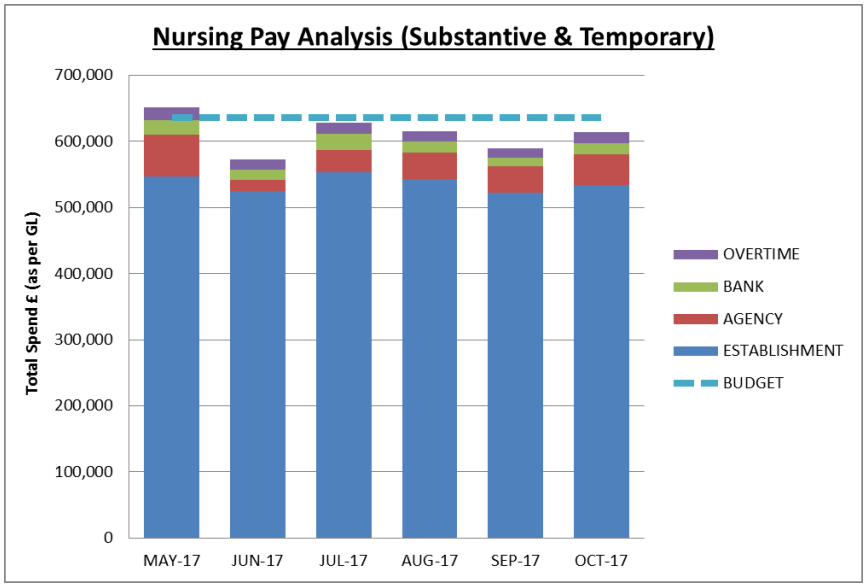
8. Bank and agency spend

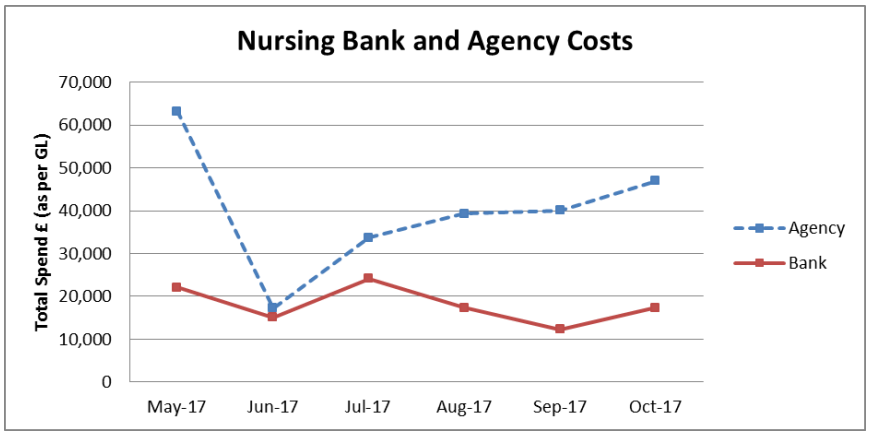
Bank and overtime payments have remained stable during the last 6 months however there is an increasing trend in agency spends which reflects the higher vacancy levels. Nursing have had to continue to pay over the NHSI set agency cap to be able to cover some specialist areas for example in Theatres and ITU (significant national shortages in these staff groups).

The pay budgets for the wards and outpatient areas are in balance and there has been an improvement in the management of these by the ward matrons.

A new system for sign off of nursing agency is in place. Agency rates above the cap for inpatients and outpatient areas can only be authorised by the deputy or DoN. Agency use is reviewed weekly by the DoN.

Nursing pay analysis is shown in the charts below:





The Deputy Director of HR will; chair a bank and agency task and finish group commencing January 2017. Nursing will be a member of this group.

Maternity Leave

Each individual area is required to cover the vacancy left by a member of staff on maternity leave which creates a cost pressure, this varies depending on the length of service and the amount of occupational maternity pay an individual is entitled to.

4.79 wte are currently on maternity leave across the nursing areas reviewed as part of this paper (November 2016).

Summary

The report provides details of the nursing response to the National Quality Boards Expectations of provider organisations and updates the Board on the current position.

The report also details compliance with RCN and NICE guidance for safe staffing levels and details compliance against recommended benchmarks. Staffing levels continue to be

reviewed regularly using an evidence based tool (SNCT) and there is a clear governance process for monitoring and escalation.

Recruitment and retention is an area of concern particularly in ITU. The Director HR in collaboration with other directors is currently developing several schemes to improve recruitment and retention at QVH.

The Board has been appraised of the increased risk due to the current vacancy levels.

Agency spend continues to be a challenge due to higher levels of vacancy and difficulty in recruiting which reflects the national shortages of specialist staff.

Recommendations

The Board is asked to:

- note the sustained position and progress against the NQB requirements, RCN and NICE guidance and the further actions required
- note the staffing level/skill mix against recommended bench marks
- note the introduction of the CHPPD tool to support safe care provision

Appendix 1

CHPPD is calculated by taking the actual hours worked (split into registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight.

Margaret Duncombe

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
May-16	1472	1495	552	518	1219	1207.5	379.5	368	101.6%	93.8%	99.1%	97.0%	380	7.1	2.3	9.4
Jun-16	1173	1173	598	575	989	954.5	345	356.5	100.0%	96.2%	96.5%	103.3%	329	6.5	2.8	9.3
Jul-16	1047	1035	414	425.5	828	747.5	287.5	287.5	98.9%	102.8%	90.3%	100.0%	249	7.2	2.9	10.0
Aug-16	1461	1449	609.5	563.5	1242	1242	333.5	333.5	99.2%	92.5%	100.0%	100.0%	395	6.8	2.3	9.1
Sep-16	1507	1518	552	517.5	1219	1231	310.5	264.5	100.7%	93.8%	101.0%	85.2%	473	5.8	1.7	7.5
Oct-16	1357	1323	598	552	1035	1035	287.5	253	97.5%	92.3%	100.0%	88.0%	394	6.0	2.0	8.0
Nov-16	1426	1449	517.5	506	1081	1196	299	195.5	101.6%	97.8%	110.6%	65.4%	413	6.4	1.7	8.1

Ross Tilly

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
May-16	1276.5	1276.5	517.5	506	885.5	885.5	310.5	276	100.0%	97.8%	100.0%	88.9%	469	4.6	1.7	6.3
Jun-16	1162	1162	713	713	851	839.5	333.5	276	100.0%	100.0%	98.6%	82.8%	479	4.2	2.1	6.2
Jul-16	1173	1150	759	690	885.5	885.5	333.5	299	98.0%	90.9%	100.0%	89.7%	422	4.8	2.3	7.2
Aug-16	943	839.5	598	563.5	678.5	632.5	264.5	253	89.0%	94.2%	93.2%	95.7%	311	4.7	2.6	7.4
Sep-16	1047	966	563.5	506	828	782	322	230	92.3%	89.8%	94.4%	71.4%	451	3.9	1.6	5.5
Oct-16	1047	1035	598	586.5	920	793.5	322	264.5	98.9%	98.1%	86.3%	82.1%	452	4.0	1.9	5.9
Nov-16	989	977.5	471.5	494.5	770.5	724.5	253	138	98.8%	104.9%	94.0%	54.5%	382	4.5	1.7	6.1

Peanut

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
May-16	984	972	372	372	720	648	0	0	98.8%	100.0%	90.0%	-	40	40.5	9.3	49.8
Jun-16	972	948	384	360	708	660	0	24	97.5%	93.8%	93.2%	-	50	32.2	7.7	39.8
Jul-16	1056	1044	408	396	744	732	0	0	98.9%	97.1%	98.4%	-	63	28.2	6.3	34.5
Aug-16	1012	977.5	368	345	713	678.5	0	11.5	96.6%	93.8%	95.2%	-	51	32.5	7.0	39.5
Sep-16	1012	989	310.5	322	678.5	667	11.5	11.5	97.7%	103.7%	98.3%	100.0%	73	22.7	4.6	27.3
Oct-16	1024	977.5	437	402.5	713	644	0	11.5	95.5%	92.1%	90.3%	-	37	43.8	11.2	55.0
Nov-16	989	1012	310.5	287.5	690	609.5	0	11.5	102.3%	92.6%	88.3%	-	67	24.2	4.5	28.7

Burns

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
May-16	1020	1008	300	300	744	708	12	24	98.8%	100.0%	95.2%	200.0%	110	15.6	2.9	18.5
Jun-16	852	852	204	192	708	660	0	0	100.0%	94.1%	93.2%	-	59	25.6	3.3	28.9
Jul-16	1080	1020	372	324	744	732	0	24	94.4%	87.1%	98.4%	-	108	16.2	3.2	19.4
Aug-16	1047	1047	287.5	276	713	713	0	23	100.0%	96.0%	100.0%	-	122	14.4	2.5	16.9
Sep-16	977.5	977.5	391	345	667	667	0	11.5	100.0%	88.2%	100.0%	-	116	14.2	3.1	17.3
Oct-16	1058	1012	529	517.5	713	713	0	0	95.7%	97.8%	100.0%	-	143	12.1	3.6	15.7
Nov-16	897	851	552	552	690	667	0	0	94.9%	100.0%	96.7%	-	115	13.2	4.8	18.0

ITU

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
May-16	1116	1080	0	0	1080	1080	0	0	96.8%	-	100.0%	-	73	29.6	0.0	29.6
Jun-16	924	900	0	0	948	780	0	0	97.4%	-	82.3%	-	45	37.3	0.0	37.3
Jul-16	1092	1008	24	48	1020	1020	0	0	92.3%	200.0%	100.0%	-	62	32.7	0.8	33.5
Aug-16	1047	1058	23	23	1081	1035	0	0	101.1%	100.0%	95.7%	-	57	36.7	0.4	37.1
Sep-16	862.5	793.5	23	23	920	724.5	0	0	92.0%	100.0%	78.8%	-	33	46.0	0.7	46.7
Oct-16	885.5	851	92	103.5	874	759	0	0	96.1%	112.5%	86.8%	-	47	34.3	2.2	36.5
Nov-16	805	770.5	115	115	782	632.5	0	0	95.7%	100.0%	80.9%	-	25	56.1	4.6	60.7

Appendix 2
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 3 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 4

Below is an example of the metric taken from the Safe Staffing tool completed by the site practitioners on a daily basis. This demonstrates the number of times per month (November) staffing did not meet the expected levels. The same metric is completed for each inpatient area although these are not all included in this paper. This information is reviewed on a weekly basis by the Director of Nursing. When staffing levels are amber or red, incidents and complaints are also reviewed and triangulated to identify issues and take remedial action.

SAFE STAFFING DASHBOARD

BURNS ITU

NOVEMBER 2016

M	T	W	Th	F	S	Su
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

GREEN	*Staffing meets planned requirement*
AMBER	*Staffing does not meet planned requirement but care is safe*
RED	*Staffing does not meet planned requirement & the senior nurse has been informed*

NOVEMBER 2016

M	T	W	Th	F	S	Su
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

When amber or red rationale to be provided below

Appendix 5

All incidents reported that raise concerns regarding adverse nurse staffing numbers are reviewed by the relevant Head of Nursing and the Director and deputy Director of Nursing are sighted on the investigation. Staff are actively encouraged to report incidents, near miss or no harm to enable learning. Comparison data over the past 3 years does not identify any significant trends and there have been no moderate or serious incidents from February 2015 that were directly related to staffing levels.

	2013/14	2014/15	2015/16	2016/17 (Part)
Q1	5	3	9	11
Q2	7	2	5	6
Q3	1	11	6	-
Q4	3	12	9	-
Total	**16**	**28**	**29**	**17**

KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Committee: Quality & Governance
Date last reviewed: 17 November 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 research and innovation.

Current Risk Rating 4 (C) x 3 (L) = 12 Amber
Residual Risk Rating 4 (C) x 2 (L) = 8 Yellow

Rationale for current score
ITU compliance
Paediatric inpatient compliance
Seven Day Standards for urgent care
Recruiting to specific posts
Trainee recruitment and cost vs delivery
Internal and spoke governance resource
External and internal research funding

Risk
Patients, clinicians & commissioners lose confidence in services due to inability to show external assurance by outcomes, reduction in research output and fall in teaching standards.
Quality affected by lack of clinical governance .

HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY
National Standards:
ITU (ICS, SECCAN, ODN Burns)
Paediatrics (ODN burns and RCPCH)
General eg NICE, CQC
Trainee doctor contract
Seven Day Services

COMPETITION
Positive:
Potential for Horder collaboration on research or education.
Private patients
Negative:
NHS, NHS funded & private providers
Consultant workforce changes: Part time/ retiring early/LLPs
BMRF risk

INNOVATION
Efficient job planning
Efficient theatre/OPD use
Optimum OOH care/training
Multi-professional education,
Human factors and simulation
Research strategy
Outcomes publication
New services

RESILIENCE
Engagement of workforce
Shared care, local networks
Leaders: CDs and governance leads
Demand in many services with opportunities in STP.
CEA incentives
Management support for operational initiatives
Single points of failure

Controls and assurances:
Clinical governance group and leads
Revising clinical indicators NICE refresh and implementation
CQC action plan; ITU actions including ODN/ICS
Spoke visits service specification EKBI data management
Relevant staff engaged in risks OOH and management
Networks for QVH cover-e.g. burns, surgery, imaging
Training and supervision of all trainees with deanery model
Creation of QVH Clinical Research strategy

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, 910
Plan for sustainable ITU on QVH site-CRR 904, 844
Recruitment challenges – CRR - 922
Achieving sustainable research investment– BAF only
Balance service delivery with medical training cost – BAF only
ITU planning – DRR 955

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/01/2017**		**Agenda reference:**	**15-17**	
Report title:	**Medical Director's report**				
Sponsor:	Ed Pickles, Medical Director				
Author:	Ed Pickles, Medical Director				
Appendices:	None				
Executive summary					
Purpose:	The purpose of this report is to provide information and assurance to the Board				
Recommendation:	The Board is asked to **NOTE** the contents of the report				
Purpose:			**Discussion**		
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: **Y** *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *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.				
Next steps:	None				

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 05 January 2017
Reference number: 15-17
Report from: Ed Pickles, Medical Director
Author: Ed Pickles, Medical Director
Appendices: N/A
Report date: 19 December 2016

Medical Director's report

1. Clinical Governance

a) Mortalities

	Oct 2016	Nov 2016
QVH mortalities	0	1
Mortalities elsewhere within 30 days of QVH admission	1	2

The mortality elsewhere in October is the subject of an SI investigation which has been reported via STEIS. The death resulted from a recognised intra-abdominal complication associated with the insertion of a percutaneous enteral gastrostomy (PEG) tube, inserted at the time of a major head and neck cancer resection and reconstruction. An RCA is ongoing, and interim recommendations have been implemented until its conclusion. The case will be discussed at the Joint Hospital Governance meeting on 9th January 2017.

The mortality on the QVH site in November represents a palliative burns transfer, with an expected death. The two November off site deaths are unlikely to be related to their treatment at the QVH. These will also be discussed at the January JHCG meeting.

We will be reviewing the CQC report: "Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England" (December 2016) and ensuring compliance with any recommendations.

b) Clinical Indicators
We routinely collect data on transfers out, returns to theatre and unexpected readmissions to hospital within 30 days of discharge. Rates remain stable. There have been six unexpected transfers from the QVH across October and November. The information is considered by clinical teams and at the Joint Hospital Governance meeting.

c) Never events
Two never events were detailed in the last MD board report in November 2016.

- ID16368 05/09/2016: Collagenase injection administered to the patient on the Left ring finger (as opposed to the Left middle finger). Consultant Plastic Surgeon.

- ID 16536. 30/09/2016: Retained corneal eye shield following oculoplastic surgery. Fellow in Oculoplastic surgery.

These have both had completed Root Cause Analyses (RCAs), which have been scrutinised by the Clinical Governance Committee. Actions have been implemented to mitigate against repeat. These actions will be monitored by the committee.

d) Intensive Care
The immediate actions relating to CQC recommendations have been completed. The relationship and co-location with the Step Down Unit is in development, with all ITU, HDU and SDU staff now under the same management. A review of the strategy for ITU provision at QVH is required, incorporating staffing, location, admission criteria and networking with regional units and will be a focus of early 2017.

e) Human Factors (HF) Training
The JHCG meeting in November 2016 was devoted to a presentation on Human Factors in Acute Care by Dr Rob Galloway, BSUH Consultant in Emergency Medicine, and HEEKSS lead for Human Factors training. The presentation was very well received, was filmed, and is available through Qnet.
8 members of QVH staff / month continue to attend HF training at the Princess Royal Infirmary.
Regular meetings for theatre staff will commence in January 2017 looking at theatre incidents, with a particular focus on HF.
The multidisciplinary critical incident simulation training has been extended from monthly, in situ theatre training to include Peanut ward, trialling a new paediatric simulator. MIU will be the next focus of training.

f) Seven Day Services
The second audit period of seven day services, focusing on Consultant review of emergency admissions within 14 hours, twice daily review of high dependency patients, and availability of diagnostic and intervention services was published in December 2016. Results are significantly below the national mean. They will be discussed at the JHCG meeting. Reasons include small sample size, poor documentation, which will be improved by the introduction of EDM. We have begun to map which conditions do require consultant review within 14 hours, and the accepted lines of delegation where otherwise.
A review of surgical consultant job planning will hopefully create spare capacity with which to mirror on-site weekend presence of surgical consultants to the current anaesthetic arrangement.

g) Clinical Audit
Data has commenced on QVH's contribution to the National Head and Neck Cancer Audit (HANA) - Saving Faces audit.
Meetings have been scheduled with the specialty Audit and Governance Leads to start audit planning for the new financial year (2017/2018). All audits will be scheduled on the Trust's Clinical Audit Programme which is monitored by the Clinical Governance Group on a quarterly basis.

The compilation of data for the 2017 Quality Account has commenced. Clinical Audit will be the subject of the internal clinical governance audit by the trust auditors.

2. Medical & Dental Staffing

A new consultant orthodontist was appointed on the 31 October.

A business case for a further oral and maxillofacial surgeon has been approved, initially covering the sabbatical of an existing consultant which commences in February 2017. The AAC panel interview is expected in January 2017.

One consultant is currently subject to a MHPS (Maintaining High Professional Standards) investigation, with regard to conduct. The investigation is complete. The case will now proceed to a panel hearing in January 2017, in line with the QVH Disciplinary Policy and Procedure.

a) Job planning
Electronic systems to aid medical job planning are currently being assessed. This is an important tool in our ambition for accurate, consistent, transparent, annual job planning.

b) Junior Doctor Contract
Our intake of doctors with numbered rotations in plastic surgery in February 2016 will move onto the new junior doctors' contract. Rotas for the first cohort have been devised and approved. The systems for exception reporting (whereby junior doctors can report where their actual working hours are not compliant with agreed conditions) are in place. Exceptions will be reported to the Guardian of Safe Working Hours (Mr John Boorman) and may incur a fine to the trust. The exceptions will form part of a new regular report to Board by Mr Boorman (statutory requirement).
The OMFS registrar rota represents the biggest difficulty in the future, staffed by a small number of doctors, who are often required to assist in long elective operations, in addition to on-call commitments. This has been added to the risk register.
Seminars for all medical staff to introduce them to the new contract and rotas, and their responsibilities are being held in December and January.

c) Appraisal and Revalidation
The current completed appraisal rate within 12 months of the last appraisal for trust appointed medical staff is 85%.We are now using the ASPAT quality assurance tool to assess the quality of appraisals and are collecting feedback from appraisees, to be fed back to appraisers at the end of the year.
Peer forums for appraisers have been instigated, to help appraisers support each other in their development.

3. Medical Education

a) Plans for the further integration of education of medical, nursing and allied professions continue. A new QVH Workforce, Education and Wellbeing

Board chaired by the Interim Director of HR will meet monthly, to which the Local Academic Board will report.

b) The GMC National Training Survey Action plan was reviewed at the LAB.

c) An opening ceremony for the microsurgical training room in the education centre, funded by QVH Charities, was held on the 19th December. The principle benefactors were in attendance.

d) The HEEKSS Library Quality and Assurance Framework inspection was in October 2017. Feedback was positive, although some concerns were raised including space and funding. This is being addressed through business planning.

4. Research

The Blond McIndoe Research Foundation (BMRF) is to cease laboratory based research on the QVH site in January 2017, but will continue to operate, at least, as a grant awarding charity. The proposed Joint Venture between the QVH, BMRF and Horder Healthcare has not been progressed. The QVH is seeking to continue 2 research projects currently undertaken by the BMRF – the "Scar Bank" and the "Microcarrier" work which is nearing completion. A new QVH Research strategy will be devised. The first steps towards this will be presented at the board seminar in February 2017.

5. Medical Devices

The medical devices maintenance and repair contract with Avensys UK is significantly overspent for the 2016/7 year to date. The trust met with Avensys in December 2016 and discussed the terms of the contract. Negotiations for a return of commission fees to the QVH are ongoing. Current significant medical devices expenditure is only on approval of the Executive Management Team.

Dr Edward Pickles
Medical Director
19th December 2016

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Committee – Finance & Performance Committee
Date last reviewed – December 14th 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. Some spoke sites (Medway) have capacity issues which can impact upon our services at that site

Current Risk Rating **5 (C) x 4 (L) = 20 Red**
Residual Risk Rating 5 (C) x 3 (L) = 15 Amber

Rationale for current score
- Case mix and referral changes resulting in increase in day cases and so higher volumes to be seen & treated plus an overall growth in open pathway baseline of 16.2% & skin 2WW of 30%
- Demand and Capacity issues in MaxFax
- Data capture from off site services can impact upon full coding & also planning;
- Capacity issues in referring trusts have a negative impact upon QVH

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 meetings with forward plans activity/booking- includes Cancer;
- National Cancer Breach Allocation Guidance has changed from Oct 16 and has a fairer allocation of the breach for shared breaches where a referral is later than day 38;
- Monthly business unit performance review meetings & dashboard in place with a focus on exceptions, actions and forward planning;
- New management structure in MaxFax/Plastics/Theatres which aligns the surgical management;
- Theatre productivity programme in place

Gaps in controls / Assurance
- Not all spoke sites on QVH PAS so access to timely information can be limited plus some spoke sites have reporting issues; - 728 , 799
- Shared pathways for cancer cases with late referrals from other trusts; - DRR
- Demand and capacity modelling with benchmarking requires continual 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
- Increase in referrals greater than growth assumptions eg. 2WW skin referrals increased by 30% in past year, The growth assumption based on last 2 years was 7.7% whereas by M6 we are showing an increase of 16.2% against the baseline; - DRR

KSO 4 – Financial Sustainability

Risk Owner: Director of Finance & Performance
Committee: Finance & Performance
Date last reviewed: 15th December 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 5 (C) x 4 (L)= 20 RED
Residual Risk Rating 5 (C) x 4 (L) = 20 RED

Rationale for current score (at Month 8)
- Surplus - £1.25m/£1.8m (1.2%)
- CIP slippage - (0%)
- Capital Plan slippage – (20%)
- Finance & use of resources – 2

Rationale for score
- Plan to deliver control total including mitigations – traction required and concerns re underlying performance
- Existing CIPP performance +ve

HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY
- NHS Sector financial landscape
  - Regulatory Intervention
  - Autonomy
- Single Oversight Framework
- Commissioning intentions
- Annual NHS contract
- 5YFV & Sustainability and transformation footprint plans
- Proposed 2 year tariff arrangements
- Planning timetables – Trust v STP

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

Controls / Assurances
- Performance Management regime in place
- Standing Financial Instructions revised and ratified
- 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.
- Budget Setting and Business Planning Processes (including capital programme)
- Monitoring and delivery of the capital programme
- Investment in relation to backlog maintenance

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**
- Structure, systems and process redesign and enhanced cost control. **(DRR 880)**
- Income/ activity – retention, capture and coding **CRR 879, 882**
- Carter Report Review and implementation
- Costing Transformation Programme
- Enhanced pay and establishment controls including performance against the agency cap

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 5 January 2017
Reference no: 17-17
Report from: John Thornton, Committee Chair
Report date: 20 December 2016

Finance and performance assurance report

Introduction

This is a short report covering the main issues from the F&P meeting on 19th December. I will provide additional verbal updates as required.

1. Operational performance

RTT performance in MaxFacs continues to improve and all other areas are on target. We continue to meet our aggregate target. It is unlikely that we will consistently achieve better than the target of 92% due to patient choice. But we are in control of our performance and doing well relative to other trusts.

2. Workforce performance

Levels of compliance in statutory and mandatory training and in appraisals are improving and are now on target again.

Concerns remain about the level of turnover of staff across the trust and the difficulty of recruiting in some key areas. This has led to high levels of Agency staff. We are currently breaching our caps both in terms of overall numbers and the levels we are required to pay to get agency staff. If this doesn't improve it will have a financial and reputational impact on the Trust. The Committee can't give assurance that this will be resolved soon.

The Committee discussed the introduction of a new pay review procedure which the executive think will give much needed guidance to management on pay issues and a greater level of control over changes to pay.

3. Financial performance

The Trust generated a surplus for the month which was slightly behind our original budget but ahead of our current running forecast.

Income was ahead of budget but both pay and non pay costs exceeded budget again. Both areas of cost are now ahead of budget for the year to date. Executive are introducing tighter cost controls for Q4. But it was agreed that rather than short term initiatives toward the year end we need to embed a stronger culture of cost control and ownership throughout the hospital.

The current forecast is still to meet plan but it is recognised as tight and a number of recovery plans will need to deliver.

4. Business Planning agenda

Following the decision at last month's F&P to accept the control totals provided to us, the business has continued to work through the implications for the business.

There continue to be a number of outstanding issues with contract negotiations and there are some concerns about the impact of the imposed CQUIN programme for next year. But overall the view is that nothing has arisen to make us reconsider our acceptance of the control total targets.

Any shortfall against this year's targets will of course make next year's challenge significantly harder. But committees view was that the control totals and underlying surplus were very stretching but achievable.

Committee approved the business plans for submission covering both 2017/18 and 2018/19.

5. Change Management Policy

A paper was presented covering in detail how any impact on individual staff terms and conditions caused by structural changes in the organisation would be handled. The main issue addressed was protection of pay and other conditions for staff whose grade is changed.

The view of the executive was that the current terms offered by QVH were too generous and that this hampered our ability to make required changes. The paper provided a comparison of QVH terms to a range of other hospitals.

After extensive discussions 'staff side' have still not agreed to support these changes. The executive therefore requested that committee ratify the policy without staff side support.

Following a long discussion and in light of the strong united executive support for this change the committee approved the new policy. It was requested that committee be provided with an update on any reaction to the changes across the business in three months' time.

6. F&P Effectiveness Review

All members of the committee had been asked to provide feedback on the strengths and weakness of the current F&P effectiveness against its mandate and terms of reference. Comments had been collated and shared with all attendees.

In summary the view was that the committee was working well and there wasn't any need for fundamental change. Most of the proposed improvements were on tone and style. For example ensuring all areas were given equal consideration and that everyone contributed to the discussion.

It was agreed that the committee shouldn't be a forum for setting strategy but that it should be able to track progress against medium term strategic goals not just short term goals.

The terms of reference were considered and it was felt that the current 'purpose' was too closely focussed on 'in-year delivery'. It was agreed that this should be amended to include approval of plans for future years. Clare is to propose an appropriate change to the wording.

John Thornton

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	05/01/17	Agenda reference:	18-17		
Report title:	Operational Performance				
Sponsor:	Director of Operations – Sharon Jones				
Author:	Business Managers				
Appendices:	None				
Executive summary					
Purpose:	To provide assurance as to current operational performance				
Recommendation:	To note the report				
Purpose: [tick one only]	Approval ~~Y/N~~	Information ~~Y/N~~	Discussion ~~Y/N~~	Assurance ~~Y/N~~	Review ~~Y/N~~
Link to key strategic objectives (KSOs): [Tick which KSO(s) this recommendation aims to support]	KSO1: ~~Y/N~~ *Outstanding patient experience*	KSO2: ~~Y/N~~ *World-class clinical services*	KSO3: ~~Y/N~~ *Operational excellence*	KSO4: ~~Y/N~~ *Financial sustainability*	KSO5: ~~Y/N~~ *Organisational excellence*
Implications					
Board assurance framework:	**Controls / Assurance** • Regular access meeting reviews and forward planning activity/booking- includes Cancer; • National Cancer Breach Allocation Guidance has changed from Oct 16 onwards and has a fairer allocation of the breach for shared breaches where a referral is later than day 38; • Monthly business unit performance review meetings in place with a focus on exceptions, actions and forward planning; • Demand and Capacity planning ongoing; • Patient tracking lists accessible by all relevant managers; • Performance Dashboard in place; • New management structure in MaxFax/Plastics/Theatres which aligns the surgical management; • Productivity programme in place for theatres;				
Corporate risk register:	**Risks** • Not all spoke sites on QVH PAS so access to timely information can be limited plus some spoke sites have reporting issues; - 728 , 799 • Shared pathways for cancer cases with late referrals from other trusts; - Directorate Risk Register (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)				
Regulation:	CQC – operational performance covers all 5 domains and in particular:- • Are they effective? • Are they responsive to people's needs? • Are they well-led				
Legal:	The NHS Constitution, states that patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, (i.e. patients should wait no longer than 18 weeks from GP referral to treatment) or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'.				
Resources:	Nil above current resources				
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	19/12/16	Decision:	Noted	
Next steps:	None				

Report to: Board of Directors
Meeting date: 3 January 2017
Reference number: 18-17
Report from: Sharon Jones, Director of Operations
Author: Business Managers
Appendices: Trajectory performance
Report date: 13 December 2016

Operational Performance: Targets, Delivery and Key Performance Indicators

1. Diagnostic Waits

There were two Radiology diagnostic breaches in November. The trust therefore delivered against the diagnostic target of 99% of patients to have their diagnostics completed within 6 weeks of referral. Sleep services had no diagnostic breaches in November.

2. Monitor 18 RTT Open Pathway Target

The Trust achieved 91.70% against the 92% target for October and the 91.50% trajectory (0.5% tolerance for STP funding in Q3). The trust is currently (at the time of writing) reporting 90.98% for November with final submission date after validation 19th December. As previously stated, there have been some particular issues within Max Fax services and the early November data is showing that the action taken to address these is gradually improving their position. The actions were detailed in a previous month's paper.

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

Summary of speciality achievement in October:-

	Over 18	Under 18	Total	Percentage
Corneo	47	1369	1416	96.68%
Max Fax	412	2851	3263	87.37%
Plastics	244	2854	3098	92.12%
Cardiology	3	62	65	95.38%
Rheumatology	0	29	29	100%
Other - sleep	11	759	770	98.57%
Total	**717**	**7924**	**8641**	**91.70%**

As previously stated, a recovery plan with extra clinics is in place for Max Fax, and their demand and capacity model alongside their booking processes are being reviewed to ensure sustainability. However the performance of this business unit will remain fragile over the remainder of the year.

3. Trajectory Monitoring

As part of the criteria to gain access to the Sustainability & Transformation Fund, the Trust has agreed trajectories against four key areas for 2016/17. These are:-

- Diagnostics;
- MIU – 4 hour wait;
- 18 weeks Open Pathways;
- 62 day cancer achievement.

The payment of the first quarter is based on the agreement of a stretching, but credible improvement plan including milestones with NHSI and NHSE to deliver on core standards including accident and emergency (MIU) four hours target, RTT open pathway 92%, and 62 day Cancer target. This has been achieved. For the remaining three quarters, payment will be dependent upon the delivery of the agreed trajectories. The monitoring mechanism is being finalised and will be part of this report going forward. The payment mechanism is also weighted as shown below:-

Access Standards Weighting – 30% of STF funding broken down as follows:-

Standard	**Weighting**
18 RTT	12.5%
A&E/MIU	12.5%
Cancer 62 Days	5%
Diagnostics	0%

There is also tolerance on the delivery of the access standards as follows:-

Period	**Tolerance**
Q1	None as fund allocated on agreement of trajectories only
Q2	1%
Q3	0.5%
Q4	0%

The risks for QVH are the current Max Fax performance, our small volumes and shared breaches for the 62 day cancer.

Q1 and Q2 summary of trajectory and performance to date:-

- The Trust only had to agree the trajectories to gain payment in Q1;
- The Trust needed to deliver a minimum of 91.1% for the 18RTT standard for Q2. This allows for the 1% tolerance.
- The Trust achieved the 18 RTT Q2 trajectory with an final position of 91.08 over the three months;
- The Trust marginally failed the Q1 & Q2 Cancer 62 day waiting times (CWT) trajectory – however the main driver was late referrals and shared breaches with other trusts which also has a significant impact when combined with our low denominator;
- Please note, that for the CWT 62day pathways, there is always a quarterly reconciliation exercise undertaken. This means that quarterly figure will reflect any late shared patient treatments. These changes are only attributed to the quarterly figure and not the monthly figures;
- Diagnostics has continued to achieve the standard;
- For more detail please see appendix 1

4. Elective Day Cases

- The trend of increases in day case activity continues. The trust previously had a weekly average of elective day cases of 190 and this has now increased to 203;
- In November, the weekly activity was 221; 221; 227; and 227 respectively – giving a weekly average of 224 compared to a weekly average of 229 cases in October & the year to date average of 203 cases per week. The difference between the two months appears to be related to length of procedure time required and so indicates a variation in case mix complexity for this month. This is expected when treating patients in chronological order and is not expected to be a trend. It also suggests that the work in ensuring that actual rather than estimated minutes for scheduling is being effective;
- However, the issue is that whilst day case activity has increased overall, the income relating to this is proportionally lower than that if we had the same increase in elective/in patient activity.
- There was a generator failure on 14th November which resulted in the loss of activity as below:

Speciality	Number of patients	Type of patient	Pre coding average Income lost (estimate)
Eyes	7	Day case	5,600
Max Fax	4	Day case	2,400
Max Fax	8	OPD 1st appt.	1,072
Total			**9,072**

- There was sickness within the plastics Consultant body. Work was undertaken to mitigate this which meant that only one pm list was lost and an estimated loss of £3,500 income

5. Elective/In Patient Activity

- Year to date the weekly average of elective in-patients has been 75; in November this was 73; 73; 78; and 73 respectively – giving a weekly average of 74 compared to a weekly average of 78 in October;
- The average numbers of elective in-patients is consistent at these numbers whilst day cases are still tending to increase;
- In both areas, patients are scheduled with clinical need being prioritised (cancer) and then chronological order.

6. Medway Backlog

- The work highlighted in last month's report continues and will be a long term issue. The lack of visibility of a live patient tracking list, the continued data quality issues and other known 18RTT issues in Medway means that progress will be slow;
- Medway commenced reporting 18RTT in October and did not inform us of this. This will be raised at the next contract meeting which is in early January. This has not changed the above position i.e. they are still not able to give us a live patient tracking list with a good level of data quality. Once the QVH data warehouse project is completed, then we will be able to take more informed view as to the size of the problem and the solutions;
- In the meantime, where we can, we are putting extra clinics on at Medway. However the issue here is whether Medway can give us additional clinic space as they are prioritising their services. We have gained an additional Monday evening clinic as from Sept plus some further clinics from October 1st;
- For context, Medway's performance for October was 77.9% with the third longest waits in the country.

7. Cancelled Operations

- There were zero breaches of both the 28 day and urgent cancelled operation standards in November;
- There were 21 operations cancelled on the day in November – of which 20 were elective cases; and 1 hand trauma case;
- 11 day cases in eyes and max fax were cancelled (as above) for the generator failure;
- 4 day cases in plastics were cancelled due to no surgeon due to sickness;
- 1 was cancelled in plastics due to lack of time on the operating list and the previous case over running;
- 5 day cases in plastics were cancelled due to issues on the day due to a mix of staffing issues in and operations needing to be re-scheduled to accommodate rebooking cancelled cases in order of clinical priority and chronologically;
- There were 15 urgent operations cancelled on the day in October – 5 of which were elective cases; 1 hand trauma; and 9 other trauma cases;
- All trauma cases were re-booked within 48hrs.

8. Monitor Cancer Standards

- Below is the Trusts performance for October 2016. The breach report is attached as **Appendix 2.**
- The main issue with the 62 CWT target remains shared breaches. There were only 2 that were full QVH breaches, one of which was the patients choice to delay, the other required multiple diagnostic tests.

Month	Target	Standard	Total	Breaches	Performance
October	2WW GP referral to first seen (urg. susp. cancer)	93%	187	9	95.2%
October	31 day Decision to first treatment	96%	54	4	93.1%
October	31 day Decision to subsq treatment (surgery)	94%	38	2	95.0%
October	62 day GP referral to first treatment	85%	24	5.5	77.1%%
October	62 day Consultant upgrade to first treatment	85% (local)	0	0	

9. Actions within Cancer

These continue as highlighted in previous reports

10. Business Unit Specific Operational and Performance Issues

- Business unit specific updates are given below;
- The Business Manager of the day process continues to work well, with the Business Manager being a clear point of escalation for any issues.

11. Max Fax/Oral Surgery Business Unit

The key focus points for Max Fax/Oral Surgery Business Unit are to increase activity and to improve performance against the open pathway target of 92%.
Actions currently being undertaken to address this are as follows:-

- Open pathway – this has shown a continued improvement in performance from 87.0% in September to 87.4% in October;
- Admitted pathway - Continuation of daily monitoring of theatre utilisation to ensure all lists are filled to capacity alongside working with the Pre assessment team to ensure the MF team have a robust process to offer patient short notice cancellations. The aim of this work is to have a pool of preassessed patients who can and are willing to come in at short notice;
- Non Admitted pathway – By using an Agency nurse that is block booked at a reduced rate in outpatients (whilst clinical infrastructure recruits to the vacant post) the service has been able increase outpatient procedure clinics to 8 per week;
- The team are to extend MOS into a third evening session to reduce the current number of patients waiting for an outpatient procedure.
- Further exploration of outpatient procedure recording and coding is being undertaken to ensure the appropriate codes are available to the outpatient team at each appointment;
- In addition to maximising existing activity we are still running clinics on alternate Saturdays to reduce current waiting times;
- The Orthodontic team are meeting their plans across all areas

12. Plastics Business Unit

- Breast day cases and electives continue to be below activity plan year to date. However these lists are being utilised for skin day cases which have continued to increase;
- Skin day cases are now 430 above plan year to date; which if this continues equates to approximately 740 cases above plan by year end;

- 2WW referrals in skin had increased by 20% 2014/15 to 2015/16 with a 19% conversion rate to cancer. However, in the past few months, there is now a 30% increase in referrals and so it is expected that the yearly increase for 16/17 will be greater than 20%.

Maximising Productivity

- There is daily monitoring of lists booked for next day and for the next week by the team leaders and business manager with late cancellations being proactivity managed;
- All lists are being booked to the maximum minutes available – a new process is being put in place which may result in what appears to be overbooking due to the discrepancy between estimated list minutes and actual list minutes;
- There is now in place a post case daily review of actual length of cases against planned minutes so that booking can move to actual not estimated timings;
- When one case lists are booked, we are working with the clinical teams so that a local anaesthetic patient is booked at start of list for Consultant whilst major case is being prepared. This will mean that a local anaesthetic case is undertaken in main theatres but this an efficient and productive use of resources;
- The Trust is working with the mid Sussex MSK team to provide Consultant presence at the Crawley site – this will initially comprises of 2 sessions a month increasing over time to 8 sessions a month. The Consultant is supported by an extended scope hand therapist. Surgical activity from these clinics is likely to be undertaken at QVH;
- Further meetings with Sussex Community Dermatology Services (SCDS) have been held in relation to tender for West Kent dermatology which goes live in April 2017. The internal business case is being completed for approval for additional staffing for QVH to support this service.

13. Second Trauma Theatre

- Activity within trauma since opening of second trauma theatre in September 2015 continues to be monitored on a regular basis. One of the main benefits of this was to minimise the late inductions and these continue to be low;
- 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; 9 in May; 2 in June; 2 in July; 7 in August 5 in September; 0 in October; and 4 in November.

14. Ophthalmology Business unit

- The ophthalmology unit has recruited to all the clinical fellows posts and they will come into post over the next few months;
- There is work ongoing to review what appears to be a change in case mix in and continues to see a rise in non-elective activity alongside the decrease in Outpatients proceedures'
- The business unit are exploring options to close the financial gap and has gained additional
- Activity with BSUH providing additional capacity for their cataract work. The October cohort of referrals consists of 97 referrals received of which 59 have agreed to come to QVH. An additional 50 patients have been referred to QVH in November;
- The femtosecond laser has been delivered and staff is being trained to use this piece of equipment. The aim is to have this up and running in January and to treat more patients on site rather than at Centre to Site, where currently all those patients breach the 18 RTT standards. This means that once that backlog has been cleared, this will contribute to the overall trust attainment of the18RTT target and trajectory.

15. Sleep Services

- The data for November shows that the service is ahead of their activity plan This has
- Impacted positively on activity and income for the business unit who are forecasting a surplus for year end;
- The sleep department remain challenged with regard to staffing. Additional staff (agency and locums) have supported the unit to achieve the activity for day cases and OPD which will ensure all available beds are filled and patients are treated in a timely manner. A

technician has been recruited and has started in November. However use of agency staff will continue until the unit have recruited all staff but with the aim to reduce usage as substantive staff start with the Trust;

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16. Clinical Support Services

- The new AQP Community ENT service has now started across four sites (including QVH), with slightly higher demand than expected in the first month, especially from Coastal West Sussex. Discussion around expansion of services is already being discussed;
- 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;
- At the request of local commissioners the MSK Physiotherapy team have launched a self-referral pilot to MSK physio which should improve pathways for the patients and reduce demand on primarily care capacity. This has been in place for 3 months without adversely impacting on waiting times and with positive feedback from patients and GPs. Further communications are now going to be initiated and a formal review of the service will take place in due course;
- As previously mentioned, QVH have begun supplying a hand consultant and Extended Scope Hand therapist to attend the newly created Sussex MSK Partnership hub in Crawley. This will ensure QVH is an integral part of the local hand and wrist MSK pathway as it develops.

17. MIU

The Trust MIU performance in November was 99.75%.

18. Link to Key Strategic Objectives

- Outstanding patient experience
- Operational excellence
- Financial sustainability

19. Implications for BAF or Corporate Risk Register

Risks associated with this paper are already included within the Corporate Risk Register.

20. 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'.

21. Recommendation

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

Appendix 1 – Trajectory Performance

RTT 18	Open Pathways							
	Baseline	April	May	June	July	August	September	October
Trajectory	92.90%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Actuals		92.1%	92.6%	91.5%	90.7%	91.0%	91.6%	91.70%
YTD		92.1%	92.4%	92.1%	91.7%	91.6%	91.6%	91.58%
End of Qtr Position		**Quarter 1**		92.1%	**Quarter 2 QTD**		91.1%	

Cancer	CWT 62 Day							
	Baseline	April	May	June	July	August	September	October
Trajectory	83.5%	81.6%	81.6%	81.3%	81.6%	81.6%	81.6%	85.4%
Actuals		82.9%	67.5%	91.1%	90.4%	80.0%	71.4%	77.1%
YTD		82.9%	74.7%	80.8%	83.7%	83.0%	81.1%	80.46%
End of Qtr Position		**Quarter 1**		81.1%	**Quarter 2 QTD**		81.2%	

Diagnostic	6 Week Diagnostic							
	Baseline	April	May	June	July	August	September	October
Trajectory	1.18%	0.61%	0.89%	0.89%	0.89%	0.89%	0.89%	0.89%
Actuals		0.61%	1.27%	0.00%	0.00%	0.00%	0.17%	0.14%
YTD		0.61%	0.90%	0.62%	0.47%	0.39%	0.36%	0.32%
End of Qtr Position		**Quarter 1**		0.62%	**Quarter 2**		0.05%	

Diagnostic	6 Week Diagnostic							
	Baseline	Nov						
Trajectory	1.18%	0.89%						
Actuals		0.39%						
YTD		0.33%						
End of Qtr Position		**Quarter 3**						

A&E	4 hour							
	Baseline	April	May	June	July	August	September	October
Trajectory	99.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
Actuals		98.75%	99.24%	99.31%	99.09%	99.67%	98.65%	99.56%
YTD		98.75%	99.01%	99.11%	99.10%	99.22%	99.12%	99.18%
End of Qtr Position		**Quarter 1**		99.11%	**Quarter 2**		99.13%	

A&E	4 hour							
	Baseline	Nov						
Trajectory	99.00%	98.00%						
Actuals		99.77%						

YTD		99.25%						
End of Qtr Position		**Quarter 3**						

Appendix 2 – Cancer Breaches

62 Day Referral to Treatment

Reporting Mth	Tumour Type	First seen Trust	Treating Trust	Wait Days	Breach reason	Accountability
Oct-16	Breast	Dartford & Gravesham NHS Trust	Queen Victoria NHS Foundation Trust	67	Patient choice for immediate reconstruction at QVH. DVH referred to QVH on 35 of pathway.	0.5
	Head & Neck	Queen Victoria NHS Foundation Trust	Queen Victoria NHS Foundation Trust	82	Multiple tests required	1
	Head & Neck	Queen Victoria NHS Foundation Trust	Queen Victoria NHS Foundation Trust	66	Patient choice to delay	1
	Skin	Medway NHS Foundation Trust	Queen Victoria NHS Foundation Trust	91	Patient referred to QVH from Medway on day 58	0.5
	Skin	Medway NHS Foundation Trust	Queen Victoria NHS Foundation Trust	97	Delay at Medway referred to QVH on day 48	0.5
	Skin	Medway NHS Foundation Trust	Queen Victoria NHS Foundation Trust	145	Patient referred to QVH from Medway on day 68, RCA to be completed for delay in treatment at QVH.	0.5
	Skin	Medway NHS Foundation Trust	Queen Victoria NHS Foundation Trust	112	Patient referred to QVH from Medway on day 84 of pathway	0.5
	Skin	Queen Victoria NHS Foundation Trust	Maidstone & Tunbridge Wells NHS Trust	95	Patient required review by multiple MDTs due to potential alternative diagnoses at presentation	0.5
	Skin	Brighton & Sussex University Hospitals NHS Trust	Queen Victoria NHS Foundation Trust	65	6/10 - 20/10 Patient unavailable due to sudden death of partner.	0.5

31 Day to First Treatment

Reporting Month	Tumour Type	Wait Days	Breach reason
Oct-16	Skin	55	BCC initially suspected, Histology proven SCC after excision.
	Skin	38	BCC initially suspected, Histology proven SCC after excision.
	Skin	34	Surgery booked for 20/10. 6/10 Pt husband has died and she did not want surgery until after funeral on 20/10.
	Skin	32	Pt age 101: deaf and blind. Rely on daughter who could not make 13/10 date for surgery originally

31 day to Subsequent Treatment (surgery)

Reporting Month	Tumour Type	Wait Days	Breach reason
Oct - 16	Skin	105	Patient DNA. Unable to contact pt by phone or letter – contacted GP
	Skin	55	21/09 Pt cancelled surgery as he had another appt at a local Hospital

2 Week Waits

Reporting Month	Tumour Type	Wait Days	Breach reason
Oct-16	Skin	27	Referral received on 13/09, placed patient on waiting list and attempted contact by phone without success. Patient responded to the letter we sent and we offered another date of 27/09. Patient declined this as appointment was too early in the morning.
	Head & Neck	25	DNA and rebooked
	Head & Neck	25	Patient cancelled appt and so rebooked
	Head & Neck	24	Difficulty in contacting patient by phone therefore letter sent which delays process
	Head & Neck	21	DNA first appt and so next available offered
	Head & Neck	21	Patient cancelled first appt and so next available offered
	Head & Neck	19	No capacity at DVH or MMH therefore booked to be treated at however patient wants to be seen at DVH.
	Head & Neck	17	Difficulty in contacting patient
	Head & Neck	15	Patient offered QVH as DVH and MMH had no capacity however patient wished to be seen at DVH OPA, therefore given next available this morning 23/11/2016

Queen Victoria Hospital NHS
NHS Foundation Trust

References			
Meeting title:	**Board of Directors**		
Meeting date:	05/01/17	**Agenda reference:**	19-17
Report title:	**Finance Report Month 8**		
Sponsor:	Clare Stafford, Director of Finance and Performance		
Author:	Jason McIntyre, Deputy Director of Finance		
Appendices:	Finance Report Month 8 (November 2016)		

Executive summary					
Purpose:	The report details the Trust's financial performance for the 8 months to 30th November 2016. The Trust delivered a surplus of £238k in month; £92k behind plan and £11k better than forecast. The YTD surplus has increased to £1.2m. Recovery plans are being assessed and developed to ensure delivery of plan.				
Recommendation:	The Board 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 finance and use of resources score is 2 – which is the second highest rating achievable			
Legal:	None			
Resources:	None			

Assurance route				
Previously considered by:	Finance and performance committee			
	Date	19/12/16	Decision	Noted

Queen Victoria Hospital
NHS Foundation Trust

Finance Report
November 2016

Executive Director: Clare Stafford

Contents

Summary Position – YTD M08 2016/17

Queen Victoria Hospital NHS Foundation Trust

Table 1 – Plan Performance

Financial Performance	2016-17	November 2016			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	63,082	5,370	5,434	(64)	41,910	42,496	(586)
Other Income	4,407	394	318	75	3,353	3,110	243
Total Income	**67,488**	**5,764**	**5,752**	**11**	**45,264**	**45,607**	**(343)**
Pay	(42,565)	(3,613)	(3,544)	(70)	(28,474)	(28,378)	(96)
Non Pay	(18,721)	(1,580)	(1,522)	(58)	(12,796)	(12,556)	(240)
Financing	(4,275)	(332)	(356)	24	(2,747)	(2,850)	103
Total Expenditure	**(65,561)**	**(5,526)**	**(5,422)**	**(103)**	**(44,016)**	**(43,784)**	**(232)**
Surplus / (Deficit)	**1,927**	**238**	**330**	**(92)**	**1,247**	**1,823**	**(575)**
Surplus (Deficit) %	2.9%	4.1%	5.7%	-1.6%	**2.8%**	4.0%	**-1.2%**
Adj. Donated Depn.	(288)	3	(24)	27	(165)	(192)	27
NHSI Contol Total	**2,215**	**235**	**354**	**(119)**	**1,412**	**2,015**	**(602)**

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

Table 2 – Forecast Performance

Forecast performance at Month 8	Forecast	Actual	Variance
Category (£k)	M8	M8	M8
	£000	£000	£000
Total Clinical Income	**5,307**	**5,330**	**23**
Total Non Clinical Income	**325**	**394**	**69**
Total Income	**5,632**	**5,724**	**92**
Pay expenditure	**(3,547)**	**(3,613)**	**(67)**
Non pay expenditure	**(1,600)**	**(1,580)**	**20**
Financing	**(356)**	**(332)**	**23**
Total Expenditure	**(5,502)**	**(5,526)**	**(24)**
Baseline Surplus/ (Deficit)	**130**	**198**	**68**
Business unit recovery plans	**83**	**40**	**(43)**
Agency reductions/ Temporary staffing review			-
New CIPP	**15**		**(15)**
Total Interventions	**98**	**40**	**(58)**
Forecast surplus	**228**	**238**	**10**

Summary - Plan performance

- The Trust delivered a surplus of £238k in month; £92k behind plan and £10k more than forecast. The YTD surplus has increased to £1.25m, £0.6m behind plan.
- Income is £11k better than plan ; a deficit in clinical income has been fully offset by other income.
- The clinical income deficit of £64k includes :
  - Sustainability and Transformation funding of £75k for Month 8 (£150k YTD) has not been recognised as it is dependent on achieving the in month control total.
  - Month 8 reported performance includes a £58k benefit from activity coding revisions relating to month 7.
  - Inpatient casemix continues to be an issue and critical care activity is lower than YTD trend this month (a reflection of reduced inpatient complexity) and MIU underperformance has also continued.
- Other income is higher this month due to increased activity from the clean room, prosthetics and income relating to a maxillofacial nursing project.
- Pay is overspent by £70k in month of which £30k is due in part to Anaesthetic Consultants' backpay. Overspending within medical and theatre staffing have continued. This is partly offset by an underspend in nursing.
- Non Pay is overspent by £69k in month due to activity related overspends on clinical supplies and drugs .
- Financing costs are underspent by £24k due to revised depreciation costs . It is anticipated these costs will increase in future periods, the forecast remains unchanged.
- The Single Oversight Framework finance and use of resources score is 2 – which is the second highest rating achievable (Appendix 1).

