Queen Victoria Hospital NHS
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 2 March 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: 2 March 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
Director of Finance and Performance	-	Clare Stafford

In full attendance (non-voting):

Director of Human Resources & OD	-	Geraldine Opreshko
Director of Operations	-	Sharon Jones (apologies)
Head of Communications and Corporate Affairs	-	Clare Pirie
Deputy Company Secretary	-	Hilary Saunders
Governor Representative:	-	John Belsey
Business Manager	-	Paula Smith

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 2 March 2017 at 10:00
Cranston Suite, East Court, College Lane, East Grinstead, West Sussex RH19 3LT

Agenda: session held in public			
Welcome			
33-17	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**Page**
34-17	**Draft minutes of the meeting session held in public on 5 January 2017 (for approval)** *Beryl Hobson, Chair*	*Approval*	1
35-17	**Matters arising and actions pending** *Beryl Hobson, Chair*	*Review*	12
36-17	**Chief executive's report** *Steve Jenkin, Chief Executive*	*Assurance*	15
Key strategic objective 1: outstanding patient experience			
37-17	**Board Assurance Framework** *Jo Thomas, Director of Nursing*	*Assurance*	20
38-17	**Corporate risk register (CRR)** *Jo Thomas, Director of Nursing*	*Review*	21
39-17	**Quality and governance assurance report** *Ginny Colwell, Non-executive director and committee chair*	*Assurance*	45
40-17	**Quality and safety report** *Jo Thomas, Director of Nursing*	*Assurance*	48
41-17	**Infection Control annual report** *Jo Thomas, Director of Nursing*	*Assurance*	81
Key strategic objective 2: world-class clinical services			
42-17	**Board Assurance Framework** *Ed Pickles, Medical Director*	*Assurance*	114
43-17	**Medical director's report** *Ed Pickles, Medical Director*	*Assurance*	115
44-17	**New junior doctors' contract and exception reporting** *Ed Pickles, Medical Director*	*Information*	119
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
45-17	**Board Assurance Framework** *Paula Smith, Business Manager (on behalf of Sharon Jones, Director of Operations) and Clare Stafford, Director of Finance*	*Assurance*	133
46-17	**Financial and operational performance assurance report** *Beryl Hobson, Trust Chair*	*Assurance*	135
47-17	**Operational performance** *Paula Smith, Business Manager (on behalf of Sharon Jones, Director of Operations)*	*Assurance*	138

48-17	**Financial performance** *Clare Stafford, Director of Finance and Performance*	*Assurance*	147
Key strategic objective 5: organisational excellence			
49-17	**Board assurance framework** *Geraldine Opreshko, interim Director of Human Resources and Organisational Development*	*Assurance*	165
50-17	**Workforce report** *Geraldine Opreshko, Director of Human Resources and Organisational Development*	*Assurance*	166
Board governance			
51-17	**Charitable Fund Corporate Trustee** *Beryl Hobson, Chair*	*Assurance*	179
52-17	**Nomination and remuneration committee** *Beryl Hobson, Chair*	*Assurance*	181
53-17	**Committee Terms of Reference** • **Finance and performance** *Clare Stafford, Director of Finance and Performance* • **Nomination and remuneration** *Beryl Hobson, Trust Chair*	*Approval*	183
54-17	**Draft agenda for the May 2017 business meeting** *Clare Pirie, Head of Communications and Corporate Affairs*	*Information*	192
Any other business (by application to the Chair)			
55-17	*Beryl Hobson, Chair*	*Discussion*	-
Observations and feedback			
56-17	**Feedback from key events and other engagement with staff and stakeholders** *All*	*Discussion*	-
57-17	**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@gvh.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

Queen Victoria Hospital NHS
NHS Foundation Trust

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 5 January 2017, 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
	Steve Jenkin (SJ)	Chief Executive
	Ed Pickles (EP)	Medical Director
	Lester Porter (LP)	Senior Independent Director
	Clare Stafford (CS)	Director of Finance and Performance
	John Thornton (JT)	Non-Executive Director
In attendance:	John Belsey (JEB)	Governor Representative
	Sharon Jones (SLJ)	Director of Operations
	Geraldine Opreshko (GO)	Director of Human Resources & Organisational Development
	Clare Pirie (CP)	Head of Communications and Corporate Affairs
	Nicky Reeves (NR)	Deputy Director of Nursing
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
Apologies:	Jo Thomas (JMT)	Director of Nursing
Public gallery	Two members of the Council of Governors	

Welcome	
01-17	**Welcome, apologies and declarations of interest** The Chair opened the meeting and wished everyone a Happy New Year. She went on to welcome SJ to his first public Board meeting since being appointed Chief Executive, and also NR, (Deputy Director of Nursing) who was attending on behalf of JMT today. Apologies were noted as above. There were no new declarations of interest.
Standing items	
02-17	**Draft minutes of the meeting sessions held in public on 3 November 2016 for approval** The minutes of the meeting held on 3 November were **APPROVED** as a correct record.
03-17	**Matters arising and actions pending** The Board received and **APPROVED** the current record of matters arising and actions pending,
04-17	**Chief Executive's report** SJ opened by thanking the Chair, members of the Executive Management Team and staff at the hospital for providing him with such a warm welcome. He went on to discuss his report briefing the Board on progress and updating on external issues that could impact on the Trust's ability to achieve its internal targets, and asked the Board to note in particular the following: • The Single Oversight Framework which had been introduced in October 2016 to replace the Risk Assessment Framework (previously used by Monitor). Although the Trust had been placed in segment 1 during the shadow implementation period, it had subsequently been moved to segment 2 in ratings published in December. SJ reported that there had been no consultation with the Trust prior to this change, but advised that arrangements were in place to meet with NHSI to clarify any misunderstandings around reporting; in the meantime, he assured the Board there was no cause for

	concern at this stage;
	• From April 2017, Western Sussex Hospitals Foundation Trust (WSHFT) would take over the leadership of Brighton and Sussex University Hospitals Trust (BSUH). The Board questioned the implications for QVH of this change. SJ felt these were unknown at present but acknowledged that these could impact on the Sustainability and Transformation Plan, reiterating the importance of remaining engaged in the planning process. The Board went onto discuss the following:
	  • Simon Stevens, Head of NHS England, had raised the outstanding Burns issue and was asking for swift resolution. Questions remain around both paediatric and adult burns including the costs pressures involved in potential solutions.
	  • The potential opportunities and challenges posed by this leadership change; further discussion would be scheduled for the Board's next seminar in February.
	• The Care Quality Commission had published its review into current methods of investigating patient deaths in England, entitled 'Learning, Candour and Accountability'. The government's initial response included requirements for trusts to:
	  • Identify a patient safety director (most likely to be the Medical Director) to ensure the resourcing and prioritisation of this programme;
	  • Appoint a non-executive director to oversee progress.
	Whilst the Trust did not have a high death rate, EP observed that there was still room for improvement in communicating difficult news to families.
	
	There were no further questions and the Board **NOTED** the update.

05-17	**Board Assurance Framework overview** The BAF overview was presented for information. SJ explained that graphs detailing trends contained in previous reports had been removed. To improve clarity these would be replaced by additional narrative in the future. Other changes to the BAF would be explored in more detail at the February Board seminar. There were no further questions and the Board **NOTED** the update.
06-17	**Sustainability and Transformation Plan** SJ acknowledged that whilst the Board had previously discussed the Sustainability and Transformation Plan (STP) informally, it should now be considered further in light of the recently published STP and the implications for the wider health economy, as well as for QVH. To this end, the Sussex and East Surrey footprint and the Central Sussex and East Surrey Alliance place-based delivery plan was included within the Board reports. SJ reported that initial feedback from both NHSE and NHSI was that more radical change would be required to achieve the aims of improving health and well-being and quality of local health and care services, whilst delivering financial stability for the health and care system. The Board considered the plan and debated the implications at length. Particular concerns included: • That there had been limited clinical and public engagement to date. It was noted, however, that an STP communications network meeting was due to take place the following week and that one of the Trust's clinicians had been nominated to join the digital project workstream. A programme director had been appointed to support the work of the STP, which would be funded on a proportional basis by the 23 organisations involved. • The QVH Board had not at present delegated authority for any of the proposed changes. It was important to note, therefore, that much of the work undertaken around STPs had no basis in statute at present, with no written agreement and no terms of reference. • Uncertainty around spend and the need for the Trust to understand what the financial implications of

	any changes might be. There was no additional money in the system to support implementation of the STPs; • Acknowledgement that this was an enormous piece of work which would impact on the Executives' time and Trust's finances; however, this would play into and strengthen our current work on strategy. The Trust would still be required to think separately about its tertiary role; • Reports of two large NHS hospitals gaining more revenue through treating private patients. Auditors would to be asked to look into details and feedback at the February seminar if timescales allowed. **[Action: CS]** In summary SJ concluded that QVH was strongly placed to support both the development of community care, and also the networked approach to specialist acute care as already reflected in our hub and spoke arrangements across both Sussex and Kent. There were no further questions and the Board **NOTED** the update.
Key strategic objective 1: outstanding patient experience	
07-17	**Board assurance framework** NR advised that the BAF for KSO1 had been refreshed, and the current risk rating now stood at 12 (amber). This reflected the current failure to attract staff with the right skills, mirroring the national shortage of nurses and practitioners in theatres and ITU, (although current low bed occupancy offset the risk). The Board sought assurance that the Trust was striving to address the problem and was advised that tactics employed so far included: • Local media plans, but which to date had been unsuccessful; • Career fairs, university recruitment events etc; • Targeted work undertaken by the Director and Deputy Director of Nursing as part of the six-monthly workforce review, to ascertain exact staffing requirements within Theatres; • Work undertaken by the Theatre productivity group; GO updated the Board on a current proposal for advertising and marketing options; these had proven to be more effective than traditional methods but the EMT would need to agree a way in which to offset the additional associated costs. There were no further questions and the Board **NOTED** the contents of the update.
08-17	**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. NR drew the Board's attention to the following two new risks which had been added since the last Board meeting: • Risk ID 1003 – Information Technology Network Outage, and • Risk ID 1004 – Information Technology Servicer Software Operating system. The Board was assured that actions and mitigations were already in place and being monitored by the IT Manager and the Director of Finance. Two risks relating to the Junior doctor industrial action had been de-escalated, with the rationale being approved by the Medical Director. Due to some anomalies around risk review dates, the Board queried whether the risk register presented today was the most recent version. NR agreed to check and if necessary circulate the latest version via email. **[Action: NR]**

	Following the recent departure of the Trust's risk manager, the Board was assured of plans to recruit a replacement who would be starting in March 2017. It was also satisfied with plans in place to manage the current vacancy until that time. There were no further questions and the Board **NOTED** the contents of the update.
09-17	**Patient story** NR advised that due to the Christmas break, it had not been possible to identify a patient to attend today's meeting. Plans were in place however to invite a patient to the March meeting.
10-17	**Quality and governance assurance report** GC presented the regular quality and governance report. This provided information and assurance in respect of Q&GC meetings and activities in November and December. Highlights included: • Of a total of 223 Trust policies, only 36 were still outstanding; • During a discussion on patient safety issues, the Committee had requested further assurance in respect of a potential major issue. The Board questioned the ways in which the Committee gained assurance and was advised these included details of action plans, implementation of recommendations, or even via external third parties. There were no further questions and the Board **NOTED** the contents of the update.
11-17	**Quality and governance: proposed changes to current meeting arrangements** GC presented a proposal on changes to the current Quality and Governance Committee governance structure. These were designed to improve assurance to the Committee and Board whilst continuing to promote effective quality and governance engagement throughout the organisation. From April 2017, the Committee would move formal meetings to alternate months, scheduled in the month when there was no Board meeting. The other months would be used to engage local clinical teams during their routine quality and governance activity. It was anticipated this change would strengthen and raise awareness of the governance processes across the Trust, whilst improving levels of engagement between committee members and front line staff. Assuming the Board was supportive, the Committee's terms of reference would be amended to reflect these changes. The Board sought assurance that Q&GC data would still be available to its members on a monthly basis, and was advised that the new structure would enable this. GC also assured the Board that a review of the new format would be undertaken in May 2018 to monitor any impact these changes might have on quality. After due consideration the Board **APPROVED** the proposed changes.
12-17	**Quality and safety** NR presented the regular Quality and Safety report which included updated quality information and assurance on the quality of care at QVH • All CQUIN milestones for Q2 had been achieved. The Board commended in particular the work undertaken by the Trust to achieve the flu CQUIN noting that more staff had been vaccinated than before but the CQUIN also included a number of staff signing to state they had been offered vaccination and chosen not to take it at that stage; • The Trust had contributed to the recently published CQC report on 'Learning, candour and

	accountability' referenced under the CEO update; • MRSA screening compliance for the Trust had improved with figures now 98% compliant; work continued to remind all staff of the importance of complying with policies and procedures to ensure safe care for all patients; • The paediatric 'transfer out' was as a result of toxic shock, and the patient was returned to QVH within 24 hours; • The one mortality recorded in November related to a Burns patient; regrettably this had been anticipated and unavoidable. The Board sought additional clarification in respect of the following: • Current challenges in staffing levels: Nursing staffing levels were reviewed on a daily basis, three times a day and assessed against the dependency and needs of each individual patient. The Trust was acutely aware of vacancies in ITU and Theatres, and monitored the situation closely but there was no indication that substantive staff shortages were impacting detrimentally on quality. SJ reminded the Board that there were 1.500 nurse vacancies in Kent, Surrey and Sussex alone and that the Trust was not unique in this respect; • The probable likelihood of recurrence of delayed appointments at Medway: SLJ explained that issues were likely to continue based on a combination of increase in referrals and limited clinical space. Whilst patients were offered a transfer to QVH, many chose not to take up this option; • The ex-gratia payment made to a patient to cover the cost of private treatment, (also highlighted at the recent Audit Committee). CS confirmed that this payment had been authorised by the CEO at the time; and that clear guidelines on authorising such requests would be available for the future. • Confusion around current MIU opening times: CP confirmed that all published information contains the correct times and that additional comms work would be carried out to promote the MIU shortly **[Action: CP]** • It was agreed that narrative provided under 'next steps' within the Q & S report would be more specific in future.**[Action: JMT]** • Patient complaints: EP conceded that whilst a particular situation had not been handled well, learning requirements related to the individual involved rather than the wider Trust. The Board was pleased to note the comments made in respect of the Prosthetics department, (described by a patient as 'superb') and suggested these types of examples be used to raise the Trust's profile externally. There were no further questions and the Board **NOTED** the contents of the report.
13-17	**6-monthly nursing workforce review** NR presented the six-monthly workforce review, reminding the Board that this was a mandatory report following the 'Hard Truths' government paper published in 2014. The Trust was required to undertake six-monthly reviews of inpatient areas to demonstrate safe care and evidence-based review and deployment of resources to provide quality care. Today's report covered the period from 01 April to 31 October 2016, comprising a review of inpatients, outpatients and MIU. It also incorporated the impact of the 2016/17 cost improvement programme and nursing consultation, in addition to the sustained challenges of vacancies (particularly in ITU which, as previously noted, reflected national shortages in this area). It was noted that the report was based on general wards and excluded day surgery work. NR acknowledged the need to recalibrate and focus on day cases. EP concurred but cautioned the Board not to assume day cases required any less nursing resource. Work would also continue on refining the discharge process and patient pathways.

	GO highlighted the range of nursing ratios set out in the report's appendices and went on to describe how nursing ratios could have a significant impact on vacancy rates. More work would be undertaken to provide greater clarification to the Board in this respect. The Chair reported that at the November Finance and performance committee meeting, the Director of Nursing had reported on further work being undertaken in respect of changes to case-mix/bed modelling. This would be led by the recently appointed business manager for clinical infrastructure. There were no further questions and the Board **NOTED** the contents of the review.
Key strategic objective 2: world class clinical services	
14-17	**Board assurance framework** EP presented the BAF for KSO2. The current rating 12 (amber) reflected current gaps in controls and assurance. In particular EP highlighted the difficulties in recruiting to specific posts, exacerbated by changes within the KSS deanery and the declining pool in trust grade doctors. Also of concern was the potential impact of the new junior doctor contract, particularly in relation to maxillofacial registrars. Systems for exception reporting (whereby junior doctors can report where actual working hours are not compliant) were in place. Exceptions would be reported to the Guardian of Safe Working Hours (GSWH), John Boorman, and breaches could result in a fine to the trust. The exceptions report would form part of a new regular statutory report to Board by the Trust's GSWH and would be incorporated into the Medical Director's report. It was suggested that the GSWH could be asked to attend a future Board seminar to provide additional context. There were no further questions and the Board **NOTED** the latest update.
15-17	**Medical director's report** EP presented his regular MD update, highlighting the following: • The two 'never events' reported previously had been investigated, with results scrutinised by the Clinical Governance Committee. An action plan had been produced, and recommendations implemented to mitigate against a recurrence. The Committee would continue to monitor the situation. • The immediate actions relating to CQC recommendations had been completed. The relationship and co-location with the Step Down Unit is being developed with ITU, HDU and SDU now under the same management. A review of the strategy for ITU provision incorporating staffing, location, admission criteria and networking with regional units will be a focus in early 2017. • Electronic systems to aid medical job planning were currently being assessed and a business case developed. It was hoped their introduction would facilitate accurate, consistent and transparent annual job planning. • The QVH Charity had supported the purchase of certain equipment following the decision by Blond McIndoe Research Foundation (BMRF) to cease laboratory based research on site. QVH was aiming to continue with two research projects currently undertaken by the BMRF • Negotiations for a return of commission fees to the QVH in respect of the repair contract with Avensys were continuing. • Although feedback was positive following the HEEKSS Library Quality and Assurance Framework inspection, some concerns had been raised including space and funding; these were addressed through business planning.

	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	
16-17	**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 remained at 20. She went on to apprise the Board of the risks from potential Cyber security threats. Mazars (Trust internal auditors) were currently developing an internal action plan for consideration. The Executive Management Team would then consider which KSO this was most aligned to and any decision would be approved by the Quality and Governance Committee. CS would report back to the Board once this was complete. **[Action: CS]**
17-16	**Financial and operational performance assurance report** JT presented an assurance report in respect of the Finance and Performance Committee. This included feedback on the recent committee effectiveness review against its mandate and terms of reference. In summary the committee was working well although it had been agreed by the membership that the committee shouldn't be a forum for setting strategy but rather tracking progress against medium term strategic - not just short term - goals. The committee had reviewed its terms of reference and felt that the current 'purpose' was too closely focussed on 'in-year delivery'. It was agreed that these should be amended to include approval of plans for future years. A revised version of the ToRs would be returned to the Board for approval at a later date **[Action: CS]** There were no further comments and the Board **NOTED** the contents of the update.
18-17	**Operational performance** Following on from the KSO3 update, SLJ went on to highlight the following: • The Trust had achieved the RTT18 open pathway target for November (92.21%). Although back on track, the current position was still challenging with an increase in referrals. • As previously reported, the Trust had marginally failed the Q1 and Q2 62-day waiting times trajectory. The main reason was late referrals and shared breaches with other trusts which had a significant impact when combined with the Trust's low denominator. • All other targets for October had been achieved. The Board sought and received assurance in respect of the sustainability of the 18-week RTT18 trajectory (92%), particularly with regard to MaxFacs. Clarification was also provided in respect of the rise in skin cancer referrals which was thought to be as a result of increased awareness by GPs. There were no further comments and the Board **NOTED** the contents of the update.
19-17	**Financial performance** The Board was reminded that the Finance report had been scrutinised in depth by both the Executive Management Team and the recent Finance and Performance Committee prior to today's meeting. The Board went on to consider cost control culture, noting that business managers and the performance

	review process were contributing to this, but that the Trust also needed ensure permanent removal of costs. There were no further questions. The Chair thanked CS for her report, the contents of which were **NOTED** by the Board.
20-17	**Business planning 2017/18 – 2018/19** CS presented a report on the financial planning process for 2017/18 and 2018/19. She reminded the Board that it was required to approve the annual budget prior to the beginning of the financial year and before final submission to NHSI. However, due to acceleration of planning timetables and timing of Board meetings that approval had been delegated to the Finance and Performance Committee in line with its Terms of Reference. It was being presented today for formal ratification. CS reported that the Trust had submitted a plan consistent with its control totals and had now signed contracts. There was more work to be done on CQUINS and 'new to follow-up' ratios. Currently, the biggest gap is in the contract with West Kent but it is a cost and volume contract so not of significant concern. The accelerated timescales meant that there was still work to be done through January and February including a process of 'executive star chamber' and sign-off by budget managers. The Chair thanked CS for her report, the contents of which were **NOTED** by the Board.
Key strategic objectives 5: organisational excellence	
21-17	**Board assurance framework** GO presented the latest KSO5 update, noting that for clarity, recent changes had been underscored. The current risk rating stood at 12 (amber), with the rationale including: • Capacity planning and workforce modelling; • Junior doctors' contract; • Impact of corporate restructuring; • Current managers' skill set in workforce, activity and financial planning, and • The unknown impact of the STP The colour coding on the ratings will be corrected next time. There were no further questions and the Board **NOTED** the contents of the update.
22-17	**Workforce report** GO introduced the workforce report providing the Board with a breakdown of key workforce indicators and information linked to performance. The report was taken as read, but GO drew the Board's attention in particular to the following: • As reported under item 13-17, whilst restructure consultations were on-going, a number of posts were being specifically left vacant or covered on a temporary basis until these processes had been concluded. A number of managers also used establishment and pay budgets flexibly to balance service needs. • Finance and HR continued to work closely together to refine the processes and paperwork that would improve establishment control data and improve vacancy monitoring and reporting; • Agency use had increased to cover specialist areas such as Theatres, Burns and ITU (due to national shortages as reported previously). A working group had been established to monitor and ensure the Trust was adhering to rostering principles

	• Turnover had plateaued this month, although the figure remained higher than the average. Work continued on monitoring and seeking solutions to the issue; • There had been a significant improvement in compliance rates for statutory and mandatory training for the third successive month. Appraisal rates had also increased by 12%, with ongoing support for managers helping to increase compliance. The Chair commended GO for the improvement; • The staff survey had now closed, with a higher response rate than last year being reported. The results would be embargoed until February; • The launch of the new management and leadership programme 'Leading the way' was imminent. The Board sought clarification as to whom this training was targeted. GO explained that in the first instance, this would include volunteers only; however, LP and BH urged GO to consider including others who may not have volunteered, but for whom the training would be more relevant. **[Action: GO]** GO provided a brief summary of the course and its aims, and agreed to forward details to the Board via email. **[Action: GO]** The Trust planned to continue to run the training in 2017/18 but would need assurance that funding was available. There were no further questions and the Board **NOTED** the contents of the update.
Board governance	
23-17	**Risk Management strategy** The Board received the latest Risk Management Strategy, recommended for approval by the Quality and Governance Committee. As required under section 2.4 of the Schedule of Matters Reserved for the Board, this policy required formal approval by the Board. NR advised that the strategy had been refreshed but was still very much a work in progress; further changes would be implemented as it continued to be refined. The Board noted this was much improved. It went on to **APPROVE** the strategy, noting that it would be returned for further review and approval in due course.
24-17	**Management of Incident and Risk Policy** The Board received the latest policy on management of incident and risk, which had been recommended for approval by the Quality and Governance Committee. Again, as required under section 2.4 of the Schedule of Matters Reserved for the Board, this policy now required formal approval by the Board. Key changes to the policy included shortening and streamlining the original policy and incorporating recommendations made by the CQC during its inspection in 2015. JT highlighted the Risk Assessment matrix contained within the policy, and urged the Executive to ensure there was a direct correlation between this and the Board Assurance Framework. It was agreed that the current BAF refresh process would include reference to the wording in the matrix. **[Action: all members of EMT]** There were no further questions and the Board **APPROVED** the policy for Management of Incident and Risk.
25-17	**Audit committee assurance report** As Committee Chair, LP presented an update on the most recent meeting. Highlights included the following: • Assurance provided by the Director of Operations on the management of risks associated with KSO3 Operational Excellence and on the work being done to mitigate those risks; • The results of the informal effectiveness review undertaken in Q3. Although generally positive, there

	were a number of detailed suggestions for improvement which would be incorporated in the Audit Committee's work programme as appropriate. A more prescriptive exercise would be undertaken in 2017/18. Other members of the Committee acknowledged that the recently introduced BAF sessions had been very productive but still required further development in order to provide the assurance which the Committee was seeking. There were no further comments and the Board **NOTED** the contents of the update.
26-17	**Board effectiveness assurance review** In complying with the FT Code of Governance, CP presented a report which evaluated the Board's performance and that of its committees and individual directors over the last twelve months. In response to the Board's request for further information about the Trust's plans for its Well-Led review, CP advised the following: • Exploration of a peer review approach had not concluded in time for QVH's review, although this approach might gain national support in the future; • A specification would be developed in preparation for tendering, and CS would keep the Board apprised of progress. **[Action: CS]** This would focus on areas on which the Trust was seeking assurance, as identified in the self assessment undertaken in Q3. It was agreed that as fees to undertake the review could be in the region of £30-£50k, it was important to adopt a targeted approach. The Board noted the importance of implementing a cost effective programme whilst ensuring NHSI were kept fully informed of our intentions. There were no further questions and the Board **NOTED** the contents of the report and the Trust's plans for the Well-Led review in 2017/18.
27-17	**Annual approval of Board sub-committee Terms of Reference** The Board undertook the annual review of the Terms of Reference for its committees as follows: • Audit; • Finance and Performance (noting that these might be returned to the Board following additional amendments); • Quality and Governance, (which now incorporated changes approved under item 11-17); • Nomination and Remuneration (noting these might be returned to the Board following the committee meeting scheduled for 19 January) There were no further questions and the Board **APPROVED** the Terms of Reference for the next twelve months.
28-17	**QVH Charity assurance report** BH reported that at the meeting held on 22 December, the Committee had approved an application for the purchase of research equipment following the recent change of direction for the Blond McIndoe Research Foundation. It had also considered a proposal for development of the Hospital Street. The annual report and accounts and Terms of Reference were also recommended for approval by the Corporate Trustee which was meeting later today. BH also reminded the Board that at its seminar meeting in early December, and acting as the Corporate Trustee, it had considered work to develop the Charity's future strategy.

	There were no further questions and the Board **NOTED** the contents of the verbal update.
29-17	**Draft agenda for March 2017 business meeting** The draft agenda for January 2017 was reviewed and its contents **NOTED** by the Board.
Any other business	
30-17	There was none
Observations and feedback	
31-17	**Feedback from key events and other engagement with staff and stakeholders** • BH reported that she and the CEO had had a productive meeting recently with local MP Sir Nicolas Soames; • BH and GC reported on the NHS Providers conference which they had both attended in November; • LP and BH had recently attended the 'operating game' event hosted by the HFMA. Whilst the Board agreed that the HFMA induction days were good value, it was not felt this particular event would be appropriate for a new NED; • CS commended the HFMA national conference she had attended recently and offered to circulate the slide pack to the Board for information; • CP updated the Board on the current NED recruitment campaign. Despite on this occasion running an internal campaign instead of using an agency, the Trust had received a high response rate (19 applications); • Following today's Board meeting and in response to queries raised throughout, the Chair asked that introductory front covers were in future explicit in stating whether a report should be 'noted', 'discussed, 'approved' or 'for information'. **[Action: ALL]** • NEDs to ensure that any matters requiring escalation to the Board should be highlighted on the respective committee assurance reports **[Action: NEDs]**
32-17	**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**
5 January 2017						
1.	**06-17**	Additional context and information to be sought from KPMG in respect of recent report of particular NHS Trusts receiving greater revenue through private than NHS patients. Feedback to be included at February seminar if timescales permit.	**CS**	Feb seminar	**10 02 17** Private patients discussed at February Board seminar. Agreed not priority work at this stage	**Complete**
2.	**08-17**	Latest version of Corporate Risk Register to be circulated to the Board via email	**JMT**	Jan	**06 01 17** Circulated via email	**Complete**
3.	**12—17**	Additional comms work to be carried out to raise awareness of MIU opening times	**CP**	TBA		**Pending**
4.	**16-17**	EMT to agree to which KSO cyber security is most aligned and gain approval through Q&GC. Board to be apprised of outcome.	**CS**	March	Cyber security could impact on delivery of each of the KSOs. Recommendation that the issue sits within KSO4; consistent with roles/responsibilities and management hierarchy. Current reporting arrangements to remain i.e. Information Governance Group and/or Information Management and Technology Steering Group for oversight and scrutiny; Q&GC on an exception basis for assurance to the Board.	**Complete**
5.	**17-16**	F&PC ToRs to be returned to the Board for approval following revision	**CS**	March	The amendment was discussed and accepted at F&PC on 20/02/2017 and included for approval.	**Complete**
6.	**22-17**	Details of 'Leading the way' programme to be circulated to BoD for information	**GO**	March	**08 02 17** Circulated via email	**Complete**
7.	**22-17**	In addition to the cohort of volunteers identified for the 'Leading the way' development programme, the Board has requested that this be expanded to capture others to whom training is most relevant. GO to review and report back.	**GO**	March		**Pending**

Matters arising and actions pending from previous meetings of the Board of Directors (BoD)						
No.	**Reference**	**Action**	**Owner**	**Action due**	**Latest update**	**Status**
8.	**24-17**	BAF review to include reference to the risk matrix as set out in Management of Incident and Risk policy	**SJ**	March		**Pending**
9.	**26-17**	Specification to be developed for tendering for Well-Led review. Board to remain apprised of progress on timescales etc.	**CP**	March		**Pending**
10.	**31-17**	Report front covers to state purpose eg. To 'note', 'discuss, 'approve' or 'for information'.	**ALL**	March		**Pending**
11.	**31-17**	Matters requiring escalation to the Board to be highlighted within respective Committee assurance reports	**NEDs**	March		**Pending**
3 November 2016						
12.	**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~~ March	**13 01 17** KPMG complies with the Financial Reporting Council's rotation requirements regarding senior audit staff; to mitigate against the threat over over-familiarity with a particular client. This means that the Partner or Director will rotate at least once every seven years, and the Manager or Senior Manager will rotate at least once every 10 years. Neil Hewitson (Director) has worked with the Trust since 2014/15 so has another 5 years before mandatory rotation is required. Charlotte Goodrich (senior manager) has been with the Trust since 2015/16. In addition, there might be other factors influencing rotation e.g. promotions, staff leaving etc. the Director reports directly to KPMG's Head of Audit (internal management structure) i.e. in the current arrangement there is no partner.	**Complete**
1 September 2016						
13.	**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~~	**Complete**

Matters arising and actions pending from previous meetings of the Board of Directors (BoD)						
No.	**Reference**	**Action**	**Owner**	**Action due**	**Latest update**	**Status**
					~~achieve.~~ **05 01 17** A report is to be submitted to the January Q&GC	
14.	**161-16**	Measurements to assess how FTSU process is perceived by staff to be incorporated in next staff Friends and Family Test.	**GO**	March May	~~**03 11 16**~~ ~~Feedback to be provided to March BoD~~ 05 01 17 Staff FFT survey does not close until late March so feedback will be provided in public session of May BoD	**Pending**

Board Assurance Framework – Risks to achievement of KSOs

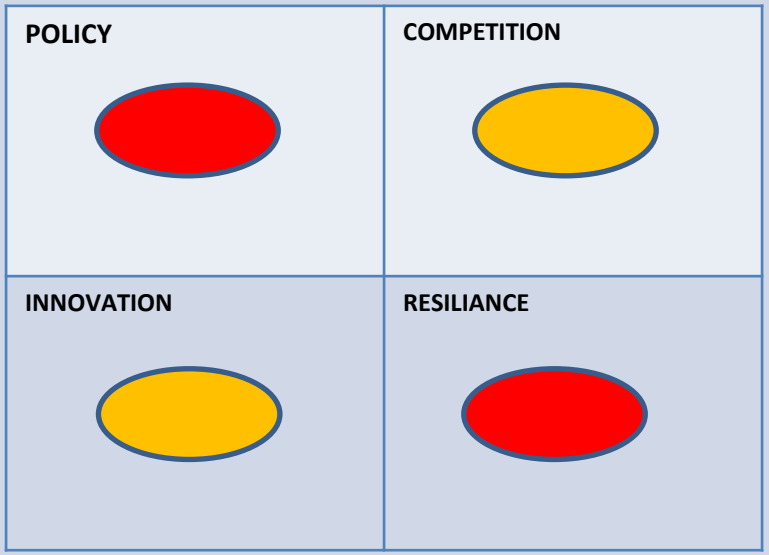
KSO 1 Outstanding Patient Experience	KSO 2 World Class Clinical Services	KSO 3 Operational Excellence	KSO 4 Financial Sustainability	KSO 5 Organisational Excellence
Patients lose confidence in the quality of our services and the environment in which we provide them due to increasing patient safety incidents, 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

The BAF was reviewed at Clinical Cabinet and Executive Management Team meetings on 20 February, using the risk assess matrix. No changes were made to document.

	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



Queen Victoria Hospital NHS
NHS Foundation Trust

Chief Executive's Report					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02/03/17**		**Agenda reference:**	**36-17**	
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): [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:					
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Executive Management Team				
	Date:	20/02/2017	Decision:	Review of BAF	

CHIEF EXECUTIVE'S REPORT
MARCH 2017

With this being just my second Board meeting and the last of the 2016/17 financial year, I am summarising some of the highlights and challenges we face going forward. It has been a tough year for the NHS and we have not been exempt; however, we continue to do well on access targets, patient feedback remains very good, and financially although stretched we have not had the same issues as our acute partners with increased demands on their A & E departments.

Innovation and national profile
In 2016/17 there has been a considerable focus on the pioneering plastic surgery techniques developed at the hospital, some of which are still in use today, linked to the 75th anniversary of the founding at the hospital of The Guinea Pig Club. Named for the experimental treatment given to airmen burned in World War Two, the camaraderie and shared experiences of the Guinea Pig Club's members helped them to support each other during their lengthy and painful rehabilitation, and QVH is still at the forefront of the psychosocial aspects of burns healing as well as surgery.

Current research linked to the life-changing reconstructive surgery, burns care and rehabilitation services provided at QVH includes the clinical trials of a smart bandage which changes colour when it detects infections. The nature of burns wounds means signs and symptoms of infections are common but true infection is rare. A colour-changing bandage will provide an early-warning that infection is developing, allowing better and timelier treatment for patients.

Queen Victoria Hospital is also now home to the country's only scar biobank. The scar biobank will help scientists and doctors work towards improved healing for the millions of people affected each year by scarring. Researchers carefully process and store scar samples in order to provide a resource to analyse how the scar has formed. The scar tissue is donated by QVH patients undergoing surgical revision or reconstructive surgery and the work is funded by the Blond McIndoe Research Foundation.

A further recent example of innovation at QVH is the work with academic and technical partners to develop 'smart specs' for people suffering facial palsy. Miniaturised sensors in the frames of the glasses measure facial symmetry by tracking the movement of muscles, and the intensity of those movements, giving feedback through a smart phone or tablet. This could transform the ability of both clinicians and patients to monitor their progress, as well as significantly increasing recovery as patients are more motivated to practice facial movements.

QVH continues to provide excellent services treating sleep disorders and conditions of the hands, eyes, skin and teeth for people in East Grinstead and the surrounding areas. In 2016 we added a community-based ear, nose and throat (ENT) service, offering specialist advice and treatment for a range of ENT conditions, with clinics are held in East Grinstead, Haywards Heath, Crawley and Worthing.

Recently we have made a £200k investment in a femtosecond laser that allows the specialist eye team to use ultra-short infrared laser pulses to treat a range of conditions with an exceptional degree of precision and predictability.

Financial stewardship
This year has seen a recovery plan put into place which has largely been successful, although at the time of writing there remains a considerable risk of not achieving our control total. Our income remains challenging although we are seeing more activity through day patients.

Significant investment is planned over the next few years to catch up on back-log maintenance at the hospital and in our IM & T infrastructure, in addition to enhancing our clinical care offering.

Delivering outstanding care

In April 2016 the Care Quality Commission stated that patient care at the hospital was outstanding. The inspectors found compassionate and considerate care throughout the hospital with numerous examples of staff going above and beyond what would be expected. The CQC reported that QVH staff have a clear culture of compassion and an exceptionally strong awareness and empathy with patients, with excellent emotional support for both patients and carers. In June 2016 the national NHS inpatient survey showed that QVH continues to achieve some of the best feedback from patients in the country. In July 2016 the national cancer patient survey showed that patients rate QVH as one of the very best hospitals in the country for cancer care.

These are standards of care which we strive to maintain and take great pride in delivering. There are however significant workforce challenges within the local health economy and we are not immune. Nurse vacancies in theatres, ITU and our paediatric ward have proved difficult to fill, and this sometimes creates additional strain on our already hard-working front-line colleagues. It is a testament to their commitment and fortitude that we still provide outstanding care; QVH has an extremely committed staff but we must not rely on goodwill alone. The Trust is looking at creative ways to boost our recruitment processes.

We are enthusiastic in ensuring all of our staff have a real voice in shaping and improving the way we work. Initiatives such as *Leading the Way*, our new leadership and management development programme which was launched last month should prove to be an excellent way of enhancing our staff engagement. The appointment of a Freedom To Speak Up guardian in QVH will play a key role in helping encourage staff to raise any concerns and providing confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled.

At Executive level, appointments have been made to the CEO and Medical Director roles within the last six months, and a new Non-Executive Director will join us shortly.

Looking forward

With considerable national uncertainty surrounding the worsening financial position of NHS providers and the focus on STPs required to deliver credible plans that improve the health and wellbeing of the local population, improve the quality of local health and care services, and deliver financial stability in the local health and care system, our priorities remain clear. We will refresh our strategy to take account of the changing landscape, and in doing so will continue to focus on improving patient care, remain committed to strong financial stewardship and work to support a thriving workforce.

We will continue to engage with our provider partners and commissioners to ensure we remain relevant to improving services for patients, utilise the skills of our clinicians to develop innovative services and enhance the QVH brand.

TRUST ISSUES

Board Assurance Framework (BAF)
Attached is the BAF front sheet. KSO risk scores and horizon scanning of level of risk remain unchanged from January 2017. The Corporate Risk Register is also presented later in the agenda.

SECTOR ISSUES

Sussex & E Surrey Sustainability and Transformation Plan
The Executive Board of the STP has appointed consultants to carry out a review of the acute services clinical strategy. The focus is to assess capacity across Sussex and E Surrey as well as review current and future demand for acute and specialist services. A particular option will be to consider new models of care, providing services out of hospital settings. Extensive engagement with all health and social care partners within the STP footprint is taking place and the work should be completed in early April.

