Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 07 September 2017

Session in public at 10.00

The Board Room
Blond McIndoe Building
Queen Victoria Hospital
Holtye Road
East Grinstead
West Sussex
RH19 3DZ

Queen Victoria Hospital
NHS Foundation Trust

MEETINGS OF THE BOARD OF DIRECTORS: 07 September 2017

Members (voting):

Chair	-	Beryl Hobson
Senior Independent Director	-	John Thornton
Non-Executive Directors:	-	Ginny Colwell
	-	Kevin Gould
	-	Gary Needle
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 Operations	-	Sharon Jones
Director of Workforce & OD	-	Geraldine Opreshko
Director of Communications and Corporate Affairs	-	Clare Pirie
Deputy Company Secretary	-	Hilary Saunders
Lead Governor	-	John Belsey

Annual declarations by directors 2017/18

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.
Ginny Colwell Non-Executive Director	Board advisor for Hounslow & Richmond Community Healthcare NHS Trust	Nil	Nil	Nil	Nil	Nil	Nil
Kevin Gould Non-Executive Director	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Gary Needle Non-Executive Director	Director, Gary Needle Ltd	Nil	Nil	Nil	Nil	Nil	Nil
John Thornton Senior Independent Director	1. Non-Executive Director: Golden Charter Ltd 2. Director of Oakwell Consulting Ltd	Nil	Nil	Nil	Nil	Nil	Nil
Ed Pickles Medical Director	Nil	Nil	Nil	Nil	I am a member of a private anaesthetic partnership, which provides anaesthetic services to several surrounding independent sector hospitals. This work may include NHS contract work.	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.
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 Director of Communications & Corporate Affairs	Nil	Nil	Nil	Nil	Nil	Nil	Nil
John Belsey Lead governor	Director of Golfguard Ltd Director of Mead Sport & Leisure Ltd	Nil	Nil	Trustee of Age UK Ltd, East Grinstead & District	None anticipated	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
Ginny Colwell Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
Kevin Gould Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
Gary Needle 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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	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.
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 Director of Communications & Corporate Affairs	NA	NA	NA	NA	NA	NA	NA
John Belsey Lead governor	NA	NA	NA	NA	NA	NA	NA

Queen Victoria Hospital NHS
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 7 September 2017
10:00 – 13:00
The Board Room, Blond McIndoe Building, Queen Victoria Hospital RH19 3DZ

Agenda: session held in public			
Welcome			
132-17	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**Page**
133-17	**Draft minutes of the meeting session held in public on 6 July 2017 (for approval)** *Beryl Hobson, Chair*	*Approval*	1
134-17	**Matters arising and actions pending** *Beryl Hobson, Chair*	*Review*	8
135-17	**Chief executive's report** *Steve Jenkin, Chief Executive*	*Assurance*	9
Key strategic objective 1: outstanding patient experience			
136-17	**Patient Story** *Jo Thomas, Director of Nursing*	*Assurance*	-
137-17	**Board Assurance Framework** *Jo Thomas, Director of Nursing*	*Assurance*	14
138-17	**Corporate risk register (CRR)** *Jo Thomas, Director of Nursing*	*Review*	15
139-17	**Quality and governance assurance report** *Ginny Colwell, Non-executive director and committee chair*	*Assurance*	33
140-17	**Quality and safety report** *Jo Thomas, Director of Nursing*	*Assurance*	35
141-17	**Safeguarding annual report 2016/17** *Jo Thomas, Director of Nursing*	*Assurance*	66
142-17	**Emergency preparedness, resilience and response and business continuity annual report** *Jo Thomas, Director of Nursing*	*Assurance*	96
143-17	**Patient experience annual report** *Jo Thomas, Director of Nursing*	*Approval*	113

144-17	**Infection prevention and control annual report** *Jo Thomas, Director of Nursing*	*Approval*	131
Key strategic objective 2: world-class clinical services			
145-17	**Board Assurance Framework** *Ed Pickles, Medical Director*	*Assurance*	162
146-17	**Medical director's report** *Ed Pickles, Medical Director*	*Assurance*	163
147-17	**Consultant revalidation annual update** *Ed Pickles, Medical Director*	*Assurance*	170
148-17	**R & D annual report** *Ed Pickles, Medical Director*	*Assurance*	189
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
149-17	**Board Assurance Framework** *Sharon Jones, Director of Operations and Clare Stafford, Director of Finance*	*Assurance*	216
150-17	**Financial and operational performance assurance report** *John Thornton, Non-Executive Director*	*Assurance*	218
151-17	**Operational performance** *Sharon Jones, Director of Operation*	*Assurance*	221
152-17	**Financial performance** *Clare Stafford, Director of Finance and Performance*	*Assurance*	234
Key strategic objective 5: organisational excellence			
153-17	**Board assurance framework** *Geraldine Opreshko, Director of Workforce & OD*	*Assurance*	251
154-17	**Workforce monthly report** *Geraldine Opreshko, Director of Human resources & OD*	*Assurance*	252
155-17	**Engagement & retention options paper** *Geraldine Opreshko, Director of Human resources & OD*	*Assurance*	264
Board governance			
156-17	**Proposed STP governance & leadership model for system-wide transformation** *Steve Jenkin, Chief Executive*	*Approval*	289
157-17	**Well led framework** *Clare Pirie, Director of Communications and Corporate Affairs*	*Approval*	332

158-17	**Board committee effectiveness** *Clare Pirie, Director of Communications and Corporate Affairs*	*Assurance*	391
Any other business (by application to the Chair)			
159-17	*Beryl Hobson, Chair*	*Discussion*	-
Observations and feedback			
160-17	**Questions from members of the public** *We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to Hilary.Saunders@qvh.nhs.uk clearly marked "Questions for the board of directors". Members of the public may not take part in the Board discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.*	*Discussion*	-

Date of the next meetings

Board of Directors:	**Sub-Committees**	**Council of Governors**
Public: 02 November at 10:00	**Charity:** 14 Sept 2017 at 09:00 **Audit**: 20 Sept 2017 at 14:30 **Q&G:** 21 Sept 2017 at 09:00 **F&P:** 25 Sept 2017 at 14:00 **Corp. Trustee**: 05 October 2017 **N&R:** 19 Oct at 10:00	**Public**: 16 Oct 2017 at 15:00

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 6 July 2017, 10.00 – 13.00, Boardroom, Blond McIndoe Research Centre, QVH RH19 3DZ**	
Present:	Beryl Hobson, (BH)	Trust Chair
	Ginny Colwell (GC)	Non-Executive Director
	Steve Jenkin (SJ)	Chief Executive
	Sharon Jones (SLJ)	Director of Operations
	Gary Needle (GN)	Non-Executive Director
	Jo Thomas (JMT)	Director of Nursing
	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)	Lead Governor
	Clare Pirie (CP)	Director of Communications and Corporate Affairs
	Dee Vaidya (DV)	EA to Director of Finance and Performance (minutes)
	David Hurrell (DH)	Deputy Director of HR
Apologies:	Geraldine Opreshko (GO)	Director of Human Resources & Organisational Development
Public gallery	Seven members of the public, (including six governors)	

Welcome	
104-17	**Welcome, apologies and declarations of interest** The Chair opened the meeting and welcomed DH who was representing GO today. She went on to welcome those in the public gallery.
Standing items	
105-17	**Draft minutes of the meeting sessions held in public on 4 May 2017 for approval** The minutes of the meeting held on 4 May were **APPROVED** as a correct record with the exception of the following: s.68-17: Board Assurance Framework, third point: JMT requested for 'physicians' to be amended to 'surgeons.'
106-17	**Matters arising and actions pending** The board received and **APPROVED** the current record of matters arising and actions pending.
107-17	**Chief Executive's report** SJ presented his CEO report, asking the Board to note in particular that: • There are significant challenges surrounding recruitment and retention and that this is connected to national issues. • QVH has organised a staff barbeque, which will take place on Wednesday 13 July. • The 'QVH conversations' involved the chief executive meeting with and listening to groups of staff, and SJ highlighted that there was a good cross-mix from across the trust. Noted that in the national staff Friends and Family Test the rates of satisfaction with QVH as a place to work had dropped. The QVH listening events included what a good/bad day involved and what we can do more of. The key points that arose from these discussions were that a o a cascaded team brief would be beneficial, o wanting a better understanding of what other people do and; o what opportunities are there for education and learning

	An action plan will be developed based on these listening events. • The freedom to speak up guardian has been elected and started their new role in May 2017. They attended the National Guardian Quarterly meeting and an unedited review will come to the Board. The Board discussion of the report included: • How issues raised in the QVH Conversations would be feedback, and the need to balance responding to individuals with using line management to address issues. • Plans for an executive chair for the STP; how an executive chair works in terms of governance and accountability; what authority they would have. • Noted that there will be a paper on STP governance in September 2017. Agreed that this would be circulated ahead of the Board meeting. There were no further questions and the Board **NOTED** the update.
Key strategic objective 1: outstanding patient experience	
108-17	**Patient story** BH provided an introduction to the patient story and reminded those present that the rationale behind the 'patient story' session was to ensure that the patient remained at the centre of what we do as an organisation. JMT proceeded to tell the board an account of a working-age male, Matthew, who initially visited two other hospitals and commented on the professional, efficient and empathic service offered by QVH. He described how the front desk at MIU was busy; however he was professionally greeted and seen within 10 minutes. JMT went on to share Matthews' views on the nursing staff and described them of being of a cheery disposition and having made him comfortable, with effective pain relief. Matthew applauded QVH's post op experience and commented the nursing staff and the surgeon had involved Matthew in all conversations and there was the right amount of interaction. Overall Matthew described his experience at QVH outstanding and thanked all staff involved in his treatment. BH said that it was important to learn from patient stories and further added that we should not just be focusing on those that have had a positive experience, but those where the trust can obtain learning.
109-17	**Board Assurance Framework** As part of the KSO1 update, JMT reported there have been several updates including the positive performance in the CQC 2016 inpatient survey and reported that the Trust sustained better than national average. Recruitment and retention continues to be a challenge with reported high vacancy rates. JMT further explained the national shortages of nurses and practitioners in theatres, critical care and paediatrics which have an impact on service provisions. There were no further questions and the Board **NOTED** the contents of the report.
110-17	**Corporate Risk Register (CRR)** JMT reported this was the latest register that was presented at the Executive Management Team meeting and the Quality and Governance Committee meeting. She continued to update the Board that four new risks had been added, one had been reopened and four have been closed.

	In response to a question, JMT explained that the number of people who require safeguarding mandatory training has been reviewed, with plans in place to deliver the additional training needed. Risk ID 1035 relates to the inability to recruit adequate numbers of skilled critical care nurses across a range of bands. In response to a question about the implications for this from a legal point of view, JMT responded that we do not have 75% of the critical care staff with a critical care course. There is no legal consequence for this it is however the critical care qualified nurse ratio is an indicator that regulators consider when reviewing services as part of the safe and caring domains. It was agreed JMT would review risk ID1035 with the critical care team and note the progress update in the corporate risk register. GN commented on the risk rating on the recruitment and retention challenge and queried if it was rated correctly. SJ noted that it is currently rated at a score of 16. This has not been an issue which has had to be considered previously however this is something that the executive management team review regularly.
111-17	**Quality and governance assurance report** GC presented the regular quality and governance report, providing information and assurance in respect of the sub-committee meetings held in May and June. Discussion included the mock CQC inspections being carried out by staff and governors. JMT confirmed that this is being communicated to the governors.
112-17	**Quality and safety** JMT presented the regular quality and safety report and highlighted the challenges in workforce, in particular within Peanut, Critical Care and Theatres. The Board paid particular attention to the table showing shifts meeting planned staffing levels and queried if the trust had local intelligence with respect to other trusts with regards to shift cover. JMT said that she did not have that level of detail and would look at comparative data for the Board. Action JMT. QVH is working with SASH in a rotation of critical care staff for the benefit of staff and both hospitals.
113-17	**Annual safeguarding report** JMT provided the Board with a summary of the CQC 2016 Inpatient Survey and noted the full report had been presented at the June Quality and Governance Committee meeting. JMT added highlighted that QVH has sustained and improved our position. Work will continue to review the action plan and highlight the areas where we can improve. JT recognised the scores are significantly better than other trusts. BH commended the team and noted the good result.
114-17	**6-monthly nursing workforce review** JMT presented the 6 monthly nursing workforce review and requested the Board review, and seek assurance that the contents of the report reflect the quality and safety of care provided by the nursing workforce. JMT proposed to bring back this report in four months in order to align reporting cycles. GC drew attention the retention issue and queried if this had been escalated to a national debate. JMT

	reported we are liaising with regional directors and will be attending an NHS Improvement retention programme event on 14 July 2017. Discussions were held on whether there were any particular themes on why staff were leaving. JMT said reasons given included moving to trusts such as SASH where pay is slightly higher due to outer London weighting.
Key strategic objective 2: world class clinical services	
115-17	**Board assurance framework** EP reported this has remained unchanged from the previous meeting. Noted the risk register has been updated in the light of the recent inquest. There were no further questions and the Board **NOTED** the contents of the report.
116-17	**Medical director's report** EP presented the regular medical director update and highlighted the following: • There was one never event reported to STEIS in April 2017. This related to a retained swab used during dental surgery and removed in theatre recovery. No harm was suffered by the patient. EP further added the root cause analysis would be presented to the Quality and Governance Committee meeting in August 2017. • The Trust successfully completed our data submission to the third audit period of the NHS England seven day services audit. • The results have been discussed with NHS England during a visit on the 15 May 2017. After discussion of the trauma case mix, NHS England has asked QVH to develop our own pathways for required consultant review and agree them with commissioners. • In response to a question EP confirmed the audit reviewed a weeks' worth of patients and found 51% of patients received a consultant review within 14 hours.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
117-17	**Board assurance framework** <u>KSO3</u> SLJ reported that the BAF for KS03 remained unchanged from the previous meeting. There were no further questions and the Board NOTED the update. <u>KSO4</u> CS asked the board to note: • The costing transformation programme business case has been developed, approved and the procurement is now underway. There were no further questions and the Board **NOTED** the contents of the report.
118-17	**Financial and operational performance assurance report** JT presented the assurance report in respect of matters discussed at the finance and performance committee meeting on 26 June 2017. Recruitment and retention of employees continues to be of concern to the committee. The committee obtained some assurance from the fact that turnover levels are stabilising and the level of agency staff is currently within our cap. JT went on to discuss the ward and outpatient productivity programmes and explained these were presented to the committee in detail. The committee endorsed the approach and the goals that were set

	out and will monitor progress against objectives at future finance and performance committee meetings.
119-17	**Operational performance** SLJ presented the regular operational performance report and highlighted the following: • After validation, the Trust achieved a final RTT18 of 91.6%. This is on track for the Trust's trajectory. • It was recognised that there is national pressure on the 62-day cancer waiting time target. All trusts have been requested to submit an action plan and have been categorised into one of four groups. SLJ reported the Trust has been placed into the 'best performing' category. In response to a question on the Medway backlog SLJ responded that due to the high number of patients with no clock start dates, it is difficult to take a view of the current performance with any accuracy.
120-17	**Financial performance** CS presented the financial report and in particular, highlighted the following points: • The Trust delivered a surplus of £183k in month, which is £32k behind plan. It was noted that this is a significant improvement in relation to the Trust's month 1 performance. • The key driver for the patient treatment income has been the performance within plastics. • CS raised concerns over income and noted that although this has improved, the Trust is not in a position where it needs to be and is offset by underspends in pay. • The Trust's use of resources score is 2. • Capped Expenditure Process: noted that the original gap of £95mil was reduced to £55mil, which was based upon Brighton's re-negotiation on the control total. The Trust submitted balance plans 2 weeks ago. • CS further noted that the Trust is doing more than national expectations around Carter back office review. • In response to a question on MIU CP highlighted continuing communication through posters within QVH and at GPs as well as social media, the paid for advertising has finished.
Key strategic objectives 5: organisational excellence	
121-17	**Board assurance framework** DH reported that the wording within the strategic objective section has been updated. Discussions took place around the residual risk rating and it was noted that this may be reduced once the impact of the assurances and the controls in place were achieved. There were no further questions and the Board **NOTED** the contents of the report.
122-17	**Workforce** DH presented the regular workforce report and highlighted the following: • It was identified that for the second month there has been a net increase in staff in post. This has been partly due to the IR35 effect and corresponding reduction in agency with staff transferring to payroll. • The Trust is in implementation stage with TRAC (applicant tracking system) • DH drew attention to an alteration in the way turnover is calculated. From April 2017, senior trust fellow doctors are included within the calculations that had been previously omitted in error. DH added that in the month of April there has been an impact of 0.7%; there would have been an in-month reduction in turnover, but this change has meant a flat line. • There has been a reduction across the board in statutory and mandatory training. This has received particular attention at the performance reviews and is being challenged. • Discussions were held concerning recruitment and retention and it was agreed that GO would submit a

	report detailing action to address the current issues.
Board governance	
123-17	**Memorandum of Understanding with BSUH** EP presented the memorandum of understanding (MOU) with Brighton and Sussex University Hospital and highlighted the MOU sets out to the nature of the partnership between BSUH and QVH and provides the framework within which all parties can address strategic issues of mutual interest. There was discussion of the level to which BSUH are engaged in this. EP commented BSUH are eager for a sustainable maxfax service. Updates on issues cover by the MOU will be included in the regular medical director's update. The board unanimously **APPROVED** the BSUH MOU.
124-17	**IM & T strategy** CS presented the IM&T strategy. The strategy document outlines the route map for the Trust's clinical information systems for the next five years, which is underpinned by an IT technical strategy and an information strategy. The strategy details the objective of developing a best of breed electronic patient record over the next five years. The strategy has been presented to the board seminar, IM&T steering group, the consultant's advisory group and EMT. In terms of costings, an assessment has been made for the next five years, which equates to circa. £1mil per year with the exception of the last year, when it will be higher, due to the PAS replacement. CS highlighted the risk of the lack of the Chief Information Officer and how we mitigate the risk. Further work is required on education and awareness across the board. In response to a question, CS reported the director of finance will be the executive lead and chair the IM&T strategy implementation group. The process of benefits realisation was discussed and CS confirmed that benefits realisation will be an integral part of the business case development and implementation process. The board **APPROVED** the strategy.
125-17	**Board committee appointments** BH updated the Board on the recent appointment of two new NEDs and highlighted that at the end of August new committee chairs will be appointed and the NED attendance at committees agreed. CP directed the Board to the s.7 of the report which detailed the committee attendance across the NEDs. The Board **APPROVED** the distribution of the committee responsibilities from September 2017.
126-17	**Changes to QVH Constitution** CP presented a report outlining the changes to the QVH constitution and sought approval from the Board. It was highlighted that Amendment 4 should be dated 20 October 2016. Subject to the amendment above, the board **APPROVED** the changes to the constitution.

127-17	**Annual approval of SFIs, SoA and Scheme of Delegation** CP presented the review of the corporate governance documentation and requested the Board to approve the revised standing orders, reservation of powers/scheme of delegation and standing financial instructions. The Board **APPROVED** the revised standing orders, reservation of powers/scheme of delegation and standing financial instructions.
128-17	**Audit committee** LP presented an update from the audit committee meeting held on 21 June 2017 and reported that the audit committee would conduct a self-evaluation in September and the results would be provided to the December audit committee and the Board in January 2018.
129-17	**Nomination and remuneration committee** Reported a pay review for executive directors was undertaken on 18 May 2017 and the directors of finance, nursing and operations received uplifts. Noted and agreed they would proceed with recruitment to the director of HR role.
Any other business	
130-17	The Board acknowledged this would be LP's last Board meeting. BH thanked LP for his hard work and expressed her and the Board's gratitude for his commitment to QVH.
Observations and feedback	
131-17	**Questions from members of the public** There were none noted.

Chair ……. Date ……

Matters arising and actions pending from previous meetings of the Board of Directors									
ITEM	MEETING Month	REF.	TOPIC	CATEGORY	AGREED ACTION	OWNER	DUE	UPDATE	STATUS
1	July 2017	112-17	Quality & safety report	KSO1: outstanding patient experience	Trust to identify staffing levels/shift cover with other trusts and report comparative data back to the board.	JMT	TBC		Pending
2	May 2017	71-17	Quality & safety report	KSO1: outstanding patient experience	Complaints team to undertake trend analysis to drive forward improvement and report back to Board	JMT	TBC		Pending
3	May 2017	71-17	Quality & safety report	KSO1: outstanding patient experience	Details of patient mortalities and patient cancellations to be reviewed by Q&GC and reported to Board through Quality and safety report	JMT	Sept		Pending
4	May 2017	74-17	Medical Director's report	KSO2: world class clinical services	Draft partnership agreement between BSUH and QVH to be presented to the Board for review in July	EP	July	On board agenda	Complete
5	May 2017	83-17	Audit committee	Board governance	The Audit committee to review current circulation of draft minutes	CS	July	Draft minutes will now be circulated to all members of the board in line with other committees	Complete
6	Jan 2017	12-17	Board Effectiveness assurance review	Board governance	Specification to be developed for tendering for Well-Led review. Board to remain apprised of progress on timescales etc.	CP	~~March~~ Sept	02 03 17 Regulatory requirement for this to be undertaken in 2017/18. Specification to be tailored to areas which have been identified by BoD. 04 05 17 Intention is now to complete review in 2017/18. Due to purdah, revised guidance has not been published. Once available, this will be circulated to BoD 16 08 2017	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.	We seek to maintain a well led organisation delivering safe, effective and compassionate care through an engaged and motivated workforce

Current Risk Levels

The entire BAF was reviewed at executive management team meeting in August 2017. KSO 1 and 2 were reviewed at the August Quality and Governance Committee and KSO 3, 4 and 5 were reviewed at the August Finance and Performance Committee. Changes agreed at EMT are shown in underlined type on the individual KSO sheets.

	Q2 2016/7	Q 3 2016/7	Q 4 2016/7	Q 1 2017/8	Residual risk
KSO 1	8	8	8	12	8
KSO 2	12	12	12	12	8
KSO 3	20	20	20	20	15
KSO 4	120	20	20	16	16
KSO 5	12	12	12	16	16

Chief Executive's Report					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07 September 2017**		**Agenda reference:**	**135-17**	
Report title:	**Chief Executive's Report**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Steve Jenkin, Chief Executive				
Appendices:	None				
Executive summary					
Purpose:	To update the Board on progress and to provide an update on external issues that may have an impact on the Trust's ability to achieve its internal targets.				
Recommendation:	For the Board to **NOTE** the report				
Purpose:	Information	Information	Information	Information	Information
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	External issues will be considered as part of the BAF 'horizon scanning' section				
Corporate risk register:	None				
Regulation:	NA				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Executive Management Team				
	Date:	21.08.2017	Decision:	Review BAF	

CHIEF EXECUTIVE'S REPORT
SEPTEMBER 2017

TRUST ISSUES

Director of Workforce and OD

Geraldine Opreshko has been appointed as our Director of Workforce and Organisational Development taking up post from 1 August. There was good competition for the role and a strong shortlist. Geraldine is an experienced NHS senior manager who has led the HR Directorate for the past year in an interim role.

Director of Finance

Since the last meeting I have received the resignation of Clare Stafford, Director of Finance and Performance. Clare has accepted a similar role at Brighton and Sussex University Hospitals NHS Trust (BSUH) and will commence on 1 October 2017. As this will be Clare's last Board meeting I would like to take this opportunity to thank her for her significant contribution during her two years with QVH and wish her well in her new role.

Whilst we go through a recruitment process to find her successor, Jason McIntyre Deputy Director of Finance will assume the role of Acting Director of Finance. Elin Richardson, associate director of business development will report to the chief executive and have a particular focus on supporting strategic work on the future of QVH and our partnership working with BSUH.

Research at QVH

National figures for NHS research activity across England in 2016/17 were released on 2 August. I am delighted to be able to say that QVH was one of the most improved Trusts in England for the number of studies undertaken and for number of participants recruited. QVH participated in 12 research studies, an increase of 50% on the previous year. In addition, 352 patients participated in these studies.

This reflects a major push by a small and dedicated team of research nurses, clinicians, and governance staff, who have all worked together to develop our research portfolio on an extremely tight budget. More patients than ever are being offered the opportunity to take part in research, and we have successfully met ambitious targets for study setup.

2017/18 promises to be an even more rewarding year for research at QVH, with several exciting new studies on the horizon and recruitment already looking strong.

Annual General Meeting

Over 50 members of the public attended QVH AGM held at East Court on 31 July. As well as sharing our achievements of the last year both finance and performance, the audience heard from our external auditors KPMG. The highlight was two presentations from Brian Bisase, Consultant Oral and Maxillofacial surgeon on Head and Neck reconstruction followed by Mark Cutler, Consultant Maxillofacial Prosthetist.

Staff Briefings

Two briefings were held during August with all staff invited and attended by around 60 members of staff. The focus was on developing our business, workforce challenges, our partnership working and looking to the future of QVH. In addition, learning from the recent inquest was incorporated into the discussions. Two further briefings are planned for September.

From September we will also be introducing a regular bi-monthly cascade briefing, Team Brief, ensuring that key messages are delivered face-to-face by team leaders throughout the Trust, and that feedback from teams is received swiftly.

Staff Awards
This year's QVH Staff Awards take place on 7 September with an impressive 159 nominations across all seven categories that is more than double last year. Following a social media campaign nearly 60 nominations were received from patients for the Outstanding Patient Experience award, which is a notable success and will ensure a particularly strong focus on patient care at the event. Around 240 staff are expected to attend the event.

Anita Hazari one of our consultant plastic surgeons has been awarded the Royal College of Surgeons Emerging Leaders Award. Anita received her award form Clare Marx, President of the Royal College of Surgeons and Lady Estelle Wolfson, who has given her name to the emerging leaders fellowship programme.

Facial Palsy
Our facial palsy experts (Andi Heaton, Tamsin Gwynn, Charles Nduka, Catriona Neville, Rahman Malhotra and Ruben Kannan) recently attended the 13th International Facial Nerve Symposium in Los Angeles, the largest gathering of facial nerve experts in the world. The team from QVH gave 12 talks in total on a variety of subjects and increased the recognition of QVH as a world leader in facial palsy care. The 14th International Symposium will take place in four years' time in Seoul.

Acid Burns
Over the past few weeks there has been considerable media coverage of the treatment of acid burns with QVH consultants Baljit Dheansa and Nora Nugent giving local and national media interviews on the subject.

Board Assurance Framework (BAF)
Attached is the BAF front sheet, the following points are worth noting:

Recruitment and retention remains one of the most significant challenges facing the NHS and is impacting substantially on QVH particularly in paediatrics, critical care and theatres. The Board is receiving a report on Attraction and Retention at this meeting.

SECTOR ISSUES
Sussex & East Surrey Sustainability & Transformation Partnership (STP)
NHS England and NHS Improvement assess CCGs and providers through the CCG Improvement and Assessment Framework (IAF) and the Single Oversight Framework (SOF). In Next Steps on the Five Year Forward View, NHSE indicated the importance of Sustainability and Transformation Partnerships in delivering integrated care across England.

Reflecting the increasingly central role of STPs, NHSE committed in Next Steps to publishing an assessment of STPs' performance, aligning with the CCG Improvement and Assessment Framework and Single Oversight Framework. At their Board meeting on 21 July 2017, NHS England published an indicative baseline STP progress assessment. STPs have been given an overall rating based on performance across nine domains. STPs are categorised as 'outstanding', 'advanced', 'making progress or 'needs most improvement. The methodology is similar to that used for the CCG IAF.

This is a baseline assessment, recognising the scale of the challenges faced in some areas of the country. Our Sussex & E Surrey STP was rated as 'needs most improvement' alongside Bristol N Somerset S Gloucestershire STP, Humber Coast & Vale STP, Northamptonshire STP and Staffordshire STP. NHS England has stated that these ratings are not a comment on the performance of STPs to date. Rather, they indicate the relative starting points on the road to better care. Sussex and East Surrey is one of the more complex STP areas, with 24 organisations involved in the partnership, including four councils.

A memorandum of understanding between partners has now been agreed in principle and the clinical board is providing clinical leadership to the partnership. The main focus is on the four 'place based plans' which will be developed locally to deliver community-based, personalised, integrated health and social care.

BSUH

BSUH was inspected by CQC in April 2017 and has announced they found significant improvements in services and as a result BSUH's overall rating has been revised from 'inadequate' to 'requires improvement', although CQC is recommending that BSUH should remain in special measures.

NATIONAL ISSUES

Getting It Right First Time

During July 2017 a report on general surgery was published setting out 20 recommendations to enhance patients' experience of care, improve patient outcomes and reduce post-surgical complications. The report is part of he Getting It Right First Time (GIRFT) programme, designed to identify and reduce unwarranted clinical variations in service and practice across the NHS. It is led by front-line clinicians who act as clinical leads for the reviews.

The GIRFT team have visited QVH to look at major head and neck cancer surgery, for which we are the third largest centre in the country. We have rates of readmission better than average and better than the two larger centres, and are performing better than average across a range of other measures too. GIRFT for ophthalmic surgery also showed good performance at QVH. We do have a higher than average follow-up ratio, possibly reflecting complexity of our work, and we are working to make sure we are as efficient as possible.

Steve Jenkin
Chief Executive

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing
Committee: Quality & Governance
Date last reviewed: 29 August 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, moderate risk
Residual Risk Rating 4 (C) x 2 (L) = 8 , low risk

Rationale for current score
Positives:
Compliance with regulatory standards
Meeting national quality standards and bench marks
Very strong FFT recommendations
Very good performance in CQC 2016 inpatient surveys, sustained better than national average.
Patient safety incidents triangulated with complaints and outcomes monthly no significant early warning triggers
Negatives:
Affordable plan for modernisation of the estate in development
Recruitment and retention challenges, high nursing vacancy rates
National shortages of nurses and practitioners in theatres, critical care and paediatrics impacting on service provision .
Brexit

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 reviewing service provision, productivity and efficiency,
Integration of health and social care provision which will create new opportunities for patients and providers
National staff shortages and failure to attract to QVH

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

RESILIENCE
Many services single staff member.
Nursing consultation completed.
Generational workforce analysis shows high nos. of nursing staff could retire in next 5 years

Controls / assurance
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
Quality and safety strategy in place BAF
Sub group for theatre workforce/recruitment, proposals approved at HMT June 2017CRR 1035
Update on estates strategy at board seminar 02/02/17
Interim paediatric staffing model in place to address vacancies in paeds CRR 1049
Joined NHSI nursing retention initiative

Gaps in controls / assurance
Development of full estates strategy and development control plan, incorporating patient expectations CRR 670
Robust clinical outcomes to be developed to ensure as effective baseline of clinical care . CRR 845, 728, DRR 746,609
Lack of structured feedback from PLACE audits BAF only
Trust wide recruitment and retention strategy in development CRR 922
Vacancies in critical care and theatres, added to CRR 1035,1019
Long term strategy required for paediatric service CRR 1049

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	**07/09/17**	**Agenda reference:**	**138-17**		
Report title:	Corporate Risk Register June and July 2017				
Sponsor:	Jo Thomas, Director of Nursing and Quality				
Author:	Karen Carter-Woods Head of Risk and Patient Safety				
Appendices:	None				
Executive summary					
Purpose:	To provide an update on the corporate risk register and assurance that the management and monitoring of this is well led at local and corporate level. The Board should note the continued risks for the trust in respect of workforce vacancies.				
Recommendation:	The Board is asked to review the corporate risk register and note that 2 new risks were added during June and July and no risks were closed.				
Purpose:	Approval **N**	Information **Y**	Discussion **Y**	Assurance **Y**	Review **Y**
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:	No new implications for the BAF.				
Corporate risk register:	This document				
Regulation:	Compliance with regulated activities in Health and Social Care Act 2008 and the CQC's Fundamental Standard. All trusts are required to maintain a corporate risk register and demonstrate systems are in place to effectively manage risk				
Legal:	As above				
Resources	No changes				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	11/08/17	Decision:	Reviewed	
Previously considered by:	EMT				
	Date:	21/08/17	Decision:	Amendments made which will be reflected in the August version of the CRR	
Next steps:	NA				

Queen Victoria Hospital NHS
NHS Foundation Trust

Corporate Risk Register Report
June and July 2017 Data

Key issues

Two new risks were added to the Corporate Risk Register between 01/06/2017 and 31/07/2017 with a score of 12+

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x5=15	1061	Poor working environment and increased demand in appointments team	Identified by Director of Operations
3x5=15	1069	Failure to achieve e-referral CQUIN	No project plan or working group in place; no progress made to date

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

3. **No risks scoring 12+ were closed** during June and July 2017

4. The corporate risk register is reviewed at Quality & Governance Committee meetings and bimonthly in the public section of the Trust Board.

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 and updated accordingly.

6. No specific group/individual with protected characteristics are 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 improving 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 Trust's 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 with CQC authorisation and does not indicate that the Trust is not:

- Safe
- Effective
- Caring
- Well led
- Responsive

Recommendation
12. Q&GC is asked to **note** the contents of the report.

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Rating (initial)	Current Rating	Trend	Progress Updates	Date Reviewed
1069	14/07/17	Failure to acheive e-referral CQUIN	Failure to achieve 100% utilisation of e-Referral Service for referrals from GP practices to consultant-led, first outpatient appointments at Acute Trusts by Oct 2018. As per Standard contract, with effect from 1st Oct 18, the provider need not accept (and will not be paid for any first outpatient attendance resulting from) Referrals by GPs to consultant-led acute outpatient services made other than through the NHS e-Referral Service. THe CQUIN also requires that the trust publishes all relevant services and make all of their first outpatient Appointment slots available on NHS eRS by 31 March 2018 following the given trajectory.	Interim with experience of delivering e-referral at a London Teaching Hospital will join the trust on July 17th. Outpatient productivity group recommenced on July 10th with e-referrals as a sub group.	Sharon Jones	Richard Grier	Compliance (Targets / Assessments / Standards)	15	15	NEW		14/07/17

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Rating (initial)	Current Rating	Trend	Progress Updates	Date Reviewed
1061	03/07/17	Poor working environment and increased demand in appointments team	Inadequate size of the monitor screens given the size of fields staff need to be able to view clearly and use Patient Centre - staff are having to use an earlier version of PAS. Telephone headsets faulty and or broken with no spares available. There are other equipment requirements specified in the DSE report such as chairs, wrist rests etc. The appts team have also had no investment in additional resources although referrals and therefore appts have increased. May 16 - May 17 referral comparision shows an increase of 15.9% and even though some of these relate to the AQP services and sleep (and so do not go through appts) this still demonstrates a significant increase. Therefore backlogs build up, which although dealt with via overtime, does increase the risk of appts being lost or put on an incorrect pathway. There are also issues with the pathway as patients have to phone in to get an appt time and this causes a backlog of calls to the switchboard and increased patient complaints and staff stress. SOPs either not in place or very	New headsets in place, with a couple of spare sets being ordered; New monitors ordered and should be installed by 3/7/17; Other equipment being ordered; New appt process being developed and to be piloted in plastics in July and Aug and then rolled out to the other specialities if pilot successful; Peer review from neighbouring trust being explored; Interim Business Manager being sourced whilst substantive recruitment takes place; Interim Business Manager to develop SOPs with team leader; Vacancies covered by bank (where possible) whilst recruitment happens	Sharon Jones	Stephanie Joice	Compliance (Targets / Assessments / Standards)	15	15	NEW		03/07/17
1059	22/06/17	Remote site: Lack of co-location with support services for specific services	Lack of co-location with clinical specialities & facilities which may be required to manage complications of procdures undertaken at QVH	SLA with BSUH re: CT scanning, acute medical care, paediatric care and advice Guidelines re: pre-assessment & admission criteria, to QVH Skilled and competent medical and nursing staff with mandatory training focused on QVH specific risks Clinical governance oversight of scope of practice at QVH	Dr Edward Pickles	Dr Edward Pickles	Patient Safety	20	20	NEW	**Response to Prevention of Future Deaths notice required by August 2nd**	22/06/17

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Rating (initial)	Current Rating	Trend	Progress Updates	Date Reviewed
1054	19/05/17	Safeguarding Children mandatory Level 3 training data is currently at 46% instead of 95%	Safeguarding Children uptake of level 3 training is currently at lower level than required due to training list having been updated. It will take time to deliver training to all those that require it.	two level 3 safeguarding children sessions for consultants now being provided on QVH site each year Named Nurse undertaking 1:1 meeting with all relevant consultants Bespoke training session being provided for site practitioners/trauma coordinators QVH safegaurding prompt cards being drafted for level 2 and 3 staff elearning options information sheet has been drafted for consultants	Jo Thomas	Pauline Lambert	Patient Safety	12	12	↔	**19/7/17: Monitoring of booking lists and staff due for training**	30/10/17
1052	12/05/17	Limited spaces in busy Corneo and OPD environments could be problematic for children	Limited space for children in busy outpatient and corneo departments can be hazardous for both children and adult patients	Meeting with Corneo department safeguarding representative Discussion with Director of Nursing Follow up with Outpatients Manager Quality Account action to review all OPD paediatric areas Monitored at quarterly Patient Experience Group	Jo Thomas	Pauline Lambert	Patient Safety	12	12	↔	**17/7/17: HoN, Outpatient managers and Patient Experience manager asked to identify suitable waiting areas for children**	31/08/17
1051	03/05/17	Missing patient records: impact on review / risk assessment	When safeguarding concerns arise and patient records are missing, patient risk assessment or review cannot occur	Evolve/EDM should be long term solution as safeguarding section and documentation is in place Records must not leave QVH, only copies to be sent to BSUH or other trusts when required - process confirmed by Karen Carter Woods Risk Manager 17.7.2017 still some missing records being reported as problem asked staff to complete Datix when this occurs	Jo Thomas	Pauline Lambert	Patient Safety	12	12	↔	**17/7/17: 'missing records still a problem' - to be clarified if pertains to adults or children: Risk owner e-mailed for clarification**	31/08/17

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Rating (initial)	Current Rating	Trend	Progress Updates	Date Reviewed
1049	28/04/17	Unable to recruit qualified paediatric staff leading to challenges maintaing a 24 hour service	Unable to cover shifts with qualified paediatric nurses, particularly at night. On occasions, this can lead to patients being transferred to alternative hospitals in the event that they need inpatient care. Potential loss of more staff, and variability of closure of the ward	* Use of agency and bank as available and movement of QVH staff to cover shortfall * Transfer of patients when safe staffing cannot be maintained * Review of rota to identify new ways of working to address the shortfall in the short term & ongoing rota scrutiny * line-booked agency	Jo Thomas	Nicola Reeves	Patient Safety	15	15	↔	**17/7/17: All agency staff provided are suitably qualified** **Paediatric Ward 'workforce' paper to EMT 19/7** 28/06/2017: Discussed at Paediatric Governance meeting - SG Lead and Non-Elective Head of Nursing to review this risk and either provide additional information to reflect to the impact of the inconsistency of the ward closures has or create a new risk for this.	28/06/17

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Rating (initial)	Current Rating	Trend	Progress Updates	Date Reviewed
1035	09/01/17	Inability to recruit adequate numbers of skilled critical care nurses across a range of Bands	* Intensive Care Society recommends 50% of qualified nurses working on CCU team should have ITU course: this is currently complied with due to existing workforce, new staff joining from C-Wing and transfer of vacancy rates * move of step-down beds to CCU resuted in transfer os staff and vacancies.	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 4. Multiprofessional bedstate and capacity reviews QDS	Jo Thomas	Nicola Reeves	Patient Safety	12	12	↔	**6/7/17: Nursing workforce paper presented at Board: 47% vacancy in Critical Care (reflects transfer of vacancies from C-wing to establish Step-Down Unit. X2 RN's transferred to CC from C-wing & utilising HCA's in CC** 28/06/2017: Discussed at CC Governance meeting: The vacancy rate remains at around 50% (13 WTE vacant positions)This is a National problem	28/06/17

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Rating (initial)	Current Rating	Trend	Progress Updates	Date Reviewed
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	12	12	↔	**18/7/17: interviews held and post appointed to.** 9/6/17: ECF approved for B7 Outreach Nurse,to go out to advert 21/02/17: Interim appointment made and service continues whilst pathway being appraised.	17/05/17
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	15	↔	**2/8/17: discussed at Operations meeting; request by Director of Operations for closure as pertains to 'junior' doctors not consultants as per description rationale for re-opening** 8/5/17: Discussed at CGG: requested to be re-opened by Chair (MD) as consultants are not 'on-site' at weekends, they are on-call & attend for Ward Rounds. 11/4/17: discussed with BIU - only one vacancy currently: CLOSED 22/03/17: update requested: Still remains a significant issue as unable to recruit middle grades or find suitable agency doctors – leading to cancellation of elective activity and associated loss of income.	08/05/17

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Rating (initial)	Current Rating	Trend	Progress Updates	Date Reviewed
971	28/06/16	Anaesthetic Department currently understaffed by at least 2 whole time equivalents since a 20% increase in general anaesthetic	1) Patient safety - decreased flexibility to run to assistance if there is a life threatening problem in another theatre. We would normally have at least on trainee doubled up on a list, giving the ability for the 'spare' anaesthetist to leave their patient in safe hands and go and help in an emergency. We are regularly running days without this safety net. 2)Patient safety - on long head and neck cancer lists the anaesthetists can be responsible for a patient non-stop for 12 to 18 hours. Lack of anaesthetic staff occasionally leads to this being done by a single anaesthetist without backup or breaks. 3)Patient safety one anaesthetist can be tasked with giving anaesthetic input in 3 different theatres - this risks a hurried and distracted approach and also risks theatre downtime if a list has to be halted while this anaesthetist is finishing of a case in another theatre. 4)Corporate risk - it is likely that we will have to cancel lists at short notice - when the scheduling of anaesthetic is so short, it only takes one person being off sick to disrupt the smooth running of theatres. 5)Corporate risk - theatre efficiency suffers because there is seldom a 'spare' anaesthetist to help out either putting a patient on or taking them off the table. List often have to stop to allow the anaesthetist to go and see a staggered admission rather than have the ability for someone to go and see them concurrently. 6)Wellbeing risk - the department is stretched and relying on good will to carry out day to day activity.	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	12	↔	**24/7/17: reviewed with MD - two further 3 month locum appointments approved. Business case to be developed for substantive appointments** **24/4/17: reviewed with MD - second locum appointed, not yet in post** **To remain on RR until substantive staff recruited.** 20/3/17:risk owner e-mailed for update 3/4/17:follow-up email sent requesting update 11/4/17:further e-mail sent requesting update as a matter of urgency 05/01/2017: One locum appointed October 2016 Advert for second locum to go out shortly. Business case still ongoing, but shows anaesthetic staffing deficit 2.5 WTE at present.	24/04/17

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Rating (initial)	Current Rating	Trend	Progress Updates	Date Reviewed
968	20/06/16	Delivery of commissioned services whilst not meeting all national standards/criteria for Burns and Paeds	Potential increase in the risk to patient safety 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 paediatrics hold an appropriate NMC registration * Visiting consultant for paediatric's X3 sessions per week from BSUHT *Robust incident reporting in place *Named Paeds safeguarding consultant in post *Strict admittance criteria based on pre-existing and presenting medical problems, including extent of burn scaled to age. *Surgery only offered at selected times based on age group (no under 3 years OOH) *Paediatric anaesthetic oversight of	Jo Thomas	Nicola Reeves	Compliance (Targets / Assessments / Standards)	12	12	↔	**July 2017:** **Rveiew of all safety / clinical governance issues at monthly paeds governance meeting; including all incidents & children transferred out for care.** **This links with 1049**	28/06/17

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Rating (initial)	Current Rating	Trend	Progress Updates	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	Richard Grier	Compliance (Targets / Assessments / Standards)	15	15	↔	**2/8/17: r/v at Ops meeting = no change** 21/12/2016 Risk reviewed at Buisiness Unit Managers meeting - No change 08/08/2016 Risk reviewed with IM Lead additional action added - No further changes at this stage Update from risk owner A request was made to Medway for all patients on the specialty code 140 (oral surgery) to be sent to QVH; When this arrived, it showed significant data quality issues, with duplicate entries, patients on 2WW and patients who had already been treated. The QVH access team validated this data file. A subsequent file was requested but this showed even more data quality issues, with clock start dates ranging back a hundred years. QVH Performance & Access Manager has visited to Medway throughout June and will continue to visit fortnightly. She has spent time with the Medway informatics team, reviewing their patient lists and explaining what we require. A new data file will be sent to us but we still expect some data issues to be present. She is also supporting the QVH Medway based admin team with this work. This is a	27/07/17

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Rating (initial)	Current Rating	Trend	Progress Updates	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 retention of nursing and ODP staff	1. Continual review of recruitment processes 2. HR team review difficult to fill vacancies with operational managers 3. Medical staffing team enhanced to improve recruitment to medical vacancies 4. HR attending weekly operational review meeting 5. Targeted recruitment of theatre staff to be commenced April 2016 6. Specialist agency used to supply nursing and ODA cover 7. 3.1 WTE starting in Feb and March 2016 8. E-Safe Staffing system in use for some ward areas 9. 5% cap on agency spend across the organisation	Jo Thomas	Nicola Reeves	Patient Safety	12	12	↔	**July 2017: improved recruitment & retention C-wing: < 5 wte vacancies.** **DoN & HR director attended NHSI recruitment & retention masterclass July '17: trust to undertake NHSI improvement methodology** **To discuss at EMT: ? close as covered in other risks**	17/05/17

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Rating (initial)	Current Rating	Trend	Progress Updates	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 2 Information security acceptable use e-mail policy in place	Clare Stafford	Nasir Rafiq	Information Governance	12	12	↔	**28/03/2017: Risk tolerances were agreed in December 2016 - ITAD Policy to go to April 2017 IGG.** **QVH encryption software requires business case.** **e-mail surveillance software still not activated** 06/12/2016 Risk to be reviewed as part of IGG 28/09/2016: Technical issues following trial - logged call with support 25/07/2016: Encryption technology for radiology not procured. IT asset disposal policy to be re-drafted and considered by IGG on Tuesday 2nd August 2016. Propose that data leakage prevention software is activated (02/08/2016)	06/06/17
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	12	20	↔	**06/12/2016: Reviewed by Senior Management Team. DoF to review further to ensure score accurate reflects current status.**	06/12/16

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Rating (initial)	Current Rating	Trend	Progress Updates	Date Reviewed
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	12	↔	**06/12/2016 Risk reviewed at senior management team and risk to be reworded**	06/12/16
853	15/10/15	Insufficient space in MIU to treat patients	Building footprint too small for activities of both trauma clinic and MIU walk-in patients, totalling aprox 17,000 patients per annum Lack of privacy and dignity for patients as MIU pts seen in a curtained only area. Clinic patients are seen in appropriate examination rooms.	Plans are in place to move the trauma clinic to an alternative location in 2016 which will free up the required space for walk-in patients.	Jo Thomas	Nicola Reeves	Patient Safety	12	12	↔	**July 2017: works in progress & on schedule for new trauma clinic in A-wing by end of July Consultation in MIU for new working patterns MIU / trauma clinic** 05/01/2017: Work about to commence 08/12/2016: Risk discussed at Q&GC as should be updated to reflect Health records changes and move from Kings House	17/05/17

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Rating (initial)	Current Rating	Trend	Progress Updates	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 assessed and managed. Locum cover promised is now in place. This mitigates against the risk posed by maternity leave	Dr Edward Pickles	Dr Tim Vorster	Patient Safety	12	12	↔	**24/7/17: 'Extending of on-call surgical hours being explored as part of job-planning' - to be added to job planning 17/18** 24/4/17: reviewed with MD & updated: -extended hours consultant anaesthetist cover now in place: to 8pm weekdays and 8am-5pm at weekends plus out of hours trauma -Extending of on-call surgical hours being explored as part of job-planning 20/3/17: risk owner e-mailed for update 3/4/17: follow-up email sent 11/4/17: further e-mail sent requesting update 05/09/2016 - Risk owner contacted by HoR for update on risk as part of risk review process.	24/04/17
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	10	12	↔	**24/7/17: reviewed with MD - Risk Owner e-mailed for update**	07/03/17

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Rating (initial)	Current Rating	Trend	Progress Updates	Date Reviewed
789	12/03/15	Failure to meet Trusts Medical Education Strategy	Inability to meet Trusts Medical Education Strategy: limited pool of non-deanery trainees	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 7. Action Plan being developed in response to GMC survey	Dr Edward Pickles	Chetan Patel	Compliance (Targets / Assessments / Standards)	15	15	↔	**24/7/17: reviewed with MD - from Sept 2017 there will be a full complement of Plastics trainees (from Deanery) - vacancies in Maxfax (registrar level)October 2017 - GMC survey 2017: disappointng for Plastics and CST** 24/4/17: reviewed with MD -Recruitment drive continues -Discussions ongoing with the Deanery re: allocation of trainees -Ongoing exception reporting 02/11/2016 Risk reviewed with Medical Director - No changes	24/04/17

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Rating (initial)	Current Rating	Trend	Progress Updates	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 mismatched data	Sharon Jones	Sheila Black	Information Governance	12	12	↔	**2/8/17: Reviewed at Operations meeting - Risk Owner e-mailed for update** 28/03/2017: Some work has been done to attempt to resolve the issue but the risk remains. Further work continuing - QVH and BSUH to resolve. 15/02/2017: Work has begun to reconcile the data by an IG approved Philips sub-contractor 21/12/2016 Risk reviewed at Business Unit Managers meeting - No change 06/12/16: Software fix installed in Nov 2016, issue still not resolved, on-going work to resolve issue by Philips. Testing at Ashford and St Peters not had the anticipated results. 30/09/2016: Update from PACS Manager: Technical issue is with Philips, requires for the VNA and SQL servers to be upgraded. Philips to provide reconsolidation tool to identify the mismatches. Lengthy process therefore completion date is 31 March 2017. 28/09/2016: No further updates - next meeting scheduled for 7th October 2016 Reviewed in RPC meeting 13/09/16 IGG to Review Risk Score at September 2016 meeting (06/09/2016)	15/06/17

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/09/2017**		**Agenda reference:**	**139-17**	
Report title:	**Quality and governance assurance report**				
Sponsor:	Ginny Colwell, NED and Committee Chair				
Author:	Ginny Colwell, NED and Committee Chair				
Appendices:	None				
Executive summary					
Purpose:	To provide assurance to the Board in relation to matters discussed at the Quality and Governance Committee 17th August 2017				
Recommendation:	The Board is asked to **NOTE** the contents of the report				
Purpose:				**Assurance**	
Link to key strategic objectives (KSOs):	KSO1: **Y/N**	KSO2: **Y/N**	KSO3: **Y/N**	KSO4: **Y/N**	KSO5: **Y/N**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	17/08/17	Decision:		
Next steps:	NA				

Report to:	Board of Directors
Meeting date:	07 September 2017
Reference number:	139-17
Report from:	Ginny Colwell, committee chair and NED
Author:	Ginny Colwell, committee chair and NED
Appendices:	N/A
Report date:	24 August 2017

Quality and Governance Assurance Report
Meeting held in August 2017
Areas of particular note for assurance

1. The committee received an update on the 13 CQUIN schemes (£1.1 million). There is a risk to the Trust achieving the e-referral CQUIN and so this has been added to the risk register.

2. A detailed Root Cause Analysis (RCA) regarding the death of a patient and subsequent coroner's findings was received by the committee. The original RCA has had additional information/actions added and has now been resubmitted to the CCG.

3. The Quarter 1 infection control report was presented and provided good assurance on the activity taking place.

4. The committee received an extensive report and action plan regarding site security. The prioritised action plan will be monitored in a subgroup and return to Q&GC on a 6-monthly basis.

5. A number of annual reports were reviewed by the committee prior to submission to the Board. These included Infection Prevention and Control, Safeguarding, Research and development, Patient Experience, Emergency Preparedness and Information Governance. Next year the Q&GC additional meeting will be brought forward to enable review of these reports to align with the Board schedule.

6. The committee received the national cancer patient survey and Children and young people's inpatient survey. QVH compared well, and action plans will be developed and monitored in subgroups.

7. Other papers received followed the annual schedule- further detail on the quality matrix information is available in the Executive report

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	**07/09/17**	**Agenda reference:**	**140-17**		
Report title:	Quality and Safety Report, September 2017				
Sponsor:	Jo Thomas, Director of Nursing and Quality				
Author:	Jo Thomas, Director of Nursing and Quality				
Appendices:	NA				
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. The Board should note the continued challenges for the Trust in respect of the nursing workforce vacancies. Enhanced scrutiny of the safety of the care provided and the patient experience continues and the impact on access standards is also being monitored.				
Recommendation:	The Board is asked to review and seek assurance that the contents of the report reflect the quality and safety of care provided by QVH.				
Purpose:	Approval **N**	Information **Y**	Discussion **N**	Assurance **Y**	Review **Y**
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:	No new implications for the BAF.				
Corporate risk register:	The nursing workforce risks have been reviewed and amended on the CRR.				
Regulation:	Compliance with regulated activities in Health and Social Care Act 2008 and the CQC's Fundamental Standard.				
Legal:	As above				
Resources	No changes				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	11/08/17	Decision:	Reviewed and approved	
Next steps:	NA				

Executive Summary - Quality and Safety Report, September 2017

Domain	Highlights
Safe	There has been one case of hospital acquired MSSA bacteraemia in the Burns Unit (July 2017). Root cause analysis is awaited to determine cause. Immediate actions taken to stop any further cross infection.
Effective	A clinical audit of Pain in Children is being undertaken in MIU - this is based on the national audit standards set by the Royal College of Emergency medicine.
Caring	There were 11 new complaints in June and July relating to a range of issues including communication, clinical care/treatment and one relates to patient choice of operating day. 98 % of inpatients completing the June and July FFT surveys would recommend QVH.
Responsive	MIU performance continues to perform better than national indicator. In June 99% and in July 100% of patients were assessed and treated within 4 hours.
Nursing Workforce	The vacancy rate for nurses, theatre practitioners and health care assistants is 20.75%, and the number of posts we are recruiting to is 66 WTE. The trust is participating in the NHSI retention support programme and has attended the launch of this in July 2017 with the aim of improving retention in participating trust in the next 12 months. Staff continue to work flexibly and appropriate use of agency staff, and bank staff continues to support the safe delivery of quality care. Interim opening hours for Peanut ward remain in place in order to maximise the staffing resource available and provide safe care. This is due to the vacancy factor and the unavailability of paediatric agency nurses. The provision of triage and referral services for children out of hours continues. Prospective audit of the impact of this is being carried out. Vacancies in theatres and critical care remain high. The move of step down patients from Canadian Wing to Critical Care has been positive with a decrease in risk as the most acutely unwell patients being cared for in one area. The nursing workforce in critical care has been better utilised and positive comments about this new arrangement have been fed back.

Safe - Current Compliance

Domain	Current Compliance	Next Steps
Infection control	There has been one case of hospital acquired MSSA bacteraemia in the Burns Unit (July 2017). Root cause analysis is awaited to determine cause. There have been 0 MRSA bacteraemia cases and 0 Clostridium difficile infections (CDI) attributed to QVH in Q1 2017. On July 4th 2017 water samples from the Wassenberg machine in theatres showed a high Total Viable Count (TVC) of mycobacterium. The machine was immediately taken out of service and remedial action undertaken including filter changes and water chlorination. Further samples sent but there is a 28 day wait for culturing. Whilst machine not in use non-lumened scopes and equipment are to be cleaned using a manual decontamination protocol as approved by the Health Technical Memorandum guidance. Any lumened scopes and equipment not suitable for manual decontamination are being sent to East Sussex Hospitals NHS Foundation Trust decontamination services.	Work continues with senior nursing staff to improve documentation and line care on all patients. Authorised Engineer for decontamination attending site to review all actions and water sample results and machine to remain out of action until this has happened, potential date for this is the 16th August. MRSA screening of trauma patients is below the target, Heads of Nursing and IPAC are working together to identify the causes for this as a new process has been implemented. Formal management of non-compliance will be undertaken. A retrospective audit of MRSA screening has been undertaken, which identified gaps in staff knowledge, surrounding which patients to screen and when. IPAC are meetings with ward matrons to schedule additional training.

Medication errors	**June:** Nine patient safety medication related incidents were reported – intervention by Pharmacy staff prevented harm occurring. **July:** Four patient safety medication related incidents were reported, all with no or low harm.	This is a reduction against previous months. The Pharmacy Medicines Governance & Medication Safety officer leads the investigation for all medication incidents, working closely with clinical leads undertaking in-depth scrutiny of errors and ensuring that the learning from incidents is identified and shared. Wherever possible, and in areas of highest incidents, a member of the pharmacy team attends specialty governance meetings to discuss and advise.
Serious Incidents/ Never Event	There were no Never Events or Serious Incidents occurred in June or July 2017.	Work is underway to streamline the initial response to all incidents that require consideration as a Serious Incident or Never Event; this includes mapping the process from initial reporting of incident to discussion and agreement between senior executive team and Head of Risk.
Pressure ulcers	**June:** There were two grade 2 hospital acquired pressure sores recoded this month. Both were reported within the Burns ITU. **July:** There was one Grade 2 hospital acquired pressure sore recorded this month which occurred on the inpatient ward.	A route cause analysis (RCAs) is undertaken for all grade 2 and above hospital acquired pressure sores, and learning will be presented to the Nursing Quality Forum for peer review and scrutiny. Following this critical appraisal, the RCAs will be presented to the Trust's Quality and Governance Committee.
Falls	**June:** There were four inpatient falls which occurred in the inpatient ward. **July:** There were three inpatient falls reported. Two occurred in the critical care unit and one in the inpatient ward.	A falls deep dive investigation was undertaken at the beginning of 2017 and the findings will be presented to the Nursing Quality Forum in August 2017. A new Falls Pathway will be launched at the Nursing and Quality Forum in August 2017 and trialled across the Trust.

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 2 2016/17		Quarter 3			Quarter 4			Quarter 1 2017/18			Quarter 2	12 month total/ rolling average
			Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	
Infection Control															
MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile acquired at QVH post 72 hours after admission	1	0	0	0	0	0	1	0	0	0	0	0	0	0	1
MRSA screening - elective	98%	>95%	94%	96%	96%	98%	97%	98%	97%	97%	98%	98%	97%	99%	97%
MRSA screening - trauma	97%	>95%	93%	93%	95%	98%	93%	96%	94%	99%	95%	96%	96%	94%	95%
Incidents															
Never Events	0	0	0	1	1	0	0	0	0	0	1	0	0	0	3
Serious Incidents	3	0	0	0	0	1	0	0	1	0	0	1	0	0	3
OOH inductions:															
All patients: Number of patients operated on out of hours 22:00 - 08:00		5	7	5	0	4	4	5	2	1	2	6	5	8	28
Paediatrics under 3 years: : Induction of anaesthetic was between 18:00 and 08:00		0	0	1	0	0	0	0	0	0	0	0	0	0	1
Paediatric transfers out (<18 years)			0	1	0	1	0	1	2	1	3	0	1	TBC	10
Medication errors															
Total number of incidents involving drug / prescribing errors	191		12	9	8	13	4	11	16	11	8	10	8	4	114
No & Low harm incidents involving drug / prescribing errors	191		12	9	8	13	4	11	16	11	8	10	8	4	114
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		0.7	2.3	1.8	5.3	0.6	0.7	0.7	1.1	2	2.7	0.5	1.7	1.7
Harm free care rate (QVH)	97%	>95%	91%	91%	97%	96%	98%	96%	97%	97%	100%	100%	100%	98%	97%
Harm free care rate (NATIONAL benchmark) - one month delay	94%	>95%	94.2%	94.1%	94.2%	94.3%	94.3%	94.1%	94.0%	94.1%	94.0%	94.2%	unavail	94.2%	
Pressure Ulcers															
Hospital acquired - grade 2	11	15	2	0	1	1	1	0	1	0	0	2	2	1	11
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%	100%	100%	97%	96%	100%	100%	100%	100%	100%	100%	100%	100%	99.4%
Patient Falls															
Patient Falls assessment completed within 24 hrs of admission	94%	>95%	100%	98%	100%	96%	98%	96%	100%	97%	100%	100%	100%	100%	98.7%
Patient Falls resulting in no or low harm (all falls)	40		0	3	2	5	2	6	10	2	3	7	6	4	50
Patient Falls resulting in moderate or severe harm or death	0		0	0	0	0	0	0	1	0	1	1	0	0	3

Effective - Current Compliance

Domain	Current Compliance	Next Steps
Mortality	**June:** There were no QVH mortalities and two patients died elsewhere within 30 days of discharge. **July:** There were no QVH mortalities and no patients died elsewhere within 30 days of discharge.	The Trust's Policy on how the Trust Responds to and Learns from Deaths which have occurred at QVH has now been drafted and is awaiting executive review before being sent out for consultation across the Trust. The expected date for ratification September 2017.
Transfers out	There were five emergency or unexpected transfers out in June 2017. One of these was a paediatric patient. Three unexpected and emergency transfers out occurred in July 2017.	Details of the Trust's transfers continue to be disseminated across the Trust via the monthly Clinical Indicators Report. This report now identifies those patients who were admitted to the Critical Care Unit or Step Down.
Antimicrobial Stewardship	The Antimicrobial App for the Trust was launched in June 2017. The launch was promoted via Connect and email, as well as on induction for all new junior doctors commencing work in August 2017. The 2016/17 CQUIN for a 1% reduction in: overall antibiotic use, carbapenem use and piperacillin/tazobactam use, was met. The Clinical directors have been written to informing them that this CQUIN continues into 2017/18.	The CQUIN for 2017/18 aims to achieve a further 1% reduction in overall, carbapenem and piperacillin/tazobactam use. An action plan has been compiled to achieve this. The shortage of piperacillin/tazobactam continues and is still being managed appropriately at the Trust. A drive to improve the documentation of indication and review/ stop date for antimicrobials is underway.

Clinical audit	QVH is now submitting cataract data to the National Ophthalmology Audit, which is commissioned by the Royal College of Ophthalmologists. Consultant/ doctors training took place on 2nd August, and further training will be scheduled to for those who could not attend this date. This audit is now continuing until Aug 2019.	A clinical audit of Pain in Children is being undertaken in MIU - this is based on the national audit standards set by the Royal College of Emergency medicine. The Trust is not eligible to participate in this national audit which looks at current performance in emergency departments but has chosen to take it forward in MIU to improve patient experience.
CQC	As part of our preparations for the next unannounced CQC inspection the Trust is undertaking a programme of mock inspections (mini-mocks) across the Trust, which will be carried out by a team of clinical and non-clinical staff members from QVH. The team will use their professional judgement, supported by objective data and evidence collected to assess how the area performed against the CQC's 5 domains.	Results of the mini-mock inspections will be fed back to individual areas at the soonest opportunity to ensure gaps identified can be remedied.

Effective - Performance Indicators

Metric	2015/16 total / average	Target	Quarter 2 2016/17		Quarter 3			Quarter 4			Quarter 1 2017/18			Quarter 2	12 month total/ rolling average
			Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	
Mortality															
QVH Mortalities	6	0	0	0	0	1	0	0	0	0	0	1	0	0	2
Mortality elsewhere within 30 days of discharge	15	0	0	2	3	2	1	1	2	2	1	4	2	0	20
Readmissions															
Emergency Readmissions Within 30 Days	1.87%	2.24%	3.02%	2.64%	1.91%	2.27%	1.98%	2.07%	2.02%	2.83%	2.64%	3.07%	4.72%	3.39%	2.78%
Emergency Readmissions Within 7 Days	1%	1.21%	1.34%	1.81%	1.02%	1.10%	1.12%	1.31%	1.05%	1.60%	1.03%	1.18%	1.90%	2.24%	1.35%
Paediatric safeguarding															
Paediatric safeguarding cases*			20	12	25	17	15	24	10	16	15	18	21	23	191
Allegations against staff			1	0	0	0	0	0	0	0	0	0	0	0	1
Safeguarding adults															
Adult Safeguarding cases*			10	6	7	4	5	4	2	10	4	5	8	5	70
Allegations against staff			0	0	0	0	0	0	0	0	0	0	0	0	0
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	0	1	1	0	0	0	0	1	0	4
Prevent Referrals			0	0	0	0	0	0	0	0	0	0	0	0	0
Infection control audit															
Hand hygiene audit %			99%	99%	95%	99%	100%	100%	100%	99%	99%	100%	100%	99%	99%
Bare below the elbows %			100%	100%	99%	99%	99%	99%	99%	99%	99%	100%	100%	100%	99%
Trust Cleaning %			92%	92%	91%	91%	90%	89%	89%	90%	86%	88%	89%	88%	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	There are two Productivity and Efficiency Groups reviewing Ward and Outpatient effectiveness. These groups have been tasked with reviewing patient pathways and overall systems in our clinical areas to ensure we are able to deliver efficient effective care to our patients.	Terms of reference for the Productivity and Efficiency Group have been agreed, work streams have been defined and are meeting moving forwards.
Complaints	June and July – eleven complaints were received. Eight relate to relate to communication, two relate to clinical care/treatment and one relates to patient choice of operating date (ten have been graded as minor and one as moderate).	As part of staff training they are made aware that instead of treating concerns and complaints with suspicion, they are to be used to see how we might improve our service going forward, especially as in the majority of cases, patients and carers who raise issues, when asked what outcomes they would like to see, say that they do not want the same thing that happened to them to happen to anybody else. We will continue to put patients first and, listen to their concerns, fears and feedback so that we can continually strive towards delivering quality care and services that they can trust.

Friends and Family Test (FFT)	Inpatients: In June 98% of inpatients (response rate of 33.5%) who completed FFT survey would recommend QVH. In July this was again 98% (with a slightly improved response rate of 38% (national target is 40%)) who completed the FFT survey would recommend QVH. Outpatients: The FFT score for out-patients in June was 95%. A total of 2093 outpatients out of a possible 13757 completed the questionnaire either by paper, SMS or integrated voice message (response rate of 15%). In July this was 94% (response rate of 16.5% (national target is 20%)) with 2158 out of 13064 completing the survey.	The FFT score remain stable, however the Patient Experience Manager together with Matrons and Heads of Nursing continue to remind staff to hand out the surveys in an aim to improve our response rate and source of feedback.

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

Caring - Performance Indicators

Metric	2015/16 total / average	Target	Quarter 2 2016/17		Quarter 3			Quarter 4			Quarter 1 2017/18			Quarter 2	12 month total/ rolling average
			Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	
Complaints															
Complaints per 1000 spells *	2.7		4.6	2.3	3.0	2.0	1.2	5.4	2.8	2.1	2.0	2.2	2.2	3.9	2.8
Claims per 1000 spells *	1.1		0.0	0.0	0.6	0.7	0.0	1.4	0.0	1.1	2.0	1.1	1.6	0.0	0.7
Friends and Family Test															
FFT score acute in-patients: likely and very likely to recommend QVH	99%	>90%	98%	98%	98%	97%	97%	98%	98%	99%	99%	99%	98%	98%	98%
FFT score acute in-patients: unlikely and very unlikely to recommend QVH	0%		1%	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	0%
FFT score MIU: likely and very likely to recommend QVH	94%	>90%	96%	97%	96%	97%	95%	97%	97%	94%	98%	98%	96%	95%	96%
FFT score MIU: unlikely and very unlikely to recommend QVH	3%		5%	2%	2%	3%	3%	2%	1%	2%	0%	1%	3%	3%	2%
FFT score OPD: likely and very likely to recommend QVH	95%	>90%	94%	94%	95%	94%	94%	94%	94%	95%	95%	95%	95%	94%	94%
FFT score OPD: unlikely and very unlikely to recommend QVH	2%		3%	3%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
FFT score DSU: likely and very likely to recommend QVH	97%	>90%	96%	94%	98%	98%	97%	96%	96%	97%	97%	97%	96%	96%	97%
FFT score DSU: unlikely and very unlikely to recommend QVH	1%		2%	3%	0%	0%	0%	0%	1%	0%	1%	2%	0%	1%	1%
FFT score Sleep disorder centre: likely and very likely to recommend QVH	97%	>90%	100%	94%	96%	96%	91%	96%	99%	100%	98%	94%	93%	100%	96%
FFT score Sleep disorder centre: unlikely and very unlikely to recommend QVH	1%		0%	1%	0%	0%	0%	0%	0%	0%	1%	1%	2%	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%	94%	100%	100%	100%	100%	100%	100%	100%	99%	100%	99%	100%	99%

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

Responsive - Current Compliance

Domain	Current Compliance	Next Steps
Compliance in Practice (CiP)	The inspection schedule for Q1 2017/18 has concluded. Overall compliance for the period was 85.6%, matching the previous quarter's score and maintaining the rating of 'Good'. The Safeguarding section registered a slight decline in performance. This can be attributed to the introduction of new lines of enquiry which have highlighted some gaps in knowledge, particularly in relation to the DoLS acid test. Stronger performance was seen in the Professional Record Keeping Standards section, which achieved a rating of 'Good' for the first time. The newly devised department action plan has now gone live and will be issued alongside the department report.	CiP inspection process will be postponed for one quarter to be replaced with 'mini mock' inspections in preparation for an anticipated visit from the CQC later in 2017. Latest CiP Quarterly Assurance Report (Q1 2017/18) to be presented at the next Quality and Governance Committee. Feedback to be provided to the safeguarding team regarding the results of the new lines of enquiry. Monitor the use of the new action plan in relation to both the completion of any actions and any technical issues.

Incident Reporting	**June:** 151 incidents were reported in total, 70 of which were Patient Safety incidents; 58 of these were No Harm/Near Miss incidents, ten were Minor Harm. There were two Moderate Harm incidents and 2 CAT2 Pressure Ulcers. **July:** 161 incidents were reported in total, 68 of which were Patient Safety incidents; 54 of these were No Harm/Near Miss incidents, there were seven Minor Harm incidents and seven Level of Harm Unknown. There was one CAT2 Pressure Ulcer. Identified themes: Unplanned admission to ITU/Transfer out, Cardiac Arrest/MET calls, Lack of resources (staff, equipment, facilities, etc.) and investigation delays	Work is ongoing to ensure compliance with the Duty of Candour statute. A pilot form has been introduced, to be completed and included within the patients notes reminding staff of each of the required stages. The Trust is committed to ensuring that all incidents are investigated thoroughly and high standard reports produced: investigation training is scheduled to be implemented within the Trust from the autumn of 2017. This will be multi-professional, initially for key staff, encompassing a structured approach to incident investigation, from information collection to analysis, report writing and recommendations / action plans.

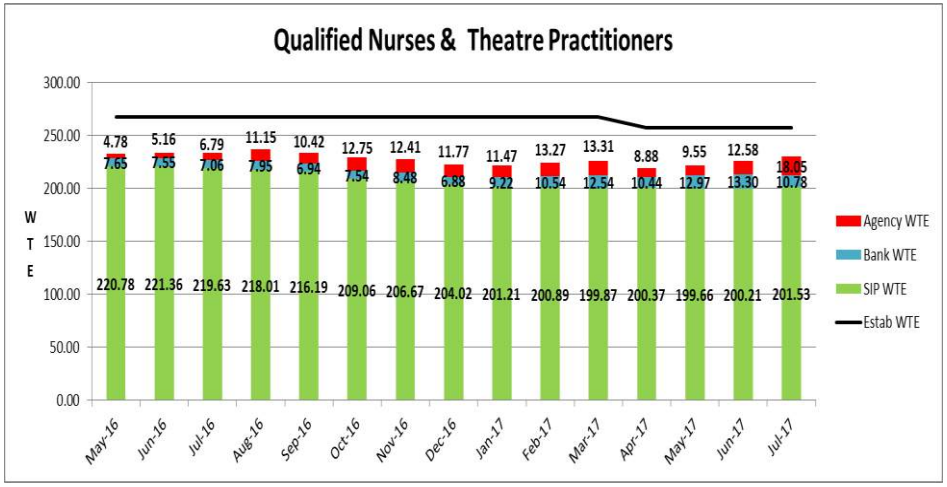
Nursing Workforce - Current Compliance

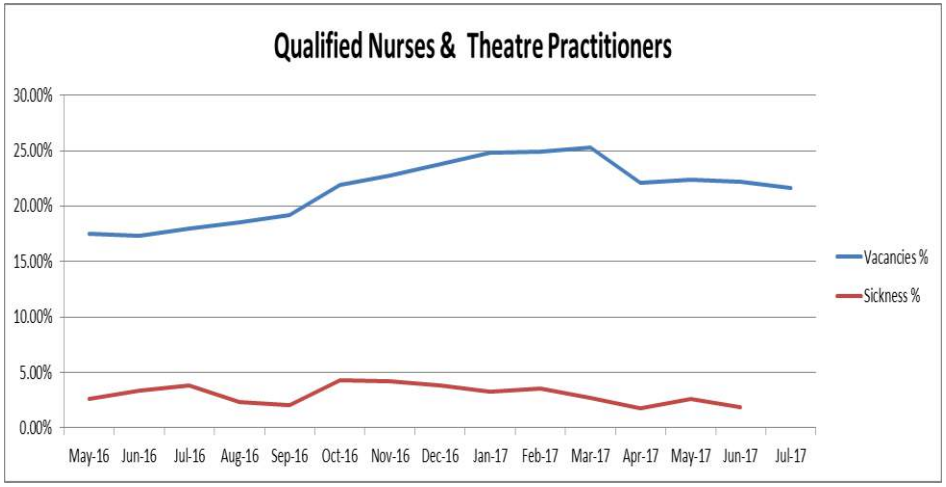
Domain	Current Compliance	Next Steps
Ross Tilley	On 7/122 occasions staffing numbers did not meet planned levels, all escalated, no unsafe care. Reasons for not meeting planned staffing levels were staffing adjusted to bed occupancy, vacancy and short notice sickness. In addition, on occasions, staff were moved to support other areas. There were no Datixes linked to shifts where there was reduced staff.	Staffing according to bed occupancy and acuity. All dates where escalation re staffing required have been triangulated with Datix safety incidents, ward FFT scores and complaints information no incidents or harms align with these dates. Ward productivity group is reviewing occupancy as part of a larger piece of work.
Margaret Duncombe	On 16/122 occasions staffing numbers did not meet planned level, safe care provided. All escalated safe care achieved. Reasons for not meeting planned staffing levels due to staffing adjusted to bed occupancy, vacancy and short notice sickness.	Flexible use of staff continues as per comment for Ross Tilley. Sickness on C wing is being actively managed and additional scrutiny of quality indicators has been undertaken. One fall in June did occur on a shift with reduced staffing levels due to reduced patient numbers. One pressure ulcer reported in July, not attributable to staffing numbers. Changes in the pathway of step down cases has resulted in an overall reduction in dependency and bed numbers.
Burns	On 7/122 occasions staffing numbers did not meet planned levels, all escalated , safe care achieved. Reasons for not meeting planned staffing, vacancy and short notice sickness.	All dates where escalation re staffing required have been triangulated with Datix safety incidents, ward FFT scores and complaints information.

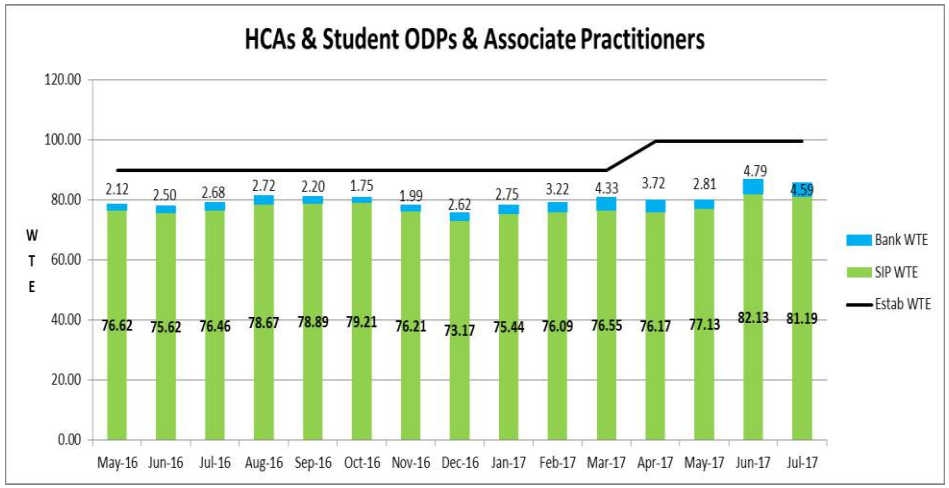
Peanut	On 35/122 occasions staffing numbers shift did not meet levels of care. Safe care was maintained by adjusting ward opening times to make best use of resources. Due to ongoing recruitment and retention challenges interim opening hours of 07.00 to 00.00 with on call cover after 00.00 have been in place. Staff are rostered to work nights when there is elective activity. The consequence of this has been, during June and July, the ward has been closed to admissions on 22 nights with burns ward taking referrals. Reasons for not meeting planned staffing include no requirement to be open due to lack of patients, increasing vacancy and short notice sickness.	Director of Nursing and Medical Director fully briefed on the situation flexible working solution. EMT have agreed the revised opening hours and this paper will also be presented for information agreed at EMT in July and to be discussed at HMT in August. Shifts where escalation required have been triangulated with Datix safety incidents, complaints information and ward FFT scores. No incidents or harms align to these dates but there have been minimal 'transfers out' due to the staffing levels. Line booking of one agency nurse now in progress and ongoing recruitment.
Critical Care (ITU)	On 8/122 occasions, staffing numbers did not meet planned levels, escalated and safe care achieved with staff being redeployed from step down and on one night site practitioner providing cover.	Two pressure ulcers have been reported in June, one was identified on a day with reduced staffing and RCA is in progress. 2 falls occurred in July but neither was attributed to reduced staffing numbers. There are substantive and bank staff currently being processed via recruitment. High vacancy in this area adds risk to the quality of care mitigation is in place led by HoN and ward matron. Changes in the critical care pathway has led to an increase in numbers of patients which has had a positive impact on staff morale.
Site Practitioner Team	On 23/122 occasions, staffing numbers did not meet planned levels of two staff on duty. Reasons for not meeting planned staffing are vacancy related. One member of the team are is currently on secondment within the trust offering support to another areas and one member of staff has left the team.	There was always a Site practitioner day and night with the Deputy Director of Nursing, Heads of Nursing and critical care providing additional support as required to the team and the Trust.