Summary - Forecast performance

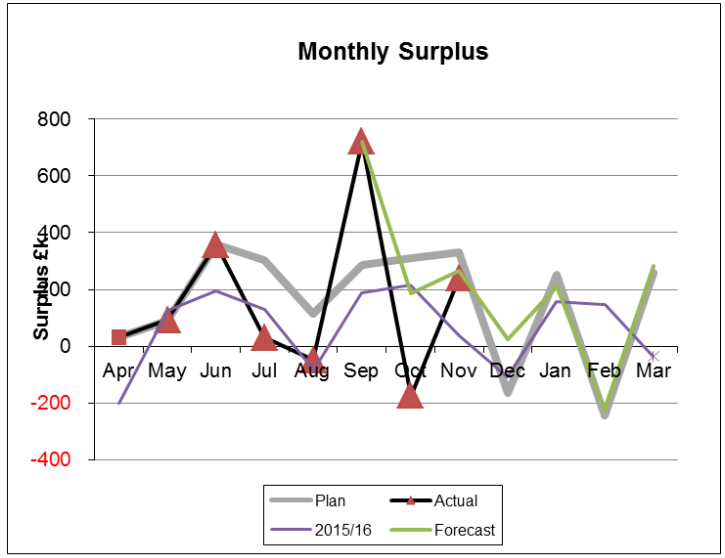
- The actual performance is £10k better than forecast, mainly driven by additional non clinical income.
- Pay is higher than forecast due to both increased W.T.E. and agency premium in addition to non recurrent backpay. Non pay expenditure is less than forecast due in part to under delivery against activity recovery plans and reduced depreciation charges.
- The Trust is forecast to achieve plan by the end of the year.

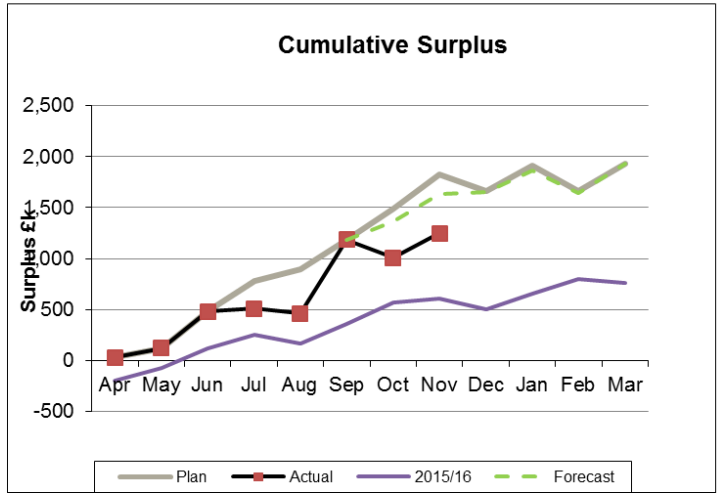
Action

Recovery plan actions continue to be reviewed to ensure delivery by the end of the year.

Surplus Trend Position – M08 2016/17

Queen Victoria Hospital
NHS Foundation Trust





Summary

- There is a £238k surplus in month against a planned surplus of £330k; this includes a benefit of £58k relating to the previous month and does not include the potential achievement of £75k Sustainability and Transformation funding.
- The monthly financial profile reflects the impact of working days, seasonal variation, bank and school holidays.
- This reflects the revised plan submitted to NHSI in June. The graph reflects the revised surplus and not the control total; excluding the impact of donated depreciation.

NB The 2015-16 position excludes the impact of the accounting adjustments relating to the revaluation exercise.

Activity Performance by POD : M08 2016/17

Queen Victoria Hospital NHS Foundation Trust

Activity Performance		Month 08 (November)			Month 08 (November)			Year to date			Year to date			2016-17 Activity Trend							
POD	Currency	Plan Acty	Act Acty	Acty Var	Plan £k	Actual £k	Var £k	Plan Acty	Act Acty	Acty Var	Plan £k	Actual £k	Var £k	M01	M02	M03	M04	M05	M06	M07	M08	Trend
Minor injuries	Attendances	1,095	866	(229)	73	58	(15)	8,532	7,224	(1,308)	568	481	(87)	799	921	859	989	917	961	912	866	
Elective (Daycase)	Spells	1,039	1,048	9	1,113	1,048	(65)	8,038	8,242	204	8,608	8,406	(202)	973	1,019	1,061	1,076	1,009	1,004	1,052	1,048	
Elective	Spells	338	325	(13)	817	760	(57)	2,636	2,621	(15)	6,363	5,989	(373)	345	302	325	318	311	343	352	325	
Non Elective	Spells	446	440	(6)	966	975	9	3,474	3,553	79	7,523	8,017	494	379	445	433	497	440	473	446	440	
XS bed days	Days	93	39	(54)	24	10	(14)	728	732	4	186	188	1	237	130	111	19	66	64	66	39	
Critical Care	Days	75	18	(57)	143	26	(116)	583	458	(125)	1,110	604	(506)	58	76	47	59	89	45	66	18	
Outpatients - First Attendance	Attendances	3,703	3,879	176	471	490	19	28,799	30,224	1,425	3,662	3,835	173	3,666	3,834	3,836	3,505	3,861	3,845	3,798	3,879	
Outpatients - Follow up	Attendances	10,546	11,004	458	887	933	46	82,095	82,492	397	6,904	7,024	120	10,198	10,112	10,641	9,715	10,042	10,491	10,289	11,004	
Outpatient - procedures	Attendances	2,341	2,165	(176)	354	309	(44)	18,233	16,811	(1,422)	2,754	2,461	(292)	2,201	2,117	1,980	1,953	2,154	2,152	2,089	2,165	
Other	Other	2,609	3,079	470	421	387	(34)	20,321	25,891	5,570	3,286	3,390	104	2,630	2,937	3,061	2,784	3,891	3,823	3,686	3,079	
Work in progress and coding adjustment						222	222					178	178									
					5,268	5,217	(51)				40,964	40,574	(390)									

Table 2 - Performance by Service Line

Activity Financial Performance	Month 08 (November)			Year to date		
Service Line	Plan £k	Actual £k	Var £k	Plan £k	Actual £k	Var £k
Clinical Infrastructure	174	156	(17)	1,353	1,505	152
Clinical Support	408	392	(16)	3,178	3,218	40
Eyes	529	474	(55)	4,053	3,847	(206)
Oral	1,135	1,043	(92)	8,842	8,482	(360)
Plastics	2,698	2,580	(118)	21,014	20,597	(417)
Sleep	308	349	42	2,397	2,746	349
Other incuding WIP/ coding	16	222	206	128	178	50
Grand Total	5,268	5,217	(51)	40,964	40,574	(390)

Table 1 Analyses patient activity levels to plan in month and YTD by POD and also detailed recent activity trends by activity type.

Table 2 Analyses performance by service line.

NB An adjustment has been included with clinical income to reflect estimated gain from the completion of coding, outpatient procedures and material work in progress i.e. critical care.

The above only includes SLAM activity income does not include all "patient activity income " such as S&T funding, RTA, some private patients, Burns consortium funding .

- Minor injuries attendances are 229 less than planned (slight deterioration compared to trend) due to the reduction in opening hours / staffing issues - £15k reduction in the month and £87k YTD. A recovery plan will be developed to address this underperformance with updates provided at future meetings.
- Daycase activity is 9 above plan and £65k under for the month, 204 and £202k under for the year to date, which reflects activity under performance in Breast , Burns, Corneo, and Maxillofacial being partly offset by high over performance in Skin but at a lower complexity rate.
- Elective activity, in the month has under performed by 13 spells and under performed by £57k . This is mainly within Maxillofacial (£58k). Year to date underperformance is : Plastics - Burns (volume) and Oral-Maxillofacial (casemix and volume) and Corneo (volume).
- Non-elective activity has over performed by 6 spells and £9k in month. The YTD over performance is largely within Plastics (Skin and Hands) and Clinical infrastructure (MIU non electives)
- Critical care days have under performed by 57 days (circa 1.8 beds) in month and £116k, with an offset adjustment for 19 days work in progress (£30k). The YTD position of £506k under plan is mainly Plastics (Skin). The critical care trend has deteriorated significantly in recent months a reflection of complexity of referred activity.
- Outpatient procedures £44k under plan in month and £292k YTD spread across all business units except sleep.
- Service line underperformance in month: Plastics due to Burns (90K) and Hands (£76K) and Skin over performance of £44k; Oral £92k Maxillofacial inpatients £77k; Eyes – Corneo plastics inpatients ;
- The YTD under performance is due to Eyes-Corneo plastics; Oral - Maxillofacial, Plastics- Breast and Burns .

Financial Position by Business Unit – M08 2016/17

Queen Victoria Hospital NHS Foundation Trust

Variance by type: in £ks	Activity Income		Other Income		Pay		Non Pay		Position	for November 2016			Total Year To Date		
performance against financial plan	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	Annual Budget	Actual	Budget	Variance	Actual	Budget	Variance
Operations															
1.1 Plastics	(66)	(512)	5	69	(122)	(376)	(40)	(519)	14,147	1,053	1,276	(224)	8,313	9,651	(1,338)
1.2 Oral	(66)	(331)	8	28	(13)	(62)	3	(17)	7,255	579	647	(68)	4,536	4,918	(383)
1.3 Eyes	(35)	(159)	13	(28)	4	58	(17)	(91)	3,625	291	327	(35)	2,214	2,433	(220)
1.4 Sleep	42	340	(5)	(39)	(7)	(64)	6	(11)	1,653	184	149	35	1,352	1,127	226
1.5 Clinical Support	24	141	21	131	9	115	34	(74)	(2,916)	(140)	(228)	88	(1,608)	(1,921)	314
1.6 Other Med & Admin	(37)	(165)	-	-	(4)	(38)	10	27	(173)	(44)	(13)	(31)	(289)	(113)	(176)
Operations Total	**(139)**	**(686)**	**43**	**162**	**(134)**	**(369)**	**(4)**	**(684)**	**23,591**	**1,924**	**2,158**	**(234)**	**14,518**	**16,095**	**(1,577)**
Nursing & Clinical Infrastructure															
2.1 Clinical Infrastructure	9	223	19	10	44	233	(10)	(81)	(8,106)	(606)	(668)	62	(5,017)	(5,403)	386
2.5 Director Of Nursing	-	-	6	43	10	94	6	19	(1,249)	(82)	(104)	22	(677)	(833)	156
Nursing & Clinical Infrastructure	**9**	**223**	**25**	**54**	**54**	**327**	**(3)**	**(62)**	**(9,356)**	**(688)**	**(772)**	**84**	**(5,694)**	**(6,236)**	**542**
Corporate Departments															
3.1 Non Clinical Infrastructure	-	-	8	51	2	(77)	(14)	(95)	(3,885)	(326)	(322)	(4)	(2,719)	(2,598)	(121)
3.2 Commerce & Finance	(8)	(38)	0	1	(1)	(37)	(2)	(25)	(2,532)	(219)	(209)	(11)	(1,796)	(1,698)	(98)
3.4 Finance Other	74	(85)	(2)	10	(35)	114	(16)	756	(2,822)	(207)	(229)	22	(884)	(1,678)	794
4.1 Human Resources	-	-	11	11	40	(13)	3	(2)	(930)	(64)	(119)	54	(640)	(636)	(4)
5.4 Corporate	-	-	1	9	9	(15)	12	(5)	(1,626)	(113)	(135)	22	(1,096)	(1,085)	(11)
6.1 Research	-	-	(11)	(55)	(7)	(44)	24	125	(109)	(3)	(9)	6	(47)	(72)	25
6.2 Clinical Audit	-	-	-	-	3	19	(34)	(144)	(404)	(64)	(34)	(31)	(394)	(269)	(125)
Corporate Total	**66**	**(123)**	**8**	**28**	**10**	**(54)**	**(27)**	**610**	**(12,308)**	**(998)**	**(1,056)**	**57**	**(7,577)**	**(8,037)**	**460**
QVH Total	**(64)**	**(586)**	**75**	**243**	**(70)**	**(96)**	**(34)**	**(137)**	**1,927**	**238**	**330**	**(92)**	**1,247**	**1,823**	**(575)**

Summary

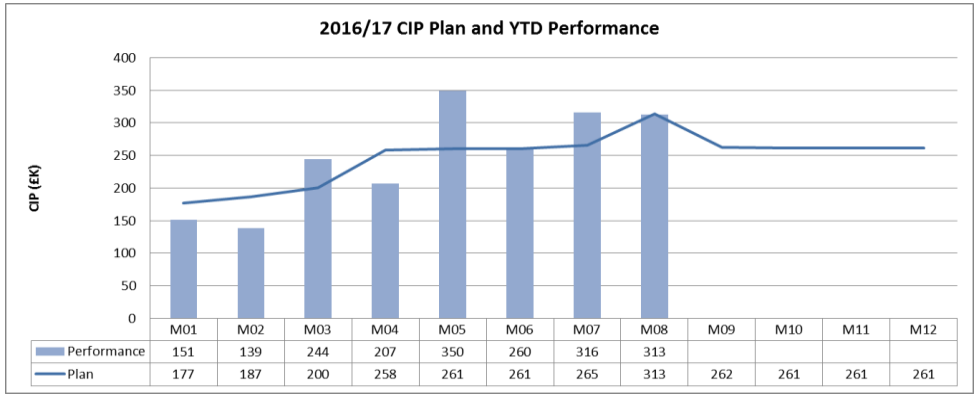
- Activity Income: £64k below the plan . The M8 figures benefit from £58k relating to M7 and also do not recognise any Sustainability Transformation Funding (£75k for month & £150k YTD) for the period. The year to date position is £586k below plan with material underperformance within the Plastics, Oral and Eyes Business Units. Private patient income continues to under perform, by 14k in month due to slippage on CIPP schemes. Other income: the positive variance in month is due to clean room, prosthetic services and project income.
- Pay: The overspend in month is largely due to medical pressures within Plastics and include £30k of back pay paid in month due to agreed increased cover. Overspends on agency and locums and temporary payments , Anaesthetics SPR posts and theatres agency staff.
- Non Pay expenditure , including financing, is overspent by £27k in month due to activity related overspends continuing on clinical supplies , equipment and drugs. There is an underlying deficit of circa £100k per month within clinical equipment and supplies . For the year to date this had been offset by planned interventions including the release of budget reserves and the prior year income provision adjustment .
- The significant variance in Finance reflects timing issues in relation to work in progress and coding.

CIPP - M08 2016/17

Queen Victoria Hospital NHS
NHS Foundation Trust

Table 1 - Performance by category £k	Annual plan	YTD CIP Plan	YTD Actual	YTD Variance	Annual plan	Forecast	Forecast Variance
Revenue Generating schemes	1,282	858	985	127	1,282	1,429	148
Non pay - Drugs	90	78	54	(24)	90	54	(36)
Non pay - Other	319	197	137	(61)	319	212	(107)
Non pay - Supplies	231	138	153	15	231	235	4
Pay	1,047	651	651	-	1,047	1,047	-
Grand Total	**2,968**	**1,922**	**1,980**	**58**	**2,968**	**2,978**	**9**

Table 2 - Performance by area £k	Annual plan	YTD CIP Plan	YTD Actual	YTD Variance	Annual plan	Forecast	Forecast Variance
Clinical Infrastructure & Nursing	605	360	320	(40)	(605)	(545)	(60)
Clinical Support	279	177	178	0	(279)	(279)	(0)
Corporate	572	364	338	(26)	(572)	(520)	(52)
Eye	343	219	190	(29)	(343)	(299)	(44)
Oral_Maxfax	362	210	70	(141)	(362)	(123)	(239)
Plastics	392	312	314	1	(392)	(392)	-
Plastics_Peri-Op	296	199	214	15	(296)	(300)	4
Sleep	120	80	357	277	(120)	(520)	400
Grand Total	**2,968**	**1,922**	**1,980**	**58**	**(2,968)**	**(2,978)**	**9**



Cost Improvement & Productivity Programme (CIPP)

- At M8 the Trust has achieved 103% of planned Cost Improvement Programme YTD.
- Overall the Trust CIP has achieved £1.98m savings against the YTD plan of £1.92m.
- The YTD position is attributable to over performance in Sleep (£277k).
- The following areas are currently underperforming this year: ENT AQP £46k, ENT BSUH Initiative £49k, Urology activity £21k, review of spoke site SLA £25k and savings from maintenance contract £16k.
- The Trust is forecasting savings of £3m, which is £0.1m less than the 2016/17 CIPP target – Table 3. The Trust has identified recovery plans which will offset the underperformance of total CIPP target.
- The Business unit recovery plans identified £40k of saving in month and £78k YTD.
- The Femtosecond Laser activity is due to start in Q4 which will further mitigate the CIPP gap.

Actions

- **Business units are addressing gaps through a number of Trust wide initiatives, service recovery plans and further identification of saving opportunities.**
- **Recovery actions and performance will be reviewed urgently to assess the causes of slippage and mitigating actions to recover position.**

Table 3 - Total CIPP Challenge	Cip target	Identified schemes	Gap from target	Forecast slippage	Total Gap & Slippage
Clinical Infrastructure & Nursing	679	605	(74)	(60)	(134)
Clinical Support	350	279	(71)	(0)	(71)
Corporate	510	572	63	(52)	11
Eye	135	343	208	(44)	164
Oral_Maxfax	379	362	(18)	(239)	(256)
Plastics	353	392	39	-	39
Plastics_Peri-Op	590	296	(295)	4	(291)
Sleep	103	120	17	400	417
Grand Total	**3,100**	**2,968**	**(131)**	**9**	**(122)**

Balance Sheet –M08 2016/17

Queen Victoria Hospital NHS Foundation Trust

Balance Sheet as at the end of November 2016	2015/16 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	43,588	43,173	43,045
Other Receivables	-	-	-
Sub Total Non-Current Assets	43,588	43,173	43,045
Current Assets			
Inventories	439	449	448
Trade and Other Receivables	5,846	7,742	5,764
Cash and Cash Equivalents	7,285	6,318	8,138
Current Liabilities	(7,654)	(7,285)	(7,237)
Sub Total Net Current Assets	5,915	7,223	7,113
Total Assets less Current Liabilities	49,504	50,396	50,158
Non-Current Liabilities			
Provisions for Liabilities and Charges	(572)	(606)	(606)
Non-Current Liabilities >1 Year	(7,378)	(6,989)	(6,989)
Total Assets Employed	**41,553**	**42,801**	**42,563**
Tax Payers' Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	20,174	21,421	21,183
Revaluation Reserve	9,143	9,143	9,143
Total Tax Payers' Equity	**41,553**	**42,801**	**42,563**

NB Analysis is subject to rounding differences

Summary

- Net current assets have increased by £110k in Month 8. The key movement is within Trade and other receivables which has increased by £1.98m with cash correspondingly lower by £1.8m. This is due to late payment of invoices by NHS England (now received).

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 – M08 2016/17

Queen Victoria Hospital NHS Foundation Trust

Capital Programme	Annual Plan £000s	YTD Spend £000s	YTD Plan £000s	YTD Variance £000s	Full Year Forecast £000s	Full Year Variance £000s
Estates projects						
Backlog maintenance	550	-	190	190	550	-
Education and Wellbeing Centre	250	-	-	-	-	250
Trauma Centre	140	-	30	30	98	42
Car parking - general	100	-	30	30	-	100
Other projects	646	252	474	222	820	(174)
Estates projects	**1,686**	**252**	**724**	**472**	**1,468**	218
Medical Equipment	**354**	**475**	**247**	**(228)**	**650**	**(296)**
IT Equipment & Software						
Infrastructure Improvement Programme (IIP)	400	404	400	(4)	404	(4)
Electronic Document Management (EDM)	600	279	400	121	600	-
Other projects	82	-	-	-	-	82
IT Equipment & Software	**1,082**	**683**	**800**	**117**	**1,004**	78
Total capital spend	**3,122**	**1,410**	**1,771**	**361**	**3,122**	**0**

Summary

- The capital programme is £361k (20%) behind plan at the end of November. An improvement of 11% compared to Month 7.
- The Estates programme is £472k (65%) behind plan. The principal development within the Estates programme is the backlog maintenance. Six business cases for works identified in the recent site-wide condition survey are now being implemented and planned to be completed in 16/17.
- Medical equipment expenditure is £228k (92%) above plan as a result of the purchase of a femtosecond laser funded from the revision of programme following agreement with EMT.
- The 2016/17 IT programme mainly consists of the remainder of the Infrastructure Improvement and Electronic Document Management projects which started in 2015/16. The infrastructure project is now complete and EDM is progressing in line with plan. Other, smaller projects have been postponed.

Issues

- Achievement of the annual plan is still largely dependent on achievement of the revised Estates programme.
- The IT programme is progressing and delays are not expected.

Risks

- Delays in implementing the Estates programme could put the achievement of the plan at risk.

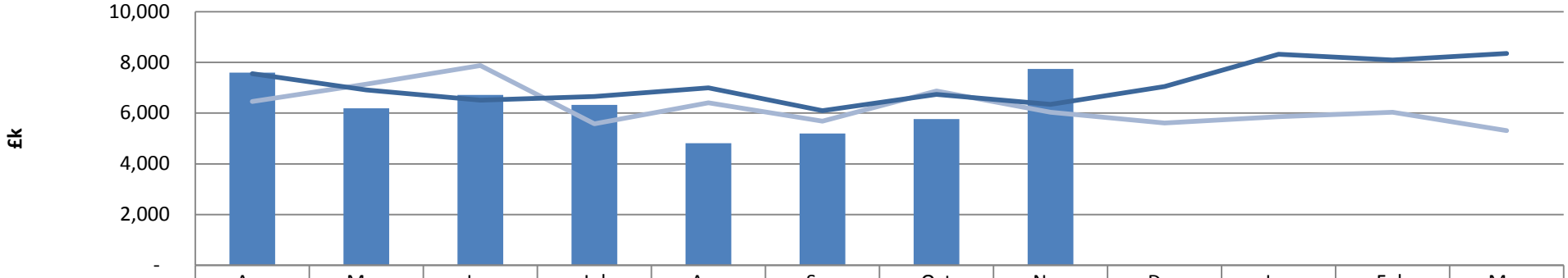
Action

- Progress is being actively monitored through biweekly meeting on progress and the implementation of additional control to ensure full delivery.

Debtors – M8 2016/17

Queen Victoria Hospital NHS Foundation Trust

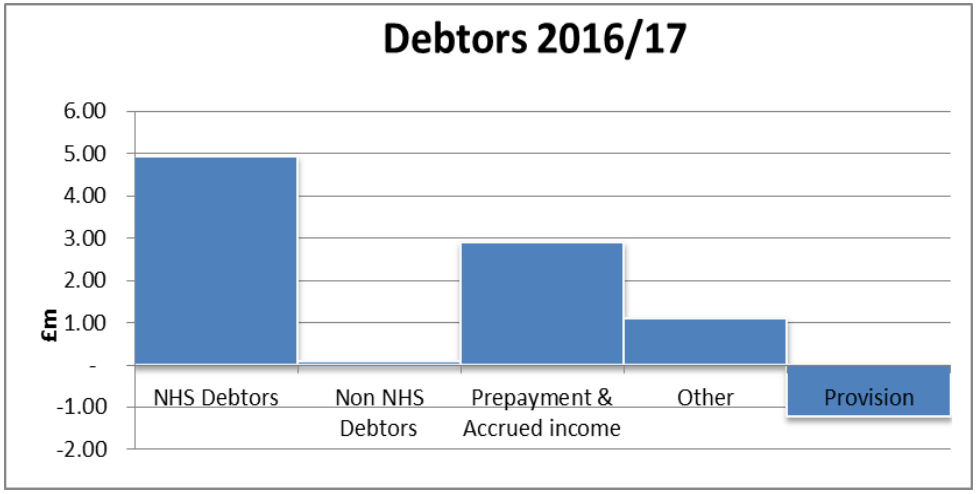
Debtor Trend



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total 2016/17	7,593	6,194	6,722	6,322	4,811	5,196	5,764	7,742				
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 increased by £2.0m (34%) from Month 7.
- The Month 8 debtor balance of £7.7m is 24% higher than the average monthly balance in 2015-16. This is largely due to outstanding NHS England invoices totalling £1.8m at the month end, payment was received in Month 9 - 1st December.
- Month 8 there is £772k of accrued income for activity over-performance and NCAs which is an decrease of £278k compared to the previous month. This is a timing issue related to commissioner agreement for overperformance billing



Next Steps

- Financial services are working closely with business managers to ensure billing is accurate, timely and resolutions to queries are being actively pursued.

Cash – M8 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**	**5.739**	**6.873**	**8.398**	**8.118**	**8.139**	***6.318***	***7.727***	***7.674***	***7.680***
Receipts from invoiced income	3.576	6.771	5.787	6.294	6.021	5.230	5.177	3.714	*7.600*	*5.850*	*5.850*	*5.850*
Receipts from non-invoiced income	0.172	0.209	0.124	0.147	0.815	0.152	0.175	0.249	*0.156*	*0.100*	*0.100*	*0.100*
Total Receipts	**3.749**	**6.980**	**5.911**	**6.441**	**6.836**	**5.382**	**5.351**	**3.964**	***7.756***	***5.950***	***5.950***	***5.950***
Payments to NHS Bodies	(0.640)	(0.427)	(0.375)	(0.374)	(0.407)	(0.486)	(0.573)	(0.377)	*(0.450)*	*(0.450)*	*(0.450)*	*(0.450)*
Payments to non-NHS bodies	(1.608)	(1.669)	(2.878)	(1.541)	(1.527)	(1.277)	(1.377)	(1.998)	*(1.958)*	*(2.133)*	*(2.074)*	*(2.074)*
Net payroll payment	(1.901)	(1.881)	(1.983)	(1.890)	(1.939)	(1.914)	(1.920)	(1.939)	*(1.920)*	*(1.920)*	*(1.920)*	*(1.920)*
PAYE & NI payment	(0.839)	(0.900)	(0.904)	(0.941)	(0.894)	(0.911)	(0.900)	(0.906)	*(0.921)*	*(0.900)*	*(0.900)*	*(0.900)*
Pensions Payment	(0.562)	(0.554)	(0.560)	(0.562)	(0.545)	(0.556)	(0.560)	(0.564)	*(0.600)*	*(0.600)*	*(0.600)*	*(0.600)*
PDC Dividends Paid	0.000	0.000	0.000	0.000	0.000	(0.519)	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)**	**(7.205)**	**(5.308)**	**(5.311)**	**(5.662)**	**(5.330)**	**(5.784)**	***(6.347)***	***(6.003)***	***(5.944)***	***(6.511)***
Actual Closing Balance	**5.483**	**7.033**	**5.739**	**6.873**	**8.398**	**8.118**	**8.139**	**6.318**				
Forecast Closing Balance									***7.727***	***7.674***	***7.680***	***7.118***
Revised 16/17 Plan	**5.483**	**7.033**	**6.188**	**6.965**	**7.423**	**6.959**	**7.407**	**8.035**	**7.389**	**7.540**	**7.419**	**7.187**

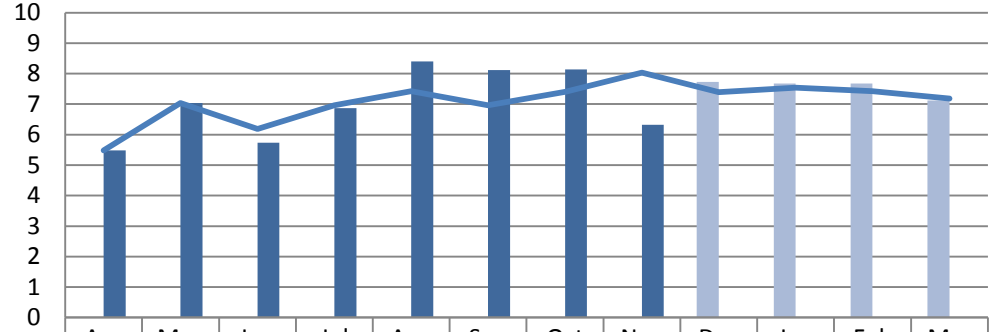
Summary

- The in month cash position is favourable on the basis of current liquidity and debt service ratios.
- The cash balance at the end of M8 has an adverse variance of £1.7m against the revised plan submitted to Monitor. This is due to lower than expected receipts from invoiced income arising from late payment by NHS England for November SLA invoices.
- Cash balances are forecast to remain above or in line with plan for the remainder of 2016/17.

Next Steps

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

Cash Balances Forecast

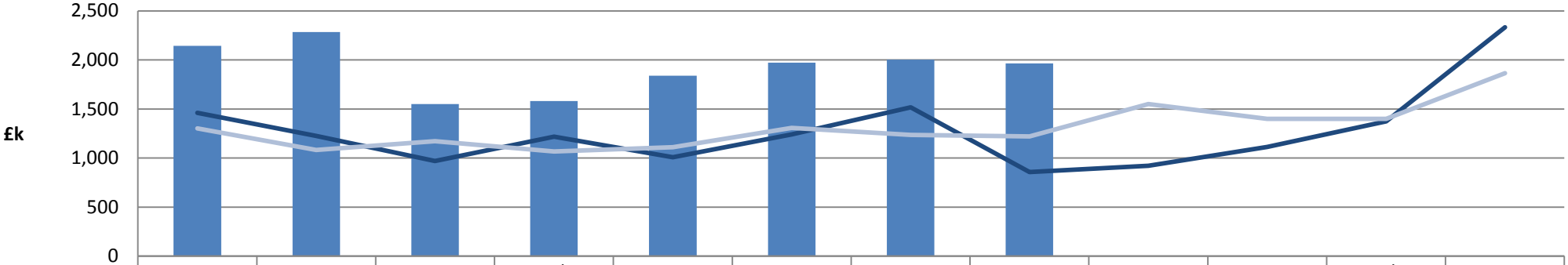


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Forecast									7.727	7.674	7.680	7.118
Actual	5.483	7.033	5.739	6.873	8.398	8.118	8.139	6.318				
PLD	5.483	7.033	6.188	6.965	7.423	6.959	7.407	8.035	7.389	7.540	7.419	7.187

Creditors – M8 2016/17

Queen Victoria Hospital NHS Foundation Trust

Trade Creditors



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	2144	2283	1549	1580	1838	1971	2003	1964				
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 8 is £2.0m compared to an average of £1.31m during 2015-16. This is due to a number of invoices received for capital expenditure not yet due to be paid.
- The Trust's BPPC percentage has increased in month by 5% and the average days to payment has reduced to 27 days. Accounts payable are taking action on invoices awaiting authorisation to address underperformance.
- Savings from prompt payment discounts taken in month amounted to £2k, in line with plan.

Better Payment Practice Code (16/17) November	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	1,650	2,147	12,135	15,986
Total **Non NHS** trade invoices paid within target	14,769	19,071	1,385	1,861	9,856	12,578
Percentage of Non-NHS trade invoices paid within target	**85%**	**85%**	**84%**	**87%**	**81%**	**79%**
Total **NHS** trade invoices paid	893	4,538	55	241	492	2,544
Total **NHS** trade invoices paid within target	632	3,289	28	165	289	1,398
Percentage of NHS trade invoices paid within target	**71%**	**72%**	**51%**	**69%**	**59%**	**55%**

Next Steps

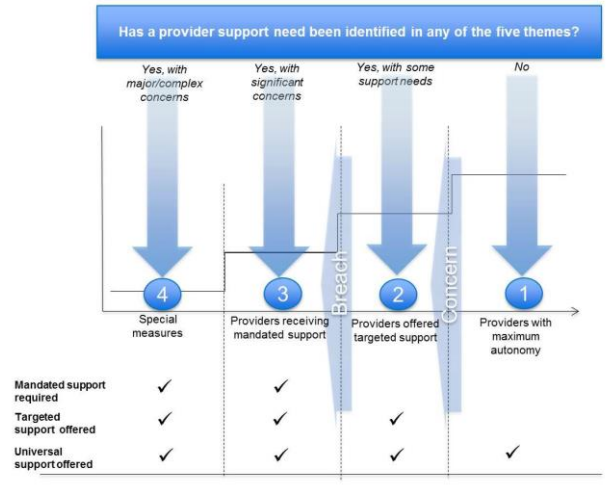
- Financial services and Procurement to continue to review invoices with no corresponding purchase order (in breach of Standing Financial Instructions (SFIs)) on a monthly basis to improve payment times and encourage best practice.

Appendices

Appendix 1a : Single Oversight Framework (replacing the Financial sustainability risk rating) – Introduction

The Single Oversight Framework was implemented in October 2016 by NHS Improvement.

It is based around five themes which are:
Quality of care (safe, effective, caring, responsive);
Finance and use of resources;
Operational performance;
Strategic change and Leadership and improvement capability (well-led).
Levels of support are provided depending on the issues identified within these – see diagram opposite.



The Finance and Use of Resources score:

- This replaces the Financial Sustainability Risk Rating (FSRR) measure used until September 2016, and is consistent in approach, to monitor financial sustainability, efficiency and compliance with sector controls such as agency staffing . Despite implementation it is still being f developed.
- The rating includes the same four metrics as the previous FSR measure and adds a measure of compliance against the cap placed on agency spend .
- The more obvious change is that the scores have been reversed and 1 is now the best score
- This will be monitored from monthly returns, annual plans and any significant one-off events.
- See table opposite for the financial metrics used to assess financial performance by scoring providers 1 (best) to 4 against each metric
- Averaging scores across all the metrics to derive a use of resources score
- Where providers have a score of 4 or 3 in the financial and use of resources theme, this will identify a potential support need under this theme, as will providers scoring a 4 (i.e. significant underperformance) against any of the individual metrics.
- Key NHSI Triggers: Poor levels of overall financial performance (average score of 3 or 4); Very poor performance (score of 4) in any individual metric; Potential value for money concerns

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

Appendix 1b: Finance and Use of Resources score (Single Oversight Framework)

Use of Resources Score: November 2016					
	Metrics £k	Measure	Rating	Weight	Score
Continuity of Services:					
Capital Service Cover					
Operating surplus	3,994	**3.06**	**1**	20%	**0.20**
Capital Servicing Obligation YTD	1,303				
Liquidity					
Working Capital	6,746	**39.2**	**1**	20%	**0.20**
Operating Costs (per day)	172				
Financial Efficiency:					
I&E Margin (%)					
Surplus (deficit) year to date	1,247	**2.76%**	**1**	20%	**0.20**
Income year to date	45,264				
I&E Margin Variance From Plan					
Actual surplus margin	2.76%	**-1.24%**	**3**	20%	**0.60**
Plan surplus margin	4.00%				
Agency Cap					
Agency Spend	1,570	**24.75%**	**2**	20%	**0.40**
Agency Cap	1,259				
Use of Resources: November 2016			**2.00**		

Summary

- The Single Oversight Framework applies from 1 October 2016, replacing the Monitor 'Financial Sustainability Risk Assessment Framework'
- The finance rating of the framework – use of resources - for the Trust's YTD position has been calculated above. The current performance is due to variance to plan and agency cap measures which has reduced score from the planned 1 to an actual of 2.

Appendix 3: Forecast

Queen Victoria Hospital NHS Foundation Trust

Income and Expenditure 2016-17 at Month 8	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Forecast	Forecast	Forecast	Forecast	Total Outurn	Budget 2016-17	Var
Category (£k)	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Annual	Annual	Annual
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Total Clinical Income	4,965	5,275	5,333	5,087	5,212	5,630	5,004	5,330	4,827	5,179	4,755	5,254	61,851	63,082	(1,231)
Total Non Clinical Income	402	712	440	431	325	304	346	394	325	335	326	326	4,667	4,407	260
Total Income	5,367	5,988	5,773	5,518	5,537	5,934	5,350	5,724	5,152	5,514	5,082	5,580	66,518	67,488	(971)
Pay expenditure	(3,497)	(3,596)	(3,483)	(3,525)	(3,677)	(3,489)	(3,594)	(3,613)	(3,547)	(3,547)	(3,547)	(3,547)	(42,661)	(42,565)	(95)
Non pay expenditure	(1,483)	(1,945)	(1,576)	(1,608)	(1,554)	(1,390)	(1,659)	(1,580)	(1,600)	(1,600)	(1,573)	(1,573)	(19,140)	(18,721)	(419)
Financing	(355)	(356)	(355)	(355)	(355)	(333)	(306)	(332)	(356)	(356)	(356)	(356)	(4,170)	(4,275)	105
Total Expenditure	(5,336)	(5,896)	(5,415)	(5,488)	(5,586)	(5,212)	(5,559)	(5,526)	(5,502)	(5,502)	(5,475)	(5,475)	(65,970)	(65,561)	(409)
Baseline Surplus/ (Deficit)	31	92	359	30	(49)	722	(209)	198	(350)	12	(393)	105	547	1,927	(1,380)
Interventions															
Business unit recovery plans							34	40	103	103	103	103	487		487
Agency reductions/ Temporary staffing review									35	35	35	35	141		141
New CIPP									15	31	41	50	137		137
Annual leave adjustment									90				90		90
Other interventions									304			(207)	97		97
STF Funding Q2-Q4									214			214	428		428
Actual/Forecast surplus	31	92	359	30	(49)	722	(175)	238	411	182	(214)	301	1,927	1,927	0
Cumulative surplus	31	123	481	511	462	1,184	1,009	1,247	1,658	1,840	1,626	1,927	1,927		

Financial Control total targets						1,183		1,658			1,927			

Summary

A baseline forecast has been developed during Q2 based on actual performance adjusted for non recurrent items and cost pressures. Interventions have been risk adjusted and applied to the baseline to determine the most likely forecast. The mostly likely scenario (detailed above), forecasts that the annual plan is achieved . A worse case scenario has been modelled - surplus of £1.6m , (interventions delivering less than forecast & impact on STF funding). The best case scenario is a surplus of £2.1m due to revised assumption re CQUIN/ fines and challenges.

The forecast assumes the following :-

- No further deterioration of clinical income performance or industrial action
- CQUIN delivery risk of circa £0.14m/ Fines and challenges of circa £0.1m
- CIPP delivery in line with forecast
- STF funding delivery of £0.86m

Agency Ceiling and Actual Spend for year to date 2016/17.														
Period 2016-17 / £ks	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**	**Year to Date Total**	**Annual Total**
Agency Ceiling:	168	168	168	167	167	167	127	127	127	127	127	127	1,259	1,768
Agency Spend:	149	230	122	213	256	190	216	195					1,571	
Difference:	19	-62	46	-46	-89	-23	-89	-68	127	127	127	127	-312	
%age from ceiling:	11.3%	-36.9%	27.4%	-27.8%	-53.6%	-14.0%	-69.7%	-53.2%					**-24.8%**	

Summary

NHS foundation trusts are held to account for delivering 2016/17 agency expenditure for all staff in line with their expenditure ceiling. This ceiling is a maximum level for all agency staff expenditure.

From October compliance with agency ceiling is part of the measures used to determine the use of resources metrics within the Single Overview Framework. NHS Improvement has provided further guidance in a letter and additional disclosure from 24th October 2016.

Performance

The Trust achieved the ceiling for Q1 but agency expenditure pressures in Q2 resulted in the Trust breaching the ceiling.
November's year to date variance to the ceiling of -24.8% gives a use of resources score of 2 for the agency spend element, the second highest rating, but is on the threshold of 50% for a rating of 3.

The proportion of clinical agency has increased during the course of the year. Q1 Clinical agency represented 40% of agency expenditure, Q2 45% and M6 50%. Nursing agency has increased from an average of £42k month (Q1) to an average of £79k (Months 4-8).

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page						
References						
Meeting title:	Board of Directors					
Meeting date:	05/01/17		**Agenda reference:**	20-17		
Report title:	**Business Planning 2017/18 and 2018/19**					
Sponsor:	Clare Stafford, Director of Finance and Performance					
Author:	Jason McIntyre, Deputy Director of Finance					
Appendices:	Business planning 2017/18 and 2018/19					
Executive summary						
Purpose:	The purpose of this paper is to provide an update on the Trusts' Business planning approach for 2017/18 to 2018/19.					
Recommendation:	The Board is asked to note the contents of this report.					
Purpose:		**Information**		**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:	NHS improvement Operational and Planning guidance for 2017/18 and 2018/19.					
Legal:	None					
Resources:	None					
Assurance route						
Previously considered by:	Finance and performance committee					
	Date:	19/12/16	Decision:	Noted		

Report to:	Finance and Performance Committee
Meeting date:	16th December 2016
Report from:	Clare Stafford, Director of Finance and Performance
Author:	Jason McIntyre, Elin Richardson, Clare Stafford
Title:	Business Planning – 2017/18 & 2018/19

Purpose

1. This paper provides the Committee with an update on the financial planning process for 2017/18 and 2018/19 and provides the latest iteration of the Trust's revenue and capital budgets for review, challenge and approval.

2. There is a requirement for the Trust Board to approve the annual budget; prior to the beginning of the financial year and before final submission to NHS Improvement (NHSI). Due to the acceleration of planning timetables and timing of Board meetings, that approval has been delegated to the Committee in line with the Terms of Reference and as previously agreed. The paper will be presented at the next Board meeting for ratification, along with any material changes made prior to submission.

3. Note that contract negotiations have yet to conclude; although there is a national expectation that contracts will be signed by 23rd December 2016.

National Context

4. In July 2016, NHS Improvement and NHS England jointly published Strengthening Financial Performance and Accountability in 2016/17; a document widely known as the "NHS financial reset plan", which introduced a new two year planning cycle.

5. Guidance, draft tariffs, control totals and proposed sustainability and transformation funding (STF) allocations were issued by late September for the same two year period.

National Tariff Payment System

6. On 2 August 2016, NHS Improvement (NHSI) and NHS England (NHSE) launched their policy proposals for 2017/18 and 2018/19 National Tariff Payment System (NTPS) and associated engagement round.

7. The statutory engagement was launched on 8th November 2016 and closed on 6th December 2016. Whilst formal feedback has not been published, we are aware that the objection threshold has not been met despite significant concerns being raised by both providers and commissioners. It is likely that the draft tariff used for modelling the Trust plan will be published as the final tariff in the new year.

8. The national assumptions in relation to the draft tariff are shown in Table 1 overleaf.

9. **Table 1 – National Assumptions**

Tariff Uplift	2017/18	2018/19
Efficiency factor	-2.0%	-2.0%
Pay	1.3%	1.3%
Non Pay	0.8%	0.8%
Net Uplift	0.1%	0.1%

10. It is important to note that the figures above are based on the average impact across the NHS and will vary in a local setting depending on both the portfolio of services and local cost pressures.

HRG4+ and Identification Rule Changes

11. The move to phase 3 of HRG version 4+ as the currency for patient care activity is intended to align the prices trusts receive for activity with the costs of providing that care. The additional layers of granularity for complications and comorbidities are intended to ensure that provision of more complex and costly care attracts a suitably increased price.

12. In addition, NHSE have undertaken a review of their Identification Rules (IR). These rules are the mechanism by which healthcare activity is identified as specialised in nature and thus chargeable to NHSE rather than CCGs. In undertaking this review and a redefining of some of the rules, significant amounts of activity that were previously charged to NHSE (Specialised) will now be charged to CCGs and NHS England (Dental).

CQUIN

13. CQUIN underwent a short consultation period in early October 2016 and final CQUIN schemes were published in November 2016. In line with the NTPS and Standard Contract, these CQUIN schemes also have a duration of two years.

14. NHSE are continuing to enable providers to earn up to 2.5% of annual contract value (2% for specialised services) through the achievement of specific CQUIN schemes.

15. There is a key difference for 2017-19. Whereas previously there was a certain amount of flexibility between the requirement for national and local schemes, this year 1.5% will be linked to the delivery of mandated national schemes. There are several national schemes, each aligned to different provider types, each having a minimum weighting of 0.25% i.e. a Trust would have a maximum of 6. There is the flexibility to agree (within the confines of the minimum weighting rule) the number of applicable national CQUINs but there is no flexibility to agree local CQUINs for CCG contracts.

16. The remaining 1% will be used to “support local systems” and split:
    a. 0.5% will be available subject to full provider engagement and commitment to the STP process; and
    b. 0.5% will be held within a system-wide risk reserve. Release of this element of the CQUIN is dependent upon our local health system delivering its system-wide control total.