With considerable uncertainty within the wider NHS I have circulated to Board members a key document from The Kings Fund concerning STPs and I provide the link below:
https://www.kingsfund.org.uk/publications/delivering-sustainability-and-transformation-plans

NATIONAL ISSUES

NHS England
Chief Executive Simon Stevens announced at their Board meeting on 9 February 2017 that the Five Year Forward View delivery plan will be published at the end of March, and would "beef up the implementation capability which exists at STP level." The delivery plan will set out NHS England's plans for the next two years and beyond. A key focal point of the delivery plan will be to address urgent and emergency care; Stevens said, "Part of the answer (is a more) streamlined urgent treatment centre offer, extended access to convenient primary care, and substantial changes to the way 111 is networked."

2016/17 provider deficits
Figures published by the regulator on 20 February show the NHS provider sector forecasting a £873m, year-end deficit, against the maximum "control total" of £580m. Increased pressure on emergency services caused "one of the toughest winters on records" said NHS Improvement, and resulted in thousands of escalation beds being open each day and the loss of elective income due to cancelled operations. The current forecast deficit remains significantly higher than planned, which is both unaffordable and unsustainable.

Steve Jenkin
Chief Executive

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing
Committee: Quality & Governance
Date last reviewed: 03 February 2017

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
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
Update on estates strategy at board seminar 02/02/17

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, added to CRR 1035,1019

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**2 March 2017**		**Agenda reference:**	**38-17**	
Report title:	**Corporate Risk Register – January 2017**				
Sponsor:	Jo Thomas				
Author:	Jo Thomas				
Appendices:	None				
Executive summary					
Purpose:	For assurance that risks are being identified, reviewed and updated in a timely manner				
Recommendation:	The Committee 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 is considered monthly by the Clinical Cabinet , Quality and Governance Committee, Audit Committee and Executive Management Team in February 2017.				
Next steps:	NA				

Corporate Risk Register Report – January 2017 Data

Key issues

1. **Four new risks were added** to the Corporate Risk Register between 01/01/2017 and 31/01/2017 with a score of 12+ as below:

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x4=12	1035	Failure to recruit adequate numbers of skilled critical care nurses across a range of Bands	DDoN
3x4=12	1036	Temporary Lack of Nursing Support for Lower Limb Trauma Outreach Service	DDoN
3x4=12	1037	Lack and not fit for purpose medical record shelving capacity in health records	Review by members of the Health Records Working Group
3x4=12	1038	Information Governance Security Risk	Review by members of the Health Records Working Group

2. **No risks with a score of (12+) were changed** during January 2017

3. **No risks scoring 12+ were closed** during January 2017

4. The corporate risk register was reviewed at the monthly Clinical Governance Group and Quality & Governance Committee in early January 2017.

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

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
1037	19/01/17	Lack and not fit for purpose medical record shelving capacity in health records	1.Staff injury from increased moving and handling of notes in crates for staff that can be in a stack of four crates 2.High shelving could result in Falls from ladder use and notes falling on staff 3.Staff/Contractors injury from slip/ trip / fall over notes/boxes 4.Increased notes handling due to swapping of notes to fit for purpose shelving 5.Risk of notes not being available to clinical staff 6.Fire risk due to crates being stored in close proximity	1.The number of boxes are being reduced by increasing shelving 2.Reduction in boxes has meant boxes are now in three areas outside of the records library area. They are becoming more organised and spaced out to improve access 3.As number 1 4.As number 1 5.Procedures for Misplaced files, racking, are making notes up being reviewed and updated and action number 1. 6.Reduction and planned placement of boxes to reduce fire risk and number 1.	Jo Thomas	Graham Rayner	Staff Safety	NEW	12	6	Increase destruction of old records on-going Have bespoke Manual handling training delivered to team finished end of January 2017 SOP review, Procedure for Misplaced files, racking, making notes up end of January 2017 1.Increase shelving space, complete by Mid-February, which is estimated to rack all the crates presently. Replace all not fit for purpose shelving.	2/2/17
1038	19/01/17	Information Governance Security Risk	1.Inappropriate access to unauthorised users which could result in access to patients records within the main library 2.Delay to obtain health records from boxes and notes not being found causing either Incorrect /uninformed decision made on patient care, though this has greatly reduced from the beginning of Jan 17 3.Notes are being stored outside of medical records that maybe considered not secure enough a.In the back corridor of the education centre b.In the EDM office c.In the Rycroft ward d.In the hall way leading medical 4.Risk of notes not being available to clinical staff. 5.Kings House has been vacated but 100% assurance of patient identification could not be achieved due to the nature of the flooring which supports the storage that patient records (paper bits) could be trapped under this flooring.	1.All areas are secure against public access, though the main hall to the medical library is regularly stuck 2.The number of boxes are being reduced by increasing shelving 3.Reduction in boxes has meant boxes are now in three areas outside of the records library a.In the back corridor of the education centre i.Being moved by 27.01.17 b.In the EDM office i.Being Moved by 03.02.17 c.In the Rycroft ward i.Is in a more secure area its removal is dependent on some unknown factors presently for review 03.02.17 d.In the hall way leading medical i.These are sealed by non-tamper tags, and being Moved by 03.02.17 4.Procedures for Misplaced files, racking, making notes up being reviewed and updated and actions 2 and 3 also support this 5.A Document outlining what action have been undertaken to provide reasonable assurance 03.02.17, a	Jo Thomas	Graham Rayner	Patient Safety	NEW	12	4	Implement visitor book for staff visiting medical records, beginning of January with a communication Increase destruction of old records on-going SOP review, Procedure for Misplaced files, racking, making notes up end of January 2017 Increase shelving space, complete by Mid-February 2017, which is estimated to rack all crates	2/2/17

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
1035	09/01/17	Failure to recruit adequate numbers of skilled critical care nurses across a range of Bands	* Failure to recruit adequate numbers of skilled critical care nurses across a range of Bands *The Guideline for Provision of Intensive Care Services (2015) recommends that no more than 25% of nurses on each shift are agency nurses. On occasion this is breached in Burns ICU *General Provision of Intensive Care Standards requires that greater than 75% of the ICU workforce have a recognised qualification in ICU Nursing. In Burns ICU currently the percentage of ICU trained staff is 63%.	1. Burns ITU has a good relationship with 3 nursing agencies. Via these agencies we have a bank of 8 - 10 nurses who regularly work on our unit,and are considered part of our team. temporary staff are formally orientated to the unit with a document completed and kept on file. Concerns are raised and escalated to the relevant agencies where necessary. Follow up reports are chased. Recruitment drive in progress. Once fully established the unit should require little or no agency support. 2 Staffing is reviewed on a daily basis at the bed meetings and appropriate changes are made. 3 Review of patient pathway to be undertaken to avoid where possible peaks and troughs in activity	Jo Thomas	Nicola Reeves	Patient Safety	NEW	12	9		9/1/17
1036	09/01/17	Temporary Lack of Nursing Support for Lower Limb Trauma Outreach Service	Temporary Lack of Nursing Support for Lower Limb Trauma Outreach Service	Referrals to be reviewed by Trauma Coordinators and will be discussed on a case-by-case basis to identify management plan. Temporary staffing options being reviewed Options appraisal being created to review service delivery model	Jo Thomas	Nicola Reeves	Patient Safety	NEW	12	6		13/1/17
1029	28/12/16	Loss of PACS manager for QVH	The PACS manager was working at QVH under a temporary contract. Unfortunately, the PACS manager has decided not to continue with her fixed-term position and will leave the trust imminently.	Philips delivers a managed service to QVH, so QVH can access PACS support during a transitional period. External PACS remediation manager is in place by QVH to support the hospital with their remediation process with Philips PACS. QVH sits within a consortium of PACS users, and support will be asked from one of the other NHS organisations sitting in this consortium.	Sharon Jones	Sheila Black	Patient Safety	↔	12	5		19/1/17

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
1025	15/12/16	BAF - KSO4 - Financial Sustainability	BAF - KSO4 - Financial Sustainability 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	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	Clare Stafford	Jason Mcintyre	Finance	↔	20	20	Income/ activity – retention, capture and coding Structure, systems and process redesign and enhanced cost control Development and delivery of a quality led sustainable CIP incorporating identification, implementation, monitoring, quality impact and governance arrangements. Focus in theatres productivity Enhanced pay and establishment controls including performance against Carter Review and report	15/12/16
1026	15/12/16	BAF - KSO 5 - Organisational Excellence	KSO 5 -Organisational Excellence 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	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	Geraldine Opreshko	David Hurrell	Staff Safety	↔	12	8	Recruitment and retention challenges and impact upon Pay and agency controls Leadership development launches in Jan 2017 Workforce planning	15/12/16

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
1024	15/12/16	BAF-KSO1 - Outstanding Patient Experience-Trust is not able to recruit and retain workforce with the right skills at the right	BAF - KSO1 - Outstanding Patient Experience - Trust is not able to recruit and retain workforce with the right skills at the right time.	Monthly safer nursing care metrics and CQUIN data collection External assurance and assessment undertaken by regulatory bodies/stakeholders 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	Jo Thomas	Nicola Reeves	Compliance (Targets / Assessments / Standards)	↔	12	12	Vacancies in critical care Recruitment and retention strategy	15/12/16
1020	14/12/16	BAF - KSO2 - World Class Clinical Services	BAF - KSO2 - World Class Clinical Services 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 .	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	Dr Edward Pickles	Mike Sexton	Patient Safety	↔	15	10	Job planning Balance service delivery with medical training cost Achieving sustainable research investment Recruitment challenges Plan for sustainable ITU on QVH site- Scope delivering and monitoring seven day services (OOH) Limited data from spokes/lack of service specifications Limited extent of reporting /evidence on internal and external standards	8/12/16

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
1021	14/12/16	BAF - KSO3 - Operational Excellence	BAF - KSO3 - Operational Excellence - 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	Regular access meeting reviews and forward plans activity/booking- includes Cancer; Patient Access Manager – new role and joined the Trust on Sept 21st; Monthly business unit performance review meetings in place with a focus on exceptions, actions and forward planning; Finance and Performance Committee in place; PTL accessible by all relevant managers; Performance Dashboard in place; Business Planning meetings and cycle put in place from Sept 15 for 16/17	Sharon Jones	Mike Sexton		↔	20	10	Demand and capacity modelling with benchmarking requires continual development for each specialty Late referrals for 18RTT from neighbouring trusts, two of which are in special measures and others with severe pressures; Shared pathways for cancer cases with late referrals from other trusts Not all spoke sites on QVH PAS so access to timely information can be limited	21/12/16
1022	14/12/16	BAF - KSO5 - Organisational Excellence	BAF - KSO5 - Organisational Excellence - 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	Developing long term workforce planning (3 years) for FY16/17 and linking to business planning process Leadership programme designed for Business Units management teams and corporate services Workforce strategy to be implemented by Q4 FY15/16 and will include plans for improving recruitment and retention Implementing a Board approved staff survey action plan HR/OD metrics revised to support the Business Units Theatres recruitment day in January 2015 Performance review meetings to identify and address identified staffing shortfalls	Geraldine Opreshko	David Hurrell	Staff Safety	↔	20	10	Continuing retention problems in theatres and ward areas and medical staff in Max Facs Continuing resources to support the development of staff Current level of management competency in workforce planning	14/12/16

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
1019	14/12/16	BAF - KSO 1 Outstanding Patient Experience	BAF - KSO 1 Outstanding Patient Experience 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.	Programme of 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 and CQUIN data collection External assurance and assessment undertaken by regulatory bodies/stakeholders Regular monitoring of FFT and patient survey results Patient membership on the Patient Experience Group, National inpatient audits Quality Account/CQUINS Benchmarking of services against NICE guidance, and priority audits undertaken Compliance in Practice (CIP) audits assessing the clinical environment Recruitment days for specific staff groups Nursing Consultation	Jo Thomas	Steve Davies	Patient Safety	↔	12	8	Vacancies in critical care PMO approach to CQUIN Management being developed, post still vacant Recruitment and retention strategy Lack of structured feedback from PLACE audits Décor Improvement identified by the CQC Robust clinical outcomes to be developed to ensure as effective baseline of clinical care Quality and safety strategy being developed. Development of full estates strategy and development control plan incorporating patient expectations	17/11/16
1018	13/12/16	Sleep Unit Staffing Levels and Difficulty Recruiting	Sleep Unit maintain high patient activity, steadily growing each year which requires technical and consultant staff. Sleep is a new and relatively unknown field of medicine which leaves national gap for trained staff - including technical and consultant. In previous year, recruitment of Band 6 Senior staff has been unsuccessful requiring sponsorship of work visa on overseas candidate.	- Use of agency and overtime of current staff - Outline and trial of a trainee to registered Sleep tech post in place - Locum consultants (x 3)	Colette Thompson	Colette Thompson	Compliance (Targets / Assessments / Standards)	↔	15	9		24/1/17

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
1017	01/12/16	Staff at risk of exposure to chemical fumes due to inadequate ventilation in the Decontamination rooms.	Staff exposed to chemical fumes whilst working in the Decontamination room as the ventilation is inadequate to remove fumes from area.	Oscillating fan in situ which is not recommended by Lead Infection Control Nuse. 05.12.16 There is an extraction system installed in this room which is confirmed working. There is however little supply air as per design for this room. The endoscopy washer being located in this room is the cause of the problem and estates have had approval off the Ventilation authorising engineer from a design perspective to install a split DX air con unit to supply cool air. estates otaining costs.snd	Clare Stafford	Steve Davies	Staff Safety	↔	15	6		16/1/17
1015	08/11/16	Patient safety due to lack of junior doctors in plastics particularly at weekends	Lack of junior doctor cover due to vacancies which we are unable to recruit to and deanery unable to fill spaces.	Agency Doctors being recruited. Plan for Consultants to be on site from 8am - 2pm at weekends which will require changes to job plans and funding	Sharon Jones	Paula Smith	Patient Safety	↔	15	9	Attempting to recruit agency doctors	13/1/17
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	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	10/1/17

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
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	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	10/1/17
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	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	Appoint new Locums (x2)	16/1/17

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
896	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 Potential loss of income if burns derogation lost	*Paeds review group in place *Mitigation protocol in place surrounding transfer in and off site of paeds patients *Established safeguarding processes in place to ensure children are triaged appropriately, managed safely *Robust clinical support for paeds by specialist consultants within the Trust *All registered nursing staff working within paediatric hold an appropriate NMC registration and are paediatric trained * Visiting consultant for paediatrics X3 sessions per week from BSUHT *Robust incident reporting in place *Serious Incidents are managed through the CGG *Named paeds safeguarding consultant in post *Strict admittance criteria based on pre-existing and presenting medical problems, including extent of burn scaled to age. *Surgery only offered at selected times based on age group (no under	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.	20/12/16

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
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	10/1/17
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	20/12/16

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
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	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. 05.12.16 Costs obtained to upgrade facilities, circa £12K.Approval now required to proceed.snd Asbestos R&D survey completed	Sharon Jones	Colette Thompson	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.	19/1/17

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
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	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	20/12/16

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
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 prioritised.	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 prioirtised. No new work to be taken on without assessment of priority. Risk assessments to be completed if necessary. Recruit to vacant positions. Dec 16 underway for band 3. Not enough hours for band 7 pharmacist post for job, covered by bank	19/1/17

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
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	Jo Thomas	Nicola Reeves	Patient Safety	↔	12	6	Plan to use specialist agency to be used when recruting staff for theatre	20/12/16
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.	19/1/17

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
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	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	6/12/16

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	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	6/12/16
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	Elin Richardson	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.	6/12/16

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
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	13/1/17
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.	20/12/16

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
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	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	3/6/16
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	Samantha Farr	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	20/12/16

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
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	30/11/16
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	Dr Edward Pickles	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	30/11/16

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
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 mismatached data	Sharon Jones	Sheila Black	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	19/1/17
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	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	18/10/16

Open corporate risks with January trends (n=38)

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Trend	Current Rating	Residual Rating	Actions	Date Reviewed
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	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	13/1/17

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Quality and Governance Committee**				
Meeting date:	**2 March 2017**		**Agenda reference:**	**39-17**	
Report title:	**Quality and Governance Assurance Report**				
Sponsor:	Ginny Colwell, NED and Committee Chair				
Author:	Ginny Colwell, NED and Committee Chair				
Appendices:	NA				
Executive summary					
Purpose:	To provide assurance to the Board in relation to matters discussed at the Quality and Governance Committees January and February 2017.				
Recommendation:	The Board is asked to **NOTE** the contents of the report				
Purpose:	Assurance				
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:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	9/2/17	Decision:	For information	
Previously considered by:	Quality and Governance Committee				
	Date:	12/1/17	Decision:	For information	
Next steps:	N/A				

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	2 March 2017
Reference number:	39-17
Report from:	Ginny Colwell, Chair
Author:	Ginny Colwell, Chair
Appendices:	N/A
Report date:	22 February 2017

Quality and Governance Assurance Report
Meetings held in January and February 2017
Areas of particular note

1. Patient Safety. Assurance was received that the monitoring of the use of the WHO checklist continues.

2. Patient experience. Eight complaints were received in January and two complaints have been referred to the Ombudsman (1 out of time). No common themes were identified.

3. The Medical Director updated the committee on the progress of Human Factors training which has been received very well. We will be seeing how we can take this forward.

4. Quality Account proposals for 2017/18 were discussed

5. CQUINS. Quarter 3 is predominantly on track with the exception of MSK reporting, risk £15k

6. The RCA (Route Cause Analysis) Report concerning a serious incident was discussed. Assurance was received that lessons have been learnt. It was agreed that all RCA reports for serious incidents will be presented at Q&G. There was also some debate as to whether they should come to the **Action**- Board- please discuss.

7. Infection control- There has been another case of hospital acquired clostridium difficile resulting in us breaching out target. Our new Infection control Nurse attended the committee and gave assurance of actions being taken.

8. A requested report was received providing assurance on the quality measures in place for the AQP contract: Urology and Community ENT services.

9. A report covering the review of NHS Trusts on Learning, candour and accountability was received. Our response will be presented to the March meeting.

10. Other reports were received as scheduled

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	**02 March 2017**		**Agenda reference:**	**40-17**	
Report title:	Quality and Safety Report, December 2016 and January 2017				
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		Assurance	Review
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:	NA				

Executive Summary - Quality and Safety Report, March 2017

Domain	Highlights
Safe	There were no Never Events or Serious Incidents in December 2016 or January 2017. The Trust had an introduction and progress review meeting with NHS Improvement (NHSI) on the 27th January 2017; and no formal quality or governance concerns were raised. The directors were asked about which quality and safety issues were a priority and why. Discussion included the workforce challenges of having people with the right skills at the right time; particularly the shortage of nursing and ODP staff in theatres, and nurses in critical care - this mirrors the national shortages. Out of hours cover including the introduction of additional consultant anaesthetist sessions was discussed as a mitigation in place to improve service provision. The burns derogation work was highlighted due to changes from the agreed timelines. The Trust will continue to work with commissioners, NHS England and the Burns Network to resolve these issues whilst we await the findings of the Carnall Farrah work (commissioned by the Sussex and East Surrey STP) reviewing Sussex/East Surrey service provision and the major trauma centre at BSUH.
Effective	An internal audit is currently being undertaken by Mazars LLP, on the Trust's CQC improvement plan (following the scheduled inspection in November 2015) and ongoing assurance and reporting framework.
Caring	There were two new complaints in December and eight in January relating to a range of issues including medical records and unforeseen complication during surgery. 97 % and 98% of inpatients completing the December and January FFT survey would recommend QVH.
Responsive	MIU performance continues to perform better than national indicator. In December 99.51% of the 821 patients and in January 99.64% of the 840 patients were assessed and treated within 4 hours.

Nursing Workforce	M11 total nursing, theatre practitioner and HCA vacancies have increased to 80.97 WTE, (22.64%) this does not reflect the reduction of 15 wte from the nursing consultation and CIP. This level of vacancy adds risk to care delivery and affects staff morale. The increased risk is reflected in the BAF and CRR. The HR team have been asked to lead a scoping exercise on international recruitment. Trained sickness in M10 has decreased to 3.81% from 4.33% and an increase in HCA sickness to 4.66% from 2.63% . In M11 Trained bank usage has increased to 9.22wte from 6.88% agency usage has remained static at11.47wte, for HCA bank usage remains constant at 2.75wte and no agency (data source M11 ESR).
CQUIN	All CQUIN schemes milestones for Q3 have been approved by the CCGs and specialist commissioners, and full payment agreed.

Safe - Current Compliance

Domain	Current Compliance	Next Steps
Infection control	There have been no further cases of hospital acquired MRSA colonisation in the Burns Unit. Enhanced infection control measures remain in place. There has been one Clostridium difficile infection (CDI) attributed to QVH in December 2016. This brings the total number of CDI year to date to two cases against a target of zero. This has been deemed a lapse in care as issues raised in the first case root cause analysis were still evident in the second. There was a drop in compliance for trauma MRSA screening in December 2016 with 93%.	Immediate actions to improve practice from the CDI root cause analysis have been identified by the Infection Control team in conjunction with senior nursing staff. These include a complete revision of the uniform and dress code policy which is under consultation. Other actions are the assessment of cleaning and decontamination procedures currently in place including the hand hygiene products. A new stool charts in is being trialled in Canadian wing wards as part of the learning from the CDI root cause analysis. There has also been a restructuring of the patient pathway through theatres and wards based on Infection Control principles and the admission policy has been amended by the Head of Nursing to reflect the changes.
Medication errors	**December 2016:** Four patient safety medication related incidents – all were reported with no or low harm. **January 2017:** 11 patient safety medication related incidents were reported, all with no or low harm.	Work is ongoing to reduce the harm from medication errors across the Trust, whilst still encouraging a reporting and learning culture. A written training package for nurses is to be trialled in March 2017, with the future aim for it to be an e-learning package. Errors themes are reviewed on a monthly basis, and targeted support where hotspots arise. The doctors eLearning module is being amended to reflect prescribing errors relating to insulin and steroids. This Will be in place for next intake of junior doctors.

Serious Incidents/ Never Event	No Serious Incidents or Never Events occurred in December 2016 or January 2017.	The Trust's Risk Management Strategy has been ratified for use. Going forward, learning from incidents will be combined with learning from other work streams including clinical audit findings and mortality reviews.
Pressure ulcers	**December:** There was one hospital acquired grade 2 pressure ulcer in ITU. **January:** There were no grade 2 or above hospital acquired pressure ulcers reported.	NHS Improvement (NHSI) are re-launching the National Stop the Pressure Programme; and have requested a copy of the Trust's improvement plan to understand the work being taken forward in relation to pressure ulcer management. This will also help NHSI identify where focussed support can be provided. The deadline for plan submission is Tuesday 28th February.
Falls	**December:** There were two reported inpatient falls which occurred in Step-down and the inpatient ward. **January:** There were four reported inpatient falls which occurred in Ross Tilley.	Trust compliance with the completion of the patient falls assessment within 24 hours of admission remains above 95% over this period December 97.5% and January 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 4 2015/16		Quarter 1 2016/17			Quarter 2			Quarter 3			Quarter 4	12 month total/ rolling average
			Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	
Infection Control															
MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile acquired at QVH post 72 hours after admission	1	0	0	0	0	1	0	0	0	0	0	0	1	0	2
MRSA screening - elective	98%	>95%	98%	98%	98%	96%	95%	96%	94%	96%	96%	98%	97%	98%	97%
MRSA screening - trauma	97%	>95%	95%	96%	95%	97%	95%	95%	93%	93%	95%	98%	93%	96%	95%
Incidents															
Never Events	0	0	0	0	0	0	0	0	0	1	1	0	0	0	2
Serious Incidents	3	0	1	0	0	0	0	0	0	0	0	1	0	0	2
OOH inductions:															
All patients: Number of patients operated on out of hours 22:00 - 08:00		5	4	6	2	10	2	2	7	5	0	4	4	5	3.8
Paediatrics under 3 years: : Induction of anaesthetic was between 18:00 and 08:00		0	0	0	0	0	1	0	0	1	0	0	0	0	0.2
Paediatric transfers out (<18 years)			1	1	1	1	1	3	0	1	0	1	0	1	11
Medication errors															
Total number of incidents involving drug / prescribing errors	191		16	14	12	15	6	12	12	9	8	13	4	11	132
No & Low harm incidents involving drug / prescribing errors	191		16	14	12	15	6	12	12	9	8	13	4	11	132
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		1.9	2.8	1.9	2.5	2.1	0.5	0.7	2.3	1.8	5.3	0.6	0.7	1.9
Harm free care rate (QVH)	97%	>95%	100%	97%	97%	100%	93%	97%	91%	91%	97%	96%	98%	96%	96%
Harm free care rate (NATIONAL benchmark) - one month delay	94%	>95%	94.1%	>95%	93.9%	93.9%	94.2%	94.3%	94.2%	94.1%	94.2%	94.3%	94.3%	TBC	
Pressure Ulcers															
Hospital acquired - grade 2	11	15	1	1	3	0	1	0	2	2	1	1	1	0	13
Hospital acquired - grade 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital acquired - grade 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VTE initial assessment	98%	>95%	96%	100%	100%	100%	97%	100%	100%	100%	97%	96%	100%	100%	98.9%
Patient Falls															
Patient Falls assessment completed within 24 hrs of admission	94%	>95%	100%	100%	100%	95%	95%	94%	100%	98%	100%	96%	98%	96%	97.6%
Patient Falls resulting in no or low harm (all falls)	40		1	7	5	5	9	4	0	3	2	5	2	6	49
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	**December:** There were no QVH mortalities and one patient died elsewhere within 30 days of discharge. **January**: There were no QVH mortalities and one patient died elsewhere within 30 days of discharge.	The Trust's Clinical Indicator Report now includes rolling trends reports for mortality, transfers out, readmissions and returns to theatres. These graphs allow the Trust to track key indicators over time.
Transfers out	There were two emergency or unexpected transfers out in December 2016 and eight in January 2017.	Paediatric transfers (less than 18 years) are monitored and reviewed by the paediatric team to ensure appropriateness and continuity of care.
Antimicrobial Stewardship	Work continues to implement the National antimicrobial stewardship recommendations. The Trust's implementation plan is progressing well, and all actions are currently completed or moving forward. A route cause analysis (RCA) for the case of Clostridium difficile infection has been completed and is awaiting commissioner approval. Issues around antimicrobial prescribing have been identified, and raised with the relevant Clinical Director. An antimicrobial training package has been developed for nursing staff and is awaiting roll out.	Work continues on CQUIN data collection and the Trust is on track to meet the reductions in consumption. However, improvement is needed around documented clinical review which requires further clinician engagement. Concerns have been raised about the lack of onsite microbiologist cover at QVH due to shortages BSUH. The interim plan is for a microbiologist to dial into the MDT review, to ensure access to specialist microbiology advice is maintained. This issue was previously raised at the contract meeting; and will continue to be reviewed to monitor the short to medium workforce issues relating to microbiology cover.

NICE Compliance	Benchmarking of Trust compliance has been completed for: **QS126:** Motor neurone disease (July 16) **- fully compliant** (community therapy service) For an update of the Clinical Effectiveness Quality Priority: 20% of applicable NICE Clinical guidance, please see: CQUIN and Quality Account Priorities section.	The Trust is working with the Motor Neurone Disease to undertake an audit of QS126: in March 2017 on our community provision.

Clinical audit	The Trust is now adding Breast patients to the national Breast and Cosmetic Implant Registry. Data collection has commenced on QVH's contribution to the National Head and Neck Cancer Audit (HANA) - Saving Faces.	The Quality and Compliance Team are working with the Cancer and Information Teams to ensure that perspective head and neck cancer patients can be submitted to the Neck Cancer Audit (HANA) - Saving Faces on an ongoing basis.
Outpatient mapping	A process mapping exercise was undertaken on the Trust's appointment process, which sought to identify areas of inefficiency. It was identified that a number of the current steps do not add any value and may confuse patients; as appointment letters are sent with confirmed dates, but no allocated time slot. In addition, patients often receive several reminder letters asking them to ring the Appointments department to book a time. It has been highlighted that changing these inefficiencies is likely to decrease DNAs, and improve utilisation of available appointments.	Changes to the appointment letters will be taken forward to remove the need for patients to phone and book an appropriate time slot - this is expected to be implemented in March 2017 Going forward, DNA rates across all specialties will be monitored to ensure a downward trend is realised as a result of changes made.

Effective - Performance Indicators

Metric	2015/16 total / average	Target	Quarter 4 2015/16		Quarter 1 2016/17			Quarter 2			Quarter 3			Quarter 4	12 month total/ rolling average
			Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	
Mortality															
QVH Mortalities	6	0	1	2	0	0	0	0	0	0	0	1	0	0	4
Readmissions															
Emergency Readmissions Within 30 Days	1.87%	2.24%	2.49%	2.18%	2.11%	2.15%	2.14%	2.46%	3.02%	2.64%	1.91%	2.27%	1.91%	1.52%	2.23%
Emergency Readmissions Within 7 Days	1%	1.21%	1.42%	1.16%	0.73%	1.01%	1.04%	1.11%	1.34%	1.81%	1.02%	1.10%	1.12%	1.25%	1.17%
Paediatric safeguarding															
Paediatric safeguarding cases*			28	20	19	26	20	14	20	12	25	17	15	24	215
Allegations against staff			0	0	0	0	0	1	1	0	0	0	0	0	2
Safeguarding adults															
Adult Safeguarding cases*			2	1	0	6	6	7	10	6	7	4	5	4	58
Allegations against staff			0	1	0	0	0	0	1	0	0	0	0	0	2
Female genital mutilation (FGM) Risk Assessments undertaken			0	0	0	0	0	0	0	0	0	0	0	0	0
DoLS Applications			0	0	1	2	0	0	0	0	1	0	1	1	6
Prevent Referrals			0	0	0	0	0	0	0	0	0	0	0	0	0
Infection control audit															
Hand hygiene audit %			99%	99%	100%	99%	99%	99%	99%	99%	99%	99%	100%	100%	99%
Bare below the elbows %			95%	99%	100%	100%	100%	100%	100%	100%	99%	99%	99%	99%	99%
Trust Cleaning %			90%	90%	88%	88%	88%	92%	92%	92%	91%	91%	90%	89%	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	The Trust has received the National Inpatient Survey 2016. The results are currently being analysed and an action plan developed to address areas for improvement.  **Have we improved since the 2015 survey?** A total of 63 questions were used in both the 2015 and 2016 surveys. Compared to the 2015 survey, your Trust is: ■ Significantly BETTER on 3 questions ■ Significantly WORSE on 3 questions ■ The scores show no significant difference on 57 questions  **How do we compare to other trusts?** The survey showed that your Trust is: ■ Significantly BETTER than average on 58 questions ■ Significantly WORSE than average on 2 questions ■ The scores were average on 7 questions	Picker will present the results to the next Joint Hospital Governance Meeting in March 2017. Findings and actions resulting from the in-depth analysis will be presented to the Clinical Governance Group (CGG) and Quality and Governance Committee (Q&GC). The Trust's Patient Experience Group (PEG) will monitor action implementation.

Complaints	In December and January – ten complaints were received. Three relate to clinical care (nursing x2)/medical), two to missing health records, and one to unforeseen post-op complication, unforeseen complication during surgery, injury in the course of treatment and delayed diagnosis (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. Going forward our aim is to focus on learning the lessons, and ensuring that we are triangulating all patient feedback including surveys, complaints, concerns and comments, to undertake some trend analysis to drive forward improvements in the experience of our patients, service users and carers.
Friends and Family Test (FFT)	Inpatients: In December 97% of inpatients (response rate of 48%, n=262) who completed FFT survey would recommend QVH. In January this was 98% (response rate of 45% (national target is 40%) n=212) who completed the FFT survey would recommend QVH. Outpatients: The FFT score for out-patients in December was 94%. A total of 1842 outpatients out of a possible 11644 completed the questionnaire either by paper, SMS or integrated voice message. The response rate for outpatients was 16% (national target is 20%). In January the score remained the same at 94% and 2016 out of 11923 took part. This was a response rate of 17%.	Although the Trust's response rate has remained consistent throughout, work continues to encourage more patients to complete the survey as we wish to aim for 50%. FFT continues to be implemented and we aim to ensure that we are acting on this valuable feedback.

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

Caring - Performance Indicators

Metric	2015/16 total / average	Target	Quarter 4 2015/16		Quarter 1 2016/17			Quarter 2			Quarter 3			Quarter 4	12 month total/ rolling average
			Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	
Complaints															
Complaints per 1000 spells *	2.7		1.9	3.5	1.9	4.4	3.5	0.0	4.6	2.3	3.0	2.0	1.2	5.4	2.8
Claims per 1000 spells *	1.1		1.3	2.1	1.3	0.0	0.7	0.0	0.0	0.0	0.6	0.7	0.0	1.4	0.7
Friends and Family Test															
FFT score acute in-patients: likely and very likely to recommend QVH	99%	>90%	100%	99%	99%	99%	98%	99%	98%	98%	98%	97%	97%	98%	98%
FFT score acute in-patients: unlikely and very unlikely to recommend QVH	0%		0%	0%	0%	0%	0%	1%	1%	0%	0%	0%	0%	0%	0%
FFT score MIU: likely and very likely to recommend QVH	94%	>90%	92%	94%	92%	95%	94%	94%	96%	97%	96%	97%	95%	97%	95%
FFT score MIU: unlikely and very unlikely to recommend QVH	3%		3%	3%	4%	3%	2%	5%	5%	2%	2%	3%	3%	2%	3%
FFT score OPD: likely and very likely to recommend QVH	95%	>90%	93%	94%	94%	95%	94%	94%	94%	94%	95%	94%	94%	94%	94%
FFT score OPD: unlikely and very unlikely to recommend QVH	2%		2%	2%	2%	2%	2%	3%	3%	3%	2%	2%	2%	2%	2%
FFT score DSU: likely and very likely to recommend QVH	97%	>90%	96%	96%	96%	97%	97%	97%	96%	94%	98%	98%	97%	96%	97%
FFT score DSU: unlikely and very unlikely to recommend QVH	1%		1%	1%	1%	1%	1%	2%	2%	3%	0%	0%	0%	0%	1%
FFT score Sleep disorder centre: likely and very likely to recommend QVH	97%	>90%	97%	97%	96%	98%	97%	98%	100%	94%	96%	96%	91%	96%	96%
FFT score Sleep disorder centre: unlikely and very unlikely to recommend QVH	1%		0%	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	0%
Privacy and dignity															
Mixed Sex accommodation breach	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient experience - Did you have enough privacy when discussing your condition or treatment (indicates a yes response)	99%	>90%	97%	97%	99%	95%	91%	92%	94%	100%	100%	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	The inspection schedule has been completed for Q3 2016/17. Overall compliance for the period was 83.9% (rating of 'Good'). There has been a slight decline from the previous quarter, which can be attributed to the introduction of new questions relating to Information Governance and the Patient Administration System (PAS) which has identified some areas of underperformance. Sections focusing on patient experience, safety measures and systems and safe staffing continue to perform well. Latest round of inspections for Q4 are currently underway.	An action plan is to be devised by the Trust's Information Governance Lead to assist in addressing areas of underperformance in this area. The next round of inspections (Q1 2017/18) will commence towards the end of April 2017.
Incident Reporting	**December 2016:** 139 incidents were reported in total, 71 of which were Patient Safety and all of these were no or low harm. The main themes for Patient Safety incidents were soft tissue damage and adult safeguarding concerns. **January 2017:** 134 incidents were reported in total, 78 were Patient Safety and all of these were no or low harm. The main themes for Patient Safety incidents were Drug Errors (Prescribing) and Communication Failure.	Directorate and Departmental Risk Registers continue to be reviewed on a monthly basis at the business unit meetings; which includes the movement of scores and closures.

Nursing Workforce - Current Compliance

Across Sussex and East Surrey and Kent there is a shortfall of circa 1500 nurses (STP workforce data). National shortages of nurses include qualified theatre practitioners and ITU nurses and QVH IS finding it extremely hard to recruit nurses with these skills. Workforce plans to address recruitment and retention include; different approach to advertising posts, access to funded education, and a new leadership course within the trust. The HR team have been asked to lead a scoping exercise on the viability of an international recruitment scheme at QVH. Feedback from prospective candidates shows that proximity to London , and no south east weighting prevents them from continuing with substantive applications.

On the 31st January the difference in the number of nurses, theatre practitioner and HCAs between budgeted WTE and staff in post was 80.97 WTE with a net increase in this staff group of 0.54 WTE compared to the previous month end . This does not reflect the reduction of 15 WTE from the nursing consultation and CIP giving a total of 66.47 vacancies. It is recognised that this level of vacancy could add risk to the quality of care delivery and affects staff morale. The increased risk is reflected in the BAF and CRR. Adverts for all posts including theatre and pre- operative posts are on NHS Jobs. There has been a lot of interest and high calibre applications for the Band 2 posts, which has resulted in job offers, less success is seen in the qualified posts.

The theatre workforce review has been completed, there are currently 25 WTE vacancies for nursing an theatre practitioners which equate to 15.50% vacancies based on the existing funded WTE of 148.17. To provide safe and effective care we continue to line book 5 WTE agency nurses per week in theatres . Critical care vacancies remain high, however there are 3.3 WTE post being processed by recruitment which leaves 6.97 wte vacancies. This has had an impact on the capacity in critical care. The beds are reviewed daily in relation to the skill mix of substantive, bank and agency staff available to ensure a safe standard of care. Its also important to note that much of the care we provide is multi-professional, not solely nursing.

Detailed review of staffing levels , planned and actual continues on a daily basis, staff are redeployed to ensure safe care and best use of resources. This is having a negative impact on staff regularly being asked to work in other areas. There is detailed scrutiny of all staffing incidents requiring escalation to senior staff and these are triangulated with key safety metrics including falls , pressure damage, medication incidents and complaints to look for direct or indirect safety and quality issues. In December there were 16 incidents and January 15 incidents across the 4 ward areas which were escalated and resolved with resources being reallocated or temporary staffing being booked. All were triangulated against patient safety indicator report (Datix) ward Friends and Family (FFT) data and Complaints to review if there was any correlation between staffing levels and incident. There was only one patient incident which occurred on any of the corresponding dates; a patient fall (no harm) where the patient was found by his bed and chair sitting on the floor. The ward was one HCA short there was no direct reference to the fall occurring due to the HCA staffing level.

(FFT) data and Complaints to review if there was any correlation between staffing levels and incident. There was only one patient incident which occurred on any of the corresponding dates; a patient fall (no harm) where the patient was found by his bed and chair sitting on the floor. The ward was one HCA short there was no direct reference to the fall occurring due to the HCA staffing level.