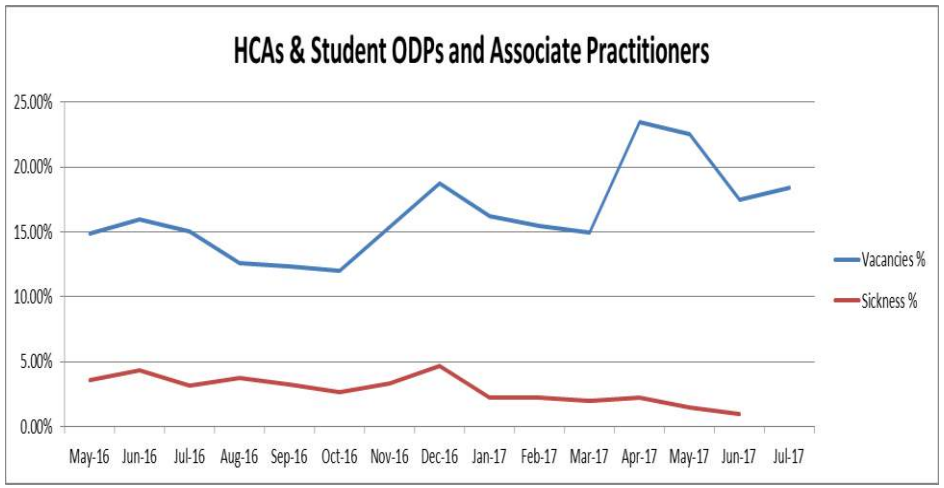
Data extracted from the workforce score card in appendix 1

Nursing Workforce - Performance Indicators









BURNS WARD 12 MONTH ROLLING		SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	DoN Rating: Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Staff Utilisation														Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
														No / %					
Vacancies	WTE	2.2	4.4	4.4	4.4	6.7	6.7	6.7	9.65	7.15	8.84	8.84		10%					33.29 wte Staff complement based on revised budget June 2017 but final budgets not yet signed off
Est =	(hrs)	82.5	715	715	715	1088	1088	1088	1568	1161	1436	1436							
Temp staffing exc RMN	Bank	72	N/A	74.25	147	145	248	366	276	394	372	337		10%					
	Agency	30	69	57.5	57.5	11.5	293	110	0	34.5	178	92							
Sickness	%	1.8%	2.2%	2.0%	1.7%	2.0%	3.4%	1.9%	1.8%	1.3%	1.1%	3.8%		2%					Sickness being monitored by HoN
Shift meets est %	RN	100%	96%	95%	96%	97%	99%	98%	98%	99%	94%	98%		95%					
Day	HCA	88%	98%	100%	94%	100%	97%	100%	94%	97%	95%	98%		95%					
Shift meets est %	RN	100%	100%	97%	97%	95%	104%	97%	93%	98%	102%	100%		95%					
Night	HCA	100%	100%	100%	100%	300%	100%	100%	100%	100%	100%	100%		95%					
Training / Appraisal														Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
														No / %					
Appraisals	%	N/A	66%	N/A	78%	69%	67%	69%	81%	86%	81.3%	83.3%		95%					improvement in month
Statutory & Mand.	%	N/A	88%	N/A	90%	94%	94%	91%	93%	91%	86.8%	86.8%		95%					
Drug Assessments	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	93%	93%	89%	95%					
Staff FFT Score	%	_	_	_	_	_	_	_	_	_	_	_	_	_					
Budget	(YTD)	10663	14951	15406	27000	72240	56203	134000	40384	34632	38138	31005		<0					
Safe Care														Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
														No / %					
Pressure Ulcers	G2+	2	0	0	0	0	0	0	0	0	0	0		0					
Falls	With harm	1	0	0	0	0	0	0	0	1	0	0		0					
Medication Errors	All	1	0	1	0	1	0	0	0	0	1	1		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	9	3	6	2	3	8	2	3	4	3	2							
VTE reassessment	%	100%	100%	100%	66.7%	100%	100%	100%	100%	100%	100%	100%	100%	95%					
Nutrition assessment (MUST)	Initial	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%					0% reassessment due to sample size - only one patient applicable but not reassessed.
	7 day r/v	100%	100%	100%	100%	100%	100%	0%	100%	100%	100%	100%	100%						
Patient numbers		65	43	62	47	46	39	56	37	60	61	56		N/A					
Patient FFT Score	%	100%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%		95%					

CRITICAL CARE 12 MONTH ROLLING		SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	DoN Rating					QVH
Staff Utilisation	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies	WTE	7.11	9.11	8.26	7.89	7.89	7.89	7.89	7.89	14.39	9.02	9.02		10%					Budgeted establishent 28.16 wte - not yet signed off
Est =	(hrs)	1155	1480	1342	1282	1282	1282	1282	1282	2338	1465	1465							
Temp staffing exc RMN	Bank	79	8	64.7	5.75	16.5	0	150	227.5	101.5	169	189		10%					OT hours only zero bank hours March 2017
	Agency	40	310	115	139	195.5	368	226	448.5	252.5	265	586							
Sickness	%	1.4%	1.5%	1.7%	4.8%	4.3%	3.1%	3.8%	1.0%	1.5%	0.9%	0.7%		2%					
Shift meets est %	RN	92%	96%	96%	94%	99%	95%	95%	99%	100%	97%	97%		95%					
Day	HCA	100%	113%	100%	100%	100%	100%	115%	100%	100%	90%	100%		95%					
Shift meets est %	RN	79%	87%	81%	84%	94%	97%	78%	94%	91%	92%	95%		95%					
Night	HCA	100%	100%	100%	100%	100%	150%	100%	100%	100%	100%	100%		95%					
Training / Appraisal	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals	%	41.2%	21%	57%	57%	57%	58%	83%	88%	88%	100%	89.5%		95%					
Statutory & Mand.	%	78.4%	83%	86%	86%	80%	82%	77%	79%	80%	89.3%	88.3%		95%					Improvement plan requested
Drug Assessments	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	not avail	not avail		95%					
Staff FFT Score	%	_	_	_	_	_	_	_	_	_	_	_	_	_					
Budget	(YTD)	28789	24244	14435	2000	4502	17418	33000	13367	34161	58686	894		<0					Budgets not signed off reconcilliation required
Safe Care	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	G2+	0	1	0	1	0	1	0	0	0	2	0		0					
Falls	With harm	0	0	1	0	0	0	0	0	0	0	0		0					
Medication Errors	All	0	1	1	0	0	3	0	0	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	9	12	8	9	6	12	3	10	6	9	20							
VTE reassessment	%	66.7%	80%	N/A	33.3%	100%	66.7%	100%	N/A	100%	0%	100%	100%	95%					
Nutrition assessment (MUST)	Initial	100%	80%	N/A	100%	100%	100%	100%	N/A	100%	50%	100%	100%	95%					
	7 day r/v	50%	100%	N/A	100%	N/A	100%	N/A	N/A	100%	N/A	100%	100%						
Patient numbers		_	_	_	_	_	_	_	_	_	_	_	_	N/A					
Patient FFT Score	%	_	_	_	_	_	_	_	_	_	_	_	_	95%					

CANADIAN WING 12 MONTH ROLLING		SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	DoN Rating Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Staff Utilisation	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies	WTE	7.66	9.16	11.85	11.85	11.85	6.45	7.12	7.12	4.79	6.29	8.99		10%					This vacancy needs to be matched against budget which is currently not accurate. 50.18 wte currently. Finance working with Deputy Director of nursing to correct..
Est =	(hrs)	1245	1488	1925	1925	1925	1048	1157	1157	778	1022	1460							
Temp staffing exc RMN	Bank	364	227	280	374	317	368	509.5	243.5	316.5	555	407		10%					Final budget not singed off currently due to discrepencies. Working with finance to ensure correct moving forward.
	Agency	440	289	172.5	299	162	188	314.5	54	174.5	115	173							
Sickness	%	3.2%	3.3%	4.0%	3.2%	2.1%	3.3%	3.2%	2.2%	3.2%	3.5%	2.6%		2%					Sickness being managed as per policy.
Margaret Duncombe	*Safe Staffing*													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Shift meets est %	RN	101%	97%	102%	96%	98%	99%	98%	99%	100%	97%	99%		95%					
Day	HCA	94%	92%	98%	100%	98%	94%	95%	102%	100%	90%	97%		95%					
Shift meets est %	RN	101%	100%	111%	98%	100%	93%	98%	95%	100%	97%	94%		95%					Staffing is matched to patient acuity to ensure safe staffing. HCA vacancy currently which has led to challenges with temporary staffing cover.no unsafe care
Night	HCA	85%	88%	65%	58%	81%	59%	89%	93%	100%	100%	73%		95%					
Ross Tilley	*Safe Staffing*													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Shift meets est %	RN	92%	99%	99%	93%	99%	96%	95%	99%	100%	100%	100%		95%					
Day	HCA	90%	98%	105%	98%	95%	102%	92%	100%	98%	100%	98%		95%					
Shift meets est %	RN	94%	86%	94%	97%	95%	87%	98%	89%	94%	83%	99%		95%					lower staffing levels at night reflect bed occupancy
Night	HCA	71%	82%	55%	57%	71%	84%	89%	90%	96%	95%	85%		95%					
Training / Appraisal	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals	%	100%	100%	100%	90%	91%	98%	98%	100%	100%	98%	94%		95%					
Statutory & Mand.	%	83%	N/A	83%	85%	85%	87%	89%	88%	88%	91%	94.5%		95%					improving position
Drug Assessments	%	100%	97.5%	100%	100%	100%	100%	100%	100%	100%	100%	100%		95%					
Staff FFT Score	%	–	–	–	–	–	–	–	–	–	–	–	–	–					
Budget	(YTD)	13962	27912	40597	42000	42346	85078	103000	11267	20589	28289	33744		<0					Budget not signed off some reconciliation required. Overspend relates to SDU move and staffing requirements

CANADIAN WING 12 MONTH ROLLING		SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	DoN Rating					
Safe Care		No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Margaret Duncombe																			
Pressure Ulcers	G2+	0	0	0	1	0	0	0	0	0	0	1		0					investiagtion underway by Ward Matron to ascertain learning.
Falls	With harm	0	0	1	0	0	1	1	1	0	0	0		0					
Medication Errors	All	2	1	1	2	5	5	3	4	0	1	0		0					Review by ward pharmacist and ward matron new training package developed
C. Diff		0	0	0	1	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	13	11	8	7	15	12	7	11	8	8	6							
VTE reassessment	%	100%	100%	90.9%	58.3%	100%	100%	100%	100%	100%	100%	100%	90%	95%					
Nutrition assessment (MUST)	Initial	100%	100%	100%	94.4%	100%	100%	100%	100%	100%	100%	100%	100%	95%					
	7 day r/v	100%	100%	100%	100%	100%	100%	100%	100%	33.3%	100%	100%	100%						
Patient numbers		157	173	158	149	116	114	166	171	170	169	160		N/A					
Patient FFT Score	%	98%	98%	98%	97%	97%	97%	100%	98%	100%	96%	99%		95%					
Ross Tilley														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	1	0		0					
Medication Errors	All	4	6	4	1	2	7	0	2	6	2	1		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	15	10	9	8	11	9	4	3	11	6	8							
VTE reassessment	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%					
Nutrition assessment (MUST)	Initial	94.1%	100%	83.3%	100%	100%	93.8%	100%	100%	100%	100%	100%	100%	95%					
	7 day r/v	100%	100%	N/A	75%	N/A	100%	N/A	N/A	100%	100%	100%	100%						
Patient numbers		207	210	207	185	157	137	189	168	206	212	234		N/A					
Patient FFT Score	%	99%	98%	97%	98%	99%	99%	97%	100%	97%	99%	97%		95%					

PEANUT WARD 12 MONTH ROLLING		SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	DoN Rating Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Staff Utilisation								No / %											
Vacancies	WTE	2	2	2.6	4.5	4.5	4.5	4.5	6	6.49	6.5	6.5		10%					Staff complement based on revised June 2017 budget figures 23.25 wte
Est =	(hrs)	325	325	422	731	731	731	731	975	1054	1056	1056							
Temp staffing exc RMN	Bank	231	90.5	216.25	119.25	322	260	365	234.5	265	381	373		10%					Line booking of agency requested to provide consistency of care. Bed closure at night have resulted. Twighlight shift trial in progress.
	Agency	34	34.5	46	33.5	80	34.5	34.5	50	46	46	210							
Sickness	%	3.3%	7.3%	2.6%	5.0%	8.0%	6.4%	3.1%	3.2%	2.6%	3.1%	3.7%		2%					Increasein sicknessis being monitored by HoN
Shift meets est %	RN	98%	96%	102%	95%	100%	99%	96%	98%	101%	90%	99%		95%					
Day	HCA	104%	92%	93%	97%	94%	97%	106%	100%	100%	97%	103%		95%					
Shift meets est %	RN	98%	90%	88%	75%	89%	70%	56%	51%	49%	51%	59%		95%					reflects interim planned staffing levels and reduced opening hours
Night	HCA	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		95%					
Training / Appraisal								No / %											
Appraisals	%	N/A	66%	75%	75%	75%	64%	64%	77%	80%	84.0%	83.3%		95%					improvement plan requested
Statutory & Mand.	%	N/A	84%	79%	79%	82%	84%	85%	84%	88%	90.2%	91.3%		95%					as above
Drug Assessments	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	not avail		95%					
Staff FFT Score	%	_	_	_	_	_	_	_	_	_	_	_	_	_					
Budget	(YTD)	12903	16973	15559	18000	21223	21307	29000	2222	4611	5910	11060		<0					
Safe Care								No / %											
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	1	1	1	1	0	0	1	1	0	0	1		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	3	6	2	1	1	3	4	1	2	5	5							
VTE reassessment	%	_	_	_	_	_	_	_	_	_	_	_	_	95%					N/A
Nutrition assessment (MUST)	Initial	_	_	_	_	_	_	_	_	_	_	_	_	95%					N/A
	7 day r/v	_	_	_	_	_	_	_	_	_	_	_	_						
Patient numbers		216	226	202	163	149	139	191	191	209	205	222		N/A					
Patient FFT Score	%	96%	97%	98%	96%	98%	96%	97%	100%	100%	100%	99%		95%					

Patient Experience Report

01 June 2017 – 31 July 2017

Performance Indicators	July 2017	June 2017	May 2017	April 2017	Mar 2017	Feb 2017	Jan 2017	Dec 2016	Nov 2016	Oct 2016	Sept 2016	Aug 2016	Jul 2016
Number of new formal complaints received in the month	7	4	4	3	4	4	8	2	3	5	4	7	0
Number of complaints referred to the Ombudsman for 2nd stage review	0	1	0	0	0	0	2	0	0	0	0	0	0
Number of complaints re-opened	1	0	0	1	0	0	0	0	0	1	0	0	0
Number of complaints closed	3	2	5	1	2	4	0	6	2	3	1	2	5
Number of complaints upheld	2	1	0	1	0	2	0	5	1	2	1	1	1
Number of complaints upheld in part	0	1	2	0	1	0	0	0	1	0	0	1	3
Number of complaints unsupported	1	0	3	0	1	2	0	1	0	1	0	0	1

Complaints

Open Complaints

In June and July 2017 we received eleven new complaints. 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.

- **Number of complaints received**

11

- **Complaints main subjects**

Communication
Attitude
Appointments
Medical Treatment

- **Directorates**

Maxillofacial
Prosthetics
Plastics
Theatres
Corneo
Sleep

Closed Complaints

Overall five complaints were closed this month. Four were upheld and one was unsupported

• Number of complaints upheld	• Complaint subject	• Learning from complaints	• Directorate
4 	Attitude Communication 	Additional customer care training for individuals 	Maxillofacial Sleep 

Parliamentary and Health Service Ombudsman (PHSO)

There has been one case referred to the PHSO during this period.

This is a complaint that was made back in July 2015. The concerns have been raised in relation to cancer diagnosis. We are currently awaiting the outcome of the PHSO investigation.

Patient Experience – NHS Choices/Care Opinion

This month the NHS Choices/Care Opinion websites received five comments. The Patient Experience Manager has responded to all comments.

All reviews are emailed to senior staff within departments and ward areas for information and action where possible.

1. Truly Remarkable People and Care - read by 94

'I cannot praise the staff at QVH highly enough. From the moment I arrived to the time of my discharge, I felt totally confident that I was receiving the highest quality of care in the shortest possible time. It was as if I was in an expensive private hospital.

At the front desk of the MIU I was greeted professionally and efficiently. It was very busy but I was seen within 10 minutes. Within 40 minutes I was in a consultation with two fabulous specialists who decided to admit me for surgery having fully and clearly explained the extent of my injury.

The nursing staff on the ward were simply amazing. Cheery, professional and moral boosting. They got through the paperwork rapidly and sensitively and got me into a comfortable bed with pain relief.

The anaesthetist was tip top. The anaesthetist visited me in my bed and clearly explained the options with the benefits and risks of each. They helped me make the right decisions very quickly. The anaesthetist has in fact subsequently telephoned me after discharge to see that all is ok. Above and beyond the call of duty and hugely appreciated.

I was in theatre until about 11 pm. The surgeon took time to chat to me in the recovery room, they must have been exhausted but care was their number one priority.

The visit from the specialist and the surgeon at my bed the following day was excellent. They fully involved me in the conversation about next step decisions.

Post op the nursing staff were awesome. Checked up on me regularly with just the right amount of interaction. They showed empathy and quickly got that I wanted to be left alone as much as poss until I was feeling a bit better. Perfect balance.

All in all, first class. I get that the NHS is stretched, but these people were simply amazing. In my short time in the hospital I received fabulous treatment from doctors, nurses, a surgeon and a host of other lovely people, all from different nationalities. Please pass my deepest thanks onto these lovely people and my hope that our current ghastly political climate will not dishearten them.

Thank you one and all. Please contact me if you require further details.'

2. Sleep Clinic, Victoria Hospital – read by 27

'I was referred to the Sleep Clinic in East Grinstead by my GP with a bad snoring issue that I've had for 20 years+. I was getting tired during the day and my wife was fed up with sleepless nights. A couple of weeks after referral I was sent a sleep monitor in the post and asked to use it for a couple of nights before seeing the consultant. The consultant diagnosed obstructive sleep apnoea immediately and within three weeks I was in again for a CPAP machine fitting. This involved a three hour visit where I had to sleep in a comfortable, peaceful room with a nasal mask to sort out the breathing problem. It worked well and now I have been given a free, top of the range CPAP machine with the latest humidifier technology that even uploads my sleeping data to the hospital wirelessly from home.

I'm going to use for the first time overnight tonight, but the practice run was very promising. I can't fault the service - everyone is friendly, efficient, polite and understanding. I felt in very good hands. I also really liked the hospital architecture from the 1930's - it was a famous centre for treating pilots for burns in WW2 and has a lovely caring atmosphere. If you have a sleep issue you are very lucky if you are referred here.'

3. Fantastic experience child orthodontic operation – read by 42

'My daughter had 4 teeth removed and an impacted tooth 'exposed and bonded' all under general anaesthetic. After a very traumatic experience at St Faiths dental clinic previously, she was extremely nervous. I can not thank the whole team at QVH enough, they provided excellent care from the minute she was admitted. The staff on Peanut ward were cheerful, caring, approachable, funny.... I could go on. The theatre staff were just as wonderful and all in all my daughter had a very positive experience. She herself said that it was so much better than she expected, and she was very grateful to all the staff. Well done and thank you!'

4. I had 2 teeth out – read by 101

‘I went yesterday not looking forward to the operation infact i thought of walking out i was that worried but throughout the staff were great. The member of staff who put me under was very good i felt like i had half bottle of cpt morgans haha then i woke felling the most rested ive ever felt.’

5. Dissatisfied – read by 105

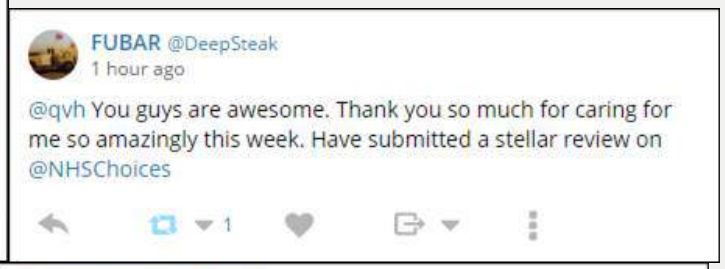
‘I went into walk in centre on the 29/4/17 to have hand x-ray on my broken hand. I was then booked in to see hand specialist. I was then booked in to have k wires inserted in to my hand. This landed up been 3 scheduled appointments to undergo surgery which were all cancelled. This is now 14 days since i broken my hand. Incompetence staff not liaising correctly...due to delayed surgery. I’ve also have a loss of earnings….’

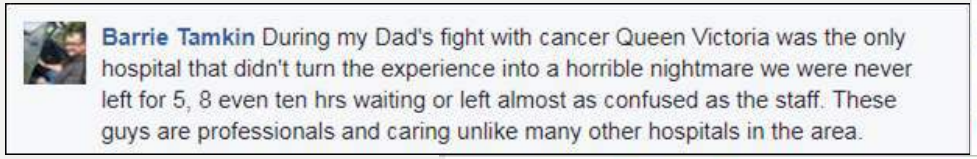
6. Failure to be seen – read by 115

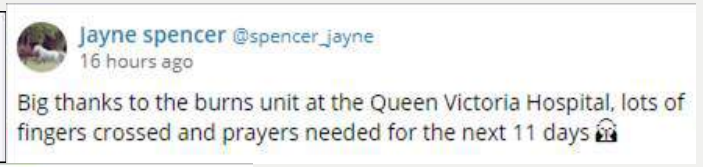
‘My son waited for an appointment. Rang 7:30am on the day to be told treatment would be at 1:30pm. Travelled in heavy traffic but arrived at hospital at 1pm after leaving home at 11:30am from Kent. Told by surgeon may not be seen worst case scenario due to them having to leave and close a theatre, at 3pm. Speaking with another patient whose appointment was also 1:30pm that her theatre had changed from 3 to 8. My son was also theatre 3 but no change. At 4pm all things seemed positive and after 22 hours of no food and feeling anxious my son is told there is one person before him and he would be next. Time was ticking. A member of staff comes out and said "Charlie can we see you a minute" my heart sank and I am now feeling very emotional and angry as I knew what they were going to do. It is now 5pm of which after this time I assume they do no more appointments but hold on there are others still there being seen. My son walks out of the treatment area to be told you will not have your treatment today due to traumas. Rubbish!! He is 23 year old young male who was the kindest person and most easiest to turn away. I was am still am absolutely furious!! I felt shaky and could not say anything because I had already in myself lost control. Calm, patient and understanding I am and have always been. My family who all work every single day and have paid endless money into the NHS through our taxes and national insurance never or very little go doctors or use any facility as we do not waste services time. Services however waste people like my son and I, our time. Time is precious! We will both lose holiday, my son has paid fuel and we have wasted a day sitting in a hospital that should have informed us at 7:30am when my son made a call that there is a risk of not being seen today so we will change your day. We could have telephoned work. We could have made a choice. Every other patient was seen. Not to be horrible but a patient who had hardly any teeth and was there to have 5 more removed and who's theatre was changed and seen at 3pm even said to my son that she felt her time would be after my son's. 23 hours of now food my son was demoralised. How do they pick and choose who to let down? It always seems to be those that put in the system have to lose out on their precious time (a days holiday) or money. I am very cross now today (the day after attending the hospital) with myself that I didn't voice my anger as this is what I have seen be done by others. I have seen them shout abuse and be really nasty but guess what they actually got results. Is this how we should have been? I now feel the service owes my son. There are local hospitals nearer us. Private and NHS that should now provide this service to my son. A family of four who pay should get treated with respect. I am not cruel but it has annoyed me knowing and seeing what I have over the years by people that pay nothing get more. I am absolutely disgusted and will pursue this matter further.’

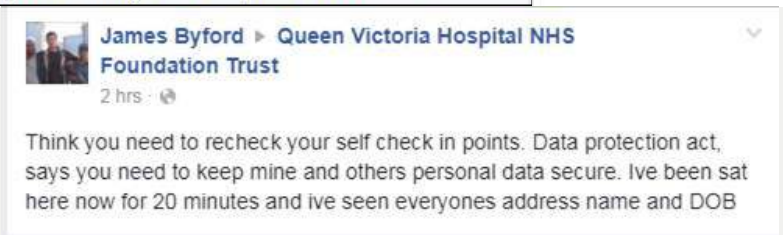
Patient Experience – Twitter/Facebook

The following are a few examples of the tweets and comments posted onto our Facebook page:









Friends and Family Test (FFT) – How we are doing?

The Friends and Family Test is a national scheme enabling patients to tell us and other patients what they think about the care they receive.

The following patients are asked 'How likely are you to recommend our hospital to friends and family if they needed similar care or treatment?'

- patients who spend at least one night on a ward in our hospitals or visit hospital for a day for surgery or a procedure
- patients who attend our MIU department
- patients who attend our outpatient departments

Each month we publish details about how many people completed the Friends and Family Test and what they thought about their care.

	Increase compared to previous month
	Same as previous month
	Decrease compared to previous month

month	Area	% of patients who would recommend us	% of patients who would not recommend us	response rate	number of response	number of patients eligible
	Inpatients					
April		99%	0%	39.5%	224	567
May		99%	0%	51%	329	645
June		**98%**	**0%**	**33.5%**	**216**	**647**
July		**98%**	**0%**	**38%**	**255**	**672**
	Outpatients					
April		95%	2%	16%	1855	11675
May		95%	2%	15%	2067	14165
June		**95%**	**2%**	**15%**	**2093**	**13757**
July		**94%**	**2%**	**16.5%**	**2158**	**13064**
	MIU					
April		98%	0%	24%	220	919
May		98%	1%	20%	202	994
June		**96%**	**3%**	**22%**	**233**	**1060**
July		**95%**	**3%**	**22%**	**239**	**1097**
	Day Surgery					
April		97%	1%	40%	295	740
May		97%	2%	37%	285	778
June		**96%**	**0%**	**48%**	**308**	**649**
July		**96%**	**1%**	**54%**	**323**	**597**

FFT Themed Analysis

The following are the top 10 themes used by our outpatients (and the number of times) in the past month following completion of the Friends and Family surveys. This information provides the Trust with real time patient feedback analysis, both positive and negative.

Positive		Negative	
Implementation of care	728	**Implementation of care**	13
Staff attitude	882	**Staff attitude**	23
Waiting time	187	**Waiting time**	37
Communication	201	**Communication**	13
Environment	197	**Environment**	12
Patient mood/feeling	123	**Patient mood/feeling**	6
Clinical treatment	124	**Clinical treatment**	4
Admission	106	**Admission**	9
Staffing levels	27	**Staffing levels**	3
Catering	6	**Catering**	0

The following are some of the negative comments made about 'communication' (a report of all the comments has been shared with the Matron and Head of Nursing for the Outpatient areas):

- 'Appointments are consistently not on time. On my most recent visit I was seen over an hour past my appointment time. I see different registrars who do not know me and have limited opportunity to read and understand my medical records or history. This leads me to lack confidence in their understanding of my condition and thus their ability to recognise any emerging concerns. The nurses appear to wander around without purpose and I wonder if an administrator might be more cost effective in showing patients into rooms or logging us in and out, thus allowing nurses to focus on their core tasks.'

- 'Was kept waiting an hour with no communication and then someone whose appt was half an hour later than ours was seen before us.'

- 'Last time was great but this time the doctor was rude and he rushed us I didn't feel I could ask questions'

- 'Was instructed to make an appointment for 10 days time. On phoning was told i could only have 8 days in the future or nothing. Arranged the 8 day offer but on seeing doctor again he refused to do anything because he wanted 10 days to have elapsed as he initially instructed. The nurse then had to make the appointment for me for 2 days later to give the 10 days initially requested but refused. A waste of a day plus costs.'

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	**07/09/17**	**Agenda reference:**	**141-17**		
Report title:	Safeguarding Annual Report				
Sponsor:	Jo Thomas, Director of Nursing and Quality				
Author:	Pauline Lambert, Paediatric safeguarding named nurse, and Natalie Jones, Adult safeguarding named nurse				
Appendices:	Appendices A-F within this report				
Executive summary					
Purpose:	The annual safeguarding report is produced for the Trust Board to provide assurance that the it is undertaking its safeguarding duties and responsibilities safely and effectively for adults and children. The report is reviewed and scrutinised by the Quality and governance committee before being presented with the Board for information. QVH safeguarding systems and arrangements have continued to improve and strengthen during the last year. They are more transparent and safeguarding support for staff is well established. Safeguarding audits continue to provide assurance for the organisation and also identify any key development areas.				
Recommendation:	The Board is asked to review the report and **NOTE** the assurance within the contents of the report which reflects the quality of safeguarding services at QVH.				
Purpose:	Approval **N**	Information **Y**	Discussion **N**	Assurance **Y**	Review **Y**
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:	No new implications for the BAF.				
Corporate risk register:	None				
Regulation:	Compliance with regulated activities in Health and Social Care Act 2008 and the CQC's Fundamental Standard.				
Legal:	As above				
Resources	No changes				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	17/08/17	Decision:	Reviewed and recommendation for board to approve	
Next steps:	None				

Queen Victoria Hospital NHS
NHS Foundation Trust

Queen Victoria Hospital NHS Foundation Trust (QVH) Safeguarding Annual Report 2016-17

Document Control; Strategic Safeguarding Group 24/08/17, Quality and Governance Committee 11/08/17
Executive sponsor: Jo Thomas, Director of Nursing and Quality, Executive Board Lead for Safeguarding

Authors:
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Date: Covers period 1st April 2016 to 31st March 2017

Type: Annual Report
Version: FINAL
Pages: 30
Status: Public. Written and prepared for the Trust Board
Circulation: QVH Trust Board

QVH Safeguarding Annual Report Summary for 2016-2017

Each year a Safeguarding Report is produced for QVH Board to provide assurance that the Trust is undertaking its safeguarding duties and responsibilities safely and effectively.

The report is reviewed and scrutinised by the Quality and Governance Committee before being shared with the Board for information.

QVH safeguarding systems and arrangements have continued to improve and strengthen during the last year. They are more transparent and safeguarding support for staff is well established. Safeguarding Audits continue to provide assurance for the organisation and also identify any key development areas.

Board members were briefed on 1st December 2016 regarding the Safeguarding standards the organisation is expected to demonstrate to West Sussex Safeguarding Boards, commissions and inspectors. External regulation is undertaken on a regular basis by Clinical Commissioners, West Sussex Safeguarding Boards and the CQC.

Current challenges are:

Paediatric safeguarding Level 3 training data, changes to QVH staff requirement list means the data target will be a challenge in the coming year

Adult safeguarding level 3 training and data reporting will be put in place during 2017-2018.

Limited space and facilities for children in outpatient departments.

Safeguarding advice and support for staff 24 hours per day when Peanut ward is closed, alternative support options being put in place.

Demonstrating QVH compliance with Mental Capacity Act

Guidance on QVH clinical interfaces with children who are looked after and attend as patients at QVH.

Current achievements are:

Established specialist safeguarding team in place

Robust connections with West Sussex Safeguarding Boards

Overview of all relevant QVH polices, protocols, standards and guidance

Roll out of PREVENT training for the organisation's clinical staff

Meeting NICE PH50 Domestic Abuse Violence standards.

Meeting NICE CG89 When to suspect child maltreatment standards.

QVH contributions to safeguarding reviews.

Content:

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

2.	Legislative Frameworks and National Safeguarding Agenda.
2.1	**Safeguarding Adults:** Safeguarding means *"protecting an adult's right to live in safety, free from abuse and neglect" (Care Act 2014)* The arena for safeguarding adults continues to evolve since the implementation of the Care Act (2014). However, the aims of safeguarding adults remain unchanged. Organisations such as QVH, must stop abuse or neglect wherever possible, prevent harm and reduce the risk of abuse or neglect to adults with care and support needs, safeguard adults in a way that supports them in making choices about how they want to live their lives and provide information in accessible ways to help adults understand how to stay safe and what to do to raise a concern. In order for staff at QVH to achieve these aims, it is necessary to ensure that we are all clear about our roles and responsibilities, create strong multi-agency partnerships and support the development of a positive learning environment. As an organisation, QVH follows the Sussex Safeguarding Adults policy & procedures document published in April 2015, and updated in July 2016 (Edition 3) as this provides an overarching framework to coordinate all activity undertaken where a concern relates to an adult experiencing or at risk of abuse or neglect. Edition 3 includes changes introduced by the revised Care and Support Statutory guidance first published in November 2014. These procedures represent new standards for best practice in Sussex and have been endorsed by Brighton & Hove, East Sussex and West Sussex Safeguarding Adults Boards. It is available online, with links to this on the internal intranet (QNET). This document is reviewed and updated by the West Sussex Safeguarding Adults Board. Links to the West Sussex Safeguarding Adults board are available to everyone via QVH website.
2.2	**Safeguarding Children:** *'The welfare of the child is paramount'* principle was enshrined in the Children Act 1989 and has driven the development of systems and arrangements used to safeguard and/or protect children since that time. Section 11 of The Children Act 2004 places a statutory duty on all NHS organisations to ensure that services are designed to safeguard and promote the welfare of children. National guidance also stipulates that NHS trust must identify a lead nurse for Child Sexual Exploitation (CSE) and Looked After Children (LAC, sometimes referred to a 'children in care'). These responsibilities have been added to the Paediatric Safeguarding Named Nurse Job Description. The post holder is currently reviewing information and protocols available to staff to aid safe effective clinical practice and these will be ready by September 2017.
2.3	**Mental Capacity Act (MCA) 2005 & Deprivation of Liberty Safeguards (DoLS):** The Mental Capacity Act 2007 (MCA) and the Deprivation of Liberty Safeguards (DoLS) implemented in April 2009 have placed an increased emphasis on ensuring that the rights of vulnerable people (aged 16 and over) to make decisions are protected and decisions made on behalf of people are only made using the legal framework. Capacity is described as a person's ability to make a specific decision at a specific time. Capacity can fluctuate and therefore assessment of capacity must be regularly reviewed and updated.

	The DoLS were added into the MCA and is an additional Safeguard providing guidance on procedures that ensures care and treatment for those who lack capacity to consent to their accommodation is only delivered in their best interest and using the least restrictive options to ensure their safety. To be lawful, it needs to be authorized by the local authority. QVH staff working with patient's, need to understand and comply with the requirements set out in the MCA 2005. The QVH Mental Capacity and Deprivation of Liberties Policies are currently being reviewed and will be updated by October 2017. Deprivation of Liberties (DOLs) processes have been subject to considerable criticism ever since their introduction in 2009. In March 2014, two events challenged their use. The House of Lords post-legislative scrutiny committee proposed a replacement as they concluded that the DoLS system was not 'fit for purpose'. Then a Supreme Court judgment (usually referred to as "*Cheshire West*") gave a wider definition of deprivation of liberty than that which had been previously understood to apply in the health and social care context. The judgment laid down an "acid test" for deprivation of liberty: • a person lacks capacity (and) • whether a person is subject to continuous supervision and control (and) • is not free to leave. The government asked the law commission to undertake a review of DOLS processes. The purpose of the review was to consider how the law should protect people who lack capacity to consent to their care and treatment and who need to be deprived of liberty to receive care or treatment. The final report was released in March 2017 with 47 recommendations. Proposed changes are wide reaching but as yet there is no parliamentary timetable to enact them. The Crime and Policing Act 2017 provides new legislation regarding the death of a person where there is an authorized DoLs. Patients with DoLs are no longer classed as 'in state of detention'. Those patients with a DoLs are no longer required to be automatically referred to the coroner. At year end compliance rates for Mental Capacity Act training are currently at **63%** across the organisation. Risk Assessment, controls and mitigations are in place to improve training data during 2017.
2.4	**Modern Slavery Act 2015** The Modern Slavery Act 2015 is designed to tackle slavery in the UK and consolidates previous offences relating to forced labour, servitude, human trafficking , exploitation and slavery. The act extends to England and Wales. In order to enable staff working at QVH to protect vulnerable patients, a protocol to assist in the identification and support of victims of modern slavery using services at QVH has been developed. QVH case examples are discussed in training.

3.0	Clinical Commissioning Groups (CCGs) Safeguarding Standards
	During 2016-2017 the CCGs have used the *Safeguarding Vulnerable People in the Reformed NHS : Accountability and Assurance Framework* (March 2013) to produce a set of Sussex Safeguarding Standards to make explicit their expectations of NHS providers in relation to safeguarding. The CCGs across Sussex have in place quality and safety systems, and processes in order to enable continuous improvements and the 'safeguarding standards guidance' now forms part of these systems. The standards guidance was developed to enable assurance to be provided to demonstrate patients of all ages are safeguarded effectively. The guidance enables all parties to identify key benchmarks to ensure an effective, systematic, auditable approach to ensuring the safeguarding of all patients, whatever their age. The standards were shared with the QVH Board at a safeguarding seminar during November 2016. The standards enable the safeguarding team at QVH, as well as commissioners to audit against benchmarks to ensure effective measures are in place. The format of this report has been updated and is now organised based on these standards.
3.1	**STANDARD 1: Strategic Leadership**
	The executive board lead for safeguarding vulnerable people, MCA & DoLS is the Director of Nursing who oversees compliance with legislation and responsibilities are in place to protect people who use services at QVH and that these are understood by staff and implemented throughout the organisation**.** The QVH Safeguarding Strategy (2015) supports a progressive response to the changing landscape framing the delivery of healthcare services at QVH. Appendix E provides an overview of QVH safeguarding documents and information available for staff or the public via the Website or QNET intranet. QVH has robust safeguarding governance arrangements in place, which are led and supported by a team of specialist safeguarding clinicians. The QVH governance structure provides transparent lines of accountability, clear partnership connections with internal QVH meetings which are in place to scrutinise practice, systems and delivery of health care. The QVH safeguarding team comprises of; • Jo Thomas, Director of Nursing and Quality, Executive Board Lead for Safeguarding • Natalie Jones, Named Nurse for Safeguarding Adults, MCA & DoLS Lead and Prevent Lead • Dr M Z (Oli) Rahman, Named Doctor Safeguarding Children (via BSUH SLA) • Pauline Lambert, Named Nurse Safeguarding Children, Child Sexual Exploitation (CSE) lead and Looked After Children (LAC) lead. • Debra Yeoh, Nurse Specialist Safeguarding Children • Katy Fowler, Nurse Specialist Safeguarding children & WRAP Training Facilitator The purpose of this team is to continuously work to ensure all staff including volunteers understand their safeguarding responsibilities and are supported to undertake these. This is achieved through case discussions, advice, practice review and audit; provision of training; provision of policy, procedures, protocols and guidance.

	The Non-Executive Director who chairs the Quality and Governance Committee is working to support scrutiny of the agenda with 'Safeguarding' identified as a discreet responsibility. Across QVH there is a network of link champions for safeguarding from all services. They attend either or both safeguarding steering groups to discuss clinical issues, access information, review learning and to share practice improvement across the organisation. The Joint Hospital Governance Group provides a far reaching internal audience where safeguarding discussions are also undertaken, such as sharing learning from Safeguarding Reviews and Audit, and how improvements in practice might be applied in QVH. Driving improvement in all aspects of safeguarding practice is a continuous process and as such has to be reviewed, evaluated, developed and adapted over time. The Named Nurses have Adult Safeguarding and Paediatric Safeguarding training and development strategies (2016 to 2021) to steer and facilitate staff competency development. A summary of training options, staff evaluations and audits are included in APPENDIX B. The delivery of effective safeguarding is dependent on multiagency working. Strategic work is often set by the children and adult Safeguarding Boards in West Sussex and translated into work streams which are monitored by QVH Strategic Safeguarding Group or QVH Safeguarding Team to ensure relevant involvement and contributions for the trust. QVH through the safeguarding team has well established links with local and regional safeguarding networks and committees. **West Sussex Adult Safeguarding NHS Professionals Network:** This group is chaired by the Designated Nurse for safeguarding adults from Coastal West Sussex CCG. The Adult Safeguarding NHS Professionals group meet quarterly. These meetings include all adult safeguarding leads across Sussex & Surrey, including Safeguarding Adult's Board representation. The forum is an area to share learning, reflect on practice and support peers. QVH Safeguarding Adults Named Nurse attends these meetings. **West Sussex Safeguarding Children NHS professional Networks:** This group is chaired by the West Sussex Designated Nurse for safeguarding children. The group meets quarterly. The group is attended by all West Sussex NHS Trust Named Nurses and provides a forum which can share learning from practice, inform and influence the WSSCB. Representatives from QVH attend regularly and raise awareness of QVH issues and safeguarding practices. QVH has a case peer review system in place in the Burns Unit. Meetings to discuss paediatric and adult cases occur every Monday (except Bank Holidays). These meetings review injury mechanism and explanation, medical and nursing treatment, risk assess, discuss any safeguarding, patient capacity or deprivation of liberties issues and agree actions required. Safeguarding supervision is offered to all adult safeguarding link champions on a quarterly basis. The sessions are held with named nurse for adult safeguarding and provide champions with a network for support and advice as well as for peer support, scenario based discussions and reflective practice. The purpose of these groups is to strengthen communication, networking and dissemination of safeguarding information and practice across the organisation. Data to demonstrate uptake will be available next year. Regular safeguarding supervision is provided to the specialist paediatric safeguarding nurses

on a regular basis, all other staff on a case by case basis. Bespoke safeguarding children training for teams/services also provide opportunities for case discussions and reflection of practice. The Paediatric Safeguarding Named Nurse is gradually meeting with all hospital consultants to discuss and review whether safeguarding systems are working for them and their teams.

Safeguarding priorities are central to achieving high quality and safe care. Quality and it component parts of safety, effectiveness and patient experience are at the heart of QVH values. As an organisation QVH are committed to the protection and prevention of abuse & neglect for all vulnerable people whilst in the care of Queen Victoria Hospital NHS Foundation Trust (QVH). The safeguarding team continue to review and strengthen systems, methods and arrangements for managing episodes where we might be considering or suspect abuse/neglect has occurred either within the organisation or prior to admission. Staff are provided with support to manage any concerns identified.

Humanity: Protecting the vulnerable and those at risk, is a key component of our trust objectives. Focussing on quality and patient experience we work alongside partner agencies to promote the safety, health and well-being of people who use our services.

QVH has effective systems in place to highlight and respond to shortfalls in capacity which have an impact on the ability to meet safeguarding responsibilities. These are highlighted to the board through the internal DATIX reporting system, and regularly discussed at the strategic safeguarding group meetings and reviewed by Named Nurses.

There is currently one corporate risks identified in relation to paediatric safeguarding.

- In March 2017 the safeguarding Children level 3 training list was reviewed and updated. Consultants who have face to face contact with children and site practitioners have been added to the level 3 training list. This means the level three training rate has dropped from 92% to 46% whilst we get these additional staff up to date with level 3 training requirements. This should be resolved by October 2017. The next QVH Level 3 training session is due to be delivered on 25th September 2017. For those consultants working in other organisations their level 3 competencies can be transferred across.
  Current risk rating Moderate = 12

There are two adult safeguarding departmental risks – both to be reviewed in August 2017

- adult safeguarding, need to increase percentage of staff who have completed level 2 adult safeguarding training (risk rating 9 - LOW) Nursing and Quality department
- adult safeguarding named nurse limited resources for QVH (risk rating 6 - LOW) Nursing and Quality department

There are six paediatric safeguarding departmental risks:

1. Clinical staff will only be aware of the national Child Protection Information System (CP-IS) alert if they actively access the Summary Care Record A there is no automatic feed for this information. (risk rating – LOW = 9)
2. Paediatric safeguarding IT access database risk of failing as unsupported electronic system, IT department support the team when problems arise (risk rating – LOW = 9)
3. Managing patient information when there are unexpected out of hours attendances at QVH, new patient form in place, patient record to be created and DATIX completed (risk rating – LOW = 9)
4. Limited space in Corneo OPD department for children , options being explored (risk

	rating – LOW = 9) 5. Peanut ward closures means there is no paediatric safeguarding advice for hospital teams when safeguarding team members are off duty (risk rating – LOW = 9) 6. National Guidance lack of clarity regarding expectations of LAC lead nurse for QVH. Responsibility added to Paediatric safeguarding Named Nurse job descriptions. Details being worked through. (risk rating – LOW =9) QVH has a safeguarding audit programme in place for 2016 to 2018 which includes information on the audit methodology being used, involvement of managers and staff and how the findings from audit will be disseminated. 2016 audit analysis is included later in this report in Appendix D.
3.2	**STANDARD 2: Lead effectively to reduce the potential of abuse**
	QVH has policies, processes and procedures in place to enable staff to report any concerns they have for patients or members of the public attending QVH sites. If their concerns are not heard there are escalation processes which can be used. Training and procedures also highlight how diversity, beliefs and values of people who use QVH may influence the identification, prevention and response to safeguarding concerns. The documents and information provided for the organisation and staff is identified in APPENDIX E. QVH has a clear, accessible and well-publicised complaints procedure. This includes information about how to complain to external bodies such as regulators and service commissioners, relevant advocacy and advisory services. Information regarding Gillick competence, mental capacity and Lasting Powers of Attorneys (LPAs) is cross-referenced with the other policies (such as consent) and safeguarding procedures. QVH place great importance on ensuring patients have an excellent experience. The trust continues to develop ways to engage and listen to patients, collecting views, comments and ideas from them, their families and carers which then form future plans to further improve patient experience. Board committees review results from Family and Friends Tests and the annual staff Survey. QVH safeguarding team have produced information for families. There is a QVH safeguarding children and young people leaflet for families. There is an updated information leaflet regarding attendance at the trust with dog bite injuries for all patients. Work on a set of QVH posters and leaflets encouraging patients to talk to staff, clinical managers, PALs and the safeguarding team if they have any concerns about for a patient continues, with an aim to being rolled out during 2017. There is also information available via staff for patients/relatives when a patient is deprived of their liberty. One area of focus for audit in 2017-18 will be on QVH compliance to the Mental Capacity Act (MCA) 2005. The standards that will be used will be aligned to the MCA 2005 and CQC essential standards of quality and safety. The recurring audit of quality of safeguarding referrals will run during September to October this year. The audit process will be strengthened and will be repeated on an annual basis.

3.3	STANDARD 3: Responding effectively to allegations of abuse
	QVH have arrangements in place to ensure that patients are safeguarded by responding appropriately to any allegation of abuse or neglect. <u>Safeguarding Adults Activity</u> The Safeguarding Adult Named Nurse receives notification of any suspected safeguarding incidents involving adults via the DATIX reporting system. The lead responds to each DATIX report. The response may be in the form of advice or it may trigger a referral to the local authority for investigation under section 42 of the care act 2014. This activity allows the lead to maintain oversight of all safeguarding adult referrals to social care. During 2016-17 a *'Making Safeguarding Personal - QVH Adult Safeguarding referral form'* was introduced to make this process easier, more straight forward for staff and to enable referrals to be made in a timely way. To match paediatric safeguarding all forms will be printed on identifiable yellow paper and kept in patient health records in a safeguarding section of the record. The table in Appendix C provides details of the monthly safeguarding adult activity reported on DATIX for the past year. The governance around these systems require further development during 2017. <u>Safeguarding Children Activity</u> The Paediatric Safeguarding team receive reports of any safeguarding children concerns which occur within QVH via a centralised email address. Follow up by Specialist Paediatric Safeguarding Nurses provides support for staff managing these situations as well as a means to scrutinise case management and follow up outcomes with statutory partners when required. Safeguarding children incidents are reported on the DATIX system when the level of harm indicates the need for referrals to social care or police. Analysis of information provided is returned directly to the staff member reporting concerns or situations requiring referral. The paediatric safeguarding team have a secure Access database and log information about any concerns raised. This provides a mechanism for quality assurance of cases and easy access to data for audit purposes. See Appendix C for overview of paediatric safeguarding activity during the past year. The Access data base is not a supported system, which means the IT department support the team when any problems arise. Alternative ways to capture this data for the longer term continue to be explored, this item is included in the QVH Strategic Safeguarding action plan see Appendix F. The QVH Electronic Document management system is currently being rolled out across the trust. There is a safeguarding section for all patients which will be used as needed and a range of forms available to staff on the QNET safeguarding page for use when required. <u>Allegations Against Staff</u> The Director/Deputy Director of Human Resources would manage the Trust response to any allegations against trust staff. *'Allegations against staff'* procedures are followed. During the last year concerns relating to 3 members of staff have been considered and managed with the Deputy Director of Nursing and HR.

	When required investigations are co-ordinated by West Sussex County Council. Advice was taken from the Local Authority Designated officer on one occasion; a formal investigation was not instigated. We do not currently have any data with which to compare with other trusts.
3.4	**Standard 4: Safeguarding practice and procedures**
	The Safeguarding Team develop a plethora of guidance for the organisation, staff and patients in the form of policy, procedures, protocol, guidelines and leaflets. For a list of what is in place for QVH please refer to Appendix E. All documents are placed on the Website or QNET. All documents are systematically reviewed and updated in collaboration with relevant services and governance groups. Information is monitored and reviewed regularly and updated on the QNET, including information on who to contact for advice and support. A new set of laminated safeguarding prompt cards are being developed for staff at QVH and will be shared at training and governance events once approved during September 2017 onwards. <u>Prevent:</u> The delivery of the '*Prevent*' agenda in the trust, is led by the Adult Safeguarding Named Nurse who is 'Prevent Lead' for the trust. Staff are made aware of the Prevent delivery plan which is a tool kit for staff and is available to via the QNET. The QVH Prevent agenda has evolved over 2016-17. The implementation of the nationally directed mandatory training (as a one off session*) Workshop to Raise Awareness of Prevent* (WRAP) has been well received. The roll out of this workshop commenced in June 2016 and was reviewed in December 2016. WRAP compliance data is at 57% across QVH. WRAP sessions will continue but be reduced in frequency of delivery during 2017 and 2018. The delivery of training will be undertaken in 2017-18 by one of the Paediatric Safeguarding Specialist Nurses. Sessions will be run quarterly to align with NHS England Reporting requirements. In order to deliver prevent training, staff MUST hold a Unique Reference Number received from the Home Office. QVH currently have 3 members of staff who have this – Named Nurse Adult Safeguarding, Named Nurse Paediatric Safeguarding and 1 Paediatric Safeguarding Specialist Nurse. This training will continue to be in addition to other adult and child safeguarding training sessions until role out is complete. QVH Safeguarding Forms which are available via the QNET are written in accordance with the local and national guidelines. For example the 'Adult Safeguarding information' form captures 'making safeguarding personal' information demonstrating the adults wishes and feelings. Where it is identified that a patient may lack capacity this is included and the best interest checklist can also be shared with the relevant local authority on request. Where a patient is identified as needing any form of control, restraint or therapeutic holding QVH have policies in place to protect all patients against the risk of such control or restraint being unlawful or excessive. All QVH staff are required to understand their legal responsibilities under the Mental

Capacity Act including LPAs, Court of Protection, best interest decision making, capacity assessments and when it is necessary to deprive a person of their liberty. This is discussed in training and an audit is currently underway to test knowledge and compliance.

Domestic violence and abuse (DVA)

Managing domestic violence and abuse situations can be challenging for staff. Managing risks, keeping individuals safe and seeking the right specialist advice are all important aspects of patient care when DVA is being considered a possibility or has been confirmed. Raising awareness of and managing DVA situations is included in all level 2 safeguarding training.

The QVH psychological therapies team can undertake Domestic Abuse Stalking Honour (DASH) risk assessments, the QVH safeguarding team or Worth DVA specialist services can provide advice and support to staff at QVH, consultants or site practitioners can refer to Multi Agency Risk Assessment Conferences (MARAC) if required.

Patient DVA procedures have been ratified this year. Staff experiencing DVA policy is waiting for approval by QVH staff side group

NICE DVA standards were used to self-assess QVH practice, we assessed ourselves as compliant. The standards were used during August 2016 to audit staff practice across QVH. Results were shared in relevant QVH governance groups.

Safeguarding Audit

Audit of service efficacy is an integral element of the work of the Safeguarding Team. A three year cycle of audit activity is being developed including core elements such as NICE guidance alongside aspects of clinical practice. (see Appendix D)

During 2016-17 two safeguarding audits were undertaken: NICE CG 89 When to suspect child maltreatment, and NICE PH 50 DVA quality standards audit Feb 2016.

NICE PH 50 DVA quality standards Feb 2016

This quality standard covers the management of known domestic violence and abuse in adults and young people aged 16 years and over. The audit provided assurance that QVH practice is compliant with required standards.

NICE CG 89 When to suspect child maltreatment

NICE Guidance 'CG 89 When to suspect child maltreatment' provides an evidence based summary of clinical features associated with child maltreatment which might be observed when a child is seen by health care professionals. The audit provided assurance that QVH practice is compliant with required standards.

To obtain more comprehensive medical staff data for these two audits, a survey monkey audit is due to be rolled out during September 2017.

Recognition of Child Sexual Exploitation (CSE) or child sexual abuse requires careful assessment and consideration when concerns arise. The Paediatric Safeguarding Named Nurse is the CSE lead for QVH and supports staff to access specialist advisors if required.

Looked after children (LAC) or Children in Care are a group of children and young people who are cared for by the local authority. There can be consent implications for these children and clinicians needs to understand what voluntary or court agreement is in place for each child.

	The Paediatric Safeguarding Named Nurse is the LAC lead for QVH and supports staff to understand court orders and how to make contact with a child's social worker or NHS LAC team from the area in which they live. If QVH staff comes across private fostering arrangements for children less than 16 years of age they need to notify social care services so that a social care assessment can be undertaken of the situation. Raising awareness of staff responsibilities in these situations is included in paediatric safeguarding training sessions. The safeguarding team have close links with the communications team at QVH where there are strict guidelines for dissemination of information internally for all staff across the organisation, including updates and reviews. The communications team are working to improve the governance of organisational communication, in order to strengthen the staff accountability in reading and understanding electronic mail.
3.5	**STANDARD 5: Staff competence**
	In 2016 it was agreed at executive level that ALL staff working in the organisation would receive their level 1 training in adult safeguarding in a leaflet format. This was distributed in August with staff payslips, and ALL managers of staff were asked to complete a signatory sheet for their team in order to assure all parties that the staff member had received, read and understood the information contained in it. Staff have access to a comprehensive training programme for safeguarding, including MCA which is monitored in accordance with NHS England intercollegiate documents. **Adult Safeguarding Training:** QVH Adult Safeguarding learning and development strategy was updated in October 2016. This framework is aligned with the core skills framework document, with the national guidance from the NHS England Safeguarding Adults: Roles and competences for health care staff – intercollegiate document. A new format for the implementation of basic awareness training was introduced in August 2016, for ALL staff and has been well received. This is reflected in the current compliance rate of **100%** for QVH staff at level 1. HR do not yet have all the signed sheets to confirm this figure. The implementation of level 2 training in April 2016, has been very well received and evaluated by clinical staff (see Appendix A), and this is reflected in the current compliance rates. Staff training data for level 2 Safeguarding Adults is currently at **67%**. During 2017-18, this will be rolled out to ALL front facing staff across the organisation. All safeguarding adults link champions, department leads, site practitioners, heads of nursing and psychological therapy lead are required to complete training at level 3. This is reflected in the learning and development strategy 2016-21, and includes personal reflection, scenario based discussions, lessons learnt from audit, WRAP training, and peer discussions. Staff having to demonstrate competency at this level are required to discuss this at annual appraisal, so therefore metrics are not able to be quantified. **Paediatric Safeguarding Training:** QVH Paediatric safeguarding learning and development strategy was ratified during March 2016. This framework is aligned to national guidance. It provides transparent QVH

	expectations for staff including the Board with regard to paediatric safeguarding training and development. The list of staff requiring level three training and options for completing was further adjusted in March 2017 to include consultants who have face to face contact with children and young people and site practitioners who support hospital staff out of hours. This will impact on training data percentages for level 3 from, April 2017 onwards. QVH are now providing level 3 paediatric safeguarding sessions on site twice a year for consultants which can be accessed by other QVH staff requiring level 3 competencies. For those consultants working part time in site their level three update evidence can come from other employers. Bank staff are expected to be fully up to date with all mandatory training requirements. HR have confirmed they are removed from the bank staff list if non- compliant. **Specialist Support** Provision of clinical supervision and support for specialist safeguarding staff is provided by West Sussex Designated professionals who are employed by Clinical Commissioning Groups. Trust policy requires that provision of specialist safeguarding advice and support to QVH staff is accessed on a case by case arrangement from safeguarding team members when needed. All staff have statements within their job descriptions and person specifications that recognise responsibilities for safeguarding and these are reviewed through the appraisal and/or PDR process. Named Nurses for safeguarding received regular supervision from the West Sussex Designated Nurses.
3.6	**STANDARD 6: Safer recruitment**
	QVH work to ensure that those working or who are in contact with children, young people and adults are safely recruited and Human Resource processes take account of the need to safeguard and promote the welfare of all. Making sure that QVH do everything we can to prevent appointing people who pose a risk to vulnerable people is an essential part of safeguarding practice and QVH recruit staff and volunteers following safer recruitment procedures. All staff at the Trust are employed in accordance with the NHS pre-employment check standards. As part of their induction, new employees, including volunteers are expected to undertake mandatory training in safeguarding. During 2017-18 and internal Safeguarding Audit will be undertaken which includes as the objective: "all staff which are eligible for a criminal record check under the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 have received the appropriate level of DBS check".

3.7	STANDARD 7: Learning from incidents
	Statutory Safeguarding Reviews: Safeguarding Adult Reviews (SAR) Safeguarding Adult Boards (SABs) must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. In January 2017, QVH were notified by Wandsworth Adult Safeguarding Board that they had made a decision to undertake such an investigation under section 44 of the Care Act, for an adult who died in July 2016 as a result of a fire in her home. A range of services were involved in her care between 2015 until her death in 2016, including QVH. All agencies (including QVH) were asked to provide chronologies outlining their involvement with the adult. The purpose of conducting a SAR is to: • establish whether there are lessons to be learnt from the circumstances of the case • review the effectiveness of policies and procedures and their application (both multi-agency and individual organisations) • inform and improve local practice by acting on learning to reduce the likelihood of similar harm occurring again The SAB will include the findings from the SAR in its annual report, highlighting what action it has taken, or intends to take in relation to those findings. A SAR report should provide a sound analysis of what happened, why and what actions needs to be taken to prevent a reoccurrence, and contain findings of practical value to organisations and professionals. **Safeguarding Children Reviews:** Serious Case Reviews (SCRs) When a child dies or is seriously harmed, including death by suspected suicide, and abuse or neglect is known or suspected to be a factor in the death, West Sussex safeguarding Children Board (WSSCB) is required to conduct a Serious Case Review into the involvement of organisations and professionals in the lives of the child and the family. The purpose of a Serious Case Review is to establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard children, identify what needs to be changed and, as a consequence, improve multi-agency working to better safeguard and promote the welfare of children. One Serious Case Review involving QVH was commenced in January 2017 by WSSCB. QVH provided unexpected out of hours care to a child known to and working with a range of other services. The review process is underway and will complete in November 2017. Findings will not be released until approved by WSSCB. **Child Death Reviews.** The WSSCB is also required to conduct a review of every child death to identify whether there are any lessons to be learned to prevent child deaths in the future. **Other types of reviews.** The WSSCB carry out a range of learning activities in order to understand how to improve safeguarding. This includes reviews into individual cases and reviews of practice across areas of safeguarding.

	QVH Staff have access to specialist advice and support through named nurses, specialist nurses and link champions. Where QVH must take part in a safeguarding investigation/enquiry, where appropriate, staff and staff groups are provided with debriefing/supervision sessions by Named Nurses and other senior staff at QVH.
3.8	**STANDARD 8: Commissioning**
	Contract Monitoring -Sussex Clinical Commissioning Groups (CCG's) Safeguarding Standards CCG's as commissioners of local health services need to assure themselves that the organisations from which they commission services have effective safeguarding arrangements in place. A self-assessment tool is completed annually and contributes to providing evidence of assurance in conjunction with assurance site visits and submission of audits as part of an audit programme. There is overlap between this report and the Section 11 self-assessment for WSSCB. CCG exception reports are provided by QVH Safeguarding Team in April, July, October and January of each year. No issues of concern were raised during the last year. **External regulation and inspection by CQC and Monitor** West Sussex safeguarding standards and compliance reporting is completed on a quarterly basis by Paediatric Safeguarding Named Nurse and the Adult Safeguarding Named Nurse on behalf of QVH. Any safeguarding issues or concerns would be captured and reported to the Board alongside the Board's monthly safeguarding metrics. Monthly CQC reporting via the Deputy director of Nursing over the last year: • no specific paediatric safeguarding concerns were raised during the last year. • no specific adult safeguarding concerns were raised during the last year. QVH CQC overall - good rating.
3.9	**STANDARD 9: Safeguarding data requested by Department of Health**
	Female Genital Mutilation (FGM) Understanding of FGM and mandatory reporting duty is incorporated into QVH mandatory safeguarding training for staff. DH/NHS approved and recommended FGM e-Learning packages are also available to staff to enhance their knowledge and understanding of this subject. FGM guidance and information, with particular regard to risk assessment, mandatory reporting and recording, can be accessed by staff via the Trust QNET Safeguarding page. At QVH no FGM risk assessments were undertaken on any patients during the last year. Prevent Returns QVH submit quarterly reports to Regional Coordinator at NHS England with prevent information which reflects the number of prevent referrals and details of staff compliance with training. This information is also copied to the CCG for assurance. At QVH no PREVENT referrals were made during the last year.

4.0	Conclusions and Assurance
4.1	All health care at QVH is patient centred and QVH works closely with partners to ensure effective safeguarding is achieved for all vulnerable patients whether they are children, young people, adults or other family members . National metrics are reported on a monthly basis to CQC and DH include: FGM assessments and PREVENT referrals. QVH continuously strives to develop staff knowledge, competence and support its staff to achieve the best outcomes for patients at risk of harm. QVH promotes a culture where staff are able to raise concerns and to whistle blow without fear, this is evidenced in the staff survey. QVH also promotes feedback from patients and encourages them to raise concerns about anything they see and are worried about. There are close working links with the Patient Experience Manager and the Director of Nursing.
4.2	Training for staff is reviewed annually and updated in line with legislative requirements. Paediatric safeguarding systems in QVH have been well established for many years. They continue to be strengthened. There is a transparent overview of what is in place and of paediatric safeguarding activity occurring in the organisation. The embedding of Adult Safeguarding has developed throughout 2016-17, and this is reflected in the metrics of activity. Safeguarding governance arrangements have been strengthened during the last year.
4.3	QVH has a range of internal assurance processes in place. An overview of adult and paediatric safeguarding activities in QVH are in place. QVH staff training programmes for adult and paediatric safeguarding have been reviewed and continue to be strengthened. Staff provide feedback which identifies areas in which to improve training. Evaluations are reviewed after each training session. QVH has an overview of all relevant safeguarding information and documents, which are systematically developed, reviewed and/or updated. One corporate and eight safeguarding departmental risk assessments are in place. These are discussed at strategic safeguarding group quarterly, monitored monthly and reviewed at least every 6 months.
4.4	QVH has local external regulation undertaken by the CCGs, WSSCB and WSSAB. NHS Improvement ensures QVH are registered with the CQC. A Care Quality Commission (CQC) inspection occurred during 2015. The report published in 2016 identified two areas that the safeguarding team have worked on to improve: reporting of departmental risks and increase uptake of MCA training. Both these have improved and are reflected in this report.

4.5	Local safeguarding peer review and assurance processes are in place. Named Nurses for Safeguarding are well supported by the Director of Nursing, Deputy Director of Nursing, Heads of Nursing and the West Sussex Designated Professionals. QVH staff are guided and supported by a team of specialist safeguarding clinicians. This team are supported by Peanut Paediatric ward staff and Site Practitioners out of hours.
4.6	Partnership working with WSSCB and WSSAB is in place. A number of practice developments have been implemented in the last year including: management of CSE, DVA and the roll out of the national Prevent training workshop.
4.7	Effective contract monitoring is undertaken through audits and regular exception reporting to WSSCB, WSSAB, CCGs and the CQC.

5.0	**The QVH safeguarding team present this report to provide assurance to the Board that the Safeguarding agenda is robustly overseen and managed within the trust and with partners.**

APPENDIX A

Adult Safeguarding, MCA & DoLS, WRAP (Prevent Training) Metrics:

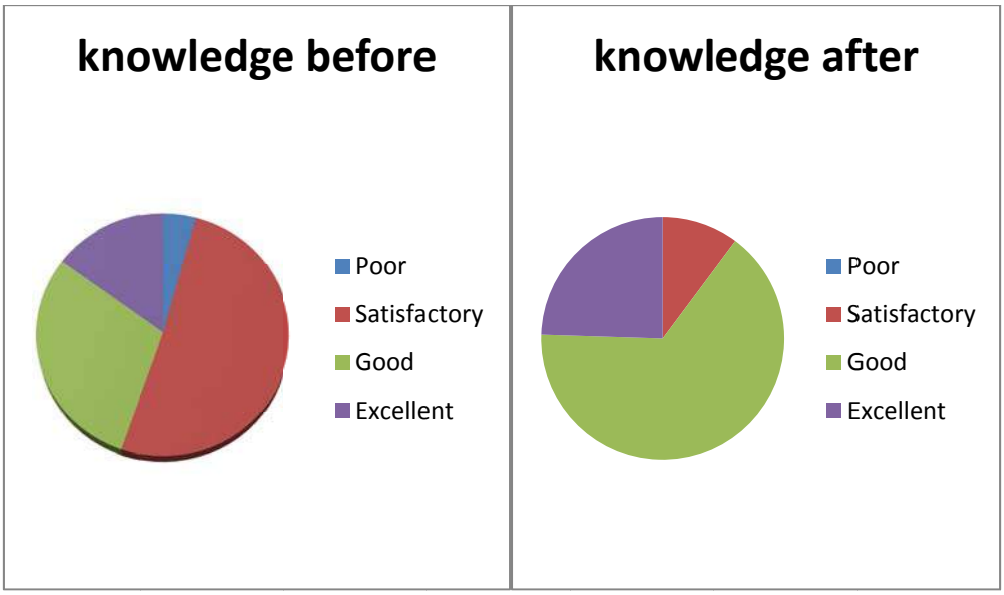
Month	% Staff Leaflet (permanent) Adult SG L1	% Staff Trained (permanent) Adult SG L2	% Staff (permanent) MCA L2	% Staff Trained (permanent) WRAP
April 2016	**93%**	**7%**	**46%**	
May 2016	**88%**	**12%**	**47%**	**2%**
June 2016	**89%**	**14%**	**49%**	**12%**
July 2016	**89%**	**18%**	**49%**	**14%**
August 2016	**100%**	**29%**	**51%**	**19%**
September 2016	**100%**	**32%**	**54%**	**26%**
October 2016	**100%**	**35%**	**54%**	**34%**
November 2016	**100%**	**40%**	**46%**	**50%**
December 2016	**100%**	**41%**	**46%**	**50%**
January 2017	**100%**	**51%**	**63%**	**67%**
February 2017	**100%**	**55%**	**58%**	**68%**
March 2017	**100%**	**62%**	**63%**	**75%**

Comments from Staff regarding the New L2 Adult Safeguarding training sessions:

"Session was very informative, aims and objectives met, session could do with being longer as a lot of information in 2 hours. "	Anonymous Nurse on C-Wing, October 2016
"Excellent, although biscuits would be nice!"	Mark Gorman, Consultant
"Thank you for your enthusiasm!"	Consultant unknown November 2016
"Excellent presentation, very engaging. Limited knowledge prior to session, now feel much better informed"	Staff Nurse, Peanut ward December 2016
"QVH Case examples were useful"	MaxFax, December 2016
"Excellent update, especially re-familiarising with DoLS process"	C Wing Nurse, March 2017
"I am new to the NHS and I now feel more informed and I leave this session with detailed knowledge"	HCA Theatres, March 2017
"A very interesting and informative session. Natalie is a very engaging and knowledgeable trainer"	Sarah Prevett, IPaCT

Staff who attended training between April 2016- March 2017 for Adult Safeguarding L2 were asked to rate their knowledge of Adult Safeguarding before the session, and again after the session. The

graphs below reflect the feedback from clinical staff since the introduction of this training in April 2016:



A Pre-reading workbook is distributed to staff prior to their session on Adult Safeguarding L2. They are advised to use this workbook to aid their learning throughout the session, and to use the reflective tool in the back to demonstrate learning. Throughout 2016-17, the evaluations reflect that **97%** off staff would recommend this workbook to colleagues in order to improve learning outcomes.

Appendix B – Training Evaluation Report –Paediatrics

Paediatric Safeguarding Metrics 2016-2017:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Paediatric SG training Level 1 as %	87	89	91	90	88	88	89	89	90	92	92	92
Paediatric SG training Level 2 as %	83	86	90	88	86	86	85	86	86	88	88	86
Paediatric SG training Level 3 as %	78	80	82	90	82	83	80	80	85	92	92	92

Level 3 training level updated during March 2017 now includes Consultants and Site practitioners. First onsite training session was in February 2017.

Training Audits by WSSCB

LEVEL 1

Part 1: Observation of Training Session (content)
Importance of communication and support from the safeguarding team clearly articulated. Compliant for level 1 and also some of level 2.
Part 2: Observation of Training (Quality)
High quality training delivered with passion and advocacy for safeguarding children which was clearly conveyed. The trainer's style is articulate and sensitive to the needs of the audience.

Actions to be considered by agency:
None

LEVEL 2

Part 1: Observation of Training Session (content)
Good compliance for level 2, Information and discussion regarding FGM and the mandatory reporting duty clearly articulated. Private fostering arrangements not included.
Part 2: Observation of Training (Quality)
High quality training session using power point and interactive discussions. Examples from practice relevant to QVH highlighted to underpin learning.
Actions to be considered by agency:
To highlight to staff the duty to report Private Fostering arrangements to the Local Authority via the MASH.

Random Sample of training evaluations during 2016 -20 (based on returned evaluation forms)

Safeguarding Children Level 2 on 8th March 2017

Rate the Session	Poor	Satisfactory	Good	Excellent
Were aims and objectives of the session met?			1	9
How would you rate the quality of the content of the session?				10
How would you rate the skills and knowledge of the trainer for the session?				10
How well was the event organised?			1	9
Overall how would you rate the event?				10

Comments:
The best child protection tuition I have ever been to. I valued this training session which was delivered brilliantly. The depth of knowledge impacted and supporting people to contribute was refreshing A hard area that supported me to reflect further on how to assess colleagues. Thank you Very enjoyable training and will leave well informed. Very exploratory, very well presented. Very good update – very helpful Very informative, topic covered very well – interesting A harassing topic that was covered well. With a human touch – memorable. Really helpful and interesting.

Safeguarding Children Level 3 on 27th February 2017 (First level 3 session delivered on QVH site)

Presenters: Ms Tania Cubison, Burns Consultant, Dr Oli Rahman, Paedasit5rician and QVH Paediatric Safeguarding Named Doctor, Dr Jo Webber, Psychologist, Pauline Lambert, QVH Paediatric Safeguarding Named Nurse

Rate the Session	Poor	Satisfactory	Good	Excellent
Were aims and objectives of the session met?			2	7
How would you rate the quality of the content of the session?				9
How would you rate the skills and knowledge of the trainer for the session?				9
How well was the event organised?				9
Overall how would you rate the event?				9

Comments:
It was an interesting session with a good variety of speakers and managed to cover a vast amount of areas of safeguarding. Case studies made it especially interesting. I would have liked a longer session! Good presentations. Informative. Excellent thank you. Photos very informative. Enjoyed different professionals input and perspectives. It was a really good opportunity to understand the elements of child protection. Also case study really helped to understand the different situations and how to act upon it. Burns evaluations – excellent update, very interesting approach. Very clear, great refresher. Enjoyed. Very informative – my first session of level 3.

APPENDIX C:

Safeguarding Activity Reported to Board 2016-2017

Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of Paediatric Safeguarding incidents reported on DATIX	0	4	1	2	3	2	2	1	1	0	2	2
Paediatric safeguarding activity	19	26	20	14	20	12	25	17	15	24	10	16
Paediatric SG training Level 1 as %	87	89	91	90	88	88	89	89	90	92	92	92
Paediatric SG training Level 2 as %	83	86	90	88	86	86	85	86	86	88	88	86
Paediatric SG training Level 3 as %	78	80	82	90	82	83	80	80	85	92	92	92
SCR - child	0	0	0	0	0	0	0	0	0	1	0	0
FGM assessments	0	0	0	0	0	0	0	0	0	0	0	0
Allegations against staff	0	0	0	1	0	0	0	0	0	0	0	0
Prevent referrals	0	0	0	0	0	0	0	0	0	0	0	0
WRAP training as %	-	2	12	14	20	26	40	50	50	67	68	75
DOLS application	1	2	0	0	0	0	1	0	1	1	0	0
Case Reviews - Adult	0	0	0	0	0	0	0	0	0	1	0	0
Adult SG training level 1 – Leaflet as %	93	88	89	89	100	100	100	100	100	100	100	100
Adult SG training level 2 as %	7	10	14	18	23	34	40	44	41	51	55	62
Adult SG training level 3 as %	-	-	-	-	-	-	-	-	-	-	-	-

APPENDIX D SAFEGUARDING AUDIT PROGRAMME 2015-2017, 3 year cycle

2015 Topic/s	**Progress**	**Next Steps**
Paediatric safeguarding records audit	Due to complete March 2016	Completed Report to Paediatric Governance group

2016 Topic/s	**Progress**	**Next Steps**
NICE PH50 DVA	Baseline assessment march 2016 Organisation audit to start August 2016	Completed Report had gone to Strategic Safeguarding Group
NICE CG89	Organisation audit to start August 2016	Completed Report had gone to Strategic Safeguarding Group

2017 Topic/s	**Progress**	**Next Steps**
Referrals audit – adult and children	Due Sep to December 2017	
CG89 and PH 50 Survey monkey for medical staff	Due June to August 2017	
Adults MCA audit	In progress	

APPENDIX E

Policy, procedures, protocols, guidance and information for QVH, staff and patients

QVH SAFEGUARDING DOCUMENTS AND INFORMATION March 2017

1	Item	Date	Location	Actions
1.1	QVH assurance statement	2015	Website	Review 2017
1.2	QVH safeguarding strategy	2016	Website	Finalised, added to website
1.3	QVH Website and QNET	Last updated 2017	Intranet	Ongoing review and update as required by QVH safeguarding leads
1.4	Sussex Child Protection and Safeguarding Procedures	2016	Link via QNET	Ongoing review and update as required by WSSCB
1.5	QVH safeguarding annual report	2016-17		Next due May 2017 Drafted
1.6	QVH and BSUH Paediatric SLA	2016 updated		Copy with Deputy Director of Nursing
1.7	QVH Safeguarding Strategic Group terms of reference	October 2016		Held by PA for Director of Nursing
1.8	QVH Safeguarding Children Steering Group terms of reference	October 2016		Due for review October 2017
1.9	QVH Safeguarding Adults Steering Group terms of reference	2016		Due for review
1.10	QVH safeguarding prompt cards for clinical staff	June 2017		New Drafted ready for consultation

2	Item	Date	Location	Actions
2.1	QVH Managing allegations against staff	2015	QNET	
2.2	QVH Whistle blowing policy	2015	QNET	
2.3	QVH Patient experience strategy			Mentioned in Patient experience report
2.4	QVH Handling complaints policy	2014	QNET	
2.5	QVH producing user information policy	2015	QNET	
2.6	QVH Interpreting policy	2013	QNET	Check has been updated
2.7	QVH supervision support guidance	2014	QNET	
2.8	QVH Recruitment and selection policy (includes Checking and DBS)	2015	QNET	
2.9	QVH Risk management and incidents policy	2014	QNET	
2.10	QVH Consents policy	2015	QNET	Includes Gillick competence/Fraser Guidelines –staff development re implementation of Fraser guidelines offered by Named Doctor
2.11	QVH Information security policy,-Patient photographic and video recording	2015	QNET	
	Police taking photographs on QVH site			Guidance added to Access Requests Procedures
2.12	QVH C&YP Chaperone Policy	2016	QNET	
2.13	QVH information governance policy	2015	QNET	
2.14	QVH Health records policy	2012	QNET	Being updated NR leading
2.15	QVH support for staff experiencing DVA policy/guidance	2017		DRAFT needs to be reviewed by Staff side and then ratified
2.16	QVH JD and person specification template	2016	QNET	
2.17	QVH Restrictive Physical Interventions and Therapeutic Holding Policy	2016	QNET	Child section expanded and EQIA completed
2.18	QVH Abduction or suspected Abduction of an Infant/Child Policy	2016	QNET	Finalised May 2016
2.19	QVH Routine pregnancy screening anaesthetics and surgery	2016		Leaflet approved and AC setting up training
2.20	QVH DVA procedures for patients	2017		Ratified, check on QNET

QVH SAFEGUARDING CHILDREN AND YOUNG PEOPLE

3	Item	Date	Location	Actions
3.1	QVH Child Protection and Safeguarding Policy and Procedures	Updated 2016	QNET	
	Includes • QVH Peanut missing children risk assessment • QVH children not brought to appointments risk assessment • QVH Referral Form			
3.2	QVH Paediatric Safeguarding Learning and Development strategy Plus appendix A level 3 development options	2016	QNET	
3.3	QVH safeguarding children Trauma Proforma and child protection documents	Updated 2017	QNET	
3.4	NAI photographs Policy and protocol	Being drafted 2017		Stacey Hussell and PL
3.5	QVH trainee doctor and dentists paediatric safeguarding guidance	Updated 2016	QNET	
3.6	QVH safeguarding children leaflet for all staff	2016	QNET	
3.7	QVH safeguarding children volunteers guidance	2016	QNET	
3.8	QVH Paediatric safeguarding risk assessments	ongoing	Overseen by strategic safeguarding Group	
3.9	QVH NMC examples of revalidation forms-completion for safeguarding practice	2016		
3.10	QVH posters for patients • Information sharing • Do you need to tell us something	2017	QVH site	Information to be included in set of standardised posters for wards
3.11	QVH leaflet for patients • Dog bites	2016	QNET	Being reviewed and updated 2017 to cover adults
3.12	QVH leaflet for families • Safeguarding children and young people	2016	QNET	

QVH SAFEGUARDING ADULTS

4.	Item	Date	Location	Actions
4.1	QVH Safeguarding Adults Policy	2016	QNET	
4.2	QVH Safeguarding Adults Learning & Development Strategy	2016		To add to QNET
4.3	QVH Adult safeguarding, MCA/DoLS Steering Group Terms of Reference	2016	Q-Net	
4.4	QVH *Prevent* Delivery Plan	2016	Q-Net	
4.5	QVH Safeguarding Adults Leaflet (For all staff including volunteers)	2016	Q-Net	
4.6	QVH Examples of Revalidation Forms	2016 (DRAFTED)	Q-NET	
4.7	QVH Mental Capacity Act 2005 Policy & Procedures	2015	Q-Net	Under Review
4.8	QVH Deprivation of Liberty Safeguards Policy	2015	Q-Net	Under Review
4.9	QVH Adult safeguarding risks assessments	ongoing	Overseen by strategic safeguarding Group	

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APPENDIX F
TITLE: Safeguarding Strategic Group Action Plan

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

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

Strategic Objective	QVH initial assessment	Rating (RAG)	Action Required	Timescale	Implement-ation Lead	Progress/ comments
1. To provide senior and Board leadership	QVH require: • Lead Board Director • Nominated Non-Executive Board Director • Paediatric Safeguarding Named Nurse • Paediatric Safeguarding Named Doctor • Adult Safeguarding Named Nurse • MCA & DOLs lead • Prevent lead • WRAP Facilliators • Child Sexual Exploitation Lead	Green	Review allocated specialist resources in coming year	Ongoing	Director of Nursing & Quality	Safeguarding team in place No vacant posts Departmental risks in place KPIs to Board Annual report to Board
2. Senior leadership responsibility and lines of accountability for safeguarding	QVH require: • Safeguarding Accountability and communication document on Website	Green	Sustain systems Annual	Ongoing	Director of Nursing a & Quality	Website and QNET update 2017 Quality assurance processes in place

arrangements are clearly outlined to employees and members of QVH, as well as to external partners.	• Safeguarding Strategy on website • Safeguarding QNET page • Safeguarding Policy, standards, protocols, guidance • Information for staff • Information for patients • Safeguarding training strategy and program in place • Longer term solution to manage safeguarding activity data required.		review and update training program Use Evolve/EDM safeguarding section as new system rolled out. Options being explored		with Named professionals	Policy review and updates Training uptake data and evaluations scrutinized monthly
3. QVH contribute to the work of West Sussex LSCB and SAB and their strategic Business Plans and priorities, and provide support to ensure that the Boards meet their statutory responsibilities.	QVH require; • Regular representation at LSCB • Regular representation at SAB • Completion of Section 11 self-audit • Monthly reports to CQC • Bi-monthly reports to LSCB and SAB • Quarterly reports to CCGs • Quarterly reports to NHS England – *prevent* coordinator	Green	Overlap between reporting requirements – manage and sustain effectively Regular representation at LSCB and SAB Regular updates from NHS England – optional teleconferences		Director of Nursing a & Quality with Named professionals	Safeguarding Children Section 11 self-assessment updated March 2016 Waiting for feedback from WSSCB March 2017
4. QVH support their safeguarding leads to contribute to and influence the work of the LSCB and SAB subgroups and other	QVH require; • Named professionals involvement in specific subgroups • Supervision from designated	Green	Paed SG Named Nurse to join Improving Practice group		Director of Nursing a & Quality with	Supervision in place

national and local safeguarding implementation networks.	professionals for named professionals • Attendance at West Sussex networks • Attendance at Regional Networks				Named professionals	

DELIVERING THE STRATEGY

Ensure all aspects of safeguarding work and practice are considered and incorporated into all QVH services.

Service developments take account of the need to safeguard all patients and are informed by service users and quality impact assessments.

Processes in place to disseminate, monitor and evaluate outcomes of all case review recommendations and actions.

Ensure there are effective arrangements in place to share information when required.

Safeguarding training and systems compliance will be monitored by safeguarding leads.

QVH will demonstrate it is meeting its statutory requirements via annual reporting and an audit programme.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	**07/09/17**	**Agenda reference:**	**142-17**		
Report title:	Emergency Preparedness Resilience and Response (EPRR) and Business Continuity Annual Report 2016/17				
Sponsor:	Jo Thomas, Director of Nursing and Quality				
Author:	Nicky Reeves, Deputy Director of Nursing and Quality				
Appendices:	Appendices 1-4 contained within this report				
Executive summary					
Purpose:	This annual report provides a summary of the work undertaken in relation to Emergency Planning and Business Continuity within QVH in 2016/17. The Civil Contingencies Act 2004 placed a number of duties on responding agencies to a Major Incident. QVH is a Category One responder which include the following responsibilities: • To carry out a risk assessment of our operational areas • To make emergency plans • To make business continuity plans • To warn and inform the public • To cooperate with other responders through a Local Resilience Forum • To share information with other responders This report provides assurance that the trust has met these responsibilities. The Quality and governance committee has received six monthly updates in 2016/17 to provide assurance that this work has been undertaken.				
Recommendation:	The Board is asked to review and **APPROVE** the report, noting the assurance that the Trust meets the requirements for EPRR and business continuity.				
Purpose:	Approval **Y**	Information **N**	Discussion **N**	Assurance **Y**	Review **Y**
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:	No new implications for the BAF.				
Corporate risk register:	No new risks identified on the CRR whilst reviewing annual performance.				
Regulation:	Compliance with regulated activities in Health and Social Care Act 2008 and the CQC's Fundamental Standard.				
Legal:	As above				
Resources	No changes				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	11/08/17	Decision:	Reviewed and recommended for approval	
Next steps:	NA				

Queen Victoria Hospital NHS
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Emergency Preparedness Resilience and Response and Business Continuity Annual Report 2016 - 2017

Nicola Reeves
Deputy Director of Nursing

Introduction

The Civil Contingencies Act 2004 placed a number of duties on responding agencies to a Major Incident. QVH are categorised as a Category One responder which include the following responsibilities:

- To carry out a risk assessment of our operational areas
- To make emergency plans
- To make business continuity plans
- To warn and inform the public
- To cooperate with other responders through a Local Resilience Forum
- To share information with other responders

During 2016/17 Emergency Preparedness Resilience and Response and Business Continuity Executive leadership within QVH was held by the Deputy Director of Nursing and Quality who represented the organisation at the Local Health Resilience Partnership Executive Group (LHRP).

QVH has a responsibility not only to update policies and plans related to Emergency Planning, but also to test these plans and conduct exercises in resilience and Business Continuity. Maintaining effective continuity of our business is of critical importance to QVH. We are committed to the implementation, maintenance and continual improvement of an effective Business Continuity Management (BCM).

The Quality and Risk Committee has received six monthly updates in 2016/17 to provide assurance that this work has been undertaken. This report provides a summary of the work undertaken in relation to Emergency Planning and Business Continuity within QVH in 2016/17.