Local Context

17. Given the acceleration in timetables, volume of guidance issued and significant changes within, the Trust has had to adopt a proportionate response, focusing on the prioritisation of material issues and the utilisation of clearly articulated assumptions to devise plans and to meet the timetable.

18. Both the guidance and detailed approach to planning were presented at previous Committee meetings and have been designed to incorporate Sustainability and Transformation Plan (STP) assumptions; in addition to principles for activity, income and expenditure planning.

19. Whilst the change in timetable and introduction of a two year planning cycle has been widely welcomed, it has created a number of short-term challenges in-year; particularly with respect to allocation of resource and external engagement.

20. The Business Planning Steering Group (BPSG), reporting to the Trust’s Executive Management Team (EMT) for oversight and scrutiny and to the Committee for assurance, has continued to develop and oversee the process.

NTPS, HRG4+ and IR changes

21. Our analysis indicates that HRG4+ has had an overall positive benefit of £0.4m.

22. The IR changes have resulted in £1.2m being removed from our specialised contract with NHSE and redistributed across 33 other commissioners. Approximately 40% transfers across to our NHSE Dental contract (2 commissioners) and the remaining 60% is spread across 31 CCGs both within our host contract and outside of it.

23. The impact of CQUIN changes is c£380k in 2017/18 and c£400k in 2018/19.

Control Total and STF

24. Final control totals for 2017/18 and 2018/19 were issued in November 2016; the calculation being an output of the 2016/17 control total (£2.2m) with a number of adjustments applied as shown below:

    - Net tariff uplift of 0.1% in 2017/18 and 0.1% in 2018/19;
    - Relative price impact of the introduction of HRG4+;
    - Known costs of transition to national education and training tariffs; and
    - Local adjustment for increase in the 'Clinical Negligence Scheme for Trusts (CNST) costs. National expectation was 17.5%; Trust impact was 33%. The control totals for 2017/18 and 2018/19 were reduced by £110k to reflect additional cost of CNST (2017/18 price increase £121k).

25. Details of the control totals, including the internal surplus required, are shown in Table 2 below.

Table 2 – Control Totals

	2016/17 £m	2017/18 £m	2018/19 £m
General Element STF	0.900	0.942	0.942
Target Element STF	0.000	0.000	0.000
Control total	2.215	1.716	1.874
Donated Depn Adjust	0.288	0.259	0.233
Surplus	1.927	1.457	1.641
Less full receipt of STF	(0.900)	(0.942)	(0.942)
Underlying Surplus	1.027	0.515	0.699

26. After significant internal debate the Trust confirmed acceptance of the control totals and associated STF access criteria in the first submission of the operational plan (24th November 2016).

27. Further guidance indicating flexibility on the 2018/19 control total was recently issued but is subject to delivery of the 2017/18 control total in full.

Activity planning approach

28. The activity plan was generated by applying the STP activity assumptions with additional local planning adjustments where appropriate. Activity growth was modelled at 2.6% for 2017/18 and 2.7% for 2018/19. In addition local adjustments were completed to reflect outturn, activity transfers, non-recurrent items, full-year-effect of 2016/17 in year changes, commissioner intentions, approved service developments and activity changes to meet performance standards.

Income and Expenditure Budgets

Income Budgets and phasing

29. Clinical income budgets for 2017/18 and 2018/19 are based on planned activity for the same period.

30. The activity plans/phasing of clinical income has been developed in consultation with business managers to better match actual patterns. The basis of activity profiles are detailed by Point of Delivery (POD) in the table below.

Table 3 - Point of Delivery/Activity phasing

POD	Activity Currrecy	Phasing
MIU	Attendences	Calendar days in month
Elective (inc Daycase)	Spells	Calendar Days in month
Outpatient	Attendences	Number of working day adjusted for QVH trends
Direct Access	Tests	Number of working day adjusted for QVH trends
Other	Other	Number of working day adjusted for QVH trends

31. Non-clinical income budgets are based on recurrent outturn adjusted for non-recurrent issues.

Expenditure Budgets

32. Opening expenditure budgets for 2017/18 will be based on the next year's base budgets (NBB). NBB is the current budget for 2016/17 adjusted for the following:
    a. Non-recurrent funding received;
    b. Full year effect of any cost pressure funding received – i.e. where the services did not receive the full twelve months funding for 2016/17;
    c. Sense checked against 2016/17 forecast outturn;
    d. Approved 2017/18 cost pressures;
    e. Adjusted for CIPPs target and identified savings; and
    f. Agreed 2017/18 developments.

33. Phasing be profiled in equal 12ths and adjusted for profile of cost pressures, developments and cost improvement/productivity plans.

Pay Expenditure Budgets

34. Standard costing template was/will be used to estimate the annual costs of staff in post, using their existing pay scales and all other elements of pay; i.e. on call, unsocial hours enhancements. The November payroll information was used to establish staff in post.

35. Vacancies have been costed at midpoint of the relevant pay scale. The costed establishments were compared to the recurrent budgets to assess impact and identify pressures.

36. The tariff was uplifted by 2.1% to fund national pay inflation, apprenticeship levy and incremental drift. The impact of incremental drift will be reviewed and impact assessed before funding allocated.

37. National and local clinical excellence awards included in pay costing will be reviewed centrally as part of the business planning process. National awards will be matched with national external income received and any movement in awards will be adjusted for.

38. Nursing rotas are developed using the rota costing model and staffing levels reviewed by the Deputy Director of Nursing. All pay budgets and establishments will be compared to E-roster and ESR as final validation checks and amendments made as appropriate.

Non-Pay expenditure Budgets

39. Non pay costs have been reviewed during the business planning process. Non-recurrent items have been clearly identified and removed. The recurrent non-pay forecast has been compared to the NBB to clearly identify costs pressures. Unavoidable cost pressures have been submitted and will be reviewed as part of the prioritisation process by the EMT. Activity related cost pressures will be reviewed against planned activity movements.

40. Non-pay inflation will be held centrally based on tariff guidance. In year application for non-pay inflation funding will be made to the Deputy Director of Finance after evidencing price increase.

41. Non pay inflation will cover the follow areas:-
    a. Drugs increases as provided for in the tariff;
    b. Services provided by other NHS Trusts;
    c. Increases in premiums for CNST;
    d. Utilities;
    e. Maintenance contracts; and
    f. Other contracts subject to unavoidable inflationary increases.

42. Pass through drugs and device expenditure budgets will be adjusted to reconcile to the agreed CCG income and activity plans. The expenditure budgets for pass through items will be ring-fenced to ensure alignment to agreed income plans.

Reserves

43. The table below shows the inflation and contingency reserves required for 2017/18 and 2018/19. The contingency is available to fund sustainability and transformation/place-based investment requirements and non-recurrent issues that arise during the year.

Table 4 - Reserve Analysis

Category	2017/18 £m	2018/19 £m
Pay (pay award, incremental drift, apprenticeship levy)	0.89	0.86
Non pay	0.49	0.55
Contingency	0.65	0.65
Total	2.03	2.06

Cost pressures

44. Cost pressure budgets for 2017/18 and 2018/19 have been created for £2.3m 2017/18 and £1.6m 2018/19. This is composed of the following:
    a. Contingency;
    b. Pre-approved expenditure commitment via EMT; and
    c. Unavoidable cost pressures and service expenditure pressures that have been identified by corporate and clinical/operational teams.

45. The cost pressures bids are subject to review and approval by EMT during January 2017. The aim will be to minimise/mitigate where possible to reduce the impact on the financial position.

Financial plan 2017/18 to 2018/19

46. The table below provides a bridge between 2016/17 forecast and recurrent outturn.

Table 5 – Forecast outturn to recurrent outturn

Description	2016/17 Forecast Outturn £k	2016/17 Non Recurrent Adjustment £k	Recurrent Outturn £k
Clinical Income	63,216	(748)	62,468
Other Income	4,566	(1,100)	3,466
Total Income	**67,782**	**(1,848)**	**65,934**
Pay	(42,394)	(150)	(42,544)
Non pay	(19,217)	949	(18,268)
Total Expenditure	**(61,611)**	**799**	**(60,813)**
Operational EBITDA	**6,171**	**(1,049)**	**5,122**
Financing	(4,243)	0	(4,243)
Surplus	**1,928**	**(1,049)**	**879**

47. The key movements between forecast outturn and recurrent outturn are detailed overleaf:

a. Income – centrally funded non-recurrent Electronic Document Management (EDM) programme £1.2m; offset by non-recurrent expenditure. In addition the 2016/17 STF of £0.9m; and
b. Expenditure – EDM expenditure £1.2m, redundancy costs and the non-recurrent VAT reclaim.

48. The table and narrative below detail the key movements from recurrent outturn to the 2017/18 opening budget and 2018/19 opening budget.

Table 6 – Recurrent outturn bridge to 2017/18 and 2018/19 plans

Description	2016/17 Recurrent Outurn £k	2017/18 Net Tariff Uplift & Inflation £k	2017/18 Cost Pressures £k	2017/18 CIPP £k	2017/18 Plan £k	2018/19 Net Tariff Uplift & Inflation £k	2018/19 Cost Pressures £k	2018/19 CIPP £k	2018/19 Plan £k
Clinical Income	62,468	62	(10)	2,241	64,762	65	0	1,749	66,575
Other Income	3,466	35	1	0	4,442	35	0	0	4,477
Total Income	**65,934**	**97**	**(9)**	**2,241**	**69,204**	**100**	**0**	**1,749**	**71,052**
Pay	(42,544)	(893)	(786)	939	(43,285)	(866)	(676)	780	(44,046)
Non pay	(18,268)	(343)	(1,361)	72	(19,900)	(418)	(676)	520	(20,474)
Total Expenditure	**(60,813)**	**(1,237)**	**(2,146)**	**1,011**	**(63,184)**	**(1,284)**	**(1,352)**	**1,300**	**(64,520)**
Operational EBITDA	5,122	(1,139)	(2,155)	3,253	6,020	(1,184)	(1,352)	3,049	6,533
Financing	**(4,243)**	**(127)**	**(195)**	**0**	**(4,565)**	**(132)**	**(195)**	**0**	**(4,893)**
Surplus	**879**	**(1,267)**	**(2,350)**	**3,253**	**1,455**	**(1,316)**	**(1,547)**	**3,049**	**1,640**
STP Funding					940				940
Underlying Surplus					**515**				**700**
check					**(0)**				**0**

49. The key movements between recurrent outturn and opening plan are detailed below:
    a. Tariff uplift and inflation - £1.3m 2017/18, £1.3m 2018/19;
    b. Cost improvement, productivity and growth £3.2m 2017/18, £3.0m 2018/19;
    c. Local cost pressures of £2.3m 2016/17 and £1.6m 2017/18; and
    d. The surplus for both years is comprised of the underlying surplus and STF allocations.

Cost Improvement, Productivity and Growth Programme (CIPP)

50. The CIPP target for 2017-19 is 5% and 4.5%. For 2017/18 this is a reduction of 0.7% (c£455k) since the first plan submission; linked to impact of tariff changes and changes in cost assumptions.

51. The target is significantly higher than the efficiency factor required in the tariff (2%); recognising further national planning assumptions/mandates, the revenue impact of historic investment decisions, externally-led revaluation exercises and other local cost pressures.

52. As in 2016/17, the CIPP target has been devolved to business units and directorates and the process of identifying opportunities has been ongoing since beginning of quarter 3. Plans have been presented through two business plan

submissions, performance reviews, support meetings and will be further scrutinised by EMT in January.

53. As at 16th December 2016, schemes identified equate to 50% of the target (£1.6m). The current position is summarised in the table below. Urgent work is required to improve CIPP identification and complete granular level plans for delivery.

Table 7 – CIPP Analysis 2017/18

Category	£k	%
Income - revenue generating schemes	1,112	34%
Pay	430	13%
Non pay	83	3%
Unidentified	1,628	50%
Total CIPP Target 2017/18	**3,253**	**100%**

54. The cost reduction equates to £0.51m of the total identified and the contribution from income generation mostly relates to new work-streams resulting from 3rd party tenders and work transferring or being repatriated from other organisations.

CIPP Governance

55. After a delay in recruitment, the new Programme Management Office (PMO) is now in place. The remit incorporates the CIPP, CQUIN and significant business cases; the immediate focus being on the development of robust governance and reporting arrangements. With respect to the CIPP, the PMO will support the ongoing identification, planning and delivery of quality-led initiatives; as well as the Trust's ambition to have, at any point in time, a two-year rolling programme of opportunities.

56. As was the case in 2016/17, a quality impact assessment (QIA) will be carried out for each scheme to assess potential effects of implementation. This process has been led by the Director of Nursing; the route to Board assurance being through presentation and review at the Quality and Governance Committee.

57. An internal audit will take place in Q4 of 2016/17; so that performance of the PMO can be maximised early in the new financial year.

Budget sign off

58. Business unit and directorate managers will be required to sign off their budgets and activity plans confirming that they have been fully engaged in the process. The sign off process will take place in Q4; other activities being prioritised to deliver the national timetable.

Capital Plan

59. 2016/17 planning included the ambition to create a multi-year programme and significant progress has been made in year. The underpinning work has been completed with respect to estates backlog maintenance programme (5 years) and the workplan and investment required to deliver the Information Management and

Technology Strategy will be finalised in the last quarter of this financial year. The focus for 2017/18 will be to understand the equipment replacement requirements.

60. As previously indicated, the capital programme for 2017-19 will be c£3.1m and funded from internal sources only i.e. estimated depreciation, any slippage from the current year and cash from historic surpluses.

61. The capital planning process for 2017/18 is not yet complete; subject to final prioritisation and approval by EMT. The indicative programme, based on intelligence to date is shown in Table 8 below.

Table 8 – Capital programme 2017/18

Indicative Programme	2017/18 (£k)	2018/19 (£k)
Internal Source of Funds	3,100	3,100
Building and infrastructure	1,350	1,350
Equipment	700	700
Information, Management & Technology	800	800
Contingency	250	250
Total	**3,100**	**3,100**

62. Building and infrastructure - £1.35m includes:
    - Compliance works to electrical, ventilation, water, medical gas, fire safety and asbestos management systems; and
    - Upgrade works to roofs, external fixtures, lighting, boiler replacement, car parks and other works that are necessary to maintain the Trust's estate and support the optimum delivery of services.

63. Equipment - £0.70m includes:
    - Requirements from approved/prioritised business cases linked to development and cost improvement opportunities;
    - Replacement of end-of-life or obsolete kit; in advance of the rolling replacement programme; and
    - The quality assessment of new and replacement medical equipment will continue to be facilitated through the medical devices group.

64. Information Management & Technology (IM&T)
    - Expenditure necessary to deliver the IM&T strategy which incorporates the nationally mandated objectives (electronic patient record, paper-lite, access to records), in addition to local requirements (upgrade, mobility, interoperability, access, security); and
    - Expenditure necessary to complete the roll-out of EDM; due to be completed at the end Q2 2017/18.

65. A contingency has been created to address in-year urgent requirements.

66. The Trust will continue to review all investment/divestment decisions to ensure the best use of its estates and resources. There is a requirement for investment and/or developments cases to test all options so that best value is evidenced.

67. The Capital Planning Group, now one year old, is fulfilling its purpose of providing oversight, challenge and recommendation in regard to capital planning and delivery.

Liquidity

68. The Trust's cash balances maintain a score of 1 in the liquidity measure of the single oversight framework which is the highest rating.

Single Oversight Framework: Finance and use of Resources measure

69. The 2017/18 financial plan has a 'Use of Resources' (UOR) measure of 1 which is the highest attainable; 201819 (UOR =1).

Table 9 – UOR 2017/18 and 2018/19

Use of Resources 2017/18					
	Metrics £k	Measure	Rating	Weight	Score
Continuity of Services:					
Capital Service Cover					
Operating surplus	6,020	2.62	1	20%	0.20
Capital Servicing Obligation YTD	2,294				
Liquidity					
Working Capital	6,637	38.3	1	20%	0.20
Operating Costs (per day)	173				
Financial Efficiency:					
I&E Margin (%)					
Surplus (deficit) year to date	1,455	2.10%	1	20%	0.20
Income year to date	69,204				
I&E Margin Variance From Plan					
Actual surplus margin	2.10%	0.00%	1	20%	0.20
Plan surplus margin	2.10%				
Agency Cap					
Agency Spend	2,100	18.78%	2	20%	0.40
Agency Cap	1,768				
Use of Resources 2017/18			1.00		

Use of Resources 2018/19					
	Metrics £k	Measure	Rating	Weight	Score
Continuity of Services:					
Capital Service Cover					
Operating surplus	6,468	2.82	1	20%	0.20
Capital Servicing Obligation YTD	2,294				
Liquidity					
Working Capital	6,637	43.8	1	20%	0.20
Operating Costs (per day)	151				
Financial Efficiency:					
I&E Margin (%)					
Surplus (deficit) year to date	1,575	2.22%	1	20%	0.20
Income year to date	71,052				
I&E Margin Variance From Plan					
Actual surplus margin	2.22%	0.00%	1	20%	0.20
Plan surplus margin	2.22%				
Agency Cap					
Agency Spend	2,100	18.78%	2	20%	0.40
Agency Cap	1,768				
Use of Resources 2017/18			1.00		

Contract Status

70. The status of commissioner contract agreements, as at 15th December 2016, is shown in the table below:

Table 10 – Commissioner Contract Status

Commissioner	Status

NHS Horsham and Mid Sussex	Host CCG for itself plus 20 other associates:
	• 10 CCGs agreed (inc. Horsham and Mid Sussex).
	• 6 CCGs close to agreement with limited concerns.
	• 1 CCG becoming non contract due to volumes below de minimis levels.
	• 4 CCGs without agreement and moderate to significant concerns:
	  ○ West Kent CCG does not recognise the forecast outturn for 2016/17 and is offering significantly less than the Trust's proposal. Negotiations are ongoing.
	  ○ High Weald Lewes and Havens CCG have not made an offer and are constructing a proposal that actively pursues non-payment of follow up outpatients above a set ratio. Negotiations are ongoing.
	  ○ Medway CCG has not made an offer. This is being escalated.
	  ○ Guildford and Waverley have proposed a significant reduction in activity (c33%) with no supporting detail. Negotiations are ongoing.

NHS England Specialised (NHSE)	Trust and NHSE in active negotiations. Key issues are: • Continued receipt of c. £750k block funding from the previous national burns network funds; and • Application of a £400k QIPP saving.
NHS England Dental	Contact has been minimal with dental commissioners as specialised commissioning is expected to lead these negotiations as well. Trust is negotiating directly with dental commissioners where the key issue is the recognition of the need to fund the IR changes.

71. Contract signature is due 23rd December 2016. Despite the risks outlined, there is sufficient confidence that estimated annual contract values with all commissioners can be agreed within this timeframe and without the need for mediation.

72. It is likely that the detail of CQUIN schemes and service development and improvement plans etc. will not be fully agreed for this date and an extended deadline to resolve will be agreed (long-stop).

Risk and Mitigation

73. The Trust faces a number of financial risks in 2017/18 which need to be managed through the remainder of the planning process and by rigorous management throughout the year. These are detailed in Appendix 1.

Summary and next steps

74. Summary performance:
    a. Proposed budget for 2017/18 equals the control total of £1.176m; UOR of 1;
    b. Proposed budget for 2018/19 equals the control total of £1.874m; UOR of 1;
    c. Capital plan is £3.1m from internally generated funds for both years; and
    d. CIPP targets of £3.2m and £3.0m respectively.

75. Next steps:
    a. Complete contract negotiations and sign contracts by 23rd December 2016;
    b. Address any contract issues where a long stop has been agreed in January 2017;
    c. Complete and upload activity, workforce and finance templates, triangulation tool and supporting narrative, after having considered first draft feedback, to the NHS submission portal by 23rd December;
    d. Present paper to the Trust Board for ratification, highlighting any material changes, post submission;
    e. Urgent focus on CIPP identification and work-up; with granular level plans and QIAs in place prior to the year-end;
    f. Final review, challenge and agreement of business plans, service developments, cost pressures, CIPP opportunities and detailed capital plans for incorporation into budget uploads; and
    g. Business unit/Directorate budget sign-off.

76. The committee is asked to:
    a. Note the content of the report and the next steps;
    b. Approve the revenue and capital plans for 2017/18 and 2018/19 prior to submission to NHSI on the 23rd December 2016.

Appendix 1 – Risk Outlook

Risk	Detail/Mitigations
Contracts - offers not received/or with gaps	The Commissioning Support Unit (CSU) leading negotiations on behalf of our host CCG and will escalate through their internal processes should an offer not be received by Monday 19th December. For offers with gaps, continue to negotiate on a case by case providing robust evidence to support. Note that contracts are cost and volume; therefore activity undertaken will be paid.
QIPP schemes (predominantly NHSE)	QIPP schemes are unsupported by evidence and/or clearly articulated implementation plans. Trust will engage in relevant activities to identify mutually beneficial QIPP schemes but until these are agreed, Trust position will be to maintain that the QIPP risk sits with the commissioner.
High new to follow-up ratios : plastic surgery, ophthalmology and sleep.	Some commissioners are considering introducing non-payment clauses for follow ups above a set ratio. Combined with this, NHSI, through the NTPS, is keen to disincentivise excessive follow up activity by transferring 30% of the follow up costs for outpatients in surgical specialities to first appointments. A targeted piece of work reviewing follow ups at the Trust needs to be undertaken to understand the drivers behind our relatively high rates and take appropriate action.
Burns Network Funding c(£750k)	Historic block funding in addition to its activity based contract for burns; originating with national burns funding but now considered part of the contract baseline. NHSE are now challenging the validity of this as an ongoing block. Evidence and arguments are being prepared to ensure the continuation of this funding.
Elevated level of challenge	A general lack of understanding of IR changes and HRG4+ across commissioners may well lead to an increase in scrutiny. Furthermore, the propensity to 'under commission' and thus for the Trust to 'over perform' can also lead to an increased challenge on data – a process which places the burden of proof on Trusts and creates additional administrative workload. A system of pre-emptive challenge checks is put in place through the Business Intelligence Unit at the Trust and our internal timetable ensures resources are available to respond to challenges within the tight deadlines set.
CQUIN	Change in focus of CQUIN to support system-wide control delivery will disadvantage the Trust even when the Trust delivers its full commitments. There is a further risk that this is, as yet, still not well understood across all parties and therefore clearer definition will be sought and written into contracts. CQUIN delivery will have increased scrutiny from the PMO.
Delivery of cost improvement, productivity and growth agenda	Significant target and requires investment to deliver. Detailed plans required – milestones, KPIS, interventions. RAG rating of individual schemes with mitigating actions and monitoring and reporting via performance reviews, F&P and the new PMO.
2016/17 Outturn	Failure to deliver will impact on 2017-19. An additional recover plan has been agreed and will be implemented week 2, Q3. Progress against existing plans, recovery to be monitored weekly; supported by enhanced expenditure controls

KSO5 – Organisational Excellence

Risk Owner: Director of HR & OD
Committee: Board of Directors
Date: December 2016

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

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

Current Risk Rating 4 (C) x 3 (L) = 12 Amber
Residual Risk Rating 4 (C) x 2 (L) = 8 Yellow

Rationale for current score
-Capacity planning & workforce modelling
-Junior doctors contract
-Additional corporate restructuring
-managers skill set in workforce/activity/financial planning
-unknown impact of STP

HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY
-Consultant contract negotiations resume in 2017
-Junior doctor contract implementation Feb 2017
-CQC recommendations
-introduction of agency caps
- Support recommendations in FTSU review

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 inhibit flexibility to address local issues e.g. retention of skilled nursing staff
-Workforce systems need to become user friendly to benefit from self service and other e-solution investment

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 launches Jan 2107
-engaged in NHS Employers workforce retention programme nationally
-Workforce strategy to be developed and implemented by Q3 FY17/18
- Increased compliance requirement to 95% from Jan '17 for all staff
-Implementing a Board approved staff survey action plan winter each year
-HR/OD metrics revised to support the Business Units
-Performance review meetings to identify and address identified staffing shortfalls
-HR support to corporate functions to implement successfully re-structures
New pay protocol launched

Gaps in controls and Assurances
-Current level of management competency in workforce planning
-Continuing resources to support the development of staff – successful in funding bid for management and leadership development, programme launches in Jan 2017
-Continuing retention problems in theatres and ward areas and medical staff in Max Facs - workforce theatre productivity group now meeting **CRR 922**
- Capacity of recruitment team to support the required initiatives to address recruitment and retention challenges including pay and agency controls
Band and agency task group to be formed

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	05/01/17	**Agenda reference:**	22-17		
Report title:	**Workforce Report – December 2016 (November Data)**				
Sponsor:	Geraldine Opreshko, Director of HR/OD				
Author:	Geraldine Opreshko, Director of HR/OD, and Jill Dale, ESR and Workforce Intelligence Manager				
Appendices:	A: Workforce Report				
Executive summary					
Purpose:	The Workforce and OD report for December (November data) 2016 provides the Board of Directors with a breakdown of key workforce indicators and information linked to performance.				
Recommendation:	The Board are asked to note the report.				
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:	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 and performance committee				
	Date:	19/12/16	Decision:	Noted	

Human Resources & Organisational Development

Workforce Report – December 2016

Reporting Period: November 2016

1.1 Contextual narrative

The December 2016 Workforce Report covers the November 2016 reporting period, to note in this report:

- Section 1.2 provides the high level summary of the report on a page

- In November the difference in the number between budgeted WTE and staff in post (section 2) was 124 WTE, with a net reduction in to the Trust staff in post by 1 WTE, the balance between starters and leavers. It is important to note that whilst restructure consultations are on-going a number of posts are being specifically left vacant/covered on a temporary basis until these processes are concluded. Within the Trust a number of managers do use their establishment and pay budgets flexibly to balance service needs e.g. skill mix and temporary staff.

- As the annual business planning process continues, Finance and HR are working closely together to refine the processes and paperwork to improve establishment control data from the New Year for robust vacancy monitoring and reporting.

- There were 29 non-medical candidates in the recruitment process at the end of November.

- The 12 month turnover rate has decreased to 16.9% for permanent/fixed term staff with a reduction in the number of leavers compared to the previous month. The turnover figure remains a little high and although the numbers are not great, work in on-going to address this including information gathering, monitoring, analysis and attendance at the National NHS Employers Workforce Retention Programme.

- Our agency usage (section 5) has increased and we have had to continue to pay over the NHSI set agency cap to be able to cover some specialist areas for example in Theatres, Burns and ITU due to national shortages and vacancies in Outpatients. Bank usage also increased during November to cover special projects, for example, the relocation of health records and as a result of extensive recruitment to the bank.

- The final sickness absence figure (section 6) for October 2016 was 2.69% slightly above the forecast figures, it is anticipated that the indicative figure for November will rise to around 2.8% based on initial data and comparison with previous periods. The top three reasons for sickness in October were: Musculoskeletal at 19%, Cold/Cough/Flu at 17% and Anxiety/Stress/Depression at 12%.

- In November compliance rates for statutory and mandatory training increased for the third successive month.

- Appraisal rates have increased in November in all the business units and corporate areas of the Trust. As predicted on-going support for managers e.g. streamlining the appraisal documentation, running appraisal training along with challenge at performance review meetings has increased compliance.

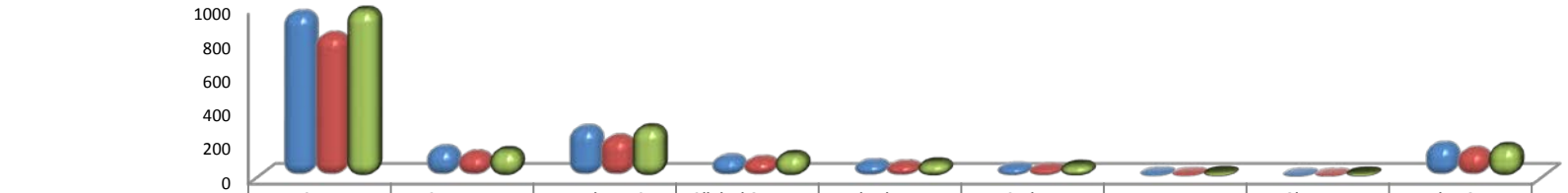
1.2 Summary

Trust Workforce KPIs	Primary Data Source	Definition/Measure	Workforce KPIs (RAG Rating)			Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Compared to Previous Period	2016/17 Monthly Trend (Apr-Oct)
Establishment WTE *Note 1	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	963.92	962.72	962.72	962.72	962.72	962.72	962.72	◄►	
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	842.72	840.09	842.78	849.39	841.27	838.92	▼	
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	120.00	122.63	119.94	113.33	121.45	123.80	▲	
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%	12.5%	12.7%	12.5%	11.8%	12.6%	12.9%	▲	
Agency WTE	Healthroster	Fill by Agency Workers expressed as a WTE of hours worked				4.5	16.5	19.5	14.1	15.7	25.8	25.0	25.7	29.7	30.7	30.8	▲	
Bank WTE *Note 2	Healthroster	Fill by Bank Workers expressed as a WTE of hours worked				27.4	30.2	37.2	29.8	28.5	32.9	26.1	28.8	28.1	31.3	37.4	▲	
Trust rolling Annual Turnover % (Excluding Trainee Doctors) *Note 3	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%	14.9%	14.8%	15.1%	16.6%	16.8%	16.7%	17.1%	17.1%	17.4%	17.6%	16.9%	▼	
Monthly Turnover *Note 3	ESR	Current month leavers WTE divided by the Current month staff in post, expressed as a percentage				2.3%	1.2%	1.1%	2.1%	0.9%	1.3%	1.2%	1.5%	1.5%	1.7%	1.5%	▼	
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%	99.0%	98.8%	97.5%	98.8%	97.9%	98.5%	▲	
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%	2.1%	2.6%	2.6%	2.5%	2.0%	2.7%	***2.8%***	***November Indicative Figure***	
Statutory & Mandatory Training (Permanent & Fixed Term staff)	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%	87.3%	87.8%	85.4%	82.2%	83.4%	85.8%	▲	
% staff appraisal compliant (Permanent & Fixed Term staff)	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%	76.6%	77.8%	73.4%	66.9%	63.7%	75.7%	▲	
Friends & Family Test - Treatment	Survey	Quarterly staff survery to indicate likelihood of recommending QVH to friends & family to receive care or treatment ***Measure - Extremely likely/likely % : Extremely unlikely/unlikely%***				Quarter 4: Of 136 responses: 96.4% : 1.5%			Quarter 1: Of 187 responses: 96.7% : 2.1%			Quarter 2: Of 42 responses: 92.9% : 4.8%			National Staff Survey		▼ Responses ▼Likely ▲ Unlikely	
Friends & Family Test - Work	Survey	Quarterly staff survery to indicate likelihood of recommending QVH to friends & family as a place of work ***Measure - Extremely likely/likely % : Extremely unlikely/unlikely%***				Quarter 4: Of 136 responses: 69.8% : 17.0%			Quarter 1: Of 187 responses: 68.4% : 19.3%			Quarter 2: Of 42 responses: 57.1% : 32.0%			National Staff Survey		▼ Responses ▼Likely ▲ Unlikely	

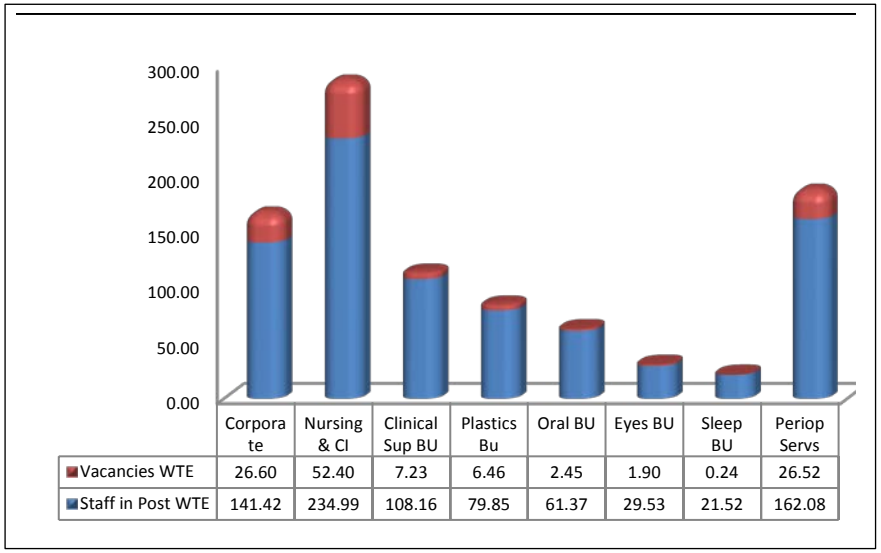
*Note 1 - 2016/17 Establishment not available in April data reporting period updated in May, and in June when finalised version became available
*Note 2 - Bank WTE does not include extra hours worked by medical staff within establishment or overtime worked by all staff groups
*Note 3 - Turnover has been recalculated to exclude rotational trainee doctors from January 2016 onwards

2. Establishment and Staff in Post

Budgeted Establishment /Staff in Post WTE & Headcount as at 30th November 2016



	QVH	Corporate	Nursing & CI	Clinical Sup BU	Plastics Bu	Oral BU	Eyes BU	Sleep BU	Periop Servs
Budgeted Establishment WTE	962.72	168.02	287.39	115.39	86.31	63.82	31.43	21.76	188.60
Staff in Post WTE	838.92	141.42	234.99	108.16	79.85	61.37	29.53	21.52	162.08
Headcount	981	156	290	133	88	73	33	28	180



	Corporate	Nursing & CI	Clinical Sup BU	Plastics Bu	Oral BU	Eyes BU	Sleep BU	Periop Servs
Vacancies WTE	26.60	52.40	7.23	6.46	2.45	1.90	0.24	26.52
Staff in Post WTE	141.42	234.99	108.16	79.85	61.37	29.53	21.52	162.08

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

Business Unit	Vacancies as % of Establishment	Vacancies WTE	Comparison to last month
Corporate	15.83%	26.60	▲
Nursing & Clinical Infrastructure	18.23%	52.40	◄►
o *of which* Qualified Nursing	23.08%	38.23	▼
o *of which* HCAs	16.10%	7.37	▲
Clinical Support BU	6.27%	7.23	▼
Plastics BU	7.48%	6.46	▼
Oral BU	3.84%	2.45	▼
Eyes BU	6.05%	1.90	◄►
Sleep BU	1.10%	0.24	▼
Perioperative Services	14.06%	26.52	▲
o *of which* Qualified Nursing & Theatre Practitioners	22.26%	22.71	▲
o *of which* HCA's and Student/Asst Practitioners	14.53%	6.43	▲
QVH Total	**12.86%**	**123.80**	▲

3. Recruitment Activity for November 2016

Number of Posts Advertised (Non-Medical)	36.35 WTE
Number of New Job Offers (Non-Medical)	9.30 WTE
Number of Candidates already in the Recruitment Process (as at month end) – job offers made, candidates not yet started	24.78 WTE

Business Unit	Number of (New) Non-Medical Posts Advertised during reporting period (WTE)	Number of Non-Medical Candidates in the Recruitment Process (WTE)
Corporate	2.00	4.00
Nursing & CI	16.45	13.49
o ***Of which*** **Nursing Staff**	10.41	4.00
o ***Of which*** **HCA's**	3.00	6.89
Clinical Support	2.00	3.81
Plastics Business Unit	0.00	0.00
Eyes Business Unit	0.00	0.48
Sleep Business Unit	1.80	0.00
Oral Business Unit	0.00	0.00
Perioperative Services	14.00	3.00
o ***Of which*** **Nursing & Theatres Practitioners**	13.00	1.00
o ***Of which*** **HCA's/Student ODPs**	0.00	0.00
Total (QVH Overall)	36.25	24.78

Medical and Dental Recruitment

Recruitment in Plastic Surgery continues to present an on-going challenge at Registrar level in particular with the Plastics Business Unit being reliant on locums until the end year. Applicants from a recent recruitment day are currently undergoing pre-employment checks with projected start dates in January 2017. Interviews are due to be held in December for other posts.

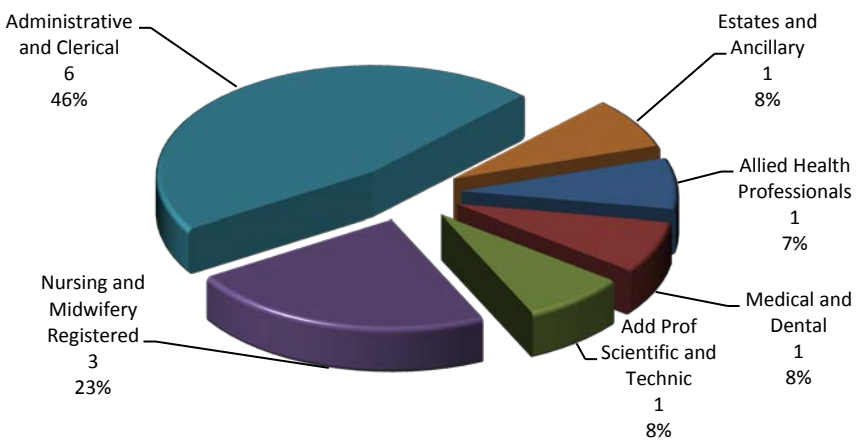
The Trust has recently been informed by the Training Programme Director of Oral and Maxillofacial Surgery that there will be a shortfall of LETB candidates to take up posts in April 2017. This Business Unit is now exploring alternatives for filling these posts to meet service demand.

Medical Locums

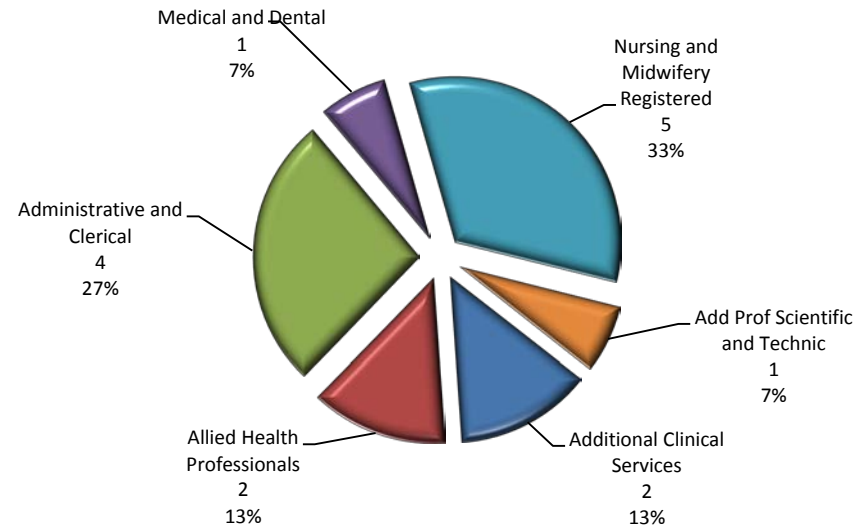
Plastics – Two agency locums are required to cover vacancies and short term sickness. One other vacancy is being covered by an NHS Locum. There may be a requirement for continuation of locum use into January 2017 pending successful recruitment in December 2016.
Clinical Support - An agency Consultant is covering the maternity leave of a visiting Consultant from BSUH, it is expected that this will end in April/May 2017.
Ophthalmology - The Trust is using one NHS Locum Consultant to support Glaucoma and other Ophthalmology services and cover the career break of a substantive Consultant.
Anaesthetics - Two NHS Locums for a year to cover career breaks.

4. Turnover – Starters and Leavers

Number of Starters (Headcount) by Staff group for November 2016



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



Business Unit	Starters (WTE)	Leavers (WTE)
Corporate	**3.32**	**1.00**
Nursing & Clinical Infrastructure	**5.00**	**5.25**
o *Of which* **Nursing Staff**	*3.00*	*3.61*
o *Of which* **HCA's**	*0.00*	*1.00*
Clinical Support	**1.60**	**1.50**
Plastics Business Unit	***1.00**	***1.00**
Eyes Business Unit	**0.00**	**0.00**
Sleep Business Unit	**1.00**	**0.00**
Oral Business Unit	**0.00**	**1.37**
Perioperative Services	**0.00**	**2.76**
o *Of which* **Nursing & Theatres**	*0.00*	*1.76*
o *Of which* **HCA's & ODPs**	*0.00*	*1.00*
QVH Total (* Note)	**11.92**	**12.89**

Turnover Summary

Turnover rate – for the month of November the turnover rate (excluding rotational trainee doctors) was **1.53%** for Permanent/Fixed term staff, a slight reduction on last month.

Turnover rate for 12 months (Period: 1st December 2015 to 30th November 2016) excluding rotational trainee doctors was **16.92%** for Permanent/Fixed term staff, a decrease on the previous month.

**** Note: Starters and Leavers WTE figures include rotational trainee doctors***

5. Bank and Agency – October Activity Data

5.1 Bank and Agency Usage (WTE) by Business Unit and Staff Group

By QVH Business Unit	Current Month (November 2016) Agency usage in WTE	Current Month (November 2016) Bank usage in WTE	Current Month (November 2016) Agency & Bank usage in WTE	Previous Month (October 2016) Agency & Bank in WTE	November 2016 compared to last month
Corporate	12.33	6.23	18.56	**17.77**	▲ Agency ▲Bank
Nursing and CI	3.60	13.44	17.04	**14.85**	▼ Agency ▲Bank
Clinical Support	2.61	3.65	6.26	**6.09**	▲ Agency ▼ Bank
Plastics Business Unit	2.03	1.88	3.91	**4.00**	▲ Agency ▼ Bank
Eyes Business Unit	0.00	1.86	1.86	**1.09**	◄► Agency ▲Bank
Sleep Business Unit	0.78	1.95	2.73	**1.84**	▲ Agency ▲Bank
Oral Business Unit	0.00	1.49	1.49	**0.42**	◄► Agency ▲Bank
Perioperative Services	9.48	6.91	16.39	**15.88**	▲ Agency ▼ Bank
QVH Total	**30.84**	**37.40**	**68.24**	**61.94**	▲ Agency ▲Bank

By Staff Group	Current Month (November 2016) Agency usage in WTE	Current Month (November 2016) Bank usage in WTE	Current Month (November 2016) Agency & Bank usage in WTE	Previous Month (October 2016) Agency & Bank in WTE	November 2016 compared to last month
Qualified Nursing	12.41	8.48	20.89	**20.29**	▼ Agency ▲Bank
HCAs	0.00	1.99	1.99	**1.75**	◄► Agency ▲Bank
Medical & Dental	1.36	0.00	1.36	**1.01**	▲ Agency ◄►Bank
Other Clinical e.g AHP & ST&T	3.53	2.15	5.68	**5.81**	▼ Agency ▼ Bank
Non-Clinical	13.54	24.78	38.32	**33.08**	▲ Agency ▲Bank
QVH Total	**30.84**	**37.40**	**68.24**	**61.94**	▲ Agency ▲Bank

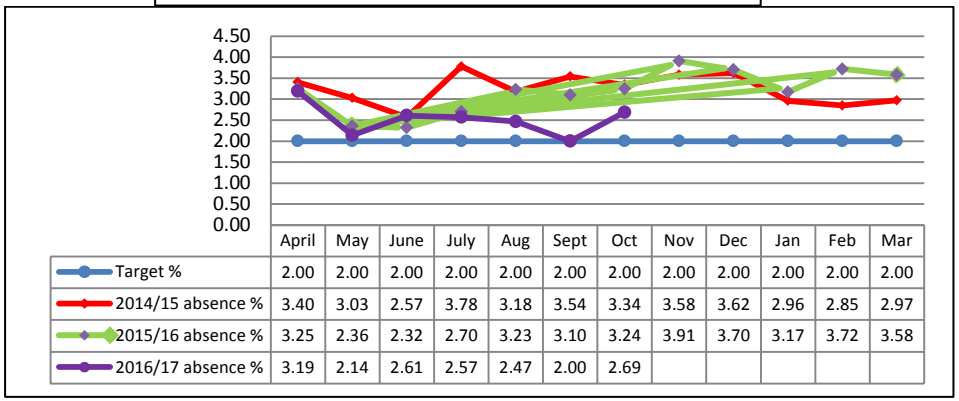
5.2 Agency Usage in line with NHS Improvement Rules by Business Unit and Staff Group

By QVH Business Unit	November 2016 Number of Shifts *UNDER NHSI Agency Hourly Charge Cap*	November 2016 Number of Shifts *OVER NHSI Agency Hourly Charge Cap*	November 2016 Total Number of Agency Shifts	Previous Month (October 2016) Agency Shifts	November 2016 compared to last month
Corporate	152	***116***	268	**265**	▲
Nursing and CI	19	***59***	78	**94**	▼
Clinical Support	45	***24***	69	**62**	▲
Plastics Business Unit	22	***22***	44	**37**	▲
Eyes Business Unit	0	***0***	0	**0**	◄►
Sleep Business Unit	13	***0***	13	**12**	▲
Oral Business Unit	0	***0***	0	**0**	◄►
Perioperative Services	1	***170***	171	**161**	▲
QVH Total	**252**	***391***	**643**	**631**	▲

By Staff Group	November 2016 Number of Shifts *UNDER NHSI Agency Hourly Charge Cap*	November 2016 Number of Shifts *OVER NHSI Agency Hourly Charge Cap*	November 2016 Total Number of Agency Shifts	Previous Month (October 2016) Agency Shifts	November 2016 compared to last month
Qualified Nursing	20	***199***	219	**217**	▲
HCAs	0	***0***	0	**0**	◄►
Medical & Dental	0	***37***	37	**28**	▲
Other Clinical e.g AHP & ST&T	58	***30***	88	**92**	▼
Non-Clinical	174	***125***	299	**294**	▲
QVH Total	**252**	***391***	**643**	**631**	▲

6. Sickness Absence

Trust Sickness Absence Percentage –October 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 %	3.40	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	2.14	2.61	2.57	2.47	2.00	2.69					

Sickness Absence % by Business Units

Business Unit	Sickness Percentage	Current month compared to last month
Corporate	1.44%	▼
Nursing and Clinical Infrastructure	3.37%	▲
Clinical Support	1.39%	▼
Plastics Business Unit	3.31%	▲
Eyes Business Unit	4.26%	▲
Sleep Business Unit	0.07%	▼
Oral Business Unit	1.99%	▲
Perioperative Services	3.68%	▲
QVH Total	**2.69%**	▲

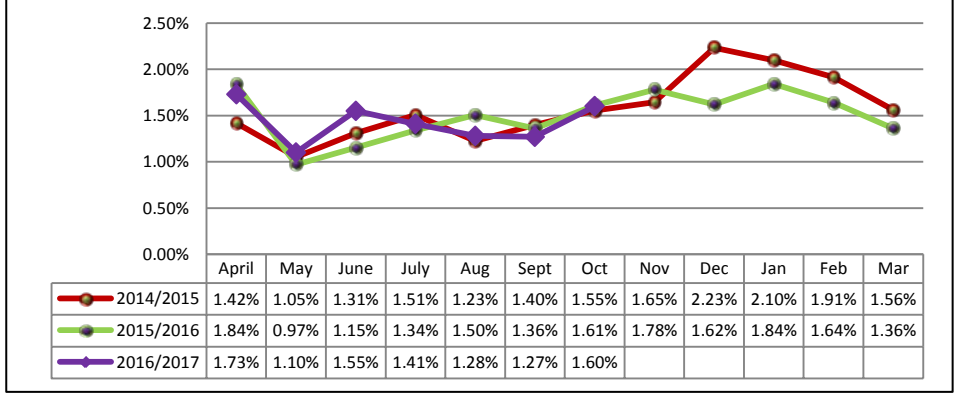
Short term Sickness Absence

Short Term sickness for October was **1.60%,** an increase on last month although lower than the same period last year.