A review of the staffing rosters below shows the percentage that planned staffing levels met the actual , the expectation is that this will be achieved at 95% or above or an explanation/escalation of why this is less.

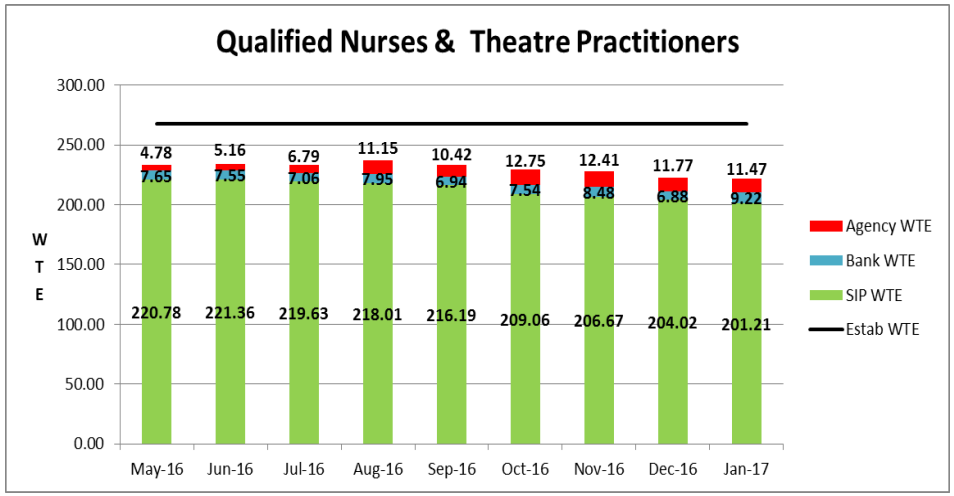
	Day	Night	Ward FFT score
	% planned hours met actual	% planned hours met actual	
All inpatient wards	98.1	93.3	N/A
ITU	99.5	97	N/A
Peanut	97	94.5*	98%
Burns ward	98.5	97.5	100%
CWing	97.5	87**	99%

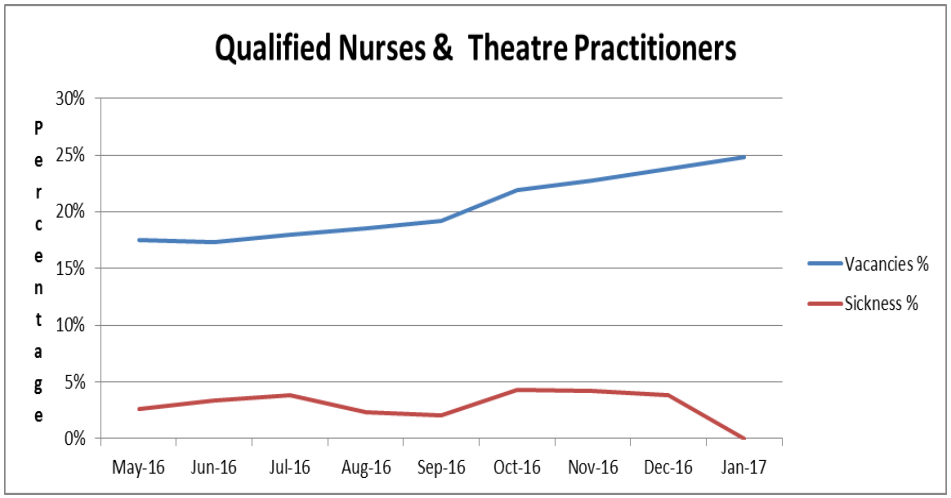
*Peanut ward has very low number s of patients at night and so second staff member is not always booked as per template
**CWing occupancy is significantly reduced at night and staffing reflects these variances which can differ from template thus reducing % compliance

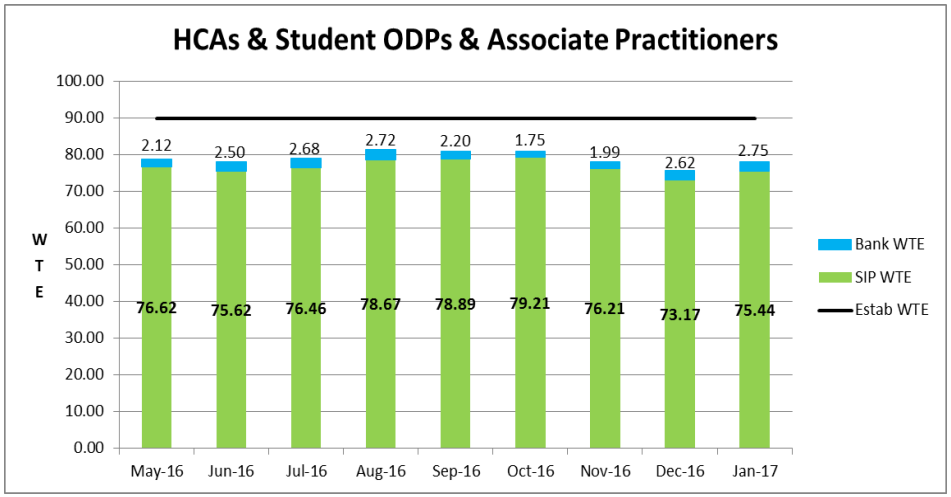
From this analysis and triangulation there are no significant patient safety or experience impact from the high vacancy rates, however this will continue to be closely monitored. Trained sickness in M10 has decreased to 3.81% from 4.33% and an increase in HCA sickness to 4.66% from 2.63% . In M11 Trained bank usage has increased to 9.22wte from 6.88% agency usage has remained static at 11.47wte, for HCA bank usage remains constant at 2.75wte and no agency (data source M11 ESR). The majority of the agency spend on nursing is above the payment cap. This is due to the specialist nature of the skill set required which are very limited in the Tier 1 agency staff.

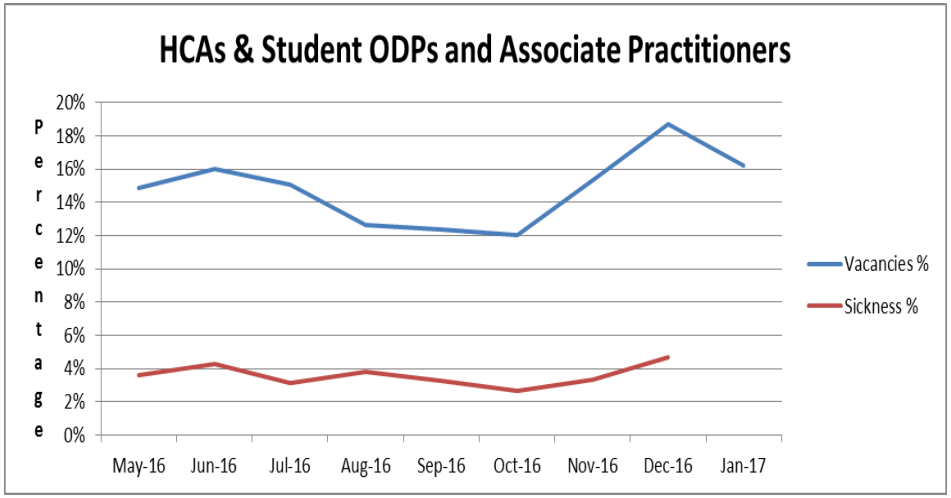
*Data extracted from the workforce score card in appendix 1

Nursing Workforce - Performance Indicators









CQUIN and Quality Account Priorities - Current Compliance

Domain	Current Compliance	Next Steps
CQUIN	All CQUIN schemes milestones for Q3 have been approved by the CCGs and specialist commissioners, and full payment agreed.	Work continues with the national and local (specialist) CQUIN implementation plans, to ensure achievement of the Q4 milestones. Work has began on the 2017/18 national and local schemes (six and one scheme respectively). Both the Director of Nursing and Quality and the Project Management Office have held briefing meetings with all CQUIN leads. Designated leads are currently formulating plans and milestones to ensure achievement over the next financial year.

Quality Account	Work continues on the achievement of the three Quality Priorities for 2016/17: **1**. **Safety:** The average duration of investigations for no and minor harm incidents in December 2016 and January 2017 continues to be 3-4 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 **NG45:** Routine preoperative tests for elective surgery **3. Patient Experience:** Improve walkways. All walkways have now been resurfaced. Phase 2 (resin bound surfacing) was undertaken and completed in December 2016. The Wayfinding project mobilisation took place during October 2016, and the site analysis and audit including consultation with stakeholders, patients/visitors and staff was completed in December 2016.	All QVH staff have been sent a letter asked to identify three new Quality Priorities for 2017/18, ideally following the 2016/17 format, namely: 1**. Patient safety**: having the right systems and staff in place to minimise the risk of harm to our patients and, if things do go wrong, to be open and learn from our mistakes 2. **Clinical effectiveness**: providing high quality care, with world class outcomes, whilst being efficient and cost effective 3. **Patient experience**: meeting our patients' emotional as well as physical needs. Suggestions must be measurable and baseline metrics will be devised for chosen priorities.

BURNS ITU 2016 / 2017		MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	DoN Rating					
Staff Utilisation							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies	WTE	3.5	2.96	4.44	4.44	5..24	9.3	7.11	9.11	8.26	7.89	7.89		7.5%					Targetted recruitment for ITU has not been succesful. However 3 .3 WTE staff recruited via other means and are currently being processed.
Est =	(hrs)	541.25	481	721.5	719	848	1511.3	1155	1480	1342	1282	1282							
Temp staffing exc RMN	Bank	244.5	6	43	12	68	19	79	8	64.7	5.75	16.5		10%					
	Agency	444	128.5	166	24	148.5	400.5	40	310	115	139	195.5							
Sickness	%	5.8%	3.5%	3.2%	2.8%	2.1%	0.5%	1.4%	1.5%	1.7%	4.8%	4.3%		2%					Small improvement in month
Shift meets est %	RN	98%	93.9%	96.8%	97%	92%	101%	92%	96%	96%	94%	99%		95%					
Day	HCA	100%	100%	100%	100%	200%	100%	100%	113%	100%	100%	100%		95%					
Shift meets est %	RN	95.1%	98.7%	100%	82.0%	101%	96%	79%	87%	81%	84%	94%		95%					
Night	HCA	200%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		95%					
Training / Appraisal							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals	%	86.5%	86.5%	87%	90%	76.2%	76%	41.2%	21%	57%	57%	57%		85%					Improvement plan requested, new ward matron appointed
Statutory & Mand.	%	90%	90%	90%	85.4%	88%	90%	78.4%	83%	86%	86%	80%		85%					
Drug Assessments	%	92%	100%	100%	95%	95%	95%	100%	100%	100%	100%	100%		95%					
Staff FFT Score	%	–	–	–	–	–	–	–	–	–	–	–	–	–					
Budget	(YTD)	79311	3739	28657	27162	25017	31804	28789	24244	14435	2000	4502		<0					
Safe Care							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	G2+	0	0	0	1	0	1	0	1	0	1	0		0					
Falls	With harm	0	0	0	0	0	0	0	0	1	0	0		0					
Medication Errors	All	2	1	2	0	3	1	0	1	1	0	0		0					
C. Diff		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					
Incidents Reported (Datix)	Patient Safety	5	10	9	4	8	11	9	12	8	9	6							
VTE reassessment	%	100%	100%	100%	100%	100%	100%	66.7%	80%	N/A	33.3%	100%	66.7%	95%					1 patient non assessed
Nutrition assessment (MUST)	Initial	100%	100%	100%	100%	100%	0%	100%	80%	N/A	100%	100%	100%	95%					
	7 day r/v	100%	N/A	100%	100%	100%	100%	50%	100%	N/A	100%	N/A	100%						
Patient numbers		21	–	–	–	–	–	–	–	–	–	–	–	N/A					
Patient FFT Score	%	–	–	–	–	–	–	–	–	–	–	–	–	95%					See 'Burns Ward' for monthly combined score.

BURNS WARD 2016 / 2017		MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	DoN Rating					
Staff Utilisation		No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies	WTE	4.26	4.7	7.23	3.54	4.54	6.51	2.2	4.4	4.4	4.4	6.7		7.5%					
Est =	(hrs)	693.2	763.75	1174	573	735	1057	82.5	715	715	715	1088							
Temp staffing exc RMN	Bank	356	142.5	223	180	225	160	72	N/A	74.25	147	145		10%					
	Agency	107.5	84	174	41	36	46.5	30	69	57.5	57.5	11.5							
Sickness	%	3.8%	4.2%	5.5%	3.1%	2.2%	1.4%	1.8%	2.2%	2.0%	1.7%	2.0%		2%					
Shift meets est %	RN	95.1%	95.9%	98.8%	100%	94%	100%	100%	96%	95%	96%	97%		95%					
Day	HCA	100%	97%	100%	94%	90%	96%	88%	98%	100%	94%	100%		95%					
Shift meets est %	RN	93.7%	96.6%	95.2%	93%	98%	100%	100%	100%	97%	97%	95%		95%					300% relates to additional HCA cover above template on 3 nights due to needs of patients.
Night	HCA	100%	200%	200%	100%	100%	100%	100%	100%	100%	100%	300%		95%					
Training / Appraisal		No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals	%	94%	94%	94%	82%	76%	80%	N/A	66%	N/A	78%	69%		85%					Improvement plan requested
Statutory & Mand.	%	92%	92%	92%	89.6%	92%	93%	N/A	88%	N/A	90%	94%		85%					Improvement in month
Drug Assessments	%	93%	100%	100%	93%	93%	93%	100%	100%	100%	100%	100%		95%					
Staff FFT Score	%	_	_	_	_	_	_	_	_	_	_	_	_	_					
Budget	(YTD)	154025	10530	6959	20282	21387	11789	10663	14951	15406	27000	72240		<0					
Safe Care		No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	G2+	0	0	0	0	0	0	2	0	0	0	0		0					
Falls	With harm	1	0	0	0	0	0	1	0	0	0	0		0					
Medication Errors	All	1	1	1	0	1	1	1	0	1	0	1		0					
C. Diff		0	0	0	0	0	0	0	0	0	0	0		0					
MRSA		0	0	0	0	4	0	0	0	0	0	0		0					
Incidents Reported (Datix)	Patient Safety	3	2	7	4	4	5	9	3	6	2	3							
VTE reassessment	%	100%	100%	66.7%	100%	50%	50%	100%	100%	100%	66.7%	100%	100%	95%					
Nutrition assessment (MUST)	Initial	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%					
	7 day r/v	100%	N/A	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%						
Patient numbers		32	44	24	69	59	55	65	43	62	47	46		N/A					
Patient FFT Score	%	100%	100%	99%	100%	94%	100%	100%	100%	94%	100%	100%		95%					

CANADIAN WING 2016 / 2017		MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	DoN Rating					QVH
Staff Utilisation	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies	WTE	8.6	4.16	5.96	5.18	6.42	6.42	7.66	9.16	11.85	11.85	11.85		7.5%					4 WTE staff offered posts and currently progressing through recruitment process
Est =	(hrs)	1397.5	676	968	841	1043	1043	1245	1488	1925	1925	1925							
Temp staffing exc RMN	Bank	731	286	292	420	112	299	364	227	280	374	317		10%					Bank and agency usage less than the wte vacancy .
	Agency	411	293	108	178	57	245	440	289	172.5	299	162							
Sickness	%	4.2%	7.1%	2.4%	3.5%	3.9%	2.8%	3.2%	3.3%	4.0%	3.2%	2.1%		2%					Sickness being managed as per policy. Includes sickness due to surgery and recovery. Improvement in month.
Margaret Duncombe	*Safe Staffing*													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Shift meets est %	RN	99.2%	102%	102%	100%	99%	99%	101%	97%	102%	96%	98%		95%					
Day	HCA	98.3%	100%	93.8%	96%	103%	92%	94%	92%	98%	100%	98%		95%					
Shift meets est %	RN	99%	100%	99.1%	97%	90%	100%	101%	100%	111%	98%	100%		95%					lower staffing levels at night reflect bed occupancy and some short notice sicness
Night	HCA	100%	86.1%	97%	103%	100%	100%	85%	88%	65%	58%	81%		95%					
Ross Tilley	*Safe Staffing*													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Shift meets est %	RN	95.9%	97.8%	100%	100%	98%	89%	92%	99%	99%	93%	99%		95%					
Day	HCA	98.4%	98.2%	97.8%	100%	91%	94%	90%	98%	105%	98%	95%		95%					
Shift meets est %	RN	98.7%	95.5%	100%	99%	100%	93%	94%	86%	94%	97%	95%		95%					lower staffing levels at night reflect bed occupancy
Night	HCA	86.2%	88.5%	88.9%	83%	90%	96%	71%	82%	55%	57%	71%		95%					
Training / Appraisal	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals	%	100%	95%	96%	100%	100%	100%	100%	100%	100%	90%	91%		85%					
Statutory & Mand.	%	90%	90%	92.9%	92.9%	87%	72%	83%	N/A	83%	85%	85%		85%					
Drug Assessments	%	100%	100%	100%	100%	100%	100%	100%	97.5%	100%	100%	100%		95%					
Staff FFT Score	%	–	–	–	–	–	–	–	–	–	–	–	–	–					
Budget	(YTD)	98162	12567	16553	9059	7991	11692	13962	27912	40597	42000	42346		<0					

CANADIAN WING 2016 / 2017		MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	DoN Rating					QVH
Safe Care	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Margaret Duncombe (& Step Down)																			
Pressure Ulcers	G2+	0	2	0	0	0	1	0	0	0	1	0		0					
Falls	With harm	2	1	1	0	0	0	1	0	1	0	0		0					
Medication Errors	All	3	6	5	2	3	6	2	1	1	2	5		0					Review by ward pharmacist and ward matron new training package developed
C. Diff		0	0	1	0	0	0	0	0	0	1	0		0					
MRSA		0	0	0	0	0	0	0	0	0	0	0		0					
Incidents Reported (Datix)	Patient Safety	9	14	16	5	9	12	13	11	8	7	15							
VTE reassessment	%	100%	100%	69.2%	90.9%	100%	80%	100%	100%	90.9%	58.3%	100%	100%	95%					
Nutrition assessment (MUST)	Initial	100%	100%	94.1%	100%	100%	100%	100%	100%	100%	94.4%	100%	100%	95%					
	7 day r/v	75%	100%	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%						
Patient numbers		166	166	123	137	112	162	157	173	158	149	116		N/A					
Patient FFT Score	%	99%	100%	99%	97%	99%	96%	98%	98%	98%	97%	97%		95%					
Ross Tilley														Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	G2+	0	1	0	0	0	0	0	0	0	0	0		0					
Falls	With harm	1	1	0	0	1	0	1	0	0	0	0		0					
Medication Errors	All	5	0	6	4	4	3	4	6	4	1	2		0					
C. Diff		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					
Incidents Reported (Datix)	Patient Safety	17	5	9	15	8	9	15	10	9	8	11							
VTE reassessment	%	94%	85.7%	82.4%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%					
Nutrition assessment (MUST)	Initial	100%	100%	100%	100%	100%	100%	94.1%	100%	83.3%	100%	100%	93.8%	95%					
	7 day r/v	75%	66.7%	N/A	100%	N/A	100%	100%	100%	N/A	75%	N/A	100%						
Patient numbers		199	148	201	218	240	191	207	210	207	185	157		N/A					
Patient FFT Score	%	99%	97%	98%	98%	99%	100%	99%	98%	97%	98%	99%		95%					

PEANUT WARD 2016 / 2017		MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	DoN Rating					
Staff Utilisation							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies	WTE	2.36	2.72	1.34	3.74	2.74	2	2	2	2.6	4.5	4.5		7.5%					line booking of agency being explored to provide consistency of care
Est =	(hrs)	383.5	442	217	607	445	325	325	325	422	731	731							
Temp staffing exc RMN	Bank	205.5	48.5	15.5	40	95	68	231	90.5	216.25	119.25	322		10%					
	Agency	0	0	0	12	12	4	34	34.5	46	33.5	80							
Sickness	%	5.6%	4.0%	5.7%	7.6%	2.1%	2.4%	3.3%	7.3%	2.6%	5.0%	8.0%		2%					increase in short term sickness has resulted in higher usage of bank and agency
Shift meets est %	RN	100%	96.3%	98.8%	98%	101%	97%	98%	96%	102%	95%	100%		95%					
Day	HCA	100%	103%	100%	94%	88%	94%	104%	92%	93%	97%	94%		95%					
Shift meets est %	RN	93.4%	94.9%	90%	93%	98%	95%	98%	90%	88%	75%	89%		95%					
Night	HCA	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		95%					
Training / Appraisal							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals	%	91%	91%	91%	81%	89%	94%	N/A	66%	75%	75%	75%		85%					improvement plan requested
Statutory & Mand.	%	94%	94%	93%	91%	90%	92%	N/A	84%	79%	79%	82%		85%					
Drug Assessments	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		95%					
Staff FFT Score	%	_	_	_	_	_	_	_	_	_	_	_	_	_					
Budget	(YTD)	9228	4314	8844	11878	13516	16305	12903	16973	15559	18000	21223		<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					
Falls	With harm	0	0	0	0	0	0	0	0	0	0	0		0					
Medication Errors	All	2	0	0	1	2	0	1	1	1	1	0		0					
C. Diff		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					
Incidents Reported (Datix)	Patient Safety	6	4	2	3	5	4	3	6	2	1	1							
VTE reassessment	%	_	_	_	_	_	_	_	_	_	_	_	_	95%					N/A
Nutrition assessment (MUST)	Initial	_	_	_	_	_	_	_	_	_	_	_	_	95%					N/A
	7 day r/v	_	_	_	_	_	_	_	_	_	_	_	_						
Patient numbers		190	180	197	188	235	213	216	226	202	163	149		N/A					
Patient FFT Score	%	98%	100%	97%	99%	100%	98%	96%	97%	98%	96%	98%		95%					

Queen Victoria Hospital NHS
NHS Foundation Trust

Monthly Patient Experience Report

1 January 2017 – 31 January 2017

Performance Indicators	Jan	Dec	Nov	Oct	Sept	Aug	Jul
Number of new formal complaints received in the month	8	2	3	5	4	7	0
Number of complaints referred to the Ombudsman for 2nd stage review	2	0	0	0	0	0	0
Number of complaints re-opened	0	0	0	1	0	0	0
Number of complaints closed	0	6	2	3	1	2	5
Number of complaints upheld	0	5	1	2	1	1	1
Number of complaints upheld in part	0	0	1	0	0	1	3
Number of complaints unsupported	0	1	0	1	0	0	1
Number of new claims	2	0	1	1	0	0	4
Number of closed claims	2	1	1	0	0	2	0

Complaints

Open Complaints

Eight new complaints were received in January 2017, a significant increase from the number received last month (two). 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.

Theatres/Clinical Infrastructure

1. **Day Surgery – Nursing/Health Records – Communication/ Unattainable Health Records -** Failure to communicate to the patient the reason why there was a delay in taking them through for surgery which was due to the notes not being available. **Investigating lead – Consultant/Perioperative Theatre Manager**

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

   Comment/Action – Case still under investigation. Please note that this occurred during the relocation of the Health Records Department.

Clinical Infrastructure

2. **Outpatients – Health Records – Unattainable Health Records** - Health records unavailable at appointment. Patient waited 40 mins to be told that they could not perform extraction without notes. **Investigating lead – Business Unit Manager**

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

   Comment/Action – Case still under investigation.

Plastics

3. **Outpatients – Medical – Unforeseen post-operative complication** - Patient underwent hand surgery. When raised concerns about changes in finger this was overlooked. Subsequently diagnosed with an infection which has resulted in further surgery. Patient would like an explanation as to why their concerns appear to have been initially overlooked and not investigated. **Investigating lead – Consultant/Clinical Director**

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

   Comment/Action – Case still under investigation.

Eyes

4. **Outpatients – Medical – Unforeseen complication during surgery** - Patient unhappy with outcome of surgery and lack of aftercare provided following complication. **Investigating lead – Consultant/Clinical Director**

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

   Comment/Action – Case still under investigation. Surgery performed by clinician that is no longer at Trust. Patient has been given a further appointment with consultant to review their current visuals.

5. **Outpatients – Nursing – Injury in the course of treatment** - Patient raised concerns about the treatment provided and that during the course of treatment their eyelid was caught by an instrument. Also concerns about the information that had been given to the patient when they made an SOS call to the unit. **Investigating lead – Clinical Director/Matron**

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

   Comment/Action – Case still under investigation.

Burns

6. **EBAC – Nursing – Communication -** Patient attended for a dressing change and alleges that the treating nurse made some judgmental comments towards the patient in relation to how they sustained their injury. Patient has now refused to return to have any further treatment. I**nvestigating lead – Matron**

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

Comment/Action – Case still under investigation. Review being undertaken on how to provide treatment to this patient in the community.

Oral Surgery

7. **Outpatients – Medical – Overall medical care -** Concerns raised by family of deceased patient. Patient previously treated for melanoma and family wish to know why regular CT scans were not performed. Following a stroke patient admitted to hospital where a CT scan was performed. Family advised that this showed that cancer had returned and had spread throughout the patient's body. . Family wish to know why was this not picked up at their 3 monthly review. Patient subsequently died from condition related to stroke. **Investigating lead – Consultant/Clinical Director**

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

   Comment/Action – Case still under investigation.

8. **Offsite (Medway) – Appointments – Referred** for dental consubstantiation and has been advised that there is a delay of up to 36 weeks for an initial consultation. **Investigating lead – Business Unit Manager**

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

   Comment/Action – Case still under investigation.

Closed Complaints

There have been no complaints closed during this period.

Parliamentary and Health Service Ombudsman (PHSO)

There have been two new cases referred to the PHSO during this period.

Case one: This refers back to 2012 when a patient had a psychotic episode following a general anaesthetic. To ensure patients safety 1-1 specialist nursing (agency) was put in place. The patient is unhappy that they experienced this type of episode and that they had 1-1 specialist nursing and wishes to have an explanation as to what happened during their care and treatment.

Please note that the patient initially raised concerns informally in November 2012 and a full explanation was given at the time. Patient then contacted the Trust again in September 2016 expressing concerns with the explanation given back in 2012. As we were unable to provide any further explanation than that already given the patient has resorted in contacting the PHSO on this matter.

Please further note that although this case is clearly out of time in regards to the NHS Complaints procedure (complaint to be made within one year of issue) is at the discretion of the PHSO that they wish to review this case. When submitting the paperwork to the PHSO this matter will be pointed out to them and also the fact that the specialist nurses were provided by an agency.

Case two: This case was initially reported as a formal complaint in August 2016 regarding delayed treatment plan and decisions being made in relation to lower limb surgery. During last admission patient alleges that nursing staff appeared uncaring towards patient's situation. In the response back to the patient from the Trust it was agreed that there had been a delay in providing this patient with treatment which was due to the complexities of this patient's medical history. Apologies were given if nursing staff were uncaring towards the patient. Patient has since been referred to London hospital for a second opinion.

The patient has contacted the Ombudsman with several issues that they are unhappy with and in addition they have asked for financial recompense.

Claims

There were two new claims opened this month and two claims closed (details below)

New cases opened

Incident date	Claim date	Speciality	Service	Description (allegations within solicitors letter)	Complaint	Incident
08/11/2016	04/01/2017	Plastics	Medical	Alleged negligent treatment/surgery to left arm causing nerve damage/loss of sensation/numbness.	No	No
27/07/2019	04/01/2017	Maxfac	Medical	During jaw surgery there was a complication that arose (bone splintered) which necessitated in the area requiring additional screws.	No	No

	Cases closed							
Incident date	**Claim date**	**Closed date**	**Speciality**	**Service**	**Description (allegations within solicitors letter)**	**Complaint**	**Incident**	**Outcome**
11/09/2012	15/03/2013	24/01/2017	Plastics	Medical	Allegation that removal of breast implant fell below a reasonable standard leading to dehiscence and infection.	No	No	Settled: Damages awarded £45,000
04/06/2014	27/07/2014	19/01/2017	Histopathology	Medical	Delay in diagnosis and treatment of melanoma.	No	Yes	Settled: Damages awarded £5,000

Patient Experience – NHS Choices/Patient Opinion

In January 2017, the NHS Choices/Patient Opinion website received one comment relating to the outpatient department.

"Outpatients facilities"

Posted by 'Anonymous tea-drinker (as the patient)',

I attended for an outpatient's appointment a few weeks ago in the main outpatients department. I was informed on check-in that the clinic was running late which was useful to know and I appreciated being informed. Upstairs there was standing room only in the waiting room, and this may have been because other clinics were going on? However, not only was it frustrating to have nowhere to sit down, I didn't want to go away for a drink/something to eat in fear of missing my appointment - however there were no facilities in the waiting room for a hot drink, only water.

Response from Nicolle Ferguson, Patient Experience Manager, Queen Victoria Hospital NHS Foundation Trust. We are preparing to make a change

Dear Anonymous-tea-drinker

Thank you for posting your comment. We know that most people's experience of QVH starts in our outpatient department and therefore it is vital that we provide accessible, friendly and efficient access to these areas. As a result of your comment we are undertaking a review of our outpatient facilities. I hope to be in a position to come back to you shortly with ideas about how we can improve the patient experience in these areas.

This comment and our response were viewed by public users 271 times.

This was also Tweeted with the following comment: *Constructive feedback & positive outcome for @qvh on @patientopinion read full story here http://bit.ly/2kKgCOX#PatientExperience … #NHSpic.twitter.com/ctBfoIYqvV*

Friends and Family Test (FFT)

The following are the FFT results for January 2017. The chart also includes December 2016 which was unavailable in December's report.

December – Inpatients: In December 2016, 97% of patients would recommend us. 262 out of 544 patients completed the survey. This is a response rate of 48% (national target is 40%). .

January - **Inpatients: 98%** of patients said that they would recommend us. Out of the **468** patients eligible to complete the questionnaire **212** did, which gives is a response rate of 45%**.**

December – Outpatients: In December 2016 the recommendation is 94% (extremely likely/likely). 1842 patients out of 11644 completed the survey. This is a response rate of 16% (national target is 20%).

January – Outpatients: Again **94%** of our patients would recommend us and **2016** patients out of **11923** completed the survey, giving us a response rate of **17%.**

December – MIU: In December the score was 95%. 209 out of 818 patients completed the survey. This is a response rate of 26% (national target is 20%).

January – MIU: The score was **97%** with **188** out of **837** patients completing the survey**.** This is a response rate of **23%.**

December – Day Surgery: In December 97% of the patient said that they would recommend us. 385 out of 941 patients completed the survey, which is a response rate of **41%.**

January – Day Surgery: For this month **96%** of patients would recommend us. **336** out of **826** of patients completed the survey which again gives us a response rate of **41%**

Inpatient Friends and Family Test (FFT) data – November 2016

The following is a comparison of the FFT Data – November 2016 – Hospitals within the South East region (Queen Victoria Hospital is highlighted for ease of reference only). Please note that the statistics for November is the latest data available from NHS England.

Trust Name	Total Responses	Total Eligible	Response rate	Percentage Recommended	Percentage Not recommended
England – total (including Independent Sector Providers)	**241,839**	**953,881**	**25.4%**	**96%**	**2%**
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	981	8,477	11.6%	94%	2%
DARTFORD AND GRAVESHAM NHS TRUST	1,064	5,648	18.8%	98%	0%
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	2,970	10,853	27.4%	94%	2%
EAST SUSSEX HEALTHCARE NHS TRUST	1,636	5,928	27.6%	98%	1%
FRIMLEY HEALTH NHS FOUNDATION TRUST	3,778	11,849	31.9%	97%	1%
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	1,589	6,196	25.6%	96%	1%
MEDWAY NHS FOUNDATION TRUST	1,244	5,334	23.3%	88%	5%
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	276	629	43.9%	97%	0%
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	1,173	4,704	24.9%	94%	2%
SURREY AND SUSSEX HEALTHCARE NHS TRUST	1,163	4,982	23.3%	95%	2%
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	2,286	6,060	37.7%	96%	1%

The following chart is a comparison of the FFT Data for November 2016 of specialist hospitals. We do well compared to others however we will make contact with Moorfields Eye Hospital to gather any advice and to ascertain how they manage to get such a good response rate from their patients.

Trust Name	Total Responses	Total Eligible	Response rate	Recommended	Not recommended
GREAT ORMOND STREET HOSPITAL	775	3,036	25.50%	99%	0%
LIVERPOOL WOMEN'S NHS TRUST	81	986	8.2%	96%	2%
MOORFIELDS EYE HOSPITAL	1,027	1,735	59.20%	99%	0%
MOUNT VERNON HOSPITAL	509	974	52.30%	99%	0%
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	276	629	43.9%	97%	0%
THE ROYAL NATIONAL ORTHOPAEDIC HOSPITAL	446	892	50.00%	96%	1%
NATIONAL HOSPITAL FOR NEUROLOGY AND NEUROSURGERY	406	1828	22.20%	96%	2%
PAPWORTH HOSPITAL	482	946	51.00%	98%	1%

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**2 March 2017**		**Agenda reference:**	**41-17**	
Report title:	**Infection Control Annual Report 2015/16**				
Sponsor:	Jo Thomas Director of Nursing				
Author:	Sarah Prevett ICN & Sheila Loveridge ICNS				
Appendices:					
Executive summary					
Purpose:	To provide assurance to the Trust Board that there is in place an overarching leadership mechanism for QVH and that the organisation has effective Infection Prevention and Control arrangements in place for all patients, staff and visitors as outlined in the Q3 update and Annual Report for the year 2015/16.				
Recommendation:	The Board of Directors are requested **receive** the Infection Control Annual Report 2015/16. This report was approved by the Quality and Governance for upload onto the QVH external webpage.				
Purpose	Approval **N**	Information **Y**	Discussion **Y**	Assurance **Y**	Review **N**
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:					
Corporate risk register:	Any areas of concern would be added to the CRR as appropriate.				
Regulation:	Compliance with regulated requirements for infection, prevention and control.				
Legal:	As above				
Resources:	No additional resources required to produce the report				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	12/01/17	Decision:	Approved	
Next steps:	NA				

Queen Victoria Hospital NHS Foundation Trust (QVH) Infection Prevention and Control Annual Report 2015- 2016

Document Control
Executive sponsor: **Jo Thomas, Director of Nursing and Quality, Director of Infection Prevention and Control**
Author: **Sheila Loveridge, Lead Infection Control Nurse/Deputy DIPC**
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Content:

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1.	**Purpose of Report**
1.1	The Board as the overarching leadership mechanism for QVH need to assure themselves that the organisation has effective Infection Prevention and Control arrangements in place for all patients, staff and visitors. The Board of Directors is committed to the Code of Practice for the Prevention and Control of Healthcare Associated Infections as outlined in the Health & Social Care Act (2015). Clean, Safe Care (Department of Health, 2008) outlines the accountability of the Board in reducing infections and the importance of hospital cleanliness. The Board has ensured that the risks of infection are included on the Trust's Risk Register and reviewed monthly by the Infection Prevention & Control Team (IPACT). The Code outlines a need for management arrangements to include accredited microbiology services, clinical leadership; evidence based protocols and the design and maintenance of the environment to take into account infection prevention. The Infection Control Committee (ICC) reports to the Quality & Risk Committee (a subcommittee of the Board of Directors) providing sufficient information to assess assurance. The Board of Directors has requested regular appraisal of infection, prevention and control related matters. It has endorsed its support to provide funds to assist in the minimisation of the risks of infection to all patients and staff. This report will inform: • Trust Board • Governors • Clinical Commissioning group (CCG) • Public Health England (PHE) • NHS Improvement (NHSI) • Care Quality Commission (CQC) • Trust Staff
1.2	QVH is required to be registered with the Care Quality Commission (CQC). In order to be registered, QVH must assure that those who use the services are safe and that staff are suitably skilled and supported. As a Foundation Trust, QVH is licensed with NHSI which is conditional upon registration with the CQC. QVH are required to demonstrate that they have Infection Prevention and Control leadership and commitment at all levels of the organisation and that they are fully engaged and in support of local accountability and assurance structures i.e. relevant commissioners. QVH must ensure a culture exists where Infection Prevention and Control is everybody's business and poor practice is identified and tackled. QVH must have in place effective Infection Prevention and Control arrangements to provide clean safe care to all patients. These arrangements include appropriate methods to prevent the acquisition of infection by patients and to prevent the transmission of organisms between patients. QVH has a zero tolerance approach to health care acquired infection (HCAI). This is achieved through the implementation of antimicrobial stewardship, surveillance, screening, audit, promotion of hand hygiene and patient and staff education, including staff induction, mandatory updates and individual departmental training as required.