Policy

Emergency Preparedness policies are held centrally on the Trust intranet pages; for ease they are divided into sections to reflect specific guidance. Policy review is ongoing; seasonal policies (Cold Weather and Heatwave) have been changed in line with national guidance and local action cards for major incident have also been revised; this work is ongoing and administered by the compliance officer.

Incident Co-ordination Centre (ICC)

The ICC is located in the Jubilee Meeting room. The equipment is tested on a bi monthly basis by the emergency planning lead. This process has demonstrated that all necessary equipment was in good working order including the fax machine; telephone lines; computer and television.

Assurance process

Internally:
Bi-monthly on-call manager meetings continue; on-call logs and incidents are reviewed and learning is captured and actioned. The inclusion of new on-call managers within the rota with a range operational experience makes these bi-monthly meetings a useful forum for discussion, sharing experience and learning. To ensure mangers receive the support and to facilitate correct decision making a buddy system is in place whereby all on-call managers without an operational remit have the contact details of a clinical manager to call for advice as required.

EPRR updates have been presented six monthly at Quality and Governance Committee and the annual report is presented for information at Board. These updates have been presented by the Director of Nursing or Deputy Director of Nursing during 2016/2017.

Externally:
All NHS Trusts who are category 1 and 2 responders (Civil Contingencies Act 2004) are required to complete a self-assessment and submit a statement of readiness to NHS England stating compliance against the national requirements of EPRR. We are considered a Category 1 responder. The Trust reviewed its compliance with the EPRR Core Standards (appendix 1) and the Statement of Readiness as part of the LHRP process in September 2016. This was submitted to NHS England in October 2016 and discussed at the Quality and Governance Committee in November 2016. The process will be repeated in autumn 2017. In 2016 the organisation demonstrated partial compliance following the review and the work plan to address these is contained within appendix 2.

Practice Exercises and Live Events

During 2016/17 QVH has tested its emergency planning resilience during a number of external table top exercises, including Exercise Apollo (flu planning) the most significant being Exercise Vesta in September 2016 which was a specific Burns related scenario.

In addition there have been a number of “live” incidents including a Generator failure in November 2016 and a burst pipe resulting in significant operational challenges to business continuity in January 2017.

The learning from these exercises and incidents are utilised to ensure the emergency plan remains up to date and is reviewed in the light of any recommendations as a result of these scenarios. Any changes to the emergency plans are approved via the Quality and Governance

Committee. Other than general review of the plans, no significant changes have been made following incidents other than relating to the burns plan which now includes surge and escalation advice from the London South East Burns Operational Delivery Network

Winter Planning

Snow

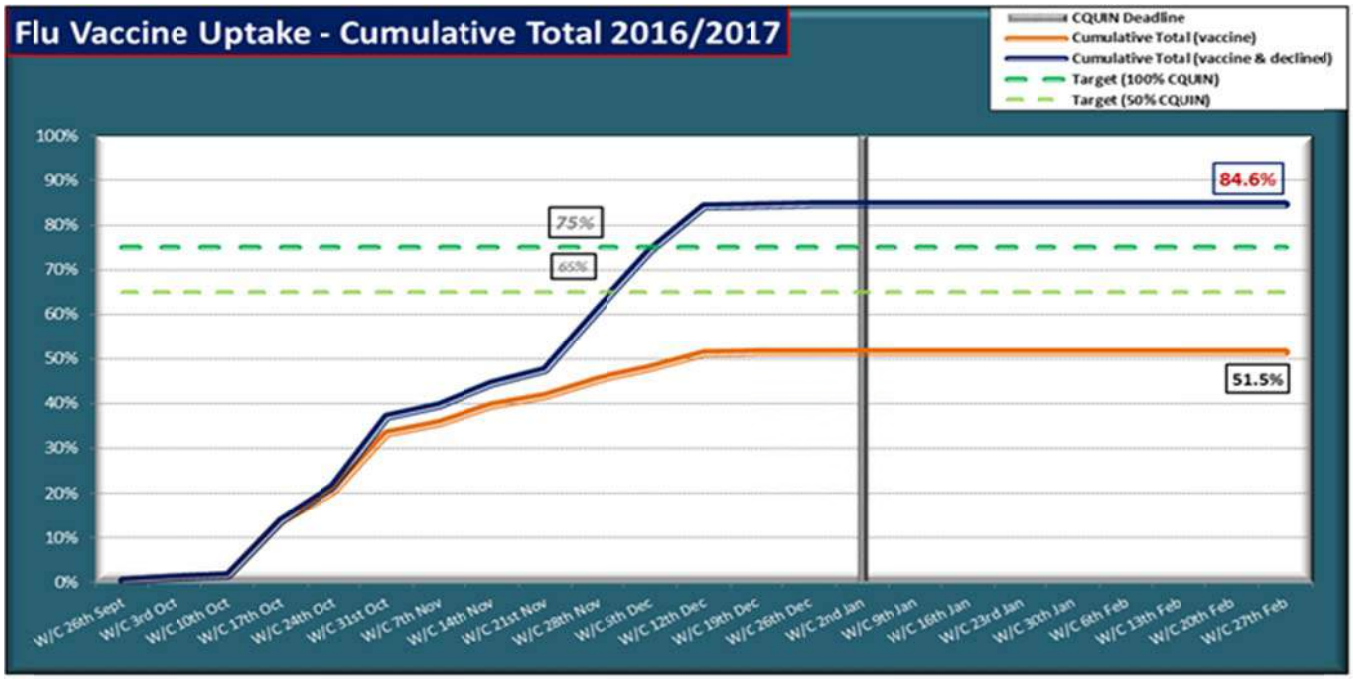
There was one significant snowfall in the winter of 2016/17 that impacted on QVH. This had minimal operational impact other than a requirement to muster staff resources to clear the car parks and walk ways. A business continuity incident was not called.

Flu

The 2016/17 flu vaccination programme concluded in March 2017 with all data submissions to IMMFORM uploaded successfully.

Final uptake for staff receiving the vaccination was 51.5%, a slight improvement on the 49.2% for 2015/16. This year, a CCG locally agreed variance to the CQUIN allowed us to include all staff officially declining the vaccination producing a final figure of 84.6%, exceeding the target of 75% (see chart and graph below).

ImmForm Data Submission			% of staff group headcount
All Doctors	149	55	36.9% 5.6%
Qualified nurses	215	101	47.0% 10.2%
All other professional qualified	141	74	52.5% 7.5%
Support to clinical staff	483	279	57.8% 28.2%
ImmForm	988	509	51.5%
CCG	988	836	84.6%



Training
Face to face training continues to be delivered at Induction and clinical and non-clinical mandatory update sessions. Mandatory training for Non-clinical staff is delivered every 3 years. This involves an overview of the roles and responsibilities and reminders of the relevant sections of the plan.

Fit testing
Fit testing has taken place in all services throughout 2016/17 and this was managed at a departmental level.

Business Continuity
Maintaining the effective continuity of our business operations is of critical importance to QVH. We are committed to the implementation, maintenance and continual improvement of an effective Business Continuity Management capability in line with BS 25999 Business Continuity Management. This includes the development of BC Plans for core business activity.

All business continuity plans can be accessed by the on call managers and site practitioner team and all departmental leads have a copy of their plan.

Other activity undertaken over the year:
- Training sessions on Emergency Planning Preparedness were delivered for all new employees on induction and current employees at mandatory training as an ongoing rolling programme.
- Bi monthly meeting for on-call managers, control personnel and bleep holders.
- The Trust maintained its membership with the Sussex Resilience forum
- Attendance at the LHRP executive Group

NHS England Core Standards for Emergency preparedness, resilience and response

v4.0

The EPRR Core Standards spreadsheet has 7 tabs:

Introduction - this tab,. outlining the content of the other 6 tabs and version control history

EPRR Core Standards tab - with core standards nos 1 - 37 (green tab)

Business Continuity tab:- with deep dive questions to support the review of business continutiy planning for EPRR Assurance 2016-17 (blue tab) with a focus on organisational fuel use and supply.

HAZMAT/ CBRN core standards tab: with core standards nos 38- 51. Please note this is designed as a stand alone tab (purple tab)

HAZMAT/ CBRN equipment checklist: designed to support acute and NHS ambulance service providers in core standard 43 (lilac tab)

MTFA Core Standard (NHS Ambulance Services only): designed to gain assurance against the MTFA service specification for ambulance service providers only (orange tab)

HART Core Standards (NHS Ambulance Services only): designed to gain assurance against the HART service specification for ambulance service providers only (yellow tab).

This document is V4.0. The following changes have been made :

- Inclusion of Business Continuity questions to support the 'deep dive' for EPRR Assurance 2016-17, replacing the Pandemic Influenza tab
- Inclusion of the HART service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Inclusion of the MTFA service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Updated the requirements for primary care to more accurately reflect where they sit in the health economy
- update the requirement for acute service providers to have Chemical Exposure Assessment Kits (ChEAKs) (via PHE) to reflect that not all acute service providers have been issued these by PHE and to clarify the expectations for acute service providers in relation to supporting PHE in the collection of

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																				
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	• Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.	Director of Nursing is accountable emergency officer. Deputy Director of Nursing is EPRR Lead.			
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		Debrief procedure is well documented and all serious incidents are completed with hot debrief and then full debrief at a later date. Trust has two qualified DiC HEP members of staff who advise on EP/CBRN and BC issues.	Review of EPO and BC support	**Deputy Director of Nursing**	31st December 2016
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		Section 1 of the emergency plan outlines the trust commitment to emergency preparedness.			
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		Minutes of board meetings and papers are available			
Duty to assess risk																				
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks eg. Flooding, COMAH sites etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	**A**	Each part of the plan is currently being risk assessed with information shared and consultation with the relevent departments.	EP lead	End of November 16
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		MOUs with Sussex 4x4 and 4x4 assist who can provide transport in severe weather, 4x4 assist are also capable of bringing in rations to the site or water if needed.	Hotel services to gain assurances from food suppliers for their services	Hotel Services	End of November 16
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**A**	Risk assessments will be shared with all departments and external stakeholders once completed	EP lead	End of October 2016
Duty to maintain plans – emergency plans and business continuity plans																				
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; •take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; •include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.	**Emergency plan is place**			
		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Emergency plan is place**			
		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y	Y	Y			Y	Y					Y			**Emergency plan is place**			
		Severe Weather (heatwave, flooding, snow and cold weather)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Emergency plan is place**			
		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y		**Emergency plan is place**			
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y	Y	Y			Y		Y	Y				Y		**Emergency plan is place**			
		Mass Casualties	Y	Y	Y			Y		Y	Y				Y		**Emergency plan is place**			
		Fuel Disruption	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		supply of approx 3 days for our generators.	No plan in place at the moment. QVH will engage with LHRP and stakeholders to develop plan ASAP	DDoN	End of 2016
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		**Emergency plan is place**			
		Infectious Disease Outbreak	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y		**Emergency plan is place**			
		Evacuation	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y		**Emergency plan is place**			
		Lockdown	Y	Y	Y			Y	Y					Y	Y		**Emergency plan is place**			
		Utilities, IT and Telecommunications Failure	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y		IT failure we have a paper system as a backup for patient critical functions. Telecommunications failure we have charged mobile phones and sim cards in place that are all checked weekly.	Overarching IT to be deveopled ASAP	DDon	End of 2016
		Excess Deaths/ Mass Fatalities	Y	Y	Y					Y	Y				Y		Lead Consultant histopathology has developed a strategy for this possible outcome, which we are currently working on to incorporate into the winter and pan flu plans. This will include temproary fridge areas and mortuary facilities and teams to run them.	Review of arrangements and insertion in to relevant Eplan	DDoN	End 2016
		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab			Y												**N/A**			
		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab			Y												**N/A**			
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	Plans are reviewed yearly or in the event of new strategic guidance on each of the sections of the plan.			
10	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	Refresher training carried out yearly and new LHRP flow algorithm is available to advise on call managers of what level Business continuity, serious or critical incident we are dealing with and who to contact at what level for assitance and			
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**G**			
12	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y	Y	Y			Y	Y								**A**	Standard Operating Procedure currently being revised, In the	**EP lead**	Nov-16
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Specifiy who has been consulted on the relevant documents/ plans etc.	**G**			
14	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold)at the end of an incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Debrief procedure is well documented and all serious incidents are completed with hot debrief and then full debrief at a later date.			
Command and Control (C2)																				
15	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	**Site practitioner team are the on duty 24 hour contact via switchboard**			
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Y	Y	Y		Y	Y	Y	Y	Y	Y			Y	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.	**A**	Bronze and Silver training can be run on site and are being developed, currently at planning	EP lead	Mar-17
17	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/coOordination centre and manage any events required.	Emergency Operations centre identified in plan as is an alternative in the event of power failure.			
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Trauma co-ordinator or site practioner, whoever is not the bronze commander will act as the loggist at the commencement of any incident out of hours, other loggists can be called in during working hours.			
19	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y		Evidence from recent Doctors industrial action validates the reporting process for the trust.			
20	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Y		Y												**N/A**			
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident	Y		Y												**N/A**			
Duty to communicate with the public																				

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.	Information is received by at least two staff with in the the trust the EP Lead and the EP advisor. this is then promulgated to relevent departments to cascade, eg, heatwave warnings, bad weather alerts. PALS and coms team wil then advise on communications for warning patients about, heat , cold or other hazards that we are required to warn the public of.			

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	G			
Information Sharing – mandatory requirements																				
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). •Social networking tools may be of use here.	G			
Co-operation																				
25	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	Y	Y			Y	Y	Y	Y	Y		Y	Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat.	EP advisor attends LRHP and EP lead attends SHRP regularly and report back to Director level any relevant information.			
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	• Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities	Active involvement with planning and participating in exercise apollo sept 16 and regional burns surge exercise London sept 16			
27	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y	• Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements •Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area	Arrangements in the emergency plan, site team and oncall			
28	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.				Y					Y	Y				Y		N/A			
29	Arrangements outline the procedure for responding to incidents which affect two or more regions.				Y						Y				Y		N/A			
30	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y	Y	Y			Y	Y			Y		Y			Evidence can be seen from recent doctors industrial action in the reporting system and sitreps for NHS England.			
31	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared										Y						N/A			
32	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months									Y	Y						N/A			
33	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y	Y	Y			Y	Y	Y		Y			Y		attended by deputy director of nursing.			
Training And Exercising																				
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs.	A	TNA for EP is currently under review and will be completed shortly. Representatives attending regional exercises. Communiation tests	CT	Nov-16
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties; • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years	Training plan is held within the staff development centre, exercise plan is held in the deputy director of nursings office and accessible via a shared folder on the intranet to staff involved in emergency planning.			
36	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y	Y	Y			Y	Y	Y	Y	Y			Y		two exercises involve trust staff in Sept 16.			
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y	Y	Y		Y	Y	Y	Y	Y	Y			Y		A	Training and exercising is currently running as per exercise	DDoN	Mar-17

Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
2015 Deep Dive																			
DD1	Organisation has undertaken a Business Impact Assesment	• The organisation has undertaken a risk based Business Impact Assessment of services it delivers, taking into account the resouces required against staffing, premises, information and information systems, supplies and suppliers • The organisation has identified interdependencies within its own services and with other NHS organisations and 3rd party providers • Risks identified thought the Business Impact Assessment are present on the organisations Corporate Risk Register	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• updated Business Imact Assessment • corporate risk register	G			
DD2	Organisation has explicitly identified its Critical Functions and set Minimum Tolorable Peroiods of disruption for these	• The organisaiton has identified their Critical Functions through the Business Impact Assesment. • Maximum Tolerable Periods of Disruption have been set for all organisaional functions - including the Critical Functions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Business Continuity plan explicitly details the Critical Functions • Business Continuity plan explicitly outlines all organisations functions and the maximum torlerable period of disrution	G			
DD3	There is a plan in place for the organisation to follow to maintain critical functions and restore other functions following a disruptive event.	• The organisation has an up to date plan which has been approved by its Board/Governing Body that will support staff to maintain critical functions and restore lost functions • The plan outlines roles and responsibilities for key staff and includes how a disrutive event will be communicated both internally and externally	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• an organisation wide Business Continuity plan that has been updated in the last 12 months and agreed the Board/Governing Body	G			
DD4	Within the plan there are arrangements in place to manage a shortage of road fuel and heating fuel	• The plan details arrangements in place to maintain critical functions during disruption to fuel. These arrangements include both road fuel and were applicable heating fuel.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• detail within the plan that explicitly makes reference to shortage of fuel and its impact of the business.	G			
DD5	The Accountable Emergency Officers has ensured that their organisation, any providers they commission and any sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301 or subsequent guidance which may supersede this .	EPRR Framework 2015 requirement, page 17	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		A	Further work is required with new Business Managers across all areas to ensure a more joined up approach to continuity, however all areas do have BC plans which are centrallly held by EPRR Lead.		
DD6	Review of Critical Services Fuel Requirement Data Collection Programme (F1:F18)	Please complete the data collection below - this data set does not count towards the RAG score for the organisations. Please provide any additional information in the "Other comments" free text box.	Y	Y		Y	Y	Y	Y						Y	• NHS Ambulance Trusts have already provided this information in a national collection in May 2016.	A	Please review response to core standard 8		

Fuel Demand Summary

When providing information on the fuel requirements for both business as usual and to operate a critical service please ensure the supply and demand balances whereby:

Total Daily fuel use (F1) = own bunkered fuel use (F5) + any 3rd party bunkered fuel use (F6) + any forecourt fuel use (F9)

Section 1: Business as Usual Demand

		Petrol	Diesel	Other (inc LPG, Kerosene
F1	How much fuel do you use daily when providing a business as usual service? (litres) -	1,773		

Section 2: Bunkered Fuel

		Petrol	Diesel	Other (inc LPG, Kerosene
F2	Do you hold bunkered fuel If no go to F6			Yes
F3	What is the total bunkered fuel capacity? (litres)			10,000
F4	On average, what volume of bunkered fuel do you hold? (litres)			8,000
F5	Do you use your own bunkered fuel when providing a business as usual service? If no go to F6			No
F6	Do you access a 3rd party or another service's bunkered fuel when providing a business as usual service? If no go to F8			No
F7	If you have answered "Yes" to F6 or have bilateral supply agreements to operate a business as usual service, please provide a description of any agreement(s), amount of supply and companies / organisations involved.			

1) What happens if I have mutual aid agreements with another Critical Service provider to utilise their bunkered stock, do I need to record the bunkered stock or will they?
DECC is requesting that the supplier records the bunkered stock holdings and the user records the demand. As the user of these bunkered fuels in this instance, please record the use of these stocks under the section referring to access to third party bunkered stock.
2) Should we assume that in the build up to an emergency our bunkered stocks would be full, as we would be prioritising deliveries and therefore the days' stock held calculations should be based on full capacity and not average daily stock holdings?
The prioritisation of supply will be dependent on the facts of any fuel shortage scenario, and will be a decision taken at the time. Data provided in the template should provide DECC with a sufficient evidence base to make decisions based on capacity and BAU bunkered stocks. Therefore please fill out the template as requested, providing notes where you think that estimates are required, or where you have had to average data in order to fit the template.
3) Our choice of bunkered fuel supplier varies depending on supply cost or availability. Who do I record as the primary supplier?
Please provide the supplier you get most of your fuel from, but also note that this varies and provide details of the other suppliers and average quantities.
4) The terminal our bunkered fuel is supplied from varies depending on who our supplier is. What should we report?
Please report your largest supplier based on average BAU, but also provide notes on any secondary service providers and average quantities obtained from those providers.

ERROR - Bunkered Fuel Volume Used greater than Bunkered Fuel Volume held (Q.10)

ERROR - Bunkered Fuel Volume Used more than total daily fuel use (Q.7)

Section 3: Petrol Stations / Forecourts

		Petrol	Diesel	Other (inc LPG, Kerosene
F8	Do you use forecourts to operate a business as usual service? If no go to F10	Yes		
F9	What is the average daily forecourt fuel use to operate a business as usual service? (litres) -	1,773		

Critical Service Operation Only

Please refer to question 4 of the guidance notes for further information on how to identify the fuel requirements of a critical service.
During an emergency it is expected that organisations will not be operating as normal and will only be delivering those essential services that are Critical.
Low fuel consumption alternatives should also be explored as part of the Critical Service identification process. For example, if there is the possibility that a Critical Service activity can be carried out remotely, and therefore does not require the use of fuel, this should be removed from the supply requirements to
The below section refers to the fuel requirements to deliver a Critical Service only.

Section 4: Critical Service Demand

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F10	How much fuel would you use daily if you were providing a critical service? (litres) - Our critical service would be considered to be the provision of our Burns ITU and head and neck cancer service only. The main requirement would be to source fuel to get staff to and from work. We currently would be requreing in the region of 10 staff per	272		

Section 5: Critical Service Bunkered Fuel

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F11	Do you have access to either your own or 3rd party bunkered fuel if you were providing a critical service (either from general access or mutual supply agreements)? No If no go to F14	No		
F12	What volume of your own bunkered fuel would you use daily if you were providing a critical service? (litres)			
F13	What volume of 3rd party or another service bunkered fuel (either from general access or mutual supply agreements) would you use daily if you were providing a critical service? (litres)			
F14	If you have answered "Yes" to F13 or have bilateral supply agreements to operate a critical service, please provide a description of any agreement(s), amount of supply and companies / organisations involved. If no go to F15			

Section 6: Critical Service Petrol Stations / Forecourts

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F15	Will you need access to Designated Filling Stations (DFS) if you were providing a critical service? Yes If no go to F17	Yes		
F16	What volume of fuel would you use daily from Designated Filling Stations (DFS) if you were providing a critical service? (litres) -	272		

Critical Service Operation Only

F17 To ensure that there are adequate Designated Filling Stations* (DFS) to meet the demands of all critical users , please detail in the table below the number of vehicles required to operate a critical service
A Designated Filling Station (DFS) is a retail filling station with the purpose of only supplying road fuel for critical use only. The DFS list will be compiled to provide sites giving a good geographic coverage of the UK to meet the predicted regional demand for fuel for critical services.

Vehicles	Number of Vehicles required to operate a critical service		
	Petrol	Diesel	Other (inc LPG)
With NHS Logo	None		
Without NHS Logo	None		
Private vehicles	25 to 30		
Total	25 to 30		

F18 If you have answered "Yes" to question 2 (Do you hold bunkered fuel?) please detail which company primarily supplies your bunkered fuel and where known which local or regional supply depot or terminal does the fuel gets delivered from. Please select from drop down list provided or select "other" and please detail.

Who primarily supplies your bunkered fuel? Please Select from drop down list.	If other or multiple suppliers please state:	Which Terminal is your bunkered fuel supplied from? Please Select from drop down list.	If other please state:	Average Number of Deliveries per Month

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental Health care providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**						**Evidence of assurance**				
	Preparedness											
38	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control	CBRN Specific part of the emergency plan, is in place and has been re written to include current national guidance for community units. New equipment has been purchased to protect staff and is being introduced.		EP lead	Nov-16
39	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	Y	Y	Y	Y	• Site inspection • IT system screen dump	Plan is available on intranet and paper copies should be in each department, there are also action cards for decon and step1,2,3 in the Minor injuries unit.			
40	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	Y	Y	Y	Y	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)	RA in place for likelyhood of risk to trust, RA is also in place for decontamination activies as described in the plan.		CT	Sep-16
41	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Y		Y			• Resource provision / % staff trained and available • Rota / rostering arrangements	N/A			
42	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	Y	Y	Y	Y	Y	• Provision documented in plan / procedures • Staff awareness	Clearly outlined on first page of the cbrn section of the emergency plan.			
	Decontamination Equipment											
43	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))	A	New equipment boxes will be stocked and organised once a cadre of trained staff is available to use the equipment there in. Training is currently ongoing but will be completed by end of Nov 2016	**CT**	end of Nov 2016
44	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017	Y		Y				N/A			
45	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place	Y		Y				N/A			
46	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		Y		Y				N/A			
47	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Y		Y				N/A			
	Training											
48	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training		Y		Y				N/A			
49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme	Records of EP awareness and CBRN training are kept within Staff Development centre and on staff education files. All clinical staff receive annual ep awareness. Non clinical staff are provided with 3 yearly ep			
50	The organisation has sufficient number of trained decontamination trainers to fully support it's staff HAZMAT/ CBRN training programme.		Y		Y				N/A			
51	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	Y	Y	Y	Y	Y		We have a Community CBRN decontamination and CBRN/HAZMAT training package in place, targeting potential incident commanders and staff expected to deal with casualties from MIU both clinical and non clinical			

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.			
No	**Equipment**	**Equipment model/ generation/ details etc.**	**Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.**
	EITHER: Inflatable mobile structure		
E1	Inflatable frame		
E1.1	Liner		
E1.2	Air inflator pump		
E1.3	Repair kit		
E1.2	Tethering equipment		
	OR: Rigid/ cantilever structure		
E2	Tent shell		
	OR: Built structure		
E3	Decontamination unit or room		
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)		
E5	Shower heads		
E6	Hose connectors and shower heads		
E7	Flooring appropriate to tent in use (with decontamination basin if needed)		
E8	Waste water pump and pipe		
E9	Waste water bladder		
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).		
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme		
	Ancillary		
E12	A facility to provide privacy and dignity to patients		
E13	Buckets, sponges, cloths and blue roll		
E14	Decontamination liquid (COSHH compliant)		
E15	Entry control board (including clock)		
E16	A means to prevent contamination of the water supply		
E17	Poly boom (if required by local Fire and Rescue Service)		
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)		
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)		
E20	Waste bins		
	Disposable gloves		
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe		
E22	FFP3 masks		
E23	Cordon tape		
E24	Loud Hailer		
E25	Signage		
E26	Tabbards identifying members of the decontamination team		
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.		
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)		
E29	Hooded paper suits		
E30	Goggles		
E31	FFP3 Masks - for HART personnel only		
E32	Overshoes & Gloves		

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations have an MTFA capability at all times within their operational service area.	• Organisations have MTFA capability to the nationally agreed safe system of work standards defined within this service specification. • Organisations have MTFA capability to the nationally agreed interoperability standard defined within this service specification. • Organisations have taken sufficient steps to ensure their MTFA capability remains complaint with the National MTFA Standard Operating Procedures during local and national deployments.			Y													
2	Organisations have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability.	• Deployment to the Home Office Model Response sites must be within 45 minutes.			Y													
3	Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene within 10 minutes of that confirmation (with a corresponding safe system of work).	• Organisations maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA capability matrix. • Organisations ensure that, as part of the selection process, any successful MTFA application must have undergone a Physical Competence Assessment (PCA) to the nationally agreed standard. • Organisations maintain the minimum level of training competence among all operational MTFA staff as defined by the national training standards. • Organisations ensure that each operational MTFA operative is competent to deliver the MTFA capability. • Organisations ensure that comprehensive training records are maintained for each member of MTFA staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the MTFA skill sets.			Y													
4	Organisations ensure that appropriate personal equipment is available and maintained in accordance with the detailed specification in MTFA SOPs (Reference C).	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable. • All MTFA equipment is maintained to nationally specified standards and must be made available in line with the national MFTA 'notice to move' standard. • All MTFA equipment is maintained according to applicable British or EN standards and in line with manufacturers' recommendations.			Y													
5	Organisations maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability.	• Organisations ensure that Control rooms are compliant with JOPs (Reference B). • With Trusts using Pathways or AMPDS, ensure that any potential MTFA incident is recognised by Trust specific arrangements.			Y													
6	Organisations have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.				Y													
7	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.				Y													
8	Organisations maintain an appropriate register of all MTFA safety critical assets.	• Assets are defined by their reference or inclusion within the National MTFA Standard Operating Procedures. • This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).			Y													
9	Organisations ensure their operational commanders are competent in the deployment and management of NHS MTFA resources at any live incident.				Y													
10	Organisations maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
11	In any event that the organisations is unable to maintain the MTFA capability to the interoperability standards, that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
12	Organisations support the nationally specified system of recording MTFA activity which will include a local procedure to ensure MTFA staff update the national system with the required information following each live deployment.				Y													
13	Organisations ensure that the availability of MTFA capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
14	Organisations maintain a set of local MTFA risk assessments which are compliment with the national MTFA risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
15	Organisations have a robust and timely process to report any lessons identified following an MTFA deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
16	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
17	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.				Y													
18	FRS organisations that have an MTFA capability the ambulance service provider must provide training to this FRS	Training to include: • Introduction and understanding of NASMed triage • Haemorrhage control • Use of dressings and tourniquets • Patient positioning • Casualty Collection Point procedures.			Y													
19	Organisations ensure that staff view the appropriate DVDs	• National Strategic Guidance - KPI 100% Gold commanders. • Specialist Ambulance Service Response to MTFA - KPI 100% MTFA commanders and teams. • Non-Specialist Ambulance Service Response to MTFA - KPI 80% of operational staff.			Y													

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations maintain a HART Incident Response Unit (IRU) capability at all times within their operational service area.	• Orgaiations maintain the four core HART capabilities to the nationally agreed safe system of work standards defined within this service specification. • Orgaiations maintain the four core HART capabilities to the nationally agreed interoperability standard defined within this service specification. • Orgaiations take sufficient steps to ensure their HART unit(s) remains complaint with the National HART Standard Operating Procedures during local and national deployments. • Orgaiations maintain the minimum level of training competence among all operational HART staff as defined by the national training standards for HART. • Orgaiations ensure that each operational HART operative is provided with no less than 37.5 hours protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven week period). • Orgaiations ensure that all HART operational personnel are Paramedics with appropriate corresponding professional registration (note s.3.4.6 of the specification). • As part of the selection process, any successful HART applicant must have passed a Physical Competence Assessment (PCA) to the nationally agreed standard and the provider must ensure that standard is maintained through an ongoing PCA process which assesses operational staff every 6 months and any staff returning to duty after a period of absence exceeding 1 month. • Orgaiations ensure that comprehensive training records are maintained for each member of HART staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets.			Y												
2	Organisaions maintain a HART Urban Search & Rescue (USAR) capability at all times within their operational service area.				Y													
3	Organisations maintain a HART Inland Water Operations (IWO) capability at all times within their operational service area.				Y													
4	Organisations maintain a HART Tactical Medicine Operations (TMO) capability at all times within their operational service area.				Y													
5	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	• Four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. Note: This standard does not apply to pre-planned operations or occasions where HART is used to support wider operations. It only applies to calls where the information received by the provider indicates the potential for one of the four HART core capabilities to be required at the scene. See also standard 13. • Organisations maintain a minimum of six competent HART staff on duty for live deployments at all times. • Once HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations can ensure that six HART staff are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. • Organisations maintain a HART service capable of placing six competent HART staff on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). Competence is denoted by the mandatory minimum training requirements identified in the HART capability matrix. • Organisations maintain any live (on-duty) HART teams under their control maintain a 30 minute 'notice to move' to respond to a mutual aid request outside of the host providers operational service area. An exception to this standard may be claimed if the live (on duty) HART team is already providing HART capabilities at an incident in region.			Y												
6	Organisations maintain a criteria or process to ensure the effective identification of incidents or patients at the point of receiving an emergency call that may benefit from the deployment of a HART capability.				Y													
7	Organisations ensure an appropriate capital and revenue depreciation scheme is maintained locally to replace nationally specified HART equipment.	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should have processes in place to use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable.			Y													
8	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.				Y													
9	Organisations ensure that the HART fleet and associated incident technology are maintained to nationally specified standards and must be made available in line with the national HART 'notice to move' standard.				Y													
10	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.				Y													
11	Organisations maintain an appropriate register of all HART safety critical assets. Such assets are defined by their reference or inclusion within the National HART Standard Operating Procedures. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).				Y													
12	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the HART estate specification.				Y													
13	Organisations ensure their incident commanders are competent in the deployment and management of NHS HART resources at any live incident.				Y													
14	In any event that the provider is unable to maintain the four core HART capabilities to the interoperability standards,that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
15	Organisations support the nationally specified system of recording HART activity which will include a local procedure to ensure HART staff update the national system with the required information following each live deployment.				Y													
16	Organisations maintain accurate records of their compliance with the national HART response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
17	Organisations ensure that the availability of HART capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
18	Organisations maintain a set of local HART risk assessments which compliment the national HART risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
19	Organisations have a robust and timely process to reportany lessons identified following a HART deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
20	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
21	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.				Y													

	Core standard	Clarifying information	RAG	Action to be taken	Core Standard	Lead	Timescale
Governance							
1	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites)	A	Risk assessment process to be reviewed. Existing policy in situ but detailed review required to assess. Each part of the plan is currently being risk assessed with information shared and consultation with the relevant departments,	5	EP team	Oct-16
2	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks e.g.. Flooding, COMAH sites etc.	A	Risk assessments in place. Benchmarking against other organisation will take place during autumn. Hotel services to gain assurances from food suppliers for their services	6	DDoN	Dec-16
3	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	A	Review of process for oversight of risk assessments and policy in collaboration with Head of Risk. Risk assessments will be shared with all departments and external stakeholders once completed, new Head of Communications in post so we will be completely reviewing	7	DDoN	Dec-16
4	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Fuel Disruption.	A	To write a policy in collaboration with the LHRP. This is a national piece of work. No plan in place at the moment. QVH will engage with LHRP and stakeholders to develop plan ASAP	8	DDoN	Dec-16
		Utilities, IT and Telecommunications Failure.	A	IT to write an overarching business continuity plan as recommended by the internal audit process	8	Head of IT	Dec-16
		Excess Deaths/ Mass Fatalities.	A	Review guidance in trust policy to ensure this is addressed	8	Emergency planning nurse	Nov-16
5	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision. - Specify who should be consulted before making the decision. - Specify who should be informed once the decision has been made (including clinical staff).	A	Review guidance in trust policy to ensure this is clearly addressed. Share		Emergency Head of Nursing	Nov-16
6	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management.	A	Review media and communication management within the existing policies. Standard Operating Procedure currently being revised, In the event of Royalty op carbon steeple will be in place co-ordinated by Royal protection Division Met Police.	12	Head of communications	Dec-16

	Core standard	Clarifying information	RAG	Action to be taken	Core Standard	Lead	Timescale
7	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England published competencies are based upon National Occupation Standards.	A	Review existing knowledge base of on call staff and provide training as required. Utilise existing training packages as provided by LHRP. Bronze and Silver training can be run on site and are being developed, currently at planning stage however will be in place by end of this financial year for roll out. Gold awareness is incorporated	16	DDoN	Oct-16
8	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents.	• Staff are clear about their roles in a plan. • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate. • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective. • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective.	A	Review existing knowledge base of on call staff and provide training as required. Utilise existing training packages as provided by LHRP. Bronze and Silver training can be run on site and are being developed, currently at planning stage however will be inBronze and Silver training can be run on site and are being developed, currently at planning stage however will be in place by end of this financial year for roll out. Gold awareness is incorporated into SMT meetings.	16	DDoN	Oct-16
9	Preparedness ensures all incident commanders (on call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		A	Review existing knowledge base of on call staff and provide training as required. Utilise existing training packages as provided by LHRP. Bronze and Silver training can be run on site and are being developed, currently at planning stage however will be inTNA for EP is currently under review and will be completed shortly.	37	DDoN	Oct-16
10	The Accountable Emergency Officers has ensured that their organisation, any providers they commission and any sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301 or subsequent guidance which may supersede this.	EPRR Framework 2015 requirement, page 17.	A	Review existing SLA and procurement arrangements	DD5	DDoN	Dec-16
11	Review of Critical Services Fuel Requirement Data Collection Programme (F1:F18).		A	Further work is required with new Business Managers across all areas to ensure a more joined up approach to continuity, however all areas do have BC plans which are centrally held by EPRR Lead.	DD5	DDoN	Dec-16
12	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab. • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	A	New equipment boxes will be stocked and organised once a cadre of trained staff is available to use the equipment there in. Training is currently ongoing but will be completed by end of Nov 2016	43	Emergency planning nurse	Nov-16
13			A				

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	**07/09/17**	**Agenda reference:**	**143-17**		
Report title:	Patient Experience Annual Report 2016/17				
Sponsor:	Jo Thomas, Director of Nursing and Quality				
Author:	Nicolle Ferguson, Patient Experience Manager				
Appendices:	None				
Executive summary					
Purpose:	The patient experience annual report describes the progress made to ensure that patient feedback is used to improve services and assurance that patient experience is being sustained and improved. The experiences of our patients, their carers' and their families are gathered from surveys, focus groups, complaints, concerns and compliments. This enables us to create a full picture of our patients' views and to understand the top issues, key themes and identify areas of improvement. Patient Experience features as one of the Trust's quality priorities for 2017/18, therefore placing it firmly at the heart of the Trust's continuous drive to improve the quality of the services we provide. The Trust has developed a patient experience programme that allows patients to provide their feedback in real-time through the inpatient surveys or social media; or at a later date through NHS Choices/Care Opinion, postal surveys, focus groups, face to face engagement or, of course, PALS and complaints.				
Recommendation:	The Board is asked to review and **APPROVE** that the contents of the report, and to note the assurances provided regarding the experiences of patients using QVH services.				
Purpose:	Approval **y**	Information **Y**	Discussion **N**	Assurance **Y**	Review **Y**
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:	No new implications for the BAF.				
Corporate risk register:	The nursing workforce risks have been reviewed and amended on the CRR.				
Regulation:	Compliance with regulated activities in Health and Social Care Act 2008 and the CQC's Fundamental Standard.				
Legal:	As above				
Resources	No changes				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	11/08/17	Decision:	Reviewed and recommended for approval	
Next steps:	NA				

Queen Victoria Hospital NHS
NHS Foundation Trust

Patient Experience Annual Report

1 April 2016 – 31 March 2017

Nicolle Ferguson, Patient Experience Manager
Queen Victoria Hospital

Overview

Over the past year, progress has continued in taking forward work to measure, report and improve the patient experience and to actively involve patients and the public in this process. Although there have been challenges within our workforce our aim is always to ensure that involving patients and families and making improvements to services becomes part of everyday practice.

The patient experience annual report describes the progress we have made to ensure that patient feedback is used to improve services and the patient's experience of using our services. The experiences of our patients, their carers' and their families are gathered from surveys, focus groups, complaints, concerns and compliments. This enables us to create a full picture of our patients' views and to understand the top issues, key themes and identify areas of improvement.

Patient Experience features as an the Trust's quality priorities for 2017/18, therefore placing it firmly at the heart of the Trust' continuous drive to improve the quality of the services we provide.

We have developed a patient experience programme that allows patients to provide their feedback in real-time through the inpatient surveys or social media; or at a later date through NHS Choices/ Care Opinion, postal surveys, focus groups, face to face engagement and of course PALS and complaints.

At Board level the Trust's Director of Nursing has responsibility for patient expreience which includes delivery of our patient experience strategy, compliance with the national Friends and Family Test reporting and demonstrating that we have used patient experience feedback to improve the experience of care.

This report is shared with the Trust Board, Quality and Governance Committee, Patient Experience Group, our stakeholders including Clinical Commissioning Group, Healthwatch and Care Quality Commision.

Patient Experience Reporting

Trust wide Patient Experience Reports are routinely reviewed by the Clinical Governance Group (monthly) Quality and Governance Committee (bi-monthly) and the Board of Directors (bi-monthly) meetings.

The reports continue to bring together a range of patient experience information from across the Trust. This ensures that key patient experience monitoring information is routinely considered at the most senior level.

Friends and Family Test

When a patient is discharged they will be asked to answer the following question 'How likely are you to recommend our Ward/ Minor Injury Unit /Outpatient Department / Day case area to friends and family if they needed similar care or treatment?'

Patients are invited to respond to the question by choosing one of six options, 'extremely likely' 'likely' 'neither likely nor unlikely' 'unlikely' 'extremely unlikely' and 'don't know'.

As of April 2015 all patients that attend the hospital are asked to complete a FFT questionnaire. To enable us to drive this agenda forward we outsourced this service to support the data collection and reporting elements If a patient has been treated in our Minor Injury Unit, Outpatient Departments or Therapy Department they will be sent either a SMS text to their mobile phone or an Interactive voice message (IVM) to their landline phone within 48 hours of their appointment and asked to rate and comment on their experience. Patient's feedback is anonymous and is completely FREE of charge for patients to reply.

All wards and departments continue to display their monthly Friends and Family Test results on information boards which provide an opportunity for wards to demonstrate to patients and their carers, actions they are taking in response to feedback. The information shown gives the Matron and ward managers an opportunity to discuss this openly with staff, patients and their loved ones to identify improvements.

How likely are you to recommend our ward to family and friends?

The response to the Friends and Family Test question for In-Patients who are 'extremely likely' to recommend us to a friend or family during that period from Margaret Duncombe ward, Ross Tilley ward, Burns ward and Peanut ward were (the national response rate target to achieve is 40% for inpatient returns).

As with previous years, the vast majority of our patients are happy with the care they receive, citing the friendliness, helpfulness, excellence, clinical outcomes, professionalism and overall very positive patient experience.

Where patients felt their visit could have been improved, cited waiting times in clinic as their main concern. Of the other suggested improvements, the majority concerned issues related to clinic experiences while waiting such as the availability of refreshments, communication about waiting times and process.

Other issues concerned parking, staff behaviour and appointments management. The Patient Experience Group will monitor improvements against the issues raised over the coming year.

The following chart shows Friends and Family Test inpatient recommended rate

Inpatients	2016/17	National average 2016/17
QVH recommended rate	98%	96%
QVH response rate	46%	26%

The following chart show the breakdown per month for inpatients

QVH Inpatients	% recommended rate	% response rate`	Baseline % response rate
April 2016	99%	38.5%	40%
May	98%	49.5%	40%
June	98%	57%	40%
July	99%	48%	40%
August	99%	42%	40%
September	98%	39%	40%
October	98%	48%	40%
November	97%	44%	40%
December	97%	48%	40%
January 2017	98%	45%	40%
February	98%	48%	40%
March	99%	48%	40%

The following chart show the breakdown per month for outpatient:

QVH Outpatients	% extremely likely & likely	overall % response rate`	Baseline % response rate
April 2016	94%	19%	20%
May	95%	18%	20%
June	94%	19%	20%
July	94%	17%	20%
August	94%	16%	20%
September	94%	16%	20%
October	94%	19%	20%
November	94%	19%	20%
December	94%	16%	20%
January 2017	94%	17%	20%
February	95%	16%	20%
March	95%	16%	20%

National Inpatient Survey 2016

The results presented here are from the Inpatient Survey 2016, carried out by Picker Institute Europe on behalf of the Queen Victoria Hospital NHS Foundation Trust. This survey is part of a series of annual surveys required by the Care Quality Commission for all NHS Acute trusts in England. Between August 2016 and January 2017, a questionnaire was sent to 1,250 recent inpatients; 492 responses were received from patients at Queen Victoria Hospital.

The latest national NHS inpatient survey shows that Queen Victoria Hospital continues to achieve some of the best feedback from patients in the country.

The annual national survey of inpatients at all NHS hospital trusts in England covers all aspects of patients' care and treatment. This year's survey carried out by the Care Quality Commission (CQC) surveyed 77,850 people who received care at an NHS hospital in July 2016. The findings help the NHS to continually improve, enabling hospitals to see how they are doing year-on-year and how they compare with others.

Overall, QVH scored better than other trusts across all ten relevant sections of the survey.

QVH scored significantly better than other trusts for 49 of the 63 questions asked, and about the same as other trusts for the remaining 14 questions.

Areas where QVH scored particularly highly were:

- Feeling safe during their hospital stay
- Privacy, respect and dignity
- Whether they felt they were well looked after by hospital staff
- Whether staff did all they could to control pain
- Staff providing a quiet environment at night
- Being involved in decisions around care and treatment, and having confidence about decisions made by staff
- Whether there was enough information given to family or friends about how to help care for them if needed
- Advice and information about what would happen after discharge including having medicines explained to them in a way they could understand (if applicable)
- Whether there were enough nurses on duty
- Opportunities to feed back

The Trust will continue to seek and learn from patient experience feedback to improve our services.

<u>Key facts about the 492 inpatients who responded to the survey:</u>

- 74% of patients were on a waiting list/planned in advance and 23% came as an emergency or urgent case.
- 76% had an operation or procedure during their stay
- 47% were male; 53% were female
- 1% were aged under 20; 8% were aged 20-39; 34% were aged 40-59; 25% were aged 60-69 and 32% were aged 70+.

Patient Experience Group (PEG)

Every two months the multi-disciplinary members of PEG meet to discuss and triangulate patient experience, quality, complaints and national surveys to identify themes and areas of concern. This meeing is chaired by the Director of Nursing.

This group meets bi-monthly and is chaired by the Director of Nursing and Quality. The PEG meeting forms and integral part of the Trust's learning from our patients on their experience of being treated and cared for at the Trust from a wider range of sources including complaints, PALS enquires and inviting participation from patients in national and local surveys.

Nicolle Ferguson, Patient Experience Manager

The data sources and feedback are discussed and triangulated at the PEG meeting and actions assigned to leads to address concerns, understand more or respolve the problem causing the feedback. This provess enables the Trust ti quickly, and through evidence, identify hotspots.

The outputs from PEG are discussed at the Quality and Govenernace Committee, a sub-committee of the Board. Also feeding the work of PEG are any care reviews or reports from Healthwatch West Sussex.

Over the past year a lot of work has gone into improving our food as the following are just some of the actions that have come out of this work:

We aimed to improve our patients' experience of QVH food as measured by the NHS friends and family test surveys. There has been steady progress on this throughout the year. A detailed plan led by the head chef has improved the menu, the presentation of the food and the food temperature. A food task and finish group led by a matron and chaired by one of our governors has concluded. As a result of this the following are some of the actions that have come out of this work:

- New menus in place.
- Menus now displayed in a booklet with pictures of the dishes.
- The nursing staff are to ensure that the stainless steel lids remain on food at all times to ensure that the temperature of food is maintained.
- Pathways in covered walkway have been resurfaced.
- Senior chef has visited a neighbouring Trust to look at how they supply food, etc. Our aim was to increase the standard of patient and retail catering to the highest possible standard. Measure the catering, not just a snapshot but how can we look at benchmarking the process.
- It was agreed that salt and pepper sachets would be added to each patient's meal tray. This will allow patients to make their own choices whether to add this to their meal or not, increasing individual wishes, improving expectations of taste, etc.

The group have been involved with the following projects which are still ongoing:

- **Wayfinding report**; including recommendations, has been received; revenue cost pressure of c100k (including signage and installation) means its unaffordable to roll-out as a single action
- Will be adopting the principles within the strategy and address piecemeal as we complete refurbishments/backlog programme
- A number of areas have already been completed (e.g. the trauma clinic)
- Estimate that it will take c 2 years to complete; unless funding (revenue or charitable) was available. Plan to submit a charitable funds bid.
- **Car Parking**; The recently devised Travel Plan highlights a number of opportunities to alleviate car parking pressures on site. These range from short-term incremental gains to development of a multi-storey car park. The suggested costs for the latter are prohibitive; as such the trust will focus on more tactical opportunities e.g.:
    - Reviewing travel arrangements in line with sustainability objectives

- Re-prioritising patient and visitor parking on-site
- Securing alternative off-site provision for some staff parking
- Re-lining car-parks for incremental gains
- Identifying on-site areas for additional parking subject to the appropriate planning permissions

Complaints

In accordance with NHS Complaints Regulations (2009), this Annual Report provides detailed information about the nature and number of complaints Queen Victoria Hospital NHS Foundation Trust received, as well as feedback and concerns via the Patient Advice and Liaison Service (PALS). The Trust deals with complaints and concerns from patients and users, their relatives/carers, in accordance with its Complaints Policies and Procedures and the Care Quality Commission's (CQC) *Essential Standards of Quality and Safety.*

Definitions

The Trust uses the following definitions:

- complaints are expressions of displeasure or dissatisfaction where the complainant wishes a formal investigation to be undertaken;
- concerns are issues that are of interest or importance affecting the person raising them, including displeasure or dissatisfaction and where the complainant is content for the issue to be dealt with via the PALS route;
- feedback is information/suggestions about care or services that we provide, which may be complimentary or critical;
- Compliments are expressions of thanks and praise.

The distinction between a 'concern' and a 'complaint' is challenging. Both indicate a level of dissatisfaction and require a response. It is important that concerns and complaints are handled in accordance with the needs of the individual, and investigated with an appropriate level of scrutiny.

In order to ensure that complainants have access to appropriate support, as part of our complaints handling process, complainants are signposted to SEAP (Support Empower Advocate Promote) for help in making their complaint. All complainants are signposted to the Parliamentary and Health Service Ombudsman (PHSO) of the NHS complaints process in case they wish to take their complaint further.
The Trust has an integrated service – Complaints and PALS - to manage complaints, concerns and feedback in accordance with its Complaints Policy.

Complaints received

The time limit for making a complaint as laid down in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 is currently 12 months after the date on which the subject of the complaint occurred or the date on which the matter came to the attention of the complainant.

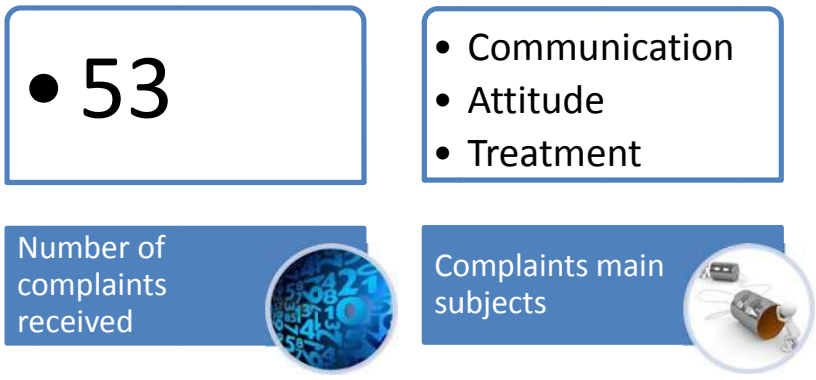
All complaints are acknowledged within 3 working days. The Trust also aims to respond to all complaints in an honest, open and timely manner.

The Trust aims to remedy complaints locally through investigation and meetings if appropriate. However, if the complainant remains dissatisfied they have the right to refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO) as the final step of the complaints system.

The NHS complaints procedure is the statutorily based mechanism for dealing with complaints about NHS care and treatment and all NHS organisations in England are required to operate the procedure.

At Queen Victoria Hospital we aim at all times to provide local resolution to complaints and take all complaints seriously. We listen carefully, we are open, honest and transparent in our responses and welcome the opportunity to do all we can to put things right. Our complaint system gives the opportunity for complainants to meet with managers/clinicians to discuss their concerns and we ensure that staff are made aware if concerns are raised about them and encourage them to look at ways they can change their practice or behaviors where appropriate.

Many complaints are resolved locally by front line staff that are empowered to resolve the client's concerns/issues to their satisfaction in a timely manner. The Trust actively encourages front line staff to deal with concerns as they arise so that they can be remedied promptly, taking into account the individual circumstances at the time. This timely intervention can prevent an escalation of the complaint.



During 2016/17 we received 53 formal complaints which are equal to the previous year. Under the NHS complaints regulations, the Trust is required to acknowledge receipt of complaints within 3 working days. Of the 53 complaints we investigated 50 complied with this requirement. The remaining 3 complaints were acknowledged as soon as possible, however, due to other complexities such as clarifying the address or gaining the necessary patient consent.

We take all negative feedback very seriously and our Chief Executive sees all complaints when they arrive and reviews all responses personally before they are sent. Complaints handling and any trends or themes identified from them are shared and discussed regularly by the Executive Team and the Board of Directors.

Investigation outcomes

The complaints investigator is required to conclude, on completion of the investigation, whether a complaint is upheld, upheld in part or not upheld. Establishing if a complaint is upheld/not upheld can be complex, as often there are a number of concerns/allegations within an individual complaint, some of which may prove to be unfounded whilst other elements are. Any complaint involving both aspects have been classed as upheld in part, hence the figure of 43.

In 2016/17, 48 formal complaints were closed. The complaints resolution process includes identifying and implementing appropriate actions. In response to complaints this year, actions have included:

- Complaints received during 2016/17 included the following themes:

Complaints received 2016/17 by subject of complaint	Total number of complaints received	complaints upheld	complaints upheld in part	Complaints unsupported
Access and waiting (waiting time in clinic)	3	1	2	0
Aids, appliances and equipment	1	1	0	0
Appointments delay/cancellation (outpatient)	5	5	0	0
Attitude of staff	10	1	8	1
Car parking	1	1		0
Communication/information to patients (written and oral)	8	3	5	0
Health records	2	2	0	0
Medication/prescribing	3	1	1	1
Surgery treatment/procedure	8	1	3	4
Treatment (medical)	7	2	1	4
Treatment (nursing)	5	3	2	0
Totals:	**53**	**21**	**22**	**10**

The twenty one complaints considered to be upheld included incidents related to service failure. This is categorised for example as: appointment cancellations and communications.

The twenty two upheld in part complaints were categorised as such because there were clear concerns about a patient's experience being poor. This included poor communication, certain aspects where care

could be improved and expectations not being met. The relevant Divisions addressed these issues at the time of the complaint and the complainant notified of the changes made in response to them raising a complaint.

The ten complaints that were unsupported, as the investigation concluded that care and treatment was timely and appropriate.

The assessment of the outcome of complaints as to status of upheld, not upheld or partially upheld continues to be developed.

There have been a number of complaints about **poor staff attitude**. These focused on what was perceived as unprofessional or insensitive behaviour by doctors, optometrists or reception staff. Although instances of this are low, and regardless of whether the behaviour was intended, this is not what we expect from our staff and we need to learn from such examples to improve matters for other patients in future

Another key theme for complaints is **communication and information;** patients, their relatives and carers need to be fully informed about their care and treatment. Effective communication is essential for delivering quality patient care and building good relationships based on compassion and shared respect. Clear, accurate, and timely communication is absolutely essential to maximizing performance, improving patient outcomes, and decreasing risk exposure.

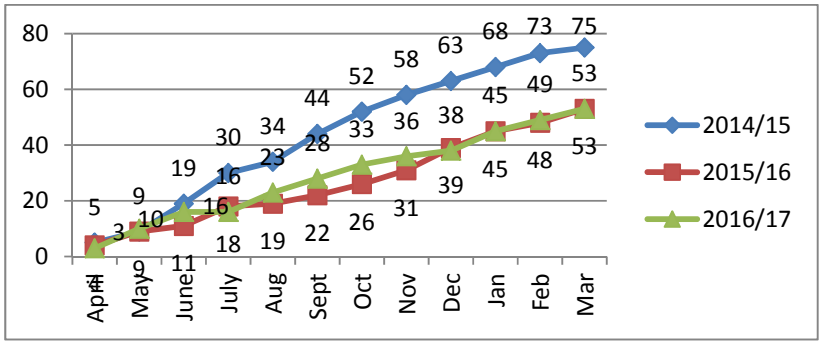
Refining communication skills and reinforcing communication protocols improves patient safety and patient satisfaction. There has been an increased focus on communication skills and effective sharing of information within customer care training at Trust induction and as part of on-going staff training, and this will continue.

Of the 53 complaints, the following charts displays the breakdown of the profession of the person(s) or key teams identified within the body of the original complaint. It is important to note that, upon investigation not all allegations were upheld.

Profession	Total number of complaints received	Total number of complaints upheld/upheld in part
Medical (including surgical)	25	20
Professions supplementary to medicine	2	1
Nursing	14	5
Scientific, Technical and Professional	1	0
Security	1	1

Trust Administrative staff / members	10	9
TOTAL	**53**	**33**

At total of 53 complaints were received and investigated by the Trust during 16/17 which is the same as 15/16, compared to 75 in 14/15. The following accumulative chart shows how complaints activity to date compares with activity during the two previous financial years.



The Trust values the opportunity that each complaint brings to learn and improve and recognises the importance of sharing the learning from complaints across the organisation for the benefit of our patients and staff. We continue to strive to demonstrate the changes that have made as a result of the learning from complaints and to sustain the changes for long term improvement.

- A patient raised concerns about the poor communication by the on-call team when they telephoned the hospital for clinical advice. It has been reiterated to the ward and the on-call teams that our duty of care towards our patients extends 24 hours a day. If a patient has a medical concern we should see them at any time and furthermore if a junior doctor has a query they should contact the on-call consultant or the patients named consultant. **Action completed.**
- Reiterated to staff in various clinical areas that they must effectively communicate with patients at all times. **Action completed.**
- Training to staff in Corneo Plastics about dealing with patients with Dementia. **Action completed.**

Parliamentary and Health Service Ombudsman (PHSO)

During 2016/17 two complainants referred their complaint to the Ombudsman following the Trust's investigation, which is the same number as 2015/16 and one in 2014/15.

It is important to note that the complaints being reviewed by the PHSO were not all from 2016/17 (one complaint was originally investigated by the Trust in 2012. The decision made by the PHSO, for both cases, were that no further actions were required or recommendations made.

Nicolle Ferguson, Patient Experience Manager

Further analysis of formal complaints

- None of the fifty three patients approached advocacy services to support them through the complaints process.

- The Trust received no requests for a complaint response in large print or brail.

- As in previous years, all formal complaints were received in the English language with no requests made by a complainant (or enquirer) for the assistance of the Trust's Interpreting Service.

- The Trust received no formal complaints where people stated that they had a learning disability nor did this become evident during any of the investigations.
- Of the 53 complaints, 1 complainant took the option of meeting with a senior member of staff on completion of the investigation. Following this meeting, a full summary of the investigation and meeting was provided for the complainant.

- No external reviews of care were commissioned as part of the Trust investigation during 2016/2017.

- In line with Duty of Candour (November 2014) the trust investigation responses have been scrutinised to ensure they are open and transparent. Where it has been established that errors occurred this was shared with the complainants and an apology given and lessons identified to enhance learning for the Trust.

Learning from complaints, concerns and feedback

The Trust seeks to make changes following incidents, complaints and concerns to improve the care and services received by patients, users and their representatives.

As soon as a complaint is received, it is the responsibility of the Patient Experience Manager to immediately consider whether the complaint should be escalated (for example to the Director of Nursing, Medical Director) to establish whether any immediate and/or remedial action(s) should be taken, prior to the investigation, in the interest of safeguarding safety, equality and quality.

Work continues to ensure that the Trust complies with equality and diversity principles. It is noticeable that the received complaints have not verged on an unfair/discriminatory act pertinent to these individual characteristics. Where the complaint warrants further investigation pertaining to an individual characteristic then this would be forwarded back to the Lead for Equality and Diversity for scrutiny and assessed for the nine individual protected characteristics.

Where nursing issues are raised within the complaint, a copy of the complaint is sent to the Heads of Nursing for learning and training purposes.

Monthly patient experience reports are produced and shared with the managers, heads of service, matrons/ward managers and clinical directors to review within the individual governance meetings to ensure service improvements and learning takes place.

Comparative complaint figures (specialist hospitals)

It is important to note that each organisation will verify in its classification (interpretation) of what is deemed a formal complaint and what is a concern, whilst working within the Complaints Regulations.

Number of complaints by hospital and year	2014/15	2015/16	2016/17
Queen Victoria Hospital	74	53	53
Royal National Orthopaedic Hospital	92	88	121
Moorfields Eye Hospital	174	197	203

Patient Advice and Liaison Service (PALS)

This section of the annual report concentrates on the nature and number of PALS contacts and issues raised within those contacts during 2016/17. PALS remain an invaluable source of help/guidance to people using services and for the Trust to understand the experiences of our patients.

During 2016/17 a total of 62 PALS enquiries were received. 35 of these enquiries were initial complaints, however none of these needed to be referred to the formal complaints procedure at the time of contact.

In addition we also deal with information, advice and support requests. Many service users will contact PALS for reasons other than complaints. This may be about:

- Care and treatment
- Services which the trust provides
- Signposting to other services
- Outpatient clinic appointments (patients may occasionally ask PALS to attend with them)
- Assisting families who arrive in East Grinstead with a patient but do not live locally and require local orientation and signposting, to further help about local finding somewhere to stay e.g. local hotels

Examples of typical enquiries about advice and information include:

- What is the waiting time for a procedure?
- How do I get a copy of my health records?
- Who can I contact to discuss my concern?
- My transport hasn't arrived and I'm going to miss my appointment. Who do I contact?

- I was an inpatient last week and lost my glasses. What do I need to do?

Work continues on more effective advertising and visibility of PALS within the hospital, promoting an open and engaging culture which may help in more timely and appropriate resolution of concerns and issues at the point at which they occur.

The PALS telephone contact line is operated during working hours Monday to Friday. A voice mail service is available during 'out of hours' and calls are returned on the next working day. During 'out of hours' the Site Practitioner is the contact for patients/relatives who have urgent issues which require action.

PALS is an invaluable service for enabling patient involvement and engagement, providing a rich source of effective feedback about the patient experience.

Website feedback

During the year, the Trust has been responding to feedback posted onto social media websites. This is an important source of feedback for us with 60 comments regarding the Trust being posted over the past 12 months on the two main patient feedback websites, NHS Choices and Care Opinion.

As some of the comments are anonymous, it is not always possible to identify which service or staff members the person is referring to. Every effort is made to respond and contact details of our Patient Experience Manager is posted to encourage the writer to contact us directly so that we can address their concerns.

All comments are viewed by all staff via the Trust's intranet website and passed to relevant staff across the Trust for action.

Future developments 2016/17

The Trust and its Patient Experience Manager aim to increase confidence of our patients by having a flexible approach to resolving concerns. There is extensive work with staff on the wards and in departments to help prevent complaints by listening to and responding when things can be put right. When further support is needed, the Trust aims to ensure that the complaints process is signposted locally so that patients know how or where to complain.

Improving access to information for patients on a range of patient experience initiatives, including complaints is a key focus for the Trust. The predominant method for making a complaint remains letter or email but by signposting other options such as the Trust's website, social media and patient opinion websites we ensure patients are given a choice. Where contact is initially made in person or by telephone, staff support the complainant in registering their concerns formally with the Trust.

In order to improve the services provided to patients further, additional developments will be implemented.

- We will continue to work alongside Trust teams to improve the patient and carers experience. As such we believe further developments during 2017/18 will promote this.
- The production of a newsletter or bulletin to share learning on actions which have worked well and spread good practice in improving patient experience across the Trust.
- Look at a robust system to triangulate complaints, claims and Serious Incidents/Safeguarding to best effect.
- Further improving complaints management process and complaint resolution skills to help improve the quality and timeliness of complaint responses.
- The Patient Experience Manager will continue to work with each of the directorates and teams to ensure a fully collaborative approach is provided regarding improving the patient and carers experience.

Nicolle Ferguson, Patient Experience Manager

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/09/17**	**Agenda reference:**	**144-17**		
Report title:	**Infection prevention and control annual report 2016/17**				
Sponsor:	Jo Thomas, Director of Nursing and Quality, DIPC				
Author:	Sheila Loveridge, Lead infection control nurse, Deputy DIPC				
Appendices:	Appendices A-C included in the report				
Executive summary					
Purpose:	The infection prevention and control annual report provides the Board with the overarching assurance that there is systematic leadership for the effective management of infection prevention and control arrangements in place for all patients, staff and visitors. The Board 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) and 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 received regular updates on infection, prevention and control related matters via the Quality and governance committee. Reducing Healthcare Associated Infection (HCAI) remains a top priority for the Trust. The Infection Control Annual Report demonstrates the Trust's excellent record in respect of Healthcare Associated Infection and details the work undertaken in respect of audit and surveillance during 2016/17, along with a range of other initiatives.				
Recommendation:	The Board is requested to review and **APPROVE** the annual report.				
Purpose	Approval **Y**	Information **Y**	Discussion **Y**	Assurance **Y**	Review **Y**
Link to key strategic objectives (KSOs):	KSO1 **Y**	KSO2: **Y**	KSO3 **Y**	KSO4: **Y**	KSO5: **Y**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	The BAF has been reviewed and no amendments are required following completion of this report				
Corporate risk register:	The CRR has been reviewed and no amendments are required following completion of this report				
Regulation:	Compliance with regulated activities in Health and Social Care Act 2008 and the CQC's Fundamental Standard.				
Legal:	As above				
Resources:	No changes				
Assurance route					
Previously considered by:	Infection Prevention and Control Group				
	Date:	09/08/17	Decision:	Reviewed and submitted to Q&GC	
Previously considered by:	Quality and governance committee				
	Date:	11/08/17	Decision:	Reviewed and subject to minor amendment for recommended for approval at Board	
Next steps:	NA				

Queen Victoria Hospital NHS Foundation Trust (QVH) Infection Prevention and Control Annual Report 2016 - 2017

Document Control; Infection prevention and control group 09/08/17, Quality and Governance Committee 11/08/17
Executive sponsor: Director of Nursing and Quality, Director of Infection Prevention and Control
Author: Lead Infection Control Nurse/Deputy DIPC
Date: June 2017
Type: Annual Report
Version: Final
Pages: 30
Status: Public. Written and prepared for the Trust Board
Circulation: QVH Trust Board

Content:

1. Purpose of Report

1.1 The Board as the overarching leadership mechanism for QVH need to assure themselves that the organisation has effective 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 Group (ICG) reports to the Quality & Governance Committee (a subcommittee of the Board of Directors) providing analysis and outcome information for assurance.

The Board of Directors has received 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. Root cause analyses are undertaken on any reportable infections or clusters of microorganism colonisation to identify any gaps in good practice and any lessons learnt are shared across the trust. Policy breaches such as the wearing of theatre masks or caps inappropriately are immediately challenged by IPACT and other members of staff are encouraged to also provide challenge where needed.

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. This role is incorporated into the Director of Nursing and Quality portfolio.

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 NHSI
- 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 report which is provided so the Board can be assured that the Trust is undertaking its duties and responsibilities, and delivering its statutory 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 data is transparent and clear so that they can confirm they are assured that the services provided are safe and clean. The report contains audit and surveillance results for information.

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 Group (IPG).

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 2016/17 utilises 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 hospital acquired infections (HAIs). This is achieved through implementation of antimicrobial stewardship, surveillance, screening, audit, production and maintenance of policies, isolation and outbreak management, promotion

of hand hygiene and patient and staff education including staff induction and mandatory updates.

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 structural 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 structure chart.) The QVH 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 group meets quarterly and provides a report to the Quality and Governance Committee. The committee also receives a quarterly infection control report on each of the key elements of infection control management.

The IPACT comprises of;

- Director of Nursing and Quality, Executive Board Lead for Infection Prevention and Control (DIPC)
- Lead infection control nurse specialist/Deputy DIPC
- 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 Trust was successful in recruiting a part time Lead Infection Control Nurse Specialist/Deputy DIPC in November 2016 on a rolling six month contract.

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 supporting IPACT and the consultant microbiologist.
- Estates project meetings
- Learning & Development Group
- Medicines Management Optimisation Governance Group (MMOGG)
- Patient Led Assessment of the Care Environment (PLACE)
- Patient Information Group
- Product Selection Group
- Pathology Meeting

IPACT work closely with all clinical teams, Estates and Facilities and Hotel Services. This is to ensure that infection prevention and control is considered at the beginning of every new project and development as well as any refurbishments.

Across QVH infection prevention and control link staff from all services attend 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 group meets quarterly, or more frequently if required. During 2016/2017 the group have approved new documentation aimed at improving clinical practice, examined root cause analyses for reportable organisms, and approved updated guidance.

Reporting arrangements
The ICG provides regular reports to the Quality & Governance Committee through the DIPC.

In addition, the DIPC also provides updates to the Hospital management Team, Executive Management Team and to the Trust Board. Antimicrobial issues are reported to the Medicines Management Optimisation Governance Group and copied to the ICG for information.

3.4 Infection Prevention and Control clinical activity

The infection prevention and control nurse checks all clinical samples taken to identify and positive specimens (colonisation and infection). Every positive specimen taken from a patient on the microbiology returns from BSUH is scrutinised for clinical relevance. This has to be carried out manually due to the IT infrastructure at BSUH which is unable to separate clinically relevant specimens for QVH from non relevant ones. Though labour intensive this scrutiny allows IPACT to have sight of every specimen taken from QVH. 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:

- Nursing Quality Forum
- Clinical Audit
- Professional Networks
- Estates and Facilities meetings
- Health and Safety Group
- Learning & Development Group
- Medicines Management Optimisation Governance Group (MMOGG)
- Patient Led Assessment of the Care Environment (PLACE)
- Patient Information Group
- Product Selection Group
- Quality & Governance Committee
- Pathology meeting
- Hotel Services meetings

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 in their clinical areas 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 infection control nurse has not been able to attend the Sussex Infection Prevention and Control Representatives Meetings this financial year due to capacity issues.

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 infection (CDI)
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 *CDI*, 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, Microbial Pharmacist and Clinician.
- IPACT report the figures as previously outlined
- An action plan will be devised and updated monthly until all outstanding actions are completed.

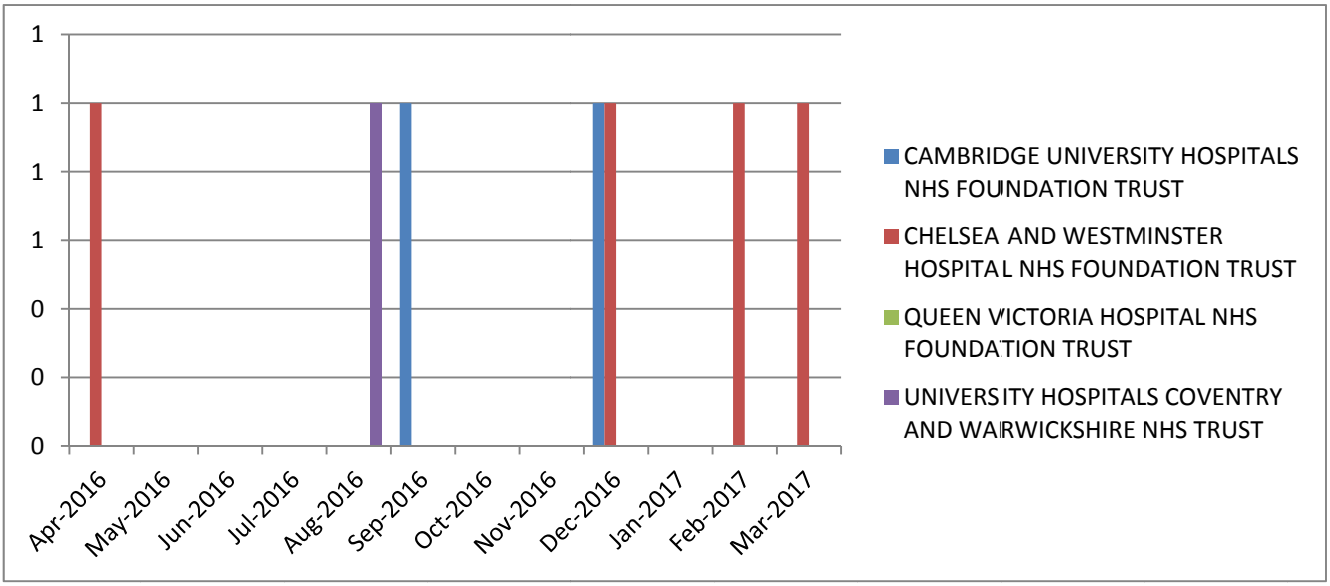
4.2 MRSA Bacteraemia

QVH have a limit of zero cases of avoidable MRSA bacteraemia every year – the trust achieved this target in 2016/17 with zero cases.

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
Apr 2016 – Mar 2017	0	0

To date there has not been a revision of this target for 2017/18.

Trust acquired MRSA bacteraemia benchmark



Source validated PHE DCS HCAI data April 2017

4.3 Clostridium difficile infection (CDI)

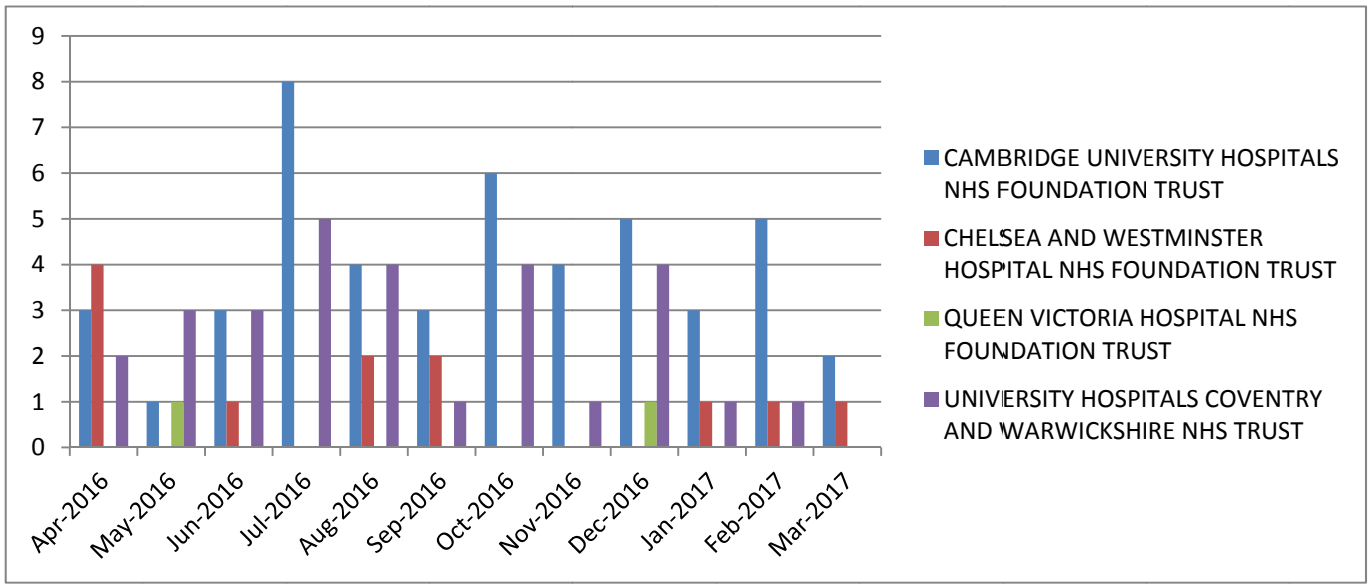
In 2014/15 NHS England introduced a change in the methodology for calculating organisational CDI objectives and encouraged commissioners to consider sanctions for breach of CDI objectives only where those CDIs were associated with lapses in care. The CDI lapse in care objective target for QVH was set at zero. The Trust had two cases in 2016/2017 against a limit of zero. Both were trust acquired cases, one in January 2016 and the other in December 2016.Both were considered lapses in care due to antibiotic and nursing documentation. The second case had received antibiotics in the community however as a specimen was taken after 72 hours it was deemed as Trust acquired.

Period	No. of cases of CDI
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
Apr 2016 – Mar 2017	2

As the CDI lapse in care objective target for the Trust remains at zero for 2016/2017, the possibility of continuing to breach 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.

Trust acquired CDI benchmark



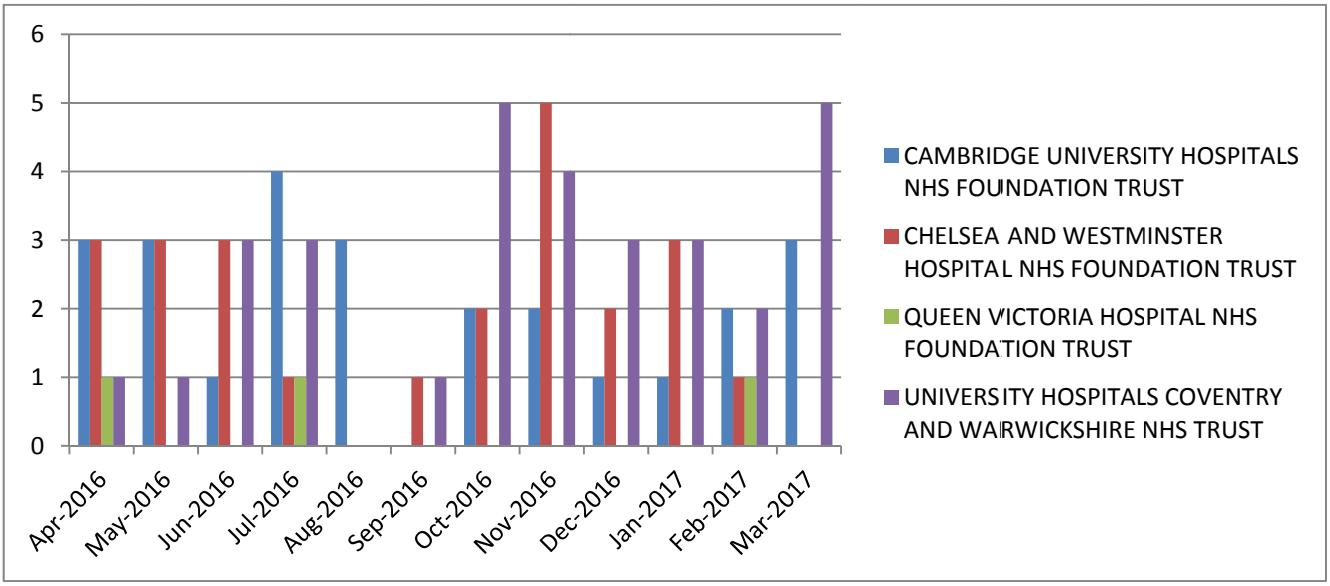
Source validated PHE DCS HCAI data April 2017

4.4 MSSA bacteraemia

No target has been set for MSSA bacteraemia to date. 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
Apr 2016 – Mar 2017	3

Trust acquired MSSA bacteraemia benchmark

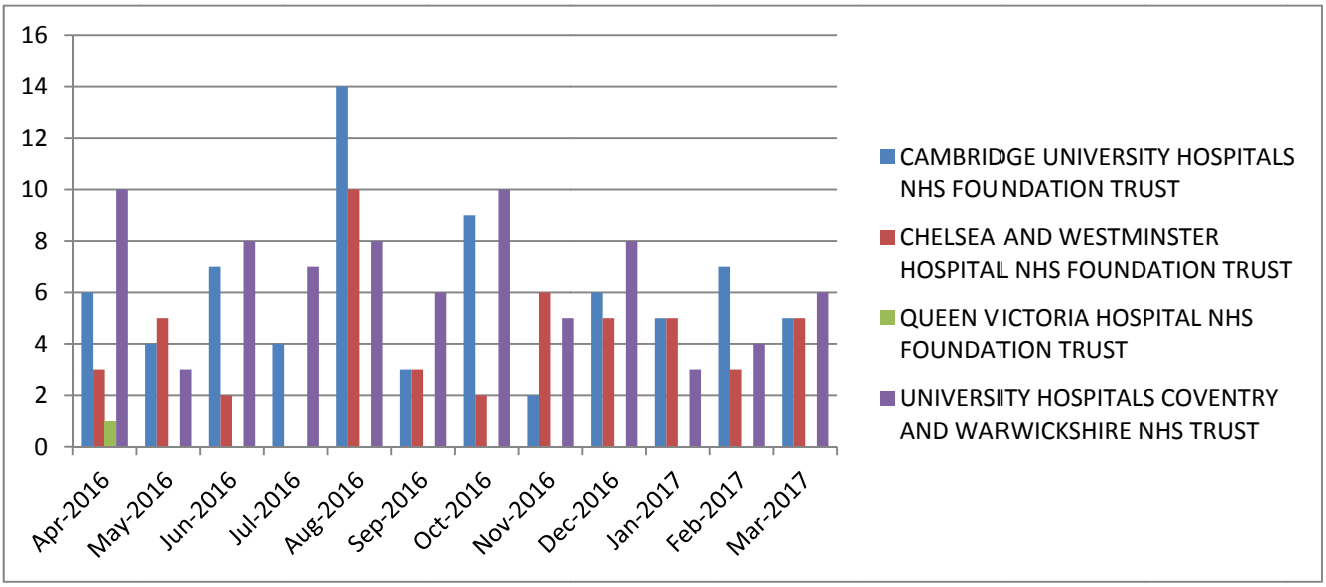


Source validated PHE DCS HCAI data April 2017

4.5 E. Coli bacteraemia

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

Trust acquired E.coli bacteraemia benchmark



Source validated PHE DCS HCAI data April 2017

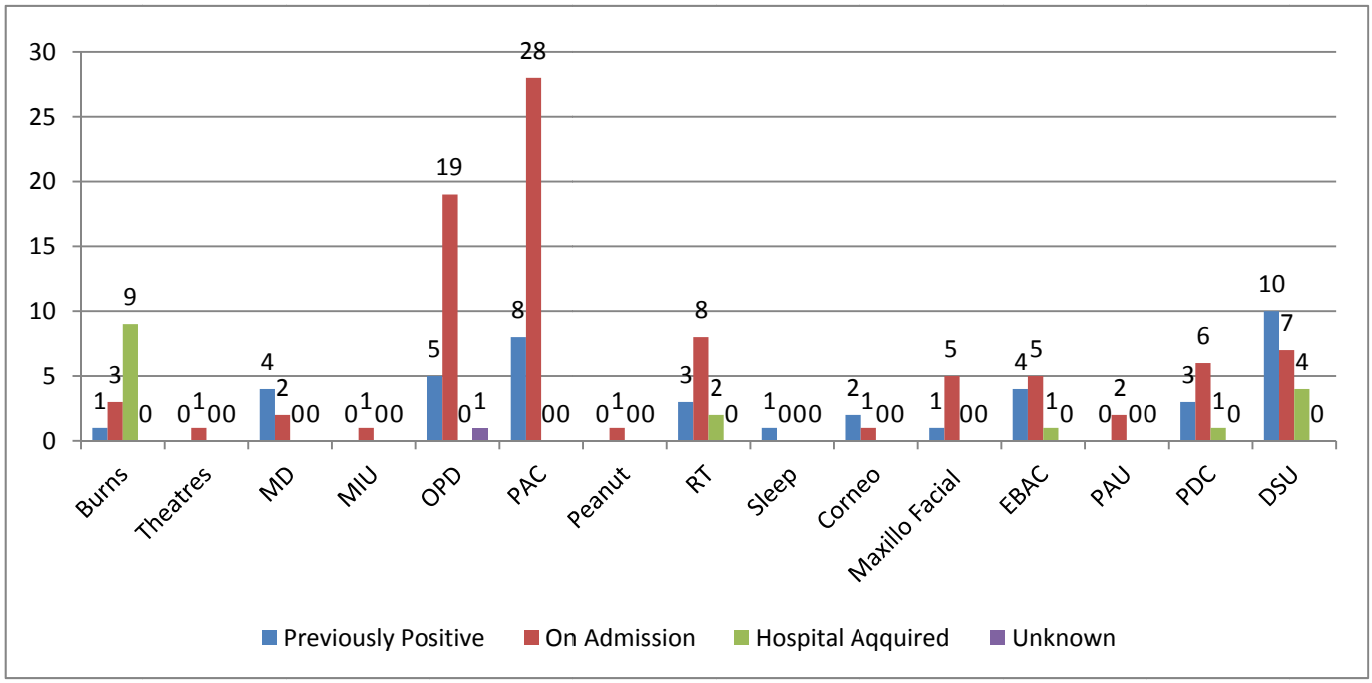
4.6 Glycopeptide resistant enterococci bacteraemia (GRE)

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
Apr 2016 – Mar 2017	0

4.7 MRSA positive patients April 2016 to March 2017 (Infected and colonised)

There were a total of 149 patients who were identified as having an MRSA infection or colonisation.