Long term Sickness Absence

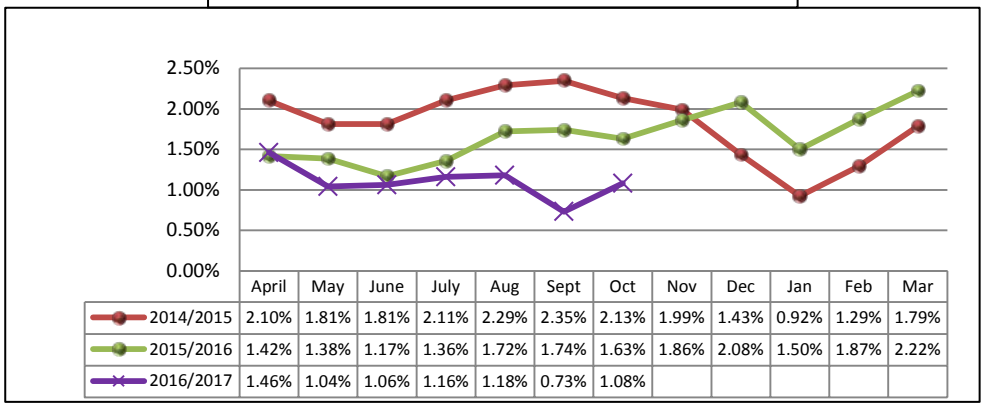
The long term sickness absence rate for October was **1.08%,** an increase on last month although lower than the same period last year.

Trust Sickness Absence Percentage – 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%
2016/2017	1.73%	1.10%	1.55%	1.41%	1.28%	1.27%	1.60%					

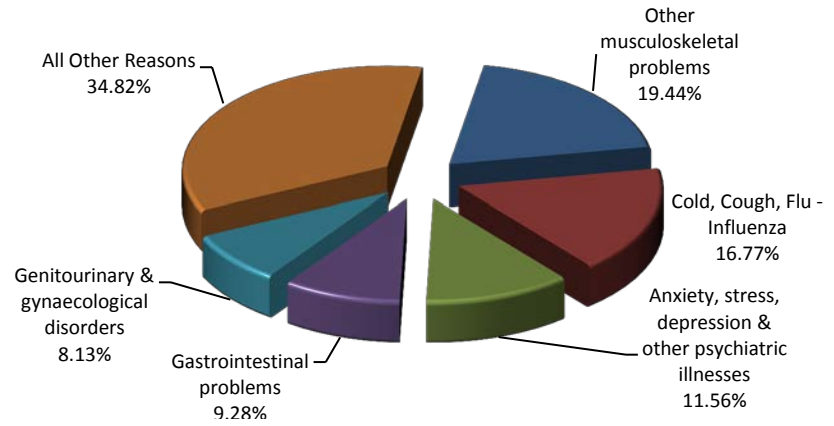
Trust Sickness Absence Percentage – Long Term



	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%	1.04%	1.06%	1.16%	1.18%	0.73%	1.08%					

6.1 Sickness Absence Reasons

Top sickness absence reasons for October 2016



Health & Wellbeing

Building on The Trust Wellbeing week held at the end of June, the trust celebrated World Mental Health day on the 10th October and ran a programme of activities for Positive Minds week' running on 31st October to 4th November. All the workshops were well received with positive feedback for the sessions on stress, mental and physical health, healthier lives and rest and relaxation.

We have appointed a new Employee Assistance Programme provider who started in October 2016.

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

Specialist Hospital	Region	Absence Rate
Alder Hey Children's Hospital	North West	4.80%
Birmingham Children's Hospital	West Midlands	3.36%
Birmingham Women's Hospital	West Midlands	4.78%
Christie Hospital, Manchester	North West	3.39%
Clatterbridge Cancer Centre	North West	3.94%
Great Ormond Street Children's Hospital	London	2.17%
Liverpool Heart & Chest Hospital	North West	3.32%
Liverpool Women's Hospital	North West	3.96%
Papworth Cardiothoracic Hospital	Cambridgeshire	3.11%
Robert Jones & Agnes Hunt Orthopaedic Hospital	Shropshire	3.34%
Royal Brompton & Harefield Cardiothoracic Hospital	London	2.48%
Royal Marsden Cancer Hospital	London	2.60%
Royal National Orthopaedic Hospital	London & Middlesex	2.61%
Royal Orthopaedic Hospital, Birmingham	West Midlands	4.99%
Sheffield Children's Hospital	North East	4.30%
Velindre Cancer Centre, Cardiff	Wales	3.56%
Walton Centre for Neurology & Neurosurgery	North West	4.24%

Sickness Absence Summary

The overall sickness absence rate at QVH for October was **2.69%.** This is an increase compared to the previous month although significantly lower than the same month for the last three years.
The indicative sickness absence rate for November is around 2.8%.

Highest reason for absence recorded: Other Musculoskeletal
Highest first day absence: Monday
Number of one day sickness absence episodes: 72

Due to a delay in the release of HSCIC benchmark data, July 2016 is the latest data available for sickness absence.

When comparing the sickness absence rates for July 2016 for the 18 Specialist Hospitals in the benchmark group including QVH, the QVH rate of 2.57% is below the group average of 3.38% and is 3rd lowest in the benchmark group.

7. Training, Education and Development

Appraisal Compliance Rate as at 1st December 2016		
Area	**Permanent & Fixed Term Staff APPRAISAL Compliance**	**Current month compared to last month**
Corporate	76.43%	▲
Nursing & CI	76.68%	▲
Clinical Support	87.69%	▲
Plastic Surgery	72.41%	▲
Eyes	62.50%	▲
Sleep	85.19%	▲
Oral	71.43%	▲
Periop Services	68.97%	▲
QVH Total	75.73%	▲

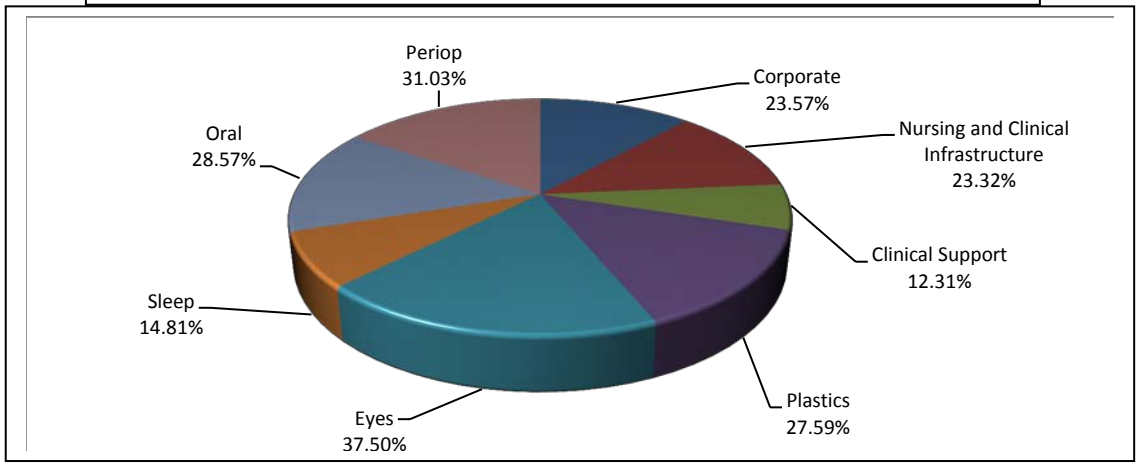
QVH PDR compliance target - 85%
Green 85%+ Amber 70-85% Red 0-70%

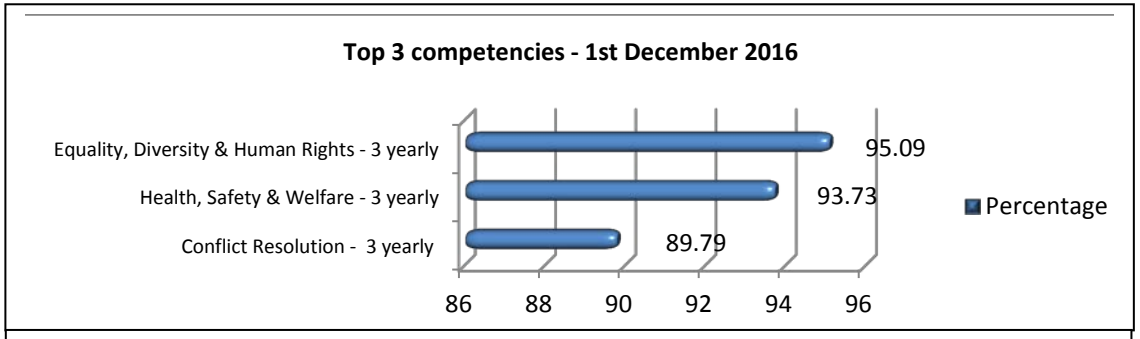
7.1 Statutory & Mandatory Compliance Rates

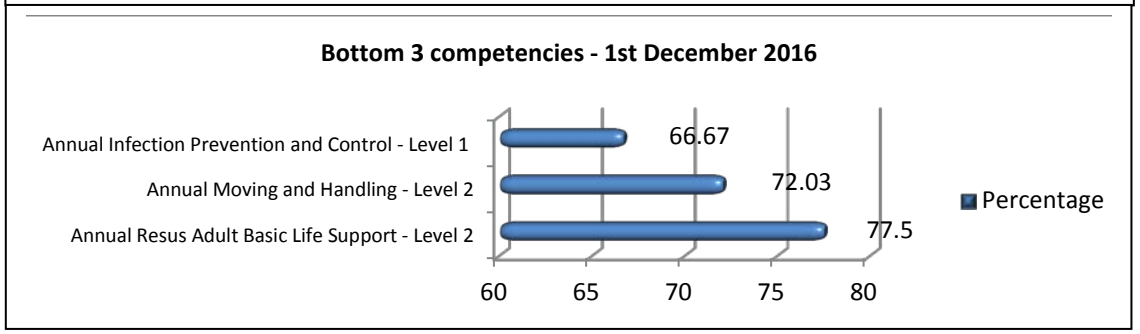
QVH Compliance for 18 competencies as at 1st December 2016 EXC PDR		
Area	**Permanent & Fixed Term Staff Compliance**	**Current month compared to last month**
Corporate	84.35%	▲
Nursing & CI	85.99%	▲
Clinical Support	89.14%	▲
Plastic Surgery	82.04%	▲
Eyes	87.12%	▼
Sleep	89.01%	▼
Oral	86.32%	▲
Periop Services	84.84%	▲
QVH Total	85.77%	▲

QVH compliance target - 80%
Green 80% + Amber 70-79% Red 0-70%

Outstanding Appraisals % for each Business Unit as at 1st December 2016







7.2 Learning and Development – Medical Education

Medical Education Summary

Educational activities in November/December

- A simulation awareness day took place on 28 November, demonstrating how simulations can be used for learning
- The next Junior Doctors' Forum is scheduled for 12 December
- A bid to HEE for funding for SAS doctors has been successful and plans are being put in place for the funds; two courses have been booked for 2017
- Integrated education work underway to implement proposals

Upcoming developments

- An evening CPD meeting, open to all, is planned for 18 January, the speaker is a Trust Hand Consultant
- Changes to the doctors' induction programme are being planned for the next induction, being held in February in response to feedback from the medical staff. There will now be two sessions in the programme with the mandatory training component forming the 2nd session being held a week after the initial induction.

Statutory and Mandatory Training Compliance

- Permanent medical and dental staff are currently showing 20% of competencies out of date, i.e. 80% compliant, a 3% drop on the previous month
- Medical and dental bank staff are showing 35% of competences out of date, which is a drop of 1% on the previous month.

8. Medical Workforce

Appraisals

The total compliance rate is 85.71% excluding LETB trainee and bank doctors (an increase of 5.11% on previous month). Particular areas of concern are Anaesthetics and Plastic Surgery in which doctors despite several reminders have not booked an appraisal meeting.

It is worth noting that some of these areas are very small and should one appraisal be out of date, this has a significant impact on the compliance percentage rate i.e. Sleep Disorder Centre and Histopathology. The Clinical Directors of the relevant areas will be emailed to inform them of the low appraisal compliance for action.

Additionally, it should be noted that the until the recent Appraisal, Revalidation and Remediation Policy was implemented, the Trust was recording appraisal compliance for medical and dental staff based on a 15 month rather than a 12 month period. This is because the GMC allows a 3 month grace period. Therefore, with all appraisals now having to be done within a 12 month period, the compliance figure is expected to improve over time.

Junior Doctors Training Contract

Offers in respect of the February 2017 cohort will be sent out in December 2016, followed by further implementation in April. By the end of October 2017 it is expected that all doctors in training will be employed on the new Terms and Conditions of Service.

Plastic surgery rotas are completed, Anaesthetics is near completion and Oral and Maxillo-facial rotas are in progress. In the next two months the Trust will complete an Equality Impact Assessment which will serve to identify any possible impact on the workforce of the new contract.

Additionally, a policy outlining the process of exception reporting will also be produced in readiness for the January Local Negotiating Committee meeting.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	05/01/17	**Agenda reference:**	**23-17**		
Report title:	**Risk Management Strategy**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Alison Vizulis, Head of Risk				
Appendices:	None				
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 **Y**		Assurance **Y**	
Link to key strategic objectives (KSOs):	KSO1: **Y**	KSO2: **Y**	KSO3: **Y**	KSO4: **N**	KSO5: **Y**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	Management of BAF as per Risk Management and Incident Reporting Policy				
Corporate risk register:	As above				
Regulation:	It is a requirement of NHSI and the CQC to have current Risk Management and Incident reporting policy, and a process to achieve its requirements.				
Legal:	Compliance with regulated activities in Health and Social Care Act 2014 and the CQC's Essential Standards of Quality and Safety.				
Resources:	No changes				
Assurance route					
Previously considered by:	Clinical Governance Group				
	Date:	12/12/16	Decision:	Ratified	
Previously considered by:	Quality & Governance Committee				
	Date:	08/12/16	Decision:	Approved	
Previously considered by:	Clinical Cabinet				
	Date:	21/11/16	Decision:	Ratified	
Next steps:	Presented to Board of Directors for information				

Queen Victoria Hospital NHS
NHS Foundation Trust

RISK MANAGEMENT STRATEGY	
CLASSIFICATION	Risk Management
TRUST POLICY NUMBER	
APPROVING COMMITTEE	Quality & Governance Committee
RATIFYING COMMITTEE	Quality & Governance Committee
DATE APPROVED	October 2016
DATE FOR REVIEW	October 2017
DISTRIBUTION	All Staff
CONSULTATION	EMT Clinical Governance Group Quality & Governance Committee Clinical Governance group
RELATED POLICIES (List not Exhaustive)	• Risk Management and Incident Reporting Policy • Being Open Policy • Claims Handling Policy • Handling Complaints and Concerns Policy • Whistleblowing Policy • Health and Safety Policy • Consent Policy • Clinical Audit Policy • Standing Financial Instructions • Fraud Policy
DIRECTOR LEAD	Jo Thomas, Director of Nursing & Quality
AUTHOR	Alison Vizulis, Head of Risk
EQUALITY & HUMAN RIGHTS IMPACT ANALYSIS	AC.QVH.004
THIS DOCUMENT REPLACES	

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RISK MANAGEMENT STRATEGY

Table of Contents

Executive Summary

The QVH Risk Management and Incident Reporting (RM and IR) Policy can be defined as a high level statement of intent or set of principles with widespread application that provides a basis for consistent decision-making and resource allocation in terms of risk management. It is a statement of the standard that is to be achieved rather than how to implement a standard, and provides a "must do" requirement for staff, which may be used to support an individual or the Trust during legal action.

This Risk Management Strategy can be defined as a high-level plan designed to achieve the long term risk management aims within the organisation, which are derived from the Risk Management and Incident Reporting Policy.

Aims/Background and Scope
The purpose of the Risk Management Strategy is to detail the Trust's framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health and Safety legislation, and key regulatory requirements such as Care Quality Commission and NHS Improvement, and its strategic objectives. This Risk Management Strategy underpins the Trust's performance and reputation, and is fully endorsed by the Trust Board.

The most important outcome is that the Trust must learn lessons from every adverse incident, or untoward event/situation that occurs or is identified. It is therefore essential that departments should review their working practices following every significant accident, incident, complaint, claim, inspection or audit; and that lessons for improving working practice are systematically learned, aiming to provide, and maintain, high standards and continuity of service delivery. It is also important that, through risk management, lessons learned are shared with other relevant areas of practice and are reported to relevant external authorities.

Risk management will be the key system through which clinical, non-clinical, organisational and financial risks are managed by all staff to their reasonable best for the benefit of patients, staff, visitors and other stakeholders. Those key systems will be fully embedded at every level of the organisation and will ensure compliance with current and future risk management related standards and legislation.

1. Introduction

An understanding of the risks that face NHS Trusts is crucial to the delivery of healthcare services moving forward. The business of healthcare is by its nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to providing the Trust Board at the Queen Victoria Hospital NHS Foundation Trust (QVH) with assurance on the framework for clinical quality and corporate governance.

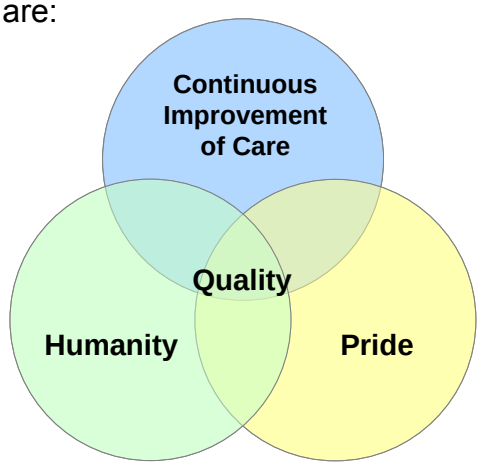
The Trusts Key Strategic Objectives are to:

- Provide outstanding experience for every patient;

- Deliver world class clinical services;
- Be operationally excellent;
- Have financial sustainability; and
- Provide organisational excellence

To ensure that the care provided at QVH is safe, effective, caring, responsive and well-led, the Trust Board must be founded on and supported by strong values and governance structures.

The Trusts values are:



QVH is committed to developing and implementing a Risk Management Strategy that will identify, analyse, evaluate and control the risks that threaten the delivery of its critical success factors. The Board Assurance Framework (BAF) will be used by the assuring committees and Trust Board to identify, monitor and evaluate risks to the achievement of the strategic objectives. It will be used alongside other key management tools, such as performance and quality dashboards, and financial reports, to give the Board a comprehensive picture of the organisational risk profile.

The BAF is managed and overseen by the Head of Risk, and it is updated monthly by the responsible Director on Qnet. The BAF is reviewed monthly as part of the Executive Management Team meeting, and is reviewed by each relevant committee of the Trust Board, with the whole BAF being reviewed at every Board meeting. There is a periodic review of the BAF at the Audit Committee.

The management of risk underpins the achievement of the Trust's objectives. QVH believes that effective risk management is imperative to not only providing a safe environment and improved quality of care for service users and staff, but also to the financial and business planning process where a successful and competitive edge and public accountability in delivering health services is required. This illustrates that risk management is the responsibility of all staff

The risk management process involves the identification, evaluation and treatment of risk as part of a continuous process aimed at helping the Trust and individuals reduce the incidence and impacts of risks that they face. Risk management is therefore a fundamental part of both the operational and strategic thinking of every part of the service delivery within the organisation. This includes clinical, non-clinical, corporate, business and financial risks.

The Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy, values and activities. This strategy will dovetail with the Organisational Development Strategy, with recognising and highlighting staff contributions to the management of governance and risk.

This Risk Management Strategy represents a developing and improving approach to risk management which will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, effective performance management and accountability for organisational learning in order to continuously improve the quality of services.

The Trust Board recognises that complete risk control and/or avoidance is impossible, but the risks can be minimised by making sound judgments from a range of fully identified options and having a common understanding at Trust Board level on risk appetite.

As part of the Annual Governance Statement, QVH will make a public declaration of compliance against meeting risk management standards. The Trust currently has good systems and processes for risk management in place as evidenced by internal and external audit opinion.

This 4 year strategy is subject to review and approval at Quality & Governance Committee. The review will form part of the annual review of risk management report presented annually to the committee.

2. Strategic Aim & Goals

The strategic aim of the Trust is to make risk management the key system through which clinical, organisational and financial risks are managed by all staff. These should be managed to their reasonable best for the benefit of patients, staff, visitors and other stakeholders, and to ensure that the Trust remains within its licensing authorisation as defined by the CQC and NHS Improvement and to deliver a risk management framework which highlights any risks which may prevent the Trust from complying with its provider licence to the Executive Team and Trust Board.

3. QVH Key Strategic Objectives 2016/17

Key Strategic Objectives				
Director of Nursing	Medical Director	Director of Operations	Director of Finance	Director of HR & OD
KSO 1 Outstanding Patient Experience	KSO 2 World Class Clinical Services	KSO 3 Operational Excellence	KSO 4 Financial Sustainability	KSO 5 Organisational Excellence
We put the patient at the heart of safe, compassionate and competent care that is provided by well led teams in an environment that	We provide world class services that are evidenced by clinical and patient outcomes and underpinned by our reputation for high	We provide streamlined services that ensure our patients are offered choice and are treated in	We maximize existing resources to offer cost-effective and efficient care whilst looking for opportunities to	We seek to maintain and develop a strong professional and caring culture through clear standards, high expectations and

meets the needs of the patient and their families.	quality education and training and innovative R&D	a timely manner.	grow and develop our services	exemplary leadership

4. Risk Management Objectives

The Risk Management Objectives are agreed as a set of priorities that feed in to the Trust strategic objectives providing evidence that risk is being managed robustly.

The Trusts Risk Management Policies and procedures are devised to support the achievement of both the Risk Management and the Key Strategic Objectives. A range of monitoring and assurance mechanisms is built into the organisational reporting hierarchy, e.g. dashboards, key performance indicators and performance review meetings.

5. Risk Appetite

Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives.

Risk appetite is a core consideration in any corporate risk management approach. No organisation, whether in the private, public or third sector can achieve its objectives without taking a risk. The question for the decision-makers is how much risk do they need to or are prepared to take?

The UK Corporate Governance Code states that “the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic decisions”. As well as meeting the requirements imposed by corporate governance standards, organisations are increasingly being asked to express clearly the extent of their willingness to take risk to meet their strategic objectives.

Risk appetite, correctly defined, approached and implemented, should be a fundamental business concept that makes a difference to how organisations are run. The strategy will be to develop an approach to risk appetite that is practical and pragmatic, and that makes a difference to the quality of decision-making, so that decision-makers understand the risks in any proposal and the degree of risk to which they are permitted to expose the organisation while encouraging enterprise and innovation.

6. Four Year Risk Management Plan 01/04/2016 to 31/03/2020

The Risk Management Plan below will be developed by the Head of Risk and will correlate against the Trust’s Key Strategic Objectives and its ‘Values’ in order to ensure continuity and progression in the Trust’s strategic direction for risk management. This includes issues relating to business, financial, clinical and non-clinical risks, and will include the Trusts risk management objectives through to the expiration of QVH 20/20.

No. and CQC Reference	Description	How Achieved	Plan Year including Year Target Date
CQC Theme - Safety (S), Effectiveness (E), Caring (C), Responsive (R), Well-Led (W))			
1 (S, E, C, R, W)	Completion of Sign up to Safety Pledges as per deadlines ***(Transforming, Consolidating and Improving)***	Completion of actions identified within the pledges by the nominated deadline (See separate Action Plan)	**2016/17** **2017/18** Throughout 2017/18
2 (S, E, R, W)	Continued roll out of NaTSSiPs including auditing of the use of checklists ***(Transforming, and Improving)***	1. Development of the Invasive Procedure Checklist and continued roll-out 2. Review of the invasive procedure checklist (Consider changing to a prompt sheet) 3. Identification of invasive procedures 4. Completion of Risk Assessments for identified procedures 5. Development of SoPs for identified invasive procedures 6. Auditing of the invasive procedure checklist	**2016/17** **then continued improvements throughout 2017 - 2020**
3 (S, E, C, R, W)	Continued work on compliance with the CQC requirements (including Compliance in Practice Assessments) ***(Transforming, Consolidating and Improving)***	1. Completion of monthly CQC reporting (and additional committee reporting) 2. Involvement in CiP assessments 3. Provision of information as required for CQC preparations and inspections	Ongoing throughout **2016/17** **2017/18** **2018/19** **2019/20**
4 (S, E, C, R, W)	Improve the methods of identifying and distributing lessons learnt from incidents, risks, complaints and claims ***(Transforming, and Improving)***	1. Datix system updated to identify lessons learnt 2. Lessons learnt included in staff feedback messages and in the weekly CONNECT newsletter 3. Lessons learnt included within Risk Reports to Business Unit meetings (in agendas and papers) 4. Lessons learnt included within M&M meetings, at Joint Clinical Audit Sessions and Forums e.g. NAG, Junior Doctors Forum and HCA Forum	Ongoing throughout **2016/17** **2017/18** **2018/19** **2019/20**
5 (S, E, C, R, W)	Review and update of the Risk Management Policy ***(Transforming, and Improving)***	Policy updated and full consultation completed	**2016/17** **2019/20**
6 (S, E, C, R, W)	Review and update of the Risk Management Strategy ***(Transforming, and Improving)***	Strategy updated and full consultation completed	**2016/17**
7 (S, E, R, W)	Continued review and update of Risk Management (and H&S) training to ensure it remains up-to-date and reflects staff feedback for change	Updated Risk Management & H&S training (presentations, leaflets, quiz's and simulation events) to reflect national updates and staff feedback (and to reduce the possibility of it becoming "stale"	**2016/17** **2017/18** **2018/19** **2019/20**

	(Transforming, Consolidating and Improving)		
8 (S, E, R, W)	Embed ownership of risks within Business Units and Corporate Departments ***(Transforming, Consolidating and Improving)***	Revised risk review processes including: • Monthly review of CRR by Executive Directors • Improved discussions at Business Unit Meetings • Raising awareness of risk owner responsibilities and the definition of a risk; and • Increased follow ups by the Risk team	**2016/17** **2017/18**
9 (S, E, R, W)	Embed and improve levels of incident reporting ***(Transforming, Consolidating and Improving)***	1. Staff feedback messages from Datix improved 2. Re-launch of improvement to improve low harm incident reporting levels 3. Ongoing monitoring of incident (and near miss) reporting levels 4. Provision of additional ad-hoc risk management /H&S training sessions	**2016/17** **2017/18**
10 (R, W)	Revision of the H&S Group reporting papers to improve governance arrangements ***(Improving)***	Introduction of report coversheet Introduction of reporting template for members Revision of the agenda & ToR	**2016/17**
11 (S, E, C, R, W)	To complete the Annual Departmental H&S Risk Assessments as per scheduled ***(Improving)***	Schedule of H&S assessments to be updated	**2016/17**
12 (R, W)	Continually update Datix to reflect staff feedback and national requirements e.g. improved feedback messages and learning ***(Improving)***	Identify improvements to Datix system from training, horizon scanning and Datix amended to reflect changes	**2016/17** **2017/18**
13 (S, E, C, R, W)	Improve the role and involvement of the Human Factors ***(Transforming, and Improving)***	Bespoke training for individuals Lead roles updated with specific duties undertaken	**2016/17** **2017/18**
14. (S, E, C, R, W)	Inclusion of Risk Management within business planning processes and outcomes ***(Transforming, and Improving)***	Improved inclusion within project management, CIP and other aspects of business planning work	**2016/17** **2017/18** **2018/19** **2019/20**

7. The Trust Risk Registers (BAF, Corporate and Department/Business Unit Risk Registers) (See also Section 15 of the Risk Management and Incident Reporting Policy)

Risk assessments carried out across the Trust must utilise the format as set out in the Risk Management and Incident Reporting Policy (available on Qnet). Each Department will undertake Risk Assessment's on identified risks, adding the information to Datix (the Trust's electronic Risk Management System). This risk information will then be recorded on a department risk register (unless scoring 12+, which then automatically transfers it to the Corporate Risk Register (CRR)).

A generic scoring framework grid is used for rating, and the management of risk as per the Risk Management and Incident Reporting Policy (available on Qnet).

8. Risk Management Processes

A. Risk Identification and Assessment – See section 14 of the Risk Management and Incident Reporting Policy

B. Risk Scoring - See section 15 of the Risk Management and Incident Reporting Policy

C. Risk Reviews and Monitoring - See section 15 of the Risk Management and Incident Reporting Policy

The monthly Business Unit and Department meetings will review their risks and document any changes to controls, actions and scores.

- The Board will monitor and retain ownership of the Board Assurance Framework.
- The Quality & Governance Committee will monitor the corporate risk register.
- The Clinical Governance Group will review and monitor patient safety risks.
- The Health & Safety Group will monitor staff/contractor/visitor/estates related risks.

D. Risk Financing – Even when the Trust has taken reasonable measures to eliminate or reduce risks, some risks will always remain – This is called Risk Acceptance or Risk Tolerance.

The output and implications of risk assessing and identification should be considered as part of the business planning processes.

9. Health & Safety

The Trust is committed to ensuring the safety of staff and visitors is a high priority and has systems in place to identify, monitor and respond to all aspects of safety. Staff or visitor incidents are reported on the incident reporting system and dealt with through the same process described in the Risk Management & Incident Reporting Policy. There is a Health and Safety Policy and the Health & Safety Group reports to the Quality & Governance Committee.

10. Incident Reporting

All clinical and non-clinical incidents, accidents or near miss occurrences should be reported and investigated, and that lessons are appropriately shared across the organisation, within the local health economy and within the wider NHS. The Trust Risk

Management and Incident Management Policy gives further details on the processes of reporting, investigation and monitoring/reviewing of trends and lessons learnt.

11. Analysis of Incidents, Complaints and Claims

The Trust ensures a systematic approach to the analysis of incidents, complaints and claims. This information will be included in the annual risk report along with assurance of systems performance, and regular reviews of these types of information are undertaken to triangulate themes and key findings.

The Annual Risk Report is provided to the Quality & Governance Committee once a year with an exception report provided in year for the remainder of the meetings with period "deep dives". This is then fed into the onward Trust Board reporting.

12. Lessons Learnt and the Promotion of Improvements in Practice

The Trust's systematic approach to encourage learning and promote improvements in practice based on analysis of incidents, complaints and claims, is a key aspect of the Risk Management Strategy.

The Quality & Governance Committee is responsible for ensuring lessons learnt from detailed investigation of adverse events are embedded into organisational culture and practice.

13. Being Open/Transparency and Duty of Candour

The Trusts Being Open Policy gives more detail on this aspect and can be accessed on Qnet.

Effective communication with patients begins at the start of their care and should continue throughout their time with the Trust and this should be no different when a patient safety incident occurs. Openness about what has happened and discussing incidents promptly, fully and compassionately can help patients cope better with the after effects. Saying sorry is not an admission of liability and patients have a right to expect openness in their healthcare. In line with the guidance from the National Patient Safety Agency, the Trust has developed Guidelines for Being Open when a patient is harmed as a result of a patient safety incident.

14. Supporting Staff involvement in Investigations

The Trust recognises that staff can often feel vulnerable when involved in serious incident investigations, complaints, Inquests, Police investigations or the litigation process. It is particularly important that individuals are appropriately supported during and after the case. Individuals, regardless of grade or position, may feel anxious about their involvement and their future role in the progress of the case. The Trust is committed to providing appropriate support packages for the individuals concerned. Please refer to the Risk Management and Incident Reporting Policy on the intranet/policies and procedures/risk management for further information. Statement templates can also be accessed.

15. External Reporting and Monitoring

The Trust is obliged to meet the requirements of a range of external organisations including NHS Improvement, the Care Quality Commission, the Health and Safety Executive, etc

NHS Improvement will oversee and provide support organisations with the aim of achieving a good or outstanding CQC rating, and provide help around the five themes of quality, finance, operational performance, leadership and improvement capability, and strategic change.

The Care Quality Commission is the independent regulator of health and social care in England, and the CQC has split its inspection standards in to five main areas:

- Safe – Patients are protected from harm
- Effective – Patients needs are met (best practice)
- Caring – Patients are treated with compassion, dignity and respect
- Responsive – Patients are given treatment and care at the right time
- Well-led – Organisations can demonstrate excellent clinical leadership, within an open and honest culture.

16. Organisational Arrangements

A diagram illustrating the Trusts committee structure is given in Appendix A.

17.1 Board of Directors (Monthly Committee)

The Board of Directors is ultimately accountable for the management of all risks in the organisation. The Chief Executive, supported by Board Members, has responsibility for the introduction and implementation of the Risk Management Strategy, and for ensuring that adequate systems of internal control which support the achievement of the organisation's objectives are in place.

The Board has delegated responsibility to the Quality and Governance Committee, Clinical Cabinet and the Audit Committee to oversee the Trust risk management strategy across all services. Therefore the Board will receive or send reports involving risk management through the following:

- Receives minutes / reports from the Clinical Cabinet, Quality & Governance Committee, Audit Committee.
- Reports to the Board of Governors via the Chief Executive. A nominated Governor also attends Board of Directors Meeting.
- Reporting down through the organisation – Board agenda and key issues from it raised at the Clinical Cabinet by the Chief Executive.
- Following review by the Clinical Cabinet the Board also receives a monthly Quality and Risk Exception Report that includes the risks graded 12 and above.
- Two Board Assurance Framework reports per year.

17.2 Executive Management Team

This weekly meeting of the Executive Directors has a set agenda which includes discussion of the BAF, Risks, and incidents.

17.3 Clinical Cabinet (Monthly Meeting)

The Clinical Cabinet is a high level operational committee which deals with all aspects of hospital management including risk management and patient safety. The Clinical Cabinet reviews the monthly risk exception report and risk information prior to submission to the Trust Board to ensure issues from moderate and above risks and incidents are being addressed by the relevant clinical director. The Clinical Cabinet also advises on operational risk issues within the directorates.

It also receives:

- Reports/minutes from the Clinical Directorates including the Clinical Support Division.
- Key operational issues from sub committees reported through the relevant chairperson directly to executive lead attending Clinical Cabinet as required (monitoring of sub committees is the function of the Quality & Governance Committee).
- Receives the minutes from the Quality & Governance Committee.
- Reporting down through the organisation – Monthly report detailing a summary of action points sent to each directorate meeting. Feedback to other committees through directorate lead or chairperson.

17.4 Quality & Governance Committee (Monthly Committee)

The Quality & Governance Committee is a nominated assurance committee of the Trust Board with the responsibility to ensure that all reasonable steps are being taken to manage risk and drive continuous improvement in quality and patient safety.

The committee has overall responsibility for the Corporate Risk Register however the Clinical Cabinet will also review corporate risks as set out within the committee duties. Monitoring of these risks including incidents via exception reporting are a key function with the aim to ensure appropriate actions and learning has taken place.

This committee receives reports or minutes from a number of sub committees as detailed in the Quality & Governance Committee Reporting Schedule **(Appendix A)** to ensure risk management issues are addressed.

The Quality and Governance Committee communicate to the following:

- Receives minutes from groups and committees as detailed in the structure chart **(Appendix A)**.
- To ensure all open corporate risks are monitored on a regular basis the committee will receive the complete risk register monthly. In addition the committee will also view annually the risks assigned to each Key Strategic Objective.
- Reporting throughout the organisation – Committee minutes sent to all committees as the reporting structure chart **(Appendix A)**

17.5 Audit Committee

Although not directly involved in the risk management process the Audit Committee monitors the Board Assurance Framework to ensure that the principle risks to the achievement of the key strategic objectives have effective controls in place. The Audit Committee should provide assurance to the Board that:

- It has reviewed the appropriateness of risk management and assurance processes which are in place;
- It has reviewed and approved the Statement of Internal Control.

The Audit Committee reports quarterly to the Board.

17.6 Clinical Governance Group

An operational patient safety/clinical governance meeting that review's a range of patient safety and risk and incident information in detail. This group provides the approval for investigation RCA reports to be closed on internal "Ambers", and reviews final copies of SI/Never Event RCA's before submission externally to the Clinical Commissioning Group. Actions carried over from closed RCA reports are transferred to a learning log and then tracked until closure.

17.7 Business Unit Meetings

The Business Units will have systems in place to ensure risks are identified, analysed, prioritised and documented at all levels and across all areas. This will include:

- comprehensive departmental risk assessments
- specific risk assessments of service developments or changes to usual practice
- specific risk assessment of any areas of concern possibly identified from other risk management activity e.g. incident reporting trend review, complaints, claims, PALS contacts, clinical audits
- review of key risk management data including incident reporting, complaints, claims, inquests, PALS contacts, clinical audit reports
- provision and careful monitoring of effective risk management action plans including those developed following complaints, incidents, claims
- review and implementation of national guidance and warnings e.g. NPSA initiatives and Safety Alerts, MHRA Safety Notices and Hazard Alerts, NCEPOD and national enquiry reports, National Service Frameworks and NICE guidance
- Continuous review of compliance against key national standards

Comprehensive Risk Registers will be established and maintained in all areas and within Business Units. Risk Registers will be maintained and appropriately reviewed in accordance with the Trust's Risk Management and Incident Reporting Policy.

Departmental governance groups all have clear terms of reference, and meet regularly and report in turn to the Quality & Governance Committee, via risk management representatives.

17.8 Departmental Meetings

Additional corporate department monthly/quarterly meetings are held which also include risk and incident reviews e.g. Information Governance Group, Information Management

& Technology, Human Resources, Risk Management Department. These groups also feedback to the Quality & Governance Committee.

18. Internal Audit

Internal Audit is an independent and objective appraisal service within an organisation. As such, its role embraces two key areas:

- The provision of an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement agreed objectives of the organisation.

- Internal Audit will provide an independent and objective consultancy service, specifically to help line management improve the organisation's risk management, control and governance arrangements.

An Internal Audit Annual Plan will be completed detailing the purpose and scope of the assignments to be carried out including their prioritisation. The plan will clearly define its relationship with the Board Assurance Framework. Internal Audit will also review, appraise and report on matters as set out in the organisation's Standing Financial Instructions.

19. Clinical IT Safety

The Trust has two Clinical Safety Officer's who have been trained and accredited by NHS Digital to provide the appropriate risk assessment of Clinical IT systems. This individual also has the necessary authority to deploy what is needed to meet the requirements of NHS Digital's, Standardisation Committee for Care Information (SSCI0160). This individual.

20. Risk Management Training

20.1 Training needs analysis

An annual training needs analysis will be conducted and coordinated through the Staff Development Centre and Human Resources Department. The Head of Risk will advise on the risk management needs for all staff groups and volunteers.

The Trust will ensure there are systems in place to monitor that risk management training needs, identified within the training needs analysis, are addressed effectively.

20.2 Ensuring the effective delivery of all risk management training for all staff groups and volunteers

The outcome of the risk management training needs analysis is recorded within the Trust's Staff Development and Human Resources Department. The Trust will maintain contemporary records of all staff in employment and volunteers. Volunteer records are maintained by The Charitable Funds Manager.

The Staff Development and Human Resources Department updates records of all new starters and leavers and records the specific training needs of all staff groups**.**

20.3 The system for ensuring all staff are booked onto the relevant training programme in accordance with training needs analysis is as follows:-

The training needs analysis will identify risk management training to all trust posts (the list of Trust posts is generated by Human Resources database).

20.4 The process for ensuring all staff undertake the relevant training programmes and that non-attendees are followed up is as follows:-

Line managers work with their staff to highlight training requirements via a range of mechanisms including appraisal etc Staff will be initially allocated to a training programme waiting list if a space is not immediately available. Managers will receive reminders which name the members of staff that have outstanding training. These reminders will be repeated until the training is completed. Reports detailing the percentages of training provided and outstanding are presented at a range of meetings with overall compliance levels being reported to the Trust Board for monitoring purposes.

Training programmes are developed for each training course by the relevant trainer. All training sessions will be evaluated and changes / improvements implemented accordingly.

Within the Annual Risk Management Report, the Quality and Governance Committee will ensure monitoring arrangements are in place to review the overall effectiveness of the delivery of risk management training for all staff groups and volunteers, in relation to the:

- System for ensuring that all staff are booked onto the relevant programmes
- Process for ensuring that all staff undertake the relevant training programmes and those non-attendees are followed up.
- Where monitoring identifies deficiencies, the Quality & Governance Committee will make recommendations, action plans will be developed and changes implemented accordingly.

20.5 Effective delivery of risk management awareness training for Board members and senior managers

Risk management training will be provided for Board members and senior managers through the mandatory training process. Ad hoc sessions in relation to changes in legislation will be provided as required.

Attendance / participation records will be co-ordinated centrally on the Trust's Staff Development and Human Resources System.

Risk management awareness and specific topic training will be provided for Board members and senior managers based on individual training needs analysis and any deficiencies highlighted by the Board members and senior managers themselves. Areas for improvement will be incorporated into the next training event.

The Quality & Governance Committee will ensure monitoring arrangements are in place to review the overall effectiveness of the delivery of risk management awareness training for Board members and senior managers, in relation to:

- The system by which attendance / participation records are co-ordinated centrally
- The programme of regular updates.

Where monitoring identifies deficiencies, recommendations will be made, with an associated action plan for changes to be implemented accordingly.

21. Roles and Responsibilities

21.1 Accountability and Responsibility Arrangements

The Board of Directors is ultimately accountable for the management of all risks in the organisation. The Chief Executive, supported by Board Members, has responsibility for the introduction and implementation of the Risk Management Strategy. These responsibilities are met in a variety of ways:

21.2 Role and responsibility of the Board of Directors

The Board of Directors is accountable for ensuring a system of internal control which supports the achievement of the organisation's objectives is in place. The system of internal control ensures that:

- The Trust's Principal Objectives are agreed.
- Principal risks to those objectives are identified
- Controls which eliminate or reduce these risks are implemented.
- The effectiveness of these controls is independently assured.
- Reports on unacceptable or serious risks and the effectiveness of control mechanisms are received from the Executive Directors and independent assurors.
- Action plans are agreed to improve control over serious or unacceptable risks.
- Policies are in place to determine what level of risks should be retained.

This system (of internal control) will be managed through the Accountable Officer who is the Chief Executive and supported by an effective committee structure.

<u>The Chief Executive</u>
The Chief Executive is the Accountable Officer and has overall responsibility for Risk Management. The Chief Executive has delegated this responsibility to an Executive Lead for Risk Management (Director of Nursing). The Executive Lead for Risk Management is responsible for reporting to the Trust Board on the development and progress of Risk Management, and for ensuring that the Risk Management Strategy is implemented and evaluated effectively.

Executive and Non-Executive Directors

The Executive and Non-Executive Directors have a collective responsibility as a Trust Board to ensure that the Risk Management processes are providing them with adequate and appropriate information and assurances relating to risks against the Trust's objectives.

The Executive and Non-Executive Directors are responsible for ensuring that they are adequately equipped with the knowledge and skills to fulfil this role. Risk Management training sessions can be accessed via the Risk Department but as a minimum, the Trust Board members are included within the induction and statutory and mandatory training arrangements.

The Executive Directors are accountable and responsible for ensuring that the Corporate Departments are implementing the Risk Management Strategy and related policies. They also have specific responsibility for managing the Trust's principal risks, which relate to their Directorates. For example:

- The Director of Finance for managing the Trust's principal risks relating to ensuring financial balance.

- Director of Nursing for managing the principal risks relating to risk and infection control as DIPC.

- The Medical Director is responsible for managing risks associated with the Medical Workforce.

- These designated Directors sit on the appropriate Committee(s) and Groups which cover their area of risk.

- The Non-Executive Directors have a responsibility to scrutinise and, where necessary, challenge the robustness of systems and processes in place for the management of risk.

The Quality & Governance Committee is chaired by the Non-Executive for Patient Safety.

The Director of Nursing is the executive lead with responsibility for managing the strategic development and implementation of risk management, patient safety, and quality.

Other Staff Responsibilities

The remaining staff duties are included in the Risk Management and Incident reporting Policy which can be accessed via Qnet.

22. Monitoring of the effectiveness of this Strategy

The overall implementation of this strategy shall be monitored through the annual internal audit review, and effectiveness of the reporting to the Quality & Governance Committee, which is an assurance committee of the Trust Board.