	The Director of Infection Prevention & Control (DIPC) has overall responsibility for infection prevention, including antimicrobial stewardship.
1.3	The effectiveness of Infection Prevention and Control systems is assured and regulated by a number of mechanisms. They include: • Internal assurance processes and Board accountability • Partnership working with external colleagues and commissioners • External regulation and inspection by Care Quality Commission (CQC) and Monitor • Local Infection Prevention and Control peer review and assurance processes • Effective contract monitoring
1.4	QVH Board members review monthly Infection Prevention and Control metrics and receive an annual Infection Prevention and Control report which is provided so the Board can be assured that the Trust is undertaking its Infection Prevention and Control duties and responsibilities, and delivering its statutory Infection Prevention and Control responsibilities safely and effectively. The Board should critically appraise the QVH Infection Prevention and Control report by making sure patient safety, staff activity, governance arrangements and Infection Prevention and Control data are transparent and clear so that they can confirm they are assured.
2.	**Infection Prevention and Control legislative frameworks and national Infection Prevention and Control agenda.**
2.1	The focus for Infection Prevention and Control has changed over the last few years with the introduction of the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (reviewed 2015). The code now reflects the role of infection prevention (including cleanliness) in optimising antimicrobial use and reducing antimicrobial resistance. It places a series of new duties and responsibilities on providers. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone. Good management and organisational processes are crucial to make sure that high standards of infection prevention (including cleanliness) are developed and maintained. The Health and Social Care Act (2015) recognises that effective Infection Prevention and Control require executive support, multi-agency responsibility and partnership working. The Code of Practice (Part 2) sets out the 10 criteria against which the Care Quality Commission (CQC) will judge a registered provider on how it complies with the infection prevention requirements, which is set out in regulations. As an organisation, QVH follows the Infection Prevention and Control policies as these provide an overarching framework to coordinate all activity undertaken. The policies are available online, with hard copies available on request. This document is reviewed and updated by the Infection Prevention and Control Nurses and ratified by the Infection Control Committee.
2.2	The Infection Prevention and Control agenda continues to evolve and develop as understanding; learning and further challenges emerge over time. The QVH Infection

	Prevention and Control Strategy 2015/16 supports progressive response to the changing landscape framing the delivery of healthcare services at QVH.
3.	**Internal assurance processes and Board accountability.**
3.1	As an organisation we are committed to the protection and prevention of HCAI for of patients, staff and visitors whilst on the premises or in the care of QVH. We continue to review and strengthen systems, methods and arrangements for managing episodes of suspected or confirmed infection. Protecting the physically vulnerable is a key component of our trust objectives – focusing on quality and patient experience - we work alongside partner agencies to promote the safety, health and well-being of people who use our services.
3.2	**Infection Prevention and Control Arrangements** QVH has robust Infection Prevention and Control governance arrangements in place, which are led and supported by a team of specialist Infection Prevention and Control clinicians. (See Appendix A for QVH Infection Prevention and Control governance chart.) The QVH governance structure provides transparent lines of accountability, clear partnership connections with internal QVH meetings which are in place to scrutinise practice and systems. The Infection Prevention and Control team comprises of; • Director of Nursing and Quality, Executive Board Lead for Infection Prevention and Control (DIPC) • Senior Nurse Specialist for Infection Prevention and Control • Sarah Prevett, Infection Prevention and Control Nurse Specialist • Consultant Microbiologist (via BSUH SLA since April 2012) The purpose of this team is to ensure all staff including volunteers understand their Infection Prevention and Control responsibilities and are supported to undertake these. This is achieved through case discussions, advice, practice review and audit; provision of training; provision of policy, procedures and guidance. The Infection Control Nurse Specialist (ICNS),, left the Trust in January 2016.The Infection Control Nurse (ICN) specialist acted up for an extended period (at Band 7) as initial recruitment was not successful and should be commended for keeping the service successfully running. Members of the IPACT continue to participate actively in multi-disciplinary committees and working groups such as: • Infection Control Group • Quality &Governance Committee • Health and Safety Group • Clinical Audit • Professional Network • Estates project meetings • Learning & Development Group • Medicines Management Optimisation Group Committee (MMOG) • Patient Led Assessment of the Care Environment (PLACE) • Patient Information Group • Product Selection Group • Pathology Meeting

	Across QVH Infection Prevention and Control Infection Prevention and Control link staff from all services attend Infection Prevention and Control link meetings to share practice, discuss clinical issues, access information, review learning and to share practice improvement across the organisation. The Quality and Governance Committee provides a more wide reaching audience where Infection Prevention and Control discussions are also undertaken, such as sharing learning from root cause analysis.
3.3	**The Infection Prevention and Control Group** The purpose of the ICG is to promote the highest standards of practice in the Trust in the prevention and control of infection, and to ensure compliance with the Code of Practice for the Prevention and Control of HCAI (2015). **The ICG Duties are**: • To assess infection risks and to take action to reduce or control such risks. • To ensure that prevention and control of infection is embedded in everyday practices and applied consistently. • To develop and approve policies for prevention and control of infection, based on current evidence and consistent with national guidance. • To oversee the Trust's infection surveillance and audit programme. • To ensure staff receive appropriate training in infection prevention and control, and that lessons learned are disseminated. • To take the lead in the event of an infection "outbreak". • To keep the Board of Directors informed of infection related matters. • To monitor, review and advise in regard to antimicrobial stewardship. **Membership of the ICG:** • Director of Infection Prevention & Control (Chair) • Consultant Microbiologist • Infection Control Nurse Specialist (Vice Chair) • Infection Control Nurse • Consultant for Communicable Disease Control • Matrons • Clinical Leads (or their representatives) • Pharmacist (Antimicrobial) • Decontamination Lead • Estates and Hotel Services Representatives • Occupational Health (receives minutes and provides exception report). The quorum of the Committee is two of Chair, Vice Chair and Microbiologist, plus five other members. The Committee meets quarterly, or more frequently if required. Reporting arrangements The ICG provides regular reports to the Quality & Governance Committee through the DIPC. In addition, the DIPC also provides regular updates to the Clinical Cabinet and to the Trust Board of Directors. Antimicrobial issues are reported to the Medicines Management Optimisation Group and copied to the ICG for information.

3.4	**Infection Prevention and Control clinical activity** The Infection Prevention and Control Nurses check all clinical samples taken to identify and positive specimens (colonisation and infection). This information and clinical advice is shared with the ward staff when appropriate. Members of the IPACT continue to participate actively in multi-disciplinary committees and working groups such as: • Clinical Audit • Professional Network • Estates project meetings • Health and Safety Committee • Learning & Development Group • Medicines Management Optimisation Group Committee (MMOG) • Patient Led Assessment of the Care Environment (PLACE) • Patient Information Group • Product Selection Group • Quality & Governance Committee • Pathology Meeting
3.5	**Infection Prevention & Control Link Persons (ICLP)** Infection prevention and control remains central to the maintenance and promotion of high standards throughout the Trust. The ICLP Group meets every two months and reports back to the IPACT. Its purpose is to provide a link between the IPACT and ward/departmental staff in all clinical and non-clinical areas in order to facilitate the dissemination of information and to promote compliance with Infection Control Policies and the Health & Social Care Act (2015). ICLP have continued to be actively involved in audit and surveillance and have carried out the High Impact Interventions (HII) from the Department of Health (DoH) Saving Lives Campaign and carry out the regular monthly hand hygiene audits. Every meeting includes an educational element.
3.6	**External Meetings** The DIPC attended meetings with colleagues from other Trusts. The ICN also attends the Sussex Infection Prevention and Control Representatives Meetings when possible, using the opportunities to expand knowledge, network with others in infection control and to identify and share new practices that may aid in the reduction of HCAI.
4.	**Mandatory Surveillance**
4.1	Mandatory surveillance data is required to be submitted to Public health England (PHE) for the following alert organisms: *Staphylococcus aureus* (*S. aureus)* bacteraemia – both Meticillin Resistant *Staphylococcus aureus* (MRSA) and Meticillin sensitive *Staphylococcus aureus*, (MSSA) *Clostridium difficile* (*C.difficile)* infection *Escherichia coli* (*E. coli*) bacteraemia Glycopeptide Resistant Enterococci bacteraemia (GRE) and Vancomycin Resistant Enterococcus bacteraemia (VRE)) are reported to the CCG as required and to the PHE on a quarterly basis.

In addition, monthly reports are made to the CCG and the Trust Board; these are also published on the Trust webpage for the public to read. Weekly reporting is also undertaken to PHE/ CCG for MRSA and *C.difficile*, and any other outbreaks that may occur.

IPACT also monitor Urinary Tract Infection (UTI), *Acinetobacter*, *Pseudomonas* and any other Multi Drug Resistant (MDR) organisms. An alert organism spreadsheet is in place to assist with this.

Root Cause Analysis
The Trust continues with the protocol for RCA review and, for all MRSA bacteraemia, the Post Infection Review (PIR) process.

- A Datix form and RCA / PIR must be completed for each confirmed case and, where applicable, a SUI form.
- IPACT then organise an investigation meeting as per the review process. This is attended by the DIPC, Medical Director, ICNS, Head of Nursing, ward Matron, Consultant Microbiologist and Clinician.
- IPACT report the figures as previously outlined
- An action plan will be devised and updated monthly until all outstanding actions are completed.

4.2 MRSA Bacteraemia

QVH have a limit of zero cases of avoidable MRSA bacteraemia every year – the trust achieved this target in 2015/16 with zero cases.
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Period	No. of cases of MRSA bacteraemia	DoH target
Apr 2006 – Mar 2007	2	4
Apr 2007 – Mar 2008	3	3
Apr 2008 – Mar 2009	2	3
Apr 2009 – Mar 2010	1	1
Apr 2010 – Mar 2011	2	1
Apr 2011 – Mar 2012	2	1
April 2012 – Mar 2013	2	1
Apr 2013 – Mar 2014	0	0
Apr 2014 – Mar 2015	0	0
Apr 2015 – Mar 2016	0	0

To date there has not been a revision of this target for 2016/17.

4.3 *Clostridium difficile*

In 2014/15 NHS England introduced a change in the methodology for calculating organisational CDI objectives and encouraged commissioners to consider sanctions for breach of CDI objectives only where those CDIs were associated with lapses in care. The *C.difficile* lapse in care objective target for QVH was set at zero. The Trust had one case in January 2016 against a limit of zero.

Period	No. of cases of CDAD
Jan 2004 – Dec 2004	5
Jan 2005 – Dec 2005	5
Jan 2006 – Dec 2006	5
Jan 2007 – Mar 2007	1
Apr 2007 – Mar 2008	5
Apr 2008 – Mar 2009	4
Apr 2009 – Mar 2010	1
Apr 2010 – Mar 2011	6
Apr 2011 – Mar 2012	0
Apr 2012 – Mar 2013	0
Apr 2013 – Mar 2014	1
Apr 2014 – Mar 2015	1
Apr 2015 – Mar 2016	1

As the *C.difficile* lapse in care objective target for the Trust remains at zero for 2016/2017, the possibility of breaching this extremely challenging limit has remained on the risk register.

The CCG will continue to review the details of a confirmed case and determine if it should count towards the total/aggregate number of cases apportioned to the Trust. If the Commissioner concludes that there has not been a `lapse` in care the case may still be attributable to the Trust but a sanction unlikely. The contractual sanction if a breach is identified remains the same at £10,000 per positive case.

4.4 MSSA bacteraemia

No target has been set MSSA. There has been a noticeable increase in cases. This is a countrywide trend and has been noted by the DoH.

Period	No. of cases of MSSA bacteraemia
Apr 2012 – Mar 2013	6
Apr 2013 – Mar 2014	0
Apr 2014 – Mar 2015	1
Apr 2015 – Mar 2016	7

4.5 *E. Coli* bacteraemia

No target has been set for *E.coli* bacteraemia. Two confirmed cases identified during the year.

Period	No. of cases of *E. coli* bacteraemia
Apr 2012 – Mar 2013	0
Apr 2013 – Mar 2014	0
Apr 2014 – Mar 2015	0
Apr 2015 – Mar 2016	2

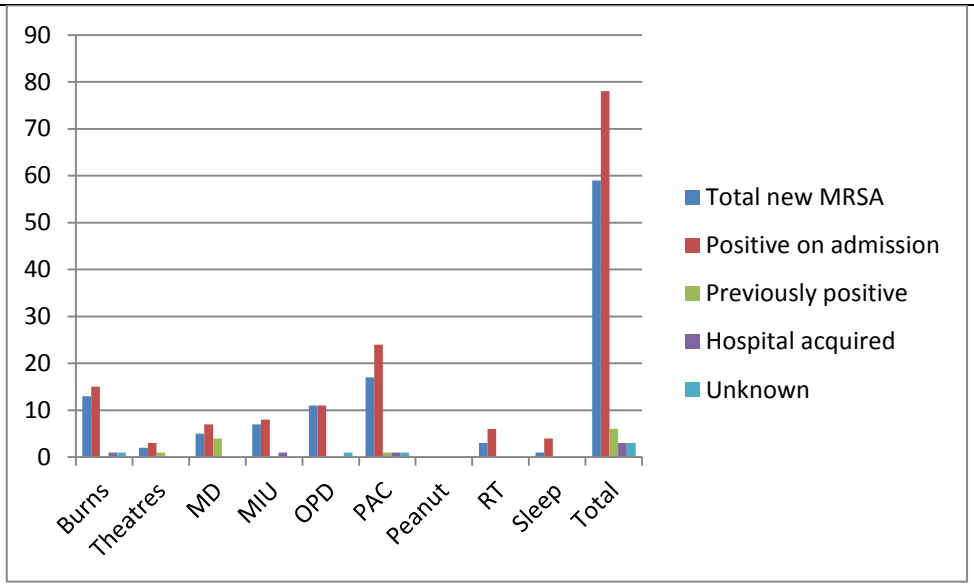
4.6 Glycopeptide resistant *enterococci* bacteraemia (GRE)

No reportable GRE's have been identified at the QVH. No target has been set.

Period	No. of cases of GRE bacteraemia
Jan 2004 – Dec 2004	0
Jan 2005 – Dec 2005	0
Jan 2006 – Dec 2006	0
Jan 2007 – Dec 2007	1
Jan 2008 – Mar 2008	0
Apr 2008 – Mar 2009	0
Apr 2009 – Mar 2010	0
Apr 2010 – Mar 2011	0
Apr 2011 – Mar 2012	0
Apr 2012 – Mar 2013	0
Apr 2013 – Mar 2014	0
Apr 2014 – Mar 2015	0
Apr 2015 – Mar 2016	0

4.7 **MRSA positive patients April 2015 to March 2016 (Infected and colonised)**

	Burns	Theatres	MD	MIU	OPD	PAC	Peanut	RT	Sleep	**Total**
Total new MRSA	13	2	5	7	11	17	0	3	1	**59**
Positive on admission	15	3	7	8	11	24	0	6	4	**78**
Previously positive	0	1	4	0	0	1	0	0	0	**6**
Hospital acquired	1	0	0	1	0	1	0	0	0	**3**
Unknown	1	0	0	0	1	1	0	0	0	**3**



5	**External regulation and inspection by Care Quality Commission (CQC), Monitor and commissioners**
5.1	<u>CQC Inspection</u> The CQC conducted an inspection of the Trust in November 2015, for which the Trust received an overall rating of Good and an Outstanding for patient care. The inspection reported no major concerns relating to Infection Control. All wards and departments were found to be clean and tidy. Staff were observed washing their hands and complying with being bare below the elbows when in clinical areas. Infection Control policies were up to date and available to all staff. Cleaning charts were displayed and were completed in all clinical areas and staff that were spoken to were aware of infection control guidance and policy. In addition, the Trust continues to monitor the standards set out in the Health & Social Care Act (2010) via an annual programme of PLACE compliance inspections. Findings are reported to various committees. <u>The Trust Board</u> The Trust Board has responsibility for overseeing infection control arrangements and has been kept informed by the DIPC reporting at every meeting. A key element of the role of DIPC is the direct line of communication with the Chief Executive. The Chief Executive carried out regular walkabouts to clinical and non-clinical areas to confirm that standards of care and cleanliness remain high. <u>Compliance in Practice Assessments</u> These assessments examine practices such as hand hygiene to assess the level of compliance. <u>Assurance Framework</u> The Trust has devised an assurance framework to ensure all aspects of the Health & Social Care Act (2010) and CQC Outcomes are met. This is reviewed quarterly by the DIPC and ICNS. It is reported to the ICG and any significant concerns are raised at the Quality & Governance Committee <u>Key Performance Indicators (KPIs)</u>

	The ICNS monitors the KPIs on a monthly basis including targets, training of the IPACT, policies, budget and audits. <u>Complaints</u> On a few occasions the IPACT has liaised with the Patient Experience Manager to assist with the investigation of complaints. The outcomes of these are fed back at the monthly IPACT and quarterly committee meetings.
6	**Infection Prevention and Control Learning and Development**
6.1	Infection Prevention and Control is part of the Trust's mandatory training programme and generally three sessions a month are held, two for clinical staff and one for non-clinical. Induction training days are also held monthly for all categories of staff, with separate sessions for new Doctors' Induction. The theme for 2015-2016 was again "Infection Prevention & Control is EVERYONE'S Responsibility" and the presentations were based on the National passport`s key learning outcomes. Topics covered included: • How does infection spread • How staff can help prevent the spread of infection (looking after themselves and the environment) • Hand hygiene and bare below the elbows • Correct wearing of PPE • Theatre clothing policy • Spillage management • Sharp safety • Safe disposal of waste • Compliance with DH Pseudomonas guidance • Deep cleaning • What is an HCAI • CPE • Taking blood cultures • The Health and Social Care Act • Food hygiene • Flu preparations including FIT testing Along with mandatory training IPACT have also given additional teaching to staff on current issues highlighted through audit and surveillance relating to infection control. This has been incorporated into the department meetings and the Burns study day. The Consultant Microbiologist continues to have a regular slot at the Joint Hospital Clinical Audit meetings. Consultants' mandatory training sessions continue. Hand Hygiene Roadshow – this continues twice a year, to raise awareness of the importance of hand hygiene and is an opportunity for staff to evaluate their hand hygiene technique, the Ward with the best technique is awarded a prize and the results announced in Connect. Infection control awareness week took place on the 25th-29th November. During the week posters were displayed on topics such as Legionella, Ebola, MRSA, hand hygiene, and sharps safety. Patient leaflets were available and we were also joined by the Daniels Representative who provided advice on the safe disposal of sharps.

Staff were asked to participate in a few quizzes relating to spillage management, correct wearing of PPE and hand hygiene. Staff were also given the opportunity to practice their hand washing using the UV light box and to be FIT tested.

Staff Training compliance

	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	**Total**
Apr-15	68.57%	70.26%	82.54%	67.16%	76.85%	80.00%	63.64%	77.97%	73.37%
May-15	80.19%	74.24%	86.24%	67.65%	76.85%	80.00%	65.78%	82.15%	76.64%
Jun-15	82.86%	73.28%	86.24%	72.58%	76.64%	80.00%	69.01%	83.37%	78.00%
Jul-15	87.50%	77.16%	86.33%	77.42%	77.57%	83.33%	71.78%	81.16%	80.28%
Aug-15	89.42%	76.55%	87.50%	75.38%	77.36%	100.00%	74.38%	84.38%	83.12%
Sep-15	94.29%	87.17%	91.17%	81.82%	89.32%	100.00%	87.42%	91.55%	90.34%
Oct-15	95.15%	93.90%	94.88%	89.06%	89.11%	100.00%	91.19%	94.42%	93.46%
Nov-15	92.45%	92.59%	96.63%	90.91%	89.69%	100.00%	93.71%	93.99%	93.75%
Dec-15	91.51%	90.19%	96.72%	91.04%	88.89%	100.00%	91.88%	92.29%	92.81%
Jan-16	88.68%	86.51%	96.22%	87.30%	86.14%	100.00%	89.63%	90.07%	90.57%
Feb-16	85.85%	84.91%	95.73%	87.30%	63.37%	100.00%	93.79%	84.38%	86.92%
Mar-16	82.08%	84.16%	96.90%	87.69%	42.45%	100.00%	87.50%	84.33%	83.14%

7 Infection Prevention and Control audit

Clinical audit is a fundamental component of clinical governance and underpins the assurance process for a high quality service (CQC, 2010). Clinical audit is a way to find out if healthcare is being provided in line with standards and allows care providers and patients know where their service is doing well, and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients (NHS England, 2015b)

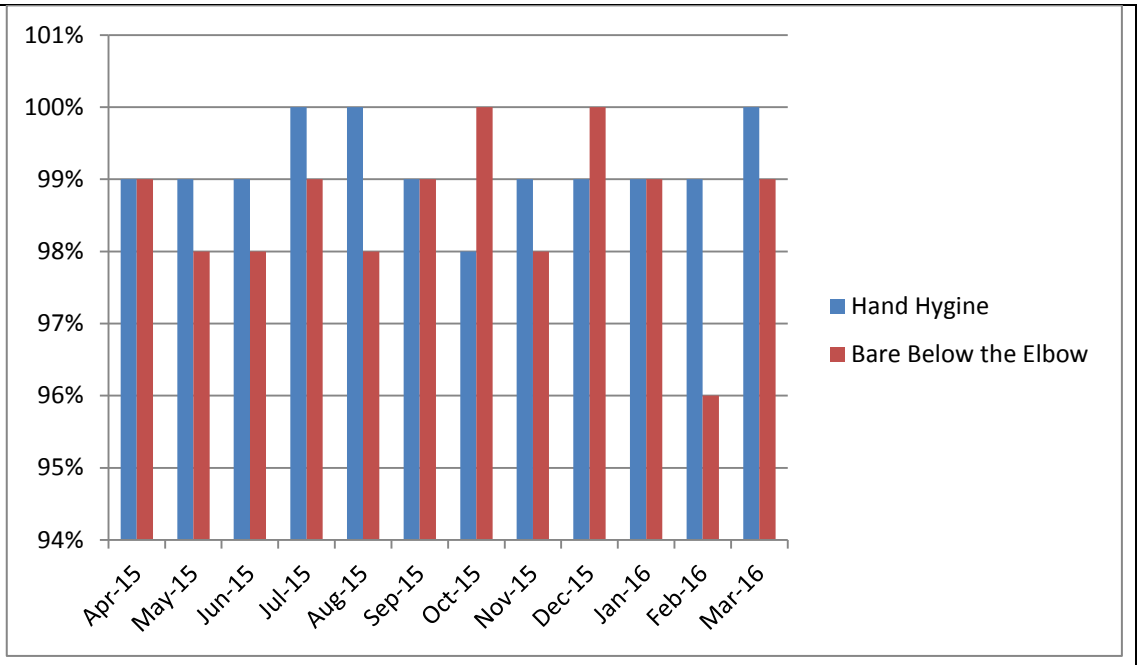
The following audits have been undertaken in the period April 2015 to March 2016. All Ward/Department Managers are informed of audit results pertinent to their area as they are completed. They are asked to complete any recommendations made within the audit reports.

Saving Lives – Department of Health Audits

The Saving Lives Delivery Programme was last revised in June 2007. Its purpose is to deliver a programme which will reduce HCAIs and allow Trusts to demonstrate compliance with the Health and Social Care Act (DH, 2010), using techniques known as HIIs, of which there are seven. The aim is to enable all healthcare workers to recognise their role and contribution to infection prevention and control through action planning, implementation, feedback and reassessment.

Each HII consists of a series of elements (known as care bundles) and cover management of the following:

	1. Central venous catheters (CVCs) 2. Peripheral intravenous catheters (audit incorporated into the Trust's Intravenous Therapy audit twice a year) 3. Renal dialysis (speciality not applicable to QVH) 4. Prevention of surgical site infection (audit incorporated into the Trust's National Patient Safety Agency Checklist annual audit) 5. Ventilated patients 6. Urinary catheters 7. Reduction of risk from C. difficile. (All cases of C. difficile are subject to RCA and learning/training needs are identified). This audit is now incorporated into the safety thermometer audit which is conducted monthly this has dramatically increased the amount of data received. Whilst the audit is conducted monthly the results are still written up twice a year. For the period July to December 2015 the results show that only one area was 100% compliant, this is HII1 - CVC Insertion. The rest of the audits were 96% or below. HII1 - CVC ongoing care was 96%, HII 5 - Ventilated patients regular observations was 89%, HII5 – Ventilated patients- ongoing care was not audited, HII6 Urinary catheter insertion was 97% and urinary catheter care was 94%. It is apparent that improvement is required in almost all areas. IPACT will report back to the Education leads to look at additional training requirements. **Surgical Site Infection (SSI) Audit** Carried out in July 2015. All elective patients admitted to one of the wards were asked to participate in the audit. 37patients were included of which 17 returned the post op questionnaire and 7 reported problems post operatively. Re-admission with an SSI was 0%; however, if all the patients that reported problems and were given antibiotic treatment are assumed to be SSI this would mean an SSI rate of 10%. If all patients who reported problems (even those not given treatment) were included this would give an SSI rate of 19%. The results indicate that there are no obvious links between the patients who reported problems with wound healing and are lower than in the previous SSI audit but it is difficult to compare these results to previous audits as this one did not look at a specific surgical group but was conducted to gain a wider view of SSI rates by looking at all elective admissions during a set period of time. **Hand Hygiene Audits** Trust-wide hand hygiene audits were undertaken monthly in all areas and areas which scored lower than 90% compliance for any staff group were asked to submit an action plan. Departments failing to achieve compliance for two months were then audited by the Matron.



Aseptic Technique

This audit was observational, to review compliance with the Aseptic Technique policy, and carried out by the Practice Educators. Due to poor compliance in previous audits this was conducted six monthly rather than annually. Results from July 2015 show a big improvement compared to the previous audit, with only 3 'no' answers received across two areas, both relating to the use of the orange bag when setting up the procedure. Results sent to practice educators for review.

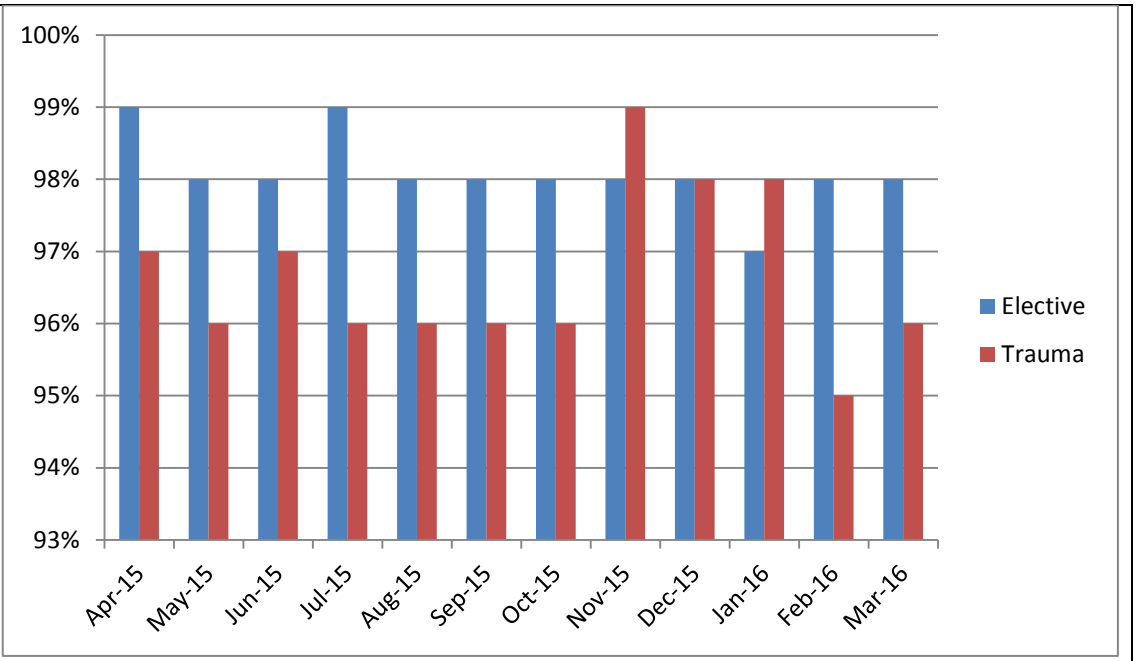
Isolation Room Audit

The trauma sheets for one day were reviewed. All patients being nursed in the bays were low risk and therefore nursed appropriately and all patients deemed to be an infection risk were isolated.

For those in isolation who were not an infection control risk it was an appropriate allocation of facilities as it related to privacy and dignity. Only 1 patient who was in isolation for Infection Control reasons did not have appropriate signage on the doors. Results emailed to department managers to remind all staff to use appropriate signage.

MRSA screening

Monthly audits are undertaken to ascertain the level of compliance with Trust policy for the mandatory screening of all elective and trauma in-patients.



Additional teaching on MRSA screening and management has been delivered throughout the Trust by the ICN.

MRSA Decontamination Audit

The aim of this audit is to establish Trust compliance with the management of patients with MRSA, specifically the eradication protocol within the policy. The audit is undertaken twice a year.

The audit conducted in April 2015 showed all patients were isolated and managed correctly by staff in terms of correct PPE, isolation and hand washing. Some work is still required around the correct application of the protocol and correct documentation. This audit was conducted retrospectively, looking at the notes of all patients newly confirmed positive in July 2015 – 13 in total. The results show that improvement is still required around documentation and including microbiology results in the patient's notes. Results sent to the practice educators to look at educational needs.

MRSA Screening Audit of High Risk Patients.

The aim of this audit is to assess Trust compliance annually with the MRSA screening policy in relation to the time limit put in place for patients that are screened at pre-assessment and who are considered to be at high risk of contracting/carrying MRSA.

On the day of the audit there were 39 patients admitted to the hospital. Of these seven were identified as being high risk. All of these high risk patients were screened as per policy and managed appropriately as in-patients on the wards.

Blood Culture Audit

There were four areas with at least one "no" answer; one of these is the use of disposable tourniquets. This has consistently been an area where improvement is needed, however as highlighted in previous audits it is not always possible to use a tourniquet therefore the audit form was amended to include a `Not Applicable` column however staff appear to be using the old forms. New forms will be distributed to all departments. Other areas requiring improvement are staff not cleaning visibly soiled skin, Patient's skin disinfected with 2% chlorhexidine for 30 seconds and allowed to dry for 30 seconds and Venepuncture site not touched again following disinfection of skin; from review of the audit forms the use of the N/A column may see this improving, as in some cases it was not necessary to include these steps in the

process. All other areas are now 100% compliant.

Cleaning chart, mattress and documentation spot check

Overall areas appear clean and tidy. Cleaning charts are often not fully completed and staff in each area were spoken to and reminded to complete these daily. Across the Trust the cleaning charts differ greatly. Infection Control to review and standardise all cleaning charts.

Mattress Audit

70 mattresses, 24 couches/ chairs and 14 plinths were checked across 10 departments, 10 were either damaged or soiled and required action to be taken. Of the 10 damaged beds, couches and chairs, 2 new mattresses were ordered, 4 couches were patched and reported. The damaged plinths were documented as either having a part reordered or in the process of being covered. No record of actions taken for the other 4 damaged mattresses. All results were fed back to the department managers for action.

Decontamination of Equipment Audit

To ascertain compliance to the Decontamination and Disinfection Policy. A total of 32 items audited, all stored for immediate use or requiring servicing, in the storeroom on Canadian Wing corridor. On the day of audit 100% of the equipment that was stored in the cupboard was visibly clean and all documentation was completed

Environmental Audits

Environmental audits continue to be covered by the PLACE inspections (as previously discussed).
Resulting action points are logged on to the Estates Piranha system, prioritised and carried out by the Estates Department. It is the responsibility of the Department Mangers to ensure all actions for their area are completed and they must then inform Hotel Services all actions have been done. Infection control issues noted include:

- De-cluttering of departments
- Repairing floor damage
- General cleaning

Sharps Box Audit

11 Wards/Departments were visited and 133 containers were sighted. The audit found no sharps containers with protruding sharps, 4 that were not properly assembled, (these were immediately assembled properly and staff informed) and 1 that was more than three quarters full, (staff were advised to only fill to the line). No sharps containers had the wrong lid on the wrong base. 3 sharps containers were sited on the floor or at an unsuitable height or place; staff were advised to have them bracketed if possible or remove them from public area. 3 sharps containers were seen without label endorsed. All staff reminded that the label on the sharps bin was to be completed at assembly and closure. No sharps containers had significant inappropriate non-sharp contents. Staffs were advised not to put packaging or non-sharp items in sharps containers. 2 sharps containers did not have the temporary closure in place when the container was left unattended or during movement.

Patient bedside equipment

All in-patient bed side equipment is checked annually for cleanliness and whether they are fit for purpose. The lockers that were seen in patient areas on the day were all clean and intact with no obvious problems. They are also checked by Ward staff following patient discharge – Overall equipment is clean and intact but in certain areas some equipment is looking tired such as the patient lockers on Burns. The traceability plaques attached to the bedside equipment have fallen off of some, areas

	to replace and IPACT to monitor. **Sink audit** Minor Injuries Unit, OPD, Pre-assessment, Peanut Assessment Unit, Rehab Unit, Photographic, radiology, Admissions Lounge, Peanut, Sleep, Main theatre including recovery, Rowntree and Maxillo Facial Unit all compliant with current guidance. The Burns Unit and C Wing are no longer compliant as they only have one wash-hand basin per bay (they were compliant with guidance at the time of building). Ross Tilley bays contain six beds, Margaret Duncombe and Burns bays contain 4 beds. All single rooms, clinical rooms and sluices in the Trust comply with current guidance. In addition to the clinical sinks all wards and departments have alcohol gel at the ward entrance/exit, in the corridors and at each bedside. The exception is Peanut Ward due to the nature of the patients; personal tottles are available to staff should they require them. Portable sinks are available as required. **Cleaning / toy cleaning charts** All departments are to have equipment cleaning charts in place to monitor that adequate cleaning of all environments is done regularly. This has been monitored on an alternate monthly basis with Ward/Department Managers being emailed individual results. Reminders to all staff on the importance of completing the cleaning charts have been given to Managers, ICLP and are included within mandatory training. The cleaning charts used across the Trust are currently being standardised by the IPACT to make them easier for staff to use.
8	**Infection Prevention and Control policies, procedures and guidance for QVH staff and patients**
8.1	The Infection Prevention and Control Team have developed guidance for the organisation, staff and patients in the form of policy, procedures, protocol, guidelines and leaflets. All documents are placed on the Website or QNET. All documents have been systematically reviewed and updated in collaboration with relevant services and governance groups (see Appendix C). IPACT have produced information for patients about the main Infection Prevention and Control issues which are generally raised. These are Pandemic Flu, Norovirus, MRSA, MRAB, Hand Hygiene, Group A Strep, GRE, *Clostridium difficile*. All these leaflets will be available for the public once they have been approved by the patient information group during May or June 2016. The QVH Infection Prevention and Control team are available to speak to any patients, visitors or staff if they have any concerns about infection.
9	**Local peer review and assurance processes**
9.1	QVH has a case peer review system in place in the Burns Unit. Meetings to discuss cases occur every Monday (except Bank Holidays). These meetings review injury mechanism and explanation, treatment, risk assess, discuss any Infection Prevention and Control issues and agree actions required. The purpose of these groups is to strengthen communication and dissemination of Infection Prevention and Control information and practice across the organisation.

9.2	**Flu arrangements** During 2015/16 support has been given to the management of flu, with IPACT encouraging vaccination of staff within the annual flu vaccination programme. To support in the management of patients, IPACT continued to provide assistance in the form of checklists/documentation which is saved on the Trust intranet, provide advice on the management of patients and general support to the processes of caring for affected patients. The Emergency Planning Lead continues to co-ordinate the FIT testing programme for clinical staff to ensure safe practice is delivered, update the emergency plan and submit the Trust vaccination data as this is a mandatory requirement. Total flu vaccination uptake was 52.6% for 2015/6 (clinical and non-clinical staff). Vaccine uptake across England was 45.1% (confirmed data) and locally within West Sussex 42.2% (PHE, 2015). This is a nationwide reduction from the previous year. Flu vaccination numbers will be a CQUIN in 2016/2017 with the intention of improving the uptake of flu vaccinations for frontline staff up to 75%.
10	**Untoward Incidents including Outbreaks**
	April 2015 to June 2015 • 15% flame burns patient confirmed Glutamate Dehydrogenase (GDH) positive (not C.difficile positive). Antibiotic therapy prescribed by the Consultant Microbiologist. Awaiting rehabilitation bed at another hospital. Strict universal precautions implemented. No secondary cases. • Noted an increase in the number of Streptococcus Pyogenes cases on Peanut ward. IPACT investigated, samples sent for typing, these returned not the same. • Burns out-patient confirmed Panton Valentine Leukocidin Staphylococcus aureus (PVL-SA) positive. Reported to PHE. Infection control precautions implemented. Consultant Microbiologist advised treatment if symptomatic. Burns out-patient confirmed Corynebacterium ulcerans positive. PHE informed. Teleconference held. Full infection control precautions implemented, patient to be treated with antibiotics, reswabbed and vaccination booster advised. Staff who cared for the patient contacted via letter through Occupational Health with signs and symptoms as a precaution. Minimal risk to staff as personal protective equipment worn. • Patient previously confirmed Corynebacterium Ulcerans positive has been treated and rescreened. The swabs sent pre and post antibiotics returned clear. • IPACT investigated potential norovirus outbreak on the Burns Unit however there was no outbreak, one patient symptomatic. Infection control precautions implemented. • There has been one incidence of Vancomycin Resistant Enterococci (VRE) in a wound swab from a patient on the Burns Unit; a full RCA has been completed. Source of acquisition unknown as patient being cared for in two acute Trusts. Not reportable to Public Health England. No secondary cases. Lessons learnt: remind Doctors to be bare below the elbows during clinical care, Doctor to be reminded to complete the blood culture audit tool and Domestic Supervisor to score all cleanliness audits. • There has been one case of Meticillin Resistant Staphylococcus Aureus MRSA (not a bacteraemia) in a Corneo patient; a full RCA is in progress. • Period of increased incidence: three patients confirmed with MSSA bacteraemia in June. One patient admitted to Ross Tilley ward, specimens on admission confirmed positive. The other two patients are currently on the Burns Unit.