5 External regulation and inspection by Care Quality Commission (CQC), NHSI and commissioners

The CQC did not conduct any inspections in between April 2016 to March 2017. 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 Quality and Governance Committee, Clinical

Governance Group and other quality groups.

The Trust Board

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 walkabouts to clinical and non-clinical areas to confirm that standards of care and cleanliness remain high.

Compliance in Practice Assessments

These assessments examine practices such as hand hygiene to assess the level of compliance. The results are collated and fed back to the relevant clinical area as well as the Quality and Governance Committee

	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Combined
C	mpulsory	Infection Prevention/Uniform								
21	Are hand hygiene posters displayed throughout the department?	92%	100%	100%	100%	73%	100%			941%
22	Are staff bare below the elbow (one plain wedding ring only)?	95%	100%	95%	100%	100%	100%			983%
23	Are staff washing/gelling their hands at the right moments? (WHO 5 moments - before patient contact, before aseptic, after body fluid experience, after patient contact, after contact with patient	83%	96%	100%	100%	100%	95%			959%
24	Are staff wearing the correct personal protective equipment when caring for patients?	100%	100%	100%						100.0%
24	Have you received appropriate training on MRSA screening and how to manage MRSA positive patients?				97%	94%	100%			970%
25	Did you observe staff disposing of waste correctly?	100%	100%	97%						989%
25	Are the cleaning and water flushing logs up to date?				82%	73%	88%			810%
26	Are the sharps boxes assembled correctly e.g. label filled in, temporary closure mechanism being used?	71%	43%	30%	48%	50%	52%			439%
27	Does the area appear clean on high and low surfaces?	100%	100%	100%	100%	100%	100%			100.0%
28	Have you observed staff cleaning equipment after each patient use and labelling it with the `I am clean stickers`?	100%	75%	90%						883%
28	Are the green 'I am clean stickers' being used for equipment that has been cleaned?				83%	100%	100%			963%
29	Does the staff member have a clear, legible and up to date ID. badge?	98%	93%	98%	93%	98%	90%			952%
29	Do hand gel dispensers contain gel?	100%	95%	98%	93%	95%	98%			965%
30	Are staff free of jewellery except for one plan wedding ring and one small pair of stud earrings?	97%	95%	98%						967%
		93.3%	90.8%	90.9%	91.9%	91.0%	90.5%			914%

Assurance Framework

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

Key Performance Indicators (KPIs)

The ICNS monitors the KPIs on a monthly basis including targets, training of the IPACT, policies, budget and audits.

Complaints

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

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 2016-2017 was once more "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 clinical, non-clinical and consultant 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 additional training session that have been identified as required through the RCA process following reportable infections.

The Hand Hygiene road show was conducted this year as part of the Annual Infection Control awareness week. This was held in December 2016 as an interactive training week for staff. Displays were set up to showing correct procedure for cleaning a patient area, correct technique for MRSA screening of patients use of the UV light box to show correct hand hygiene techniques and FIT testing for staff as part of the flu preparedness campaign

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 2016 to March 2017. 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

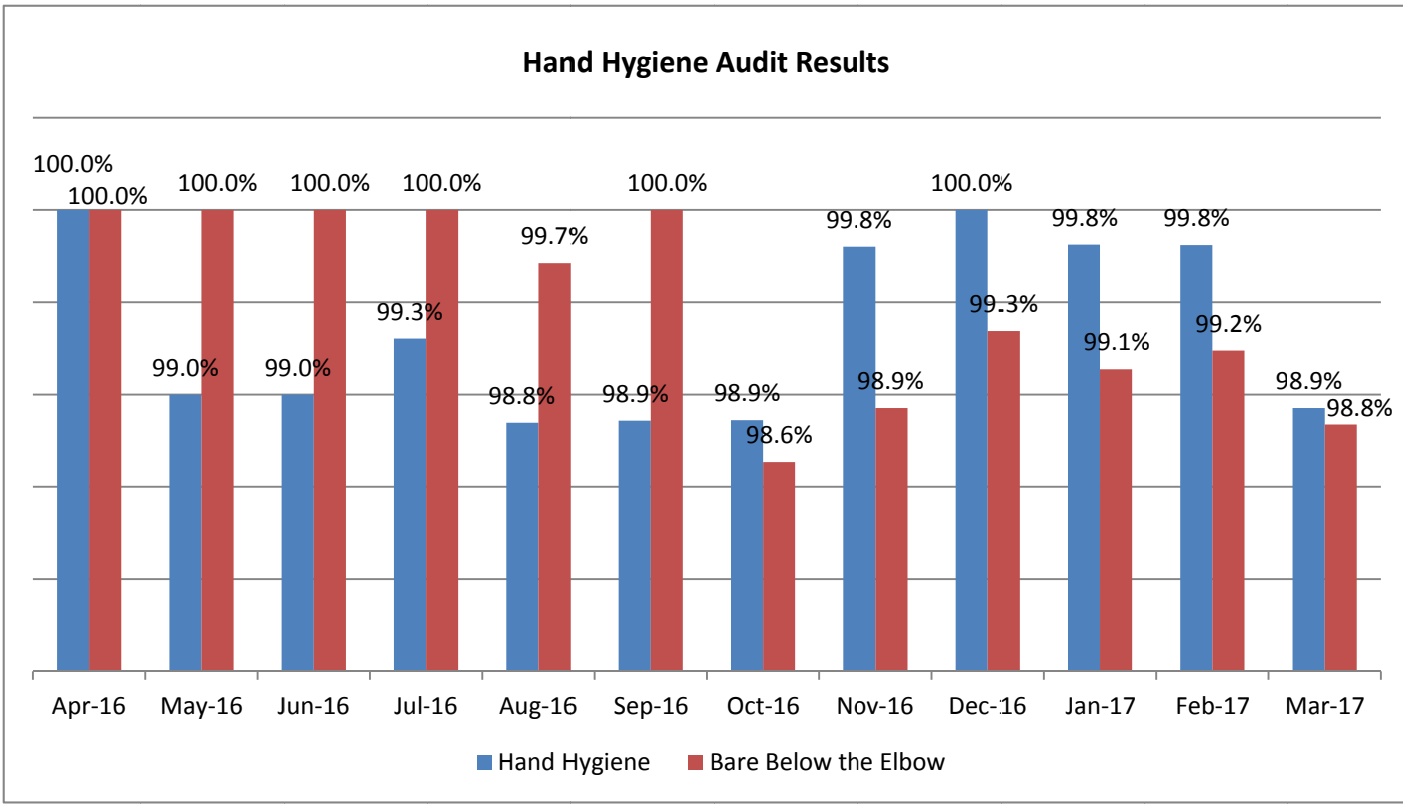
twice a year)
3. Renal dialysis (speciality not applicable to QVH)
4. Prevention of surgical site infection (audit incorporated into the Trust's National Patient Safety Agency Checklist annual audit)
5. Ventilated patients
6. Urinary catheters
7. Reduction of risk from C. difficile. (All cases of C. 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 and reported to the individual department leads on a monthly basis

Surgical Site Infection (SSI) Audit

Due to staffing capacity no SSI audits were carried out during the period April 2016 to March 2017. Any infection results are closely monitored as a daily task.

Hand Hygiene Audits



Aseptic Technique

This is an annual audit conducted in April 2016.

25 observational audits were completed. On analysis 96% were compliant having all 'yes' or 'N/A' answers which is a large improvement on previous year's results, showing a general increase in good practice.

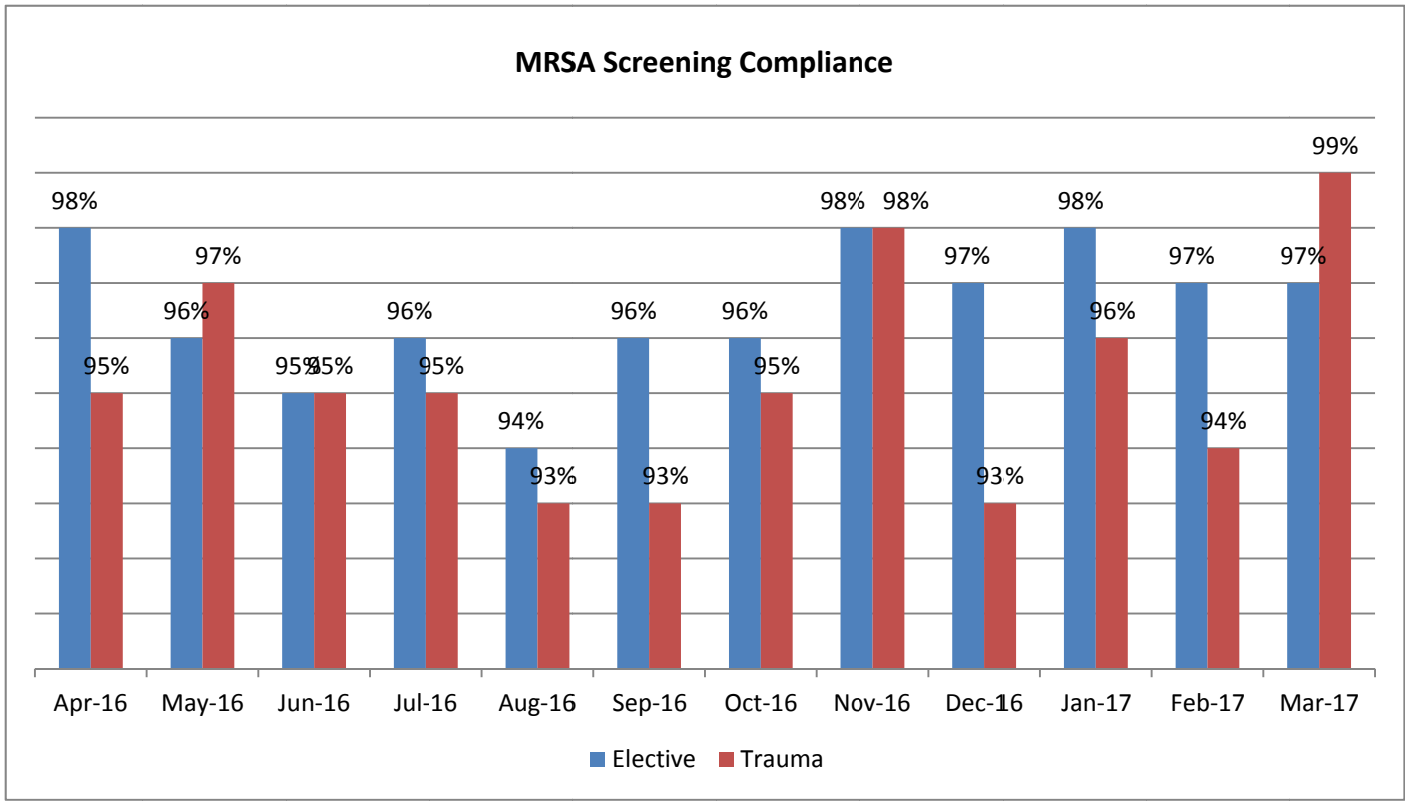
However when the data is looked at more closely, 3 of the areas with "not applicable" answers are of concern. These are:

- "Decontaminate hands with alcohol handrub"
- "Clean hands with alcohol handrub"
- "Put on sterile gloves and carry out procedure"

Staff must decontaminate their hands at all applicable stages of the aseptic technique. Sterile gloves must always be worn during an aseptic technique. Results were fed back to department leads for action regarding any confusion regarding these three topics.

Isolation Room Audit
The audit demonstrates that the Trust is allocating its isolation rooms appropriately as all patients deemed to be an infection risk have been nursed in isolation.
The trauma sheets for that day were reviewed and all patients that were being nursed in the bays were low risk and therefore nursed appropriately.
For those in isolation who were not an infection control risk it was also an appropriate allocation of facilities as it related to a privacy and dignity issue.
At all times the IPACT are monitoring and ensuring, with the cooperation of the ward staff, that all patients deemed to be high risk are isolated as per Trust policy and where this is not possible risk assessments are completed with the advice of the consultant microbiologist to minimise any risk to both the patients and staff.

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.



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. All confirmed positive patients for one month were audited. This included a total of 11 patients of which 6 were planned admissions and 5 were emergency admissions. The audit showed all patients were screened for MRSA in line with Trust policy however the results show that improvement is still required around documentation and including microbiology results in the patient's notes.

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 43 patients admitted to the hospital. Of these 5 were identified as being high risk. Out of these 4 were screened as per policy, this equals 80% compliance.

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.

Environmental Audits
Environmental audits continue to be covered by the PLACE inspections. 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 and an ongoing need for general repair and redecorating of the hospital structure
- General cleaning

Sharps Box Audit
Fourteen wards/departments were visited during the audit and ninety one sharps containers were sighted. The sharps containers were mainly from Daniels although there were also Frontier types seen. These were either old stock or the ward/department had been sent the wrong type. The audit found one sharps containers with protruding sharps (these were not necessarily overfilled but had long objects protruding from them), nine that were not properly assembled, (these were immediately assembled properly and staff were informed that sharps containers which were not assembled properly could lead to the lids coming off if dropped or during transportation) and zero that were more than three quarters full, (staff were advised to only fill to the line).Two sharps containers had the wrong lid on the wrong base. Staff were advised to check the colour of the lid and label. Zero sharps containers were sited on the floor or at an unsuitable height or place. Many areas required wall or trolley brackets and this was discussed with the staff who thought it was a good idea. Four containers were sighted with the label not endorsed. All staff understood that the label on the sharps bin was to be completed at assembly and closure and this was adhered to. Two sharps containers had significant inappropriate non sharp contents. Staff were advised not to put packaging or non-sharp items in sharps containers. Two sharps containers did not have the temporary closure in place when the container was left unattended or during movement. Small sharps containers and trays were available to take to the bedside.

Patient bedside equipment
During the audit some equipment was not able to be viewed due to patient activity. In these areas the nurse in charge was asked to check the equipment and report any concerns to the IPACT.
In the Burns unit the patient's bedside lockers were looking worn through repeated cleaning. The edging strips had come off leaving exposed wood. All the lockers in this unit will need to be condemned and replaced as soon as possible, all other equipment sighted in the ward was clean and intact.
In Peanut ward all patients' bedside equipment was, clean and intact.
Sleep Studies has domestic bedside tables as well as standard hospital lockers. These domestic lockers are clean and intact and have been cleared for use by the Infection Prevention and Control Team. Sleep Studies are to replace the bedside tables with hospital approved ones when they need replacing. All other patient's bedside equipment was clean and intact. None of the beside equipment is labelled in Sleep Studies as it was decided by the Infection Prevention and Control Team that this area was such a low risk area for outbreaks there is no need to label the equipment.
In Ross Tilley and Margaret Duncombe. All the equipment sighted was intact however some of the tables and chairs were missing the number labels. Also the patient's bedside chairs were very faded and worn, and whilst they are intact they do not look good. Ideally these will need to be replaced.

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). This has been mitigated by the placement of portable sinks in the Burns Unit and alcohol gel in the other areas. 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.

8 Infection prevention and control policies, procedures and guidance for QVH staff and patients

IPACT 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, and CDI. All these leaflets are available for the public and have been updated and approved by the patient information group.

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

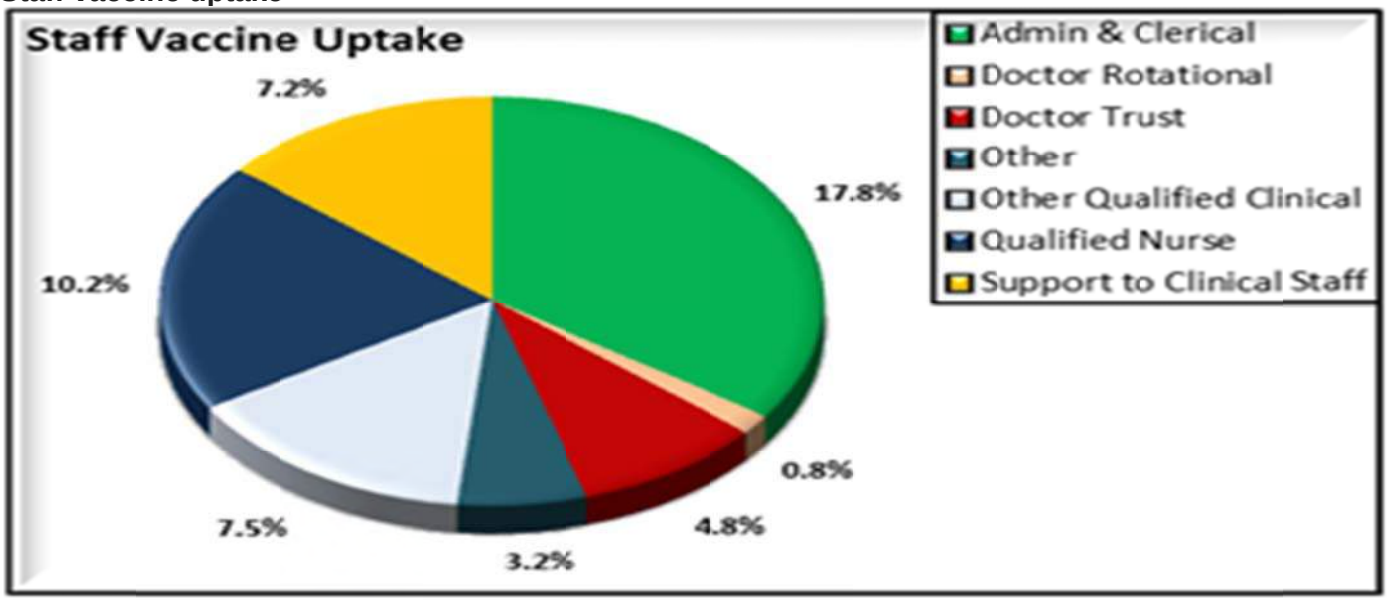
During 2016/17 support has again been given to the management of flu, with IPACT encouraging vaccination of staff within the annual flu vaccination programme. To support in the management of patients, IPACT continued to provide assistance in the form of checklists/documentation which is saved on the Trust intranet, provide advice on the management of patients and general support to the processes of caring for affected patients. The Emergency Planning Lead and the infection control nurse specialist continue 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.

The results for staff uptake are shown below.

Staff Group	Cumulative Uptake Total	% of Staff Base	Cumulative Declined Total	% of Staff Base
Admin & Clerical	176	17.8%	86	8.7%
Doctor Rotational	8	0.8%	13	1.3%
Doctor Trust	47	4.8%	25	2.5%
Other	32	3.2%	10	1.0%
Other Qualified Clinical	74	7.5%	62	6.3%
Qualified Nurse	101	10.2%	85	8.6%
Support to Clinical Staff	71	7.2%	46	4.7%
TOTAL	509	51.5%	327	33.1%
Staff Base	988			
Staff Base minus 'declined'	661			

ImmForm Data Submission			% of staff group headcount
All Doctors	149	55	36.9% 5.6%
Qualified nurses	215	101	47.0% 10.2%
All other professional qualified	141	74	52.5% 7.5%
Support to clinical staff	483	279	57.8% 28.2%
ImmForm	988	509	51.5%
CCG	988	836	84.6%

Staff vaccine uptake



10 Untoward Incidents including Outbreaks

April 2016 to June 2017

- Main theatres were required to shut down for one weekend in order to allow estates action to be undertaken to resolve the continuing positive Legionella results from all sampled outlets. Water sampling completed 10 days post work and results returned negative
- Inaccurate or missing results from the daily laboratory sheet provided by BSUH (e.g., MRSA positive results). BSUH are not able to provide a more user friendly electronic format.
- Results provided from the Winpath system appear to be name sensitive and results requested by NHS number or hospital number alone may not identify results. In addition not all results on ICE when on Winpath. Added to risk register.
- Basic osteotomy set used during surgery that was then discovered to be missing the bottom filters. Patient informed of the incident. Results show that the set was sterilised and the risk of infection to the patient is minimal.
- Air handling unit in Theatre 10 stopped working however no alert was sounded and the operating list continued. Once noted the theatre was closed and repair work carried out by the estates team. Patients involved monitored and no adverse effects noticed.

- *E.coli* bacteraemia confirmed in plastic surgery patient, April 2016. RCA completed and concluded that it was an unavoidable infection due to a chest infection related to exacerbation of COPD post-operatively.
- *CDI infection* confirmed in a plastic surgery patient, May 2016. 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, documentation and prescribing. .
- MSSA bacteraemia confirmed positive in a plastic surgery patient, April 2016. RCA completed. Patient medically unwell and transferred to ITU at the Princess Royal hospital.
- *CDI* positive result received for a patient in the community by a GP in Kent; however patient had recently been discharged from the Trust. RCA completed which showed patient was a surgical patient who was admitted to the ward for social reasons. Antibiotics given during the admission and then as a TTO. On reflection there was no evidence documented to support the need for these antibiotics and the patients *CDI* infection was probably antibiotic associated and could have been avoided.
- Two hospital acquired MRSA colonisations confirmed in burns patients in May and June. Patients had MRSA screening sent from their nose and groin on admission and at regular intervals during their stay however no wound swabs sent until later. Patients then confirmed positive in their wounds.
- MDR *pseudomonas* detected in a surgical patient's wound. Patient had a long term, slow healing peri- anal abscess and was admitted for surgical debridement and application of negative pressure dressings. Patient isolated and strict Infection control precautions implemented.
- Panton Valentine Leukocidin *Staphylococcus aureus* (PVL-SA) identified in a plastic surgery patient. Patient known to be MRSA positive and was admitted with strict infection control precautions in place.

July 2016 to September 2016

- MSSA bacteraemia confirmed positive in a plastic surgery patient, April 2016. Probable source of infection was patient's chest infection.
- Hospital acquired MRSA colonisation confirmed in a plastic surgery patient. Patient was screened for MRSA at Pre assessment clinic a month before admission which returned MRSA negative. Patient then admitted for surgery and remained an inpatient for 2 days; no screens were required to be sent at this time. Patient then had wound swabs sent during an outpatient appointment 8 days after discharge which returned MRSA positive. Declared as Hospital acquired as previous swabs were negative however the patient was in the community with a surgical wound and it is possible the infection was contracted in the community.
- An outbreak was declared on the Burns unit as seven patients were reported as having hospital acquired MRSA colonisation from the end of June 2016 to mid-July 2016. The main Burns ward was closed to new admissions to allow the unit to be double deep cleaned. The ITU remained opened to admission during this period all though strict guidance was put in place which included staff not working in both ITU and on the ward. All ITU patients were screened for MRSA on admission, weekly and then on transfer out. No positive MRSA results were received from an ITU patient. The Burns outpatient clinic was moved to the decant ward, Rycroft, to allow the department to be deep cleaned. Strict infection control precautions were implemented for all staff working in Burns unit in relation to showering and changing of scrubs. RCA's were written for each patient involved and where possible the MRSA positive samples were sent for typing. Long term recommendation made for improving the layout and function of areas within the unit were made. Outbreak report and timeline written and learning needs identified. Typing showed more than one strain of MRSA however three patients shared the same strain so cross infection could not be excluded.
- An extractor fan in theatre 9 was found to have become non-functioning. The fan was checked in the morning by the estates team and was working normally but when it was checked again at 16:30 it had broken down. There was no way to know when it stopped between the two checks. Four patients were operated on during the time period that may not have had fully functioning air extraction putting them at a very slight increased risk of getting an infection in their surgical wound. The clean air ventilation

was functioning throughout. A follow up letter was sent to all patients involved however no infections were reported as a result of the malfunction.

October 2016 to December 2016

- CDI positive result received from a plastic surgery patient. Meeting held to look at learning needs regarding nursing documentation following completion of RCA.
- Hospital acquired MRSA confirmed in a Burns patient on 3rd October 2016. Patient did not have any MRSA screens sent on admission, when screened three days after admitted patient then returned MRSA positive. Learning needs identified from the RCA show poor documentation of screening and checking of results from both Nursing and Medical staff.
- Hospital acquired MRSA confirmed in a burns patient on 11th October 2016. Patient had MRSA screening sent from their nose, groin and wounds on admission which were negative to MRSA. Patient then confirmed positive 12 days after admission. All infection control precautions implemented once result known. Learning needs identified from RCA show improvement needed in hand hygiene.

January 2017 to March 2017

- Decrease in on site consultant Microbiology support as BSUH have fewer registrars and one of the Consultant Microbiologists is retiring in April 2017.
- MSSA positive blood culture received from a Burns patient, February 2017. Learning needs identified around cvc care and documentation.

11. Associated services reports

11.1 Antimicrobial Medication report - *Antimicrobial Pharmacist*

Antimicrobial CQUIN 2016/17 - The trust met the 1% reductions for overall reductions in piperacillin/tazobactam and carbapenem usage. The estimated value to the Trust is £75,000. Given that the trust has met the 1% reductions for 2016/17, the 2017/18 expected reduction will also be 1% as opposed to 2%. The baseline year is the 2016 calendar year. Data has been submitted for this.

There continue to be shortages of piperacillin/tazobactam (Tazocin®). There have been supply interruptions since January but we have been unable to obtain any since April. The reason for the shortage is a fire in the factory in China in November 2016 that produced much of the global raw material. Tazocin is mainly used at this Trust to treat hospital acquired pneumonia, as escalation agent for surgical site infections, particularly following head and neck surgery, when the first line agent has failed. There has been no recent update from DoH as to the expected resumption of supply. As a result of the Tazocin shortage, the pressure on other antibiotics has increased and so the trust has faced intermittent shortages of co-amoxiclav and cefuroxime injections but have so far managed these without the need to make any change to practice.
For a full report, please refer to the annual antimicrobial report which is available on QNet

11.2 Decontamination report–Decontamination Lead, Theatres

The annual service and water test was taken on 28th June 2016 by Wassenburg and results received in July 2016 indicated that the mycobacteria count was greater than 100. The machine was taken out of use whilst repair work was conducted and then whilst further water samples taken and sent for analysis. During this period alternative methods of decontaminating the surgical equipment that went through the washer was needed. Some equipment was sent to Synergy for decontamination and others it was deemed safe to manually disinfect using the approved Tristel 3 stage wipe system. Further sampling showed that the machine was now safe to use, however during the process it was discovered that some equipment that had been put through the washer should not have been. Further work is now being undertaken to ensure that these are all being decontaminated in line with manufacturer's instructions and

national guidance.

Decontamination roles The current Authorised Engineer (Decontamination) remains in place. Roles of Designated User to be assigned following advice from Authorised Engineer.

Decontamination Group to be established. Terms of Reference written but not yet ratified.

Sterile Service compliance audit by Steris (EN ISO 13485:2012: Decontamination and steam sterilization of surgical instruments, theatre trays and procedure packs. ISO 9001:2008: Decontamination and steam sterilization of surgical instruments, theatre trays and procedure packs. MDD 93/42/EEC - Annex V: Theatre sets, supplementary instruments and procedure packs) the management system was found to be effectively implemented although minor nonconformities were cited: action was required from Steris and progress will be followed up by the new theatre manager.

11.3 **Facilities Department report**–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, Health watch, and an external verifier are invited to join the process with members of staff in inspecting the patient areas.
Queen Victoria Hospital predicted scores for 2017 are:

Cleanliness	99.67%
Food	96.26%
Privacy, dignity & wellbeing	71.79%
Condition, appearance & maintenance	89.96%
Dementia	72.03%
Disability	69.29%

The official scores from HSCIC will be published during August 2017

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 Head of Nursing for 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. Several system have been trialled and a preferred system to incorporate Estates and Facilities is under consideration

Cleaning Review
An Infection Prevention & Control Improvement Action plan has been implemented and the review of cleaning equipment has resulted in the additional provision of vacuum cleaners and a trial is being undertaken for microfibre flat mopping systems

Catering
Cleaning audits are undertaken weekly and temperature checks of ward and kitchen refrigerators are monitored daily.

An electronic temperature monitoring system has been provided to automatically and constantly temperature check the main kitchen refrigerators and freezers.

Laundry
All linen is laundered by Eastbourne Commercial Services Ltd and a Duty of Care visit was conducted on 30th November 2016. All processes at the laundry were correctly and robustly followed and documented.

Waste Disposal
Waste disposal is contracted to SRCL. The provision of feminine hygiene units has been introduced and the introduction of a 'tiger waste bag' stream for offensive waste is under consideration.
A Duty of Care visit to the waste treatment centre was carried out on 9th December 2016 and all processes were witnessed and documented.
SRCL sub contract the domestic and recycling of waste to Cox Skips and a Duty of Care visit will be conducted at the domestic and recycling waste disposal depot on 27th April 2017.

11.4 Estates report – Associate Director of Estates

General

- 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
- General maintenance and improvement of facilities
- Urgent works following poor weather conditions
- Urgent works following outbreaks
- Urgent works due to the January 2017 burst mains water pipe
- Review of main Theatres water treatment plant
- Legionella monthly water sampling programme
- Pseudomonas 6 monthly water sampling programme.
- All Capital backlog and Capital project schemes.

Legionella
The Trust carried out over 300 water samples in 16/17 for the monitoring of Legionella bacteria in its water systems. In February 2017 the contract was tendered for this service and the contract changed from Pro-economy to TSS.
During last year we had identified positive Legionella samples in new Theatres from a dirty utility room post works of replacing the UV treatment to silver/copper treatment. The identified outlets where chlorinated and re-tested for several month after post sampling proved negative for the presence of Legionella.

Pseudomonas
The Trust carries out testing at 6 monthly intervals. Four positives where detected within Burns areas in March 2017

PCAF Observations & Recommendations					
Asset No.	**Location**	**Time**	**Temp**	**Observation**	**Recommendation**
	Side RM 2			Positive Pseudomonas result of 57	
	E Bac RM 1			Positive Pseudomonas result of > 100	
	ITU Bay 4			Positive Pseudomonas result of 7	
	Ebac RM 1			Positive Coliform count of 1	

Following advice from IPACT remedial measures were put into place immediately and resamples for 7, 14 and 21 post positive samples where retaken. All samples returned with a negative count.

Water Coolers
Water coolers – the contract expired with Angel Springs (formally PHS) as of 19/01/17. They were last serviced June 2016 but we were unable to obtain service reports from Angel Springs related to their last service. A new contact has been awarded to **Aqua Stations.** A survey around the Trust of current locations of water stations was undertaken with IPACT and QVH's Authorised Person to ascertain locations of all dispensers within the Trust. Confirmation for the siting of the replacement units was sought from IPACT. The new dispensers will be routinely tested for the presence of the following microorganisms

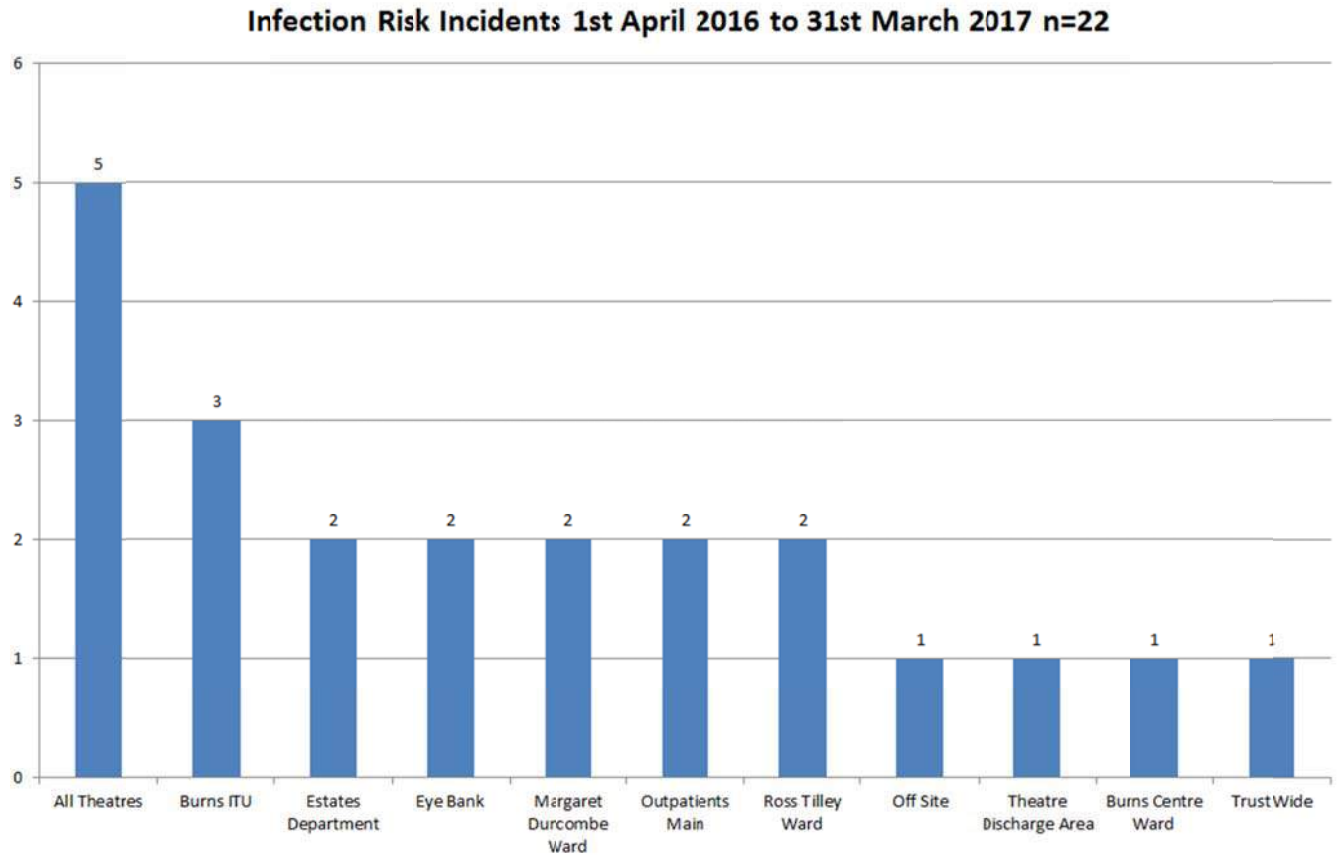
- Total Coliforms
- E. coli
- Pseudomonas aeruginosa
- Legionella

Risks
The Trusts risk register has been reviewed monthly in 16/17 and risks related to Water management have been updated or closed.

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 22 infection risk incidences on Datix through the year. (Information taken from Datix 08/08/2017)



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.

14.2 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.

Following a review of the current patient pathway of MRSA positive patients requiring day surgery the MRSA policy has been changed to allow MRSA positive patients to be admitted through Main theatres and then into discharge lounge rather than being admitted to the Wing. Staff are required to adhere to strict infection control precautions for all patients.

The infection control team have reviewed the hand hygiene products currently in use within the Trust and have made the decision to change from B Braun to DEB. New soap, hand sanitizer and moisturiser dispensers are to be fitted throughout the Trust at the start of April 2017.

Following a review of cleanliness throughout the Trust and working with Hotel services the Infection Control team have introduced the use of hepa filter vacuum cleaners to assist in cleaning the wards. These have now been given out for use in all departments with the exception of the Burns unit.

The contract for the supply of drinking fountains to the Trust has been moved to a new supplier, once approval for locations of required fountains has been given the new supplier will install new water fountains throughout which will then be maintained and monitored by the estates team.

14.3 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.

14.4 Local Infection Prevention and Control peer review and assurance processes are in place.

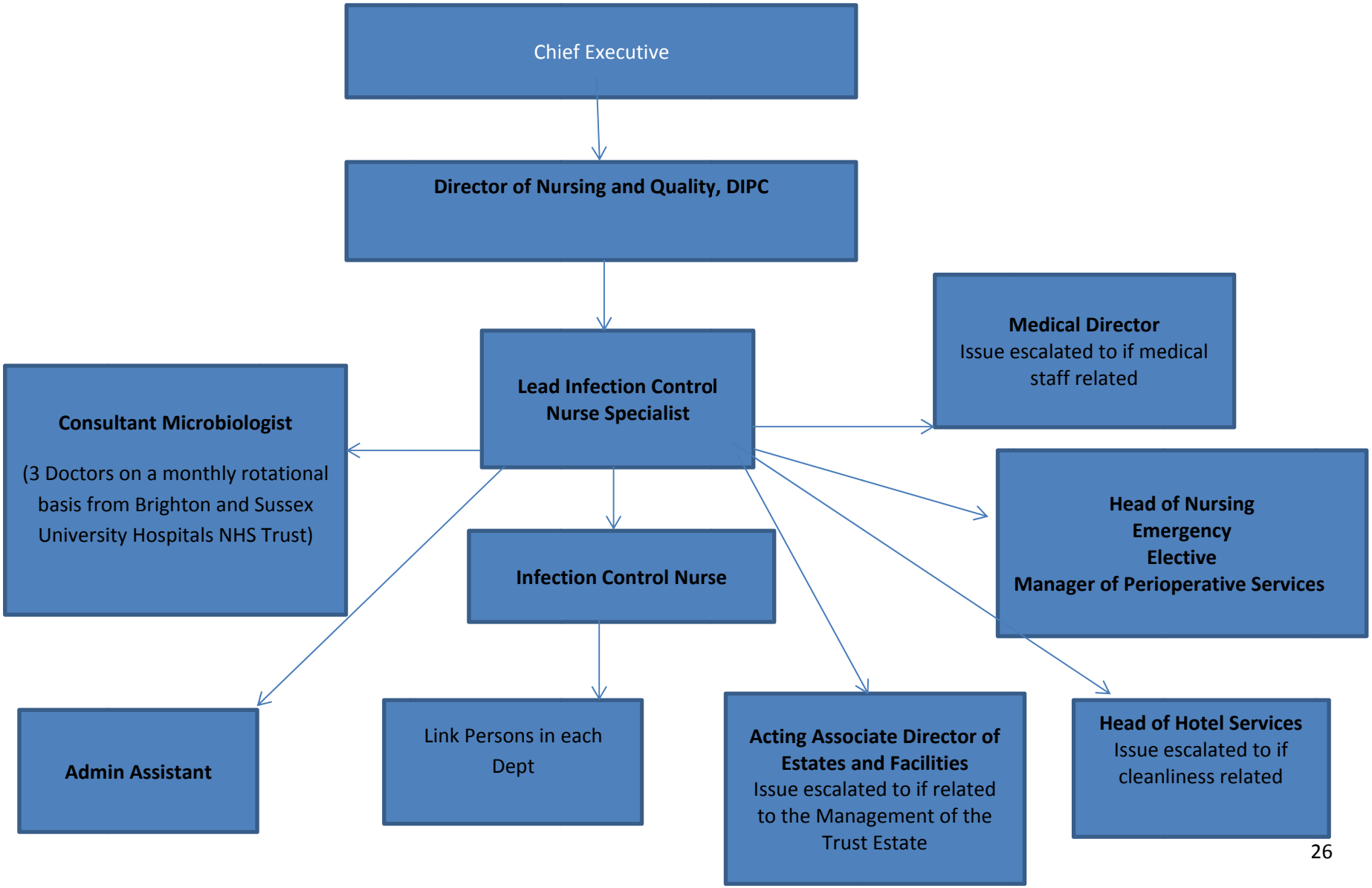
IPACT are well supported by the Director of Nursing/ DIPC

QVH staff are guided and supported by the specialist Infection Prevention and Control clinicians.

14.5 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 Structure Chart 2016/2017



Appendix B
Infection Control Annual Programme Objectives for 2017/18

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 Director of Nursing to undertake hand hygiene audit	Annual

		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 C

IC Policies Ratified April 2016 – March 2017

Reference	**Title**	**Lead Director**	**Ratifying Committee**	**Ratified Date**	Review Date	**Uploaded**
IC.7024.7	Management of Outbreaks	Director of Nursing	Infection Control Group	21/01/2016	**20/01/17**	27/01/16
IC.7003.2	Personal Protective Equipment	Director of Nursing	Infection Control Group	23/04/2015	**23/04/17**	11/05/15
IC.7007.4	Isolation Policy	Director of Nursing	Infection Control Group	23/04/2015	**23/04/18**	11/05/15
IC.7009.4	Decontamination & Disinfection Policy	Director of Nursing	Infection Control Group	23/04/2015	**23/04/18**	29/04/15
IC.7012.4	Procedure for the Management of Spillage of Blood and Body Fluid	Director of Nursing	Infection Control Group	23/04/2015	**23/04/18**	11/05/15
IC.7019.3	Guidelines for Management of Head lice	Director of Nursing	Infection Control Group	23/04/2015	**23/04/18**	29/04/15
IC.7020.3	Guidelines for Management of Scabies	Director of Nursing	Infection Control Group	23/04/2015	**23/04/18**	29/04/15
IC.7002.5	Hand hygiene	Director of Nursing	Infection Control Group	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	Director of Nursing	Infection Control Group	23/07/2015	**23/07/18**	
IC.7008.7	Management of Patients with MRSA	Director of Nursing	Infection Control Group	22/10/2015	**22/10/18**	30/10/15
IC.7016.3	Management of patients with Tuberculosis	Director of Nursing	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: 30 August 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.

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.

Current Risk Rating 4 (C) x 3 (L) = 12, moderate risk
Residual Risk Rating 4 (C) x 2 (L) = 8, low risk

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 –v- service delivery.
Internal and spoke governance resources.
External and internal research funding and organisation.
Job planning.
Coroner's Report to Prevent Future Deaths.

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:
BSUH MoU and clinical partnership development.
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 and STP networks
Leaders: CDs and governance leads
Demand in many services with opportunities in STP.
CEA incentives
Management support for operational initiatives

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
Outstanding actions in response to Coroner's PFD report – CRR 1059

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07 September 2017**		**Agenda reference:**	**146-17**	
Report title:	**Medical director's report**				
Sponsor:	Dr E Pickles, Medical Director				
Author:	Dr E Pickles, Medical Director				
Appendices:	NA				
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:	Approval	Information	Discussion	Assurance **Y**	Review
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: **Y** *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	BAF KSO2				
Corporate risk register:	NA				
Regulation:	NA				
Legal:	NA				
Resources:	None				
Assurance route					
Previously considered by:	NA				
Next steps:	NA				

Report to: Board of Directors
Meeting date: 07 September 2017
Reference number: 146-17
Report from: Ed Pickles, Medical Director
Author: Ed Pickles, Medical Director
Appendices: N/A
Report date: 30 August 2017

Medical Director's Report September 2017

1. Clinical Governance

See also the Clinical Effectiveness Section of the Quality and Safety Board Report.

a) Mortalities

	June 2017	July 2017
QVH mortalities on-site	0	0
Mortalities elsewhere within 30 days of discharge from QVH	2	0

The case notes of the mortalities occurring will be reviewed by the Medical Director, discussed at local governance meetings and included for discussion at a future Joint Hospital Clinical Governance meeting where of relevance to a wider clinical staff group.

From the report covering September, all deaths on-site and within 30 days of discharge will be reported to board as part of the Quality and Safety Report, in line with the requirements of the National Quality Board: 'Learning from Deaths' policy. In October the Medical Director and Head of Risk are attending a training course in undertaking Structured Judgement Reviews (SJR) of case notes. This is the first opportunity to attend this NHSI delivered training. All QVH related deaths will be subject to SJR.

b) Clinical Indicators

We routinely collect data on transfers out, returns to theatre and unexpected readmissions to hospital within 30 days of discharge. There were five unexpected transfers out in June and three in July which was within our normal limits of variation.

c) Never events and serious incidents

No never events or serious incidents were reported in June or July.

A Regulation 28 'Report to Prevent Future Deaths' (PFD) from the West Sussex Assistant Coroner was received by the trust on the 8 June 2017, relating to an inquest held in May 2017. The report is now in the public domain, published on-line by the Courts and Tribunals Judiciary. The Trust has responded to the PFD by the required date of the 2nd August 2017, including an action plan developed in response to the coroner's concerns. The case has been presented to, and discussed by, the Board of Directors and the Council of Governors, as well as our own clinical governance groups and clinicians. The completion of the action plan will be monitored through the Clinical Governance Group, overseen by the Quality and Governance Committee.

In July, the CEO, Director of Nursing and Quality, and Medical Director presented the case, response and action plan to a single issue Quality Surveillance Group, with NHS England, NHS Improvement, Health Education England, the Clinical Commissioning Group, CQC and NHS Specialised Commissioning in attendance.

The case involved a serious complication from insertion of a percutaneous endoscopic gastrostomy (PEG tube), used for delivering nutrition to a patient following their major head and neck cancer resection and reconstructive surgery. The tube was inserted despite being contraindicated for this particular patient in our own local guidelines, and the recognition of the complication and subsequent transfer to Brighton for further treatment was not as timely as would have been expected. We have apologised to the family.

Following a careful review of our own practices, the clinicians have decided to suspend PEG insertions at the QVH for a period of six months, to see if alternative pathways of referral via the respective multidisciplinary teams can deliver a timely and successful service.

d) Clinical Audit

QVH continues to participate in an NHSI national audit on surgical site infection in cataract, breast and head and neck cancer surgery, as part of the GIRFT (Getting It Right First Time) programme. This is being led by several junior doctors across the trust.

QVH is now submitting cataract data to the National Ophthalmology Audit, which is commissioned by the Royal College of Ophthalmologists. This audit is now continuing until Aug 2019.

e) Getting It Right First Time (GIRFT)

The QVH clinical and managerial maxillofacial teams attended a presentation by the National GIRFT project team, which uses nationally available patient data to examine variations in outcome and process between providers. The analysis provided some minor areas where we may be able to improve, around admission on the day of surgery and coding. Overall, though, the results were extremely encouraging, providing further evidence of both our large volume of maxillofacial surgery, and the quality of outcomes for our patients.

2. Critical Care

The Step Down Unit and Intensive Care Unit cohorts of higher risk patients have been amalgamated, so that all intensive care, high dependency and 'at risk' patients Level 1 patients, particularly those with new tracheostomies, are being cared for in a five bedded 'Critical Care Unit'. Canadian Wing continues to provide an 'Enhanced Recovery Area' for orthognathic and uncomplicated free flap surgery. The amalgamation has been successful, although limitations of nursing recruitment and retention mean that consistently providing five open beds is difficult to achieve. Further developments in estates and equipment provision for the new CCU are in progress.

3. Sustainability and Transformation Plan and Regional Services

The Clinical Sussex and East Surrey STP Clinical Board continue to meet fortnightly. Membership includes the Medical Directors of the acute providers and lead clinicians from the CCGs, with the predominant aim being to reduce unwarranted variations in acute care, particularly in cost and outcome. Workshops are to be held with the aim of unifying CCG guidelines for referral of elective surgical conditions. The QVH will be represented at these workshops.

The transfer of inpatient maxillofacial surgery trauma services from BSUH to QVH has been generally successful. It has, however, contributed to an increased trauma workload, of over 10% across plastic and maxillofacial surgery. The new trauma clinic will open in September 2017, with an increased capacity for trauma outpatient reviews.

The draft Partnership Agreement between BSUH and QVH for specialist services provision, including paediatric burns, lower limb ortho-plastic trauma, dermatology and maxillofacial surgery, approved by this Board in July 2017 has yet to be presented to the BSUH Board, although this is expected in September. The QVH CEO and the MD are meeting with BSUH Executive counterparts this month to discuss specific clinical partnerships that may be of mutual benefit.

4. Medical & Dental Staffing

There are currently 101 doctors for whom the QVH is their Designated Body. (LETB trainees have a prescribed connection to their Deanery). All doctors are registered with a licence to practice.

a) Job planning

'Allocate', an electronic system to aid medical job planning will soon be in use. Current job plans are being uploaded, before job planning reviews will commence. A new job planning policy is currently in negotiation with the Local Negotiating Committee and the Consultants.

b) GMC National Training Survey

In March 2017, junior doctors at the QVH who are on HEE training rotations, responded to the annual GMC National Training Survey. Over 80 questions are asked, resulting in 17 quality indicators. Indicators with a dark green flag represent results that are significantly better than average, a red flag represents results that are significantly worse. Pink and light green flags are worse / better, without statistical significance. Results are presented below, demonstrating changes over the last 5 years.

In anaesthetics , the result was improved on 2016, with significantly better overall satisfaction than other trusts.

Programme Group	Indicator	2013	2014	2015	2016	2017
Anaesthetics	Overall Satisfaction					
Anaesthetics	Clinical Supervision					
Anaesthetics	Clinical Supervision out of hours					
Anaesthetics	Reporting systems					
Anaesthetics	Work Load					
Anaesthetics	Team Work	New	New	New	New	
Anaesthetics	Handover					
Anaesthetics	Supportive environment					
Anaesthetics	Induction					
Anaesthetics	Adequate Experience					
Anaesthetics	Curriculum Coverage	New	New	New	New	
Anaesthetics	Educational Governance	New	New	New	New	
Anaesthetics	Educational Supervision					
Anaesthetics	Access to Educational Resources					REMOVED

Programme Group	Indicator	2013	2014	2015	2016	2017
Anaesthetics	Feedback					
Anaesthetics	Local Teaching					
Anaesthetics	Regional Teaching					
Anaesthetics	Study Leave					

Oral and Maxillofacial Surgery results show improvement in some areas and deterioration in others, but overall are relatively stable.

OMFS	Overall Satisfaction					
OMFS	Clinical Supervision					
OMFS	Clinical Supervision out of hours					
OMFS	Reporting systems					
OMFS	Work Load					
OMFS	Team Work	New	New	New	New	
OMFS	Handover					
OMFS	Supportive environment					
OMFS	Induction					
OMFS	Adequate Experience					
OMFS	Curriculum Coverage	New	New	New	New	
OMFS	Educational Governance	New	New	New	New	
OMFS	Educational Supervision					
OMFS	Access to Educational Resources					REMOVED
OMFS	Feedback					
OMFS	Local Teaching					
OMFS	Regional Teaching					
OMFS	Study Leave					

However, in plastic surgery, results for both for Core Surgical Training (CST, or old 'SHO' grade) and for the Specialist Trainees (old Registrar grade) have deteriorated markedly.

CST	Overall Satisfaction					
CST	Clinical Supervision					
CST	Clinical Supervision out of hours					
CST	Reporting systems					
CST	Work Load					
CST	Team Work	New	New	New	New	
CST	Handover					
CST	Supportive environment					
CST	Induction					
CST	Adequate Experience					
CST	Curriculum Coverage	New	New	New	New	
CST	Educational Governance	New	New	New	New	
CST	Educational Supervision					
CST	Access to Educational Resources					REMOVED
CST	Feedback					
CST	Local Teaching					
CST	Regional Teaching					
CST	Study Leave					

Specialty Trainees in Plastic Surgery ('Registrar Grade')

Plastic surgery	Overall Satisfaction					
Plastic surgery	Clinical Supervision					
Plastic surgery	Clinical Supervision out of hours					
Plastic surgery	Reporting systems					
Plastic surgery	Work Load					
Plastic surgery	Team Work	New	New	New	New	
Plastic surgery	Handover					
Plastic surgery	Supportive environment					
Plastic surgery	Induction					

Plastic surgery	Adequate Experience					
Plastic surgery	Curriculum Coverage	New	New	New	New	
Plastic surgery	Educational Governance	New	New	New	New	
Plastic surgery	Educational Supervision					
Plastic surgery	Access to Educational Resources					REMOVED
Plastic surgery	Feedback					
Plastic surgery	Local Teaching					
Plastic surgery	Regional Teaching					
Plastic surgery	Study Leave					

It is important to remember that the results are based on very small numbers of LETB appointed trainees. For example, there were only three trainees contributing to the survey from CST (resulting in a 33% dissatisfaction rate if one trainee is not content with their training), and seven from plastic surgery specialist training. The significance of the results is therefore not always easy to interpret, with the responses of one trainee potentially accounting for large swings, but this does not detract from the importance given to the results.

Headline factors accounting for the deterioration in the survey results for plastic surgery may include; reduced numbers of trainees resulting in rota gaps; unusual numbers of consultants on sick leave, worsened ratio of service delivery commitments to training as service pressures increase; introduction of a new junior doctor rota. However, we must reflect and act rigorously on feedback relating to supervision and support. In particular, pink and red flags for clinical supervision out of hours across both surgical specialties require examination.

We are currently seeking further feedback from trainees and working on an action plan which will address each red and pink flag. The action plan will be monitored through the Local Academic Board.

In view of the deteriorated results from the survey, and following trainee doctor involvement in the serious incident subject to the Report to Prevent Future Deaths, Health Education England; London and the South East will be undertaking a quality assurance visit in October or November of 2017, the results of which will be reported to the Board of Directors via the Medical Directors report.

Dr Edward Pickles
Medical Director
30 August 2017

References			
Meeting title:	Board of Directors		
Meeting date:	07 September 2017	Agenda reference:	147-17
Report title:	**Consultant revalidation annual update**		
Sponsor:	Dr Ed Pickles		
Authors:	• Ed Pickles, Medical director • Dr Lekha Chandrasekharan, Appraisal lead • Katie Ally, Medical workforce administrator		
Appendices:	None		

Executive summary					
Purpose:	The purpose of this report is to provide assurance to the Board that the Trust's doctors are compliant with relevant professional standards, have up-to-date skills and competencies, and are fit to practice.				
Recommendation:	The Board is asked to **NOTE** the contents of this report				
Purpose:		**Information**	**Discussion**		
Link to key strategic objectives (KSOs):		**KSO2:**			
		World-class clinical services			

Implications	
Board assurance framework:	Yes
Corporate risk register:	None
Regulation:	Yes: Responsible Officer and General Medical Council legislation
Legal:	None
Resources:	None
Assurance route	
Previously considered by:	N/A (for Board of Directors information only)

Framework of Quality Assurance for Responsible Officers and Revalidation – Annual Board Report 1st April 2016 to 31st March 2017

1. Executive summary

Revalidation is the process by which doctors will have to demonstrate to the General Medical Council (GMC) that they are compliant with relevant professional standards, have up to date skills and competencies and are fit to practice. Revalidation of licenced doctors will be required every 5 years.

Appraisal and revalidation are the focal point of ensuring and enhancing the delivery of high quality care to our patients. Additionally, it is intended to assist in the early identification of performance issues.

Doctors in both training and non-training grades are required to participate in the revalidation process. However, doctors in training are revalidated through Health Education England London and the South East (HEELaSE)

As of March 2017, 92 doctors had a 'prescribed connection' with the Responsible Officer (RO) with 72 doctors completing an appraisal at the QVH during the reporting period.

2. Purpose of the Paper

Appraisal for the purposes of revalidation is made up of two elements:

- The appraisal element, which is the process by which a doctor is supported in their continuing professional development
- The revalidation element, whereby a doctor demonstrates that they remain up to date and fit to practice.

The purpose of this report is to provide the Board with information regarding the current position as of 31 March 2017 in respect of the numbers of doctors who have been revalidated, any pertinent issues and general assurance regarding the revalidation process including future plans for improvement.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practice and Revalidation) Regulations Order of Council 2012'

performance of their doctors;

- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

This is the fourth formal report to the Board laying out the role and responsibilities of the Responsible Officer and detailing how the revalidation team at QVH have delivered, documented and assured the process has been carried out in accordance with national requirements. Dr Ed Pickles, Medical Director was appointed RO from the 3rd October 2016.

The Responsible Officer regulations are wide-ranging but in summary cover the whole governance system that exists around the recruitment, monitoring, training and development of all medical staff at the QVH. The revalidation system is still in its first 5 year cycle and is growing in complexity year on year. The RO is obliged to attend regional meetings and events to ensure the organisation is kept up to date with new developments. The QVH revalidation team are also instrumental in ensuring our systems and processes are reviewed and continue to deliver the changing requirements.

4. Governance Arrangements

A report on completed and missed appraisals is submitted on a quarterly basis to NHS England. Incidents/complaints relating to medical and other staff are reviewed monthly at the Clinical Governance Group, to which the Medical Director (Responsible Officer) is joint Chair. Concerns raised through any other mechanism, such as whistle-blowing, are managed according to Trust policy but within the Responsible Officer regulations.

The Trust has systems in place to collect the information in line with revalidation requirements. Doctors have access to their individual revalidation file in which they are expected to upload and maintain their own appraisal and revalidation documents. The system is administrated by dedicated staff in the Medical Workforce Office who provides assistance and advice on revalidation issues both to the doctors and the Responsible Officer.

The Responsible Officer is required to submit an Annual Organisational Audit in May of each year which is designed to provide assurance to the Board, High Level Responsible Officers and other interested bodies. Crucially, it provides a mechanism for assuring NHS England, the England Revalidation Implementation Board and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent. The Responsible Officer is subject to annual audit covering his "total practice" but primarily focused on the governance systems and quality control in place within the organisation. The appraiser is appointed from outside the Trust by NHS England.

An accurate list of prescribed connections is managed by the Medical Workforce Office. When a new doctor is recruited information on their RO is sought from their current employer. The new doctor is added to the list. When a doctor leaves the Trust the doctor is removed from the list.

a. Policy and Guidance

The Trust has a published Appraisal, Revalidation & Remediation Policy which aims to ensure doctors within its employ receive high quality appraisals. This along with other supporting information enables the RO to make a recommendation to the General Medical Council (GMC). The policy includes a number of QA processes. In addition, all new applicants are asked questions based on the Trust's values, in additional to the standard clinically based questions.

The purpose of this is to assess organisational fit and ensure that they are able to converse and understand medical terminology at an appropriate level in English. References follow a set format and must include last employer, most recent Responsible Officer declaration.

A similar although more extensive assessment process using Stakeholder Panels is part of the recruitment process for Consultants and consideration will be given to the possible introduction for permanent non-consultant career grade staff.

Appraiser Job descriptions and personal specifications provide explicit guidance on the expectations of the role and provide clarity on lines of responsibility & accountability and are share with all new appraisers.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data as at 31 March 2017

Specialty	Number of doctors	Number of completed appraisals*	% Compliance
Head & Neck	13	12	92.3
Plastic Surgery	40	38	95.0
Anaesthetics	22	19	86.4
Corneo-plastics	11	11	100
Radiology	2	2	100
Histopathology	2	2	100
Sleep Studies	2	2	100

*Also includes staff who joined QVH within reporting period with a valid medical annual appraisal or an approved missed appraisal.

Level	Number of doctors	Number of completed appraisals*	% Compliance
Consultants	60	55	91.6
Staff grade, Associate Spec, Specialty Drs	8	8	100.0
Doctors on temporary or short-term contracts	24	23	95.8
TOTAL	**92**	**86**	**93.47**

*Also includes staff who joined QVH within reporting period with a valid medical annual appraisal or an approved missed appraisal.

(See **Annual Report Appendix A;** Audit of all missed or incomplete appraisals audit)

b. Appraisers

There are currently 19 trained appraisers. 4 appraisers relinquished the appraiser role and 3 new appraisers have been recruited within the last 12 months with a further 5 who have expressed an interest in the role. We are collaborating with East Sussex Healthcare NHS Trust and Brighton and Sussex University Hospitals Trust to provide quality assured training for new appraisers to ensure quality and consistency.

It is important that medical appraisers maintain and develop their skills on an ongoing basis. This is primarily the responsibility of the appraiser, however in order to support our appraisers QVH deliver annual in-house refresher training which incorporates peer support group discussions with 1 more scheduled for later this year. The aim of these sessions is to continually improve the documentation of evidence, evaluation and completion of the Medical Appraisal Form by both Appraiser and Appraisee whilst also providing a greater understanding of the NHS England's audit process. It has been agreed to provide this training on a regular basis of 3 times a year. The Revalidation Team aim to improve the attendance rate at these sessions over the coming 12 months to ensure medial appraisers can maintain and develop their skills whilst supporting consistency throughout the Trust. (See action plan)

c. Quality Assurance

The Trust samples appraisal outputs using NHS England's generic Appraisal Summary and PDP Audit Tool (ASPAT). The data identifies further training needs for doctors and appraisers

Triangulation of data from incident and complaint reporting to the appraisal documentation is undertaken and this has been an area of development (see part e below).

At present separate records of mandatory and statutory training are used to confirm compliance.

Quality assurance of appraisals has begun by monitoring feedback from appraisees using Survey Monkey as a tool for collecting data. The response rate is slowly improving. The feedback will be cascaded to the individual appraisers in order for reflection whilst also support key areas of development and discussion at the appraiser network groups over the coming year. See action plan

(See **Annual Report Template, Appendix B;** Quality assurance audit of appraisal inputs and outputs)

d. Access, security and confidentiality

There are secure systems in place for access to revalidation files. The file of each doctor can only be accessed by the individual doctor themselves, the Responsible Officer, the Head of Medical HR and the Medical Workforce Administrator.

Doctors are required to anonymise correspondence with patient identifiable data which is then submitted for the purposes of revalidation. Further action needs to be taken in this respect to ensure that all doctors undertake this prior to submission.

No information governance breaches have been reported.

e. Clinical Governance

As the organisation lack the capacity to supply individual corporate data, such as incidents, complaints and performance metrics, we remain dependant on the individual doctor to collect and present this information themselves as a result of the disparate information systems currently in existence. This has been an area of improvement over the previous 12 months and

resulted in the development of a data pack which will be launched over the coming months. The pack will provide doctors and appraisers with data relating to the doctors statutory and mandatory training compliance, plus recorded incidents and complaints. (See action plan)

6. Revalidation Recommendations

It should be noted by the Board that all recommendations to the GMC were made on time.

See **Annual Report Appendix C;** Audit of revalidation recommendations

7. Recruitment and engagement background checks

All doctors, including locums, are recruited in line with NHS Employment Check Standards.

All locum doctors are sourced through the Crown Commercial Service (formerly Government Procurement Service) or Health Trust Europe. These bodies are required to meet the NHS Employment Check Standards.

The Trust has extended its clinical offering to patients through expanding services using clinicians who do not have a prescribed connection with the Trust. These include locums, visiting doctors and doctors who provide services through a Limited Liability Partnership and Any Qualified Provider. The Trust has processes in place to ensure that the information required to support the NHS Employment Check Standards and RO Regulations are met, however the speed of growth has presented some challenges relating to the information flows. This has been identified as an area of development.

Receipt of information relating to previous appraisals and revalidation data is low and further improvement is required.

See **Annual Report Appendix E**: Audit of recruitment and engagement background

8. Monitoring Performance

All doctors are required to have an annual appraisal which is undertaken with a designated, trained appraiser. Should issues arise in the interim these are fed back through the Clinical Directors and Clinical Leads and are, where possible, dealt with informally in the first instance.

Incidents and trends relating to performance will also be fed back through the Clinical Governance Group which reports on a monthly basis.

Any serious concerns regarding practice from any other source will be reported to the Medical Director.

9. Responding to Concerns and Remediation

The Trust has an Appraisal, Revalidation and Remediation Policy which includes the Trust's approach to remediation and links with other related policies. The Trust manages concerns raised about doctors and dentists in accordance with the NHS Framework, Maintaining High Professional Standards.

As of 31 March 2017 there were 0 doctors in remediation or subject to a disciplinary process. 1 doctor is carrying a formal written warning relating to conduct following an MHPS disciplinary hearing.

See **Annual Report Appendix D**; Audit of concerns about a doctors practice

10. Risk and Issues

The key risks that have been identified are as below:

- That the Trust's information systems do not adequately capture and report all concerns and incidents relating to performance.
- That the appraisal system is not sufficiently robust to detect and manage concerns of poor performance.
- That Trust recruitment, induction and monitoring of medical staff does not detect and manage poor performance.

11. Board Reflections

The Responsible Officer regulations are being introduced and in part adapted over time. The process has highlighted nationally the resources needed at organisational level to support the process are greater than expected and fall to organisations themselves to provide. The identification of concerns and their subsequent management has brought to the fore the need to provide robust systems to manage those doctors with capability or conduct issues. It is likely that organisations will be required to work together to address this, though placing greater demands on the RO and team.

12. Corrective Actions, Improvement Plan and Next Steps

The following table reflects the result of the Annual Organisation Audit (AOA) 2017 plus audits included herein.

Corrective Actions/Areas for Improvement/Further development	**Action/Timescales All actions to be completed by 31st March 2018 unless stated below.**
Attendance at Appraiser Annual Update Session and Peer Networking Group Session	All appraisers to attend a minimum of one update session per year, and to be included as a compulsory element on ESR for all appraisers.
Cascade medical appraisal feedback data to appraisers	ASPAT and SurveyMonkey appraisee feedback to be collated and circulated to all appraisers.
Distribute data packs to doctors and appraisers prior to annual appraisal.	Timely distribution of data pack prior to appraisal.
Recruitment and Engagement background checks – information flows	More robust procedure for the collection of appraisal and revalidation data on appointment, in line with NHSE Information Flows to Support Medical Governance and RO Statutory functions.
Improve rates of appraisal for trust grade junior doctors.	Make clear requirements of GMC and QVH of formal appraisal in addition to education supervisor and ISCP information. Education and communication required, in liason with Medical education.

13. Recommendations

The Board is asked to accept the report and note that it will be shared, along with the annual audit with the High Level Responsible Officer.

It is also asked to approve the ‘Statement of Compliance’ which confirms that the Trust is in compliance with the regulations.

Audit of all missed or incomplete appraisals audit* (over the course of the reporting year) – **source of information – RO/ESR**

Doctor factors (total)	**19**
Maternity leave during the majority of the 'appraisal due window'	0
Sickness absence during the majority of the 'appraisal due window'	0
Prolonged leave during the majority of the 'appraisal due window'	3
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	11
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	5
Lack of engagement of doctor	0
Other doctor factors	0
Describe doctor under investigation	0
Appraiser factors	**0**
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
Organisational factors	**1**
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	1
Other organisational factors (describe)	0

*Headcount basis

Annual Report Appendix B

Quality assurance audit of appraisal inputs and outputs – for the reporting year up until March 31st 2017 – source of information: audit undertaken by Appraisal Lead & Medical Workforce Administrator using ASPAT tool

Total number of appraisals completed		Number
Scale: 0 Unsatisfactory 1 Needs improvement 2 Good Score each item out of two	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards

1. Setting the scene and overview of supporting information

a) The appraiser sets the scene summarising the doctor's scope of work	10	19 / 20
b) The evidence discussed during the appraisal is listed *(not all senior appraisers feel that this is necessary, so if not required score 2)*	10	18 / 20
c) There is documentation of whether the supporting information covers the scope of work	10	15 / 20
d) Specific evidence is summarised with a description of what it demonstrates	10	14 / 20
e) Objective statements about the quality of the evidence are documented	10	17 / 20
f) All statements made by the appraiser are supported by evidence	10	15 / 20
g) Appraiser comments about evidence refer/fit in to the four GMC domains and associated attributes	10	19 / 20
h) Reference is made to whether speciality specific guidance for appraisal has been followed e.g. college recommendations for CPD and quality improvement activity *(this is not a GMC requirement so if the senior appraiser does not feel that this is necessary, score 2)*	10	16 / 20
i) Reference to completion of locally agreed required training (e.g. safeguarding training, basic life support training) is made *(please insert agreed requirements, score 2 if none agreed)*	10	14 / 20
2. Reflection and effective learning		
a) There is documentation of evidence showing that reflection on learning has taken place or that the appraiser has discussed the need for reflection	10	16 / 20
b) There is documentation of evidence showing that learning has been shared with colleagues or that the appraiser has challenged the doctor to do so	10	18 / 20

c) There is documentation of evidence showing that learning has improved patient care/practice or that the appraiser has explored how this might be taken further with the doctor	10	19 / 20

3. The PDP and developmental progress		
a) There is positive recording of strengths, achievements and aspirations in the last year	10	15 / 20
b) There is documentation of appropriate challenge in the discussion and PDP e.g. significant issues discussed and new suggestions made	10	16 / 20
c) The completion (or not) of last year's PDP is recorded	10	16 / 20
d) Reasons why PDP learning needs were not followed through are stated (*if the PDP was completed then score 2)*	10	15 / 20
e) There are clear links between the summary of discussion and the agreed PDP	10	17 / 20
f) The PDP has SMART objectives (specific, measurable, achievable, relevant, timely)	10	16 / 20
g) The PDP covers the doctor's scope of work and personal learning needs	10	19 / 20
h) The PDP contains between 3-6 items	10	17 / 20
4. General standards and revalidation readiness		
a) The documentation is typed and uploaded onto an electronic toolkit in clear and fluent English	10	18 / 20
b) There is no evidence of appraiser bias or prejudice and no identifiable patient/third party information	10	16 / 20
c) The stage of the revalidation cycle is commented on	10	2 / 20
d) There is documentation regarding revalidation readiness relating to supporting information (e.g. states that feedback and satisfactory QIA are already done). Any outstanding supporting information/other requirements for revalidation are commented on with a plan of action if revalidation is due that year	10	7 / 20
e) Appraisal statements (including health and probity) have been signed off or if not, an explanation given (*if signed off score 2)*	10	17 / 20
TOTAL SCORE (OUT OF 500)	390	

Annual Report Appendix C

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2016 to 31 March 2017	
Recommendations completed on time (within the GMC recommendation window)	9
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	9
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
Describe other	
TOTAL [sum of (late) + (missed)]	9

Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[2]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern		1	0	0
Capability concerns (as the primary category) in the last 12 months		0	0	0
Conduct concerns (as the primary category) in the last 12 months		1	0	0
Health concerns (as the primary category) in the last 12 months		0	0	0
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2017 who have undergone formal remediation between 1 April 2016 and 31 March 2017 Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice A doctor should be included here if they were undergoing remediation at any point during the year				1
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				1
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment				0

[2] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

contracts, etc) All Designated Bodies	
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	0
Other Actions/Interventions	0
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	0
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	0
GMC Actions: Number of doctors who:	0
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	0
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	0
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	3
Number of NCAS assessments performed	0

Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	3
Temporary employed doctors	33
Locums brought in to the designated body through a locum agency	5
Locums brought in to the designated body through 'Staff Bank' arrangements	1
Doctors on Performers Lists	0
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	7
TOTAL	49

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	Disclosure and Barring Service (DBS)	2 recent references	Name of last responsible officer	from last responsible [illegible]	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors	3	3	3	3	3	3	3	2	1	3	3	3	2	2	2	3
Temporary employed doctors	33	33	33	33	31	28	20	8	32	33	33	20	17	5	30	33
Locums brought in to	5	5	5	4	4	4	4	0	0	4	4	4	0	0	0	5

the designated body through a locum agency																
Locums brought in to the designated body through 'Staff Bank' arrangements	1	1	1	1	1	1	1	0	0	1	1	1	0	1	0	1
Doctors on Performers Lists	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other (independent contractors, practising privileges, members, registrants, etc)	7	7	7	7	7	7	4	6	6	7	7	7	2	6	5	7
Total	49	49	49	48	46	43	32	16	39	48	48	35	21	14	37	49

For Providers of healthcare i.e. hospital trusts – use of locum doctors:

Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery	89.48		326.00	0	0

Medicine	0.32	222.00	0	0	0
Psychiatry	0	0	0	0	0
Obstetrics/Gynaecology	0	0	0	0	0
Accident and Emergency	0	0	0	0	0
Anaesthetics	29.18	0	0	0	0
Radiology	2.0	0	0	0	0
Pathology	3.4	0	0	0	0
Other	11.33	0	0	0	0
Total in designated body (This includes all doctors not just those with a prescribed connection)	**135.71**	**0**	**0**	**0**	**0**
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less	0	0	0	0	0
3 days to one week	0	0	0	0	0
1 week to 1 month	6	6	3	0	0
1-3 months	2	2	0	0	0
3-6 months	1	1	1	0	0
6-12 months	1	1	1	0	0
More than 12 months	0	0	0	0	0
Total	**10**	**10**	**5**	**0**	**0**

Queen Victoria Hospital NHS Foundation Trust - Statement of Compliance

The board of Queen Victoria Hospital NHS Foundation Trust can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   GMC Connect is regularly reviewed RA and RO

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   Appraisers attend at least 1 training session annually in order to update skills this sessions incorporate peer review and calibration of professional judgement discussion.

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Completed appraisal rate is 93.47%. Out of date appraisals are chased on a monthly basis in order to ascertain reason for delay and responses filed accordingly.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

   RO sources this information from separate data at present.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Concerns elevated to RO and addressed through Trust policy (MHPS).

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

Through the medical transfer of information document.

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

Employment guidelines are met and improvements in RO guidelines achieved but no yet fully achieved. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance. Yes

Signed on behalf of the designated body

(Chief executive or chairman (or executive if no board exists)

Official name of designated body: Queen Victoria Hospital NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Report cover page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/09/2017		Agenda reference:	148-17	
Report title:	Research and development annual report 2016/17				
Sponsor:	Ed Pickles, Medical Director				
Authors:	• Sarah Dawe, Research and development manager, • Julian Giles, Clinical lead for Research and Development, and Consultant Anaesthetist. • Ed Pickles, Medical Director				
Appendices:	None				
Executive summary					
Purpose:	The purpose of this report is to provide the Board with an annual update in respect of research and development activity at the Trust in 2015/16.				
Recommendation:	The Board is asked to **NOTE** the contents of the report				
Purpose:		**Information**	**Discussion**		
Link to key strategic objectives (KSOs):		**KSO2:**			
		World-class clinical services			
Implications					
Board assurance framework:	Yes				
Corporate risk register:	None				
Regulation:	Yes, NHS research framework good practice				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	17/0817	Decision:	Approved	

Queen Victoria Hospital
NHS Foundation Trust

Research & Development Annual Report 2016-2017

Contents

Foreword

This has been a busy and successful year for research at the Queen Victoria Hospital. Research underpins the excellent care we strive to deliver, and the reputation of the hospital is founded upon a long tradition of ground-breaking innovative research that stretches back sixty years.

I am happy to say that there has been a significant upswing in both the quantity of studies undertaken and the number of patients recruited into high-quality projects during the last year. We have recruited 333 patients into studies on the NIHR national portfolio in 2016/17. This represents a six-fold increase in recruitment into studies that are deemed to be of national importance. Several of these prestigious projects are 'home grown'. Charles Nduka is a recipient of an NIHR i4i award. I have just completed a study funded by the Research for Patient Benefit scheme run by the NIHR. We are also forging increasingly strong alliances with several academic partners, who have acknowledged our ability to deliver studies to time and target. Particular examples of this are our collaboration with the University of Oxford in their research into Dupytrens contracture. This is a common debilitating disease for which many patients are treated at the QVH. We have also worked with the University of Nottingham to develop new techniques to treat facial palsy.

Our increased research activity has made us increasingly reliant on our very hard-working research team. Gail Pottinger, Simon Booth and Debbie Weller have worked hard to ensure that as many patients as possible are offered the opportunity to be involved in research. Sarah Dawe and Emma Foulds have been instrumental in making sure that we comply with the serpentine regulatory framework that governs research within the NHS. I congratulate the team on all their hard work, and it is certainly now bearing fruit. We will have difficulty sustaining this pace of growth in our activity though, unless our local CRN are able to provide additional funding support. We hope this doesn't prevent us from taking part in all the projects that are open to us in the forthcoming 2017/18 year.

Our seventh annual Trust Research Day was particularly successful. We were pleased to welcome our first international keynote speaker, Professor Koshima from the University of Tokyo Hospital, who came to describe the latest advances in microsurgery. He paid tribute to the contribution of QVH surgeons in the development of plastic surgical techniques.

We bid farewell to Dr Brian Jones who had been on secondment from the University of Brighton as the director of research development. We learnt the value of having academic partners, and we wish Brian well in his new role.

The Blond McIndoe Research Foundation (BMRF) closed its laboratories at the end of 2016. This was a sad day for research at the QVH. The laboratories have been on the QVH site for many years, and there have been many successful projects between the BMRF scientists and our clinicians during this time. However the BMRF have now changed the way that they support research. They are moving towards becoming an independent grant-awarding body, rather than undertaking research within their own laboratories. I am glad to say that the QVH has been one of the first recipients of funding from the reborn BMRF. They have kindly made a substantial grant to support the work we have been doing to collect discarded scar tissue in an attempt to understand why patients develop scars. We hope this will be the start of a new and successful collaborative relationship.

Julian Giles
Clinical Lead for R&D
Consultant Anaesthetist

Highlights

- QVH has had an extremely successful year for activity in National Portfolio research studies. We have significantly increased the number of participants recruited into these studies, as well as increasing the overall number of studies we are involved in. Recruitment increased from 55 in 2015-16 to 352 in 2016-17, with the number of Portfolio studies increasing from 6 to 26. This reflects a major strategic push to develop our Portfolio activity. We also have several major studies in the pipeline for 2017-18, so expect this boost in recruitment to continue.
- The Trust had six fully grant-funded studies ongoing in 2016-17. We are a collaborator on an MRC (Medical Research Council) grant with the University of Brighton for an award to develop novel infection detection dressings. The grant was worth £1.2 million across all partners.
- We are also the holder of a prestigious NIHR i4i grant, for which Charles Nduka was the lead applicant. This was a collaborative effort with the University of Nottingham Trent and a commercial partner (Emteq), to fund a study to develop a new device to assist with the rehabilitation of facial palsy patients. The grant is worth a total of £846,000 across all three partners.
- The Anaesthetics Department, led by Dr Julian Giles, was engaged in an NIHR (National Institute for Health Research) RfPB grant-funded study (£79,688) looking at non-site-specific pain following breast surgery, whilst the Burns Department was working on a collaborative study with the BMRF (Blond McIndoe Research Foundation) funded by a grant from Sparks (£211,402**)** to look at the use of sprayed cells on paediatric burns. The grant supported the full-time salary of a PhD researcher.
- Our Burns Research Nurse Simon Booth has been working on an NIHR grant-funded MRes at the University of Brighton (£37,504), and further nurse (Liz Blackburn) is also undertaking an NIHR-funded MRes.
- The Trust currently has four Chief Investigators on National Portfolio research studies (Julian Giles, Baljit Dheansa, Simon Booth and Charles Nduka), and two members of NIHR faculty (Julian Giles and Charles Nduka). It is unusual for a Trust of our size to have either Chief Investigators or NIHR faculty on their staff.
- We have begun recruitment for a major new study looking at potential biomarkers in the role of scar formation. Funding has been secured for the purchase of lab equipment and materials necessary for the study, and for 4 days/week of a lab-based researcher to carry out the study.
- We have established a very successful programme of regular undergraduate projects with Brighton and Sussex Medical School. This year we hosted our seventh cohort of students, who spent nine months of their 4th year with us working on research/audit projects, supervised by QVH consultants. Their studies were all presented at our Research Day on Monday 27 June. Students have been greatly impressed with the support they have received at QVH, and the departments they have worked in have also benefitted from the energy students have brought to studies. These projects have also helped to foster closer links with our colleagues at BSMS.
- We were very fortunate to have two high-profile speakers at our seventh annual Research Day in June. Prof Isao Koshima (University of Tokyo Hospital) spoke to a packed audience about advances in microsurgery, and Prof Matt Costa (University of Oxford) presented the DRAFFT trial and changing clinical practice in UK trauma. Our Research Days are helping to build a multidisciplinary approach, and foster a culture where participation in R&D is a regular part of clinical life.
- The Trust is grateful for the continuing support of the CRN, who have awarded core funding to support a variety of research posts at the hospital. We are actively working with the CRN to grow research in Portfolio studies and to continue to improve set-up times.

Research Activity

The number of patients receiving NHS services provided or sub-contracted by the Queen Victoria Hospital NHS Foundation Trust in 2016-17 that were recruited during that period to participate in research approved by a research Ethics Committee was 365.

Participation in clinical research demonstrates QVH's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

QVH was involved in conducting 32 clinical research studies in 2016-17, as per the tables below.