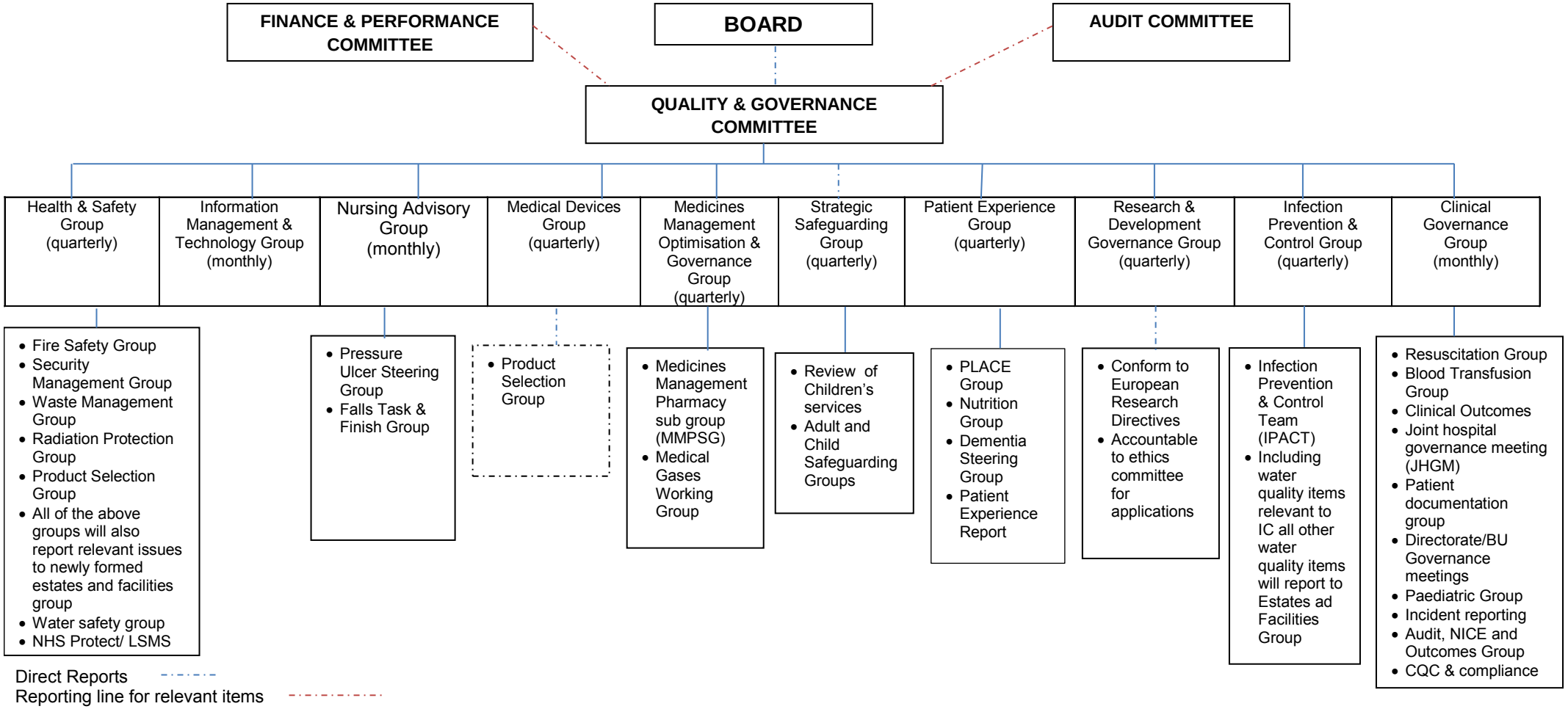
23. References

- An Organisation with a Memory: *Department of Health 2000* *www.dh.gov.uk*
- Building a Safer NHS: *Department of Health (2002)* *www.dh.gov.uk*
- Building a Memory: preventing harm, reducing risks and improving patient safety: *National Patient Safety Agency (2005)* *www.npsa.nhs.uk*
- Being Open: *National Patient Safety Agency (2005)* *www.npsa.nhs.uk*
- National Standards, Local Action, Health and Social Care Standards and Planning Framework: *Department of Health (2004)* *www.dh.gov.uk*
- Assurance: The Board Agenda: *Department of Health*. *(2002)* www.dh.gov.uk
- The Handbook to the NHS Constitution www.dh.gov.uk
- Acute Hospitals: Provider Handbook www.cqc.org.uk
- The NHS Outcomes Framework 2013/14 – DoH *www.dh.gov.uk*
- Equity and Excellence: Liberating the NHS – DoH 2010 *www.dh.gov.uk*
- Assurance: The Board Agenda – DoH 2002
- Management of Risk: A Strategic Overview – HM Treasury 2000

Appendix A

Queen Victoria Hospital NHS
NHS Foundation Trust

THE QUALITY & GOVERNANCE COMMITTEE STRUCTURE AND SUB-COMMITTEES



Date: Sep 2015: Review JMT Sept 2016; December 2016

Queen Victoria Hospital NHS
NHS Foundation Trust

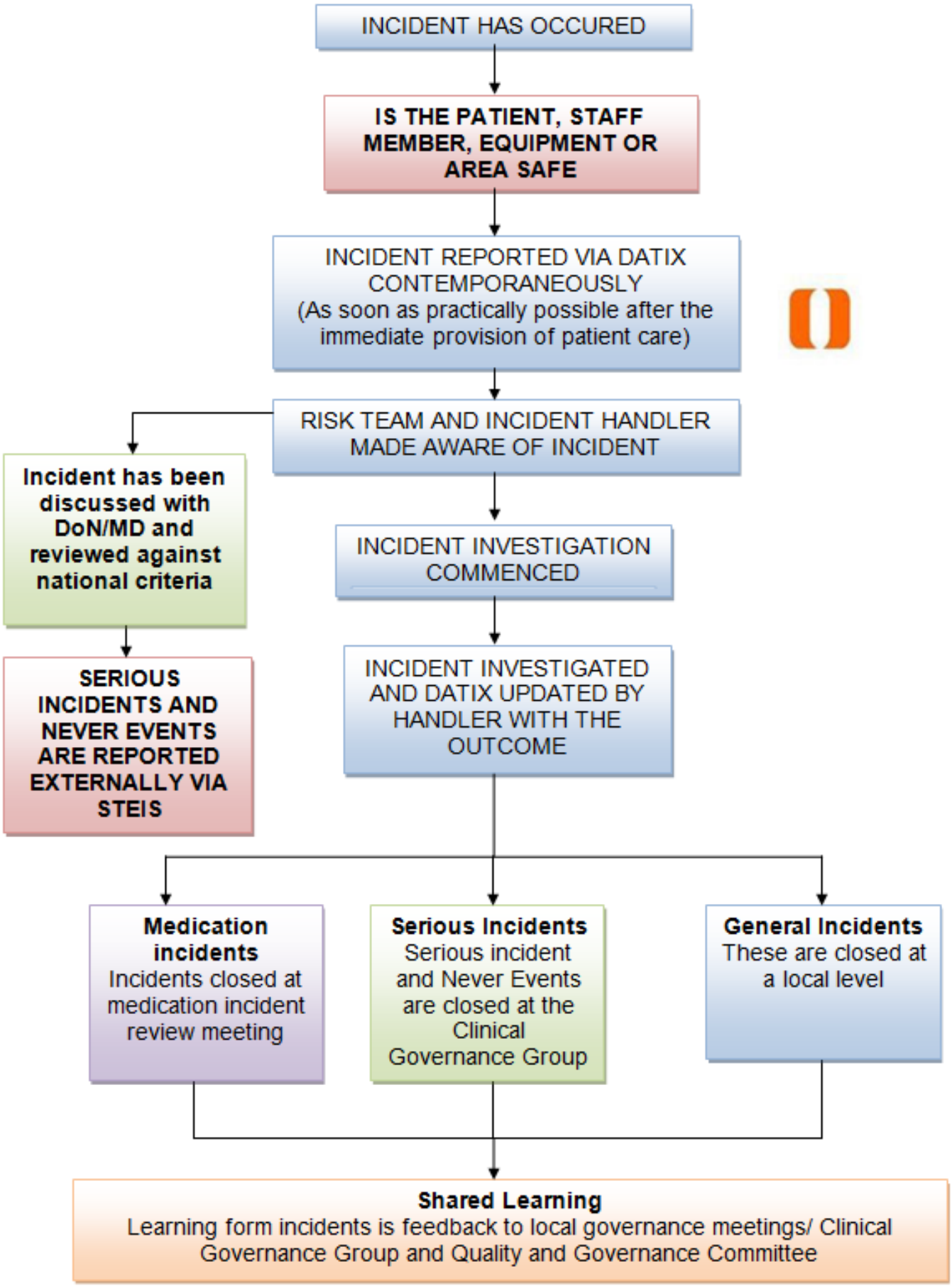
Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	05/01/17		**Agenda reference:**	**24-17**	
Report title:	**Risk Management and Incident Reporting Policy**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Alison Vizulis, Head of Risk				
Appendices:	None				
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:	Approval **Y**		Discussion **Y**		
Link to key strategic objectives (KSOs):	KSO1: **Y**	KSO2: **Y**	KSO3: **Y**		
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*		
Implications					
Board assurance framework:	Management of BAF as per Risk Management and Incident Reporting Policy				
Corporate risk register:	As above				
Regulation:	It is a requirement of NHSI and the CQC to have a current Risk Management and Incident Reporting policy, and a process to achieve its requirements.				
Legal:	Compliance with regulated activities in Health and Social Care Act 2014 and the CQC's Essential Standards of Quality and Safety.				
Resources:	No changes				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	08/12/16	Decision:	Approved	
Previously considered by:	Clinical Governance Group				
	Date:	12/12/16	Decision:	Approved	
Next steps:	For Trust Board ratification				

Queen Victoria Hospital NHS
NHS Foundation Trust

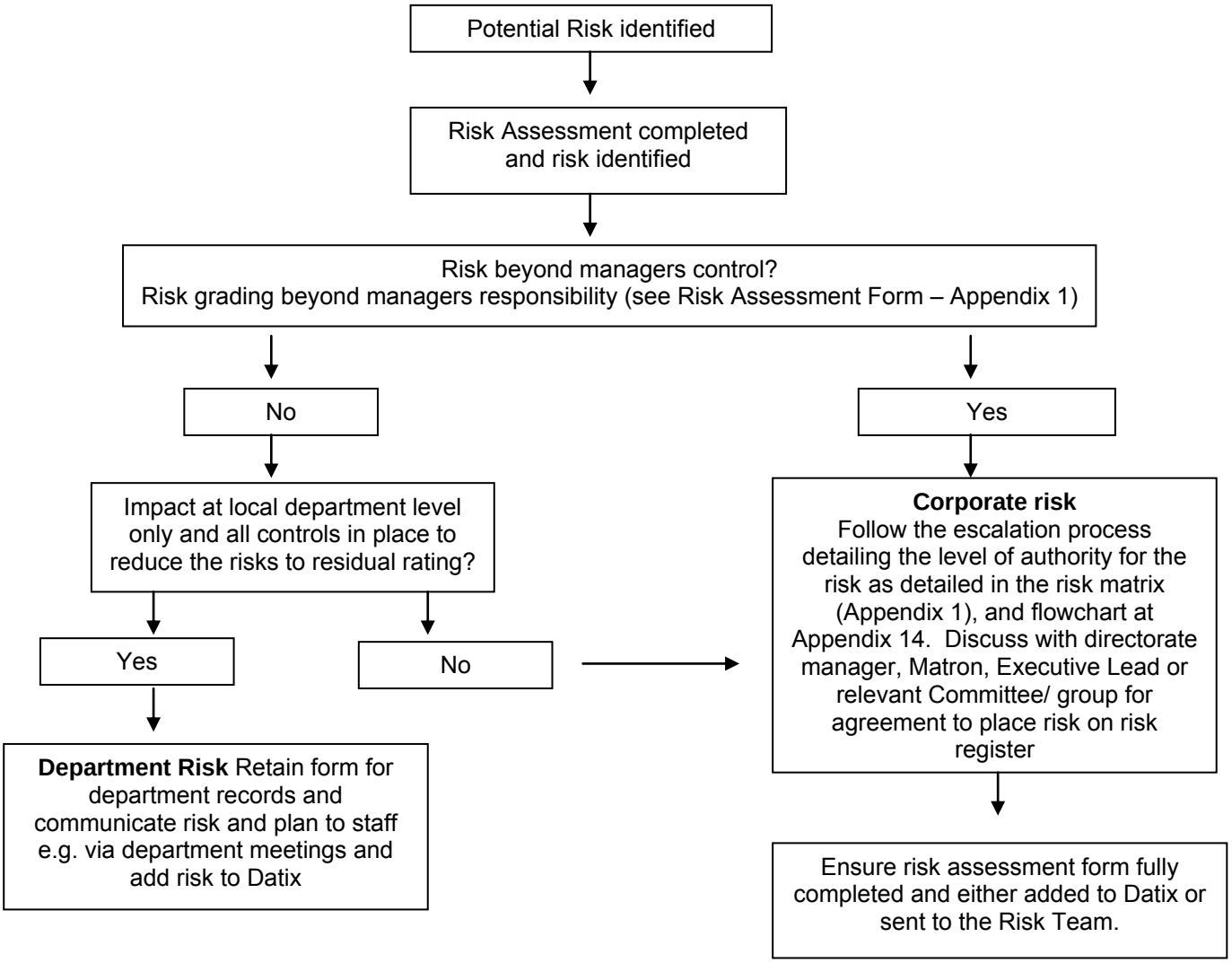
Risk Management and Incident Reporting Policy

CLASSIFICATION	Risk Management
TRUST POLICY NUMBER	RM.6003.6
APPROVING COMMITTEE	Quality & Governance Committee
RATIFYING COMMITTEE	Trust Board
DATE RATIFIED	13/10/2016
DATE FOR REVIEW	October 2018
DISTRIBUTION	All Staff
RELATED POLICIES (This list is not exhaustive)	Health & Safety Policy Information Security Policy Being Open Policy Claims Handling Policy Handling Complaints and Concerns Policy Risk Management Strategy Learning & Development Strategy Voicing Concerns (Whistleblowing) Policy Safeguarding policies (Paediatrics and Adult)
DIRECTOR LEAD	Director of Nursing & Quality
AUTHOR	Head of Risk
CONSULTATION	Q&R Committee members Clinical Governance Group members Internal & External Audit (List not exhaustive)
EQUALITY AND HUMAN RIGHTS IMPACT ANALYSIS	
THIS DOCUMENT REPLACES	RM.6003.5
This document is available in alternative formats upon request, such as large print, electronically or community languages. Learning and Development on 01342 414459	

Incident Reporting Flow Chart



Risk Reporting Flow Chart



Executive Summary

Risk Management

Risk management is the recognition and effective management of all threats and opportunities that may have an impact on the safety and quality of care, staff safety, organisational reputation, ability to deliver statutory responsibilities and the achievement of objectives and values.

QVH is committed to developing and implementing a risk management policy and processes that will identify, analyse, evaluate and control the risks to improve patient safety, support staff, and provide assurance to the Trust Board. The Trust endeavours to collate all information on incidents and risks by utilising an electronic Risk Management system (Datix).

Incident Reporting

The Datix system is used for all incident reporting across the Trust. There is a link to the system provided on every desktop computer in the form of "Risk Homepage" icon.

The line manager should complete the investigation within 10 days (moderate or greater cases may require longer) and record the details within the investigation section. The handler may be a different person to the line manager whilst the investigation is being undertaken. If additional information is required from other staff or specialist leads e.g. the Infection Protection and Control Team or Pharmacy, then the handler should be amended to the relevant lead for this area so that they can add a contribution to the investigation section of the incident report.

Once all relevant staff have completed their comments and the manager is satisfied that the investigation is complete; then the manager should change the handler to a Risk Team member, and select the incident as "awaiting final approval", where it is then checked and closed by the Risk Team.

The Risk Team will monitor the incidents on a regular basis, providing support and advice to managers and reporters. A full review of all incidents reported the previous month will be conducted by the Risk Team, to ascertain the actual or potential level of harm to patients and the potential level of risk. Shared learning is discussed at the Clinical Governance Group, Quality and Governance Committee and a range of forums e.g. Nursing Advisory Group.

Incidents of concern will be reviewed with specialist leads and Clinical Directors, with the 5 x 5 (four-colour) matrix also being used to assist in classifying incidents as internal "Red incidents" (major) or internal "Amber" incidents (moderate). All other incidents will be "closed" on the main system following investigation and finally approved on Datix if the investigation is deemed sufficient.

The grading process for incidents detailed in this policy within Section 5.1 and Appendix 1 should instigate the investigation level required.

The Risk Team and / or the Director of Nursing & Quality or the Medical Director will determine if an incident should be declared as a SI (including Never Events).

Examples of what constitutes an SI are detailed in Appendix 5 of this policy. If in doubt the Brighton & Hove Clinical Commissioning Group can be contacted for advice.

Risk Assessment
All risks should be recorded on the Trusts Risk Management system (Datix). On occasions e.g. as part of project management work, it may be more appropriate to maintain a separate risk register (or log) on an excel spreadsheet. If this option is chosen then an overarching risk should be added to Datix explaining that collated information on a range of risks is held elsewhere and a combined score allocated to the risk.

A Risk Assessment (Appendix 1) should be completed for all risks that are contained on the Datix system, and any risks scoring 12 and above will be included in the Corporate Risk Register. Risks scoring below 12 will be allocated to Departmental Risk Registers for local management.

A Risk Assessment is a careful examination of what could cause harm to staff, visitors, patients or the organisation. An assessment determines whether sufficient precautions are in place or more needs to be done to prevent harm. Risk Assessments should be conducted routinely when there is a change in practice or when a risk is identified.

Initially the Risk Assessment should be completed (either paper based or electronically on Datix) using the Risk Scoring Matrix detailed within the Risk Assessment form to quantify the risk. The Risk Assessment must then be passed to the appropriate manager and the escalation process followed as described in the Risk Assessment form and matrix (see Appendix 1).

Risks are routinely reviewed through regular Directorate, departmental or committee meetings. At these meetings there should be discussion and agreement on the description and rating on the risk and a review of the controls and actions to mitigate the risk. Information is documented in monthly/quarterly analysis reports.

The level of action is determined by the risk grading and is for guidance only. Where management action is insufficient to reduce the risk rating this should be escalated via the line management structure. Each new risk on the Register is assigned a responsible committee by the Risk Team where they will be monitored for progress.

The risk escalation and management process is detailed in section 4 of this policy.

Risks on the register can be closed once the required actions are completed and the risk score is reduced to the target rating. However, agreement to this must be with the risk owner and executive lead and / or the responsible Committee. The Risk Team will then, if in agreement, close the risk on the system. Although it may be closed, the risk will still be available for future reference. Local departmental risks not on the corporate risk register may be closed by the manager once the risk is mitigated or reduced to the target rating.

Contents

1 Introduction

1.1 The Trust aims to provide and maintain safe and healthy conditions for patients, staff and visitors. The Trust has a responsibility to ensure there are safe systems of work and that all employees have access to adequate information, training and supervision. The Trust is committed to creating a safe working environment, compliant with legal requirements.

1.2 Risk Assessment is a fundamental tool of risk management, the aim of which is to ensure, as far as is reasonably practicable, that there is limited harm caused as a result of the Trust's activities. This harm could be to patients, employees, visitors, others or the Organisation in respect of resources, reputation or a threat to organisational objectives.

1.3 Incident reporting is a fundamental tool of risk management, the aim of which is to collect information about adverse incidents including near misses, ill health and hazards involving staff, patients and others, which collectively help to facilitate wider organisational learning.

1.4 This Policy is intended to:

- Provide information and guidance to staff to enable them to assist the Trust in reducing incidents and managing risk effectively and in a "live" manner via the use of incident reporting and risk registers;
- Inform staff of the agreed procedures to follow when reporting an incident and / or identifying and assessing risk;
- Outline requirements for reporting incidents to external organisations;
- Ensure that lessons are learned and appropriate action is taken, monitored and evidenced following an incident to prevent, as far as possible, a recurrence.

1.5 This policy should be read in conjunction with the Trust's Risk Management Strategy which outlines the formal arrangements for risk management at the Queen Victoria Hospital, found on Qnet.

1.6 Definitions – see Appendix 9.

2 Scope

This policy applies to all employees of the Trust in all locations including Non-Executive Directors, temporary employees, Bank Staff, locums and contracted staff.

3. Duties

The duties of the committees involved in Risk Management are detailed within the Risk Management Strategy located on Qnet within the policies folder. The list below includes individual responsibility for Risk Management.

3.1 <u>All Staff</u>;
There is an expectation that all staff participate in work to reduce risk and improve the quality and safety of services provided. All staff have a responsibility to:

- contribute to the identification and mitigation of risk and improvement in quality and safety;

- familiarise themselves with relevant policies and maintain an awareness of relevant updates;
- report incidents in line with this policy and escalate issues that present a risk to the organisation or might compromise patient or staff safety;
- understand and follow the reporting procedures for incidents / near misses;
- be responsive to and share lessons learned from incidents / near misses;

3.2 Trust bank, locum or agency staff, visiting consultants, contractors and volunteers

There is an expectation that all bank, locum or agency staff, visiting consultants, contractors and volunteers will participate in reducing risk and improving the quality and safety of services provided, and this can be achieved by:

- Escalation of any identified risks and incidents to their line manager (should they not be able to report them directly);
- Becoming familiar with relevant policies/maintaining an awareness of relevant updates, an`d communicating any queries and issues to their line managers;
- Being responsive to and sharing lessons learned from incidents / near misses

3.3 Ward and Departmental Managers, Clinical Directors and Senior Managers (band 8 and above excluding Executive Directors)

Responsible for:

- working with directorate staff to ensure that new risks are identified and that existing risks are reviewed and monitored and that, where identified, action plans are developed and completed along with organisational learning;
- ensuring that corporate and department risks are presented at the Directorate / department meetings where appropriate, and that risks are escalated to the corporate risk register as detailed in the escalation process within this policy;
- ensuring that all risks are reviewed regularly within department and directorate meetings;
- taking a proactive approach to risk identification and ensuring that, where risks are assessed, mitigating action is identified and implemented;

encouraging staff to report incidents;

- Triangulating complaint information by ensuring that appropriate complaints and claims are also reported as incidents;
- supporting staff involved in an incident, complaint or claim;
- investigating incidents / near misses which occur within their department;
- taking action to minimise / prevent recurrence of such incidents;
- ensuring that systems are in place to feedback to staff from lessons learned from incidents / near misses including feedback at team meetings and via the learning log etc at the Clinical Governance Group;
- ensuring that actions are completed following incidents;
- co-ordinating and reviewing action plans arising from serious incidents and ensuring that improvement measures are implemented and effective;
- identifying within the Directorate patterns and trends that may assist in the prioritisation of future audit activity;
- ensuring that their staff are up to date with mandatory risk management training;
- disseminating this policy to their staff, in an appropriate format.
- The Clinical Directorate team has a collective responsibility to advise the Risk Team of any changes to the risks, or new risks that may impact on other parts of the organisation.

3.3 Patient Experience Manager

Responsible for reviewing, analysing and reporting claims and complaints internally and externally for sharing learning where required and for ensuring the process is

coordinated with the Risk Team responsible for incidents and risks. To support staff involved in a complaint or claim.

To ensure that any patient safety or potential safety issue reported as a complaint is notified to the Risk Team through the Trust's electronic reporting system, if not already completed.

3.4 Risk Management Team (Risk Team)

The Risk Management Team will be referred to as the Risk Team throughout this Policy. The main duties of the Risk Team including the head of Risk related to this policy are as follows;

- managing the incident reporting system and processes that provide information on issues of risk, patient and staff safety;
- producing monthly incident reports at Directorate and Trust level;
- producing monthly exception reports on risk management activity within the Trust;
- producing quarterly aggregated analysis reports for incidents mapped against complaints and claims;
- acting as the central body of knowledge, ensuring action plans are developed and completed where required;
- ensuring escalation via use of Risk Registers to the Quality & Governance Committee where identified risks are unable to be reduced by Directorates or departments;
- immediately escalating any concerns to the Director of Nursing or the Medical Director (as appropriate);
- ensuring that, where there is organisational learning as a result of investigations, this is disseminated to all relevant staff and teams;
- supporting staff involved in an incident, complaint or claim;
- completing incident investigations as appropriate;
- communicating incidents and learning as appropriate to external agencies;
- Health & Safety management;
- Risk representation at Directorate meetings.

3.5 Head of Risk

The Head of Risk is responsible for the Risk Team. Key duties of the post holder include establishing effective systems and structures for the identification, assessment, monitoring, control of risks and learning from incidents involving patient, staff and visitor safety across the organisation. To ensure that appropriate mapping and evidence collation for CQC and regulatory and best practice requirements are in place in relation to clinical and non-clinical risk management. The Head of Risk is the lead for risk management, supporting teams to implement best practice associated with effective systems of risk management, identification and dissemination of learning and appropriate governance reporting mechanisms. The Head of Risk also leads on Health and Safety compliance within teams and the Trust.

3.6 Director of Nursing (also the Caldicott Guardian):

The Director of Nursing and the executive lead with responsibility for managing the strategic development and implementation of Risk Management, and Quality.

The Director of Nursing is also the Caldicott Guardian for the Trust with overall responsibility for patient safety information governance related incidents, with operational aspects being undertaken by the Information Governance Manager.

3.7 Director of Finance (Senior Information Risk Officer, (SIRO))
The Director of Finance is the Trust's nominated SIRO and as such has the responsibility for managing information governance incidents and associated reporting which is undertaken operationally by the Information Governance Manager.

3.8 Medical Director
The Medical Director is the nominated "Patient Safety Champion", and the executive lead with responsibility for managing the strategic development and implementation of clinical governance.

Chief Executive
3.9 The Chief Executive has overall responsibility for risk management, delegating discrete responsibility to the appropriate Executive Director according to their portfolio.

4. Risk Management Processes

The Trust uses Datix to store and manage its information on risks, incidents, complaints and claims. The Risk Team act as system "Administrators" across all of the modules of Datix, and as such can provide and reset passwords and access levels. The Risk Team regularly upgrade the system when updates are released by the provider company. Emails are sent to staff to inform them of planned updates. Additions/redesign of the system can be undertaken to a limited degree by adding extra fields to accommodate certain material/subject matter. However, there is limited ability for this to be completed due to the National Reporting and Learning System (NRLS) mapping.

Managers are given access to Datix based upon individual requirements which are reassessed on a regular basis to ensure that they are commensurate with the remit of the roles that they are undertaking.

A summary flowchart of the steps involved in the identification and management of incidents is included at the front of this document, with more detail included at section 5.

5 Incident Reporting Process for reporting incidents/near misses involving staff, patients and others (see also **Appendix 3**)

The Datix system is used for all incident reporting across the Trust. There is a link to the system provided on every desktop computer via Qnet.

A copy of all of the incidents reported in the preceding month is added to Qnet e.g. October incidents are added in November. This list is added following completion of the monthly reporting that is undertaken by the Risk Team, thereby allowing data cleansing to have been completed.

A copy of the monthly trend analysis that is reported to Clinical Cabinet and the Trust Board is available for staff to view on Qnet each month.

Summary of timescales:

i. Reporting of incidents – ***As soon as is possible*** after the occurrence once patient safety has been assured. If this is not possible then at least by the end of the staff members shift.
ii. Identification of SI, red or amber incidents – ***As with (i) above***.
iii. Completion of investigation – ***Within 10 working days*** for no harm/minor harm and near miss incidents. ***Within 20 working days*** for moderate harm incidents and ***within 42 working days*** (where possible) for incidents graded as severe harm or catastrophic (also includes Never Events and Serious Incidents).
iv. Closure of incident – ***Within 14 working days*** of the completion of the investigation.

n.b. Serious Incidents should be reported on STEIS (the national SI reporting system) within 2 working days of identification.

5.1 Reporting and Investigating the Incident

Step 1
The reported completes the form (via Qnet) ensuring mandatory fields marked with a red star have been inputted, and then selecting the most appropriate manager to investigate the incident. The manager will be informed of the new incident by an automated email containing the relevant reference number and link to the incident. It is the individual reporting the incident responsibility to ensure appropriate action and or escalation is taken immediately to prevent further harm or complications to individual(s) concerned. Ideally the incident should be reported immediately after the event. If this is not possible it must be reported by the end of the shift. In the event of a staff member being unable to work the electronic system they must inform their line manager/site practitioner who can assist them in the process.

Step 2
The line manager should complete the investigation within 10 days (moderate or above cases may require longer) and record the details within the investigation section. Relevant documents, notification, or views from other managers can be accessed or added to the incident through Datix (advice and training on this can be provided by the Risk Team).

If information is required from more than one area e.g. the investigation is completed by the most appropriate manager this could be a Head of Nursing, Service Manager or Business Unit Manager with corresponding change of handler. This allows further information to be added by subsequent investigators or contributors. Once all managers have completed their comments on the investigation the incident is submitted to the Risk Team for review and closure.

Guidance on grading the incident can be provided from the Risk Team or from the Risk grading matrix within the Risk Assessment Form (**Appendix 1)**. Any incident of immediate concern must be escalated without delay to the appropriate line manager and the senior management team as detailed in the escalation process in Section 4.3 above (also within the Risk matrix on the Risk Assessment form **Appendix 1**).

Step 3
Once completed the manager should change the handler to a Risk Team member and select the incident as "awaiting final approval" where it is then checked and closed by the Risk Team.

Step 4
The Risk Team will monitor the incidents on a regular basis, providing support and advice to managers and reporters. A full review of all incidents reported the previous month will be conducted each month by the Risk Team as a minimum to ascertain the risk or potential risk of the incident. Incidents identified as being of concern or those that could generate a range of learning will be re-graded as internal "ambers" or "reds" using:

- The risk management grading matrix;
- Discussions with Clinical Directors/Specialist Leads;
- Discussions with the Head of Risk, Director of Nursing and the Medical Director.

All other incidents will be "closed "on Datix if the investigation is deemed sufficient.

5.2 Incident Reporting System Administration

Incident categorisation and severity gradings/ratings are reviewed regularly by the Risk Team and amended as required. Appropriate senior managers are assigned as handlers for incidents across the Trust. Changes to the online reporting form are made by the Risk Team as required and communicated to staff.

6 Levels of Investigation

6.1 Investigation triggers

The assigned manager for the incident (handler selected by reporter) will determine the level of severity by risk assessing the incident using the Risk Assessment Matrix (**Appendix 1**) (also included in the Datix investigation screen). The staff member should conduct the appropriate investigation, escalating the incident as described within Section 6.3 below. The Risk Team provides a 'safety net' for all incidents through the monthly review to ensure all appropriate levels of investigation are undertaken.

The Patient Experience Manager will receive complaints or claims and determine the level of investigation on a case by case basis.

The Coroner will advise on the actions required for an inquest in liaison with the Patient Experience Manager.

6.2 Determining the severity of an incident

The following National Patient Safety Agency definitions are used for the severity of an incident when considering the actual effect it had on a person:

- **Catastrophic** - Any unexpected or unintended incident which caused the death of one or more persons;
- **Severe (Major)** - Any unexpected or unintended incident which caused permanent or long term harm, to one or more persons;

- **Moderate** - Any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area and which caused short term harm, to one or more persons;
- **Low Severity -** Any unexpected or unintended incident which required extra observation or minor treatment and caused minimal harm, to one or more persons;
- **No Harm –** Any unexpected or unintended incident which ran to completion but no harm occurred;
- **Near Miss** - Incidents where harm was prevented from occurring.

The Trust Risk Matrix **(Appendix 1)** should be used by the manager responsible to determine the potential severity of the incident should it occur again or if a near miss has occurred, the possible consequences it could have by evaluating the likelihood of it recurring and the potential severity to produce the risk score.

All Moderate Incidents are graded as 'Amber' and all 'Severe' or 'Catastrophic' are graded as Red.

6.3 Level of investigation required

Not all investigations require a full Root Cause Analysis (RCA). The level of investigation conducted should be proportionate to the severity of the event. This decision should be taken by the appointed investigator, supported by advice given from the Risk Team which will be gained from the Clinical Director, Specialist Lead, Head of Risk, Director of Nursing and Medical Director. The severity of the event will be used as a key indicator to decide the level of investigation and RCA Report completion.

Below is a simple guide for investigation levels and incident grading/ratings:

- **Inquests** – See Appendix 4 for full criteria;

- **Legal Claims –** Refer to Claims Handling Policy located on Qnet under Corporate Policies

- **Complaints –** Refer to Handling Complaints & Concerns Policy located on Qnet under Corporate Policies

- **SI (includes Never Events), Severe (Major) or Catastrophic (also for any internal "red" incidents)** – A comprehensive (full) RCA is required and if necessary an incident investigation team to conduct the investigation. The appropriate Clinical Director is involved in the investigation and reviews the final report before submission to the appropriate committee. A comprehensive RCA is routinely conducted for all Never Events and MRSA bacteraemia and cases of Clostridium difficile;

- **Moderate Harm (also for any incidents identified as being an internal "amber"**) – A concise (short) RCA is required to compare the events of what did happen against what should have occurred and to identify any key learning points for dissemination. The Risk Team will liaise with the appropriate lead or Clinical Director and identify an investigation team, and the Clinical Director will review the final version of the RCA prior to submission to the appropriate committee. A full RCA can be requested if deemed necessary dependent upon the progression of the individual investigation;

- **Low Harm** – Local investigation by the manager usually requiring discussions with staff involved and review of notes / evidence. The actions taken are then recorded on Datix within the investigation section.

  If any moderate or severe consequences are deemed to be possible from a recurrent low harm event, the incident can be escalated by the Risk Team to an internal “amber” or “red” and an RCA will be required;

- **No Harm** – The same principles apply to the no harm investigation process

If the following types of incident occur, then a specialist RCA Report (adapted from the Kent, Surrey and Sussex Network), is completed:

- Hospital acquired, grade 2 or above pressure ulcer occur; or
- A patient fall with a severity of moderate or above.

Patient Safety incidents graded as moderate, major or catastrophic harm should be discussed with the patient as per the Being Open Policy and Duty of Candour legislation. Details of the incident and discussions should be recorded in the patient notes and on Datix. Information should include whether the incident has been discussed with the patient, their family and/or carer(s) (as appropriate) and where this occurred.

6.5 Recommendations and Action plans

For all investigations, it is good practice to consider whether actions are required for improvement or changes to practice. This will not be required in all cases (e.g. for some complaints and minor incidents). However, it is important that for each investigation it is demonstrable that consideration has been given to the root cause.

The investigation section of each incident within Datix is used to record the actions taken during the investigation. For Serious Incidents and internal “red” and “amber” incidents the trust “SMART” (Specific, Measurable, Achievable, Realistic, Timeframe) format action plan will be completed. Leads for identified actions should be informed of the required action and associated timescale before the RCA has been finalised.

Timescales and leads are agreed with the investigation team at the end of the investigation and are recorded on the action plan. The timescales allocated to actions within action plans should be realistic and should reflect Trust processes that may be involved e.g. review and update of a policy should allow for consultation processes, etc.

A completed RCA report can be closed by the Clinical Governance Group as any actions identified as being open will be transferred to the “Learning from Incidents Action Log”, which is maintained by the Risk Team. Action leads are responsible for completing the actions as per the nominated timescales (as per the Summary of Timescales at Section 5) and should inform the Risk Team when completion has occurred, providing the appropriate evidence to support this which is retained by the Risk Team.

The Clinical Governance Group reviews the “Learning from Incidents Action Log” at each meeting to monitor open actions to closure.

6.6 Incident Closure

It is essential that all incidents are followed up and reviewed prior to closure. The following criteria are used to close incidents at QVH:

Minor incidents (minor/no harm severity incidents) - Closed by the Risk Team during the monthly review mechanisms and once appropriate actions have been completed.

Serious Incidents, Red (High Risk) or Amber (moderate risk) incidents – The RCA Reports that are completed for this type of incident are reviewed as part of the Clinical Governance Group papers. The Clinical Governance Group approves closure of these incidents once corrective actions or action plans have been agreed. If any actions are identified as being open, these are then transferred to the "Learning from Incidents Action Log"

In addition to the above, all the incidents reported within the previous month are reviewed as part of the Directorate meetings, with a summary report identifying any trends. Issues of concern e.g. any internal "red" "amber" or Serious Incidents are discussed, along with the need to add any new risks to the Risk Register arising from the occurrence of an incident.

6.7 Triangulation and Dissemination of Learning from Incidents (including SIs)

The Head of Risk, Patient Experience Manager and the Quality and Compliance Manger (or appropriate representatives) meet at least six-weekly to correlate commonalities arising from the following:

- Internal "Red" or "Amber" incidents
- Serious Incidents
- Complaints
- Claims
- Local Clinical Audit Projects
- National Clinical Audits
- NCEPOD and associated studies
- NICE guidance

This meeting is also used to inform future work e.g. a clinical audit can be identified from the occurrence of an incident/complaint (or an incident/complaint trend). See also Section 12 for further triangulation work undertaken by the Trust.

The Head of Risk, Patient Experience Manager, and Head of Quality and Compliance meet monthly, and a summary triangulation report is compiled, which is reported in to the monthly Business Unit Performance Monitoring mechanism.

6.8 Internal Communication within the Organisation

Datix has a mechanism to allow feedback to be given to incident reporters once an investigation has been completed.

The following incident reports are available for staff to view on Qnet:

- A copy of all of the incidents reported in the preceding month e.g. October incidents are added in November. This list is added following completion of the monthly reporting that is undertaken by the Risk Team, thereby allowing data cleansing to have been completed.
- A copy of the monthly trend analysis reported to Clinical Cabinet and the Trust Board.
- A copy of the six-monthly Risk Report that has been reported to the Quality and Governance Committee.

Patient and staff safety incident and risk data is analysed and discussed at a range of meetings within the Trust, including:

- Trust Board - Monthly reporting;
- Clinical Cabinet - Monthly reporting;
- Quality and Governance Committee - Quarterly and monthly reporting.

Specialty/Directorate patient and staff safety incident and risk data:

- Business Unit Meetings – Monthly reporting;
- Medicines Management Optimisation and Governance Pharmacy Sub-Group;
- Medical Devices Group – Quarterly reporting.

Staff Safety incident and risk data:

- Health and Safety Group – Quarterly reporting – Staff safety incidents and risks.

7 External Reporting

7.1 The Risk Team reports patient safety incidents monthly to the National Patient Safety Agency (NPSA) through the National Reporting and Learning System (NRLS).

7.2 The Risk Team or the Trusts nominated leads will report incidents to external agencies. Examples of some of the external bodies are given below:

- Care Quality Commission;
- Lead commissioner and NHS South of England;
- Social Services;
- Health & Safety Executive;
- Business Services Authority (Counter fraud & Security Management);
- Security Incident Reporting System (SIRS) (where processes available to support this);
- Medicines and Healthcare Products Regulatory Agency (MHRA);
- National Health Service Litigation Authority (NHSLA) – Reported by the Patient Experience Manager;
- Other healthcare organizations with shared responsibility of care.

The Information Governance Manager reports Information Governance Incidents to the Information Commissioners Office (ICO).

A standard list of all reportable situations and to whom they should be reported is detailed within **Appendix 4**.

7.3 If an incident is caused directly as a result of a medicine, medical device, products or equipment then the staff involved must complete as much detail as possible, inform the Electro-medical Engineering (EME) Department/external maintenance company and inform the Risk Team at the earliest opportunity. The Risk Team will report the incident to relevant regulatory body. The drug, device or product must be removed from service if there is any doubt or concern as to the safety of the user or patient.

7.4 When a patient safety incident displays one or more of the following characteristics, the Trust should consider involving the police:

- Evidence or suspicion that the actions leading to harm were intended;
- Evidence or suspicion that adverse consequences were intended;
- Evidence or suspicion of gross negligence and / or recklessness in a serious patient safety incident, including as a result of failure to follow safe practice or procedure or protocols.

7.5 If the police or the Health and Safety Executive (HSE) are to be involved, the principals set out in the 'Memorandum of Understanding: Investigating Patient Safety incidents Involving Unexpected Death or Serious Untoward Harm' should be followed. The Memorandum sets out the general principles for the NHS, police and HSE to observe when liaising with one another. It focuses on investigating patient safety incidents in the NHS, although the principles and practices it promotes apply to other locations where healthcare is provided. Details of the Memorandum are available from the Risk Team, but can also be found on the Department of Health Website.

7.6 The lead commissioner should always be advised before the police or HSE are involved in any investigation.

8 Reporting Serious Incidents (SI)

8.1 The grading process for incidents detailed in this policy within Section 6.3 and **Appendix 1** should instigate the investigation level required. The Head of Risk, Director of Nursing and/or the Medical Director will determine if an incident should be declared as a SI. Examples of what constitutes an SI are detailed in **Appendix 5** of this policy and this includes incidents identified as "Never Events". The "NHS England Process for the Reporting and Learning from Serious Incidents Requiring Investigation 2015" details the requirements for dealing with an SI. This document is available from the internet or the Risk Team. Once agreed the following steps should be taken:

- Notify the lead commissioner (the Risk Team or Director of Nursing will normally do this) and agree the initial grading (detailed in **Appendices 1 & 3**) using the NPSA grading framework;
- Notify the Deanery if incident involves a doctor in training (see **Appendix 4**). The notification form is stored within the N:\Risk Management\SUI Info\SUI Incident Reporting Information folder;
- Ensure and patient safety incidents are uploaded to the NPSA through the NRLS system;
- Report the incident on the STEIS system on the internet within 2 working days (this is completed by the Risk Team, details of the process to be used are kept within the Risk Management/ SI shared folder);

- Complete the full RCA and report findings using the template at **Appendix 6**. During the investigation, an After Action Review (AAR) process should be considered. Advice on this is provided by the Risk Team;
- Send completed report (including action plan) to the Risk Team within the timescales detailed in the table below;
- The report will be submitted to either the Clinical Cabinet or Quality & Governance Committee for approval prior to sending to lead commissioner.

Level of investigation	Timescale to send to Risk Team	Timescale to report to CCG
1) Concise investigations (suited to less complex incidents managed locally)	30 working days	60 working days
2) Comprehensive investigation (suited to complex issues which should be managed by a multi-disciplinary team involving experts and/or specialist investigators)	30 working days	60 working days
3) Independent investigations (suited to incidents where the integrity of the internal investigation is likely to be challenged or other criteria as in the NHS England Framework)	45 working days	6 months of being commissioned.

**See also Appendix 6 for more detailed timescales*

8.2 **Allegation of abuse by a member of staff**

In the event of an allegation of abuse by a member of staff made by a patient or other staff member the situation must be dealt with immediately to ensure all parties involved are kept safe. The following must happen as a minimum:

- The department manager (site practitioner and on call manager out of hours) must be informed immediately;
- The accused staff member moved to another location or assigned tasks away from patients if any doubt over safety for others;
- If patient accused in 1:1 situation ensure two staff members attend needs until further notice;
- Inform police re allegation immediately so evidence can be obtained;
- Consider report as safeguarding issue;
- Record event on Datix system.

9 RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

Specified injuries

The following are reportable specified injuries if they arise 'out of or in connection with work'. The Risk Team must be informed immediately, to enable the Health and Safety Executive to be contacted within one working day of the accident

- fractures, other than to fingers, thumbs and toes;
- amputations;
- any injury likely to lead to permanent loss of sight or reduction in sight;
- any crush injury to the head or torso causing damage to the brain or internal organs;
- serious burns (including scalding) which: cover more than 10% of the body; or cause significant damage to the eyes, respiratory system or other vital organs;
- any scalping requiring hospital treatment;
- any loss of consciousness caused by a head injury or asphyxia;
- any other injury arising from working in an enclosed space which: leads to hypothermia or heat-induced illness; or
  requires resuscitation or admittance to hospital for more than 24 hours

Lost-time accidents to employees

Over-seven-day injuries
Accidents must be reported where they result in an employee or self-employed person being away from work, or unable to perform their normal work duties, for more than seven consecutive days as the result of their injury. The seven-day period does not include the day of the accident, but does include weekends and rest days.

Over-three-day injuries
You must record accidents, but not report them where they result in a worker being incapacitated for more than three consecutive days. If you are an employer, who has to keep an accident book, the record you make in this will be enough.

This list is not exhaustive therefore the Risk Team must be contacted for further assistance. See also Appendix 8.

10 Information Governance Risks and Incidents

Information risks and incidents can occur during the processing of person identifiable data. For further guidance refer to the Trust Information Security Policies located on Qnet. The Risk and Incident reporting processes within this policy and its supporting policies should be used for all information governance issues to ensure actions are aligned with Trust systems. This could be for a new information security procedure or an identified hazard for potential breach of person identifiable data.

All information governance incidents identified as being internal "reds", "ambers", or Serious Incidents, or those with a severity of moderate, major or catastrophic are assessed against the Health and Social Care Information Centre (HSCIC) Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious

Incidents by the Information Governance Manager, Head of Risk and Director of Nursing and Director of Finance.

The Information Governance Manager will report all of the above categories of information governance related incidents to the Information Commissioner's Office. The Director of Nursing (as the Caldicott Guardian) is responsible for those that are categorised as patient safety, and the Director of Finance is responsible for the remainder as the Senior Information Risk Owner (SIRO).

11 Raising Concerns

11.1 If a member of staff has serious concerns about the safety of patients or the conduct and performance of a colleague, then the Raising Concerns (Whistleblowing) Policy should be considered. This policy can be located on the Qnet. 'Whistleblowing' means alerting someone to malpractice or suspected malpractice within an organisation. The Public Interest Disclosure Act 1998 protects employees from being penalised for disclosing information or 'whistleblowing' about alleged wrong doing.

11.2 The Trust is dedicated to using the NPSA guidance and the Duty of Candour legislation for managing "Being Open" when communicating with patients, families and carers following a patient safety incident in which the patient was harmed. Refer to the Being Open Policy on Qnet for further information and guidance.

12 Coordination for Management, Analysis and Improvement of Incidents, Complaints and Claims

12.1 Please refer to the Claims Handling Policy and the Handling Complaints and Concerns Policy located on Qnet for details on the process of handling Claims and Complaints.

12.2 In order for the Trust and staff to learn from the reporting of incidents, complaints and claims, information needs to be aggregated from a number of sources, analysed for patterns and trends, and reviewed by services for the implementation of actions leading to improvement and increased patient and staff safety. Sources of information are collated by the Clinical Audit Department in liaison with other departments and may include:

- risk assessments;
- reported incidents and subsequent learning;
- reporting from patients/carers and subsequent investigation of complaints;
- investigation of claims or independent reviews;
- recommendations made by the Coroner and solicitor (inquest action plans);
- issues identified from supporting staff through investigations or inquests etc;
- external patient safety alerts;
- national guidance;
- quality dashboard;
- patient experience.

Concerns or issues identified from this information are addressed on an ongoing basis at the appropriate committee or directorate. For example the "Learning from Incidents Action Log" and external patient safety alerts are presented to the Clinical Governance

Group (process for dealing with CAS alerts is given at Appendix 13). When an issue is raised each responsible committee should consider the following:

- the need to target resources on risk reduction (or mitigation) measures to achieve the best benefit or gain for patients, staff and the Trust as a whole – This may include utilising projects or initiatives for more than one outcome;
- key performance indicators that are needed to measure safety;
- the effectiveness of specific safety campaigns or initiatives;
- how best to target training to manage risk and improve patient safety.

12.3 The Head of Risk notifies the Patient Experience Manager if it is suspected that an incident may lead to a complaint or claim. The Patient Experience Manager in turn notifies the Head of Risk if it is identified that a complaint/claim could have arisen from an incident to double check that it has been previously reported.

13 Process for the aggregation of incidents, complaints and claims

13.1 Incidents are reported through the electronic reporting system as described within this policy and are reviewed on a monthly basis by the Risk Team and additional committees and groups. The Risk Team will ensure that all incidents are followed up by the manager and close the incident if the correct actions have been taken or will grade/rate incidents to internal "red" or "amber" as per Section 6 above. The Risk Team will report the incident externally where required as detailed in Section 7.

13.2 Complaints and claims incident data is recorded in a similar way on the Datix system. Although there is no mandatory requirement to upload this information to NHS England through the NRLS, a best practice check is made to link incidents, complaints and claims as this provides a succinct record of an individual event.

Information on linked complaints, claims and incidents is reported in the quarterly Risk Reports to the Quality and Governance Committee, with the aim of demonstrating whether or not the Trust had recognised things that could have gone wrong prior to the occurrence of a complaint. This aggregation of data also allows a more coordinated and thorough approach to the investigation of incidents, complaints and claims to avoid duplication of effort.

14 Identification, Assessment and Management of Risks

The following steps are involved in the management of risks at QVH:

- Risk identification;
- Risk assessment;
- Addition of new risk to appropriate Risk Register;
- Monitoring of risk(s) on Risk Register;
- Risk closure once fully mitigated/risk level accepted;
- Management responsibility and escalation for levels of risk;
- Types of Risk Register and minimum contents.

14.1 <u>Risk Identification</u>

Risk identification is a key component of a robust Risk Management Framework. In the absence of a risk identification process, the organisation is unable to effectively manage its key risks and demonstrate whether "control" is being maintained.

Risk identification is the process of determining risks that could potentially prevent the organisation from achieving its objectives. For QVH this includes the provision of safe patient care, clinical excellence, outstanding patient experience, World class clinical services, and financial stability and sustainability.

14.2 Risk Assessment - Completing a Risk Assessment

A risk assessment is a careful examination of what could cause harm to staff, visitors, patients or the organisation. An assessment determines whether sufficient precautions are in place or more needs to be done to prevent harm. Ward and Departmental Managers, Clinical Directors, Senior Managers and Executive Directors are responsible for ensuring risk assessments are undertaken in their area and can seek advice from the Risk Team (See also definitions in section 1.6). Risk Assessments should be conducted on a continual basis whenever a risk is identified through a variety of sources such as:

- Following a service review or inspection;
- Following an incident, complaint or claim with a high potential to reoccur even after investigation and actions completed;
- Following a change in legislation or guidance;
- Following poor audit results;
- For planned environmental risk assessments;
- Following results of performance and target ratings;
- Following identification of a hazard or potential harm to patients, staff, others and the organisation;
- Ability to meet a key strategic objective;
- Ability to meet external targets or assessments e.g. surveys

The risk assessment must be completed as soon as practicable once the risk is identified. This will be determined on discussion at meetings and or the availability of specialist advisors. If there is immediate concern the escalation process detailed in Appendix 1 must be followed.

The five steps listed below should be followed to complete an assessment with advice available from the Risk Team:

Step 1- Look for the hazards

Consider all the work activities carried out in an area or department, ward or Directorate and select those risks (including financial risks) which have a potential to cause harm to patients, staff, visitors or the organisation. The hazard may already have been identified through the reporting of an incident on the Datix system or potential failure to a target or standard.

Step 2 - Decide who / what might be affected and how

Consider:

- patients;
- all persons normally working in the Ward or Department;
- visitors and those who may not work in the Ward or Department all the time;
- equipment;

- objectives, targets, standards such as Care Quality Commission;
- the Organisation.

Include people you share the workplace with who may be harmed by the activities, including contractors, maintenance workers etc.

Step 3 – Evaluate the risks and decide whether existing precautions (controls) are adequate or more should be done (actions)

Consider:

- how likely it is that each hazard could cause harm? What will the potential impact be? This will determine whether or not more needs to be done to reduce the risk;
- whether the requirements of the law and best practice have been met;
- whether general or specific safety standards are in place;
- quantifying the risk using the Trust Risk Scoring matrix located on the Risk homepage on each desktop computer within the Trust, and at **Appendix 1**.

Step 4 – Record the findings

A record must be kept of any significant findings of the assessment. This means recording the significant hazards and conclusions, clearly indicating existing controls and further actions necessary to reduce the risk to the lowest possible level.

Initially the Risk Assessment (Appendix 1) should be completed (either paper based or electronically on Datix) using the Risk Scoring Matrix also detailed within the Risk Assessment form to quantify the risk. The Risk Assessment must then be passed to the appropriate manager and the escalation process followed as described in the Risk Assessment form and matrix and the risk should be added to Datix, which will lead to it being added to a Risk Register (See Section 14.3).

Step 5 – Review

Risks are routinely reviewed through regular Directorate, departmental or other committee meetings. At these meetings there should be discussion and agreement on the description and rating on the risk and a review of the controls and actions to mitigate the risk.

It is also necessary to review the risk assessments when:

- there has been an associated incident or near miss, or trend identified;
- there has been a change in environment;
- there has been a change in process;
- a new procedure is proposed
- new equipment is proposed

Once a risk has been identified and communicated across the organisation it is essential it is managed until reduced to the residual rating or eliminated completely. The level of action is determined by the risk grading and is for guidance only. Where management action is insufficient to reduce the risk rating this should be escalated via the line management structure. Each new risk on the risk register is assigned a responsible committee and an Executive Director by the Risk Team where they will be monitored for progress. The committees are detailed within the Risk Strategy located on Qnet. A number of risks on the risk register may not fall within a specific committee however are still monitored through the individual process detailed below:

- Risk identification;
- Risk assessment;
- Addition of new risk to appropriate Risk Register;

- Monitoring of risk(s) on Risk Register;
- Risk closure once fully mitigated/risk level accepted;
- Management responsibility and escalation for levels of risk;
- Types of Risk.