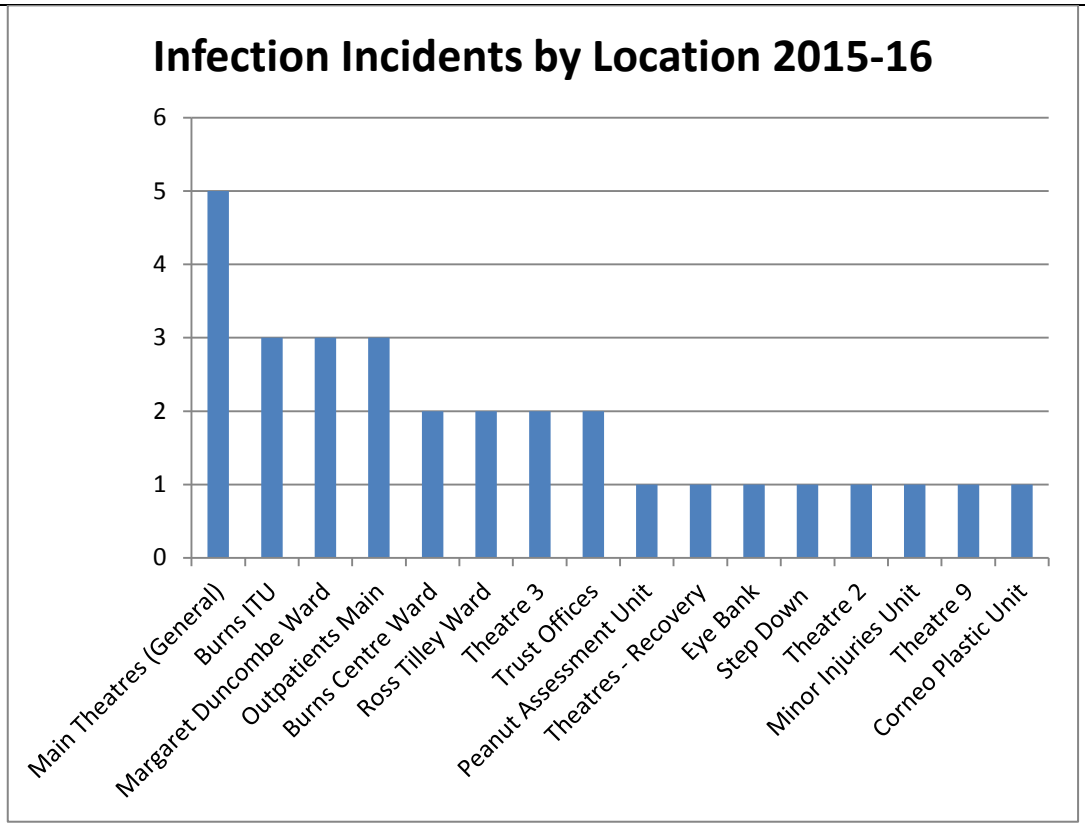
	Both patients have SA in numerous sites and have had a number of invasive devices inserted and theatre episodes. Full RCAs have been completed. Results awaited for the typing of specimens, time line showed no obvious links. Consultant Microbiologist advised on treatment. No specific infection control measures required. All cases reported to PHE. • There had been one case of Meticillin Resistant Staphylococcus Aureus MRSA (not a bacteraemia) in a Corneo patient last month; RCA still in progress. • MRSA acquisition in Theatres and EBAC (not a bacteraemia and not reportable to PHE); RCAs in progress. Paediatric burns patient confirmed Streptococcus Pyogenes positive at the end of May. RCA concluded unknown source of acquisition as paediatric patients only swabbed as clinically indicated and not routinely screened on admission e.g. for MRSA as per Department of Health guidance. **July 2015 to September 2015** • Period of increased incidence: Three patients confirmed with Meticillin sensitive Staphylococcus aureus (MSSA) bacteraemia in June and two further cases, one in July and August. One patient positive on admission to Ross Tilley, but three burns patients' infections are hospital acquired. All of these patients had Staphylococcus aureus (SA) in numerous sites therefore probable root cause, skin/soft tissue infection as SA migrated into sites. The paediatric patient's source of acquisition was unknown as paediatric patients are not routinely screened and this patient was treated via our out-patient services. Reportable to Public Health England (PHE). Full root cause analysis (RCAs) completed along with an incident report. Ribo-typing results returned from the reference laboratory with different strains (for the first two cases on burns), no evidence of cross-infection. The timeline showed no obvious links. Consultant Microbiologist advised on treatment. No specific infection control measures required. IPACT continue to monitor rates. • EBAC patient confirmed with non-toxigenic Corynebacterium diphtheriae and Streptococcus pyogenes in their leg wound. PHE informed and advised on patient treatment, confirmation received no contact tracing required for close contacts or staff. Patient provided incorrect contact details initially so difficulty contacting. Full infection control precautions implemented and Microbiologist reviewed. No secondary cases. • Four hospital acquired Meticillin Resistant Staphylococcus aureus cases (MRSA, not a bacteraemia) RCAs were undertaken. Identified learning needs; patients not being screened as per policy on admission, documentation not being legible and clear. Not reportable to PHE. Further reminders given to staff. • Two patients on Margaret Duncombe ward confirmed with campylobacter species (DNA detected). IPACT investigated, discussed with the Consultant Microbiologist and concluded this was not an outbreak. No further cases. **October 2015 to December 2015** • Multidrug resistant Klebsiella pneumonia confirmed in an Out-patient. Full infection control precautions implemented for admission and Consultant Microbiologist provided advice on antibiotic therapy. • Invasive Streptococcus Pyogenes infection (Group A Strep) confirmed in a plastics patient. RCA completed actions required are to remind staff of the importance of completing full screens including MRSA swabs on admission. Full precautions implemented on the ward and Consultant Microbiologist advised on treatment. PHE aware.

	• MRSA acquisition on a patient with 9% mixed depth flame burns. Patient being treated on outpatient basis - unknown acquisition source. Precautions in place when visiting EBAC. • Three patients confirmed with Vancomycin resistant enterococci (VRE, two on Canadian Wing and one in EBAC), full precautions implemented. Reviewed by the Consultant Microbiologist, time line undertaken, typing results confirmed different strains. Not positive in blood cultures. • One patient confirmed with Campylobacter whilst and in-patient. PHE informed. RCA undertaken. Full precautions advised. No further cases seen in the Trust. No obvious source of the Infection. • Patient in the community confirmed C. diff positive in November having received outpatient maxfax treatment at QVH during October and November. Notes reviewed by Infection Control Nurse and Antimicrobial Pharmacist. Patient given antibiotics (Metronidazole), no specimens sent. Information sent to Clinical Commissioning Group. Not attributed to QVH. **January 2016 to March 2016** • C.difficile confirmed in a plastic surgery patient. Infection control precautions observed at all times, advice given by the Consultant microbiologist on treatment. RCA completed and concluded that it was antibiotic related. Learning needs identified related to communication and prescribing. No further cases identified, isolated incident. Reported to PHE. • E. coli bacteraemia confirmed in a Burns patient. RCA completed and concluded that it was an unavoidable infection due to a urinary tract infection and patient being immunocompromised. No actions identified. Reported to PHE. • E. coli Catheter Acquired Urinary tract infection (CAUTI) identified in a Burns patient. Datix completed. • Carbapenemase-producing Enterobacteriaceae positive result received for a plastic surgery patient. Patient was managed appropriately throughout their admission. No treatment required for the organism as advised by the Consultant Microbiologist. PHE aware. • MSSA bacteraemia confirmed positive in a Burns patient. RCA completed. Patients managed appropriately throughout and advice on treatment given by the Consultant Microbiologist. PHE aware. • Patient reported on the daily lab sheet received from BSUH as being MRSA positive. IPACT informed the ward and implemented infection control precautions. 3 days later it was noted that the result changed to say patient MRSA negative. BSUH asked to investigate and confirmed the positive result was incorrect and had occurred due to human error. They will speak to the member of staff involved. Ward informed that patient is not positive and does not require precautions. • Hospital acquired MRSA confirmed in an ITU/SDU patient. All Infection control precautions implemented once result known. RCA completed. Possible cause identified as patient being moved from department to department due to their changing medical needs. Not reportable.
11.	**Associated services reports**
11.1	**<u>Antimicrobial Medication report</u>** *-From Sandhia Finch, Antimicrobial Pharmacist* • Quarterly reporting of antimicrobial costs and usage to MMOGG, ICG • Continuous audit of restricted antimicrobials. • Promoted European and World Antibiotics Awareness Day in November 2015

	• Achieved revision of infection treatment guidelines and surgical prophylaxis guidelines • Updated the antimicrobial section of the Trust's prescribing training module for Junior Doctors. • Collection of antimicrobial consumption data for 2013/14 for submission to the English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) • Updated the Antimicrobial Policy • Compiled a Trust Antimicrobial Stewardship Assurance Framework for all the main relevant national directives • Filed compliance within the set deadline for the Public Health England Patient Safety Alert: Addressing antimicrobial resistance through implementation of an antimicrobial stewardship programme • Started monthly audit of compliance with antimicrobial prescribing documentation and review in February 2015. • Completed an annual audit of surgical prophylaxis on Canadian Wing. For a full report, please refer to the annual antimicrobial report which is available on QNet
11.2	**Decontamination report**– From Jo Davies, Decontamination Lead, Theatres • Annual Sterile Service compliance audit against CfPP 0101 for the external Synergy Health Care contract for reusable sterile equipment was overall compliant (August 2015). • Annual audit of the flexible scope washer disinfector device against CfPP 0106 was overall compliant. However issues raised again identified the lack of engineering support from the Estates department (August 15). • QVH scope site annual IPAC and decontamination audits completed
11.3	**Facilities Department report**– From Christine Rush, Interim Head of Facilities • **Patient Led Assessment of the Care Environment (PLACE)** The assessments are a requirement of the Health & Social Care Information Centre to be conducted annually that assesses the patient environment in a variety of categories. Patient representatives are invited to join the process with members of staff in inspecting the patient areas. Queen Victoria Hospital scores for 2016 were: Cleanliness 99.75% Food 90.67% Privacy, dignity & wellbeing 87.80% Condition, appearance & maintenance 91.47% Dementia 67.36% Disability 72.49% These scores showed an improvement over the 2015 assessment scores. • **Cleaning** The trust complies with the National Standards for Cleanliness and the domestic supervisor undertakes 12-15 cleaning audits a week. A score above 80% shows compliance. Other members of staff including the IPC lead, estates staff and members of the H&S and Risk department are invited to accompany and contribute to

	the process. The results are sent to the Ward/Department Manager and scores below 80% are provided to the Matron of the area. The average score for the trust is generally in excess of 90%. IPAC also conducts inspections together with the hotel services team leader on a monthly basis for all areas throughout the trust • **Electronic Auditing** A review is currently being undertaken to introduce an electronic auditing system to ensure an efficient & effective reporting programme for cleaning standards. • **Cleaning Review** An independent review of cleaning services was carried out during 2016. An action plan has been compiled and a number of recommendations have been implemented and completed. • **Catering** Following an EHO visit in February 2016 when a lower score was awarded, the main kitchen has been upgraded and robust management processes implemented. The EHO has made unannounced visits on 3 occasions and awarded a much improved score of 4. Cleaning audits are conducted on a weekly basis and temperature checks of ward and kitchen refrigerators are monitored daily. • **Laundry** All linen is laundered by Eastbourne Commercial Services Ltd and a Duty of Care visit is scheduled for 30th November 2016 • **Waste Disposal** Waste disposal is contracted to SRCL. The provision of feminine hygiene units is to be introduced in December 2016. A Duty of Care visit to the waste treatment centre is scheduled for 9th December 2016
11.4	**Estates report** – Steve Davies, head of Estates IPACT continues to work closely with the Estates Department. In addition to attending Estates meetings, this has required input on projects from the initial planning stage through to completion and final "sign off". Projects have included: • Carpet in clinical areas replacement programme • Heating replacement programme • General maintenance and improvement of facilities • Urgent works following poor weather conditions • Urgent works following outbreaks • Review of plans for the patient refreshment area • Refurbishment of patient bathrooms/toilets Following Pseudomonas guidance issued last year testing continues; this is an ongoing programme with concerns dealt with as they arise. It remains on the Trust risk register. Results are fed back at the IPACT and ICC meetings **Current Status:** • Water samples from different areas of the Trust are continued to be taken on a monthly basis and monitored for positive results for legionella and Total Visible Counts (TVC). A three year contract for this testing has just been awarded to TSS, previously Pro Economy have provided this contracted

	service. • All water storage tanks are monitored on a regular basis by Estates and to date the tank that is currently operational remains clean from sediment build up. • <u>New Theatre Complex</u> In July 2016 the water treatment to new Theatres changed from being treated by Ultra- Violet which had been found to be ineffective in this design installation to the Orca system of silver copper treatment, the same as the main site. The results for this area are now good with no Legionella being found at the outlets tested. • The contract for Water coolers within the Trust is to be reviewed with possibility of a new supplier being appointed. • The Trusts risk register has been reviewed in November'16 and risks related to Water management have been updated or closed. • There is a water safety programme in place now to manage water related pathogen risks within the Trust with a third party Authorising Engineer (AE [water]] appointed providing independent audits and advice.
11.5	**Infection Control Risk** The Infection Prevention and Control Nurses also receive notification of any suspected Infection Prevention and Control incidents via the DATIX reporting system. The nurses respond to each Datix report. The response may be in the form of advice or it may trigger further investigation. This activity allows the lead to maintain oversight of all Infection Prevention and Control incidences. There were 31 incidences related to Infection Control reported on Datix through the year.

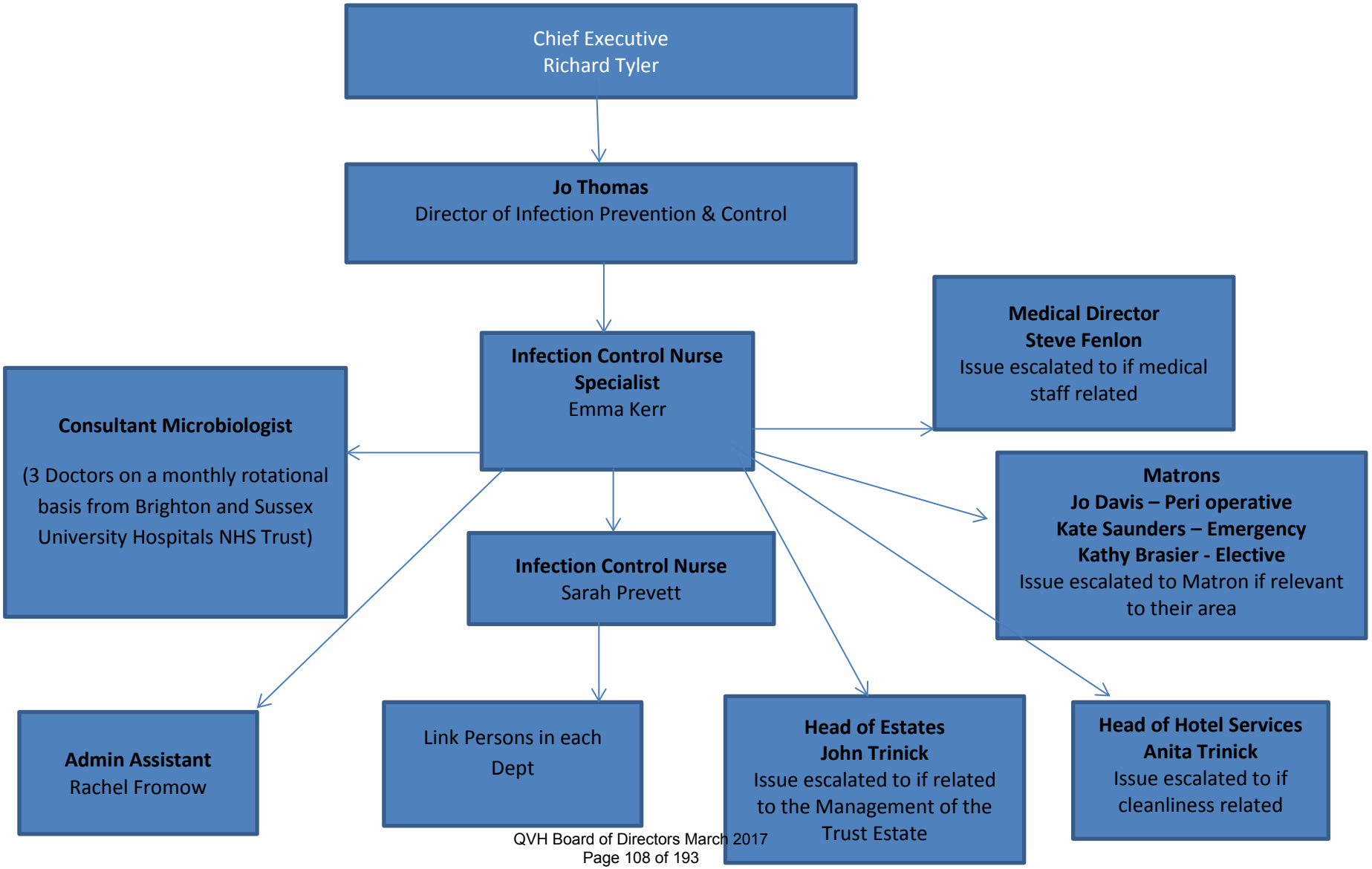


12	**Contract monitoring -Sussex Clinical Commissioning Groups (CCG's) Infection Prevention and Control Standards**
12.1	CCG's as commissioners of local health services need to assure themselves that the organisations from which they commission services have effective Infection Prevention and Control arrangements in place. A self-assessment tool is completed annually and contributes to providing evidence of assurance in conjunction with assurance site visits and submission of audits as part of an audit programme. There is overlap between this report and the Section 11 self-assessment for WSSCB. CCG exception reports are provided by QVH in April, July, October and January of each year. The only areas of concern raised during the last year were: • Decontamination • MRSA colonisation outbreak
13	**Infection Prevention and Control Risks**
13.1	There are currently departmental risks due to the lack of capacity with one part time ICN in post. This has meant that the service has had to be mainly reactive for the last quarter of this year.
13.2	The Trust need to increase the percentage of staff who have completed Infection Prevention and Control training.
14.	**Conclusions and assurance**
14.1	All health care at QVH is patient centred and QVH works closely with partners to ensure effective Infection Prevention and Control is achieved for all patients, visitors and staff. QVH continuously strives to develop and support its staff to achieve the best Infection

	Prevention and Control practice. QVH also promotes feedback from patients and encourages them to raise concerns about any Infection Prevention and Control issues they see and are worried about.
7.2	QVH has a range of internal assurance processes in place. An overview of Infection Prevention and Control activities in QVH are in place. QVH staff training programmes for Infection Prevention and Control have been reviewed and strengthened. Areas to improve training update have been identified. QVH has an overview of all relevant Infection Prevention and Control information and documents, which are systematically developed, reviewed and/or updated.
7.3	QVH has local external regulation undertaken by the CCGs. Monitor ensures QVH are registered with the CQC. A Care Quality Commission (CQC) inspection is due in 2016.
7.4	Local Infection Prevention and Control peer review and assurance processes are in place. IPACT are well supported by the Director of Nursing/ DIPC QVH staff are guided and supported by the specialist Infection Prevention and Control clinicians.
7.5	**The QVH Infection Prevention and Control team present this report to provide assurance to the Board that the Infection Prevention and Control agenda is robustly overseen and managed within the trust and with partners.**

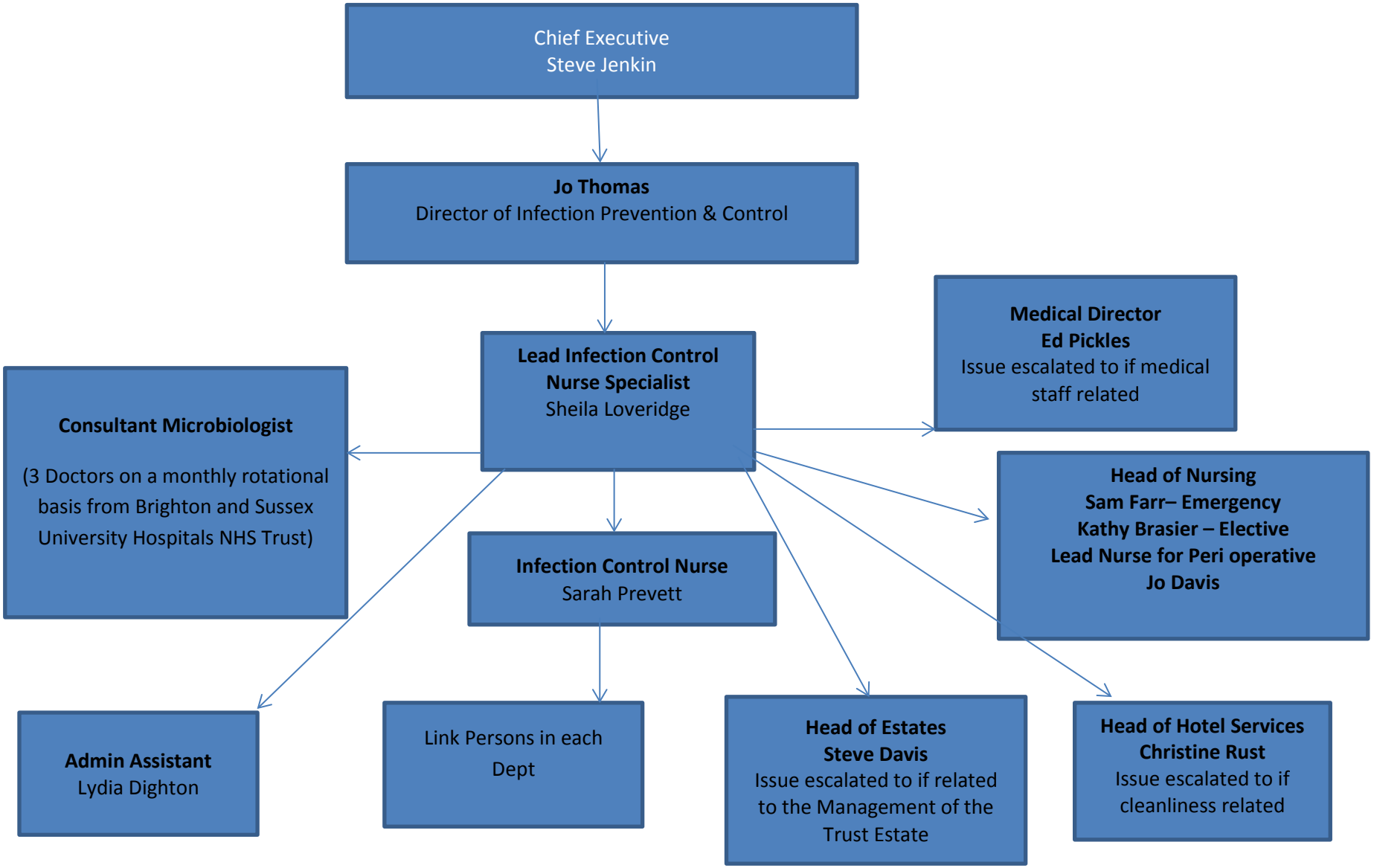
APPENDIX A

Infection Prevention and Control Governance Structure 2014/2015



APPENDIX B

Infection Prevention and Control Governance Structure 2016/2017



Appendix C
Infection Control Annual Programme Objectives for 2016/17

Infection prevention and control continues to be a top priority at both National and local level. The IPACT, under the direction of the DIPC and with the full support of the Board of Directors and Governors, will continue to ensure that the highest possible standards in infection prevention and control are applied and achieved at the QVH.

This action plan contains new areas of activity and a number of on-going areas of particular importance. A large amount of activity is on-going and not included in the action plan.

Department	Section	Action	Frequency
Microbiology	Management	Continued review of pathology provider to ensure safe and efficient service delivered	On-going
Microbiology	Management	Continued review of pathology provider IT systems, e.g., the provision of electronic reporting in a useable, reliable format and request for regular list of blood cultures taken	On-going
Microbiology	Management	Continued review of antimicrobial prescribing	On-going
Microbiology	Management	Maintain input into Clinical Audit Meetings and Consultant mandatory training	Quarterly
Microbiology	Management	Maintain input into the review of any new Estates project from start to finish	On-going
IC	Management	Continue to review the Board Assurance Framework related to the Health and Social Care Act (2010)	Quarterly
IC	Management	Quarterly IPACT report for Board	Quarterly
IC	Management	Assist the Decontamination Lead with the monitoring of decontamination of equipment	Ongoing
IC	Management	Assist with the implementation of the Surviving Sepsis campaign Trust-wide	One-off action
IC	Management	NICE QS 61 Guideline – Infection prevention and control, ensure action plan completed	Annual
IC	Management	Review policies in line with DoH and NICE National guidance and Trust timescale	As required
IC	Management	Continued attendance at external meetings and Infection Prevention Society annual conference	On-going
IC	Management	DIPC to raise attendance on PLACE inspections with the Matrons, Estates and Risk Management Depts	As required
IC	Surveillance	Continue mandatory surveillance and reporting in line with DH requirements including MRSA, MSSA, *C. difficile* and *E. Coli*	Monthly
IC	Surveillance	Enhanced surveillance (RCA/PIR) of *C. difficile*, MRSA, MSSA and *E. coli* bacteraemia	When new case identified
IC	Surveillance	Continue speciality specific surgical site infection audit	Annual
IC	Audit	Audit sharps policy compliance	Theatres bi-monthly; Trust wide annual
IC	Audit	Continue hand hygiene audit and compliance	Monthly
IC	Audit	DIPC, Chief Executive, Medical Director and Deputy	Annual

		Director of Nursing to undertake hand hygiene audit spot checks	
IC	Audit	Spot check of infection control documentation and mattress decontamination	Bi-monthly
IC	Audit	Continue to review external contracts e.g. laundry	As required
IC	Audit	Continue to implement the DH Saving Lives audit programme	On-going
IC	Audit	Continue PLACE inspections	Two weekly
IC	Audit	Audit compliance with MRSA policy Audit compliance with MRSA screening	Twice yearly Monthly
IC	Audit	Monitor staff knowledge on the management of patients suspected of Ebola	Bi-monthly
IC	Audit	Meet with Practice Educators to discuss increasing compliance with audits such as blood cultures, saving lives, aseptic technique and MRSA decontamination	As required
IC	Education	Updates for Clinical Practice Educators / Department Managers / departments	As required
IC	Education	Mandatory training: Clinical Non-clinical Induction Junior doctors Consultants	X2 month X1 month X1 month X6 year X2 year
IC	Education	Link person training	Every 2 months
IC	Education	Infection control awareness week	Annual
IC	Education	Hand hygiene roadshow	Twice a year
IC	Education	Hand hygiene training	On-going
IC	Education	Deliver training to staff on current issues and attend department meetings on request	As required
IC	Education	Organise drop in sessions for staff	Quarterly
Estates	Management	Involvement in the Capital Programme	As required
Estates	Management	Review of estates policy and new guidance	As required
Estates	Management	Involvement in reviewing water sampling and ventilation results	As required
Estates	Management	Involvement in the prioritising of general refurbishment works within the Trust	As required
Estates	Management	Update for IPACT and ICC	Monthly / Quarterly
Estates	Audit	Waste facility	Annual
Decontamination	Management	Review of decontamination and disinfection policy	As required
Decontamination	Management	Add to risk register Surgical instrument decontamination and flexible endoscopes	On-going
Decontamination	Management	Update for ICC	Quarterly
Decontamination	Management	Review decontamination/traceability processes for equipment trust-wide	As required
Decontamination	Management	Audit decontamination/traceability processes for all spoke sites	Annual
Decontamination	Management	JAG audit	Twice a year
Decontamination	Audit	Synergy service	Annual

Appendix D

IC Policies Ratified April 2015 – March 2016

Reference (Type. Number. Version)	Title	Lead Director	Author	Ratifying Committee	Ratified Date	Review Date	Uploaded
IC.7024.7	Management of Outbreaks	Jo Thomas	IPACT		21/01/2016	**20/01/17**	27/01/16
IC.7003.2	Personal Protective Equipment	Jo Thomas	Amanda Parker	Infection Control Committee	23/04/2015	**23/04/17**	11/05/15
IC.7007.4	Isolation Policy	Jo Thomas	Amanda Parker	Infection Control Committee	23/04/2015	**23/04/18**	11/05/15
IC.7009.4	Decontamination & Disinfection Policy	Jo Thomas	Jo Thomas	Infection Control Committee	23/04/2015	**23/04/18**	29/04/15
IC.7012.4	Procedure for the Management of Spillage of Blood and Body Fluid	Jo Thomas	Jo Thomas	Infection Control Committee	23/04/2015	**23/04/18**	11/05/15
IC.7019.3	Guidelines for Management of Head lice	Jo Thomas	Jo Thomas	Infection Control Committee	23/04/2015	**23/04/18**	29/04/15
IC.7020.3	Guidelines for Management of Scabies	Jo Thomas	Jo Thomas	Infection Control Committee	23/04/2015	**23/04/18**	29/04/15
IC.7002.5	Hand hygiene	Jo Thomas	Amanda Parker	Infection Control Committee	23/07/2015	**23/07/18**	19/08/15
IC.7014.4	Policy for the Prevention of Healthcare Associated Infection in Peripheral Venous and Arterial Cannulae	Jo Thomas	Jo Thomas	Infection Control Committee	23/07/2015	**23/07/18**	
IC.7008.7	Management of Patients with MRSA	Jo Thomas	Jo Thomas	Infection Control Committee	22/10/2015	**22/10/18**	30/10/15
IC.7016.3	Management of patients with Tuberculosis	Jo Thomas	IPACT	Infection Prevention Group	21/01/2016	**21/01/19**	11/02/16

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KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Committee: Quality & Governance
Date last reviewed: 2 February 2017

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 and burns derogation.
Paediatric inpatient compliance.
Seven Day Standards for urgent care.
Junior doctor recruitment, and conflict between education vrs service delivery.
Internal and spoke governance resources.
External and internal research funding and organisation.
Job planning.

Risk
Patients, clinicians & commissioners lose confidence in services due to inability to show external assurance by outcome measurement, reduction in research output, fall in teaching standards., or lack of effective clinical governance.

HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY
National Standards:
ITU (ICS, SECCAN, ODN Burns)
Paediatrics (ODN burns and RCPCH)
General eg NICE, CQC
Junior Doctor contract
Seven Day Services
Learning, Candour and Accountability

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

INNOVATION
Efficient electronic 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 and governance structure.
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
Job planning – DRR 955
Compliance with new Junior Doctor contract terms and conditions – RR TBC

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**QVH Business Meeting of the Board of Directors**				
Meeting date:	**2 March 2017**		**Agenda reference:**	**43-17**	
Report title:	**Medical Directors Report**				
Sponsor:	Dr E Pickles, Medical Director				
Author:	Dr E Pickles, Medical Director				
Appendices:					
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: [one only]	Approval	Information **Y**	Discussion	Assurance Y	Review
Link to key strategic objectives (KSOs): [Tick which KSO(s) this recommendation aims to support]	KSO1: *Outstanding patient experience*	KSO2: **Y** *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	BAF KSO2				
Corporate risk register:					
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:	NA				
Next steps:	NA				

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 02 March 2017
Reference number: 43-17
Report from: Ed Pickles, Medical Director
Author: Ed Pickles, Medical Director
Appendices: N/A
Report date: 23 February 2017

Medical Director's Report March 2017

1. Clinical Governance

a) Mortalities

	Dec 2016	Jan 2017
QVH mortalities on-site	0	0
Mortalities elsewhere within 30 days of discharge from QVH	1	1

The mortalities elsewhere will be included for discussion at the March Joint Hospital Clinical Governance meeting.

The mortality detailed in the January 2017 MD Board report (unexpected death following PEG insertion) which was the subject of a SI investigation and reported via STEIS has had a completed RCA and action plan. The case was discussed at the Joint Hospital Clinical Governance meeting in January. The RCA has been reviewed by the Q&G committee and Clinical Governance Group and has been submitted for review by the Clinical Commissioning Group.

The NHSI meeting discussing how trusts should respond to 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) has been postponed to the 21st March 2017. Ed Pickles and Ginny Colwell are planning to attend and QVH compliance will be assured via the Q&G committee.

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 eight unexpected transfers from the QVH across December and January. None of the patients were children. The information is considered by clinical teams and at the Joint Hospital Governance meeting.

c) Never events / SIs

There have been no never events since the last board report. One serious incident (a patient fall) has been reported via STEIS and an RCA is underway which will report initially to the CGG.

d) Clinical Audit

Data collection continues on a two year retrospective data submission for the National Head and Neck Cancer Audit (HANA) - Saving Faces audit. This is an extremely complex data collection and submission requiring collaboration between QVH Clinical Audit, Information and Cancer teams, as well as head and neck cancer teams from Kent, Surrey and Sussex. It is one of the few national (HQUIP) audit programmes which is of relevance to the QVH specialist work. There may be resource implications for our ongoing participation.

The compilation of data for the 2017 Quality Account continues.
Clinical Audit is currently the subject of the internal clinical governance audit by the trust auditors.

e) Antimicrobial Stewardship
Work continues to implement the National antimicrobial stewardship recommendations. The Trust's implementation plan is progressing well, and all actions are currently completed or moving forward. A route cause analysis (RCA) for the case of Clostridium difficile infection has been completed and is awaiting commissioner approval. Issues around antimicrobial prescribing have been identified, and raised with the relevant Clinical Directors.

f) NICE Guidance
Benchmarking of Trust compliance has been completed for: QS126: Motor neurone disease (July 16) - fully compliant (community therapy service)

2. Sustainability and Transformation Plan and Regional Services

The Sussex and East Surrey STP, with the involvement of Carnall Farrar, has formed a Clinical Steering Group. Membership includes the Medical Directors of all acute providers in the footprint, along with CCG and NHSI representation. The first meeting is on the 23rd February 2017. The MD met with Dena Marshall, the Programme Director of the STP in February. There is recognition that extensive clinical engagement is now required to develop the STP plans.

A business plan for the transfer of maxillofacial services from East Sussex Hospitals to the QVH has been approved by the EMT. 2 maxillofacial surgeons from ESHT will commence operating at the QVH in April 2017, with both elective and trauma work transferring. This can be accommodated within current capacity. The possibility of further work from BSUH is under consideration.

A draft Partnership Agreement between BSUH and QVH for specialist services provision, including paediatric burns, lower limb orthoplastic trauma, dermatology and maxillofacial surgery is in development.

3. Medical & Dental Staffing

A new consultant maxillofacial surgeon was appointed on the 16th February, subject to satisfactory references, etc. This will initially cover the sabbatical of Mr Darryl Coombes, but is expected to increase the breadth of maxillofacial surgery services offered by the trust, with additional income generation.

Job plans for two new plastic surgery consultant posts to cover skin and breast surgery and to have input into services at the RSCH have been approved by the Royal College of Surgeons.

a) Job planning
Business plans for electronic systems to aid medical job planning have been approved. This is an important tool in our ambition for accurate, consistent, transparent, annual job planning.

b) Appraisal and Revalidation
The current completed appraisal rate within 12 months of the last appraisal for trust appointed medical staff is over 85%. Mandatory training compliance by permanent medical staff is slightly improved at over 83%, and greatly improved in bank staff (83%)

c) Junior Medical Staff
Recruitment challenges at registrar level in plastic surgery and maxillofacial surgery continue with a potential shortfall of HEE trainees in both specialties.

4. Medical Education

A Trust Hand Surgery Consultant, presented at an evening lecture CME meeting on the topic of "A brief history of plastic surgery – how did it come to this?" with excellent feedback.

The Director of Medical Education, has delivered the first of his workshops on the requirements of the new Junior Doctor contract for educational supervisors

A bid to HEE for funding for SAS doctors has been successful and plans are being put in place for utilising the funds; two courses have been booked for 2017

Changes to the doctors' induction programme were implemented at the induction, held in February in response to feedback from the medical staff.

Continuing feedback from interim and exit questionnaires has been collated and will be considered at LFGs and the Local Academic Board

5. Research

Plans for the QVH employment of a research scientist, previously employed by the BMRF, to continue the 'Scar Collection' project have been finalised, and the necessary equipment acquired. Funding has been secured thanks to the generosity of the BMRF and the QVH charities.
A research strategy for the QVH will be discussed at the private session of the board on the 2nd March, and then developed further.

6. Medical Devices

Negotiations with Avensys UK, who hold the medical devices maintenance and repair contract for the trust has resulted in a return of funds to the trust of over £9K, reducing the overspend in this area. Current significant medical devices expenditure remains only on approval of the Executive Management Team.

Dr Edward Pickles
Medical Director
22nd February 2017

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**QVH Board of Directors meeting**				
Meeting date:	**02/03/2017**		**Agenda reference:**	**44-17**	
Report title:	**New Junior Doctors Contract and Exception Reporting**				
Sponsor:	Dr E Pickles, Medical Director				
Author:	Dr E Pickles, Medical Director				
Appendices:	NA				
Executive summary					
Purpose:	Information regarding the New Junior Doctors Contract and future mandated reports to the Board of Directors from the Guardian of Safe Working and Exception Reports.				
Recommendation:	The Board is asked to **NOTE** the contents of this report				
Purpose: [one only]		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:	BAF KSO 2				
Corporate risk register:	No				
Regulation:	No				
Legal:	No				
Resources:	Financial support for exception report fines imposed by the Guardian of Safe Working				
Assurance route					
Previously considered by:	NA				
Next steps:					

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	02 March 2017
Reference number:	44-17
Report from:	Ed Pickles, Medical Director
Author:	Ed Pickles, Medical Director
Appendices:	N/A
Report date:	23 February 2017

New Junior Doctors Contract and Exception Reporting

Background

The new 2016 contract, terms and conditions for Junior Doctors came into effect on 3 August 2016. It has been introduced in England for GP trainees and trainees in hospital posts approved for postgraduate medical/dental education (this does not include trust grade posts), in line with a phased implementation timetable from October 2016. The first cohort of doctors employed by the QVH on the new contract was a group of four core trainees in plastic surgery, who commenced work on the 1st February 2017. The staged introduction across other groups of doctors will be completed by September 2017, as doctors in training rotate into the trust.

In broad terms, the contract:

- Focuses both on safe working hours & education & training
- Introduces a 'work schedule' – sent with offer letter minimum 8 weeks prior to start
- Introduces a new pay structure – nodal points based on responsibility not on time served. The previous system of 'banding' goes.
- Pays additional out of hours payments at a flat rate of 37%
- Pays weekend availability allowances for on-call
- Allows flexible premia for some specialties e.g. Maxillo-facial
- Doesn't allow fixed leave to be imposed by the work schedule – 6 weeks' notice
- Separates pay from concerns about safety e.g. working hours should not become pay disputes
- Puts mechanisms in place to deal with safety and educational concerns at the time
- Requires a Guardian of Safe Working Hours & additional responsibilities for Educational Supervisors

Safe Working Hours

The contract puts in strict controls around maximum average hours worked per week, maximum shift length, maximum number of consecutive shifts and night shifts, the rest period between shifts and the breaks during shifts. Doctors can work a maximum of 1 weekend in 2.

The work schedule for doctors must be compliant with these new rules, aiming for a slightly less than 48 hour average to allow for variations in shift length.

Where actual working patterns and rest periods do not comply with the work schedule, junior doctors are expected to report these exceptions to their clinical and educational supervisor. This exception report is then forwarded to the Guardian of Safe Working, who will seek assurance from the DME, HR and the Medical Director that the causes are being addressed.

In some circumstances the Guardian of Safe Working (GOSW) will apply a fine to the trust for non-compliance with the work schedule. These circumstances include breeches of:

- A maximum 48 hour average working week (or 56 hour week if the junior doctor has opted out of the European Working Time Directive)
- A maximum of 72 hours work in any 7 day period
- Where continuous rest between shifts has fallen to below 8 hours, work scheduled for the following day should be no more than 5 hours.
- Where breaks (30 minutes for 5 hours worked) across a 4 week period are not achieved on at least 75% of occasions

The Guardian of Safe Working

The GOSW for QVH is Mr John Boorman, Consultant Plastic Surgeon. Mr Boorman was appointed to the role in July 2016, and has attended the relevant training. He is due to retire from clinical practice in 2017, but is willing to continue the GOSW role.

The GOSW is an independent senior person who ensures that the safety aspects of the 2016 TCS are being upheld and intervenes where this is not the case. The Director of Medical Education has a similar oversight of education and training & remains responsible for overseeing the quality of the educational experience. In practice both will work closely together supported by the Head of Medical HR and the Medical Education Manager. The GOSW is provide assurance to the Board that doctors are being rostered and working safely. He / she will see all exception reports and undertake regular reviews of exception reports/work schedules to ensure that hours remain safe.

The GOSW ensures that work schedule review processes are followed and requires a work schedule review to be undertaken where there are regular or persistent breaches in safe working hours which have not been addressed. He / she is empowered to require departments to take appropriate action where they are unresolved issues.