Study ref in appendix	Study	Start date	CI/PI	Status	National Portfolio study	Recruit-ment in 2016-17
1	Epidemiology of Critical Care provision after Surgery (EpiCCS) - SNAP 2	21/03/17	Julian Giles	Closed	Yes	104
2	Implementation, impact & costs of policies for safe staffing		External	Registered	Yes	0
3	MindSHINE 3	20/03/17	External	Open	Yes	10
4	A nationwide survey of prosthetic eye users: a collaborative study with all NHS ocular prosthetic service providers.	21/02/17	Raman Malhotra / Emma Worrell	Open	No	0
5	Developing and validating a new self-report measure of compassion	27/01/17	Jenny Gu (External)	Open	Yes	17
6	Knowledge, attitudes and perceptions of 1. General practitioners 2. Junior doctors 3. Antimicrobial pharmacists 4. Dentists & nurses towards antimicrobial prescribing in England		External	Registered	Yes	0
7	Intraoperative Hypotension in Elder Patients (IHypE)	30/11/16	Julian Giles	Open	Yes	14
8	Ex-vivo Infection Detection - EVIDEnT	15/11/16	Simon Booth	Open	Yes	16
9	Evaluating the ten year impact of the Productive Ward		External	Registered	Yes	0

10	Antibiotic Levels in Burn wound Infection (ABLE)	01/09/16	Simon Booth	Open	Yes	8
11	EuPatch	01/07/16	Samer Hamada	Open	Yes	1
12	Informing the Development of Online CBT Materials for an Integrated Approach to Delivering CBT		External	Open	Yes	0
13	Mycobacterium szulgai infections - a case series from England and Wales		External	Open	Yes	1
14	WEB-RADR - Comparison of ADR reports received via Yellow Card app with casenotes		External	Open	Yes	0
15	Repurposing anti-TNF for treating Dupuytren's disease (RIDD)	03/10/16	External	Suspended	Yes	0
16	Investigation of Potential Biomarkers in the Role of Scar Formation	16/03/16	Baljit Dheansa	Open	No	5
17	Use and usefulness of patient experience data: national survey of patient experience leads in NHS acute trusts		External	Registered	Yes	0
18	A Study to Address Some Human Resource Planning/ Development Issues in the seven day NHS to Bridge Skill Gaps in Hospitals		External	Registered	Yes	0
19	A survey to provide baseline activity in relation to ward sister/charge nurse supervisory roles		External	Registered	Yes	0
20	SUBMIT	13/09/16	Asit Khandwala	Open	Yes	6
21	NexoBrid for children with thermal burns	24/05/16	Baljit Dheansa	Open	Yes	0
22	A study to refine the CAR burns scales	03/11/15	Simon Booth	Closed	Yes	16
23	Molecular mechanisms and pathways of chronic inflammatory and degenerative diseases. (Dupuytren's patients)	30/11/15	Loz Harry	Open	Yes	126
24	SILKIE	30/09/15	Simon Booth	Closed	Yes	33

25	Incidence of obstructive sleep apnoea risk in surgical patients	16/06/14	Tim Vorster	Suspended	No	0
26	Post-treatment Care Pathway in Long-term Head & Neck cancer	16/07/14	Brian Bisase	Closed	No	8
27	Molecular Genetics of Adverse Drug Reactions	31/01/12	Baljit Dheansa	Open	Yes	0

Study ref in appendix	Studies not involving patient recruitment in 2016-17	Start date	Principal Investigator
28	Extrinsic lingual muscle involvement by oral cancer	28/09/15	Bill Barrett
29	S100 and CD31 in tongue cancer	01/06/14	Bill Barrett
30	Molecular prediction of metastasis in oral tongue squamous cell carcinoma	19/07/12	Bill Barrett
31	Clinical evaluation of the effect that sprayed culture keratinocytes have on early wound healing in children (grant funded)	20/09/11	Baljit Dheansa

Study ref in appendix	Studies fully recruited and in follow up during 2016-17	Start-date	Chief Investigator
32	The effectiveness of Lugols Iodine to assist excision of marginal dysplasia at resection of oral and oralpharyngeal squamous carcinoma	10/07/12	Paul Norris

Involvement in NIHR Portfolio studies

Accruals for NIHR Portfolio studies are recorded and monitored via a national database, and the level of CRN funding received by the Trust is partly determined by accrual figures. In a very pleasing development, the number of Portfolio participants recruited greatly exceeded the number of non-Portfolio, reflecting a strategic push to increase the proportion of Portfolio studies we undertake.

QVH recruited **352** Portfolio participants in 2016-17 – up from 55 the previous year.

Funding

Grant funding

The Trust had six fully grant-funded studies ongoing in 2016-17. We are the proud holder of a prestigious NIHR i4i grant, for which Charles Nduka was the lead applicant. This was a collaborative effort with the University of Nottingham Trent and a commercial partner (Emteq), to fund a study to develop a new device to assist with the rehabilitation of facial palsy patients. The grant is worth a total of **£846,000** across all three partners.

We are also a collaborator on a MRC (Medical Research Council) grant application with the University of Brighton for an award to develop novel infection detection dressings. The grant was worth **£1.2 million** across all partners, with **£19,403** for QVH.

The Anaesthetics Department, led by Dr Julian Giles, was engaged in an NIHR RfPB grant-funded (**£79,688)** study looking at non-site-specific pain following breast surgery, whilst the Burns Department was working on a collaborative study with the BMRF funded by a grant from Sparks (**£211,402)** to look at the use of sprayed cells on paediatric burns. This grant supported the salary of a PhD researcher.

Our Burns Research Nurse Simon Booth was working on an MRes at the University of Brighton, funded by an NIHR grant for **£37,504**, and a further nurse (Liz Blackburn) was also engaged on an NIHR-funded MRes (also with full salary cover).

Core funding

The CRN awarded the Trust **£65,541** core funding in 2016-17, **£7500** flowthrough funding, and **£3014** contingency funding. The CRN determined the level of funding using an algorithm based on the number of patients recruited to Portfolio studies over the previous two years. This activity-based funding formula is a key driver for how research work is prioritized at QVH.

Funding was allocated according to CRN guidelines in the following way:

Resource	Staff	Name	Allocation
Research Practitioner	Debbie	Weller	34,766
Research Nurse	Simon	Booth	15,177
Research Nurse	Gail	Pottinger	2367
Consultant	Julian	Giles	4657
Consultant	Loz	Harry	3014
Clinical Trials Pharmacist	Judy	Busby	1668
R&D Manager	Sarah	Dawe	10,678
Training			214
Office expenses			187
Travel			341
Overheads			2986

The Trust also received **£4,500** from the Brighton and Sussex Medical School to support the IRP students who undertake fourth-year research projects at the hospital.

Commercial and other external study funding

Further income was received for undertaking external trials in 2016-17 as follows:

External study	Income (£)

Thea	2821
Nexobrid	3314
Silkie	8755
RIDD	5300

Charitable Funding

The Blond McIndoe Research Foundation generously provided funding for a 0.8WTE Research Technician to work on a study investigating potential biomarkers in the role of scar formation.

Publications

Within the R&D Community we have often struggled to understand how we define the role of 'development'. Development is clearly important, but what is it and how we define its success is more difficult. One way of considering what development might be is to consider how things we do at the QVH affect people elsewhere. The QVH has long influenced the way that care is delivered within the broader health care community. Our influence extends far beyond the confines of East Grinstead.

At the suggestion of James Gardiner, one of the much valued lay members of the R&D Governance Group, we have included a synopsis of the publications that the clinicians at the QVH have contributed to in the last year. We consider that this provides some measure of how we help to develop excellent care. The 'gold standard' for research is usually considered to be a controlled clinical trial. We are pleased to say that the QVH is heavily involved in clinical trials. We develop 'home grown' studies and we also act as a centre for 'multi-centre' clinical trials. However, research trials are only the tip of the iceberg. Evidence-based healthcare also relies on people producing high quality publications that describe things such as case series, editorials, and the drawing up of guidelines by acknowledged experts. I am happy to say that all these types of publication are represented in the list below. As you will see many of these publications are not purely 'research' but often showcase how the ideas developed at the QVH can affect the way care is delivered far more broadly.

Cooper L, Lui M, Nduka C. Botulinum toxin treatment for facial palsy: A systematic review. J Plast Reconstr Aesthet Surg. 2017 Jun;70(6):833-841. doi: 10.1016/j.bjps.2017.01.009. Epub 2017 Feb 16. Review. PubMed PMID: 28389084.

Hussain A, Nduka C, Moth P, Malhotra R. Bell's facial nerve palsy in pregnancy: a clinical review. J Obstet Gynaecol. 2017 May;37(4):409-415. doi: 10.1080/01443615.2016.1256973. Epub 2017 Jan 31. PubMed PMID: 28141956.

Cooper L, Mosahebi A, Henley M, Pandya A, Cadier M, Mercer N, Nduka C. Developing procedure-specific consent forms in plastic surgery: Lessons learnt. J Plast Reconstr Aesthet Surg. 2017 Mar;70(3):428-430. doi: 10.1016/j.bjps.2016.11.015. Epub 2016 Nov 26. PubMed PMID: 27964830.

Ziahosseini K, Venables V, Neville C, Nduka C, Patel B, Malhotra R. Occurrence and severity of upper eyelid skin contracture in facial nerve palsy. Eye (Lond). 2016 May;30(5):713-7. doi: 10.1038/eye.2016.21. Epub 2016 Mar 4. PubMed PMID: 26939561; PubMed Central PMCID: PMC4869134.

Malhotra R, Ziahosseini K, Litwin A, Nduka C, El-Shammah N. CADS grading scale: towards better grading of ophthalmic involvement in facial nerve paralysis. Br J Ophthalmol. 2016 Jun;100(6):866-70. doi: 10.1136/bjophthalmol-2015-307167. Epub 2015 Oct 15. PubMed PMID: 26472405.

Neville C, Aslett M, Venables V, Nduka C, Kannan R. An objective assessment of Botulinum toxin type A injection in the treatment of post facial palsy synkinesis and hyperkinesis using the Synkinesis Assessment Questionnaire (SAQ). Journal of Plastic Reconstructive & Aesthetic Surgery · June 2017. DOI: 10.1016/j.bjps.2017.05.048

Mavridou, I., McGhee, J. T., Hamedi, M., Fatoorechi, M., Cleal, A., Ballaguer-Balester, E., Cox G, Nduka, C. FACETEQ interface for emotion expression in VR. In Virtual Reality (VR), 2017 IEEE (pp. 441-442). IEEE.

Br J Oral Maxillofac Surg DOI: http://dx.doi.org/10.1016/j.bjoms.2017.04.014 Care of long-term survivors of head and neck cancer after treatment with oral or facial prostheses, or both. E. Worrell, L. Worrell, B. Bisase

J Laryngol Otol. 2016 May;130(S2):S83-S89 Oral cavity and lip cancer: United Kingdom National Multidisciplinary Guidelines. Kerawala C, Roques T, Jeannon JP, Bisase B

Int J Surg Pathol 2016 Sep 12. Epub 2016 Sep 12. Dentigerous Cyst and Ameloblastoma of the Jaws: Correlating the Histopathological and Clinicoradiological Features Avoids a Diagnostic Pitfall. Andrew W Barrett, Kenneth J Sneddon, John V Tighe, Aakshay Gulati, Laurence Newman, Jeremy Collyer, Paul M Norris, Darryl M Coombes, Michael J Shelley, Brian S Bisase, Rachael D Liebmann

Br J Oral Maxillofac Surg 2015 Sep 29. Epub 2016 Sep 29. Current surgical management of metastases in the neck from mucosal squamous cell carcinoma of the head and neck. Ben Green, Brian Bisase, Daryl Godden, David A Mitchell, Peter A Brennan

Head and neck sarcomas: A single institute series. Vassiliou LV, et al. Oral Oncol. 2017. Vassiliou LV, Lalabekyan B, Jay A, Liew C, Whelan J, Newman L, Kalavrezos N.

Transoral laser microsurgery versus radiation therapy in the management of T1 and T2 laryngeal glottic carcinoma: which modality is cost-effective within the UK? Prettyjohns M, et al. Clin Otolaryngol. 2017.

Prettyjohns M, Winter S, Kerawala C, Paleri V; the NICE cancer of the upper aerodigestive tract guideline committee. Robinson M, Bhide S, Capel M, Cox L, Fenlon M, Newman L, Orr S, Roques T, Smith A, Spraggett S, Talwar B, Thavaraj S, Thornton J, Wong WL.

Mucosal melanoma of the upper airways tract mucosal melanoma: A systematic review with meta-analyses of treatment. Jarrom D, et al. Head Neck. 2017. Jarrom D, Paleri V, Kerawala C, Roques T, Bhide S, Newman L, Winter SC.

Dentigerous Cyst and Ameloblastoma of the Jaws. Barrett AW, et al. Int J Surg Pathol. 2017. Barrett AW, Sneddon KJ, Tighe JV, Gulati A, Newman L, Collyer J, Norris PM, Coombes DM, Shelley MJ, Bisase BS, Liebmann RD.

Inflammatory pseudotumour of the maxilla. Kichenaradjou A, et al. Oral Maxillofac Surg. 2016. Kichenaradjou A, Barrett AW, Norris P, Rowell N, Newman L.

Current Concepts in Osteoradionecrosis after Head and Neck Radiotherapy. Dhanda J, et al. Clin Oncol (R Coll Radiol). 2016. Dhanda J, Pasquier D, Newman L, Shaw R.

Efficacy, outcomes, and complication rates of different surgical and nonsurgical treatment modalities for recurrent/residual oropharyngeal carcinoma: A systematic review and meta-analysis. Jayaram SC, Muzaffar SJ, Ahmed I, Dhanda J, Paleri V, Mehanna H. Head Neck. 2016 Jul

Current Concepts in Osteoradionecrosis after Head and Neck Radiotherapy. Dhanda J, Pasquier D, Newman L, Shaw R. Clinical Oncology (R Coll Radiol). 2016 Jul 28(7):459-66.

The Molecular Biology of Head and Neck Cancer. Dhanda J, Shaw RJ In: Maxillofacial Surgery. Brennan et al (Ed). 2017 3rd Edition. UK Churchill Livingstone

Facial Feminization Surgery. Altman K In: The Transgender Handbook: A guide for transgender people, their families and professionals. . Eds: Bouman WP, Arcelus, J. 2017. Nova Science Publishers. New York.

The Role of the Orthognathic Surgeon in Facial Feminization Surgery. Altman K. In: Orthognathic Surgery: Principles, Planning & Practice. Eds: Naini FB, Gill DS. 2017. Wiley Blackwell

Roxburgh, J., A. D. Metcalfe, and Y. H. Martin. The effect of medium selection on adipose-derived stem cell expansion and differentiation: implications for application in regenerative medicine. Cytotechnology 68.4 (2016): 957-967.

Masud, D., Moustaki, M., Staruch, R. and Dheansa, B., 2016. Basal cell carcinomata: Risk factors for incomplete excision and results of re-excision. Journal of Plastic, Reconstructive & Aesthetic Surgery, 69(5), pp.652-656.

Staruch, R.M.T., Jackson, P.C., Hodson, J., Yim, G., Foster, M.A., Cubison, T. and Jeffery, S.L.A., 2016. Comparing the surgical timelines of military and civilians traumatic lower limb amputations. Annals of Medicine and Surgery, 6, pp.81-86.

Sayma, M., Booth, S., Weller, D. and Dheansa, B., 2017. A retrospective study: Can we differentiate between repeat self-inflicted burn patients and those who commit a self-inflicted burn as an individual occurrence?. Journal of Plastic, Reconstructive & Aesthetic Surgery.

Gilleard, O., Walsh, K., King, I., Tsang, C., Rahman, S. and Dheansa, B., 2016. Evaluation of a new suture otoplasty technique. JPRAS Open, 7, pp.16-18.

Weir, A.G., Page, P.R. and Dheansa, B.S., 2016. Comparison of Short-Term Surgical Outcomes Between NHS and Private Sector Abdominoplasty Surgery. In Aesthetic Plastic Surgery of the Abdomen (pp. 523-526). Springer International Publishing.

Effect of Manuka Honey on Eyelid Wound Healing: a Randomised Controlled Trial
R Malhotra, K Ziahosseini, C Poitelea, A Litwin, S Sagili Ophthal Plast Reconstr Surg. 2016 Jul 13. [Epub ahead of print]

Can we improve the tolerance of an ocular prosthesis by enhancing its surface finish? AS Litwin, E Worrell, JCP Roos, B Edwards, R Malhotra Ophthal Plast Reconstr Surg. 2017 Mar 7. doi:10.1097/IOP.0000000000000891

Periorbital Autologous Fat Grafting in Facial Nerve Palsy. WF Siah, AS Litwin, C Nduka, R Malhotra. Ophthal Plast Reconstr Surg. 2017;33(3):202-208.

Emergency Eye Care of Post-surgical Facial Palsy - Technical Tip: External Weights to treat lagophthalmos. K Ziahosseini, V Venables, C Neville, C Nduka, R Malhotra. (Accepted J Neurol Surg B Skull Base – July 2016)

A hazard of hyaluronidase use for orbital blocks. P Tan, SM Ali, R Malhotra Anaesthesia. 2016 Aug;71(8):988-9. doi: 10.1111/anae.13597.

Orbital exenteration: review of indications, technique and complications. S Sagili, R Malhotra (Accepted Expert Review of Ophthalmology-May 2016)

Infrastructure

The R&D Department presently consists of one Clinical Lead for R&D, one R&D Manager (0.66WTE) and one Research Governance Officer (13.8 h/wk).

Funding was received from the Comprehensive Research Network (CRN) to help support the R&D Manager's post. Other income to support the R&D infrastructure comes from commercial studies, which in addition to paying general Trust overheads, pay a fee for R&D Department services in handling their applications and setting up contracts.

Clinical Research Staff

In 2016-17, the Trust supported one Burns Research Nurse (0.5WTE), one Lead Research Nurse (0.5WTE) and one 1WTE Research Practitioner.

The Anaesthetics Dept has one Research Registrar (0.2WTE). These have traditionally been funded out of clinical budgets, but increasing support for them is being obtained from grant awards.

The Trust supported two MRes students in 2015-16, funded by grant awards. The students were registered at the University of Brighton.

Some clinical departments also each have their own arrangements for Research Fellows, which are funded by the departments themselves and which are not managed by the R&D Department.

Comprehensive Research Network (CRN)

The Trust is a member of the Surrey, Sussex and Kent Comprehensive Research Network (CRN). We work with the CRN to maximize opportunities for Portfolio studies, identify new studies the Trust may participate in, and implement new national systems and structures. The CRN distributes R&D resources amongst its members according to an activity-based algorithm. The Clinical Lead for R&D sits on the CRN Partnership Board, and the R&D Manager regularly attends local meetings, working closely with their Chief Operating Officer and the Lead Research Management & Governance Manager. Meeting CRN targets is a priority area for the Trust.

CRN targets

National targets have been introduced to stretch and improve performance, with a variety of metrics being measured. Study set-up time and time to first recruit and were tracked according to national metrics, with regular data returns made to both the CRN and the NIHR. These reports are made publically available on the QVH website.

QVH has performed extremely well on these high level objectives, with a mean time from Date Site Selected to Date Site Confirmed (local QVH approval) of **13 days** in 2016-17.

Intellectual property

The Trust has engaged the services of NHS Innovations South East to assist with commercializing and developing its intellectual property, and this year they have been advising us on royalties for a tracheostomy dressing device originally developed at QVH.

Consumer involvement

QVH continues to work to find meaningful ways to involve patients and members of the public in its research activity. We are fortunate to have on our R&D Governance Group two very involved patient representatives, who take an active role in advising on and monitoring the research activities of the Trust. Patients are also often involved in the early stages of research projects via focus groups, who feed into protocol development. We have set up a Research Panel which has been established to suggest as well as review new research ideas for the QVH as they are being formulated. Work has also been undertaken on raising patient awareness of research via a publicity campaign, with features on local radio & television, in newsletters (QVH News, Research & You). We have also used leaflets, posters and videos within the hospital to inform patients and the public of the research we do.

Training and Development

The Trust supported (via grant awards) two nurses to undertake MRes courses at the University of Brighton, and one (grant funded) PhD student, also registered at the University of Brighton.

Local Training

Individual training tailored to the individual is provided by the R&D Department to all new researchers who require guidance developing their protocols, navigating the approvals process and setting up their studies. We are fortunate to have the additional help of Claire Rosten from the University of Brighton, who has provided us with invaluable advice on study design, methodology and putting together grant applications.

It is a legal requirement that all staff involved in clinical trials complete Good Clinical Practice (GCP) training, and the Trust has facilitated this for staff – either by providing an onsite trainer, enabling access to off-site courses at other Trusts, or by paying for staff to do an individual online course. One member of staff is a qualified GCP trainer, and also runs courses outside the Trust on behalf of the CRN. Commercial companies also regularly run refresher GCP courses for staff involved in the clinical trials they run at the Trust.

The R&D Manager regularly attends induction to speak to all new clinical recruits. They are all issued with an R&D pack which includes all up to date R&D policies. This is a useful forum to quickly identify trainees who are interested in R&D, and provide them with guidance and assistance.

CRN training

The Trust also has access to training provided by the CRN for any studies which are accepted onto the National Portfolio. These mainly focus on GCP training, but training is also provided for research nurse skills.

Annual Trust R&D Day

We were delighted with the success of our seventh Trust R&D Day on 27 June 2016, which featured two very high profile speakers - Prof Isao Koshima (University of Tokyo Hospital) and Prof Matt Costa (University of Oxford), as well as showcasing current and planned studies from QVH staff, and studies undertaken by Brighton and Sussex Medical School IRP students. These meetings have proved to be very popular with clinicians from all departments. The full programme was as follows:

- BSMS IRP student presentations (Benjamin Moxley-Wyles; Syed Naqib; Dhiraj Sharma; Parviz Sorooshian) and Prize Giving
- University of Brighton translational research (Bhavik Patel, Colin Smith, Greg Scutt)
- Prof Isao Koshima (University of Tokyo Hospital)

- Prof Matt Costa (University of Oxford) – The DRAFFT trial and changing clinical practice in UK trauma
- University of Brighton and QVH joint projects (Simon Booth, Diana Alves)
- QVH research groups updates (Sue Catt, MJ Hallam, Jag Dhanda, Charles Nduka)

Departmental research meetings

Individual departments also run their own Audit & Research meetings, providing a forum to discuss new ideas and present completed studies.

Research Design Service

Our Research Design Service (RDS) at the University of Brighton provides a good service in training staff in RfPB grant applications, and supporting individual researchers on a one-to-one basis.

NIHR faculty membership

Julian Giles has been made a member of the faculty of the National Institute for Health Research (NIHR), by virtue of his successful grant application to the NIHR RfPB funding stream. Charles Nduka is also a member of faculty, following his NIHR i4i award.

Governance Structure

R&D at the Trust is managed via a Research & Development Governance Group. Its members include: Clinical Lead for R&D, Chief Pharmacist/Clinical Trials Pharmacist, Anaesthetics Lead, Burns Lead, Corneoplastics Lead, Hand Surgery Lead, Maxillofacial Lead, Director of Nursing, Oncoplastics Lead, Healthcare Science Lead, Orthodontics Lead, R&D Manager, Finance Dept representative (R&D budget accountant), Designated Individual with responsibility for Human Tissue Authority license, External academic advisor from the BMRF, External academic advisor from BSMS, and two External academic advisors from the University of Brighton. The Group also has two very active patient representatives who play a valuable role in advising on new projects.

The R&D Governance Group reports to the Quality and Risk Committee, and the R&D Manager provides a presentation to them once annually.

The Director of Nursing acts as the Trust's Nominated Consultee for research participants unable to consent.

***Trust policies which cover R&D*:**
Adverse Event Reporting Policy, Research Fraud Policy, Code of Practice for Researchers, Pharmacy policy for Clinical Trials, Intellectual Property Policy, Overheads Policy. In addition, we have a comprehensive range of Standard Operating Procedures, in line with national guidance, to ensure consistency in our approach to R&D approvals: P02-Manage Study Participating Planning Tool v1; PO3 Confirm Study Approvals v1; PO4 Setup and Control External Agreements v1; PO5 Setup and Control Internal Agreements v1; PO6 Setup and Control Study Processes v1; PO7- Give NHS Permission v1; PO8-Oversee Study v1; S04-Ensure Study Funding and Approvals are Managed v1; S05-Manage Study Sponsor Planning Tool v1; S06-Give Decision on Sponsoring v1; S07-Provide and Manage External Agreements v1; S08-Ensure NHS Permission is Received by the CI v1; S09-Ensure Study Oversight v1; S10-Ensure Study Closedown is Managed v1.

R&D approvals

The Trust uses national systems to manage studies in proportion to risk, and has adopted the Research Support Services framework recommended Standard Operating Procedures (SOPs). The R&D Dept provides extensive guidance with using the national IRAS applications system. Researchers are given bespoke one-to-one support with their applications.

There are national CRN targets for the processing of R&D applications (40 days from the receipt of valid research application; 30 days from local approval to first recruit. QVH approval times for clinical trials and for commercial studies are reported quarterly to the NIHR, and published on the QVH website.

QVH has highly effective and efficient research approvals systems. Our mean time from receipt of valid application to local approval (Confirmation of Capacity and Capability) for all studies was **13 days** in 2016-17. Mean time to recruit of first participant for all studies that recruited in 2016-17 was **37 days** – this included one outlier study (148 days) which has been extremely difficult to recruit to nationally. The median time to first recruit from local approval was **26 days** for all studies that recruited in 2016-17.

Sponsorship status

Some research carried out at QVH is investigator-led ie designed and conducted by our own staff, and these require the Trust to provide structures to support pre-protocol work and peer-review, as well as the subsequent management of active projects. We currently have three Chief Investigators at the Trust who have initiated QVH-Sponsored National Portfolio studies, as well as several Chief Investigators on non-Portfolio studies.

No research study may begin in the NHS without a Sponsor being identified. The Trust continues to offer its researchers the benefits of providing Sponsor status for the studies they initiate. QVH believes that it is right to support its researchers in developing new projects, and to encourage the spirit of intellectual enquiry, and so continues to provide Sponsorship status for all non-CTIMPs plus phase IV CTIMPs. The Trust's capacity for R&D, and it's commitment to research, is clearly stated in its official RDOCS (R&D Operating Capability Statement), which is a publically available document endorsed by the Board and published on the QVH website, according to national guidelines.

Registered Research & Development projects (with HRA Approval) ongoing in 2016-17

1. **Epidemiology of Critical Care provision after Surgery (EpiCCS) - SNAP 2**
   Principal Investigator: J Giles
   Status: Closed
   EpiCCS will describe the epidemiology of perioperative risk and outcome, and critical care referral and admission after inpatient surgery in the UK. A secondary aim is to estimate the clinical effectiveness of planned postoperative critical care admission as an intervention to reduce postoperative morbidity.
   EpiCCS will be a prospective observational cohort study.
   Data will be collected by perioperative anaesthetists on all patients undergoing inpatient surgery in participating UK hospitals for one week. Postoperative morbidity will be recorded for patients who remain in hospital on Day 7 after surgery. In a sub-group of patients, quality of recovery will also be recorded on Day 3, both for inpatients and for those already discharged from hospital (through telephone interview). Mortality data will be collected through linkage facilitated by the HSCIC. The dataset will also include patient risk factors, and questions about clinical decision-making and resource availability related to critical care referral and admission.
   The epidemiology of perioperative risk stratification, postoperative care and patient outcome will be described. Multivariable regression, instrumental variable and propensity score

matched analyses will be conducted to ascertain the clinical effectiveness of postoperative critical care admission in reducing adverse outcomes after inpatient surgery.

2. **Implementation, impact & costs of policies for safe staffing**
   Principal Investigator: External
   Status: ongoing
   The Francis Inquiry highlighted the lack of evidence-based decisions on nurse staffing as a factor contributing to poor care and higher death rates at Mid-Staffordshire. He recommended that the research evidence be used by NICE (the National Institute For Health and Care Excellence) to develop guidance on safe nurse staffing levels. Guidance for acute adult wards was published in 2014. NICE also endorsed the Safer Nursing Care Tool (SNCT), which estimates nursing staff requirements for acute hospital wards by assigning patients to one of five categories, based on how ill they are and the typical time taken to care for similar patients (known as 'dependency').

   Our study will examine implementation of safe staffing policies in the NHS. We will undertake a national survey to identify how implementation of safe staffing approaches have varied. At four case study sites we will examine implementation in more depth, using economic and qualitative methods. We will look at how patients' need for nursing care, as measured by the SNCT, varies from day to day and compare it to actual staffing, and explore the costs and consequences of different approaches

3. **MindSHINE 3**
   Principal Investigator: External
   Status: Open to recruitment
   Stress, anxiety and depression are significant causes of sickness absence among NHS employees, and contribute to the NHS having higher rates of sickness absence than any other public sector organisation in the UK. The effects of psychological distress not only impact healthcare workers as individuals, but can also have negative consequences for their patients via a compromised quality of care.

   The term mindfulness refers to a specific way of paying attention, non-judgmentally, to present moment experiences. The development of mindfulness skills is considered to lead to a number of therapeutic benefits including increased compassion for oneself and others, and reductions in negative emotional states. A wealth of empirical research supports the effectiveness of mindfulness-based interventions (MBIs) among both clinical and non-clinical populations. More specifically, recent research reports significant benefits of traditionally delivered, face-to-face MBIs among NHS employees, and mindfulness-based self-help (MBSH) among medical students. Especially when considering the limited number of qualified practitioners available to deliver face-to-face MBIs, and the 24/7 nature of NHS working hours, MBSH may offer particular potential among NHS employees in terms of flexibility, accessibility and cost-effectiveness.

   The proposed Randomised Controlled Trial (RCT) is primarily intended to investigate the effectiveness of smartphone-delivered MBSH intervention 'Headspace' in reducing stress among NHS staff. A large sample of NHS staff will be randomly allocated to receive either Headspace or an active control condition (NHS website for work-stress). The RCT will also aim to answer questions relating to the effectiveness of Headspace in improving other markers of psychological well-being and psychological distress, sickness absence, and compassion. Objective and subjective measures of engagement will be taken, and mediation and moderation analysis will be conducted in order to establish the processes and factors influencing MBSH engagement and outcomes.

4. **A nationwide survey of prosthetic eye users: a collaborative study with all NHS ocular prosthetic service providers.**
   Principal Investigator: R Malhotra

Status: open
Patients who wear an ocular prosthesis often suffer with dry eye symptoms. Up to 90% will also complain of socket discharge, many on a daily basis. No literature exists on their quality of life post eye loss or adapting to monocular vision. Psychometric questions from the National Eye Institute Visual Functioning Questionnaire, investigate the patient's quality of life and how the loss of an eye has impacted on patients' well-being.
Participants receive a questionnaire covering aetiology, length of prosthetic eye use, length of eye wear, age of prosthesis, cleaning regime, lubricant use, inflammation, comfort and discharge. Lower scores relate to a better-tolerated prosthesis. Is there an association between deposit build up, frequency of ocular polish, to socket discharge and dry eye symptoms? A series of quality of life questions probe the effects of monocular vision on day-to-day activities, hobbies, driving and how each patient regards their own general health after the loss of an eye.

5. **Developing and validating a new self-report measure of compassion**
Principal Investigator: External
Status: ongoing
Compassion is defined as consisting of the following five elements: (1) recognising suffering, (2) understanding the universality of suffering in human experience, (3) feeling moved by the person suffering and connecting with their distress, (4) tolerating uncomfortable feelings aroused (e.g. distress, anger, fear) so that we remain open to and accepting of them in their suffering, and (5) acting or being motivated to act to alleviate suffering. This definition of compassion was put forward following a review of theoretical conceptualisations of compassion. As part of the same review paper, the authors also systematically reviewed questionnaire measures of compassion and concluded that none of the existing measures comprehensively captured the construct and many had poor or inadequately tested psychometric properties. The current project aims to address the omission in the literature and develop a new, psychometrically-robust questionnaire measure of compassion, both towards the self and towards other people. Participants will be 1,300 NHS employees working in an NHS Trust in the Kent, Surrey, and Sussex region.

6. **Knowledge, attitudes and perceptions of 1. General practitioners 2. Junior doctors 3. Antimicrobial pharmacists 4. Dentists & nurses towards antimicrobial prescribing in England**
Principal Investigator: External
Status: ongoing

7. **Intraoperative Hypotension in Elder Patients (IHypE)**
Principal Investigator: J Giles
Status: Closed
Blood pressure falling during an operation is very common, particularly in those aged over 65. Despite this, there is no widely agreed definition on what blood pressure values constitute a 'low' reading and there remains some uncertainty over when to treat it despite the existence of national guidelines. The purpose of this study is to describe the lower limit of blood pressure encountered during surgery in those aged greater than 65 in the UK. It may be possible that managing blood pressure differently in the future might reduce strain on different body systems, including the kidneys, heart and brain.
This study involves the analysis of data routinely collected during normal clinical care. No additional treatments, observations or tests are being made. Routine information about health will be noted including: medicines, method of anaesthesia, operation, blood pressure as well as evidence of strain to the kidneys or heart from the results of routine postoperative blood tests.

8. **Ex-vivo Infection Detection - EVIDEnT**
Principal Investigator: S Booth
Status: recruiting

Burn wound infections are difficult to diagnose. Diagnosis involves removing dressings, which may slow the healing process. A new dressing (SmartwoundT) may help to diagnose infection without needing to remove dressings, and capsules within the dressing will change colour if the number of bacteria in the burn wound indicate that it is infected. Before it is used with patients, we need to check whether the capsules can identify when bacteria are, or are not, present in wounds. This study will use samples from patients with and without infected wounds to check whether the capsules change colour in the presence of bacteria that are causing a wound infection. The samples will come from burn wound fluid (exudate) taken from used wound dressings, and from swabs and gauze used during normal care of patients with burns. Both adults and children with and without infected burn wounds, who attend one of four participating Burns Services will be asked to participate. Participants will be asked to consent to have their dressings kept by the study team once they have been removed during the course of their normal treatment, and for swab samples to be taken. From these a sample of exudate will be tested. Information will be recorded from participants' notes about their health, care, suspected presence of infection and need for antibiotics. Participants will be followed-up within 21 days, either as part of normal scheduled clinic visits or by phone, and will be asked about their wound healing and health status. The Smartwound dressing's ability to detect infection will be measured using visual assessment of colour change. Bacteria from the swab will be tested separately to confirm presence of infection. Findings from this study will indicate whether capsules are effective in detection of infection prior to studies into the development of their use in dressings.

9. Evaluating the ten year impact of the Productive Ward

Principal Investigator: External

Status: open

Our overall research question is whether the 'Productive Ward: Releasing Time to Care' programme (PW) has had a sustained impact at the clinical microsystem level in English NHS acute trusts since its introduction in 2007.

Clinical microsystems can be a team, practice, ward or clinical unit; this proposal focuses on a quality improvement intervention specifically designed to improve the efficiency of hospital wards. The PW programme aims to: (1) increase the proportion of time nurses spend in direct patient care, (2) improve experience for staff and patients, and (3) make structural changes to the use of ward spaces to improve efficiency in terms of time, effort and money. Consequently the PW has the potential to meet health needs (by improving the efficiency of care) and is directly concerned with the organisation and delivery of health care. The NHS Institute for Innovation & Improvement (NHSI) developed PW in 2005 and 2006 and first implemented it in England in 2007. It is a self-directed quality improvement (QI) toolkit consisting of three foundational or 'core' modules and eight process modules. In subsequent years, the PW has been adopted and implemented internationally.

Our study will identify and evaluate any sustained impacts and wider legacies of the PW in Trusts in England which have adopted the programme. We will explore how varying times of adoption ('early', 'late') and differing local approaches to implementation (e.g. whole hospital roll out, pilot wards) have shaped such impacts and/or wider legacies over the previous decade.

10. Antibiotic Levels in Burn wound Infection (ABLE)

Principal Investigator: S Booth

Status: Recruiting

Burn wounds have a high risk of developing infections. Oral or intravenous antibiotics are routinely given to manage such infection; however, the appropriate use of antibiotic therapy as a means of treating infection has become a topic of international debate due to rise in antimicrobial resistance (AMR). Several issues within the management of burn wound infection have led to the question of therapeutic levels being found in the burn wound. The most common antibiotic used, Flucloxacillin, belongs to a family of antibiotic known as Beta-

Lactam antibiotics. Unfortunately this group of antibiotics is known to bind to serum proteins in the blood, meaning a fraction of the original dose is available and active at treating infection. Secondly, the antibiotic needs to be transported to the area which needs treating. The body does this by transporting the drug through the blood; however, burn wounds have an impaired blood supply which would lead to the supposition that very low levels enter the wound. Furthermore, the wound environment may have an altered pH which may further prevent effective utilisation of the antibiotic as antimicrobials such as Flucloxacillin have a narrow band of acid/alkali that they can be effective in.
The main question that the study will answer will be whether we can find therapeutic levels of antibiotics in patients wounds, which are sufficient to treat the infection.
Participants will give consent to participate and then give a wound exudate swab and blood test to measure their levels of antibiotic. At each subsequent dressing change the wound swab and blood samples will be repeated until the participant finishes their course of antibiotics. This is likely to be up to a maximum of 4 blood samples and 4 additional wound swabs
The study population will be adults with burn injuries over and including 1% total body surface area who are being treated with antibiotics for suspected or confirmed infection.

11. EuPatch

Principal Investigator: S Hamada
Status: recruiting
Amblyopia (also called lazy eye) is the most common disease affecting vision in childhood. It affects between 2 to 5% of the population and 90% of visits to children's' eye clinics are for the purpose of treating amblyopia. Currently 30% of children treated for amblyopia do not reach normal vision after a year or more of treatment. Amblyopia is usually treated with glasses wearing and by patching the better eye.

There is controversy whether a long period of glasses wearing before patching, called refractive adaptation, helps in treating children with amblyopia. Refractive adaptation has not been tested in a randomised controlled trial, and currently we do not know how long children wear glasses each day.

The purpose of this study is to perform the first randomised controlled trial to test whether refractive adaptation before patching improves the number of successfully treated children with amblyopia. We will use electronic monitors to measure how much children wear their glasses and patches each day and will determine how this relates to their improvement in vision. We will also investigate whether different types of amblyopia respond better to different treatments.

12. Informing the Development of Online CBT Materials for an Integrated Approach to Delivering CBT

Principal Investigator: External
Status: open

13. Mycobacterium szulgai infections - a case series from England and Wales

Principal Investigator: External
Status: open

14. WEB-RADR - Comparison of ADR reports received via Yellow Card app with casenotes

Principal Investigator: External
Status: Open
At the moment reporting of adverse drug reactions by hospital personnel is mainly done by paper or through the web-based form. The aim of creating a new reporting tool, the app, is to increase reporting and to make reporting easy with the hope of gathering new information

about ADRs which will help to evaluate the benefit-harm of drugs. However, it is important to make sure that the reports received through the app capture the clinical data accurately. The following study will be aimed at investigating the accuracy and trustworthiness of reports received through the app. The live App data covers the whole of the UK. All adverse drug reactions reported through the Yellow Card app from patients and health care professionals (HCPs) nationally. HCPs will include pharmacists, doctors and nurse specialists. Depending on workload, the study team will investigate all reports, where the reporter agrees to supply extra information from patient case notes.

15. Repurposing anti-TNF for treating Dupuytren's disease (RIDD)

Principal Investigator: L Harry

Status: Suspended

Dupuytren's disease is a very common condition that causes the fingers to curl into the palm and can be extremely debilitating. In early disease hard nodules develop in the palm. There is no approved treatment for early disease. Once patients have established deformities, the diseased tissue can be removed surgically or cut using less invasive techniques such as a needle or an injection of an enzyme. However, recovery following surgery usually takes several months and the recurrence rates with the nonsurgical techniques are high.
We have unravelled the molecular mechanisms that start and maintain the disease process. Based on these findings we plan to test a drug currently approved for use in patients with rheumatoid arthritis. The drug will be injected directly into the diseased tissues in the palm to maximise it's effect. We will first conduct a small trial in 40 patients with established disease to determine the best dose inhibiting the activity of the cells responsible for the disorder (Part 1).
Next we will assess whether the drug at this dose prevents progression in 138 patients with early disease (Part 2). If effective, this will represent the first targeted therapy involving a simple injection for patient's with early Dupuytren's disease that will preserve hand function and avoid the need for surgery.

16. Investigation of Potential Biomarkers in the Role of Scar Formation

Principal Investigator: B Dheansa

Status: recruiting

The reason for the development of a scar is not clearly understood and the causes are multi-factorial. In simple terms, scarring may be a direct consequence of evolutionary changes that have lead to a rapid healing of the wound site in order to prevent infection. As a consequence of this speed of wound epidermal closure, the cells in the dermis of the skin are prone to produce inappropriate amounts of extracellular matrix molecules. It is this over production that leads to the formation of a scar.
The only example of scar-free healing is in utero. Surgery performed on a foetus in the third trimester (and these often save lives of unborn children) do not leave any traces of surgical intervention. A child is born without a scar. This amazing ability is lost shortly after birth and for the rest of adulthood, any post-traumatic event to the skin results in the production of a scar.

The Queen Victoria Hospital (QVH) is a regional centre for burns and plastic surgery. The hospital treats patients with acute wounds and those undergoing surgical reconstruction or scar revision. As part of this treatment scar tissue will often be removed and disposed of as clinical waste. This redundant scar tissue offers the possibility of developing a clearer understanding of the mechanisms of scar formation.

17. Use and usefulness of patient experience data: national survey of patient experience leads in NHS acute trusts

Principal Investigator: External

Status: Open

18. **A study to address some human resource planning/development issues in the seven day NHS to bridget sill gaps in hospitals**
Principal Investigator: External
Status: Open
An extensive analysis of the literature above led us to conclude that job re-design in a seven-day NHS will empower HCAs to perform skillfully, following a carefully designed/monitored skill-training package. This is exploratory research to generate data through structured interviews with health care assistants and their supervisors, as well as FGDs, observations and interactions with concerned professionals and recipients of services (patients and the public). The research questions are:

    a. How do HCAs experience nursing care as part of the skill-mix and modernisation strategies? What aspects of nursing care are needed in terms of a job re-design for HCAs and how far the modernisation strategy is replicable in an enriched job re-design for a seven-day NHS?

    b. How does the absence of clearly defined job descriptions for HCAs and registered nurses affect job satisfaction for HCAs and how this can be improved in a job re-design in seven day NHS?

    c. What new skills are needed by the HCAs to perform during weekends and evenings in an enriched job role?

19. **A survey to provide baseline activity in relation to ward sister/charge nurse supervisory roles**
Principal Investigator: External
Status: Open

20. **SUBMIT**
Principal Investigator: A Khandwala
Status: recruiting
Metacarpal fractures are common, accounting for 40% of all hand injuries and many can be treated non-operatively. However, surgery is reserved for cases in which an adequate reduction of both angular and rotational deformity cannot be maintained or where an adjacent ray is damaged.
A variety of surgical strategies exist, including percutaneous kirschner wiring, intramedullary fixation, and fixation with plate and screw construction. A plate secured along the dorsal midline of the metacarpal has been shown to be the best biomechanical method of fixation, and allows early aggressive hand therapy post-operatively.
Traditionally, bicortical fixation is the standard practice, where both dorsal and palmar cortices of the metacarpal are drilled though. However, such practice is not without risk. In this method, the flexor tendons and neurovascular bundles at risk from over-zealous drilling through the palmar cortice. Correct screw size selection is also critical as overly long screws can irritate and cause rupture of flexor tendon. More recently, with the advent of a new generation of locking plates, unicortical fixation, where only the near cortex is drilled, has been used to treat fractures. Unicortical fixation is a surgically less complex operation, can theoretically cause less damage to surrounding soft tissues and avoids the complications associated with incorrectly sized screws.
This trial aims to compares the functional outcomes and complications of patients having unicortical versus bicortical fixation for diaphyseal metacarpal fractures.

21. **NexoBrid for children with thermal burns**
Principal Investigator: B Dheansa
Status: recruiting
Nexobrid is a gel containing enzymes derived from the pineapple plant. These enzymes can remove or breakdown unhealthy tissue, thereby avoiding the need for surgery. Whilst

Nexobrid is approved for use in adults, it is currently not licensed for use in paediatric cases. The present study aims to assess the use of Nexobrid in children with deep burns between 1 and 30% total body surface area, versus standard of care.

22. A study to refine the CAR burns scales

Principal Investigator: S Booth

Status: PIC study

A burn injury can greatly impact upon a person's quality of life. In order to provide the most useful support it is vital for health workers such as doctors, nurses, psychologists and physiotherapists to know what are the most important issues to patients affected by burns. Therefore in collaboration with burn patients themselves, a survey has been developed which explores adult's experiences of living with a burn injury. The plan is for all adults that are seen in hospital for a burn injury to complete this survey, so health professionals can identify their support needs and their treatment progress.

We are asking adults living with a burn to complete this survey to test out the questions. The results of this study will help us shorten and refine the survey, so it can be used in burn units throughout the UK to provide the best possible care and support for patients and their families.

23. Molecular mechanisms and pathways of chronic inflammatory and degenerative diseases

Principal Investigator: L Harry

Status: recruiting

Using synovial tissue in explant cultures obtained from rheumatoid arthritic patients undergoing joint replacement surgery, the Kennedy Institute was the first research laboratory in the world to identify the pathogenic role of the inflammatory cytokine tumour necrosis factor alpha (TNF) in Rheumatoid Arthritis (RA). Biological therapies that block the function of TNF are now clinically proven and over one million people worldwide have been treated successfully with this drug. However, this is not a cure for RA, so current research activities at the Kennedy are aimed at understanding those events that trigger RA, and developing better therapies for this disease. Patients scheduled to undergo a surgical procedure as a result of arthritis or other inflammatory diseases, will be given the option to take part in our study. In addition waste tissue will be obtained from an amputation as a result of a traumatic injury and adipose as a result of an abdominoplasty. A qualified clinician / GCP trained team member will take written, informed consent prior to surgery. Waste tissue from surgery is collected in a sample pot and couriered to the Kennedy Institute. This waste tissue includes joints (cartilage and bone), periarticular tissue, connective tissue (muscle and fascia) and other soft tissue such as skin.

The tissue will be processed ex vivo to liberate single cell suspensions, which will then be cultured for up to 5 days or long term lines will be derived. Cell supernatants will be analysed for cytokine, MMP and other inflammatory mediators by ELISA and cell phenotype determined by Flow cytometry. In addition mRNA will be harvested and gene expression determined by TaqMan PCR. The histopathology of the tissue will also be looked at.

24. SILKIE - Can skin grafting success rates in burn patients be improved by using a low friction environment – a feasibility study?

Principal Investigator: B Dheansa

Status: closed

This study aims to find out if it is feasible to use low friction (slippery) sheets for burn patients requiring skin grafts.

Skin grafts are required to ensure healing after burns that are deeper or take longer than 21 days to heal. Each year approximately 1000 skin grafts are undertaken in England and Wales; 75% in adults and 25% in children (1). Around 20% will fail completely or partially, with some wounds needing re-grafting. Further surgery, taking skin from another part of the body, longer hospital stays and increased scarring are all consequences which can be distressing for patients and expensive for the NHS.

Graft loss can be caused by rubbing or stretching skin and moving new graft cells causing failure of attachment to the wound. Friction between dressings and bed sheets can cause

this rubbing or stretching causing shearing. If dressings and patients were able to slide over the sheet when the patient moves in bed, then the graft may have more chance of 'taking'. Reduced friction bed sheets are in use in the UK with premature babies and other patients to prevent pressure sores, but not yet in burns services.
Adult and paediatric patients with burns and scalds who are selected to undergo skin grafting to achieve healing after burn injury as part of normal clinical care and are nursed on sheets for at least one overnight hospital stay.

25. Quantifying the incidence of obstructive sleep apnoea (OSA) in a surgical cohort attending pre-assessment

Principal Investigator: T Vorster
Status: recruiting
OSA (obstructive sleep apnoea) is a condition that causes interrupted breathing during sleep as a result of a blockage or partial blockage to the airway. The resultant lack of oxygen causes the individual to come out of deep sleep in an attempt to restore normal breathing. This happens cyclically overnight and results in unrefreshed sleep. Symptoms can include loud snoring and regularly feeling tired during the day despite getting adequate sleep. We plan to screen all surgical patients for OSA using two validated screening tools called the STOP-Bang questionnaire and the Epworth Sleepiness Scale. Studies have shown that a STOP-Bang score of 4 or more OR an Epworth score of 12 or more is suggestive of OSA.

26. Post-treatment care pathway in long-term survivors of head and neck cancer with oral and/or facial prosthesis

Principal Investigator: N Ghazali
Status: recruiting
The study aims to understand the experience of the post-treatment pathway of care in a group of long-term HNC survivors; explore the impact of ablative HNC surgery; explore the perceived need of supportive care (i.e. allied health services, psychosocial care, peer support, and complementary care) both at long-term follow-up and, retrospectively, during treatment and at 2 years post-treatment; explore the usage of supportive care (i.e. allied health services, psychosocial care, peer support, and complementary care) at long term follow up, and retrospectively, during treatment and at 2 years post-treatment; and explore the outcomes of supportive care service usage valued by patients.

27. Molecular genetics of adverse drug reactions

Principle Investigator: B Dheansa
Status: open
Adverse drug reactions (ADR's) are a common cause of drug-related morbidity and may account for about 6.5% of all hospital admissions. A meta-analysis of studies performed in the USA has shown that ADRs may be the fourth commonest cause of death. ADRs are also a significant impediment to drug development, and a significant cause of drug withdrawal. The purpose of this research is to (a) identify patients with different types of adverse drug reactions; (b) using DNA obtained from blood or Saliva samples from these patients, identify genetic factors which predispose to adverse reactions. The net effect of our research will be the development of genetic tests which can help in predicting individual susceptibility to adverse reactions prior to the medication's administration. Patients with a pre-disposition to reacting adversely can be prescribed alternative medication of monitored more closely during their treatment. This will reduce the harm for patients and save valuable resources for the NHS.
We aim to recruit 250 cases for each reaction for a period of eight years throughout multiple sites in the UK. Specific adverse drug reactions we are looking at include:

- Statin induced myotoxicity, characterised by high CK
- Severe hypersensitivity reactions including Stevens-Johnson Syndrome and ToxicEpidermal Necrolysis
- Anaphylaxis induced by NMBA anaesthetics
- ACE inhibitor or ARB induced angioedema

- Taxane hypersensitivity
- Chemotherapy induced peripheral neuropathy
- Bleomycin induced lung toxicity
- Clozipine induced agranulocytosis or neutropenia
- Bisphosphonate-related osteonecrosis of the jaw
- Tenofovir associated renal injury
- Serious bleeds induced by warfarin or other anticoagulants

28. Extrinsic lingual muscle involvement by oral cancer
Principal Investigator: Bill Barrett
Status: ongoing

29. S100 & CD31 in tongue cancer (Perineural and vascular invasion in tongue cancer: is detection improved using markers for nerves and blood vessels?)
Principal Investigator: Bill Barrett
Status: ongoing
Microscopic invasion of nerves and blood vessels in oral cancer is an unfavourable prognostic indicator, but depends on the histopathologist sampling the tumour adequately and then identifying these features in tissue sections using routine haematoxylin and eosin (H&E) stains. There is evidence that suggests that staining the section for a marker of nerves (S100 protein) and the cells lining blood vessels and capillaries (CD31) increases the microscopic detection of perineural and vascular invasion by 52% and 12% respectively. Thus nerve and vascular invasion could be significantly underreported.

We are currently auditing the incidence of perineural and vascular invasion by cancers arising in subsites
within the oral cavity, and aim to assess the degree of underreporting, if any, in a sample of 60 cancers of the tongue. Thirty of these were originally reported as showing nerve invasion in the excision specimen, thirty were reported as negative. Only two were reported as showing vascular invasion.

30. **Molecular prediction of metastasis in oral tongue squamous cell carcinoma (external study)**
Principle Investigator: B Barrett
Status: ongoing
A cDNA microarray study carried out in Utrecht (Netherlands) discovered genetic differences between primary squamous cell carcinomas of the oral cavity and oropharynx that spread to the neck and those that do not. This work leaves the door open to genetic analysis of a tumour of the tongue that has yet to spread to the neck. It may be possible to check the genetic makeup of the tumour, using a combination of antibodies to help surgeons decide how likely a tumour is to spread to the neck and to decide whether or not a neck dissection operation or radiation to the neck is necessary. This could avoid unnecessary morbidity and mortality.
Patients with squamous cell carcinoma of the oral tongue are to be identified with at least 5 year follow up i.e. diagnosed before October 2004. Two groups are to be identified: those with spread to the neck, and those who did not develop spread to the neck. Case notes are to be reviewed and all clinical data and treatment, overall and event free survival are to be recorded. The histopathology slides and blocks of tumour archival material are to be identified will be used to make a tissue microarray. This is a research technique which allows for genetic analysis of samples to be done more quickly than routine techniques. No new samples collection or patient interventions are to be undertaken. The data will then be analysed to see which markers show differential expression between the two groups, or have relationship to overall and event free survival. These markers, used in combination, may be used in future prospective studies and in treatment planning.

31. **Clinical evaluation of the effect that sprayed culture keratinocytes have on early wound healing in children**
Chief Investigator: B Dheansa
Status: completed; grant funded study; PhD project
Data from patients between the age of 1 and 15 years who have suffered a burn injury and received treatment in the QVH Burns Unit will be used to establish a database of scarring severity following treatment for burn of scald injuries. The data to be stored will be photographs, records of skin colour and the speed of healing. The severity of scarring will be evaluated using the Internationally recognised Manchester scar scale which measures skin colour, scar contraction and skin smoothness and is a recognised measure of scarring. Additional information such as cause of burn, area and depth of burn, time to heal, area healed at each dressing change or prior to treatment and any complications will be assessed or measured and recorded. Other information including referral source, first aid administration, previous health problems, medication and employment status will also be collated for research purposes. Existing data in the form of photographs and Manchester scar scale score will also be used provided the patient has consented to the use of photographic images for research purposes using the consent form currently in use.

32. **A multi-centre, randomised controlled trial assessing the effectiveness of Lugol's Iodine to assist excision of moderate dysplasia, severe dysplasia and carcinoma insitu at mucosal resection margin of oral and oropharyngeal squamous cell carcinoma**
Principle Investigator: P Norris
Status: in follow-up
Research evidence suggests that persistence of precancer tissue at the edges of tissue resected to treat oral cavity and oropharynx cancer leads to greater risk of recurrence of cancer at the primary site.
Currently, tumour tissue can be distinguished clinically by the surgeon operating to remove cancer.
Unfortunately, detected precancer change in the tissue next to the cancer itself is much more difficult. This leads to precancer tissue persisting at the edges of the removed tissue in around a third of patients treated. We aim to test whether use of a staining method will enhance accuracy of removal of precancer tissue. Precancer cells are abnormal in many ways. One effect of the changes is that they cannot store glycogen. This means that they do no stain darkly with iodine, as normal tissue does. This difference may allow us to better identify these precancer cells at the time of cancer excision and so remove all precancer cells at the same time. This may reduce the risk of second primary cancers developing in the same area of the mouth and throat. This study will be a randomised, controlled, blinded trial. Patients will be randomised to have cancer resection with or without the staining method. We will then compare the proportion of cancers removed which have precancer cells at the edges in each of the groups. This will allow us to assess whether this method is effective in helping us to remove all of the precancer tissue.
The pathologist will assess resected cancer specimens in exactly the same way as it is carried out currently. They will not know which patients are in the staining group and so assessment of the effect of using the stain is blinded.

Planned projects: studies which had not been given approval as of 01/04/17, but which are expected to start in 2017

- Validation of the MIRROR facial expression tracking application in healthy subjects and facial paralysis patients
- FRAME – a study to validate a device to assist with facial palsy rehabilitation exercises
- RE-ENERGIZE – a study to look at the effect of glutamine on burns healing

- ICON – a study to investigate the use of Ciclosporin 1mg/ml eye drop emulsion for the treatment of severe keratitis in adult patients with dry eye disease
- A follow-up study to refine the CAR burns scales
- A study to investigate paediatric nail bed injuries
- Perioperative Quality Improvement Programme

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Committee – Finance & Performance Committee
Date last reviewed – August 30th 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, major risk
Residual Risk Rating 5 (C) x 3 (L) = 15, moderate risk

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 as described in F&P papers;
- Long term sickness levels in the Plastics team;
- Demand and Capacity issues in MaxFax alongside lack of PTL and visibility of waiting list at Medway with increased referrals due to the electronic referral service plus resumption of BSUH ENT list;
- Data capture from off site services is impacting upon demand and capacity planning;
- Capacity issues in referring trusts have a negative impact upon QVH as we get late referrals to this site plus where we provide services at spoke sites, we are constrained in providing extra clinics etc. as we do not own the estate, and the host trust will always prioritise their activity for any spare capacity

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;
- 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: 30th August 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 4 (C) x 4 (L)= 16, major risk
Residual Risk Rating 4(C) x 4 (L) = 16, major risk

Rationale for current score (at Month 04)

- Surplus £609k/£819k surplus plan (-0.8%)
- CIP forecast delivery - (C£0.35m gap)
- Finance & Use of resources – 1
  - Capital Service cover - 2
  - Liquidity -1
  - I&E Margin –1
  - I&E Margin Var from plan – 2
  - Agency Cap – 1
- STP variance to control total and operating plan risk

Rationale for residual score

- CIPP pipeline schemes identified to bridge the gap ; granular level planning underway.
- Recovery plans to address underlying position have been developed
- Forecast delivery in line with plan/ control total
- High risk factor – availability of staffing in particular nursing
- Commissioner challenge and scrutiny over existing arrangement
- Potential changes to commissioning agendas

HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY

- NHS Sector financial landscape
  - Regulatory Intervention
  - Autonomy
  - Capped expenditure process
- 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.

Gaps in controls / assurances

- Structure, systems and process redesign and enhanced cost control. **(DRR 880)**
- Carter Report Review and implementation
- Costing Transformation Programme – business case developed, approved and procurement underway.
- Enhanced pay and establishment controls including performance against the agency cap

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/09/17**		**Agenda reference:**	**150-17**	
Report title:	**Finance and performance assurance report**				
Sponsor:	John Thornton, Committee Chair				
Author:	John Thornton, Committee Chair				
Appendices:	NA				
Executive summary					
Purpose:	To provide assurance to the Board in relation to matters discussed at the Finance and performance committee on 24 July 2017, (noting there was no meeting in August)				
Recommendation:	The Board is asked to **NOTE** the contents of the report				
Purpose:	Assurance				
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance and performance committee				
	Date:	24/07/17	Decision:	For information	
Next steps:	N/A				

Report to: Board of Directors
Meeting date: 07 September 2017
Reference no: 151-17
Report from: John Thornton, committee chair
Report date: 25 August 2017

Finance and performance assurance report

1. Operational performance

There have been increasing service pressures in Plastics and Maxfacs due to a lack of capacity, and this is putting pressure on our ability to hit our RTT18 week target. The original plan was to hit the trajectory target by September but this is now in doubt. Work is being done to increase capacity by reviewing work schedules.

Validation of the Medway patient lists is still ongoing. If the current figures were included our performance would drop to low 80's against the target of 92%. Although there is no financial penalty this year for missing the 18-week target the team are still committed to achieving it.

On the 62-day cancer target there is some concern at the number of breaches linked to QVH pathways and at the number of breaches which only missed the target by a few days. Committee requested a further update and assurance on this target.

2. Workforce performance

Retention and recruitment of employees, especially in some key specialised areas, continues to be possibly the major challenge for QVH. June had more starters than leavers and we had over 60 candidates in the recruitment process. We have also received a good allocation of junior doctors in plastics. But turnover overall remains an issue.

The Trust had been invited to join the NHSI retention support programme workshop where the Trust with peer support formulated an action plan with the aim of reducing turnover within a defined period. The Board will receive more detail on this initiative.

Executive were challenged on whether enough was being done to invest in the skills and capabilities of our workforce beyond the mandatory training. Committee was advised that the there is still strong support for the 'leading the way' programme. But there was no core training budget and we need to capitalise on the apprentice levy. This issue will be partly covered by the board report on retention. The Committee reserved the right to revisit this topic following the board discussion.

3. Financial performance

The Trust achieved a strong surplus in June which helped us to meet our control total target for the first quarter overall and the related central payment.

The concern is that despite high levels of activity in some areas income was still below plan and was offset by a large under spend on pay. If net recruitment increased significantly and pay was in line with budget we would struggle to meet out required surplus unless we can grow our income. The key driver of under performance on income is weak performance in plastics. It isn't considered likely that the team can make up the shortfall but they have been challenged to deliver budget for the balance of the year.

Performance on other areas remains strong with a good cash position, good progress on the capital expenditure budget and some progress on CIPPs. We are rated 1 (strong) on the 'use of resources' target and at this stage of the year the executive team still think that the annual control total can be achieved.

4. Reference and Educational Costs Collection

For the first time the collection of this data has been combined. Committee was asked to confirm that it was satisfied with the collection process.

The process will be the same as recent years and hasn't changed since it was last audited by KPMG two years ago.

Committee gave its approval.

5. Performance dashboard update

EMT has been putting together an integrated performance dashboard covering the key metrics that we are measured against.

We discussed if the time involved would be justified by the value added. It was agreed that as this built on the reports used for the business unit reviews and were now common in other trusts we should continue to develop this tool.

The committee noted the progress made.

John Thornton
Chair

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	September 7th 2017	Agenda reference:	151-17		
Report title:	Operational Performance				
Sponsor:	Director of Operations – Sharon Jones				
Author:	Business Managers				
Appendices	Appendix 1: Trajectory Performance for 18RTT and 62CWT Appendix 2: Cancer Breaches				
Executive summary					
Purpose:	To provide assurance as to current operational performance				
Recommendation:	To note the report				
Purpose: [tick one only]	Approval ~~Y/N~~	Information ~~Y/N~~	Discussion ~~Y/N~~	Assurance ~~Y/N~~	Review ~~Y/N~~
Link to key strategic objectives (KSOs): [Tick which KSO(s) this recommendation aims to support]	KSO1: ~~Y/N~~ *Outstanding patient experience*	KSO2: ~~Y/N~~ *World-class clinical services*	KSO3: ~~Y/N~~ *Operational excellence*	KSO4: ~~Y/N~~ *Financial sustainability*	KSO5: ~~Y/N~~ *Organisational excellence*
Implications					
Board assurance framework:	**Controls / Assurance** • Regular access meeting reviews and forward planning activity/booking- includes Cancer; • Monthly business unit performance review meetings in place with a focus on exceptions, actions and forward planning; • Demand and Capacity planning ongoing; • Patient tracking lists accessible by all relevant managers; • Performance Dashboard in place; • New management structure in MaxFax/Plastics/Theatres which aligns the surgical management; • Productivity programme in place for theatres;				
Corporate risk register:	**Risks** • Not all spoke sites on QVH PAS so access to timely information can be limited plus some spoke sites have reporting issues; - 728 , 799 • Shared pathways for cancer cases with late referrals from other trusts; - Directorate Risk Register (DRR); • Demand and capacity modelling with benchmarking requires further development for each speciality (DRR); • Late referrals for 18RTT from neighbouring trusts, two of which are in special measures and others with severe pressures (DRR)				
Regulation:	CQC – operational performance covers all 5 domains and in particular:- • Are they effective? • Are they responsive to people's needs? • Are they well-led				
Legal:	The NHS Constitution, states that patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, (i.e. patients should wait no longer than 18 weeks from GP referral to treatment) or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'.				
Resources:	Nil above current resources				
Assurance route					
Previously considered by:	N/A				

Report to:	Board of Directors
Meeting date:	07 September 2017
Reference number:	151-17
Report from:	Sharon Jones, Director of Operations
Author:	Business Managers
Appendices:	Appendix 1: Trajectory Performance for 18RTT and 62CWT Appendix 2: Cancer Breaches
Report date:	21 August 2017

Operational Performance: Targets, Delivery and Key Performance Indicators

1. Diagnostic Waits

There was one diagnostic breach in Radiology in July related to an off-site CT scan. There were no diagnostic breaches in Sleep Studies. The trust therefore delivered 99.8% against the diagnostic target of 99% of patients to have their diagnostics completed within 6 weeks of referral.

2. Monitor 18 RTT Open Pathway Target

The Trust achieved 90.03% for June and 87% for July against the 92% target. There are several emerging and present service pressures in attaining and maintaining the trajectory. Some of these are small in number but high in impact due to our small denominator. These are as follows & in no order of importance:-

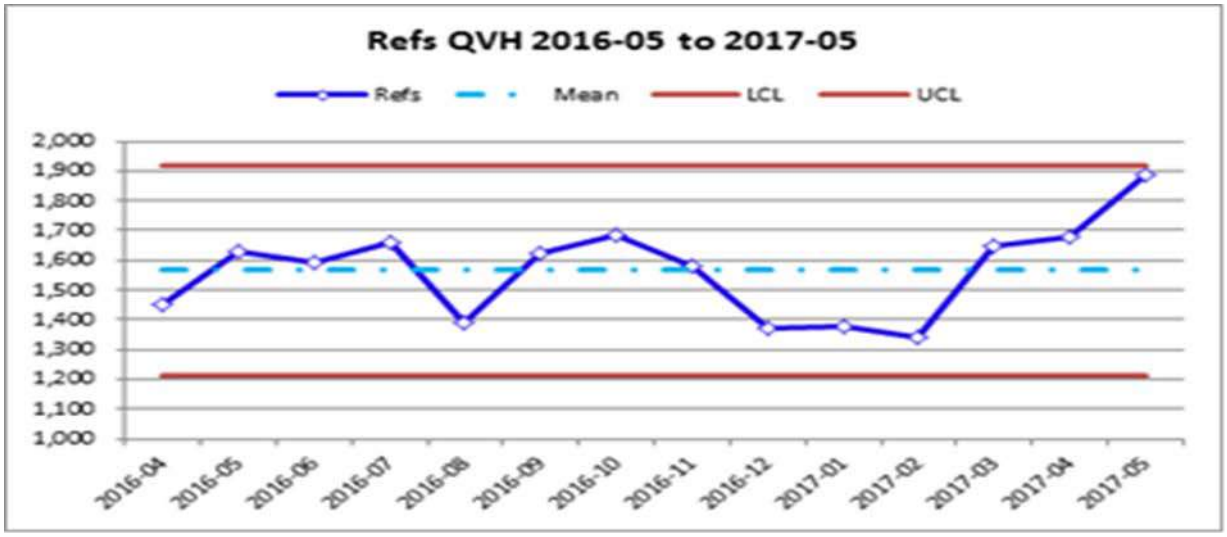
- Within plastics, as highlighted last month, there are a number of Consultants on long term sick leave across May, June, July & August.. Where possible, locums have been used but it has not been possible to source 100% cover due to availability and also, where there is cover, not all of the case mix has been fully covered. This is due to the specialist nature of our work and is particularly an issue in hands. There has been an accumulative impact of this, and so the pressure on 18RTT will continue to be shown in the next three months position which will mean a further deterioration prior to improvement. Planning is underway to regain performance, but is limited as firm return to work dates are not yet in place for all the consultants and phased return to work programmes;

- This has been against a backdrop of fewer juniors placed from the deanery and or a short gap between placements (in both max fax and plastics) which means a shift in the proportion of first appointments against follow up appointments to accommodate the grades and experience of the doctors. However, the rotas/placements improve from October;

- Referrals on the elective pathway into the trust have also increased significantly over the past year and so there is an 'overheating' of the system and it appears that CCG demand management (for both elective and non-elective activity) is not having the planned impact;

- Referrals submitted in the monthly activity return (MAR) Unify Return show that they are 15.9% higher comparing May-17 to May-16 and 12.2% higher comparing Apr-17 to May-

17. The graph below shows the referral increase. At the time of writing, the information team are preparing a three year trend in referrals by speciality;



- Due to the increase in demand, the appointments team have work hard but struggled to keep up with the increased numbers in the system and so an underlying backlog was developing. Now the appointments service has been transferred to the operations team, this backlog is being addressed. However, this has been exacerbated by a reduction in clinic availability due to sickness as described above, fewer junior grade doctors and also a relative reduction due to the increased demand;

- Therefore additional shifts are being undertaken by the appointments team at the weekends to ensure that all appointments are on the system and this work is nearly complete. However, this will mean that the position will further decrease before it improves;

- A recovery plan is being developed which is a mix of validation of some of the longer waiters, additional theatre and clinic sessions and the consideration of outsourcing. The limiting factor in the development of the recovery plan without the need to outsource is the availability of the workforce and in particular the nursing workforce. The number of theatre nurse vacancies is significantly hampering our ability to put on additional theatre sessions. Whilst the nursing vacancies is less of an issue in the outpatients department, the nursing workforce in that area are providing extra hours in the 'in hours' period and so are understandably not available for the weekend or evening sessions. Therefore outsourcing options are being explored;

- The SLA with BSUH to provide ENT operating resumed with the first list on Tuesday 20th June. There was a break in provision due to the BSUH consultant leaving and BSUH needing to recruit a replacement. During this period, QVH max fax activity was scheduled into this list. The resumed BSUH activity will help deliver the ENT planned activity & associated income for 17/18, however this could affect the Business unit's ability to deliver the RTT18 week trajectory. The time period since the contract was agreed in early 16/17 to the current date has seen both referral growth into Max Fax services and also greater visibility of the Medway Max Fax issues. The performance of both the SLA and 18RTT will be kept under close review and it may be that one option to improve the 18RTT performance of QVH is to give notice on this contract;

- The summary below reflects the issues highlighted above in performance;

Summary of speciality achievement in June:-

	Over 18	Under 18	Total	Percentage
Corneo	60	1457	1517	96.04%
Max Fax	545	3253	3798	85.65%
Plastics	344	2813	3157	89.10%
Cardiology	10	74	84	88.10%
Other - sleep	13	1157	1170	98.89%
Total	**972**	**8778**	**9750**	**90.03%**

Summary of speciality achievement in July:-

	Over 18	Under 18	Total	Percentage
Corneo	76	1264	1340	94.33%
Max Fax	709	3183	3892	81.78%
Plastics	463	2744	3207	85.56%
Cardiology	5	80	85	94.10%
Other - sleep	14	1196	1210	98.84%
Total	**1267**	**8467**	**9734**	**86.98%**

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

3. Elective Day Cases

- The plan for day cases for 2017/18 is a weekly average of 239 patients;
- In July the weekly activity was 231; 198; 192; and 192 respectively giving a weekly average for July of 203 patients treated compared to 222 in June;
- The difference in numbers patients treated per week is related to the length of procedure time required and so indicates a variation in case mix complexity. This is expected when treating patients in chronological order;
- Non-surgical day cases have a planned weekly average of 11 and for July this was 19; 17; 28; and 10 respectively giving a weekly average of 18;

4. Elective/In Patient Activity

- The plan for elective patients treated per week for 2017/18 is 47 per week;
- In July the numbers of patients treated was 38; 39; 47; and 40 respectively giving a weekly average of 41;
- The average numbers of elective in-patients is broadly consistent within this range whilst day cases show a greater variation and are still tending to increase;
- In both areas, patients are scheduled with clinical need being prioritised (cancer) and then chronological order. This is one of the main drivers for the differences seen in activity compared to income.
- Non-surgical elective activity has a plan of 31 per week and for July this was 35; 33; 33; and 33 respectively giving a weekly average of 33;
- In July Peanut (Paediatrics) the ward had staffing available for 19 nights if required for either elective or trauma patients;

- On 11 nights the ward was closed as no staff available meaning trauma admissions potentially had to be restricted;

- On 1 night a child was appropriately managed in a side room on C-wing with a Paediatric nurse caring for them;

5. Medway Backlog

- The work highlighted in last month's report continues;

- The additional data validator (for a fixed time period) based at Medway has now validated all patients with a clock start date and we are now concentrating on those with no clock start date – with an expected completion date of the next two weeks from writing;

- Currently the out-patient waiting list of patients with no appointment is still not visible to the Trust and so cannot yet be validated;

- Due to above, it is difficult to take a view of the current performance with any accuracy;

- However, as previously highlighted, it is very likely that the Medway data, once fully visible will result in further deterioration in the 18RTT position. Short and long term plans are being developed to manage this. As part of this we continue to undertake extra clinics at Medway as much as possible. Unfortunately this is undertaken in an ad hoc manner due to their physical capacity constraints. For context, Medway some of the longest 18RTT waits in the country. Therefore any additional or spare capacity to undertake procedures is difficult for us to acquire as capacity to undertake additional work is at a premium at the Medway site and needed by Medway to attain their required increases in performance. This will impact upon our ability to reduce the backlog and get to a sustainable demand and capacity position;

- As previously stated this work is being undertaken against growing demand for max fax services, and in particular dental work, across all sites. As highlighted at the board seminar, work is being undertaken as to the contribution this work delivers, with a focus on the Medway site.

6. Cancelled Operations

- There were 25 non-urgent operations cancelled on the day in July (compared to 9 in June; 14 in May; 26 in April and 35 in March) – of which 20 were elective cases and 5 were hand trauma cases;

- 11 elective cases in plastics were cancelled - 9 due to surgeon sickness on the day; and 2 due to time constraints of other cases taking longer than expected; The 2 hand trauma cases were cancelled due to other cases taking longer than expected;

- 4 elective Max Fax case were cancelled on the day – 2 due to trauma cases; 1 due to lack of time due to other cases taking longer than expected; and 1 due to no critical care bed;

- 4 elective Corneo patients were cancelled – 2 due to trauma cases; 1 due to lack of time in theatres due to other cases over-running and 1 due to surgeon sickness;

- There was 1 ENT case cancelled due to insufficient time on the day;

- All 5 hand trauma cases were cancelled due to time constraints and other cases taking longer than expected;

- 3 urgent cases were cancelled on the day in July – I due to no critical care bed and 2 due to other cases taking longer than expected - all of these were re-scheduled within 10 days of their cancellation date;

- The 2 patients cancelled due to no critical care bed meant 730 minutes of operation time lost on the day;

- In August at the time of writing 2 patients have been cancelled due to no critical care bed on the day meaning a loss of 945minutes of operating time;

7. Monitor Cancer Standards

- Below is the Trusts performance for June 2017. The breach report is attached as **Appendix 2.**

Month	Target	Standard	Total	Breaches	Performance
June	2WW GP referral to first seen (urg. susp. cancer)	93%	264	4	98.5%
June	31 day Decision to first treatment	96%	55	2	96.4%
June	31 day Decision to subsq treatment (surgery)	94%	36	2	94.4%
June	62 day GP referral to first treatment	85%	19.5	5.5	71.8%

The data for Quarter 1 can be seen below:

Quarter	Target	Standard	Total	Breaches	Performance
Q1 17-18	2WW GP referral to first seen (urg. susp. cancer)	93%	756	43	94.3%
Q1 17-18	31 day Decision to first treatment	96%	173	7	96.0%
Q1 17-18	31 day Decision to subsq treatment (surgery)	94%	111	5	95.5%
Q1 17-18	62 day GP referral to first treatment	85%	69.5	18.5	73.4%

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 trauma referrals for out of hours trauma from BSUH are higher than the plan as raised earlier in this paper. Further validation is now being done to calculate the conversation rate from referrals to treatments. A meeting with BSIUH is planned for early September and this data along with current pathways will be reviewed;

- The BSUH ENT operating list is working well and although this has limited the number of dental procedures going through theatre it is contributing positively towards the current ENT activity levels and income, however as mentioned previously, this will be kept under review as part of our 18RTT plan;

- There are also further discussions exploring a networked model (wider than just providing on call trauma cover) with Brighton and Sussex University Hospitals NHS Trust. These discussions involve both the operational and clinical management teams from both trusts;

- The key focus point for Max Fax/Oral Surgery Business Unit is to improve the current RTT18 performance against the open pathway target of 92%; the business unit is exploring ways to increase activity, the limiting factor for both inpatient and outpatient pathways is the availability of the nursing resource;

- The overall YTD activity in both Maxillofacial and ENT is above plan, however in Maxillofacial this is largely driven by an over performance in non-elective, the business unit is currently investigating why a number of elective areas are underperforming in particular the H&N specialist cancer top up;

- Orthodontics are currently underperforming against the plan, this is largely driven by a registrar vacancy, however this post has now been appointed to and the post holder starts in October;

- Additional Saturday theatre lists have been scheduled until the end of October 2017, as and when the workforce allows, and this will reduce the current waiting list;

- The service continues to face a period of challenge relating to staffing and the training of senior registrars, until April 2018 the number of senior registrars within the business unit has reduced from five to three. Due to the requirement that all staff on the on call are dual qualified we have been unable to appoint a locum the service, efforts are continuing;

- However, the service has been successful in recruiting additional speciality dentists & this will increase the capacity for outpatient appointments and procedures at QVH, Medway and Darenth Valley hospitals;

- Following approval of the ECT business case earlier this year, the first ECT case went ahead successfully on the 24th July with a further 3 patients currently being considered for the treatment via the multi-disciplinary team process;

11. Plastics Business Unit

- Within plastics there are a number of Consultants on sick leave in May, June, July & August hence planning is undertaken to ensure clinical activity can be maintained by use of locums where possible;

- Activity and hence income are both below plan in relation to day case activity in breast; and hands; some of this has been driven by the absences mentioned above, however the service is further reviewing how lists are booked and utilised to ensure all lists are used to a maximum;

- A recovery plan to ensure activity plans in relation to day cases and elective activity are achieved from September are being completed;

- Average timings for theatre procedures is currently being shared with Consultants with a view to amending current timings utilised to book lists in theatres;

- The first list for Sentinel Lymph Node Biopsies (SLNB) commenced in June with a plan to treat eight patients by the beginning of August and a further eight planned for September;

- All activity and associated coding is being reviewed to ensure all is captured;

- The new trauma clinic building works are underway with a planned opening date of 4th September;

- All current trauma processes and pathways are being reviewed and assessed to ensure maximum efficiency when the clinic opens;

12. Second Trauma Theatre

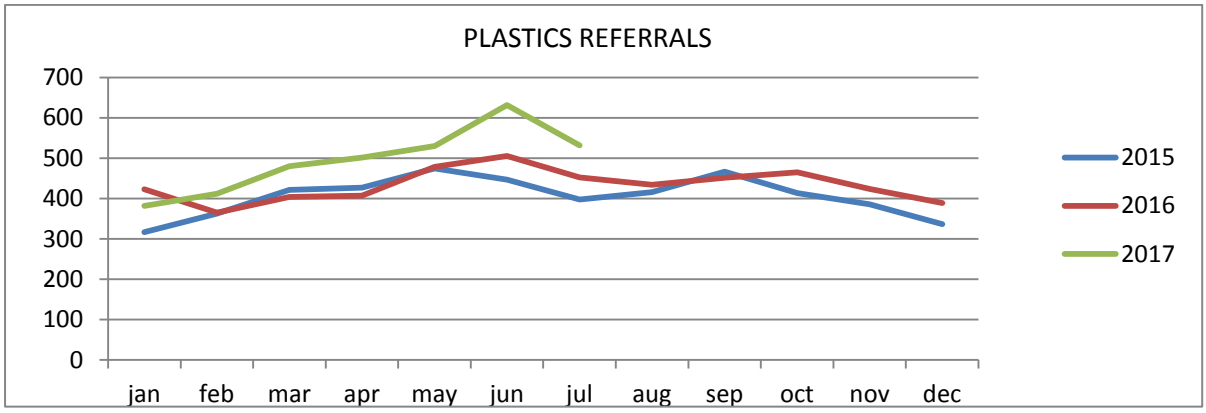
- Activity within trauma since opening of second trauma theatre in September 2015 continues to be monitored on a regular basis. One of the main benefits of this was to minimise the late inductions and these continue to be low;

- Inductions after 10pm were 5 in January 2017; 3 in February; only 1 in March; 2 in April; 6 in May; 5 in June; and 8 in July

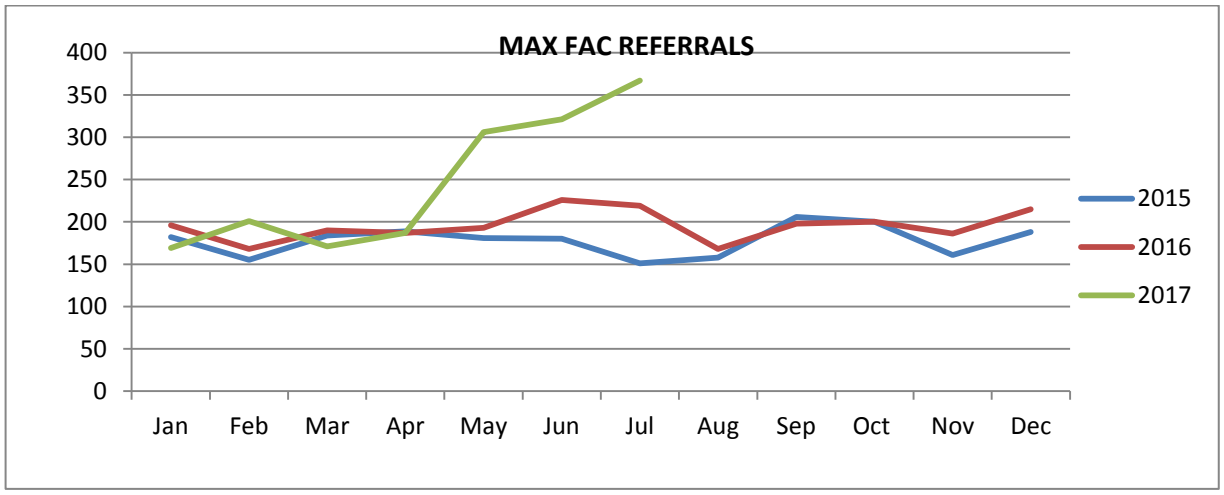
- In 2014/15 total trauma cases were 4023; in 2015/16 4032 a 0.25% increase; the year end for 2016/17 was 4079 cases which demonstrated a 1.13%increase;

- For 2017/18 the theatre 3 is being managed proactively as a 'flex theatre' between trauma and elective activity;

- Trauma referrals into plastics can be seen below:



- Trauma referrals into Maxilo-facial can be seen below:



- In April 2017 QVH started to accept Maxilo-facial trauma referrals from East Sussex NHS Trust (ESHT) and from May to accept them from Brighton and Sussex NHS Trust (BSUH)

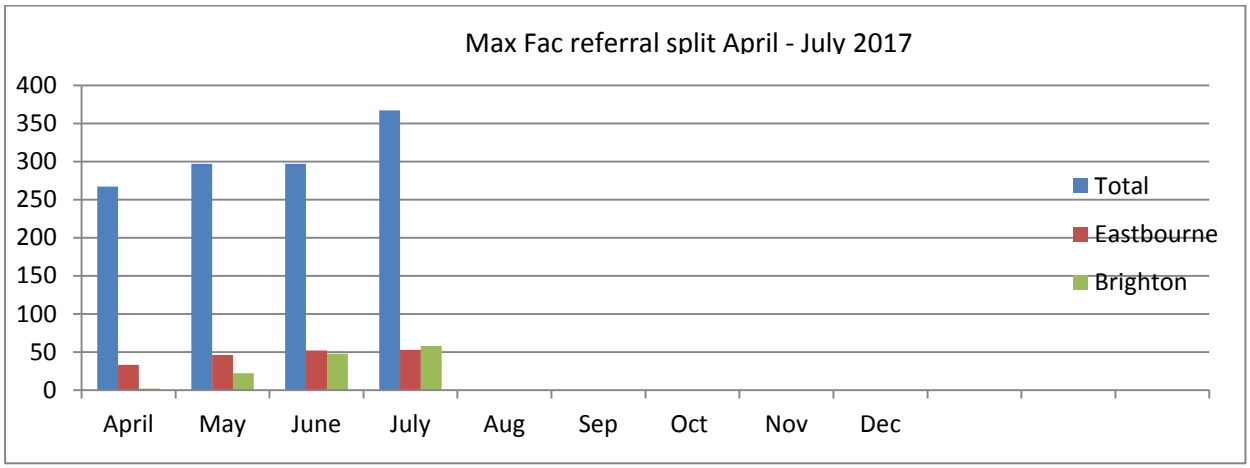
- The BSUH arrangement was for the out of hours period only;

- The expected referrals per week from ESHT was 5 – 6, i.e. around 20 – 24 a month; and from BSUH 2 – 3, i.e. around 8 – 12 a month;

- The data below demonstrates that in actual fact the month referrals from ESHT have been 30; 45; 50; and 50 respectively and from BSUH 25; 48; and 55 respectively;

- However, the main area of growth has been from our existing referrals routes and the growth there has been much more significant than the increase from BSUH & EHST;

- The graph below demonstrates the numbers of referrals from these two Trusts against the total number of referrals:-



13. Ophthalmology Business unit

- The business unit has delivered activity above plan in month year to date. However income and activity has been variable to date and the business unit is investigating this. Income is down in month 4. This relates to the assumption in the plan that the glaucoma work would start in July. The consultant returned from sabbatical in July 24th, and so this activity will increase in month 5;

- The consultant for the joint appointment between Maidstone and Tunbridge wells has taken place and the consultant will commence his role from the 1st October 2017

14. Sleep Services

- The business unit continue to deliver their activity to the proposed plan and have delivered above their plan on activity and income for the first two months of the year;

- The sleep department remain challenged with regard to staffing. Additional staff 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/bank staff will continue until the unit have recruited all staff. The business unit is working hard to convert as many agency staff as possible to bank staff or substantive staff;

- Space is an issue particularly at Bognor memorial hospital due to increasing volumes of activity. We need to identify further space at this site or elsewhere in the region. Discussions ongoing at present

15. Clinical Support Services

- The AQP Community ENT service is now running successfully across five sites (including QVH), with continued higher demand than expected. Demand is expected to continue to rise in Coastal West Sussex where the number of alternative providers has reduced;

- 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 September and work is progressing to progress an urgent on the day solution for primary care capacity, linked to our MIU;

- 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. QVH is also working with SMSKP to explore hosting ESP activity at QVH and create support and links with our MSK physio team.