15 Risk Registers

15.1 Addition of a new risk to a Risk Register – As per Step 3 of Section 14

New risks are added to the Datix system by either the Head of Department or the Risk Management Team. Risks are assigned a risk owner (or handler) on the Datix system and the seniority of the handler is based upon the risk score e.g. risks assigned to the Corporate Risk Register will have a senior manager as the risk owner.

Every risk on Datix is aligned to a specific group or committee for monitoring purposes (as per the Risk Management Strategy) and each risk also has an Executive Director lead that is responsible for ensuring the risks are monitored and reviewed in accordance with this policy. A nominated committee or group is added to each risk.

A summary of all new risks are added to a tracker sheet by the Risk Team and this is used to inform reporting for a range of committees and groups e.g. Clinical Cabinet and Trust Board.

Should duplicate risks be identified, information is combined in to one risk with the duplicate being rejected.

15.2 Monitoring of risk(s) on Risk Register – See Step 4 of Section 14

Risks are monitored at a range of committees and groups, including those with a specialist subject matter e.g. Infection Prevention and Control Committee, Medical Devices Group, Health and Safety Group. Escalation/de-escalation of risk scores/ratings may be undertaken as part of the risk review and monitoring process. Changes to risk scores/ratings will routinely be generated as an outcome of the completion of actions, which in turn can often be transferred to become controls. A summary of changes that have been applied to risk scores is added to a tracker sheet by the Risk Team and this is used to inform reporting for a range of committees and groups e.g. Clinical Cabinet and Trust Board.

The following risk register report (monthly list of risks) is available each month for staff to view on Qnet:

- A copy of all of the open risks. This list is added following completion of the monthly reporting that is undertaken by the Risk Team, thereby allowing data cleansing to have been completed. It contains all open risks at the time of reporting and can be exported and sorted by a range of fields including Executive Director Lead, and risks scoring 12 and above (the corporate risk register). Additional support in accessing and interpreting this information can be obtained from the Risk Team if required.

15.3 Risk closure once fully mitigated/risk level accepted: See step 5 of section 14

Risks on the register can be closed once the required actions are completed and the risk score is reduced to the target rating. However, agreement to this must be with the risk owner and executive lead and / or the responsible Committee. The Risk Team will then, if in agreement, close the risk on the system. Although it may be closed, the risk

will still be available for future reference.

Local departmental risks may be closed by the manager once the risk is mitigated or reduced to the target rating. Risk owners are advised to engage team members in the discussions surrounding the closure of risks prior to this being completed.

Details of closed risks are summarised on a monthly tracker sheet and then transferred for reporting to a range of committees and groups e.g. Clinical Cabinet, Trust Board, Clinical Governance Group and Quality & Governance Committee.

A summary of all closed risks are added to a tracker sheet by the Risk Team and this is used to inform reporting for a range of committees and groups e.g. Clinical Cabinet and Trust Board.

15.6 Management responsibility and escalation for levels of risk – See step 6 of section 14

It is important for staff members and managers to be clear on the level of authority applied to a risk and its monitoring. The Risk Matrix in **Appendix 1** of this policy includes a chart under the Risk Assessment Matrix section that details the authority that staff have when identifying risks and what escalation actions they should undertake.

The flow chart at Section 4.1 explains the process to follow once a Risk Assessment has been completed and acts as a guide for managers when deciding whether the risk can be managed at a department/local level or if it needs to be placed on the Corporate Risk Register.

In summary, this determination will depend upon the risk score, as below:

- All risks with a score/rating of **12 and above** will be included and monitored as the Corporate Risk Register.
- All risks with a score/rating of **less than 12** will be included and monitored as the Department/Local level Risk Register.

The following table denotes the management responsibility for risks:

Risk Grading	Manager Responsibility	Monitoring Committee/Group	Frequency of Risk Review
Risk score/rating of 10 or below Very low or Low (1-10)	Department manager/risk lead is the handler	Departmental risk – reviewed at department/directorate meetings	At least once a quarter (3 monthly)
Moderate (12-15) OR High (16-25)	Service Manager, Matron, Clinical Director or Directorate Manager will be assigned as the risk lead. Directorate Manager, Clinical Director or Executive lead will be the risk owner.	Directorate meetings, Clinical Cabinet and Trust Board Directorate meetings, Clinical Cabinet & Trust Board	At least once a month

15.7 Types of Risk Register and minimum contents – See Step 7 of Section 14

There are four main types of Risk Register in use at QVH:

- Board Assurance Framework (BAF)
- Corporate Risk Register
- Department/Local Risk Register

- Project Risk Register

15.7.1 Board Assurance Framework (BAF)
The Board Assurance Framework (BAF) contains any identified risks to the Trust not achieving its key strategic objectives, and it is owned and reviewed at Trust Board level.

The BAF is managed and overseen by the Head of Risk, and it is updated monthly by the responsible Director on Qnet. The BAF is reviewed monthly as part of the Executive Management Team meeting, and is reviewed by each relevant committee of the Trust Board, with the whole BAF being reviewed at every Board meeting. There is a periodic review of the BAF at the Audit Committee.

An example of the format of the BAF is given at **Appendix 13.**

15.7.2 Corporate Risk Register
This is a register and record of all risks to the organisation that score 12 and above. It is a dynamic document which is constantly changing as new risks are added, controls and actions to mitigate risks updated, and existing risks closed or reduced. The Corporate Risk Register is designed to provide overarching analysis for all types of risk e.g. from incidents, complaints, claims, standards, targets and follows a standard presentation format (**Appendix 2**) It must contain as a **minimum** the following;

- Identification number;
- Date risk opened;
- Title;
- Executive lead;
- Risk owner;
- Risk type;
- Source;
- Current rating;
- Residual rating;
- Description;
- Controls and actions;
- Date reviewed.

15.7.3 Department / local level Risk Register
As described in the definitions of this policy, low level risks (those having a score/rating of 10 or below) are recorded on department/local level risk registers by managers and the Risk Team. This information is retained in the Datix system. The risk score must be assessed using the Trust risk matrix detailed in Appendix 1.The minimum data must include the following;

- Date risk opened;
- Description;
- Current rating;
- Residual rating;
- Controls and actions;
- Date reviewed.

15.7.4 Project Risk Registers
Risks identified as part of specific project management should be listed by the

nominated Project Manager when creating the project documentation. The format of this can be discussed with the Risk Team. As a minimum, a list of risks should be developed in an Excel spreadsheet, with a summary risk added to Datix to capture the overall description and scoring. The minimum field headings should be as follows:

- Date risk opened;
- Description;
- Current rating;
- Residual rating;
- Controls and actions;
- Date reviewed.

16 Frequency and minimum content of report on incidents, complaints and claims

16.1 Organisational Overview Report

A Quarterly Risk Report is produced by the Risk Team and presented to the Quality & Governance Committee with the aim of giving a risk profile overview of reported incidents, claims and complaints. The report includes quantitative and qualitative data from incidents, complaints, claims and other data, as a minimum the report includes:

- Reporting trends across the Trust including near misses;
- Reporting trends across Directorates including near misses;
- Types of incidents and complaints;
- Severity of incident or events;
- Serious Incidents including 'Never Events' root causes and lessons learned;
- Information on inquests and claims;
- Open actions from the "Learning from Incidents Action Log";
- Compliance of response to safety alerts;
- Notification of incidents to CQC which will include: deaths caused by consequence of service and not the illness or condition being treated, applications for deprivation of liberty, outbreaks of infectious disease;
- Incidents that have had an impact on the Trusts ability to deliver the service;
- Monitoring of outcomes and trends from falls, pressure sores and medication incidents;
- New and Closed risks during the quarter and information on risk score/rating changes;
- Triangulated information on Complaints, Incidents and Claims

A separate, monthly exception report is produced for the months occurring in-between the quarterly reporting to the Quality and Governance Committee to highlight any specific points.

Information from the report may be analysed against NPSA data to benchmark against other Trusts if the Risk Team, however, due to time-lags in data availability this has been identified to be of limited benefit.

Where specific trends are identified to a Directorate they will be notified requesting discussion at the Directorate meeting, and actions implemented to resolve the issues.

16.2 Communication of Reports to an Individual or Group

The quarterly Risk Report presented to the Quality & Governance Committee is published on Qnet to ensure all staff and managers have access to them.

A monthly report containing all incidents and risks, claims and complaints is produced and discussed at each specific directorate meeting. Wherever possible a Risk Team member attends the meetings to provide consistency and knowledge outside of the service on similar behaviours, patterns or trends. In addition, standard reports are established on the Datix system for each Matron, Directorate Manager or Clinical Director to access and view aggregated trends on issues such as reporting rates, harm rates, falls etc in any specific timeframe. If there are issues or concerns from these reports they can be discussed at the Directorate meeting. Feedback to individuals from the Directorate meetings must be completed through local departmental meetings.

The Risk Team also produces a monthly Patient Safety Dashboard containing aggregated analysis of falls, harm events, early warning system compliance and reporting rates. This is discussed at the monthly Clinical Governance Group and is available for all staff to view via Qnet. New or progress to current Complaints and Claims are discussed at the Directorate meetings to ensure they link with incidents and risks.

A range of other reports are developed and presented for specialist groups or individuals on request, e.g. Blood Transfusion, Medical Devices, Data Protection to assist with the identification of areas requiring improvement, and associated remedial work. These groups will formally report back through the committee reporting structure detailed in the Risk Management Strategy.

17 Learning from analysis of the aggregated reports

All Directorate meetings include a standing agenda item for Quality & Risk issues and, as mentioned above in Section 14 are discussed with the Risk Team representative in attendance. Any lessons learned and changes made as a result of an investigation should be fed back to staff involved by the Matron or Clinical Director so they can see that the Trust is committed to improving the quality of care that patients receive. All staff contributing to any investigation should be given the opportunity to view the outcome, whether this is an SI report or response to a less serious letter of complaint. Lessons learned/changes in practice as a result of a clinical incident, complaint or claim will be raised at departmental meetings and more widely disseminated through the Directorate. Issues effecting the whole organisation are fed back to the Clinical Cabinet through the directorate committee minutes and by the individuals attending the meeting. Evidence of organisational learning will be detailed through the Minutes of the meeting or within the “Learning from Incidents Action Log” presented and monitored through the Clinical Governance Group. Organisational learning is also through the quarterly Risk Report submitted to the Quality & Governance Committee.

Sharing lessons learned with other organisations is achieved through the reporting of incidents via the National Reporting and Learning System (NRLS) (see Appendix 10 for processes) to NHS England and the Clinical Commissioning Group (CCG) (if declared as an SI) and to the organisations detailed in Section 7 of this policy.

18 Changes in Practice

Lessons learned from incidents, claims and complaints resulting in a change in culture and practice are shared back to each department through the Directorate meetings, through the "Learning from Incidents Action Log" submitted to the Clinical Governance group, through the quarterly Risk report submitted to the Quality & Governance Committee and available to all staff on Qnet.

Matrons are responsible for ensuring that organisational policy change is implemented in their respective areas, either directly or through various committees within the organisation. Where Trust-wide training needs are identified, these should be submitted for consideration to the Learning & Development Operational Group.

19 Risk Reduction Measures

Risk reduction measures following incidents, complaints or claims should be acted upon immediately by the department or Directorate responsible. However, if there are costs requiring additional funding, or delays to this process, a Risk Assessment should be completed and the process followed within this policy to determine whether the risk should be placed on the Risk Register. The risk will then be continually monitored until reduced to residual rating, or escalated through the organisation as detailed in Section 4 according to the requirements for the level of risk. If appropriate a business case may require completion.

20 Support for Staff

All staff must be encouraged to report incidents and concerns and know that they will be supported if involved in stressful / traumatic situations. Supporting arrangements are detailed in Appendix 7 which documents the responsibilities of individuals and departments to support staff, the timing and types of support available, and the monitoring of the management of staff welfare

21 Training and Awareness

The following Risk Management and Health and Safety training is available for staff as a minimum, however, additional courses may be added as required or developed:

- Included within staff induction (one-off) – Basic overview of Risk Management, and includes incident reporting and risk identification processes.

- Statutory and Mandatory Risk Management and Health and Safety Training (three-yearly attendance) – Detailed information on Risk Management and Health and Safety. Includes refresher sessions on incident reporting and investigation and risk identification and management processes.

- Essential Risk Management Course (available twice yearly) (three-yearly attendance) – One day course Detailed information on incident and risk reporting and management processes, also includes health and safety and human factors information.

- Ad hoc Risk Management Training provided to Directorates/Specialties as requested (as required) – Bespoke sessions provided at request.

- Ad hoc Datix training provided to individuals and Directorates/Specialties as requested (as required) – Bespoke sessions provided at request.

- Control of Substances Hazardous to Health (COSHH) training (available twice yearly) (three-yearly attendance) – 2 hour session on COSHH assessment and management.

21.1 Recording, monitoring and following up non attendance

Details on booking and recording attendance of Risk Management and Health and Safety training is detailed in the Learning and Development Strategy. The Director of Nursing will ensure the attendance list from the Board of Directors training is sent to the Staff Development Centre for recording onto the Trust Learning Management System. Attendance information will be retained by the Learning and Development Department.

Staff identified as having out of date Risk Management and Health and Safety training will be followed up as per the standard Trust non-attendance processes as described within the Learning and Development Strategy. Monitoring of attendance levels will be included within the normal mandatory training reports as detailed in the learning and development strategy.

22 Equality

This policy and protocol will be equality impact analysed in accordance with the Trust Procedural Documents Policy, the results of which are published on our public website and monitored by the Equality and Diversity team.

23 Review

This policy will be reviewed in 3 years' time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

24 Monitoring Compliance with this Policy

The Risk Team has overall responsibility for monitoring the effectiveness of this policy. The following table details additional monitoring for this policy;

Activity being monitored	Methodology to be used for monitoring	Responsibility for monitoring	Frequency of monitoring and reporting	Process for review, action/ improvement
Risk Awareness Training for Senior Management				
Risk Management training attendance including Trust Board members	Ongoing attendance reporting and follow ups	SDC	Monthly	Included within Committee training reports.
Risk Management Process				
Risk identification and Assessment and use of the Risk Register	Ongoing review of risk assessments and risks added to the risk registers (corporate and local/department)	Risk Team	Monthly reporting	Q&G & Business unit meeting reports Committee and other committee reporting
Supporting staff involved in an incident, complaint or claim				
Supporting staff The immediate support offered to staff (internally and, if necessary, externally) The ongoing support offered to staff (internally and, if necessary, externally) The advice available to staff in the event of their being called as a witness (internally and, if necessary, externally) The action for managers or individuals to take if the staff member is experiencing difficulties associated with the event	Case reviews	Head of Risk	Annual Q&R Report	Q&G Committee
Incident Reporting & Investigation				
Reporting and investigation processes of all incidents/near misses involving staff, patients and others The process for reporting to external agencies and shared learning	Quarterly and monthly risk reports.	Head of Risk	Monthly and Quarterly reporting Annual summary report	Head of Risk to follow up poor compliance Q&G Committee and other committee/group reporting and follow up of actions and poor compliance
The processes for staff to raise concerns, e.g. whistle	Case reviews and monthly and	Head of Risk	Monthly and quarterly	Included within Risk Reports and

Activity being monitored	Methodology to be used for monitoring	Responsibility for monitoring	Frequency of monitoring and reporting	Process for review, action/ improvement
blowing/open disclosure	quarterly reporting			other committee meeting reporting.
Investigations				
The process for staff training requirements for investigation and reporting incidents	Staff training report	Staff Development Centre	Quarterly	Reported to Learning & Development Strategy Group for review and subsequent actions.
How actions are followed up (Incidents, Complaints & Claims)	The "Learning from Incidents Action Log" reported to the Clinical Governance Group	Head of Risk	Monthly	Clinical Governance Group review and action as required.
Analysis & Improvement				
How incidents, complaints and claims are analysed	Risk reports Risk Team and PALS Claims and Complaints meeting notes	Head of Risk	Quarterly Monthly	Quality & Governance Committee reporting. Identified actions within minutes and followed up at following meeting by Chairperson.
How action plans are followed up and dissemination of learning	"learning from incidents action log" reported to the Clinical Governance Group" Dissemination of Risk Management Newsletter with key learning points Discussions at team/dept meetings	Head of Risk	Monthly	Clinical Governance Group review and action as required. Copies of newsletter and dept minutes
Timescales for minimum requirements for analysis and improvement.	Frequency of reports to Quality & Governance Committee "Learning from incidents action log" reported to the Clinical policy Committee	Patient Safety and Governance Manager	Quarterly Monthly	Quality & Governance Committee will review and action poor compliance Clinical Governance Group follow up overdue actions.

25 References

- Revised Never Events Policy and Framework (NHS England, 2015)
- Revised Serious Incident Framework (NHS England, 2015).
- Duty of Candour (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 (Department of Health, 2014)
- Health and Social Care Act (Department of Health, 2012)
- Seven Steps to Patient Safety for Primary Care, National Patient Safety Agency, 2005.
- Memorandum of Understanding: Investigating patient safety incidents involving unexpected death or serious untoward harm; a protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and Health and Safety Executive, 2006.

Appendix 1

Queen Victoria Hospital NHS
NHS Foundation Trust

Risk Assessment Form

Activity (or area) being assessed			
People/Service affected by the risk *Tick all that apply*	Patient ☐ Contractor ☐	Trust Staff ☐ Agency/locum ☐	Visitor/Relative ☐ Other *(eg service)* specify……
Directorate			
Location			
Name of assessor			
Name of specialist advisor (if required)			
Date of assessment			

What is the hazard / risk? Something which has the potential to cause injury, illness, harm, loss or damage – **Please keep brief (less than 30 words)**				
Say how the hazard / risk could cause harm Give a **very brief description** of the risk scenario or event.				
Existing controls in place. What is already in place to reduce the likelihood or consequence (severity) of harm occurring? Such as preventative measures, corrective measures (contingency planning), direct controls to ensure particular outcome achieved and monitoring controls such as audit and checking activities.	1. 2. 3. 4. 5. 6.			
Risk Rating (*Rate from 1 to 5 for consequence and likelihood using the risk matrix)*	**Severity (Consequence):**		**Risk Score**	
	Likelihood:			

Proposed action What action can be taken to implement new controls to reduce the likelihood and/or the consequence (severity) of the risk? **State who is responsible for implementing each action.** What is the timescale for implementation?	1. 2. 3. 4. 5. 6.			
Risk Rating after proposed action for new controls in place Re-assess the likelihood and consequence (severity) to show how the proposed action will be effective in reducing the risk. Consider controls for preventative measures, corrective measures once risk occurs, direct control to ensure particular action achieved and any monitoring controls.	**Severity (Consequence):**		**Risk Score**	
	Likelihood:			
Date risk discussed / approved				
Committee responsible for the risk.				

Risk Assessment

Identify the risk (following an incident, routine risk assessment, change in practice or process) using the process detailed below and then record evaluate and rate the risks in terms of severity and likelihood on the Trust's Risk Assessment Form. Consider existing precautions and reflect these in the rating.

Risk Assessment Matrix - This is formed from the Severity (Consequence) x Likelihood = Risk Grading

		Likelihood				
		Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Severity (Consequence)	Catastrophic 5	5	10	15	20	25
	Major 4	4	8	12	16	20
	Moderate 3	3	6	9	12	15
	Minor 2	2	4	6	8	10
	Negligible 1	1	2	3	4	5

Very Low	Take action to mitigate and where possible close risk. If risk beyond manager's control discuss with line manager and member of the Risk Team or discuss at Directorate meeting and agree to placement on corporate risk register. Send risk assessment form to the Risk Team.
Low	Take action to mitigate and where possible close risk. If risk beyond manager's control discuss with line manager and member of the Risk Team or discuss at Directorate meeting and agree to placement on corporate risk register. Send risk assessment form to the Risk Team.
Moderate	Take action to reduce risk. Ensure Directorate Manager or Matron informed (or on call manager if out of hours). Contact the Risk Team within 24 hours. Send to Risk Team. Discuss at Directorate meeting and agree to placement on corporate risk register. Risk escalated to Clinical Cabinet and Board.
Major	Take action to reduce risk. Ensure Directorate Manager or Matron informed (or on call manager if out of hours). Contact the Risk Team within 24 hours. Send risk assessment form to the Risk Team. Discuss at Directorate meeting and agree to placement on corporate risk register. Risk escalated to Clinical Cabinet and Board.
Catastrophic	Take action to reduce risk. Ensure Directorate Manager or Matron informed immediately (or on call manager if out of hours). Contact the Risk Team within 24 hours. Send risk assessment form to the Risk Team. Discuss at Directorate meeting and agree to placement on corporate risk register. Risk escalated to Clinical Cabinet and Board.

If a member of staff has immediate concerns regarding an identified risk they are empowered to escalate to a senior manager on duty.

1. Determine the severity (consequence) of the risk using the table below:

Score	Descriptor	Actual or potential impact on patient, staff or public	Actual or Potential Impact on Organisation	People affected	Potential for complaint/litigation
1	Negligible	No harm / adverse outcome, minimal intervention	Potential failure to meet standards, Short term low level staffing, No or minimal impact or breach of guidance/ statutory duty	One or No-one	Treatment or service suboptimal / informal complaint or inquiry
2	Minor	Minor harm caused / possible. Damage resolved within 1 month. Time off work up to 3 days	Variation from target / objective. Minor loss / interruption of service. Low staffing level. Single failure to meet standards.	One	Formal complaint possible Litigation unlikely
3	Moderate	Moderate harm caused / possible. Damage requiring professional intervention. Harm takes up to one year to resolve. Time off work > 4 days. Major patient safety implication if findings not acted upon.	RIDDOR Reportable Financial loss Staffing level or competency low affecting delivery of service. Local target missed / breach in statutory duty Threat to Strategic Objective	Small numbers e.g. 3 - 10	Litigation possible but not certain. Potential for complaint
4	Major	Major harm caused / possible. Damage leading to incapacity / disability. Mismanagement of care with longer-term effects. Time off work > 14 days, referral to occupational health. Mis-diagnosis or poor prognosis.	Significant threat to Strategic Objective. Local adverse publicity National target missed Service Closure Failed financial targets Multiple breaches to statutory duty / recommendations. Enforcement notice. Non compliance to national standards	Moderate number e.g. loss of specimens, Vaccination problems	Complaint expected. Litigation likely.
5	Catastrophic	Death caused /possible. Damage involving multiple injuries or irreversible health effects. Totally unacceptable level of care or treatment / gross failure in patient / staff safety	Multiple failure to national targets / standards / breaches in statutory duty Failed Strategic Objectives National adverse publicity HSE Investigation Financial failure (unable to meet financial obligations)	One or many persons involved e.g. Cervical screening disaster. Fire evacuation etc.	Complaint certain. Litigation expected.

2. What is the likelihood of the consequence occurring?

Score	Descriptor	Description
1	Rare	Will probably never happen / recur
2	Unlikely	Do not expect it to happen / recur but it is possible
3	Possible	Could happen / recur occasionally
4	Likely	Will probably happen / recur
5	Almost certain	Will undoubtedly happen / recur, possibly frequently

Appendix 2 - Risk Register Field Headings (Used for Corporate and Department Risk Register)

ID	Opened	Title	Executive Lead	Risk Owner	Risk Type	Source	Current Rating	Residual Rating	Description	Controls in Place	Actions	Date Reviewed

Appendix 3

Incident Reporting & Investigation Process

Member of staff reports near misses and actual incidents on the Datix WEB System (selects manager to investigate and enters as the handler)

Note – If staff member unable to access computer they should report with line manager assistance

Where incident reported immediately (as long as patient safety maintained). Alternatively, incident must be reported by the end of the shift.

↓

Manager receives email from incident and commences investigation (names of all involved must be included within contacts section).

Investigation to be completed within 10 working days for minor/no harm /near miss incidents.

Risk Team review reported incidents.

Risk Team also follow up with Handler/Manager when catastrophic/major/moderate and internal red and amber incidents identified to undertake initial investigations to clarify events.

Investigations on Serious Incidents (SI's) to be completed within 30 working days (*internal deadline****)***

Investigations in to catastrophic/major/moderate severity incidents and those graded as internal reds and ambers are assessed individually as to the length of time for investigations to be completed due to the depth and level of investigation required.

↓

Incident categorised as catastrophic/major/ moderate or graded as an internal red or amber concern (graded by Risk Team or investigator)

↓

If SI or major/catastrophic or internal red incident - Complete comprehensive Root Cause Analysis (RCA) Report and send to Risk Team to arrange review by Clinical Cabinet or Clinical Governance Group.

If moderate or internal amber incident - Complete concise RCA report and return to Risk Team.

Risk Team can provide advice/support where required.

↓

Clinical Governance Group reviews and closes RCA reports following completion of investigations. Outstanding actions transferred to the "learning from incidents action plan".

↓

Use risk matrix for incident grading and subsequent escalation process. Consider if Serious Incident (SI) – discuss with Medical Director/Director of Nursing/Risk Team. If SI, Risk Team to follow procedure in policy.

↓

Incident with a severity grading of minor/no harm or near miss

↓

Complete investigation and change handler to Head of Risk. Provide feedback to reporter and department e.g. via team meetings.

↓

Complete investigation

↓

Incident reviewed by Risk Team and closed if all actions appropriate

↓

Trust wide Report of monthly incidents produced by Risk Team and uploaded onto Risk Homepage.

Directorates review their incidents at monthly Directorate meetings.

Clinical Cabinet and Trust Board receive information on Serious Incidents, and internal red and amber incidents on a monthly basis.

↓

Aggregated report produced quarterly and presented to Quality & Risk Committee.

Incidents, Risks, Claims and Complaints discussed at monthly directorate meetings with actions implemented where required.

Incidents identified as a greater concern (SIs, internal reds or ambers and those with a severity of moderate or above) must be highlighted to the Risk Team.

Appendix 4

External Reporting following Incidents

The reporting to external organisations following certain incidents has been delegated by the Chief Executive to the named reporter whom could be a department or individual. This is a clear requirement of the Care Quality Commission (CQC). Any patient safety incident requiring reporting to the CQC should be reported to NHS England via the National Reporting Learning System (NRLS)

Detail	Organisation	Reporter
Incidents of harm or potential harm to patients and any incident reported to the police or that may stop the service from operating safely and properly. This includes Serious Incidents	NHS England via NRLS *All patient safety incidents sent via to the NRLS system cover the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*	Risk Team
Serious Incident	Lead Commissioner – Horsham and Mid Sussex CCG **bhccg.SISussex@nhs.net** is the main email for reporting all SI's and correspondance If involving doctor in training – The Deanery must also be informed via Kensur-dean.SUI@nhs.net	Executive Director or Risk Team
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)	Health & Safety Executive	Risk Team
Safeguarding Issues	Social Services	Safeguarding leads and Heads of Nursing
Letters of Claims against the Trust reported within 24 hours of receipt	National Health Service Litigation Authority (NHSLA)	Patient Experience Manager

Detail	Organisation	Reporter
Medical Devices or Equipment Issues	NHS England via NRLS *If deemed a fault of the device report to Medicines and Healthcare Products Regulatory Agency (MHRA)*	Risk Team
Information Security Breaches Assessed against the HSCIC Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation v 5.1 for categorisation	Information Commissioners office	Finance Director
Security Incidents	Counter Fraud & Security Management service by Security Management System Via (SIRS)	Risk Team
Radiation incident (over exposure)	The Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) to CQC	Radiography Manager
Patient death that was a consequence of the service provided and not caused by an illness or condition being appropriately treated	NHS England via NRLS (send info immediately and do not wait for monthly upload). Include core data listed at end of this table plus the following; • Date & time of death; • The time person was found; • Where the person died; • The cause of death if known; • Whether death was expected; • If expected – unique code of last person to see patient and their job title; • Details of surgical procedure at the time or 7 days prior to death; • Patient restrained at time of death; • Whether concerns of controlled or other drugs relating to the death; • Whether concerns on use of medical devices relating to the death	Head of Risk

Detail	Organisation	Reporter
Inquest - A death MUST be referred to the Coroner if it fulfils any of the following criteria: o The patient has died within 24 hours of admission (even if the cause is known); o The death was sudden or unexplained or a doctor cannot decide on the cause of death; o Death was the result of an accident/violence /self-harm (even if some time has elapsed since the original incident); o The patient died during surgery, within 24 hours of completion of surgery, or the patient has never recovered consciousness following an anaesthetic, regardless of the length of time that has passed since the administration of the anaesthetic; o Death was the result of neglect or self-neglect; o Death was from hypothermia for which no underlying cause has been identified; o Death was the result of poisoning including acute alcohol poisoning; o Death was connected with the administration of drugs, therapeutic or otherwise; o A medical or nursing mishap may have contributed to the death; o The patient was in prison or police custody (even if in hospital at the time of death); o Death was the result of a termination of pregnancy; o Death was the result of an industrial injury or disease; o Death was from a condition for which the patient was in receipt of an industrial or war injury disability pension; o Stillbirth if there is any doubt if the infant was born alive or not; o No doctor has treated the patient during the final illness, or no doctor has seen the patient within 14 days preceding the death;	The Coroner's role is to establish the cause of death. – Inquest.	Lead Clinician responsible for the patient

Detail	Organisation	Reporter
Unauthorised absences of a person detained under the Mental Health Act 1983 when the person is still absent after midnight on the day their absence began	Care Quality Commission (immediately) as per Regulation 17 of *the* Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended) and the Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended) *Include information - Section under Mental Health Act the person is liable to be detained, the reason for their detention and the circumstances in which they became absent*	Risk Team
Notification about the death of a person detained under the Mental Health Act 1983 where the person dies while receiving, or as a result of, the care, treatment or support provided by the service.	Care Quality Commission (immediately) *Refer to the* Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended) and the Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended) *Regulation 17 for the information required.* *N.B. Do not provide the name but a unique identifier code* Include core data listed at end of this table plus the following; • Date & time of death; • The time person was found; • Where the person died; • The cause of death if known; • Whether death was expected; • If expected – unique code of last person to see patient and their job title; • Details of surgical procedure at the time or 7 days prior to death; • Patient restrained at time of death; • Whether concerns of controlled or other drugs relating to the death; Whether concerns on use of medical devices relating to the death	Risk Team

Detail	Organisation	Reporter
Any application by the service to the Court of Protection or supervisory body to deprive an adult of their liberty.	Care Quality Commission (immediately) *Include Information – Date of application, whether application has been made before, address of supervisory body or court* *See also Regulations 9, 13 and 18, of the* Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended) and the Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended)	Risk Team
A level of staff absence or vacancy, or damage to the service's premises that mean that people's assessed needs cannot be met.	NHS England via NRLS (send info immediately and do not wait for monthly upload)	Risk Team
The failure of a utility for more than 24 hours.	NHS England via NRLS (send info immediately and do not wait for monthly upload)	Risk Team
The failure of fire alarms, call systems or other safety-related equipment for more than 24 hours.	NHS England via NRLS (send info immediately and do not wait for monthly upload)	Risk Team
Any circumstance or event that means the service cannot or may not be able to meet people's assessed needs safely.	NHS England via NRLS (send info immediately and do not wait for monthly upload)	Risk Team
If emergency absence is required and likely to last longer than 28 days	Care Quality Commission (within 5 working days of absence) *Include same details as above*	Company Secretary
Any suspicion, concern or allegation from any source that a person using the service has been or is being abused, or is abusing another person (of any age),If the alleged abuser is a member of staff or volunteer, or if	NHS England via NRLS *Include; relevant dates, witnesses, type of abuse, circumstances, relationships, (See Regulation 13 of the* Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended) and the	Risk Team

Detail	Organisation	Reporter
the alleged abuser is another person using the service or abuse occurs on the premises (Child protection issues reported through normal channels)	Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended) *Outcome 20N) Use unique identifier code.* *Also Include for children under 18 - The date the allegation was notified to the police, local safeguarding children board and the strategic health authority (where appropriate). - The type of abuse (using the categories in the Department for Children, Families and Schools document Working Together). Anything the registered person has done as a result of the allegation.*	
Give 28 days' notice if the registered person is going to be absent from the service for 28 or more days or Where an absence is planned less than 28 days before it begins., registered persons inform the Care Quality Commission without delay before the absence begins	Care Quality Commission (immediately) as per Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended) and the Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended) *Provide the following; the reason for the absence, how long it will last, who will run the service while the registered person is away along with the qualifications and address of the person who will be responsible for the service. If the length of the absence is unknown, propose to the Care Quality Commission how long the situation will continue before a new manager will be proposed for registration.*	Company Secretary
Notification of registered provider returning to the service	Care Quality Commission (less than 7 days after return) as per Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended) and the Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended)	Company Secretary
If any changes to the organisation's name business address or nominated individual.	Care Quality Commission (before or immediately after changes made) as per Regulation 6 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended) and the Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended)	Company Secretary
Incidents arising from cross-Trust working, eg, QVH staff working at spoke sites	Trust / partnership organisation involved	Head of Risk

Wherever possible the following core data should be sent to the Care Quality Commission when reporting incidents for the above criteria unless otherwise stated;

- Date admitted to the service;
- Date of birth;
- Gender;
- Ethnicity;
- Disability;
- Any religion or belief;
- Sexual orientation;
- Relevant dates and circumstances, using unique identifiers and codes where relevant;
- Actions taken from the incident
- Other requirements included within the Datix & National reporting Learning System.

Appendix 5 - <u>Examples of Serious Incidents for All settings an immediate action required (Appendix 4 details external reporting and responsibilities:</u>

(Not exhaustive, and intended as a guide only):

Serious Incident (SI) - A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more people. This includes suicide / self-inflicted death, and homicide by a person in receipt of mental health care within the recent past.
- Unexpected or avoidable injury to one or more people that has resulted in serious harm.
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent the death of the service user or serious harm.
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or where abuse occurred during the provision of NHS-funded care.
- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
  - Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues
  - Property damage;
  - Security breach/concern;
  - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
  - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
  - Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
  - Activation of Major Incident Plan (by provider, commissioner or relevant agency)

- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organization

A Never Event - All Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death:

1. **Wrong site surgery**
2. **Wrong implant/prosthesis**
3. **Retained foreign object post-operation**
4. **Mis-selection of a strong potassium containing solution**
5. **Wrong route administration of medication**
6. **Overdose of insulin due to abbreviations or incorrect device**
7. **Overdose of methotrexate for non-cancer treatment**
8. **Mis-selection of high strength midazolam during conscious sedation**
9. **Failure to install functional collapsible shower or curtain rails**
10. **Falls from poorly restricted windows**
11. **Chest or neck entrapment in bed rails**
12. **Transfusion or transplantation of ABO-incompatible blood components or organs**
13. **Misplaced naso- or oro-gastric tubes**
14. **Scalding of patients.**

The above criteria for SI identification is taken from the NHS England Never Event Framework and NHS England Serious Incident Framework effective from 1 April 2015. Please also refer to the Never Events listed within the definitions of the Risk Management & Incident Reporting Policy

Action Summary

- ✓ Call the Director of Nursing & Quality or the Risk Team for advice during normal working hours.
- ✓ Out of hours, contact the bleep holder and On-call Manager. If deemed reportable then email: **<u>bhccg.SISussex@nhs.net</u>**. The QVH Risk Team will record on STEIS database within 2 working days of incident.

Appendix 6

Investigation – Guidance (Routine and Root Cause Analysis (RCA))

The Trust uses the following Root Cause Analysis Reporting templates, with each aligned to a different level of investigation:

Incident/ Investigation Type	Level of investigation & RCA Type	Timescale for Completion of RCA	Process and Dept Timescales to be included
Independent	Independent	45 Working days (submission to CCG within 6 months following the commission date)	• RCA submission to CCG • Outstanding actions added to Learning Log • RCA to appropriate M&M/Joint Clinical Audit Meeting/Nursing Advisory Group for dissemination of learning
Serious Incident	Comprehensive (***Appendix 6.1)***	30 Working Days (submission to CCG within 60 Working Days)	• RCA completed by Investigator and/or Risk team • RCA to Medical Director/Director of Nursing/Clinical Director/ /Lead for comment/ agreement • RCA to Clinical Governance Group/Clinical Cabinet for approval/closure • RCA submission to CCG • Outstanding actions added to Learning Log • RCA to appropriate M&M/Joint Clinical Audit Meeting/Nursing Advisory Group for dissemination of learning
Internal "Red" incident	Comprehensive (***Appendix 6.1)***	30 Working Days (submission to CCG within 60 Working Days)	• RCA completed by Investigator and/or Risk team • RCA to Medical Director/Director of Nursing/Clinical Director/ /Lead for comment/ agreement • RCA to Clinical Governance Group/Clinical Cabinet for approval/closure • Outstanding actions added to Learning Log • RCA to appropriate M&M/Joint Clinical Audit Meeting/Nursing Advisory Group for dissemination of learning
Internal "Amber" incident	Concise (***Appendix 6.2)***	30 Working Days	• RCA completed by Investigator and/or Risk team • RCA to Medical Director/Director of Nursing/Clinical Director/ /Lead for comment/ agreement

			• RCA to Clinical Governance Group/Clinical Cabinet for approval/closure • Outstanding actions added to Learning Log • RCA to appropriate M&M/Joint Clinical Audit Meeting/Nursing Advisory Group for dissemination of learning
Hospital Acquired Grade 2 and above pressure ulcer incidents	Pressure Ulcer Toolkit (***Appendix 6.3)***	30 Working Days	• RCA completed by Investigator and/or Risk team • RCA to Director of Nursing/ Lead for comment/ agreement • RCA to Clinical Governance Group/Clinical Cabinet for approval/closure • Outstanding actions added to Learning Log • RCA to Nursing Advisory Group for dissemination of learning
Patient fall in hospital resulting in a fracture	Patient Fall Toolkit ***(Appendix 6.4)***	30 Working Days	• RCA completed by Investigator and/or Risk team • RCA to Director of Nursing/ Lead for comment/ agreement • RCA to Clinical Governance Group/Clinical Cabinet for approval/closure • Outstanding actions added to Learning Log • RCA to Nursing Advisory Group for dissemination of learning

These reports have been adapted to reflect best practice, and include human factors and non-technical skills analysis sections to provide detailed retrospective analysis to assist with the identification of key learning points. The templates will continue to be evaluated on an ongoing basis to reflect national guidance and best practice.

PLEASE READ - Instructions for use when completing RCA Report Templates

1. **Refer to the Risk Management and Incident Reporting Policy**
2. **Determine the level of investigation to be undertaken**
   Refer to NHS England "Three Levels of investigation' (Level 1 = Concise; Level 2 = Comprehensive; Level 3 = Independent), and to the Trusts 'Triggers for Investigation' (Section 6.1 of the Risk Management and Incident Reporting Policy).
3. **Select the appropriate RCA Report Template for completion dependent upon the incident investigation/type.**
4. **Request statements from the individuals involved in the incident and those administering patient care (including witnesses).**
5. **Gather the information and commence completion of the report as per the template instructions.** This should be completed from factual information only (do not include here-say or assumptions). Information should be obtained from the patient notes, statements, chronology, policies and procedures and any additional information made available as part of the investigation.
6. **Additional support and guidance to complete the RCA report** can be obtained from the Risk Team.

Appendix 6.1 – Comprehensive Root Cause Analysis Report Template (for use with Serious Incidents and internal "Red" Incident Investigations)

Queen Victoria Hospital NHS
NHS Foundation Trust

Root Cause Analysis Investigation Report

EXECUTIVE SUMMARY

Add information here

Incident Details

Incident date:
Datix ID:
SI Number:
Incident type:
Specialty:
Effect on patient:
Severity level:

Pre-investigation risk assessment

A Potential Severity (1-5)	B Likelihood of recurrence at that severity (1-5)	C Risk Rating (C = A x B)

Background and Context

Add information here

Terms of Reference

Specific problems to be addressed, who commissioned the report, investigation lead and team, aims, objectives and outputs, scope, boundaries and collaborations, administration arrangements (accountability, resources, monitoring, timescales.

Add information here

The Investigation Team

Add information here

Scope and Level of Investigation

Add information here

Investigation type, process and methods used

Add information here

Involvement and support of patient and relatives

Include how the patients and relatives have been informed and involved in the investigation process.

Add information here

Involvement and support provided for staff involved

Add information here

Information and evidence gathered

(Include:-Title and date of Guidance, Policies, Medical records, interview records, training schedules, staff rotas, equipment, etc. If incident relates to an inpatient fall please include a ward map)

Has the information been checked (Y/N)?
Confirm what information has been checked from the given list above

Add information here

Chronology of events

Add information here

Detection of incident

Note at which point in the patients treatment the error was identified.

Add information here

Notable practice

Points in the incident or investigation process where care and/or practice had an important positive impact and may provide valuable learning opportunities.
(e.g. Exemplar practice, involvement of the patient, staff openness etc)

Add information here

Care and service delivery problems

A themed list of the *key* problem points. (Where many problems have been identified the *full* list should be included in the appendix)

Add information here

Contributory factors

A list of significant contributory factors (where many contributory factors are identified a full list or 'fishbone diagrams' should be included in the appendix)

Add information here

Human Factors Aspects

Systems Issue	What Went Wrong?
Equipment e.g. equipment required in more than one place, running out of equipment	***Add information here***
Information, Data and records e.g. Delays in accessing patient records, information, incorrect information available	***Add information here***
Jobs/tasks/protocols e.g. Deviations from systems and processes e.g. patient being operated upon without being seen by the operating surgeon/Consultant, and conflicting theatre slots with meetings	***Add information here***
Environment e.g. Varying layouts of Theatres/procedure rooms, and staff undertaking procedures at varying locations/frequencies and not using permanent locations	***Add information here***
Work Design e.g. Seeing systems/protocols as "add ons" not as an integral part of the processes, and no acknowledgement of staff breaks/interruptions	***Add information here***
Culture and Organisation e.g. Acceptance of time pressures leading to regular workarounds, staff feeling unable to challenge or speak up, misunderstanding of the purpose of completion of paperwork, procedures and audits	***Add information here***
Communication *Staff – Patient Communication:* e.g. Consent/patient involvement issues Access to translation services *Communication between teams and different staff groups:* e.g. Failures to speak up when deviations to practice occur Lack of double checking processes when side for procedure is not obvious *Between frontline staff and management:* e.g. Poor consultation on new ways of working	***Add information here***
Organisation Unrealistic expectations of staff to cope with time pressures and workload	***Add information here***

(Adapted from the Clinical Human Factors Group, 2011 and Vincent, 2010)

Non-Technical Skills

Non-Technical Skill Category	What Went Wrong?
Communication e.g. incorrect information being given, and misinterpretation	***Add information here***
Situation Awareness (lack of awareness of surroundings) e.g. not gathering enough information, overlooking anomalies, and not recognising increasing risks	***Add information here***
Decision Making Staff continuing with a task as opposed to checking when uncertain Over-reliance on assumptions regarding the correct location	***Add information here***
Teamwork e.g. Failures to speak up when lists/forms/procedures not followed, inadequate information sharing, teams too big, or little support for staff	***Add information here***
Leadership Deviations of procedural compliance, not ensuring that the whole team had a shared awareness of the risks involved	***Add information here***
Coping with stress Not dealing effectively with work pressures, or requiring staff to work faster	***Add information here***
Coping with fatigue e.g. Physical and mental tiredness	***Add information here***

(Adapted from the Non-technical skills for Anaesthetists, Surgeons and Scrub Practitioners (ANTS, NOTSS and SPLINTS)) (Flin et al, 2008).

Root causes

These are the most fundamental underlying factors contributing to the incident that can be addressed. Root causes should be meaningful, (not sound bites such as communication failure) and there should be a clear link, by analysis, between root CAUSE and EFFECT on the patient.

Add information here

Lessons learned

Key safety and practice issues identified which may not have contributed to this incident but from which others can learn.

Add information here

Recommendations and Action Plan

Add information here and actions below:

Action Description (Specific)	Success Criteria (measurable)	Plan (Achievable and Realistic)	Time-scale (Time-limited)	Lead (Specific)	Date Completed
Standing action on all SI RCA reports Medical Director or Director of Nursing (as appropriate to incident) to review investigation report to consider if any action required under Trust Policy/professional body guidance				Medical Director or Director of Nursing	
Standing action on all SI RCA reports 12 months after the SI occurrence review actions for sustained improvements resulting from the lessons learnt.				Head of Risk	

Arrangements for shared learning

Describe how learning has been or will be shared with staff and other organisations

Add information here

Distribution list

Add information here

Appendices

Add information here

Author:

Job Title:

Date:

Appendix A

Investigation Timeline

Date / Time	Event	Comments Key findings of contributory factors such as service delivery or care delivery problems. Identify good practice where relevant

Appendix 6.2 – Concise Root Cause Analysis Report Template (for use with internal "Amber" Incident Investigations)

Internal Incident Investigation Report

Form Completion Guidance
Section 1 - Completion by the Risk Team
Section 2 – Completion by the investigator
Section 3 - Completion by the investigator. Risk Team to record outstanding actions on the "learning from incidents action plan"
Please email completed investigation to the nominated risk lead for the incident

Section 1 - Incident Coding

Please note: This form is required because the investigation section within the Datix form is either incomplete or does not provide all the necessary information.

Brief Summary of Incident Description (extracted from Datix):

Add information here

Incident Details:

Datix ID: Date of Incident:

Add information here

Investigation Lead: Investigation Completion Date:

Risk Rating		
Likelihood	Severity	Rating
Risk Grading		

Reason for Risk Grading:

Add information here

Nominated Risk Team member to provide support for investigation: ***Add information here***

Date incident submitted to the Clinical Governance Group for review: ***Add information here***

Page 4 of this document includes a timeline template. This will not always be required but should be used for more complex incidents involving a number of different people and or systems. Advice can be sought from the Risk Team

Section 2 – Investigation

Useful information
To assist in the learning from the incident an After Action Review could be useful. If this is required please contact the nominated Risk Team member detailed in section 1above (it will be the investigators responsibility to arrange the attendees).
Note: If the investigator deems the incident to be of little significance and therefore not requiring an investigation please explain the reason for this on the form within section 2 and discuss with the Risk Team.

1. What was Expected? – Describe the normal process, procedure or course of action that should have happened:

Type here:

2. What Actually Happened? - Describe the actual events of the incident (if required use the timeline attached to record each step leading up to and immediately after the incident):
(If incident relates to an inpatient fall please include a ward map)

Type here:

The following actions were completed at the time that the incident was identified:

Useful information
Consider the following 4 P's -
1. People involved
2. Paper (documents such as health records, policies, training records, training programme's, national guidelines, qualifications etc)
3. Parts – Consider equipment involved or required,
4. Place – site of the incident and the surroundings

3. Why Was There A Difference (to what was expected)? - Describe the key findings of why the incident occurred, taking into consideration the reason for specific actions along with constraints on people, resources, time and information available:

Type here:

Has the documentation e.g. patient notes, results etc been checked for the case in question (Y/N) if no why not?