The GOSW will escalate issues to the Board where there are concerns over working hours. The DME shall report annually to the Board on all work schedule reviews relating to education and training.

The GOSW will report quarterly and annually to the Board. This information is to be included in the Trust's Quality Account. The Board is required to report to HEEKSS, GMC and GDC. Reports are also provided to NHS England, Local Negotiating Committee.

Exception Reporting

Doctors should report exceptions where day to day work varies from that set out in the work schedule. They must be submitted within 24 hours where there are immediate safety concerns, within 7 days where payment is requested and within 14 days for standard exceptions. Any issues should at first be addressed by the educational supervisor, to establish whether this is truly exceptional or whether it requires a work schedule review. The GOSW will be able to review all exception reports.

An 'immediate safety concern' is one which indicates an immediate and substantial risk to patient safety or to the doctor making the report and needs to be raised verbally by the doctor to the Consultant on-call or Business Manager in the first instance. The doctor must confirm such reports electronically to their Educational Supervisor (ES). The QVH has such an electronic system now available.

In response, the Consultant on-call or Business Manager's responsibilities are that where it is agreed that there are immediate safety concerns, they shall grant the doctor time off immediately or ensure immediate provision of support to the doctor. They will inform the Educational Supervisor and the GOSW within 24 hours.

For serious but not immediate concerns, the consultant on-call shall ask doctor to submit an exception report to their Ed Supervisor. For significant but not serious concerns, the consultant on-call shall ask the doctor to raise an exception report within 48 hours.

Fines

Where the outcome of the exception reports has been agreed by the doctor and the ES, they will be reviewed by the GOSW to check whether the provisions set out in the TCS have been breached. Fines will be levied when working hours breach one or more of the provisions set out above. In some cases the GOSW may need to review a pattern of exceptions to identify if a fine should be levied.

Fines will be levied against a department where the doctors work, at 4 x the rate of pay for the time of the breach (basic plus enhanced if appropriate). The doctor will receive a penalty rate of 1.5 times the locum rate (basic plus enhanced if appropriate), and the GOSW will retain the remainder of the fine for future disbursement for the benefit of education, training and the working environment of the trainees. Fines should not be used to supplement the facilities, study leave, IT provision and other resources that are defined by HEEKSS as fundamental requirements for doctors in training and which should be provided by the Trust. Details of fines are to be published in the Trust annual report.

Future Reporting to the Board of Directors

The GOSW will report no less than once per quarter to the Trust Board either directly or through a committee of the Board, on all work schedule reviews relating to safe working hours including rota gaps. The GOSW will also produce a consolidated report annually accompanied by a plan for improvement to reduce these gaps which will be included in the Trust's Quality Account and must be signed off by the Chief Executive. Both reports will be made available to the LNC.

Where the GOSW has escalated a serious issue in line with Schedule 6, para 10 of the TCS, and the issue remains unresolved, they must submit an exceptional report to the next Trust Board. The Board is responsible for providing annual reports to external bodies including HEE (Local Office), CQC, the GMC and the GDC.

There may be circumstances where the GOSW identifies that certain posts have issues that cannot be remedied locally, and require a wider solution. Where such issues are identified, the GOSW shall inform the Board and the Board will raise these issues with partner organisations to find a solution.

QVH Progress

CT2s in Plastic Surgery starting on 1st February 2017 have commenced on the 2016 contract. Offers for the April rotation are being sent in February 2017. 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 are near completion and Oral and Maxillo-facial rotas are in progress. An Equality Impact Assessment which serves to identify any possible impact on the workforce of the new contract has now been completed and was discussed with the Local Negotiating Committee on 23rd January 2017. Most of the findings are in line with that identified nationally so no further action to be taken other than the EIA to be repeated in a year to eighteen months' time. Next steps are to share findings with next Junior Doctors' Forum and Local Academic Board.

An Exception Reporting and Workforce Schedule Review Policy has been shared with the Local Negotiating Committee meeting held on 23rd January 2017. Work now needs to be undertaken to finalise internal processes for the disbursement of fines and additional payments which will be incorporated into the policy. Expected ratification to Quality and Governance Committee is March 2017.

Queen Victoria Hospital NHS
NHS Foundation Trust

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

Executive summary

A few paragraphs on the key points of the paper that you want the board to note, including any areas of risk and any decisions that you would like the board to take.

Introduction

As part of the Terms and Conditions of Service (TCS) for Doctors and Dentists in Training (England) 2016, it is incumbent on all Trusts to appoint a Guardian of Safe Working (GOSW). It is a requirement that the GOSW to report compliance with the new TCS to the Board on a quarterly and annual basis. The principle role is of the GOSW is to:

- Act as a champion of safe working hours for doctors on approved training programmes.
- Provide assurance to doctors and employers that doctors are safely rostered and enabled to work hours that are safe and in compliance with the Terms and Conditions of Service.
- Receive copies of all exception reports in respect of safe working hours which will enable to GOSW to record and monitor compliance.
- Escalate issues in relation to working hours, raised in exception reports, to the relevant Executive Director, for decision and action, where these have not been addressed at departmental level.
- Require any intervention to mitigate any identified risk to doctor or patients safety in a timescale commensurate with the severity of the risk.
- Require a work schedule review to be undertaken, where there are regular or persistent breaches in safe working hours, which have not been addressed.
- Have the authority to intervene in any instance where the GOWN considers the safety of patients/and or doctors and dentists is compromised, or that issues are not being resolved satisfactorily.
- Distribute monies received as a consequence of financial penalties to improve the training and service experience of doctors.

This purpose of this report is to provide the Board with information with regard to the working hours of doctors and dentists in training. It will include information on rota gaps, bank and agency usage and any action taken to ensure safe working hours.

High level data

Number of doctors / dentists in training (total):	XXX
Number of doctors / dentists in training on 2016 TCS (total):	XXX
Amount of time available in job plan for guardian to do the role:	0.25 PAs / 1 hours per week
Admin support provided to the guardian (if any):	XX WTE
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

a) Exception reports (with regard to working hours)

This section should include raw aggregated data, broken down by specialty, grade and rota. Where an employer has a large number of doctors in training, it may be more appropriate to include total figures by grade and then detail on a small number (no more than 10) of specialties and/or rotas that give the most reason for concern (eg those with large numbers of exceptions reported). In such cases, the full data set should be included at the end of the paper as an appendix. There should additionally be an aggregated table of all reports indicating the timeframes within which they have been addressed or otherwise responded to. Where reports have not been addressed in the time frames set out in the TCS, a short note – either at the end of this section or in the issues arising section below – should set out the areas where this happened and what has been done to address this.

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Plastic Surgery				
Anaesthetics				
Oral & Maxillo-facial Surgery				
Orthodontics				
Total				

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
CT2				
Dental Core Trainee (DCT)				
ST3+				
Orthodontics				
Total				

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Plastic Surgery CT2				
Plastic Surgery ST3+				
Anaesthetics ST3+				
Oral & Maxillo-facial Surgery (DCT)				
Oral & Maxillo-facial Surgery (ST3+)				
Orthodontics				
Total				

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7	Still open

			days	
CT2				
Dental Core Trainee (DCT)				
ST3+				
Orthodontics				
Total				

Note: Any employer who still has doctors on the old 2002 contract (almost all employers until October 2017 and lead employers (and associated host organisations) for some time after this) will additionally need to include information on hours monitoring / diary card exercises to ensure that assurance can be given for all doctors in training, not only those on the new TCS.

Hours monitoring exercises (for doctors on 2002 TCS only)					
Specialty	Grade	Rostered hours	Monitored hours	Banding	WTR compliant (Y/N)
Plastic Surgery					
Anaesthetics					
Oral & Maxillo-facial Surgery					
Orthodontics					
Total					

* The response rate to this exercise was below 75% so no statistically valid figures are available.

** The response rate to this exercise was below 75% but no issues with shift lengths or breaks were reported and the rota has historically been compliant

b) Work schedule reviews

This section should include raw aggregated data on the number of work schedules reviewed in the past quarter as a result of exception reporting, broken down by specialty, grade and rota. This could be broken down by grade only, or if there were a concentration in a small number of departments (likely) then also split by department. As with exception reports, where work schedule reviews have not been carried out in the time frames set out in the TCS, a short note – either at the end of this section or in the issues arising section below - should set out the areas where this happened and what has been done to address this. The narrative should also indicate whether any reviews went to a higher (level 2, level 3) stage (this should be very few). Any open appeals (currently at level 2 or 3) with regard to work schedule reviews should also be noted in this section.

Work schedule reviews by grade	
CT2	
Dental Core Trainee (DCT)	
ST3+	
Orthodontics	
Total	

Work schedule reviews by department

Plastic Surgery	
Anaesthetics	
Oral & Maxillo-facial Surgery	
Orthodontics	
Total	

c) Locum bookings

i) Bank

This section should start by presenting a cost summation (in cash terms) of bank usage across the quarter. Depending on volume, it might be sensible to break this down by department and/or grade. This section should then list, in aggregated fashion, all the locum work requested and worked via the bank during the last quarter. This data should be presented by department, by grade and by reason. Where a trust has a large amount of bank usage, it may be more appropriate to list the top ten users only, and to include the full data set in an appendix.

Locum bookings (bank) by department					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Plastic Surgery					
Anaesthetics					
Oral & Maxillo-facial Surgery					
Orthodontics					
Total					

Locum bookings (bank) by grade					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
CT2					
Dental Core Trainee (DCT)					
ST3+					
Orthodontics					
Total					

Locum bookings (bank) by reason*					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Plastic Surgery					
Sickness					
Increase in workload					
Total					

** It might also be useful to include information about the length of advance notice of the booking*

request; in particular, highlighting "last minute" bookings for any reason other than short term sickness.

ii) Agency

This section should start by presenting a cost summation (in cash terms) of agency usage across the quarter. Depending on volume, it might be sensible to break this down by department and/or grade. It may also be sensible to highlight areas where the agency capped rates have been breached.

This section should then list, in aggregated fashion, all the locum work requested and worked via an agency during the last quarter. This data should be presented by department, by grade and by reason. Where a trust has a large amount of bank usage, it may be more appropriate to list the top ten users only, and to include the full data set in an appendix.

Locum bookings (agency) by department				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Plastic Surgery				
Anaesthetics				
Oral & Maxillo-facial Surgery				
Orthodontics				
Total				

**It might also be useful to include a narrative explaining how the work left uncovered by unfilled requests was delivered. For example: Were clinics cancelled? Were teams left to cope with fewer staff? Did consultants pick up the slack? Did non-resident on-call staff have to come in and so breach rest requirements?*

Locum bookings (agency) by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT2				
Dental Core Trainee (DCT)				
ST3+				
Orthodontics				
Total				

Locum bookings (agency) by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy				
Sickness				
Total				

***It might also be useful to include information about the length of advance notice of the booking request; in particular, highlighting "last minute" bookings for any reason other than short term sickness.*

d) Locum work carried out by trainees

This section should identify, in an anonymised fashion (perhaps referencing specialty and grade), doctors who have been carrying out work as a locum for the trust via the staff bank (as per the TCS), outside of the contract of employment (via an agency) or for another NHS organisation (via another staff bank, again, as per the TCS). This should be aggregated in a similar fashion to the locum usage above, aggregating the number of shifts worked, the total hours worked, and the overall total hours worked once contracted hours have been considered.

Once again, if there are a large number of trainees undertaking such work, it may be appropriate only to list here the trainee(s) whose patterns of work might give cause for concern (i.e. those working the most hours)

Locum work by trainee						
Specialty	Grade	Number of shifts worked	Number of hours worked	Number of hours rostered per week	Actual hours worked per week	Opted out of WTR?
Plastic Surgery						
Anaesthetics						
Oral & Maxillo-facial Surgery						
Orthodontics						
Total						

Note: In the above example, two trainees have breached the 48-hour limit; however, both have opted out of the working time regulations (WTR) and are therefore not in breach of contract, whether they are working safely or not would depend upon the pattern of their work.

e) Vacancies

This section should list all vacancies among the medical training grades (including trust doctors) during the previous quarter. These should be reported for each month separately, split by specialty / rota and grade.

Vacancies by month						
Specialty	Grade	Month 1	Month 2	Month 3	Total gaps (average)	Number of shifts uncovered
Plastic Surgery						
Anaesthetics						
Oral & Maxillo-facial Surgery						
Orthodontics						
Total						

f) **Fines**

This section should list all fines levied during the previous quarter, and the departments against which they have been levied. Additionally, the report should indicate the total amount of money levied in fines to date, the total amount disbursed and the balance in the guardian of safe working hours' account. A list of items against which the fines have been disbursed should be attached as an appendix[1].

Fines by department		
Department	Number of fines levied	Value of fines levied
Plastic Surgery		
Anaesthetics		
Oral & Maxillo-facial Surgery		
Orthodontics		
Total		

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter

Qualitative information

This section should be a short narrative outlining any other information that the guardian has picked up feels it is necessary to share, for instance through discussions with trainees and/or supervisors or via the junior doctor forum.

Issues arising

This section is the key part of the paper and should be used to draw together the above data into a narrative to highlight any possible areas of concern with regard to safe working hours – including any concerns that guardian may have over the amount of time available for supervisors and / or the guardian him/herself to do the job. The guardian should attempt to triangulate the data about working hours – for example, cross-referencing locum usage, vacancies, fines and exception reports to identify departments, rotas or grades which may be at particular risk of breaching safe working. It should not be used to highlight individual trainees whose own practices may be putting them at risk – such matters should be dealt with via appropriate trust processes. This is the place to highlight system, cultural or work pressure issues which may put doctors at risk.

Actions taken to resolve issues

This section should describe any actions already taken to resolve the issues described above. It may be possible to draw in data on work schedule reviews to indicate concerns which have already been addressed, however, it may be that the guardian has to use this section to highlight departments which have not, cannot or (in a small number of cases) will not take appropriate steps to ensure safe working hours.

Summary

This section should be a short summation of the information above, and should be used by the guardian to make an overall statement about the working hours across the organisation. This is the key quality assurance statement for the board, so the guardian should take the opportunity to give a view both as to overall working hours across the organisation and to any concerns that three may be about specific departments.

[1] This information will be used to inform the organisation's annual report, which mist include clear detail on how the money has been spent (Schedule 5, para. 15).

Questions for consideration

If the guardian is comfortable with the overall safety of working hours in the organisation, or feels that while there are issues, these are on the way to being resolved, then this section may simply ask the board to note the report and to consider the assurances provided by the guardian.

If on the other hand the guardian feels that there are issues outlined in the report which are not being (or cannot be) tackled, then the guardian should use this section to ask the board to consider what escalation, internally, externally or both, might be recommended in order to ensure that safe working hours would not be compromised in the future.

Appendices

As indicated in the text above.

Queen Victoria Hospital NHS
NHS Foundation Trust

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING

Executive summary

A few paragraphs on the key points of the paper, including any areas of risk and any decisions that you would like the board to take.

Introduction

A short preamble to the main body of the paper, setting out the purpose of the report with reference to the requirements of the terms and conditions of service (TCS).

High level data

Number of doctors / dentists in training (total): XXX

Number of doctors / dentists in training on 2016 TCS (total): XXX

Annual vacancy rate among this staff group: XX%

Annual data summary

This section should list all vacancies among the medical training grades (including trust doctors) during the previous year. This is an annual aggregate of the relevant data from the previous four quarterly reports. These should be reported for each month separately, split by specialty / rota and grade.

The detailed month-by-month breakdown featured in the quarterly reports should be repeated at the end of this report as an appendix.

Specialty	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average WTE)	Number of shifts uncovered (over the year)	Average no. of shifts uncovered (per week)
Anaesthetics	ST5+							
Plastic surgery	CT1+							
Plastic surgery	ST3+							
Max-fac	DCT2+							
Max-fac	ST3+							
Corneo / oculoplastics	ST6+							
Orthodontics	ST1+							
Total								

Issues arising

This section should be used to highlight any residual or recurrent issues or concerns suggested by the above data. Specifically it should include areas where rota gaps are persistent across more than one quarter. The narrative should cover, as a minimum, the following:

- *the reason for the gap (eg Health Education England gap, trust doctor gap, visa restrictions)*
- *the obstacles to resolving any particular issues (internal, external systemic).*

Actions taken to resolve issues

This section should identify and describe steps already taken by the employer to resolve the issue (number of recruitment episodes undertaken, outcome of these, rota redesign, service resdesign etc). It may be possible to draw in data on work schedule reviews to indicate concerns which have already been addressed, however, it may be that the guardian has to use this section to highlight departments which have not or cannot take appropriate steps to ensure safe staffing levels.

Summary

This section should be a short summation of the information above, and should be used by the guardian to make an overall statement about the staffing levels within the junior medical workforce across the organisation – specifically vacancy rates and the resultant rota gaps. The guardian may also wish to draw in concerns linked to workload. This is the key quality assurance statement for the board.

Questions for consideration

If the guardian is comfortable with the overall staffing level in the organisation, or feels that while there are issues these can be resolved, then this section may simply ask the board to note the report and to consider the assurances provided by the guardian.

If on the other hand the guardian feels that there are issues outlined in the report which are not being (or cannot be) tackled, then the guardian should use this section to ask the board to consider what escalation, internally or externally (or both) might be recommended in order to ensure that safe staffing levels would not be compromised in the future.

Appendices

As indicated in the text above.

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Committee – Finance & Performance Committee
Date last reviewed – February 14th 2017

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
- Data warehouse project in place and beginning to give off site PTL visibility with associated validation being undertaken so the scale of the issue (particularly at Medway) can be seen and managed accordingly

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 e.g.. 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 February 2017

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 10)
- Surplus - £1.6m/£1.9m (-0.5%)
- CIP slippage - (0%)
- Capital Plan slippage (-18%)
- 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 cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**2 March 2017**		**Agenda reference:**	**46-17**	
Report title:	**Finance and performance assurance report**				
Sponsor:	Beryl Hobson, Trust Chair				
Author:	Beryl Hobson, Trust Chair				
Appendices:	NA				
Executive summary					
Purpose:	To provide assurance to the Board in relation to matters discussed at the Finance and performance committee on 20 February 2017.				
Recommendation:	The Board is asked to **NOTE** the contents of the report				
Purpose:	Assurance				
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:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance and performance committee				
	Date:	20/02/17	Decision:	For information	
Next steps:	N/A				

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	2 March 2017
Reference number:	46-17
Report from:	Beryl Hobson, Trust Chair
Author:	Beryl Hobson, Trust Chair
Appendices:	N/A
Report date:	23 February 2017

Finance and performance assurance Report
Meeting held on 20 February 2017

Introduction

This is a report from the F&P Committee meeting on 20th February – as John Thornton was on holiday it was chaired by Beryl Hobson. Due to sickness we did not have another NED in attendance and the meeting was therefore inquorate. It was agreed to proceed with the meeting with any decisions to be ratified by the board rather than the committee.

1. Operational performance

The Trust achieved a diagnostics rate of 99.56% (target 99%) and RTT18 of 91.63% (target 92%) for January – this is slightly better than December which may indicate that the Max Facs recovery plans are taking effect. The committee was advised that the team are confident that we will be able to reach the RTT18 target of 92% by May – as the committee has previously reported, it is unlikely that we will consistently achieve better than the 92% target, due to patient choice.

A femtosecond laser is now in use which means patients no longer need to be referred to the Centre for Sight which had previously resulted in breaching the 18-week limit.

2. Workforce performance

As reported to the last board meeting, concerns continue about the level of turnover across the Trust and the difficulty in recruiting which has led to us continuing to breach the agency cap. The committee cannot give assurance that this will be resolved in the near future. On the positive side, recruitment of healthcare assistants has been successful with a high number of good quality applicants. Disappointingly, there was a decrease in the appraisal target to 78.5% (target 85%), and it was noted that the target had not been achieved in any month in this financial year. Indications are that appraisals are seen as a 'tick box' exercise with little value (the staff survey may reveal further views on this) - there will be a focus on quality of appraisals and personal development – this will be addressed through the leadership development work which has recently been launched. The sickness absence rate for December was 2.9% which is relatively low for the winter months (down from 3.6% and 3.7% in the previous 2 years).

3. Financial Performance

The financial position at month 10 was a deficit of £76K in month, £328K behind plan and £134k less than forecast. The year to date surplus has decreased to £1.6M, £269K less than plan. As the control total has not been achieved, the £75K sustainability and transformation funding cannot be

included in month 10 income. There is now a significant risk to delivery of the year end plan and to achieving the control total. Recovery plans continue to be developed but at this stage, the committee is unable to provide assurance that the plan will be delivered in full at the year end.

The committee was assured that the capital programme is likely to be on target by the end of the financial year.

4. Wards and Outpatients Review

For some months, the committee has been concerned about the impact of the change in case mix on our cost base. The committee received a verbal report from the Director of Nursing stating that the business manager is starting the review, which will include a bed review, length of stay, efficiency, workforce modelling and ratios of staff to patients. A further report will be given to the April F&P committee. In terms of priorities, this review had the possibility of making a more significant impact than the review of MIU although they will be running simultaneously.

5. Minor Injuries Unit (MIU)

In view of the financial performance of the MIU, the previous meeting of F&P had asked for a paper for discussion at this meeting. The report showed a drop in the use of the service which is significantly more than anticipated by the earlier closing hours which had been introduced in March 2016. It also stated that the methodology for setting this year's plan had not been accurate for the current circumstances.

The report had not previously been seen by the Executive Management team until their meeting on the same day as the committee. It was agreed both at that meeting and at F&P that further work was needed to understand more about the usage of the service and the increase in local A&E attendance, and separating out work generated by the trauma clinic which currently shares the space. The role of MIU should also be considered within the context of the STP and the need for urgent care centres. It was agreed that further communications work to promote the service to both the public and GPs will be undertaken

6. Procurement Transformation Plan

Whilst QVH has not been formally required to comply with the requirements of Lord Carter's work on productivity, we aim to be a 'fast follower' where appropriate. A report was received by the committee which outlined our self-assessment against the relevant criteria and the results were positive overall although a lack of strategic procurement support has been identified. The committee felt this was a very good piece of work. The next steps will be to develop action plans and to replicate the process in other areas such as pharmacy and administration.

7. Terms of reference

The committee considered changes to its terms of reference to reflect the changes in planning cycles. The board is asked to approve the revised version.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	02/03/17	Agenda reference:	47-17		
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: [Provide guidance as to where board members can cross reference the information in this report. List the major risks identified and cross-reference to risk register and risk score, if appropriate. Include the risk of not adopting the recommendation].	**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: [As above]	**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 19/12/16			
	Date:	N//A	Decision:	Noted
Previously considered by:	Finance and Performance Committee			
	Date:	20/02/17	Decision:	Noted
Next steps:	None			

Report to:	Board of Directors
Meeting date:	2 March 2017
Reference number:	47-17
Report from:	Sharon Jones, Director of Operations
Author:	Business Managers
Report date:	14 February 2017

Operational Performance: Targets, Delivery and Key Performance Indicators

1. Diagnostic Waits

There were three Sleep study diagnostic breaches in January out of a total of 675 diagnostic waiters. The sleep breaches related to staff vacancies and inability to schedule all patients within the time period. Radiology had no diagnostic breaches in December. The trust delivered against the diagnostic target of 99% of patients to have their diagnostics completed within 6 weeks of referral with a 99.56% compliance rate

2. Monitor 18 RTT Open Pathway Target

The Trust achieved 91.54%% against the 92% target for December and the 91.50% trajectory (0.5% tolerance for STP funding in Q3). The trust is currently (at the time of writing) reporting 90.84% for January with final submission date after validation on the 17th February. The service pressures in attaining this target are as described in last 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 December:-

	Over 18	Under 18	Total	Percentage
Corneo	67	1357	1424	95.29%
Max Fax	398	2919	3317	88.00%
Plastics	240	2666	2906	91.74%
Cardiology	7	73	80	91.25%
Rheumatology	2	41	43	95.35%
Other - sleep	17	858	875	98.06%
Total	**731**	**7914**	**8645**	**91.54%**

A summary of achievement against the STP trajectories for 18RTT and 62 CWT are included in **Appendix 1.**

3. 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 January, the weekly activity was 173; 238; 221; and 219 respectively – giving a weekly average of 213 compared to a weekly average of 212 cases in December & 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;
- The trend of day case activity increasing with the associated issues previously discussed continues.
- In January there was a water leak issue and a heating issue in DTC leading to cancellations of both out-patient and theatre activity equating to around £20K.

4. Elective/In Patient Activity

- Year to date the weekly average of elective in-patients has been 75; in January this was 50; 82; 82; and 80 respectively – giving a weekly average of 74 compared to a weekly average of 66 in December;
- 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.

5. Medway Backlog

- The work highlighted in last month's report continues;
- In the meantime, where we can, we are putting extra clinics on at Medway in an ad hoc manner due to their capacity constraints;
- For context, Medway has the third longest 18RTT waits in the country.

6. Cancelled Operations

- There were no breaches of the 28 day cancelled operation standard in January;
- There were 26 operations cancelled on the day in January – of which 23 were elective cases; 3 were urgent operations;
- 10 day cases in plastics were cancelled due to the water leak and heating issue in Day Treatment centre; the other 4 were cancelled due to lack of time or equipment issues;
- 5 Max Fax case were cancelled due to the water and heating issues and 1 due to lack of time;
- 2 Corneo patients were cancelled due to lack of time on the day due to other cases taking longer than expected;
- 3 urgent Max Fax cases were cancelled on the day but were all rescheduled within 7days.

7. Monitor Cancer Standards

- Below is the Trusts performance for December 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 patient's choice to delay; the other required multiple diagnostic tests.

Month	Target	Standard	Total	Breaches	Performance
December	2WW GP referral to first seen (urg. susp. cancer)	93%	164	11	93.3%
December	31 day Decision to first treatment	96%	87	8	90.8%
December	31 day Decision to subsq treatment (surgery)	94%	34	2	94.1%
December	62 day GP referral to first treatment	85%	35.5	6	83.1%
December	62 day Consultant upgrade to first treatment	85% (local)	3	1	66.7%

8. Actions within Cancer

These continue as highlighted in previous reports

9. 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.

10. Max Fax/Oral Surgery Business Unit

- The key focus point for Max Fax/Oral Surgery Business Unit is to increase activity and improve performance against the open pathway target of 92%;

- Additional Saturday lists have been scheduled until the end of March 2017 to reduce the current waiting list;
- Additional Saturday and evening minor oral surgery clinics continue to run and an audit is to be undertaken in relation to these clinics to ensure full utilisation of these sessions;
- Continued assessment of outpatient procedure coding to ensure the appropriate codes are available to the outpatient team at each appointment;
- The business case for transferring in patient and trauma max fax work from East Sussex Hospital Trust was approved and is now moving into the implementation phase with a planned start date of April 1st 2017;

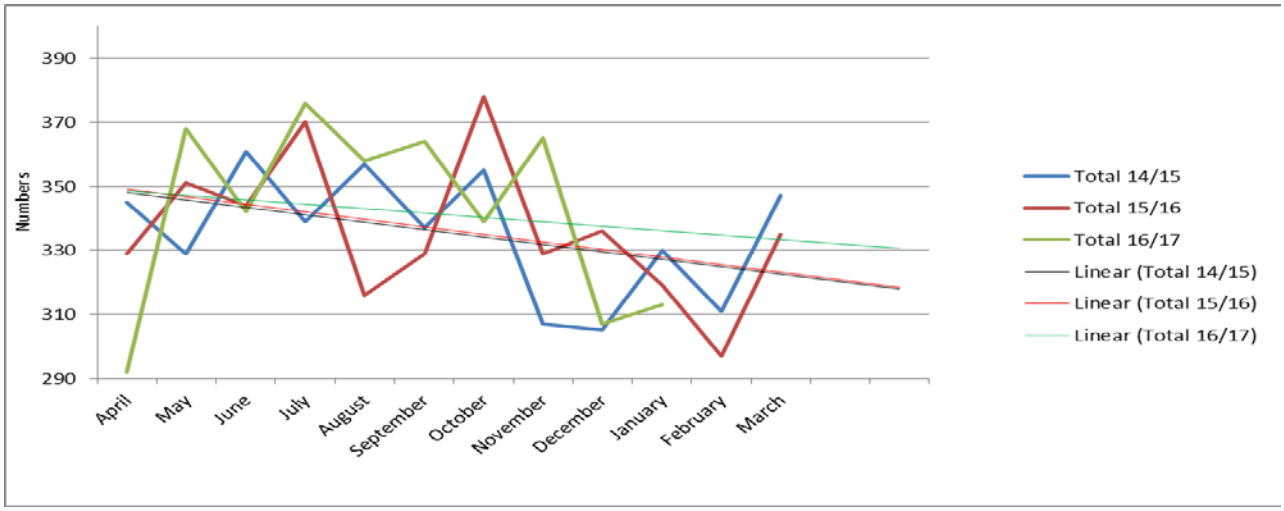
11. Plastics Business Unit

- Activity overall in breast continues to be below plan in month 10 predominantly in day cases and out-patient follow-ups;
- Hands activity was below plan in month 10 in both non-elective surgery and first out-patient appointments;
- Skin continues to perform above plan in day cases; and both first and follow-up appointments;
- Skin day cases are now 695 above plan year to date; which if this continues equates to approximately 830 cases above plan by year end compared to the prediction of 740 above plan by the end of month 8;
- In month 10 plastics was slightly below activity plan mainly due to non-elective activity but overall year to date plastics is above activity plan mainly due to the increased skin referrals;
- ITU activity within plastics is not achieving and hence its income plan is below plan;
- 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%;
- A final detailed implementation and mobilisation plan is being developed in relation to the successful West Kent Dermatology tender

12. 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; 4 in November; 4 in December 2016; and 5 in January 2017
- For the final three months of the year, theatre three will revert to elective activity;
- The total amount of trauma activity over the last three financial years can be seen in the graph below & is showing a consistent downward trend with the trend in 14/15 and 16/17 being nearly identical. It can be seen that there is always a decrease in the winter months with higher volumes in the summer months. However overall, there appears to be a case to convert theatre three back to an elective theatre and to use it flexibly if trauma volumes warrant it converting back to a trauma theatre.

Trauma Activity – Number of Cases



13. 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;
- Activity in the business unit has increased above plan but a case mix reduction with elective and non elective work has had a significant impact on income and break even position. A recovery plan to increase income, reduce costs and improve the run rate position by year end is being developed by the business unit;
- There is ongoing work to review what appears to be a change in case mix and continued decline in non-elective and elective activity alongside a decrease in Outpatients procedures over the current year;
- The femtosecond laser has been commissioned with the first cases being undertaken in February. The service is repatriating activity that has been outsourced to a private provider. The Trust will continue to use the external provider for some but less frequently. This will reduce costs and give resilience to the 18RTT position as currently these patients breach the standard. Therefore once the backlog has been cleared this will contribute to the overall trust attainment of the 18RTT target and trajectory.

14. Sleep Services

- The data for December 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;
- A spoke sleep service is due to start in April at the Bognor Regis War Memorial Hospital. This will improve the experience for patients from this area who can be seen locally. The plan is to increase referrals from this region to continue to support the growth of the business unit;
- The sleep department remain challenged with regard to staffing. Additional staff (agency and locums) has 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. The use of agency staff will continue until the unit have recruited all staff. Three staff have resigned in December and means our use of agency will continue but the service is working to convert as many agency staff as possible to bank staff or substantive staff;

15. Clinical Support Services

- The new AQP Community ENT service has now started across four sites (including QVH), with continued higher demand than expected in the first three months, especially from Coastal West Sussex. Discussion around expansion of services is already taking place with a likely additional clinic in Coastal West Sussex from April/May 2017.
- QVH continues to work with the Healthy East Grinstead Partnership (a rapid test site for Primary Care Home) and in particular continues to develop MSK self-referral and other smaller projects to improve primary care capacity locally. In addition the new Respiratory service is planned to start in the next few months;

- 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.

16. MIU

The Trust MIU performance in January was 99.75%.

17. Link to Key Strategic Objectives

- Outstanding patient experience
- Operational excellence
- Financial sustainability

18. Implications for BAF or Corporate Risk Register

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

19. 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'.

20. Recommendation

The Board is asked to **NOTE** the contents of the report.

Appendix 1 – Trajectory Performance for 18RTT and 62CWT

RTT 18	Open Pathways												
	Baseline	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Trajectory	92.90%	92.0%	92.0%	92.0%	92.0%	92.0%	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%	92.2%				
YTD		92.1%	92.4%	92.1%	91.7%	91.6%	91.6%	91.58%	91.66%				
End of Qtr Position		Quarter 1		92.1%	Quarter 2		91.1%	Quarter 3			Quarter 4		

Cancer	CWT 62 Day												
	Baseline	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Trajectory	83.5%	81.6%	81.6%	81.3%	81.6%	81.6%	81.6%	85.4%	85.3%	85.3%			
Actuals		82.9%	67.5%	91.1%	90.4%	80.0%	71.4%	77.1%	89.7%	83.1%			
YTD		82.9%	74.7%	80.8%	83.7%	83.0%	81.1%	80.46%	81.52%				
End of Qtr Position		Quarter 1		81.1%	Quarter 2		81.2%	Quarter 3			Quarter 4		

Appendix 2 – Cancer Breaches

62 Day Referral to Treatment

Reporting Mth	Tumour Type	First seen Trust	Treating Trust	Wait Days	Breach reason	Accountability
Nov-16	Skin	Medway NHS Foundation Trust	Queen Victoria NHS Foundation Trust	68	Referral received at QVH from MMH on day 36	0.5
	Skin	Medway NHS Foundation Trust	Queen Victoria NHS Foundation Trust	112	Referral received at QVH from MMH on day 60	0.5
	Skin	Medway NHS Foundation Trust	Queen Victoria NHS Foundation Trust	111	Patient referred to QVH from MMH on day 69	0.5
	Skin	Brighton & Sussex University Hospitals NHS Trust	Queen Victoria NHS Foundation Trust	65	Administration error - incorrect referral date	0.5

31 Day to First Treatment

Reporting Month	Tumour Type	Wait Days	Breach reason
Nov-16	Breast	34	Joint Operation required BSUH & QVH - two surgeons to be available on the same day.
	Skin	84	BCC suspected– on excision SCC
	Skin	34	Patient choice to delay
	Skin	46	BCC suspected – on excision SCC
	Skin	36	BCC suspected – on excision SCC
	Skin	53	BCC suspected – on excision SCC
	Skin	63	BCC suspected – on excision SCC
	Skin	38	BCC suspected – on excision SCC
	Skin	36	BCC suspected – on excision SCC
	Skin	47	BCC suspected – on excision SCC
	Skin	37	BCC suspected – on excision SCC

31 day to Subsequent Treatment (surgery)

Reporting Month	Tumour Type	Wait Days	Breach reason
Nov - 16	Skin	36	BCC suspected – on excision SCC

2 Week Waits

Reporting Month	Tumour Type	Wait Days	Breach reason
Nov -16	Head & Neck	18	Patient choice - Sickness Pt sickness cx 15th accepted 22/11.
	Head & Neck	17	Patient choice
	Head & Neck	15	Patient choice - Unable to attend on 02.11 as no transport - hospital transport offered.
	Skin	18	Patient choice - previous appointment cancellation. 22/11 cx by pt on the day as child unwell.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**02/03/2017**		**Agenda reference:**	**48-17**	
Report title:	**Finance Report M10 January 2017**				
Sponsor:	Clare Stafford, Director of Finance and Performance				
Author:	Jason McIntyre, Deputy Director of Finance				
Appendices:	Finance Report M10 January 2017				
Executive summary					
Purpose:	The report details the Trust's financial performance for the 10 months to 31st January 2017. The Trust delivered a deficit of £76k in month; £269k below plan and £134k less than forecast. The YTD surplus has reduced to £1.6m.				
Recommendation:	The Board is asked to note the contents of this report.				
Purpose: [one only]		Information **Y**	Discussion **Y**	Assurance **Y**	Review **Y**
Link to key strategic objectives (KSOs): [Tick which KSO(s) this recommendation aims to support]			KSO3: **Y**	KSO4: **Y**	KSO5: **Y**
			Operational excellence	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:					
Corporate risk register:					
Regulation: [What other standards are likely to be impacted by the proposal – such as NHSLA or CQC]	The finance and use of resources score is 2.				
Legal:					
Resources:					
Assurance route					
Previously considered by:	Finance & Performance Committee				
	Date:	20/02/17	Decision:	N/A	
Next steps:	N/A				

Queen Victoria Hospital
NHS Foundation Trust

Finance Report
January 2017

Executive Director: Clare Stafford

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Summary Position – YTD M10 2016/17

Queen Victoria Hospital NHS
NHS Foundation Trust

Table 1 – Plan Performance

Financial Performance	2016-17	January 2017			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	4,996	5,342	(346)	52,001	52,766	(766)
Other Income	4,407	461	332	129	4,173	3,760	413
Total Income	**67,488**	**5,457**	**5,674**	**(217)**	**56,174**	**56,527**	**(353)**
Pay	(42,565)	(3,536)	(3,544)	8	(35,510)	(35,466)	(44)
Non Pay	(18,721)	(1,645)	(1,522)	(124)	(15,577)	(15,588)	10
Financing	(4,275)	(351)	(356)	5	(3,445)	(3,563)	117
Total Expenditure	**(65,561)**	**(5,533)**	**(5,422)**	**(111)**	**(54,532)**	**(54,616)**	**84**
Surplus / (Deficit)	**1,927**	**(76)**	**252**	**(328)**	**1,641**	**1,910**	**(269)**
Surplus (Deficit) %	2.9%	-1.4%	4.4%	-5.8%	**2.9%**	3.4%	**-0.5%**
Adj. Donated Depn.	(288)	(20)	(24)	4	(205)	(240)	35
NHSI Contol Total	**2,215**	**(56)**	**276**	**(332)**	**1,846**	**2,150**	**(304)**

Table 2 – Forecast Performance

Forecast performance at Month 10	Forecast	Actual	Variance
Category (£k)	M10	M10	M10
	£000	£000	£000
Total Clinical Income	**5,316**	**4,996**	**(320)**
Total Non Clinical Income	**410**	**461**	**51**
Total Income	**5,726**	**5,457**	**(269)**
Pay expenditure	**(3,590)**	**(3,536)**	**54**
Non pay expenditure	**(1,702)**	**(1,646)**	**56**
Financing	**(376)**	**(351)**	**25**
Total Expenditure	**(5,668)**	**(5,533)**	**135**
Baseline Surplus/ (Deficit)	**58**	**(76)**	**(134)**

Summary - Plan Performance

- The Trust delivered a deficit of £76k in month; £328k behind plan and £134k less than forecast. The YTD surplus has decreased to £1.6m, £269k less than plan.
- Income is £217k less than plan.
- The clinical income deficit of £346k includes:
  - Sustainability and Transformation funding for M10 of £75k has not been recognised as the control total has not been achieved.
  - Patient activity income has underperformed in month within emergency activity, , continuing Critical Care underperformance and Day case/Elective underperformance.
- Other Income over performance is driven by EDM £75k offset by an equivalent overspend in the non pay position, and Clinical Excellence Award income offset within pay .
- Pay is underspent by £8k in month. The underlying overspends within medical staffing and theatres have continued in month which has been partly offset by unfilled vacancies and the re-categorisation of agency recruitment costs to non pay expenditure.
- Non-Pay is overspent by £124k in month. £75k relates to EDM expenditure offset within other income. A further £35k relates to reclassification of agency recruitment fees. The underlying overspend on clinical supplies is lower this month (£78k) due to less activity in month and is partially offset this month by non-recurrent IT underspend.
- The Single Oversight Framework finance and use of resources score is 2 – which is the second highest rating achievable (Appendix 1).