16. MIU

- The Trust MIU performance in July was 100% for all weeks;

- Activity through the MIU was 270; 280; 229; and 229 respectively in July – giving a weekly average of 252 patients;

- The planned weekly activity for 2017/18 is 209 patients a week and as at July the year to date average has been 231 patients and so the improved performance has continued (weekly average for June was 227 patients.

17. Recommendation

The Committee is recommended 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%	91.5%	91.6%	91.7%	91.8%	91.9%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Actuals		91.6%	91.61%	90.03%	86.98%								

Cancer	CWT 62 Day												
	Baseline	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Trajectory	83.5%	83.5%	83.5%	83.5%	83.5%	83.5%	83.5%	83.5%	83.5%	83.5%	83.5%	83.5%	83.5%
Actuals		84.6%	64.0%	71.8%									

Appendix 2 – Cancer Breaches

62 Day Referral to Treatment

Reporting Month	Tumour Type	First seen Trust	Treating Trust	Wait Days	Breach reason	Accountability
01-Jun	Head & Neck	Queen Victoria NHS Foundation Trust	Queen Victoria NHS Foundation Trust	76	Complex workup required	1
	Head & Neck	Queen Victoria NHS Foundation Trust	The Royal Marsden NHS Foundation Trust	87	Patient choice late in pathway to be referred to another trust – date had been offered prior to breach	0.5
	Head & Neck	Queen Victoria NHS Foundation Trust	Queen Victoria NHS Foundation Trust	75	Complex pathway and diagnostics	1
	Head & Neck	Queen Victoria NHS Foundation Trust	Queen Victoria NHS Foundation Trust	69	Complex pathway and diagnostics	1
	Skin	Queen Victoria NHS Foundation Trust	Queen Victoria NHS Foundation Trust	78	Incidental finding	1
	Skin	Medway NHS Foundation Trust	Queen Victoria NHS Foundation Trust	78	complex pathway	0.5
	Skin	SUSSEX COMMUNITY DERMATOLOGY SERVICE	Queen Victoria NHS Foundation Trust	69	Patient choice – date was offered before breach	0.5

31 Day to First Treatment

Reporting Month	Tumour Type	Wait Days	Breach reason
Jun-17	Breast	33	administration delay in letters
	Breast	40	Admin error – incorrect breach date first identified

31 day to Subsequent Treatment (surgery)

Reporting Month	Tumour Type	Wait Days	Breach reason
Jun-17	Breast	39	Complex work up for surgery required
	Breast	54	Patient choice

2 Week Waits

Reporting month	Tumour type	Wait days	Breach reason
Jun-17	Head & Neck	25	Patient choice.
	Head & Neck	21	Capacity for OPD appointment
	Head & Neck	15	Patient choice
	Skin	15	Patient choice

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/09/2017**		**Agenda reference:**	**152-17**	
Report title:	**Finance Report M4 July 2017**				
Sponsor:	Clare Stafford, Director of Finance and Performance				
Author:	Jason McIntyre, Deputy Director of Finance				
Appendices:	Finance Report M4 July 2017				
Executive summary					
Purpose:	The Trust delivered a surplus of £14k in month; £210k below plan. The YTD surplus has increased to £609k; £210k behind plan. The main driver is the YTD under-recovery of income of £430k which is partially offset by expenditure underspends. The Trust is forecasting to achieve plan by the end of the year.				
Recommendation:	The Board is asked to **NOTE** the contents of this report.				
Purpose:		Information **Y**	Discussion **Y**	Assurance **Y**	Review **Y**
Link to key strategic objectives (KSOs):			KSO3: **Y**	KSO4: **Y**	KSO5: **Y**
			Operational excellence	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	The Finance Use of Resources rating is 1.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:	N/A	
Next steps:	N/A				

Queen Victoria Hospital
NHS Foundation Trust

Finance Report
July 2017

Executive Director: Clare Stafford

Contents

Summary Position – YTD M04 2017/18

Queen Victoria Hospital NHS
NHS Foundation Trust

Table 1 – Financial Performance

Financial Performance	2017-18	July 2017			Year to Date 2017-18		
Income and Expenditure	Annual Plan £k	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	Actual £k	Budget £k	Variance (Favourable/ (Adverse))
Patient Activity Income	66,056	5,316	5,520	(204)	21,446	21,805	(359)
Other Income	3,706	428	401	27	1,567	1,637	(71)
Total Income	**69,762**	**5,744**	**5,920**	**(177)**	**23,012**	**23,442**	**(430)**
Pay	(44,437)	(3,642)	(3,703)	61	(14,328)	(14,812)	484
Non Pay	(19,372)	(1,717)	(1,619)	(98)	(6,586)	(6,315)	(271)
Financing	(4,489)	(371)	(374)	3	(1,489)	(1,496)	8
Total Expenditure	**(68,297)**	**(5,729)**	**(5,696)**	**(33)**	**(22,403)**	**(22,623)**	**221**
Surplus / (Deficit)	**1,465**	**14**	**224**	**(210)**	**609**	**819**	**(210)**
Surplus (Deficit) %	2.1%	0.3%	3.8%	-3.5%	**2.6%**	3.5%	**-0.8%**
Adjust for Donated Depn.	(252)	(21)	(21)	-	(84)	(84)	-
NHSI Contol Total	**1,717**	**35**	**245**	**(210)**	**693**	**903**	**(210)**

Summary - Plan Performance

- The Trust delivered a surplus of £14k in month; £210k below plan. The YTD surplus has increased to £609k; £210k behind plan. The main driver is the YTD under-recovery of income of £430k which is partially offset by expenditure underspends.

- Income has underperformed in month by £177k. The key drivers are:-
  - Clinical Income was below plan in month by £110k due to under performance in Plastics (Breast Surgery/ Hand surgery) due largely to medical sickness (£88k) , Plastics (Burns) due to lower levels of non-elective activity, Eyes (Corneoplastic Surgery) medical staffing issues which has been partially offset by over delivery within MIU, predominantly in non-elective activity, Radiology and Sleep Studies.
  - Sustainability and Transformation funding of £63k in month has not been recognised because the control total has not been achieved.
  - CQUIN risk of £39k has been factored into the YTD position.

- There has been an in month over-recovery of the provider SLA and Eye Retrieval Clean income which has been off set by reduced research income in month.

- Pay expenditure is underspent by £61k increasing the YTD underspend to £484k. The pay underspend is mainly driven by vacancies within AHPs / Healthcare scientists and Nursing. The Trust has incurred £171k of agency in month and £529k of agency expenditure YTD (netted off above) which is less than the allocated cap of £648k for the period.

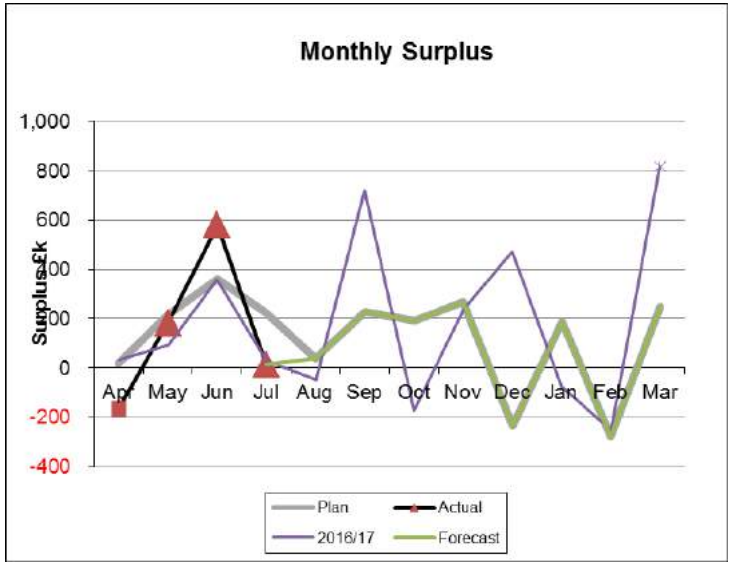
- Non pay is overspent by £98k in month and £271k YTD. The key driver to this was the £82k overspend on clinical supplies which has been seen as a result of the increased in month activity. The other notable area of high expenditure was in catering (£22k) for provisions these were offset by the credit received for the electricity over charge last month (£34k). The YTD drivers include overspends on clinical supplies (£119k) and unidentified CIPP (£213k). These are partially offset by other establishment costs (£36k)

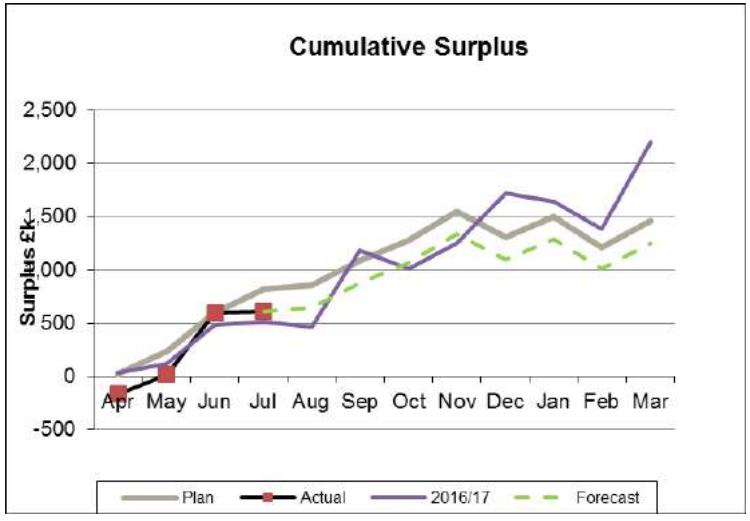
- The Finance Use of Resources rating is 1.

- The Trust is forecasting to achieve plan by the end of the year. However there are risks to full year delivery; particularly currently within the Plastics and Oral business units.

Surplus Trend Position – M04 2017/18

Queen Victoria Hospital
NHS Foundation Trust





Summary

- There is a £14k surplus in month against a planned surplus of £224k. The YTD surplus is £609k which is £210k behind plan.
- The monthly financial profile reflects the impact of working days, seasonal variation, bank and school holidays.
- The graph reflects the surplus and not the control total; excluding the impact of donated depreciation.

Activity Performance by POD : M04 2017/18

Queen Victoria Hospital NHS
NHS Foundation Trust

Table 1 - Performance by POD

Activity Performance			Month 04 (July)			Month 04 (July)			Year to date			Year to date		
POD	Currency	PY Average Activity	Plan Acty	Act Acty	Acty Var	Plan £k	Actual £k	Var £k	Plan Acty	Act Acty	Acty Var	Plan £k	Actual £k	Var £k
Minor injuries	Attendances	1,116	925	1,095	170	67	79	12	3,662	4,065	403	264	293	29
Elective (Daycase)	Spells	1,290	1,114	1,029	(85)	1,210	1,081	(130)	4,310	4,077	(233)	4,629	4,362	(267)
Elective	Spells	400	344	343	(1)	791	744	(47)	1,354	1,270	(84)	3,087	2,789	(298)
Non Elective	Spells	551	458	541	83	1,146	1,251	105	1,814	2,003	189	4,535	4,715	180
XS bed days	Days	103	118	30	(88)	32	8	(24)	468	201	(267)	126	56	(70)
Critical Care	Days	63	61	76	15	77	86	9	242	220	(22)	305	233	(72)
Outpatients - First Attendance	Attendances	4,664	3,909	3,855	(54)	536	507	(29)	15,429	14,989	(440)	2,113	2,011	(102)
Outpatients - Follow up	Attendances	12,918	10,649	10,701	52	749	760	11	41,997	41,384	(613)	2,955	2,975	20
Outpatient - procedures	Attendances	2,707	2,387	2,132	(255)	314	273	(42)	9,445	9,553	108	1,245	1,242	(3)
Other	Other	4,281	2,650	2,924	274	468	492	24	10,487	14,070	3,583	1,814	1,979	165
Work in progress and coding adjustment						130	35	(95)				731	791	60
						5,520	**5,316**	**(205)**				**21,805**	**21,446**	**(359)**

Table 2 - Performance by Service Line

Activity Financial Performance	Month 03 (June)			Year to date		
Service Line	Plan £k	Actual £k	Var £k	Plan £k	Actual £k	Var £k
Clinical Infrastructure	238	324	86	902	1,179	277
Clinical Support	433	489	55	1,715	1,927	212
Eyes	590	505	(85)	2,135	2,069	(66)
Oral	1,089	1,076	(14)	4,311	4,122	(189)
Plastics	2,715	2,504	(212)	10,727	9,898	(829)
Sleep	324	383	59	1,283	1,460	177
Other incuding WIP/ coding	130	35	(95)	731	791	60
Grand Total	5,520	5,316	(205)	21,805	21,446	(359)

NB

* Other clinical income has been added to analysis (i.e. STF, RTA, Private patients) to reconcile to total Clinical Income.

** Further activity trend analysis is included at Appendix 3.

*** Total in month and YTD service line performance does not reconcile to activity income analysis by business unit page 6 as non SLAM activity income has not been disaggregated to business unit.

Summary

- **Minor injuries** attendances are 170 greater and £12k above plan. YTD activity is 403 attendances and £29k above plan due to revised opening hours and increased promotion of the service.
- **Daycase** activity in month is 85 spells and £130k below plan Eyes (Corneoplastics (£71k) and Plastics (Hand Surgery) (£51k) are the key drivers in month. YTD activity is 294 spells and £241k under plan with Plastics (Hand Surgery) contributing £227k to the under delivery. Capacity has been reduced as a number of key clinical staff are on long term sick. This has also been affected by slippage on Plastic CIPP contribution schemes (SNLB/Hand Activity/MOHs) .
- **Elective** activity in the month has underperformed by 1 spell and £47k - casemix (Plastics (Breast) £49k). YTD activity is 84 spells and £298k under plan largely within Oral (£175k) and Plastics (Hand Surgery)(£113k). The Oral underperformance is linked to increased emergency activity transferred from BSUH, which is adversely affecting ability to deliver planned activity. Hand Surgery underperformance has been contributed to by medical sickness.
- **Non-elective activity** has over performed by 83 spells and £105k in month (MIU & Oral). The YTD position reports an overperformance of 189 spells and £180k in the same areas. There is an overperformance on Oral due to BSUH transfer activity - which is being partially offset by underperformance within Plastics (Burns/ Hands). The overperformance within MIU has been largely identified as a miscoding issue, £282k of non-elective activity will be reattributed to Plastics & Oral following a data cleanse next month.
- **Critical care** days have overperformed by 15 days in month and £9k. The YTD position is £72k under plan however this is partially offset when the WIP accrual for critical care long stayers who have yet to be discharged is applied, which is coded separately.
- **Outpatient** attendances (FA/FUs) are £18k below plan in month and £82k below plan YTD. The in month underperformance is primarily within Skin Surgery and Corneoplastics. Outpatient procedures are £42k under plan in month and £3k YTD. This underperformance is largely driven by underperformance in Oral Orthodontics (£76k) , which has been largely offset by Plastic sub specialities (£58k).
- The YTD under performance is largely driven by planned activity (Elective & Daycase) within the Plastics (Breast, Burns & Hands) and Oral (Maxillofacial and orthodontics) service lines which is being offset by overperformance within clinical support (Radiology) , Clinical infrastructure, (MIU), Sleep and WIP and other income - which will be recoded to service lines when coding is complete. The two key concerns are the underperformance within plastics medical sickness and the impact of emergency activity on the delivery of planned activity in Oral.

Actions

- Plastics and Oral business unit continue to refine developing recovery plans to address underperformance. These will be tested and assessed via performance review meetings.

Financial Position by Business Unit – M04 2017/18

Queen Victoria Hospital NHS
NHS Foundation Trust

Variance by type: in £ks	Activity Income		Other Income		Pay		Non Pay		Position	for July 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	106	(538)	45	(14)	98	45	(51)	(146)	13,928	1,321	1,124	197	4,038	4,692	(653)
1.2 Oral	(49)	(213)	2	9	(43)	23	(23)	(53)	6,828	476	590	(114)	2,079	2,313	(233)
1.3 Eyes	(68)	(75)	15	(15)	(0)	(1)	(9)	(13)	4,308	323	385	(62)	1,221	1,326	(105)
1.4 Sleep	67	178	(0)	0	(11)	(53)	(14)	(43)	1,887	200	159	41	722	640	82
1.5 Clinical Support	85	291	(2)	(35)	63	231	(14)	(12)	(3,046)	(119)	(251)	132	(526)	(1,001)	475
1.6 Other Med & Admin	1	(4)	-	-	(11)	(28)	1	10	(408)	(42)	(34)	(9)	(157)	(135)	(22)
Operations Total	**141**	**(361)**	**59**	**(55)**	**96**	**216**	**(111)**	**(256)**	**23,497**	**2,157**	**1,972**	**185**	**7,377**	**7,833**	**(456)**
Nursing & Clinical Infrastructure															
2.1 Clinical Infrastructure	142	251	(5)	(7)	33	181	(21)	(46)	(6,761)	(409)	(558)	149	(1,875)	(2,254)	379
2.5 Director Of Nursing	-	-	3	15	(14)	10	3	(2)	(1,412)	(109)	(101)	(8)	(448)	(471)	23
Nursing & Clinical Infrastructure	**142**	**251**	**(1)**	**8**	**19**	**191**	**(18)**	**(48)**	**(8,174)**	**(518)**	**(660)**	**141**	**(2,323)**	**(2,725)**	**402**
Corporate Departments															
3.1 Non Clinical Infrastructure	-	-	9	24	25	5	6	(105)	(3,950)	(289)	(329)	40	(1,393)	(1,317)	(76)
3.2 Commerce & Finance	-	-	9	7	(17)	16	31	43	(2,650)	(197)	(221)	24	(818)	(883)	66
3.4 Finance Other	(488)	(249)	(45)	(18)	(53)	58	(26)	(4)	(3,977)	(861)	(248)	(612)	(1,207)	(995)	(212)
4.1 Human Resources	-		8	31	(0)	4	(19)	(40)	(892)	(85)	(74)	(11)	(302)	(297)	(5)
5.4 Corporate	-		5	5	(10)	(13)	12	19	(1,695)	(151)	(158)	7	(554)	(565)	11
6.1 Research	-		(16)	(74)	(1)	(4)	20	91	(159)	(10)	(13)	3	(40)	(53)	13
6.2 Clinical Audit	-		-	-	3	11	10	36	(536)	(31)	(45)	13	(131)	(179)	48
Corporate Total	**(488)**	**(249)**	**(30)**	**(24)**	**(53)**	**77**	**35**	**41**	**(13,858)**	**(1,624)**	**(1,088)**	**(536)**	**(4,445)**	**(4,289)**	**(156)**
QVH Total	**(204)**	**(359)**	**28**	**(71)**	**61**	**484**	**(94)**	**(264)**	**1,465**	**14**	**224**	**(210)**	**609**	**819**	**(210)**

Non Pay expenditure: In month there has been high levels of expenditure for clinical supplies relating to activity (£82k) within theatres. A review of the surgical instrument packs is being undertaken to identify whether efficiencies can be realised. There was also the continuation of the non pay unidentified CIP driving a further £50k overspend. The previous months unexpectedly high electricity charges have been credited as they were invoiced in error giving an in month positive variance of £33k within non clinical infrastructure in month . The YTD position is driven by clinical supplies and the unidentified CIPP reflected in the position which has been partially offset by the underspend on premises costs.

Summary

Activity Income: The two areas of key concern are Plastics (£106k positive in mth £538k adverse YTD) and Oral (£49k in mth £213k YTD) business units which are driving underperformance (more detail on activity performance slide). This has been offset by overperformance in month and YTD within sleep (demand), clinical support (radiology demand) , clinical infrastructure (MIU). There was an in month deterioration for STF £63k and the CQUIN provision was increased by £39k in month to £63k in total. There has been some ledger adjustments to the plastic activity plan and actuals in month from Finance other in month.

Other income: There has been an in month over recovery of the West Kent Dermatology Income (£46k) as the SLA has been agreed within plastics , additional Eye Retrieval Clean room income (£15k) which has been offset by research income.

Pay: The key drivers of the pay underspend are:-

- HCAs (£70k in mth £164k YTD) This is largely within theatres due to the change in staff mix proposed in the business case which has now been enacted;
- Nursing (£46k in month and £194k YTD) this is mainly the vacancies being carried within ITU (£21k in month £103k YTD) and MIU (£20k in month £74k YTD)
- AHPs/Healthcare scientists (£51k) underspent in month £118k YTD). This is within clinical support services due to vacant posts within radiography, therapies and histopathology.
- Admin (£42k in month £283k YTD) vacancies within corporate areas and West Kent dermatology offsetting income variance.
- This has been partially offset by agency costs of £149k in month and £442k YTD which have been netted off to determine financial performance against staffing categories above.

CIPP – M04 2017/18

Queen Victoria Hospital NHS Foundation Trust

Table 1 – CIPP Performance in Month & YTD

Business Unit	Month 4 Plan	Month 4 Actual	Month 4 Variance	YTD CIPP Plans	YTD Delivery	Performance Against Target
Clinical Infrastructure & Nursing	34	23	(12)	137	98	(39)
Clinical Support Services	30	40	10	117	117	0
Corporate	154	154	(0)	175	175	-
Eyes	15	6	(9)	41	28	(13)
Non Clinical Infrastructure	12	12	-	47	43	(4)
Oral	46	105	59	128	213	85
Plastics	74	20	(54)	210	128	(82)
Sleep	6	5	(1)	21	19	(2)
Grand Total	**370**	**364**	**(6)**	**874**	**819**	**(55)**

Table 2 – CIPP Forecast

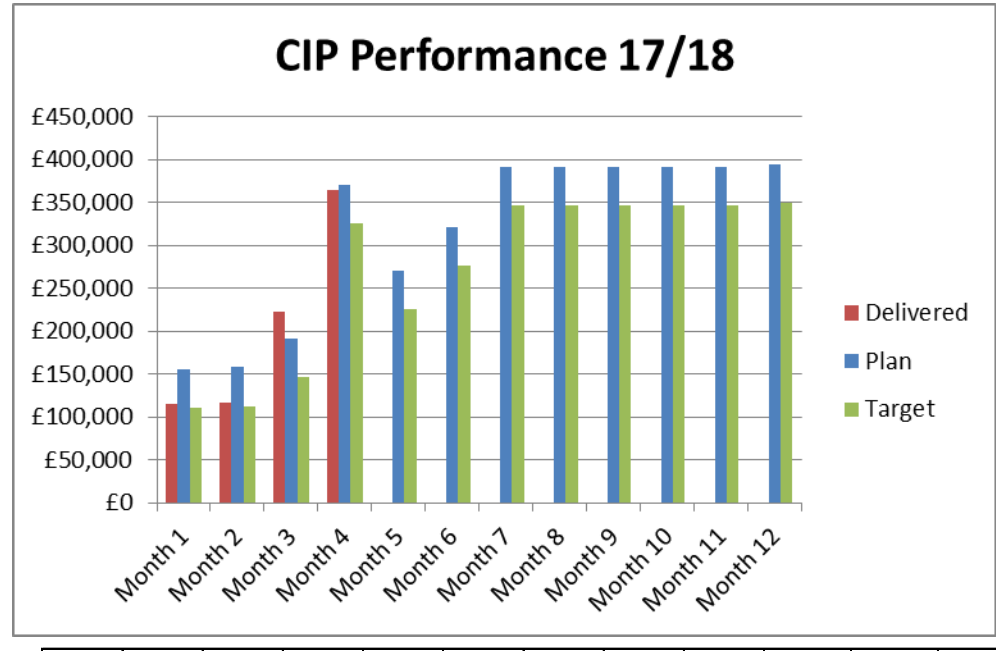
Business Unit	CIPP target	Identified schemes	Gap from target	Forecast Delivery	Performance Against Target
Clinical Infrastructure & Nursing	806	576	(230)	460	(346)
Clinical Support Services	417	399	(19)	399	(19)
Corporate	515	601	87	601	87
Eyes	126	168	41	187	60
Non Clinical Infrastructure	133	140	7	102	(31)
Oral	301	740	439	648	347
Plastics	885	1,124	239	466	(419)
Sleep	95	71	(24)	66	(29)
Grand Total	**3,278**	**3,819**	**541**	**2,928**	**(350)**

Summary

- The Trust delivered savings of £364k in month £6k below plan and £55k YTD less than plan. The YTD delivery represents 94% of identified savings.
- The key drivers of the YTD underperformance are slippage on contribution schemes for plastics £82k (Hand surgery £29k, SLNB schemes £20k and MOHs non delivery £13k) , Clinical Infrastructure £39k (£28k staff reductions), Eyes £13k (FEMTO laser of £19k). This has been largely offset by the over delivery of the Macfacs Trauma Contribution (£122k).
- The Trust added a number of additional schemes in month to bridge unidentified gap in month
- The Trust is forecasting delivery of £2.93m against a target of £3.28m. There is a shortfall of £350k, there is concerted work underway to address the issues preventing the non delivery of key CIPPs within Plastics as well as in depth work being carried out to identify savings within theatres these are anticipated to bridge the forecast gap.

Actions

- **An in depth theatre review to be undertaken looking into the utilisation and booking of theatre lists.**
- **Current CIPP will be reviewed to determine if further savings can be generated/ underperformance mitigated.**
- **A review of issues delaying implementation of schemes or schemes being brought forward will be identified and actions taken to address.**



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Delivered	£120,545	£116,535	£223,214	£363,686	£0	£0	£0	£0	£0	£0	£0	£0
Plan	£155,362	£157,808	£191,090	£370,139	£270,832	£321,364	£391,500	£391,500	£391,500	£391,500	£391,500	£394,500
Target	£110,320	£112,766	£146,047	£325,096	£225,790	£276,322	£346,458	£346,458	£346,458	£346,458	£346,458	£349,458

Balance Sheet – M04 2017/18

Queen Victoria Hospital NHS
NHS Foundation Trust

Balance Sheet as at the end of July 2017	2016/17 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	44,279	43,950	44,084
Other Receivables	-	-	-
Sub Total Non-Current Assets	44,279	43,950	44,084
Current Assets			
Inventories	429	430	428
Trade and Other Receivables	7,068	8,168	7,639
Cash and Cash Equivalents	7,784	7,560	7,048
Current Liabilities	(7,413)	(7,741)	(6,847)
Sub Total Net Current Assets	7,868	8,417	8,268
Total Assets less Current Liabilities	52,147	52,367	52,352
Non-Current Liabilities			
Provisions for Liabilities and Charges	(684)	(684)	(684)
Non-Current Liabilities >1 Year	(6,600)	(6,212)	(6,212)
Total Assets Employed	**44,862**	**45,471**	**45,457**
Tax Payers' Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	22,614	23,223	23,209
Revaluation Reserve	10,011	10,011	10,011
Total Tax Payers' Equity	**44,862**	**45,471**	**45,457**

Summary

- The increase in net current assets of £149k reflects the £14k surplus achieved in month and increased debtors.
- Cash has increased by £513k in month due to the receipt of the final STF payment of £1m which relates to 2016-17.

Issues

- Sufficient cash balances need to be generated by the Trust to provide liquidity, service the capital plan and to meet future loan principal repayment obligations.

Actions

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

NB Analysis is subject to rounding differences

Capital – M04 2017/18

Queen Victoria Hospital NHS Foundation Trust

Capital Programme	Annual Plan £000s	YTD Actual £000s	YTD Plan £000s	YTD Variance £000s	Full Year Forecast £000s	Full Year Variance £000s
Estates projects						
Backlog maintenance - Roofs	179	162	179	17	179	-
Backlog maintenance - Health & Safety	226	4	75	71	226	-
Backlog maintenance - Cladding & Fenestration	179	-	60	60	179	-
Backlog maintenance - Energy Management	124	68	41	(27)	124	-
Backlog maintenance - Internal Accommodation	194	34	65	31	194	-
Trauma Clinic	112	73	112	39	125	(13)
Other projects	681	160	168	8	668	13
Estates projects	**1,695**	**501**	**700**	**199**	**1,695**	-
Medical Equipment	**576**	**130**	**175**	**45**	**576**	**-**
Information Management & Technology (IM&T)						
EDM	130	77	60	(17)	130	-
Ordercomms (IM&T Strategy)	310	-	-	-	310	-
Health & Social Care Network (IM&T Strategy)	150	-	-	-	150	-
Other projects	289	-	30	30	289	-
Information Management & Technology (IM&T)	**879**	**77**	**90**	**13**	**879**	-
Contingency	**250**	**-**	**-**	**-**	**250**	-
Contingency	**250**				**250**	-
Total	**3,400**	**708**	**965**	**257**	**3,400**	**-**

Summary

- The capital programme has been developed through the 2017/18 business planning process via the Capital Planning Group and with EMT and Board approval.
- The largest element of the Estates programme is backlog maintenance. The Trust is in year 2 of a 5 year programme.
- The IT programme is largely based on the IM&T Strategy . Project board is being established to oversee the delivery of the individual elements. The EDM project is continuing in line with plan. The Evolve product is fully live in Sleep and Oral services and due to be deployed in the Eyes and Plastics business units by the end of the calendar year.
- Capital YTD expenditure is £708k, £257k behind indicative plan.

Issues

- Achievement of the annual plan is largely dependent on projects being delivered in line with project plans.

Risks

- Material delays in project delivery could put the achievement of the plan at risk.

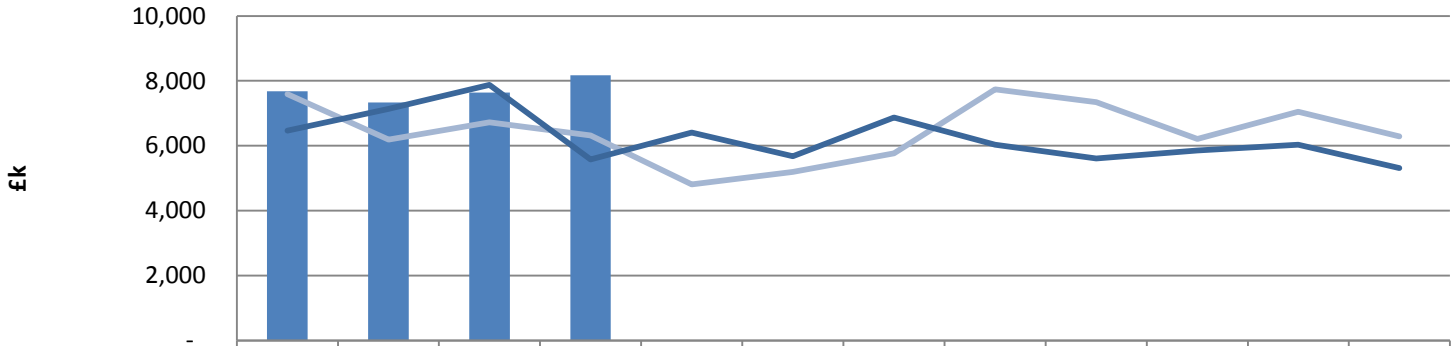
Action

- Progress will be actively monitored by the Capital Planning Group and reported to the Finance & Performance Committee.

Debtors – M04 2017/18

Queen Victoria Hospital NHS Foundation Trust

Debtor Trend

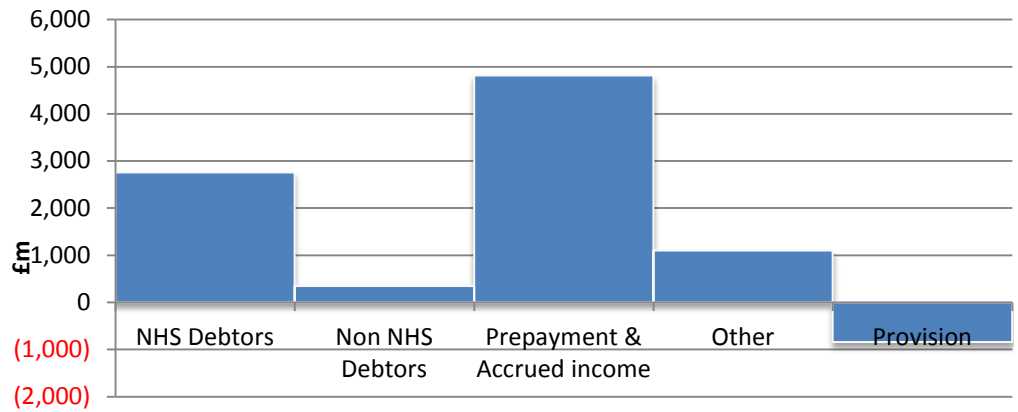


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total 2017/18	7,679	7,330	7,639	8,168								
Total 2016/17	7,593	6,194	6,722	6,322	4,811	5,196	5,764	7,742	7,347	6,207	7,049	6,287
Total 2015/16	6,462	7,137	7,879	5,581	6,405	5,678	6,871	6,033	5,609	5,853	6,033	5,315

Summary

- The debtor balance increased by £529k (7%) from M03.
- The month 4 debtor balance of £8.2m is 27% above the average monthly balance in 2016-17. This is due to an increase in the invoices raised (relating to over-performance in M02); a rise in prepayments and reduced NHS receipts.
- At M04 there is £3.34m of accrued income for activity over-performance and NCAs which is a decrease of £1.1m compared to the previous month. This is due to the receipt of £1m from NHS England for STF Funding in the month.

Debtors 2017/18



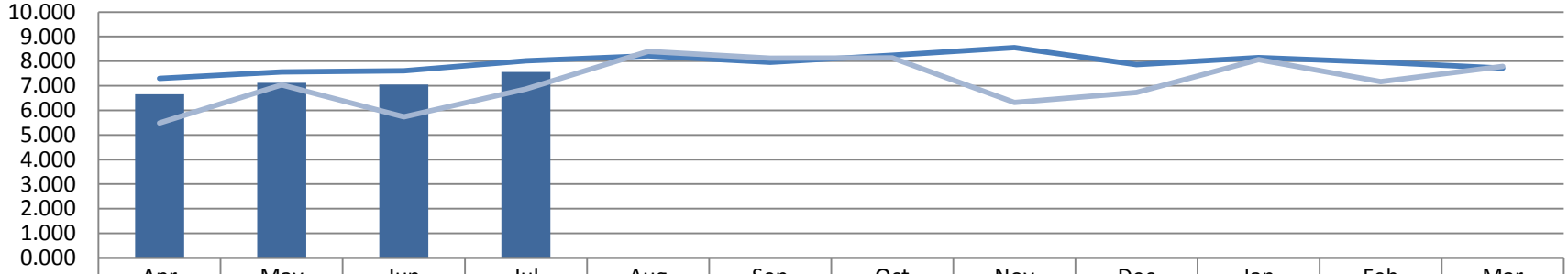
Next Steps

- Financial services continue to work closely with business managers and the business development team to ensure billing is accurate, timely and resolutions to queries are being actively pursued.

Cash – M04 2017/18

Queen Victoria Hospital NHS Foundation Trust

Cash Balances Summary



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18 Actual	6.657	7.124	7.048	7.561								
17/18 NHSI Plan	7.294	7.563	7.604	8.012	8.216	7.960	8.243	8.554	7.862	8.143	7.959	7.718
2016/17 Actual	5.483	7.033	5.739	6.873	8.398	8.118	8.139	6.318	6.729	8.069	7.166	7.784

Cash Balance	Actual (£m)			
	Apr	May	Jun	Jul
Opening Balance	**7.784**	**6.657**	**7.124**	**7.048**
Receipts from invoiced income	4.620	5.989	5.579	4.692
Receipts from non-invoiced income	0.142	0.158	0.134	1.152
Total Receipts	**4.763**	**6.147**	**5.714**	**5.844**
Payments to NHS Bodies	(0.488)	(0.513)	(0.312)	(0.340)
Payments to non-NHS bodies	(2.049)	(1.715)	(1.463)	(1.492)
Net payroll payment	(1.909)	(1.968)	(1.980)	(1.966)
PAYE, NI & Levy payment	(0.886)	(0.924)	(0.970)	(0.961)
Pensions Payment	(0.557)	(0.560)	(0.572)	(0.573)
PDC Dividends Paid	0.000	0.000	0.000	0.000
Commercial Loan Repayment	0.000	0.000	(0.492)	0.000
Total Payments	**(5.890)**	**(5.680)**	**(5.790)**	**(5.332)**
Actual Closing Balance	**6.657**	**7.124**	**7.048**	**7.561**
17/18 NHSI Plan	**7.294**	**7.563**	**7.604**	**8.012**

Summary

- The cash position is favourable on the basis of liquidity and debt service ratios.
- The cash balance at the end of Month 4, although higher than last month, has an adverse variance of £0.4m against the NHSI plan due to a lower level of NHS receipts in month.
- Cash balances are forecast to return to plan in M05.

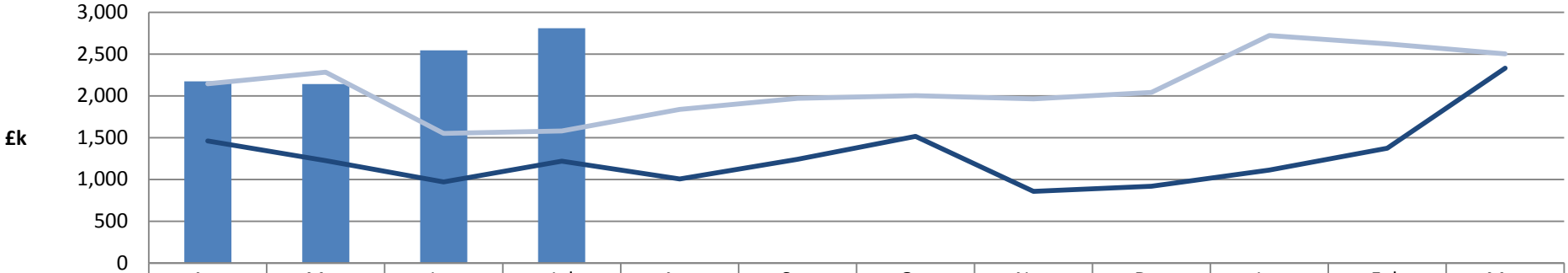
Next Steps

- The Trust will continue to review short term cash flow on a daily basis to manage liquidity and inform decision making.
- Financial services will work with commissioners to ensure payments are made in a timely manner.

Creditors – M04 2017/18

Queen Victoria Hospital NHS Foundation Trust

Trade Creditors



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	2175	2140	2543	2810								
2014/15	1460	1225	970	1219	1007	1242	1516	858	920	1113	1374	2332
2016/17	2144	2283	1549	1580	1838	1971	2003	1964	2040	2721	2623	2503

Summary

- Trade creditors at month 4 is £2.8m compared to an average of £2.1m during 2016-17. There is an increase of £0.3m in month, due to a capital project and NHS provider remaining on the ledger awaiting approval.
- The Trust's BPPC percentage has remained the same in month when compared with Month 3 and the average days to payment has decreased to 26 days.
- Savings from prompt payment discounts taken in month amounted to £2k, in line with plan.

Better Payment Practice Code (17/18) July	2016/17 Outturn # Invs	2016/17 Outturn £k	Current Month # Invs	Current Month £k	YTD # Invs	YTD £k
Total **Non-NHS** trade invoices paid	18,533	22,571	1,561	1,669	6,195	7,454
Total **Non NHS** trade invoices paid within target	14,932	17,627	1,369	1,486	5,370	6,320
Percentage of Non-NHS trade invoices paid within target	**81%**	**78%**	**88%**	**89%**	**87%**	**85%**
Total **NHS** trade invoices paid	801	4,496	50	178	277	1,058
Total **NHS** trade invoices paid within target	504	2,879	35	150	179	723
Percentage of NHS trade invoices paid within target	**63%**	**64%**	**70%**	**84%**	**65%**	**68%**

Next Steps

- Financial services are continuing to review areas where invoice authorisation is delayed.

Appendices

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

Table 1

Single Oversight Framework					
Use of Resources Score: July 2017					
	Metrics £k	Measure	Rating	Weight	Score
Continuity of Services:					
Capital Service Cover					
Operating surplus	2,098	2.46	2	20%	0.40
Capital Servicing Obligation YTD	854				
Liquidity					
Working Capital	7,987	46.6	1	20%	0.20
Operating Costs (per day)	171				
Financial Efficiency:					
Control Total Margin (%)					
Surplus (deficit) year to date	693	3.0%	1	20%	0.20
Income year to date	23,012				
Margin Variance From Plan					
Actual surplus margin	3.01%	-0.8%	2	20%	0.40
Plan surplus margin	3.85%				
Agency Cap					
Agency Spend	529	-18.4%	1	20%	0.20
Agency Cap	648				
Use of Resources: July 2017			1		

Table 2

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%

Summary

- The use of resources score is a 1, the highest available, reflecting the delivery of a surplus less than 1% from plan, with a strong liquidity position and is within the capital servicing parameters.
- Table 2 details a definition of each of the metrics and the scoring mechanism.

Appendix 2: Agency Ceiling

Table 1 Agency Ceiling performance

	Month 1 £'000	Month 2 £'000	Month 3 £'000	Month 4 £'000	Month 5 £'000	Month 6 £'000	Month 7 £'000	Month 8 £'000	Month 9 £'000	Month 10 £'000	Month 11 £'000	Month 12 £'000	Total £'000	YTD £'000
Agency Ceiling	162	162	162	162	162	162	135	135	135	127	127	127	1,758	648
Agency Actuals	171	58	129	171										529
Variance	(9)	104	33	(9)										119

Summary

- NHSI has allocated each NHS provider an agency cap as a mechanism to reduce agency expenditure across the provider sector. QVH has been allocated an agency cap of £1.76m for the year. The cap is monitored on a monthly basis via the monthly financial monitoring returns.
- The YTD agency expenditure of £529k is £119k less than the NHSI ceiling of £648k. Corporate agency contracts have moved to Trust bank between the end of 2016/17 and beginning of 2017/18 accounting for part of the reduction. However a continuation of in month expenditure for the remainder of the year will breach the cap.
- Performance on the agency ceiling is one of the 5 metrics included within the Use of Resources measure in the single oversight framework.

Table 1 Activity by POD trend analysis

	2016-17 Activity Trend												2017-18				
POD	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	M01	M02	M03	M04	Trend
Minor injuries	799	921	859	989	917	961	912	865	817	837	702	910	918	993	993	1,095	
Elective (Daycase)	973	1,019	1,061	1,076	1,009	1,004	1,056	1,064	1,030	1,029	1,059	1,136	908	1,029	1,029	1,029	
Elective	345	302	325	318	311	343	352	326	310	325	291	322	275	329	329	343	
Non Elective	379	445	433	497	440	473	446	440	416	381	355	447	453	502	502	541	
XS bed days	237	130	111	19	66	64	66	39	71	59	109	146	41	39	39	30	
Critical Care	58	76	47	59	89	45	66	37	43	52	58	34	28	30	30	76	
Outpatients - First Attendance	3,666	3,834	3,836	3,505	3,861	3,845	3,815	3,935	3,300	3,617	3,355	3,756	3,777	3,935	3,935	3,855	
Outpatients - Follow up	10,198	10,112	10,641	9,715	10,042	10,491	10,312	11,042	9,477	10,324	10,111	10,905	9,416	11,117	11,117	10,701	
Outpatient - procedures	2,201	2,117	1,980	1,953	2,154	2,152	2,099	2,412	2,045	2,378	1,729	2,640	2,012	2,308	2,308	2,132	
Other	2,630	2,937	3,061	2,784	3,891	3,823	3,688	3,931	3,454	3,873	3,433	4,017	3,264	3,291	3,291	2,924	
Work in progress and coding adjustment																	

KSO5 – Organisational Excellence

Risk Owner: Director of Workforce & OD
Committee: Trust Board
Date: 30 August 2017

Strategic Objective
We seek to maintain a well led organisation delivering safe, effective and compassionate care through an engaged and motivated workforce

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 4 (L) = 16, major risk
Residual Risk Rating 4 (C) x 4 (L) = 16, major risk

Rationale for current score
-Capacity planning & workforce modelling
-Additional corporate restructuring
-managers skill set in workforce/activity/financial planning
-unknown impact of STP
-Staff survey results and SFFT show staff engagement is lower than previous years
-impact of recruitment and retention in key national shortage specialties

HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY
-Consultant contract negotiations resume in 2017
-Junior doctor contract implemented Feb 2017
-CQC recommendations
-Introduction of agency caps and IR35
- Support recommendations in Freedom To Speak Up 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

RESILIENCE
-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 plan (3 years) for FY17/18 and linking to business planning process – includes skills mix/safe staffing reviews
-Leadership programme launched Jan 2017 with encouraging on going high demand
-Engaged in NHS Employers workforce retention programme nationally
-Increased compliance requirement to 95% for MAST and Appraisal from Jan 2017
-Performance review meetings to identify and address identified staffing shortfalls and particular workforce challenges
-Project underway to better understand the employee journey/lifecycle
-Part of NHSI Retention Support Programme
-Investment made in key workforce e-solutions, implementation has begun
-Engagement and Retention paper presented to Board Sept 2017

Gaps in controls and Assurances
- Current level of management competency in workforce planning
- Continuing resources to support the development of staff – optimal use of imposed apprenticeship levy budget
- Continuing attraction and retention problems in theatres , critical care and paediatrics
Workforce theatre productivity group ongoing
-Capacity of recruitment team to support the required initiatives to address recruitment and retention challenges including pay and agency controls
- Further expertise required in use of social media as a tool

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/09/2017**		**Agenda reference:**	**154-17**	
Report title:	**Workforce Report**				
Sponsor:	Geraldine Opreshko, Director of Workforce & OD				
Author:	Jill Dale, ESR and Workforce Intelligence Manager				
Appendices:	A. Workforce Report				
Executive summary					
Purpose:	The Workforce and OD report for August 2017 (July data) provides the Board of Directors with a breakdown of key workforce indicators and information linked to performance.				
Recommendation:	The Board is asked to **NOTE** the report.				
Purpose: [one only]	Approval **N**	Information **N**	Discussion **Y**	Assurance **N**	Review **N**
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: **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:	NA				
	Date:		Decision:	Noted	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Human Resources & Organisational Development

Workforce Report – August 2017

Reporting Period: July 2017

1.1 Contextual narrative

- Section 1.2 and 1.3 provide a high level summary of the report on two page, please note that June 2016 data has been presented for comparison purposes although it should be noted that Perioperative Services (Anaesthetics, Theatres and Pre-Assessment departments) were reported within the Nursing & Clinical Infrastructure Business Unit until August 2016.

1.2 Current Month Picture

KPI	Narrative
Vacancies	In July the difference in the number between budgeted WTE and staff in post (section 2) was 138 WTE, an increase in vacancies from June and a decrease in the net staff in post with higher than average leavers in the month. There were 32 WTE doctors in the Recruitment pipeline (3 consultants and 29 trainee doctors – 22 started in August, 4 due to start in September and 3 in October) and 26 WTE non-medical candidates being cleared to start In July. In the month, requests to advertise were held for two weeks whilst TRAC Recruitment software system was being implemented and anecdotal feedback from the Recruitment Team has identified faster clearances of candidates, in one example, a non-clinical candidate was cleared to start in one week. On the 1st of July the new establishment control process went live with Executive approval for establishment changes introduced.
Turnover	In July both the rolling 12 month Trust Turnover (Section 3) and the monthly turnover percentages have increased with more leavers than previous months. At 18.98% this is the highest turnover rate the Trust has experienced.
Temporary Staffing	Agency usage (section 4) has increased in July in the Trust and demand for temporary cover remains high in specialist clinical areas such as Burns, ITU, Perioperative services due to national recruitment shortages and with locums filling gaps in trainee doctor rotas. We regularly have ten regular agency workers in Theatres supporting team working and patient care. We continue to monitor the therapies workforce. In July, agency usage rose in non-clinical corporate areas where three agency workers are covering vacancies on medium term placements.
Sickness	The Trust overall sickness absence figure (section 5) decreased in June 2017 to 2.04%. This is lower than the forecast figure for June and lower than the June rates for the last four years. It is anticipated that the indicative figure for July will be between 2.3% and 2.5%, higher than the target rate but still within the 'green' RAG rating category. A breakdown of reasons for absence split into short term and longer term (over 28 calendar days) is included from January to June 2017 the top 3 reasons have remained consistent throughout the six month period as: ***Top short term reasons were**: Cold/Cough/Flu, Gastrointestinal and Headache/migraine problems,* ***Top longer term reasons were**: Anxiety/Stress/Depression, Other Musculoskeletal problems and Injury/Fracture*.
Appraisals	On the 1st April 2017 the Appraisals and MAST compliance RAG ratings changed to Red 0 - 79.99%, Amber 80-94.99%, and Green 95% and above. In addition, two new board reportable competencies were added to the Trust Competency Matrix, namely, Fire Safety – 2 yearly and Adult Safeguarding Level 2 – 3 yearly. The impact of this will be that percentages that last year may have been green or amber may now show as amber or red.
MAST	In July, both the Trust Appraisal rate and MAST compliance increased by over 0.5% to 84.07% and 89.24% compared to June. At individual competence level, compliance rates have risen in 13 of the 19 board reportable competences compared to June with the compliance rate for 18 of the 19 competences over 80%. For the Safeguarding Children (Version 2) - Level 3 - 3 Years competence, following a recent review medical staff have been added to this competence requirement which has dropped the compliance percentage. An action plan has been formulated including providing additional face to face training sessions to increase compliance within in next six months from the current rate of 51%.

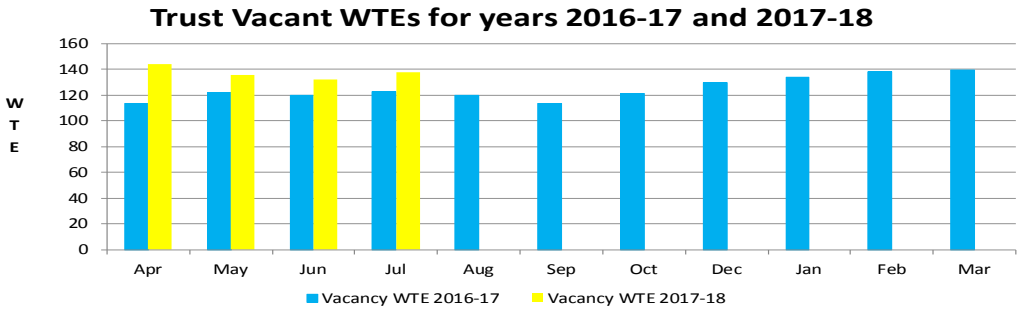
1.3 KPI Summary

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2016-17			Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Establishment WTE				962.72	962.72	962.72	962.72	962.72	962.72	962.72	962.72	962.72	969.76	969.76	969.76
Staff In Post WTE				840.09	842.78	849.39	841.27	838.92	833.01	828.91	824.59	822.81	825.71	834.28	837.51
Vacancies WTE				122.63	119.94	113.33	121.45	123.80	129.71	133.81	138.13	139.91	144.05	135.48	132.25
Vacancies %	>12%	8%<>12%	<8%	12.74%	12.46%	11.77%	12.62%	12.86%	13.47%	13.90%	14.35%	14.53%	14.85%	13.97%	13.64%
Agency WTE				24.98	25.73	29.73	30.69	30.84	25.22	26.04	25.48	26.36	16.02	15.15	17.38
Bank WTE *Note 2*				26.12	28.80	28.09	31.25	37.40	31.22	35.72	37.76	47.79	40.37	44.05	48.60
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	17.14%	17.09%	17.43%	17.58%	16.92%	17.58%	16.72%	16.55%	17.06%	17.02%	17.09%	17.92%
Monthly Turnover				1.2%	1.5%	1.5%	1.7%	1.5%	1.3%	1.4%	1.0%	1.6%	1.3%	1.1%	2.1%
Stability %	<70%	70%<>85%	>=85%	98.8%	97.5%	98.8%	97.9%	98.5%	98.5%	98.7%	99.2%	98.8%	98.7%	99.07%	98.36%
Sickness Absence %	>=4%	4%<>3%	<3%	2.57%	2.47%	2.00%	2.69%	2.69%	2.90%	3.20%	3.01%	2.43%	2.06%	2.75%	2.0%
% staff appraisal compliant (Permanent & Fixed Term staff)	<70%	70%<>85%	>=85%	77.8%	73.4%	66.9%	63.7%	75.7%	80.1%	78.7%	82.3%	92.6%	83.3%	84.78%	83.46%
Statutory & Mandatory Training (Permanent & Fixed Term staff)	<70%	70%<>80%	>=80%	87.8%	85.4%	82.2%	83.4%	85.8%	86.8%	87.0%	88.9%	89.3%	87.2%	81.57%	88.51%

Friends & Family Test - Treatment	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 1: Of 187 responses: 96.7% : 2.1%	2016-17 Quarter 2: Of 42 responses: 92.9% : 4.8%	2016-17 Quarter 3: National Staff Survey 91%	2016-17 Quarter 4: Of 236 responses: 95.3% : 2.1%	2017-18 Quarter 1: Of 273 responses 95.2% : 2.6%
Friends & Family Test - Work	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 1: Of 187 responses: 68.4% : 19.3%	2016-17 Quarter 2: Of 42 responses: 57.1% : 32.0%	2016-17 Quarter 3: National Staff Survey 62%	2016-17 Quarter 4: Of 236 responses: 64.0% : 18.7%	2017-18 Quarter 1: Of 273 responses 57.5% : 24.2%

*Note 1 - 2017/18 Establishment not available in May data reporting period, establishment updated for April, May and June in this report
*Note 2 - Bank WTE does not include extra hours worked by medical staff within establishment or overtime worked by all staff groups.
*Note 3 - New RAG ratings for 2017/18 for Appraisals and for Statutory & Mandatory Training plus 2 new Board Reportable competences introduced - Fire Safety and Safeg

2. Vacancies and Recruitment



VACANCY PERCENTAGES	Jul-16	Jun-17	Jul-17	Compared to Previous Month
Corporate	12.34%	10.58%	11.05%	▲
Nursing and Clinical Infrastructure	14.88%	17.98%	19.89%	▲
Clinical Support	10.07%	11.95%	11.66%	▼
Plastics	11.17%	4.25%	3.89%	▼
Eyes	11.14%	3.05%	6.78%	▲
Sleep	3.13%	1.28%	-9.79%	
Oral	9.09%	13.51%	13.51%	◄►
Periop		18.54%	19.27%	▲
QVH Trust Total	12.74%	13.64%	14.22%	▲

NON-MEDICAL RECRUITMENT	Posts advertised this month	Recruits in Pipeline
Corporate	2.60	1.00
Nursing and Clinical Infrastructure	1.55	11.20
of which are Qualified Nursing	*1.00*	*5.40*
of which are HCAs	*0.00*	*3.00*
Clinical Support	1.60	4.00
Plastics	0.00	5.60
Eyes	1.00	1.00
Sleep	0.00	0.00
Oral	1.80	1.00
Periop	13.00	1.80
of which are Qual Nursing & Theatre Practitioners	*10.00*	*1.80*
of which are HCA's and Student/Asst Practitioners	*3.00*	*0.00*
QVH Trust Total	21.55	25.60

MEDICAL RECRUITME
Clinical Support
of which are Deanery Trai
of which are SAS doctors
of which are Consultants (
Plastics
of which are Deanery Trai
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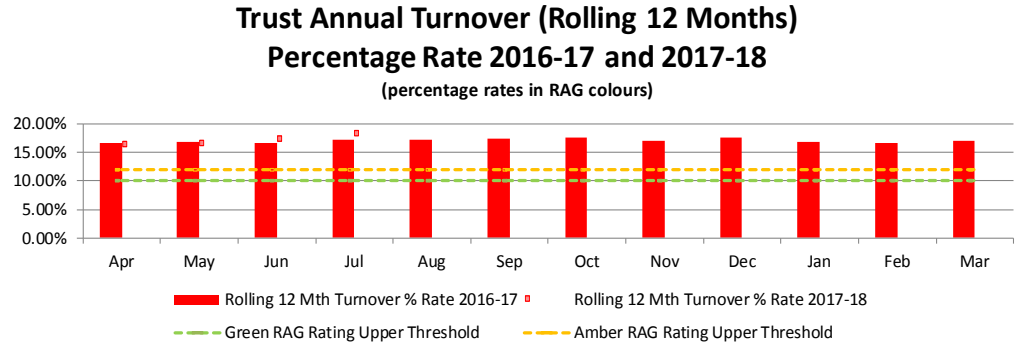
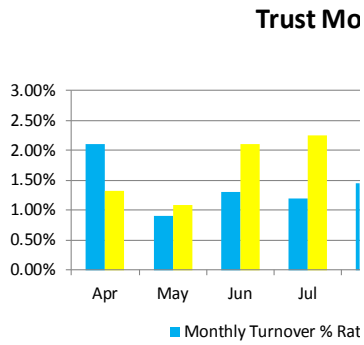
QVH Trust Total
of which are Deanery Trai
of which are SAS doctors
of which are Consultants (

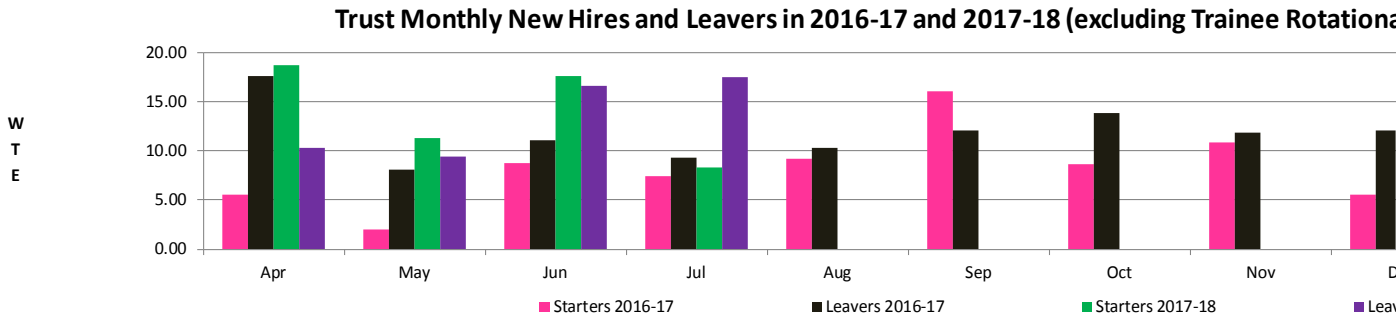
3. Turnover, New Hires and Leavers

ANNUAL TURNOVER ROLLING 12 MTHS excl. Trainee Doctors	Jul-16	Jun-17	Jul-17	Compared to Previous Month
Corporate	17.15%	14.09%	16.17%	▲
Nursing and Clinical Infrastructure	17.79%	22.65%	23.49%	▲
Clinical Support	16.69%	19.09%	17.84%	▼
Plastics	19.08%	19.49%	20.83%	▲
Eyes	18.75%	18.34%	24.99%	▲
Sleep	14.62%	13.62%	13.46%	▼
Oral	12.70%	11.17%	11.13%	▼
Periop		14.89%	16.86%	▲
QVH Trust Total	17.14%	17.92%	18.98%	▲

MONTHLY TURNOVER excl. Trainee D
Corporate
Nursing and Clinical Infrastructure
Clinical Support
Plastics
Eyes
Sleep
Oral
Periop
QVH Trust Total







4. Temporary Workforce

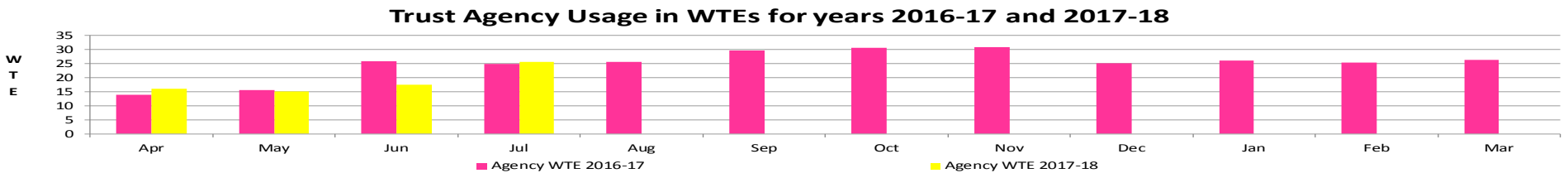
Performance:

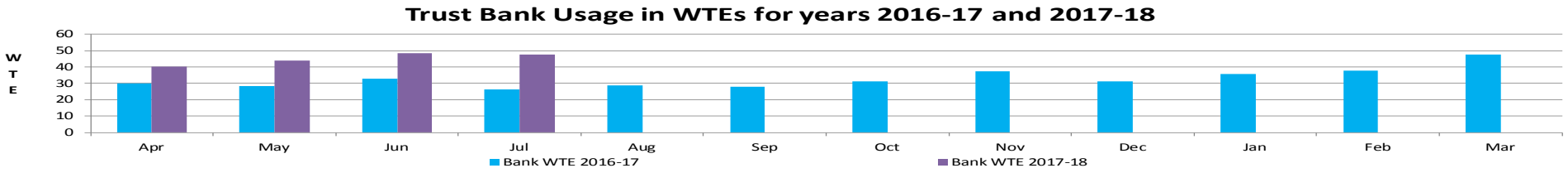
Agency				
BUSINESS UNIT (WTE)	Jul-16	Jun-17	Jul-17	Compared to Previous Month
Corporate	14.77	0.60	2.44	▲
Nursing and Clinical Infrastructure	6.96	3.82	6.45	▲
Clinical Support	2.19	3.77	4.11	▲
Plastics	0.46	0.51	1.10	▼
Eyes	0.00	0.00	0.00	◄►
Sleep	0.60	0.00	0.00	◄►
Oral	0.00	0.00	0.00	◄►
Periop		8.69	11.52	▲
QVH Trust Total	24.98	17.38	25.64	▲

Bank				
BUSINESS UNIT (WTE)	Jul-16	Jun-17	Jul-17	Compared to Previous Month
Corporate	2.55	6.35	5.18	▼
Nursing and Clinical Infrastructure	16.79	19.62	20.12	▲
Clinical Support	2.07	5.40	5.21	▼
Plastics	2.77	1.74	1.72	▼
Eyes	0.30	2.46	2.32	▼
Sleep	1.12	2.71	3.36	▲
Oral	0.52	1.66	2.28	▲
Periop		8.66	7.42	▼
QVH Trust Total	26.12	48.60	47.60	▼

Agency				
STAFF GROUP (WTE)	Jul-16	Jun-17	Jul-17	Compared to Previous Month
Qualified Nursing	6.79	12.58	18.05	▲
HCAs	0.00	0.00	0.00	◄►
Medical and Dental	0.74	0.46	1.10	▲
Other AHP's & ST&T	2.49	3.70	4.04	▼
Non-Clinical	14.96	0.64	2.44	▲
QVH Trust Total	24.98	17.38	25.64	▲

Bank				
STAFF GROUP (WTE)	Jul-16	Jun-17	Jul-17	Compared to Previous Month
Qualified Nursing	7.06	13.30	10.78	▼
HCAs	2.68	4.79	4.59	▼
Medical and Dental	0.00	0.00	0.00	▼
Other AHP's & ST&T	1.52	3.63	3.46	▼
Non-Clinical	14.85	26.88	28.77	▲
QVH Trust Total	26.12	48.60	47.60	▼





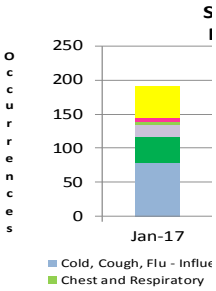
5. Sickness Absence

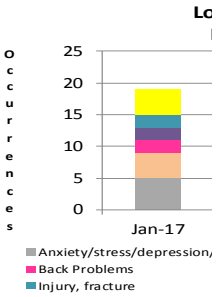
Performance:

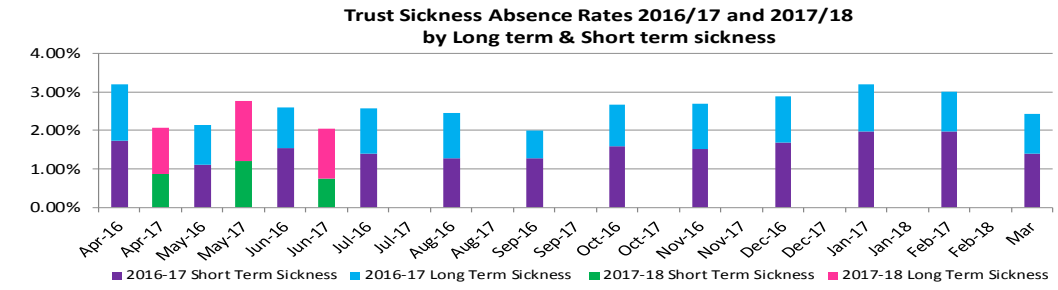
SHORT TERM SICKNESS	Jun-16	May-17	Jun-17	Compared to Previous Month
Corporate	1.95%	0.55%	0.71%	▲
Nursing and Clinical Infrastructure	1.82%	1.33%	0.98%	▼
Clinical Support	1.04%	2.01%	0.73%	▼
Plastics	1.28%	0.50%	0.29%	▼
Eyes	0.79%	0.79%	0.00%	▼
Sleep	1.07%	0.00%	0.30%	▲
Oral	1.83%	0.30%	0.41%	▲
Periop		2.04%	1.06%	▼
QVH Trust Total	1.55%	1.21%	0.76%	▼

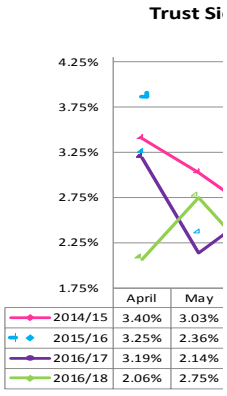
LONG TERM SICKNESS	Jun-16	May-17	Jun-17	Compared to Previous Month
Corporate	1.48%	1.38%	1.33%	▼
Nursing and Clinical Infrastructure	1.32%	1.83%	1.31%	▼
Clinical Support	1.22%	1.77%	1.71%	▼
Plastics	0.00%	3.84%	2.53%	▼
Eyes	0.00%	1.89%	2.11%	▲
Sleep	0.00%	0.00%	0.00%	◄►
Oral	1.16%	0.53%	0.91%	▲
Periop		0.45%	0.37%	▼
QVH Trust Total	1.06%	1.55%	1.29%	▼

ALL SICKNESS (with RAG ratings)	Jun-16	May-17	Jun-17	Compared to Previous Month
QVH Trust Total	2.61%	2.75%	2.04%	▼









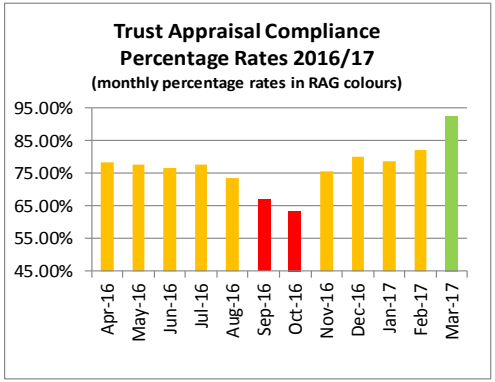
6. Training, Education and Development

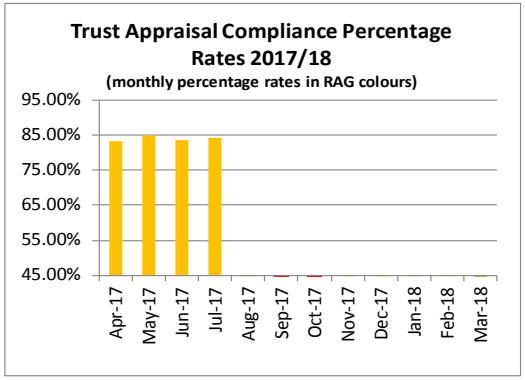
New Targets/RAG ratings for 2017/18:

% staff - appraisal compliant	<80%	80%<>95%	>=95%
% staff - Statutory & Mandatory Training compliant	<80%	80%<>95%	>=95%

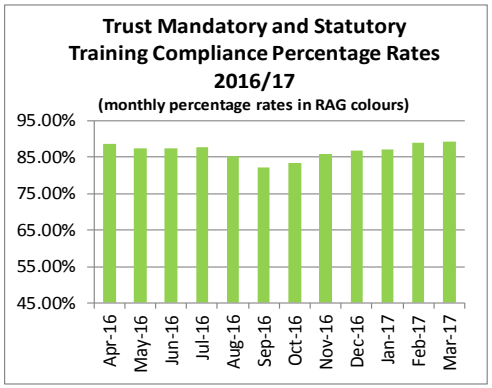
Performance:

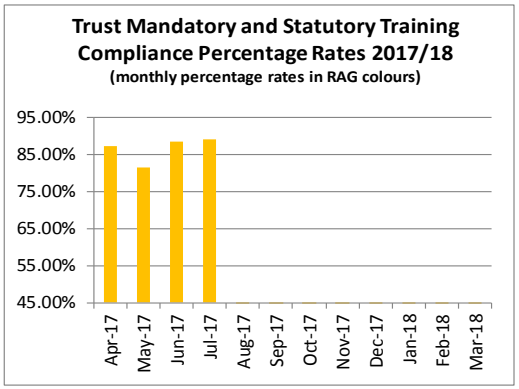
APPRAISALS	Jul-16	Jun-17	Jul-17	Compared to Previous Month
Corporate	76.97%	84.76%	87.12%	▲
Nursing and Clinical Infrastructure	75.88%	89.34%	88.81%	▼
Clinical Support	88.29%	87.02%	87.88%	▲
Plastics	66.50%	83.91%	78.41%	▼
Eyes	83.33%	94.12%	90.91%	▼
Sleep	76.92%	89.29%	93.55%	▲
Oral	84.71%	73.53%	85.29%	▲
Periop		70.76%	70.18%	▼
QVH Trust Total	77.82%	83.46%	84.07%	▲





MANDATORY AND STATUTORY TRAINING	Jul-16	Jun-17	Jul-17	Compared to Previous Month
Corporate	86.51%	89.48%	90.36%	▲
Nursing and Clinical Infrastructure	87.20%	88.29%	90.72%	▲
Clinical Support	90.52%	92.97%	94.15%	▲
Plastics	87.93%	77.34%	77.08%	▼
Eyes	92.81%	90.03%	92.17%	▲
Sleep	95.65%	94.71%	86.24%	▼
Oral	89.35%	89.18%	87.81%	▼
Periop		88.76%	88.97%	▲
QVH Trust Total	87.80%	88.51%	89.24%	▲





7. Medical and Dental Workforce

Medical Workforce

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- **Plastic Surgery**: Confirmation from Health Education London (Deanery) of eleven Plastic Surgery trainees for October which is nearer to our quota of thirteen and a considerable increase from the last few years, It is hoped that we will have a full complement of registrars in October, with the new two year registrar posts adding stability.
- **Oral and Maxillofacial Surgery:** Risks remain around vacancies due to shortfall of HEE registrar trainees who are doubly qualified (General Medical and General Dental Councils). The Orthognathic Fellow is due to start in September 2017 along with Trainee Specialty Dentists who have been appointed to work mainly at our spoke sites. A risk was with the Dental Core Trainees due to start in September due to HEKSS not releasing the details until early August 2017 leaving just four weeks to recruit to any unfilled posts in which we have now been successful. Our concerns have been escalated to the Deanery.
- **Medical and Dental Locum Bank and Agency Locums** continue to be used to support the service although much reduced from earlier in the year.
- **2016 Junior Doctor Contract:** 20 trainee doctors are now on the new contract with the remainder due to move over in September and October 2017. The rotas in Oral and Maxillofacial Surgery have been redesigned and are in draft pending the service exploring a number of options to ensure compliance. We are addressing this through joint working with Eastbourne in relation to DCT's (Juniors)
- **Honorary Contracts:** the number of requests for honorary contracts continues to increase with a 14% increase so far this year over 2016.

Medical Education

Educational activities in July

- In July the results of the GMC survey of junior doctors were released.
    - In Anaesthetics QVH received three green flags (above average results) for workload, handover and local teaching, an improvement on last year's results.
    - In Oral & Maxillofacial Surgery the Trust received two light green flags (slightly above average) for team work and handover, and two pink flags (slightly below average) for clinical supervision and clinical supervision out of hours. This is also an improvement on last year's results.
    - The results in plastic surgery were less positive. In core plastic surgery, we received three red flags (below average results) and four pink flags. We also received one green flag, for workload. In higher plastic surgery, we received two red flags and eight pink flags. We have been asked to provide action plans to HEE KSS for these areas. The Medical Education Manager, Director of Medical Education, Director of HR&OD, and Medical Director are in the process of putting in place a wider action plan for our local use to ensure that there are improvements for next year.

Upcoming developments

- New junior doctors started at the beginning of August – this is our largest intake of the year, with 22 new starters (deanery and trust trainees). They will receive induction on their first day, followed by departmental induction.
- A successful bid to charitable funds means that work will shortly be underway to improve the facilities in the Education Centre. The new simulation room will also be shortly up and running.
- Plans are in place to launch new education pages for the QVH website, including a searchable calendar of events, within the next couple of months.
- A lecture evening is planned for Weds 6 September; a Consultant Anaesthetist, will be speaking on "A journey through trauma and the military lessons learnt; bombs, blasts, disasters and the Resource Limited Austere Environment".

Statutory and mandatory training compliance

- Permanent/fixed term medical and dental staff are currently showing 83% compliant, which is the same as the previous month. Of the non-compliant competences 22% are booked to attend a future course.
- Medical and dental bank workers are showing 32.3% compliant, a slight improvement on the previous month.

8. Organisational Development and Wellbeing

- The new TRAC, recruitment monitoring system went live at the beginning of July. This is intended to provide an improved experience and transparency for both candidates and recruiting managers as well as reduce our time to hire. Early indications are positive.
- Work has started to upload all medical and dental job plans into the new e-job plan system
- Workforce shortages and retention is now acknowledged as one of the greatest risks across the NHS and continues to impact on QVH. NHSI have invited QVH as well as a number of other Trusts to participate in a retention support programme due to our high turnover of nursing staff. An Engagement and Retention options paper is presented to Board separately.
- A focused project continues at the trust in the form of 1:1 Employee Conversations identifying those who have been in post for varied periods ('Stay interviews'), and those who have chosen to leave the Trust ('Exit interviews'). This will continue throughout August and September and emerging themes include:

  Good Practice:

  Being given the opportunity to understand the roles of others; visibility of managers/ senior managers; ideas are listened to/ encouraged and empowered to make changes to improve systems;

  Ideas for recognising, rewarding, developing staff:

  Development of clerical staff; introducing regional pay weighting to KSS hospitals; building relationships between departments and that operate in silos;

  Doing it differently:

  Car parking; more working from home/remote access; improved transport links to get to and from work – especially from the train station.
- The QVH charity has funded a number of events to recognise and celebrate the contribution made by our workforce. Around 300 staff participated in the summer barbeque and in September we will be acknowledging staff achievement with an awards and long service ceremony in September.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/09/2017**		**Agenda reference:**	**155-17**	
Report title:	**Engagement and Retention Improvement Plan - Options Paper**				
Sponsor:	Geraldine Opreshko, Director of Workforce & OD				
Author:	Geraldine Opreshko, Director of Workforce & OD				
Appendices:	1-4 (incorporated in report)				
Executive summary					
Purpose:	Attraction and Retention of staff is one of the biggest risks and challenges across the NHS currently. This paper considers the context in which QVH is currently operating and presents many of the options available to the Trust to try and improve its current position				
Recommendation:	The Board are asked to **discuss** the report.				
Purpose:	Approval **N**	Information **N**	Discussion **Y**	Assurance **N**	Review **N**
Link to key strategic objectives (KSOs):	KSO1: **Y**	KSO2:	KSO3: Y	KSO4:	KSO5: **Y**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	Trust reputation as a good employer of choice and ensuring there are sufficient and well trained staff to deliver high quality care				
Corporate risk register: [As above]	Engagement and retention of the workforce				
Regulation:	The Trust is part of the NHSI Retention Improvement Programme, covered in the paper				
Legal:	None known				
Resources:	Within paper				
Assurance route					
Previously considered by:	Executive Management Team				
	Date:	30/08/17	Decision:	Noted	
Next steps:	TBA				

Workforce Engagement and Retention Improvement Plan

Options Discussion Paper

Geraldine Opreshko
Director of Workforce & OD
August 2017

Contents:

Context

NHS Vacancy statistics published at the end of July 2017 reports that more than 86,000 NHS posts were vacant in the first three months of 2017, a rise of almost 8,000 when compared to the same period last year. Nurses and midwives account for the highest proportion of shortages with 11,400 vacant posts in March 2017. Media coverage and the NHS Provider sector generally have expressed serious concerns about long term sustainability. There are many factors that have influenced this position including:

- Across the NHS there are now significant workforce shortages particularly in clinical areas for some general nursing as well as paediatrics, critical care and theatres. Although this has been a challenge across the NHS for some time the impact at QVH has only been felt in the last 18 months – two years. It is difficult to recruit and turnover in these areas are high – at QVH this figures was 23.49% in July 2017 (nurses and HCA's, excludes perioperative)
- Given that 60-70% of NHS providers costs are workforce there continues to be a mis-match between the number of staff required to meet activity demand and patient need, expected staffing ratios, and workforce expectations whilst education commissions are cut and budgets are reduced year on year.
- Pay restraint is having a significant impact now, many years of capped pay rises along with the scars of the Jnr' Dr's dispute is having a significant impact on the psychological contract between the workforce and the NHS
- Workforce planning and strategy is addressed by all of the arm's length bodies (ALB's) differently - HEE, NHSE, NHSI and even CCG's all take a slightly different approach so there is still no national workforce strategy or clear leadership form the centre.
- This in turn has impacted on the fact we have not been training and recruiting enough Dr's, nurses and some other clinical staff so we as an NHS have been reliant on overseas staff. Although QVH has not been reliant to date we are now at a point where recruitment of EU nurse would be an possibility but uncertainty about Brexit, language test and immigration have increased the challenge and costs of recruiting.
- Given the disjointed approaches it has meant that innovation is stifled and just takes too long to develop/agree new workforce models or even the different ways of working particularly for the millennium generation of workers who have a different expectation of the workplace.
- The impact of an ageing workforce across the NHS is extremely high risk, and in particular the impact of special classes (enabling many clinicians to retire at 55) and the changes to pension rules where many long servers have full pension pots. Retirements account for 20% off all leavers in the NHS and around one third of the NHS workforce is eligible for retirement. At QVH currently more than a third of our workforce (370) is over the age of 55 and one fifth in nursing .
- The NHS is much busier – at QVH our activity has increased by 16%, so our workforce are stating that they feel under pressure and this is increasingly reflected in the QVH job satisfaction and engagement scores in the NHS staff survey and staff friends and family results.