Useful information
Consider contributory factors such as:
- *Care delivery Problem – an issue that occurs in the process of care, usually acts or omissions by people;*
- *Service Delivery Problem – an act or omission identified that are not directly associated with patient/staff care*

Consider current safeguards (control measure to prevent harm) and their effectiveness such as:
- *Physical barriers – swipe access, controlled drug cupboards*
- *Natural barriers – system for checking drugs, WHO checklist, name band confirmation prior to treatment*
- *Human action barriers – falls prevention checks and interventions, placing diathermy in quiver*
- *Administrative barriers – protocols and procedures, supervision, training*

Human Factors Aspects

Systems Issue	What Went Wrong?
Equipment e.g. equipment required in more than one place, running out of equipment	***Add information here***
Information, Data and records e.g. Delays in accessing patient records, information, incorrect information available	***Add information here***
Jobs/tasks/protocols e.g. Deviations from systems and processes e.g. patient being operated upon without being seen by the operating surgeon/Consultant, and conflicting theatre slots with meetings	***Add information here***
Environment e.g. Varying layouts of Theatres/procedure rooms, and staff undertaking procedures at varying locations/frequencies and not using permanent locations	***Add information here***
Work Design e.g. Seeing systems/protocols as "add ons" not as an integral part of the processes, and no acknowledgement of staff breaks/interruptions	***Add information here***
Culture and Organisation e.g. Acceptance of time pressures leading to regular workarounds, staff feeling unable to challenge or speak up, misunderstanding of the purpose of completion of paperwork, procedures and audits	***Add information here***
Communication *Staff – Patient Communication:* e.g. Consent/patient involvement issues Access to translation services *Communication between teams and different staff groups:* e.g. Failures to speak up when deviations to practice occur Lack of double checking processes when side for procedure is not obvious *Between frontline staff and management:* e.g. Poor consultation on new ways of working	***Add information here***
Organisation Unrealistic expectations of staff to cope with time pressures and workload	***Add information here***

(Adapted from the Clinical Human Factors Group, 2011 and Vincent, 2010)

Non-Technical Skills

Non-Technical Skill Category	What Went Wrong?
Communication e.g. incorrect information being given, and misinterpretation	***Add information here***
Situation Awareness (lack of awareness of surroundings) e.g. not gathering enough information, overlooking anomalies, and not recognising increasing risks	***Add information here***
Decision Making Staff continuing with a task as opposed to checking when uncertain Over-reliance on assumptions regarding the correct location	***Add information here***
Teamwork e.g. Failures to speak up when lists/forms/procedures not followed, inadequate information sharing, teams too big, or little support for staff	***Add information here***
Leadership Deviations of procedural compliance, not ensuring that the whole team had a shared awareness of the risks involved	***Add information here***
Coping with stress Not dealing effectively with work pressures, or requiring staff to work faster	***Add information here***
Coping with fatigue e.g. Physical and mental tiredness	***Add information here***

(Adapted from the Non-technical skills for Anaesthetists, Surgeons and Scrub Practitioners (ANTS, NOTSS and SPLINTS)) (Flin et al, 2008).

Section 3 – Action Plan

What have we learned?

Briefly describe the learning from the incident including good practice and list within the table below the required actions (if identified) to prevent a repeat incident including communication of the incident to relevant stakeholders. This may also include follow up training, a change in process and or behaviour surrounding the event to ensure different actions are taken in the future. Please consider the effectiveness and need for further barriers as detailed in the table above within section 2 point 3.

Type here:

ID no.	Action Description (Specific)	Success Criteria (measurable)	Plan (Achievable and Realistic)	Time-scale (Time-limited)	Lead (Specific)	Date Completed

Please state & explain how you will feedback learning from this incident to appropriate staff

Investigation Timeline

Date / Time	Event	Comments Key findings of contributory factors such as service delivery or care delivery problems. Identify good practice where relevant

Appendix 6.3 – Pressure Ulcer Toolkit Report Template (for use with Hospital Acquired Grade 2 and above Pressure Ulcer Incident Investigations)

Queen Victoria Hospital NHS
NHS Foundation Trust

CONFIDENTIAL

Pressure Ulcer Incident Investigation Report

Incident Number	DATIX
Date of Incident	
PU Category	
Date submitted to Clinical Governance Group for closure	
Incident grade	Red / Amber
Patient location / directorate where PU identified (if Burns specify if ward or ITU)	

Please confirm that the following detail is included in the report	
Underlying Cause identified	
Being Open policy followed	
Lessons Learned	
Recommendations	
Mechanism for shared learning	
Report anonymised	
Action Plan states accountability and date for completion of actions	
Was a SVA alert raised? (if appropriate)	
If applicable, was a SAAR taken forward? If not, please state reason why?	
SAAR Outcome and Allegation	
Any actions resulting from the SAAR process relating to organisation are included in the RCA Action Plan	
Recommendations/Further information requested have been updated	

Report prepared by	
Contact details	

Best Practice Investigation and Audit Tool

Pressure Ulcer Assessment and Prevention

Introduction

A brief executive summary/background will need to be entered to provide an overview of the incident.

Write a very brief story of the patient journey up to this point including presenting condition and medical history.

Ask- When, who, where, what, how, why?

This follows the format for an investigation process.

- *Past medical history*
- *Co-morbidities (if any)*

Pre-Investigation Risk Assessment

A Potential Severity (1-5)	B Likelihood of Recurrence at that Severity (1-5)	C Risk Rating (C = A x B)

A	Risk assessment	Yes	No	Action / Comments
Q1	Has the patient been assessed using the Waterlow risk assessment tool?			
Q2	Is there evidence to demonstrate that a tissue viability risk assessment (Body map/photos) was completed on admission to a hospital? (within 4 hours)			
B	**Patient/ Clients with pressure ulcers**			
Q3	Does the initial risk assessment indicate that the patient has an existing pressure ulcer or previous pressure damage? If 'No,' go to Q6.			
Q4	If the patient has existing pressure ulcers, is there evidence that they are receiving preventative interventions?			
Q5	Was the patient transferred from the care of another provider? If 'Yes' go to Q 35			
C	**Patient 'at risk' of pressure ulcer**			
Q6	Does the risk assessment indicate that the patient is 'at risk' of getting a pressure ulcer?			
Q7	If the patient is assessed as 'at risk', is there evidence that a care plan has been developed, detailing preventative interventions?			

D	**Patient's physical and mental well being**			
Q8	Is the patient concordant and consenting to care? If 'No' has their capacity to make decisions related to this episode of care been formally assessed? *The provider should be demonstrating they have consistently tried to enable the patient to be concordant. If consistent attempts are unsuccessful this would constitute an unavoidable ulcer due to the patient exercising informed choice.*			
Q9	Has the patient been assessed for pain and appropriate analgesia prescribed and monitored?			
Q10	Is there evidence that the patient is re-assessed in response to changes in their physical and/or mental well-being and pain control?			
E	**Nutrition and Hydration**			
Q11	Is there weekly documentation of: • Weight • MUST score • Body Mass Index			
Q12	Following a MUST assessment, were the recommendations for the scores followed? i.e. • Completion of food and fluid charts • Timely referral to the dieticians • Provision of supplements			
Q13	If nutritional support was planned, was this • Implemented? • Evaluated? Was patient helped to eat and drink if required?			
F	**Skin inspection/skin cleansing regimes**			
Q14	Following risk assessment, is skin inspection documented?			
Q15	If 'Yes', is there evidence of action taken (if required) following skin inspection?			
Q16	Is there evidence that the patient receives regular skin inspection, according to the recognised risk assessment tool used in your area? If applicable is there documented risk assessment/care planning regarding anti-embolism stockings?			
Q17	If the patient/client is identified as having non blanching erythema, is there evidence that follow-up skin inspections have been carried out?			
Q18	If the patient/ client is identified as having dry skin, is there evidence that they are being treated with emollients?			
Q18	Is the patient continent?			
Q19	If 'No', has the appropriate care planning been implemented?			
Q20	Has the possibility of moisture lesion been considered?			
G	**Patients with reduced mobility**			
Q21	Does the patient have reduced mobility?			
Q22	If 'Yes', is there evidence that more frequent skin inspections are carried out? (At least once per 8 hour shift or 3 times in a 24 hour period.)			

H	**Independent movement and position changes**			
Q23	Is there evidence that independent movement is encouraged as part of patient education?			
Q24	Do care plans give an indication on how frequently position changes are to be carried out?			
Q25	Has a manual handling assessment been completed?			
I	**Equipment** All beds are electric profiling beds with accompanying high spec foam mattresses.			
Q26	Did the patient require additional specialist equipment? • Alternating pressure mattress • Specialist cushion • heel pads • Other (specify) •			
Q27	If 'Yes', is the rationale for the use of equipment and date of first use recorded in the nursing notes? Has this been discussed with, and education provided with the patient/family/carers?			
Q28	If 'Yes', is there evidence that the specialist equipment was used in conjunction with a repositioning regime and the patient had regular assessment in relation to their equipment?			
J	**Multidisciplinary working (including Adult Social Care)**			
Q29	Is there evidence of effective interagency working, communication and joint care planning?			
K	**Staff Education and Audit**			
Q30	Are regular updates provided for staff caring for patient/ clients at risk of developing pressure ulcers?			
Q31	Is a patient/carer information leaflet available?			
Q32	Has the patient/carer been provided with proactive health promotion advice?			
Q33	Are the Senior Specialist Nurses available to advise on appropriate care planning?			
L	**Patients transferred from other healthcare providers with existing Cat 2 or above pressure ulcers**			
Q34	Was the pressure injury documented in full (including EPUAP grading) on the discharge summary?			
Q35	Has the healthcare provider been informed of the incident and who is the named person leading on the investigation. If indicated, was a Safeguarding Alert raised?			

Adapted from NHS Quality Improvement Scotland
Best practice statement audit tool Pressure Ulcer Prevention. 2009

Human Factors Aspects

Systems Issue	What Went Wrong?
Equipment e.g. equipment required in more than one place, running out of equipment	
Information, Data and records e.g. Delays in accessing patient records, information, incorrect information available	
Jobs/tasks/protocols e.g. Deviations from systems and processes e.g. patient being operated upon without being seen by the operating surgeon/Consultant, and conflicting theatre slots with meetings	
Environment e.g. Varying layouts of Theatres/procedure rooms, and staff undertaking procedures at varying locations/frequencies and not using permanent locations	
Work Design e.g. Seeing systems/protocols as "add ons" not as an integral part of the processes, and no acknowledgement of staff breaks/interruptions	
Culture and Organisation e.g. Acceptance of time pressures leading to regular workarounds, staff feeling unable to challenge or speak up, misunderstanding of the purpose of completion of paperwork, procedures and audits	
Communication *Staff – Patient Communication:* e.g. Consent/patient involvement issues Access to translation services *Communication between teams and different staff groups:* e.g. Failures to speak up when deviations to practice occur Lack of double checking processes when side for procedure is not obvious *Between frontline staff and management:* e.g. Poor consultation on new ways of working	
Organisation Unrealistic expectations of staff to cope with time pressures and workload	

(Adapted from the Clinical Human Factors Group, 2011 and Vincent, 2010)

Non-Technical Skills

Non-Technical Skill Category	What Went Wrong?
Communication e.g. incorrect information being given, and misinterpretation	
Situation Awareness (lack of awareness of	

surroundings) e.g. not gathering enough information, overlooking anomalies, and not recognising increasing risks	
Decision Making Staff continuing with a task as opposed to checking when uncertain Over-reliance on assumptions regarding the correct location	
Teamwork e.g. Failures to speak up when lists/forms/procedures not followed, inadequate information sharing, teams too big, or little support for staff	
Leadership Deviations of procedural compliance, not ensuring that the whole team had a shared awareness of the risks involved	
Coping with stress Not dealing effectively with work pressures, or requiring staff to work faster	
Coping with fatigue e.g. Physical and mental tiredness	

(Adapted from the Non-technical skills for Anaesthetists, Surgeons and Scrub Practitioners (ANTS, NOTSS and SPLINTS)) (Flin et al, 2008).

Conclusion

If all risk assessments, preventative interventions and continuous re-evaluations of implemented care have been instigated and a pressure ulcer develops, then it may be deemed unavoidable.

Unavoidable pressure ulcer	Avoidable pressure ulcer
Confirmed unavoidable by CGG:	

Underlying Cause Identified

If avoidable injury identified please enter root cause(s)
Lessons learned are included in the action log

Being Open / Duty of Candour

Please detail what information/support has been shared with patient family and carers.

1. Was the patient informed?
2. Was the incident documented?

Action Log – please link the action numbers to the appropriate questions from the checklist *i.e. Action No 1- Q23*

No:	Recommendation:	Action(s) to be taken:	Lead for the Completion of Action:	Deadline for Action:	Success Measures: lessons learned:	Evidence of Progress and Completion:	Link to Trust Wide Action Plan (if appropriate):

APPENDIX

Guidance

The audit tool has been developed to enable NHS provider organisations to accurately define whether a patient who has developed a hospital acquired pressure ulcer category 2 or above has received the appropriate care planning and treatment.

The audit/checklist will allow the patient safety teams to accurately distinguish between an avoidable and unavoidable pressure injury, whilst also allowing all registered nurses to effectively audit their practice.

By all staff grades having the opportunity to complete a nursing case notes review and recognise the required standards of care and documentation, the practice of holistic nursing care and ongoing assessment will be embedded within the teams. As best practice QVH will complete this form for all hospital acquired pressure ulcers including grade 3 and 4.

How to complete the audit tool/checklist:

- Checklist completed within 72 hours
- If audit tool completed and compliant, the decision is made whether this patient developed an unavoidable pressure ulcer in NHS care -downgrade will be considered by Patient Safety Manager
- If audit highlights area of concern- an investigation report and action log to be completed by the nursing and therapy teams focusing on these identified action points (identifying the learning points for improvement).
- If patient has been transferred from another provider with an existing pressure ulcer- the organisations will need to coordinate their response and communicate on who will lead on the investigation report.

“Unavoidable” means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person’s clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence”

Physical and social factors which may lead to unavoidable pressure ulceration

- Haemodynamic or spinal instability may preclude turning or repositioning.
- Patients following the end of life individualised care plan (or other end-of-life pathways) may not be able to tolerate repositioning as frequently as their skin may require.
- The patient has not previously been seen by a healthcare professional.
- The patient has been fully informed regarding risk, has full mental capacity to make an informed decision but chooses not to receive assessment/or treatment to reduce the risk of pressure injury which may include re-positioning.
- The patient is known to a healthcare professional but an acute/critical event occurs which affects mobility or the ability to reposition; for example the patient being undiscovered for a period following a fall or loss of consciousness.

Adapted from Tissue Viability Society. Achieving Consensus in Pressure Ulcer Reporting. JTV 2012

Pressure ulceration causes much distress to patients and family, and can be taken as an indication of poor nursing care. It is vital that both parties understand when pressure damage can be prevented, and those circumstances when skin failure at the end of life cannot be avoided. Appropriate risk assessment, provision of all appropriate care, and use of pressure relieving equipment to minimise the risk of any loss of skin integrity are required. The recognition of Skin Changes at Life's End (SCALE) ulcers may herald the imminent demise of a loved one. Families require support and good communication from nursing staff at this difficult time.

Skin changes at life's end: SCALE ulcer or pressure ulcer? Beldon P.2011

Appendix 6.4 – Patient Fall Toolkit Report Template (for use with Patient fall in hospital resulting in a fracture Incident Investigations)

Queen Victoria Hospital NHS
NHS Foundation Trust

Confidential

Post Fall Investigation		
Patient Name: **Age:**	**Date of Fall:** **Time:**	**Ward:** **Speciality**:
Ward Environment	**Findings**	
Falls rate (per 1,000 bed days) in the last 12 months? Is the ward above or below the Trust's falls rate		
Staffing	**Findings**	
What is the normal **Nurse to patient Ratio** for the ward on each shift?		
What was the **Nurse to Patient Ratio** on the day of the fall (shift by shift)		
Were there bank and agency staff within the nurse to patient ratios at the time of the fall?		
Did the bank and agency staff have a ward induction checklist completed that covered falls expectations		
Are the substantive members of the ward team familiar with the expectations re falls management		
Names of individual members of staff who were interviewed as part of this investigation ***If incident internal amber/red = statements taken.*** ***If SI then interviews & statements***		
Events leading up to fall		
Date of admission / Reason for Hospital Admission / Past Medical History / Hospital Timeline / Working Diagnosis		
Was the admission related to falls?		
What was happening on the ward leading up to the fall e.g. what was the acuity/ dependency on the ward.		
Had the patient recently been transferred to the ward		

Has the patient had a previous fall prior to this admission?	
Description of the fall - What *was the patient doing when they fell?*	
About the Fall	**Findings**
Was the fall witnessed/un-witnessed	
Where were the nursing staff at the time of the fall and what were they doing?	
Has the falls risk assessment been completed daily, if condition changes or after a fall?	
What was the patient's falls risk score?	
Is the falls risk assessment score accurate?	
Have all actions in the falls action plan been completed?	
Does the patient have a history of dementia /cognitive impairment or delirium?	
Do they have capacity have they been assessed?	
What is the patient's normal mobility?	
Was a manual handling assessment performed?	
Has the patient been assessed by a Physiotherapist/Occupational Therapist?	
If the patient used a walking aid, did the patient have access to this aid?	
Does the patient have identified hearing problems?	
Does the patient wear a hearing aid?	
Were they wearing a hearing aid at the time of the fall?	
Does the patient have identified sight problems?	
Does the patient wear glasses	
Were they wearing glasses at the time of the fall?	

Environmental Factors :	Findings
Was the patient nursed in a high visibility area/near to the nurses station on the ward?	
Was the bed at its lowest height?	
Was the call bell within reach?	
Can the patient physically use it?	
Were there any additional communication requirements i.e. **BSL/lip-speaking/ interpreter required** **Overseas Interpreter required** **Information in Easy Read** **Other information not covered above**	
Was the patient assessed for bedrails?	
Did the patient have capacity to agree to using bedrails?	
Was a "one to one" Special being used	
Was the "Butterfly" scheme considered?	
Had the patient had an AMT performed? **What was the score and date performed?**	
List the last four NEWS scores prior to the fall	
Did the patient suffer "Harm" please describe	
How was the patient moved off the floor?	
Toileting	
If the patient was on the commode, how was the commode positioned in relation to the bed?	
Has a urinalysis been taken on admission?	
Has a Continence assessment /and or a toileting chart been commenced?	
When were patients bowels last opened?	

Had the patient's condition improved/ deteriorated leading up to the fall e.g. increased mobility, risk taking, diarrhoea sepsis, delirium, sleep disturbances etc.? **If yes, was the falls risk reviewed in view of this?**	
What footwear was being used /condition of feet? **If using hospital slipper socks was the size correct, what condition are the grips on slippers - do they need re-placing**	
Post falls management	**Notes**
Has the post falls checklist in the Safety Booklet been completed?	
Was the N.O.K contacted in a timely manner?	
Was the Medical falls proforma used for a medical review post fall?	
Review the medication chart with particular focus on polypharmacy, anticoagulants and night sedation post admission?	
Were post fall observations undertaken	
Did the patient have a lying and standing BP taken manually before they fell? If yes what were the findings / actions taken?	
If there was a fall in either systolic / diastolic blood pressure was this acted upon and documented?	
Was the patient Medically Ready for Discharge (MRFD)?	
If the patient was MRFD how long had they been and what were they waiting for?	
Staff	**Notes**
How many staff were directly involved in the controlling the fall with the patient?	
What, if any injuries were sustained to staff as part of the patient fall	

Learning	
Did we do everything we could to prevent this fall?	
What could we have done to reduce the likelihood of this fall occurring?	
How has the learning been shared with the team?	
Involvement and support of patient and relatives. How has the learning been shared with the family?	
Root cause	
Lessons Learned: 1.	
Investigation/AAR report written by: **Date of AAR/investigation:**	

Human Factors Aspects

Systems Issue	What Went Wrong?
Equipment e.g. equipment required in more than one place, running out of equipment	
Information, Data and records e.g. Delays in accessing patient records, information, incorrect information available	
Jobs/tasks/protocols e.g. Deviations from systems and processes e.g. patient being operated upon without being seen by the operating surgeon/Consultant, and conflicting theatre slots with meetings	
Environment e.g. Varying layouts of Theatres/procedure rooms, and staff undertaking procedures at varying locations/frequencies and not using permanent locations	
Work Design e.g. Seeing systems/protocols as “add ons” not as an integral part of the processes, and no acknowledgement of staff breaks/interruptions	
Culture and Organisation e.g. Acceptance of time pressures leading to regular workarounds, staff feeling unable to challenge or speak up, misunderstanding of the purpose of completion of paperwork, procedures and audits	

Communication *Staff – Patient Communication:* e.g. Consent/patient involvement issues Access to translation services *Communication between teams and different staff groups:* e.g. Failures to speak up when deviations to practice occur; or Lack of double checking processes when side for procedure is not obvious *Between frontline staff and management:* e.g. Poor consultation on new ways of working	
Organisation Unrealistic expectations of staff to cope with time pressures and workload	

(Adapted from the Clinical Human Factors Group, 2011 and Vincent, 2010)

Non-Technical Skills

Non-Technical Skill Category	What Went Wrong?
Communication e.g. incorrect information being given, and misinterpretation	
Situation Awareness (lack of awareness of surroundings) e.g. not gathering enough information, overlooking anomalies, and not recognising increasing risks	
Decision Making Staff continuing with a task as opposed to checking when uncertain Over-reliance on assumptions regarding the correct location	
Teamwork e.g. Failures to speak up when lists/forms/procedures not followed, inadequate information sharing, teams too big, or little support for staff	
Leadership Deviations of procedural compliance, not ensuring that the whole team had a shared awareness of the risks involved	
Coping with stress Not dealing effectively with work pressures, or requiring staff to work faster	
Coping with fatigue e.g. Physical and mental tiredness	

(Adapted from the Non-technical skills for Anaesthetists, Surgeons and Scrub Practitioners (ANTS, NOTSS and SPLINTS)) (Flin et al, 2008).

Action Plan

ID no.	Action Description (Specific)	Success Criteria (measurable)	Plan (Achievable and Realistic)	Time-scale (Time-limited)	Lead (Specific)	Date Completed

Falls investigation template adapted from a Brighton & Sussex University Hospitals form

Appendix 1- Floor plan of area of fall

Appendix 7

Support for Staff – Duties

Trust Risk Team - The Risk Team will provide support and advice to managers completing investigations and to staff involved in incidents.

Health & Safety Committee - The Health & Safety Group has overall responsibility for the monitoring of the management of staff welfare.

Employee Health and Wellbeing Service (Formerly Occupational Health Department) - The Employee Health and Wellbeing Service provides a confidential supportive environment for individuals and advise them and their management on planning their return to work or on appropriate modifications. The Employee Health and Wellbeing Service also refers to GP's, workplace counsellors or specialist agencies as required.

Human Resources and Organisational Development - The Human Resources and Organisational Development Department is available to provide advice to staff and managers on options available for providing support.

Patient Experience Manager - The Patient Experience Manager is available to provide support to all staff involved in a claim or complaint, required to provide statements or give evidence at any inquest / hearing.

Director of Nursing - The Director of Nursing will, as appropriate, arrange for legal representation to provide specialist support to staff required to give evidence.

Line Manager consisting of Ward / Department Managers, Clinical Directors, Department Managers and Senior Managers (Band 8 and above) - must ensure debrief facilities are available and if required provided by specialists such as the psychotherapy team, be vigilant in recognising staff in need of support offering additional help for those involved in a traumatic / stressful complaint, incident (i.e. cardiac arrest) or claim and if appropriate refer to Occupational Health Department, taking advice from the Human Resources Department as required;

On Call Manager – Senior Manager on duty for the hospital during out of hours available to deal with incidents requiring escalation to a senior level.

All staff - It is the responsibility of any employee who considers that he or she is suffering harmful effects from work related stress associated with a traumatic / stressful complaint, incident or claim to raise the matter in the first instance with their line manager.

Immediate and Ongoing Support

It is recommended that staff involved in traumatic / stressful complaints, incidents and claims are treated with sensitivity and informed of the progress of any investigation.

The support required for staff will vary between the type of incidents and the individuals involved therefore each event will be based on a case by case basis.

Immediate Support

Immediate support should be provided by the individual's line manager but can include other advisors such as the Risk Team, Patient Experience Manager, Chaplain and the The Employee Health and Wellbeing Service. The line manager must offer (and organise if accepted) staff involved the opportunity for a debrief immediately after or at an agreed time following the event. If the event does not involve other people a one to one discussion should take place to ensure the staff member feels supported and reassure them of support and options available throughout the process.

Other forms of support for staff can be through the Staff Side Representation accessed through Trust representatives or through the Employee assistance Programme

The Employee Assistance Programme (EAP) is available to all permanent and fixed term staff by a company called CIC. It is a confidential information, support and counselling service. There is a helpline available 24 hours a day, 7 days a week, 365 days a year,

staffed by trained and BAC accredited Counsellors. Any staff that need to access face to face counselling will be able to do so through CIC. Details for this are available on the intranet/ departments / Human Resources/ Employee assistance Programme Folder. The telephone number for the company is 0800 085 1376

Ongoing Support

The line manager should also consider, if necessary fitness to practice by obtaining advice from Human Resources and Occupational Health.

Staff may request support through Human Resources department should they feel unable to liaise with their line manager

In the event of staff experiencing difficulties with their current role following an incident claim, complaint, grievance or disciplinary options are available for managers to consider. These include to work off site (depending on current job role), and to relocate or change job role until the issue is resolved. This can be arranged through their line manager and Human Resources department. Further options available are occupational health referral and or GP referral along with staff side support and representation and the Employee Assistance Programme detailed above. Care First are also able to offer post incident debriefings and support at additional cost to the Trust.

Out of Hours Support

The employee assistance Programme as detailed above is available for staff. In addition the “On Call Manager” should be contacted if required to provide advice, support and arrangements for further support.

Advice available to staff in the event of being called as a witness internally and externally

Staff asked to provide statements or called as a witness to serious incidents have the option to request staff side representation. They may request support from a member of the Risk Team, their line manager, another manager, work colleague or the Patient Experience Manager. The decision for this is down to the individual concerned. The Claims and Complaints Manager will support staff required to attend an inquest or professional hearing prior to and during the process. If necessary and appropriate the Head of Corporate Affairs will request representation from Trust Solicitors to provide further specialist support for staff.

Actions for managers to take for a staff member experiencing difficulties associated with the event

If staff continue to face difficulties associated with the event and it impacts on their ability to continue to perform their role effectively, managers should:

- Make a referral to the Employee Health and Wellbeing Service;
- Ensure they directly receive information provided on the Employee Assistance Programme in the event they may require counselling (this is at the staff members request only and will not be known by the Trust)
- Request staff member to complete the work related stress personal checklist and if necessary the associated risk assessment detailed within the Managing Stress at Work Policy located on QNet;
- Discuss with individual and Human Resources and Organisational Development options available to them such as to relocate departments, consider alternative job role, discussion of event with a peer within the Trust or external support through professional body or GP.

Monitoring – Monitoring for the effectiveness of support for staff is detailed within the main Risk Management and Incident Reporting Policy under section 22.

Appendix 8

What should be reported to the Enforcing Authority (HSE/LA) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 RIDDOR)

Examples: **Specified Injuries**	**Examples:** **Over 7 day injuries**	**Examples:** **Reportable diseases**	**Examples:** **Dangerous occurrences**
Work related injury to staff attributable to: • The manner of conducting the work • The plant or substances used • The condition of the premises 1. Diagnosed fractures, except fingers, thumbs or toes. 2. Amputation of an arm, hand, finger, thumb, leg, foot or toe 3. Injury causing permanent blindness or reduction of sight in one or both eyes. 4. Crush injury to the head or torso causing damage to the brain or internal organs of the chest or abdomen 5. Any burn/scald which is >10% of body; or causes significant damage to the eyes, respiratory system or other vital organs . 6. Any degree of scalping requiring hospital treatment 7. Loss of consciousness caused by head injury or asphyxia 8. Any other injury arising from working in an enclosed space which: i) leads to hypothermia or heat-induced illness, or ii) requires resuscitation or admission to hospital for more than 24 hours. This includes, where an act of non-consensual violence has occurred and has caused a reportable injury It is reportable asap	Where a person at work is incapacitated for routine work for more than 7 consecutive days (excluding day of accident) resulting from an accident, arising out of, or in connection with that work activities. It is reportable within 15 days. eg a staff member suffers a back injury when lifting a heavy load and is unable to work for 8 days. **Non-fatal injuries to Non-Workers** Where any person not at work has an injury and suffers: i) an injury, and is taken from the of the accident to hospital for treatment in respect of that injury ; or ii) a specified injury on hospital premises It must be reported asap eg a patient slips on a wet floor and fractures their hip, not due to their medical condition eg a member of the public suffers a reportable injury within the hospital site which is caused by the conditions on site. eg a visitor to a clinic off site, slips on ice, sprains her ankle, and is taken to hospital **Road traffic accidents** <u>Only</u> if they relate to: 1. loading or unloading of a vehicle 2. work alongside the road eg construction or maintenance work 3. escape of a substance being conveyed by the vehicle 4. a train It is reportable asap. It does not include road traffic accidents at work	Where a doctor diagnoses that a person is suffering from a specified disease written in RIDDOR associated with specified work activities. 1. Carpel tunnel syndrome where the person's work involves regular use of percussive or vibrating tools. 2. Cramp in the hand or forearm, where the person's work involves prolonged periods of repetitive movement of the fingers, hand or arm. 3. Occupational dermatitis, where the person's work involves significant or regular exposure to a known skin sensitizer or irritant. 4. Hand arm vibration syndrome, where the person's work involves regular use of percussive or vibrating tools, or the holding of materials which are subject to percussive processes, or processes causing vibration. 5. Occupational asthma, where the person's work involves significant or regular exposure to a known respiratory sensitizer 6. Tendonitis or tenosynovitis in the hand or forearm, where the person's work is physically demanding and involves frequent, repetitive movements Report asap after diagnosis received. **Fatality (workers or non-workers)** 1. Work related accident 2. Fatality due to occupational exposure to a biological agent 3. Death of a person within 1 year of an injury, whether or not it was originally reported It is reportable asap	These are events which do not necessarily result in a reportable injury, but have the potential to cause significant harm. There are 27 categories in relation to the following: Lifting equipment, Pressure systems, overhead electric lines, electrical incidents causing explosion or fire, explosives, biological agents, radiation generators and radiography; breathing apparatus, diving operations, collapse of scaffolding , train collisions, wells, pipelines or pipeline works, structural collapse, explosion or fire, release of flammable liquids or gases, hazardous escapes of substances It is reportable asap It does not include injuries or deaths as a result of a surgical operation or medical treatment. **Gas incidents** Causing death or major injury Gas fitter finds a gas equipment which is or could have been likely to cause death or major injury. It is reportable asap **Exposure to Carcinogens, Mutagens & Biological Agents** 1. Cancer attributed to an occupational exposure to a known human carcinogen or mutagen (including ionising radiation) 2. Any disease attributed to an occupational exposure to a biological agent Report asap once received diagnosis

Appendix 9 – Risk Management & Incident Reporting Policy

Definitions

Hazard – Situations with the potential to cause harm.

Risk – Can be defined as the probability of incurring harm, adverse incidents or outcomes. The definition applies equally to all types of risk including patient safety, staff safety, financial, targets and assessment, environment and infrastructure.

Risk assessment – An assessment of what could cause harm to people or the organisation. To achieve this, the likelihood of the risk occurring and the severity (consequence) of impact are calculated to provide a risk score. Existing controls to prevent occurrence or reduce severity are considered along with actions required to mitigate or reduce the overall risk.

Controls – Existing precautions already in place to help prevent a risk from occurring or if it does reduce the severity.

Actions – Tasks required to reduce risk consequence (severity) or likelihood

Risk Score/Rating – The total score of consequence (severity) x likelihood of a risk.

Residual (Target) Rating – The final risk score of consequence (severity) x likelihood once all controls are in place.

Board Assurance Framework (BAF) – This document contains any identified risks to the Trust not achieving its key strategic objectives, and it is owned and reviewed at Trust Board level.

Corporate Risk Register – All risks to the organisation recorded on the Trust Datix Risk Management System that have been assessed as having a risk score of 12 or above

Department/Local Level Risk Register – All risks to the organisation recorded on the Trust Datix Risk Management System that have been assessed as having a risk score of below 12.

Project Risk Register – A local level risk register devised by the Project Manager as part of the creation of the project documentation e.g. it is included in the project mandate, brief and Initiation Documentation. The document is often held as an Excel spreadsheet. Key risks and an overall summary should be added to the Datix system to support the monitoring process.

Strategic Risk Review (higher level committee review) - Corporate risk register risks scoring 12 and above that are escalated to higher level committees for review and subsequent action where necessary.

Department/Local Level Risk Review – Risks scoring below 12 that are reviewed and managed by departments and directorates.

Incident – An event or circumstance that could have resulted, or did result in unnecessary damage, loss or harm to a person or organisation.

Level of harm arising from an event/incident – An unexpected or unintended incident resulting in injury, suffering, disability or death;

Patient Safety Incident - Is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

Serious Incident (SI) - A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more people. This includes suicide / self-inflicted death, and homicide by a person in receipt of mental health care within the recent past.

- Unexpected or avoidable injury to one or more people that has resulted in serious harm.

- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent the death of the service user or serious harm.

- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or where abuse occurred during the provision of NHS-funded care.

- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
    - Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues
    - Property damage;
    - Security breach/concern;
    - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
    - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
    - Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
    - Activation of Major Incident Plan (by provider, commissioner or relevant agency)

- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organization.

Never Event (NE) - All Never Events are defined as Serious Incidents although not all Never Events necessarily result in serious harm or death:

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post-operation
4. Mis-selection of a strong potassium containing solution
5. Wrong route administration of medication
6. Overdose of insulin due to abbreviations or incorrect device
7. Overdose of methotrexate for non-cancer treatment
8. Mis-selection of high strength midazolam during conscious sedation
9. Failure to install functional collapsible shower or curtain rails
10. Falls from poorly restricted windows
11. Chest or neck entrapment in bed rails
12. Transfusion or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso- or oro-gastric tubes
14. Scalding of patients.

The above criteria for SI identification is taken from the NHS England Never Event Framework and NHS England Serious Incident Framework effective from 1 April 2015.

Information Security Risk – Are those identified as threats against the nature, value or quality of the information assets of the Trust, the likelihood of occurrence and the impact upon the Trust of such an occurrence.

QVH uses the HSCIC Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation v 5.1 to assist with assessing the level of investigation required for information governance related incidents.

Appendix 10 - Guidance on the Preparation of a Statement

You may be requested to prepare a statement in relation to an Incident, which relates to the Risk Management and Incident Reporting Policy.

A. Following an Incident/Complaint/Occurrence

Once a member of the Risk Team has assessed an incident or the Patient Experience Manager has assessed information on a complaint/claim. Some Incidents lead to claims by the injured party or other third parties, which are often made after a significant period has elapsed. Such a record is prepared in contemplation of any potential claims in respect of the relevant Incident to ensure the Trust has the best information to decide how to deal with a claim – *Appendix A* of this Policy should be used.

B. The Coroner's Court – *Appendix A* of this Policy should be used.

Upon request, you should inform either the Director of Nursing(Ext 4359) or Medical Director (Ext 4256), and the Head of Risk Ext 4157) and Patient Experience Manager (Ext 4355).

If you are required to attend the Coroner's Court please inform the Director of Nursing/Medical Director as appropriate, as arrangements will be made to assist and support you at the Court. The Patient Experience Manager is usually the nominated person for this role.

C. The Police – *Appendix B* of this Policy (also known as form MG11) should be used.

All the guidelines set out under (B.) above apply equally to statements requested by the Police and the Coroners Court. In addition:

If the Police request to take a statement from you, seek to make an appointment to meet and complete this. While being co-operative, do not feel obliged to give a statement immediately, even if the Police are present on the ward. Seek to have this meeting off the ward, if possible, in an office e.g. with the Head of Risk, Patient Experience Manager or the Director of Nursing, or in a quiet room away from the wards. In addition, seek to have any of the following staff members attend this meeting with you

- Deputy Director of Nursing (Ext 6607)
- Patient Safety and Risk Officer (Ext 4363)

Inform your Union Representative/Medical Defence Union of the request.

For your own records, take a copy of your statement before you give it to the relevant Police Officer or, if a Police Officer writes your statement with you, obtain a copy before you part.

For your own records, take down details of the Police Officer to whom you give your statement or who writes it with you - name, title, and contact number.

The following guidelines should be followed in preparing these statements.

A. Purpose/Objective of writing a statement (or giving one to the Police):

1.1 Written statement - For you to put down on paper all that you know/remember about an occurrence while it is fresh on your memory.

1.2 Verbal statement (Given to the Police) - For you to state all that you know/remember about an occurrence while it is fresh on your memory.

1.3 In both of the above cases your statement, together with statements from all other members of staff that had any involvement in the Incident/occurrence, creates an accurate record of all the facts relating to what occurred.

B. Style/Format of statements:

The following guidelines are **not** listed in order of importance. You should follow them all as far as possible. For clarity, a skeleton statement is attached (Appendix A which can be used for incident investigations and those required by the Coroner. Form MG11 should be used for Police statements if a written record is requested).

2.1 Write legibly in black ball-point pen. Do not use a felt tip or pencil.

2.2 Number each paragraph and keep each paragraph short, detailing only 1 or 2 events in each paragraph.

2.3 Use simple clear English, explaining any technical terms, so your statement is an easy and understandable read for any layman.

2.4 Use the past tense throughout, as you are recording facts that have happened.

2.5 Keep your statement very factual, keeping any opinions or points of view to a minimum.

2.6 Ensure you put down all you know/remember and that it is true, accurate and as complete as possible.

C. Statement Contents:

1. Introduction

(i) *Purpose* - I (insert your full name) have been asked to prepare a statement regarding my involvement in the care of (insert name of patient).
(ii) *Personal details* – provide details of your professional qualifications and experience, your job title and employer.
(iii) Insert any qualifications that you have or are studies that you are currently doing.

2. Sources of information

(i) Confirm the extent of your recollection of the patient and the care provided.
(ii) Please set out any other information (such as health records and any other documentation) that you have considered prior to preparing your statement.

3. Narrative

(i) Set out details of your involvement with the patient and his/her clinical care.

(ii) This should be based on what you know from:-

(a) Specific recollection
(b) Your entries in the records
(c) Your invariable practice

(ii) The statement should be in chronological order.

(iv) You should explain any medical jargon or other abbreviations to enable the statement to be understood by a lay person.

(v) You should explain relevant background: for example, why you became involved.

(vi) With regard to medication you should explain the type of drug and the objective of its prescription.

(vii) If you were involved in making clinical decisions, then please explain the basis of your decision in the light of the patient' past medical history and the other information available to you at that time.

(viii) If you were working as part of a team, it is entirely appropriate to say in your statement what other members of the team were doing at any given time. However, it is important in these circumstances not to speculate on what others might have been doing if you do not know.

4. Summary

It would be helpful to summarise the main point so your involvement including, for example, the period of your involvement by reference to dates, the number of times that you saw the patient, your diagnosis and management plan.

5. Statement of Truth

The statement should be signed and dated and you should conclude the statement with the sentence:- "This statement, consisting of (enter the Number of pages), is true to the best of my information, knowledge, and belief".

Note: *Attach a copy of any documents that you refer to in your statement.*
Sign, print your name and date your statement the date you sign it.
All staff should keep copies of any statements that they provide.
(Statements should not be filed in the patient's medical records)

Appendix A - Statement Template/Example (for incident/occurrence and the Coroner)

WITNESS STATEMENT OF (ENTER YOUR NAME)

I, (enter your name) of Queen Victoria Hospital NHS Foundation Trust, Holtye Road, East Grinstead, RH19 3DZ **WILL SAY AS FOLLOWS:**

1. I make this statement in relation to the treatment I provided to (insert patients full name) "the patient" on (insert the date).

2. I qualified as a nurse in (insert the date). In (insert the date) I started working at the Queen Victoria Hospital NHS Foundation Trust ("the Trust") as a (insert what position you started the Trust as then state when you became your current position.)

3. Please insert any qualifications that you have or are studies that you are currently doing.

4. The Trust is an acute specialist hospital which accepts tertiary referrals from all over the UK for burns, trauma and corneoplastics, but we also have a community hospital on-site.

5. On (insert date) between (insert time) I was working on (location of incident i.e. name of ward/unit/department) in my role as (job title) and was assisting the patient with their treatment.

6. Subsequent paragraphs should be numbered and include the main details of your statement.

7. If referring to a patient's health records eexplain where the notes have been relied upon in their entirety by using the phrase 'According to the notes….'

8. Include any relevant conversations using direct speech and inverted commas, e.g. Dr X said 'I will return in….'

9. At the conclusion of the statement included the following sentence - This statement, consisting of (enter the No of pages), is true to the best of my information, knowledge, and belief.

Signed …….. Date ……

WITNESS STATEMENT

CJ Act 1967, s.9; MC Act 1980, ss.5A(3)(a) and 5B; Criminal Procedure Rules 2005, Rule 27.1

Statement of ..... URN: | | | | |

Age if under 18 **Over 18**..... (if over 18 insert 'over 18') Occupation: **Police Officer 203153**.....

This statement (consisting of: ....**1**..... pages each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything in it which I know to be false, or do not believe to be true.

Signature: ..... Date: .....

Tick if witness evidence is visually recorded ☐ *(supply witness details on rear)*

Signature: ..... Signature witnessed by: .....

Witness contact details

Home address: .....

..... Postcode: .....

Home telephone number ..... Work telephone number .....

Mobile/pager number ..... Email address: .....

Preferred means of contact: .....

Male / ~~Female~~ (delete as applicable) Date and place of birth: .....

Former name: ..... Ethnicity Code (16+1): ..... Religion/belief: .....

Dates of witness non-availability .....

.....

Witness care

a) Is the witness willing and likely to attend court? **No**. If 'No', include reason(s) on **MG6.**

b) What can be done to ensure attendance?

c) Does the witness require a Special Measures Assessment as a vulnerable or intimidated witness? **No**. If 'Yes' submit **MG2** with file.

d) Does the witness have any specific care needs? **No**. If 'Yes' what are they? (Disability, healthcare, childcare, transport, , language difficulties, visually impaired, restricted mobility or other concerns?)

Witness Consent (for witness completion)

a)	The criminal justice process and Victim Personal Statement scheme (victims only) has been explained to me	Yes ☐	No ☐			
b)	I have been given the Victim Personal Statement leaflet	Yes ☐	No ☐			
c)	I have been given the leaflet 'Giving a witness statement to police — what happens next?'	Yes ☐	No ☐			
d)	I consent to police having access to my medical record(s) in relation to this matter: (obtained in accordance with local practice)	Yes ☐	No ☐	N/A ☐		
e)	I consent to my medical record in relation to this matter being disclosed to the defence:	Yes ☐	No ☐	N/A ☐		
f)	I consent to the statement being disclosed for the purposes of civil proceedings e.g. child care proceedings, CICA	Yes ☐	No ☐			
g)	The information recorded above will be disclosed to the Witness Service so they can offer help and support, unless you ask them not to. Tick this box to decline their services:		☐			

Signature of witness: ..... Print name: .....

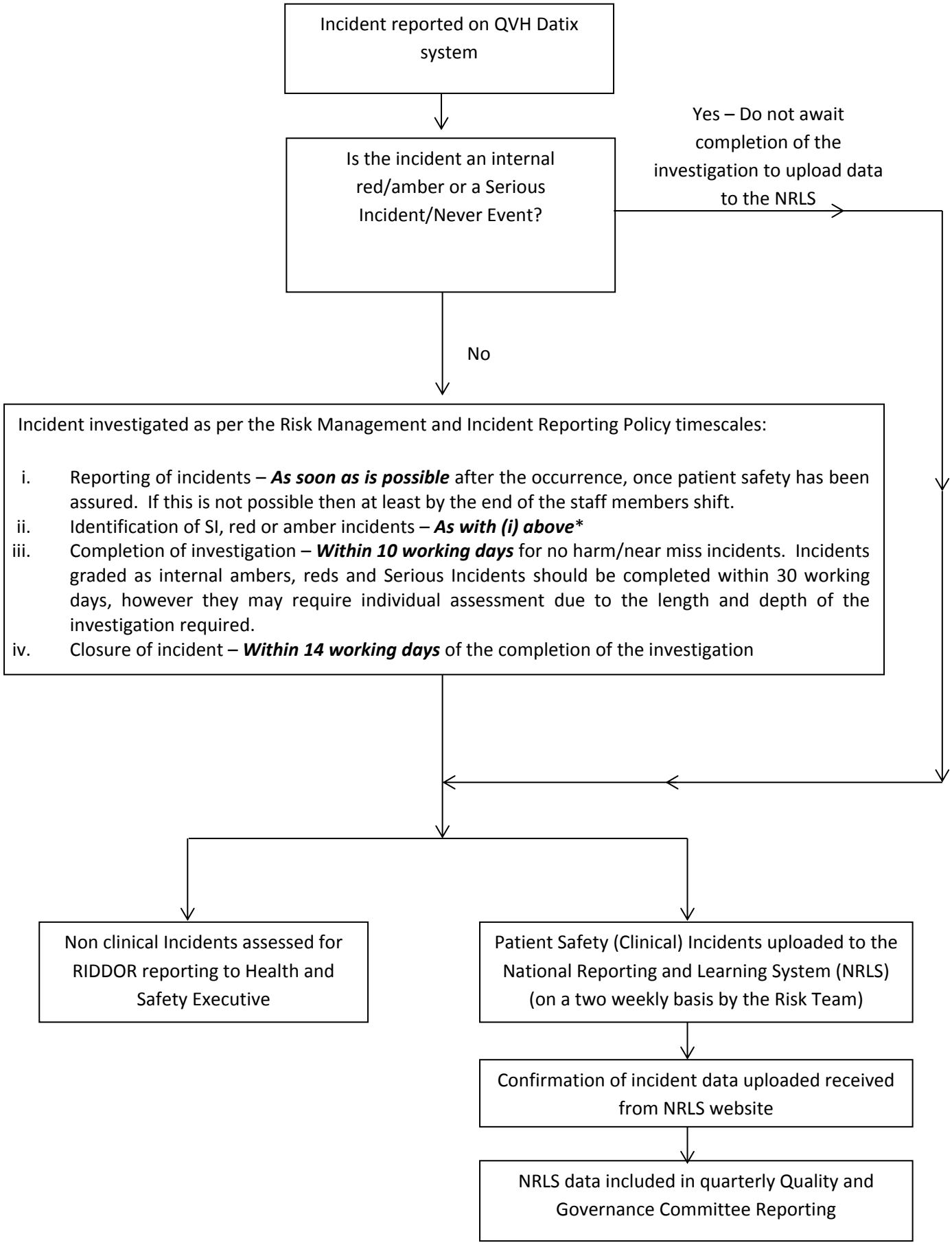
Signature of parent/guardian/appropriate adult: ..... Print name: ....

Address and telephone number if different from above: .....

Statement taken by (print name): ..... Station: .....

Time and place statement taken: .....

Appendix 11(a) National Reporting and Learning System (NRLS) Reporting Flowchart



Appendix 11(b) National Reporting and Learning System (NRLS) Upload Process

NRLS Upload Process

- Information is collected by running various reports In Datix Rich Client
- Reports ready for upload are placed in the Risk Management Folder (RMF) –
- RMF – NRLS – NRLS Uploads - Year – File Name

Note – File Name retained in the shared drive is constructed as follows:

Period of Incidents being uploaded followed by Date of Uploading.
e.g. Incident period 16th – 20th September 2014 being uploaded on 28th January 2015 would have a File Name of: 16092014-20092014-28012015

Datix

- THIS IS FOR **PATIENT SAFETY** INCIDENTS ONLY – **DO NOT INCLUDE ANY OTHER INCIDENTS** – ENSURE "PATIENT SAFETY" IS ENTERED IN THE "TYPE" FIELD.
- **ENSURE "Y" IS IN THE REPORT NRLS FIELD**.
- *(NB-Also run a "Patient Safety" / NRLS= "N" report. Review this report to ensure that the "No" status is correct. Correct if necessary)*
- Select period by Open Incident Date
- Include Start Date
- CHECK EACH REPORT TO ENSURE NO NAMES (OR INITIALS) ARE INCLUDED – MUST BE JOB TITLE OR "PATIENT" ONLY. THIS APPLIES TO FRONT SHEET AND INVESTIGATION BOX.
  TIP: RUN THROUGH ALL THE FRONT SHEETS THEN ALL THE INVESTIGATIONS
- Check "Severity" – TIP: From listing select "Add Column" – select "Severity" – Look for MODERATE/MAJOR/CATESTROPHIC – Check this is accurate
- Then go to SET UP (must be "in" an incident to do this)
- Then go to NPSA MAPPING
- Select BATCH UPDATE CCS
- Then BATCH UPDATE UNIT TYPE
- Then go to "Incidents" then NPSA EXPORT TO XML – This will come up with ERRORS – DO NOT keep an electronic copy of errors but **DO keep a paper copy on file**.
- File this listing in the RMF using period only for file name (i.e. – Do Not include Upload Date)
- From the paper copy – check and amend errors – e.g. Complete ALL THREE Datix CCS Fields
- Repeat from NPSA Export and File in RMF Using FULL NAME (i.e. Time Period followed by Upload Date).