Summary - Forecast Performance

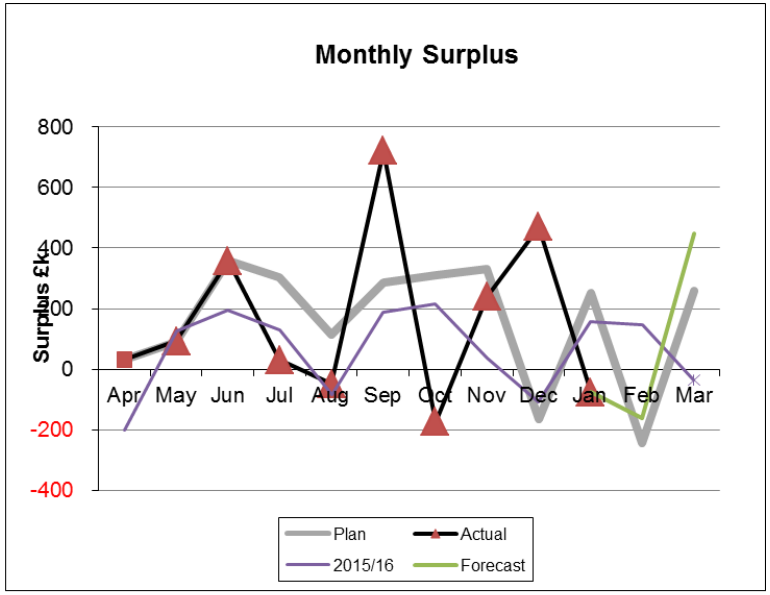
- The actual performance is £134k less than forecast.
- Income is less than forecast due to the material reduction in emergency activity in month and a further deterioration within critical care and underlying planned activity trends.
- Pay is less than forecast due to non recurrent reclassification of agency recruitment fees as non-pay expenditure.
- Non pay is less than forecast due to reduction in clinical supplies expenditure due to reduced activity in month and non-recurrent IT savings.
- The Trust retains the forecast to achieve plan by the end of the year although there is a significant risk to delivery as a result of M10 financial performance.

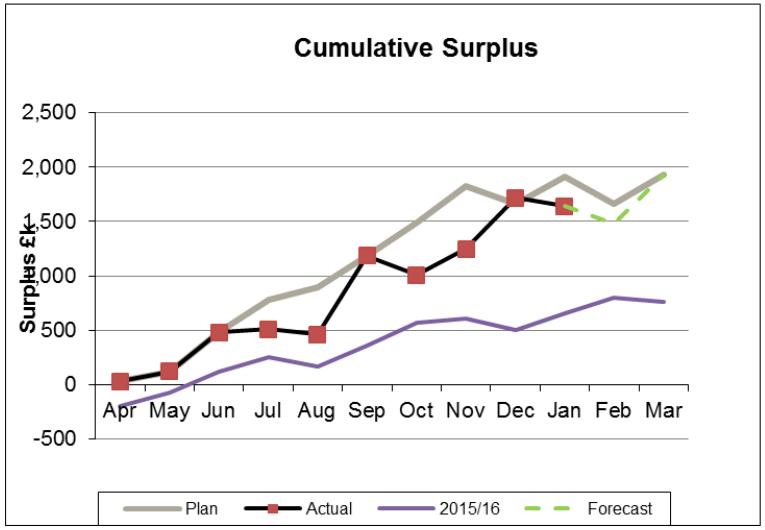
Action

- **Recovery plan actions continue to be developed to ensure plan is delivery by the end of the year**

Surplus Trend Position – M10 2016/17

Queen Victoria Hospital
NHS Foundation Trust





Summary

- There is a £76k deficit in month against a planned surplus of £252k and a forecast surplus of £58k.
- 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.
- The Trust has to delivery a further surplus of £329k (£286k to meet plan & £43k offset the reduction in donated deprecation reduction) in last two months of the year to meet plan and the control total.

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

Activity Performance by POD : M10 2016/17

Queen Victoria Hospital NHS Foundation Trust

Table 1 - Performance by POD

Activity Performance		Month 10 (January)			Month 10 (January)			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	M09	M10	Trend
Minor injuries	Attendances	1,078	837	(241)	72	56	(16)	10,594	8,877	(1,717)	706	591	(114)	799	921	859	989	917	961	912	865	817	837	
Elective (Daycase)	Spells	1,023	1,045	22	1,095	1,063	(32)	9,995	10,336	341	10,704	10,551	(153)	973	1,019	1,061	1,076	1,009	1,004	1,056	1,064	1,029	1,045	
Elective	Spells	333	323	(10)	804	779	(25)	3,273	3,255	(18)	7,901	7,506	(395)	345	302	325	318	311	343	352	326	310	323	
Non Elective	Spells	439	384	(55)	951	834	(116)	4,313	4,353	40	9,342	9,845	503	379	445	433	497	440	473	446	440	416	384	
XS bed days	Days	92	62	(30)	24	16	(8)	903	865	(38)	231	221	(10)	237	130	111	19	66	64	66	39	71	62	
Critical Care	Days	74	44	(30)	140	44	(96)	724	564	(160)	1,379	713	(666)	58	76	47	59	89	45	66	37	43	44	
Outpatients - First Attendance	Attendances	3,644	3,588	(56)	464	455	(8)	35,770	37,169	1,399	4,549	4,716	167	3,666	3,834	3,836	3,505	3,861	3,845	3,815	3,935	3,284	3,588	
Outpatients - Follow up	Attendances	10,379	10,346	(33)	873	903	30	101,948	102,349	401	8,573	8,733	160	10,198	10,112	10,641	9,715	10,042	10,491	10,312	11,042	9,450	10,346	
Outpatient - procedures	Attendances	2,304	2,270	(34)	348	327	(21)	22,640	21,384	(1,256)	3,419	3,133	(286)	2,201	2,117	1,980	1,953	2,154	2,152	2,099	2,412	2,046	2,270	
Other	Other	2,568	3,095	527	414	416	2	25,233	33,210	7,977	4,074	4,180	106	2,630	2,937	3,061	2,784	3,891	3,823	3,688	3,931	3,370	3,095	
Work in progress and coding adjustment						68	68					68	68											
					5,184	4,963	(221)				50,878	50,257	(621)											

Table 2 - Performance by Service Line

Activity Financial Performance	Month 10 (January)			Year to date		
Service Line	Plan £k	Actual £k	Var £k	Plan £k	Actual £k	Var £k
Clinical Infrastructure	171	177	6	1,680	1,892	213
Clinical Support	401	379	(22)	3,940	3,976	36
Eyes	521	467	(54)	5,050	4,776	(274)
Oral	1,117	1,050	(67)	10,979	10,499	(480)
Plastics	2,656	2,435	(221)	26,093	25,574	(520)
Sleep	303	386	83	2,976	3,464	487
Other incuding WIP/ coding	16	68	52	160	77	(83)
Grand Total	5,184	4,963	(222)	50,878	50,257	(621)

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 income, some private patients, Burns consortium funding .

- Minor injuries attendances are 241 less than plan due to the reduction in opening hours / staffing issues - £16k reduction in the month and £114k YTD.
- Daycase activity in month is 22 spells above plan and £32k under plan (lower complexity) – Oral and Eyes service lines. YTD activity is 341 spells above plan and £153k under financial plan which reflects greater activity at a lower rate of complexity with underperformance in Oral and Eyes being offset by over performance in Plastics but at a lower complexity rate.
- Elective activity in the month has underperformed by 10 spells and £25k (Eyes). Year to date underperformance is: Plastics - Burns (volume) and Breast; Oral-Maxillofacial (casemix and volume); Corneo (volume).
- Non-elective activity has underperformed by 55 spells and £116k in month (Plastics) which is a material deviation from trend. The YTD over performance has reduced to £503k which is largely within Oral, Plastics (Skin and Hands) and Clinical infrastructure (MIU)
- Critical care days have underperformed by 30 days in month and £96k, with an offset adjustment for work in progress. The YTD position of £666k under plan is mainly within Plastics (Skin). The critical care trend has deteriorated significantly in recent months - a reflection of reduced complexity of referred activity.
- Outpatient procedures are £21k under plan in month and £286k YTD spread across Clinical Support, Eyes and Plastics with the exception of sleep which is £92k greater than plan. This underperformance will partially reduce when coding is complete.
- Service line underperformance in month: Plastics £221k due to Breast and Burns, Oral £67k, Eyes £54k – Corneo plastics inpatients. This has been partially offset by Sleep of £83k YTD the key underperformance are within Eyes, Oral and plastics.

Financial Position by Business Unit – M10 2016/17

Queen Victoria Hospital NHS Foundation Trust

Variance by type: in £ks	Activity Income		Other Income		Pay		Non Pay		Position	for January 2017			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	(191)	(636)	34	110	(107)	(568)	(67)	(597)	14,147	903	1,234	(331)	10,199	11,890	(1,690)
1.2 Oral	(114)	(464)	6	39	(28)	(112)	(18)	(61)	7,255	476	630	(154)	5,484	6,083	(599)
1.3 Eyes	(35)	(228)	(5)	(37)	1	61	(17)	(121)	3,625	263	319	(56)	2,703	3,027	(325)
1.4 Sleep	71	476	(5)	(48)	(7)	(85)	(16)	(62)	1,653	188	144	44	1,669	1,389	281
1.5 Clinical Support	(10)	162	39	176	3	125	(16)	(101)	(2,916)	(218)	(234)	16	(2,058)	(2,420)	362
1.6 Other Med & Admin	(24)	(208)	-	-	5	(34)	11	46	(173)	(22)	(14)	(8)	(339)	(143)	(196)
Operations Total	**(303)**	**(899)**	**69**	**239**	**(133)**	**(613)**	**(122)**	**(895)**	**23,591**	**1,591**	**2,079**	**(488)**	**17,657**	**19,825**	**(2,168)**
Nursing & Clinical Infrastructure															
2.1 Clinical Infrastructure	25	322	2	22	93	378	12	(89)	(8,106)	(539)	(670)	131	(6,122)	(6,755)	633
2.5 Director Of Nursing	-	-	8	71	4	106	(0)	17	(1,249)	(92)	(104)	12	(847)	(1,041)	194
Nursing & Clinical Infrastructure	**25**	**322**	**10**	**92**	**97**	**483**	**12**	**(71)**	**(9,356)**	**(631)**	**(774)**	**143**	**(6,969)**	**(7,796)**	**827**
Corporate Departments															
3.1 Non Clinical Infrastructure	-	-	1	60	(5)	(84)	(29)	(134)	(3,885)	(355)	(322)	(33)	(3,399)	(3,242)	(158)
3.2 Commerce & Finance	(9)	(55)	2	3	33	(14)	(15)	(52)	(2,532)	(197)	(209)	11	(2,233)	(2,115)	(118)
3.4 Finance Other	(59)	(134)	73	81	11	226	(40)	1,253	(2,822)	(285)	(271)	(14)	(770)	(2,196)	1,427
4.1 Human Resources	-	-	(2)	19	(6)	(22)	13	(17)	(930)	(69)	(73)	5	(803)	(783)	(20)
5.4 Corporate	-	-	-	9	16	16	4	(6)	(1,626)	(115)	(135)	20	(1,337)	(1,356)	19
6.1 Research	-	-	(24)	(91)	(8)	(62)	35	183	(109)	(7)	(9)	2	(60)	(91)	31
6.2 Clinical Audit	-	-	-	-	3	25	23	(133)	(404)	(8)	(34)	26	(445)	(336)	(108)
Corporate Total	**(68)**	**(189)**	**50**	**82**	**44**	**86**	**(9)**	**1,093**	**(12,308)**	**(1,035)**	**(1,053)**	**17**	**(9,047)**	**(10,119)**	**1,072**
QVH Total	**(346)**	**(766)**	**129**	**413**	**8**	**(44)**	**(119)**	**127**	**1,927**	**(76)**	**252**	**(328)**	**1,641**	**1,910**	**(269)**

Summary

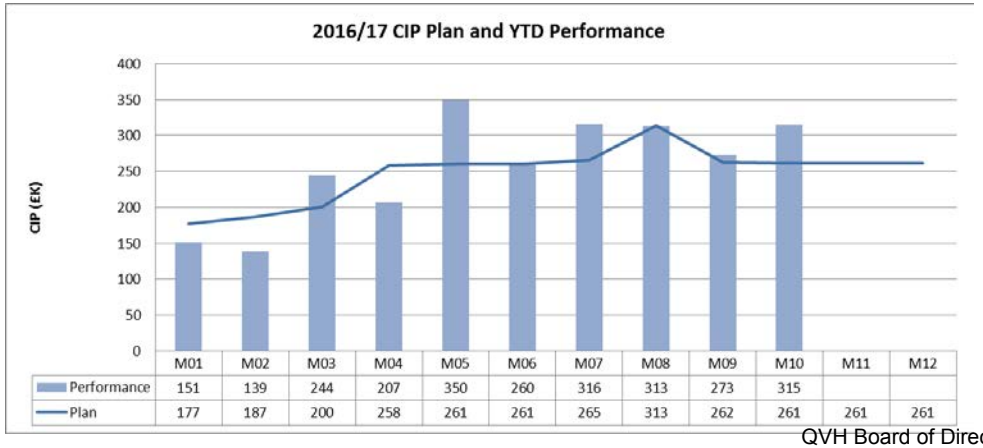
- Activity Income: £346k below plan for the month, being primarily Plastics and Oral. Finance Other underperformance reflects the M10 Sustainability Transformation Funding of £75k which has not been recognised. The year to date position is £766k below plan with material underperformance within the Plastics, Oral and Eyes Business Units.
- Other income: the positive variance in month is due to matching the additional EDM expenditure, CEA award and RTA income.
- Pay: The underspend of £8k in month includes the movement of £35k recruitment fees to non-pay. There is an underlying over-spend largely due to medical pressures within Plastics and Maxillofacial, overspends on agency and locums and temporary payments, Anaesthetics SPR posts and theatres agency staff.
- Non Pay expenditure, including financing, is overspent by £119k in month. Additional costs this month for EDM (£75k) and recruitment fee reclassification (£35k) are both offset within income or pay. Various non recurrent savings, including IT licences, of £80k in month help mitigate the underlying deficit of circa £100k per month within clinical equipment and supplies, which has dipped this month. For the year to date this had been offset by planned interventions. The significant variance in Finance reflects planned reserves release.

CIPP – M10 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	1,070	1,301	231	1,282	1,566	284
Non pay - Drugs	90	84	54	(30)	90	54	(36)
Non pay - Other	319	258	170	(89)	319	209	(110)
Non pay - Supplies	231	184	194	9	231	235	4
Pay	1,047	849	849	-	1,047	1,047	-
Grand Total	**2,968**	**2,446**	**2,567**	**122**	**2,968**	**3,111**	**143**

Table 2 - Performance by area £k	Annual plan	YTD CIP Plan	YTD Actual	YTD Variance	Annual plan	Forecast	Forecast Variance
Clinical Infrastructure & Nursing	605	482	432	(50)	605	545	(60)
Clinical Support	279	228	229	1	279	280	0
Corporate	572	469	452	(17)	572	539	(33)
Eye	343	281	238	(43)	343	299	(44)
Oral_Maxfax	362	286	82	(204)	362	114	(248)
Plastics	392	352	354	1	392	392	-
Plastics_Peri-Op	296	247	257	9	296	300	4
Sleep	120	100	523	423	120	643	523
Grand Total	**2,968**	**2,446**	**2,567**	**122**	**2,968**	**3,111**	**143**



Cost Improvement & Productivity Programme (CIPP)

- At M10 the Trust has achieved 105% of planned Cost Improvement Programme YTD.
- Overall the Trust CIP has achieved £2.57m savings against the YTD plan of £2.45m.
- The YTD position is attributable to over performance in Sleep (£423k) and Radiology (78k).
- The following areas are currently underperforming this year: ENT AQP £65k, ENT BSUH Initiative £76k, Urology activity £27k, review of spoke site SLA £35k and savings from maintenance contract £20k.
- The Trust is forecasting a savings of £3.1m, in line with the 2016/17 CIPP target – Table 3, based on the YTD performance.
- The Trust has identified recovery plans which will offset the underperformance of total CIPP target. The Business unit recovery plans identified £56k of saving in month and £214k YTD.
- The Femtosecond Laser activity is due to start in February, which will contribute to the CIPP position. Additional recovery plans (theatres 3) has started and delivered 33 spells in month.

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	(70)
Corporate	510	572	63	(33)	29
Eye	135	343	208	(44)	164
Oral_Maxfax	379	362	(18)	(248)	(266)
Plastics	353	392	39	-	39
Plastics_Peri-Op	590	296	(295)	4	(291)
Sleep	103	120	17	523	540
Grand Total	**3,100**	**2,968**	**(131)**	**143**	**11**

Balance Sheet – M10 2016/17

Queen Victoria Hospital NHS
NHS Foundation Trust

Balance Sheet as at the end of January 2017	2015/16 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	43,588	43,207	43,123
Other Receivables	-	-	-
Sub Total Non-Current Assets	43,588	43,207	43,123
Current Assets			
Inventories	439	440	456
Trade and Other Receivables	5,846	6,207	7,347
Cash and Cash Equivalents	7,285	8,069	6,729
Current Liabilities	(7,654)	(7,522)	(7,178)
Sub Total Net Current Assets	5,915	7,194	7,354
Total Assets less Current Liabilities	49,504	50,401	50,477
Non-Current Liabilities			
Provisions for Liabilities and Charges	(572)	(606)	(606)
Non-Current Liabilities >1 Year	(7,378)	(6,600)	(6,600)
Total Assets Employed	**41,553**	**43,195**	**43,271**
Tax Payers' Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	20,174	21,815	21,891
Revaluation Reserve	9,143	9,143	9,143
Total Tax Payers' Equity	**41,553**	**43,195**	**43,271**

NB Analysis is subject to rounding differences

Summary

- Total assets employed have reduced by £76k in month due increases in liabilities which has been partially offset by an increases in current assets.

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 – M10 2016/17

Queen Victoria Hospital NHS
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	117	370	253	585	(35)
Education and Wellbeing Centre	250	-	-	-	-	250
Trauma Centre	140	-	80	80	132	8
Car parking - general	100	2	90	88	10	90
Other projects	646	560	601	41	567	79
Estates projects	**1,686**	**679**	**1,141**	**462**	**1,294**	392
Medical Equipment	**354**	**514**	**324**	**(190)**	**822**	**(468)**
IT Equipment & Software						
Infrastructure Improvement Programme (IIP)	400	388	400	12	400	-
Electronic Document Management (EDM)	600	381	500	119	600	-
Other projects	82	7	28	21	7	75
IT Equipment & Software	**1,082**	**776**	**927**	**151**	**1,007**	75
Total capital spend	**3,122**	**1,969**	**2,392**	**423**	**3,122**	**-**

Summary

- The capital programme is £423k (18%) behind plan at the end of January.
- The Estates programme is £462k (40%) behind plan. The principal development within the Estates programme is the backlog maintenance. Six business cases for works identified in the site-wide condition survey are now being implemented and are planned to be completed in 16/17 with the exception of part of the Jubilee Building roofing work which will be carried out in early 17/18. The remainder of the programme has been reviewed and unutilised funds made available for additional medical equipment.
- Medical equipment expenditure is £190k (60%) above plan as a result of the purchase of a femtosecond laser and other items funded from reductions in the Estates programme.
- The 2016/17 IT programme mainly consists of the remainder of the Infrastructure Improvement and Electronic Document Management (EDM) projects which started in 2015/16. The infrastructure project is now complete and EDM is being rolled out across the trust, to be concluded in 17/18. Other, smaller projects have been postponed.

Issues

- Achievement of the annual plan is still largely dependent on achievement of the revised Estates programme.

Risks

- A large part of the estates programme must be completed in the final weeks of the year if the annual plan is to be achieved. This could be jeopardised by bad weather.

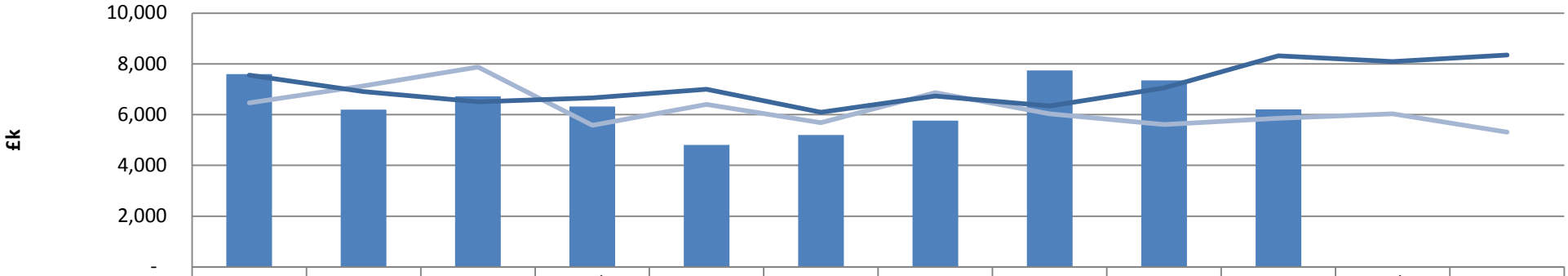
Action

- Progress is being closely monitored by the Capital Planning Group and estates programme via weekly meetings with Estates team.

Debtors – M10 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	7,347	6,207		
Total 2015/16	6,462	7,137	7,879	5,581	6,405	5,678	6,871	6,033	5,609	5,853	6,033	5,315
Total 2014/15	7,553	6,911	6,505	6,658	6,995	6,092	6,735	6,342	7,052	8,323	8,093	8,351

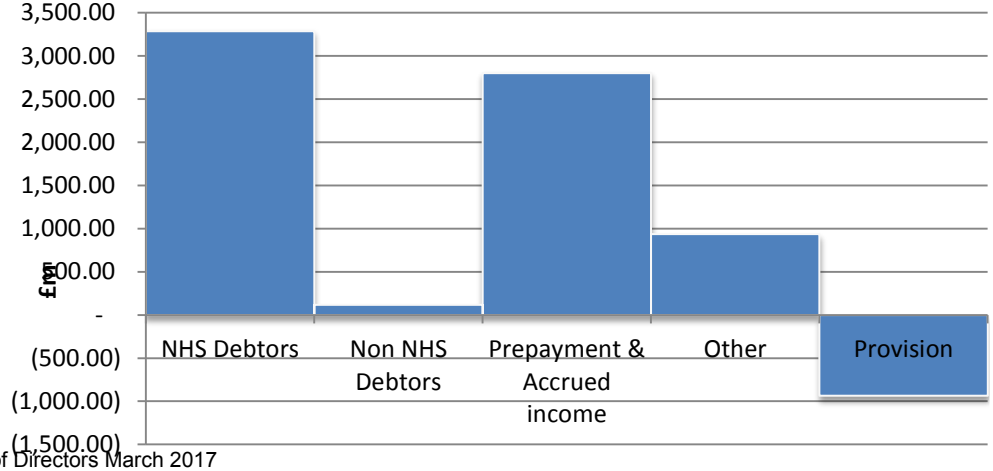
Summary

- The debtor balance decreased by £1.1m (15%) from M9. This is due to receipts from commissioners for over performance and outstanding SLA invoices.
- The month 10 debtor balance of £3.2m is on par with the average monthly balance in 2015-16.
- At M10 there is £1.51m of accrued income for activity over-performance and NCAs which is an decrease of £5k compared to the previous month.

Next Steps

- Financial services continue to work closely with business managers to ensure billing is accurate, timely and resolutions to queries are being actively pursued.
- Financial services are focusing on reducing aged debt, in particular with local provider trusts, in time for year end.

Debtors 2016/17



Cash – M10 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**	**6.729**	***8.069***	***7.775***
Receipts from invoiced income	3.576	6.771	5.787	6.294	6.021	5.230	5.177	3.714	5.700	6.117	*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	0.316	0.158	*0.100*	*0.100*
Total Receipts	**3.749**	**6.980**	**5.911**	**6.441**	**6.836**	**5.382**	**5.351**	**3.964**	**6.016**	**6.275**	***5.950***	***5.950***
Payments to NHS Bodies	(0.640)	(0.427)	(0.375)	(0.374)	(0.407)	(0.486)	(0.573)	(0.377)	(0.391)	(0.266)	*(0.750)*	*(0.450)*
Payments to non-NHS bodies	(1.608)	(1.669)	(2.878)	(1.541)	(1.527)	(1.277)	(1.377)	(1.998)	(1.291)	(1.266)	*(2.074)*	*(2.074)*
Net payroll payment	(1.901)	(1.881)	(1.983)	(1.890)	(1.939)	(1.914)	(1.920)	(1.939)	(1.936)	(1.922)	*(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)	(0.912)	*(0.900)*	*(0.900)*
Pensions Payment	(0.562)	(0.554)	(0.560)	(0.562)	(0.545)	(0.556)	(0.560)	(0.564)	(0.568)	(0.569)	*(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)**	**(5.605)**	**(4.935)**	***(6.244)***	***(6.511)***
Actual Closing Balance	**5.483**	**7.033**	**5.739**	**6.873**	**8.398**	**8.118**	**8.139**	**6.318**	**6.729**	**8.069**		
Forecast Closing Balance											***7.775***	***7.213***

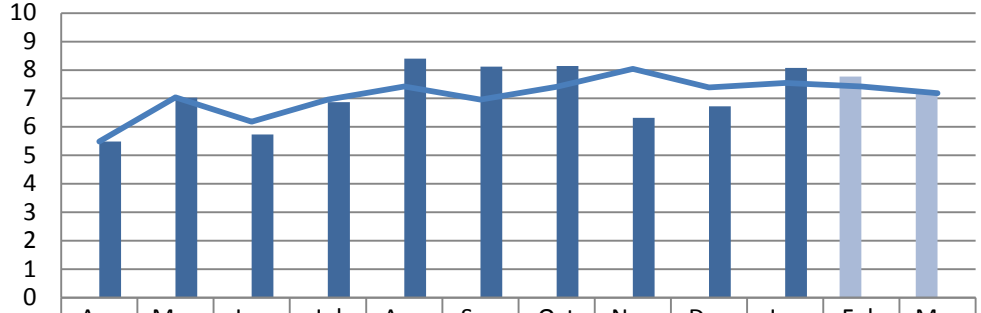
Summary

- The in month cash position is favourable on the basis of current liquidity and debt service ratios.
- The cash balance at the end of M09 has a favourable variance of £0.5m against the plan. This is due to significantly lower than expected payments for capital projects in month.
- 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

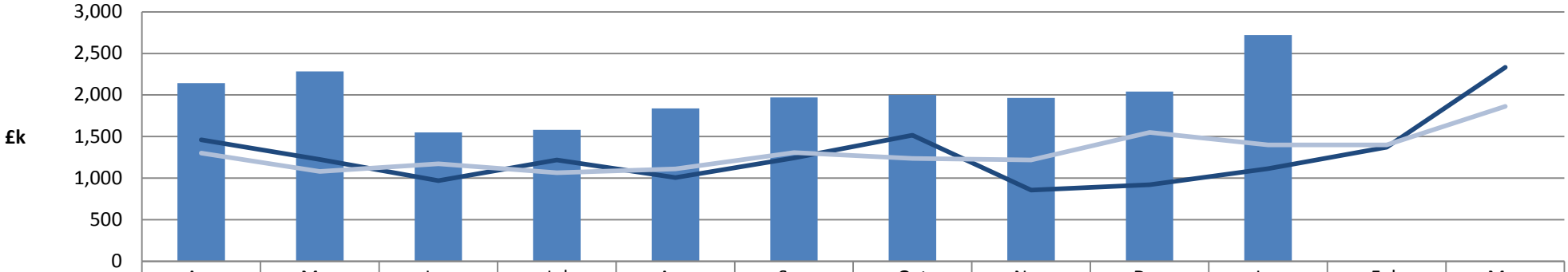


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Forecast											7.775	7.213
Actual	5.483	7.033	5.739	6.873	8.398	8.118	8.139	6.318	6.729	8.069		
Plan	5.483	7.033	6.188	6.965	7.423	6.959	7.407	8.035	7.389	7.540	7.419	7.187

Creditors – M10 2016/17

Queen Victoria Hospital NHS
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	2040	2721		
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 M10 is £2.7m, an increase of £0.7m in month, due to receipt of a large number of provider SLA billing for prior months. The balance will reduce in M11 as invoices are authorised and paid.
- The Trust's BPPC percentage has decreased in month by 5% and the average days to payment has decreased to 31 days. This is due to the knock on effect of the bank holidays in late December and performance is expected to recover.
- Savings from prompt payment discounts taken in month amounted to £2k, in line with plan.

Better Payment Practice Code (16/17) January	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	1,438	1,393	15,201	18,837
Total **Non NHS** trade invoices paid within target	14,769	19,071	1,057	925	12,202	14,689
Percentage of Non-NHS trade invoices paid within target	**85%**	**85%**	**74%**	**66%**	**80%**	**78%**
Total **NHS** trade invoices paid	893	4,538	59	163	602	2,945
Total **NHS** trade invoices paid within target	632	3,289	29	55	344	1,591
Percentage of NHS trade invoices paid within target	**71%**	**72%**	**49%**	**34%**	**57%**	**54%**

Next Steps

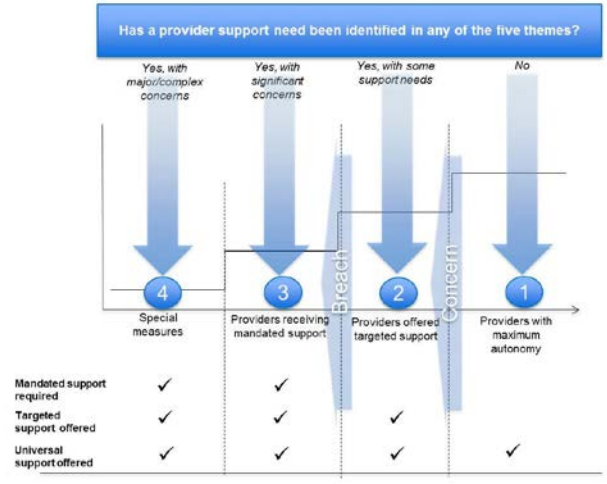
- Financial services and Procurement to continue to monitor breaches of the SFIs on a monthly basis and identify underperforming areas to improve payment times and encourage best practice.

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 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: January 2017					
	Metrics £k	Measure	Rating	Weight	Score
Continuity of Services:					
Capital Service Cover					
Operating surplus	5,087	**2.72**	**1**	20%	**0.20**
Capital Servicing Obligation YTD	1,869				
Liquidity					
Working Capital	6,726	**39.5**	**1**	20%	**0.20**
Operating Costs (per day)	170				
Financial Efficiency:					
I&E Margin (%)					
Surplus (deficit) year to date	1,641	**2.92%**	**1**	20%	**0.20**
Income year to date	56,174				
I&E Margin Variance From Plan					
Actual surplus margin	2.92%	**-0.46%**	**2**	20%	**0.40**
Plan surplus margin	3.38%				
Agency Cap					
Agency Spend	1,963	**29.74%**	**3**	20%	**0.60**
Agency Cap	1,513				
Use of Resources: January 2017			**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 is calculated as above.

Appendix 3: Forecast for Discussion

Income and Expenditure 2016-17 at Month 9	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	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	5,038	5,370	5,094	4,996	4,816	5,283	62,099	63,082	(983)
Total Non Clinical Income	402	712	440	431	325	304	346	394	359	461	461	461	5,096	4,407	690
Total Income	5,367	5,988	5,773	5,518	5,537	5,934	5,384	5,764	5,453	5,457	5,277	5,744	67,195	67,488	(293)
Pay expenditure	(3,497)	(3,596)	(3,483)	(3,525)	(3,677)	(3,489)	(3,594)	(3,613)	(3,500)	(3,536)	(3,594)	(3,594)	(42,698)	(42,565)	(133)
Non pay expenditure	(1,483)	(1,945)	(1,576)	(1,608)	(1,554)	(1,390)	(1,659)	(1,580)	(1,137)	(1,645)	(1,631)	(1,472)	(18,681)	(18,721)	40
Financing	(355)	(356)	(355)	(355)	(355)	(333)	(306)	(332)	(347)	(351)	(376)	(376)	(4,198)	(4,275)	77
Total Expenditure	(5,336)	(5,896)	(5,415)	(5,488)	(5,586)	(5,212)	(5,559)	(5,526)	(4,984)	(5,532)	(5,601)	(5,442)	(65,576)	(65,561)	(15)
Baseline Surplus/ (Deficit)	31	92	359	30	(49)	722	(175)	238	469	(75)	(324)	302	1,618	1,927	(309)
Cumulative surplus	31	123	481	511	462	1,184	1,009	1,247	1,716	1,641	1,317	1,618			

Summary

The forecast presented last month has been revised based on M10 actual performance.

The deterioration in clinical performance has increased the risk of delivering control total by the end of the year. The forecast scenarios range between best case of achieving plan (£1.9m surplus) and worst cases of a surplus of £1.5m. The most likely is a surplus of £1.6m which is circa £0.3m below plan. This reflects the Trust not receiving STF funding of £0.2m and forecast underperformance of £0.1m which is not material given size of budget. Additional measures continue to be developed to support the delivery of the plan and mitigate position.

The forecast assumes the following :-

- The forecast clinical income has been based on YTD performance with no further material deterioration of clinical income trends anticipated.
- Fines and challenges of c£0.08m.

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	1,513	1,768
Agency Spend:	149	230	122	213	256	190	216	195	239	153			1,963	
Difference:	19	-62	46	-46	-89	-23	-89	-68	-112	-26	127	127	-450	
%age from ceiling:	11.3%	-36.9%	27.4%	-27.8%	-53.6%	-14.0%	-69.7%	-53.2%	-87.7%	-20.6%	100.0%	100.0%	**-29.7%**	

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 since have resulted in the Trust breaching the ceiling.
- The year to date variance to the ceiling is 30% adverse which reduces the use of resources score to 3 for the agency element.
- The use of clinical agency has increased during the course of the year. Q1 Clinical agency represented 47% of agency expenditure whereas Q3 figure has increased to 62%. Nursing agency has increased from an average of £42k month (Q1) to an average of £88k (Q3).
- An agency task and finish group has been established to determine actions to reduce reliance of the Trust on agency staffing going forward.

KSO5 – Organisational Excellence

Risk Owner: Director of HR & OD
Committee: Finance and Performance Committee
Date: 15 February 2017

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
- Staff survey results likely to be more challenging
-lack of revenue funding to support e-solutions in short term

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 . Skill mix in theatres agreed and campaign being planned **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 has met

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02/03/2017**		**Agenda reference:**	**50-17**	
Report title:	**Workforce Report**				
Sponsor:	Geraldine Opreshko, Director of HR & OD				
Author:	Jill Dale, ESR and Workforce Intelligence Manager				
Appendices:	A. Workforce Report				
Executive summary					
Purpose:	The Workforce and OD report for February 2017 (January data) 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: [one only]				Assurance	
Link to key strategic objectives (KSOs): [Indicate which KSO(s) this recommendation aims to support]	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: **Y** *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 bank and agency usage.				
Regulation:	None known				
Legal:	None known				
Resources:					
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	20/03/17	Decision:	Noted	
Next steps:	NA				

Human Resources & Organisational Development

Workforce Report – February 2017

Reporting Period: January 2017

1.1 Contextual narrative

The February 2017 Workforce Report covers the January 2017 reporting period, to note in this report:

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

Staffing and Vacancy Profile

- On the 31st January the difference in the number between budgeted WTE and staff in post (section 2) was ***134 WTE*** with ***a net reduction*** in the Trust staff in post of ***4 WTE*** compared to the previous month end. In January there were ***11 (headcount) starters*** including 2 trainee doctors and ***29 (headcount) leavers*** including 15 trainee doctors with 15.4 WTE (16 Headcount) staff that left the Trust on the 31st January being counted in the staff in post for the date.
- 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.
- The annual business planning process for 2017/18 is underway, Finance and HR are working closely together to refine the processes to tighten establishment control to ensure robust vacancy level monitoring and reporting throughout the year.
- There were ***28 WTE*** non-medical posts progressing through the recruitment process and a further ***5 WTE*** new job offers for non-medical posts

Turnover

- The 12 month rolling turnover rate has ***decreased to 16.7%*** for permanent/fixed term staff but with an increase in the ***monthly turnover*** to **1.4%.** This is because the rolling turnover figure is calculated on a rolling average staff in post numbers in the period and the monthly turnover is based on actual leavers in the month (both figures are excluding rotational trainee doctors). Turnover remains above target figure and work in on-going to address this including information gathering, monitoring, analysis and attendance at the National NHS Employers Workforce Retention Programme.

Contingent Workforce (Temporary Staffing)

- 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.
- Bank and Agency usage (section 5) has increased in January in the Trust and demand for temporary cover remains consistent in specialist clinical areas such as Burns, ITU, Perioperative services for non-medical where we continue to pay over NHSI set agency caps due to national shortages. In Plastic Surgery agency doctors are covering vacancy gaps in the junior doctors training rotation. Agency usage has continued to drop in non-clinical areas as we have replaced agency workers with bank or fixed term contracts or converted existing agency workers onto these alternatives.