These are all significant challenges across the NHS and as a small Trust QVH are now feeling the impact perhaps more acutely than some due in part to our specialties.

Improving general staff satisfaction retention rates is crucial to addressing workforce supply, nationally and locally acknowledging that there are no more people in the system and we are all fishing in the same pond. It is also expensive and time consuming to recruit so time and resource needs to be invested and ultimately we need to create an environment where staff feel supported, happy, healthy, have access to flexible working, with opportunities to develop.

However there is no silver bullet – we have to take a multi-dimensional approach to attract and retain the best staff that we need

NHS Employers and NHSI have acknowledged that workforce (retention of) is the single biggest challenge and risk in the NHS now.

NHSI Retention Support Programme

In July 2017 NHSI launched the Retention Support Programme with the objective of improving staff retention in NHS Trusts and bringing down the leaver rates across the NHS. The programme has started with two groups of 20 providers.

- One cohort for providers with above average nurse leaving rates (based on central interrogation of the ESR data warehouse)
- One cohort of mental health trusts with above average leaving rates for all clinical staff

NHSI identified that QVH should be one of the Trusts in the first cohort.

NHSI has stated that the retention programme will offer a range of support, including:

- A series of master classes for Directors of Nursing and HR Directors to discuss ways of improving retention
- Further work with NHS Employers to explore how NHSI can help build on its current national retention programme (in which QVH are already engaged)
- The piloting and roll out of an engagement tool designed to help trusts understand why staff leave, and a tool on analysing staff surveys
- Materials, guidance and webinars on how to improve retention rates.

Next Steps - Expectation from NHSI

The Director of Nursing (DoN) and Director of Workforce (DoW) attended an NHSI nurse retention Masterclass in London in June and the DoN with the Workforce Information Manager attended the first Masterclass in the formal programme in Birmingham on 14 July.

The stated overall aim of the programme is to improve retention in participating Trusts within the next 12 month period. We have not been given a set template so are expected to use a format that works locally for us utilising whatever other resources are made available to us through the programme. NHSI have allocated clinical and workforce leads to the Trust and who are likely to visit QVH in August or September. A Trust improvement plan must be submitted to NHSI by 6 October 2017.

We have been asked to consider the following milestones for the next 90 day period:

Month 1	Month 2	Month 3
• Understand our Trust data • Review current initiatives underway and gauge their impact on staff • Develop SMART aims • Identify primary drivers • Set up project governance	• Identify areas of improvement • Focus on engagement with staff and relevant stakeholders to test and develop our plans • Refine aim, drivers and initiatives	• Identify measurable gains and overall impact we expect to make on turnover rate • Identify clear actions and delivery leads

Next Steps for QVH

Having set the context and alongside NHSI expectations there is still much in the control of QVH where we can make a difference. The diagram below highlights the various stages of the employee lifecycle as we need to consider how we will effectively attract, select, develop, deploy, manage reward and retain our staff. Some initiatives are under way but the purpose of the discussion paper is to lay out all possible and realistic options and for the executive to debate and agree the priority areas that we feel will have the most positive impact for QVH and how we intend to take forward our participation in the NHSI Retention Programme.

The employee lifecycle

Everything we do to support this work must be underpinned by excellent communications and engagement activities as well as effective leadership.

Professor Sir Mike Richards, CQC Chief Inspector of Hospitals stated recently that one of the strongest indicators of a high performing organisation that delivered good quality care was the quality of its leadership. A positive, open culture are important drivers of change so it is important to create a culture where staff feel valued and empowered to suggest improvements and question poor practice – and feel safe to do so.

Our leaders need not only to lead, but be seen to lead. Therefore visibility and spending time on the 'shop floor' talking to our people will help give staff the confidence that they can speak up safely.

"Positivity, compassion, respect, dignity, engagement and high quality care are key to creating the cultures we need in the NHS. And, just as importantly, we must deal decisively, consistently and quickly with behaviours inconsistent with these values, regardless of the seniority of people exhibiting them."

Michael West, Head of Thought Leadership, Kings Fund.

Measuring Success

We will know when we have been successful in year one because we will:

- increase the number of staff who would recommend QVH as a place to work – > 65% (2nd quarter SFFT 58%)
- decrease the vacancy rate in nursing from around 19% (July 2017) to less than 15%
- decrease our overall vacancy rate to less than 12.% (13-15% first quarter 2017/18, 14.22% July 2017))
- decrease our annual turnover rate to less than 16%, from of 18.98% (July 2017)
- improve the annual staff survey engagement rate to > 4.00 (3.87 for 2016, 4.01 in 2015, overall score for the NHS was 3.79 in 2016)
- spend within our agency ceiling target specified by NHSI (thereby improving continuity of care)
- improve communication between managers and staff (benchmark 2016 NHS staff survey)
- have reduced our time to hire new people by at least two weeks. (NHS average 14.5 weeks, TRAC 13 weeks)
- maintain sickness levels below 3%

Improvement Plan

Attraction and Retention

Employer brand – what is our USP, what does our brand say about QVH, what would attract someone to apply for a job do we convey and live our culture and values effectively. Review how and where we promote the Trust.

Challenges	Proposed Actions	Resource implication (cost and time)	Priority level/By When	Progress to date
1.The current vision 'Delivering excellence' does not convey or sell anything about what we do as a surgical Trust	1. change 'tag' line on all of our materials to 'Rebuilding lives…..'. This better reflects what do for our patients	1.none	1.immediate	August 2017 - agreed
2.our mediums for promoting the Trust (jobs) are limited and traditional	2.a.engage a marketing agency to devise a core 'brand' for all media and promotional materials including recruitment advert copy writing 2.b.devise a rolling programme of attendance at all careers/job events specifically at all local Universities including attractive 'give aways' 2.c.have a shortened version application form to enable people to apply for jobs and have first interview at an event 2.d. have a clear strategy about the use of social media to promote the Trust including the exec team and senior managers trained in the use of twitter as a promotional tool and 'sharing' jobs and news on Linked in 2.e.more video footage of Trust and staff and patient stories with links to UTube and TRAC microsite	**Propose a protected initial budget of £50,000:** 2.a. cost of design etc, cost of brochure for printing and e-PDF version. 2.b.design and purchase promotional giveaways for all such events 2.c. Done 2.d. Communications Manager to provide training and awareness 2.e.some initial videos completed	2.a.immediate 2.b October 2017 2.c.form complete 2.d.end September	Appendix One, shows cost/ benefit analysis agreed by EMT

3. Improve candidate and recruitment manager experience of attracting new staff	3. Launch TRAC an improved recruitment tracking system introduced and incorporates a microsite, increased transparency for managers and will ultimately reduce time to hire. Candidates get an immediate impression of the Trust	Successful business case for investment	Implemented July 2017	
4.refresh the Trust values underpinned by a robust behavioural framework and ensure interview processes are underpinned by Trust values	4. A number of staff focus groups to be held to review the effectiveness of our values, include patient input. Re-launch and develop the behavioural framework that underpins values	4. Training input, possibly external facilitation which will have a cost implication	Spring 2018	
5.Induction and orientation- **New hires first impressions of the Trust tend to stick for a long time so the Impression on arrival at the Trust must be positive.**	Amend Trust policy that states all new starters join the Trust on the same day every. Change the recruitment process whereby an individual's start date is not dependant on a corporate induction. The first day should be spent on local induction with the new manager and team. By the end of the summer there will be more culture, more welcome, more values less 'tick box' as the content for the corporate induction including more Trust stories from clinicians.	Two generic risk assessment forms have been agreed for all non-clinical/clinical new hires as some mandatory training may not be evidenced on start date Induction Policy to be reviewed	Underway – change September from 2017 Outcome will be an improved experience for both managers and new starters	
6. Stay and exit (leavers) interviews- **It is fundamentally important to understand the reasons why people not only leave, but why they stay at QVH, particularly as we have many staff leave in less than 2 years**	a.Removal of the 'other' option for reasons for leaving on paperwork and ESR so clear reasons for leaving are stated b.Introduction of an informal stay interview process targeting an initial 80 staff with various lengths of service and diversity c.renewed focus on exit interviews with personnel letters from HR inviting people to a meeting/prompting to complete d.CEO to invite all new starters on a rolling programme to meet after first 3 months in post	a.none Internal resourcing	Underway b&c has started, some initial findings area included at appendix three and SFFT Appendix 2 Appendices three and four d. CEO will have first meeting in October with new starters from	Refer to appendix two and three for further information

			June/July
7.'Ideal' rosters no longer necessarily meet the needs of a diverse workforce	Review approach to all flexible working including for new mums, older workers, preparation for retirement and learn from other case studies ie Buckinghamshire	Resource required to learn from others Re-set 'rules' on current rosters	November 2017

Nurse specific attraction (in addition to above)

Challenges	Proposed Actions	Resource implication (cost and time)	Priority level/By When	Progress to date
There is nothing on the Trust website that focuses on a nurses career at QVH/reward and recognition packages	Development of nursing area on the Trust website to draw in potential applicants as an employer of choice	External specialist required	November 2017	
The UK supply of nurses is increasingly limited, consider overseas options **Non EU nationals from India and the Philippines are subject to robust entry and visa requirements including a challenging IALTS test. It can take 9 -12 months from interview to get people started in a post with PIN issued.** **EU nationals are now in short supply and due to the unknown impacts of BREXIT are likely to be more mobile and stay for a short period. That said there are still some routes available to us and a number of Trusts have successfully used SKYPE interviews, thereby reducing time and cost. Candidates are still subject to IALTS testing.**	Full proposal received from a specialist agency. We could consider partnering with another Trust who have more expertise in overseas recruitment or engage directly with an agency.	Non EU nurses can cost around £10,312.00 per nurse and have to be guaranteed a minimum annual salary for certificate of sponsorship Cost is around £36,390 for 10 EU nurses via SKYPE. Attrition rates are evidences as very high These costs do not include provision of the first 3-6 months accommodation or take into account that nurses would be working as HCA's until IALTS passed and PIN numbers are granted	Not prioritised	Not recommended for progression
Currently there is no predetermined support for Return to Practice initiatives	We have had some success this year further to a visit to the University of Brighton and currently have three return to practice nurse on the bank including an Open University student supported by HEKSS. Use success as a case study to	Minimal currently	Ongoing opportunity	We will review in Autumn 2017 if this is a successful approach to recruitment and development

	attract further nurses		
No clear process in place to capture student nurses early and attract them 8-9 months prior to PIN	-pay pre-reg nurses at bottom of B4 until PIN confirmed - pay NMC first year registration -offer first increment at end of the 6 month probationary period and second increment at 12 months -offer an internal rotation opportunity once recruited	NMC registration £130.00 Cost of accelerated increment in year Ensure built into workforce planning process for HCA recruitment Ensure services can manage an appropriate number of newly qualified nurses	Attending careers fair at University of Brighton in December. Make offers for May and September start
Currently no specific options are presented to attract more experienced nurses (e.g. short term recruitment premia costs/travel costs)	-consider offering a non-consolidated 'golden hello' for staff in national shortage specialties (critical care, theatres, paediatrics), paid in two or three lump sums over a 12 months period (1x joining, 1x 6 months, 1 x 12 months) -cover additional travel costs for 12 months period for travel in excess of 15 mile radius for new recruits	Minimal when off set against agency and overall recruitment costs	Further discussion required at EMT and researching local area for impact on wider health economy
No offers to attract staff from out of the local commutable area	Offer capped relocation costs	Revise relocation policy urgently	Autumn 2017
Ageing registered nursing workforce presents a high risk – around 1/5 are aged over 55 and could retire	Consult on approaches that would support a phased and flexible retirement Practice Development Nurses/Trust Educator organise team based sessions around shift template and e-roster practices Review success in other Trusts	Get expert advice from pensions agency and learn from others experience (eg UCLH)	Spring 2018
Perception that there are no internal opportunities at QVH so staff more likely to leave to gain experience and	Set up opportunities for 'fast track' internal movement within the Trust for B5 and B6 nurses to move sideways or even	Internal resource to change processes and consult with staff side.	Autumn 2017

progression	down. Create opportunities to 'try' out working in another area ie C Wing from outpatients Already piloted at UCLH and they are willing to share details/process	Approach UCLH to share learning	
Staff look outside the Trust rather that explore how to progress within QVH	Support the above with career clinics and advice and educational opportunities	Explore with HEKSS the use of Career Ambassadors for advice and guidance	Autumn
Ensure staff get a full range of ongoing CPD due to size and specialist nature of QVH.	Creative rotations across organisational boundaries to enable nursing staff to keep up key skills and competencies Critical care rotation with SASH will be piloted	Ensuring adequate cover of critical care rota	underway
No defined career pathways from apprentice through foundation degree	Early stages, linked to the apprentice levy. A long term option	Further information from HEKSS and impact of backfill when nurses on rotation	Spring 2018
How best to 'supplement' the qualified nursing workforce with new roles	Develop a workforce plan that incorporates the Band 4 Nursing Associate and Assistant Practitioner roles	Use Levy for Foundation degree programme	Three Associate Practitioners have begun training in theatres, piloting nurse associate in Peanut ward
Improve bank pay rates ensuring consistency across the STP footprint in particular	The STP Temporary Staffing Collaborative are collating data from all Trusts to provide a set of principles and a benchmark	Part of STP Temporary Staffing collaborative	September 2017
Ensuring a buddy/mentor is available for all new starters to improve induction experience	Build into objectives from Trust Educator and practice mentors		
Less than 60% or our staff would recommend QVH as a place to work	Invite our people to recommend a friend to the Trust in return for a 'reward'	£250.00 once 'friend' has started and £250 on completion of 6	

Reward and Recognition

"People work for money but go the extra mile for recognitions, praise and rewards", Dale Carnegie

Whilst reward and recognition can be split crudely into pay and benefits, we need to think more in terms of a Total Reward package. This does include such things as the working environment promoting a health and safe workplace, appraisals that are meaningful, high quality and balanced

Challenges	Proposed Actions	Resource implication (cost and time)	Priority level/ By When	Progress to Date
Supporting staff to see the wider benefits of working in the NHS not just focussed on pay grade	Section on QNet promoting total reward, salary sacrifice, discount schemes Promote access to Total Reward Statements	Identify specialist time to undertake work	Spring 2018	
Engaging the wider workforce in health and wellbeing activities and encourage managers to take an active role in the well-being of staff	Promotion of Employee Assistance Programme, physio self-referral and Occupational health A programme of wellbeing events across the year Wellbeing events (link to CQUIN) Change appraisal paperwork to encourage 2-way wellbeing conversations between manager and direct report	Ensuring it remains a priority for the Trust and learn from other case studies To plan with Occupational Health Paperwork changed and updated		
A programme that engage and motivate staff and help improve staff job satisfaction	Staff Events: - Long service recognition - Awards - Barbeque Introduce a cascade style team brief Access to learning and education (see below)	Barbeque supported by QVH charity and attended by around 300 in July Staff awards being held in early September 2017 Team brief to be launched in	Completed September 2017 September 2017	

		September 2017	
Ensure staff are able to access a number of ways of speaking out and raising any concerns	Promotion of FTSU and the principal guardian role	Guardian	Complete and promotion ongoing
As a specialist Trust staff report feeling isolated from the bigger picture and understanding the flow and diversity of services and what others do in the hospital	Promote an 'in your shoes' shadowing programme	Internal resource to develop and launch	Winter 2017/Spring 2018

Education, Training and Development including leadership development

Challenges	Proposed Actions	Resource implication (cost and time)	Priority level/By When	Progress to Date
Simulation facilities to support multi professional learning are old and outdated	Submit charitable bid upgrade current simulation facilities to state of the art in support of multi professional learning and improve attraction of clinical staff	External bid being prepared	To be submitted October 2017	
No clear structure for nurse education governance, impacts on identifying a recruitment pipeline of student nurses and cohesive support for practice mentors	Re-establish the trust educator post Develop clear nurse education governance Build relationships with other HEI's Run accredited specialist units in-house (burns and max fax)	Post re-established In dialogue with South Bank University in relation to student rotation and accreditation of specialist education modules	September 2017 September 2018	
Exploit the opportunities as part of the apprentice levy across a range of professions including an entry level nursing pathway	-All HCA;s to undertake care certificate -promote role of assistant practitioner - build into workforce plan nurse associate at Band 4 -support other staff groups with	Resource time to spend the levy appropriately and sustain releasing so many staff from the workplace for learning	Assistant practitioners identified in theatres and a nurse associate in Peanut Ward	

	accredited learning opportunities		
As a small Trust being able to retain talent if there are no available posts	Design a pipeline for maximising potential (Talent) locally and across the STP system	Director of Workforce Attending Pt 4 of a HEKSS programme to look at collaboration on identifying and retaining Talent in the wider system	October 2017
More staff need to develop skills and behaviours conducive to being an effective manager and leader at QVH	Build on next stage of Leading the Way leadership programme		Ongoing
No current promotion of career opportunities for non-registered clinical staff	Charitable bid to the League of Friends, proposal awaited	£90k per student over 3 years	October 2017
Engaging Medical and dental staff in leadership programme and the modelling inclusive behaviours	Develop clinical leadership initiatives with Medical Director		

Appendix One

The paper above, Attraction and Retention2.a, recommends the Trust make an initial investment of £50,000 in branding, marketing and developing our social media presence. This would effectively be a budget pressure for the Trust so the examples below are intended to demonstrate the impact of staffing issues just in Theatres providing just a snap shot of costs and lost income due to staff shortages.

			Substantive Employee			Bank Only Worker			Agency			
Job title	Band	Hours per shift	QVH Hourly rate (spine point 5.5)	QVH On cost per hour (24.5%)	QVH Total Cost per Shift per worker **(SUBSTANTIVE)**	QVH Hourly rate (point 5.5 inclusive of WTD)	QVH On cost per hour (24.5%)	QVH Total Cost per Shift per worker **(BANK)**	Average Agency hourly rate ***(Note 1)***	Total Agency charge per shift **(AGENCY)**	Saving using Substansive staff compared to agency per shift	Saving Using Bank staff compared to Agency per
Theatre Practitioner	5	9.50	£13.07	£3.20	£154.57	£14.64	£3.59	£173.19	£29.70	£282.15	£127.59	£108.97
Theatre Practitioner	5	9.50	£13.07	£3.20	£154.57	£14.64	£3.59	£173.19	£29.70	£282.15	£127.59	£108.97
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Theatre Practitioner	5	9.50	£13.07	£3.20	£154.57	£14.64	£3.59	£173.19	£29.70	£282.15	£127.59	£108.97
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Theatre Practitioner	5	9.50	£13.07	£3.20	£154.57	£14.64	£3.59	£173.19	£29.70	£282.15	£127.59	£108.97
Theatre Practitioner	5	9.50	£13.07	£3.20	£154.57	£14.64	£3.59	£173.19	£29.70	£282.15	£127.59	£108.97
Theatre Practitioner	5	9.50	£13.07	£3.20	£154.57	£14.64	£3.59	£173.19	£29.70	£282.15	£127.59	£108.97
DAILY COST OF COVERING TEN SHIFTS IN THEATRES					**£1,545.65**			**£1,731.85**		**£2,821.50**	**£1,275.85**	**£1,089.65**

Note 1 - based on an average of the agency hourly rate of the three agencies regularly used to fill 10+ shifts a day in Theatres.
Note 2 -On average 1-2 extra lists per month have been allocated on a Saturday as Overtime. This has been paid as overtime to full time employees, other ad-hoc Theatres OT is for extending shift length rather than working whole shift as overtime.

<u>Assumptions</u>:

Pay savings (<u>theatres only)</u>:

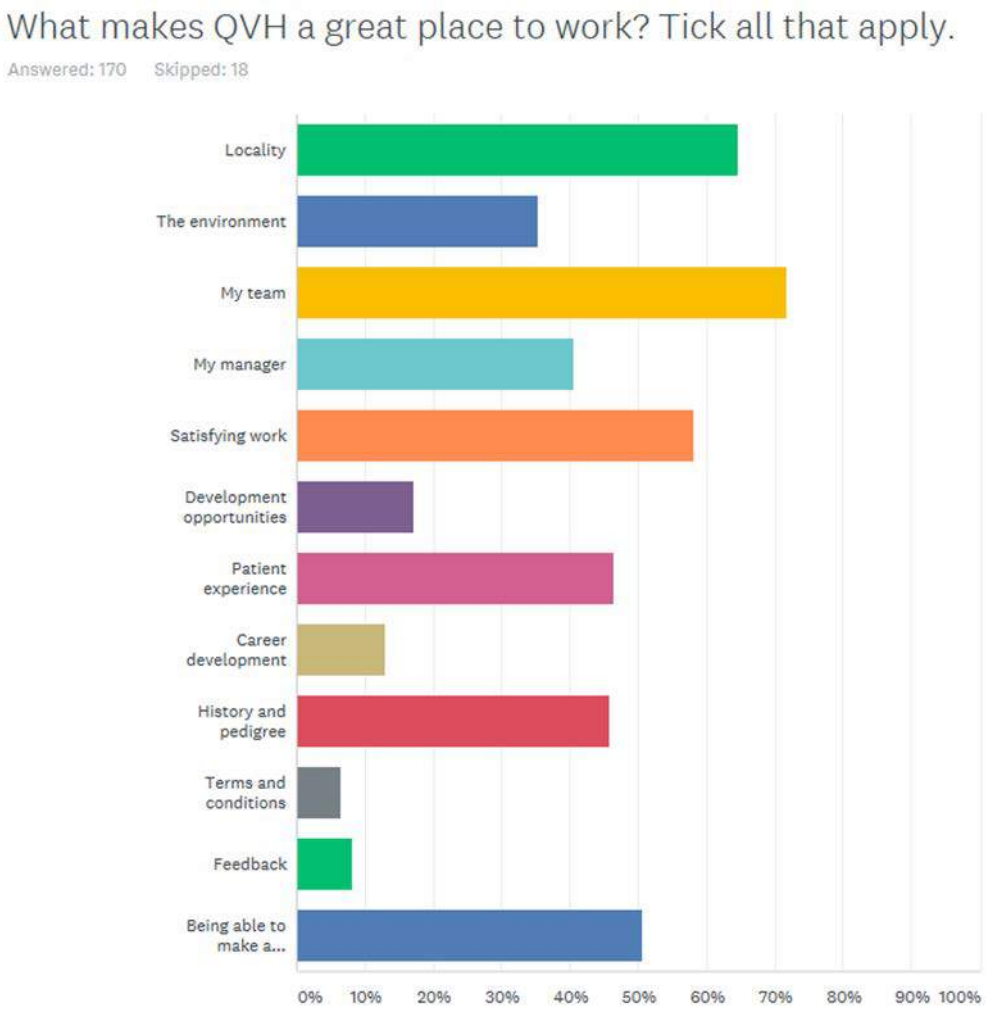
- The cost differential between substantive employment and temporary agency cover is c£30k per annum, per Band 5 w.t.e (flat rate)
- Theatres employs between 10 and 13 w.t.e. agency staff on a regular basis
- Reducing agency usage by 1.00 w.t.e. would equate to an overall cost reduction of c£30k per annum, 2.00 w.t.e. = c£60k, 3.00 w.t.e. = c£90k etc.
- Return on investment will be measured via a) an increase in appointments, b) a reduction in agency spend, c) a reduction in staff turnover, d) reduction in cancelled lists and e) increase in activity (and associated income)
- There will be a lead-in time/time lag on any return on investment due to the time necessary to develop and roll-out the strategy as well as 'time to hire', notice periods etc.
- The working assumption is that no benefits should be expected inside 6 months of investment
- At 01/07 we are planning for a net increase in starters, above the current baseline, as follows:
  - Planning expectation is that we will add one w.t.e six months after investment and a further two one month after and a further three one months after that (This is to demonstrate that we can make a return on investment within around 6 months so overall payback within 12 months, based on cost reduction alone
  - Based on the above the projected full year cost reduction would equate to c£180k

Activity increase:

- At present, between 2-4 lists are cancelled per month in the Day Treatment Centre
- The key driver/limiting factor is the availability of staff (nursing)
- Each list includes between 6-8 patients
- The specialties most affected are skin and eyes (cataracts)
- The spell value ranges between £650-£850
- Lost income ranges from c£94k - £326k per annum based on the information above

Appendix Two

Staff responses to second quarter 2017 Staff Friends and Family Test



Appendix Three – QVH stay and exit interviews up to 29 August 2017

Employee Feedback Conversations – 35 conversations held – Key themes:	
Question	**Summary of themes**
What do you look forward to when you come to work at QVH each day?	Variety; colleagues; being part of a team; environment; patients; making a difference; new experiences; going home
Overall, how well do you feel the organisation engages and communicates with employees?	Well; variably; barriers between departments; better than other hospitals; don't always have access to the system; staff don't always have time to attend event i.e. breakfast with Steve; departments work in Silo's
What do you least like about QVH?	Resistance to change; communication; lack of career progression; parking; canteen food; staff shortages; lack of public transport links
Do you have suggestions about how we can improve as an organisation?	Transparency; treat staff with respect; benefits package; involvement of all stakeholders; middle management training; canteen to cater for more allergies i.e. gluten free; car parking; senior management more visible i.e. Directors/ Business Unit Managers; communication improvements; career progression
Would you recommend QVH as an employer/ place to work?	Yes; less than would have previously; morale is low; the patients make QVH a nice place to work
Do you believe that your work has meaning and know how it contributes to the wider Trust?	Yes; lack of appreciation
Is the organisation providing you with the opportunities to grow and develop as a person and as a professional?	Yes and no; lack of external funding; patient always comes first; training opportunities; to move up I'd have to move on; time to attend training courses is hard
Are you treated respectfully by your colleagues/ managers?	Yes; colleagues and immediate managers yes; senior management no
What type of feedback do you receive about your	Appraisals; probation reviews; 1:1's; lack of informal feedback; lack of appreciation

performance (appraisal)?	
Do you feel there is good leadership within your department?	Yes; immediate managers yes; no for senior managers; approachable; senior management are not visible
Have you experienced work-related stress?	Yes; management are supportive; not in my current role; frustration but not stress
Have you experienced musculoskeletal (MSK) issues as a result of work activities?	No; have MSK issues but can't blame work solely
Are you aware of the support available for your health and wellbeing?	Yes; only Occupational Health
In the last 12 months, have you thought about leaving the organisation or actively job searched?	Yes; thought about it; always looking
Is there anything else that is important to you that we did not cover during this meeting?	Morale is low; lack of appreciation; staffing issues; career progression; parking; learning and development; transport links; departments working in silos; visibility of senior management and execs; everyone is helpful; great place to work; workload pressures; listening and feedback following

Departing Employee Conversations – 14 conversations held – Key themes:	
Question	**Summary of themes**
What do you look forward to when you come to work at QVH each day?	The team; people; patients; variety
Overall, how well do you feel the organisation engages and communicates with employees?	Not very well; lots of emails; communication problems
What do you least like about QVH?	Salary; management; communication; lengthy recruitment process
Do you have suggestions about how we can improve as an organisation?	Communication; induction needs improving
Would you recommend QVH as an employer/ place to work?	50% yes; 50% no
Do you believe that your work has meaning and know how it contributes to the wider Trust?	Yes
Do you feel the organisation provided you with opportunities to grow and develop/ career opportunities as a person and as a professional?	Yes; colleagues yes; managers no
Do you feel you have been treated respectfully by your colleagues/ managers?	Yes; colleagues yes; managers no
What type of feedback did you receive about your performance (appraisal)?	Appraisals; no feedback received at all
Do you feel there is good leadership within your department?	Yes; visibility of senior management
Have you experienced work-related stress?	4 no; 5 yes; 1 didn't answer

Have you experienced musculoskeletal (MSK) issues as a result of work activities?	No
Are you aware of the support available for your health and wellbeing?	Yes
What attracted you to your new post?	Salary; returning to a previous organisation; job role issues
Is there anything else that is important to you that we did not cover during this meeting?	Environment needs updating; management issues; staffing issues; returning on the bank

Chief Executive's Report					
References					
Meeting title:	Board of Directors				
Meeting date:	7 September 2017		Agenda reference:	156-17	
Report title:	Proposed STP governance & leadership model for system-wide transformation				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Carnall Farrar				
Appendices:	Appendix A: Draft Sustainability and Transformation Partnership Memorandum of Understanding (MoU) to support Sussex and East Surrey governance Appendix B: Draft terms of reference for the proposed governance structures				
Executive summary					
Purpose:	To brief the Board on a review of the Sussex and East Surrey STP governance infrastructure and to request approval of revised governance arrangements to support improved delivery of the STP.				
Recommendation:	Note the review of the current STP governance arrangements and consider the following recommendations: It is recommended that the Governing Body/Board/Cabinet, if required: 1. Approve in principle the revised STP governance and leadership infrastructure to support the delivery of the STP 2. Approve in principle, and authorise the Chief Executive to sign, the Draft Memorandum of Understanding for STP Governance. This will provide a mechanism for securing ongoing commitment to sustained engagement with, and delivery of, the STP 3. Approve in principle the draft terms of reference for the proposed governance and leadership model				
Purpose:	Information	Information	Information	Information	Information
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Executive Management Team				
	Date:	03/07/2017	Decision:	Approved	

Governance for transformation

1.0 Background

1.1. The NHS Five Year Forward View (FYFV) published in 2014 envisaged an inclusive and whole system approach to service transformation.

1.2 The NHS Shared Planning Guidance for 2016/17 – 2020/21 (published in March 2016) asked every local health and care system to come together to create their own local plan for accelerating the implementation of the FYFV.

1.3 NHS England proposed 44 geographical planning footprints (referred to as Sustainability and Transformation Plans (STP)) to aggregate coherent health and social care communities and to permit 'place based' approaches that could drive the change required to address three gaps: the health and wellbeing, the care and quality and the finance and efficiency gaps.

1.4 The guidance recognised that growing financial problems in different parts of the NHS cannot be addressed in isolation. Instead NHS providers and commissioners were required to come together to manage the collective resources available for services for their local population.

1.5 The most recent national guidance **'Next Steps on the NHS Five Year Forward View'** published on 31st March 2017 highlights the need to strengthen STPs, their leadership and infrastructure. The guidance describes the formation of 'Sustainability and Transformation Partnerships'. These are not new statutory bodies and hence supplement rather than replace the accountabilities of individual organisations. The guidance states it is a case of 'both the organisation and our partners', rather than 'either/or'.

1.6 The guidance outlines that to succeed all STPs need a basic governance and implementation 'support chassis' to enable this type of effective working. All NHS organisations will therefore from April form part of a Sustainability and Transformation Partnership.

1.7 The guidance requires the establishment of an STP board drawn from constituent organisations including appropriate non-executive participation, partners from general practice, and in local government wherever appropriate. The Partnership will also establish formal CCG Committees in Common or other appropriate decision making mechanisms where needed for strategic decisions between NHS organisations.

1.8 The guidance also states, in the unlikely event that it is apparent to NHS England and NHS Improvement that an individual organisation is standing in the way of needed local change and failing to meet their duties of collaboration, the regulators will– on the recommendation of the STP as appropriate – take action to unblock progress, using the full range of interventions at their disposal.

1.9 Also, where this has not already occurred, The Partnership will re/appoint an STP chair/leader using a fair process, and subject to ratification by NHS England and NHS

Improvement, in line with the national role specification. NHS England will provide funding to cover the costs of the STP leader covering at least two days a week pro rata.

1.10 While STPs carry a big burden of expectation, they also represent a huge change in working practices. They mark a move away from a focus on individual organisations and market competition towards system working. Complex, with a large number of stakeholders, each STP also starts from a different point in terms of local relationships. Collaboration with other services and sectors beyond the NHS is needed to focus on the broader aim of improving population health and wellbeing and not just on delivering better quality and more sustainable health care services.

1.11 This move from 'silo' working within organisations to collaborative working in footprints requires governance arrangements to support collective decision-making and action to plan and deliver the changes required.

1.12 The current focus on the new care models identified in the Five Year Forward View, and the transformation of local integrated care services delivered through place-based systems of care, requires organisations to work together to deliver services well these new accountable systems are led, directed and held to account will be crucial to their success.

1.13 The Sussex and East Surrey STP has at its core an agreed approach of the Places (ESBT, Coastal, and the North and South of the central corridor) being the building blocks from which decisions and budgets are delegated down to localities and up to the STP where commissioning and/or provision on a larger population basis is evidently beneficial.

2.0 The importance of good governance

2.1 STPs are the latest mechanism to drive system-wide collaboration and planning. They bring with them an important opportunity to improve the way the whole system works together to deliver high quality and sustainable services through new placed based models of care. Since STPs do not change the statutory responsibilities of individual organisations they raise important questions for how governance and engagement will be managed to support collective decision-making.

2.2 Where STPs are beginning to work well, common factors include improved relationships, a focus on place, a clearly articulated story, commitment at all levels and transparency.

2.3 Good governance is the cornerstone of effective and faster decision-making and transparency. It ensures an efficient and effective organisation working in the interests of patients and public by the right people making the right decision at the right time in the right place. Effective governance should drive STP implementation and ensure the best possible decisions are made to support the needs of each population.

2.4 Good governance helps to form closer working relationships and identify areas where duplication can be avoided and incentives aligned. This will mean a cultural shift from maintaining individual power bases to a more collaborative way of

working that supports joint decision-making.

2.5 To navigate the many complexities and maintain momentum, governance models must be clear, robust and flexible. During 2017, practical steps must be taken to implement the vision as STPs take shape in a financial and care context that is already very demanding. This is likely to test governance arrangements – as will the involvement of the public as service and structural changes are subject to consultation.

3.0 Governance issues for STPs

3.1 A number of issues need to be considered to ensure that governance is the driving force behind the STP, and supports effective decision-making that is accountable to patients and the public. Issues include:

- **Accountability**

  Although individual organisations remain accountable for their own plans, there is a need to define who will be accountable for the delivery of the STP, and how the statutory duties for each constituent organisation relate to the broader roles and responsibilities within the STP.

- **Place Based Accountability**

  As the new models of place based care begin working to pool budgets and integrate services more closely, formal governance arrangements need to be developed between the providers working together and the commissioners contracting for the new systems. At the same time the STP governance structures need to assess how to relate to the emerging place based partnerships.

- **Patient and public engagement**

  Governance arrangements must ensure that the perspectives of local communities are considered at every phase of development and delivery. The new models of place based care will play a crucial role as the health and wellbeing delivery vehichle for their local population.

- **Building the right relationships with local government**

  Governance structures must support effective working across place based partnerships and commissioners of both health and social care. The STP will need to help organisations make joined-up decisions for the patients and populations they commonly serve.

- **Organisational structures and efficiencies**

  There is an inherent tension between making decisions quickly to speed up transformation and making the right decisions openly and transparently, with the support of the main stakeholders in the system. A governance structure needs to be streamlined yet facilitate two-way communication with individual trust boards, CCG governing bodies, local authority cabinets and health and wellbeing boards.

- **The clinical voice**

It is essential that the clinical voice is preserved within STPs and sits equally alongside the managerial voice to drive service transformation and improvement.

- **Independent scrutiny**

  No matter how governance structures develop, the non-executive community should be represented throughout the decision-making process to ensure that scrutiny, transparency and decision-making remains firmly in the interest of the public and patients.

- **Audit and assurance**

  The STP should encourage the review of benefits of the different systems and support new ways of working that deliver place-based quality assurance, wider footprint benchmarking, and sharing of learning, as well as forge a closer link with local authorities and their overview and scrutiny function.

4.0 Review of progress in Sussex and East Surrey (SES)

4.1 In Sussex and East Surrey, 24 organisations have come together to form the STP footprint (organisations listed in Appendix A). This health and care system faces significant financial, quality and performance challenges. The NHS financial gap is projected to grow to £653m by 20/21 (£864m for health and social care). However, given the deteriorating financial position, this is likely to be higher. Across the footprint care and quality issues exist particularly in cancer detection and care, mental health, stroke rehabilitation and social support with significant challenges in primary care.

4.2 The initial focus in SES was the development of the STP to address the challenges. The October 2016 STP submission identified key priorities and initiatives to help deliver on the three gaps of improved health and wellbeing, quality of care and financial sustainability.

4.3 The leaders of SES come together regularly within a programme structure to provide direction to the system and delivery of the STP.

4.4 However, the transformation ambition set out in the STP has not been progressing at the pace and scale required to make significant progress on the issues faced. The system leaders are concerned that the programme mechanisms in place are not sufficiently effective to jointly address the deteriorating financial position and the delivery of the STP.

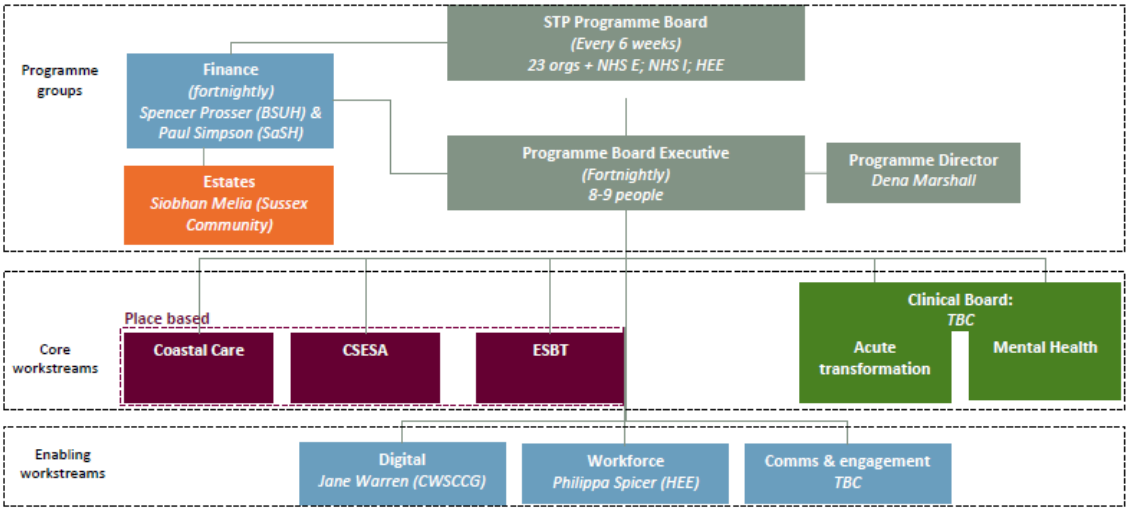
4.5 Consequently, an STP 'review and refresh' exercise was commissioned to identify the challenges in the system and ways to move forward. A key component of this work was to review the governance and leadership infrastructure.

4.6 The review has helped to clarify the roles and responsibility of the STP, the interactions with place-based care and the individual organisations. As a result recommendations have been made for revised programme governance and decision making processes to increase effectiveness.

5.0 Current governance arrangements in Sussex and East Surrey

5.1 Since the October 2016 STP submission, the SES leaders have been coming together regularly in a programme executive and programme board to provide direction to the system and delivery of the STP.

Figure 5.1: Existing Sussex and East Surrey STP governance structure



6.0 Outcome of the governance review

6.1 Feedback from interviews, and a workshop with STP system leaders held on 21st February 2017, suggested a general, overall consensus that:

- The current STP governance is not sufficient to support effective collective decision-making, nor is there clarity on where authority and accountability lie
- The current set-up does not have an effective reporting and monitoring mechanism
- This needs resolving quickly

6.2 The outcomes from the workshop identified overall general agreement with the principles and proposed revised governance structure. However, it was emphasised that there was also a need for a change in culture and approach to joint working and that some existing behaviours will need to change to allow the governance structure to work effectively.

6.3 There was also general agreement that organisations will need to delegate more control to place-based accountable care systems, and to the STP overall, to enable effective joint working. This will need to be agreed with each organisation.

7.0 Objectives of the SES STP governance arrangements

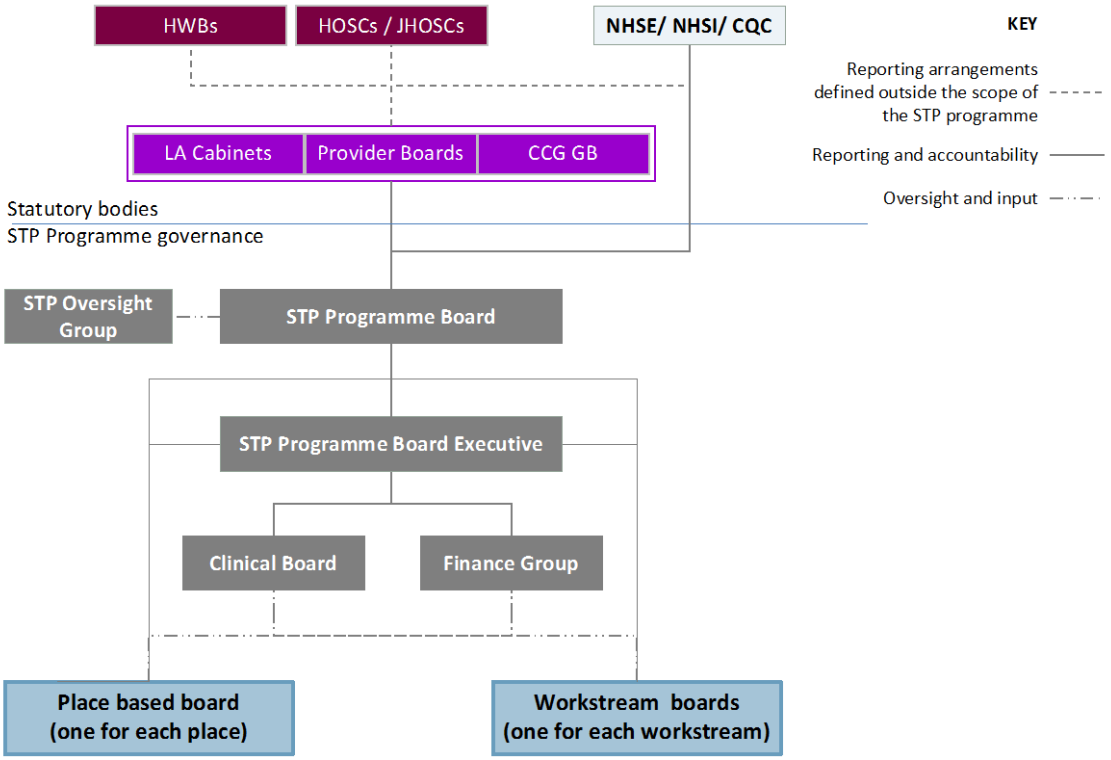
7.1 Following the review, and with input from system leaders across the STP, it has been agreed that the objectives for effective governance arrangements in Sussex and East Surrey should be to:

- Support effective collaboration and trust between SES health and social care organisations and the places to work together to deliver the transformation aimed at closing the three gaps
- Define the roles and responsibilities of the leadership
- Provide a robust framework that facilitates more effective decision-making and defines what decisions are made at which level, including place level
- Clarify decision-making authority and accountability, which is aligned with governance of places and individual organisations
- Provide assurance around progress and delivery of both the STP programme and place-based plans
- Clarify the reporting and monitoring mechanism
- Allow for transparent communication between a complex network of stakeholders
- Make the most of the scarce and limited resources available
- Learn lessons from other programme and governance arrangements

8.0 Revised governance structure

8.1 In response a new governance structure has been proposed. Figure 8.1 sets out the relationship between the constituent STP leadership groups, working groups and the statutory bodies.

Figure 8.1 Proposed revised Sussex and East Surrey STP governance structure



8.2 The STP governance arrangements make recommendations for system transformation to the statutory bodies, including all organisational boards. These organisational boards have their own governance and engagement arrangements with their regulators and other committees (e.g. health and wellbeing boards and health oversight and scrutiny committees).

8.3 Governance relating to statutory bodies is outside the STP programme's governance arrangements and is included in the visual representation (Figure 8.1) to highlight their relevance as stakeholders, especially when considering communications and engagement plans.

8.4 The STP programme is related to health and wellbeing boards in that the STP programme is framed by the Health and Wellbeing Strategies and will, in turn, inform the further development of the Health and Wellbeing Strategies.

9.0 Roles and responsibilities

9.1 The STP Programme is made up of groups with discrete functions that they need to perform to effectively monitor, manage and ultimately deliver the STP.

9.2 The proposed revised role of each group and their related responsibilities are defined in more detail in their individual terms of reference which can be found in Appendix B.

9.3 Membership will reflect the ongoing development of new organisational structures.

Governance Structure	Role and responsibilities
STP Programme Board Membership includes: • Accountable officers of the CCGs • Chief executives of the provider organisations • Chief executives of the local authorities • NHS England and NHS Improvement representatives • Health Education England representative • Clinical Board co-chairs • Finance Group chair • Oversight Group chair Meets once every six weeks	Strategic oversight and delivery of the STP on behalf of all partner organisations across Sussex and East Surrey
	Allow the members, through their representatives, to make aligned decisions
	Assess cross organisational and programme level risks
	Provide overall assurance of STP planning, delivery and risk management
	Ensure appropriate links are made with other SES strategic programmes
	Connect with national bodies and other external organisations (e.g. Clinical Senate, Health Education England) to ensure it draws on the support available
	Feed in best practice and learning from other areas into the development and delivery of the programme
	Align with national policy direction
	Act as a meeting forum and single communication channel with regulators with regard to SES STP and for applications for transformational funding
	Produce options, recommendations, proposals for ratification by the members

Governance Structure	Role and responsibilities
STP Programme Board Executive Membership includes: • STP convenor, Provider SRO • CCG STP SRO • Local authority STP SRO • Clinical Board co-chairs • Finance Group chair • Place-based leadership (SPoL) • Workstream SROs • STP Programme Director • Comms and engagement lead Meets once every fortnight	Act as the engine to drive delivery of the STP Promote consensus on change to be delivered Make recommendations to the STP Programme Board Manage cross organisational and programme level issues, risks and dependencies Oversee the development of the programme plan and its deliverables Ensure that appropriate links are made with other SES strategic programmes Ensure that place-based plans and STP workstreams are aligned and aggregated to the overall outcomes of the STP Provide steer to the wider programme team who will deliver the STP work on a day-to-day basis
STP Clinical Board Membership includes: • Clinical chairs of the CCGs • Medical directors of the provider organisations • Clinical director of the 3Ts • South East Coast Clinical Senate representative • NHS provider trusts nursing director representatives • Primary commissioning practice nurse representative (as required) • Director of adult social services representative (as required) • Director of children's services representative (as required) • Director of public health representative Meets once every fortnight	Review, advise and make recommendations for health and care transformation across Sussex and East Surrey from a clinical and care professional perspective Oversee the development of the clinical strategy Provide clinical and care professional input in, and support to, all STP workstreams and place-based arrangements Promote clinical and care professional consensus on potential options Make recommendations to the STP Programme Board Executive
STP Finance Group Membership includes: • Chief finance officers of the CCGs • Finance directors of the provider organisations • County council finance leads	Ensure the Sussex and East Surrey Sustainability and Transformation Plan delivers financial sustainability across the whole system and uses available resources to best effect Provide financial leadership as well as strategic advice and guidance to develop and deliver the STP and make

Meets once every fortnight	recommendations to the STP Programme Board Executive on financial matters
Governance Structure	**Role and responsibilities**
STP Oversight Group Membership includes: • Chairs of the CCGs • Chairs of the provider organisations • Leaders of the local authorities Meets once every 2 months	Provide oversight of the development and delivery of the STP and gives feedback to the Sussex and East Surrey STP Programme Board on elements of the plan
	Provide NHS governing bodies, trust boards and political leaders a forum to steer the development of cross organisational working within the STP remit but does not have statutory or formal responsibilities
	Connect the organisation-based accountability structures with the broader STP programme and provide assurance for STP governance and infrastructure.
	Consider and review political and public engagement ahead of transformation and potential consultation
Place-based boards Frequency of meeting as agreed by each place	Responsible for overseeing the delivery of the place-based plans
	Responsible for delivering the outcomes (health, quality and financial) for their population
	Design, develop and establish new model of care and organisational forms to enable the achievement of these outcomes
Workstream programme/ delivery boards Frequency of meeting as agreed by each workstream	Responsible for overseeing the design and delivery of their workstream to meet the ambition and outcomes required of it to align to the STP
	Provide operational leadership to the workstream programme and ensure operational targets are being met (e.g. timelines, outcomes, milestones).
	Ensure all delivery team members working across organisations are aligned on their effort and expectations set out in the workstream plan and interdependencies with other workstreams are highlighted and actively addressed
	Make strategic recommendations to the

	STP Programme Board Executive acting as the subject matter experts in the various fields

10.0 Principles for revised SES STP governance arrangements

10.1 Any group of individuals that works together to a common end will develop its own culture. If that culture is to be the right one it will need to be planned and managed. This applies just as much to a grouping of chief executives as it does to any other group. The culture of these groupings will also need to be in keeping with the culture of the organisations that make up the STP.

10.2 A common set of principles identifying the necessary culture and the best ways of working together will support with effective governance arrangements. Constituent organisations' accountable officers should agree these principles and capture them in a **Sustainability and Transformation Partnership 'Memorandum of Understanding'** (MoU). A draft MoU is attached in appendix A.

10.3 The following proposed principles are an amalgamation of good governance principles from elsewhere and input from the SES STP Chairs meeting on 16 February 2017. To be effective the STP programme should have:

10.3.1 **Collective authority**

- Organisational leaders take decisions within their delegated powers and bring to bear the authority of their organisational positions
- Design of meetings facilitates consistent engagement of key leaders with delegation of attendance by exception only
- Formal decision-making rests with statutory organisations, which own and drive the work through their leaders' participation in all elements of the programme

10.3.2 **Inclusivity**

- All decision-making organisations are members of the STP Programme Board
- Wider partners and other stakeholders are often reflected in groups/ forums to support the STP Programme Board
- There are clear arrangements for patient and public engagement

10.3.3 **Clinical leadership**

- STP leaders want to strengthen involvement in the content of the plans particularly among clinicians as well as other frontline staff, patients and the public
- Clinical board is central to the programme's structure
- Clinical leaders and care professionals take on a leadership role
- The clinical/ service workstreams and wider clinical engagement are clinically led

10.3.4 **Efficient process and effective decision-making in place**

- Clear governance structure and reporting arrangements

- A small STP Programme Board Executive supports the STP Programme Board
- Colleagues are able to represent each other, with structures to support this
- The relationship with statutory bodies, and the associated decision-making processes are clear

10.3.5 **Clarity and transparency**

- When considering the scope, aims and priorities of the programme
- Within governance structures, decision making and delegation of authority
- Translating to an open book approach to financial and other data

10.3.6 **Effective programme structure**

- Includes the key elements: clinical transformation, enabling strategies, finance and productivity
- Workstreams are grouped and reporting through clinical, finance and management groups
- Workstreams are supported and resourced appropriately

10.3.7 **Co-production and patient and service user involvement**

- There is active dialogue between people who use services and people who prvide them

11.0 Decision making

11.1 The STP MoU also sets out the decision-making arrangements for the STP. This includes:

11.1.1 **Principle of subsidiarity**

The SES STP has a multi-layered governance structure and decisions will be taken at the appropriate level, whether that is locally, in places or STP-wide. The aspiration is to do work at scale across the STP where it adds value and decisions will be made at that level. Where solutions are most appropriately delivered locally, decisions should be made at that level. This means decisions need to be made as close as possible to the people affected by them. The MoU needs to acknowledge and respect the principle of subsidiarity.

11.1.2 **Degree of consensus required**

It is the collective that makes decisions jointly to bind organisations to action, not individual members from each organisation. No individual member (e.g. the chair) can make binding decisions on behalf of other members. The approach for decision making should first be to seek consensus on issues. The STP will be accountable for the whole of SES population and therefore may be required to intervene or mediate conflicting priorities for the good of the whole population.

11.1.3 **Delegation of authority**

The principles of what needs to be delegated are still to be individually agreed with each constituent organisational body. Formal decisions impacting individual organisations and those within statutory requirements will be signed off by statutory

boards. They may, however, choose to exercise these collectively or delegate some authority to the STP Programme Board. Agreement is needed from statutory organisations on the delegated authority arrangements.

11.2 The STP MoU also includes sections on:

11.2.1 **Reporting mechanism**

Regularly reporting the status of the programme at the various forums is imperative for the successful monitoring of the programme.

11.2.2 **Risk and assurance**

Implementation of STP projects is likely to generate risks that affect more than one organisation. Many financial risks can effectively be pooled with each participant responsible for finding financial resource to cover their share of any cost should the risk not be successfully managed and become a reality. Risks to quality of care cannot easily be subdivided and the consequences of something going wrong with an STP project will impact on the reputation of each of the participants as if they were the sole organisation involved. Clarity about ownership and management of risks is particularly important in inter-organisational projects.

11.2.3 **Escalation process**

Standard programme management procedures should be in place to manage risks and issues at the correct level (for example a workstream issue is addressed by the workstream concerned).

11.2.4 **Dispute resolution**

To a very large degree STPs will depend on the unanimity of the organisations within the footprint. There is no legal mechanism for majority voting or for compelling organisations to submit to plans that their boards in all conscience cannot endorse. However there are also likely to be disagreements as projects progress on matters of detail and these disagreements will need to be resolved. The MoU will anticipate such disagreements from the outset and to agree how they will be addressed and resolved.

11.2.5 **Code of conduct**

Leadership and behavioural change is critical to make the governance work. Behaviours will reflect principles and are defined in the code of conduct within the STP MoU.

11.2.6 **Conflict of interest**

A conflict of interest occurs when an individual's ability to exercise judgement is impaired or influenced by their involvement in another role or relationship.

11.2.7 **Communication and consultation**

What happens as a result of STPs will play out in the public arena. The public has a legitimate interest in influencing what happens to health and social care services in their area. High quality consultation coupled with transparency and clarity of communication will be essential and needs to be planned for as soon as possible. However the legal duty to consult lies with individual organisations.

12.0 Conclusion

12.1 Governance is the conscience for every organisation, and with the move to align organisational strategy with new place-based ways of working it is important to make sure ideas for governance follow and reflect the new realities of the NHS.

12.2 Done well, governance will assure that the STP programme is accountable to the populations served and that the best possible decisions are made at the right time. If governance is not handled proactively the STP may fail to live up to its potential and leaders will struggle to establish effective ways of working which are needed to translate plans into action.

13.0 Recommendations

13.1 It is recommended that the Governing Body/Board/Cabinet:

1. Approve in principle the revised STP governance and leadership infrastructure to improve support for delivery of the STP which will continue to be reviewed;
2. Approve in principle, and authorise the Accountable Officer/ Chief Executive to sign, the Draft Memorandum of Understanding for STP Governance. This will provide a mechanism for securing ongoing commitment to sustained engagement with, and delivery of, the STP; and
3. Approve in principle the draft terms of reference for the proposed governance and leadership model.

14.0 Next steps

14.1 **Continuous review process**

Subject to agreement from all constituent members, and taking into account any required amendments, these revised governance arrangements will be adopted by all statutory organisations that constitute the SES STP and the shared MoU will be signed. Due to the changing nature and dynamics of STP development, however, these governance arrangements should be periodically reviewed.

It is recommended that the STP programme instigate an overarching STP programme review process and review all governance on six-monthly basis until the STP programme moves into 'business as usual' mode.

APPENDIX A Draft Sustainability and Transformation Partnership Memorandum of Understanding (MoU) to support Sussex and East Surrey governance

This memorandum of understanding is made on [ ] 2017

1 Parties

The parties to this MoU are the following NHS commissioners and providers and local authorities in the Sussex and East Surrey footprint:

1. NHS Brighton and Hove CCG
2. NHS Coastal West Sussex CCG
3. NHS Crawley CCG
4. NHS East Surrey CCG
5. NHS Eastbourne, Hailsham and Seaford CCG
6. NHS Hastings and Rother CCG
7. NHS High Weald Lewes Havens CCG
8. NHS Horsham and Mid Sussex CCG
9. Brighton and Hove City Council
10. East Sussex County Council
11. Surrey County Council
12. West Sussex County Council
13. Brighton and Sussex University Hospitals NHS Trust
14. Central Surrey Health
15. East Sussex Healthcare NHS Trust
16. First Community Health and Care
17. Integrated Care 24
18. Queen Victoria Hospital NHS Foundation Trust
19. South East Coast Ambulance Service NHS Foundation Trust
20. Surrey and Borders Partnership NHS Foundation Trust
21. Surrey and Sussex Healthcare NHS Trust
22. Sussex Community NHS Foundation Trust
23. Sussex Partnership NHS Foundation Trust
24. Western Sussex Hospitals NHS Foundation Trust

2 Background

2.1 NHS Shared Planning Guidance for 2016/17 – 2020/21 asked every local health and care system to come together to create their own Sustainability and Transformation Plan (STP) for accelerating the implementation of the Five Year Forward View (FYFV).

2.2 The Sussex and East Surrey footprint was identified as one of the STP footprint areas in which people and organisations will work together to develop robust plans to transform the way that health and care is planned and delivered for their populations.

2.3 The Parties have agreed to work together to enable transformative change and the implementation of the FYFV vision of better health and wellbeing, improved quality of care, and stronger NHS finance and efficiency.

2.4 The Parties have agreed and submitted their STP in October 2016 but agree that it is a living document that may be varied and updated from time to time.

3 Leadership

3.1 Leadership of the STP should be visible, build consensus and communicate a shared vision for Sussex and East Surrey. The leadership should also provide direction, oversight and motivation for improving health and care and implementation of the STP in Sussex and East Surrey

3.2 The Partnership will re/appoint an STP chair/leader using a fair process, and subject to ratification by NHS England and NHS Improvement, in line with the national role specification. NHS England will provide funding to cover the costs of the STP leader covering at least two days a week pro rata.

4 Duration of the MoU

4.1 This MoU will take effect on the date it is signed by all Parties.

4.2 The Parties expect the duration of the MoU to be for the period of 2017-2021 in line with the duration of the STP or otherwise until its termination

5 Objective

5.1 The Objective of this MoU is to provide a mechanism for securing the Parties' agreement and commitment to sustained engagement with and delivery of the STP to realise a transformed model of care in Sussex and East Surrey

6 Agreed principles

6.1 The Parties have agreed to work together in a constructive and open manner in accordance with the following agreed principles for ways of working and culture:

1. Collective authority
2. Inclusivity

3. Clinical leadership
4. Efficient process and effective decision-making in place
5. Clarity and transparency
6. Effective programme structure
7. Co-production and patient and service user involvement

7 Effect of the MoU

7.1 This MoU does not and is not intended to give rise to legally binding commitments between the Parties.

7.2 The MoU does not and is not intended to affect each Parties' individual accountability as an independent organisation.

7.3 Despite the lack of legal obligation imposed by this MoU, the Parties:

7.3.1 have given proper consideration to the terms set out in this MoU; and

7.3.2 agree to act in good faith to meet the requirements of the MoU.

8 Governance

8.1 The Parties have agreed to establish an STP Programme Board to co-ordinate achievement of the Objective.

8.2 The Parties have agreed terms of reference for the governance infrastructure (Appendix B).

8.3 The terms of reference describe arrangements for aligned decision making of the Parties which they agree is necessary to achieve the Objective.

8.4 Each Party will nominate a representative to the STP Programme Board and notify the STP Leader of his or her name and a deputy who is authorised to attend for him or her in his or her absence.

8.5 The Parties agree that the STP Programme Board will be responsible for co-ordinating the arrangements set out in this MoU and providing overview and drive for the STP.

8.6 The STP Programme Board will meet at least once every six weeks or as otherwise may be required to meet the requirements of the STP.

8.7 The STP Programme Board does not have any authority to make binding decisions on behalf of the Parties.

9 Subsidiarity

9.1 The Parties acknowledge and respect the importance of subsidiarity.

9.2 The Parties agree for the need for many decisions to be made as close as possible to the people affected by them.

9.3 The SES STP has a multi-layered governance structure and decisions will be taken at the appropriate level, whether that is locally, in places or STP wide.

9.4 The aspiration is to do work at scale across the STP where it adds value and decision making will be done at that STP level. Where solutions are most appropriately delivered locally, in such circumstances decision-making should be done at that local level.

9.5 However, the STP will be responsible for the whole of SES population, which requires overall control to ensure one part of the system delivery does not unfavourably impact another part.

9.6 The highest level of oversight and leadership, with decision making abilities is the STP Programme Board. The membership is representative across health and social care in Sussex and East Surrey at executive level.

9.7 This collective of organisational leaders will take decisions within their delegated powers and bring to bear the authority of their organisational positions. By including all health and social care leaders in the STP Programme Board, it supports clear and transparent governance arrangements for decision-making.

9.8 Where a deputy attends in place of a formal member, that deputy assumes the role of the member for that meeting, including the delegated authority afforded to the members.

9.9 The STP Programme Board is responsible for collective decision making relating to the strategic elements of the STP. The types of decisions they will take include:

- Approval of the Sussex and East Surrey STP priorities
- Approval of STP infrastructure and leadership
- Budget for the Sussex and East Surrey STP programme

These key decisions need to be unanimous particularly as they have budget and resource implications.

9.10 For decisions that do need to be taken to statutory organisation boards, the STP Programme Board will make collective recommendations to these bodies (for example service changes).

9.11 The STP Programme Board Executive that reports to the overall STP Programme Board takes STP programme operational-level decisions on a regular basis (the role of this group and related responsibilities are defined in individual terms of reference in Appendix B). These types of decisions will include:

- Resolving STP programme risks and issues that don't need to be escalated to the STP Programme Board
- Reviewing progress and recommending action relating to the STP-wide workstreams and place-based plan delivery

9.12 In all decisions at STP level, the first priority should be to ensure it meets STP-wide targets, benefiting the total population.

10 Degree of consensus required

10.1 The approach for decision making should first be to seek consensus on key issues.

10.2 Where reaching consensus is not possible, a voting approach can be considered with agreed principles regarding quorum and abstentions.

10.3 The degree of consensus should be agreed for each STP constituent group.

10.4 In the absence of agreed majority voting, all decision must be unanimous.

11 Delegated authority

11.1 All STP organisations are collectively accountable for closing the three gaps in care and quality, health and wellbeing and financial sustainability in Sussex and East Surrey.

11.2 To enable efficient system working, statutory organisations will delegate some decision making to the appropriate level through their presentation on STP leadership groups and places.

11.3 For authority delegated to the STP level, members will be responsible for carrying out the necessary engagement with their local organisation or places in order to make the decisions on their collective behalf, and this will be done alongside the regular porting of progress and content necessary for statutory organisations to maintain oversight of the programme.

11.4 It is proposed that decisions that focus on collective working across STP, that have limited impact on individual organisations, or those that are operational in nature, should be delegated to representatives on the STP groups including the programme board, programme board executive, finance group, clinical board (the role of these groups and related responsibilities are defined in individual terms of reference in Appendix B)

12 Reporting mechanism

12.1 Full status reports and deliverables from all aspects of the programme should be presented at the STP Programme Board Executive.

12.2 Each workstream and place should be providing updates of their progress, upcoming milestones, risks and issues and, decisions that have been made within the reporting period to enable the tracking of collective progress.

12.3 The STP Programme Board will receive summary updates where specific input and action from the board are needed.

12.4 The principle of an ‘open book’ approach between all parties to request for information (e.g. financial data) to ensure transparency.

13 Risk management and assurance

13.1 Each organisation must satisfy itself that risks to the strategy in their totality are being managed effectively, not just those risks that the organisation itself has agreed to own and manage.

13.2 Governing bodies/boards/cabinets will want to be assured in respect of the risks owned by their organisation and of the risks owned by partner organisations if there are consequences across the partnership.

13.3 Where external assurance is sought for footprint-wide risks committees in common to oversee management of risks will be considered.

13.4 The pooling of resources to commission external assurance may also be of use in dealing with footprint- wide risks. But each board will still need to take a view on the value of such assurance and act accordingly.

14 Escalation Process

14.1 When an unanticipated issue cannot be resolved through normal programme management procedures, the issue is escalated to the group they report in to for decisions.

14.2 The group that has identified the issue for escalation should include suggested mitigating actions for review and possible agreement.

14.3 It is the Programme Director who assesses how critical the issue is and, where possible, the highlighting of the issue should be delayed until the next scheduled meeting if no negative impact will be experienced. Only critical issues will be highlighted outside normal meeting schedules.

14.4 The escalation process only applies to issues which cannot be resolved at the appropriate level and require senior involvement, impact more than one programme (workstream or place) or impact the STP-wide programme.

14.5 However, the programme should always strive to address issues at the lowest possible level.

14.6 Where the STP Programme Board needs to escalate an issue, it is the individual organisations leader who takes the issue to their own statutory bodies.

14.7 If the risk or issue only affects a subset of the constituent organisations, it is up to the STP Programme Board chair to decide whether to only approach those organisations that are affected of send it to all.

15 Dispute resolution

15.1 The Parties will attempt to resolve any dispute between them in respect of this MoU by negotiation in good faith.

15.2 All members of the STP programme will make every effort to work collaboratively in the best interests of the Sussex and East Surrey system and actively avoid disputes.

15.3 Individual member's concerns should be raised, in writing, with the STP convenor in the first instance. The STP convenor will attempt to resolve the concern through informal discussion and mediation.

15.4 For disagreement involving the STP convenor, members should approach an alternate STP SRO. That STP SRO will follow the same process of attempting to resolve informally before going down the formal route.

15.5 If agreement still cannot be reached, the STP convenor will propose formal resolution which may involve regulators. Independent mediation should always be the last resort.

16 Code of conduct

16.1 Leadership and behavioural change is critical to making the governance work.

16.2 Behaviours will reflect principles and are defined in the code of conduct as:

- Be ambitious and promote innovation
- Collaborative working focused on collective success to deliver more than the sum of the component parts
- Each member brings their own delegated authority to the table
- Test developing thinking with their organisations to ensure alignment, understanding and ownership across the STP programme
- Members support colleagues to work through difficult issues, sharing analysis before taking action
- All members act in the best interests of service users and the wider SES public
- At all times act in good faith towards each other, building trusting relationships with an open, partnership approach, to avoid surprises
- Share information, experience, materials and skills to learn from each other and develop effective working practices, eliminate duplication of effort, mitigate risk and reduce cost
- Members engage in an open book approach to financial and other data
- Effectively manage internal stakeholders and consult with and engage external stakeholders
- Adopt a positive outlook and behave in a positive, proactive manner
- Actively avoid a culture of blaming others to engender joint responsibility
- Adhere to statutory powers, requirements and best practice to ensure compliance with applicable laws and standards

17 Conflict of interest

17.1 All members involved at all levels of the STP programme are expected to declare a conflict of interest ahead of the discussion it relates to, or as soon as the conflict becomes apparent, to the chair or the group they are a member of.

17.2 It is to the chair's discretion to disqualify the individual from taking part in the discussion.

18 Communication and consultation

18.1 Due to the legitimate public interest in influencing what happens to local health services high quality consultation coupled with transparency and clarity of communication will be an essential part of the STP development and delivery, and will be planned for as soon as possible.

18.2 The legal duty to consult lies with individual organisations.

18.3 However the STP leadership groups have a key role to play in facilitating and co-ordinating actions to fulfil this duty.

19 General provisions

19.1 The Parties agree that this MoU may be varied only with the written agreement of all the Parties.

Signed by the parties or their duly authorised representatives on the date set out above.

Signed by duly authorised for and on behalf of ([PARTY 1])

Signed by duly authorised for and on behalf of ([PARTY 2])

APPENDIX B – Terms of reference for STP governance infrastructure

STP Programme Board

Terms of reference

Purpose

The STP Programme Board is responsible for strategic oversight and delivery of the Sustainability and Transformation Plan (STP) on behalf of all partner organisations across Sussex and East Surrey (SES), allowing members, through their representatives, to make aligned decisions.

The STP Programme Board assesses cross organisational and programme level risks, provides overall assurance of STP planning, delivery and risk management as well as ensuring that appropriate links are made with other SES strategic programmes.

The STP Programme Board connects with national bodies and other external organisations (e.g. Clinical Senate, Health Education England) to ensure it draws on the support available, feeds in best practice and learning from other areas into the development and delivery of the programme and, aligns with national policy direction.

The STP Programme Board acts as a meeting forum and single communication channel with regulators with regard to the SES STP and for applications for transformational funding.

The STP Programme Board produces options, recommmendations and proposals for ratification by the members.

The purpose and remit of the STP Programme Board will be reviewed as part of the overarching programme governance review or in one year's time, whichever is sooner, and then at least six monthly after that.

The overall remit of this group is to:

- Set strategic direction, scope and priorities for the STP
- Provide oversight of the STP programme and facilitates collective decision-making relating to the strategic elements of the STP
- Review recommendations from the STP Programme Board Executive, providing the necessary challenge and scrutiny to plans
- Delegate such matters as they see fit to the STP Programme Board Executive
- Assess STP programme risks and provide assurance that effective mitigations are in place
- Provide assurance that the STP programme aligns to SES strategy and local programmes of work
- Agree the terms of reference for new programmes of work setting out ambition, outcomes, timescales, resources and success criteris
- Act as the point of escalation to resolve competing priorities and remove barriers

that may prevent progress

- Ensure compliance with regulatory framework
- Collectively respond to challenges to system resilience, clarifying with regulators the precise role of the STP
- Support collective engagement with regulators, the public and other stakeholders regarding the STP (public consultation if necessary)

Working with constituent organisations:

- Establish clear agreements on delegated authority from each constituent organisation
- Support the statutory requirements of individual organisations including the need to develop and deliver 'public value'
- Make decisions on behalf of their respective organisation within delegated authority in the development and delivery of STP programme
- Take key decisions for sign-off to individual boards to obtain approval for decision outside delegated authority agreements
- Actively foster cross-organisational relationship building and transparent communication
- Champion the STP programme both within their organisation and within the wider STP footprint

Membership

Representation is across health and social care in Sussex and East Surrey at executive level.

Members will be expected to send an appropriate deputy, who is fully briefed and with adequate delegated authority, where they are unable to attend.

Membership includes:

- Chief officers/ accountable officers of the CCGs
- Chief executives of the provider trusts
- Chief executives of the local authorities
- NHS England and NHS Improvement representatives
- Health Education England representative
- Clinical Board co-chairs
- Finance Group chair
- Oversight Group chair

The following may regularly attend meetings:

- Healthwatch representative
- Communications and engagement lead
- STP Programme Director

Table 1: Initial membership of Sussex and East Surrey Programme Board

Name	Title	Organisation
Michael Wilson	Chief executive and STP convenor **(chairperson)**	Surrey and Sussex Healthcare NHS Trust
Adam Doyle	Accountable officer	NHS Brighton and Hove CCG
Katie Armstrong	Clinical accountable officer	NHS Coastal West Sussex CCG
Amit Bhargava	Clinical accountable officer	NHS Crawley CCG
Ian Ayres	Chief officer	NHS East Surrey CCG
Amanda Philpott	Chief officer	NHS Eastbourne, Hailsham and Seaford CCG NHS Hastings and Rother CCG
Wendy Carberry	Accountable officer	NHS High Weald Lewes Havens CCG
Geraldine Hoban	Chief officer	NHS Horsham and Mid Sussex CCG
Marianne Griffiths	Chief executive	Brighton and Sussex University Hospitals NHS Trust Western Sussex Hospitals NHS FT
Stephen Cass	Chief Executive	Central Surrey Health
Adrian Bull	Chief executive	East Sussex Healthcare NHS Trust
Sarah Billiald	Chief executive	First Community Health and Care
Yvonne Taylor	Chief executive	Integrated Care 24
Steve Jenkin	Chief executive	Queen Victoria Hospital NHS FT
Fiona Edwards	Chief executive	Surrey and Borders Partnership NHS FT
Siobhan Melia	Chief executive	Sussex Community NHS FT
Daren Mochrie	Chief executive	South East Coast Ambulance Service NHS FT
Sam Allen	Chief executive	Sussex Partnership NHS FT
Geoff Raw	Chief executive	Brighton and Hove City Council
Becky Shaw	Chief executive	East Sussex County Council
David McNaulty	Chief executive	Surrey County Council
Nathan Elvery	Chief executive	West Sussex County Council
Pennie Ford	Director of assurance and delivery	NHS England
Paul Bennett	Portfolio director	NHS Improvement
Philippa Spicer	Local director	Health Education England, Kent Surrey and Sussex

Minesh Patel	Clinical chair, Clinical Board co-chair	NHS Horsham and Mid Sussex CCG
George Findlay	Medical director, Clinical Board co-chair	Western Sussex Hospitals NHS FT
Richard Brown	Medical Director, Surrey & Sussex LMCs	Interim GP Provider representative STP Executive
Paul Simpson	Chief finance officer, Finance Group chair	Surrey and Sussex Healthcare NHS Trust
Beryl Hobson	Oversight Group chair	Queen Victoria Hospital NHS FT

Quorum

A meeting will be quorate with a minimum of fifteen members present including at least the following or their nominated deputy:

- Chairperson
- At least one CCG accountable officer or chief officer
- At least one acute trust chief executive
- At least one mental health trust chief executive
- At least one community provider chief executive
- At least one local authority executive representative
- At least one clinical lead

Meeting frequency

Once every six weeks

Reporting responsibilities, decisions and accountability

The STP Programme Board members will report to their individual constituent organisations.

The STP Programme Board is responsible for making recommendations to the CCG governing bodies, trust boards and local authority cabinets/health and wellbeing boards to support decision making outside any delegated authority. All STP Programme Board members will steer recommended decisions through their constituent boards for formal statutory sign off, as laid down within their constitutions.

Delegated authority from constituent boards to STP Programme Board members is being explored and could include the following delegated to the STP Programme Board

- Early stages of working leading up to decision
- The development of options for consideration

Constituent organisations will still need to:

- Sign off preferred options
- Make decisions about service change
- Make decisions about governance changes, representation and structural changes that will impact individual organisations

In order to develop recommended decisions, the Chair will work to establish unanimity as the basis for the recommendations of the Board.

Conflict of Interest:

Any actual or potential conflicts of interest must be declared.

Date terms of reference agreed: June 2017

Date terms of reference due to be reviewed: March 2018

STP Programme Board Executive

Terms of reference

Purpose

The STP Programme Board Executive acts as the engine to drive delivery of the Sussex and East Surrey Sustainability and Transformation Plan (STP), to promote consensus on change to be delivered and to make recommendations to the STP Programme Board.

The STP Programme Board Executive manages cross organisational and programme level issues, risks and dependencies, oversees the development of the programme plan, its deliverables and ensures that appropriate links are made with other SES strategic programmes.

It ensures that place-based plans and STP workstreams are aligned and aggregated to the overall outcomes of the STP for the betterment of the population across Sussex and East Surrey.

The group members will provide steer to the wider programme team who will deliver the STP work on a day-to-day basis.

The purpose and remit of the STP Programme Board Executive will be reviewed as part of the overarching programme governance review or in one year's time, whichever is sooner, and then at least six monthly after that.

The overall remit of this group is to:

- Drive STP programme progress within the scope and parameters set by the STP Programme Board
- Provide guidance to the wider programme team (including STP workstreams and places)
- Make recommendations to the STP Programme Board
- Promote consensus on the changes that need to be delivered amongst statutory organisations
- Take operational-level decisions on a regular basis
- Oversee the management of programme resources
- Shape the STP Programme Board's agenda
- Seek input from, and disseminate information from STP Programme Board Executive discussion to, the groups they represent (e.g. the CCG SRO is responsible for collating input from CCGs and communicating this consensus to the STP Programme Board Executive as well as communicating key STP Programme Board Executive discussions to all CCGs).
- Keep an accurate record of discussions that can be shared at the discretion of STP Programme Board Executive members to the groups they represent

- Accept such matters as the STP Programme Board sees fit to delegate

Membership

Members represent the individual group and/or workstreams they are responsible for.

All members will hold each other to account to ensure that they are acting with the aim of transforming health and care for the Sussex and East Surrey population and not on behalf of their own organisations.

Membership is a subset of the STP Programme Board with representation from each care sector.

Members will be expected to send an appropriate deputy, who is fully briefed and with adequate delegated authority, where they are unable to attend.

Membership includes:

- STP convenor, provider SRO
- CCG STP SRO
- Local authority STP SRO
- Clinical Board co-chairs
- Finance Group chair
- Place-based single point of leadership (SPoL)
- Workstream SROs
- STP Programme Director
- Communication and engagement lead
- GP Provider representative

Table 1: Initial membership of Sussex and East Surrey Programme Board Executive

Name	**Role**	**Organisation and title**
Michael Wilson	STP convenor, provider SRO **(Chairperson)**	Surrey and Sussex Healthcare NHS Trust, chief executive
Wendy Carberry	STP CCG SRO	NHS High Weald Lewes Havens CCG, chief officer
TBC	STP local authority SRO	TBC
Minesh Patel	Clinical Board co-chair	NHS Horsham and Mid Sussex CCG, chair
George Findlay	Clinical Board co-chair	Western Sussex Hospitals NHS FT, medical director
Paul Simpson	Finance Group chair	Surrey and Sussex Healthcare NHS Trust, Director of Finance
Katie Armstrong	Coastal Care locality SPoL	NHS Coastal West Sussex CCG, clinical accountable officer

Keith Hinkley	East Sussex Better Together locality SPoL	East Sussex County Council, Director of Adult Social Services
Geraldine Hoban	Central Sussex and East Surrey Alliance (North) locality SPoL	NHS Horsham and Mid Sussex CCG, chief officer
Adam Doyle	Central Sussex and East Surrey Alliance (South) locality SPoL	NHS Brighton and Hove CCG, chief officer
Adrian Bull	Digital workstream SRO	East Sussex Healthcare NHS Trust, chief executive
Elizabeth Gill	Urgent and emergency care workstream SRO	NHS High Weald Lewes Havens CCG, chair
Siobhan Melia	Estates & Workforce workstreams SRO	Sussex Community NHS FT, chief executive
Sam Allen	Mental health workstream SRO	Sussex Partnership NHS FT, chief executive
Dan Wood	Communications and engagement lead	Independent Consultant
Richard Brown	Medical Director, Surrey & Sussex LMCs	Interim GP Provider representative
Dena Marshall	Programme director	

Quorum

A meeting will be quorate with a minimum of eight members present including at least the following or their nominated deputy:

- Chairperson
- At least one representative from a CCG
- At least one representative from an acute trust
- At least one representative from another trust

Meeting frequency

Once a fortnight

Reporting responsibilities

The STP Programme Board Executive will report to the STP Programme Board.

Decisions

The parameters for decision making by the Programme Board Executive will be determined by the Programme Board and will fall within the governance framework. In general these will include operational decisions regarding:

- Facilitating programme process (within the scope, timeline and parameters set by the STP Programme Board) and guiding the wider programme team
- Reviewing the work of STP workstreams and place-based plans to enable and support performance improvement and to ensure shared goals and targets are met
- Resolving risks and issues (outside of those that will need STP Programme Board escalation)
- Resolving operational conflicts with regard to dependencies and interdependencies
- STP programme resource management

All other decisions that need to be made outside the above will be escalated to the STP Programme Board with recommendations on how to proceed.

Formal decisions will be taken through the STP partners' respective governing boards for sign off and agreement via the STP Programme Board members.

Conflict of Interest:

Any actual or potential conflicts of interest must be declared.

Date terms of reference agreed: June 2017

Date terms of reference due to be reviewed: March 2018

STP Clinical Board

Terms of reference

Purpose

The purpose of the Sussex and East Surrey (SES) Clinical Board is to review, advise and make recommendations for health and care transformation across Sussex and East Surrey from a clinical and care professional perspective.

As well as overseeing the development of the clinical strategy as part of the SES Sustainability and Transformation Plan (STP), the Clinical Board will also provide clinical and care professional input in, and support to, all STP workstreams and place-based arrangements.

It will strive to promote clinical and care professional consensus on potential options, and make recommendations to the STP Programme Board Executive.

The purpose and remit of the Clinical Board will be reviewed as part of the overarching programme governance review or in one year's time, whichever is sooner, and then at least six monthly after that.