NRLS WEBSITE

NRLS

- From RMF –go to "Passwords" – NRLS Password. Open and follow Link
- NB – TYPE in details from password folder.
- Select "Upload Incidents"
- Browse and select Incident file for period you wish to upload from RMF
- When "Successful" advice displayed – **Log Out**

Appendix 12 – Serious Incident Closure Checklist (For completion prior to submission of the completed Root Cause Analysis report) STEIS No…….

This checklist provides a tool which can be used by providers and commissioners in their assessment of systems investigation into serious incidents. The STEIS report must be fully completed including date investigation is completed, lesson learned and actions taken			
Phase of investigation	Element	Answer (yes/no)	If no, was there a robust rationale and that prevents this affecting the quality of the investigation?
Set up/ preparation	Is the Lead Investigator appropriately trained?		
	Was there a pre-incident risk assessment?		
	Did the core investigation team consist of more than one person?		
	Were national, standard NHS investigation guidance and process used?		
Gathering and mapping	Was the appropriate evidence used (where it was available) i.e. patients notes/records, written account?		
	Were interviews conducted?		
	Is there evidence that those with an interest were involved (*making use of briefings, de-briefings, draft reports etc*.)?		
	Is there evidence that those affected (*including patients/staff/ victims/ perpetrators and their families*) were involved and supported appropriately?		
	Is a timeline of events produced?		
	Are good practice guidance and protocols referenced to determine what should have happened?		
	Are care and service delivery problems identified? *(This includes what happened that shouldn't have, and what didn't happen that should have. There should be a mix of care (human error) and service (organisational) delivery problems)*		
	Is it clear that the individuals have not been unfairly blamed? (*Disciplinary action is only appropriate for acts of wilful harm or wilful neglect*)		
Analysing information	Is there evidence that the contributory factors for each problem have been explored?		
	Is there evidence that the most fundamental issues/ or root causes have been considered?		
Generating solutions	Have strong (effective) and targeted recommendations and solutions (targeted towards root causes) been developed? Are actions assigned appropriately? Are the appropriate members i.e. those with budgetary responsibility involved in action plan development? Has an options appraisal been undertaken before final recommendation made?		
Throughout	Is there evidence that those affected have been appropriately involved and supported?		
Next steps	Is there a clear plan to support implementation of change and improvement and method for monitoring?		
Overall assessment and feedback			

Protocol for CAS alert processing

Check the website daily: https://www.cas.dh.gov.uk/Home.aspx

Nominated CAS lead(s) –Patient Safety and Risk Officer / Risk Support Officer additional cover – Head of Risk

Additional weekly check by Patient Safety Officer to ensure all reported alerts are being administered in a timely manner

Log in details are kept by the Risk Management team.

Click on "View my alerts" – top left.

To view an individual alert, click on the title.

For a new alert, when it has been opened, click on the "Attachments" link to open the pdf of the alert, this is the part that is circulated.

Save the pdf in the alerts folder:

- Risk Management shared folder > SABS and CAS alerts > SABS and FSN 2015
- Open a new sub folder for each alert using the alert number – see files already there – and save the pdf (with a suitable title) in it.

Go back to the alert website, and change the "Response status" to "Assessing relevance". There is a deadline for this, usually 2 days from the date of issue of the alert.

The alert will contain a deadline dates for actions underway and actions complete.

Firstly, ascertain if the alert is relevant to QVH or not.

- For MDA alerts (medical devices) send an email to ward / department managers, MDO, EME and any other relevant person – eg, if manual handling equipment include the manual handling advisor, if relating to feeding devices include the dieticians. Attach the alert and say something along the following lines: "Please see attached alert and let me know as soon as possible whether or not this device is used in your department".

- For EFA alerts (estates) send as above but to Estates managers. However, if the alert relates to HV systems, it can be put straight to "Action not required" as there is no HV at the trust (see email from estates in the SABS and CAS alerts folder).

- For PSA alerts (patient safety), in the first instance send to the Director of Nursing and/or Head of Risk and/or Medical Director to assess whether it is relevant to QVH and, if so, to whom it should be circulated.

All replies to emails sent out, for all types of alerts, must be saved in the alert folder which has been set up in "SABS and FSN 2015".

If the alert is not relevant: all departments should reply to say that this is the case, and all replies are kept (add the department for easy reference). When this is established, the alert can then be changed to "Action not required" in the "Response status" section on the website and in the "Response notes" area add text to the effect that it is not relevant to the trust because xyz… (see previously closed alerts for examples). This has now closed the alert.

If the alert is relevant to QVH: the “Response status” should be changed to “Action required: ongoing”. The relevant people should be asked to let you know once actions have been completed, and by what date (see the deadline date on the alert). Save all subsequent emails as above. It is best practice to note deadlines in the calendar so that they are not missed (plus reminder dates if necessary). Once it is confirmed that actions are complete, on the website change the “Response status” to “Action completed” and put a brief summary of actions in the “Response notes” section. The alert is now closed.

To see all currently open alerts:
On the website “landing page” which lists the alerts, in the “Response status” box towards the right hold the CTRL key and highlight “Acknowledged”, “Assessing relevance “, “Action not started” and “Action required: ongoing” – then click Search alerts for a list.

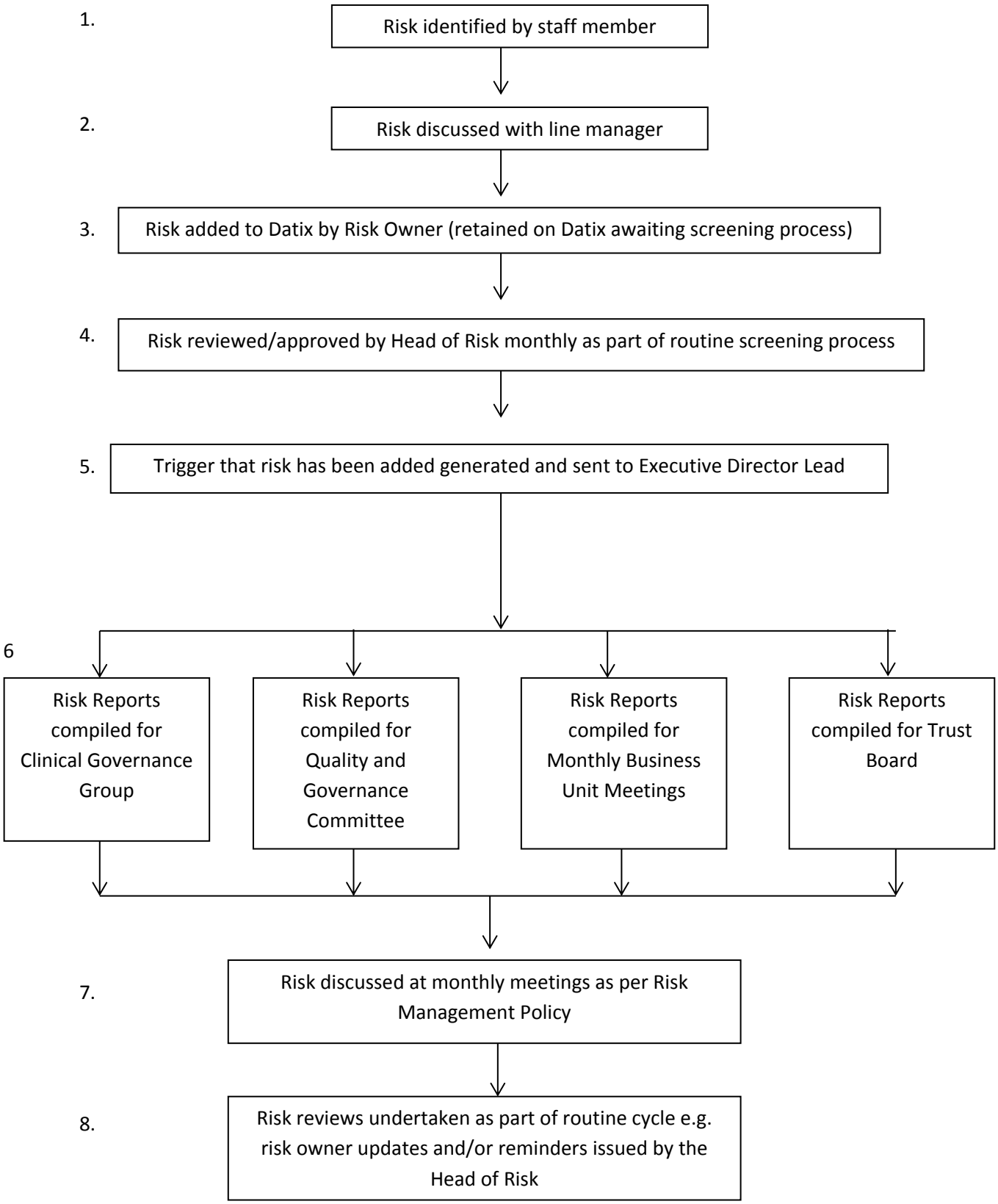
Other searches can be generated from this area. Results can be exported to Excel for reports for, eg, Clinical Governance Group (make sure they are saved as Excel Workbooks rather than a webpage).

Any queries or difficulties including lack of responses from departments should be reported to the Head of Risk / Director of Nursing.

Rachel Fromow
June 2015

Revised Mike Sexton December 2015

Process for adding a new risk to the Corporate Risk Register



n.b. Sections 4-6 are dependent upon the date that papers are collated for dissemination and may not be fully completed if reports are run between 1st and 7th of the month due to previous monthly reporting.

GENERAL RISK ASSESSMENT
Assess the risks to the health and safety of your employees, including females of child-bearing age and new and expectant mothers

Are risks present?

YES

Assess risks and reduce or remove, if possible

Inform your employees (either directly or through a safety representative) of the risks identified and of the importance in informing you that they are pregnant, have given birth in the last six months or breastfeeding, as early as possible.

NO

Inform your employees (either directly or through a safety representative) that no significant risks have been identified. However, it is still important that they inform you that they are pregnant, given birth in the last six months or breastfeeding, as early as possible.

You have been notified that an employee is pregnant, given birth in the last 6 months or is breastfeeding.

Revisit your general risk assessment as completed in Stage one, above.

Has a risk been identified?

YES

Can the risk be removed?

YES

Remove risk

NO

Action 1
Can the new or expectant mother's working conditions/ hours of work be adjusted?

YES

Adjust conditions hours

NO

Action 2
Can she be given suitable alternative work?

YES

Give suitable alternative work on same terms and conditions

NO

Action 3
Suspend her on paid leave for as long as necessary to protect her health and safety, or that of her child

NO

No immediate risk has been identified.
You must monitor and review this assessment regularly as circumstances may change.

NOTE: Employers have a legal duty to revisit, review and revise the general risk assessment if they suspect that it is no longer valid, or there have been significant changes to anything it relates to.

Queen Victoria Hospital NHS
NHS Foundation Trust

NEW & EXPECTANT MOTHERS RISK ASSESSMENT FORM

The appropriate manager should complete this form and ensure appropriate action is taken to reduce risks BEFORE the new mother commences / recommences work and as soon as the expectant mother has confirmed her condition in writing.

A fully completed copy is to be sent to:

- **New / Expectant Mother**
- **Human Resource**
- **Occupational Health Nurse Advisor**
- **Trust Risk Manager**

Please refer to the Trust's Guidance in the Risk and Incident Management Policy for completion of risk assessment.
If you have not completed risk assessment training, please contact the Staff development centre on extension 4230

DETAILS OF NEW / EXPECTANT MOTHER

Name:
Address:
DOB:
Ward / Department:
Working hours:
Main work tasks:

NEW / EXPECTANT MOTHER RISK ASSESSMENT FORM

HAZARDS	YES	NO	N/A
1. Anaesthetic gases			
2. Biological agents			
3. Glutaraldehyde, Formaldehyde			
4. Heights			
5. Lead			
6. Manual handling			
7. Mercury			
8. Night working			
9. Noise			
10. Photocopiers			
11. Radiation			
12. Slippery surfaces			
13. Solvents			
14. Temperature extremes			
15. Use of power tools			
16. Display Screen Equipment			
17. Vibration			
18. Other			

EXISTING CONTROL MEASURES

Hazard	Existing Control Measures

EVALUATING RISK

Hazard	Likelihood	x	Severity	=	Risk Score

ACTION PLAN

Hazard	Risk Rating	Action Required To Control Risk

FURTHER INFORMATION	Yes	No
More detailed assessment required		
Further information / investigation required to complete the risk assessment		
Any other relevant information		

ASSESSMENT SIGN OFF

Assessors name and title:

Date of assessment:

Copy of assessment to:

- **New / Expectant Mother** **Yes / No** **Date Sent:**
- **Human Resource** **Yes / No** **Date Sent:**
- **Occupational Health Nurse Advisor** **Yes / No** **Date Sent:**
- **Trust Risk Manager** **Yes / No** **Date Sent:**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/01/17**		**Agenda reference:**	**25-17**	
Report title:	**Audit committee**				
Sponsor:	Lester Porter, NED and committee Chair				
Author:	Lester Porter, NED and committee Chair				
Appendices:	NA				
Executive summary					
Purpose:	To provide assurance to the board in relation to matters discussed at the Audit Committee on 14 December 2016				
Recommendation:	The Board is asked 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:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	N/A				

Queen Victoria Hospital NHS
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Report to:	Board of Directors
Meeting date:	5th January 2017
Reference number:	25-17
Report from:	Lester Porter, Chair
Author:	Lester Porter, Chair
Appendices:	N/A
Report date:	18th December 2016

Audit Committee report

Meeting held on 14th December 2016

1. Assurance was provided by the Director of Operations on the management of risks associated with KSO3 Operational Excellence and on the work being undertaken to mitigate those risks.

2. Assurance was also provided to the Audit committee on the effective operation of the Quality and Governance Committee by the Chair of that committee including the proposed changes in frequency, due to be submitted to the Board for approval.

3. The decision of the Council of Governors to reappoint the Trust's external auditors, KPMG, for a period of three years with an option to extend for a further year, at a 2016/17 cost of £53425, a reduction of around £11000 on the 2015/16 fee, was confirmed by the Chair.

4. A summary of the 'clean' audit report on the QVH charity was provided by KPMG. The QVH Charity annual report and accounts were then approved by the committee for submission to the Corporate Trustee in January.

5. Mazars presented a summary of progress on the internal audit work programme for 2015/16 including a 'Limited' assurance given to an audit of Health Records Management. The Director of Nursing was asked by the Chair to ensure that progress on implementing the recommendations was regularly monitored at an appropriate senior management level. It was also agreed that all internal audit recommendations should, in future, show the Executive Director lead owner, as well as the line manager directly responsible for overseeing implementation. Mazars have also now taken on responsibility for monitoring and reporting to the committee on the progress made in implementing their recommendations.

6. The results of an informal feedback exercise completed by attendees on the effectiveness of the Audit Committee were circulated and discussed. Although generally positive, there were a number of detailed suggestions for improvement which will be incorporated into the Audit Committee's work where appropriate. It was agreed that a more formal review using the HFMA self-assessment tool should be undertaken in twelve months' time

7. The Audit Committee Terms of Reference were reviewed by the committee and approved for submission to the Trust Board.

8. There were no other matters requiring the attention of the Board.

LWMP

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/01/17**		**Agenda reference:**	**26-17**	
Report title:	**Board effectiveness review**				
Sponsor:	Clare Pirie, Head of Communications and Corporate Affairs				
Author:	Hilary Saunders, Deputy Company Secretary				
Appendices:	NA				
Executive summary					
Purpose:	The purpose of this report is to comply with the FT Code of Governance, which requires the Board of Directors to undertake a formal annual evaluation of its own performance and that of its committees and individual directors.				
Recommendation:	The Board is asked 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:	None				
Corporate risk register:	None				
Regulation:	FT Code of Governance				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	N/A				

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	05 January 2017
Agenda item reference no:	26-17
Sponsor:	Clare Pirie, Head of Communications and Corporate Affairs
Author:	Hilary Saunders, Deputy Company Secretary
Date of report:	12 December 2016

Board of Directors Annual Effectiveness Review

Purpose

1. The purpose of this paper is to comply with the FT Code of Governance, which requires the Board of Directors to undertake a formal annual evaluation of its own performance and that of its committees and individual directors. The Code also requires that details of this evaluation are included in the Annual Report and Accounts.

Background

2. In October 2015, the Board approved a series recommendations arising from a systematic governance review undertaken in the preceding months. The recommendations were designed to strengthen the Board's governance arrangements and maintain its regulatory ratings for governance. The revised systems and processes have been in place for just over a year now, and it is therefore timely to consider how well these arrangements are facilitating the Board to discharge its duties effectively.

Collective performance of the Board

3. The Board has continued to ensure that the organisation has a robust and effective risk management system, with the introduction of a new style BAF launched in January 2016. Each section of the Board agenda is now prefaced by the relevant part of the BAF, with the front sheet being incorporated as part of the CEO report. Detailed explanations of risk scores are provided within the relevant section of the Board report. On a quarterly basis, the Audit committee also undertakes a thorough interrogation of an individual KSO, seeking assurance in respect of gaps and controls. The corporate risk register is reviewed by both the Board and the Audit committee on a regular basis.

4. The Schedule of Matters Reserved for the Board, Standing Financial Instructions and Standing Orders were updated and approved by the Board in April 2016.

5. The Board appointed a new Chief Executive and a new Medical Director in Q3 of this financial year. Following the departure of non-executive director, Ian Playford, and with Lester Porter, the Senior Independent Director due to stand down in August, a skill mix review was undertaken in preparation for recruiting two new NEDs to the Board in 2017.

6. The Board ensures it continues to meet its responsibility to engage with stakeholders through various means, including the regular scrutiny of Friends and Family Test and patient experience results. In recent months a QVH patient has been invited to each Board meeting to describe their experience of care at the Trust. The Governor Representative role continues to enable strong and direct engagement between governors and the Board, especially NEDs. In 2016, the Board reviewed QVH's

membership base and extended eligibility for membership to the 12 south London boroughs as well as the previous geography of Kent, Surrey and East and West Sussex. This review was aligned to the requirement for a public membership profile that most fairly enfranchises the people who are the recipients of the Trust's services, and increased the total proportion of QVH patients eligible for membership from 94% to 98%.

7. In preparation for the Well-Led review in 2017/18, the Board undertook a governance and capability self-assessment in Q2, the results of which were discussed at the Board's away day in October. Whilst general satisfaction levels remained high in respect of strategy and planning, capability and culture, processes and structures and measurement, the following were highlighted as areas for improvement in 2017/18:

    - Additional clarity around plans to delivery strategy, stakeholder engagement, the Trust's vision, values and strategic goals;
    - Further work in respect of staff development, communication and empowerment, and
    - With the recent appointments of a new Chief Executive and Medical Director, and with two new NED appointments scheduled for 2017, additional support would be provided in respect of managing the transition of Board members.

Recommendation

8. The board of directors is asked to **NOTE** the contents of the annual review.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03/01/17**		**Agenda reference:**	**27-17**	
Report title:	**Annual approval of Board sub-committee Terms of Reference**				
Sponsor:	Clare Pirie, Head of Communications and Corporate Affairs				
Author:	Hilary Saunders, Deputy Company Secretary				
Appendices:	Statutory Committee ToRs • Audit • Nomination and remuneration Sub-committee ToRs • Finance and performance • Quality and governance				
Executive summary					
Purpose:	As part of the annual Board effectiveness review, the Board is asked to review and approve its committees' terms of reference. Key changes for the Q&GC ToRs include proposed 2 monthly meeting structure, non-voting rights for Governors, revised review date for TORs				
Recommendation:	The Board is asked to review and **approve** the latest ToRs				
Purpose:	**Approval**				
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:	NA				
Corporate risk register:	NA				
Regulation:	NA				
Legal:	NA				
Resources:	None				
Assurance route					
Audit previously considered by	Audit committee				
	Date:	14/12/16	Decision:	Recommended for approval	
F&PC ToRs previously considered by:	Finance and performance committee				
	Date:	19/12/16	Decision:	Recommended for approval	
Q&GC ToRs previously considered by:	Quality and governance committee				
	Date:	08/12/16	Decision:	Recommended for approval	
N&RC ToRs previously considered by:	Nomination and remuneration committee				
	Date:	Via email	Decision:	Further discussion required prior to final approval	
Next steps:	Once approved the respective terms of reference will be implemented and reviewed annually (or more frequently if necessary). The next scheduled review will take place in January 2018.				

Terms of reference

Name of governance body

Audit Committee

Constitution

The Audit Committee ("the committee") is a statutory, non-executive committee of the Board of Directors.

Accountability

The Committee is accountable to the Board of Directors for its performance and effectiveness in accordance with these terms of reference.

Authority

The Committee is authorised by the Board of Directors to:

- investigate any activity within its terms of reference.
- commission appropriate independent reviews and studies.
- seek relevant information from within the Trust and from any employee (all departments and employees are required to co-operate with requests from the committee).
- obtain relevant legal or other independent advice and to invite professionals with relevant experience and expertise to attend meetings of the committee.

Purpose

The purpose of the Committee is the scrutiny of the organisation and maintenance of an effective system of governance, risk management and internal control. This should include financial, clinical, operational and compliance controls and risk management systems. The Committee is also responsible for maintaining an appropriate relationship with the Trust's internal and external auditors.

Duties and responsibilities

On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of the Trust's:

1. **Integrated governance, risk management and internal control**
   The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

   In particular, the Committee will review the adequacy and effectiveness of:
   - All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board of directors.
   - The underlying assurance processes, including the board assurance framework, that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
   - The draft quality accounts, including the rigour of the process for producing the

quality accounts, in particular whether the information included in the report is accurate and whether the report is representative of both the services provided by the Trust, and of the issues of concern to its stakeholders.
- The Board of Director sub-committees, including terms of reference, workplans and span of reporting on an annual basis.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.
- The policies and procedures for all work related to counter fraud and security as required by NHS Protect.

In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key governance bodies of the Trust (for example, the Quality and Governance Committee) so that it understands processes and linkages.

2. Financial reporting

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the Board of Directors including those of budgetary control are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the annual report and financial statements before submissions to the Board of Directors focusing particularly on:
- The wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statement in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Letters of representation
- Explanations for significant variances

The Committee should review the Trust's standing financial instructions, standing orders and the scheme of delegation on an annual basis and make recommendations for change to the Board of Directors.

Internal audit

The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2013 and provides appropriate independent assurance to the Committee, Chief Executive (as accounting officer) and Board of Directors. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External audit
The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment allow (and making recommendations to the council of governors when appropriate).
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual audit plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation.
- Reviewing all external audit reports, including the Trust's annual quality report (before its submission to the board of directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Whistle blowing
The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns raised were investigated proportionately and independently.

Counter fraud
The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Protect's standards and shall review the outcomes of work in these areas.

Management
The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit).

Other assurance functions
The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission and the NHS Litigation Authority) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

In addition, the Committee will review the work of other Committees within the organisation whose work can provide relevant assurance to the Committee's own areas of responsibility. In particular, this will include any clinical governance, risk management or quality committees that are established.

In reviewing the work of a clinical governance committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

Meetings

Meetings of the Committee shall be formal, minuted and compliant with relevant statutory and good practice guidance as well as the Trust's codes of conduct.

The Committee will meet quarterly.

At least once a year, the Committee should meet privately with representatives of the external and internal auditors.

The Chair of the Committee may cancel, postpone or convene additional meetings as necessary for the Committee to fulfil its purpose and discharge its duties.

The Board of Directors, Chief Executive (as accounting officer), representative of the external auditor and head of internal audit may request additional meetings if they consider it necessary.

Chairmanship

The Committee shall be chaired by a non-executive director, appointed by the Trust Chair following discussion with the Board of Directors.

If the Chair is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the Committee shall be chaired by one of the other non-executive director members of the Committee.

The representative of the external auditor, head of internal audit, and counter fraud specialist have the right of direct access to the Chair of the Committee to discuss any matter relevant to the purpose, duties and responsibilities of the Committee or to raise concerns.

Secretariat

The Deputy Company Secretary shall be the secretary to the Audit Committee and shall provide administrative support and advice to the chair and membership. The duties of the secretary shall include but not be limited to:

- Preparation of the draft agenda for agreement with the Chair
- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers
- Taking the minutes of meetings and keeping a record of matters arising and

issues to be carried forward
- Maintaining the Committee's work programme.

Membership

Members with voting rights

The Committee will comprise at least three non-executive directors who shall each have full voting rights. The Chair of the Trust shall neither chair nor be a member of the Committee but can attend meetings by invitation of the Committee Chair.

Ex-officio attendees without voting rights

- Chief Executive (as Accounting Officer) who shall discuss with the Committee at least annually the process for assurance that supports the annual governance statement. The Chief Executive should also be in attendance when the Committee considers the draft annual governance statement along with the annual report and accounts.
- Representatives of the Trust's internal auditors.
- Representatives of the Trust's external auditors.
- The Trust's counter fraud specialist who shall attend at least two meetings of the Committee in each financial year.
- Representative of the QVH Council of Governors

The Chair, members of the Committee and the Governor representative shall commit to work together according to the principles established by the Trust's policy for engagement between the Board of Directors and Council of Governors.

In attendance without voting rights

The following posts shall be invited to attend routinely meetings of the Committee in full or in part but shall neither be a member nor have voting rights:

- Executive Director of Finance.
- Executive Director of Nursing.
- The secretary to the Committee (for the purposed described above).
- Designated deputies (as described below).
- Any other member of the Board of Directors, senior member of Trust staff or advisor considered appropriate by the chair of the Committee, particularly when the Committee will consider areas of risk or operation that are their responsibility.

Quorum

For any meeting of the Committee to proceed, two non-executive director members of the Committee must be present.

Attendance

Members and attendees are expected to attend all meetings or to send apologies to the chair and Committee secretary at least one clear day* prior to each meeting.

Attendees may, be exception and with the consent of the chair, send a suitable deputy if they are unable to attend a meeting. Deputies must be appropriately senior and empowered to act and vote on behalf of the Committee member.

Papers

Meeting papers to be distributed to members and individuals invited to attend at least five clear days prior to the meeting.

Reporting

Minutes of the Committee's meetings shall be recorded formally and ratified by the Committee at its next meeting.

The Committee chair shall prepare a report of each Committee meeting for submission to the Board of Directors at its next formal business meeting. The report shall draw attention to any issues which require disclosure to the Board of Directors including where executive action is continually failing to address significant weaknesses.

Issues of concern and/or urgency will be reported to the Board of Directors in between its formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the Trust chair. Instances of this nature will be reported to the Board of Directors at its next formal business meeting.

The Committee will also report to the Board of Directors at least annually on its work in support of the annual governance statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts

The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

In addition, the Committee shall make an annual report to the council of governors in relation to the performance of the external auditor to enable the council of governors to consider whether or not to re-appoint them.

Review

These terms of reference shall be reviewed by the Committee annually or more frequently if necessary. The review process should include the company secretarial team. The Board of Directors shall be required to ratify all changes.

The next scheduled review of these terms of reference will take place in December 2016 in parallel with the next annual review of the effectiveness of the Board of Directors.

* Definitions

- In accordance with the Trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

Terms of reference

Name of governance body

Finance and performance committee (F&PC)

Constitution

The finance and performance committee ("the committee") is a standing committee of the board of directors.

Finance and performance committee meetings should be formal and the Terms of Reference, membership and delegated powers should be approved by the Trust Board.

Accountability

The finance and performance is accountable to the board of directors, which holds it to account for its performance and effectiveness.

Authority

The committee is authorised by the board of directors to seek any information it requires from within the trust and to commission independent reviews and studies if it considers these necessary.

Purpose

The purpose of the committee is to assure the board of directors of:

- In-year delivery of financial and performance targets; and
- In-year delivery of the trust's strategic initiatives.

To provide this assurance the committee will maintain a detailed overview of:

- the trust's assets and resources in relation to the achievement of its financial plans and key strategic objective four: financial sustainability;
- the trust's operational performance in relation to the achievement of its activity plans and key strategic objective three: operational excellence; and
- the trust's workforce profile in relation to the achievement of key performance indicators and key strategic objective five: organisational excellence.

To fulfil its purpose, the committee will also:

- identify the key issues and risks requiring discussion or decision by the board of directors;
- advise on appropriate mitigating actions; and
- make recommendations to the board as the amendment or modification of the trust's strategic initiatives in the light of changing circumstances or issues arising from implementation

Duties and responsibilities

Responsibilities

On behalf of the board of directors, the committee will be responsible for the oversight and scrutiny of the trust's:

- monthly financial and operational performance
- estates strategy and maintenance programme
- information management and technology strategy, performance and development.

The committee will make recommendations to the board in relation to:

- capital and other investment programmes
- cost improvement plans
- business development opportunities and business cases.

Duties

Financial and operational performance

- Review, interpret and challenge in-year financial and operational performance
- Review, interpret and challenge workforce profile metrics including including sickness absence, people management, bank and agency usage, statutory and mandatory training compliance and recruitment
- Oversee the development and delivery of any corrective actions plans and advise the board of directors accordingly
- Review and support the development of appropriate performance measures, such as key performance indicators (KPIs), and associated reporting and escalation frameworks to inform the organisation and assure the board of directors.
- Refer issues of quality or specific aspects of the quality and risk committee's remit, to the quality and risk committee and maintain communication between the two committees to provide joint assurance to the board of directors.

Estates and facilities strategy and maintenance programmes

- Review the delivery of the trust's estates and facilities strategy and planned maintenance programmes as agreed by the board of directors.
- Consider initiatives and review proposals for land and property development and transactions prior to submission to the board of directors for approval.

Information management and technology strategy, performance and development

- Review the delivery of the trust's IM&T strategy and planned development programmes as agreed by the board of directors.

Capital and other investment programmes& decisions

- Oversee the development, management and delivery of the trust's annual capital programme and other agreed investment programmes.

- Evaluate, scrutinise and approve the financial validity of individual significant investment decisions (that require Board approval), including the review of Outline and Full Business Cases. Business cases that require Board approval will be referred to the committee following initial review by the Executive Management Committee and/or Capital Planning Group.

Cost improvement plans

- To oversee the delivery of the trust's cost improvement plans and the development of associated efficiency and productivity programmes.

Business development opportunities and business cases

- Evaluate emerging opportunities on behalf of the board of directors.
- Consider the merit of developed business cases for new service developments and service disinvestments prior to submission to the board of directors for approval.

Chairmanship

The finance and performance committee shall be chaired by a non-executive director, appointed by the trust chair following discussion with the board of directors.

A second non-executive director shall be the deputy chairperson of the F&PC and shall chair meetings in the event that the chairperson is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting.

Secretariat

The executive assistant to the director of finance and performance shall be the secretary to the F&PC and shall provide administrative support and advice to the chairperson and membership. The duties of the secretary shall include but not be limited to:

- Preparation of the draft agenda for agreement with the chairperson
- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers
- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward
- Maintaining the F&PC's work programme.

Membership

Members with voting rights

The following posts are entitled to membership of the Finance and performance committee and shall have full voting rights:

- Non-Executive Director (Chair)
- Non-Executive Director
- Non-Executive Director
- Chief Executive
- Director of finance and performance
- Director of operations
- Director of HR and OD

Ex-officio members with voting rights

- The director of nursing
- Any other member of the board of directors or senior manager considered appropriate by the chair of the committee.

Unless defined within these terms of reference ex-officio members of the F&PC have all of the rights and privileges of membership, including the right to vote.

In attendance with no voting rights

- The following bodies shall be invited to nominate an ex-officio member of the F & PC to represent their interests:
    - Council of Governors
- The following post is invited to attend meetings of the F & PC but shall not be a member or have voting rights:
    - The executive assistant to the director of finance and performance as secretariat

Quorum

For any meeting of the committee to proceed, two non-executive directors and one executive director of the trust must be present.

Attendance

Members are expected to attend all meetings or to send apologies at least 24 hours prior to each meeting.

Frequency of meetings
The committee will meet once in each calendar month, on the third Monday of the month. The chair of the committee may cancel, postpone or convene additional meetings as necessary for the committee to fulfil its purpose and discharge its duties.
Papers
Papers to be distributed to members and those in attendance at least three days in advance of the meeting.
Reporting
Minutes/a report of the meeting shall be prepared by the chairperson and secretary after every meeting and submitted to the Board of Directors at its next formal business meeting. Issues of concern and/or urgency will be reported to the board of directors in between formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the trust chair. Instances of this nature will be reported to the board of directors at its next formal business meeting.
Review
These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency. The next scheduled review of these terms of reference will take place in December 2017.

Terms of Reference

Name of governance body

Quality and Governance (Q&G) Committee

Constitution

The quality and governance committee ("the committee") is a standing and permanent sub-committee of the board of directors, established in accordance with the trust's standing orders, standing financial instructions and constitution.

Accountability

The committee is accountable to the board of directors for its performance and effectiveness in accordance with these terms of reference.

Authority

The board of directors has delegated authority to the committee to take the following actions on its behalf:

- Approve specific policies and procedures relevant to the committee's purpose, responsibilities and duties
- Engage with the trust's auditors in cooperation with the audit committee
- Seek any information it requires from within the trust and to commission independent reviews and studies if it considers these necessary.

Purpose

The purpose of the committee is to assure the board of directors of:

- The quality and safety of clinical care delivered by the trust at either its hub site in East Grinstead or any other 'spoke' sites
- The management and mitigation of clinical risk
- The governance of the trust's clinical systems and processes.

To provide this assurance the committee will maintain a detailed overview of:

- Health and safety
- Clinical and information governance
- Management of medicines and clinical devices
- Safeguarding
- Patient experience
- Infection control
- Research and development governance
- All associated policies and procedures.

To fulfil its purpose, the committee will also:

- Identify the key issues and risks requiring discussion or decision by the board of directors and advise on appropriate mitigating actions
- Make recommendations to the board about the amendment or modification of the trust's strategic initiatives in the light of changing circumstances or issues arising from implementation
- Work closely with the audit and finance and performance committees as necessary.

Responsibilities and duties

Responsibilities

On behalf of the board of directors, the committee will be responsible for the oversight and scrutiny of:

- The trust's performance against the three domains of quality; safety, effectiveness and patient experience.

- compliance with essential professional standards, established good practice and mandatory guidance including but not restricted to:
    - Care Quality Commission national standards of quality and safety
    - National Institute for Care Excellence (NICE) guidance
    - National Audit Office (NAO) recommendations
    - Relevant professional bodies (e.g. Royal colleges) guidance
- delivery of national, regional, local and specialist care quality (CQuIN) targets.

Duties

- Support the compilation of the trust's annual quality accounts recommend to the board of directors its submission to the Care Quality Commission
- Recommend quality priorities to the board of directors for adoption by the trust
- Ensure that the audit programme adequately addresses issues of relevance and any significant gaps in assurance
- To receive a quarterly report on healthcare acquired infections and resultant actions
- To receive and review quarterly integrated reports encompassing complaints, litigation, incidents and other patient experience activity
- To ensure that workforce issues, where they impact or have a direct relationship with quality of care are discussed and monitored
- Review quarterly quality components of the corporate risk register and assurance framework and make recommendations on areas requiring audit attention, to assist in ensuring that the trust's audit plans are properly focused on relevant aspects of the risk profile and on any significant gaps in the assurance
- Ensure that management processes are in place which provides assurance that the trust has taken appropriate action in response to relevant independent reports, government guidance, statutory instruments and ad hoc reports from enquiries and independent reviews
- Ensure there are clear lines of accountability for the overall quality and safety of clinical care and risk management
- Hold business units and directorates (clinical infrastructure/non clinical infrastructure) to account on all matters relating to quality, risk and governance.

Meetings

Meetings of the committee shall be formal, minuted and compliant with these terms of reference and the trust's relevant codes of conduct.

The committee will meet once every two months in the calendar month before the board. During the calendar month where there is no formal committee meeting members of the committee will attend the local governance and departmental meeting of the key business units and clinical infrastructure to assess the clinical governance processes in place and to gain a deeper understanding of quality in the local services and departments. Members will provide formal feedback to each Q&GC on their observations of these meetings. This will be administered by the Director of Nursing's secretariat.

The chairperson of the committee may cancel, postpone or convene additional meetings as necessary for the committee to fulfil its purpose and discharge its duties.

Chairmanship

The committee shall be chaired by a non-executive director, appointed by the trust chair following discussion with the board of directors.

If the chairperson is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the committee shall be chaired by one of the other non-executive director members of the committee.

Secretariat

The personal assistant to the director of nursing shall be the secretary to the committee and shall provide administrative support and advice to the chairperson and members. The duties of the secretary shall include but not be limited to:

- Preparation of the draft agenda for agreement with the chairperson
- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers
- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward
- Maintaining the committee's work programme.

Membership

Members with voting rights

The following posts are entitled to permanent membership of the committee with full voting rights:

- non-executive directors (x 2)
- Chief Executive
- Director of Nursing
- Medical Director
- Deputy Director of Nursing
- Director of Finance
- Director of Operations
- Director of HR and Organisational Development.

Designated deputies (as described below) are entitled to temporary membership of the committee with full voting rights.

Ex-officio members

The following bodies shall be invited to nominate an ex-officio member of the committee to represent their interests:

Without voting rights

- Council of Governors of Queen Victoria Hospital NHS Foundation Trust. The chairperson, members of the committee and the governor representative shall commit to work together according to the principles established by the trust's policy for engagement between the board of directors and council of governors.
- The trust's internal auditor
- Clinical Commissioning Group (CCG) – principle commissioner of the trust's services

In attendance without voting rights

The following posts shall be invited to attend routinely meetings of the committee in full or in part but shall not be a member or have voting rights:

- The secretary to the committee (for the purposes described above)
- Business managers
- Allied health professional lead
- Infection control lead
- Head of risk
- Patient experience lead
- Pharmacy lead
- Company secretary
- Audit and outcomes lead

Quorum

For any meeting of the committee to proceed, the following combination of members must be present:

- one non-executive director
- either the director of nursing or deputy director of nursing must be present
- One other director with voting rights;
- Four members without voting rights

Attendance

Members are expected to attend all meetings or to send apologies to the chairperson and committee secretary at least one clear day* prior to each meeting.

Applicable members may, by exception and with the consent of the chairperson, send a suitable deputy if they are unable to attend a meeting. Deputies must be appropriately senior and empowered to act and vote on the behalf of the committee member.

Papers

Meeting papers shall be distributed to committee members and individuals invited to attend committee meetings at least five clear days* prior to the meeting.

In the event of a significant adverse variance in any of the key indicators of clinical performance or patient safety, the responsible executive director will make an immediate report to the committee chairperson copied to the trust chair and chief executive, for urgent discussion at the next meeting of the committee and escalation to the trust board.

Reporting

Minutes of the committee's meetings shall be recorded formally and ratified by the committee at its next meeting.

Minutes of committee meetings and an assurance report from the committee chairperson shall be submitted to the board of directors at its next formal business meeting.

Issues of concern and/or urgency will be reported to the board of directors in between formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the trust chair. Instances of this nature will be reported to the board of directors at its next formal business meeting.

Final and approved minutes of committee meetings shall be shared with the clinical cabinet and a quarterly update from the committee chairperson shall be provided to the audit committee.

The committee chairperson and governor representative to the committee shall report verbally at quarterly meetings of the council of governors.

Review

These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team. The board of directors shall be required to approve all changes.

The next scheduled review of these terms of reference will take place in January 2018.

Definitions

In accordance with the trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

Terms of reference

Name of governance body

Nomination and Remuneration ('Nom and Rem' or 'N&R') Committee

Constitution

The nomination and remuneration committee (the committee) is constituted as a statutory non-executive committee of the trust's board of directors.

Accountability

The committee is accountable to the board of directors for its performance and effectiveness in accordance with these terms of reference.

Authority

The committee is authorised by the board of directors to:

- Appoint or remove the chief executive, subject to the approval of the council of governors, and set the remuneration and allowances and other terms and conditions of office of the chief executive.
- Appoint or remove the other executive directors and set the remuneration and allowances and other terms and conditions of office of the executive directors, in collaboration with the chief executive.
- Consider any activity within its terms of reference.
- Seek relevant information from within the trust. (All departments and employees are required to co-operate with any request made by the committee).
- Instruct independent consultants in respect of executive director remuneration.
- Request the services and attendance of any other individuals and authorities with relevant experience and expertise if it considers this necessary to exercise its functions.

Purpose

The purpose of the committee is to:

- Determine the structure, size and composition (including the skills, knowledge, experience and diversity) of the board of directors, making use of the output of the board evaluation process as appropriate, and to make recommendations to the board and to the appointments committee of the council of governors, as applicable, with regard to any changes.
- Identify and appoint candidates to fill all executive director and other positions that report to the chief executive and to decide and keep under review their terms and conditions of office, including:
    - Salary, including any performance-related pay or bonus;
    - Provisions for other benefits, including pensions and cars;
    - Allowances;
    - Payable expenses;
    - Compensation payments.

- Set the overall policy for the remuneration packages and contractual terms of the executive management team.

Responsibilities and duties

Responsibilities

On behalf of the board of directors, the committee has the following responsibilities:

- To identify and appoint candidates to fill posts within its remit as and when they arise.
- In doing so, to adhere to relevant laws, regulations, trust policies and the principles and provisions regarding the levels and components of executive directors' remuneration as defined by section D of the Monitor *Code of Governance* [to be included as an annex to the terms of reference].
- To be sensitive to other pay and employment conditions in the trust.
- To keep the leadership needs of the trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy.
- To give full consideration to and make plans for succession planning for the chief executive and other executive directors taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the board in the future.
- To sponsor the trust's leadership development and talent management programmes to support succession plans and meet specific recruitment and retention needs.
- To work with the appointments committee of the council of governors to ensure that processes for the nomination and remuneration and performance appraisal of the trust chairperson and non-executive directors and chief executive and executive directors are aligned.

Duties (nominations)

- When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment.
- Use open advertising or the services of external advisers to facilitate candidate searches.
- Consider candidates from a wide range of backgrounds on merit against objective criteria.
- Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.
- Consider any matter relating to the continuation in office of any executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract.

Duties (remuneration)

- Establish and keep under review a remuneration policy in respect of executive board directors and other positions that report to the chief executive.
- Establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the trust.
- Use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors and other positions that report to the chief executive, while ensuring that increases are not made where trust or

individual performance do not justify them.
- Monitor, and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels.
- Consult the chief executive about proposals relating to the remuneration of the other executive directors.

Meetings

Meetings of the committee shall be formal, minuted and compliant with relevant statutory and good practice guidance as well as the trust's codes of conduct.

The committee will usually meet quarterly.

The chairperson of the committee may cancel, postpone or convene additional meetings as necessary for the committee to fulfil its purpose and discharge its duties.

The board of directors, chief executive and director of human resources and organisational development may request additional meetings if they consider it necessary.

Chairmanship

The committee shall be chaired by the chairperson of the trust.

If the chairperson is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the committee shall be chaired by the senior independent director of the trust.

Secretariat

The company secretary, working closely with the director of human resources and organisational development, shall be the secretary to the committee and shall provide administrative support and advice to the chairperson and membership. The duties of the secretary shall include but not be limited to:
- Preparation of the draft agenda for agreement with the chairperson
- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers
- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward.
- Maintaining the committee's work programme.

Membership

Members with voting rights

The committee shall comprise all non-executive directors of the trust who shall each have full voting rights.

Ex-officio attendees without voting rights
- Chief Executive
- Director of Human Resources and Organisational Development

In attendance without voting rights
- The secretary to the committee (for the purposes described above)
- Any other member of the board of directors, senior member of trust staff or external advisor considered appropriate by the chairperson of the committee.

Quorum

For any meeting of the committee to proceed, two non-executive members of the committee must be present.

Attendance

Members and attendees are expected to attend all meetings or to send apologies to the chairperson and committee secretary at least one clear day* prior to each meeting.

Attendees, including the secretary to the committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

Papers

Meeting papers shall be distributed to members and attendees at least five clear days prior to the meeting.

Reporting

Minutes of the committee's meetings shall be recorded formally and ratified by the committee at its next meeting.

The committee chairperson shall prepare a report of each committee meeting for submission to the board of directors at its next formal business meeting.

Review

These terms of reference shall be reviewed by the committee annually or more frequently if necessary. The review process should include the company secretarial team. The board of directors shall be required to approve all changes.

The next scheduled review of these terms of reference will take place in October 2016, in parallel with the next annual review of the effectiveness of the board of directors.

*** Definitions**

- In accordance with the trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

Queen Victoria Hospital NHS
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 2 March 2017 at 10:00
Cranston Suite, East Court, College Lane, East Grinstead, West Sussex RH19 3LT

Agenda: session held in public			
Welcome			
-17	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**Page**
-17	**Draft minutes of the meeting session held in public on 5 January 2017 (for approval)** *Beryl Hobson, Chair*	*Approval*	paper
-17	**Matters arising and actions pending** *Beryl Hobson, Chair*	*Review*	paper
-17	**Chief executive's report** *Steve Jenkin, Chief Executive*	*Assurance*	paper
Key strategic objective 1: outstanding patient experience			
-17	**Board Assurance Framework** *Jo Thomas, Director of Nursing*	*Assurance*	paper
-17	**Corporate risk register (CRR)** *Jo Thomas, Director of Nursing*	*Review*	paper
-17	**Patient story** *Jo Thomas, Director of Nursing*	*Assurance*	-
-17	**Quality and governance assurance report** *Ginny Colwell, Non-executive director and committee chair*	*Assurance*	paper
-17	**Quality and safety report** *Jo Thomas, Director of Nursing*	*Assurance*	paper
Key strategic objective 2: world-class clinical services			
-17	**Board Assurance Framework** *Ed Pickles, Medical Director*	*Assurance*	paper
-17	**Medical director's report** *Ed Pickles, Medical Director*	*Assurance*	paper
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
-17	**Board Assurance Framework** *Paula Smith, Business Manager (on behalf of Sharon Jones, Director of Operations) and Clare Stafford, Director of Finance*	*Assurance*	paper
-17	**Financial and operational performance assurance report** *John Thornton, Non-Executive Director*	*Assurance*	paper
-17	**Operational performance** *Paula Smith, Business Manager (on behalf of Sharon Jones, Director of Operations)*	*Assurance*	paper
-17	**Financial performance** *Clare Stafford, Director of Finance and Performance*	*Assurance*	paper
Key strategic objective 5: organisational excellence			

-17	**Board assurance framework** *Geraldine Opreshko, interim Director of Human Resources and Organisational Development*	*Assurance*	paper
-17	**Workforce report** *Geraldine Opreshko, interim Director of Human Resources and Organisational Development*	*Assurance*	paper
-17	**Staff Survey results** *Geraldine Opreshko, interim Director of Human Resources and Organisational Development*	*Discussion*	paper
Board governance			
-17	**Sustainability and Transformation plan** *Steve Jenkin, Chief Executive*	*Discussion*	-
-17	**Charitable Fund Corporate Trustee** *Beryl Hobson, Chair*	*Assurance*	paper
-17	**Nomination and remuneration committee** *Beryl Hobson, Chair*	*Assurance*	paper
-17	**Draft agenda for the May 2017 business meeting** *Clare Pirie, Head of Communications and Corporate Affairs*	*Information*	paper
Any other business (by application to the Chair)			
-17	*Beryl Hobson, Chair*	*Discussion*	-
Observations and feedback			
-17	**Feedback from key events and other engagement with staff and stakeholders** *All*	*Discussion*	-
-17	**Questions from members of the public** *We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to Hilary.Saunders@qvh.nhs.uk clearly marked "Questions for the board of directors". Members of the public may not take part in the Board discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.*	*Discussion*	-

Date of the next meetings

Board of Directors:	**Sub-Committees**	**Council of Governors**
Public: 04 May at 10:00	**Q&G:** 9 March 2017 at 09:00 **F&P:** 20 March 2017 at 14:00 **N&R:** 20 April at 12:00 **Audit**: 22 March 2017 at 14:00 **Charity:** 30 March 2017 at 09:00 **Corp. Trustee**: 02 Nov 2017 at 14:00	**Public**: 10 April 2017 at 16:00

NB: Feedback on board meeting to be provided by JEB (governor representative)