Sickness

- The final sickness absence figure (section 6) for December 2016 ***increased*** *to* ***2.9%*** although was slightly lower than the forecast figure. It is anticipated that the indicative figure for January will drop to around 2.9% based on initial data and comparison with previous periods. The top three reasons for sickness in December were: Cold/Cough/Flu at 25%, Anxiety/Stress/Depression at 17% and at Musculoskeletal at 14%

Appraisals & Statutory and Mandatory Training

- In December compliance rates for statutory and mandatory training ***increased to 87.0%.*** To maintain consistency for the remainder of the financial year we will continue to report on eighteen competences and then expand those competences reported in April 2017 to include Fire and Adult Safeguarding Level 2. In April we will also look to revise the RAG rating indicators to help boast training compliance, the new indicators being: Red 0-79%, Amber 80-95% and Green over 95%.
- Appraisal rates have ***decreased to 78.7%*** in the majority of business units and corporate areas of the Trust. On-going support for managers e.g. streamlining documentation, running appraisal training and challenge at performance review meetings will continue to target compliance.

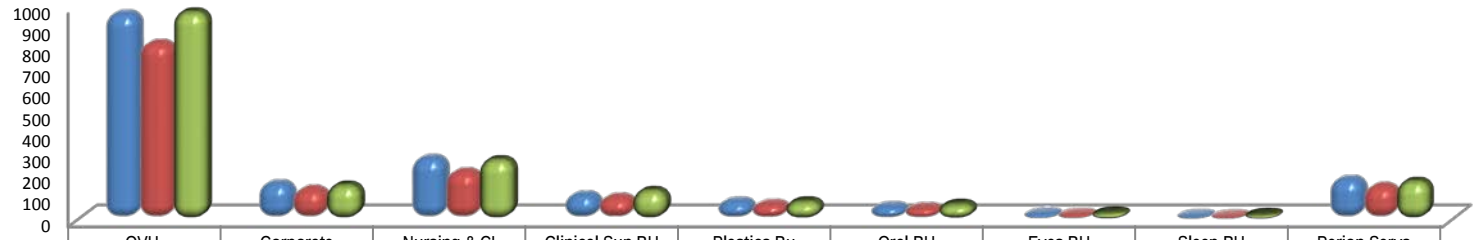
1.2 Summary

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	Dec-16	Jan-17	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	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	833.01	828.91	▼	
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	129.71	133.81	▲	
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%	13.5%	13.9%	▲	
Agency WTE	Healthroster	Fill by Agency Workers expressed as a WTE of hours worked				4.5	16.5	19.5	14.11	15.68	25.77	24.98	25.73	29.73	30.69	30.84	25.22	26.04	▲	
Bank WTE *Note 2*	Healthroster	Fill by Bank Workers expressed as a WTE of hours worked				27.4	30.2	37.2	29.83	28.50	32.87	26.12	28.80	28.09	31.25	37.40	31.22	35.72	▲	
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%	17.6%	16.7%	▼	
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%	1.3%	1.4%	▲	
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%	98.5%	98.7%	▲	
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%	2.7%	2.9%	***2.8%***	***January 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%	86.8%	87.0%	▲	
% 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%	80.1%	78.7%	▼	
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			Qtr 4 results pending	▼ 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			Qtr 4 results pending	▼ Responses ▼Likely ▲ Unlikely	

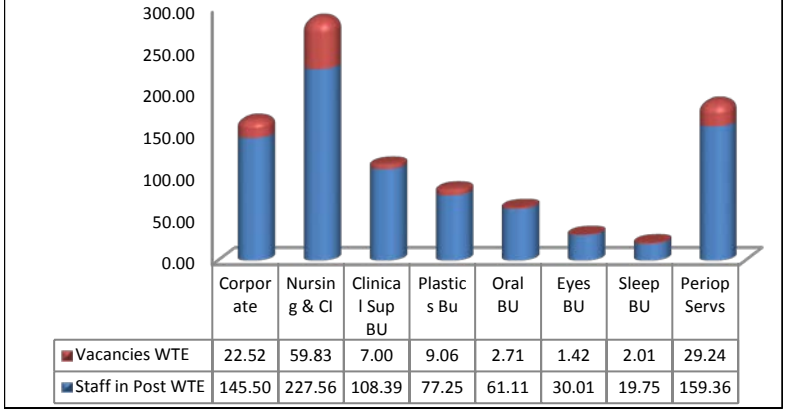
*Note 1 - 2016/17 Establishment not available in April data reporting period updated in May, and in June when finalised version became available
*Note 2 - Bank WTE does not include extra hours worked by medical staff within establishment or overtime worked by all staff groups
*Note 3 - Turnover has been 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 January 2017



	QVH	Corporate	Nursing & Cl	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	828.93	145.50	227.56	108.39	77.25	61.11	30.01	19.75	159.36
Headcount	971	160	280	135	85	73	34	26	178



	Corporate	Nursing & Cl	Clinical Sup BU	Plastics Bu	Oral BU	Eyes BU	Sleep BU	Periop Servs
Vacancies WTE	22.52	59.83	7.00	9.06	2.71	1.42	2.01	29.24
Staff in Post WTE	145.50	227.56	108.39	77.25	61.11	30.01	19.75	159.36

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

Business Unit	Vacancies as % of Estab	Vacancies WTE	Comparison to last month
Corporate	13.40%	22.52	▼
Nursing & Clinical Infrastructure (all staff)	20.82%	59.83	▲
o *of which* Nursing	25.08%	41.54	▲
o *of which* HCAs	17.76%	8.13	▼
Clinical Support BU	6.07%	7.00	▼
Plastics BU	10.50%	9.06	▲
Oral BU	4.25%	2.71	◄►
Eyes BU	4.52%	1.42	▼
Sleep BU	9.24%	2.01	▲
Perioperative Services (all staff)	15.50%	29.24	▲
o *of which* Nursing & Theatre Pract.	24.86%	25.36	▲
o ***of which* HCA's & Student Pract.**	14.56%	6.44	▼
QVH Total	**13.90%**	**133.79**	▲

3. Recruitment Activity for January 2017

Number of Posts Advertised (Non-Medical)	33.09 WTE
Number of New Job Offers (Non-Medical)	4.80 WTE
Number of Candidates (Non-Medical) already in the Recruitment Process (as at month end) – job offers made, candidates not yet started	28.15 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	3.00	4.00
Nursing & CI (all staff)	11.79	13.55
o ***Of which*** **Nursing Staff**	7.79	4.91
o ***Of which*** **HCA's**	1.00	5.64
Clinical Support	2.5	3.8
Plastics Business Unit	1.00	0.00
Eyes Business Unit	0.00	0.00
Sleep Business Unit	0.80	1.80
Oral Business Unit	0.00	0.00
Perioperative Services (all staff)	14.00	5.00
o ***Of which*** **Nursing & Theatres Practitioners**	12.00	1.00
o ***Of which*** **HCA's/Student ODPs**	2.00	2.00
Total (QVH Overall)	33.09	28.15

Medical and Dental Recruitment

Recruitment in Plastic Surgery continues to present an on-going challenge at Registrar level and Plastics is still reliant on locums until March, however this should drop from 4 to 2 vacancies in February. One Registrar started in January 2017 reducing the locum requirement and other posts are being advertised.

At Consultant level in Plastic Surgery, there are two NHS locums one covering a phased return and the other, a career break (anticipated return July 2017). In addition, recruitment is underway with NHS locum cover anticipated for the resignation of a Consultant Plastic Surgeon, due to finish end of March 2017. Additionally, a further Consultant Plastic Surgeon (new post) will be recruited at the same time which is split between BSUH and QVH (breast and lower limb).

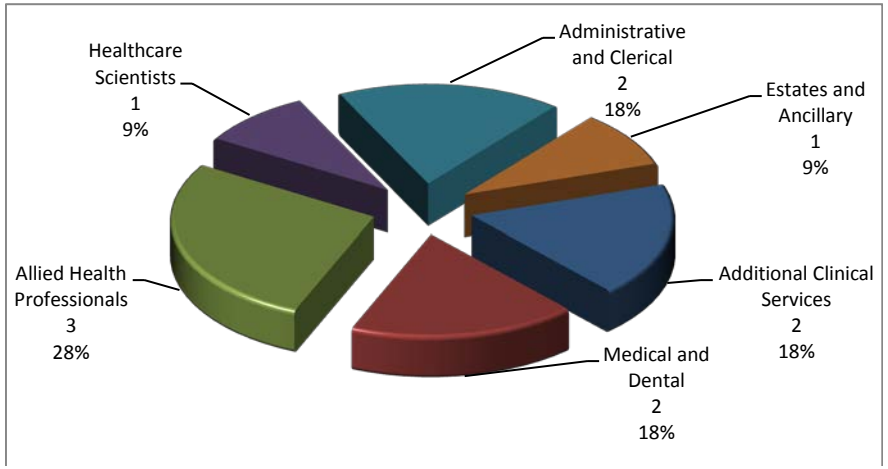
Risks still remain in Oral and Maxillofacial Surgery relating to anticipated vacancies due to a potential shortfall in HEE trainees. The Business Unit is exploring alternatives for filling these posts to meet service demand and intend to recruit two middle grade posts shortly with interim locum cover expected. An Advisory Appointments Committee for a new Consultant in Oral and Maxillofacial Surgery will be held in February 2017 which will cover a career break in the first instance and then become substantive. Short term locum cover will be required.

Medical Locums

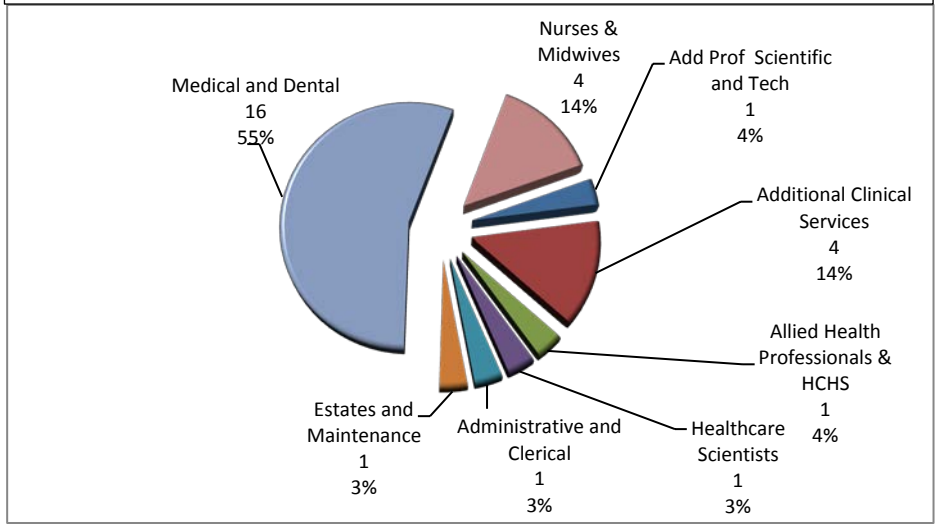
Plastics – Two agency locums and one NHS locums are covering vacancies and sickness, this locum use will continue into February pending successful recruitment.
Clinical Support - An agency Consultant is covering the maternity leave of a visiting Consultant from BSUH, it is expected that this will end 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.
OMFS – expected career break to commence 1st March of a Consultant Surgeon

4. Turnover – Starters and Leavers

Number of Starters (Headcount) by Staff group for January 2017



Number of Leavers (Headcount) by Staff group for January 2017



Business Unit	Starters (WTE)	Leavers (WTE)
Corporate	**2.00**	**0.00**
Nursing & Clinical Infrastructure (all staff)	**1.65**	**6.66**
o *Of which* **Nursing Staff**	*0.00*	*2.60*
o *Of which* **HCA's**	*1.65*	*0.46*
Clinical Support	**2.59**	**0.51**
Plastics Business Unit	***2.00**	***4.00**
Eyes Business Unit	**0.00**	***2.00**
Sleep Business Unit	**0.00**	**1.00**
Oral Business Unit	**0.00**	**0.00**
Perioperative Services (all staff)	**1.00**	***11.45**
o *Of which* **Nursing & Theatres**	*0.00*	*2.00*
o *Of which* **HCA's & ODPs**	*0.00*	*0.00*
QVH Total (* Note)	***9.25**	***25.62**

Turnover Summary

Turnover rate – for the month of January the turnover rate (excluding rotational trainee doctors) was **1.43%** for Permanent/Fixed term staff, an increase on last month.

Turnover rate for 12 months (Period: 1st February 2016 to 31st January 2017) excluding rotational trainee doctors was **16.72%** 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 – January 2017 Activity Data

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

By QVH Business Unit	Current Month (January 2017) Agency usage in WTE	Current Month (January 2017) Bank usage in WTE	Current Month (January 2017) Agency & Bank usage in WTE	Previous Month (December 2016) Agency & Bank in WTE	January 2017 compared to last month
Corporate	6.49	6.31	12.80	**12.60**	▼ Agency ▲ Bank
Nursing and CI	3.59	14.26	17.85	**14.81**	▼ Agency ▲ Bank
Clinical Support	3.08	3.07	6.15	**5.15**	▲ Agency ▲ Bank
Plastics Business Unit	3.36	1.67	5.03	**4.64**	▲ Agency ▼ Bank
Eyes Business Unit	0.00	0.71	0.71	**1.20**	◄► Agency ▼ Bank
Sleep Business Unit	1.01	1.80	2.81	**2.02**	▲ Agency ▲ Bank
Oral Business Unit	0.00	1.45	1.45	**0.53**	◄► Agency ▲Bank
Perioperative Services	8.50	6.46	14.96	**15.49**	▼ Agency ▼ Bank
QVH Total	**26.04**	**35.72**	**61.76**	**56.44**	▲ Agency ▲ Bank

By Staff Group	Current Month (January 2017) Agency usage in WTE	Current Month (January 2017) Bank usage in WTE	Current Month (January 2017) Agency & Bank usage in WTE	Previous Month (December 2016) Agency & Bank in WTE	January 2017 compared to last month
Qualified Nursing	11.47	9.22	20.69	**18.65**	▼ Agency ▲ Bank
HCAs	0.00	2.75	2.75	**2.62**	◄► Agency ▲Bank
Medical & Dental	3.64	0.00	3.64	**2.12**	▲ Agency ◄►Bank
Other Clinical e.g AHP & ST&T	4.26	2.08	6.34	**4.71**	▲ Agency ▲ Bank
Non-Clinical	6.67	21.67	28.34	**28.34**	▼ Agency ▲ Bank
QVH Total	**26.04**	**35.72**	**61.76**	**56.44**	▲ Agency ▲ Bank

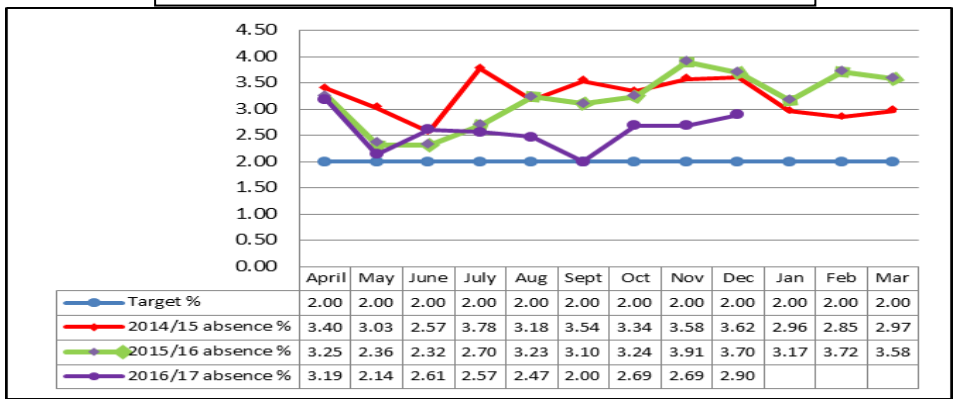
5.2 Agency Usage in line with NHS Improvement Rules by Business Unit and Staff Group

By QVH Business Unit	January 2017 Number of Shifts *UNDER NHSI Agency Hourly Charge Cap*	January 2017 Number of Shifts *OVER NHSI Agency Hourly Charge Cap*	January 2017 Total Number of Agency Shifts	Previous Month (December 2016) Agency Shifts	January 2017 compared to last month
Corporate	78	***63***	141	**154**	▼
Nursing and CI	11	***58***	69	**80**	▼
Clinical Support	57	***16***	73	**59**	▲
Plastics Business Unit	0	***73***	73	**62**	▲
Eyes Business Unit	0	***0***	0	**0**	◄►
Sleep Business Unit	17	***0***	17	**7**	▲
Oral Business Unit	0	***0***	0	**0**	◄►
Perioperative Services	4	***152***	156	**154**	▲
QVH Total	**167**	***362***	**529**	**516**	▲

By Staff Group	January 2017 Number of Shifts *UNDER NHSI Agency Hourly Charge Cap*	January 2017 Number of Shifts *OVER NHSI Agency Hourly Charge Cap*	January 2017 Total Number of Agency Shifts	Previous Month (December 2016) Agency Shifts	January 2017 compared to last month
Qualified Nursing	15	***188***	203	**209**	▼
HCAs	0	***0***	0	**0**	◄►
Medical & Dental	0	***85***	85	**52**	▲
Other Clinical e.g AHP & ST&T	74	***22***	96	**75**	▲
Non-Clinical	78	***67***	145	**180**	▼
QVH Total	**167**	***362***	**529**	**516**	▲

6. Sickness Absence

Trust Sickness Absence Percentage – December 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	2.69	2.90			

Sickness Absence % by Business Units

Business Unit	Sickness Percentage	Current month compared to last month
Corporate	2.29%	▼
Nursing and Clinical Infrastructure	3.48%	▲
Clinical Support	2.09%	▲
Plastics Business Unit	3.18%	▲
Eyes Business Unit	0.00%	▼
Sleep Business Unit	2.04%	▲
Oral Business Unit	0.72%	▼
Perioperative Services	4.47%	▲
QVH Total	**2.90%**	▲

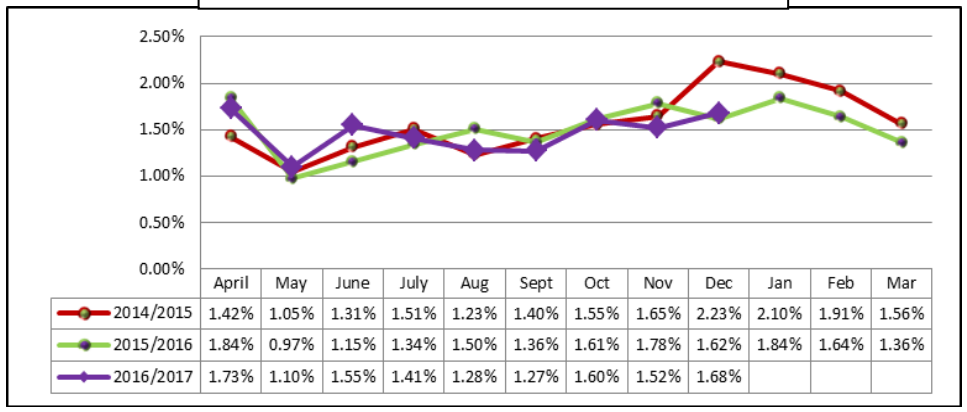
Short term Sickness Absence

Short Term sickness for December was **1.68%,** an increase on last month and slightly higher than the same period last year.

Long term Sickness Absence

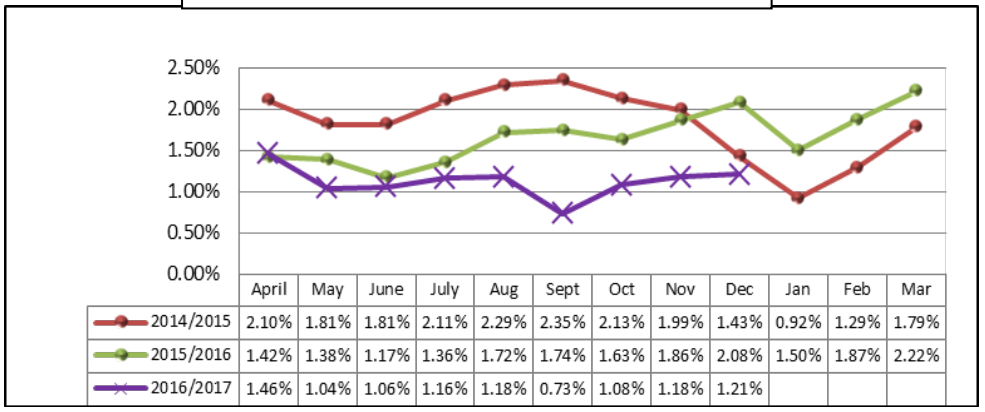
The long term sickness absence rate for December was **1.21%,** a slight increase on last month although significantly lower than the same period last year.

Trust Sickness Absence Percentage – Short Term



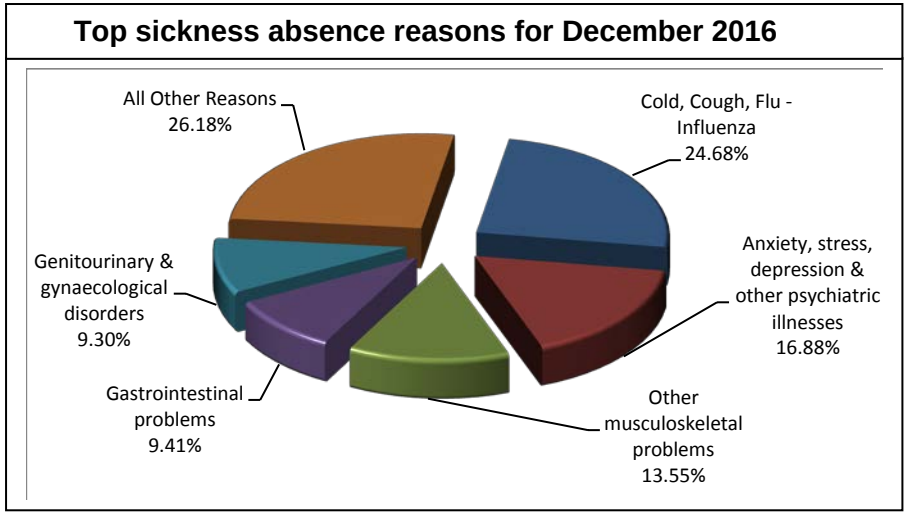
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2014/2015	1.42%	1.05%	1.31%	1.51%	1.23%	1.40%	1.55%	1.65%	2.23%	2.10%	1.91%	1.56%
2015/2016	1.84%	0.97%	1.15%	1.34%	1.50%	1.36%	1.61%	1.78%	1.62%	1.84%	1.64%	1.36%
2016/2017	1.73%	1.10%	1.55%	1.41%	1.28%	1.27%	1.60%	1.52%	1.68%			

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%	1.18%	1.21%			

6.1 Sickness Absence Reasons



Health & Wellbeing

Further to a successful tender process, from 1st February 2017 Surrey and Sussex Healthcare NHS Trust (SASH) have become the Occupational Health provider at QVH with an on-site presence three days a week.

The Employee Assistance Programme (EAP) is sourced separately via Care First.

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

Specialist Hospital	Region	Absence Rate
Alder Hey Children's Hospital	North West	**5.67%**
Birmingham Children's Hospital	West Midlands	**3.54%**
Birmingham Women's Hospital	West Midlands	**4.84%**
Christie Hospital, Manchester	North West	**3.74%**
Clatterbridge Cancer Centre	North West	**4.79%**
Great Ormond Street Children's Hospital	London	**2.37%**
Liverpool Heart & Chest Hospital	North West	**3.98%**
Liverpool Women's Hospital	North West	**4.98%**
Papworth Cardiothoracic Hospital	Cambridgeshire	**3.57%**
Robert Jones & Agnes Hunt Orthopaedic Hospital	Shropshire	**2.81%**
Royal Brompton & Harefield Cardiothoracic Hospital	London	**2.99%**
Royal Marsden Cancer Hospital	London	**2.82%**
Royal National Orthopaedic Hospital	London & Middlesex	**2.94%**
Royal Orthopaedic Hospital, Birmingham	West Midlands	**4.02%**
Sheffield Children's Hospital	North East	**5.21%**
Velindre Cancer Centre, Cardiff	Wales	**3.85%**
Walton Centre for Neurology & Neurosurgery	North West	**4.72%**

Sickness Absence Summary

The overall sickness absence rate at QVH for December is **2.90%**. This is slightly lower than the predicted rate of 3.0% and significantly lower than the same month for the last three years.

*The indicative sickness absence rate for January is around **2.8%***

Highest reason for absence recorded: Cold, Cough, Flu
Highest first day absence: Tuesday
Number of one day sickness absence episodes: 84

*When comparing the sickness absence rates for **October 2016** for the 18 Specialist Hospitals in the benchmark group including QVH, the QVH rate of 2.69% is below the group average of 3.75% and is **2nd lowest** in the benchmark group.*

7. Training, Education and Development

Appraisal Compliance Rate as at 1st February 2017

Area	Permanent & Fixed Term Staff APPRAISAL Compliance	Current month compared to last month
Corporate	86.71%	▼
Nursing & CI	78.15%	▼
Clinical Support	90.98%	▼
Plastic Surgery	71.60%	▼
Eyes	77.42%	▲
Sleep	84.00%	▼
Oral	71.83%	▼
Periop Services	67.90%	▼
QVH Total	78.73%	▼

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

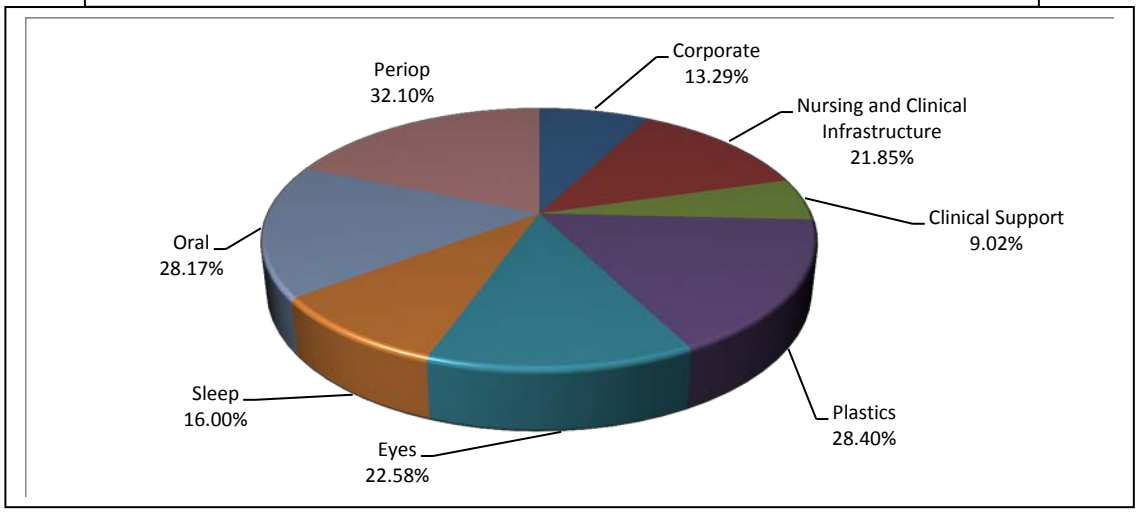
7.1 Statutory & Mandatory Compliance Rates

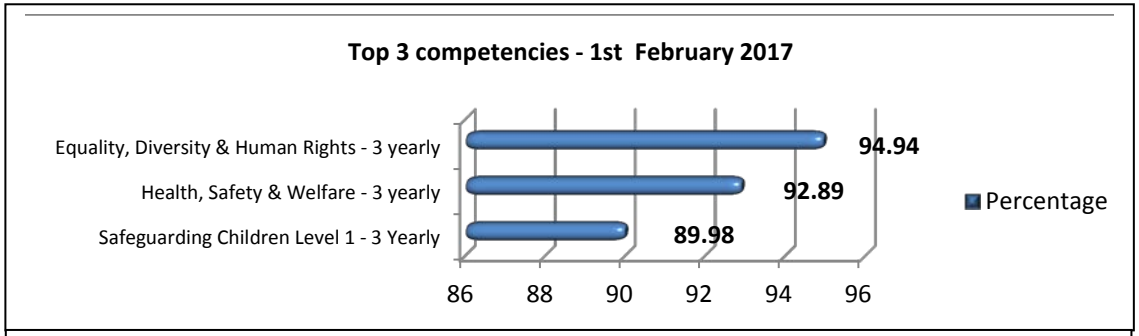
Compliance for 18 competencies as at 1st February 2017 EXC PDR

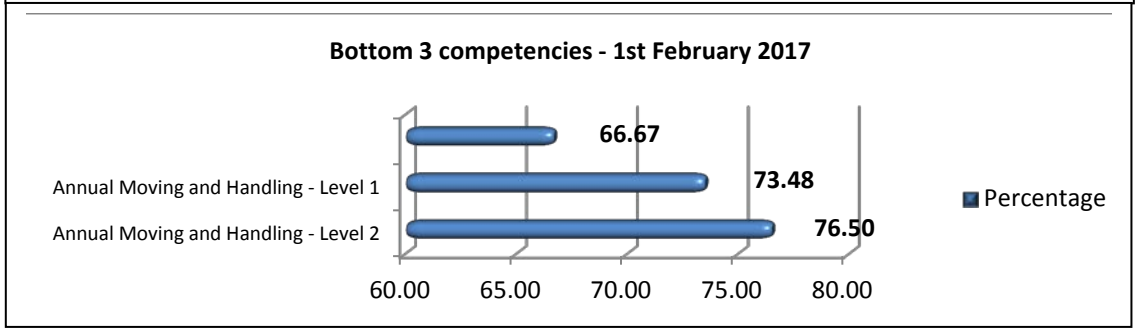
Area	Permanent & Fixed Term Staff Compliance	Current month compared to last month
Corporate	85.68%	▲
Nursing & CI	86.66%	▼
Clinical Support	91.16%	▲
Plastic Surgery	80.05%	▼
Eyes	94.39%	▲
Sleep	94.32%	▲
Oral	85.94%	▼
Periop Services	86.53%	▲
QVH Total	87.00%	▲

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

Outstanding Appraisals % for each Business Unit as at 1st February 2017







7.2 Learning and Development – Medical Education

Medical Education Summary

Educational activities January

- A Trust Hand Consultant, presented at an evening lecture meeting on the topic of "A brief history of plastic surgery – how did it come to this?" – the meeting was very well received (see feedback below).
- The Director of Medical Education, has delivered the first of his workshops on the requirements of the new Junior Doctor contract for educational supervisors
- The next round of Local Faculty Group meetings is underway

Upcoming developments

- A bid to HEE for funding for SAS doctors has been successful and plans are being put in place for utilising the funds; two courses have been booked for 2017
- Changes to the doctors' induction programme were implemented at the induction, 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 16.3% of competencies out of date (a drop of 3.3% on last month), i.e. 83.7% compliant.
- Medical and dental bank staff are showing 17% of competences out of date (a huge improvement on the previous month), i.e.83% compliant.

Feedback

- Every attendee at the lecture evening scored that they were satisfied or very satisfied in all areas. Some of the comments:
    - "Really enjoyable evening – excellent presentation"
    - "Thank you for such an excellent presentation. It was presented with humour. I gained a lot of knowledge."
    - "Excellent. Good choice. Good speaker. Good food."

8. Medical Workforce

Appraisals

The total compliance rate for medical staff is 83.5% excluding LETB trainees and bank doctors (similar figure to previous month). A particular area of concern is Oral and Maxillo-facial in which several doctors, who are non-compliant, have been sent their first reminder to book an appraisal meeting.

It is worth noting that some of these areas showing a lower compliance have a small number of staff 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 will be following up 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 for CT2s in Plastic Surgery have been sent to those starting on 1st February 2017. Offers for the April rotation are being sent in February 2017. 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 are near completion and Oral and Maxillo-facial rotas are in progress. An Equality Impact Assessment which serves to identify any possible impact on the workforce of the new contract has now been completed and was discussed with the Local Negotiating Committee on 23rd January 2017. Most of the findings are in line with that identified nationally so no further action to be taken other than the EIA to be repeated in a year to eighteen months' time. Next steps are to share findings with next Junior Doctors' Forum and Local Academic Board.

An Exception Reporting and Workforce Schedule Review Policy has been shared with the Local Negotiating Committee meeting held on 23rd January 2017. Work now needs to be undertaken to finalise internal processes for the disbursement of fines and additional payments which will be incorporated into the policy. Expected ratification to Quality and Governance Committee is March 2017.

Workforce and Organisational Development

The QVH new leadership and management development programme, Leading the Way was launched in January. Over 50 members of staff attended two events and over 70 expressions of interest have been received.

Nominations have now been invited for the Trust's Freedom to Speak up Guardian.

The NHS staff survey results are embargoed until 7 March 2017. The Trust response rate was 55.5% which is higher than the NHS average of just over 42%.

Queen Victoria Hospital NHS
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Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02/03/17**		**Agenda reference:**	**51-17**	
Report title:	**Corporate Trustee meeting**				
Sponsor:	Beryl Hobson, Trust and committee Chair				
Author:	Beryl Hobson, Trust and committee Chair				
Appendices:	NA				
Executive summary					
Purpose:	To provide assurance to the board in relation to matters discussed at the Corporate Trustee meeting on 5 January 2017				
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				

Report to:	Board of Directors
Meeting date:	02 March 2017
Reference number:	51-17
Report from:	Beryl Hobson, Chair
Author:	Beryl Hobson, Chair
Appendices:	N/A
Report date:	20 February 2017

Corporate Trustee

Meeting held on 5 January 2017

At its meeting on 5th January, the corporate trustee:-

1. Approved and signed off the 2015/6 charity accounts and noted that the auditors had no issues of concern;

2. Approved the Terms of Reference of the Charity Committee and a policy for management of charitable funds;

3. Received an update on recent legacies to the QVH Charity.

Queen Victoria Hospital NHS
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Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02/03/17**		**Agenda reference:**	**52-17**	
Report title:	**Nomination and remuneration committee**				
Sponsor:	Beryl Hobson, Chair				
Author:	Beryl Hobson, Chair				
Appendices:	NA				
Executive summary					
Purpose:	To provide assurance to the board in relation to matters discussed at the Nomination and remuneration committee meeting held on 19 January 2017				
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				

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Report to: Board of Directors
Meeting date: 02 March 2017
Reference number: 52-17
Report from: Beryl Hobson, Chair
Author: Beryl Hobson, Chair
Appendices: N/A
Report date: 20 February 2017

Nomination and remuneration committee

Meeting held on 19 January 2017

At its meeting on 19 January, the Nomination and remuneration committee:

1. Ratified the minutes of the two previous meetings. (These included the appointments of the CEO and Medical Director, as previously reported to the Board at its public meeting on 3 November 2016);

2. Discussed the process for the appraisals of both Non- Executive and Executive Directors;

3. Discussed the current position regarding the interim senior executive posts;

4. Discussed amendments to the terms of reference for the committee which will be on the board agenda for March 2017

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Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02/03/17**		**Agenda reference:**	**53-17**	
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 • Nomination and remuneration Sub-committee ToRs • Finance and performance				
Executive summary					
Purpose:	The Board is asked to review and approve the latest version of its committees' terms of reference for the Finance and performance committee and Nomination and remuneration committee Key changes for these ToRs are highlighted on each respective document.				
Recommendation:	The Board is asked to review and **approve** the latest version of these 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					
F&PC ToRs previously considered by:	Finance and performance committee				
	Date:	20/02/17	Decision:	Recommended for approval	
N&RC ToRs previously considered by:	Nomination and remuneration committee				
	Date:	19/01/17	Decision:	Recommended for 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
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. • Work with the chief executive to ~~i~~identify and appoint candidates to fill all executive director and other positions that report to the chief executive. • Work with the chief executive ~~and~~ to decide and keep under review the~~ir~~ terms and conditions of office of executive directors and other positions that report to the chief executive, including: o Salary, including any performance-related pay or bonus; o Provisions for other benefits, including pensions and cars; o 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.
- Ensure that proposed appointees meet the the "fit and proper person test", and confirm their awareness of the circumstances which would prevent them from holding office.
- 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 t~~The committee will work with the chief executive ~~about proposals relating to~~to determine 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 chair~~person~~ 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 chair~~person~~ of the trust.

If the chair~~person~~ 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~~head of corporate affairs and communications, 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 chair~~person~~
- 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 chair~~person~~ 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 chair~~person~~ 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 chair~~person~~ 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 2017~~6~~, 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 committee 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~~Delivery of financial and performance plans and targets; and
- ~~In-year delivery~~Delivery of the trust's strategic initiatives.

To provide this assurance the committee will maintain a detailed overview of:

- ~~the~~The trust's assets and resources in relation to the achievement of its financial plans and key strategic objective four: financial sustainability;
- ~~the~~The trust's operational performance in relation to the achievement of its activity plans and key strategic objective three: operational excellence; and
- ~~the~~The trust's workforce profile in relation to the achievement of key performance indicators and key strategic objective five: organisational excellence.

- Business planning assumptions, submissions and acceptance/delivery of targets

To fulfil its purpose, the committee will also:

- ~~identify~~Identify the key issues and risks requiring discussion or decision by the board of directors;
- ~~advise~~Advise on appropriate mitigating actions; and
- ~~make~~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 and challenge construction of operational and financial plans for the planning period as defined by the regulators.
- 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 ~~October 2016~~February 2018.

Queen Victoria Hospital NHS
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 4 May 2017 at 10:00
Venue: To be advised

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 2 March 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	**Patient Story**		
-17	**Board Assurance Framework** *Jo Thomas, Director of Nursing*	*Assurance*	paper
-17	**Corporate risk register (CRR)** *Jo Thomas, Director of Nursing*	*Review*	paper
-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
-17	**Inpatient survey** *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
-17	**Guardian of safe working** *Ed Pickles, Medical Director*	*Information*	paper
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
-17	**Board Assurance Framework** *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** *Sharon Jones, Director of Operation*	*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, Director of Human Resources and Organisational Development*	*Assurance*	paper
-17	**Staff survey results and action plan** *Geraldine Opreshko, Director of Human Resources and Organisational Development*	*Assurance*	paper
Board governance			
-17	**Board of Director Annual Declarations** *Clare Pirie, Head of Communications and Corporate Affairs*	*Assurance*	paper
-17	**Audit committee** *Lester Porter, Chair*	*Assurance*	paper
-17	**QVH Charity** *Lester Porter, Chair*	*Assurance*	verbal
-17	**Draft agenda for the July 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: **Public**: 06 July at 10:00	**Sub-Committees** **N&R:** 18 May at 10:00 **Audit**: 18 May 2017 at 14:30 **F&P:** 22 May 2017 at 14:00 **Q&G:** 15 June 2017 at 09:00 **Charity:** 31 July 2017 at 09:00 **Corp. Trustee**: 02 Nov 2017 at 14:00	**Council of Governors** **Public**: 31 July 2017 at 15:00

NB: Feedback on board meeting to be provided by Sharon Jones, Director of Operations