The overall remit of this group is to:

- Provide visible, collective clinical and care professional leadership to the STP programme of work
- Champion the work of the STP with internal and external stakeholders
- Provide clinical and care professional oversight, leadership and input into STP-wide workstreams (starting with acute transformation)
- Provide clinical and care professional oversight, leadership and input into the place-based plans and their respective initiatives. This is in addition to clinical steer already in place in places
- Provide challenge to STP programme using best practice and relevant evidence base and make recommendations, with appropriate input from across partners, to STP Programme Board and STP Programme Board Executive
- Work with the finance group to ensure workstreams and places will deliver impact and improve population health through economic analysis, as well as deliver financial sustainability
- Represent clinicians and practitioners across Sussex and East Surrey with focus being on the broader system instead of individual organisational interests
- Promote clinical and care professional engagement in the development and delivery of the STP
- Champion the STP's clinical and service proposals amongst colleagues, partners and stakeholders

- Ensure views and experiences from the public and patients are included in the development and implementation of plans
- Ensure that plans adopt the principle of co-production and co-design whenever relevant
- Act as interface between the STP and South East Coast Clinical Senate

Work will include:

- Owning and communicating the Sussex and East Surrey case for change
- Reviewing the potential opportunities for improvement and rationalisation of clinical service provision in SES based around the agreed principles of patient safety, improved outcomes and better value for money
- Reviewing the potential implications for social care and prevention in developing new models of care and pathways
- Commenting on and inputting into the emerging plans of the STP workstreams
- Highlighting the need for patient, carer and public involvement, engagement and consultation as appropriate
- Providing clinical leadership and promoting a culture of multi-professional engagement and collaboration

Membership

Clinical / practitioner representation is across health and care in Sussex and East Surrey at a senior level.

Members will be expected to send an appropriate deputy, who is fully briefed and with adequate delegated authority, where they are unable to attend.

Membership includes:

- Clinical chairs of the CCGs
- Medical directors of the provider trusts
- Clinical director of the 3Ts
- South East Coast Clinical Senate representative
- NHS provider trusts nursing director representatives
- Provider trust mental health lead
- Primary commissioning practice nurse representative (as required)
- Director of adult social services representative (as required)
- Director of children's services representative (as required)
- Director of public health representative

The following may regularly attend meetings:

- Communications and engagement lead
- STP Programme Director

Table 1: Initial membership of Sussex and East Surrey Clinical Board

Name	**Title**	**Organisation**
Minesh Patel	Clinical chair **(co-chairperson)**	NHS Horsham and Mid Sussex CCG
George Findlay	Medical director **(co-chairperson)**	Brighton and Sussex University Hospitals NHS Trust Western Sussex Hospitals NHS FT
David Supple	Clinical chair	NHS Brighton and Hove CCG
Katie Armstrong	Clinical chief officer	NHS Coastal West Sussex CCG
Amit Bhargava	Clinical chief officer	NHS Crawley CCG
Elango Vijaykumar	Clinical chair	NHS East Surrey CCG
Martin Writer	Clinical chair	NHS Eastbourne, Hailsham and Seaford CCG
David Warden	Clinical chair	NHS Hastings and Rother CCG
Elizabeth Gill	Clinical chair	NHS High Weald Lewes Havens CCG
David Walker	Medical director	East Sussex Healthcare NHS Trust
Andrew Catto	Chief Medical Officer	Integrated Care 24
Ed Pickles	Medical director	Queen Victoria Hospital NHS FT
Fionna Moore	Medical director	South East Coast Ambulance Services NHS FT
Justin Wilson	Medical director	Surrey and Borders Partnership NHS FT
Des Holden	Medical director	Surrey and Sussex Healthcare NHS Trust
Richard Quirk	Medical director	Sussex Community NHS FT
Rick Fraser	Medical director	Sussex Partnership NHS FT
Peter Larsen-Disney	Clinical director of 3Ts	Brighton and Sussex University Hospital NHS FT
Lawrence Goldberg	Chair	South East Coast Clinical Senate
Fiona Allsop	Director of nursing and quality	Surrey & Sussex Healthcare NHS TrustExec
Emma Wadey	Chief nurse, interim and Director of quality and safety	South East Coast Ambulance Service NHS FT
Liz Mouland	Chief nurse and Director of clinical services	First Community Health and Care
Diane Hull	Director of nursing	Sussex Partnership NHS FT

Cynthia Lyons	Director of Public Health	East Sussex County Council

Quorum

A meeting will be quorate with a minimum of fifteen members present including at least the following or their nominated deputy:

- At least one acute trust medical director
- Between the community and mental health medical and nursing directors, at least one member representing each such service
- At least one acute, community or mental health nursing director
- At least one CCG clinical chair

Meeting frequency

Once a fortnight

Reporting responsibilities

The STP Clinical Board will report to the STP Programme Board Executive.

Decisions

The group provides clinical advice and recommendations to the Sussex and East Surrey STP Programme Board Executive and when required, the STP Programme Board.

Any formal decisions will be taken through the STP partners' respective governing boards for sign off and agreement via the STP Programme Board members.

Conflict of Interest:

Any actual or potential conflicts of interest must be declared.

Date terms of reference agreed: June 2017

Date terms of reference due to be reviewed: March 2018

STP Finance Group

Terms of reference

Purpose

The purpose of the STP Finance Group is to ensure the Sussex and East Surrey Sustainability and Transformation Plan delivers financial sustainability across the whole system and uses available resources to best effect.

The STP Finance Group provides financial leadership as well as strategic advice and guidance to develop and deliver the STP and makes recommendations to the STP Programme Board Executive on financial matters.

The purpose and remit of the STP Finance Group will be reviewed as part of the overarching programme governance review or in one year's time, whichever is sooner, and then at least six monthly after that.

The overall remit of this group is to:

- Provide director level advice and support to the programme, to ensure that the strategy is fully costed, that its impact on the wider health and social care system is modelled and understood and that it meets the requirements to deliver a financially sustainable health system
- Actively participate in discussions to progress financial planning in support of delivery of the STP, including how this relates to local "Place-Based" plans
- Share operational plans and supporting information to help the Finance Group understand the health and care financial picture across Sussex and East Surrey
- Agree the underpinning principles that are most critical to the successful delivery of the STP programme and that should drive operational planning. To do this:
    - The STP financial plan and member organisations' operational plans should deliver the triple aims of the STP
    - The initiatives, in aggregate, should aim to achieve a balanced financial plan across the STP. Initiatives without plans or a low likelihood of delivery will be excluded
    - Organisations should make the most of all available efficiencies, funding sources and opportunities along with reasonable investments for improvement
- Ensure that the proposals and plans developed are financially robust
- Work with the Clinical Board to develop an overall clinical model which will deliver financial sustainability
- Review and sign off the financial content for recommendation to the STP Programme Board
- Review savings plans and monitor in year performance and mitigations and forecast

outturns

- Support each other as professionals and ensure colleagues are kept informed about the work and are engaged as appropriate
- Facilitate resolutions to discrepancies that treat individual organisations fairly whilst acting in the best interests of services users and the health and care system as a whole
- Be ambassadors for the programme and ensure they are financial advocates for proposals

Membership

Financial representation is across health and care in Sussex and East Surrey at a senior level.

Members will be expected to send an appropriate deputy, who is fully briefed and with adequate delegated authority, where they are unable to attend.

Membership includes:

- Chief finance officers of the CCGs
- Finance directors of the provider trusts, including community and mental health trusts
- County council finance leads

The following may regularly attend meetings but by invitation only:

- NHS England specialised commissioning finance lead
- NHS England primary care commissioning finance lead
- STP Programme Director

Table 1: Initial membership of Sussex and East Surrey Finance Group

Name	Role	Organisation
Paul Simpson	Finance director **(chairperson)**	Surrey and Sussex Healthcare NHS Trust
Pippa Ross-Smith	Chief finance officer	NHS Brighton and Hove CCG
Neil Cook	Chief finance officer, interim	NHS Coastal West Sussex CCG
Barry Young	Chief finance officer	NHS Crawley CCG NHS Horsham and Mid Sussex CCG
Ray Davey	Chief finance officer	NHS East Surrey CCG
John O'Sullivan	Chief finance officer	NHS Eastbourne, Hailsham and Seaford CCG NHS Hastings and Rother CCG

Alan Beasley	Chief finance officer	NHS High Weald Lewes Havens CCG
Karen Geoghegan	Executive director of finance	Brighton and Sussex University Hospitals NHS Trust Western Sussex Hospitals NHS FT
Jonathan Reid	Director of finance	East Sussex Healthcare NHS Trust
Adrian Baillieu	Director of finance	First Community Health and Care
Tony Barfoot	Finance Director	Integrated Care 24
Clare Stafford	Executive director of finance & performance	Queen Victoria Hospital NHS FT
David Hammond	Director of finance	South East Coast Ambulance Service NHS FT
Graham Wareham	Director of finance	Surrey and Borders Partnership NHS FT
Mike Jennings	Director of finance	Sussex Community NHS FT
Sally Flint	Director of finance	Sussex Partnership NHS FT
Alun Shopland	Finance director	Central Surrey Health, Surrey
Nigel Manvell	Assistant director, finance and procurement	Brighton and Hove City Council
Ian Gutsell	Head of finance	East Sussex County Council
Sian Ferrison or Will House	Transformation and development manager/ Strategic finance manager	Surrey County Council
Chris Salt or Katherine Eberhart	Group manager, financial services/ finance director	West Sussex County Council

Quorum

A meeting will be quorate with a minimum of ten members present including at least the following or their nominated deputy:

- At least two CCG chief finance officers
- At least three provider finance directors

Meeting frequency

Once a fortnight

Reporting responsibilities

The STP Finance Group will report to the STP Programme Board Executive.

Decisions

The group provides financial advice and recommendations to the Sussex and East Surrey STP Programme Board Executive and when required, the STP Programme Board.

Any formal decisions will be taken through the STP partners' respective governing boards for sign off and agreement via the STP Programme Board members.

If an organisation puts forward plans that don't conform to the agreed principles, the Finance Group is responsible for assessing that plan then pursuing and agreeing a resolution that is compatible with delivering the STP programme.

Conflict of Interest:

Any actual or potential conflicts of interest must be declared.

Date terms of reference agreed: June 2017

Date terms of reference due to be reviewed: March 2018

STP Oversight Group

Terms of reference

Purpose

The STP Oversight Group provides oversight of the development and delivery, including systems and processes, of the STP and gives feedback to the Sussex and East Surrey STP Programme Board on elements of the plan.

The group provides NHS governing bodies, trust boards, and local authority leaders a forum to steer the development of cross organisational working within the STP remit, and provides non-executive input, but does not have statutory or formal responsibilities.

They connect the organisation-based accountability structures with the broader STP programme and provide assurance for STP governance and infrastructure.

The STP Oversight Group considers and reviews political and public engagement ahead of transformation and potential consultation.

The purpose and remit of the STP Oversight Group will be reviewed as part of the overarching programme governance review or in one year's time, whichever is sooner, and then at least six monthly after that.

The overall remit of this group is to:

- Provide oversight to the STP to ensure the SES population perspective are considered at every phase of development and delivery of the plan
- Provide oversight also of STP systems and processes
- Enhance communication and engagement with individual trust boards, CCG governing bodies, local councillors and councils, as well as wider stakeholders that could include political and the public relationships
- Provide support and challenge to the pace of the STP development and delivery
- Provide support and challenge to the programme to ensure the STP achieves affordable system sustainability balanced by improved health and social care outcomes and reduced health inequalities for the SES population
- Provide challenge, support and guidance to enable descisions to be made in light of the interests of the health and wellbeing of the population in Sussex and East Surrey
- Facilitate consensus building across organisations in the STP and the public
- Review opportunities for better alignment of health and wellbeing strategies, joint needs assessments and, the achievement of a population based approach to health and care
- Provide assurance for STP governance and infrastructure

Be aware of the need for individual constituent organisations to comply with the relevant statutory requirements

- Play a part in reviewing the achievement following the delivery of STP programme deliverables
- Actively foster cross-organisational relationship building and transparent communication

Membership

Representation is across health and social care in Sussex and East Surrey at constituent board level.

Members will be expected to send an appropriate deputy, who is fully briefed and with adequate delegated authority, where they are unable to attend.

Membership includes:

- Chairs of the CCGs
- Chairs of the provider trusts
- Leaders of the local authorities

The following may regularly attend meetings:

- NHS England South (South East) representative
- Healthwatch representative
- STP Chair
- CCG STP SRO
- LA STP SRO
- STP Programme Director

Table 1: Initial membership of Sussex and East Surrey Oversight Group

Name	Title	Organisation
Beryl Hobson	Chair **(chairperson)**	Queen Victoria Hospital NHS FT
Dr David Supple	Clinical chair	NHS Brighton and Hove CCG
Kieran Stigant	Lay chair	NHS Coastal West Sussex CCG
Alan Kennedy	Lay chair	NHS Crawley CCG
Dr Martin Writer	Clinical chair	NHS Eastbourne, Hailsham and Seaford CCG
Dr David Warden	Clinical chair	NHS Hastings and Rother CCG
Dr Elango Vijaykumar	Clinical chair	NHS East Surrey CCG
Dr Elizabeth Gill	Clinical chair	NHS High Weald Lewes Havens CCG
Dr Minesh Patel	Clinical chair	NHS Horsham and Mid Sussex CCG

Mike Viggers	Chair	Brighton and Sussex University Hospitals NHS Trust & Western Sussex Hospitals NHS Trust
David Clayton-Smith	Chair	East Sussex Healthcare NHS Trust
Elaine Best	Chair	First Community Health and Care
Judy Oliver	Chair	Integrated Care 24
Richard Foster	Chair	South East Coast Ambulance Service NHS FT
Dr Ian McPherson	Chair	Surrey and Borders Partnership NHS FT
Alan McCarthy	Chair	Surrey and Sussex Healthcare NHS Trust
Peter Horne	Chair	Sussex Community NHS FT
Caroline Armitage	Chair	Sussex Partnership NHS FT
Cllr Daniel Yates	Chair	Brighton and Hove Health and Wellbeing Board
Cllr Keith Glazier	Leader	East Sussex County Council
Cllr David Hodge	Leader	Surrey County Council
Cllr Christine Field	Deputy leader	West Sussex County Council

Quorum

A meeting will be quorate with a minimum of five members present including at least one representative each from CCGs, providers and local authorities, or their nominated deputy.

Meeting frequency

Once every two months

Reporting responsibilities and decisions

The STP Oversight Group is a partnership meeting designed to bring system leaders together and as such does not have statutory or formal responsibilities.

Existing statutory organisations and committees (e.g. Health and Wellbeing Boards) retain their existing accountabilities and decision making remits.

Conflict of Interest:

Any actual or potential conflicts of interest must be declared.

Date terms of reference agreed: June 2017

Date terms of reference due to be reviewed: March 2018

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	07 September 2017		**Agenda reference:**	157-17	
Report title:	**Well led framework**				
Sponsor:	Clare Pirie, director of communications and corporate affairs				
Author:	Clare Pirie, director of communications and corporate affairs				
Appendices:	1. Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and foundation trusts, NHS Improvement, June 2017				
Executive summary					
Purpose:	This paper summarises the requirement for an external review and asks for Board approval for the planned process and the timescales.				
Recommendation:	The Board are asked to **APPROVE** the proposed approach.				
Purpose:	**Approval**	Information	Discussion	Assurance	Review
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:	None at present				
Corporate risk register:	None at present				
Regulation:	As required by the Trust's regulator				
Legal:	None				
Resources:	None at present				
Assurance route					
Previously considered by:	NA				
Next steps:	Board will be kept informed and engaged in the review process as set out in the paper, with a final report to Board expected in March 2018.				

Queen Victoria Hospital
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	07 September 2017
Reference number:	157-17
Report from:	Clare Pirie, Director of communications and corporate affairs
Author:	Clare Pirie, Director of communications and corporate affairs
Appendices:	Appendix 1: Well led guidance
Report date:	23 August 2017

Leadership and governance developmental review

Introduction

This paper summarises the requirement for an external review and asks for Board support for the planned process and the timescales.

Background

In the process of application for foundation trust status, Monitor subjected the governance of all applicant NHS trusts, including QVH, to rigorous scrutiny.

Following authorisation, foundation trust boards are responsible for ensuring that governance arrangements remain fit for purpose, and were required to undertake an external review of governance every three years. This has now changed to once every 3 – 5 years, and QVH is due to carry out a review in 2017/18.

In 2015, the Board agreed to adopt the following timetable:

- 2015/16 – governance review under the leadership of the newly appointed chair;
- 2016/17 – internal review of governance arrangements;
- 2017/18 – external review to be undertaken. This was paused to await publication of the revised NHS Improvement

Guidance

Updated guidance from NHS Improvement was issued in June 2017 (see appendix A), replacing earlier guidance from Monitor.

The updated guidance retains a strong focus on integrated quality, operational and financial governance, alongside strengthened content on leadership, culture, system working and quality improvement.

The well-led framework is structured around eight key lines of enquiry (KLOEs) developed in partnership with the Care Quality Commission (CQC) so that information prepared for the external leadership and governance review can also be used in any CQC inspection. Each KLOE is supplemented by a series of characteristics of good organisations and good practice, which illustrates the kinds of activities that might be expected to be in place.

Is there the **leadership capacity and capability** to deliver high quality sustainable care?	Is there a clear **vision** and credible **strategy** to deliver high quality sustainable care to people who use services, and robust plans to deliver?	Is there a **culture of** high quality sustainable care?
Are there clear responsibilities, **roles** and systems of accountability to support good governance and management?	**Are services well-led?**	Are there clear and effective processes for managing **risks,** issues and **performance?**
Is robust and appropriate **information** being analysed and challenged?	Are the **people** who use services, the public, **staff** and **external partners engaged** and involved to support high quality sustainable services?	Are there robust systems and processes for **learning,** continuous **improvement** and **innovation**?

Objective
The review should be about identifying areas of leadership and governance at QVH where further targeted development work may be useful to improve the likelihood of future good performance.

In the challenging environment in which trusts are operating, it is also important to demonstrate to our regulators that our leadership and governance supports our aim to continuously improve the services that we provide.

This review could also help us to look at our key challenges including the risks and mitigations around being a small trust.

Commissioning an external reviewer

We have explored the possibility of a peer review process with a number of other southern NHS FTs. There was support for this from the QVH executive team and from NEDs, recognising the potential for organisational learning as well as the development and relationship building opportunities this would bring for the individuals involved. It was also recognised that this could be a less expensive option for the Trust. However, the process of setting up a peer review group has not progressed in a timely manner and therefore is not a viable option for QVH at this time. We will continue to participate in national approaches to developing peer review, which seem to now have some momentum.

An external reviewer will be selected, ensuring that they have the necessary skills and experience to take a holistic view of the organisation, connecting findings from across the different parts of the review, and support action planning including suggesting appropriate interventions.

As the cost of the review is likely to be under £50K, this means we can seek quotes from organisations selected by QVH, rather than procure through a more complex tender process.
Reviewers should not have carried out audit or governance related work for the Trust in the previous three years; this would exclude our existing auditors, KPMG.

We will produce a specification of requirements (expected outputs, timescales etc.) and agree evaluation criteria (weighting attached to price, value, compliance, track record etc.) and agree with the reviewer at the start of the review process the format in which we would like to receive the findings.
It is proposed that we manage cost and ensure a useful output by developing a clear specification so that the external review focusses on areas where QVH would like assurance or identification of best practice. We will however not set out the methodology we require, but ask reviewers bidding for this work to use their experience to set out the methods they propose to use.

Possible activities undertaken by the independent review team include:

- Desktop document review
- One to one interviews with Board and staff
- Board and stakeholder surveys
- Focus groups with internal and external stakeholders including Council of Governors
- Board and committee observations
- Board skills inventory

Self-assessment - 2016
The first step in the review process is a self-assessment questionnaire. This was carried out in September 2016 with all Board and Council of Governor members invited to respond. Board members and 12 of the governors responded to

approximately 40 questions intended to provide insight into how directors and governors gauge the Board's leadership and governance performance.

The findings were discussed at the Board seminar on 6 October. Overall the self-assessment was positive. The key themes for improvement identified were:

- Confidence - There were relatively high level of 'not sure' amongst governors with some 'not sure' responses from Board members. Managing transition of Board members – recognition that QVH will have had a change of CEO, medical director, two NEDs in the course of a year.
- Staff development, communication, empowerment
- Governors – there was a clear view from governors that they needed more support on holding NEDs to account and their relationship with the Board. There was also a high level of 'not sure' response from governors across all the questions.

Following executive team discussion in November 2016 and Council of Governors discussion in January 2017 the issues raised in the self-assessment were addressed as follows.

Actions following self-assessment

Issue	**Detail**
Confidence - relatively high level of 'not sure;	Addressed through Board seminars. Board members specifically needed assurance on: • Robust plan to deliver strategy • Staff know vision, values, strategic goals • Culture of collective responsibility • Actively engage stakeholders on performance • Stakeholders can easily find out how & why key decisions made • The impact on all areas is understood before decisions made
Managing transition of Board members	New CEO, medical director and two NEDs now in post. This transition may be an area for specific assurance in external review.
Staff development, communication, empowerment	Leading the Way programme launched January 2017 Communications manager in post February 2017 leading to improved internal communications Further funding for learning and development secured from League of Friends

	QVH Conversations and face to face staff briefings through summer Plans to introduce bi-monthly cascade briefing from September.
Governors	There was a clear view from governors that they needed more support on holding NEDs to account and their relationship with the Board. There was also a high level of 'not sure' response from governors across all the questions. This was reviewed at the council of governors meeting in January 2017 and led to general satisfaction that this increased the level of understanding and assurance on what holding NEDs to account means. This will be an ongoing process as new governors join each year.

Self-assessment - 2017
Due to the change of guidance and the changes in Board membership since the 2016 self-assessment, it is proposed that the self-assessment should be repeated by Board members to ensure the eight key lines of enquiry in the new guidance are covered appropriately. It is not proposed to re-survey governors.

The self-assessment will be shared with the external reviewer for discussion of areas for scrutiny.

Review process
It is expected in the guidance that each of the eight key lines of enquiry will be reviewed and rated using a scheme that allows the prioritisation of findings, guides and action planning, and the escalation of any immediate concerns. We can, however, set our own priorities around where we would like attention focussed.

The external facilitator will work with the Trust board to prioritise the findings of the report, and agree recommendations and developmental actions required in response.

On completion we are required to send NHS Improvement a letter confirming the review has been completed; setting out any areas of concern and any areas of good practice that could be shared with others.

Outline timetable

Develop specification	September 2017
Procurement and appointment	October/November
Review process	Dec/Jan/Feb
Board Development Seminar to receive outcome presentation	Board seminar arranged for 01 February 2018
Internal consideration of draft report Governance Improvement Action Plan and Board/Governor Development Plans developed to address any specific shortcomings identified in the recommendations	Feb/March
Final report to Board Plus action plan	01 March 2018
Report and actions shared with NHS Improvement	March 2018

Recommendation

The Board are asked to **APPROVE** the contents of this report.

NHS Improvement

Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts

June 2017

support collaborate challenge improve inspire

Delivering better healthcare by inspiring and supporting everyone we work with, and challenging ourselves and others to help improve outcomes for all.

Contents

1. Introduction

The boards of NHS foundation trusts and NHS trusts (referred to from here on as providers) are responsible for all aspects of the leadership of their organisations. They have a duty to conduct their affairs effectively and demonstrate measurable outcomes that build patient, public and stakeholder confidence that their organisations are providing high quality, sustainable care.

Providers are operating in challenging environments characterised by the increasingly complex needs of an ageing population, growing emphasis on working with local system partners to create innovative solutions to long-standing sustainability problems, workforce shortages and the slowing growth in the NHS budget.

As set out in *Developing people – improving care*, these challenges require changes in how leaders equip and encourage people at all levels in the NHS to deliver continuous improvement in local health and care systems and gain pride and joy from their work. Robust governance processes should give the leaders of organisations, those who work in them, and those who regulate them, confidence about their capability to maintain and continuously improve services.

In-depth, regular and externally facilitated **developmental reviews of leadership and governance** are good practice across all industries. Rather than assessing current performance, these reviews should identify the areas of leadership and governance of organisations that would benefit from further targeted development work to secure and sustain future performance.

The external input is vital to safeguard against the optimism bias and group think to which even the best organisations may be susceptible. We therefore strongly encourage all providers to carry out externally facilitated, developmental reviews of their leadership and governance using the well-led framework every three to five years, according to their circumstances.

2. About this guidance

This guidance on our updated well-led framework for leadership and governance developmental reviews sets out the process and content of these developmental reviews. It supports providers to maintain and develop the effectiveness of their leadership and governance arrangements. It replaces *Well-led framework for governance reviews: guidance for NHS foundation trusts* (April 2015), and applies to both NHS trusts and foundation trusts

The guidance retains a strong focus on **integrated quality, operational and financial governance** and includes a new framework of key lines of enquiry (KLOEs) and the characteristics of good organisations. It provides strengthened content on leadership, culture, system-working and quality improvement.

In a change from previous frameworks, and in support of our commitment to working more closely with our regulatory partners, the structure of our framework (KLOEs and the characteristics) is **wholly** shared with the Care Quality Commission (CQC), and underpins CQC's regular regulatory assessments of the well-led question. This means that information prepared for regulation can also be used for development, and vice versa.

The main elements of this framework are also reflected in NHS England's improvement and assessment framework for clinical commissioning groups (CCGs).

However, while CQC's regulatory assessments are primarily for assurance, developmental reviews are primarily for providers themselves to facilitate continuous improvement. Drawing on the latest research and evidence, we also describe updated good practice to help providers identify their own areas for development and key barriers to overcome.

This good practice is not a checklist: a mechanical 'ticking off' of each item is unlikely to lead to better performance. The attitude of organisational leaders to the review process, the connections they draw between the framework's different areas, and their judgements about what needs to be done to continually improve, are much more important.

We therefore strongly encourage providers to engage with the review processes openly and honestly, selecting an external facilitator to provide tailored support and prioritise actions arising from reviews.

We also encourage providers to make more use of peer review, to utilise and enhance skills within the NHS, draw on learning from others and share learning back with the system. This is how providers individually and together will gain the greatest benefit from these reviews.

A note on system working

We know the increasing focus on working with partners across health and social care, for example in sustainability and transformation partnerships (STPs), creates a tension for providers as they continue to work on organisational performance as part of wider system performance.

We maintain our focus on organisations because this is the statutory basis for service provision, but we have increased the emphasis in this guidance on working proactively with partners. Many of the principles of good governance at organisational level are applicable at system level and we encourage local system partners to use this framework for development if it is appropriate.

How to use this guidance: comply or explain

This guidance is issued on a **'comply or explain'** basis. This means we strongly encourage providers to carry out developmental reviews or equivalent activities approximately every three years to ensure they identify potential risks before these turn into issues. Better performing providers are probably already doing this, and, for example, using internal audit functions to work on particular areas of concern.

In keeping with the Single Oversight Framework we use to identify the level of support providers need, we are providing extra flexibility based on individual circumstances. This means we can agree longer timeframes for review (up to a maximum of five years) where risks seem lower and shorten the timeframe where risks seem higher, or where particular circumstances suggest a review may be necessary (eg significant turnover of board members, organisational transactions, or significant deterioration in some aspect of performance).

On that basis:

- **Comply** means we strongly encourage all providers to carry out developmental reviews every three years or within the agreed timeframe agreed with NHS Improvement using this guidance.
- **Explain** means a provider needs to give a considered explanation if it uses alternative means to assure itself regarding its leadership and governance or chooses to omit material components of the framework (eg one or more of the eight KLOEs). Departing from the guidance may be justified where a provider can demonstrate it is meeting the actions expected under the guidance in a similar manner, for example partial reviews over consecutive years. We will always consider the circumstances of an individual case.

3. Managing reviews

This section describes the common steps of a developmental review. Providers are free to tailor their approach to suit their organisational circumstances, provided they incorporate the principal areas of enquiry set out in the framework. Annexes A to D provide further detail as noted below.

Stage	Notes
Initial investigation to determine scope of review (see Annex A)	The board should reflect on its performance with an initial investigation that involves self-review against the framework. This should identify any areas in the framework or extra areas outside the framework (eg arising from internal and external audit review findings, annual or corporate governance statements) that require particular focus as part of the review. Clarifying the scope of the review will enable the board to engage external facilitators with appropriate skills. The board should be as honest as possible in this assessment as the congruence between the provider's self-review and the external facilitator's perception can indicate the provider's level of insight.
Commissioning an external reviewer (see Annex B)	External facilitation is a key part of developmental reviews: it provides objectivity and challenge that may not available within the provider. Choosing an external facilitator is the provider's responsibility. As well as the skills and experience needed to address specific areas of focus arising from self-review, the provider must ensure their supplier can take a holistic view of the organisation, connecting findings from different parts of the review and supporting action-planning, including suggesting appropriate interventions. Providers should also ensure reviewers are suitably independent of the board. This includes avoiding using reviewers who have done audit or governance-related work for the provider in the previous three years, unless there are suitable safeguards against conflict of interest

	(ie information barriers). We also encourage providers to consider involving peer reviewers as part of their external facilitation team, where appropriate, to make use of and enhance leadership and governance capability in the NHS.
Detailed review (see Annex C)	Following review and discussion of the initial investigation, the external facilitator should carry out detailed review against relevant aspects of the framework using a variety of methods that offer insight into the provider's leadership and governance processes. Each of the eight KLOEs should be reviewed at a basic level and rated using a scheme that allows the prioritisation of findings and guides action-planning and the escalation of any immediate concerns. External facilitators should engage with peer reviewers, where commissioned, for specialist input (for example on clinical governance, leadership, culture, improvement).
Board report and action planning	The external facilitator should work with the provider board to prioritise the review findings, and agree recommendations and developmental actions in response. These should be detailed in a report for the board. We encourage providers to agree the format of the report with their facilitator at the start of the process.
Letter to NHS Improvement	Once the action-planning is done, providers should send NHS Improvement a letter confirming they have completed the review, any material issues that have been found and/or any areas of good practice that could be shared with others, for example through a case study.
Implementing the action plan (see Annex D)	By far the most important part of a review is what the provider does as a result, and how this is given priority among other organisational activities. We encourage providers to draw on the support offers and resources available from agencies across the NHS and more widely (see our Improvement Hub).

4. The well-led framework and descriptions of good practice

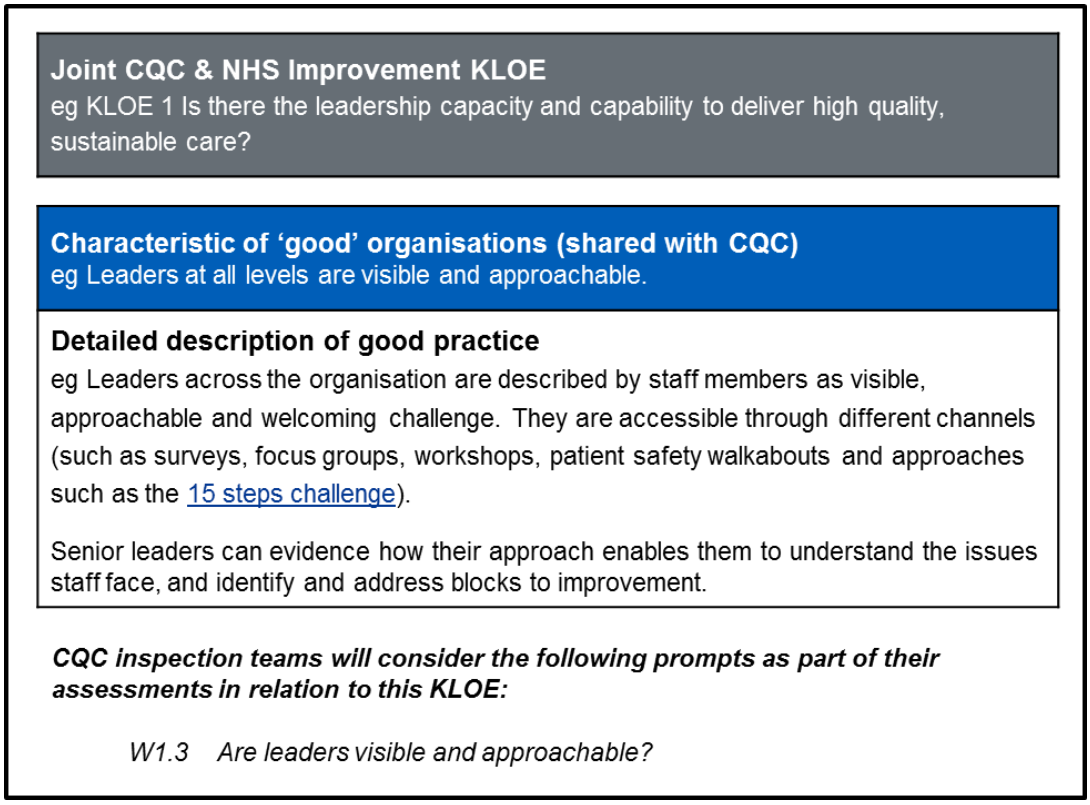
The well-led framework is structured around eight key lines of enquiry (KLOEs):

1 Is there the **leadership capacity and capability** to deliver high quality, sustainable care?	2 Is there a clear **vision** and credible **strategy** to deliver high quality, sustainable care to people, and robust plans to deliver?	3 Is there a **culture** of high quality, sustainable care?
4 Are there clear responsibilities, **roles** and systems of accountability to support good governance and management?	**Are services well led?**	5 Are there clear and effective processes for managing **risks**, issues and **performance**?
6 Is appropriate and accurate **information** being effectively processed, challenged and acted on?	7 Are the **people** who use services, the public, **staff** and **external partners engaged** and involved to support high quality sustainable services?	8 Are there robust systems and processes for **learning**, continuous **improvement** and **innovation**?

In the pages that follow, each of the framework's KLOEs is supplemented by **characteristics of good organisations**, and **detailed descriptions of good practice**.

For read-across with CQC's assessment process, we have also included the prompts that CQC inspection teams use to assess each KLOE.

Each section follows the format shown on the next page.



Key terms used in the descriptions of good practice

- **The board:** we use this term when we mean the board as a formal body.
- **Senior leaders**: we use this term when we mean the organisation's most senior internal leaders, ie formal board executive and non-executive directors and their direct reports.
- **Leaders across the organisation**: we use this term when we mean people at all levels in the organisation (including senior leaders as defined above) who have formal responsibility for the management of others, service delivery, or particular pieces of work.
- **Staff members**: we use this term to mean everyone in the organisation.
- **Protected characteristics:** this refers to the characteristics defined in the Equalities Act 2010.

KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?

Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed.

Senior leaders can evidence how the organisation has the relevant capability, experience, expertise and capacity across its leadership to manage quality, operations and finance effectively at all levels across the organisation to ensure:

- development and delivery of the corporate strategy and any associated strategies and plans
- continuous organisational development and improvement.

Senior leaders across the organisation, and especially executive and non-executive board members:

- are clear about their roles
- demonstrate personal values and styles aligned with the interests of patients, carers and frontline staff, and the seven principles of public life
- are self-aware and seek personal development and learning
- prioritise safeguarding and quality.

The board is stable, diverse and members function effectively as a team with:

- clear role definition, communication and constructive challenge
- appreciation of diversity of thought, experience and background
- awareness of how their own behaviour affects the rest of the organisation
- awareness of the organisation's impact on the local health economy and environment
- regular time out together to identify, reflect and act on success and failures.

The board regularly reviews its effectiveness (performance, governance, working relationships, skills) and impact on the organisation, and acts on the findings, sharing them openly with staff, patients and the public.

All board subcommittees (such as the audit committee) and subgroups carry out and act on annual self-assessments of their effectiveness.

The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and takes action to address them.

Senior leaders, especially board members, are able to describe:

- the quality, operational and financial issues and challenges the organisation faces, and the priorities within these
- the underlying reasons for these challenges, with reference to wider system factors and benchmarking
- what the organisation is doing to address these challenges and monitor progress in the short, medium and long term.

Senior leaders can evidence that they engage and are encouraged to engage in rigorous and constructive challenge of each other on governance processes, including but not limited to the teams and executives responsible for them.

The chair and non-executive directors participate fully in this challenge and review process, both through the board and by taking part in relevant board subcommittees (such as the audit committee) and subgroups.

Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, development, deployment and support processes and succession-planning.

Senior leaders can evidence that the organisation takes a strategic approach to developing leadership and managing talent to ensure there are enough appropriately skilled, diverse and system-focused leaders to deliver high quality, effective, continuously improving, compassionate care.

Senior leaders can evidence that a leadership strategy and succession plan are in place and regularly reviewed, based on quantitative and qualitative data. They should cover clinical and managerial leadership positions at board level and key roles below board level (such as clinical, operational, finance leads).

Senior leaders can evidence that leadership development, coaching and mentoring programmes are accessible to leaders and potential leaders at all levels and support the development of high quality, sustainable care cultures by:

- bringing together clinical and managerial staff
- supporting team-working and system-working

Continues...

- ensuring leaders gain a broader systems perspective (for example through the use of secondments or stretch assignments)
- ensuring there is a balance of experiential learning alongside coaching and classroom-based learning
- focusing on knowledge, skills, attitudes and behaviours
- ensuring that those with protected characteristics are represented in the take up of development opportunities

Leaders at every level are visible and approachable.

Leaders across the organisation are described by staff members as visible, approachable and welcoming challenge. They are accessible through different channels (such as surveys, focus groups, workshops, patient safety walkabouts and approaches such as the 15 steps challenge).

Senior leaders can evidence how their approach enables them to understand the issues staff face, and identify and address blocks to improvement.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W1.1 Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?

W1.2 Do leaders understand the challenges to quality and sustainability and can they identify the actions needed to address them?

W1.3 Are leaders visible and approachable?

W1.4 Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?

KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well-defined objectives that are achievable and relevant.

Senior leaders can evidence that there is a clear, well-thought out, comprehensive picture of how the organisation's services will look in the future, centred on the people who use services and their carers, and they have mapped a route to achieving this. This is supported by a vision and values that present a clear and compelling picture of patient and service user centred care in the context of the wider local health and care system.

Senior leaders can evidence a clear focus on continuous improvement, staff and user engagement and ambitions to be a learning organisation in a wider learning system.

Senior leaders can evidence how the organisation's key quality, operational and financial priorities have informed the development of the strategy, which has a small number of clear quality, operational and financial objectives that steer the organisation sustainably towards its vision. The strategy covers:

- safety, clinical outcomes, patient experience,
- workforce capacity and capability
- productivity and efficiency, affordability, financial performance
- the organisation's part in delivering the priorities of the local health and care economy
- sustainable development in relation to the environment
- staff health and wellbeing.

The strategy is aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population.

Senior leaders can evidence that the organisation's strategy clearly articulates the shared purpose and principles for working with other organisations, and the system's goals in the wider local and national context:

- the organisation's strategy should be aligned to plans for sustainability and transformation across the wider local health and care economy
- there should be an explicit link to the multiyear plans to maintain or achieve clinical and financial sustainability across the wider local health and care economy
- there is a narrative on how the organisation plans to respond to key NHS initiatives on quality, operational productivity and sustainability
- there is a narrative on how the organisation will meet the needs of and work to improve wider population health.

Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.

Senior leaders can evidence how the strategy, vision, values and goals across quality, operations and finance have been shared and promoted across all parts of the organisation, supported by an appropriate communication plan.

Staff members can explain the organisation's goals and initiatives to others when asked, and their own part in delivering the aspects relevant to them.

External partners, including commissioners, key patient groups and service delivery partners, can describe the goals and initiatives relevant to them, and how they support delivery of local health and care economy and/or national priorities.

The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners.

Senior leaders can evidence that a structured approach has been taken to strategy development, integrating quality, operations (including workforce capacity) and finance. This includes evidence of how the organisation has understood:

- its current operating environment, its current weaknesses, and the future for which it needs to plan, both in a local health and care context, and in response to national priorities
- the goals and objectives that arise from this
- the determinants of its quality, operational and financial performance
- the options for change and how these are prioritised over the short, medium and long term (for example one year, two to five years and over five years), so that short-term responsiveness contributes to longer term aims.

This also includes evidence of how it has planned to implement the proposed solutions and review the approach/adapt to a changing environment.

Senior leaders can evidence how they have identified stakeholders and involved them in developing the strategy. This will include at least:

- people who use the services and their representatives
- staff
- external partners (such as health and local authority commissioners, other health and care providers, local Healthwatch, local politicians and MPs).

These stakeholders are able to describe how their involvement has influenced the outcomes of the strategy development process.

Progress against delivery of the strategy and local plans is monitored and reviewed, and there is evidence of this. Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.
Senior leaders can evidence how the organisation's strategic goals and objectives, reflecting those of the local health and system, are cascaded through the organisation by informing the objectives and performance targets for business units, teams and staff members. Senior leaders can evidence that there are detailed delivery plans; progress against them is monitored and aggregated in a structured way, and the board and local health and care economy leaders regularly discuss and respond to them as appropriate, focusing on delivering the strategic goals and objectives. Senior leaders can explain and evidence how the strategy is regularly reviewed and refreshed, if needed, to ensure that it remains achievable and relevant.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W2.1 Is there a clear vision and a set of values, with quality and sustainability as the top priorities?

W2.2 Is there a robust realistic strategy for achieving the priorities and delivering good quality, sustainable care?

W2.3 Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?

W2.4 Do staff know and understand what the vision, values and strategy are, and their role in achieving them?

W2.5 Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?

W2.6 Is progress against delivery of the strategy and local plans monitored and reviewed and is there evidence to show this?

KLOE 3 Is there a culture of high quality, sustainable care?

Leaders at every level live the vision and embody shared values, prioritise high quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services. Behaviour and performance inconsistent with the vision and values are acted on regardless of seniority.

Senior leaders can evidence that there is a compelling vision and a clear set of values across the organisation, with staff members demonstrating their commitment to high quality, effective, continually improving, compassionate and sustainable care.

Senior leaders can evidence that staff recruitment, promotion and appraisal processes are aligned with the organisation's vision and values and behaviours and reinforce a culture of inclusive, diverse leadership.

Leaders across the organisation develop positivity, pride and identity across the organisation through, for example:

- celebrating the successes of teams and individuals, including rewarding staff who consistently deliver care or perform beyond expectation
- emphasising how the work makes a difference to patients and the community
- building a sense of positivity about the future.

Staff survey results demonstrate high levels of positivity and pride.

Leaders across the organisation celebrate behaviour consistent with the organisation's vision and values, and address behaviour which is contrary to them, wherever and at whatever level this behaviour occurs.

Senior leaders can evidence that there is a comprehensive induction programme for all staff groups (including junior doctor and agency staff) derived from the vision, values and strategy.

Senior leaders can evidence that the provider has a culture of integrity and probity, including fraud awareness and prevention and appropriate standards of business conduct.

Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.

Senior leaders can evidence that they look for and take appropriate and timely action to address issues arising from:

- reported incidents and concerns
- complaints and feedback from patients, service users and carers
- input from governors, patient groups, local Healthwatch networks
- internal and external reviews of its culture.

Senior leaders can evidence that the reporting of errors and speaking up is normalised. Staff members are encouraged to raise concerns and report incidents, and to regard complaints and feedback from patients as means of learning for continuous improvement and innovation. They are supported to regard complaints positively.

Senior leaders can evidence that there are appropriate and effective mechanisms, which staff members are aware of and have confidence in, for raising concerns and reporting errors and incidents. The national whistlebower policy has been adopted, and there is an accessible Freedom to Speak Up Guardian who provides regular updates to the board.

Senior leaders can evidence that there are appropriate and effective mechanisms for turning concerns/incidents into improvement actions based on inquiry about the root causes of what has happened, where constructive challenge is welcome at all levels of the organisation, including the board.

There are processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations.

Senior leaders can evidence that they promote and demonstrate their commitment to continued learning and development for all staff members, so they have appropriate levels of quality, operational and financial skills, qualifications and understanding. Senior leaders can evidence they act on issues such as low training and appraisal rates.

Senior leaders can evidence that there are processes to ensure that all staff members, including senior leaders, are able to:

- do any necessary mandatory training, including updating professional registration/revalidation
- understand functions across the range of activities in the organisation, not just their own (such as finance for non-finance managers)
- develop through leading or taking part in challenging projects or other appropriate learning opportunities, with rapidly increasing equality of access to these opportunities, especially for those with protected characteristics
- take part in high quality appraisal and career development conversations, aiming to help individuals achieve their potential.

Senior leaders can evidence that staff have the freedom to work autonomously, where appropriate and safe, and there is appropriate devolution of decision-making and permission to experiment with new ways of working appropriate to their skills and grounded in a strong safety culture.

Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing.

All staff members demonstrate commitment to acting compassionately towards their colleagues through:

- using a variety of approaches to listen to staff views
- understanding where they need to improve support, engagement, wellbeing and staff feeling valued
- empathising and taking intelligent action in response to what they find.

Seniors leaders can evidence ownership of an organisational development strategy, co-developed with staff across the organisation and regularly updated, that articulates what the organisation is doing to improve.

Senior leaders can evidence that there are systems to monitor, manage and support staff pressure.

Equality and diversity are actively promoted and the causes of any workforce inequality are identified and action taken to address these. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.

Senior leaders can evidence that members of staff with protected characteristics are treated equitably, and can safely share concerns and be listened to in a meaningful and sustained way.

They can evidence the organisation's commitment to inclusion and equality through:

- proactive engagement with staff, staff networks, trades unions and other staff organisations on the inclusion and equality agenda
- comparing metrics on staff engagement, bullying, harassment, recruitment and promotion among those with protected characteristics and the wider workforce
- ownership and regular monitoring of an effective equality and diversity strategy and plan, shared with all staff and other local interests as needed
- participating in developmental initiatives relating to building an inclusive workforce and wider healthcare services
- action on areas identified for development through any of these means.

There is a culture of collective responsibility between teams and services. There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively and responsibility is shared.

Senior leaders can evidence that there are appropriate and effective mechanisms to enable effective team working at all levels in the organisation, including the board, and within and across teams (for example between finance and operations). In practice, this means:

- collaboration and co-operation within and across teams, role modelled by the leaders of those teams and senior leaders
- individuals and teams provide practical support to others, particularly in difficult circumstances
- conflicts are resolved quickly
- responsibility is shared to deliver high quality care
- shared leadership so that everyone contributes their experience and ideas
- clear objectives in collaborative work with different members or teams understanding each other's needs and responsibilities
- performance at team level is measured and understood by team members (or by individuals involved in any cross-team collaborations).

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W3.1 Do staff feel supported, respected and valued?

W3.2 Is the culture centred on the needs and experience of people who use services?

W3.3 Do staff feel positive and proud to work in the organisation?

W3.4 Is action taken to address behaviour and performance that is inconsistent with the vison and values, regardless of seniority?

W3.5 Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?

W3.6 Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations?

W3.7 Is there a strong emphasis on safety and well-being of staff?

W3.8 Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?

W3.9 Are there co-operative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?

KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.

Board members can evidence that they understand their personal accountability for the quality, operational and financial performance of the organisation.

Senior leaders can evidence that they are clear about who is responsible and accountable for the provision, quality and performance of services, including decision-making, delivery, and management of risks and issues in relation to quality, operations and finance. This is demonstrated in:

- clear and consistently applied levels of delegations and processes for recording decisions and escalation, which are monitored for compliance
- a clear organisational structure that cascades responsibility for delivering quality, operational and financial performance from 'board to front line to board'
- clear policies in place to ensure that conflicts of interest are identified and managed.
- a clear management structure that defines accountabilities for use of resources (including workforce, financial budgets, IT, estates, etc)
- effective systems and processes that enable close working between quality, operational and finance functions
- clear processes for planning and budgeting for all income and expenditure
- the robust and timely implementing of controls in response to issues/concerns raised by internal or external audit, or encounters with serious fraud.
- regular reviews of governance processes across quality, operations and finance

Senior leaders can evidence that there is a robust system of internal control, overseen by board subcommittees, to safeguard patient safety, service quality, investment, financial reporting and the organisation's assets.

Working with partners

Senior leaders can demonstrate that there are arrangements to ensure appropriate interaction with processes and governance systems that involve groups of partners and/or stakeholders from other local health and care organisations.

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Senior leaders can evidence that all interested parties are clear about roles, responsibilities, structures and processes for planning, budgeting and reporting on any partnerships, joint ventures, shared services and sources of non-NHS income and understand, for example, protocols for:

- governing the use of any pooled budgets, with appropriate management structures to support and enforce the agreed practice
- the escalation and resolution of issues between parties
- dealing with overspends and underspends that are reviewed regularly.
- sharing data
- the termination of any arrangements.

The board and other levels of governance in the organisation function effectively and interact with each other appropriately.

The board operates as an effective unitary board demonstrating:

- clarity around its function, including the powers it reserves for itself and those it delegates to subcommittees and others
- stable and regularly attending membership (including non-executive directors) of a size appropriate to the requirements of the organisation
- appropriate balance between challenge and support, for example between executive and non-executive directors, and between governors and non-executive directors (where applicable)
- appropriate information flows supporting decision-making and the timely resolution of risks and issues
- that it operates within its terms of reference, and regularly reviews achievement against them.

The board's agenda is appropriately balanced and focused between:

- strategy and current performance (short term and long term)
- quality, operations and finance
- making decisions and noting/receiving information
- internal matters and external considerations
- business conducted at public board meetings and that done in confidential sessions.

Staff are clear on their roles and accountabilities.
Staff members understand the organisation's key quality, operational and finance priorities, and how their own goals and objectives contribute to the organisation's performance as a whole and how this is measured. Staff members understand they are accountable for delivering high quality, sustainable care, and optimising use of the organisation's resources. They are supported to identify and tackle obstacles in relation to these aims, escalating risks effectively.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W4.1 Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?

W4.2 Do all levels of governance and management function effectively and interact with each other appropriately?

W4.3 Are staff at all levels clear about their roles and do they understand what they are accountable for and to whom?

W4.4 Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care?

KLOE 5. Are there clear and effective processes for managing risks, issues and performance?

There is an effective and comprehensive process to identify, understand, monitor and address current and future risks.

Leaders across the organisation are able to describe the current and future quality, operational and financial risks that relate to their areas of work, and the plans to mitigate them.

Senior leaders can evidence that the organisation has effective, timely, horizon-scanning, scenario-planning and reporting processes so that it is sufficiently aware of changes in the internal and external environment (including risks from the wider local health and care economy) that may affect delivery of strategy and/or affect quality and financial sustainability.

Senior leaders can evidence that a board assurance framework and dynamic risk registers are in place and assessed by the board at least quarterly and demonstrate:

- attention to both internal and external risks, and their impact on planning
- a robust process for collating, evaluating, quantifying and reporting key risks
- a clear understanding of the board's risk appetite and tolerance, which is reviewed regularly (at least annually) and appropriately communicated to staff
- a commitment to learning lessons from inquiries (for example, safeguarding lessons from the 2015 Savile review), internal and external reviews of their own organisation, and of other organisations, and sharing this learning with staff, patients and the public.

Senior leaders can evidence that there is a clear risk management process understood by staff members, including the board, its subcommittees and subgroups, so that they identify, assess, understand, assign responsibility for and act on risks relevant to their area of responsibility. This includes internal escalation and external escalation if the risks affect other organisations.

Senior leaders can evidence that emergency preparedness/crisis management planning has been carried out and there is a robust business continuity plan.

Financial pressures are managed so that they do not compromise the quality of care. Service developments and efficiency changes are developed and assessed with input from clinicians so that their impact on the quality of care is understood.

Senior leaders can evidence that service development or efficiency initiatives:

- are developed with relevant stakeholders (especially service users, their carers, clinical and operational staff), with due regard to the public sector equality duty.
- make use of relevant published research, evidence, benchmarking data and operational experience
- identify measures and early warning indicators to be monitored during and after implementation, with an associated risk management plan
- are assessed consistently according to their impact on quality and sustainability, including the cumulative and aggregate impact of smaller schemes on patient pathways or professional groups
- are monitored during implementation and afterwards, with mitigating actions taken if necessary.

The organisation has the processes to manage current and future performance.

Senior leaders can evidence that there is a performance management system for quality, operations and finance across all departments, which comprises:

- appropriate performance measures relating to relevant goals and targets
- reporting lines within which these will be managed, including how this will happen across teams (for example finance and operations)
- policies for managing/responding to deteriorating performance across all activities, at individual, team, service-line and organisational levels, with clear processes for re-forecasting performance trajectories
- a programme or portfolio management approach that allows the co-ordination of initiatives across the organisation, and with external partners as required
- a clear process for identifying lessons from performance issues and sharing these across the organisation on a regular, timely basis
- clear processes for reviewing and updating policies regularly to take account of organisational learning, and changes in the operating environment and national policy.

Performance issues are escalated to the appropriate committees and the board through clear structures and processes.

Senior leaders can evidence that there are clear processes for:

- escalating quality, operational and financial performance issues through the organisation to the relevant committees as part of and outside the regular meeting cycle as required, linked to the organisation's risk matrix and consistent with the organisation's risk appetite.
- creating robust action plans, with clear ownership, timeframes and dependencies, all of which are monitored and followed up at subsequent meetings until they are resolved.

Senior leaders can further evidence that:

- these processes are effective
- the appropriate individuals/management levels are aware of the issues and are managing them through to resolution
- themes arising from the most frequent risks and issues are analysed to identify barriers that need to be removed to drive improvement.

Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve concerns.

Senior leaders can evidence that there is a clear, co-ordinated, continuous programme of clinical audit, peer review and internal audit, overseen and challenged by the board, which:

- aligns with priorities identified from risk intelligence and/or gaps in other assurance.
- competent individuals or teams (as appropriate) carry out to meet the needs identified
- is oriented to action, to address gaps from the audits in a timely manner and monitor them to ensure they are driving improvement
- ensures learning from the audits is shared across the organisation to facilitate wider improvement.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W5.1 Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?

W5.2 Are there processes to manage current and future performance? Are these regularly reviewed and improved?

W5.3 Is there a systematic programme of clinical and internal audit to monitor quality, operational, and financial processes, and systems to identify where action should be taken?

W5.4 Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?

W5.5 Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?

W5.6 When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?

KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?

Quality and sustainability both receive sufficient coverage in relevant meetings at all levels.

Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary.

Senior leaders can evidence that the board, its committees and subgroups as a core part of their meetings:

- receive and discuss information covering quality, operations and finance**,** and their inter-relationships; each committee's particular focus arising from its terms of reference
- appropriately challenge and interrogate the information and assumptions presented to inform decision-making, making use of benchmarking and other external sources as appropriate

Senior leaders can evidence that core financial information is presented and robustly challenged throughout the organisation. This information is presented in the context of non-financial information, risks and mitigations, and there is a balance between actuals and projections, detail of cost and income categories, granularity of divisional/ locality/ business unit information, and links with operational drivers.

Senior leaders can evidence that service line reporting approaches (ideally at patient level) are used for financial reporting and patient level costing has been or is being implemented.

Integrated reporting supports effective decision-making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people, with quality, operational and financial information.

Senior leaders can evidence that the reporting approach integrates quality, operations and finance, appropriate to the size and complexity of the organisation. The board, its committees and sub-committees, use it to:

- ensure that the impact of all service development and efficiency programmes is understood on the quality and sustainability of all relevant areas of the organisation before decisions are made
- understand areas of good and under-performance
- support evidence-based decision-making, using sensitivity analysis where appropriate

Senior leaders can evidence that there are monthly dashboards covering the most important indicators for the scrutinising committee. These dashboards are used effectively and:

- present the most recent (or recent enough to be relevant) data available
- where appropriate give preference to absolute data over relative data
- present both information for improvement and for assurance:
    - **measurement for improvement** means that data is presented using appropriate statistical methods to enable tracking of processes, balancing measures and outcomes over time, paying attention to variation rather than simply comparing against targets and thresholds at particular times
    - **measurement for assurance** means information is compared with target levels of performance (along with a red-amber-green rating), historic own performance and external benchmarks (where available and helpful).
- are frequently reviewed and updated to maximise effectiveness of decisions; and where useful metrics are lacking, the board commits time and resources to developing new metrics
- form a pyramid of reports, with increasing granularity that can be used to understand individual, business unit, service line, divisional and organisational performance as required.

Performance information is used to hold management and staff to account.

Senior leaders can evidence that there are quality, operational and financial reporting procedures, which provide robust information on organisational performance and enable key strategic and operational risks to be identified and managed. This information can be accessed by any staff members who require it for their work.

Senior leaders can evidence that the board, its committees and subcommittees regularly use information to understand and support the improvement of all areas of the organisation, including qualitative/ narrative text to explain outlying performance alongside the agreed metrics. This includes performance information relating to:

- divisions, localities, service lines and clinical units
- across patient pathways, internal and external
- the organisation's strategy and any associated plans.

Senior leaders can evidence that they make use of relevant indicators in relation to the people or the human resources (HR) strategy, for example:

- safe staffing
- workforce capacity and capability to deliver the future strategy
- intelligence on values, behaviours and attitudes
- HR health indicators, including information on equality and diversity
- performance appraisal, training and development; and leadership.

The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.

Senior leaders can evidence that the information the board, its subcommittees and subgroups receive comes from reliable and suitable sources and covers an appropriate mix of qualitative and quantitative intelligence.

Senior leaders can evidence that there are robust and reliable processes, systems and controls for producing the information covering data collection, checking, processing and reporting, which are captured in clear standard operating procedures.

Senior leaders can evidence that arrangements for supporting how performance indicators are prepared and reported are reviewed regularly.

Information technology systems are used effectively to monitor and improve the quality of care.
Senior leaders can evidence that, through dedicated chief information officer and chief clinical information officer leadership, the organisation is delivering higher quality, more effective and lower cost care through effective use of information technology (IT), data and analytics. Senior leaders can evidence that the organisation is constantly looking to learn from others – both nationally and internationally – on how best to identify and exploit the opportunities that IT, data and analytics provide to monitor and improve the quality of care. Senior leaders can evidence a mature understanding of the role of digital technology as a change management and improvement mechanism to transform operating procedures and care delivery models. Senior leaders can evidence that IT adheres to the latest standards of cyber security to minimise risk to patient care and organisational reputation. Senior leaders can evidence that the organisation's IT adopts all of the relevant data and information standards, enabling accurate timely and comprehensive use of data across the enterprise and effective sharing with trusted partners across the local health and care system. Staff members understand the benefits of working 'paper-free' and have sufficient understanding of the role of IT, data and analytics to improve patient outcomes, organisational and system sustainability. Staff members demonstrate confidence in the use of IT, data and analytics relevant to their roles to support patient care.

Data or notifications are consistently submitted to external organisations as required.
Senior leaders can evidence that the relevant departments understand the routine and exceptional data requirements of external bodies. Senior leaders can evidence that there are appropriate and effective mechanisms for the collection, preparation and sign-off of the necessary information on routine and exceptional bases to support timely delivery to external organisations.

There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
Senior leaders can evidence that there are an information governance (IG) framework and documented processes and procedures to support the co-ordinated and integrated care through appropriate and lawful information-sharing and the effective management of records. Senior leaders can evidence that the organisation is able to maintain the confidentiality and security of the personal confidential data it processes and all reasonable care is taken to prevent inappropriate access, modification or manipulation of that data. This includes ensuring there are arrangements to: • secure against unauthorised access to data • safeguard against unauthorised modification of data • make readily accessible the required data to authorised users only.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W6.1 Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?

W6.2 Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and challenge it appropriately?

W6.3 Are there clear and robust service performance measures, which are reported and monitored?

W6.4 Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?

W6.5 Are information technology systems used effectively to monitor and improve the quality of care?

W6.6 Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?

W6.7 Are there robust arrangements (including appropriate internal and external validation), to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?

KLOE 7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture.

Staff members are committed to actively seeking the views of patients, service users, carers and the public, both directly and via other groups (such as local Healthwatch organisations, patient representative groups, members and governors (where appropriate)) through a variety of channels and with due regard to the public sector equality duty.

Senior leaders can evidence that these views, including those received as concerns and complaints, are regarded as a way to understand and improve performance, and routinely used to inform service development.

The board receives and reviews quantitatively and qualitatively analysed data at least quarterly, triangulated with other risk intelligence, and addresses any risks or development areas identified.

Senior leaders can evidence that the organisation communicates to the public fully, regularly, and in accessible ways:

- the decisions taken by the Board and the rationale for them
- performance measures and outcomes that include objective coverage of both good and bad performance.

For foundation trusts, senior leaders can evidence how governors are enabled to hold the non-executive directors individually and collectively to account for the performance of the board of directors and to represent the interests of NHS foundation trust members and of the public.

The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture.

Senior leaders can evidence that staff at all levels are actively involved in planning and delivery of significant service developments in a variety of ways and with due regard for the public sector equality duty. Senior leaders can evidence how staff input has influenced plans.

Continues...

Staff members can describe how they are encouraged to feed back, through a variety of channels, on an ongoing basis as well as through specific mechanisms. This will include but is not limited to an annual staff survey.

The Board reviews quantitatively and qualitatively analysed data, triangulated with other risk intelligence (such as complaints, incidents), and addresses any development areas identified. Senior leaders can evidence how stakeholder input has influenced plans.

The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.

External stakeholders describe working relationships with the organisation as positive, underpinned by trust, respect and co-operation.

Senior leaders can evidence that there are appropriate and effective mechanisms to enable the organisation to work proactively with local health and care system partners to:

- build a shared understanding of population health, patient needs and system challenges
- design improvements to create long term sustainability.

Senior leaders can evidence their commitment to developing positive and effective working relationships with local health and care system partners by:

- dedicating appropriate face-to-face time to working with counterparts in other organisations to build trusting relationships
- regularly attending systems meetings from staff with appropriate capacity, experience and seniority
- engaging external stakeholders in formal internal governance committees where appropriate
- proactively seeking and acting on feedback on the quality of these relationships (for example through 360° stakeholder surveys)
- co-operating constructively with third parties with specific roles in relation to the organisation (such as commissioners and other providers).

Senior leaders can evidence that the organisation responds with flexibility and agility to changes in the local health economy, and takes part in pooled activities which may include:

Continues...

- common quality improvement (QI) approach
- pooled transformation and improvement resources
- trust-building efforts for finance, clinicians, etc
- delegated decision-making
- local area talent management planning and leadership development
- local health economy plans delivery groups

Senior leaders can evidence that the organisation proactively engages and shares data openly on relevant quality, operational and financial performance with all major external stakeholders (including health and local authority commissioners, Health and Wellbeing Boards, Healthwatch, patient groups and MPs).

Senior leaders can evidence that the organisation's decision-making is transparent, and the processes in place enable stakeholders, including commissioners, to find out easily how and why the board has made key decisions in addition to responding to freedom of information requests.

Staff members proactively engage with relevant delivery partners (general practitioners, local authorities, third sector providers, other community, mental health, acute and specialist providers) to identify improvement opportunities, performance or resourcing issues and to ensure overall quality along pathways.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W7.1 Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?

W7.2 Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?

W7.3 Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected equality characteristic?

W7.4 Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?

W7.5 Is there transparency and openness with all stakeholders about performance?

KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.

Leaders across the organisation can articulate and demonstrate their commitment to the organisation's improvement approach, across quality, operations and finance functions by:

- taking a proactive approach to innovation and improvement, including active engagement in the delivery of initiatives (some initiatives could be led personally by individual board members)
- setting realistic but stretching performance objectives for the organisation
- encouraging learning from sector, national and international best practice, the creation of best practice where it doesn't exist and sharing back learning widely.

Senior leaders can evidence how they create a safe and hospitable environment for experimentation and learning, by:

- seeing failure not as a negative but as learning that can be embedded in future practice to deliver performance improvement
- taking time out to identify and act on the board's own successes and failures
- demonstrating how reviewing quality, operational and financial information has resulted in actions that have successfully improved performance.

There is knowledge of improvement methods and the skills to use them at all levels of the organisation.

Senior leaders can evidence that they actively encourage the use of a standardised improvement methodology embedded across the organisation to improve the quality, efficiency and productivity of services. This can be any method chosen by the organisation.

Board members demonstrate at least a basic awareness of the key improvement concepts (such as variation and system thinking) and can show how they have used these in improvement initiatives (such as understanding performance in terms of variation).

Continues...

Senior leaders can evidence that quality/continuous improvement training is offered to staff at all levels, and staff with appropriate leadership and analytical skills are available to lead and support improvement and innovation.

Staff members demonstrate their confidence and competence by improving their services involving patients and carers, and by sharing their skills with others though coaching and training.

The service makes effective use of internal and external reviews, and learning is shared effectively and used to make improvements.

Senior leaders can evidence how the organisation has learned from internal and external reviews and the effectiveness of its response to recommendations from external auditors and assessors.

Senior leaders can evidence how, where appropriate, external support networks and expertise are used to support ideas for development and improvement (for example use of benchmarking, working with patient groups, participating in peer learning networks on a range of topics, linking with healthcare providers and other improvement interventions and tools).

Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.

Senior leaders can evidence that:

- staff are clear about their personal priorities and objectives
- managers give timely and balanced feedback about progress towards objectives
- staff and teams are able to review these objectives against information and data
- there are appropriate and effective mechanisms for teams to work together to resolve problems, review team objectives, processes and performance on a regular basis.

There are organisational systems to support improvement and innovation work, including staff objectives, rewards, data systems and ways of sharing improvement work.

Senior leaders can evidence that there is an improvement strategy that promotes the adoption of the chosen improvement methodology and ensures it is reflected in the organisation's systems and processes. This means that:

- improvement is seen as the way to address performance in teams, between teams, or along pathways as appropriate
- staff objectives and appraisal processes include innovation and improvement
- improvement and innovation successes are celebrated throughout the organisation and learning is shared widely in the organisation, with other organisations in the health and care system, and more widely though contributions to conferences and journals.

Senior leaders can evidence that all staff members are supported to carry out improvement work with:

- appropriate resources (time and money) to deliver the projects they identify
- timely access to the data they need (such as service line data), the tools they need to analyse it (such as templates or software to generate statistical process control/run charts, etc) and analytical expertise to support them if required.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W8.1 In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?

W8.2 Are there standardised improvement tools and methods, and do staff have the skills to use them?

W8.3 How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?

W8.4 Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?

W8.5 Are there systems in place to support improvement and innovation work including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?

Annex A: Scoping your developmental review

This annex summarises some points you should consider in preparing for a review. It is not exhaustive, but should help to start the process.

Scope of the review

The scope of developmental reviews should cover the eight KLOEs in this guidance at an appropriate level. There may also be development areas the provider is aware of outside the framework arising from, for instance, internal and/or external audit review findings, or information from the annual governance statement and the corporate governance statement. The board should tailor the scope, or place emphasis within the review accordingly.

Self-review

Purpose of regular self-review

The purpose of regular self-review is to promote self-knowledge, reflection and vigilance, and the development and improvement of leadership and governance. It helps providers identify their strengths and development areas to deliver continuous improvement. High performing providers are likely to carry out some form of self-review of their leadership and governance regularly and frequently.

As with the scope of the developmental review, boards are responsible for setting the scope of regular self-reviews, but we suggest they should cover the full scope of the well-led framework at an appropriate level. Ideally, self-reviews will be carried out annually but providers should determine this for themselves.

Completing self-reviews

A nominated provider lead or team may co-ordinate the self-review but it should be completed and signed-off by the full board. In practice, this could mean that a nominated board member works with the board secretary and

their staff to gather the information and the evidence against each question and present their findings and initial conclusions to the board for discussion and challenge. The whole board is responsible for arriving at an overall conclusion.

The output of the self-review will include the self-review questionnaire (or equivalent), ratings and rationale for the ratings. This information may help inform the CQC well-led provider information request as part of the regular regulatory assessment process, but supplying the full self-review is not mandatory.

Preparation for development reviews

Self-review is an important first step in preparing for externally facilitated developmental reviews. Providers should assess themselves to provide insight for themselves and the external facilitator into how they gauge their own leadership and governance performance and identify any particular areas of interest or concern either within or outside the eight questions.

A good self-review should help identify where the provider needs to focus and therefore inform the choice of external reviewer.

During a developmental review, the self-review should be presented to the external facilitator for comments and further discussion. The reviewer will then agree areas for further scrutiny with the board.

Rating the self-review

Each of the KLOEs should be rated using a scheme that allows prioritisation of findings and escalation of concerns, informed by the good practice examples in the framework. Each judgement should be backed up by evidence where appropriate.

Rating will aid prioritisation and ensure that issues are brought to the attention of the board. Boards should ensure that their approach facilitates continuous improvement rather than a compliance mindset. The reviews should not be about ‘meeting a bar’, but rather about prioritising improvement actions.

Key line of enquiry	Priority rating	Explanation of self-rating assessment	How is the board assured? Evidence for assessment	What are the principal actions/areas for discussion with your external review team
1. Is there the leadership capacity and capability to deliver high quality, sustainable care?				
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?				
3. Is there a culture of high quality, sustainable care?				
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?				
5. Are there clear and effective processes for managing risks, issues and performance?				
6. Is appropriate and accurate information being effectively processed, challenged and acted on?				
7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?				
8. Are there robust systems and processes for learning, continuous improvement and innovation?				

Annex B: Commissioning an external facilitator

This annex sets out what to consider when choosing an external team to facilitate developmental reviews against this framework.

Boards need to assure themselves that the appointed external facilitator is independent and able to provide a robust and reliable judgement of a provider's leadership and governance.

As part of the commissioning process, facilitators should also demonstrate:

- a clear and concise understanding of the purpose and objective of the review; knowledge of how to carry out a rigorous leadership and governance review, covering the specific areas detailed in the well-led framework; and the ability to use an appropriate range of tools and approaches
- relevant skills and experience, including:
    - credibility and experience in carrying out leadership and governance reviews at healthcare providers; ideally, the selected team will be multidisciplinary with a broad range of skills relevant to all aspects of board leadership and governance, such as strategic planning, quality governance, cultural assessment, organisational development and management information and analysis
    - experience in supporting healthcare providers to develop their leadership and governance with an understanding of continuous quality improvement and methodologies
    - knowledge of the healthcare sector, and the internal and external challenges faced by providers
    - knowledge of the regulatory framework the provider operates in
    - an ability to manage the review process: reviewers should provide a credible and detailed plan of the proposed project governance regime including the approach to the quality assurance of the work, risk

management, reporting and escalation lines, and evidence of clear leadership for the work with a named individual.

- named personnel (and CVs in the response), and clarity about their role and what they will do during the review.

Peer review input

Our ambition is that, over time, making use of and participating in developmental reviews will become an integral part of the role of senior leaders across the NHS. This is one of the main ways in which we can share the valuable learning, experience and ideas within the NHS leadership community and make it accessible to everyone, across our organisations.

This ambition will take some time to realise, but as a first step, we encourage providers where possible to involve, or to select suppliers who offer to involve, appropriately skilled peer reviewers as part of the external facilitation team. We will be providing further support and guidance about this in due course.

We will also be compiling a list of peer reviewers and this list will be available on request. We will include details about this on our website later this year. https://improvement.nhs.uk/resources/well-led-framework/

Annex C: Carrying out a developmental review

This annex sets out:

- potential methods of carrying out a review
- the process of prioritising and rating your findings
- action-planning.

There is no 'one size fits all approach' to developmental reviews: we encourage providers to think about how to shape the methodology to support their needs. Providers are responsible for commissioning these reviews and so should assure themselves that the review tools and methods are suitable for their circumstances.

Because of this, the guidance below provides examples of tools and is not prescriptive. Experienced reviewers can use their own tools and methods.

Prioritising and rating findings

The findings from the review will usually be presented in a report for the board, covering methodology, scope, findings, and areas of good practice or weakness against which to plan developmental actions. It is important that issues or concerns are prioritised but plans for maintaining good practice should also be considered.

We encourage providers to agree the format in which they would like the findings to be presented at the start of the review process.

Action-planning

The board is ultimately accountable for delivering improvements, and so action-planning should involve the whole board. The board should consider how to track actions and the timeframe for resolution. Developmental reviews are most useful where issues are resolved in a timely manner.

NHS Improvement has a range of support offers (see Annex D) that boards may draw on when addressing issues.

Examples of tools

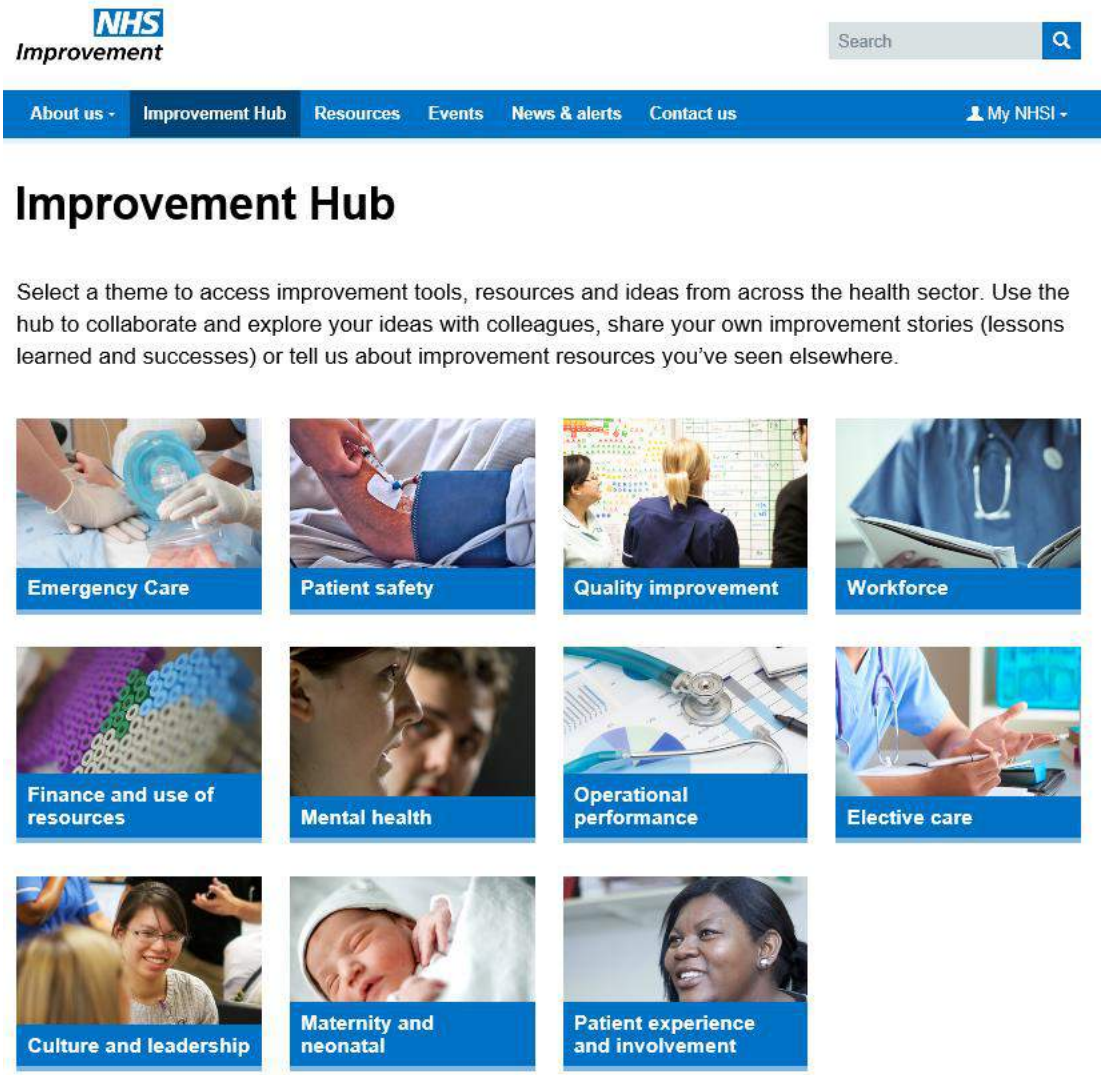
Tool	Suggested components	Purpose
Desktop document review	Board and key subcommittee agendas, minutes and papers; board assurance framework; audit reports; strategic documents, eg the provider's strategy and business plan, quality strategy, quality improvement plan and people strategy; and internal/ external audit reports, annual governance and corporate governance statements, alongside any other relevant reviews.	To provide a view of: • how ongoing issues and risks in the provider are communicated and managed • the quality of information produced to support decision-making • how the board prioritises issues at the provider and divides its attention.
One-to-one interviews	All board members, the trust secretary, lead governor, head of quality governance, head of workforce, clinical directors and heads of business units, and local stakeholders (including clinical commissioning groups and patient representatives).	To gain individuals' views of the provider's governance and to provide a 'safe' environment in which to explore issues and discuss sensitive information, as appropriate.
Stakeholder surveys	Staff and patient groups, commissioners and providers	To get internal and external parties' views of the provider's governance to cross-reference with the board's own views and test the board's awareness.
Focus groups with internal and external stakeholders	Staff, patient groups, commissioners, contracted or outsourced suppliers	To get internal and external parties' views of the provider's governance to cross-reference with the board's own views and test the board's awareness.

Tool	Suggested components	Purpose
Board and subcommittee observations	Observations of at least one board meeting and relevant subcommittees, including audit and quality.	To identify the dynamics of the board, including agenda management, depth and breadth of information used to make decisions and progress priorities, and the way they challenge and hold each other to account for the leadership of the provider.
Board skills inventory	Matching skills to the requirements of the board's work and identifying any gaps.	To ensure the board has the skills and experience needed.
Board self-assessment	Board members to rate how effective they believe the board is.	To provide a view of how effective the board believes itself to be.
Peer practices	On areas of governance in the sector, in similar organisations or providers.	To assess how the provider compares against any known examples of particularly effective and robust governance practices.

Annex D: Accessing support and further reading

New support offers are available all the time. The easiest way to find out about them is to visit the Improvement Hub: https://improvement.nhs.uk/improvement-hub/

This includes resources from across the NHS, as well as discussion forums and case studies.



Further reading

Good governance practice

British Quality Foundation (2013) EFQM Excellence Model

Committee on Standards in Public Life (1995) The 7 principles of public life

Department of Health (2011) Board Governance Assurance Framework for Aspirant Foundation Trusts

Department of Health (ongoing) Information Governance

NHS Providers and DAC Beachcroft (2015) *Foundations of Good Governance: A Compendium of Best Practice* (3rd edition)

NHS Leadership Academy (2013) *The Healthy NHS Board 2013: Principles for Good Governance*

NHS England (2017) Managing Conflicts of interest in the NHS

Reviews and investigations

Department of Health (2016), Operational productivity and performance in English NHS acute hospitals: Unwarranted variations (Lord Carter)

Department of Health (2014), Examining new options and opportunities for providers of NHS care: The Dalton Review

Department of Health (2014) Better leadership for tomorrow: NHS Leadership Review. (Lord Rose)

Francis, R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

Lampard K., Marsden E. (2015) Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile

National Advisory Group on the Safety of Patients in England (2013), A promise to learn – a commitment to act: Improving the safety of patients in England

National Improvement and Leadership Development Board (2016) Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services

Smith, E. (2015), Review of centrally funded improvement and leadership development functions, Final report of review on behalf of NHS England, Monitor, NHS Trust Development Authority, Health Education England, Public Health England and the Care Quality Commission.

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This publication can be made available in a number of other formats on request.

Board of directors report cover-page				
References				
Meeting title:	**Board of Directors**			
Meeting date:	**07 09 17**	**Agenda reference:**	**158-17**	
Report title:	**Board committee effectiveness**			
Sponsor:	Clare Pirie, Director of Communications and Corporate Affairs and			
Author:	Hilary Saunders, Deputy Company Secretary			
Appendices:	None			
Executive summary				
Purpose:	The purpose of this paper is to seek Board approval for implementation of a rolling programme of committee evaluations.			
Recommendation:	The Board of Directors is asked to **APPROVE** implementation of the proposed evaluation programme			
Purpose:	**Approval**			
Implications				
Regulation:	FT Code of Governance			
Legal:	None			
Resources:	None			
Assurance route				
Previously considered by:	Executive management team			
	Date:	12 07 17	Decision:	Approved
Next steps:	Providing this proposal meets board approval, the programme will take immediate effect.			

Report to: Board of Directors
Meeting date: 07 September 2017
Reference number: 158-17
Report from: Clare Pirie, Director of Communications and Corporate Affairs
Author: Hilary Saunders, Deputy Company Secretary
Appendices: Appendix A: timetable
Report date: 23 August 2017

Board committee effectiveness

Purpose

The purpose of this report is to gain Board approval for a programme of annual self-assessments for its five committees, including QVH Charity.

Background

To comply with the FT Code of Governance, and aligned to the 'Well-led' review which the Trust is about to launch, the Board is required to undertake an annual evaluation of its own performance and that of its committees and individual directors. The Code also requires that details of this evaluation are included in the Annual Report and Accounts.

In June, the Audit committee approved a framework for a review of its effectiveness and the adequacy of its terms of reference and work plans.

At the same meeting, the committee asked the Executive Management Team to consider ways in which assurance could be provided for the Board's remaining committees. Concerns had been raised regarding the practicalities of running (potentially) five concurrent assessments. This would add undue pressure to already stretched resources, and could result in reviews being undertaken in a perfunctory manner, not achieving the desired purpose.

Proposal

The EMT has considered the options and would propose a 3-year rolling programme comprising full evaluations and light touch reviews in alternate years. The proposed timetable is shown as appendix A.

If approved, this programme will align to work of the 'Well led' review and also support the Board's annual evaluation of its own performance in the future.

Recommendation

The Board of Directors is asked to **APPROVE** its committees' programme of annual self-assessments.

Next steps

Assuming the Board approves this proposal, Committee chairs and executive leads will develop frameworks (formal and informal) for reviewing effectiveness, tailored to the individual committee's needs. Timings of self-assessments will be incorporated into work programmes.

Queen Victoria Hospital
NHS Foundation Trust

Appendix A

Programme of board committee self-assessments

Committee	2017		2018		2019		2020	
	Q1	Q3	Q1	Q3	Q1	Q3	Q1	Q3
Audit		Full		Light-touch		Light-touch		Full
Q&GC			Full		Light-touch		Light-touch	
F&PC		Light-touch		Full		Light-touch		Light-touch
N&RC			Light-touch		Full		Light-touch	
QVH Charity		Light-touch		Light-touch		Full		Light-touch